

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 22 February 2023
Exeter College Future Skills Centre, Exeter Airport Industrial Estate, EX5 2LJ

AGENDA

As of 15.02.23

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	Shan Morgan, Chair	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 25 January 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	Suzanne Tracey, Chief Executive Officer	Information (Verbal)	09:47 20
8.	Patient Story	Carolyn Mills, Chief Nursing Officer	Information (Verbal/paper)	10:07 15
9.	Deep Dive Strategic Workforce Planning / Workforce Plan	Hannah Foster, Chief People Officer	Information (Paper)	10:22 30
	C	OMFORT BREAK		10:52 10
10.	Performance			
10.1	Integrated Performance Report	Carolyn Mills, Chief Nursing Officer	Information (Paper)	11:02 45
11.	Assurance			
11.1	Governance Committee Update	Tony Neal, Non-Executive Director & Committee Chair	Information (Paper)	11:47 5
12.	Information			



12.1	Items for Escalation to the Board Assurance Framework	Shan Morgan, Chair	Discussion (Verbal)	11:52 1		
13.	Any Other Business 11:5					
	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 29 March 2023.					
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 12:03



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

Wednesday 25 January 2023 via MS Teams

MINUTES

PRESENT	Mrs C Burgoyne	Non-Executive Director		
TRESENT				
	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 10:15)		
	Professor B Kent	Non-Executive Director		
	Mr S Kirby	Non-Executive Director		
	Professor M Marshall	Non-Executive Director		
	Mr A Matthews	Non-Executive Director		
	Dame S Morgan	Chair		
	Mr T Neal	Non-Executive Director		
	Mr J Palmer	Chief Operating Officer		
	Mrs T Reeves	Director of Nursing, Eastern Services (Deputy for Chief Nurse)		
	Mrs S Tracey	Chief Executive Officer		
	Mr C Tidman	Deputy Chief Executive Officer		
APOLOGIES:	Mrs C Mills	Chief Nursing Officer		
IN ATTENDANCE:	Dr K Davies	Medical Director, Northern Services (for item 009.23)		
	Ms G Garnett-Frizelle	PA to Chairman (for minutes)		
	Mrs B Hoile	Comms & Engagement Coordinator (for item 008.23)		
	Mrs M Holley	Director of Corporate Governance		

		ACTION
001.23	CHAIR'S OPENING REMARKS	
	The Chair welcomed the Board, members of the public, Governors and observers to the meeting. Ms Morgan 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.	
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002.23	APOLOGIES	
	Apologies were noted for Mrs Mills; Mrs Reeves was attending as her Deputy.	
003.23	DECLARATIONS OF INTEREST	
	The following declaration was noted: Mr Tidman informed the Board of Directors that his daughter was employed as a journalist by the Health Service Journal.	
	The Board of Directors noted the declaration.	
004.23	MATTERS DISCUSSED TO BE DISCUSSED IN THE CONFIDENTIAL MEETING	



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	The Chair noted that the Board would receive updates at its confidential meeting from the Digital Committee, Finance and Operational Committee, Governance Committee and the Integration Programme Board, as well as a Northern Services Medical Staffing Business Case, an update on the Corporate Roadmap, the Board Assurance Framework and a presentation from Matthew Gould on transformation.					
005.23	MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 30 NOVEMBER 2022					
	The minutes of the meeting held on 30 November 2022 were considered and approved as an accurate record subject to the following amendments:					
	Minute 158.22, page 4 of 16, fourth bullet point: clarification to be added that it was Wynyard Medical Ward that had been renamed.					
	Minute 159.22, page 5 of 16, third paragraph change to "Mr Kirby suggested that the Trust could set itself a challenge to look at what would be the payback from placing an eighth some of the resource put into the acute into the community."					
	Minute 159.22, page 6 of 16 action to be added to the action tracker regarding blister packs no longer being provided for patients to see if anything could be done to reinstate this provision.					
	Minute 161.22, page 11 of 16, first bullet point, second sentence change to "Was this an anomaly or had the dialogue changed underlying service improved?"					
006.23	MATTERS ARISING AND BOARD ACTION SUMMARY CHECK					
	Action check 158.22, November 2022 Mr Neal asked what the national interpretation was of the ongoing high number of both A&E presentations and Cancer referrals. Mrs Tracey agreed to look into this further and provide a fuller update in her next CEO's report to the January Board meeting. Mrs Tracey advised the Board that the Cancer part of this action would be covered in her Chief Executive's report and the Deep Dive on Cancer on the Agenda. There was more work done to be done regarding A&E presentations and an update on this would be brought to the February meeting.					
	The Board agreed that actions 163.22(1) and 163.22(2) which both related to the Six-Monthly Safe Staffing report should remain on the tracker until presentation of the next report to the May Board meeting.					
	166.22, November 2022. Mrs S Matthews raised a question regarding what special provision had been funded to meet the additional needs of people transferred from Marston and other immigration centres to hotels in Ilfracombe. Mr Palmer advised there was a broader discussion with the Local Authority regarding a long-term partnership to ensure provision could continued and agreed to write to Mrs Matthews to provide a detailed response. Mr Palmer said that no special funding stream had been made available from the ICB or others, but a small amount of reactive services had been made available from Barnstaple including attendance by the Vaccination Outreach Team to this cohort in December 2022 to offer a diphtheria pathway, and the Respiratory Team were offering a clinic for TB screening with paediatric TB screening about to start. The Integrated Care Board (ICB) was about to move to monthly meetings with all partners to have ongoing					



discussions about support. Mr Palmer said that he would send Mrs Matthews these details and the letter would be published on the Trust's public website. Ms Morgan suggested that a further update should be provided to the Board in due course.

166.22(3), November 2022. Mrs S Matthews suggested that the Trust could consider working with GP Surgeries regarding making a confidential space available to patients to access supported IT for virtual appointments. Professor Harris agreed to look into this further. Professor Harris said that a pilot was being set up at the Castle Place GP Practice in Tiverton and if effective a conversation would be had with the Integrated Care System (ICS) and Local Care Partnerships (LCP) and non-affiliated GP Practices on how this might be taken forward.

The Board of Directors noted the updates.

007.23 CHIEF EXECUTIVE OFFICER'S REPORT

Mrs Tracey provided the following updates to the Board.

National Update

- Cancer referrals it had been a record year for patients receiving cancer treatment, with 320,000 having received treatment between November 2021 and October 2022. More patients had also had cancer checks, with over 2.8m patients seen, up a fifth on numbers before the pandemic. Of these, 6% resulted in a cancer diagnosis. This was important progress for the NHS, as more patients getting checked could impact cancer survival rates. Recent data had also shown that 100,000 patients were diagnosed at stage 1 and 2 when their cancer was easier to treat. Spending on cancer awareness campaigns had doubled and these encouraged people to go for tests, but this formed part of the context for the significant increase in referrals nationally.
- A national scheme had been announced, with £200m funding to buy short-term placements to promote swifter transfers out of acute hospitals. This followed an earlier announcement of £5m funding to support adult social care discharge. Guidance for the latest funding advised it should be used to purchase bedded step-down capacity and associated clinical support for patients with no criteria to reside but who could not be discharged with the capacity available. The funding would be held by NHSE and ICBs would claim against it. Plans were being formulated in respect of how this would be utilised.
- There was a national focus on waiting lists. The Trust had received a letter from NHSE that set out the expectation that Trusts must issue appointments for all patients who had been waiting over 78 weeks before the end of January and the appointments should be for a date before the end of March 2023. The letter indicated that whilst NHSE would accept some inpatient cancellations, cancelling outpatient appointments even during strike action was less acceptable.
- Following a recent ballot, the British Medical Association (BMA) had said that junior doctors would take industrial action in March 2023 for three days. The BMA said that its members had faced a 26% decline in the value of pay over the last 15 years.
- The national focus to encourage people to get their flu jabs continued, with latest data showing that 5500 patients were in hospital in the first week of January with flu, as well as a further 9000 with Covid nationally.
- NHSE had appointed three new Non-Executive Directors to its Board who were leaders in the fields of nursing, mental health and life sciences.



• Planning guidance was received in late December 2022, with headlines noted as the inclusion of clarity on the 4-hour target for 2023-24, with Trusts asked to plan on the assumption that they would achieve 76% of all patients being seen or admitted within 4 hours. The guidance also set out core performance and improvement metrics on ambulance handovers, bed occupancy and mental health access and included moving to an activity-based tariff system to support elective recovery. The document indicated a delay in specialised services transferring to ICSs and a target for agency spend of no more than 3.7% of total pay bill.

System Issues

- Work was underway on the One Devon Joint Forward Plan; there was a requirement for all ICBs, with partner Trusts and other system partners to prepare this before 1 April 2023. It would be shared with NHSE and Health and Wellbeing Boards and published on 30 June 2023. Consultation on the draft was expected to commence by 31 March 2023 with those for whom the ICB has core responsibility, including those registered with a GP Practice, unregistered patients who usually resided in the area and Health and Wellbeing Boards. Processes for signing off the plan had to be agreed and the system would be held to account for delivery. The principles would be fully aligned with the system's partnership ambitions. The plan would support subsidiarity by building on existing local strategies and plans, as well as reflecting universal NHS commitments and it should be delivery focussed with specific objectives, trajectories and milestones. Systems had flexibility to determine the scope of the plan and how it would be structured and developed, but there was a minimum requirement that the plan should describe how the ICB and partner Trusts intended to arrange and provide services to meet the population's physical and mental health needs, including the delivery of universal NHS commitments. NHSE will work with systems to ensure there is alignment between the Joint Forward Plan and planning submissions.
- The Trust was committed to taking part in a One Devon elective pilot to support
 the Devon system to recover the surgical backlog, initially looking at
 Orthopaedics, Ophthalmology and issues relating to spinal surgical services
 working closely with acute provider specialty teams. The focus would be to
 maximise day case activity, standardise pathways, increase efficiencies in
 theatre utilisation and help support and develop further cross-site working.
- The update from the One Devon Board meeting had been circulated.

Local issues

- There had been two internal critical incidents declared in Eastern services and the NHS in Devon had declared a system incident twice. Both Northern and Eastern services had been at Opel 4 several times during December and January related to significant numbers of patients requiring urgent and emergency care and the acuity of patients presenting, staffing challenges due to sickness, issues with discharge, and increased cases of flu, Covid and Norovirus locally.
- December and January presented a complex infection control position which had added to pressures on services, although the situation appeared to be improving with mask wearing stood down. Focus on encouraging vaccination continued with vaccination centres running a number of outreach clinics. These challenges, together with the impact of industrial action, had led to the postponement of some elective activity which was always a last resort. Work continued to support the health and wellbeing of staff.



- Industrial action took place during December and January by nursing and ambulance staff, with further RCN strike action planned on 6 and 7 February. The Trust had robust Emergency Preparedness, Resilience and Response plans in place; the work of the senior team to manage the impact of industrial action had been very beneficial.
- The organisation remained in a challenging financial environment where it was being requested to recover the waiting list position alongside finances. The Trust had been looking at what it could do to recover the deficit and prevent it from worsening. As a result, the delivering best value programme was being relaunched to ensure that all opportunities were explored to make the best use of resources.
- The Care Quality Commission (CQC) undertook an inspection of the Trust in November 2022 and planned the Well-Led part of the inspection in January 2023. This had been postponed following the announcement that all CQC Inspections should be stood down during the current period of intense pressure on services. It will be rearranged for a later date.
- As an educational provider for apprenticeships, the Trust had undergone an inspection in December 2022 by OFSTED of the delivery of management apprenticeships and initial feedback was very positive. The final report was expected in February 2023.

Professor Kay asked what the criteria for allocation of funding from the national discharge scheme were. Mrs Tracey said the focus was on step-down beds with Trusts encouraged to proceed if it meets the criteria and reclaim the funding through the ICB. Mr Palmer added that the Trust wanted to ensure that it had procured as much agency backfill as possible using this funding. He and Mr Tidman were in discussions to see whether it would be possible to release an after-Christmas domiciliary care incentive to ensure care placements could be resourced sufficiently. He added that the possibility of a mixed workforce with Social Care to create a step-down facility with a higher bedded capacity was being discussed.

Professor Marshall noted the update on the increase in cancer referrals and asked to what extent they were appropriate referrals as the increased pressure across the system could be driving some increase in referral rates by GPs and asked whether there had been a reduction in conversion rates. Mrs Tracey said that the national figures showed that only 6% of referrals converted to a cancer being diagnosed, but there was more work to be done on the trends in conversion rates. She added that there had been guidance put in place for tests and arrangements GPs needed to carry out for referrals.

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

008.23 | PATIENT STORY

Mrs Hoile joined the meeting.

Mrs Reeves presented the Patient Story video to the Board which had been developed to present the lived experience of a carer and events around the care of his mother. She advised that the key areas that came out of the story were:

- The story emphasised the importance of carer involvement in the care planning for patients.
- The carer had agreed to work with the Trust and had met with the Director of Nursing for Eastern services to discuss how to take a number of initiatives forward.



• The story highlighted the importance of planning for discharge from admission with one of the challenges being the need for staff to be permanently based.

Ms Morgan commented that this had been a topical story given the extent of delayed discharges. She said that there had been some very constructive feedback provided by the carer and she had been struck by his comment that families and carers should be seen as partners in care by the hospital.

Mrs Tracey said that it would be important to look at how to achieve the balance of making care personalised against the operational pressures which may impact this.

Professor Kent said that communication was a major factor in the story, as it was in much patient experience feedback received. She added that in the past the process had always been that as soon as a patient was admitted to hospital, staff should start thinking about that patient's discharge plan, but this had perhaps slipped during the pandemic. Messaging on this needed to be reinforced for staff, particularly emphasising the benefit of working on this as an interdisciplinary team rather than in silos.

Mr Palmer commented that a lot of work was being undertaken in Northern services on "expect a day of discharge" with all staff across the multi-disciplinary team being up to speed on the expected day of discharge for a patient. He said that the story underlined the importance of getting an identical approach to urgent community response team across both sites which was why a single team for community had been created. He added that the story strengthened the case for the investment the Trust was looking to make in medicine for Northern services, as it highlighted the need for having constancy of purpose and a recognisable rota for medicine populated by substantive staff which would make a difference to the ability to identify discharge potential appropriately.

Mr Neal suggested that the impact of the process changes that the carer was contributing to should be looked at in due course through the Patient Experience Committee. **Action.** Professor Kay said that it would be important to get patients and carers involved in their understanding and learning of what is possible, as well as getting the processes right as many people may not be aware of what is possible.

Mrs Reeves said that a report on the work that was being undertaken with carers would be presented at the next Patient Experience Committee meeting. She added that as a direct result of the story reinforced communication for clinical teams was being developed to remind them of processes that will help them in planning discharges.

Ms Morgan thanked Mrs Reeves for presenting the story and asked for the Board's thanks to be passed on to the carer.

The Board of Directors noted the Patient Story

Mrs Hoile left the meeting.

009.23	CANCER DEEP DIVE	
		Dr Davies joined the meeting



Mr Palmer presented Cancer Deep Dive and advised the Board that there would be a second deep dive update to the Board at the July meeting following completion of the Clinical Strategy. The Board noted the following points:

- The paper described the level of complexity around cancer services, including
 the demand pressures and the impact of implementation of EPIC, but also the
 opportunities presented by EPIC for optimisation in a number of key specialties
 that would be rolled out in coming months.
- There had been demand and capacity mismatch in a number of high-volume services, with the most challenged areas being dermatology and urology.
- There had been some challenges on data quality and work had been undertaken on the health check on the cancer patient tracking list which mirrored the work undertaken on the elective recovery position and had been successful so far.
- The recovery plan outlined how the organisation was responding to challenges, with further improvements noted in the number of patients held on the 62-day waiting list.
- Development of the Strategy was being led by Dr Mike Hanneman, Cross-Site Clinical Director.

Professor Harris informed the Board that the second deep dive would have more of a clinical voice. He said that he agreed that the issues in cancer related to a demand and capacity mismatch which began during the pandemic, although there were already underlying problems. He added that there was real focus on this work and the organisation was on the path to recovery.

Dr Davies, Cancer Lead for Northern Services, added that the increase in demand had been further impacted by ongoing workforce issues, but she was confident that there were sound improvement plans in place. She added that the appointment of Dr Hanneman as the Cross Site Clinical Director had been very beneficial.

Mr Matthews asked how the disparity in performance between Northern and Eastern services would be addressed, giving the example of 62-day waits which were significantly worse in Northern services as were 28-day diagnostics, although 2-week waits were relatively better in Northern. Mr Palmer responded that the current way of presenting the data did make the two services look quite separate and there had been some distinct challenges for Northern services. However, the 62-day validated position was now clear, and pathway management would help to balance demand and capacity. There was also focus on driving through other clinical opportunities, such as outsourcing. There were collaboration opportunities, with discussions currently underway for urology on how. Eastern might support Northern. He noted that the Trust also provided support for urology and other tumour sites to Torbay, which meant any changes to pathways needed to be done in a measured way to minimise the impact.

Dr Davies commented that with regard to Mr Matthew's point about the diagnostics and 2-week wait targets, the 62-day and 28-day targets related to surgical capacity which is more time consuming. With regard to the 2-week wait target, every effort was made to bring that in close to 7 days, as the sooner you can bring that in the more likely you are to catch up on the other pathways. She agreed with Mr Palmer that many of the specialties across Northern and Eastern were actively looking at closer working and this would accelerate over time.



Mr Kirby noted that around 80% of dermatology referrals were not high risk and asked whether there was more that could be done with GP surgeries to better manage referrals to this service. Professor Harris commented that general practice was under overbearing pressure both locally and nationally and agreed that the acute service needed to find better ways of working with them to help, as when a GP practice is under pressure their threshold for referral dropped which then impacted the acute service. Dr Davies confirmed that there were regular conversations with GP colleagues and added that conversion rates locally for skin cancer referrals were in fact better than elsewhere in the country. It was noted that some of the systems of regular feedback to GPs had been impacted during the pandemic with regular meetings stood down, but these were now restarting.

Mr Kirby referred to Mr Palmer's earlier comment about the support that was provided to Torbay, in particular for the urology pathway, and asked what percentage of the total workload this represented and suggested this should be reflected in the Trust's data, as it was otherwise being judged on a far greater catchment area. Professor Harris said that the majority of Torbay's complex cancer patients came to the Royal Devon, but this was part of the territory for the organisation being between a secondary and tertiary centre for cancer.

Mr Kirby said that the deep dive highlighted another area where there were reporting issues which were related to the electronic patient record (EPR) and whilst he recognised that there would always be some issues to be resolved when undertaking a major digital transformation, could more be done with EPIC to get senior input to help resolve some of the problems, as there was a danger that people could lose faith in the data. Mrs Hibbard assured Mr Kirby that conversations were taking place with EPIC regarding solutions for the issues he had described and they were working very supportively with the Trust. Mr Palmer added there were two areas being worked through, the first of which related to data quality for which there were weekly meetings at Executive level. The second issue related to build and in the area of greatest challenge, which was dermatology build, there had been full engagement of the EPIC senior team with the Trust in a Task and Finish Group meeting twice a week for two hours.

Professor Kent noted that training activity on EPIC for outcoming was outlined in the report and asked if there was an indication that an uptick in performance could be expected following training being provided. Professor Harris responded that it was appropriate for clinicians to outcome on EPIC, but ensuring they completed the training could be difficult due to their other clinical priorities. He was confident that this would work through but would take time.

Mr Neal asked whether there was any learning from the process undertaken for the deep dive and whether there was confidence that triage of waiting lists was working effectively. He asked whether the balance of harm would be included in the second part of the deep dive planned for July. Mr Palmer said that it had been very useful to stand back and put the current position in context over a four year period. Mr Palmer advised that some triangulation regarding quality and safety had been drawn out in the paper, but the data was not deep enough at this stage. The Patient Experience Survey had shown whilst there had been a slight deterioration relating to experience and quality, the Trust was still ranking very highly against the national picture. It was noted that the second part of the deep dive would contain data around survival outcomes and any suppression factors that had created a challenging position on harm. Dr Davies gave assurance that when clinicians know



that patients would not be seen within two weeks, they automatically triage the referral letters to ensure that those with urgent need were prioritised and seen as soon as possible.

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Mrs Burgoyne asked whether there were any plans to look at system wide working around clinical and diagnostic capacity and whether this would be an area that could move into a three-year transformation programme taking all the opportunities that were coming in to look at this in a different way. Mr Palmer responded that system working was being covered by the acute sustainability programme of work. Professor Harris added that there were opportunities to collaborate in the system, with some specialties such as urology already ahead of the curve on this. He further advised that there was a digital opportunity for reducing the dermatology waiting list that was being explored. Full details could not be given at this time in the public meeting as it was still under discussion, but the Board would receive an update in the confidential meeting and it would be shared at a public meeting once discussions had successfully concluded.

Professor Kay commented that she did not have a true understanding of some of the data quality issues with EPIC and asked whether there could be a focus on this at Board meetings before the second deep dive was presented in July to help Board members fully understand what the issues were. Professor Harris said that he would be happy to shine a spotlight on EPR to provide a balanced picture of not only the issues but also all the bonuses that had come from the EPR. Ms Morgan said that a number of briefing sessions were being planned for the Non-Executive Directors and the EPR/EPIC would be included. Mrs Tracey reminded the Board that any organisation that implemented an EPR would go through a period of optimisation and resolution of data quality issues. The Trust had a very clear process in place for these data quality issues led by Mrs Hibbard with fortnightly meetings of a Task and Finish Group which was reporting to the Finance and Operational Committee. Mr Tidman said it was important to overlay this with the health inequalities view. He advised that a Task and Finish Group was looking at the impact not just at an aggregate level, but also on different segments of the population. This would be included in the second deep dive to the July Board meeting.

Ms Morgan thanked the Executives and Dr Davies for their work on this and the Board for the wide-ranging discussion.

The Board of Directors noted the Cancer Deep Dive

Dr Davies left the meeting.

010.23 INTEGRATED PERFORMANCE REPORT

Mrs Foster presented the Integrated Performance Report (IPR) for activity and performance for November and December 2022 with the following key points highlighted:

- December had been a very challenging month with industrial action, bank holidays, very cold weather and an internal, as well as a system wide critical incident just after Christmas, although the position had improved in January.
- Good progress had been made in elective and diagnostics, although there were still some areas of concern such as non-obstetric ultrasound.
- There had been positive action on green to go with further progress expected with the additional funding mentioned in the Chief Executive's Report.



- Reductions in time to hire were evident as a result of the improvements made in the recruitment process.
- It was believed that the Trust would achieve its yearend plan financially, but it would be challenging particularly in the current operational context.

Mr Kirby said that it was commendable that the Trust was the only organisation in Devon that was on track to hit its original target for the year. He noted staff attrition rates and asked whether this was a typical NHS profile or related to the Trust's selection and retention processes. Mrs Foster responded that some of this related to new data that the Board were seeing for the first time, adding that she would be bringing a paper on the Workforce Plan baseline to the next Board meeting which would provide greater detail. She said that retention was a key area of focus, with the introduction of buddy systems and funding being sought for pastoral support for new starters.

Mr Kirby said that the organisation had always benchmarked well on infection prevention and control (IPC) measures and asked whether the Trust might potentially take more risk, and if it did would that impact on throughput and productivity. Mrs Reeves said that the approach taken to IPC had been one of creativity and flexibility, balancing risks, for example cohorting contacts of Norovirus in a different way that has allowed maintenance of the flexibility of the bed base without compromising standards. She added that this had been clearly debated through the command structure as it went outside guidance, and she was confident that the organisation was doing everything it should in a safe way.

Professor Marshall noted that there appeared to have been a significant increase in complaints in Eastern services in the Autumn and asked for clarification of reasons for this. Mrs Reeves responded that themes across complaints were access, waiting for procedures and communication. She advised that the analysis of the data for those three months would come through in the next quarterly report to the Patient Experience Committee. She added that there had been renewed focus on promptly resolving complaints, with some additional resource having been allocated to help close some longstanding complaints. Professor Marshall asked what other patient experience indicators were considered. Mrs Reeves said that this was constantly under review, looking at what other organisations were doing but it was difficult to get measures that could be used consistently month on month that would be meaningful and she would welcome suggestions. It was noted this would be followed up when the next six-monthly complaints report was due.

Professor Kent noted that the green to go figures should start to improve with the national discharge scheme, but it would be challenged by the staffing position in social care and close oversight of this would be very important over the coming months. Mr Tidman said there were senior level discussions underway with Health and Social Care and he had recently attended a Health and Wellbeing Board meeting to review plans going forward. He added that a whole system view was needed to find a joint solution.

Professor Kent noted the increase in international recruitment and asked for assurance that there was sufficient resource in place, given the closure of the training area at the Nightingale, to ensure that the quality of the support offered was not impacted. Mrs Foster advised that the international recruits were coming from a greater number of countries meaning that onboarding work with them had



been quite intense, including pastoral support, help with accommodation etc, as well as new starter surveys and meetings with the Inclusion Lead for the Trust.

Mr Matthews noted that, following the previous improvement in 111 call abandonment, this now appeared to have deteriorated again significantly in December with 40% call abandonment reported. He asked for clarification of who would be holding the new provider to account and what impact this had had for the Emergency Department (ED). Mr Palmer responded that this was an expression of staffing levels, with the 111 service drawing from base Trusts to populate its rota and when Trusts were under pressure and prioritising staff into their own services, this had a knock-on effect. This had been escalated to the ICB as commissioner of the service. With regard to impact on ED, there was a lag on data and no huge change in conversion rates or minors demand was evident in the December report, but this would be tracked through January's report.

Mr Matthews noted in the stroke reporting for discharge home, the North was reporting 70%, with the East reporting 30%, whilst the national average was 20% and asked whether these figures were correct. Professor Harris advised that he would need to look at this outside the meeting. **Action.**

Mr Matthews noted the plan to spend £25m in capital spend in the last three months of the financial year and asked whether the Trust was on course to do this and whether there was confidence that controls could be maintained over this and best value for money achieved. Mrs Hibbard said this happened every year with two contributory factors; firstly, there were always delays in the approval process for national funding through PDC and this impacted spending, however this is built into the timing of plans each year. Secondly, in times when there are very constrained internal capital resources, careful planning with the divisions on use of resource was needed, for example backlog maintenance, and was reassessed each year to look at what cannot be planned for. She said that it was still on track and there was always a plan for contingencies where things may slip, with capital spend that could be brought forward from the next year so that capital limit was not wasted.

Mrs Burgoyne said that it was good to hear about conversations that were taking place with the DAS and the Health and Wellbeing Board and asked whether there was a plan that would demonstrate long term aims and short-term measures, in particular whether there were plans similar to those elsewhere in the system, such as the discharge hotel. Mr Tidman said there were three levels to this; firstly to get agreement with social care partners on joint planning for the next three years; secondly to be clear on how they would be held to account; and thirdly there were short term tactical things that could be done, such as extending agency arrangements, the possibility of incentive schemes to encourage the domiciliary workforce to do additional shifts, and whether there could be a bedded solution. A care hotel was not being discussed currently, but all areas would be explored. He added that this would be looked at in more detail at a future Board Development Day.

Mrs Burgoyne commented that credit should be given for the excellent communications that had been a feature of the last few months and Mrs Foster commended the work of the Communications Team. She added that a lot of work had gone into getting the right tone and messaging in communications about industrial action.



Mrs Burgoyne said that she would welcome input from the Executives on areas of focus for the Patient Experience Committee. Ms Morgan said that the Governors were also considering what contribution they could make to patient experience and would welcome the opportunity to feed into the Committee's considerations.

Mr Neal asked whether there was anything that could be considered at local level to empower managers to recognise when wellbeing was being impacted, as pressures could increase very rapidly and although there were good processes in place overall for managing and monitoring wellbeing, it might not be reactive enough in the current climate of rapidly changing pressures. Mrs Foster said that wellbeing was a focus for all Executive and Trust Directors with it being an agenda item for both Gold and Silver Commands. Psychological safety was particularly important in periods of intense pressure. Efforts had been made to ensure that staff counselling sessions were protected as far as possible and there was ongoing monitoring of leave.

Mr Neal said that he had been pleased to see emails going out over the last few weeks asking for feedback from staff on any lessons learned over the winter period and asked how this would be captured and fed back. Mr Palmer said that the reason these questions had been asked of the organisation was that two connected things had been done over the last 25 days – the bringing together of strategic Gold Command to provide the best governance to manage the frequent requests for escalation and within that the introduction of the Patient Flow Taskforce to strengthen the clinical voice particularly around safety in real time within the organisation. It was also intended to drive a more innovative conversation on what the Trust's frailty model needed to look like for the coming years.

Ms Morgan thanked Mrs Foster and the Executive Team for their responses to a wide range of questions which had provided some important issues to be picked up at future Board and Council of Governors Development Days, including measurement of patient experience and partnership working with social care. **Action.**

No further questions were raised and the Board of Directors noted the IPR.

011.23 TOWARDS INCLUSION

Mrs Tracey advised the Board that, due a change in timing of meetings of the Steering Group for Inclusion, it had not been possible to provide a written report, however this would be addressed going forward. A summary of progress against the plan had been emailed out to Board members at the start of the meeting.

Key highlights noted were:

- Progress against the three areas of focus:
 - Staff priorities there were two areas of focus, promoting inclusive leadership and raising awareness of inclusion issues, and how to debias the recruitment process. Whilst good progress had been made, it had not been at the scale hoped. Five sessions on inclusive leadership had been delivered with 45 leaders attending and a further six were planned during February and March 2023. One of the constraints had been having enough trained staff to deliver the sessions, so a Train the Trainer model was being developed to build in house capacity. With regard to the recruitment process, a new AAC consultant recruitment model would be in place over the coming weeks with



feedback from this to be used to help align overall recruitment processes. In addition, further work would be undertaken over the next quarter to roll this out to leadership posts. Work had also been undertaken to create best practice to help people drive their careers with rollout expected from mid-February. The rollout of the programme would start with the Ethnic Minorities Staff Network and then the Disability and LGBTQ+ Network members.

- Patient priorities the focus had been on how to improve access and communication. A key element was co-production of a patient communications framework to ensure that all information would be produced in a better format and take account of issues that some people faced. The Trust is the first in the country to be accredited as communication accessible. It had been planned to launch the framework shortly, however this had been delayed slightly pending the outcome of a national consultation currently underway on the future of accessible information standards. Communication accessible training was underway, with 14% of staff having completed it in Eastern services and 6% in Northern services.
- Community priorities this has been linked in to work on health inequalities at LCP level and the Trust has been very involved in identifying objectives. This work of the LCP should be concluded towards the end of the financial year. The Trust had also been successful in securing virtual ward funding which should help to address health inequalities in relation to heart failure.

Ms Morgan thanked Mrs Tracey for the personal leadership she was giving to this area of work which reinforced the values of the Trust.

Professor Kay commented that there was a real sense of tangible progress, particularly around the patient priorities and the communications accessible work, and that this, together with the work Mr Tidman was leading on health inequalities through the Task and Finish Group and the work with carers and patients outlined in the Patient Story, were starting to outline a powerful offer for patients. Mrs Tracey agreed that all these key elements needed to be stitched together to make this very real for the local population.

The Board of Directors noted the Towards Inclusion update.

012.23 GOVERNANCE COMMITTEE

Mr Neal presented the update to the Board of Directors highlighting that the overall tone of the meeting had reflected the operational pressures that the organisation was under, managing wellbeing and safety and risk. He emphasised the value of the good quality divisional updates to the Committee. It was noted that the final sub-Committee, the Clinical Effectiveness Committee, was now fully merged across Northern and Eastern and was chaired by Professor Harris. The Committee received the Learning from Deaths report and a follow-up from a deep dive.

No questions regarding the Governance Committee update were raised.

The Board of Directors noted the update.

013.23 KIRKUP REPORT

Mrs Reeves presented the Kirkup Report which set out the consequences of failing to meet national standards. The Board noted that the report contained the findings of an investigation into East Kent which had identified that over a period of eleven



years clinical care in maternity services had often been sub-optimal. This had led to significant harm and the organisation had failed to listen to families and missed opportunities to bring about improvement in clinical outcomes. The organisation took false assurance with the investigation having concluded that outcomes could have been different in 97 of the 202 care episodes reviewed. The report recommended that Boards remained focussed on delivery of personalised, safe maternity and neonatal care, ensuring that experiences were understood and responded to with respect and compassion. Boards were asked to ensure that the report was presented at a public Board meeting and that the recommendations were taken forward fully. NHS England was focussed on the production of a single delivery plan to bring together the recommendations and actions from a number of different reports. The recommendations covered four areas of focus: identifying poorly performing units, ensuring care was delivered with compassion and kindness, team working with a common purpose and responding with challenge and honesty. The report contained clear next steps and the Trust was working with the local maternity and neonatal system who would lead on oversight of the maternity specific elements. The Board was also asked to think about the assurance it had around its own services.

Professor Marshall asked whether patient experience and complaint data could be used to look at broader issues around how staff are feeling about their professional responsibility for how they behave towards patients, which could perhaps help to identify any potential problems at an early stage. Mrs Reeves agreed that there was a real opportunity to think differently about how information could be triangulated differently, not just in maternity services. Mr Palmer said that the Governance Committee had asked for the support of the Royal Colleges for a number of services where there had been concerns. He added that there was increasing confidence in the capability and desire to tackle behaviour in real time if needed. He agreed that more needed to be done in all reporting to triangulate data on quality and safety to make sense of outcome data.

Mrs Foster said that much of the report related to poor culture and reminded the Board that the Trust was developing its cultural roadmap as part of its strategy. The work on a just and learning culture would help to enable staff to act with compassion. Mrs Tracey said that organisational behaviour was an important point for the Board to consider. She was assured that despite pressures, the Board's focus was always on what was right for patients but the Board should consider how it could retain this focus under challenging circumstances. She added that empowerment of staff was a core value of the organisation with staff encouraged and supported to do the right thing.

Mr Kirby agreed with Mrs Tracey that the risk of this happening increased when organisations were under greater pressure in terms of performance and finance. He reminded the Board that when the Ockenden Report had been published they had agreed that the Governance Committee should have delegated authority to have oversight of the action plan and asked whether that decision should be revisited, particularly in the context of the wider conversation about the safety, quality, performance and finance divide.

Mr Kirby said that it was clear from the report that having an open and honest relationship with regulators was vital and he believed that the Board was very open to learn and develop and work with regulators for a joint, common purpose.



Mr Matthews noted that the report mentioned that some issues had arisen due to the way that integration of the Trusts involved had occurred and asked whether this was something the organisation should also reflect on given its own recent merger, in particular how the two maternity units had integrated and the culture. He also noted that there was a focus on the importance of the LMNS role and asked whether this role was sufficiently resourced and had the right authority to conduct this role. Mrs Reeves agreed that integration was key and advised that maternity services at the Trust were further along the pathway of integration than some services. The Trust was currently advertising for an Associate Director of Midwifery role which would help to bring both practice and approaches to supporting students together, as well as leading the governance arrangements across the service, which would help to mitigate some of the slight variations between the two units. The teams were already working together on evidence collation and this was a good example of where there could be learning for both services.

Professor Kay agreed with Mrs Foster that the culture of an organisation was key and advised the Board of work done by the University of Exeter Medical School, which had looked at student clinicians with increased workloads and pressures. This had found that as these increased, student clinicians began to lose empathy and there might be something for organisations to look at in more depth on how training was provided across groups of clinicians to build resilience and remove compassion fatigue. She added that this could also be part of wider inclusion training for staff to look at how to avoid "othering" and recognise and address compassion fatigue. Mrs Reeves agreed that there was a need for vigilance to identify compassion fatigue. She advised that, together with the work that was underway on culture, there were also civility sessions taking place for staff.

Professor Kent welcomed the report and recommendations and said that whilst it was absolutely right to investigate and criticise, it was also important to support all the teams involved in the care of women and newborns, praise where appropriate and support teams to work constructively, to ensure that whilst learning continues and develops, teams feel supported and valued, as otherwise there could be future problems with recruitment and retention in the service. Mrs Reeves agreed and said that the organisation was doing well with recruitment to maternity services across both sites and had recently won an award for the quality of its student midwife programme.

Ms Morgan thanked Board members for a constructive discussion on this very important and sobering report. She said that it would be important for the Board to come back at a future date to look at the overall picture on maternity services.

The Board of Directors noted the Kirkup Report

014.23 | CLINICAL NEGLIGENCE SCHEME FOR TRUST MATERNITY RETURN

Mrs Reeves presented the Clinical Negligence Scheme for Trusts return for maternity services. The Board of Directors were asked to review the presentation and sign-off the evidence presented for compliance for Year 4. The Board noted that currently there were still two separate returns presented, one for Northern services and one for Eastern, but for Year 5 this will have been amalgamated into one return. The Board were reminded that the maternity incentive scheme had been developed to help improve quality and safety and included 10 safety actions for each of which organisations had to demonstrate evidence. Compliance would lead to some financial benefit for the organisation. The deadline for submission of



the return was 2 February 2023. There had been agreement that the Trust could include evidence collected during December 2023 if the Board of Directors were in agreement; the audit report included evidence up to November 2023 and showed 4 out of 10 compliance for one site and 5 out of 10 for the other site, however the further evidence that had been gathered during December demonstrated compliance for the Eastern service, with the 90% target for training having been exceeded and Northern services returning 7 out of 10 compliant with areas of noncompliance relating to training, transitional care facility and the audit of Attain . The return had not been scrutinised through the Audit Committee due to timeframes for reporting.

It was proposed that for those areas where there was a gap in assurance in the audit report presented to the Board, the Audit team should scrutinise the additional evidence collated by the maternity team on 31 January 2023 to provide additional assurance that this evidence supported the proposed compliance position.

Ms Morgan asked whether Board would be sent copies of the Audit Team's assessment of the additional evidence and Mrs Reeves agreed that that could be done. Mrs Hibbard agreed that this would be vital and asked whether there was confidence that the Trust would act appropriately on the Audit Team's assessment if they concluded that they were not assured of compliance. Mrs Reeves said that whilst the Team were confident in the data collected, they were fully accepting of the need for independent scrutiny by Internal Audit to provide an additional layer of assurance that the evidence supported the submission.

Mr Neal suggested that it would be helpful once the final assessment from Internal Audit had been received to review the maternity risks, as some of the scores should have improved.

Mr Kirby suggested that there would need to be an additional step in this process for him and Mr Neal to review the outcome of the Internal Audit review and liaise with the Chair and Chief Executive to advise whether they were comfortable with the submission. He added that he had been surprised, given discussions at Maternity Safety meetings he had attended, at the drift away from where the organisation had expected to be. The Board agreed Mr Kirby's suggestion, adding that Mr Matthews as Chair of the Audit Committee should also be involved in these discussions and provided that Internal Audit were satisfied with the conclusions around the additional evidence, the return would be signed-off for submission by the deadline.

015.23 | ITEMS FOR ESCALATION TO THE BOARD ASSURANCE FRAMEWORKS

Ms Morgan asked whether Board members had identified any new risks or anything to add to existing risks from their discussions.

Mr Tidman suggested that as review of the Board Assurance Framework (BAF) was linked to review of the Corporate Strategy and Roadmap for next year, this should be taken as part of the planned session at the Board Development Day on 2 March 2023, rather than discussion at this Board meeting. This would enable the Board to undertake an environmental scan and review if the risks in the BAF remained the top 10. Mrs Holley commented that whilst she agreed this would be very helpful, discussion of the BAF should remain on the Board agenda as a standard item as good practice.



016.23	Mr Kirby asked whether, given that financial pressure was increasing, with the need to be cognisant of the potential impact of that on safety, patient experience and performance, Risks 4 and 8 needed to be added to in terms of increased vigilance to ensure that values are not compromised. Ms Morgan said that the BAF was on the Agenda for discussion at the confidential Board meeting and this could be explored in more detail then. The Board of Directors noted the comments. ANY OTHER BUSINESS	
	No other business was raised by Board members.	
017.23	PUBLIC QUESTIONS	
	The Chair invited questions from members of the public, staff and Governors in attendance at the meeting.	
	Mrs Matthews said that EPIC had been raised several times in the Board's discussions. Data quality issues were clearly important, as were the advances highlighted by Professor Harris in virtual clinical assessment and treatment support. However, she said that patients and staff continued to question the efficacy of EPIC, seeing it as time-consuming and taking the focus from direct patient care to indirect care and may be a contributory element to staff leaving. She suggested that a note could perhaps be included in patient correspondence, prior to admission to explain why nursing staff were clerking patients in at the bedside on tablets as patients had reported frustration that nurses were spending more time on documentation and not "caring" for patients. Professor Harris responded that many staff found EPIC very beneficial and efficient, for example Community Nurses, Allied Health Professionals, Junior Doctors, Intensivists and Anaesthetists and Emergency Physicians. However, he said that with the introduction of any comprehensive EPR there would be some issues and the Trust was working hard to make sure these were ironed out to ensure both patients and staff got the most benefit from it. He advised that entering patients' details directly on to a tablet or other device meant that it needed to be done only once in real time but agreed there could be a perception issue for patients and accepted Mrs Matthews' point that patients needed to be informed about why things were done differently now.	
	Mrs Matthews said that the transfer of Gastroenterology to Exeter was successful for new referrals, and asked whether the same was true for follow-up of existing, longstanding patients in North Devon. Professor Harris said that there was a difficulty in North Devon with the number of Consultants available to treat Gastroenterology patients. He added that the introduction of EPIC meant that patients from North Devon could now be triaged which had not been possible before.	
	Dr McElderry thanked the Board for their discussion on the Kirkup Report. She noted that the report mentioned a lack of team work between different departments within the maternity and neonatal care services at the Trust involved and the difficulties with joint learning days and some training, such as CTG and fetal monitoring training which would be worrying for any organisation. Ms Morgan thanked Dr McElderry for her observations and agreed that joint working was very	



	important. She commented that in continued monitoring of maternity services, it would be important to also make sure that staff were encouraged and supported to work jointly.	
	There being no further questions, the meeting was closed.	
018.22	DATE OF NEXT MEETING	
	The date of the next meeting was announced as taking place on Wednesday 22 February 2023.	





PUBLIC MEETING OF THE BOARD OF DIRECTORS 25 January 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	Ву	Target date	Remarks
024.22	February 2022	A session to be arranged for the Board during 2022-23 to receive an update on progress on work both at Trust and system level on transforming services, what outcomes are being looked for and how pathways can be changed.	МН	December 2022 February 2023	Update to be provided at September Board. Action ongoing. Update September 2022 – This will be added to the programme for a future Board Development Day. Action ongoing. Update December 2022 – On the list of topics for BDDs 2023. Action ongoing.
158.22	November 2022	Mr Neal asked what the national interpretation was of the ongoing high number of both A&E presentations & Cancer referrals Mrs Tracey agreed to look into this further & provide a fuller update in her next CEO's report to the January Board meeting.	ST	January 2023 February 2023	Update January 2023 – Mrs Tracey emailed Mr Neal regarding this question. Further update to January Board. Action ongoing. Update 25.01.22 - Mrs Tracey advised that cancer would be covered in her CEO's report, as well as through the Deep Dive on the Agenda for the January meeting. There was more work to be done regarding A&E presentations and a further update on this would be brought to the February meeting. Action ongoing.
159.22	November 2022	It was noted in the Patient Story that blister packs were no longer provided for patients which could lead to hospital admissions for some patients not taking medication correctly as a consequence. The Board requested that this be looked at to see if there was anything that could be done to provide blister packs for patients' medication.	СМ	February 2023	Update 14.02.23 – Mrs Mills advised that blister packs were provided by the hospital pharmacies in both Northern and Eastern Services for two weeks for patients who had been admitted already using blister packs, as well as for those patients with a newly identified need. Action complete.

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163.22(1)	November 2022	Professor Kent asked for the next six monthly safe staffing report to include registered Associate Nurse numbers to differentiate from Registered Nurses.	СМ	May 2023	Update 28.12.22 – data requested will be included in next report to May Board. Action ongoing.
163.22(1)	November 2022	Request that next six monthly safe staffing report should include more detail regarding the Weighted Activity Unit for AHPs in Quartile 4 for Northern and Eastern sites.	СМ	May 2023	Update 28.12.22 – detail requested will be included in next report to May Board. Action ongoing.
166.22	November 2022	Mrs S Matthews suggested that the Trust could consider working with GP Surgeries regarding making a confidential space available to patients to access supported IT for virtual appointments. Professor Harris agreed to look into this further.	АНА	January 2023	Update 25.01.23 – Professor Harris advised that a pilot was being setting up at the Castle Place GP Practice in Tiverton and if effective, a conversation would be had with the ICS and LCPS and non-affiliated GP Practices on how this might be taken forward. Action complete.
005.23	January 2023	A number of amendments were requested for the minutes of the November public Board meeting.	GGF	February 2023	Update 26.01.23 – Amendments made. Action complete.
008.23	January 2023	The carer from the Patient Story presented to Board was noted as being involved in work on a number of initiatives relating to improving process carer involvement with care planning for patients with the Director of Nursing for Eastern services. The outcomes and impact of this work should be looked at in due course by the Patient Experience Committee.	СМ	April 2023	Update February 2023 -Next update to April Board. Action ongoing.
010.23	January 2023	Mr Matthews queried the stroke data on page 64 of the Integrated Performance Report relating to stroke as Northern services were reporting achieving 70%, with 30% reported for Eastern services and a national average of 20% which appeared out of kilter. Professor Harris agreed to review this outside the meeting and update Mr Matthews.	Aha	February 2023	Update 15.02.23 – An update has been reflected in the wording of the IPR for Eastern on the agenda for February Board which clarifies the reason for this anomaly. Action complete.
011.23	January 2023	Themes around measurement of patient experience and partnership working with social care to be added to the list of topics for future Board and Council of Governor Development Days.	GGF	February 2023	Update February 2023 – Added to the list of topics for BDDs. Action ongoing.

Signed:

Shan Morgan Chair

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Agenda item:	8, Public Board me	eeting	Date: 22 Februar	y 2023		
Title:	Patient Story: One Northern Devon's High Flow programme					
Prepared by:	Sarah Delbridge, E	Engagement Mana	ger			
Presented by:	Carolyn Mills, Chie	ef Nursing Officer				
Responsible Executive:	Carolyn Mills, Chie	ef Nursing Officer				
	opportunities we processes to mana. The purpose of pro-	have for learnin age, improve and a esenting a patient	g and the effections assure service qualestory to Board men	•		
Summary:	 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 its relevance to the strategic objectives of the Board. 					
Actions required:				ations of this story for our trategic objectives of the		
Status (x):	Decision	Approval	Discussion	Information		
History:	The Royal Devon University Healthcare NHS Foundation Trust's 2022-27 Trust strategy and 2022-25 Patient Experience strategy articulate the Trust's ambition to collaborate and work in partnership with patients, carers, stakeholders and the local community to develop accessible, high-quality and patient-centric services and facilities. This patient story is set within the context of the Trust's strategic objectives: to work in partnership to improve the health of our communities and develop accessible, high quality and responsive services, that outcomes are improved when our patients participate and set out what matters most to them and that place-based partnerships remain fundamental to both addressing health & wellbeing and tackling health inequalities within Devon. From July 2022, Integrated Care Systems (ICS) were formally established across England and within each ICS, new place-based partnerships were created. These partnerships form the foundations of ICS', building on existing local arrangements and relationships to provide collaborative arrangements responsible for leading the detailed design & delivery of health and care services across their localities and/or communities.					



There are five place-based partnerships (Local care partnerships – LCPs) in Devon, including two covering the footprint of the Royal Devon - the Northern LCP and the Eastern LCP. Our Royal Devon colleagues are playing a key role in shaping the development of these new Local care partnerships to ensure that they help enable people to stay well and supported in their own communities; whilst ensuring effective engagement with the voluntary and third sector, focusing on prevention/upstream interventions and addressing persistent and unacceptable health inequalities.

One Northern Devon is one of the key partners of the Northern LCP, consisting of a trailblazing partnership of public services (including the Trust), businesses and voluntary and community groups; with the single ambition to bring together organisations and communities to create positive change and improve the quality of life of residents across Northern Devon.

One Northern Devon's High Flow programme is one such example of where a new approach to partnership working that puts the person at the centre of care is having a positive impact.

High Flow launched in January 2020 and is a personalised and holistic support programme for the 15 most intensive users of public services in Northern Devon.

In this story we hear from Carolyn, one of the people who is supported by the High Flow programme.

The principle of High Flow is to start with what matters to the person and build the services around the person. This approach aims to support people who often have complex needs and under our current model of care would likely have lots of appointments with different services which can be overwhelming and result in potential disengagement with services.

Carolyn has held senior positions working in healthcare and education, and had also worked in the army. Carolyn experienced traumatic events in her childhood and whilst serving in the army, and subsequently her health deteriorated despite having multiple appointments with various different agencies. Carolyn explains how the High Flow approach made a positive difference to her care.

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

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Agenda Item:	9, Public Board Meeting	Date: Wednesday 22 Fe	ebruary 2023
Title:	Strategic Workforce Planning – A Baseline Assessment		
Prepared by:	Philip Pyle, Strategic Workforce Planning Lead		
Presented by:	Hannah Foster, Chief People Officer		
Responsible Executive:	Hannah Foster, Chief People Officer		
Summary:	This paper draws together strategic workforce data intelligence illustrating past performance, workforce supply, demand and the approach to developing strategic workforce planning capability across the Trust from 23/24 and beyond.		
Actions Required:	The Board is asked to review and discuss the information set out in the report.		
Status (x):	Decision Approval	Discussion	Information
		X	
History:	This document reflects the first step in the Trust Strategic Workforce Planning journey, setting out the approaches being taken, the current position and element of workforce planning that have been delivered to date.		
Link to strategy/ Assurance framework:	The strategic workforce plan is an essential enabler to delivery of all four of the Trust CARE 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

The purpose of this paper is to provide the Board of Directors with an assessment of the current position of the Trust in relation to strategic workforce planning. This paper is accompanied by a slide deck, which contains illustrative content.

2. Background

Royal Devon University Healthcare Trust is required to deliver safe, effective and high quality services. This is set against a backdrop of rising population demand, a need to recover to pre-Covid performance levels, financial deficit and ever-increasing workforce supply challenges.

Understanding workforce supply, demand and how as an organisation Royal Devon will develop a sustainable workforce that is capable of delivering within the activity-finance-workforce paradigm, is a core purpose of strategic workforce planning and is inherently linked to the Trust Strategy.

Over recent months the Trust has strengthened its workforce data proposition and is committed to utilising this intelligence to inform the actions needed to sustain and develop our workforce over the next 5-years. This intelligence will support the co-creation of the Trust people strategy, a core enabler to both the clinical and overarching Trust strategy, providing key insights such as long term workforce supply forecasting and alignment to associated enabling strategies such as apprenticeships.

This paper therefore introduces Board members to strategic workforce planning in the context of Royal Devon, by providing an overview of strategic workforce intelligence, current operating context and future focussed strategic workforce planning aims.

3. Analysis

This report and slide presentation introduces Board members to a variety of strategic workforce illustrations, in addition to a baseline capability assessment (appendix 7) that identifies areas for improvement. This report acts primarily as a baseline assessment and therefore future Board updates will build on this grounding by introducing proactive and future focussed insights that act as an early warning indicator.

The majority of data referred to herein is up to and including October '22. The majority of data illustrated is derived from the electronic staff record (ESR) and because none of the illustrations in this report or accompanying slide deck exist in an off-the-shelf format, require complex and resource intensive manipulation. With this report originally intended for discussion at the December '22 Board of Directors meeting, October '22 was the agreed data point. It is recognised that the Board will have seen a more recent data point for two metrics referred to in this report (vacancy and turnover) in other documentation.

Notwithstanding this, a significant amount of work has taken place very recently in respect of the 23/24 operational plan. As a result data contained in appendix 5 introduces a new data point with an operational lens, though this does not

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have a material bearing on other illustrations in this report which look over a much longer term.

In the main the analysis in this report is designed to illuminate a handful of key points that build a high level understanding of workforce supply, how this has changed over time and how this is likely to change going forward. These insights are therefore generally at a high level, though the opportunity has been taken to address specific queries that have emerged from ICB colleagues in 22/23, such as non-clinical workforce growth.

4. Resource/legal/financial/reputation implications

Whilst no immediate implications have been identified from the initial strategic workforce planning exercise, it is expected that any decisions made from this information would likely have a positive impact on resource (in line with 'the 5 rights' described on page 12), with potential financial implications. It should however be noted that by planning for the correct levels of resource to meet demand, this will reduce the risk of unplanned resource requirements needing to be met with temporary workforce, thus mitigating financial impact.

5. Link to BAF/Key risks

Strategic workforce planning is listed as a key action in the BAF risk relating to workforce capacity and will also directly impact a number of other risks on both the BAF and Corporate Risk Register.

6. Proposals

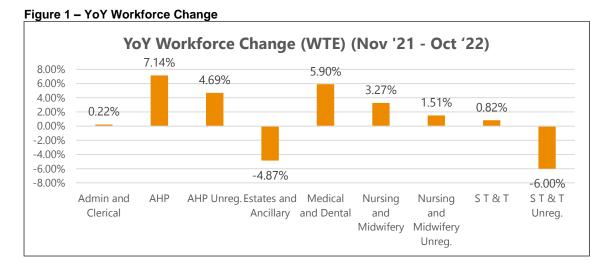
This paper has been written with a view to stimulating discussion. It therefore does not contain any submissions that require approval.



Indicators of Past Performance

The Royal Devon workforce grew by 1,652wte over the 5-year period ending 31st March 2022, representing 17.34% growth overall at an average rate of 3.47% per year. At the end of October 2022 the Trust employed 11,322wte staff and in the six months year to date (as at Oct 2022) workforce growth remains positive, however has slowed to 1.29%.

Over the 12 months (Nov 2021 – Oct 2022), seven of the Trust's nine professional/staff groups experienced positive growth including registered Allied Health Professionals (7.14%), Medical & Dental (5.90%) and registered Nursing & Midwifery (3.27%), however there has been reduction in workforce capacity in Estates & Ancillary (-4.87%) and un-registered Scientific, Technical & Therapeutic roles (-6.00%).

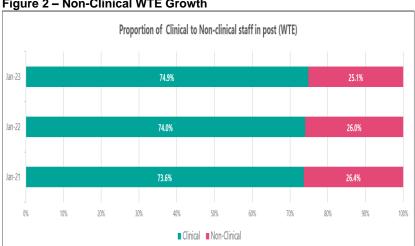


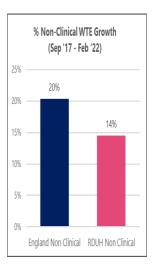
Royal Devon is one of the largest constituent members of Devon ICB and represents 21.7% (13,250/61,200) of the total health & social care workforce employed across the entirety of Devon. With Devon ICB heavily challenged financially, it is understandable that occasional challenges are posed to the Trust and recently there has been a suggestion that Devon as an ICB benchmarks adversely in respect of non-clinical workforce growth, relative to the national average.

It is important for the Board of Directors to note that generalised references have the ability to misrepresent the true Royal Devon picture – analysis illustrated in the below reveals that non-clinical workforce growth across Royal Devon is significantly less than the national average, and, over the last three years the proportion of non-clinical to clinical staff employed has reduced.



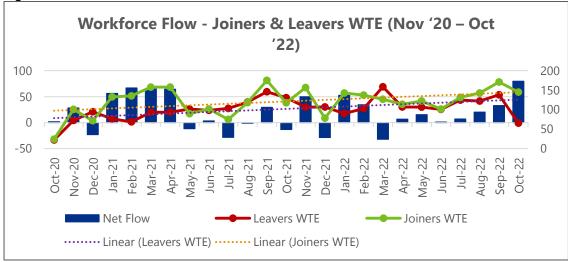
Figure 2 - Non-Clinical WTE Growth





Workforce flow is a measure of net workforce capacity change and aside from statistically minor nuances, is essentially the measured difference between joiners and leavers. Over the 2-year period November 2020 - October 2022, in 17 out of 24 months the Trust has experienced a positive flow of workforce capacity (figure 3), including a noticeable upturn in performance from August '22 onwards buoyed by the impact of the 'accelarating filling our vacancies' programme.





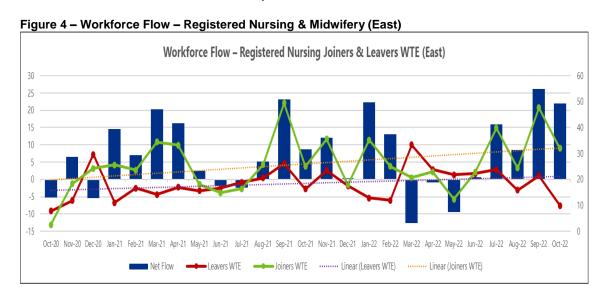
In the main there are many similarities across both North and East in respect of workforce change, right down to staff group level. However, there are at least two clear areas where it is possible to identify significant variation between North and East performance.

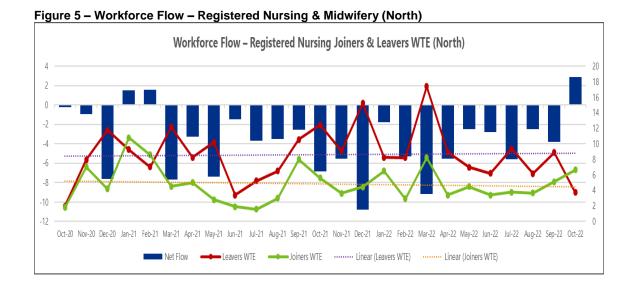
Workforce flow for registered Nursing & Midwifery in the East has been positive and in 18 out of 24 months (Nov 2020 - Oct 2022), the East experienced more joiners than leavers and as a result, an overall increase in workforce supply (figure 4). In the North however, over the same period of time registered Nursing & Midwifery experienced 21 out of 24 months where there were more leavers than joiners and thus the opposite workforce pattern to the East (figure 5).

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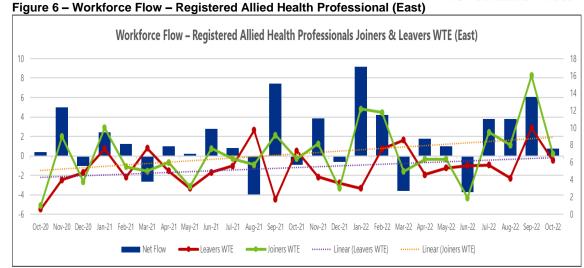
Similarly, the same pattern emerged with the registered Allied Health Professional staff group where over the same period of time, the East experienced growth in 17 out of 24 months, whereas the North experienced regression in 12 out of 24 months. This serves to highlight the importance of understanding North and East workforce patterns in the context of overall Trust performance. With the East containing 2½ times the whole-time equivalent workforce supply of the North, positive Eastern trends will inadvertently mask North deterioration due to the relativity of scale.

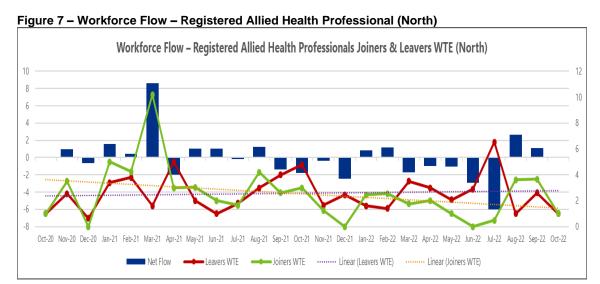






NHS Foundation Trust





Whilst Royal Devon workforce growth on the whole has been positive, albeit not to the extent where Corporate and Divisional risk registers are anything other than inundated with vacancy challenges, understanding the detail behind 'leavers' will contextualise the increasing demands for resourcing and the reliance on pipeline supply.

The loss of workforce supply can be considered through the lens of turnover and leavers data intelligence, with the latter measuring actual volume and the former measuring the proportion of the workforce that has left the organisation over a rolling 12-month period. The volume of leavers across Royal Devon (both North & East) has increased noticeably over the last 2 years, with this translating to a Trust turnover figure of 13.1% in the 12-months up to and including October 2022. Perhaps more dramatic is the attrition observed in this same period of time. Attrition measures the proportion of recruits that have left their role within 12-months of joining and as an organisation and averaged over the last two years, Royal Devon has lost nearly 1 in 5 of all recruits within their first 12 months of joining. Therefore, with the Trust intending to increase its planned workforce capacity by 185wte in 22/23; the need to ameliorate 1150wte vacancies held as at March 2022; managing to retain only 87% of the workforce that it employed 12 months ago and losing nearly 1 in 5 recruits, the demand for recruitment volume in the near term and strategic workforce planning in the long term, has never been greater.

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Workforce Supply

Royal Devon University Healthcare Foundation Trust employs 13,250 staff (headcount as at September 2022), with 9,583 employed in the East and 3,667 employed in the North. There are four clinical divisions in the East with Specialist services holding the highest headcount of 2,514 and Community services the lowest at 1,288. In the North there are three clinical divisions, with Clinical Support & Specialist Services containing the highest headcount (1,471) and Medicine the lowest (722).

There are noticeable differences in the composition of the East and North workforce (appendix 1), both in respect of professional mix and banding profile. The East is characterised by a traditional NHS staffing model, with the highest volume of workforce contained within the Band 5 and Band 2 pay grades. This is consistent with the size of the registered and un-registered Nursing & Midwifery staff group in the East, which represents 39% of the total East workforce. In the North however, there is significantly less workforce capacity at the band 2 level and whilst registered and un-registered Nursing & Midwifery is intended to contain the greatest concentration of the North workforce, the reality of a heavily challenged vacancy position actually results in the greatest amount of workforce capacity residing in administrative and clerical roles.

There are also notable profession specific differences in the availability of workforce supply in the North compared to the East. As an organisation that employs 13,250 staff, for every individual employed in the North, 2.61 individuals are employed in the East i.e. a ratio of 2.61:1. Imaging, Pharmacy and Medical Consultants stand out as services/roles where a numerical inequity exists, relative to the Trust ratio as illustrated in the below table:

	Ratio of Workforce Supply East:North
Trustwide	2.61:1
Imaging Professionals	4.32:1
Consultant	3.55:1
Pharmacy	3.48:1

Anecdotally, stakeholder intelligence suggests that workforce challenges in the North are long standing and, in some cases, severe. As a result, the North has had no option but to devise forward thinking workforce solutions on account of 'off the shelf' registered workforce supply simply not being available. In the East, there is evidence of workforce issues that have historically afflicted the North now manifesting.

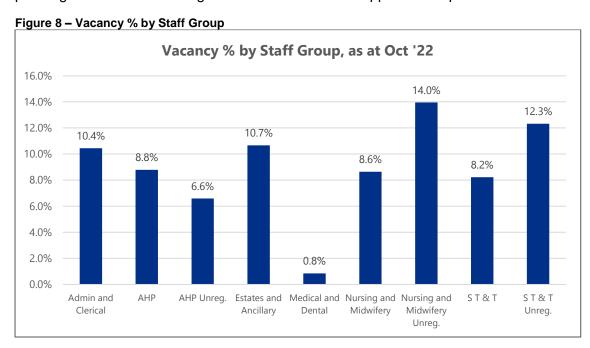
Workforce supply can be quantified by viewing the Trust's vacancy position, which at the end of October 2022 stood at just short of 9%. Digging a little deeper though, it is evident that all staff groups face some degree of challenge, with registered Nursing & Midwifery (8.6%) and Un-registered Nursing & Midwifery (14%) notable examples, particularly considering the size of these staff groups.

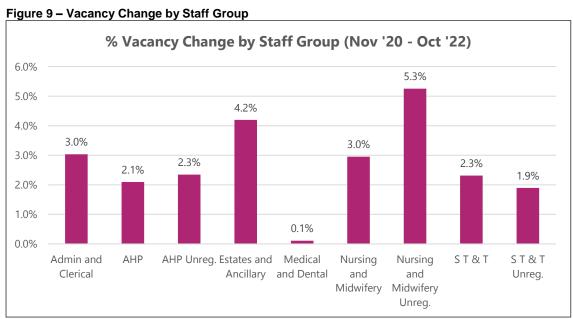
This is where understanding the distinction between workforce growth and vacancy is important in understanding whether sufficient workforce capacity exists to deliver the desired level of activity. We saw in figure 1 that the registered Nursing & Midwifery staff group had experienced year on year growth of 3.27%, yet we also note this staff group containing an increasing number of vacancies (figure 9). This is because the level of

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WTE growth achieved has not managed to keep pace with the level of WTE demand. As a result and despite significant progress made in driving recruitment volume and for example tapping in to the 'new to NHS recruitment source', there is a clear need to continue driving registered Nursing supply in particular, in the near term targeting international recruitment as a means of bolstering near term resourcing requirements pending the fruition of strategic interventions such as apprenticeships.





With a suboptimal labour market and operational workforce capacity disrupted by increasing sickness levels and the legacy effect of Covid, Royal Devon places a reliance on contingency staffing arrangements through bank and agency. Temporary staffing arrangements are delivered on an East and North basis. In the East, there appears to be a sizeable volume of individuals that hold a bank contract, whether as their only role with the Trust or as a secondary assignment in addition to a substantive contract of

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employment. In the North, there is far less bank resource to call upon with only 19% of the bank only contract volume of the East, and, where only 16% of staff with a North substantive contract hold a secondary bank contract (East – 30%). Interestingly though the bank arrangement in the North appears to be relatively effective, at least on the registered and un-registered Nursing & Midwifery front. In the period Nov 2021 – Oct 2022, 60% of all bank shift requests were filled (vs. 44% East) and subsequently less agency spend was incurred (appendix 2).

The remaining dimension to consider workforce supply through is that of workforce demography, in particular the organisation's age profile and exposure to retirement risk. In the context of vacancy, turnover and attrition challenges already identified, it is necessary to understand the role an aging workforce will have in determining the net workforce supply available with which to deliver services. Analysis of Royal Devon's age profile has revealed that the average retirement age across the organisation is 61yrs, with this varying across staff groups ranging from registered Nursing & Midwifery (58yrs) to Estates & Ancillary (63yrs). In time it is expected that as occupational pension schemes harmonise and the state retirement age continues to stretch, the Trust's retirement age will increase also. However, this won't materialise for some time yet and therefore a retirement forecast will need to be incorporated in any future projections of workforce supply and recruitment demand.

At this point in time it is important to note that assuming current retirement patterns continue, Royal Devon will for example lose circa 140 registered Nursing & Midwifery staff in the next 12 months due to retirement alone. There are also a further 447 registered Nursing & Midwifery staff between the ages 51-55yrs, that are between 3 and 7 years away from retirement (appendix 3).

Workforce Demand

A number of well-known factors including; population growth, patient complexity and deprivation combine to drive demand for health and care services. Generically these characteristics are evident up and down the country to a greater or lesser extent and so to understand what this means for Royal Devon, these factors have been analysed, specifically in the local context of the South West and Devon ICB (appendix 4).

In 2021 the UK had 12.6million people aged 65yrs+, equating to 18.5% of the total population. Of the four countries that comprise the UK, Wales is the oldest with 21.2% aged 65yrs+, followed by Scotland (19.4%), England (18.2%) and Northern Ireland (16.9%). Within the UK, older populations are unevenly distributed, particularly in local areas with low population density in rural and coastal areas. Overall, in 2021 24.8% of the population in rural towns and 27.7% of coastal communities were aged 65yrs+. Consistently, younger populations are concentrated in larger towns and cities e.g. Greater London where only 12.2% of the population are 65yrs+.

Population ageing is a worldwide phenomenon and over the next 30 years the global number of older people is expected to more than double, driven by a combination of factors such as those born in the 'baby boom' 1950s & 1960s entering old age from 2022; improvements in life expectancy and improved living standards. Between 2020 – 2042 the UK population is expected to increase by 7.15%, though for the South West and Devon ICB this will reach 11.46% and 11.70% respectively. The Devon ICB population is expected to increase from 1.2m to 1.36m by 2042, with 30.66% of residents aged 65yrs+, compared to 24% in 2021.

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The demand for health and care services should not solely be considered through the lens of linear activity increases, but also in the context of patient complexity. At present in Devon 72% of patients that have more than one long term condition and 88% of patients with more than two long term conditions are aged 50yrs+. With multiple long-term conditions concentrated in the elderly population and having established the expectation of significant growth in the ageing Devon population, it would be logical to conclude that Devon will face increased exposure to both volumetric and complexity based demand for health and care input.

A final indicator of demand potential to consider in this summary is deprivation. There are many measures of deprivation including, but not limited to, income, employment, health, education, crime and living environment. These indicators are consolidated into a singular Index of Multiple Deprivation (IMD) and this reveals that Devon ICB is regarded as an area of high deprivation. Alongside the population growth, aging population and rurality of many Devon localities described above, deprivation is an additional layer of complexity for Devon to contend with. When considering each of these factors alongside one another and when benchmarked against the South West and national average, these population metrics suggest Devon is one of the most challenged ICB's.

Workforce planning is the process of understanding the demand for people and skills, identifying the gap between this demand and existing workforce supply, and, then developing a strategy that optimises the demand/supply balance. In the NHS workforce demand is typically viewed on a short term basis with workforce planning focussed on an annual operational planning cycle, rather than looking ahead to the development of workforce plans that mitigate future workforce trends, such as retirement. The Trust is currently developing its approach to workforce planning to ensure that it offers both a significantly strengthened approach to operational planning, but also that it develops the sophistication to undertake strategic workforce planning from 23/24 and beyond.

The approach to strategic workforce planning is outlined below and so for the purposes of this workforce demand summary, the 23/24 operational plan is the mechanism for understanding workforce demand in the near term. The workforce component of the operational plan seeks to triangulate a forecast of the WTE level workforce the Trust expects to have in 23/24, against the activity level the Trust expects to deliver and within the financial means available. A summary of the 23/24 workforce plan is contained in appendix 5 and sets out in WTE terms the workforce growth expected in 23/24 and how in year savings of £23.9m will be delivered. The 23/24 workforce plan has a clear commitment to a significant reduction in agency utilisation, with this predicated on a business case to centralise bank arrangements that has received triple lock approval.

With the operational planning process accompanied by planning guidance that sets out national priorities that drive the recovery of services across domains such as RTT, Cancer and Diagnostics, having a strong grasp of strategic workforce intelligence will ensure that operational performance expectations are understood in the context of workforce issues and emergent risk. The NHS typically reports on workforce KPIs such as vacancy, sickness and turnover and whilst this is helpful in understanding why operational performance might have been impaired, it doesn't look ahead and forecast the future workforce position. Appendix 6 contains an example of analysis undertaken in respect of a service that has a key role within cancer performance and demonstrates

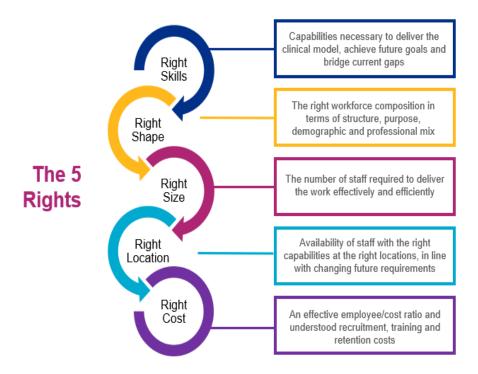


the type of strategic data insights that will be used to support service planning going forward.

Strategic Workforce Planning

Strategic workforce planning is the process of generating and analysing information to inform future demand for people and skills. It defines future workforce requirements, establishes the gap between the present and the future and then translates this in to a set of actions designed to achieve the desired workforce model and mitigate risk.

Strategic workforce planning has five core objectives as summarised in the illustration below.



In order to achieve these five objectives and ultimately develop a plan on how workforce will play its part in the delivery of high quality, efficient services both now and well into the future, it is necessary to establish enabling building blocks that will underpin the Royal Devon approach to strategic workforce planning going forward.

These building blocks are captured within the below strategic workforce planning aims, which have been designed to reflect stakeholder feedback, the findings of the capability assessment (appendix 7), and, strategic workforce planning best practice.



Strategic Workforce Planning aims

Embedded

• Strategic workforce planning is routinely undertaken across all Divisions, aligned to business planning and anchored within Divisional/Trust workforce governance arrangements.

Collaborative

•Strategic workforce planning is a collaborative effort, approached in partnership between HR Business Partners, clinical & operational teams and inclusive of supporting stakeholders.

Connected

• Strategic workforce planning is expressly connected to Trust strategy, key enabling strategies and initiatives.

Insights

•Strategic workforce planning is informed by a breadth and depth of high quality workforce intelligence insights.

Methodology

• Strategic Workforce Planning is robust, focussed on long term workforce solutions and applied using a consistent methodology.

Embedding

It is important that strategic workforce planning is regarded as a business as usual activity, with senior clinical and operational colleagues responsible for leading services, routinely on the pulse of evolving service and workforce requirements. It is also necessary that a mechanism exists that allows opportunities and risk to be escalated, whilst providing Divisional Triumvirates with assurance that strategic workforce planning is taking place at speciality level.

Collaborative

A significant shift is required in the way in which the Trust approaches workforce planning at Divisional and service level. Workforce planning is a process that is enrichened when it is approached as a collaborative effort, where colleagues from different professional backgrounds and services come together and jointly devise a workforce solution.

The initial shift in the Royal Devon approach will be to empower People Business Partners to work strategically and facilitate workforce planning at speciality level in partnership with clinical and operational peers. This widened involvement will also seek to involve the contributions of Finance and BI colleagues and depending on the service concerned, will also seek to involve neighbouring specialities where there is an obvious link in the patient pathway i.e. pathway-based workforce planning.

Connected

Royal Devon has undergone significant change in recent times and as a result there are a number of emergent strategic priorities, including integration, clinical strategy, digital strategy, people strategy and the Our Future Hospital Programme. In the meantime, many day-to-day service delivery challenges exist and in support of this a variety of initiatives are in place and designed to combat these very staffing challenges.

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The role of workforce planning in this context is to act as the glue in the middle, paving the way for services to link, influence and take advantage of a variety of talent, resourcing and transformation initiatives.

Insights

In order to understand workforce supply, demand, demography, trends, gaps and emergent risk, Royal Devon needs to establish a breadth of accurate and reliable strategic workforce intelligence. As with the majority of NHS provider organisations workforce data is typically focussed on present day performance against KPIs and general reporting. Whilst this requirement will remain, specific strategic workforce planning data will be developed and provided to those responsible for undertaking workforce planning, enabling strategic workforce decisions to be informed by previously unearthed workforce intelligence.

Methodology

In order to determine 'the workforce plan' it is necessary to follow a robust strategic workforce planning process, applied with widespread consistency across the Trust and delivered with the necessary level of skill, such that the adoption of a workforce planning process delivers meaningful value.

A Royal Devon strategic workforce planning process, toolkit and skills development all feature as initiatives that will support colleagues to undertake workforce planning at service level, in turn becoming the workforce methodology that Royal Devon is well versed and reliant upon, as the Trust plans its future.

Conclusion

This report acts as the first step in introducing Board members to strategic workforce data insights, factors driving workforce demand and our organisation's existing level of strategic workforce planning capability. In conclusion, the key points are as follows;

- As an organisation Royal Devon University Healthcare Trust has grown by 17% over the last 5 years.
- The vast majority of staff groups have experienced year on year growth (Nov '21-Oct '22), however this is not necessarily sufficient to keep pace with WTE demand.
- Non-clinical WTE growth across the organisation is managed and compares favourably when benchmarked.
- The rate at which staff are joining the organisation has steadily increased over the last two years, though this is countered by an increasing rate of leavers.
- The rate of retention has steadily decreased from 82.6% to 78.6% over the last two years.
- The aging of the Trust workforce is a risk to the Trust's ability to replenish and stabilise workforce supply, particularly across the registered Nursing & Midwifery staff group.
- Attrition of new starters is high, with 18% of new starters opting to leave their new role within the first 12months of joining.
- Population growth and in particular the aging of the Devon population, will represent an added layer of demand complexity relative to other ICBs.



In order to deliver the required £23.9m operational plan CIP saving a significant (£8.5m) year on year agency reduction will be required, with the remainder being delivered through a managed level of vacancy.

 The capability to deliver and operationalise strategic workforce planning across the organisation is in its infancy.

Recommended Next Steps

Having established a baseline understanding of the Trust's workforce supply, factors that will drive demand and the need to develop strategic workforce planning capability it is proposed that:

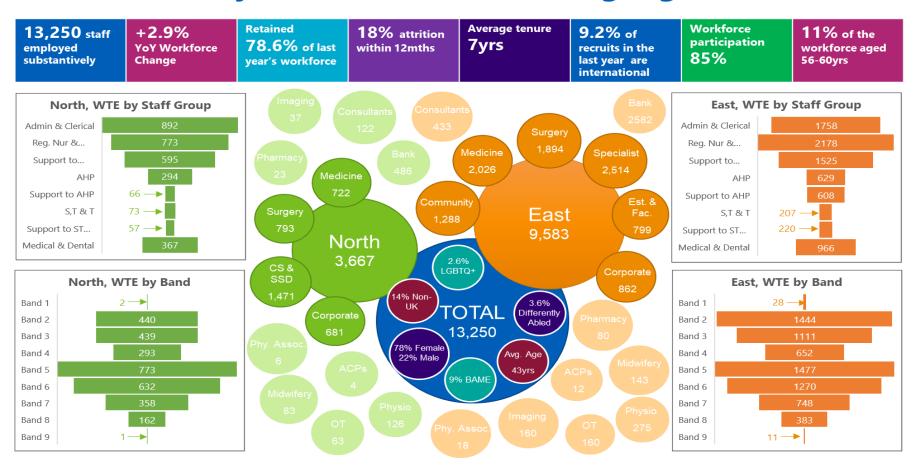
- Dashboard style workforce metrics are introduced to the Divisional Performance Assurance Framework (PAF), enabling improved divisional oversight of issues and risk that stimulates a need to undertake workforce planning.
- Building blocks associated with the five strategic workforce planning aims described above are established and allowed time to mature, including but not limited to the development of a strategic workforce planning data toolkit, strategic workforce planning methodology and delivery of training.
- A plan to operationalise strategic workforce planning within Divisions is developed, including a schedule of focussed workforce planning activity and Divisional governance mechanism.
- In view of the North/East difference identified in respect of registered Nursing & Midwifery and Allied Health Professionals, a targeted plan for the North is developed and monitored.
- Metrics are developed to enable an advanced level of scrutiny of performance against the 23/24 operational plan.
- The development of strategic workforce planning capability and maturity features in six-monthly updates to the Board as part of the People Plan update.



Appendix 1

Data as at Sep '22

Royal Devon Workforce Highlights





44% of

bank shifts

filled

10

ST&T

nursing/HCSW

13

S T & T Unreg.

11.7 average

number of bank

hours worked

per month

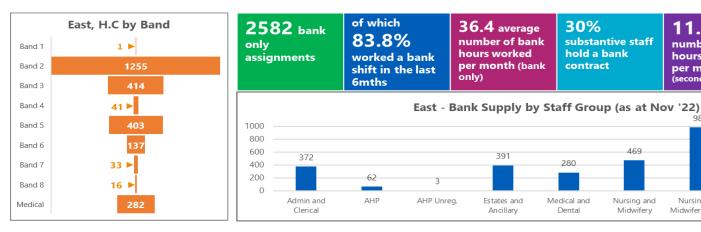
(secondary)

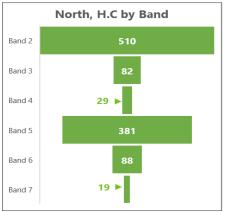
Nursing and

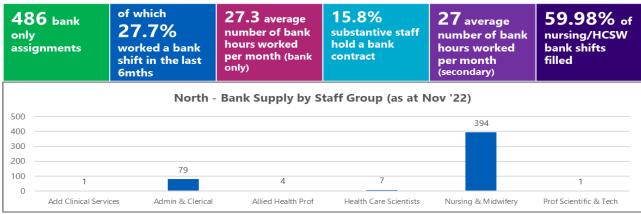
Midwifery Unreg.

Appendix 2

Temporary Workforce Overview



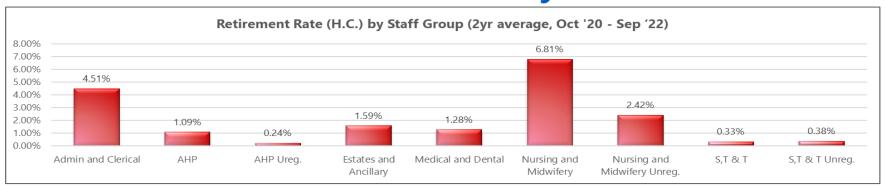






Appendix 3

Retirement Analysis

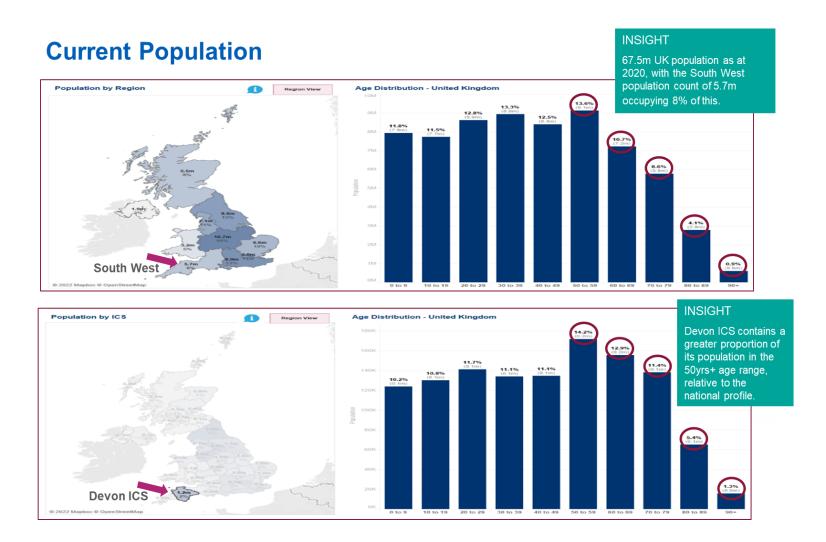


		Ave	rage age of	f Retiremen	t (2yr. avera	ige)		
62	60	62	63	60	58	61	59	61
Admin and Clerical	AHP	AHP Ureg.	Estates and Ancillary	Medical and Dental	Nursing and Midwifery	Nursing and Midwifery Unreg	S,T & T	S,T & T Unreg.

Average age of Retirement for the	61	Retirement Potential by Staff Group												
whole Trust (2 yr. average)	61	51-5	55yrs	56-6	56-60yrs		5yrs	66-70yrs		71 y	/rs+			
		H.C	%	H.C	%	H.C	%	H.C	%	H.C	%			
Admin and Clerical		488	15.9%	415	13.5%	280	9.1%	75	2.4%	17	0.6%			
AHP		120	10.5%	107	9.4%	28	2.5%	4	0.4%	1	0.1%			
AHP Ureg.		49	7.5%	64	9.8%	43	6.6%	5	0.8%	0	0.0%			
Estates and Ancillary		120	15.3%	127	16.2%	115	14.7%	19	2.4%	17	2.2%			
Medical and Dental		154	10.0%	89	5.8%	40	2.6%	11	0.7%	5	0.3%			
Nursing and Midwifery		447	12.5%	385	10.8%	182	5.1%	34	1.0%	3	0.1%			
Nursing and Midwifery Unreg.		240	12.4%	210	10.9%	133	6.9%	19	1.0%	7	0.4%			
S,T & T		37	11.5%	26	8.1%	12	3.7%	4	1.2%	0	0.0%			
S,T & T Unreg.		37	10.8%	26	7.6%	16	4.7%	1	0.3%	0	0.0%			



Appendix 4





Population Projection

INSIGHT

Devon ICS population is forecast to rise from 1.2m to 1.36m by 2042. Of the 1.36m, almost 1 in 3 (30.66%) will be aged 65yrs and over (up from 24% in 2021).

National South West Region Devon ICS



+7.15% population growth overall

+11.46% population growth overall

+11.70% population growth overall

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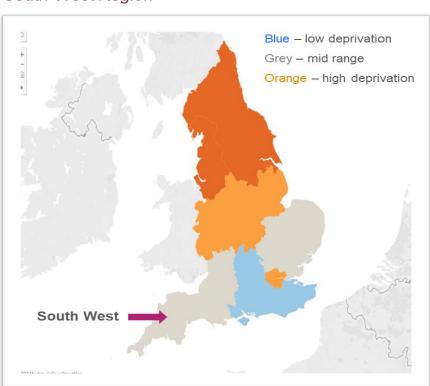
Index of Multiple Deprivation

INSIGHT

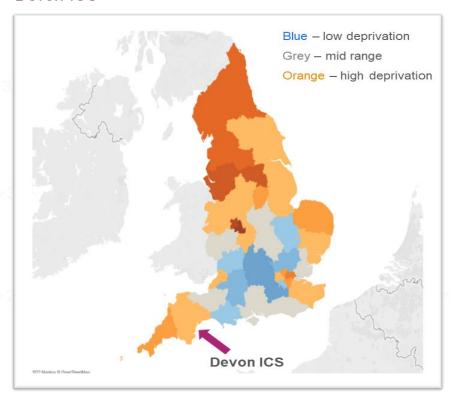
SW Region Index of Multiple Deprivation (IMD) score is 18.24, versus national average of 21.44, rating SW as 3rd least deprived nationally (of 7 regions).

Devon ICS, however, has an IMD of 20.22, ranking Devon as 17th highest of 42 ICBs'.

South West Region



Devon ICS



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Appendix 5

23/24 Operational Plan (Final Submission)

	Establishment	Baseline						Plan							Establishment
Scenario 3 (Final submission)	End of Year Mar-23	Staff in post outturn (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	End of Year Mar-24
	Funded WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Funded WTE
Total Workforce WTE	12314	12267	11992	11947	11947	11942	11957	11973	12012	12037	12057	12062	12087	12072	12328
Substantive WTE	12314	11447	11318	11263	11224	11206	11242	11276	11360	11409	11472	11480	11526	11568	12328
Total Bank	0.00	553	471	517	555	566	544	522	472	443	405	400	373	347	0.00
Total Agency	0.00	265	202	167	168	170	171	174	179	184	179	181	188	156	0.00

Notes & Rationale

- Plan delivers £23.9 CIP saving as per scenario 3, including;
 - o £15.3m substantive workforce saving via vacancy management
 - o £8.6m agency saving
- Forecast (planned) WTE based on actual workforce growth experienced in 22/23, then adjusted to ensure a managed average vacancy gap of 320WTE per month.
- Bank forecast based on 22/23 WTE utilisation, adjusted to account for forecast annual WTE growth and profiled to account for seasonality.
- Agency forecast based on 22/23 WTE utilisation, adjusted to account for forecast annual WTE growth, 23/24 CIP saving and profiled to account for seasonality.
- o 23/24 Agency forecast equates to a 89WTE per month reduction in agency utilisation relative to 22/23

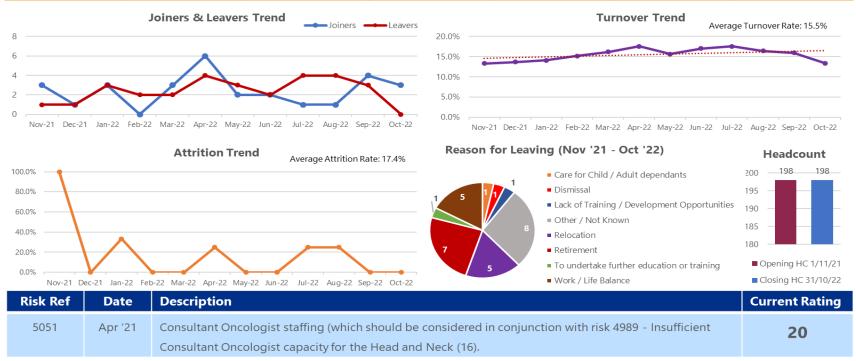
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Appendix 6

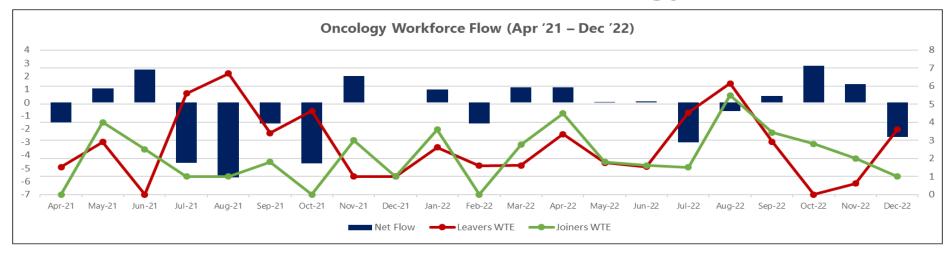
CANCER SPOTLIGHT – Oncology (East)

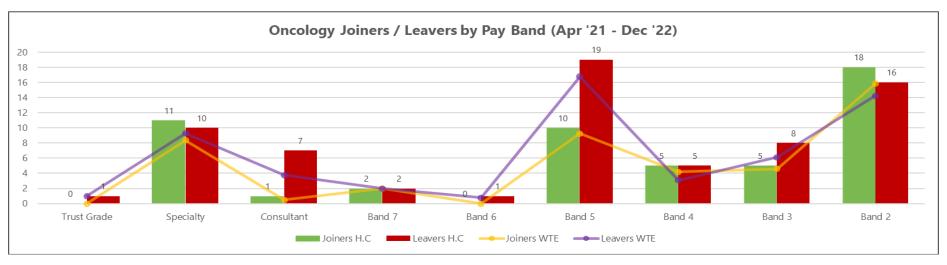
		Average (Nov '21 – Oct '22)				
Headcount	Funded WTE	Contracted WTE	Vacancy WTE	Vacancy %	Turnover %	Sickness %
198	196.4	174.6	21.8	11.1%	15.5%	8.3%
YTD Perm Pay Budget	YTD Perm Pay Spend	Variance £	Bank Spend YTD £	Agency Spend YTD £	Overtime YTD £	% Pay on Bank/Agency
£5,730,632	£5,728,810	-£1,821	£94,021	£282,929	£91,438	6.17%





CANCER SPOTLIGHT – Oncology (East)

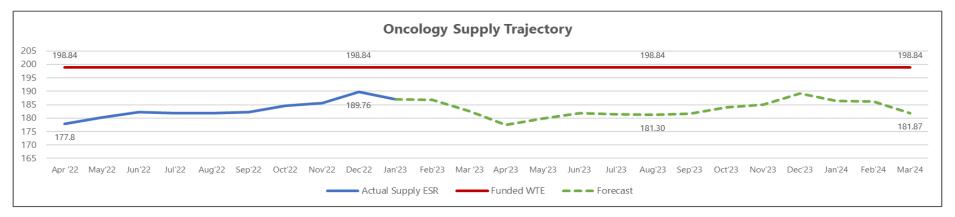






CANCER SPOTLIGHT – Oncology (East)

Funded WTE as at Jan '23	Actual WTE as at Jan '23	Variance to M10 Funded WTE		Variance from M12 22/23 Funded WTE	Forecast Variance to M12 22/23 Funded WTE	N/17 72/7/	Variance from M12 23/24 Funded WTE	
100.04	107.07	11.77	100.04	11.77	16.23	100.04	11.77	16.97
198.84	187.07	5.92%	198.84	5.92%	8.16%	198.84	5.92%	8.54%



Workforce Supply	Apr '22	May'22	Jun'22	Jul'22	Augʻ22	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
Actual WTE (ESR)	177.80	180.26	182.29	181.90	181.78	182.21	184.53	185.57	189.76	187.07														
Funded WTE	198.84	198.84	198.84	198.84	198.84	198.84	198.84	198.84	198.84	198.84	198.84	198.84	198.84	198.84	198.84	198.84	198.84	198.84	198.84	198.84	198.84	198.84	198.84	198.84
Forecast WTE										187.07	186.63	182.61	177.38	179.80	181.81	181.42	181.30	181.72	184.01	185.04	189.13	186.41	186.17	181.87

	Department	M12 22/23 WTE Outturn	M12 22/23 Forecast Vacancy WTE	M12 23/24 Funded WTE	23/24 Forecast Turnover (excl. retirement)	23/24 Forecast Retirement	23/24 Recruitment Demand (WTE)	23/24 Recruitment Demand (H.C)	22/23 Recruitment Delivered M9 22/23 (H.C.)
Onc	ology (East)	182.61	16.23	198.84	30.99	5.05	52.27	61	29



Appendix 7

As the Royal Devon University Healthcare NHS Foundation Trust develops its approach to strategic workforce planning, the opportunity has been taken to inform this with a baseline assessment of current strategic workforce planning practice. The methodology informing this assessment included a survey issued to in excess of 75 clinical and operational leaders with a responsibility for workforce planning across North & East, and, qualitative feedback collected through informal interviews conducted with a similar stakeholder audience.

Findings are set out below and have been thematically compiled to represent a Royal Devon narrative aligned to the envisaged Royal Devon strategic workforce planning process below.



Step 1 - Define

The first step in the planning process is to stipulate why a workforce plan is necessary and outline the challenge that is to be addressed. Best practice activity within this step should include:

Alignment between the intended plan and broader organisational strategic aims.

- Sensitivity to the needs of service users and organisational processes.
- A clear definition of current challenges and underlying drivers.
- Understanding of the goals and benefits of change.



What are we doing well?

Both qualitative stakeholder feedback and the findings of the capacity & capability survey provide evidence of encouraging practice, with over 40% of survey respondents having the strategic direction of the service and more than a 1 year horizon in mind, when considering future workforce requirements. The emergence of the Trust's clinical and digital strategy will further enable this.

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What should we look to improve?

Despite the suggestion that the long-term features as a consideration within workforce planning decisions, 79% of those surveyed stated that being faced with a vacancy was the activating thought that led to workforce needs being considered. This suggests that workforce planning is approached as a one-off exercise driven by necessity, rather than as an embedded strategic planning routine.

Step 2 – Assess

Step 2 in the planning process involves the assessment of existing workforce supply, using largely quantitative means to understand workforce demography, capacity, capability and composition. Best practice activity within this step should include:

- Clear understanding of workforce supply supported by accurate, reliable data.
- Ability to forecast workforce change across a breadth of workforce insights including flow, joiners, leavers, attrition & retirement.
- Understanding of assumptions underpinning workforce design e.g. recognised staffing standards and productivity.
- Data, both available and easy to use, informing strategic workforce planning conversations.



What are we doing well?

There is a widespread understanding of the need to consider workforce data and though self-reliant, there are some good examples of practice led by HR Business Partners where clinical and operational teams are introduced to KPI and demographic workforce information.

What should we look to improve?

The vast majority of feedback suggests that where data is utilised to inform a strategic workforce discussion, it is limited in its breadth, isn't holistic and doesn't offer insights that enable trends to be understood or forecasts to be projected. It is also clear that workforce planning specific data is not routinely produced at organisational level and the prospect of clinical and operational leads having to independently source data, is a deterrent to strategic workforce planning.

Step 3 – Understand

This step in the planning process should identify the workforce required to meet the predicted service needs. Best practice activity within this step should include:

- Understanding of required skills and competencies, rather than the taxonomy of current roles and professions.
- The ability to shape workforce design and re-organise clinical/operational responsibilities around changes in working practices.
- Job design that identifies the most effective combination of skills and competencies, approached from a pure perspective outside of the rationality of finance and talent supply.

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 Understanding of forecast workforce capacity requirements, across both operational and strategic planning timeframes.



What are we doing well?

Stakeholder feedback suggest a reasonable degree of agility in respect of how future workforce requirements are identified. This is largely dependent on professional discipline where alongside examples such as the Salford nursing skill mix tool, national benchmarks, insights derived through academic partnerships and forecast activity data, are all used to forecast future workforce need.

What should we look to improve?

There appears to be considerable variation in the extent to which the positive practice described above is implemented across the board. On balance the majority of feedback indicates that a consistent methodology to inform future workforce requirements is not in place and as a result, it is difficult to take assurance that the plan proposed is indeed the 'right plan', or at least a plan that is cognisant of a variety of operational and strategic interdependencies.

Step 4 - Model

Step 4 of the planning process measures the gap between existing workforce supply (step 2) and the future desired workforce model (step 3). Best practice activity within this step should include:

- A robust understanding of current workforce availability (preferably using the lens of skills and competencies).
- Quantification of latent existing supply within the workforce (e.g. unused bank /locum hours).
- Translation of historical workforce behaviours and trends into forecast plans e.g. flow analytics.
- A gap analysis of the difference between the current and target workforce model in terms of capacity, capability and composition.



What are we doing well?

At organisational level there is a good understanding of workforce challenges across a range of professional disciplines. As a result, there is evidence of strategic talent and resourcing activity that is designed to build the skill and competencies that Royal Devon will need in the future, thus addressing the anticipated talent and capacity gap.

What should we look to improve?

The extent to which the above is informed by reliable data and the extent to which Divisions' are connected to corporately driven talent and capacity strategies, offers room for improvement and indeed is being actively addressed at this time. At speciality

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level in particular where today's operational delivery is always the most urgent of demands, it is often difficult to stay abreast of corporately led initiatives designed to support such challenges.

Step 5 - Design

This step in the planning process is focussed on setting out the specific actions that are necessary in order for the target workforce model to be achieved i.e. this is 'the workforce plan' action plan. Best practice activity within this step should include:

- Exploration of initiatives that allow existing workforce resource to be optimised.
- Strategies that deliver talent acquisition.
- Strategies that develop existing talent and enable workforce transformation.
- Clear understanding of responsibilities and accountability for delivery of workforce action plan.



Basic Practice Intermediate Practice Advanced Practice

What are we doing well?

Where this is done well in the organisation a common theme emerges with a team approach taken to identifying how present day challenges might be overcome, and, how future challenges might be mitigated. Relationships with HR and finance colleagues are then relied upon to assess feasibility and progress with implementation, in turn boosting delivery prospects.

What should we look to improve?

Stakeholder feedback suggests that in the main, the identification of workforce improvement initiatives at speciality level is opportunistic and often as a result of a funding opportunity, or a particularly severe problem that needs to be addressed. Whilst workforce planning processes in Royal Devon should look to retain the agility to respond to new opportunities, a systematic and consistently applied approach to workforce planning will enable greater consensus and sharing of delivery responsibilities when implementing the workforce plan.

Step 6 – Evaluate

Step 6 of the planning process provides the mechanism within which to measure progress against the workforce plan action plan. Best practice activity within this step should include:

- Implementation of workforce plan monitored routinely and embedded within an appropriate governance mechanism.
- Measured impact assessment of initiatives implemented to date.
- Evaluation of initiatives implemented to date, leading to expansion/refinement of plan.
- An on-going outward looking perspective and 'what if' adjustment to plan as the strategic workforce planning landscape evolves.

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Basic Practice Intermediate Practice

Advanced Practice

What are we doing well?

Robust evaluation is often something organisations subconsciously compromise on, such is the desire to progress with the next improvement goal. Informal interviews with senior clinical and operational leaders have endorsed this sentiment and as a result, consideration is actively underway in regard to how strategic workforce planning is embedded and how Royal Devon might answer the question of 'how do you know it's working?', in the future.

What should we look to improve?

A key theme to emerge from stakeholder feedback is the need to assess whether the intended benefit of an improvement initiative has been realised, once implemented. There is a sense that a conveyor belt of discrete improvement initiatives has emerged over recent years, yet the impact of this has potentially not been assessed to a full enough extent or translated into a change in the workforce model, that for example might lend itself to strategic priorities such as improved productivity.



Glossary

Workforce flow, represents substantive (permanent & fixed term) workforce stock 'in' & 'out'.

Head Count, is the number of individuals employed substantively (permanent & fixed term) at a given point in time. NB individuals' holding more than one assignment are counted as 1 employee.

Funded WTE, is the WTE number of posts that can be recruited to and agreed within the budget setting process.

Contracted WTE, is the volume of WTE workforce capacity engaged in a substantive contract of employment (permanent & fixed term).

Participation rate, is the average WTE output per employee measured in % terms in relation to theoretical full time capacity e.g. 0.8wte = 80% participation rate.

Joiner, is an individual who is new to role, substantively (not bank), including both permanent and fixed term. The only exception to this is the medical & dental staff group, where FTCs have been excluded as the vast majority are rotating trainees.

Internal mover, is an individual that has changed role but remained within the Trust e.g. promotion, re-deployment, secondment etc.

Leaver, is an individual who has left their substantive position with the trust and has not returned within a 3 month period (i.e. not a retire and return or internal mover). NB rotating trainee doctors employed under FTCs are excluded.

Retirement rate, measures the proportion of the workforce that left the organisation due to retirement over a given period of time. NB any retired individuals that subsequently returned to the organisation, are captured as a new joiner with the 'retire & return' reason.

Gross Vacancy, measures the difference between funded and contract WTE and can be expressed in either WTE or percentage terms, before any internal manipulation to achieve CIP savings.

Operational Vacancy, is the gross vacancy adjusted internally to deliver in year CIP savings e.g. 0.40wte and below slicing. This is the figure reported in the Trust IPR.

Turnover, measures the % of workforce that has left the organisation (as per "leaver" description) in a rolling 12mth period and can be expressed in either head count or WTE terms.

Retention, measures the proportion of the workforce with 12 months or more service, that have been retained relative to the previous year i.e. the percentage of last years workforce that have been retained.

Tenure, represents length of service according to the length of time in post (not organisation). It is a useful measure of stability and experience.

Attrition, measures the number of new starters (to post and not just to organisation), that have left their role within 12 months of joining, in head count terms, excluding honorary and fixed term contracts i.e. if there are 100 joiners and 10 choose to leave their post within 12 months, the attrition rate is 10%.

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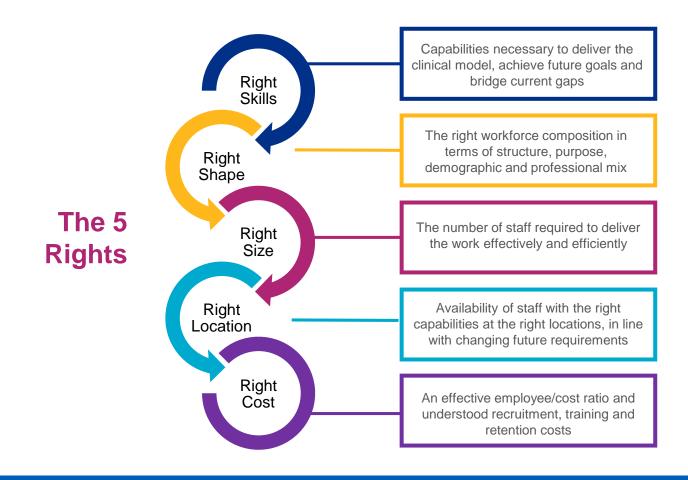
Strategic Workforce Planning

A Baseline Assessment Board of Directors, February 2023

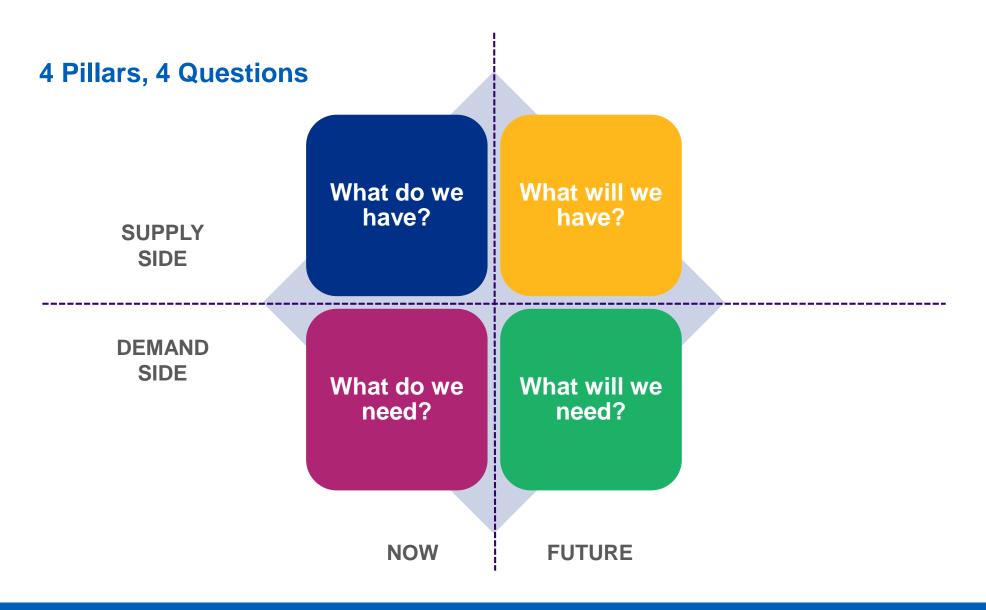


Introduction to Strategic Workforce Planning?

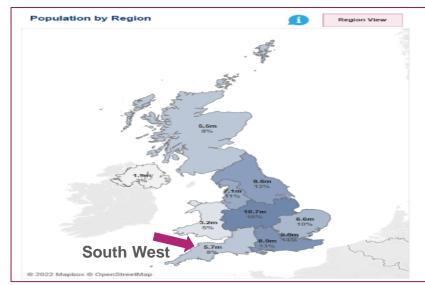
Workforce planning is the process of generating and analysing information to inform future demand for people and skills. It defines future workforce requirements, establishes the gap between the present and the future and then translates this in to a set of actions designed to achieve the desired workforce model and mitigate risk.

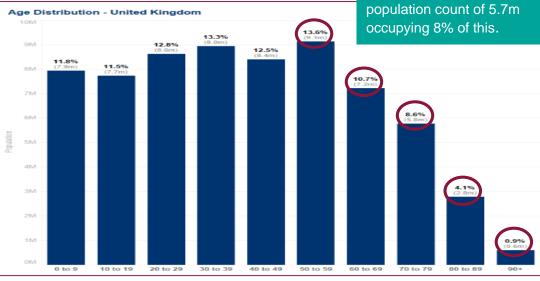


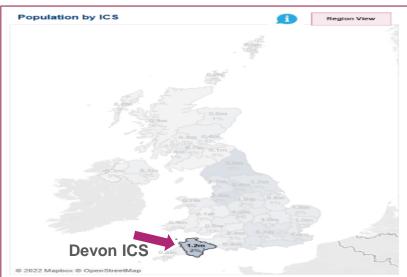
Introduction to Strategic Workforce Planning



Current Population



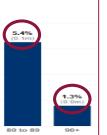






INSIGHT

Devon ICS contains a greater proportion of its population in the 50yrs+ age range, relative to the national profile.



INSIGHT

67.5m UK population as at 2020, with the South West

Population Projection

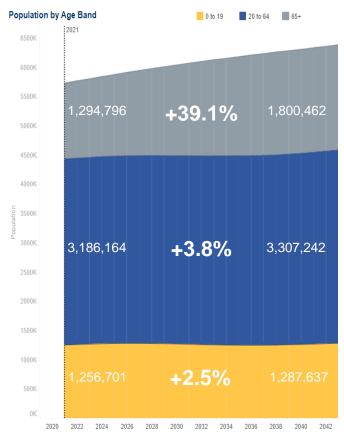
INSIGHT

Devon ICS population is forecast to rise from 1.2m to 1.36m by 2042. Of the 1.36m, almost 1 in 3 (30.66%) will be aged 65yrs and over (up from 24% in 2021).

National

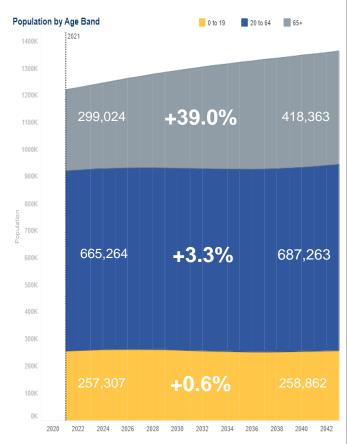
Population by Age Band 70M-65M-12,787,487 +36.4% 17,386,355 60M 50M 35M +1.4% 39,037,493 39,573,241 20M 15M-10M -1.8% 5M -2022 2024 2026 2028 2030 2032 2034 2038

South West Region



+11.46% population growth overall

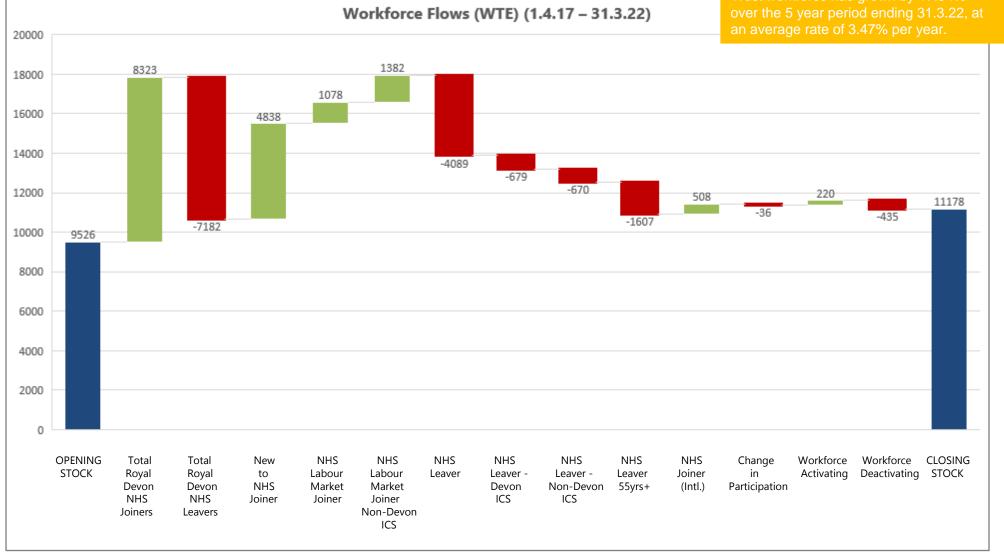
Devon ICS



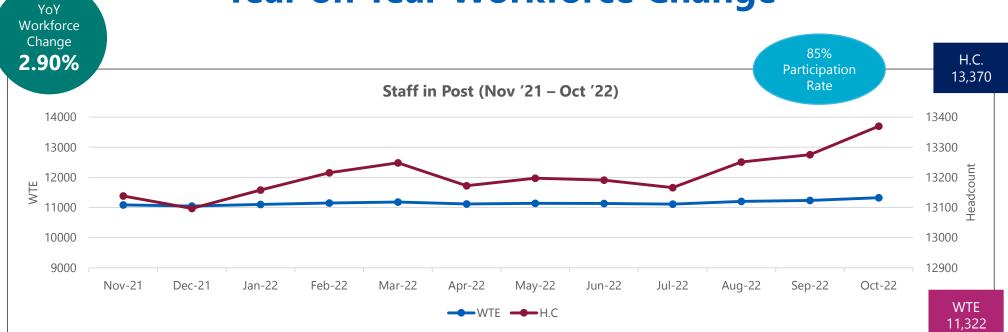
+11.70% population growth overall

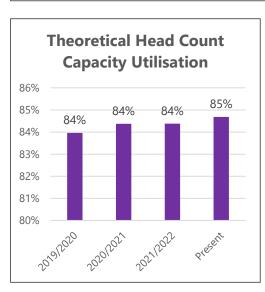
Workforce Flow

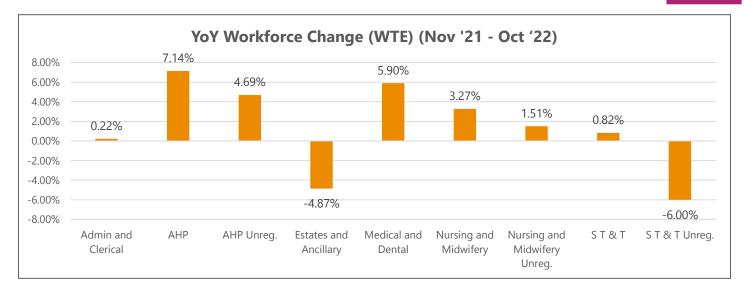




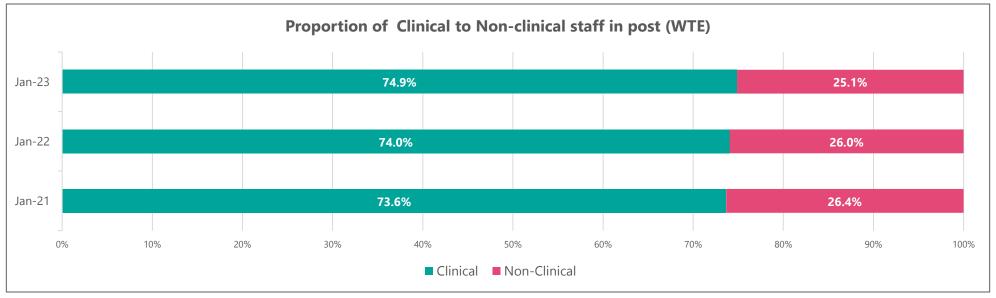
Year on Year Workforce Change

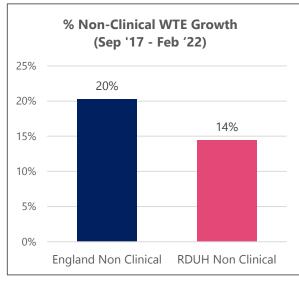


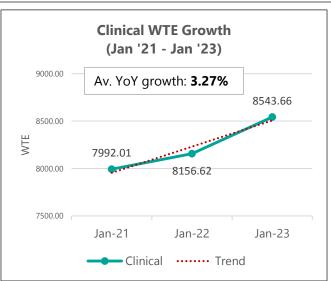


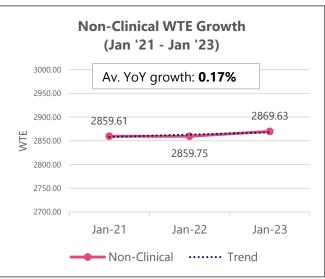


Clinical / Non-Clinical Workforce Comparison

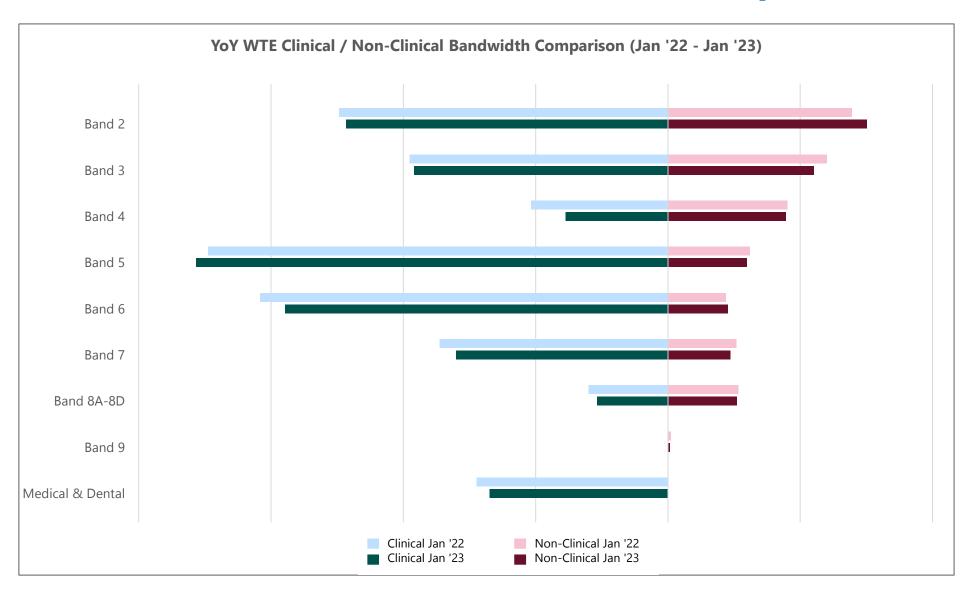




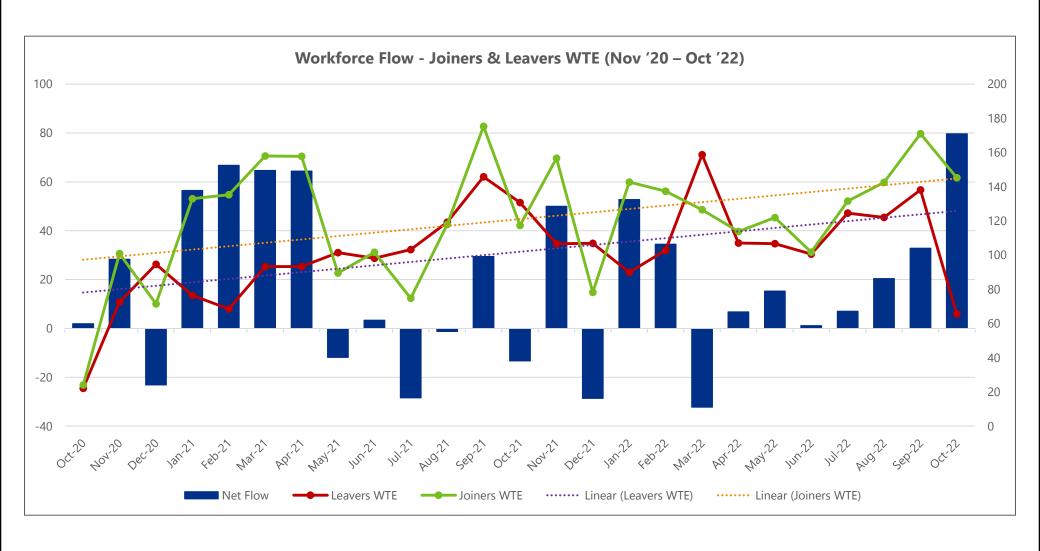




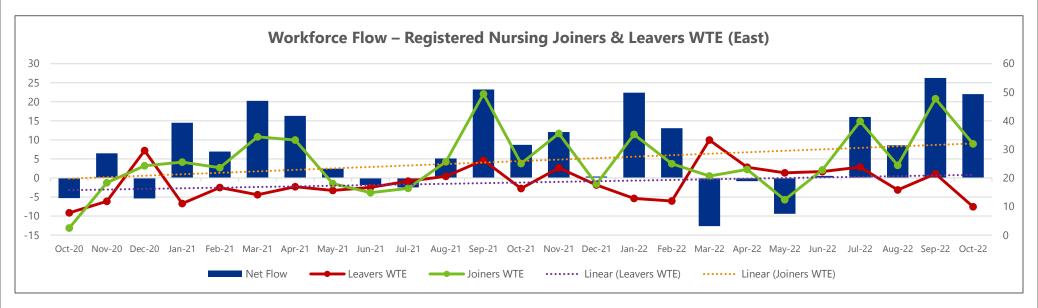
Clinical / Non-Clinical Workforce Comparison

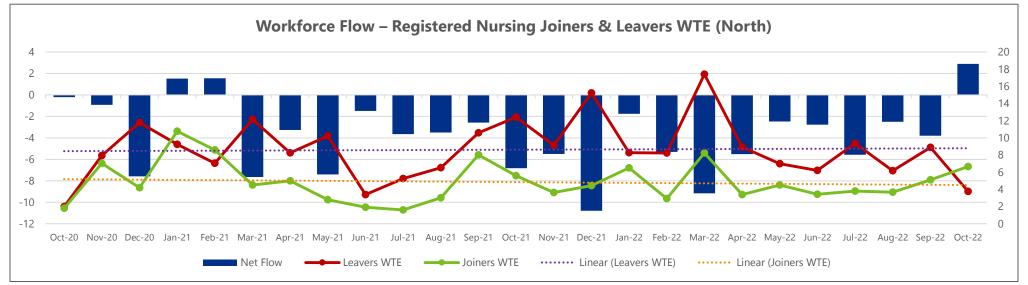


Workforce Flow

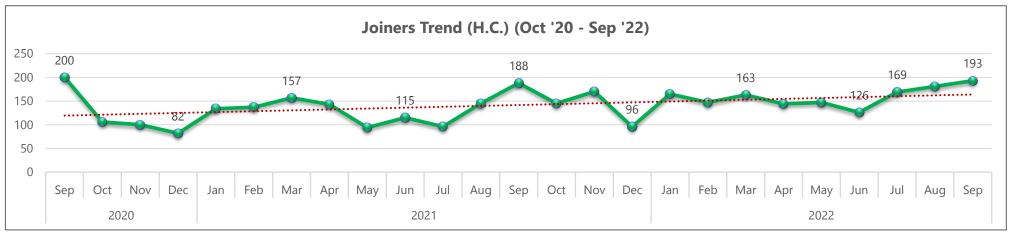


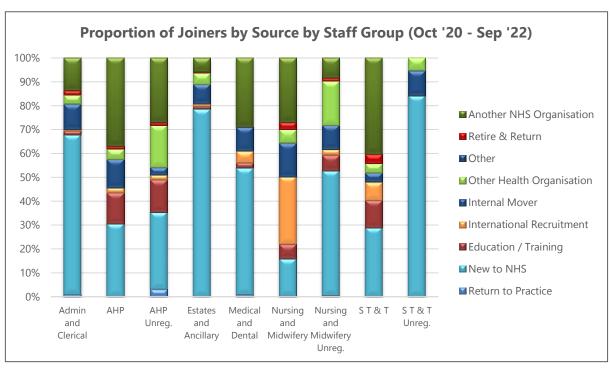
Workforce Flow – East/North Difference

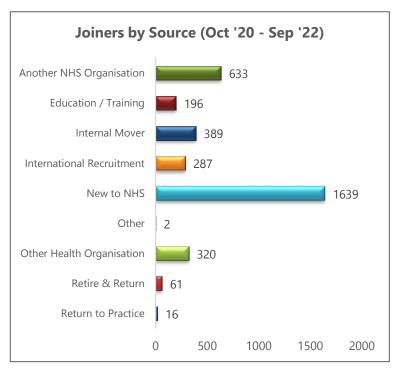




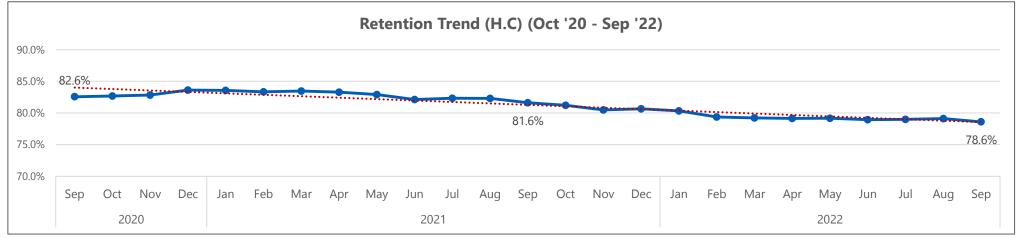
Joiner Analysis

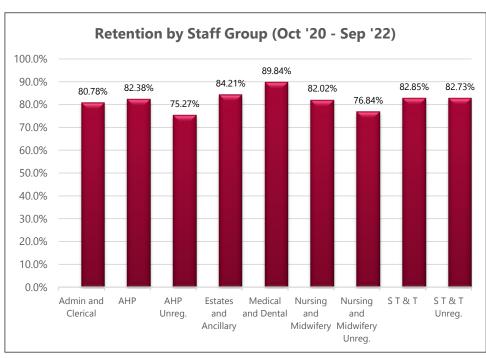


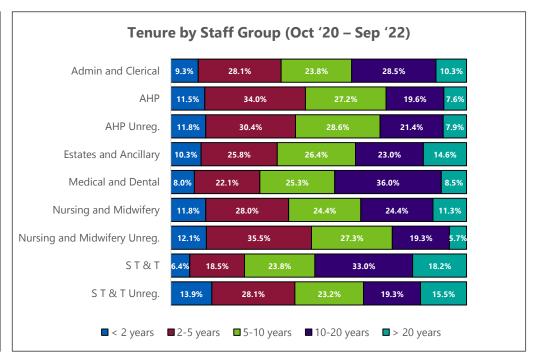




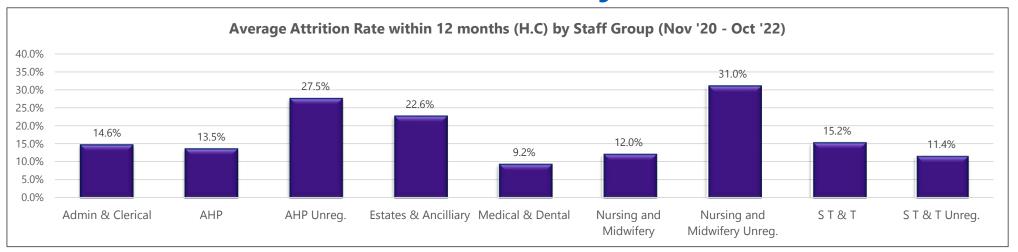
Retention Analysis







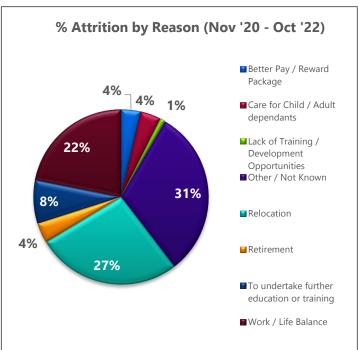
Attrition Analysis



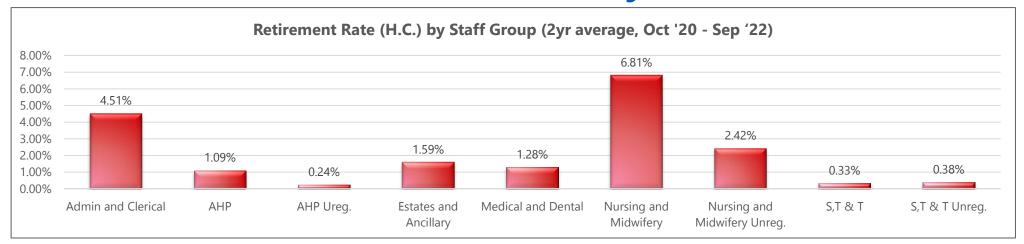


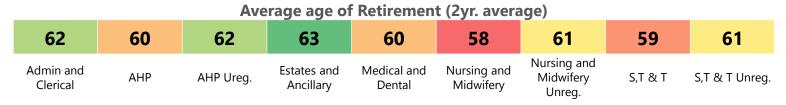






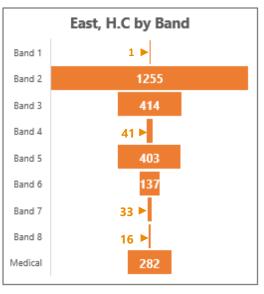
Retirement Analysis





Average age of Retirement for the	61	Retirement Potential by Staff Group											
whole Trust (2 yr. average)	61	51-5	5yrs	56-6	0yrs	61-6	5yrs	66-7	Oyrs	71 y	rs+		
		H.C	%	H.C	%	H.C	%	H.C	%	H.C	%		
Admin and Clerical		488	15.9%	415	13.5%	280	9.1%	75	2.4%	17	0.6%		
AHP		120	10.5%	107	9.4%	28	2.5%	4	0.4%	1	0.1%		
AHP Ureg.		49	7.5%	64	9.8%	43	6.6%	5	0.8%	0	0.0%		
Estates and Ancillary		120	15.3%	127	16.2%	115	14.7%	19	2.4%	17	2.2%		
Medical and Dental		154	10.0%	89	5.8%	40	2.6%	11	0.7%	5	0.3%		
Nursing and Midwifery		447	12.5%	385	10.8%	182	5.1%	34	1.0%	3	0.1%		
Nursing and Midwifery Unreg.		240	12.4%	210	10.9%	133	6.9%	19	1.0%	7	0.4%		
S,T & T		37	11.5%	26	8.1%	12	3.7%	4	1.2%	0	0.0%		
S,T & T Unreg.		37	10.8%	26	7.6%	16	4.7%	1	0.3%	0	0.0%		

Temporary Workforce Overview

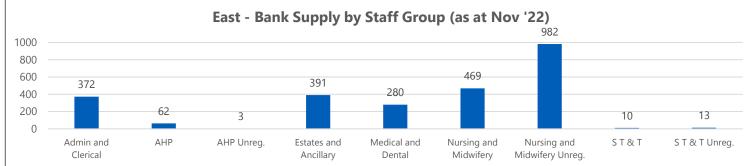


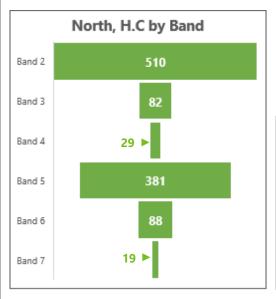


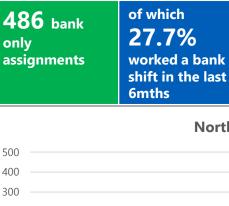
36.4 average number of bank hours worked per month (bank only)

30% substantive staff hold a bank contract

11.7 average number of bank hours worked per month (secondary) 44% of nursing/HCSW bank shifts filled





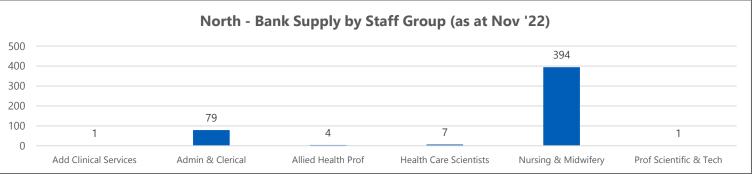


27.3 average number of bank hours worked per month (bank only)

15.8% substantive staff hold a bank contract

27 average number of bank hours worked per month (secondary)

59.98% of nursing/HCSW bank shifts filled

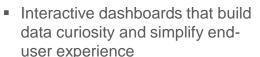


Strategic Workforce Planning – delivery to date



Strategic Workforce Planning Intelligence



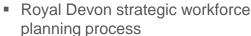


- Strategic workforce planning framework, releasing new insights e.g. ICB workforce migration
- Strategic workforce planning dashboard
- Strategic workforce planning data toolkit



Strategic Workforce Planning Methodology





- Strategic workforce planning delivery model, including responsibility reset
- Strategic workforce planning guide and facilitation resources
- Strategic workforce planning skills development
- including optioneering tool





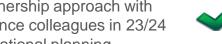






Collaboration & **Ownership**

- Partnership approach with Finance colleagues in 23/24 operational planning
- Adoption of responsibility for Provider Workforce Return (transition underway)
- Connection to internal Nursing. AHP and Medical strategy & stakeholders
- External partner relationships established with ICB and HEE, creating opportunities for knowledge share and access to enabling tools















Agenda item:	10.1, Public Board		Date: 22 Februa	ry 2023		
Title:	Integrated Performance Report	– spanning both Northern	and Eastern services with	in Royal Devon University He	ealthcare NHS Foundation Trust	
Prepared by:	Hannah Foster, Chief People Off Adrian Harris, Chief Medical Offi Angela Hibbard, Chief Finance O Carolyn Mills, Chief Nursing Offic John Palmer, Chief Operating Of Chris Tidman, Deputy Chief Exec	cer fficer cer ficer				
Presented by:	Carolyn Mills, Chief Nursing Offic	cer				
Responsible Executive: Summary:	Hannah Foster, Chief People Off Adrian Harris, Chief Medical Offi Angela Hibbard, Chief Finance O Carolyn Mills, Chief Nursing Offi John Palmer, Chief Operating Of Chris Tidman, Deputy Chief Exec To advise the Board of the Trust	cer fficer cer ficer utive	y performance standards :	and targets; and progress on	the implementation of the Trus	t Strategy and
Actions required:	key supporting projects. The Board is asked to receive the delivery.	ne Performance Report ar	nd note the current risks	and the proposed action pla	ans to mitigate the risks against	performance
	,	A	Diamonian		Information	
Status (*):	Decision	Approval	Discussion		Information X	
History:	This is a standing agenda item at	each meeting of the Boar	d of Directors.			
Link to strategy/ Assurance framework:	This paper details the Trust's pe a key objective within the Trust's	•	ey performance standards	and targets. Achievement of	of these performance standards	and targets is
Monitoring Information				Please specify CQC standar appropriate	rd numbers and tick ✓other box	es as
Care Quality Commission Standards			Outcomes			
NHS Improvement / England			✓	Finance		✓
Service Development Strategy				Performance Managemen	t	✓
Local Delivery Plan				Business Planning		1
Assurance Framework	Parkanananan			Complaints		1
Equality, diversity, human rights imp	olications assessed					
Other (please specify)						

Integrated Performance Report – **January 2023 Position**



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Our People

Finance

Overview - Executive Themes and Actions to Raise at Board

Overview

This IPR covers the period of January 2023 which continued the themes of December 2022 including significant complex challenges resulting from multiple days of industrial action across the service, infection outbreaks (COVID, Influenza and Norovirus), staff workforce challenges and elevated levels of delayed discharges led to extreme pressure on all parts of the Devon Urgent and Emergency Care system. Equally consistent were **the remarkable efforts** of our teams to absorb these pressures and to keep our patient population safe. After the initial intense pressures through the first half of January, we saw a significant de-escalation and this has meant that we have been able to lessen the intensity of the command structure – at the time of writing we are sitting at OPEL3 on both sites and have exited from a number of our Winter escalation areas, whilst also maintaining the largest proportion of our ring fenced elective activity. It has been positive to see this period of de-escalation, but we are **carefully tracking COVID levels** with an expectation that demand is likely to peak before the end of February.

Recovering for the Future

Whilst 4 hour **ED Performance** has continued to be impacted by the patient flow challenges we have seen a **7.0% improvement in 4 hour performance** for Northern (from 52.1% to 59.1%) and in Eastern (from 56.5% to 63.5%); a 14.1% reduction in 30min+ ambulance handover delays in North and 23.5% reduction for East; and a 50.4% reduction for 60min+ handover delays for Northern and 67.1% for Eastern. Some of this reflects the vicissitudes of the ambulance industrial action, but there is an undoubted return on the efforts of our teams here as well. Whilst the numbers of medically fit for discharge patients waiting has improved it is still of really very significant concern (more of this below), however we can show that our system is making a significant contribution to improving patient pathways as our admission avoidance numbers through the **Urgent Community Response team have increased for the third month in a row (and perform at 93% against the 2 hour target).**

Elective inpatient activity saw an overall improvement in Northern Services and a decrease in Eastern Services which reflects that we essentially lost the first two weeks of the year to operational pressures. However, we did manage to restore ringfences in relatively short order and therefore have been able to maintain position against our end of year targets for both 78 week and 104 week waiting patients. **At the time of writing we have indicated that we hope to exceed target** (1152 and 54 78 and 104 week waits respectively) dependent on the outcome of the most recent (6 and 7th February) and potential further (1-3rd March) industrial action. It is pleasing that the spinal and orthopaedic teams are now down to single figure numbers of 104 week waiting patients and this reflects their commitment to additional clinics and cases per clinic across Sites.

We have now shared our draft cancer recovery action plan with NHSE and are continuing to see a positive decrease in the number of patients waiting for treatment whilst improving our data quality to increase confidence in reporting. Our current position shows that we have 359 patients waiting over 62 days and that this continues to reduce (this was 630 in August). There has also been a related reduction in the volume of patients waiting longer than 62 days for cancer treatment following urgent GP referral (reduction of 50 from end December to end January for Northern, and 18 for Eastern). There is a further Improvement in Northern's Dermatology 2ww position which is important given that it is such a high volume specialty, but this is counterbalanced particularly by our ongoing challenges in urology and gynaecology for Northern Services and Breast 2ww and Skin in Eastern.

Diagnostic activity will be coming under greater focus over the coming month with a regional "focus on diagnostics" planned for March – goals are: consistent reduction in 6 week wait backlogs month on month for CT, MRI echocardiography, colonoscopy, gastroscopy, audiology and NOUS by May 2023; optimal level of tests per hour (CT: 3-4 scans per hour, MRI: 2-3 scans per hour, NOUS: 3 scans per hour, Echo: 1 scan per 45 mins, including reporting, and Endoscopy: 95 % of planned endoscopy lists taking place); review of opportunities to optimise histopathology services by the end of March; reduction of DNA levels to 3% and maintain levels at 3% or below, where this level is already being achieved. With our diagnostics data now restored, we will develop our plan over the next monthly Board cycle.

Overview - Executive Themes and Actions to Raise at Board

We continue to focus very strongly on the development of the **2023/24 operational plan**, at Trust and System level. We have now developed a set of scenarios that are under consideration by Chief Executives and the System as we prepare for an important Board to Board with NHSE on the 9th March where we will seek to move to agreement on next year's plan and potentially to a three year position. We have run in depth events with the whole senior leadership team to run through our plans and will be launching Delivering Best Value this month in alignment with these agreements. **We are currently running ahead of our end of year deficit plan of £18.3m with a forecast outturn of £16.3m against an in month position of £15.6m**. Capital spend YTD is £27.9m compared to a plan of £40m. There is confidence the capital programme will recover based on the value of open orders, and is forecast at year end to be £53m (compared to plan of £51.5m).

Collaborating in Partnership

The Help People Home Without Delay programme has continued to drive at improving patient discharge to home with social care support throughout January. There is no doubt that the bringing together of the Community Division and the drive to deliver this programme has benefited the time to transfer across pathways and there has been strong leadership from the community team and site triumvirates. However, such has been the patient volume challenge and the continued deficit of care hours in social care and care homes that our Winter Plan targets for lowering medically fit to discharge patients have not yet been realised. At the time of writing, we are about to take a set of escalations into our imminent discussions with Lesley Watts (the national lead for discharge and Chief Executive of Chelsea and Westminster NHS Trust) to consider what more can be done and whether there are other applications for the currently available non-recurrent end of year spend which we co-own with Devon County Council (£1.7m).

Excellence and Innovation in Patient Care

Triangulation of the performance positions with the quality metrics remains important so as to identify any trends that may show a consequential impact of the ongoing pressures the Trust is facing.

In January, there were three serious incidents for Northern Services, two for Eastern and one Never Event. There were **two falls resulting in moderate harm within the Trust's Northern Services and four in Eastern**. We also saw increases in pressure ulcer incidence for Northern (December) and Eastern (January) which we believe were linked to focussed work on early identification (Northern) and increased patient acuity (Eastern). We continued to see an **increase in the volume of trauma patients** being admitted to both Northern and Eastern sites, continuing the challenges in scheduling surgery within 36 hours of admission for those with a fractured neck of femur, particularly on the Eastern Site. We note in this cycle that the 3 month weekend rolling SHMI, whilst below upper limit is above local peers (Northern Services) and detailed work is being undertaken to understand more fully the reasons for this. We also **note positively Improved nursing fill rates across all four metrics** (HCA, and RN & RM, Day and Night) for Northern and Eastern in January.

The CQC well-led inspection has now been rescheduled for the 23rd and 24th March; and our important Northern Services Acute Medicine business case will be submitted to the regional triple lock on the 22nd February.

A Great Place to Work

The Trust continues to **improve its vacancy position** moving to 7.91% Trust wide (10.08% Northern; 7.03% Eastern) at the end of December. Alongside this the (12 month) **turnover position sees an improvement for Northern and slight decrease for Eastern**. In the detail, retirement is cited as the chief reason for leaving by 40% of Registered Nurses in North, and 29% of registered nurses in East. **Sickness predictably increased from 6.12% in November to 7.16% in December**, with 55% of all sickness in December was attributable to coughs, colds, sickness and COVID-19.

Data Quality Update

Data Quality and reporting

Diagnostics

As previously reported, the implementation of Epic for Northern services in July has resulted in issues affecting both external and internal reporting. This has affected Endoscopy and Physiological Measurement activity and waiting list reporting, but not imaging reporting as that is not currently an Epic module.

Significant progress has been made on resolving these issues, with January Board (IPR) reporting, December external (DM01) reporting, and now weekly external Waiting List Minimum Data Set (WLMDS) reporting all based on Epic data, with the exception of Audiology, which is still based on a snapshot of Trak data pre go-live. These improvements have been enabled through specific modality Task and Finish Groups, including operational / clinical leads, EPR and BI representation, and have covered data quality issues related to front-end user data entry, EPR configuration issues and / or BI scripting issues.

There are now two remaining issues to resolve prior to obtaining high data quality assurance:

- Echo-Cardiography: until very recently there has been a data entry issue regarding the incorrect classification of Planned / 6 week patients. This is currently being manually corrected by the responsible BI analyst, but a meeting has already taken place with front-end clinicians and EPR team to identify and correct any issues at source. The data therefore being produced is considered to be accurate but resolution of the above will negate the need for post-adjustment by the BI team.
- Audiology: configuration changes were put in place at the end of January 2023, output reporting data will be tested during February with a plan to report accurate and
 complete information from Epic for internal and external reporting by the end of February 2023. This means that the February IPR (January data) will include Trak
 snapshot data but the March IPR will report on Epic data.

NHSE anticipate that we will share our outline plan for data layer development to report from Epic imminently.

Long waiting diagnostic patients

Through the external Tier 1 NHSE process, queries have been raised regarding the volumes of Diagnostic long waits that are currently being reported on external WLMDS submissions. Investigation has identified that this issue is directly linked to the Northern reporting issues noted above. The high volume of long waits is associated with the submission of Snapshot Trak data for Northern services, which have not been updated for some time. The resolution of reporting (with the exception of Audiology) is expected to significantly improve this reported position to reflect a more accurate picture. A revised submission has now been made, which has been shared with clinical and operational teams for validation of genuine long waits. Further correction will then happen at source to result in a cleansed data set.

Cancer waiting times

The major data quality issues post Northern go live have now been resolved, with corrections reflected in the IPR. Further work is currently in progress to provide greater end to end assurance over data quality (from user entry to extracting information) but all known issues have been resolved. Work commissioned from an external provider to provide additional assurance of data quality has been completed, with the draft report provided to the Trust for comment. The overall position in relation to data quality and assurance over reported information was very positive. Recommendations primarily relate to training requirements and to develop a comprehensive suite of data quality metrics. This report will be shared in detail at the next FOC.

RTT / waiting list reporting (both sites)

Improvements have been made in this area over recent months, with removal of duplicate pathways and missing values. Revised scripting has now been completed to ensure the reporting of a 'single version of the truth' across various reports, and this script is currently undergoing technical validation. The final stage is to make a test submission to the national RTT data quality tool prior to use for internal and external reporting going forwards. NHSE expects a validated position that will be reflected in their LUNA diagnostic tool by the end of the month.

An update on these Executive led activities was provided to the Finance and Operational Committee in the February cycle and this was then shared in detail with NHSEI SW and national team. In particular NHSE are keen for us to share our overarching action plan that brings all of these activities together.

Board Scorecard – Looking to the Future

Successes

- Continued optimisation of EPIC to support Northern Services.
- Nightingale Hospital increasing its range of services and Theatres moving to 90% capacity
- Recruitment & retention plans are showing positive results with vacancies and turnover reducing
- Mutual aid offered to neighbouring Trusts, whilst maintaining good ambulance handover and elective ringfences
- Elective & Cancer recovery plans still on track despite urgent care pressures
- UEC performance improved in Jan
- Data quality work now providing greater assurance

Opportunities

- Insourcing & outsourcing and mutual aid capacity to further reduce long waiters
- Extra discharge funding to support reduction in 'Green to Go' patients
- Integration of 8 high priority services at our Northern services and our operational functions
- Elective recovery 10 week challenge to provide extra support/impetus
- Maximising the use of the protected elective care at the Nightingale over the next 3 months to drive down long waiters
- Peninsula Acute Sustainability programme & nominated fragile services offers opportunities to improve service collaboration
- £2m funding for a new discharge lounge at NDDH will support daily patient flow
- Digital innovations to fast-track patient care e.g. Dermatology Al pilot / Cataract pathway

Priorities

- Staff Health and Wellbeing
- Reducing the number of Green to Go patients through the Help People Home Without Delay
- Pipeline for recruitment processes to fast-track new starters
- Delivering Best Value to meet financial and productivity plan
- Continued validation work on long waits with NHSEI IST and improvement of 104 week waits
- Launching the Trust's transformation approach

Risk/Threats

- Potential loss of confidence in reporting due to data quality issues
- Further COVID & Flu waves
- Vacancies in community and social care to support patients home
- Local Authority financial pressures impacting on jointly funded discharge schemes
- Staffing Resilience Medical Staff (Northern) / nursing/ HCA/ ancillary
- Continued Industrial action
- Staff Morale with constant pressure and cost of living challenges
- Clearing the Dermatology Cancer backlog
- Risk of reduced ERF funding in 23/24 and associated impact upon activity
- Inability to hit financial targets whilst also reducing waiting lists

Northern Services Executive Summary

Northern Services

Operational Performance Dashboard

Domain	Measure/metric	Definition	Last Month Dec-22	This Month Jan-23	Vs prior month	Planned	National target
	Outpatient activity (New)	Vs baseline (2019/20)	102.3%	106.1%	3.8%	70.6%	104%
	Outpatient activity (FU)	Vs baseline (2019/20)	106.2%	110.1%	3.9%	68.4%	75%
	Elective inpatient activity	Vs baseline (2018/20)	37.9%	41.6%	3.7%	114.7%	104%
<u>Ł</u>	Elective daycase activity	Vs baseline (2019/20)	95.8%	95.7%	-0.1%	90.8%	104%
ACTIV	RTT 18 week performance	Fatients seen (18 weeks us total Incomplete pathways	48.0%	46.0%	-2.0%		92%
ELECTIVE ACTIVITY	Incomplete pathways	Total count	25702	24967	-2.9%	15842	
ш	RTT 52+ weeks waited	Total count	3531	3523	-0.2%	1136	
	RTT 78+ weeks waited	Totalcount	600	562	-6.3%	96	
	RTT 104+ weeks waited	Total count	13	9	-30.8%	0	
ii;	2 week referrals	Performance	75.30%	67.50%	-7.8%		93%
CANCER	28 day faster diagnosis standard	Performance	44.00%	44.90%	0.9%		75%
70	Urgent GP referral 62 day	Performance	42.90%	48.72%	5.8%		85%



Domain	Measure/metric	Definition	Last Month Dec-22	This Month Jan-23	Vs prior month	Planned	National target
	Non-elective Inpatient activity +1LOS	Vs baseline (2019/20)	98.3%	87.9%	-10.4%	96.6%	
	A&E attendances	Vs baseline (2019/20)	125.8%	104.0%	-21.8%	108.8%	
	4 hour wait performance	Patients seen (4 hours vs total attendances	52.1%	59.1%	7.0%		95%
\RE	Ambulance handover delays >30 minutes	Total count	304	261	-14.1%		
URGENT CARE	Average daily number of patients waiting and ready for discharge	Total count					
URGE	Average daily number of patients delayed as awaiting community assessment / referral / bed	Total count					
	Average daily number of patients delayed as awaiting resource / assessment to start care at home	Total count					
	Average daily number or patients delayed as awaiting residential / nursing home bed	Total count					
	6 week wait referral to diagnostic test	completed in 6 weeks	41.0%	43.2%	2.2%	N/A	99%
S	MRI activity	Vs baseline (2019/20)	110.2%	104.9%	-5.3%	114.0%	
DIAGNOSTICS	CT activity	Vs baseline (2019/20)	117.7%	125.6%	7.9%	105.6%	
AGNO	Medical Endoscopy activity	Vs baseline (2019/20)	106.1%	106.1%	0.0%	148.1%	
ā	Non-obstetric ultrasound activity	Vs baseline (2019/20)	78.4%	102.9%	24.6%	118.8%	
	Echocardiography activity	Vs baseline (2019/20)	99.0%	73.9%	-25.1%	17.9%	

Eastern Services Executive Summary

Eastern Services

Operational Performance Dashboard

Domain	Measure/Metric	Definition	Last Month Dec-22	This Month Jan-23	vs Prior month	Planned	National target
	Outpatient Activity (NEW)	vs baseline (2019/20)	82.9%	91.3%	8.3%	103.6%	104%
	Outpatient Activity (FOLLOW-UP)	vs baseline (2019/20)	138.7%	141.0%	2.4%	90.0%	75%
	Elective Inpatient Activity	vs baseline (2019/20)	71.8%	61.9%	-9.9%	115.6%	104%
TIVIT:	Elective Daycase Activity	vs baseline (2019/20)	94.6%	104.7%	10.1%	120.3%	104%
ЕLEСТІVЕ АСТІVІТУ	RTT 18 Week performance	Harrents seen (16 weeks vs total incomplete	54.1%	56.8%	2.8%		92%
ELECT	Incomplete Pathways	Total count	55110	54270	-1.5%	50145	
	RTT 52 Weeks waited	Total count	5008	4449	-11.2%	4787	
	RTT 78 Weeks waited	Total count	899	765	-14.9%	1555	
	RTT 104 Weeks waited	Total count	139	103	-25.9%	0	
α	14 Day Urgent	Performance	75.6%	74.4%	-1.2%		93%
CANCER	28 day faster diagnosis standard	Performance	81.7%	69.8%	-11.9%		75%
0	Urgent GP referral 62 day	Performance	69.0%	72.8%	3.9%		85%

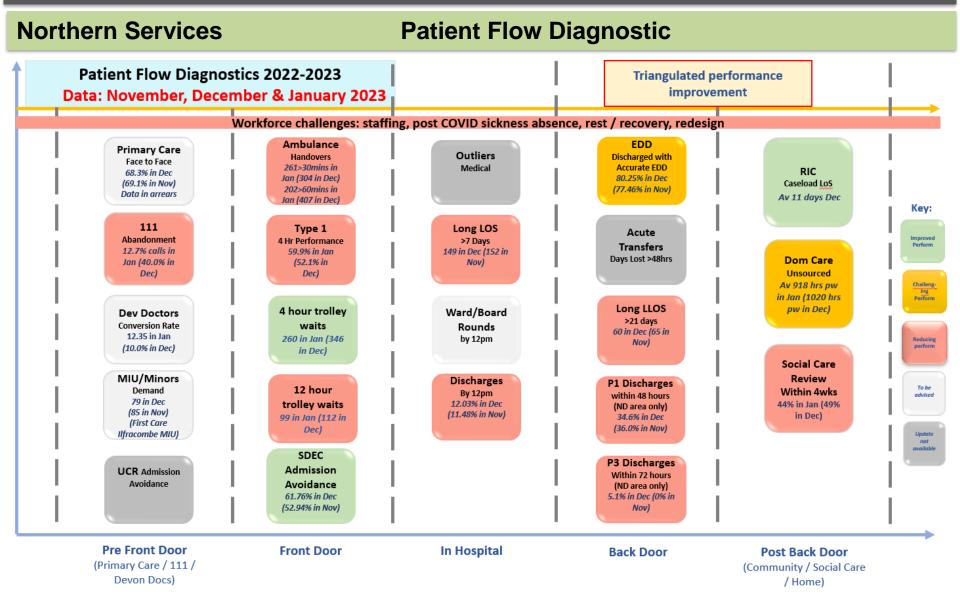
Positive value

Negative value < 5%

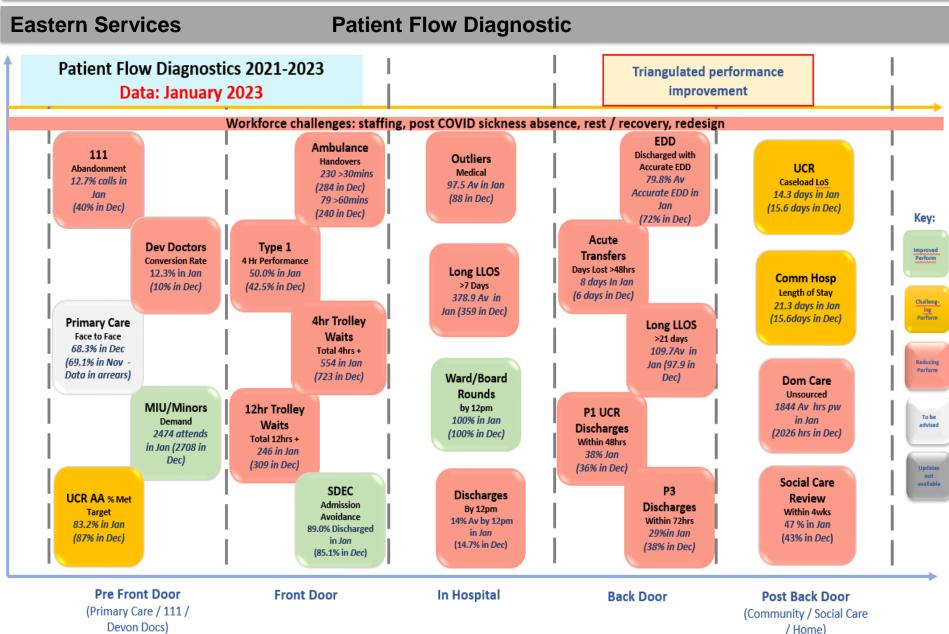
Negative value > 5%

Domain	MeasurelMetric	Definition	Last Month Dec-22	This Month Jan-23	vs Prior month	Planned	National target
	Non-elective Inpatient activity +1 LOS	Vs baseline (2019/20)	95.9%	89.4%	-6.4%	115.7%	
	A&E attendances	vs 19/20 baseline	92.2%	81.8%	-11.3%	97.8%	
	4 hour wait performance	Patients seen <4hrs vs total attendances	56.5%	63.5%	7.0%		95%
щ	Ambulance handover delays >30 mins	Total count	284	230	-23.5%		
URGENT CARE	Daily Average Green (Medically Fit) Transfer List	Total count	102	109	6.4%		
IRGEN	Volume of Average Daily Completed Transfers	Total count	11.8	12.6	6.3%		
_	Average Time to Transfer (Medically Fit to Discharge) – All Transfers	Total count	4.8	4.4	-9.1%		
	Average Weekly Hours Requiring Personal Care Backfill	Total count	1141	994	-12.9%		***************************************
	UCR: Referrals	Total count	871	914	4.7%		
	UCR: Length of Stay on Caseload	Total count	14.0	14.0	0.0%		
	6 week wait referral to diagnostic test	% of diagnostic tests completed in 6 weeks	63.0%	64.3%	1.4%		99%
s	MRI activity	vs 19/20 baseline	101.9%	100.2%	-1.7%	104.3%	
оѕпс	CT activity	vs 19/20 baseline	99.9%	104.7%	4.8%	106.5%	
DIAGNOSTICS	Medical Endoscopy activity	vs 19420 baseline	114.1%	123.3%	9.2%	90.6%	
	Non-obstetric ultrasound activity	vs 19420 baseline	107.5%	124.5%	16.9%	84.0%	
	Echocardiography activity	vs 19/20 baseline	190.0%	193.6%	3.6%	94.8%	

Northern Services Executive Summary

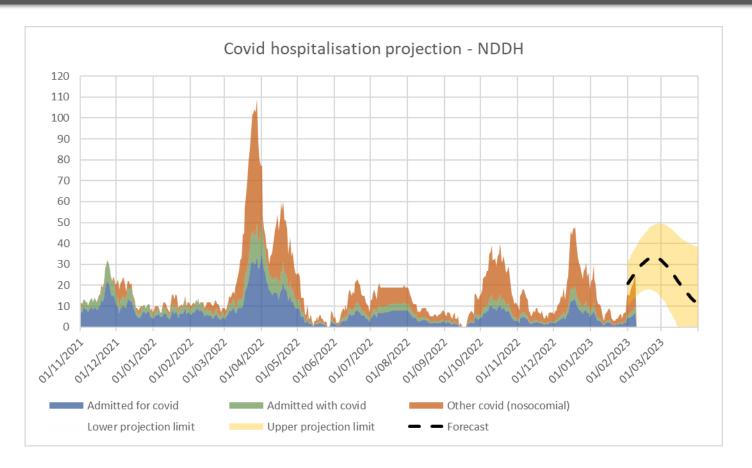


Eastern Services Executive Summary

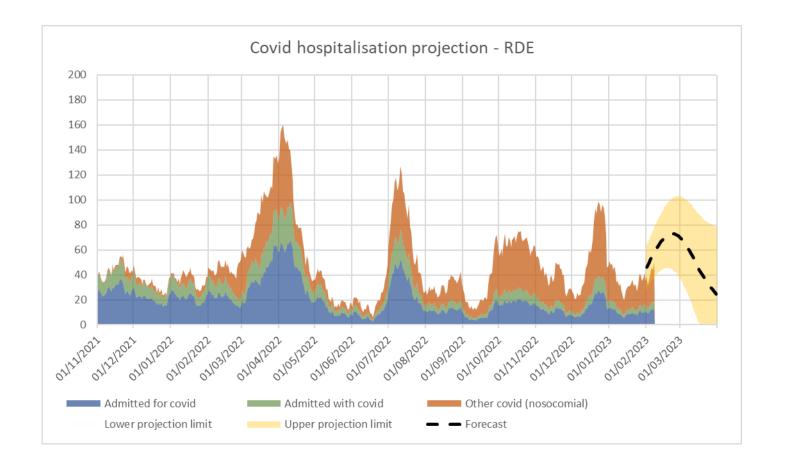


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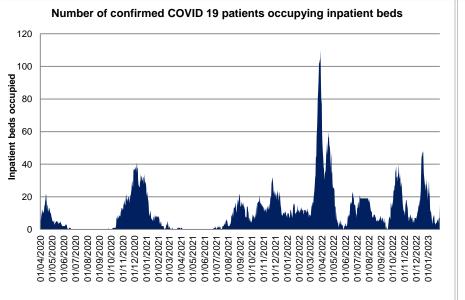
Northern Services COVID-19 Projections

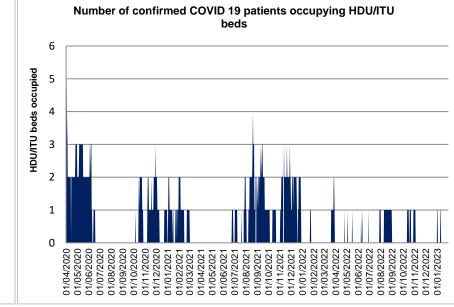


Eastern Services COVID-19 Projections



Northern Services COVID-19 Inpatient Activity — Overview of inpatient activity in relation to caring for patients with COVID-19



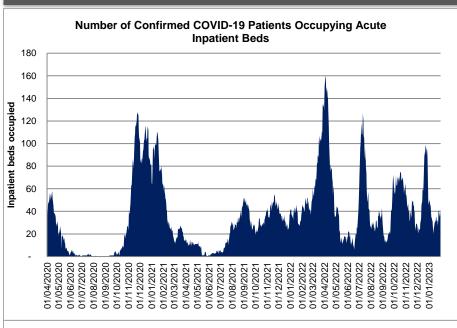


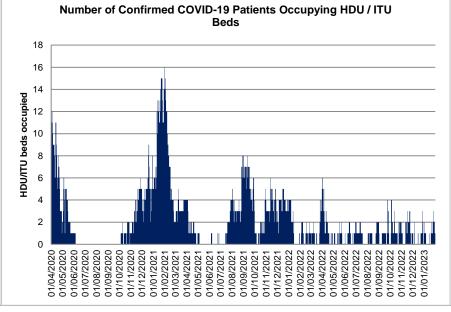
COVID patients in Critical Care beds

There was a reduction in the number of patients in January that required hospital admission due to Covid and Flu. This decreased IP&C restrictions that had been put in place during December.

Eastern Services COVID-19 Inpatient Activity

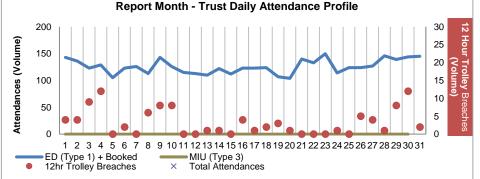
Overview of inpatient activity in relation to caring for patients with COVID-19

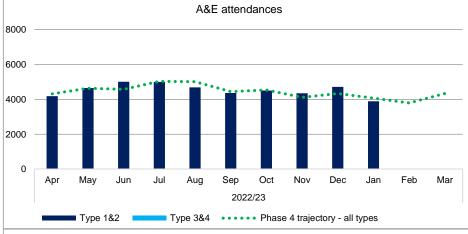


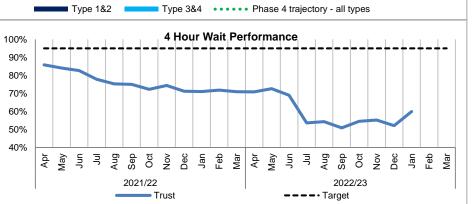










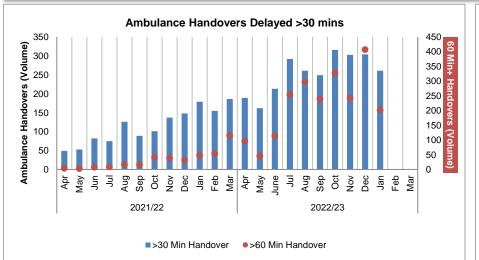


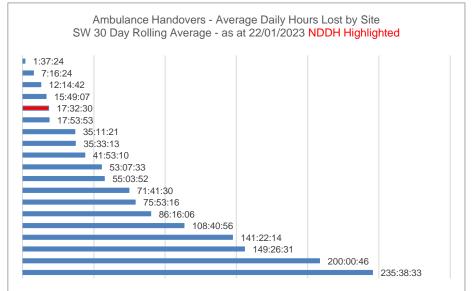
Type of Activity	Denominator	Patients > 4 Hours	% Performance
ED Only	3906	1599	59.06%

- ED remained busy during January with a peak of 150 attendances on the 23rd January.
- In January the total average daily hours lost in ambulance handover delays was 15 hours. This was a huge improvement following the delays in December. The lower numbers of Flu and Covid positive patients helped to ensure that ambulance handovers were completed in a timely manner.
- Northern Services went into Opel 4 on the 29th January and remained in Opel 4 until the 7th February
 - In January the overall number of ED attendances decreased by 357 patients against December. The service reported a 7.8% increase in January against the 4 hour target in December.
- Industrial Action took place within the Ambulance Service on the 11th and 23rd January. Contingencies were put in place including increasing staffing numbers within ED on these days with good effect.
- SDEC opened on the 27th December which enabled an increase in the Urgent Care bed base by 10.
- Bideford MIU (Type 3+4) remains closed and in Ilfracombe First Care continue to provide minor injury services on Fridays, Saturdays, Sundays and Mondays between the hours of 10am-6pm and this will remain in place until the end of the financial year. Additionally GP practices in these areas continue to provide some minor injury services. This service is due to cease in March and discussions are currently taking place regarding extending the term of the service.

Northern Services Emergency Department — key metrics relating to activity & performance in urgent &

emergency care services





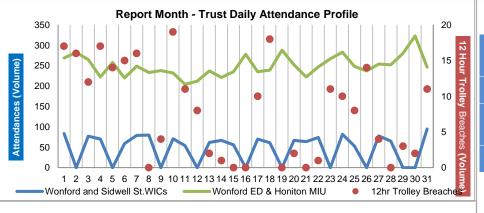
Overall Performance:

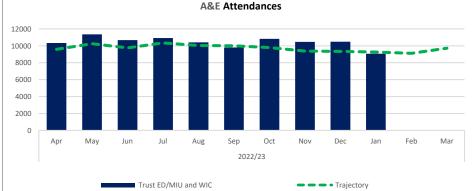
- 60 min handovers decreased by 205 in January, 30 min handovers also decreased by 43.
- Due to the low numbers of Flu, Covid and RSV patients attending the department it meant that areas in the department weren't restricted by IP&C measures which then led to quicker ambulance handover times.

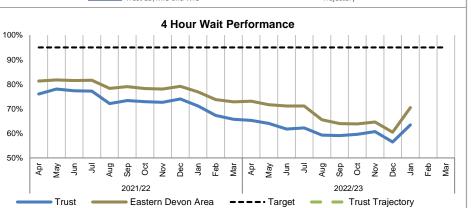
Integrated Performance Report February 2023

Eastern Services Emergency Department

Key metrics relating to activity & performance in urgent & emergency care services







Overall Performance

Type of Activity	Denominator	Patients > 4 Hours	% Performance
ED Only	6592	3296	50.00%
All RD&E Delivered Activity (including Honiton MIU and the WICs)	9066	3313	63.46%
Total System Performance (including MIUs)	11863	3506	70.45%

- All type performance against the 4 hour wait target improved from 56.46% in December to 63.46% in January
- 12 hour trolley wait for a bed reduced from 309 in December to 246 in January, although remains higher than the average from July to November of 157

Key drivers:

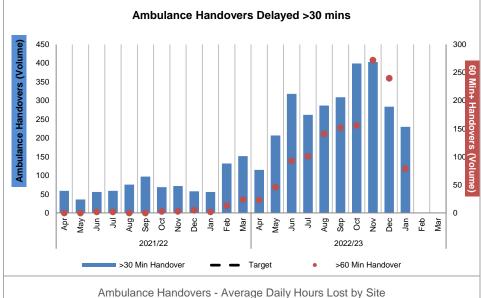
- Bed capacity pressure and restricted flow to beds in the hospital
- Increase in IPC occurrences complicating flow out of the department
- Reduced capacity at Sidwell Street WIC –closed on Monday and Thursday (blue line on the chart)
- Current vacancies and sickness in Medical and Nursing teams
- ED Reconfiguration works

To note:

- Sidwell Street WIC planned to reopen on Mondays in February
- ED Reconfiguration to Majors completed 19th December
- 6 new Resus bays now in use
- New ED reception and waiting room due to open 13th February
- From 13th February minors will run out of the old resus bays and the see and treat rooms adjacent to the new reception area
- Current minors due to undergo refurbishment
- SDEC activity increasing from 537 in December to 625 in January (a record month)
- Virtual Ward activity growing as pathways are developed, with 56 admissions in the first 2 weeks of January

Eastern Services Emergency Department

Key metrics relating to activity & performance in urgent & emergency care services







Overall Performance:

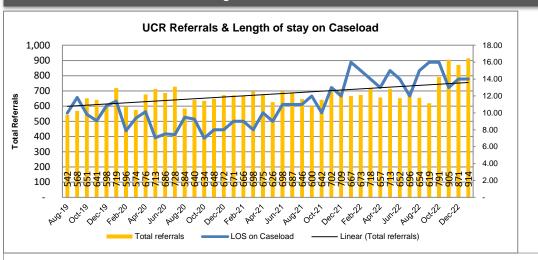
- Ambulance handover delays continue although performance has improved from 284 hours in December to 230 hours in January, despite consistent ambulance arrival numbers
- As with Northern, the Eastern handover performance compares favourably to other Trusts in the region

Actions

- Ongoing recruitment to fill nursing and medical staffing vacancies
- Ongoing work to improve pathways for specialty expected patients.
- Focus on improving the 15 min to triage performance in ED.
- Development of further pathways in the Virtual Ward

Trust Urgent Community Response

Admission avoidance and discharge



Eastern UCR Demand and Flow Performance

- There were 315 admission avoidance referrals in November, 329 in December and 340 in January. Performance against the national 2 hour target in January was 93%.
- The direct push pathway from SWAST to UCR went live in November. Referrals were lower than anticipated with 7 in November, 14 in December and 14 in January. We are continuing to promote this admission avoidance pathway across North and East.
- Time to transfer improved across all pathways from December to January. For Pathway 1, it was below the average for the previous 12 months (3.49 days v 3.8 days). For Pathway 2, it was below average compared to the previous 12 months (6.13 days v 7.45 days). For Pathway 3, it was below average compared to the previous 12 months (5.68 days v 7.71 days). We will look to further improve on these gains via the Help People Home Without Delay Phase 2 in the coming six months.
- Referrals were the highest recorded since August 2019, and 37% more compared with January 2022.

Northern UCR and Response and Recovery Data

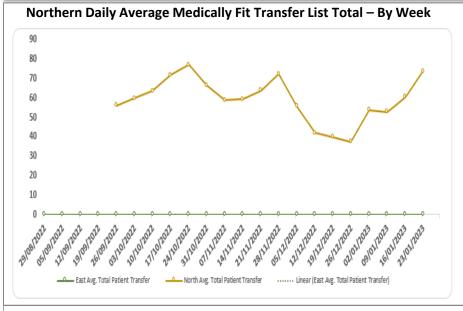
Northern data not currently reportable via Epic. This is being addressed with the digital and operational teams. Data provided outside of EPIC;

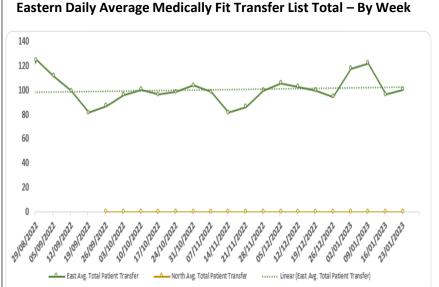
- Pathway 1 discharges 105 discharges, averaging 26.5 per week impacted by reduction in agency and high number of referrals (33).
- Continued increased referrals for UCR 2 hour response (Oct 36, Nov 44 and Dec 54).

Actions to improve performance and outcomes

- Help People Home without delay phase 2 scope is currently being signed off and will contain a prevention and flow element with an aim to deliver improvements by next Winter.
- Teams have continued through January to proactively review the number of patients who require a care act assessment and refer those patients on for an assessment in a timely way.
- Work continues across Eastern and Northern to bring in line reporting for Green to Go and Time to Transfer timings working with operational and digital teams.
- Vacancy rate was 11.9% across Community Services in January which is an increase from 11.7% in December. Additional local recruitment events have demonstrated success in January.

Trust Discharge





Medically Fit Transfer List (Green to Go List)

- Work is progressing aligning the Northern and Eastern G2G lists, processes and reporting and this is being overseen by Trust Strategic Command.
- For Northern the total list increased in January. This was due to an increase in demand and the impact of stepping down the additional 182 agency hours on Pathway 1 Time to Transfer. The list is now reducing with this agency provision reinstated through Hospital Discharge funding.
- For Eastern, the average number of patients on the green to go list decreased at the beginning of January and has stabilised throughout January.

Actions to improve performance and outcomes

• Eastern and Northern have utilised additional Hospital Discharge funds to bring in capacity where identified and extending existing schemes where possible.

For Eastern:

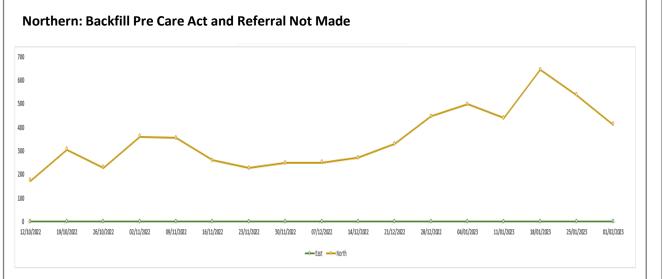
- Additional agency support came online from 17 January to provide additional capacity to areas with high levels of vacancies in some teams in particular Exeter and Tiverton. This was initially 2 runs but has now been approved to increase to 6 runs from 27th February to 31st March utilising Hospital Discharge funds.
- Funding extended through Hospital Discharge funding for 1:1 support for complex discharges on pathways 2 and 3.

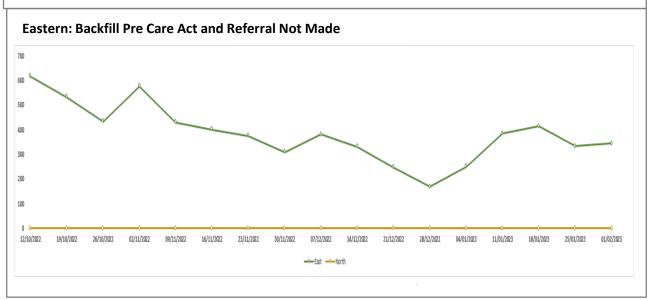
For Northern:

- Additional agency cover (182 hours) agreed in December and due to finish mid-January has funding extended from the Hospital Discharge Fund from 30th January to 31st March expediting Pathway 1 Discharges.
- An additional 6 beds at Deer Park for Pathway 2 became fully operational in January and are looking to increase beds with Hospital Discharge funding.
- Exploring testing Live in Carer model in Northern using Hospital Discharge funds.

Northern and Eastern Community Services Backfill Pre Care Act

Unallocated domiciliary care hours, and waiting list position





Northern: The decrease in backfill in Northern reflects the extension of agency cover.

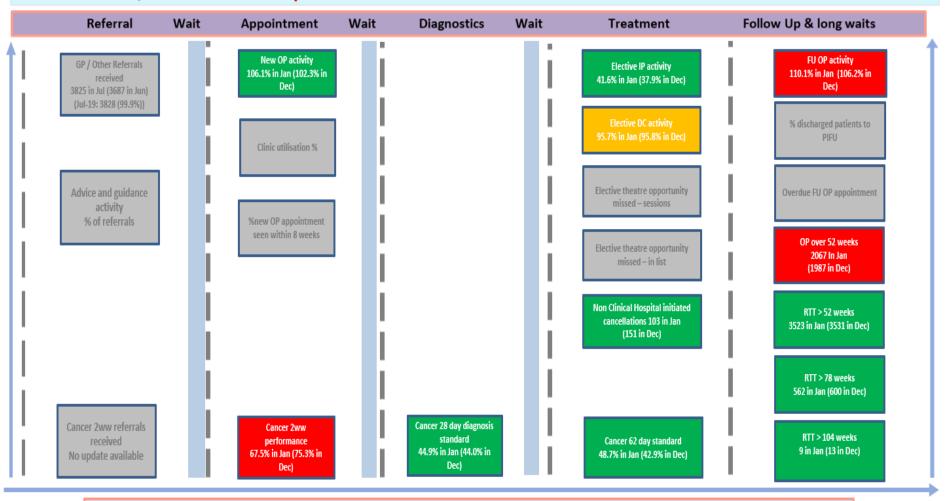
Teams are also working on a robust escalation process for monitoring STS reviews and for how long unallocated packages of care stay on agency.

Eastern: Teams remain focused on timely referral for onward assessment and are escalating delays to CSMs. With the increase in agency support it is anticipated this will start to reduce again.

Eastern will review the learning of the escalation process from Northern with a view to implementation.

Northern Services Planned Care Metrics 2022-2023

Data: November, December & January 2023



Enabling work streams: Clinical prioritisation, PTL management, Patient support, Validation, Access management processes, Communications + ownership, EPIC build

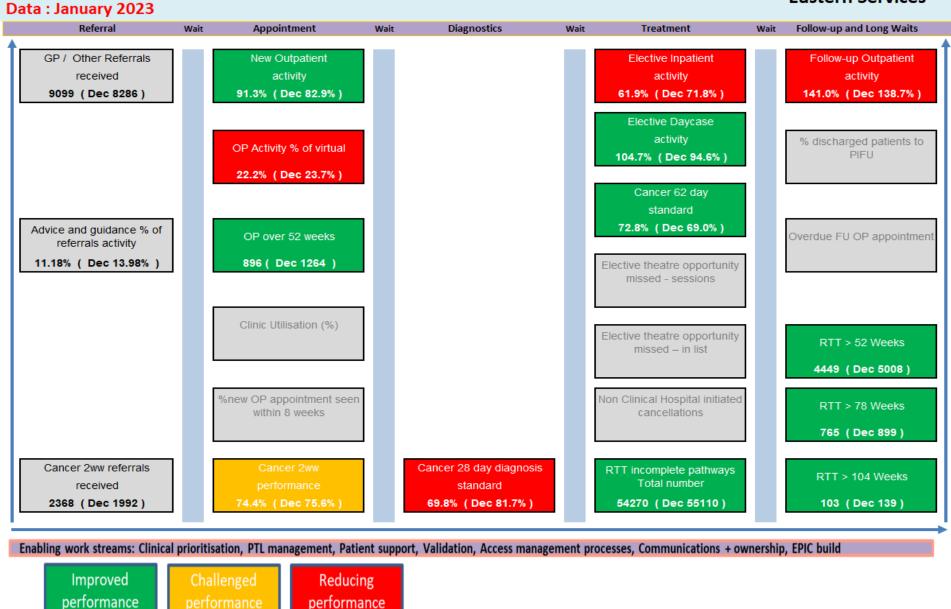
Improved performance

Challenged performance

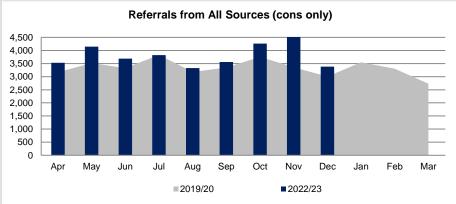
Reducing performance

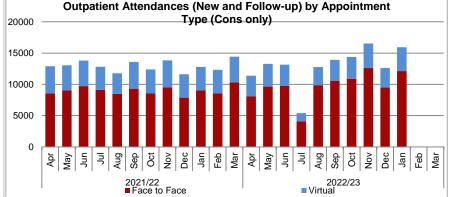
Planned Care Metrics 2022-2023

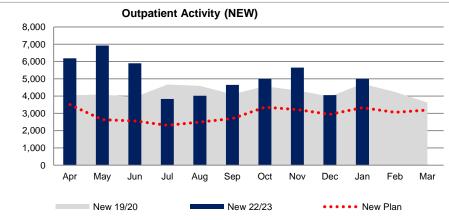
Eastern Services

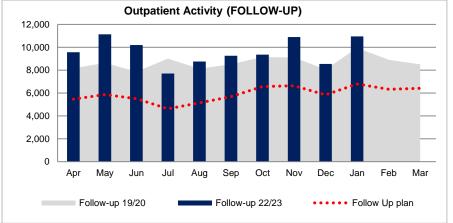


Northern Services Elective Activity- Referrals and Outpatients

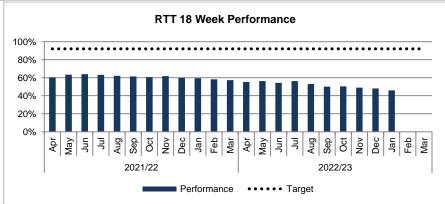




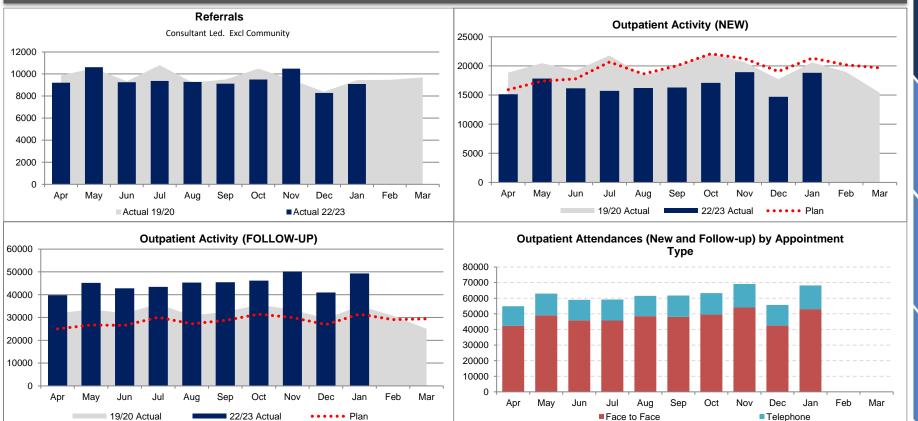




- There were a total of 15,942 Outpatients appointments held in January. Of these, 4998 were New appointments and 10944 were Follow-up appointments.
- Of new and follow up appointments held in January, 76% of appointments were held Face to Face and 24% were Virtual appointments.
- There was a slight decline in RTT 18 week performance in January. The focus still remains on reducing the amount of 104 and 78 week waits between now and year end.
- Work in month has taken place following NHSE issuing a 6 point plan in January. The first of which is to ensure all patients without a decision to admit who will reach 78 weeks by March end to have an outpatient appointment by the end of January.



Eastern Services Elective Activity- Referrals and Outpatients

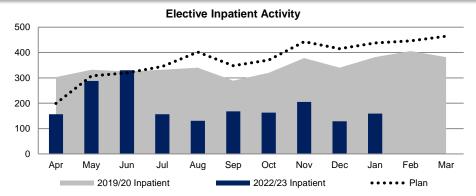


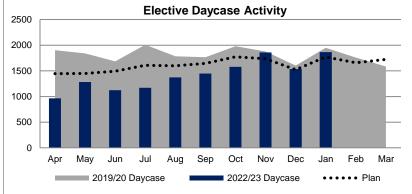
For referrals and all outpatient activity, January saw an increase in activity similar to November volumes, despite ongoing industrial action and significant bed / flow issues throughout the month.

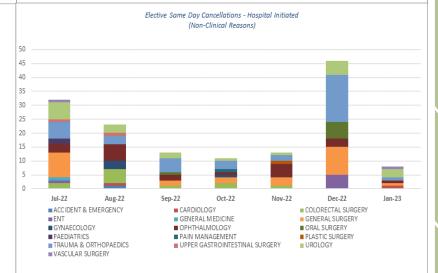
Outpatient new: increased to 91% in January, which is an improvement on the December position and back in line with the November position. The improvements on the December position were across all specialties, but surgical specialties (T&O, Urology, Ophthalmology, General Surgery) are still showing lower volumes than 2019/20, and so are the major focus of the clinical productivity programme to enable increased clinic throughput

Outpatient follow-up: Increased to 141% in January, which is in line with the November position. As previously reported data quality issues (Midwifery in particular) are still present in outpatient follow-ups, which is overstating this position. They are in the process of being resolved with the intention to complete before the end of March.

Northern Services Elective Activity- Inpatient and Daycase

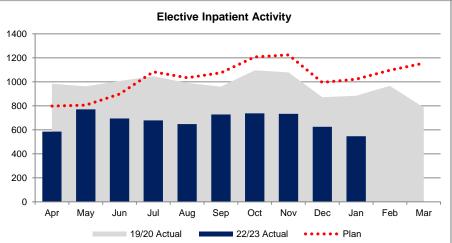


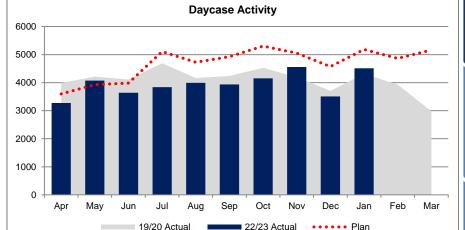




- Highest clinical priority patients and long waiting patients continue to be monitored weekly via the Patient Tracking Meeting (PTL).
- On the 29th January Northern Services declared Opel 4, during this time 18 patients had their surgery cancelled due to the use of all escalation areas including Endoscopy.
- Elective Inpatient activity increased during January by 30 and Day case activity increased during January by 330. Further work is underway to restore the level of elective inpatient capacity.

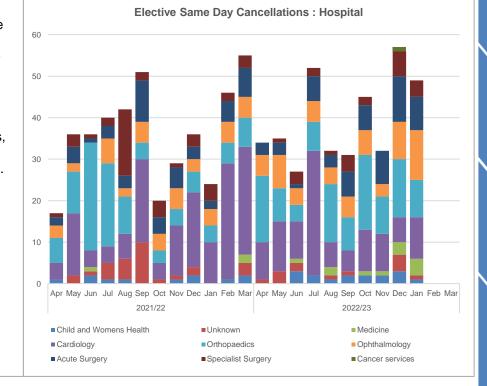
Eastern Services Elective Activity- Inpatient and Daycase



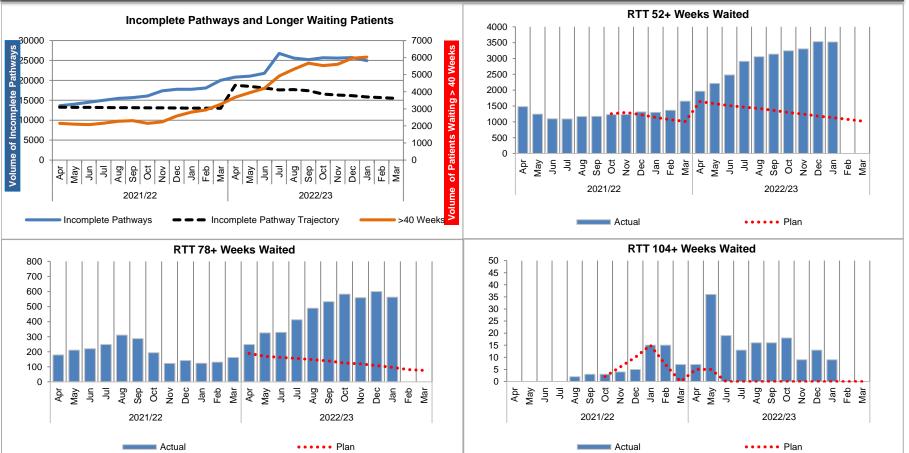


Daycase: activity rose to 105% in January, which is more in line with the November position. The increase was attributed to General Surgery and Cardiology in particular. Nightingale activity for Ophthalmology and T&O also increased month on month, which is positive.

Elective: activity reduced in January to 62%, which was a third consecutive month of falls in activity and is of concern. Bed pressures, including a short reallocation of the ringfenced elective orthopaedic beds, throughout January contributed to this, with all surgical specialties showing low volumes. The high volumes of cancellations aligns with this.



Northern Services Elective Activity- Long Waiting Patients

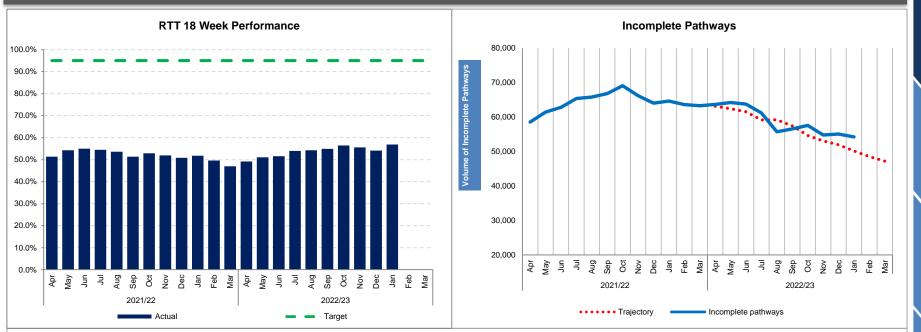


- The focus still remains on ensuring that Northern Services meet the target of 0 patients waiting over 104 weeks for treatment by the end of March.
- In referral to treatment times the focus still remains on reducing 104 and 78 week waits between now and year end. Actions are in place to ensure non-admitted patients who will breach 78 weeks by the end of March 23 have a clinic appointment booked, and patients on admitted waiting lists are offered dates for admission.
- The number of patients waiting 78 weeks reduced by 38 in January and the number of patients waiting 104 weeks also reduced by 4.

Northern Services Elective Activity- Long Waiting Patients Continued

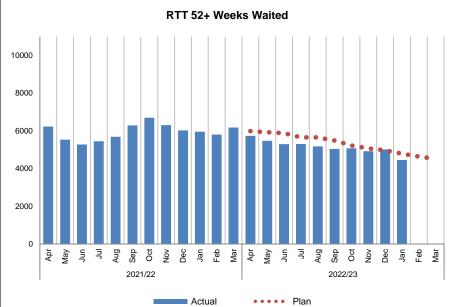
	Specialty						2023	1/22									2022/23							
	эресіаіту	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	
	T&O	416	327	260	225	221	222	225	244	267	312	344	391	460	522	529	594	590	594	596	552	600	586	
ŝ	Cardiology	8	6	5	1	2	7	12	12	10	10	11	15	13	23	27	37	42	72	92	130	164	171	
ée	Ophthalmology	492	393	311	323	458	373	371	367	401	390	336	459	561	632	720	865	824	823	831	800	820	751	
<u>></u>	Other	425	352	353	366	315	414	438	454	490	436	504	594	694	757	903	1055	1208	1248	1331	1434	1536	1593	
52	Urology	108	122	118	124	127	134	120	126	119	125	132	153	182	204	235	268	284	284	279	306	326	347	
	Grand Total	1484	1244	1099	1091	1167	1174	1230	1235	1316	1301	1367	1655	1967	2212	2483	2912	3058	3137	3246	3307	3531	3523	
	T&O	47	49	55	51	63	62	42	23	22	41	21	33	65	126	97	114	137	140	130	106	118	109	
ŝ	Cardiology	0	0	0	1	0	1	0	0	0	0	0	0	2	1	0	0	1	1	4	5	4	1	
/ee	Ophthalmology	72	82	78	93	106	86	45	18	16	19	17	27	44	33	43	58	54	85	116	140	148	147	
+	Other	39	50	58	69	98	90	79	49	72	28	58	62	89	106	134	170	204	238	251	226	240	221	
78	Urology	21	28	28	33	41	39	23	29	29	32	32	37	43	53	50	63	65	62	66	70	78	74	
	Grand Total	179	211	220	248	311	287	194	122	141	123	131	162	248	325	329	412	471	533	582	559	600	562	
	T&O	0	0	0	0	0	1	0	0	0	1	0	3	2	28	13	5	6	5	5	1	0	0	
s Š	Cardiology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
We e	Ophthalmology	0	0	0	0	0	0	0	1	1	5	4	0	1	0	0	1	2	2	1	3	2	0	
1	Other	0	0	0	0	2	1	3	2	3	9	10	3	3	4	1	2	2	4	8	1	7	5	
10	Urology	0	0	0	0	0	1	0	0	0	0	1	0	0	3	4	4	4	5	3	4	3	4	
I	Grand Total	0	0	0	0	2	3	3	4	5	15	15	7	7	36	19	13	15	16	18	9	13	9	

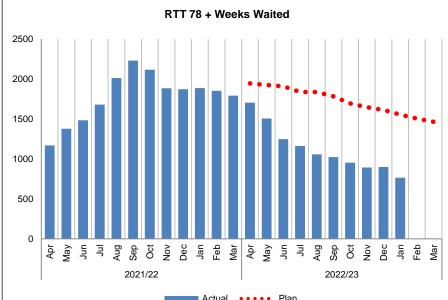
Eastern Services Elective Activity- Inpatient and Daycase

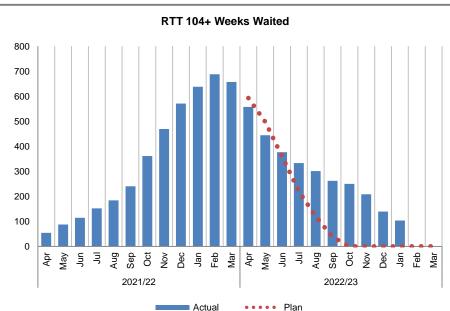


The increase in non-admitted and admitted activity continues to have a positive impact on RTT performance and incomplete pathways, with a continued reduction in the volume of incomplete pathways in line with trajectory. Whilst the volume of incomplete pathways is still very high, this is a positive position moving into 2023/24.

Eastern Services Elective Activity – Long Waiting Patients







All positions continue to show a positive picture in terms of run-rate, with a reduction in long waits across all areas after a static position in December. Significant efforts continue around long waits, with the aim of continuing to improve this position.

Eastern Services Elective Activity- Long Waiting Patients

	Specialty						202	1/22										202	2/23					
	Specialty	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	
	Orthopaedics	1859	1720	1628	1535	1482	1533	1595	1617	1610	1537	1492	1568	1499	1416	1364	1419	1374	1436	1487	1478	1402	1237	
s,	Cardiology	414	399	417	407	418	491	530	484	442	414	377	416	429	457	487	520	545	482	428	457	489	443	
ě e e	Ophthalmology	1315	1013	941	1046	1212	1399	1489	1456	1610	1404	1365	1608	1345	1164	929	858	688	578	546	452	458	399	
* +	Colorectal Surgery	445	437	437	448	455	451	498	514	526	553	517	523	526	593	609	618	546	508	513	535	538	541	
22	Upper GI	80	86	76	81	94	95	114	99	91	102	107	106	104	104	109	113	101	101	127	140	161	152	
	Total	6224	5531	5272	5445	5682	6284	6691	6299	6021	5952	5802	6173	5731	5473	5289	5298	5173	5034	5074	4920	5008	4449	
	Orthopaedics	581	654	697	698	761	810	782	775	843	846	827	820	773	684	584	528	472	457	417	387	339	281	
ø	Cardiology	108	111	120	126	152	165	175	137	121	134	138	133	153	149	134	129	130	121	94	113	125	121	
ee k	Ophthalmology	61	70	91	137	279	384	343	264	246	307	325	331	271	223	155	140	94	77	80	53	64	45	
* *	Colorectal Surgery	128	172	175	195	219	233	250	252	260	248	221	183	188	183	149	153	127	119	120	127	127	128	
22	Upper GI	23	22	21	23	34	34	35	29	22	19	21	22	30	22	19	28	22	22	29	32	38	41	
	Total	1170	1377	1483	1679	2013	2231	2117	1884	1873	1887	1853	1791	1704	1505	1248	1162	1058	1023	952	892	899	765	
	Orthopaedics	23	35	47	65	81	114	178	252	340	397	437	445	364	299	261	230	191	162	153	124	72	50	
8	Cardiology	6	12	23	28	25	27	46	51	49	59	63	57	58	45	32	31	22	16	12	14	9	10	
Nee-	Ophthalmology	0	0	0	0	1	4	6	12	18	18	30	24	13	8	2	6	9	8	5	4	5	2	
4 >	Colorectal Surgery	19	23	28	34	38	41	54	64	75	87	80	75	67	63	46	42	45	42	48	33	26	19	
10	Upper GI		2	0	2	3	3	7	4	4	2	2	3	2	4	1	1	1	0	0	3	5	5	
	Total	54	87	114	152	184	240	361	469	571	638	688	657	557	444	376	333	301	262	250	208	139	103	

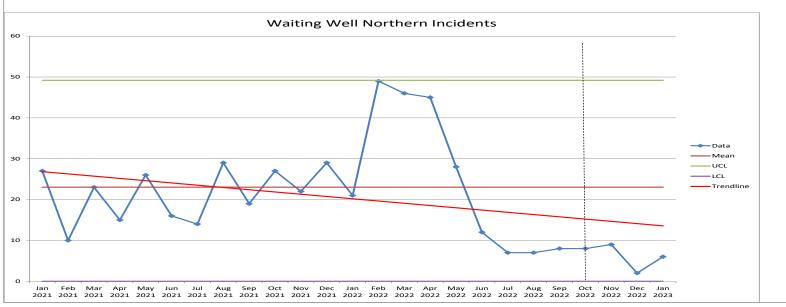
Northern Services Waiting Well

There were no Moderate, Major or Catastrophic incidents reported during January 2023.

Patient survey

- Northern services are planning to replicate the patient survey process that is already in place in eastern services.
- · The aims of the survey are to
 - identify any patients who no longer want or need to be on a waiting list (patient validation)
 - Ensure patients are empowered to seek appropriate help from the health system when needed
 - Refer any identified patients that need further community support to local voluntary sector organisation(s)

January 2023 Waiting Well Northern Incidents	None	Minor	Total
Follow up delay	0	3	3
Diagnostic request delay	0	1	1
New	1	0	1
Surgery	1	0	1
Total	2	4	6



Integrated Performance Report

Executive Lead: John Palmer

Eastern Services Waiting Well

Patient survey support key aims

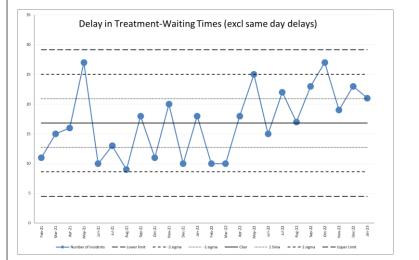
- Identify any patients who no longer want or need to be on a waiting list (patient validation)
- Ensure patients are empowered to seek appropriate help from the health system when needed
- Refer any identified patients that need further community support to local voluntary sector organisation(s)
- The table reflects total activity since the survey was implemented

Patients Sent Survey	15315
Completed Survey	10000
No response (all contact methods tried)	2053
Work In Progress	3262
Outcome of completed Survey	
Remove from WL	1701
Remain on list with clinical review	3106
Remain on list and referred for community lifestyle support and advice	1393
Remain on list	3800

- Survey increased from 500 to 1000 per week this month, required to expand to 2000 per week to meet new requirements on administrative (patient contact) validation of waiting lists. Further resource is required to meet this requirement.
- Expanded survey process will be rolled out across northern during February

Eastern Services Waiting Well

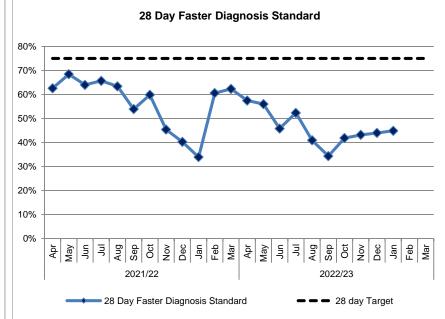
Across the same time period in Eastern 21 incidents were reported for January 2023, these are broken down by the level of harm against stage of pathway below.



	None	Minor	Moderate	Major	Catastrophic	Total
Follow up delay	3	6				9
Diagnostic Delay	2	3				5
Surgery	3	1				4
New	3				·	3
Total	11	10	0	0	0	21

Northern Services Cancer 14 and 28 Day





2 Week Wait Performance

The significant challenges in the high volume speciality of Dermatology as a result of transition from System1 to Epic was the main contributor towards the drop in 2 week wait performance in August - October. The dermatology position has been recovering due to additional clinical capacity and is anticipated to achieve the target in in coming months, performance is currently 82% for January. This improvement can be seen impacting on the overall site position since November. Unfortunately a number of other specialties have significant capacity pressures and were significantly below the 14 day target for 1st OPA for January. The largest volumes of breaches were observed in urology 34% - 60 breaches, Gynae 52% -54 breaches, Breast 72% - 37 breaches and Skin 82% 28 breaches. Of note gynae performance is expected to improve in February, Breast capacity constraints are the result of industrial action causing clinic cancellations.

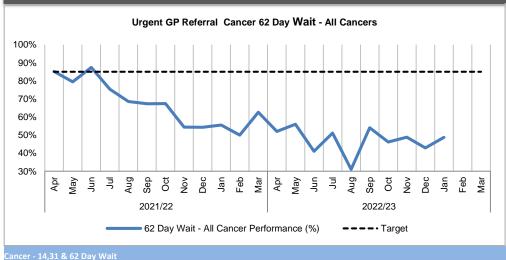
- All services are working to reduce first out patient waiting times to 7 days
- Additional capacity has commenced or is about to commence in Dermatology, Urology, Lower GI and Gynaecology.

28 Day Faster Diagnosis Standard

- The 2ww performance is directly impacting on ability to confirm diagnosis within 28 days.
- The majority of tumour sites are still struggling to achieve the 28 day faster diagnosis target and actions to support delivery are being monitored as part of the Trust's Cancer Recovery Action Plan.
- Colorectal faster diagnosis breaches have significantly increased as a result of access to endoscopy for colonoscopy; options to insource additional endoscopy capacity are being explored.
- Urology additional cystoscopy capacity is now in place and a new prostate pathway is planned to go live the week commencing the 13th February.
- Skin performance is expected to improve following achievement of the 2 week wait target and this has occurred in January.
- Additional capacity is in place to support improvement Gynaecology diagnostic pathway performance, additional 2ww and hysteroscopy activity is planned.

Northern Services Cancer 62 Day – Proportion of patients treated within 62 days following referral by a GP for

suspected cancer



62.60% 68.42%

204.0

242.0

229.0

321.0

233.0

236.0

N/A

- · Data Quality post EPIC implementation has now been resolved and treatment volumes are in line with pre- EPIC baseline.
- Weekly PTL meetings are in place across all tumour sites.
- Extensive validation has resulted in a smaller total PTL size which is emphasizing the 62 day + position.
- · The majority of pathway delays are in within the diagnostic phase of the pathway, particularly in Urology and Colorectal tumour sites. 62 day performance will improve with actions aligned to deliver 28 FDS.
- Capacity remains a pressure for some specialties and Oncology capacity for new patient appointments and treatments are subject to significant capacity constraints
- Every service has an up to date Cancer Recovery Action Plan with specific actions against delivery of each of the national CWT indicators where operational standards are not being achieved, these are monitored at the Northern Cancer Steering Group.

2022/23

Perfo	rmance(%) and Number of							202	1/22										202	2/23					
	Breaches	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	
	All Urgent (%)	93%	79.44%	82.20%	79.29%	80.49%	83.25%	79.84%	81.06%	75.82%	77.89%	70.96%	75.14%	76.57%	75.44%	87.12%	87.89%	84.31%	64.36%	63.23%	63.50%	72.86%	75.29%	68.07%	
Day	All Urgent (N)	93%	120.0	105.0	148.0	133.0	103.0	150.0	132.0	163.0	159.0	183.0	172.0	190.0	154.0	102.0	86.0	83.0	299.0	285	254	224	151	237	
14	Symptomatic Breast (%)	93%	6.56%	1.56%	0.00%	8.16%	0.00%	2.17%	0.00%	3.57%	1.75%	3.64%	7.58%	2.67%	8.70%	71.74%	79.31%	100.00%	0.00%	100.00%	100.00%	83.33%	75.00%	35.71%	
	Symptomatic Breast (N)	93 /6	57.0	64.0	40.0	45.0	16.0	46.0	11.0	54.0	56.0	53.0	61.0	73.0	42.0	13.0	12.0	0	1	0	0	2	4	9	
	All Decision To Treat (%)	96%	94.10%	98.98%	94.70%	96.11%	89.36%	86.59%	88.00%	82.22%	88.09%	83.65%	87.25%	84.11%	83.54%	81.80%	76.90%	96.30%	97.37%	97.30%	81.82%	92.86%	80.95%	93.55%	
	All Decision To Treat (N)	90%	6.0	2.0	4.0	3.0	6.0	11.0	9.0	16.0	10.0	17.0	13.0	17.0	12.0	17.0	15.0	1	1	1	6	8	12	4	
Day	Subsequent - Surgery (%)	94%	91.60%	94.11%	100.00%	90.00%	66.66%	60.00%	66.66%	91.66%	55.55%	41.66%	75.00%	71.42%	54.54%	20.00%	40.00%	100.00%	100.00%	100.00%	50.00%	60.00%	73.33%	66.67%	
31 Ö	Subsequent – Surgery (N)	9476	2.0	1.0	0.0	1.0	4.0	4.0	3.0	1.0	4.0	4.0	2.0	4.0	5.0	4.0	3.0	0	0	0	3	4	11	1	
	Subsequent - Anti-Cancer Drug %	98%	100.00%	100.00%	100.00%	95.65%	83.33%	96.60%	92.59%	100.00%	95.83%	82.60%	90.32%	96.29%	96.15%	92.60%	94.40%	100%	100%	97%	88%	75%	93%	80%	
	Subsequent - Anti-Cancer Drug		0.0	0.0	0.0	1.0	5.0	1.0	2.0	0.0	1.0	4.0	4.0	1.0	1.0	2.0	1.0	0	0	1	3	13	3	6	
	All Screening Service (%)	90%	33.30%	0.00%	33.30%	3330.00 %	50.00%	44.44%	100.00%	66.60%	100.00%	33.00%	100.00%	28.57%	100.00%	75.00%	100.00%	100%	0%	17%	0%	100%	0%	100%	
Day	All Screening Service (N)	90 /8	2.0	1.0	2.0	1.0	1.0	2.5	0.0	1.0	0.5	1.0	3.0	2.5	0.0	1.0	0.0	0	2.5	0.5	0	2	0	2	
62 [Consultant upgrade (%)	90%	72.05%	87.20%	96.25%	89.65%	76.74%	83.60%	67.34%	76.71%	78.73%	73.23%	80.00%	62.00%	57.44%	60.00%	74.50%	66.67%	6.00%	65.22%	75.76%	57.14%	72.73%	60.00%	
	Consultant upgrade (N)	9076	9.5	5.5	1.5	4.5	10.0	5.0	8.0	8.5	6.5	8.5	11.0	10.0	10.0	11.0	7.0	6	71.43	8	8	13.5	6	6	

2021/22

28 day Ref to diagnosis (N)

28 Ref to diagnosis (%)

413.0

492.0

329.0

254.0 268.0

241.0

263.0

395

556

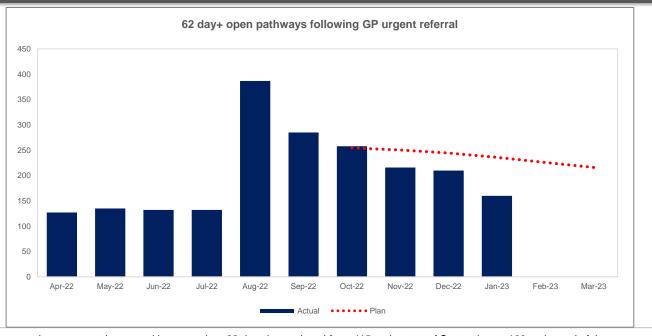
394.0

381

371

Northern Services Cancer 62 Day Backlog

Cancer patients awaiting treatment more than 62 days following GP urgent referral



- The number of patients on active cancer pathways waiting more than 62 days has reduced from 415 at the start of September to 160 at the end of January.
- Despite the reduction in >62 day volumes, the increase scrutiny of PTL meetings has caused the overall PTL volume to decrease and therefore the percentage of pathways over 62 days remains high at 16.9%, but does demonstrate a decreasing trajectory.
- The tumour sites with the largest number of patients waiting over 62 days are Urology (71) and Colorectal (37).

Key actions:

Colorectal

- Endoscopy insourcing in place and further insourcing capacity with additional provider is being explored.
- Locum consultant post out to recruitment

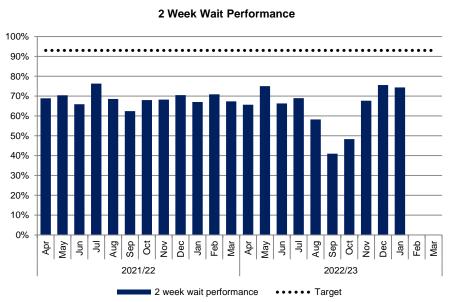
Urology

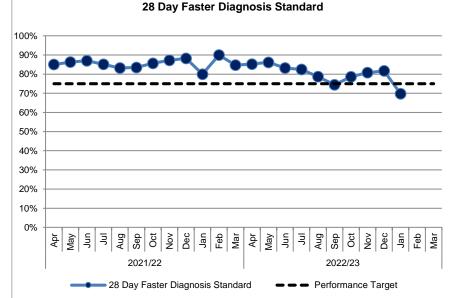
- Locum consultant post out to recruitment
- LATP biopsy Additional capacity agreed, staff training planned to sign off additional operators locally.
- Outsourced cystoscopy capacity in place throughout Q4
- · Additional Ultrasound capacity aligned with Flexible Cystoscopy capacity being scoped.
- New prostate pathway to be implemented in February

Gynae

Additional 2ww and hysteroscopy sessions are taking place.

Eastern Services Cancer 14 and 28 Day





2 Week Wait Performance

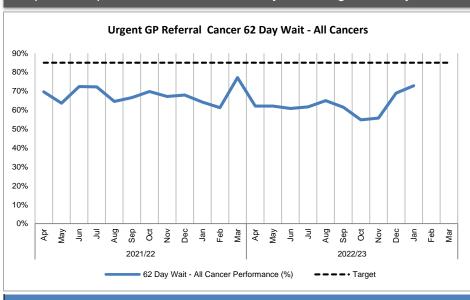
- Performance has been increasing since September, although remains significantly below target due to an imbalance of demand/capacity.
- A significant improvement has been noted in Breast (28.2% in October and 96.5% in January) and Skin (38.5% in October and 92.6% in January). Part of this is due to a lower number of referrals during this period, approximately 8% fewer than November.
- Lower GI 2WW performance is continuing to decline (28.5% in January, down from 35.8% in December). This is due to staffing within the Nurse Triage team due to sickness and issues with capacity across Endoscopy and Radiology (as 2/3 of patients go straight to test).

28 Day Faster Diagnosis Standard

- Colorectal performance has continued to decline due to Outpatient capacity and Endoscopy capacity (27.6% in January, down from 38.6% in December). Additional clinics are being sought to improve capacity this is routinely monitored and a capacity/demand exercise is currently being undertaken.
- Endoscopy capacity issues are also impacting the Upper GI performance. The team are still undertaking waiting list initiatives to increase capacity. A proposal for additional capacity is being planned. In addition to current waiting list initiatives, the Endoscopy Team have been granted funding for an additional 20 lists until the end of March.
- Of note there has been a considerable decline in performance for Haematology (77.8% in December, dropping to 15.8% in January). The reasons for this are predominantly clinical admin.

Eastern Services Cancer 62 Day

Proportion of patients treated within 62 days following referral by a GP for suspected cancer



Performance against the 62 Day Cancer Target improved by 3.8% to 72.8% in January. Risks & mitigations

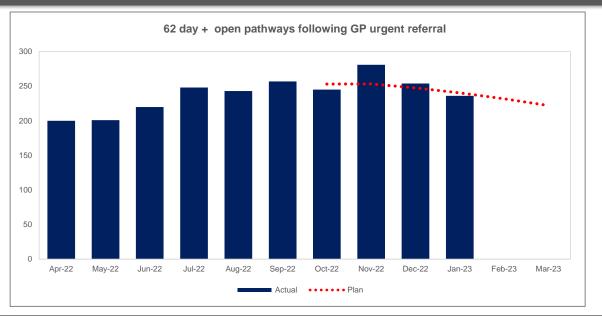
- Oncology and Haematology are no longer able to absorb capacity require to
 implement new statutory NICE guidance for patients when this is
 released. Conversations are on-going within the Trust, Cancer Alliance and ICB to
 sufficiently fund services to uplift staffing to allow for adequate capacity to absorb
 additional workload year on year. This includes recognition of the uplift required to
 sufficiently staff implementations in 2022/23 to help mitigate risks to service, patients
 and staff wellbeing
- Although the new theatre timetable and clinical prioritisation with the POD are in effect, theatre capacity remains a significant issue (more complex surgeries/Tertiary patients and an increased demand).
- Delays in Urology due to an increase in demand for RALPs (in part due to Tertiary referrals) – a third surgeon is currently undergoing training on robotics. CNS Team are in process of recruiting which will support and stabilise the service.
- Additional agency staff for Theatres are currently being explored to support increasing theatre activity.

Cancer -	14, 31,	62 & 104	Day Wait	
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	Performance(%) and	TARGET						202	1/22									2022/23						
	Number of Breaches	IARGEI	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
	All Urgent (%)	93%	68.9%	70.4%	65.9%	76.3%	68.6%	62.5%	68.0%	68.2%	70.5%	67.1%	70.9%	67.3%	65.6%	75.0%	66.3%	69.0%	58.3%	41.0%	48.3%	67.6%	75.6%	74.4%
Day	All Urgent	93%	650	600	833	514	665	841	702	723	642	622	580	781	760	605	762	763	1027	1434	1236	813	487	566
14[Symptomatic Breast (%)	93%	3.7%	14.9%	8.7%	42.0%	30.4%	8.1%	29.0%	11.3%	7.9%	15.8%	35.8%	13.3%	20.9%	35.2%	58.1%	57.4%	62.9%	16.7%	40.5%	72.5%	95.8%	94.1%
	Symptomatic Breast	93%	52	57	63	29	32	57	49	47	58	48	34	65	34	46	18	20	13	30	25	14	1	2
	All Decision To Treat (%)	96%	96.8%	97.4%	94.2%	94.0%	93.1%	91.5%	95.2%	91.0%	93.2%	92.0%	92.4%	92.9%	88.5%	86.9%	87.9%	85.4%	89.8%	89.5%	93.0%	87.0%	89.3%	69.4%
	All Decision To Treat	90 /0	9	7	18	18	19	24	14	29	22	23	19	19	31	41	34	37	22	21	12	28	24	137
	Subsequent - Surgery (%)	94%	83.1%	81.9%	77.3%	88.5%	76.5%	87.5%	85.4%	79.5%	72.7%	75.6%	76.5%	62.8%	64.2%	67.1%	76.0%	75.3%	71.2%	61.1%	77.6%	87.2%	81.1%	60.0%
Day	Subsequent - Surgery	94 /0	12	15	17	9	16	11	12	16	24	19	19	29	29	26	25	21	17	28	17	11	14	40
31 [94%	99.3%	100.0%	97.1%	99.2%	98.3%	99.2%	100.0%	97.1%	100.0%	97.7%	99.2%	99.1%	100.0%	99.2%	95.9%	98.8%	97.6%	98.6%	99.0%	99.2%	99.1%	100.0%
	Subsequent - Radiotherapy	3470	1	0	4	1	2	1	0	4	0	3	1	1	0	1	4	1	2	1	1	1	1	0
	Subsequent - Anti-Cancer Drug (%)	98%	96.8%	98.5%	100.0%	100.0%	100.0%	100.0%	98.7%	98.9%	98.6%	97.2%	100.0%	100.0%	100.0%	98.6%	100.0%	100.0%	97.5%	100.0%	100.0%	100.0%	100.0%	98.4%
	Subsequent - Anti-Cancer Drug	90 /0	3	1	0	0	0	0	1	1	1	2	0	0	0	1	0	0	2	0	0	0	0	1
Jay	All Screening Service (%)	000/	0.0%	16.7%	0.0%	0.0%	15.4%	50.0%	100.0%	15.4%	14.3%	33.3%	0.0%	0.0%	12.5%	28.6%	33.3%	0.0%	0.0%	0.0%	0.0%	25.0%	33.3%	10.3%
62 E		90%	2	5	5.5	3	5.5	4	0	5.5	6	2	5	3	3.5	2.5	2	2	4	1	2	3	2	13
104 days	Volume of Patients Waiting Longer than 104 Days at Month End		33	42	42	32	45	36	36	38	46	39	37	40	52	53	70	68	58	59	54	84	81	84

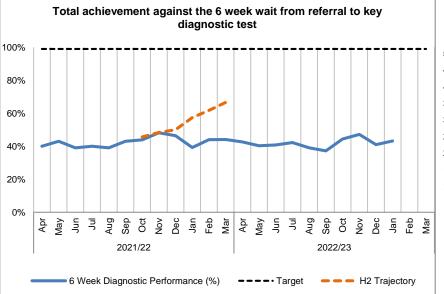
Eastern Services Cancer 62 Day Backlog

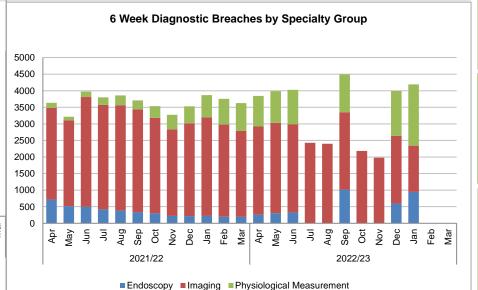
Cancer patients awaiting treatment more than 62 days following GP urgent referral



- 12.7% of patients on a cancer pathway at the end of January had waited longer than 62 days for diagnosis and treatment (NHSE benchmark 6.4%; 11.5% Peninsula performance).
- The number of patients waiting for diagnosis and treatment is significantly higher than plan reflecting the impact of increased demand.
- The long waiting trend decrease has continued throughout January with those Patients >62 day showing a steady reduction. The activity described within the submitted trajectory for each tumour site needs to be maintained throughout the coming weeks. This will prevent tip over from >64 day to >104-day cohorts.
- · Validation to support our current position will continue.
- The harm review process has been amended and implemented across all Tumour Sites. This information in time will feed into breach validation narrative and support areas of improvement through clinical support.
- The improvement seen in December in the number of patients awaiting diagnosis and treatment has continued, resulting in a return to a favourable position compared to plan at the end of January.

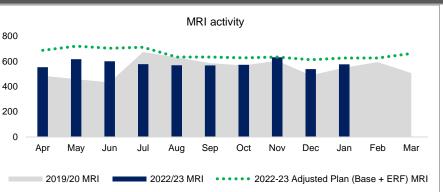
Northern Services Diagnostics - Fifteen key diagnostic tests

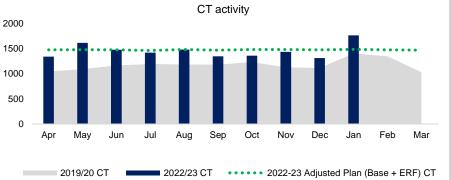


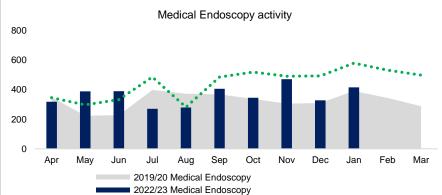


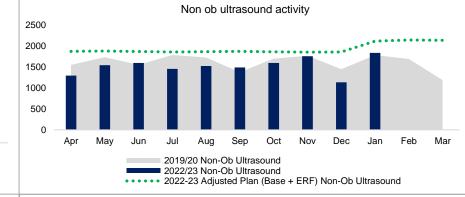
		Achiev	rement aga	ainst the 6	week wait	from refer	rral to key	diagnostic	test														\setminus
Area	Diagnostics by Specialty	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22 May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	
	Magnetic Resonance Imaging	52.2%	62.2%	47.4%	55.4%	54.8%	59.6%	64.9%	69.5%	62.2%	51.8%	69.1%	74.9%	96.5% 96.7%	94.6%	97.7%	100.0%	100.0%	99.4%	99.7%	99.7%	96.9%	
	Computed Tomography	61.3%	68.9%	66.1%	62.2%	64.2%	64.5%	66.1%	61.4%	60.4%	48.0%	56.8%	53.0%	55.6% 55.2%	64.7%	65.2%	56.1%	66.8%	81.9%	76.3%	75.2%	78.4%	
Imaging	Non-obstetric ultrasound	32.2%	29.6%	24.1%	25.2%	25.4%	28.9%	27.0%	37.6%	35.4%	32.1%	36.1%	40.1%	35.2% 32.9%	30.9%	33.1%	35.2%	35.2%	35.8%	40.9%	36.2%	54.9%	
	Barium Enema	-	-	-	-	-	-	-	-	-	-	-	-		-	-	-	-	-	-	-	-	
	DEXA Scan	12.0%	15.3%	15.5%	12.2%	14.5%	14.6%	12.5%	11.7%	11.9%	10.0%	12.6%	12.4%	11.6% 10.7%	10.5%	11.5%	14.6%	13.8%	14.5%	17.9%	14.3%	15.7%	
	Audiology - Audiology Assessments	89.9%	97.5%	98.3%	98.3%	99.2%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0% 100.0%	100.0%							100.0%	
	Cardiology - echocardiography	96.0%	99.6%	96.7%	84.8%	67.6%	67.9%	58.6%	57.5%	53.2%	37.1%	37.6%	36.2%	31.4% 26.6%	28.3%						27.9%	18.6%	
Physiological Measuremen	Cardiology - electrophysiology	-	-	-	-	-	-	-	-	-	-	-	-		-	-	-	-	-	-	-	-	
t	Neurophysiology - peripheral neurophysiology	90.5%	95.5%	71.2%	56.3%	48.1%	70.2%	86.6%	94.3%	95.5%	81.6%	90.5%	96.4%	96.3% 96.8%	92.5%			88.5%			97.9%	93.8%	
	Respiratory physiology - sleep studies	47.5%	57.7%	41.0%	73.9%	89.3%	68.8%	57.8%	50.9%	49.0%	50.4%	32.4%	29.3%	22.5% 34.3%	30.8%			17.4%			64.8%	52.3%	
	Urodynamics - pressures & flows	23.1%	36.2%	30.4%	21.9%	18.6%	37.7%	49.4%	51.4%	45.1%	44.6%	35.8%	25.9%	20.4% 25.4%	23.3%			1.4%			39.4%	30.8%	
	Colonoscopy	42.9%	38.2%	32.5%	38.7%	35.8%	47.1%	54.7%	51.5%	61.6%	72.3%	85.0%	72.0%	62.3% 48.6%	43.8%			27.6%			30.6%	32.7%	
Fadanası	Flexi sigmoidoscopy	46.6%	42.1%	39.3%	40.7%	42.9%	52.5%	55.7%	64.6%	74.4%	70.4%	84.2%	74.6%	64.8% 71.8%	70.3%			28.5%			42.9%	30.9%	
Endoscopy	Cystoscopy	28.7%	42.4%	41.7%	46.6%	43.8%	55.5%	51.1%	62.6%	59.1%	51.8%	51.9%	63.9%	67.0% 75.6%	73.3%			59.8%			74.4%	42.6%	
	Gastroscopy	37.3%	41.4%	39.7%	56.9%	49.2%	61.0%	65.9%	81.8%	86.4%	83.7%	87.4%	82.0%	70.9% 61.9%	60.8%			53.1%			44.9%	39.1%	
Total		38.9%	43.2%	39.4%	40.3%	39.1%	42.7%	43.9%	48.2%	46.4%	39.2%	43.9%	41.1%	42.6% 40.2%	40.8%	42.2%	39.0%	37.2%	44.4%	47.2%	41.0%	43.2%	

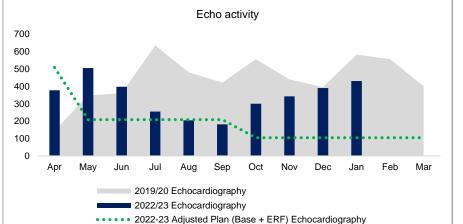
Northern Services Diagnostics - Diagnostic activity compared to plan across key diagnostics modalities











Northern Services Diagnostics - Diagnostic activity compared to plan across key diagnostics modalities

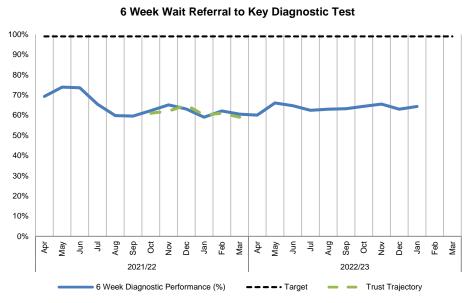
In January the Diagnostic DM01 was reported with up to date data from Epic having resolved a number of DQ issues. Only Audiology hearing assessments are now a snapshot from pre Epic.

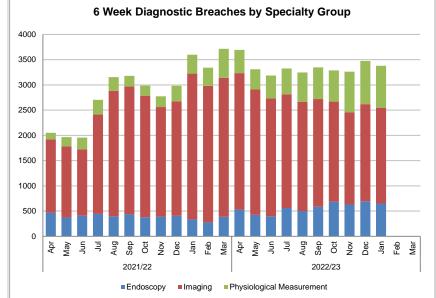
Key issues at modality level:

- MRI Whilst activity is below plan, demand is being met. Additional capacity is planned until the end of March 2023. There has been a recent increase in referrals and we have had to increase inpatient slots to support flow when in OPEL 4 which had meant reducing routine outpatient numbers during this time.
- CT Non-Cardiac CT Whilst activity is below plan it was meeting demand. Since October however there has been an increase in 2 week rule referrals which has affected this position. We have booked a further 16 days of the mobile service before the end of March 2023 to increase capacity. Discussions with Eastern services have taken place to see if there is any potential of capacity at the Nightingale however this will be a pilot of one day per week from April 2023.
- Cardiac CT Additional cardiac CT lists have been taking place since October and will continue to the end of March. CT cardiac lists at RD&E have been agreed, providing an additional 14 scans per session, these commenced in early December and continue until the end of March 2023.
- **U/S-** Outsourcing capacity has been secured and commenced at the Tyrell on the 10th January 2023 this will use the funding that has been sourced for 1200 scans to be used before end of March 2023. At present due to some issues with the outsourcing company we are predicting around 1050 scans to be completed over the 7 weeks. We are also looking to complete some insourcing lists before the end of March 2023 to support further recovery.
- **DXA –** An SLA is in place with Taunton for one list per month only due to the difficulties in sourcing patients who are able to agree to travel to attend these clinic. Our DXA assistant practitioner is progressing with training and appointment slots are being increased in stages as competencies are met and signed off. This will improve capacity.
- Endoscopy Consultant Gastroenterologist vacancies and nursing vacancies & sickness remains a key constraint. Bi-weekly Task and Finish Group has been set up to review ongoing data quality post Epic implementation and to review utilisation of lists. Current capacity is ringfenced for cancer and urgent cases only. An insourcing provider has been unable to fulfil 2 weekends per month so an additional provider has been identified and plans are in place to secure additional activity.
- **Echocardiogram** Inpatient demand for ECG continues to outstrip capacity. Service currently supporting 13 additional lists per month with a total of 11 patients per session. A data cleanse of 1130 patients is being undertaken to rationalize testing following a recent review of inappropriate and duplicate requests throughout Reset week.
- Sleep studies demand continues to see an increase. The service is currently out to recruitment and the team are currently restructuring clinics to allow additional reporting capacity to support these additional diagnostics.

Eastern Services Diagnostics

Volumes of patients waiting longer than 6 weeks for one of fifteen key diagnostics tests

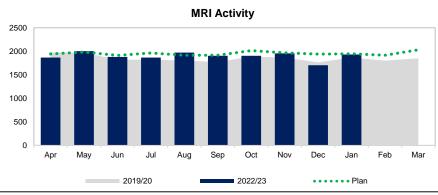


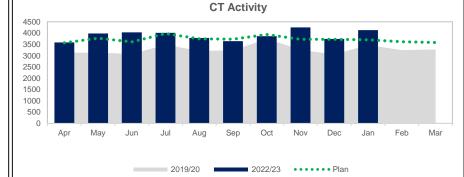


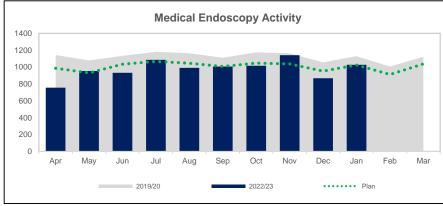
Area	Diagnostics By Specialty	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
	Colonoscopy	73.3%	67.0%	57.1%	64.7%	66.5%	64.0%	63.5%	58.3%	51.6%	54.9%	53.9%	53.9%
Endoscopy	Cystoscopy	71.9%	88.6%	83.1%	82.8%	95.2%	91.5%	88.9%	93.2%	87.4%	83.5%	88.1%	47.8%
Епаозсору	Flexi Sigmoidoscopy	74.8%	61.6%	59.6%	73.0%	76.2%	74.6%	74.5%	62.2%	51.3%	49.6%	44.8%	82.1%
	Gastroscopy	76.8%	61.7%	57.2%	68.0%	72.4%	56.7%	68.7%	68.0%	69.8%	78.3%	74.8%	74.7%
	Barium Enema	-	-	-	-	-	-	-	-	-	-	-	-
	Computed Tomography	48.7%	58.0%	64.3%	73.2%	76.8%	77.1%	81.3%	85.4%	89.5%	92.3%	86.2%	87.9%
Imaging	DEXA Scan	99.2%	88.0%	97.8%	97.1%	98.9%	98.4%	98.2%	99.4%	99.2%	98.4%	100.0%	100.0%
	Magnetic Resonance Imaging	65.8%	64.9%	66.3%	73.9%	74.3%	69.6%	69.1%	72.9%	73.7%	75.6%	68.5%	70.7%
	Non-obstetric Ultrasound	56.9%	53.3%	51.6%	55.1%	51.6%	53.1%	52.7%	51.2%	54.5%	56.7%	56.8%	56.6%
	Cardiology - Echocardiography	84.1%	88.3%	82.1%	86.2%	80.9%	74.5%	71.4%	72.7%	75.2%	65.0%	66.6%	66.9%
	Cardiology - Electrophysiology	-	-	-	-	-	-	-	-	-	-	-	-
Physiological Measurement	Neurophysiology - peripheral neurophysiology	71.9%	54.5%	52.9%	73.2%	69.6%	72.5%	67.1%	61.2%	55.4%	65.4%	43.2%	49.4%
	Respiratory physiology - sleep studies	60.5%	65.5%	60.6%	67.6%	68.3%	60.0%	58.6%	65.8%	61.4%	63.1%	60.6%	57.8%
	Urodynamics - pressures & flows	35.2%	29.6%	26.0%	30.1%	30.3%	34.5%	28.6%	26.9%	25.7%	33.7%	28.8%	38.5%
Total		62.1%	60.5%	60.0%	66.0%	64.7%	62.4%	63.0%	63.2%	64.4%	65.5%	63.0%	64.3%

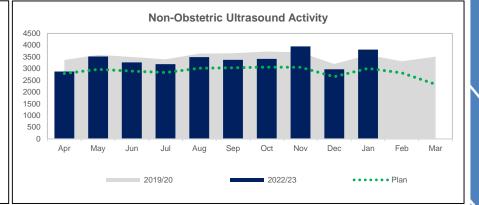
Eastern Services Diagnostics

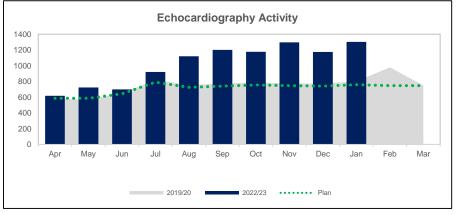
Volumes of patients waiting longer than 6 weeks for one of fifteen key diagnostics tests











Eastern Services Diagnostics

Volumes of patients waiting longer than 6 weeks for one of fifteen key diagnostics tests

Validation in this area is ongoing. Initial indications are that 64.3% of patients were waiting less than 6 weeks – an improvement of 1.3% from the end of December.

There is a regional "focus on diagnostics" planned for March – goals:

- Achieve a consistent reduction in 6 week wait backlogs month on month for CT, MRI echocardiography, colonoscopy, gastroscopy, audiology and NOUS by May 2023
- Achieve optimal level of tests per hour (CT: 3-4 scans per hour, MRI: 2-3 scans per hour, NOUS: 3 scans per hour, Echo: 1 scan per 45 mins, including reporting, and Endoscopy: 95 % of planned endoscopy lists taking place)
- Review of opportunities to optimise histopathology services by the end of March
- Reduce DNA levels to 3% and maintain levels at 3% or below, where this level is already being achieved

CT

- CT performance improves as activity levels return to normal. Recovery continues as projected
- Extended North Devon capacity for Cardiac CT on the CDC mobile located on the Wonford site

MRI

- MR continues to see a deteriorating position.
- Opel 4 inpatient activity has affected outpatient capacity on the main site, all available CDC and mobile capacity continues to be fully utilised for outpatient activity
- BI leading further discussions with Cardiology to explore planning for MRI cardiac recovery

Non Obstetric US

- US breach trend continues to improve. MSK US recovery plans on track to start from March when the new MSK consultant joins the team
- US diagnostics and treatment codes continue to be include in this DM01 but this will change in line with national guidance

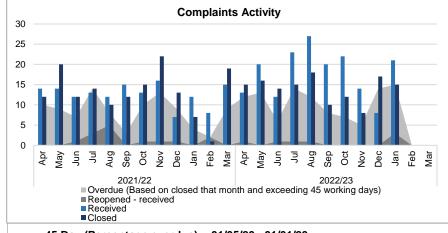
Echo

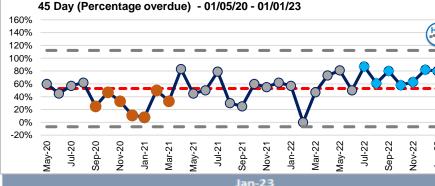
- · Activity continues to exceed plan but demand is high & therefore performance challenged.
- Ongoing weekend physiologist clinics continue but the funding for 260 outsourced echos has now been exhausted resulting in an increasing number of breaches this month, compounded by increasing demand.
- Work on the dashboard continues with BI as well as with the productivity team to optimise test requests.

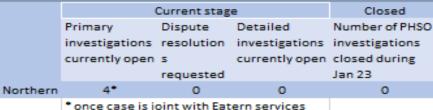
Endoscopy

- The endoscopy team delivered 14 additional weekend lists in January with 10 planned for February.
- In week gaps are being filled where possible (only 3 unfilled lists in January compared to 25 unfilled lists in October).
- The endoscopy team have also been successful in securing some additional funding from NHSE to provide an extra twenty endoscopy lists between now and the end of March.

Northern Services Patient Experience





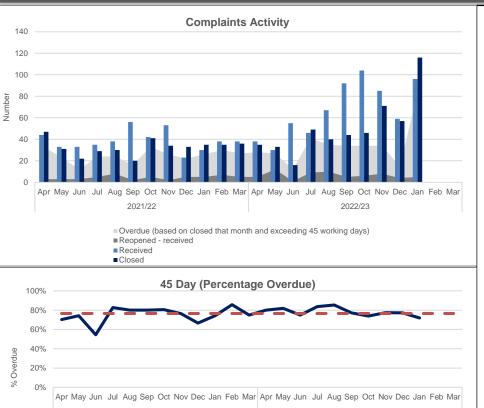


The complaints team continue to focus on improving the timeliness of responses.

Complaints resolved by early resolution are now included in the reporting figures. Early resolution is encouraged by the Parliamentary and Health Service Ombudsman and the change should give an accurate picture of measures being taken to improve the timeliness of complaint resolution.

	-																						
							1	2021/22									2	2022/23					
	Month	Apr	May	Jun	Jul	Aug	Sep	0ct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Complaints	Complaint received acknowledged within 3 Da	92%	100%	100%	93%	100%	100%	100%	100%	92%	100%	100%	95%	93%	100%	100%	96%	100%	100%	100%	100%	100%	100%
Timeliness	45 Day (Percentage overdue)	83%	45%	50%	79%	30%	25%	60%	55%	62%	57%	0%	47%	73%	81%	50%	87%	61%	80%	58%	63%	82%	80%
	Over 6 Months	17%	0%	0%	7%		0%	7%	9%	8%	0%	0%	5%	7%	25%	0%		0%	20%	0%	0%	0%	13%

Eastern Services Patient Experience



Additional resource and sustained efforts to reduce the backlog of complaints has further increased the number of complaints closed during January. In line with the new complaints standard framework all concerns that were still open at the end of 2022 have now been converted to a complaint hence the complaint numbers have increased slightly.

The reopened rate remains low indicating that the majority of complainants are satisfied with the quality of responses they are receiving and feel their concerns have been addressed satisfactorily.

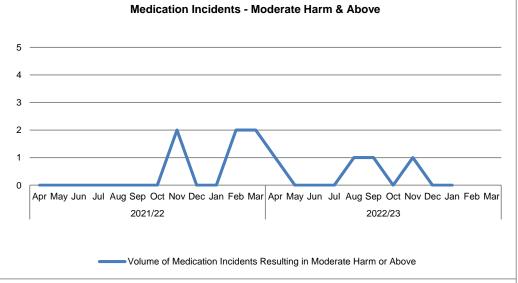
The acknowledgement rate still requires an improvement and the process is currently being reviewed.

Number of new PHSO investigations received during month	Primary investigations currently open	Detailed investigations currently open	Number of PHSO investigations closed during mon
0	3	n	1

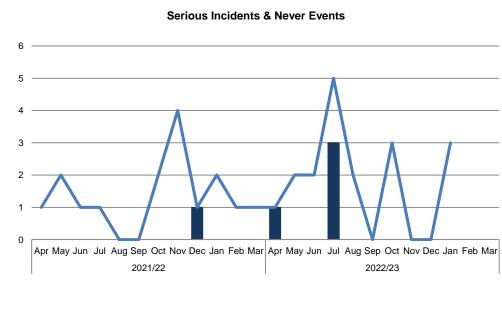
proportion of complaints closed, that were closed after 45 days or longer

						202	1/22										202	2/23				
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Мау	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Complaint received and acknowledged within 3 days	93.88%	94.87%	94.44%	100.00 %	96.08%	95.31%	94.12%	96.55%	89.66%	94.59%	95.83%	88.00%	84.78%	69.57%	67.27%	86.99%	97.01%	70.00%	74.00%	86.67%	80.58%	80.00%
45 Day (Percentage overdue)	70.21%	74.19%	54.55%	82.76%	80.00%	80.00%	80.49%	76.47%	66.67%	74.29%	85.71%	75.00%	80.00%	81.82%	75.00%	83.67%	85.37%	77.27%	73.91%	77.46%	77.19%	72.00%
Over 6 months	2	2	0	4	1	1	4	3	3	6	3	5	11	11	4	12	11	11	16	7	3	21

Northern Services Incidents



There were no medication incidents reported of moderate harm or above in January 2023.

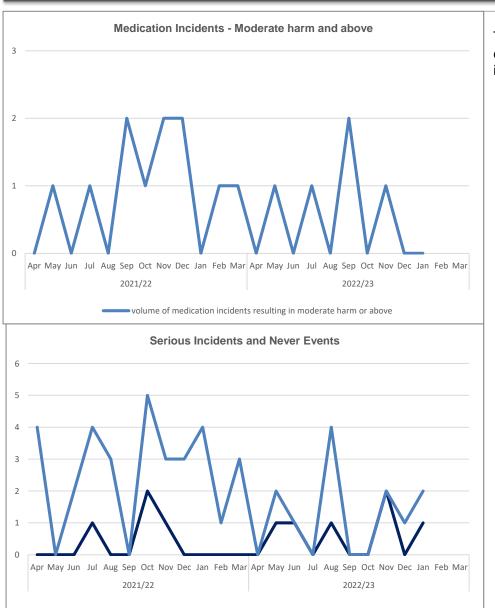


In January 2023 there were 3 serious incidents that are subject to formal investigation.

Volume of Never Events

Volume of Serious Incidents

Eastern Services Incidents



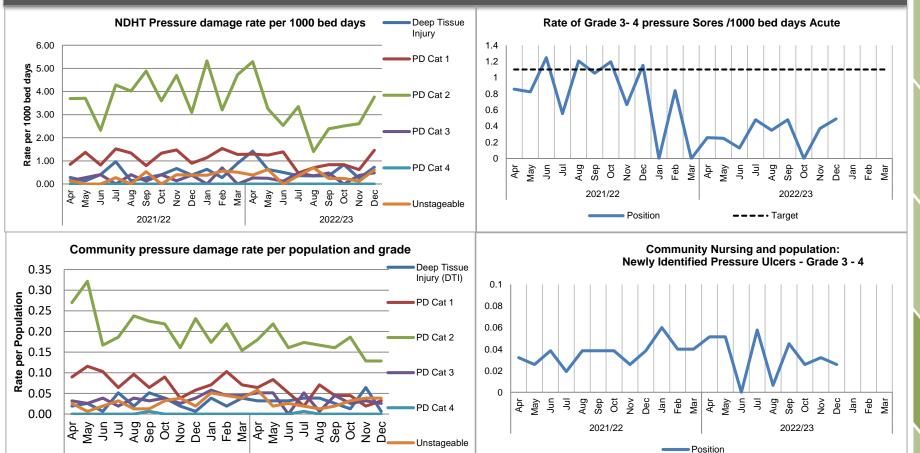
volume of serious incidents

There were two incidents which met the Serious incident criteria in January 2023; these are subject to formal investigation.

Executive Lead : Carolyn Mills

volume of never events

Northern Services Pressure Ulcers - Rate of pressure ulceration experienced whilst in Trust care



- For the month of December there has been an increase in category 1 & 2 pressure ulcers which is directly linked to focussed work to identify pressure damage early, and facilitate prompt intervention.
- Ongoing trend of reduction in pressure ulcers in community nursing.

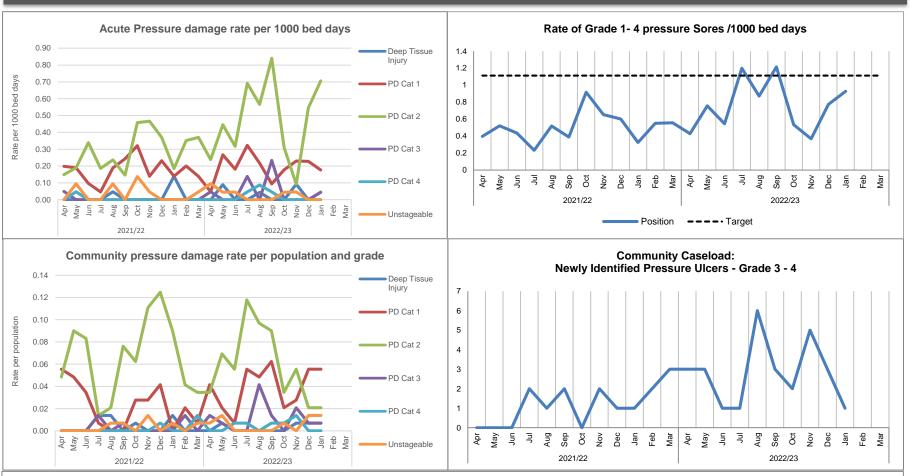
2021/22

Work to align the data reporting processes between Eastern and Northern has been commissioned by the CNO

2022/23

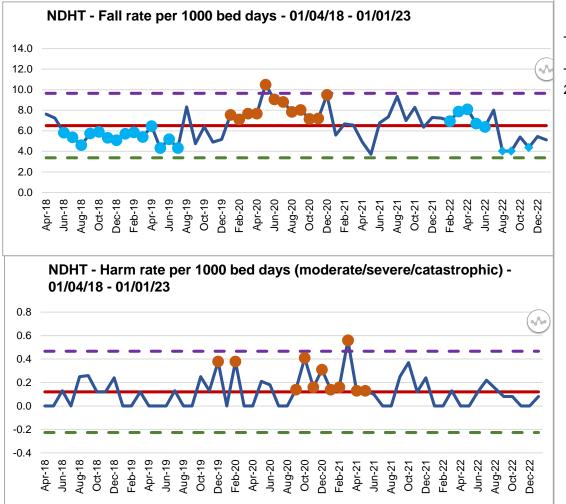
Eastern Services Pressure Ulcers

Rate of pressure ulceration experienced whilst in Trust care



- Pressure ulcers broadly remain within normal variation; there are some increases noted within acute care, for which the high escalation is believed to be a contributory factor due to outlying patients.
- Any anomalous pressure ulcers reporting continues to be investigated.
- Pressure ulcers within Community remain within normal variation.
- The dynamic powered mattress solution has been resolved with patients now receiving the correct surface for their risk.

Northern Services Falls - Rate of incidence of falls amongst inpatients and categorisations of patient impact

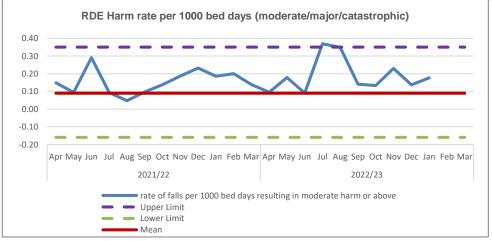


The overall falls rate remains within normal variation.

There were two falls of moderate or above in January 2023 which are subject to investigation.

Eastern Services Slip, Trips & Falls

Rate of incidence of slips, trips & falls amongst inpatients and categorisation of patient impact



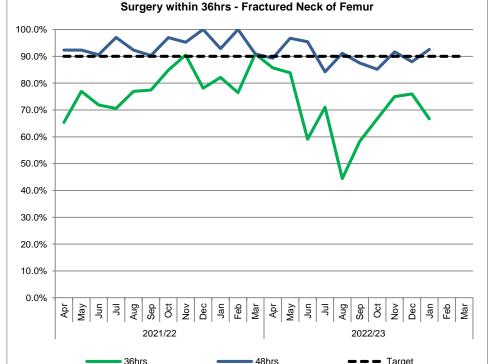
Month	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Admissions																								
Falls	116	112	120	110	129	132	162	160	179	143	152	206	167	141	167	269	222	190	225	227	200	189	0	0
Moderate & Severe Fall	3	2	6	2	1	2	3	4	5	4	4	3	2	4	2	8	8	3	3	5	3	4	0	0

- · Falls continue to be within normal variation.
- There were three falls which resulted in fractures, two of which were observed falls. Appropriate levels of investigation were undertaken and no initial suboptimal care issues were identified at the point the fall was reported.
- The fourth fall involved a patient who collapsed to the floor. This was a patient with significant frailty who has since died. The incident was reviewed within the Executive Safety Huddle, and there were no identifiable acts or omissions which contributed to the fall and it did not meet the threshold for a serious incident. This will be subject to an investigation which will be shared with the family and Duty of Candour was undertaken at the time.
- The January edition of iBulletin contained an article featuring current falls improvement work being implemented by Medical Services.

Northern Services Efficiency of Care - Patients risk assessed for VTE

Northern Services	Aug-22	Sep-22	Oct-22	Nov-22	Jan-23	Feb-23
NDDH	73%	60%	65%	81%	76%	82%

 The snapshot position taken from the Epic system in relation to the % of patients risk assessed for VTE on admission, demonstrates a stable position.



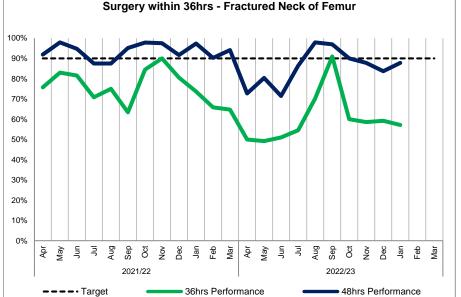
- In January 2023, 66.7% of medically fit patients with a fractured neck of femur (NOF) received surgery within 36 hours. The Trust admitted a total of 27 patients with a fractured neck of femur in that month who were medically fit for surgery from the outset and of these, 18 patients received surgery within 36 hours.
- The nine patients in total that breached 36 hours were due to lack of theatre time and awaiting space on theatre lists. There is an increasing volume of Trauma admissions being seen impacting on capacity. Two patients waited longer than 48 hours; therefore 92.6% of patients received their surgery within 48 hours.

Eastern Services Efficiency of Care

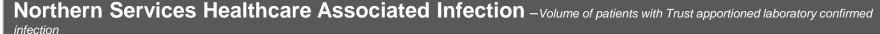
Patients risk assessed for VTE, given prophylaxis, & operated in 36 hours for a fractured hip

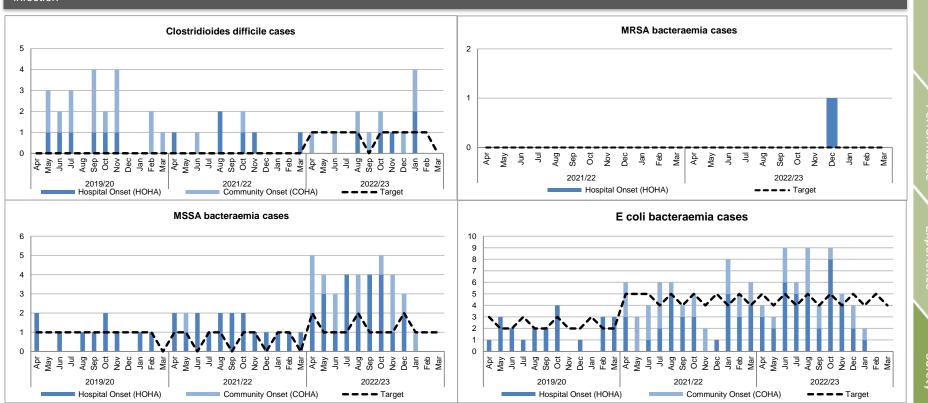
Eastern Services	Aug-22	Sep-22	Oct-22	Nov-22	Jan-23	Feb-23
RDE Wonford	76%	75%	73%	72%	81%	88%

 The snapshot position taken from the Epic system in relation to the % of patients risk assessed for VTE on admission, demonstrates a stable and improving position.



- In January 23, 57.1% of medically fit patients with a fractured neck of femur (FNOF) received surgery within 36 hours. There were a total of 55 patients admitted, 49 of these patients were medically fit for surgery from the outset and 28 patients received surgery within 36 hours.
- Trauma numbers remain high, with 149 Trauma Patients being admitted in January.
- Where clinically appropriate all FNOF cases are given priority in theatres over elective patients. 73 Trauma Patients had their surgery during January in PEOC Theatres, which was to the detriment of elective activity.
- 6 medically fit patients had to wait over 48 hours for their surgery, longest wait was 71 hours.
 - The Hip Fracture Lead has reviewed all cases during the month and is confident that the quality of the clinical care remains high and the patients who breached 36 hours, did not come to any clinical harm due to a longer wait for surgery.
 - Work is being actively progressed to increase the volume of Orthopaedic and Spinal activity that can be redistributed to the Nightingale Hospital, to free up theatre capacity on the Wonford site it is anticipated this could be enacted over the coming months.





Clostridioides difficile (C dif): There were 4 cases of Trust attributed C difficile cases in January 2023. The total to date of 13 has exceeded the limit of 10 for the year for Northern Services. 2 of the cases had C dif diagnosed during their admission and 2 had recent admissions in NDDH. All 4 cases had received high risk antibiotics. In one case the choice of antibiotic was not within guidance. This has been discussed with the clinical team

These healthcare associated infections remain within normal variation for the current month:

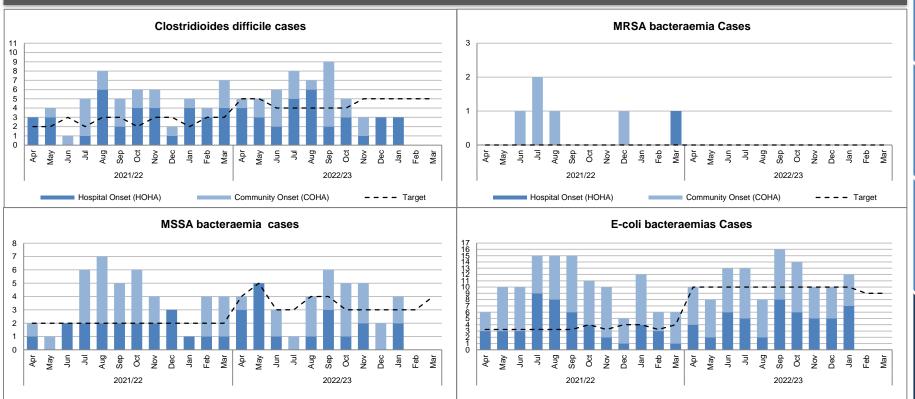
- Escherichia coli (E coli)
- Methicillin sensitive Staphylococcus aureus (MSSA)
- Methicillin resistant Staphylococcus aureus (MRSA)

Bacteraemia and C difficile cases are reviewed and discussed at the Infection Prevention and Decontamination Assurance Group.

Eastern Services Healthcare Associated Infection

Community Onset (COHA)

Volume of patients with Trust apportioned laboratory confirmed infection



C. difficile – All three cases have been investigated. In all cases no new learning was identified and all cases were concluded to be unavoidable. All were associated with antibiotic treatment, one of which was extensive but all prescribing was concluded to be appropriate.

Hospital Onset (HOHA)

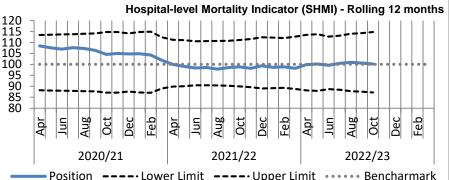
Community Onset (COHA)

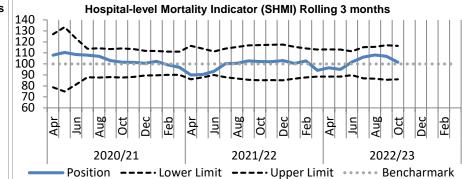
MSSA bacteraemia – Both hospital onset cases were investigated with no learning identified in terms of prevention although both highlighted the importance of accurate wound and peripheral cannula care documentation which was poor . Investigations of the community onset cases have also been completed cases and again no Trust learning was identified. One of these cases was associated with substance misuse which is an increasing trend in the South West.

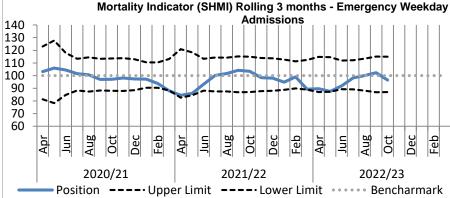
E.Coli bacteraemia – Six cases were associated with urinary tract infection as a source with two catheter associated. Three cases were a hepatobiliary source with no Trust learning identified. The remaining cases were associated with other sources including a patient who declined intervention to expediate a birth post 40 weeks gestation then developed chorioamnionitis.

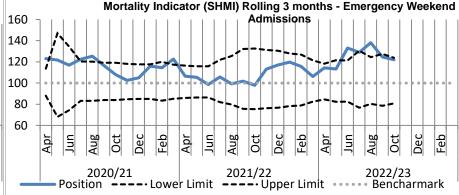
Hospital Onset (HOHA)

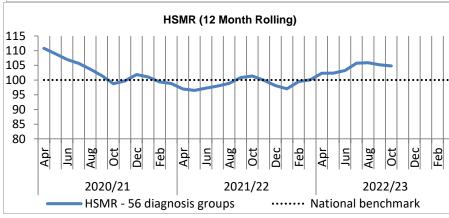








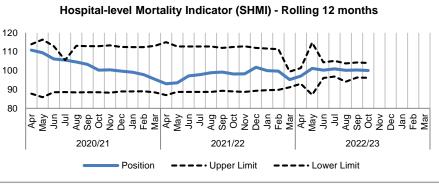




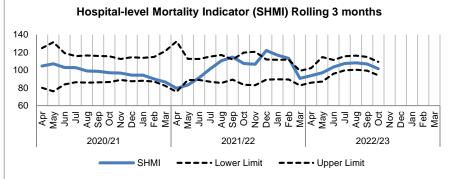
- The overall mortality figures are within national confidence intervals for 12 month and 3 month rolling SHMI and are below all our Peninsula peers. The 12 month HSMR has plateaued and may now be starting to fall.
 - Although the most recent 3 month weekend rolling SHMI is below the upper limit it remains above most local peers. As such additional work is underway to identify the reasons for this, with three working hypotheses being explored. co-morbidity coding differential at weekends, patients presenting later due to delays elsewhere in the system prior to hospital attendance, or increasing weekend demand patterns. An update outlining this work was provided to the February Governance Committee. Further meetings with the CMO and site Medical Directors are planned regarding weekend models of care.
- The Medical Examiners continue to give independent scrutiny of all hospital deaths raising areas of concern to the mortality review process, governance/Datix, and clinicians where appropriate.

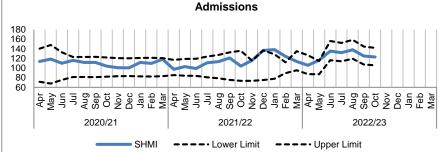
Eastern Services Mortality Rates – SHMI & HSMR

Rate of mortality adjusted for case mix and patient demographics

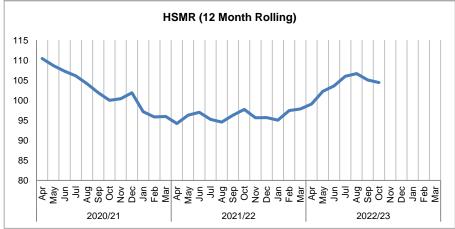






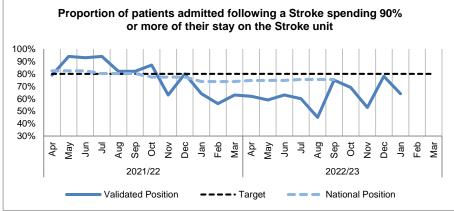


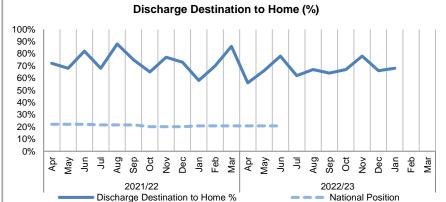
Mortality Indicator (SHMI) Rolling 3 months - Weekend

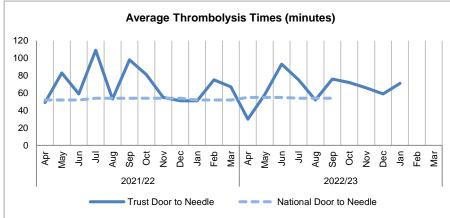


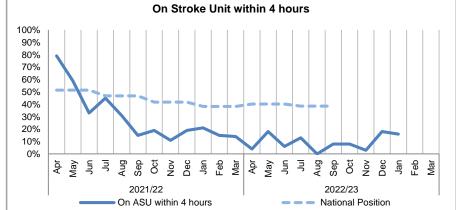
- The SHMI Position remains within the 'as expected' levels for all measures included within the IPR.
- Trust HSMR data has been merged since integration and the charts show
 the combined positions within the RDU (Northern and Eastern Services)
 from April 2022. The rise in HSMR is driven principally by the aggregation
 of Northern Services data since April 2022 but the 12 month rolling HSMR
 has plateaued and may be starting to fall.
- The Medical Examiners continue to give independent scrutiny of all hospital deaths raising areas of concern to the mortality review process, governance/Datix, and clinicians where appropriate. No new emergent themes are being identified through this process.

Northern Services Stroke Performance – Quality of care metrics for patients admitted following a stroke





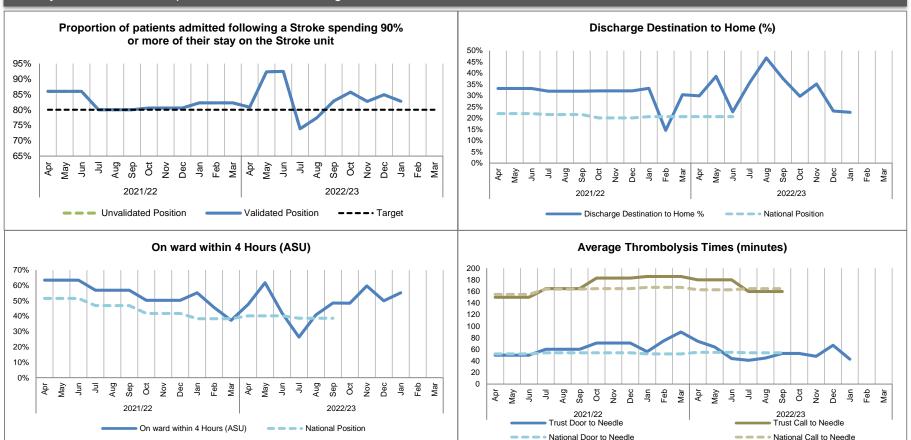




- 90% stay: Performance against this indicator remains variable due to ongoing challenges with patient flow. The Stroke clinical teams provide outreach to
 outlying wards to ensure stroke patients are receiving appropriate stroke care. The Patient Flow Improvement Group continue to focus on reviewing the
 ringfencing processes with the site management team.
- Discharge destination: This metric is relatively stable and is above the national average.
- ASU in 4 hours: This target remains challenging due to the high level of occupancy and but has remained stable in relation to the December position.
- Thrombolysis times: Thrombolysis time is broadly stable over time. Overall the number of eligible stroke patients for thrombolysis is low.

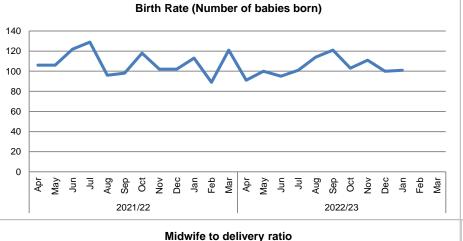
Eastern Services Stroke Performance

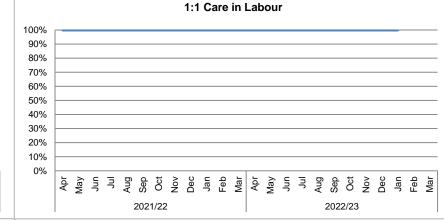
Quality of care metrics for patients admitted following a stroke

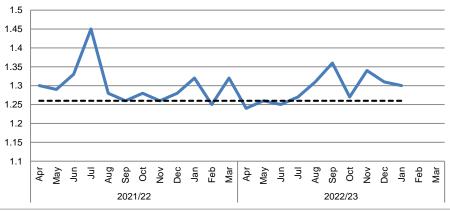


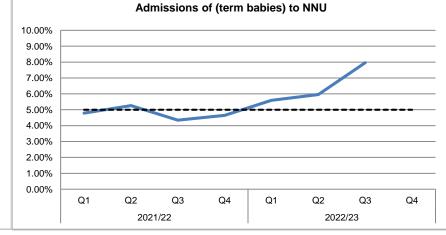
- 90% stay -The proportion of patients admitted spending 90% of their stay on the stroke unit has remained stable in January and is above target. This has been due to the continued concerted effort to try and transfer patients more quickly to the ward. In January 82.8% was achieved against the 90% stay indicator and 55.2% of stroke patients were transferred to the unit within 4 hours, which is above the national position.
- The decline in the 'discharge destination to home percentage' actually reflects a positive position, with an increasing number of patients being discharged home from hospital earlier, under the care of the Early Supported Discharge Stroke Support Team (SST); however, the methodology currently used by SSNAP (Sentinel Stroke National Audit Programme) counts patients discharged home under the SST as an onward transfer of care, which adversely impacts on the reported figures.
- Other indicators remain positive and are either above, or in-line with the national position.

Northern Services Maternity - Metrics relating to the provision of quality maternity care





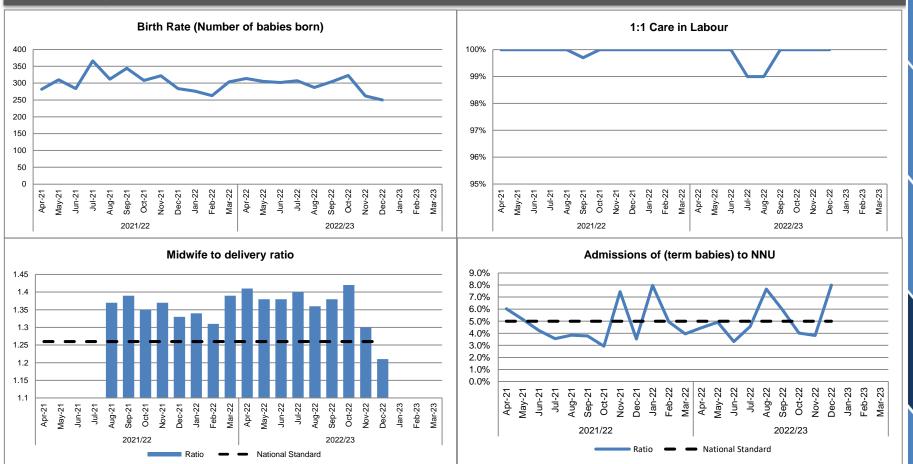




- Admissions of term babies to NNU due mainly to not having a transitional care facility in North. Transitional care review underway and service working with estates team to develop an options appraisal for the development of transitional care provision.
- All Admissions continue to be reviewed by the ATAIN process.

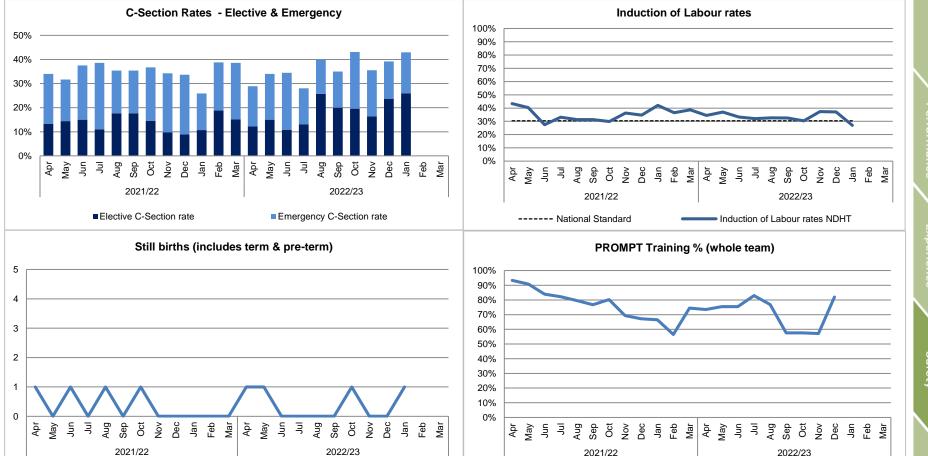
Eastern Services Maternity

Metrics relating to the provision of quality maternity care



- The step change in the Midwife to Delivery ratio in November 2022 is due to a change in the way midwifery ratio is calculated. Allowance for Annual leave and sickness is now no longer factored
- The birth rate is consistent with the national picture
- · There were no red flags for December
- The midwife to birth ratio is currently at 1:31.
- There was a slight increase in admissions to NNU. Q3 ATAIN is being undertaken and will be reported via Maternity Governance.

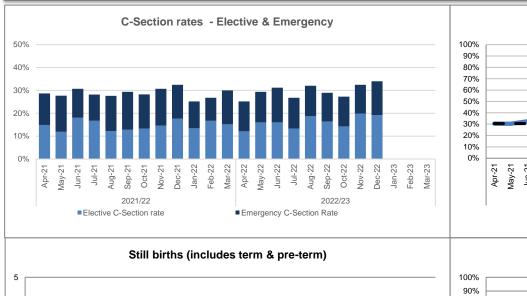
Northern Services Maternity – Metrics relating to the provision of quality maternity care

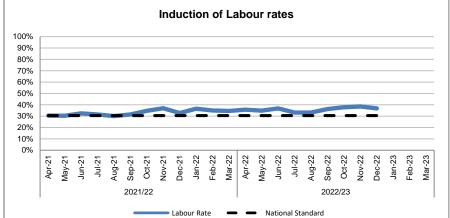


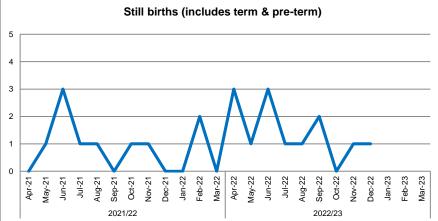
- PROMPT training compliance data not available in January 2023. Indications are that compliance has deteriorated due to January training sessions being cancelled due to Industrial Action, staffing challenges and acuity.
- The maternity team are focussed on rescheduling catch up sessions to support improved compliance and performance is being closely monitored through Divisional Performance meetings.

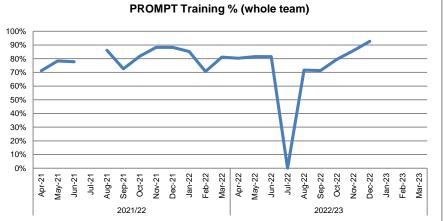
Eastern Services Maternity

Metrics relating to the provision of quality maternity care



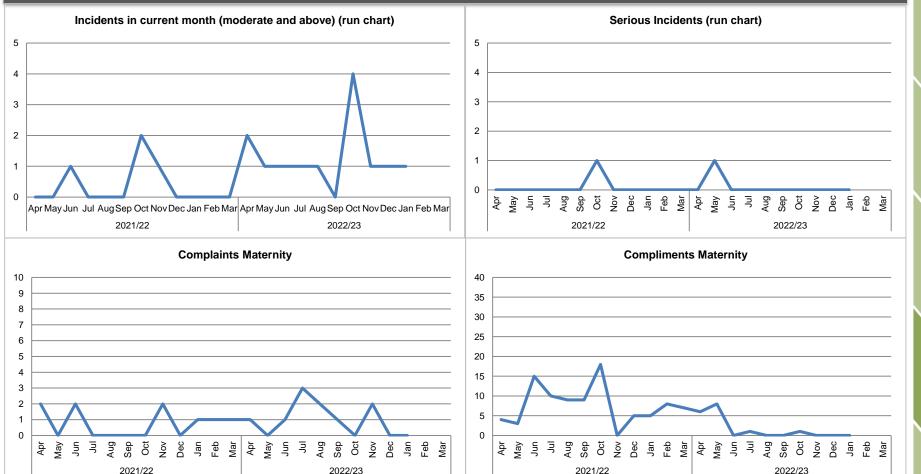






- Induction of labour rates continue to rise and are above the national rate. Despite this we are achieving a high rate of physiological births
- Staff training reached in excess of 90% in December 2022 as per the CNST submission

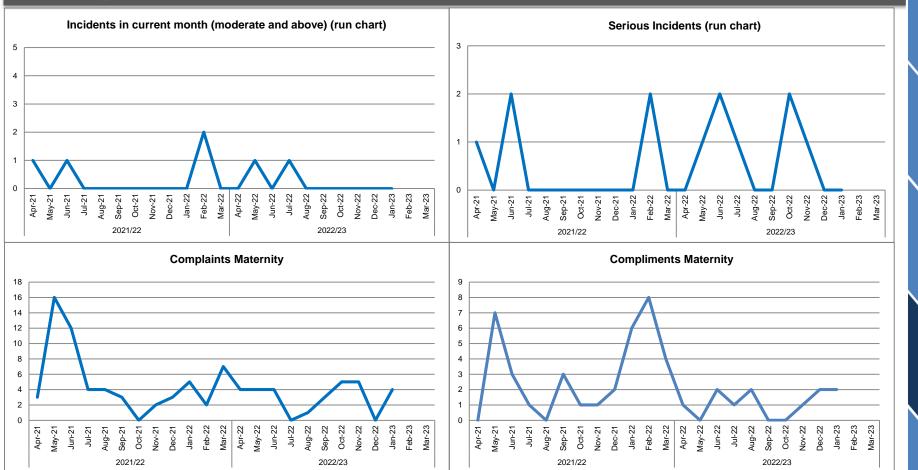
Northern Services Maternity - Metrics relating to the provision of quality maternity care



- · There was one incident reported as moderate in January however, following review this has been downgraded.
- The maternity team actively engage with the Maternity Voices Partnership (MVP) to review and contribute to the development of maternity services and ensure the voice of women and their families. The MVP provides a report at each Patient Experience Committee.

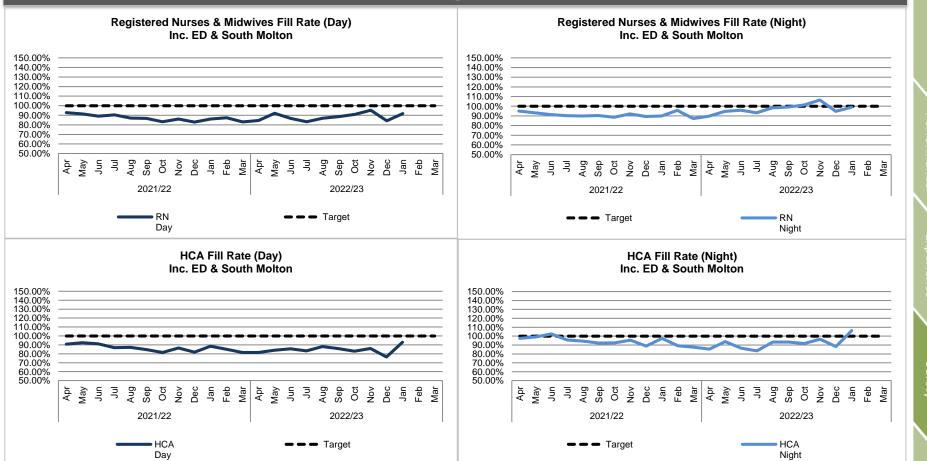
Eastern Services Maternity

Metrics relating to the provision of quality maternity care



- There was no variation in incidents.
- · Serious incidents remain consistent
- · Complaints remain at a low level with early resolution a key factor.

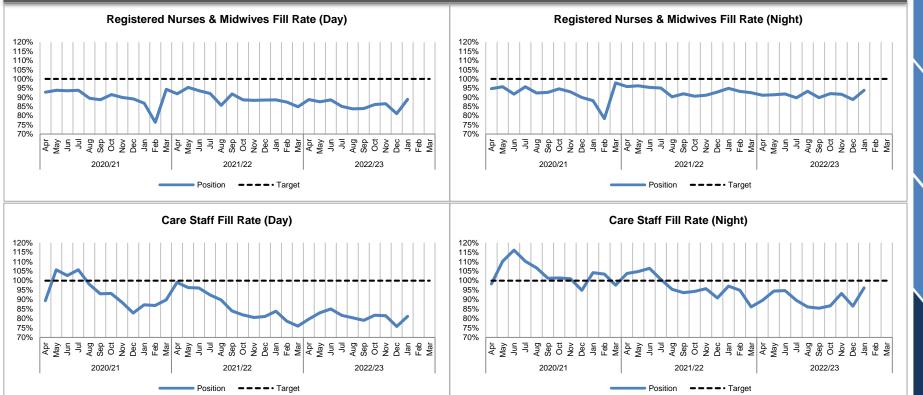
Northern Services Safe Clinical Staffing Fill Rates



- There has been an overall increase in fill rate in January 2023. There were no reported incidents relating to staffing (staffing shortages) at moderate or above.
- Staffing risks are assessed and mitigated through a number of established processes and strong professional oversight by members of the Senior Nursing and Midwifery teams on a daily basis.

Eastern Services Safe Clinical Staffing – Fill Rate

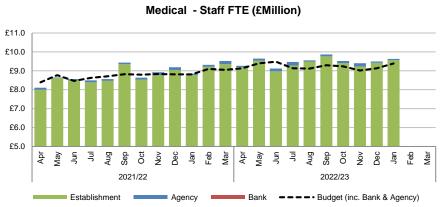
Proportion of rostered nursing and care staff hours worked, against plan

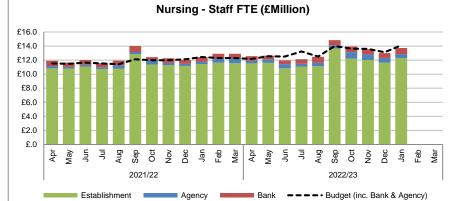


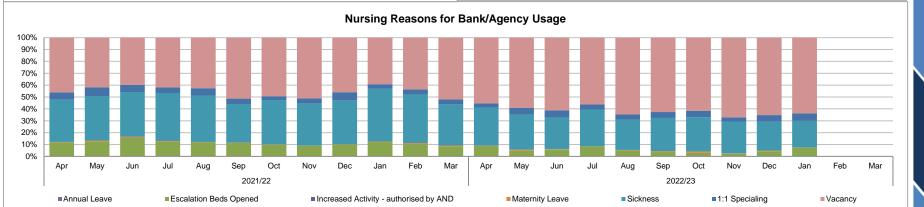
- There was an improved fill rate across all four metrics in January 2023, with a overall fill rate of 90%.
- Review of incidents demonstrated that 13 staff shortage incidents were reported in January 2023. Eight of these were categorised as incidents of inadequate staffing. Eleven of the incidents reported were identified as resulting in no harm, and the remaining incidents were identified as low / minor harm.
- A review of all patient incidents which resulted in moderate or greater harm was conducted. There were 18 incidents meeting this criteria. None of these identified staffing as a contributory or causal factor in the incident.

Eastern Services Safe Clinical Staffing

Cost of Medical & Nursing Staffing by month against Budget & reasons for temporary staff

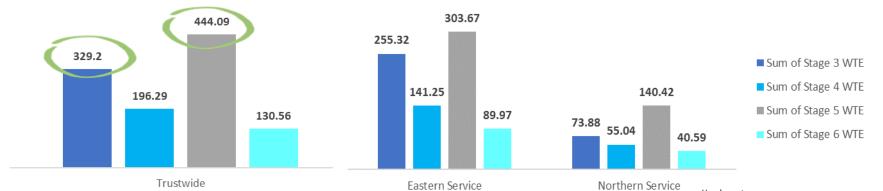




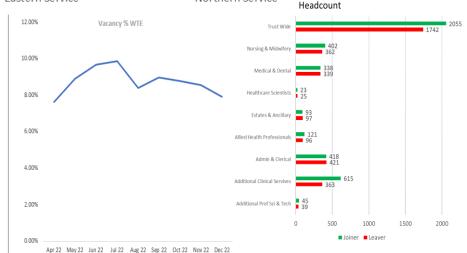


- There continues to be a month on month reduction in the need for use of agency staffing to cover nursing vacancies. Whilst the vacancy rate continues to be challenging this suggests some positive impact from the targeted recruitment work which has been undertaken.
- The ongoing demand for staff resources to meet open escalation beds is indicative of the high operational pressures throughout January 2023

Trust Recruitment Update

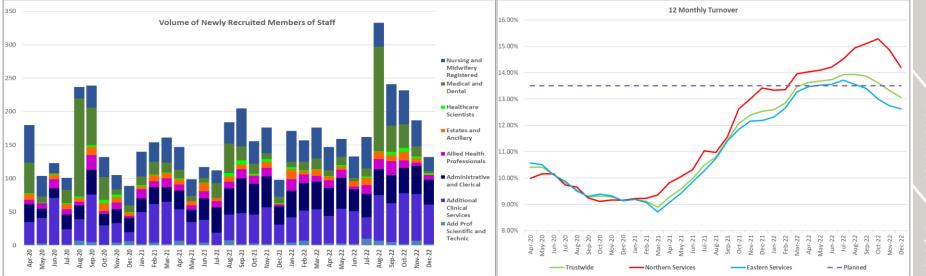


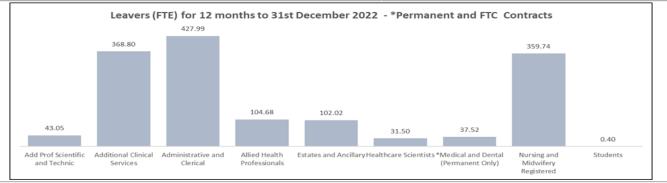
- The overall vacancy rate is 7.91% which is almost 1% lower than the medium forecast last month as the Accelerating Vacancies program is showing benefits. North reporting 10.08% down from 11.37% and the East 7.03% down from 7.41%. This trend is forecasting ongoing progress. Overall our pipeline is healthy for both the Northern and Eastern sites with activity moving at a positive pace.
- We have 466 substantive candidates in Stage 5 (Pre-Employment Checks) which is a significant decrease on previous months (down from 1000+ due to increase in productivity rather than vacancy level). This highlights the Recruitment Team's effort to reach this target.
- 147 (130.56 WTE) accepted candidates are currently scheduled for an upcoming Induction and new start (data through to end of February)
- We are now able to report our average time to hire (Advert Approved to Contract Accepted) – This is currently at a Trust average of 70.4 calendar days which is below the national average. The target is to improve this significantly further.
- We are highlighting in green in the above graphs that we are not seeing the "wave" as high in Stage 3. This positive activity continues into Stage 5 in reaching a manageable target of 500 or below.
- 17 IR Nurses arrived in January in Eastern Services, with the revised number for February-March at 36. The Northern Services IR Nurses due to arrive in January were delayed until February, due to lack of available accommodation. The expected total for February & March is 15.





Trust Turnover



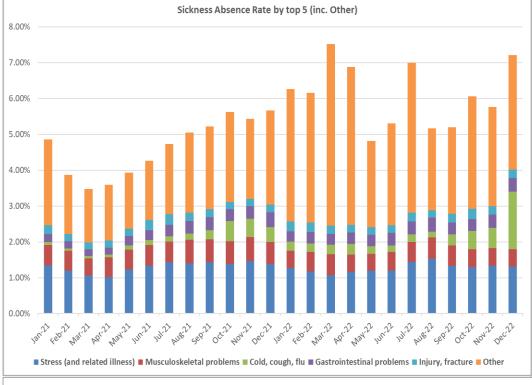


Turnover

- Turnover continues to reduce for Northern and Eastern services. While Northern turnover remains above the planned 13.5%, the past two months indicate an improving position since the October peak.
- The turnover rate for Additional Clinical Services on both sites and Estates and Ancillary in Eastern remains higher than the planned for mark. There is a notable difference in the rate for Registered Nursing and Midwifery in the North which is 14.1% compared to 11.2% in the East retirement the leaving reason given by nearly 40% of all RN leavers in the North for the same period, compared to 29% in the East. Moving to A&C, the overall position continues to improve in the past two months, but for North the rate remains >14%. Junior Doctors are not consistently categorised in all metrics at present and will be reviewed as data improvements continue. This has already been reviewed for leavers data, with only permanent Medical and Dental leavers included to ensure the number of leavers are not artificially inflated by junior doctor rotations.
- Actions to bolster our Registered Nursing workforce numbers continue, including open days hosted to promote our Trust and region as a great place to live and work, particularly
 those newly qualified and just beginning their careers.
- Though the volume of new starters decreased month on month taking into account the seasonal holidays, the hire numbers for December are markedly higher than December 2021,

as the drive continues to fill our healthcare support worker vacancies. Integrated Performance Report

Trust Sickness Absence



Sickness Absence (Data shown for latest complete month: Dec-22) Trust position

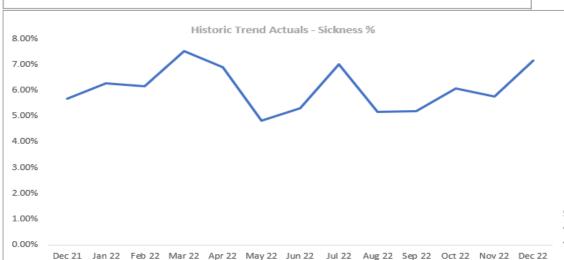
- Overall sickness rose in December to 7.16% from 6.12%. Northern Site position was 7.17% and Eastern Site position was 7.16%. Both sites had an average increase of 1%. This was within the threshold of the Critical forecasting (7.20%).
- The forecast for January through to March predicts a worsening sickness rate based on historical data and the increases being reported in the category of colds, coughs and flu.
- The combination of Cold, Cough, Flu and Covid-19 infections amounted to 55% of all the sickness episodes recorded in December, fuelling the high rate for the month.

Northern Site Position

- Additional Clinical Services showed a 2.2% increase from November to 10%
- Registered Nursing and Midwifery up by 1.4% to 7.3%
- Allied Health Professionals also up by almost 2% to 6.5%

Eastern Site Position

- Increased rates in proportion with those recorded in the North month on month:
- Additional Clinical Services rate up to 10.9%
- Registered Nursing at 7.2%
- Allied Health Professionals up to 5.8%
- Estates and Ancillary over 11%

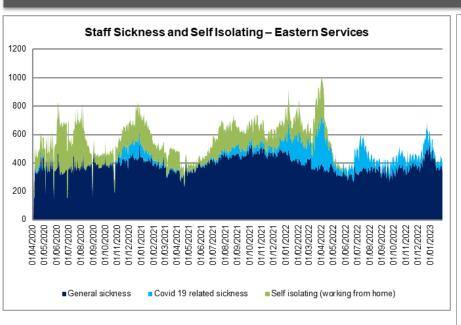


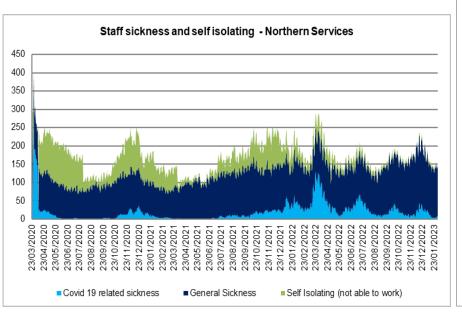
Critical Linear Sickness Forecast 7.40% 7.30% 7.20% 7.10% Jan 23 Feb 23 Mar 23 Medium Linear Sickness Forecast 6.20% 6.00% 5.80% Jan 23 Feb 23 Mar 23 **Positive Linear Sickness Forecast** 5.00% 4.80% 4.60% Jan 23 Feb 23 Mar 23

Integrated Performance Report February 2023

Executive Lead: Hannah Foster

Trust Workforce – Covid related absence





As at 7th February, the total number of staff in Eastern services with Covid related absence stands at 70, consistent with the daily totals reported throughout January - a considerable drop from the spike seen in December. Data from the North follows a similar pattern with low and stable numbers recorded over January currently standing at 19.

There are currently 17 members of staff with an open sickness episode attributed to Long Covid, of whom 13 work in Eastern Services and 4 in Northern Services.

The programme of flu vaccinations continues with sessions offered across trust sites. However, the offer of a Covid autumn booster dose will end when the current campaign ends on 12th February.

The NHS Digital Foundry system collects vaccination data for our workforce and includes attendances at non trust sites such as primary care/pharmacy settings. The percentage of staff receiving the Covid booster stands at 61%, level with the 61% recorded as having had the Flu vaccine. These rates are for the RDUH as a whole and cannot be split by north/east. The table below shows 2022 rates for RDUH but 2021 rates for eastern services only.

Using these comparisons based on the monthly ImmForm submission made to NHSE, the overall rate for Covid vaccine uptake is significantly lower this year. The higher levels attained last year can be partly attributed to staff being mandated in early 2022 to have received Covid vaccines, unless medically exempt. This requirement was subsequently removed.

Flu vaccinations are lower this year by 6% and this is attributable in part to the campaign beginning later this year in the North. The Trust continues to encourage uptake through a range of comms messages.

	2022 Flu RDUH Total	2021 FLU RDE only	2022 Flu Variance	2022 Covid RDUH Total	2021 Covid RDE only	2022 Covid Variance
Medical and Dental	65%	100%	-35%	69%	88%	-19%
Nursing and Midwifery Registered	63%	75%	-12%	58%	81%	-23%
All other prof qual clinical staff	62%	86%	-24%	64%	84%	-20%
Support to Clinical Staff	59%	57%	2%	56%	76%	-20%
No direct patient care	61%	46%	15%	70%	82%	-12%
Total	61%	67%	-6%	61%	80%	-19%

RDUH Finance Overview

Financial Performance - key performance indicators

	Consolidated Metrics					
Domain	Measure / Metric	Unit of	Last Month	This Month	Year End	
	I&E Surplus / (Deficit) - Total	Measure £'000	Dec-22 -12,835	Jan-23 -15,638	Mar-23 -16,763	
	I&E Surplus / (Deficit) - Total I&E Surplus / (Deficit) v budget	£'000	-12,633	-13,636	1,500	
	Income variance to budget - Total	£'000	405	219	1,409	
	-			-	The state of the s	See below
	Income variance to budget - Total	%	0.06%	0.03%	0.15%	FOT includes £1.5m additional allocation to ICB block
	Income variance to budget - Patient Care	£'000	477	404	1,725	contract.
	Income variance to budget - Commercial income	£'000	-72	-185	-316	Commercial activities are under-recovered mostly due to car parking, nursery, fertility and catering.
inre	Pay variance to budget - Total	£'000	-226	72	544	Pay budgets are reduced to reflect undelivered savings and productivity against plan and off-set by allocating reserves for developments that have not yet
andit.	Pay variance to budget - Total	%	-0.05%	0.01%	0.09%	commenced.
e and Expe	Agency expenditure (Inc. COVID expenditure) variance to Plan	£'000	-7,044	-8,072	-9,965	Usage particularly in nursing and medical workforce reflecting vacancies, sickness, Covid impact and ESRF delivery.
Income	Non Pay variance to budget	£'000	-179	-294	-456	Non pay continues to reflect increased drugs expenditure YTD and FOT not recoverable above block contract income off set by slippage on investments and non-recurrent underspends.
	Non Pay variance to budget	%	-0.07%	-0.11%	-0.14%	
	PDC, Depreciation, Interest Paid / Received variance to budget	£'000	3	3	3	
	PDC, Depreciation, Interest Paid / Received variance to budget	%	0.01%	0.01%	0.01%	
	Cost Improvement Programme - Total Current Year achievement	£'000	13,161	14,932	17,799	
	Cost Improvement Programme - Year to date/ Current Year variance to budget	£'000	-11,180	-12,554	-16,136	See report narrative. FOT improvement following review of delivery previously assumed in underspends.
	Cash balance	£'000	54,735	38,617	48,754	YTD: Timing of settlement of net working capital, particularly payments to suppliers, capital programme slippage and the impact of late changes to the June plan that was not reflected in the Balance Sheet (£11.4m)
_						FOT: The balance sheet was not updated for the late
ask	Cash variance to budget - above / (below)	£'000	19,136	9,105	19,198	revenue changes made to the final Annual Plan.
- ಪ	Better Payment Practice v 95% target - volume	%	92%	92%	92%	
Capital	Better Payment Practice v 95% target - value Capital Expenditure variance to plan - Total above / (below)	% £'000	93% -8,963	93% -12,065	93%	See report narrative. There is confidence the programme will recover based on the value of open orders and oversight by the Capital Steering Groups.
	Capital Expenditure variance to plan - CDEL above / (below)	£'000	-6.658	-8.387	0	As above.
	Capital Expenditure variance to plan - PDC above / (below)	£'000	-2,305	-3,678	0	Whilst there is slippage on planned commencement of Diagnostics CDC in East due to delayed approval, capital planning will ensure PDC allocations are fully utilised by year end.

Key

Positive variance value

Negative variance value <5%
Negative variance value >5%

Integrated Performance Report

RDUH Summary Finance Position

Month 10 Summary Finance Position - YTD

- · The Board has approved a deficit plan of £18.3m
- · Cumulative deficit of £15.6m achieves plan predominantly by Delivering Best Value slippage being off-set by nonrecurrent expenditure underspends.

Month 10 Summary Finance Position - FOT

• The planned deficit of £18.3m is now forecast at £16.8m arising from additional ICB allocations.

Risks and Mitigations

Trust Commentary

- · The table opposite sets out the current assessment of gross risk and mitigation opportunities that have been consolidated and assessed on likelihood of materialising.
- · Residual risk of £4.0m has been quantified and will be delivered through further non recurrent balance sheet mitigations by year end.

Delivering Best Value (DBV) Programme

- · The DBV programme for the year is £33.9m
- £14.9m has been achieved YTD against £27.5m target being £12.6m adverse to plan. The shortfall was covered through other NR slippage and under spends as set out above.
- Current assessment is of delivering £17.8m of the total programme being £16.1m adverse to plan and is reflected in the risks and mitigations table for months 11-12 (with month 1-10 being mitigated within the YTD overall position). Of the forecast shortfall £14.6m for the year relates to productivity opportunity that is affected by current pressures in Urgent and Emergency Care impacting the ability to deliver the elective activity plan. £8.3m is forecast to be delivered non recurrently.

Delivering Best Value		Year to	Year to	Year to
Programme	Full Year	Date	Date	Date
£'m	Plan	Plan	Actual	Variance
Divisional CIP	5.5	4.3	4.6	0.3
Mycare benefits	1.9	1.5	0.7	-0.8
Productivity	14.6	11.6	0.0	-11.6
Covid Cost Reduction	6.5	5.6	5.0	-0.6
Further Stretch	5.4	4.5	4.6	0.1
Total	33.9	27.5	14.9	-12.6

Actual	Forecast
Forecast	Variance
6.2	0.7
0.9	-1.0
0.0	-14.6
5.5	-1.0
5.2	-0.2
17.8	-16.1

Consistency with reporting to NHSEI and the Integrated Care System for Devon

- The reporting to NHSEI via the ICS has now brought a renewed focus on consistency of reporting.
- · The Board has historically received financial information comparing actual to budget being a flexed version of the plan submitted to NHSEI for the financial year. Whilst this gives the Board assurance of consistency with information provided to internal budget managers, system and national reporting requirements compare actual to fixed plan and when taken in isolation can give the appearance of differential reporting to Board and Regulator.
- The appendices include a reconciliation of the YTD fixed plan to budget and transparency on the variances reported against fixed plan and budget.

		Year to Dat	te	Yea	ast	
			Variance			Variance
Month 10 2022/23	Budget	Actual	Fav / (Adv)	Budget	Actual I	Fav / (Adv)
Summary Income & Expenditure	£,000	£,000	£,000	£,000	£,000	£,000
Patient Income	707,893	708,297	404	852.675	854,400	1,725
Commercial Income	94,410	94.225		119,049	118.733	(316)
Total Income	802,303	802,522	(/	971,724	-,	1,409
Pay	(505,653)	(505,581)	72	(612,878)	(612,334)	544
Non Pay	(270,804)	(271,098)	(294)	(325,659)	(326,115)	(456)
Total Expenditure	(776,457)	(776,679)	(222)	(938,537)	(938,449)	88
EBITDA	25,846	25,843	(3)	33,187	34,684	1,497
PDC, Depreciation, Interest & gain from absorption	71.608	71,611		59.372	59.375	. 3
Net Surplus / (Deficit)	97,454	97,454		92,559	94,059	1,500
Removal of exceptional items	(113,092)	(113,092)	0	(110,822)	(110,822)	0
Net Surplus / (Deficit) after exceptional items	(15,638)	(15,638)	0	(18,263)	(16,763)	1,500

Data

Delivery Risk	Most Likely £m
Deficit plan	-18.3
Risks	
Overall DBV shortfall	-16.1
ERF cost risk - additional 104wk schemes	-1.5
Additional costs of energy not funded	-1.7
Overspend issues	-5.2
Contractual risk	-1.0
Other issues	-1.4
Gross Risk	-26.8
Mitigations	
Underspending areas	8.2
Balance Sheet mitigations	9.9
Slippage	4.1
Funding / contractual negotiations	6.0
Unidentified mitigations	0.0
Total Mitigations	28.3
Net delivery (risk) / mitigation of planned deficit	1.5
Deficit Forecast	-16.8

Consolidated - Commentary

Capital

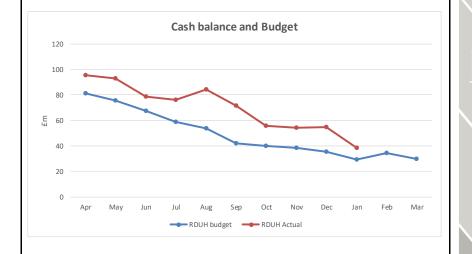
- The capital programme for the year is £53.0m and is forecast to be £1.5m higher than plan due to increases in PDC schemes off-set by an increase in forecast donations.
- Confirmation has been received that the 2021/22 and 2022/23 IFRS16 impact of leases meeting the criteria will be covered by a central allocation.
- · Capital expenditure to M10 was £27.9m; whilst the programme is behind plan there is confidence the programme will recover based on the value of open orders. The respective Capital Programme Groups are actively monitoring risks and mitigations to ensure delivery.

Cash

- · Closing cash as at the end of January is £38.6m and is £9.1m higher than plan due to timing of settlement of net working capital, slippage in the capital programme and the impact of late changes to the June plan that was not reflected in the Balance Sheet (£11.4m).
- Forecast cash balance of £48.8m at the end of the year.
- Better Payment Practice of paying 92.8% YTD, of Non-NHS invoices paid within 30 days (target 95%) this remains challenging due to the level of invoicing within pharmacy and the resourcing needed to reconcile and approve within the pharmacy team. Plans are progressing.

	,	ear to Date	•	Full Year Forecast				
	Plan	Actual	Variance	Plan	Actual	Variance		
	£'000	£'000	Fav/(Adv)	£'000	£'000	Fav/(Adv)		
Capital Funding Sources:								
CDEL	25,613	25,613	0	33,306	33,306	0		
Donated	892	535	357	892	2,257	1,365		
Leases	1,834	1,834	0	2,303	2,375	72		
PDC	11,638	11,638	0	14,953	15,053	100		
Total Capital Income	39,977	39,620	357	51,454	52,991	1,537		
Expenditure:								
Developments	11,074	8,276	2,798	14,707	14,380	327		
Equipment	9,762	4,788	2,331	14,919	16,228	(1,310)		
Estates projects	5,453	2,441	4,974	6,050	5,041	1,009		
Digital	13,688	12,407	1,962	15,221	16,715	(1,494)		
Unallocated	0	0	0	558	627	(69)		
Total Capital Expenditure	39,977	27,912	12,065	51,454	52,991	(1,537)		
Under / (Over) Spend	0	11,708	12,422	0	(0)	(0)		

Data



Royal Devon University Healthcare NHS Foundation Trust	Y	ear to Date	е		Outturn			
			Actual				Actual	
			Variance				Variance	
Income Statement - Consolidated								
D	Budget	Actual	to		Budget	Actual	to	
Period ending 31/01/2023			Budget Fav /				Budget Fav /	
Month 10			(Adv)				(Adv)	
IVIDITATI TO	£'000	£'000	£'000		£'000	£'000	£'000	
Income								
Patient Care Income	707,893	708,297	404		852,675	854,400	1,725	
Operating Income	94,410	94,225	(185)		119,049	118,733	(316)	
Total Income	802,303	802,522	219		971,724	973,133	1,409	
Employee Benefits Expenses	(505,653)	(505,581)	72		(612,878)	(612,334)	544	
Drugs	(84,434)	(85,677)	(1,243)	2	(98,333)	(101,539)	(3,206)	
Clinical Supplies	(67,745)	(68,075)	(330)	3	(82,125)	(83,921)	(1,796)	
Non-Clinical Supplies	(13,993)	(13,825)	168	3	(17,229)	(16,447)	782	
Misc Other Operating Expenses	(88,210)	(86,407)	1,803	3	(91,947)	(87,874)	4,073	
Services Received	(16,422)	(17,114)	(692)	3	(36,025)	(36,334)	(309)	
Total Costs	(776,457)	(776,679)	(222)	1	(938,537)	(938,449)	88	
EBITDA	25,846	25,843	(3)		33,187	34,684	1,497	
Profit / (Loss) on asset disposals	0	3	3		0	3	3	
Total Depreciation	(31,394)	(31,394)	0		(41,615)	(41,615)	0	
Total Operating Surplus / (Deficit)	(5,548)	(5,548)	0		(8,428)	(6,928)	1,500	
Interest Receivable	1,158	1,158	0		1,570	1,570	0	
Interest Payable	(2,345)	(2,345)	0		(2,804)	(2,804)	0	
PDC	(8,844)	(8,844)	0		(10,812)	(10,812)	0	
Gain from Transfer by Absorption	113,033	113,033	0		113,033	113,033	0	
Net Surplus / (Deficit)	97,454	97,454	0		92,559	94,059	1,500	
Remove donated asset income & depreciation, AME impairment	(113,092)	(113,092)	0		(110,822)	(110,822)	0	
and gain from transfer by absorption	, , , ,	,			, ,	, ,		
Net Surplus/(Deficit) after donated asset & PSF/MRET Incom	e (15,638)	(15,638)	0		(18,263)	(16,763)	1,500	

KEY MOVEMENTS AGAINST BUDGET

Overall achievement against plan

- 1. NR pay underspends off-set by slippage on Delivering Best Value and reserves.
- 2. Drugs expenditure not recoverable above block contract income.
- 3. Under spends linked to low er levels of elective activity and classification within non-pay categories.

Royal Devon University Healthcare NHS Foundation Trust		Year to Date		ſ		Outturn		l	Prior Year	
Statement of Financial Position - Consolidated			Actual	ľ			Actual			Actual YTD
Period ending 31/01/2023	Plan	Actual	Variance Over / (Under)		Plan	Actual	Variance Over / (Under)		Mar-22	Movement Incr. / (Dec.)
Month 10	£000	£000	£000	ı	£000	£000	£000		£000	£000
Non-current assets										
Intangible assets	60,014	61,064	1,050	1	58,263	59,117	854		57,500	3,564
Other property, plant and equipment (excludes leases)	401,489	390,077	(11,412)	1	423,476	423,575	99		392,293	(2,216)
Right of use assets - leased assets for lessee (excludes PFI/LIFT)	54,006	53,297	(709)	2	52,915	53,622	707		1,840	51,457
Other investments / financial assets	5	5	0		5	5	0		5	0
Receivables	2,726	2,856	130		2,726	2,726	0		2,725	131
Total non-current assets	518,240	507,299	(10,941)		537,385	539,045	1,660		454,363	52,936
Current assets										
Inventories	13,550	14,581	1,031	3	13,550	13,550	0		13,275	1,306
Receivables: due from NHS and DHSC group bodies	18,810	31,482	12,672	4	17,810	20,619	2,809		29,931	1,551
Receivables: due from non-NHS/DHSC group bodies	21,550	22,967	1,417	4	16,000	16,000	0		16,575	6,392
Other assets: including assets held for sale & in disposal groups	0	0	0		0	0	0		0	0
Cash	29,512	38,617	9,105	5	29,556	48,754	19,198	10	88,920	(50,303)
Total current assets	83,422	107,647	24,225		76,916	98,923	22,007		148,701	(41,054)
Current liabilities										
Trade and other payables: capital	(7,000)	(4,047)	2,953		(11,000)	(11,000)	0		(21,284)	17,237
Trade and other payables: non-capital	(83,561)	(75,512)	8,049		(80,061)	(80,229)	(168)		(84,970)	9,458
Borrowings	(11,860)	(14,384)	(2,524)	6	(11,763)	(13,042)	(1,279)		(6,277)	(8,107)
Provisions	(200)	(217)	(17)		(200)	(200)	0		(200)	(17)
Other liabilities: deferred income including contract liabilities	(10,900)	(17,979)	(7,079)	7	(10,500)	(10,500)	0		(17,649)	(330)
Total current liabilities	(113,521)	(112,139)	1,382		(113,524)	(114,971)	(1,447)		(130,380)	18,241
Total assets less current liabilities	488,141	502,807	14,666	ı	500,777	522,997	22,220		472,684	30,123
Non-current liabilities										
Borrowings	(104,710)	(104,697)	13		(103,136)	(105,295)	(2,159)		(63,038)	(41,659)
Provisions	(970)	(932)	38		(970)	(970)	0		(970)	38
Other liabilities: deferred income including contract liabilities	(1,877)	0	1,877	8	(1,877)	0	1,877		(1,877)	1,877
Total non-current liabilities	(107,557)	(105,629)	1,928		(105,983)	(106,265)	(282)		(65,885)	(39,744)
Total net assets employed	380,584	397,178	16,594		394,794	416,732	21,938		406,799	(9,621)
Financed by										
Public dividend capital	353,396	349,514	(3,882)		358,468	358,567	99		343,514	6,000
Revaluation reserve	48,956	49,894	938		63,956	63,956	0		49,900	(6)
Income and expenditure reserve	(21,768)	(2,230)	19,538		(27,630)	(5,791)	21,839	10	13,386	(15,616)
Total taxpayers' and others' equity	380,584	397,178	16,594	9	394,794	416,732	21,938		406,799	(9,621)
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KEY MOVEMENTS

- 1 Timing of MYCARE Asset Under Construction (Intangible) and slippage on capital programme (PP&E) forecast to recover by year end
- 2 Variance to budget includes £2.0m lease premium adjustment (previously held in deferred income) reducing the lease assets and £1.3m of higher than budget assets largely due to the value of community property leases being higher
- 3 Pharmacy and theatre stock level increases
- 4 Timing issue no bad debt risk.
- 5 Cash £9.1m higher than plan due to timing of settlement of net working capital and the impact of late changes to the June plan that was not reflected in the Balance Sheet and slippage on the capital programme.
- 6 Loans and Leases due in 1 year primarily due to YTD accrued loan interest, a re-analysis of lease liability splits and the value of community property leases being higher than planned.
- 7 Deferred income is £7.1m higher than budget and will be released over the course of H2 as expenditure is incurred.
- 8 Non-current deferred income of £1.9m relating to the lease premium for Bowmoor House and Noy Scott House that has now been released against the right-of-use asset values for those properties within property, plant and equipment (as per IFRS-16 national guidance).
- 9 Reserves are £16.6m higher than plan due to the plan not being updated for the late revenue changes made £9.1m is the cash benefit.
- The FOT cash balance is £19.2m higher than plan as the balance sheet was not updated for the late revenue changes made and improvement in planned deficit of £1.5m.

Royal Devon University Healthcare NHS Foundation Trust		Year to Date			Outturn			
Cash Flow Statement - Consolidated			Actual			Actual		
Period ending 31/01/2023	Plan	Actual	Variance Fav. / (Adv.)	Plan	Actual	Variance Fav. / (Adv.)		
Month 10	£000	£000	£000	£000	£000	£000		
Cash flows from operating activities								
Operating surplus/(deficit)	(9,007)	(5,551)	3,456	(9,561)	(6,931)	2,630		
Non-cash income and expense:								
Depreciation and amortisation	32,606	31,394	(1,212)	39,665	37,915	(1,750)		
Impairments and reversals	3,700	0	(3,700)	3,700	3,700	0		
Income recognised in respect of capital donations (cash and non-cash)	(222)	(726)	(504)	(268)	(2,257)	(1,989)		
(Increase)/decrease in receivables	2,227	(8,074)	(10,301)	8,777	9,886	1,109		
(Increase)/decrease in inventories	(269)	(1,306)	(1,037)	(269)	(275)	(6)		
Increase/(decrease) in trade and other payables	(30,450)	(11,718)	18,732	1 (27,801)	(4,377)	23,424		
Increase/(decrease) in other liabilities	(7,001)	412	7,413	(7,488)	(7,148)	340		
Increase/(decrease) in provisions	0	(21)	(21)	0	0	0		
Net cash generated from / (used in) operations	(8,416)	4,410	12,826	6,755	30,513	23,758		
Cash flows from investing activities								
Interest received	185	1,158	973	203	1,570	1,367		
Purchase of intangible assets	(13,014)	(10,401)	2,613	(13,389)	(12,489)	900		
Purchase of property, plant and equipment and investment property	(30,870)	(34,287)	(3,417)	(43,892)	(50,968)	(7,076)		
Proceeds from sales of property, plant and equipment and investment property	0	3	3	0	3	3		
Receipt of cash donations to purchase capital assets	382	109	(273)	850	2,180	1,330		
Net cash generated from/(used in) investing activities	(43,317)	(43,418)	(101)	(56,228)	(59,704)	(3,476)		
Cash flows from financing activities								
Public dividend capital received	9,882	6,000	(3,882)	14,954	15,054	100		
Loans from Department of Health and Social Care - repaid	(635)	(635)	0	(1,270)		0		
Other loans received	0	854	854	0	854	854		
Other loans repaid	(3,659)	(3,659)	0	(4,606)	(4,606)	0		
Other capital receipts	134	0	(134)	174	174	0		
Capital element of finance lease rental payments	(5,714)	(6,402)	(688)	(5,796)	(7,493)	(1,697)		
Interest paid	(1,677)	(1,318)	359	(1,995)	(1,952)	43		
Interest element of finance lease	(425)	(468)	(43)	(513)	(560)	(47)		
PDC dividend (paid)/refunded	(5,572)	(5,667)	(95)	(10,830)	(11,176)	(346)		
Net cash generated from/(used in) financing activities	(7,666)	(11,295)	(3,629)	(9,882)	(10,975)	(1,093)		
Increase/(decrease) in cash and cash equivalents	(59,399)	(50,303)	9,096	(59,355)	(40,166)	19,189		
Cash and cash equivalents at start of period	88,911	88,920	9	88,920	88,920	0		
Cash and cash equivalents at end of period	29,512	38,617	9,105	29,556	48,754	19,198		

KEY MOVEMENTS

1 Late changes to final plan were not accurately reflected in Balance Sheet categories.

Royal Devon University Healthcare NHS Foundation Tr	ust									
Capital Expenditure - Consolidated			Astusl s		4	Total ave	amalituus faa		ha	
Period ending 31/01/2023			Actual e	xpenaitu	re to date	l otal exp	enditure for	ecast for t	ne year	Cumantad
Month 10										Expected
					Variance				Variance	Completion Date
		Source of			slippage /	Forecast			slippage	
Scheme		Funding	Plan	Actual	(higher)	future	Plan		/ (higher)	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	
Schemes >= £500k										
MYCARE (Northern)	N	CDEL/PDC	10,061	10,062	(1)	399	10,061	10,461	(400)	22/23
ED Reconfiguration	E	CDEL	5,714	4,991	723	110	6,871	5,101	1,770	23/24
Estates Infrastructure 22/23	Е	CDEL	2,991	2,135		2,093	4,520	-		22/23
Diagnostics CDC	Е	PDC	3,169	0	3,169	1,977	4,110	1,977	2,133	24/25
Cardiology Day Case Unit	Е	PDC/DON	833	26	807	1,573	2,500	1,599		24/25
Operating leases renewed in 2022/23	N&E	CDEL	1,834	778	1,056	906	2,303	1,684	619	22/23
Backlog Maintenance	N	CDEL	1,235	505	730	1,077	1,840	1,582	258	22/23
Aseptic Unit	N	CDEL	1,200	0	1,200	55	1,700	55	1,645	23/24
Ophthalmology Hub	N	CDEL/DON	1,249	630	619	783	1,249	1,413	(164)	22/23
Equipment	N	CDEL	805	367	438	2,242	1,105	2,609	(1,504)	22/23
NHP - OBC Funding	N	PDC	883	862	21	198	1,060	1,060	0	22/23
Discharge Lounge	N	PDC	0	0	0	2,000	0	2,000	(2,000)	22/23
R14 Genetics NovaSeq 6000	Е	PDC	0	872	(872)	91	0	963	(963)	22/23
Digital Histopathology (Eastern)	Е	CDEL/PDC	452	0	452	905	905	905	0	22/23
LINAC Replacement	Е	CDEL	753	512	241	25	836	537	299	22/23
Mortuary	N	CDEL	550	65	485	935	800	1,000	(200)	22/23
Nightingale Hospital Accelerator Programme	Е	CDEL	765	814	(49)	0	765	814	(49)	22/23
MYCARE (Eastern)	Е	CDEL	362	1,078	(717)	2	714	1,080	(366)	22/23
Replacement of Fluoroscopy Room 2 Siemens Artis Zee	Е	CDEL	536	223	313	41	598	264	334	22/23
Room 9 - Xray Replacement	Е	CDEL	0	0	0	540	0	540	(540)	22/23
General Space Moves	N	CDEL	0	38	(38)	13	689	51	638	22/23
Staff facilities (creating the environment)	Е	PDC	163	69	95	393	283	461	(178)	24/25
Endoscopy Expansion	Е	PDC	0	7	(7)	495	0	502	(502)	23/24
Wi-Fi Refresh	N	CDEL	0	0	0	450	500	450	50	22/23
Total Schemes >= £500k			33,555	24,034	9,522	17,302	43,410	41,336	2,074	
Schemes <= £500k	N&E	CDEL	6,022	3,878	2,143	6,996	7,539	10,875	(3,336)	22/23
Schemes <= £500k	N&E	PDC	300	0	300	780	406	-	, , , , , , , , , , , , , , , , , , ,	22/23
Schemes <= £500k	N&E	DON	100	0	100	0	100		` ,	22/23
Total Capital Expenditure			39,977	27,912	12,065	25,079	51,454	52,991	(1,537)	
									, , ,	

Year to date slippage planned to recover by year end ensuring CDEL and PDC allocations are fully utilised.

£1.0m reduced expenditure relates to £1.5m reduction in forecast PDC allocations off-set by £0.5m additional donations.

					Actual	Actual	
Reconciliation of movements in SOCI Plan to Budget	YTD Fixed Plan (NHSEI reporting)	Adjustment s to Plan	YTD Flexed Plan (Board Reporting)	YTD Actual	v Plan Variance (NHSEI Reporting)	v Budget Variance (Board Reporting)	Explanation of adjustments to plan
Statement of comprehensive income	£'000	£'000	£'000	£'000	£'000	£'000	
Operating income from patient care activities	679,226	28,667	707,893	708,297	29,071	404	NHSEI pass-through drugs & devices exceeding plan off- sets additional expenditure, in year contract adjustments e.g. additional pay award contributing to expenditure.
Other operating income	83,254	11,156	94,410	94,225	10,971	(185)	£1.5m R&D income - off-sets additional expenditure £2.6m services provided - off-sets additional expenditure £3.4m Income in advance released - off-sets additional expenditure £1.7m training income - off-sets additional expenditure £1.0m contributions to staff costs £0.8m charitable contributions to expenditure
Total Income	762,480	39,823	802,303	802,522	40,042	219	
Employee expenses - Total	(474,481)	(31,172)	(505,653)	(505,581)	(31,100)	72	For the purposes of internal accountability corresponding expenditure budget has been released to ensure appropriate reporting. These adjustments distort
Operating expenses excluding employee expenses	(297,006)	(5,192)	(302,198)	(302,492)	(5,486)	(294)	variances that are reported through NHSEI and ICS reporting compared to information presented to the Board and it is important the differences are understood.
Total Expenses	(771,487)	(36,364)	(807,851)	(808,073)	(36,586)	(222)	
OPERATING SURPLUS/(DEFICIT)	(9,007)	3,459	(5,548)	(5,551)	3,456	(3)	
FINANCE COSTS						0	
Finance income	185	973	1,158	1,158	973	0	
Finance expense	(2,344)	(1)	(2,345)	(2,345)	(1)	0	4
PDC dividends payable/refundable	(8,840)	(4)	(8,844)	(8,844)	(4)	0	4
NET FINANCE COSTS	(10,999)	968	(10,031)	(10,031)	968		4
Other gains/(losses) including disposal of assets	0	0	0	3	3		4
Share of profit/(loss) of associates/joint ventures	0	0	0	0	0		
Gains/(losses) from transfers by absorption	113,026	7	113,033	113,026	0	(7)	
Movements in fair value of investments, investment property and	0	0	0	0	0	0	
financial liabilities		0	0		0	0	
Corporation tax expense	93,020	4,434	97,454	97,447	4,427	(7)	
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	93,020	4,434	91,454	91,441	4,427	(1)	1
Adjusted financial performance							1
Surplus/(deficit) for the period/year	93,020	4,434	97,454	97,447	4,427	(7)	
Add back all I&E impairments/(reversals)	3,700	(3,700)	0	0.,.41	(3,700)	0	1
Adjust (gains)/losses on transfers by absorption	(113,026)	(7)	(113,033)	(113,026)	(0,100)	7	1
Surplus/(deficit) before impairments and transfers	(16,306)	727	(15,579)	(15,579)	727	0	
Remove capital donations/grants/peppercorn lease I&E impact	668	(727)	(59)	(59)	(727)	0	1
Adjusted financial performance surplus/(deficit)	(15,638)	0		(15,638)	0	0	1



Agenda item:	11.1, Public Board	Meeting	Date: 22 Februa	ry 2023	
Title:	Governance Committee (GC) Report				
Prepared by:	Jacky Gott, Assistant Director of Governance				
Presented by:	Tony Neal, Chair of the GC and Non-Executive Director				
Responsible Executive:	Suzanne Tracey, Chief Executive Officer				
Summary:	A report by exception from the Governance Committee				
Actions required:	For noting				
Status (x):	Decision	Approval	Discussion	Information	
Status (x).				х	
History:	The last Governance Committee Report was presented to the Board of Directors on 25 January 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 9 February 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 on a quarterly basis, 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:		
	 Prof. Adrian Harris, Chief Medical Officer provided the GC with an update on the significant challenges affecting the NHS, and the GC noted that: Overall, following the last update in December 2022, and the very difficult position in December and January, the Trust is seeing an unexpected improving picture, particularly in unscheduled care pathways. The full reasons for this are not known, however this may be due to a change in public behaviour as a result of the media coverage regarding the NHS. It was recognised that this could result in a delayed disease burden like that seen during Covid which may have an impact later in the year. The GC heard that the industrial action is the most challenging issue at present. The impact on strike days is managed well and safely, but cancellations and other adjustments made to facilitate the strike action will have a long-term impact on services, patients and performance. Assurance was provided to the GC that safety remains a priority over performance and finance and that the Executive Team and Board is unified in this. Acknowledgement that all external local partners continue to support the Trust in developing plans to manage the challenges. 		
	b) Emergency Weekend Admission Alert Update		
	Dr Mark Daly, Mortality Lead, provided a comprehensive update report on the adverse change in the mortality indices noted at the last GC in December 2022 and reported to Board in January 2023.		
	In summary, the Mortality Review Group continue to investigate the concerns regarding the deterioration in mortality figures for patients admitted at weekends, more markedly at		

Northern site for patients admitted on a Saturday. Dr Daly presented an update on the analysis of data so far which has not yet identified the cause but assurance was provided that further analysis is underway, including the following key working hypotheses:

- 1) incomplete recording of comorbidity data at weekends
- 2) quality of care compromised at weekends due to staffing models
- 3) impact of primary and community service provision at weekends

The GC requested a further update to the next GC in April along with the Q3 Learning from Deaths report.

c) Clinical Effectiveness Committee:

Prof. Adrian Harris presented the report, confirming that the Eastern and Northern CECs have fully merged and one combined meeting is held with the Chief Medical Officer as the Chair. The GC noted the ongoing work to align and integrate the sub-groups.

The GC were advised that work continues to progress to more formally reincorporate a range of reporting to the scheduled CEC meetings, such as integrated Sub-Group reporting, NICE compliance reporting and GIRFT reporting.

d) People Workforce Planning and Wellbeing Committee (PWPWC):

Hannah Foster, Chief People Officer presented the PWPWC report, highlighting the current low compliance figures for a number of mandatory training modules. The GC received assurance that the reasons behind the low compliance in some topics was known and there are plans to increase compliance and mitigate risks in these areas. Renewal rates in fire safety, resus training and IPC are key areas of focus and the risk assessment on the CRR will be reviewed in line with current position.

The GC were also informed of the work to improve the provision of support to staff from overseas, particularly for nursing and Allied Health Professionals staff groups was noted, however further focus is required for medics which will be taken forward by the 'Accelerating filling our vacancies' programme.

The GC received an update on the Project Simplify and approved the revised policy template for People policies subject to some small amends. The GC also requested that the best practice from this template is incorporated into the Procedural documents policy templates for all procedural documentation.

e) Safety & Risk Committee

Carolyn Mills, Chief Nursing Officer, presented the comprehensive update from the S&RC's held in December 2022 and January 2023:

Never Events – the GC received two completed NE investigation reports for a wrong site surgery at Eastern Services and another at Northern services. In both incidents, there was no harm to the patients involved. The actions taken in response to these incidents was noted by the Committee as well as the linkages with other providers, NHS Devon and NHSi to identify any shared learning. The GC also noted that the Trust has created an Executive Director led Task and Finish Group. Dr Dave Beard has been appointed as Interim Clinical Director for Quality and Safety and will be leading the work on the standardisation of LocSIPPs (Local safety standards for invasive Procedures) as well as supporting the Safety & Quality Team. The GC were advised that a Never Events Seminar for staff was held on 6 December 2022, to share key messages about Never Events and actions, human factors and a personal story from a consultant involved in a Never Event. The S&RC will receive an update on the Never Events improvement work at each meeting.

- Cardiology risk update the GC noted the positive progress and the enhanced assurance provided to the S&RC. A Cardiology Transformation Group (CTG) has been developed to provide oversight and scrutiny for recovery of cardiology waiting times. The progress towards the delivery of a number of priority areas such as Cardiology Day Care Unit and outpatient clinical room capacity was noted.
- Ockenden Report Action Plan Update, Ockenden Assessment of Compliance and Update on Action Plan to achieve CNST Compliance – the GC received an update and assurance report from Maternity Services. These are presented at Appendix A.
- Serious Incident (SI) investigation trajectories the GC received an update on the progress with addressing the SI investigation backlog, noting that both Eastern and Northern services aim to meet the trajectory by the beginning of March 2023.
- Patient Safety Strategy implementation project plan the GC received and noted the good progress with the full project plan for the Patient Safety Strategy Implementation Project Delivery Group (PSSIPDG). This group provides operational oversight to a number of workstreams to redesign the Trust's current patient safety processes and Governance arrangements in line with the requirements of the NHS Patient Safety Strategy (2019) and the Patient Safety Incident Response Framework (PSIRF, 2022).
- **Risk Management policy** the GC noted that the S&RC have approved the revised Risk Management policy and the implementation plans to launch in April 2023.
- Board Assurance Framework Risk 8 Significant deterioration in standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcome – the GC were advised that the S&RC reviewed this risk as a standing agenda item. The S&RC noted the unprecedented operational pressures across both the NHS in Devon and at the Trust, resulting in:
 - the use of additional escalation areas,
 - increased pressure and the cohorting of patients within EDs, AMUs and SDECs,
 - a focus on expediting early discharge combined with significant staffing challenges across all clinical professional groups and significant infection control pressures,

In this context, it was felt that an increase in the likelihood of risk from a score of 3 (Possible) to a score of 4 (Likely) was indicated. This increase in likelihood would result in the overall BAF risk 8 rating increasing from a total score of 12 (Moderate) to a total score of 16 (Significant).

 Mental health pathway risks – the GC discussed the continued pressures on the Trust and impact on adults and children as a result of the wider mental health pathway issues. The GC heard that the Exec to Exec level discussions with Devon Partnership Trust and other partners would be restarting to ensure that system level decisions were being made in the best interests of patients.

f) Safeguarding Committee

Carolyn Mills, Chief Nursing Officer, highlighted to the GC that Level 3 Safeguarding Adults and Children training compliance rates remain below the expected statutory levels but gave assurance that good progress is being made and the Safeguarding Committee continue to review the plans in place to improve compliance rates. Assurance was taken that all patient

facing & clinical staff across the Trust will have undertaken Safeguarding Level 1 training, providing a basic level of safeguarding training assurance across the organisation.

The GC were also assured that the Safeguarding Committee continue to review the Safeguarding risks on the Corporate and Divisional risk registers as well as the actions being taken to mitigate them in order to ensure the Trust meets the requirements set out in the first joint NHS England and NHS Improvement Safeguarding Accountability and Assurance Framework (SAAF).

The GC noted that following the integration in April 2022, work has been undertaken to bring the Northern and Eastern safeguarding teams under one aligned trust-wide structure. The senior safeguarding leadership structure has been confirmed, with new arrangements to take effect from 1 April 2023. Further alignment of the safeguarding teams will now commence with a commitment to have dedicated Safeguarding teams based at both Northern and Eastern sites.

g) Children & Young Persons Bi-Annual Report

Carolyn Mills, Chief Nursing Officer, presented an update on the preparatory work to establish the Children & Young People Assurance Committee.

The GC noted the planned Internal Audit of compliance with national children's standards which is expected to start in March 2023 and complete in May 2023. This will provide an objective baseline assessment of Children and Young People services across the Trust; providing a starting point for discussions/action within the proposed Children and Young People Assurance Committee and concurrently, a system for the ongoing monitoring of compliance with national children's standards.

Assurance was received that governance and performance routes for children and young people are already established within divisions but the Committee will provide direct link/oversight to Board.

h) Whistleblowing report

Melanie Holley, Director of Governance provided the GC with information regarding a number of allegations received in August 2022 relating to a digital programme which have been managed following the process set down in the Trusts Whistelblowing Policy.

Due to the serious nature of the allegations made, an external independent investigator was appointed to undertake the investigation. The investigation commenced in November 2022 and concluded early in January 2023. The detailed investigation report concluded that there was no evidence to support any of the allegations, but made some recommendations which will be developed into an action plan. Melanie advised that the findings have been shared with the Whistleblower together with details of the appeal process.

The GC were assured that the Trust has responded appropriately to the concerns raised and approved the recommendations. The GC will monitor the emerging action plan through to conclusion and an update will be provided back to the GC in 6 months.

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.



Appendix A: Maternity Quarterly update CNST and response to the Ockenden report

- 1. QUARTERLY UPDATE ON PROGRESS WITH CNST MIS YEAR 4 AND THE RESPONSE TO THE OCKENDEN REPORT AT RDUH WITH CONCERNS FOR ESCALATION TO THE SAFETY AND RISK COMMITTEE
- 1.1 The purpose of this paper is to present to the committee a quarterly update on RDUH maternity services progress toward compliance with evidential requirements set out in the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 4 ten safety actions and compliance against the 7 IEA's within the Ockenden report. Detail includes updates against the delivery of actions required to reach full compliance.

1.2 **CNST**

Year 4 of the CNST MIS was launched on 9 August 2021. This national scheme supports the delivery of safer maternity care through an incentive element of Trust contributions to CNST. The scheme rewards Trusts that can meet ten safety actions designed to improve the delivery of best practice in maternity and neonatal services. The scheme content has been refined from Year 3 and following a period of pause in response to the pandemic, was relaunched from May 2022 then updated again in October 2022 with refined guidance and a new deadline for Board declaration forms of Thursday 2nd February 2023.

2. Reporting schedule

A number of safety actions have specific lines of reporting to the Trust Board and associated timeframes. Each Safety Action has a designated lead who is responsible for ensuring that reporting requirements detailed within the updated guidance are adhered to and to raise any risk to the delivery of actions by way of escalation to the maternity senior team.

3. Declarations of compliance

The newly merged RDUH trust maternity services has sought clarification from NHSR regarding reporting compliance. NHSR advise that as NDHT and RD&E Trusts merged during the Year 4 reporting period, two separate returns will be accepted however joint returns will commence 2023/24 (MIS Year 5). The merged trust will develop proposals for assurance and tracking of evidence for joint site returns.

The RDUH audit team support maternity services by providing detailed scrutiny of both Ockenden and CNST actions and evidence. A report for the board is expected December 2022 and will outline the risks and support the position within this paper.

4. Update on progress towards full compliance with the ten safety actions as required for CNST. 2023 will be the final split site submission for RDUH. Both sites are currently undergoing internal audit of evidence to inform action plans and final compliance declaration.

Governance Committee: 9th February 2023 Item 5 – Emergency Weekend Admission Alert Update



4.1 **NORTH:** Full compliance is anticipated for 6 of the 10 safety actions, 4 Safety Actions at risk of non-compliance:

Safety Action 2: (element one) By 31st October 2022, Trusts have an up to date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme

Risk: The newly formed organisation does not have a maternity specific digital strategy in place by 31st Oct 22

Mitigation: Both sites have a dedicated Digital Lead Midwife in post. The trust is developing a digital strategy which will underpin a maternity specific strategy. Services have sought clarification of compliance declaration for newly merged trusts from NHSR

Safety Action 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?

Risk: Inability to conduct audit of compliance due to staffing

Mitigation: North are reviewing current ATAIN pathways and developing a plan for dedicated transitional care unit with indicative timeframes for achieving. There will be a combined trust site action plan to support North to ensure all ATAIN cases are reviewed regularly. The service has developed a focused audit schedule for CNST utilising staff returning form long term leave.

Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

Risk 1: Inability to undertake CO readings on all women due to compliance with IP&C regulations in some community accommodation. All women accessing community antenatal care via the Barnstaple hub (35% of all women) did not have CO breath tests undertaken due to IP&C non-compliant clinical spaces (no ventilation) for the vast majority of the reporting period for CNST evidence. Compliance states that you must evidence 80% of all women receive the CO breath test at booking and 80% at 36 weeks gestation.

Mitigation: IP&C regulations now ceased, service has re-instated CO breath tests in all settings however, for full compliance a 4-month period must be audited which is in progress. The service is exploring compliance reporting with NHSR due to the COVID pandemic impact on compliance which was out of the services control.

Risk 2: Ability to record CO readings as detailed in Safety Action 2 MSDS data issues within EPIC, inability to pull CO data at booking.



Mitigation: Public Health lead midwife performing manual audit of paper notes and EPIC data to conclude compliance. Indicative timeframe for completion of audit Dec 22.

Safety action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?

In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

Risk: Ability to release staff to attend training due to staffing challenges

Mitigation: Training compliance risk assessment and associated action plan in place. Face to Face and virtual training offer in place. Dedicated PROMPT compliance action plan in place to deliver full compliance by Jan 23, additional study day dates in Dec 22 and community PROMPT sessions commence Dec 22.

4.2 **EAST:** Current position it is anticipated full compliance of 8 of the 10 safety actions. The previous report highlighted 3 areas with related risk the report with provide assurance where those areas have progressed and the mitigation has been successful

Update on progress towards full compliance with the ten safety actions:

Safety Action 2: (element one) By 31st October 2022, Trusts have an up to date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme

Risk: The newly formed organisation does not have a maternity specific digital strategy in place by 31st Oct 22

Mitigation: Both sites have a dedicated Digital Lead Midwife in post. The trust is developing a digital strategy which will underpin a maternity specific strategy. Services have sought clarification of compliance declaration for newly merged trusts from NHSR

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



Risk: Do not currently meet the BAPM national standards for junior medical staffing for level 2 unit

Mitigation: Although Eastern is non compliant it is progressing this element and an action plan is in place.

This risk and mitigating actions were highlighted in the October Safety and Risk Report. Eastern should be compliant as an action plan is in place. There is on-going workforce review and options appraisal to support requirement for separate Tier 2 rota to meet national standard.

Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

Risk 1: Ability to support 90% of eligible staff (linked with Safety Action 8) to attend local multi-professional Fetal monitoring training due to staffing challenges.

Mitigation: Dedicated Fetal Monitoring Lead Midwife is now in post. Maternity training risk assessment on divisional risk register. East will be on target and compliant by the 5th of December.

Risk 2 CO2 monitoring at booking is providing a conflicting picture the MSDS data suggests we are not compliant this is due to the collection of data from the epic system. Manual audits have continuously been undertaken to mitigate this position and East have 100% assurance that we are meeting the trajectory.

There continues to be issues with the BI draw from the Epic system which creates additional manual work for maternity teams to mitigate risk. A risk assessment is live on the divisional and corporate risk registers to reflect this matter.

Safety action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?

In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

Risk: Ability to release staff to attend training due to staffing challenges and space to hold face-to-face training if extra days are required.

Mitigation: Training compliance risk assessment and associated action plan in place with a clear TNA supported by the LMNS. East will be compliant with trajectory demonstrating an action plan for 22/24 which includes all 6 core competencies.



5. Monitoring of progress

A dedicated action plan to monitor and record compliance with evidential requirements is in place. Progress towards compliance is monitored via joint site monitoring meetings and through speciality governance. Both sites are currently undergoing Internal Audit process for robust compliance status and to inform any further actions required to reach compliance. A report will be available to the board in December 2022.

6. Response to the initial Ockenden report 7 IEA's:

RDUH hosted a regional Insight team visit in September where compliance with the 7 IEA's was reviewed. East have evidenced full compliance with all 7 IEA's. North remain partially compliant with 2 due to lack of ability to provide evidence of data due to lack of auditable data capture in paper records previously in use however, are assured of full compliance by Feb 23 when a cohort of eligible cases can be audited as evidence extracted from EPIC (a time period of 6 months minimum is required to allow data to be extracted from a woman's pregnancy journey).



6.1 Response to the final Ockenden report

The Final report of the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (The Ockenden Report March 22) details a series of repeated failings and the resulting devastating impact on many families over a period of over 20 years. Building on the 12 clinical priorities from the Immediate and Essential Actions set out in the First Ockenden Report (Dec 20), the report provides an additional 15 Immediate and Essential Actions for local and system actions based around 4 key pillars:

- Safe Staffing
- A well-trained workforce
- Learning from incidents
- Listening to families

Whilst trusts have not been asked to formally review status against these additional IEA's or to provide any evidence of compliance, RDUH maternity services have developed a paper to provide assurance to the Trust Board describing the mechanisms in place to provide assurance and monitor the recommendations of the report. The document contains 92 KLOE and is rag rated

Unmet Urgent	Red
Partial Compliance	Amber
Complete	Green
National Action	Grey

The complete document is available on request.

The report provides assurance in mitigation around the exceptions to those KLOE specific to both sites due to variation in service

Exceptions to final Ockenden

Workforce Planning and Sustainability

RDUH

Risk:3.0 Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.

Mitigation Business Partners to collate and share workforce data from preceding 3 years.

EAST ONLY

Risk:6.0 All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical



practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.

Mitigation: Newly qualified midwives to remain in rotational roles whilst awaiting national team guidance

East has an imbedded a supportive training programme for all students and newly qualified midwives that supports integrated midwifery exposure and case loading.

Risk:7.0 All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.

Mitigation: Awaiting band 7 development document from the national team. Both sites have a Band 7 leadership development and support package in place.

Risk:8.0 All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.

Mitigation: Both sites offer an informal programme. RDUH East package has been provided to the national team as a good exemplar for a national approach.

Risk:9.0 All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.

Mitigation: Awaiting national steer on HDU training requirements. There are currently no national recommendations on this topic due to complexities of competencies.

North only

Risk:11 The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.

Mitigation: There is currently vacancy in the consultant body resulting in gaps. Consultant EOI's have been submitted.

Safe Staffing

RISK:12.0 When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.



Mitigation: Escalation processes exist in both sites and are under review to ensure all parties are cited.

North only

Risk:13 In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.

Mitigation: Protocol in place, no formal risk assessment -A review is underway

Risk:28.0 All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board.

Mitigation: Maternity self-assessment tool has been reviewed and generated an action plan. The teams are awaiting the new tool proposed at the end of November 2022.

Risk: 29.0 Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.

Pending national guidance

Risk: 30.0 All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.

Mitigation: PA time has been allocated to a new consultant with responsibility for governance including guideline/ policy and audit.

Risk 33.0 All maternity services must ensure they have midwifery and obstetric coleads for audits.

Mitigation: Cross site audit midwife to be recruited.

Complex antenatal care

Risk: 51.0 Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.

Mitigation: RDUH provide this service but are awaiting a network position.

Risk: 52.0 Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.

Mitigation: All midwives will have the knowledge to deal with multiple pregnancy and make appropriate referral to the obstetric specialist. Complex multiple birth reviewed at East and review underway in North.



Risk 59 There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.

Mitigation: RDUH is participating in LMNS work. The network lead obstetrician is based in East and provides direct reporting to the network and Periprem.

Labour and Birth

Risk: 63.0 It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust.

Mitigation: Formal risk assessment in place which includes transfer times and potential issues in both sites.

North Only

Risk: 65 Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.

Mitigation: North to adopt East model. Digital lead midwives in each site to begin scoping exercise Jan 23

Postnatal care

Risk: 76.0 Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary

Mitigation: Audit of postnatal readmissions required and added to the audit schedule.

Neonatal care

Risk: 89.0 Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.

Mitigation: As per safety action 4 CNST an action plan is in place.

7.0 Maternity Safety Champion Updates (CNST safety action 9)

The organisations Maternity and Neonatal Safety Champions meet Bi-Monthly to review safety intelligence and triangulate data, including; the number of incidents reported as serious harm, litigations and claims data, themes identified and actions being taken to address any issues; staff feedback from frontline champions and conduct regular engagement sessions (safety Walkabouts); minimum staffing in maternity services and training compliance. QI and innovation projects are supported directly with safety champion input. An example of this would be the successful implementation of the antenatal ward round October 2022. As per Safety Champion TOR's and in compliance with CNST Safety Action 9, a quarterly report will be presented to safety and risk commencing January 2023.

Governance Committee: 9th February 2023 Item 5 – Emergency Weekend Admission Alert Update



8.0 It is recommended that the committee accept this paper as an update to compliance against CNST Maternity Incentive Scheme for Trusts and the Initial Ockenden IEA's.

References:

HOC March 2022: Ockenden Report FINAL: Findings, conclusions and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust: https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf

NHSR May 2022: Maternity Incentive Scheme – year four. OCT update Available: https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/