THERE WILL BE A PUBLIC MEETING OF THE BOARD OF DIRECTORS OF THE ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST

At 09:30 on Wednesday 31 January 2024
Boardroom, Noy Scott House, Royal Devon & Exeter Hospital

AGENDA

Item	Title	Presented by	Item for approval, information, noting, action or discussion	Time Est.
1.	**Chair's Opening Remarks**	Shan Morgan, Chair	Information	09:30 2
2.	**Apologies**	Shan Morgan, Chair	Information	09:32 1
3.	**Declaration of Interests**	Melanie Holley, Director of Governance	Information	09:33 2
4.	**Matters to be discussed in the confidential Board**	Shan Morgan, Chair	Noting	09:35 2
5.	**Minutes of the Meeting of the Board held 29 November 2023**	Shan Morgan, Chair	Approval (Paper)	09:37 5
6.	**Matters Arising and Board Actions Summary Check**	Shan Morgan, Chair	Information (Paper/Verbal)	09:42 5
7.	**Chief Executive's Report**	Sam Higginson, Chief Executive Officer Chris Tidman, Deputy Chief Executive Officer	Information (Verbal)	09:47 20
8.	**Patient Story**	Carolyn Mills, Chief Nursing Officer	Information (Paper)	10:07 15
9.	**Performance**			
9.1	**Integrated Performance Report**	Chris Tidman, Deputy Chief Executive	Information (Paper)	10:22 45
	COMFORT BREAK			11:07 10
10.	**Policy & Strategy**			
10.1	**Health Inequalities Strategy –**	Chris Tidman, Deputy Chief Executive	Approval (Paper)	11:17 30
11.	**Assurance**			
11.1	**Strategic Roadmap Update**	Chris Tidman, Deputy Chief Executive	Information (Paper)	11:47 10
11.2	**Board Assurance Framework**	Melanie Holley, Director of Governance	Information (Paper)	11:57 10

11.3	**Clinical Negligence Scheme for Trusts Maternity Return**	Carolyn Mills, Chief Nursing Officer Sally Bryant, Associate Director of Midwifery	Approval (Paper)	12:07 10
11.4	**Digital Committee**	Tony Neal, Non-Executive Director & Committee Chair	Information (Paper)	12:17 5
11.5	**Finance & Operational Committee**	Steve Kirby, Non-Executive Director & Committee Chair	Information (Paper)	12:22 15
11.6	**Governance Committee**	Martin Marshall, Non-Executive Director & Committee Chair	Information (Paper)	12:37 5
11.7	**Integration Programme Board**	Alastair Matthews, Non-Executive Director & Programme Board Chair	Information (Paper)	12:42 5
11.8	**Our Future Hospital Programme Board and Update on our Future Hospital Programme**	Steve Kirby, Non-Executive Director & Programme Board Chair	Information (Paper)	12:47 10
11.9	**Charity Committee Update –**	Alastair Matthews, Non-Executive Director & Committee Chair	Information (Paper)	12:57 5
12.	**Information**			
12.1	**Items for Escalation to the Board Assurance Framework**	Shan Morgan, Chair	Discussion (Verbal)	13:02 1
13.	**Any Other Business**			13:03
	At the conclusion of the formal part of the agenda, there will be an opportunity for members of the public gallery to ask questions on the meeting's agenda. Where possible, questions should be notified to members of the Corporate Affairs team before the meeting. Every effort will be made to give a full verbal answer to the question but where this cannot be done, the Chair will ask a director to make a written response as soon as possible.			
14.	**Date of Next Meeting:** The next meeting of the Board of Directors will be held at 09:30 on Wednesday 28 February 2024.			
15.	The Chair will propose that, under the provisions of section 1(2) of the Admission to Public Meetings Act 1960, the public and press should be excluded from the meeting on the grounds of the confidential nature of the business to be discussed.			

Meeting close at 13:13

MEETING IN PUBLIC OF THE BOARD OF DIRECTORS OF THE ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST

Wednesday 29 November2023
Boardroom, Noy Scott House, Royal Devon & Exeter Hospital

MINUTES

PRESENT	Mrs H Brazier	Trust Director (deputy for Chief Operating Officer)
	Mrs H Foster	Chief People Officer
	Professor A Harris	Chief Medical Officer
	Mrs A Hibbard	Chief Financial Officer
	Mr S Kirby	Non-Executive Director
	Professor M Marshall	Non-Executive Director
	Mr A Matthews	Non-Executive Director
	Professor T McIntyre-Bhatty	Non-Executive Director
	Mrs C Mills	Chief Nursing Officer
	Dame S Morgan	Chair
	Mr T Neal	Non-Executive Director
	Mr P Roberts	Interim Chief Executive Officer
	Mr C Tidman	Deputy Chief Executive Officer
APOLOGIES:	Mrs C Burgoyne	Non-Executive Director
	Professor B Kent	Non-Executive Director
	Mr J Palmer	Chief Operating Officer
IN ATTENDANCE:	Ms G Garnett-Frizelle	PA to Chair (for minutes)
	Mrs K Allen	Director of Strategy (for item 187.23)
	Ms C Baldwick	Deputy Medical Director, Eastern & Northern (for item 189.23)
	Mrs Z Harris	Divisional Director Community Services (for item 184.23)
	Mrs M Holley	Director of Governance
	Dr L Webb	Associate Medical Director Community Services (for item 184.23)

DRAFT

178.23	**CHAIR'S OPENING REMARKS**	
	The Chair welcomed the Board, Governors, staff and members of the public to the meeting. Ms Morgan reminded everyone it was a meeting held in public, not a public meeting and asked members of the public to only use the 'chat' function in MS Teams at the end to ask questions focussed on the agenda and reminded everyone that the meeting was being recorded via MS Teams. Ms Morgan thanked all the Governors attending, both in person and via Teams. **The Chair's remarks were noted.**	
179.23	**APOLOGIES**	
	Apologies were noted for Mrs Burgoyne, Professor Kent and Mr Palmer, noting that Mrs Brazier was attending on his behalf.	
180.23	**DECLARATIONS OF INTEREST**	
	Mrs Holley informed the Board that the following declaration had been received for Professor McIntyre-Bhatty: • Non-Executive Member, NHS Hampshire & Isle of Wight Integrated Care Board	

	• Governor, University for the Creative Arts • Chair, AIM Community Ltd (an educational charity) • Independent Reviewer, European Association for Quality Assurance in Higher Education (ENQA) **The Board of Directors noted the declaration.**	
181.23	**MATTERS DISCUSSED TO BE DISCUSSED IN THE CONFIDENTIAL MEETING**	
	The Chair noted that the Board would receive at its confidential meeting updates on Finance and Operational Committee and Cash Draw Down submission to NHS England.	
182.23	**MINUTES OF THE MEETING HELD ON 1 November 2023**	
	The minutes of the meeting held on 1 November 2023 were considered and approved.	
183.23	**MATTERS ARISING AND BOARD ACTION SUMMARY CHECK**	
	The Board of Directors noted and agreed the updates to actions.	
184.23	**CHIEF EXECUTIVE OFFICER'S REPORT**	
	Mr Roberts acknowledged the continued pressures in Urgent and Emergency Care (UEC), as well as in other services, adding that whilst there had been some days of good performance, No Criteria to Reside (NCTR) remained a significant issue blocking system flow. There had been discussion within the system on what could be done to boost capacity and a decision was still awaited on whether there was support for some of the additional things that had been suggested that would be outside the Winter Plan. There had also been discussions on how to reduce ambulance waiting times across the system. There had been good progress made on elective care, particularly considering the periods of industrial action. The Trust had had an invited visit from the regional cancer team on 28 November to look at progress on cancer services and an update on outcomes from that visit would be shared with the Board once received, although initial feedback was believed to be positive. Month 7 had been challenging for the organisation financially with a further move off plan from £11.3m to £17m. NHSE had required resubmission of reprofiled financial plans together with profiles of the impact of getting closer to the financial plan on Urgent and Emergency Care and Elective Care. Significant work was being undertaken to ensure there was better control over vacancy, better discipline around agency usage, programmes of work on non-pay expenditure and drug expenditure and to maximise recovery of income earned by the Trust, all of which would provide the potential to get closer to the original plan. There had been a good level of engagement with staff to understand the impact of the focus on financial management. <u>National Update</u> • Following the Government reshuffle, a new ministerial team was in place at the Department of Health. • The second round of public hearings in the Covid inquiry were underway with experts and Government officials giving evidence, with a focus on examining Government decision-making throughout the pandemic.	

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- The Terms of Reference for the Thirlwall Public Inquiry following the Lucy Letby case had been made public. The Inquiry was looking at the case and wider questions regarding NHS management, governance and culture.
- This year's vaccination campaign for flu and Covid was well underway with 42% uptake of the flu vaccination and 35.8% for the Covid vaccination to date.
- An announcement had been made by the British Medical Association that it would go out to ballot consultants on the possible pay deal.

System Issues

- NHS Devon had announced the appointment of Mr Steve Moore as its new Chief Executive Officer with a start date of February 2024.
- Professor Harris attended the Devon Health and Care Scrutiny Committee on 9 November 2023 to present the Trust's recent Care Quality Commission (CQC) report and improvement plan which were well received.

Local issues

- The two hospital charities would be merging from 4 December 2023 to become the Royal Devon Hospitals Charity. Staff have worked to develop a new identity for the charity that will make it more relevant and recognisable.
- It was announced in November 2023 that the Trust is the host organisation for the peninsula Research Delivery Network and, working together with the University of Exeter, £3m investment had been received to open a Centre for Healthcare Technology.
- Three teams of staff at the Royal Devon were nominated for national Health Service Journal awards. The team which had led a project to reduce the use of gases in anaesthetics that are harmful to the environment won the Toward Net Zero award.
- The CQC were currently on site to undertake an inspection of maternity services, with Eastern services being inspected on 29 November and Northern on 30 November.

Professor Marshall asked whether it was thought consultants would accept the proposed pay deal and was informed that local feeling was that they would accept. Mrs Mills noted that there were a number of communications coming through from the Royal College of Nursing on the disequity of the proposed settlement for consultants compared to the settlement for staff on Agenda for Change.

The Board of Directors noted the Chief Executive's update.

185.23 COMMUNITY STRATEGY

Mrs Harris and Dr Webb joined the meeting.

Mrs Harris summarised the following key points on work since the last Board discussion on community at the June meeting:

- Clear divisional priorities included focus on end of life, falls and frailty
- The Division had been closely involved in winter planning, with good progress on UEC funded schemes, urgent community response development, virtual ward and admission avoidance, complex discharge pathways, demand and capacity modelling with relevant escalations to the Integrated Care Board (ICB).
- There were some areas that were still a work in progress, including primary care, Devon Partnership Trust and mental health, and social care.
- There were six key asks of the Board contained within the paper. Board support would be very important to help the cultural shift that would be needed.

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Ms Morgan noted that the ICB had funded primary care to oversee patients in short stay Care Home rehabilitation beds, but were not providing funding for community services for these patients and asked for clarification of what that meant for the Trust. It was noted that the pathway 2 short stay Care Home rehabilitation beds were not additional beds, but were block booked, with 8 short stay beds in one Care Home enabling more effective support of those patients. The ICB had led a demand and capacity modelling exercise for pathways 1-3, with modelling for pathway 2 showing a need for an additional 56 short stay Care Home beds across North and East. The Local Negotiating Committee had advised on behalf of Primary Care that the additional work would be undertaken providing that Primary Care were paid for it and funding was made available for this, but the same had not been made available to the Trust and a risk assessment had been completed which clearly articulated that if existing community staff were redirected from rehabilitation to supporting the patients in short stay beds, there would be a significant impact on other patients in the community. This had been formally escalated to the ICB, but to date no formal response had been received. Ms Morgan advised she would be happy to raise this with the Chair of the ICB at their next one to one if this would be helpful. **Action.**

Mrs Foster asked whether the Trust was strategically partnered with the Third Sector, as there were many younger retirees in Devon who could be significant enablers if they were engaged with. Mrs Harris confirmed that the Trust worked with the voluntary sector at place level based in clusters, but that the voluntary sector had always had non-recurrent funding that they could rely on which was decreasing year on year so that the sector was no longer able to provide the help they would have previously.

Professor Marshall asked what the priorities were that would demonstrate community adding value to the whole system. In addition, he noted that the focus on the recommendation on place based multidisciplinary teams would require a significant change in working patterns with protected time to work in the community and working in partnership with consultants would be key. Ms Morgan agreed, adding that this would be a good topic for further discussion at a Board Development Day. **Action.**

Professor Marshall suggested that the Trust should be more explicit about its attitude to working with General Practice. Dr Webb advised that there was a significant piece of interface work being undertaken to look at how primary and secondary care communicate with an ambition to save up to 15% of primary appointments through improved communication, but relationship building would take time. Dr Webb was working with Castle Place Practice to use them to test and pilot initiatives. It would be important to include primary care in the strategy and to get more support from the ICB on dynamic risk assessment. Mrs Harris noted that the tender for GP provision for homeless people had come up recently and the Trust have been contacted about this.

Mrs Harris advised that there were six proposals in the report presented, with more support being requested for some, including on investment and finding creative ways of shifting resource and investment in additional geriatrician time. A further priority would be the new rehabilitation model to support people to focus on prevention.

Mr Neal noted the work on the virtual ward and asked how much further this could be developed. He also noted the work on end of life and asked what was being done to support patients who had expressed their wish to die at home. Mrs Harris responded that there had been a focus on training and upskilling staff across all community teams to support early identification of end of life in the last 12 months of life and provide support to patients and their families and carers to have advanced care planning conversations.

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The virtual ward had primarily been used for patients who had had contact with the acute trust and gone home with virtual ward support, but the model was changing and would become part of the Care Coordination Hub. In addition, a proposal was being taken through governance processes to look at Urgent Community Response being able to feed into the virtual ward, so that Teams would have more confidence to keep people at home with access to consultants and medical teams through the virtual ward. There was also work to be done with GPs on how they could use the virtual ward and there was an opportunity for it to be used in palliative care.

Mr Matthews commented that the report referenced an independent review by NHS Confederation of NHS spend which noted that on average systems that invested more in community care saw a 15% reduction in non-elective admission rates and 10% lower ambulance conveyance rates. He asked where the Trust would benchmark in this regard compared to the region and nationally and whether the Integrated Care System (ICS) would be looking at this. Mrs Harris agreed this would need quantifying; she had discussed with Business Intelligence colleagues who needed support to allow them capacity to work with the division on this. Mrs Hibbard reminded the Board that it had previously received a proposal on creating a shared business intelligence service, initially between the Trust and the ICB and that the management of change process was underway with the hope to TUPE ICB staff in February 2024, which would give access to their skill set, and in turn increase the capacity for Business Intelligence support to divisions.

Mr Matthews asked what challenges there were to having the capacity to retrain and attract the right skill mix of staff to deliver the vision outlined in the strategy and was advised that there were some staffing challenges due to rurality with some areas where it was more difficult to recruit and retain staff. However, bringing support workers in through apprenticeship schemes worked well, giving those staff training to support developing competencies. The model of care suggested required staff with a different skill set requirement, as they would need to be more experienced and competent to make difficult, quick decisions around risk appetite to keep patients at home. Teams have creative ideas regarding how to bring in staff to meet these needs, rather than continuing to recruit in the same way.

Mr Matthews asked what could be changed in the Integrated Performance Report to ensure focus on this, including where investment was needed. Ms Morgan suggested that metrics could be included for review on a six-monthly basis. **Action.** Mrs Harris said that she would continue to look at how to make information included in the IPR more useful and reflective.

Mr Tidman said that the community strategy aligned with the corporate strategy ambition to intervene early to avoid health inequalities, adding that a good economic evidence base was needed to show that long term investment in prevention could lead to reduction in admissions. This could be used to help build an independently verified business case to help support a shift within the system. Dr Webb said that there had been a shift in the culture but there was more that could be done, particularly on virtual ward take up in North.

Mrs Hibbard said that there had been a commitment in the financial strategy regarding guaranteeing flow of funding year on year, but the impact of 2023-24 on numbers was not yet known. She added that she had reflected on how to support community to be more visible in the system and she said that she believed the disadvantage of being an integrated Trust was that the ICB did not have to negotiate the funding for community. A full contract rebase for 2024-25 had been requested with a suggestion of community as a separate

DRAFT

	area for negotiation. The Team had been asked to do a detailed breakdown of cost for community services to provide a strong baseline for that negotiation. Mr Roberts said that there was a significant allocative efficiency argument to be made about community services, with a clear link to health inequalities work. In terms of NHS productivity, primary care was most successful and primary care should be a very strong feature of what was being proposed. Professor McIntyre-Bhatty agreed that the inequalities issue was critical and added that it would be worth looking at some elements of this area sooner to understand how to better integrate with primary care. It would also be important to mainstream what was happening with the voluntary sector and community to ensure everything was being done that could be. He noted comments about working with the ICB on investment in community and said that it would be important for the Trust to quantify what it wanted to do in terms of allocation. Mrs Hibbard agreed, adding that the Trust needed to be more assertive with the ICB on being paid for services that it delivered and to encourage the ICB to use surplus to support deficit organisations to make investments that will make a difference. Professor Harris noted the comments regarding a culture of non-admission and discharge that needed to be developed and said that this was not just to challenge with staff, but would also need to addressed with patients and families, as many would see the hospital as a place of safety. He added that this would need leadership and courage to take this forward and acknowledgement that it will be a time for learning and to do everything possible to make sure the right thing was done for patients and their families. Professor Marshall noted that there were benefits for the organisation as an integration Trust, adding that there was already evidence in existence to show that investment in primary and community services lead to good outcomes at lower cost. Ms Morgan thanked Mrs Harris and Dr Webb for their presentation and the discussion generated. The Board supported the vision, the need for a change in culture and being clear about what is the right place for patients, and the outline proposals subject to more detail and modelling. The Board had agreed that an evidence base would need to be drawn together and noted the role of the ICB and funding. A session would be scheduled for a future Board Development Day to discuss in more detail, including what the strategy would mean in practice, and a timescale for this would be agreed outside the meeting and a further presentation to a future Board meeting would arranged to look at next steps. **Action.** Mrs Harris and Dr Webb left the meeting.	
186.23	**PATIENT STORY**	
	Mrs Mills presented the Patient Story video to the Board which related to the Trust's strategic objective to strengthen Cancer Services and continue to deliver improvements in cancer pathways and diagnostic waiting times. The video featured a patient diagnosed with primary breast cancer in June 2021 and outlined her experience from various services, the benefits of being able to access results, reports and appointment through EPIC for patients and areas that the patient had found difficult. The patient had explained that it would have helped her if it had been explained at the start of the pathway that the proposed treatment might evolve and change over time. It had also been daunting after having had very close contact with clinicians for over a year during her to treatment to be discharged and she was not prepared for the sense of loss that she felt.	

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The patient's comments on areas where she felt things had not worked as well for her as they could have been were noted and it was suggested that the issue around changes in patient pathways could be explained in initial consultations, so that patients were aware that things may change. In addition, it was suggested that more signposting of services, such as those provided by the Force charity, could help patients feel less alone once discharged at the end of treatment.

Mrs Mills said that the story would be shared with the Team to reinforce messages, noting that it reflected the findings in the National Cancer Survey which was on the agenda.

The Board of Directors noted the Patient Story.

187.23 INTEGRATED PERFORMANCE REPORT

Mrs Foster presented the Integrated Performance Report for October 2023 with the following points highlighted:

- There had been further industrial action during the early part of October 2023, however the trajectory for elective had remained on track.
- The position in urgent care remained challenging, with attendances at the highest level for the year to date.
- GP streaming had been reinstated on both sites.
- The Trust had written to the ICS to advise that NCTR had not improved as much as expected in the plan, with lack of confirmation of funding a concern.
- Cancer remained challenging. Diagnostics were ahead of plan, however there was a long way to go to achieve the target of 85% by the end of the year. Work had been undertaken to look at length of wait across both sites to see what could be done to equalise this, which would mean patients travelling.
- There was continued focus on safety and finance and balancing risks.
- There had been significant improvement in closing complaints, with the highest number closed since April 22.
- Finance remained off track in month 7, and the deficit position and risk had increased as a result. A financial recovery programme had been put in place at the end of October, with further additional controls being put in place since then.
- Recruitment and retention figures remained good, although some new recruits had taken longer to settle into roles, meaning agency had not reduced as much as hoped. However, there were now additional, very robust controls in place around agency and recruitment. Patients with additional needs, including mental health patients needing specialling, had contributed to increased agency spend.
- Focus remained on wellbeing for staff.

Ms Morgan asked if there were any trends noted about the kind of complaints being received and was advised that there was a general rise in complaints but no particular trends had been noted for the month, with the main theme remaining communication. Professor McIntyre-Bhatty asked whether the data regarding complaints would be looked at in detail by the Patient Experience Committee, including whether there were any particular clusters of complaints about particular areas, departments or individuals. Mrs Mills responded that the Board had previously discussed how it could be sighted on the level of detail and membership of the Patient Experience Committee had been reviewed to include three Non-Executive Directors. In addition, a quarterly report would be circulated to Board members outside formal Board meetings to provide assurance that the detailed review was taking place.

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Ms Morgan noted that one of the risks/threats on the Balanced Scorecard was “Balancing Devon System support with the demands of Urgent and Emergency Care and Elective Recovery Tier 1 performance” and asked whether this related to the support being provided to the wider system for ambulance diverts. Mr Roberts responded that discussions were taking place regarding this and that there was an acceptance that there would almost certainly be reallocation of ambulance conveyancing due to the position in Plymouth and Torbay. The aim was to find an agreed way of looking at relative risk between the acute Trusts within the system, as this was not currently in place with judgements being made by the ambulance Trust based on how many ambulances were outside, rather than what was happening inside the hospital. There needed to be better understanding of what progress was being made in Plymouth and Torbay on some of the fundamental issues that were impacting this. Finance would be part of the equation, with the proposals that had previously been forward to close the bed gap in the Winter Plan, but a response had not yet been received relating to this.

Mr Matthews noted that the bed gap to be closed in the Winter Plan assumed getting to 5% on NCTR, however this remained off track. If this was not resolved, the consequence appeared to be loss of elective capacity and income and he asked whether thought needed to be given to proactively reprioritising some elective activity. Mrs Brazier said that efforts were underway to ringfence elective Orthopaedic wards and increase day surgery rates and the additional funding that was being sought for investment in other schemes would help with this. An action plan had been developed with the support of the ICB on NCTR, and although time to transfer had improved, demand continued to increase. Daily review was undertaken. Mrs Hibbard said that in terms of loss of income, the comparison was to 2019-20 threshold where elective activity would also have been cancelled to a significant degree as this was before ringfences were in place. Therefore, the challenge to earn the income was less because of this profiling. Mr Tidman suggested that a follow-up should be sent to the system advising that there was a concern that the 60-bed gap was probably understated in terms of where NCTR was to add more weight to the request. **Action.** Professor McIntrye-Bhatty said that although there were a lot of actions outlined with the ICS, they would not necessarily have the impact wanted. Mrs Brazier said that although there were actions to try and improve NCTR which could have an impact, a decision had not yet been given on whether funding would be available. Mr Roberts added that a set of proposals for further investment had previously been circulated for information and they could be recirculated. **Action.**

Mr Matthews noted that there had been a plan to undertake around 5000 inpatient operations by this point with only around 60% completed and asked what the plan was for managing this, as there could be a build-up of more complex patients that needed to be inpatients rather than managed through Day Case. Mr Tidman said that the vast majority of elective work was day case; there was regular review and there was no evidence that complex cases were building up.

Mr Matthews noted that the IPR stated that the clinical lead in East looked at all fractured neck of femur cases that were not done within 36 hours to review the clinical impact but did not state that this was also done in North and asked for clarification. Mrs Brazier confirmed that this was also undertaken in Northern services.

There was discussion of agency and locum usage and Mrs Foster advised that there were actions in place but there was often a long tail on recruitment. Mrs Hibbard added that the Trust was currently over the agency cap. She added that linkages between the workforce trajectory and planning were being looked at for 2024-25 planning.

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	Mr Neal noted the continued increase in Accident and Emergency (A&E) attendances and asked if there were steps in place to challenge the formula. Mrs Hibbard confirmed that the Trust was on block contract for this year for A&E attendances for 2023-24. She added that the contract rebase she had previously mentioned needed to be done across all activity with growing appetite to do this across the ICB, however the difficulty would be projecting what growth to put into the contract for the upcoming year. Mr Neal noted that there had been an incident of major harm from delay in follow-up relating to Ophthalmology Services which was being investigated and asked whether a review of triage of the waiting-well list was needed. Professor Harris advised that investigation of this case was ongoing, however there were Failsafe Officers whose role it was to scrutinise the Ophthalmology waiting list to ensure that errors of this kind were not made. There had been a system error, with the individuals being asked to take on some additional work leading them to not scrutinise the lists to the level that would be expected and they had now been retasked to do this. Professor Marshall asked how improvements in recruitment had been achieved, whether improvements had been seen across the whole of the NHS and whether the Government's immigration policy might impact this going forward. Mrs Foster said that the Trust had put in work to accelerate recruitment processes the previous summer which had paid dividends in reducing time to hire etc. Retention had improved across the NHS due to a number of reasons, including the pay settlement and changes in the wider economy, as well better recruitment from within the local economy. International recruitment was reducing, as there was a clearer idea of the pipeline for future requirements. Mrs Mills added that international recruitment had formed an important part of recruitment for the year, with a further cohort arriving in December 2023 and one planned for 2024. Work was being undertaken to look at options for strategic workforce planning for nurses, midwives and allied health professionals. She added that international recruitment, even taking account of supernumerary time, was cheaper than apprenticeships/developing our own staff. It was noted that the nursing and midwifery vacancy position was broadly aligned with both Plymouth and Torbay. Mrs Foster commented that the long-term workforce plan was on the agenda for discussion at the next Board Development Day on 6 December 2023. Professor Marshall noted that there was reference in the IPR to dermatology, oncology and urology being the most fragile services, but outside of formal meetings he believed that cardiology was discussed as the most fragile. He asked if that was correct and how the Board held itself to account for that if specific data was not presented. Professor Harris said that the Trust was very aware of the length of waiting lists for cardiology and that the term fragile was unhelpful in this domain, as cardiology was very robust, with the issue relating to waiting times for a range of procedures. A Cardiology Transformation Meeting was held fortnightly chaired by the Chief Operating Officer and progress was making progress. Professor Marshall asked whether this was an area for a deep dive. Mrs Mills commented that all these areas were on the Corporate Risk Register and were subject to regular review in terms of risk and mitigations. Harm events were also reviewed and reported through the IPR. Mr Roberts suggested that a specific update on Cardiology should be added to the January Board agenda. **Action.** In addition, thought should be given to how the Board could get assurance on areas of concern. Ms Morgan noted that the "Challenge of taking and applying learning from Never Events" was listed under Risks and Threats on the balanced scorecard and asked for clarification on how these challenges were seen and responded to. Professor Harris said that a number of things had been put in place, most notably clinical leadership, to address the challenges. Detailed work had been undertaken to understand where the problem lies and the Clinical	

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Lead was working with teams to educate them on the risks. There has been a change in approach to National Safety Standards for Invasive Procedures (NatSSIPS) NHS wide and the Trust was adapting its processes in line with this. However, it was clear that irrespective of checking processes, the issues related to human factors and human factor training was due to start in December, with multidisciplinary leaders who will be taught how to mitigate for human factors and who will then cascade this onwards to teams. Professor Harris advised that EPIC provided a number of “hard stops” where a button has to be pressed when a pathway is moved, but this can be distracting for clinicians and there is a fear that this may inadvertently be contributing to the problem. The Team have been asked to visit other sites using EPIC to see how they have streamlined this process.

Mrs Hibbard commented that it was important to note that the Board had recently held an Extraordinary meeting where it had received and discussed a detailed financial recovery plan, which meant there were no specific financial questions that were raised at this meeting.

The Board of Directors noted the Integrated Performance Report.

188.23 HEALTH INEQUALITIES PROGRAMME UPDATE

Mrs Allen joined the meeting.

Mr Tidman reminded the Board that a Task and Finish Group had been set up a year ago which looked at how the Trust performed against the NHSE reporting requirements on health inequalities which were specific to the recovery programme, ensuring that waiting lists were being reduced in a measured way to ensure that patients were not being left behind. The Group had also looked at the broader health inequalities agenda. It had been agreed that a progress report on health inequalities should be presented to the Board twice a year and the report presented provided a level of assurance against the NHSE requirements. However, Mr Tidman advised that he felt this was a fairly narrow focus and there was more data that the Trust could look at and this would be addressed in more detail in the Health Inequality Strategy that would be presented to the January meeting of the Board. The report presented also provided an update on work that the Trust was doing in partnership, particularly with Local Care Partnerships (LCPs), including progress in North Devon through the work of One Northern Devon and other small pilot programmes. It would be key going forward to take learning from the pilots to inform the Trust’s strategy to do things at a bigger scale.

Mrs Allen highlighted the key point from the report:

- There was work undertaken on the three areas covered in the report – the Trust’s role as a healthcare provider to look at barriers to accessing healthcare, its role as a partner to look at how it can help tackle housing, fuel poverty and other elements that impact people’s health and its role as an anchor institution in Devon which has a significant impact on the economy, society and environment of the county.

Ms Morgan commented that she had attended two meetings of One Northern Devon and had been impressed on the depth of knowledge there was on a small group of the most disadvantaged members of the community, adding that work in East Devon was starting to catch-up with North. She asked the best way for the Trust to link in with these initiatives. Mrs Allen said that it was important to “go where the energy was” and that learning from North had shown that partners come with different priorities which did link with areas of commonality which needed to be understood and forming a habit of partnership working was vital.

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	Professor Marshall noted that with regard to the priority on restoring services inclusively, the data did not show a significant social-economic difference and asked if the data on this was trusted. Whilst he supported the suggestion in the report regarding social prescribers, they did need a lot of support and supervision to be successful and this would need to be built into the plan of work. Finally, Professor Marshall commented that the report did not contain much detail on the Trust's role as an anchor organisation. Mr Tidman advised that he was confident in the data, however it provided a narrow lens view to answer specific questions from NHSE. Mrs Allen advised that there were two models of social prescribing community networks being used, with some having peer support and some not. Those with peer support generally worked better and there was less burn-out amongst the social prescribers. Ms Morgan suggested that this should be included in the follow-up discussion that the Board would have on community services. **Action.** Mr Neal asked for further comment on the digital deprivation data. Mrs Allen said that the Trust had to make sure that services were accessible and inclusive, taking account of people's ability to access services digitally. Mr Tidman said that this would be covered in the Health Inequalities Strategy. Mrs Foster noted the ICB funding allocations to Northern and Eastern LCPs which were allocated in small amounts across a number of initiatives and asked whether this would provide value for money. Mrs Allen responded that notification of funding had been received in August 2023 with the objective being to spend the allocation by the end of the year. It had been decided to use this funding to supplement and build up projects already in place in the workplan, prioritising projects required looking at the root cause for repeat attendance through Emergency Care. Approximately £34k had been set aside for evaluation to ensure impact of work was understood. Ms Morgan asked if there was a sense of the areas where the Trust was likely to make the biggest difference with the resources available. Mr Tidman said that he believed that early intervention in targeted areas would have an impact, as well as targeting smoking. Mrs Allen added that the conditions with deprivation markers, such as respiratory, cardiovascular, mental health were more prevalent in deprived areas and these were where the biggest impact could be made. **The Board of Directors noted the Health Inequalities Progress Report.**	
189.23	**SURVEYS**	
	Mrs Mills presented the NHS England National Cancer Patient Experience Survey 2022 to the Board of Directors noting that it had previously been discussed at the Patient Experience Committee. There were a number of very high-level actions in the report which would be reviewed by the Teams. The report showed really strong performance for the Cancer service. Mr Neal noted that there were some comments in the survey relating to primary care and asked if these would be shared with primary care. Mrs Mills responded that she did not know if the results had been shared with primary care but would find out and if not would make sure they were shared. **Action.** Mr Neal asked whether there was anything unexpected in the report and was advised that the Teams would be looking at the outcomes to see whether the work they had done had made an impact and for any areas where improvements could be made.	

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Professor Marshall noted that patients being able to get a second opinion was covered in the report, adding that whilst he was sure that many patients would want this it may be quite expensive and asked for clarification on the position at the Trust. Mrs Brazier said that clinicians would always cater for a second opinion when requested by a patient.

Professor Marshall noted that the report was very long and questioned whether the full report needed to be presented to the Board, in particular as it had already been discussed at the Patient Experience Committee. The Board of Directors discussed the question of the length of papers presented to the Board generally and Ms Morgan agreed that shorter and more focussed papers would be helpful. She advised that there was an item on the agenda regarding how the Board could work more effectively and this would be an element to be considered.

The Board of Directors noted the NHS England National Cancer Patient Experience Survey 2022.

190.23 SIX MONTHLY SAFE STAFFING REVIEW

Mrs Mills reminded the Board that there was a statutory requirement to present a safe staffing report for nursing, midwifery and allied health professionals on a six-monthly basis. Key issues were noted as:

- The impact of delivery of 2023-24 recruitment and retention plans were evident in the report across professional groups. Focus going forward will be on ensuring that the controls in place for vacancies and on agency use, for example for enhanced observation, to ensure that reasons for use are legitimate in the context of wards now being generally fully staffed.
- No changes in establishment, either in terms of numbers or skill-mix, were reported.
- There had been no regulatory interest in staffing over the reporting period and the Trust was compliant with regulatory requirements and related standards.
- There are no risks on the Corporate Risk Register related to nursing, midwifery or allied health professionals, with several having been removed during the reporting period because of progress made.
- Data had been included in the report regarding the total number of incidents reported over the last six months, 18,053 of which 236 related to staffing incidents, a decrease since the last reporting period of October 2022-March 2023. Some themes had been noted from these incidents, including the inability to get one to one care for patients on occasion.
- A new safer care nursing tool had been launched nationally which will allow organisations to benchmark skill mix and establishment, as well as acuity and dependency of patients. The tool is quite subjective and the outcomes needed to be triangulated with professional judgement and external benchmarking.
- The review of community nursing had shown that there should be a refocus on skill mix and establishment for both registered and unregistered staff. In addition, it was demonstrated that there was a differential in skill mix and establishment across North and East that would be looked at in greater detail.

Ms Morgan asked for clarification of the difference in skill mix between North and East noted in the report and was informed that this related only to community nursing, with a higher level of registered nurses compared to unregistered staff in Northern services than in Eastern. It was noted that this had come out of the first use of the new national safe care nursing tool for community and more work would be undertaken to fully understand this result.

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Mr Matthews noted that 27 maternity Red Flags had been raised in the last six months which all related to supernumerary status of the labour ward co-ordinator in Eastern services and asked for clarification of what this meant. It was noted that it was a requirement that the Labour Ward co-ordinator must have supernumerary status. Whilst this would always be rostered for, there were 27 occasions during the reporting period where this was not possible due to a number of reasons, for example occasions where specific clinical needs meant that the staff member was required to work clinically and it was deemed to be a lesser risk to redeploy the staff member. It was noted that 27 occasions were a very low percentage of total shifts over a six-month period.

Professor McIntyre-Bhatty asked whether staff understood the improvements in recruitment and retention. Mrs Mills commented that there were still some areas where there were exceptions with specific challenges on staffing remained, but the feeling on the ground reported was that staff feel more settled and feel more confident that they will be working with teams they know and will not be redeployed frequently as a result of vacancies in other areas.

Professor Marshall commented that whilst safe staffing related to headcount, it would also relate to experience and expertise of staff and asked how this was considered and whether there was any evidence that new clinicians were less ready for practice because of the changing nature of training and the impact of the pandemic on training. Mrs Mills responded that experience and expertise was taken account of in terms of recruitment of staff and where apprenticeships would be located, so that newly qualified and apprentices where spread across areas as much as possible. It was noted that some international recruits had taken longer than the 12-week supernumerary period agreed across the South West to settle into their new roles, adding that there had been a decrease in quality of some of the international recruits through the International Recruitment Hub and the Trust had a higher level of scrutiny of candidates than it would be prepared to take through this route. With regard to nurses coming from UK Universities, they were generally of high calibre. Mrs Foster commented that the amount of international recruitment into countries had reduced the experience level by default. She added that in terms of whether staff felt the impact of improved recruitment and retention, she was hopeful that this would be demonstrated in responses to the recent national Staff Survey.

Ms Baldwick joined the meeting for presentation of the medical safe staffing report. Professor Harris reminded the Board that there was no statutory obligation regarding medical safe staffing meaning there was no benchmark data for this. As a result, the medical safe staffing report was not comparable to that produced for nursing, although the ambition was to continue to improve the data over time. He highlighted the following points:

- There had been periods of industrial action by consultants and junior doctors during the six-month reporting period which had been challenging. However, they had been managed well and patients had been kept safe.
- As there was little safe staffing data available generally for medical staffing, the report looked at incidents reported together with data from the Guardian of Safe Working report.
- Risk scores for most specialties had reduced over the reporting period, with the exception of two for Northern services.
- With the assistance of the HR Team, it was now possible to start generating data to demonstrate how many doctors and their equivalents there were on each site and within areas on each site. The intention for future reports would be to try and benchmark but this would be internal benchmarking, as there was no external benchmarking data available.

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	Ms Morgan asked if there were any areas of particular concern to Professor Harris and he advised that medicine in North Devon was still a concern, although there had been some progress. He added that work would continue to incrementally improve the position, but this would be episodic and dependent on finding the right individual who fits the role and wants to join the organisation. Ms Morgan asked whether this issue was reflected adequately in the risk assessment and Professor Harris advised that he believed it was although there were difficulties in mitigating the risk with reliance on long-term locums., He added that there was also a very good incident reporting culture in the Trust which helped to highlight incidents around safety. **The Board of Directors noted the Six Monthly Safe Staffing Review**	
191.23	**AUDIT COMMITTEE**	
	Mr Matthews presented an update from the Audit Committee meeting held on 6 November 2023 with the following key issue noted by the Board of Directors: • Delivery of the internal audit plan had been challenging due to a number of staffing issues and an issue with a sub-contract at Internal Audit South West. It had been agreed that a catch-up with Internal Audit would be scheduled for December 2023 to check on progress for recovery of the plan, as it will be important to ensure than any reprioritisation of audits is undertaken in good time. Professor McIntyre-Bhatty noted that the Committee had received one final report and three draft reports with limited assurance and asked whether that was an unusually large number. Mr Matthews agreed that this was more than would normal, however, he felt the strength of the audit plan was that the Executive Team would ask for areas that were of concern to be audited, so to an extent it was unsurprising that some of these areas would then receive a limited assurance report. It was noted that the Audit Committee was aware that there had been a slight drift downward overall of ratings and would be monitoring this for the rest of the year. Mrs Hibbard added that the Trust had improved the way it linked the Audit Plan to key risks using the Governance Committee and she would expect to see a decline for this reason. Ms Morgan asked for clarification on section 3.7 of the report which mentioned governance across the Integrated Care Board and the Integrated Care System as an emerging issue. Mrs Hibbard advised that as shared services were expanded across Devon there was a question regarding what assurance organisations and Audit Committees would need for a service provided by another organisation and if the Trust were to host a service, what level of assurance would it need to provide to others. Mr Matthews added that the Committee had discussed how it might involve Internal Audit South West in this process. Ms Morgan further noted the Counter Fraud Progress Report presented to the Audit Committee and that the Committee had escalated the issue of secondary jobs and working whilst on sick leave to the Chief People Officer and asked for an idea of the scale of this. Mr Matthews advised that the Internal Audit Team had informed the Committee that nationally there had been a significant number of cases of secondary jobs and working whilst on sick leave and had given an example of a successful prosecution of a case involving a relatively small sum, which would not normally have been pursued. **The Board of Directors noted the Audit Committee update.**	
192.23	**FINANCE & OPERATIONAL COMMITTEE**	

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Mrs Hibbard presented the Finance and Operational Committee update from the meeting held on 24 November 2023. The Board of Directors noted:

- The Committee received a draft of the internal planning process and a detailed workplan of the programme of work already underway. The Trust was due to launch planning guidance internally which would be subject to any national guidance issued over the coming weeks. An ICS planning day was scheduled for Monday 4 December 2023 to help get as much consistency as possible with planning across the system. The Trust would be focussing on lessons learned from 2023-24 which had been particularly challenging in terms of planning, particularly when bringing planning together for the two former organisations onto one ledger.
- The Committee received a business case for Spinal Surgery at the Nightingale Hospital which was a really good example of collaborative working across the system, as it would not only benefit patients within the Trust's catchment area, but would also offer support to University Hospitals Plymouth. The financial flows would allow a transfer of activity from the independent sector to the NHS and there was assurance of underwriting from the ICB that no organisation would be financially disadvantaged if that did not happen. It was noted that the business case had already gone through the triple lock process. The Committee recommended approval of the business case to the Board of Directors.

The Board of Directors noted the update and:

- **Approved the Spinal Business Case**
- **Noted the recommendation of no change to the Board Assurance Framework risk scores**

193.23 INTEGRATION PROGRAMME BOARD

Mr Matthews presented an update from the Integration Programme Board meeting held on 21 November 2023 and highlighted the following:

- The Operational Services Integration Group (OSIG) process had started as the next step in driving full integration. The process will be divided into two phases, with Phase 1 underway and due to complete in the early Spring of 2024.

Ms Morgan asked what were the issues of most concern and the risks within the OSIG programme of work. Mr Matthews responded that the major risks had been mitigated by the work that had been completed leading up to going out to consultation and he did not anticipate any major risks during Phase 1. The challenge would be moving to Phase 2 in a way that ensured that clinical integration and benefits for patients came to the fore and were not out of step with the managerial integration. In addition, it was important to achieve the integration at the right cost which would also have challenges. Mr Roberts commented that there was an inherent risk within this process to people feeling valued and supported and this would need to be closely monitored to ensure that vulnerabilities and concerns were understood and that staff felt listened to.

Ms Morgan asked what an appropriate timescale was for when progress on this work could be considered by the Board and Mr Matthews advised that he believed a Board discussion should be scheduled for the early Spring as Phase 1 was completed and the move to Phase 2 was due, probably to the February Board meeting. **Action.**

The Board of Directors noted the Integration Programme Board update.

194.23 OUR FUTURE HOSPITAL PROGRAMME BOARD

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	Mr Tidman presented the Our Future Hospital Programme Board update from the meeting held on 16 November 2023. The Board noted the two key issues discussed which were: • Assurance had been received on funding for the onsite staff accommodation and the Trust was currently going out for a design and build contractor for this work. Work was underway to coordinate the staff moves that would be needed as part of this. • Representation had been made to the National Team to advise that the Trust was in a position where it could proceed and have an outline business case within the next two years ready to go. It was still difficult to say at this stage when the first builds would start nationally, but the Trust would want to be in a position to proceed with a phased build. Engagement with local stakeholders continued to ensure their support. The National Team still needed to get the Programme Business Case signed off by the Treasury in March 2024. Ms Morgan asked when it was expected that the Trust would be in a position to get "spades in the ground" for the residential accommodation. Mr Tidman said that he would expect that a business case could be brought to the Board in February 2024. It would then need to be submitted to the National Team with the hope that it would be signed off by April 2024, which would mean "spades in the ground" by the early Autumn of 2024. **The Board of Directors noted the Our Future Hospitals Programme Board update.**	
195.23	**APPROVAL OF CHANGES TO STANDING ORDERS**	
	Ms Morgan informed the Board that she had been concerned for some time about the amount of time taken up at Board meetings to receive and agree routine reports and other items. Mrs Holley had undertaken to look at best practice in other organisations, including frequency of Board meetings, with many organisations holding bi-monthly Board meetings together with Development and Strategy days. As a result of that Ms Morgan would like to propose a change of frequency of Board meetings from ten per annum to six per annum, with a review of this approach at the end of six months. Before changes were finalised and agreed at the January Board, it was proposed that further research would be undertaken by Mrs Holley on best practice elsewhere including how to make best use of sub-committees of the Board. In addition, consideration would be given to how the best way to manage routine papers currently presented to the Board and a review would be undertaken of the list of statutory reports, in order that, by streamlining, the Board could be more effective in how it operates whilst remaining publicly accountable. Ms Morgan would also discuss the proposed changes with the Council of Governors. **The Board of Directors noted the direction of travel with regard to future arrangements for Board meetings based on best practice.**	
196.23	**ITEMS FOR ESCALATION TO THE BOARD ASSURANCE FRAMEWORK**	
	The Board of Directors agreed that nothing had been discussed that needed to be added as a new risk to the Board Assurance Framework or further points to be added to existing risks.	
197.23	**ANY OTHER BUSINESS**	
	No other business was raised for discussion.	
198.23	**PUBLIC QUESTIONS**	

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Mrs Matthews had submitted a question in advance which related to a point she had raised at the October Board regarding whether there was any evidence of impact on mental health patients from the proposals by Devon County Council (DCC) to close mental health Link Centres, in particular whether there had an increase in attendance at ED. She had been informed that Devon Partnership Trust (DPT) had attended a recent Council of Governors meeting where this question was asked and had undertaken to provide a response. Mrs Holley advised that the Deputy Chief Executive of DPT, Mr Mantay had attended the Council of Governors meeting and advised that Link Centres were commissioned by DCC who were currently undertaking a consultation on areas of this service. DPT would be responding to this consultation to say that they did not support the proposal, but they recognised that local authorities were also under significant financial pressure. Mrs Matthews asked whether any impact on staff and services had been seen from the closure of the Link Centres and Mrs Brazier responded that this would be hard to measure, but she was not aware of any feedback from the Team directly relating to this.

Ms Bearfield submitted the following question:
"The importance of data sharing in managing services in the Trust is well understood now, but there is considerable concern among the public and relevant agencies, British Medical Association included, about NHSE awarding the Federated Data Platform contract to Palantir and, given its history, scepticism regarding NHSE's insistence that there will be no breach of confidentiality or monetisation. What are the implications of the Palantir contract for the RD&E and EPIC, and will the Trust have any local control? What will the Trust be saying to NHSE about this?"

Professor Harris responded that detail relating to the Federated Data Platform contract was not yet available, so implications relating to Trust data were not yet known. He advised that what was not currently known was whether the data would remain in the UK data warehouse or whether it would be taken outside the UK by Palantir, however currently no personal data that would enable identifying an individual was shared with any institution. It was acknowledged that this was a potential risk which would be discussed at the Digital Committee. **Action.**

Mr Richards said that Mr Tidman had estimated (at the last Council of Governors' meeting) the cost of NCTR at £12m per annum, therefore achieving the target of 5% would save £8m per annum having a sizeable impact on the budget overspend. There was recognition nationally that not all delays were as a result of issues in social care, with some of them relating to NHS delays, with a national ratio of 60% of delayed discharge attributable to the NHS and 40% to local authorities. Mr Richards asked for clarification of the Trust's ratio of NHS versus social care delays and as DCC was not under Level 4 scrutiny, why did the Trust not put them under more pressure. In addition, Mr Richards asked whatever the Trust's equivalent ratio relating to delayed discharges, what was the action plan to improve the process. Mr Tidman responded that when this had previously been discussed both at Board and the Council of Governors, it had been in the spirit of acknowledging this was a collective endeavour for the NHS and social care to try and do better for patient. He added that DCC partners had been very supportive of looking at the totality of what was spent and seeing if there was anything proactive that could be done through early intervention. A piece of work was being undertaken within the ICB looking at the cost of placements and what could be done by sharing the risks. Mrs Hibbard added that there was no payment mechanism in place that would allow the Trust to recharge DCC for delays caused by social care. The Trust was paid for a patient's episode of care whilst in a hospital setting but this was based on an average length of stay.

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Ms Hallett said that investing in prevention and community services had been a long-held intention within the NHS and asked what would be different this time. In addition, Ms Hallett said that having worked in SDEC and Hospital at Home, the more you personalised care in the community the less throughput you could get, whereas having patients coming to a setting was more effective as you could see more through batching. She asked how the Trust would find the financial resources for more personalised care given the current financial environment. Professor Harris said that for the hospital at home initiative, the Trust tried to identify those patients who needed interventions but did not need to be in a hospital setting for this. He added that it was known that home was safer for many patients in terms of mental health, reablement, and infection. Costs were well within the range for patients being admitted, but it was acknowledged that as the complexity of patients using the hospital at home model increased this may change. Mr Tidman added the digital capability now available, for example through wearables, could contribute to breaking the cycle.

Mrs Kay Foster asked for clarification of the comment earlier in the meeting that it was cheaper to recruit nurses from abroad than to train nursing apprentices. Mrs Mills said that from a Trust's perspective, the cost difference for training nursing apprentices as opposed to recruiting international nurses was significant because of the "off the job" element of the apprenticeship. Apprentices were paid a full salary, but did not work full hours due to the classroom training that was part of their apprenticeship. Mrs Kay Foster asked if international recruits could bring their families with them, as this would add additional financial cost through provision of services. Mrs H Foster said that this would depend on the circumstances, but there could be benefits where both partners were working. She added that the reality was that for international recruits, the Trust would lose 12 – 16 weeks whilst they were supernumerary, but following that they would be working full time, whereas for apprentices the Trust would be paying them a full-time salary for three years but would lose 40% of their time whilst they were studying. Mrs H Foster added that this was a topic of discussion nationally in relation to the long-term workforce plan for the NHS.

Mr Cox commented that with regard to the exit criteria for the National Operational Framework, the last IRP mentioned productivity under the finance section and noted that this did not seem to be referenced often in Board papers. Mrs Hibbard advised that productivity sat in the finance section of the IPR because it was the measure of how the organisation increased its output at a relative beneficial rate to the increase in cost base to demonstrate delivery of more for the same or less. This was reported through the Finance and Operational Committee which had received at its October meeting a report on relative productivity across the whole of Devon and how the Trust benchmarked against that. Mrs Hibbard and Mr Palmer worked closely together to build in what they consider to be productivity benefits as part of activity planning which then flowed through to financial planning. The value in the Delivering Best Value was the same for plan and real, as some of the growth funding was set aside into the Delivering Best Value programme.

Mr Cox asked how frequently anaesthetists in Northern were required for transfer of patients off site, leaving emergency surgery unable to take place during their absence. Professor Harris responded that this happened on average once a month or less, and added that there was now a retrieval service in the South West which had alleviated this issue to a degree.

199.23	**DATE OF NEXT MEETING**	
	The date of the next meeting was announced as taking place on 31 January 2024.	

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PUBLIC MEETING OF THE BOARD OF DIRECTORS
29 November 2023
ACTIONS SUMMARY

This checklist provides a status of those actions placed on Board members in the Board minutes, and will be updated and attached to the minutes each month.

PUBLIC AGENDA					
Minute No.	**Month raised**	**Description**	**By**	**Target date**	**Remarks**
060.23	April 2023	A discussion to take place at a future Board meeting regarding acceptable levels of vacancy and what the expected vacancy rate would be if the expectation was not to be at 100% recruitment. (Action added after May Board meeting as it had been missed initially).	HF	~~July 2023~~ ~~September 2023~~ ~~October 2023~~ ~~November 2023~~ ~~December 2023~~ January 2024	**Update 19.07.23 –** Further work is required to understand acceptable vacancy levels, due to the multifaceted nature of this area that requires balancing of operational & financial plans. It would also be helpful to understand thresholds used in other organisations & their rationale to make an informed decision. It is proposed that a paper is presented to the next Board meeting to propose a recommendation based on the above factors, with a view that maximum & minimum tolerated vacancy levels could be reflected in the relevant IPR charts. **Action ongoing.** **Update 21.09.23 –** Due to close links with the long term workforce plan, this is going to be included in the wider strategic update in October 2023, along with our gap analysis against the Long Term Workforce Plan. **Action ongoing.** **Update October 2023 –** strategic update deferred from October to November Board. Due date changed. **Action ongoing.** **Update 16.11.23 –** The strategic update is now being taken in a different format at the Board Development Day in December. The vacancy information will therefore need to be

					separated out, re-worked and brought to Board. Request that this is added as a matter arising at January Board. **Action ongoing.**
077.23(1)	May 2023	~~Data regarding ED attendances in other coastal areas to be reviewed, to see if similar increases in attendances had been seen and if there was any learning for the Trust from their experiences.~~ Updated action added following Board meeting in September 2023 to give thought to the national allocation formula given the increase in demand for Northern Services noted in the briefing paper circulated.	~~JP~~ Execs	~~September 2023~~ ~~November 2023~~ January 2024	**Update 20.07.23** – Initial analysis indicates comparable patterns of growth in type 1 ED attendances in other coastal healthcare systems, at levels in excess of type 1 growth observed nationally. Opportunities for learning from other systems being explored. **Action complete.** **Update 26.07.23 –** Following a further update at the July Board from Mr Palmer, it was agreed that the information with a breakdown of ED attendances and any coastal implications should be circulated to the Board and the ICS for information. **Action ongoing** **Update 21.09.23** – Updated briefing paper incorporating ED attendance trend data to August 2023 circulated. **Action complete.** **Update 27.09.23** – Following discussion at September Board, it was agreed that Mr Palmer would provide wording for an additional action to be added following feedback from Board members that thought would need to be given to formula given the increase in demand for Northern Services in particular noted in the briefing paper circulated. **Action ongoing.** **Update 25.10.23** – Executive consideration in train about next available opportunity to submit representation for recognition of increased demand within the national allocation formula. **Action ongoing.**

099.23(1)	June 2023	Following a discussion about length of stay for stroke patients and whether delay in admission to the Acute Stroke Unit impacted length of stay and further impacted where patients were discharged to in the community, the Board was advised that the Acute Peninsula Sustainability review was looking at this and this could be brought to a future meeting.	CT	~~September 2023~~ ~~October 2023~~ ~~November 2023~~ January 2024	**Update 19.07.23 –** Briefing note to be distributed by September 2023. **Action ongoing.** **Update 21.09.23 –** The Acute Provider Collaborative has identified stroke as a fragile service and data/KPIs are being collected on all peninsula services. A briefing on stroke will be contained within this in due course. A briefing note on RDUH's North and East stroke performance is being prepared for the Board. **Action ongoing.** **Update 26.10.23 –** Delayed due to operational pressures on stroke team. Briefing note to be circulated before the end of December 2023. **Action ongoing.** **Update 28.12.23 –** Katherine Allen asked to provide an update, response awaited. **Action ongoing.** **Update 22.01.24 –** Briefing circulated to Board members. **Action complete.**
162.23(3)	October 2023	As part of the Board's Christmas visits, an element to be incorporated to sample how many patients were waiting to be discharged and understand the reasons for the delay.	All	January 2024	**Update 24.01.24 –** Given time constraints on Board members, whilst the Christmas visits were arranged, the focus was on visiting as many areas as possible to thank staff and wish staff well, therefore this additional element was not picked up on this occasion. The Board are asked to consider if there is an alternative/more appropriate way to sample this information which could be presented back to the Board. **Action ongoing.**
167.23	October 2023	Future presentation of the BAF should include a "clean" copy of the master BAF (ie without track changes).	MH	January 2024	**Update 23.01.24 –** Both clean copy and copy with track changes of the BAF included in public Board meeting books. **Action complete.**

173.23(1)	October 2023	A tabletop exercise to be planned to look at the flags from the Letby case and explore how the Trust would have responded to similar flags to test processes.	MH	January 2024	**Update 24.01.24** – Due to competing demands on the Corporate Governance Team, including the submission for the Thirlwall Inquiry in early January, an extension is requested until April to undertake a table top exercise. **Action ongoing.**
185.23(1)	November 2023	It was noted (during discussion of the Community Strategy) that a risk assessment had been completed which articulated the risk that if existing community staff were redirected from rehabilitation to supporting patients in short stay beds in Care Homes, there would be a significant impact on other patients in the community. This had been escalated to the ICB, but no formal response had been received. Ms Morgan suggested that she could raise this with the Chair of the ICB at their next 1:1 meeting.	SM	January 2024	**Update 18.12.23** – SM discussed with Sarah Wollaston on 14.12.23 and followed up with an email on 22.12.23 with further details, provided by Zoe Harris. **Action complete.**
185.23(2)	November 2023	Discussion on community strategy adding value to the whole system, what the strategy would mean in practice, next steps etc to be added to the list of topics for a future Board Development Day.	MH	January 2024	**Update 30.11.23** - Added to the BDD list of topics**. Action complete.**
185.23(3)	November 2023	Consideration to be given to possible six-monthly inclusion of metrics in the IPR on community, including on workforce and where investment might be needed	JP	January 2024	**Update 25.01.24** – Proposals for investment (and re-investment) to be incorporated within financial & operational planning for 24/25 including contract & system discussions with Devon ICB, & discussions with social care partners. Further iteration of community content incorporated within January IPR. **Action complete.**
187.23(1)	November 2023	Following discussion regarding the 60 bed gap noted in the Winter Plan had assumed getting to 5% on NCTR which remained off track, Mr Tidman had suggested a follow up should be sent to the ICS advising that there was a concern that the 16 bed gap was probably understated in terms of where NCTR was to add more weight to the request for additional funding for schemes.	CT	January 2024	**Update 28.12.23** – Escalation made to ICS and a further £1m of UEC funding released to de-risk the bed gap and the NCTR position. **Action complete.**
187.23(2)	November 2023	Mr Roberts agreed to circulate a set of proposals, previously shared with the Board, for further investments.	PR	January 2024	**Update 15.01.24** – Letter sent to ICS in October 2023 with proposals re the Winter Plan recirculated to the Board. **Action complete.**

187.23(3)	November 2023	Following discussion on cardiology services, Mr Roberts suggested that a specific update on cardiology be added to the January Board agenda	AHa	January 2024	**Update 24.01.24 –** Update on Cardiology Services added to the Confidential Board Agenda for January meeting. **Action complete.**
188.23	November 2023	Support for social prescribers in community to be added to the follow-up discussion on community services planned for a future Board Development Day	JP	July 2024	**Update 25.01.24 –** Scheduled for update July 2024. **Action ongoing.**
189.23	November 2023	Mrs Mills to establish if the results of the NHS England National Cancer Patient Experience Survey had been shared with primary care (as there were specific comments in the report relating to primary care) and if not, she would make sure it was shared with them.	CM	January 2024	**Update 20.12.23** The National Cancer Patient Experience Survey results for Royal Devon have been circulated to the Primary Care Network, via the Director of Strategy & Engagement. **Action complete and propose to close.**
193.23	November 2023	Following discussion of Phase 1 of the Operational Services Integration Group process currently underway, it was agreed that an update to the Board on outcomes should be scheduled for the early Spring of 2024, potentially the February Board meeting.	JP	March 2024	**Update 25.01.23 –** Proposed that update be brought forward to March 2024 meeting. **Action ongoing.**
198.23	November 2023	Following a question raised by a Governor regarding the Federated Data Platform contract awarded to Palantir and whether the Trust would have any local control on how data was shared, it was agreed that the potential risk would be discussed at the Digital Committee.	Aha/TN	January 2024	**Update 24.01.24 –** A paper on the Federated Data Platform is on the agenda for consideration at the next meeting of the Digital Committee scheduled for 01.02.24. **Action complete.**

Signed:

Shan Morgan
Chair

Agenda item:	8, Public Board Meeting	Date: 31 January 2024		
Title:	Patient story: Heart Failure Remote Monitoring			
Prepared by:	Bethany Hoile, Comms & Engagement Coordinator			
Presented by:	Carolyn Mills, Chief Nursing Officer			
Responsible Executive:	Carolyn Mills, Chief Nursing Officer			
Summary:	This patient story is set within the context of the Trust's strategic objective of excellence and innovation in patient care; through embracing new technologies and ways of working to deliver the best possible care, the Trust empowers our patients to take control over their own health. The Trust piloted a remote monitoring system for selected patients with heart failure between July 2023 and January 2024. A key aim of the pilot was to provide remote access to heart failure services to those who may be disadvantaged through rural deprivation, digital exclusion, mental health conditions or disability. The pilot also aimed to improve outcomes for patients with heart failure, avoid unnecessary hospital admissions and help the heart failure team prioritise face-to-face appointments with those patients who need them most. In this story, we hear from Harold, a 75 year old gentleman with a background of chronic heart and kidney disease, and his experience of using remote monitoring. Prior to starting the remote monitoring, Harold had four hospital admissions within six months, including acute decompensated heart failure. Harold lives in a rural location in North Devon and works on the family farm. The funding for this pilot came from NHS England's Innovation for Healthcare Inequalities Programme (InHIP), which aims to address local healthcare inequalities experienced by deprived populations, through the use of the latest health technologies and medicines. A key driver of the integration of the Royal Devon was to fulfil a strategy of equitable and sustainable care across North and East Devon. This story shows ways in which this is being achieved.			
Actions required:	The Board of Directors is asked to reflect on the implications of this story for patients and carers and to reflect on its relevance to the strategic objectives of the Board.			
Status (x):	Decision	Approval	Discussion	Information
			X	
History:	Patient stories reveal a great deal about the quality of our service provision, the opportunities we have for learning and the effectiveness of systems and processes to manage, improve and assure service quality.			

	The purpose of presenting a patient story to Board members is to: • Set a patient focussed context to the meeting, bringing patient experience to life and making patient's stories accessible to a wider audience • To support Board members to triangulate patient experience with reported data and information • For Board members to reflect on the impact of the lived experience for these patient(s) and carer(s) and its relevance to the strategic objectives of the Board.
Link to strategy/ Assurance framework:	The issues raised in this patient story are relevant to the delivery of the Trust's Better Together strategy and strategic objectives.

Monitoring Information

Please *specify* CQC standard numbers and tick ✓other boxes as appropriate

Care Quality Commission Standards	Outcomes	Regulation 17	
NHS Improvement		Finance	
Service Development Strategy	X	Performance Management	
Local Delivery Plan		Business Planning	
Assurance Framework		Complaints	
Equality, diversity, human rights implications assessed			X
Other *(please specify)*			

Agenda Item:	10.1, Public Board Meeting	**Date: 31 January 2024**		
Title:	Draft Health Inequalities Strategy			
Prepared by:	Katherine Allen, Director of Strategy, Chris Tidman, Deputy Chief Executive			
Presented by:	Chris Tidman, Deputy Chief Executive			
Responsible Executive:	Chris Tidman, Deputy Chief Executive			
Summary:	This paper sets out the Trust's *draft* health inequalities strategy explaining the role we play in tackling health inequalities as a care provider, a partner and an anchor institution. Whilst the resources available to invest in new initiatives are relatively small compared to the overall Trust budget, there is real interest from our clinicians in how they can address health inequalities and an increasing data capability to draw on. There is also a clear overlap with the ambitions that the Board has to better optimise the capabilities of our community teams to intervene earlier to promote wellness and independence – often with the patients that are also the most disadvantaged. The strategy sets out a 2 year workplan and a proposal that the Board receive a 6 monthly report on progress.			
Actions Required:	The Board is asked to consider and approve the draft RDUH health inequalities strategy and associated workplan.			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
		x		
History:	The development of this strategy followed the publication of the Devon ICB Joint Forward Plan and Integrated Care Strategy which indicated an important role for providers in tackling health inequalities. It also encompasses the NHSE Health Inequalities statement requirements on NHS providers. The Board previously commissioned a Task and Finish group on understanding how best the Trust can contribute to reducing Health Inequalities and this, alongside other key contributions from individual board members, has helped shape the strategy. The Board has previously received two reports on health inequalities, largely focussed on the equitable recovery of our waiting times.			
Link to strategy/ Assurance framework:	Tackling health inequalities is a core component of the Trust's strategic objective of collaboration and partnerships.			

Monitoring Information

Care Quality Commission Standards	Outcomes		
NHS Improvement		Finance	
Service Development Strategy	✓	Performance Management	
Local Delivery Plan	✓	Business Planning	✓
Assurance Framework	✓	Complaints	
Equality, diversity, human rights implications assessed			✓
Other *(please specify)*			

Royal Devon
University Healthcare
NHS Foundation Trust

Health inequalities Strategy

2024-2029 Final Draft

January 2024

"In England, health is getting worse for people living in more deprived districts and regions, health inequalities are increasing and, for the population as a whole, health is declining. In particular, lives for people towards the bottom of the social hierarchy have been made more difficult."

Professor Sir Michael Marmot, "Health equity in England: The Marmot Review 10 years on", 2021

"Prevention, population health management and tackling health inequalities are not a distraction from the immediate priorities: indeed, they are the key to sustainable solutions to those immediate performance challenges".

"There will never be a perfect time to shift the dial toward focusing more on preventative services and interventions. It is easy to argue - especially in the current climate of financial constraints and performance issues - that addressing these issues should be something we consider when the current pressures have died down. But that has always been the case."

"The truth is, unless we make the change, the continual focus on improving flow through acute hospitals will simply channel more and more of an older and increasingly unhealthy population into acute hospitals, which will never be large or efficient enough to cope."

The Hewitt Review: an independent review of integrated care systems, 2022

DRAFT

Health inequalities strategy 2024-29

Contents

1. Introduction 3
2. Definitions 4
3. Strategic context and evidence base 5
4. Health inequalities data 10
5. The Royal Devon's role in tackling health inequalities 14
Health inequalities strategy on a page 15
6. Governance and programme management 17
7. Conclusion 19
Appendix A: NHSE and national evidence base 20
Appendix B: Strategic alignment 22

DRAFT

1. Introduction

Welcome to the first Health Inequalities strategy developed by the Royal Devon, which is an enabling strategy of our Better Together strategy.

Chronic, persistent and unacceptable health inequalities result in poorer health, reduced quality of life, higher costs of care and early death for many people. Marginalised and deprived populations experience health outcomes far worse than the general population. They experience exclusion from services, and economic and social marginalisation.

This strategy has been developed in a context of a twin-demic of Covid recovery and cost of living poverty crisis as well as an NHS challenged to address the imbalance of supply and demand for care. There is a growing body of national policy and evidence suggesting NHS providers have a key role in tackling health inequalities.

The Royal Devon University Healthcare NHS Foundation Trust's health inequalities strategy outlines the evidence-based and partnership contribution we can make as an NHS provider to tackling health inequalities.

To ensure our approach is rooted in the needs of our local community and our Trust priorities we have organised our work on tackling health inequalities into three areas: Royal Devon as a healthcare provider; Royal Devon as a partner; and Royal Devon as an anchor institution.

As a healthcare provider we will adapt our services to ensure inclusion and the health inequality lens supports the clinical strategy's intention to shift to targeted preventative interventions to proactively support better health; we will work with partners on the wider determinants of health; and as an anchor institution within our communities, we will use our capabilities and economies of scale to positively influence people's lives through our employment of 16,000 people and our procurement policies as well as the way we deliver care.

This strategic approach enables a framework to align the multiple initiatives across the Trust which influence health inequalities, such as research and development, sustainability, workforce and digital. And, importantly, our methodology is one which starts with asking people to describe the issue in their own words so that the data gathering, solution and activities remain focused on solving the right problem.

This strategy has the following vision and objectives:

Health inequalities vision:

Reducing health inequalities through involvement, insight and partnerships

Health inequalities objectives:

Royal Devon will

- Use its role as a **provider of healthcare** to reduce health inequalities
- Use its role as a **partner** to reduce health inequalities
- Use its role as an **anchor institution** to reduce health inequalities

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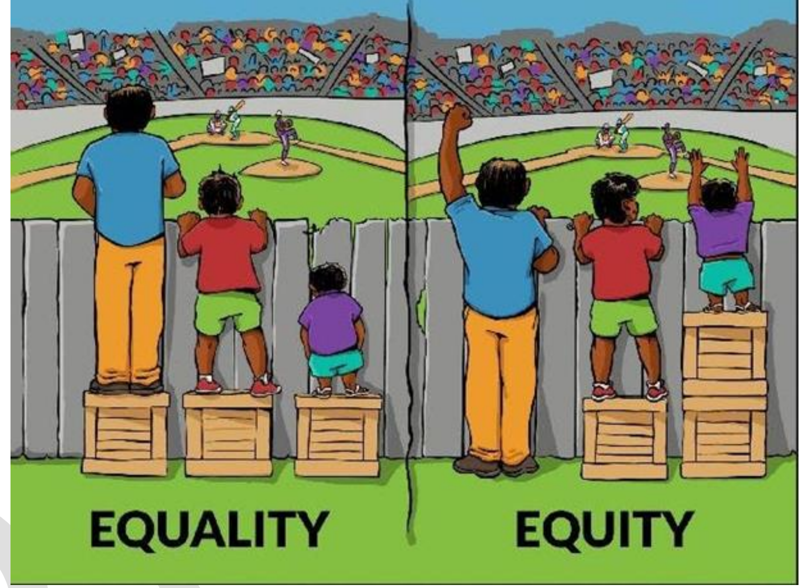
2. Definitions

Health inequalities are differences in health across the population, and between different groups in society, that are systematic, unfair and avoidable. They are caused by the conditions in which we are born, live, and work and which influence our opportunities for good mental and physical health.

Inclusion health is a term favoured by public health and Devon County Council to describe a policy agenda that aims to redress the extreme health and social inequities among the most vulnerable and marginalised in a community.



Equality means treating everyone the same or providing everyone with the same resource, whereas equity means providing services relative to need.

Most health inequality strategies recognise that reducing the steepness of the social gradient in health involves actions which are universal, but with a scale and intensity matched to the level of disadvantage: this is known as **proportionate universalism**.

Wider determinants Wider determinants are a diverse range of social, economic and environmental factors which impact on people's health. Such factors are influenced by the local, national and international distribution of power and resources which shape the conditions of daily life. They determine the extent to which different individuals have the physical, social and personal resources to identify and achieve goals, meet their needs and deal with changes to their circumstances.

The wider determinants of health are interlinked: for example, someone who is unemployed may be more likely to live in poorer quality housing with less access to green space and less access to fresh, healthy food. This means some groups and communities are more likely to experience poorer health than the general population. These groups are also more likely to experience challenges in accessing care.

Core 20+5 is an approach designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement. **Core20** is the most deprived 20% of the population as measured by the index of multiple deprivation; **Plus** are those ICS-chosen groups experiencing poorer than average health access and/or outcomes who may not be captured within the Core20 and who would benefit from tailored healthcare approaches i.e. inclusion health groups; 5 refer to the five key clinical areas of health inequalities.

For adults they are **maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension** with smoking cessation recognised as a common positive intervention for all. For children the **5** are **asthma, diabetes, epilepsy, oral health and mental health**. Devon is using Core20+5 to segment the population to prioritise attention and resources. See appendix A for the Core20+5 explainer).

3. Strategic context and evidence base

3.1 Clinical data on health inequalities and impact on NHS demand

Health inequalities have always existed but the evidence from multiple sources indicates they are worsening. In both the 2020 Health Equity Study, authored by Sir Michael Marmot, and the evidence base to the NHS England major conditions strategy (2023) there is confirmation that improvement in life expectancy has stalled and the deprivation gap in life expectancy is widening and driven by preventable and manageable disease. 42% of the burden of poor health is attributable to modifiable risk factors (see figure 1).

The Covid-19 pandemic exacerbated inequality and highlighted the unequal impact of the disease on different population groups, some of whom were not previously thought to be an at-risk group. The success of specific strategies to target homeless people and ethnic minorities with vaccination support are examples where adapting the service delivery model makes a positive difference to people's health and wellbeing.

The current UK 'cost-of-living crisis' is further worsening the socio-economic inequalities that drive many health disparities. The disease groups in figure 1 contain many of the areas where this strategy and the community services element of the clinical strategy (see section 3.4) overlap and where joint prevention strategies and targeting approaches will be effective.

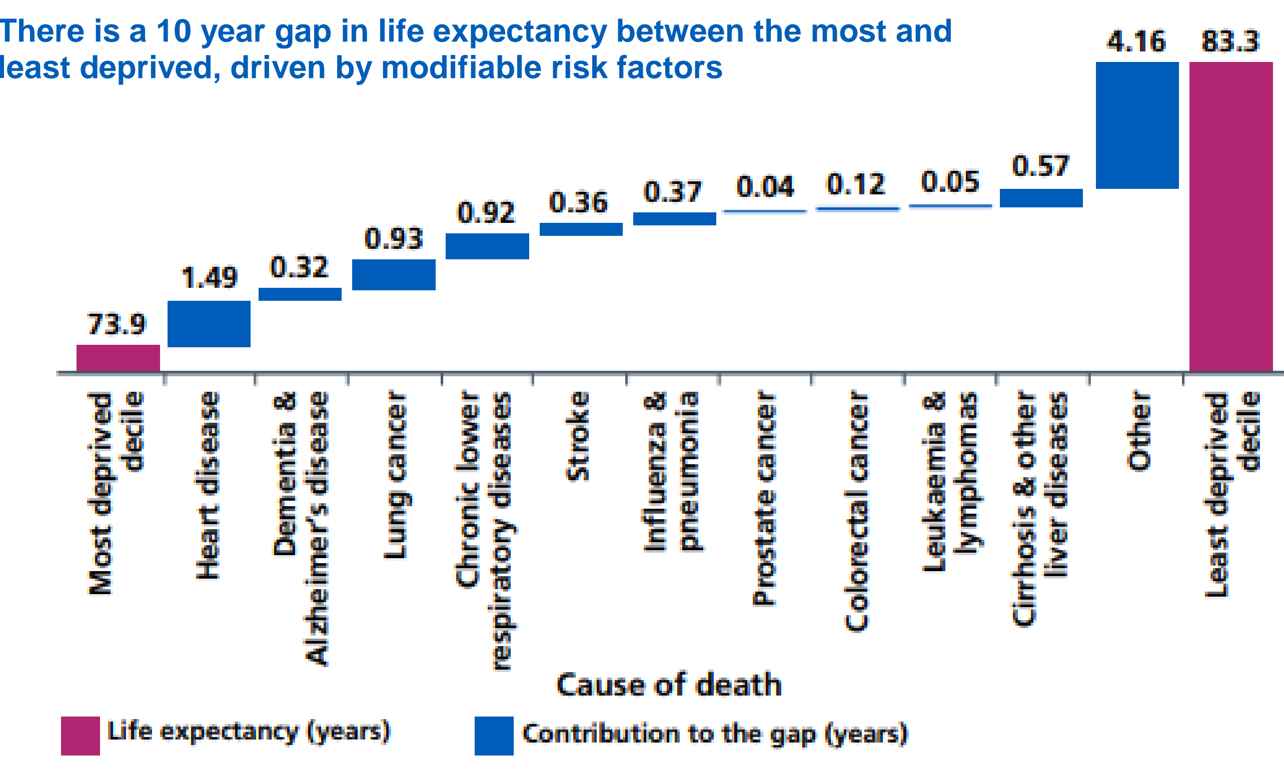
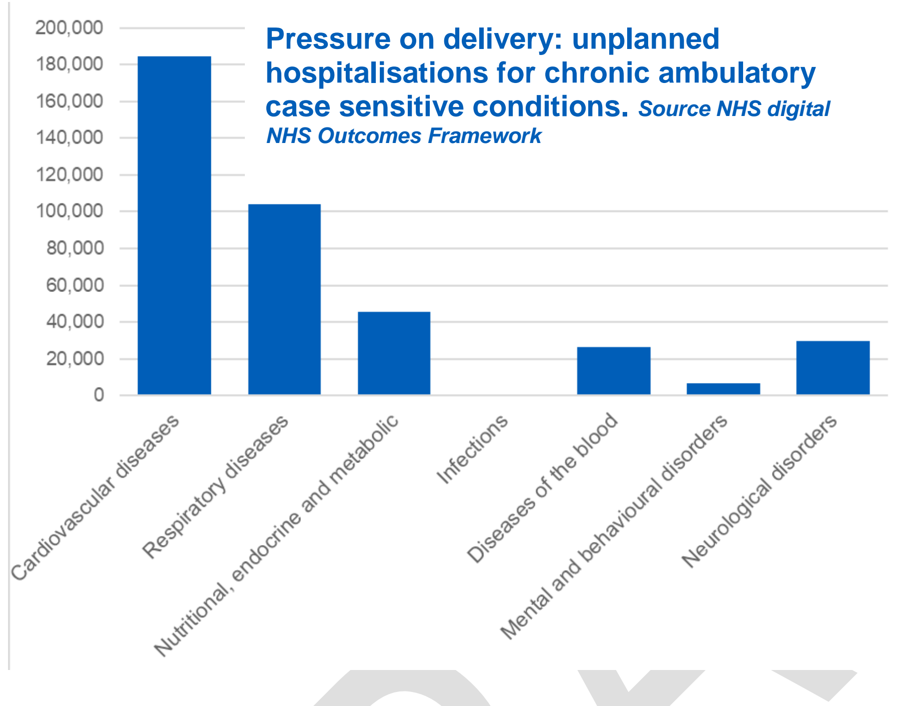


Figure 1: NHS England health inequality analysis, 2023

The demand presenting to the NHS has led policy leaders to examine the impact of health inequality and deprivation on admissions to hospital. Figure 2 shows the correlation between emergency admissions for hypertension, respiratory and mental health. Those three conditions are three of the five identified in Core 20+5 as being more prevalent in deprived communities.

This data indicates an evidence base for prioritising the areas to target based on the known impact on demand from certain disease groups.



Summary findings

- CVD and respiratory diseases are the leading causes of emergency admissions for chronic ambulatory care sensitive conditions.

  There is a strong demographic bias in terms of who gets admitted to hospital.

- Prevalence of LTCs increases risk of admission and complexity of cases.

- Multi morbidity exacerbates pressure on delivery. Prevalence is higher and onset earlier in those living in more deprived areas.

Figure 2: Failure to manage preventable conditions may exacerbate pressure on operational delivery. Nuffield Trust analysis of ambulatory care sensitive conditions and admissions, 2022

Royal Devon's catchment has a North and South seaboard and the Chief Medical Officer's report in 2021 highlights the substantially higher burden of physical and mental health conditions in coastal communities. The report highlights four main points, which resonate with local leaders and communities in Devon:

1. *"older, retired citizens – who have more and increasing health problems – often settle in coastal regions but without the same access to healthcare as urban inland areas. In smaller seaside towns, 31% of the resident population was aged 65 years or over in 2019, compared to just 22% in smaller non-coastal towns*
2. *difficulties in attracting NHS and social care staff to peripheral areas is a common issue. The report found coastal communities have 14.6% fewer postgraduate medical trainees, 15% fewer consultants and 7.4% fewer nurses per patient than the national average, despite higher healthcare needs*
3. *an oversupply of guest housing has led to houses in multiple occupation (HMOs) which lead to concentrations of deprivation and ill health. Directors of public health and local government leaders raise concerns about the challenges of poor quality but cheap HMOs,*

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encouraging the migration of vulnerable people from elsewhere in the UK, often with multiple and complex health needs, into coastal towns

4. *the sea is a benefit but also a barrier: attracting NHS and social care staff to peripheral areas is harder, catchment areas for health services are artificially foreshortened and transport is often limited, in turn limiting job opportunities. The least wealthy often have the worst health outcomes."*

3.2 National policy context

Reducing health inequalities is one of the main priorities of the NHS Long-Term Plan, refreshed in the NHS at 75 update in 2023. The Health and Care Act 2022 enshrines this priority in legislation by stating that addressing health inequalities in outcomes, experience and access is one of the four core aims of an integrated care board (ICB).

In response to the continuing rise of chronic ill-health, NHS policy (NHS@75 report) shifts the focus to the following:

1. Preventing poor health	2. Personalisation and participation	3. Co-ordinated care, closer to home
• Shift funding to evidence-based prevention measures • Collaborate with partners to reach those at greatest risk • Advocate for action to tackle the wider determinants of health	• Ensure people have control in planning their own care • Ensure continuity of relationship with clinical team • Prioritise patients' experience and voice, particularly marginalised groups	• Accelerate plans to strengthen general practice, primary care, and community care • Better care for those with complex needs and frailty by community teams and hospital at home services, supported by outreach

Figure 3: summary of the NHS&75 report, 2023

The NHS Long-Term Plans have signalled the intent to focus on health inequality, inclusion and prevention with the operating plans committing to ring-fenced budgets for prevention allocated to each ICS. This policy draws from the evidence that focusing upstream on modifiable behaviours means more people living longer in better health, which reduces the costs of that care. There is a risk that in a NOF 4 ICS, this ringfenced investment may be stalled- however, section 5 sets out the economic case for this investment.

The NHS England Health Inequality statement, published in 2023 sets out the responsibilities of NHS providers. To fulfil duties of service provision in ways which comply with the NHS Act 2022, Royal Devon is required to:

- Understand healthcare needs including by adopting population health management approaches, underpinned by working with people and communities.

- Understand health access, experience and outcomes including by collecting, analysing and publishing information on health inequalities set out in the Statement.

- Publish information on health inequalities within or alongside annual reports in an accessible format.

- Use data to inform action including as outlined in the Statement.

Trust Boards are expected to use health inequality data to inform strategy development, policy options review, resource allocation, service redesign, service delivery decisions and service evaluations. These obligations are included in the delivery plan supporting this strategy (section 5).

3.3 Financial case for prevention and health inequalities

The Healthcare Financial Management Association report 'Health Inequalities: establishing the case for change' from May 2023 draws together the evidence indicating that inequalities in health can drive demand for NHS services. Avoidable differences between population groups can impact the prevalence of conditions, and the ability and willingness of people to seek treatment prior to crisis and care costs increase the less planned the care.

At a time of intense demand on the NHS, significant financial pressure, and critical workforce shortages often means providers favouring a response to the immediate presenting problem rather than thinking about the long-term repeat presentations.

It is therefore an explicit medium-term aim of this strategy to have developed a business case for investing in targeting health inequality as a way of reducing demand on our NHS services (see section 5).

Serving a population which has more healthy years in retirement age will reduce the complexity and volume of healthcare need, providing the return on investment of interventions. Marmot links poor health to loss of economic productivity and higher welfare spend which creates the alignment to wider health and wealth policies across national and inter-governmental policy. Levelling Up and Local Government policies, as expressed via Local Plans, increasingly recognise the link between health, housing, skills, employment, crime, environment and the need for commitment from all partners to tackle these root causes of deprivation to ensure the health and wealth of a local area.

Making the case for longer term change to tackle health inequalities during a period of extreme pressure for the NHS, with short term recovery targets, is challenging. For this reason the workplan supporting delivery of this strategy recognises the need to target areas using the available evidence base; approach in ways with proven benefit and in partnership with the communities impacted. The evaluation which demonstrates impact will underpin delivery. This evidence is crucial to develop effective partnerships, maintain stakeholder buy-in and make the business case for sustainable funding.

3.4 RDUH strategy: Better Together

The Better Together strategy was developed to support the integration of two Trusts following the creation of the Royal Devon in 2022. One of the key drivers of the merger rationale was to address health inequalities across North and East Devon and to ensure access to healthcare and outcomes were equitable.

The Integration Programme Board was established to oversee the merger and that key milestones are being achieved. The current major milestone being delivered is the creation of a new operating structure based on service delivery, rather than site focus. This is being driven by a belief that equity is best delivered by leadership teams with a responsibility for delivering high

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quality services across the entirety of our catchment population – rather than responsibilities defined by geographical boundaries.

As well as equity of acute service provision, the Better Together strategy has a mission that signals a clear shift towards preventing ill health through targeted intervention: "*Working together to help you to stay healthy and to care for you expertly and compassionately when you are not*".

Being a collaborative partner with patients and stakeholders as well as with other providers, primary care, the ICS, local government, wider public services and the voluntary sector and using our combined expertise and data to make decisions that address health inequalities. Working in partnership is central to reducing health inequalities. Only 20% of someone's health is directly influenced by the NHS, the greatest influence is from someone's socio-economic context and influencing these wider determinants requires effective partnerships.

A multi-agency effort involving central government, the NHS and local government working in close partnership, harnessing the contribution of the voluntary, statutory and private sectors, has been shown to have the greatest impact in tackling health inequalities, and directly links with many of Royal Devon's strategy, for example:

- Using our digital capability to improve access to specialist healthcare for marginalised groups
- To recover our waiting lists in a fair way
- Investing in our community services to prevent avoidable hospital admissions

The Board has signalled support for the emerging community services strategy which will ensure improved discharge pathways, but more fundamentally support a range of physical or digital interventions delivered either directly or by partners that build wellness and independence. As well as improving health outcomes overall and delivering better value for money for the taxpayer, this form of early intervention helps to break the cycle of services not meeting people's needs and disadvantaged citizens experiencing worse health outcomes. A key area of overlap between this strategy and the community service element of the clinical strategy is presented in figure 4.

Figure 4: Showing the link between the RDUH clinical strategy: community services and the Health Inequality strategy

4. Health inequalities data

In recent years the depth of data and analytical capabilities have significantly increased in recognition that narrowing the inequality gap requires better data and insight. There are four main categories of data which will be accessed to support delivery of this strategy, working with our local care partnerships.

- **Population Health** data (called population health management) joins up data across local health and care partners and enables population segmentation and risk stratification. This gives practitioners insight into the holistic needs of different population groups and the drivers of health inequalities. Partners can identify a local 'at risk' cohort and create the evidence base for the targeted action needed. PHM means using data, evidence and knowledge in all forms to create local intelligence that aids decision-making.

- **National data platforms**. NHS England has invested in several data platforms to support the use of data in guiding local decisions to reduce the health inequality gap. The health inequalities improvement dashboard focuses on Core20+5 data and is contained within NHS National Data Platform (the Foundry) which identifies significant health inequalities statistical analysis and suggests actionable insights.

- **Local data capabilities**. The RDUH's EPIC electronic patient record has the functionality to record and report risk factors for health and healthcare inequalities across our acute and community patient caseload. It's health determinant tool also has the analytical power to combine data sets to indicate trends and patient cohorts. There are clear opportunities to use this data to inform and prioritise our health inequalities work as well as to collaborate on further research with partners.

- Our police, council and charity partners also collect data for example on anti-social behaviour, place of safety; housing supply, fuel poverty, evictions and housing standards; and gaps in community resilience respectively. Data sharing agreement to enable the overlay with health data will guide and target the interventions to reduce health inequalities and enable effective partnership working.

- **Neighbourhood qualitative data**. We will take concerted steps to understand the lived experience of people who are impacted by health inequalities. It is only be listening to the lived experience that services can understand how they must adapt their provision models to mitigate disadvantage and deprivation.

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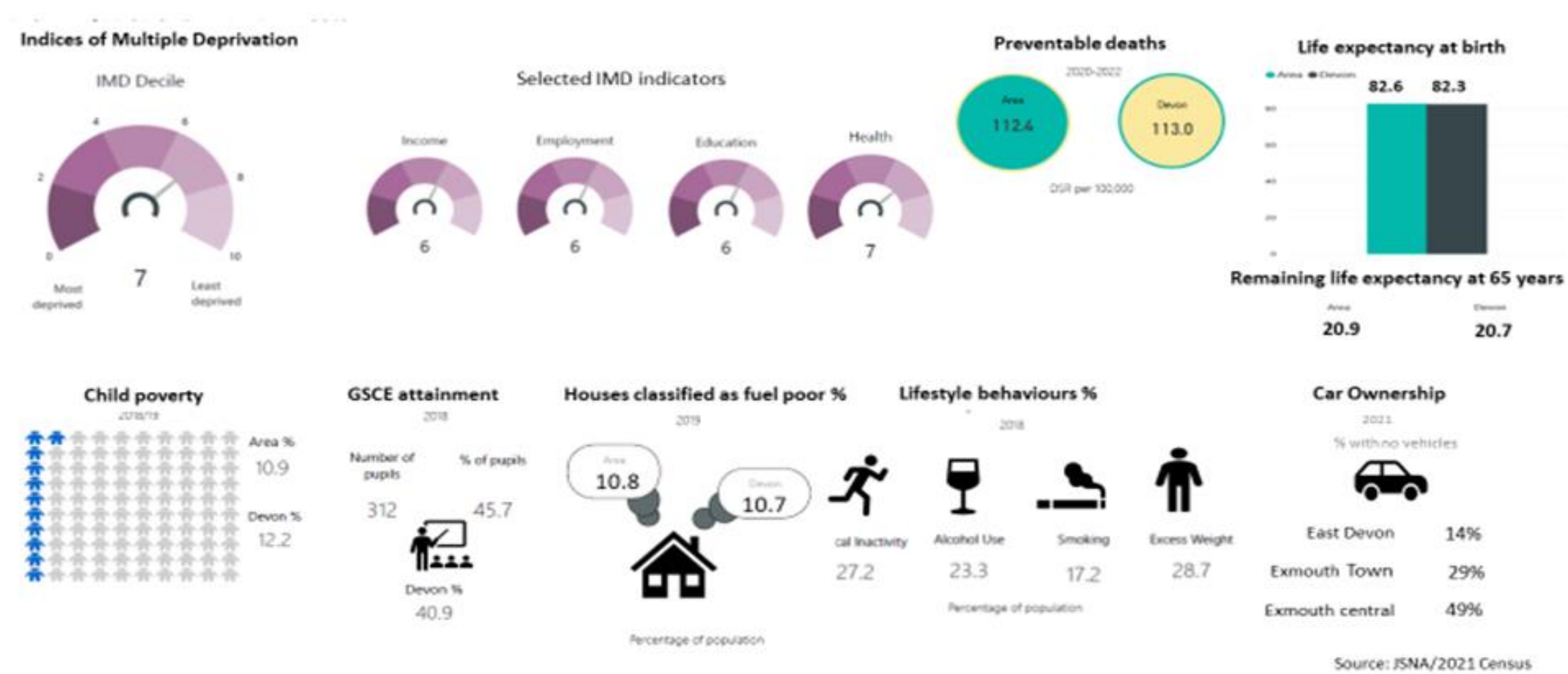
4.2 The data on health inequalities in North and East Devon

The following snapshots of East and North Devon show the type of data that will be commonly used to stratify risk, segment the population and plan interventions.



Whilst these are a narrow selection of data, the comparison between North and East reveals stark comparative differences between health outcomes, particularly in child poverty, educational attainment, fuel poverty and car ownership, which have implications for Devon in addressing health inequalities.

Northern Local Care Partnership: Selected data

4.3 Using the data on health inequalities in North and East Devon

There is no shortage of data and often the key challenge is translating knowledge into meaningful action and impact, particularly when tackling the wider determinants of health requires an alignment of the priorities of all partners.

However, as the fuel poverty case study below shows, health inequalities are structural, multi-factorial and influence the service delivery of most public sector organisations. The approach summarised below is expanded in section 6.

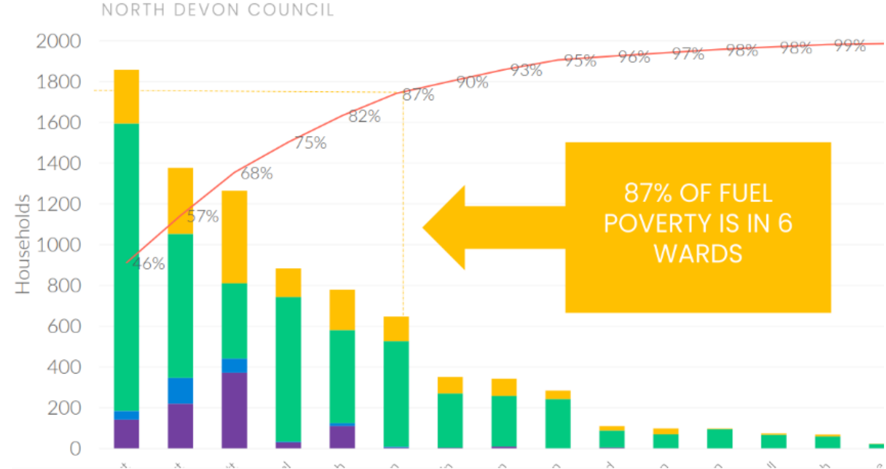
A. Understanding the impact of fuel poverty and aligning priorities

The table below shows how partners articulate the impact health inequalities is having on their service delivery and outcomes.

Impact	Priority
Fuel poverty is an issue in most rural areas. For example, Torridge has 12.4% of homes in fuel poverty compared to 11% nationally. Cold homes cause excess deaths and they exacerbate conditions such as arthritis – costing the NHS £2.5bn a year	Fuel poverty becomes a priority for the NHS
Children in fuel poor households have poorer educational outcomes and are more likely to miss school due to ill-health or be socially excluded.	Fuel poverty becomes a priority for Schools, Councils, Employers and local businesses maintaining local skills pipeline, Mental Health and the NHS
Fuel poor houses are often rented accommodation. Occupants have lower wages and more likely to feel insecure in their accommodation	Fuel poverty becomes a priority for District Councils, employers and the voluntary sector / charities supporting those being evicted
Rural homes are often older and poorly uninsulated	Fuel poverty becomes a climate issue for Devon

B. Identifying those impacted

Segment the population and gather all available data on each segment, i.e. low income, private rental, health conditions and use partner data if appropriate, i.e. from Energy Saving Trust, EPC ratings, Dept of Work and Pensions.



C. Stratify data and agree priorities

Share and use the data to stratify the population and agree priorities.

D. Act!

Locate and discuss the impacts with the target population. Agree interventions. Do the interventions and evaluate impact with partners and people.

5. The Royal Devon's role in tackling health inequalities

The Royal Devon's role in tackling health inequalities is in three objectives:

- As a provider of care
- As a partner
- As an anchor institution

This section explains how the Trust will convert its strategic intent into a series of deliverables for each objective. This is summarised on the 'Strategy on a Page' overleaf.

5.1 RDUH as a provider of healthcare tackling health inequalities

Objective	Development work: Year 1	Work programme: Year 2 onwards	Outcomes
Use our role as a **healthcare provider** to reduce health inequalities	*As per NHSE Statement…..* • **Understand healthcare needs**. Develop data capabilities: EPIC, PHM, One Devon Dataset, JNSA. Alongside community and partner engagement • **Understand health access**, experience & outcomes • **Collect, analyse and publish** health inequalities information at Board (biannual recovery report and NHSE HI statement) • **Publish** information on HI in annual report • **Use** data/evidence to inform action	• RDUH Core 20+5 delivery programme launched in CVD and diabetes • EPIC-PHM etc combined dataset • Elective recovery – HI input to outpatient transformation, digital inclusion, virtual/remote care delivery • Urgent care recovery – HI input to high intensity users (+High Flow), social prescribing and community connectors • Maturity of personalised care, make every contact count, value-based care and effective	**More years in better health (QALY + SHMI)** **North and East service integration levels up**

Year 1 will focus on building the evidence base. RDUH has the capability through its data analytics and highly-skilled, multi-professional clinical teams who are in contact with 100,000s of patients to risk stratify and understand the needs of its patient population. There is a robust evidence base behind 'make every contact count' to indicate the positive influence clinicians have on the healthy wellbeing behaviours of patients. Whilst it is recognised that asking about lifestyle issues such as alcohol intake and smoking takes time and adds more of a data collection burden for clinicians, the utility of the data and the impact of the conversation on the patient can be profound.

For Year 2, by using the data collected, Royal Devon can then begin to mitigate some of this inequity. Having achieved a dataset, the population groups can be segmented and targeted for a differential approach to care provision that meets their needs.

With improved data and targeted investment from the ICB and NHS grants, we will also begin to explore the priority areas of Core20+5, elective recovery and urgent and emergency care.

Health inequalities strategy on a page

Vision	Objective	Development work: Year 1	Work programme: Year 2 onwards	Outcomes
Reduce health inequalities through involvement, insight and partnership working	Use our role as a **healthcare provider** to reduce health inequalities	As per NHSE Statement…. • **Understand healthcare needs**. Develop data capabilities: EPIC, PHM, One Devon Dataset, JNSA. Alongside community and partner engagement • **Understand health access**, experience & outcomes • **Collect, analyse and publish** health inequalities information at Board (biannual recovery report and NHSE HI statement) • **Publish** information on HI in annual report • **Use** data/evidence to inform action	• RDUH Core 20+5 delivery programme launched in CVD and diabetes • EPIC-PHM etc combined dataset • Elective recovery – HI input to outpatient transformation, digital inclusion, virtual/remote care delivery • Urgent care recovery – HI input to high intensity users (+High Flow), social prescribing and community connectors • Maturity in make every contact count, value-based care and effective interventions as NHS	**More years in better health (QALY + SHMI)** **North and East service integration levels up**
	Use our role as a **partner** to reduce health inequalities	• Participate in strong **One Northern Devon** partnership and contribute resources and effort to a shared prevention workplan • Support the development of **One Eastern Devon** to same partnership model as OND • Support maturity of **LCPs** as the ICS delegates more functions to local place level • Support delivery of the RDUH community strategy, particularly prevention • Establish DPIAs with partners to enable joint action	• Pursue joint prevention, regeneration and Levelling Up partnership initiatives • **North** - focus on local priorities: mental health, fuel poverty, high intensity user, social prescribing, homelessness, cost of living • **East** - focus on local priorities: mental health, loneliness, homelessness • Partner economic case for health inequality improvement programmes	**Services have adapted to people's needs** **Improved health outcomes** **& Reduced cost of delivery**
	Use our role as an **anchor institution** to reduce health inequalities	• Map all the health inequality opportunities and activities across RDUH functions i.e. apprenticeships (social mobility), Green Plan, Digital, Estates, Finance and Procurement and clinical models of care delivery • Publish progress in line with the NHSE statement and equality legislation	• Secure sustainable funding for health inequalities improvement initiatives • Benchmark the health inequality anchor activities with cost/benefit analysis • RDUH and District Council Local Plan alignment	**RDUH has net +ve impact on the socio-economic health and wealth of Devon**

5.2 RDUH working in partnership to tackle health inequalities

Objective	Development work: Year 1	Work programme: Year 2 onwards	Outcomes
Use our role as a **partner** to reduce health inequalities	• Participate in strong **One Northern Devon** partnership and contribute resources and effort to a shared prevention workplan • Support the development of **One Eastern Devon** to same partnership model as OND • Support maturity of **LCPs** as the ICS delegates more functions to local place level • Support delivery of the **clinical strategy, particularly community services and prevention** • Establish DPIAs with partners to enable joint action	• Pursue joint prevention, regeneration and Levelling Up partnership initiatives • **North -** focus on local priorities: mental health, fuel poverty, high intensity user, social prescribing, homelessness, cost of living • **East: -** focus on local priorities: mental health, loneliness, homelessness • Partner economic case for health inequality improvement programmes	**Services have adapted to people's needs** **Improved health outcomes** **& Reduced cost of delivery**

The establishment of the ICSs and place-based partnerships (local care partnerships) in legislation offers RDUH an opportunity to accelerate efforts to tackle heath inequalities given the mandate set out in the legislation and in NHSE guidance.

In addition we are a founding member of the One Northern Devon partnership board which takes membership from all local partners and has agreed a programme of work aimed at tackling local health inequality priorities. This approach is being replicated with One Eastern Devon and we will continue to take on a leadership role within all these partnership fora going forward.

This objective also defines RDUH's role in supporting delivery of the programmes within Devon's Joint Forward Plan and the Local Care Partnership workplans (North and East). The alignment between the ICS's Joint Forward Plan and RDUH's Better Together strategy is contained in appendix B.

5.3 RDUH as an anchor institution

Objective	Development work: Year 1	Work programme: Year 2 onwards	Outcomes
Use our role as an **anchor institution** to reduce health inequalities	• Map all the health inequality opportunities and activities across RDUH functions i.e apprenticeships (social mobility), Green Plan, Digital, Estates, Finance and Procurement and clinical models of care delivery • Publish progress in line with the NHSE statement and equality legislation	• Secure sustainable funding for health inequalities improvement initiatives • Benchmark the health inequality anchor activities with cost/benefit analysis • RDUH and stakeholder alignment, i.e. District Council Local Plans	**RDUH has net +ve impact on the socio-economic health and wealth of Devon**

Employing a 16,000 strong professionally diverse workforce; caring for 600,000+ local residents; and spending £1billion on the provision of healthcare makes the Royal Devon an anchor institution within the community of Devon (see figure 6).

The RDUH will use this status to positively impact the local economy, society and economy through:

- purchasing more locally wherever possible
- using social value measures in commissioning and procurement
- ensuring access to work, and making sure that job roles are high quality

- supporting families to live healthy, sustainable lives
- supporting the wider transition to a net zero economy, helping to reduce emissions and improve air quality

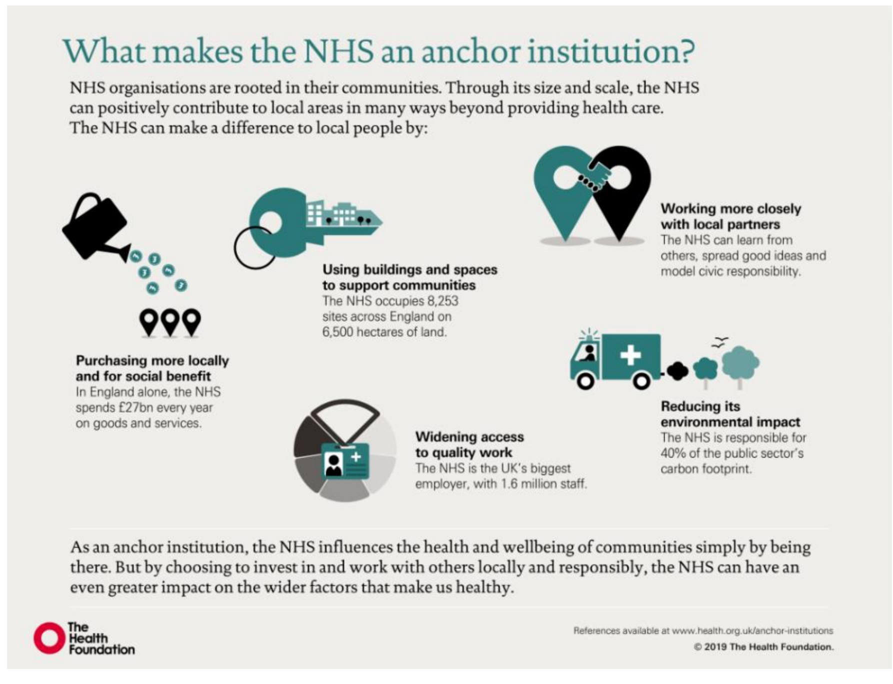


Figure 6: Health Foundation definition of an NHS anchor institution

Anchor institutions also tend to have more corporate professional resources which are essential to supporting partnership work and momentum, i.e. bid writers for grants, accountants, IG specialists for DPIAs, administrators to take meeting minutes and so on. Royal Devon offers these services as contributions when working in partnership.

6. Governance and programme management

The governance of health inequalities work is complex, matrix and system wide. It also differs across projects and within each of the objectives of this strategy.

Three layers of governance are emerging with the new ICS architecture: initiatives that are implemented at system level (i.e. recovering waiting times equitably, smoking); at place level (i.e. high intensity users); and at person level (i.e. homelessness, apprenticeships).

Each area has its own appropriate governance and reporting structures.

Within the NHS England statement there is an expectation that the Royal Devon quantifies its impacts and publishes its activities to improve health inequality. The following governance structure details the process to support assurance of compliance with the 'statement'.

6.1 Trust governance to support delivery and prioritisation of this strategy

Body	Role
RDUH Board	Approves and monitors delivery of health inequality strategy. Receive bi-annual reports charting progress in delivering the three objectives of this strategy. All reports will align to the requirements of NHS England Health Inequalities statement
Strategic Trust Delivery Group	STDG will receive the report ahead of Board and validate impact, benefit and progress of the activities.
Joint N&E Operational Board	Members of our OB are also members of each LCP. N&E Devon localised updates will be presented to Ops Board containing update on Local workplans, health inequality projects, prevention, anchor institution activities and relevant grant funded projects.
One Northern Devon / One Eastern Devon	Coalition of willing partners who meet to agree local priorities and programmes across health, economy, environment. Membership of all health bodies, councils, police, fire, business, education, VCSE, third sector.
Strategy and Partnership team	Delivery of a workplan which includes: • RDUH health inequality strategy delivery (and support to community strategy) • One Northern Devon + North LCP workplans • One Eastern Devon + East Devon LCP workplans • ICS workplans i.e. smoking (secondary prevention)

As the Local Care Partnerships develop and take responsibility for more local commissioning functions and decisions, this governance will evolve.

During this transition the Health Inequalities strategy delivery reports and requirements under the NHSE Health Inequalities statement, i.e. waiting list report by deprivation and ethnicity will report to Trust Delivery Group, relevant sub-committee and Board of Directors.

6.3 Resources to deliver the strategy

Firstly, there is a huge interest in addressing health inequalities amongst our clinicians, and in understanding what our data is telling us. EPIC also gives us a data repository. This dataset coupled with the curiosity of our clinicians is a natural resource that we are able to tap into.

To support this, Royal Devon has a small internal team of health inequality practitioners who support the delivery of this strategy and the One Northern and Eastern Devon workplans. This team maintains the partner relations and community networks which provide the infrastructure and coalitions required and ready to work in partnership on the wider determinants of health.

Investment is also available through our Local Care Partnerships. For example, through securing external grant income, One Northern Devon oversees a budget of between £0.5-£1m, wholly discharged on projects targeted at health inequalities and prevention.

As Integrated Care Boards (ICBs) have a statutory duty to reduce health inequalities, as defined in the Health and Care Act 2022 and are allocated ringfenced funding, we will need to ensure that this duty is maintained.

7. Conclusion

The NHS is uniquely placed to make a strong contribution to reducing health inequalities.

Due to the level of health inequality in our communities and the impact this has on the complexity and demand approaching our NHS services, working with partners on ways to tackle the root causes has become our core business.

We are already mid-flight in delivering this strategy. This strategy condenses all of the data, expertise, research and depth of partner relationships that Royal Devon has invested in over many years. We have generated a positive reputation as a constructive partner who works collectively and shares expertise to address the challenges facing our communities.

This strategy sets out a realistic and achievable framework for RDUH to demonstrate that addressing health inequalities can contribute to resolving some of the demographic, demand and financial challenges facing the NHS.

As society's expectations and demands on the NHS become more complex and intense, this strategy offers a way of meeting those expectations through personalisation, co-production and supporting the empowerment and resilience of local people.

Appendix A: NHSE and national evidence base

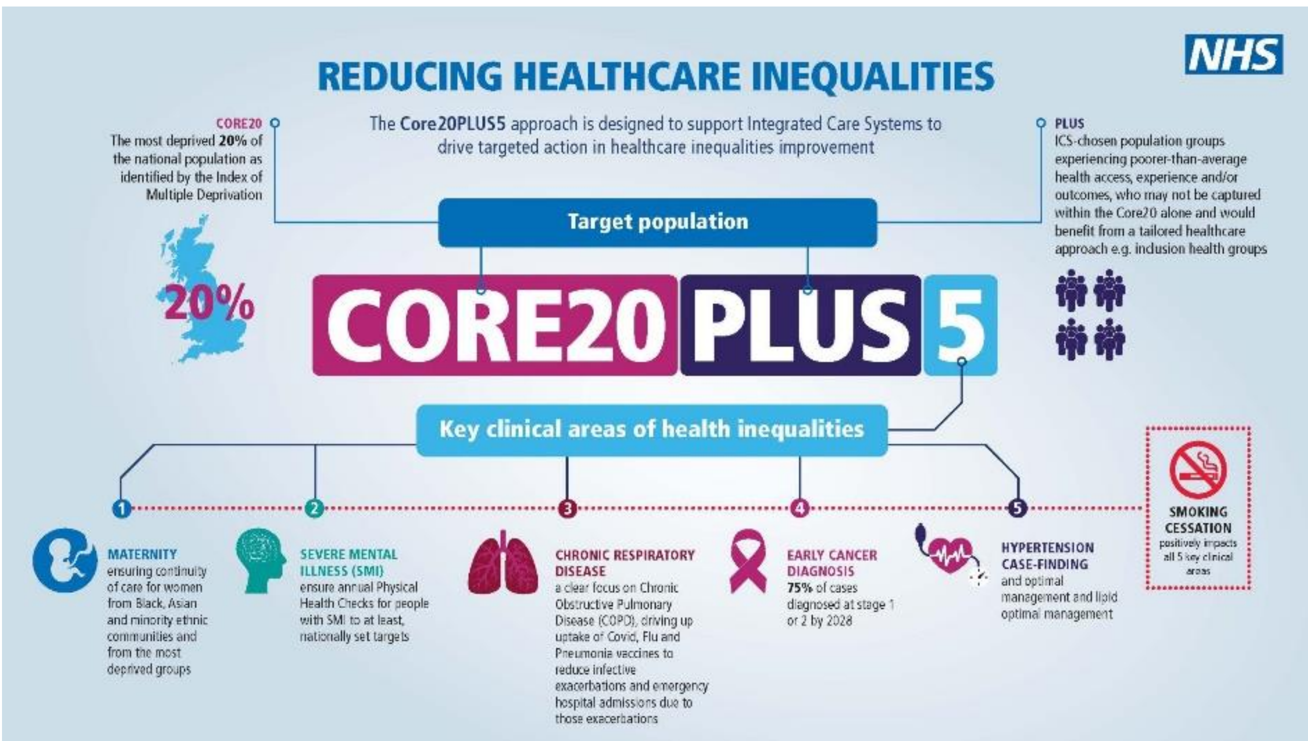
Further reading: the NHSE health inequalities statement and obligations, 2023

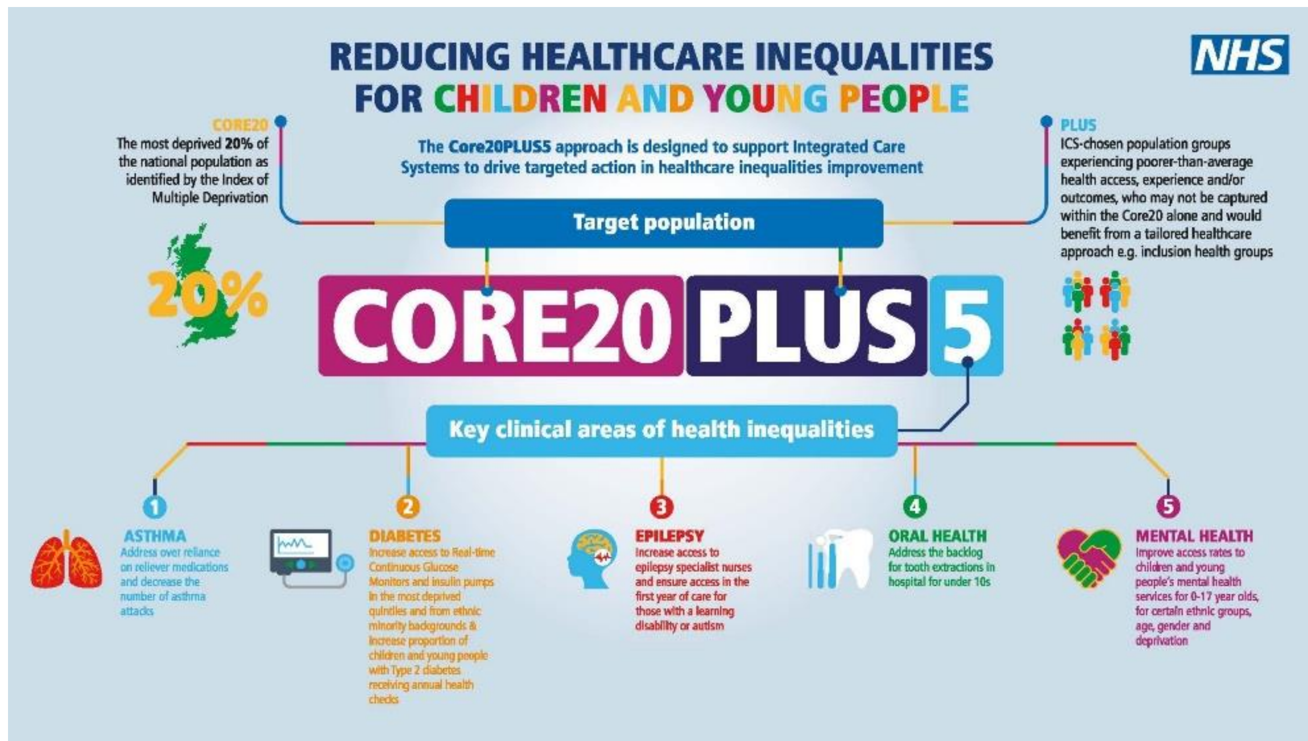
Statutory basis for addressing health inequalities

The NHS is mandated to consider health inequalities as a result of its legal duties and the regulatory framework in which it operates.

- The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society.
- Public Sector Equality Duty (s.149 Equality Act 2010)
- Social Value Act 2013
- The right of everyone to the highest attainable standard of physical and mental health has been recognised formally in the UK since 1976 when the Government approved the International Covenant on Economic, Social and Cultural Rights (ICESCR).
- Health and Care Act 2022 committed to reduce inequalities between patients with respect to their ability to access health services, and the outcomes
- The Care Quality Commission's (CQC) strategy (2021) outlines a commitment to supporting and enabling health and care providers and wider systems to reduce health inequalities within services and the wider population, for the first time.
- NHS England and NHS Improvement's *System oversight framework 2021/22* onwards, commenced the ICS focus on improving population health and tackling unequal access, experience and outcomes.
- 2023 NHS England statement on health inequalities NHS England » NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006)
- Core20+5 (overleaf)

Core20+5 for adults and children





Appendix B: Strategic alignment

The alignment between the ICS's Joint Forward Plan and RDUH's Better Together strategy

ICS delivery programme	Better Together strategic objective • Collaboration and Partnership • A great place to work • Recovering for the future • Excellence and Innovation	RDUH enabling strategy
Acute service sustainability	C A R E	Clinical strategy Digital strategy People strategy Finance strategy
Housing	C	Health inequalities strategy
Community development and learning	C	Health inequalities strategy
Employment	C A	People strategy Health inequalities strategy
Health protection	E	Clinical strategy
Suicide prevention	C	Health inequalities strategy
Primary and community care	C	Clinical strategy Health inequalities strategy
Mental Health, Learning Disability and Neurodiversity	C R	Clinical strategy Health inequalities strategy
Children and young people	R E	Clinical strategy Health inequalities strategy

ICS enabling programme	Better Together strategic objective	RDUH enabling strategy
Climate Change	C A R E	Green Plan Estates strategy Digital strategy Clinical strategy
Population health	C R E	Clinical strategy Transformation strategy Health inequalities strategy

		Digital strategy Data strategy
System development	C	Better Together Transformation strategy Digital strategy
Workforce	A R	People strategy
Digital and data	C A R E	Digital strategy Data strategy Clinical strategy
Estates and infrastructure	A R E	Estates strategy Green Plan Clinical strategy Digital strategy
Finance	R	Finance strategy Transformation strategy
Communities and involvement	C R	Health inequalities strategy Digital strategy Clinical strategy (+ communications, engagement and marketing strategy)
Research, innovation and improvement	R E	Digital strategy Transformation strategy Green Plan
Equality, diversity and inclusion	C A	People strategy Digital strategy

Agenda item:	11.1, Public Board Meeting		Date:	31 January 2024
Title:	Royal Devon "Better Together" Strategy Roadmap 2022-27 – report period October-December 2023 (Q3 23/24)			
Prepared by:	Katherine Allen, Director of Strategy			
Presented by:	Chris Tidman, Deputy Chief Executive Officer			
Responsible Executive:	Chris Tidman, Deputy Chief Executive Officer			
Summary	This paper presents the Royal Devon Strategy roadmap progress report for Quarter 3 23/24, a forward look across Q4 and 2024/5.			
Actions required:	The Board of Directors is asked to note this paper			
Status (x):	Decision	Approval	Discussion	Information
				x
History:	Every quarter the Trust Board of Directors receive a report presenting the progress in delivering the Royal Devon "Better Together" Strategy, As the new financial year approaches the look ahead has been extended to 12 months.			
Link to Strategy / Assurance Framework	Royal Devon Strategy			

Monitoring information

Please *specify* CQC standard numbers and tick ✓ other boxes as appropriate

Care Quality Commission Standards			
NHS Improvement		Finance	
Service Development Strategy	x	Performance Management	
Local Delivery Plan	x	Business Planning	X
Assurance Framework	x	Complaints	
Equality, diversity, human rights implications assessed			
Other (please specify)			

Royal Devon 'Better Together' Strategy Roadmap 2023-24

1. Executive Summary

1.1 This paper presents the Royal Devon Strategy roadmap: 2023/24 quarter 3 (Q3) progress report (covering the period 1 October-31 December 2023) as well as a 3 and 12 month respectively look-ahead indicating the ambitions for the Trust in delivering its strategy.

1.2 The roadmap connects delivery of the strategy to operational delivery which is wider than the Operational Plan. The majority are milestones which are requirements and/or have agreed funding and delivery programmes in place. There are some milestones which are prospective and without identified funding but which are being speculatively progressed into plans or business cases as they deliver key elements of our strategy.

1.3 This quarterly progress update of the Royal Devon 'Better Together' strategy shows that the number of milestones for this quarter was significantly lower than in previous quarters but that the majority of roadmap milestones were achieved in Q3.

1.4 Following the approval and publication of the enabling strategies in October 2023 (clinical, estates, people, digital, data, finance) the strategy leads have ensured implementation plans were developed which aligned to the clinical strategy and Better Together strategy.

1.5 The key milestones from each strategy implementation plans have been indicated in the roadmap. These plans are currently being aligned to the delayed operational planning guidance for 2024/5 meaning next year's milestones may change.

1.6 Ahead of April 2024, the roadmap will undergo a final review to cross reference the 2024/5 roadmap against the system NOF4 exit criteria, Devon system programmes of work and ensure that the roadmap contains the key elements of the RDUH 2024/25 operational plan and improvement priorities.

1.7 As the Trust enters its third year of delivering the Better Together strategy and now with the entire suite of enabling strategies in place, the key outcome metrics for each corporate objective are proposed for agreement (see appendix 2 for proposed metrics).

2. Royal Devon Strategy and Roadmap: Q3 23/24 progress report

2.1 The following section takes the key highlights from the achievements from October-December 2023 (Q3 2023/24):

2.2 **RD&E Paediatric ED work commences**
The estates improvement work on the Paediatric ED at Wonford started on time in October 2023. This is an enabler to offering a great place to work, improving family experiences and our recovery programme – milestone complete

2.3 **Tiverton Endoscopy Unit**
The Tiverton endoscopy mobile unit service has commenced. This is an enabler to our recovery programme and will enable improved access to diagnostics across North and East Devon – milestone complete.

2.4 **Genomics sequencer**
RDUH received an Illumina Nova Seq X Plus genome sequencer. The purchase of the Illumina NovaSeq X Plus was made possible thanks to significant contribution of £2.179m from the NIHR – milestone complete.

2.5 **Cardiology lab – shared use**
In November RDUH and Torbay agreed arrangements for RDUH to use capacity in Torbay's cardiology labs. This is a really positive development for acute service sustainability and recovery – milestone complete.

2.6 **Long-term Workforce Plan**
The RDUH long-term workforce plan was submitted to the Board of Directors in November 2023. This contributes to both the recovery and great place to work in ensuring we have workforce plans in place to meet patient need – milestone complete.

2.7 **Enabling strategies implementation plans**
The suite of enabling strategies were launched in October, with a number of events lined up for staff to find out more about what this means for the Trust. The clinical strategy launch events were led by the CEO and Director of Transformation during December 2023 – milestone complete.

The RDUH enabling strategy leads have mapped their key milestones for 24/25. The Director of Strategy will continue to meet enabling strategy leads quarterly throughout 2024/25 to monitor deliver and interdependencies

2.8 **PASP / Fragile programme: Urology**
Urology clinical and operational leads across the South, East and North Devon have developed a sustainable service model for Urology. Implementation will be phased across the services according to recruitment, governance and operational planning – milestone complete.

2.9 **Health Tech**
The Trust successfully tendered for the South West Health Tech Research Centre, an investment worth £3m over 5 years. The programme aligns with BRC and existing NIHR infrastructure and launches on 1 April 2024 – milestone complete.

2.10 The Table 1 shows the milestones that were achieved in Q3 2023/24 of the Royal Devon corporate roadmap (1 October-31 December 2023) and their alignment to the strategic objectives.

Table 1: Q3 2023/24 H2 Royal Devon strategy roadmap

		2023		
		H2, Q3		
	Strategic Objectives	Oct	Nov	Dec
Overall Corporate Strategy Roadmap - Year 2 of 5	Collaboration & Partnership		Cardiology networking: RDUH using Torbay labs	PASP / fragile programme: First phase of SEND Urology - weekend oncall
	A great place to work		Long-term Workforce Plan	
	Recovering for the future	RD&E paed ED work commences		
		Tiverton Endoscopy Unit capital funding agreed	Enabling strategies implementation plans agreed	
	Excellence & Innovation in patient care	Genomic sequencer at RD&E - £2.2m of NIHR investment		Health Tech tender won by RDUH - £3m over 5 years

2.11 As per the agreed change control process, all changes to the corporate roadmap are recorded in appendix A.

2.12 There were two formal change controls relevant to the Q3 period. Also, a number of additional milestones were added to the roadmap from the RDUH enabling strategies. The detail is reported in Appendix 1, table 3.

3. Royal Devon Corporate Roadmap Jan-April 2024 (Q4)

3.1 Table 2 shows the look ahead to the milestones proposed for the next three months from 1 January 2024 – 31 March 2024.

			2024		
			H2, Q4		
		Strategic Objectives	Jan	Feb	Mar
Board Programme	Overall Corporate Strategy Roadmap - Year 2 of 5	Collaboration & Partnership	Health Inequalities Strategy to Board	PASP phase 2 commences	
			High Intensity User programme launched at NDDH and RD&E EDs	Fragile phase 2 programme launches	
		A great place to work		Wonford: Develop Staff Accommodation OBC/ Key Worker Housing (Estates)	NDDH: Develop Staff Accommodation OBC
				Admin transformation programme launch	
		Recovering for the future		Health records model and business case	
					ERF programme evaluation
		Excellence & Innovation in patient care			Discharge management incl summaries (EPIC)
				Patient-entered data project (EPIC)	
				Portal-first letters (digital by default)	Implement data layer FBC completed (Data strategy)

Table 2: Q4 2023/4 and Q1 2024/5 Royal Devon strategy roadmap

4. 2024/5 12 month look ahead (draft)

Overall Corporate Strategy Roadmap - Year 3 of 5

Strategic Objectives	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	2024 H1, Q1			2024 H1, Q2			2024 H2, Q3			2025 H2, Q4		
Collaboration & Partnership	Agree support arrangements for EPR roll out across Devon (MOU)	SEND Pathology OBC	Devon Shared Services Business Cases for Digital, Finance, People	Soft FM options appraisal launched	Mid-year evaluation of Fragile and ND high priority services . Close down IPB		PASP modelling report	Exeter Heating Network OBC		PAPC - Review of PASP modeloing and next steps		Soft FM options appraisal (OBC)
Collaboration & Partnership	OSIG: Care Group structure implemented (Phase 1)	Primary Care Support Unit business case/options		OSIG: Care Group structure (Phase 2 starting)				OSIG: Care Group structure (Phase 2 implemented)				
Collaboration & Partnership	CPIG: Year 3 clinical integration plan						CPIG: Year 3 clinical integration plan (6-month review)					
A great place to work	Approval of NDDH Staff Residences Full Business Case	Staff health and wellbeing facilities open (shower blocks / PEOC café)			Completion of NDDH admin decant for OFH prep			NDDH Staff Residences (start of build)	People Digital System FBC		Key Worker Housing FBC	
A great place to work	People Digital System Outline Business Case			RDUH Admin Strategy and pilot								
Recovering for the future	Revised SOC for OFH approved (NDDH)	Northern MRI OBC		Acute assessment options appraisal (SDEC etc)			Breast Unit OBC commences	RD&E Childrens Emergency Dept Opens	OFH OBC commences			Vascular Hybrid Theatre FBC (subject to funding)
Recovering for the future	Cardiology Day Care Unit (CDCU) opens	NDDH Theatre Expansion OBC (funding source tbc)		Buttercup One-Stop Community Diagnostic opens	Evaluation of North Devon 'Make Safe' business case - 18-month on			Tiverton Endoscopy Unit opens				
Recovering for the future	Urology - fragile service model implementation							RDE Urgent Treatment Centre (OBC)(funding source tbc)				Increase of Virtual Ward beds (from 80 to 100)
Excellence & Innovation in patient care	Launch of Year 2 of Biomedical Research Centre	Evaluate AI Pilot in Dermatology	EPIC social determinants of health module									
Excellence & Innovation in patient care	ASAP tools in assessment areas	COSD patient 7 pathology	Registry implementation (clinical research)	Closed loop scanning								
Excellence & Innovation in patient care	Healthcare Tech Research Centre commences							Implement Data Warehouse with NHS Devon				

4.1 Each milestone, programme or deliverable on the roadmap has been assigned an Executive Director SRO and is contained within current plans and aligned to Better Together and enabling strategy delivery.

5. Measuring delivery

5.1 Appendix A outlines the metrics that will be used to assess delivery of the Better Together strategy via the four corporate objectives.

5.2 There are some caveats to the realisation of delivery namely funding availability and capacity to deliver all plans; any continuation of industrial action; general election and any changes to health policy; the impact of EPR procurements in Devon.

6. Recommendations

The Board is asked to note:

6.1 The progress made during October-December 2023 (Q3 23/24) and the achievement of the milestones.

6.2 The roadmap milestones for the next 3 and 12 months and consider whether they are sufficiently ambitious and targeted at the areas of greatest priority and opportunity.

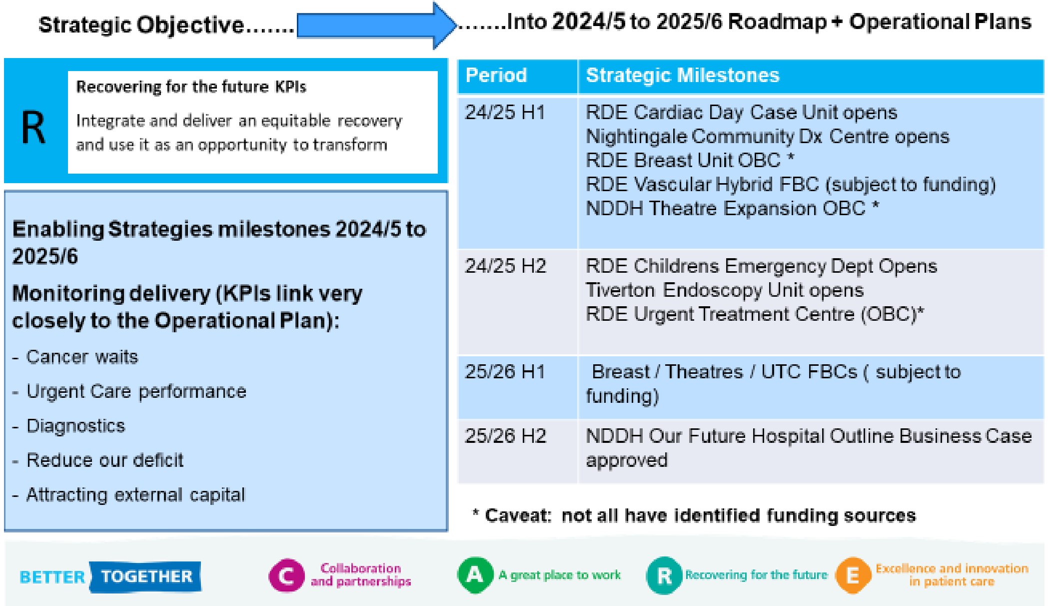
Appendix A: Corporate roadmap change control record

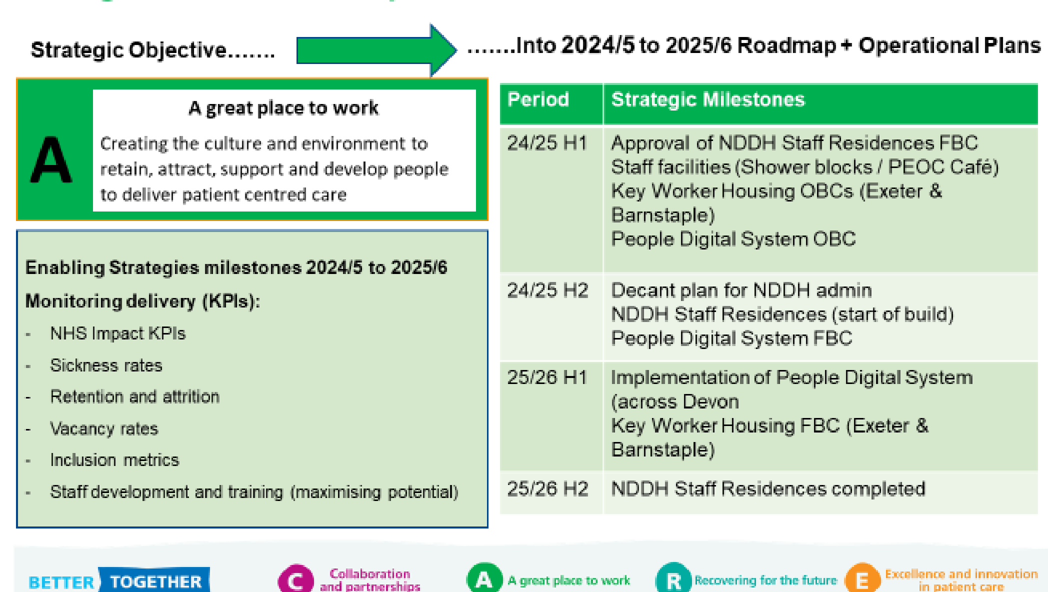
As per the change control process agreed at the meeting of the Board of Directors in October 2022, the following changes have been made since the paper presented to the Board of Directors in April 2023. These changes are either delays to milestones, items being brought forward, new commitments or redundant commitments. Each change to the roadmap schedule has been approved by the relevant executive SRO.

Table 3: Change controls proposed from Q3 2023/24 milestones

Commitment	Original date due	Proposed new date	Reason for change
NDDH: Develop Staff Accommodation OBC/ Key Worker Housing	December 2023	February 2024	The NDDH Staff Accommodation OBC has been developed and went to TDG in December 2023. It is planned to be taken to the Board of Directors in February 2024. This milestone has been moved forward on the roadmap
Health Inequalities strategy	Nov 2023	January 2024	Following feedback from TDG and the launch of new NHSE guidance on health inequalities adjustments to the draft strategy were required.
NEW: Genomic Sequencing investment	n/a	October 2023	Milestone added from the R&D strategy
NEW: Cardiology labs	n/a	November 2023	Milestone added to Roadmap from Peninsula Acute Provider Collaborative programme
NEW: PASP SEND urology development	n/a	December 2023	Milestone added to Roadmap from Peninsula Acute Provider Collaborative programme
NEW: Health Tech tender	n/a	December 2023	Milestone added from the R&D strategy
NEW: OFH OBC Options Reviewed	n/a	January 2024	Milestone added to Roadmap from Estates Strategy
NEW: Digital Services Integration – Single RDUH SSID	n/a	February 2024	Milestone added to Roadmap from EPIC development
NEW: One stop clinic (Buttercup ward) implemented	n/a	March 2024	Milestone added to Roadmap from Clinical Strategy
NEW: Implement data layer FBC completed	n/a	March 2024	Milestone added to Roadmap from Data Strategy
NEW: Wonford: Develop Staff Accommodation OBC/ Key Worker Housing	n/a	March 2024	Milestone added to Roadmap from Estates Strategy

Appendix 2: Strategic Objectives metrics and roadmap to deliver the Better Together strategy





Collaboration and Partnership

Royal Devon University Healthcare NHS Foundation Trust

Strategic Objective……… ……Into 2024/5 to 2025/6 Roadmap + Operational Plans

C — **Collaboration and Partnerships**

Work in partnership to improve health and tackle health inequalities

Enabling Strategies milestones 2024/5 to 2025/6

Monitoring delivery (KPIs):

- Increased local supply chain
- Equality and diversity of employment
- Clinical service integration
- Reduced carbon footprint
- Health inequalities workplan delivery and elective recovery (deprivation & ethnicity)

Period	Strategic Milestones
24/25 H1	• Implement OSIG structure – Integration milestone • Agree support arrangements for EPR roll out across Devon (MOU) • Next phase of Peninsula Acute Sustainability Programme (PASP) • Programme of support to peninsula fragile services • Business case for Primary Care Support Unit • Devon Shared Services business cases
24/25 H2	• Exeter Heating Network OBC • Implement Data Warehouse with NHS Devon
25/26 H1	• Public engagement on PASP
25/26 H2	• Peninsula Strategic Business Case • Support EPR go live across Devon

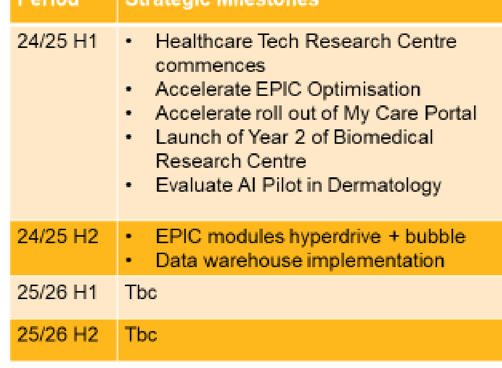
BETTER TOGETHER | C Collaboration and partnerships | A A great place to work | R Recovering for the future | E Excellence and innovation in patient care

Excellence and innovation

Royal Devon University Healthcare NHS Foundation Trust

E — **Excellence and innovation in patient care**

We will embrace new technologies, research and innovation to deliver the best possible care



Period	Strategic Milestones
24/25 H1	• Healthcare Tech Research Centre commences • Accelerate EPIC Optimisation • Accelerate roll out of My Care Portal • Launch of Year 2 of Biomedical Research Centre • Evaluate AI Pilot in Dermatology
24/25 H2	• EPIC modules hyperdrive + bubble • Data warehouse implementation
25/26 H1	Tbc
25/26 H2	Tbc

Enabling Strategies milestones 2024/5 to 2025/6

Monitoring delivery (KPIs):

- EPIC MyChart portal sign ups
- Use of RPA and AI in clinical care
- Patients recruited to clinical trials
- Increased clinical data dashboards
- Research income and trial activity
- Students in QI / transformation training
- CQC action plan

Agenda item:	11.2, Public Board Meeting	Date: 31 January 2024	
Title:	Quarterly review of the Board Assurance Framework		
Prepared by:	Melanie Holley Director of Governance		
Presented by:	Melanie Holley Director of Governance		
Responsible Executive:	Sam Higginson, Chief Executive Officer		
Summary:	To present to the Board of Directors the Board Assurance Framework for the Royal Devon.		
Actions required:	Link to status below and set out clearly the expectations of the Board when considering the paper.		
History:	The BAF was last presented to the Board of Directors on 1 November 2023. In line with the Boards schedule of reports, the BAF is presented quarterly for review.		
Link to strategy/ Assurance framework:	The issues discussed are key to the Trust achieving its strategic objectives		

Status (x):	Decision	Approval	Discussion	Information
		x	x	

Monitoring Information

Please *specify* CQC standard numbers and tick ✓other boxes as appropriate

Care Quality Commission Standards	Outcomes		
NHS Improvement		Finance	
Service Development Strategy		Performance Management	
Local Delivery Plan		Business Planning	
Assurance Framework		Complaints	
Equality, diversity, human rights implications assessed			
Other *(please specify)*			

1. Purpose of paper

To present to the Board of Directors (BoD), the quarterly review of the Board Assurance Framework (BAF) for the Royal Devon University Healthcare NHS Foundation Trust.

2. Background

On 1 April 2022, the Royal Devon & Exeter NHS Foundation Trust integrated with Northern Devon NHS Trust and was renamed the Royal Devon University Healthcare NHS Foundation Trust (Royal Devon). Prior to April 2022 a BAF existed for both Trusts and was reviewed quarterly at the Joint Board Meetings.

The BoD approved a Corporate Strategy for Royal Devon on 27 April 2022. A new BAF was created which outlined the risks of the Trust not achieving the strategic objectives which are detailed within the Corproate Strategy.

The BAF was reviewed in April 2023 alongside the Trusts Corporate Risk Register.

The BoD agreed that as part of the operational planning process and in line with good governance, the BAF should once again undergo a review to ensure it accurately updates the risks to the Trust not achieving the strategic objectives. The BoD approved the proposed revised BAF in July 2023 as part of the routine quarterly review.

Individiual BAF risks were last reviewed during December 2023 and January 2024 by the Board Committees.

The list of BAF risks is detailed in Appendix A.

3. Analysis

Summary of current and target assessments of risks

Risk ID	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Position ↔ ↓ ↑	Target
1	16	16	16	16	16		↔	8
2	16	16	16	16	16		↔	8
3	20	20	20	16	16		↔	12
4	25	25	25	20	25		↑	12
5	25	25	25	20	20		↔	9
6	New risk			20	20		↔	8
7	9	9	9	9	15		↑	6
8	12	16	16	16	16		↔	4
9	16	16	Not reviewed	16	16		↔	8
10	New risk			25	25		↔	4

Summary of current risk scores heat map

Impact	Likelihood				
	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Very Likely			7	5,6	4,10
4 Likely				1,2,3,8,9	
3 Possible					
2 Unlikely					
1 Rare					

Points for the BoD to note:

Risk 2 – Failure to recruit, retain and train
The People, Workforce Planning and Wellbeing Committee (PWPW) reviewed Risk 2 on 18 January 2024. Some minor amendments being made. Assurance was provided that the right actions are being planned, however, the risk remains high. During this review cycle, an additional line for 'forecast risk' was added to the graph. A discussion was held about when the likelihood may reduce on this risk, however due to the current vacancy freeze and financial controls, the Committee felt that the risk levels in this area were unlikely to reduce in the current calendar year.

Risk 3 – Trust unable to invest in its Capital Plans
The FOC reviewed risk 3 on 18 January 2024. There has been no demonstrable change in the capital position that justifies a change in scoring at this stage. Guidance on the 2024/25 operational planning process is yet to be received. This will determine whether there is any increase in risk to BAU capital. The Trust continues to engage where appropriate with national programmes for any strategic capital to support development. Where strategic capital is required to support elective capacity, support is sought from NHS England national programme leads to emphasise the need for prioritised funding. In addition, innovative solutions are being sought to take advantage of potential national slippage.

Work is continuing through the national hospitals programme to support the Northern site redevelopment and whilst work is progressing on some of the enabling works, the short form business case for phase 1 and the Strategic Outline Case for the full programme are still subject to national timetabling and approval.

Risk 4 – Non Delivery of the Financial Plan (Trust and System)
The FOC reviewed risk 4 on 18 January 2024. Although there has been no change in the current narrative, there has been a change in the forecast risk.

The forecast risk has been reviewed in line with the controls set out which will impact on the 2024/25 operational plan. Through the focus on the MTFP and narrative around multi-year financial recovery, alongside what has been delivered to date the Devon ICS should be in a better position to negotiate a planned deficit for 2024/25 which will be acceptable by regulators. It is assumed this will improve the risk score during April if we are able to achieve sign off. A further improvement to the risk score should deliver during the first quarter as the improvements in budget and plan alignment, ownership for delivery and enhanced controls will support in year delivery.

Risk 5 – Elective Demand and Waiting List Backlogs are not delivered
The FOC reviewed risk 5 on 18 January 2024. The narrative has been updated to reflect the increasing imperative from NHSE, noth regionally and nationally, to develop system wide solutions to identified shortfalls in elective capacity, with the attendant impact both in terms of time and complexity upon the articulation and approval of solutions where funding is required.

The narrative has also been updated to reflect the recent approval of the Spinal Surgery Business case, and the intended development of further business cases in relation to both Cardiology, and to Ora Maxillofacial Surger, as additional sources of assurance.

No change in risk score. The risk score has been reviewed and is recommended to remain at a score of 20 on the basis of the continued likelihood of the Trust's inability to deliver its elective commitments as articulated in the Trust's Financial and Operational Plan and the associated impact and consequence.

In addition, a forecast has been included which maintains the current risk score of 20 through to September 2024.

Risk 6 – Our people do not feel looked after or valued
The PWPW reviewed Risk 6 on 18 January 2024. Some minor amendments were made. Assurance was provided that the right actions are being planned, however, the risk remained high. During this review cycle, an additional line for 'forecast risk' was added to the graph.

Risk 7 – Risk of not maximising Epic benefits (Trust and System)
The Digital Committee reviewed the risk in January. After reviewing with the team, it was agreed that the risk regarding 'lack of skills / confidence of staff and patients' had been mitigated and no longer applicable, therefore, the residual risk is focussed around realising the remaining financial beneftis from North / East MY CARE Business Cases, which are dependent on various managements of change.

The likelihood score has increased due to the fact that benefits realisation is already behind plan, the trajectory to improve the risk score is likely to be at least 12 months whilst the MOCs are worked through (these timescales have had oversight from the CEO / Deputy CEO and CMO). Risk score changed from 9 to 15.

Risk 8 – Risk of a significant deterioration in quality and safety of care
The Safety and Risk Committee was stood down in December 2023 due to Industrial Action; however BAF Risk 8 has been reviewed by the Chief Nursing Officer and Chief Medical Officer (Executive Leads for Risk 8) and is being submitted to the Board of Directors with their updates. BAF Risk 8 will also be re-presented at February's Safety and Risk Committee.

Risk 9 – Our Future Hospitals, delays in funding / failure to deliver clinical strategy for Northern services
Whilst there has been a government announcement, it is still too soon to say whether it is possible to reduce the current risk score back down to a 4 x 3. Much will depend on the release of the capital funding for the phase 1 enabling works on accommodation and the confirmation around the timing of the preferred option.

Risk 10 – Urgent and Emergency Care Targets are not delivered
The FOC reviewed the risk on 18 January 2024. Updates are proposed to the narrative to reflect the conclusion of the 2023/24 Winter Funding investment process, and the impact of the increasingly ad-hoc and short-term funding granted. Additional assurances, including the

feedback from the programme of External Visits, and from implementation of the Trust's Improvement Programme are referenced.

The risk score has been reviewed and is recommended to remain unchanged at 25 due to the likelohod of the Trust being unable to deliver the urgent and emergency care commitments (incorporating both 4 Hour Waiting Times Performance, and No Criteria to Reside) contained within the Trust's Financial and Operating Plan with the associated organisational and financial impact.

In addition, a forecast has now been incorporated which moves the current score of 25 in April 2024 to a score of 20 and thereafter unchanged from 20 through to September 2024.

4. Resource/legal/financial/reputation implications

None

5. Link to BAF/Key risks

In addition to being an incredibly useful management tool, regulators require BoDs to have a robust BAF in place as part of the Boards assurance and risk management process.

6. Proposals

For the Board of Directors to:

- Review the current 10 BAF risks, asking questions and providing challenge to ensure that mitigations and actions are progressing timely and ensuring that the scores accurately reflect the current position of the risks.
- To identify any further risks which are not listed.
- To note that in addition to this report, the Board will receive regular updates from the Sub Committees of the Board for the BAF risks that have been delegated for review by Sub Committees.
- To approve the increase in risk score for Risk 7 from 9 to 15.

APPENDIX A
Summary of BAF Risks January 2024

	Strategic Risk (High level version)	SRO	Committee	Current	Target
1	**Degree & complexity of change impacts on leadership resilience & capacity to deliver**	CEO	Board	16	8
2	**Failure to recruit, retain and train the required to ensure the right no. of staff with the right skills in the right location**	HF	GC (via PWPW)	16	8
3	**Trust unable to invest in its capital plans**	AHi	FOC	16	12
4	**Non delivery of the financial plan** (Trust and system)	AHi	FOC	25	12
5	**Elective demand and waiting list backlogs are not delivered**	JP	FOC	20	9
6	**Our people do not feel looked after/valued, employee experience is poor and people feel health and wellbeing are not prioritised**	HF	GC (via PWPW)	16	8
7	**Risk of not maximising EPIC benefits** (Trust and system)	AHa	Digital	15	6
8	**Risk of a significant deterioration in quality and safety of care**	CM	GC (via S&RC)	16	4
9	**Our Future Hospitals – Delays in Funding/failure to deliver clinical strategy for Northern services**	CT	OFH	16	8
10	**UEC targets are not delivered**	JP	FOC	25	4

Risk 1 Degree & Complexity of Change Impacts on Leadership Resilience & Capacity to Deliver

Principal risk (what could prevent us achieving this strategic priority)	There is a risk that the degree and complexity of internal and external demands (and the scale of operational change) has a significant negative impact on leadership and senior management capacity, morale and therefore capability.							**Strategic priority**	A great place to work
Lead Committee	Board	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Our People		
Executive lead	CEO / Deputy CEO	**Likelihood**	4 – Likely	3 – Possible	2 – Unlikely	**Risk appetite**	Minimal		
Initial date of assessment	14/09/2022	**Consequence**	4 – Major	4 – Major	4 – Major	**Risk treatment strategy**	Modify		
Last reviewed	10/01/2023 17/04/2023 18/07/2023 26/10/23	**Risk rating**	**16 – Significant**	**12 – Medium**	**8 – Low**				
Last changed	10/01/2023 17/04/2023 18/07/2023 26/10/2023								

25
20
15
10
5
0
Sep-22 Nov-22 Jan-23 Mar-23 May-23 Jul-23 Sep-23 Nov-23 Jan-24 Mar-24 May-24
Current Risk Level
Tolerable Risk Level
Target Risk Level

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Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating** (assured or inconclusive with further actions required)
• Increased complexity of internal and external demands as we recover services post COVID • Financial constraints preventing solutions being implemented. • Significant strategic and operational change- both within the Trust and across the Devon system. • Heightened regulatory scrutiny in relation to the NHS System Oversight Framework (SOF4) criteria. • Ongoing impact of managing and mitigating the impact of industrial action on leadership resilience	• Corporate Road Map in place to manage pace of strategic change and to ensure capacity & capability is in place to deliver/ use of Board Development Sessions to ensure capacity is in place • Trustwide Executive and site management structure to support the broader leadership teams. • Trust Delivery Group in place for Trustwide operational matters and Operations Boards set up for each site to ensure agile decision making • Leadership Group established for progression, support and development of senior managers, to provide resilience. • Active Board role input supporting System Recovery Board to ensure proportionate and triangulated across all domains • Executive coaching and mentoring support in place for Executive Directors. • Executive led Leadership Group meetings / engagement events focussed on delivery of operational and strategic priorities • Inclusive Leadership training set up and being delivered to senior leadership team. • Specialist and executive resourcing team in place substantively to support executive, specialist and hard to fill roles. • Management Support Programme launched. • Leadership development programme based on 'Controlling the Controllables'. • Cycle of risk and succession planning for the leadership group commenced, including identification of plans to eliminate single points of failure. • Extensive comms plan based on authenticity and gratitude – naming challenges but celebrating success	• Limited ability to control demands that originate outside of the organisation.	• Working with partner organisations to streamline reporting and improvement interventions to/with regulators. • Ensuring that improvement interventions requested go through a consistent system governance process. • Board Development session to be held on determining timing of road map priorities based on available capacity and urgent demands.	• Performance Assurance Framework (PAF). • Performance and Governance System around delivery. • Intelligence from the quarterly People Pulse surveys and the annual staff survey. • Successful recruitment to senior leadership posts. • Monthly workforce reports on turnover/ sickness • Appraisal and 360 feedback • Feedback from Trust and system leaders • Regular reporting of annual leave usage for the senior leadership team (March 2023) • Data from health & wellbeing conversations (May 2023) • Intelligence on flexible working requests including approval rates (October 2023) • Information on completion of stress risk assessments (December 2023) • Internal progression metrics (October 2023) • Metrics in relation to leadership competency (May 2023) • Reports on attrition/vacancy levels for 8a+ (July 2023)	• • PWPW operates at a level below Governance Committee – Board to consider greater visibility of workforce metrics through Board and sub-committee reporting.	There are a number of actions in place to provide further assurance and to understand the impact of this risk; however, there is a limited amount that can be done to control the external environment and the demands outside of the organisation. Whilst there is assurance that the right actions are included on this plan, it is unlikely that the demands are going to ease and therefore it is expected that the risk score will remain at the current level.

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Risk 2 Failure to Recruit, Retain and Train the Required to Ensure the Right No. of Staff with the Right Skills in the Right Location

Principal risk (what could prevent us achieving this strategic priority)	Failure to recruit, retain and train the required to ensure the right number of staff with the right skills in the right location					Strategic objective	A great place to work
Lead Committee	Governance Committee (via People, Workforce Planning & Wellbeing Committee)	Risk rating	Current exposure	Tolerable	Target	Risk type	Our People
Executive lead	Hannah Foster	Likelihood	4 – Likely	3 – Possible	2 – Likely	Risk appetite	Minimal
Initial date of assessment	14/09/2022	Consequence	4 – Major	4 – Major	4 – Major	Risk treatment strategy	Modify
Last reviewed	~~10/08/23 – GC~~18/01/2024 – PWPW 19/10/2023 - GC	Risk rating	16 – Significant	12 – Medium	8 – Low		
Last changed	~~10/08/23 – GC~~18/01/2024 – PWPW 19/10/2023 - GC						

Current Risk Level
Tolerable Risk Level
Target Risk Level
Forecast Risk Level

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Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gap in assurance / action to address gap (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating (assured or inconclusive with further actions required)
• National shortages. • Competitive recruitment market. • Inability to attract candidates in certain staff groups. • Inability to retain existing staff with particular challenges relating to short tenure.~~.~~ • Not fully utilising digital capability. • Challenging financial climate with ~~headcount reduction for non-clinical roles.~~vacancy freeze, • Potential for	• Trust strategy including great place to work objective and Trust values, to create an effective, healthy and inclusive working environment with a just and learning culture to support recruitment and retention • Growing our own workforce with links to key educational providers and own academy status to provide apprenticeships. • Successful international recruitment campaigns. • Sharing of resources Trustwide i.e. clinical / medical staff working across northern and eastern services. • Specialist and executive resourcing team ~~supporting executive, specialist and hard to fill roles.~~in place. • Career Gateway system • Recruitment fairs ~~scheduled for next 12-months.~~ • Dedicated workforce planning capacity • Delivering Best Value retention stream. • New recruitment branding delivered. • Stay conversations piloted and in place. • Candidates can access helpful information and resources prior to their start date on Learn+. • Strategic resourcing group to support recruitment to posts.	• Lack of strategic workforce plan for the Devon ICS. • Inability to convert temporary workforce to permanent posts. • Sustainable finance solution for pipeline of apprentices sufficient to support retention and transformation. • Staff do not always feel empowered to make changes to mitigate this risk.	• Automated ID & DBS checks for new starters. • Further use of Career Gateway to develop workflows and improve automation. • Development of local 5-year workforce plan. • Position management to move to ESR to provide clear articulation of vacancies at position level ~~(September 2023).~~ • Automate new starter checklist for managers. • Implement discounts and special offers for new starters as part of their welcome. • Prioritise staff accommodation improvement 'must-dos' e.g. rest areas. • Apprenticeship pay and reporting proposal. • Survey new starters in week one, month one and month three, then use the results to improve the new starter experience and drive improvements. • Completion of actions within the NHS Long Term Workforce Plan 2023. • Optioneering tool developed and in use.	• Regular monitoring of a range of metrics, including those linked to recruitment and retention at PWPW. • Strategic Workforce Planning Hub • Metrics in the Integrated Performance Report (IPR). • Benchmarking through the ICS Cultural Dashboard. • Employee experience intelligence including quarterly People Pulse surveys and the annual staff survey including measurement of people promise. • Reporting of progress against the NHS People Plan. • Reporting on recruitment pipelines. • Survey results about induction process experience from new starters and recruiting managers. • Weekly workforce infographic data, showing workforce loss / gain and	• Candidate experience information to be ~~able~~ collected and analysed to inform improvements. (Jul~~y~~ 2023) • Improved health and wellbeing dashboard to be launched (Dec 2023) • Further insight into apprenticeship pipeline to be included in development dashboard (~~Dec 2023~~Apr 2024) • Information about progression metrics to be added to development dashboard (Apr~~Mar~~	**Assured** – The PWPW was assured that the right actions are planned to mitigate this risk. ~~Whilst good progress is being made in terms of vacancy rates, the Committee noted that there are still areas of high risk and that this position is vulnerable and could change. It was therefore~~

increasing GP numbers to adversely impact recruitment and retention of doctors in the acute setting. • The impact of continued industrial action.	• Northern medical workforce business case ~~approved~~, to increase substantive medical capacity. • Proactive health and wellbeing offer in place. • ~~Career Gateway & Learn+ interface including autoenrollment of new starters onto mandatory training and reporting to other key stakeholders.~~ • Interface between Career Gateway and ESR, reducing manual data entry. • Healthcare Support Worker band 2 to 3 process enacted. • Step into health launched to encourage former military candidates to apply for roles across the trust. • Improvements in recruitment and retention have led to a reduced vacancy rate.			details of the pipeline. • Monthly Workforce dashboard in place. • Vacancy Control Process (VCP) ~~including recruiting to turnover for some roles.~~ • Recruitment risks regularly escalated to Senior Responsible Officers (SRO)s • Proactive retirement age profiling in place. • Single strategic resourcing role list with risk based prioritisation, that is regularly reported to the Divisions. • Attraction intelligence available to understand why people are joining the organisation. • Development and learning dashboard in place and presented regularly at People Development Group • Digitalised exit surveys ~~now~~ launched ~~with two months of data collected~~ • Health and wellbeing metrics	2024) • Analysis of exit survey data once enough information has been collected (Dec 2023)	~~agreed that the risk score should remain the same.~~Whilst vacancy levels and turnover have generally moved in a positive direction, it was felt by the Committee that because of the current recruitment freeze and financial controls that the risk score would be unlikely to reduce this calendar year.

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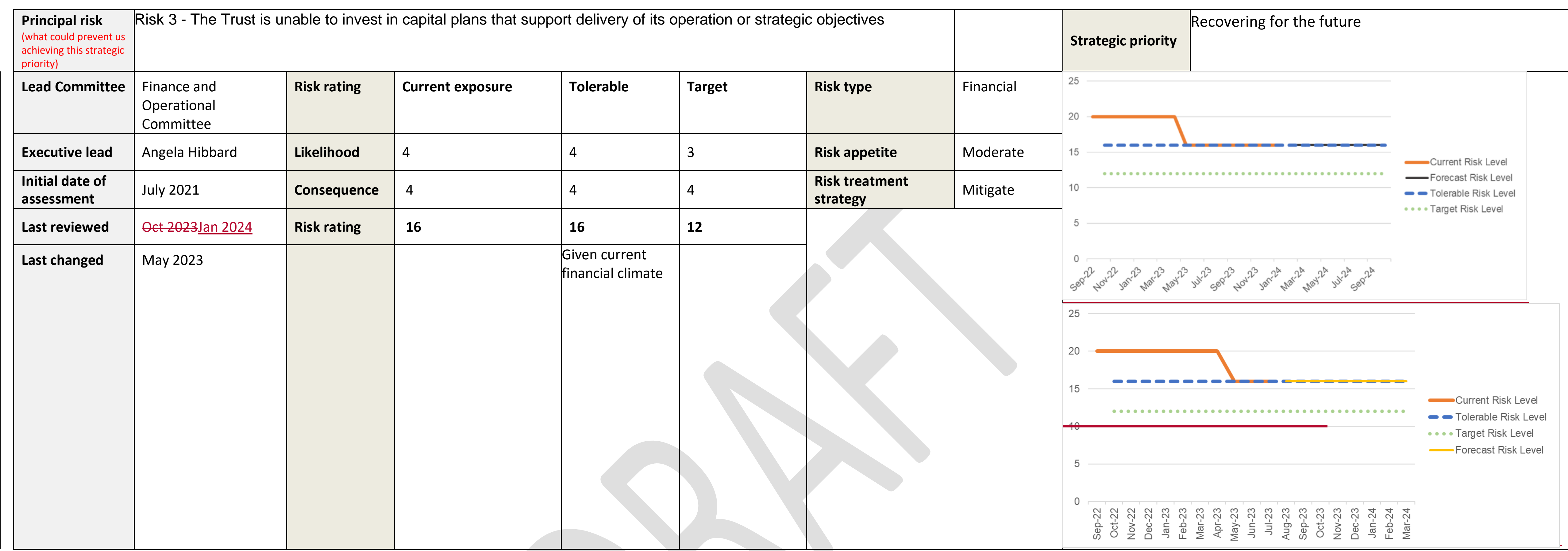
Risk 3 Trust unable to invest in its Capital Plans

Principal risk (what could prevent us achieving this strategic priority)	Risk 3 - The Trust is unable to invest in capital plans that support delivery of its operation or strategic objectives							Strategic priority	Recovering for the future
Lead Committee	Finance and Operational Committee	Risk rating	Current exposure	Tolerable	Target	Risk type	Financial		
Executive lead	Angela Hibbard	Likelihood	4	4	3	Risk appetite	Moderate		
Initial date of assessment	July 2021	Consequence	4	4	4	Risk treatment strategy	Mitigate		
Last reviewed	~~Oct 2023~~Jan 2024	Risk rating	16	16	12				
Last changed	May 2023			Given current financial climate					



Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
The new NHS Capital regime is managed under ICS level CDEL limits, reducing the ability for Foundation Trusts to invest above a set limit. In addition, capital sources are becoming more constrained at a time that backlog maintenance costs are increasing. The ability to carve out strategic capital form internal CDEL limits is therefore challenging. Additional national capital is made available during the year but as a System with a deficit financial plan and in SOF4 restrictions on assessing this capital are likely. In addition, the national hospital programme (a source of future funding for the North) is over subscribed and plans are likely to be reduced within an affordability envelope. The strategic threat is therefore that capital is insufficient to manage the growing BAU capital needs and strategic capital development will be limited impacting on the delivery of our corporate strategy	**External** Engagement with the ICS & Regional Capital funding process to ensure fair share allocation of ICS CDEL Engage with ICS prioritisation process for national tranches of funding to ensure ICS process reflects priority of Royal Devon strategic capital needs Link to financial revenue risk and the controls around development of a financial recovery trajectory **Internal** Internal Strategic capital prioritisation process Oversight meetings: Research, Innovation and Commercial Opportunities Group, Strategic Estates Development Group	**External** Evidence of link of strategic capital requests to the financial recovery trajectory NHSEI approved financial plan – link to risk 2 Approved SOC for Northern Services development programme though NHP Robust prioritisation process of ICS capital needs linked to OCS LTP/Strategy **Internal** Alignment of capacity and elective recovery with capital investment need Alignment of external funding bids to strategic capital priorities due to the short-term nature of turn around against national funds Evidence of contribution of capital plans to financial recovery trajectory	**External** Refresh of ICS capital prioritisation process with visibility of outputs to ICS leaders Continued engagement with NHP team to set out need to progress Northern Services OFH Refresh of ICS NHP direction of travel following outputs from ICS strategic work programmes (i.e. acute services sustainability) Liaison with NHSEI to communicate importance of strategic capital for Devon ICS and link to operational recovery **Internal** Link to financial revenue risk on financial recovery trajectory Specific evidence of high priority strategic capital schemes such as PEC for Royal Devon on how they will contribute to financial recovery. Strategic Estates plan – being developed across North and East	**External** **Internal** IPR reporting on board capital programme spend Board meeting minutes Board updates and Business Cases Reporting of progress against 5 Year Financial Strategy through SEDG	**External** Capital prioritisation signed off by ICS leaders **Internal** Visibility of risk on capital restrictions through clinical governance/ Safety and risk	

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Risk 4 Non Delivery of the Financial Plan (Trust and System)

Principal risk (what could prevent us achieving this strategic priority)	Risk 4 - The Trust and wider Devon ICS have ambitious deficit plans with a challenging level of savings required, which are -at risk of non-delivery							**Strategic priority**	Recovering for the future
Lead Committee	Finance and Operational Committee	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Finance		
Executive lead	Angela Hibbard CFO	**Likelihood**	5	4	3	**Risk appetite**	Moderate		
Initial date of assessment	July 2021	**Consequence**	5	4	4	**Risk treatment strategy**	Mitigate		
Last reviewed	~~October 2023~~Jan 2024	**Risk rating**	**25**	**16**	**12**				
Last changed	~~May~~ October 2023			Given current financial climate					

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Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gap in assurance / action to address gap and issues relating to COVID-19 (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
The Trust and Devon system have been placed in NOF4 due to the financial and operational performance which places us in the highest tier of national intensive support and additional regulatory scrutiny. The approved financial plan for 2023/24 is extremely challenging due to the underlying deficit across the Devon system and convergence of income towards the national formula. The three year trajectory of financial recovery is also likely to require a continuous high level of savings delivery to reach financial sustainability. The scale and pace of savings required to be delivered results in a real risk that the target cannot be met in year with the consequence of failing to deliver the overall financial plan internally and across Devon and the regulatory consequences of non delivery including staying in the NOF4 regulatory oversight. The inevitable strategic threat is that the balance between financial and operational recovery is lost and decisions are driven in a way that do not align with our Trust values and may be taken outside of the Trust's control.	**External** Active Executive engagement within ICS work programmes and System Recovery Board Direct Trust engagement with the region through established finance networks. ICS Financial Principles framework including how growth funding is allocated and risk share agreed under the new aligned payment incentive guidance Continued work across the ICS strategic work programmes to improve the financial plan run-rate to a more beneficial position into 2024/25 Common system narrative due to the Deloittes drivers of the deficit work System improvement plan aligned to NOF4 exit criteria to focus on delivery Devin ICS MFTP which models the financial trajectory over the 3-5 year period **Internal** Finance and Operational Committee refocused to a core group to enable detailed assurance to be given to the Trust Board. Comprehensive improvement plan for RDUH aligned to the NOF4 exit criteria joining financial, elective and UEC recovery Enhanced budgetary control and ownership of delivery through use of performance assurance framework to hold to account for delivery RDUH finance strategy linked to clinical strategy and contribution to corporate strategy on longer term financial recovery which sets out the financial modelling assumptions aligned to the Devon ICS LTFM. This includes an investment appraisal criteria to support prioritisation of funding Central governance around delivering best value programme in year and longer-term strengthened and embedded from start of the financial year Review of HFMA getting the basics right checklist and action plan being delivered and assured through the	**External** Agreement on next steps to take forward inequities work as a system once a trajectory for financial balance is achieved Delivery plans behind the MTFP which evidences how the MTFP will be delivered **Internal** Delivery plan behind the level of savings set out in the RDUH finance strategy	**External** ICS workplan on financial recovery linked to strategy need for transformation and key enablers to unlock potential - supported through the work of Deloittes Refresh of the Devon ICS LTFM **Internal** Development of multi-year savings / transformation programme to evidence how the finance strategy will be delivered link to benchmarking information	**External** Minuted "View from the Bridge" Updates including: ICS updates on Devon financial position NHSEI updates Updates to inform Board debate from other system committees and meetings Recognition of NDHT subsidy by CCG/ICS subject to NOF 4 approach Feedback from System recovery Board into RDUH finance and operational committee **Internal** Oversight of financial position provided to the Board through the IPR and to Finance and Operational Committee for exceptional items Finance and Operational Committee scrutiny of the Improvement Plan and in particular Delivering Best Value Sub-committee reports to Board Integrated Performance Report Audit committee assurance on grip and control actions Financial Recovery Plan actions to reduce run rate of spend in year	Detailed risk mitigation plan for non-delivery of system workstreams Detailed route to cash for system stretch savings to provide assurance on delivery of the forecast position	

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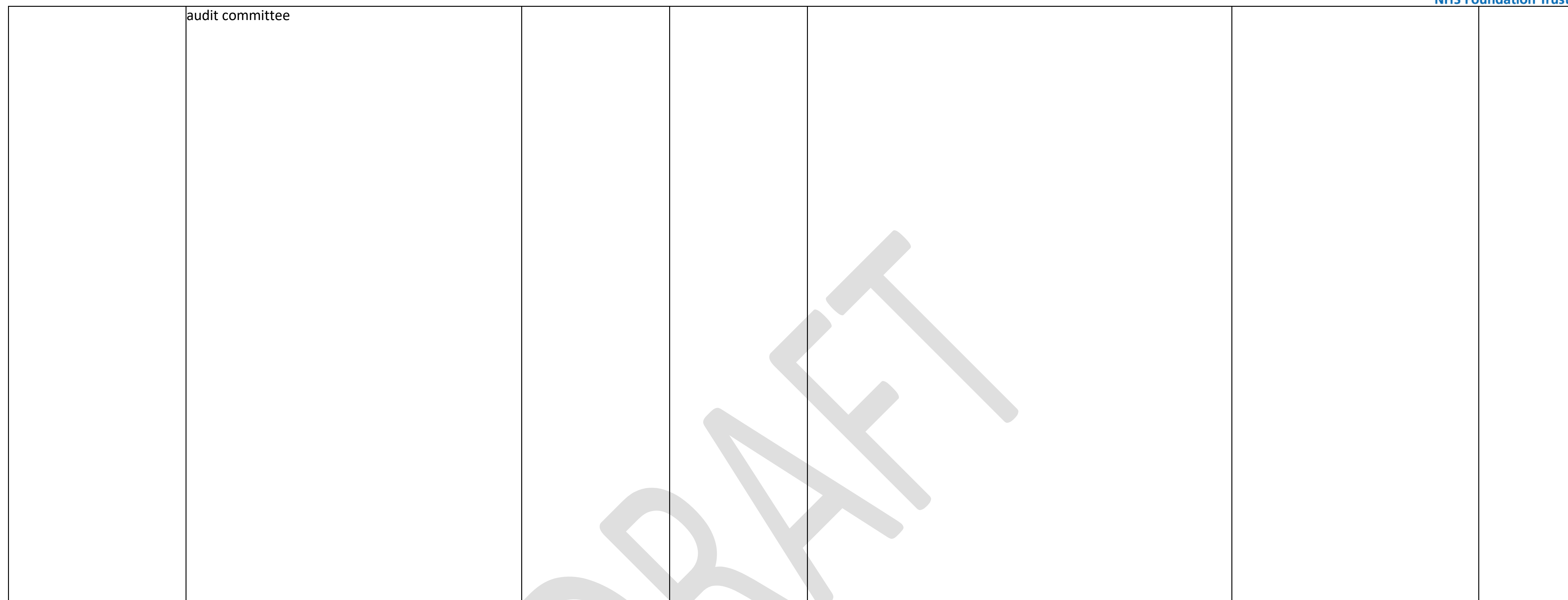
	audit committee					



Risk 5 Elective Demand and Waiting-List Backlogs are not delivered

Principal risk (what could prevent us achieving this strategic priority)	Risk 5 - There is a risk of the Trust being unable to meet new demand for elective services (including cancer) and / or to provide required levels of activity to either address the waiting list backlog or to deliver the commitment contained within the Trust's Financial & Operational Plan	Strategic priority	Recovering for the Future

Lead Committee	Finance & Operational Committee	Risk rating	Current exposure	Tolerable	Target	Risk type	Regulatory, Quality, Reputational
Executive lead	Chief Operating Officer	**Likelihood**	4–likely	4 – likely	3 – possible	**Risk appetite**	minimal
Initial date of assessment	October 2022	**Consequence**	5 – catastrophic	3 – moderate	3 – moderate	**Risk treatment strategy**	Avoid
Last reviewed	~~July 2023~~October 2023	**Risk rating**	**20 – high**	**12 – moderate**	**9 – moderate**		
Last changed	~~October 2023~~January 2024						

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
A widespread and sustained organisational insufficiency of clinical service capacity for patients needing elective care including cancer care as a result of • Workforce fragility and shortages including as a result of industrial action, • inability to sufficiently invest in infrastructure to either increase capacity or replace equipment, • inability to control increased demand for care services, • inability to deliver productivity and efficiency commitments inherent within the Trust's Financial & Operational Plan	Detailed annual planning cycle, Access to Elective Recovery Fund (ERF) and Targeted Investment Fund (TIF) Regular data led reporting to Trust Board, ICS and, NHSEI (region and nationally) on progress against elective recovery trajectory Use of Nightingale Hospital Exeter to provide additional diagnostic and procedure capacity to aid recovery Proactive development of Strategic and Outline Business Cases, to enable timely and detailed responses to national funding when advised as available Active participation in and response to recommendations of One Devon Elective Pilot, and in Further Faster programme Development of effective relationships with ICB and NHSE (both regionally and nationally, including senior attendance at a wide range of system led meetings including Chief Operating Officer / Director of Performance update meetings, System ~~Delivery &~~ Improvement Assurance Group (SIAG), Devon System Elective Improvement ~~Planned Care~~ Board, ~~Provider Performance Oversight Meeting,~~ and Nightingale Hospital Programme Board, and in welcoming best practice visits to the Trust	Awaiting decisions following finance and capital investment requests to support changes to existing estate and clinical models Workforce constraints remain – including recruitment of consultants and other specialist posts in some areas and inability to recruit sufficient nursing staff to open planned escalation areas over the winter period. Co-dependency on ~~STP~~ both ICB and regional partners particularly with regards to strength and sufficiency of capacity of respective elective care service provision, and ability to offer mutual aid capacity where needed Increasing imperative for development of system solutions (eg spinal and cardiology) to identified capacity constraints, with associated time impact for assessment of capacity by providers within system, and demonstration of both collective and individual Trust benefits Pace of development of clinical innovation programme to enable shortfalls in capacity to be overcome Understanding of inequalities of access to care, and associated healthcare impacts	• Expansion of procedures able to be offered from Nightingale, and increased utilisation of Nightingale (December 2022 and ongoing) • Assurance is being sought from the Devon system regarding underwriting of NHE to support continued service delivery (Deputy Chief Executive) • Optimisation work to reduce the impact of MY CARE on outpatient throughput is progressing, and preparations made for the mandating of personalisation in EPIC (Chief Medical Officer). • ERF investment across multiple programmes • Potential further non recurrent investment in outsourcing in Q4 • Continued pursuit of protected elective capacity both in-house and as part of new ventures with Independent Sector partners • Development of Tier 1 Funding proposal to support continued usage of insourcing and outsourcing arrangements on a	Performance metrics • IPR • PAF • RTT Data • Cancer Metrics • Activity and Referrals data Volume, value and aggregate activity impact of approved Elective Recovery Fund (ERF) bids Internal investment & external sponsorship Changes in Trust's Cancer Tiering Status (September 2023) Bed modelling Ability to increase utilisation of independent sector ToRs / Minutes and Action Logs of internal meetings strengthened as part of Operational Governance Framework • Delivery Group • PAF • Operations Boards • Access meeting ToRs/Minutes of external/STP meetings: • Devon Planned Care Board • System Asset Programme Board • Cancer Cabinet • Hospital Escalation status • System Delivery & Improvement Group Programme of and feedback from external visits incl NHSE Cancer Improvement Visit (Autumn 2023) Completion of NHSEI 10-week challenge (Winter 2022) Capital and revenue investments confirmed in Community Diagnostic Centre, Tiverton Endoscopy Unit ~~(phase 10~~, and Cardiology Day Case Unit Funding secured for purchase of a robot for Northern Services, and lease of an additional robot for Eastern Services (Summer 2023) Development of a TIF bid for a vascular hybrid and / or trauma theatre capacity, admissions ward and revenue investment in orthopaedics (September 2023) Development and approval of Devon system spinal surgery business case (November 2023) Proposed development of Cardiology, and Oral Maxillofacial Surgery business cases (Spring 2024)	Current operational and financial planning cycle focuses on 1-2 year plan delivery. Lack of available capital and recurrent revenue funding to support required service changes, and timeliness of regional/ national decision making Sporadic and short notice timeframes in which capital funding is indicated as potentially available and applications are required to be submitted Timeframe for delivery of MY CARE optimisation Local model of care agreed but no agreed Devon ICB future model of care Lack of ICB agreed approach to community engagement, and engagement of wider system partners	

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		amongst different population groups	time-limited basis whilst ERF schemes for 23/24 are optimised to maintain current run rate of delivery • Securing of funding for a- vascular hybrid and / or trauma theatre capacity, admissions ward and revenue investment in orthopaedics • Analysis of system demand and capacity in challenged specialties, and identification where feasible of pan-provider and system coordinated responses including system funding requests (eg spinal surgery, cardiology) *Please note: all actions are ongoing, and being coordinated by the Chief Operating Officer-unless otherwise indicated*			

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Royal Devon University Healthcare NHS Foundation Trust

Risk 6 Our People do not feel looked after/valued, employee experience is poor and people feel health and wellbeing are not prioritised

Principal risk (what could prevent us achieving this strategic priority)	Our people do not feel looked after or valued. Employee experience is poor and people feel their health and wellbeing is not prioritised.					Strategic objective	A great place to work
Lead Committee	Governance Committee (via People, Workforce Planning & Wellbeing Committee)	Risk rating	Current exposure	Tolerable	Target	Risk type	Our People
Executive lead	Hannah Foster	Likelihood	4 - Almost Certain	3 - Possible	2 - Likely	Risk appetite	Minimal
Initial date of assessment	12/07/2023	Consequence	4 - Major	4 - Major	4 - Major	Risk treatment strategy	Modify
Last reviewed	~~21/09/23~~18/01/2024 – PWPW ~~10/08/23~~19/10/2023 - GC	Risk rating	16 – Significant	12 – Medium	8 – Low		
Last changed	~~21/09/23~~18/01/2024 – PWPW ~~10/08/23~~19/10/2023 - GC						

Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (Evidence that the controls/ systems which we are placing reliance on are effective)	Gap in assurance / action to address gap (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating (assured or inconclusive with further actions required)

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• Demand for services exceeds capacity, increasing workload, potential for burnout, moral injury or/and work related stress. • Not fully utilising digital capability, increasing workload for staff. • Challenging financial climate with ~~headcount reduction for non-clinical roles.~~vacancy freeze • Working excessive hours is becoming a cultural norm within the NHS leading to burnout. • Integration change fatigue, long waits and public criticism impacting morale. • Increasing levels of violence and aggression towards our people. • Insufficient psychologically safety/inclusion culture. • Insufficient supportive line management to provide positive employee experience and enable wellbeing. • Lack of management time/capacity to support respecting, welcoming, valuing and developing people. • Operational and financial pressures preventing career development, progression and fulfilment. • Capital constraints preventing quality working environment and/or staff accommodation. • Ongoing Industrial Action impacting rest, leave, operational and leadership capacity. • Lack of integrated ways of working and collaboration, leading to silo working and poorer employee experience.	• Trust strategy including great place to work objective and Trust values, to create an effective, healthy and inclusive working environment with a just and learning culture to support recruitment and retention. • Proactive health and wellbeing offer. • Our Charter. • Promoting a Positive Working Environment Policy and subsequent documentation created with a focus on just and learning culture. • Staff Incident Review Group. • Managing Incivility: becoming a responsible bystander and other strategies training. • Pastoral support, including dedicated role for international recruits. • Freedom to Speak Up Guardians. • Enhanced development offer for existing staff. • Protection and promotion of taking of annual leave. • Staff recognition schemes. • Focus and resources in place for inclusion, employee experience and culture work. • Significant comms and engagement activity with staff via various channels. • Investment in recruitment and retention activity. • Dedicated Staff Rest Space Group. • Line manager induction workshops. • Extraordinary People Awards • Executive inclusion commitments • Board level oversight of inclusion direction	• Process streamlining and automation are not happening quickly enough to reduce workload of staff. • Not all processes and policies support the desired cultural direction. • Training to prevent violence and aggression is not always undertaken by all relevant staff. • Evidence that staff can take breaks. • Protection of management time. • On call arrangements that support work life balance. • Impact of ambitious ICS operational plan. • Impact of NHS Long Term Workforce Plan. • Staff do not always feel empowered to make changes to mitigate this risk. • Inclusion strategy owned at board level.	• Completion of the actions within the Cultural Development Roadmap. • Single Trustwide violence and aggression lead. • Completion of all stages of project simplify. • Line managers and leaders programme to be introduced, including an option to complete individual modules. • ~~Masterclass to help staff to understand and uphold our values being developed.~~ • Systemwide launch of campaign to prevent violence and aggression. • Launch of a revised approach to reward and recognition. • #TeamRoyalDevon week. • Improve flexible working options for all groups. • New flexible retirement options. • ~~Inclusion to be included in future Board Development Day~~ • Phase 1 of the new hospital programme to develop new staff accommodation. • Management of Change (MoC) through Operational Services Integration Group (OSIG)	• Regular monitoring of a range of metrics, including the Integrated Performance Report (IPR). • Benchmarking through the ICS Cultural Dashboard. • Employee experience intelligence, including quarterly People Pulse surveys and the annual staff survey including measurement of people promise. • Reporting on progress against the cultural development roadmap. • Reporting to the Staff Health & Wellbeing Group and sub-groups. • Health & Wellbeing metrics are available, but will be consolidated into a more comprehensive dashboard (see gap). • Feedback to the Inclusion Steering Group from staff inclusion networks • National Guardians Office statistics on Freedom to Speak Up reporting. • Employee Experience and Survey action plan delivery monitored at PAF meetings. • Development and learning dashboard in place and presented regularly at People Development Group. • Digitalised exit surveys ~~now launched with two months of data collected.~~in place. • ~~Health and wellbeing metrics.~~	• Candidate experience information to be ~~able~~ collected and analysed to inform improvements. • Improved health and wellbeing dashboard to be launched (Dec 2023). • Further insight into apprenticeship pipeline to be included in development dashboard (~~Dec 2023~~Apr 2024) • Information about progression metrics to be added to development dashboard (~~Mar~~ Apr 2024) • Analysis of exit survey data once enough information has been collected (Dec 2023)	**Assured** – The PWPW was assured that the right actions are planned to mitigate this risk. ~~The PWPW received assurance that employee experience scores are increasing, however in the current context, including industrial action and ongoing operational pressures, it was agreed for this risk to remain the same.~~The PWPW was assured that the right actions are in place and indicators such as sickness levels are showing normal seasonal trends. However, despite some positive trends, it was agreed that the score should remain the same, given the current context, operational pressures, financial

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						controls and the vacancy freeze.

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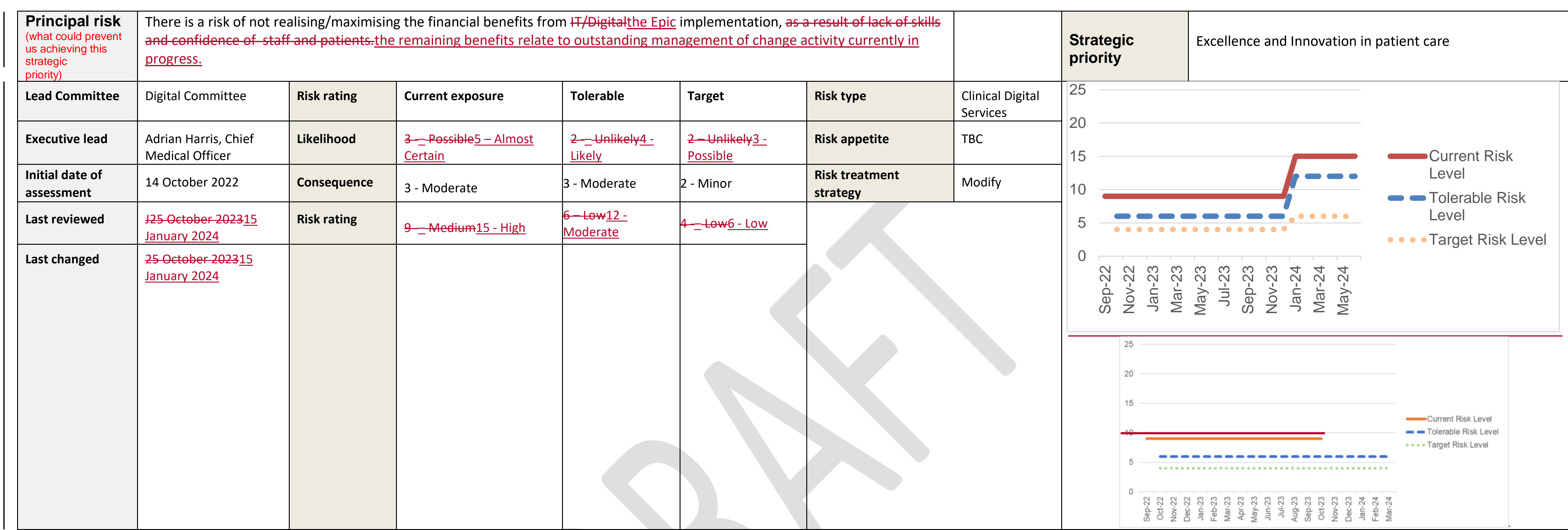
Risk 7 Risk of not maximising ~~EPIC~~ Epic benefits (Trust and System)



Principal risk (what could prevent us achieving this strategic priority)	There is a risk of not realising/maximising the financial benefits from ~~IT/Digital~~the Epic implementation, ~~as a result of lack of skills and confidence of staff and patients.~~the remaining benefits relate to outstanding management of change activity currently in progress.							Strategic priority	Excellence and Innovation in patient care
Lead Committee	Digital Committee	Risk rating	Current exposure	Tolerable	Target	Risk type	Clinical Digital Services		
Executive lead	Adrian Harris, Chief Medical Officer	Likelihood	~~3 – Possible~~5 – Almost Certain	~~2 – Unlikely~~4 - Likely	~~2 – Unlikely~~3 - Possible	Risk appetite	TBC		
Initial date of assessment	14 October 2022	Consequence	3 - Moderate	3 - Moderate	2 - Minor	Risk treatment strategy	Modify		
Last reviewed	~~J25 October 2023~~15 January 2024	Risk rating	~~9 – Medium~~15 - High	~~6 – Low~~12 - Moderate	~~4 – Low~~6 - Low				
Last changed	~~25 October 2023~~15 January 2024								

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Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gap in assurance / action to address gap and issues relating to COVID-19 (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
~~There is a risk that staff across the Trust are resistant to change, particularly integration and EPIC/EPR~~ ~~There is a risk that patients and staff (technical, clinical, and managerial) lack the skills and confidence to implement and exploit digital technology meaning that the benefit of investment could be lost or not maximised~~ ~~Staff are at risk of change fatigue due to the number of significant programmes and staff have raised concerns particularly in relation to being able to effectively deliver across both geographies with limited capacity~~There is a risk that documented financial benefits identified in the Eastern / Northern MY CARE business cases will not be realised / maximised	**Trust committee/governance & clinical service structures including:** Assigned Executive/ Site Director portfolios/accountabilities including relevant statutory roles Single clinical digital services structure in place from April 2023 across RDUH. Single governance process for digital improvement- Series of eight advisory groups reporting to the Clinical Digital & Operational Oversight Group active (as of May 2023) Digital Committee in place across Eastern and Northern Services as a direct Sub-Committee of the Board of Directors Reporting to the Board of Directors via the Digital Committee Appointment of RDUH (cross site) Director of Service Improvement and sub structure to support benefit delivery and integration with transformation programme Clinical Digital services governance meeting commences July 2023 Management of change policy Admin Transformation Programme Manager Role in post Full time comms lead appointed within Transformation to support trust wide engagement on all transformation Projects and Programmes **Support & resources for users/patients:** • Additional 2.5 WTE posts in place focusing on development of MYCARE (patient portal).MyCare marketing campaign launched to increase sign up to 100,000 patient users • Epic IT helpdesk supporting end users/staff with enquiries/issues • Epic training/personalisation sessions to support confidence and efficiency in the use of Epic at a collective and individual level • Tip sheets created and readily available on the EPR system/dashboard to support staff	Secure integrated structure across Eastern and Northern Services not yet agreed and in place in all areas. ~~Digital and Clinical strategies still to be completed as enabling strategies.~~ ~~Two Advisory Groups yet to be set up (ETA Nov 23)~~ Continued use of paper letters (appointment) whilst encouraging patient sign up to MYCARE comms referring to reduced carbon footprint leading to Patient complaints	~~Substantive, integrated CDS structure in place but others still to follow.~~ MOC in east / north, decisions required around workload, scanning service and location of paper records storage (12 months) ~~Tightening links between finance and digital committee on benefits identification and realisation process to be implemented between digital, operations and finance~~ ~~Refresher training to commence December 2023 for all Eastern staff, blending delivery modalities to include self-guided tip sheets, ad-hoc 'video tip sheets', online learning master classes and face to face training.~~ Improved Comms and transparency around functionality of MYCARE & reasons behind paper appt letters – transparency with patients	Bi-m~~M~~onthly reporting to the Board of Directors from the Digital Committee. Support from CEO, Deputy CEO & CMO regarding MOC Clinical digital services and digital services updates monthly to operations boards (N&E) with further updates alt-months to Digital committee. Clinical digital advisory group and oversight group governance structure in place escalating to CEC if required. Benefits realisation progress reporting to Board of Directors / FOC Reporting of benefits – DBV working groups and board. ~~Ongoing recruitment is in progress subject to approval working trust wide as a joint team.~~ ~~Monthly digital focus EPR benefits realisation group (Trustwide) Admin benefit delivery agreed July 2023 with no further EPIC admin benefits expected.~~ ~~Ongoing EPIC training / personalisation sessions to support confidence and efficiency in the use of Epic at a collective and individual level. Refresher training to commence September 2023 for all Eastern staff, blending delivery modalities to include self-guided tip sheets, ad hoc 'video tip-sheets', online learning, master classes and face to face training. Combined with Hyperdrive upgrade to simplify use/ interaction with Epic~~ Patient portal – MYCARE – continuing to drive engagement and comms to increase levels of sign up, currently 80,000 users with 5% (avg) increase per month. Target 100,000 by December 2023 and 120,000 by March 2024. ~~Through transformation comms lead, commencing a programme of 'non-financial' EPIC benefits capture to support engagement with Epic and transformation.~~ Clinical and Digital enabling strategies ~~underway~~complete / published	~~Single structure agreed and implemented July 2023. Substantive funding shortage for full EPR analyst and training capacity required which may contribute to change fatigue for some staff.~~ Benefits- FBC assumptions not fully realisable in some areas. Limited alternative savings available but still being scoped. ~~Engagement with Age UK to support engagement with the use of Patient Portal – they have a digital champion programme to increase older people's engagement and support with digital systems, for those particularly digitally 'excluded'~~	

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	• IO Team (NMAHP & MIO Teams) supporting end users across the Trust Other • Stakeholder & staff Communication & Engagement Plan Partnership Agreement with Staffside and Trade Union partners. Active engagement of staff in key programmes • Clinical (medical) leadership capacity strengthened • Health & Wellbeing support for our people • Transformation Strategy launched Jan 2023 Digital and Clinical strategies completed as enabling strategies. Substantive, integrated CDS structure in place Tightening links between finance and digital committee on benefits identification and realisation process to be implemented between digital, operations and finance Refresher training now embedded within ongoing training schedule, blending delivery modalities to include self-guided tip sheets, ad-hoc 'video tip sheets', online learning master classes and face to face training. Single structure agreed and implemented July 2023. Substantive funding shortage for full EPR analyst and training capacity required which may contribute to change fatigue for some staff. Engagement with Age UK to support engagement with the use of Patient Portal – they have a digital champion programme to increase older people's engagement and support with digital systems, for those particularly digitally 'excluded'					

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Risk 8 Risk of a significant deterioration in quality and safety of care ~~July 2023~~]January 2024

Principal risk (what could prevent us achieving this strategic priority)	Significant deterioration in standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm, poor clinical outcomes and delivery of sub-optimal patient care.							**Strategic priority**	Excellence & innovation in patient care
Lead Committee	Safety and Risk Committee	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient Safety		
Executive lead	Chief Nursing Officer	**Likelihood**	4 - Likely	3 - Possible	2 - Unlikely	**Risk appetite**	Low		
Initial date of assessment	18th October 2022	**Consequence**	4 - Major	3 - Moderate	2 - Minor	**Risk treatment strategy**	Modify		
Last reviewed	~~15th September 2023~~16 January 2024	**Risk rating**	**16 - Significant**	**9 - Moderate**	**4 - Low**				
Last changed	~~23rd October 2023~~9 January 2024								

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Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**

Widespread loss of organisational ability to focus on quality of care, including patient safety processes due to workforce gaps/staff, Industrial Action, working under pressure to deliver flow & covid recovery, and a failure to engage patients and carers in care leading to: - an increased incidence of avoidable harm; - an increased exposure to 'Never Events'; - higher than expected mortality; - a failure to escalate, report and learn from quality incidents.	**Trust committee/governance & clinical service structures including:** • Assigned Executive & Site Director portfolios/accountabilities • Monthly meeting of Safety & Risk Committee & reporting sub groups (IPC/H&S/Patient safety etc.) • Patient Experience Committee • Clinical Effectiveness Committee • Safeguarding Committee **Strategies, policies and procedures:** • Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems • Risk management framework and policy • Performance management framework • QIA process / criteria for completion **Systems and monitoring:** • Incident Reporting investigation process, SIs/Never Event Reports, Claims • Lessons learned from Never Events • Annual Quality Priorities • Retrospective EPIC dashboards • CQUINs & contract monitoring • Recording of escalation systems NEWS etc • Medicines Management • National Surveys • NICE, NSF and Clinical Audit • Capital Programme • Maternity Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) ~~/Ockenden~~and Three Year Delivery Plan • Performance reporting and accountability/ performance reviews/ performance dashboards • Clinical audit programme & monitoring arrangements local and national • External audit of quality/patient safety e.g. GIRFT/Royal college reviews • Defined safe medical & nurse/midwifery staffing levels for all wards & departments • Ward assurance/ metrics & accreditation programme • Triangulation of insight from: • Patients and carers – complaints/PAL's/ Health Watch, other stakeholders • Dialogue with regulators to get feedback on local and benchmarked status re quality standards	Regular Divisional risk reports to S&RC/GC The trust has had a high number of never events, these are serious incidents which are wholly preventable. ~~Trust wide safety oversight~~ Community services were not well represented within the board service and performance measure	Strengthen the reporting of medical and clinical education through PWPW report to GC ***Action will be delivered through the creation of a Board Committee for People which will include the reporting of clinical and medical education January 2024 Trust Secretary / Chief Executive*** Implement the NatSSIP's action plan to create standardised operating protocols & safety culture (NB this is a quality priority for 23/24) ***Completion timeframe as per 23/24 quality priority objectives – Chief Nursing Officer & Chief Medical Officer*** Implementation of National Patient Safety Strategy (inc. PSIRF) ***~~Completion by November 2023 – Chief Nursing Officer & Chief Medical Officer~~Action complete – new Learning from Patient Safety Events (LFPSE) service went live on 01/12/23*** Formation of new Royal Devon Safety Committee (in line with National Patient Safety Strategy requirements) and new Royal Devon Risk Management Committee	**External Independent Inspections** • CQC • Royal Colleges • GIRFT reviews • Commissioning/network reviews • Audit SW Assurance **Internal Audit programme** • Clinical audit outcomes • Ward assurance/ metrics & accreditation programme **Statutory reporting** • Learning from deaths report • Guardian of Safe Working report • Six monthly safe staffing reports – Medical and NMAHP • SHMI • Annual complaints report • Annual IPC report • Board integrated performance report • Quality report (incl. quality priorities) • NHS England Three Year Delivery Plan for Maternity and Neonatal Services (CNST MIS Standards) **Other reporting** • Regular board sub-committee performance/progress reports to GC (patient experience, safeguarding, safety and risk, clinical effectiveness) • Maternity Safety Champion activities • Mandatory training reporting • Health & safety reporting • Claims, inquest reports • Freedom to speak up reports • Whistle blowing reports • Ad-hoc requested specialist specific reports e.g. End of Life • Progress report cultural development • National Patient Safety Alerts compliance reports • HSIB **Screening Quality Assurance Services assessments and reports of:** • Antenatal and New-born screening • Breast Cancer Screening Services • Bowel Cancer Screening Services • Cervical Screening Services **Accreditation/Regulation annual assessments and reports of**; • Pathology (UKAS) • Endoscopy Services (JAG) • Medical Equipment and Medical Devices (BSI) - - Blood Transfusion Annual Compliance Report	Comprehensive systems approach to Patient Safety Management; delivered through implementation of the National Patient Safety Strategy (PSIRF)	

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	People: • Processes in place for staff to raise quality and other related concerns e.g. freedom to speak up guardian, whistle blowing policy • Maintenance of competent clinical staff through recruitment, induction, mandatory training, registration, supervision & re-validation **Industrial Action:** • Gold, Silver, EPPR plans in place to manage business continuity		***Completion by January 2024 – Chief Nursing Officer & Chief Medical Officer*** To review/change/expand the current IPR metrics & other governance and performance meetings to better represent the breadth of services the Trust is accountable for. ***Completion by Autumn 2024 – Chief Operating Officer***	• PLACE **Action Plans** • National survey action plans • Performance recovery plans **QIA outcomes related to operational planning and Delivering Best Value 2023/24**		

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Risk 9 Our Future Hospitals – Delays in Funding/Failure to Deliver Clinical Strategy for Northern Services

Principal risk (what could prevent us achieving this strategic priority)	Continued delay of a positive decision on the Our Future Hospital Strategic Outline Case, resulting in planning blight, a reliance on short term sub optimal investment and a deleterious impact on the recruitment and retention of staff to North Devon						**Strategic priority**	Recovering for the future / Great Place to Work
Lead Committee	OFH Programme Board	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Workforce/ Estate	
Executive lead	Chris Tidman, Deputy Chief Executive	**Likelihood**	4 Likely	3 Possible	2 Unlikely	**Risk appetite**	Minimal	
Initial date of assessment	18/10/2022	**Consequence**	4 Major	4 Major	4 Major	**Risk treatment strategy**	Modify	
Last reviewed	18/07/2023 26/10/2023	**Risk rating**	**16**	**12**	**8**			
Last changed	18/07/2023 26/10/2023							

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**

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Next phase of the ~~national~~ NHP ~~results~~ (including RAAC) ~~in~~ means NDDH scheme being pushed back until post 2030; Hospital 2.0 pushback suggesting ambition ~~due to complexities of ambition~~ for complete hospital rebuild compared to more deliverable part rebuild/ part refurb. Increase in design complexity and delays ~~l~~leading to risk around critical backlog maintenance and lack of confidence amongst clinical staff of scheme delivery. Underlying financial deficit of the Devon system leads to a more radical Acute Sustainability review of hospital configuration, meaning a detailed Pre Consultation Business Case, slowing down decision making	**Trust Committee / Board Governance** OFH Programme Board meets monthly and reports progress to Board of Directors, including developing options around phase 1 enabling works and deliverability / affordability of various options from part rebuild/refurb to full rebuild Early enabling work starting on accommodation blocks to demonstrate progress. Phase 1 ~~OBC~~ business case being completed and importance socialised with DHSC and NHSE. **System Governance** Trust active participant in Peninsula New Hospital Programme Board. July 2021 SOC supported by the Devon CCG/ICS are clinically necessary and affordable. Devon NHPs now part of ToR of the ICS Finance Committee and agreement to review OBCs in light of Peninsula Acute Sustainability Programme **Stakeholder Management** Robust internal comms approach with senior clinical staff around understanding process and approach to options Proactive engagement with NHP Executive and political stakeholders particularly NHS England as programme sponsor to stress the importance of early enabling works to demonstrate progress, risks of extended delay and having a deliverable scheme that can pass HM Treasury affordability tests. NHP roadshow visit to North Devon on 2nd August, monthly NHP forum meetings, new regional NHP structure from end 2023.	Risk of delay by NHP & ICB/Region may not be understood by healthcare delivery partners Risk of delay may not be fully understood by national politicians	Critical Backlog maintenance and mitigation plans to be assessed and shared with NHP team & ~~ICB~~ NHSE (Dec 2023), so financial and service impacts of any delay on capacity or capital funding is clearly understood Visits from politicians and NHSE to outline the risks of delay. Letters to DHSC and local MPs to confirm risk position.	SOC, Board and Committee reports Internal Gateway Assurance ~~Letters from NHP outlining funding for Phase 1 OBC~~MOU for Phase 1 residence short form business case (RIBA stage 4) and letter for NHP SRO Dec 2023 confirming PDC funding allocated for 2024-25. Political statements supporting the early investment in staff accommodation in North Devon & commitments to maintaining momentum		Whilst we now have a government announcement, it is still too soon to say whether it is possible to reduce the current risk score back down to a 4 x 3. Much will depend on the release of the capital funding for the phase 1 enabling works on accommodation and the confirmation around the timing of the preferred option.

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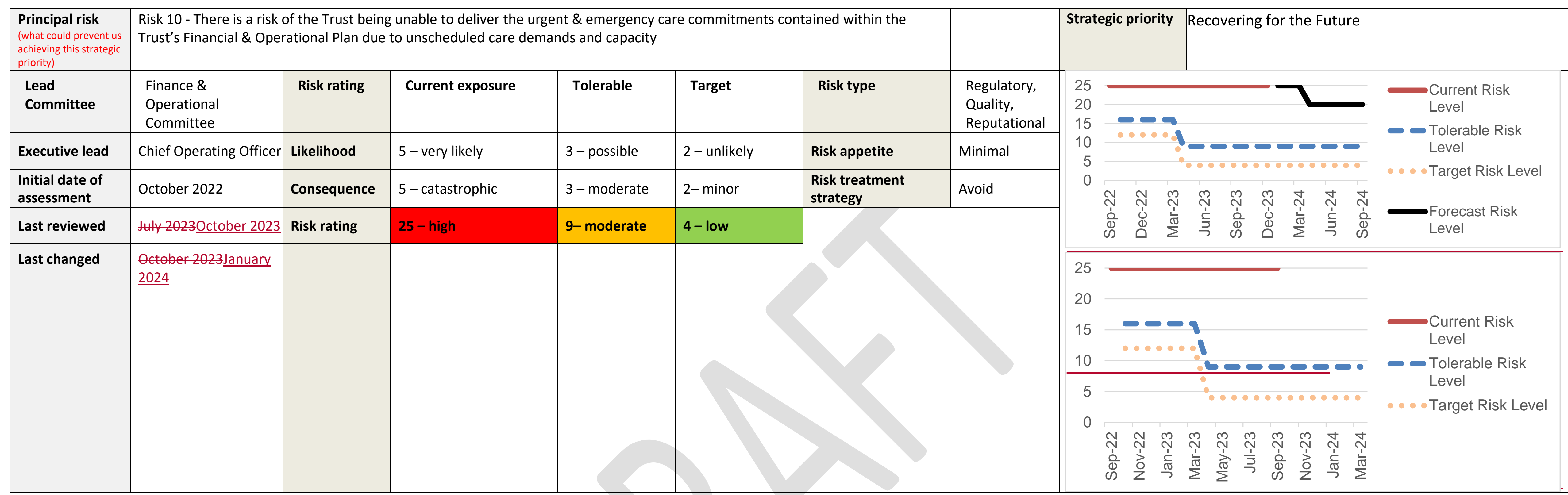
Risk 10 UEC Targets are not delivered



Principal risk (what could prevent us achieving this strategic priority)	Risk 10 - There is a risk of the Trust being unable to deliver the urgent & emergency care commitments contained within the Trust's Financial & Operational Plan due to unscheduled care demands and capacity	Strategic priority	Recovering for the Future

Lead Committee	Finance & Operational Committee	Risk rating	Current exposure	Tolerable	Target	Risk type	Regulatory, Quality, Reputational
Executive lead	Chief Operating Officer	Likelihood	5 – very likely	3 – possible	2 – unlikely	Risk appetite	Minimal
Initial date of assessment	October 2022	Consequence	5 – catastrophic	3 – moderate	2– minor	Risk treatment strategy	Avoid
Last reviewed	~~July 2023~~October 2023	Risk rating	25 – high	9– moderate	4 – low		
Last changed	~~October 2023~~January 2024						

Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gap in assurance / action to address gap and issues relating to COVID-19 (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
A widespread and sustained organisational insufficiency of clinical service capacity for patients needing urgent care due to unscheduled care demands and capacity, as a result of • System and care partners' failure to deliver necessary improvements to support achievement of 5% No Criteria to Reside • workforce shortages including as a result of industrial action, • inability to control increased demand for care services, including demand for urgent and emergency care • inability to deliver productivity and efficiency commitments inherent within the Trust's Financial & Operational Plan • wider system demand/support for urgent & emergency care through ambulance diverts	Detailed annual planning cycle, including development of operational capacity and resilience plan (Winter plan), Regular data led reporting to Trust Board, ICS and, NHSEI (region and nationally) on progress against urgent & emergency care improvement trajectories Development of effective relationships with ICB and DCC, including senior attendance at a wide range of system led meetings including Chief Operating Officer / Director of Performance update meetings, System ~~Delivery &~~ Improvement Assurance Group, Devon System ~~Urgent~~ Unscheduled Care Board, ~~Provider Performance Oversight Meeting,~~ and active participation in and escalation into Devon System SOF4 Improvement Programme including weekly Tier 1 UEC meetings with NHSE (region), and monthly meetings with National Director of UEC Detailed system wide and organisational winter planning Four week pilot undertaken October to November 2022 with adjusted postcode catchments to support TSDT and UHP Trusts. Further ten week adjustment to postcode catchments to support TSDT and UHP agreed. Discussions ongoing as to the most sustainable basis by which any ambulance activity might be diverted to RDUH going forward	Co-dependency on system partners particularly with regards to strength, sufficiency of capacity and availability of urgent care including out of hours services within primary care, and social care Lack of visibility of and volatility in funding decisions of system partners, particularly with regards to social care Shortfalls in funding within health system leading to increasing fragmentation and short term nature of funding decisions leading to increasing difficulty in (and resource required to) implement sustainable solutions Workforce constraints remain – including recruitment of consultants and other specialist posts in some areas and inability to recruit and / or retain sufficient nursing staff to maintain WIC service delivery or to open planned escalation areas over the winter period. Continuing workforce fragility for external care providers (e.g. domiciliary care and nursing home care) Ability of neighbouring Trusts to respond to equivalent UEC pressures and demand, and to	Infrastructure for emergency patients has progressed throughout 2022/23 including. • Continued progress of the ED Redevelopment programme, and inclusion of a Paediatric ED element to the programme. Securing of necessary further funding release by system partners by end Q1 23/24. Refresh of the Operational Capacity and Resilience Plan (Winter Plan) approved by Board in October 2022. Further refresh to be undertaken in Autumn 2023 as an integral part of the Trust UEC plan Implementation at pace of Trust's UEC Improvement Plan through Autumn and Winter 2023 Proposed service transfer of Exmouth MIU (Spring 2023) *Please note: all actions are ongoing and being coordinated by the Chief Operating Officer unless otherwise indicated*	Performance metrics • IPR (monthly) • PAF (monthly) • Activity and Referrals data (IPR monthly) Likelihood of discontinuation of adjustment to postcode catchments 10/10/2023 ~~and potential for~~ Winter Director appointment for Devon, and instigation of dynamic conveyancing ~~Anticipated~~ update on UEC funding (Community £3.2m vs £5.2m fair share) Winter Plan (Autumn 2023) Bed modelling (Autumn 2023) Development Plan for Trust's Community Services (Autumn 2023) ToRs / Minutes and Action Logs of internal meetings strengthened as part of Operational Governance Framework • Trust Delivery Group • PAF • Operations Boards ToRs/Minutes of external/STP meetings: • Devon Urgent Care Board • Hospital Escalation status • System Delivery & Improvement Group Schedule of 1:1s with Devon County Council Director of Integrated Adult Social Care Programme of and feedback from external visits (Autumn 2023) Implementation and impact of Trust Improvement Plan	Current health operational and financial planning cycle focuses on 1-2 year plan delivery. Lack of visibility of funding availability and funding decisions of social care system partners System funding availability leading to increasingly ad-hoc and short-term funding decisions Local model of care agreed but no agreed Devon ICB future model of care Lack of ICB agreed approach to engagement of wider system partners	

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		maintain delivery of identified fragile services Continuation of ambulance catchment change, alongside ongoing requests for further ambulance diverts to support Devon system Pace of development of clinical innovation programme to enable shortfalls in capacity to be overcome				

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Risk 1 Degree & Complexity of Change Impacts on Leadership Resilience & Capacity to Deliver

Principal risk (what could prevent us achieving this strategic priority)	There is a risk that the degree and complexity of internal and external demands (and the scale of operational change) has a significant negative impact on leadership and senior management capacity, morale and therefore capability.							**Strategic priority**	A great place to work
Lead Committee	Board	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Our People		
Executive lead	CEO / Deputy CEO	**Likelihood**	4 – Likely	3 – Possible	2 – Unlikely	**Risk appetite**	Minimal		
Initial date of assessment	14/09/2022	**Consequence**	4 – Major	4 – Major	4 – Major	**Risk treatment strategy**	Modify		
Last reviewed	10/01/2023 17/04/2023 18/07/2023 26/10/23	**Risk rating**	**16 – Significant**	**12 – Medium**	**8 – Low**				
Last changed	10/01/2023 17/04/2023 18/07/2023 26/10/2023								

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Current Risk Level
Tolerable Risk Level
Target Risk Level

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Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating** (assured or inconclusive with further actions required)
• Increased complexity of internal and external demands as we recover services post COVID • Financial constraints preventing solutions being implemented. • Significant strategic and operational change- both within the Trust and across the Devon system. • Heightened regulatory scrutiny in relation to the NHS System Oversight Framework (SOF4) criteria. • Ongoing impact of managing and mitigating the impact of industrial action on leadership resilience	• Corporate Road Map in place to manage pace of strategic change and to ensure capacity & capability is in place to deliver/ use of Board Development Sessions to ensure capacity is in place • Trustwide Executive and site management structure to support the broader leadership teams. • Trust Delivery Group in place for Trustwide operational matters and Operations Boards set up for each site to ensure agile decision making • Leadership Group established for progression, support and development of senior managers, to provide resilience. • Active Board role input supporting System Recovery Board to ensure proportionate and triangulated across all domains • Executive coaching and mentoring support in place for Executive Directors. • Executive led Leadership Group meetings / engagement events focussed on delivery of operational and strategic priorities • Inclusive Leadership training set up and being delivered to senior leadership team. • Specialist and executive resourcing team in place substantively to support executive, specialist and hard to fill roles. • Management Support Programme launched. • Leadership development programme based on 'Controlling the Controllables'. • Cycle of risk and succession planning for the leadership group commenced, including identification of plans to eliminate single points of failure. • Extensive comms plan based on authenticity and gratitude – naming challenges but celebrating success	• Limited ability to control demands that originate outside of the organisation.	• Working with partner organisations to streamline reporting and improvement interventions to/with regulators. • Ensuring that improvement interventions requested go through a consistent system governance process. • Board Development session to be held on determining timing of road map priorities based on available capacity and urgent demands.	• Performance Assurance Framework (PAF). • Performance and Governance System around delivery. • Intelligence from the quarterly People Pulse surveys and the annual staff survey. • Successful recruitment to senior leadership posts. • Monthly workforce reports on turnover/ sickness • Appraisal and 360 feedback • Feedback from Trust and system leaders • Regular reporting of annual leave usage for the senior leadership team (March 2023) • Data from health & wellbeing conversations (May 2023) • Intelligence on flexible working requests including approval rates (October 2023) • Information on completion of stress risk assessments (December 2023) • Internal progression metrics (October 2023) • Metrics in relation to leadership competency (May 2023) • Reports on attrition/vacancy levels for 8a+ (July 2023)	• • PWPW operates at a level below Governance Committee – Board to consider greater visibility of workforce metrics through Board and sub-committee reporting.	There are a number of actions in place to provide further assurance and to understand the impact of this risk; however, there is a limited amount that can be done to control the external environment and the demands outside of the organisation. Whilst there is assurance that the right actions are included on this plan, it is unlikely that the demands are going to ease and therefore it is expected that the risk score will remain at the current level.

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Risk 2 Failure to Recruit, Retain and Train the Required to Ensure the Right No. of Staff with the Right Skills in the Right Location

Principal risk (what could prevent us achieving this strategic priority)	Failure to recruit, retain and train the required to ensure the right number of staff with the right skills in the right location					**Strategic objective**	A great place to work
Lead Committee	Governance Committee (via People, Workforce Planning & Wellbeing Committee)	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Our People
Executive lead	Hannah Foster	**Likelihood**	4 – Likely	3 – Possible	2 – Likely	**Risk appetite**	Minimal
Initial date of assessment	14/09/2022	**Consequence**	4 – Major	4 – Major	4 – Major	**Risk treatment strategy**	Modify
Last reviewed	–18/01/2024 – PWPW 19/10/2023 - GC	**Risk rating**	**16 – Significant**	**12 – Medium**	**8 – Low**		
Last changed	—18/01/2024 – PWPW 19/10/2023 - GC						

Current Risk Level / Tolerable Risk Level / Target Risk Level / Forecast Risk Level

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating** (assured or inconclusive with further actions required)
• National shortages. • Competitive recruitment market. • Inability to attract candidates in certain staff groups. • Inability to retain existing staff with particular challenges relating to short tenure. • Not fully utilising digital capability. • Challenging financial climate with vacancy freeze, • Potential for increasing GP numbers to adversely impact recruitment and retention of doctors in the acute setting. • The impact of continued industrial action.	• Trust strategy including great place to work objective and Trust values, to create an effective, healthy and inclusive working environment with a just and learning culture to support recruitment and retention • Growing our own workforce with links to key educational providers and own academy status to provide apprenticeships. • Successful international recruitment campaigns. • Sharing of resources Trustwide i.e. clinical / medical staff working across northern and eastern services. • Specialist and executive resourcing team in place. • Career Gateway system • Recruitment fairs • Dedicated workforce planning capacity • Delivering Best Value retention stream. • New recruitment branding delivered. • Stay conversations piloted and in place. • Candidates can access helpful information and resources prior to their start date on Learn+. • Strategic resourcing group to support recruitment to posts. • Northern medical workforce business case, to increase substantive medical capacity. • Proactive health and wellbeing offer in place. • Interface between Career Gateway and ESR, reducing manual data entry. • Healthcare Support Worker band 2 to 3 process enacted. • Step into health launched to encourage former military candidates to apply for roles across the trust. • Improvements in recruitment and retention have led to a reduced vacancy rate.	• Lack of strategic workforce plan for the Devon ICS. • Inability to convert temporary workforce to permanent posts. • Sustainable finance solution for pipeline of apprentices sufficient to support retention and transformation. • Staff do not always feel empowered to make changes to mitigate this risk.	• Automated ID & DBS checks for new starters. • Further use of Career Gateway to develop workflows and improve automation. • Development of local 5-year workforce plan. • Position management to move to ESR to provide clear articulation of vacancies at position level • Automate new starter checklist for managers. • Implement discounts and special offers for new starters as part of their welcome. • Prioritise staff accommodation improvement 'must-dos' e.g. rest areas. • Apprenticeship pay and reporting proposal. • Survey new starters in week one, month one and month three, then use the results to improve the new starter experience and drive improvements. • Completion of actions within the NHS Long Term Workforce Plan 2023. • Optioneering tool developed and in use.	• Regular monitoring of a range of metrics, including those linked to recruitment and retention at PWPW. • Strategic Workforce Planning Hub • Metrics in the Integrated Performance Report (IPR). • Benchmarking through the ICS Cultural Dashboard. • Employee experience intelligence including quarterly People Pulse surveys and the annual staff survey including measurement of people promise. • Reporting of progress against the NHS People Plan. • Reporting on recruitment pipelines. • Survey results about induction process experience from new starters and recruiting managers. • Weekly workforce infographic data, showing workforce loss / gain and details of the pipeline. • Monthly Workforce dashboard in place. • Vacancy Control Process (VCP) • Recruitment risks regularly escalated to Senior Responsible Officers (SROs) • Proactive retirement age profiling in place. • Single strategic resourcing role list with risk based prioritisation, that is regularly reported to the Divisions. • Attraction intelligence available to understand why people are joining the	• Candidate experience information to be collected and analysed to inform improvements. (Jul 2023) • Improved health and wellbeing dashboard to be launched (Dec 2023) • Further insight into apprenticeship pipeline to be included in development dashboard (Apr 2024) • Information about progression metrics to be added to development dashboard (Apr 2024) • Analysis of exit survey data once enough information has been collected (Dec 2023)	**Assured** – The PWPW was assured that the right actions are planned to mitigate this risk. Whilst vacancy levels and turnover have generally moved in a positive direction, it was felt by the Committee that because of the current recruitment freeze and financial controls that the risk score would be unlikely to reduce this calendar year.

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				organisation. • Development and learning dashboard in place and presented regularly at People Development Group • Digitalised exit surveys launched • Health and wellbeing metrics		

Risk 3 Trust unable to invest in its Capital Plans

Principal risk (what could prevent us achieving this strategic priority)	Risk 3 - The Trust is unable to invest in capital plans that support delivery of its operation or strategic objectives							**Strategic priority**	Recovering for the future
Lead Committee	Finance and Operational Committee	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Financial		
Executive lead	Angela Hibbard	**Likelihood**	4	4	3	**Risk appetite**	Moderate		
Initial date of assessment	July 2021	**Consequence**	4	4	4	**Risk treatment strategy**	Mitigate		
Last reviewed	Jan 2024	**Risk rating**	**16**	**16**	**12**				
Last changed	May 2023			Given current financial climate					

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Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
The new NHS Capital regime is managed under ICS level CDEL limits, reducing the ability for Foundation Trusts to invest above a set limit. In addition, capital sources are becoming more constrained at a time that backlog maintenance costs are increasing. The ability to carve out strategic capital form internal CDEL limits is therefore challenging. Additional national capital is made available during the year but as a System with a deficit financial plan and in SOF4 restrictions on assessing this capital are likely. In addition, the national hospital programme (a source of future funding for the North) is over subscribed and plans are likely to be reduced within an affordability envelope. The strategic threat is therefore that capital is insufficient to manage the growing BAU capital needs and strategic capital development will be limited impacting on the delivery of our corporate strategy	**External** Engagement with the ICS & Regional Capital funding process to ensure fair share allocation of ICS CDEL Engage with ICS prioritisation process for national tranches of funding to ensure ICS process reflects priority of Royal Devon strategic capital needs Link to financial revenue risk and the controls around development of a financial recovery trajectory **Internal** Internal Strategic capital prioritisation process Oversight meetings: Research, Innovation and Commercial Opportunities Group, Strategic Estates Development Group	**External** Evidence of link of strategic capital requests to the financial recovery trajectory NHSEI approved financial plan – link to risk 2 Approved SOC for Northern Services development programme though NHP Robust prioritisation process of ICS capital needs linked to OCS LTP/Strategy **Internal** Alignment of capacity and elective recovery with capital investment need Alignment of external funding bids to strategic capital priorities due to the short-term nature of turn around against national funds Evidence of contribution of capital plans to financial recovery trajectory	**External** Refresh of ICS capital prioritisation process with visibility of outputs to ICS leaders Continued engagement with NHP team to set out need to progress Northern Services OFH Refresh of ICS NHP direction of travel following outputs from ICS strategic work programmes (i.e. acute services sustainability) Liaison with NHSEI to communicate importance of strategic capital for Devon ICS and link to operational recovery **Internal** Link to financial revenue risk on financial recovery trajectory Specific evidence of high priority strategic capital schemes such as PEC for Royal Devon on how they will contribute to financial recovery. Strategic Estates plan – being developed across North and East	**External** **Internal** IPR reporting on board capital programme spend Board meeting minutes Board updates and Business Cases Reporting of progress against 5 Year Financial Strategy through SEDG	**External** Capital prioritisation signed off by ICS leaders **Internal** Visibility of risk on capital restrictions through clinical governance/ Safety and risk	

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Risk 4 Non Delivery of the Financial Plan (Trust and System)

Principal risk (what could prevent us achieving this strategic priority)	Risk 4 - The Trust and wider Devon ICS have ambitious deficit plans with a challenging level of savings required, which are at risk of non-delivery							**Strategic priority**	Recovering for the future
Lead Committee	Finance and Operational Committee	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Finance		
Executive lead	Angela Hibbard CFO	**Likelihood**	5	4	3	**Risk appetite**	Moderate		
Initial date of assessment	July 2021	**Consequence**	5	4	4	**Risk treatment strategy**	Mitigate		
Last reviewed	Jan 2024	**Risk rating**	**25**	**16**	**12**				
Last changed	October 2023			Given current financial climate					

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Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
The Trust and Devon system have been placed in NOF4 due to the financial and operational performance which places us in the highest tier of national intensive support and additional regulatory scrutiny. The approved financial plan for 2023/24 is extremely challenging due to the underlying deficit across the Devon system and convergence of income towards the national formula. The three year trajectory of financial recovery is also likely to require a continuous high level of savings delivery to reach financial sustainability. The scale and pace of savings required to be delivered results in a real risk that the target cannot be met in year with the consequence of failing to deliver the overall financial plan internally and across Devon and the regulatory consequences of non delivery including staying in the NOF4 regulatory oversight. The inevitable strategic threat is that the balance between financial and operational recovery is lost and decisions are driven in a way that do not align with our Trust values and may be taken outside of the Trust's control.	**External** Active Executive engagement within ICS work programmes and System Recovery Board Direct Trust engagement with the region through established finance networks. ICS Financial Principles framework including how growth funding is allocated and risk share agreed under the new aligned payment incentive guidance Continued work across the ICS strategic work programmes to improve the financial plan run-rate to a more beneficial position into 2024/25 Common system narrative due to the Deloittes drivers of the deficit work System improvement plan aligned to NOF4 exit criteria to focus on delivery Devin ICS MFTP which models the financial trajectory over the 3-5 year period **Internal** Finance and Operational Committee refocused to a core group to enable detailed assurance to be given to the Trust Board. Comprehensive improvement plan for RDUH aligned to the NOF4 exit criteria joining financial, elective and UEC recovery Enhanced budgetary control and ownership of delivery through use of performance assurance framework to hold to account for delivery RDUH finance strategy linked to clinical strategy and contribution to corporate strategy on longer term financial recovery which sets out the financial modelling assumptions aligned to the Devon ICS LTFM. This includes an investment appraisal criteria to support prioritisation of funding Central governance around delivering best value programme in year and longer-term strengthened and embedded from start of the financial year Review of HFMA getting the basics right checklist and action plan being delivered and assured through the audit committee	**External** Agreement on next steps to take forward inequities work as a system once a trajectory for financial balance is achieved Delivery plans behind the MTFP which evidences how the MTFP will be delivered **Internal** Delivery plan behind the level of savings set out in the RDUH finance strategy	**External** ICS workplan on financial recovery linked to strategy need for transformation and key enablers to unlock potential - supported through the work of Deloittes Refresh of the Devon ICS LTFM **Internal** Development of multi-year savings / transformation programme to evidence how the finance strategy will be delivered link to benchmarking information	**External** Minuted "View from the Bridge" Updates including: ICS updates on Devon financial position NHSEI updates Updates to inform Board debate from other system committees and meetings Recognition of NDHT subsidy by CCG/ICS subject to NOF 4 approach Feedback from System recovery Board into RDUH finance and operational committee **Internal** Oversight of financial position provided to the Board through the IPR and to Finance and Operational Committee for exceptional items Finance and Operational Committee scrutiny of the Improvement Plan and in particular Delivering Best Value Sub-committee reports to Board Integrated Performance Report Audit committee assurance on grip and control actions Financial Recovery Plan actions to reduce run rate of spend in year	Detailed risk mitigation plan for non-delivery of system workstreams Detailed route to cash for system stretch savings to provide assurance on delivery of the forecast position	

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Risk 5 Elective Demand and Waiting-List Backlogs are not delivered

Principal risk (what could prevent us achieving this strategic priority)	Risk 5 - There is a risk of the Trust being unable to meet new demand for elective services (including cancer) and / or to provide required levels of activity to either address the waiting list backlog or to deliver the commitment contained within the Trust's Financial & Operational Plan							Strategic priority	Recovering for the Future
Lead Committee	Finance & Operational Committee	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Regulatory, Quality, Reputational		
Executive lead	Chief Operating Officer	**Likelihood**	4–likely	4 – likely	3 – possible	**Risk appetite**	minimal		
Initial date of assessment	October 2022	**Consequence**	5 – catastrophic	3 – moderate	3 – moderate	**Risk treatment strategy**	Avoid		
Last reviewed	October 2023	**Risk rating**	**20 – high**	**12 – moderate**	**9 – moderate**				
Last changed	January 2024								

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Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gap in assurance / action to address gap and issues relating to COVID-19 (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
A widespread and sustained organisational insufficiency of clinical service capacity for patients needing elective care including cancer care as a result of • Workforce fragility and shortages including as a result of industrial action, • inability to sufficiently invest in infrastructure to either increase capacity or replace equipment, • inability to control increased demand for care services, • inability to deliver productivity and efficiency commitments inherent within the Trust's Financial & Operational Plan	Detailed annual planning cycle, Access to Elective Recovery Fund (ERF) and Targeted Investment Fund (TIF) Regular data led reporting to Trust Board, ICS and, NHSEI (region and nationally) on progress against elective recovery trajectory Use of Nightingale Hospital Exeter to provide additional diagnostic and procedure capacity to aid recovery Proactive development of Strategic and Outline Business Cases, to enable timely and detailed responses to national funding when advised as available Active participation in and response to recommendations of One Devon Elective Pilot, and in Further Faster programme Development of effective relationships with ICB and NHSE (both regionally and nationally, including senior attendance at a wide range of system led meetings including Chief Operating Officer / Director of Performance update meetings, System Improvement Assurance Group (SIAG), Devon System Elective Improvement Board, and Nightingale Hospital Programme Board, and in welcoming best practice visits to the Trust	Awaiting decisions following finance and capital investment requests to support changes to existing estate and clinical models Workforce constraints remain – including recruitment of consultants and other specialist posts in some areas and inability to recruit sufficient nursing staff to open planned escalation areas over the winter period. Co-dependency on both ICB and regional partners particularly with regards to strength and sufficiency of capacity of respective elective care service provision, and ability to offer mutual aid capacity where needed Increasing imperative for development of system solutions (eg spinal and cardiology) to identified capacity constraints, with associated time impact for assessment of capacity by providers within system, and demonstration of both collective and individual Trust benefits Pace of development of clinical innovation programme to enable shortfalls in capacity to be overcome Understanding of inequalities of access to care, and associated healthcare impacts	• Expansion of procedures able to be offered from Nightingale, and increased utilisation of Nightingale (December 2022 and ongoing) • Assurance is being sought from the Devon system regarding underwriting of NHE to support continued service delivery (Deputy Chief Executive) • Optimisation work to reduce the impact of MY CARE on outpatient throughput is progressing, and preparations made for the mandating of personalisation in EPIC (Chief Medical Officer). • ERF investment across multiple programmes • Potential further non recurrent investment in outsourcing in Q4 • Continued pursuit of protected elective capacity both in-house and as part of new ventures with Independent Sector partners • Development of Tier 1 Funding proposal to support continued usage of insourcing and outsourcing arrangements on a	Performance metrics • IPR • PAF • RTT Data • Cancer Metrics • Activity and Referrals data Volume, value and aggregate activity impact of approved Elective Recovery Fund (ERF) bids Internal investment & external sponsorship Changes in Trust's Cancer Tiering Status (September 2023) Bed modelling Ability to increase utilisation of independent sector ToRs / Minutes and Action Logs of internal meetings strengthened as part of Operational Governance Framework • Delivery Group • PAF • Operations Boards • Access meeting ToRs/Minutes of external/STP meetings: • Devon Planned Care Board • System Asset Programme Board • Cancer Cabinet • Hospital Escalation status • System Delivery & Improvement Group Programme of and feedback from external visits incl NHSE Cancer Improvement Visit (Autumn 2023) Completion of NHSEI 10-week challenge (Winter 2022) Capital and revenue investments confirmed in Community Diagnostic Centre, Tiverton Endoscopy Unit, and Cardiology Day Case Unit Funding secured for purchase of a robot for Northern Services, and lease of an additional robot for Eastern Services (Summer 2023) Development of a TIF bid for a vascular hybrid and / or trauma theatre capacity, admissions ward and revenue investment in orthopaedics (September 2023) Development and approval of Devon system spinal surgery business case (November 2023) Proposed development of Cardiology, and Oral Maxillofacial Surgery business cases (Spring 2024)	Current operational and financial planning cycle focuses on 1-2 year plan delivery. Lack of available capital and recurrent revenue funding to support required service changes, and timeliness of regional/ national decision making Sporadic and short notice timeframes in which capital funding is indicated as potentially available and applications are required to be submitted Timeframe for delivery of MY CARE optimisation Local model of care agreed but no agreed Devon ICB future model of care Lack of ICB agreed approach to community engagement, and engagement of wider system partners	

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		amongst different population groups	time-limited basis whilst ERF schemes for 23/24 are optimised to maintain current run rate of delivery • Securing of funding for a vascular hybrid and / or trauma theatre capacity, admissions ward and revenue investment in orthopaedics • Analysis of system demand and capacity in challenged specialties, and identification where feasible of pan-provider and system coordinated responses including system funding requests (eg spinal surgery, cardiology) *Please note: all actions are ongoing, and being coordinated by the Chief Operating Officerunless otherwise indicated*			

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Risk 6 Our People do not feel looked after/valued, employee experience is poor and people feel health and wellbeing are not prioritised

Principal risk (what could prevent us achieving this strategic priority)	Our people do not feel looked after or valued. Employee experience is poor and people feel their health and wellbeing is not prioritised.						**Strategic objective**	A great place to work
Lead Committee	Governance Committee (via People, Workforce Planning & Wellbeing Committee)	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Our People	
Executive lead	Hannah Foster	**Likelihood**	4 - Almost Certain	3 - Possible	2 - Likely	**Risk appetite**	Minimal	
Initial date of assessment	12/07/2023	**Consequence**	4 - Major	4 - Major	4 - Major	**Risk treatment strategy**	Modify	
Last reviewed	–18/01/2024 – PWPW 19/10/2023 - GC	**Risk rating**	16 – Significant	12 – Medium	8 – Low			
Last changed	–18/01/2024 – PWPW 19/10/2023 - GC							

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Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24
Current Risk Level
Tolerable Risk Level
Target Risk Level
Forecast Risk Level

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating** (assured or inconclusive with further actions required)
• Demand for services exceeds capacity, increasing workload, potential for burnout, moral injury or/and work related stress. • Not fully utilising digital capability, increasing workload for staff. • Challenging financial climate with vacancy freeze • Working excessive hours is becoming a cultural norm within the NHS leading to burnout. • Integration change fatigue, long waits and public criticism impacting morale. • Increasing levels of violence and aggression towards our people. • Insufficient psychologically safety/inclusion culture. • Insufficient supportive line management to provide positive employee experience and enable wellbeing. • Lack of management time/capacity to support respecting, welcoming, valuing and developing people. • Operational and financial pressures preventing career development, progression and fulfilment. • Capital constraints preventing quality working environment and/or staff accommodation. • Ongoing Industrial Action impacting rest, leave, operational and leadership capacity. • Lack of integrated ways of working and collaboration, leading to silo working and	• Trust strategy including great place to work objective and Trust values, to create an effective, healthy and inclusive working environment with a just and learning culture to support recruitment and retention. • Proactive health and wellbeing offer. • Our Charter. • Promoting a Positive Working Environment Policy and subsequent documentation created with a focus on just and learning culture. • Staff Incident Review Group. • Managing Incivility: becoming a responsible bystander and other strategies training. • Pastoral support, including dedicated role for international recruits. • Freedom to Speak Up Guardians. • Enhanced development offer for existing staff. • Protection and promotion of taking of annual leave. • Staff recognition schemes. • Focus and resources in place for inclusion, employee experience and culture work. • Significant comms and engagement activity with staff via various channels. • Investment in recruitment and retention activity. • Dedicated Staff Rest Space Group. • Line manager induction workshops. • Extraordinary People Awards • Executive inclusion commitments	• Process streamlining and automation are not happening quickly enough to reduce workload of staff. • Not all processes and policies support the desired cultural direction. • Training to prevent violence and aggression is not always undertaken by all relevant staff. • Evidence that staff can take breaks. • Protection of management time. • On call arrangements that support work life balance. • Impact of ambitious ICS operational plan. • Impact of NHS Long Term Workforce Plan. • Staff do not always feel empowered to make changes to mitigate this risk. • Inclusion strategy owned at board level.	• Completion of the actions within the Cultural Development Roadmap. • Single Trustwide violence and aggression lead. • Completion of all stages of project simplify. • Line managers and leaders programme to be introduced, including an option to complete individual modules. • Systemwide launch of campaign to prevent violence and aggression. • Launch of a revised approach to reward and recognition. • #TeamRoyalDevon week. • Improve flexible working options for all groups. • New flexible retirement options. • Phase 1 of the new hospital programme to develop new staff accommodation. • Management of Change (MoC) through Operational Services Integration Group (OSIG)	• Regular monitoring of a range of metrics, including the Integrated Performance Report (IPR). • Benchmarking through the ICS Cultural Dashboard. • Employee experience intelligence, including quarterly People Pulse surveys and the annual staff survey including measurement of people promise. • Reporting on progress against the cultural development roadmap. • Reporting to the Staff Health & Wellbeing Group and sub-groups. • Health & Wellbeing metrics are available, but will be consolidated into a more comprehensive dashboard (see gap). • Feedback to the Inclusion Steering Group from staff inclusion networks • National Guardians Office statistics on Freedom to Speak Up reporting. • Employee Experience and Survey action plan delivery monitored at PAF meetings. • Development and learning dashboard in place and presented regularly at People Development Group. • Digitalised exit surveys in place. •	• Candidate experience information to be collected and analysed to inform improvements. • Improved health and wellbeing dashboard to be launched (Dec 2023). • Further insight into apprenticeship pipeline to be included in development dashboard (Apr 2024) • Information about progression metrics to be added to development dashboard (Apr 2024) • Analysis of exit survey data once enough information has been collected (Dec 2023)	**Assured** – The PWPW was assured that the right actions are planned to mitigate this risk. The PWPW was assured that the right actions are in place and indicators such as sickness levels are showing normal seasonal trends. However, despite some positive trends, it was agreed that the score should remain the same, given the

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poorer employee experience.	• Board level oversight of inclusion direction					current context, operational pressures, financial controls and the vacancy freeze.

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Risk 7 Risk of not maximising Epic benefits (Trust and System)

Principal risk (what could prevent us achieving this strategic priority)	There is a risk of not realising/maximising the financial benefits from the Epic implementation, the remaining benefits relate to outstanding management of change activity currently in progress.					**Strategic priority**	Excellence and Innovation in patient care
Lead Committee	Digital Committee	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Clinical Digital Services
Executive lead	Adrian Harris, Chief Medical Officer	**Likelihood**	–5 – Almost Certain	–4 - Likely	3 - Possible	**Risk appetite**	TBC
Initial date of assessment	14 October 2022	**Consequence**	3 - Moderate	3 - Moderate	2 - Minor	**Risk treatment strategy**	Modify
Last reviewed	15 January 2024	**Risk rating**	–15 - High	12 - Moderate	–6 - Low		
Last changed	15 January 2024						

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Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gap in assurance / action to address gap and issues relating to COVID-19 (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
There is a risk that documented financial benefits identified in the Eastern / Northern MY CARE business cases will not be realised / maximised	**Trust committee/governance & clinical service structures including:** Assigned Executive/ Site Director portfolios/accountabilities including relevant statutory roles Single clinical digital services structure in place from April 2023 across RDUH. Single governance process for digital improvement- Series of eight advisory groups reporting to the Clinical Digital & Operational Oversight Group active (as of May 2023) Digital Committee in place across Eastern and Northern Services as a direct Sub-Committee of the Board of Directors Reporting to the Board of Directors via the Digital Committee Appointment of RDUH (cross site) Director of Service Improvement and sub structure to support benefit delivery and integration with transformation programme Clinical Digital services governance meeting commences July 2023 Management of change policy Admin Transformation Programme Manager Role in post Full time comms lead appointed within Transformation to support trust wide engagement on all transformation Projects and Programmes **Support & resources for users/patients:** • Additional 2.5 WTE posts in place focusing on development of MYCARE (patient portal).MyCare marketing campaign launched to increase sign up to 100,000 patient users • Epic IT helpdesk supporting end users/staff with enquiries/issues • Epic training/personalisation sessions to support confidence and efficiency in the use of Epic at a collective and individual level • Tip sheets created and readily available on the EPR system/dashboard to support staff	Secure integrated structure across Eastern and Northern Services not yet agreed and in place in all areas. Continued use of paper letters (appointment) whilst encouraging patient sign up to MYCARE comms referring to reduced carbon footprint leading to Patient complaints	MOC in east / north, decisions required around workload, scanning service and location of paper records storage (12 months) Improved Comms and transparency around functionality of MYCARE & reasons behind paper appt letters – transparency with patients	Bi-monthly reporting to the Board of Directors from the Digital Committee. Support from CEO, Deputy CEO & CMO regarding MOC Clinical digital services and digital services updates monthly to operations boards (N&E) with further updates alt-months to Digital committee. Clinical digital advisory group and oversight group governance structure in place escalating to CEC if required. Benefits realisation progress reporting to Board of Directors / FOC Reporting of benefits – DBV working groups and board. Patient portal – MYCARE – continuing to drive engagement and comms to increase levels of sign up, currently 80,000 users with 5% (avg) increase per month. Target 100,000 by December 2023 and 120,000 by March 2024. Clinical and Digital enabling strategiescomplete / published	Benefits- FBC assumptions not fully realisable in some areas. Limited alternative savings available but still being scoped.	

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	• IO Team (NMAHP & MIO Teams) supporting end users across the Trust Other • Stakeholder & staff Communication & Engagement Plan Partnership Agreement with Staffside and Trade Union partners. Active engagement of staff in key programmes • Clinical (medical) leadership capacity strengthened • Health & Wellbeing support for our people • Transformation Strategy launched Jan 2023 Digital and Clinical strategies completed as enabling strategies. Substantive, integrated CDS structure in place Tightening links between finance and digital committee on benefits identification and realisation process to be implemented between digital, operations and finance Refresher training now embedded within ongoing training schedule, blending delivery modalities to include self-guided tip sheets, ad-hoc 'video tip sheets', online learning master classes and face to face training. Single structure agreed and implemented July 2023. Substantive funding shortage for full EPR analyst and training capacity required which may contribute to change fatigue for some staff. Engagement with Age UK to support engagement with the use of Patient Portal – they have a digital champion programme to increase older people's engagement and support with digital systems, for those particularly digitally 'excluded'					

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Risk 8 Risk of a significant deterioration in quality and safety of care]January 2024

Principal risk (what could prevent us achieving this strategic priority)	Significant deterioration in standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm, poor clinical outcomes and delivery of sub-optimal patient care.							**Strategic priority**	Excellence & innovation in patient care
Lead Committee	Safety and Risk Committee	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient Safety		
Executive lead	Chief Nursing Officer	**Likelihood**	4 - Likely	3 - Possible	2 - Unlikely	**Risk appetite**	Low		
Initial date of assessment	18th October 2022	**Consequence**	4 - Major	3 - Moderate	2 - Minor	**Risk treatment strategy**	Modify		
Last reviewed	16 January 2024	**Risk rating**	**16 - Significant**	**9 - Moderate**	**4 - Low**				
Last changed	9 January 2024								

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Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24
Current Risk Level
Tolerable Risk Level
Target Risk Level
Forecast Risk Level

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Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Widespread loss of organisational ability to focus on quality of care, including patient safety processes due to workforce gaps/staff, Industrial Action, working under pressure to deliver flow & covid recovery, and a failure to engage patients and carers in care leading to: - an increased incidence of avoidable harm; - an increased exposure to 'Never Events'; - higher than expected mortality; - a failure to escalate, report and learn from quality incidents.	**Trust committee/governance & clinical service structures including:** • Assigned Executive & Site Director portfolios/accountabilities • Monthly meeting of Safety & Risk Committee & reporting sub groups (IPC/H&S/Patient safety etc.) • Patient Experience Committee • Clinical Effectiveness Committee • Safeguarding Committee **Strategies, policies and procedures:** • Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems • Risk management framework and policy • Performance management framework • QIA process / criteria for completion **Systems and monitoring:** • Incident Reporting investigation process, SIs/Never Event Reports, Claims • Lessons learned from Never Events • Annual Quality Priorities	Regular Divisional risk reports to S&RC/GC The trust has had a high number of never events, these are serious incidents which are wholly preventable.	Strengthen the reporting of medical and clinical education through PWPW report to GC ***Action will be delivered through the creation of a Board Committee for People which will include the reporting of clinical and medical education January 2024 Trust Secretary / Chief Executive*** Implement the NatSSIP's action plan to create standardised operating protocols & safety culture (NB this is a quality priority for 23/24)	**External Independent Inspections** • CQC • Royal Colleges • GIRFT reviews • Commissioning/network reviews • Audit SW Assurance **Internal Audit programme** • Clinical audit outcomes • Ward assurance/ metrics & accreditation programme **Statutory reporting** • Learning from deaths report • Guardian of Safe Working report • Six monthly safe staffing reports – Medical and NMAHP • SHMI • Annual complaints report • Annual IPC report • Board integrated performance report • Quality report (incl. quality priorities) NHS England Three Year Delivery Plan for Maternity and Neonatal Services (CNST MIS Standards)	Comprehensive systems approach to Patient Safety Management; delivered through implementation of the National Patient Safety Strategy (PSIRF)	

	• Retrospective EPIC dashboards • CQUINs & contract monitoring • Recording of escalation systems NEWS etc • Medicines Management • National Surveys • NICE, NSF and Clinical Audit • Capital Programme • Maternity Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) and Three Year Delivery Plan • Performance reporting and accountability/ performance reviews/ performance dashboards • Clinical audit programme & monitoring arrangements local and national • External audit of quality/patient safety e.g. GIRFT/Royal college reviews • Defined safe medical & nurse/midwifery staffing levels for all wards & departments • Ward assurance/ metrics & accreditation programme • Triangulation of insight from: • Patients and carers – complaints/PAL's/ Health Watch, other stakeholders • Dialogue with regulators to get feedback on local and benchmarked status re quality standards **People:** • Processes in place for staff to raise quality and other related concerns e.g. freedom to speak up guardian, whistle blowing policy • Maintenance of competent clinical staff through recruitment, induction, mandatory training, registration, supervision & re-validation **Industrial Action:** • Gold, Silver, EPPR plans in place to manage business continuity	Community services were not well represented within the board service and performance measure	***Completion timeframe as per 23/24 quality priority objectives – Chief Nursing Officer & Chief Medical Officer*** Implementation of National Patient Safety Strategy (inc. PSIRF) ***Action complete – new Learning from Patient Safety Events (LFPSE) service went live on 01/12/23*** Formation of new Royal Devon Safety Committee (in line with National Patient Safety Strategy requirements) and new Royal Devon Risk Management Committee ***Completion by January 2024 – Chief Nursing Officer & Chief Medical Officer*** To review/change/expand the current IPR metrics & other governance and performance meetings to better represent the breadth of services the Trust is accountable for. ***Completion by Autumn 2024 – Chief Operating Officer***	**Other reporting** • Regular board sub-committee performance/progress reports to GC (patient experience, safeguarding, safety and risk, clinical effectiveness) • Maternity Safety Champion activities • Mandatory training reporting • Health & safety reporting • Claims, inquest reports • Freedom to speak up reports • Whistle blowing reports • Ad-hoc requested specialist specific reports e.g. End of Life • Progress report cultural development • National Patient Safety Alerts compliance reports • HSIB **Screening Quality Assurance Services assessments and reports of:** • Antenatal and New-born screening • Breast Cancer Screening Services • Bowel Cancer Screening Services • Cervical Screening Services **Accreditation/Regulation annual assessments and reports of**; • Pathology (UKAS) • Endoscopy Services (JAG) • Medical Equipment and Medical Devices (BSI) - - Blood Transfusion Annual Compliance Report • PLACE **Action Plans** • National survey action plans • Performance recovery plans **QIA outcomes related to operational planning and Delivering Best Value 2023/24**		

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Risk 9 Our Future Hospitals – Delays in Funding/Failure to Deliver Clinical Strategy for Northern Services

Principal risk (what could prevent us achieving this strategic priority)	Continued delay of a positive decision on the Our Future Hospital Strategic Outline Case, resulting in planning blight, a reliance on short term sub optimal investment and a deleterious impact on the recruitment and retention of staff to North Devon							**Strategic priority**	Recovering for the future / Great Place to Work
Lead Committee	OFH Programme Board	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Workforce/ Estate		
Executive lead	Chris Tidman, Deputy Chief Executive	**Likelihood**	4 Likely	3 Possible	2 Unlikely	**Risk appetite**	Minimal		
Initial date of assessment	18/10/2022	**Consequence**	4 Major	4 Major	4 Major	**Risk treatment strategy**	Modify		
Last reviewed	18/07/2023 26/10/2023	**Risk rating**	**16**	**12**	**8**				
Last changed	18/07/2023 26/10/2023								

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**

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Next phase of the NHP (including RAAC) means NDDH scheme being pushed back until post 2030; Hospital 2.0 pushback suggesting ambition for complete hospital rebuild compared to more deliverable part rebuild/ part refurb. Increase in design complexity and delays leading to risk around critical backlog maintenance and lack of confidence amongst clinical staff of scheme delivery.	**Trust Committee / Board Governance** OFH Programme Board meets monthly and reports progress to Board of Directors, including developing options around phase 1 enabling works and deliverability / affordability of various options from part rebuild/refurb to full rebuild			SOC, Board and Committee reports Internal Gateway Assurance		Whilst we now have a government announcement, it is still too soon to say whether it is possible to reduce the current risk score back down to a 4 x 3. Much will depend on the release of the capital funding for the phase 1 enabling works on accommodation and the confirmation around the timing of the preferred option.
	Early enabling work starting on accommodation blocks to demonstrate progress. Phase 1 business case being completed and importance socialised with DHSC and NHSE.	Risk of delay by NHP & ICB/Region may not be understood by healthcare delivery partners	Critical Backlog maintenance and mitigation plans to be assessed and shared with NHP team & NHSE (Dec 2023), so financial and service impacts of any delay on capacity or capital funding is clearly understood	MOU for Phase 1 residence short form business case (RIBA stage 4) and letter for NHP SRO Dec 2023 confirming PDC funding allocated for 2024-25.		
	System Governance Trust active participant in Peninsula New Hospital Programme Board. July 2021 SOC supported by the Devon CCG/ICS are clinically necessary and affordable. Devon NHPs now part of ToR of the ICS Finance Committee and agreement to review OBCs in light of Peninsula Acute Sustainability Programme					
Underlying financial deficit of the Devon system leads to a more radical Acute Sustainability review of hospital configuration, meaning a detailed Pre Consultation Business Case, slowing down decision making	**Stakeholder Management** Robust internal comms approach with senior clinical staff around understanding process and approach to options					
	Proactive engagement with NHP Executive and political stakeholders particularly NHS England as programme sponsor to stress the importance of early enabling works to demonstrate progress, risks of extended delay and having a deliverable scheme that can pass HM Treasury affordability tests. NHP roadshow visit to North Devon on 2nd August, monthly NHP forum meetings, new regional NHP structure from end 2023.	Risk of delay may not be fully understood by national politicians	Visits from politicians and NHSE to outline the risks of delay. Letters to DHSC and local MPs to confirm risk position.	Political statements supporting the early investment in staff accommodation in North Devon & commitments to maintaining momentum		

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Risk 10 UEC Targets are not delivered

Principal risk (what could prevent us achieving this strategic priority)	Risk 10 - There is a risk of the Trust being unable to deliver the urgent & emergency care commitments contained within the Trust's Financial & Operational Plan due to unscheduled care demands and capacity							**Strategic priority**	Recovering for the Future
Lead Committee	Finance & Operational Committee	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Regulatory, Quality, Reputational		
Executive lead	Chief Operating Officer	**Likelihood**	5 – very likely	3 – possible	2 – unlikely	**Risk appetite**	Minimal		
Initial date of assessment	October 2022	**Consequence**	5 – catastrophic	3 – moderate	2– minor	**Risk treatment strategy**	Avoid		
Last reviewed	October 2023	**Risk rating**	**25 – high**	**9– moderate**	**4 – low**				
Last changed	January 2024								

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Sep-22 Dec-22 Mar-23 Jun-23 Sep-23 Dec-23 Mar-24 Jun-24 Sep-24
Current Risk Level
Tolerable Risk Level
Target Risk Level
Forecast Risk Level

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Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
A widespread and sustained organisational insufficiency of clinical service capacity for patients needing urgent care due to unscheduled care demands and capacity, as a result of • System and care partners' failure to deliver necessary improvements to support achievement of 5% No Criteria to Reside • workforce shortages including as a result of industrial action, • inability to control increased demand for care services, including demand for urgent and emergency care • inability to deliver productivity and efficiency commitments inherent within the Trust's Financial & Operational Plan • wider system demand/support for urgent & emergency care through ambulance diverts	Detailed annual planning cycle, including development of operational capacity and resilience plan (Winter plan), Regular data led reporting to Trust Board, ICS and, NHSEI (region and nationally) on progress against urgent & emergency care improvement trajectories Development of effective relationships with ICB and DCC, including senior attendance at a wide range of system led meetings including Chief Operating Officer / Director of Performance update meetings, System Improvement Assurance Group, Devon System Unscheduled Care Board, and active participation in and escalation into Devon System SOF4 Improvement Programme including weekly Tier 1 UEC meetings with NHSE (region), and monthly meetings with National Director of UEC Detailed system wide and organisational winter planning Four week pilot undertaken October to November 2022 with adjusted postcode catchments to support TSDT and UHP Trusts. Further ten week adjustment to postcode catchments to support TSDT and UHP agreed. Discussions ongoing as to the most sustainable basis by which any ambulance activity might be diverted to RDUH going forward	Co-dependency on system partners particularly with regards to strength, sufficiency of capacity and availability of urgent care including out of hours services within primary care, and social care Lack of visibility of and volatility in funding decisions of system partners, particularly with regards to social care Shortfalls in funding within health system leading to increasing fragmentation and short term nature of funding decisions leading to increasing difficulty in (and resource required to) implement sustainable solutions Workforce constraints remain – including recruitment of consultants and other specialist posts in some areas and inability to recruit and / or retain sufficient nursing staff to maintain WIC service delivery or to open planned escalation areas over the winter period. Continuing workforce fragility for external care providers (e.g. domiciliary care and nursing home care) Ability of neighbouring Trusts to respond to equivalent UEC pressures and demand, and to	Infrastructure for emergency patients has progressed throughout 2022/23 including. • Continued progress of the ED Redevelopment programme, and inclusion of a Paediatric ED element to the programme. Securing of necessary further funding release by system partners by end Q1 23/24. Refresh of the Operational Capacity and Resilience Plan (Winter Plan) approved by Board in October 2022. Further refresh to be undertaken in Autumn 2023 as an integral part of the Trust UEC plan Implementation at pace of Trust's UEC Improvement Plan through Autumn and Winter 2023 Proposed service transfer of Exmouth MIU (Spring 2023) *Please note: all actions are ongoing and being coordinated by the Chief Operating Officer unless otherwise indicated*	Performance metrics • IPR (monthly) • PAF (monthly) • Activity and Referrals data (IPR monthly) Likelihood of discontinuation of adjustment to postcode catchments 10/10/2023 Winter Director appointment for Devon, and instigation of dynamic conveyancing update on UEC funding (Community £3.2m vs £5.2m fair share) Winter Plan (Autumn 2023) Bed modelling (Autumn 2023) Development Plan for Trust's Community Services (Autumn 2023) ToRs / Minutes and Action Logs of internal meetings strengthened as part of Operational Governance Framework • Trust Delivery Group • PAF • Operations Boards ToRs/Minutes of external/STP meetings: • Devon Urgent Care Board • Hospital Escalation status • System Delivery & Improvement Group Schedule of 1:1s with Devon County Council Director of Integrated Adult Social Care Programme of and feedback from external visits (Autumn 2023) Implementation and impact of Trust Improvement Plan	Current health operational and financial planning cycle focuses on 1-2 year plan delivery. Lack of visibility of funding availability and funding decisions of social care system partners System funding availability leading to increasingly ad-hoc and short-term funding decisions Local model of care agreed but no agreed Devon ICB future model of care Lack of ICB agreed approach to engagement of wider system partners	

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		maintain delivery of identified fragile services Continuation of ambulance catchment change, alongside ongoing requests for further ambulance diverts to support Devon system Pace of development of clinical innovation programme to enable shortfalls in capacity to be overcome				

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Agenda item:	11.3, Public Board Meeting	Date: 31 January 2024
Title:	Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 5 report	
Prepared by:	Natalie Wickins, Divisional Director - Specialist Services, Eastern Services Tony Layton, Divisional Director - Clinical Support and Specialist Services, Northern Services Alison Macefield, Head of Midwifery and Gynaecology Alexis Webb, Divisional Business Manager - Specialist Services, Eastern Services Helen Hughes, Clinical Midwifery Matron for Quality and Safety Carla Custons-Cole, Project and Service Change Manager Tracey Reeves, Director of Nursing, Eastern Services	
Presented by:	Carolyn Mills, Chief Nursing Officer Sally Bryant, Associate Director of Midwifery, Royal Devon	
Responsible Executive:	Carolyn Mills, Chief Nursing Officer	
Summary:	NHS Resolution is operating Year 5 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) which sets out 10 key safety actions to continue to improve delivery of best practice within maternity services, as part of the national ambition to halve the rates of stillbirth, neonatal and maternal deaths and intrapartum brain injuries in England by 2030. Trusts that can demonstrate that they have achieved all 10 standards will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. Should the Trust not achieve all 10 maternity safety actions, the Board is required to 'declare' and submit an Action Plan for the actions not achieved. A summary of the declaration for Royal Devon University Healthcare NHS Foundation Trust (RDUH) is presented at Appendix 1. Detailed evidence is available to support each of the standards. Reporting on maternity services is included within the Integrated Performance Report and more detailed quarterly updates to the Board & Governance Committee. The evidence to support RDUH's declaration has been reviewed via Audit South West Assurance, as per previous years, to provide objective scrutiny of the evidence to support the Trust's declaration and is presented at Appendix 1. Compliance is confirmed in 8 of the 10 standards. A mitigation action plan regarding safety actions 1 and 9 is included as part of the Trust's submission in Appendix 2	
Actions required:	The Board of Directors is therefore asked: • to note the report which details current and anticipated compliance towards the 10 key safety actions; • to receive assurance that mitigating actions are in place to meet the required standards by 01 February 2024 as set out in the safety actions and technical guidance document.	

Status (x):	Decision	Approval	Discussion	Information
		X		
History:	The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. NHS Trusts that can demonstrate they have achieved all of the 10 key safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. Compliance with the scheme also forms one element of determining success measures for delivery of the NHS England three year delivery plan for maternity and neonatal services. NHS Trusts that do not meet the 10 key safety actions will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not yet achieved. Such a payment would be at a lower level than the 10% contribution to the incentive fund.			
Link to strategy/ Assurance framework:	The issues discussed are key to the Trust achieving its strategic objectives.			

Monitoring Information

Please *specify* CQC standard numbers and tick ✓other boxes as appropriate

Care Quality Commission Standards	Outcomes	All	
NHS Improvement		Finance	
Service Development Strategy		Performance Management	
Local Delivery Plan		Business Planning	
Assurance Framework	X	Complaints	
Equality, diversity, human rights implications assessed			
Other *(please specify)*			

1. Purpose of paper

The purpose of this paper is to provide the Board of Directors with evidence of the Royal Devon maternity services progress against the 10 key safety actions as part of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 5.

This is the first CNST MIS submission as a single Trust as previous submissions have been undertaken as separate organisations (RD&E & NDHT).

2. Background

In November 2015, the Government announced a national ambition to halve the rates of stillbirth, neonatal and maternal deaths and intrapartum brain injuries in England by 2030.

In order to achieve this goal, maternity services were asked to make a public commitment to placing a “Spotlight on Maternity” (NHS England, 2016). Safer Maternity Care: The National Maternity Safety Strategy – Progress and Next Steps proposed a number of steps NHS Trusts should take to ensure progress in the prevention of serious incidents within maternity care.

Year 5 of the CNST MIS was officially launched in May 2023, and continued to support the delivery of safer maternity care through an incentive element to Trust contributions to the CNST. The scheme, developed in partnership with the national maternity safety champion, Dr Matthew Jolly, rewards NHS Trusts that meet 10 key safety actions designed to improve the delivery of best practice and outcomes in maternity and neonatal services.

Compliance with the scheme also forms one element of determining success measures for delivery of the NHS England three year delivery plan for maternity and neonatal services.

Quarterly updates on progress towards compliance with the evidential requirements set out in the CNST MIS Year 5 have been presented to the Safety and Risk Committee.

It is also recognised that the CNST MIS expectations and associated compliance measures for Trusts have increased year on year, with a demonstrable increase in the expansion of depth of evidence required to show compliance with Year 5 requirements, specifically in respect of compliance with Safety Action 6: Saving Babies Lives Care Bundle (v3).

As part of the 2023 Audit & Assurance plan, in November 2023, ASW Assurance undertook a preliminary review of the evidence being collated to support the Trust’s submission for the fifth year of the CNST MIS. A re-audit of remaining CNST evidence was undertaken in the w/c 08 January 2024 to reassess the Trust’s current compliance position in preparation for final submission to the Board.

The findings within the audit report (See Appendix 1) support the Royal Devon self-assessment detailed below, confirming that the year-end position for the Trust’s maternity services will be:

- The Trust will be able to declare full compliance with 8 out of 10 safety actions.

3. Current position and anticipated final position at submission

3.1 Current position:

Full compliance in two out of ten safety actions; and with further minor additions to evidence will increase the level of compliance to eight out of ten by submission date (see Figure 1).

Figure 1:

	CNST Safety Action Criteria	Assessment of Evidence Part 1 Nov 2023	Assessment of Evidence Part 2 Jan 2024	Management Action to be completed Jan 23	Anticipated final outcome
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?			N/A	
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?			N/A	
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?			Board, LMNS and ICB sign off of the Eastern and Northern ATAIN Action plans	
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?			Approval of the BAPM Action plans by the Maternity Governance Group, the LMNS and the Neonatal Operational Delivery Network (ODN)	
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?			Minutes of the January 2024 Trust Public Board confirms that the Trust is compliant with BirthRate+. Copy of the Action tracker which details the actions agreed as part of the Maternity Establishment Review on the 8 January 2024.	
6	Can you demonstrate that you are on track to meet compliance with all elements of the Saving Babies' Lives care bundle Version 3?			Demonstrate compliance against the implementation of 70% of interventions across all 6 elements of SBLV3 and implementation of at least 50% of interventions in each element.	
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users?			Evidence that the MNVP 2023/24 plan has been agreed, sign off from LMNS will take place week commencing 15/01/2024	

8	Can you evidence the following 3 elements of local training plans and ‘in-house’, one day multi professional training?			N/A	
	1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework.				
	2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB.				
	3. The plan is developed based on the “How to” Guide developed by NHS England.				

	CNST Safety Action Criteria	Assessment of Evidence Part 1 Nov 2023	Assessment of Evidence Part 2 Jan 2024	Management Action to be completed Jan 23	Anticipated final outcome
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?			Perinatal Quality Surveillance Model to provide assurance that the minimum data is being reported monthly, this will also include a quarterly review of thematic learning of all maternity Serious Incidents (SIs).	
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?			The Maternity Governance Group (17/1/24) will need to see: • Numbers of HSIB Referrals. • Assurance that families have received information on the role of HSIB/MNSI and EN scheme for all of the HSIB referrals during the reporting period. • Compliance with duty of candour for the HSIB referrals during the reporting period.	

3.2 Anticipated final position at submission:

At time of submission, the Trust will be able to declare full compliance with 8 out of the 10 safety actions (see Figure 2).

Figure 2:

	CNST Safety Action Criteria	Anticipated final outcome		CNST Safety Action Criteria	Anticipated final outcome
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?		6	Can you demonstrate that you are on track to meet compliance with all elements of the Saving Babies' Lives care bundle Version 3?	
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users?	
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?		8	Can you evidence 3 elements of local training plans and 'in-house', one day multi professional training?	
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?		9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	

3.3 Risks to compliance:

Standard 1: Perinatal Mortality Review Tool:
For two out of seven cases identified within the reporting period, the mandated timeframe for the completion of the review was not met. The primary reason for this breach was attributed to the lack of closure of the report on the PMRT portal, although the 72hr reports were completed. Therefore the Trust will not be compliant with this safety action.

The MIS year 5 guidance states that the above should be reported quarterly to the Trust Executive Board, which ASW Assurance interpret as the Trust Board of Directors. The data required has been previously reported to Trust Committees i.e. the Governance Committee (Committee of the Board) and other groups i.e. Maternity Governance, Mortality Group, or the Maternity and Neonatal Safety Champions Meeting.

The Board is asked to confirm their position whether a Committee of the Board with an escalation route offers sufficient assurance. If the Trust deems the current reporting routes as sufficient, it may wish to confirm its position with NHS Resolution.

ASW Assurance have also noted the level of thematic analysis shared, as well as the consequent action plans arising from issues and themes identified.

Standard 9: Board Assurance on Maternity and Neonatal Safety and Quality Issues:
In order to meet compliance with SA9, the following evidence would need to be provided:

- Reporting routes mapped to each of the six requirements of the Perinatal Quality Surveillance Model to provide assurance that the minimum data is being reported monthly; this must also include a quarterly review of thematic learning of all maternity Serious Incidents (SIs).
- The Trust may want to consider holding monthly Safety Champion meetings or alternatively providing the minimum data required for monthly review to attendees outside of the meeting.
- Evidence that the Maternity Single System Board report is reported to the Trust Board in Quarter 4 and that it includes thematic learning.
- Evidence that the Trust has reviewed the clinical quality surveillance model in full and in collaboration with the Local Maternity and Neonatal System (LMNS) lead and Regional Chief Midwife, and evidence that Trust level intelligence is being shared to ensure early action and support for areas of concern or need.
- Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the Perinatal 'Quad' leadership team, minimum quarterly (a minimum of two in the reporting period) and that any support required of the Board has been identified and is being implemented.

4. Items of note to the Board of Directors

4.1 In order to meet compliance with Safety Action 3, the Trust Board, along with the LMNS and ICB, is formally required to sign off the *Eastern and Northern Avoiding Term Admissions Into Neonatal Units (ATAIN)* Action Plans. Please refer to Appendix 3.

The Board is also asked to commit to ongoing oversight of the implementation of the ATAIN action plans through regular reporting. This will be achieved via an escalation from Neonatal Governance Group, via Safety and Risk Committee/Governance Committee, as well as via the Neonatal Operational Delivery Network.

4.2 In order to meet compliance with Safety Action 5, there is a requirement to formally minute as part of the January 2024 Trust Public Board that the Trust is compliant with BirthRate+. The 2023/24 Maternity Annual Staffing Review (undertaken in January 2024) and the six monthly Nursing, Midwifery, and Allied Health Professionals Safe Staffing report (presented to the Board in November 2023) have both assessed the Trust's funded establishment is compliant with outcomes of BirthRate+ or equivalent calculations. Additionally, BirthRate+ is due to be repeated this year as part of a routine three-yearly assessment.

4.3 In order to meet compliance with Safety Action 6, there is a requirement to formally minute as part of the January 2024 Trust Public Board that the Trust is compliant with Saving Babies' Lives Care Bundle v3. This validation has been undertaken by both the LMNS and ASW Assurance, with a report compiled for the Safety and Risk Committee.

5. Resource/legal/financial/reputation implications

Non-compliance to the full 10 key safety actions will not permit the Royal Devon from recovering their contribution to the Year 5 CNST MIS; but as per NHS Resolution guidance, the Trust may be eligible for a small discretionary payment from the scheme

(this would be at a lower level than the 10% contribution to the incentive fund) to support progress against actions that have not been achieved.

6. Link to BAF/Key risks

Nil

7. Proposals to the Board of Directors

The Board of Directors is asked to:

- Formally note the ATAIN Action Plans (Appendix 3) in the Board minutes and commit to oversight of their implementation as detailed in 4.1;
- Formally note the Trust's compliance with BirthRate+ and Saving Babies' Lives v3 as detailed in 4.2 & 4.3;
- Make a recommendation to the RDUH Chief Executive Officer regarding the Trust is compliant with 8 out of the 10 Safety Actions assuming that the relevant actions to achieve compliance are completed, and non-compliance with Safety Action 1 and 9;
- Note the areas of non-compliance, the learning taken from this year's programme, and commit to supporting both the audit action plan and delivery action plan to move the position forward in Year 6 of the CNST MIS.

Royal Devon University Healthcare Foundation Trust
Final Internal Audit Report: CNST Maternity Evidence Review Part 2

Report Reference: RDUHFT28-24
January 2024

Distribution List (for action):

- Sally Bryant, Associate Director of Midwifery
- Alison Macefield, Head of Midwifery
- Helen, Hughes, Clinical Midwifery Matron for Quality and Safety
- Natalie Wickins, Divisional Director - Specialist Services - Eastern
- Anthony Layton, Divisional Director, Clinical Support and Specialist Services Division - Northern
- Alexis Webb, Divisional Business Manager- Specialist Services – Eastern
- Carla Custons-Cole, Project and Service Change Manager
- Tracey Reeves, Director of Nursing – Eastern Services
- Beverley Allingham, Director of Nursing – Northern Services
- Carolyn Mills, Chief Nursing Officer

Additional Copies (final report, for information):

- Melanie Holley, Director of Governance
- Colin Dart, Director of Operational Finance
- Paul Roberts, Interim Chief Executive Officer

Executive Summary

AUDIT BACKGROUND, SCOPE AND OBJECTIVES

Background, Objectives and Scope of the Audit

In November 2023 we undertook a review of the evidence collated in support of the Trust's self-assessment for the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). At the time of the review there was insufficient evidence to demonstrate compliance for 9 of the 10 safety actions, and subsequently the Chief Nurse commissioned a follow up review of the additional evidence collated, which took place in January 2024. The outcome of the Trust's self-assessment is scheduled for presentation to the Board in January 2024, prior to the submission of the required declaration to NHS Resolution by the deadline of 1 February 2024.

OVERALL CONCLUSION

Since our last review, significant effort has been made by the Trust to locate additional evidence to demonstrate compliance with the nine safety actions where we had previously highlighted that there was insufficient evidence to support a compliant declaration. Based on the additional evidence provided as part of this follow up review, we are satisfied there is adequate available evidence to support 'full compliance' with two of the ten Safety Actions. This position could be further improved if the additional evidence identified (but not yet collated and available for inspection) is in place for five of the Safety Actions, prior to the submission of the Trusts declaration, thus enabling a declaration of compliance in respect of seven (out of ten) Safety Actions.

Our assessment of each Safety Action is summarised in the table overleaf, with the full detail of each assessment provided to the Maternity Management Team under separate cover, and the details of the additional evidence required and rational for why three of the Safety Action standards are considered non-compliant, contained within the detailed findings section of this report.

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Key:

Rating	Description
✓	Evidence provided is appropriate or requires minimal additional evidence. Any issues identified are not significant.
– ✓	Requiring additional evidence that should be obtainable prior to the submission deadline. If adequate evidence is obtained prior to submission, the Safety Action would be compliant.
–	Evidence provided is appropriate, however, in our opinion, this evidence requires further explanation (including additional detail and/or adjustment prior to submission).
✗	Evidence provided does not adequately demonstrate compliance with the element of the Safety Action.

	CNST Safety Action Criteria	Assessment of Evidence Part 1 Nov 2023	Assessment of Evidence Part 2 Jan 2024
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	✗	✗
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	✓	N/A
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	–	– ✓
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	✗	– ✓
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	–	– ✓
6	Can you demonstrate that you are on track to meet compliance with all elements of the Saving Babies' Lives care bundle Version 3?	✗	✗
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users?	–	– ✓
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training? 1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework. 2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB. 3. The plan is developed based on the "How to" Guide developed by NHS England.	–	✓
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	–	✗
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	–	– ✓

We would like to acknowledge the help and assistance given by the Maternity/Specialist Services staff deployed to support the provision of additional evidence, and the individual Safety Action Leads, during the course of this review.

Rating of Recommendations

Recommendations raised in this report have been rated in accordance with the organisation's risk matrix.

Amanda Lowe, Director of Audit and Assurance Services

Report Data

Date of Work Undertaken	8 January – 15 January 2024
Date of Issue of Draft Report	17 January 2024
Date of Return of Draft Report	XXXX
Date of Approval of Final Report	XXXX
Lead Auditor	Hanna Somerwill, Senior Audit and Assurance Specialist
Client Lead Manager(s)	• Sally Bryant, Associate Director of Midwifery • Alison Macefield, Head of Midwifery - Eastern Services • Helen, Hughes, Clinical Midwifery Matron for Quality and Safety • Natalie Wickins, Divisional Director - Specialist Services - Eastern • Anthony Layton, Divisional Director, Clinical Support and Specialist Services Division - Northern • Alexis Webb, Divisional Business Manager- Specialist Services – Eastern
Client Lead Director	Carolyn Mills, Chief Nursing Officer
Governance/Regulatory Links	CNST Maternity Standards Year 5

Action Plan

The action plan below sets out a series of recommendations that will not only look to address deficiencies in respect of the Year 5 CNST self-assessment and supporting declaration to NHSR, but will also assist with improvements to the process in preparation of CNST Year 6:

Rec no.	Recommendation	Risk rating	Agree/ disagree	Management action (SMART)	Evidence required to close action	Action lead/ manager responsible	Action date
1	In order to meet compliance with SA3 the following evidence will need to be provided: • Approval of the Eastern and Northern ATAIN Action plan by the Head of Midwifery, Deputy Head of Midwifery, and Clinical Directors for both obstetrics and neonatology. • Trust Board, LMNS and ICB sign off of the Eastern and Northern ATAIN Action plan, as well as ongoing oversight of plan progress through regular reporting.	(6)	Agree	Signatures collected and submitted for audit Request for Trust Board sign off in January 2024 Board meeting	Signatures Board presentation, paper, minutes	Alexis Webb (complete) Carolyn Mills	18/01/24 31/01/24
2	The following evidence is required for SA4: • Approval of the BAPM Action plans by the Maternity Governance Group, the LMNS and the Neonatal Operational Delivery Network (ODN). • CNST Workforce Compliance Reports for Eastern and Northern detailing the Trust compliance/non-compliance with BAPM, requires presentation to Maternity Governance on the 17th January 2024. The minutes will need to demonstrate this declaration and should be saved as evidence.	(6)	Agree	BAPM action plans to Mat Governance in Jan 2024, and submitted to Charli Mardon at LMNS/ODN. CNST workforce compliance reports presented at Jan 2024 Mat Governance.	Maternity Governance papers and minutes.	Helen Hughes (complete)	18/01/24
3	In order to meet compliance with SA5 the following evidence will need to be provided: • Minute of the January 2024 Trust Public Board that confirms that the Trust is compliant with BirthRate+. • Copy of the Actions tracker which details the actions agreed as part of the Maternity Establishment Review on the 8 January 2024.	(6)	Agree	Request for Trust Board sign off in January 2024 Board meeting Supply Action Tracker	Board presentation, paper, minutes Action Tracker	Carolyn Mills Alison Macefield (complete)	31/01/24 18/01/24

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-	**This recommendation was already included within the action plan arising from our initial assessment (Report Ref: RDUHFT29-24, Recommendation 13)** In order to meet compliance with SA 6 the Trust will need to demonstrated compliance against the implementation of 70% of interventions across all 6 elements of SBLV3 and implementation of at least 50% of interventions in each element. In order to achieve this the Trust will have to provide additional evidence listed by the LMNS as documented in the Saving Babies Live v3 Implementation Tool, in order in order to the meet the required % of compliance.	**16**	Disagree	Evidence from LMNS to suggest that further data submission has secured compliance for this Safety Action	As per uploads to NHS Futures Platform	Helen Hughes, Charli Mardon (complete)	18/01/24
4	In order to meet compliance with SA7 the following evidence will need to be provided: • Copy of the approved MNVP work plan 2023/24. • Evidence that the MNVP 2023/24 plan has been agreed, sign off from LMNS will take place week commencing 15/01/2024.	**(6)**	Agree	MNVP 23/24 work plan submitted to Charli Mardon	MNVP 23/24 work plan LMNS sign off	Charli Mardon	26/01/24
5	In order to meet compliance with SA9 the following evidence will need to be provided: • Reporting routes will be mapped to each of the six requirements of the Perinatal Quality Surveillance Model to provide assurance that the minimum data is being reported monthly, this will also include a quarterly review of thematic learning of all maternity Serious Incidents (SIs). • The Trust may want to consider holding monthly Safety Champion meetings or alternatively providing the minimum data required for review monthly to attendees outside of the meeting. • Evidence that the Maternity Single System Board report is reported to the Trust Board in Quarter 4 and that it	**(12)**					

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	includes thematic learning. • Evidence that the Trust has reviewed the clinical quality surveillance model in full and in collaboration with the LMNS lead and Regional Chief Midwife, and evidence that Trust level intelligence is being shared to ensure early action and support for areas of concern or need. • Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the Perinatal 'Quad' leadership team, minimum quarterly (a minimum of two in the reporting period) and that any support required of the Board has been identified and is being implemented.						
6	In order to meet compliance with SA10 evidence of the following being reported to the Maternity Governance Group on the 17 January 2024 will need to be provided: • Numbers of HSIB Referrals. • Assurance that families have received information on the role of HSIB/MNSI and EN scheme for all of the HSIB referrals during the reporting period. • Compliance with duty of candour for the HSIB referrals during the reporting period.	**(6)**	Agree	Paper presented at Jan Mat Gov	Paper and minutes	Helen Hughes (complete)	18/1/24

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Review of Additional Evidence

What We Checked

We reviewed the additional evidence collated by the Trust to support the Safety Standard criteria as set out in NHS Resolution's guidance for the *Maternity incentive scheme (MIS) – year five* with a view to providing an independent assessment of the quality of the evidence provided, prior to review by the Board of Directors and any subsequent declaration made to NHS Resolution in February 2024.

What We Found

As shown in the executive summary we have re assessed the evidence provided to support for all 10 Safety Actions, there have been a number of improvements, but as detailed below, there remain a high number of areas whereby additional evidence is required:

Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
The Trust is **not compliant** with this safety action for the following reasons:

- The Trust has not met the target of 95% of reviews being started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.
- The Board of Directors have not received a quarterly report starting from the 30 May 2023 that includes details of the deaths reviewed, any themes identified and the consequent action plans. This report should also confirm that:
  - The Perinatal Mortality Review Tool has been used to review eligible perinatal deaths and that all perinatal deaths are reported to MBRRACEUK within 7 days.
  - The perspectives of care and any questions have been sought from the parents for 95% of the perinatal deaths.
  - 95% of the perinatal reviews have been started within two months of the death.
  - A minimum of 60% of multi-disciplinary reviews have been completed to the draft report stage within four months of the death and published within six months.

The MIS year 5 guidance states that the above should be reported quarterly to the Trust Executive Board, we interpret this requirement as the Trust Board of Directors. The data required has instead been reported to other Trust Committees, groups such as Maternity Governance, the Governance Committee, Mortality Group or the Safety Champions Meeting, our review of the reports supplied as evidence does not cover all expected areas within the minimum evidential requirement, such as any themes identified and the consequent action plans. If the Trust deems the current reporting routes as sufficient, it may wish to confirm with NHS Resolution their expectations in terms of the reporting requirements.

Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

At this time, the Trust has **insufficient evidence** to support a statement of compliance. The evidence requirements that remain outstanding are as follows:

- Evidence of sign off by email, of the Eastern and Northern ATAIN action plans by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead or individuals deemed appropriate by the Trust.
- Minutes of the Maternity Governance Group on the 17 January 2024 to evidence that the Eastern and Northern ATAIN action plans have been reported.
- Email confirmation from the Local Midwifery Neonatal System (LMNS) that the Northern and Eastern ATIAN action plans have been signed off, approval planned week commencing 15/01/2024.

Going forwards the ATAIN action plan must be regularly reported at the Maternity or Neonatal Governance Group.

SA4 Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

At this time, the Trust has **insufficient evidence** to support a statement of compliance. The evidence requirements that remain outstanding are as follows:

- Minutes of the Maternity Governance Group on the 17 January 2024 to evidence that the Eastern and Northern CNST Clinical medical workforce updates been reported. The minute of this meeting **must** also record the Trusts compliance or non-compliance with British Association of Perinatal Medicine (BAPM) national standards of medical staffing.

Going forwards BAPM action plans need to be monitored at the Maternity Governance Group.

Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

At this time, the Trust has **insufficient evidence** to support a statement of compliance. The evidence requirements that remain outstanding are as follows:

- The minutes of the January 2024 Board, confirming the Trusts funded establishment is compliant with outcomes of BirthRate+ or equivalent calculations.
- The Action Tracker/plan from the Maternity Establishment review on Monday 8 January 2024.

Safety Action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Our current assessment is that the Trust is **not compliant**, as there is a significant amount of evidence still to collate in order that this can be considered compliant. The LMNS as part of their quarterly review process, will make the final judgement on whether the Trust meets the required levels of compliance through its validation of the Saving Babies Lives Toolkit and the supporting evidence uploaded by the Trust onto NHS Futures.

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Assessment of compliance as at 15 January 2024 is summarised in the table below:

Element	IA Assessment	LMNS Assessment
One - Reducing Smoking in Pregnancy (*Includes 10 Interventions*).	40%	40%
Two - Fetal Growth: Risk Assessment, Surveillance, and Management *(Includes 20 Interventions).*	50%	60%
Three - Raising Awareness of Reduced Fetal Movement (RFM) *(Includes two Interventions).*	50%	50%
Four - Effective Fetal Monitoring During Labour (Includes five Interventions).	0%	20%
Five - Reducing Pre-term Birth *(Includes 26 Interventions).*	34%	34%
Six - Management of Pre-existing Diabetes in Pregnancy *(Includes six Interventions).*	0%	16%

NB. The differences in the % scores for elements two and three is due to differences in the guidance documents provided for review. For element five, we were not aware that the regional team were developing a guideline for one of the interventions and that this it is not yet finalised; the LMNS have therefore assessed this intervention as compliant.

The LMNS have provided an extension to the Trust to supply additional evidence for their validation of the toolkit and will be reviewing any additional evidence supplied on Friday 19 January 2024. This could change their view on the % scores for each of the elements of Saving Babies lives, however, considerable work is required and the significant improvement needed to meet the required scores is unlikely. It should be noted, however that although for CNST the Trust will have to declare compliance on its position at the point of declaration, the implementation date as per the Saving Babies Lives Care Bundle Guidance is March 2024. The Trust could therefore potentially meet this target date outside of CNST.

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users

At this time, the Trust has **insufficient evidence** to support a statement of compliance. The evidence requirements that remain outstanding are as follows:

- Email confirmation from the Local Midwifery Neonatal System (LMNS) that the Devon Maternity and Neonatal Voices Partnership work plan has been signed off, and funding approved, its approval is planned for the week commencing 15 January 2024.

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

As raised in our previous review of evidence in November 2023, the training plan in its current format needs additional work and should be revisited for year 6 to ensure each of the individual minimum requirements for each of the elements with the core competency framework are being covered within the maternity training provided.

The Trust is currently not meeting the 80% training compliance targets for all of the staff groups required, however, there is an action plan in place to reach compliance by April 2024. MIS guidance therefore indicates that the Trust can therefore declare a **compliant** position.

Safety Action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

The Trust is **not compliant** with this safety action for the following reasons:

- Although learning from HSIB and EN cases are reported to the Safety Champions Meeting, there is no evidence to support monthly review of thematic learning on all cases.
- The Safety Champions Meeting where the majority of the data required for this Safety Action meets bi monthly. The MIS requirement is that there is a monthly review of maternity and neonatal quality undertaken, using a minimum data set to include a review of thematic learning of all maternity Serious Incidents (SIs). A Maternity System Board Report is out for consultation within the system, once implemented this report will fully cover this particular minimum evidential requirement. The Trust may want to consider making the Safety Champions meetings monthly.
- IPR reports to the Board include maternity quality data, however this data is not in line with the Quality Surveillance tool requirements. The IPR data does includes numbers of maternity SIs, however this is limited to overarching numbers and does not include thematic learning.
- There is no evidence to support the Trusts perinatal clinical quality surveillance model in full and in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife, provide evidence to show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need.
- There is no evidence in the Board minutes that the Board Safety Champion(s) are meeting with the Perinatal 'Quad' leadership team at a minimum of quarterly (a minimum of two in the reporting period) and that any support required of the Board has been identified and is being implemented.

Safety Action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?

At this time, the Trust has **insufficient evidence** to support a statement of compliance. The evidence requirements that remain outstanding are as follows:

- A HSIB and EN cases paper should be reported to Maternity Governance on the 17 November it should include the following:
  - A sentence denoting the Number of qualifying Cases for HSIB and EN from 6 December 2022 to 7 December 2023 and a sentence providing assurance that all of these cases have been reported.
  - A sentence providing assurance that for all qualifying cases for HSIB and EN during the above period, that the families have been informed on the role of the HSIB/NMSI and the Early Notification Scheme.
  - A sentence providing assurance that for all qualifying cases for HSIB and EN during the period above that the Trust has adhered to Duty of Candour.

ASW Assurance – About Us

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Confidentiality

This report is issued under strict confidentiality and, whilst it is accepted that issues raised may need to be discussed with officers not shown on the distribution list, the report itself must not be copied/circulated/disclosed to anyone outside of the organisation without prior approval from the Director of Audit and Assurance Services.

Inherent Limitations of the Audit

There are inherent limitations as to what can be achieved by systems of internal control and consequently limitations to the conclusions that can be drawn from this review. These limitations include the possibility of faulty judgment in decision-making, of breakdowns because of human error, of control activities being circumvented by the collusion of two or more people and of management overriding controls. Also, there is no certainty that controls will continue to operate effectively in future periods or that the controls will mitigate all significant risks which may arise in future. Accordingly, unless specifically stated, we express no opinion about the adequacy of the systems of internal control to mitigate unidentified future risk.

Rating of Audit Recommendations

The recommendations in this report are rated according to the organisation's risk-scoring matrix and have been arrived at by assessing the risk in relation to the organisation as a whole.

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Overall Assurance Opinion Definition

The overall assurance opinion on the front page of this report is based on the following definitions:

Significant	Controls are well designed and are applied consistently. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Controls are generally sound and operating effectively. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

Rating of Individual Findings

The following ratings have been used to summarise our evaluation of each area reviewed and helps form our overall assurance opinion:

	Processes are appropriately designed and appear to be operating well. Any areas for improvement that were identified are not significant and are unlikely to reoccur.
	Controls and arrangements are generally appropriately designed working well but we have identified areas where these arrangements should be further strengthened. We do not have significant concerns regarding this area and any issues that were identified are unlikely to reoccur if properly managed.
	Urgent action is needed to address weaknesses in the processes which are in place to manage the task or function. We have significant concerns regarding this area and consider that issues may arise or reoccur.

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Maternity incentive scheme - Guidance

Trust Name	Royal Devon University Healthcare NHS Foundation Trust
Trust Code	T074

This document must be used to complete your trust self-certification for the maternity incentive scheme safety actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. **Your trust name will populate each tab. If the trust name box is coloured pink please update it.**

Guidance Tab - This has useful information to support you to complete the maternity incentive scheme safety actions excel spreadsheet. **Please read the guidance carefully.**

The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested.

There are multiple additional tabs within this document:

Tab A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed within each condition of the scheme with each maternity incentive scheme safety action. Note, 'N/A' (not applicable) is available only for set questions. The information which has been populated in this tab, will automatically populate onto tab D which is the board declaration form.

Tab B - **safety action summary sheet** - This will provide you information on your Trust's progress in completing the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet - This sheet will enable your Trust to insert action plan details for any safety actions not achieved.

Tab D - Board declaration form - This is where you can track your overall progress against compliance with the maternity incentive scheme safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the trust board, commissioners and before submission to NHS Resolution.

Upon completion of the following processes please add an electronic signature into the allocated spaces within this document. Two electronic signatures of the Trust's CEO and AO of the ICS will be required in Tab D as outlined in order to declare compliance stated in the board declaration form with the safety actions and their sub-requirements, one signature to confirm that the declaration form has been submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services and two signatures to declare that there are no external or internal reports covering either 2022/23 financial year or 2023/24 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 1 February 2024.

If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **nhsr.mis@nhs.net**
Technical guidance and frequently asked questions can be accessed here:
https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

Submissions for the maternity incentive scheme must be received no later than 12 noon on 1 **February 2024** to nhsr.mis@nhs.net
You are required to submit this document signed and dated. Please do not send evidence to NHS Resolution.

Version Name: MIS_SafetyAction_2024

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 30 May 2023 onwards been notified to MBRRACE-UK within seven working days?	Yes
2	For deaths from 30 May 2023, was MBRRACE-UK surveillance information completed within one calendar month of the death?	Yes
3	For at least 95% of all deaths of babies who died in your Trust from 30 May 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
4	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 30 May 2023 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	No
5	Were 60% of these reviews completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death?	No
6	Were 60% of the reports published within 6 months of death?	No
7	Were PMRT review panel meetings (as detailed in standard C) rescheduled due to the direct impact of industrial action, and did this have an impact on the MIS reporting compliance time scales?	No
8	Is there an action plan approved by Trust Boards to reschedule these meetings to take place within a maximum 12-week period from the end of the MIS compliance period.	N/A
9	If PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many meetings in total were impacted?	N/A
10	PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many cases in total were impacted?	N/A
11	Have you submitted quarterly reports to the Trust Executive Board from 30 May 2023 onwards? This must include details of all deaths reviewed and consequent action plans.	No
12	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Yes

Safety action No. 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023? Final data for July 2023 will be published during October 2023.	Yes
2	Did July's 2023 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes
Has the Trust Board confirmed to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics:		
3	i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks also have the Continuity of Carer (CoC) pathway indicator completed.	Yes
	If maternity services have suspended all Continuity of Carer (CoC) pathways, criteria ii is not applicable:	
4	ii. Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided.	Yes
5	Did the Trust make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023?	Yes
6	Has the Trust at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust?	Yes

Safety action No. 3

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.		
1	Was the pathway(s) of care into transitional care jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies? Evidence should include: ● Neonatal involvement in care planning ● Admission criteria meets a minimum of at least one element of HRG XA04 ● There is an explicit staffing model ● The policy is signed by maternity/neonatal clinical leads and should have auditable standards. ● The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.	Yes
2	Are neonatal teams involved in decision making and planning care for all babies in transitional care?	Yes
b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.		
3	Is there evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks?	Yes
4	Is there an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks?	Yes
5	Is there evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan?	Yes
6	Is there evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan?	Yes
c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.		
7	Is there a guideline for admission to TC that include babies 34+0 and above and data to evidence this occuring?	Yes
8	OR An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation?	N/A

Safety action No. 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas after February 2023 following an audit of 6 months activity :		
1	a. Locum currently works in their unit on the tier 2 or 3 rota?	Yes
2	**OR** b. they have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)?	N/A
3	**OR** c. they hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	N/A
4	Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance?	Yes
5	**OR** Was an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and Local Maternity and Neonatal System (LMNS) meetings? https://rcog.org.uk/media/uuzcbzg2/rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf	N/A
6	Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, and can the service provide assurance that they have evidence of compliance?	No
7	**OR** Has an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings? https://www.rcog.org.uk/media/c2jkpjam/rcog-guidance-on-compensatory-rest.pdf	Yes
8	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person?	Yes
9	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance?	Yes
Do you have evidence that the Trust position with the above has been shared:		
10	At Trust Board?	Yes
11	With Board level safety champions?	Yes
12	At LMNS meetings?	Yes
b) Anaesthetic medical workforce		
13	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)	Yes
	The rota should be used to evidence compliance with ACSA standard 1.7.2.1 (A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients)	
c) Neonatal medical workforce		
14	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing and is this formally recorded in Trust Board minutes?	No
15	If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies. If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies. Does the Trust have evidence of this?	Yes
Was the agreed action plan shared with:		
16	LMNS?	Yes
17	ODN?	Yes
d) Neonatal nursing workforce		
18	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing? And is this formally recorded in Trust Board minutes?	No
19	If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies. If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies. Does the Trust have evidence of this?	Yes
Was the agreed action plan shared with:		
20	LMNS?	Yes
21	ODN?	Yes

Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	a) Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated	Yes
2	b) Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated in a) above? Evidence should include: ● Midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. ● The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. ● The midwife to birth ratio ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
3	c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. Can you provide evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating **100% compliance** with supernumerary labour ward co-ordinator status? The Trust can report compliance with this standard if failure to maintain supernumerary status is a one off event, however **the Trust cannot report compliance with this standard if the coordinator is required to provide any 1:1 care for a woman and/or care in established labour during this time.** If the failure to maintain supernumerary status is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in an action plan. This plan must include mitigation/escalation to cover any shortfalls. Please note - Completion of an action plan will not enable the Trust to declare compliance with this standard.	Yes
4	d) Have all women in active labour received one-to-one midwifery care?	Yes
5	If you have answered **no** to standard d, have you submitted an action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour?	N/A
6	Does the action plan include a timeline for when this will be achieved and has this been signed off by Trust Board?	N/A
7	e) Have you submitted a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period?	Yes

Safety action No. 6

Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you provided assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024?	Yes
2	Do you hold quarterly quality improvement discussions with the ICB, using the new national implementation tool? Confirmation is required from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust using the implementation tool that included the following: ● Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. ● Progress against locally agreed improvement aims. ● Evidence of sustained improvement where high levels of reliability have already been achieved. ● Regular review of local themes and trends with regard to potential harms in each of the six elements. ● Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts.	Yes
3	Using the new national implementation tool, can the Trust demonstrate implementation of 70% of interventions across **all** 6 elements overall?	Yes
4	Using the new national implementation tool, can the Trust demonstrate implementation of at least 50% of interventions within **each** of the 6 individual elements?	Yes

Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Is a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) in place which is in line with the Delivery Plan?	Yes
2	Has an action plan been co-produced with the MNVP following annual CQC Maternity Survey data publication (January 2023), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board?	Yes
3	Is neonatal and maternity service user feedback collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions?	Yes
4	Can you provide minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from co-production between service users and staff?	Yes
5	Do you have evidence that MNVPs have the infrastructure they need to be successful such as receiving appropriate training, administrative and IT support?	Yes
6	Can you provide the local MNVP's work plan and evidence that it is funded?	Yes
7	Do you have evidence that the MNVP leads (formerly MVP chairs) are appropriately employed or remunerated (including out of pocket expenses such as childcare) and receive this in a timely way?	Yes
8	Can you provide evidence that the MNVP is prioritising hearing the voices of families receiving neonatal care and bereaved families, as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation?	Yes

Safety action No. 8

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 1 December 2022 to 1st December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	A local training plan is in place for implementation of Version 2 of the Core Competency Framework	Yes
Can you evidence that the plan has been agreed with:		
2	Quadrumvirate?	Yes
3	Trust Board?	Yes
4	LMNS/ICB?	Yes
5	Has the plan been developed based on the four key principles as detailed in the "How to" Guide for the second version of the core competency framework developed by NHS England?	Yes
6	Can you evidence service user involvement in developing training?	Yes
7	Can you evidence that training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports?	Yes
8	Can you evidence that you promote learning as a multidisciplinary team?	Yes
9	Can you evidence that you promote shared learning across a Local Maternity and Neonatal System?	Yes
Can you demonstrate the following at the end of 12 consecutive months ending December 2023? **80% compliance at the end of the previously specified 12-month MIS reporting period (December 2022 to December 2023) will be accepted, provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period.** **In addition, evidence from rotating obstetric trainees having completed their training in another maternity unit during the reporting period (i.e. within a 12 month period) will be accepted.** **If this is the case, please select 'Yes'**		
Fetal monitoring and surveillance (in the antenatal and intrapartum period)		
10	90% of obstetric consultants?	Yes
11	90% of all other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)?	Yes
12	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres?	Yes
Maternity emergencies and multiprofessional training		
13	90% of Obstetric consultants?	Yes
14	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota?	Yes
15	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives?	Yes
16	90% of maternity support workers and health care assistants attend the maternity emergency scenarios training?	Yes
17	90% of obstetric anaesthetic consultants?	Yes
18	90% of all other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota?	Yes
19	Can you demonstrate that **at least one** emergency scenario is conducted in a clinical area or at point of care?	Yes
20	Can you demonstrate that 90% of all team members have attended an emergency scenario in a clinical area **or** does the local training plan (Q1) include a plan to implement attendance at emergency scenarios in a clinical area for 90% of all team members?	Yes
Neonatal basic life support		
21	90% of neonatal Consultants or Paediatric consultants covering neonatal units?	Yes
22	90% of neonatal junior doctors (who attend any births)?	Yes
23	90% of neonatal nurses (Band 5 and above who attend any births)?	Yes
24	90% of advanced Neonatal Nurse Practitioner (ANNP)?	Yes
25	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)?	Yes
26	All trusts must have an agreed plan in place, including timescales, for registered RC-trained instructors to deliver the in-house basic neonatal life support annual updates and their local NLS courses by 31st March 2024.	Yes
27	Have you declared compliance for any of Q10-Q25 above with 80-90%?	Yes
28	If you are declaring compliance for any of Q10-Q25 above with 80-90%, can you confirm that an action plan has been approved by your Trust Board to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period?	Yes

Safety action No. 9

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	**Required Standard A. Evidence that all six requirements of Principle 1 of the Perinatal Quality Surveillance Model have been fully embedded and specifically the following:-**	
2	Does your Trust have evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues?	Yes
3	Does your Trust have evidence that a review of maternity and neonatal quality is undertaken by the Trust Board at every Trust Board meeting, using a minimum data set to include a review of the thematic learning of all maternity Serious Incidents (SIs)? It must include: • number of incidents reported as serious harm • themes identified and action being taken to address any issues • Service user voice feedback • Staff feedback from frontline champions' engagement sessions • Minimum staffing in maternity services and training compliance	No
4	Do you have evidence that the perinatal clinical quality surveillance model has been reviewed in full in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife? And does this evidence show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need.	No
Required standard B. Have you submitted evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of:		
5	The Trust Board?	No
6	LMNS/ICS/Local & Regional Learning System meetings?	No
7	Do you have evidence that the progress with actioning named concerns from staff feedback sessions is visible to staff?	Yes
8	Do you have evidence that Trust's claims scorecard is reviewed alongside incident and complaint data? Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trust's Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting.	Yes
9	**Required standard C. Have you submitted evidence that the Maternity and Neonatal Board Safety Champions are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures?**	Yes
10	Have you submitted the evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace with confirmation of specific resources accessed and how this has been of benefit?	Yes
11	Have there been a minimum of two quarterly meetings between board safety champions and quadrumvirate members between 30 May 2023 and 1 February 2024?	Yes
12	Have you submitted evidence that the meetings between the board safety champions and quad members have identified any support required of the Board and evidence that this is being implemented?	No

Safety action No. 10

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Complete the field on the Claims Reporting Wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	Yes
2	Have you reported all qualifying cases to HSIB/CQC/MNSI from 6 December 2022 to 7 December 2023?	Yes
3	Have you reported all qualifying EN cases to NHS Resolution's EN Scheme from 6 December 2023 until 7 December 2023?	Yes
	For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that:	
4	The family have received information on the role of HSIB/MNSI and NHS Resolution's EN scheme	Yes
5	There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour	Yes
	Can you confirm that the Trust Board has:	
6	Sight of Trust legal services and maternity clinical governance records of qualifying HSIB/MNSI/EN incidents and numbers reported to HSIB/MNSI and NHS Resolution?	Yes
7	Sight of evidence that the families have received information on the role of HSIB/MNSI and the EN scheme?	Yes
8	Sight of evidence of compliance with the statutory duty of candour?	Yes

Section A : Maternity safety actions - Royal Devon University Healthcare NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	No
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	No
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?	Yes

Section B : Action plan details for Royal Devon University Healthcare NHS Foundation Trust

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action	Q1 NPMRT
To be met by	Q1 = 2024/25
Work to meet action	*1. The Trust has not met the target of 95% of reviews being started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.* *2. The Board of Directors have not received a quarterly report starting from the 30 May 2023 that includes details of the deaths reviewed, any*
Does this action plan have executive level sign off	Yes
Action plan agreed by head of midwifery/clinical director?	Yes
Action plan owner	*Helen Hughes, Simon Walker and Naomi Curtis*
Lead executive director	*Carolyn Mills, Chief Nursing Officer*
Amount requested from the incentive fund, if required	*£0.00*
Reason for not meeting action	*The MIS year 5 guidance states we should be reporting quarterly to the Trust Executive Board, i.e. the Trust Board of Directors. The data required has instead been reported to other Trust Committees, groups such as Maternity Governance, the Governance Committee, Mortality Group or the Safety Champions Meeting. Out Internal Audit review of the reports supplied as evidence did not cover all expected areas within*
Rationale	*This action plan will ensure the trust meets the safety action by ensuring reviews are started and we meet the expected time frame for draft reports. We will also have a robust reporting timeframe in place with a nominated lead covering the elements.*
Benefits	*The key SMART benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action are as follows:* *Delivery of this action will ensure as a Trust we are compliant with Safety Action 1 and will positively impact on the safety and quality of patient*
Risk assessment	*Failure to maintain the required standards for compliance with NPMRT, as well as this specific safety action within CNST, will result in a negative impact on patients at a very emotionally senstive time and a potential impact on our reputation with legal and financial ramifications.*

	How?	Who?	When?
Monitoring	CNST will be a standard item on the agenda for Maternity Governance; we will map all reporting processes	Helen Hughes	Monthly starting February 2024

Action plan 2

Safety action: Q9 Safety Champions

To be met by: Q1 = 2024/25

Work to meet action: *The Trust is not compliant with this safety action for the following reasons:*
• Although learning from HSIB and EN cases are reported to the Safety Champions Meeting, there is no evidence to support monthly review of thematic learning on all cases.

Does this action plan have executive level sign off: Yes

Action plan agreed by head of midwifery/clinical director?: Yes

Action plan owner: *Sally Bryant and Ali Macefield*

Lead executive director: *Carolyn Mills, Chief Nursing Officer*

Amount requested from the incentive fund, if required: *£0.00*

Reason for not meeting action: *The explaination as to why the trust did not meet this safety action is stated within the Work to meet action section.*

Rationale: *This action plan will ensure the trust meets the safety action by ensuring accurate and timely reporting processes are in place alongside a robust evidence storage process.*

Benefits: *The key SMART benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action are as follows:*
Delivery of this action will ensure as a Trust we are compliant with Safety Action 9 and will positively impact on the safety and quality of patient

Risk assessment: *Failure to maintain the required standards for compliance with this specific safety action within CNST has the potential to have a negative impact on the safety and quality of patient care within our maternity service. This in turn has the potential to impact on our reputation with legal and financial ramifications.*

	How?	Who?	When?
Monitoring	CNST will be a standard item on the agenda for Maternity Governance; we will map all reporting processes	Helen Hughes	Monthly starting February 2024

Action plan 3

Safety action:

To be met by:

Work to meet action: *Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off:

Action plan agreed by head of midwifery/clinical director?:

Action plan owner

Lead executive director — *Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required

Reason for not meeting action — *Please explain why the trust did not meet this safety action*

Rationale — *Please explain why this action plan will ensure the trust meets the safety action.*

Benefits — *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*

Risk assessment — *What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Action plan 4

Safety action

To be met by

Work to meet action — *Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off

Action plan agreed by head of midwifery/clinical director?

Action plan owner — *Who is responsible for delivering the action plan?*

Lead executive director — *Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required

Reason for not meeting action — *Please explain why the trust did not meet this safety action*

Rationale — *Please explain why this action plan will ensure the trust meets the safety action.*

Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Action plan 5

Safety action		**To be met by**	

Work to meet action	*Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Amount requested from the incentive fund, if required	
Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Action plan 6

Safety action | | **To be met by** |

Work to meet action: *Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off

Action plan agreed by head of midwifery/clinical director?

Action plan owner: *Who is responsible for delivering the action plan?*

Lead executive director: *Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required

Reason for not meeting action: *Please explain why the trust did not meet this safety action*

Rationale: *Please explain why this action plan will ensure the trust meets the safety action.*

Benefits: *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*

Risk assessment: *What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Action plan 7

Safety action | | **To be met by** |

Work to meet action: *Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off

Action plan agreed by head of midwifery/clinical director?

Action plan owner | *Who is responsible for delivering the action plan?*

Lead executive director | *Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required

Reason for not meeting action | *Please explain why the trust did not meet this safety action*

Rationale | *Please explain why this action plan will ensure the trust meets the safety action.*

Benefits | *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*

Risk assessment | *What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Action plan 8

Safety action

To be met by

Work to meet action | *Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off

Action plan agreed by head of midwifery/clinical director?

Action plan owner | *Who is responsible for delivering the action plan?*

Lead executive director | *Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required

Reason for not meeting action | *Please explain why the trust did not meet this safety action*

Rationale | *Please explain why this action plan will ensure the trust meets the safety action.*

Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Action plan 9

Safety action		**To be met by**	

Work to meet action	*Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Amount requested from the incentive fund, if required	
Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Action plan 10

Safety action		**To be met by**	

Work to meet action	*Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Amount requested from the incentive fund, if required	
Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Maternity Incentive Scheme - Board declaration form

Trust name	**Royal Devon University Healthcare NHS Foundation Trust**
Trust code	**T074**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	No	Yes	-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	No	Yes	-	
Q10 EN scheme	Yes		-	
Total safety actions	**8**	**2**		
Total sum requested			**-**	

Sign-off process confrming that:

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2023/24) or the previous financial year (2022/23)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.
* If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

Electronic signature of Trust Chief Executive Officer (CEO):	
For and on behalf of the Board of	Royal Devon University Healthcare NHS Foundation Trust
Name:	
Position:	
Date:	

Electronic signature of Integrated Care Board Accountable Officer:	
For and on behalf of the board of	Royal Devon University Healthcare NHS Foundation Trust
Name:	
Position:	
Date:	

APPENDIX 3 - CNST MIS YEAR 5 ATAIN Eastern Action Tracker 2023-2024

ATAIN- Quarterly Assurance Group
2023-2024
Action Tracker

Date Last meeting October 2023 — Oct-23

Date added to tracker	Action Number	DRIVER Specific	MONITORING Measurable	ACTIONS Specific, Achievable, Realistic	Person Responsible	Time-Frame to Achieve	STATUS	Amendment requested (1)	Requestor	Amendment requested (2)
		Issue/Gap/Objective requiring action	*How we know we've succeeded*			*Timebound*				
Jan-23	1	Lack of **Neonatal** time to undertake review and data cleanse	improved neonatal oversight and review of data	1) review of neonatal time and input to ensure ATAIN has neonatal oversight 2) Request to be raised to explore protected data person.	Louise Rattenbury	1st February	Feb-23			Review timeframe on next review
Jan-23	2	**Maternity**- Reported that 4 hours data time insufficient	timelier reporting	Maternity to ascertain how to efficiently collate maternity data of term admissions in collaboration with neonatal data.	Trish Heale	Apr-23	reviewed as part of the over all ATAIN process	Define more timely reporting	AW	Review timeframe on next review
Jan-23	3	ATAIN meetings are once per quarter and it was reported that this has been challenging to gain consistent attendance with subsequent need to rearrange to ensure CNST compliance.	improved attendance	to review diaries and prioritise attendance	All	May-23	May-23	Define quoracy for ATAIN meetings	AW	Review timeframe on next review
Jan-23	4	Poor compliance for quarterly reporting and onward escalation to local governance groups - linked to action 1 (Report collated by **Maternity**)	Timelier reporting and escalation	1) reports to be highlighted as 'Urgent' and followed-up verbally due to the pressure on email traffic to prevent delay 2)for the purposes of CNST there should be evidence that the reports are shared with the Neonatal Safety Champion and then shared with the LMNS.	Trish Heale	May-23	linked to action 15	Name lead for Safety Champion and LMNS liaison Clarity of content of reports	AW DMcG	Review timeframe on next review
New Chair assigned - Lisa Brown May 2023.										
May-23	5	**Reescalation** : ATAIN meetings are once per quarter and it was reported that this has been challenging to gain consistent attendance with subsequent need to rearrange to ensure CNST compliance.	improved attendance	to review diaries and prioritise attendance	All	Aug-23	August	Define quoracy for ATAIN meetings	AW	Review timeframe on next review
				Escalation to HOM and DHOM	Lisa Brown	May-23	May-23			Review timeframe on next review
May-23	6	Q3 and Q4 reports remain outstanding.	Timelier reporting and escalation	TH to share reports with group for circulation by 2nd June. (MH to ensure this occurs)	Trish Heale/MH	Jun-23				Review timeframe on next review
				TJ to Add reports to NNU governance for sign off.	Tom Johnson	Jun-23		Clarity of content of report	DMcG	Review timeframe on next review
				MH to add report to Maternity Governance group	Mel Hayward	Aug-23		Clarity of content of report	DMcG	Review timeframe on next review
				LB to add both reports for review on next meeting.	Lisa Brown	Aug-23		Clarity of content of report	DMcG	Review timeframe on next review
				LB escalated to HOM	Lisa Brown	May-23				Review timeframe on next review
May-23	7	Lack of due diligence and governance and assurance processes Agenda TOR Reporting etc	Governance Assurance	1) review and develop, TOR, Agenda and include reporting processes once process has been reviewed	Lisa Brown	Dec-23		Supported, please prioritise	DMcG	Review timeframe on next review
May-23	8	align previous action tracker and minutes to new meeting.	combined action trackers and minutes	1) review Action trackers and create one action tracker	Lisa Brown	Dec-23		Supported, please prioritise	DMcG	Review timeframe on next review
May-23	9	Atain Process outdated and noted single point of failure Cumbersome and time consuming	reviewed and assured attain process	MD, LB, HH to meet as a priority to review/ better understand the current process/ data capture required for ATAIN in 2023.	Lisa Brown Helen Hughes	Aug-23	LB presented new proposed process to ATAIN group Oct 2023	Minutes requested	DMcG	Review timeframe on next review
				LB and HH to collate proposal to ATAIN of new ATAIN process	Lisa Brown Helen Hughes	Oct-23	new process agreed	Supported, please prioritise	DMcG	Review timeframe on next review
Aug-23	10	2023/2024 ATAIN Data Noted that RDUH currently at 7% which is higher than previously.	Governance Assurance	Tom Johnson to meet with Neonatal CNMS to review current case review process and look to identify a plan to review further.	Tom Johnson	Sep-23		And actions to address TC shortfall	DMcG	Review timeframe on next review
				Tom Johnson, Trish Heale and Harriet Aughey to review data with network to identify anomalies.	Tom Johnson, Trish Heale, Harriet Aughey	Sep-23				Review timeframe on next review
				Tom Johnson, Trish Heale and Harriet Aughey to review Q1 data (64 cases) to provide Q1 report back to attain group by email by the 29th September.	Trish Heale, Harriet Aughey	Sep-23				Review timeframe on next review
Aug-23	11	Timelier Reporting	Governance Assurance	Trish Heale to ensure Q2 report is collated and shared in preparation for next meeting. (October)	Trish Heale	Oct-23		Clarity of content of report; review in Jan meeting	DMcG	Review timeframe on next review
Aug-23	12	Data Assurance - Datix Vs Badger (Via network)	Business intelligence	Harriet Aughey to undertake a 4-week snap shop data comparison with what is reported on Datix and what is captured by the network and compare/ report back to group.	Harriet Aughey	Oct-23				Review timeframe on next review
Oct-23	13	integration : acknowledgement of needing to join ATAIN processes in future with Northern as a single reporting organisation.	integration	LB to Liaise with northern services to review and agree integration time lines	Lisa Brown	April 2024- Q1	integrated meeting Q1 2024	Ensure proper handover given change in leadership	DMcG	Review timeframe on next review
Oct-23	14	system updates PASP and Maternity services update	system updates	LB to Flag with HOM	Lisa Brown	Nov-23				Review timeframe on next review
Oct-23	15	Adoption of new proposed ATAIN reporting process	reviewed and assured attain process	Eastern to identify maternity and neonatal representatives responsible for collating and reviewing monthly term admission data.	Mel Hayward Harriet Aughey	Dec-23		Agreed - should form part of quarterly meetings/ToR	DMcG	Review timeframe on next review
				to adopt Northern Excel spreadsheet to collate and record/ review to support easier integration in future		Dec-23				Review timeframe on next review

				SBAR report of trends and learning to be collated and submitted to NNU and mat gov monthly.		Dec-23		Agreed - should form part of quarterly meetings/ToR	DMcG	Review timeframe on next review
				quarterly SBAR review and onward escalation via maternity safety champions forum	Lisa Brown	Dec-23				Review timeframe on next review

APPENDIX 3 - CNST MIS YEAR 5 ATAIN Northern Action Tracker 2023-2024

Item No	Link to ATAIN admission criteria (i.e.Respiratory, Jaundice, Hypoglycaemia, HIE, Observation, Poor feeding)	Recommendation identified following case review	Action plan to achieve compliance with recommendation (SMART)	Lead Responsible	Expected date for completion	Progress/comments	Date completed	Amendment Requested (1)	Requestor	Amendment requested (2)
1	feeding/observation/ jaundice	for the trust board to iniate/re-invigorate plans for a fully functionally and staffed TC as required by commissioning.	it remains unclear to us why this has been postponed and taken off the plans in the last years Money from CNST had already been provided for implementation of TC	CEO	1.1.2018	taken to Neil Schofield, Group Manager for Women's and Children's Services, Northern	15.1.24	Link to TC action plan (sheet 3)	NS	Review Timeframe at next review
2	feeding	infant feeding is not always implemented in the most effective way	cont education with emphasis on identifying most needy patients	infant feeding lead	continued	this highlights the need to recruit for a specialist Infant Feeding Co-oordinator	ongoing	Define education programme; update on recruitment	NS/SB	Review Timeframe at next review
3	respiratory	some patients need more frequent review to assess the quickly changing respiratory needs during the transition to extra-uterine life	include this learning point in induction pack for all medical staff ~~introduction pack for middle grades and remind consultant~~	neonatal lead	continued	Part of the neonatal induction pack Discussed during neonatal simulation scenarios	ongoing	Inclusion in induction programme and mandatory training days	NS, to be led by TF/DD	Review Timeframe at next review
4	Timing of delivery	use evidence based guidelines to plan elective delivery (either by IOL or CS)	ensure IOL guideline up-to-date with indications table	Governance Lead	continuous programme of guideline review	continuous programme of guideline review. IOL guideline has been reviewed and will be presented for ratification at Guideline Group and Maternity Governance	01.04.24	Evidence of ongoing updates via Mat Gov	JG/NS	Review Timeframe at next review
5	Prompt escalation of Emergency Cesearean section	emergency delivery of neonate via CS - baby to be transferred to resuscitaire for assessment by practitioner with neonatal resuscitation skills and not to be passed directly to parents	communications not limited to maternity newsletter,effective handover, clinical updates (PROMPT)	Inpatient Matron	continued	communications request sent to coordinator re newsletter communications sent to PeriPrem co-ordinator re optimal cord clamping and skin-to-skin published in effective handover 20/12/2023	20/12/2023	Evidence of ongoing updates via Mat Gov	JG/NS	

Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 5

Trust Board of Directors

31 January 2024

Carolyn Mills, Chief Nursing Officer,

Sally Bryant, Associate Director of Midwifery

Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 5

NHS Resolution is operating Year 5 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) which sets out 10 key safety actions to continue to improve delivery of best practice within maternity services, as part of the national ambition to halve the rates of stillbirth, neonatal and maternal deaths and intrapartum brain injuries in England by 2030.

The scheme rewards NHS Trusts that meet 10 key safety actions designed to improve the delivery of best practice and outcomes in maternity and neonatal services with a rebate on their CNST premium.

It is recognised that the CNST MIS expectations and associated compliance measures for NHS Trusts have increased year on year, with a demonstrable increase in the expansion of depth of evidence required to show compliance with Year 5 requirements, specifically in respect of compliance with Safety Action 6: Saving Babies Lives Care Bundle (v3).

This is the first CNST MIS submission as a single Trust as previous submissions have been undertaken as separate organisations (RD&E & NDHT).

Assurance Process

- November 2023 Audit
- January 2024 re-audit
- Final Report

- Local Maternity & Neonatal System (LMNS) sign off of key evidence and datasets
- LMNS support for action planning

- Evidence uploaded onto NHS Futures Platform
- MBRACE data
- MSDS
- National Neonatal Research Database
- HSIB
- CQC Key Lines of Enquiry

- Board satisfied with evidence submitted and support for action plans
- No conflict of evidence with CQC and HSIB
- Declaration signed by CEO to confirm that Trust Board of Directors are satisfied with evidence
- ICB Accountable Officer apprised of outcome and confirms assurance

RDUH anticipated position at submission

	CNST Safety Action Criteria	Anticipated final outcome		CNST Safety Action Criteria	Anticipated final outcome
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?		6	Can you demonstrate that you are on track to meet compliance with all elements of the Saving Babies' Lives care bundle Version 3?	
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users?	
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?		8	Can you evidence 3 elements of local training plans and 'in-house', one day multi professional training?	
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?		9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	

Non-compliance – Safety Action 1

Standard 1: Perinatal Mortality Review Tool
For two out of seven cases identified within the reporting period, the mandated timeframe for the completion of the review was not met. The primary reason for this breach was attributed to the lack of closure of the report on the PMRT portal, although the 72hr reports were completed. Therefore the Trust will not be compliant with this safety action.

The MIS year 5 guidance states that the above should be reported quarterly to the Trust Executive Board, which Audit South West interpret as the Trust Board of Directors. The data required has been previously reported to Trust Committees i.e. the Governance Committee (Committee of the Board) and other groups i.e. Maternity Governance, Mortality Group, or the Maternity and Neonatal Safety Champions Meeting.

The Board is asked to confirm their position whether a Committee of the Board with an escalation route offers sufficient assurance. If the Trust deems the current reporting routes as sufficient, it may wish to confirm its position with NHS Resolution.

ASW Assurance have also noted the level of thematic analysis shared, as well as the consequent action plans arising from issues and themes identified.

Non-compliance – Safety Action 9

Standard 9: Board Assurance on Maternity and Neonatal Safety and Quality Issues:
In order to meet compliance with SA9, the following evidence would need to be provided:

- Reporting routes mapped to each of the six requirements of the Perinatal Quality Surveillance Model to provide assurance that the minimum data is being reported monthly; this must also include a quarterly review of thematic learning of all maternity Serious Incidents (SIs).
- The Trust may want to consider holding monthly Safety Champion meetings or alternatively providing the minimum data required for review monthly to attendees outside of the meeting.
- Evidence that the Maternity Single System Board report is reported to the Trust Board in Quarter 4 and that it includes thematic learning.
- Evidence that the Trust has reviewed the clinical quality surveillance model in full and in collaboration with the Local Maternity and Neonatal System (LMNS) lead and Regional Chief Midwife, and evidence that Trust level intelligence is being shared to ensure early action and support for areas of concern or need.
- Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the Perinatal 'Quad' leadership team, minimum quarterly (a minimum of two in the reporting period) and that any support required of the Board has been identified and is being implemented.

Items of Note to the Board

- In order to meet compliance with Safety Action 3, the Trust Board, along with the LMNS and ICB, is formally required to sign off the Eastern and Northern Avoiding Term Admissions Into Neonatal Units (ATAIN) Action plans. Please refer to Appendix 3.

The Board is also asked to commit to ongoing oversight of the implementation of the ATAIN action plans through regular reporting. This will be achieved via an escalation from Neonatal Governance Group, via Safety and Risk Committee/Governance Committee, as well as via the Neonatal Operational Delivery Network.

- In order to meet compliance with Safety Action 5, there is a requirement to formally minute as part of the January 2024 Trust Public Board that the Trust is compliant with BirthRate+. The 2023/24 Maternity Annual Staffing Review (undertaken in January 2024) and the six monthly Nursing, Midwifery, and Allied Health Professionals Safe Staffing report (presented to the Board in November 2023) have assessed the Trust's funded establishment is compliant with outcomes of BirthRate+ or equivalent calculations. Additionally, BirthRate+ is due to be repeated this year as part of routine three-yearly assessment.

- In order to meet compliance with Safety Action 6, there is a requirement to formally minute as part of the January 2024 Trust Public Board that the Trust is compliant with Saving Babies' Lives Care Bundle v3. This validation has been undertaken by both the LMNS and ASW Assurance, with a report compiled for the Safety and Risk Committee.

Proposal to the Board of Directors

The Board of Directors is asked to:

- Formally note the *Avoiding Term Admissions Into Neonatal Units (ATAIN) Action Plans* in the Board minutes and commit to oversight of their implementation;
- Formally note the Trust's compliance with BirthRate+ and Saving Babies' Lives v3;
- Make a recommendation to the RDUH Chief Executive Officer regarding the Trust is compliant with 8 out of the 10 Safety Actions assuming that the relevant actions to achieve compliance are completed, and non-compliance with Safety Action 1 and 9;
- Note the areas of non-compliance, the learning taken from this year's programme, and commit to supporting both the audit action plan and delivery action plan to move the position forward in Year 6 of the CNST MIS.

Agenda item:	11.4, Board Public Meeting		Date: 31 January 2024	
Title:	Digital Committee Update			
Prepared by:	Colin Garforth, Programme Support Manager			
Presented by:	Tony Neal, Non-Executive Director and Committee Chair			
Responsible Executive:	Adrian Harris, Chief Medical Officer			
Summary:	Briefing of items discussed at Digital Committee held on 7 December 2023			
Actions required:	Link to status below and set out clearly the expectations of the Board when considering the paper.			
Status (x):	Decision	Approval	Discussion	Information
				X
History:	The last Digital Committee update was presented to the Board of Directors in Oct 2023.			
Link to strategy/ Assurance framework:	The issues discussed are key to the Trust achieving its strategic objectives			

Monitoring Information

Please *specify* CQC standard numbers and tick ✓other boxes as appropriate

Care Quality Commission Standards	Outcomes		
NHS Improvement		Finance	
Service Development Strategy		Performance Management	
Local Delivery Plan		Business Planning	
Assurance Framework		Complaints	
Equality, diversity, human rights implications assessed			
Other *(please specify)*			

1. Purpose of paper

To provide a briefing on the Digital Committee held on 7 December 2023.

2. Background

The Digital Committee provides a direct feed into the Board of Directors and senior/corporate oversight to assure that:

- a robust, effective fit-for-purpose framework is in place for the technical, clinical and operational delivery of the digital agenda and digital maturity aspirations;
- the digital agenda contributes to the Trust operating within the law and compliance with statutory and regulatory requirements whilst concurrently delivering safe, quality and effective, digitally enabled sustainable care.
- the Trust has effective systems of internal control in relation to the digital agenda and associated governance arrangements and
- the digital agenda is aligned to overall direction of the Trust, the Integration Programme and the wider ICS.
- innovative use of technology supports the delivery of service transformation to ensure we continue to improve at all levels
- Oversee the development and delivery of the Digital Strategy Implementation Plan, noting interdependencies, risks and milestone achievements.

The Digital Committee Chair, on behalf of the Digital Committee, is responsible for reporting back to the Board of Directors on a monthly basis.

3. Analysis

The Digital Committee (DC) receives status reports from the relevant sub committees each month. The DC is assured from the reports that these sub committees function effectively.

The DC raises the following matters for information with the Board of Directors:

3.1 Digital Business Plan Update

- Planning is underway, taking into consideration the schemes and objectives highlighted in the enabling strategies, ICS and Peninsula programmes.
- Initial workshop held in November (with further to follow) with the aim of delivering a realistic business plan, and developing an agile review process to agree high priorities / 'must dos'.
- Consideration will be made around what activity will not be able to be delivered, including the impact of the recruitment freeze.
- A digital balance scorecard has been developed and is available on the Hub, which will start to illustrate the risks to the organisation.

3.2 Capital Plan 2024/25

- Allocation of CDEL funds for next FY are still to be determined.
- Indications are that digital services funding will be similar to 23/24 FY.
- Across Eastern and Northern Services, there is a request for £9M capital funding

- This funding is required to maintain existing service delivery, this does not include new developments.
- Inclusion of End User Devices in replacement costs will need to be reviewed following confirmation of capital allocation.
- Concerns were raised that there would be insufficient funds for developmental schemes identified as part of the enabling strategies, as decisions are currently being made to maintain service delivery and ensure the Trust remains safe.
- A divisional level risk assessment regarding capital funding allocation is being developed to understand the impact for Digital Services and the wider Trust.
- Digital Capital plan will be submitted via existing financial governance groups for approval. (i.e. Capital Programme Group and Operations Board)

3.3 ICS Shared Services Update

- ICB are re-engaging with Channel 3 to prepare the implementation business cases for the Target Operating Model and Shared Service Desk.
- Workshops are being planned across Devon.
- It was noted these BCs have not gone through any formal governance for approval, and as a result, the Royal Devon cannot commit to making any changes.
- A decision on Torbays EPR Procurement is expected shortly; the Royal Devon has requested an executive meeting with Torbay to ensure understandings are aligned regarding what a rollout of Epic actually means.

3.4 BCA Devices

- Paper submitted highlighting consistent non-compliance with BCA device checklist submissions (currently at 70% vs target of 95%).
- As this presents a clinical risk, it was recommended that these be fed through Patient Safety & Risk group, with divisional governance picking this up.
- Target could also be included as a priority within divisional PAF reporting, supported by a comms campaign to improve compliance.

4. Link to BAF/Key risks

4.1 BAF Risks

- Epic Benefits Realisation risk was discussed; likelihood score was thought to be too low (should be 4 or 5), as progress is already behind on realisation of financial benefits.

5. Proposals

It is proposed that the Board of Directors notes the report from the Digital Committee.

Agenda item:	11.5, Public Board Meeting			Date: 31 January 2024
Title:	Finance and Operational Committee Board Update			
Prepared by:	Colin Dart, Director of Operational Finance			
Presented by:	Steve Kirby, Non-Executive Director & Committee Chair			
Responsible Executive:	Angela Hibbard, Chief Finance Officer John Palmer, Chief Operating Officer			
Summary:	This is an update paper to give the Board of Directors assurance on the financial and operational business undertaken through the Finance Committee and to recommend any decisions for full board approval			
Actions required:	The Finance and Operational Committee makes the following recommendations to the Trust Board of Directors: • APPROVE the risks related to finance and operational recovery. No risk scores were changed. All other updates are for noting.			
Status (x):	Decision	Approval	Discussion	Information
		X		X
History:	The Finance and operational Committee was held on 18 January 2024 with a detailed meeting pack to support agenda items. The meeting was quorate.			
Link to strategy/ Assurance framework:	The issues discussed are key to the Trust achieving its strategic objectives			

Monitoring Information

Please *specify* CQC standard numbers and tick ✓other boxes as appropriate

Care Quality Commission Standards	Outcomes		
NHS Improvement		Finance	X
Service Development Strategy		Performance Management	X
Local Delivery Plan		Business Planning	X
Assurance Framework		Complaints	
Equality, diversity, human rights implications assessed			
Other *(please specify)*			

1. Purpose of paper

To provide, as requested by the Board of Directors, a report on matters arising from the Finance and Operational Committee (FOC) at the meeting held on 18 January 2024. A full copy of the approved FOC minutes is available upon request.

2. Background

The role of FOC is to provide additional assurance to the Trust Board of Directors through the public and confidential Board meetings on financial and operational matters. The committee is for assurance only and there is no decision-making authority in the terms of reference. However, the committee scrutinise any issues to enable clear recommendation to be made to the Board of Directors.

Items received for information are by exception to enable a greater level of assurance behind the financial, data quality and operational issues reported in the IPR.

3. Updates

3.1 Assurance Updates

2023/24 Operational performance by exception
The Chief Operating Officer (COO) advised the Committee on the following:

- Over 4,000 clock stops have been lost through industrial action. Without this impact the regional and system teams acknowledge the Trust would have been on plan for elective activity. There is increasing optimism with the level of recovery to reach the target position
- The Trust supported neighbouring hospitals during a system critical incident in early January – performance levels were maintained at RDUH.
- A positive UEC position was maintained during December and discussions will be taken forward to access quarter 4 capital should the 70% target be achieved for type 1 and 76% for types 1-3. The additional funding would enable the increase of the SDEC footprint and an urgent treatment centre in the North.
- UEC data is expected to show a worsening position in January however the commissioning of Exmouth MIU will help to improve the position.
- GP streaming is working effectively and will roll into 2024/25.
- Demand pressures remain high for NCTR but turnaround times remain quick.
- GIRFT are supporting a review of Cardiology with system support being sought to appoint two cardiologists for the opening of the Cardiology Day Case unit at the end of March, recognising this would have to be supported by revenue funding.
- A 10 week elective recovery challenge through to the end of March is being supported by the National Elective Recovery Lead deployed in Devon.
- Cancer performance remains challenging for fragile services including urology and dermatology. The outcome of the Regional Visit in November confirms support of the progress being made. The Committee noted forthcoming

issues with the urology service across Devon which will be discussed in more detail at the Board of Directors meeting.

No other escalations presented as brought through other agenda items.

The Committee noted the report.

Improvement Plan delivery
The Director of Improvement provided an update on the work of the operational improvement plan and the impact of delivery that had not been covered under operational escalations.

- Analysis is being undertaken to review overnight breaches in ED to support delivery - engagement and morale is good with no concerns being raised.
- An improvement plan is in place to improve discharges and ECIST have been asked to provide support as pre-noon discharges remain low. The improvement plan will also look at grip and control of NCTR in the North.
- All diagnostics modalities are reviewing actions required to improve performance and improvement trajectories. This programme of work will contribute to improving cancer pathways.
- The CMO and CNO are leading the Improvement Working Group which continues make progress and supports the priorities.

The Committee noted the report.

Implementation of New Vacancy Control Process
The Director of People provided assurance on the new vacancy control process and reported on the level of capacity required to manage the process and the time required from senior members of the panel in order to consider all requests submitted. The Chief Finance Officer (CFO) highlighted a briefing provided by the South West Director of Finance on the expectation that spend controls will remain in place throughout 2024/25 for organisations in deficit. The panel is responsive to feedback and will undertake continuous reviews to streamline the process. Overall, there is assurance that a robust process is in place.

The Committee discussed the wider challenge being made to headcount including strategic initiatives to deliver productivity together with a planning process to review vacancies that had existed for some time.

The Committee noted the report.

Finance Exception Report
The Director of Operational Finance presented the month 9 finance exception report including:

- The BoD approved a financial recovery plan which delivered a forecast deficit of £34.6m. NHSE introduced a revised process to approve adverse movements from financial plans through an ICS approach taking account of the position of all parties, to agree an overall system position. The outcome of the process is an ICS forecast outturn deficit control total of £89.3m and the RDUH control total deteriorating to £40.0m deficit, which is £12m adverse to the original plan.
- The Committee noted that the recovery plan was re-phased in month 8 to take account of data capture income benefits and to set realistic targets for the remainder of the year.
- In month 9 RDUH is £1.6m favourable position to the original planned deficit although £1.2m adverse to the financial recovery plan phasing. This was driven by a £0.5m impact from industrial action in December and a phasing shortfall in the level of additional income from demand and capacity counting. As part of the financial recovery plan, any impact from industrial action in quarter 4 will be reported separately to NHSE as a risk to the revised control total.
- FOC noted that a £37m deficit at month 9 meant there could be no more than an average of £1.1m deficit each month until year-end.

The Committee noted the report.

Delivering Best Value, System savings and Financial Recovery Plan
The Director of Strategic Finance and Productivity presented the report which reflects that the DBV programme is £1.2m behind plan year to date in total driven by timing of income and phasing in the financial recovery plan. This is made up of a positive variance on the original DBV plan of £2.8m, a shortfall of 1.2m against the system savings and a shortfall of £2.7m against the FRP. However, a total of £42.3m of recurrent and non-recurrent savings have been delivered across the three categories.

The full year position of the original DBV and system savings will be adverse to the original plan of £60m by £15m however this is mitigated by the financial recovery plan savings actions which total a forecast of £32m of additional recurrent and non-recurrent actions.

FOC discussed the progress on data capture and were advised that the impact of backdated coding has been included in estimates and confirmation of this is expected from NHSE imminently which would consolidate income and validate estimates included in the forecast. Further checks are being made on scripts to validate and provide assurance on internal data. Nationally there has been a large increase in ERF activity during December which is being investigated and whilst there is a risk to income guidance on how to apply the ERF rules has been followed.

FOC also discussed slippage on system savings was advised that there is an expectation that the full year effect of system savings will deliver as part of the

2024/25 plan and a systematic review has been requested to assess whether the original plans are still deliverable.

The Committee noted the report.

Capital Escalation Report
The Director of Operational Finance presented the report and outlined the current process for monitoring capital through the Northern and Eastern Capital Programme Groups with the intention to merge the Groups in the new financial year. Both Groups are accountable to the Operations Board and the capital position is reported to the Board of Directors through the Integrated Performance Report.

The Committee noted the complexities of managing the capital programme and reporting of the programme to provide transparency. Overall, there was confidence that the capital plan will be delivered.

The Committee noted the escalations within the report, specifically for the Endoscopy scheme, which has previously been reported in detail to the Committee.

FOC noted the control and process for the capital programme and requested presenting a periodic review back to the Committee.

Longer Term DBV Opportunities and Benchmarking Review
The Director of Strategic Finance and Productivity presented the report and referred to a session held with programme leads to evaluate progress and identify ideas which are now being quantified. The first draft of the 2024/25 plan is expected by the end of January which will then be assessed in conjunction with the system plan that would include a clinical productivity target informed by benchmarking.

The CFO advised that NHSE will be releasing bespoke 10 high impact changes to each organisation based on productivity with an expectation for the changes to be evidenced in plans.

The Committee welcomed the early view of plans and challenged the need to capture future years plans.

The Committee NOTED the report.

Data Quality Update
The Committee received and NOTED the report.

ERF Funding

The Committee is responsible for the process to request ERF funding moves from fixed-term to substantive. The CFO verbally highlighted that one request had been approved by the CFO and COO for a middle grade in plastic surgery who is already in post funded until the 31st March; there was clear evidence that the postholder is delivering activity with no increase to the run rate.

The Committee SUPPORTED the decision to approve the post.

3.2 Other Items for Trust Board of Directors approval

BAF review

The CFO presented the report and advised that there were no material changes to the financial risks other than reflecting when an improved forecast position is likely to be seen.

It was noted that the narrative for operational risks had been updated the COO agreed to include an extended forecast risk beyond the yearend in future reports.

The Committee APPROVED the risks related to finance and operational recovery. There was no change in scoring.

4. Resource/legal/financial/reputation implications

The Trust as well as the wider Devon ICS has set out a challenging operational and financial plan for delivery in 2023/24. The risks of this were set out at planning stage but with a commitment to the high level of ambition.

5. Link to BAF/Key risks

A detailed review was undertaken and no risk scores were amended.

6. Recommendations

The Finance and Operational Committee makes the following recommendations to the Trust Board of Directors:

- APPROVE the risks related to finance and operational recovery. No scores were amended in this cycle.
- All other updates are for noting

Agenda item:	11.6, Public Board Meeting		Date: Wednesday 31 January 2024	
Title:	Governance Committee (GC) Report			
Prepared by:	Jacky Gott, Assistant Director of Governance			
Presented by:	Martin Marshall, Chair of the GC			
Responsible Executive:	Sam Higginson, Chief Executive Officer			
Summary:	A report by exception from the Governance Committee			
Actions required:	For noting			
Status (x):	Decision	Approval	Discussion	Information
				x
History:	The last Governance Committee Report was presented to the Board of Directors on 1 November 2023.			
Link to strategy/ Assurance framework:	The Governance Committee reviews and monitors the Corporate Risk Register and identifies and escalates operational risks which it considers could have strategic significance and which the Board might consider placing on the Board Assurance Framework.			

Monitoring Information

Please *specify* CQC standard numbers and tick ✓other boxes as appropriate

Care Quality Commission Standards	Outcomes		
NHS Improvement		Finance	
Service Development Strategy		Performance Management	
Local Delivery Plan		Business Planning	
Assurance Framework	✓	Complaints	
Equality, diversity, human rights implications assessed			
Other *(please specify)*			

1.	EXECUTIVE SUMMARY
1.1	To provide, as requested by the Board of Directors (Board) a report by exception, from the Governance Committee following the meeting on 14 December 2023.
2.	BACKGROUND
2.1	The Governance Committee is responsible for ensuring that effective governance is embedded in the organisation and that risks associated with compliance and legislation and regulatory standards are identified and mitigated. It provides assurance to the Board that the Trust has effective systems of internal control in relation to risk management and governance.
2.2	The Governance Committee Chair, on behalf of the Governance Committee, is responsible for reporting back to the Board, in line with the Board's Schedule of Reports after each meeting of the GC, issues by exception.
2.3	A copy of the approved Governance Committee minutes is available for inspection pursuant to the Governance Committee's terms of reference.
3.	ANALYSIS
3.1	In line with the schedule of reports, the Governance Committee receives exception reports from the relevant sub committees each time they meet. As of the date of this report, the Governance Committee is assured from the reports that the sub-committees continue to function effectively.
3.2	The Governance Committee (GC) raises the following matters for information with the Board: a) Clinical 'View from the Bridge': Carolyn Mills, Chief Nursing Officer informed the GC of two key challenges facing the clinical services: • Industrial Action (IA) periods 20-23 December 2023 and 3-9 January 2024: the GC were reassured that appropriate actions were being taken to ensure services are kept safe during the upcoming IA, and acknowledged the increased concern due to the timing and length of the IA periods. • Vacancy controls in place to support delivery of the financial recovery plan: Carolyn advised the GC that there are clear, transparent criteria for the Vacancy Control Panel and that there is a clinical Executive Director representative to ensure that safe decisions are made. Following news reports relating to another Trust who were successful in increasing their Theatre productivity, the GC discussed how the Royal Devon plans to use theatres to their maximum capacity. The GC was assured by the ICB representative that the Royal Devon was actively involved in the Planned Care system workstream to maximise productivity, and the system Quality meetings which focus on a patient centred approach and communication with patients, reprioritising, clinical trials, etc. b) Governance Committee Effeciveness Review: Martin Marshall, Chair of Governance Committee and Non-Executive Director, provided an update on the recent Effectiveness Review undertaken by members of the GC, advising that the overall responses received, whilst limited in numbers, were largely positive with all questions rated as 'satisfied' or above. However, the results did show a drop in some

	scores compared to last years results, and the GC discussed in detail the possible reasons for this. Paul Roberts, Chief Executive Officer, advised that the GC that Shan Morgan, Chair of the Trust, has requested he provide his observations along with recommendations on how the Governance Committee structure could be further enhanced. Paul's observations will be used in the Governance Review which will be undertaken once the new CEO is in post. c) Policy monitoring reports The GC received and noted the following policy monitoring reports: • External Visits Policy – an audit confirmed that the External Visits logged by the Trust were managed according to the the process outlined in the policy. It was noted that a separate report on the position of the External visits, the outcomes and any associated risks or actions would be presented to the GC in February 2024. • Procedural Document Policy: an audit confirmed that Procedural Documents were managed according to the processes outlined in the policy. It was noted that a separate report outlining the position of Trust wide policies will be presented to the Safety and Risk Committee in January 2024. d) Whistleblowing reports: The GC received a summary into the following concerns which have been managed in line with the process set down in the Trusts Whistleblowing Policy. • Anonymous allegations relating to inappropriate appointment to role: update noted, declarations are included as a standard question at interview. • Anonymous concerns raised re Heavitree Haemodialysis Unit: updated noted. • Anonymous allegation re timber going missing from Gardener's Shed: updated noted, a revisit was to be undertaken in January. • MYCARE Northern Devon Whistleblowing Action Plan Update: update noted and assurance provided that action plan is complete. The GC were assured that the Trust's process has been followed and were satisfied with the outcomes and recommendations. e) Internal audit programme update The GC received an update from Phil Rogers, Assistant Director of Audit & Assurance Services on the position of the Internal Audit programme. The GC discussed the increase in limited assurance reports which will be debated at the next Audit Committee in more detail but acknowledged that this was likely due to the high risk or complex areas selected for auditing. The GC were advised of areas of key learning from the Closed Action Review (limited opinion), which has demonstrated the need for evidence to support robust closure of actions. The GC were assured that there was a recovery plan in place to support the achievement of the remainder of the Internal Audit Programme for this financial year. f) Patient Safety Incident Response (PSIR) Policy and Plan: Carolyn Mills provided the GC with the draft PSIR Policy and Plan which the GC approved. The GC noted the following key points: • The PSIR plan and policy replace the Serious Incident (SI) Framework, and sets out the Trust's approach to developing and maintaining effective systems and processes for responding to patient safety events for the purpose of learning and improving patient safety. There is a high level of confidence that the systems and processes are in place to support delivery • An outline of the revised Governance and Oversight framework for patient safety, and confirmation that the new Patient Safety Committee will report to the GC, who will also

receive performance data against the patient safety incident response plan, including the progress of investigations, and any learning identified.
- The trajectory in place to complete any outstanding SI investigations and reports by the end of March 2024, which will be reported to the GC via the Safety & Risk report.
- Once the new PSIRF structure is embedded, the Integrated Performance Report slides for the Board of Directors will be reviewed to incorporate any required changes. It is anticipated that this will be in April 2024.
- National training is being developed for Trust Boards, specifically in senior leadership teams and this will be shared once released.

The ICB confirmed to the GC that they had approved the documents and were impressed with the collaborative approach taken by the Royal Devon in producing the documents, and commended the quality of the policy and plan.

g) Learning from Deaths (LfD) Q1 & Q2 update

Dr Mark Daly, Trust Mortality Lead Consultant, presented the update for Q1 and Q2 and the GC noted the following:

- The continued investigations into the raised mortality rates among patients admitted as emergencies at weekends versus weekdays. With regard to the Hospital Standardised Mortality Ratios (HSMRs) for the period April 2022 to March 2023 relating to emergency weekend and weekday admissions - these are statistically within the expected range for the Trust as a whole and for Eastern services, however the HSMR for Northern services emergency weekend admissions remains statistically higher than expected. This had been rising since the July 2021 to June 2022 rolling 12-month period, but has stabilised over the last 3 data periods.
- The GC were advised of the significant analysis undertaken to understand the reasons and the following key findings:
  - Patients admitted at the weekend in the North have greater comorbidity; are more likely to be frail; are more likely to be coded as having specialist palliative care input; and are more likely to be in the 85+ age group.
  - While there was no evidence that medical staffing levels in the acute setting was a factor, it is recognised that there are differences in the way in which services are provided at weekends in the North.
  - The wider service provision levels in the community in the North may be contributing to the different profile of patients admitted at weekends.
  - A decrease in weekend admissions alongside an increase in the acuity of patients admitted has resulted in the denominator (admitted patients) being smaller while the risk of dying among patients in the numerator is higher.
  - A steady decrease in the use of 'R codes' in the coding of patients admitted at weekends, meaning that the patients' diagnoses have been more clearly identified by the time they are admitted.

The GC were assured that the mortality rates had been thoroughly investigated, and noted the further actions planned which include

  - Assessment of the implications of weekend service provision findings on the current risk action plans for Northern Medical Workforce.
  - Further thematic analysis of inpatient deaths of patients admitted at weekends in 2022-23 in the North in order to identify any underlying themes relating to care provision for this cohort of patients.
  - A series of Structured Judgement Reviews (SJR) reviews of a sample of patients from the Northern weekend emergency admissions group who were admitted following a long ED wait to ascertain any trends or themes of problems in care,

	• The outcomes of the continued thematic reviews of SJRs were noted and the GC were reassured of the processes in place to feed back learning to the Divisions and monitor outcomes of this. The GC noted the work to redefine the Divisional reporting mechanisms into the Mortality Review Group, with a greater emphasis on learning and improvement activity.
	
	h) Divisional Governance updates
	
	• Clinical and Specialist Support Services at Northern Services – the GC received an update from Tony Layton, Divisional Director, and Charlotte Overney, Assistant Director of Nursing, on the position of governance in the Division, highlighting the following:
	    o The Division does not have an Associate Medical Director (AMD) in post (this is replicated in Eastern Services) which has impacted on the ability to have multi-disciplinary discussions within divisional governance meetings. The GC were advised that access to Clinical Leads or the AMD for Surgery has been available if necessary.
	    o The Clinical Director of Cancer Services will be presenting a report to the Safety and Risk Committee on the position and actions being taken to mitigate harm for patients who breached the 62 day cancer target between June 2022 to April 2023.
	    o The risks held on the corporate and divisional risk registers associated with staffing challenges amongst medical and non-medical workforce.
	
	• Specialist Services at Eastern Services – the GC received an update from Natalie Wickins, Divisional Director, on the position of governance in the Division, highlighting the following:
	    o The increase of children and young people (CYP) being admitted to paediatric inpatient wards awaiting assessment, as a result of an surge in the prevalence of children in mental health crisis. This has accelerated during the pandemic, and there is a lack of system provision for timely assessment of a CYP in mental Health crisis within Child and Family Health Devon's Child and Adolescent Mental Health Services (CAMHS) services, and limited social care placement opportunities. The GC were advised of the actions being taken and support is being received from the newly established Children's Strategy Forum.
	    o As a result of new national guidance that came into effect in August 2023, and along with many other Radiopharmacy facilities across the country, the Trust's Radiopharmacy service was deemed no longer compliant with regulations during a recent external quality assurance inspection. Business continuity arrangements have been put inplace and the GC noted that the Trust are collaborating with the ICB regarding a Regional Radiopharmacy Solution.
	
	Carolyn Mills advised the GC that Maternity services across both sites had experienced some difficulties in collating evidence for the Clinical Negligence Scheme for Trusts (CNST) internal audit and the Care Quality Commission (CQC) maternity services inspection. As a result, consideration was being given to the appropriate governance arrangements and structure for the two large divisions. The GC noted that a single Performance Assurance Framework (PAF) meeting will be held from January 2024 to give more oversight on the governance and assurance at a divisional level, and that Tracey Reeves, Director of Nursing will be providing consultancy support to the midwifery leadership team over the next 6 weeks.
	
	The GC received assurance from Prof. Adrian Harris, Chief Medical Officer, that he is giving personal attention to the Trust's Associate Medical Director vacancies alongside Dr Karen Davies and Dr Anthony Hemsley, Trust Medical Directors, to try and secure

cross-site leadership.

The GC discussed how it shares learning and took an action to consider options for sharing examples of good practice/innovation it receives across divisions and sites.

i) Freedom to Speak Up (FTSU) Guardians report:

The GC received a report from Simon Domoney, Lead Freedom to Speak Up Guardian, and noted the following:

- In comparison to Trusts of a similar size, the Royal Devon are mid to low for the numbers of FTSU cases reported. The GC noted the work underway to promote the service which is expected to have a positive impact on reporting levels
- Within the last 3 quarters no concerns were raised anonymously, which is a very positive shift and indicates that staff feel safe to speak up openly
- The GC supported the recommendation to increase the number of Freedom to Speak Up Guardians across all sites and services over the next 2-3 years. The GC noted that the aim would be to have a Guardian, Champion or Ambassador available in each department/ward at all times.
- Bullying and harassment remains the top theme of reporting. The GC supported the recommendation to incorporate Civility training into mandatory training.

j) Clinical Effectiveness Committee (CEC)

Prof Adrian Harris presented the report, which outlined the following:

- Integration of Procedural documents – the CEC continue to ensure the appropriate governance approval within and across each site for standard operating procedures and clinical guidelines. Assurance was received that constructive challenge is continuing to be provided to further progress and enhance collaborative working whenever single site items are received – this is an ongoing cultural shift but one that continues to diminish as items come forward to CEC.

  In particular, Prof Adrian Harris commended the work underway by Dr Corrine Hayes to align the Low-molecular-weight heparin (LMWH) clinical treatment pathways and guidelines across Eastern and Northern services. This is being progressed through the Medicines Management Group structure and recommendations will report back to CEC when confirmed.

- Neurophysiology reporting – the CEC approved a proposal for healthcare scientists in Neurophysiology, Eastern Services, to undertake the clinical reporting of all electroencephalograms (EEGs) that have been determined to be normal. The overarching long-term goal is the training/development of all Neurophysiology healthcare scientists to undertake the clinical reporting of all EEGs in the department – both normal and abnormal with the aim of moving away from outsourcing the clinical reporting of EEGs from Medi-services and via agency consultants. Providing an in-house service will be a more cost-effective and will ensure more rapid and integrated care pathways for those requiring diagnosis and treatment, and will ensure the department are in line with national standards for reporting. The CEC noted the plans to to ensure competence and accuracy in reporting.

- National Clinical Audits – An update was received on the current position with regards to reporting of National Clinical Audits through to the CEC. Assurance was provided that there continues to be engagement and participation with National Audits with only a few areas of non-participation which is being addressed. Continued efforts are being made to reduce the backlog of National Audit Reporting

coming through to CEC, with CEC having clear oversight of the speciaities that hold a backlog of reporting. The Chief Medical Officer has written to all Clinical Leads, Divisional Management Teams and Governance Leads to re-affirm expectations for reporting, and the central audit team continue to attend governance meetings to update on the divisional progress in reporting outcomes and actions and those that remain outstanding. Updates will contunie to be provided to the CEC.

k) People, Workforce Planning and Wellbeing Committee (PWPW)

Hannah Foster, Chief People Officer presented the report and the GC noted the following:

- Recruitment and Resourcing – the PWPW commended the work being done by the accelerating filling our vacancies programme and the work of the Strategic Resourcing Group, who have worked hard to focus resource on areas that have historically been challenging to recruit to. Credit was given to how well this group has strengthened the governance behind the prioritisation of risk, preventing agency usage for some positions and also providing much more comprehensive oversight into the workforce risks across the Trust. Notably, vacancy levels are currently at the lowest levels in recent history, with registered nurses currently over-established as a whole.

- The annual National Education and Training Survey (NETS) – a survey which measures the experience of clinical learners, including the levels of pastoral and educational support was provided. The current survey ended in November 2023 and the results are awaited and will be reported via PWPW to GC. The GC were provided with a summary of the findings from last years survey, noting that the results were largely positive.

- The GC endorsed an Inclusive Job Statement to be added to all job adverts moving forward, prior to discussion and consideration by the Board of Directors. The Inclusive Job Statement is at Appendix A for the Board's review.

l) Safety & Risk Committee (S&RC)

Carolyn Mills, Chief Nursing Officer, presented the GC with an update from the S&RC, which included the following key items:

- National Safety Standards for Invasive Procedures (NatSSIPs) Task and Finish Group – the GC noted the progress of this group to facilitate the delivery of the action plan as detailed on the NatSIPPs risk assessement which sits on the Corporate Risk Register. The action plan is focussed on the effective implementation of NatSIPPs 2 as a key component in reducing the likelihood of Never Events (NEs) occurring.

- Never Event Summit – the GC were advised of an event held on Tuesday 31st October 2023. This was a multi professional meeting made up of clinical and corporate functions so that all might consider how their professions contribute to the development of solutions to prevent NEs from occurring. The GC requested that a summary of outcomes from the NE Summit was provided in the next S&RC report.

- The GC noted that the main business of the S&RC meeting related to the Patient Safety Incident Response Plan and Policy, which is detailed in Section (f) of this report.

m) Patient Experience Committee (PEC)

The GC received a report provided by Carole Burgoyne, Non Executive Director and Chair of PEC, and noted the following:

	• National Cancer Patient Experience (CPES) 2022 results – the GC were advised of the results and noted that the survey results were presented to the Board of Directors on the 29 November 2023. Although the Trust scored highly across the expected ranges; the Committee noted six high-level actions for improvement which the Patient Experience Operational Group (overseen by the Patient Experience Committee) will monitor delivery of, via the action plan, by April 2024. • CQC National NHS Adult Inpatient Survey 2022 – the GC were advised of the results and noted that the survey results were presented to the Board of Directors on the 01 November 2023. The Trust ranked joint second nationally for inpatient satisfaction alongside three other acute and general combined NHS Trusts. • The GC noted all PEC workplans (including Patient Experience, Complaints and Patient Feedback) were progressing well and where progress was delayed, their end dates had been amended but no concerns were raised in regards to achieving completion.
4	RESOURCE / LEGAL / FINANCIAL / REPUTATIONAL IMPLICATIONS
4.1	No resource/legal/financial or reputation implications were identified in this report.
5.	LINK TO BAF / KEY RISKS
5.1	The Governance Committee reviews the Corporate Risk Register twice a year and identifies and escalates risks as appropriate to the Board of Directors that the Joint Governance Committee considers may be strategic and therefore the Board of Directors might consider escalating to the Board Assurance Framework.
6.	PROPOSALS
6.1	It is proposed that the Board of Directors notes the report from the Governance Committee.

Inclusive Job Statement

November 2023

Reflecting our community

Inclusive job statement

The Inclusion Lead has been working with the Head of Strategic Resourcing on an inclusive job statement. The ambition is to include the below proposed statement on all jobs, with amends to be added for Executive and Senior leadership posts to reflect the need. This allows us to respond directly to the need in place, whilst also ensuring we reinforce our commitment to inclusion to all candidates.

We have consulted with our Staff Networks on this piece and are looking for feedback and approval before it goes to Board:

“As an inclusive employer, the Royal Devon values diversity and is committed to creating a culture of inclusivity where everyone can be themselves and reach their full potential. We believe in fostering a sense of belonging and actively encourage applications from individuals of all backgrounds, cultures, and abilities. We recognise the advantages of having a diverse workforce that reflects the communities we serve.”

Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	11.7, Public Board Meeting			Date: 31 January 2024
Title:	December 2023 and January 2024 Integration Programme Board update to the Royal Devon Board of Directors			
Prepared by:	Fran Lowery, Head of Corporate PMO			
Presented by:	Alastair Matthews, Non-Executive Director Programme Board Chair			
Responsible Executive:	Chris Tidman, Deputy Chief Executive Officer			
Summary:	This document provides a summary of the key areas discussed at the 12 December 2023, and 23 January 2024 Integration Programme Boards, and provides an update on the Integration Programme delivery.			
Actions required:	To note the update.			
Status (x):	Decision	Approval	Discussion	Information
			X	
History:	A monthly report is produced after each IPB to report to the Royal Devon Board of Directors. This report includes both 12 December 2023 and January 2024 IPB meetings, as there was no December 2023 Board of Directors meeting, and there were no issues requiring escalation to the Board from the December IPB meeting.			
Link to strategy/ Assurance framework:				

Monitoring Information

Please *specify* CQC standard numbers and tick ✓other boxes as appropriate

Care Quality Commission Standards	Outcomes		
NHS Improvement	X	Finance	
Service Development Strategy		Performance Management	
Local Delivery Plan		Business Planning	X
Assurance Framework	X	Complaints	
Equality, diversity, human rights implications assessed			
Other *(please specify)*			

INTEGRATION PROGRAMME
Programme Exception Report

1.0 Overview

The IPB met on 12 December 2023 and also 23 January 2024 to gain assurance on the progress of the Integration Programme for Year 2 of integration (1 April 2023 to 31 March 2024).

The Integration Programme highlights are:

- The Operational Services Integration Group launched the management of change (Phase 1) on 27 November 2023, with a 60-day review scheduled on 8 February 2024
- The Corporate Service Delivery Group completed all corporate service's deep dives in December 2023
- The Clinical Pathway Integration Group outlined the clinical integration methodology to the Board Development day in November 2023. CPIG also continues to oversee the 8 high priority services as well as urology
- A paper proposing the Management of Change prioritisation process was presented by the CPO for assurance
- The Year 2, Quarter 3 PTIP update paper was presented to IPB for assurance on progress against the post-integration actions

This exception report presents the main matters arising from the integration programme activities, and summarises key risks and issues across the following headings:

- Operational Services Integration Group update
- Corporate Services Delivery Group
- Clinical Pathway Integration Group
- Management of Change prioritisation process
- Year 2, Quarter 3 PTIP update paper
- Integration programme delivery year 2: governance and programme

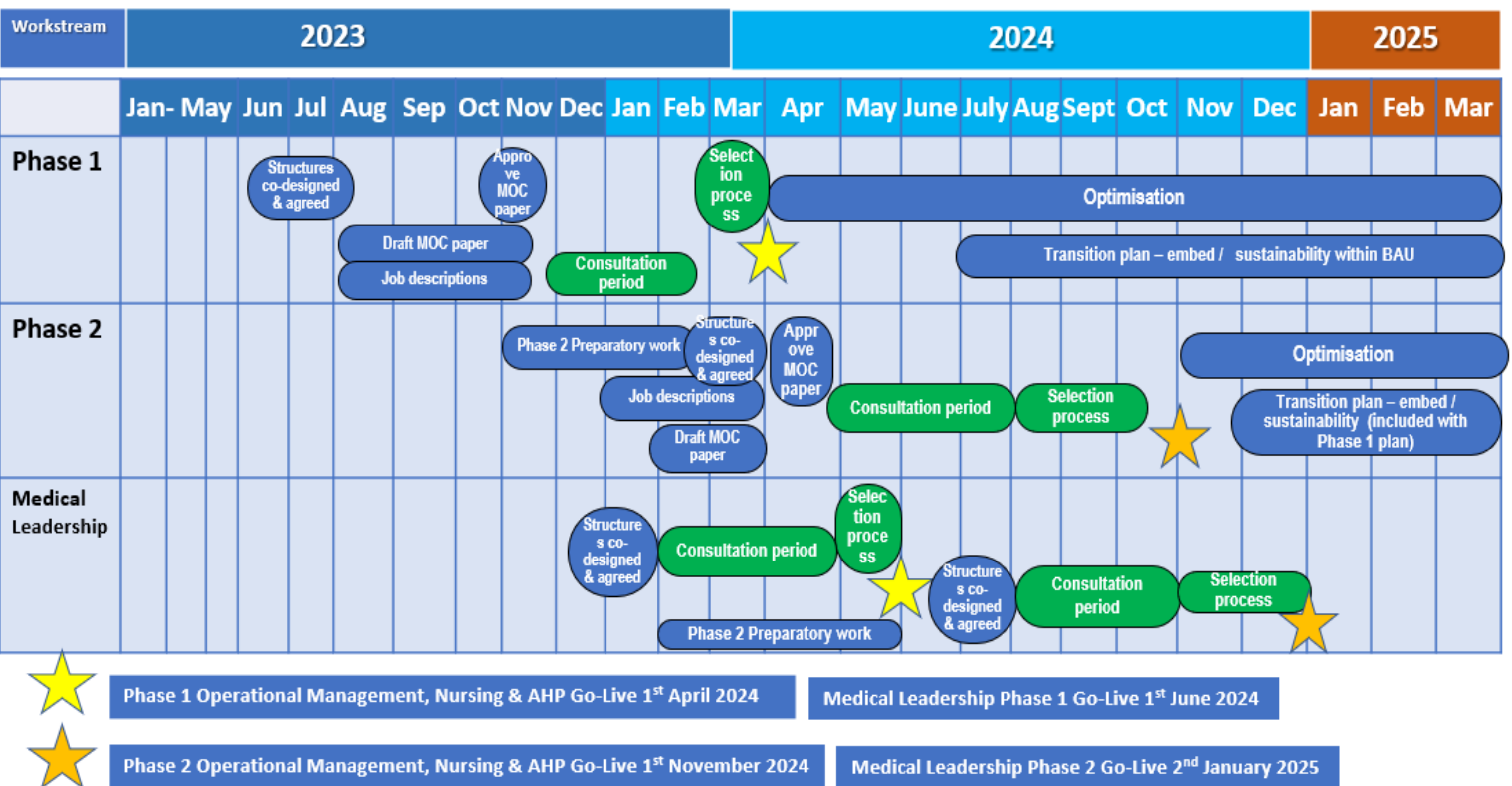
2.0 Operational Services Integration Group update

The COO gave updates on the progress of the Operational Services Integration Group (OSIG) which is progressing well. The formal Operational MoC phase 1 started on Monday 27 November 2023. The COO outlined the recent work carried out, including:

- 1:1s for Phase 1 staff will be completed on 24 January 2024
- Three engagement sessions held for Band 8B staff, with FAQs being added to during Management of Change

- Weekly meetings held with Trust Directors, and a 45-day review meeting held with Staffside on 18 January 2024
- Integration of clinical services (Moncaster Blueprint) discussed with Transformation Team & proposal supported by CMO & CNO
- Medical Leadership Structure proposed model (2 options) developed and being reviewed by Execs, Trust Directors, and AMDs/DMD, and then divisional teams.
- Phase 2 'AS IS' staffing information received and undergoing validation.
- Digital group reporting digital systems integration progress and readiness into OSIG.
- The Target Operating Model remains a working document, and the Communications & Engagement Plan continues to be updated.

The timeline remains on track and has been updated with the Medical leadership workstream – see below:



Next month the following key milestones are planned:

- 60-day review of MoC with Staffside on 8 February 2024
- Review of feedback themes with Trust Directors and Execs
- Confirm Phase 1 selection process & timings.
- Phase 2 'AS IS' staffing information validated, and costed, in order to identify 5% savings to be delivered, by end of January 2024.

An OSIG financial update will be provided to IPB ahead of sharing with March's Board of Directors to confirm the forecast cost impact of phase 1, as well as the likely financial implications of phase 2

3.0 Corporate Services Delivery Group

CSDG met on 18 December 2023, chaired by the DCEO, with CFO and CPO in attendance. The DCEO confirmed that the monthly corporate PAF is now embedded, bringing the corporate services together to focus on key issues including their financial YTD position, DBV delivery and people data.

The DCEO also confirmed that CSDG will provide oversight of the ICB shared service programmes of work to track business cases and requests. He confirmed that many of the more transformational service changes are likely to happen through system integrated working.

In the January CSDG meeting on 23rd, there was a focus on the Corporate Service DBV plans, with each lead outlining their plans to date.

It was also agreed that a review of the DBV savings to date relating to integration are compiled and shared with IPB in April.

4.0 Clinical Service Integration Group

The Chief Medical Officer provided a verbal update on the Clinical Service Integration Group (CPIG). The meeting scheduled for 12 December was cancelled due to Opel 4 pressures. The CMO confirmed that the Moncaster clinical services integration methodology was discussed at the Board development day in November 2023 with support from the attendees

It was also confirmed that the OSIG Programme Director is working with the Transformation Director to agree the baseline review process by the Transformation Team of all the general clinical services (i.e.: those not included in the High Priority Group) to enable integration to be prioritised according to risk and opportunity and progress monitored.

An end of year 2 update report will be provided to IPB in April to confirm the progress to date of integration for the 8 high priority services as well as urology. This report will also outline the process for clinical integration in 2024/25 for not just the High Priority services, but all the other clinical services, including anticipated timeframes and management oversight and monitoring.

5.0 Management of Change prioritisation process

The CPO presented a paper 'Management of Change prioritisation process' for assurance to IPB, which went to CSDG in December 2023. The paper was requested following concerns highlighted by the Director of People regarding the demand from

management of change (MoC) on the People Team.

The paper recommends the need for oversight and appropriate prioritisation of change processes taking place across the Trust and Devon system, and has been discussed at TDG and CSDG. As a result, the CPO confirmed a process has been agreed to manage and prioritise the demands of MoCs, including Devon system demands. There are currently no major issues being flagged in resourcing but this will need careful monitoring as new demands emerge. The process will be tested at February's CSDG.

6.0 Year 2, Quarter 3 PTIP update paper

This paper provided assurance to IPB on Post-transaction integration plan (PTIP) actions completed for year 2, quarter 3 2023/24. There has been monitoring, support and delivery of the Year 2 Corporate Services PTIP plans by the CPMO, working closely with the PTIP leads. These cover 3 portfolios: corporate services, CNO portfolio and the CMO portfolio.

This report provided a review on progress for the second year, third quarter, from 1 October 2023 to 31 December 2023 on the delivery. There are 58 Year 2 corporate services PTIP actions in place for 2023/24, with 45 completed actions as at 31 December 2023. No risks are being raised by the leads, and delivery progress is monitored through CSDG monthly.

7.0 Integration Programme delivery and management year 2: audit plan, governance and programme plan

7.1 Programme governance and risk management

The Head of Corporate PMO met with the Deputy Director of Governance on 13 December 2023 to review the year 2 RAID log. There were no new issues identified, and the next risk surgery is planned for 7 February 2024.

Progress against four strategic risks from NHSE Amber Transaction Risk rating letter (March 22) continue to be managed– the table is shown on the next page:

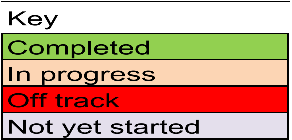
Risk	Proposed action	Status
Dedicated Finance Committee	Implement Finance Committee (date)	Complete
Royal Devon 3% saving v ICS 5-6%	Best Value Programme developed/ monitored to deliver efficiency savings. Royal Devon Financial Recovery programme in place, OSIG anticipates identifying efficiencies in phase 2	Amber
Delay in developing Clinical Strategy impacting on patient benefits	Clinical Strategy, led by CMO & CNO. It was approved by the Board of Directors on 26 July 2023	Complete
Clinical integration plans providing assurance to NHSE	Clinical Integration being overseen by CPIG to provide assurance to IPB.	On track

7.2 Integration year 2 audit plan

The Head of CPMO met with the Head of ASW to draft the Corporate services and general integration ToR to bring back to IPB for approval. Once received these will be signed off by IPB with the audit due to report back to IPB in April 2024.

7.3 Integration Programme delivery – for H2, Quarter 4 (Jan - March 2024)

The high-level programme plan for the delivery of the 4th quarter of year 2 is shown on below:



Key
Completed
In progress
Off track
Not yet started

		2024		
		H2, Q4		
Steering Group	**Key workstreams**	Jan	Feb	Mar
1. Programme Management IPB	**Programme deliverables**	Year 2 audits: Corporate and desktop review ToR	Year 2 audits: Corporate and desktop review in progress	Develop year 3 programme, close down year 2 - report
	Delivering Best Value	DBV stocktake review		
	Integration OD & Culture	OD approach to embed and sustain changes, lessons learnt Yr. 2		
2. Clinical Pathway Integration Group CPIG	**CPIG**			Meeting 13 March
	High risk clinical service integration	8 HP services and Urology plans - over seen by Divisions & CPIG		
	General clinical service integration	Finalise general clinical services integration plan- to launch 1 April 24		CMO and CNO launch - baseline assessment
	Clinical MoCs/EoIs	None planned		
3. Operational Services Integration Group OSIG	**Operational restructure - Phase 1**	Phase 1 MoC in progress	Phase 1 MoC completed	Phase 1 restructure implemented
	Operational restructure - Phase 2	OSIG Phase 2 planning, incl job descriptions/ benefits		Structure agreed
	Operational MoCs/EoIs	None planned		
4. Corporate Services Delivery Group CSDG	**Corporate PAF**			
	Trust Systems/ integration efficiencies		Single payroll - 1st Feb	e-rostering
	Policies			
	Corporate MoCs/EoI	Year 2 MoC plan-Q3 review		Year 2 MoC plan-Q4 review

Agenda item:	11.8, Public Board Meeting	Date: 31 January 2024
Title:	Our Future Hospital Programme – Trust Board Update	
Prepared by:	Zahara Hyde, Our Future Hospital Programme Director Chris Tidman, Deputy Chief Executive & Programme SRO	
Presented by:	Chris Tidman, Deputy Chief Executive & Programme SRO	
Responsible Executive:	Chris Tidman, Deputy Chief Executive & Programme SRO	
Summary:	On the basis of current information from the New Hospital Programme draft market prospectus , it is anticipated that there will be a delay to the main build phase of the Our Future Hospital programme from 2027 to 2031. Whilst representations continue around the potential for an alternative phasing should other NHP schemes slip, this paper sets out the strategic and operational risks of a potential 4 year delay and potential mitigations.	
Actions required:	The Board of Directors are asked to note the current position and the escalation of the risks being highlighted.	

Status (x):	Decision	Approval	Discussion	Information
				X

History:	OFH Programme Board reports regularly to Board SOC for OFH previously approved by Board
Link to strategy/ Assurance framework:	The issues discussed are key to the Trust achieving its strategic objectives

Monitoring Information

Please *specify* CQC standard numbers and tick ✓other boxes as appropriate

Care Quality Commission Standards	Outcomes		
NHS Improvement		Finance	X
Service Development Strategy	X	Performance Management	
Local Delivery Plan	X	Business Planning	X
Assurance Framework	xX	Complaints	
Equality, diversity, human rights implications assessed			
Other *(please specify)*			

1. Purpose

This paper sets out the current position of the Our Future Hospital (OFH) programme and highlights the risks of programme delay currently being escalated to the National Hospital Programme (NHP) team as well as NHSE South West.

2. Background

- The national health infrastructure programme was announced in 2019 with 40 new hospitals projects to be built by 2030.

- In May 2023, eight months ago, the Secretary of State announced the expansion of NHP to include an additional five hospitals that had extensive RAAC (reinforced autoclaved aerated concrete). The announcement indicated that the original programme of 40 hospitals was being extended to 2035 with some projects not beginning building until after 2030.

- The redevelopment of facilities at North Devon District Hospital was originally scheduled to be delivered by 2030. However, in May 2023 it was named as one of those delayed, although no criteria was given to support this decision, other than it was necessary to reprofile a number of the cohort 4 schemes in line with the overall financial settlement and market capacity . At the same time, the Trust was also advised of a significant increase in the funding envelope of up to £670m to ensure that the majority of wards could be re-built with 100% single room facilities. A complete rebuild was deemed unaffordable using the NHP costing model.

- Since this announcement, the Trust has continued to escalate the risks of delay to NHP representatives as follows;
  - the critical backlog maintenance risk, associated mostly with ageing theatre and ITU infrastructure.
  - The risk that physical capacity can no longer meet the predicted patient demand

  In both these instances, there is a significant risk that services to patients could be disrupted leading to patients either facing delay or travel, a loss of income to the Trust and a need for short term remedial capital investment that may become an abortive cost.

- On a more positive note, it has been confirmed by the New Hospital Programme that funding has been set aside in 24/25 and 25/26 for the Phase 1 enabling works beginning with the demolition and rebuilding of some of the oldest parts of estate – the staff residences. This was identified as a priority both to support the main hospital rebuild as well as to support staff recruitment in the context of limited affordable housing in the North Devon area.

3. Current Status

- An alternative phased plan has been developed to avoid critical equipment failure alongside mitigating future growth in demand for a hospital already operating at close

to capacity. Whilst predicting estates risk is always difficult, the air handling units on a number of the theatres and our intensive care unit (ICU) are end-of-life and therefore the risk of failure and unplanned downtime is much higher. Given the lack of suitable alternatives for the North Devon population, this is a significant strategic risk that cannot wait until 2031-33 for a solution. In the event of failure of the air handling units (AHUs) or the single MRI, the Trust would either have to spend significant sums on modular or mobile solutions (see Appendix 1) whilst renovating the existing theatre /ICU suite – estimated at approximately £32m. These costs would also become abortive once the new hospital is commissioned. In addition, there would be a significant loss of productivity and operational impact. The phased programme plan prioritises the theatres and ICU rebuild from Oct 2027-Oct 2029.

- Demand and capacity analysis also originally identified that NDDH will become short of theatre, ICU and inpatient bed capacity by 2028, but it is now clear that some patient services are already exceeding capacity. Appendix 1 also sets out the estimated capital costs of providing extra capacity to meet immediate demand growth that would be required in addition to the mitigation of critical failure risk - totalling an additional £16m; much of this is short term mitigation that would be overtaken by the new hospital building (with the exception of MRI diagnostics).
- The phasing the Trust has proposed to NHP (see below) would address capacity constraints through a first acute build phase providing a new Theatre and ICU block as well as providing a new Women's and Children's healthcare unit replacing the oldest building on site which is no longer functionally suitable. Bed capacity shortfalls would also be partially addressed by the provision of surgical in-patient beds as part of the theatre build releasing approximately 12 beds in the main tower block and also allowing the 18 bed Jubilee modular elective ward to be redeployed as general medical beds.
- To maintain flexibility, we have requested that the NHP allow the Trust to work up the Outline Business Case on the basis of a 'Ready to Go' option, that would allow an earlier start date should other schemes slip.

Proposed phases for 'Ready to Go Option':

Phase	Start date	End date (incl. approvals process)
Phase 0 – Enabling	7/9/23	31/7/26
Phase 1 Residences	22/11/23	17/12/25
Strategic Outline Case	4/3/24	17/12/24
Outline Business Case	18/12/24	16/6/26
Full Business Case	17/6/26	8/9/27
Phase 2 build		
Acute build 1 (TBC)	7/10/27	9/10/29
Acute build 2 (TBC)	10/10/29	30/9/31
Acute build 3 (TBC)	1/10/31	28/9/33

4. Service Sustainability Risk

- Whilst the focus of the risk mitigation is clearly around the estate condition, there is also significant concern about the impact a further delay could have on sustainability of key services at NDDH. One of the main drivers for the merger was to stabilise a number of high priority clinical services through the proactive recruitment of senior clinical staff. One of the key enablers to support recruitment was the construction of a new hospital for North Devon. Over the last few years this recruitment risk has been partially addressed across many specialities with successful recruitment campaigns (for example in general surgery, orthopaedics, intensive care and cardiology) and is supported by a clearly laid out trust wide clinical strategy. However, there is a risk that a delay in the replacement of key infrastructure (such as modern operating theatres and intensive care beds) could affect the retention of existing staff and the sustainability of clinical services. In turn this acts a major blocker to further recruitment of key workforce.

5. Summary & Recommendations

- Whilst good progress is being made with the business case for the phase 1 Staff Residences rebuild, the NHP have confirmed that the current planned timeline included within their draft market prospectus for the main hospital build is for a start in 2031 (compared to original plan of 2027).
- This delay introduces a number of significant operational and strategic risks to the Trust as well as the Devon ICS.
- In order to ensure that the risks of delay to the North Devon population are fully understood, the Trust have escalated the issue to senior regional colleagues in order to support further conversations with the NHP team, and with the objective of getting agreement to work up the Outline Business Case on the basis of a ‘Ready to Go’ option. . In the meantime, the capital expenditure risks associated with potential interim and remedial works have been validated and shared with NHSE and the Devon ICB.
- The Board is asked to note the report and to support the strategy for escalation of the potential risks.

Appendix 1

	Risk identified	Delay Mitigation	Mitigation Cost Impact	Deliverable (securing healthcare provision)	Delay Mitigation	Total Estimated Cost
Elective Care	Loss of theatre capacity; Replacement to maintain current theatre capacity whilst repairing	Convert CSSD into 2 theatres; create a new CSSD (new build/internal relocation) *	£15M	Population growth (2027 onwards) along with intensity gradient shift - increasing day case load	As left (CSSD into 2 theatres) plus modular build of 3 theatre unit replacing vanguard (theatre 9 due for return Jan 2028)	£25M
Patient flow	Require increase in ambulatory care options to support effective patient flow	Creation Same Day Emergency Care (SDEC) and Discharge Lounge	£2.5M Complete 2023	Increase ambulatory care pathways; reduce NEL IP demand	Master-planning of main tower Level1 - reconfig of existing space and relocation key depts out of main tower	£11M
Local Acute Care & Elective	Failure of ICU estate	Use theatre recovery area as short term with mutual aid; provide modular with recovery	£12M	Expand ITU bed base	Options to be explored for alternative ICU provision – linked to tsMRI build below so less than critcal failure	£5M
Acute & Urgent Care	Increased infection control requirments	Increase single rooms;	N/A			
Acute & Urgent Care (D1)				Increase IP bed base – population growth	Create additional clinical capacity in main tower; decant of non-clinical services	£3M

NB.

Capital costs are estimates based on industry experience and recent Trust projects

Agenda item:	11.9, Public Board Meeting	Date: 31 January 2024
Title:	Report from the 11 January 2024 Charity Committee meeting	
Prepared by:	Clare Degenhardt, Financial Accounts Manager	
Presented by:	Alastair Matthews, Non-Executive Director (Chair of the Charity Committee)	
Responsible Executive:	Angela Hibbard, Chief Financial Officer	
Summary:	The purpose of this document is to provide the Corporate Trustee with an overview of the matters discussed at the 11 January 2024 Fundraising focus meeting.	
Actions required:	The Corporate Trustee is asked to acknowledge the matters discussed at the Charity Committee meeting.	

Status (*):	Decision	Approval	Discussion	Information
			Yes	Yes
History:				
Link to strategy/ Assurance framework:				

Monitoring Information

Please *specify* CQC standard numbers and tick ✓other boxes as appropriate

Care Quality Commission Standards	Outcomes		
NHSI		Finance	✓
Service Development Strategy		Performance Management	
Local Delivery Plan		Business Planning	
Assurance Framework		Complaints	
Equality, diversity, human rights implications assessed			
Other *(please specify)*			

1. Purpose of paper

The purpose of this document is to provide the Corporate Trustee with an overview of the matters discussed at the recent Charity Committee meeting.

2. Background

2.1 The Charity Committee's purpose is:

- To oversee the operation of the Charity on behalf of the Trustee;
- To give assurance to the Trustee that charitable funds are managed and operated in accordance with the governing documents and comply with relevant legislation and guidance from the Charity Commission for England and Wales; and
- To make recommendations, as agreed at its meetings, to the Trustee, for its approval or otherwise.

2.2 The Charity Committee meets four times per year. The October and March meetings are full governance meetings, whilst the January and June meetings focus largely on fundraising.

2.3 Copies of the Minutes of the 11 January 2024 Charity Committee meeting together with the supporting papers are available from the Financial Accounts Department if required.

2.4 Section 3 below provides an overview of the matters discussed at the January 2024 Fundraising Focus Charity Committee meeting.

3. Analysis

3.1 <u>Fundraising strategy / Charity re-brand</u>

Andy Keeble, Senior Marketing and Communications Officer provided the Committee with an update on the Charity re-brand. Andy reported on the positive impact and engagement received following the relaunch of the Charity, both from staff and externally.

The objectives of the relaunch included informing staff and the general public about the Charity merger and rebrand, navigate messaging to reassure existing

supporters of the Charity across multiple geographical locations, grow the database and social media following and create a buzz about the new charity.

The launch activity included an internal launch, awareness roadshows (internal and external), information on Hub, the launch of a new website and media contact.

Positive results have been seen through the number of website contacts and the increased social media following.

Andy reported that no significant concerns had been raised by staff and the public in the North on losing the established Over and Above Charity identity and explained how messaging and social media had been managed during the Charity relaunch to provide reassurance that fundraising can still be undertaken for local areas.

3.2 Fundraising and Finance updates

Ian Roome provided the Committee with an update on Fundraising activity since the last meeting.

The two charity shops continue to perform well. The level of cash differences was discussed, and it was agreed that the shop manager should review the daily position to assess whether additional training for shop volunteers was helping to eliminate errors. A new till system is planned to be installed by the end of March 2024, which should also help to resolve the issues.

The Committee noted the success of the charity shops, and requested that the business case for a charity shop in Exeter should be progressed as soon as possible. Ian Roome referred to the different options being considered within the resources available and agreed to provide an update to the next meeting.

The Fern Centre funds were in a healthy position with a small surplus achieved for the period to 31 October 2023. Surpluses from the charity shops are available to support the Fern Centre when required.

The Committee noted that recruitment is also underway for a replacement Fern Centre Manager.

The Committee noted that general fundraising activities are progressing well with a good uptake in activities.

Clare Degenhardt provided an overview of the Charity's income and expenditure for the period to 31 October 2023. Donations and Legacy income were £1.3m, compared to a forecast of £1.6m for the full year. Grant expenditure was low, at only £300k compared to a full year forecast of £1.3m. The Committee discussed ways of encouraging increased grant expenditure – see item 3. Below.

The performance of the Charity was discussed and noted by the Charity Committee.

3.3 Report from the Charity Working Group

Katherine Allen provided a report from the Charity Working Group, focussing on the proposed process for agreeing how legacy income should be spent.

The Committee agreed that all unrestricted legacies will be paid into a new unrestricted legacy fund to ensure the safeguarding of large legacies.

The proposed process suggests three main categories of expenditure for legacies:

- Health inequalities and prevention
- Capital
- A great place to work (staff health and wellbeing)

The Committee reviewed the proposals, and suggested that the expenditure criteria should be linked to the Trust's strategic objectives. It was felt that this would support delivery of the strategic objectives, and also reduce the level of scrutiny required, as expenditure plans would be aligned with strategic objectives.

It was agreed that the process must explicitly state that charitable income is used for charitable purposes and not for items that should be funded through exchequer funding.

The Committee supported the proposal for legacy expenditure subject to further work to link expenditure to the strategic roadmap.

3.4 Fund expenditure plans

Katherine Allen presented an update on encouraging fund expenditure. Fund managers with funds over £50k had been contacted earlier in 2023, and asked to provide expenditure plans. There were still a number of larger funds with no expenditure plans, with actual expenditure for the year to date remaining low.

It was agreed that planned expenditure should be presented to the next meeting of the Committee, including targets, linked to the level of reserves and proposed level of reserves moving forward. Katherine Allen will circulate a proposal to the Committee for approval and will provide an update at the next meeting.

The Committee noted that the Charity had significant cash balances, much of which were being held on deposit and earning interest. The Committee will consider whether any cash should be moved to longer term investments, based on the level of spending plans presented to the next meeting.

3.6 Health and wellbeing update

The Health and Wellbeing (HWB) group had provided the Committee with a report on the bids for the £65k funding pot to support staff health and wellbeing. A review panel was set up to evaluate each bid against set criteria to make recommendations back to the HWB Group as to which bids to support. The total approximate funding requests totalled over £460k. Some bids were declined as they were not suitable for charitable funding, or could be funded by other charitable monies. If further funding became available, then additional bids could be considered. The team did note that the administration of the process had been very time consuming, and that future bidding rounds would require some dedicated administrative support.

The Committee noted that items which had not been able to be funded might link to the proposed legacy expenditure criteria and it was suggested that these items should be considered under the new process.

4. Resource/legal/financial/reputation implications

It is the Board of Directors' responsibility to ensure that the NHS Body fulfils its duties as the Corporate Trustee when it manages the charitable funds.

5. Link to BAF/Key risks

There are no additional risks identified.

6. Proposals

The Corporate Trustee is asked to acknowledge the matters discussed at the 11 January 2024 Charity Committee meeting.