Royal Devon University Healthcare NHS Foundation Trust

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

Wednesday 26 October 2022 via MS Teams

MINUTES

PRESENT	Mrs H Foster	Chief People Officer
	Professor A Harris	Chief Medical Officer
	Mrs A Hibbard	Chief Financial Officer
	Professor J Kay	Senior Independent Director (from item 143.22)
	Professor B Kent	Non-Executive Director
	Mr S Kirby	Non-Executive Director
	Mr A Matthews	Non-Executive Director
	Mrs C Mills	Chief Nursing Officer
	Dame S Morgan	Chair
	Mr T Neal	Non-Executive Director
	Mr J Palmer	Chief Operating Officer
	Mrs S Tracey	Chief Executive Officer
	Mr C Tidman	Deputy Chief Executive
APOLOGIES:	Mrs C Burgoyne	Non-Executive Director
IN ATTENDANCE:	Ms S Delbridge	Communications Officer (for item 141.22)
	Ms G Garnett-Frizelle	PA to Chairman (for minutes)
	Mrs M Holley	Director of Governance

		ACTION
134.22	**CHAIR'S OPENING REMARKS**	
	The Chair welcomed the Board, members of the public, Governors and observers to the meeting, and reminded everyone it was a meeting held in public, not a public meeting. She asked members of the public to only use the 'chat' function in MS Teams at the end to ask any questions which should be focussed on the agenda and reminded everyone that the meeting was being recorded via MS Teams. **The Chair's remarks were noted.**	
135.22	**APOLOGIES**	
	Apologies were noted for Mrs Burgoyne	
136.22	**DECLARATIONS OF INTEREST**	
	There were no new declarations of interests raised for noting.	
137.22	**MATTERS DISCUSSED IN THE CONFIDENTIAL MEETING**	
	The Chair noted that a meeting of the Finance and Operational Committee had taken place that morning. The Board had received updates at its confidential meeting from the Digital Committee, Governance Committee, Integration	

	Programme Board and Our Future Hospitals Programme Board, as well as updates on the Corporate Strategy Roadmap and the revised Board Assurance Framework.	
138.22	**MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 28 SEPTEMBER 2022**	
	The minutes of the meeting held on 28 September 2022 were considered and approved as an accurate record.	
139.22	**MATTERS ARISING AND BOARD ACTION SUMMARY CHECK**	
	Action check The actions were noted as per the tracker with the following additional update: *008.22(1) Update on diagnostics briefing and business case to be presented at March 2022 public Board meeting*. Mr Palmer adviosed that the Community Diagnostics Centre bid had been approved by the region to go forward to the final national panel which it was believed would meet on 3 November 2022. Mr Palmer extended his thanks to the Team who continued to focus on moving this forward. **The Board of Directors noted the updates.**	
140.22	**CHIEF EXECUTIVE OFFICER'S REPORT**	
	Mrs Tracey provided the following updates to the Board. <u>National Update</u> • The new Prime Minister had appointed Mr Steve Barclay as Secretary of State for Health, a position he had previously held for a short period during the Summer of 2022. • The Treasury had confirmed that the NHS would not receive additional funding to cover inflation costs, increasing the prospect of further real term pay cuts for staff in coming years as the NHS will have to to find funding for pay increases of above 3% from existing budgets. Julian Kelly, Chief Financial Officer, advised that increases in inflation would force the NHS to scale back services unless the Government provided extra funding, adding that the NHS in England would have to find an additional £20bn in efficiency savings over the next three years due to the increased cost of goods and services. • The new Chancellor, Jeremy Hunt, had indicated that all departments including Health and Social Care, would face a round of difficult spending cuts, despite assurances that reverses in the Health and Social Care levy would not result in reductions to the NHS budget. This was despite a recent report from the NHS Confederation which demonstrated direct correlation between investment in the NHS and growth in the UK's economy, with analysis showing that for every £1 invested in the NHS, £4 made its way back into the economy through increased productivity and boosted participation. • Latest NHS workforce figures showed that a record number of staff voluntarily resigned during the first quarter of 2022-23; almost 35,000 staff voluntarily resigned, up from 28,000 during the same period in 2020-21 and just over 19,000 in 2019-20. The most common reason stated was work life balance. • There were almost 7 million patients on the waiting list nationally in August, up from 6.8 million in July. In addition, breaches of a year plus increased to approximately 388,000 in month. The month on month reduction in 18-month	

	waiters had slowed, with the position standing at 50,888 at the end of August. The number of patients waiting more than 12 hours in A&E for a decision to admit jumped to new record of 32,776 in September. • NHS Blood and Transplant had raised its alert level to Amber following several months of low stock levels warning that this might result in cancellation of non-urgent operations by some hospitals. Stocks of O type blood had dropped nationally to less than 2 days' worth. Members of the public had been encouraged to come forward in high numbers to donate blood. • The National Audit Office (NAO) had highlighted in a report on integrated care systems (ICS) the apparent tension between meeting national targets and addressing local needs. Challenging financial savings targets, longstanding workforce issues and wider pressures on the system particularly in social care contributed to the higher risk that ICS's would find it challenging to fulfil the hopes that stakeholders had for them. The NAO has called on the Department of Health and NHSE to clarify a realistic set of medium-term objectives to ensure that ICS's can make progress on prevention and local priorities. • All Trusts had received a letter from the National Team with support for the expansion of operational resilience measures for Winter. Over 8 million people had their autumn booster in just over a month, but given the challenges already noted and the possibility of a high prevalence of flu this year, it would be important to make sure that best practice from across the country was included in plans. The letter also outlined better supporting people in the community, including putting in place a community-based falls response service in all systems, maximising the use of virtual wards and active consideration of the establishment of an acute respiratory infection hub for same day assessment, and providing additional support for care homes through reducing unwarranted variation in ambulance conveyance rates. Trusts were encouraged to deliver ambitions to maximise bed capacity and support the ambulance service by ensuring timely discharges. There had also been a recent announcement of £500m to support social care to speed up the discharge process across mental and physical health pathways, with details of how this will be allocated awaited. • The new Winter Improvement Collaborative should be in place by the end of October 2022 focussing on the root cause of delays for ambulance handovers. There is also support for elective recovery and a request for Boards to review relevant performance data and delivery plans to establish whether assurance mechanisms were effective and in line with the elective recovery plan • Urgent cancer referrals were at 118% of pre-pandemic levels, whilst cancer treatment and diagnostic levels across the country were nearer to 100% of pre-pandemic levels. The focus was on trying to resolve the mismatch between demand and capacity. • Trusts have been asked to self-assess against the UK HSA Guidance on the Management of Covid-19 patients and the Infection Prevention Control (IPC) Manual, using the IPC Framework. • The report from Bill Kirkup in relation to baby deaths in East Kent had been received the previous week and was being worked through. <u>System Issues</u> • A meeting had taken place as part of the Exeter Civic University agreement agreed by the Board last year. The purpose of the agreement was to use the influence of the University of Exeter, working in partnership with other anchor organisations across Exeter, to ensure a thriving and sustainable economy, happy and healthy people and a vibrant culture. The meeting reviewed the first	

year of progress with particular interest on the work being undertaken to enhance the health and wellbeing of citizens and reduce health inequalities.

- Work was underway across the ICS on the Devon Operating Model with a number of meetings arranged for leaders to socialise and sense check the proposed way forward to achieve a system-based approach. ICS governance was continuing to develop, with key appointments of a Chief Financial Officer and a Chief Delivery Officer now made.
- The Board had a paper from the Acute Provider Collaborative on the agenda for consideration. The Collaborative was a key part of the work underway to ensure that the system had sustainable care models based on pathways, medical, surgical and paediatric assessment in the first instance. The Trust will ensure that this aligned with the work it is undertaking on developing its clinical strategy.
- One Northern Devon and the Eastern Local Care Partnership had provided information on plans in place for statutory and voluntary bodies to help mitigate the impact of the cost of living crisis following concerns about the impact on people's physical and mental health and wellbeing. Information provided locally will be fed into a system level summit planned for early November to take stock of plans and work with partners to address any significant gaps.
- Over the last month because of pressures across the whole system the decision had been taken to make some planned, temporary changes to ambulance catchment boundaries to provide support to University Hospitals Plymouth and Torbay and South Devon. The arrangements will be in place from 10 October until 7 November 2022 and will see patients from two additional postcodes brought to the Wonford site with the hope that this will avoid unscheduled diverts to Exeter from other Trusts. It is estimated this will be 4-5 patients per day.

<u>Local issues</u>

- The Trust had recently undertaken a Reset Week as a focus for resetting the position going into the Winter period. 67 beds were freed up across both sites, Emergency Department hours reduced by 556 and lunchtime discharges improved by 75%. As a result, there were also 33 fewer complex long stay patients at the end of the week and it had allowed ring-fences to be maintained around elective work and a conversation about securing the entirety of the cardiology ring fence in Eastern services. There had also been improvements in the Green to Go position through the Executive sponsored "help people home without delay" programme and the anticipated recruitment improvements would be integral to overall delivery of the plan.
- There had been increasing rates of Covid-19 and the Trust's Joint Clinical Effectiveness Committee had agreed that from Friday 21 October all clinical areas had to revert to wearing fluid resistant surgical masks. Patients who had had previous vaccinations but not the latest booster were not as protected against the two new variants of Covid-19 and as uptake of booster vaccinations has been low across the UK, there had been a sharp rise in admissions.
- The Trust had held its first Team Royal Devon week from 17–23 October 2022 which linked to the Trust's strategy objective of making the organisation a great place to work. The week featured events, staff discounts and giveaways and inclusion offers, with a focus on how all staff work together across the organisation to do their best for patients, communities and each other.
- October had also been Freedom to Speak Month, with the theme for 2022 freedom to speak up for everyone with the Trust focussing on speak up for safety, civility, inclusion and everyone.
- The Trust had received the results of the National Cancer Experience Survey which had been outstanding, with outcomes demonstrating that patients were

well-supported from diagnosis to treatment. The survey had been completed by 1300 patients on both Northern and Eastern sites who had received a diagnosis and treatment between April – June 2021.

- Mrs Tracey had attended the first National Genomics summit earlier in October, at which a world first national genetic testing service developed by the Trust in collaboration with the genomics researchers at the University of Exeter and clinicians and academics worldwide was launched. The service provides rapid processing of DNA samples of babies and children with rare diseases and would benefit about 1000 babies and young children with results and diagnosis now possible within a much shorter timeframe than previously.
- The National Institute for Healthcare Research had awarded £800m to 20 new biomedical research centres across the country, one of which is in Exeter. The The award will allow the Centres to translate scientific discoveries into new treatments, diagnostic tests and medical technologies to improve patients' lives. The bid had been led in partnership by the Trust and the University of Exeter, together with health partners across the peninsula and the Centre would be the first in the South West. £15m had been awarded to translate scientific discoveries into tangible benefits for patients, with a focus on neurodegeneration, rehabilitation, diabetes, genetics and clinical mycology.

Ms Morgan asked whether there were any lessons from the Reset Week that could be adopted for the longer term. Mr Palmer said that the week formed part of the kick start of the Winter plan pre-Christmas. A number of workforce initiatives had been put in place to drive 7-day working, including ward clerking at weekends, and leadership posts in nursing and medical teams which had led to similar discharge levels being achieved on Saturday and Sunday as during the week. This had also helped with refining of some of the resource allocation in the Winter plan.

Professor Kent asked whether there had been any positive or negative impact on services at the RD&E noted following the temporary ambulance boundary changes. Mrs Tracey responded that any change would have an impact and whilst this might only involve 4 patients per day, average length of stay could be up to 9 days with the cumulative effect of this impacting 20-25 beds. She added that it was a concern that the good work undertaken during the Reset Week to create capacity and protect ring-fencing may be impacted by this, although it was being managed at present. Professor Harris commented that whilst this was the right thing to do for the system, it had involved a number of compromises for the Royal Devon. It was also a less than ideal solution for individual patients involved, as it can be harder to repatriate them as there is less understanding of their local health and social care environment and this can lead to increased length of stay. Mr Palmer added that the Trust had done the right thing to provide support to the system and help ensure that patients were cared for appropriately and the solution, whilst not ideal was better than the Trust receiving emergency ambulance diverts, as it had allowed a more planned approach to be taken.

Professor Kent said that the impact of this on patients and their families was important and asked whether there were plans to get feedback from these patients. Mr Palmer responded that this would be done and reflected in a future iteration of the IPR. Mrs Tracey suggested that the Patient Experience Committee could commission a piece of work to look at this in more detail. **Action.**

Mr Kirby commented that whilst the Trust would want to play its part in supporting the wider community in terms of mutual aid, he had a concern that there was a

	possibility that it would be a net loser and suggested that it was important for the Trust to keep a record of the support it provides. Mrs Tracey agreed that it was important to strike the right balance. Mrs Hibbard confirmed that data was being collected so that conversations could be had within the system. Mr Palmer added that the agreement to take this on had been carefully crafted with discussions taking place about access to University of Plymouth's independent sector elective capacity to make sure that the Trust's position does not deteriorate to an unacceptable level during this period. In addition, there had been sign off at regional level that there would be a suitable financial adjustment to reflect the data. **The Board of Directors noted the Chief Executive's update.**	
141.22	**PATIENT STORY**	
	Ms Delbridge joined the meeting. Mrs Mills presented the Patient Story video to the Board which was related to the virtual ward and was an important part of services offered to patients and in managing bed pressures. The story presented offered perspectives from two patients describing the benefits of technology for those who would otherwise have had to be either an inpatient to receive the level of monitoring required for diagnosis or had regular outpatient attendances. Mrs Mills added that the virtual ward had had a positive impact on each of the patient's experience, including on their ability to manage their day to day life and reduction in trips to the hospital. Ms Morgan said that she had been struck by one patient saying they felt respected and "in the loop" and the other commenting that it had made a difference in terms of her childcare responsibilities, the process had been very easy and had given her peace of mind. Professor Kent said that the story had provided a good illustration of the impressive use of technology to transform care, enabling it to be provided to patients where it was most suitable for them. Mr Matthews commented that, in addition to the improved patient experience, one of the patients had said that they had finally been able to receive a diagnosis and treatment which had not been possible in the past. Mr Neal asked whether there was work being undertaken to build a vision of how the Trust wanted to build on this provision going forward. Professor Harris responded that this was an evolving process, with the Trust having an ambition to maximise Epic and the use of wearables. Currently, clinicians were trying to find the clinical conditions to fit the technology but this would change over time as they become more familiar with the technology and the development of the Trust's digital strategy would also provide pointers on new directions to explore. Mrs Foster said that it would be important in the future to also correlate staff experience of using the new technologies which could then be used to feedback to the wider staff body to demonstrate the positives from a workforce perspective. Mr Palmer said that a focus for the Trust was helping people home and a challenge over the coming years for the Trust to develop in concert with social care would be how more could be done to help stabilise people at home. One of the areas being trialled over the Winter was further development of the virtual ward and he believed that connecting virtual wards into community and primary care would be the next stage. Working with social care to stabilise patients at home and proactively manage their conditions would have further benefits for the organisation.	

	The Board of Directors noted the Patient Story. *Ms Delbridge left the meeting.*	
142.22	**WINTER PLAN 2022-23**	

	Mr Palmer presented the Winter Plan for 2022-23 to the Board of Directors, noting his thanks to Gill Heathcote and Nicol Cleverdon for their work on the integrated plan presented.
	
	Key highlights from the presentation were noted as:
	• Whilst there were still some gaps over the next six months that would have to be taken on by additional efficiencies or *in extremis* cancellations of activity or movements to additional beds in the community, the plan presented was manageable.
	• A great deal of partnership work had gone into the plan. Where there were headings that showed bed equivalents of 64 across the system, this had been achieved with intensive work with social care partners.
	• There had been a number of phases of work over the last few months:
	  ○ Executive commitment to the recruitment pipeline and Green to Go.
	  ○ The reset programme of work which had had a positive impact on both sites, creating a sense of acceleration.
	  ○ Phase 1 of the plan – drive through the learning from the reset programme and make sure that elective ring fences hold with Standard Operating Procedures in place.
	• It is expected that further bed base interventions would be needed between January and March 2023.
	• Findings from the Reset Week included the importance of investment in transport over the whole week, staff for seven days with leadership in place, ensuring that ancillary services were held at the right level, and holding the focus on ring fencing. The reset programme scoped out and delivered an intended improvement.
	• Winter Plan Phase 1 would run through to the end of December 2022, embedding all the improvements in processes.
	• Phase 2 would run from January to March 2023 bringing in the additional beds that had been identified and funded across Eastern and Northern Services. Maintenance of ring fencing would remain an area of significant focus.
	• The plan could only be delivered with significant partnership, engagement and involvement and once signed off by the Board, further Comms work was planned with partners in the system and within the organisation.
	
	Ms Morgan thanked Mr Palmer for the presentation, noting that it was a complex and ambitious plan and the Reset Week had provided a good start for the implementation of the subsequent phases. She asked what was his greatest concern about the success of the plan. Mr Palmer responded that this would be ensuring delivery on holding ring fences and delivering balanced healthcare over the course of the winter months, in particular as it is recognised that this had been a significant challenge for the Trust for the last five years.
	
	Professor Kent asked how much collaboration there had been with patient and community groups on developing the plan to ensure there was “buy in” from the start. Mr Palmer said that engagement on the Winter Plan takes place across the year, and there had been a debrief with partners on last year’s plan to inform the learning for this year’s planning. Local Care Partnerships, which include voluntary	

sector partners, had reviewed the plan and provided feedback. He agreed that delivery of the plan was reliant on local groups and organisations being part of the solutions, in particular where they provide the "wrap around" for patients that cannot always be provided by statutory bodies.

Mr Kirby asked the following questions:

1. When would recruitment start? Mr Palmer advised that recruitment had started some months ago, with the challenge of ensuring that recruits stay. The Recruitment Team were generating data for the Executive Team on pinch points and how appointments can be accelerated where possible.
2. If it becomes necessary to go out to the private sector for outsourcing, how are those relationships managed, i.e. is this done at a strategic level or at an *ad hoc* spot purchase level? Mr Palmer said the organisation had some advantages from its current position on Tier 1 for elective recovery, with wide access to independent sector discussions. If emergency activity was needed, the ICB would usually negotiate that for the Trust, although the Royal Devon also has EPRR powers.
3. Are there any novel ways that could be used to encourage all staff to take up their booster vaccinations? Mrs Mills confirmed that there was a very targeted approach on the Eastern site to approach staff directly to invite them to attend for boosters. She added that there had been greater uptake for Covid-19 booster than for the seasonal flu vaccination amongst staff and advised that she and other Executives were recording some short videos to remind staff of the importance of uptake of both boosters and flu vaccinations this year. Mrs Mills agreed to circulate data regarding uptake of both booster and flu vaccination outside the meeting. **Action.**
4. Is the organisation fully sighted on the potential impact of works in ED at the RD&E site and how ED flow would be managed? Mr Palmer said that it was anticipated there would be a period of 5-6 weeks that would be most disrupted during the work, with the ED corridor being out of use from 7 November. This had all been planned for, including the ceasing on 7 November of the additional ambulance catchment area work previously noted by the Board.

Mr Matthews noted that the plan states there would be bed deficits of 57 and 76 in January and February but that ring fences would be maintained and asked whether there were realistic opportunities for mitigation of the position. Mr Palmer responded that this was a fair challenge, with February in particular predicted to be a very challenging month. There were two opportunities to try and close the worst gaps: the first would be to enact bed escalation *in extremis* which there was funding for, in the first instance on the acute site but possibly also moving into the community if staffing can be arranged. Secondly, the reset programme had demonstrated that with concerted effort it was possible to get back within bed base, and it might therefore be necessary to hold further reset weeks over the coming months.

Ms Morgan said that there had been a long-standing concern expressed at Board meetings of the impact on flow of delayed discharge and asked if there were any early lessons from the Reset Week on improving discharges. Mr Palmer responded that there had been more social care staff on site during the Reset Week working with ward staff on discharges which had had a positive impact. Further plans are being looked at to use some of the additional resources allocated to Social Care and Integrated Care for similar work. In addition, some of the actions tested in the Executive sponsored "help people home without delay" initiative had

	worked well and had been accelerated, for example referring patients from the ambulance stack straight to the urgent response service. The enhanced care support to aid the care home transfers programme was due to start two weeks ahead of time and there were four of the beds intended for the live in carer model already on stream. Mr Neal asked whether anything was being planned to enhance staff wellbeing, particularly during January and February. Mr Palmer said that significant work had been undertaken during the summer period to ensure that key leads had taken leave. In addition, during the Reset Week there had been daily Comms messages to staff to ensure they understood what the organisation was trying to do and felt supported and this had been followed directly by the Team Royal Devon week. He confirmed however that there was more work to do. Mrs Foster added that the intention was to take the learning from Team Royal Devon week on what had gone well to see what could be built into business as usual going forward and to support managers to create a good environment with positive team engagement. This would be fed into the Winter Plan. Charitable Funds would also be made available to the Operations Team for activities and support during the Winter period. Mr Kirby asked if there was any information available on the rate of readmissions following the Reset Week. Mr Palmer advised this was not yet available but would be checked. Ms Morgan asked how the Trust's plan compared to others in the system. Mr Palmer said that key features would be very similar, but the Trust's plan would be distinguished by the level of detailed work to create the bed model. In addition, the way that the Trust had planned in elective elements, potential percentage resulting from two or three further Covid waves and flu over the coming months would set the organisation apart in terms of the level of detail. Whilst the modelling distinguishes the Trust from others, the plan would not be dramatically different. Ms Morgan commented that it might be worth reviewing the value of the input made into modelling by the Trust compared to other local Trusts. **The Board of Directors approved the Winter Plan for 2022-23.**.	
143.22	**INTEGRATED PERFORMANCE REPORT**	
	Mrs Hibbard presented the Integrated Performance Report (IPR) for activity and performance for September 2022 with the following key points highlighted: • Urgent and ED care pressures continued to increase during September, with the continued high level of green to go patients and rising Covid numbers impacting both staff and beds. The Trust continued to provide support to the system during this period with ambulance diverts. • Elective recovery remained an area of focus, but was still behind trajectory. Pressures on the urgent care pathway had a significant impact on elective capacity, as well as continuing staffing pressures. • Improvement had continued in both the 78-week and 104-week waits, with more to do and ring-fenced capacity a priority in the Winter Plan. The Trust is receiving support from NHSEI in the 10-week challenge, helping to maintain focus on the position of long-waiting patients. • Additional capacity put in place at both the Nightingale Hospital and the Jubilee Ward was helping to improve the position. The Board of Directors noted that	

	the South West Elective Orthopaedic Team had won a prestigious award for partnership and innovation. • Cancer performance was challenged across all targets, with some improvements expected with the provision of additional support in the East and a plan to stabilise the position in the North. • Diagnostics performance was benefiting from the additional capacity that had been put in place in the East, although there was a less positive picture in the North; work continued to address this as part of the Winter and Elective Recovery Plan. • Complaints had increased during September and work was underway to understand any themes and learning. • There had also been an increase in pressure ulcer damage which the Tissue Viability Team were reviewing to ensure actions were put in place. • Although there were no new Never Events reported during September, this remained a key area of learning. • Workforce measures continued to indicate the pressures on staffing, with high sickness absence levels and reliance on agency staffing. Although turnover appeared to be plateauing, it remained higher than would be wished. • Recruitment and retention remained a focus. As previously reported, the first Team Royal Devon event took place in October, with learning to be taken into future events. • The cultural dashboard had not been included as there were a number of ICS metrics within the data that required ratification. • The finance position remained challenging, with a continued level of scrutiny of the Trust's financial plan. The Trust was managing a number of issues where guidance or the economic outlook were having an impact, resulting in a remaining risk of delivering the financial position. The position remained dynamic, with focus on areas the Trust does have control over to evidence it had delivered what the Trust said it would and continuing discussions with the Regulators on areas where the Trust has less control. • Approval of the cardiology day case unit on the Eastern site was a significant step forward, although there had been a challenge on the Trust's delivery times. In addition, seed funding for endoscopy in Tiverton had been approved. Mr Matthews asked if it would be possible to get an idea of what trajectory for cancer performance it was hoped would be achieved by the actions that were being put in place. Mr Palmer said that the position had not changed over the last few months. Dermatology had revealed a difficult position post-Epic implementation and this, combined with a demand and capacity mismatch, had thrown the entire cancer position out of kilter. A reduction in the overall PCR for cancer for Northern services was emerging which had started to have an impact on overall reduction for the organisation. The Trust was being tracked at the highest level on the proportion of the waiting list that is 62 days and over which was close to 15% at its peak in August. Rapid work to validate the PTL and a demand and capacity plan for Dermatology, Gynaecology and Colo-Rectal for Northern had helped to stabilise the position, which was currently about 13%. Work was continuing on the delivery plan for Northern and Eastern with good support now in place with the new Joint Lead for Cancer. The trajectory for the 62-day waits would be included in the next IPR to provide assurance. Mr Matthews said that the Board had discussed at Finance Committee its concerns about delivery of the cost improvements in the better value programme and asked whether there was confidence that changes made for the future would provide a	

	better handle on delivery. Mrs Hibbard responded that delivery of the best value programme was contributing to the risk of delivering the £18m deficit. Non-delivery could be mitigated through non-recurrent means which if not recovered over time would create further pressures. Although it was difficult to add further pressures onto operational teams currently to look at this, the Finance Team are looking forward to how to improve governance on delivering better value, support that can be given to teams and education and training that can be put in place. Mr Matthews noted that both in the paper presented and in Mrs Hibbard's introduction, the Board was advised that 78-week waits were improving, but the data provided did not support this, but rather indicated it was getting worse. Mr Palmer said that the Team are continuing to work through the validation of the PTL for Northern services for 78-week waits and Eastern services have seen a significantly improving position. There may however be a lag in the data from the September report. Mr Kirby asked the following two questions: 1. Is there a threshold at which Covid patients are admitted or was there an admission avoidance option that ought to be explored? Professor Harris responded that Covid was treated as any other disease with patients with a primary diagnosis of Covid who are deemed ill enough admitted and decisions physiologically driven. Although mortality and morbidity from Covid had improved, significant numbers of patients who were admitted with another condition also had Covid, although it was difficult to disaggregate how much of a contribution this was making to their morbidity. He confirmed that no patients were being admitted inappropriately. 2. Weekend SHMI mortality rates in both Northern and Eastern sites had taken a sharp upward turn – was there further comment on reasons for this? Professor Harris said that the baseline had dropped off nationally although the reason was not yet fully understood. The upturn locally was of concern, and although Professor Harris had looked at other metrics to see if there was any evidence to support concerns around weekends; nothing had been found at this point but work to understand would continue. Mr Neal asked the following two questions: 1. Is there a view on what ratio of stress to harm is normal in the system or nationally, and if so where the Trust stands in relation to this? Mrs Mills responded that nothing was statistically available linking the ratio of stress to adverse effects. There was however a great deal of information available, supported by publications from the CQC for example, about the overall impact of high stress environments on staff's ability to function as they otherwise might. 2. Where can the Board get snapshots of where Trust performance is a worry compared to the national picture? Mrs Tracey responded that she had attended a national leadership session recently where it had been noted that national dashboards should be available within the next few weeks. The intention once received would be to look at how these could be used on key areas of performance to help provide a national and regional context. Professor Kent said that whilst it was good to see that the career gateway appears to be effective, with over 1000 vacancies was the investment in recruitment	

	providing as much benefit as could be expected. Mrs Foster said that the Trust was being successful in the market, with recent recruitment events held in North and East and 100 job offers made on the day. Whilst some people are lost in the pipeline, there were already 130 new staff booked into induction days over the next three weeks. Current figures show that the Trust was recruiting 1.3 staff for every 1 staff member leaving the organisation. It was noted that time for checks for new members of staff had been reduced by 30% over a two-month period. Mrs Foster added that Comms messaging to staff on the progress being made was a vital part of the ongoing work. Mrs Tracey added that the Executive Team were looking at different routes to get Comms messages out to staff including trialling infographics around recruitment and bed capacity. In addition, there was a broader piece of work looking at best ways to communicate on a two-way basis. Professor Kay commented that much of the recruitment and retention data continued to be backward looking and asked if there were key indicators that could be included that were red flags or early warning signs relating to turnover, sickness and retention. Mrs Foster said that she felt it would be helpful to include information on vaccine uptake for the next few months. With regard to other data, this is being worked on as part of the new workforce dashboard. **No further questions were raised and the Board of Directors noted the IPR.**	
144.22	**PEOPLE PLAN UPDATE**	
	Mrs Foster shared a presentation on local progress against the NHS People Plan. The Board noted that: • The NHS People Plan was published in July 2020 with a significant number of actions. There had not been updates to the People Plan since that time, however much of the Trust's strategy is aligned to it. Delivery of the People Plan is being monitored at ICS level. • There are four strands to the People Plan and the People Promise with seven commitments. The Plan also contained the vision for HR and OD teams. • The Trust's great place to work objective was its interpretation of how it would develop the culture and environment and have the reporting and methodology in place to support staff to work to the best of their ability. • Internal work had been done to agree what would be measured and how, and what was expected to be achieved by 2027. • With regard to the Employee Value Proposition, work done at system level and work done to develop the Trust's strategy had shown that the People Promise is the same as the Employee Value Proposition. • Since the last update to the Board, there had been some significant key achievements including the launch of the Trust's Charter, the Career Gateway, introduction of Learn Plus across Eastern services, the Culture Club, involvement in the Booker Prize, work with the Leadership Academy and confirmation of accreditation with the Veterans Covenant Health Alliance. • Key measurable achievements included the Vivup Salary Sacrifice Scheme, apprenticeships which are at 10%, just and learning culture including use of mediation to prevent formal grievance processes and the new Career Gateway. • Expected progress over the next six months included draft of the 5-year strategic workforce plan in January 2023, further automation of pre-employment checks, delivery of high priority actions in the vacancies programme, new leadership and management programme to be in place, people function policies delivered, improved management information and	

reporting and further progress towards greater digital enablement within the People function.

Professor Kay asked for clarification on what the apprenticeships were in and Mrs Foster responded that there were apprenticeship schemes across many staff groups in the organisation. Professor Kay asked what was planned around data upskilling and data analysts and Mrs Foster advised that whilst there were some apprenticeships in IT, this would need to be developed further as part of the overall Digital Strategy. Mrs Hibbard added that a review of the Trust's Business Intelligence Service was being undertaken, part of which would look at the Data Strategy linked to the Digital Strategy with one of the clear deliverables being understanding future workforce needs and mapping what needed to be done in the short, medium and longer term.

Professor Kent noted the improvement in timescales for pre-employment checks and asked how difficult it had been to get some of the checks, particularly those relating to safety, automated. Mrs Foster said that whilst processes were automated to an extent, there was further work ongoing to look at automating ID checks for example.

Mrs Foster presented an early draft update on workforce planning and the retirement trajectory which would be presented back to the Board of Directors at their January meeting. The draft workforce plan would be informed by the Clinical Strategy and the ICS workforce plan expected in April 2023.

Key points highlighted included:

- Turnover had increased over the last two years, in line with much of the system.
- Leaver insights – retirement is the highest reason for leaving across all staff groups.
- Average age of retirement is 61 years. Highest risk groups for retirement are Admin and Clerical, Estates and Ancillary staff.
- The Trust had a slightly larger younger cohort of staff compared to other Trusts in Devon. The system overall has 21% of staff over 55 years of age.
- Some validation of data was still needed before the next presentation of this work in January 2023.

Ms Morgan noted that in the chart showing reasons for leaving, the bar for the Other category was nearly as high as that for retirement and asked if this could be explored further. In addition, she commented that the highest risk staff groups for retirement were groups where the organisation would face strong competition to recruit from the retail and hospitality sectors. Mrs Foster said that exit data was an area of focus in both Northern and Eastern services. Some qualitative work undertaken gave more detail on reasons for leaving with flexibility being an issue. With regard to Admin and Clerical and Estates and Ancillary staff, focus had been on Nursing and Healthcare Assistant recruitment over the last few months with some good outcomes, but there was work now underway looking at other groups.

Professor Kent asked whether there were any steps that could be taken to try and delay the decision to retire. Mrs Foster said that there was a great deal of work going on at national level on nurse retention, with the difficulty being how to do things that were operationally sustainable. Mrs Mills commented that the Trust was taking part in a self-assessment against the NHSEI retention best practice guidance and a workplan will be developed from this. Maternity services were also

	part of a national NHS Wellbeing Pilot looking at how to maximise the wellbeing of staff including those nearing potential retirements. Mr Matthews asked whether there was anything related to pensions that acted as a disincentive or could be used as an incentive and whether any changes could be made. Mrs Foster responded that a new flexible pension option was due to be launched in April 2023, but overall there was too little flexibility in the NHS Pension Scheme. **The Board of Directors noted the update.**	
145.22	**ACUTE PROVIDER COLLABORATVE UPDATE & TERMS OF REFERENCE**	
	Mrs Tracey advised the Board that the paper presented provided a summary of progress of the work of the Peninsula Acute Provider Collaborative established earlier in 2022 and was asked to endorse the proposals included in the report. Mr Matthews asked how the work with the Acute Provider Collaborative impacted on the Trust's Memorandum of Understanding with Torbay and South Devon NHS Foundation Trust. Mrs Tracey responded that the Trust had received notification from Torbay that whilst the work of the Acute Provider Collaborative was ongoing, the work of the SEND network would be paused. Mr Matthews said that the report stated that Plymouth was the only tertiary centre and asked whether it was not the case that the Trust was delivering some tertiary services. Mrs Tracey said that it was clear that this referred to the major trauma centre in Plymouth and there was no proposal at this stage of any changes to specialist services already delivered by the Royal Devon. Mr Kirby asked how this fitted with the Devon long term plan and, noting that previous attempts to bring organisations together had not been successful, what was different this time that would make this successful. Mrs Tracey responded that the Acute Provider Collaborative was a key component of the Devon long term plan and strategy; which would be demonstrated when the Operating Model is presented to the Board. With regard to why the Collaborative would work when previous attempts had not gained traction, Mrs Tracey said that there had been some outcomes from the work that had been undertaken as the forerunner to this on decisions about Emergency Departments meaning that the Collaborative was not starting from scratch. In addition, there seemed to be greater impetus in this group with more leadership capacity devoted to it and support for it across One Devon. Professor Harris added that he felt there had been a fundamental change since the last time this had been attempted, with a willingness to be honest and for vested parties being prepared to give things up and contemplate difficult decisions. He said that there was some question for him of whether the Collaborative could get to where it wanted to be within the very ambitious timeframe but there was a necessity to push forward. Ms Morgan said that this was very strongly supported by the ICS as a way forward for the system as a whole. Mr Kirby commented that it would be disappointing if the Collaborative were side-tracked by the inclusion of Cornwall in the group, as he felt that the issues relating to Cornwall were an almost intractable problem unless Devon were sorted out. Professor Kay said that whilst she did think it was good to see this operating across the peninsula, it did seem a little counter-cultural as this was one system of many	

	which was looking to be integrated through the ICS. She added that she did have concerns about the additional workload for the same group of people already involved in many other important and time-consuming projects. Mrs Tracey agreed that there was an increasing pull to system work, but that the intention was to try and keep the system focussed on a few key issues and make good progress on them. She said that this runs parallel to the work the Trust was doing on the clinical strategy, so the focus was on doing the work once and doing it effectively. The Board agreed the Terms of Reference presented and the proposals outlined in the document, with the caveat of the time constraints this might impose. **The Board of Directors noted the update and approved the Acute Provider Collaborative Terms of Reference.**	
146.22	**GOVERNANCE COMMITTEE UPDATE**	
	Mr Neal provided an update from the Governance Committee meeting held on 14 October 2022 with the following key issues highlighted to the Board: • Very positive survey results, including from the National Inpatient Survey for 2021 and the National Cancer Patient Experience Survey for 2021, were noted in the Patient Experience Committee update. • A comprehensive report had been received from the Safety and Risk Committee, including an update on cardiology waiting times. Further work was commissioned by the Committee regarding the improvement trajectory and the associated actions required to mitigate the risk within a reasonable timescale. • The Chief Nursing Officer had provided an update on progress on the Ockenden Action Plan, which it was noted had been included in the meeting papers for Board members. **The Board of Directors noted the Governance Committee update.**	
147.22	**TOWARDS INCLUSION**	
	Mrs Tracey provided a verbal update on progress on the Towards Inclusion agenda, advising that no written report was available at this time due to a delay in the Inclusion Steering Group meeting. A full written update would be provided for the next quarterly report to the Board of Directors. Highlights noted were: • Staff Development – as noted in the Chief Executive's report, the Trust had recently held its first Team Royal Devon week. There were two parts of the staff development objective – raising awareness and helping to develop staff's careers – and sessions were offered linked to this, including Let's Talk about Race and Bystander Awareness, as well as a number of other sessions supportive of the inclusion agenda. • Leadership training – the pilot session had now been completed with a group of 15 leaders and feedback from this group would be reviewed and any changes needed made to the training. It was then hoped to roll this out to a wider group of leaders across the remainder of this year. • Delivery of inclusion training had continued across the organisation, including to apprentices, students, physiotherapy and occupational therapy teams, the NIHR Clinical Research Network South West team, the transformation team and the clinical research team.	

	• As part of Black History Month in October 2022 the Trust had released its first resource pack to accompany the inclusion calendar. The pack included resources to support learning, helpful information about the month, staff comments and signposting to further resources and support. • The Trust planned to run a programme called Driving Your Career aimed at helping to improve the current disparity between groups who may not progress as readily through the career structure. **The Board of Directors noted the verbal update on inclusion.**	
148.22	**ITEMS FOR ESCALATION TO THE NDHT & RD&E BOARD ASSURANCE FRAMEWORKS**	
	Ms Morgan asked whether Board members had identified any new risks or anything to add to existing risks from their discussions. None were raised.	
149.22	**ANY OTHER BUSINESS**	
	No other business was raised by Board members.	
150.22	**PUBLIC QUESTIONS**	
	The Chair invited questions from members of the public, staff and Governors in attendance at the meeting. Ms Bearfield asked what happened to patients removed from the ambulance stack, as reported in the IPR update and whether there was a pathway for mental health patients and a pathway for other medical problems. Mr Palmer responded that there was a shared analysis between the Ambulance Service and the Urgent Care Response Team on how patient disposition is measured. If the Ambulance Service identified a patient that met the criteria, a telephone call was made to have a clinical conversation following which a referral was emailed to the Urgent Care Team. This provided an admission avoidance approach not previously available. Dr McElderry asked what assurances could be given regarding the Trust's cyber security and also on heat resilience of servers, particularly in light of the protracted debilitating effect of the breakdown of IT systems reported at Guy's and St Thomas' during the heatwave in the summer months due to servers overheating. Professor Harris responded that the Trust takes cyber security very seriously with a dedicated Cyber Security Officer in post and by ensuring that everyone understood their responsibility in ensuring the organisation was as safe as possible from cyber threat. Cyber security was reported through the Trust's Digital Committee. With regard to the resilience of data centres, they consumed significant amounts of power getting very hot, so were vulnerable to significant swings in ambient temperatures. The Trust has four data centres, with the bulk of the work taking place through the data centres on the Eastern site. Adequate cooling was in place and although it was always possible that a combination of scenarios could lead to overheating, it was unlikely. However, the Trust has robust business continuity plans in place, with every clinical area having a USB device available that has its own battery power available should overall power be lost with work undertaken on a regular basis in clinical areas to ensure these devices were looked after and kept up to date on data.	

	Ms Haworth-Booth noted Mr Kirby's comment earlier in the meeting regarding keeping a record of how much mutual aid is provided by the Trust, and asked whether it was the case that Plymouth had Devon-wide responsibility for tertiary care which might impact on their need for more mutual aid. Mrs Tracey thanked Ms Haworth-Booth for her question and clarified that whilst Plymouth was the provider for major trauma, neurosurgery and cardiac surgery, specialist services were delivered across the peninsula including at the Royal Devon. Plymouth had significant contracts with specialist services and their capacity on the basis of that extra payment should be considered, however, over the last 12 months there had been increasing reliance on mutual aid for a number of reasons. There is an expectation that each organisation will do its part to deliver its responsibilities. Mr Palmer added that delivering the additional catchment coverage for ambulances during this period is very exceptional and was being done to help provide the right support to the Devon system. It was hoped that going forward there would be a more planned approach possible with improved planning through the Integrated Care Board. Mrs Kay Foster suggested that there must be a knock-on effect of this extension of the Trust's catchment area on the local community and the Trust's waiting list which needed to be considered. Mrs Kay Foster noted the update from the Chief Executive on the Team Royal Devon week and informed the Board that she had received a thank you from a member of the Board for her work as a Governor as part of this initiative which she had very much appreciated. Mrs Matthews advised that she had recently been involved in discussions around the clinical strategies in Eastern services regarding urgent and emergency care and cancer services and asked how the work from these consultations sat with the peninsula acute sustainability programme. Professor Harris responded that Plymouth and Torbay were also developing their clinical strategies, however many of the people involved would be the same across organisations; he explained that, for example, he was responsible for one element of urgent care work for the ICS and Mark Hamilton, Chief Medical Officer at UHP, was responsible for the surgical side of this. There was overall oversight of the various work going on, and there would almost certainly be some incongruities but he expected these to be ironed out over time as the work progressed. This would not however be easy as difficult decisions would need to be made. There being no further questions, the meeting was closed.	
151.22	**DATE OF NEXT MEETING**	
	The date of the next meeting was announced as taking place on the afternoon of Wednesday 30 November 2022.	