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 28 September 2022
Via MS Teams

MINUTES

PRESENT	Mrs C Burgoyne	Non-Executive Director
	Mrs H Foster	Chief People Officer
	Professor A Harris	Chief Medical Officer
	Mrs A Hibbard	Chief Financial Officer
	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:	Professor J Kay	Senior Independent Director & Non-Executive Director
IN ATTENDANCE:	Ms G Garnett-Frizelle	PA to Chairman (for minutes)
	Mrs M Holley	Director of Governance
	Ms B Parry	Communications Manager (for item 126.22)
	Ms D Secombe	Clinical Matron for Safety & Patient Experience (for item 126.22)

		ACTION
119.22	**CHAIR'S OPENING REMARKS**	
	The Chair welcomed the Board, members of the public, Governors and observers to the meeting. The Chair reminded everyone it was a meeting held in public, not a public meeting, and asked for questions at the end focussed on the agenda. She asked members of the public to only use the 'chat' function within MS Teams at the end to ask any questions and reminded everyone that the meeting was being recorded via MS Teams. **The Chair's remarks were noted.**	
120.22	**APOLOGIES**	
	Apologies were noted for Professor Kay.	
121.22	**DECLARATIONS OF INTEREST**	
	The following new declarations were noted:	

	Professor Kent was no longer a Non-Executive Director on the South West Academic Health Science Network Board. Professor Kay was now a Board Member of the South West Institute of Technology and a Member for the Office for Students Teaching Excellence Framework Advisory Board, and Chair of U-Maths (National University Mathematics Specialist Schools). Mr Palmer was no longer Owner and Director of JC Palmer Ltd. **The Board of Directors noted the new declarations.**	
122.22	**MATTERS DISCUSSED IN THE CONFIDENTIAL MEETING**	
	The Chair noted that a meeting of the Finance and Operational Committee had taken place that morning and in addition updates from the Digital Committee, the Integration Programme Board, MyCare Programme Board and Our Future Hospitals Programme Board were received. The Board also received a Strategic Outline Case for Breast Care, the draft interim Board Assurance Framework and the Research and Development Annual Report.	
123.22	**MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 31 AUGUST 2022**	
	The minutes of the meeting held on 31 August 2022 were considered and approved as an accurate record subject to the following amendment: *Minute number 110.22, page 12* Ms Hassan to be corrected to Ms Hashem. **Action**	
124.22	**MATTERS ARISING AND BOARD ACTION SUMMARY CHECK**	
	Action check The actions were noted as per the tracker with the following additional updates: *014.22 Dr Kyle to attend Board three months after Epic Go Live in NDHT to provide a further update on outpatient transformation work, in particular relating to providing an update on the inequities work at system level*. The Board of Directors agreed that, due to the significant agenda for the October Board meeting, this action should be deferred to the November Board meeting. **The Board of Directors noted the updates.**	
125.22	**CHIEF EXECUTIVE OFFICER'S REPORT**	
	Mrs Tracey provided the following updates to the Board. <u>National Update</u> • Following the death of Her Majesty the Queen, a letter of condolence from the Chair and Chief Executive was sent to the Royal Family on behalf of the Trust. Her Majesty had strong connections with Devon, not least through the County's strong military tradition and the Trust also had two centres named for her; the Princess Elizabeth Orthopaedic Centre and the recently opened Jubilee Ward.	

	The organisation's connection is also reflected in its designation as the Royal Devon University Healthcare NHS Foundation Trust. As a mark of respect, flags were lowered and a book of condolence was made available through the Chapel at both sites which will be sent on to the Royal Family. Mrs Tracey offered thanks to staff for their efforts during this period, particularly during the additional Bank Holiday that was put in place for the State Funeral. Activity was maintained on both sites with many staff volunteering to ensure staffing numbers were maintained. • A new Secretary of State for Health & Social Care, Therese Coffey, was appointed by the new Prime Minister, Liz Truss. In her first speech, Ms Truss had said that putting the health service on a firm footing was one of her three priorities and she pledged to improve access and build hospitals. Miss Coffey had stated in various interviews following her appointment that her priorities were A, B, C and D representing Ambulances, Backlog, Care and Doctors and Dentists. The new Secretary of State is interested in understanding the detail of what is happening and her focus is expected to be on performance over the next six months. • The new Chancellor had announced a growth plan on 23 September which set out a range of policies to boost growth in the economy and outlined more than £45bn of tax cuts and spending. As a result of this, the health and care levy would be scrapped. Although the Chancellor had said this would not impact on planned NHS funding, details remain unclear. • The Chancellor confirmed the energy support packages for business which also apply to the NHS which will be important as energy costs have already increased by £4m this year. • Changes announced to personal taxation are intended to reduce the cost of living burden, but they may not have significantly impacted on the majority of NHS staff or patients. The Trust has now received notifications of ballots for industrial action from Unions, including the Royal College of Nursing, Unison and Unite. • Nationally, the number of patients waiting for tests had fallen for the third month in a row and was its lowest level since the launch of the NHS Elective Recovery Plan. National figures also showed that it had been the busiest summer ever for ambulance staff dealing with the most serious call-outs, with paramedics dealing with around 237,000 Category 1 incidents between June and August 2022, up by a third on pre-pandemic levels. • Further progress had been made on the longest waits with patients waiting more than 18 months down almost a third. For the Trust's Eastern services where the focus had been on 104 week waits, the position had been improved by almost 45%. The focus for the NHS remained on eliminating all 104 week waits by April 2023 and staff continue to progress these ambitions, whilst seeing more patients in hospital with Covid-19 during this summer than during the previous two summers. Covid numbers were increasing across both Northern and Eastern sites. • Both A&E and ambulance response times were better in August than the previous month. • The number of patients receiving cancer care and treatment remained high and more patients were checked for cancer in July following a GP urgent referral than in any previous July. • Discharging into the community and social care continued to apply additional pressure on bed capacity nationally with only 45% of patients discharged when they were ready during August.	

	• The Winter Plan had been announced with measures to boost capacity with the aim of delivering more beds, extra staff to answer 999 and 111 calls and plans to help ensure that patients are discharged on time. • The new phase of the Covid vaccination programme started in September 2022. <u>System Issues</u> • Since the statutory establishment of the Integrated Care Board and NHS Devon at the beginning of July, there had been focus on developing the operating model for Devon and it is expected that this will be shared with the Board in late October or early November. • There are four strategic objectives for NHS Devon with 12 priorities 2022-2023. The four objectives were improving services with a focus on urgent and emergency care, rebalancing priorities, making more efficient use of resources and developing the culture and how the system operates. <u>Local issues</u> • There had been a temporary change to community services with the transfer of 16 beds from Exmouth Community Hospital to Honiton Community Hospital for approximately eight weeks, whilst extensive renovation work that has been underway in Exmouth for some months is concluded. This includes the surgical day case unit and pre- and post-operative areas and the inpatient ward. Mr Neal asked if there was any information on what lay behind the significant rise in Category 1 999 calls. Mrs Tracey replied that in part this may be some catch-up on the very low numbers that were seen during the pandemic where some people did not seek treatment. Mr Palmer added that there seemed to be a pattern of a spike following a Covid wave, and this could be the case here following the Covid wave during July 2022. In addition, this may also relate to the very challenged position for NHS 111 over recent months with patients unable to get through who may then call 999. **The Board of Directors noted the Chief Executive's update.**	
126.22	**PATIENT STORY**	
	Ms Parry and Ms Seccombe joined the meeting. Mrs Mills presented the Patient Story video to the Board which was relayed to the experiences of a patient in the Eastern locality who had made a number of complaints over a period of nine years which primarily related to her accessibility requirements as she is registered blind. All of her individual complaints had been resolved at the time, but a review undertaken by Ms Seccombe had revealed that the changes made had not been sustained mainly for human factors reasons. This had not been a good experience for the patient and had affected her confidence in the system and her ability to access the system. There is now a solution in place which it is believed is sustainable and Epic forms part of it. Ms Seccombe had worked with the patient to use her experience to share with a number of forums, in particular preceptees and new staff and to help as an *aide memoire* for staff when thinking about communicating with patients with special needs and how they use Epic to ensure these patients are identified proactively.	

	Mrs Hibbard noted that one of the issues identified was that letters were being sent to the patient for appointments despite the fact that she was registered blind and asked why, two years post-Go Live of Epic in Eastern services, letters were still being sent as the default when the Trust had the technology available to adapt its method of communication with all patients. Mr Matthews agreed and asked whether there was still a problem with the system of sending letters automatically that needed to be reviewed. Professor Harris responded that Epic can do this but there are many competing demands for adaptation of Epic that must be prioritised. Whilst he agreed with the view expressed, he added that digital poverty for a proportion of patients needed to be considered. Professor Kent noted the comment in the video about the patient being a "secret shopper" and said that this would apply to Board members too. Mr Palmer commented that this had been a helpful stimulus in terms of outpatient transformation to make sure that it was co-produced with patients. Mrs Burgoyne thanked Ms Seccombe for her work on this and suggested that it would be helpful to take this back to the Patient Experience Committee to look at how using this real-life experience could be built on to tease out what other learning could be gained from it. Mrs Tracey agreed and said that it was also important to look at how more patients could be involved at an early stage in transformation work. Mr Neal agreed that it was important to build proactively and to look at the whole range of accessibility needs. Mrs Mills commented that building on and expanding the patient involvement network in North was an explicit part of the Patient Experience Strategy. Ms Morgan thanked Mrs Mills for the presentation of this powerful patient story and Ms Seccombe for her valuable work in this area. **The Board of Directors noted the Patient Story.**	
127.22	**INTEGRATED PERFORMANCE REPORT**	
	Professor Harris presented the Integrated Performance Report (IPR) for activity and performance for August 2022 with the following key points highlighted: • Both sites continued to experience intense operational pressures, albeit with a slight reduction in the numbers of ED attendances. Bed pressures had continued with high volumes of Green to Go patients which had increased to an average of 106 per day in Eastern services and a peak of 79 in Northern services. Actions had been put in place to improve the position with the introduction of the Help Me Home programme on both sites in collaboration with key stakeholders. A reset week, led by Mr Palmer, was also planned on both sites from 5 – 11 October 2022, the emphasis of which was to reduce the number of inpatients by 100. • Staffing remained challenging during August, with continued focus on recruitment activity. Sickness absence rates had, however, improved during August and the volume of newly recruited staff had also increased, with the highest number of new recruits since April 2020. • Data quality continued to be challenging since the implementation of Epic in Northern services in July 2022, but progress had been made with the inclusion of previously omitted activity data included in the report presented. Work was	

continuing on aligning reporting for both sites with the anticipation of uniformity being achieved over the next three months.

Mr Palmer informed the Board that he had received a number of helpful emails from Non-Executive Directors in relation to how the report is presented, for example relating to how virtual versus face-to-face data for outpatients is detailed and how achievement against plan is scored. These comments have been logged and will be fed back in to the debrief with the Teams.

Ms Morgan thanked Professor Harris for his overview and invited the Non-Executive Directors to pose strategic questions.

Mrs Burgoyne noted the significant amount of work that was in place for urgent care but that there continued to be a lot of areas still rated as Red. She asked whether there was a shared view across the system of what good would look like and whether the system was able to hold all parts to account to start turning Red to Amber then Green for those areas. Mr Palmer responded that Demand and Capacity Plan generated by the system was the best that there was at this stage. He added that he felt that there needed to be more work done on demand and capacity at the outset for the system to get its diagnostics right. However, he said that the system was relatively happy that the allocation that had been made would provide a good opportunity to run the acute system and elements of the social care system in the way that was needed over the next six months. He noted that some results had started to be seen over the last 10-15 days with the Help Me Home programme starting to have an impact. In addition, he advised that the organisation was looking to have a strategic conversation with social care partners about the next six to eighteen months.

Mr Kirby posed the following questions:

1. To what extent were social care involved in the planned reset week and whether the reset week would be able to test out some hypotheses of how to deal with issues going forward?

   Mr Palmer responded that part of the reset week related to process improvement. For the Eastern locality the ambition was to reduce inpatients between 70 – 100, targets for daily bed movements for all specialties, reduce overall patient inpatient delays and increase 12:00 pm discharges. For the Northern locality, the focus is on trying to maximise the SDEC, reintroducing the discharge lounge, specialty targets, and criteria led discharge. Partners had been involved in planning of this exercise and a supplementary was due to go out to them to remind them of plans and their part in helping the Trust with this. The new out of hours and 111 provider is being brought up to speed. It will be important to ensure that the the Help People Home programme and the reset programme are strongly linked to ensure they work together and benefit each other. Mrs Hibbard asked what was planned to make sure that the benefits from the reset week endured beyond the week and Mr Palmer said that social care needed to be a strong partner with the Trust in all three phases of the winter plan – the reset week, and the pre- and post-Christmas plans. He commented that the best accountability framework for ensuring performance was through the System Delivery Improvement Group. In addition, the Oversight Group looking at demand and capacity spend will also operate as an accountability space.

2. There were a number of instances noted in the report in particular relating to pressure damage where staff had failed to remove devices or failed to recognise the effect of fitting devices and asked whether training was being prioritised in particular where there may be patient safety or outcome issues.

   Mrs Foster commented that the Learning Management System which had been introduced in the Northern locality last year had been introduced in the Eastern site during August, underpinned by a common core training skills framework. Mrs Mills commented that the issues noted in the report about pressure damage related to basic knowledge, skills and good practice rather than pressure ulcer training specifically. She added that she was not aware that access to clinical training had been impacted over the last few months.

3. The report highlighted Dexa sessions in Taunton not being filled because patients could not be found in the Northern site to go to Taunton and Mr Kirby asked whether this was a transport issue or a patient preference issue.

   Mr Palmer said that he this would require some further checking, but in general terms within the routine winter plan there is always focus on ensuring that transport is in place.

Mr Matthews posed the following questions:

1. How does the increasing incidence of Covid noted play into the plan and were there any new ideas on how to manage a significant wave of Covid over winter to reduce the impact on services?

   Professor Harris commented that it was expected that there would be two Covid peaks over the winter period. He added that, in line with recent guidance, Covid was being treated more in line with how any other infection would be treated, as people with incidental Covid are no longer presenting as ill as in previous waves. Mrs Mills said that stopping testing patients in ED for Covid unless they were symptomatic and stopping cohorting Covid contacts who did not have active Covid would make a significant difference to flow through the hospital. More guidance was expected on changing thresholds on testing and isolation, however it had to be borne in mind that this would be in low prevalence of Covid. Mr Palmer added that modelling suggested that Covid waves should be anticipated to peak in November 2022 and March 2023 and a 15-20% bed increase because of Covid had been built into the winter plan.

2. Would the recently announced additional funding of £500m for patients on leaving hospital for a period of time have any impact?

   Mr Palmer responded that it was not yet clear how the £500m discharge fund would be dispersed. An area of focus would be what the domiciliary care incentive in the system would be for this winter.

Professor Kent asked the following questions:

1. The report highlighted that stroke care was falling significantly below target. Given the ongoing pressures noted were there plans to protect dedicated stroke beds?

Professor Harris agreed that the figures for stroke were not where they should be for either site, however he advised that there was not sufficient capacity to ring fence those beds. The solution had to be de-escalation work as previously described by Mr Palmer with the reset week and getting patients home as soon as possible.

2. Northern data indicated an ongoing challenge with turnover. What were the reasons given for staff leaving the organisation?

   Mrs Foster responded that whilst there had been positive signs regarding turnover in the Eastern locality, the same had not been true in Northern, however her hope was that there was a lag factor influencing this. Some analysis of turnover data in Northern had been undertaken and would be used to help retention. There was work being undertaken on the Welcome piece for new staff to aid with retention. There had been a recent successful recruitment event for Healthcare Support Workers. Mrs Mills added that there was some wider learning that could be taken from the pastoral support that is offered to international nurse recruits and applied more generally to other staff groups.

   Mr Kirby commented that he had been advised that there a number of midwives who had a specific remit relating to staff retention and asked whether this was a common model in use with other staff groups. Mrs Foster replied that pastoral support roles were being put in place for a number of areas but she was not aware of specific midwifery roles with a retention remit. Mrs Mills said that the midwifery arrangement was local to the Division with strong links to the professional midwifery advocate role. Mrs Foster informed the Board that the business case that was being developed related to additional capacity for support to enable people to be retained.

Mr Neal noted the increase in cases of *c diff* infections in Eastern services and that the standard deep clean of wards had been suspended due to bed capacity issues. Given that operational pressures were expected to continue and Covid numbers were increasing with the next wave expected over the coming weeks, he asked whether there was a point when a decision would need to be made to go ahead with the deep clean despite these factors to balance out infection risks. He further asked whether there were other standard processes that had been suspended due to operational pressures and if so, how were these being managed. Mrs Mills responded that the ward that would have been used for *c diff* isolation had been prioritised for Covid patients, with *c diff* patients managed in a different way. Although deep cleans have traditionally been undertaken, many organisations no longer use them as it is felt that if national cleaning standards are met on a regular basis, they should not be necessary. On the wider question regarding processes that had been suspended, Mrs Mills advised that ward refurbishment had also been impacted by bed pressures. Whilst neither are high risk in terms of patient safety, they may impact patient experience. She advised that she and Mr Tidman had had some discussions about how to manage this with a longer-term strategy.

Mr Kirby said that it was clear from the IPR that there was some lag in delivering best value and asked whether consideration was being given to how this might be clawed back later in the year. Mrs Hibbard responded that this was being reviewed, with a post-month 5 review of current pressures and the risk of delivery if the finance plan had moved out. A number of areas to strengthen the position are

	being looked at. One of the biggest areas of risk relates to the assumptions on the productivity plan because of the finance regime regarding how the Elective Recovery Fund flows through the system. Governance around delivery of best value was also an area of focus looking at how to strengthen this and provide support to Divisions to help them focus on what they need to deliver on savings. Mrs Burgoyne asked how important the rollout of the flu and autumn booster vaccination programmes would be in terms of the potential Covid wave and the impact on services in the hospital that would have. Professor Harris responded that the indications from Australia were that the flu season had been particularly bad this year, so both campaigns would be extremely important this year. As in previous years, teams would be working hard to ensure that every member of staff was given the opportunity to have a flu vaccination. Mrs Foster commented that there was some concern nationally that staff uptake of vaccination would not be as high as previously and this would be tracked locally through the People, Workforce, Planning and Wellbeing Committee. She added that support both from the Board and from Unions to encourage staff to take up the offer would be key. Mrs Tracey commented that there was currently clearly a very difficult operating context for the Trust. She said that traditionally the organisation had measured itself against the national standards and the corresponding quality impacts and said that whilst the Trust would continue to strive to meet those standards, but asked the Board how it would decide the point at which the Trust was so far below the standard that it was a major concern and not acceptable, notwithstanding the extreme pressures. Ms Morgan agreed that this would be an important discussion for the Boar to have at a future date. Mrs Hibbard suggested that the Quality Impact Assessment process could be used to look at what would trigger a score of 25 which would be unacceptable and work back from there to set a level. Mrs Mills said that she and Professor Harris had undertaken a piece of work at the request of the Governance Committee to identify the sources of intelligence regarding quality and quantity and how this could be used by the Executives to escalate to the Board. She suggested that a similar exercise could be undertaken for other elements of the balanced scorecard. Professor Kent said that it would be useful to see the data following the reset work. Mrs Tracey said that two dashboards had been created to look at the two key priorities of improving green to go and recruitment. **No further questions were raised and the Board of Directors noted the IPR.**	
128.22	**ANNUAL COMPLAINTS REPORT**	
	Mrs Mills presented the Annual Complaints Report with the following points brought to the Board's attention: • The report had already been presented to the Patient Experience Committee and discussed in detail. • Complaints had increased over the last year. • Two key themes were identified for learning from complaints, with communication the most common theme. • There were nine closed cases which had been referred to the Ombudsman during 2021-22. Of these, two were partially upheld, with the remainder not taken forward by the PHSO.	

- The report contained a forward look at work to be undertaken following integration to standardise systems and processes.
- There had been poor performance in meeting the commitment to respond to complaints within a 45-day timeframe. Improvement trajectories had been identified for complaints in Northern Services. There is a slightly different model in Eastern Services with concerns and complaints looked at separately. Concerns should be resolved within 14 days but there has been an historical issue with this not being met and the process will be changed so that going forward if a concern is not resolved within 14 days, it will automatically become a complaint with a view to not having any concerns outstanding beyond December 2022. The longer-term aim is that the target of 45 days would be met by June 2023.
- There had been particular issues in the Division of Medicine in Eastern Services with managing complaints within timescales and additional support has been put in with some retired clinical members of staff returning to support the Division with complaints.

Mr Neal noted that communication had been a frequent issue in complaints over a number of years and asked if anything was being missed in learning from complaints to try and address this. Mrs Mills said that this to some degree highlighted the complexity of some of the services provided with complaints about communication often from people who had accessed different parts of the system. She added that there was always learning to be taken from complaints and there was a need to do a more detailed thematic review of what underpinned some of the complaints with complex issues around communication, as illustrated in the Patient Story presented to the Board.

Mr Tidman commented that the importance of timeliness was a strong theme in the report, but added that on occasion the style and tone of communications could exacerbate complaints, for example not giving a full apology in responses. He asked if there was training for staff on being honest and open in their reflections. Mrs Mills responded that there was not specific training, but the sign-off process for complaints responses had been changed, so that responses were all signed off by her and the Chief Medical Officer to ensure consistency and with a designated lead for Patient Experience across both locations and she had undertaken training with the Complaints Team on their role in check and challenge of responses with the Divisions. The Patient Experience Lead has been reviewing all responses as part of improving processes, and the tone and focus of responses and Directors on each site have also been involved to encourage local ownership of the processes.

Mr Matthews commented that he was surprised that there was no theme relating to delays in treatment and Mrs Mills responded that she believed that this would come through in the next report.

Mrs Foster said that she would hope that MyCare would begin to address some of the communication issues for patients accessing a number of different services and would help patients' families with understanding what was happening with their treatment. Professor Harris agreed that this could be beneficial but with regard to relatives, patients would need to give relatives access to their Patient Portal in order for the relative to be able to check what was happening with their relative's treatment.

The Board of Directors noted the update.

129.22	**APPROVAL OF STANDING ORDERS**	
	Mrs Holley presented the Standing Orders which had been reviewed following integration and changes in some job titles and the opportunity had also been taken to ensure that Standing Orders were fully aligned to the Council of Governors rules and procedures. **The Board of Directors approved the revised Standing Orders.**	
130.22	**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. Mrs Tracey suggested that consideration should be given to whether the current political uncertainty was adequately reflected. **Action.**	
131.22	**ANY OTHER BUSINESS**	
	Professor Kent informed the Board that it was currently Organ Donation Week which was a national initiative to raise awareness of the difference that organ and tissue donation can make. She added that she wanted to acknowledge the hard work of the Organ Donation teams on both sites and the generosity of donor families.	
132.22	**PUBLIC QUESTIONS**	
	The Chair invited questions from members of the public, staff and Governors in attendance at the meeting. Mrs Sweeney said that the Patient Story had been inspiring in that there had clearly been discussion with the patient to help co-design solutions arising from their complaint and suggested that this should be encouraged more widely with patients. In addition, Mrs Sweeney noted the considerable delay in responding to complaints which she felt was troubling. Mrs Mills clarified that whilst there was a delay in the final outcome of a complaint being communicated to patients, they did receive acknowledgement from the Trust within three working days of receipt of their complaint and to clarify any issues from the complaint. Mr Tanner asked whether the Trust had any plans to protect itself from losing staff to the independent sector with reference to the ongoing regional NHSE/I community diagnostic services tender. Mrs Tracey responded that she was the Senior Responsible Officer for the Planned Care Board across Devon which had looked at the need for additionality to make good on backlogs. A risk of losing staff to the independent sector as a result of bringing independent sector providers into the patch had been identified and work had been commissioned to look at this in more detail including how to mitigate this risk. Mrs Tracey had also escalated this risk to the Regional Steering Group for Elective Recovery and it was due to be discussed with them next week. Mr Kirby asked whether it would be possible to put a legal clause into any partnership agreement with independent sector providers which would preclude them from recruiting NHS staff and Mrs Tracey responded that it would be difficult to prevent staff from taking up employment if	

	they wished. Mr Palmer added that the independent sector was under similar workforce pressures and the Trust was working closely with them to make sure that the best possible use was made of the model. There being no further questions, the meeting was closed.	
133.22	**DATE OF NEXT MEETING**	
	The date of the next meeting was announced as taking place on the afternoon of Wednesday 26 October 2022.	