Royal Devon University Healthcare NHS Foundation Trust

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

At 13:10 on Wednesday 26 October 2022
Seminar Rooms 15-17, Sandy Park Conference Centre & via MS Teams

AGENDA

This meeting will be recorded via MS Teams7

As of 19.10.22

Item	Title	Presented by	Item for approval, information, noting, action or discussion	Time Est.
1.	**Chair's Opening Remarks**	Shan Morgan, Chair	Information	13:10 2
2.	**Apologies**	Melanie Holley, Director of Governance	Information	13:12 1
3.	**Declaration of Interests**	Melanie Holley, Director of Governance	Information	13:13 2
4.	**Matters discussed in the confidential Board**	Shan Morgan, Chair	Noting	13:15 2
5.	**Minutes of the Meeting of the Board held 28 September 2022**	Shan Morgan, Chair	Approval (Paper)	13:17 5
6.	**Matters Arising and Board Actions Summary Check**	Melanie Holley, Director of Governance	Information (Paper/Verbal)	13:22 5
7.	**Chief Executive's Report**	Suzanne Tracey, Chief Executive Officer	Information (Verbal)	13:27 20
8.	**Patient Story**	Carolyn Mills, Chief Nursing Officer	Information (Verbal/paper)	13:47 15
9.	**Winter Plan 2022-23**	John Palmer, Chief Operating Officer	Approval	14:02 45
	BREAK			14:47 10
10.	**Performance**			
10.1	**Integrated Performance Report**	Angela Hibbard, Chief Financial Officer	Information (Paper)	14:57 30
11.	**Policy and Strategy**			
11.1	**People Plan Update** • **Local Progress against the People Plan** • **Workforce Planning Update & Retirement Trajectory**	Hannah Foster, Chief People Officer	Information (Paper)	15:27 20

11.2	**Acute Provider Collaborative including Terms of Reference**	Suzanne Tracey, Chief Executive Officer	Approval (Paper)	15:47 10
12.	**Assurance**			
12.1	**Governance Committee Update**	Tony Neal, Non-Executive Director & Committee Chair	Information (Paper)	15:57 5
12.2	**Towards Inclusion**	Suzanne Tracey, Chief Executive Officer	Information	16:02 10
13.	**Information**			
13.1	**Items for Escalation to the Board Assurance Framework**	Shan Morgan, Chair	Discussion (Verbal)	16:12 1
14.	**Any Other Business**			**16:13**
	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.			
15.	**Date of Next Meeting:** The next meeting of the Board of Directors will be held at approximately 13:00 on **Wednesday 30 November 2022.**			
16.	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 16:23

Royal Devon University Healthcare NHS Foundation Trust

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

Wednesday 28 September 2022
Via MS Teams

MINUTES

PRESENT	Mrs C Burgoyne	Non-Executive Director
	Mrs H Foster	Chief People Officer
	Professor A Harris	Chief Medical Officer
	Mrs A Hibbard	Chief Financial Officer
	Professor B Kent	Non-Executive Director
	Mr S Kirby	Non-Executive Director
	Mr A Matthews	Non-Executive Director
	Mrs C Mills	Chief Nursing Officer
	Dame S Morgan	Chair
	Mr T Neal	Non-Executive Director
	Mr J Palmer	Chief Operating Officer
	Mrs S Tracey	Chief Executive Officer
	Mr C Tidman	Deputy Chief Executive
APOLOGIES:	Professor J Kay	Senior Independent Director & Non-Executive Director
IN ATTENDANCE:	Ms G Garnett-Frizelle	PA to Chairman (for minutes)
	Mrs M Holley	Director of Governance
	Ms B Parry	Communications Manager (for item 126.22)
	Ms D Secombe	Clinical Matron for Safety & Patient Experience (for item 126.22)

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

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

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

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

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

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

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

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

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

Mr Kirby posed the following questions:

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

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

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

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

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

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

Mr Matthews posed the following questions:

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

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

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

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

Professor Kent asked the following questions:

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

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

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

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

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

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

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

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

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

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

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

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

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

The Board of Directors noted the update.

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

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

Royal Devon University Healthcare NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS
28 September 2022
ACTIONS SUMMARY

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

PUBLIC AGENDA					
Minute No.	**Month raised**	**Description**	**By**	**Target date**	**Remarks**
008.22 (1)	January 2022	Update on diagnostics briefing and business case to be presented at March public Board meeting.	JP	~~March 2022~~ ~~April 2022~~ ~~July 2022~~ ~~August 2022~~ ~~September 2022~~ ~~October 2022~~ November 2022	**Update February 2022** – Preparation of the business case is in progress. Presentation of the 2-5 year draft strategy expected for March confidential Board and then presentation at the public Board in April 2022. **Action ongoing** **Update March 2022** – Paper on agenda for discussion at Confidential Board and proposed discussion at public Board following receipt of NHSEI feedback, now anticipated in Summer 2022. **Update March 2022** – The business case would be submitted following presentation at the March Confidential Board meeting with feedback following the conclusion of the decision-making process expected from NHSE/I in July 2022. To be updated at the July Public Board meeting. **Action ongoing.** **Update May 2022** – The business case has been submitted to NHSEI, reflecting the revised revenue funding for 22/23. Feedback remains awaited & an outcome from the decision-making process is expected from NHSEI in July 2022. An update will be provided at the August Public Board meeting. **Action ongoing.** **Update August 2022** – Formal confirmation has been received from NHSEI of £9.8m

					revenue funding for 2022/23. An outcome as to consideration of the request for capital funding for 2022/23 and revenue funding in 2023/24 remains awaited with the last indication from NHSEI being a likely decision in September, against the original expectation of a July decision. **Action ongoing.** **Update September 2022** – An outcome of the formal consideration of the request for capital funding for 2022/23 & revenue funding in 2023/24 remains awaited. **Action ongoing.** **Update September 2022** – Mr Palmer informed the Board that the Trust was in advanced discussions with NHSE/I regarding the business case, with the clinical measurements proposition being worked through. **Action ongoing.** **Update October 2022** – NHSE regional team process is now at final stages of review. Notification of outcome of regional review anticipated in next week, ahead of formal consideration by NHSE national team. **Action ongoing.**
014.22	January 2022	Dr Kyle to attend Board three months after Epic Go Live in NDHT to provide a further update on O/P transformation work, in particular relating to provide an update on the inequities work at system level.	Ski	~~October 2022~~ November 2022	**Next update due October 2022. Action ongoing.** **Update September 2022** – due to the significant agenda for the October Board meeting, it was agreed that this action be carried forward to the November meeting. **Action ongoing.**
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.	MH	September 2022	**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.**

113.22	August 2022	The research potential of Epic to be explored further outside the meeting with Mr Visick and Professor Gibbons.	Aha	October 2022	**Update October 2022** – Meeting scheduled for 07.11.22 for key eastern, northern and NIHR Clinical Information & Research Leads to discuss this further. **Action complete.**
123.22	September 2022	Minute number 110.22 of meeting held on 31 August 2022 to be amended to replace Ms Hassan with Ms Hashem.	GGF	October 2022	**Update September 2022** – Amendment made. **Action complete.**
130.22	September 2022	Consideration to be given to whether the current political uncertainty was adequately reflected in the Board Assurance Framework risks.	MH	October 2022	**Update October 2022** – reviewed as part of BAF review undertaken for October Board. **Action complete.**

Signed:

Shan Morgan
Chair

Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	8, Public Board Meeting	**Date:** 26 October 2022
Title:	Patient story: Virtual Ward Care (Acute Hospital @ Home initiative)	
Prepared by:	Bethany Hoile, Engagement Coordinator	
Presented by:	Carolyn Mills, Chief Nursing Officer	
Responsible Executive:	Carolyn Mills, Chief Nursing Officer	
Summary:	Patient stories reveal a great deal about the quality of our service provision, the opportunities we have for learning and the effectiveness of systems and processes to manage, improve and assure service quality. The purpose of presenting a patient story to Board members is to: • Set a patient focussed context to the meeting, bringing patient experience to life and making patient's stories accessible to a wider audience • To support Board members to triangulate patient experience with reported data and information • For Board members to reflect on the impact of the lived experience for these patient(s) and its relevance to the strategic objectives of the Board.	
Actions required:	The Board of Directors is asked to reflect on the implications of this story for patients and to reflect on its relevance to the strategic objectives of the Board. Link to status below and set out clearly the expectations of the Board when considering the paper.	

Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
			X	

History:	The 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 together with our patients to help them stay healthy, to care for them expertly and compassionately when they are not and to allow them more control over their own care through embracing new technologies, research and innovation. This also aligns with the development of the Trust's Digital strategy. In October 2020, The Trust launched the Epic electronic patient record system in Eastern services and in July 2022, Epic went live within our Northern services. We now have a common electronic patient record system across Northern and Eastern services, and across acute and community services. This offers us huge potential to transform and improve the way patients access care and how we communicate with each other.

	One of the early digital opportunities the Trust is exploring is remote monitoring. The Virtual Ward (Acute Hospital at Home) is supporting patients at home, who would otherwise come into the hospital environment as an inpatient. The Virtual Ward concept is a safe and efficient alternative to NHS bedded care that is enabled by technology. Virtual wards support patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home. This includes either preventing avoidable admissions into hospital or supporting early discharge out of hospital. The use of the Virtual Ward (Acute Hospital at Home) links with national NHS priorities to deliver Virtual Ward capacity across systems. Our Eastern Acute Medical Unit is piloting this with patients and, where suitable, offering a range of portable devices for patients to use to be monitored at home. Examples of kit currently offered include i-watches and Kardia machines. Data is uploaded into Epic and monitored by the clinical teams. This patient story serves to bring to life the experience of two patients who have used this new technology. They have used heart monitoring devices at home and been monitored by virtual clinical teams. Sally suffered heart palpitations since her 20s. Recent bad episodes have made it difficult for Sally to function in her role as a midwife. After being admitted to the Eastern Acute Medical Unit, she was given a Kardia device to take home. Sally had previously found devices clunky and uncomfortable and she didn't necessarily experience palpitations when wearing the device. The modern device was small, discreet and only required using when she experienced palpitations. This captured crucial data and led to her finally receiving a diagnosis and being prescribed beta blockers which have proven successful in reducing the severity of her heart palpitations. Vienna was also given a Kardia monitor to monitor heart palpitations. When she attended her appointment at Wonford, she was identified as suitable for monitoring remotely by the hospital at home nurses. Vienna was shown how the device worked and told how to contact the nursing team if needed. She was then able to return home and spend the week caring for her young daughter, rather than becoming an in-patient or having to drive in daily whilst being monitored. In this story, Sally and Vienna describe their experience of using technology to be monitored and cared for remotely and the positive impact this had on their lives.
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	
Assurance Framework		Complaints	

Equality, diversity, human rights implications assessed	X
Other *(please specify)*	

Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	9, Public Board Meeting		**Date:** 26 October 2022	
Title:	Winter Plan 2022/23			
Prepared by:	Heather Brazier, Director of Operations (Northern Services) Sally Dootson, Director of Operations (Eastern Services) Gill Heathcote, Divisional Director, Operations (Eastern Services) Nicol Cleverdon, Director of Operations Support Manger (Northern Services) Ellie Johnston, Operations Projects Support Coordinator (Eastern Services)			
Presented by:	John Palmer, Chief Operating Officer			
Responsible Executive:	John Palmer, Chief Operating Officer			
Summary:	The Winter Plan for 2022/23 outlines how the respective Eastern and Northern site teams will individually and collectively manage operational pressure associated with the Winter months. The forecast demand for urgent and emergency care as well as further COVID-19 waves, with attendant impact on staffing levels, have each been reviewed and plans adapted to be flexible to changing need.			
Actions required:	The Board of Directors is asked to approve the Winter Plan 2022/23 for the Royal Devon University Healthcare NHS Foundation Trust.			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
		X		
History:	The Winter Plan which accompanies this paper is an update of the respective Operational Capacity and Resilience Plans for Northern Devon Healthcare NHS Trust and Royal Devon and Exeter NHS Foundation Trust which were considered by the then Joint Boards of Directors in October 2021. This plan, which has a specific focus on Winter, has been developed based on the current understanding of demand, implementation of schemes that have been successful in previous winters, and review of the evidence base for new schemes. It has been developed in line with NHS Devon Integrated Care System winter planning and national guidance has been discussed and considered by the Trust's Strategic Delivery Group.			
Link to strategy/ Assurance framework:	The issues discussed are key to the Trust achieving its strategic objectives, particularly the objective to deliver an equitable recovery and capacity for further change.			

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 the attached Winter Plan is to provide assurance to the Trust's Board of Directors as to the robustness of the plans in place to manage operational capacity and the associated anticipated demand for inpatient beds, across the forthcoming Winter period.

The plan details the Trust's understanding of the modelling of demand, alongside its proposed Winter schemes, and the processes and procedures for responding to any fluctuations in demand including those for COVID, elective and cancer care, and for other non-covid infectious conditions including seasonal flu and pandemic influenza.

2. Background

The plan has been prepared by the respective site operational management teams, in consultation with clinical and managerial colleagues, prior to review by the Trust Strategic Delivery Group.

The plan has been developed to link in with the escalation plans of system partners including NHS Devon Integrated Care System and with national guidance. The plan itself builds upon the Operational Capacity and Resilience Plans for 2021/22 and continue to build upon the organisational response frameworks developed in response to the COVID pandemic.

3. Resource/legal/financial/reputation implications

The provision of a robust Winter plan is important in order to support the Trust in continuing to provide safe, high quality care to all patients (both urgent and elective) in times of significantly heightened demand for urgent and emergency care. Through the management of such care pressures, and the return of service delivery to normal operating levels as quickly as possible following period of escalation, the capacity plan supports both emergency and elective care service delivery.

4. Link to BAF/Key risks

The primary risks to the plan are surges in urgent and emergency care demand, both for COVID patients and for non COVID patients, beyond forecast levels, greater system fragility for emergency care and onward care than anticipated, and the risk of workforce shortages either through recruitment challenges, particularly to fixed term contract posts, or through increased staff sickness.

Sufficiency of care capacity is a risk noted on and regularly reviewed as part of the organisational Board Assurance Frameworks (BAF).

5. Proposals

The Board of Directors are asked to approve the Trust's Winter Plan for 2022/23.

Royal Devon University Healthcare
NHS Foundation Trust

Royal Devon University Healthcare NHS Foundation Trust

Winter Plan

2022-23

To be used in conjunction with: NHS England Operational Pressures Escalation Levels Framework
In consultation with: Divisional Teams Eastern Services Urgent Care Steering Group Eastern Locality Delivery Group Northern Patient Flow Steering Group **Approval required from:** Joint Delivery Group Royal Devon University Healthcare NHS Foundation Trust Board of Directors
Contact for Review: Heather Brazier - Director of Operations – Northern Services Gill Heathcote - Divisional Director for Operations – Eastern Services

CONTENTS

1.0 INTRODUCTION

The Winter Plan 2022/23 outlines how both Eastern and Northern Services will manage operational pressure associated with the winter months. In previous years the Winter Plan has been incorporated within the Operational Capacity and Resilience Plan. This year a standalone Winter Plan has been created to cover the whole Trust.

Royal Devon University Healthcare NHS Foundation Trust has experienced continuing challenges so far in 2022, with additional waves of COVID-19, high levels of urgent and emergency admissions, and onward care delays, whilst elective recovery continues. The forecast demand for urgent and emergency care as well as further COVID-19 waves, with attendant impact on staffing levels, have been reviewed and plans adapted to be flexible to changing need.

The effectiveness of this plan requires all partner organisations to have robust and consistent plans in place that are responsive with sufficient capacity to support surges in demand and that deliver effective patient flow throughout the year. The NHS Devon System Delivery and Improvement Group and Locality Care Partnerships will monitor whole system compliance and support partnership working.

2.0 OWNERSHIP AND GOVERNANCE

Executive Director Lead

John Palmer, Chief Operating Officer

Operational Delivery Leads

Heather Brazier, Director of Operations – Northern Services
Sally Dootson, Director of Operations – Eastern Service

- The Joint Delivery Group has overall responsibility and oversight of the plan, which it carries out through the Eastern Services Urgent Care Steering Group and Northern Services Patient Flow Steering Group, reporting to both the Eastern and Northern Services Operations Boards.
- Version control and governance of the Winter Plan will remain the responsibility of the Eastern Services Operations Support Unit.
- This plan will be distributed to the Trust Executive Team, to individuals on the Director, Manager and Senior Nurse on-call rotas and the Site Management Offices. The approved plan will also be made available on the Trust's Intranets.
- In addition, this plan will also be distributed to partner organisations in the local healthcare community including NHS Devon.
- Divisions have the responsibility for communicating and adhering to their specific plans.

3.0 OVERVIEW

The Winter Plan sets out the following:

- Objectives of the plan
- Risks that could impact upon the delivery of services
- Modelling of demand
- Funding sources
- Winter schemes
- Response to operational challenges
- Supporting staff health and wellbeing
- Communication strategy

4.0 OBJECTIVES OF THE WINTER PLAN

The objectives are as follows:

- Support staff health and wellbeing and build confidence in operational plans.
- Ensure that the Trust has sufficient urgent and emergency care capacity to provide high quality and safe care for patients, including those with COVID-19.
- Optimise cancer and elective care to reduce waiting times for our patients.
- Minimise ambulance handover delays.
- Work collaboratively across the Devon system to prevent inappropriate attendance and admission, and support timely discharge.
- Deliver operational resilience in the most cost-effective way possible.

5.0 THE DEVELOPMENT OF THE PLAN

The 2022/23 Winter Plan has been developed based on the current understanding of demand, implementation of schemes that have been successful in previous winters and an evidence base for new schemes.

It has been developed in line with NHS Devon Integrated Care System winter planning and national guidance.[1]

A review has been undertaken of the NHS England and Improvement (NHSE/I) winter assurance framework as requested by NHS Devon System Delivery and Implementation Group, with a large focus on emergency department provision.

6.0 RISKS THAT COULD IMPACT UPON THE DELIVERY OF SERVICES

There is however always a risk that predicted demand may change and schemes may be difficult to recruit to on a non-recurring basis, leading to difficulty in delivering the forecasted benefits.

6.1 Risks

The following risks have been identified which, if materialised, could impact on patient care and service delivery:

- Failure to successfully deliver all elements of the plan, including difficulty in recruiting fixed term staff
- Increase in Emergency Department attendances causing difficulty in meeting Emergency Department targets.
- Increase in non-elective admissions above predicted numbers, putting pressure on paediatric, intensive care and medical beds particularly.
- COVID-19 surge:
    - Exceeding ITU and respiratory support capacity
    - Loss of workforce due to sickness/isolation
    - Loss of domiciliary care hours and care home beds
    - Exceeding mortuary capacity
- Outbreaks of COVID-19, norovirus or other infectious diseases impacting on bed availability.
- Unplanned absence of staff from issues such as an increase in COVID-19 infections or flu sickness.
- Adverse weather conditions, such as snow and ice, flood and high winds.

[1] https://www.england.nhs.uk/wp-content/uploads/2022/08/B1929_Next-steps-in-increasing-capacity-and-operational-resilience-in-urgent-and-emergency-care-ahead-of-winte.pdf

- Partner agencies, such as GPs, social care, unable to cope with increased demand resulting in patients diverting to the Trust.
- A change in the baseline provision of community health and social care services from previous years' levels.
- High numbers of patients who are waiting for onward care.
- Patient transport resilience is compromised.
- Increased costs, for instance through providing additional staff, accommodation, transport
- Reassigning staff to work in unfamiliar areas at times of staffing shortage.

There is a separate COVID-19 risk assessment, which is also recorded and reviewed on the Corporate Risk Register.

6.2 Potential Impact of Risks on Services

The list below outlines the potential impact on services in the event of significant pressure affecting patient flow as described above.

- Potential adverse patient safety and quality impact.
- Cancellation of elective admissions, including oncology and haematology treatments, due to the number of emergency admissions and/or delays in patients waiting for onward care, therefore reducing ability to meet cancer and referral to treatment waiting times.
- An impact on the delivery of the 4- hour performance target.
- Failure to meet ambulance handover times may affect both quality and safety for patients.
- Declaration of OPEL 4 escalation status which could result in divert of non-elective admissions.
- Additional exposure to financial expenditure risk.
- Reputational impact from regulators and local media as a result of failure to deliver targets and potential adverse patient outcomes.

7.0 DEMAND MODELLING

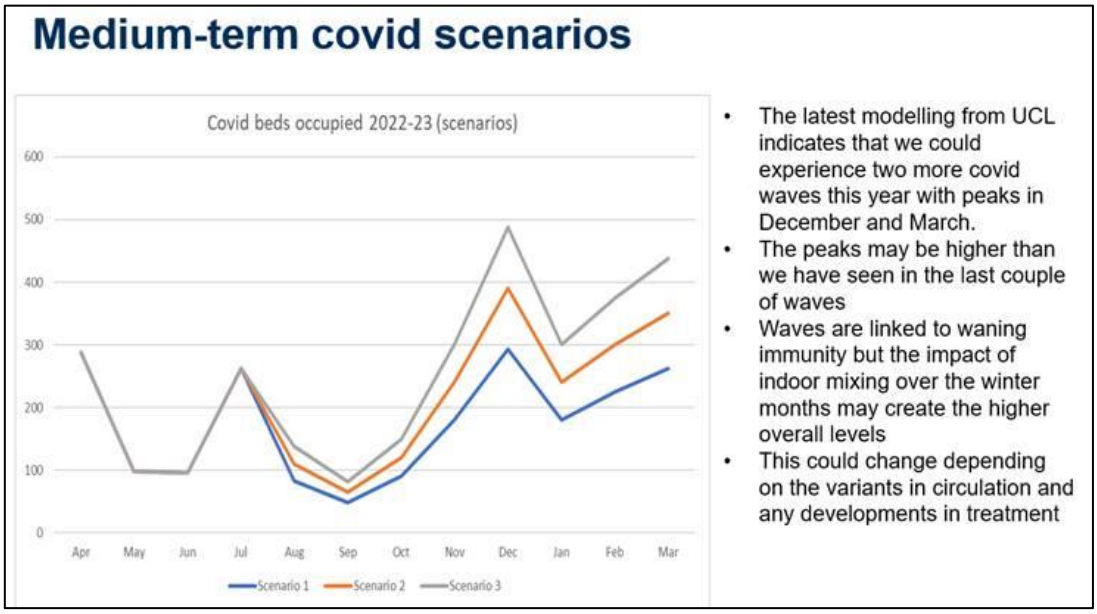
Modelling future bed demand has been complex due to uncertainty around the impacts of the pandemic. NHS Devon has carried out a bed modelling exercise for Devon providers based on the forecast demand for beds in totality, including elective and non-elective activity. The Trust has also carried out its own modelling.

Both models suggest that non-elective demand will continue to significantly exceed the Trust's capacity for the foreseeable future due to a combination of future COVID-19 waves, flu demand, the need to continue a level of elective activity and steadily growing underlying demand.

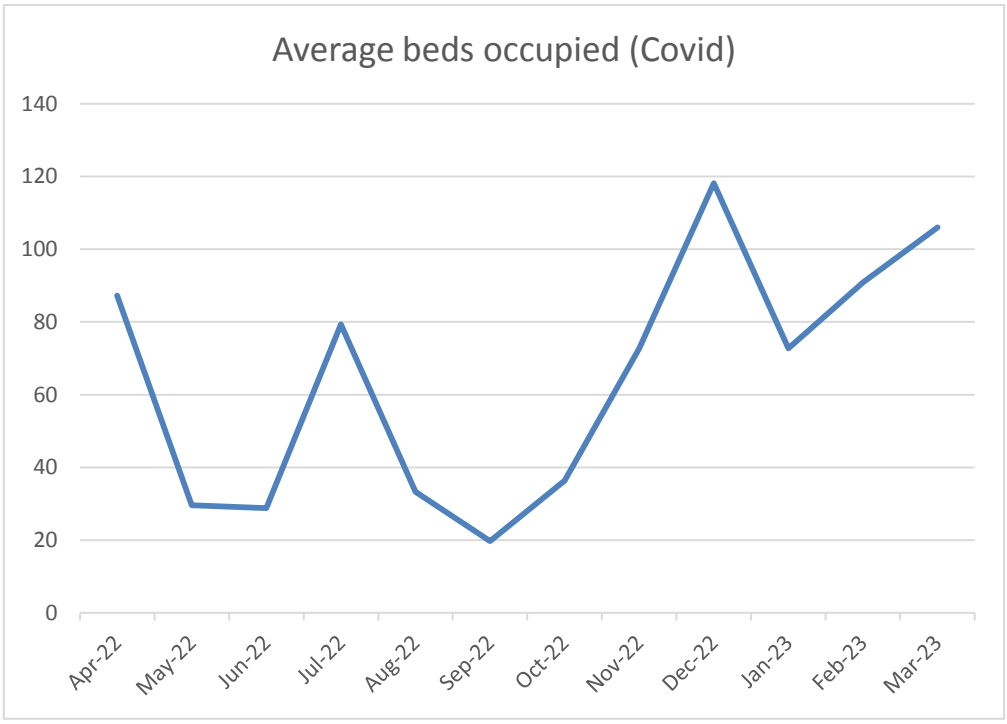
7.1 COVID-19 modelling

All indications are that the variants that are escaping the current vaccine are upper airways disease and therefore less severe, and hopefully will result in shorter stays, if a stay is required at all.

The latest UCL Modelling for medium term COVID-19 scenarios are as follows for Devon:

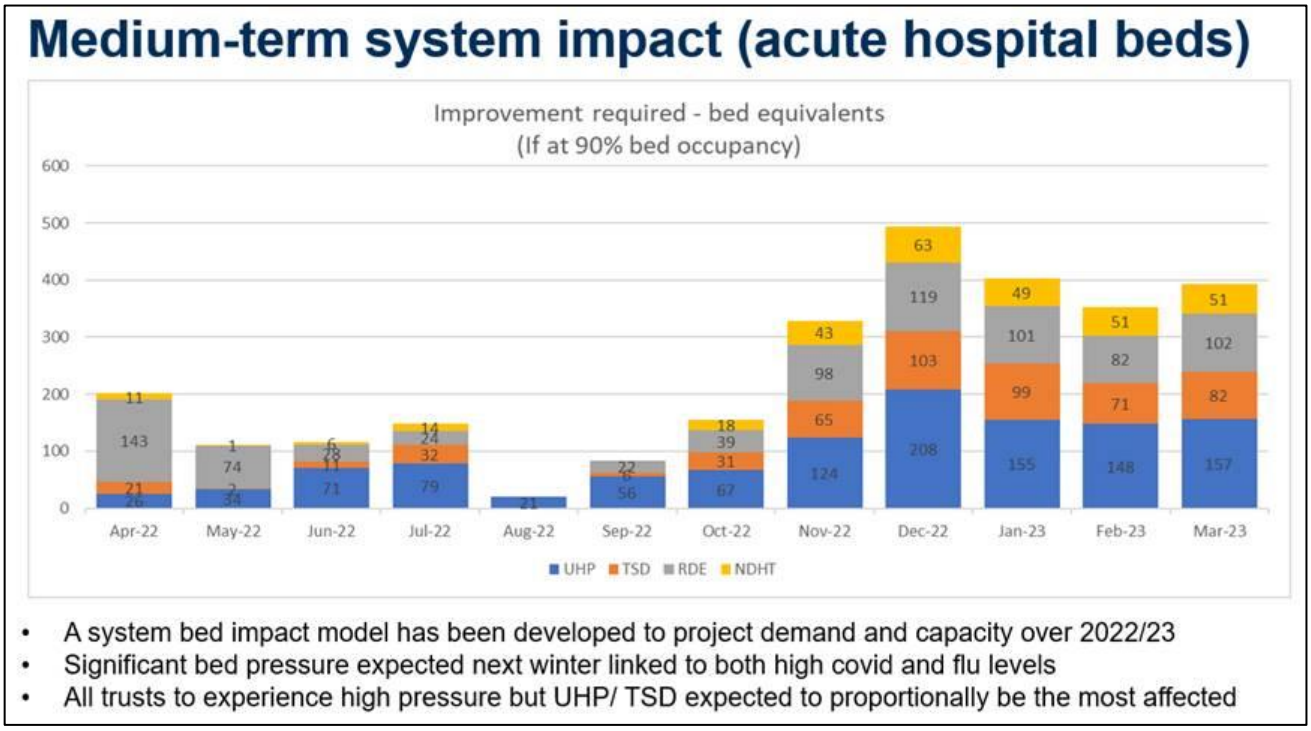


For Eastern Services the most likely scenario for COVID inpatients is forecast as shown below:

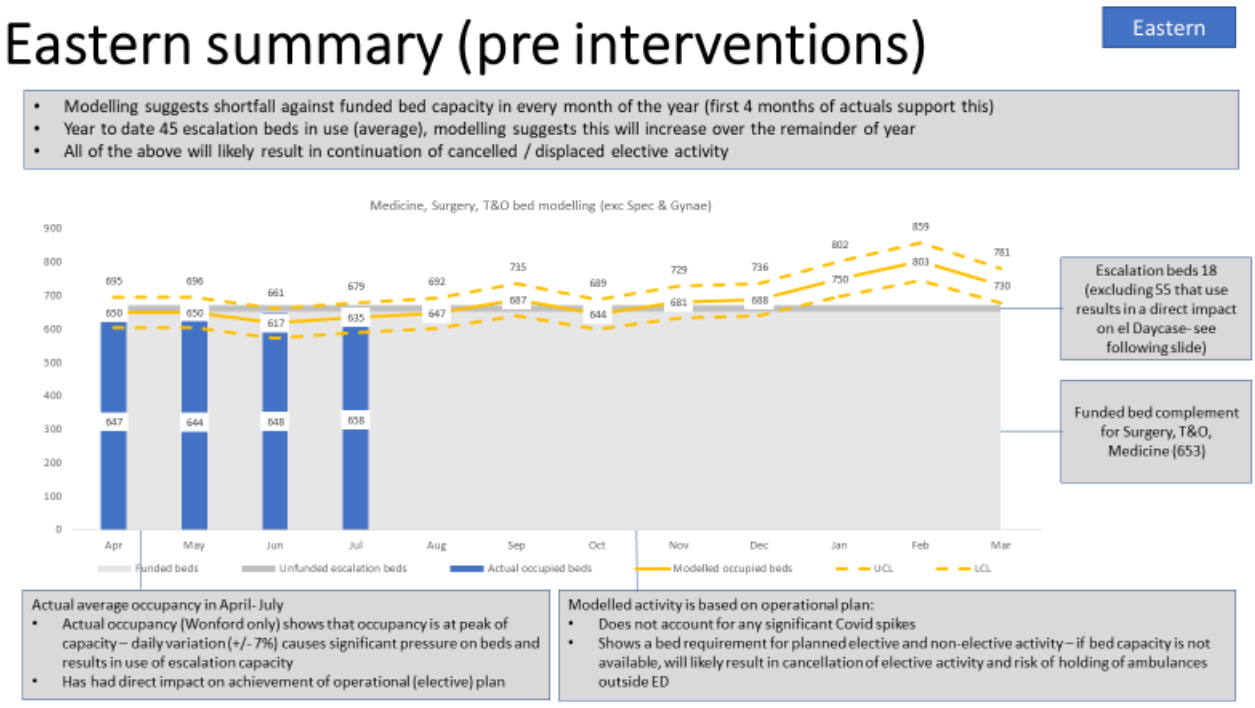


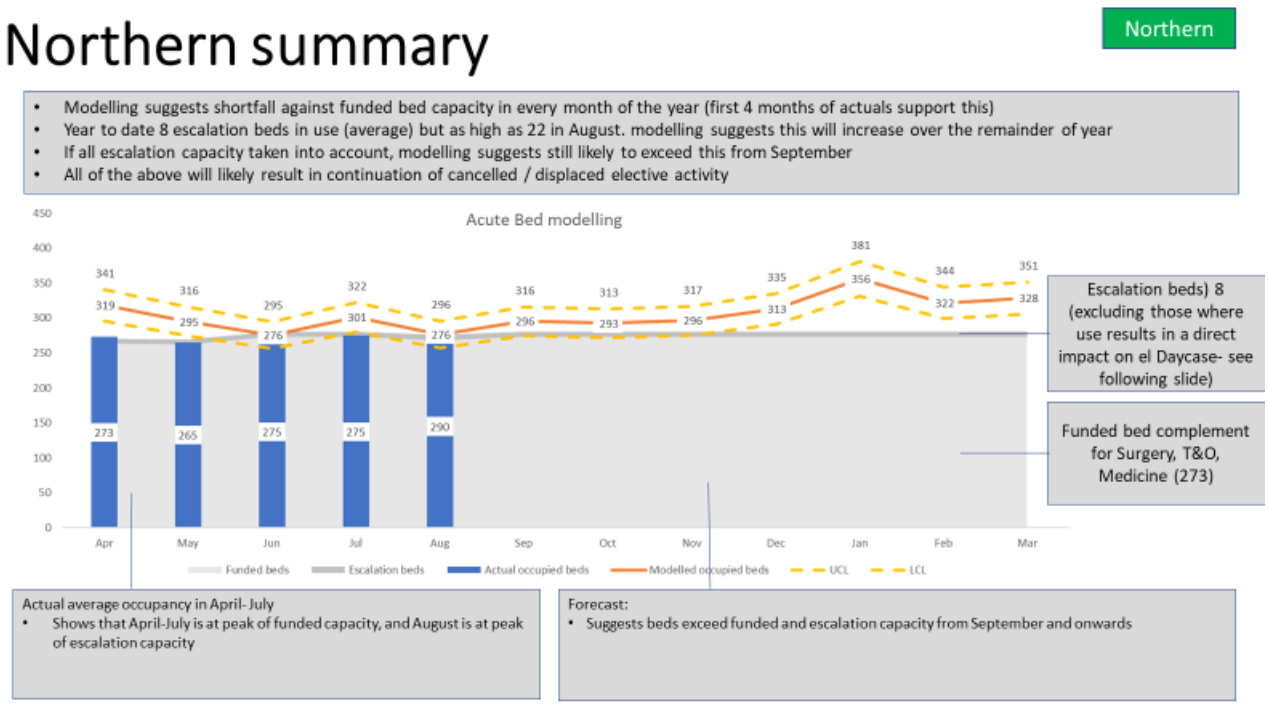
7.2 Bed Modelling

The NHS Devon system impact model provides an overall predicted bed demand for each acute hospital:



The Trust modelling work shows the following:





This modelling shows a significant shortfall of funded inpatient beds before any mitigating actions are taken:

- Eastern Services – up to 150
- Northern Services – up to 92

8.0 FUNDING

8.1 NHSE funding for Devon

NHS England have provided £23.9m non-recurring revenue to the NHS Devon Integrated Care System to address demand and capacity gaps for this winter. The Trust has been successful in receiving a proportion of this funding

The funding provided to Royal Devon is summarised below:

Investment Priority	Eastern Services	Northern Services
Acute Escalation Beds + Flow	18 beds £1.798m	11 beds £1.355m
Discharge Capacity	40 beds £2.5m	24+ beds £1.5m
Total beds	58 (19%)	35+ (11%)
Total Cost and %	**£4.298m NNR £0.285k Cap (19.5%)**	**£2.855mNNR (12%)**

8.2 Better Care Funding

The Better Care Fund winter pressures grant is part of the improved Better Care Fund and is a social care grant designed to:

- Reduce delays from hospitals
- Reduce extended lengths of stay in hospital settings
- Improve weekend hospital discharge arrangements so that patients are assessed and discharged earlier
- Speed up the process of assessing and agreeing what social care is needed for patients in hospitals
- Managing demand for community health and social care

The DHSC published guidance on 31st March 2022 on how NHS and local authorities can work together to plan and implement hospital discharge, recovery and reablement in the community. It states that NHS bodies and local authorities should agree the discharge models that best meet local needs that are affordable within existing budgets available to NHS commissioners and local authorities.

The funding allocated to support patient flow is shown below:

Funding source	Eastern Services	Northern Services
BCF (Eastern only), iBCF and iBCF Winter	£2,905,857	£883,658

8.3 Eastern Services winter funding

Planning for the 2022/23 Winter Plan began in July this year. Divisional teams within Eastern Services were asked to submit bids for schemes which would add significant value to capacity management and would help improve current services throughout the winter period. Eastern Services had a value of £434,000 allocated to spend on internal winter schemes this year, and as was expected, a higher number of bids were submitted than there was funding available for. The schemes were presented to the Discharge and Flow Working Group for understanding of the requests before submitting to the Eastern Site Triumvirate to complete a shortlisting process.

Funding was allocated to those schemes which were expected to add the most value this winter. As with every year, all schemes will be monitored throughout their timeline, and progress reports will be generated each month through the Operations Support Unit to track spend and progress and address key challenges. These will be monitored through the monthly Eastern Services Urgent Care Steering Group. An assessment of all schemes will be undertaken in April 2023 to evaluate processes and ensure learning is taken forward and addressed in advance of the 2023/24 winter planning process.

9.0 WINTER SCHEMES

9.1 Planned schemes

The plan for 2022/23 is set out in the below table which aims to summarise the key elements to the strategies in place to support the Trust through the winter period.

The key elements of the plan are:

- Strengthen our services to ensure we continue to safely care for patients
- Protect the health and wellbeing of our staff throughout COVID-19
- Work with our partners to support people where they live

Site	Intervention	Description
STRENGTHENING OUR SERVICES		
Trust wide	Reset week 	• Reduce number of inpatients by 130 • Increase the number of patients who get home for lunch to 33% • Reduce delays in admitting patients to a bed from the Emergency Department (250 hours reduction) • Reduce the number of long staying patients by 20 • Focus effort on reducing delays for every part of the inpatient journey • Run weekend as if it is a weekday
Trust wide	Additional bed capacity	• 18 beds for Eastern services • 11 beds for Northern services • A quality and equality impact assessment is being carried out to determine if and where these beds could be safely staffed and provided
Trust wide	Recruitment of nurses, doctors, consultants, therapists and administrative staff	• Additional clinical and non-clinical resource available to support the higher acuity of outlying patients.
Trust wide	Home for Lunch	• Encourage discharges to enable patients' home for lunch
Trust wide	Criteria Led Discharge	• Tackle delays in discharge, support patient experience and improve the discharge pathway
Trust wide	Additional DISCO cover	• Additional Discharge Coordinators to facilitate discharge
Eastern Services	Enhanced Therapy support	• Additional Therapist presence to support escalation areas
Eastern Services	COVID and Flu testing for patients	• Ensure rapid testing facilities for inpatients to reduce risk of transmission and ensure prompt treatment

Site	Intervention	Description
Eastern Services	Expansion of SPOA team	• Additional Single Point of Access clinicians to support assessments and help reduce length of stay for patients waiting for onward care on the Green to Go list (No Criteria to Reside Pathways 1-3) • Registered Social Worker presence to support escalation areas
Eastern Services	Weekend Echo cover	• Provide Echo sessions on weekends to reduce waiting times for inpatients
Eastern Services	Clinical Secretaries	• Admin support to clinical teams in areas where there is a shortage of Junior doctors
Eastern Services	Weekend Ward Clerks	• Provide cross template cover on weekends to support the clinical teams on wards
Eastern Services	HfOP senior cover	• Additional senior grade Doctor to provide a consistent senior presence for out-lying wards
Eastern Services	Discharge Lounge weekend opening	• Extension of the Discharge Lounge opening hours to include weekends 09:00-15:00 in order to support discharges and improve flow
Eastern Services	Acute Ambulatory Service	• The Acute Ambulatory Service will move from Wynard Ward to dedicated space in Cherrybrook from the beginning of November, providing a vastly improved patient experience
Eastern Services	Pharmacy support to AMU	• Additional technician to support medicines reconciliations and discharges for Acute Medical Unit
Northern Services	Transfer team	• To support Clinical Site Management with patient transfers from ED, MAU and the Wards.
Northern Services	Liaison Officer	• To ensure wards have direct contact to SPOA to support timely discharge and flow.
Northern Services	Doctors Assistants	• To support all Medical wards with tasks to ensure swift patient flow.
Northern Services	Clinical admin	• To support Clinical Site Management with administrative duties so that the Clinical staff are able to concentrate on patient flow.
Northern Services	Pathfinder multi-professional discharge	• To support increased pressures over winter
Northern Services	GP Streaming Monday	• Sunday 14:00-22:00 staffed by Trust employed GPs
Northern Services	Internal Professional Standards (IPS)	• Provide a high-quality emergency care pathway • Support clear escalation process with specific triggers

Site	Intervention	Description
SUPPORTING OUR STAFF		
Trust wide	Recruitment of additional frontline staff	• Enhanced efforts to recruit additional staff to frontline roles to support teams and maintain our high standard of patient care
Trust wide	COVID-19 vaccinations and Flu vaccinations for all staff	• Offering COVID-19 vaccinations and Flu vaccinations to ensure the highest level of protection for all our staff
Trust wide	COVID-19 protection	• PPE for all staff • Continued FIT testing for all clinical staff • Regular review of visiting guidance in line with the Trust COVID-19 alert status • Enhanced Infection Prevention and Control measures to ensure maximum staff and patient safety
Trust wide	Remote working	• Additional support for colleagues working remotely • Divisions to procure essential equipment to ensure staff can continue to work effectively
Trust wide	Staff wellbeing initiatives	• Enhanced face to face visits from Health & Wellbeing team to 'check-in' with staff promote services and offer support and guidance. • Chaplaincy walkarounds daily focusing on high-pressured areas. • Winter-focused wellbeing communications. • Launch of health and wellbeing conversations (October 2022) – upskilling managers to be regularly checking in on the wellbeing of their staff and noticing signs early. • Focus on financial wellbeing support and money saving tips (linked to energy tariff increase on 1st October, 2022). • Enhanced Mental Health First Aid training provision • Enhanced Trauma response (TRIM) • Managers discretion with allowing sufficient time for breaks e.g. allowing time to walk to canteen to get hot food/drinks • Consideration of Staff Rest Spaces with poor weather and limited space in staff rooms due to social distancing • Ensuring quality rostering and adequate rest days • Ensuring sufficient breaks and comms to reinforce the importance of this • Ensuring meetings do not regularly happen over lunch periods to allow managers/senior managers and admin workers sufficient breaks at times of high pressure

Site	Intervention	Description
WORKING WITH OUR PARTNERS TO SUPPORT PEOPLE WHERE THEY LIVE		
Trust wide	Help People Home Without Delay programme	• To support people to return home from hospital with no delay, freeing up acute bedded capacity to respond to urgent care, elective and cancer demands.
Trust wide	Winter Communication campaign for the public	• Extensive comms campaign developed in partnership with other Acute Trusts, Devon County Council, GPs and the CCG to help inform, support the public over the winter months
Eastern Services	Enhanced Discharge Capacity	• Increase UCR capacity • Increase current capacity for Live in Carers • Provide additional UCR staff to pull patients from the ambulance stack (outstanding calls) for lower acuity patients (category 3 and 4) to avoid transfer to ED • 1:1 agency support for placements (TPRC) • 10 additional Pathway 2 Reablement beds
Eastern Services	Supporting Frequent Attenders	• A pilot to improve outcomes for people who are frequent attenders to acute services to identify more effective means of meeting their needs and reducing demand upon health and social care services
Northern Services	Enhanced Discharge Capacity	• 14 additional Pathway 2 Reablement beds • Increased workforce capacity for clinical review and coordination (equivalent to 10 beds)

9.2 Expected impact of the schemes

The Trust has worked very hard to identify actions that can be taken to mitigate risk and secure additional funding. The ability to deliver a fully mitigated position is limited by funding, ability to recruit staff and physical space.

The impact of the schemes identified above, along with the need to protect some escalation beds for elective activity has been modelled and is shown in the two tables below. As can be noted, there will be months when there is insufficient bed capacity which will impact on elective activity and pressure in the Emergency Department, and the holding of ambulances outside ED. This will also affect the delivery of key performance targets.

Impact of interventions

Eastern

- Suggests the impact of proposed interventions should materially improve position if they deliver the beds / bed equivalents projected
- In months of high pressure, would likely manifest in elective cancellations and impact on ED / holding of ambulances etc.

Bed surplus / (deficit) position (Eastern)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Bed surplus / (deficit) excluding any interventions or escalation capacity	(42)	(43)	(8)	(26)	(39)	(82)	(36)	(76)	(83)	(149)	(206)	(128)
Impact of winter scheme interventions						1	46	76	87	109	109	122
Use of escalation bed capacity that has limited effect on elective care and urgent care flow	18	18	18	18	18	18	18	18	18	18	18	18
Bed surplus / (deficit) including impact of winter schemes and escalation capacity	(24)	(25)	10	(8)	(21)	(63)	28	18	22	(22)	(78)	12
Sufficient capacity to deliver plan?	No	No	Yes	No	No	No	Yes	Yes	Yes	No	No	Yes

Impact of interventions

Northern

- Suggests the impact of proposed interventions should materially improve position – escalation beds would still be required in all months
- Model projects that there would be insufficient bed capacity for all months from August, which would manifest in significant elective cancellations, and pre-admission in emergency department (e.g. long stays in ED, 12 hour trolley waits etc.)

Bed surplus / (deficit) position (Eastern)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Bed surplus / (deficit) excluding any interventions or escalation capacity	(10)	(3)	(2)	(2)	(22)	(43)	(40)	(44)	(62)	(108)	(71)	(78)
Impact of winter scheme interventions					-	-	20	42	45	65	65	64
Use of escalation bed capacity that has limited effect on elective care and urgent care flow	8	8	8	8	8	8	8	8	8	8	8	8
Bed surplus / (deficit) including impact of winter schemes and escalation capacity	(2)	5	6	6	(14)	(35)	(12)	5	(9)	(35)	2	(7)
Sufficient capacity to deliver plan?	No	Yes	Yes	Yes	No	No	No	Yes	No	No	Yes	No

At the points of highest pressure for the respective sites, the combined impact of our interventions provide between c50 – 120 bed equivalents for Eastern Services and between c20 and 60 beds for Northern Services.

In the months where bed deficits against the bed model remain in place, the Trust will continue to drive efficiencies (as per the Reset Programme); prepare in extremis plans for additional acute beds; and prepare plans for in extremis elective cancellations – all in order to keep our patients safe.

10.0 RESPONSE TO OPERATIONAL CHALLENGES

10.1 Management of COVID-19 demand

10.1.1 Inpatient and Critical Care beds escalation plan

As noted above a surge of COVID-19 patients is expected between October and March. During the first wave of COVID-19, which peaked in April 2020, the increase in COVID-19 was more than offset by reductions in demand for non-COVID-19 patients, which led to a low level of hospital bed occupancy. In subsequent waves there has not the same reduction in non-COVID-19 work.

Eastern and Northern services have escalation plans for managing COVID-19 inpatients across the acute and community bed base. This is managed dynamically through Gold Command and tailored according to operational circumstances. In all cases, the decision to escalate into the next phase of the plan will be taken by the Incident Gold Commander in conjunction with the Medical and Nursing Directors, as well as the Directors of Infection Prevention and Control.

The Staffing Hubs are responsible for ensuring appropriate trained staff are available to work in any COVID-19 escalation areas.

There are several areas that have clear escalation plans should a COVID-19 surge occur. Specific escalation plans have been agreed for each of these areas and will be triggered and overseen by the silver hubs within the incident management structure. The exceptions to this are the inpatient beds and critical care plans, which Gold Command will oversee.

Within Eastern services these are as follows:

- Emergency Department
- Admission Units
- Respiratory HDU
- Critical care
- Specialist areas that would need to take patients with COVID-19, including Paediatrics, Stroke, Renal and Cardiology

Within Northern services these are as follows:

- Emergency Department
- Inpatient Beds
- Critical Care
- Specialist areas that would need to take patients with COVID-19 such as Stroke and Cardiology.

10.1.2 Partnership working to manage COVID-19 patients across Devon

Trusts across the South, East and Northern Devon (SEND) Network work together to help manage surges in demand across the three hospitals. This has been formalised in the Transfer and management of COVID-19 patients across SEND pathway document, which has been ratified through the governance routes in the two Trusts.

10.1.3 Trust-wide strategic management of COVID-19

An incident management framework is in place using the Joint Emergency Services Interoperability Principles (JESIP). This involves a Strategic, Tactical and Operational command structure supported by a number of advisory cells such the Clinical Effectiveness Committee, Infection Prevention and Control Team and COVID-19 Testing Steering Group. The details of the Trust-wide response to COVID-19, are collated into an Incident Response Framework, which is available alongside this document on the Trust intranet pages.

10.1.4 COVID-19 vaccination

The Trust remains heavily engaged in delivering an ongoing offer to staff for first, second and booster vaccinations. A 5th phase of Autumn Booster Programme for cohorts 1-9 will begin week commencing 5th September 2022, which includes Health and Social Care staff.

Within Eastern services the programme will be offered at the Greendale Vaccination Centre, a staff hub on the Exeter site at the Lamp Test building as well as a roving Community Hospital plan. Within Northern services the programme will be available on the Barnstaple site and within the community sites, South Molton, Bideford, Ilfracombe and Holsworthy.

10.1.5 COVID-19 testing

COVID-19 testing for patients and staff continues. As national and local guidance changes in response to community prevalence, impact of current strain, vaccination rates and treatment options for COVID positive patients, the COVID testing guidance will be updated, and should be referred to for the most up to date position. The Joint Clinical Effectiveness Committee oversees this process.

10.2 Elective and Cancer care

The Trust has increasing backlogs of patients waiting for treatment, in part due to the reduction in surgical bed capacity due to non-elective admissions. The Trust has set up a Planned Care Steering Group to oversee the work to increase capacity. Patients are reviewed and priority status reassessed as necessary whilst they are waiting so that treatment can be expedited if necessary.

Funding has been received through the Elective Recovery Fund, Accelerator Programme and Community Diagnostic Hub programme to increase elective diagnostic and treatment capacity.

A Joint Cancer Cabinet for the Trust has been set up, chaired by the Chief Medical Officer, and a detailed action plan is in place.

After being decommissioned as a COVID-19 hospital in March 2021, the Nightingale Hospital Exeter (NHE) was purchased by the former RD&E on behalf of NHS organisations across Devon and the South West region. Following a clinically led redesign programme, the Nightingale has been redeveloped into an ICS facility and now accommodates the following services; Southwest Ambulatory Orthopaedic Centre (SWAOC), Centre of Excellence for Eyes (CEE), Devon Diagnostic Centre (DDC), Rheumatology Centre, and Nurse OSCE training facilities.

Where possible elective beds will be ring-fenced to support elective recovery and oncology and haematology beds ring-fenced for critical treatments.

10.3 Seasonal Flu Plan

The Trust's Seasonal Influenza Management Policy is reviewed every 5 years against national guidance and to incorporate any learning from the previous year's flu season. The plan is activated when Public Health England's national surveillance scheme indicates that influenza virus A or B is circulating and there is a substantial likelihood that people presenting with an influenza-like illness are infected with influenza virus, or once flu is circulating in the community or initial cases are identified in hospital. The plan is next due for review in 2024.

10.4 Influenza Pandemic Plan

Whilst influenza pandemics have been relatively infrequent, a new pandemic could emerge at any time. The Trust's response to an influenza pandemic will be based on this Framework and the Trust's Seasonal Influenza Management Policy and Influenza Pandemic Contingency Plan. Reference should also be made to the RD&E Business Continuity Strategic Response and Recovery Plan and individual Service Continuity Plans. The plan is next due for review in 2022.

10.5 Domestic Services Specialist Cleaning

The Domestic Services team are providing an enhanced cleaning service in response to the COVID-19 pandemic. Additional staff have been recruited in order to support this increase in demand, undertaking both social cleans and deep cleans where necessary. A member of the Domestic Services Operational Team attends the daily bed meetings and at Gold Command meetings in order to ensure that patient moves and changes to ward usage are appropriately supported.

10.6 Non-Emergency Patient Transport Services

At times of escalation, information should be provided to First Care Ambulance and Devon County Council Patient Transport Advice Service about any likely increase in demand on Patient Transport Services (e.g. potential for increased discharges).

10.7 Emergency Preparedness and Business Continuity

The Trust's Emergency Preparedness Plan sets out the arrangements for responding to any major incident. The Trust has a Strategic Business Continuity and Recovery Plan. The plan is made available on the Trust's intranet sites.

10.8 Adverse Weather Conditions

The Trust receives warnings of severe weather from the Met Office. The Trust also receives additional information from a Met Office Adviser via the Local Resilience Forum if forecast weather has the potential to cause disruption. The Trust has plans for severe winter weather and heat waves which can be found on the Emergency Preparedness page of the trust intranet. The plans are reviewed each year against national guidance which corresponds to Met Office Cold Weather Alert and Heat Health Watch periods. Please refer to Eastern Services Adverse Weather and Unforeseen Incident Policy[2]and Northern Services Adverse Weather Policy[3].

[2] Adverse Weather and Unforeseen Incident Policy – Eastern Services

[3] Adverse Weather Policy – Northern Services

11.0 SUPPORTING STAFF HEALTH AND WELLBEING

11.1 Staffing levels

A key impact on staff well-being is the level of safe staffing levels and this is an area that is of high focus as one of the two Trust priorities. The overall position on staffing for established nursing posts has improved slightly to a current vacancy rate of 85 Registered Nurses (RN) (previously 112) and 131 (previously 138) for HealthCare Support Workers (HCSW). It is also worth noting that the Trust is continuing to operate during times of lowest recorded unemployment levels and highest recorded vacancy levels at a national level across all industries.

Staff sickness has continued to be problematic reaching a peak of 6.99% in the last three months. Over the same period sickness of HCSWs peaked at 10.21% for one month and RNs 7.04%. When the Trust is in an escalated position for any length of time it impacts on staff with frequent area moves to try and maintain overall safe staffing numbers. Staff moves impact on staff morale and therefore absence figures.

The 12-month sickness rate for Eastern Services is 6.04% with 9.11% for HCSW and 6.20% for RNs. The 12-month sickness rate for Northern Services is 5.60% with 7.91% for HCSW and 6.25% for RNs. Overall, the Trust 12-month sickness rate is 5.91% for all staff groups.

The high level of escalation beds open contributes to staffing issues as there are not funded and recruited to posts in nursing, medical staff, therapists and pharmacists for these beds. A higher level of acuity of patients and changes to the ward base for some specialties has also led to an increased establishment requirement. This has been compounded by changes in junior doctor contract which has reduced the hours they are able to work on the wards. Along with all other organisations, there is a risk that clinical areas run on staffing levels which have been amended with professional judgement balanced with the overall Trust position and not been at the level that would normally be planned.

The Trust has a number of controls in place to ensure that overall safe staffing levels are maintained. This includes daily staffing meetings led by our Assistant Directors of Nursing, formalised weekly Staffing HUB meetings to review current position and week ahead and agree actions to be taken; use of bank and agency, offering enhanced pay to mission critical shifts and use of AOA (Allocation on Arrival), staff working additional paid hours. The Trust has also successfully used non-clinical staff to support on the wards with basic tasks such as running errands to Pharmacy, assisting patients with completion of meal cards and basic cleaning around the patient's bed area.

In addition, with recruitment being a core focus by the Trust a number of workstreams have been set up to run as short-term task and finish focused groups to improve recruitment flow and capacity– these are: Branding & Attraction; Recruitment Process; Demand, Supply & Prioritisation; Onboarding & Induction; Welcome & First Six-Months; Accommodation; Retention; Medical Recruitment.

11.2 Flu Vaccination Plan

Seasonal flu is a highly infectious respiratory illness caused by a variety of different flu viruses. All frontline healthcare workers are offered a flu vaccination, to protect staff and their families and to prevent the transmission of flu to patients and visitors who may be very vulnerable to flu. The vaccination programme is managed by the Flu Immunisation Planning Team which includes the Seasonal Vaccination Lead, Occupational Health and Pharmacy. An extensive flu peer vaccination programme will be established in all wards, clinical departments e.g. ITU, Emergency Department,

Operating Theatres and in the community including inpatient services and community nursing and therapy services. The aim of the peer vaccination programme is to increase uptake of flu vaccine by frontline staff through local promotion of the benefits and making vaccination easily accessible in the clinical area thus negating the need for frontline staff to attend vaccination clinics provided by the Occupational Health Service. Vaccination can potentially be offered 24 hours a day, seven days a week using the peer vaccination programme which increases accessibility to staff who work shift patterns. The flu vaccine will also be offered to staff attending the Lamp Test building at Wonford for COVID-19 booster vaccinations.

11.3 Remote working

In order to support social distancing and work-life balance, the Trust continues to support remote working. Staff are able to work flexibly, in agreement with their manager, with many staff working a hybrid model of some days on site and some at home each week. Appropriate IT equipment has been made available and a set of Home Working principles developed and communicated. A more formal policy is being developed with Staff Side to ensure that there is clarity on how this approach can continue into the future.

12.0 COMMUNICATION OF THE PLAN

A detailed communications plan, which will evolve over the winter period in line with operational need, outlines a multifaceted approach that informs and engages several key stakeholders to support the delivery of the winter plan. This includes:

- A series of internal communications and engagement activities to support staff health and wellbeing and build confidence in the, such as a winter plan illustration, regular intranet updates, screensavers, all-staff emails, all-staff webinars, Heads of Department meetings and senior leadership sessions.
- Working with ICS Devon partners to implement an external-facing, targeted communications campaign which aims to shape public behaviour and promote healthier life choices.
- Working with system partners, and in particular primary care, to help ease pressures across the Royal Devon.
- Aligning to several pre-existing campaigns and programmes already underway, including the staff morale and wellbeing interventions programmes.

A copy of the winter 2022/23 communication strategy has been provided in Appendix 1.

The key elements comprising the 2022/23 winter plan have been outlined under section 9.0. A graphic, which is included below illustrates many of these key elements.
https://prezi.com/view/lfIAijY6y5b0JyMdG2ti/

APPENDIX 1: WINTER 2022/23 COMMUNICATION PLAN

INTRODUCTION

Winter is always a challenging time for the health and social care system. Maintaining 'patient flow' through our services is the single most important factor in determining whether the Trust is able to deliver quality healthcare.

The NHS remains under sustained and significant pressure as we approach another challenging winter period. The Royal Devon typically operates at maximum capacity in the run-up to and during the winter months, with increased bed occupancy levels and attendances to our emergency department.

This, alongside the possibility of further COVID-19 waves and a difficult flu season, will likely impact several areas, including staff health and wellbeing, urgent and emergency care capacity and patient flow.

The winter plan outlines how the Trust will work to prepare and manage an increase in service demand over the winter period, with recent bed modelling suggesting that non-elective demand will continue to exceed the Trusts capacity for the foreseeable future.

This communications plan, which will evolve over the winter period in line with operational need, outlines a multi-channel approach that informs and engages several key stakeholders to support the delivery of the winter plan.

While communications and engagement cannot directly solve operational issues, we will use our communications expertise to support operational plans over the winter months. Where operationally feasible, the plan will align across Eastern and Northern services, to reduce

duplication and streamline approach.

BACKGROUND

Capacity planning

The Royal Devon, through the winter plan, describes the approach for maintaining patient flow, delivering services that promote people's independence, by preventing admissions wherever possible, only keeping people in hospital for as long as they need to be, and ensuring patients are discharged in a timely way.

Our capacity planning and bed modelling work outlines how to manage pressures this winter and how to use our resources in the most effective way, so we can deliver the best possible patient care.

Help Us Help You is a national NHS campaign that has been designed to reach the most vulnerable groups in our society providing them with clear, practical guidance on what they can do to stay as healthy as possible.

This campaign alongside our approach detailed in the winter plan, will, if communicated through the right channels and in the right way, help to ease seasonal pressures.

We want to ensure:

- People are looked after in the right environment for their needs
- Patients remain safe and our capacity is safeguarded as we face a winter with COVID-19 and potential high flu levels
- Our workforce is strengthened and there is clear guidance for staff to follow in times of escalation, providing reassurance and helping to support their wellbeing
- We reduce delays to people's care.
- We reduce the need to postpone non-urgent elective surgery.

Achieving this improves our patients' experience of our services and will deliver better outcomes.

We need the public and system partners to support us to achieve our vision by helping us to make the demand on our services manageable through using them appropriately.

Help Us Help You / Think 111 First

If services are used appropriately, the demand on the emergency department, bed occupancy and overall capacity will be more manageable.

HUHY is a nationally led campaign which encourages the public to stay as healthy as possible and to use the most suitable services, aiming to relieve seasonal pressures on NHS services. It is designed to ensure that people who are most at-risk of preventable emergency admissions are motivated to take actions to keep them well and/or out of hospital unnecessarily this winter.

These programmes have established communications plans and/or approaches in place. This plan does not work to replace these – rather, given the overlap between some of the programmes. It serves to establish how the Trust will align and operationalise the messaging at the local level in a way that also supports the delivery of the winter plan and wider operational objectives.

More detail about the One Devon have external-facing winter communications campaign, which begins in October 2022, can be found in part 4 below.

OBJECTIVES

The winter plan objectives fall under the Trust's first strategic goal, "the sound delivery of existing services". The objectives have been adapted in response to the COVID-19 pandemic and are as follows:

1. Support staff health and wellbeing and build confidence in operational plans.
2. Ensure that the Trust has sufficient urgent and emergency care capacity to care for patients, including those with COVID-19.
3. Optimise cancer and elective care to reduce waiting times for our patients.
4. Work collaboratively across the Devon system to prevent inappropriate attendance and admission, and support timely discharge.
5. Deliver operational resilience in the most cost-effective way possible.

Winter plan objective	**Communication and engagement objectives**
Support staff health and wellbeing and build confidence in operational plans	• Continue to support the development, implementation and/or marketing of the interventions set out in the staff morale and wellbeing paper (led by Hannah Foster). • Support the wellbeing, inclusion and employee experience teams to promote the services and support available to staff. • Develop a feedback loop for staff to flag what's working well and any new ideas for supporting wellness over the winter months. • Provide regular and timely updates on the winter plan to ensure staff understand the plan, the part they play in it and feel motivated to support it.
Ensure that the Trust has sufficient urgent and emergency care capacity to care for patients, including those with COVID-19	• Provide regular, timely and accurate operational updates (ie OPEL level, surge planning, hospital reconfiguration, COVID-19). • Roll out updated discharge campaign linked to national 'HomeFirst' campaign across Trust and use 'Home for Lunch' messaging to communicate the importance of a safe, timely discharge to patients and their family/carers, and the actions they can take to facilitate this.

	• Promote the discharge lounge(s) to staff through regular updates about their use and success, and case studies. • Carefully worded updates to primary care. • Promote messages about staying home if an infectious disease (flu, COVID-19, norovirus etc.) is suspected, and to call 111/999 if urgent care is needed. • Promote flu vaccines/COVID-19 vaccine for staff.
Optimise cancer and elective care to reduce waiting times for our patients.	• Continue to provide information to patients on waiting lists and updates to staff (part of the 'Waiting Well' programme). • Continue to support the Outpatient Transformation and Recovery Programme (separate communications and engagement plan developed). • Continue to support the System Asset Programme at the NHS Nightingale Hospital Exeter (separate communications and engagement strategy developed).
Work collaboratively across the Devon system to prevent inappropriate attendance and admission and support discharge	• Support and promote the winter communications campaign for Devon, developed by Devon ICS members to help prevent inappropriate attendance and admission through: o encouraging the public to get their flu and COVID-19 vaccinations o supporting people to make informed decisions to manage their health and get prepared for winter o giving people the information they need to access the right care in an urgent or emergency situation. • Align discharge messaging across system partners
Deliver operational resilience in the most cost-effective way possible	• Share learning and innovation across staff groups and services • Support promotion of integrated working across Eastern and Northern services to avoid duplication and improve efficiency.

Audiences/stakeholders

For the purposes of the communications plan, broadly speaking the key audiences can be segmented as follows:

- Staff
- Patients/visitors/general public
- System partners and wider stakeholder audience

The key messages and campaign actions have been developed around these segments to allow us to manage the campaign effectively, but it is recognised that there are further sub-segments.

Messages and actions will be tailored to the specific audience/stakeholder, ensuring there is a clear and appropriate call to action.

Audience/stakeholder	Influence	Importance to campaign objectives	Communications aims
Royal Devon staff	High, direct	High	Understand our plan for winter and what they can do to help Understand the impact of the decisions they make Support the culture of promoting independence Support staff health and wellbeing
GPs	High, direct	High	Understand our plan and what they can do to help
Domiciliary care partner agencies and care homes	High, direct	High	Understand our plan, awareness of OPEL, and what they can do to help Understand how to help us prevent admissions and facilitate timely discharges
Devon NHS	High, indirect	High	Understand our plan and support our conversations with referrers Understand how they can help us promote our key messages with the public
Other providers within the system	Medium, indirect	Medium	Understand our plan and work with us to develop opportunities to share communications resources and key messages
National bodies NHSE/NHSI	High, indirect	Medium	Understand our plan and gain assurance of care system management
Voluntary sector	Medium, indirect	Medium	Understand our drive to promoting independence and the detrimental impact of a hospital stay can have on someone's independence Understand our approach and how they can help

Audience/stakeholder	Influence	Importance to campaign objectives	Communications aims
Inpatients, carers and families	Direct, high influence	High	Understand what they can expect from us and what we ask of from them Understand that a shorter stay in hospital is better for the patient Understand the impact of their decisions relating to discharge and support us to maintain patient flow Understand any ongoing COVID-19 guidance and restrictions and the need for change if this occurs
General public	Medium, inactive observers, becoming high and active when the need for healthcare arises	High	Understand the pressure the system is under Understand what the emergency department is for and the alternatives Understand the resources available to support them (111, HandiApp, NHSquicker) Understand any ongoing COVID-19 guidance and restrictions and the need for change if this occurs Encourage uptake of booster vaccine and flu vaccine (detailed in winter vaccination plan)
Councillors/MPs	Medium, indirect, inactive observers	Medium	Feel informed and reassured that we have a plan for winter
Save Our Hospital Services and other pressure groups	Medium, active observers	Medium	Understand what they can do to support us in getting our messages out to the public Understand which messages are unhelpful
Media	High, indirect,	High	Understand how they can help us promote messages

Audience/stakeholder	Influence	Importance to campaign objectives	Communications aims
	active observers		Understand how their behaviour can be unhelpful and why

Key messages

- We all have a role to play in supporting local NHS services to keep moving during winter, so the NHS can deliver the best possible care.
- Self-care can help minimise time in hospital – get your flu jab and COVID-19 booster if you're eligible – other healthy living messages
- The emergency department is for urgent, life-threatening conditions, and there are alternatives for less serious conditions – reduced waiting times, greater convenience of other options.
- Think 111 First – get advice on the best healthcare option from 111. If referred to ED those who use 111 as a triage service will be seen before walk ins.
- Patients should be in hospital only if necessary and only for a short-time, because being in hospital for longer than necessary can do more harm than good.

Sub-messages – staff

- Your health and wellbeing is our priority, please access the support and resources available
- We have a robust plan and we have implemented a number of changes this year to support us to manage winter pressures alongside the continued challenge of COVID-19. Whatever your role, it is essential that you understand the plan and how you can contribute.
- To strengthen our services as best we can, we're increasing staff levels across several areas – check out our winter plan for more information.
- We're doing all we can to support you, your teams and your services over the next few months – take a look at our winter plan to find out more.
- It's vital that everyone follows COVID-19 guidance on testing, isolation, masks and social distancing that are in place linked to the Trust alert level.
- Maintaining patient flow is everybody's business.
- Delays at the emergency department for ambulance crews impact on the availability of ambulances to deal with life threatening emergencies.
- Think Home First when it comes to discharges and work to get patients 'Home for lunch'
- Please be prepared to start conversations about discharge early on with patients and their families, and think about how to address any potential delays caused by patients and their families.

- We want to embed a culture across the Trust in which we promote independence in everything we do.

- We know that this winter will be challenging - there is a range of free resources and advice available to help support you and your wellbeing.

- Thank you for everything you are doing to help us deliver excellent patient care at this time.

- Please get the flu vaccine and COVID-19 booster to protect yourself, your patients and your colleagues.

Line managers and HoDs

- Help us to make sure your team know about the winter plan and the role we all play in maintaining patient flow across the Trust.

- Support your teams to make the right decisions when it comes to discharging patients efficiently

- Please continue to check in with your teams and support their wellbeing, signposting to available resources**.**

Sub-messages - patients/visitors/general public

- Our services will be extremely busy over the winter period. You can help us by 'Thinking 111 First' and only attending the emergency department if you have an urgent or life-threatening illness or injury and by using the alternatives for less urgent needs.

- HUHY national messaging

- We will do everything we can to help you/your loved one maintain their independence.

- Staying in a hospital bed for longer than is necessary can cause more harm than good. Think Home First when you come into hospital.

- Help us get you or someone you care for home by lunch

- Please help us by staying well this winter - if you are eligible for a free flu or COVID-19 booster vaccine, it is because you need it, so please get it to protect yourself.

- If you are unwell and displaying symptoms of COVID-19, flu, a stomach virus or cold like symptoms please don't visit the hospital.

Sub-messages - system partners and wider stakeholders

- We have a robust plan to help us manage winter pressures, but we will need your support.

- Please consider what you can do in your role/organisation to help us provide the best possible care for people this winter, whether that's through supporting us to prevent admissions or helping us to discharge our patients in a timely way.

- Please help us by continuing to only refer patients to our emergency department when necessary.

- If you need support with a patient please call the relevant team at Royal Devon for advice if you can.

- Please consider how you can support us to encourage people to use our services appropriately.

APPROACH

Part 1: Support staff health and wellbeing and build confidence in operational plans

The activities in this part aim to reassure staff that we have a plan, to encourage buy-in to the plan and to set realistic expectations. How the winter plan is framed will be key to it landing well with staff, and so an empathetic, caring and 'all-in-this-together' tone should be adopted across all communications, with messaging focusing on how the plan will help staff, rather than how they can help to implement the plan.

This feeds into sustaining the health and wellbeing of staff, which is a key priority for the Royal Devon leadership team.

The key communications actions we will take during this phase are outlined below.

- Develop communications for staff outlining what we are planning and when changes may happen:
    - Topics – bed escalation / 111 First / COVID-19 (COVID safe, vaccination, guidance)
    - Slide-set/Prezi for use at key meetings outlining key elements of the plan and roles of staff.

- Work alongside staff health and wellbeing colleagues to develop the winter wellbeing campaign. This interactive campaign will focus on engaging staff in staying safe and well, and boosting morale as much as possible throughout the challenging winter period.

- Support other staff morale and wellbeing interventions as supported by JDG. A detailed intervention action plan has been developed outside the scope of this plan, so while not directly linked, the winter communications plan aligns too and enhances this ongoing work.

- Waiting well external communication – external message to support those on waiting lists

- Develop seasonal communications to public which support them to make the best choices when in need of care.

Part 2: Ensure that the Trust has sufficient urgent and emergency care capacity to care for patients, including those with COVID-19

We will use our communications expertise to support operational plans over the winter months and will focus on supporting staff understand how to direct their efforts to the most benefit to patient flow, what people can do to support us, and the appropriate use of the emergency department and alternatives.

The key actions are outlined below.

- Provide regular, timely and accurate operational updates alongside opportunities for staff to feedback
- Continue roll out of new discharge communications ‘Think Home First’ and early discharge campaign ‘Home for lunch’
- Promote use of discharge lounge(s) as key part of maximising flow
- Promote culture of supporting people to maintain independence.
- Support and promote outcomes from Northern services patient flow improvement project and joint green to go focussed work.
- Carefully worded updates to primary care - in addition to Outpatient Transformation and Recovery Programme (separate communications and engagement plan developed) around e-referrals for advice and guidance.
- Promote use of Think 111 First to support appropriate use of the emergency department.
- Continue to promote national HUHY messaging and system comms
- Promote importance of not attending hospital if showing symptoms of certain illnesses – COVID-19. Flu, Norovirus
- Internal comms to acknowledge staff and say thank you – encourage looking after each other.

Part 3: Optimise cancer and elective care to reduce waiting times for our patients.

The communications team is supporting several projects across the RD&E and Devon system which support this objective.

This includes Outpatient Transformation and Recovery Programme (separate communications and engagement plan developed), the System Asset Programme at the NHS Nightingale Hospital Exeter Programme (separate communications and engagement strategy developed), and providing information to patients on waiting lists.

This work will continue outside the scope of the winter communications plan, but all programmes will remain aligned in their key messages and approach.

Part 4: Work collaboratively across the Devon system to prevent inappropriate attendance and admission and support discharge

To support the operational system work that’s ongoing/in the pipeline, One Devon have developed an external-facing winter communications campaign which begins in October 2022. The plan focuses on:

1. **Think 111 First** – choose well and behaviour change campaign to encourage contacting 111 before attending ED, or visit 111 online

2. **Flu and COVID-19 booster vaccination** – increase uptake in all groups and added messaging on measure in place to keep people safe, limit exposure, etc.
3. **GP access** – promotion of enhanced access, different models of care
4. Digital offer – online and video consultations, NHS app, ORCHA health and wellbeing app library, HANDi paediatric app and links with RSV
5. **Mental health** - support available for people, especially as we approach Christmas and New Year, and launch of 24/7 crisis lines, as well as crisis cafes and IAPT services
6. **Pharmacy and self-care** – promoting the GP community pharmacy consultation service (CPCS) for minor illness, raising awareness of pharmacy services, and the new local self-care campaign "Treatment starts at home"
7. **Inequalities** – focus on seldom heard groups working with local communities and community champions to undertake engagement and insight work, ensuring services are inclusive, translated, and easy read documentation. Support to access services and information outside of digital platforms, particularly for people with learning and/or physical disabilities.
8. **Early discharge** – system-wide campaign to support early discharge from hospital and improve flow

We will support the operationalisation of the One Devon plan through our existing external communication channels, including our website, social media channels, patient screens, member updates, and embedding key messages in business-as-usual media work.

Part 5: Deliver operational resilience in the most cost-effective way possible

As a new objective for the winter plan the communications team will work with operational leads to understand how best to capture and share learning and innovation to support operational resilience.

Regular update promoting this learning and 'best practice' will be shared with staff and feedback mechanisms in place to capture additional innovation/thoughts.

Continue to support teams across the Trust to integrate to support efficiency and minimise duplication of work.

On-going/reactive

These are the communication activities which could be needed at any time and which will be deployed to respond quickly to operational pressures. We will:

- Establish dedicated communications capacity at all times in-hours to support teams to get messages out quickly and in the most effective way.

- Ensure communications team supports teams with preparation for anticipated out of hours communications needs.

- Ensure communications team proactively monitors local developments, as well as information and campaigns from NHS England and UK Heath Security Agency.

- Work with partners across the system to respond to reputational risks relating to performance and winter pressures in a timely, coordinated and credible way, which also recognises the efforts of staff.

Timeline of key actions – this will be developed and updated to meet operational need as we move through the winter period

Phase	Completed by	What	Audience	Outcome

MEASURES OF SUCCESS AND EVALUATION

- Feedback from staff at each phase of the campaign through surveys and informal feedback, to determine:
    - Whether staff understand our winter plan and feel motivated to support it
    - Whether staff are feeling positive about coming to work
    - Whether they feel our communications are responsive to operational need
- We will monitor page visits on Hub/BOB and our external Trust website
- Engagement levels through our staff Facebook groups regularly assessed
- Click through rates and areas of highest interest for staff.

Royal Devon University Healthcare
NHS Foundation Trust

Winter Plan

Board - John Palmer

26.10.22

Current overarching plan

- Essentially the extant plan for the next few months has been to focus in on generating flow and restoring a de-escalated bed base through the following activities:

  - Intensive Winter related Executive led activities focusing on our **recruitment pipeline** and **green to go** to improve **patient flow**;
  - Running our **reset programme** to **de-escalate our bed position** and to **ensure our ring fences** (orthopaedics, general surgery and cardiology) can be maintained;
  - Having run this process to then **embed the most successful interventions into phase 1 of the Winter Plan** (pre-Christmas maintenance of ring fences through improved processes) and then to ensure our **bed base interventions are ready post-Christmas** (11 in Northern, 18 in Eastern) when modelling shows they will be needed.

RDUH Winter Plan delivery

COVID 1

COVID 2

Potential System support to 7th November (ED works)

Patient Flow Reset (E)	Winter Plan Phase 1	Winter Plan Phase 2	Maintenance of ring fence
Reduce inpatients by 100 Run weekend as a weekday Specialty targets Reduce inpatient journey delays Increase 12pm discharges		Acute and community beds	Target Set and SOP: Orthopaedics, General Surgery, Cardiology
Patient Flow Reset (N)	Winter Plan Phase 1	Winter Plan Phase 2	Maintenance of ring fence
Maximise utilisation of SDEC Discharge Lounge Specialty targets EPIC enabled utilisation of SDEC Criteria Led Discharge		Acute and community beds	Target Set and SOP: Orthopaedics, General Surgery, Cardiology
Maintenance of Ringfences	Phase 1 – £3m package for ortho/gen surg/cardiology	Phase 2 – £3m package for ortho/gen surg/cardiology	Maintenance of ring fence

ROYAL DEVON RECOVERY WEEK

7 DAYS TO BREAK THE CYCLE

5-11 OCTOBER

Calling everyone, including...

THERAPISTS, SCIENTISTS, PORTERS, WARD CLERKS, MANAGERS, SOCIAL WORKERS, MEDICS, NURSES, PHLEBOTOMISTS, SITE PRACTITIONERS, PHARMACISTS, TECHNICIANS, DISCHARGE CO-ORDINATORS, DRIVERS.

Too many patients are having to wait for the care they urgently need

And with Covid and winter pressures, the need can only increase.

Everyone can help

We're looking for you, the experts in your fields. If just 10% of staff are willing to work for two more hours this week, that's 2,000 extra hours of concentrated effort to break the cycle.

Time to banish the backlogs and bottlenecks

By getting more current patients safely home as quickly as possible.

Work 2 extra hours for Recovery Week - and earn more for your time

If you feel able to add two hours or more to your work, you'll be paid at enhanced rates. Just let your manager know as soon as possible if you can.

130

Fewer inpatients

By clearing escalation areas Northern– 18 beds: SDEC, Day Surgery and Ambulatory Assessment Area

Eastern - 51 beds: WYDC, Knapp, TAU, Capener, TAU, DCU, Ashburn therapy

More discharges, fewer admissions
Additional hot clinics, expert support from community teams

250

Fewer ED hours

- Better flow from ED to transfer
- Better flow through discharge

33%

Home before lunch

- Discharge Lounge
- Early identification
- Great communication
- Focus and teamwork

20

Fewer long stay patients

Focus on a pre-identified list of complex patients by a dedicated team

THANK YOU

NHS
Royal Devon University Healthcare
NHS Foundation Trust

Reset results

- The **results from the patient flow reset** which has initiated the Winter Plan have been significant for both sites and have achieved the initial de-escalation sought. All told we have **freed 67 beds across the two sites; reduced ED hours by 556; improve lunchtime discharges by 75%; and have 33 fewer complex long stay patients than pre-reset**. This has allowed ring fences to be maintained and is allowing the immediate conversation about securing the entirety of the cardiology ringfence in Eastern to be realised over the coming weeks.
- Equally the improvements in **green to go medically fit patients** (with positive results thus far) and the anticipated improvements in **recruitment** will be material to the delivery of the overall plan.

NHS
Royal Devon
University Healthcare
NHS Foundation Trust

Agenda item:	10.1, Public Board Meeting	Date: 26 October 2022
Title:	Month 6 Integrated Performance Report – spanning both Northern and Eastern services within Royal Devon University Healthcare NHS Foundation Trust	
Prepared by:	Hannah Foster, Chief People Officer Adrian Harris, Chief Medical Officer Angela Hibbard, Chief Finance Officer Carolyn Mills, Chief Nursing Officer John Palmer, Chief Operating Officer Chris Tidman, Deputy Chief Executive	
Presented by:	Angela Hibbard, Chief Finance Officer	
Responsible Executive:	Hannah Foster, Chief People Officer Adrian Harris, Chief Medical Officer Angela Hibbard, Chief Finance Officer Carolyn Mills, Chief Nursing Officer John Palmer, Chief Operating Officer Chris Tidman, Deputy Chief Executive	
Summary:	To advise the Board of the Trust's performance against key performance standards and targets; and progress on the implementation of the Trust Strategy and key supporting projects.	
Actions required:	The Board is asked to receive the Performance Report and note the current risks and the proposed action plans to mitigate the risks against performance delivery.	

Status (*):	Decision	Approval	Discussion	Information
				X

History:	This is a standing agenda item at each meeting of the Board of Directors.
Link to strategy/ Assurance framework:	This paper details the Trust's performance in respect of key performance standards and targets. Achievement of these performance standards and targets is a key objective within the Trust's Strategy.

Monitoring Information		Please specify CQC standard numbers and tick ✓other boxes as appropriate	
Care Quality Commission Standards	Outcomes		
NHS Improvement / England	✓	Finance	✓
Service Development Strategy		Performance Management	✓
Local Delivery Plan		Business Planning	
Assurance Framework		Complaints	
Equality, diversity, human rights implications assessed			
Other (please specify)			

Royal Devon University Healthcare NHS Foundation Trust

Contents

Overview – Executive Themes and Actions to Raise at Board

The September IPR demonstrates another challenging month for our services with continued pressures on staffing and patient flow impacting on our ability to deliver national standards. The following highlights aim to draw out the key messages and themes that the data presents.

Recovering for the future

Urgent and Emergency care (UEC) continued to face significant pressure in September, due largely to the continued high numbers of Green to Go patients. In addition, increasing COVID numbers towards the end of the month began to impact on staffing and the need to ringfence isolation beds. Despite these pressures, the Trust continued to support the wider Devon system by accepting a number of ambulance diverts during the latter half of the month as the Secretary of State strengthened system expectations about holding all hospitals in Devon at under 6 hour waits. In order to achieve a more planned approach, the Trust has agreed to regularise this additional system flow to Eastern Services by expanding catchment post codes in to UHP and TSDT catchments for a period up to 7th November (when our next step of ED works commences). Our SDEC services continue to deliver an excellent same day emergency care service, which is a vital component of releasing pressure in our Emergency Departments within our Winter Plan. Our Urgent Care Response team have also been critical in supporting pathway 1 patients at home following discharge, in readiness for their social care assessment. It is notable that the length of stay on the caseload has risen this month to 16 days which is putting extra pressure on the Urgent Care Response team, which impacts their ability to work optimally. Winter plans are being enacted across the Devon system on the back of the £23m non recurrent funding and initiatives such as the **Help People Home without Delay Programme** and the **'Reset' week** in October has helped to support our UEC position. The Executive team continue to review the actions to improve patient flow with partners, and we will be taking the learning from the successful reset week into our Winter Plan. The Chief Executive will refer to some of the promising initial data from the reset in her Board report.

The performance dashboards continue to illustrate a challenging position for the Trust and although there are some month on month improvements across both sites the Trust is behind planned trajectory in the majority of elective activities. **Elective recovery** continues to be a huge focus with the Trust currently achieving 76% of plan in Elective inpatients in the East and 48.6% in the North and Day Case activity at 80% of the planned trajectory in the East and 86.8% in the North. Whilst activity has been lost due to the combination of staffing pressures, patient flow and bed pressures leading to cancellations – **we have continued to improve both the 78week and 104week exposures month on month**. **The Winter Plan is predicated on retaining ringfenced elective beds and this will be an absolute priority for the Winter Plan.** The Board will note from the Financial and Operational Committee agenda that NHSEI has initiated a 10 week challenge; and Long Term Elective Recovery Plan that the Trust will actively drive in the run up to Christmas in order to complete our reduction of very long waits for patients. Despite the challenges, the additional capacity laid on at both the Nightingale Hospital and the Jubilee Ward at NDDH continue to support the reduction in waiting lists, **with the SWAOC team at the Nightingale receiving the Partnership and Integration award at the BOA annual ceremony on the 19th October**.

Cancer performance also remains an areas of focus with a reduction in performance in all measures (14 day, 28 day and 62 day) in the East due to a significant increase in "skin" demand and ongoing challenges with colorectal and urological services (which will improve as endoscopy and hysteroscopy additional support is provided). In the North, Dermatology remains the major contributor to challenged performance, but with recovery plans and outsourcing in place the position has now stabilised both within the Northern site and for the whole organisation.

Overview – Executive Themes and Actions to Raise at Board

The increased elective referrals continue to challenge our diagnostic services, although Eastern services are now delivering at over 100% against plan. The Northern diagnostics position is more challenged due to staffing issues, and increased insourced and outsourced capacity is being commissioned that should show a positive impact in the October reporting cycle.

Excellence and innovations in patient care

It is important to triangulate the performance with the quality metrics to identify any trends that may show a consequence of the continued pressures the Trust is facing. **There has been an increase in complaints during September** which will be subject to further analysis although is expected to be partly driven by long waiting times which we continue to triangulate through the Waiting Well programme. Although there were **no new never events in September** this is another area this is another area that is under close review from the Executive team.

There has been a noticeable increase in pressure ulcer damage, particularly category 1 and 3 in the east, and category 2 in the north. Reasons are shown as incomplete risk assessments; susceptibility due to Covid; and equipment failures. The tissue viability team are reviewing and working up a plan to address the deteriorating performance.

On a positive note, Fractured Neck of Femur performance has improved again in month.

A great place to work

The workforce metrics indicate the pressures being felt by our people. Sickness continues to be high at 5% (before COVID), with significant vacancies across most staff groups, meaning a reliance on bank and more expensive agency staff. An ongoing concern continues to be the fill rate for lower paid HCA and ancillary staff, and this is being addressed through a targeted Executive led plan aimed at fast-tracking the recruitment process. More positively it appears as though the 12 month rolling average for staff turnover appears to be plateauing, and the numbers of staff at the pre-recruitment check stage shows that the recruitment activities are beginning to have an impact. Overseas recruitment is also making a significant contribution to our nursing numbers. **Finally, a 'Team Royal Devon' event is being held in the 3rd week of October to say thank you to our people for the care they are continuing to deliver under such challenging circumstances.**

Finance

The pressure on the finance position remains equally as challenging with a number of cost pressures having to be absorbed into the position such as rising energy prices, shortfalls on pay inflation funding and changes in the funding regime which negate our ability to earn additional income for cohorts of activity. Alongside this there is a shortfall in delivering the savings programme for the year – the majority of which is due to loss of productivity relating to the operational challenges set out, but also a shortfall in the expected annual cost efficiencies. Although these pressures are being managed through non recurrent means in the year to date position, **the current risk on delivering the overall plan of an £18m deficit still stands at £5m**. This will need to continue to be managed through to year-end which is possible of further issues do not materialise.

Board Scorecard – Looking to the Future

Successes

- Continued integration of EPIC go live in Northern Services
- Approval given for the £8m Cardiology day case unit funding at Wonford Hospital.
- Approval given for the £0.5m endoscopy enabling funding at Tiverton Hospital
- Continued recognition of the Devon system partnership work at the Nightingale Hospital
- Continued support being able to be offered to neighbouring hospitals for ambulance divert

Opportunities

- Insourcing & outsourcing capacity to further reduce long waiters in October
- Demand and Capacity funding and reset week learning to support Winter Plan
- Integration of 8 high priority services and operational functions
- Elective recovery 10 week challenge
- ERF deep dive to identify further elective recovery and best value opportunities

Priorities

- Staff Health and Wellbeing
- Launch of the Flow reset programme & Help People Home Without Delay
- Pipeline for recruitment processes to fast-track new starters
- Delivering Best Value to meet financial plan
- Continued validation work on long waits with NHSEI IST and improvement of 104 week waits

Risk/Threats

- Further COVID waves anticipated
- Green to Go Patient delays to placement
- Staffing Resilience Medical Staff (Northern) / nursing/ HCA/ ancillary
- Potential Industrial action
- Staff Morale with constant pressure and cost of living challenges
- Data Quality validation post Go Live
- Dermatology Northern position

Data Quality Update

Data Quality

Northern Epic implementation

As reported previously, the implementation of Epic for Northern services in July resulted in some metrics / data not being available for immediate inclusion in the IPR. Progress continues to be made and can be summarised as follows:

- **Activity**: elective inpatient and daycase activity, outpatient activity and emergency inpatient activity is now included in the IPR showing data for July and August plus revision to previous months following review of 2022/23 data;
- **Performance:** additional diagnostic detail is now included in the IPR with the exception of Audiology and Cardio-respiratory where further investigation is ongoing.

Work is in progress to align reporting for both sites, with the intention of uniformity across the organisation as Northern data develops further within Epic. It is anticipated that this will take place across the next three months, with a more detailed outline to be included in the next Board cycle.

Northern Services Executive Summary

Northern Services Operational Performance Dashboard

Domain	Measure/metric	Definition	Aug-22	Sep-22	Vs prior month	vs plan	vs National target
ELECTIVE ACTIVITY	Referrals	*Vs baseline (2019/20)*				N/A	N/A
	Outpatient activity (New)	*Vs baseline (2019/20)*	**87.5%**	**113.8%**	26.3%	163.7%	104%
	Outpatient activity (FU)	*Vs baseline (2019/20)*	**107.9%**	**109.2%**	1.3%	163.7%	75%
	Outpatient virtual (% of total)	*% of total OP activity*					25%
	Elective inpatient activity	*Vs baseline (2019/20)*	**38.5%**	**58.5%**	20.0%	48.6%	104%
	Elective daycase activity	*Vs baseline (2019/20)*	**76.1%**	**80.9%**	4.8%	86.8%	104%
	RTT 18 week performance	*Patients seen <18 weeks vs total Incomplete pathways*	**53.0%**	**49.9%**	-3.1%		92%
	Incomplete pathways	*Total count*	**25596**	**25205**	-1.5%		
	RTT 52+ weeks waited	*Total count*	**3058**	**3137**	2.6%		
	RTT 78+ weeks waited	*Total count*	**471**	**533**	13.2%		
	RTT 104+ weeks waited	*Total count*	**15**	**16**	6.7%		
CANCER	2 week referrals	*Performance*	**55.00%**				
	28 day faster diagnosis standard	*Performance*	**41.70%**				75%
	Urgent GP referral 62 day	*Performance*					85%

Domain	Measure/metric	Definition	Aug-22	Sep-22	Vs prior month	vs plan	vs National target
URGENT CARE	Non-elective Inpatient activity +1 LOS	*Vs baseline (2019/20)*	**67.5%**	**72.9%**	5.4%	99.4%	
	A&E attendances	*Total count*	**4684**	**4370**	-6.3%	98.4%	
	4 hour wait performance	*Patients seen <4 hours vs total attendances*	**54.3%**	**50.7%**	-3.6%		95%
	Ambulance handover delays >30 minutes	*Total count*	**261**	**249**	-4.6%		
	Average daily number of patients waiting and ready for discharge	*Total count*					
	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 of patients delayed as awaiting residential / nursing home bed	*Total count*					
DIAGNOSTICS	6 week wait referral to diagnostic test	*tests completed in 6 weeks*	*39.0%*	*38.0%*	-1.0%	*N/A*	99%
	MRI activity	*Vs baseline (2019/20)*	*90.3%*	*96.9%*	6.6%	89.6%	
	CT activity	*Vs baseline (2019/20)*	*125.0%*	*114.1%*	-11.0%	91.8%	
	Medical Endoscopy activity	*Vs baseline (2019/20)*					
	Non-obstetric ultrasound activity	*Vs baseline (2019/20)*	*88.3%*	*108.2%*	19.9%	79.5%	
	Echocardiography activity	*Vs baseline (2019/20)*					

Positive value

Negative value < 5%

Negative value > 5%

Eastern Services Executive Summary

Eastern Services Operational Performance Dashboard

Domain	Measure/Metric	Definition	Last Month Aug-22	This Month Sep-22	vs Prior month	vs Plan	National target
ELECTIVE ACTIVITY	Outpatient Activity (NEW)	vs baseline (2019/20)	88.4%	81.6%	-6.8%	81%	104%
	Outpatient Activity (FOLLOW-UP)	vs baseline (2019/20)	146.7%	139.8%	-6.9%	158%	75%
	Elective Inpatient Activity	vs baseline (2019/20)	65.5%	75.6%	10.2%	67%	104%
	Elective Daycase Activity	vs baseline (2019/20)	95.7%	92.9%	-2.9%	80%	104%
	RTT 18 Week performance	Patients seen <18 weeks vs total incomplete pathways	54.3%	52.7%	-1.5%		92%
	Incomplete Pathways	Total count	55748	55251	-0.9%		
	RTT 52 Weeks waited	Total count	5173	5252	1.5%		
	RTT 78 Weeks waited	Total count	1058	1103	4.3%		
	RTT 104 Weeks waited	Total count	301	257	-14.6%		
CANCER	14 Day Urgent	Performance	58.3%	40.9%	-17.4%		93%
	28 day faster diagnosis standard	Performance	68.7%	60.5%	-8.2%		75%
	Urgent GP referral 62 day	Performance	63.1%	59.3%	-3.8%		85%

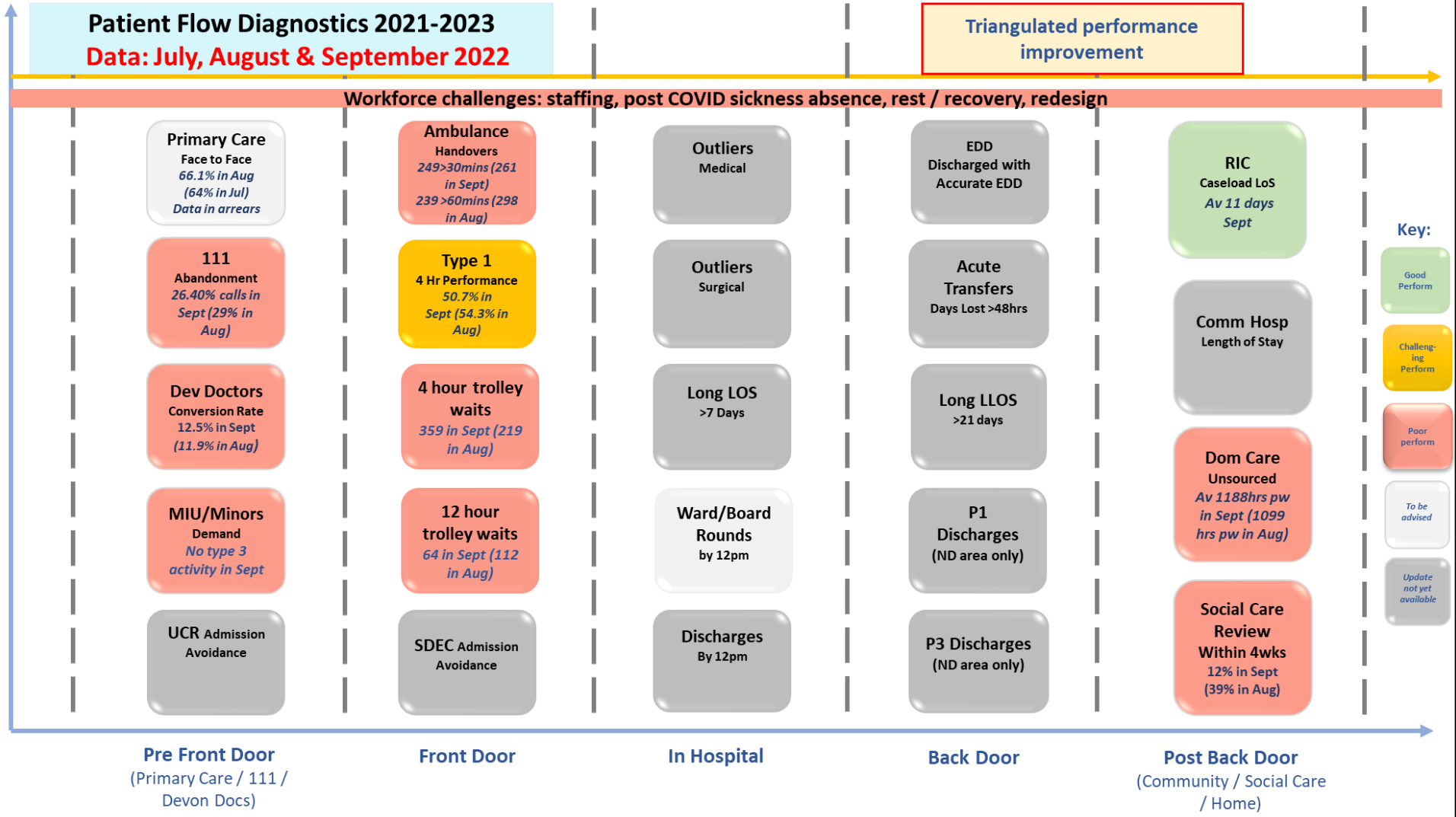
Domain	Measure/Metric	Definition	Last Month Aug-22	This Month Sep-22	vs Prior month	vs Plan	National target
URGENT CARE	Non-elective Inpatient activity +1 LOS	Vs baseline (2019/20)	100.4%	98.3%	-2.2%	93.1%	
	A&E attendances	Total count	10400	9800	-5.8%	98.1%	
	4 hour wait performance	Patients seen <4hrs vs total attendances	59.3%	59.1%	-0.2%		95%
	Ambulance handover delays >30 mins	Total count	287	309	7.1%		
	Daily Average Green (Medically Fit) Transfer List	Total count	106	98	-8.2%		
	Volume of Average Daily Completed Transfers	Total count	10.6	10.2	-3.9%		
	Average Time to Transfer (Medically Fit to Discharge) - All Transfers	Total count	5.3	5.4	1.9%		
	Average Weekly Hours Requiring Personal Care Backfill	Total count	1213	1082	-10.8%		
	UCR: Referrals	Total count	654	619	-5.7%		
	UCR: Length of Stay on Caseload	Total count	15.0	16.0	6.7%		
DIAGNOSTICS	6 week wait referral to diagnostic test	% of diagnostic tests completed in 6 weeks	63.0%	63.2%	0.2%		99%
	MRI activity	vs 19/20 baseline	116.4%	105.5%	-10.9%	99.4%	
	CT activity	vs 19/20 baseline	120.1%	106.7%	-13.4%	97.5%	
	Medical Endoscopy activity	vs 19/20 baseline	114.3%	110.7%	-3.7%	95.8%	
	Non-obstetric ultrasound activity	vs 19/20 baseline	136.1%	110.7%	-25.4%	111.2%	
	Echocardiography activity	vs 19/20 baseline	167.9%	176.4%	8.5%	162.1%	

Positive value

Negative value < 5%

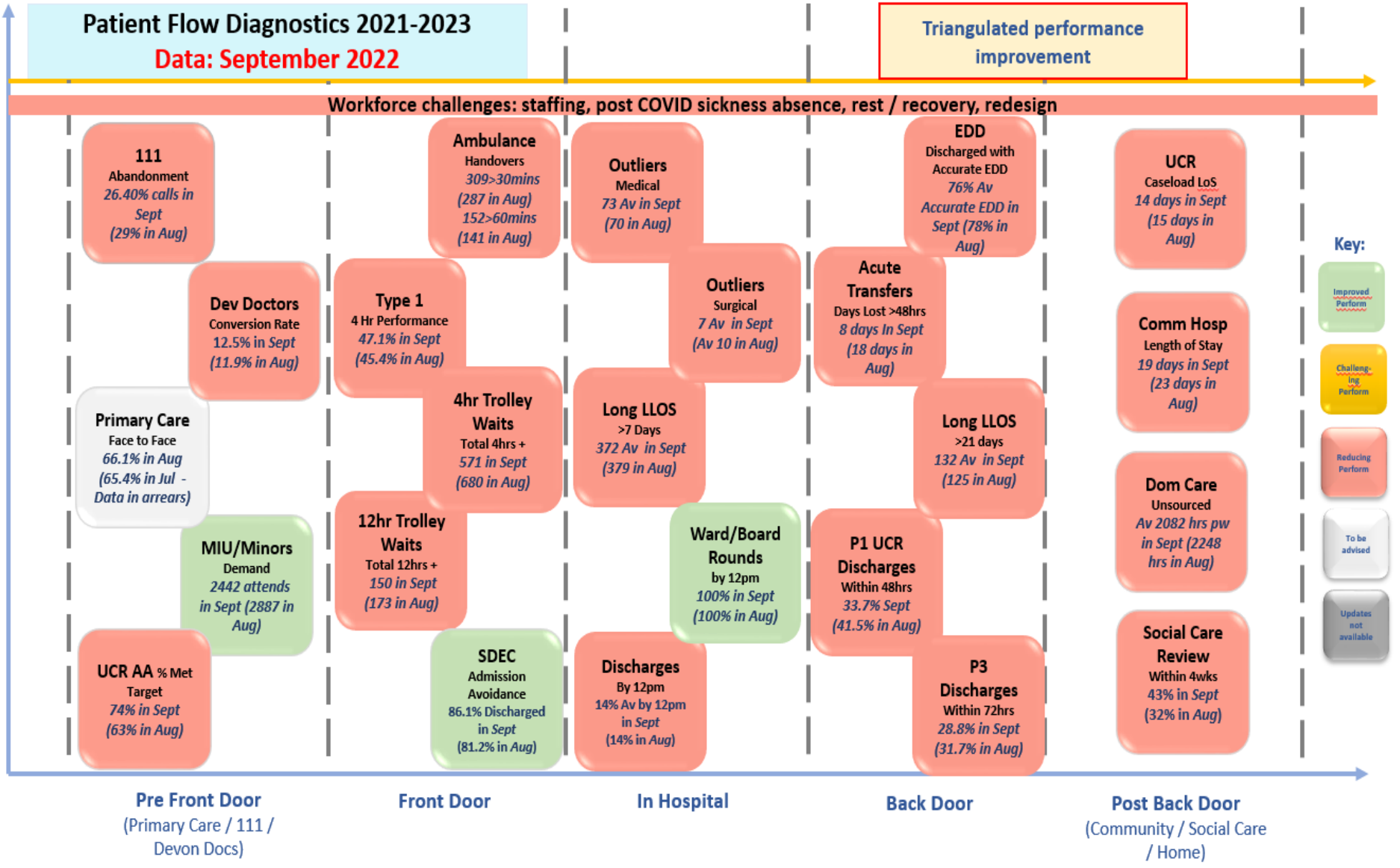
Negative value > 5%

Northern Services Patient Flow Diagnostic

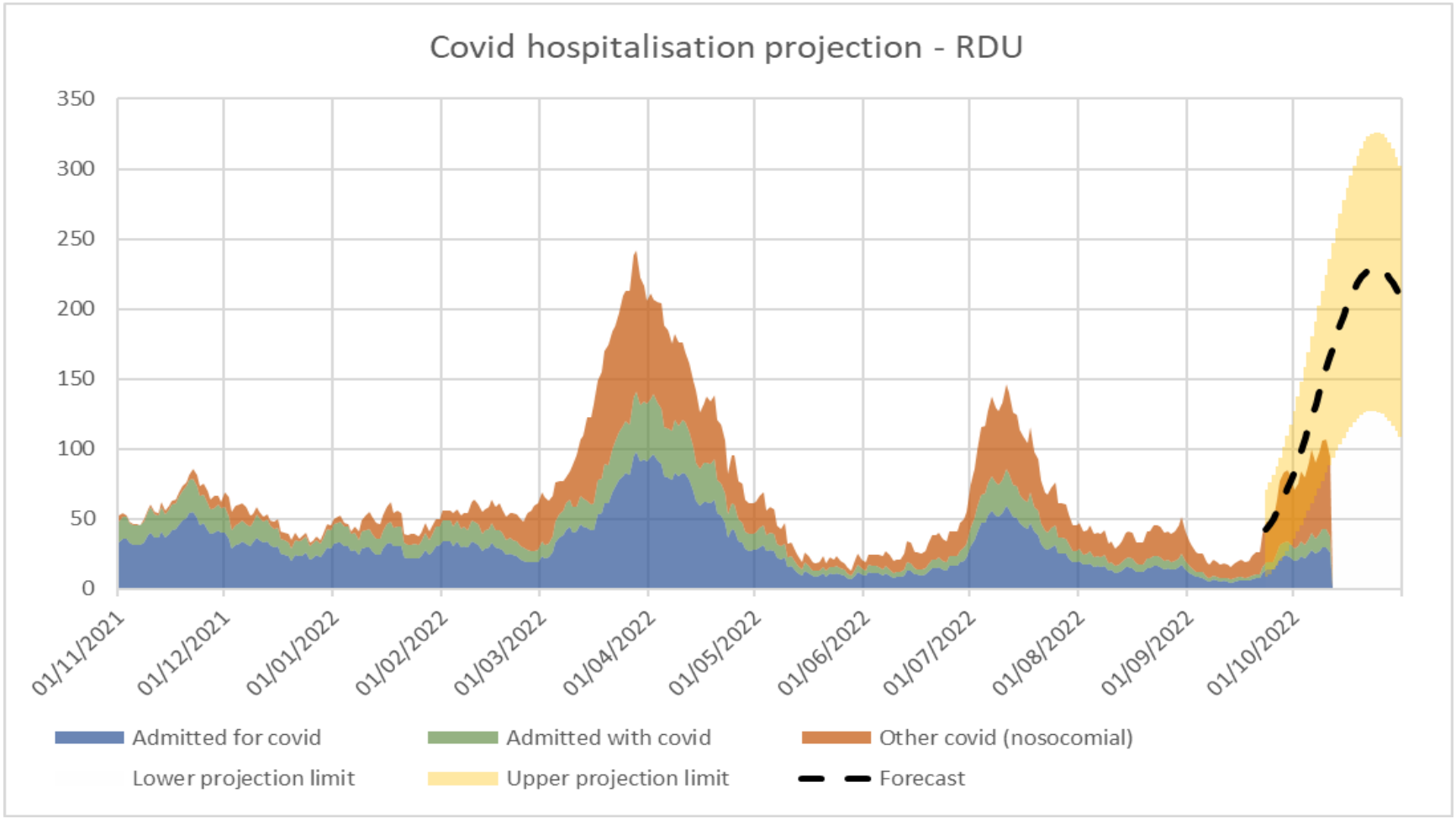


Eastern Services Executive Summary

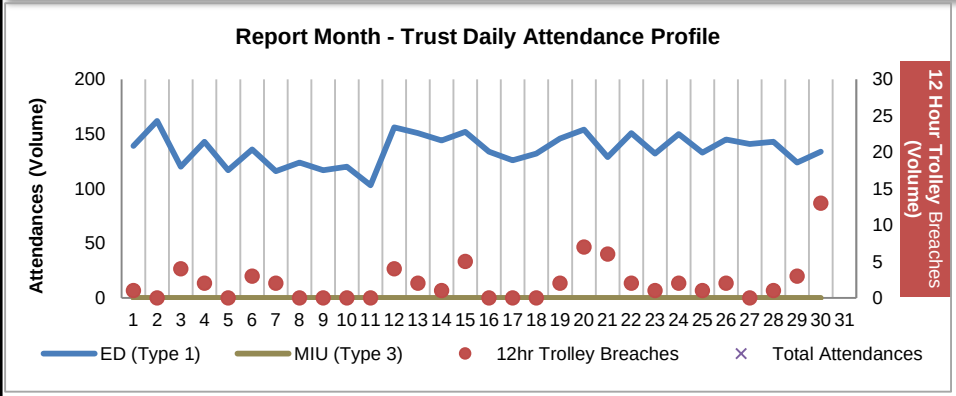
Eastern Services Patient Flow Diagnostic

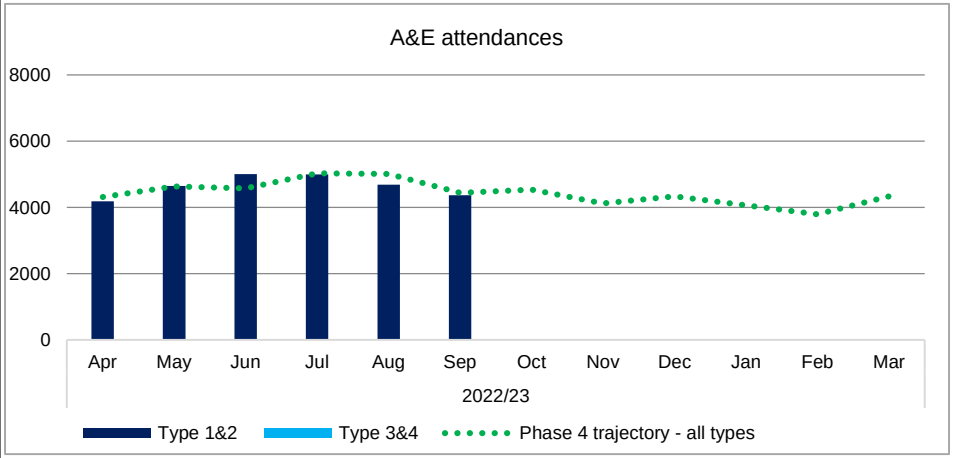


RDUH COVID-19 Projections

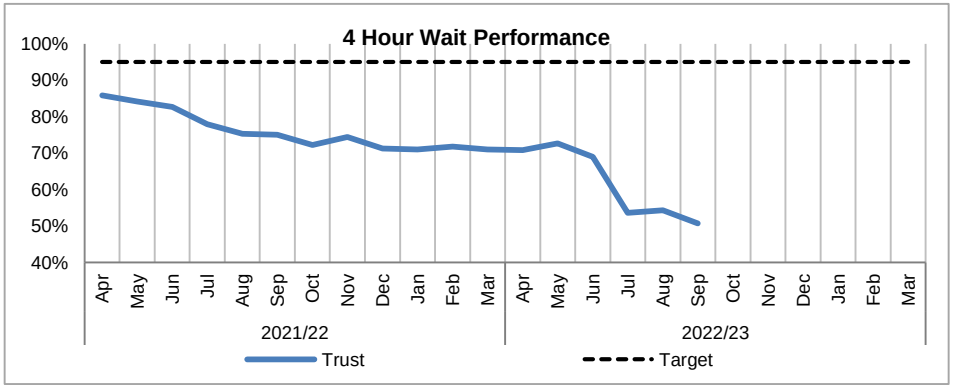


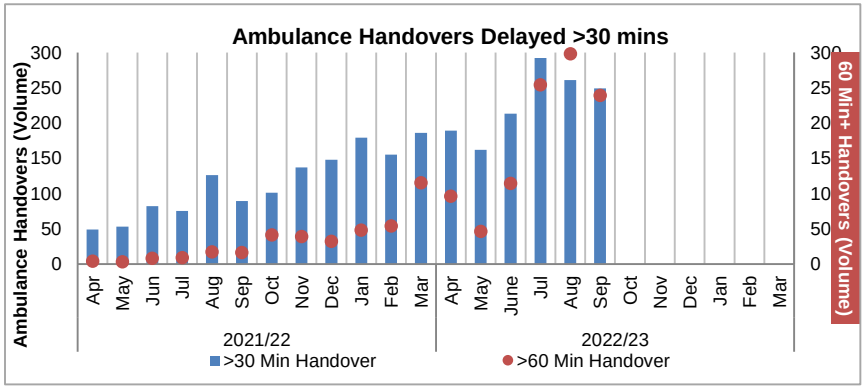
Northern Services Emergency Department – *key metrics relating to activity & performance in urgent & emergency care services*





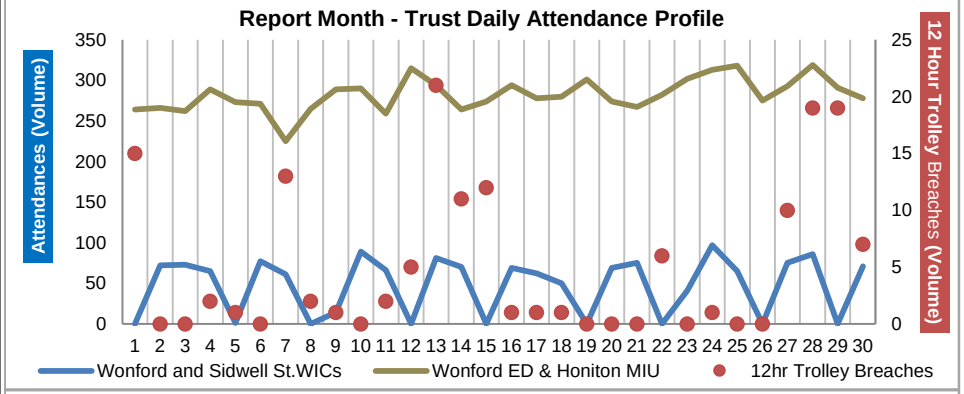
- ED remained escalated throughout September as the number of Green to go patients remained high.
- In September the total unvalidated time lost in ambulance handover delays was 574hrs 25mins ambulance handover total time lost, this is a decrease of 17% compared to September.
- In September NHSEI introduced a zero tolerance to ambulance waits over 6 hours, as a result of this Northern Services were required to accept Ambulance diverts from UHP catchment areas over a 2 week period. Subsequently in October an agreement was reached for a change in postcode catchment areas which increase the number of ambulance attendances at Eastern Services but Northern Services are excluded from this temporary change.
- 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.
- There is ongoing engagement with LOF's, local councilors in conjunction with the ICB.

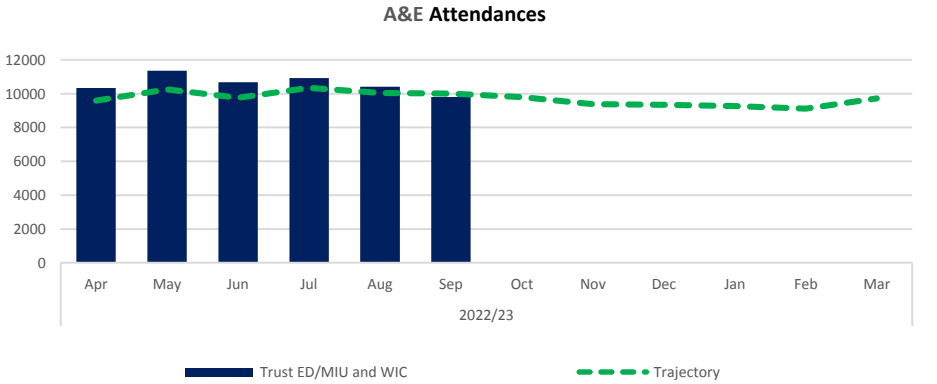


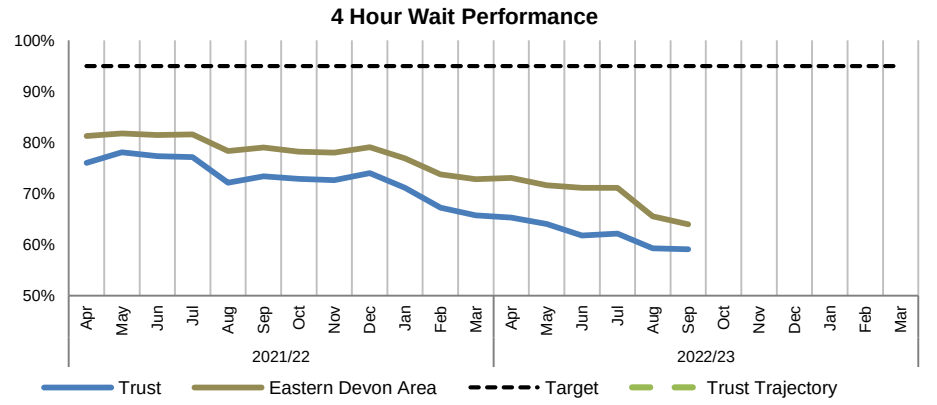


Eastern Services Emergency Department

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







Overall Performance:

Type of Activity	Denominator	Patients > 4 Hours	% Performance
ED Only	7378	3904	47.09%
All RD&E Delivered Activity (including Honiton MIU and the WICs)	9800	4010	59.08%
Total System Performance (including MIUs)	11126	4010	63.96%

All type performance against the 4 hour wait target is similar to last month with performance of 59% in September.

Key drivers:

- 111 call abandonment and lack of primary care streaming
- Bed capacity pressure and restricted flow to beds in the hospital
- Reduced capacity at Sidwell Street WIC –closed on Monday and Thursday
- Current vacancies and sickness in Medical and Nursing teams

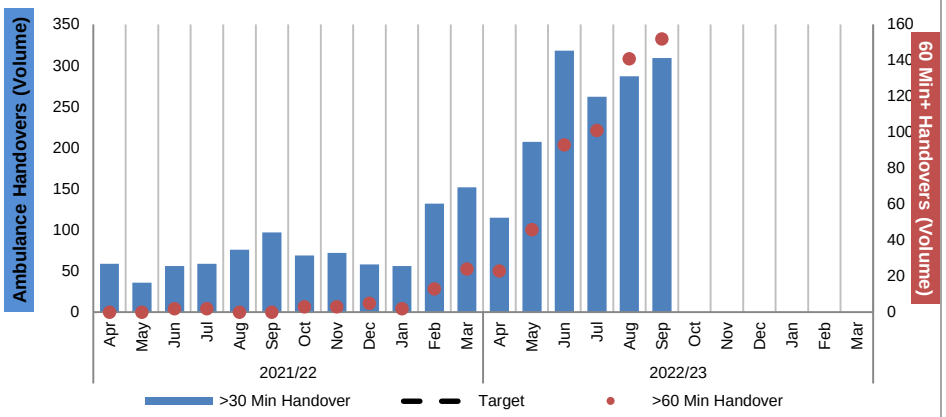
The number of patients waiting on a trolley in excess of 12 hours for an inpatient admission has reduced marginally from 173 in August (of whom 9 were patients awaiting a mental health admission) to 150 in September (7 mental health).

Recruitment progress:

- Nursing –B3 fully recruited, 7.64 WTE Band 5 vacancy
- Nurse Practitioners –4.29 vacancies. 8 WTE recruited in August / September 2022, trained and working independently by August –October 2023.
- Consultants 18.5 WTE in post October 22. 1 WTE to join in March 2023
- Medical Middle Grades –9 WTE vacancies

Eastern Services Emergency Department

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



Overall Performance:

Ambulance handover delays continue to increase, with a marked increase in the number of waits over 60 mins since June :

- August 287 delays over 30 minutes; 141 delays over 60 minutes
- September 309 delays over 30 minutes ; 152 delays over 60 minutes

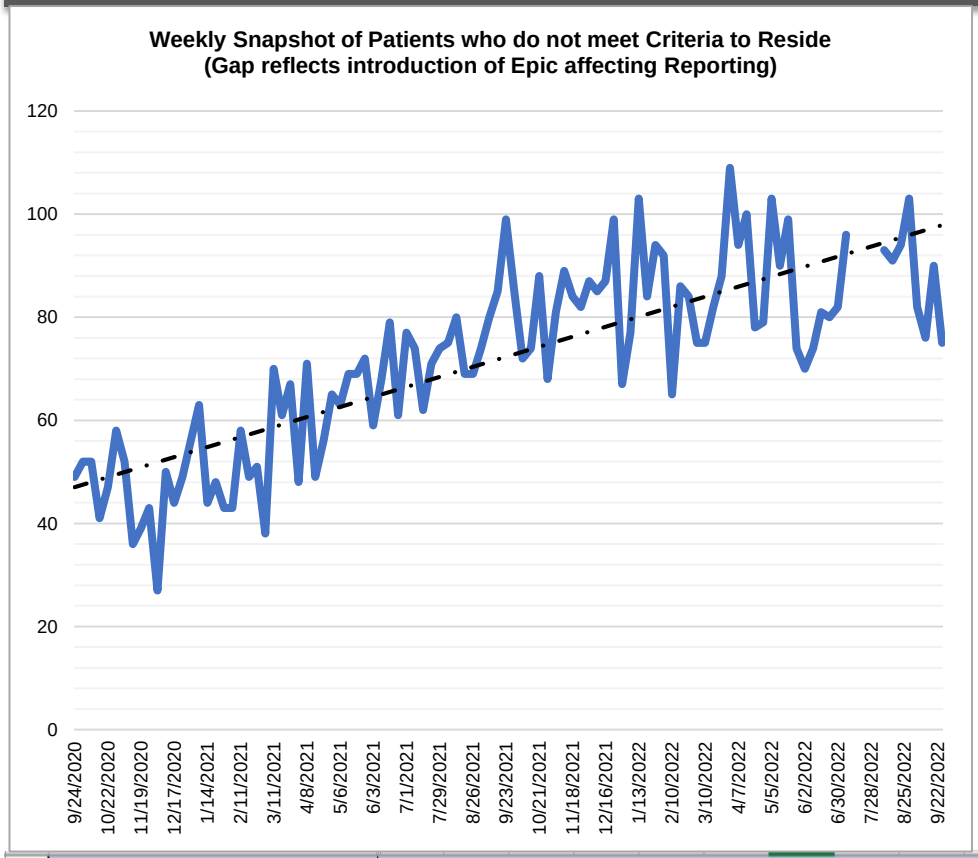
Total ambulance hours lost over the standard 15 minute wait were 694 hours in August and 609 hours in September.

Delays are attributed to lack of flow in the hospital and the delay in moving patients out of the emergency department to inpatient beds in order to make space for patients coming in via ambulance.

From 10th October Wonford have accepted an adjustment to the ambulance catchment area to support long ambulance waits across neighbouring Devon Trusts. This should result in less ad hoc requests for divert support and is time limited until 7th November when the next phase of building work begins in the ED. In the first 8 days, 31 patients have been received from the new postcodes of which 22 have been admitted.

As part of winter planning a Trust wide reset week took place from 5th-11th October. The week was received positively and resulted in reduced overall in-patient numbers, increased morning discharge and in-day bed capacity. The key enablers are being assessed and will continue supported by winter funding.

Northern Services Discharge – *Volumes of Patients Identified as Clinically Ready for Discharge*

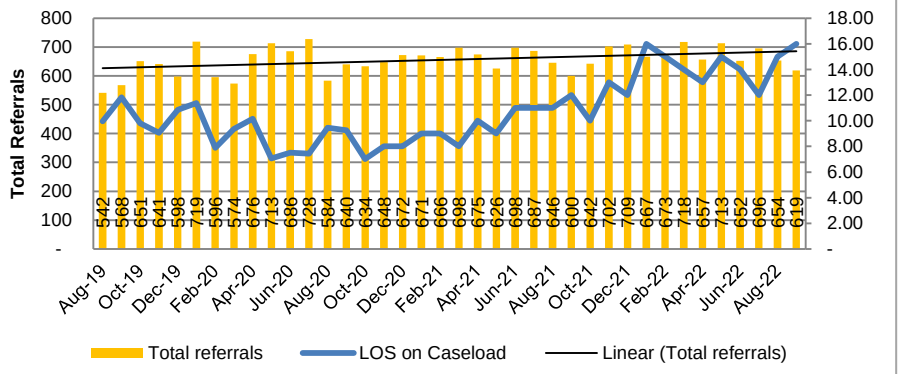


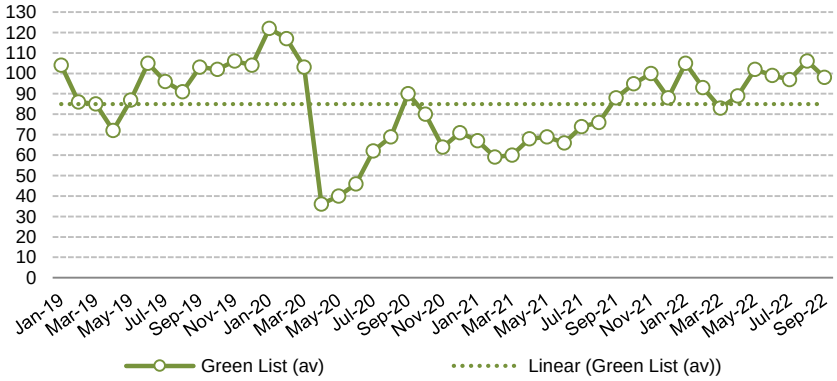
- The Trust saw a peak of 77 patients waiting and ready for discharge on the 16th September. On average there were 67 green to go patients per day in September, which whilst slightly lower, is still the highest proportion of Acute beds across Devon.
- A project called 'Help Me Home' has commenced at the end of July to help address the number of Green to Go patients across both Eastern and Northern Services.
- Discussions have commenced between the Chief Operating Officer and owner of the Evolve Group care homes about the potential of increasing use of beds within the group's homes.
- The high number of patients remaining in hospital due to lack of capacity for either care at home or residential/nursing home capacity continues to be escalated as cause for concern to the ICB. Winter schemes planned to support Northern services will be closely tracked to ensure they deliver the planned outcome.

	Delay Reason	02/05/2022	09/05/2022	16/05/2022	23/05/2022	30/05/2022	06/06/2022	13/06/2022	20/06/2022	27/06/2022	04/07/2022	11/07/2022	18/07/2022	25/07/2022	01/08/2022	08/08/2022	15/08/2022	22/08/2022	29/08/2022	05/09/2022	12/09/2022	19/09/2022	26/09/2022
Delay Reason	Awaiting Med decision/written dc summary	0	0	1	0	0	0	0	0	0	0	0	Data unavailable due to go live			0	0	1	0	0	0	0	0
	Awaiting community assessment / referral / bed	24	16	16	12	7	8	8	9	23	13	13				23	18	23	23	21	17	21	21
	Awaiting therapy decision	0	0	1	1	1	4	0	1	0	1	1				0	0	0	0	0	0	0	0
	Pathway 1 awaiting resource / assessment to start care at home	8	9	14	18	17	10	17	17	21	18	18				15	23	22	24	16	19	20	11
	Pathway 3 Awaiting residential / nursing home bed	12	7	8	10	5	6	9	7	8	15	15				13	16	18	13	11	11	15	11
	Repatriation / Transfer to another acute Trust	1	6	8	0	2	0	3	0	1	2	2				11	8	8	4	3	7	6	5
	Patient/family not in agreement with discharge plans	0	0	0	1	0	0	0	0	1	1	1				1	0	0	0	0	0	0	0
	Others	4	2	1	1	2	2	3	5	3	2	2				7	3	0	0	2	2	2	1

Eastern Services Urgent Community Response

Admission avoidance and discharge





UCR Demand and Performance

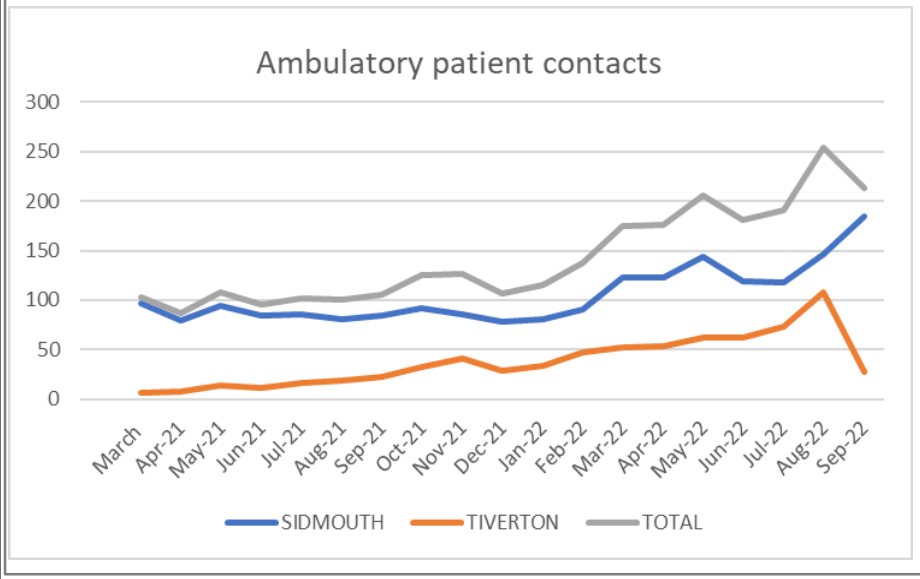
- Referrals to UCR remain relatively stable. There were 259 admission avoidance referrals in September, 63 of which required a 2 hour response which was delivered for 87% of those patients.
- The daily average Green to Go number increased by 11% compared with September 2021.
- The Length of Stay on the caseload has increased significantly in this period from ~12 days to ~16 days. This means that our UCR teams are spending longer supporting our patients post discharge whilst awaiting a social care package.
- Actions to improve the flow position are being taken as part of the Help People Home without Delay programme which is being delivered across North and East.

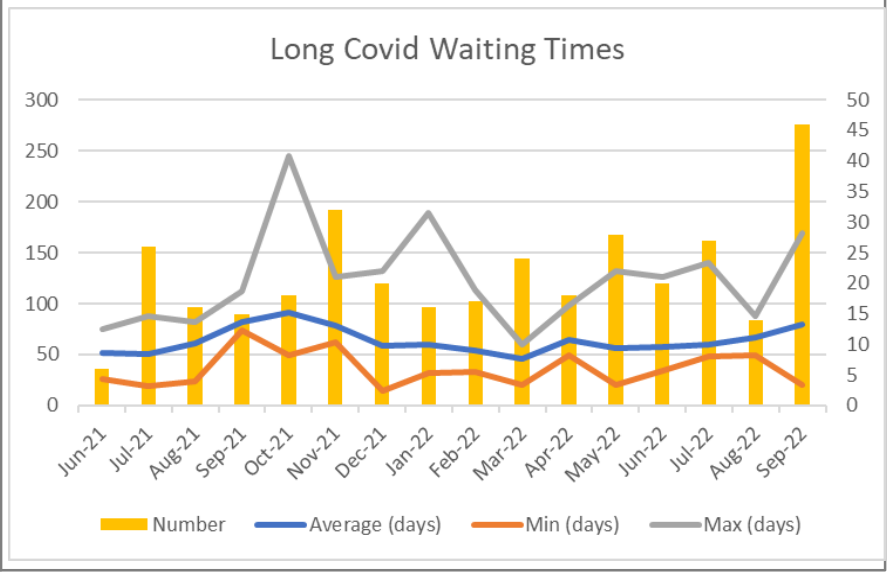
Actions to improve performance and outcomes:

- Best Practice Pathways have been defined for Pathways 1-3 to streamline the processes for supporting people out of acute and community hospital beds. Referrals for Pathway 1 (UCR) will be managed directly by locality teams enabling the Single Point of Access team to focus on more complex discharges for Pathways 2 and 3. This is expected to deliver improved time to transfer across all pathways from October with a number of dependencies including social care capacity and overall demand.
- From November, Category 3 and 4 patients from the SWAST stack can be 'pushed' to UCR, reducing demand into ED. We are expecting this model to evolve over the winter period, learning from other areas who have completed pilots previously.
- Four schemes with value of £2.5m have been funded via the Devon Demand and Capacity Fund to increase capacity (equivalent of 40 beds) including Live in Carer, UCR support to SWAST, 1:1 agency support for placements and additional Pathway 2 rehabilitation capacity. These schemes start to deliver capacity from November.

Eastern Community Services

Admission avoidance and Long Term Conditions Management





Community Ambulatory Service

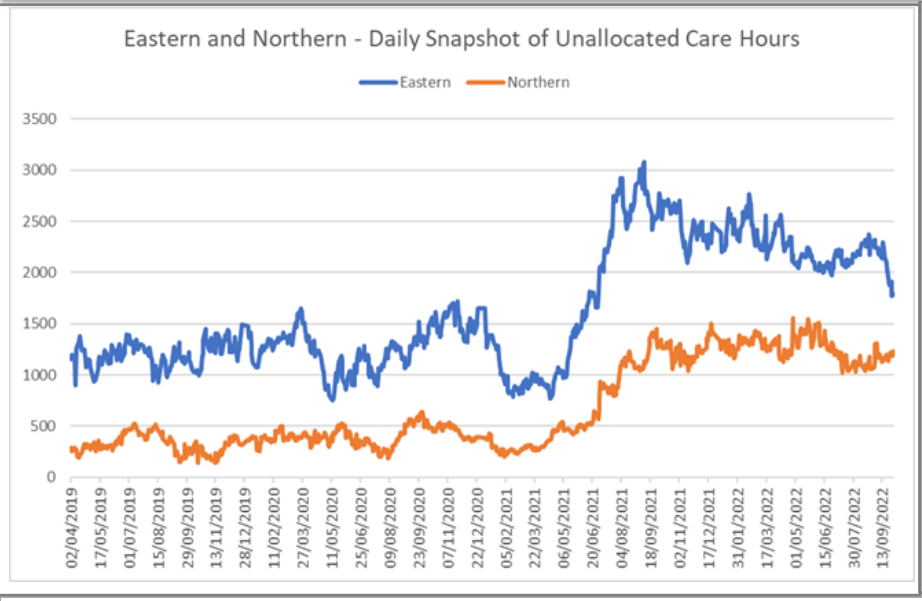
- Referrals to the ambulatory service dropped from 197 in August to 169 in September but referrals and activity remain higher than the trend over time. A new pathway for referrals from the acute site practitioners will be trialled in October to maximise the capacity of the service.
- The difference in Tiverton and Sidmouth activity on the graph reflects the movement of clinics to accommodate patients closest to where they live.
- Modelling will take place in October on existing service and potential additional treatments to improve future service planning including budget and estates.

Eastern Long COVID Service

- Average wait was 80 days in September against a national target of 42 days. This has risen significantly due to the North Devon patients being incorporated into an integrated pathway. At the time of transfer, new patients were not being assessed in North Devon.
- The number of patients contacts increased from 53 in August to 94 in September largely due to the merger of the service with North Devon.
- There are two new Medical Assessors in post that will improve the wait times. Working with the ICB and Northern Devon to ensure that funding is allocated proportionately across teams depending on the activity. A review of the rehabilitation pathway is also being delivered across North and East.

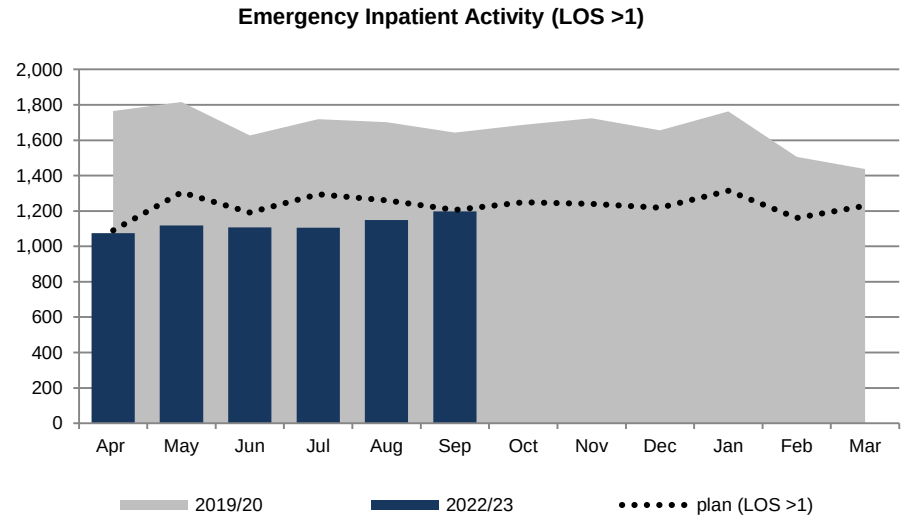
Eastern and Northern Services Social Care

Unallocated domiciliary care hours, and waiting list position



- The unsourced domiciliary care position remains static across North and has reduced for Eastern. There is more work to do with Social Care to understand how the total 'unallocated care hours' is mitigated – this is being picked up in executive sponsored work between the Trust and Social Care.
- As part of the Help People Home Without Delay programme, the Assistant Directors of Health and Social Care have been working with the teams to better understand the detail of the 'backfill' position. When Urgent Community Response assess someone in their own environment they need to generate a referral to social care as soon as they identify a long term care need; we are reviewing how efficiently our teams make these referrals in order to be clear about some of the 'unseen' demand on our teams due to the domiciliary care market position.
- Currently in Eastern, of the unallocated hours, 124hrs of backfill activity is completed by the Urgent Community Response teams every week. In North, this equates to 112 hrs of backfill . External agencies (commissioned by Devon County Council) are used to cover off a proportion of the remaining backfill.
- The waiting list for social care continues to rise, particularly in Eastern. There is significant concern around this as the needs of these people are unknown and it is likely their needs will increase the longer they wait.

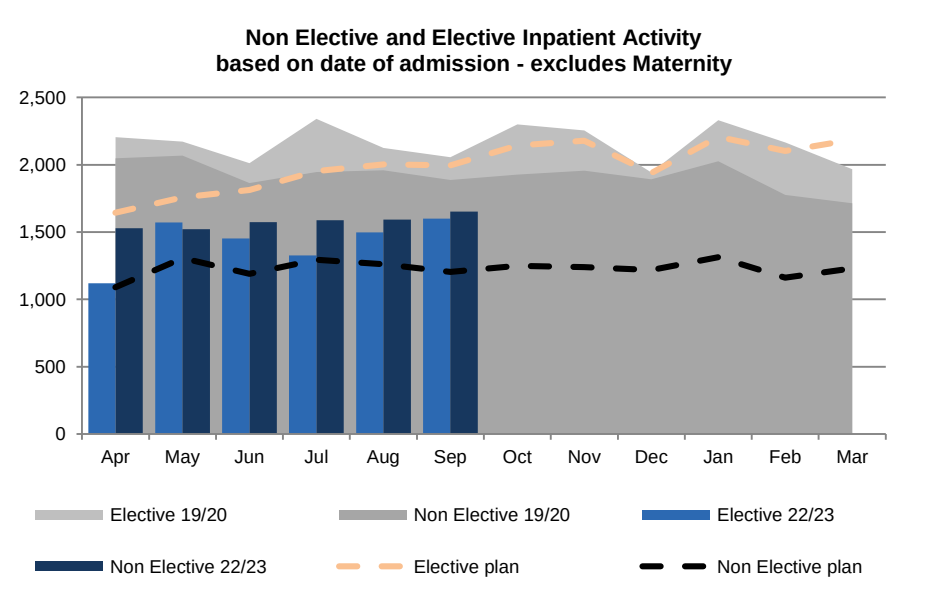
Northern Services Emergency Inpatient Activity



Emergency inpatient activity :

- Emergency activity at NDDH remains extremely challenged. Delays in discharges where care packages and residential/nursing homes are required continue to adversely impact patient flow, on average 68 beds were being utilised daily by green to go patients in September.
- Patients admitted via ED increased by 3.7% in September, compared to August
- Collaborative system working continues to address pressures: System Improvement and Delivery Group with membership from system partners in both Health and Social Care. Winter investment plans across health and social care have now been approved and recruitment plans are in place.
- The Same Day Emergency Care (SDEC) has had to be used to have inpatients bedded as a result of having such a high number of urgent care inpatients. The impact of this has meant that SDEC has not had full functionality. In early October as part of reset week it was possible to close 6 beds and use this area to deliver SDEC so supporting admission avoidance. Plans are in place to run SDEC fully throughout winter.

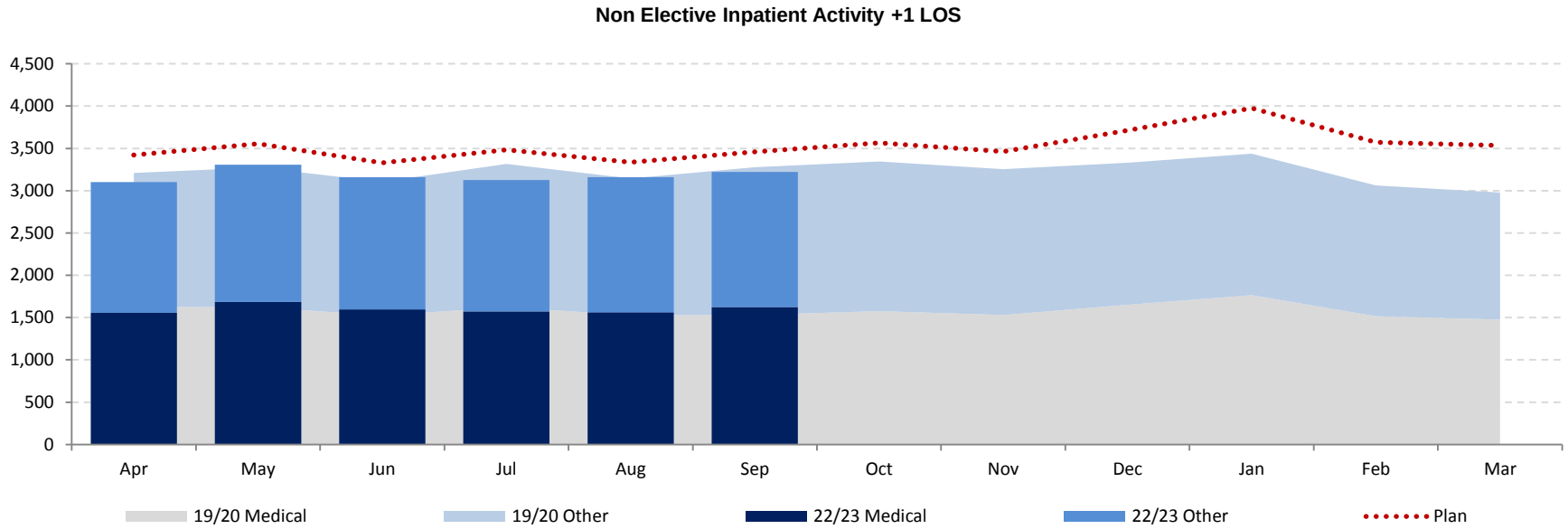
Northern Services Overall Inpatient Activity



Inpatient activity :

- The number of elective inpatients treated in September was greater than in August although it remained below plan due to elective surgical beds having to be used to support emergency care.

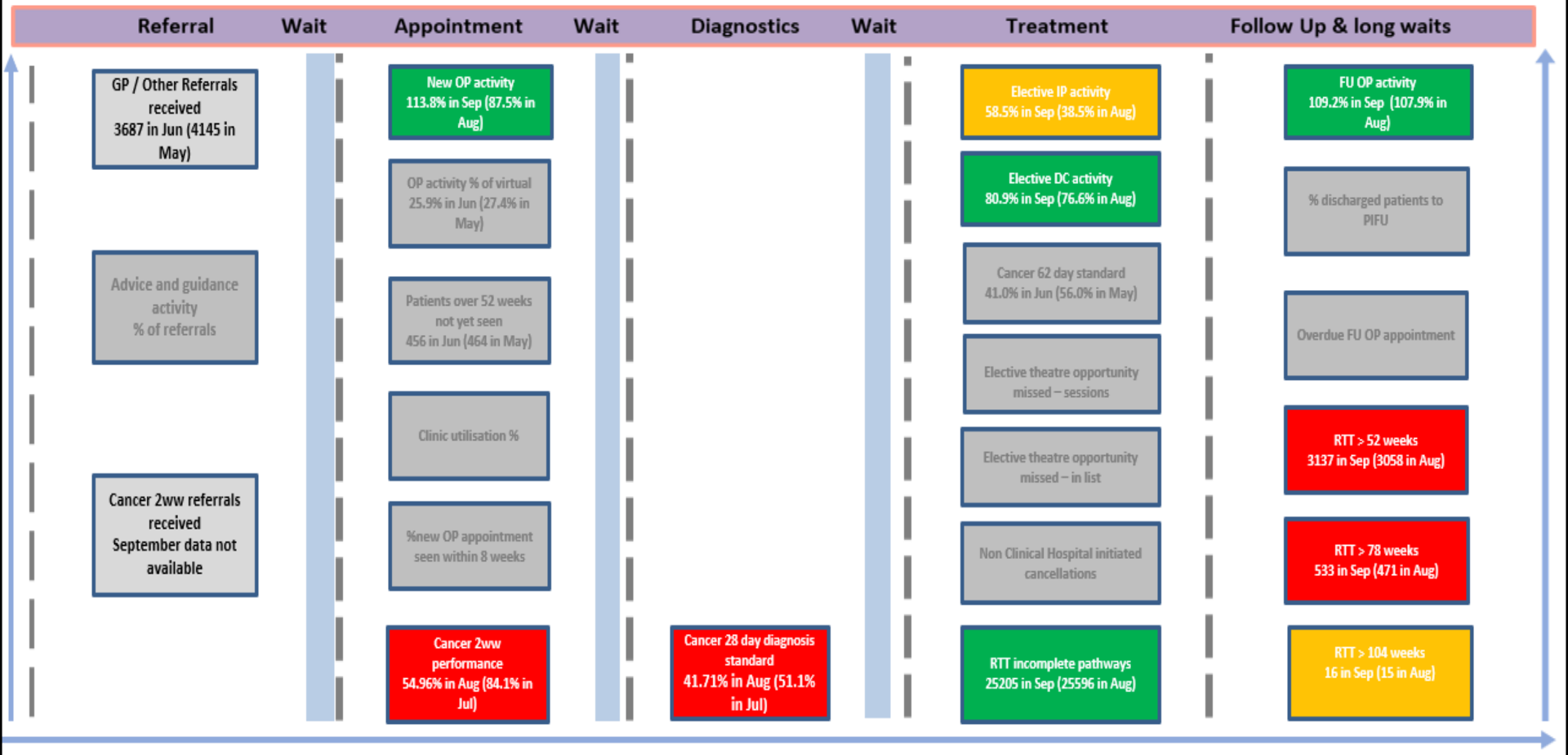
Eastern Services Non-Elective Activity



Non-elective activity was 98% of 2019/20 volumes, but within this Medical non-elective admissions were 106% of 2019/20 volumes.

Northern Services Planned Care Metrics 2022-2023

Data: July, August & September 2022



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

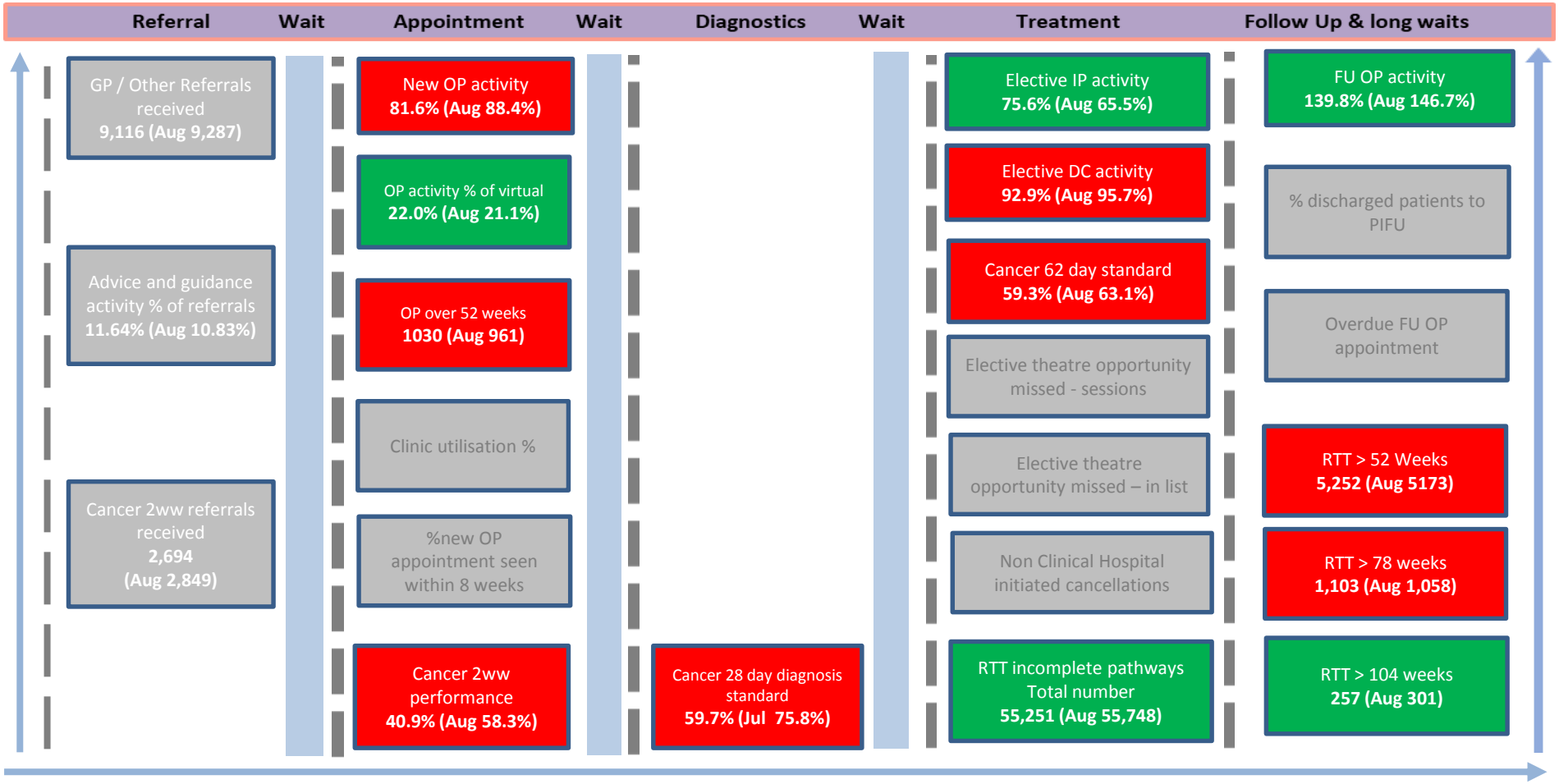
Improved performance | Challenged performance | Reducing performance

WE WORK TOGETHER

HOME . COMMUNITY . HOSPITAL

Planned Care Metrics 2021-2022
Data: September 2022

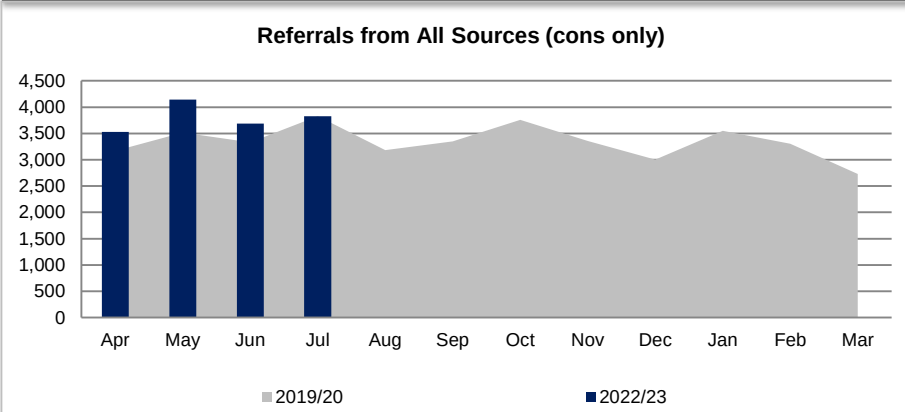
Eastern Services

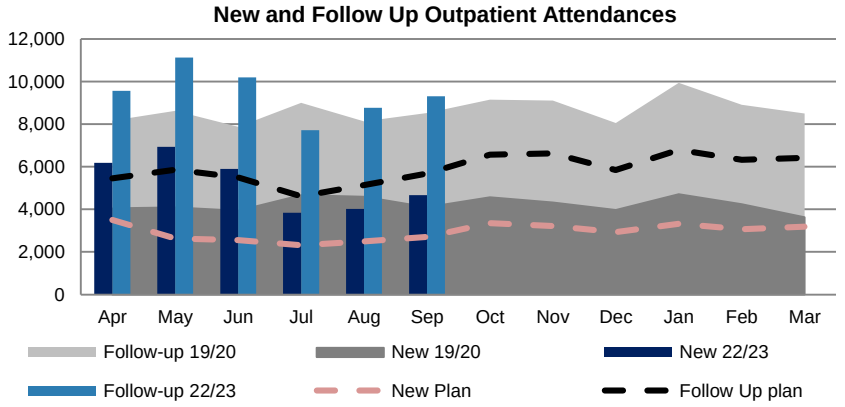


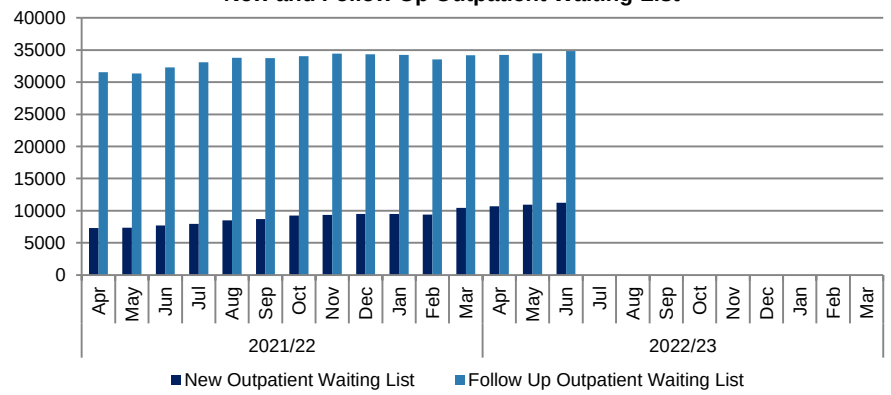
Enabling work streams: Clinical prioritisation, PTL management, Patient support, Validation, Access management processes, Communications + ownership, EPIC build

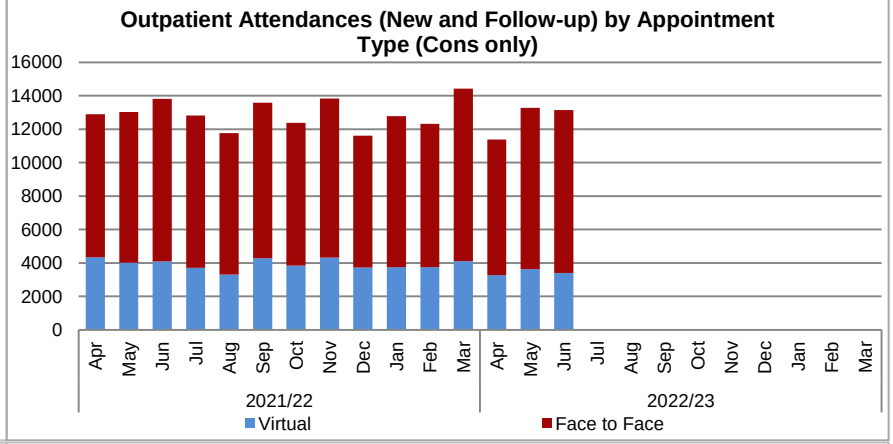
Improved performance | Challenged performance | Reducing performance

Northern Services Elective Activity- Referrals and Outpatients

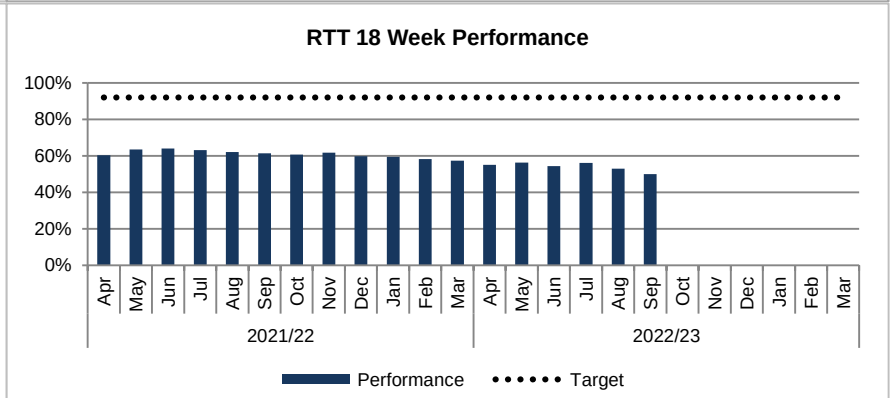




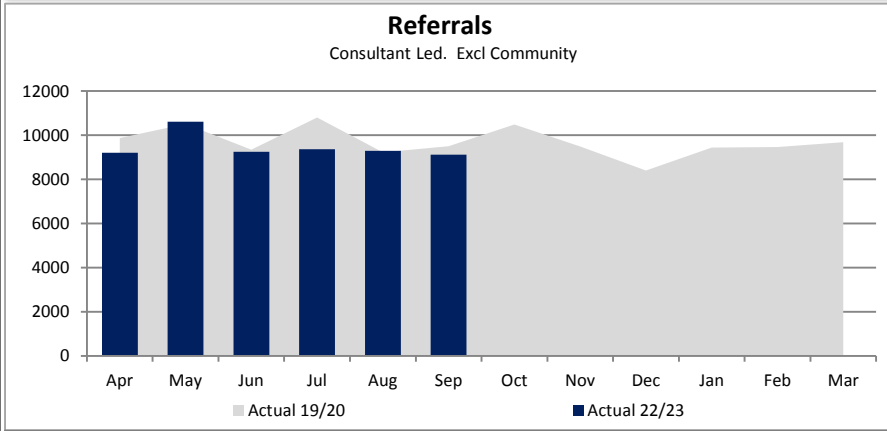


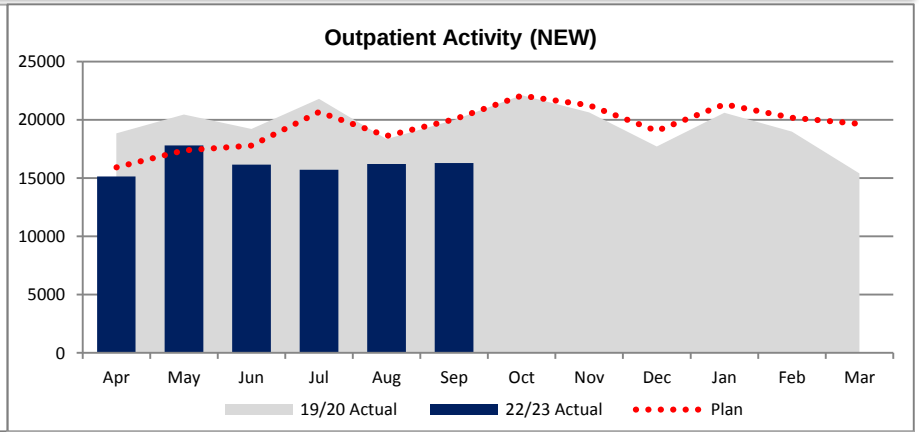


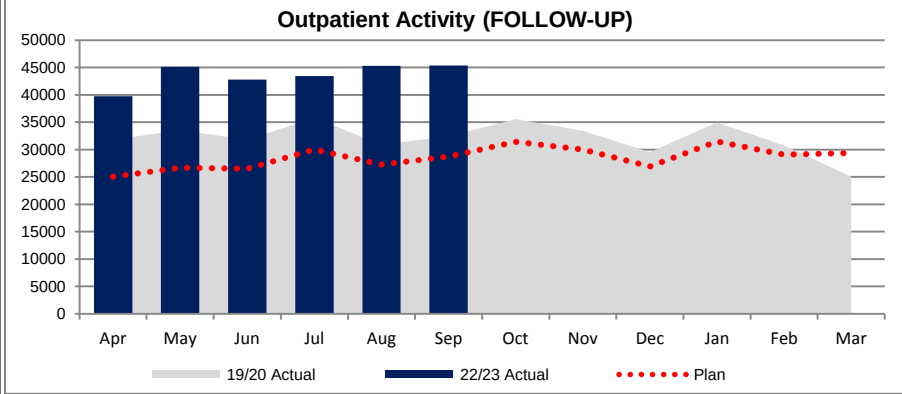
- September data is not yet available for referrals following the implementation of Epic. The data is not yet available to show the split between face to face and virtual appointment.
- At the end of September the Trust had a total of 24,706 pathways patients on a open RTT pathway, against a trajectory of 17,393. On implementation of Epic in July there was a significant rise in the number of open pathways: there are several reasons for this which include data quality issues, changes in what is reported on each system and a reduction in activity following implementation of EPIC. There has been month on month reduction in the total number of pathways since this initial rise. An external company are to start waiting list validation to address data quality issues
- In referral to treatment times the focus remains on reducing 104 and 78 week waits between now and year end.

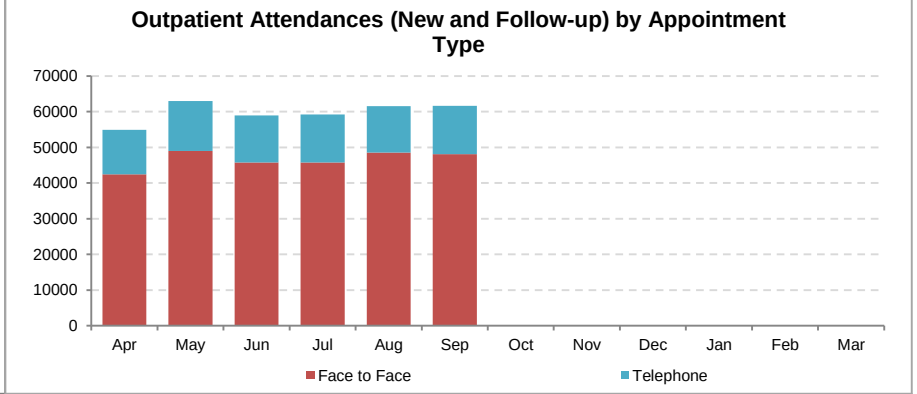


Eastern Services Elective Activity- Referrals and Outpatients









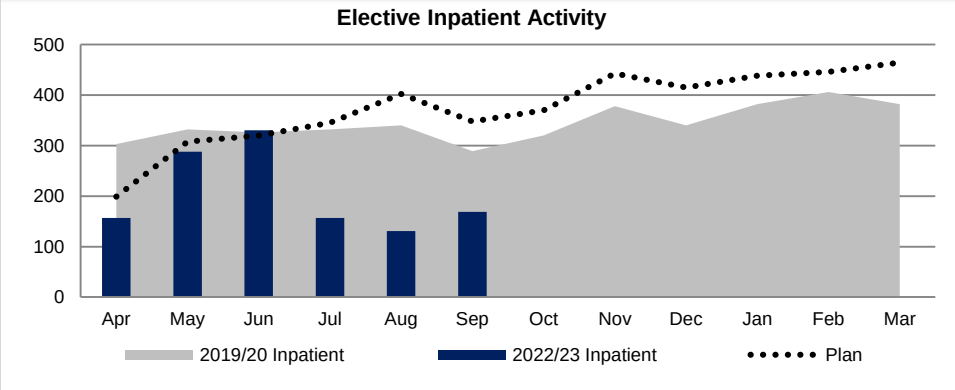
Outpatient activity (new): was 82% of 2019/20 levels compared to 88% in August, with the month on month decrease largely attributed to surgical services(Orthopaedics and General Surgery specifically). This places the position further away from plan, which was expected to increase in relation to Ophthalmology expansion at Axminster and through the Nightingale. These services have now commenced but baseline activity is lower than plan. A detailed exercise is currently underway at specialty level to identify the key drivers of the variance from plan and 2019/20 volumes.

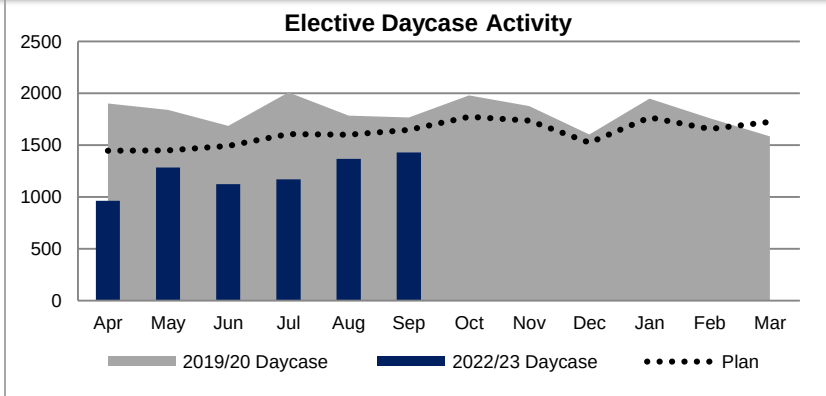
Outpatient activity (follow up): was 140% of 2019/20 activity compared to 147% in August. The significant recovery of the follow-up position, compared to the outpatient new position, continues to be reviewed, but the latest analysis has identified the following:

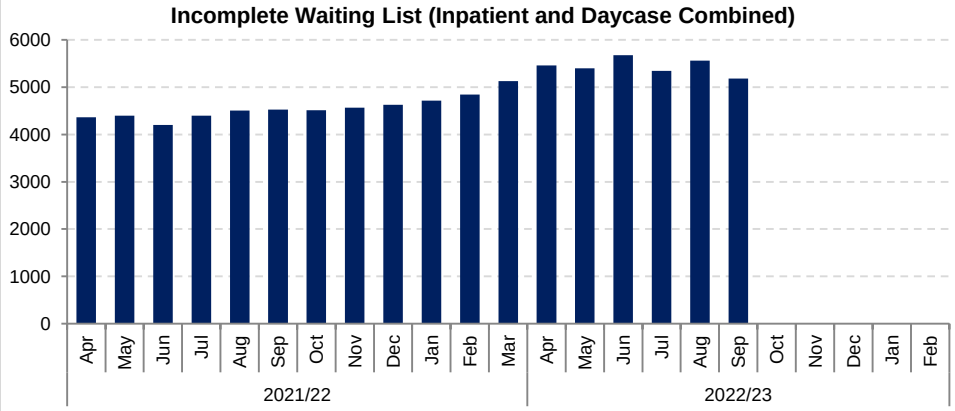
- 2% of activity appears to be recorded as follow-ups but should be reported as new (detailed review, including planned adjustments, underway)
- 12% of activity is reported as midwifery but was not recorded in 2019/20 –the initial position is that this is likely incorrectly recorded but the investigation has not yet concluded
- 13% of activity relates to an increase in community activity vs 2019/20, which can now be recorded more accurately due to the implementation of Epic
- If adjusted, the above position would move from 140% to 102% of 2019/20 –reporting will be adjusted on conclusion of the various workstreams above.

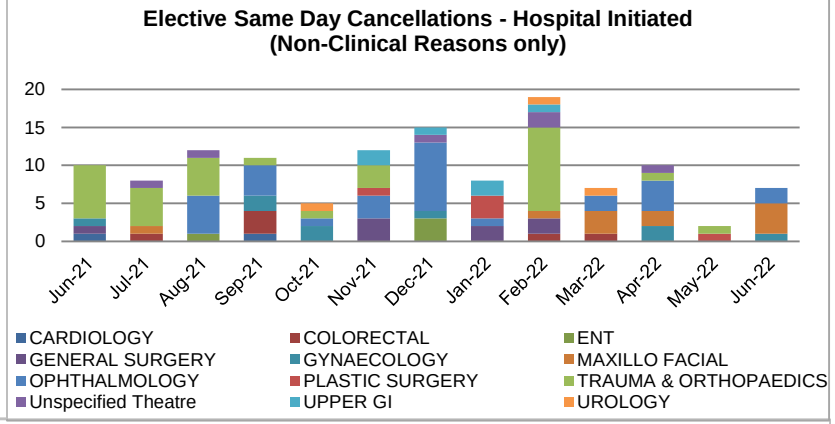
Virtual outpatient activity: was 22% in October, which is consistent with previous months.

Northern Services Elective Activity- Inpatient and Daycase



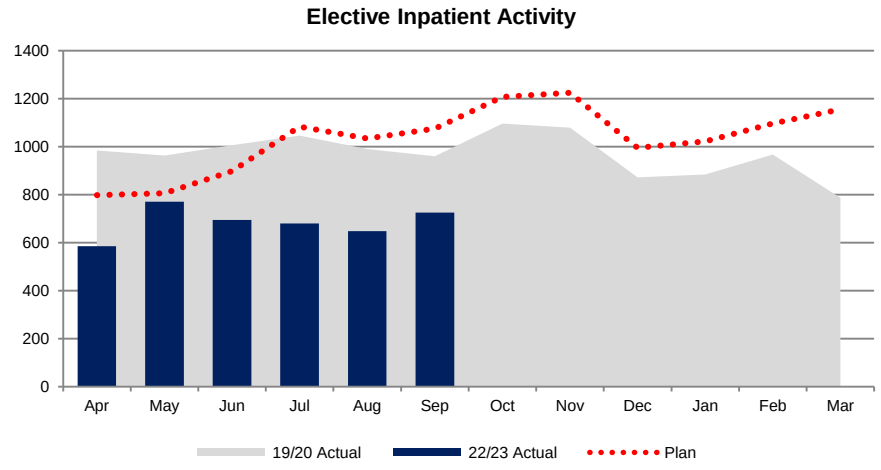


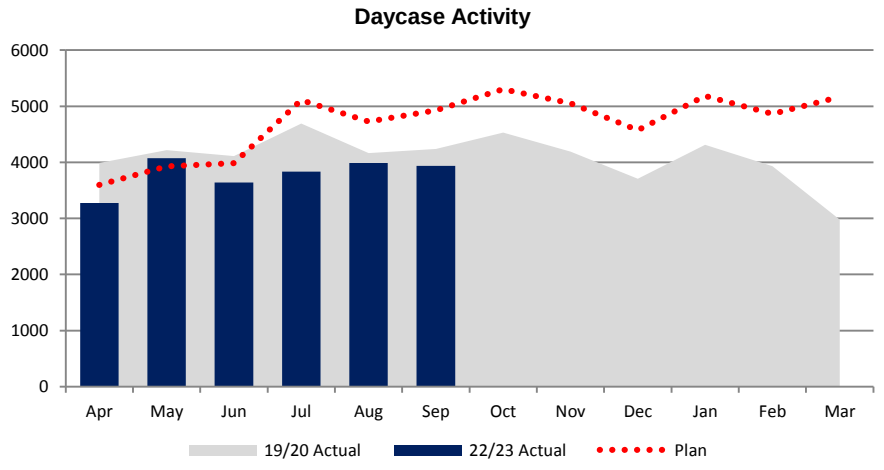




- During September there was an increase in both Elective Inpatient and Elective Day case activity, even though Northern Services continued to experience a high number of escalations due to bed pressures which led to the cancellation of several theatre lists.
- Highest clinical priority patients and long waiting patients continue to be monitored weekly via the Patient Tracking Meeting (PTL).
- Elective Same Day Cancellation data is still unavailable following the implementation of EPIC. However, in late September fewer patients had their planned surgery cancelled due to the unavailability of beds and this has continued into early October.
- Northern services have been excluded from the temporary arrangement of postcode boundaries changing for ambulance conveyancing in recognition of the impact urgent care demand has had on elective surgery at NDDH in recent months.

Eastern Services Elective Activity- Inpatient and Daycase



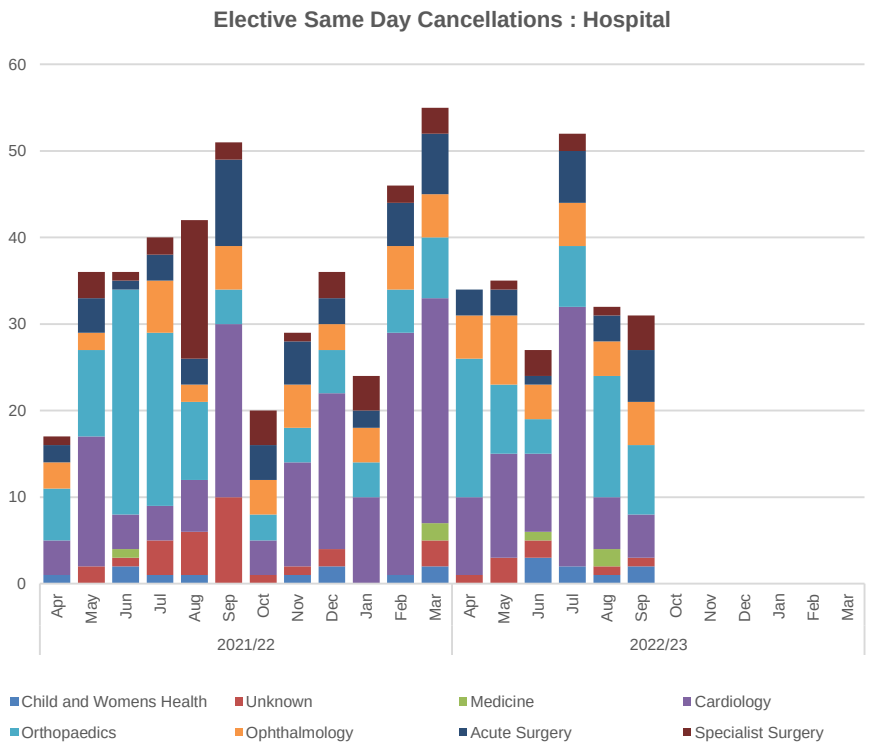


Elective inpatient activity: was 76% of 2019/20 in September, which is an improvement on 65% in August. The major area of improvement was in Orthopaedics, which increases seen across PEOC and the Nightingale.

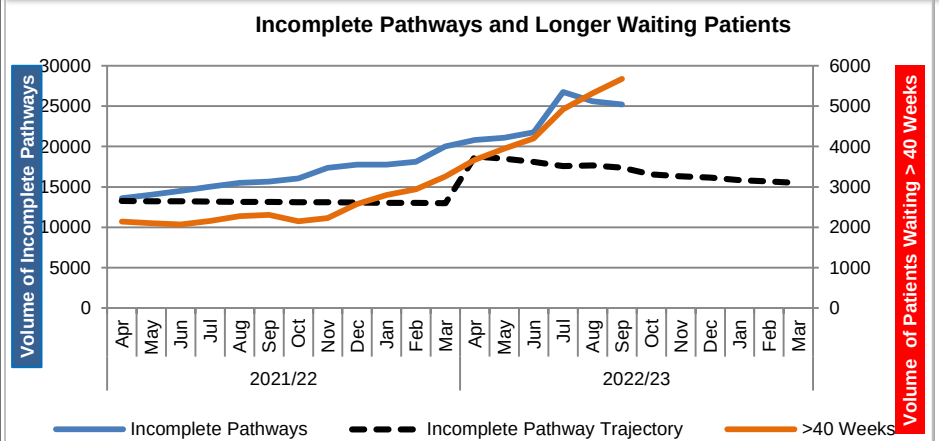
Daycase activity: was 93% of 2019/20 in September, which is a slight reduction on 96% in August.

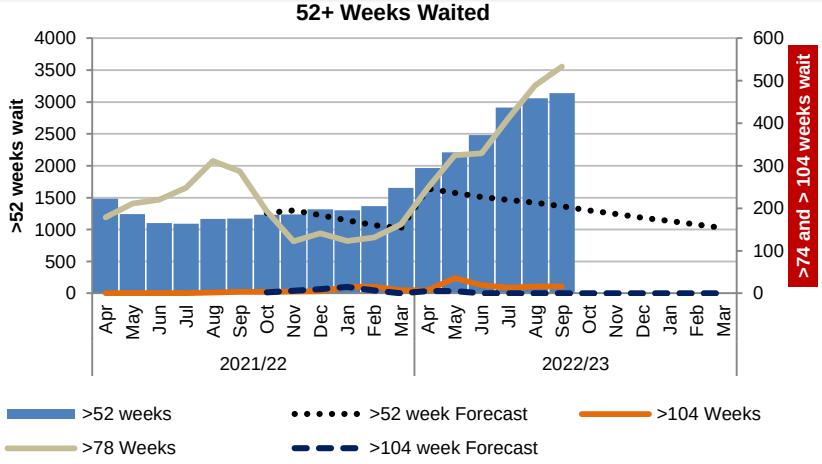
Elective inpatient and daycase activity is still considerably lower than planned levels. Further detailed review is currently underway as part of a mid-year stocktake, but the major contributory factors continue to be:

- Theatre staffing: theatre recruitment / capacity has been improving but not yet at full capacity due to staffing constraints. The Nightingale utilisation is expected to further improve from November as a result of further recruitment and an expansion of services to include foot and ankle surgery
- Ringfencing of elective beds: UEC pressures and high numbers of delayed discharges continue to place pressure on elective beds, particular across surgery and cardiology. The current month saw an increase in Cardiology elective activity as 6 beds were ringfenced for the service. Plans are in development to extend this ringfence to increase elective capacity / activity.



Northern Services Elective Activity- Long Waiting Patients





Series ">78 Weeks" Legend Entry

Specialty		2022/23																	
		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
> 40 weeks	T & O	525	457	426	459	478	480	415	482	525	599	600	675	765	812	814	951	1008	1075
	General Surgery	39	51	51	56	71	78	71	74	75	81	80	102	117	115	126	141	146	146
	Dermatology	56	62	58	71	97	126	133	151	186	215	232	277	316	335	349	387	406	413
	Gynaecology	160	159	170	187	198	192	191	180	203	203	207	210	227	263	312	381	465	501
	Neurology	95	114	125	119	89	67	54	75	94	114	125	131	154	169	158	192	193	189
	Colorectal	63	58	61	57	70	73	60	57	66	54	57	52	52	49	50	-	-	-
	Cardiology	16	20	16	10	12	14	17	21	25	30	43	49	54	69	92	144	174	225
	Ophthalmology	605	613	620	654	694	709	690	657	798	838	897	977	1088	1102	1149	1255	1252	1252
	Other	345	323	309	307	304	314	286	293	338	379	390	446	510	627	699	1043	1233	1413
	Upper GI	64	54	52	51	58	59	58	52	60	67	63	52	61	64	74	-	-	-
	Urology	176	186	184	188	201	198	174	187	208	220	244	290	329	344	376	428	443	462
	Grand Total	**2144**	**2097**	**2072**	**2159**	**2272**	**2310**	**2149**	**2229**	**2578**	**2800**	**2938**	**3261**	**3673**	**3949**	**4199**	**4922**	**5320**	**5676**

- The impact of urgent care demand and complex discharges delays continues to impact on elective care. Day Surgery and beds on the elective surgical ward (Lundy Ward) have been regularly used to support urgent care demand which has unfortunately led to the cancellation of a number of patients planned surgery. This position started to improve in late September and reset week further supported this in early October.

Northern Services Elective Activity- Long Waiting Patients Continued

Specialty		2021/22												2022/23					
		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
> 52 weeks	T&O	416	327	260	225	221	222	225	244	267	312	344	391	460	522	529	594	590	594
	Neurology	35	44	52	55	44	32	31	36	29	28	40	43	57	74	69	93	110	116
	Cardiology	8	6	5	1	2	7	12	12	10	10	11	15	13	23	27	37	42	72
	Ophthalmology	492	393	311	323	458	373	371	367	401	390	336	459	561	632	720	865	824	823
	Other	425	352	353	366	315	414	438	454	490	436	504	594	694	757	903	1055	1208	1248
	Urology	108	122	118	124	127	134	120	126	119	125	132	153	182	204	235	268	284	284
	Grand Total	**1484**	**1244**	**1099**	**1091**	**1167**	**1174**	**1230**	**1235**	**1316**	**1301**	**1367**	**1655**	**1967**	**2212**	**2483**	**2912**	**3058**	**3137**

Specialty		2021/22												2022/23					
		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
> 78 weeks	T&O	47	49	55	51	63	62	42	23	22	41	21	33	65	126	97	114	137	140
	Neurology	0	2	1	1	3	9	5	3	2	3	3	3	5	6	5	7	10	7
	Cardiology	0	0	0	1	0	1	0	0	0	0	0	0	2	1	0	0	1	1
	Ophthalmology	72	82	78	93	106	86	45	18	16	19	17	27	44	33	43	58	54	85
	Other	39	50	58	69	98	90	79	49	72	28	58	62	89	106	134	170	204	238
	Urology	21	28	28	33	41	39	23	29	29	32	32	37	43	53	50	63	65	62
	Grand Total	**179**	**211**	**220**	**248**	**311**	**287**	**194**	**122**	**141**	**123**	**131**	**162**	**248**	**325**	**329**	**412**	**471**	**533**
> 104 weeks	T&O	0	0	0	0	0	1	0	0	0	1	0	3	2	28	13	5	6	5
	Neurology	0	0	0	0	0	0	0	1	1	0	0	1	1	1	1	1	1	0
	Cardiology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Ophthalmology	0	0	0	0	0	0	0	1	1	5	4	0	1	0	0	1	2	2
	Other	0	0	0	0	2	1	3	2	3	9	10	3	3	4	1	2	2	4
	Urology	0	0	0	0	0	1	0	0	0	0	1	0	0	3	4	4	4	5
	Grand Total	**0**	**0**	**0**	**0**	**2**	**3**	**3**	**4**	**5**	**15**	**15**	**7**	**7**	**36**	**19**	**13**	**15**	**16**

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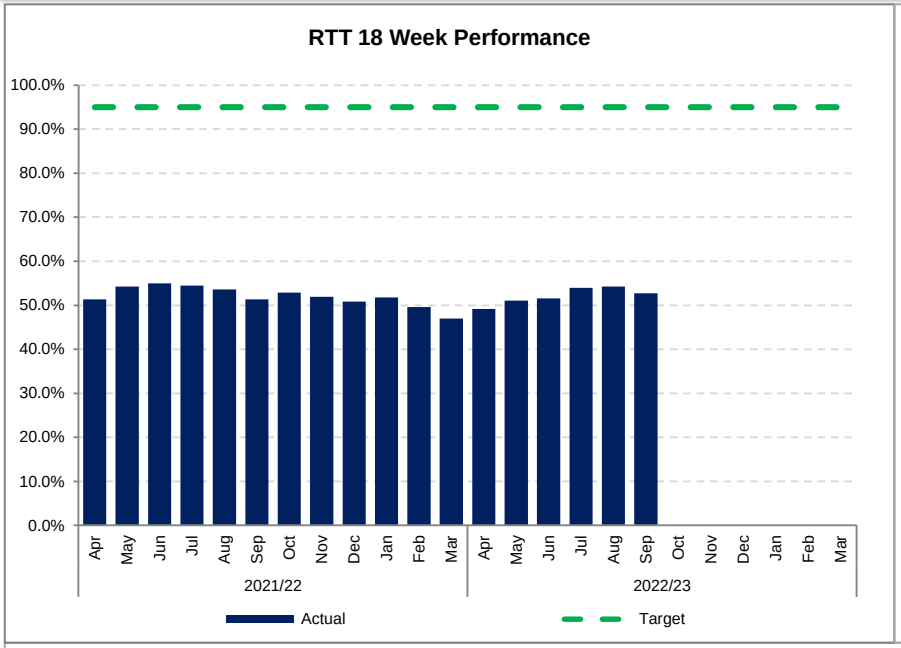
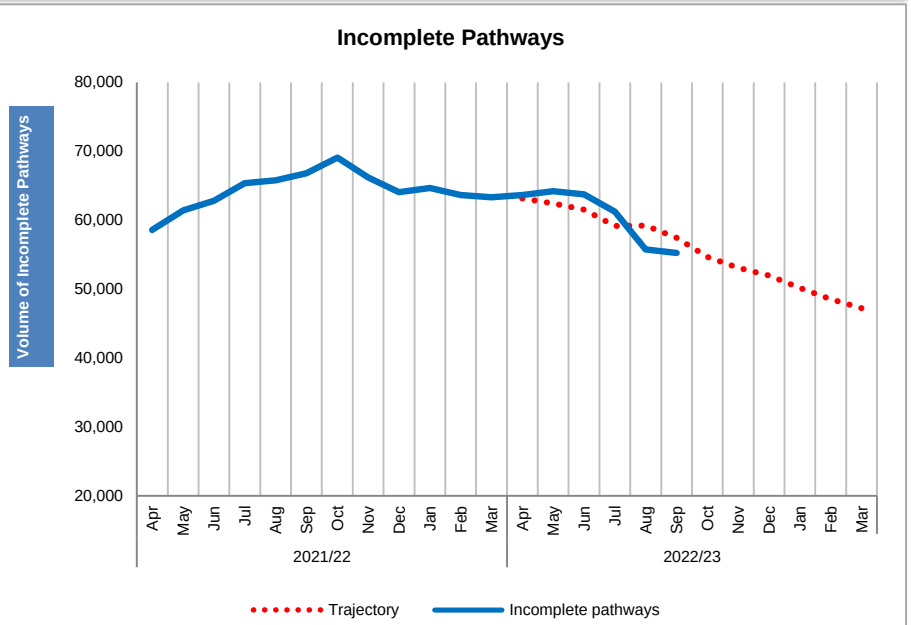
- Northern services continue to support the reduction in the Trust's overall number of patients waiting over 104 weeks for treatment by transferring some patients from Eastern services for treatment at NDDH. Patient choice (to delay surgery) remains a contributory factor to this position.
- The October reset week has been successful in re-establishing elective throughput and trajectories for delivering 104 week and 78 week wait performance are being revised as part of the 10 week plan being worked up with NHSE/I colleagues

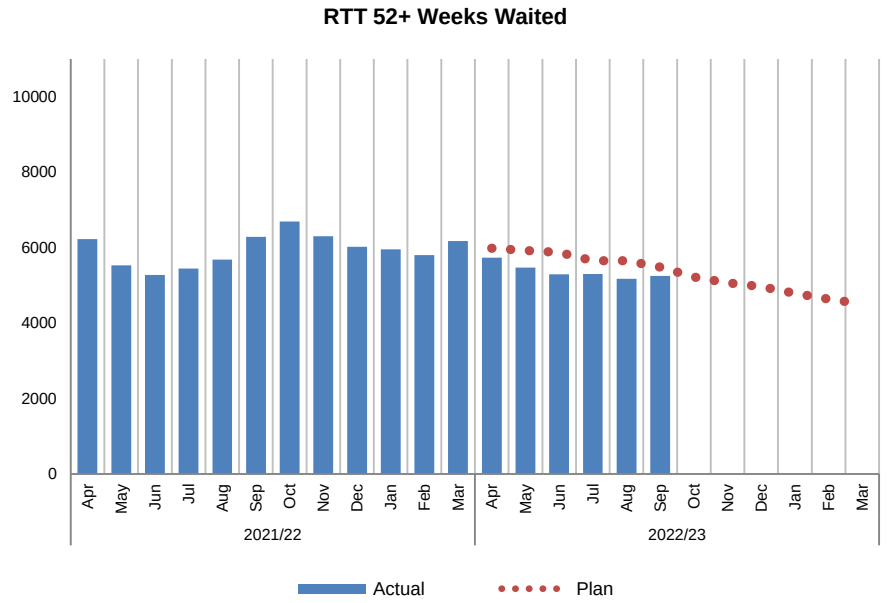
Eastern Services Elective Activity- Inpatient and Daycase

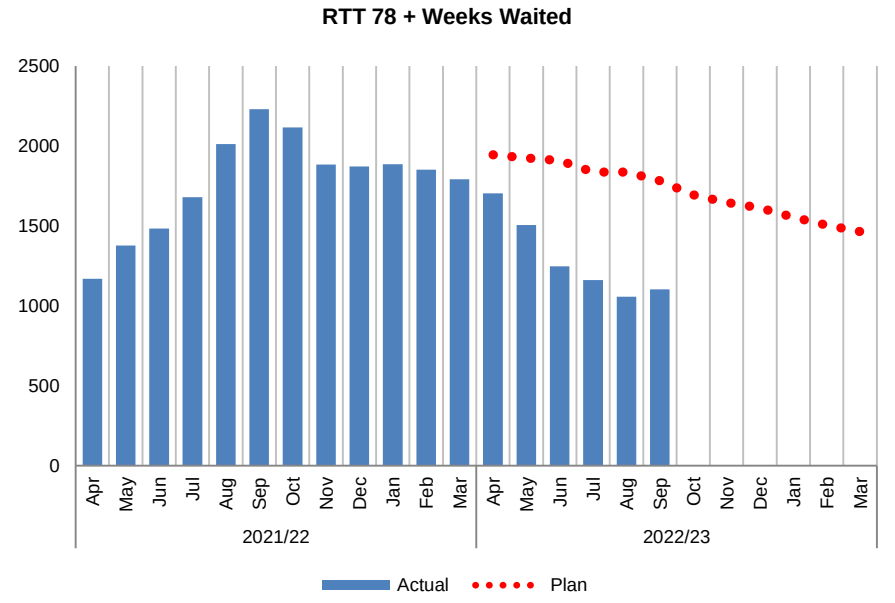


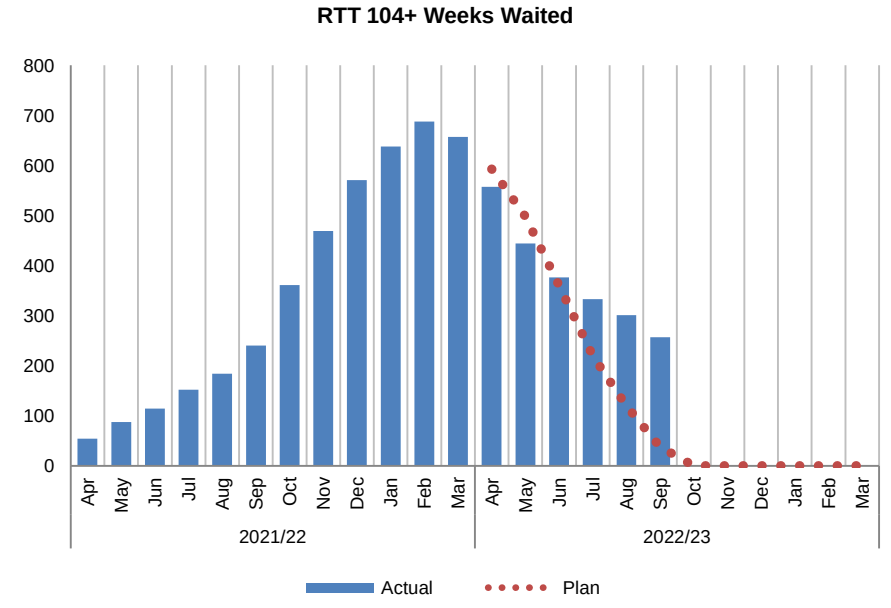


Incomplete pathways continue to track in line with the overall trajectory, although the improvement (reduction) was marginal in September, mainly attributed to General Surgery, which is currently behind plan due to capacity issues. Additional pathway validation work continues, with targeted external resource. The support has been focusing on Eastern incomplete pathways but will soon be re-attributed to Northern services as the Eastern project moves to completion.

Eastern Services Elective Activity – Long Waiting Patients







52+ and 78+: the positions deteriorated (increased) slightly between August and September, mainly attributed to the General Surgery group (Vascular, colorectal, Upper GI), where there are capacity constraints in specific complex areas.
104+: the position continues to improve from 301 to 257 at the end of September. Challenges remain with General Surgery (as noted above) and maintaining the positive run rate for Orthopaedics.

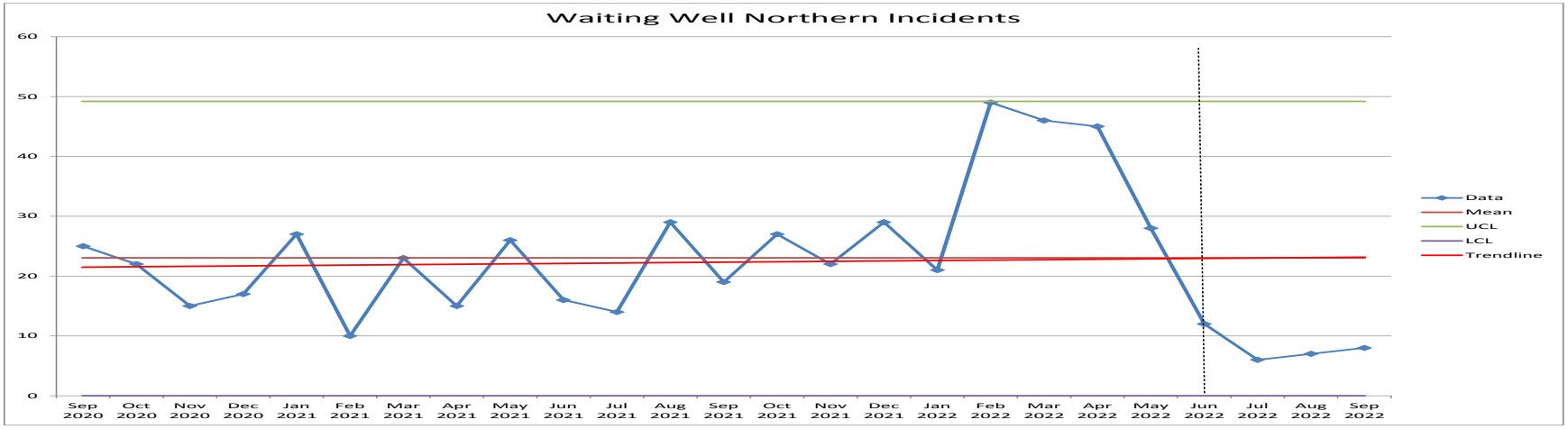
As part of the Devon healthcare system's elective care work programme with NHSE, the Trust, working in conjunction with Devon ICB and NHSE regional colleagues, will across the next 10 weeks be developing and implementing further actions to reduce the waits for treatment for patients with extended waits, and to agree a sustainable plan for the future. Further opportunities are being explored, with a particular focus on orthopaedic patient pathways, regarding further options to eliminate 104 week waits.

Eastern Services Elective Activity- Long Waiting Patients

	Specialty	2021/22												2022/23					
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
40+ weeks	Orthopaedics	2344	2347	2296	2216	2195	2130	2081	2065	2153	2161	2166	2306	2281	2181	2061	2248	2268	2270
	Cardiology	616	625	679	751	838	894	880	770	758	751	786	873	827	854	875	801	840	802
	General surgery	909	916	860	912	791	845	663	555	405	350	277	208	187	141	125	124	100	89
	Ophthalmology	1728	1756	1906	2163	2486	2660	2622	2461	2652	2818	2901	3158	2804	2961	2350	1507	1186	1057
	ENT	395	369	390	340	323	374	464	465	454	402	382	383	449	471	448	370	392	456
	Gastroenterology	338	337	393	579	637	855	857	974	862	969	850	804	640	714	521	760	319	254
	Plastic Surgery	214	254	265	306	321	322	317	306	300	301	311	297	299	318	268	253	248	229
	Respiratory Med	238	249	267	297	291	296	278	238	220	201	200	224	264	318	334	304	293	315
	Urology	283	276	318	278	251	242	286	265	298	293	298	303	271	232	180	195	167	183
	Colorectal Surgery	592	587	559	571	626	627	697	720	733	782	816	845	885	936	919	910	851	865
	Upper GI	115	123	117	136	150	145	170	159	154	161	176	182	190	178	167	183	175	175
	Other	1080	1192	1315	2000	2517	3041	2659	2200	2223	2331	2375	2528	2673	2753	2770	2885	3034	3473
	Total	8852	9031	9365	10549	11426	12431	11974	11178	11212	11520	11538	12111	11770	12057	11018	10540	9873	10168
52+ weeks	Orthopaedics	1859	1720	1628	1535	1482	1533	1595	1617	1610	1537	1492	1568	1499	1416	1364	1419	1374	1395
	Cardiology	414	399	417	407	418	491	530	484	442	414	377	416	429	457	487	520	545	499
	General surgery	594	555	539	627	621	788	629	517	368	312	233	167	137	106	95	91	66	66
	Ophthalmology	1315	1013	941	1046	1212	1399	1489	1456	1610	1404	1365	1608	1345	1164	929	858	688	591
	ENT	276	222	211	183	191	200	222	201	215	220	211	226	228	226	221	204	199	234
	Gastroenterology	178	130	97	143	132	240	323	326	283	298	319	374	222	163	157	108	96	64
	Plastic Surgery	145	154	158	160	186	208	253	228	199	194	195	199	205	208	177	168	158	150
	Respiratory Med	159	134	126	127	147	156	164	124	127	127	121	140	154	134	130	143	162	183
	Urology	198	186	204	170	156	152	162	110	116	124	138	169	163	142	126	129	94	85
	Colorectal Surgery	445	437	437	448	455	451	498	514	526	553	517	523	526	593	609	618	546	512
	Upper GI	80	86	76	81	94	95	114	99	91	102	107	106	104	104	109	113	101	101
	Other	561	495	438	518	588	571	712	623	434	667	727	677	719	760	885	927	1144	1372
	Total	6224	5531	5272	5445	5682	6284	6691	6299	6021	5952	5802	6173	5731	5473	5289	5298	5173	5252
78+ weeks	Orthopaedics	581	654	697	698	761	810	782	775	843	846	827	820	773	684	584	528	472	450
	Cardiology	108	111	120	126	152	165	175	137	121	134	138	133	153	149	134	129	130	115
	General surgery	36	49	74	132	205	340	253	185	141	109	95	98	68	43	38	37	24	26
	Ophthalmology	61	70	91	137	279	384	343	264	246	307	325	331	271	223	155	140	94	78
	ENT	44	50	57	68	79	69	75	64	64	51	36	27	26	21	24	32	37	68
	Gastroenterology	14	19	17	17	10	12	10	13	8	12	14	33	19	18	13	6	7	6
	Plastic Surgery	30	36	34	40	56	75	76	78	58	54	50	58	58	55	37	31	38	41
	Respiratory Med	12	18	25	28	34	35	20	6	10	9	17	20	32	26	26	22	24	22
	Urology	48	61	64	48	52	43	44	23	24	21	18	18	21	13	14	13	12	13
	Colorectal Surgery	128	172	175	195	219	233	250	252	260	248	221	183	188	183	149	153	127	135
	Upper GI	23	22	21	23	34	34	35	29	22	19	21	22	30	22	19	28	22	25
	Other	85	115	108	167	132	31	54	58	76	77	91	48	65	68	55	43	71	124
	Total	1170	1377	1483	1679	2013	2231	2117	1884	1873	1887	1853	1791	1704	1505	1248	1162	1058	1103
104+ Weeks	Orthopaedics	23	35	47	65	81	114	178	252	340	397	437	445	364	299	261	230	191	162
	Cardiology	6	12	23	28	25	27	46	51	49	59	63	57	58	45	32	31	22	10
	General surgery	2	4	4	7	7	25	11	10	14	16	12	11	15	7	8	9	6	5
	Ophthalmology	0	0	0	0	1	4	6	12	18	18	30	24	13	8	2	6	9	9
	Colorectal Surgery	19	23	28	34	38	41	54	64	75	87	80	75	67	63	46	42	45	44
	Upper GI	1	2	0	2	3	3	7	4	4	2	2	3	2	4	1	1	1	1
	Other	3	11	12	16	29	26	59	76	71	59	64	42	38	18	26	14	27	26
	Total	54	87	114	152	184	240	361	469	571	638	688	657	557	444	376	333	301	257

Northern Services Waiting Well

September 2022 Waiting Well Northern Incidents	None	Minor	Moderate	Total
New	1	2	0	**3**
Surgery	1	0	0	**1**
Follow up delay	0	1	0	**1**
Diagnostic request delay	1	2	0	**3**
Total	**3**	**5**	**0**	**8**



Four of the eight incidents recorded during September 2022 relate to Cancer Services.
Most of these incidents were raised around cancellations of appointments due to capacity issues, all of these patients were rebooked within a week of cancelled appointment. One incident was raised in relation to a delay in diagnosis. The lead for Upper GI has reviewed the case and has confirmed that it is unlikely that there is anything we could have changed in this situation.
There were no Moderate or above incidents reported during September.

Eastern Services Waiting Well

Patient survey support key aims

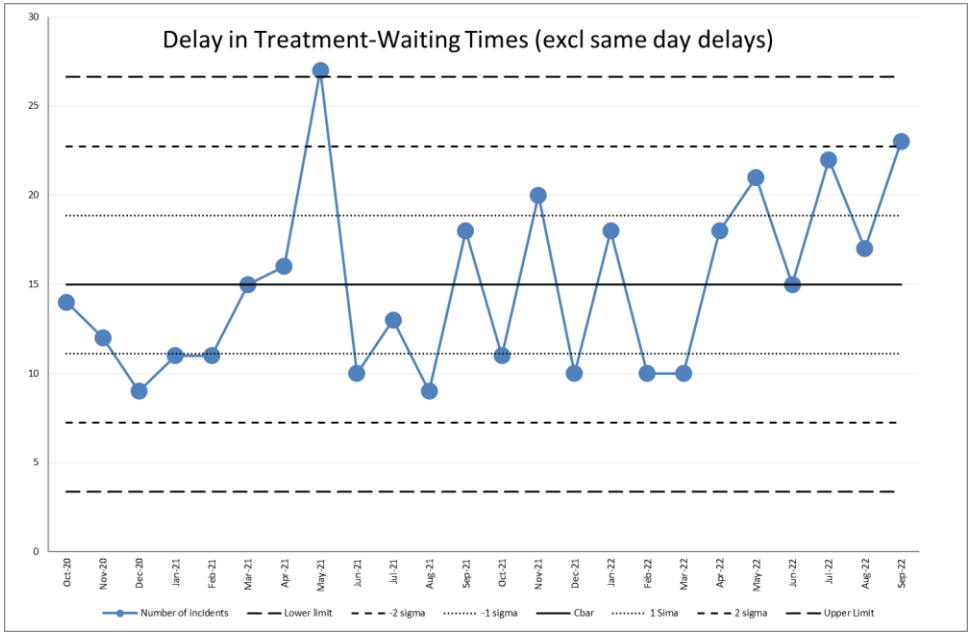
- Identify any patients who no longer want or need to be on a waiting list (patient validation)
- Ensure patients are empowered to seek appropriate help from the health system when needed
- Refer any identified patients that need further community support to local voluntary sector organisation(s)

Patients Contacted	9860
Completed Survey	7301
No response	1508
Work In Progress	1051
Escalated to clinician for review	2372
Referred for lifestyle support and advice	1085
Removed from WL	1342

Current Survey is focussed on not yet seen patients, and patients on a surgical WL. Work is ongoing to develop a system to support validation of patients on follow up pending lists. Work is underway with the ICB to develop the current survey to support with Mutual aid validation.

Eastern Services Waiting Well

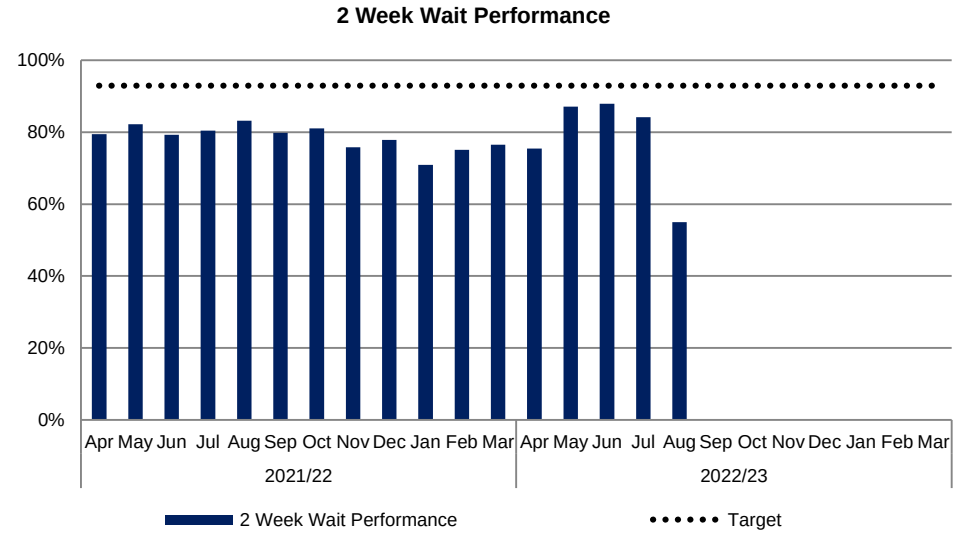
Across the same time period in Eastern 23 incidents were reported for September 2022, these are broken down by the level of harm against stage of pathway below.

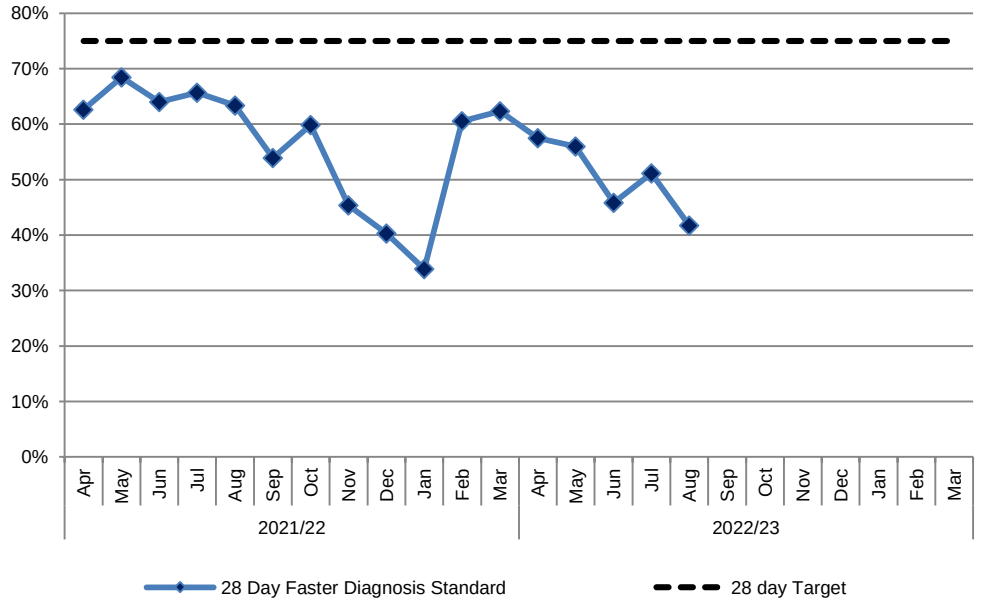


	None	Minor	Moderate	Major	Catastrophic	Total
New	5	3				8
Follow up delay	7					7
Diagnostic request delay	2	2				4
Surgery	4					4
Total	18	5	0	0	0	23

All incidents that occurred in the period reported by 06/10/2022 we graded as None or Minor as outlined in the table above. The incidents remain within normal variation.

Northern Services Cancer 14 and 28 Day





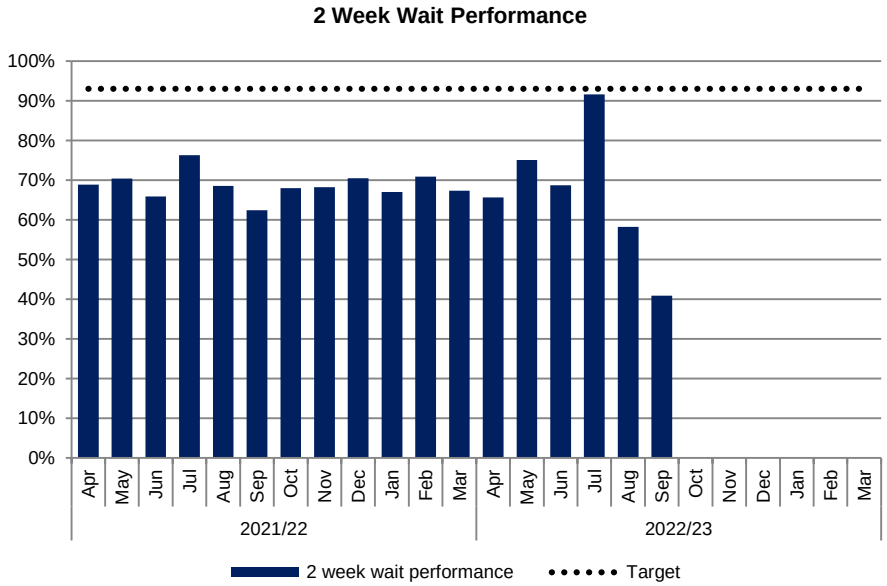
2 Week Wait Performance

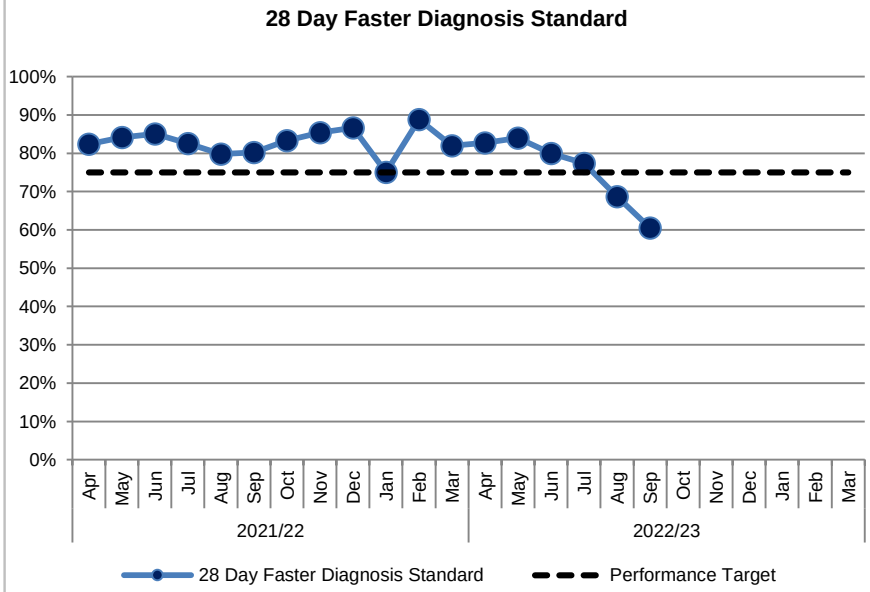
- The deterioration in performance was largely due to the significant challenges in the high volume speciality of Dermatology as a result of transition from System1 to Epic. First 2 week wait referrals were unable to be triaged and appointments booked. Secondly, the number of appointments and procedures were reduced as part of the Go Live plans.
- As the challenges with Epic in Dermatology are being resolved additional clinics have been established and insourcing is commencing on the weekend of 8th/9th October. In the first instance this additional capacity will be utilised to treat the longest waiting patients i.e those waiting over 62 days for treatment.
- Gynaecology have also run 4 additional 2WW clinics in September and a further 3 are planned in October. As of October patients are being booked within 14 days and performance is expected to recover going forward.

28 Day Faster Diagnosis Standard

- The 2ww performance is directly impacting on ability to confirm diagnosis within 28 days.
- Several tumour sites are still struggling to achieve the 28 day faster diagnosis target and actions to support these services are being monitored as part of the Trust's Cancer Recovery Action Plan.
- Colorectal faster diagnosis breaches have significantly increased as a result of challenges with consultant and clinical nurse specialist appointment availability and access to endoscopy for colonoscopy diagnosis. A newly appointed Patient Navigator started in post on 1st September, providing dedicated support in tracking and escalating pathway delays in colorectal.
- Urology performance remains below target, however work has been completed to ensure that TURBT have been prioritised. Improvement in performance is expected by the end of September.
- Skin performance is anticipated to decrease in the short term due to the difficulties on Epic implementation and improvement in Dermatology is expected to take longer.
- Hysteroscopy capacity continues to be the main challenge in achieving 28 day FDS performance in Gynaecology. 77 additional patients have been seen since April however this remains an area of concern. Conversation with Peninsula Cancer Alliance regarding funding for further additional capacity.

Eastern Services Cancer 14 and 28 Day





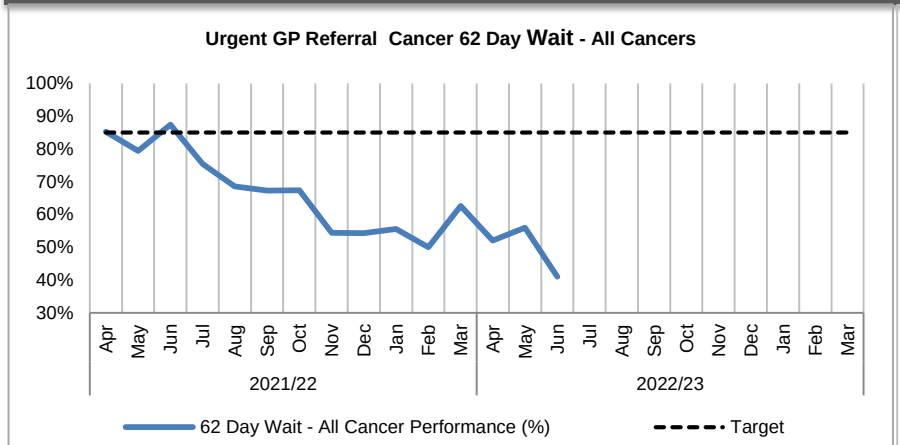
2 Week Wait Performance

- The increase in the volumes of referrals experienced throughout 2022/23 continues to be the main challenge affecting 2WW Performance across all tumour sites with a consistent increase of 15% for the first nine months of 2022 over the same period in 2021.

28 Day Faster Diagnosis Standard

- Last month the August performance was reported as 59.7% but it was adversely affected by delays in validation of the pathways caused by staff shortages. The inclusion of more pathways for August has caused reported performance to increase as anticipated to 68.7%, however, the total number of 28 day pathways remains 25% lower than expected for the month due to the ongoing staffing issues. Overall the increased demand and workforce gaps remain our biggest challenge in improving our performance, however we are reviewing tumour site level positions and working with the divisions to understand further options. The next slide sets out some of the actions in place to improve the diagnostic phase.
- Initial performance for September based on around two thirds of the month's pathways is just over 60%, but again is expected to be under-reporting the true performance.

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



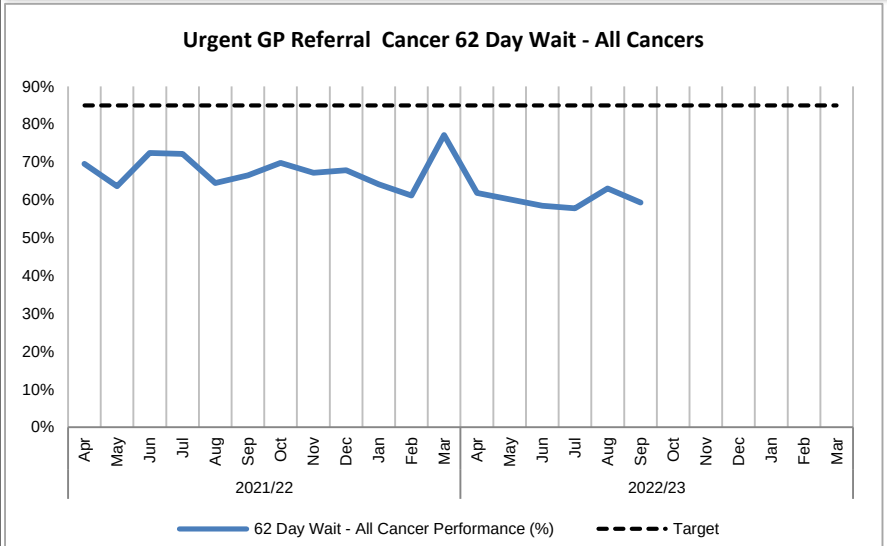
- There continue to be challenges in reporting 62 and 31 day performance due to data quality issues within Epic. Work continues to resolve these issues and return to regular reporting as soon as possible, this is being overseen by a weekly Task and Finish Group as well as multiple sub-groups.
- However, the number of patients on active cancer pathways waiting more than 62 days has reduced from 415 at the start of September to 284 at the start of October. The tumour sites with the largest number of patients waiting over 62 days are Dermatology, Urology and Colorectal. It is worth noting that Breast had no patients waiting over 62 days which represents good progress.
- Twice weekly meetings continue to review recovery plans for Dermatology – including the sourcing of additional capacity through weekend operating.
- Actions to recover the urology and colorectal positions are in place as part of the Caner Recovery Action Plan and are monitored at the Norther Cancer Steering Group.

Cancer - 14,31 & 62 Day Wait

Performance(%) and Number of Breaches		Target	2021/22 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022/23 Apr	May	Jun	Jul	Aug
14 Day	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%
	All Urgent (N)		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
	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%		
	Symptomatic Breast (N)		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		
31 Day	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%		
	All Decision To Treat (N)		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		
	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%		
	Subsequent – Surgery (N)		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		
	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%		
	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		
62 Day	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%	
	All Screening Service (N)		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	
	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%		
	Consultant upgrade (N)		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		
28 day	28 Ref to diagnosis (%)	N/A	62.60%	68.42%	63.98%	65.65%	63.38%	53.89%	59.82%	45.36%	40.26%	33.89%	60.55%	62.34%	57.47%	56.00%	45.80%	52.34%	40.90%
	28 day Ref to diagnosis (N)		236.0	204.0	242.0	237.0	229.0	321.0	233.0	394.0	413.0	492.0	292.0	329.0	254.0	268.0	241.0	173.0	263.0

Eastern Services Cancer 62 Day

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



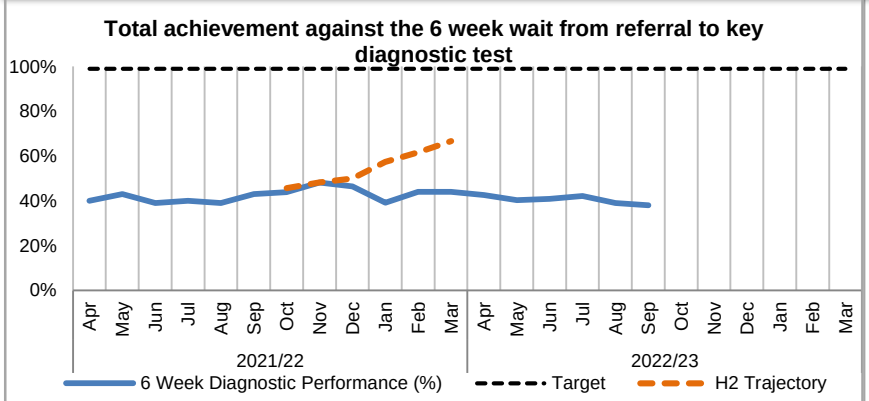
The unvalidated data for September saw a drop back to 59.3%, significantly lower than target of 85%.

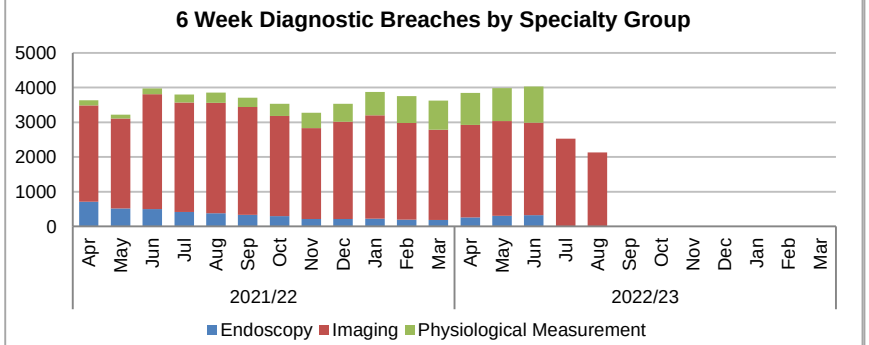
- Skin was the only tumour site to pass the 62 Day Target in September.
- Colorectal and Urology tumour sites together make up 60% of the 62+ day backlog.
- Radiology and Histology delays are contributing to the decrease in performance across many tumour sites. A plan is in place to increase histopathologist posts early 2023/24, in-house training of juniors underway with a view to filling existing and future histopathologist consultant vacancies with minimum delay.
- Delays in Urology are due to clinic and flexi cystoscopy capacity. Various staffing solutions are planned including ERF and other funding used to support additional registrars starting mid-October, use of CNS capacity to undertake biopsies and triage, increased use of surgical care Practitioners for flexi-cystoscopies
- Theatre capacity is an issue for Colorectal. An increase in capacity will start to address the backlog from November and the 62 Day performance in the following months.
- Of the open pathways at the end of September, 9.9% were 63 days or longer. This constitutes a decline of 0.5% since the position at the end of August and remains high compared with the NHS EI benchmark of 6.4%.

Cancer - 14, 31, 62 & 104 Day Wait

	Performance(%) and Number of Breaches	TARGET	2021/22 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022/23 Apr	May	Jun	Jul	Aug	Sep
14 Day	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%	75.1%	68.7%	91.7%	58.3%	40.9%
	All Urgent		650	600	833	514	665	841	702	723	642	622	580	781	759	601	677	151	1019	1437
	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%	36.8%	86.2%	93.1%	62.9%	16.7%
	Symptomatic Breast		52	57	63	29	32	57	49	47	58	48	34	65	34	43	4	2	13	30
31 Day	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%	87.2%	87.4%	84.7%	89.6%	84.6%
	All Decision To Treat		9	7	18	18	19	24	14	29	22	23	19	19	31	40	35	36	19	42
	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%	63.8%	67.1%	76.0%	75.9%	68.6%	59.0%
	Subsequent - Surgery		12	15	17	9	16	11	12	16	24	19	19	29	29	26	25	20	16	32
	Subsequent - Radiotherapy (%)	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%	95.8%	98.8%	97.4%	97.2%
	Subsequent - Radiotherapy		1	0	4	1	2	1	0	4	0	3	1	1	0	1	4	1	2	3
	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%	100.0%	100.0%	100.0%	97.1%	100.0%
	Subsequent - Anti-Cancer Drug		3	1	0	0	0	0	1	1	1	2	0	0	0	0	0	0	2	0
62 Day	All Screening Service (%)	90%	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%	16.7%	33.3%	0.0%	0.0%	25.0%
	All Screening Service		2	5	5.5	3	5.5	4	0	5.5	6	2	5	3	3.5	2.5	2	2	2	9
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	69

Northern Services Diagnostics - *Fifteen key diagnostic tests*





Following the implementation of Epic on the 9th July only Radiological diagnostic performance on CRIS had previously been included. Modalities with the exception of hearing assessments in audiology and echocardiography are now able to be reported. However there are data quality issues still being worked through

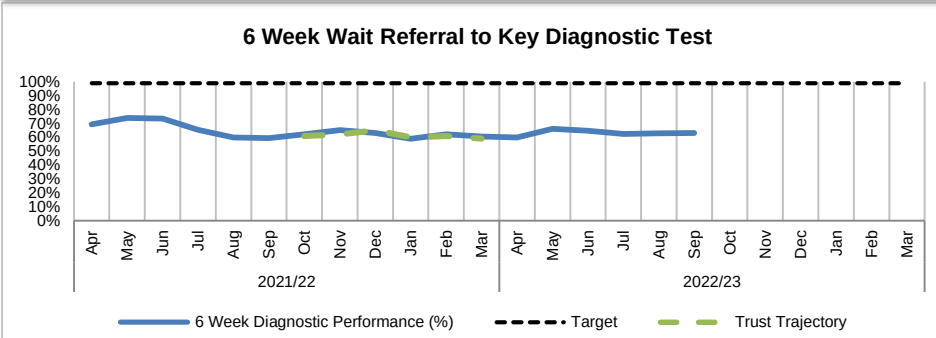
Key issues at modality level:

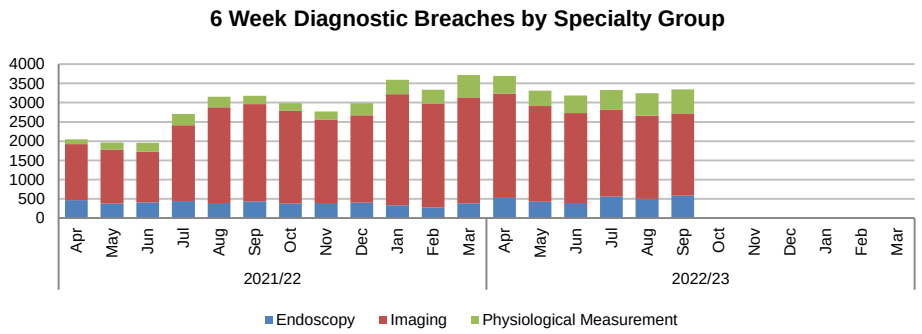
- Whilst there are differences amongst modalities, the number of patients waiting over 6 weeks for a radiological diagnostic test has decreased over the last quarter.
- MRI –Scans are being offered within 2-3 weeks and no patients are waiting over 6 weeks.
- CT – non-cardiac CT scans are now being offered within 6 weeks. Extra cardiac CT lists have been arranged where staffing is available. Potential lists at RD&E are also being explored
- U/S- Outsourcing capacity is currently being explored and meetings with a couple of companies have been arranged. Recruitment of a locum has so far been unsuccessful.
- DXA – An SLA has been set up with Taunton. However, due to the difficulties in sourcing patients to attend these clinics it has been decided there will only be 1 list per month. Discussions are also taking place with Eastern Services around support being provided for DXA scans.
- Endoscopy - Consultant Gastroenterologist vacancies continue to be the main constraint, meaning a reliance on insourcing. Since the implementation of Epic there have been both planned and unplanned reductions of insourced lists. Other insourcing providers are being explored. Further work is to be undertaken to correct data quality issues.
- Urodynamics: Staffing challenges within the Eastern Urodynamics team has led to a reduction of sessions at NDDH. Whilst patients are offered to option to travel to RD&E many patients wait to have the test at NDDH. Divisional teams are working collaboratively to resolve this. Further work is to be undertaken to correct data quality issues.

		Achievement against the 6 week wait from referral to key diagnostic test																	
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
Imaging	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%
	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%
	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%
	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%
Physiological Measurement	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%			
	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%			
	Cardiology - electrophysiology	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	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%
	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%
	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%
Endoscopy	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%
	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%
	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%
	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%
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%	38.0%

Eastern Services Diagnostics

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

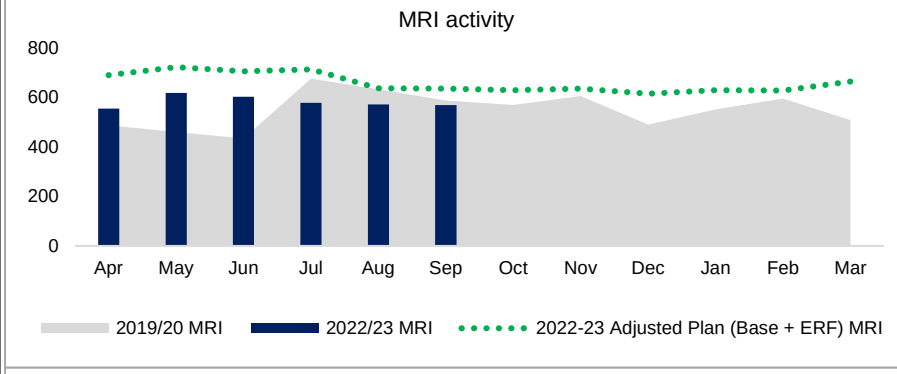


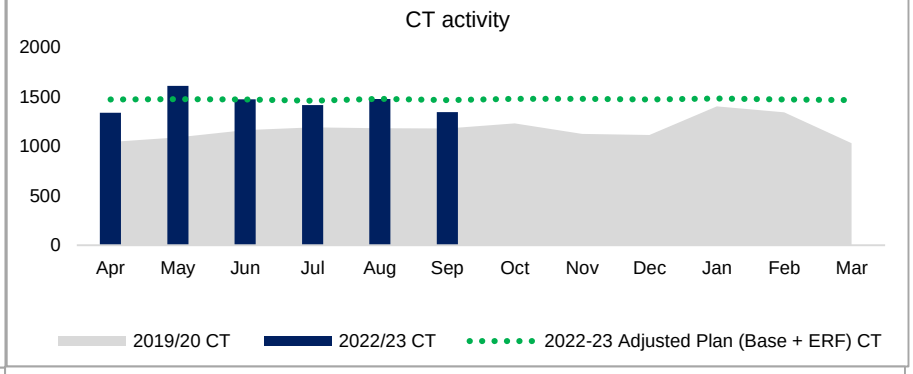


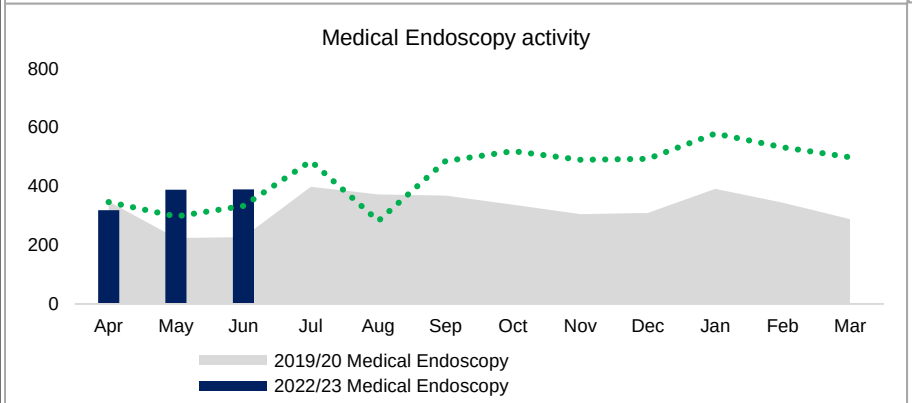
At the end of September, 63.2% of patients on the diagnostic waiting list had waited less than 6 weeks.

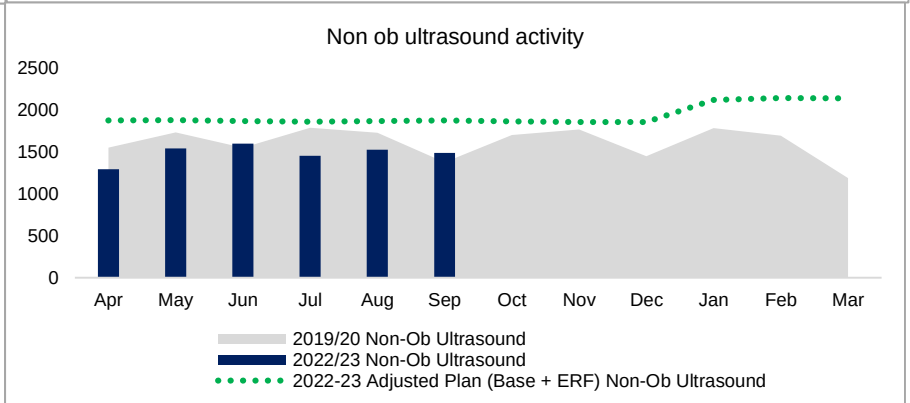
Area	Diagnostics By Specialty	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Endoscopy	Colonoscopy	64.8%	54.3%	52.0%	66.9%	73.3%	67.0%	57.1%	64.7%	66.5%	64.0%	63.5%	58.3%
	Cystoscopy	62.5%	67.1%	86.3%	86.0%	71.9%	88.6%	83.1%	82.8%	95.2%	91.5%	88.9%	93.2%
	Flexi Sigmoidoscopy	61.6%	61.4%	50.0%	59.1%	74.8%	61.6%	59.6%	73.0%	76.2%	74.6%	74.5%	62.2%
	Gastroscopy	75.1%	75.7%	73.1%	70.5%	76.8%	61.7%	57.2%	68.0%	72.4%	56.7%	68.7%	68.0%
Imaging	Barium Enema	-	-	-	-	-	-	-	-	-	-	-	-
	Computed Tomography	42.0%	51.5%	50.2%	53.8%	48.7%	58.0%	64.3%	73.2%	76.8%	77.1%	81.3%	85.4%
	DEXA Scan	66.0%	84.8%	93.7%	96.0%	99.2%	88.0%	97.8%	97.1%	98.9%	98.4%	98.2%	99.4%
	Magnetic Resonance Imaging	57.4%	61.9%	58.0%	58.1%	65.8%	64.9%	66.3%	73.9%	74.3%	69.6%	69.1%	72.9%
	Non-obstetric Ultrasound	66.2%	67.3%	66.0%	51.6%	56.9%	53.3%	51.6%	55.1%	51.6%	53.1%	52.7%	51.2%
Physiological Measurement	Cardiology - Echocardiography	81.2%	79.6%	75.8%	82.9%	84.1%	88.3%	82.1%	86.2%	80.9%	74.5%	71.4%	72.7%
	Cardiology - Electrophysiology	-	-	-	-	-	-	-	-	-	-	-	-
	Neurophysiology - peripheral neurophysiology	84.0%	84.2%	68.9%	63.9%	71.9%	54.5%	52.9%	73.2%	69.6%	72.5%	67.1%	61.2%
	Respiratory physiology - sleep studies	86.0%	81.9%	71.8%	57.7%	60.5%	65.5%	60.6%	67.6%	68.3%	60.0%	58.6%	65.8%
	Urodynamics - pressures & flows	93.3%	84.8%	76.7%	38.3%	35.2%	29.6%	26.0%	30.1%	30.3%	34.5%	28.6%	26.9%
Total		62.3%	65.1%	63.0%	59.0%	62.1%	60.5%	60.0%	66.0%	64.7%	62.4%	63.0%	63.2%

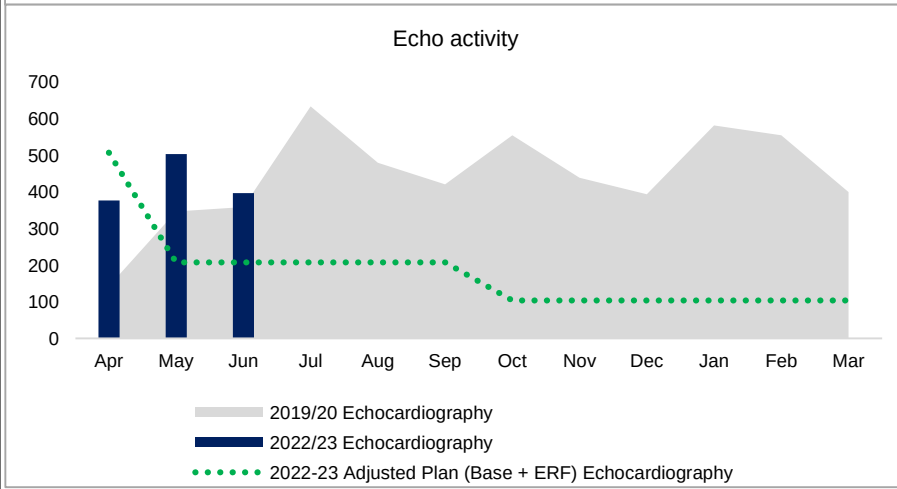
Northern Services Diagnostics - *Diagnostic activity compared to plan across key diagnostics modalities*







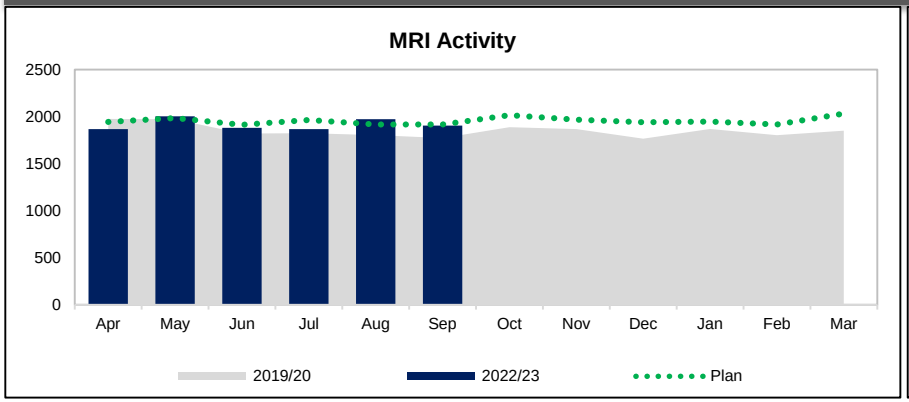


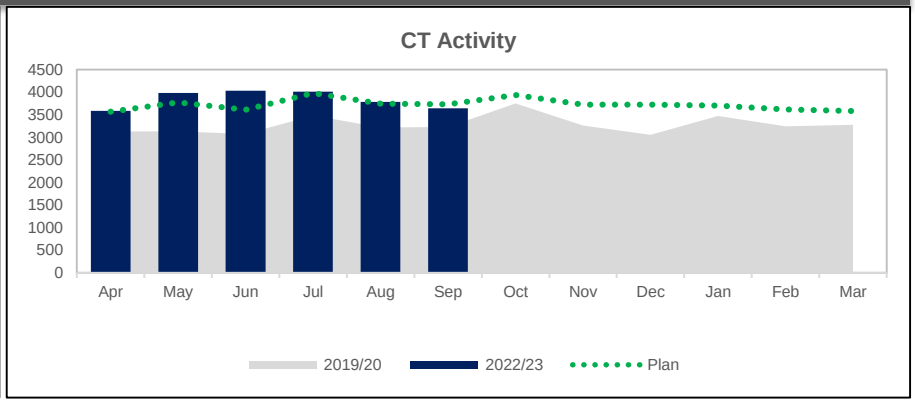


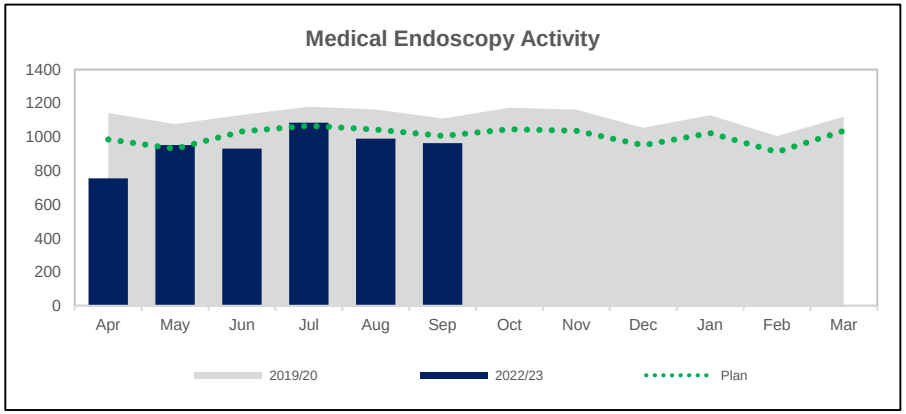
MRI – Whilst activity in September is lower than in recent months and below plan, demand is being met and patients are being offered scans within 2-3 weeks.
Non-Cardiac CT – Whilst activity in September is below plan it remains above 2019/20 activity and is meeting demand with patients being offered scans within 6 weeks.
Cardiac CT – 4 weekend lists have been arranged for October and November with the possibility of 1 list in December, providing additional capacity of 125 scans. The capacity will be used for highest clinical priority and longest waiting patients.
Echocardiogram – 13 additional lists have been arranged per month with a total of 11 patients per session.
Endoscopy – 2 Insourcing weekends per month have been planned until December 2022. Additional Insourcing companies are being explored in order to ensure that all Insourcing lists take place.

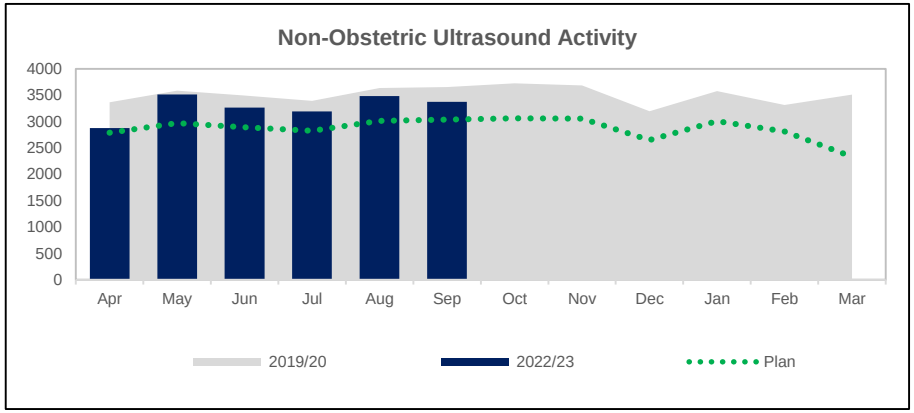
Eastern Services Diagnostics

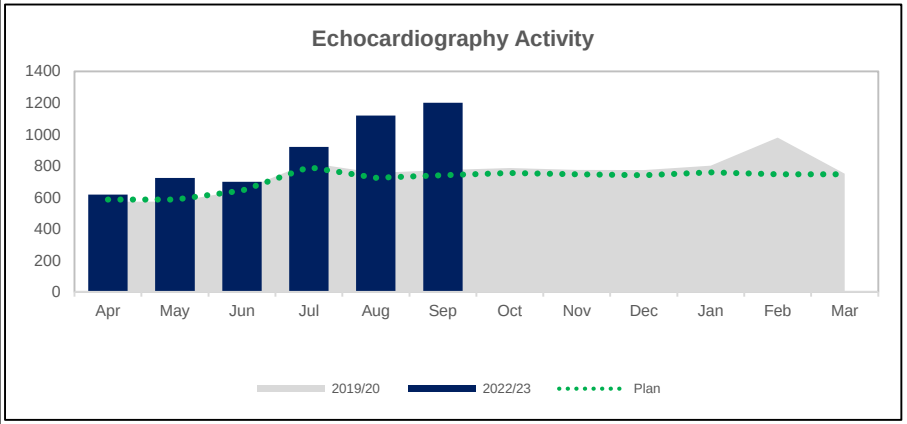
Volumes of patients waiting longer than 6 weeks for one of fifteen key diagnostics tests











Eastern Services Diagnostics

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

Endoscopy [586 breaches]

- Performance worsened in September, with 586 breaches (compared to 502 at end August).
- Of the 242 available lists in September, 215 were undertaken, leaving 27 vacant due to lack of proceduralist to cover the list. There are a similar number of vacant sessions in October, however the position is improved from November.
- 10 super weekend lists were delivered in September (all capacity used) and a further 7 planned for October (3 sessions left to fill).
- There is still a requirement for additional Endoscopy rooms to meet current and projected demand. A bid for external capital funding has been submitted to develop additional Endoscopy capacity and the outcome is awaited. Confirmation of the seed funding has been received and the design project is due to commence in mid-October.

Physiological Measurements [627 breaches]

Echocardiography

- Echo performance continues to decline, with 283 breaches at end September, despite delivering activity of 1201 against a plan of 741 (162%).
- Recruitment exercises are ongoing, however there is a national shortfall of physiology staff. The department continues to rely on agency staffing, which is likely to continue into 2023/24.
- Weekend WLI sessions continue in the short term to bolster current capacity.

Respiratory physiology

- Plans in place to address the backlog include recruitment of an Assistant Physiologist, and use of overtime to flexibly increase capacity where required , purchase of additional oximeters for paediatric studies.

Neurophysiology

- Neurophysiology performance continues to decline, with an additional 17 patients waiting longer than 6 weeks (a total of 108 breaches)
- A Consultant due back from a career break in September has since resigned –which has affected planned capacity.
- Actions to support an increase in capacity in the short term are being identified, alongside a proposed review of admin processes to identify opportunities for increased utilisation of appointments slots.

Eastern Services Diagnostics

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

Imaging [2134 breaches]

CT

- Breach position remains stable for this month. There is however an anticipated increase in 6 week wait breaches from November due to a recent planned 8 week pause in outpatient activity across the Acute scanners in order to support reduced patient waits for reporting following imaging being undertaken. Acute scanner outpatient bookings have been reinstated from 12/10/2022.
- Agito staffing model is changing from 17/10/2022, activity will be affected whilst new staff are trained over a 2 week period for both CT and MRI.
- Resus cover on the Medneo mobile van from November will be extended until 6:30pm, allowing up to 3 additional contrast patients to be booked per day.
- Reporting position much improved due to continued outsourcing.

MRI

- As forecast, the 6 week breach position deteriorated due to the planned decrease in outpatient activity across the Acute scanners as referenced above.
- As for CT, Acute scanner bookings have been reinstated from 12/10/22 with the reporting waits now managed down to acceptable levels, to be supported by continued outsourcing arrangements.

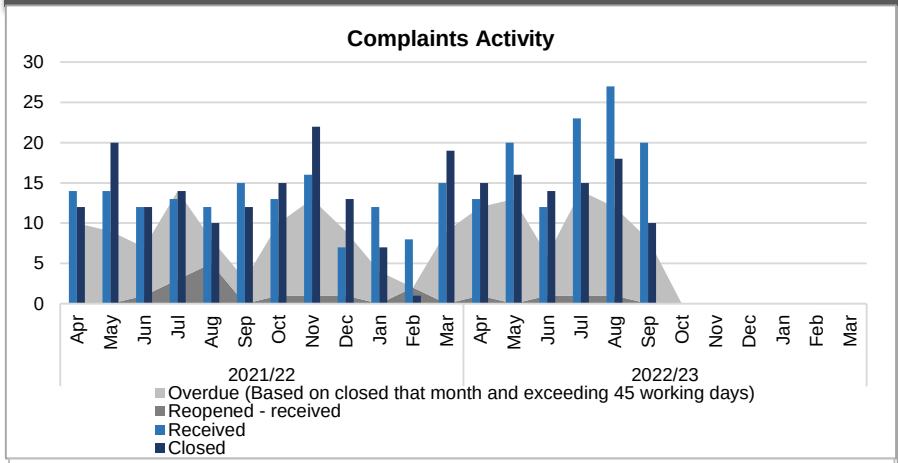
Non Obstetric Ultrasound

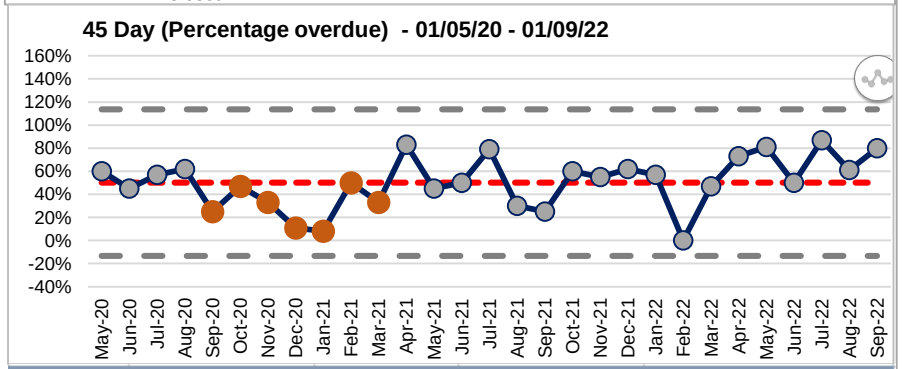
- Continued improved breach position reported this month as a result of additional lists
- Approval for US equipment has now been authorised by NHSEI; these will be ordered once it is confirmed that the funding has been received.

DEXA

- Improved breach position which is predicted to remain stable.

Northern Services Patient Experience





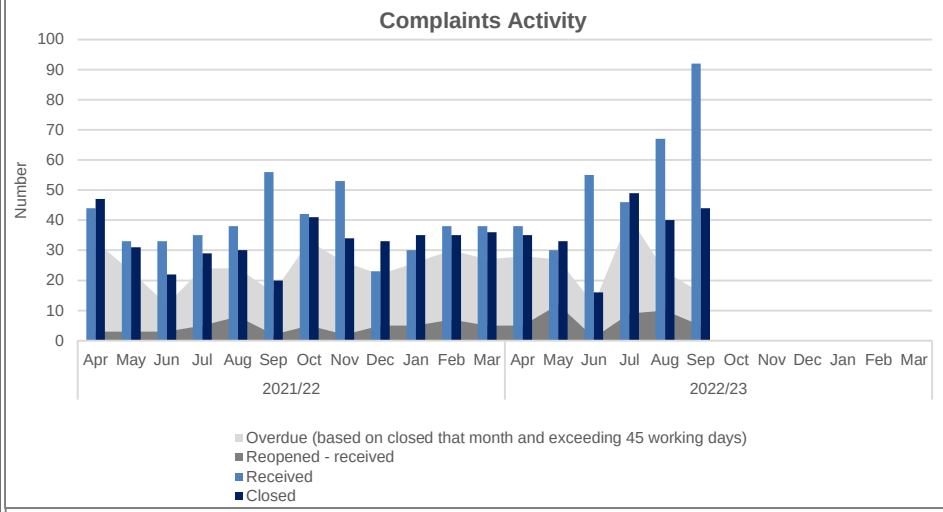
Standards:

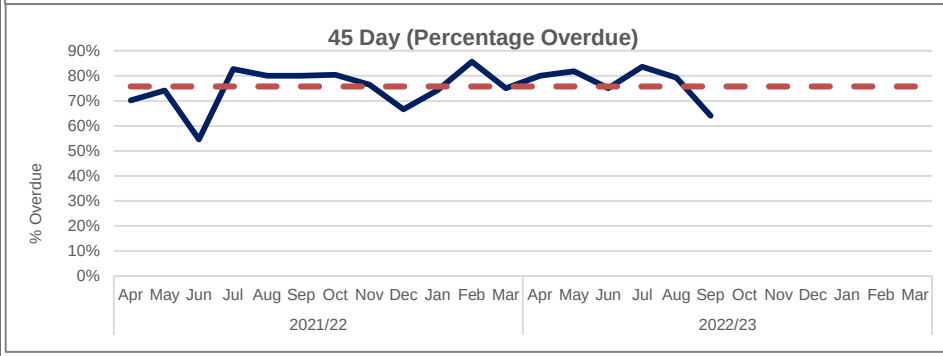
- In September, performance against the acknowledgement rate of complaints within 3 working days was 100%.
- 2 complaints exceeded the 6 month legal timeframe. The complaints were complex investigations involving more than one service. PHSO guidance was followed for these cases and the complainants were notified of the reason for the delay.
- 20% of formal complaints were responded to within the agreed timescale (45 days). Delays in responding to complaints are being addressed through the weekly complaints huddles, and monthly divisional performance assurance framework meetings.
- 1 new PHSO primary investigations were received during September. This is a joint investigation that involves Eastern and Northern services and the Trust response is being managed via the Eastern service.

Sep-22	Current stage			Closed
	Primary investigations currently open	Dispute resolutions requested	Detailed investigations currently open	Number of PHSO investigations closed during Aug 22
Northern	3	1	1	0

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

Eastern Services Patient Experience





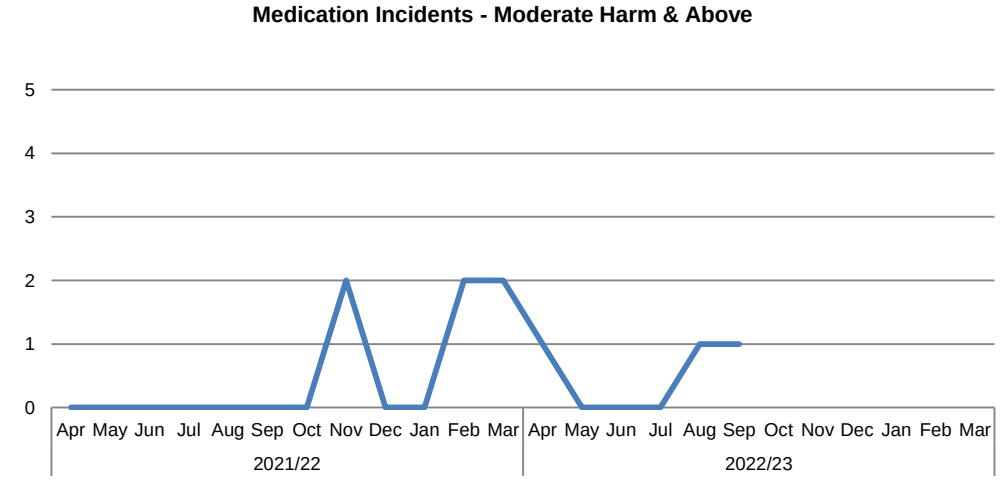
Standards:

- In September, performance against the acknowledgement rate of complaints within 3 working days was 70% due mainly to absence in the PALS team and increasing number of complaints received. Early indications are that a high percentage of the increased complaints are related to treatment delays.
- 3 complaints exceeded the 6 month legal timeframe. Delays in responding to complaints are being addressed through the weekly complaints huddles, and monthly divisional performance assurance framework meetings.
- 25% of formal complaints were responded to within the agreed timescale (45 days)
- 2 new PHSO primary investigations were received during September. 1 of which is a joint investigation that involves Eastern and Northern services and the Trust response is being managed via the Eastern service.

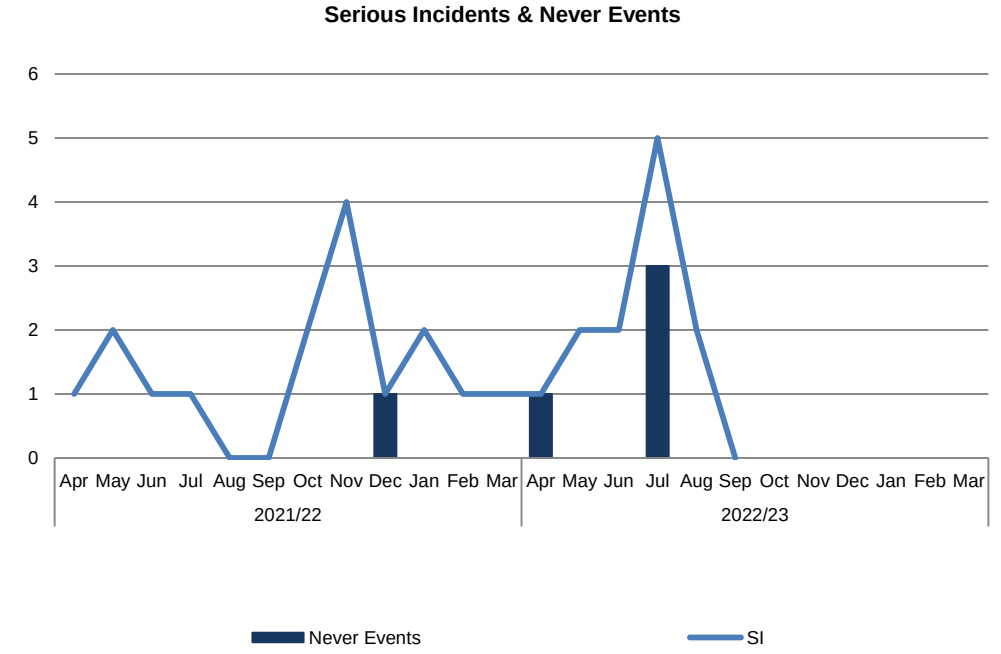
Number of new PHSO investigations received during month	Primary investigations currently open	Detailed investigations currently open	Number of PHSO investigations closed during month
2	2	1	1 (upheld)

	2021/22												2022/23					
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
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%
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%	87.50%	75.00%
Over 6 months	2	2	0	4	1	1	4	3	3	6	3	5	11	8	4	12	8	3

Northern Services Incidents

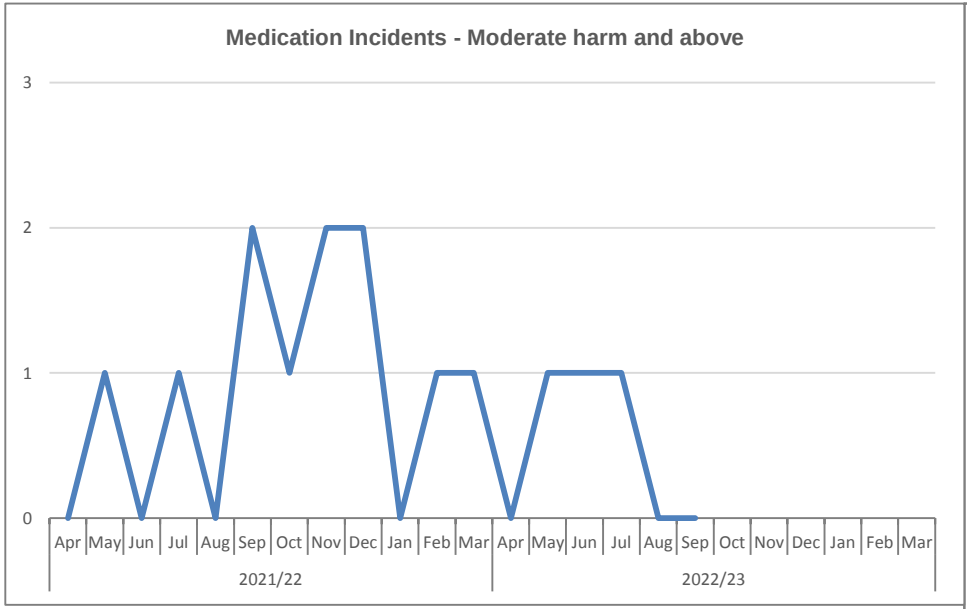


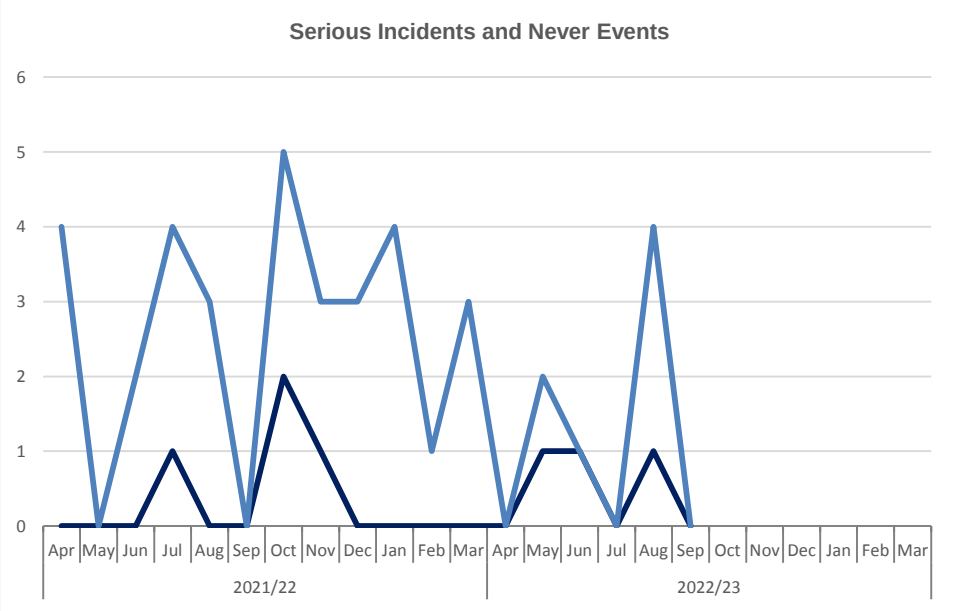
In September 2022 there was 1 medication incident which is being investigated.



There were no incidents escalated as Serious Incidents or Never events in September.

Eastern Services Incidents

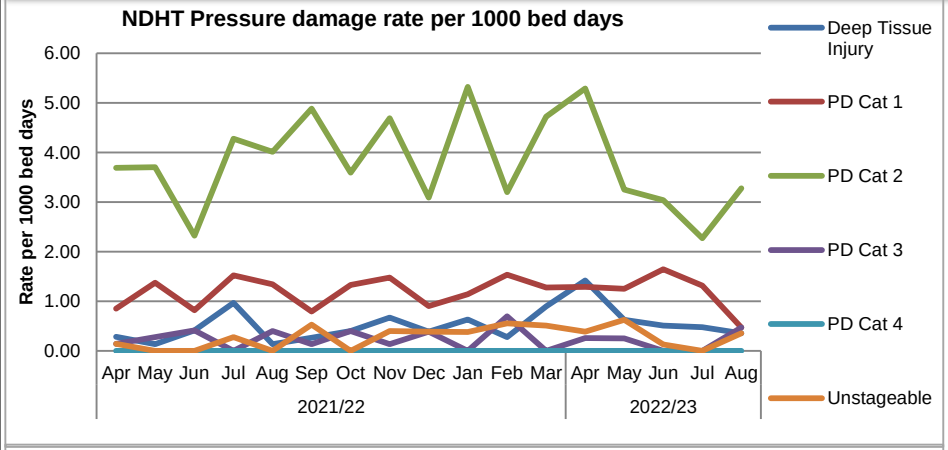


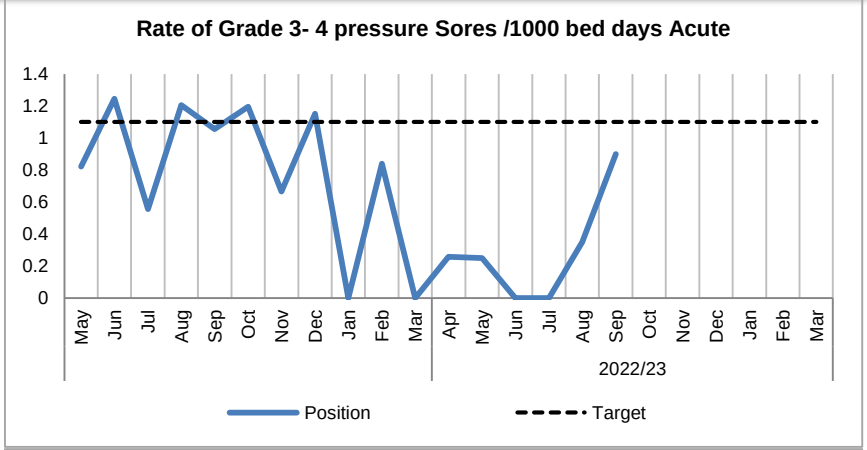


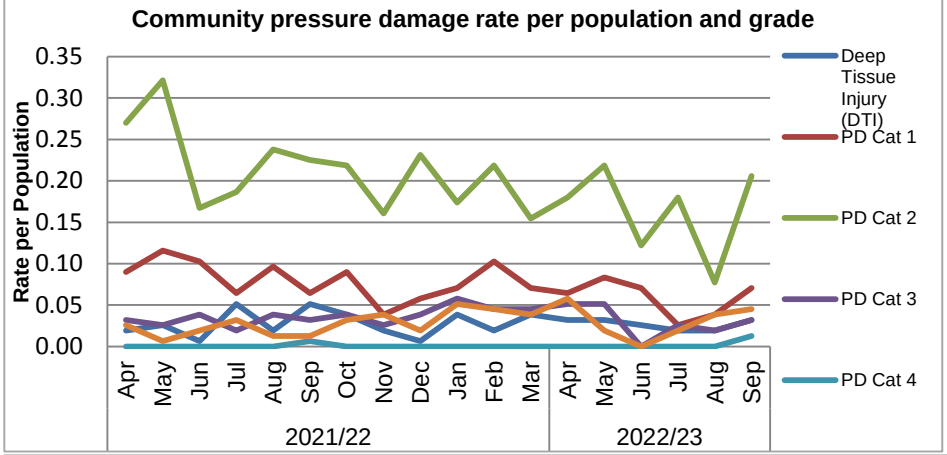
There were no medication incidents resulting in moderate or gre harm in September 2022

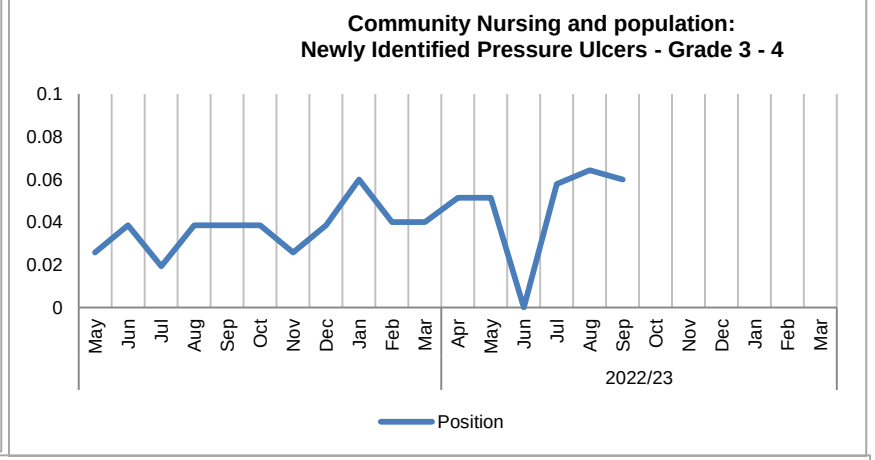
No Never Events or incidents meeting the threshold for a Serious Incident occurred in September 2022.

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









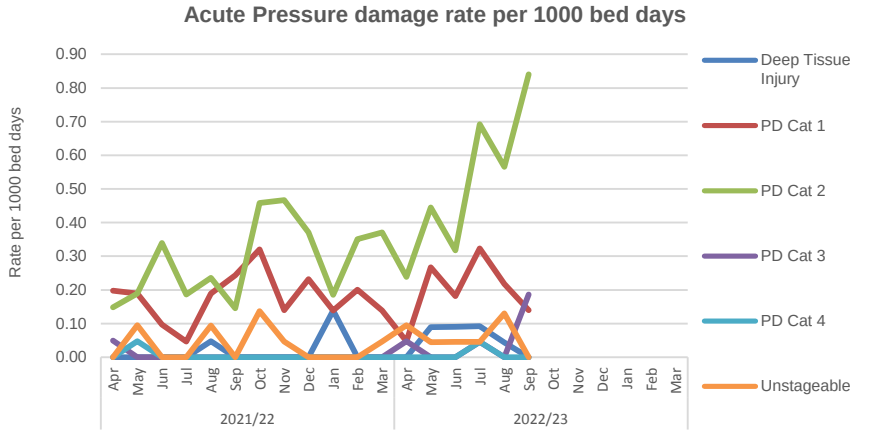
Acute – in August there was an increase in the total number of health acquired pressure ulcers reported. There was also an increase in healthcare acquired category 3 pressure ulcers in August which are subject to investigation. No common themes have been identified to date.

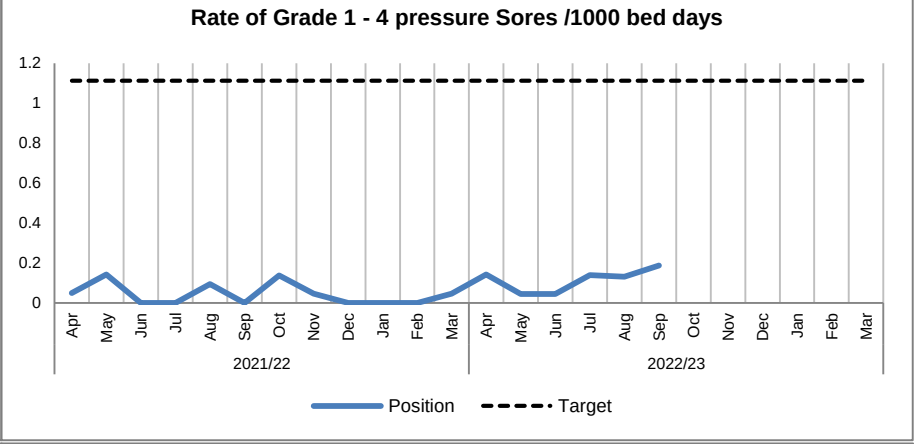
Community – in August 2022 the number of health acquired pressure ulcers within the community increased slightly, with the exception of category 2 which decreased. There was 1 category 3 pressure ulcers reported and no category 4 reported pressure ulcers.

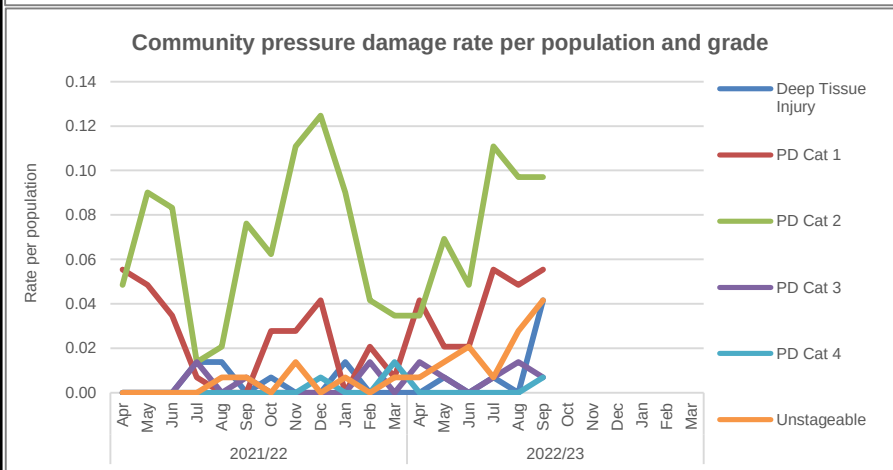
NB The September data is unvalidated and will be subject to amendment following review.

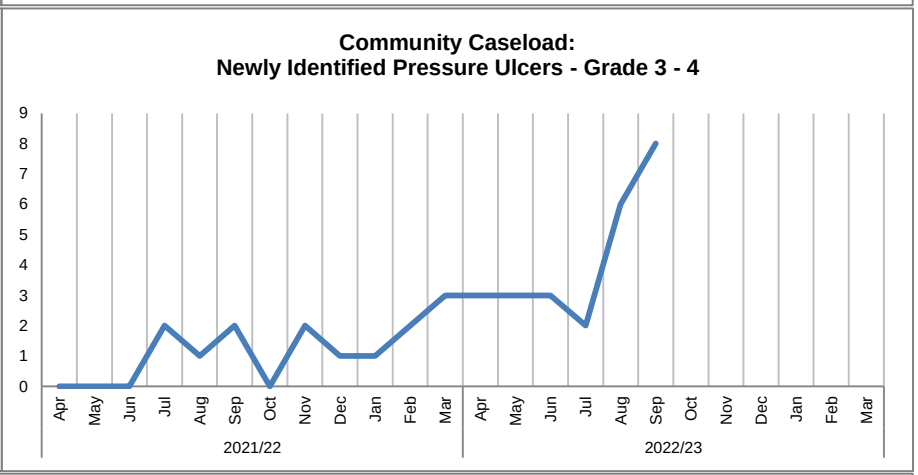
Eastern Services Pressure Ulcers

Rate of pressure ulceration experienced whilst in Trust care





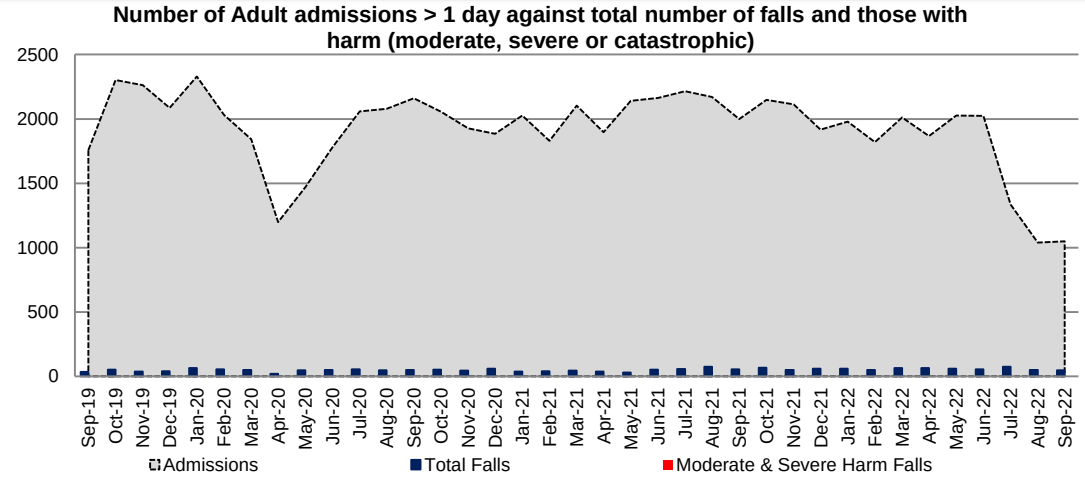




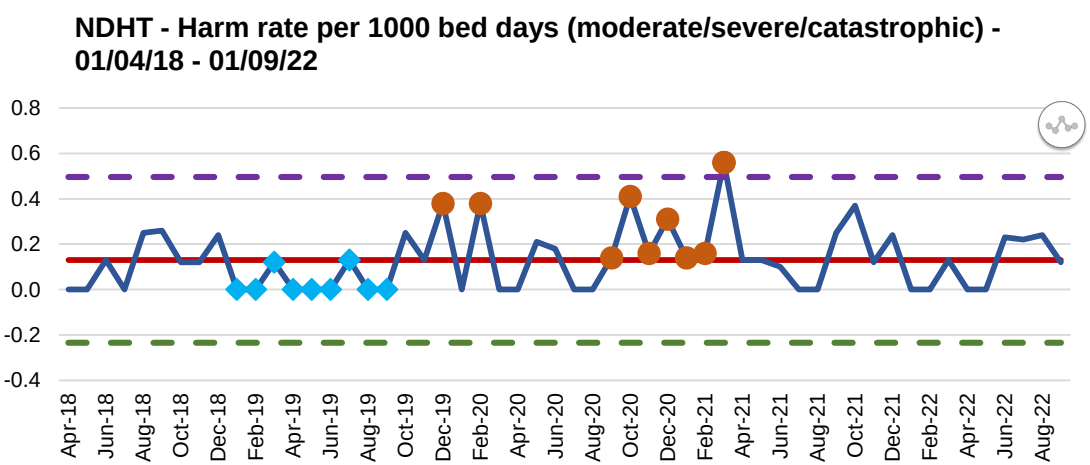
In the hospital setting there has been a significant increase in category 2 and a slight increase in category 3 pressure damage.

- Category 2 themes-preventative strategies/equipment is not initiated until damage is identified due to incomplete risk assessment.
- Cohort wards for COVID 19 recorded high numbers of harm. This is to be expected as the disease process of COVID 19 impacts on skin integrity even when patients are mildly effected by the disease. The Tissue Viability Team have undertaken an analysis of the increase in ulcers and are developing an improvement plan in partnership with northern services. The effectiveness of this will be reviewed quarterly via the TV Steering Group.
- There are increasing numbers of dynamic/powered mattress failures leading to increase in nursing time/stress and patient harm. This had been identified and we are seeking an urgent solution to resolve this.
- In the community the impact of patient non concordance and end of life care continue to impact on pressure ulcer acquisition. One category 4 PU will not be escalated for moderate investigation as the patient has capacity and chose not to follow the nursing advice to relieve pressure.

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



Month	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
Admissions	2000	2148	2112	1916	1978	1819	2012	1866	2026	2024	1336	1040	1050
Total Falls	56	67	51	60	60	49	66	65	59	55	74	49	48
Moderate & Severe Harm Falls	2	3	1	2	0	0	1	0	0	1	2	3	1

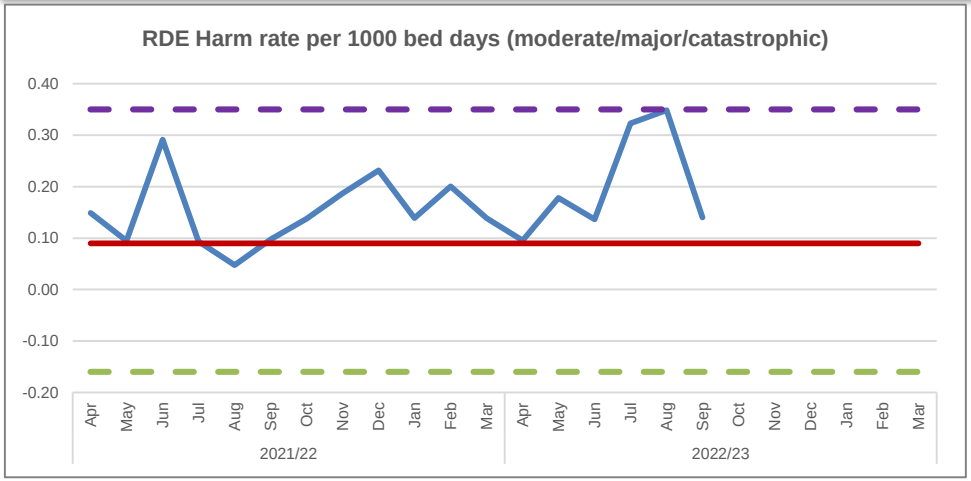


In September 2022:

- 95% of patients admitted did not fall.
- There was 1 fall which has been escalated for further investigation.
- Work continues to align policies and to support ward staff with falls risk assessments and care plans and post falls management, particularly focusing on digital optimisation in My Care.

Eastern Services Slip, Trips & Falls

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

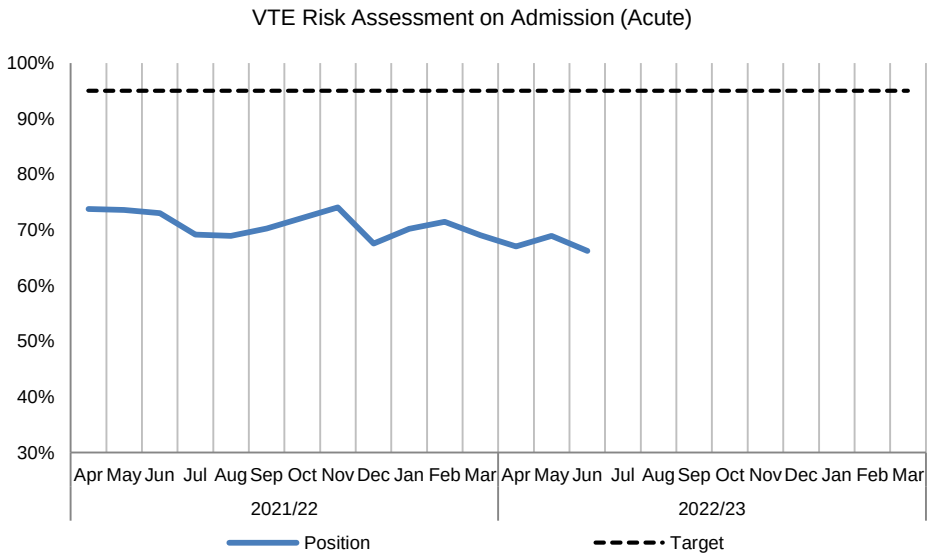


Month	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Admissions																		
Falls	116	112	120	110	129	132	162	160	179	143	152	206	167	141	167	269	222	190
Moderate & Severe Falls	3	2	6	2	1	2	3	4	5	4	4	3	2	4	3	8	8	3

There were three falls with harm reported in September 2022, two within RD&E Wonford and one with Community Hospitals.
All three falls were unobserved and resulted in moderate harm.

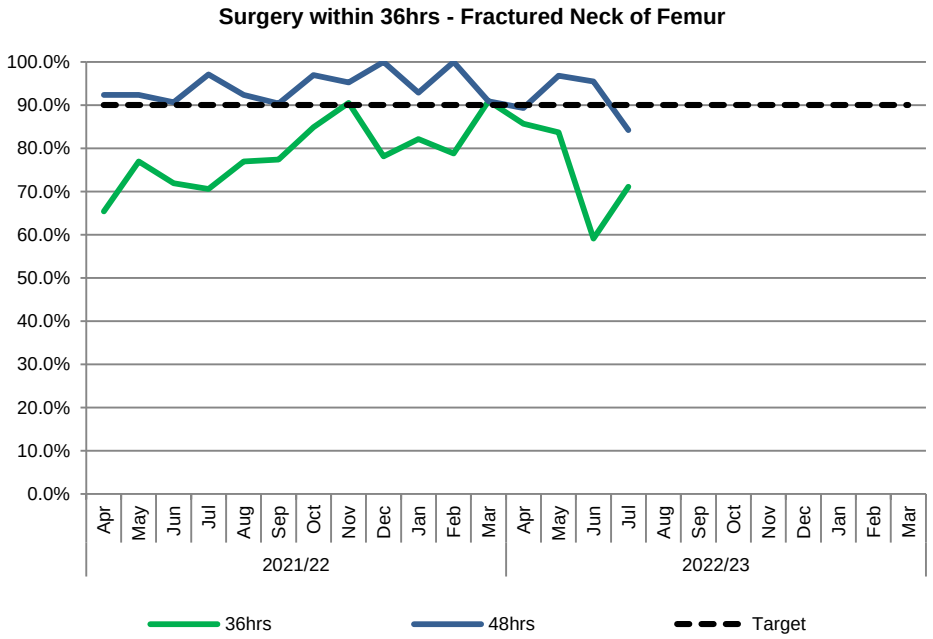
- One patient fell whilst mobilising independently, self reporting that they tripped in the bathroom.
- One patient was using a commode, the nurse had left to afford privacy, but the patient had been given the nurse call buzzer in their hand
- One patient removed their falls prevention alarm
- There were no suboptimal care issues identified in the initial incident reports and formal investigations are underway.

Northern Services Efficiency of Care – *Patients risk assessed for VTE*



In September 2022

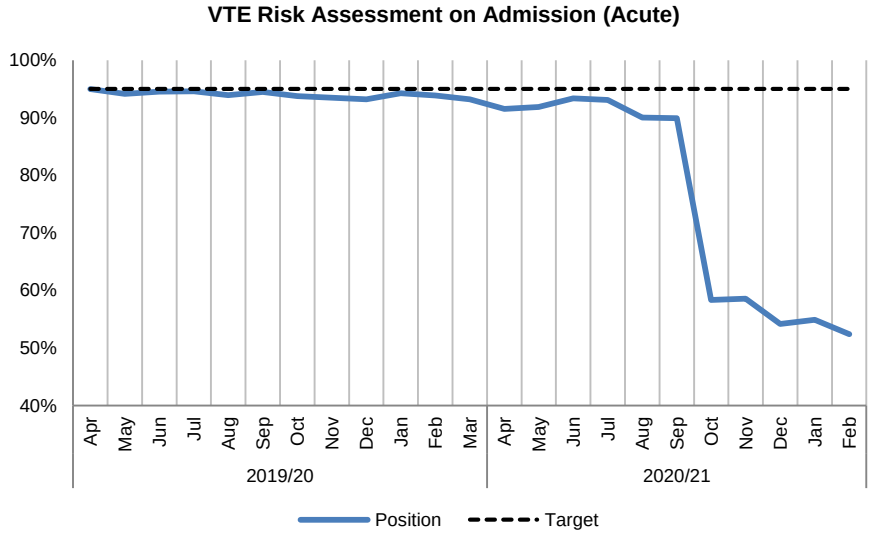
- There was a spot audit on EPIC of 55 patients undertaken in August and 65% of patients on ward assessment areas had a completed VTE assessment.
- There are challenges with pulling VTE reporting in line with previous methodology from Epic since go live, therefore whilst work is undertaken to align this process, spot audits will continue to be undertaken on a monthly basis.



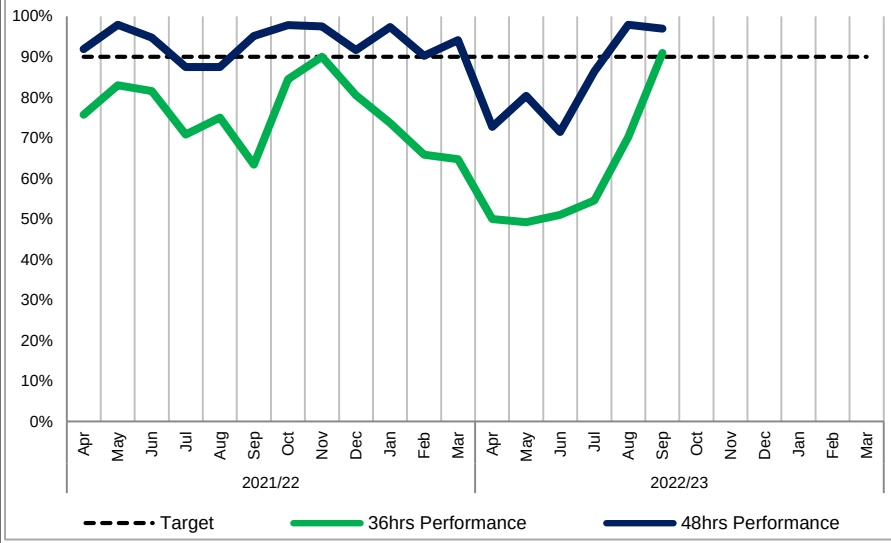
- Data in relation to the Fractured Neck of Femur Position is currently being validated for August and September, as provisional data has shown a sudden reduction in performance. The outcome of the validation will be incorporated within next month's report.

Eastern Services Efficiency of Care

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

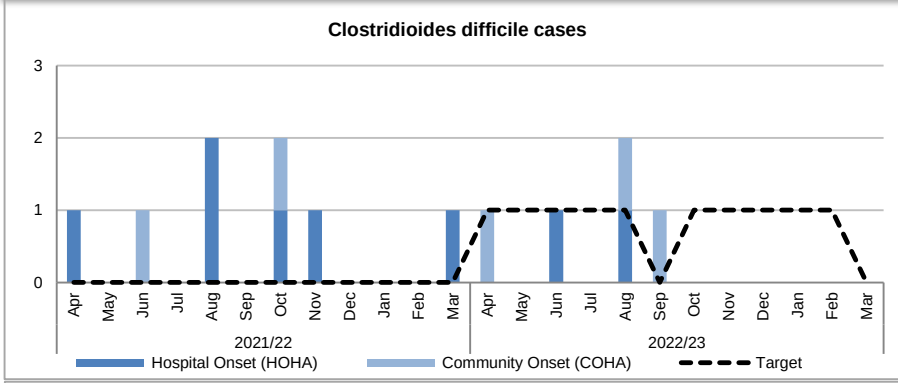


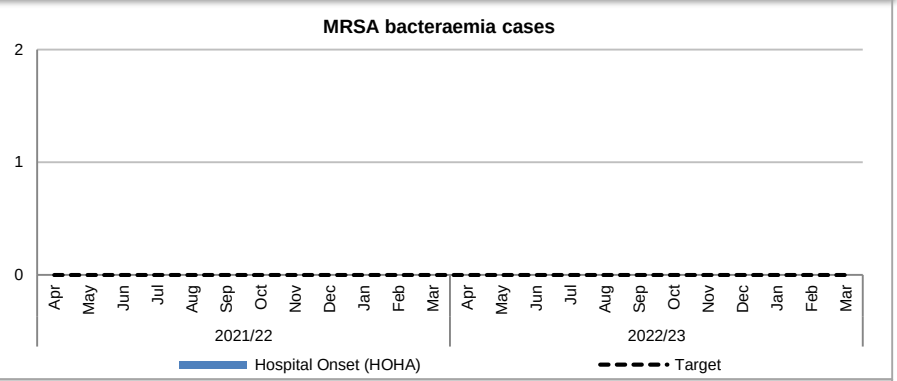
- As advised in the previous IPR, a range of actions remain underway to ensure accurate reporting of VTE position including low risk cohort exemptions, from both a clinical and reporting point of view.
- A snapshot position taken from the Epic system as of Monday 17th October (which includes the low risk cohorts) demonstrates 73% compliance across Acute and Community Sites.

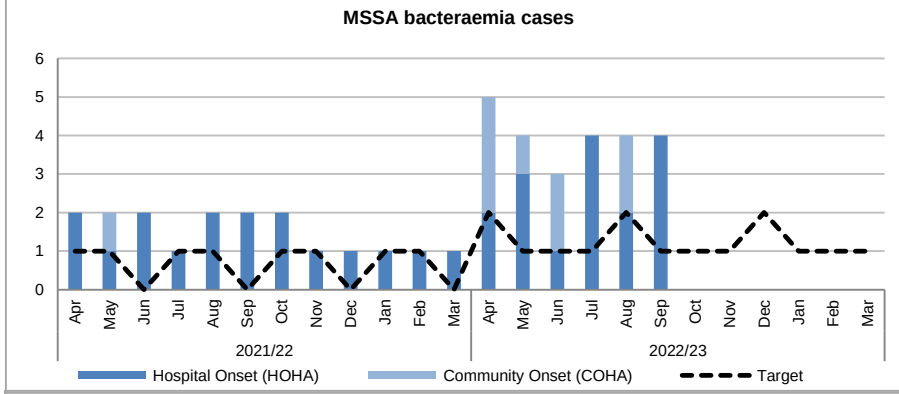


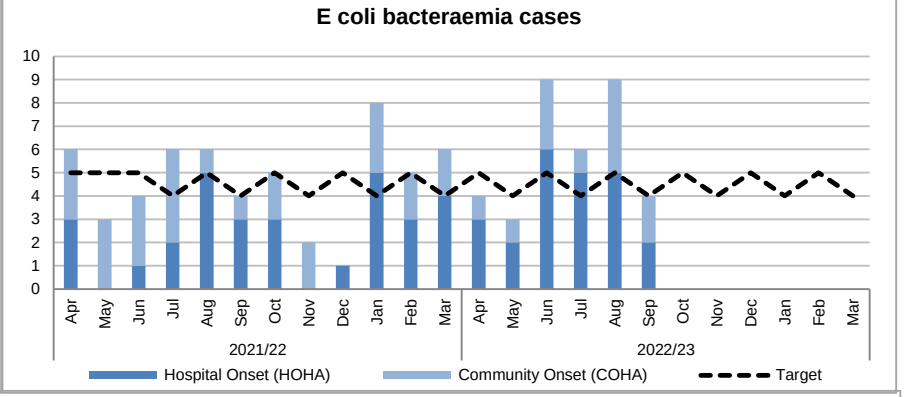
- In September, 90.9% of medically fit patients with a fractured neck of femur (FNOF) received surgery within 36 hours. There were a total of 39 patients admitted with a FNOF - 33 of these patients were medically fit for surgery from the outset and 30 patients received surgery within 36 hours. 1 medically fit patient had to wait over 48 hrs for surgery.
- In September, there were a total of 150 Trauma admissions, with 32 Trauma patients having their procedure undertaken in PEOC Theatres which had an impact on elective operating. These two factors improved performance
- Where clinically appropriate all FNOF cases are given priority in theatres over elective patients. We are still working towards having consistently 5 theatres running each day, however some days we are at 4 theatres due to theatre staffing challenges. 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 harm due to a slightly longer wait for surgery.

Northern Services Healthcare Associated Infection *–Volume of patients with Trust apportioned laboratory confirmed infection*









These healthcare associated infections remain within normal variation:
Clostridioides difficile **(C dif):** There was one Trust attributed *C dif* in September 2022.
Methicillin resistant *Staphylococcus aureus* (MRSA): There have been no cases of Trust attributed MRSA bacteraemia since February 2015

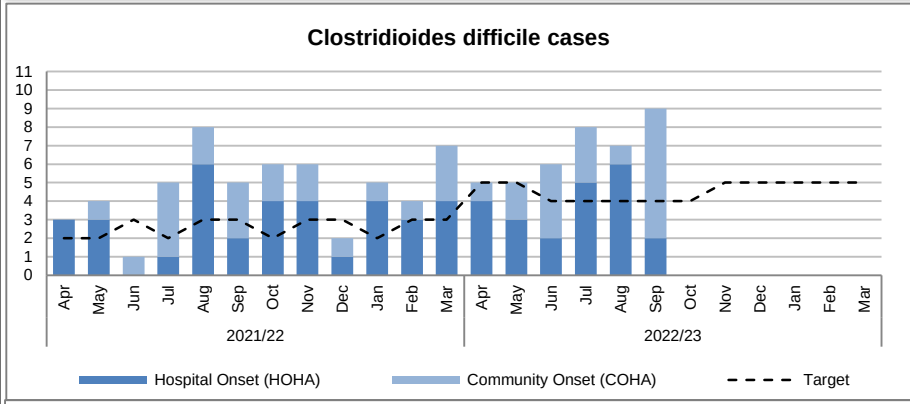
These healthcare associated infections had average number of cases in September 2022 but remain above trajectory for 22-23
Escherichia coli **(E coli):** There were 4 cases of Trust attributed *E coli* bacteraemias in September 2022. At the end of September 2022 Northern locality is 8 cases above the target trajectory. Since April 22 there has been a normal distribution of cases both by cause (the majority are urinary) and by location. No lapses in care were identified during IP&C review of the cases.

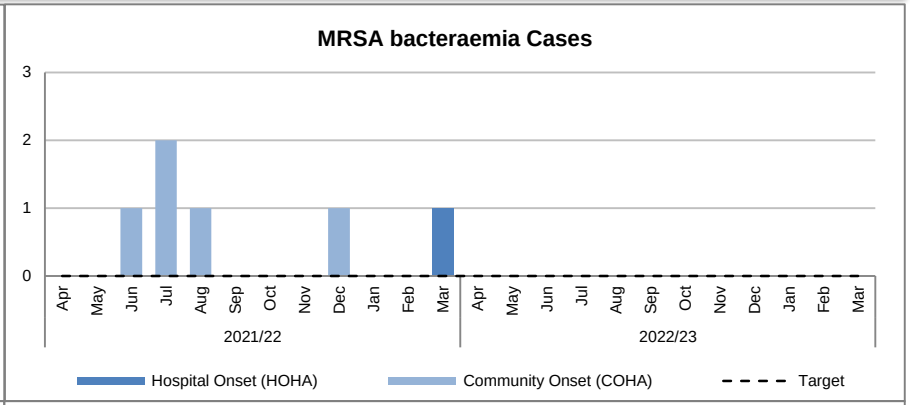
These healthcare associated infections had above average number of cases in September 2022
Methicillin sensitive *Staphylococcus aureus* (MSSA): There were 4 cases of Trust attributed MSSA bacteraemia in September 2022. Cases have been above the self-imposed target for the first 6 months of the year. No common cause has been found to explain these higher numbers and there is no obvious link in location or cause of infection. No lapses in care were identified during IP&C review of the cases.

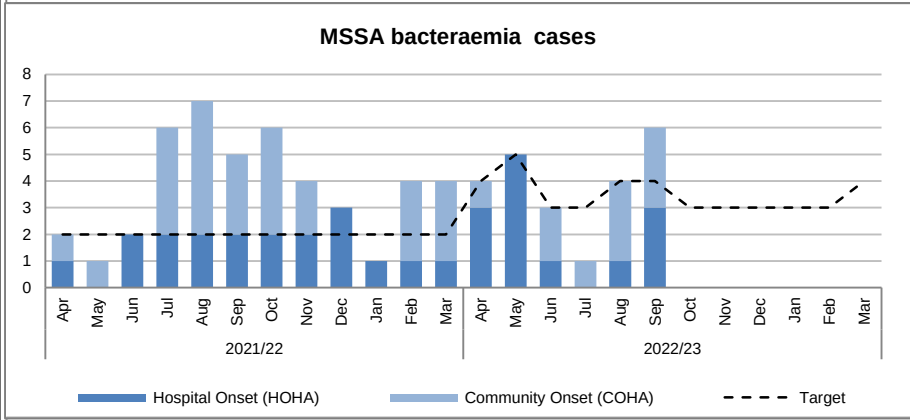
Bacteraemia and C difficile cases are reviewed and discussed at the Infection Prevention and Decontamination Group.

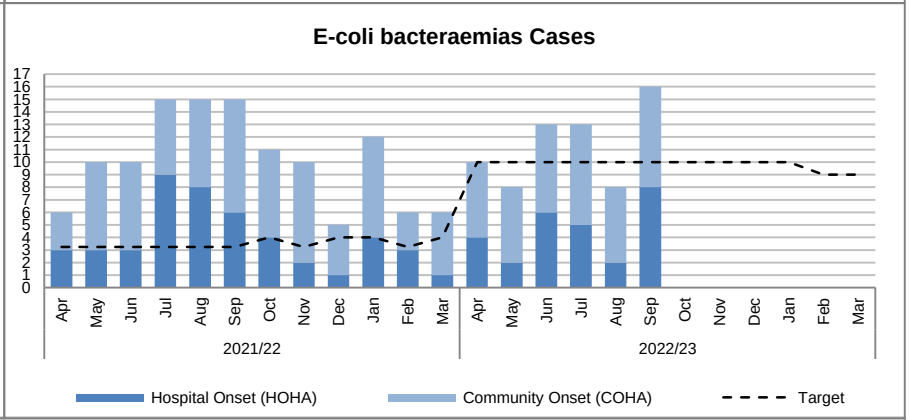
Eastern Services Healthcare Associated Infection

Volume of patients with Trust apportioned laboratory confirmed infection









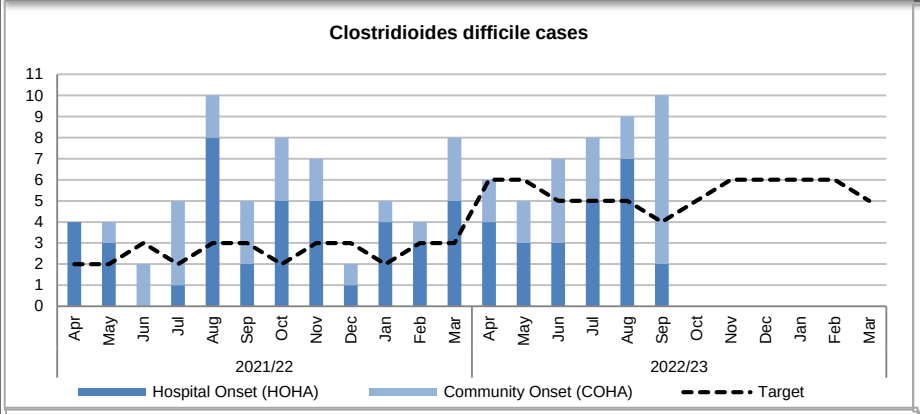
C.difficile: Each case has been investigated and no new learning regarding clinical practice identified. All cases were associated with necessary and appropriate antibiotic use. All cases caused mild symptoms only.

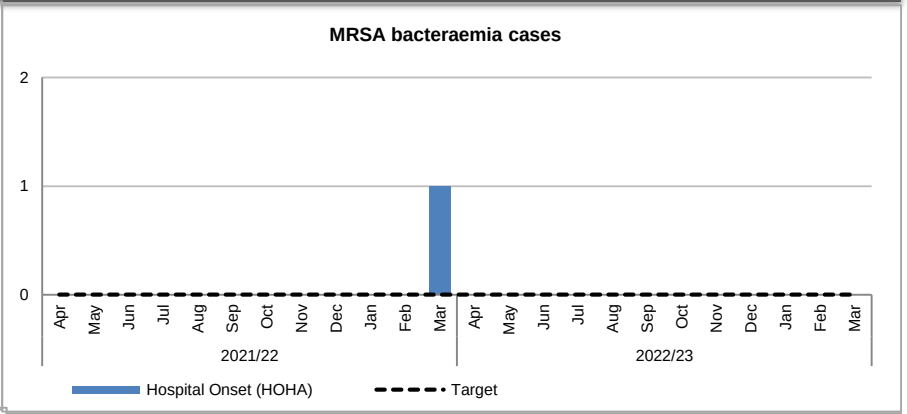
MRSA: N/A

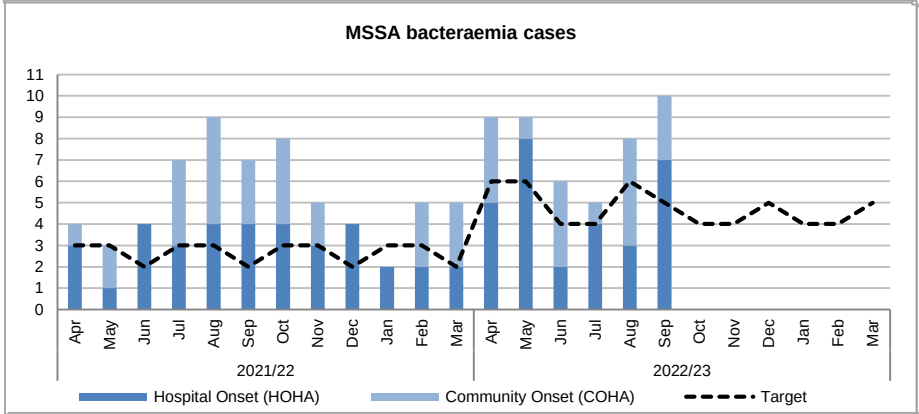
MSSA : Of the three hospital onset cases one was associated with suboptimal peripheral cannula care i.e. VIP score of 3 and no action taken remove cannula until two days later. This has been highlighted with the ward manager. No clinical practice issues were identified for the other two HOHA cases. Of the three COHA cases no learning was identified.

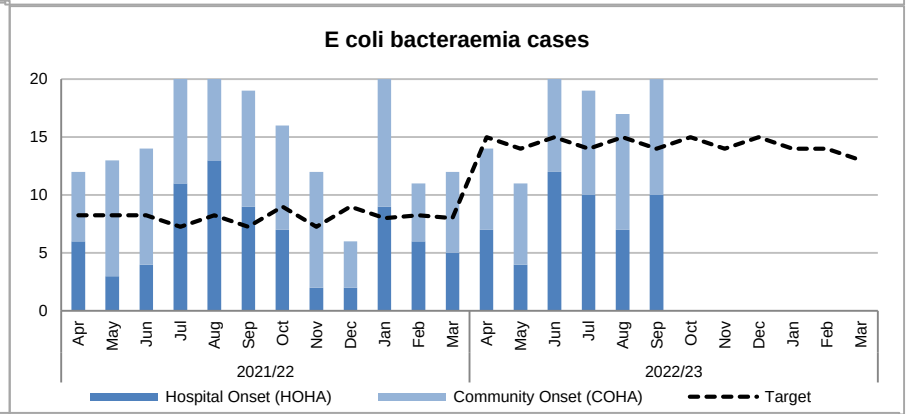
E.coli: Of the eight HOHA cases, three were associated with urinary tract infection. Of these three patients, two had indwelling urinary catheters. Similarly, three of the eight COHA cases were associated with urinary sources but only one had an indwelling catheter. The urinary catheters were inserted for appropriate reasons.

Trust Level Healthcare Associated Infection –*Volume of patients with Trust apportioned laboratory confirmed infection*

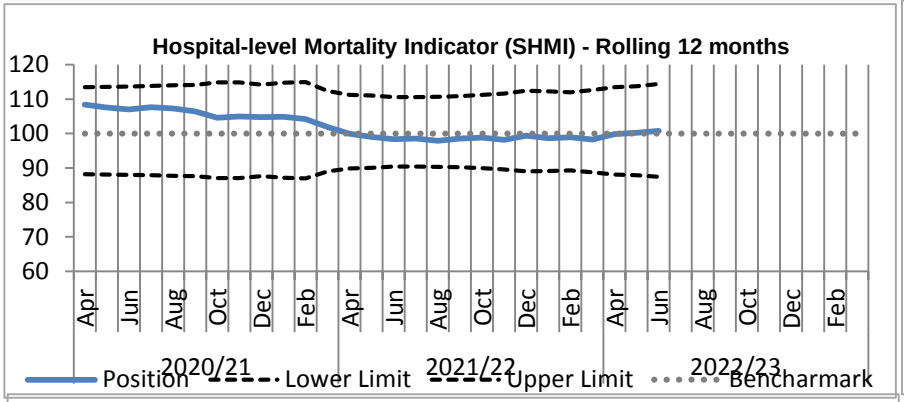


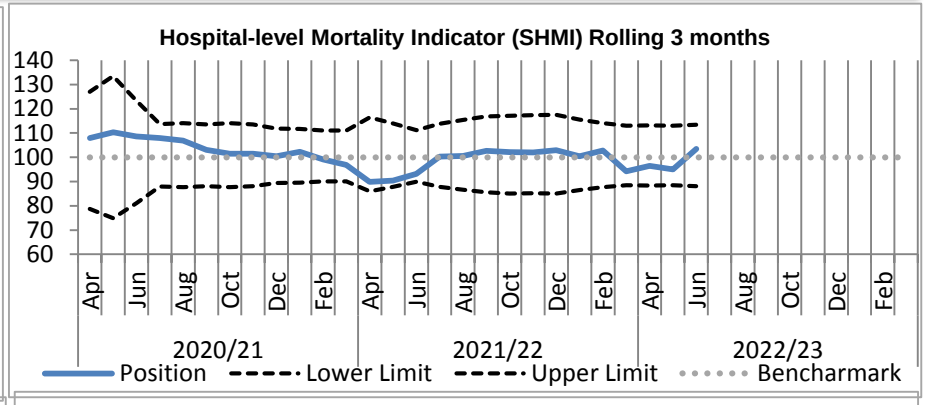


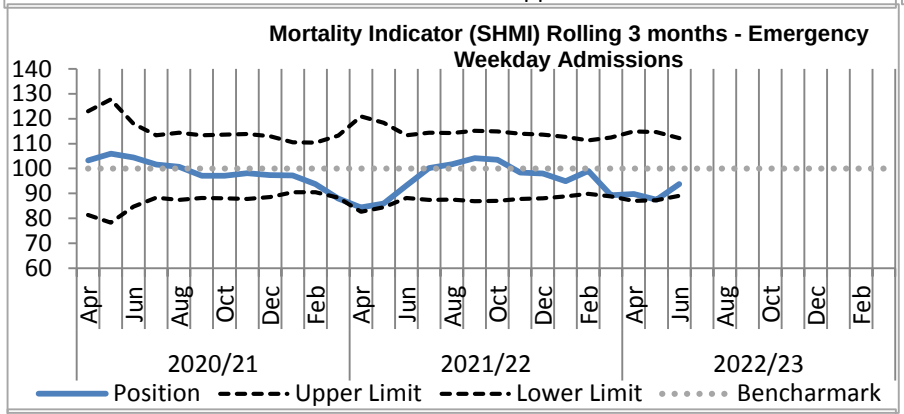


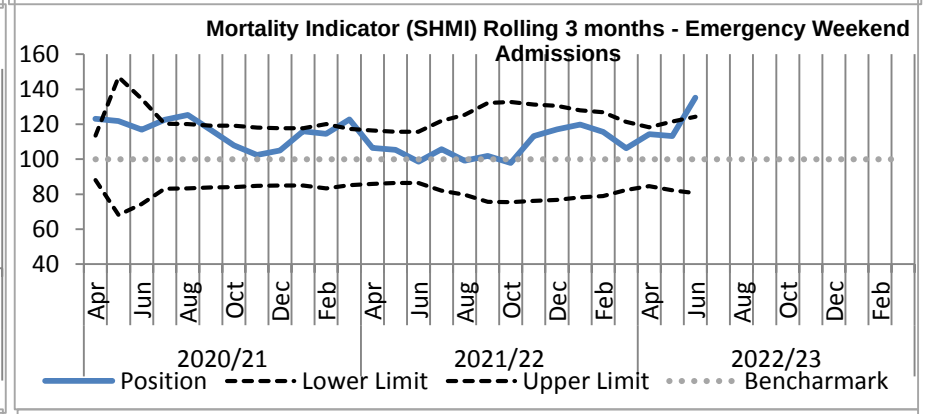


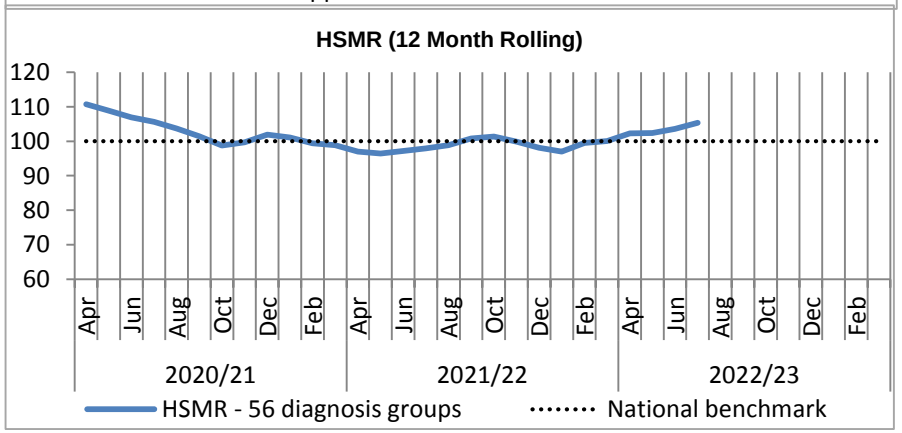
Northern Services Mortality Rates – SHMI & HSMR – *Rate of mortality adjusted for case mix and patient demographics*









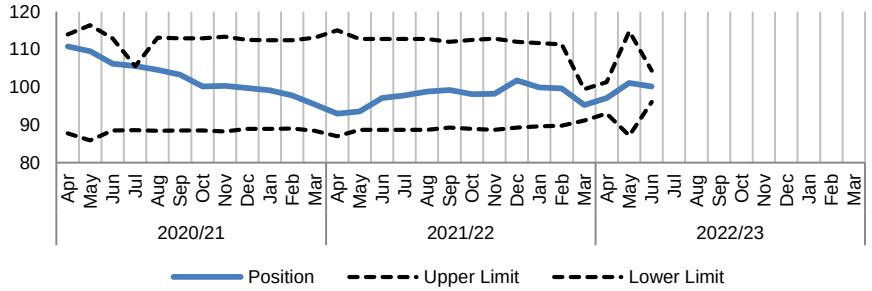


- The overall 12 month and three month SHMI and the emergency weekday SHMI is within expected limits. The HSMR has increased slightly to 105 against the target of 100. Emergency weekend SHMI for the 3 months April – June has increased to move outside of the control limits – However the nationally derived 'expected number of deaths' has reduced significantly. There doesn't appear to be an obvious cause i.e. coding backlogs or co-morbidity recording issues, investigation is ongoing reporting to the (integrated) Mortality Review Group.
- The Medical Examiner's service continues to provide independent scrutiny of all relevant deaths with escalation to review, specialty governance or investigation as appropriate.

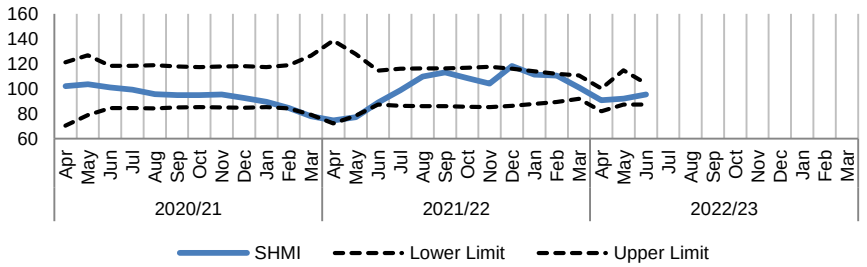
Eastern Services Mortality Rates – SHMI & HSMR

Rate of mortality adjusted for case mix and patient demographics

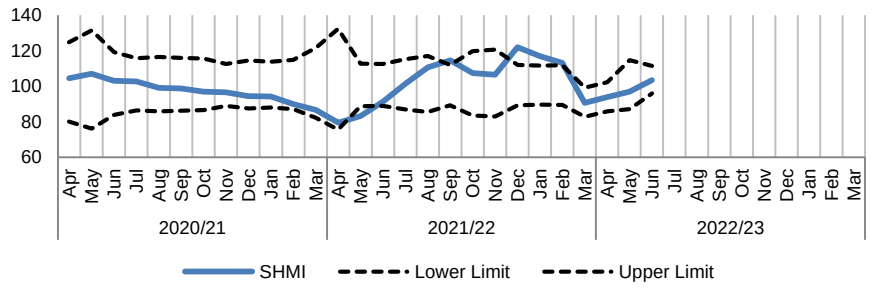
Hospital-level Mortality Indicator (SHMI) - Rolling 12 months



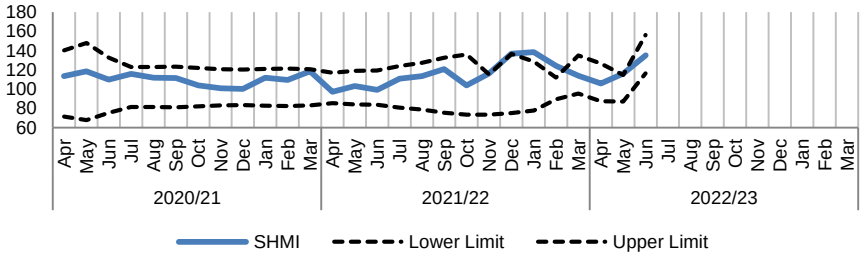
Mortality Indicator (SHMI) Rolling 3 months - Weekday Admissions



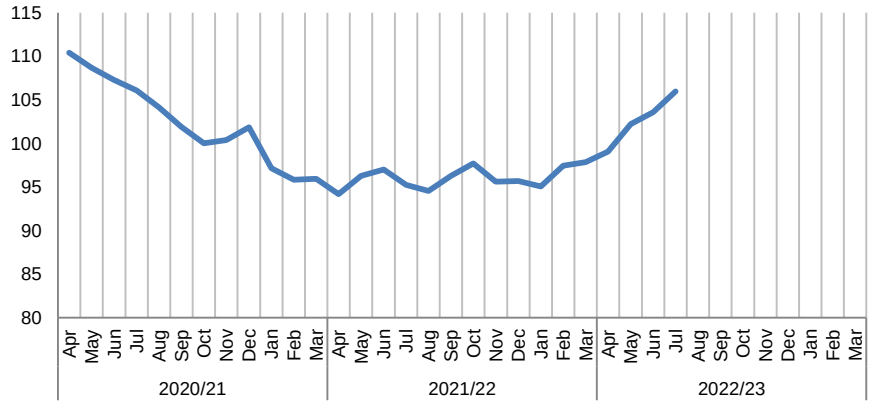
Hospital-level Mortality Indicator (SHMI) Rolling 3 months



Mortality Indicator (SHMI) Rolling 3 months - Weekend Admissions



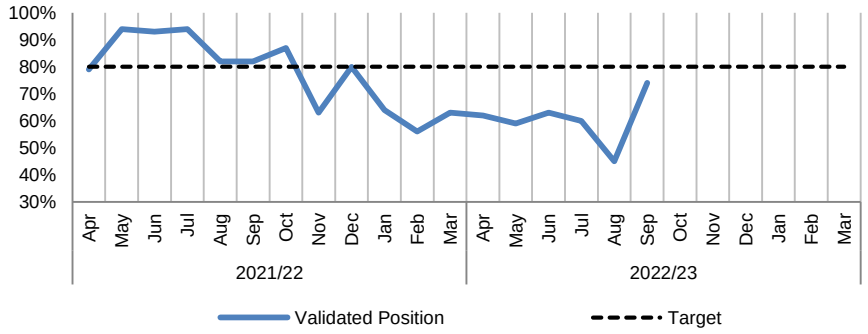
HSMR (12 Month Rolling)



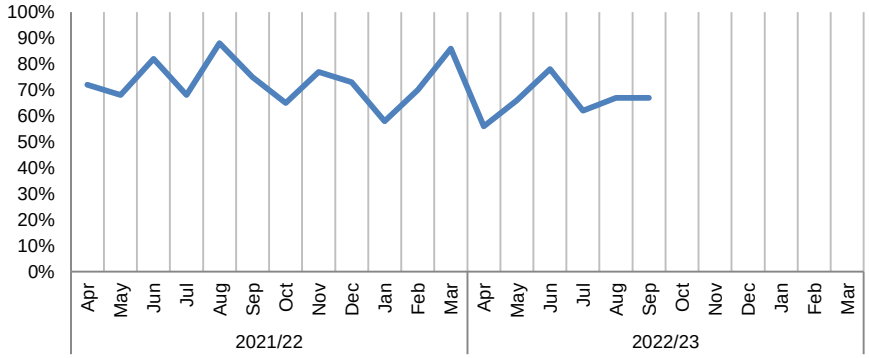
- Trust data has been merged and the charts show the combined positions within the Trust (Northern and Eastern Services) from April 2022. HSMR position has been aggregated and work is underway reporting to the Trust Mortality Group to establish consistent joint reporting regarding both SHMI and HSMR given the changes in organisational coding between sites.
- The rise in HSMR is being reviewed in detail, as it appears the nationally defined 'expected deaths' number has significantly reduced in July to 59 vs 123 in June 2022 adversely impacting the reported HSMR position against 'observed deaths'.
- The overall SHMI remains within expected limits and very close to the national benchmark. Mortality benchmarks and the underpinning data are monitored each month to look for adverse trends, data quality issues and diagnosis group alerts with appropriate action taken.
- The Medical Examiner's service continues to provide independent scrutiny of all relevant deaths with escalation to review, specialty governance or investigation as appropriate.

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

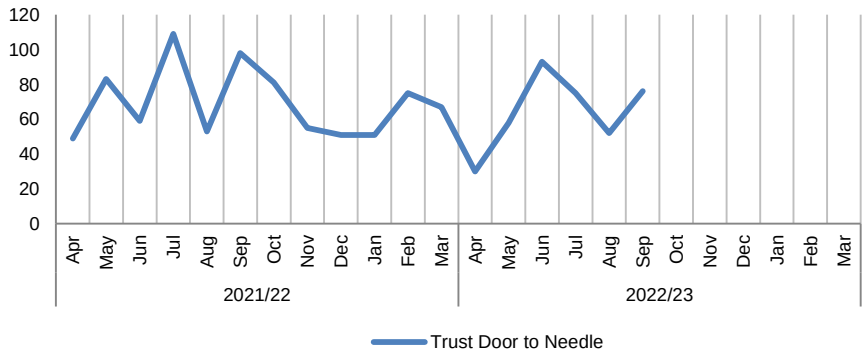
Proportion of patients admitted following a Stroke spending 80% or more of their stay on the Stroke unit



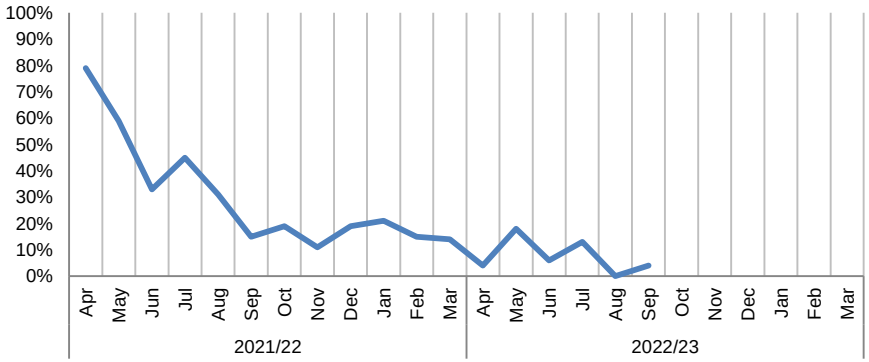
Discharge Destination to Home (%)



Average Thrombolysis Times (minutes)



On Stroke Unit within 4 hours



90% stay: Performance against this indicator has improved in September despite sustained challenges with patient flow. The Stroke clinical teams provide outreach to outlying wards to ensure stroke patients are receiving appropriate stroke care. Northern Services have commenced a comprehensive Patient Flow Project to improve flow across NDDH and the project encompasses the need to focus on improving overall stroke performance.

Discharge destination: This metric remains variable but above the national average.

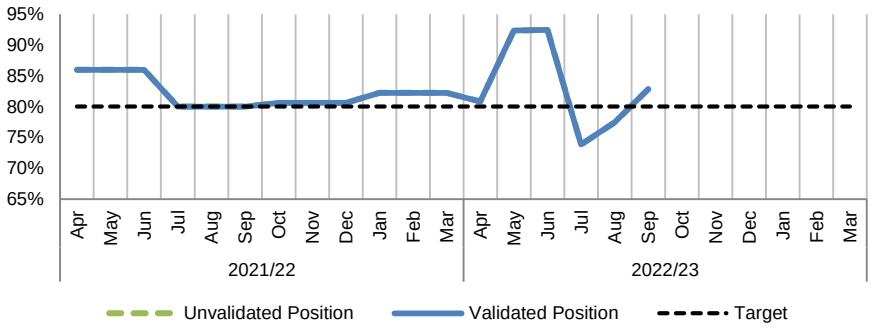
ASU in 4 hours: This position highlights the challenges with ringfencing stroke beds given the high occupancy levels.

Thrombolysis times: Thrombolysis time is broadly stable over time. Overall the number of eligible stroke patients for thrombolysis is low.

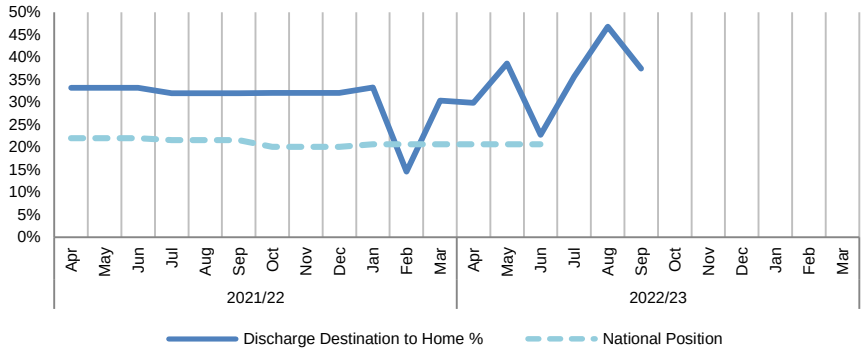
Eastern Services Stroke Performance

Quality of care metrics for patients admitted following a stroke

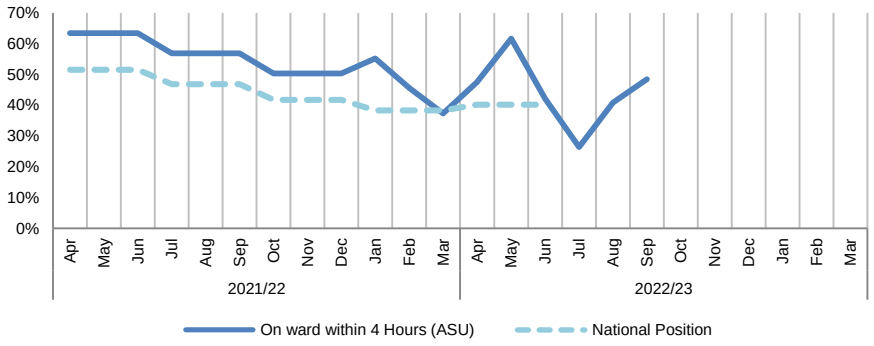
Proportion of patients admitted following a Stroke spending 90% or more of their stay on the Stroke unit



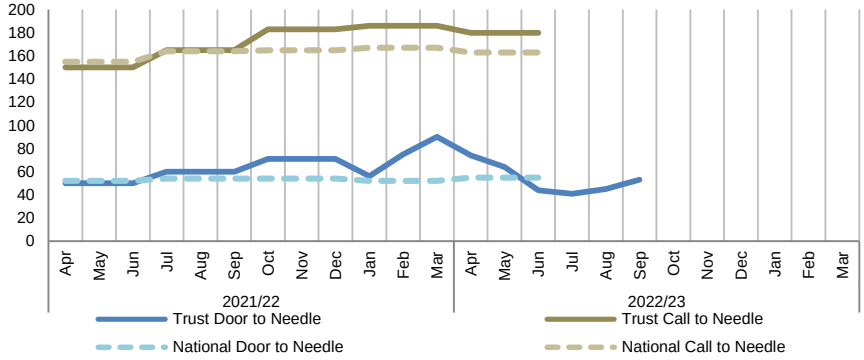
Discharge Destination to Home (%)



On ward within 4 Hours (ASU)



Average Thrombolysis Times (minutes)



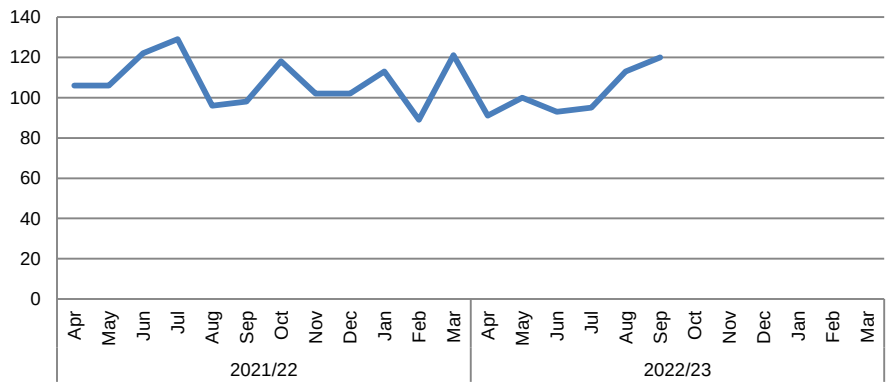
- 90% stay. A tremendous effort has been made to accommodate stroke patients on the stroke unit and to improve the transfer time to improve 90% stay. In September 82.8% was achieved against the 90% stay indicator and 48.5% of stroke patients were transferred to the unit within 4 hours, which is above the national position.

- Discharge destination to home fell slightly last month to 37.5% however we did have to move people to inpatient rehab rather than to home with ESD-Stroke Support Team due to staffing issues (temporary sickness and recruitment issues which are now resolved). This is still above the national average of 20.7%

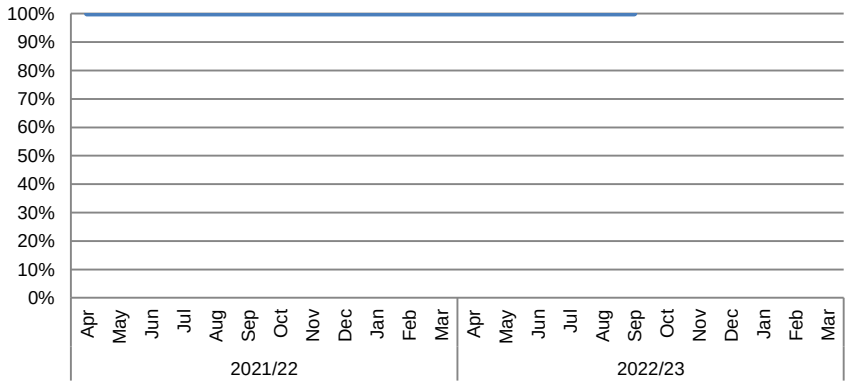
- Thrombolysis times are essentially static, the Trust door to needle time is 53 minutes, the National average is 50 minutes and our target is less than 45 minutes. We have commenced on-ward Simulation training for the ward staff as we anticipate thrombolysing more patients on the ward during the temporary ED reconfiguration works. This will help mitigate any adverse impacts regarding the Door To Needle figure. The call to needle time metrics are reported quarterly and should be refreshed next month.

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

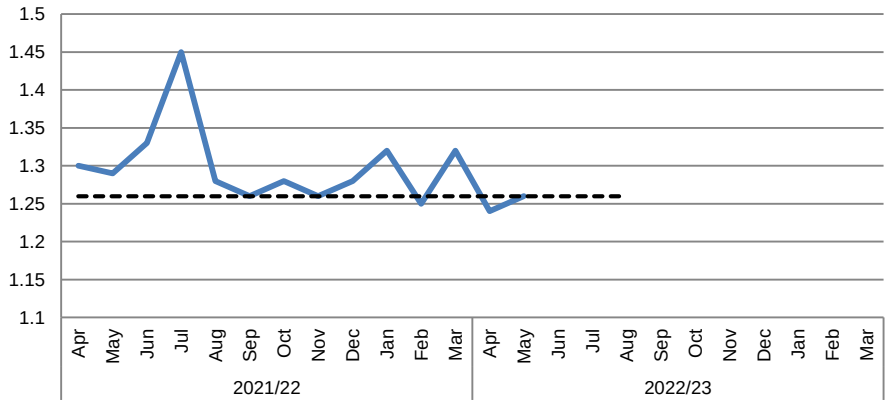
Birth Rate (Number of babies born)



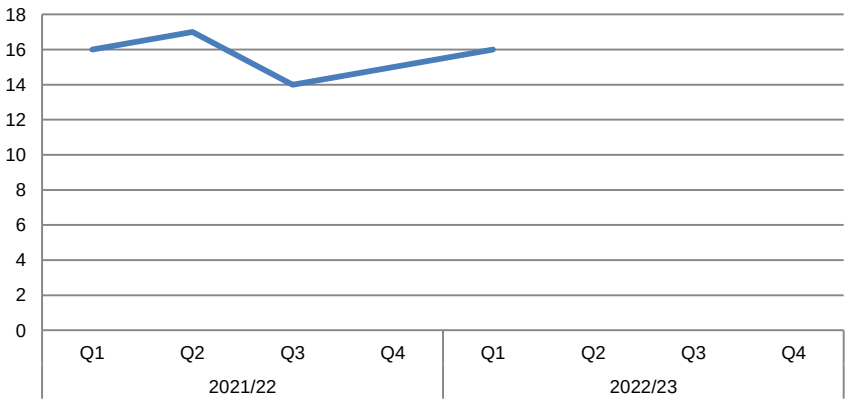
1:1 Care in Labour



Midwife to delivery ratio



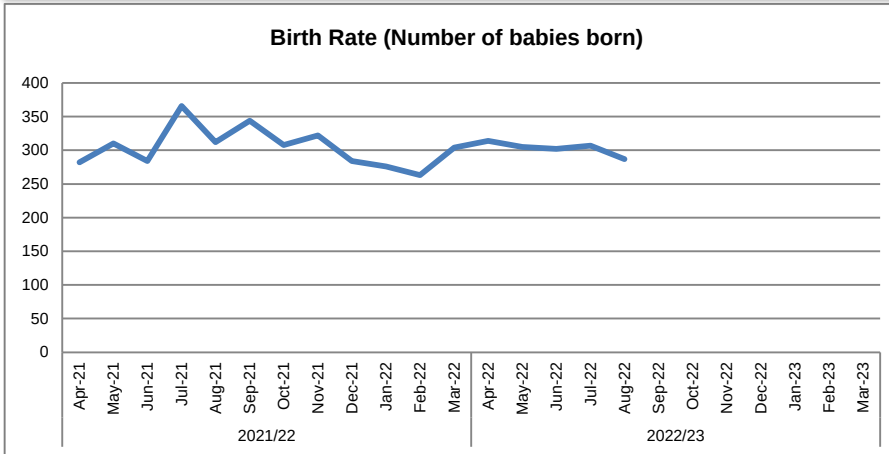
Admissions of (term babies) to NNU

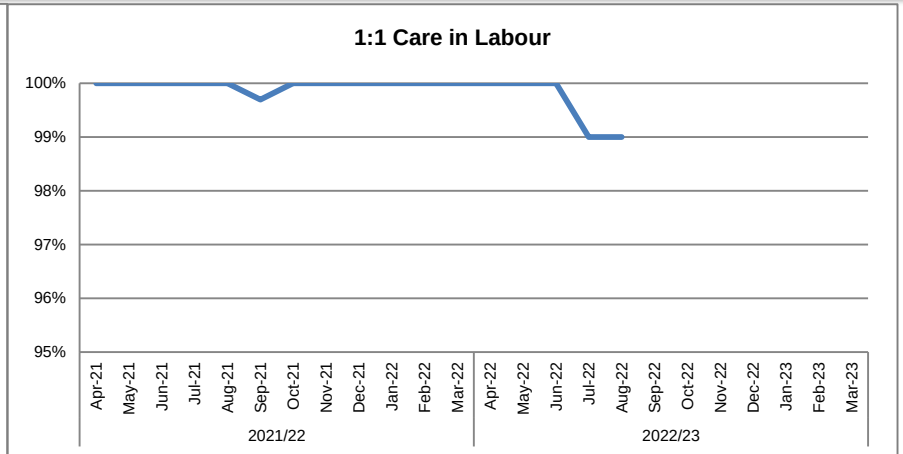


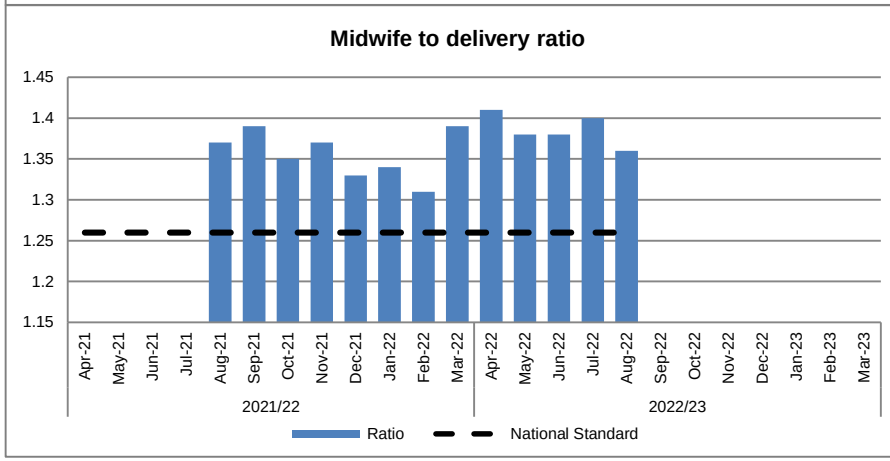
- The number of births remains within normal variation with a continued increase over the summer period and extending into autumn
- 1:1 Care in Labour is 100% and the IPR will exception report any incidents where this standard could not be met.
- Midwife to delivery ratio remains static, reflective of a more stabilised vacancy position and successful recruitment. Work continues to strengthen the midwifery workforce across the organisation with development of cross site senior midwifery roles and increased support worker provision.
- The number of term babies admitted to NNU are within normal variation.

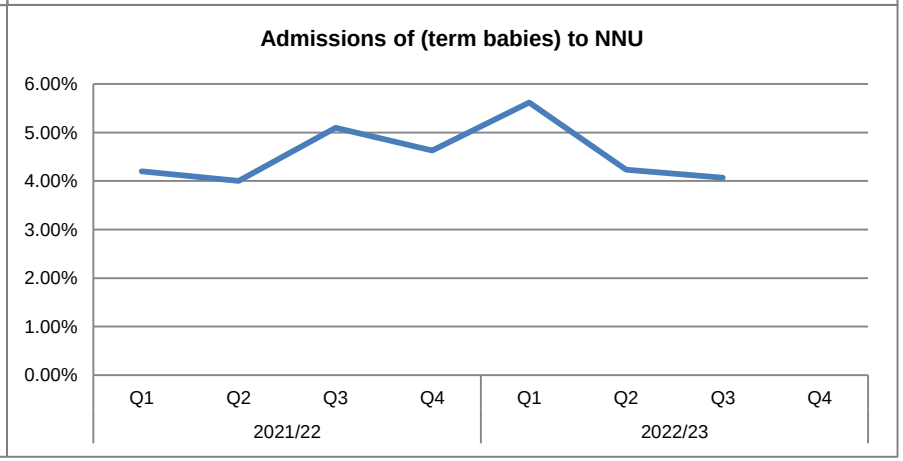
Eastern Services Maternity

Metrics relating to the provision of quality maternity care



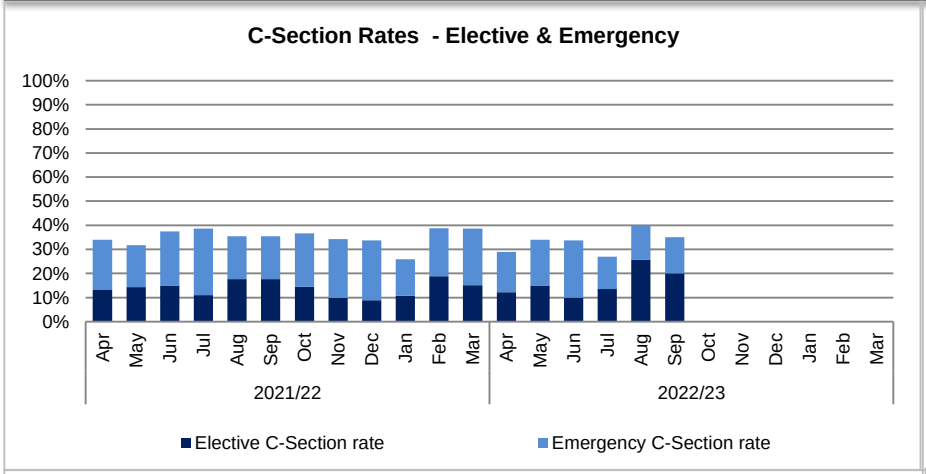


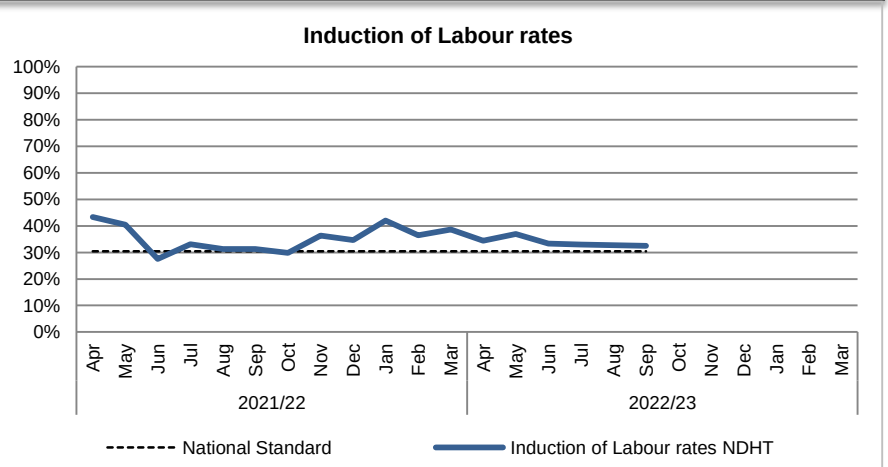


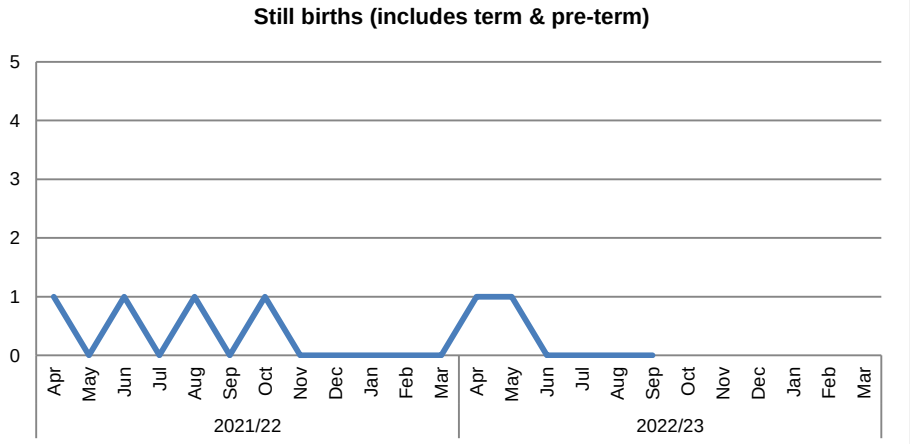


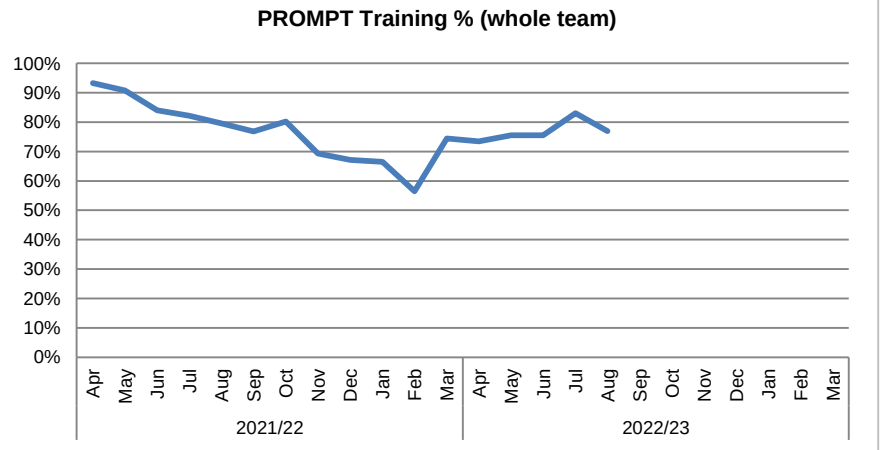
Birth rate remained stable and within normal parameters.
1 red flag raised on acuity tool for no 1:1 care in labour, this was resolved at the time.
Midwifery Ratio consistent with previous months.
Admissions to neonatal unit below the national 5% limit, cases monitored via quarterly ATAIN reports.

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





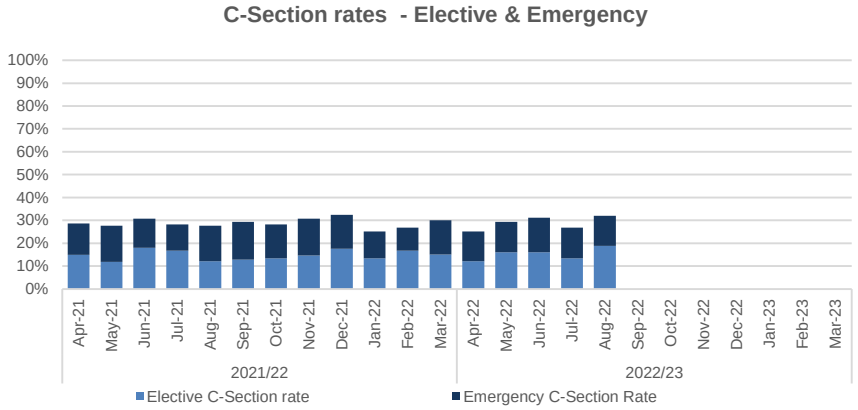


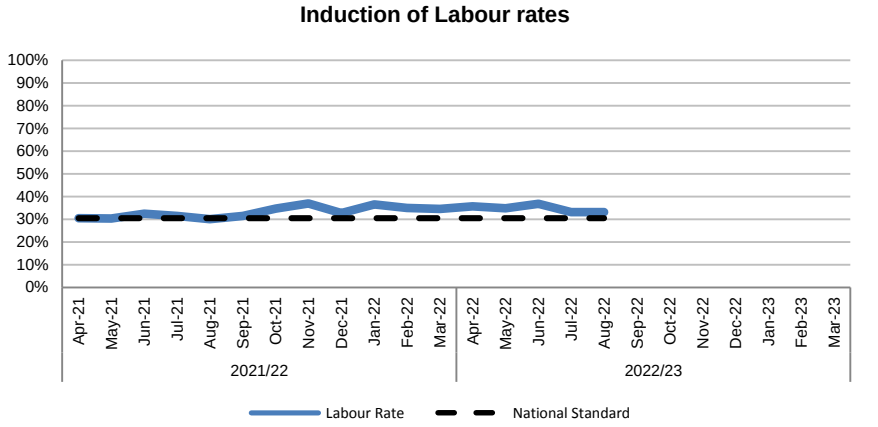


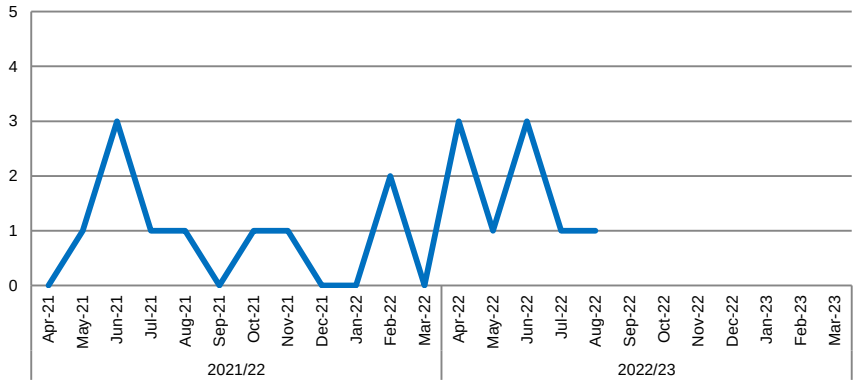
- Emergency and elective c section rates and induction of labour are aligned with the national standard for the month.
- PROMPT training compliance data unavailable for September. However the unpublished data displays an upward trajectory against the CNST target of 90%. The recovery trajectory being monitored by the Trust Directors through the monthly Performance Assurance Meetings. Compliance with the 90% target is continues to eb expected by November 22. The team are working closely with colleagues in Eastern Services to align all maternity specific training including PROMPT delivery.

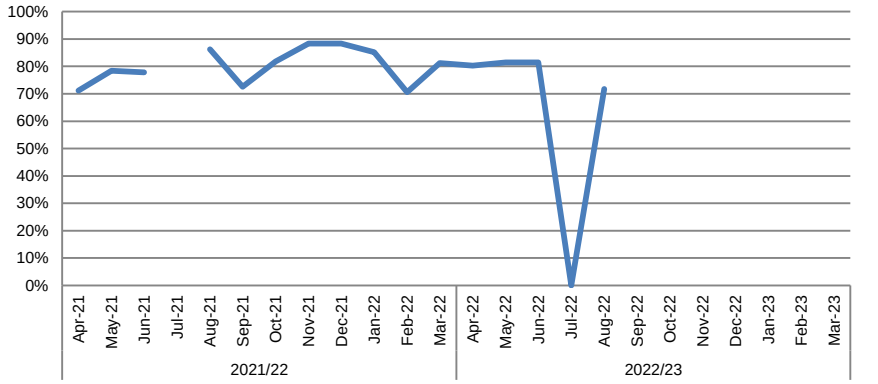
Eastern Services Maternity

Metrics relating to the provision of quality maternity care





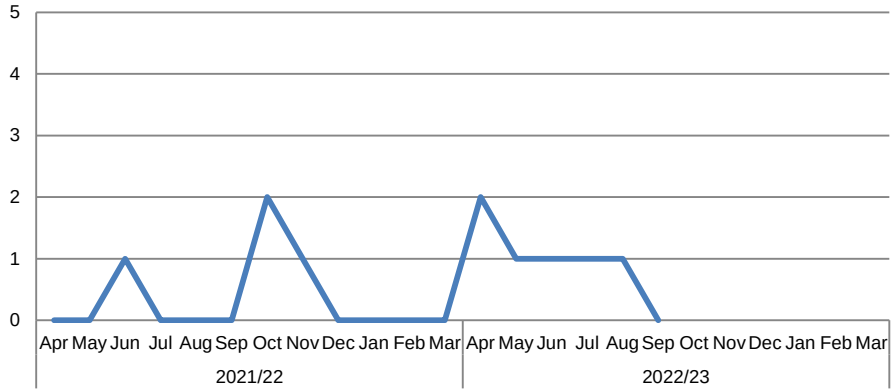




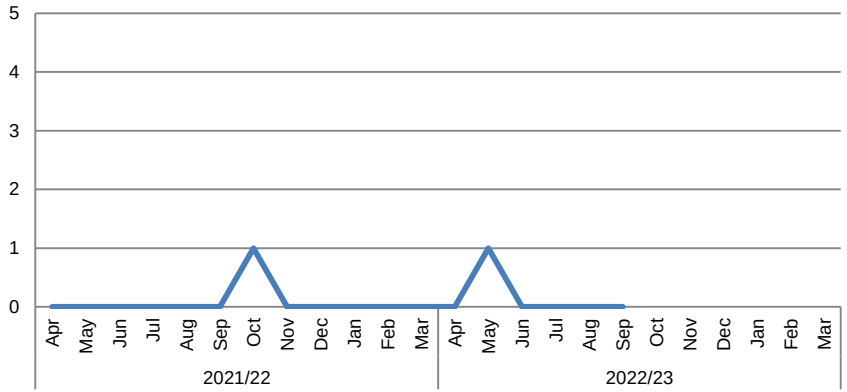
C-Section and induction of labour rates within expected range.
Stillbirths reported via MBRRACE portal and reviewed through PMRT, no concerning themes noted.
There was no PROMPT training compliance data available for July – Augusts compliance reflects usual seasonal staff rotation.

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

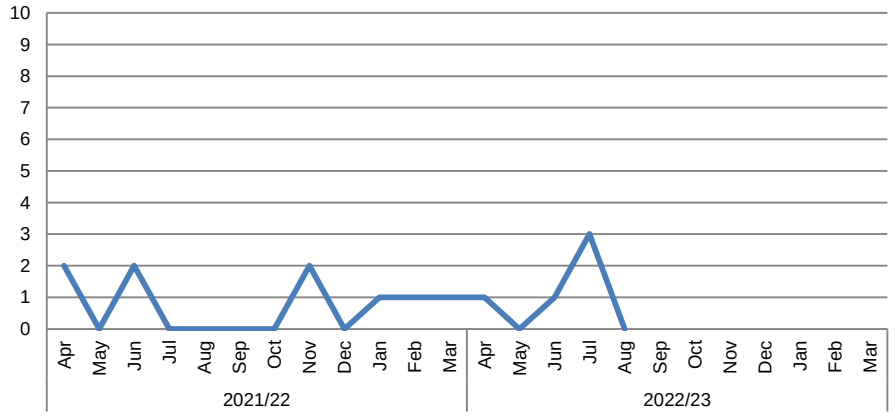
Incidents in current month (moderate and above) (run chart)



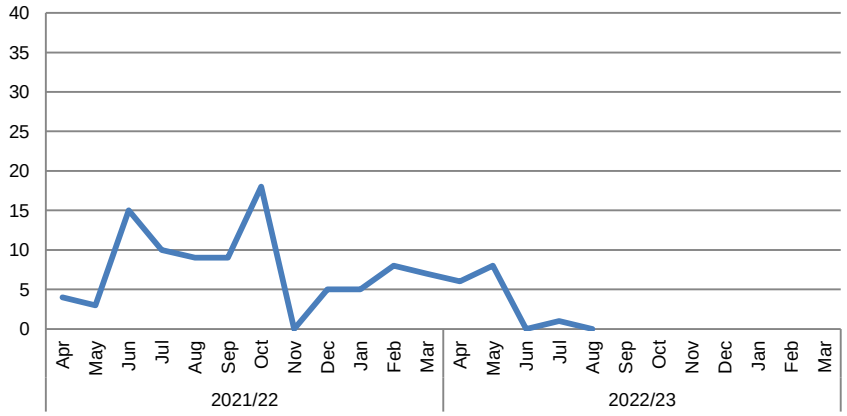
Serious Incidents (run chart)



Complaints Maternity



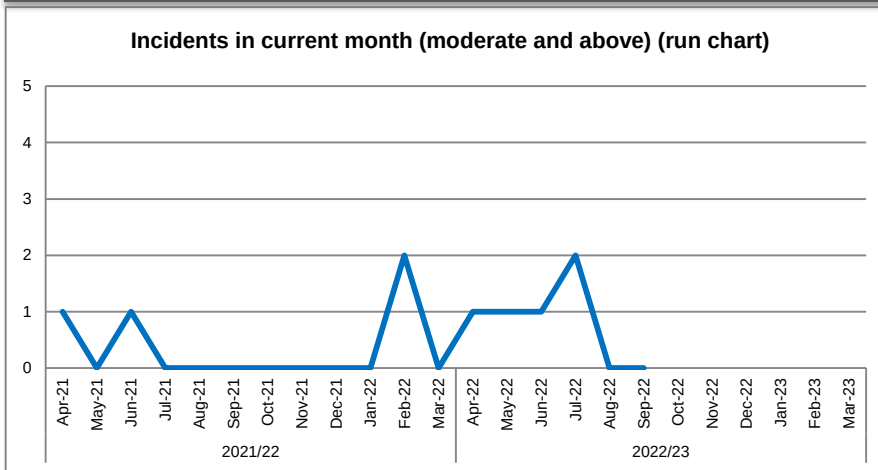
Compliments Maternity

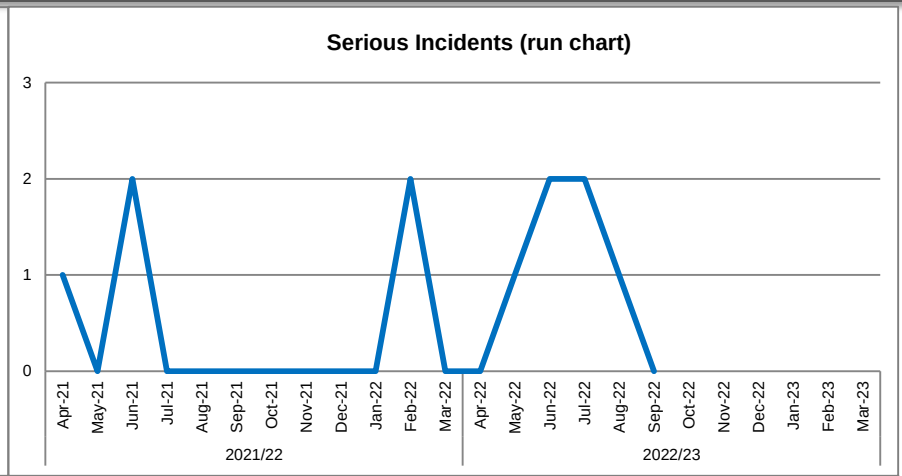


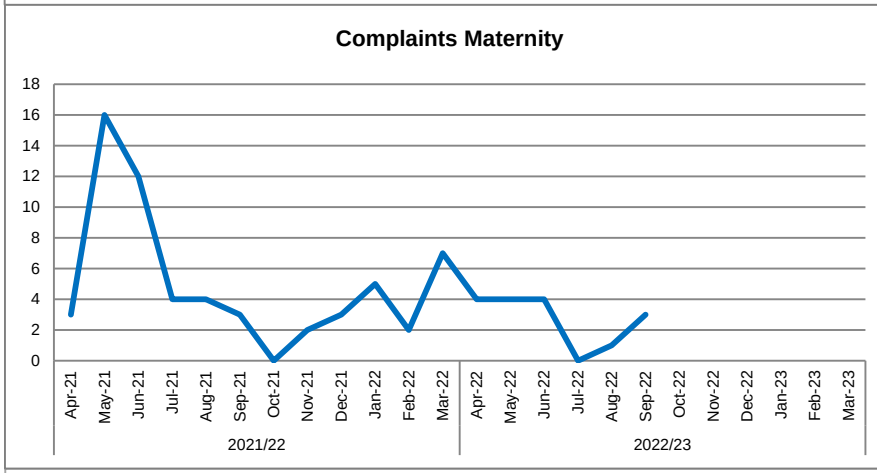
- There was 1 moderate or above incident reported for the month.
- There were no specialty specific complaints or compliments data available in September
- The Maternity Team continue to work closely with the Maternity Voices Partnership to develop continuous feedback mechanisms and processes to support responses and have recently re-launched Care Opinion.

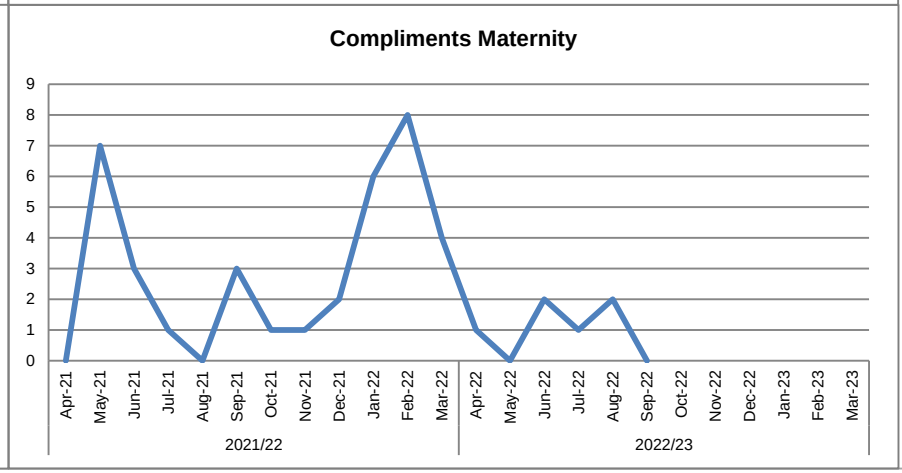
Eastern Services Maternity

Metrics relating to the provision of quality maternity care



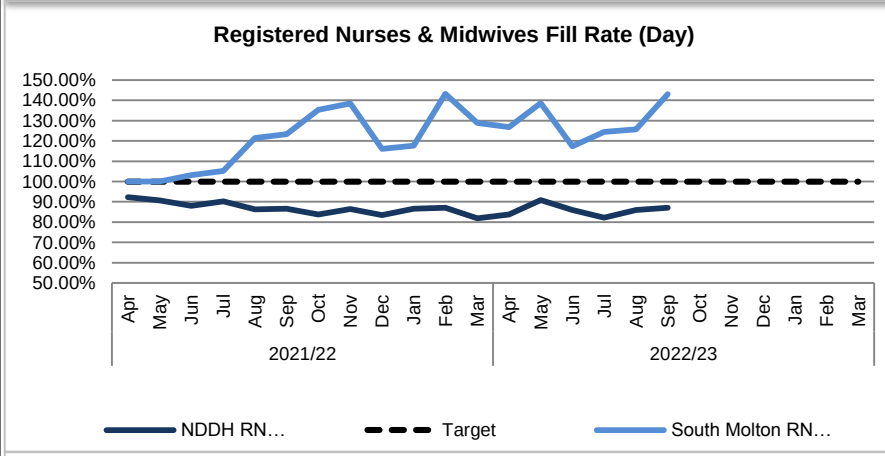


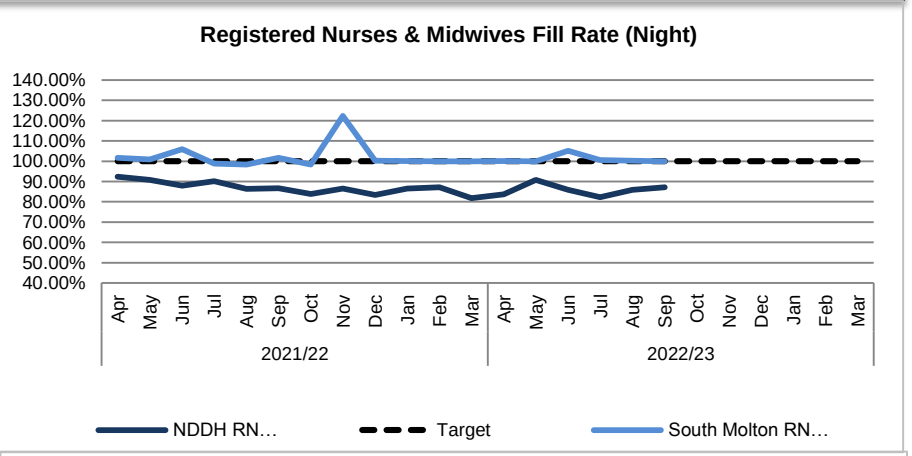


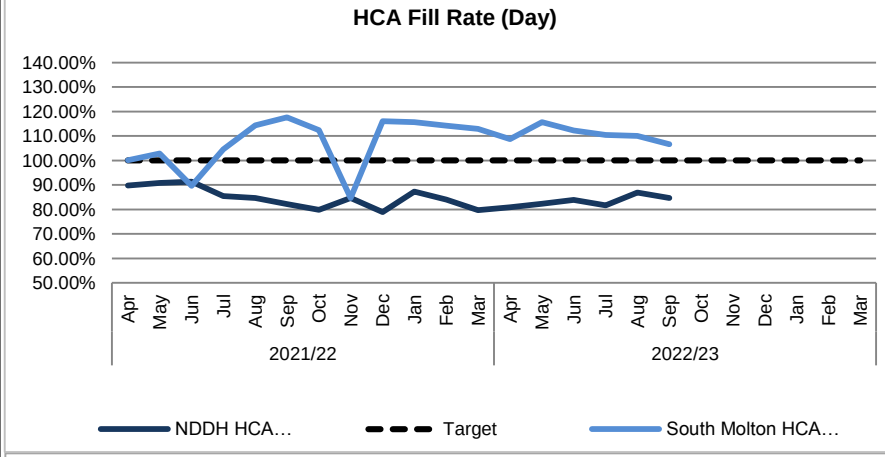


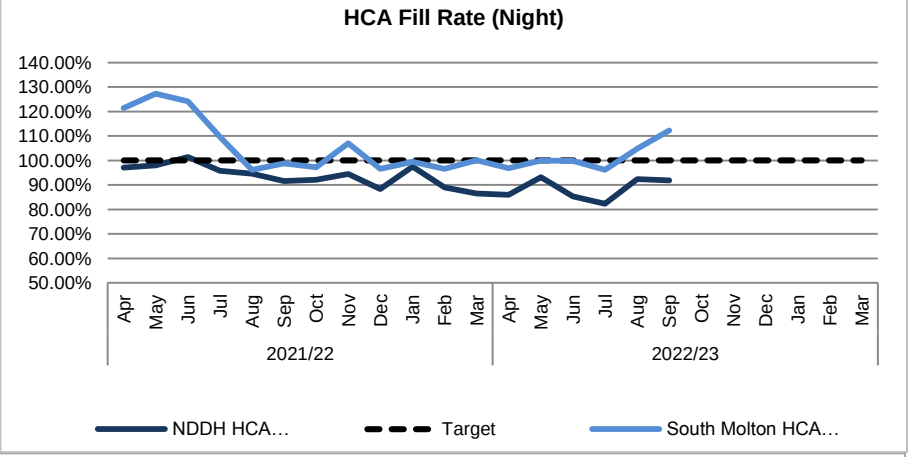
No concerning themes identified with incidents and complaints this month.
Compliments only reflect those recorded on Datix

Northern Services Safe Clinical Staffing Fill Rates





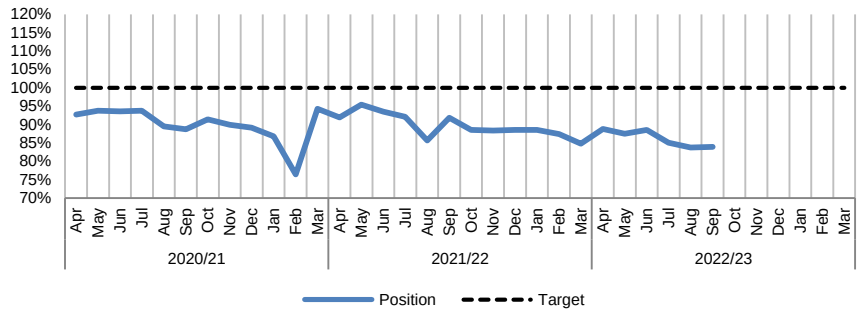


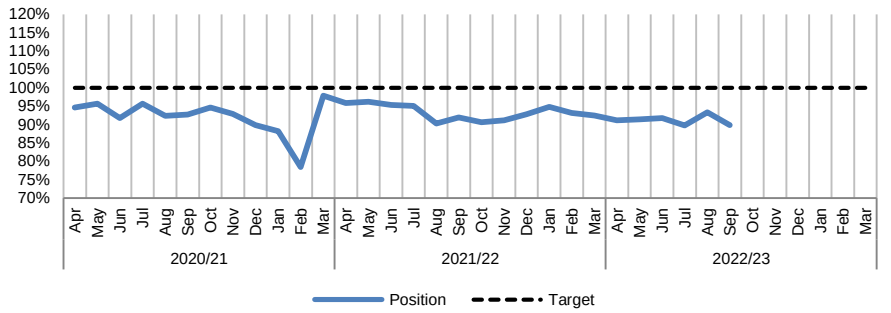


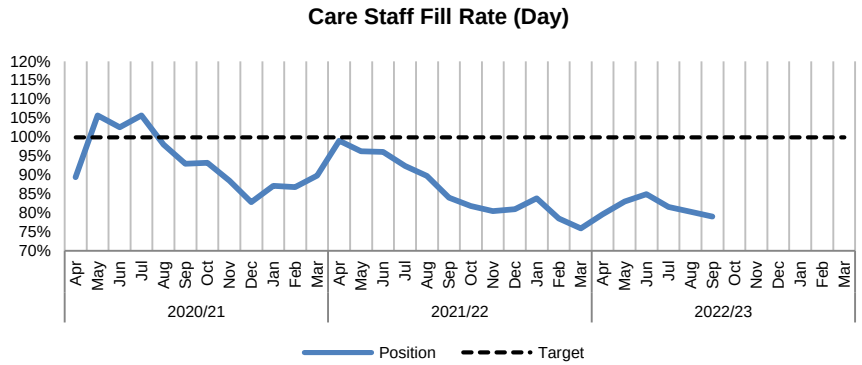
- All nursing & midwifery staffing fill rates are > 85%
- There has been an increase Registered Nurse or Midwife clinical staffing fill rates in September 2022. The Health Care Assistant fill rate has slightly decreased in September with the exception of South Molton which remains > 100% overall.
- Established processes are in place daily with senior nurse oversight to ensure safe redeployment of staff to maximise overall patient and workforce safety across all clinical areas
- South Molton fill rates remain high due to the utilisation of additional bed capacity requiring additional staff.

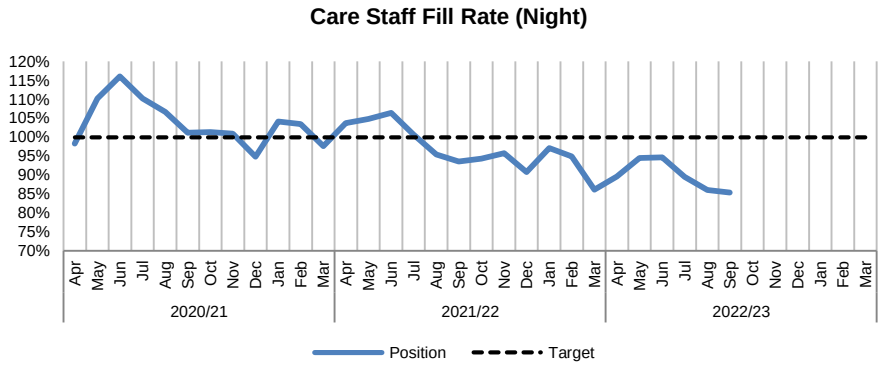
Eastern Services Safe Clinical Staffing – Fill Rate

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





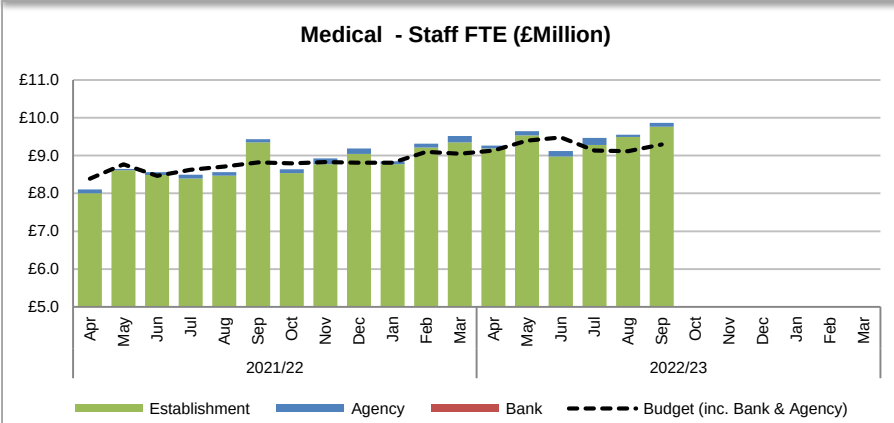


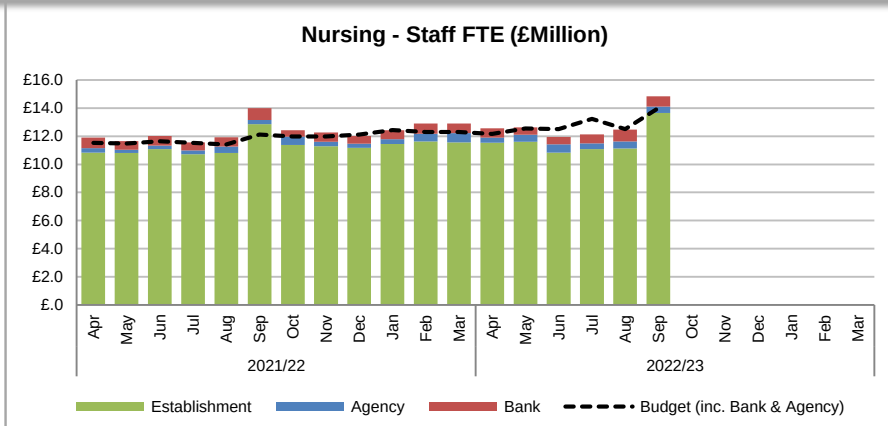


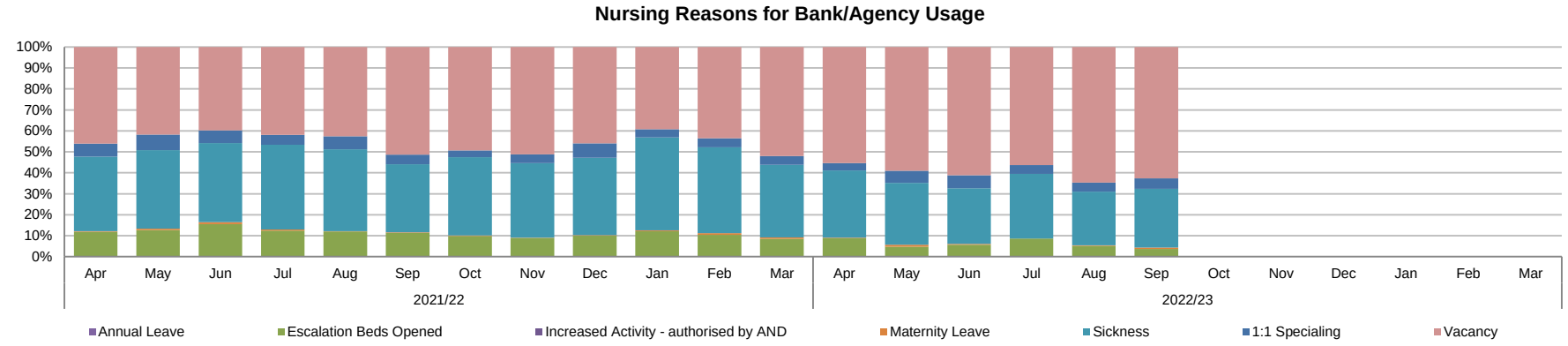
- The overall fill rate for September 2022 was 84.55%.
- The Day fill rate for care staff was below 80%. There are a growing number of HCA vacancies, particularly within Medical Services.
- There were 71 incidents Categorised as “Staff Shortages” reported via Datix . 86% of these were reports of inadequate staffing levels.
- All patient safety incidents which resulted in Moderate or greater harm were reviewed. From this review of 19 incidents none reported staffing levels.as either a causative or contributory factor.
- Risks are mitigated through the twice daily staffing meetings and clinical matrons support the wards to ensure safety of patients is not compromised

Eastern Services Safe Clinical Staffing

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

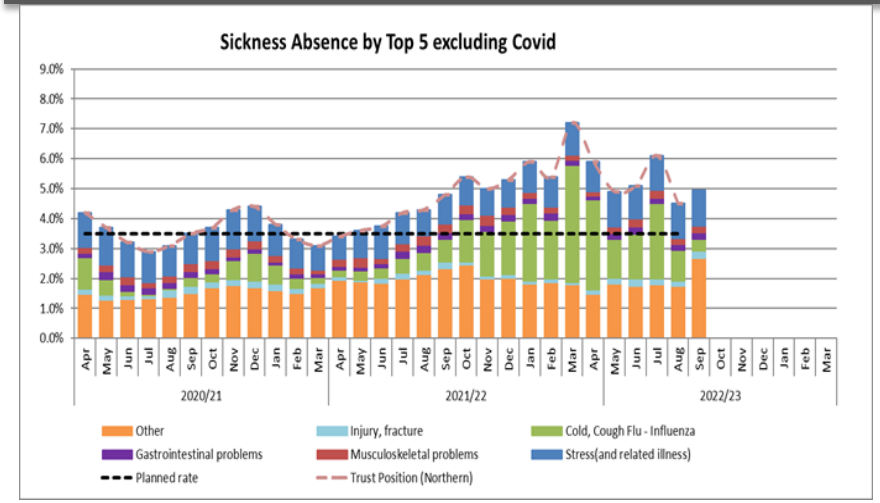


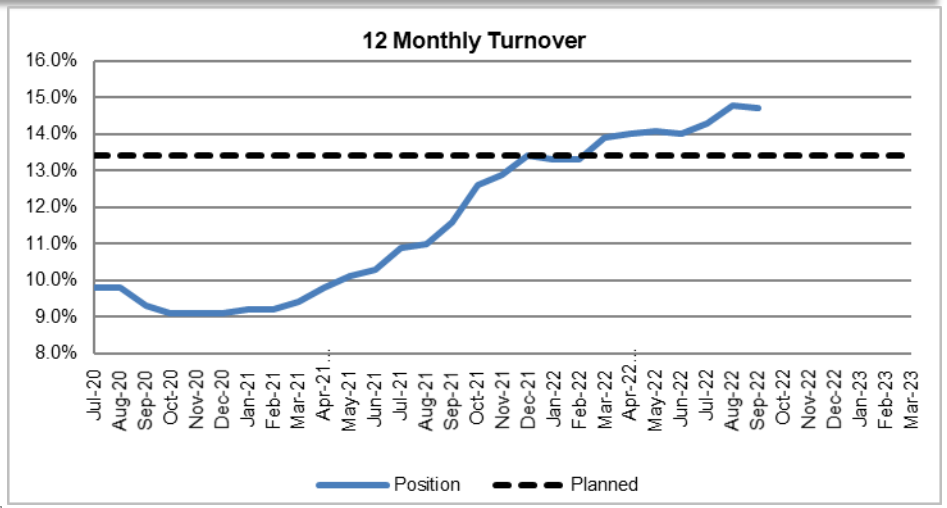


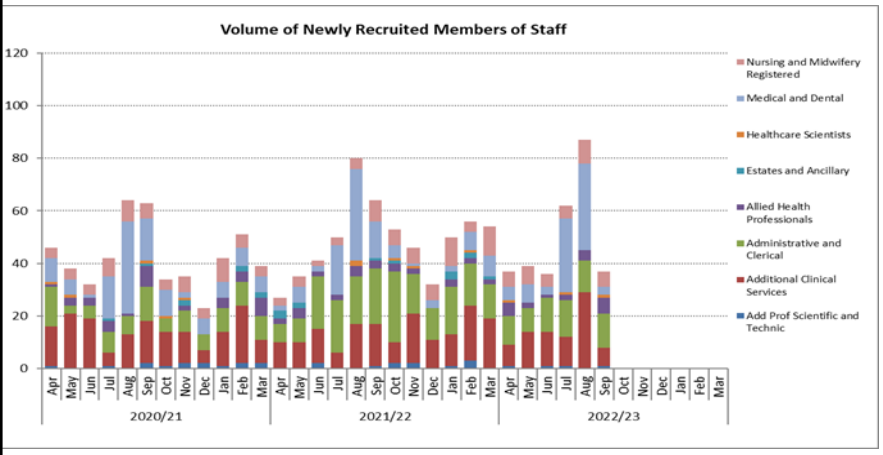


- September has continued to see operational pressures impact upon the demand for temporary staffing.
- Over 5% of the demand for bank and agency nursing staff has been to provide 1:1 support to patients presenting with significant risks
- Escalation beds remained open throughout September 2022.

Northern Services Workforce Indicators







Turnover for 12 months ending 30th September 2022	Avg FTE	Starters FTE	Leavers FTE	Turnover FTE %
Add Prof Scientific and Technic	72.67	4.92	15	20.7%
Additional Clinical Services	553.63	140.35	95	17.1%
Administrative and Clerical	783.97	74.79	112	14.3%
Allied Health Professionals	290.67	20.99	34	11.5%
Estates and Ancillary	65.40	6.95	9	14.1%
Healthcare Scientists	59.05	5.60	9	15.4%
Medical and Dental	171.38	15.50	19	11.0%
Nursing and Midwifery Registered	765.10	53.27	116	15.2%
Grand Total	2,761.88	322.36	408	14.8%

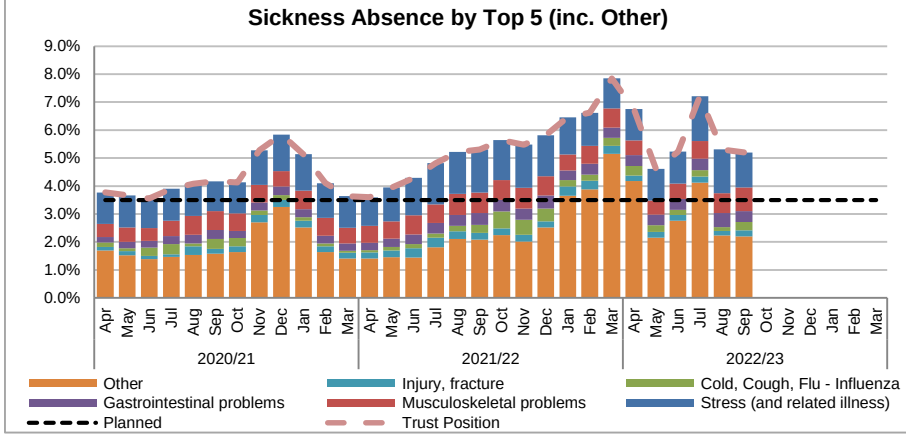
Sickness and Absence

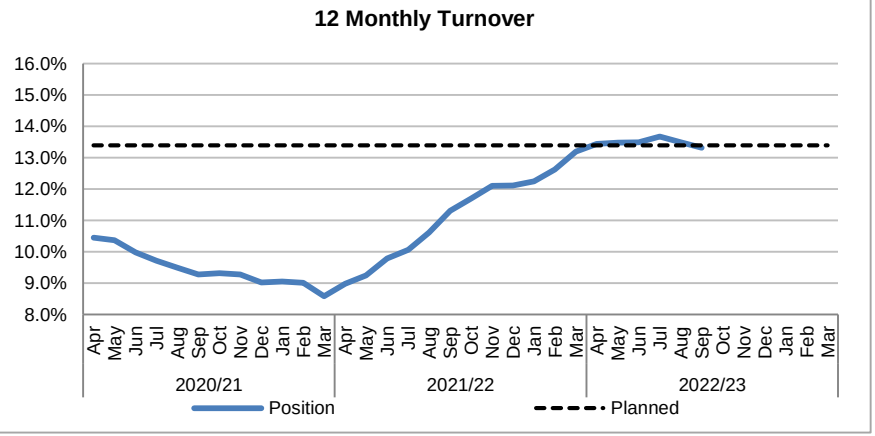
- Sickness absence levels have increased from the 12-month low point in August and unfortunately are continuing to rise as we go through October.
- Absence categorised as "Other" remains the top reason recorded for absence.
- Stress, anxiety, depression and other psychiatric illness remains the 2nd highest category but with the levels being fairly stable.

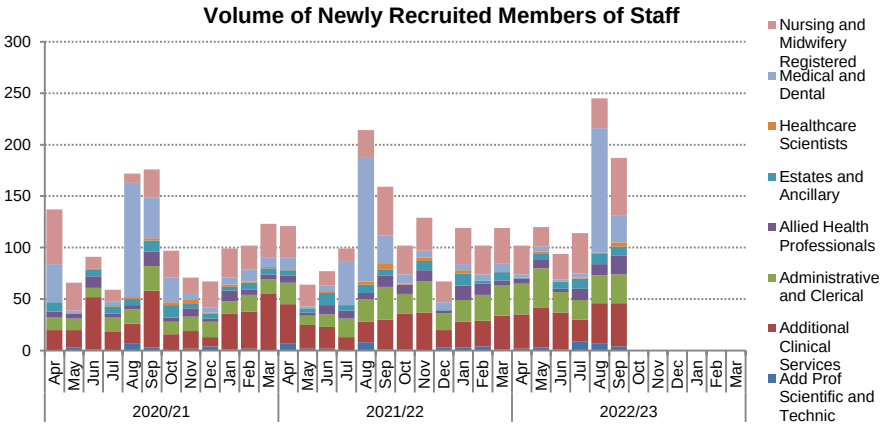
Turnover

- The 12-monthly rolling staff turnover has stabilised at 14.8%, but remains considerably higher than for the equivalent period last year and above the "planned" turnover level of 13.5%.
- The volume of newly recruited has dropped back in September from the high figures reported in August. The number of Health Care Support Workers recruited has dropped back this month but focussed recruitment drives for this staff group continue, with the latest open recruitment event taking place on 15th Oct 22.
- Health Care Support Worker (HCSW) drop-in sessions and Apprentice engagement sessions have continued, providing valuable insight as to how our HCSW's and Apprentices are feeling. Work is also under way to develop "Stay Conversations" further.

Eastern Services Workforce Indicators







Turnover for 12 months ending 30th September 2022	Avg FTE	Starters FTE	Leavers FTE	Turnover FTE%
Add Prof Scientific and Technic	209.07	27.91	28.59	13.7%
Additional Clinical Services	1,462.11	309.15	257.50	17.6%
Administrative and Clerical	1,655.03	215.26	236.02	14.3%
Allied Health Professionals	586.58	87.14	69.88	11.9%
Estates and Ancillary	621.44	67.57	99.51	16.0%
Healthcare Scientists	212.87	12.24	22.60	10.6%
Medical and Dental	427.19	12.05	15.69	3.7%
Nursing and Midwifery Registered	2,134.10	303.27	244.40	11.5%
Students	15.60	0.00	1.40	9.0%
Grand Total	**7,323.99**	**1,034.60**	**975.59**	**13.3%**

Sickness and Absence

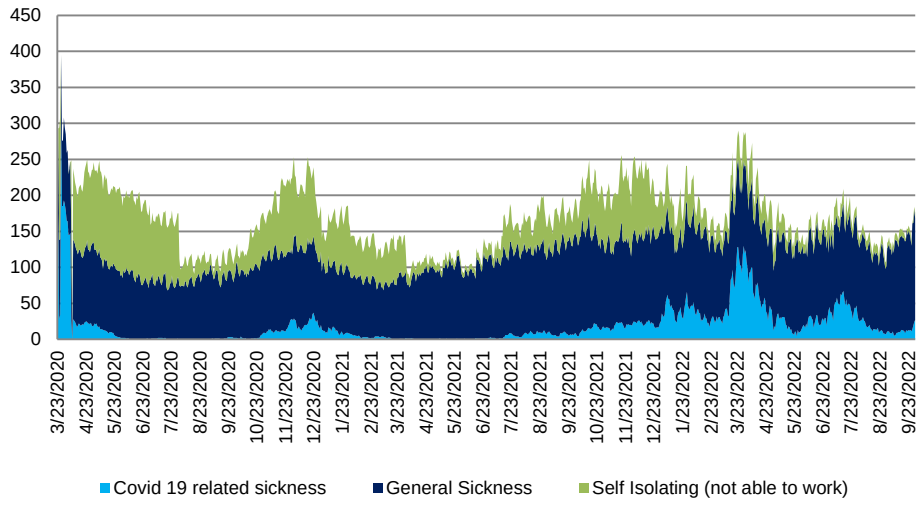
- A further slight fall in the month on month sickness rate in September, but still above 5% approaching the months where seasonal illnesses will likely become more prevalent.
- The number of days lost to Covid sickness episodes was slightly higher than in August; an indicator of the increasing numbers being seen in the current month.
- Stress (and related illnesses) accounted for almost a quarter of all sickness absence recorded in the month, though less than August's 30%.
- Whilst the month rate for Eastern has steadied following the July spike, when looking at the rolling 12 month trend, the Nursing workforce groups show a rate of over 6% for RN and Midwives, and 9% for Support to Nursing (i.e. Healthcare Support Workers); our Estates and Ancillary staff remain at over 9% for the past year.

Turnover

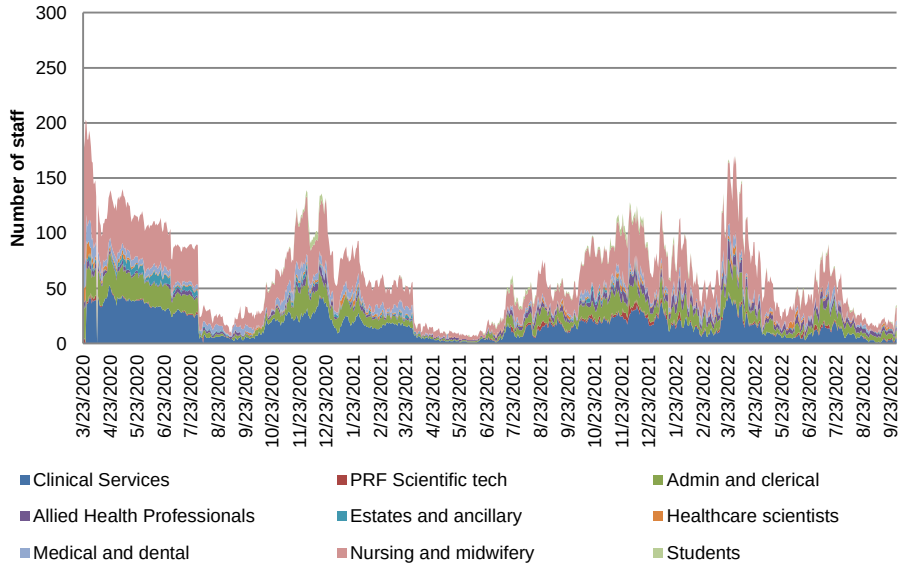
- The overall rate for Eastern Services has dipped to 13.3%, the lowest reported since March. With the exception of AHP, all of our major workforce groups showed a decreased rate from August.
- Those groups most challenged by high turnover – Additional Clinical Services (which includes Healthcare Support Workers) and Estates & Ancillary – show rates which have plateaued since the Spring and now slightly decreasing.
- The Registered Nursing/Midwifery rate fell again and in spite of a bump to AHP attrition in September, both of these groups appear to show a relatively stable position in the last 12 months.

Northern Services Workforce - Covid related and general sickness information

Staff sickness and self isolating



COVID 19 related sickness and self isolating (not able to work) by staff category

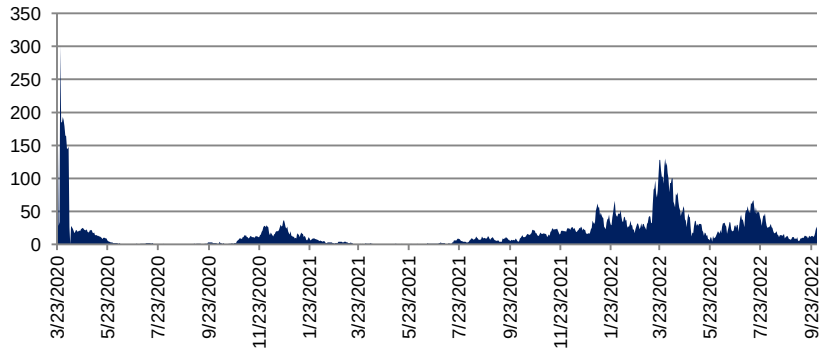


Sickness (Staff Absence and Self Isolation)

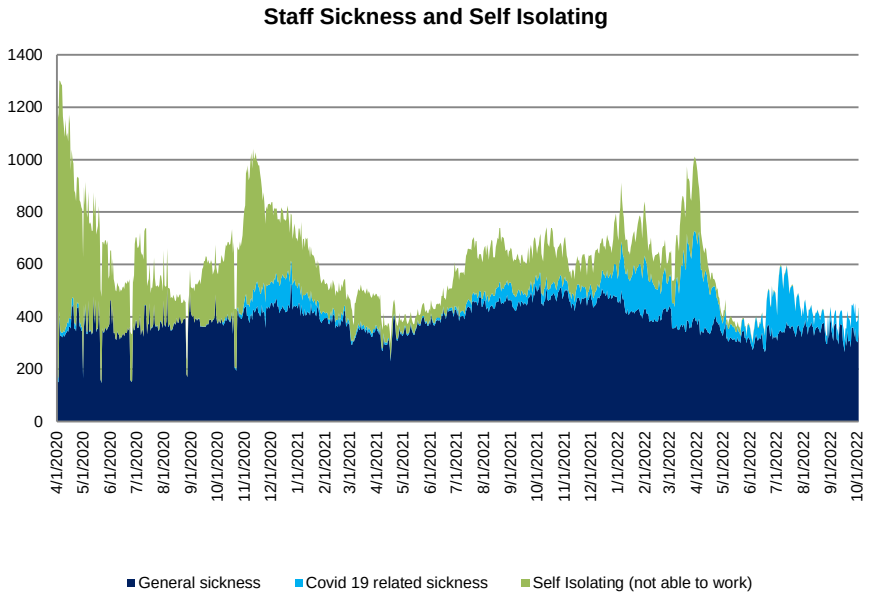
- There is an upward trend in COVID absence going into October. As at the 14th October 2022, the total number of staff with COVID-19 related absence is 37 and was 43 earlier in the week.

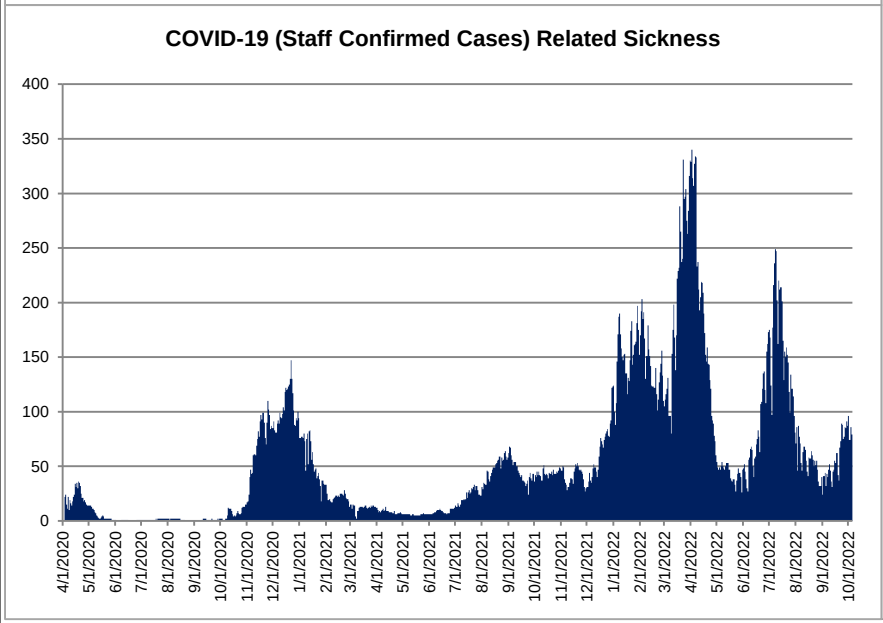
	10th Oct	11th Oct	12th Oct	13th Oct	14th Oct
% Staff Sickness - Covid Confirmed	0.76%	1.18%	1.12%	1.04%	1.04%
% Staff Sickness - Covid Incl Isolation	1.12%	1.46%	1.52%	1.29%	1.26%
% Staff Sickness - Other (non Covid)	2.874%	2.42%	2.78%	3.09%	3.01%
Total % Sickness	4.75%	5.06%	5.51%	5.42%	5.31%
Staff Group	10th Oct	11th Oct	12th Oct	13th Oct	14th Oct
Additional Clinical Services	36	39	46	42	39
Additional Professional Scientific and Technical	5	5	5	5	5
Administrative & Clerical	32	41	44	43	43
Allied Health Professionals	18	19	17	14	14
Estates and Ancillary	4	3	3	3	3
Healthcare Scientists	4	3	4	5	4
Medical & Dental	11	14	15	11	12
Nursing & Midwifery Registered	57	56	61	69	67
Students	2	0	1	1	2
Totals	169	180	196	193	189

COVID 19 related sickness



Eastern Services Workforce – Covid related and general sickness information





Staff Absence and Self Isolation

As at 12th October, the total number of staff with Covid related absence has increased from 31 one month ago to 101 and reflects the increase in Covid cases being seen in the general population over the last month At the time of writing 5% of the workforce are absent due to general sickness and Covid related absence and is a significant increase on the 3.5% reported last month

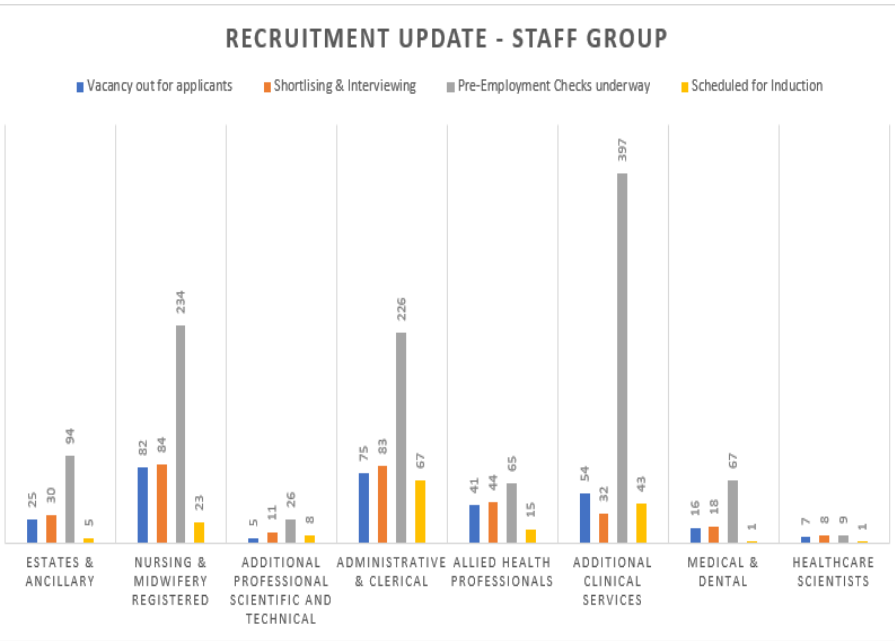
Eastern Services currently have 15 members of staff with an open sickness episode attributed to Long Covid

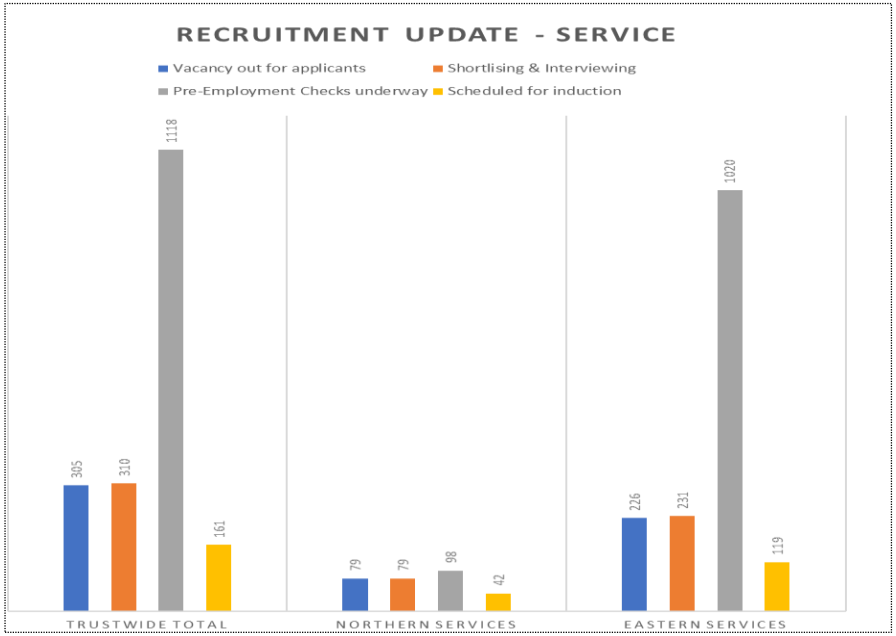
A team of 'roving' vaccinators are offering Covid-19 autumn boosters to staff on the main Wonford/Heavitree sites Monday to Friday with sessions also being held in the main Outpatients Department. Specific sessions for community hospitals have been advertised locally for staff based at those sites. All staff remain welcome to book via the national booking system or the walk-in service available at Greendale.

Seasonal flu vaccinations are being delivered through peer vaccinators who are based in almost all inpatient wards and outpatient departments, as well as community nursing bases. These are supplemented by a series of drop in sessions at the larger hospital sites.

Staff Group	General Sickness	Sickness - Covid19	Self Isolating - Symptomatic (includes Self & Household)	Self Isolating - Vulnerable Groups (Includes Pregnant and High Risk)	Total Number of staff absent with any Covid related reason
Add Prof Scientific and Technic	6	1	0	0	**1**
Additional Clinical Services	112	32	0	0	**32**
Administrative and Clerical	71	10	0	0	**10**
Allied Health Professionals	18	8	0	0	**8**
Estates and Ancillary	52	3	0	0	**3**
Healthcare Scientists	5	3	0	0	**3**
Medical and Dental	16	7	0	0	**7**
Nursing and Midwifery Registered	88	37	0	0	**37**
Students			0	0	**0**
Grand Total	**368**	**101**	**0**	**0**	**101**

Trust Other Workforce Indicators





This is the second data set since the launch of the Career Gateway (CG). The pipeline is currently showing high numbers in the Eastern 'pre-employment check' category reflecting the success of recent recruitment. To expedite the on-boarding, further actions are in place and are being monitored by the Executive.

In just 2 months, we have seen an improvement since the launch of CG in reducing our working days in the 'pre-employment checks' phase by 305 from 32 to 23 days.

International recruitment continued during September with 36 registered nurses arriving in the East with a further 3 in the North. In October we are expecting a further 10 in the East and 7 in the North. Despite continuing challenges with accommodation availability we hope to welcome a further 31 nurses over both sites during November and December. In addition HCSW recruitment days were held in both North and East resulting in over 100 job offers being made including some bank offers.

	Aug-22	Sep-22		
Total Vacancy (ESR/Finance)	**Vacancies**	**Budgeted**	**Contracted**	**Vacancies**
Add Prof Scientific and Technic	29.4	356.0	329.9	26.1
Additional Clinical Services	278.4	2520.1	2235.2	284.8
Administrative and Clerical	156.6	2606.0	2437.6	168.4
Allied Health Professionals	123.4	1003.4	885.0	118.3
Estates and Ancillary	131.6	829.7	682.7	147.0
Healthcare Scientists	24.5	341.2	320.0	21.3
Medical and Dental	17.0	1273.4	1270.3	3.1
Nursing and Midwifery Registered	274.4	3145.8	2872.6	273.3
Total	**1035.3**	**12075.6**	**11033.4**	**1042.2**

RDUH Finance Overview

Financial Performance - key performance indicators

Consolidated Metrics						
Domain	**Measure / Metric**	**Unit of Measure**	**Last Month Aug-22**	**This Month Sep-22**	**Year End Mar-23**	
Income and Expenditure	**I&E Surplus / (Deficit) - Total**	£'000	**-3,880**	**-6,108**	**-18,263**	
	I&E Surplus / (Deficit) v budget	£'000	**0**	**0**	**0**	
	Income variance to budget - Total	£'000	**188**	**-287**	**-1,877**	Mostly related to under recovery of commercial income(see below).
	Income variance to budget - Total	%	**0.05%**	**-0.06%**	**-0.20%**	
	Income variance to budget - Patient Care	£'000	**-42**	**797**	**333**	
	Income variance to budget - Commercial income	£'000	**230**	**-1,084**	**-2,210**	Commercial activities are under-recovered mostly due to car parking, nursery, fertility and catering.
	Pay variance to budget - Total	£'000	**-1,468**	**-433**	**398**	Impact of productivity CIP under delivery removed from pay variance and reported within the CIP to show true position on pay (pre CIP)
	Pay variance to budget - Total	%	**-0.06%**	**-0.14%**	**0.07%**	
	Agency expenditure (inc COVID expenditure) variance to Plan	£'000	**-3,046**	**-3,842**	**-9,000**	Usage particularly in nursing and medical workforce reflecting vacancies, sickness, Covid impact and ESRF delivery.
	Non Pay variance to budget	£'000	**1,044**	**837**	**16**	
	Non Pay variance to budget	%	**0.82%**	**0.54%**	**0.01%**	
	PDC, Depreciation, Interest Paid / Received variance to budget	£'000	**236**	**-117**	**1,463**	
	PDC, Depreciation, Interest Paid / Received variance to budget	%	**1.17%**	**-0.48%**	**2.00%**	
	Cost Improvement Programme - Total Current Year achievement	£'000	**8,426**	**15,530**	**33,935**	
	Cost Improvement Programme - Year to date/ Current Year variance to budget	£'000	**-4,365**	**-7,500**	**-19,800**	See report narrative
Capital & Cash	Cash balance	£'000	**84,341**	**71,541**	**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 revenue changes made to the final Annual Plan.
	Cash variance to budget - above / (below)	£'000	**30,402**	**29,309**	**19,198**	
	Better Payment Practice v 95% target - volume	%	**92%**	**91%**	**95%**	
	Better Payment Practice v 95% target - value	%	**92%**	**94%**	**95%**	
	Capital Expenditure variance to budget - Total above / (below)	£'000	**-4,161**	**-4,971**	**0**	See report narrative. There is confidence the programme will recover based on the value of open orders.
	Capital Expenditure variance to budget - CDEL above / (below)	£'000	**-4,034**	**-4,479**	**0**	As above
	Capital Expenditure variance to budget - PDC above / (below)	£'000	**-127**	**-492**	**0**	Slippage on planned commencement of Diagnostics CDC in East that is awaiting approval.

Key

Total value
Positive variance value
Negative variance value <5%
Negative variance value >5%

RDUH Summary Finance position

Trust Commentary

Month 6 Summary Finance Position - YTD

- The Board has approved a deficit plan of £18.3m
- Cumulative deficit of £6.1m achieves plan predominantly by Delivering best Value slippage on pay off-set by lower non-pay expenditure.
- The adverse movement in commercial income is under-recovered mostly due to car parking, nursery, fertility and catering.
- Pay variance reflects NR pay underspends off-set by slippage on Delivering Best Value and reserves.
- Favourable non-pay arises from the reduced levels of elective activity.
- Depreciation and PDC calculations are based on the balance sheet position.

Month 6 Summary Finance Position - FOT

- The planned deficit of £18.3m is forecast to be achieved.
- Movements on commercial income include continuation of trend; pay recovers as H2 impacts e.g. reducing agency expenditure materialise and non-pay reflects increased activity.

Risks and Mitigations

- The table opposite sets out the current assessment of risk and mitigation opportunities that exist in months 7 to 12 to the current planned deficit.
- Gross risk and mitigation opportunities have been consolidated and assessed on likelihood of materialising.
- Unmitigated risk of £5.2m has been identified with the main mitigation opportunities being further non recurrent benefits expected of continued expenditure underspends and other technical benefits. Work is ongoing to identify ways of mitigating this net risk position by year end.

Delivering Best Value (DBV) Programme

- The DBV programme for the year is £33.9m
- £7.5m has been achieved YTD against £15.5m target being £8.0m adverse to plan. The shortfall was covered through other NR slippage as set out above.
- Current assessment is of delivering £14.1m of the total programme being £19.8m adverse to plan and is reflected in the risks and mitigations table for months 7-12 (with month 1-6 being mitigated within the ytd overall position). Of the forecast shortfall £14.6m for the year relates to productivity opportunity that is impacted by current pressures in Urgent and Emergency Care impacting the ability to deliver the elective activity plan.

Deliverying Best Value Programme £m	FY Plan	Year to date plan	Year to date actual	Year to date variance	True Forecast	Forecast Variance
Divisional CIP	5.5	2.3	1.6	**-0.7**	3.5	**-2.1**
Mycare benefits	1.9	0.8	0.3	**-0.5**	0.9	**-1.0**
Productivity	14.6	6.4	0.0	**-6.4**	0.0	**-14.6**
Covid Cost Reductior	6.5	3.3	2.7	**-0.6**	5.3	**-1.2**
Further Stretch	5.4	2.7	2.9	**0.2**	4.5	**-0.9**
Total	**33.9**	**15.5**	**7.5**	**-8.0**	**14.1**	**-19.8**

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 Boards 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.

Data

Trust	Year to Date			Year End Forecast		
Month 6 2022/23 Summary Income & Expenditure	Actual £,000	Budget £,000	Variance Fav / (Adv) £,000	Actual £,000	Budget £,000	Variance Fav / (Adv) £,000
Patient Income	418,223	417,426	797	840,397	840,064	333
Commercial Income	53,740	54,824	(1,084)	101,920	104,130	(2,210)
Total Income	**471,963**	**472,250**	**(287)**	**942,317**	**944,194**	**(1,877)**
Pay	(298,844)	(298,411)	(433)	(606,227)	(606,625)	398
Non Pay	(154,815)	(155,652)	837	(303,877)	(303,893)	16
Total Expenditure	**(453,659)**	**(454,064)**	**405**	**(910,104)**	**(910,518)**	**414**
EBITDA	**18,304**	**18,186**	**118**	**32,213**	**33,676**	**(1,463)**
PDC,Depreciation, Interest & gain from absorption	88,253	88,412	(159)	57,957	56,466	1,491
Net Surplus / (Deficit)	**106,557**	**106,598**	**(41)**	**90,170**	**90,142**	**28**
Removal of exceptional items	(112,665)	(112,706)	41	(108,433)	(108,405)	(28)
Net Surplus / (Deficit) after exceptional items	**(6,108)**	**(6,108)**	**(0)**	**(18,263)**	**(18,263)**	**(0)**

Delivery Risk	Worse Case	Most Likely	Best Case
	£m	£m	£m
Current Deficit	-18.3	-18.3	-18.3
Risks mths 1-7	**£m**	**£m**	**£m**
Overall DBV shortfall	-12.1	-11.8	-5.3
ERF Cost Risk - additional 104wk schemes	-1.5	-1.5	-1.0
Overspend issues	-4.0	-2.5	-0.5
Contractual risk	-1.0	-1.0	0.0
Other issues	-2.2	0.0	0.0
Additional cost of energy not funded	-3.0	-1.7	-0.4
Gross Risk	**-23.8**	**-18.6**	**-7.2**
Mitigations mths 1-7			
Underspending areas	3.0	5.1	6.4
Slippage	0.9	2.2	3.3
Funding/ contractual negotiations	0.4	2.5	5.0
Balance sheet mitigations	3.6	3.6	3.6
Total Mitigations	**7.9**	**13.4**	**18.4**
Net Delivery risk on top of planned deficit	-15.9	-5.2	11.2
TOTAL RISK ADJUSTED DEFICIT	**-34.2**	**-23.4**	**-7.1**

RDUH Financial Tables

Consolidated - Commentary

Capital

- The capital programme for the year is £54.9m and is forecast to be £3.4m higher than plan due to additional CDEL required to cover new leases and additional Donations and PDC funded schemes.
- Confirmation has been received in month 6 guidance that the 2021/22 and 2022/23 IFRS16 impact of leases meeting the criteria will be covered by a central allocation. Whilst minimising the risk to Trust CDEL there remains detail to work through with NHSEI.

Year to date expenditure

- Capital expenditure to M6 was £19.9m, with the majority relating to Northern services MyCare scheme £10.1m and the Eastern services ED scheme of £3.9m.
- Other larger schemes have come online during month 6 including £1.0m on Eastern MyCare.
- There is confidence the programme will recover based on the value of open orders.

Cash

Year to Date

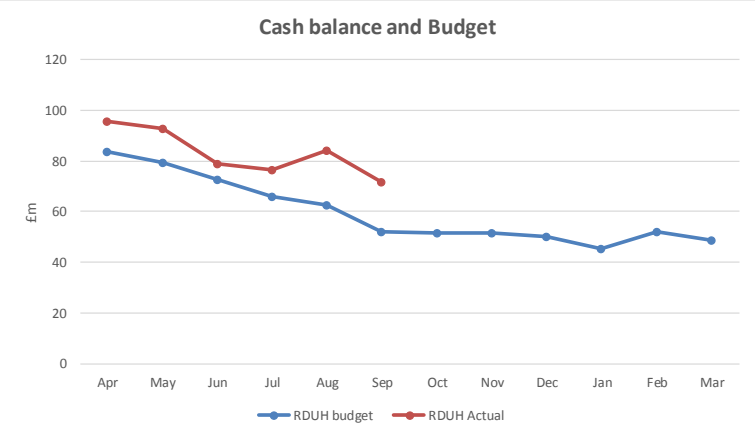
- Closing cash as at the end of August is £71.5m and is £29.3m higher than plan due to timing of settlement of net working capital, slippage in the capital programme and the impact of late changes to the June plan that was not reflected in the Balance Sheet (£11.4m)

FOT Cash

- Closing cash is forecast to be £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.
- Aged debt stands at £25.5m with £20.1m being not due at month end.

Data

	Year to Date			Full Year Forecast		
	Actual £'000	Plan £'000	Variance Fav/(Adv)	Actual £'000	Plan £'000	Variance Fav/(Adv)
Capital Funding Sources:						
CDEL	15,171	15,171	0	33,306	33,306	0
Donated	892	892	0	1,186	892	294
Leases	1,133	1,133	0	4,887	2,303	2,584
PDC	7,676	7,676	0	15,524	14,953	571
Total Capital Income	**24,872**	**24,872**	**0**	**54,903**	**51,454**	**3,449**
Expenditure:						
Developments	5,128	6,256	1,128	15,497	14,487	(1,010)
Equipment	1,878	3,795	1,141	17,735	14,918	(2,817)
Estates projects	11,152	12,074	1,917	15,908	16,361	453
Digital	1,743	2,747	785	4,981	5,130	149
Unallocated	0	0	0	782	558	(224)
Total Capital Expenditure	**19,901**	**24,872**	**4,971**	**54,903**	**51,454**	**(3,449)**
Under / (Over) Spend	**4,971**	**0**	**4,971**	**0**	**0**	**0**



RDUH Financial Tables

Royal Devon University Healthcare NHS Foundation Trust Income Statement - Consolidated Period ending 30/09/2022 Month 6	Year to Date Actual £'000	 Budget £'000	 Actual Variance to Budget Fav / (Adv) £'000		Outturn Actual £'000	 Budget £'000	 Actual Variance to Budget Fav / (Adv) £'000
Income							
Patient Care Income	418,223	417,426	797		840,397	840,064	333
Operating Income	53,740	54,824	(1,084)	1	101,920	104,130	(2,210)
Total Income	**471,963**	**472,250**	**(287)**		**942,317**	**944,194**	**(1,877)**
Employee Benefits Expenses	(298,844)	(298,411)	(433)	2	(606,227)	(606,625)	398
Drugs	(47,565)	(47,977)	412		(98,008)	(98,091)	83
Clinical Supplies	(37,956)	(39,547)	1,591	3	(76,943)	(76,602)	(341)
Non-Clinical Supplies	(7,926)	(8,127)	201	3	(15,232)	(15,627)	395
Misc Other Operating Expenses	(51,871)	(50,951)	(920)	3	(97,939)	(98,044)	105
Services Received	(9,497)	(9,050)	(447)	3	(15,755)	(15,528)	(227)
Total Costs	**(453,659)**	**(454,064)**	**405**		**(910,104)**	**(910,518)**	**414**
EBITDA	**18,304**	**18,186**	**118**		**32,213**	**33,676**	**(1,463)**
Profit / (Loss) on asset disposals	3	0	3		3	0	3
Total Depreciation	(18,478)	(18,005)	(473)	4	(42,861)	(43,345)	484
Total Operating Surplus / (Deficit)	**(171)**	**181**	**(352)**		**(10,645)**	**(9,669)**	**(976)**
Interest Receivable	503	133	370		1,207	203	1,004
Interest Payable	(1,497)	(1,430)	(67)		(2,803)	(2,803)	0
PDC	(5,304)	(5,312)	8		(10,615)	(10,615)	0
Gain from Transfer by Absorption	113,026	113,026	0		113,026	113,026	0
Net Surplus / (Deficit)	**106,557**	**106,598**	**(41)**		**90,170**	**90,142**	**28**
Remove donated asset income & depreciation, AME impairment and gain from transfer by absorption	(112,665)	(112,706)	41		(108,433)	(108,405)	(28)
Net Surplus/(Deficit) after donated asset & PSF/MRET Income	**(6,108)**	**(6,108)**	**(0)**		**(18,263)**	**(18,263)**	**(0)**

KEY MOVEMENTS AGAINST BUDGET

Overall achievement against plan

1. Commercial activities are under-recovered mostly due to car parking, nursery, fertility and catering.

2. NR pay underspends off-set by slippage on Delivering Best Value and reserves.

3. Under spends linked to lower levels of elective activity and classification within non-pay categories.

4. Year end balance sheet was higher than plan leading to increased costs.

RDUH Financial Tables

Royal Devon University Healthcare NHS Foundation Trust Statement of Financial Position - Consolidated Period ending 30/09/2022 Month 06	Year to Date Actual £000	Annual Plan £000	Actual Variance Fav. / (Adv.) £000		Outturn Actual £000	Annual Plan £000	Actual Variance Fav. / (Adv.) £000		Prior Year Mar-22 £000	Actual YTD Movement Incr. / (Dec.) £000
Non-current assets										
Intangible assets	60,916	63,663	(2,747)	1	59,117	58,263	854		57,500	3,416
Other property, plant and equipment (excludes leases)	393,807	394,820	(1,013)	1	423,354	423,476	(122)		392,293	1,514
Right of use assets - leased assets for lessee (excludes PFI/LIFT)	54,928	56,200	(1,272)	2	53,622	52,915	707		1,840	53,088
Other investments / financial assets	5	5	0		5	5	0		5	0
Receivables	2,806	2,726	80		2,726	2,726	0		2,725	81
Total non-current assets	**512,462**	**517,414**	**(4,952)**		**538,824**	**537,385**	**1,439**		**454,363**	**58,099**
Current assets										
Inventories	13,863	13,550	313		13,550	13,550	0		13,275	588
Receivables: due from NHS and DHSC group bodies	21,361	21,710	(349)		17,810	17,810	0		29,931	(8,570)
Receivables: due from non-NHS/DHSC group bodies	25,536	21,350	4,186		16,000	16,000	0		16,575	8,961
Other assets: including assets held for sale & in disposal groups	0	0	0		0	0	0		0	0
Cash	71,541	42,232	29,309	3	48,754	29,556	19,198		88,920	(17,379)
Total current assets	**132,301**	**98,842**	**33,459**		**96,114**	**76,916**	**19,198**		**148,701**	**(16,400)**
Current liabilities										
Trade and other payables: capital	(7,322)	(5,000)	(2,322)	4	(11,000)	(11,000)	0		(21,284)	13,962
Trade and other payables: non-capital	(87,721)	(81,966)	(5,755)	4	(80,229)	(80,061)	(168)		(84,970)	(2,751)
Borrowings	(14,485)	(12,066)	(2,419)	5	(13,042)	(11,763)	(1,279)		(6,277)	(8,208)
Provisions	(217)	(200)	(17)		(200)	(200)	0		(200)	(17)
Other liabilities: deferred income including contract liabilities	(19,356)	(12,400)	(6,956)	6	(10,500)	(10,500)	0		(17,649)	(1,707)
Total current liabilities	**(129,101)**	**(111,632)**	**(17,469)**		**(114,971)**	**(113,524)**	**(1,447)**		**(130,380)**	**1,279**
Total assets less current liabilities	**515,662**	**504,624**	**11,038**		**519,967**	**500,777**	**19,190**		**472,684**	**42,978**
Non-current liabilities										
Borrowings	(108,385)	(108,751)	366		(105,295)	(103,136)	(2,159)		(63,038)	(45,347)
Provisions	(942)	(970)	28		(970)	(970)	0		(970)	28
Other liabilities: deferred income including contract liabilities	0	(1,877)	1,877	7	0	(1,877)	1,877		(1,877)	1,877
Total non-current liabilities	**(109,327)**	**(111,598)**	**2,271**		**(106,265)**	**(105,983)**	**(282)**		**(65,885)**	**(43,442)**
Total net assets employed	**406,335**	**393,026**	**13,309**		**413,702**	**394,794**	**18,908**		**406,799**	**(464)**
Financed by										
Public dividend capital	349,514	350,044	(530)		358,346	358,468	(122)		343,514	6,000
Revaluation reserve	49,894	48,957	937	8	63,956	63,956	0		49,900	(6)
Income and expenditure reserve	6,927	(5,975)	12,902	8	(8,600)	(27,630)	19,030	9	13,386	(6,459)
Total taxpayers' and others' equity	**406,335**	**393,026**	**13,309**		**413,702**	**394,794**	**18,908**		**406,799**	**(464)**

KEY MOVEMENTS

1 Timing of MYCARE Asset Under Construction (Intangible) and slippage on capital programme (PP&E)

2 Variance to budget includes £2.0m lease premium adjustment (previously held in deferred income) reducing the lease assets and £1.0m of higher than budget assets largely due to the value of community property leases being higher than planned.

3 Cash £29.3m 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 (£11.4m) and slippage on the capital programme.

4 This represents a timing issue where £10.8m of payables are within 0-30 days of the invoice date.

5 Loans and Leases due in 1 year are £2.4m higher compared to plan 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.

6 Deferred income is £5.1m higher than budget and will be relaesed over the course of H2.

7 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).

8 Reserves are £13.8m higher than plan due to the plan not being updated for the late revenue changes made - £11.4m is the cash benefit.

9 The FOT cash balance is £19.0m higher than plan. It has been identified that the balance sheet was not updated for the late revenue changes made to the final Annual Plan.

RDUH Financial Tables

Royal Devon University Healthcare NHS Foundation Trust Cash Flow Statement - Consolidated Period ending 30/09/2022 Month 06	Year to Date Actual £000	Year to Date Annual Plan £000	Year to Date Actual Variance Fav. / (Adv.) £000	Outturn Actual £000	Outturn Annual Plan £000	Outturn Actual Variance Fav. / (Adv.) £000
Cash flows from operating activities						
Operating surplus/(deficit)	(174)	(3,622)	3,448	(10,648)	(9,561)	(1,087)
Non-cash income and expense:						
Depreciation and amortisation	18,478	18,651	(173)	39,161	39,665	(504)
Impairments and reversals	0	3,700	(3,700)	3,700	3,700	0
Income recognised in respect of capital donations (cash and non-cash)	(40)	(132)	92	(175)	(268)	93
(Increase)/decrease in receivables	(472)	(473)	1	12,695	8,777	3,918
(Increase)/decrease in inventories	(588)	(269)	(319)	(275)	(269)	(6)
Increase/(decrease) in trade and other payables	3,113	(25,012)	28,125	(4,377)	(27,801)	23,424
Increase/(decrease) in other liabilities	1,789	(5,501)	7,290	(7,148)	(7,488)	340
Increase/(decrease) in provisions	(11)	0	(11)	0	0	0
Net cash generated from / (used in) operations	**22,095**	**(12,658)**	**34,753**	**32,933**	**6,755**	**26,178**
Cash flows from investing activities						
Interest received	503	133	370	1,207	203	1,004
Purchase of intangible assets	(6,785)	(12,592)	5,807	(11,692)	(13,389)	1,697
Purchase of property, plant and equipment and investment property	(27,236)	(15,860)	(11,376)	(52,475)	(43,892)	(8,583)
Proceeds from sales of property, plant and equipment and investment property	3	0	3	3	0	3
Receipt of cash donations to purchase capital assets	15	348	(333)	850	850	0
Net cash generated from/(used in) investing activities	**(33,500)**	**(27,971)**	**(5,529)**	**(62,107)**	**(56,228)**	**(5,879)**
Cash flows from financing activities						
Public dividend capital received	6,000	6,530	(530)	14,833	14,954	(121)
Loans from Department of Health and Social Care - repaid	0	(635)	635	(1,270)	(1,270)	0
Other loans received	854	0	854	854	0	854
Other loans repaid	(2,279)	(2,280)	1	(4,606)	(4,606)	0
Other capital receipts	0	93	(93)	174	174	0
Capital element of finance lease rental payments	(3,803)	(2,913)	(890)	(7,493)	(5,796)	(1,697)
Interest paid	(794)	(1,029)	235	(1,998)	(1,995)	(3)
Interest element of finance lease	(284)	(244)	(40)	(513)	(513)	0
PDC dividend (paid)/refunded	(5,667)	(5,572)	(95)	(10,973)	(10,830)	(143)
Net cash generated from/(used in) financing activities	**(5,973)**	**(6,050)**	**77**	**(10,992)**	**(9,882)**	**(1,110)**
Increase/(decrease) in cash and cash equivalents	**(17,378)**	**(46,679)**	**29,301**	**(40,166)**	**(59,355)**	**19,189**
Cash and cash equivalents at start of period	**88,920**	**88,911**	**9**	**88,911**	**88,920**	**(9)**
Cash and cash equivalents at end of period	**71,542**	**42,232**	**29,310**	**48,754**	**29,556**	**19,198**

RDUH Financial Tables

Royal Devon University Healthcare NHS Foundation Trust Capital Expenditure - Consolidated Period ending 30/09/2022 Month 6				Actual expenditure to date			Total expenditure forecast for the year				Expected Completion Date
Scheme		Source of Funding		Actual £'000	Plan £'000	Variance slippage / (higher) £'000	Forecast future £'000	Forecast £'000	Plan £'000	Variance slippage / (higher) £'000	
Schemes >= £500k											
MYCARE (Northern)	N	CDEL/PDC	2	10,062	9,987	(75)	399	10,461	10,061	(400)	22/23
ED Reconfiguration	E	CDEL		3,852	3,848	(4)	919	4,771	6,871	2,100	23/24
Estates Infrastructure 22/23	E	CDEL		884	1,081	197	3,358	4,242	4,520	278	22/23
Diagnostics CDC	E	PDC		0	1,146	1,146	4,110	4,110	4,110	0	24/25
Cardiology Day Case Unit	E	PDC/DON		0	0	0	1,599	1,599	2,500	901	24/25
Operating leases renewed in 2022/23	N&E	CDEL	8	0	1,133	1,133	4,887	4,887	2,303	(2,584)	22/23
Backlog Maintenance	N	CDEL		191	335	144	1,649	1,840	1,840	0	22/23
Aseptic Unit	N	CDEL	3	0	400	400	500	500	1,700	1,200	23/24
Ophthalmology Hub	N	CDEL/DON	4	32	304	272	1,381	1,413	1,249	(164)	22/23
Equipment	N	CDEL	5	145	300	155	1,686	1,831	1,105	(726)	22/23
NHP - OBC Funding	N	PDC	6	314	530	216	988	1,302	1,060	(242)	22/23
Replacement CT Simulator	E	CDEL		0	0	0	1,071	1,071	0	(1,071)	22/23
R14 Genetics NovaSeq 6000	E	PDC		795	0	(795)	168	963	0	(963)	22/23
Digital Histopathology (Eastern)	E	CDEL/PDC		0	0	0	905	905	905	0	22/23
LINAC Replacement	E	CDEL		581	403	(178)	255	836	836	0	22/23
Mortuary	N	CDEL		0	200	200	800	800	800	0	22/23
Nightingale Hospital Accelerator Programme	E	CDEL		718	765	48	48	765	765	0	22/23
MYCARE (Eastern)	E	CDEL	1	1,036	1,006	(30)	(637)	399	714	315	22/23
Replacement of Fluoroscopy Room 2 Siemens Artis Zee	E	CDEL		9	86	77	589	598	598	0	22/23
General Space Moves	N	CDEL	7	28	0	(28)	68	96	689	593	22/23
Diagnostics Endoscopy	E	PDC		0	0	0	539	539	0	(539)	23/24
Wi-Fi Refresh	N	CDEL		0	0	0	450	450	500	50	22/23
Total Schemes >= £500k				**18,647**	**21,524**	**2,877**	**25,731**	**44,378**	**43,126**	**(1,252)**	
Schemes <= £500k	N&E	CDEL		1,254	3,348	2,093	8,766	10,019	7,822	(2,197)	22/23
Schemes <= £500k	N&E	PDC		0	0	0	406	406	406	0	22/23
Schemes <= £500k	N&E	DON		0	0	0	100	100	100	0	22/23
Total Capital Expenditure				**19,901**	**24,872**	**4,970**	**35,004**	**54,903**	**51,454**	**(3,449)**	

1. Clarifying actual number of licenses required.
2. FOT relates to increased hardware requirements - consistent with reporting to programmre board.
3. Revision of specification required to meet regulatory requirements.
4. Inflationary impact from final tender submissions. Orders placed.
5. CSSD equipment to mitigate operational risk.
6. Digital strategy to support NHP OBC.
7. Various including provision for works in CSSD.
8. 22/23 Leases that meet the requirements for national funding of IFRS16 implementation

RDUH Financial Tables

Reconciliation of movements in SOCI Plan to Budget	YTD Fixed Plan (NHSEI reporting)	Adjustments to Plan	YTD Flexed Plan (Board Reporting)	YTD Actual	Actual v Plan Variance (NHSEI Reporting)	Actual 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	**405,912**	11,514	**417,426**	418,223	12,311	797	NHSEI pass-through drugs & devices exceeding plan off-sets additional expenditure. Additional pay award exceeding plan off-sets additional expenditure.
Other operating income	**50,993**	3,831	**54,824**	53,740	2,747	(1,084)	£0.4m R&D income - off-sets additional expenditure £1.3m services provided - off-sets additional expenditure £0.9m income in advance released £0.8m contributions to staff costs £0.2m charitable contributions to expenditure £0.2m income re-classification
Total Income	**456,905**	**15,345**	**472,250**	**471,963**	**15,058**	**(287)**	
Employee expenses - Total	**(283,512)**	(14,899)	**(298,411)**	(298,844)	(15,332)	(433)	For the purposes of internal accountability corresponding expenditure budget has been released to ensure appropriate reporting. These adjustments distort variances that are reported through NHSEI and ICS reporting compared to information presented to the Board and it is important the differences are understood.
Operating expenses excluding employee expenses	**(177,015)**	3,357	**(173,658)**	(173,293)	3,722	365	
Total Expenses	**(460,527)**	**(11,542)**	**(472,069)**	**(472,137)**	**(11,610)**	**(68)**	
OPERATING SURPLUS/(DEFICIT)	**(3,622)**	**3,803**	**181**	**(174)**	**3,448**	**(355)**	
FINANCE COSTS						**0**	
Finance income	**133**	0	**133**	**503**	370	370	
Finance expense	**(1,417)**	(13)	**(1,430)**	**(1,497)**	(80)	(67)	
PDC dividends payable/refundable	**(5,304)**	(8)	**(5,312)**	**(5,304)**	0	8	
NET FINANCE COSTS	**(6,588)**	**(21)**	**(6,609)**	**(6,298)**	**290**	**311**	
Other gains/(losses) including disposal of assets	**0**	0	**0**	3	3	3	
Share of profit/(loss) of associates/joint ventures	**0**	0	**0**	0	0	0	
Gains/(losses) from transfers by absorption	**113,026**	0	**113,026**	113,026	0	0	
Movements in fair value of investments, investment property and financial liabilities	**0**	0	**0**	0	0	0	
Corporation tax expense	**0**	0	**0**	0	0	0	
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**102,816**	**3,782**	**106,598**	**106,557**	**3,741**	**(41)**	
Adjusted financial performance							
Surplus/(deficit) for the period/year	**102,816**	**3,782**	**106,598**	**106,557**	**3,741**	**(41)**	
Add back all I&E impairments/(reversals)	**3,700**	(3,700)	**0**	**0**	(3,700)	0	
Adjust (gains)/losses on transfers by absorption	**(113,026)**	0	**(113,026)**	**(113,026)**	0	0	
Surplus/(deficit) before impairments and transfers	**(6,510)**	**82**	**(6,428)**	**(6,469)**	**41**	**(41)**	
Remove capital donations/grants/peppercorn lease I&E impact	**402**	(82)	**320**	**361**	(41)	41	
Adjusted financial performance surplus/(deficit)	**(6,108)**	**0**	**(6,108)**	**(6,108)**	**(0)**	**(0)**	

Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	11.1, Public Board Meeting		**Date:** 26 October 2022	
Title:	People Plan Update			
Prepared by:	Alex Tait, Executive Support Manager			
Presented by:	Hannah Foster, Chief People Officer			
Responsible Executive:	Hannah Foster, Chief People Officer			
Summary:	This paper and appended presentations provide an overview of the work being undertaken on the NHS People Plan focussing on progress at a local level.			
Actions required:	This paper is being presented to ensure the Board are aware of the Trust progress against the NHS People Plan and have the opportunity to feed comments back to the People Function.			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
			X	
History:	A People Plan update is received by the People, Workforce Planning and Wellbeing Committee and the Board on a bi-annual basis, with the last update having been received in April 2022.			
Link to strategy/ Assurance framework:	The delivery of the NHS People Plan and People Promise directly link to our 'great place to work' strategic objective.			

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

This report has been written to provide an update on the Royal Devon University Healthcare NHS Foundation Trusts progress against the NHS People Plan[1]. Whilst much of the People Plan work is being driven within the Integrated Care System (ICS), this paper focuses primarily on progress being made within our Trust.

Additionally, an update has been provided on the scope and aims of the workforce plan, which is due to be presented in draft in January 2023, along with some retirement profiling information, which was requested by the Board.

2. Background

The NHS People Plan was published in July 2020, setting out actions over a period of four years to support transformation for our people across the whole of the NHS. A People Plan update is received by the People, Workforce Planning and Wellbeing Committee and the Board on a bi-annual basis, with the last update having been received in April 2022.

This plan has an ambitious and broad set of goals, encompassed in the following headings:

- Looking after our people
- Belonging in the NHS
- New ways of working and delivering care
- Growing for the future

Central to the NHS People Plan is the NHS People Promise (See figure 1). The elements that make up the People Promise are the things all employees should be able to say about working in the NHS by 2024. This may already be the case for many; however, this promise pledges that in the future this will be the case for everyone working in the NHS.

The People Promise gives the Trust and the ICS their Employee Value Proposition (EVP) for the future, which we need to make a reality for our people.

Figure 1 - The NHS People Promise

3. Analysis

Alignment between the objectives within the NHS People Plan and our own strategic objectives is vital if we are to deliver this ambitious plan. This has been recognised, with one of the Trust strategic objectives being ‘a great place to work’ for our people. This

[1] Link to The NHS People Plan

objective will be achieved by aligning our goals with the aforementioned four headings of the NHS People Plan ensuring our local plans, the ICS for Devon People Plan and the national programme align.

To clearly articulate how we will meet the goals set out in the NHS People Plan and our own local priorities, a Royal Devon People Plan has been drafted. This sets out our core objectives and a high-level roadmap for the next 5-years. This enables us to strategically connect our new Trust strategy with the national strategies including the NHS People Plan, the People Promise and the National HR & OD review. A PowerPoint presentation has been included (appendix 1) detailing the latest update on our local progress against the NHS People Plan and our Great Place to Work Trust objective. In May 2022, the Board requested a projection of staff due to retire in the coming years and it was agreed that a retirement profile, along with an overview of the ICS for Devon position would be presented as part of this October 2022 People Plan update to Board.

As retirement levels form part of the workforce planning process an overview of the expected aims and scope of our workforce plan has been provided along with the initial retirement profile (appendix 2).

It is planned that the first draft of the workforce plan and strategy will be shared with the Board in January 2023.

4. Resource/legal/financial/reputation implications

Whilst much progress has been made against the NHS People Plan, it is important for the Board to recognise the current workforce and operational pressures, and the potential impact these may have on delivery the People Plan.

Our new people team senior structure is now fully in place with progress having been made in areas where historically there has been little or no capacity. Key examples of this are in workforce planning and HR systems, data and insight, where much progress is now being made, however the People Function is still seeing high levels of demand in a number of areas, particularly recruitment and systems, which is having an impact on capacity.

Many of the goals within the NHS People Plan will impact outside of the People Function and will require wider engagement with operational teams. This is the area is likely to be a challenge due to continued operational pressures.

There is also much work that has been completed or is ongoing that is not specifically referenced as an ‘action’ in the NHS People Plan, but will help us to achieve the overall objectives.

5. Link to BAF/Key Risks

The NHS People Plan is referenced as a mitigation / potential mitigation on two of the new BAF risks.

6. Proposals

It is proposed that this report and appendices are discussed and accepted by the Board, with updates continuing to be provided on a bi-annual basis moving forward.

Royal Devon University Healthcare
NHS Foundation Trust

Local Progress Against the NHS People Plan

Hannah Foster, Chief People Officer

Overview of the NHS People Plan

Royal Devon University Healthcare NHS Foundation Trust

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How?

- Instil a fairer and safer culture to improve system learning
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Outcomes?

- To be a great employer that values its people, that embraces diversity and is well-led
- To support our people and listen to them
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- To have developed a new culture built on the best of both organisations that will enable us to adapt and change
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- To have built a culture of continuous learning and improvement
- To have developed a just culture

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- How many people join our organisation and how many people leave.
- How well our own internal services work for our HR teams, our managers and our people.
- How well our organisation is living our values and how well our vision of a just and learning culture has been embedded.
- How our people are progressing in their careers and the uptake of development opportunities.
- How equitable and inclusive our Trust is, including fair recruitment processes, equal opportunities for progression and potential for flexible working.

To do this we will use…

- The results from People Pulse & NHS Staff Surveys to understand how our employees are feeling and highlight areas we need to focus on.
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- Delivery of our great place to work strategic objective and local people plan will enable us to be meeting the People Promise for most of our colleagues, most of the time
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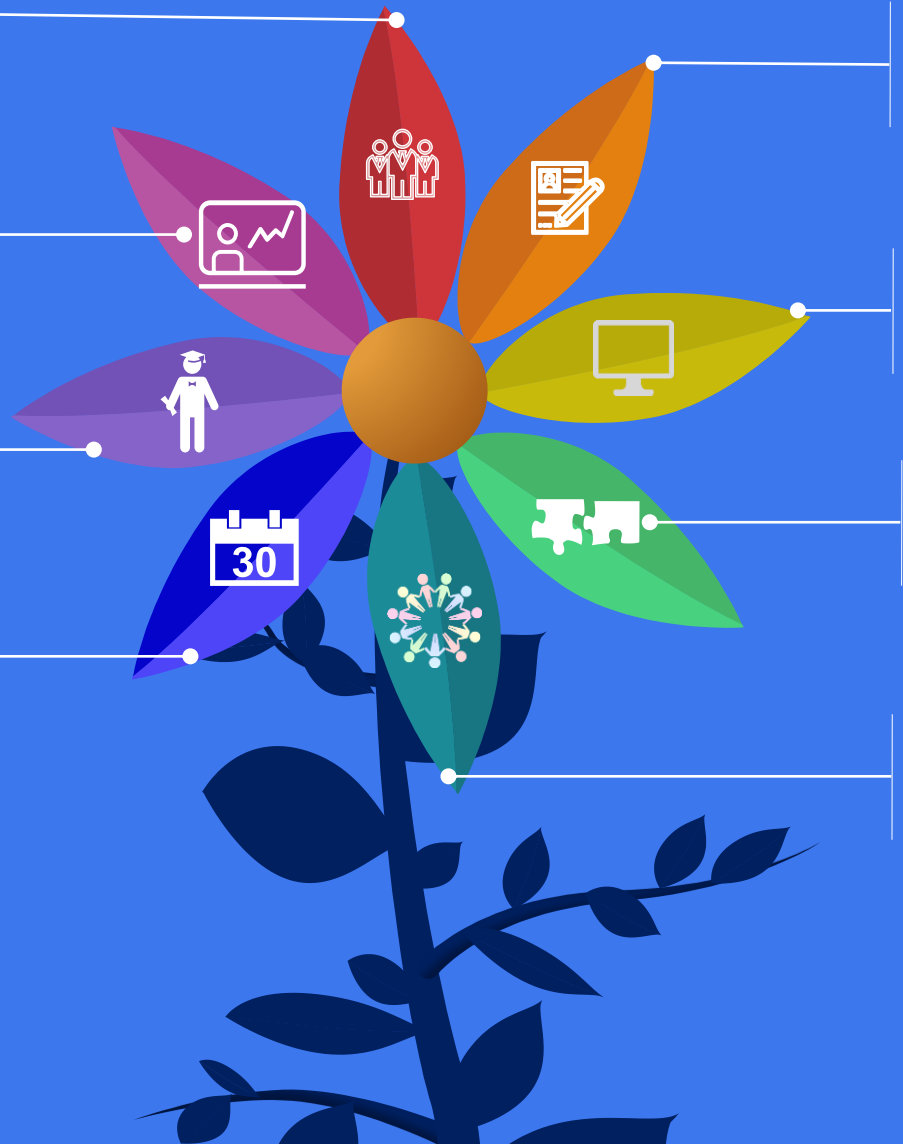

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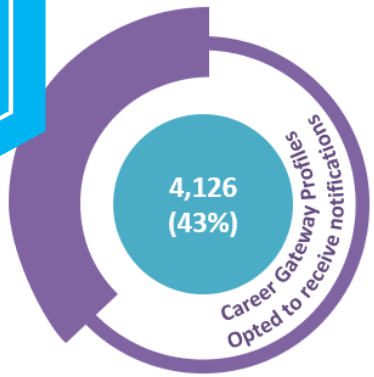

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Royal Devon University Healthcare NHS Foundation Trust

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NHS
Royal Devon
University Healthcare
NHS Foundation Trust

Progress Against NHS People Plan Actions for Employers

Hannah Foster, Chief People Officer

Health & Wellbeing Employers Actions

Royal Devon University Healthcare NHS Foundation Trust

Put in place effective infection prevention and control procedures.	Ensure that all staff have access to psychological support.	Support staff to use other modes of transport and identify a cycle-to-work lead.	Make sure line managers and teams actively encourage wellbeing to decrease work-related stress and burnout.	
Ensure all staff have access to appropriate personal protective equipment (PPE) and are trained to use it.	Appoint a wellbeing guardian.	Prevent and tackle bullying, harassment and abuse against staff, and a create a culture of civility and respect.	Every member of NHS staff should have a health and wellbeing conversation.	
All frontline healthcare workers should have a vaccine provided by their employer.	Complete risk assessments for vulnerable staff, including BAME colleagues and anyone who needs additional support, and take action where needed.	Prevent and control violence in the workplace – in line with existing legislation.	Ensure people working from home can do safely and have support to do so, including having the equipment they need.	Ensure that workplaces offer opportunities to be physically active and that staff are able to access physical activity throughout their working day.
All new starters should have a health and wellbeing induction.	Identify and proactively support staff when they go off sick and support their return to work.	Ensure staff have safe rest spaces to manage and process the physical and psychological demands of the work.	Ensure people have sufficient rests and breaks from work and encourage them to take their annual leave allowance in a managed way	Complete In Progress Early Stages / Not Started

Other Employers Actions

NHS
Royal Devon University Healthcare
NHS Foundation Trust

Requesting flexibility – whether in hours or location, should (as far as possible) be offered regardless of role, team, organisation or grade.	Encourage return to practice as a key part of recruitment drives during 2020/21, building on the interest of clinical staff who returned to the NHS to support the COVID-19 response.	Make sure future potential returners, or those who plan to retire and return this financial year, are aware of the ongoing pension flexibilities.	Review governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes.	Use HEE's e-Learning for Healthcare programme and a new online Learning Hub, which was launched to support learning during COVID-19.	When recruiting temporary staff, prioritise the use of bank staff before more expensive agency and locum options and reducing the use of 'off framework' agency shifts during 2020/21.
Continued focus on developing skills and expanding capabilities to create more flexibility, boost morale and support career progression.	51 per cent of organisations to have eliminated the ethnicity gap when entering into a formal disciplinary processes.	Cover flexible working in standard induction conversations for new starters and in annual appraisals.	Ensure people have access to continuing professional development, supportive supervision and protected time for training.	Ensure that staff who are mid-career have a career conversation with their line manager, HR and occupational health.	Publish progress against the Model Employer goals to ensure that the workforce leadership is representative of the overall BAME workforce.
Increase recruitment to roles such as clinical support workers, highlighting the importance of these roles as well as potential career pathways to other registered roles.	Employers should integrate education into their plans to restart clinical services, releasing educators & supervisors; providing an increased focus on support for students and trainees	Board members must give flexible working their focus and support.	For medical trainees, employers should ensure that training in procedure-based competencies is restored as services resume to sustain the pipeline of new consultants.	Design roles which make the greatest use of each person's skills and experiences and fit with their needs and preferences.	Discuss equality, diversity and inclusion as part of the health and wellbeing conversations described in the health and wellbeing table.
Offer more apprenticeships, ranging from entry-level jobs through to senior clinical, scientific and managerial roles.	Ensure staff are aware of the increase in the annual allowance pensions tax threshold.	Be open to all clinical and non-clinical permanent roles being flexible.	Use guidance on safely redeploying staff, developed in response to COVID-19, alongside the existing tool to support a structured approach to ongoing workforce transformation.	Overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets.	Roll out the new working carers passport to support people with caring responsibilities.

Royal Devon University Healthcare
NHS Foundation Trust

People Function Enabling Delivery of the People Plan and Great Place to Work Objective

Hannah Foster, Chief People Officer

Our plan

Enabling our Trust to be a great place to work for our people whatever their role, through delivery of services for our people, patients & communities

Where are we now?

Our team – Our people have been constrained by a turbulent working environment, resulting in some silo working and resources being deployed towards reactive rather than proactive working.

Our Processes - A lack of joined up processes, systems and digital technology has contributed towards a user experience that isn't as good as it could be, with some single points of failure.

Working Together - In some cases there is a lack of consistency with geographical boundaries having restricted joined-up working.

Leadership - There has been a lack of stability in the senior management team which has made it difficult to plan for the future. With a new senior structure now in place, this will support our future objectives.

Quality - There are a lack of agreed and measurable quality standards to help the teams to understand if what they are doing is effective. We have invested in data and insights, so this will positively impact this space.

Where are we going?

We'll develop new ways of working and will create centres of expertise. We will use engaging, accessible communication to improve employee and manager experience and will align our resources to be more focused on prevention.

We will ensure our systems are efficient and people data and processes are aligned.

We will create a one team ethos irrespective of geographical or service location, with common ways of working and sharing of best practice. We will develop a just and learning culture and ensure our people can be heard.

We will collaborate to develop our current & future leaders to be compassionate and inclusive and will make our Trust a great place to work to attract and retain our people.

We will agree our scope of service and quality standards and we will measure them. We will share this information and seek to continuously improve.

By 2027

We will be enabling culture change, with a just and learning culture lived and breathed by our people, managers and leaders.

We will be known as a great place to work, having delivered the NHS people plan and the people promise. We will attract and retain the best people.

We will have improved employee, candidate & manager experience with joined up systems and processes, maximising the use of technology.

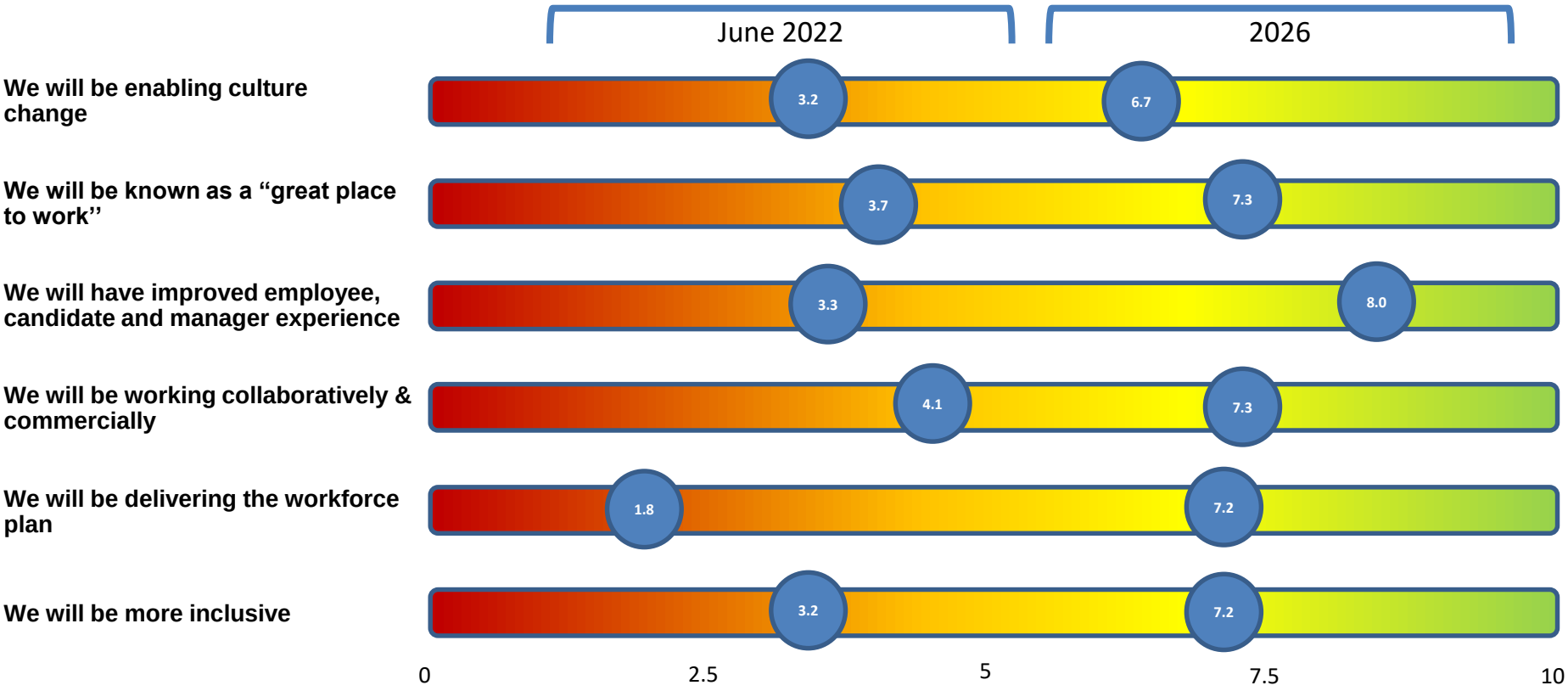
We will be working collaboratively & commercially to provide effective and efficient services to benefit us and wider community.

We will be delivering the workforce plan. We will be supporting the wider organisation to deliver the 5 year workforce plan.

We will be more inclusive, enabling the stories and information throughout the organisation to be heard to ensure we are an environment that embraces and welcomes difference.

Functional Self Assessment

Royal Devon University Healthcare NHS Foundation Trust



We asked each member of our People Function senior leadership team to tell us where they thought we currently were against each of our objectives and where they think we should be by 2026. The scores above are based on an average of these results.

Royal Devon University Healthcare
NHS Foundation Trust

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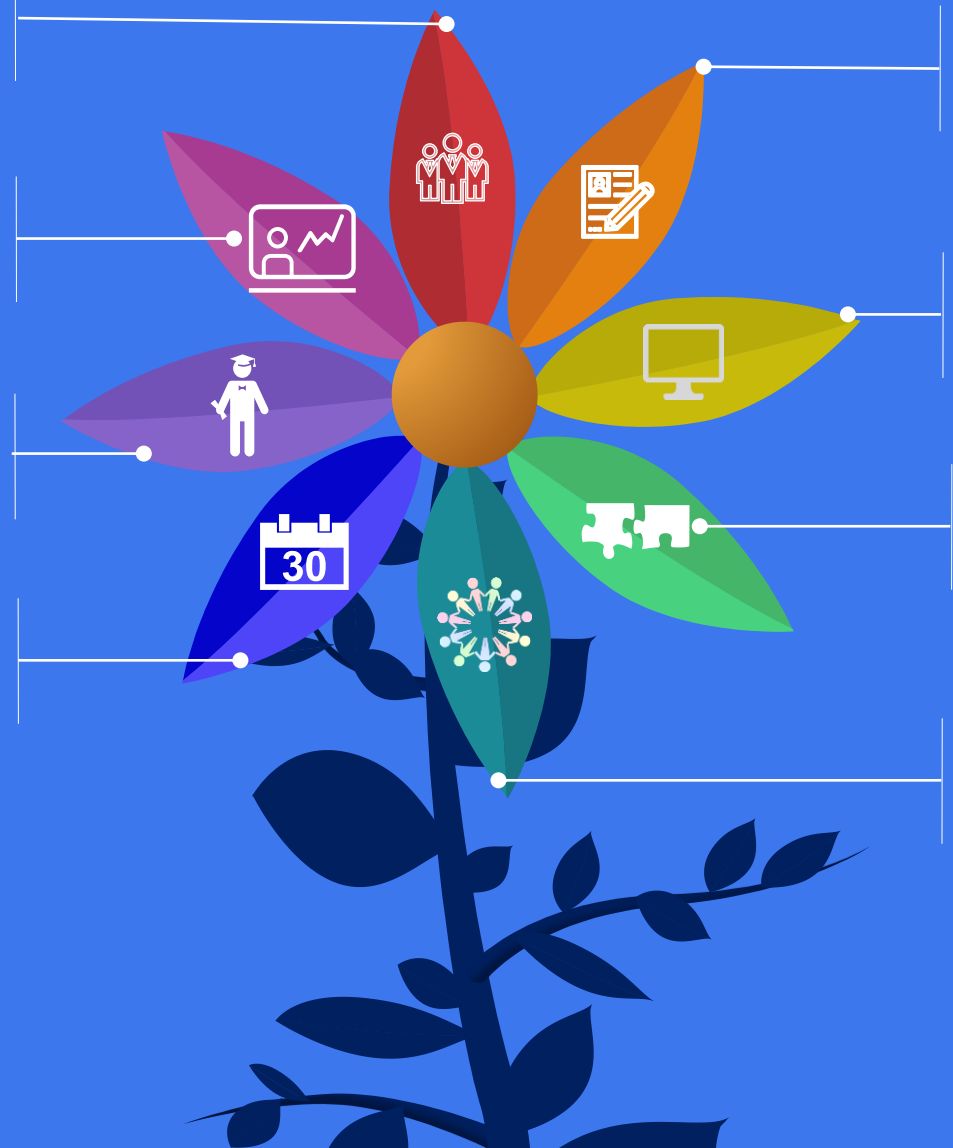

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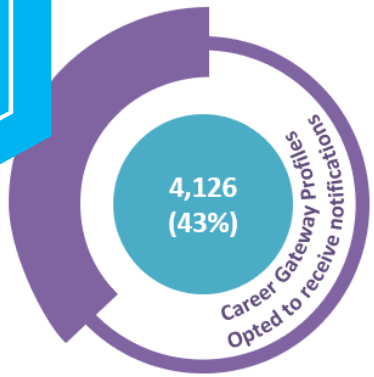

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Every member of NHS staff should have a health and wellbeing conversation.

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Review governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes.

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Ensure that staff who are mid-career have a career conversation with their line manager, HR and occupational health.

Publish progress against the Model Employer goals to ensure that the workforce leadership is representative of the overall BAME workforce.

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Employers should integrate education into their plans to restart clinical services, releasing educators & supervisors; providing an increased focus on support for students and trainees

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For medical trainees, employers should ensure that training in procedure-based competencies is restored as services resume to sustain the pipeline of new consultants.

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Discuss equality, diversity and inclusion as part of the health and wellbeing conversations described in the health and wellbeing table.

Offer more apprenticeships, ranging from entry-level jobs through to senior clinical, scientific and managerial roles.

Ensure staff are aware of the increase in the annual allowance pensions tax threshold.

Be open to all clinical and non-clinical permanent roles being flexible.

Use guidance on safely redeploying staff, developed in response to COVID-19, alongside the existing tool to support a structured approach to ongoing workforce transformation.

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Enabling our Trust to be a great place to work for our people whatever their role, through delivery of services for our people, patients & communities

Where are we now?

Our team – Our people have been constrained by a turbulent working environment, resulting in some silo working and resources being deployed towards reactive rather than proactive working.

Our Processes - A lack of joined up processes, systems and digital technology has contributed towards a user experience that isn't as good as it could be, with some single points of failure.

Working Together - In some cases there is a lack of consistency with geographical boundaries having restricted joined-up working.

Leadership - There has been a lack of stability in the senior management team which has made it difficult to plan for the future. With a new senior structure now in place, this will support our future objectives.

Quality - There are a lack of agreed and measurable quality standards to help the teams to understand if what they are doing is effective. We have invested in data and insights, so this will positively impact this space.

Where are we going?

We'll develop new ways of working and will create centres of expertise. We will use engaging, accessible communication to improve employee and manager experience and will align our resources to be more focused on prevention.

We will ensure our systems are efficient and people data and processes are aligned.

We will create a one team ethos irrespective of geographical or service location, with common ways of working and sharing of best practice. We will develop a just and learning culture and ensure our people can be heard.

We will collaborate to develop our current & future leaders to be compassionate and inclusive and will make our Trust a great place to work to attract and retain our people.

We will agree our scope of service and quality standards and we will measure them. We will share this information and seek to continuously improve.

By 2027

We will be enabling culture change, with a just and learning culture lived and breathed by our people, managers and leaders.

We will be known as a great place to work, having delivered the NHS people plan and the people promise. We will attract and retain the best people.

We will have improved employee, candidate & manager experience with joined up systems and processes, maximising the use of technology.

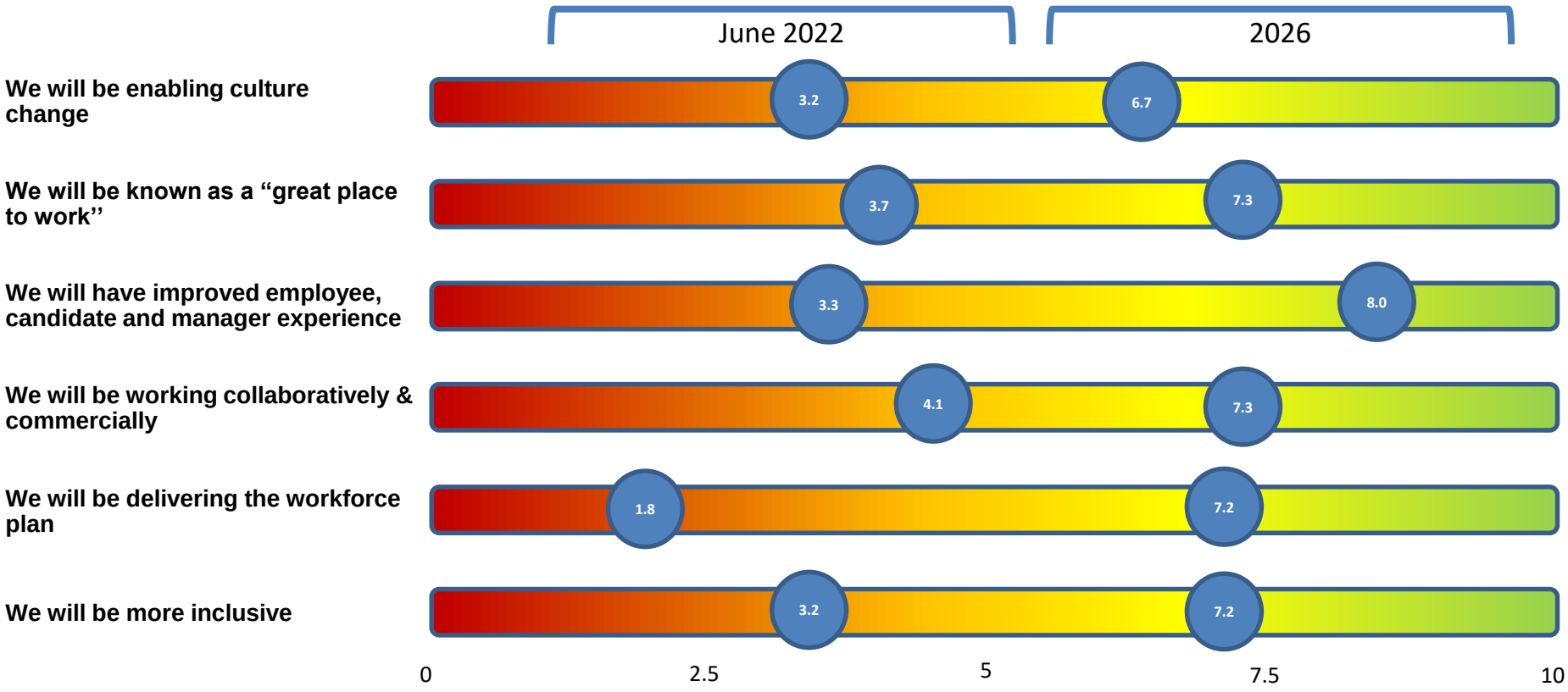
We will be working collaboratively & commercially to provide effective and efficient services to benefit us and wider community.

We will be delivering the workforce plan. We will be supporting the wider organisation to deliver the 5 year workforce plan.

We will be more inclusive, enabling the stories and information throughout the organisation to be heard to ensure we are an environment that embraces and welcomes difference.

Functional Self Assessment

Royal Devon University Healthcare NHS Foundation Trust



We asked each member of our People Function senior leadership team to tell us where they thought we currently were against each of our objectives and where they think we should be by 2026. The scores above are based on an average of these results.

Royal Devon University Healthcare
NHS Foundation Trust

Workforce Planning Update & Retirement Trajectory

26th October 2022

Hannah Foster, Chief People Officer

Background

Royal Devon University Healthcare NHS Foundation Trust

- During the presentation of the IPR at May 2022 Board, a request was made to provide a projection of staff due to retire over the next year and over the next five years.
- It was agreed that a retirement profile, along with a similar Devon position would be presented to the October 2022 Board.
- Understanding retirement is an important element of strategic workforce planning and will feature in an overall workforce plan, the draft of which is due to be presented to the Board in January 2023.
- As these two pieces of work are so closely linked, an overview of the expected scope and aims of our workforce plan has been provided along with the initial retirement profile.
- It should be noted that this work is under development, and that more detailed projections will be included as part of the overall workforce plan.

Scope

Royal Devon University Healthcare NHS Foundation Trust

- The draft workforce plan is initially due to be made up of six sections which will be as follows:
    - Indicators of past performance (i.e. joiners, leavers, growth, retirement, turnover, retention etc.)
    - An understanding of workforce supply
    - Workforce demand and gap analysis (including analysis of the local and regional population, recruitment forecasts etc.)
    - Specific insights (i.e. linking in with operational planning priorities and how these depend on workforce)
    - Strategic workforce planning capacity and capability insights
    - Strategic workforce planning aims

Our Vision for Strategic Workforce Planning

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.

Benefits of Strategic Workforce Planning

- Long range visibility
- Workforce agility & skills re-profiling
- Optimised contingent workforce spend
- Productivity & cost reduction
- Equality, Diversity & Inclusion
- Supported talent planning processes
- Planned approach to flexible/hybrid working
- Strategic collaboration
- Improved data communication
- The 5 Rights

NHS
Royal Devon
University Healthcare
NHS Foundation Trust

Retirement Profile

17th October 2022

Analysis

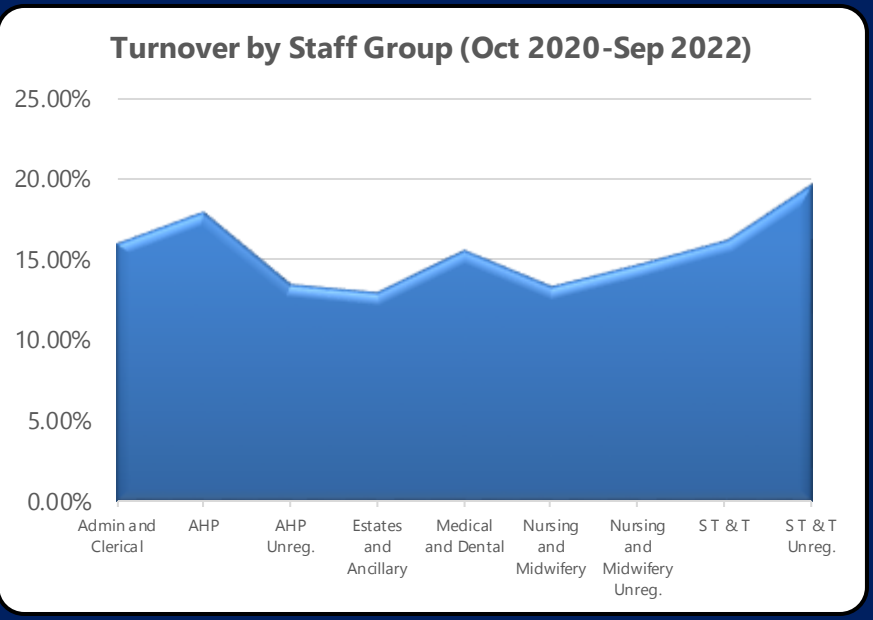
The following slides have been prepared in response to the Board request for more information on the retirement profile. This analysis is in isolation of the wider workforce analysis which is currently being developed.

This information includes:

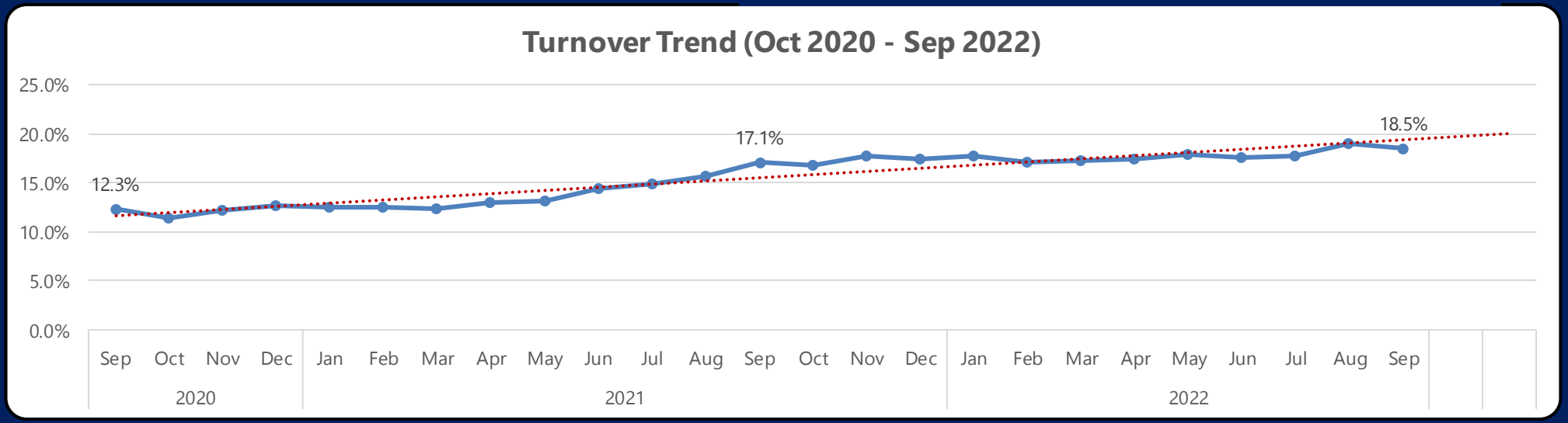
- A summary of the turnover position over the last two years across the whole Trust, split by different workforce groups.
- A profile of leavers and their reasons for leaving between September 2020 and September 2022.
- A profile of the retirement rate for Royal Devon over the last two years and a RAG rated analysis of the age profile by staff group, showing potential retirees.
- An age profile produced by Health Education England (HEE), however note the age group break downs are slightly different to Royal Devon.

Note: In variation to traditional reporting, this data reflects groups in line with different NHS professional pathways and therefore separates scientific and technical work groups. This will help us to improve our understanding of the patterns and trajectories of more professions in our workforce.

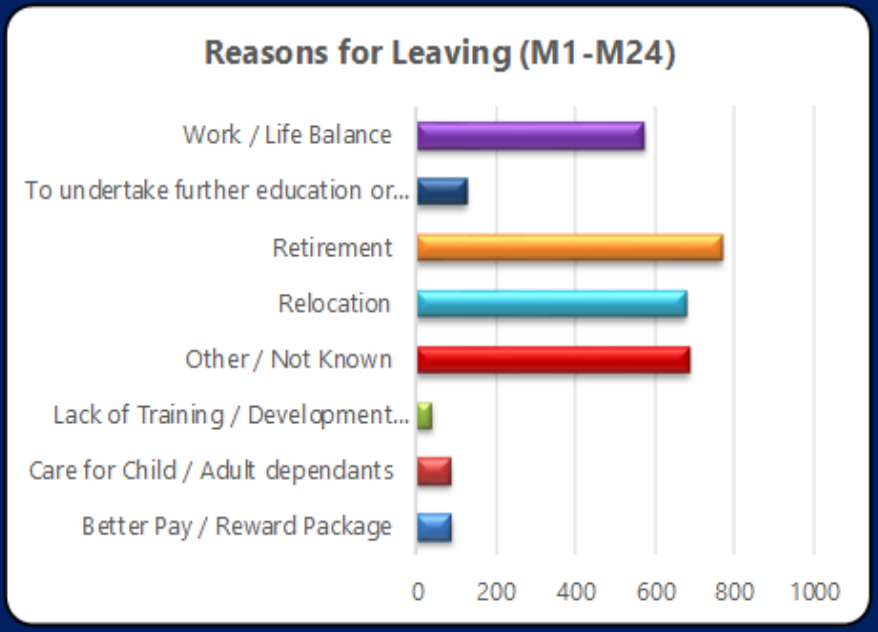
Leaver Insights



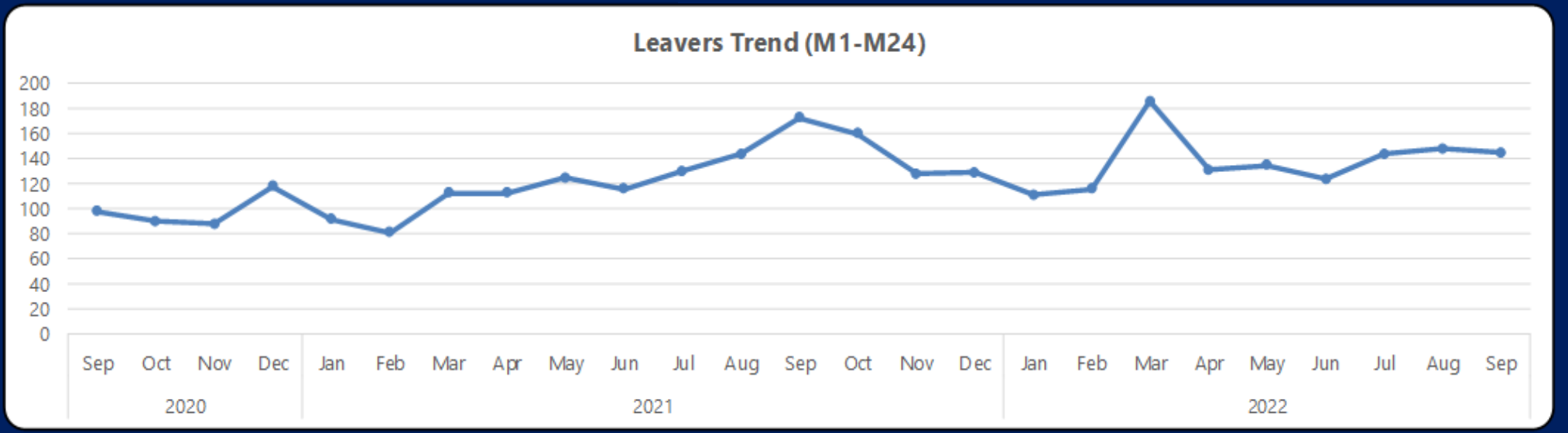
- This slide shows the turnover in the past two years.
- The turnover trend graph is based on a rolling 12-months and shows a steady increase from around 12.3% 2-years ago, to the current rate of 18.5%.
- ‘Turnover’ is voluntary turnover i.e. excludes fixed term contracts or dismissals.
- There is anecdotal evidence to suggest that many staff delayed their planned retirement during the pandemic and more recently the highly competitive job market may also be contributing to this increased turnover.



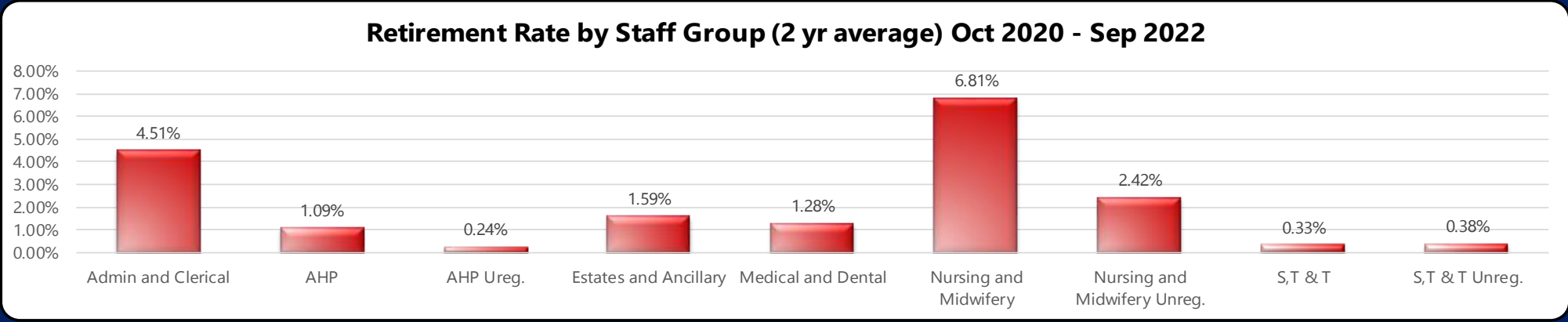
Leaver Insights



- This slide details the overall numbers of leavers per month as well as information behind why people are leaving
- It is clear that whilst there are a few reasons listed for leaving the organisation, retirement is currently the most common reason for leaving.
- It is expected that as our workforce continues to age, the rate of retirements will continue to increase.
- All of this data is from September 2020-September 2022



Retirement Insights



Average age of Retirement (2 yr average) as at Sep 2022

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.
62	60	62	63	60	58	61	59	61

Average age of Retirement for the whole Trust (2 yr average) as at Sep 2022	61

	Retirement Potential by Staff Group as at Sept 2022			
	51-60 years		61+ years	
	Headcount	%	Headcount	%
Admin and Clerical	903	29.4%	372	12.1%
AHP	227	19.9%	33	3.0%
AHP Unregistered	113	17.3%	48	7.4%
Estates and Ancillary	247	31.5%	151	19.3%
Medical and Dental	243	15.8%	56	3.6%
Nursing and Midwifery	832	23.3%	219	6.2%
Nursing and Midwifery Unregistered	450	23.3%	159	8.3%
Scientific & Technical	63	19.6%	16	4.9%
Scientific & Technical Unregistered	63	18.4%	17	5.0%

Age & Sex | Devon | All Workforce

NHS
Health Education England

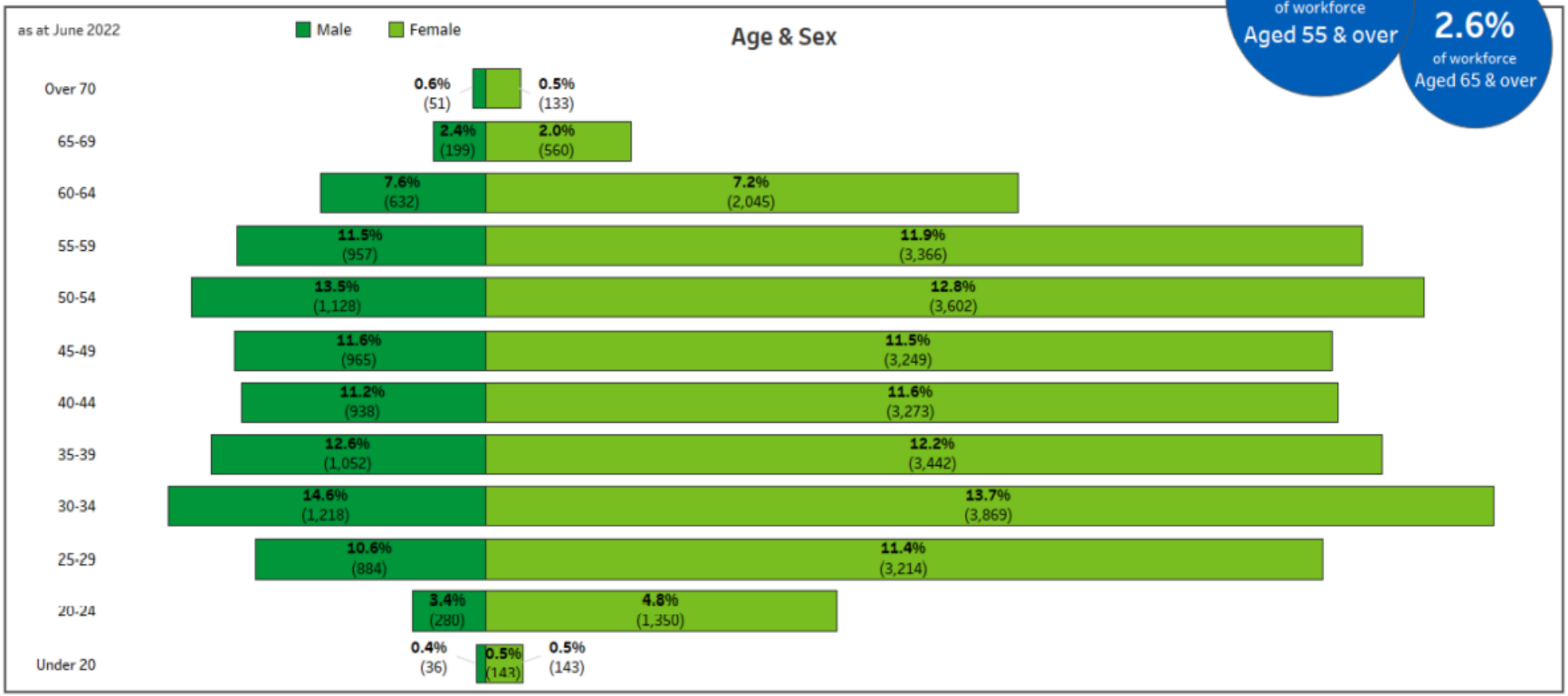
22.8% Male

77.2% Female

Under 25	25-34	35-54	55-69	Over 70
4.9%	25.1%	48.2%	21.2%	0.5%
1,809	9,185	17,649	7,759	184

21.7% of workforce Aged 55 & over

2.6% of workforce Aged 65 & over



Workforce Age | Devon | All Workforce

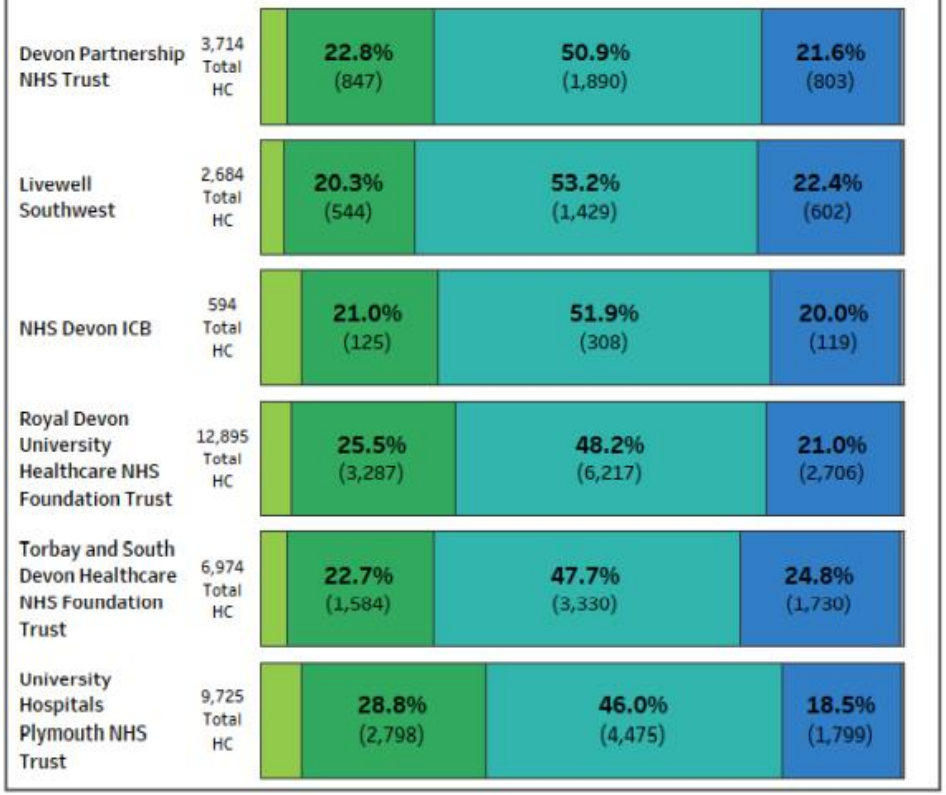
as at June 2022

Health Education England

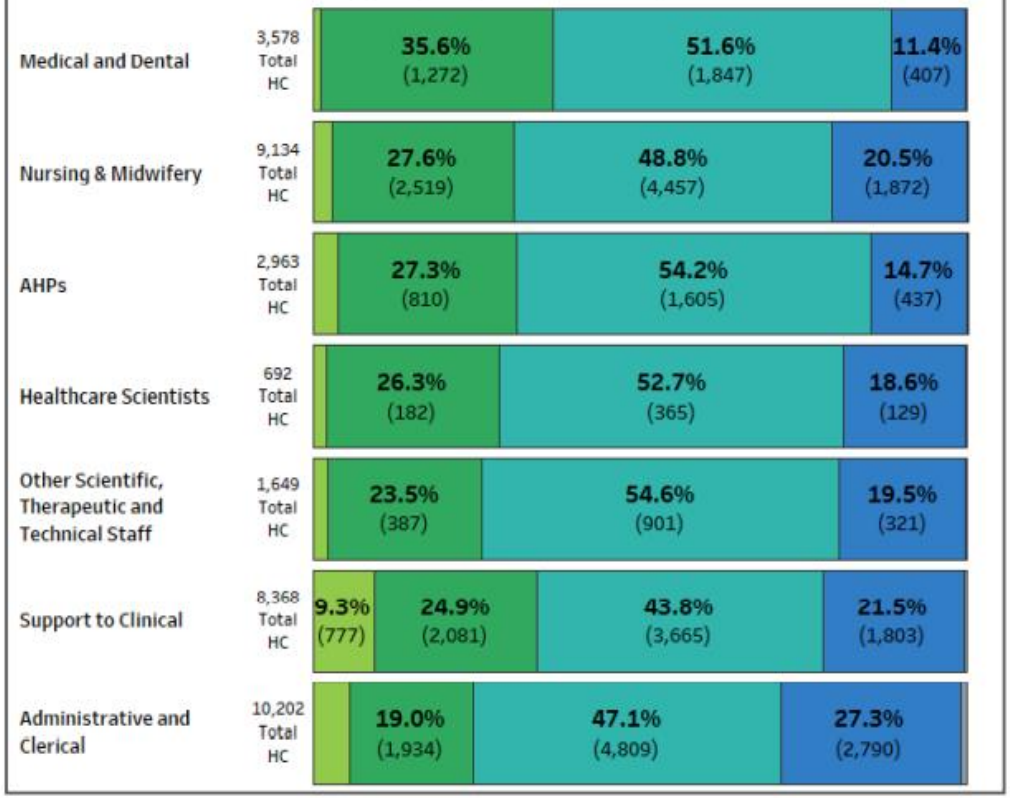
- Under 25
- 25-34
- 35-54
- 55-69
- Over 70

Under 25	25-34	35-54	55-69	Over 70
4.9%	25.1%	48.2%	21.2%	0.5%
1,809	9,185	17,649	7,759	184

Age by Trust



Age by High Level Group



Summary

- A pattern of a lower leaver and retirement rates can be seen during the initial Covid waves, however this appears to support the narrative that this has contributed to an increase in the current rate of retirements.
- Retirement makes up the largest group of leavers over the last two years, with the highest rate of retirements in Nursing and Midwifery (N&M), with around half of leavers driven by retirement. The data reflects the national concern about high rates of nursing retirements.
- Admin & Clerical (A&C) have the next highest rate of retirement, however it is of note that digitalisation may be connected to this as roles have modernised and changed.
- The Trustwide retirement age over the last two years averages out at 61 with N&M the lowest at 58 and Estates & Facilities (E&F) the highest at 63.
- Looking at the percentage of staff 51-60 and 61+ years of age, it is clear that we should expect the highest percentage of retirements in A&C and F&E.
- Almost 30% of the registered N&M workforce is over 50, highlighting the importance of developing our pipeline of future nurses.
- Whilst the age brackets are not exactly the same, Royal Devon looks to have a higher retirement risk for N&M than the wider system. The benefit and importance of the focus on retention and delaying retirement is evident.
- The Devon wide picture shows that Royal Devon has a slightly lower proportion of colleagues over 55 than the average and a higher proportion of those between 25 - 34

Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	11.2, Public Board Meeting	**Date:** 26 October 2022
Title:	Peninsula Acute Provider Collaborative including Terms of Reference	
Prepared by:	Suzanne Tracey, Chief Executive Officer	
Presented by:	Suzanne Tracey, Chief Executive Officer	
Responsible Executive:	Suzanne Tracey, Chief Executive Officer	
Summary:	Following agreement earlier in 2022 for the establishment of the Peninsula Acute Provider Collaborative as a vehicle for joint working with other Trusts across Devon and Cornwall, a summary of progress is presented together with a workplan for the next 3-6 months. This paper seeks endorsement of the work plan that will be implemented over the next 3-6 months with the aim of bringing forward recommendations for change during 2023/24.	
Actions required:	The Board of Directors is asked to: • **Note** the work undertaken to date by the Peninsula Acute Provider Collaborative and the Acute Sustainability Programme • **Discuss** and **endorse** the strategic ambition for the Programme as outlined in **Figure 2** • **Discuss** and **endorse** the design principles for the Programme as outlined in **Figure 3** • **Discuss** and **endorse** the proposal to conduct a series of clinical workshops, commencing in November 2022, to explore opportunities for sustainable service redesign to deliver better, more equitable, clinical outcomes and make best use of resources across the Peninsula • **Agree** that regular progress updates on this work will be brought to all member Boards • **Note** that the governance arrangements and the current work-plan require any further assessment of options for potential service reconfiguration to be specifically mandated to the PAPC by the Trust Boards.	

Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
		x	**x**	

History:	
Link to strategy/ Assurance framework:	

Monitoring Information

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

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

Working together to deliver service transformation in Devon, Cornwall and the Isles of Scilly
Peninsula Acute Provider Collaborative

1. Purpose of paper

To summarise progress to date and seek endorsement of the work plan that will be implemented over the next 3-6 months with the aim of bringing forward recommendations for change during 2023/24.

2. Background

Earlier this year, the Board agreed to the establishment of the Peninsula Acute Provider Collaborative as a vehicle for joint working with other acute Trusts across Devon and Cornwall.

The Terms of reference and membership were previously approved by the Board (Annex 1) together with the establishment of the Acute Services Sustainability Programme (Annex 2) – a clinically-led programme of work that will engage staff and communities in the redesign of acute services to improve clinical, workforce and financial sustainability.

At the same time, the Integrated Care Partnerships of both Cornwall and Isles of Scilly ICS and Devon ICS are each developing their ***Integrated Health and Care Strategy***. The strategy aims to set out how, in the future, all partners in the wider health and care system will work together to deliver more joined-up preventative and person-centred care – improving wellbeing, facilitating choice and supporting independent living. This strategy sets a critical context for the delivery of acute services and will be a key determinant of the future shape of healthcare across the Peninsula.

This paper aims to summarise progress to date and seek endorsement of the work-plan that will be implemented over the next 3-6 months with the aim of bringing forward recommendations for change during 2023/24.

Context

In line with the rest of England, demand is growing for primary and secondary healthcare. Increases in waiting lists, waiting times and ongoing challenges with unscheduled and emergency care activity create significant challenges in balancing demand and capacity. The availability of an appropriately skilled workforce is a major limiting factor impacting directly on the provision of health and social care in the appropriate place according to people's need.

Delivering a high quality, joined-up, sustainable health and care service for the local population is a key priority and expectation of the new Integrated Care Systems across England. This requires partners to work together to:

- Improve population health and care
- Identify and address health inequalities
- Enhance productivity and deliver best value for money across the whole resource envelope
- Address the wider determinants of health including social and economic development

Success will be dependent on organisations taking individual and collective action to drive efficiencies and deliver transformational changes that will generate immediate improvements and set the foundations for clinical and financial sustainability in the medium to long term.

Back in 2019, local NHS organisations across Devon and Cornwall came together to explore strategic opportunities for transformation that would contribute to longer-term service sustainability. However, progress with the recommendations of the ***Peninsula Clinical Services Strategy*** was adversely affected by the pandemic.

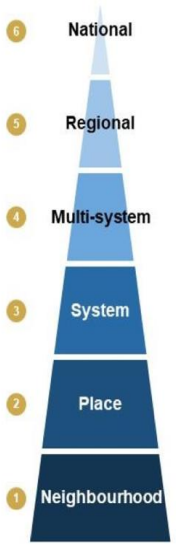
Since then, the strategic context has become even more challenging as demand for care, workforce constraints, and the underlying financial deficit have all increased.

Building on the outcome of the previous joint work, the pace and determination to develop new solutions will need to be much greater which further reinforces the need for leaders and organisations to work more closely together to make decisions to deliver service improvements in the best interest of the whole population of Devon and Cornwall.

Working together for success

The national framework for provider collaboratives[1] describes a range of levels at which collaborative working is expected to deliver improved services (Figure 1). Joint working in the areas of elective and non-elective secondary care are typically considered at an ICS level but the unique population demographics and flow of patients between boundaries across Devon and Cornwall suggest that collaboration of the acute providers across the whole peninsula population (circa 1.8m) would be in the best interest of local people.

Figure 1: Collaborations and activities that align with typical levels of service planning and delivery



Services	Predominant collaboration partners	Collaboration arrangements	Activities
• Life sciences • Highly specialist services	• Specialist providers • Research universities • Industry	• AHSCs, AHSNs • Public-private partnerships	• Services need to be planned and coordinated on a broader footprint than a single ICS, working with neighbouring ICSs, other providers and national commissioners. • Provider collaboratives might span levels 4 and 5 but even when they are not, they must be sighted on decisions relating to the delivery of services at levels four to six in order to understand and calibrate the use of its collective resources for the delivery of all provider collaborative priorities. • Linked to commissioning of 999, 111 and IUC over multi-ICS as a Lead Provider model
• Highly specialist services • Specialised services	• Specialist NHS providers across a large geographic footprint	• Specialist clinical networks • Provider collaboratives	
• Specialist and specialised services • Community and mental health • Access to UEC	• Providers working over multiple ICSs	• Specialist clinical networks • Provider collaboratives	
• Elective and non-elective secondary care • Inpatient, crisis and specialist mental health, learning disability and autism • Community	• Providers working across an ICS • Providers with patient flow into an ICS	• Provider collaboratives	• Services in Level 3 are primarily delivered on an ICS footprint. • These services therefore particularly lend themselves to planning, coordination and delivery through a provider collaborative.
• Community health • Community mental health • 'Front door' acute • Social care	• Providers • GPs • LAs • Voluntary sector	• Place-based partnerships • ICP contracts	• Services in levels 1 and 2 are likely to be planned and coordinated at borough (place) level and delivered at neighbourhood or borough level, depending on the service in question. The primary "vehicles" for collaboration in these layers are place-based partnerships (of which the members of provider collaboratives are key partners). • Provider collaboratives play a role in areas where they can add value for at scale collaboration, across multiple places. but they should not duplicate work within each place.
• Primary care • Public health and wellbeing • Prevention • Community health • Social care	• Providers • GPs • LAs • Voluntary sector	• Primary Care Networks (PCNs) • Integrated multi-disciplinary teams	

[1] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf

On that basis, earlier this year, the Chairs, Chief Executives and Medical Directors of the 4 acute Trusts in Devon (Royal Devon University Healthcare NHS Foundation Trust, University Hospitals Plymouth NHS Trust and Torbay and South Devon NHS Foundation Trust) and Cornwall (Royal Cornwall Hospitals NHS Trust) agreed that they would establish the ***'Peninsula Acute Provider Collaborative' (PAPC)***.

The role of the PAPC is to work on behalf of individual Trust Boards to set the direction and provide the strategic leadership across organisational boundaries to stabilise, sustain and transform acute care for the population of Devon and Cornwall. The ambition is summarised in **Figure 2**.

Figure 2: Strategic ambition of the Peninsula Acute Provider Collaborative

The principles underpinning the work of the Peninsula Acute Provider Collaborative, previously agreed by the Board, are attached as **Annex 3** and these form the basis upon which members will hold themselves and each other to account for both ways of working and the development of proposals for service improvement.

Progress to date

Over the past 3 months, members of the Acute Services Sustainability Programme have been working to develop an approach and work-plan that will support the redesign of services to address quality, workforce and financial challenges. This has involved several workshop sessions with Medical Directors, other key Executives and subject-matter experts to identify the key factors that will inform the future shape of services and ensure these are fully embedded in the transformation process.

What has become clear is that the emerging Integrated Health and Care Strategies are outlining a direction of travel that strengthens out-of-hospital services and in the longer term will reduce the need for hospital-based care. With enhanced primary care and community-based services, the ambition is to support people to keep well and maintain their independence.

At the same time, there will always be a requirement for acute care and the evidence base is clear that the right intervention at the right time provided by clinical teams with the right skills has a direct impact on outcomes for the individual. The role of the local District General Hospital will continue to be central to local access and coordination of acute care – providing safe, high quality services as locally as possible.

Advances in medicine mean that treatment options, even for severe injuries and illness, are changing and developing at ever increasing rates. This is extremely positive for patient outcomes but does mean that some clinical staff are, out of necessity, becoming more and more specialist and need a critical mass of patients to maintain their skills.

This is not new – the NHS has a long history of delivering high quality specialist services in specialist centres. For example, Derriford Hospital has served the whole population of the Peninsula well with major trauma, cardiac surgery, neurosurgery and other specialist services for many years. However, new technology, including remote consultation and the 'real-time' sharing of information means that the ability to provide significant elements of even the most complex care pathways remotely, closer to people's homes, is growing at pace. This opens up opportunities for delivering care in new and innovative ways – sharing expertise and extending access across wider populations.

The ability to differentiate people's care needs quickly and effectively to ensure they are then directed to the right place will become an increasing feature of future health and care services. Growing the capacity and capability of Primary Care and community services will be essential, together with access to high-quality community urgent care and diagnostic services, to enable patients to be directed to the right place according to established need. More robust pathways of care will need to be developed where the ownership, coordination and the vast majority of service delivery is local. If patients need to travel further for specialist interventions, this will need to be supported and kept to a minimum with the use of digital solutions to support remote 'work-up' and 'follow-up' of patients.

It has therefore been agreed that the starting point for establishing sustainable acute services must be to ensure that there are robust and consistent processes in place for high quality, timely, local assessment of acute care need for all people across the Peninsula, irrespective of where they live. This will then enable joined-up pathways of care to be developed across organisational boundaries supported by new technologies and digital solutions.

It is recognised that any redesign of services will need to be grounded in the reality of:

- Current and future population need including deprivation and an ageing society

- The specific challenges associated with coastal communities and rurality
- Available resources including workforce, buildings and money (capital and revenue)

Considerable work has been undertaken in recent years to explore solutions locally. The learning from these exercises together with an understanding of best practice nationally and internationally will be used to inform this process which will be clinically led.

The agreed design principles are outlined in **Figure 3** below.

Figure 3: Design principles

Work to date has enabled co-production of a methodology to engage clinicians in a process of exploring new ways of working and models of care. This has included:

- Assessing the best route in to service redesign
- Exploring critical clinical interdependencies
- Identifying the core data requirements to support the process
- Commissioning work to bring together the relevant evidence to support any emerging proposals

Careful consideration has also been given to the need to balance the time commitments of key leaders and clinicians to this process in the context of competing operational pressures.

Proposal

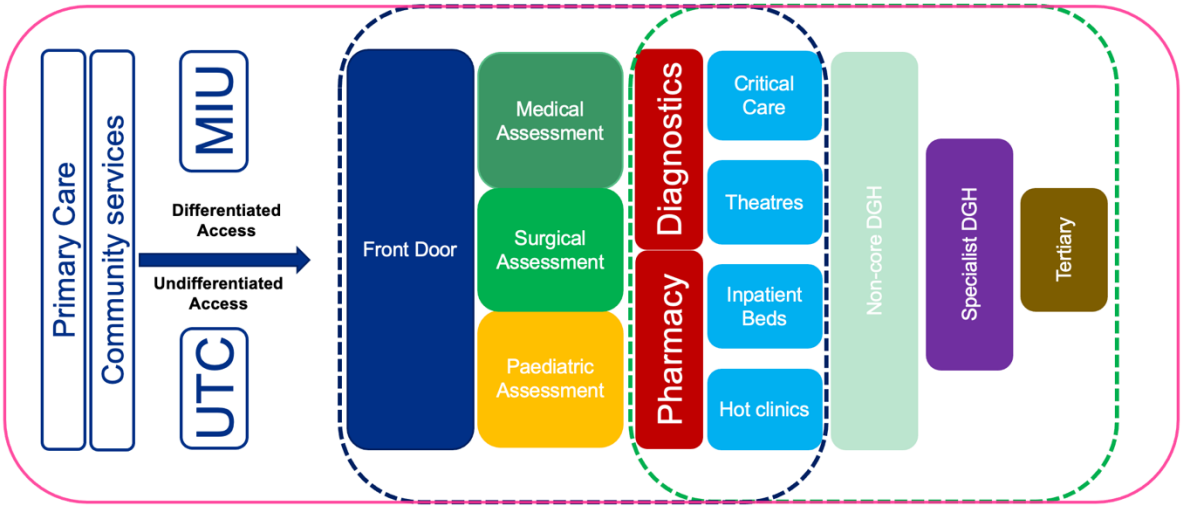
The authentic engagement of staff, stakeholders and citizens in the redesign of health and care services is central to ensuring that any process of change delivers the best possible outcome. On behalf of all Boards, it is imperative that this programme of work fully delivers on this commitment.

Clinical ownership and leadership of the initial work to explore the evidence and opportunities for change is critical to success and early discussions with Healthwatch will be essential to seek advice on the phasing of wider engagement.

A proposed approach has been put forward by the Acute Services Sustainability Programme and endorsed by the PAPC on 10th October as follows:

- The 3 index specialties for review will be medical assessment, surgical assessment and paediatric assessment. The rationale for this is that they are the key functions that operate alongside the 'front-door' of our hospitals to support the effective differentiation of need (**Figure 4**)

Figure 4: Building an acute services model



Note: Mental Health will also need to be a key consideration in the service models

- A series of 3 focused workshops (5-6 weeks apart) will be held for each of the index specialties and will involve a wide range of clinicians across the interdependent specialty, subspecialty and clinical support services.

- A series of core questions, co-produced with Medical Directors, will inform the workshop discussions. These will include assessment of critical mass for optimal outcomes, what elements of care pathways must be co-located, the future shape of the workforce and opportunities for better use of digital, technology and artificial intelligence.

- Robust workforce information will be essential to making assessments of how services can be safely and effectively staffed in the future. This will include working with the post-graduate medical Deanery to assess training requirements and optimal configuration of junior and middle grade rotas for both training outcomes and recruitment and retention of medical staff.

- There will be a clear requirement for innovative approaches to role redesign, both in-hospital and in the community, where the focus will be on the skills necessary to support the delivery of team-based care, moving away from traditional professional boundaries. This will create opportunities for new and

exciting roles for staff across all professional groups together with the potential for further vocational training opportunities and better, higher skilled jobs for local people.

Following the 3rd Workshop, a summary will be produced that outlines:

- An assessment of the challenges associated with the current configuration of services and the ability to sustainably deliver the required outcomes across the whole of the Peninsula

- Opportunities, through shared staff, role redesign and pathway redevelopment, to make best use of the workforce to support the delivery of acute care across Devon and Cornwall

- Options for service redesign which will improve outcomes and make best use of the totality of the resources available (people and finance).

These will be reviewed by the PAPC and resultant recommendations generated for consideration by the Trust Boards.

It is really important that as much scope as possible is given to the teams to bring forward the best solutions. This means keeping to a minimum the number of 'givens' they need to navigate as part of their deliberations. To that end, it is suggested that the assumptions are limited to the following:

- There will continue to be 5 acute hospitals across Devon and Cornwall
- Each acute hospital will continue to have a 'front-door' providing urgent and emergency care
- There will continue to be only one tertiary centre in the Peninsula at Derriford Hospital
- Where services currently delivered in hospital can be delivered just as effectively (or more so) out-of-hospital, this should become the default model (recognising that there may need to be transitional arrangements to support shift of resources in the longer term)

The remit of the clinical workshops will not extend to 'where' services will be delivered in the future. If the outcome of the process is that certain elements of pathways can only be safely and effectively delivered on a smaller number of sites, this will need to be agreed by Boards, in public, before any consideration of where they would be located.

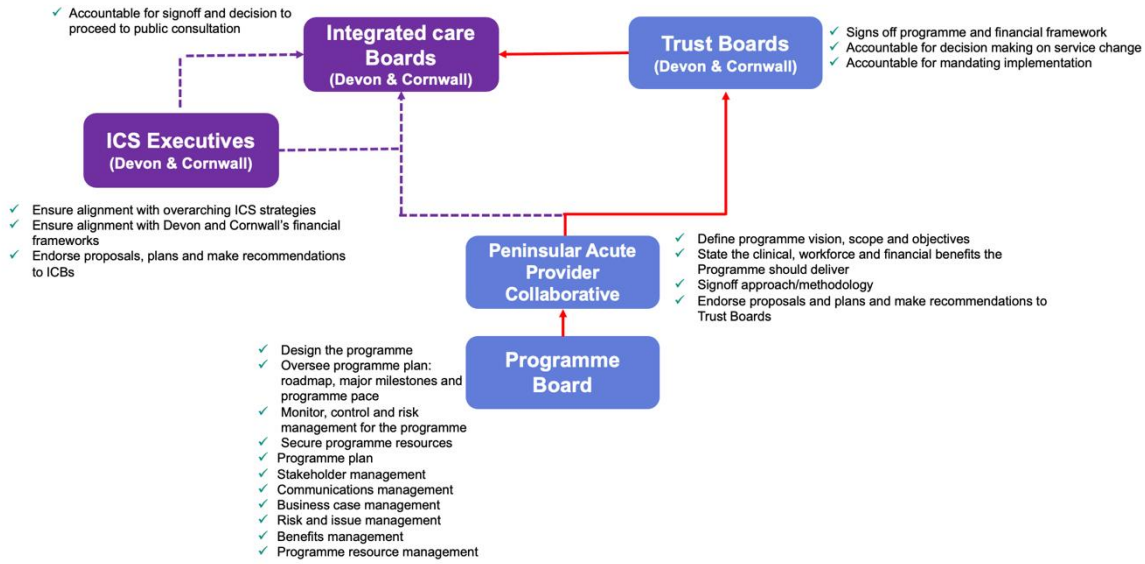
If there is any requirement to consider relocating services, options would need to be generated openly and transparently with wide engagement and consultation as required. Any recommendations would need to take full account of the potential for improved quality and outcomes; the need for clinical co-location; access for patients and their families; the best use of the current estate and any new capital investment; and affordability.

It is really important to note that the programme would need to report back on the initial workshop findings and seek a further specific mandate from Boards to proceed BEFORE exploring options for service reconfiguration if indicated.

Governance and decision-making

The overall governance of this programme of work is summarised in **Figure 5** below.

Figure 5 : Peninsular Acute Sustainability Programme - governance



This makes it clear that the decisions on any proposals for future service change and the sign-off of any proposals to proceed to public consultation are reserved for the Trust Boards and the Boards of the two ICBs. The previously agreed decision-making framework aims to limit the risk of different decisions being made by different Boards so that all partners move forward together in the best interest of the whole population of Devon and Cornwall.

3. Recommendations

The Board is asked to:

- **Note** the work undertaken to date by the Peninsula Acute Provider Collaborative and the Acute Sustainability Programme
- **Discuss** and **endorse** the strategic ambition for the Programme as outlined in **Figure 2**
- **Discuss** and **endorse** the design principles for the Programme as outlined in **Figure 3**
- **Discuss** and **endorse** the proposal to conduct a series of clinical workshops, commencing in November 2022, to explore opportunities for sustainable service redesign to deliver better, more equitable, clinical outcomes and make best use of resources across the Peninsula
- **Agree** that regular progress updates on this work will be brought to all member Boards
- **Note** that the governance arrangements and the current work-plan require any further assessment of options for potential service reconfiguration to be specifically mandated to the PAPC by the Trust Boards.

Annex 1

Peninsula Acute Provider Collaborative - Committees in Common Terms of Reference

1. Constitutional Obligations

1.1 The ICB hereby resolve to establish a Committee of the ICB known as the Acute Provider Collaborative Committees in Common (hereafter known as the APC). The Committees in Common is established in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation and the Acute Providers supporting the Devon and Cornwall footprints (see Appendix 1).

i. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into each organisations constitution and standing orders.

ii. As per the ICB's constitution, in the interest of partnership working, this committee will operate as a 'Committees in common' with representatives from each organisation (Appendix 1)

The accountability and decision making of the committee shall remain the responsibility of the individual organisations and its Board(s).

Committee in Common
• Each Board delegates authority to the Collaborative to bring forward recommendations for endorsement • When the recommendation comes forward, each Board meets at the same time, considers the same paper, and makes its own decision • It is technically possible for there to be different decisions, but any risk would need to be mitigated by the members of the Collaborative

The APC is an assurance committee of the organisations (Appendix 1) and have the ability to execute any powers assigned to them and those specifically delegated in these terms of reference and/or through each organisations constitutional scheme of reservation and delegation.

2. Purpose

2.1 The purpose of the APC is to successfully work together to drive whole system acute services transformational change across the population in Devon and Cornwall – improving outcomes and performance, sharing skills and experience, making best use of scarce workforce resources, and realising tangible financial savings and sustainability.

The APC sits alongside the existing Mental Health Collaborative and will lead the joint planning of acute services for the population of Peninsula. This enables an opportunity to exist for greater devolved accountability for resource allocation and utilisation in future with strong alignment between strategic planning and commissioning functions.

3. Responsibilities

The responsibilities of the APC will include:

- Identifying the opportunities for joint working (operationally and strategically)
- Agreeing the acute services transformational priorities and delivery plan
- Commission specific pieces of work
- Receive recommendations and/or business cases
- Make joint decisions within any delegated authority
- Make joint decisions to be endorsed by Trust Boards and ICBs

The work of the ACP will be underpinned by Task and Finish Groups and Technical Advisory Groups (e.g. Finance) as appropriate.

4. Membership

The core Membership of the Committee shall be:

The following Members have voting rights: • Acute Trust Chair(s) • Acute Trust CEO(s) • Acute Trust Medical Director(s)
Attendees <u>do not</u> have voting rights and include: • Independent Chair • APC Manager • ICB Medical Director(s)
The Chair of the APC may co-opt any non-voting Clinicians, Executive or Managing Directors, nominated deputies and lead managers as appropriate and particularly, when the APC is discussing areas of risk or operation that are the responsibility of that attendee.
Note: When a Committee Member is unable to attend, a named deputy with sufficient authority must attend in their place. Deputies will have the decision making and voting rights of the person he/she is representing.

5. Quorum

5.1 A quorum of the APC shall be at least two members from each of the organisations (Appendix 1)

5.2 With the exception of administrative matters where decisions will be made on a majority basis, decisions will be based on a consensus amongst all Members present. Where consensus cannot be achieved, the agreed decision framework will be invoked by the Chair to reach an outcome in a fair, transparent and timely way.

The decision framework is based on 3 sequential phases designed to be supportive in reaching a decision, and must be adhered to as follows:

Phase 1	each party formally laying out their concerns and suggested alternatives with the aim of achieving a negotiated outcome
Phase 2	time-limited independent mediation with those organisations directly affected by the proposals with the aim of either resolving differences or developing an alternative agreed proposal that meets the original aims
Phase 3	independent clinically led panel convened to review all evidence and make a recommendation which is binding on all organisations

5.3 People invited to attend, or those in attendance at the APC do not have the right to vote.

5.4 If the APC Chair is absent then the Members of the APC will select a chair for that meeting from the voting Members present – this will be overseen by the most senior officer responsible for governance as the Chair needs to be an independent representative of the APC

The aim will always be for consensus decisions to be made through a process of mature discussion based on clear and impartial clinical, operational and financial information. Moving to Phase 3 of the decision-making framework should be rarely, if ever, required.

6. Register of Interests

6.1 The Register of Interest will be reviewed at each meeting of the APC.

6.2 Members will be asked by the Chair of the APC to declare any interests at the beginning of each meeting. If a Member feels compromised by any agenda item they should declare a conflict of interest and leave for that agenda item.

7. Frequency of Meetings

7.1 The APC must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. It is expected that in the first instance meetings will be held monthly, moving to bi-monthly once the workplan is established and

agreed.

This will need to be kept under review in line with the scale and pace of changes and decisions required.

8. Reporting arrangements

8.1 The APC Chair shall report formally to all organisations on its proceedings after each meeting on all matters within its duties and responsibilities.

The report shall be presented to the public meeting of the ICB. The members shall make recommendations to their respective organisations Board(s) on any decisions made and area within its remit where action or improvement is needed.

8.2 The APC is authorised by the ICB to investigate any activity within its terms of reference and through the APC Memorandum of Understanding. It is authorised to seek any information it requires from any employee and all employees re directed to co-operate with any request made by the APC.

8.3 The APC may require the attendance at its meeting of any officer as required through agreement, and the production of any document that can ensure the APC meets its obligations as set out in these terms of reference.

The APC is authorised through its memorandum of understanding to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Minutes and reports of the meetings will be produced and held by the Administrator of the APC, accessible to the Chair, core Membership and the Director responsible for the administrative function. Extracts from Minutes will be made public as appropriate under the freedom of information act.

9. Statutory Functions, Committee Oversight and KPIs (Internal Monitoring)

9.1 The ICB has delegated the following authorities to the Committee:

• The Acute Provider Collaboratives Committees in Common has the authority to commission work from the Directors of Finance, Directors of Workforce or Clinical and Professional Cabinet, seeking any advice appropriate for distinct areas of work
• The Acute Provider Collaborative Committees in Common had the authority to establish Task and Finish Groups, drawing on the expertise of Directors and other staff from within the constituent organisations as appropriate

9.2 The APC will undertake an annual review of the performance and effectiveness to ensure that the APC structure, decision making and work plans reflect the current and future needs.

9.3 In addition, the APC will review the work of other sub groups or work streams within the organisations, whose work can provide relevant assurance to the APC's own scope of work. These may include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (e.g. Public Sector Audit Appointments Ltd, National Audit Office, Financial Reporting Council) or professional bodies with responsibility for the performance of staff or functions(e.g. Royal College, accreditation bodies).

9.4 The reviews will be spread throughout the year with an Annual Report produced by the Committee for the ICB.

10. Administration

10.1 The APC and its sub group(s) shall be supported administratively by its Administrator. His or her duties in this respect will include:

- Agreement of agendas with the Chair and attendees
- Preparation, collation and circulation of papers in good time
- Ensuring that those invited to each meeting attend
- Taking the minutes and helping the Chair to prepare reports to Board(s)
- Keeping a record of matters arising and issues to be carried forward
- Arranging meetings for the Chair – for example, with the internal/external auditors,
  or local counter fraud specialists
- Advising the APC on pertinent issues/areas of interest/policy developments
- Ensuring that action points are taken forward between meetings
- Providing appropriate support to the Chairperson

10.2 Following each meeting, the Administrator will:

- Maintain an attendance log and follow up as appropriate after each meeting to ensure the APC adheres to the required frequency of attendance by Members.
- Maintain a decisions log of reporting arrangements into each formal meeting of the APC and follow up as appropriate.
- Maintain a log of summary written reports provided to ICB from formal meetings.

11. Review

An annual effectiveness review will be undertaken by the Head of Governance as good governance practice and to ensure compliance with the Annual Governance Statement.

These Terms of Reference will be reviewed on an annual basis or sooner if required through the Head of Governance with recommendations made to the Boards for approval.

END

APPENDIX 1

Member Organisation of the Peninsula Acute Provider Collaborative

Royal Cornwall Hospitals NHS Trust
Royal Devon University Healthcare NHS Foundation Trust
Torbay and South Devon Foundation Trust
University Hospitals Plymouth NHS Trust

Membership (updated 17 October 2022)

Membership:

Name	Role	Organisation
Nigel Acheson	Chief Medical Officer	NHS Devon
Helen Skinner	Chief Medical Officer	NHS Cornwall
James Brent	Chair	University Hospitals Plymouth NHS Trust
Ian Currie	Medical Director	Torbay and South Devon NHS Foundation Trust
Dave Stacey	Deputy Chief Executive	Torbay and South Devon NHS Foundation Trust
Mark Hamilton	Medical Director	University Hospitals Plymouth NHS Trust
Adrian Harris	Chief Medical Officer	Royal Devon University Healthcare NHS Foundation Trust
Richard Ibbotson	Chair	Torbay and South Devon NHS Foundation Trust
Ann James	Chief Executive Officer	University Hospitals Plymouth NHS Trust
Mairi McLean	Chair	Royal Cornwall Hospitals NHS Trust
Suzanne Tracey	Chief Executive Officer	Royal Devon University Healthcare NHS Foundation Trust
Steve Williamson	Chief Executive Officer	Royal Cornwall Hospitals NHS Trust
Shan Morgan	Chair	Royal Devon University Healthcare NHS Foundation Trust
Allister Grant	Medical Director	Royal Cornwall Hospitals NHS Trust

In attendance:

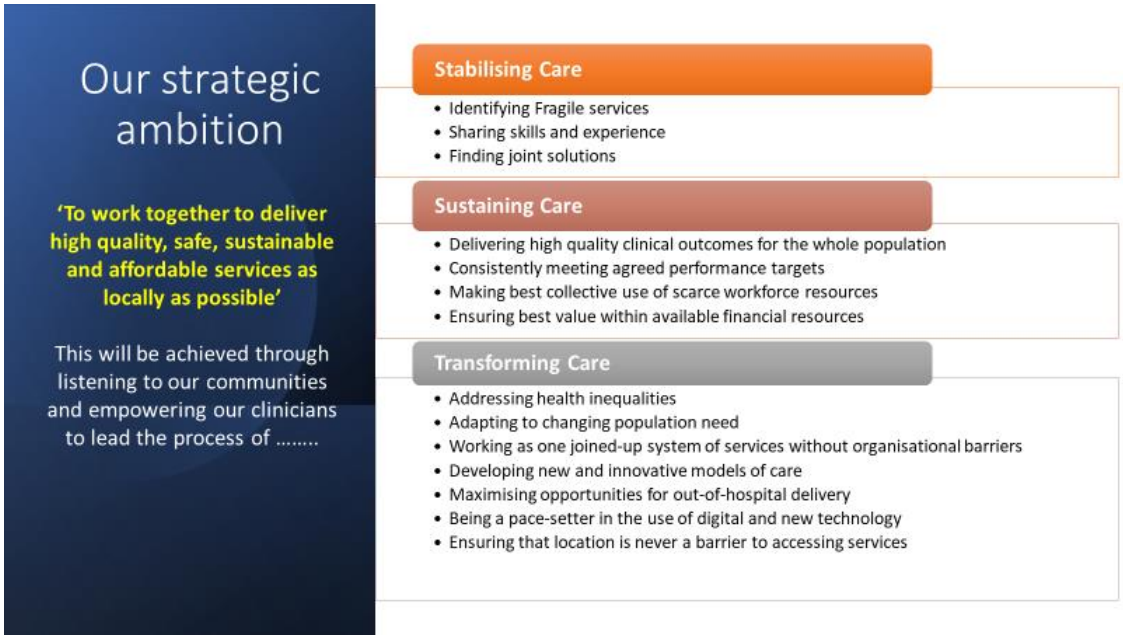
Name	Role	Organisation
Liz Davenport	Programme SRO (& CEO)	Torbay and South Devon NHS Foundation Trust
Allison Williams		NHSE/I

Annex 2

Peninsula Acute Sustainability Programme Board
Terms of Reference

Strategic ambition

The Peninsula Acute Provider Collaborative has endorsed a strategic ambition which will underpin the work of both the Collaborative *and* the Peninsular Acute Sustainability Programme. This lays the foundation for the terms of reference set out in this document. The strategic ambition is as follows:



Objectives

The objectives of the Peninsula Acute Sustainability Programme Board are to:

1. Secure a **mandate** from the NHS Devon and NHS Cornwall and Isles of Scilly leadership teams to proceed with the development and subsequent implementation of an acute sustainability programme for the Peninsula.

2. Oversee the **design and development** of the programme.

3. Oversee and ensure efficient and **effective management** of the programme.

4. Ensure that the programme defines and delivers **tangible, realisable benefits and outcomes** for the public, patients, and workforce for both the Devon and Cornwall Integrated Care Systems.

5. Ensure programme design and delivery is **aligned with the respective overarching Integrated Care Strategies and 5-year forward plans** for both Devon and Cornwall.

6. Develop a programme and implementation plan which **supports the financial assumptions and commitments** set out in the respective Devon and Cornwall financial frameworks [agreed with regulators].

Roles and responsibilities

Role

The Peninsula Acute Sustaibility Programme Board has the following role, to:

1. Nurture and foster a shared commitment from key stakeholders across the Peninsula to the Acute Sustainability Programme.
2. Ensure key stakeholders across Devon and Cornwall understand “what is the Acute Sustainability Programme?” and “Why we are doing it?”.
3. Define the programme vision, scope, and objectives.
4. Design the programme – ensuring that there is coproduction in the design with appropriate stakeholders
5. Develop and own a financial framework which sits within the wider Peninsula Financial Framework(s).
6. Set out a clear roadmap of the major milestones for the work to be done.
7. Set the pace for the programme.
8. Agree and make proposals to the Peninsula Acute Provider Collaborative, Trust Boards, ICS Executive teams, ICBs and other leadership groups as appropriate.
9. Own and manage the relationship with regulators (e.g., NHSE SW and national teams) – to keep them informed on ambition and progress in relation to the Peninsula Acute Sustainably Programme.
10. Foster a supportive and collegiate Peninsula-wide approach to working together on the programme
11. Ensure that all enabling plans are aligned to support successful delivery of the Peninsula Acute Sustainability Programme and Plan (e.g. Cornwall ICS and Devon ICS: Integrated Care Strategies and associated 5 Year Forward Plans.
12. Formally take stock of progress with the programme every 3 months (to ensure that it continues to achieve its objectives) and seek endorsement of any proposed changes from the Peninsula Acute Provider Collaborative as appropriate.

Responsibilities

The Peninsula Acute Sustainability Programme Board has the following responsibilities:

1. Define and propose the clinical, workforce and financial benefits the programme should deliver
2. Shape and design the approach to be adopted to carry out the work
3. Ensure all proposals are evidence base
4. Make proposals regarding where business cases are required to proceed
5. Make proposals where there is a requirement to invoke the major service change process because NHSE's 5 key tests for major service change have been met.
6. Ensure that all service change is supported by appropriate involvement and engagement with the public.
7. Ensure programme risk and issues are managed – proactively
8. Task individual members of the Programme Board with stakeholder engagement tasks and activities – as required
9. Ensure oversight and implementation of communications and stakeholder engagement plans
10. Secure resources for the programme
11. Receive regular progress reports from the Peninsula Acute Sustainability Working Group
12. Monitor and control the programme
13. Adopt and embed the principles set out below:

Principles

The Programme Board should adopt and embed the principles set out below:

- ✓ Collaborative working and decision making
- ✓ Clear and defined goals – shared purpose and a focus on outcomes
- ✓ Whole Peninsula thinking – doing the best thing for Devon & Cornwall
- ✓ Shared accountability to deliver change
- ✓ Role modelling of System behaviour
- ✓ Consistent leadership – setting the right tone
- ✓ Constructive challenge – listening to all voices
- ✓ Assume best intent

Membership of the Peninsula Acute Sustainability Programme Board

Members of the Programme Board are listed in the table below.

Name	Role	Organisation
Liz Davenport	Chief Executive Officer Programme SRO & Chair of Programme Board	Torbay & South Devon NHS Foundation Trust
Allison Williams	Programme Lead – Expert Advisor (Deputy Chair)	NHSE
Nigel Acheson	ICB Chief Medical Officer	NHS Devon
Helen Skinner	ICB Chief Medical Officer	NHS Cornwall
Simon Gittoes-Davies	ICB Chief Finance Officer	NHS Cornwall
Simon Tapley	ICB Chief Transformation & Strategic Planning Officer	NHS Devon
Rachel O'Connor	ICB Director for Inclusion (Commissioning)	NHS Cornwall
Kelvin Grabham	ICB Business Intelligence Lead	NHS Devon
Carolyn Mills	Chief Nursing Officer	Royal Devon University NHS Foundation Trust
Allister Grant	Medical Director	Royal Cornwall Hospitals NHS Trust
Ian Currie	Medical Director	Torbay and South Devon NHS Foundation Trust
Mark Hamilton	Medical Director	University Hospitals Plymouth NHS Trust
Adrian Harris	Medical Director	Royal Devon University NHS Foundation Trust
Colm Owens	Clinical Director	Devon Mental Health Provider Collaborative
Andrew Millward	ICB Chief Communications & Corporate Affairs Officer	NHS Devon
Carol Beckford	Programme Director	NHS Devon

Note: A Primary Care representative will be added once confirmed

Each member may nominate a named Deputy to attend and participate with their full authority in their absence. The Chair shall be notified of this prior to the meeting.

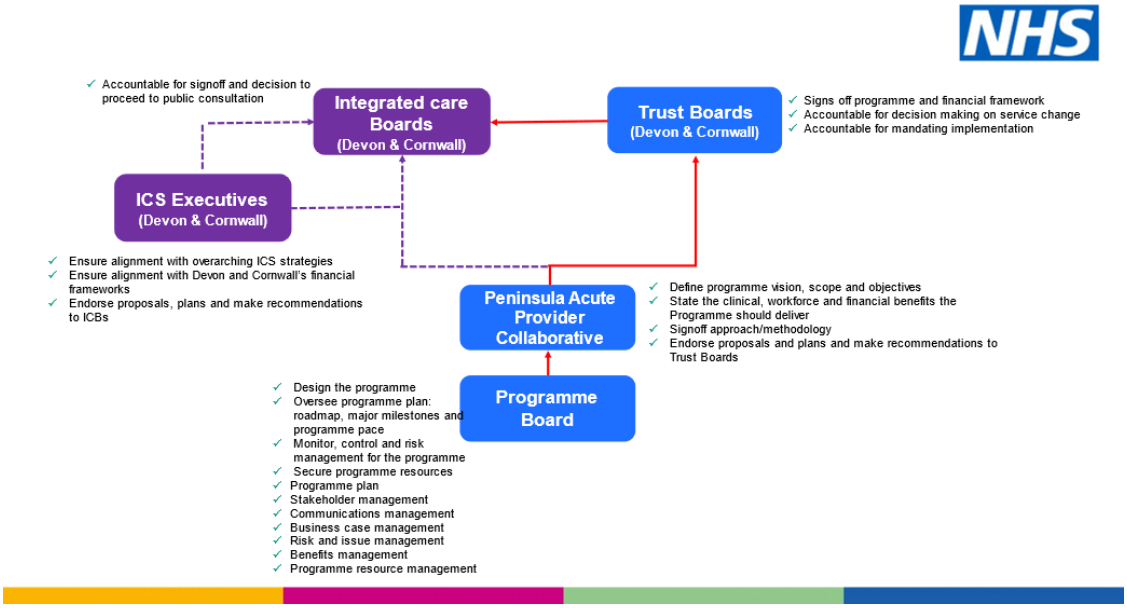
Other individuals may be invited to attend the meeting as appropriate to the agenda item.

For the programme board to be considered quorate the meeting should be comprised of:

- The SRO/Chair or Deputy Chair
- Representative from both Devon and Cornwall
- At least one representative from Cornwall
- At least two medical directors

Accountability and reporting

Programme Governance, accountability and reporting is set out in the diagram below:



The Programme Board will be directly accountable to the Peninsula Acute Provider Collaborative.

The Peninsula Acute Provider Collaborative will, in turn, secure from Trust Boards:

- Signoff to the programme (i.e., scope, approach and supporting financial framework).
- Decisions, where there a requirement to make a significant service change.
- The mandate for implementation.

Devon and Cornwall's respective ICS Executive forums will be asked to ensure:

- Alignment with their respective overarching ICS strategies and the Peninsula Acute Sustainability Programme Plan
- Alignment with their respective financial frameworks and the Peninsula Acute Sustainability Programme Plan.
- They are content to endorse plans and proposals before they are submitted to Devon and Cornwall ICBs.

Administration

The Peninsula Acute Sustainability Programme Board will meet at least monthly. Ideally meetings will be scheduled for the fourth Thursday each month. The paper deadline for papers to be discussed at the meeting is the third Wednesday of each month.

Administration by Acute Sustainability Programme – Project Support Officer.

Formal minutes of the meetings will be recorded and will normally be confirmed as accurate at the next meeting of the group.

Review

These terms of reference will be reviewed by the Programme Board and Peninsula Acute Provider Collaborative on receipt of the mandate to proceed with the Peninsula Acute Sustainability Programme – current target date for this decision – November/December 2022.

Current version: updated following comments and feedback from:

- Programme Board – 29th September 2022.
- Peninsula Acute Provider Collaborative – 10th October 2022

Annex 3

These guiding principles will form the basis of the working relationships and arrangements for the APC and the mechanism for holding partners to account.

All members of the APC will work together in the best interest of the whole population of Devon and Cornwall.

- The views and opinions of every member of the ACP will be respected even if there is no agreement

- Where System best interests may be considered contrary to the perceived or actual best interests of any one partner, these will be openly declared, constructively discussed and fully considered

- All members will openly share all and any information (financial and non-financial) relevant to the business of the APC

- Prior to local investment in any fragile services, consideration will be given to joint solutions that provide best outcomes and value for money for the whole Devon system

- In arriving at any decisions regarding the disposition of clinical services, the APC will ensure that:
    - There has been full clinical engagement in the process
    - Appropriate staff, stakeholder and public engagement has been undertaken throughout the various stages of the work
    - The underpinning data is robust and objective
    - A comprehensive options appraisal process has been undertaken in line with pre-determined and transparent criteria
    - No one organisation is disproportionally advantaged or disadvantaged by the decision
    - Financial and non-financial risk is fully shared in accordance with the pre-determined framework

- Where there is a clinical requirement to centralise services on one site, full consideration is given to reciprocal transfer of other services to make overall best use of staff, estate and other resources

- If a decision is made that has a perceived or real impact on one organisation more than another, all members of the APC will stand jointly with the relevant Board and provide support both internally and externally as required

- Once a decision has been made by the APC, and endorsed by Boards, all organisations will commit to playing their full part in the implementation process

- Decisions that are made by the APC and endorsed by Boards are 'locked-in' unless new evidence becomes available that would question the efficacy of that decision.

Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	12.1, Public Board Meeting		**Date: 26 October 2022**	
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**
				x
History:	The last Governance Committee Report was presented verbally to the Board of Directors on 31 August 2022.			
Link to strategy/ Assurance framework:	The Governance Committee reviews and monitors the Corporate Risk Register and identifies and escalates operational risks which it considers could have strategic significance and which the Board might consider placing on the Board Assurance Framework.			

Monitoring Information

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

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

1.	**EXECUTIVE SUMMARY**
1.1	To provide, as requested by the Board of Directors (Board) a report by exception, from the Governance Committee following the meeting on 14 October 2022.
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 a summary of the initial outcomes from the Royal Devon Recovery Week (5th – 11th October 2022), advising that one of the most significant achievements was the closure of escalation beds on Knapp ward at Eastern services. The data from the Recovery Week was still being reviewed but it was acknowledged that whilst not all the objectives had been fully met, it had had a positive impact and the Trust was in a better position as winter approaches. It was noted that in order to formalise the ad hoc ambulance divert requests from neighbouring Trusts, the Trust has accepted diverts from three additional catchment areas across South Devon and Plymouth. This is likely to result in 4-5 additional patients per day and the impact of this will be monitored. Adrian advised that the data from Australia indicated that the impact of the influenza season this winter is likely to be higher than in previous years. The 'flu vaccination programme is underway and uptake of the vaccination by front line staff has been positive so far. b) **Surgical Services Divisional Governance Updates** The GC received the annual divisional governance update reports from Surgical Services for the Eastern and Northern sites. Both teams provided an update on the divisional risks relating to workforce and capacity within surgical services and the GC were assured that there were appropriate mitigations to address the risks. The GC congratulated the Northern divisional team on the excellent work undertaken on the Jubilee ward at North Devon Hospital.

The Eastern divisional team provided additional assurance regarding the clinical prioritisation and theatre utilisation processes in place to ensure that patients were seen and treated as quickly as possible, and the GC noted the opening of the Preparation for Surgery unit and the Exeter Hand Unit.

c) Responding to and Learning from Deaths report Q1 2022-23 update report

Dr Mark Daly, Mortality Lead, provided a comprehensive combined update report, presenting both Eastern and Northern locality data. The report detailed the comprehensive work of the Medical Examiner's office in the first review of deaths and identifying potential learning, and the integration of the approach to mortality across both sites with overall improvements in process identified from relative strengths of each approach.

The GC scrutinised the report, noting that there were no concerns regarding the mortality data. The significant progress in addressing the backlog of reviews was commended with all outstanding reviews expected to be completed by the end of November, and sufficient capacity in place to meet current demand, backlog; and going forward, a numerically modest volume of improvement work across both sites.

The GC noted the potential threats to the current efficiency of the Medical Examiner service and its data integration with the launch of the national ME database and the need for sufficient administrative support to maintain data across both systems. The GC requested that Dr Rebecca Appelboam, Medical Examiner Lead, was invited to a future GC to discuss the challenges faced by the service, the required actions and any support required from the committee.

d) Clinical Effectiveness Committee:

Dr Anthony Hemsley, Eastern Site Medical Director presented the report on behalf of both Eastern and Northern sites and the GC noted that in the next reporting period to the Governance Committee, it is planned that residual site-specific CEC meetings will be stood down and a single CEC covering both sites will be in place.

The GC were assured that work is now underway to more formally reincorporate a range of reporting to the scheduled CEC meetings, such as integrated Sub-Group reporting, NICE compliance reporting, National Clinical Audit reporting and GIRFT reporting.

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

Hannah Foster, Chief People Officer advised the GC that the revised people policies that have been drafted as part of Project Simplify was being progressed by a Policy Group, and that the people policies identified as part of phase 1 will be in place by the end of the calendar year.

The GC also noted that Learn+ has now gone live Trust wide and work is ongoing to create one overall core catalogue of learning that will be the same across the Trust. The Committee heard that there were some challenges in aligning a small number of mandatory training topics across the Trust and were provided with assurance that a temporary solution to moving and handling capacity has been put in place

f) Patient Experience Committee

Carole Burgoyne, Chair of the Patient Experience Committee and Non-Executive Director provided the GC with an update on the improvement trajectories for the current backlog for Eastern complaints and concerns both over 45 days & over 6 months, and the backlog of Northern complaints. It was noted that at the end of Q1 2022-23, both Northern and

	Eastern Services had a significant number of complaint investigations which exceeded the internal 45-day KPI timeframe; with Eastern Services also having a significant backlog of complaints & concerns exceeding the 6-month statutory target. The GC were informed that a complaints audit and a mapping exercise were undertaken across Northern and Eastern; highlighting areas of good performance and recognised not one single contributory factor had impacted on the timeliness of complaint investigations, but instead highlighted the complexity of complaints handling, and its dependency upon several variables. The PEC provided assurance that there are a number of mitigating actions, including both sites working together to align complaints processes and working towards improvement on the Trust's internal and external KPIs and that if the forecasted trajectories for Eastern and Northern were achieved, the Trust would expect to see no concerns over 14 working days open by the end of December 2022 and a reduction in the most overdue complaints (those over 6 months) by the end of January 2023. The PEC will continue to monitor progress on complaints trajectories and the associated mitigating actions through ongoing quarterly reports. The following survey results were received and noted by the GC: • National Inpatient Survey 2021 – Northern and Eastern Services both received positive results, scoring above the national average and any recommendations or key themes for improvement have been included in existing workplans and will continue to be monitored through the Patient Experience Operational Group (PEOG). • National Cancer Patient Experience Survey 2021 – Northern and Eastern Services received response rates higher than the national average, with responses towards overall patient satisfaction and 'how well teams work together' scoring over 90%. The mitigating actions and associated learning to address any required improvements will be included within the Northern and Eastern cancer services' action plans and will continue to be monitored through PEOG. **g) Safety & Risk Committee** Suzanne Tracey, Chief Executive, provided the GC with an update on the following: • Cardiology waiting times – assurance was provided that the devices and ablation position are close to the realistic trajectory and are now moving in the right direction however there are concerns about the new outpatients and coronary outpatients' position which is deteriorating. These significant challenges have been recognised and are linked to various factors i.e. the Division and specialties ability to manage, outpatient space, recruitment and Covid related illness. Suzanne advised that the S&RC has commissioned further work to gain additional assurance from Cardiology regarding the improvement trajectory and the associated actions required to effectively mitigate the risk within a realistic timescale. • Medical staffing risks at Northern services – the GC noted that the S&RC has requested greater assurance in regard to the work is moving in the right direction. The Committee noted that the Chief Medical Officer will lead a systematic piece of work on Medical Staffing in Northern Services. • Patient Safety Strategy – the GC received further information on the implementation plan for the strategy, and the Patient Safety Incident Response Framework (PSIRF) which was published in August 2022 and is a major piece of guidance on how NHS organisations respond to patient safety incidents, and ensure compassionate engagement with those affected. Assurance was provided that appropriate plans are in place to significantly redesign current patient safety structures, policies and governance arrangements. Further updates will be provided in the coming months. • Never events – the GC noted that the GC had received two further never event investigation reports both related to wrong site nerve blocks. The GC were advised

	that the S&RC had reviewed the action plan arising from the never event thematic review in August 2022. Recognising the work already being done through the Incident Review Group (IRG) and the publication of the iBullettin, a need for a wider scope of communication of learning from incidents within the organisation was identified and the S&RC agreed that the actions will be tracked through the IRGs, which will become Trust wide in November 2022 with any issues or concerns escalated through to the S&RC. • Serious Incident trajectories – the S&RC provided the GC with an update on the progress against the trajectories for Eastern and Northern services with clearance of the current backlog expected in October 2022 and November 2022 respectively. • CQC new regulatory model – the GC were advised that the CQC are developing a single assessment framework for all providers, local authorities and integrated care systems. The aim is to focus on what matters to people who use health and social care services and their families. The framework will continue to use the five key questions (safe, effective, caring, responsive and well led) and the existing four-point ratings scale (outstanding, good, requires improvement and inadequate). There will be six evidence categories detailing the types of evidence that will be used to assess the quality of care being delivered against a quality statement. The new model is expected to launch in January 2023 and until this time the existing regulatory framework remains in place and assessments will be carried out on a risk-based approach. The S&RC commissioned a compliance check against the new quality statements with any gaps in assurance to be escalated via the S&RC for the development of an action plan. **h) Ockenden action plan update:** Carolyn Mills, Chief Nursing Officer, provided the GC with a summary of the quarterly CNST update and response to Ockenden report that was presented to the Safety and Risk Committee on 7 September 2022 for consideration. The reports are available in full at Appendix 1 and 2. i) **National amber alert issued on blood stocks** Dr Anthony Hemsley, Eastern Site Medical Director, advised the GC that the NHS Blood and Transplant (NHSBT) have triggered an “amber alert” meaning hospitals have been asked to put in place management plans to protect blood stocks. The amber alert will last initially for four weeks which should enable blood stocks to be rebuilt. Assurance was provided that the Trust Emergency Blood Management Group have met to discuss the implications of this and the actions needed to support life-saving transfusions during this alert period.
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.

Royal Devon University Healthcare NHS Foundation Trust

Governance Committee

Date:	Friday 14th October 2022
Agenda item:	13
Title:	Ockenden Action Plan Update
Prepared by:	Will Denford, Executive Support Manager Carolyn Mills, Chief Nursing Officer
Presented by:	Carolyn Mills, Chief Nursing Officer

1. ASSURANCE FOR ESCALATION TO THE GOVERNANCE COMMITTEE

1.1 The purpose of this paper is to provide assurance to the Committee on the progress made by the Royal Devon maternity services towards compliance with the 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 Immediate and Essential Actions (IEA's) within the Ockenden initial and final reports.

1.2 This paper is a summary of the quarterly CNST update and response to Ockenden report that was presented to the Safety and Risk Committee on 7 September 2022.

1.3 **CNST MIS - Year 4 summary:**

Year 4 of the CNST MIS was initially 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's content has been refined from Year 3 and following a period of pause in response to the pandemic, Year 4 has relaunched from May 2022 with refined guidance and a new deadline for Board declaration forms of 25 January 2023.

1.4 **CNST MIS – Update on progress towards full compliance with the Year 4 ten safety actions:**

Northern services

- Full compliance is anticipated for 7 out of the 10 safety actions
- 3 safety actions (nos. 3,6,8) are at risk of non-compliance

Eastern services

- Full compliance is anticipated for 7 out of the 10 safety actions.
- 3 safety actions (nos. 4,6,8) are at risk of non-compliance

Mitigating actions have been agreed for those safety actions at risk of non-compliance and associated action plans are in place to monitor and record on-going compliance. The monitoring of progress towards compliance of the ten safety actions

will continue through both joint site monitoring meetings and speciality governance meetings.

Response to the initial Ockenden report (Dec 2020) and compliance towards the 7 IEA's:

1.5 Following submission of evidence in October 2021 for compliance against the 7 IEA's noted in the initial Ockenden report, the Trust has now received reports from the national CSU team on the evidence submitted.

Within these reports, the CSU provided details on the criterion which they disagreed that evidence had been submitted by the Trust. In response, both sites challenged several of the criterion and all were accepted by the CSU.

Remaining non-compliant criterion are detailed within an action plan which is monitored and reported via speciality and divisional governance, and overseen by the maternity safety champions.

Response to the final Ockenden Report (March 2022):

1.6 The Final report of the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust was releasing in March 2022; detailing a series of repeated failings and the resulting devastating impact on many families over a period of over 20 years.

Building on the clinical priorities from the IEAs set out in the initial Ockenden Report, the Final report provides an additional 15 IEA's for local and system action, based around 4 key pillars (Safe Staffing, A well-trained workforce, Learning from incidents, and Listening to families)

Trusts have not been asked to formally review their status against these additional IEA's or to provide any evidence of compliance; however Royal Devon maternity services have conducted an initial review to benchmark their services and provide oversight and escalation of any areas of concern or risk.

This internal benchmarking has highlighted 4 areas where immediate or urgent action is required (please see below) and mitigating actions are being put into place to address them.

- **Midwifery Continuity of Carer (MCoC)**

  Please note - revised guidance regarding Midwifery Continuity of Carer was received on 21 September 2022 – see appendix 1

  Mitigating action - Northern maternity services have developed a new phased approach to the delivery of MCoC which is in line with the specific IEA. Eastern maternity services have reviewed current provision and following a temporary pause to allow a full staffing review to take place; agreement to continue with the implementation plan supported by clear recruitment strategy has been confirmed.

- **Maternity Clinical Governance Leadership**

  Mitigating action - Royal Devon maternity services have developed a new integrated approach to maternity governance including the development of a new Safety and Quality Lead Midwife role to strengthen leadership and oversee alignment of the governance structure.

- **Maternity training**

  Mitigating action - Royal Devon maternity services are developing an integrated approach to the provision of maternity specific training and are working with the LMNS to strengthen provision and alignment in accordance with CNST/Ockenden compliance.

- **Maternity escalation staffing**

  Mitigating action - Royal Devon maternity services are working with unions, staff and hospital flow teams to develop more robust staffing escalation pathways.

2. LEARNING

2.1 No specific learning issues have been identified for escalation to the Governance Committee.

3. RECOMMENDATIONS TO THE GOVERNANCE COMMITTEE FOR APPROVAL

3.1 The Governance Committee is asked to note the content of this paper and the progress towards Ockenden and CNST full compliance; and to include this report within the appendices of the Governance Committee update report made to the Board of Directors in October 2022.

To:
- Trust chief nurses
- Trust directors of midwifery
- Trust COO
- Trust CEO
- Trust medical directors
- Trust clinical directors for obstetrics

cc.
- Regional directors
- Regional chief nurses
- Regional medical directors
- Regional chief midwives
- ICB chief nurses
- LMNS Chairs

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

21 September 2022

Dear colleagues

Midwifery Continuity of Carer

We are writing to you to set out essential and immediate changes to the national maternity programme in the light of the continued workforce challenges that maternity services face. There will no longer be a target date for services to deliver Midwifery Continuity of Carer (MCoC) and local services will instead be supported to develop local plans that work for them.

Over the past two years staff have had to work in ways that they never imagined, in difficult circumstances and we know that maternity services are experiencing stress and strain. The top priority for maternity and neonatal services must continue to be ensuring that the right workforce is in place to serve women and babies across England.

At the heart of the MCoC model is the vision that women should have consistent, safe and personalised maternity care, before, during and after the birth. It is a model of care provision that that is evidence-based. It can improve the outcomes for most women and babies and especially women of Black, Asian and mixed ethnicity and those living in the most deprived neighbourhoods. This model of care requires appropriate staffing levels to be implemented safely.

There is no longer a national target for MCoC. Local midwifery and obstetric leaders should focus on retention and growth of the workforce, and develop plans that will work locally taking account of local populations, current staffing, more specialised models of care required by some women and current ways of working supporting the whole maternity team to work to their strengths. We hope this will enable your services to improve in line with the evidence, at a pace that is right.

We know trusts have submitted their MCoC plans and will have considered safe staffing levels in submitting their plans. Thank you for your work on these and your efforts to implement MCoC to date

We expect you to continue to review your staffing in the context of Donna Ockenden's final report. Your local LMNS, regional and national colleagues are here to support you with this including how to focus MCoC on those women from vulnerable groups who will benefit the most from this care.

As we have said previously:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.

2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.

3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

Trusts are not expected to deliver against a target level of MCoC, and this will remain in place until maternity services in England can demonstrate sufficient staffing levels to do so.

Approved educational institutions (AEI's) educating pre-registration midwifery students will continue the implementation of the future midwifery standards of the NMC. It is

expected that midwifery students will be taught the MCoC model, alongside other approaches to safe, high-quality care for women. The NMC has written to education providers to confirm that this remains a requirement of registration and to suggest how this can be achieved when students are placed in those organisations that are not able to fully implement MCoC at this time. Where this is the case, students will still benefit from practice supervisors and assessors being able to explain and discuss the concept and we would ask for your support to encourage this to happen.

With the advice of the independent working group established after the final Ockenden report, we will publish a national delivery plan for maternity services this winter which will bring together actions for maternity services, including next steps for improving continuity across all professional groups.

Yours sincerely,

Dame Ruth May
Chief Nursing Officer, England

Prof Jacqueline Dunkley-Bent OBE
Chief Midwifery Officer
National Maternity Safety Champion
NHS England

Dr Matthew Jolly
National Clinical Director for Maternity and Women's Health
National Maternity Safety Champion
NHS England