Royal Devon University Healthcare NHS Foundation Trust

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

Wednesday 26 April 2023
Exeter College Future Skills Centre, Exeter Airport Industrial Estate, EX5 2LJ and via MS Teams

MINUTES

PRESENT	Mrs C Burgoyne	Non-Executive Director
	Mrs H Foster	Chief People Officer
	Professor A Harris	Chief Medical Officer
	Mrs A Hibbard	Chief Financial Officer
	Professor B Kent	Non-Executive Director
	Mr S Kirby	Non-Executive Director
	Professor M Marshall	Non-Executive Director
	Mr A Matthews	Non-Executive Director
	Mrs C Mills	Chief Nursing Officer
	Dame S Morgan	Chair
	Mr T Neal	Non-Executive Director
	Mr J Palmer	Chief Operating Officer
	Mr C Tidman	Deputy Chief Executive Officer
APOLOGIES:	Mrs S Tracey	Chief Executive Officer
IN ATTENDANCE:	Ms B Hoile	Engagement Officer (for item 059.23)
	Ms G Garnett-Frizelle	PA to Chair (for minutes)
	Mrs M Holley	Director of Governance
	Mr P Luke	Director of Strategy (for item 062.23)
	Mr D Tarbet	Business Development Director (for item 061.23)

		ACTION
052.23	**CHAIR'S OPENING REMARKS**	
	The Chair welcomed the Board, 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. Ms Morgan thanked all the Governors attending. **The Chair's remarks were noted.**	
053.23	**APOLOGIES**	
	Apologies were noted for Mrs Tracey.	
054.23	**DECLARATIONS OF INTEREST**	
	Mrs Holley advised that the annual review of the Register of Interests had been undertaken and included in the meeting pack for information.	

	It was noted that a new declaration had been received subsequent to Board papers being despatched. Mr Tidman had accepted an invitation to become a member of the Devon System Recovery Board. **The Board of Directors noted the Annual Review of the Register of Interests and the new declaration by Mr Tidman.**	
055.23	**MATTERS DISCUSSED TO BE DISCUSSED IN THE CONFIDENTIAL MEETING**	
	The Chair noted that the Board would receive updates at its confidential meeting from the Digital, Finance and Operations and Governance Committees and Integration Programme Board, a Business Intelligence Options Appraisal and a review of the Board Assurance Framework and Corporate Risk Register.	
056.23	**MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 29 MARCH 2023**	
	The minutes of the meeting held on 29 March 2023 were considered and approved subject to the following amendments: Minute number 041.23, page 4 of 20, under Local Issues second bullet point "With regard to the recovering for the future objective" Minute number 041.23, page 5 of 20, paragraph beginning "Mrs Foster said that the next industrial action ..", final sentence to be amended to read "She added that for some clinicians TOIL would be more attractive than money, but ~~offering~~ managing TOIL on an ongoing basis would become much harder if the period of industrial action continued." Minute number 041.23, page 5 of 20, final paragraph, ".. and Improved Better Care Fund (iBCF)" Minute number 041.23, page 6 of 20, penultimate paragraph, final sentence "Mr Tidman suggested that ~~this~~ he could take this forward" Minute number 042.23, page 7 of 20, change to "Professor Kay said that 1 in ~~7~~ 17 people would show a rare genetic disease in their lifetime" Minute number 047.23, page 18 of 20, paragraph beginning "Mr Palmer agreed.." to be changed to read "He agreed that the work with Primary Care on ~~restratification~~ risk stratification would be important."	
057.23	**MATTERS ARISING AND BOARD ACTION SUMMARY CHECK**	
	Action check Action 041.23, "Mr Tidman to explore further with Devon County Council and the Director of Adult Social Services to attend either a formal Board meeting or a Board Development Day as an opportunity for both of them and the Trust to set out their mutual positions on hospital discharge, the out of hospital proposition and potential solutions." The Board noted that this had been added to the list of items for Board Development Days and agreed that the action could be closed.	

	Action 043.23(4), "Mr Neal asked if the impact of the reopening of Sidwell Street Walk In Centre could be assessed, together with a wider review of plans going forward for Minor Injury Unit provision". Mr Palmer advised that there had not been a material impact on the ED following the reopening of Sidwell Street Walk In Centre, although there had been a small impact on the Minors stream. However, it did have a big impact on presentation of all types, and most importantly the service was back up and running for patients. Mr Neal asked what was planned with regard to the wider review of plans for Minor Injury Unit provision and Mr Palmer responded that it was planned to look at this over the next couple of months. It was agreed that the action could be closed. Professor Marshall said that it had been noted at the last meeting, following presentation of the Staff Survey, that a discussion was planned with senior leaders and asked if there was an update from those discussions. It was noted that the meeting had been postponed but that a follow-up discussion was planned about the Staff Survey and the Board would receive an update at the June Board meeting. **The Board of Directors noted the updates.**	
058.23	**PATIENT STORY**	
	Bethany Hoile joined the meeting. Mrs Mills presented the Patient Story film to the Board and advised that the Patient Story was set within the context of the Trust's strategic objectives of excellence and innovation in patient care and recovering for the future. Discharge lounges provided a comfortable and safe environment for patients whilst they await discharge and helped to support flow through the hospital through releasing acute beds. The use of Discharge Lounges had been well received by patients and ward staff. Ms Morgan said that it had been striking in the film to see that patients saw the Discharge Lounge more as an initiative to benefit the hospital more than themselves. Mrs Mills said that the Discharge Lounge initiative was part of the work to improve flow through the hospital but the benefits for patients being discharged was recognised including the improvement to the quality of the discharge process. Professor Marshall asked what was the cost of the Discharge Lounges and were they a cost-effective intervention. Mr Palmer said that he believed that the original cost in 2021 had been around £200k, much of which had come through Urgent and Emergency Care funding and there would be associated running costs. Mr Palmer said that he believed they were a fundamental part of a modern hospital and systems work. He said that at bed meetings held throughout the day, checks were always made on how many patients were in the Discharge Lounge, as this was one of the ways of checking that flow was being maintained. Mr Palmer said that Discharge Lounges also served as a driver allowing conversations with social care to be initiated more quickly and accurately, as Pharmacy and Transport were being lined up. Mrs Hibbard commented that it was better value for money to have a sustainable staffing structure on a service provided on a long-term basis which meant not having to rely on moving patients and staff to escalation areas and having to utilise higher cost agency staffing.	

	Mrs Burgoyne commented that there might be a way of helping patients to see this as their part in helping the hospital and asked whether a variety of messaging was being used to ensure that both staff and patients could see the importance of Discharge Lounges and how everyone played a part in helping flow through using them. Mrs Burgoyne also asked if there were plans to expand the service on the back of its success and whether it was being utilised fully. Mr Kirby said that the number of discharges happening before midday reported in the IPR was quite low and asked whether patients were only counted as discharged when they left the Discharge Lounge and were there blockages moving patients from the wards. Mr Kirby also said that when the business case for the Northern Discharge Lounge had been approved, there had been a question raised about whether additional Pharmacy support for this new facility was part of the funding and asked whether it was clear that the right Pharmacy infrastructure was in place. Mr Neal commented that this offered an opportunity to help patients start preparing psychologically for going home and asked whether ward staff had visited the Discharge Lounges so that they knew what was there for their patients. Mr Palmer said that all potential discharges were reviewed at the start of the day and there would be a drive on this if not enough actual discharges were taking place against the expected number through ward rounds or targeting areas. Staff also checked for any blocks, such as transport or pharmacy issues and tried to resolve them, so that at the point a patient arrived in the Discharge Lounge as much as possible had been done to ensure they could be discharged quickly and efficiently. Mr Palmer noted the comments regarding communication adding that there was a risk in a high-pressured environment that "cleverness" around communications could be lost. He agreed that it would be helpful to keep varying communications messaging to ensure that it is picked up by staff and patients. Professor Kent agreed with the importance of raising awareness of Discharge Lounges with both staff and patients. Ms Morgan asked whether a patient would only go to the Discharge Lounge if they were not expected to stay another night in hospital and this was confirmed. Professor Harris said that the Discharge Lounge was an efficiency measure. He commented that Pharmacy could only start to prepare discharge medications once a junior doctor had prepared the discharge notice and this was where delays could happen. Although junior doctors were made aware of the importance of completing this in a timely way, it needed to be reinforced regularly as the juniors rotated and there was no standardisation across organisations. Mr Matthews had a concern that this was introducing another step in the process and another move within the hospital for patients which could make things more complicated, although he noted the responses given by the Executives. He asked whether there was a risk of building in ongoing inefficiency by accepting as normal that Pharmacy would not be ready and whether the processes could be changed to remove the inefficiencies. He further asked whether there was any good research available which would show whether the Trust should be aiming to use Discharge Lounges more or dealing with the issues in other ways.	

	Professor Harris said it was absolutely clear that Discharge Lounges were beneficial in driving flow, but acknowledged that using them was in a way tolerating inefficiency. However, this was a necessary compromise and front loading the system would be a far greater cost than that of the Discharge Lounge. Professor Harris noted that standardisation of EPR across the country would be transformative over time and one of the significant steps was discharge medication. There were ways of ensuring discharge medications were ready to go when needed, for example through the use of a non-prescriber to "press the button" when the decision is made to discharge rather than waiting for the prescriber in charge of the patient. Mrs Mills commented that EPIC was a significant enabler for ensuring continuity for patients, ensuring they got the right things at the right time. Professor Kent said that in terms of evidence around discharge, there had been systematic reviews undertaken in various different countries. She said that it was also important to remember the patient and their families and the benefits of the Discharge Lounge for them, for example where patients had to wait for a family member to be available to collect them, they could safely do this in the Discharge Lounge rather than remaining on the ward. Ms Morgan agreed and said that it was also part of the patients return to normal life and independence. Ms Morgan thanked Mrs Mills for presenting the story which she said had initiated a good discussion for Board members. **The Board of Directors noted the Patient Story** **Bethany Hoile left the meeting.**	
059.23	**CHIEF EXECUTIVE OFFICER'S REPORT**	
	Mr Tidman provided the following updates to the Board. <u>National Update</u> • Policy announcements – the Hewitt review on Integrated Care Systems (ICS) had recently been published and contained recommendations on how the newly established architecture could operate in a more seamless way. The recommendations included an increase in the share of spend on prevention and moving to a service that promoted health and wellbeing. Also included were a review of data collections to find those that were not adding value, minimise the number of national targets to no more than 10, radical reform of the GP contract, a proposal for more delegated freedoms for the most mature ICSs and a further requirement for Integrated Care Boards (ICB) to reduce running costs. • NHS England (NHSE) had released a document regarding setting up a National Improvement Board. NHSE recognised the duality in managing a regulatory role alongside promoting continuous improvement and Amanda Pritchard had confirmed that all NHSE staff would undergo training in Quality Improvement methodology. They would be reflecting on the way they interact with Trusts to ensure that short-term changes were complemented by the recognition of the need to keep improving. • It was clear that Industrial Action could continue for some time. Teams had managed well in maintaining safe rotas during periods of Industrial Action, but this was impacting on staff resilience and on patients where procedures had to be cancelled. National NHS statistics had shown that there had been 195k cancellations during the last period of Industrial Action in 2022. A further impact	

would come from staff taking time off in lieu for additional work undertaken to cover during strikes.

- The Covid-19 vaccination spring booster programme was now available targeted at around 5m people nationally including the over-75s, those aged 5 and over with a weakened immune system and adult care home residents.
- There was a breakeven national financial position reported overall, with the deficit for the current financial year forecast as £3bn. More work will take place to see how plans can be sharpened.

System Issues

- Devon's Integrated Care Strategy had been published. This set out how healthcare and other support services would be planned and organised in Devon. The Strategy draws on a number of separate sources of intelligence and information, including the joint Strategic Needs Assessment, insight from engagement activity with the public and a Change Leaders event.
- A System Recovery Board had been established to deliver the operational plan. This Board would be the senior system leadership group to oversee and drive this year's financial and operational plan, as well as ensure that all enablers were in place for the system to exit SOF4, the highest level of scrutiny. Mr Tidman, Mr Kirby and Mrs Mills were members of the System Recovery Board.

Local issues

- The Care Quality Commission (CQC) would be undertaking the Well-Led inspection of the Trust next week. In addition, the Inspection Report for Medicine, Surgery and Diagnostic Services had gone through the factual accuracy checking process and been sent back and it was expected the final report would be published within the next two to three weeks. An action plan would be developed for areas identified for improvement which would be brought back to a future Board meeting. Overall it was agreed that it was a fair report and would be used as an opportunity to improve services.
- NHSE are creating six Networks of Excellence for Genomics across the country. There will be an open bidding process, with each region with a Genomics Medicine Service able to submit a proposal. The initial term for the networks would be two years with funding of £1m per year. One of the primary goals of the networks would be to build on the expertise and infrastructure of NHS partner academic institutions. It is likely that the Trust will bid for and lead transformative approaches to diagnosing rare and inherited disease.
- South Molton Eye Centre was now open, with the first clinics held in early April. This service will help to reduce waiting times for eye conditions.
- Approval had been received for Tiverton Endoscopy Unit which was strategically important to support populations in North, East and Mid-Devon. This would be a £12m state of the art Endoscopy suite which it was hoped would be completed by Autumn 2024, with a mobile Endoscopy Unit on site in the interim. This development will help with diagnostic and cancer targets.
- 26 April was World Admin Professionals day and the Trust would be profiling colleagues working in Corporate Services and in frontline administrative roles to support clinicians. A Careers Fair was taking place at the RD&E site and thanks to staff were on social media platforms.
- The Nightingale Hospital continued to be a key part of recovery, both for the Trust and for colleagues in Torbay and Plymouth. The Nightingale Hospital had been one of only eight surgical hubs to receive national GIRFT accreditation reflecting that it was meeting the highest clinical and operational standards.

	• Achievements were noted for the last 12 months, including the reduction of patients waiting over two years from 950 to 23 with a similar reduction for those waiting over 78 weeks, improvements put in place to reduce waits for those waiting the longest for cancer treatment which had been recognised by the Regional Team and the work to maintain good ambulance handover and offering support to others in the system, which had also been recognised regionally. The Trust had also achieved its financial plan for 2022-23. Ms Morgan thanked Mr Tidman for his excellent overview and added her thanks for the improvements in delivery in key areas. Professor Kent said that she welcomed the news regarding the Networks of Excellence for Genomics and asked whether there would be subsequent monies available after the initial two-year period. Mr Tidman responded that generally once such initiatives were established, further funding would follow but the Trust would be looking to take any short-term opportunities and consolidate. Professor Marshall said that the GP contract could have implications for the Trust as although there would be a national framework, it was likely to be more locally determined with Trusts having the opportunity to input into what GPs were doing. It was quite likely that the contract would be held at network level rather than individual practice level. Professor Marshall commented in relation to the announcement about the National Improvement Board that quality improvement and regulatory activity were in practice fundamentally irreconcilable and the challenge for the Trust would be, recognising that reality, pushing improvement work in an environment that was not conducive and aligning it to what had to be done to satisfy regulations. Mr Tidman agreed but said that the Trust had to accept the regime that it operated in whilst providing an umbrella for staff to have the conditions and support they needed to make changes. Mr Kirby said that it would be helpful if the Trust could try and influence the outcome of the Hewitt review on the ICB and ICS, as they hold the key to some of the change needed and could act as a co-producer of transformable strategic change solutions rather than as another regulator. Mr Kirby said that it was important to note that the Trust had sought to gain positives out of intervention, for example using regional and national intervention to help create routes to monies and support genuinely helpful interventions. Mr Palmer said that the Nightingale Hospital receiving GIRFT accreditation was a big opportunity for the Trust to look at best practice and implement it. He advised the Board that Professor Briggs was pulling together 12 Trusts across the country, of which RDUH was one, to move harder and faster on the long waits challenge over the next year which it was believed would come with some funding. **The Board of Directors noted the Chief Executive's update.**	
060.23	**INTEGRATED PERFORMANCE REPORT**	
	Professor Harris presented the Integrated Performance Report (IPR) for activity and performance for March 2023 noting that it was important to acknowledge what had been achieved during the year, not least on financial delivery. Ms Morgan	

endorsed this and thanked Mrs Hibbard for her hard work on getting the Trust to financial delivery.

Ms Morgan said that it was good to see information included in the report on ambulance diverts as this helped to give a sense of how the Trust was working as a system player and added that it would be good to see over time the weight of the impact of those contributions, for example on beds.

Mr Neal noted the 5% No Criteria to Reside target, which he felt was very ambitious and said that he was not sure from the commentary in the report that there was a clear path to achieve this detailed. In addition, Mr Neal said that human factors were often mentioned relating to falls and Never Events and asked what was being done to manage or address this. He asked for clarification of what the Northern Services Acute Medicine Model and the bid for elective infrastructure referred to on the scorecard were.

Professor Kent noted that A&E attendances had increased and asked what the key drivers of this were. In addition, she asked whether the Trust was involved in the work taking place across North and East Devon on new housing developments, as this could have a significant impact on the amount of activity going forward as populations sizes increased. Finally, Professor Kent asked whether it was usual to have GP streaming and if so, why did the Trust not have one.

Professor Harris said that increases in A&E attendances were not always easily explained, but there had been no increase in 4 hour waits which was a measure of flow being more efficient. Professor Harris commented that it had been interesting to see that performance had improved during Industrial Action due to senior decision makers at the front door driving flow. Ms Morgan advised that she had asked for an item on lessons learned from periods of Industrial Action for the next Board Development Day.

Professor Harris noted Mr Neal's question about normalising Never Events, advising there was a great deal being done to stop this happening, but there was always a tension between education and change and getting the work done. Mrs Mills endorsed Professor Harris' comments and advised that there was information she was happy to share with the Board regarding the National Patient Safety Strategy delivery which would help give a sense of the direction of travel. **Action.**

Mr Palmer said that March had been a difficult month, with Norovirus very prevalent particularly in Eastern services and the Trust providing quite a bit of system support as well, and Industrial Action creating some unpredictability. The organisation had been working hard on No Criteria to Reside with a focus on funding streams, with some of these schemes previously provided by the ICB and Devon County Council (DCC) withdrawn during March. The ICB Gold meetings were used as a place of escalation for conversations relating to this and it was felt for the first time there was some equivalency given for ambulance waits for other Trusts and No Criteria to Reside figures for RDUH. There had now been an extension provided on some of the funding until the end of June and a wider conversation was underway about extending this for the whole year. It was therefore difficult to work out the trajectory for the year, but the Trust was in escalation and regular meetings with DCC and the ICB to agree how to construct the trajectory for the year. The Trust had just signed off £5.2m of urgent and emergency care funding for the year which would help to keep care packages up and running. The next IPR would be aligned with

	the operational plan and a trajectory for No Criteria to Reside would be included. There were some improvements on Green to Go, but they were not yet where they needed to be to balance the bed model. Mr Palmer clarified that the Northern Services Acute Medicine model was signed off by the organisation to fund the development of acute medicine in Northern Services. The bid for elective infrastructure noted in the scorecard was the release that was hoped for from Professor Briggs following very positive interactions with GIRFT, with the Trust invited to submit a Transformation Improvement Fund bid for capital. Negotiations were currently underway to ensure that the Trust can access both capital and revenue funding for the vascular hybrid theatre. Mr Palmer advised that the Trust used to have GP streaming and bringing it back required a contractual arrangement being discussed through the Gold arrangement. It is hoped that funding will be made available in the first instance for a pilot. Mr Palmer added that GP streaming adds value through supporting ED and is liked by consultants. Mrs Hibbard said that the money allocated nationally to ICBs was based on population size, and therefore if housing developments resulted in an increased population this would be reflected in funding allocations. However, she noted that there may be some lag between the development taking place and funding allocation catching up, but the system could bid for additional funding through the 106 process from the local authority to help pump prime some of the health infrastructure changes that would be needed. Mr Matthews asked whether insight could be given in future to funding for NCTR. He noted that there had been a significant rise in the number of complaints compared to a year ago, and whilst some related to delays in appointments it was not the main driver and asked whether further analysis of this was needed to draw out learning. He noted significant improvements in recruitment reported but this was hard to triangulate with the data that showed that there was still a 10% daily shortfall in both Northern and Eastern services of Registered Nurses. Mr Matthews asked for clarification of why maternity data in the IPR was reported up to the end of March for Northern but that reported for Eastern related largely to February. Professor Harris said that an answer would be provided regarding maternity data to the next meeting. **Action.** Mrs Burgoyne noted the improvement seen for the time taken to deal with complaints but that there was still a backlog, particularly in Eastern medicine. Mrs Mills said that this was the first time that an aggregated table had been included in the report for complaints. She added that there had been a change in the way that complaints were counted in the East; with informal complaints historically managed through the PALs team. These were only transferred to the Complaints Team if they were not resolved within timescales. This has now been changed and she believed that this accounted in part for the increase noted, as well as the fact that this was the first time the merged data had been presented. However, there had been an increase in complaints noted with the main theme relating to delays in appointments. Mrs Foster said that nursing presented the biggest vacancy gap, which was closing through successful recruitment, but there would be a lead in time to getting those new recruits into post. The vacancy drop in East had been greater than that in	

	North, which had a bigger vacancy rate. Mrs Mills added that there would be 30 new registered nurses qualifying from Petroc in September through the initiative with Bolton University, 20 of whom would come into the Acute Trust. It was noted that regional benchmarking data for registered nurse vacancies showed that the Trust was in a similar position to its peers. Mr Matthews asked if the 10% shortfall would start to reduce and was advised that some flexing of budgets would be needed to allow flexibility in how this was managed. She said that 10% was not an unreasonable baseline level to run with. Mrs Foster said that the Delivering Best Value work would be about finding the balance between agency, bank use and recruitment and what needed to be agreed was the acceptable level of vacancy. Mr Matthews said that it would be important to be clear if the expectation was not to be at 100% recruitment and what the expected vacancy rate would be. Ms Morgan agreed that the Board needed to understand and agree to this which could be picked up at a future Board meeting for further discussion. **Action.** Mr Kirby asked for clarification of outpatient follow-up numbers, particularly in the East. In addition, he noted the successful Urgent Community Response (UCR) data since the pathway went live in November 2022 and asked what would stop the Trust investing in this pathway to achieve more. Mr Palmer agreed that the outpatient follow-up numbers were difficult to understand which related in part to comparing and contrasting data two years on from the Covid wave. However, going forward laying out performance against plan would give a stronger reference point. The Trust had previously, with the support of Devon County Council, been able to use some discharge funding to supplement UCR but this approach may be more constrained going forward. Mrs Burgoyne asked whether the System Recovery Board would focus on NCTR. In addition, Mrs Burgoyne asked what would be the triggers to start to move patient flow diagnostics currently showing as “red” to “amber/green”. Mr Tidman advised that the System Recovery Board had held its inaugural meeting and provided a real opportunity to focus on NCTR, with understanding of all the different funding streams essential and would be set out transparently. Mr Palmer added that a letter was being developed to ensure that funding streams were understood and to lay out the Trust’s position on the need to chase down 5% NCTR. Mrs Hibbard suggested that the Finance and Operational Committee be asked to discuss the NCTR issue to bring assurance back to the Board. Mr Palmer advised that unless the Trust was able to secure a stable funding position, it would be difficult to change the back end of the pathway around social care from “red” to “amber/green”. **No further questions were raised and the Board of Directors noted the IPR.**	
061.23	**ANNUAL SUSTAINABILITY AND DEVELOPMENT PLAN**	
	Mr Tarbet joined the meeting Mr Tidman presented the Annual Sustainability and Development Plan for 2022-23 and thanked Mr Tarbet and his team for the work they had done over the last year. The Board was informed that: • Some interventions had needed central funding, but much could be achieved by what teams had been able to do on the ground, linked to the work that Mr Luke and the team were undertaking to encourage staff to submit ideas for bright ideas for small changes. • Sustainability binds people together as people want to make a difference.	

	Ms Morgan agreed that this was important for staff as evidenced in the Staff Survey results relating to support for the Green Plan and asked what the Trust's policy was on single use plastics in non-clinical settings, such as Estates and in restaurants. It was noted that single use plastics were not used in the catering facilities and use of polystyrene containers had also been stopped, but there were some issues with availability of items through the Supply Chain in other areas. Mr Kirby noted that 60% of NHS carbon emissions related to procurement related activities and a target of 10% weighting would be applied to social value criteria in procurement exercises. He asked how this would be monitored, as this could make a significant difference. Mr Tarbet responded that the Trust received a report from NHS England on its carbon footprint and whilst there was no single reporting system in place currently, developing systems for that will be a focus going forward. Mr Kirby asked if checks were made on procurements that the 10% weighting had been applied and Mr Tarbet advised that this had just started with all procurement exercises having 10% applied. Mr Tidman suggested that as part of the Trust's internal audit arrangements a check should be built in relating to the 10% weighting. **Action.** Mrs Hibbard commented that making small changes were probably delivering a financial benefit as well, although there could also be adverse impacts for example through setting different criteria than previously. It would be important to evaluate financial impact, both positive and adverse. Mr Neal congratulated Mr Tarbet and the team for the significant amount achieved during the last year and hoped that the scale of achievements would be shared with staff. He said it would be helpful to see a trajectory for carbon emissions reduction and asked whether there had been improvements in waste and incineration at the Trust. Mr Tarbet confirmed that this had improved and the Trust was also looking at new technologies that would allow incineration on site. Mr Palmer commented that it had been good to see case studies included in the report, such as the virtual ward and the campaign to reduce the use of Entonox. He asked whether consideration should be given to add this to the triple bottom line either for the Annual Report or the Financial and Operational Plan. Mrs Foster agreed that this was an area that was very important to staff and supported ingraining this into reporting and decision making and communicating this work with staff in a more systematic way. Professor Kent asked whether the Trust was maximising grants available to help make some of the changes. Mr Tidman said that the Team would take the Board's comments away to look at as part of next steps for development of the plan. Ms Morgan thanked Mr Tarbet and the team for the excellent work reported, adding that this was an area that motivates staff and part of what makes them proud of the organisation. **The Board of Directors noted the Annual Sustainability and Development Plan.** **Mr Tarbet left the meeting**	
062.23	**CLINICAL STRATEGY UPDATE**	

	Mr Luke joined the meeting Professor Harris presented the Clinical Strategy update and informed the Board that when the Trust had started the Clinical Strategy it had not been as far progressed on system work, particularly the Peninsula Acute Sustainability Programme. There had been discussion about key decisions on the distribution of services across RDUH once the Clinical Strategy was in place, but those decisions would now be made with partners across the wider peninsula to get services right for the population. The Trust would set out its offering through the Clinical Strategy and the enabling strategies, but it would be the two ICSs who would make final decisions. Professor Harris proposed that the Board should spend time discussing this in more detail at the next Board Development Day. Ms Morgan asked what the timeline and operational deadline for this would be as it was likely the next Board Development Day would be in July and Professor Harris responded that the putative deadline for presentation of the Clinical Strategy and enabling strategies to the Board was June. He added that there was however no imperative to present it then and pushing it back to presentation at the July Board would not have a significant impact. It was agreed that this would be looked at outside the meeting. Professor Marshall commented that for most patients the majority of their care was provided through Primary Care and in the community and asked for clarification on how this would be reflected. Mr Luke said that a lot of the engagement work was focussed on Primary Care and community. He said that there were things that were under the Trust's control which it did really well which included community services and more could be done by expanding some of those services. Primary Care was however not under the Trust's control and there was an emphasis on approaching this relationship transparently and honestly, playing a leadership role but ensuring that Primary Care were listened to. Primary Care Networks had been involved in the process as had community teams to get their feedback and engagement. Mrs Burgoyne noted that there were 58 strategic approaches proposed within the Clinical Strategy and said that this seemed to be a very large number to manage. She asked whether it was felt that there was the same level of understanding through the organisation as had been demonstrated by the Medical Directors from all providers across the peninsula in the recent Acute Sustainability Programme film that had been released. Mr Neal said that it was important to ensure that innovation was linked to the Trust's developing relationship with the University of Exeter and research. He agreed with Mrs Burgoyne's point regarding the number of approaches, as it was not clear whether they were deliverable and what would happen if they were not. Mr Luke said that he and the Team were confident that they could get momentum behind all of the strategic approaches. The Trust Delivery Group would take ownership of the Strategy once approved; the Group had representatives of all key service leaders, including HR, Finance and IT. He said that the Strategy had been developed by clinical and operational staff and reflected how they wanted to develop services which meant there was momentum behind it. Mr Luke said that aligning the enabling strategies to the Clinical Strategy had not been done before but it provided a blueprint of challenges that could be overcome together. He	

	added that although there were 58 strategic approaches, this had been honed down in the document to six key things so that it could be explained clearly to staff. Professor Harris responded to Mrs Burgoyne's question about the level of understanding across the organisation about transformation through collaboration saying that there would be varying levels, but with the average nurse on a ward or consultant probably having little depth of understanding at the moment. The leadership challenge for the next few years would be to ensure that individual staff did feel they understood why this has to be. Mr Kirby said that he felt there did need to be some pace to this, as some short-term strategic shifts in how things are done would be needed to help address some of the financial issues in the system. Professor Harris said that a pragmatic approach would be needed to address some things as need arose and seize opportunities. Mr Luke added that there was nothing that was waiting or would not be done because the strategy had not been formally approved. Mrs Hibbard welcomed the discussion on the system as she said it was important to reflect the system direction of travel in the Clinical Strategy. She said that the Board had previously discussed how to balance the level of ambition in the Clinical Strategy with the reality of the financial position. Whilst she had been pleased to see visionary, ambition against the affordable mentioned, she asked whether this had gone far enough as the landscape had changed very significantly with the scale of the challenge over the next few years evident in the Trust's Operational Plan. Mr Tidman agreed, but said that it had to be recognised that the wider Devon reconfiguration would mean that there would need to be investment in all parts of the system. There was investment going into North Devon, Torbay and Plymouth but no defined new hospital project for Exeter, but Exeter would still be a fundamental part of this. In saying what it would need to make Devon sustainable it would be important to manage expectations as well. Mrs Hibbard said that this messaging needed to flow through to those developing the Clinical Strategy so that there was understanding. Professor Harris confirmed that this would be made very clear. Mr Luke said that at the same time as being very clear that there was no available capital to commit, the successes that had been achieved by being organised and proactive should be highlighted. Mr Palmer agreed with comments of other Board members on the importance of collaborative positioning and agreed with the idea of developing the capital pipeline. He commented that integration had not been mentioned in the document and he would work on this with Professor Harris and Mr Luke for the final presentation. Professor Kent said that the success of the Strategy would only be achieved with significant behaviour change across the region and it would be essential to draw on expertise to get the message across. Mr Tidman said that there were national leaders within the Trust who could role model. Mrs Mills agreed with previous points about momentum and counselled about delaying too long as this could create challenges with clinical engagement.. Mrs Foster commented that the System Workforce Plan was working to a different timeline to the Trust and the Trust was developing a Workforce Plan that would have trajectories and turnover to support the Clinical Strategy.	

	Ms Morgan summarised that the Board fully supported the direction of travel outlined and had raised valuable comments regarding how this would be aligned with the operational plan and how it would be delivered in the context of the financial environment and close system collaboration. The supporting enabling strategies would be discussed as soon as possible. It would also be important to maintain momentum and the confidence of staff. **The Board of Directors noted the Clinical Strategy Update.** **Mr Luke left the meeting.**	
063.23	**CORPORATE ROADMAP UPDATE**	
	Mr Tidman presented the Corporate Roadmap Update with the following noted: • When the Board had agreed the Better Together 5-year strategy, it was agreed that clear strategic milestones were needed for the four strategic objectives. • A plan was developed for the first two years of the strategy and the update provided an overview of what had been achieved during the last quarter and what it had been agreed to let slip. It also provided a forward view for the next six months. • The update provided assurance for the Executive Team that there was management time and capacity to deliver expectations and where it was agreed that there was not, work may be put back or if necessary additional resource would be put in to enable milestones to be met. • The Board will need to consider development of a plan for the next two years at a future Board Development Day. Mr Kirby commented that there would be a discussion to be had under the Collaboration and Partnership Strategic Objective regarding mobilising the EPIC Resource Plan to support Torbay and South Devon NHS Foundation Trust, noting however that the EPIC proposal was still subject to the Torbay and South Devon Board decision and procurement process. Mr Tidman said that it was not known at this time what the outcome would be in terms of procurement but the Trust was on standby and this would be a topic for further discussion at a Board Development Day. Mr Kirby asked what impact the lateness in implementing the divisional structure was having on the organisation. Mr Tidman agreed that the restructure had not progressed as far as would have been wanted due to a number of factors. However, he noted that Teams are keen to move forward with this and it would be progressed as quickly as possible, as it was an enabler for the Clinical Strategy and for delivery and operational planning. Mr Palmer said that it had been agreed that nothing radical would be done during Year 1 post-integration, unless there was an organic proposal such as that for joining community services. This had been done as a pilot and had provided a great deal of learning. There is now a Programme Director in place and she is making good progress, with an outline plan in place. The leadership team will need to discuss whether it is comfortable with engaging and consulting with staff through the summer with implementation through the winter months. **The Board of Directors noted the Corporate Roadmap update.**	
064.23	**TOWARDS INCLUSION END OF YEAR REPORT**	

	Mrs Foster presented the end of year report for Towards Inclusion and highlighted that the Cultural Development Roadmap was in place to track all the areas of work being undertaken to support driving the right culture. Mr Neal asked whether as much progress had been made as had been hoped and Mrs Foster said that there was always more to be done, but more opportunities had been taken as they arose, for example the establishment of a Neurodiversity Network. She added that measurements were in place that enabled trend analysis which could show whether staff felt psychologically safe and will help with understanding of where hotspots and problem areas may be. Professor Kent commented that it was good to see that regional funding had been secured for Diversity and Inclusion work. Ms Morgan thanked Mrs Foster for presenting the report and said that she had the support and commitment of the Board in promoting inclusion across the organisation. **The Board noted the end of year report for Towards Inclusion.**	
065.23	**GOVERNANCE COMMITTEE UPDATE**	
	Mr Neal informed the Board that, as the Committee had only met at the end of the previous week, it had not been possible to produce a written update in time for circulation of Board papers. He advised that there were no items for escalation to the Board and a report of the meeting would be submitted for the May Board meeting. It was noted that there had been some issues with attendance for the last few meetings since the meeting day had been changed and an email had been circulated to Committee members asking for feedback on timing of the meeting and inviting suggestions for what might help improve attendance. **The Board of Directors noted the update.**	
066.23	**REVIEW OF BOARD SCHEDULE OF REPORTS**	
	Mrs Holley presented the routine annual review of the Board Schedule of Reports. It was noted that the paper presented indicated in yellow where reports were no longer included on the Board's schedule as they were being presented to other Committees and the Schedule could be updated during the course of the year if there were new reports that needed to be added and represented to the Board. Mrs Foster advised that there would be a number of new reports coming through in coming months that would need to be added to the Schedule related to the Workforce Standards reports already included. It was noted that future iterations of the report should avoid italics as they were inaccessible for people with learning difficulties and that red and green fonts should be avoided where possible. **Action.** Following discussion, it was agreed that a separate paper should be presented at a future Board meeting outlining papers that did not have a mandated timing to review. **Action.**	

	Mr Kirby noted that the People Plan was scheduled for presentation at the April meeting but had not been included on the Agenda. Mrs Foster said that this was not mandatory and there had been a discussion on management of this as part of the strategic update. Mr Tidman added that the Executive needed to work through deep dives into particular areas, such as the People Plan, when the quarterly update on the Corporate Roadmap was presented. **The Board of Directors noted the annual review of the Board Schedule of Reports.**	
067.23	**ITEMS FOR ESCALATION TO THE BOARD ASSURANCE FRAMEWORKS**	
	Ms Morgan asked if Board members had picked up any new risks for escalation to the Board Assurance Framework or current risks that needed to be expanded. Mrs Burgoyne said that the Board had discussed in detail at a number of previous Board meetings the issues relating to No Criteria to Reside and although she could see how it would fit into some of the current strategic risks, should the Board consider whether it warranted a separate risk. Mr Tidman said that this had been discussed by the Executives and the view was that it should not be a separate risk, but that the current risk needed to be reframed to draw this out as a primary risk but Mrs Burgoyne's suggestion would be followed up. **Action (CT/JP)** **The Board of Directors noted the comments.**	
068.23	**ANY OTHER BUSINESS**	
	No other business was raised by Board members.	
069.23	**PUBLIC QUESTIONS**	
	The Chair invited questions from members of the public and Governors in attendance at the meeting. Mr Wilkins asked a number of questions related to the Patient Story on discharge lounges: • Was the expected discharge date metric based on an algorithm of some sort? • Would it be helpful if the Integrated Performance Report included information on the number of patients per day or per hour transiting through the discharge lounges? • What percentage of patients were discharged via discharge lounges compared to those discharged directly from the ward? Ms Morgan thanked Mr Wilkins summarising that the questions related to how the Trust could best present the data it had about discharge and whether there were better ways of presenting it. Mr Palmer said that an expected day of discharge sets the rhythm for the day in the system, framing the expectation of how soon the patient could be discharged and helps drive flow. In some parts of the organisation there is criteria-led or nurse-led discharge where if the criteria are met, then the patient is judged ready to be discharged. This aids the process as the decision to discharge is made through the multi-disciplinary team rather than referring everything back to the original clinician involved. Mr Palmer said that a great deal of data is collected and there would be a reflection needed of how much could be shared through the Integrated	

	Performance Report, however he said there was robust assurance that checks are undertaken daily on the detail of all the data points. Mr Palmer said that he would be happy to speak to Mr Wilkins outside the meeting on the detailed points he had raised. Mrs Greenfield asked for clarification of the higher than national standard term admission rates to the Neo Natal Unit and Mrs Mills agreed to look at this outside the meeting and email a response. **Action** There being no further questions, the meeting was closed.	
069.22	**DATE OF NEXT MEETING**	
	The date of the next meeting was announced as taking place on Wednesday 31 May 2023.	