



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

At 09:30 on Wednesday 26 April 2023  
At the Future Skills Centre, Exeter College, Exeter Airport Industrial Estate, EX5 2LJ

### AGENDA

Item	Title	Presented by	Item for approval, information, noting, action or discussion	Time Est.
1.	<b>Chair's Opening Remarks</b>	Shan Morgan, Chair	Information	09:30 2
2.	<b>Apologies</b>	Shan Morgan, Chair	Information	09:32 1
3.	<b>Declaration of Interests to include Annual Review of Register of Directors Interests</b>	Melanie Holley, Director of Governance	Information	09:33 2
4.	<b>Matters to be discussed in the confidential Board</b>	Shan Morgan, Chair	Noting	09:35 2
5.	<b>Minutes of the Meeting of the Board held 29 March 2023</b>	Shan Morgan, Chair	Approval (Paper)	09:37 5
6.	<b>Matters Arising and Board Actions Summary Check</b>	Shan Morgan, Chair	Information (Paper/Verbal)	09:42 5
7.	<b>Chief Executive's Report</b>	Chris Tidman, Deputy Chief Executive	Information (Verbal)	09:47 20
8.	<b>Patient Story</b>	Carolyn Mills, Chief Nursing Officer	Information (Verbal/paper)	10:07 15
9.	<b>Performance</b>			
9.1	<b>Integrated Performance Report</b>	Adrian Harris, Chief Medical Officer	Information (Paper)	10:22 45
	<b>COMFORT BREAK</b>			11:07 10
10.	<b>Policy &amp; Strategy</b>			
10.1	<b>Annual Sustainability &amp; Development Plan</b>	Chris Tidman, Deputy Chief Executive	Information (Paper)	11:17 10
10.2	<b>Clinical Strategy Update</b>	Adrian Harris, Chief Medical Officer Phil Luke, Director of Strategy	Information (Paper)	11:27 20
11.	<b>Assurance</b>			

11.1	<b>Corporate Roadmap Update</b>	Chris Tidman, Deputy Chief Executive	Information (Paper)	11:47 15
11.2	<b>Towards Inclusion End of Year Report</b>	Hannah Foster, Chief People Officer	Information (Paper)	12:02 20
11.3	<b>Governance Committee Update</b>	Tony Neal, Non-Executive Director & Committee Chair	Information (Paper)	12:22 5
11.4	<b>Review of Board Schedule of Reports</b>	Melanie Holley, Director of Governance	Information (Paper)	12:27 5
12.	<b>Information</b>			
12.1	<b>Items for Escalation to the Board Assurance Framework</b>	Shan Morgan, Chair	Discussion (Verbal)	12:32 1
13.	<b>Any Other Business</b>			12:33
	At the conclusion of the formal part of the agenda, there will be an opportunity for members of the public gallery to ask questions on the meeting's agenda. Where possible, questions should be notified to members of the Corporate Affairs team before the meeting. Every effort will be made to give a full verbal answer to the question but where this cannot be done, the Chair will ask a director to make a written response as soon as possible.			
14.	<b>Date of Next Meeting:</b> The next meeting of the Board of Directors will be held at 09:30 on Wednesday 31 May 2023.			
15.	The Chair will propose that, under the provisions of section 1(2) of the Admission to Public Meetings Act 1960, the public and press should be excluded from the meeting on the grounds of the confidential nature of the business to be discussed.			

Meeting close at 12:43

<b>Agenda item:</b>	3.0, Public Board Meeting	<b>Date:</b> 26 April 2023		
<b>Title:</b>	Annual Review of the Board of Directors' Register of Interests			
<b>Prepared by:</b>	Melanie Holley, Director of Governance			
<b>Presented by:</b>	Melanie Holley, Director of Governance			
<b>Responsible Executive:</b>	Suzanne Tracey, Chief Executive			
<b>Summary:</b>	An update to the Royal Devon Board of Directors' Register of Interests.			
<b>Actions required:</b>	The Board is required to review and approve the Register of Interests.			
<b>Status (x):</b>	<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Information</b>
		<b>x</b>		
<b>History:</b>	The Board's Register of Interests is reviewed in full annually.			
<b>Link to strategy/ Assurance framework:</b>	Relates to the Board's overall assurance and to 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	X
Assurance Framework	X	Complaints	
Equality, diversity, human rights implications assessed			
Other ( <i>please specify</i> )			

**1. Purpose of paper**

To present an updated Board of Directors' Register of Interests for review and approval by the Board.

**2. Background**

The Trust is required to keep a Register of Board members interests and to undertake an annual review as part of the production of the Annual Report. At each Board meeting members are invited to declare any interests and may also amend their formal declaration at any time.

**3. Analysis**

The attached Register has been updated following an annual review of declarations of interest.

**4. Resource/legal/financial/reputation implications**

The Register of Board Interests is a document available for public inspection, it is posted on the trust website and additionally a copy is held in the Trust Secretary's Office for inspection by any member of the public.

**5. Link to BAF/Key Risks**

None.

**6. Proposals**

The Board is asked to review and approve the revised Board Register of Interests.

## ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST

The following is the current register, as at **26/04/2023** of the Board of Directors of the Royal Devon University Healthcare NHS Foundation Trust and their declared interests. It is available for inspection on the Trust's website ([www.royaldevon.nhs.uk](http://www.royaldevon.nhs.uk)) and also by contacting the Trust Secretary on 01392 404551.

<b>Name</b>	<b>Role</b>	<b>Interest</b>
Burgoyne, Carole Mrs	Non-Executive Director	Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust Trustee and Co-Vice-Chair Transforming Futures Multi-Academy Trust Co-opted Governor Thornbury Primary School, Plymouth Member, Plymouth Together Fund Sub Committee Volunteer, Home Park Mass Vaccination Centre (contract with RDUH)
Foster, Hannah Mrs	Chief People Officer	Committee Member, General Charity of the Royal Devon & Exeter NHS Foundation Trust Partner, Scorlinch Farm <b>Member of a political party</b> Churchwarden, St Lawrence Church, Clyst St Lawrence
Harris, Adrian Professor	Chief Medical Officer	Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust Honorary Associate Professor, University of Exeter Medical School Director of Chudleigh Chapel Court Management Company Limited Director of Menegai Medical Ltd, company number 13192153 Member of a political party Partner is a local General Practitioner
Hibbard, Angela Mrs	Chief Finance Officer	Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust
Kent, Bridie Professor	Non-Executive Director	Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust Employee of University of Plymouth – Professor of Leadership in Nursing and Director of the University of Plymouth Centre for Innovations in Health and Social Care: A JBI Centre of Excellence Honorary contract with University Hospitals Plymouth NHS Trust (Professor and staff nurse) Honorary contract with Royal Cornwall Hospitals NHS Trust (Honorary Associate Director of Nursing) Member of Royal College of Nursing (RCN) Steering Committee member, RCN Research Society Sub-committee lead Clinical Academic Roles Implementation Network (CARIN); a network of the Council of Deans of Health

Name	Role	Interest
Kirby, Steve Mr	Non-Executive Director and Vice Chair	Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust Director, St Giles Court (Bristol) Management Limited Member, Devon Integrated Care Board Finance Committee Member, Devon Strategic Recovery Board
Marshall, Martin Professor	Non-Executive Director	Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust Chair, Nuffield Trust Board Member, Gateway Charity for the Homeless, Sidmouth Member, Royal College of General Practitioners Council Member, Secretary of State for Health Working Group on Primary Prevention of CVD Member, British Medical Journal Commission on Future of NHS Member, Commission on Creative Health
Matthews, Alastair Mr	Non-Executive Director	Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust
Mills, Carolyn Mrs	Chief Nursing Officer	Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust
Morgan, Shan Dame	Chair	Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust Member of the Advisory Council of the Bennett Institute for Public Policy Husband is a salaried GP at Edington Surgery, Somerset Trustee of Maritime Museum, Falmouth
Neal, Tony Mr	Non-Executive Director	Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust Governor, Bow Community Primary School
Palmer, John Mr	Chief Operating Officer	Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust Worked as an independent Management Consultant for PRISM Improvement between December 2020 and April 2021, providing North West Anglia NHS Foundation Trust with executive leadership for winter and COVID-19. PRISM Improvement being asked to quote for operational support during Winter 2022/23.
Tidman, Chris Mr	Deputy Chief Executive	Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust Company Director, Exeter City Futures Community Interest Company (as representative of the Royal Devon & Exeter NHS Foundation Trust) Daughter is a journalist with the Health Service Journal (HSJ) Wife works as a fundraiser for Seachange, the Health and Wellbeing Hub in Budleigh Salterton.
Tracey, Suzanne Mrs	Chief Executive	Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust Chair, HFMA Provider Faculty Member, Devon County Council Health & Wellbeing Board Member, NHS Employers Policy Board Member, NHS Assembly

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

Wednesday 29 March 2023

Via MS Teams

### MINUTES

<b>PRESENT</b>	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 J Kay	Senior Independent Director
	Professor B Kent	Non-Executive Director
	Mr S Kirby	Non-Executive Director
	Professor M Marshall	Non-Executive Director
	Mr A Matthews	Non-Executive Director
	Mrs C Mills	Chief Nursing Officer
	Dame S Morgan	Chair
	Mr T Neal	Non-Executive Director
	Mr J Palmer	Chief Operating Officer
	Mr C Tidman	Deputy Chief Executive Officer
<b>APOLOGIES:</b>	Mrs S Tracey	Chief Executive Officer
<b>IN ATTENDANCE:</b>	Ms K Allen	Director of Strategy (for item 047.23)
	Ms B Hoile	Engagement Officer (for item 042.23)
	Ms G Garnett-Frizelle	PA to Chairman (for minutes)
	Mrs M Holley	Director of Governance

		ACTION
<b>035.23</b>	<b>CHAIR'S OPENING REMARKS</b>	
	<p>The Chair welcomed the Board, Governors and observers to the meeting. Ms Morgan reminded everyone it was a meeting held in public, not a public meeting. She asked members of the public to only use the 'chat' function in MS Teams at the end to ask any questions which should be focussed on the agenda and reminded everyone that the meeting was being recorded via MS Teams. Ms Morgan said thanked all the Governors attending.</p> <p><b>The Chair's remarks were noted.</b></p>	
<b>036.23</b>	<b>APOLOGIES</b>	
	Apologies were noted for Mrs Tracey.	
<b>037.23</b>	<b>DECLARATIONS OF INTEREST</b>	
	Mr Tidman had removed two interests from the Register and added one new declaration:	



	<p>Mr Tidman's son was no longer a member of the Trust's admin bank and Mr Tidman was no longer an Independent Advisor for the Performance and Audit Committee for Exeter City Supporters Trust. The new declaration added was that Mr Tidman's wife works as a fundraiser for Seachange, the Health and Wellbeing Hub in Budleigh Salterton.</p> <p>Ms Morgan noted that Mrs Burgoyne had added an update in the chat function to advise that whilst she was still a volunteer at Home Park Mass Vaccination Centre, the contract for delivery had been changed to the Royal Devon University Healthcare NHS Foundation Trust.</p> <p><b>The Board of Directors noted the updates.</b></p>	
038.23	<b>MATTERS DISCUSSED TO BE DISCUSSED IN THE CONFIDENTIAL MEETING</b>	
	<p>The Chair noted that the Board would receive updates at its confidential meeting from the Audit Committee, Charity Committee, Digital Committee, Finance and Operational Committee and Nominations Committee, as well as a Maternity Safety Presentation from the Chief Midwifery Officer, NHS England, a revised Business Case for Tiverton Endoscopy and a proposal for a Senior Independent Director. Ms Morgan advised that the presentation from the Chief Midwifery Officer had been timetabled for the confidential meeting due to availability of the presenters, but was not a confidential item. The presentation would be made available, together with the relevant recording if technically possible, on the Trust's public website.</p>	
039.23	<b>MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 22 FEBRUARY 2023</b>	
	<p>The minutes of the meeting held on 22 February 2023 were considered and approved as an accurate record.</p>	
040.23	<b>MATTERS ARISING AND BOARD ACTION SUMMARY CHECK</b>	
	<p><b>Action check</b></p> <p><i>Action 158.22 Mr Neal asked what the national interpretation was of the ongoing high number of both A&amp;E presentations and Cancer referrals. Mrs Tracey agreed to look into this further and provide a fuller update in her next CEOs report to the January Board meeting. Mr Palmer reminded the Board that the issue raised was whether the Trust's ED and Cancer position, in terms of volume and demand, was an outlier or in line with other Trusts across England. He advised that the ED volume and demand seen over the last couple of months had been very similar to the national picture, however what had differentiated Eastern services in particular had been the infection control issues as a result of Norovirus and for Northern Services the pressures from very high number of No Criteria to Reside patients. Cancer referrals were more in line with national peers, however with a lag due to the conditions that had been discussed in the Cancer deep dive presented to the January Board meeting. Mr Palmer said that peer benchmarking on both areas would be included in the Integrated Performance Report for April 2023 which would provide a sense of context. The Board of Directors noted the update and agreed that this action could be closed.</i></p> <p><i>Action 159.22 It was noted in the Patient Story that blister packs were no longer provided for patients which could lead to hospital admissions for some patients not</i></p>	

	<p><i>taking medication correctly as a consequence. The Board requested that this be looked at to see if there was anything that could be done to provide blister packs for patients' medication.</i> The Board noted that Mrs Mills had circulated a letter from the Medicines Optimisation Team at NHS Devon regarding this and it was agreed that this should be included in the public minutes so that members of the public could see the update. The Board agreed that this action could be closed.</p> <p><b>The Board of Directors noted the updates.</b></p>	
<p><b>041.23</b></p>	<p><b>CHIEF EXECUTIVE OFFICER'S REPORT</b></p>	
	<p>Mr Tidman provided the following updates to the Board.</p> <p><u>National Update</u></p> <ul style="list-style-type: none"> <li>• The Chancellor had announced changes to the pension tax regime in his last Budget, which had been welcomed by many in the NHS. He said that it would be helpful to encourage senior clinical staff to do more work, but also to think again about early retirement, as the pension cap had had a detrimental impact.</li> <li>• There had been no mention in the Budget of the New Hospital Programme, although it was understood that there would be an update on next steps over the coming weeks.</li> <li>• The Government had reached a deal in principle with Unison, Unite, and the Royal College of Nursing with strike action paused whilst unions undertook ballots with members. The proposed pay deal was for a 5% consolidated pay increase for 2023-24, flat across all bands except 1 and 2 which would receive 10.4%. There would also be a one-off consolidated award of 2% for 2022-23 and an additional one-off non-consolidated payment branded as a backlog bonus which varied by pay band.</li> <li>• There were however ongoing issues with the British Medical Association and junior doctors, with further junior doctor industrial action announced for just after the Easter bank holiday weekend. The Trust had managed the first wave of junior doctors' strike action well with significant planning and large numbers of cancellations. There was however acute concern about the timing of the next industrial action which would take place on the back of a Bank Holiday weekend and would effectively mean nine days of Bank Holiday staffing levels. This would have an impact on the Trust's work to recover long waiting times. The main concern would be to ensure that services remained safe, and the clinical and operational teams were undertaking significant planning to manage this, with a strong comms message to the public that this period would not be business as usual. Although all teams, including consultants, had stepped up during the last period of industrial action by junior doctors, there was concern that this was high risk and these concerns were being escalated to both regional and national teams.</li> <li>• Despite pressures nationally, there had been significant progress over the last 18 months on reducing the number of people waiting the longest for care. The number of people waiting over 18 months was cut by 9000 in January 2023 compared to the previous month and the number of people waiting over two years had also significantly reduced. Although Devon had some of the longest waiters, the contribution of the system as a whole had been recognised.</li> </ul> <p><u>System Issues</u></p> <ul style="list-style-type: none"> <li>• A Devon Leaders event took place on 23 March 2023 focussed on agreeing the Devon Joint Forward Plan, which was due to be submitted in June 2023.</li> </ul>	

The plan set out the ambitions for the Devon Integrated Care System (ICS) for the next 5 years and would be linked to the operational and financial context. Devon was one of only seven ICSs that recorded more inpatient elective activity in the three months to December than for the same period before the pandemic, with Devon being the best performer at 108%.

- A huge amount of work had been undertaken by the Finance, Business Intelligence and Operational teams over the last two months on the operational plan for the next financial year. Although it was acknowledged that it would be challenging, it was felt it was a credible plan for Devon.

#### Local issues

- There had been continued pressure on the urgent care system, but staff had done all they could to deliver the best care possible for patients. Pressures faced included industrial action, higher rates of No Criteria to Reside patients than would be wanted and ongoing provision of mutual aid to partner hospitals wherever possible. Staff had continued to go above and beyond during difficult times, and it would be important to now agree as part of the operating plan how to deescalate the current situation.
- With regard to the recover for the future objective, Adult ED was starting to take shape on the Wonford site with completion hoped for within the next two months, after which it would be possible to move on to the Children's Paediatric Assessment Unit build. The £8m cardiology expansion scheme had also started on the Wonford site. A new discharge lounge had been installed at North Devon District Hospital (NDDH) the previous week which it was hoped would be operational by the middle of May 2023. Finally, two surgical robots had been delivered at Wonford and NDDH.
- The Trust had received the draft report from the Care Quality Commission (CQC) following their inspection earlier in the year. The Trust had 10 days to review the report for factual accuracy and return to the CQC, with publication of the final report expected in late April. The organisation would take the feedback from the report to use as a platform to improve. It was expected that the CQC Well-Led Inspection would also take place in late April.
- The Trust had taken part in Neuro-diversity week from 13-17 March with the launch of the Neurodiversity Staff Network as part of the Trust's inclusion approach.

Ms Morgan thanked Mr Tidman for his overview and noted the issue of No Criteria to Reside highlighted. She asked what would need to happen to improve the situation. Mr Tidman said that it would be important to ensure that both the importance for flow and elective beds, and the harm that could be caused through overcrowding in ED and delays in ambulance handovers was understood across the system. The Department of Health and NHS England had issued a new Urgent Care Strategy and the system had worked to make the link between numbers and potential harm. It would be important have clear plans and trajectories with partners, and hold both the organisation and partners to account for delivery, with close working with Devon County Council also important particularly in terms of recruitment to health and social care positions and selling Devon as a great place to work. Mr Palmer commented that the No Criteria to Reside position was moving towards 25% in Northern services and around 15% in Eastern services and improvement of this would require an exceptional response from the system. The work that the Trust does on time to transfer on Pathways 1, 2 and 3 was above peer organisations, and work undertaken to resource the Urgent Care Response service had been very good, however there was deep uncertainty about the future

of a number of funding lines, both from the ICB and Devon County Council. In addition, there had been some withdrawal of funding which had led to significant uncertainty day-to-day, with complex packages much less available. Both the ICS and the regional Team had received clear briefings on the position and the national team had also been briefed over the last 48 hours. As a result of escalation there had been a funding release yesterday. He agreed with Mr Tidman that this required ongoing day-to-day grip and strong shared partnership at local level, and continuation of taking escalation to both regional and national teams until a stable funding platform was achieved.

Professor Marshall asked what the longer-term consequences of the junior doctors strike on performance and the ability to hit targets would be. Mr Palmer said that the previous industrial action had had a cumulative impact on case numbers, with around 1000 patient episodes lost. It had been possible to mitigate the 78 week wait and 104 week wait positions, but the underlying position had become more challenging. In addition, it had been necessary to be flexible with staff with regard to Time Off in Lieu (TOIL) for covering this period and this would impact activity over the next couple of months as staff took this TOIL.

Professor Marshall noted the continued pressure on staff and that this led to staff not being able to perform as they would want to, which could lead to a risk of normalising sub-optimal care because of the duration of sustained pressure. He asked how this was being addressed and minimised as far as possible. Mr Tidman responded that an awayday with clinical and operational leaders was planned with a leading item for discussion being how to ensure that sub-optimal care was not normalised. He added that recruitment was vital to this, with staff saying that sub-optimal staffing levels were their biggest worry. Professor Harris added that the risk of normalising compromises in care was discussed by senior leaders every day and areas identified where sub-optimal care might be becoming normalised were focussed on. He said that the challenge was maintaining staff morale and commitment to excellence under these very challenging, ongoing circumstances.

Mrs Foster said that the next industrial action was longer than previous strikes and would have a greater impact on pay and TOIL, as well as operationally. The risks were therefore greater, including asking staff to go above and beyond for a longer period, and potentially having to do it again over coming months if further strike action were announced. She added that for some clinicians TOIL would be more attractive than money, but offering TOIL would become much harder if the period of industrial action continued.

Professor Kay noted that Mr Tidman had underlined the importance of working in partnership to deliver improvement to No Criteria to Reside and asked what the mechanism to deliver this would be, for example would this be through the ICB or through a Task Force or Working Party. Mr Tidman said that currently the core relationship was between the ICB and the local authorities, with no separate Task Force although this was being considered. He added that he and Mr Palmer were attending meetings to try and negotiate a financial settlement that would enable the organisation to deliver 5% No Criteria to Reside. Mr Palmer was also escalating the issue to regular system and partnership meetings, which had led to regional escalation. Mr Tidman advised that in addition he and Mrs Tracey had attended the Health and Wellbeing Board, which was the formal mechanism for receiving the feedback and output from the Better Care Fund (BCF) and Improved Better Care Fund (iBC), however he acknowledged that it may be necessary to set up a

	<p>separate mechanism to look at how to go after the 5%. Mr Palmer added that Local Care Partnerships were the statutory instruments where these conversations should be happening, but were proving not fit for purpose, which had led to the set of Gold arrangements in place to take the work forward. As part of escalations over recent weeks, there had been a conversation about whether the Trust could apply the same methodology used at University Hospitals Plymouth over the last year which led to improvement to an average position of 7% for No Criteria to Reside based on two large funding releases. The Trust was asking for something similar, with a Task Force now in place for Northern Services and a request for the same to be put in place for Eastern services. It was noted that request had been for something that would be wired into the financial and operational plan for the next year. Mr Kirby said that one of the problems was that there was a differential problem regarding No Criteria to Reside across Devon and that political and top of office intervention would probably be the tactic to take this forward.</p> <p>Mrs Burgoyne asked whether there was clarity about all of the funding streams and the amount from both the NHS and Devon County Council that should be targeted at No Criteria to Reside, what was currently being targeted and should anything be changed. She further asked whether thought had been given to arranging a discussion for the Chair and Chief Executive with the politicians and the Chief Executive of Devon County Council on this issue. Finally, she asked whether the Overview and Scrutiny Committee had looked at the issue. Mr Tidman said that he did not believe that Overview and Scrutiny had been involved, but he would pick this up outside the meeting. He said that he did not believe there was absolute clarity on finances, but progress was being made on understanding the funding streams to support hospital discharge. There were gaps in next year's budget which the Trust was working through with the ICB. In addition, the ICB wanted to look more generally at the BCF and iBCF to make sure that the £200m was being spent in an optimal way. He added that the Trust was also being very clear that its own recovery plan was underpinned by a strong out of hospital proposition, both in communications to Devon County Council and the ICB, and whilst the organisation was offering to be part of the solution, it was being clear on the consequences of not getting this right. Mr Tidman advised that an offer had been made by the Director of Adult Social Services to talk to the Board, either at a formal Board meeting or a Board Development Day, to explain their position. Mr Tidman suggested that this he could take this forward as it would provide an opportunity for both Devon County Council and the Trust to set out their mutual positions and agree how to work together. <b>Action.</b></p> <p>Ms Morgan noted that Professor Kay had suggested that improving No Criteria to Reside should be an action for the Board to pursue and she added that there would be a need to review the Board Assurance Framework, as there was a fundamental risk to delivery of the Trust's operational plan if the Trust was not able to work with partners to improve No Criteria to Reside.</p> <p><b>The Board of Directors noted the Chief Executive's update.</b></p>	
<p><b>042.23</b></p>	<p><b>PATIENT STORY</b></p>	
	<p style="text-align: right;"><i>Bethany Hoile joined the meeting.</i></p> <p>Mrs Mills presented the Patient Story video to the Board and advised that this related to the Trust's strategic objectives of collaboration, partnership, and excellence and innovation in patient care, as well as to NHS England's drive for mainstream genomic testing. The focus of the story was personalisation, with</p>	

	<p>genomic medicine having the capacity to revolutionise healthcare options available to individuals and families, offering prompt and accurate diagnosis and support for managing any risks identified. The video featured a mother whose son died of a ruptured aorta at the age of 22 and whose family had undergone genomic testing which identified that she carried a gene that impacted development of the heart. The video described the impact of this on both her and her family.</p> <p>Professor Kent commented that the video demonstrated the power of research and science to transform opportunities for patients and the difference that having a joined-up system could make for patients and their families.</p> <p>Mr Neal noted that it took a tragedy for this genetic link to be recognised for this family and asked whether there were opportunities to get better at looking at data available through primary and acute care to proactively identify patients at risk. Professor Harris said currently there was not the capability to do this, but there could be an opportunity to use artificial intelligence in the future for pattern recognition, which put together with other clinical symptoms would suggest that screening may be appropriate. This would require a very large EPIC database, which may take 3-5 years to achieve. He added that care would need to be taken on the ethics around this. Professor Marshall commented that the power of genetics in prevention going forward would also be very important and said that it would be vital for the Trust to continue to build partnerships across the ICS to fully realise its potential.</p> <p>Professor Kay said 1 in 7 people would show a rare genetic disease in their lifetime, with the majority experiencing onset in childhood. She added that there was a national rapid whole genome sequencing service for acutely unwell babies and children which tested for 5000 genetic conditions, with the service provided by the Trust in partnership with the University and other Trusts providing diagnoses for 1200 severely ill babies and children annually. She commented that this was the future of healthcare but was currently very expensive.</p> <p>Professor Kent said that it was important to recognise the work of the staff involved in this case for their liaison and networking which had been very important.</p> <p>Mr Kirby asked whether the commercial potential of this was adequately exploited by the Trust and Mr Tidman said that whilst there had been opportunities in the past where Senior Research and Clinical Leads had given talks around the world which had been followed up by requests for particular screening to be done, this had been on a fairly ad hoc basis. He said that he would discuss with Mrs Hibbard on whether there was more that could be done with the right level of business support and whether there was something that could be scoped as part of a three-year financial plan for genetics. <b>Action.</b></p> <p>Ms Morgan said that this had been a very impressive story, which had raised a number of topical issues regarding the digital agenda and artificial intelligence and agreed with Professor Kent's comments on the contribution of staff in joining up services so effectively for the family.</p> <p><b>The Board of Directors noted the Patient Story</b> <i>Bethany Hoile left the meeting.</i></p>	
043.23	<b>INTEGRATED PERFORMANCE REPORT</b>	

Mrs Hibbard presented the Integrated Performance Report (IPR) for activity and performance for February 2023 with the following key points highlighted:

- The common theme for February was recognising the efforts of teams in managing an extraordinary set of complex issues including industrial action, infection control issues, discharge pressures and urgent and emergency care demand, with staff at all levels working hard to keep patients safe. These pressures had continued into March, with Opel 4 declared across both sites.
- Pressures had been reflected in performance, with deterioration in time to transfer, increases in ambulance handover times and impact on 4-hour performance in ED. However, it was noted that Sidwell Street Walk In Centre had reopened, on a phased basis initially as recruitment improved and that work was continuing on the reconfiguration of ED which would improve the space that teams had to work in.
- Focus had continued on eliminating long waits in the elective service, and despite pressures volumes had been managed to some extent. Although the Trust was below plan, which was noted as very ambitious, the Devon system had been one of the best performers in the country.
- Significant work had continued on the long wait position for elective and Cancer with an improved trajectory to yearend, despite the level of disruption managed. However, it was acknowledged that there was still work to do on long waits and this would be a continued focus in the new financial year.
- Finance – performance remained on track to deliver the yearend position, adjusting for additional deficit income received. The work of the Finance Team to make sure that what was a very challenging position was landed was acknowledged.
- A further four serious incidents were reported in month, as well as three falls, all of which would be subject to investigation with details reported through governance processes.
- There had been a slight increase in rates of pressure damage, with a potential link to the rates of escalation which were also being investigated.
- There were some areas of improvement, in particular the weekend SHMI which had improved, with straight metrics either having improved or held at both sites.
- Improvements in the vacancy rate had also been seen due to the success of the accelerated vacancy programme.
- There had been a dip in the rolling monthly turnover rate, although there were still pockets that needed to be addressed.
- Improvements were being seen in the data quality work, as assurance was built on nationally submitted data. The Finance and Operational Committee had a specific focus on this in order to bring assurance to the Board.
- The priorities within the operating plan were set out on the scoreboard with recognition of a number of risks to delivery and further detail on this would be provided to the Board in the confidential session.

Ms Morgan asked Mr Palmer how we would assess the impact on the Trust's performance of providing mutual aid to other Trust's in Devon, in particular ambulance divers, noting that whilst the Trust was keen to contribute to system working, it would be helpful to have a sense of how this impacted the organisation's performance. Mr Palmer said that, as part of monitoring of the financial and operational plan through the IPR going forward, a clear deliverable would be included to show relative impact of mutual aid provision. This would cover ambulance divers, as well as mutual aid provided for ongoing service support, for example for radiology and urology. Mr Palmer said that there was a seasonal

impact for ambulance divers with more requests during the winter period than through the rest of the year, as well as periods of catchment adjustments which had changed the pattern of support. He added that the emotional impact of taking an ambulance divert was on occasion greater than the patient numbers received and should not be underestimated. Over the course of preceding month what had been an intermittent cycle of divers had intensified, with 14 requests for extended periods of divert received over the preceding two weeks with 10 of those honoured. There had been a very intense Gold period over the last 48 hours with national oversight. The Trust was providing ongoing support and had taken 7 transfers yesterday night. Mr Palmer said that the next IPR would contain detail of what divers had looked like over the winter period, as well as detail of the current intense period where the Trust was being asked to do more. Mr Palmer concluded that every time the Trust took divers in a very leveraged system, there is a risk that this would increase utilisation of its bed base which then triggers the ring fence and this in turn impacts waiting lists. The Trust had created a recovery plan for the next year which was delivering and it would be important to not lose that. Ms Morgan acknowledged that there was a tricky balance to be achieved between managing the Trust's own elective recovery and playing the part it needed to within the system.

Professor Kay said that whilst the rate of moderate and severe falls in Eastern services appeared very flat, the absolute rate of falls appeared to show a very steep rise and asked for clarification on this. Mrs Mills said that falls data was pulled from Datix incident reports and it was often the case that multiple incident reports were completed for the same patient who had fallen on a number of occasions, not necessarily with harm. She agreed that she would look at this in more detail outside the meeting to see if this accounted for this increase in month.

**Action.**

Professor Kay commented that it would be useful to see data on the absolute establishment. She commented that in the financial data there appeared to be a quite significant upward trend in agency spend. Mrs Foster said that she could look at including absolute numbers in the IPR going forward if that would be helpful to the Board. **Action.** She advised that the senior leadership team received the recruitment picture, and in absolute terms the Trust was net gaining on nursing staff in Eastern services, although this was not the case in Northern services. With regard to agency spend, it was important to recognise that for the first time in two years the Trust was not allowing carry over of annual leave which had led to significant numbers of staff taking leave in February and March, which on top of pressures from industrial action was exacerbating the position. Mrs Foster noted that there was a plan in place to reduce agency spend. Mrs Hibbard commented that whilst the standard carry over of five days would be allowed, carry over of leave above this amount was being reduced and it was important to encourage staff to take their leave throughout the year. She added that there was always a growth in agency spend at this time of year, but it was recognised that more had been spent than planned for. Part of plans for next year would be to focus on recruitment and retention, so that the need for agency would be reduced, as well as tightening up control processes to ensure that rate paid for agency was appropriate, as there had been instances where the Trust was using more of the higher framework agencies due to supply issues. Work would also be undertaken to ensure that the use of agency was appropriate to the gaps in rotas, particularly in nursing but also looking at other staff groups.



Mr Matthews commented that it would be important to capture No Criteria to Reside in the IPR for the next financial year in a way that would tease out the numbers and the actions. Mr Matthews said that there had been reports in the media highlighting the lowest level of satisfaction ever both for the NHS and for social care and said that this would impact staff morale, particularly when they were under such sustained pressure on a daily basis. He said that communications with staff were vital to remind them of the many positive achievements and upcoming opportunities to help maintain morale during these very difficult times. Mr Palmer said that the IPR for the coming year would be structured so that it was very tightly aligned to the Financial and Operational Plan and would show the position against No Criteria to Reside.

Mr Matthews said that the IPR mentioned that outsourcing of ultrasound in Northern services would need to be stopped because of safety concerns and asked whether updates on this would be taken through the appropriate governance route. He also asked whether there were lessons that could be learned from this as the Trust was currently engaged in significant outsourcing of some services. Mr Palmer responded that it had been clear very early in the commissioning of this work for Northern services that the Team brought in were not capable of recruiting the right people and were unable to run the intensity of lists required. A very clear clinical decision had been made very quickly to withdraw the commission and there was work to drive extras within the service to keep the position balanced.

Mr Matthews noted that the national level for stroke discharge to home appeared to be around 20%, but that reported for Northern Services appeared to be around 70% and asked for clarification on why there was this disparity. Professor Harris responded that this was the effect of counting, in that the Stroke Rehab Unit in Northern Services was based within Staples Ward, meaning stroke patients went into an acute ward, then into the Rehab Unit and were then discharged, in effect being counted as discharged from an acute unit leading to such a high percentage. This is an artificial inflation of the position and Professor Harris had asked if the data could be disaggregated, so that Northern services were reporting those patients directly discharged from the acute ward.

Mr Matthews asked whether the pay award and associated back pay currently under consideration by the Unions would be covered under the existing year's finances or covered separately. He also noted that it was expected to spend £25m Capital Expenditure in the month and asked whether this was on track. Mrs Hibbard responded that the pay award had not yet been approved by the Unions, but the Trust was receiving guidance to accrue the pay award as per the offer and the funding would flow through to ICBs for this, with no impact on the Trust's yearend position. With regard to Capital Expenditure, Mrs Hibbard confirmed that teams were on track with this and the Procurement Team were in particular were working hard to ensure that all spend could be receipted.

Mr Kirby commented that the Trust had a strong Infection Control Team and where there were outbreaks of Covid, flu and Norovirus, cohorting of infected patients was put in place. He noted however that there appeared to be high levels of nosocomial infection which did not seem to align with the previous statement. Mrs Mills said that there would always be an underlying nosocomial rate of Covid infections which were not related to the reason for the patient's admission but routine testing identified the infection. She added that the Infection Control Team were very skilled at maximising bed use whilst working within the constraints of infection control

requirements. Mrs Mills said that although Covid was now business as usual, the Trust still had a responsibility to protect other patients. Mr Kirby asked if the nosocomial rates could be looked at as it did appear to be quite a high percentage compared to the number of patients admitted. **Action.**

Mr Tidman said that the Executives worked closely with the Infection Control Team. It was very clear that the Trust did not have the same amount of individual rooms as other organisations, which was a disadvantage. In addition, it was noted that overcrowding at the “front door” impacted spread if there was an outbreak of, for example, Norovirus. Mr Tidman said that he was however assured on the work the Infection Control Team were doing, as well as the cleaning teams.

Mr Neal said that it was good to hear that Sidwell Street Walk In Centre was reopening, but noted that it had been some time since the Board had reviewed Walk In Centre and Minor Injury Unit provision in East and North. He asked if the impact of reopening of Sidwell Street could be assessed and a wider look at plans going forward for Minor Injury Unit provision could be reaffirmed. Ms Morgan agreed and added that Sidwell Street should be added to the list of sites for Non-Executive visits. **Action.**

Professor Marshall asked when Northern and Eastern data would be presented together in the IPR. Professor Harris said this was being considered, but there was some evidence from merged Trusts that there is risk in doing this, as it may lead to inadvertently hiding deficiency or excellence. He said that both he and Mrs Mills felt it was important to see the data both aggregated and disaggregated because there was such variation in service. He agreed that there was a need to report as one Trust but the disaggregated data was important to give the insight needed.

Professor Kent noted that the data for patient flow in Eastern services was nearly all red and asked whether there were any thoughts on what impact this might have in upcoming Council elections in terms of how the political landscape might change. Mr Tidman said that it was not possible to speculate on this currently but he would consider it further outside the meeting and get back to her separately.

Mrs Burgoyne commented that it was clear from the IPR that the system was very challenged giving the example of 12-hour trolley waits and asked whether the Trust was satisfied that in terms of patient safety and patient experience, all necessary steps were being taken and were there any additional steps that could be put in place to help patients through the system. Mrs Mills responded that she had a high degree of confidence that patients waiting an extended period of time were being well looked after by the teams in the Emergency Department whilst they waited, that staff were doing all they could to make their experience as good as it could be in the circumstances, to ensure basic needs were met and that there was good communication with patients and their families. She added that she was assured that staff understood the risks and were focussed on looking after the patients whilst they were waiting. There were clear markers for escalation when there was a safety concern with both Emergency Departments having a dashboard on EPIC which provided a real time view of safety which would prompt a response from the wider organisation when the concerns in either Emergency Department was escalated beyond what was tolerable. Mrs Mills added that it was important to note however that whilst escalation to the wider organisation might decompress the problem in the Emergency Department, it might move the problem on to elsewhere in the organisation. However, patients in the Emergency Department with

	<p>undifferentiated diagnoses may be at greater risk than a patient already on a ward who may need to be moved. Mr Tidman said that Professor Harris, Mrs Mills and Mr Palmer had also been meeting with both Emergency Department teams to ensure that there was visibility across the whole organisation of the pressures they were under. In addition, the Executives were ensuring that they went to the Emergency Department to talk to staff and assure them that the pressures were understood and they were being acted on.</p> <p>Ms Morgan thanked Mrs Hibbard for her clear and concise overview of the IPR.</p> <p><b>No further questions were raised and the Board of Directors noted the IPR.</b></p>	
<p><b>044.23</b></p>	<p><b>GENDER PAY GAP REPORT</b></p>	
	<p>Mrs Foster presented the Gender Pay Gap Report</p> <ul style="list-style-type: none"> <li>• The paper presented contained three reports, one for the former Royal Devon and Exeter, one for the former Northern Devon Healthcare and a combined report for the Royal Devon. This was because the Gender Pay Gap report was produced each year to reflect a snapshot in time on 31 March the preceding year. From next year only one report would be produced to reflect the integrated organisation.</li> <li>• The Trust must publish its Gender Pay Gap table on its public website when the report has been submitted for national reporting.</li> <li>• Much of the NHS pay and pay systems are nationally determined, for example Agenda for Change, national contracts for medical colleagues and Very Senior Managers (VSM) on a pay benchmarking framework. Whilst this meant that the Trust was not fully in control of many aspects of pay, there were still actions that it could take.</li> <li>• There is significant gender gap in healthcare which related to a high proportion of female workforce, which was generally greater in the lower pay bands than in the higher.</li> <li>• There is a systemic issue in the wider NHS regarding when and how female colleagues work their way through progression and qualification.</li> <li>• The Trust had done work in some areas to move the gap. The first of these related to the ACCEA awards for consultants in recognition of research, expertise etc. The Trust has a certain amount of control over the scheme and work had been done at the RD&amp;E in 2019 to encourage applications to the scheme from female colleagues which had impacted both the awards and the Trust's gender pay gap. Equivalent work was not undertaken at NDHT, impacted in part by Covid with no full ACCEA process having been undertaken over the last few years, but discussions were taking place with Joint Negotiating Committee colleagues on how this could be taken forward.</li> <li>• Work had also been undertaken with VSMs to use gender pay gap information to try and ensure that systemic issues were not being exacerbated, although it would probably not influence the outcomes for future reports as it involved a relatively small number of colleagues.</li> <li>• It was noted that a higher proportion of female colleagues were being interviewed for consultant roles.</li> </ul> <p>Professor Kay said that it was difficult to understand the true picture from the median and mean data presented. She asked how the data was presented to local populations adding that the Trust would have some freedom on what data it</p>	

	<p>published and could contextualise it. She said that it would also be useful for the Board to receive a summary at an early stage of what the key questions and actions were from the report. In addition, Professor Kay asked whether temporary staff who were working on the day of the snapshot were counted as part of the median and mean data, as there was a possibility this might skew the data as a majority of locums were male. Mrs Foster said that only staff on payroll would be included, so locum and agency staff were not reflected in the data. She believed that bank staff would also not be included as they were not on an annualised salary, but would check this and the agency/locum question to confirm. <b>Action.</b> Mrs Foster said that the report was published on the Trust’s public website so that any member of the public could access it if they wished. With regard to actions, which would be included on the Inclusion Steering Group agenda for next year. These included the progression work underway, in particular the “Driving your career” programme.</p> <p>Professor Marshall asked whether there was any element of pay negotiation available for senior medics, as this may disadvantage females who are less likely to try to negotiate a higher salary. Professor Marshall asked for clarification on how the excellence awards were being used to address the gender pay gap issue, i.e. was this simply by encouraging more females to apply or also by challenging the criterion-based approach. Mrs Foster said that the Trust generally followed national pay scales although there were areas of difference that were down to local negotiation. She added that there still tended to be more female part time colleagues than male which also had an impact. With regard to the Clinical Excellence Awards, she said that the difficulty was that the Trust, in common with the rest of the country, had not run an open set during the pandemic in line with the national agreement to roll them through. There had been agreement to ensure that part time hours were not affected by the Clinical Excellence Awards. The ideal would be to undertake a new cycle of awards for the new Trust, but this would involve a significant amount of work. Professor Harris added that this had been discussed at the Joint Local Negotiating Committee (JNLC) for Eastern services and would also be discussed with the Northern services counterpart. There was a different approach on the two sites with Eastern ahead thanks to the work that had been started eight years ago by the previous Chair of the Trust and supported by Professor Harris and Mrs Foster to reform the Clinical Excellence Awards process in the East. Encouraging women to apply and negotiate had led to a significant closing of the pay gap in Eastern. Professor Harris added that there would be a difficult decision for the Northern JNLC to make on whether to roll over last years award or to hold a reapplication process which would be driven by the data.</p> <p>Ms Morgan thanked Mrs Foster for her presentation and said it was important for the Trust to make clear its commitment to reducing and not increasing the gender pay gap.</p> <p><b>The Board of Directors approved the Gender Pay Gap report.</b></p>	
<p><b>045.23</b></p>	<p><b>STAFF SURVEY RESULTS</b></p>	
	<p>Mrs Foster presented a slide deck with highlights from the recently published Staff Survey. Key points noted were:</p> <ul style="list-style-type: none"> <li>• People promise elements had been included in the Staff Survey for the first time last year.</li> <li>• The survey was undertaken in November 2022 which was a challenging time for staff operationally. A general decline had been noted nationally.</li> </ul>	

- There had been a decline in response rates nationally, with the Trust experiencing a more significant decline than other organisations.
- There had been slight drops in scores against 5 of the 9 people promise elements in Eastern services and a decline against all elements in Northern services.
- Ground had not been made up on learning which was still a concern as it had been last year.
- The Trust compared reasonably well against national peers with most areas scoring above the average, with compassionate and inclusive being close to the top score as well as staff engagement. Learning was the only score below the national average.
- The Trust also compared relatively well at regional level, in particular relating staff engagement.
- At system level the Trust again performed relatively well in comparison to system colleagues, with slightly lower scores in the flexibility and learning themes.
- There had been a drop nationally in the Staff Engagement (Advocacy) element which was reflected in the Trust's scores with significant declines in several of the advocacy scores, although these were still higher than the national average scores.
- There were low scores recorded for the question relating to having received an appraisal in the last 12 months, however this had probably been impacted by the current arrangement for appraisals to take place every 18 months rather than every 12 months.
- There had been significant improvements in the scores for staff reporting experiencing harassment and bullying and violence and for staff stating that colleagues were understanding and kind to one another. The most declined questions related to satisfaction with level of pay and the organisation acting on concerns raised by patients and service users.
- Work had been undertaken to look at inclusion data with benchmarking averages having improved.
- In summary:
  - There were positive outcomes when compared to the system more broadly, with many areas scoring very well.
  - The decline in response rate was a concern.
  - Colleagues in North did not feel as positive as those in the East, and whilst this may in part be due to some feeling of loss of identity post-integration, this will need to be kept under review.
  - The declines against recommending the Trust as a place to work or to receive care and the learning element were also of concern.

Ms Morgan asked what the process was for agreeing the priorities for action on the basis of these results over the coming year. Mrs Foster said that a briefing had taken place with managers in February 2023 with the Trust's professional partner, Picker, helping to inform discussions. In addition, drop-in sessions were being arranged for both managers and staff to look at the details and Teams had also received their own data much earlier so that they could look at and develop their own action plans at local level. These would be reported up through the governance process to the People, Workforce, Planning and Wellbeing Committee. The outcomes from the Trust-wide sessions would be fed into a Trust-wide action plan. Mrs Foster added that the Staff Survey presented one element of data at a specific point in time, but there were other elements such as the People Pulse data, that will also inform this work.

Mr Tidman advised that he had attended one of the manager briefings and it would be important to triangulate the feedback from these with the other information available. He added that he chaired a Staff Health and Wellbeing Group which looked at what could be done to improve morale, for example looking at the staff environment. It was important to get the messages out on all the good things that were being done, whilst being authentic about the challenges. Ms Morgan commented that presenting "You Said, We Did" information back to staff would be important and might help improve the response rate.

Mr Neal commented that some of the headline data and declines were concerning and asked whether there were clusters of responses across the organisation that might inform some of the actions, suggesting that this could be explained in the action planning. He also suggested that the governance processes in some of these areas, such as appraisals, learning from incidents and patient raised concerns, could be looked at to see if mechanisms needed to be strengthened or if more focus was needed. Finally, Mr Neal suggested that it would be helpful to provide a briefing to Governors on the Staff Survey results. Mrs Foster said that engagement was a key factor in why people stayed with an organisation and it would be important help managers use the information with their teams and agreed that it would be helpful to connect it more broadly through the governance system.

Mr Kirby asked whether there was a deeper, underlying problem in the North which should be looked at in more detail. Mr Kirby also asked whether the Trust should consider a return to 12-monthly appraisals, as part of the solution for operational pressures would be giving people the skills to think about how to work smartly and appraisal could play a part in that. Mrs Foster agreed that the results from the North did need to be reviewed to fully understand the decline in responses, as there were a number of elements that could be contributing to this including a sense of loss of identity, natural decline post-integration, Go Live of MyCare, staffing pressures and extremely difficult operational pressures. With regard to appraisals, Mrs Foster said that there was a plan to return to 12-monthly appraisals in the summer and a lighter touch appraisal had been developed.

Ms Morgan commented that the Trust was required to carry out a review of the integration for NHS England and there would be a deep dive as part of that process, with issues around morale and responses to these questions separate and additional to that.

Professor Kay said that there had been a piece of work in the last few years from the Staff Survey results looking at performance of Line Managers and asked whether this had been looked at in this year's Survey results. Mrs Foster responded that analysis of the results was currently being undertaken and she had not yet had the opportunity to check this particular point but would do so. She added that the work that had been undertaken to look at manager experience was following the 2019 Staff Survey which had led to a number of actions in the East which had paid dividends.

Mrs Mills agreed that this was a deeply concerning report on a number of levels, and whilst it was important to drill down into the detail there was a risk that doing so could lead to missing the overarching signals of what the results were telling the organisation. She added that the most declined questions were predominantly in the patient safety, patient experience and quality of care domain and this should

	<p>not be lost sight of. Mrs Mills said that the Trust had completed a self-assessment about the Trust’s retention work for NHS England earlier in the year which had highlighted learning, appraisal and flexible working as areas for improvement and the results of the Staff Survey had reinforced the need for actions on these areas. Ms Morgan agreed with Mrs Mills that it was important not to lose sight of the bigger picture and noted that it was planned to bring a summary of feedback from listening events with staff and the Trust-wide action plan to the May Board.</p> <p>Mr Matthews said that there were a significant number of clinical services still to be integrated and it would be very important to ensure that this was kept on track during the course of this year, as this may help with improving the shared sense of identity. He added that he was conscious that no Board meeting had been held in North Devon and this would also be worth considering going forward, as well as ensuring that the programme of Non-Executive visits included opportunities to visit Northern services and meet teams. Ms Morgan agreed and added that the Governors were also keen for some of their meetings to be held in the North.</p> <p>Mr Palmer said that the Trust had some additional investment for consultancy support for the three Trust Directors in Northern with a focus on strengthening the delivery chain, so that this runs smoothly between Trust Directors, Divisional Directors and frontline teams and some good performance improvements in the last few months had been seen. He agreed that driving integration was very important with two work programmes; the first was the Operational Services Integration Group which would deliver a revised set of operational structures for the organisation, with the second being the Clinical Pathways Integration Group to work through the 150 clinical pathways to integrate.</p> <p>Mrs Foster added that the Trust had already done a number of good things which would have an impact in Northern Services, for example the Medical Staffing Business Case and the recent purchase of a surgical robot, however there may well have been times for Northern staff when actions had been taken which may have felt that they were being “done to” rather than being involved. Mrs Foster said that the next presentation to the May Board would contain triangulation of data in North, the addition of Pulse data from the next People Pulse survey, analysis of patient safety and patient experience responses to see whether there were any specific teams flagging, as well as line manager analysis. She added that there was also a wider piece of work to be discussed with the Executive Team on how this could be fed into the governance system. Ms Morgan agreed, but with the proviso of not getting too buried in the detail, that the bigger picture messages would become obscured.</p> <p>Mr Tidman said that a face-to-face meeting with all senior clinical and operational leaders would take place on 30 March in Tiverton, where they would be encouraged to think about next steps in terms of integration and more of these events would be scheduled.</p> <p><b>The Board of Directors noted the Staff Survey Results.</b></p>	
<p><b>046.23</b></p>	<p><b>AUDIT COMMITTEE UPDATE</b></p>	
	<p>Mr Matthews presented the Audit Committee update from the meeting held on 27 February 2023, noting that the meeting had not been quorate and advised that membership would be reviewed following Professor Kay’s departure, as this would mean there would be a Non-Executive vacancy on the membership. Mr Matthews</p>	

	<p>thanked Professor Kay for her contribution to the work of the Committee over the preceding years.</p> <p><b>No questions were raised and the Board of Directors noted the update.</b></p>	
<p><b>047.23</b></p>	<p><b>HEALTH INEQUALITIES TASK AND FINISH GROUP UPDATE</b></p>	
	<p><i>Katherine Allen joined the meeting</i></p> <p>Mr Tidman reminded the Board that the work undertaken by the Group had come about following the presentation to the Board in August 2022 by Professor Sheena Asthana on Health Inequalities and Public Health Management. He advised that:</p> <ul style="list-style-type: none"> <li>• The presentation had set out the focus for the Board on addressing health inequalities, in particular where these had been exacerbated during the pandemic and ensuring that recovery from the pandemic was done in a fair and just way.</li> <li>• The Health Inequalities Task and Finish Group had been set up following Professor Asthana's presentation. The Group met three times with support from Professor Kent and Mrs Burgoyne, as well as Mrs Allen and Mr Chinnock.</li> <li>• This was a work in progress. The report contained detail on some areas which the Trust is obligated to report on under NHS guidance and a recommendation on how the Board would periodic updates on the metrics and the partnership work being undertaken to address some of the causes of ill-health and disparity.</li> <li>• The work undertaken with Clinical Information Leads had shown how valuable a tool EPIC will be. Although there is currently insufficient populated data to see the richness that will be available, the database will build up over time. This will enable analysis of some of the social determinants of health, such as smoking and alcohol, as well as the postcode analysis.</li> </ul> <p>Professor Marshall commented that much of the content of the report focussed on the problem and what to do about it, but not how this would be achieved and suggested that one of the things that could be done at Board level would be to include inequalities data into the IPR but the report had recommended that this not be included in the IPR. In addition, Professor Marshall agreed with the suggestion of working with Primary Care, but asked whether other GP practices should be considered for this work. Mrs Allen responded that the Trust was learning more about how to address health inequalities, with more evidence now available to inform this. The Team is creating a methodology which involved look at the body of evidence to see what interventions work. Individual projects would provide further evidence of how benefits were gained from interventions. She further advised that Castle Place GP practice had volunteered to be a case study, and although they were a struggling practice they represented a quite deprived community. Mr Tidman added that the Trust did work with a number of different practices in the care partnerships, but had thought that this work would provide an opportunity to work more developmentally specifically with Castle Place. This would not be exclusive however and there were other practices that the Trust could work with.</p> <p>Mr Tidman advised that the Group had considered monthly reporting to the IPR, but there was a concern that the Board would not see significant trend month to month, and quarterly or bi-annual reporting would give a better sense of change over time. Ms Morgan said that her preference would be to receive data every six months, as the IPR would need to be very focussed on tracking delivery of the operational plan as a priority.</p>	



	<p>Mr Neal noted the suggestion that inequalities could be used in clinical assessment and prioritisation. Although it was probably too early in the process to answer at this point, he asked that the Board be updated in due course on how that would be done and what the principles for this would be.</p> <p>Professor Kay commented that this was a very good first stage, and said that now would be the time to think about the “what” as well as the “how”. It would be important to refine the questions in terms of the data, for example regarding intersectionality between age and deprivation for digital poverty. She suggested that the Team could access the support of the Applied Research and Care (ARC) which the Trust hosted and of the National Institute for Health and Care Research School for Public Health at the University of Exeter. Ms Morgan agreed and added that it would also be important to engage with the system as a whole.</p> <p>Mr Palmer agreed that there a body of evidence that could be drawn upon, in terms of epidemiology and operational and clinical response, including from work undertaken in the Welsh valleys. He agreed that the work with Primary Care on restratification would be important. He agreed with Professor Kay that there were staff in the ARC Team who would be good to harness for this work.</p> <p>Professor Marshall suggested that consideration be given to putting Barnstaple forward as a “Marmot Town”.</p> <p>Mrs Hibbard agreed that this should be looked at by the Devon system, but said that there was a risk, given all the focus on finance and operational performance and recovery, this could be forgotten or even exacerbated by some of the actions that needed to be taken in the here and now. Ms Morgan said that inequalities was part of the One Devon plan being developed by the Integrated Care Partnership which goes wider than immediate healthcare needs. She agreed however with Mrs Hibbard that it would be challenging to look at preventive and other issues in the current environment.</p> <p>Professor Kay said that this issue stretched into education, prevention and early intervention work and there was work being undertaken to build community hubs to help address health related questions and inequalities, and this work could also be of help to the Trust. Mrs Allen agreed and said that the One Communities initiative that was in place would also be of help.</p> <p><b>The Board noted the Health Inequalities Task and Finish Group update.</b> <i>Katherine Allen left the meeting</i></p>	
<p><b>048.23</b></p>	<p><b>ITEMS FOR ESCALATION TO THE BOARD ASSURANCE FRAMEWORKS</b></p>	
	<p>Ms Morgan said that from discussions at the meeting it would be important to review existing risks to ensure that the importance of addressing No Criteria to Reside in terms of the impact on the Operational Plan was covered. She asked whether Board members had identified any new risks or anything to add to existing risks from their discussions.</p> <p>Mrs Holley commented that the Board had agreed that consideration should be given to adding a risk to the delivery of the Operational Plan to the Framework and Ms Morgan added that this would need to include obstacles to delivery.</p>	

	<p>Professor Marshall asked whether the workforce risk was rated sufficiently highly and Mrs Foster said there were two workforce risks relating to morale and capacity and IA and both might need to be reviewed.</p> <p>Mr Tidman said that it might be best for the Executive to look at the BAF in more detail and work up with Mrs Holley what would be a suitable BAF for the coming year. <b>Action.</b></p> <p><b>The Board of Directors noted the comments.</b></p>	
<p><b>049.23</b></p>	<p><b>ANY OTHER BUSINESS</b></p>	
	<p>No other business was raised by Board members.</p> <p>Ms Morgan advised that this would be Professor Kay's last Board meeting as a Non-Executive Director as she was due to end her Term of Office on 31 March. Ms Morgan thanked Professor Kau for her extraordinary contribution to the Board over the preceding years, noting that her contributions to Board discussions had always been clear, well-informed and insightful and their probing nature had often led to a shift in the nature of discussions. Ms Morgan said that Professor Kay had personified the valued links with the University of Exeter and those links would not be lost going forward. Professor Kay said that it had been both a pleasure and a privilege to work with the Trust which was a values led organisation, with an excellent Board which she had been proud to work with for the benefit of patient safety and care.</p>	
<p><b>050.23</b></p>	<p><b>PUBLIC QUESTIONS</b></p>	
	<p>The Chair invited questions from members of the public and Governors in attendance at the meeting.</p> <p>Mrs Sweeney thanked Professor Kay, on behalf of the Council of Governors, for the support she had provided to the Council over the years, adding that they had particularly valued her guidance on the Nominations Committee and the Non-Executive Remuneration Committee.</p> <p>Mrs Penwarden noted the Board's discussions regarding the importance of working relationships with Devon County Council and reminded the Board that there was a co-opted Governor from Devon County Council on the Council of Governors. She suggested that the Board might wish to consider how to make use of that connection more proactively. Ms Morgan thanked Mrs Penwarden for the suggestion and agreed that this was something to build on for the future to strengthen partnerships.</p> <p>Mrs Kay Foster asked whether there were "Meet the Board" events held for staff, where they could meet Board members and ask them questions, as she felt this would be an opportunity to engage with staff directly and help to improve morale. Ms Morgan thanked Mrs Foster for her suggestion and said that there was already a programme of visits by Board members to different sites at the Trust in place which offered the opportunity for staff and Board members to engage with staff at all levels. Mr Tidman added that a regular staff webinar is held, where staff have the opportunity to ask the Executive Team and other senior leaders questions. He added that the Executive Team were conscious that the move towards closer system working had the potential to lessen their contact with front line staff at the</p>	

	<p>Trust and the Executive Team were reflecting on how to get back to the floor on a more regular basis. He added that the planned awayday with the senior leadership team would provide an opportunity to discuss with them the best way to reconnect without undermining their roles as leaders. Ms Morgan commented that the webinars were a very useful tool and was a very direct way of getting feedback of what was on people's minds.</p> <p>There being no further questions, the meeting was closed.</p>	
<p><b>051.22</b></p>	<p><b>DATE OF NEXT MEETING</b></p>	
	<p><b>The date of the next meeting was announced as taking place on Wednesday 26 April 2023.</b></p>	

DRAFT

**PUBLIC MEETING OF THE BOARD OF DIRECTORS**  
**29 March 2023**  
**ACTIONS SUMMARY**

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

<b>PUBLIC AGENDA</b>					
<b>Minute No.</b>	<b>Month raised</b>	<b>Description</b>	<b>By</b>	<b>Target date</b>	<b>Remarks</b>
163.22(1)	November 2022	Professor Kent asked for the next six-monthly safe staffing report to include registered Associate Nurse numbers to differentiate from Registered Nurses.	CM	May 2023	<b>Update 28.12.22</b> – data requested will be included in next report to May Board. <b>Action ongoing.</b>
163.22(1)	November 2022	Request that next six-monthly safe staffing report should include more detail regarding the Weighted Activity Unit for AHPs in Quartile 4 for Northern and Eastern sites.	CM	May 2023	<b>Update 28.12.22</b> – detail requested will be included in next report to May Board. <b>Action ongoing.</b>
008.23	January 2023	The carer from the Patient Story presented to Board was noted as being involved in work on a number of initiatives relating to improving process carer involvement with care planning for patients with the Director of Nursing for Eastern services. The outcomes and impact of this work should be looked at in due course by the Patient Experience Committee.	CM	April 2023	<b>Update February 2023</b> -Next update to April Board. <b>Action ongoing.</b> <b>Update 19.04.23</b> – The themes addressed within January’s patient story have been incorporated into the Patient Experience Committee for ongoing discussion/review. <b>Action complete.</b>
041.23	March 2023	Mr Tidman to explore further with Devon County Council and the Director of Adult Social Services to attend either a formal Board meeting or a Board Development Day as an opportunity for both them and the Trust to set out their mutual positions on hospital discharge, the out of hospital proposition and potential solutions.	CT	April 2023	<b>Update 12.04.23</b> – Invitation made to attend either the May or June Board meeting. <b>Action ongoing.</b>
042.23	March 2023	Mr Tidman and Mrs Hibbard to discuss whether there were further opportunities for exploiting the commercial opportunities of genetic testing, with the right level of business support, and whether there was the opportunity to scope something as part of a three-year financial plan for genetics.	CT / AHi	September 2023	<b>Update 12.04.23</b> – Contact made with Divisional Director and plan being scoped. <b>Action ongoing.</b>
043.23(1)	March 2023	Mrs Mills to look at the absolute rate of falls data for Eastern Services, as whilst the rate of moderate and severe falls appeared flat, the absolute rate appeared to show a steep rise. It was noted that falls data was pulled from Datix incident reports, and the rise might be	CM	April 2023	<b>Update 19.04.23</b> – Confirmation has been received that the reported increase in falls was attributable to the extracted data set including falls and was not filtered to

		accounted for by multiple reports for one patient falling on a number of occasions, but this would reviewed to see if that was the case.			inpatient falls only. This will be amended for subsequent reports. <b>Action complete.</b>
043.23(2)	March 2023	Mrs Foster to look at inclusion of absolute establishment data in the IPR in future iterations.	HF	April 2023	<b>Update 21.04.23-</b> The metrics within the 'Our People' section of the IPR are currently under review, with meetings having taken place to discuss requirements moving forward. The team are now reviewing these requests and will be developing a proposal for the CPO to review, including timescales in the coming weeks. <b>Action ongoing.</b>
043.23(3)	March 2023	Mrs Mills to review nosocomial rates of infection reported in the IPR as Mr Kirby had noted that the rates appeared to be quite a high percentage compared to the number of patients admitted.	CM	April 2023	<b>Update 19.04.23 –</b> Assurance has been provided to CM and SK from the IPC service regarding nosocomial rates, that the Trust's current IPC approach is in line with national guidance, and that the current RDUH IPC response remains proportionate to and balanced against any potential IPC risks to patients and any impact upon patient flow/elective care etc. <b>Action complete.</b>
043.23(4)	March 2023	Mr Neal asked if the impact of the reopening of Sidwell Street Walk In Centre could be assessed, together with a wider review of plans going forward for Minor Injury Unit provision.  In addition, Sidwell Street to be added to the list of sites for Non-Executive visits.	JP MH	April 2023	<b>Update 14.04.23 –</b> Walk In Centre, Sidwell Street added to the list of site/department visits for the NEDs. <b>Action complete.</b>
044.23	March 2023	Mrs Foster to check whether Bank Staff working on the day of the snapshot for the Gender Pay Gap were included in the data; she believed they were not as they were not on an annualised salary, but would check this together with whether agency/locum staff were included.	HF	April 2023	<b>Update 21.04.23 –</b> It has been confirmed that the Gender Pay Gap calculations include all contracted employees including bank staff, but will not include agency workers. <b>Action complete.</b>
048.23	March 2023	The Executive Team to review the Board Assurance Framework and work up with Mrs Holley what would be a suitable BAF for the coming year.	Execs MH	April 2023	<b>Update 14.04.23 –</b> Board Assurance Framework review and proposal on agenda. <b>Action complete.</b>

**Signed:**

**Shan Morgan**

Chair



<b>Agenda item:</b>	8, Patient Story	<b>Date:</b> 26 April 2023		
<b>Title:</b>	Patient story: Discharge Lounges			
<b>Prepared by:</b>	Bethany Hoile, Engagement Coordinator			
<b>Presented by:</b>	Carolyn Mills, Chief Nursing Officer			
<b>Responsible Executive:</b>	Carolyn Mills, Chief Nursing Officer			
<b>Summary:</b>	<p>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.</p> <p>The purpose of presenting a patient story to Board members is to:</p> <ul style="list-style-type: none"> <li>• Set a patient focussed context to the meeting, bringing patient experience to life and making patient’s stories accessible to a wider audience</li> <li>• To support Board members to triangulate patient experience with reported data and information</li> <li>• 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.</li> </ul>			
<b>Actions required:</b>	<p>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.</p> <p>Link to status below and set out clearly the expectations of the Board when considering the paper.</p>			
<b>Status (x):</b>	<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Information</b>
			<b>X</b>	
<b>History:</b>	<p>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.</p> <p>This patient story is set within the context of the Trust’s strategic objectives: of excellence and innovation in patient care and recovering for the future.</p> <p>Discharge lounges have been developed to provide a relaxed, comfortable and safe environment for patients who are medically fit to leave hospital, whilst they await discharge to their home or to another care setting. Staffed by registered nurses and HCAs, the discharge lounge team assist with discharge plans, including finalising discharge summaries, checking that patients receive their medication, ordering transport and contacting the patient’s family, friends or carer.</p>			

	<p>The Wonford site launched its discharge lounge in 2021, and following a successful bid from a national urgent and emergency care recovery fund; construction is currently underway at the NDDH site for a brand new discharge lounge facility which should be completed in mid-June 2023.</p> <p>This patient story serves to bring to life the experiences of both patients and staff who are using the discharge lounge, asking them what the benefits of discharge lounges are, what is working well, and what requires ongoing development.</p> <p>The use of discharge lounges across the Northern and Eastern sites continue to accommodate the needs of our patients, enhancing the patient journey; yet allowing the Trust to continue to maintain a strategic focus on releasing acute beds and improving patient flow from the Emergency Department.</p> <p>Discharge lounges have been well received with both patients and ward staff, and continue to play a vital role in supporting the timely and safe discharge of patients.</p>
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 ( <i>please specify</i> )			



<b>Agenda item:</b>	9.1, Public Board	Date: 26 April 2023		
<b>Title:</b>	Integrated Performance Report – spanning both Northern and Eastern services within Royal Devon University Healthcare NHS Foundation Trust			
<b>Prepared by:</b>	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			
<b>Presented by:</b>	Adrian Harris, Chief Medical Officer			
<b>Responsible Executive:</b>	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			
<b>Summary:</b>	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.			
<b>Actions required:</b>	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.			
<b>Status (*):</b>	Decision	Approval	Discussion	Information
				X
<b>History:</b>	This is a standing agenda item at each meeting of the Board of Directors.			
<b>Link to strategy/ Assurance framework:</b>	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)			

## Contents

Section	
Overview	3 – 7
Activity & Flow, and Operational Performance	8 – 47
Patient Experience	48
Quality & Safety	49 – 71
Our People	72 – 75
Finance	76 – 79

# Overview – Executive Themes and Actions to Raise at Board

## Overview

This IPR covers the period of **March 2023** which continued the themes of December, January and February 2022/3 including complex challenges resulting from multiple days of industrial action across the service, infection outbreaks (a combination of both COVID and Norovirus), and staff workforce challenges. This maintained extreme pressure on all parts of the Devon Urgent and Emergency Care system, and resulted in a sustained period of ICS led Gold Command during which RDUH supported our neighbouring Trusts, but also provided an opportunity for significant escalation of our medically fit to discharge patients and some consequent adjustments to funding arrangements. Our staff continued to make **remarkable efforts to absorb these pressures, to keep our patient population safe and to support our neighbouring Trusts throughout.**

March started positively with a standing down of the planned industrial action by the RCN between 1<sup>st</sup> and 3<sup>rd</sup> March, although this was then followed by BMA Junior Doctor industrial action between the 13 and 16<sup>th</sup> March, and further disruption to ambulance services through GMB and UNISON action. On each occasion our operational and clinical teams pulled together robust contingency plans that our teams supported brilliantly; and we were grateful for Trust Director operational leadership throughout. As a result of the continued overall pressures, exacerbated by the complexity of industrial action, we **maintained our command structure at its highest escalation** in order to maintain close oversight of safety, flow, discharge and recruitment processes. Following a further period of BMA Junior Doctor Industrial Action between 11<sup>th</sup> and 15<sup>th</sup> April, we now prepare for a further period of RCN Industrial Action between 30 April and 02 May, as we also approach our CQC Well Led Inspection on 3<sup>rd</sup> & 4<sup>th</sup> May. At the time of writing we have been able to successfully de-escalate following a period of sustained OPEL4 on both sites, to OPEL 3 in both Northern and Eastern. Throughout these periods of significant operational and clinical challenge, we remain **very proud of our teams for making stepped improvements on our end of year elective and cancer targets, whilst also generating an increasingly robust financial and operational plan for next year.**

## Recovering for the Future

March brought a continuation of the increase in activity at our Emergency Departments, Walk in Centres, and Minor Injury Units, with **a 13.9% increase in emergency patient presentations to our Northern Services compared to February, and a 10% increase in Eastern.** When aggregated with the rise in February, this represents a 21% increase in attendances for Northern, and a 12.3% increase for Eastern across the last two months – and equates to an additional 26 attendances each day (Northern), and 36 (Eastern) respectively. In line with these pressures, the volume of ambulance handover delays increased markedly (Eastern from 112 to 165 x 60 minute delays, and from 151 to 321 for Northern). The improvement (reduction) across both Northern and Eastern sites in the average daily volume of patients considered medically fit and awaiting discharge, reflected the positive impact of process improvements, a degree of reduction in the infection prevention and control challenges, and a reduction in demand for complex discharges. In the face of the aforementioned growth in ED attendances combined with high patient acuity, this improvement was instrumental in supporting flow being maintained within the hospital. **Performance in respect of the four hour ED waiting times standard deteriorated slightly** from 62.6% to 60.3% for Eastern, and increased by 2.5% to 59.3% for our Northern Services. During the month **23 requests for ambulance divers were made** including load levelling to the Trust's Eastern Services of which the Trust was able to **agree 17**. These resulted in **26 additional patient attendances** to the Trust's Emergency Department of whom **19 patients required inpatient admission.**

Further to the reopening of Sidwell Street Walk in Centre on Mondays with effect from the end of February, we are delighted to be able to report that the **Walk in Centre was able to return to a full 7 day service with effect from 11<sup>th</sup> April** following the successful recruitment and training of additional staff. Same Day Emergency Care activity in Eastern continued to grow in March with an average of 26 attendances per day (a growth of 23.6% on February), and along with the continued growth of virtual ward activity which admitted 161 patients in March helped to provide continued organisational resilience to the UEC pressures outlined above. The **reconfiguration of the Trust's Eastern Emergency Department continues at pace**, with the reconfiguration of minors and majors part of the current phase of the programme.

# Overview – Executive Themes and Actions to Raise at Board

As part of the Trust's Operational Plan for 2023/24, **improvement plans are being refined to support improved performance in 2023/24 to meet the NHSE ambition of delivery of 76% performance by March 2024.** This improvement is predicated on work with the Devon System on actions to deliver the shared target of 5% No Criteria to Reside and the release of the new financial year's national UEC funding and restoration of Hospital Discharge Funding. In terms of elective recovery we delivered a **2022/23 year end position of 25 patients waiting longer than 104 weeks** (all within Eastern Services) and **688 patients** (293 Northern, 395 Eastern) **waiting longer than 78 weeks.** The overall volumes of elective inpatient and daycase activity were able to increase from February to March at both Northern and Eastern sites, and also increased month on month when compared to planned elective activity levels for March. As we move into the 2023/24 financial year and delivery of our new 2023/24 financial and operational plan commitments, including the elimination of all 104 week waits by the end of quarter 1, we are shifting our focus to 78 and 65 week wait patient cohorts as part of continued Tier 1 arrangements.

There has been a continuation of the **month on month improvement in the volume of longer waiting patients for cancer treatment and we finished the year with 241 patients waiting over 62 days against an original target of 198 which represents a significant reduction from the in-year peaks of 387 in August (Northern Services), and 281 in November for Eastern Services which saw us enter tier 1 arrangements last year. At the time of writing we have just been informed that we are being stood down from tier 1 to 2 oversight arrangements which is a positive reflection on the achievements of our teams.** Our wider cancer performance has seen: an improvement in 2ww performance in both North (to 80.0% in February) and East (to 77.8%); improvement in performance against the 28 day faster diagnosis standard at both sites (64.8% Northern, and 80.5% in Eastern); improvement in 62 day (GP urgent) target performance by 16.6% to 75.7% in Eastern, and deterioration in North to 29.3% respectively. The initial 62 day GP urgent position for March for Eastern Services is the highest performance this financial year, and for Northern Services improvement is expected with the actions aligned with delivery of the 2week wait and 28 day faster diagnostic standards. It is clear that theatre and diagnostic capacity remain key challenges. Business cases for CDC funding for mobile endoscopy and two endoscopy suites at Tiverton have been submitted to provide short and long term options for improving these positions. **Diagnostic waiting times performance** for routinely referred patients improved in February for both sites, with 69.2% (Eastern) and 51.5% (Northern) of patients waiting less than 6 weeks; improvements of 1.8% (Eastern) and 3.5% (Northern) respectively. This is the third consecutive month on month improvement observed at both sites, and represents a position circa ten percentage points higher than at the start of the financial year, facilitated by the ERF and additional funding that has been able to be secured to support delivery of the Trust's reduced elective waiting times position in 2022/23.

**The year end financial performance has delivered in line with expectations with a £29k positive variance from the month 11 forecast of £16.7m.** This reflects delivery of the original plan of £18.3m plus the benefit of £1.5m of additional income support from Devon ICB. The Trust recognises that in year there have been a number of emerging cost pressures due to the non-delivery of the DBV savings programme, drugs growth and inflationary cost pressures. These issues have been offset in year through the management of non-recurrent benefits and underspends allowing the overall plan to be delivered. **This is a tremendous achievement for the organisation given the challenging operational year.** As we move into the new financial year the non-delivery of the recurrent savings plan does impact and the scale of financial challenge increases into 2023/24. This is being managed in two ways, with an internal savings programme focused on productivity and cost efficiency and an ICS wide strategic programme to transform the way we work across Devon to build further savings opportunities through economies of scale. Alongside the revenue position for 2022/23, the Trust delivered a total capital programme of £56.6m of which £25m was delivered in the last month of the year. This is partly due to timing of additional nationally funded programmes, long lead times for equipment, slippage on construction schemes and delays in final decision making due to finite funds to be prioritised. **Again, huge efforts from across the organisation were made to ensure this position was delivered by the yearend.** Moving forward, focus is being put on timeliness of decision making and management of suppliers to support a more phased delivery of the programme.

# Overview – Executive Themes and Actions to Raise at Board

## Collaborating in Partnership

We continue to work with great focus and commitment on our **green to go position** in partnership with System colleagues upon which delivery of our 23/24 financial and operational plan is predicated. Across the last month there has been considerable focus on **escalation and challenge** in relation to potential loss of funding packages as we move towards the new financial year as both ICB and Devon County Council are due to make a number of potential adjustments across a range of funding streams. Our escalations at Executive level underline the importance of this issue and we continue to pursue it through all available channels. Whilst we have secured agreement to a three month continuation of funding at current levels, we remain in negotiations with the ICB and Devon County Council regarding annual funding levels.

## Excellence and Innovation in Patient Care

Triangulation of the performance positions with the quality metrics remains important so as to identify any trends that may show a consequential impact of the ongoing pressures the Trust is facing. In March there was **a Never Event in the Trust's Eastern Services** relating to a retained surgical swab, and an additional **five serious incidents (SIs) reported, with three in the Trust's Northern Services and two in Eastern respectively**. There were **six instances of falls resulting in moderate harm (three in each of the Trust's Northern and Eastern Services), and two medication incidents with a moderate impact (one in each of Eastern and Northern)**. Each are subject to investigation processes in order to maximise opportunities for learning.

Whilst remaining within normal variation, we note **slightly elevated rates of pressure damage** within both Northern acute (February, although yet to be fully validated) and Eastern (March) community services. Within Eastern the increase is primarily in category 3 pressure damage amongst the community caseload. Initial investigations have resulted in only one incident being escalated for investigation and no other lapses in care. Further investigation is being undertaken within Northern Services to understand causal and contributory factors. The **continued increase in the volume of trauma patients**, particularly within the Trust's Eastern Services, has contributed to continued challenge in scheduling surgery within 36 hours for those patients with a fractured neck of femur. The identification of further Orthopaedic pathways for which surgery can be undertaken at the Nightingale, will in turn support the release of further theatre capacity at Wonford including for trauma patients. Clinical review has been undertaken by the Hip Fracture Lead of all fractured #NOF cases during the month, and the review of those patients for whom surgery was not possible within 36 hours has not identified any harm. We note that the most recent **3 and 12 month SHMI positions** for both Northern and Eastern Services are within national confidence intervals and **HSMR** has plateaued and is now starting to fall. Reflective of the continued challenges with flow in March, both Northern and Eastern sites experienced a deterioration in the proportion of stroke patients being able to be admitted to an acute stroke unit within 4 hours. For the Trust's Northern Services, the flow challenges were also reflected in the proportion of stroke patients who spent 90% or more of their hospital stay on a stroke ward (45%, whilst in Eastern Services performance was 84.3%). Focussed work continues across both sites to reduce the volume of overdue complaints, reflecting the significant organisational focus on progressing early resolution of complaints in line with PHSO best practice guidance.

## A Great Place to Work

Our people continue to experience significant operational challenges, with sustained periods of industrial action and continued demand on our services. To support our people through these challenges, the Trust is pleased to see that vacancy rates continue to improve, with **a vacancy rate of 6.88%, nearly 2% lower than we had forecast last month** and **new hires continuing to exceed the number of people leaving the organisation** throughout April 2023 and turnover continuing to be on a downward trend and below the current planned rate. This is continuing to demonstrate the success of the recruitment focus, with a healthy pipeline of candidates preparing to start working at the Royal Devon. We know that keeping turnover on a downward trajectory will help productivity, so moving forward there will be a shift in focus, to move towards reaching the optimal level of turnover. In the coming months changes will be made to the people metrics available in the IPR, to demonstrate progress against the operational plan, as well as other key metrics. The trajectories we now have in place, predict the continuation of the positive trends seen to date.

# Overview – Executive Themes and Actions to Raise at Board

## **Data Quality and Reporting**

**The Financial and Operational Committee will review the latest iteration of the data quality plan in May. Significant progress in removing data errors from RTT reporting has been noted by NHSE in this reporting cycle.**

## **Diagnostics**

All known data quality issues relating to the Northern IPR implementation have now been resolved and all non-imaging data is now being reported from Epic (imaging is external to Epic for North and East).

Further work has also been undertaken on long waiting diagnostic patients, and long waiting reports are now circulated internally on a regular basis for action.

## **Cancer waiting times**

All known data quality issues have been resolved in relation to EPR build and script alignment. The only data quality issues that remain, and will always be present to a certain extent, are ‘front-end’ data quality issues, where information has been input incorrectly. This is addressed in a number of ways; targeted training where data quality issues are repeated in a specific area, remediation / review / correction by the central Cancer Services team, and the availability of data quality dashboards built in to Epic, so that users can identify data quality issues and correct them at source.

## **RTT / waiting list reporting (both sites)**

Improvements have been made in this area over recent months, with removal of duplicate pathways and missing values. Revised scripting has now been completed to ensure the reporting of a ‘single version of the truth’ across various reports, and this same script logic is now being used for all internal and external reporting. Some final work is underway to ensure any remaining data quality ‘front-end’ issues are identified and resolved using the same process as for Cancer waiting times referenced above.

## **March 2020 reporting**

The reference to the 2019/20 year is made throughout this document as a way of comparing recovery to pre-pandemic levels. The Covid pandemic hit the Trust in a material way part way through March 2020, and so resulted in lower volumes of elective activity in that month. As a result, this has an impact on this month’s reporting, as volumes are compared to lower March 2020 volumes. Where possible, the narrative has been updated to reflect an ‘adjusted’ March 2020 position, which takes an average of 2019/20 volumes for the year to provide a more accurate comparison.

## **Future trajectories**

The 2023/24 operational plan has been submitted and trajectories for 2023/24 will be included in the May IPR (featuring April data).

# Balanced Scorecard – Looking to the Future

## Successes

- Elective & Cancer recovery plans delivering improved end of year positions and **step down from tier 1**
- Development of financial and operational plan
- Well led and managed Industrial Action periods
- Nightingale Hospital SWAOC and Wonford PEOC moving to 90% capacity and utilisation
- Recruitment & retention plans are showing positive results in relation to vacancies
- Mutual aid offered to neighbouring Trusts, whilst maintaining good ambulance handover compared to peer
- Data quality programme now providing greater assurance
- Securing of UEC and Demand & Capacity funding to support reduction in patients whom are medically fit to discharge
- Securing of “boots on the ground” support for delivering best value.

## Opportunities

- Delivery of the 2023/4 financial and operational plan
- Refresh of the IPR in line with the financial and operational plan
- Insourcing & outsourcing and mutual aid capacity to maintain excellent clearance rate into the new financial year
- Integration of 8 high priority services at our Northern services and commencement of our next stage of the integration programme
- Rapid implementation of the Northern Services Acute Medicine Model
- Maximising the use of the protected elective care at the Nightingale to continue driving down long waiters
- Peninsula Acute Sustainability programme & nominated fragile services offers opportunities to improve service collaboration and plan delivery
- Initiation of the integration programme, OSIG and CPIG
- Opportunity secured to make a TIF bid for elective infrastructure.

## Priorities

- Safety of our services with a focus on ED and overall flow
- Staff Health and Wellbeing
- Improvement of approach to ambulance diverts
- Completion of the 2023/4 financial and operational plan
- Delivering Best Value to meet the demands of our financial and productivity plan
- Reducing the number of Green to Go patients through ICB/Region/National escalation
- Completion of our detailed Business Informatics plan.

## Risk/Threats

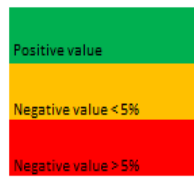
- Continued Industrial action (RCN anticipated May BH)
- Potential harm from ambulance diverting outside protocol
- Local Authority/ICB financial pressures and disruption in funding flows impacting on jointly funded discharge schemes
- Potential loss of confidence in reporting due to data quality issues
- Staffing Resilience in Northern Services – Medical, Nursing, HCA and Ancillary
- Staff Morale with constant pressure and cost of living challenges
- Inability to hit financial targets whilst also reducing waiting lists.

# Northern Services Executive Summary

## Northern Services Operational Performance Dashboard

Domain	Measure/metric	Definition	Last Month Feb-23	This Month Mar-23	Vs prior month	Planned	National target
ELECTIVE ACTIVITY	Outpatient activity (New)	<i>Vs baseline (2019/20)</i>	107.7%	154.1%	46.4%	87.9%	104%
	Outpatient activity (FU)	<i>Vs baseline (2019/20)</i>	111.9%	135.7%	23.8%	75.5%	75%
	Elective inpatient activity	<i>Vs baseline (2019/20)</i>	40.6%	51.6%	11.0%	121.5%	104%
	Elective daycase activity	<i>Vs baseline (2019/20)</i>	103.6%	129.1%	25.5%	108.7%	104%
	RTT 18 week performance	<i>Patients seen &lt; 18 weeks vs total Incomplete pathways</i>	45.0%	45.0%	0.0%		92%
	Incomplete pathways	<i>Total count</i>	24990	24656	-1.3%	15478	
	RTT 52+ weeks waited	<i>Total count</i>	3374	3278	-2.8%	1025	
	RTT 78+ weeks waited	<i>Total count</i>	458	293	-36.0%	76	
	RTT 104+ weeks waited	<i>Total count</i>	5	0	-100.0%	0	
	CANCER	2 week referrals	<i>Performance</i>	71.10%	80.00%	8.9%	
28 day faster diagnosis standard		<i>Performance</i>	54.50%	64.80%	10.3%		75%
Urgent GP referral 62 day		<i>Performance</i>	43.40%	29.29%	-14.1%		85%

Domain	Measure/metric	Definition	Last Month Feb-23	This Month Mar-23	Vs prior month	Planned	National target
URGENT CARE	Non-elective Inpatient activity +1LOS	<i>Vs baseline (2019/20)</i>	95.8%	105.8%	10.0%	105.7%	
	A&E attendances	<i>Vs baseline (2019/20)</i>	118.6%	155.3%	36.7%	143.0%	
	4 hour wait performance	<i>Patients seen &lt; 4 hours vs total attendances</i>	56.8%	59.3%	2.5%		95%
	Ambulance handover delays > 30 minutes	<i>Total count</i>	309	370	19.7%		
	Average daily number of patients waiting and ready for discharge	<i>Total count</i>					
	Average daily number of patients delayed as awaiting community assessment / referral / bed	<i>Total count</i>					
	Average daily number of patients delayed as awaiting resource / assessment to start care at home	<i>Total count</i>					
	Average daily number of patients delayed as awaiting residential / nursing home bed	<i>Total count</i>					
	6 week wait referral to diagnostic test	<i>completed in 6 weeks</i>	48.0%	51.5%	3.5%	N/A	99%
	DIAGNOSTICS	MRI activity	<i>Vs baseline (2019/20)</i>	104.2%	144.4%	40.2%	130.6%
CT activity		<i>Vs baseline (2019/20)</i>	115.1%	95.2%	-20.0%	142.3%	
Medical Endoscopy activity		<i>Vs baseline (2019/20)</i>	123.0%	89.2%	-33.7%	172.9%	
Non-obstetric ultrasound activity		<i>Vs baseline (2019/20)</i>	106.7%	104.4%	-2.3%	179.8%	
Echocardiography activity		<i>Vs baseline (2019/20)</i>	75.7%	55.0%	-20.7%	26.0%	





# Eastern Services Executive Summary

## Eastern Services

## Operational Performance Dashboard

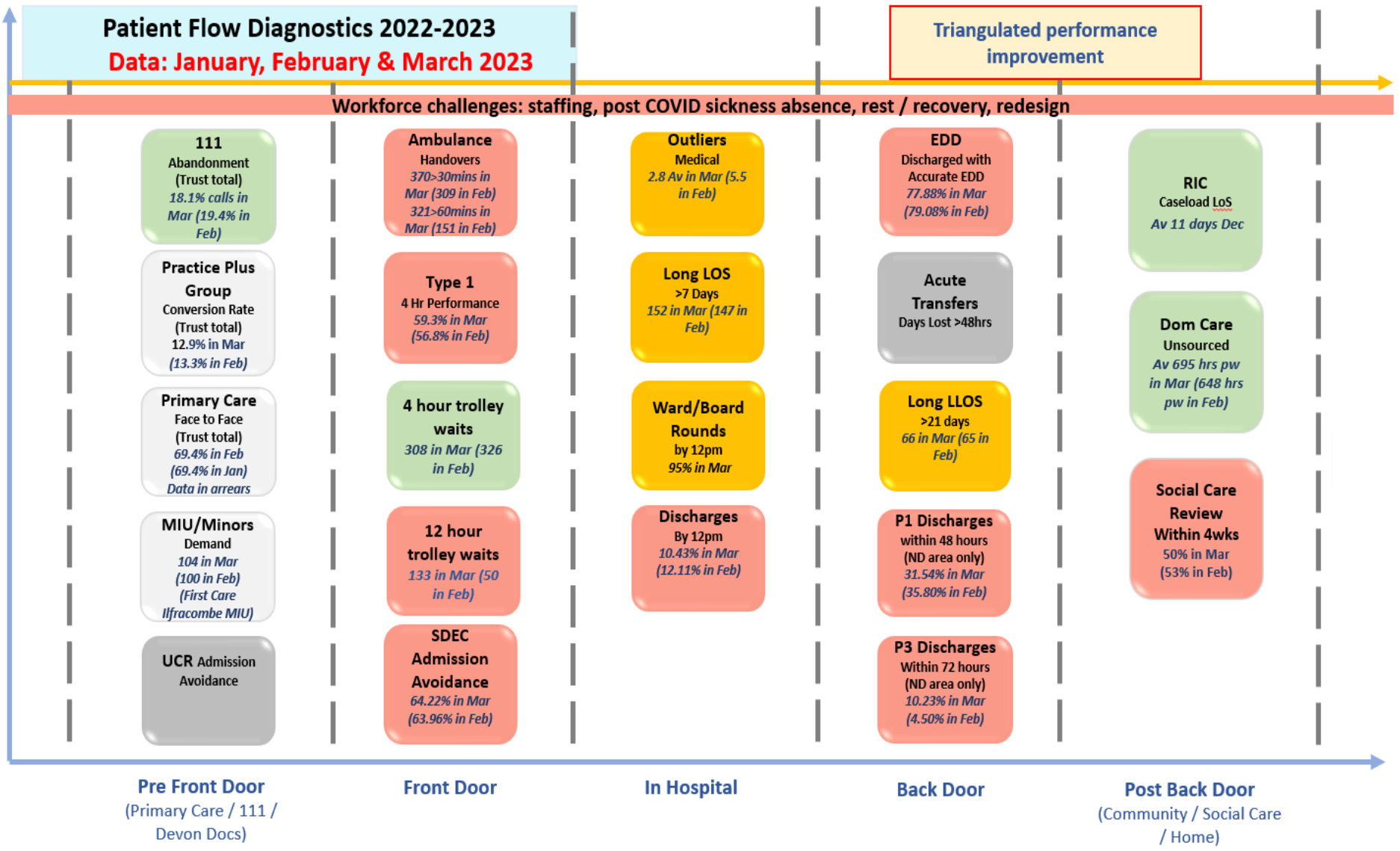
Domain	Measure/Metric	Definition	Last Month Feb-23	This Month Mar-23	vs Prior month	Planned	National target
ELECTIVE ACTIVITY	Outpatient Activity (NEW)	vs baseline (2019/20)	87.9%	<b>125.2%</b>	37.3%	127.7%	104%
	Outpatient Activity (FOLLOW-UP)	vs baseline (2019/20)	145.9%	<b>201.9%</b>	55.9%	117.4%	75%
	Elective Inpatient Activity	vs baseline (2019/20)	66.3%	<b>87.2%</b>	20.9%	146.7%	104%
	Elective Daycase Activity	vs baseline (2019/20)	99.0%	<b>151.4%</b>	52.4%	173.4%	104%
	RTT 18 Week performance	Patients seen < 18 weeks vs total incomplete pathways	57.1%	<b>54.7%</b>	-2.4%		92%
	Incomplete Pathways	Total count	54824	<b>54697</b>	-0.2%	47237	
	RTT 52 Weeks waited	Total count	4236	<b>4010</b>	-5.3%	4510	
	RTT 78 Weeks waited	Total count	635	<b>395</b>	-37.8%	1465	
	RTT 104 Weeks waited	Total count	106	<b>27</b>	-74.5%	0	
	CANCER	14 Day Urgent	Performance	77.5%	77.8%	0.4%	
28 day faster diagnosis standard		Performance	77.7%	80.5%	2.8%		75%
Urgent GP referral 62 day		Performance	59.2%	75.7%	16.6%		85%

Positive value
Negative value < 5%
Negative value > 5%

Domain	Measure/Metric	Definition	Last Month Feb-23	This Month Mar-23	vs Prior month	Planned	National target
URGENT CARE	Non-elective Inpatient activity +1LOS	Vs baseline (2019/20)	100.7%	<b>112.0%</b>	11.3%	118.7%	
	A&E attendances	vs 1920 baseline	87.6%	<b>130.3%</b>	48.7%	104.8%	
	4 hour wait performance	Patients seen < 4hrs vs total attendances	62.6%	<b>60.3%</b>	-2.3%		95%
	Ambulance handover delays > 30 mins	Total count	313	<b>318</b>	1.6%		
	Daily Average Green (Medically Fit) Transfer List	Total count	87	<b>82</b>	-6.1%		
	Volume of Average Daily Completed Transfers	Total count	11.2	<b>12.9</b>	13.2%		
	Average Time to Transfer (Medically Fit to Discharge) - All Transfers	Total count	5	<b>3.4</b>	-47.1%		
	Average Weekly Hours Requiring Personal Care Backfill	Total count	906	<b>806</b>	-11.0%		
	UCR: Referrals	Total count	746	<b>825</b>	9.6%		
	UCR: Length of Stay on Caseload	Total count	19.0	<b>15.0</b>	-21.1%		
DIAGNOSTICS	6 week wait referral to diagnostic test	% of diagnostic tests completed in 6 weeks	67.4%	69.2%	1.8%		99%
	MRI activity	vs 1920 baseline	103.5%	107.7%	4.2%	109.9%	
	CT activity	vs 1920 baseline	104.2%	109.0%	4.7%	109.3%	
	Medical Endoscopy activity	vs 1920 baseline	102.8%	100.8%	-2.0%	92.6%	
	Non-obstetric ultrasound activity	vs 1920 baseline	116.1%	117.6%	1.5%	66.5%	
	Echocardiography activity	vs 1920 baseline	194.4%	166.7%	-27.7%	99.4%	

## Northern Services

## Patient Flow Diagnostic



# Eastern Services Executive Summary

## Eastern Services

## Patient Flow Diagnostic

### Patient Flow Diagnostics 2021-2023

**Data: March 2023**

Triangulated performance improvement

Workforce challenges: staffing, post COVID sickness absence, rest / recovery, redesign

**111**  
Abandonment  
18.1% calls in Mar  
(19.4% in Feb)

**Ambulance Handovers**  
318>30mins (313 in Feb)  
165>60mins (112 in Feb)

**Outliers Medical**  
78.9 Av in Mar  
(78.2 in Feb)

**EDD**  
Discharged with Accurate EDD  
71.6% Av Accurate EDD in Mar  
(73.1% in Feb)

**UCR Caseload LoS**  
12.1 days in Mar  
(19.6 days in Feb)

**Practice Plus Group**  
Conversion Rate  
12.9% in Mar  
(13.3% in Feb)

**Type 1**  
4 Hr Performance  
46.6% in Mar  
(48.5% in Feb)

**Long LLOS**  
>7 Days  
384.3 Av in Mar  
(364.9 in Feb)

**Acute Transfers**  
Days Lost >48hrs  
4 days in Mar  
(3 days in Feb)

**Comm Hosp Length of Stay**  
19 days in Mar  
(19 days in Feb)

**Primary Care Face to Face**  
69.9% in Feb  
(69.4% in Jan)  
- Data in arrears-

**4hr Trolley Waits**  
Total 4hrs +  
578 in Mar  
(587 in Feb)

**Ward/Board Rounds**  
by 12pm  
100% in Mar  
(100% in Feb)

**Long LLOS**  
>21 days  
108.9 Av in Mar  
(106.3 in Feb)

**Dom Care Unsourced**  
1307 Av hrs pw in Mar  
(1608 hrs in Feb)

**MIU/Minors Demand**  
2718 attends in Mar  
(2543 in Feb)

**12hr Trolley Waits**  
Total 12hrs +  
249 in Mar  
(163 in Feb)

**Discharges**  
By 12pm  
16.9% Av by 12pm in Mar  
(15.3% in Feb)

**P1 UCR Discharges**  
Within 48hrs  
44% Mar  
(33% in Feb)

**Social Care Review**  
Within 4wks  
49% in Mar  
(52% in Feb)

**UCR AA % Met Target**  
88% in Mar  
(84% in Feb)

**SDEC Admission Avoidance**  
88.5% Discharged in Mar  
(87.7% in Feb)

**Virtual Ward Activity**  
Admissions  
161 in Mar  
(155 in Feb)

Key:

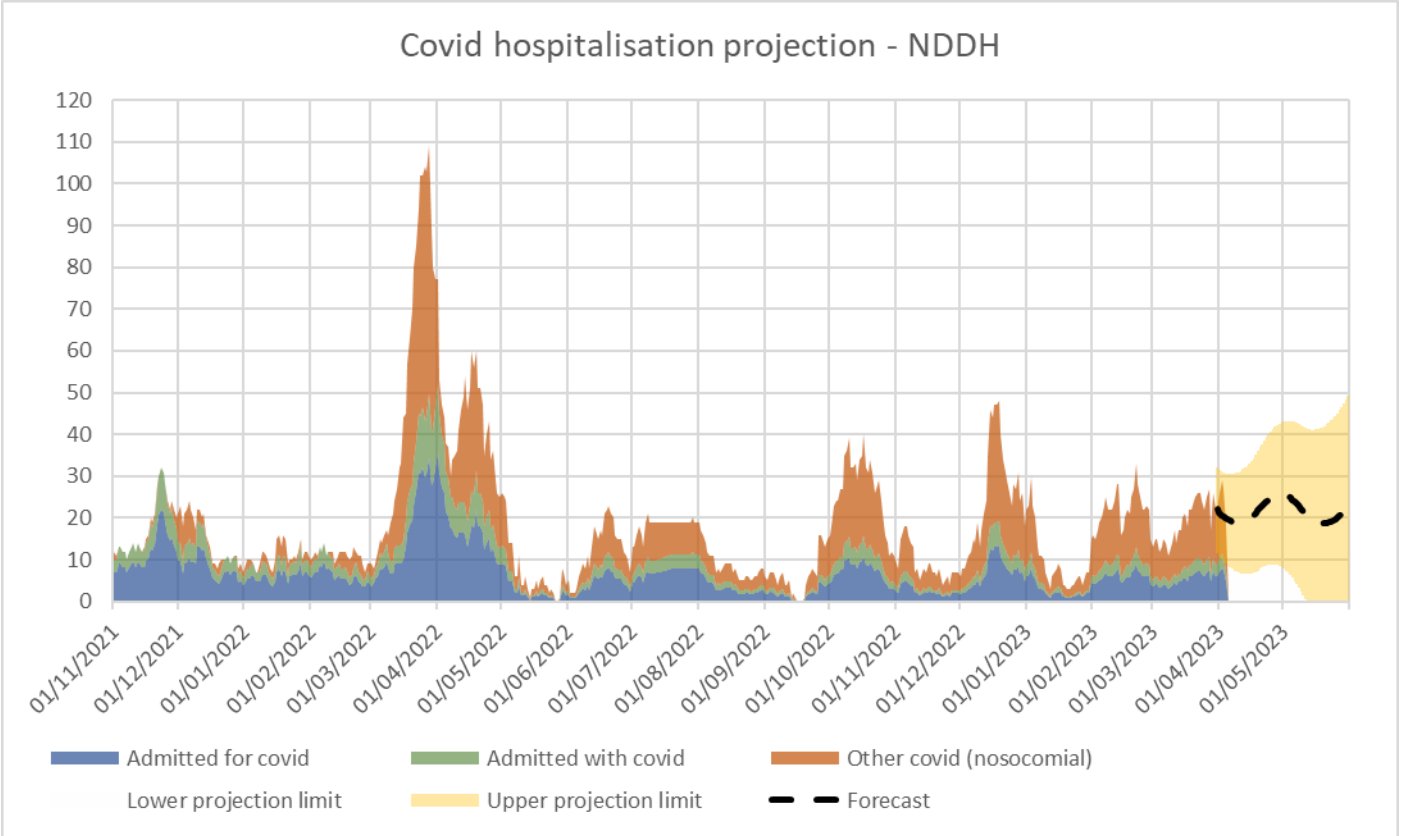
**Pre Front Door**  
(Primary Care / 111 /  
Devon Docs)

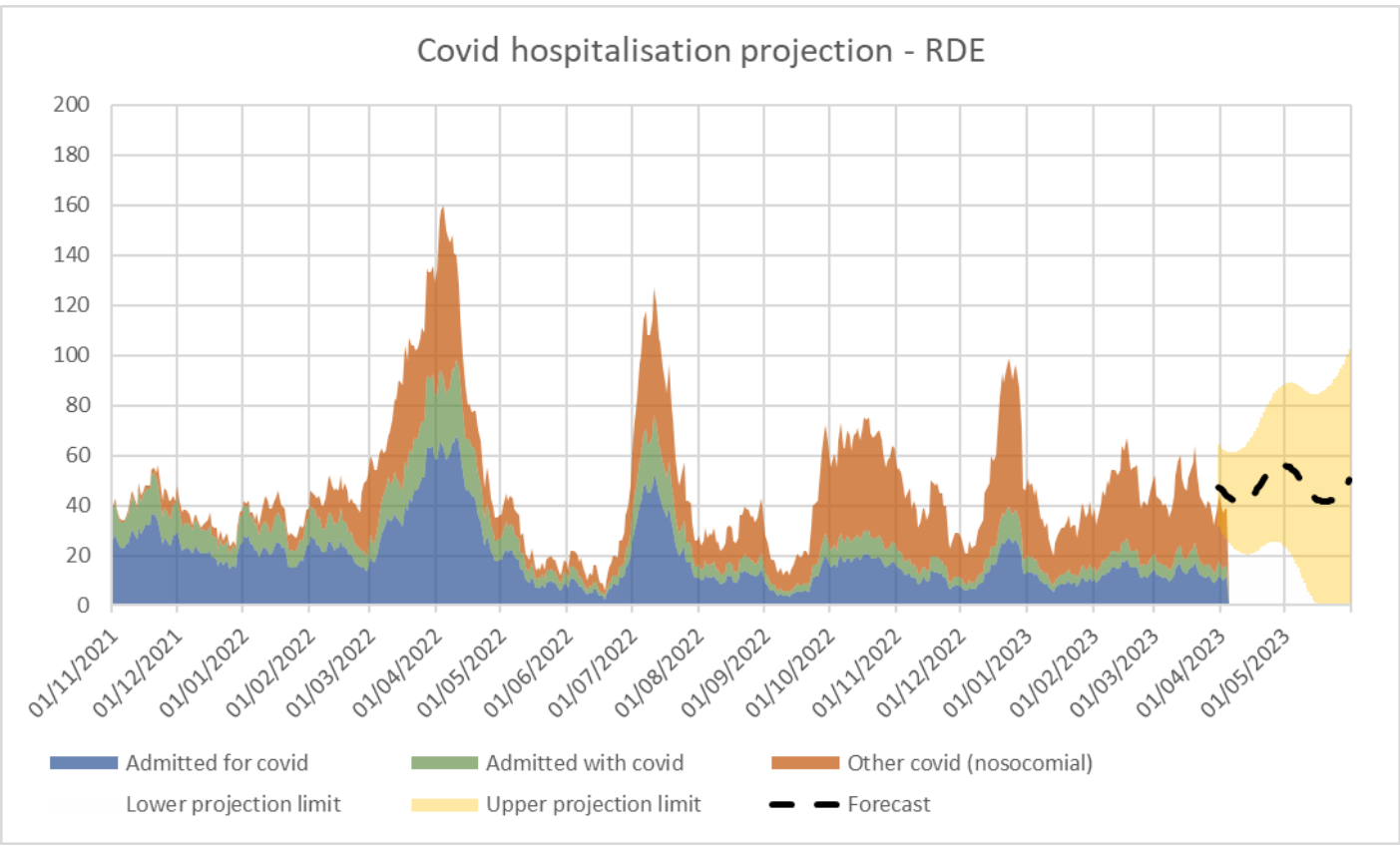
**Front Door**

**In Hospital**

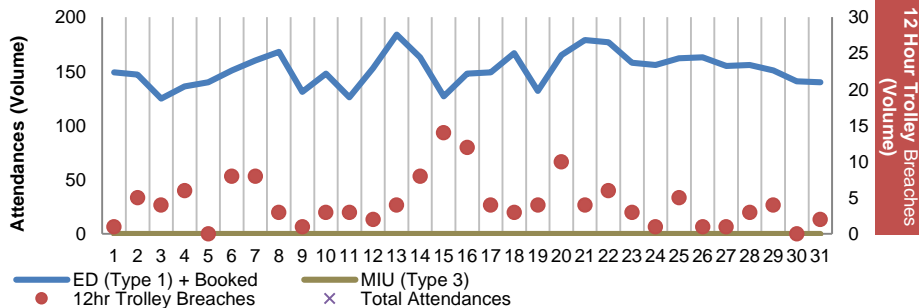
**Back Door**

**Post Back Door**  
(Community / Social Care  
/ Home)





### Report Month - Trust Daily Attendance Profile

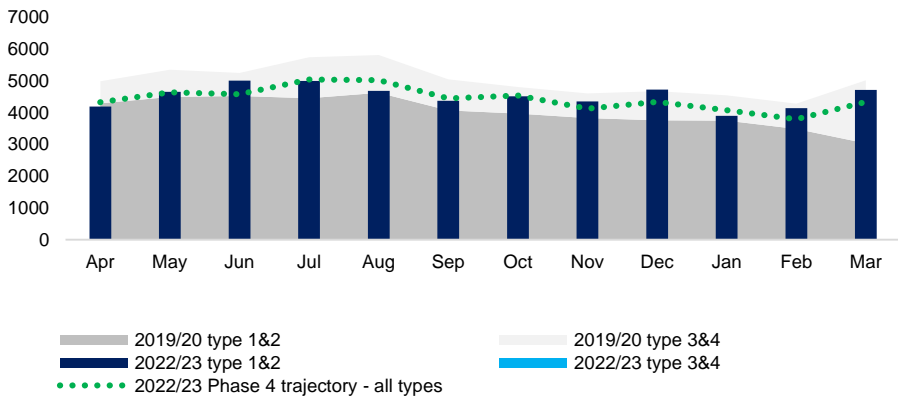


### Overall Performance:

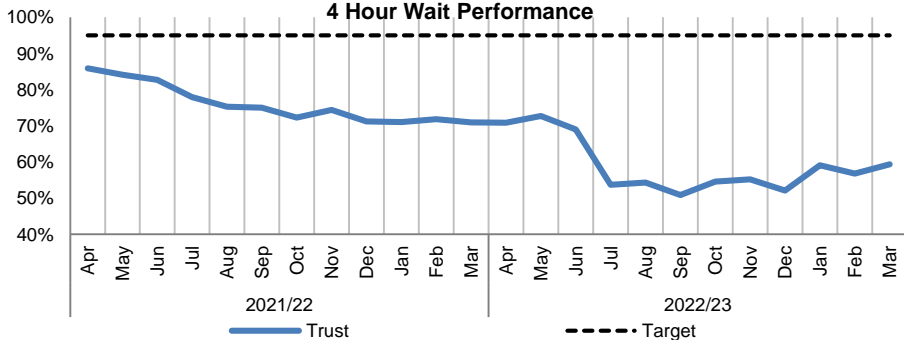
Type of Activity	Denominator	Patients > 4 Hours	% Performance
ED Only	4707	1915	59.32%

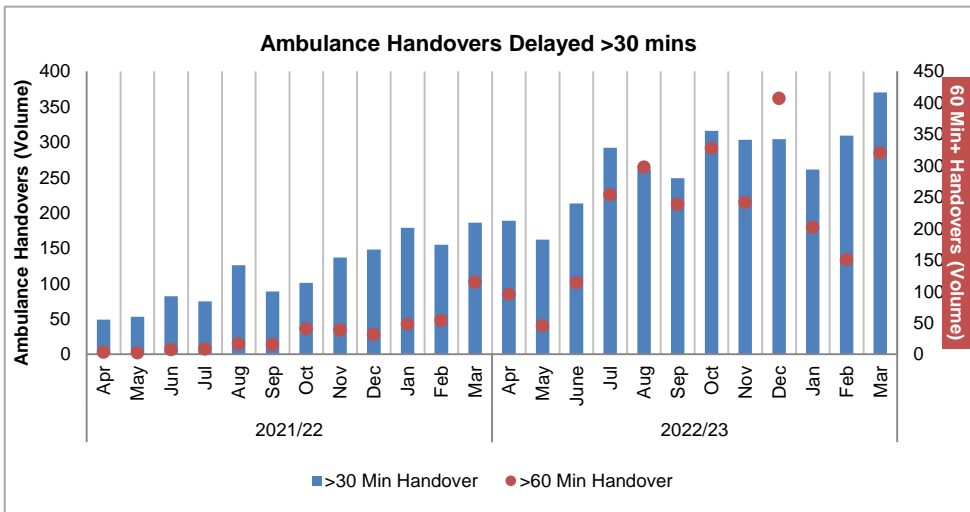
- ED saw an increase in attendances in March with a peak of 184 attendances on the 13<sup>th</sup> March.
- In March the total average daily hours lost in ambulance handover delays was 736 hours. This is an increase in comparison to 410 hours in February.
- Northern Services went into Opel 4 on the 7<sup>th</sup> March and remained in Opel 4 until the 27<sup>th</sup> March.
- In March the overall number of ED attendances increased by 575 patients against February. The service reported a 4.40% increase in March against the 4 hour target in February.
- Safety Barometer implemented and live on EPIC.
- New governance processes are being implemented to provide additional assurance of current actions being taken to improve performance. This includes twice-weekly Breach Review Huddles (attended by Group Manager, Clinical Lead and Clinical Matron) and a new monthly Urgent Care Board to monitor and oversee the implementation of the Urgent and Emergency Care Improvement Plan.

### A&E attendances

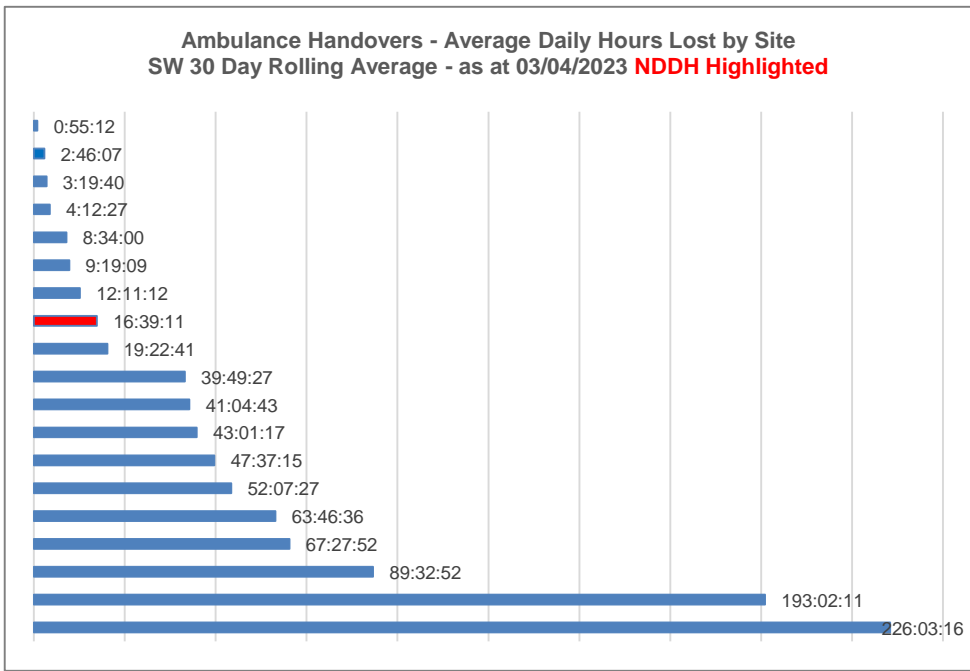


### 4 Hour Wait Performance





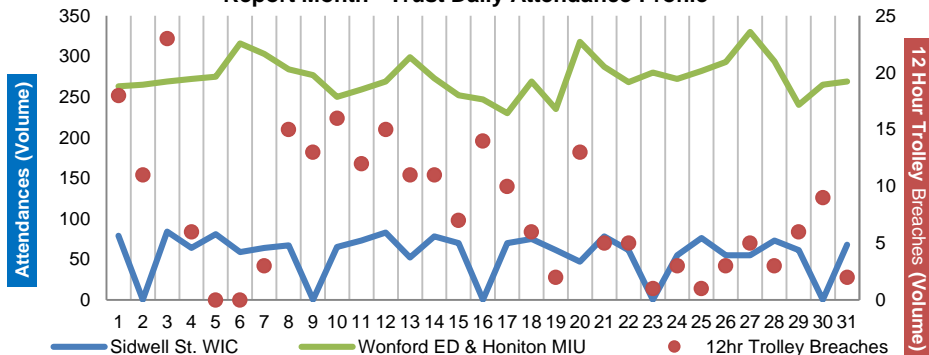
- 60 min handovers increased by 170 in March, 30 min handovers increased by 61.



# Eastern Services Emergency Department

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

### Report Month - Trust Daily Attendance Profile

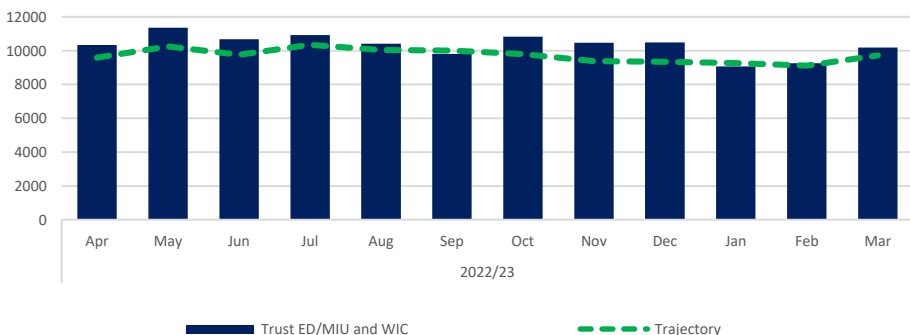


Type of Activity	Denominator	Patients > 4 Hours	% Performance
ED Only	7461	3987	46.56%
All RD&E Delivered Activity (including Honiton MIU and the WICs)	10179	4042	60.29%
Total System Performance (including MIUs)	13362	4212	68.48%

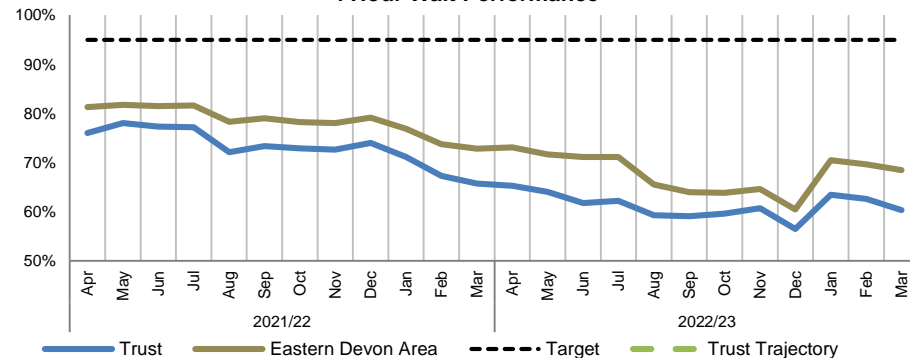
#### Overall performance

- All Type - 4 hour performance deteriorated from 62.55% in February to 60.29% in March
- ED type 1 performance **46.56%** in March (2% lower than February 2023) and the total number of 12 hour post DTA breaches increase from 163 in February to 249 in March
- ED attendances were approximately 239 per day across March 2023 representing a high level of demand

### A&E Attendances



### 4 Hour Wait Performance



#### Points for escalation

- OPEL 4 was declared during the first week of March and the Trust remained in OPEL 4 until Wednesday 29 March 2023 due to infection control and closed wards
- The acuity of patients in the emergency department was high
- There were critical gaps in middle grade rotas particularly for the twilight and night shifts throughout the week commencing 20 March
- ED reconfiguration works impacted on capacity and performance. The HOT escalation area permanently closed on Monday 13 March 2023
- Junior doctor industrial action Monday 13 March to 15 March 2023
- Early closures and planned closures at the WIC and MIU as a result of staffing challenges due to vacancy, sickness and a high number of trainees within the establishment
- Lack of GP streaming service

#### Actions being taken to improve performance

- Successful recruitment, retention and training of staff at the WIC resulted in increasing service provision from 5 days per week to 6 days per week from the 27 February. The service has since reopened 7 days a week in April 2023
- The temporary relocation of minors to the 3 old resus bays and the see and treat rooms was implemented when the new entrance and reception opened on 13 February to improve patient flow and 4 hour performance for self-presenting patients
- Minors / LAM Flip work commenced Monday 20 March 2023 and has completion date of the 25 May 2023. Once complete the permanent reconfiguration of minors and majors will improve patient flow and performance
- Recruitment into ED nursing and medical workforce to reach baseline WTEs to fill current rotas
- Focus on safety and improvements to initial time to triage (% of patients assessed within 15 mins of arrival for ambulance arrivals and walk ins)
- Working with the ICB on Low Acuity Attenders and option to explore GP streaming and location
- Task and finish group to reduce attendances of specialty expected patients to ED
- SDEC activity saw a significant increase in March, up 23.6% on February with a week day average of 26 attendances per day and another record number of attendances at 43 on a single day
- Virtual Ward activity continues to grow with 161 admissions/155 discharges and a peak number of patients of 40.

Activity & Flow

Operational Performance

Patient Experience

Quality & Safety

Our People

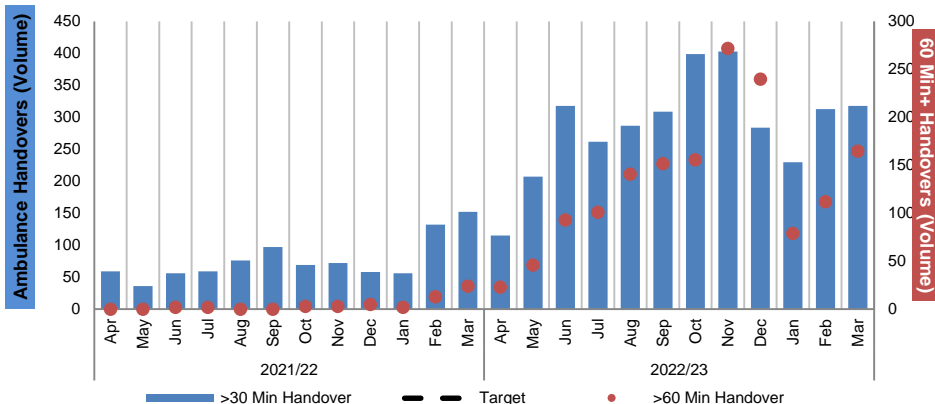
Finance



# Eastern Services Emergency Department

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

## Ambulance Handovers Delayed >30 mins



## Overall performance

- OPEL 4 was declared during the first week of March and the Trust remained in OPEL 4 until Wednesday 29 March 2023 due to infection control and closed wards
- The impact of hospital pressures on patient flow out of ED resulted in an increase in >60 min handover times from 157 in February to 208 in March.

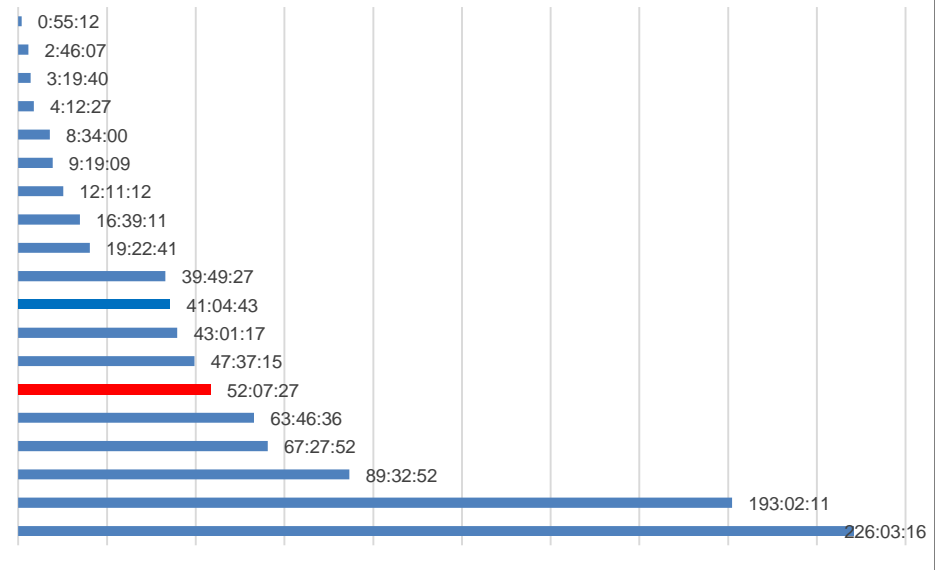
## Points for escalation

- The Trust provided mutual support to the system and load levelling ambulance divers were switched on Tuesday 7 March 2023, resulting in ambulance arrivals from PL21 and TQ13 postcodes. The divert was switched off on Monday 13 March 2023
- SWAST data quality and accuracy of SWAST BI data in reporting of Trust ambulance handover times. Unknown impact of cohorting and ambulance handover data resulting from SWAST EPR systems
- Trust ambulance handover data validation based on SWAST reported chargeable handover delays.
- Devon Ambulance Cell do not have capacity at present to correct Trust validated ambulance handover data

## Actions being taken to improve performance

- Review of Trust ambulance handover validation methodology of SWAST chargeable ambulance handover delays
- Review of ambulance handover process to be undertaken on completion of the new ambulance entrance opening in the 24 April 2023
- Monthly ambulance handover meetings established with SWAST to review processes and improvements

## Ambulance Handovers - Average Daily Hours Lost by Site SW 30 Day Rolling Average - as at 03/04/2023 **RD&E Highlighted**



Activity & Flow

Operational Performance

Patient Experience

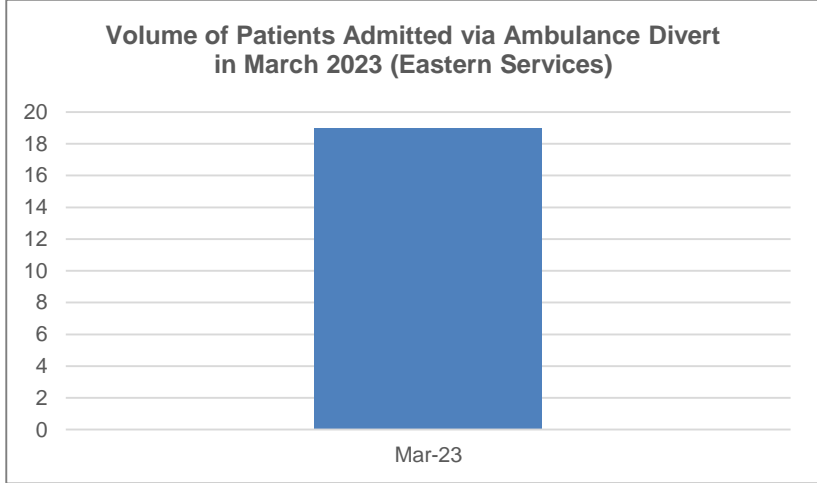
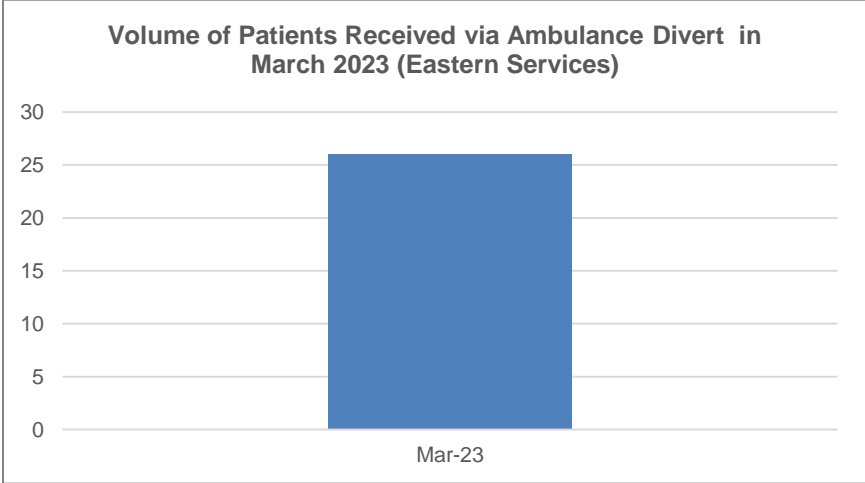
Quality & Safety

Our People

Finance

# Trust – Provision of System Support for UEC

	Number of Requested Diverts	Number of Diverts Agreed	Number of Diverts Declined	Number of Diverts Requested by UHP	Number of Diverts Requested by T&SD	Number of Diverts Requested by Others
January 2023	18	10	8	7	10	1
February 2023	4	2	2	2	1	1
March 2023	23	17	6	18	0	5



# Trust – Provision of System Support for Planned Care

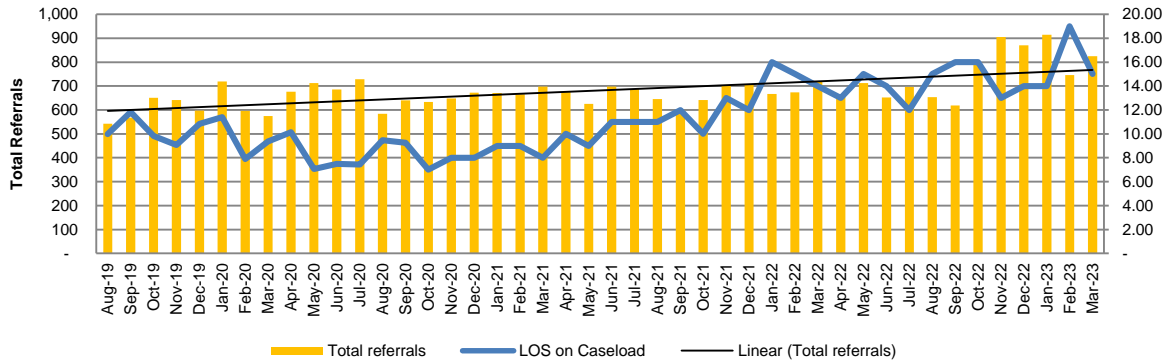
	Number of Mutual Aid Requests				
	Received	Completed	Declined	Ongoing	Under Consideration
April 2022 – March 2023	10	1	6	2	1
April 2023	1				1

- Activity & Flow
- Operational Performance
- Patient Experience
- Quality & Safety
- Our People
- Finance

# Trust Urgent Community Response

Admission avoidance and discharge

UCR Referrals & Length of stay on Caseload



## UCR Demand and Performance

- Demand for UCR (admission avoidance and supporting discharge) increased from February but remained below the November – January peak in activity. In the three months to end of March 2023, there has been a 20.7% increase in the number of referrals compared with the same period last year.

### Eastern:

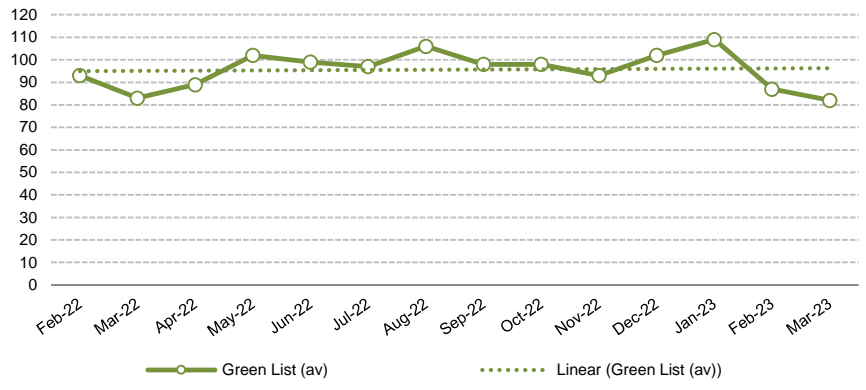
- Length of stay has decreased from an average of 15 days compared with 19 days in February, and compared with 14 days in March 2022. This reduction is due to proactive management of the caseload.
- There were 273 admission avoidance referrals in March, 41 of which needed a two hour response. 86% of these referrals were responded to within two hours.
- There were 19 referrals by SWAST. This increase is a positive and work will continue with SWAST to increase referrals from this pathway.

### Northern:

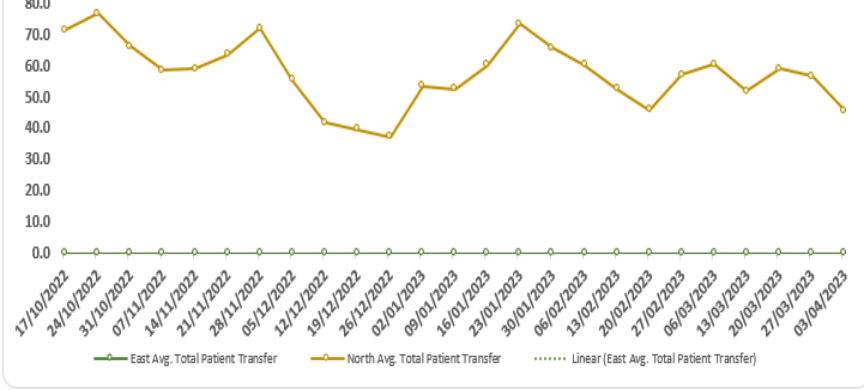
- There were 46 referrals for admission avoidance in March, 26 of which required a 2 hour response – 92% of these received the response within the 2 hours
- There was an increase in SWAST referrals to 18 referrals in March, up from 5 in February and the largest number since the pathway went live in November. This is following support to SWAST to increase the number of referrals and links between SWASTs education and triaging team to promote the UCR service

# Trust Discharge

Daily Average Green (Medically Fit) Transfer List Total - Eastern



Daily Average Green (Medically Fit) Transfer List Total - Northern



## Flow Performance

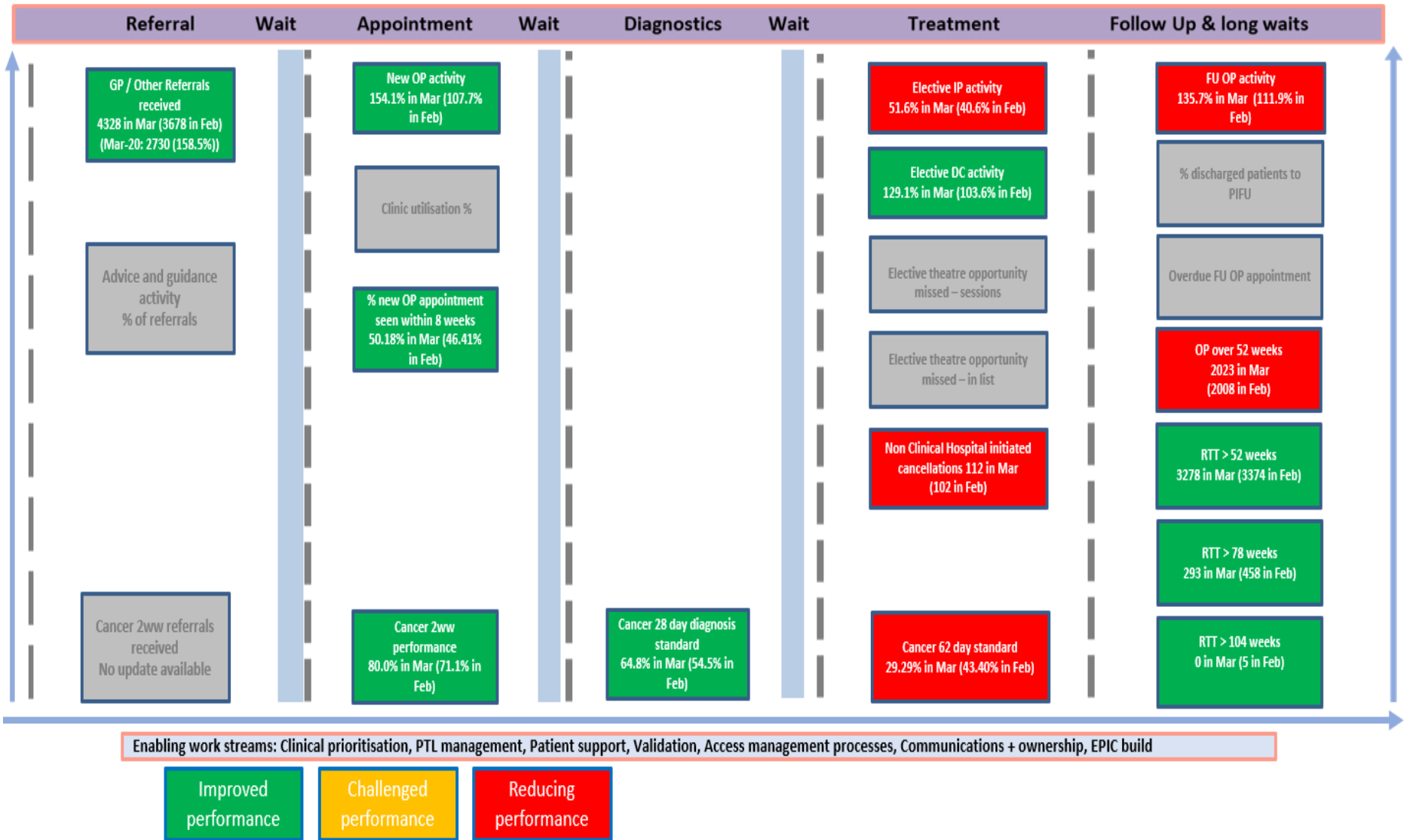
- Overall the average green to go decreased in both Northern and Eastern through March 2023. This is due to a number of complex reasons including improvements in some processes, infection control issues meaning that patients were not “green” to be discharged, and a reduction in demand for complex discharges.
- Eastern: Time to transfer improved across all pathways as follows - Pathway 1 was 2.5 days (against national target of 2 days), Pathway 2 was 6.5 days and Pathway 3 4.3 days. This is the best performance for Pathway 1 for the past 12 months and Pathway 3 for the past 12 months. For Pathway 2, this position has improved from the previous month and is below average for the previous 12 months but remains challenged due to the availability of short term placements.
- Northern: The national target for Pathway 1 Time To Transfer of 2 days was achieved for March. The demand for Pathway 2 has increased in parallel with additional capacity coming online and as a result the Time To Transfer average was 5 days. Performance in Pathway 3 has improved and is averaging at 5 days.
- There are ongoing risks around the wider system funding to support effective flow out of acute and community beds. The Trust has been liaising closely with the ICB and DCC to extend funding for the highest impact services support in particular the agency support for Pathway 1 in areas with high vacancies, Live in Carer to support complex discharges and weekend working for teams that support complex discharge and sourcing of care home placements.

## Actions to Improve performance

- In both Northern and Eastern sites we have had increased focus on the daily performance and flow across all three discharge pathways. This has helped to improve the communication and real time escalation of issues between community and acute teams, to minimise delays to discharge.
- Working with the Epic team to review daily flow dashboards to ensure scrutiny on the accuracy of Estimated Date of Discharge to improve discharge predictions and performance against the improvement trajectory, in order to achieve the No Criteria To Reside (NCTR) target of 5%.
- Test of change being worked up for 6 months across Northern and Eastern to implement the national guidance and a more consistent and proactive approach of the discharge teams.

# Northern Services Planned Care Metrics 2022-2023

Data: January, February & March 2023



Data : March 2023

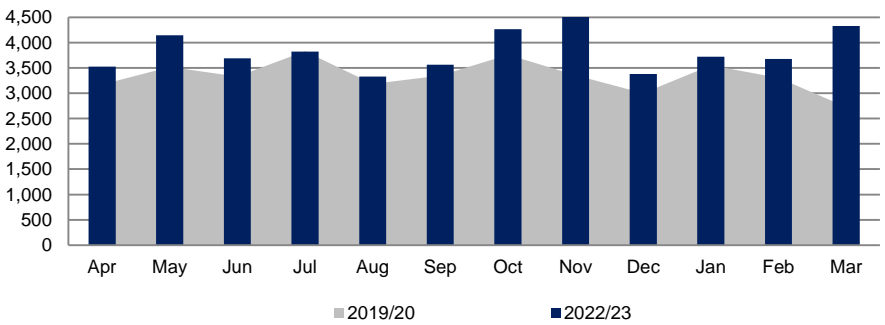


Enabling work streams: Clinical prioritisation, PTL management, Patient support, Validation, Access management processes, Communications + ownership, EPIC build

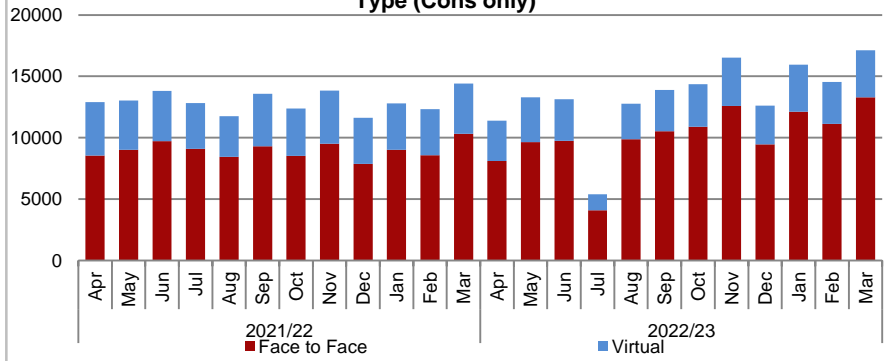


# Northern Services Elective Activity- Referrals and Outpatients

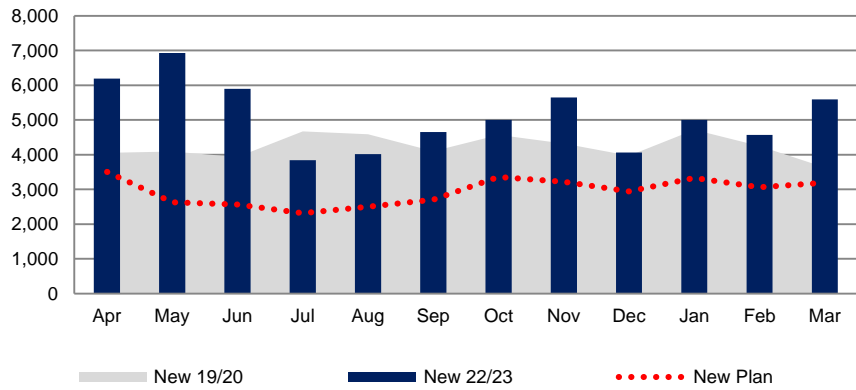
Referrals from All Sources (cons only)



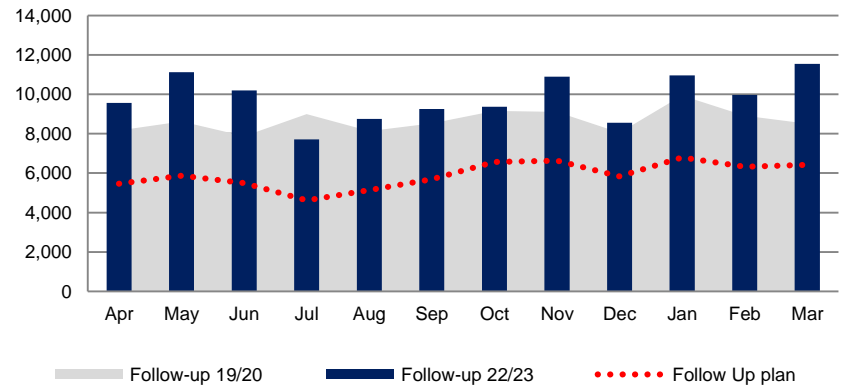
Outpatient Attendances (New and Follow-up) by Appointment Type (Cons only)



Outpatient Activity (NEW)

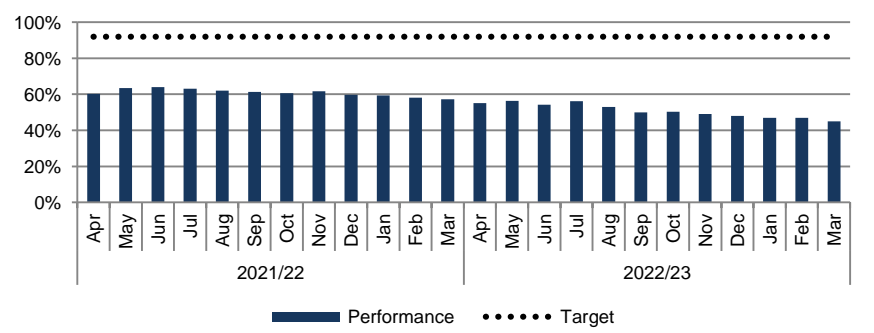


Outpatient Activity (FOLLOW-UP)



- There were a total of 17,684 Outpatients appointments held in March. Of this 17684, 5590 were New appointments and 11535 were Follow-up appointments.
- We are now able to report on Face to Face and Virtual appointments, 77.5% of appointments were held Face to Face and 22.5% were Virtual appointments.
- There was a slight decline in RTT 18 week performance in March. The focus remained on reducing the amount of 104 and 78 week waits in order to reach the target of zero 104 week waiting patients at year end. We were also under trajectory for the number of patients waiting 78 weeks at the end of March.
- As these numbers reduce focus is moving to 65 weeks wait in line with the national aspiration to have no patients waiting over 65 weeks by March 2024.

RTT 18 Week Performance



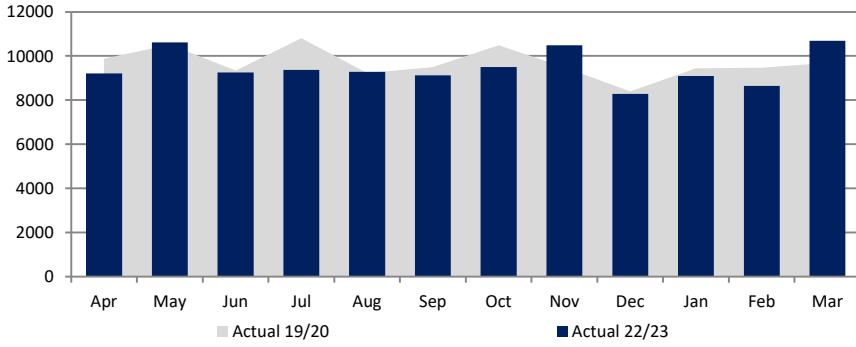


# Eastern Services Elective Activity- Referrals and Outpatients

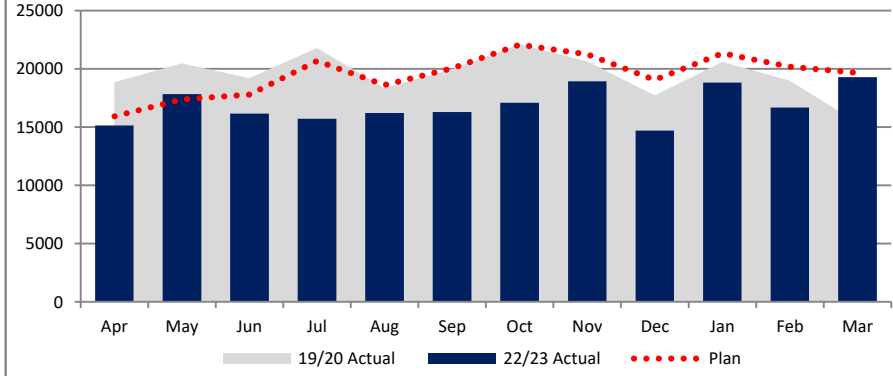


## Referrals

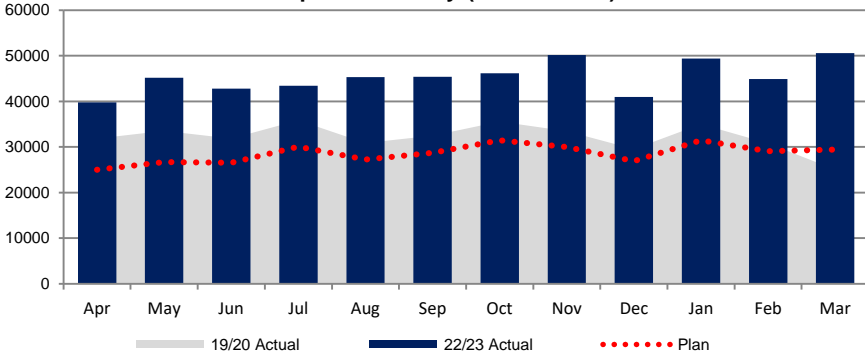
Consultant Led. Excl Community



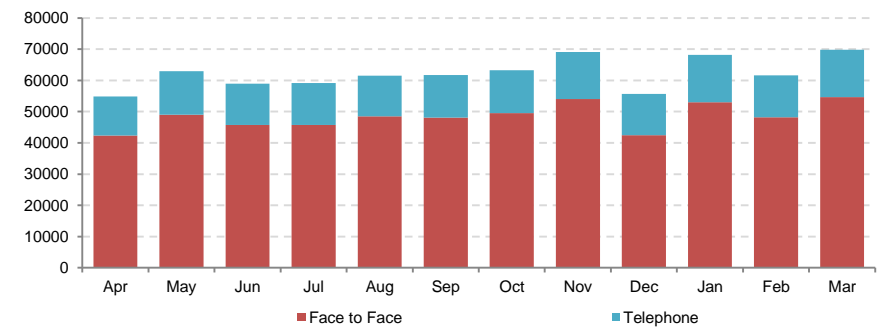
## Outpatient Activity (NEW)



## Outpatient Activity (FOLLOW-UP)



## Outpatient Attendances (New and Follow-up) by Appointment Type



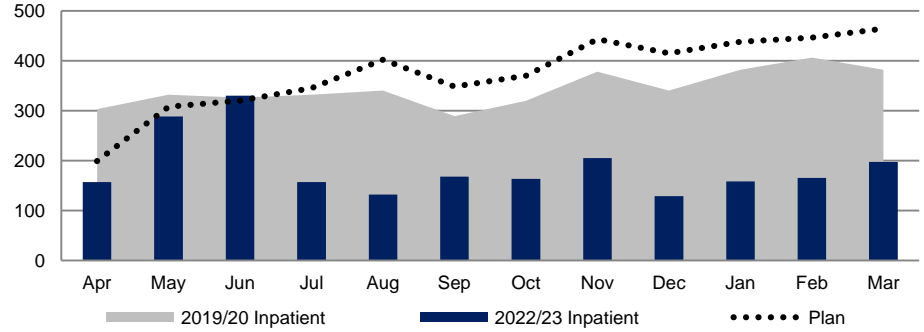
**Outpatient new:** March activity is showing as 125% of 2019/20 volumes, which is skewed due to the impact of Covid in March 2020. On an adjusted basis, the 2019/20 % is 97%, which is still very positive and was the highest volume of activity reported in the 2022/23 year. This position is driven by two major factors:

- Data quality capture: a significant increase in Ophthalmology activity reported as new Outpatients following a data quality review. This review has focussed on ensuring activity is recorded correctly in Epic as a new or follow up appointment.
- Increased activity: the vast majority of services saw an increased volume of activity in March, but specifically the surgical specialties where a number of additional clinics were put in place focussing on longer waiting patients.

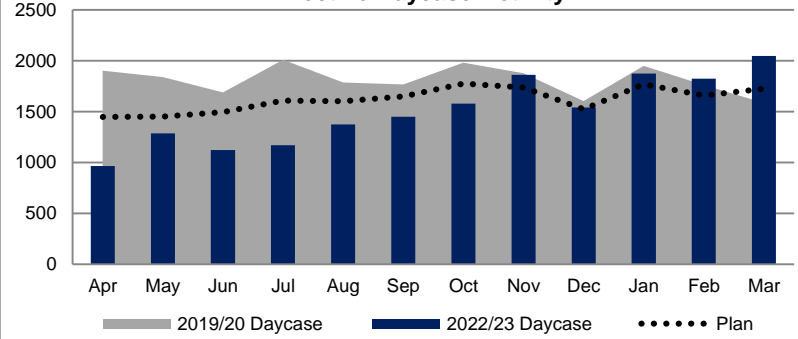
**Outpatient follow up:** March activity is showing as 202% of 2019/20, but would be 154% when adjusted for Covid in March 2020. This is still a relatively high volume of activity, and was largely driven by the same factors as above regarding higher volumes of clinical activity in March. In the 2023/24 year we expect the volume of Outpatient follow ups to reduce from this level as the accuracy of outpatient procedures improve.

# Northern Services Elective Activity- Inpatient and Daycase

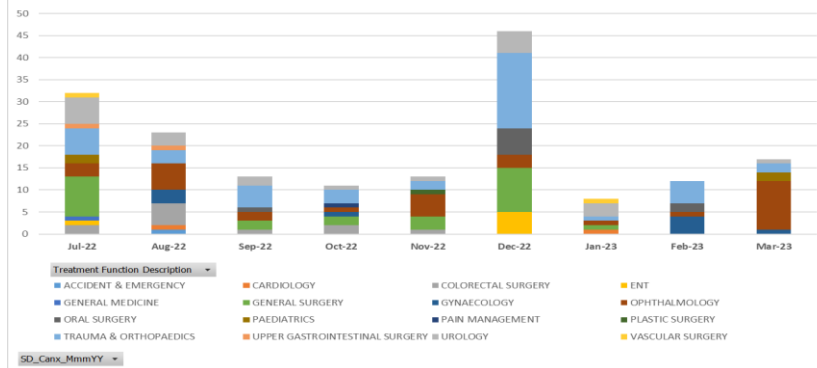
**Elective Inpatient Activity**



**Elective Daycase Activity**



**Elective Same Day Cancellations - Hospital Initiated (Non-Clinical Reasons)**

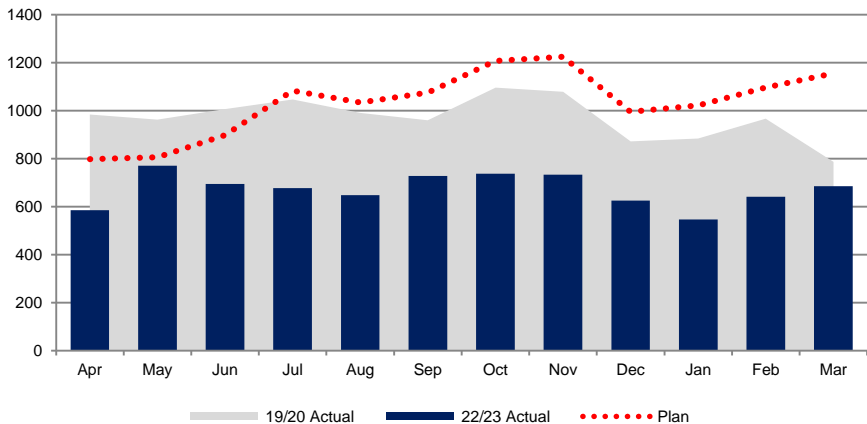


- Highest clinical priority patients and long waiting patients continue to be monitored weekly via the Patient Tracking Meeting (PTL).
- On the 20<sup>th</sup> March Northern Services remained extremely escalated and there was a requirement to escalate into both our Endoscopy and Day Surgery areas.
- Elective Inpatient activity increased during March by 32 and Day case activity increased during January by 222. Given the length of time that Northern Services remained in Opel 4 during March we were still able to maintain a good level of Elective activity despite the many challenges.
- Industrial action by junior doctors for a period of 72 hours in March led to the cancellation of a relatively small number of elective and day case patients.

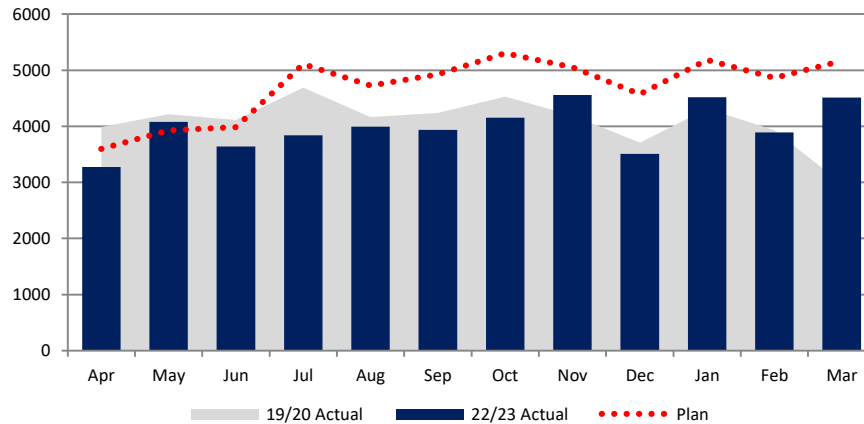


# Eastern Services Elective Activity- Inpatient and Daycase

### Elective Inpatient Activity



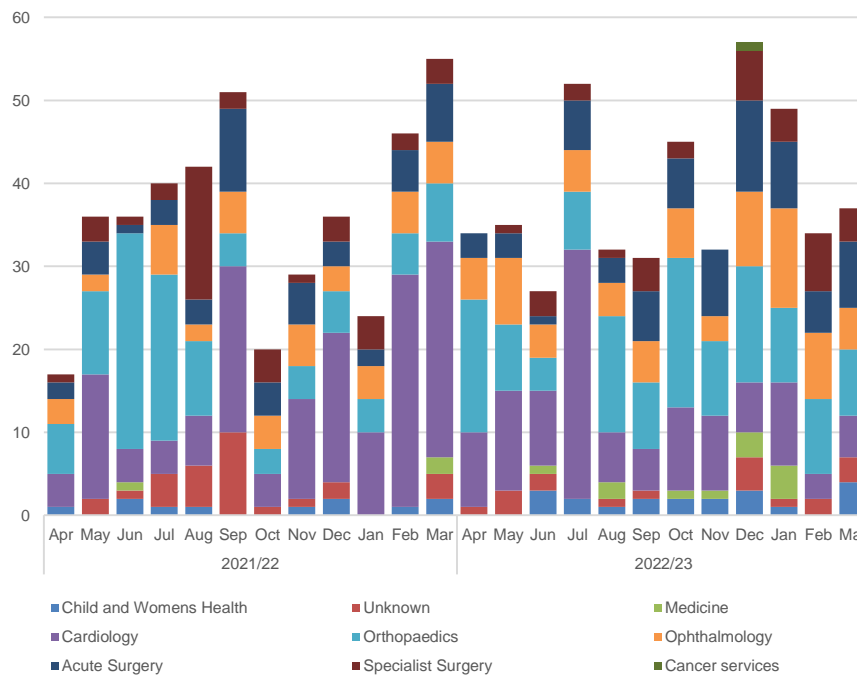
### Daycase Activity



Elective inpatient and daycase activity increased on February's position as expected. The Inpatient position was 87% of 2019/20 but would be 70% when adjusted for March 2020 Covid volumes. Daycase activity was 151% but would reduce to 108% on an adjusted basis. These are still very positive volumes and reflects a genuine run rate improvement on elective recovery.

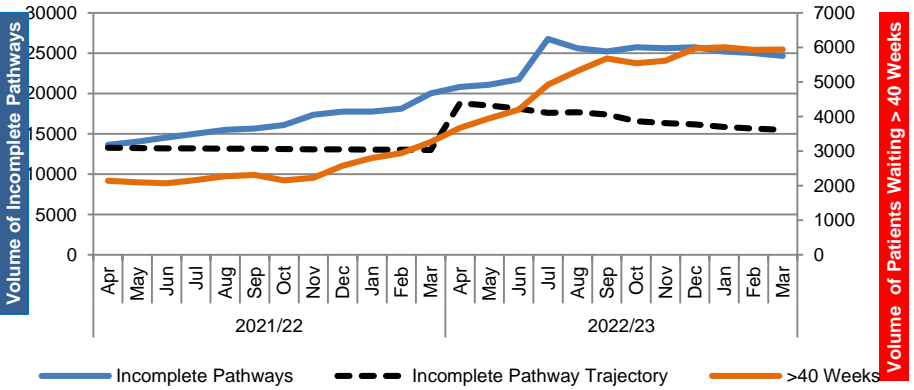
Major contributors were General Surgery, Ophthalmology and Orthopaedics, all of which put on additional sessions in March and provides a positive position for moving into the 2023/24 year.

### Elective Same Day Cancellations : Hospital

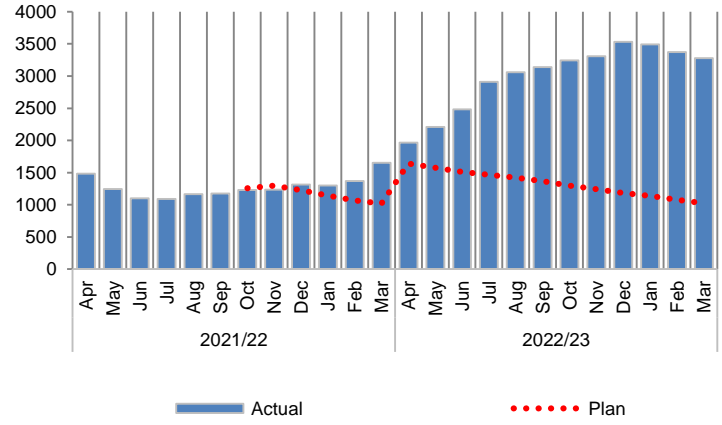


# Northern Services Elective Activity- Long Waiting Patients

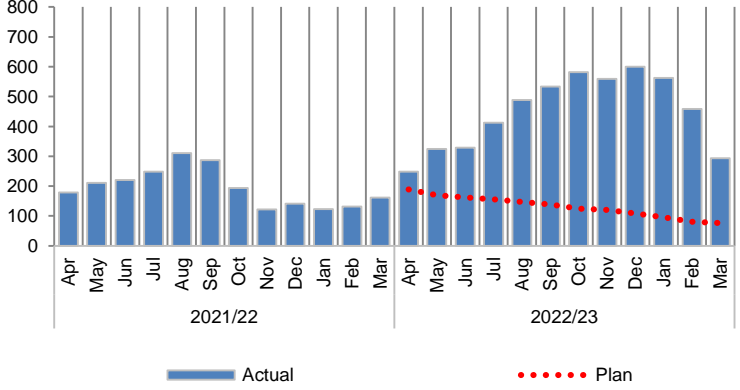
### Incomplete Pathways and Longer Waiting Patients



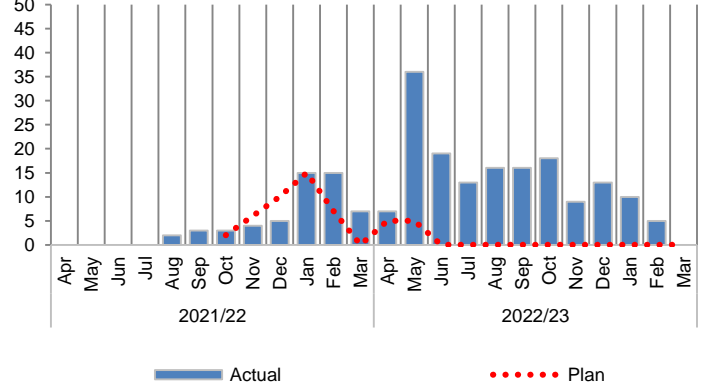
### RTT 52+ Weeks Waited



### RTT 78+ Weeks Waited



### RTT 104+ Weeks Waited



- In addition to regular meetings to monitor and improve RTT, twice weekly meetings were held throughout March with the Divisional Directors to ensure that the target of 0 patients waiting over 104 weeks for treatment was met.
- We continue to ensure that we are well under Trajectory for patients waiting 78 weeks. The number of patients waiting both 78 and 52 weeks continues to decrease, regular meetings are still be held to ensure that the focus still remains on these areas.



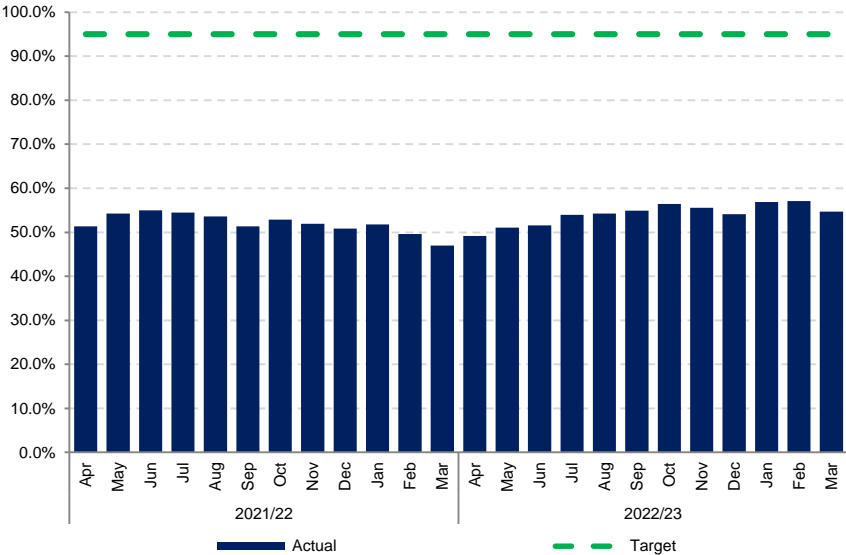
# Northern Services Elective Activity- Long Waiting Patients Continued

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	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	
40+ weeks	T & O	525	457	426	459	478	480	415	482	525	599	600	675	765	812	814	951	1008	1075	1018	958	985	948	902	854
	General Surgery	39	51	51	56	71	78	71	74	75	81	80	102	117	115	126	141	146	146	144	148	147	152	141	147
	Dermatology	56	62	58	71	97	126	133	151	186	215	232	277	316	335	349	387	406	413	385	338	312	327	292	357
	Gynaecology	160	159	170	187	198	192	191	180	203	203	207	210	227	263	312	381	485	501	500	567	614	632	688	694
	Neurology	95	114	125	119	89	67	54	75	94	114	125	131	154	169	158	192	193	189	158	139	159	155	153	153
	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	236	286	317	345	350	384
	Ophthalmology	605	613	620	654	694	709	690	657	798	838	897	977	1088	1102	1149	1255	1252	1252	1239	1214	1246	1227	1183	1076
	Other	345	323	309	307	304	314	286	293	338	379	390	446	510	627	699	1043	1233	1413	1423	1473	1675	1704	1712	1764
	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	431	485	510	511	502	508
<b>Grand Total</b>	<b>2144</b>	<b>2097</b>	<b>2072</b>	<b>2159</b>	<b>2272</b>	<b>2310</b>	<b>2149</b>	<b>2229</b>	<b>2578</b>	<b>2800</b>	<b>2938</b>	<b>3261</b>	<b>3673</b>	<b>3949</b>	<b>4199</b>	<b>4922</b>	<b>5320</b>	<b>5676</b>	<b>5534</b>	<b>5608</b>	<b>5965</b>	<b>6001</b>	<b>5923</b>	<b>5937</b>	
52+ weeks	T & O	416	327	260	225	221	222	225	244	267	312	344	391	460	522	529	594	590	594	596	552	600	570	522	503
	Neurology	35	44	52	55	44	32	31	36	29	28	40	43	57	74	69	93	110	116	117	85	85	74	79	65
	Cardiology	8	6	5	1	2	7	12	12	10	10	11	15	13	23	27	37	42	72	92	130	164	168	198	215
	Ophthalmology	492	393	311	323	458	373	371	367	401	390	336	459	561	632	720	865	824	823	831	800	820	754	675	560
	Other	425	352	353	366	315	414	438	454	490	436	504	594	694	757	903	1055	1208	1248	1331	1434	1536	1578	1539	1562
	Urology	108	122	118	124	127	134	120	126	119	125	132	153	182	204	235	268	284	284	279	306	326	347	361	373
<b>Grand Total</b>	<b>1484</b>	<b>1244</b>	<b>1099</b>	<b>1091</b>	<b>1167</b>	<b>1174</b>	<b>1230</b>	<b>1235</b>	<b>1316</b>	<b>1301</b>	<b>1367</b>	<b>1655</b>	<b>1967</b>	<b>2212</b>	<b>2483</b>	<b>2912</b>	<b>3058</b>	<b>3137</b>	<b>3246</b>	<b>3307</b>	<b>3531</b>	<b>3491</b>	<b>3374</b>	<b>3278</b>	
78+ weeks	T & O	47	49	55	51	63	62	42	23	22	41	21	33	65	126	97	114	137	140	130	106	118	104	91	56
	Neurology	0	2	1	1	3	9	5	3	2	3	3	3	5	6	5	7	10	7	15	12	12	10	5	3
	Cardiology	0	0	0	1	0	1	0	0	0	0	0	0	2	1	0	0	1	1	4	5	4	1	2	1
	Ophthalmology	72	82	78	93	106	86	45	18	16	19	17	27	44	33	43	58	54	85	116	140	148	151	109	51
	Other	39	50	58	69	98	90	79	49	72	28	58	62	89	106	134	170	204	238	251	226	240	220	189	120
	Urology	21	28	28	33	41	39	23	29	29	32	32	37	43	53	50	63	65	62	66	70	78	76	62	62
<b>Grand Total</b>	<b>179</b>	<b>211</b>	<b>220</b>	<b>248</b>	<b>311</b>	<b>287</b>	<b>194</b>	<b>122</b>	<b>141</b>	<b>123</b>	<b>131</b>	<b>162</b>	<b>248</b>	<b>325</b>	<b>329</b>	<b>412</b>	<b>471</b>	<b>533</b>	<b>582</b>	<b>559</b>	<b>600</b>	<b>562</b>	<b>458</b>	<b>293</b>	
104+ weeks	T & O	0	0	0	0	0	1	0	0	0	1	0	3	2	28	13	5	6	5	5	1	0	0	1	0
	Neurology	0	0	0	0	0	0	0	1	1	0	0	1	1	1	1	1	1	0	1	0	1	0	0	0
	Cardiology	0	0	0	0	0	0	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	1	3	2	0	0	0
	Other	0	0	0	0	2	1	3	2	3	9	10	3	3	4	1	2	2	4	8	1	7	6	3	0
	Urology	0	0	0	0	0	1	0	0	0	0	1	0	0	3	4	4	4	5	3	4	3	4	1	0
<b>Grand Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>3</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>15</b>	<b>15</b>	<b>7</b>	<b>7</b>	<b>36</b>	<b>19</b>	<b>13</b>	<b>15</b>	<b>16</b>	<b>18</b>	<b>9</b>	<b>13</b>	<b>10</b>	<b>5</b>	<b>0</b>	

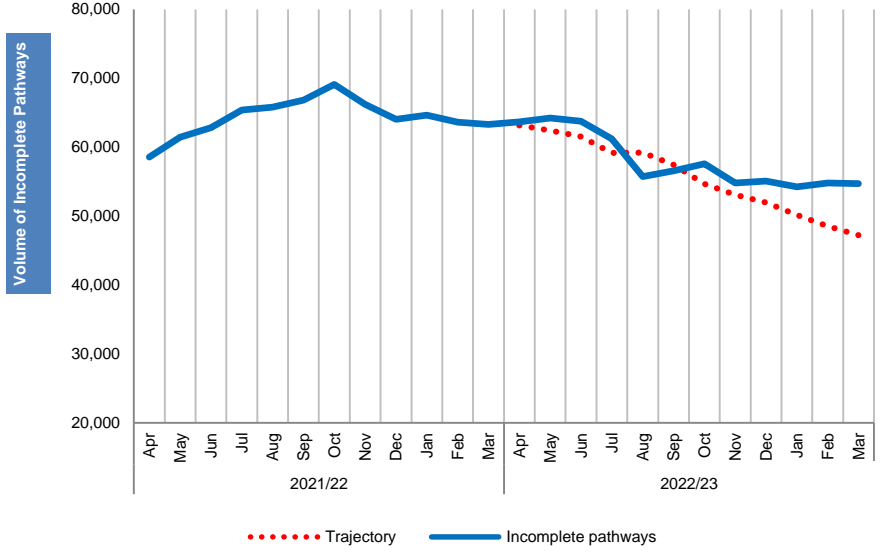


# Eastern Services Elective Activity- Inpatient and Daycase

### RTT 18 Week Performance



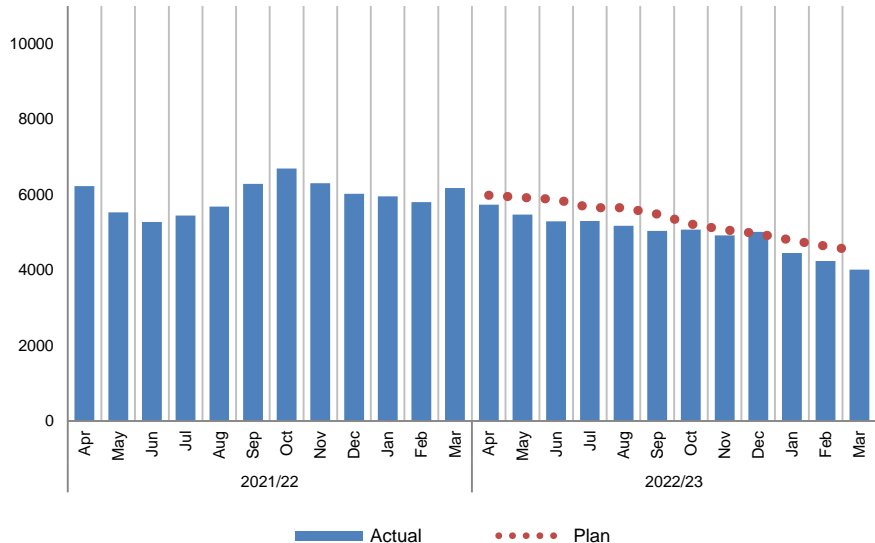
### Incomplete Pathways



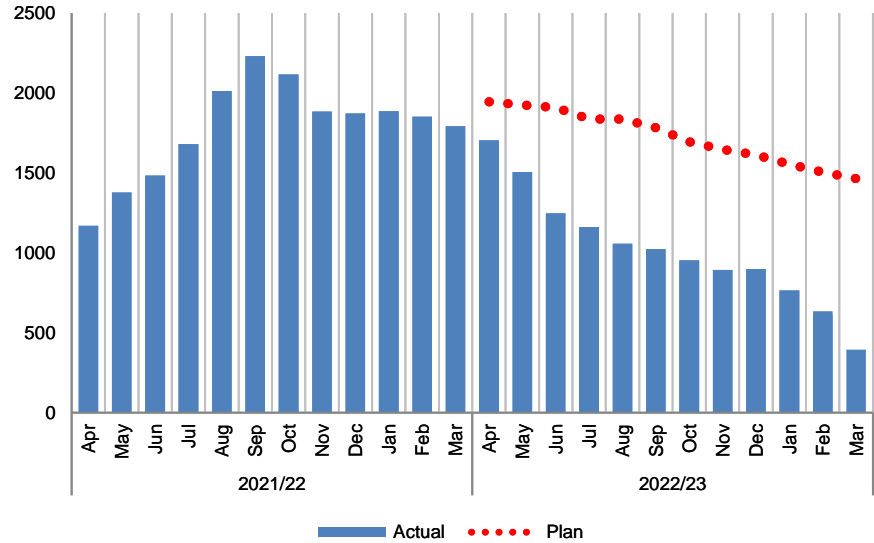
The volume of incomplete pathways reduced (improved) slightly on the February position.

# Eastern Services Elective Activity – Long Waiting Patients

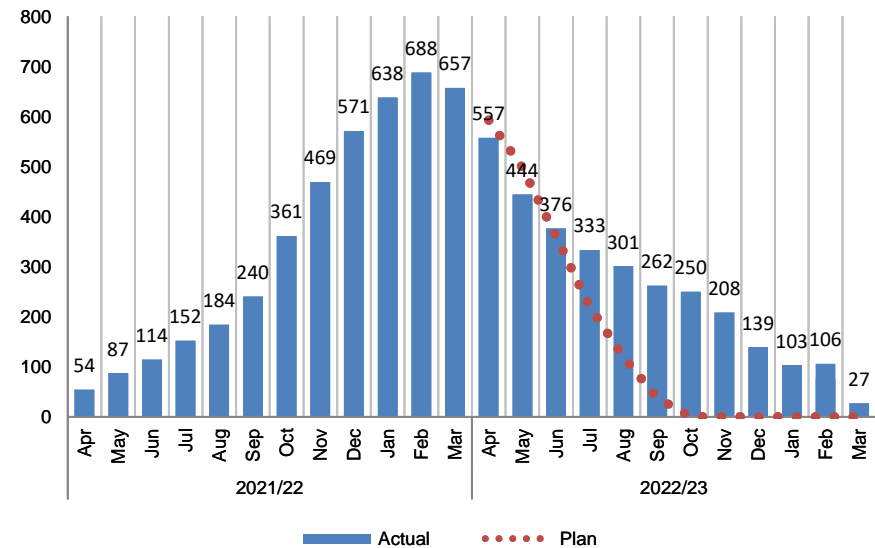
### RTT 52+ Weeks Waited



### RTT 78 + Weeks Waited



### RTT 104+ Weeks Waited



The volume of long waiting patients continued to improve in March across all waiting groups, with 104+ waits down to 27 patients from a starting position in March 2022 of 657. The 2023/24 operational plan shows an expectation of having no more 104+ waits by June 2024 and a continued improvement in the 78+ position.

# Eastern Services Elective Activity- Long Waiting Patients

Activity & Flow  
Operational Performance  
Patient Experience  
Quality & Safety  
Our People  
Finance

Specialty	2021/22												2022/23												
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
52+ weeks	Orthopaedics	1859	1720	1628	1535	1482	1533	1595	1617	1610	1537	1492	1568	1499	1416	1364	1419	1374	1436	1487	1478	1402	1237	1062	893
	Cardiology	414	399	417	407	418	491	530	484	442	414	377	416	429	457	487	520	545	482	428	457	489	443	461	418
	Ophthalmology	1315	1013	941	1046	1212	1399	1489	1456	1610	1404	1365	1608	1345	1164	929	858	688	578	546	452	458	399	390	386
	Colorectal Surgery	445	437	437	448	455	451	498	514	526	553	517	523	526	593	609	618	546	508	513	535	538	541	558	513
	Upper GI	80	86	76	81	94	95	114	99	91	102	107	106	104	104	109	113	101	101	127	140	161	152	140	107
	Total	6224	5531	5272	5445	5682	6284	6691	6299	6021	5952	5802	6173	5731	5473	5289	5298	5173	5034	5074	4920	5008	4449	4236	4010
78+ weeks	Orthopaedics	581	654	697	698	761	810	782	775	843	846	827	820	773	684	584	528	472	457	417	387	339	281	228	142
	Cardiology	108	111	120	126	152	165	175	137	121	134	138	133	153	149	134	129	130	121	94	113	125	121	96	64
	Ophthalmology	61	70	91	137	279	384	343	264	246	307	325	331	271	223	155	140	94	77	80	53	64	45	37	19
	Colorectal Surgery	128	172	175	195	219	233	250	252	260	248	221	183	188	183	149	153	127	119	120	127	127	128	102	81
	Upper GI	23	22	21	23	34	34	35	29	22	19	21	22	30	22	19	28	22	22	29	32	38	41	37	17
	Total	1170	1377	1483	1679	2013	2231	2117	1884	1873	1887	1853	1791	1704	1505	1248	1162	1058	1023	952	892	899	765	635	395
104+ Weeks	Orthopaedics	23	35	47	65	81	114	178	252	340	397	437	445	364	299	261	230	191	162	153	124	72	50	48	10
	Cardiology	6	12	23	28	25	27	46	51	49	59	63	57	58	45	32	31	22	16	12	14	9	10	10	0
	Ophthalmology	0	0	0	0	1	4	6	12	18	18	30	24	13	8	2	6	9	8	5	4	5	2	5	1
	Colorectal Surgery	19	23	28	34	38	41	54	64	75	87	80	75	67	63	46	42	45	42	48	33	26	19	19	13
	Upper GI	1	2	0	2	3	3	7	4	4	2	2	3	2	4	1	1	1	0	0	3	5	5	4	2
	Total	54	87	114	152	184	240	361	469	571	638	688	657	557	444	376	333	301	262	250	208	139	103	106	27



# Northern Services Waiting Well

March 2023 Waiting Well Northern Incidents	None	Minor	Moderate	Major	Total
Follow up delay	5	0	0	0	5
Surgery	1	0	1	0	2
New	0	0	0	0	0
Diagnostic request delay	0	0	0	0	0
<b>Total</b>	<b>6</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>7</b>

5 of the 6 incidents with no/minor harm related to validation of Stroke follow up waiting list. Patients have now been booked as a matter of urgency.

1 patient recorded as moderate harm relate to a delayed elective procedure and is currently under investigation.

## Patient survey support key aims

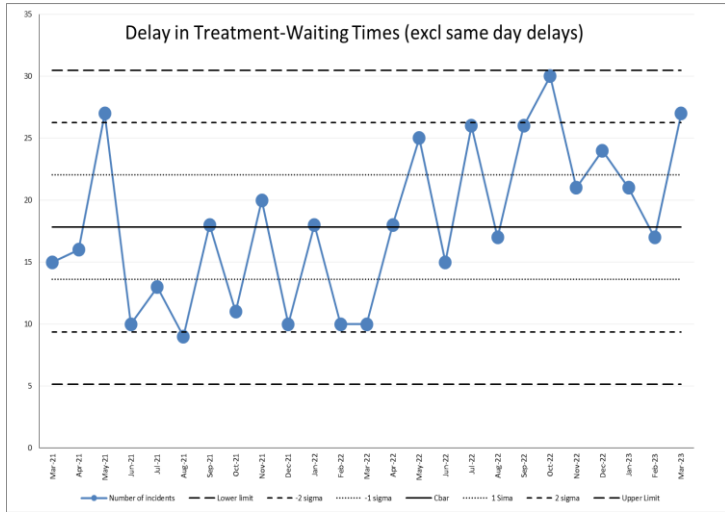
- Identify any patients who no longer want or need to be on a waiting list (patient validation)
- Ensure patients are empowered to seek appropriate help from the health system when needed
- Refer any identified patients that need further community support to local voluntary sector organisation(s)
- The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

<b>Patients Sent Survey</b>	<b>15271</b>
Completed Survey	11804
No response (all contact methods tried)	2309
Work In Progress	1158
<b>Outcome of completed Survey's</b>	
Remove from WL	1735
Remain on list with clinical review	1306
Remain on list and referred for community lifestyle support and advice	1772
Remain on list	6,991

- Some delays to patient surveys this month due to funding issues with community lifestyle support services. These are now resolved and funding is agreed for another year. DRSS have a recovery plan in place.
- Increased volumes of surveys planned for northern and eastern, working toward regular survey (every 3 months) of any patient over 26 weeks wait.

# Eastern Services Waiting Well

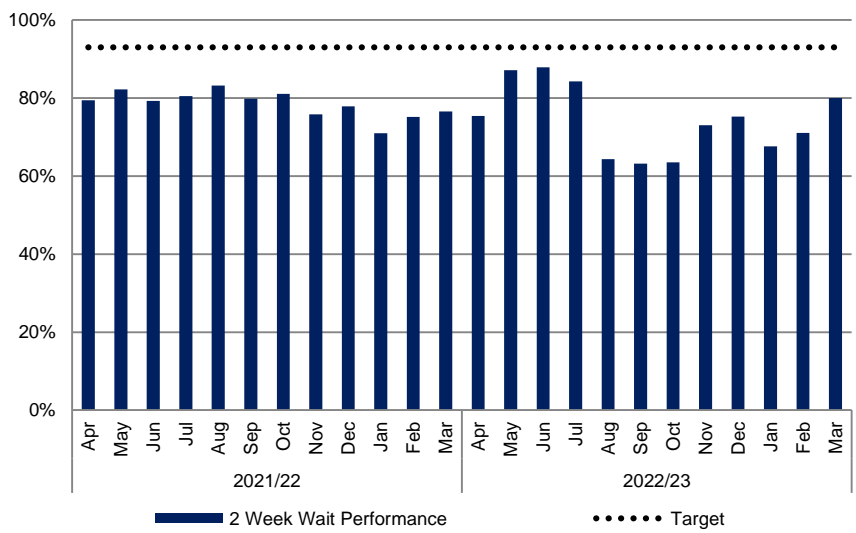
Across the same time period in Eastern 27 incidents were reported for March 2023, these are broken down by the level of harm against stage of pathway below.



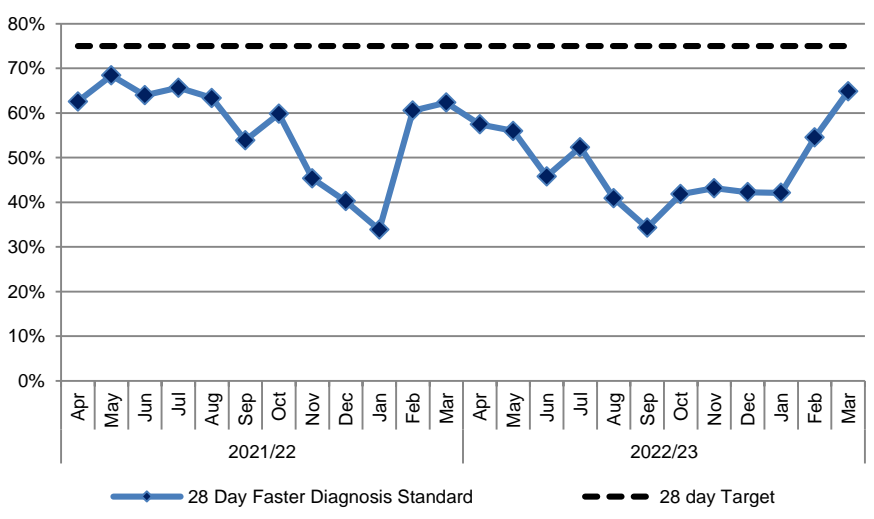
	None	Minor	Moderate	Major	Catastrophic	Total
Follow up delay	6	4				10
New	3	6				9
Diagnostic request delay	1	3				4
Surgery	4					4
<b>Total</b>	<b>14</b>	<b>13</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>27</b>

# Northern Services Cancer 14 and 28 Day

### 2 Week Wait Performance



### 28 Day Faster Diagnosis Standard



## 2 Week Wait Performance

2WW performance continues to increase across most tumour sites:

- Urology has improved from 35% (60 breaches) in January to 87% (13 breaches) in March following improvements in waiting times for one stop Haematuria clinics.
- Gynaecology has improved from 52% (54 breaches) in January to 97% (2 breaches) in March which reflects the additional 16 2WW clinics run in Q4 22/23.
- Breast position is currently at 69% (52 breaches) in March and is being closely monitored with additional clinics being arranged as appropriate.
- 2WW performance in March for Colorectal is 83%. - at present locum consultant post remains out to advert and substantive consultant post agreed and will be out for advert in near future.
- All services are working to reduce first out patient waiting times to 7 days .

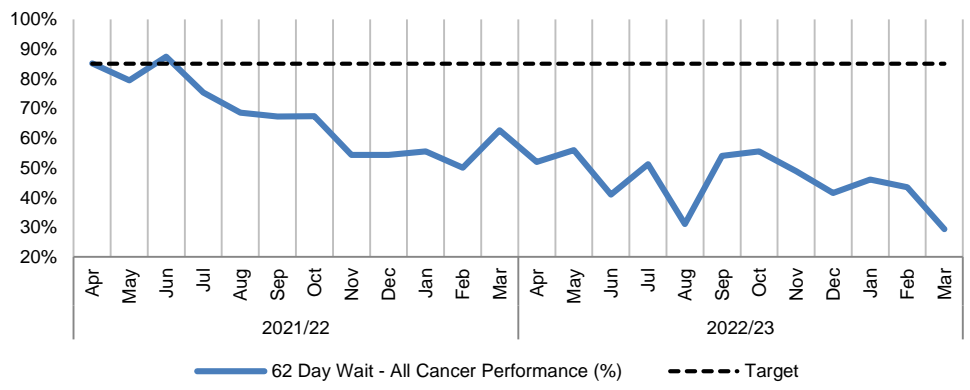
## 28 Day Faster Diagnosis Standard

- 2ww performance is directly impacting on ability to confirm diagnosis within 28 days therefore the improvement in 2 week wait performance has led to an overall improvement in the 28 day standard however some tumour sites are not achieving the national target of 75% for 28 day FDS at present. Action plans to support the delivery of this are being monitored as part of the Trust's Cancer Recovery Action Plan via the Northern Cancer Steering group.
- Gynaecology – has seen an increase in 28 day performance over the last few months and achieved 78% in March. The additional diagnostic capacity clinics delivered in Q4 22/23 have supported this recovery.
- Urology – 28 day performance has improved from 19% (79 breaches) in January to 44% (44 breaches) in March. Actions to support this improvement include - additional cystoscopy clinics, training of additional staff to perform LATPs and additional lists sourced to support LAMP turnaround times. The prostate pathway has been revised and went live from the middle of February.
- Colorectal - Although an improving picture, not achieving target of 75%. Breaches have increased as a result of delays accessing endoscopy for colonoscopy. Plans are in place to insource additional endoscopy capacity.



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

**Urgent GP Referral Cancer 62 Day Wait - All Cancers**



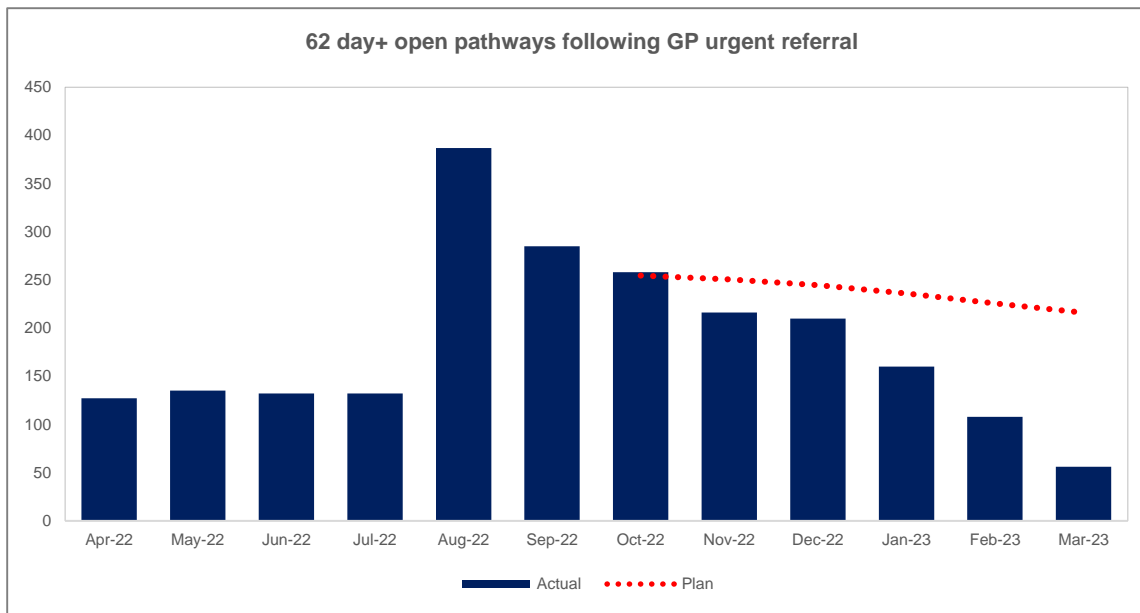
- The majority of pathway delays are within the diagnostic phase, particularly in Urology and Colorectal tumour sites.
- 62 day performance will improve with actions aligned to deliver 28 FDS and 2WW performance.
- Capacity remains a challenge across some specialties including Oncology where currently there are delays for new patient appointments and treatments.
- Patients are monitored throughout their 62 day pathway regularly and weekly site specific PTL meetings are in place for all tumour sites.
- Every service has an up to date Cancer Recovery Action Plan with specific actions against delivery of each of the national CWT indicators where operational standards are not being achieved. These are monitored at the Northern Cancer Steering Group.

Cancer - 14,31 & 62 Day Wait		Performance(%) and Number of Breaches																								
		Target	2021/22												2022/23											
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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%	63.23%	63.50%	72.86%	75.40%	67.66%	71.89%	80.77%
	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	285	254	224	152	229	199	154
	Symptomatic Breast (%)	93%	6.56%	1.56%	0.00%	8.16%	0.00%	2.17%	0.00%	3.57%	1.75%	3.64%	7.58%	2.67%	8.70%	71.74%	79.31%	100.00%	0.00%	100.00%	100.00%	83.33%	75.00%	35.71%	42.60%	57.14%
	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	0	1	0	0	2	4	9	12	12
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%	96.30%	97.37%	97.30%	81.82%	92.86%	80.56%	84.21%	90.00%	87.30%
	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	1	1	1	6	8	14	12	7	8
	Subsequent - Surgery (%)	94%	91.60%	94.11%	100.00%	90.00%	66.66%	60.00%	66.66%	91.66%	55.55%	41.66%	75.00%	71.42%	54.54%	20.00%	40.00%	100.00%	100.00%	100.00%	50.00%	60.00%	68.75%	62.50%	31.25%	31.58%
	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	0	0	0	3	4	11	6	11	13
	Subsequent - Anti-Cancer Drug (%)	98%	100.00%	100.00%	100.00%	95.65%	83.33%	96.60%	92.59%	100.00%	95.83%	82.60%	90.32%	96.29%	96.15%	92.60%	94.40%	100%	100%	97%	88%	75%	95%	81%	100%	95.83%
	Subsequent - Anti-Cancer Drug (N)		0.0	0.0	0.0	1.0	5.0	1.0	2.0	0.0	1.0	4.0	4.0	1.0	1.0	2.0	1.0	0	0	1	3	13	3	6	0	1
62 Day	All Screening Service (%)	90%	33.30%	0.00%	33.30%	33.30%	50.00%	44.44%	100.00%	66.60%	100.00%	33.00%	100.00%	28.57%	100.00%	75.00%	100.00%	100%	0%	17%	0%	100%	0%	100%	0%	66.67%
	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	2.5	0.5	0	2	0	1	0	0.5
	Consultant upgrade (%)	90%	72.05%	87.20%	96.25%	89.65%	76.74%	83.60%	67.34%	76.71%	78.73%	73.23%	80.00%	62.00%	57.44%	60.00%	74.50%	66.67%	6.00%	65.22%	75.76%	57.14%	72.73%	64.71%	68.42%	59.26%
	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	6	71.43	8	8	13.5	6	6	6	11
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%	34.31%	41.83%	43.15%	42.27%	42.12%	54.52%	64.83%
	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	270	395	556	381	459	352	255



# Northern Services Cancer 62 Day Backlog

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



- The number of patients on active cancer pathways waiting more than 62 days has reduced from 415 at the start of September to 62 at the most recent weekly PTL (10/4/23).
- The tumour sites with the largest number of patients waiting over 62 days are Urology (30) and Colorectal (9); these numbers have been consistently reducing since January.

### Key actions:

Weekly PTL meetings in place for all tumour sites.

### Colorectal

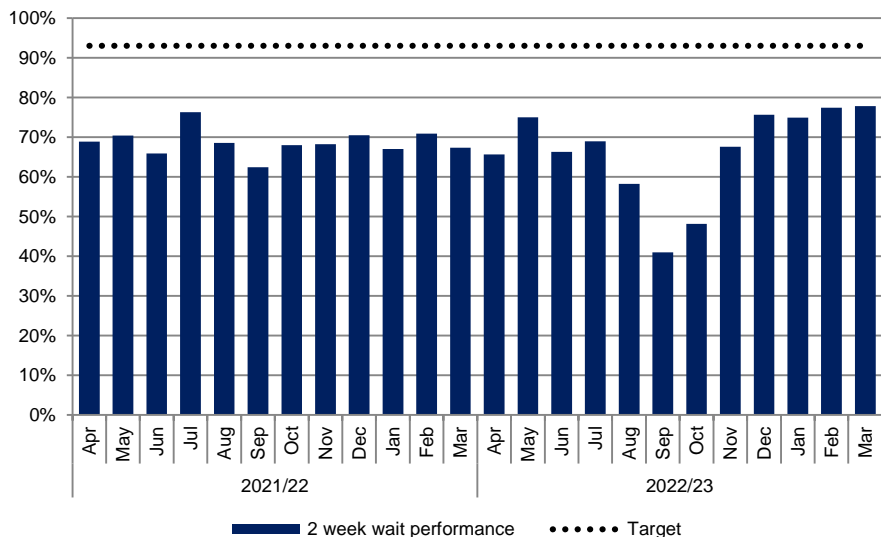
- Endoscopy insourcing in place and further insourcing capacity with additional provider is planned to start in April.
- Locum consultant post out to recruitment

### Urology

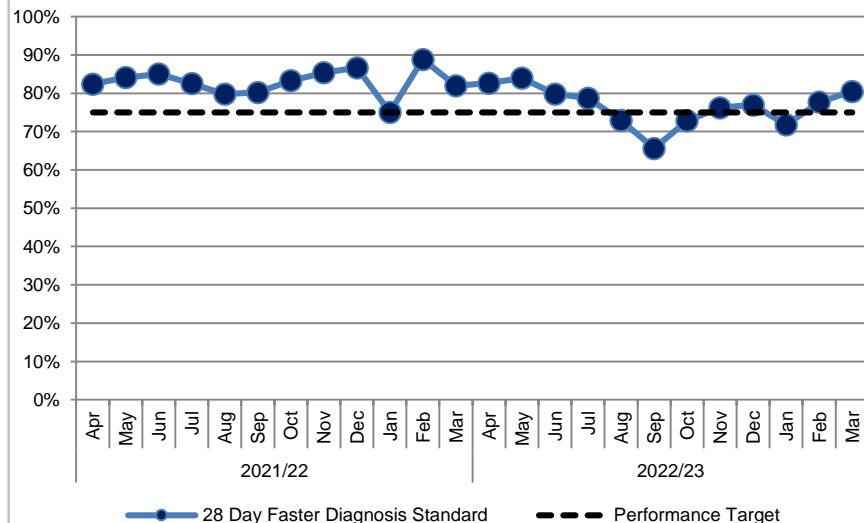
- Medical workforce not currently at full establishment which is impacting on capacity. Locum posts currently out to advert
- LATP biopsy – Additional capacity agreed, staff training in place to increase the number of staff competent to undertake this procedure and reduce waiting times.
- Outsourced cystoscopy capacity was in place throughout Q4 22/23
- Additional Ultrasound capacity aligned with Flexible Cystoscopy capacity has been implemented to support one stop haematuria clinics and reduce waiting times.
- Revised prostate pathway commenced in February and under regular review.

# Eastern Services Cancer 14 and 28 Day

### 2 Week Wait Performance



### 28 Day Faster Diagnosis Standard



## 2 Week Wait Performance

- Performance has been improving since November, although it remains significantly below target due to an imbalance of demand/capacity.
- A significant improvement has been maintained in Breast (28.2% in October and 95.97% in March) which is remarkable considering they have had Consultant sickness for the past 2 Months.
- Skin has seen a reduction in performance (92.6% in January and 87.53% in March).
- Lower GI 2WW performance improved (29.2% in January and 42.89% in March). This is due to staffing within the Nurse Triage team due to training and issues with capacity across Endoscopy and Radiology (as 2/3 of patients go straight to test).

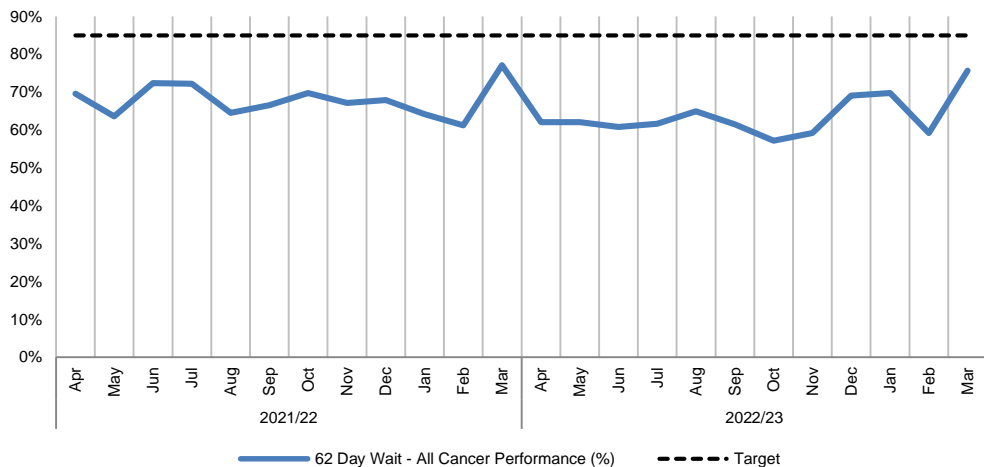
## 28 Day Faster Diagnosis Standard

- Colorectal performance has significantly improved from January (28.2% in January and 50.93% in March) back to expected performance levels. Additional clinics are being sought to improve capacity – this is routinely monitored and a capacity/demand exercise is currently being undertaken across the entire pathway.
- GI currently have 6 of 16 surgeons on long term leave. Some are due to return in the coming weeks and additional locum support has been sought. Building on the work the teams have undertaken in mapping pathways, including demand/capacity, we are adding to action plans on how to ensure different parts of these pathways are better in balance. This remains work in progress.
- Endoscopy capacity issues effect the GI performance. The team are still undertaking waiting list initiatives to increase capacity. A proposal for additional capacity is being planned. In addition to current waiting list initiatives, the Endoscopy Team were granted funding for an additional 20 lists until the end of March.

# Eastern Services Cancer 62 Day

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

### Urgent GP Referral Cancer 62 Day Wait - All Cancers



Performance against the 62 Day Cancer Target increased by 17.03% from February to 75.73% in March.

#### Risks & mitigations

- Theatre capacity remains a significant issue (more complex surgeries/Tertiary patients and an increased demand).
- Delays in Urology due to an increase in demand for RALPs (in part due to Tertiary referrals) – a third surgeon is currently undergoing training on robotics. CNS Team are in process of recruiting which will support and stabilise the service.
- Urology – In March, the Urology team sought mutual aid for RALP patients, with a plan to send 12 patients to Bristol.
- Additional agency staff for Theatres were recruited in March allowing additional lists throughout in order to reduce the backlog of patients waiting beyond breach date. Funding has been secured to continue throughout April.
- Sarcoma – More work needs to be done across the system re these pathways and differences in the offers from each Trust. A joint task force is to be convened by ICB to test deliverability of potential for one stop services at the Nightingale.

### Cancer - 14, 31, 62 & 104 Day Wait

Performance(%) and Number of Breaches		TARGET	2021/22												2022/23											
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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%	75.0%	66.3%	69.0%	58.3%	41.0%	48.2%	67.6%	75.6%	74.9%	77.5%	77.8%
	All Urgent		650	600	833	514	665	841	702	723	642	622	580	781	760	605	762	763	1027	1434	1253	818	488	553	467	562
	Symptomatic Breast (%)	93%	3.7%	14.9%	8.7%	42.0%	30.4%	8.1%	29.0%	11.3%	7.9%	15.8%	35.8%	13.3%	20.9%	35.2%	58.1%	57.4%	62.9%	16.7%	40.5%	72.5%	95.8%	93.9%	100.0%	93.0%
	Symptomatic Breast		52	57	63	29	32	57	49	47	58	48	34	65	34	46	18	20	13	30	25	14	1	2	0	4
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%	86.9%	87.9%	85.4%	89.8%	89.5%	92.2%	87.7%	89.4%	77.4%	84.9%	83.7%
	All Decision To Treat		9	7	18	18	19	24	14	29	22	23	19	19	31	41	34	37	22	21	18	31	25	60	39	70
	Subsequent - Surgery (%)	94%	83.1%	81.9%	77.3%	88.5%	76.5%	87.5%	85.4%	79.5%	72.7%	75.6%	76.5%	62.8%	64.2%	67.1%	76.0%	75.3%	71.2%	61.1%	100.0%	100.0%	100.0%	98.7%	97.4%	64.9%
	Subsequent - Surgery		12	15	17	9	16	11	12	16	24	19	19	29	29	26	25	21	17	28	0	0	0	1	3	33
	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%	95.9%	98.8%	97.6%	98.6%	99.3%	99.3%	99.1%	100.0%	99.1%	99.3%
	Subsequent - Radiotherapy		1	0	4	1	2	1	0	4	0	3	1	1	0	1	4	1	2	1	1	1	1	0	1	1
62 Day	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%	98.6%	100.0%	100.0%	97.5%	100.0%	100.0%	100.0%	100.0%	98.7%	97.4%	94.1%	
	Subsequent - Anti-Cancer Drug		3	1	0	0	0	0	1	1	1	2	0	0	0	1	0	0	2	0	0	0	0	1	3	7
	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%	28.6%	33.3%	0.0%	0.0%	0.0%	0.0%	20.0%	33.3%	0.0%	16.7%	27.3%
All Screening Service		2	5	5.5	3	5.5	4	0	5.5	6	2	5	3	3.5	2.5	2	2	4	1	2	4	2	3.5	5	16	
104 days	Volume of Patients Waiting Longer than 104 Days at Month End		33	42	42	32	45	36	36	38	46	39	37	40	52	53	70	68	58	59	54	84	81	84	81	62

Activity & Flow

Operational Performance

Patient Experience

Quality & Safety

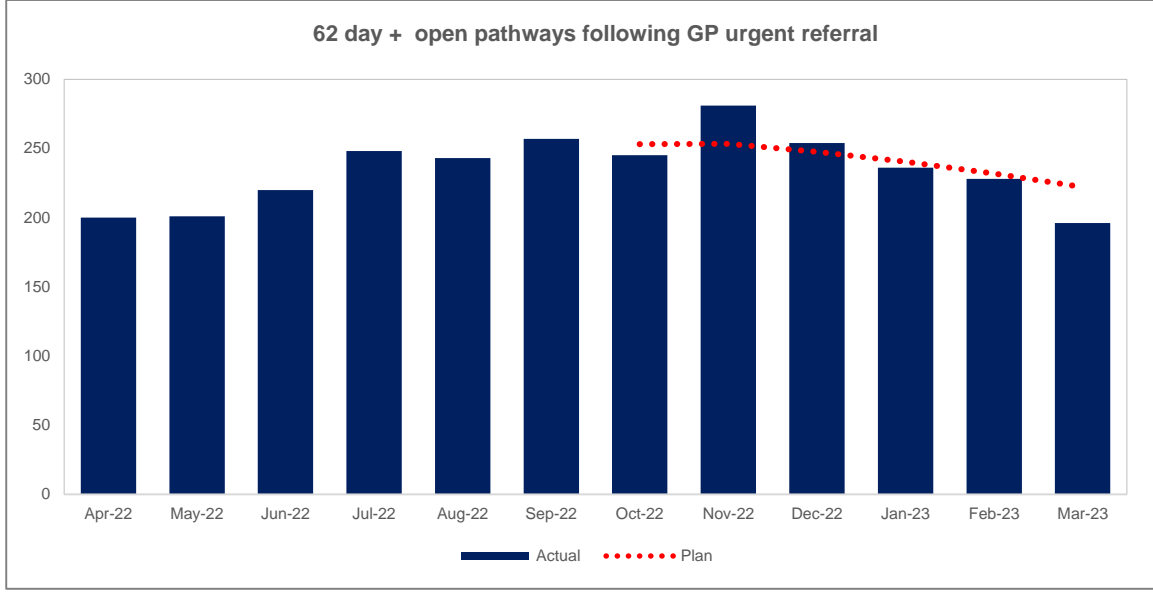
Our People

Finance



# Eastern Services Cancer 62 Day Backlog

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

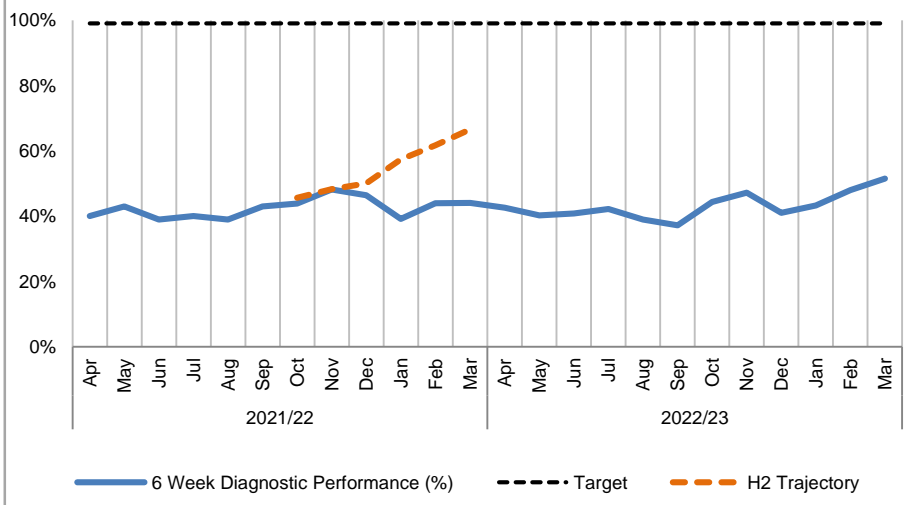


- 8.0% of patients on a cancer pathway at the end of March had waited longer than 62 days for diagnosis and treatment (NHSE benchmark 6.4%; 6.6% Peninsula performance).
- The number of patients waiting for diagnosis and treatment is significantly higher than plan reflecting the impact of increased demand.
- The decreasing long waiting trend continued throughout March with patients >62 day showing a steady reduction. Activity needs to continue at current levels to prevent tip over from >62 day to >104-day cohorts.
- Histology – experiencing turnaround time delays due to consultant vacancies. Successful recruitment process was conducted resulting in 1 appointment pending in June 2023 and a further two in Nov/Dec 2023. Continued use of Waiting List Initiatives in the interim maintain current position. Additional capital funding to support equipment has been secured via the Cancer Alliance.
- Radiology – CT and MRI reporting backlog has reduced by more than 60% as a result of continued outsourcing. Additional lists have successfully reduced Ultrasound breaches.
- Endoscopy - Super weekends are routinely planned to increase capacity - 10 lists were delivered in February and a further 20 lists during February and March have been funded by ICB. Demand continues to outstrip capacity. The Trust submitted a Business Case for CDC funding to deliver a mobile endoscopy suite to be delivered within 6 months as an interim solution. This has been approved and is planned to be operational from August 2023. A Business Case for two permanent endoscopy suites at Tiverton has been approved by the Regional Team and is due to be submitted to the National Team on 20<sup>th</sup> April and would see an increase in 2024/25 activity.
- To cover vacancies in the MDT Coordinator team, 3 agency trackers have successfully been recruited for 2 months initially, allowing the MDT Coordinators to cover all MDT work while enabling the team to keep up with validation tasks. Current recruitment; 2 posts to commence in May with only 1 secondment still vacant.

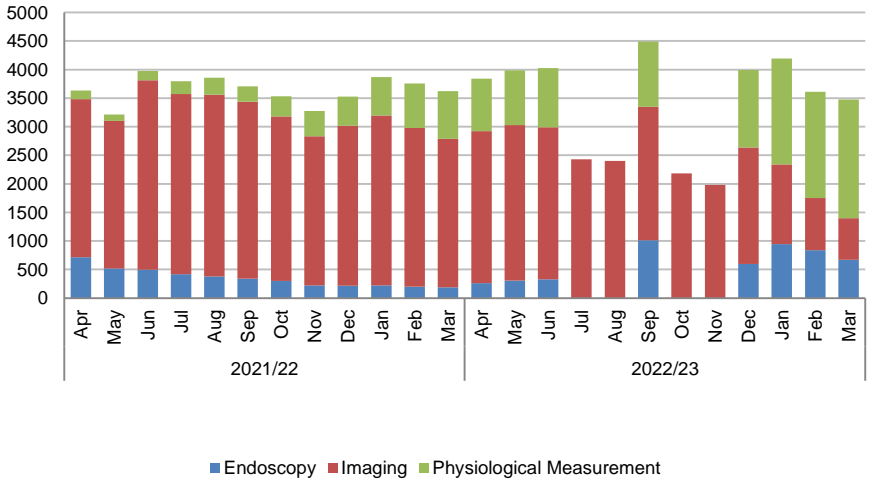
# Northern Services Diagnostics - Fifteen key diagnostic tests



### Total achievement against the 6 week wait from referral to key diagnostic test

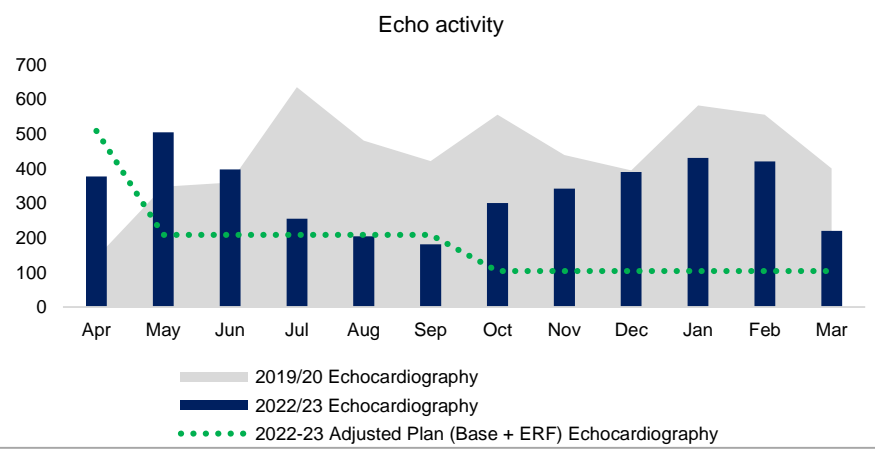
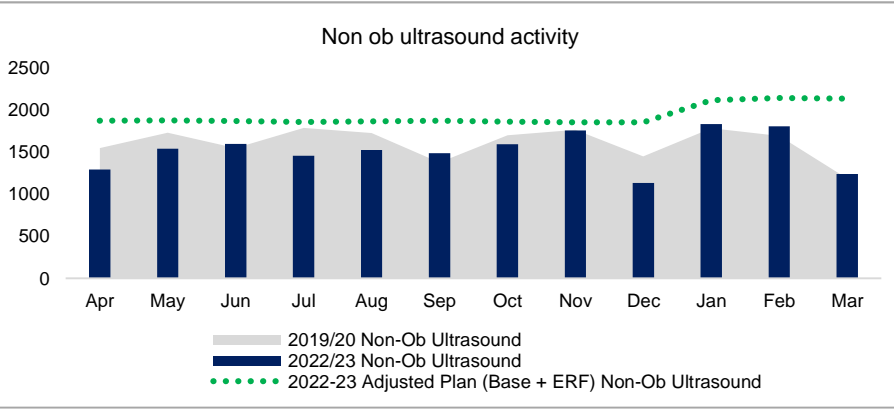
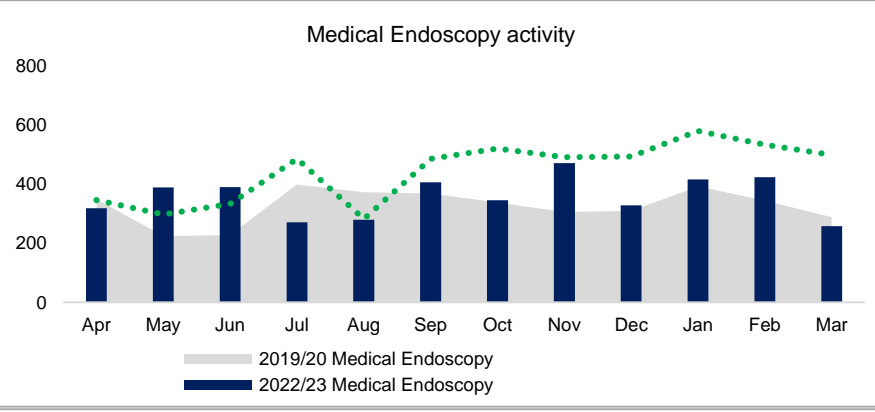
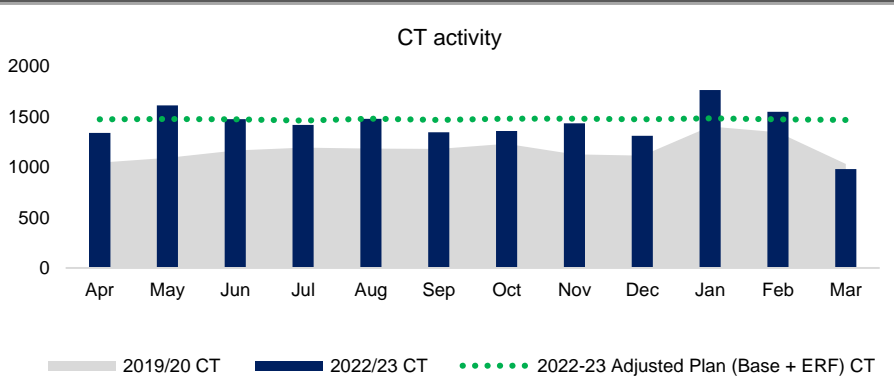
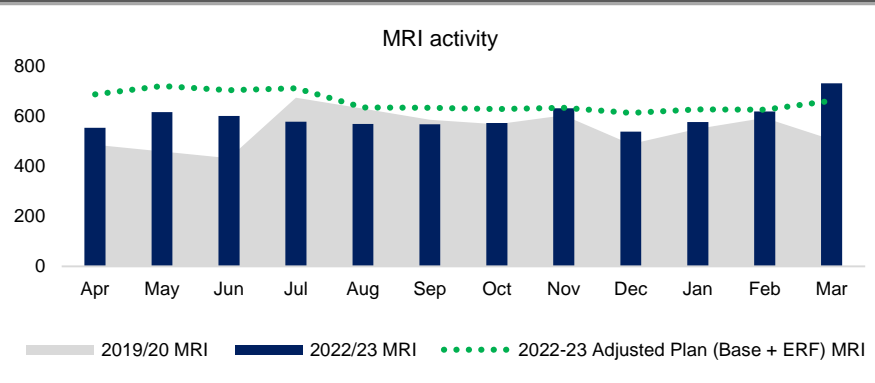


### 6 Week Diagnostic Breaches by Specialty Group



Area		Achievement against the 6 week wait from referral to key diagnostic test																							
Diagnostics by Specialty		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
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%	99.4%	99.7%	99.7%	96.9%	97.6%	97.9%
	Computed Tomography	61.3%	68.9%	66.1%	62.2%	64.2%	64.5%	66.1%	61.4%	60.4%	48.0%	56.8%	53.0%	55.6%	55.2%	64.7%	65.2%	56.1%	66.8%	81.9%	76.3%	75.2%	78.4%	87.6%	95.8%
	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%	35.8%	40.9%	36.2%	54.9%	86.1%	86.8%
	Barium Enema	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	DEXA Scan	12.0%	15.3%	15.5%	12.2%	14.5%	14.6%	12.5%	11.7%	11.9%	10.0%	12.6%	12.4%	11.6%	10.7%	10.5%	11.5%	14.6%	13.8%	14.5%	17.9%	14.3%	15.7%	19.8%	26.7%
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%	-	-	-	-	-	-	100.0%	100.0%	98.8%
	Cardiology - echocardiography	96.0%	99.6%	96.7%	84.8%	67.6%	67.9%	58.6%	57.5%	53.2%	37.1%	37.6%	36.2%	31.4%	26.6%	28.3%	-	-	-	-	-	27.9%	18.6%	23.0%	19.5%
	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%	-	97.9%	93.8%	99.1%	96.3%
	Respiratory physiology - sleep studies	47.5%	57.7%	41.0%	73.9%	89.3%	68.8%	57.8%	50.9%	49.0%	50.4%	32.4%	29.3%	22.5%	34.3%	30.8%	-	-	-	17.4%	-	64.8%	52.3%	42.5%	27.0%
	Urodynamics - pressures & flows	23.1%	36.2%	30.4%	21.9%	18.6%	37.7%	49.4%	51.4%	45.1%	44.6%	35.8%	25.9%	20.4%	25.4%	23.3%	-	-	-	1.4%	-	39.4%	30.8%	46.2%	35.7%
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%	-	30.6%	32.7%	34.2%	38.5%
	Flexi sigmoidoscopy	46.6%	42.1%	39.3%	40.7%	42.9%	52.5%	55.7%	64.6%	74.4%	70.4%	84.2%	74.6%	64.8%	71.8%	70.3%	-	-	-	28.5%	-	42.9%	30.9%	29.7%	39.4%
	Cystoscopy	28.7%	42.4%	41.7%	46.6%	43.8%	55.5%	51.1%	62.6%	59.1%	51.8%	51.9%	63.9%	67.0%	75.6%	73.3%	-	-	-	59.8%	-	74.4%	42.6%	48.4%	83.3%
	Gastroscopy	37.3%	41.4%	39.7%	56.9%	49.2%	61.0%	65.9%	81.8%	86.4%	83.7%	87.4%	82.0%	70.9%	61.9%	60.8%	-	-	-	53.1%	-	44.9%	39.1%	41.3%	47.1%
<b>Total</b>		38.9%	43.2%	39.4%	40.3%	39.1%	42.7%	43.9%	48.2%	46.4%	39.2%	43.9%	41.1%	42.6%	40.2%	40.8%	42.2%	39.0%	37.2%	44.4%	47.2%	41.0%	43.2%	48.0%	51.5%

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

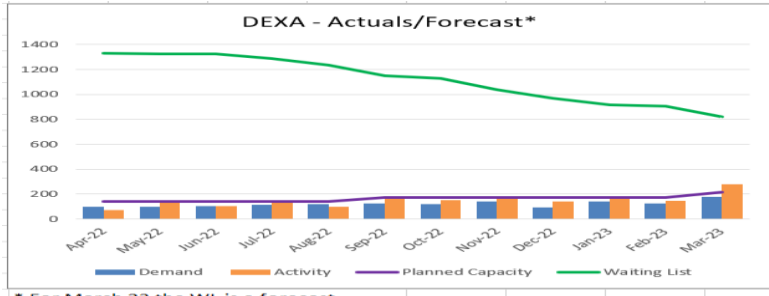


# Northern Services Diagnostics

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

Key issues at modality level:

- **MRI** – There has been a recent increase in referrals and we have had to increase inpatient slots to support flow when in OPEL 4 which had meant reducing routine outpatient numbers during this time. To help with this demand, Outpatient work was sourced through the on-site van. Planning for next year sees an increase in capacity to allow for this as well as the increase in demand. There will now be 21 additional days per month from April.
- **CT – Non-Cardiac CT** – Whilst activity is below plan it was meeting demand. Since October however there was an increase in 2 week rule referrals which affected this position, this has now stabilized. We have booked a further 16 days of the mobile service before the end of March 2023 to increase capacity. We have increased capacity in planning for 23/24 to meet demand. Unfortunately activity dropped during March as we didn't have access to extra capacity lists. Additional lists are being increased in April, with an increase to 10 lists per month.
- **Cardiac CT** - Additional cardiac CT lists have been taking place since October and have continued until the end of March. CT cardiac lists at RD&E have been agreed, providing an additional 14 scans per session, 3-4 sessions per month, these commenced in early December and will now continue into 23/24. As a result of this increase in capacity the number of patients receiving their Cardiac CT scan has improved significantly from 39.1% at the end of January to 80% at the end of March. With the ongoing additional capacity this is expected to improve further in 23/24.
- **U/S** - Work with the outsourcing company was suspended for safety reasons. There has therefore been a considerable improvement in the lists however not to the level planned. The suspension of this has also increased the work for the team rescanning some patients. . We have been able to provide some internal lists over weekends to continue to improve performance and we are also looking at outsourcing with a company known to the Trust to provide extra capacity should demand increase and it be needed over 23/24
- **Endoscopy** -Consultant Gastroenterologist vacancies and nursing vacancies & sickness remains a key constraint. Bi-weekly Task and Finish Group has been set up to review ongoing data quality post Epic implementation and to review utilisation of lists. Current capacity is ringfenced for cancer and urgent cases only. An insourcing provider had been unable to fulfil 2 weekends per month, so an additional provider has been identified and additional capacity will be in place in April. The original insourcing company has also now managed to deliver 2 weekends per month.
- **Echocardiogram** – Task and Finish group commenced on the 13<sup>th</sup> March to identify discrepancies in the waiting list. An additional of Physiology support is due to start from mid April which will be provided by the current locum. Inpatient demand for ECG continues to outstrip capacity. Service currently supporting 13 additional lists per month with a total of 11 patients per session.
- **Sleep studies** – Additional capacity has been identified across clinics and 2 CNS will commence report training in May. Bi weekly Monday clinics will commence from the 17<sup>th</sup> April seeing an additional 4-5 patients per clinic
- **DXA** – DXA improvement now being seen with 26.68% performance from 19.17%. Since the previous IPR; total waits have reduced from 866 to 772 and 6+ improved from 700 to 566 so in line with the trajectory. The contract with Taunton has been agreed in principle and will continue for 23/24. There has been a 32% reduction in the 6wks+ waitlist to date

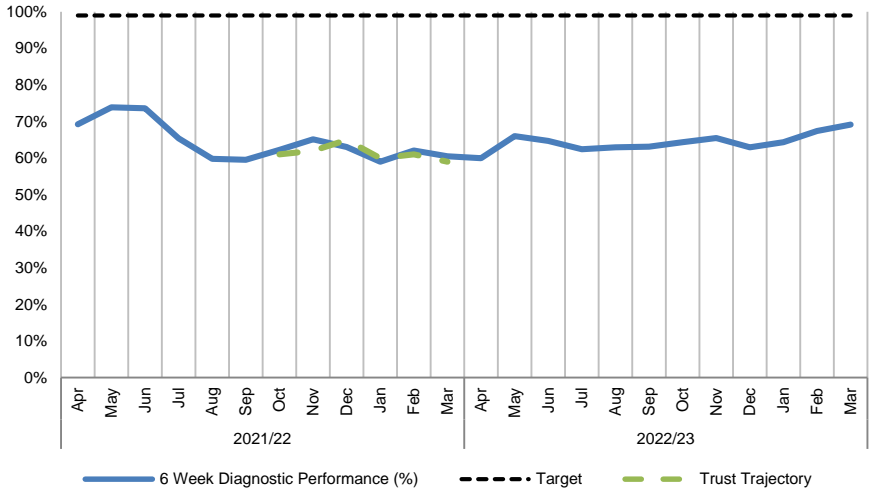


\* For March 23 the WL is a forecast

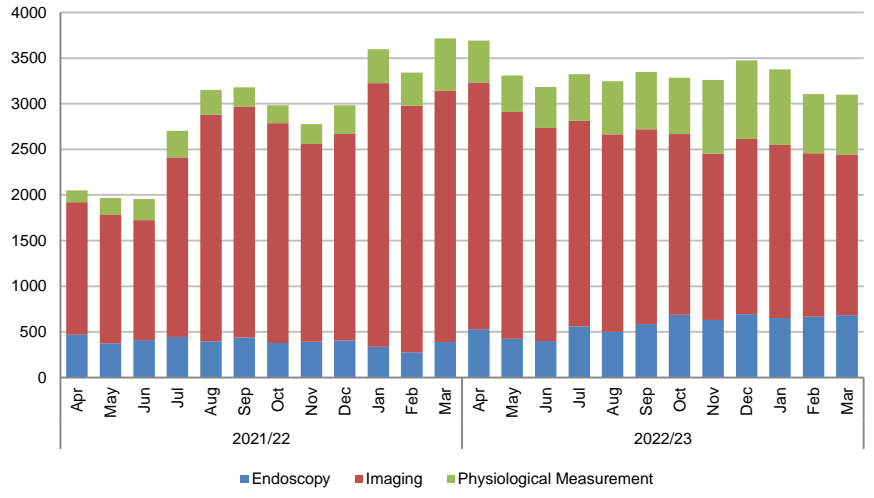
# Eastern Services Diagnostics

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

### 6 Week Wait Referral to Key Diagnostic Test



### 6 Week Diagnostic Breaches by Specialty Group



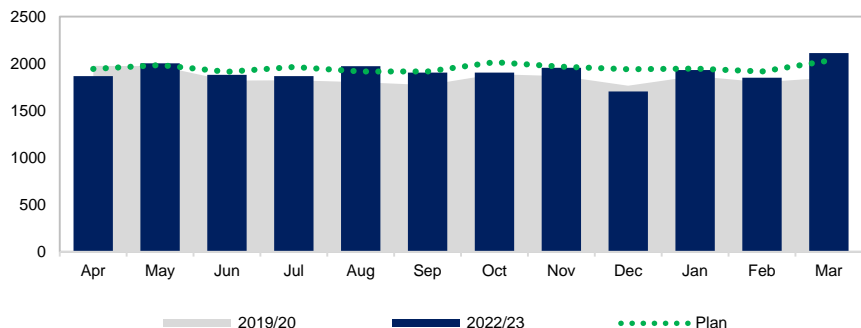
Area	Diagnostics By Specialty	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Endoscopy	Colonoscopy	57.1%	64.7%	66.5%	64.0%	63.5%	58.3%	51.6%	54.9%	53.9%	53.9%	51.2%	53.0%
	Cystoscopy	83.1%	82.8%	95.2%	91.5%	88.9%	93.2%	87.4%	83.5%	88.1%	47.8%	83.1%	83.2%
	Flexi Sigmoidoscopy	59.6%	73.0%	76.2%	74.6%	74.5%	62.2%	51.3%	49.6%	44.8%	82.1%	41.7%	50.4%
	Gastroscopy	57.2%	68.0%	72.4%	56.7%	68.7%	68.0%	69.8%	78.3%	74.8%	74.7%	73.9%	73.5%
Imaging	Barium Enema	-	-	-	-	-	-	-	-	-	-	-	-
	Computed Tomography	64.3%	73.2%	76.8%	77.1%	81.3%	85.4%	89.5%	92.3%	86.2%	87.9%	83.3%	84.6%
	DEXA Scan	97.8%	97.1%	98.9%	98.4%	98.2%	99.4%	99.2%	98.4%	100.0%	100.0%	100.0%	100.0%
	Magnetic Resonance Imaging	66.3%	73.9%	74.3%	69.6%	69.1%	72.9%	73.7%	75.6%	68.5%	70.7%	76.5%	73.4%
	Non-obstetric Ultrasound	51.6%	55.1%	51.6%	53.1%	52.7%	51.2%	54.5%	56.7%	56.8%	56.6%	60.1%	66.4%
Physiological Measurement	Cardiology - Echocardiography	82.1%	86.2%	80.9%	74.5%	71.4%	72.7%	75.2%	65.0%	66.6%	66.9%	72.6%	66.3%
	Cardiology - Electrophysiology	-	-	-	-	-	-	-	-	-	-	-	-
	Neurophysiology - peripheral neurophysiology	52.9%	73.2%	69.6%	72.5%	67.1%	61.2%	55.4%	65.4%	43.2%	49.4%	61.2%	75.1%
	Respiratory physiology - sleep studies	60.6%	67.6%	68.3%	60.0%	58.6%	65.8%	61.4%	63.1%	60.6%	57.8%	57.7%	66.4%
	Urodynamics - pressures & flows	26.0%	30.1%	30.3%	34.5%	28.6%	26.9%	25.7%	33.7%	28.8%	38.5%	32.2%	37.8%
<b>Total</b>		60.0%	66.0%	64.7%	62.4%	63.0%	63.2%	64.4%	65.5%	63.0%	64.3%	67.4%	69.2%

Activity & Flow  
 Operational Performance  
 Patient Experience  
 Quality & Safety  
 Our People  
 Finance

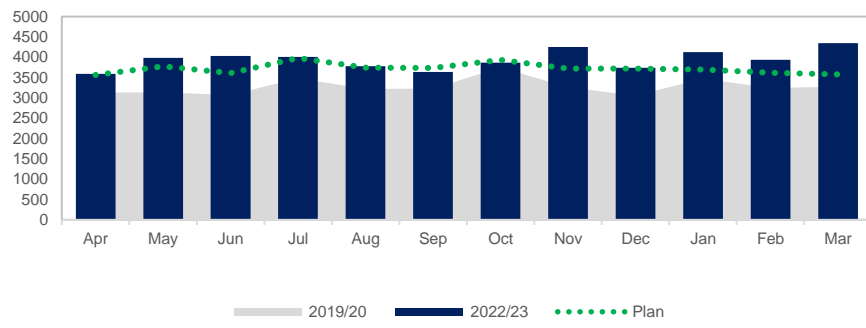
# Eastern Services Diagnostics

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

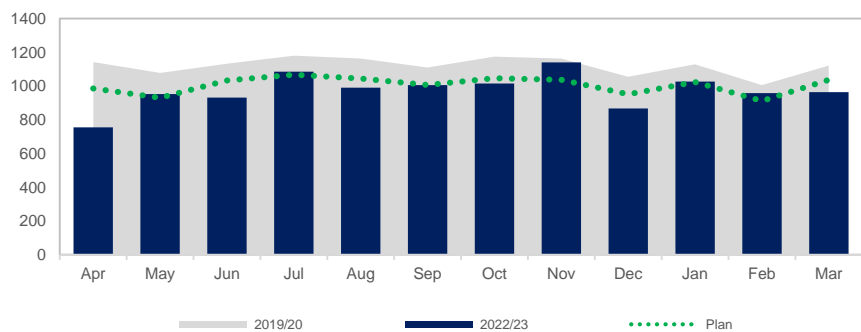
### MRI Activity



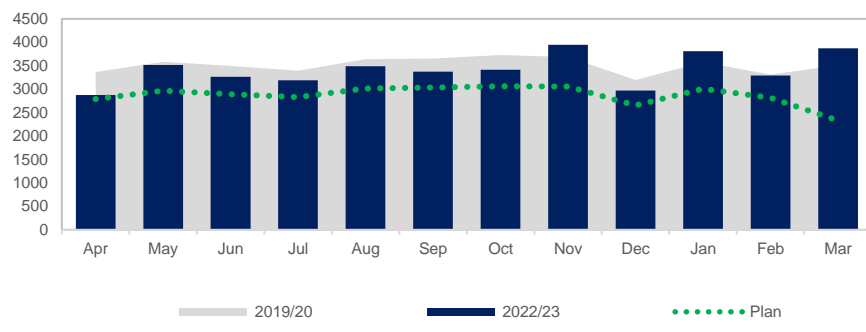
### CT Activity



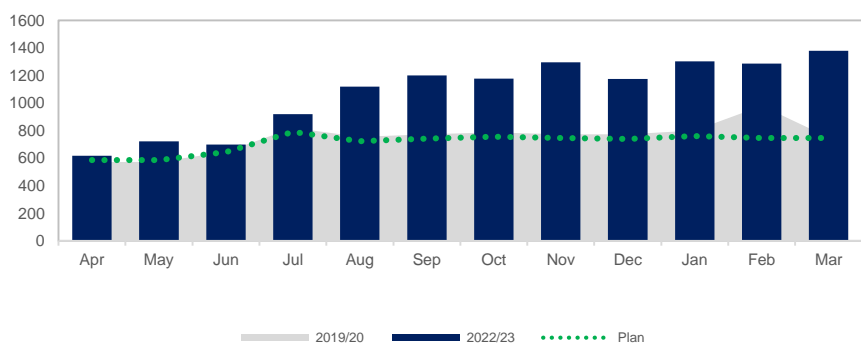
### Medical Endoscopy Activity



### Non-Obstetric Ultrasound Activity



### Echocardiography Activity



# Eastern Services Diagnostics

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

**At the end of March, 69.2% of patients were waiting less than 6 weeks – an improvement of 1.8% from the end of February**

## CT

- CT has seen improved position this month. This will continue to be monitored against the planned recovery position
- Due to the 4 day industrial action in April, 28 cardiac CT slots have been stood down as no medical cover, therefore cardiac breaches are likely to be impacted next month

## MRI

- MR sees an deteriorating position this month
- An increase in non-contrast MRI referrals, of more than 100 a week, compared to this time last year is having a direct impact on the waiting lists
- Eastern services are using all available CDC capacity, standing down any reserved slots for North Devon
- Exploring with outsourced MRI providers how to increase throughput on a daily basis to match other providers utilisation

## Non Obstetric US

- US breach trend has improved in March but continues with high MSK US breaches
- Following an validation exercise with the third party US provider a number of breaching referrals have been removed from the waiting list
- Exploring potential outsourcing services to support MSK imaging in the short term

## Echo

- Activity continues to exceed plan with the team regularly running weekend lists. However 3 resignations in the cardiac physiology team will detrimentally affect future performance. The department will seek support from HR to aid recruitment to this professional role
- BI team developing a new waiting list PTL to enable validation throughout the month

## Endoscopy

- The endoscopy team continue with the super weekends to increase capacity – 10 additional lists were delivered in March, with 9 planned for April. Along with this, ERF funding is utilised to fill in-week gaps in the rota where possible to ensure that maximum activity is achieved. A focus is currently being prioritised on the longest waits, a number of which are likely to be removed from the waiting list following the Access Policy.
- The Trust is awaiting full confirmation of funding prior to signing a contract for a mobile endoscopy unit (delivery Aug 2023)
- The business case for a permanent facility at Tiverton will be discussed at the national panel on 20th April. In the interim, discussions are underway with the ICB to continue some additional lists at the Nuffield.

## Neurophysiology

- The department has no substantive consultants and is reliant on agency locums. A proposal is being developed to increase the number of clinical scientists and reduce the agency burden. Discussions are taking place with the Strategic Resourcing group to secure a part time substantive consultant.
- Sickness absence within admin workforce has resulted in some slots being unbooked. Approval has been given to advertise a 6 month fixed term post. Support has also been offered by the central admin team
- Clinical and admin validation being undertaken for the waiting list - work to be completed at end April
- BI support is being provided to understand the demand and support development of the above proposal

## Respiratory physiology

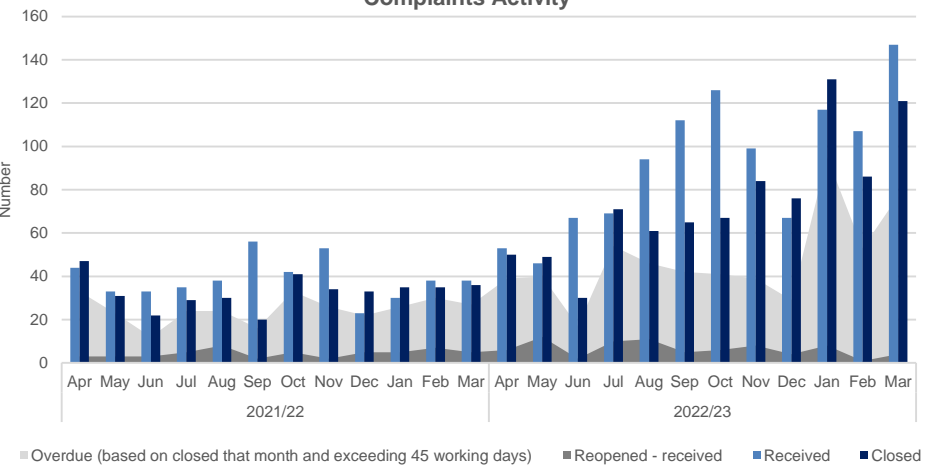
- A proposal is being developed to create a band 2/3 post to set up equipment and monitor/order stock. This work is currently undertaken by clinical staff.
- Funding has been secured to extend a band 6 respiratory physiologist for another 12 months. The Division is reviewing options to secure permanent funding for this post.

## Urodynamics

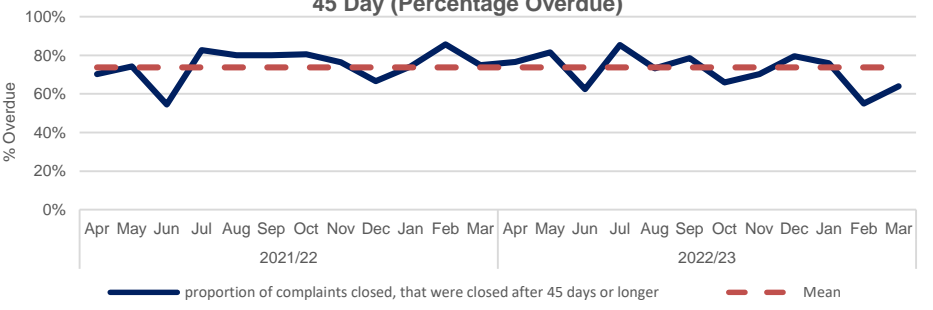
- The volume of patients waiting longer than 6 weeks for a urodynamic test continues to improve month on month.
- The scheduled opening of the service in Ottery in January 2024 will support acceleration of the backlog reduction, and restoration of waiting times to within target timeframes by the end of the 23/24 financial year.

# Trust Patient Experience

Complaints Activity



45 Day (Percentage Overdue)



Number of new PHSO referrals received during month	Primary investigations currently open	Detailed investigations currently open	Number of PHSO investigations closed during month
4	12	0	1

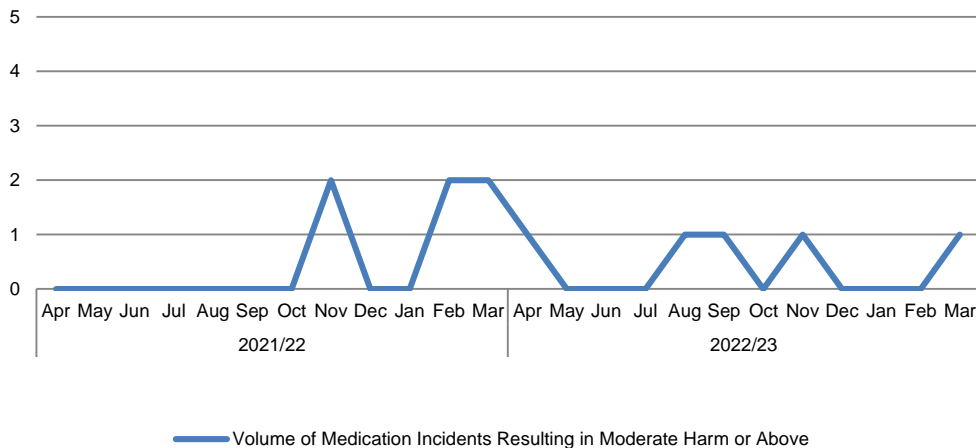
- Prior to January 2023 complaints closed by early resolution were not included in the performance data. Including early resolution data has improved the trust wide performance on timeliness of complaint handling.
- Despite the increased numbers of complaints received, Q4 22/23 saw the highest number of complaints closed ever. There has been a sustained increase in complaints being closed each quarter which demonstrates the work that has been undertaken to address the backlog.
- PHSO referrals in month are subject to primary review by the PHSO as to whether further investigation is required.
- Further work is still required to close down the oldest complaints and backlog which mainly concerns the medical division Eastern services.
- Communication remains the main theme throughout complaints along with values and behaviours. However, on comparing the top 10 themes for Q3 and Q4 it can be seen that there has been a large increase in the number of complaints around the 'wait for operation/procedure' and 'Appointment delay (inc length of wait)'. 'Discharge arrangements' has also moved into the top 5 themes where it was sitting just below the top 5 for Q3, also reflecting an increase in complaints with this theme.
- Weekly complaints huddles with the divisions continue to review complex cases and provide support.
- Work with the Ombudsman on the New Complaints Standards continues, the expected launch date of which being April 2023.

Month	2021/22												2022/23											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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%	88.89%	84.79%	67.27%	93.50%	96.51%	85.00%	87.00%	93.34%	90.29%	90.00%	90.50%	88.00%
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%	76.50%	81.50%	62.50%	85.34%	73.19%	78.64%	65.96%	70.23%	79.60%	76.00%	55.00%	64.00%
Over 6 months	2	2	0	4	1	1	4	3	3	6	3	5	12	16	4	12	11	13	16	7	3	22	14	23



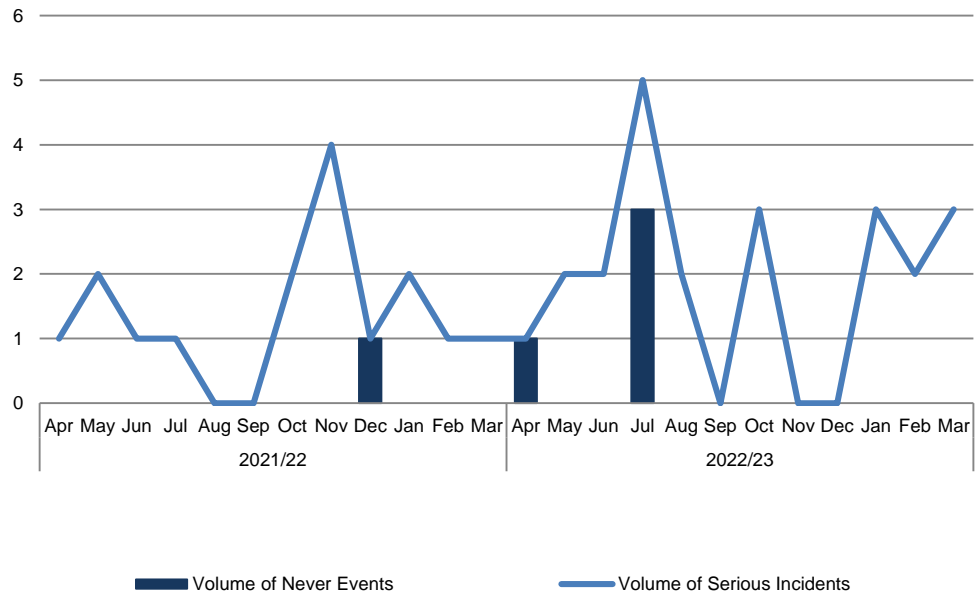
# Northern Services Incidents

**Medication Incidents - Moderate Harm & Above**



In March 2023 there was one medication incident that has been escalated for further investigation.

**Serious Incidents & Never Events**



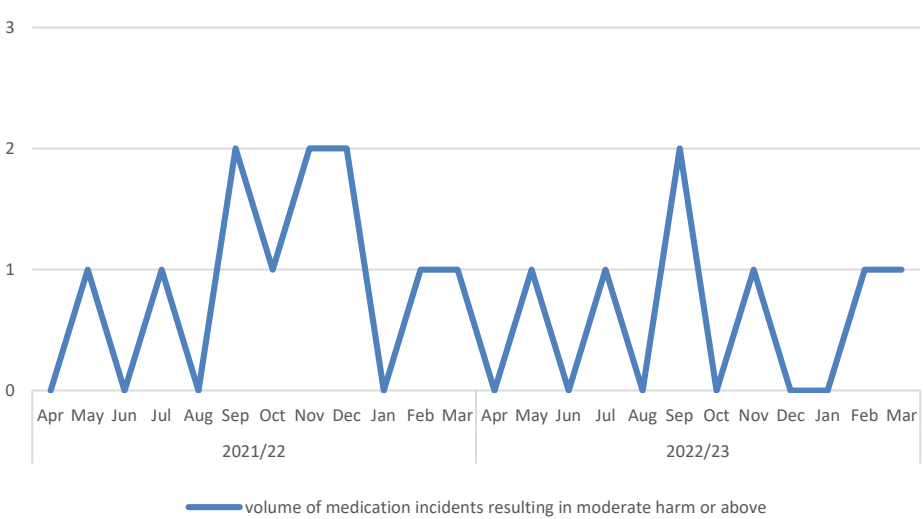
There were 3 reported serious incidents in March 2023 as follows:

- Baby transferred to NNU –incident meets HSIB criteria
- Delayed diagnosis of cancer
- Delayed diagnosis following radiology investigation

All incidents are subject to formal investigation to identify learning.

# Eastern Services Incidents

Medication Incidents - Moderate harm and above



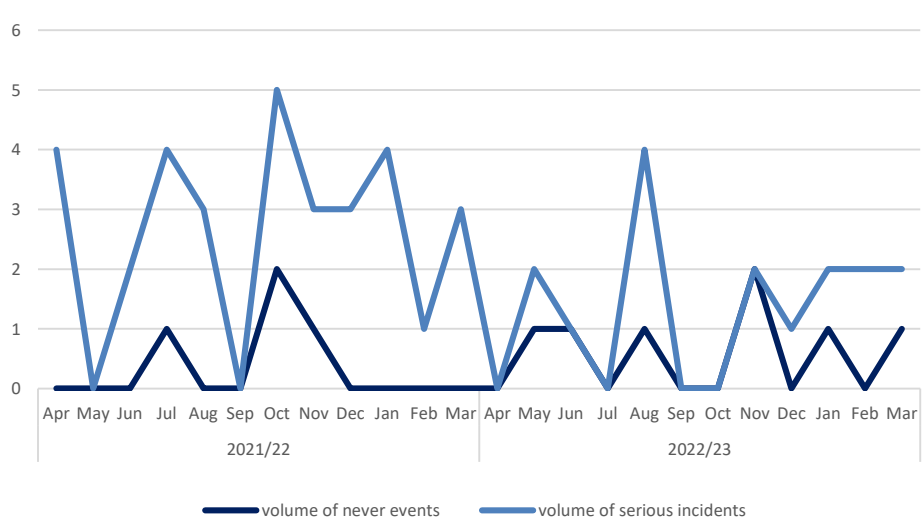
Incidents remain within normal variation. The medication incident was reported as moderate harm, and related to medication for an atypical allergic reaction.

The Trust reported one Never Event in March 2023. this was a retained surgical swab.

- The speciality have taken immediate actions
- Comms to all staff regarding expectations and responsibility around swab counts
  - Identify accountable person for swab identification
  - Update Epic to ensure accumulative swab counts are accurate, complete and logically documented
  - Review process for swab counting for:
    - Delivery, Assisted delivery, PPH/APH, Suturing, Theatres

Investigation has commenced using the revised Patient Safety Incident Investigation approach, this will enable system learning from the investigation.

Serious Incidents and Never Events

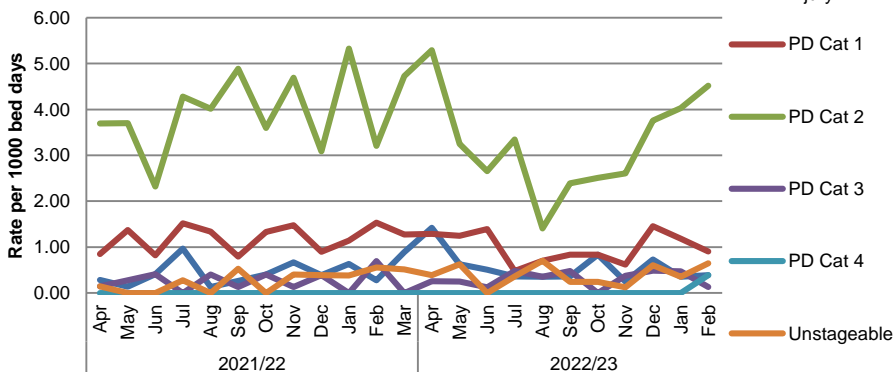


Two additional Serious incidents were identified. One of these will be a multi agency review of a sudden deterioration occurring in a walk in centre. The second was a patient who was lost to follow up resulting in deterioration of their condition.

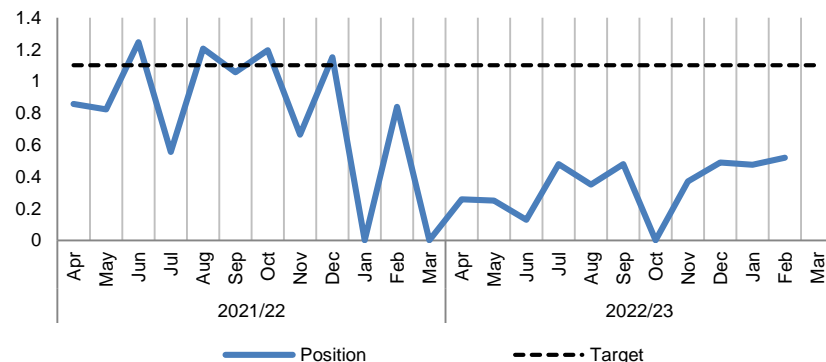
# Northern Services Pressure Ulcers – Rate of pressure ulceration experienced whilst in Trust care



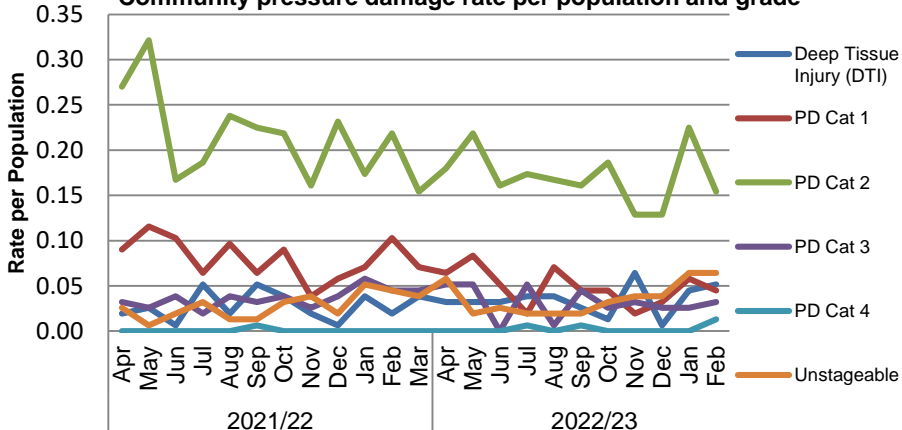
**NDHT Pressure damage rate per 1000 bed days**



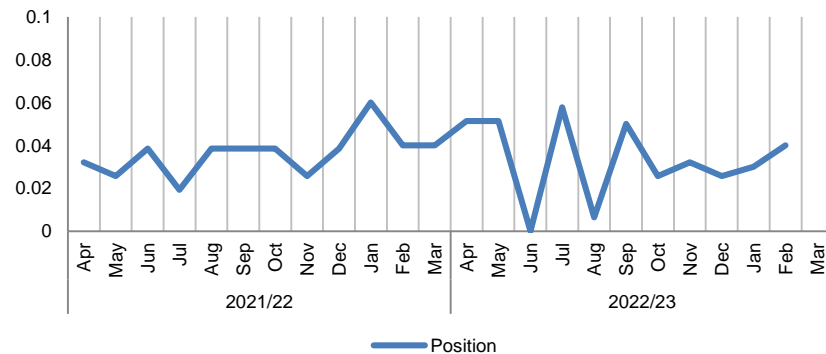
**Rate of Grade 3- 4 pressure Sores /1000 bed days Acute**



**Community pressure damage rate per population and grade**



**Community Nursing and population: Newly Identified Pressure Ulcers - Grade 3 - 4**

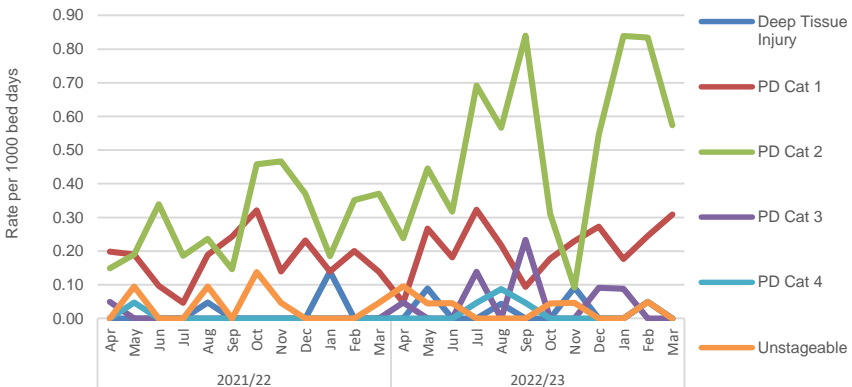


- The pressure ulcer data for February is unvalidated due to staffing challenges so may be subject to change.
- Pressure ulcers in acute and community remain within normal variation. Focussed quality improvement work continues in clinical areas with the highest numbers of pressure ulcers.
- The tissue viability team are undertaking further investigation into the rise in category 2 pressure ulcers which will be referenced in next months IPR.

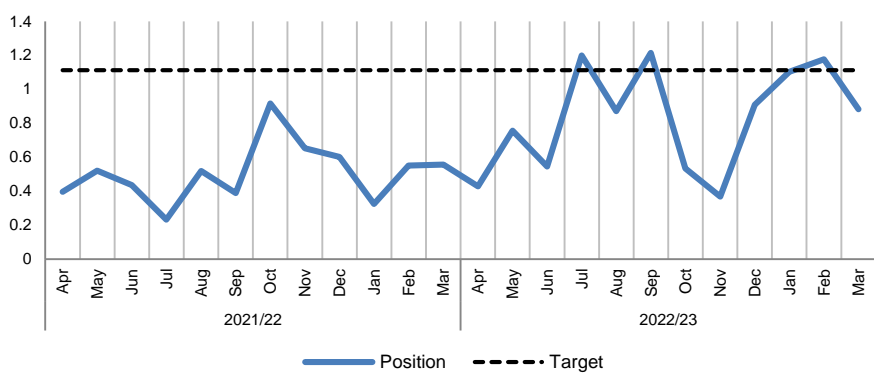
# Eastern Services Pressure Ulcers

Rate of pressure ulceration experienced whilst in Trust care

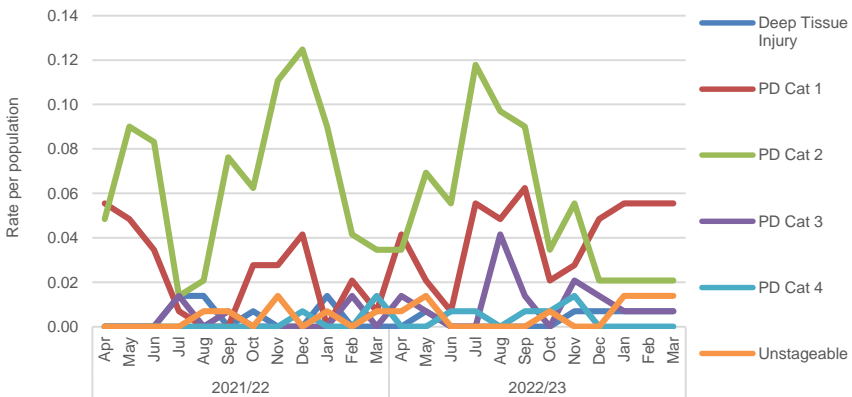
### Acute Pressure damage rate per 1000 bed days



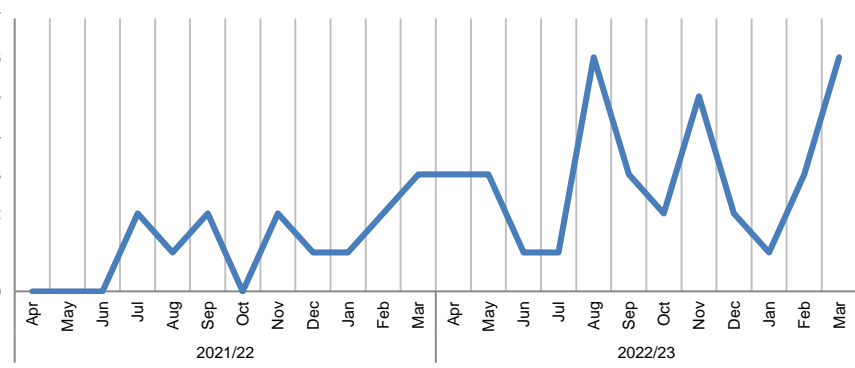
### Rate of Grade 1-4 pressure Sores /1000 bed days



### Community pressure damage rate per population and grade



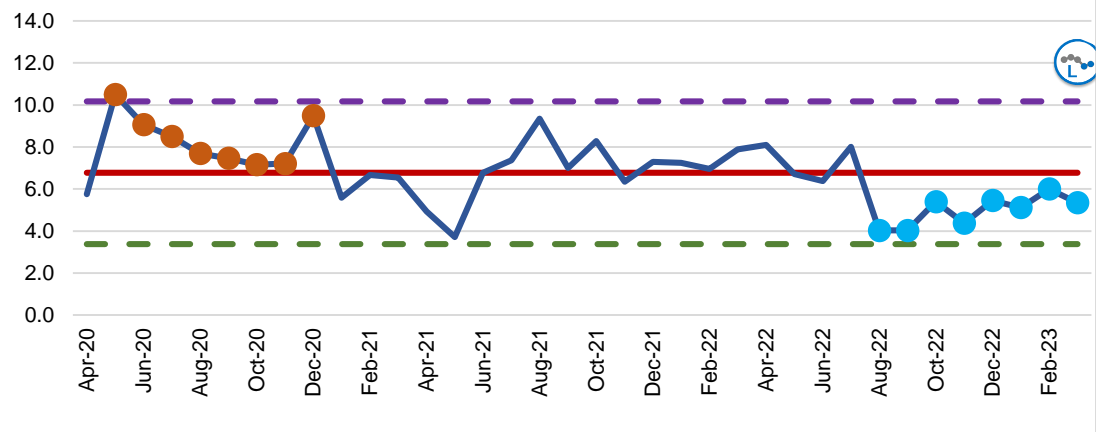
### Community Caseload: Newly Identified Pressure Ulcers - Grade 3 - 4



- Pressure ulcers remain within standard variation.
- There have been no patients developing deeper pressure damage (greater than category two) in the acute or community hospital setting.
- Although there has been an increase in the number of newly identified category three pressure ulcers reported on the community caseload the rate remains consistent at 0.1% of caseload. Only one incident has been escalated for investigation, no significant lapses of care were identified in all other incidents.

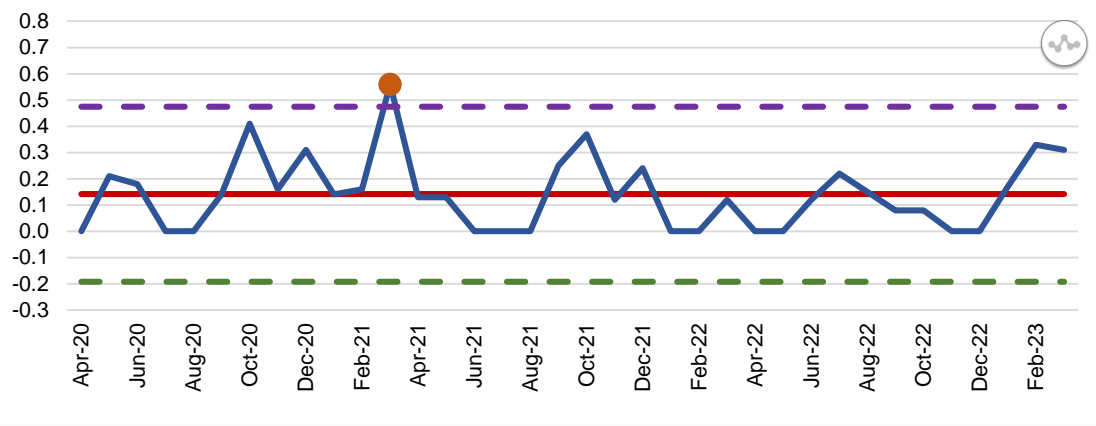
# Northern Services Falls – Rate of incidence of falls amongst inpatients and categorisations of patient impact

**NDHT - Fall rate per 1000 bed days - 01/04/20 - 01/03/23**



- Falls remain in normal variation.
- In March there were three falls with injuries. They are subject to investigation to identify learning.

**NDHT - Harm rate per 1000 bed days (moderate/severe/catastrophic) - 01/04/20 - 01/03/23**



# Eastern Services Slip, Trips & Falls

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

Activity & Flow

Operational Performance

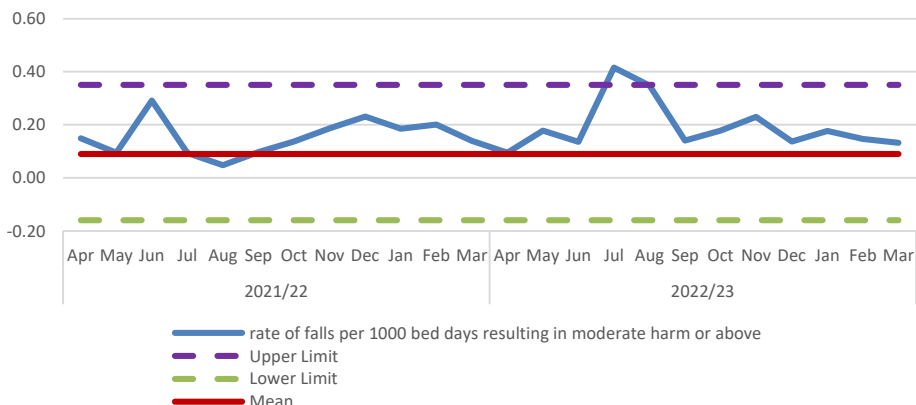
Patient Experience

Quality & Safety

Our People

Finance

RDE Harm rate per 1000 bed days (moderate/major/catastrophic)



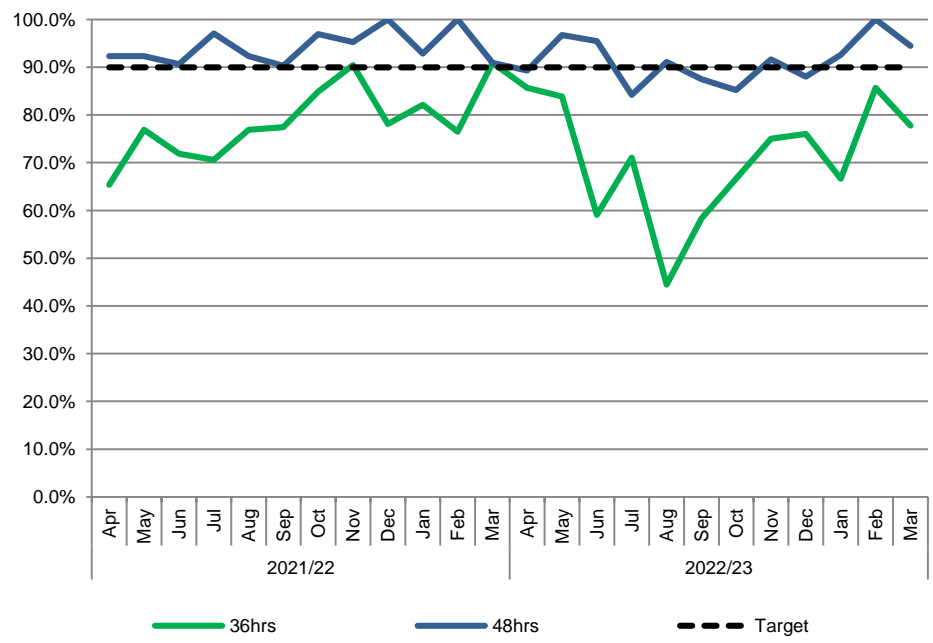
Month	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Falls	116	112	120	110	129	132	162	160	179	143	152	206	167	141	172	272	230	223	237	238	207	247	265	263
Moderate & Severe Falls	3	2	6	2	1	2	3	4	5	4	4	3	2	4	3	9	8	3	4	5	3	4	3	3

- Figures from June 2022 updated – The reporting from Datix Cloud included non-inpatient falls; this has been corrected.
- Falls remain within normal variation
- The three falls identified all resulted in moderate harm. Falls risk assessments and appropriate falls interventions were in place.
- Two falls were unwitnessed, involving patients self mobilising. The third witnessed fall occurred within a tagged bay, which was appropriately staffed.
- Initial reviews have not indicated any sub-optimal care issues.

Northern Services	Aug-22	Sep-22	Oct-22	Nov-22	Jan-23	Feb-23	Mar-23
NDDH	73%	60%	65%	81%	76%	82%	78%

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

**Surgery within 36hrs - Fractured Neck of Femur**

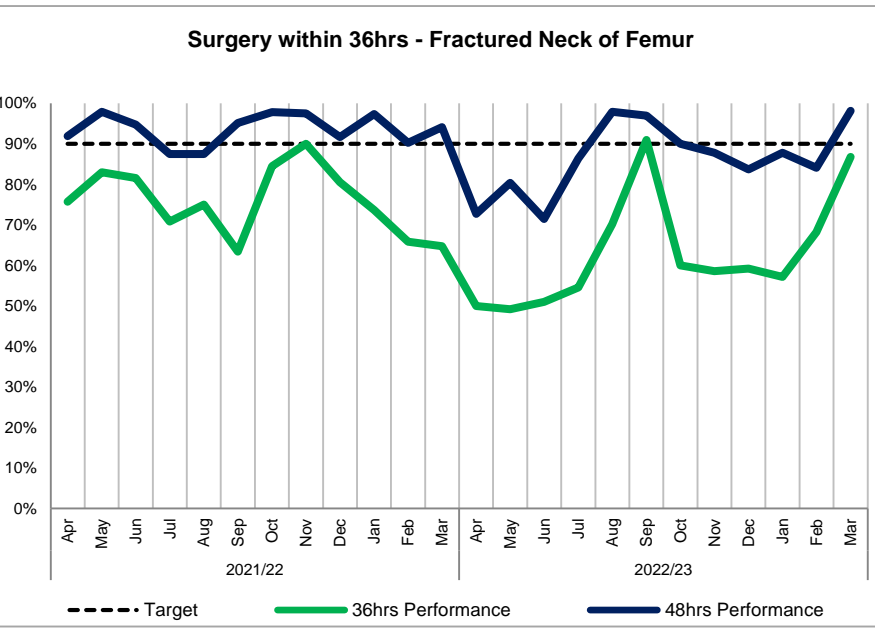


- In March 2023, 77.8% of medically fit patients with a fractured neck of femur (NOF) received surgery within 36 hours. The Trust admitted a total of 18 patients with a fractured neck of femur in that month who were medically fit for surgery from the outset and of these, 14 patients received surgery within 36 hours.
- The four patients in total that breached 36 hours were due to lack of theatre time and awaiting space on theatre lists. There is an increasing volume of Trauma admissions being seen impacting on capacity. One patient waited longer than 48 hours; therefore 94.4% of patients received their surgery within 48 hours.

# Eastern Services Efficiency of Care

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

Eastern Services	Aug-22	Sep-22	Oct-22	Nov-22	Jan-23	Feb-23	Mar-23
RDE Wonford	76%	75%	73%	72%	81%	88%	87%

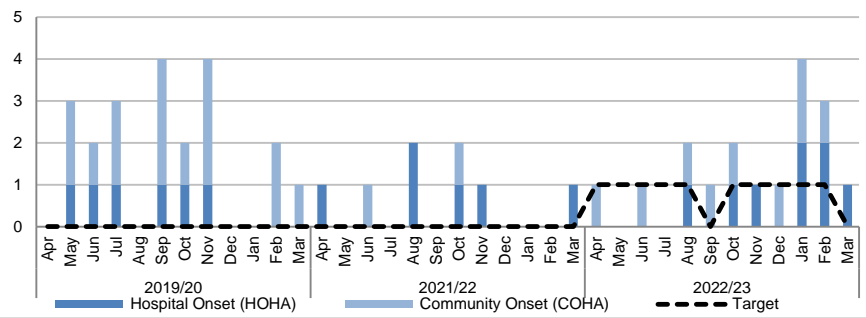


- The snapshot position taken from the Epic system in relation to the proportion of patients risk assessed for VTE on admission, demonstrates a stable position.

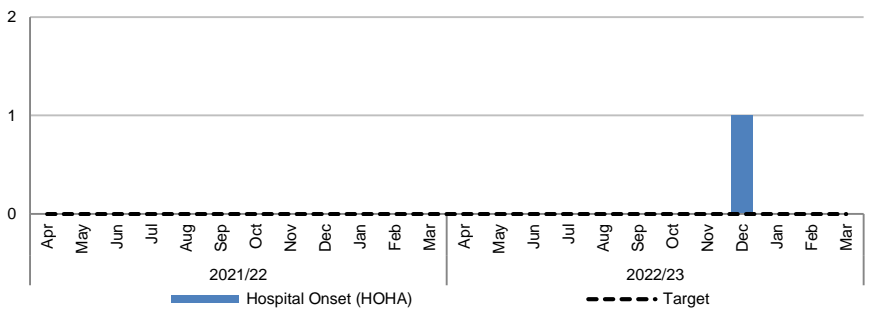
- In March 2023, 86.8% of medically fit patients with a fractured neck of femur (FNOF) received surgery within 36 hours. There were a total of 58 patients admitted with a FNOF, 53 of these patients were medically fit for surgery from the outset and 46 patients received surgery within 36 hours.
- Trauma numbers remain high, with 169 Trauma Patients being admitted in March.
- Where clinically appropriate all FNOF cases are given priority in theatres over elective patients. 54 Trauma Patients had their surgery during March in PEOC Theatres, which was to the detriment of elective activity.
- 1 medically fit patient had to wait over 48 hours for their surgery, longest wait was 48.85 hours.
- The Hip Fracture Lead has reviewed all cases during the month and is confident that the quality of the clinical care remains high and the patients who breached 36 hours, did not come to any clinical harm due to a n extended wait for surgery.
- Work is being actively progressed to increase the volume of Orthopaedic and Spinal activity that can be redistributed to the Nightingale Hospital, to free up theatre capacity on the Wonford site - it is anticipated this could be enacted over the coming months.



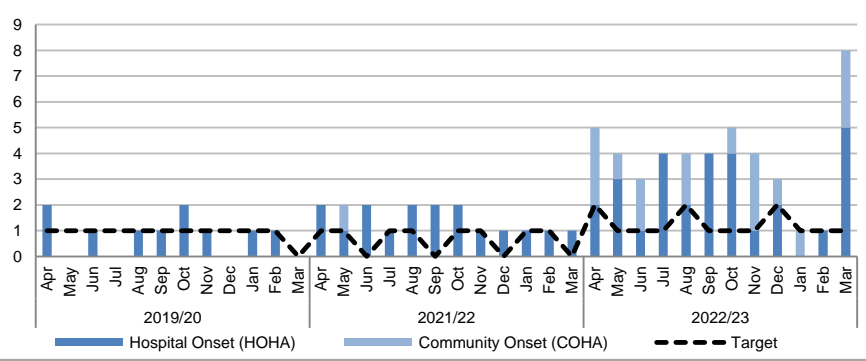
**Clostridioides difficile cases**



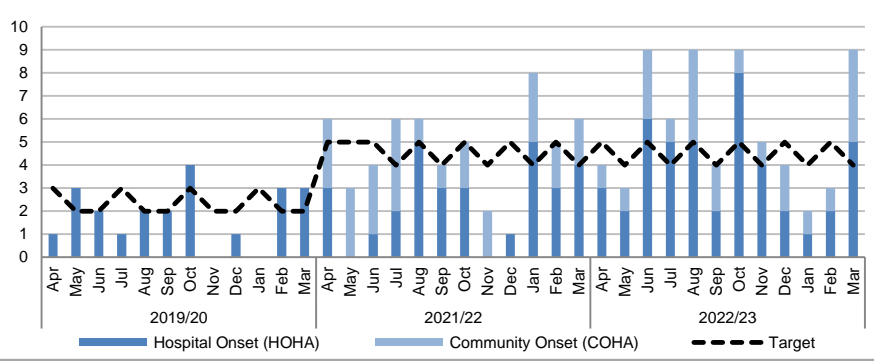
**MRSA bacteraemia cases**



**MSSA bacteraemia cases**



**E coli bacteraemia cases**



**Methicillin sensitive *Staphylococcus aureus* (MSSA)**

There were 8 cases of Trust attributed MSSA bacteraemias in March 2023. One of the 8 cases was related to a central line, but no lapses in care were identified. There were no common themes.

***Escherichia coli* (E coli)**

There were 9 cases of Trust attributed E coli bacteraemias in March 2023. 2 of the 9 cases were urinary in origin and only one of these patients was catheterised. Unusually 6 of the 9 cases were related to the biliary tract but 4 of the 6 cases had underlying biliary risk factors. There were no common links nor lapses identified.

These healthcare associated infections remain within normal variation for March 2023:

***Clostridioides difficile* (C dif)**

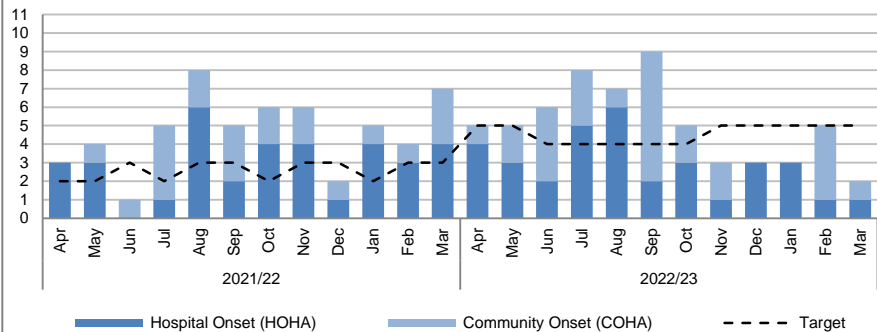
**Methicillin resistant *Staphylococcus aureus* (MRSA)**

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

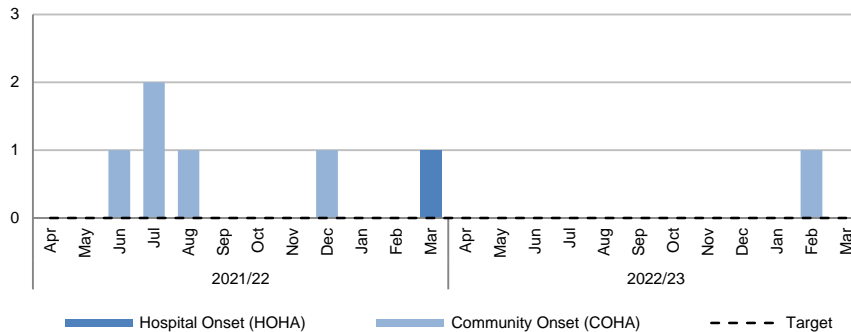
# Eastern Services Healthcare Associated Infection

Volume of patients with Trust apportioned laboratory confirmed infection

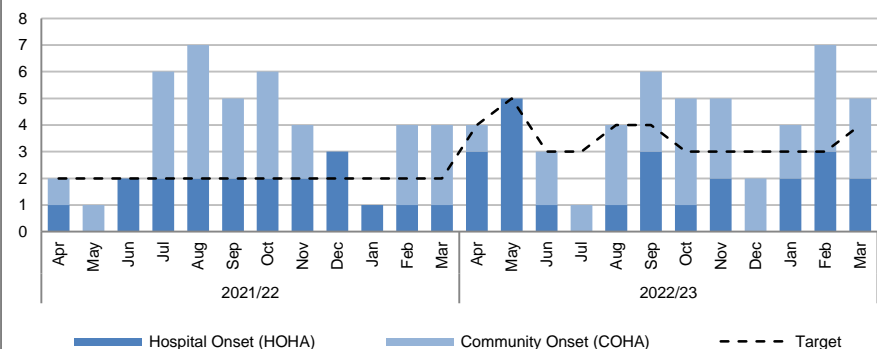
### Clostridioides difficile cases



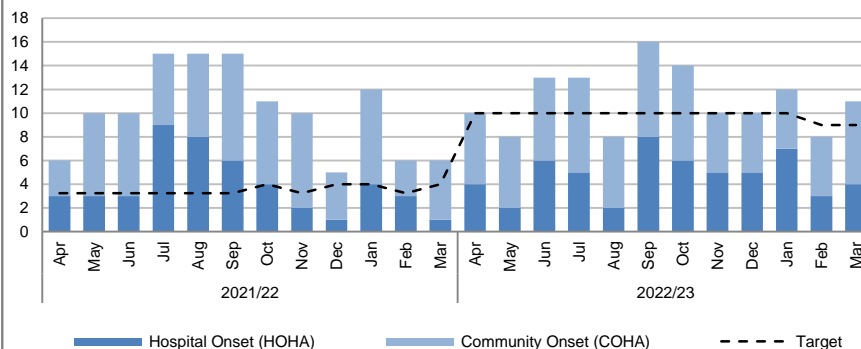
### MRSA bacteraemia Cases



### MSSA bacteraemia cases



### E-coli bacteraemias Cases

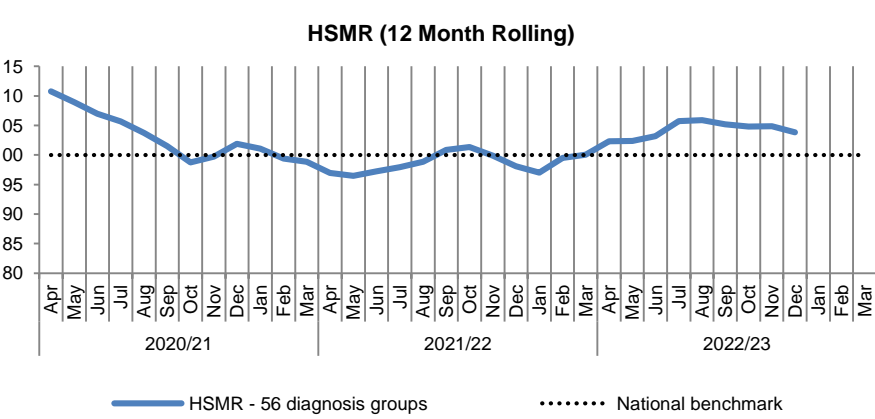
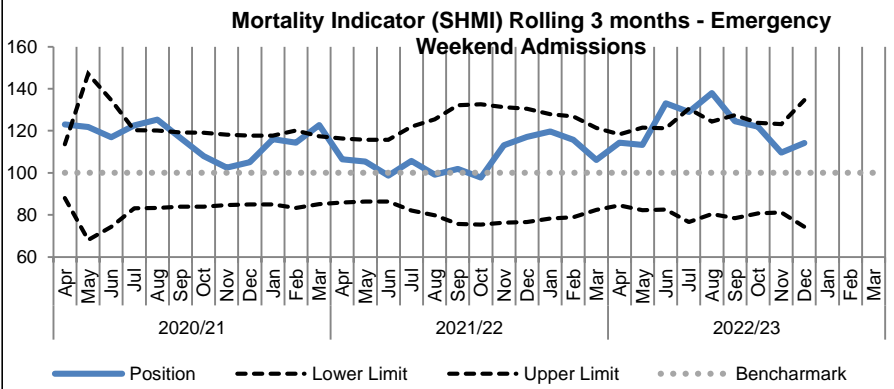
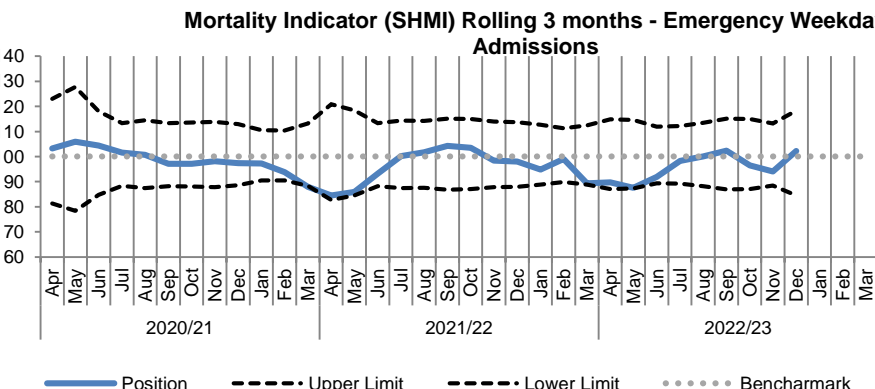
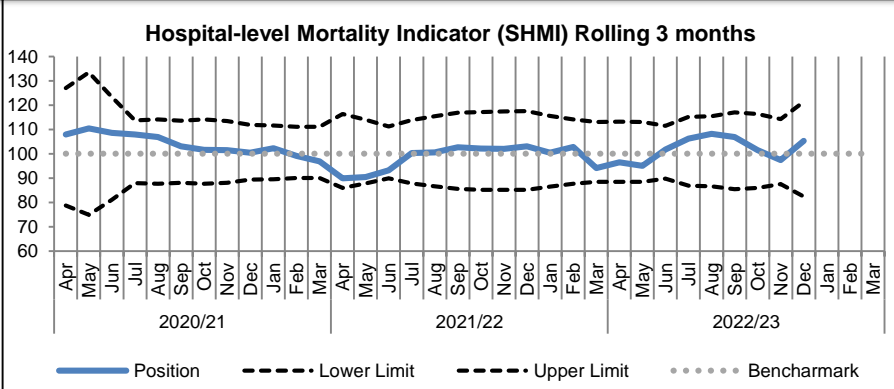
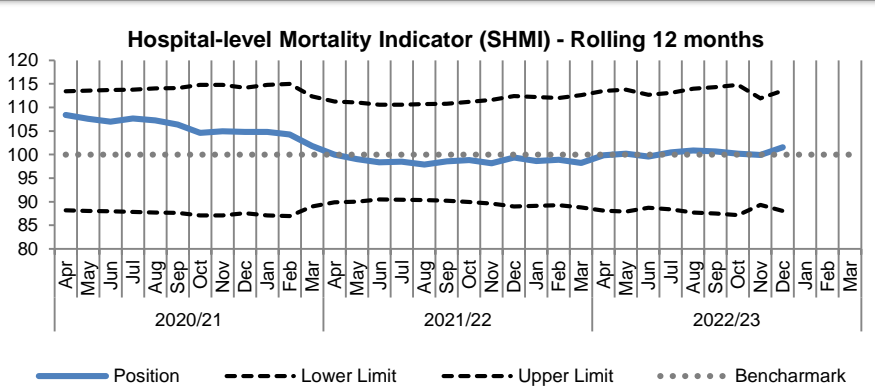


**C. difficile** – The HOHA case has been investigated and no learning identified. The COHA case involved a 5 hour visit for a blood transfusion in an ambulatory care setting, no previous inpatient stays and no antimicrobial prescribing. Given the brevity of the contact with the Trust a full investigation was not undertaken as there would not have been any Trust learning. Total for 2022/23 is 61 cases against a nationally set threshold of 55.

**MSSA bacteraemia** – All HOHA cases have been investigated. One case had a source of soft tissue injury exacerbated by immunosuppression with secondary thrombophlebitis. The investigation identified suboptimal documentation of peripheral venous cannula care. The second was a repeat/released case from February for which the source is unknown. The three COHA cases were associated with three different sources. No learning to have prevented bacteraemia was associated with these cases. Total for 2022-23 is 46. There is no national threshold for MSSA bacteraemias but the internally agreed threshold of 42 has been exceeded..

**E.Coli bacteraemia** – Of the four HOHA cases two were a urinary tract infection source, and both of these had an urinary catheter. The third case was associated with a gastrointestinal focus whilst the source for the fourth case could not be ascertained. Of the seven COHA cases four were associated with the urinary tract but none had indwelling urinary catheters. Two were associated with hepatobiliary tract. The remaining three comprised one associated with the hepatobiliary tract, one gastrointestinal tract and the third of an unknown source. The total number for the year 2022-23 is 133 against a threshold of 118 for Eastern Services.

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

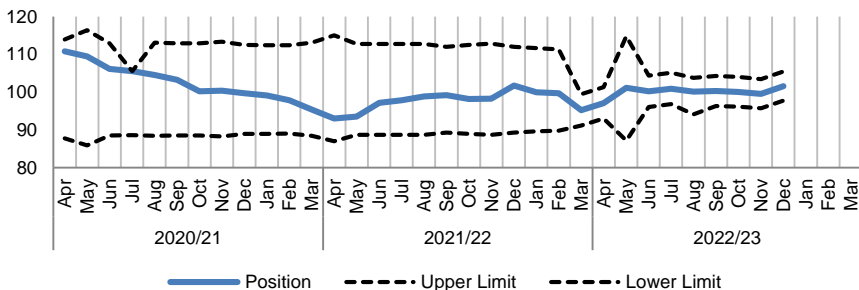


- The overall mortality figures are within national confidence intervals for 12 month and 3 month rolling SHMI and are below all our Peninsula peers. The 12 month HSMR has plateaued and is starting to fall.
- The Medical Examiners continue to give independent scrutiny of all hospital deaths raising areas of concern to the mortality review process, governance/Datix, and clinicians, where appropriate.

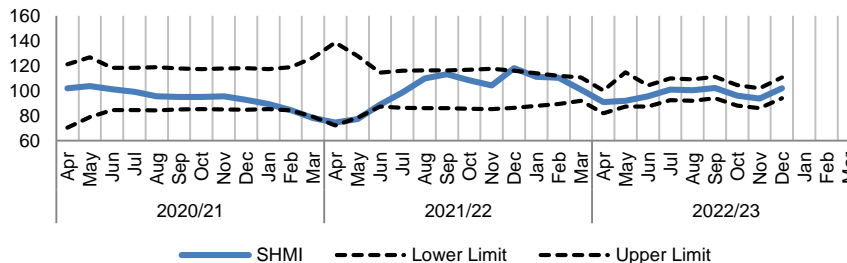
# Eastern Services Mortality Rates – SHMI & HSMR

Rate of mortality adjusted for case mix and patient demographics

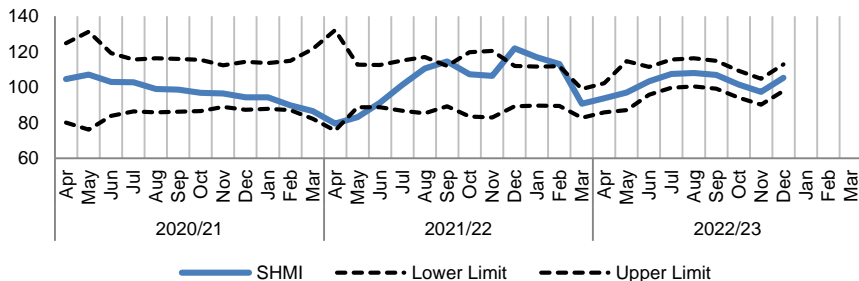
### Hospital-level Mortality Indicator (SHMI) - Rolling 12 months



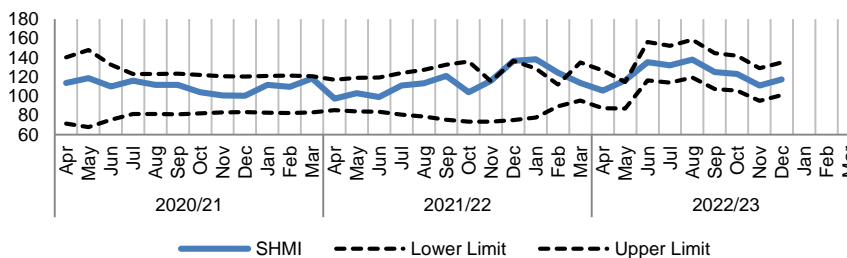
### Mortality Indicator (SHMI) Rolling 3 months - Weekday Admissions



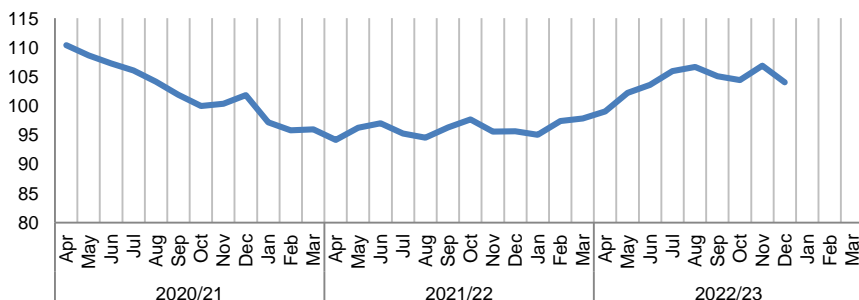
### Hospital-level Mortality Indicator (SHMI) Rolling 3 months



### Mortality Indicator (SHMI) Rolling 3 months - Weekend Admissions

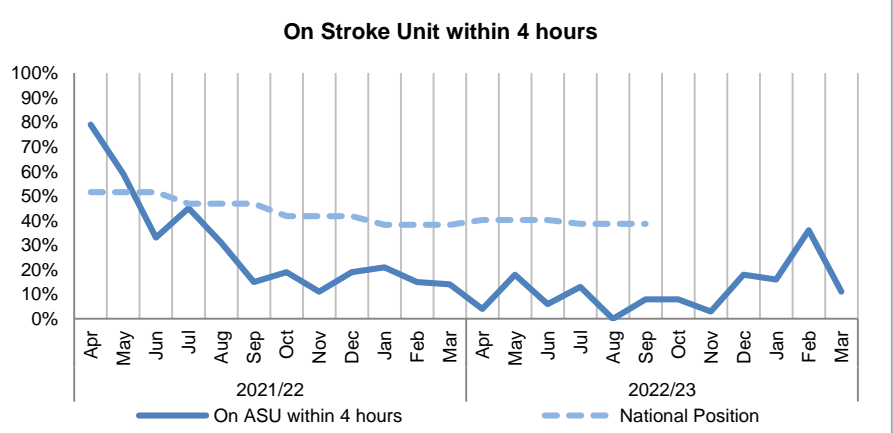
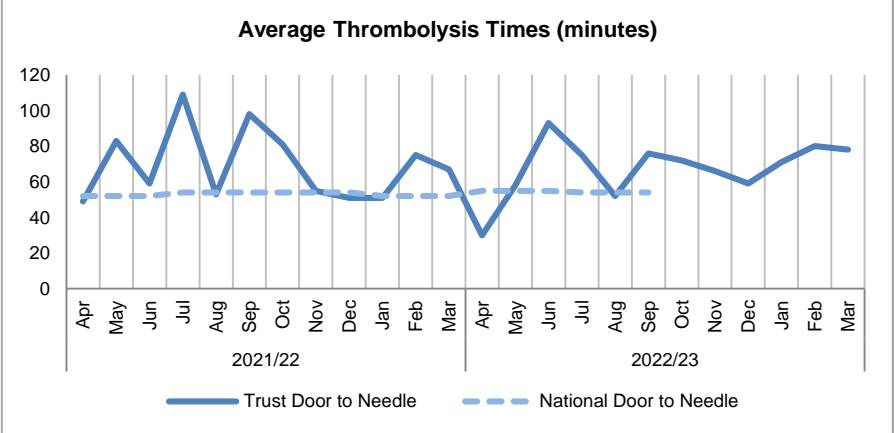
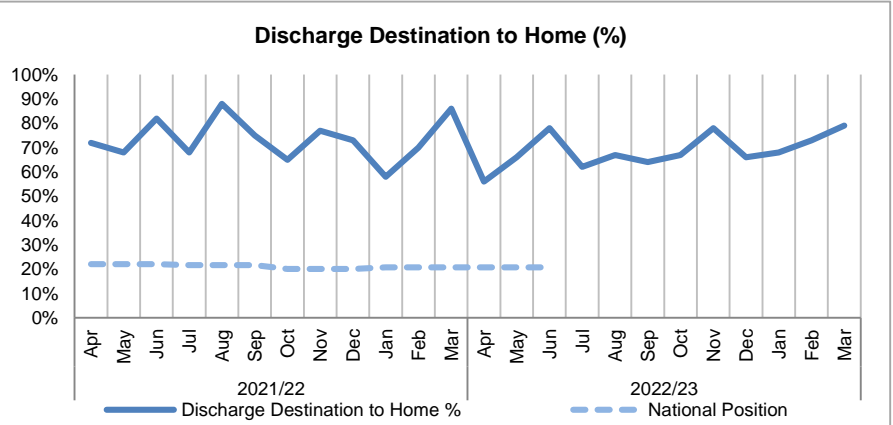
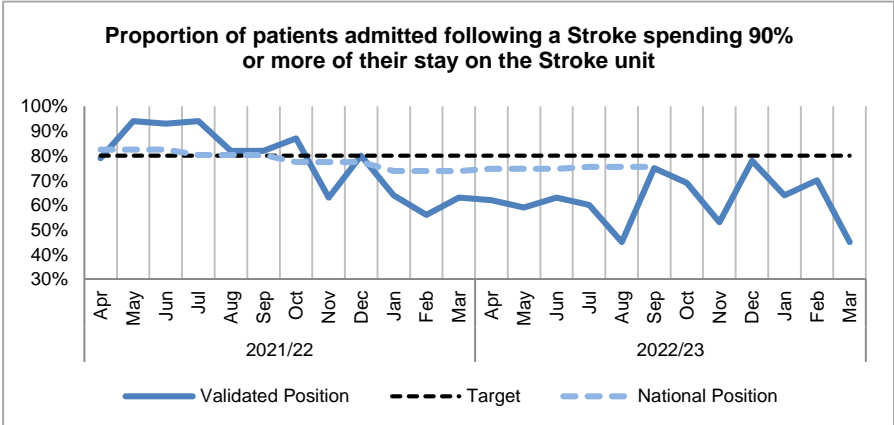


### HSMR (12 Month Rolling)



- The SHMI position remains within the expected range for all metrics.
- The HSMR position has stabilised and is starting to fall.
- The Medical Examiners continue to give independent scrutiny of all hospital deaths raising areas of concern to the mortality review process, governance/Datix, and clinicians where appropriate. No new emergent themes are currently being identified through this process.

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

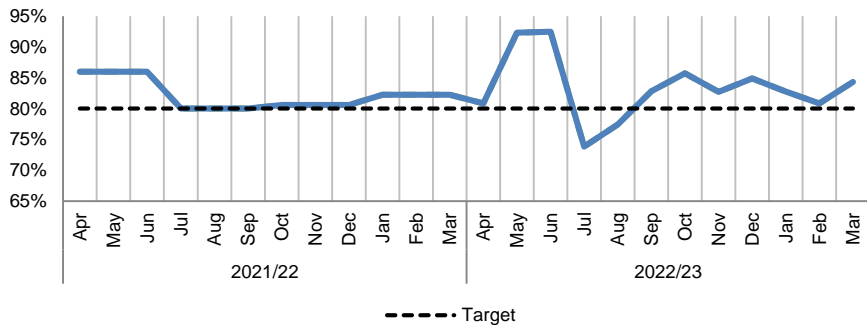


- 90% stay: Performance against this indicator remains variable due to ongoing challenges with patient flow. The Stroke clinical teams provide outreach to outlying wards to ensure stroke patients are receiving appropriate stroke care. The Patient Flow Improvement Group continue to focus on reviewing the ringfencing processes with the site management team; however, due to the significant operational and capacity challenges experienced in March, the position deteriorated compared to previous months.
- Discharge destination: This metric is relatively stable and is above the national average.
- Thrombolysis times: Thrombolysis time is broadly stable over time. Overall the number of eligible stroke patients for thrombolysis is low
- ASU in 4 hours: This target remains challenging due to the high level of occupancy and although a positive trend had started to emerge over previous months, the significant operational pressures experienced in March has adversely impacted on this metric.

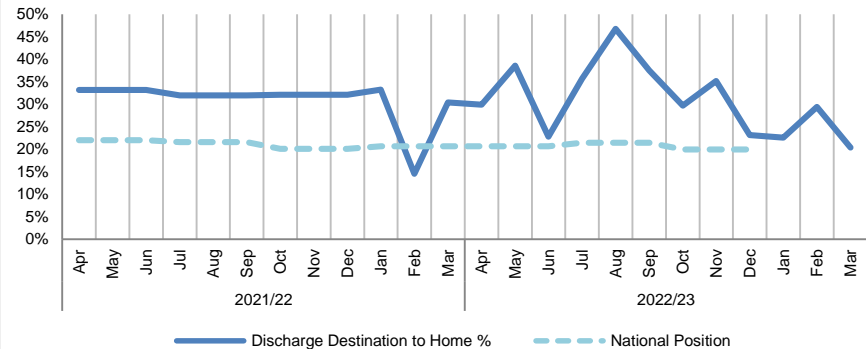
# Eastern Services Stroke Performance

Quality of care metrics for patients admitted following a stroke

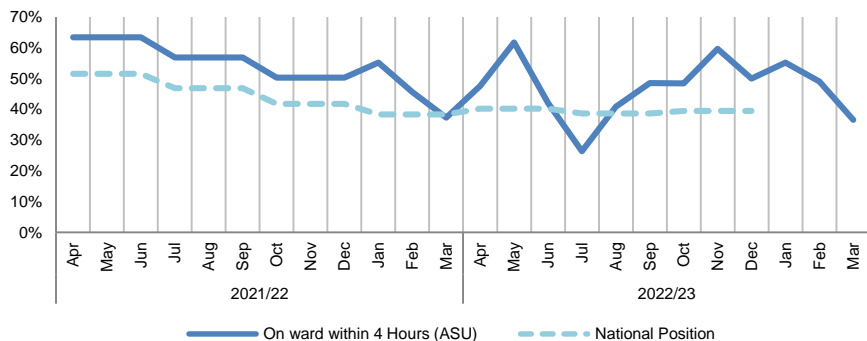
**Proportion of patients admitted following a Stroke spending 90% or more of their stay on the Stroke unit**



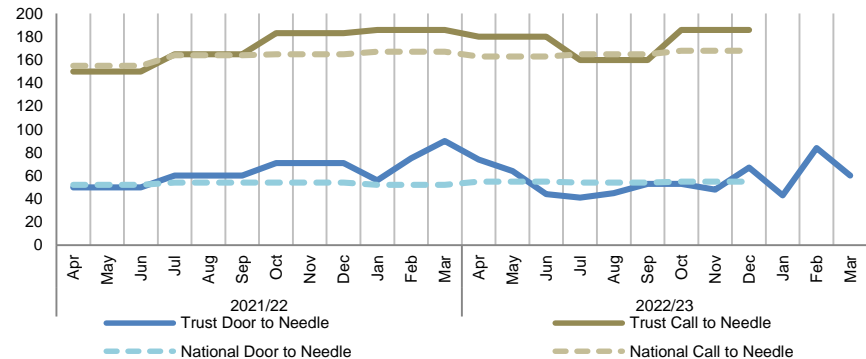
**Discharge Destination to Home (%)**



**On ward within 4 Hours (ASU)**

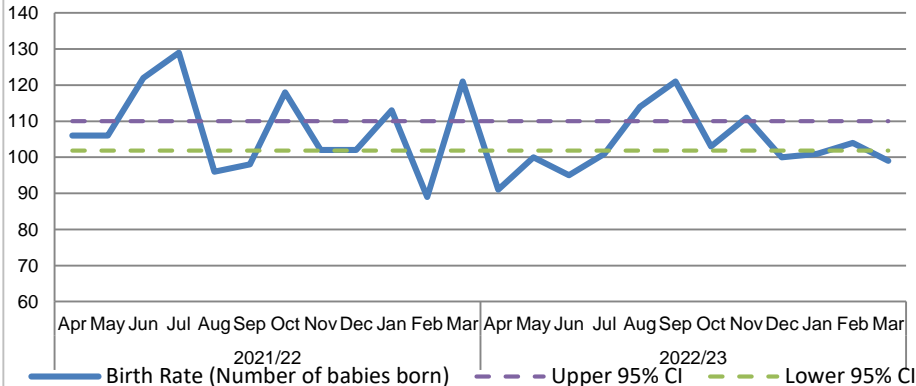


**Average Thrombolysis Times (minutes)**

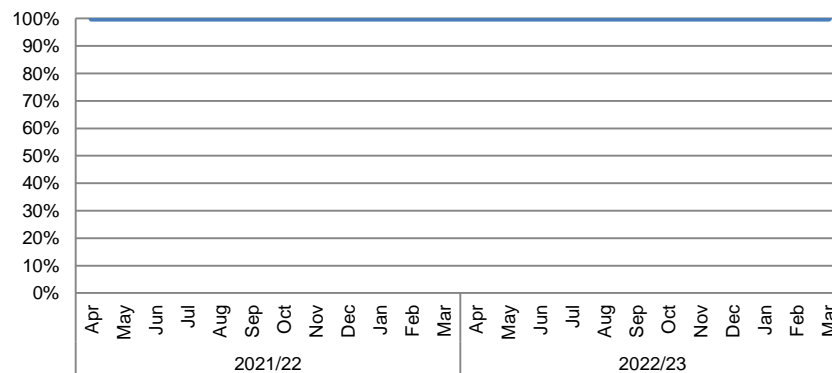


- 90% stay -The proportion of patients admitted spending 90% of their stay on the stroke unit has remained stable in March and is above target. This has been due to the continued concerted effort to try and transfer patients more quickly to the ward. In March 84.3% was achieved against the 90% stay indicator but a reduction to 36.5% stroke patients were transferred to the unit within 4 hours, demonstrating the operational pressures experienced within the emergency pathway with bed closures due to Infection Control reasons.
- The proportion of patients for whom their discharge destination is home remains stable.
- Other indicators remain positive and are either above, or in-line with the national position.
- The reduction in the Trust door to needle time seen in March reflects a smaller number of patients experiencing extended delays in Ambulance handovers, which has consequently demonstrated an improved aggregate position.

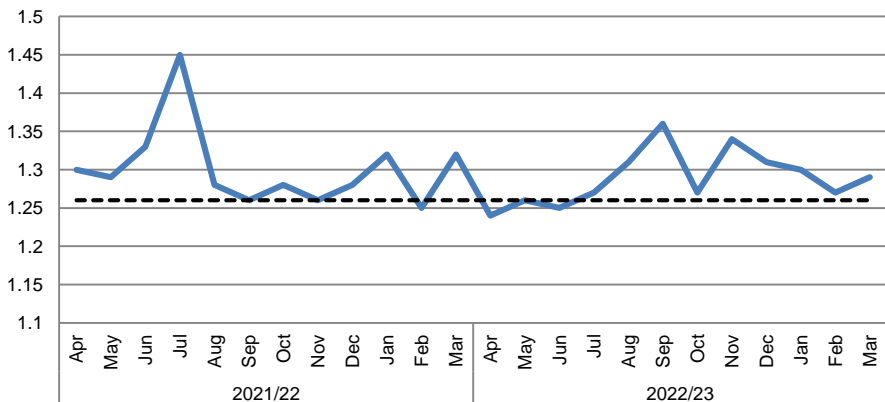
### Birth Rate (Number of babies born)



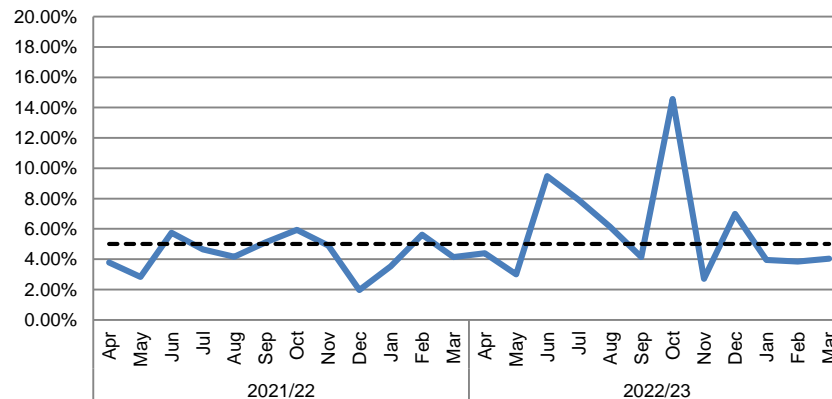
### 1:1 Care in Labour



### Midwife to delivery ratio



### Admissions of (term babies) to NNU

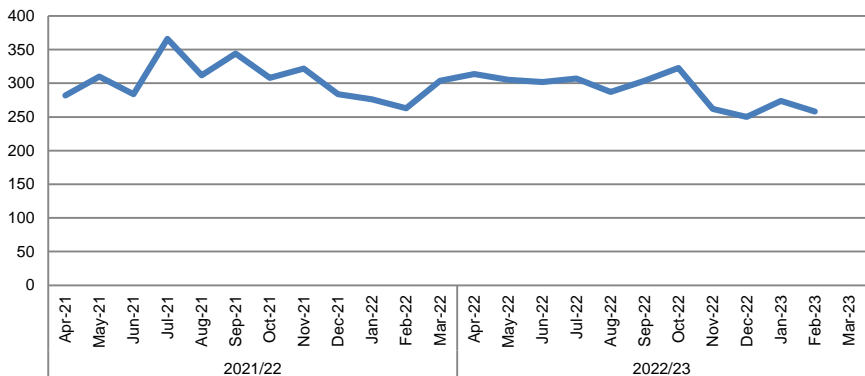


- Admission of term babies to NNU now presented as admissions in month and has remained below the National target for January, February and March
- All cases are reviewed via the ATAIN (Avoiding Term Admissions into Neonatal Units) process with no safety concerns identified in month.

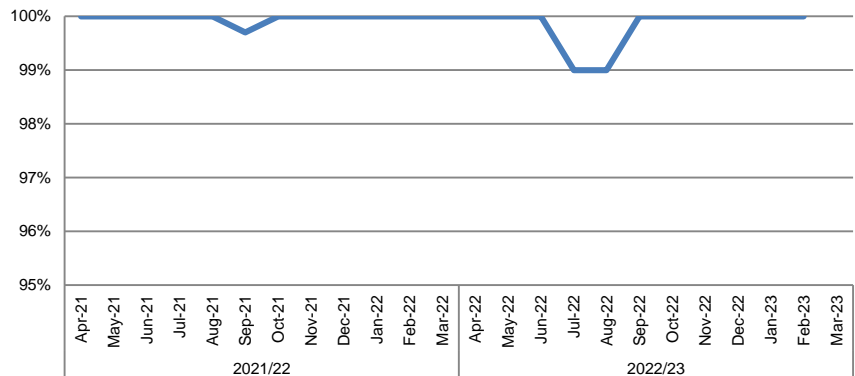
# Eastern Services Maternity

Metrics relating to the provision of quality maternity care

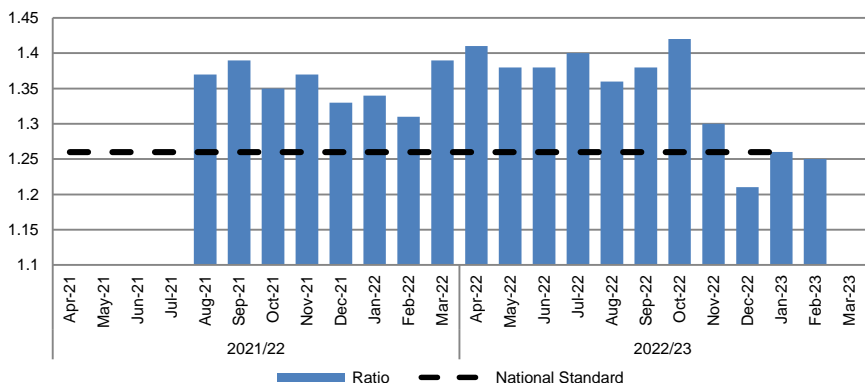
### Birth Rate (Number of babies born)



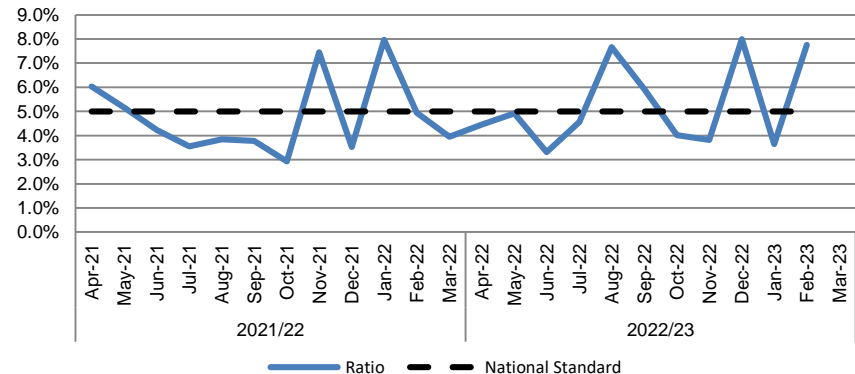
### 1:1 Care in Labour



### Midwife to delivery ratio



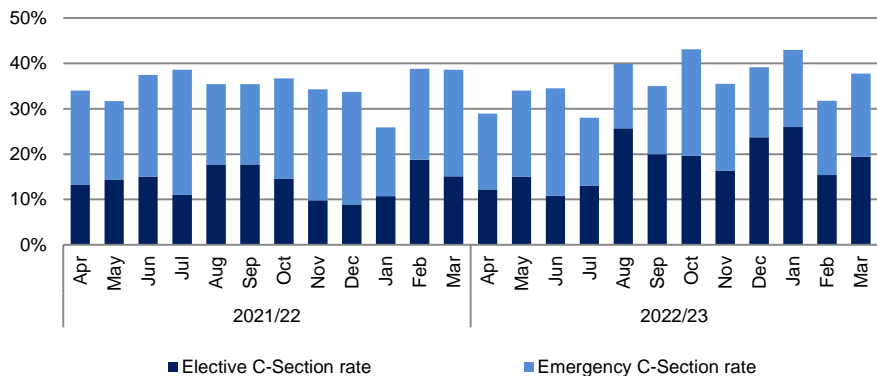
### Admissions of (term babies) to NNU



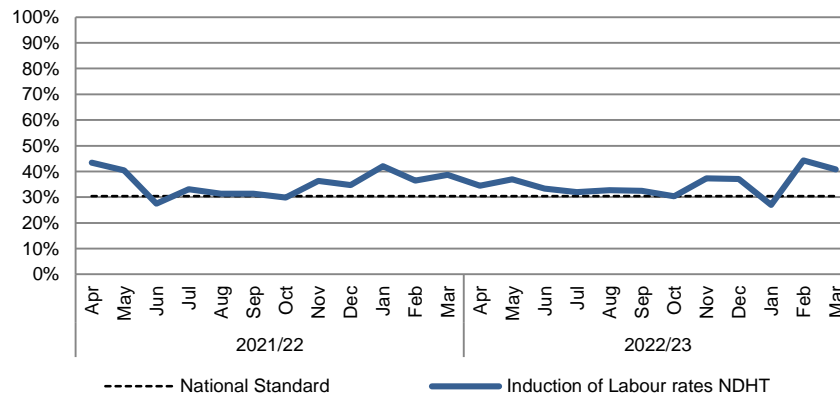
- Staffing and acuity have been challenging at times due to maternity levels within the staff group.
- 1:1 care in labour has been prioritised and remained at 100%:
- Term admissions has seen a slight increase and continues to be monitored via the ATAIN group and maternity governance.



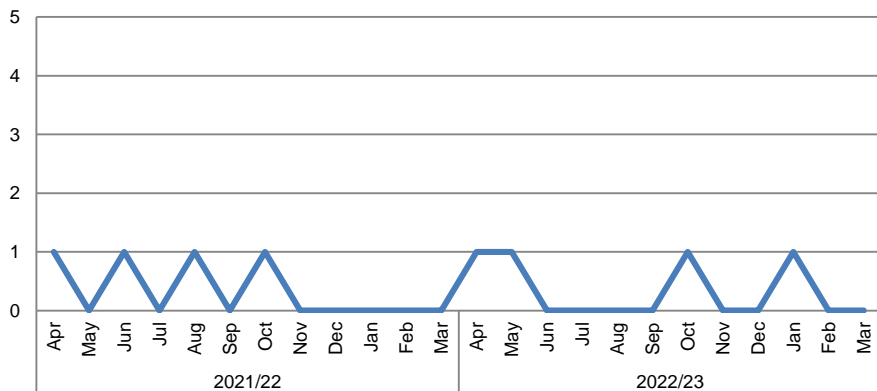
### C-Section Rates - Elective & Emergency



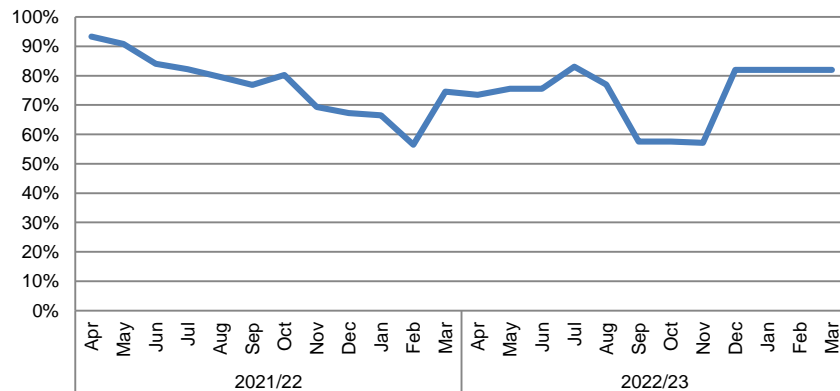
### Induction of Labour rates



### Still births (includes term & pre-term)



### PROMPT Training % (whole team)

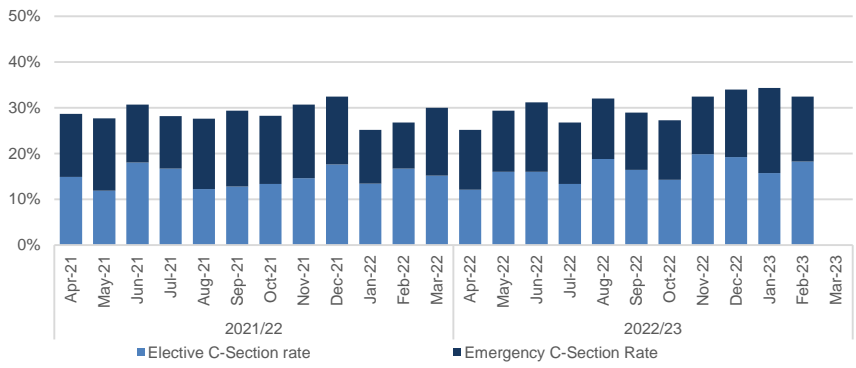


- PROMPT training compliance remains static at 82% against the target of 90%.
- The numbers of staff who are not compliant remains small across the multi-professional team. Further training scheduled to increase compliance.

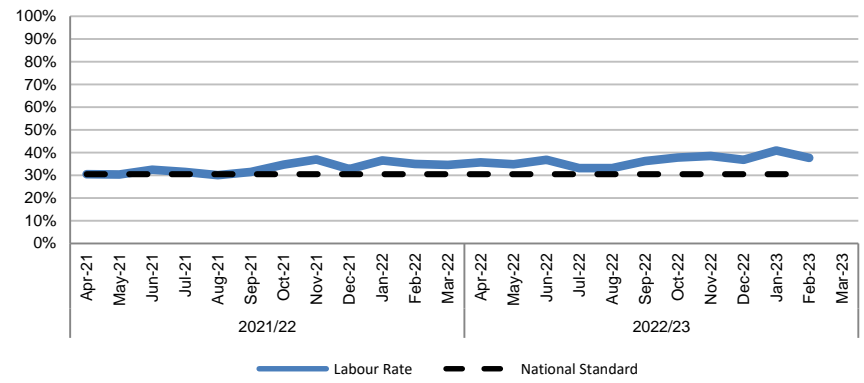
# Eastern Services Maternity

Metrics relating to the provision of quality maternity care

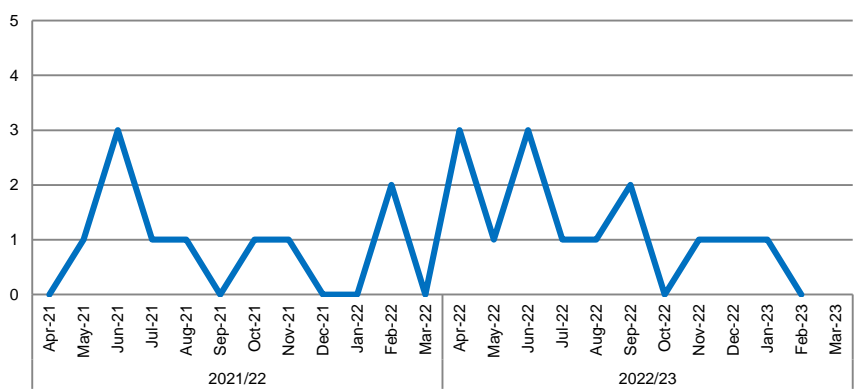
C-Section rates - Elective & Emergency



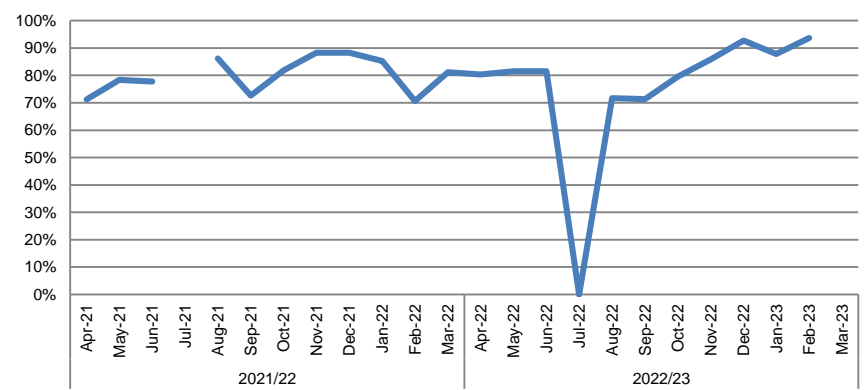
Induction of Labour rates



Still births (includes term & pre-term)

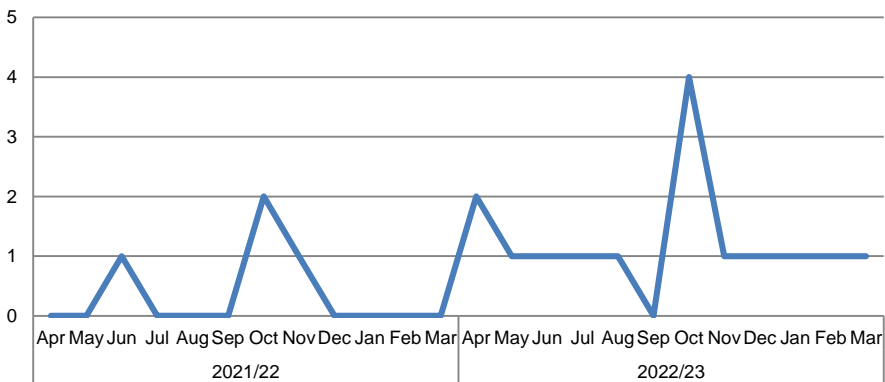


PROMPT Training % (whole team)

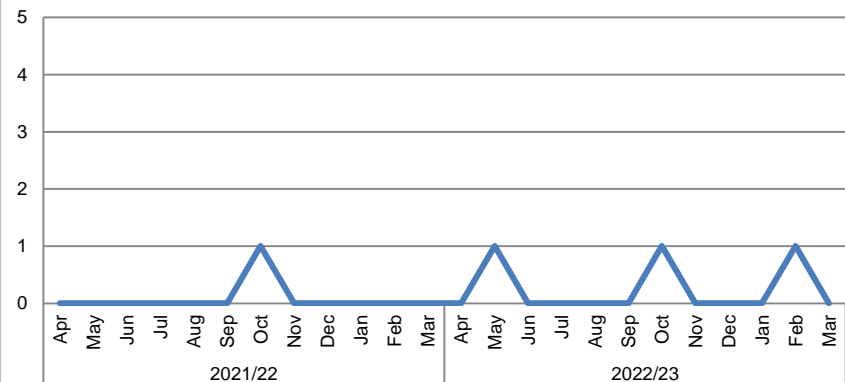


- PROMPT training compliance increased - Targeted work continues to improve compliance.

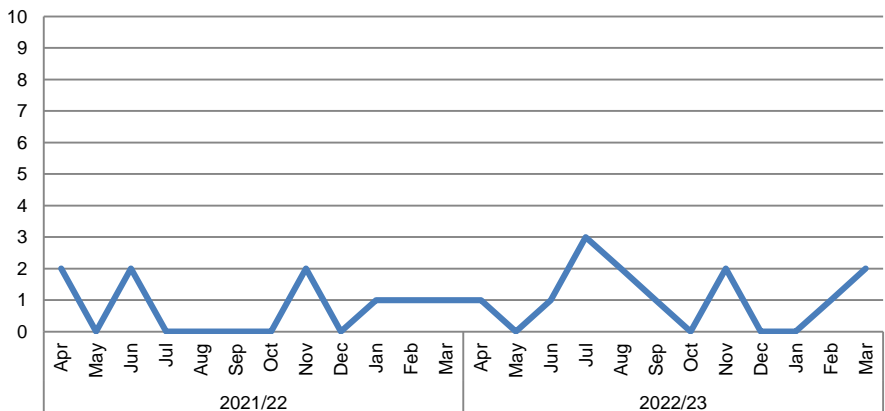
**Incidents in current month (moderate and above) (run chart)**



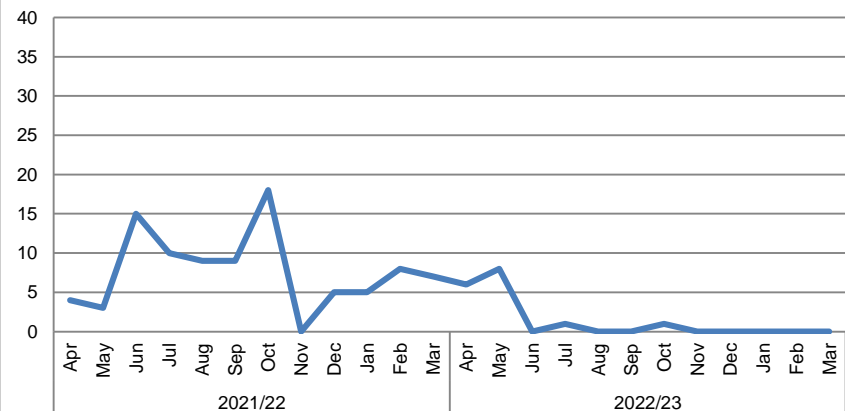
**Serious Incidents (run chart)**



**Complaints Maternity**



**Compliments Maternity**

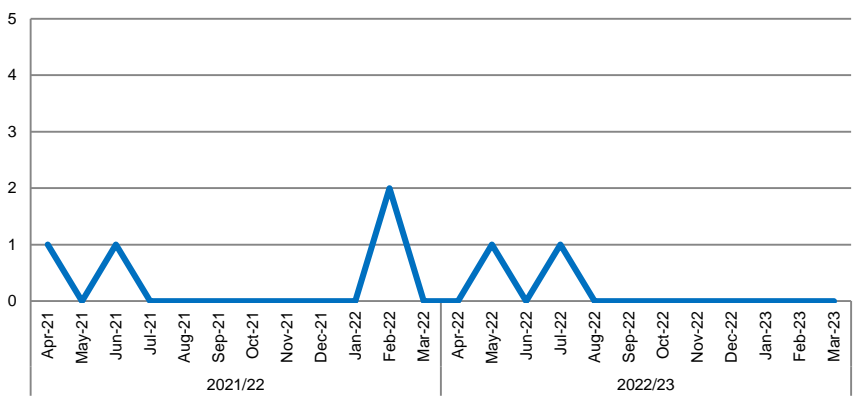


- There was 1 moderate incident in month of a historic case identified via the failsafe audit process. The case did not meet HSIB criteria and is subject to Trust investigation.
- There were no serious incidents reported in month
- There were 2 new complaints in March both relate to communication – both closed successfully by early resolution

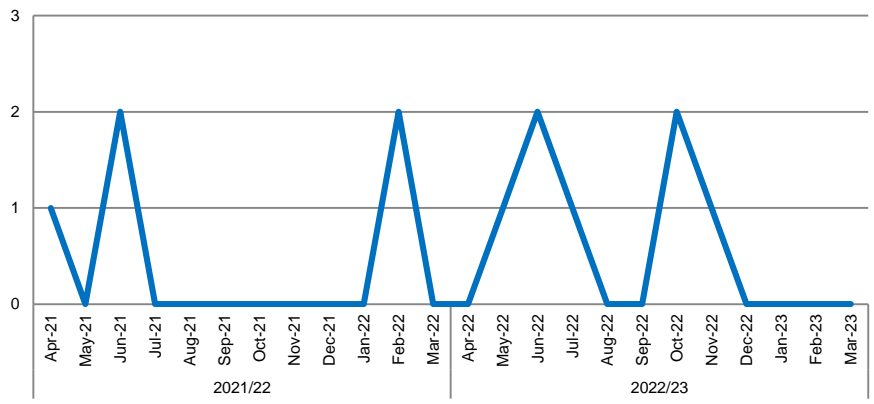
# Eastern Services Maternity

Metrics relating to the provision of quality maternity care

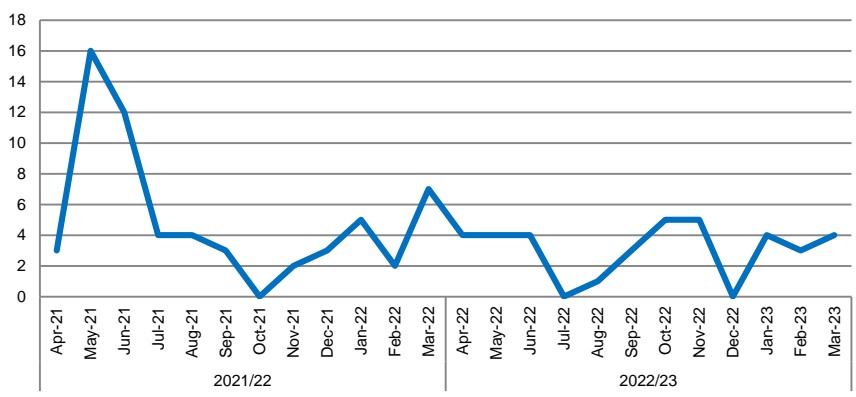
Incidents in current month (moderate and above) (run chart)



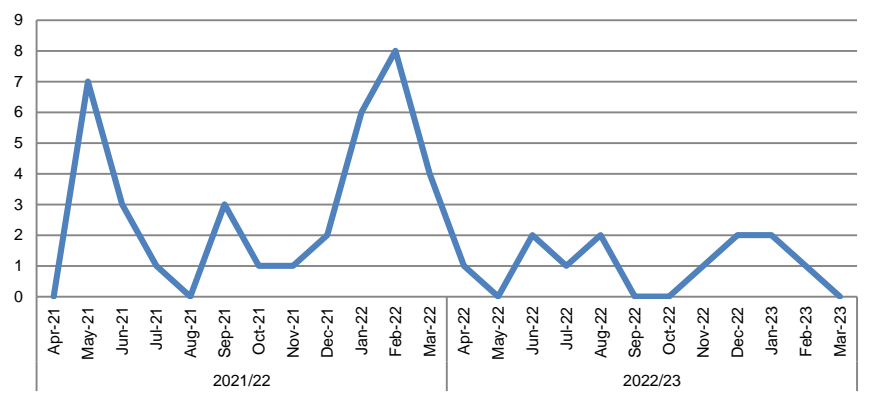
Serious Incidents (run chart)



Complaints Maternity



Compliments Maternity

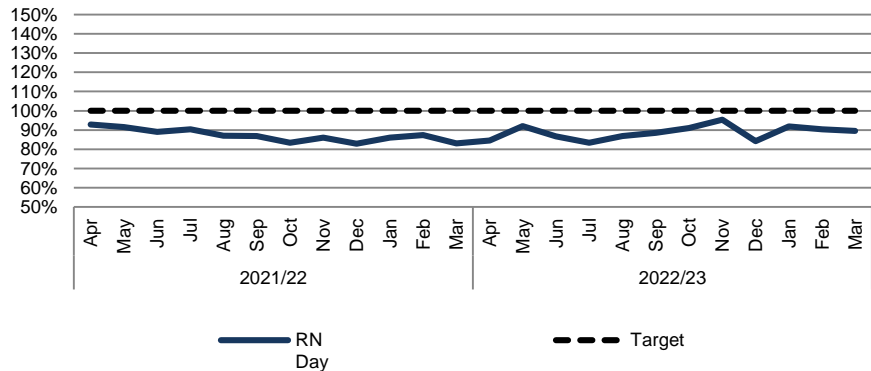


- There were 3 new complaints in February: 1 under 'commercial decisions' relating to an maternity exemption certificate, 1 regarding referral in pregnancy and 1 regarding admission arrangements

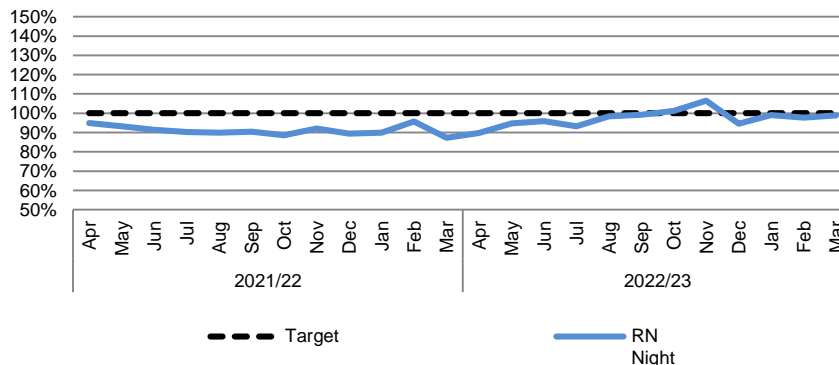
# Northern Services Safe Clinical Staffing Fill Rates



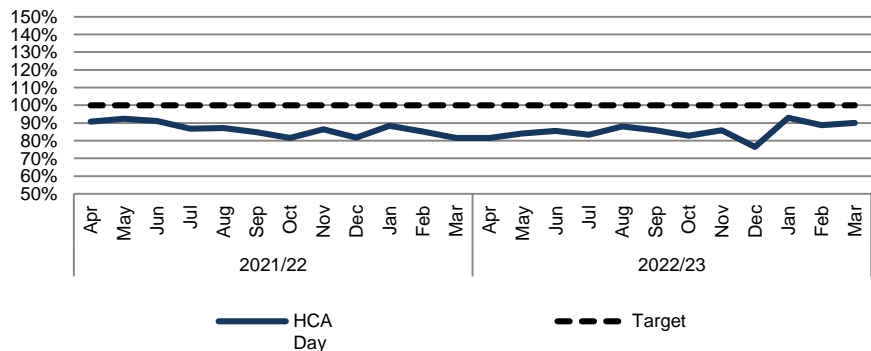
**Registered Nurses & Midwives Fill Rate (Day)**  
Inc. ED & South Molton



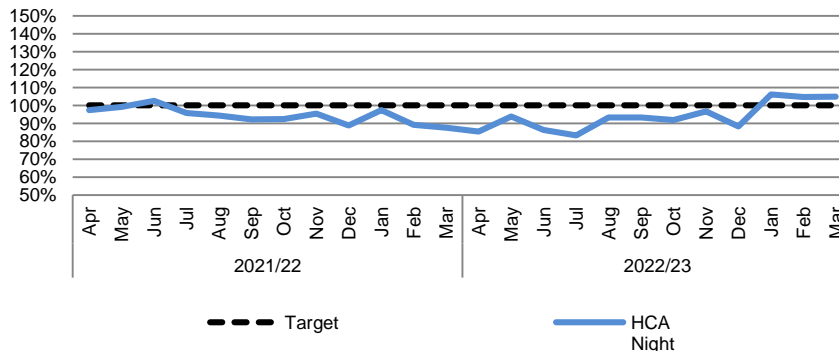
**Registered Nurses & Midwives Fill Rate (Night)**  
Inc. ED & South Molton



**HCA Fill Rate (Day)**  
Inc. ED & South Molton



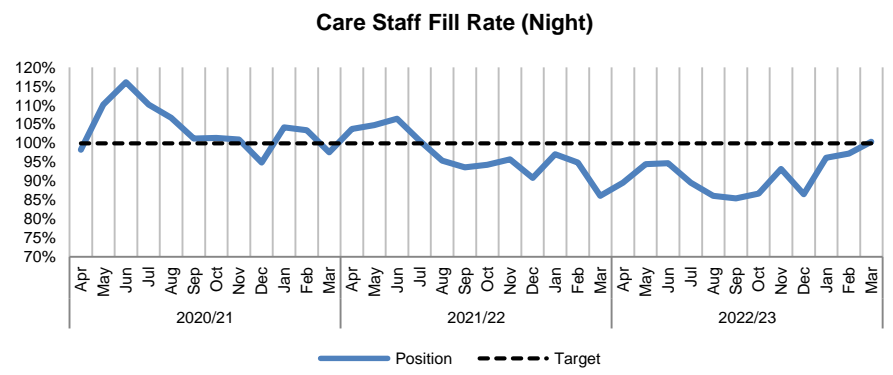
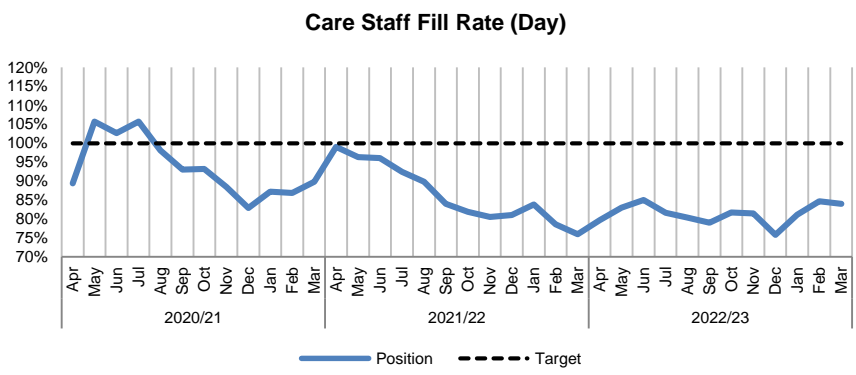
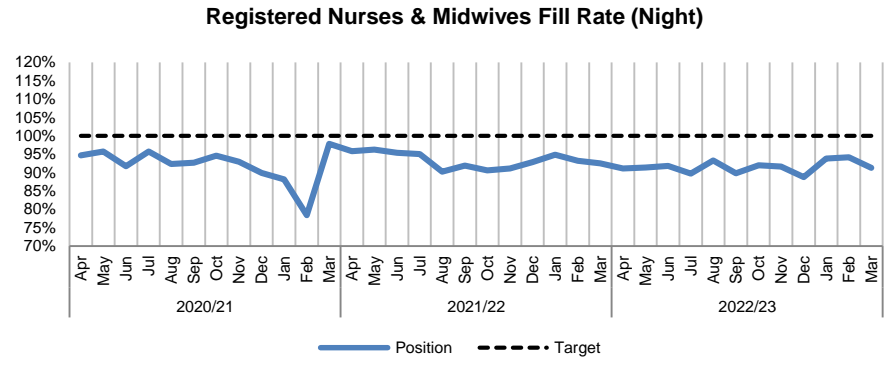
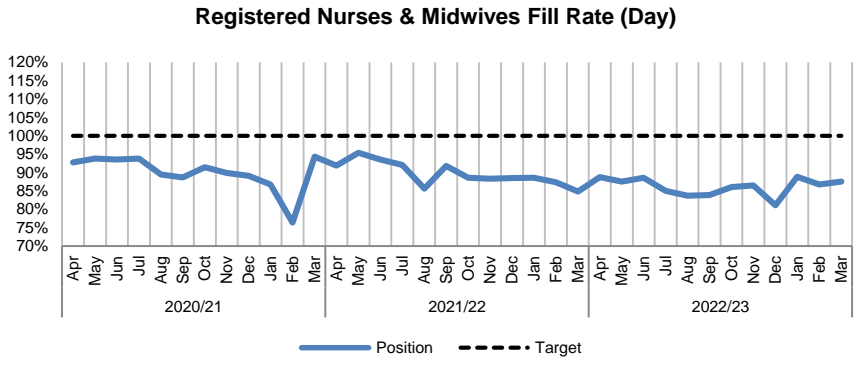
**HCA Fill Rate (Night)**  
Inc. ED & South Molton



- All clinical staffing rates are 90% or above. Daytime fill rates are more challenging due reduced availability of temporary staff.
- There were 2 reported incidents relating to low staffing in March with none scoring moderate or above.
- Staffing risks are assessed and mitigated through a number of established processes and strong professional oversight by members of the Senior Nursing and Midwifery teams on a daily basis.
- There continued to be high inpatient occupancy throughout March 2023 which has increased overall use of temporary staffing.

# Eastern Services Safe Clinical Staffing – Fill Rate

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

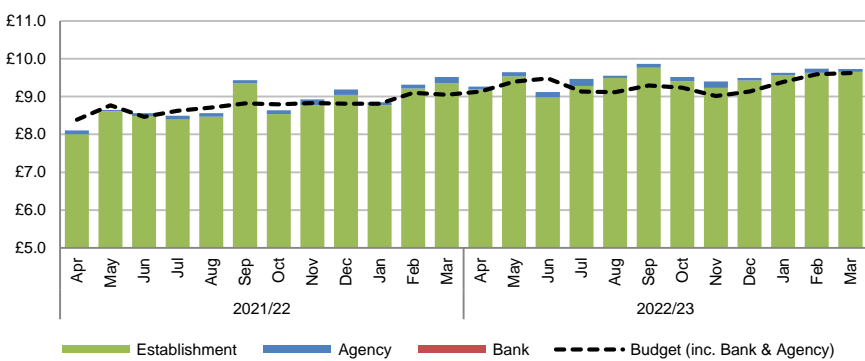


- The overall fill rate for Eastern Services was 90.8%
- There were 4 patient safety incidents reported of staff shortages in March 2023. All incidents resulted in no harm.
- A review of all patient safety incidents which resulted in moderate of greater harm has not identified incidents where staffing levels were a causative or contributory factor to patient harm.

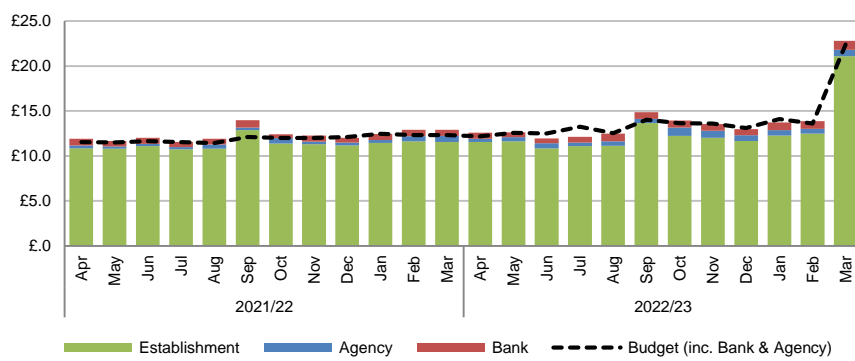
# Eastern Services Safe Clinical Staffing

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

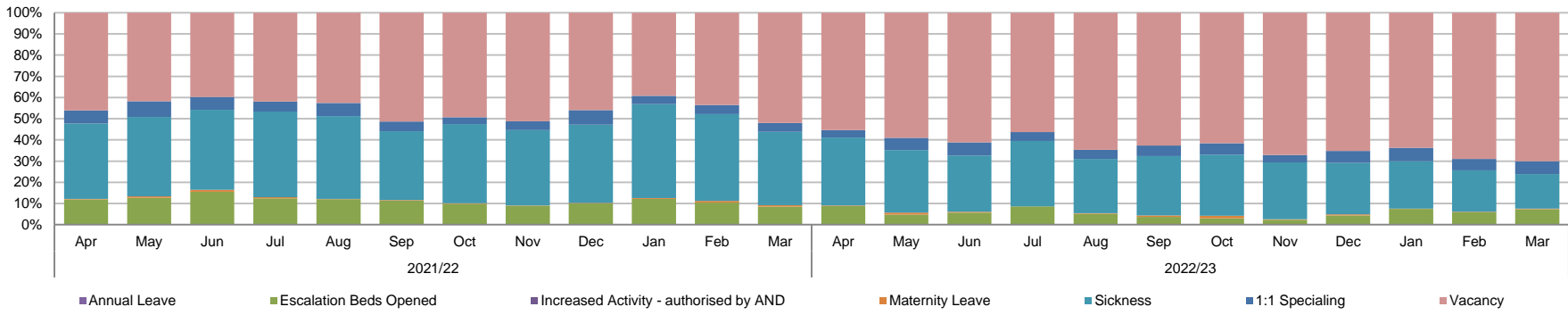
### Medical - Staff FTE (£Million)



### Nursing - Staff FTE (£Million)

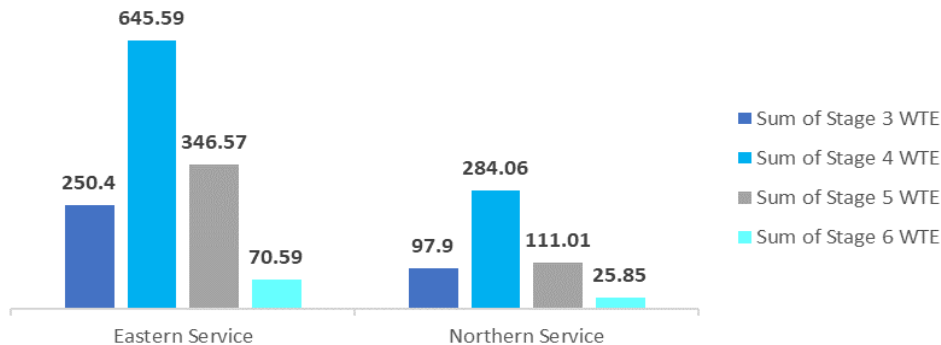
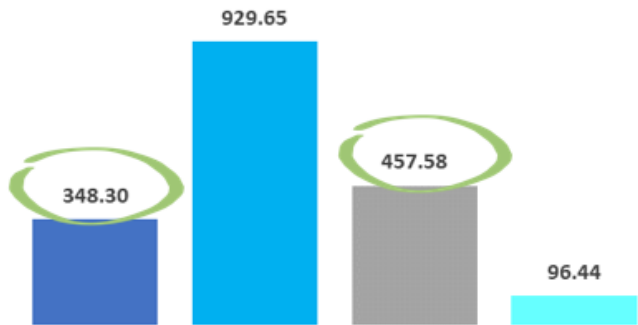


### Nursing Reasons for Bank/Agency Usage

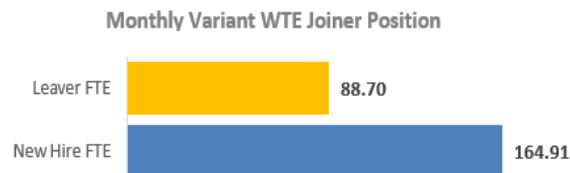
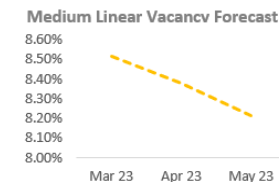
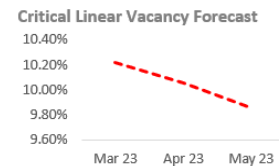
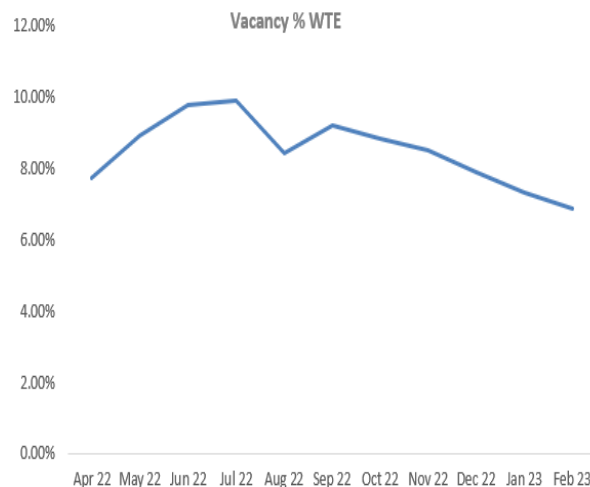


- The increase in nursing spend in March 2023 is advised as being primarily attributable to factoring in the potential back pay award currently being consulted on by the unions, as part of the 2022/23 A4C pay settlement.
- There continued to be high operational escalation throughout March 2023, which impacted upon the use of temporary staffing.
- There was notable demand for patients requiring 1:1 support due to mental health, cognitive impairment of multiple complex support needs.

# Trust Recruitment Update



- The overall vacancy rate is 6.88% which is almost 2% lower than our medium forecast last month and, encouragingly, within 0.1% of our positive forecast and further evidence to support the Accelerating Vacancies program. North reporting 9.15% down from 9.66%, and the East 5.97% down from 6.36%.
- We have 544 people (457.58) at Stage 5 (Pre-Employment Checks) which is little changed from last month, and continues the significant decrease on the 1000+ figures reported prior to March, which can be attributed to increased productivity achieved by the Recruitment and Onboarding Services.
- We are highlighting in green in the above graphs that we are not seeing the "wave" as high in Stage 3. This positive activity continues onto Stage 5 in reaching a manageable target of 500 or below.
- 119 people (96.44 WTE) are currently scheduled for an upcoming Induction and new start (data through to end of April).
- We are flagging for attention an increasing shortfall developing in the Stage 4 numbers required to fill the volume of current WTE funded vacancies. (Stage 4 is the interview and shortlisting stage.) With the exception of Medical and Dental, our AfC staff groups are showing a significant gap in shortlisted candidates versus the actual WTE required. Career Gateway data shows that there were more applications in March than in previous months which is encouraging. While the job market continues to be challenging, some suggested actions being considered and actioned are: the prompt re-advertising of unfilled or under-subscribed vacancies with a review and refresh of adverts for maximum impact; also consider scope for enhanced marketing activity to further "sell" the Trust as data shows that once applicant reaches Career Gateway we are having high % apply.
- Our average time to hire (Advert Approved to Contract Accepted) is currently at a Trust average of 69.9 calendar days, below the National Average (72 days).
- The Trust has seen 19 international nurses, 4 diagnostic radiographers and 1 midwife arrive in March. April arrivals may tip into May due to visas not yet granted.

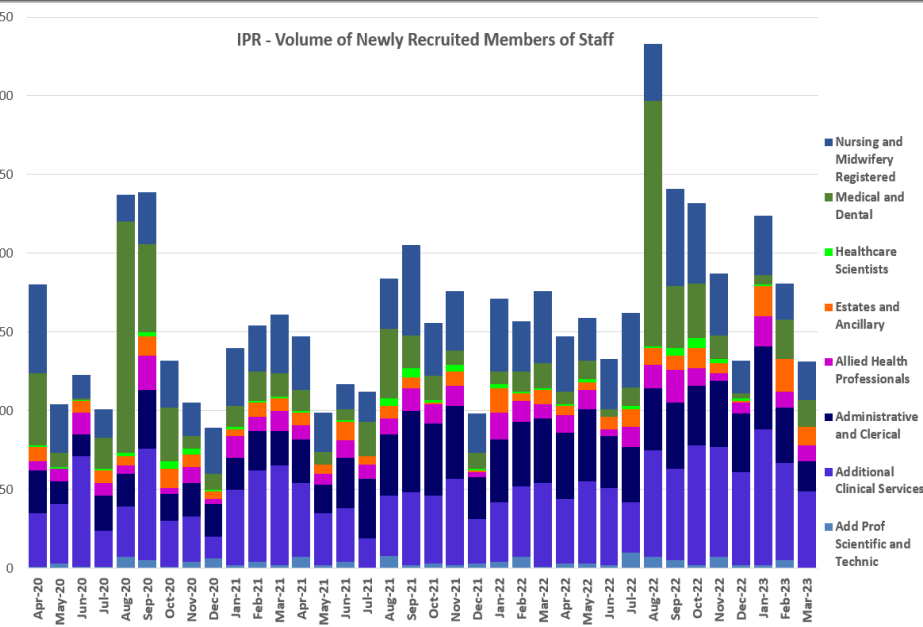




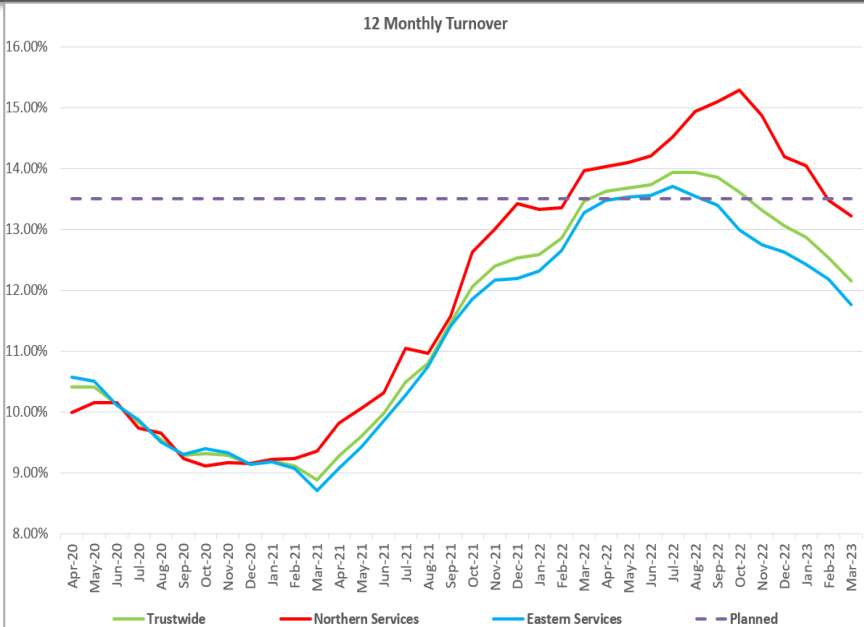
# Trust Turnover

Activity & Flow  
Operational Performance  
Patient Experience  
Quality & Safety  
Our People  
Finance

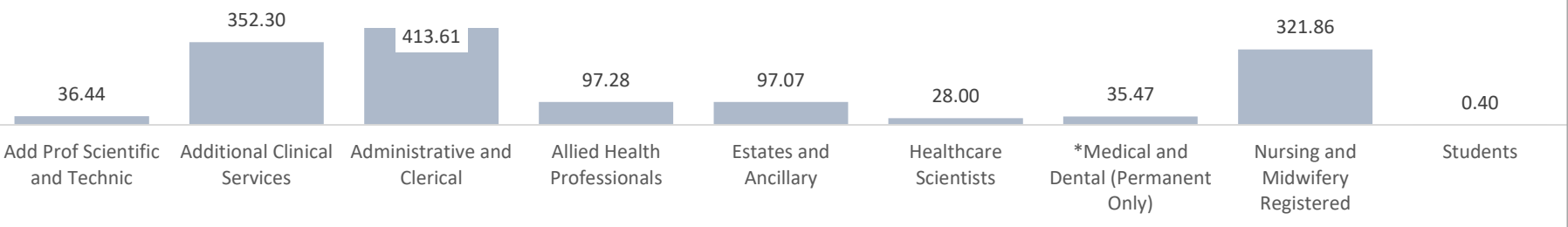
IPR - Volume of Newly Recruited Members of Staff



12 Monthly Turnover



## Leavers (FTE) for 12 months to 31 March 2023 - \*Permanent and FTC Contracts

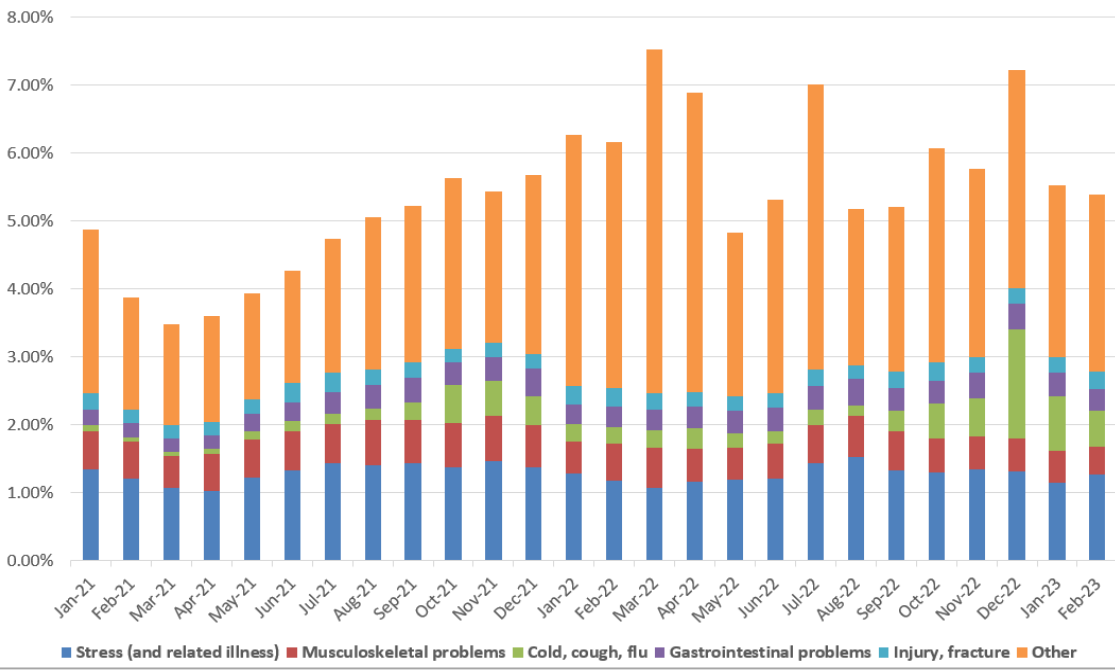


### Turnover (data as at end of March 2023)

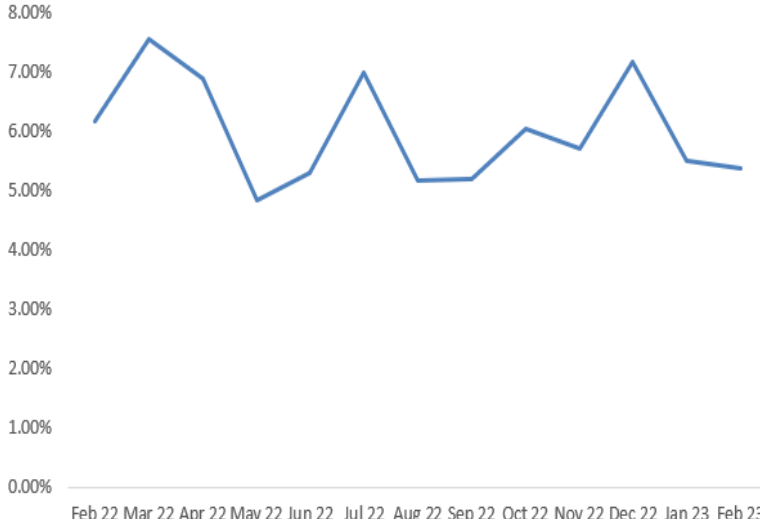
- The turnover rate continues to fall, both from a Trustwide and site point of view, with Northern Services now down to 13.2% and the East at 11.8%.
- For Additional Clinical Services (ACS) a further slight reduction in the rate dipping under 16% for the first time January 2022. The accelerated recruitment to bolster our HCSW workforce is evident when looking at each of the last six months, where ACS on-boarding accounts for over a third of all new hires. Aside from recruitment retention initiatives are in train to support staff considering leaving or needing additional support.
- The rate for Estates and Ancillary continues to be unstable with no evidence of a definite trend of improvement, however, encouragingly this month a relatively significant fall (>1%) was recorded with the rate down to 13.9% for the first time since the tail end of 2021.
- Turnover for Registered Nursing and Midwifery continues to fall for both sites to 10.7%, with Northern improving to 12% - another significant reduction from the previous month.

# Trust Sickness Absence

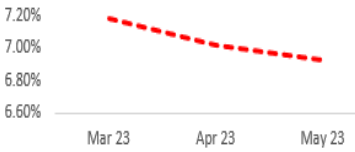
Sickness Absence Rate By Most Common Reasons (plus all Other)



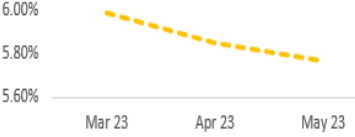
Historic Trend Actuals - Sickness %



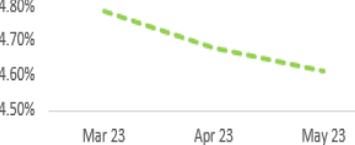
Critical Linear Sickness Forecast



Medium Linear Sickness Forecast



Positive Linear Sickness Forecast



## Sickness Absence (Data shown for latest available month: February 2023) Trust Position

- The February absence rate decreased slightly (0.1%) to 5.4%. Correspondingly, the Northern and Eastern rates were down by an equal amount to 5.1% and 5.5% respectively.
- The absence rate for February 2023 compares favourably to the same month last year, when the rate stood at 6.2%.
- While there was less time lost to Cold, Cough, Flu in February 2023 compared to the previous two months, it still accounted for 10% of time lost.
- The number of Covid-19 episodes remained significant with 16% of sickness days in February coded to that reason.
- Anxiety/Stress/Depression remains the primary reason for sickness absence in February. In the East this equates to a quarter of all sickness in the month, and a fifth for Northern Services.

### Northern Site Position

- There were month-on-month reductions in the sickness rates for Additional Clinical Services (6.6% in February from 7.3%) and Estates and Ancillary (6.2% from 8.4%).
- Registered Nursing and Midwifery also fell slightly to 6%.
- Of the main staff groups, only Allied Health Professionals (AHPs) bucked the trend with an increased rate to 4.2% from 3.6% in January.

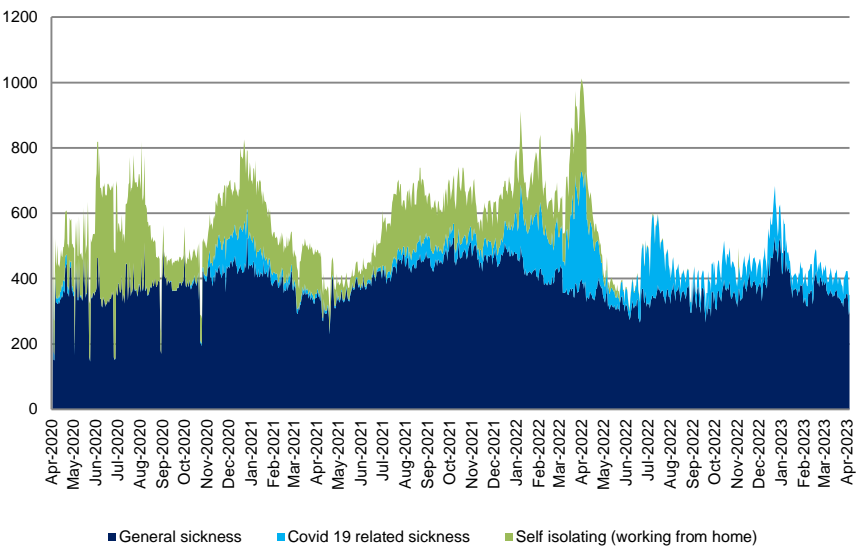
### Eastern Site Position

- Improvement for the two workforce groups most affected by sickness absence, Additional Clinical Services dropping from 8.8% in January to 7.8%; Estates and Ancillary a more marginal fall to 9.8%.
- A further decrease to for Registered Nursing, down to 5.3% in February 2023 from 5.6%.
- As was seen in the North, AHP's were the only group in the East to record an increase – rising from 3.7% to 4.6%.



# Trust Workforce – Covid related absence

### Staff Sickness and Self Isolating – Eastern Services

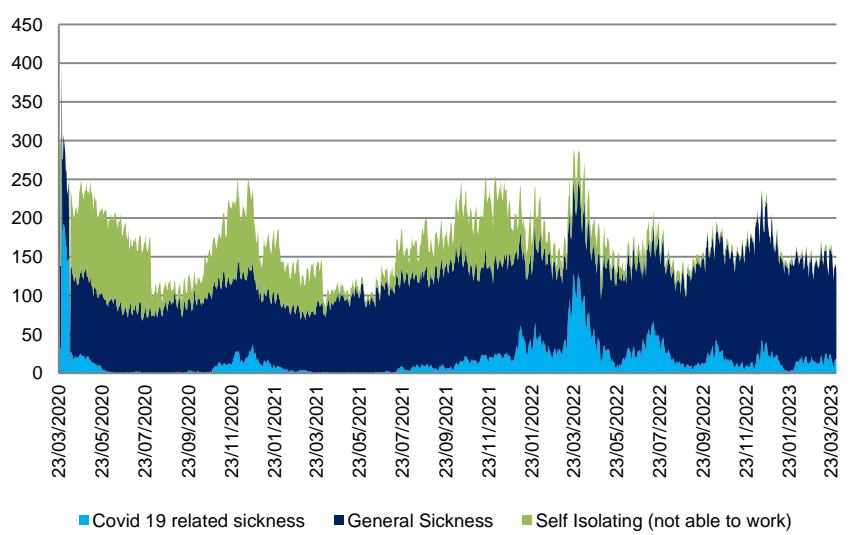


As at 11th April, the total number of staff in Eastern services with Covid related absence stands at 50 (compared to 59 at the corresponding point last month). Data from the North similarly shows a low and stable number of 12 recorded since last month's update (15).

There are currently 13 members of staff with an open sickness episode attributed to Long Covid, of which 10 are located in Eastern Services with 3 based in the Northern site.

The vaccination campaigns for the Covid Autumn Booster and Winter Flu jab have now ended. The closing table showing uptake by Trust staff was included in last month's report.

### Staff sickness and Self Isolating – Northern Services



# RDUH Finance Overview

## Financial Performance - key performance indicators

Consolidated Metrics					
Domain	Measure / Metric	Unit of Measure	Last Month Feb-23	This Month Mar-23	
Income and Expenditure	<b>I&amp;E Surplus / (Deficit) - Total</b>	£'000	-16,518	-16,734	
	I&E Surplus / (Deficit) v budget	£'000	0	1,529	
	<b>Income variance to budget - Total</b>	£'000	220	1,751	See below
	<b>Income variance to budget - Total</b>	%	0.02%	0.17%	
	Income variance to budget - Patient Care	£'000	246	1,731	FOT includes £1.5m additional allocation to ICB block contract and small favourable variances across a number of income categories.
	Income variance to budget - Commercial income	£'000	-26	20	Commercial activities are under-recovered mostly due to car parking, nursery, fertility and catering off-set by increased education and training income.
	<b>Pay variance to budget - Total</b>	£'000	251	-220	Pay budgets are reduced to reflect undelivered savings and productivity against plan and off-set by allocating reserves for developments that have not yet commenced. Adverse movement reflects impact of strike action and potential pay award pressure.
	<b>Pay variance to budget - Total</b>	%	0.05%	-0.03%	
	Agency expenditure (Inc. COVID expenditure) variance to Plan	£'000	-9,082	-10,176	Usage particularly in nursing and medical workforce reflecting vacancies, sickness, Covid impact, strike action and ESRF delivery.
	<b>Non Pay variance to budget</b>	£'000	-474	-5	Non pay continues to reflect increased drugs expenditure YTD and FOT not recoverable above block contract income off set by slippage on investments and non-recurrent underspends.
	<b>Non Pay variance to budget</b>	%	-0.16%	0.00%	
	<b>PDC, Depreciation, Interest Paid / Received variance to budget</b>	£'000	3	3	
	<b>PDC, Depreciation, Interest Paid / Received variance to budget</b>	%	0.01%	0.01%	
<b>Cost Improvement Programme - Total Current Year achievement</b>	£'000	16,300	17,499		
Cost Improvement Programme - Year to date/ Current Year variance to budget	£'000	-14,378	-16,436	See report narrative.	
Capital & Cash	Cash balance	£'000	49,720	46,033	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)
	Cash variance to budget - above / (below)	£'000	15,413	16,477	FOT: The balance sheet was not updated for the late revenue changes made to the final Annual Plan.
	Better Payment Practice v 95% target - volume	%	92%	92%	
	Better Payment Practice v 95% target - value	%	93%	93%	
	<b>Capital Expenditure variance to plan - Total above / (below)</b>	£'000	-13,942	5,146	See report narrative. Actual Capital expenditure of £56.6m fully utilises the CDEL and PDC allocations received in 2022/23.
	Capital Expenditure variance to plan - CDEL above / (below)	£'000	-9,173	1,918	Expenditure on donated assets and leases have separate funding streams to off-set.
Capital Expenditure variance to plan - PDC above / (below)	£'000	-4,769	3,228	Overall variation to plan is as a result of in-year PDC allocation adjustments that off-set.	

### Key

Total value	Blue
Positive variance value	Green
Negative variance value <5%	Yellow
Negative variance value >5%	Red

Activity & Flow

Operational Performance

Patient Experience

Quality & Safety

Our People

Finance

# RDUH Summary Finance position

## SOCI and DBV

### Month 12 Summary Finance Position - YTD

- The Board of Directors (BoD) has approved a deficit plan of £18.3m that was forecast to be improved by £1.5m from additional ICB allocations.
- Cumulative deficit of £16.7m achieves plan predominantly by Delivering Best Value slippage being off-set by non-recurrent expenditure underspends.
- The BoD is reminded that month 12 is subject to enhanced year end reporting requirements that impacts the availability of some financial information. Whilst the overall SOCI deficit position, DBV and Capital positions will be reported in the IPR as they will not be expected to change, it was agreed the finalisation of the SOFP and SOCF are impacted and would not be reported as appendices this month.
- The draft accounts are due to be submitted on 27th April 2023, being 1 day after the Board meeting. The Board should note that the full draft accounts, together with analytical review are scheduled to be reported to the Audit Committee meeting of 4th May 2023.

### Month 12 2022/23 Summary Income & Expenditure

	Year to Date		
	Budget £,000	Actual £,000	Variance Fav / (Adv) £,000
<b>Patient Income</b>	904,660	906,391	1,731
<b>Commercial Income</b>	120,371	120,391	20
<b>Total Income</b>	<b>1,025,031</b>	<b>1,026,782</b>	<b>1,751</b>
<b>Pay</b>	(656,684)	(656,904)	(220)
<b>Non Pay</b>	(335,331)	(335,336)	(5)
<b>Total Expenditure</b>	<b>(992,015)</b>	<b>(992,240)</b>	<b>(225)</b>
<b>EBITDA</b>	<b>33,016</b>	<b>34,542</b>	<b>1,526</b>
PDC, Depreciation, Interest & gain from absorption	52,423	52,426	3
<b>Net Surplus / (Deficit)</b>	<b>85,439</b>	<b>86,968</b>	<b>1,529</b>
Removal of exceptional items	(103,702)	(103,702)	0
<b>Net Surplus / (Deficit) after exceptional items</b>	<b>(18,263)</b>	<b>(16,734)</b>	<b>1,529</b>

### Delivering Best Value (DBV) Programme (To be completed)

- The DBV programme for the year is £33.9m
- £17.5m has been achieved YTD being £16.4m adverse to plan. The shortfall was covered through other NR slippage and under spends as set out above.
- Of the shortfall £14.6m relates to productivity opportunity that has been affected by current pressures in Urgent and Emergency Care impacting the ability to deliver the elective activity plan. **£7.0m has been delivered non recurrently.**

Delivering Best Value Programme £'m	Full Year Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance
Divisional CIP	5.5	5.4	5.3	-0.1
Mycare benefits	1.9	1.9	0.8	-1.1
Productivity	14.6	14.6	0.0	-14.6
Covid Cost Reduction	6.5	6.6	5.9	-0.7
Further Stretch	5.4	5.4	5.5	0.1
<b>Total</b>	<b>33.9</b>	<b>33.9</b>	<b>17.5</b>	<b>-16.4</b>

Recurrent	20.9	20.9	10.5	-10.4
Non-Recurrent	13.0	13.0	7.0	-6.0
<b>Total</b>	<b>33.9</b>	<b>33.9</b>	<b>17.5</b>	<b>-16.4</b>

## Capital & Cash

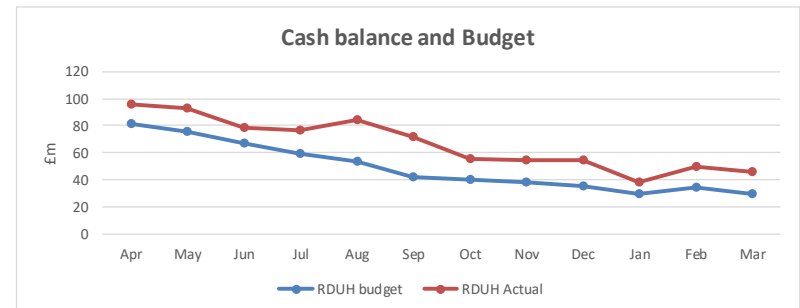
### Capital

- The capital programme for the year is £56.6m being £5.1m higher than plan due to increases in PDC schemes, donations and leases.
- £25.1m of the programme has been delivered in-month (£28.1m in prior year).
- Confirmation has been received that the 2021/22 and 2022/23 IFRS16 impact of leases meeting the criteria will be covered by a central allocation.

	Year to Date			Full Year Forecast		
	Plan £'000	Actual £'000	Variance Fav/(Adv)	Plan £'000	Actual £'000	Variance Fav/(Adv)
<b>Capital Funding Sources:</b>						
CDEL	33,306	33,306	0	33,306	33,306	0
Donated	892	1,954	1,062	892	1,954	1,062
Leases	2,303	3,159	856	2,303	3,159	856
PDC	14,953	18,181	3,228	14,953	18,181	3,228
<b>Total Capital Income</b>	<b>51,454</b>	<b>56,600</b>	<b>5,146</b>	<b>51,454</b>	<b>56,600</b>	<b>5,146</b>
<b>Expenditure:</b>						
Developments	14,707	15,839	(1,132)	14,707	15,839	(1,132)
Equipment	14,919	17,642	(2,723)	14,919	17,642	(2,723)
Estates projects	6,050	4,676	1,374	6,050	4,676	1,374
Digital	15,220	18,443	(3,223)	15,220	18,443	(3,223)
Unallocated	558	0	558	558	0	558
<b>Total Capital Expenditure</b>	<b>51,454</b>	<b>56,600</b>	<b>(5,146)</b>	<b>51,454</b>	<b>56,600</b>	<b>(5,146)</b>
<b>Under / (Over) Spend</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

### Cash

- Closing cash as at the end of March is £46.0m and is £16.5m 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).
- Better Payment Practice of paying 92.6% 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.



**Royal Devon University Healthcare NHS Foundation Trust**
**Income Statement - Consolidated**

Period ending 31/03/2023

Month 12

	Year to Date			
	Budget	Actual	Actual Variance to Budget Fav / (Adv)	
	£'000	£'000	£'000	
<b>Income</b>				
Patient Care Income	906,391	904,660	1,731	1
Operating Income	120,391	120,371	20	
<b>Total Income</b>	<b>1,026,782</b>	<b>1,025,031</b>	<b>1,751</b>	
<b>Total Costs</b>				
Employee Benefits Expenses	(656,904)	(656,684)	(220)	2
Drugs	(108,376)	(105,009)	(3,367)	3
Clinical Supplies	(84,607)	(83,398)	(1,209)	4
Non-Clinical Supplies	(17,010)	(17,840)	830	4
Misc Other Operating Expenses	(103,107)	(107,020)	3,913	4
Services Received	(22,236)	(22,064)	(172)	4
<b>Total Costs</b>	<b>(992,240)</b>	<b>(992,015)</b>	<b>(225)</b>	
<b>EBITDA</b>	<b>34,542</b>	<b>33,016</b>	<b>1,526</b>	
Profit / (Loss) on asset disposals	3	0	3	
Total Depreciation	(48,519)	(48,519)	0	
<b>Total Operating Surplus / (Deficit)</b>	<b>(13,974)</b>	<b>(15,503)</b>	<b>1,529</b>	
Interest Receivable	1,549	1,549	0	
Interest Payable	(2,880)	(2,880)	0	
PDC	(10,760)	(10,760)	0	
Gain from Transfer by Absorption	113,033	113,033	0	
<b>Net Surplus / (Deficit)</b>	<b>86,968</b>	<b>85,439</b>	<b>1,529</b>	
Remove donated asset income & depreciation, AME impairment and gain from transfer by absorption	(103,702)	(103,702)	0	
<b>Net Surplus/(Deficit) after donated asset &amp; PSF/MRET Income</b>	<b>(16,734)</b>	<b>(18,263)</b>	<b>1,529</b>	

**KEY MOVEMENTS AGAINST BUDGET**
**Overall achievement against plan**

- £1.5m Additional income from ICB's and small favourable variances across a number of income categories.
- Pay underspends off-set by slippage on Delivering Best Value and reserves. Overall impact of strike action has
- Drugs expenditure not recoverable above block contract income.
- Under spends linked to lower levels of elective activity and classification within non-pay categories.

**Royal Devon University Healthcare NHS Foundation Trust**  
**Capital Expenditure - Consolidated**  
**Period ending 31/03/2023**  
**Month 12**

Scheme	Source of Funding	Actual expenditure to date			Expected Completion Date
		Plan £'000	Actual £'000	Variance slippage / (higher) £'000	
<b>Schemes &gt;= £500k</b>					
MYCARE (Northern)	N CDEL/PDC	10,061	10,100	(39)	22/23
ED Reconfiguration	E CDEL	6,871	5,640	1,231	23/24
Estates Infrastructure 22/23	E CDEL	4,520	4,036	484	22/23
Diagnostics CDC	E PDC	905	2,047	(1,142)	22/23
Operating leases renewed in 2022/23	N&E CDEL	2,303	2,477	(174)	22/23
Backlog Maintenance	N CDEL	1,840	1,708	132	22/23
Community Diagnostics Centre	E PDC	4,110	1,977	2,133	24/25
Cardiology Day Case Unit	E PDC/DON	2,500	1,560	940	24/25
Additional 3rd Party software licenses	E CDEL	0	863	(863)	22/23
Ophthalmology Hub	N CDEL/DON	1,249	1,174	75	22/23
Equipment	N CDEL	1,105	2,136	(1,032)	22/23
NHP - OBC Funding	N PDC	1,060	1,060	0	22/23
Discharge Lounge	N PDC	0	2,000	(2,000)	22/23
Surgical Robot	N PDC	0	1,800	(1,800)	22/23
R14 Genetics NovaSeq 6000	E PDC	0	872	(872)	22/23
Mortuary	N CDEL	800	1,288	(488)	22/23
Nightingale Hospital Accelerator Programme	E CDEL	765	750	16	22/23
MYCARE (Eastern)	E CDEL	714	1,080	(366)	22/23
Additional Citrix licenses	E CDEL	0	634	(634)	22/23
Room 9 - Xray Replacement	E CDEL	0	506	(506)	22/23
<b>Total Schemes &gt;= £500k</b>		<b>38,803</b>	<b>43,707</b>	<b>(4,904)</b>	
Schemes <= £500k	N&E CDEL	11,861	11,190	671	22/23
Schemes <= £500k	N&E PDC	690	1,703	(1,013)	22/23
Schemes <= £500k	N&E DON	100	0	100	22/23
<b>Total Capital Expenditure</b>		<b>51,454</b>	<b>56,600</b>	<b>(5,146)</b>	

Capital expenditure of £56.6m fully utilises the CDEL and PDC allocations received in 2022/23.  
 Overall variation to plan is as a result of in-year PDC allocation adjustments.

<b>Agenda item:</b>	10.1, Public Board Meeting	Date:	26 April 2023	
<b>Title:</b>	Royal Devon “Annual Sustainability and Development Plan”			
<b>Prepared by:</b>	Dave Tarbet, Director Business, Innovation and Sustainability			
<b>Presented by:</b>	Chris Tidman, Deputy Chief Executive Officer			
<b>Responsible Executive:</b>	Chris Tidman, Deputy Chief Executive Officer			
<b>Summary</b>	This paper presents the Royal Devon Annual Sustainability and Development Plan; a look at what’s been achieved in 2022/23 and our priorities looking forward.			
<b>Actions required:</b>	The Board of Directors is asked to note this paper			
<b>Status (x):</b>	<b>Decision</b>	<b>Approval</b>	<b>Discussions</b>	<b>Information</b>
				x
<b>History:</b>	Annually TDG and Trust Board of Directors receive a report presenting the progress in delivering the Royal Devon’s Green Plan and other associated work on sustainability. This looks back at achievements and ahead in terms of priorities.			
<b>Link to Strategy / Assurance Framework</b>	Royal Devon Sustainability Supporting Strategy			

**Monitoring information**

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

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



# Royal Devon Sustainability Development Plan update 2022-23

## 1. Executive Summary

- 1.1 In April 2022, the Royal Devon University Healthcare NHS Foundation Trust launched its Green Plan – an aspirational plan aligned to the NHS’s net zero commitments and organised across 9 workstreams.
- 1.2 This paper presents an annual report on Royal Devon Sustainability Development covering progress made in 2022/23 and a look-ahead to priorities in 2023/24.
- 1.3 Progress has been made across all 9 areas of work and the report provides details for each of these including presenting a series of case-studies relating to how our changing care models support the sustainability and decarbonisation objective.

## 2. Royal Devon Sustainability Development – Highlights

The following section takes the key highlights from the Annual Report (22/23):

### 2.1 Workforce and System Leadership

- Linked Green Team competitions and Brilliant Ideas programme
- Introduced new training modules to Lean +
- Conducted sustainability awareness surveys

### 2.2 Sustainable Models of Care (case studies)

- The introduction of Virtual Wards makes a significant contribution to sustainable development of health services
- Introducing Patient Initiated Follow Up (PIFU) into outpatient re-design has a major impact on decarbonising patient travel
- The Emergency Department has achieved a silver accreditation under the Royal College of Emergency Medicine Greener ED programme. They have also trialled new reusable face masks and reduced the use of harmful Entonox

### 2.3 Travel and Transport

- Increased staff use of EVs through salary sacrifice lease arrangements
- Northern services achieve Cycle Friendly UK accreditation
- Business use EV charging points installed
- Change Project: Try Before You Buy foldable e-bike scheme and grant developed

### 2.4 Estates, Facilities, Energy, Waste and bio-diversity

- Installation of more LED lighting
- Software installed for building performance monitoring
- A number of feasibility studies completed relating to building retrofit improvement and gas decarbonisation
- Begun collaboration across Exeter city public partners to establish design feasibility to connect to a low carbon district heating network
- Removal of the final 2 oil boilers

- Trial completed for reusable sharps
- Continued planting and No-Mow periods to encourage Bio-diversity

#### 2.5 Medicines

- We no longer use the most pollutant anaesthetic gas Desflurane
- A programme for the reduction and in some cases removal of Nitrous Oxide made steady and significant progress.
- Pentrox replacing Entonox in most clinical services

#### 2.6 Supply-chain

- Social value introduced into tender exercises

#### 2.7 Food and Nutrition

- Food waste sent for anaerobic digestion

#### 2.8 Adaption

- The Trust has started working with the University of Exeter's European Centre for Environment and Human Health (ECEHH) to use their Local Climate Adaption Tool (LCAT) in support of its adaption plan

### 3. Forthcoming priorities

The team are focused on the following areas for 2023/24

- Supporting Culture Change
- Process Driven Change
- Policy Driven Change
- Operationalising the Plan
- Carbon Measurement

### 4. Recommendations

The Board is asked to note the progress made during the year and the prioritisation for 2023/24.

## Annual Sustainability Development Report 2022-23

### **Background**

The Greener NHS campaign is a national programme with statutory targets aimed at achieving Net-Zero (NZ) carbon dioxide (CO<sub>2</sub> or CO<sub>2</sub> equivalent) emissions from NHS activities. This involves developing and following an ambitious route map to reach NZ by 2040<sup>[1]</sup>.

To support this, the Royal Devon University Healthcare NHS Foundation Trust (RDUH) has developed a Green Plan, covering the period 2022-2025. This plan was approved by the Board of Directors in January 2022 and sets out how the Trust plans to go about achieving their long-term sustainability goals and 'Net Zero' targets. The Green Plan is a supporting pillar of the Trust's corporate strategy, being delivered as part of the "Collaboration and Partnerships" objective with the Deputy Chief Executive as Senior Responsible Officer (SRO) and led by the Director of Business, Innovation and Sustainability. The Green Plan will help guide the design and implementation of our future service sustainability and will act as a strong foundation to ensure that our environmental ambitions are embedded into everything we do.

The plan sets out the objectives, approach, key messages and outputs required to support delivery alongside a timeline and is due to be revised next in 2025. Delivery is managed by a core sustainability team who support Trust operational leads. A Sustainability Steering Group, chaired by the executive SRO, meets every two months and issues a progress report to the Board of Directors every six months.

Sustainability ideas may arise from the core team or the operational departments. Through strong teamwork and a focus on best practice project management those ideas are turned into value creating initiatives which complement the plan.

This sustainability report covers the majority of the information that will be contained in the Annual Report and therefore details progress against the Green Plan, and at a minimum, includes the mandatory reporting requirements as required by NHSE/I's Greener NHS team. The scope of this report is to capture performance over the last year of the Trust activities and historic data pre-merger where available as well as point towards future priorities.

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<sup>[1]</sup> And by 2045 net zero for the NHS footprint including all emissions influenced but not directly controlled by the service.

## Our Sustainability Targets:

In our Green Plan there are three overarching strategic targets with supporting objectives:

### 1. Embody Sustainable Healthcare

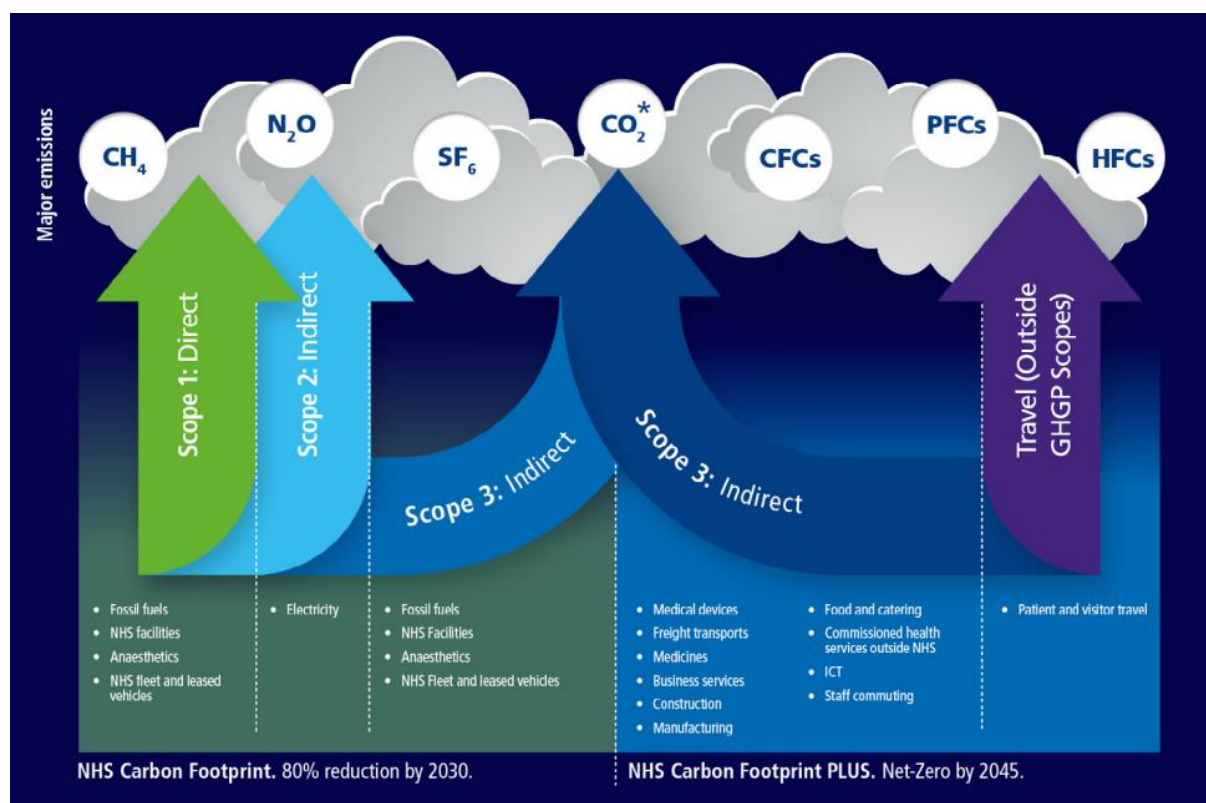
Prioritising sustainability objectives in order to make sustainable healthcare a 'business as usual' activity.

### 2. Staff Engagement

Our ability to deliver on this ambitious Green Plan will be dependent upon all parts of the organisation pulling together as one team. Whilst the Sustainability Steering group will have co-ordination, measurement and assurance roles, it will be the individual actions of our thousands of staff members, and the cumulative effect of these, that will make the plan impactful.

### 3. Carbon Reduction

The table below shows the elements that make up NHS carbon emissions – the carbon "footprint".



“NHS Carbon Footprint” includes carbon emissions that are directly produced through the use of building energy, water, waste processes, anaesthetics, inhalers and business travel.

“The NHS Footprint PLUS” includes the emissions associated with products and services that we purchase.”

In line with the NHS commitment to become Net Zero CO<sub>2</sub>, we are committed to the following targets:

<b>Objective</b>
<b>Carbon Footprint</b> <ul style="list-style-type: none"> <li>• Reduced 80% by 2030,</li> <li>• Net-Zero CO<sub>2</sub> by 2040</li> <li>• All above are against the 1990 baseline</li> </ul>
<b>Carbon Footprint Plus</b> <ul style="list-style-type: none"> <li>• Net-Zero CO<sub>2</sub> by 2045</li> </ul>
<b>Establish Methods to:</b> <ul style="list-style-type: none"> <li>• Quantify, measure, monitor and reduce CO<sub>2</sub> emissions</li> </ul>

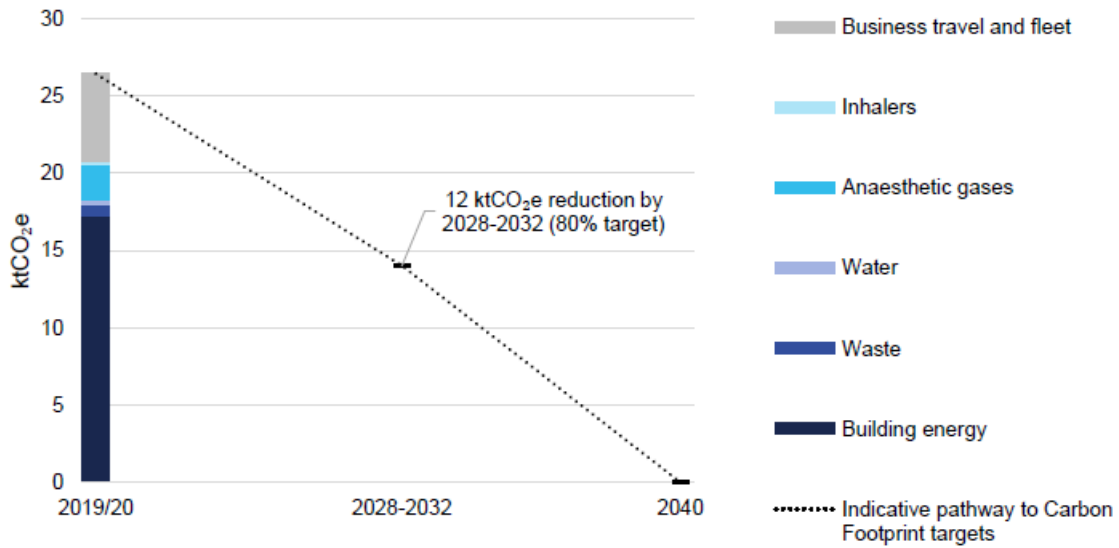
The Trust's estimated carbon footprint is 26,439 tonnes CO<sub>2</sub> equivalent. Adding personal travel, medicines, medical equipment and supply chain the broader measure of the Trust's NHS Carbon Footprint Plus is 151,711 tonnes of CO<sub>2</sub> equivalent. See below.

<b>NHS Carbon Footprint</b>	<b>26,439</b>	<b>tCO<sub>2</sub>e</b>
<i>Building energy</i>	17,190	tCO <sub>2</sub> e
<i>Waste</i>	735	tCO <sub>2</sub> e
<i>Water</i>	302	tCO <sub>2</sub> e
<i>Anaesthetic gases</i>	2,373	tCO <sub>2</sub> e
<i>Inhalers</i>	113	tCO <sub>2</sub> e
<i>Business travel and fleet</i>	5,726	tCO <sub>2</sub> e
<b>Personal travel</b>	<b>23,090</b>	<b>tCO<sub>2</sub>e</b>
<i>Staff commuting</i>	8,549	tCO <sub>2</sub> e
<i>Patient travel</i>	9,942	tCO <sub>2</sub> e
<i>Visitor travel</i>	4,599	tCO <sub>2</sub> e
<b>Medicines, medical equipment and other supply chain</b>	<b>100,564</b>	<b>tCO<sub>2</sub>e</b>
<i>Medicines and chemicals</i>	34,245	tCO <sub>2</sub> e
<i>Medical equipment</i>	20,527	tCO <sub>2</sub> e
<i>Non-medical equipment</i>	11,004	tCO <sub>2</sub> e
<i>Other supply chain</i>	34,788	tCO <sub>2</sub> e
<b>Commissioned health services outside NHS</b>	<b>1,618</b>	<b>tCO<sub>2</sub>e</b>
<b>NHS Carbon Footprint Plus</b>	<b>151,711</b>	<b>tCO<sub>2</sub>e</b>

Source: NHS England

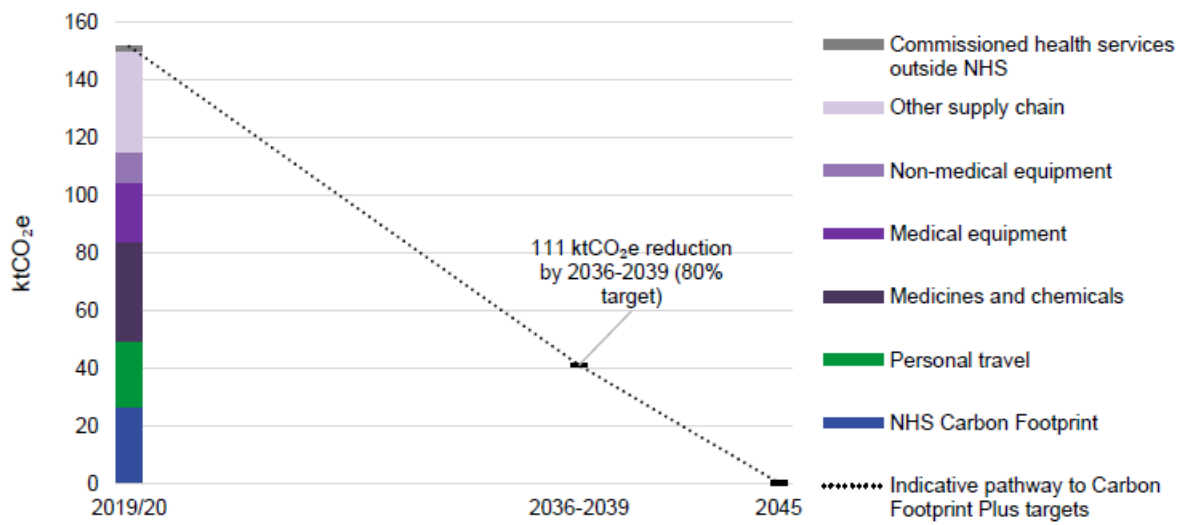
Applying average targeted reductions on an annual basis to the 2019/20 baseline (the period from which NHS England defined measuring the net zero trajectories in their reports) the Trust would need to deliver a 12,000 tonnes reduction in its Footprint and 111,000 tonnes reduction in its Footprint Plus to achieve an 80% reduction by 2028-32 and 2036-39 respectively. See below.

NHS Footprint Reduction Graph

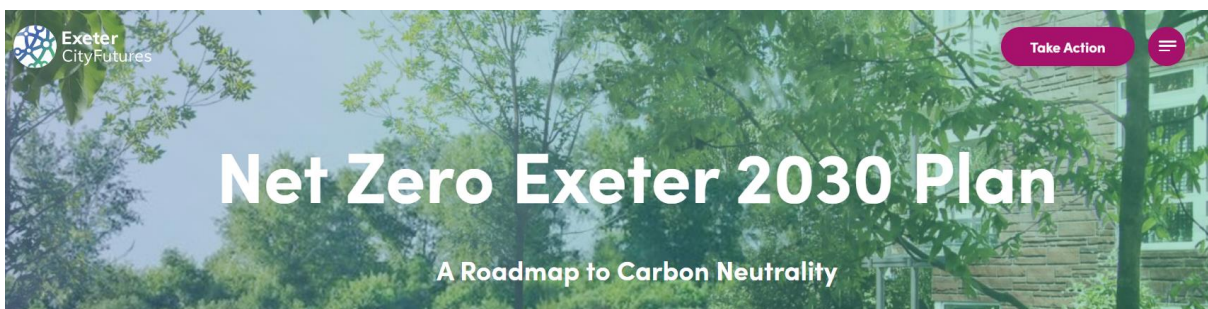


Source: NHS England

### NHS Footprint Plus Reduction Graph



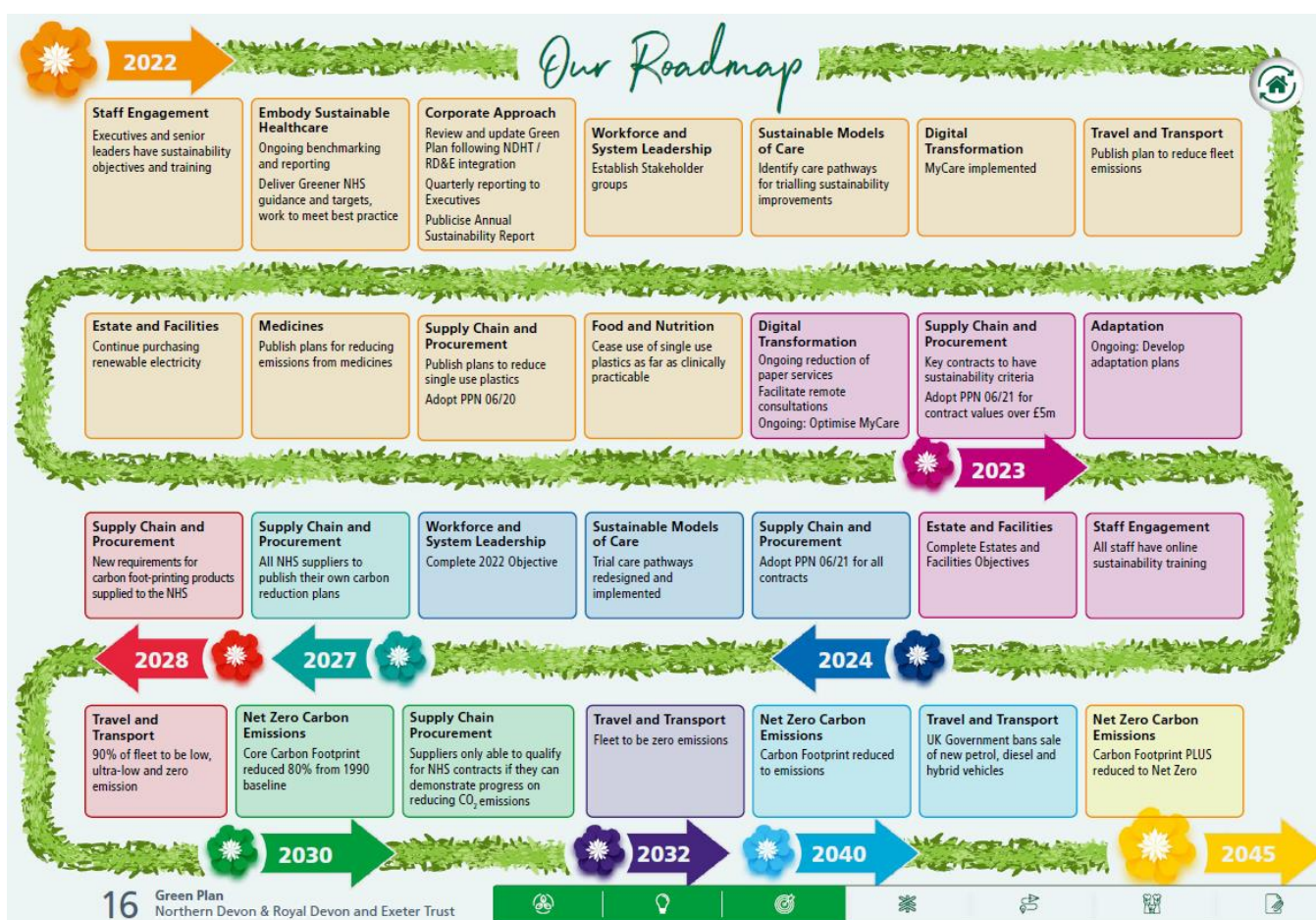
### Place-Based Initiatives and targets



The Trust has also agreed to work alongside its Exeter based public sector civic partners to accelerate the net zero objective for its Wonford and Heavitree services and aim for net zero by 2030. As a member of Exeter City Futures the city of Exeter has an ambitious plan<sup>1</sup> of action based on four themes: Sustainability, Transportation Energy and Capacity. The Trust teams are working alongside colleagues from civic partners exploring collaboration opportunity's across energy projects, waste management and transport initiatives.

## Our Net Zero roadmap

The Green Plan establishes a series of work initiatives that are designed to make progress on the three strategic targets and their supporting objectives. These are shown in the roadmap below, which includes Royal Devon's goals and National targets.



NHS England have developed several “Key Areas of Focus” that the NHS is required to target, in order to reduce carbon emissions, costs and improve our impact on people and the environment.

<sup>1</sup> <https://www.exetercityfutures.com/netzeroexeter/>

The updates below explain how we are tackling these areas of focus and are able to report on our progress.

### **Workforce and System Leadership**

In order to embed sustainability into 'business as usual', the Trust has been working to set up sustainability workstreams and where possible link them into existing initiatives. An example of this is how the Sustainability Team has supported the Brilliant Ideas initiative; anyone can submit suggestions for improvements to the Brilliant Ideas team and in the first few weeks over 70 ideas were received with many of them having a strong sustainability focus.



#### *Sustainability Awareness Survey and Behaviours at work:*

- 38.84% of staff agreed that the Trust actively supports the environment, such as resource efficiency, reducing carbon emissions and reducing waste
- 38.64% of staff said that they always turn off equipment and lights when leaving an empty room
- 51.24% of staff said they always recycle products when they can
- 47.41% of staff said they always reduce paper usage by thinking about if something can be kept digitally
- 75 staff members have accessed the training

#### *Training*

From September 2022 Net Zero NHS training has been available on Learn+. Our staff can learn about climate change and how the NHS aims to reduce its carbon footprint. The online training helps to raise awareness about the effects of climate change both on our planet and our hospital and the steps we can take to make healthcare more sustainable. The training takes 30 minutes to complete and there is no pass or fail rate.

Together, we can act to reduce the impact of climate change on our environment, and completing this training program is a great place to start.





## Sustainable Models of Care

### *Case Study 1 - Virtual Wards*

Our Acute Hospital at Home (AHAH) service, which is nationally referred to as the 'Virtual Ward' programme, is a safe and efficient alternative to receiving care as an inpatient on a hospital ward.

The service runs across both our Eastern and Northern services and we currently have capacity to support fifty-five patients (planned to increase to 100 by December 2023) across a wide range of pathways from, amongst others, cardiology, respiratory, acute kidney injury (AKI) and frailty.

Patients referred to our AHAH service receive the same care, monitoring and treatment that they would from a hospital bed or from a local community service, but from the comfort of the patient's own home. Our AHAH team, which includes doctors, nurses, pharmacists, therapists and advanced care practitioners, are in touch with patients on a regular basis throughout the day as required.

As part of the development of the AHAH service the Trust is trialling the use of wearable devices. Devices such as watches, connecting through smart phones, are recording real time data on oxygen saturation and heart rate monitoring and transferring this data into the patient's electronic record. Twice daily blood pressure monitoring from our community teams add to this daily data collection fed directly to the electronic record. This remote working allows the patient's named consultant to monitor their condition using their own smart technology.

We expect these services to develop further to include cardiology (ECGs) and respiratory (spirometers) and to also incorporate digital weighing scales. These technologies support people living with frailty, heart failure and are likely to be suitable for people receiving home based IV antibiotics as an outpatient service (OPAT: outpatient parenteral antimicrobial therapy service).

We know that being treated in your own home can have a hugely positive impact – patients can continue with their daily routine and make choices about what they can eat and wear, with the people they know and love around them. Patients also avoid the risks that an inpatient stay may have, such as deconditioning and delirium. All of this leads to a better chance of recovery for our patients.

By freeing up hospital beds and creating more capacity in this way, our AHAH service positively impacts on both healthcare service and environmental sustainability and improves the flow of patients, easing pressures on our emergency departments and helping to reduce waiting times for both planned and emergency care.

## Case Study 2 - Outpatient Redesign

During 2022 the NHS's elective recovery strategy included targets to reduce outpatient follow-ups by 25% and moving 5% of outpatient attendances to patient-initiated follow-up (PIFU) pathways by March 2023.

Patient-initiated-follow-up (PIFU) are a pathway redesign to routine follow-up pathways, putting patients and clinicians together to understand short, medium and long-term conditions. They rework the routine pathways to change from routine time-based appointments which patients attend and may or may not be demonstrating issues, to a focus on patients who are experiencing symptoms to the condition they have.

This has gone live in 20 specialties across the Trust and now provides patients with the opportunity to take their health into their own hands. This leads to a sense of empowerment for patients, that they are not only the key player in their healthcare journey as their engagement improves and increases, but that their relationship with their clinician.

Whilst it is early days for reporting benefits there is some promising evidence that PIFU results in fewer overall outpatient appointments compared to fixed appointment schedules, leading to a reduction in wasted (and low value-added) activity, avoided energy use and reduced carbon miles for patients.

## Case Study 3 - Greener ED

The Eastern Services Emergency Department has been leading the way as a national pilot site for the Royal College of Emergency Medicine Greener ED programme. Under the leadership of ED Consultant Dr Steve Fordham, the department has undertaken many of the initiatives required to reach Gold standard under the college's accreditation framework. This includes reduced paper, increased digitisation of services and information, reduced cannulisation, reduced use of Entonox (saving around 1000 litres of Nitrous Oxide per week) – see poster below - dry powder inhalers replacing some metered dose inhalers, introduction of social prescribing and an increased modal shift for staff travel and transportation.

With a silver accreditation under their belt, the department looks to push on to embed sustainable ED practices into 'business as usual' in 2023. This would achieve Gold accreditation and be facilitated by the allocation of time for managing green projects within job planning and departmental capacity.

## Reduced Entonox campaign in ED

# No to N<sub>2</sub>O?

Reducing your use of Nitrous Oxide (N<sub>2</sub>O) may be the single biggest change you can make to reduce the environmental impact of your day-to-day practice in the Emergency Department.

### What's the problem?

- Entonox is a 50:50 pre-mixed cylinder of Nitrous Oxide (N<sub>2</sub>O) and Oxygen (O<sub>2</sub>)
- Nitrous oxide (N<sub>2</sub>O) is harmful to the environment.
- N<sub>2</sub>O's global warming potential is 298 times that of carbon dioxide over 100 years.
- N<sub>2</sub>O is the leading cause of ozone-depletion from human activity

### How much do we use?

- In the RD&E Emergency Dept. we typically use 2000L Entonox every week\*
- \*this excludes use of piped nitrous from the wall supply in Resus
- Every 1000L Entonox used is equivalent to driving 3750 miles in an average sized petrol car
- Each year our usage of cylindered Entonox alone is equivalent to driving around the world 15.7 times

### Cylindered Entonox use in the RD&E ED over 12 weeks

Date of data collection (representing the previous 7 days usage)	Cylindered Entonox usage (litres)
10/03/2021	1500
17/03/2021	2000
24/03/2021	1000
31/03/2021	3000
07/04/2021	2500
14/04/2021	3500
21/04/2021	3500
28/04/2021	2000
05/05/2021	2500
12/05/2021	3500
19/05/2021	2000
26/05/2021	1500

### OK, so what are the alternatives?

#### Early conventional analgesia

- Cheap and available.
- Good adjunct, often forgotten.
- May not be enough on its own.

#### Methoxyflurane (aka Pentrox)

- Rapid onset, portable, efficacious analgesia.
- Low global warming potential, low ozone depletion potential, short environmental lifetime.
- Safe at low doses but can't be used more than twice each visit.
- More expensive.

#### Sedation

- Very effective procedural analgesia.
- Requires resus space and additional competent practitioner.
- Can be time consuming.

#### Regional anaesthesia

- E.g. Bier block, anatomical landmark or US guided nerve blocks.
- Largely under utilised. An expanding area of practice with increasing availability of ultrasound?

There is no denying that N<sub>2</sub>O can be an incredibly useful drug, and that sometimes its use may be justified.

But before you default to using it, please ask yourself:  
**'Can I say no to N<sub>2</sub>O?'**


**Royal Devon and Exeter**  
NHS Foundation Trust

**@EMExeter**

**ACADEME**  
ACADEmic Emergency Medicine Exeter

In addition to the Greener ED initiative the department was selected by the DHSC to run a 3-month national trial of reusable facemasks. This trial was successfully completed during the year and we are the first healthcare team ever to have successfully trialled this Type IIR tracked (RFID) washable facemask.

In the 4 months of the trial we achieved 8927 washes and over a year this would be over 25,000 single use facemasks avoiding incineration in ED alone. The Trust is participating in an evaluation of the whole life costing of this mask replacement to enable a comprehensive assessment to be completed by the DHSC. We hope to move to using more sustainable product under 'business as usual' shortly.



**Masks For Emergency Department Staff Only**

These masks have been through several testing protocols that have assured they perform at a high level to the medical device standards at 0, 20 and 40 washes.

As well as preparing the Trust for more universal roll-out of these masks, during this pilot we will be completing further assurance testing after 40 wear and wash cycles. During the pilot and after each wear and wash cycle, masks will be inspected. In addition, **we ask that you check the masks you use before putting them on:**

- For any obvious tearing or damage
- For any marks or soiling
- To ensure the ear loops are intact

If you find anything untoward please report this back to us straight away by emailing:  
caitlin.jensen@supplychain.nhs.uk or england.pperis@nhs.net"

**Inserts for restocking the dispenser in store room L168**

## Travel and Transport

### *Salary Sacrifice Lease cars*

Through the trust's lease car provider (Tusker), staff have an opportunity to acquire an electric vehicle and this includes free installation of home charging points. The tax benefits of this scheme have contributed significantly to the affordability of EV's although we recognise that at this time the scale of adoption has been partially limited by the higher cost of current models. We expect the EV market to mature leading to the introduction of more affordable EV's and we will work with Tusker to promote these in order to achieve a broader adoption across all staff levels in the trust.

### *Cycling Friendly UK Accreditation NDDH – Achieved September 2022*

We have begun a journey to increase our use of sustainable and active modes of travel that deliver environmental and health benefits. This includes the introduction of new cycle storage infrastructure, changing and shower facilities and becoming a Gold standard Cycle Friendly Employer. Northern Services were awarded a Gold standard of accreditation by Cycling UK during the year and have embraced the Cycle Friendly Employer accreditation to assess and aid its planning and continual improvement. The audit highlighted the lack of secure cycling parking at our Community Hospital sites and we are planning on installing secure cycling parking in 2023 to address this. We are also working on extending the accreditation to include Eastern Services.



### *EV Charging for Estate Vehicles and visiting Clinicians*

We are working towards decarbonising the travel and transport relating to our own operational activity by undertaking Green Fleet Reviews ahead of procuring EV fleet where operationally appropriate and subject to funding. We have also installed, or are finalising insulation, for 43 charging points across the estate.

In Barnstaple the initial installation of five 7kW single charge points and two 22kW single charge points for our Estate Vehicles to use as well as four 22kW single charge points for visiting clinicians has begun to reduce travel related CO<sub>2</sub>e. In Exeter 6 charge points are installed for our fleet (4 of which are at our warehousing facility) and 10 are planned for staff use at the trusts dedicated park and ride service.

### *Try B4U Buy – Implementation 2023*

As part of facilitating active and sustainable travel options for staff the team have developed a ‘Try B4U Buy’ trial for foldable e-bikes. Grant funded, these foldable e-bikes provide staff with a folding e-bike for a trial period, so that they can test whether this commuting experience works for them before perhaps committing to a purchase.



This project is being linked with the opening of the new Marsh Barton train station in Exeter with the Trust working with GWR and DCC to promote active travel. The foldable e-bikes will be available for Northern and Eastern staff to trial and the team are looking forward to launching this alongside a

new loyalty benefit scheme to reward staff undertaking sustainable behaviour change

#### *Air Quality Monitoring - Implementation 2023*

Looking into next year we are adopting the Clean Air Hospital Framework tool in order to monitor air quality internally and externally to our buildings. Initially working alongside the Council in North Devon we will provide a passive air quality monitoring system for the loading bay and the main entrance and look to assess 12 months data before assessing the potential need for a dynamic monitoring system. This work will then replicate across the Eastern site.

Minimising the environmental and health impacts associated with the movement of goods and people through our estate by becoming a Clean Air Hospital is a key objective of the Trust and links to work we are planning for decarbonising our heating across the estate.

#### *Estates and Facilities*

Whilst both the RDE and NDDH have benefited in terms of reduced cost and Co2 from investment via Energy Performance Contracts, the current constraints on capital investment make this a more challenging area to progress. There is of course significant potential to improve energy efficiency via the Our Future Hospital programme, albeit the timing is currently unclear. Therefore, for now, the Trust will prioritise investment bids based on those schemes that can deliver both a financial and CO2 payback

Current examples of successful projects include:

- Installation of over 16,000 LED lights, which last year delivered energy savings of 4,283,185KWh.
- The Trust utilises software to automatically monitor building performance
- In 2022-23 £30,000 has been spent on identifying and fixing leaks across the estate, which combined with efficiencies in the Linen Decontamination Unit have saved 14,000m<sup>3</sup> of hot and cold water reducing emissions by 116t/CO<sub>2</sub>.
- Replacing oil boilers with Air-Source Heat Pumps, saving 5t/CO<sub>2</sub> per year.
- Installation of 746kw PV across RD&E Wonford, RD&E Heavitree, North Devon District Hospital and Mardon Neurological Rehabilitation Centre. This generates enough energy to run 216 homes and last year saved 121t/CO<sub>2</sub>.

The Trust has also signed a letter of intent, committing to work with partners across the City of Exeter to develop and deliver a low-carbon district heating solution. While this builds on previous work carried out in this area, there are key differences to the previous proposal including siting of the primary heat generation plant no longer on Trust land and collaborating with a private sector provider who has secured £110m of funding to deliver the revised scheme.

#### *Energy*

## Waste

For three months during the year northern services conducted a reusable sharps container trial. These Stericycle Bio Systems re-usable sharps containers were installed in three areas:

- Main theatres 1-6,
- Emergency Department and
- Seamoor Unit.

Staff have embraced the change to their clinical practice and reported no issues with use of the different containers. The bins are emptied and decontaminated after each use, with these sharps now having an expected life of 600 uses rather than being single-use and incinerated. So far 374 single use containers have not been required and saved from incineration. Also 722kgs of single use plastic has not been required resulting in a saving of 2114 Kgs of carbon.



Waste and recycling is also a particular issue being raised by staff through the 'Bright Ideas' portal and the Facilities team are now reviewing how to move away from single room waste bins to communal recycling bins.

## Biodiversity

As well as carbon, energy and water related improvements, the Trust has used its Biodiversity and Outdoor Wellbeing Action Plan (BOWAP) to inform planting options in the Wonford Bereavement garden design and through the Spring will be designating a further 1,000m<sup>2</sup> of land as "No-Mow" in order to enhance biodiversity.



## Medicines

### *Desflurane*

The Trust no longer uses Desflurane, the most pollutant of all the anaesthetic gases, across any of its sites. Other anaesthetic volatile agents - the halogenated hydrocarbons- have seen their harmful impact reduced due to an increase in the use of total intravenous anaesthesia (TIVA). A business case is being developed to evaluate and install "capture and recycle" technology across all anaesthetic

machines in the Trust to reduce the environmental harmful effects still further.

#### *Nitrous Oxide.*

Within the eastern services, nitrous oxide is no longer used in non-maternity anaesthesia. This has allowed work to begin on the permanent decommissioning of the nitrous oxide cylinder manifold and its associated pipeline in Exeter. Northern services anaesthesia are reducing the use of nitrous oxide by switching to cylinder use only and have similarly started the work required to decommission the cylinder manifold.

#### *Entonox*

Both Trust emergency departments have moved away from Entonox and are now using Pentrox except in paediatrics. Other departments that use Entonox, are also moving over to Pentrox where clinically appropriate e.g. fracture clinic.

In maternity where Pentrox is contraindicated a business case to install "capture and fracture" technology is being developed.

#### Supply Chain and Procurement

With 60% of NHS emissions coming from procurement related activities, new rules were introduced in 2022 that require all NHS Trust's to have a minimum of 10% weighting applied to social value criteria in its procurement exercises.

Proposals for the practical use of this evaluation criteria are being incorporated into the procurement strategies of a number of new Trust cases.

#### Food and Nutrition

The Trust has previously (for eastern services) been awarded exemplar status for its food and nutrition service. Waste food collection currently takes place across both sites and sent to anaerobic digestion

#### Adaptation

The latest science presented through UK climate predictions (2018) suggest we can expect wetter, warmer winters and hotter, drier summers with alongside an increased frequency and intensity of extremes.

The Trust has begun work on developing its adaption plan and is engaged with the University of Exeter's European Centre for Environment and Human Health (ECEHH) – in the use of their Local Climate Adaption Tool (LCAT) to support evaluation and local decision making.

#### **Future priorities**

The plan for 2023/24 concentrates our efforts across 5 key areas:



1. Supporting Culture Change
2. Process Driven Change
3. Policy Driven Change
4. Operationalising the Plan
5. Carbon Measurement

### Supporting Culture Change

We will support the process of a maturing greener culture change across the organisation through our engagement and coms work - including embedding our new online rewards scheme (Jump) and introducing a series of tests of change (Try before U Buy e-bikes for example). Our magazine style hub page is a step-change in how we communicate our activity and entice staff involvement into our green work, with the recent Green Champions network a good example of this. We will seek to get feedback on how this new style coms are being received by staff.

Another important aspect of supporting the change process is how we provide an opportunity for staff education and training. The newly developed training regime on Learn + and through the nationally supported carbon literacy training will support the spread of green knowledge across all levels of staff in the organisation. We will establish targets to measure the consumption of training including capturing new appointees undergoing induction.

### Process Driven Change

We will expend a considerable amount of effort to ensure the work of the sustainability team is complementary to the projects being led under the Transformation team. We will support joint working to ensure that the success of green initiatives is agnostic to their origin – whether from our sustainability channels or through the “Brilliant Ideas” programme, these initiatives required the right type of skilled support to maximise their opportunity and impact. We will focus on creating ‘slick-process’.

### Policy Driven Change

National Policy change over the coming few years has the potential to lay the foundations for significant decarbonisation of the Trusts footprint. We will work with our colleagues in procurement to establish, through the adoption of Cabinet Office PPN notices, the methodologies required for incorporating Carbon Reduction Plans (CRP's) into our supply-chain. National initiatives like the Evergreen Supplier Assessment Tool be monitored in 2023 and we will assess adoption plans during its national launch period.

### Operationalising the Plan

The Green Plan document approved by the trust in 2022 has a series of aspirations and work during the latter part of 2022/23 has been to begin to ‘operationalise’ this plan. This work programme will now accelerate during 2023 through a series of

deep-dive assessments between the sustainability and operational teams. These assessments have established the need for more detailed planning and investment case development across the following areas:

i) [Heat decarbonisation](#)

The Trust has previously prepared a high-level decarbonisation strategy that aims to decarbonise the circa 80 buildings that make up the estate. The team wishes to progress its strategy to an organisation level Heat Decarbonisation Plan / delivery plan and HDPs for each site, with particular focus on the RD&E Wonford (General Hospital) and RD&E Heavitree sites and will seek a 100% funded grant to complete this work. These sites have the potential to connect to the Place based decarbonisation solution described earlier in this report. Early indication suggest that this scheme might be up to 30% cheaper than a site-based solution, with the anchor load that the Trust offers supporting local rollout of large-scale decarbonisation. HDPs up to Investment Grade Audit level are essential to prepare a business case that identifies whether to connect to the network or opt for an on-site heat decarbonisation solution.

Should the investment case select the place-based option as the preferred solution (best risk adjusted value for money), and is subsequently approved by the Board of Directors, the team will seek a funding solution through the Public Sector Decarbonisation Scheme (PSDS) to pay for connection charges.

ii) [EV and low emissions fleet](#)

Work will progress during 2023 to establish the investment case for the proportion of our fleet that represents an opportunity to move to electric vehicle or ultra-low emissions vehicle. Subject to funding approval we will establish the procurement strategy by assessing the different EV/ULEV vehicle frameworks. Recent studies have shown that life-time cycle costs of petrol/diesel vs EV's have now tipped in favour of EVs.

### [Carbon Measurement](#)

We will work to significantly improve our carbon measurement processes and the management of carbon reporting. Whilst NHS England are supporting a 'top-down' approach for the organisational level footprint, it is increasingly evident that the trust requires greater skill and capability for recording and reporting its carbon impact from change projects. We will focus on developing a carbon reporting data-library to ensure documentary evidence of validated carbon information is kept by the trust.

<b>Agenda item:</b>	10.2, Public Board Meeting	<b>Date:</b> Wednesday 26 April 2023		
<b>Title:</b>	Clinical Strategy Update Paper			
<b>Prepared by:</b>	Phil Luke, Director of Transformation			
<b>Presented by:</b>	Adrian Harris, Chief Medical Officer Phil Luke, Director of Transformation			
<b>Responsible Executive:</b>	Adrian Harris, Chief Medical Officer			
<b>Summary:</b>	The paper provides an update on in-year progress of the development of the Trust Clinical Strategy, and the work being undertaken to align the Clinical Strategy with the Trust enabling strategies.			
<b>Actions required:</b>	For information and approval of the final timeline of engagement and formal presentation to June Board of Directors.			
<b>Status (x):</b>	<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Information</b>
		<b>x</b>		<b>x</b>
<b>History:</b>	<p>The RDUH Clinical Strategy was commissioned in June 2022, the first draft of which was produced in December 2022 by clinical leaders following detailed clinical and operational engagement.</p> <p>There was a change in leadership of the programme in January 2023 and a broadening of the brief to simultaneously co-produce the clinical strategy alongside the enabling strategies, such as Workforce, Estates and Digital. As a result, the proposed timeline for delivery has been extended to June 2023 where it will be presented alongside the enabling strategies and demonstrate the connectivity for delivery across all services, and the vision for transforming our services over the next five years.</p>			
<b>Link to strategy/ Assurance framework:</b>	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		
NHS Improvement		Finance	
Service Development Strategy		Performance Management	
Local Delivery Plan		Business Planning	
Assurance Framework		Complaints	
Equality, diversity, human rights implications assessed			
Other ( <i>please specify</i> )			

## **1. Purpose of paper**

To update the BoD on the progress of the Clinical Strategy development and alignment with the enabling strategies.

## **2. Background**

The update follows a commission of the Clinical Strategy in June 2022 and provides assurance to the BoD of the current evolution of strategy production and timeline for Board engagement ahead of approval in June 2023.

## **3. Analysis**

The paper consists of the following:

- The timeline for the evolution of the strategy, including proposed future steps for Board engagement and approval of the strategy.
- The underpinning principles, structure and key themes and proposals within the strategy.
- A brief description of key points, which may be helpful to inform any discussion at the meeting of the BoD in April 2023.
- The work being undertaken to align the clinical strategy with the supporting strategies, such as Digital, Workforce and Estates.

## **4. Resource/legal/financial/reputation implications**

The development of the Clinical Strategy contributes to the RDUH vision for provision and development of clinical services to the population of North and East Devon.

The Strategy will define a blueprint for delivery of the 'Better Together' strategy, and, by positioning this together with the enabling strategies, provide a clear vision for transforming our services, overcoming our current challenges and delivering the best care to our patients over the next five years.

## **5. Link to BAF/Key risks**

The clinical and enabling strategies impact across the breadth of our services and therefore intersect with the BAF across multiple points, including safety, quality, finance, governance, workforce, estates and digital services.

## **6. Proposals**

The BoD is asked to:

- i) Discuss the contents of this paper and provide any steer they wish to inform the final strategy.

- ii) Approve the proposed timeline for engagement and approval of the strategy, with the Clinical and other strategies being formally being presented to the BoD in June 2023.

## Clinical Strategy

### Update for the Board of Directors April 2023

#### 1. Introduction and context

The Clinical Strategy describes the vision of the Royal Devon University Healthcare Trust (RDUHT) for provision and development of clinical services to the population of North and East Devon, to deliver high quality, sustainable emergency, elective and specialist care, with a perspective of the next five years and beyond. The strategy was commissioned by the BoD in June 2022 in order to provide a clinically and operationally developed blueprint for overcoming the challenges facing the Royal Devon and delivering the Trust's overarching "Better Together" strategy. At a time of such tremendous operational pressure and impetus for change, the development of the Clinical and enabling strategies into a compelling vision may provide an important rallying point, behind which our staff and the communities we serve can come together to transform our services over the next five years.

This document provides the BoD with an overview of the following:

- The timeline for the evolution of the strategy, including proposed future steps for Board engagement and approval of the strategy.
- The underpinning principles, structure and key themes and proposals within the strategy.
- A brief description of key points, which may be helpful to inform any discussion at the meeting of the BoD in April 2023.
- The work being undertaken to align the clinical strategy with the supporting strategies, such as Digital, Workforce and Estates.

#### 2. The development of the strategy

##### 2.1. Clinical and operational leadership

Clinical leadership and ownership of the strategy was essential from the outset and the Chief Medical and Nursing Officers provide the executive leadership of the programme. Two highly experienced clinical leaders, one from the Eastern and one from our Northern services, alongside Zahara Hyde, Programme Director for the "Our future Hospital Programme" were appointed to develop this strategy. These Clinical Chairs, Professors Bruce Campbell and David Sanders, engaged extensively with clinicians and managers throughout the North and East of the Trust, working with patient and public representatives and commissioners to obtain their perspective on the challenges and the proposed responses.

##### 2.2. Evolving brief and timeline of the strategy

Initially the intention was that Clinical Strategy would set the clinical vision as the Trust's principal strategy, and a series of enabling strategies would follow, in order to support its delivery. Since the inception of this programme, the timeline has been extended from December 2022 to June 2023 to enable a more complex brief to be delivered. The revised approach is to coproduce both the clinical and enabling strategies simultaneously, in order

that the clinical, digital, data, workforce, finance, transformation and estates strategies interconnect to produce a comprehensive, compelling and deliverable plan for transforming our services, overcoming our current challenges and delivering the best care to our patients within the available resources.

The timeline for the development of the strategy is shown in the table below.

YEAR	MONTH	ACTIVITY
2022	JUNE	Clinical Strategy commissioned
	JULY	Bruce Campbell, David Sanders & Zahara Hyde appointed
	AUGUST	Following a selection process, Channel 3 & Grant Thornton consultancies appointed to support the development of the Clinical strategy
	SEPTEMBER	
	OCTOBER	Clinical & operational engagement
	DECEMBER	First draft produced Zahara Hyde appointed Director of Estates. Phil Luke, Director of Transformation takes on leadership of Clinical Strategy. Decision made to move deadline for Clinical Strategy and align all enabling strategies Enabling strategies steering group established
2023	FEBRUARY	Leadership Engagement Session (27/02/23.) Detailed strategy shared with senior leaders with discussion about key elements.
	MARCH	Align Clinical Strategy with enabling strategies Refine strategies from continuous process of engagement
	APRIL	
	MAY	
	JUNE	Possible Board development session to review Clinical and enabling strategies in detail before Board session in June <b>Board of Directors formally consider Clinical and enabling strategies</b>
	JULY	Clinical Strategy delivery passed to TDG to ensure visibility and delivery of strategies

As shown in the above timeline, the proposed next steps for engagement and approval with the BoD are as follows:

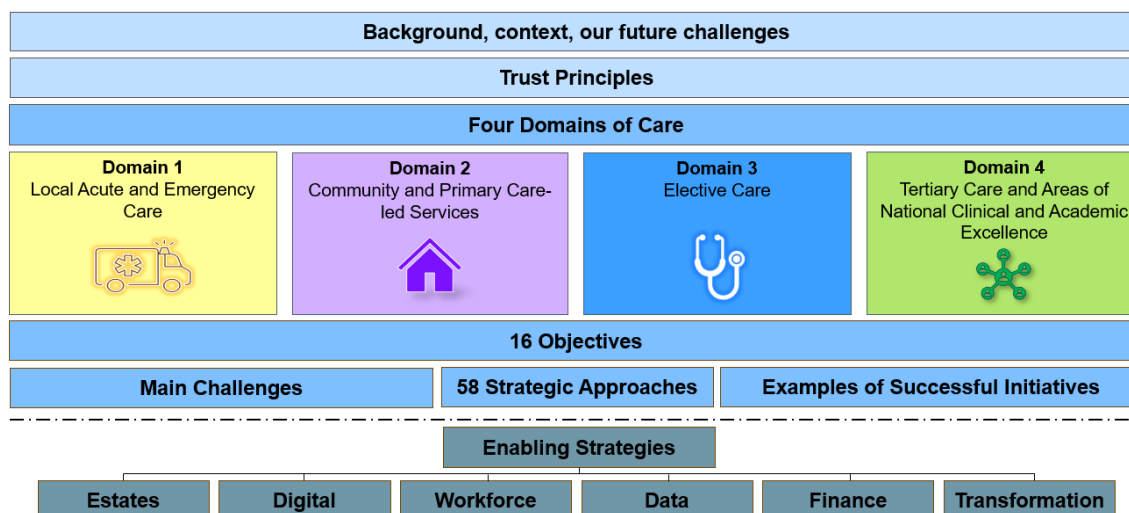
- A longer session to present the Clinical and supporting strategies in some detail to allow time for discussion and feedback, followed by
- The Clinical Strategy formally coming to the meeting of the BoD in June 2023.

### 3. The Clinical Strategy

#### 3.1. Overview and key strategic themes

The structure of the Clinical Strategy is shown in the diagram below. The principles underpinning the strategy are shown in Appendix 1 and the strategy document provides further detail on each principle.

## Structure of the Clinical Strategy



Important aims of this clinical strategy include the following:

- Stabilising and developing acute medical services at NDDH;
- Recovering our waiting times;
- Reducing acute admissions and lengths of stay;
- Increasing the separation between elective capacity and acute care;
- Strengthening cancer services; and
- Promoting our flagship services.

A summary of domains, objectives and strategic approaches to deliver them is provided in Appendix 2.

#### 3.2. Key points for note

**3.2.1. Visionary versus affordable** – An obvious tension exists between the highly constrained financial landscape and developing a strategy that is sufficiently bold and visionary to overcome current our challenges, with services which are thriving, vibrant and utilising cutting-edge technology. In many areas, adoption of new technology and transformative approaches to care goes hand in hand with delivering more cost-effective care. Inevitably however, a number of solutions to our key challenges require capital or revenue investment, to which the Trust is not currently in a position to commit. In all cases, the Clinical Strategy describes two important approaches:



- **Governance** - All cases must be subject to the appropriate governance. Whilst the Clinical Strategy sets an aspiration, it does not guarantee any business case will be approved if it does not meet the essential criteria, including affordability.
- **Proactivity** – Capital, even significant sums, can become available at short notice, with narrow windows for submitting bids. We will proactively develop cases to support the capital developments set out in the Clinical Strategy to maximise our ability to successfully bid for external funding when it becomes available.

**3.2.2. Partnership working** - The Clinical Strategy heavily promotes effective, mature, open and transparent partnership with a range of partners including other provider organisations, clinical networks, commissioners, regional teams, the voluntary sector, patient groups and academic partner institutions. A key strategic approach is Royal Devon’s participation in and implementation of the Peninsular Acute Service Programme (PASP), through which the Trust will collaborate with other provider organisations to optimise pathways of care for patients across Devon.

**3.2.3. Communicating the strategy** – A detailed comms plan setting out how the plan will be made available in an accessible way to our staff and the public via a range of media will be included in the Clinical Strategy document.

**3.2.4. Delivery of the strategy** – It is proposed that once approved by the BoD, the delivery of the strategy will be overseen by the Trust Delivery Group with 6 monthly updates coming to the BoD to advise on progress and key challenges. A key vehicle through which the strategy will be delivered will be the operational planning process, which will involve specialty teams setting out detailed plans describing how they will implement the key elements set out in the strategy.

#### **4. Alignment between the clinical and enabling strategies**

Developing the Clinical Strategy simultaneously with the enabling strategies is a complex and time-consuming process, which has not been undertaken previously within the Trust. The principal advantages are that it should ensure that the key elements of the strategy are deliverable and that support teams are working from the outset to mitigate key risks to the strategy, such as recruitment of key staff or digital capability.

A taskforce led by the Director of Strategy has been established in order to oversee the work to ensure all the strategies are well integrated. An example of the level of detail this group is undertaking is shown in Appendix 3, whereby each of the 58 strategic approaches proposed within the Clinical Strategy has been reviewed by the leads for the supporting strategies to identify key challenges and risks.

#### **Summary and recommendations**

The development of a five-year Clinical Strategy, simultaneously and jointly with enabling strategies, offers the opportunity to provide a blueprint for change, which could unite and inspire our staff to positively improve services moving forwards. It will also form a roadmap to inform prioritisation of investment based on clinical priorities and patient need.

The strategy is underpinned by a set of core principles and was shaped through a detailed process of clinical and operational engagement. This aims to ensure the objectives and strategic approaches are those which would be most beneficial for our services and patient outcomes, within the available resources.

The strategy aims to strike the right balance between being aspirational and affordable, being careful not to commit the Trust to investment beyond our capacity, whilst being proactive and forward thinking about high level changes which might transform our services.

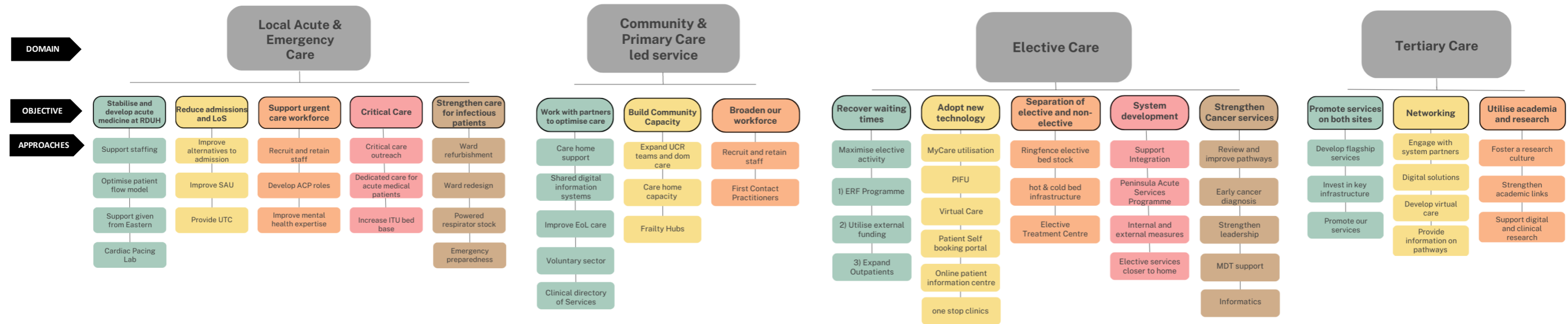
It is recommended that the Board of Directors:

- iii) Discuss the contents of this paper and provide any steer they wish to inform the final strategy.
- iv) Approve the proposed timeline for engagement and approval of the strategy, with the Clinical and other strategies being formally being presented to the BoD in June 2023.

## Appendix 1 - Joint Strategic Principles of the Clinical Strategy

<b>Joint Strategic Principles of the Clinical Strategy</b> Approved by Joint Clinical Leadership April 2021	
1	Delivering <b>safe and effective care</b> which reduces clinical variation, improves process efficiency and improves clinical outcomes
2	<b>Collaborating</b> as system partners to deliver integrated healthcare and wellbeing services
3	<b>Reducing health inequalities</b> for all our people
4	Fully exploiting <b>digital, scientific and technological</b> innovation in healthcare
5	<b>Investing in our people</b> so they can work to their full potential, feeling supported to provide the best quality care
6	<b>Getting the best value</b> for our population from our finite resource
7	Empowering people to access <b>personalised holistic care</b> which we will provide <b>closer to home</b> wherever possible
8	Championing the environment to <b>reduce our carbon footprint</b>

# Royal Devon Clinical Strategy



Appendix 3 - Example of work to align clinical with enabling strategies

Clinical Strategy  
Strategic Approaches Visual Review

No	Domain	Objective	Approach	Enabling Strategies							Capital	Revenue	Income	HIGH PRIORITY	Enabling Strategy Comments
				Division	Trust	System	Estates	Digital	Data	Workforce					
8	Local Acute & Emergency Care	Support and broaden our urgent care workforce	Recruit and retain staff		Yes										
9	Local Acute & Emergency Care	Support and broaden our urgent care workforce	Develop Advanced Clinical Practitioner roles		Yes							Yes			Will require training & development and pump priming funding
10	Local Acute & Emergency Care	Support and broaden our urgent care workforce	Improve mental health expertise		Yes							Yes			Training for clinical staff in mental health
11	Local Acute & Emergency Care	Increased facilities and arrangements for critical care	Develop critical care outreach		Yes			Yes							A team to provide support to ward patients
12	Local Acute & Emergency Care	Increased facilities and arrangements for critical care	Provide dedicated critical care for acute medical patients		Yes	Yes	Yes				£500k-£2m				Conversion of 1 bay to HDU level care
13	Local Acute & Emergency Care	Increased facilities and arrangements for critical care	Increase ITU bed base		Yes		Yes	Yes			>£10m	Yes	Yes		External funding only.
14	Local Acute & Emergency Care	Continuously strengthen our capacity and capability to care for infectious patients	Provide infection control wards		Yes	Yes	Yes				£2m-£5m		Yes	High	
15	Local Acute & Emergency Care	Continuously strengthen our capacity and capability to care for infectious patients	Introduce a ward refurbishment programme		Yes	Yes					£500k-£2m				Agreed amount (e.g £2m) each year for a rolling refurbishment programme
16	Local Acute & Emergency Care	Continuously strengthen our capacity and capability to care for infectious patients	Increase powered respirator stock		Yes						<£500k	Yes			NR revenue but not huge cost over 5 years.
17	Local Acute & Emergency Care	Continuously strengthen our capacity and capability to care for infectious patients	Improve emergency preparedness		Yes										EPRR committee to lead
18	Community & Primary Care-led Service	Work with local partners to optimise pathways and make care as seamless as possible.	Improve care home support			Yes	Yes		Yes			Yes			
19	Community & Primary Care-led Service	Work with local partners to optimise pathways and make care as seamless as possible.	Improve use of shared digital information systems		Yes			Yes	Yes		Unable to Quantify at this time				Possible IT equipment required
20	Community & Primary Care-led Service	Work with local partners to optimise pathways and make care as seamless as possible.	Improve end of life care		Yes			Yes	Yes						MDT clinics are funded activity. Also reduction in hospital occupancy reduces cost in escalation beds.
21	Community & Primary Care-led Service	Work with local partners to optimise pathways and make care as seamless as possible.	Work more closely with voluntary sector organisations		Yes		Yes		Yes						Possible requirement for limited space for VSE (5 desks)
22	Community & Primary Care-led Service	Work with local partners to optimise pathways and make care as seamless as possible.	Update the clinical directory of services (DOS)		Yes			Yes							
23	Community & Primary Care-led Service	Build community capacity to reduce acute bed occupancy	Expand Community Urgent Care Response (UCR) teams and domiciliary care capacity			Yes						Yes	Yes	High	Would be DCC commissioned.
24	Community & Primary Care-led Service	Build community capacity to reduce acute bed occupancy	Provide care home capacity			Yes	Yes				Unable to Quantify at this time	Yes	Yes		Would be DCC commissioned.
25	Community & Primary Care-led Service	Build community capacity to reduce acute bed occupancy	Develop frailty hubs		Yes							Yes			
26	Community & Primary Care-led Service	Support and broaden our community workforce	Recruit and retain staff		Yes	Yes									
27	Community & Primary Care-led Service	Support and broaden our community workforce	Build upon First Contact Practitioner roles		Yes							Yes	Yes		Physio roles. Offset by income.
28	Elective Care	Recover our waiting times	Maximise elective activity		Yes						Unable to Quantify at this time	Yes	Yes		
29	Elective Care	Improve patient experience, particularly through adoption of new technology	Better utilise the MyCare patient portal								Unable to Quantify at this time	Yes		High	
30	Elective Care	Improve patient experience, particularly through adoption of new technology	Increase use of patient-initiated follow-up (PIFU)								<£500k				Provision of booths for virtual clinics
31	Elective Care	Improve patient experience, particularly through adoption of new technology	Increase virtual care								<£500k	Yes	Yes		Provision of booths for virtual clinics
32	Elective Care	Improve patient experience, particularly through adoption of new technology	Introduce a patient self-booking portal								<£500k			High	£80K maintenance cost would be more than funded through reduced administration costs. Possible use of the NHS app or bespoke system developed locally to be determined. Revenue - 1 administrator
33	Elective Care	Improve patient experience, particularly through adoption of new technology	Create an online patient information centre					Yes				Yes			
34	Elective Care	Improve patient experience, particularly through adoption of new technology	Increase the provision of one-stop multidisciplinary clinics					Yes	Yes		Unable to Quantify at this time				
35	Elective Care	Increase separation of non-elective and elective capacity	More robustly ringfence elective bed stock												
36	Elective Care	Increase separation of non-elective and elective capacity	Develop our existing infrastructure to support					Yes			Unable to Quantify at this time		Yes		
37	Elective Care	Increase separation of non-elective and elective capacity	Make the case for an elective treatment			Yes	Yes	Yes		Yes	>£10m	Yes	Yes	High	Costs approx £70m
38	Elective Care	Develop elective services as part of a wider system	Support partnership and integration		Yes										
39	Elective Care	Develop elective services as part of a wider system	Actively engage with, share and learn from other providers			Yes		Yes		Yes					To be determined by PASP
40	Elective Care	Develop elective services as part of a wider system	Use a range of innovative service models		Yes	Yes		Yes							
41	Elective Care	Develop elective services as part of a wider system	Expand the range of services to people's homes				Yes	Yes	Yes	Yes					Could potentially require changes in Estates, workforce or digital but no specific schemes thus far.
42	Elective Care	Strengthen our cancer services	Review and improve services		Yes	Yes					Unable to Quantify at this time				
43	Elective Care	Strengthen our cancer services	Support primary care in			Yes									
44	Elective Care	Strengthen our cancer services	Strengthen leadership and		Yes	Yes						Yes			This relates to oversight & governance
45	Elective Care	Strengthen our cancer services	Provide additional support		Yes			Yes							Limited funding required for tumour site leads & admin.
46	Elective Care	Strengthen our cancer services	Increase the use of information services		Yes	Yes		Yes			Unable to Quantify at this time				Where possible, EPIC will be used to enhance services. Other systems may be considered where appropriate.
47	Tertiary Care & Areas of National Clinical and Academic Excellence	Promote and invest in our flagship services on both sites	Purposefully develop flagship services		Yes		Yes	Yes			Unable to Quantify at this time	Yes	Yes		Likely investment is equipment such as robotic surgery.
48	Tertiary Care & Areas of National Clinical and Academic Excellence	Promote and invest in our flagship services on both sites	Invest in key infrastructure				Yes				£2m-£5m				Examples include; hybrid theatre, robotic surgery, EOS systems etc
49	Tertiary Care & Areas of National Clinical and Academic Excellence	Promote and invest in our flagship services on both sites	Promote the successes and benefits of our flagship services to others		Yes										
50	Tertiary Care & Areas of National Clinical and Academic Excellence	Network with other hospitals to optimise pathways for patients and staff	Actively engage with system partners			Yes									
51	Tertiary Care & Areas of National Clinical and Academic Excellence	Network with other hospitals to optimise pathways for patients and staff	Implement digital solutions to connect care across organisational boundaries			Yes		Yes							
52	Tertiary Care & Areas of National Clinical and Academic Excellence	Network with other hospitals to optimise pathways for patients and staff	Support the development of virtual care		Yes			Yes							This is likely to apply to a very small number of tertiary patients
53	Tertiary Care & Areas of National Clinical and Academic Excellence	Network with other hospitals to optimise pathways for patients and staff	Provide clear information for patients on pathways and where to get help		Yes										
54	Tertiary Care & Areas of National Clinical and Academic Excellence	Utilise academia and research	Foster a research culture across the Trust		Yes										
55	Tertiary Care & Areas of National Clinical and Academic Excellence	Utilise academia and research	Strengthen our links with academic institutions		Yes					Yes					Links with colleges and schools may help recruitment of hard to fill vacancies i.e Healthcare Scientists
56	Tertiary Care & Areas of National Clinical and Academic Excellence	Utilise academia and research	Support multicentre research trials		Yes										
57	Tertiary Care & Areas of National Clinical and Academic Excellence	Utilise academia and research	Support hybrid clinical / research roles		Yes					Yes					May help with consultant recruitment and retention
58	Tertiary Care & Areas of National Clinical and Academic Excellence	Utilise academia and research	Harness the capacity of EPIC and other digital systems to support clinical research		Yes			Yes	Yes						

**EXAMPLE OF DETAILED ALIGNMENT OF CLINICAL STRATEGY WITH ENABLING STRATEGIES**

<b>Agenda item:</b>	11.1, Public Board Meeting	Date:	26 April 2023	
<b>Title:</b>	Royal Devon “Better Together” Strategy Roadmap 2022-27 – report period January-March 2023 (Q4)			
<b>Prepared by:</b>	Katherine Allen, Director of Strategy			
<b>Presented by:</b>	Chris Tidman, Deputy Chief Executive Officer			
<b>Responsible Executive:</b>	Chris Tidman, Deputy Chief Executive Officer			
<b>Summary</b>	This paper presents the Royal Devon Strategy roadmap progress report for Quarter 4, and forward look for 6 months			
<b>Actions required:</b>	The Board of Directors is asked to note this paper			
<b>Status (x):</b>	<b>Decision</b>	<b>Approval</b>	<b>Discussions</b>	<b>Information</b>
				x
<b>History:</b>	Every quarter TDG and Trust Board of Directors receive a report presenting the progress in delivering the Royal Devon “Better Together” Strategy 2022-27 and six-month look ahead.			
<b>Link to Strategy / Assurance Framework</b>	Royal Devon Corporate Strategy			

**Monitoring information**

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

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

## Royal Devon 'Better Together' Strategy Roadmap 2022-23

### 1. Executive Summary

- 1.1 In April 2022, the Royal Devon University Healthcare NHS Foundation Trust launched its 'Better Together' strategy and five-year delivery roadmap.
- 1.2 This paper presents the Royal Devon Strategy roadmap: 2022/23 quarter 4 (Q4) progress report (covering the period 1 January to 31 March 2023) and six month look-ahead.
- 1.3 This quarterly progress update of the Royal Devon 'Better Together' strategy reports that the majority of roadmap milestones have been achieved in Q4, with some milestones being slipped due to competing operational priorities.
- 1.4 The six-month forward look assumes that the clinical strategy and underpinning enabling strategies will be presented to the June 2023 Board of Directors meeting. The deliverables and roadmap from each enabling strategy will be collated into the roadmap. A full refresh will be considered by Board at its forthcoming Board Development session to ensure that the requirements of the strategies are understood and mapped to an achievable timeline.

### 2. Royal Devon Strategy and Roadmap: Q4 2022/2023 progress report

The following section takes the key highlights from the achievements in from January to March 2023 (Q4 2022/23):

- 2.1 **New Cardio Day Case Unit development at RD&E starts**  
This project commenced in January 2023 and is in the implementation phase. Milestone completed.
- 2.2 **RD&E new adult ED facility opening schedule starts**  
In January 2023 the new adult ED reception and waiting room opened and this was followed by the main entrance in February 2023. By March two new isolation resus bays had opened. All remaining works required, the completion of the ambulance bays and the reconfiguration of the patient pathways are on track to be concluded by May 2023. This will see the completion of the adult section of the ED reconfiguration. Milestone completed.
- 2.3 **Northern Medical Workforce Business Case**  
This business case was approved by the Board of Directors in January 2023. The triple lock decision in support was received in April 2023. Milestone completed.
- 2.4 **Transformation Strategy launched: Bright Ideas**  
The Trust launched its Transformation strategy and Bright Ideas initiative in January 2023 and in February 2023 has held Transformation Cafes across North and East Devon. Milestone completed.

- 2.5 **Transformation Strategy: Elective Recovery 3-year transformation plan launch**  
The Royal Devon elective recovery programme was launched in January 2023. Milestone completed.
- 2.6 **Launch My Portal**  
This portal was launched in February 2023. Milestone completed.
- 2.7 **Health inequalities waiting list reporting**  
The Royal Devon has commenced publication of the waiting list by ethnicity and deprivation which was included in the Royal Devon public Board of Directors report in March 2023. The strategy and workplan describing the actions to be taken as a result of this data is in draft. Milestone completed.
- 2.8 **Values & Behaviour: Embedding the values into key HR processes**  
The Trust values were launched in April 2022 and over the last 12 months, they have been embedded into the majority of our HR processes throughout the employee lifecycle, including recruitment, induction training, and appraisals. There is still some further work to be completed to ensure the values are added to existing leadership and management training as well as the Trust recognition scheme, however both of these elements are on track for completion by the end of this month. Milestone completed.
- 2.9 Table 1 on the next page shows the milestones that were achieved in Q4 2022/23 of the Royal Devon corporate roadmap (1 January – 31 March 2023).



**Table 1: Q4 2022/23 H2 Royal Devon strategy roadmap**

			2023		
			H3		
			Jan	Feb	Mar
Strategic Objectives					
Board Programme	Overall Corporate Strategy Roadmap - Year 1 of 5	Collaboration & Partnership	ICS: PASP Programme commences		Health inequalities waiting list reporting on deprivation and ethnicity )
		A great place to work			Values & Behaviour: Embedding the Values into key HR Processes
					NHS Staff Survey report received and shared
		Recovering for the future	New Cardio Day Case Unit development starts		OFH - Major Project Review Group decision due on National NHP Business Case
			RD&E new adult ED facility opening schedule starts		Tiverton Endoscopy FBC approved by Board
			Northern Medical Workforce Business Case - BoD		
		Excellence & Innovation in patient care	Transformation Strategy: Bright ideas launched	Launch My Portal	
			Transformation Strategy: Elective Recovery 3-yr transformation plan launch		

**Key**  
 Completed  
 In progress

2.11 As per the change control process agreed at the meeting of the Board of Directors in October 2022, all changes to the corporate roadmap are recorded in appendix 1.

2.12 Those change controls which are relevant to the Q4 period in this report are below:

- East & North key worker housing OBC approval

- South Molton Ophthalmology Hub opening
- Q3 milestones aligned with the enabling strategies
- EPIC Risk assessment TSD

### 3. Royal Devon Corporate Roadmap in H1, Q1 & 2, 2023/4

Table 2 on the next page shows a look ahead to the milestones proposed for the next six months from 1 April 2023-30 September 2023.

Note that further milestones are expected to be added once the enabling strategies are finalised (due at Board of Directors for approval in June 2023).

Table 2: April - September 2023 Royal Devon strategy roadmap

		2023			2023			
		H1, Q1			H1, Q2			
		Apr	May	Jun	Jul	Aug	Sept	
		Strategic Objectives						
Board Programme	Overall Corporate Strategy Roadmap - Year 2 of 5	Collaboration & Partnership	Social Care Provision SOC		ICS: PASP Programme confirms options for scoping & engagement			
			Mobilise EPIC Resource Plan to support TSD					
		A great place to work		East & North key worker housing OBC approved	Workforce Strategy			
		Recovering for the future	South Molton Ophthalmology Hub opens	OFH OBC Plan commences	OSIG: Agree divisional structure options	RD&E paed ED work commences		OSIG: divisional structure implemented
			Delivering best Value Launch	Operational Services Integration Group (OSIG) launch	Estates Strategy and site development plans			
				Discharge lounge at NDDH operational	Financial Strategy			
					Information & BI Strategy			
					Robotic Surgery commences at NDDH			
					Vascular Hybrid Theatre FBC			
		Excellence & Innovation in patient care	Northern Medical Workforce Business Case - triple lock	EPIC Risk assessment TSD - to BoD	Clinical Strategy			
			Digital Strategy					

**Key**

Completed
In progress

- 3.2 There are no changes or additions to key milestone dates, since the previous report to the Board of Directors in January 2023.

## 4. Recommendations

The Board is asked to;

- 5.1 Note the progress made during January to March 2023 (2022/23 Q4) and the current roadmap milestones for the next 6 months.

## Appendix 1: Corporate roadmap change control record

As per the change control process agreed at the meeting of the Board of Directors in October 2022, the following changes have been made since the paper presented to the Board of Directors in January 2023. These changes are either delays to milestones, items being brought forward, new commitments or redundant commitments. Each change to the roadmap schedule has been approved by the relevant executive SRO.

**Table 3: Change controls proposed for Q4 2022/23 milestones**

Commitment	Original date due	Proposed new date	Reason for change
East & North key worker housing OBC	Mar 23	May 23	The deliverable has been deferred to extend the soft market testing engagement as the provider market interest turned out to be greater than originally expected and finance personnel changes. The current plan is: <ul style="list-style-type: none"> <li>- SEDG March 23</li> <li>- OB/TDG April 23</li> <li>- OBC to Board May 23</li> </ul>
South Molton Ophthalmology hub	Feb 23	April 23	The construction of the eye centre is complete. There are a few historical digital issues that need to be resolved prior to the installation of the final devices. The opening of the hub is postponed until April 2023.
Q3 milestones aligned with enabling strategies	Jan – Mar 23	June 23	The deliverables have been deferred to June 23 to align with the enabling strategies
EPIC Risk assessment TSD	Mar 23	May 23	This is in progress as approvals timetable being finalised. A risk assessment and recommendation will be taken to May Board

# Inclusion Annual Review

2022-23



# Innovative new approach for staff, patient and community inclusion

The Inclusion Steering Group is an innovative new space in Royal Devon allowing staff, patient and community engagement priorities to intersect and inform each other. The group is chaired by Royal Devon's Chief Executive Officer and is supported by a diverse and representative staff group to give direction to our inclusion agenda. The governance mechanism is then enabled through People, Workforce Planning and Wellbeing Committee, Governance Committee and then Board to ensure a clear review of processes and risk takes place.

This mechanism allows us to meet our Public Sector Equality Duty through engaging with our colleagues and designing a programme of activities to support groups of people who are less often served.

## About the public sector Equality Duty

The duty has a key role to play in making sure that fairness is at the heart of public bodies' work and that public services meet the needs of different groups. It covers a range of public bodies, including NHS organisations, government departments, local authorities, schools and police authorities.

The general duty requires NHS organisations to have due regard to:

- eliminate discrimination, harassment and victimisation and other conduct prohibited under the Act
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.



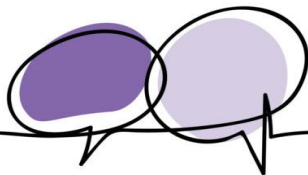
# 2022-23 Annual Plan and Delivery



We are **compassionate** and **inclusive**



We are **recognised** and **rewarded**



We each have **a voice that counts**



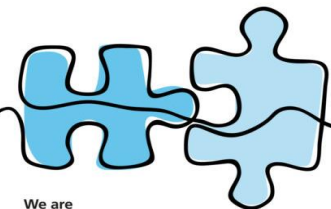
We are **safe** and **healthy**



We are **always learning**



We work **flexibly**



We are **a team**



**Programme: Towards Inclusion**  
**Trust values: We are inclusive**

**Strategic approach: Creating a sense of inclusion for all, demonstrably embraces and values diversity and equity**

**2022/23 Approach to include:**

Staff  
 Patients  
 Community

**Statutory and strategic alignment**

Trust Strategy  
 Patient experience strategy  
 Workforce Race Equality Standard

Corporate objectives  
 Workforce Disability Equality Standard  
 Equality Delivery System

**Staff priorities**

Development, recruitment and progression

1. Deliver a managers programme with inclusive leadership at it's core
2. Debias recruitment process
3. Design and deliver Driving Your Career Programme
4. Deliver an inclusion awareness campaign for all

**Measures**

1. Programme to be designed by quarter 2, with implementation to key staff groups by quarter 3.
2. Build a system of people trained in inclusive interviews by quarter 3, begin to embed in key areas by quarter 4.
3. Deliver the programme starting with Staff Network members, review before wider implementation
4. Deliver a diverse programme of activities relating to inclusion

**Outcomes:**

1. Develop a better understanding of HR/ER cases relating to inclusion, bullying and harassment, over time reducing the number of incidents reported both formally and informally
2. Increase in number of successful candidates from minority backgrounds application, shortlisting and appointment
3. Improve in the confidence of participants who take part in the programme in driving their career
4. Measure the level of engagement through social media channels and engagement with inclusion activities. As well as staff having a more nuanced understanding of the behaviours which are micro-aggressive, bullying and harassment

**Patient priorities**

Equal access and opportunity for all to ensure that people with a disability or sensory loss are communicated with in ways they can understand.

1. Co-produce a patient communication framework that all patient information will comply with.
2. Develop a transparent process for regularly reviewing and updating patient communications.
3. Support people with communication difficulties more effectively by offering all staff training in communication access skills.

**Measures**

1. Published co-produced communication framework.
2. Published co-produced Accessible Information and Communication Needs Policy
3. Numbers of staff trained in communication access skills

**Outcomes**

1. Patients are able to equitably access information relating to their care in a format suitable to them
2. An increase in the number of accessible patient communications
3. Staff who are better able to support patients with communication access

**Community priorities**

Exceptional quality healthcare for all

1. Deliver a range of projects through the N & E LCPs to address identified health inequalities
2. Restore services inclusively in line with NHSE mandate
3. Contribute to system priorities on HI e.g. Digital exclusion, homelessness, anchor institutions etc
4. Baseline assessment of the HI issues in our localities based on data and community insights

**Measures**

1. Measurable impact of interventions on HI/prevention in both N & ELCPs
2. Waiting lists for key specialities including cancer assessed against deprivation and appropriate action taken
3. Measurable impact made on key HI indicators though system-led projects supported by the Royal Devon
4. Baseline assessment completed by quarter(2 (N) & 3 (E)) and community engagement plans delivered by quarter 3 (N) and 4 (E).

**Outcomes**

1. Projects/interventions delivering outcomes set by N & E LCPs
2. Targeted waiting well initiatives based on IMD means that people from social deprived areas are not waiting longer for treatment
3. Impact achieved on core system priorities on HI through Royal Devon contribution
4. Improved understanding of key issues and priorities on HI in our localities which will drive improvements and engage communities in future action plans

**Strategic Outcomes**

- Staff live the organisation's values and feel empowered and engaged
- Enhanced staff confidence in understanding and promoting D&I , in particular the leadership team.
- Everyone has equal access to our services and have a positive experience of the Trust
- Promotion of innovative and diverse ideas enabled across teams / Trust
- Zero tolerance fully embedded in our practice

# Staff priorities update

## Staff priorities

Development, recruitment and progression

1. Deliver a managers programme with inclusive leadership at it's core
2. Debias recruitment process
3. Design and deliver Driving Your Career Programme
4. Deliver an inclusion awareness campaign for all

## Achievements

1. We have designed an Inclusive Leadership programme aimed at our newly developed Trust wide leadership group. We have began the delivery of these sessions with 45 attendees recorded. We recognise the need to accelerate this work and are in the process of setting up further sessions throughout 2023-24.
2. We have began an extensive programme of debiasing our recruitment with changes in our AAC Consultant Programme, this challenging piece of work saw an overhaul of existing systems to make way for fairer processes. We are now supporting a new process of introducing an Associated NEDs Programme to Royal Devon to ensure we have wider diversity at Board level and ensure a talent pipeline for future recruitment.
3. We have designed a "Driving your Career " and are in the process of socialising it amongst our staff. Operational pressures have impacted uptake levels and we are now working with colleagues to ensure interested staff members are able to take part.
4. An Inclusion Calendar has been delivered monthly with added events and activities shared widely through Royal Devon, this has led to strengthening of our inclusion work and requests for localised support in various teams. We also launched the first Black History Month resource with great success and plans to introduce further resources on diverse topics in the coming year.

## Other work not in the plan

### 1. Building our Staff Networks

Delivery of neurodiversity training has highlighted that staff would value a neurodiversity network. A survey asking neurodiverse staff of their experiences within the workplace has taken place. A task and finish group has been set up to support delivering improvements. We now have three networks in plans with plans to further support their development using a network maturity framework.

### 2 Project Simplify

New Promoting a Positive working environment policy approved to replace historic bullying & harassment, disciplinary and grievance policies. Supports 'Our Charter' and embedding Just and Learning Culture and represents embedding of our values. Further policy changes are imminent with the introduction of an Inclusion Policy Statement to support all of our policies to be inclusive.

### 3. Data improvement

Improved Workforce data is now allowing trial of divisional level demographic and experience data to inform leaders and inform plans..

### 4. Team inclusion training

Inclusion training delivered to various teams across Royal Devon with more planned. This is a new offer to enable team based learning on inclusion.

### 5. Successful national bids for inclusion projects

Secured 50% of funding available in SW region for D&I projects. Our First is aligned to increasing senior representation through the creation of Associate NED programme. Second to improve the experience of colleagues with disabilities within the workplace..

### 6. Inclusive approach to industrial action (IA)

Significant effort to embrace an inclusive approach to IA this included reframing core messaging to reflect compassion and understanding between those taking action and those working, as well as recognising the challenge to all colleagues in this situations.

# Patient priorities update

## Patient priorities

Equal access and opportunity for all to ensure that people with a disability or sensory loss are communicated with in ways they can understand.

1. Co-produce a patient communication framework that all patient information will comply with.
2. Develop a transparent process for regularly reviewing and updating patient communications.
3. Support people with communication difficulties more effectively by offering all staff training in communication access skills.

## Achievements

1. Proactive conversations have taken place across North and East to determine current processes, which are now understood and mapped. This piece of work has broadened from the original scope with the primary drivers being:
  - To increase the number of opportunities where we ask patients to inform us of their additional communication and information needs.
  - Increase the quality of patient Accessible Information Standards (AIS) information (communication support needs) recorded in our systems (FLAGS)
  - Increase the awareness of AIS amongst Royal Devon staff (The communication framework will be a secondary driver amongst many others)

Established that a task and finish group and additional resourcing is required to deliver this ambitious programme of work following an initial scoping meeting. Following a national consultation on the current AIS there are new standards due to be launched over the coming months, and therefore it has been timely to wait for these before any further work is commenced. Due to the extended scope of this work this action date is likely to slip into 2023/2024 and beyond.

2. The actions will be completed as a consequence of the ongoing work in Action 1.
3. The Communication Access training programme has been made available to all Royal Devon Staff and is accessed through the learning platform. Operational challenges such as elective recovery work, industrial action and workforce absences has meant that the numbers of staff undertaking the training has been lower than expected. At the end of 2022/23 8 % of staff in Northern services and 14% staff in Eastern services had completed the training. Monitoring the progress of communication access training and progress has been through the bi-monthly Patient Experience Operational Group which reports into the Patient Experience Committee. In recognition of 'communication' being our highest reportable theme across complaints and feedback, uptake of communication access training will also be monitored in the monthly divisional performance meetings throughout 2023/24. A high-level communication plan has been developed in support of communication access accreditation, with a home page on the trust intranet highlighting the access to training. Communications have also been put into all-staff updates across both Northern and Eastern services. The trust plans to apply for reaccreditation with Communication Access UK in 2023/24.

## Other work not in the plan

### 1. Review of translation and interpretation services

Oversight of services offered across northern and eastern services. Action plan in development to further align offer across both sites, and improve accessibility to interpreters.

### 2. Patient stories reflecting the lived experience of disability and receiving NHS care

There has been a proactive patient story agenda developed during 2022/23 which has included patients from protected groups including learning disability and visual impairment.

### 3. National PLACE inspections

The PLACE inspections were well attended by patient assessors across both sites to carry out this annual appraisal which considers whether the Trusts premises are equipped to meet the needs of people with a dementia of with a disability. National results are expected April 2023.

### 4. Accessibility of Estate

The Patient Experience team has started a working relationship with AccessAble. A company which works with the Trust to develop Accessibility service user access guides which assists service users and staff with signposting across the Royal Devon sites. The Trust will expect to receive a gap analysis of the accessibility of the estate in 2023/24.

# Community priorities update

## Community priorities

Exceptional quality healthcare for all

1. Deliver a range of projects through the N & E LCPs to address identified health inequalities
2. Restore services inclusively in line with NHSE mandate
3. Contribute to system priorities on HI e.g. Digital exclusion, homelessness, anchor institutions etc
4. Baseline assessment of the HI issues in our localities based on data and community insights

## Achievements

1. **NLCP:** Health equity strategy; Core 20 Plus Connector programme; Healthy Ageing Northern Devon ; Poverty Truth Commission; Healthy Weight & Physical Activity project; Tackling fuel poverty together; High Flow/primary care flow/mental health flow/secondary care flow; virtual ward for coronary patients with a focus on health inequalities; cost of living crisis support

**ELCP:** ELCP demonstrator project on care homes; Prevention priorities on social isolation; informal carers; CYP mental health.; Frequent attenders project Social prescribing in ED; cost of living crisis mapping

2. We have reported on the breakdown of our waiting lists by ethnicity and deprivation to the Board and there is an action plan to address issues identified. We are also implementing a plan of action using the five national priorities on health inequalities to ensure that deprivation, protected characteristics and ethnicity are weaved into the Trust's elective recovery work.

3. The ICB continues to develop its strategy and governance arrangements on health inequalities. We are continuing to be part of this process and influencing the discussions to ensure there is a balanced approach between meeting national "must do's" system priorities and the issues that emerge at place level. Part of the strategy includes adherence to the national Core20PLUS5 approach (which identifies a population cohort and '5' focus clinical areas requiring accelerated improvement), focusing on the wider determinants of inequalities (Marmot issues) and how to use the NHS's status as an anchor institution.

4. We are in a process where we are mapping ONS data against the Epic data we hold to give us actionable insights on health inequalities in relation to our patients/communities. The One Devon dataset has set up Action Learning sets to provide more detailed analysis of key health inequality issues at place and neighbourhood level. Our work in the North incorporates insights from the One Town network (N) and the ELCP is using insights from the health and wellbeing community conversations to identify priorities.

**The new Strategy team is currently developing its delivery plans for 2023 /4 based on the direction of travel set out in the organisational strategy and the input of a Board task and finish group. This is likely to influence our priorities and any proposed changes will be shared with the Steering Group.**

## Other work not in the plan

### One Northern Devon (OND)

OND continues to deliver a range of projects and interventions to address the wider determinants of health through its partnership. This includes supporting patients with complex needs through its flow programmes, supporting community development through its community developers as well as a range of other projects including remote monitoring for heart failure patients through a health inequality lens; workplace wellbeing; poverty truth commission, healthy ageing and fuel poverty.

### ELCP

The ELCP is establishing a new network to coordinate cross organisational working . The One Eastern Devon Partnership Forum will bring together a range of stakeholders to use their anchor status to address the wider determinants of health.

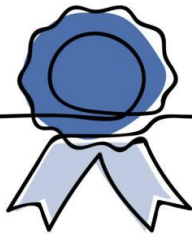
# Key Shared Priorities for Staff, Patients & Communities, 2023-24



# People Promise



We are **compassionate**  
and **inclusive**



We are **recognised**  
and **rewarded**



We each have  
**a voice that counts**



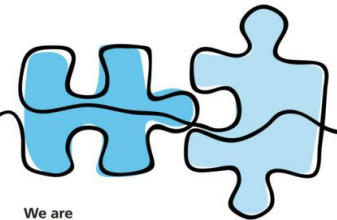
We are **safe** and  
**healthy**



We are  
**always learning**



We work  
**flexibly**



We are  
**a team**

<b>Agenda item:</b>	11.4, Public Board Meeting	<b>Date:</b> 26 April 2023		
<b>Title:</b>	Annual Review of the Board Schedule of Reports			
<b>Prepared by:</b>	Melanie Holley, Director of Governance			
<b>Presented by:</b>	Melanie Holley, Director of Governance			
<b>Responsible Executive:</b>	Suzanne Tracey, Chief Executive			
<b>Summary:</b>	The Board is asked to review and approve the Schedule of Reports for 2023/24 to ensure it receives the correct reports at the right time during the course of the year in order to conduct its business effectively.			
<b>Actions required:</b>	For the Board to review and approve the Board Schedule of Reports 2023/24			
<b>Status (*):</b>	<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Information</b>
		<b>x</b>		
<b>History:</b>	The Board Schedule of Reports is reviewed annually.			
<b>Link to strategy/ Assurance framework:</b>				

### 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 ( <i>please specify</i> )			

**1. Purpose of paper**

The purpose of this paper is for the Board of Directors (BoD) to review and approve the Schedule of Reports for 2023/24 to ensure it receives the correct reports at the right time during the course of the year in order to conduct its business effectively.

**2. Background**

The Schedule of Reports is reviewed annually.

**3. Analysis**

The Schedule of Reports is attached. The Board is asked to review the schedule to ensure it accurately reflects the business the Board must transact. Some minor changes are indicated as highlighted in yellow.

**4. Resource/legal/financial/reputation implications**

None.

**5. Link to BAF/Key risks**

None.

**6. Proposals**

The Board is asked to approve the draft Schedule of Reports for 2023/24.



BOARD OF DIRECTORS REPORTS SCHEDULE FOR 2023/24

	April	May	June	July	August	Sept	October	November	December	January	February	March	Frequency	Responsible Exec	Comment
<b>Policy &amp; Strategy</b>															
Annual Report & Quality Report update - agreed at Board 27.04.22 that this would no longer be needed as reports going through Audit Committee															Remove
Annual Accounts - Draft - as above, agreed to be removed from workplan 27.04.22															Remove
Annual Report & Quality Report - Approval			<b>P</b>										Annually, as required - C	Chief Executive / Chief Nursing Officer	
Annual Accounts - Approval			<b>P</b>										Annually, as required - C	Chief Finance Officer	
Budget Setting Update											<b>P</b>		Annually, as required - C	Chief Finance Officer	
Budget												<b>P</b>	Annually, as required - C	Chief Finance Officer	
Operational Plan - approval of draft											<b>P</b>		Annually, as required - C	Chief Finance Officer	
Operational Plan - approval of final												<b>P</b>	Annually, as required - C	Chief Finance Officer	
Operational Capacity & Resilience Plan							<b>P</b>						Annually for approval - P	Chief Operating Officer	
Towards Inclusion	<b>P</b>			<b>P</b>			<b>P</b>			<b>P</b>			Quarterly - P	Chief Executive	
Treasury Management Policy approval								<b>P</b>					Bi-Annually (next due Nov 2023) - C	Chief Finance Officer	Approved November 2021 - date of next review November 2023
<b>Performance</b>															
Integrated Performance Report	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	Every Month - P	All	
NIHR CRN SWP Annual Report and Annual Plans				<b>P</b>									Annually as required - P	Chief Medical Officer	
<b>Assurance</b>															
Six Monthly Safe Staffing Review		<b>P</b>						<b>P</b>					Bi-Annually P	Chief Medical Officer / Chief Nurse	
Annual Complaints Report to the Board						<b>P</b>							Annually - P	Chief Nursing Officer	Presentation changed from January to September meeting - requested by CM 10.08.22. Awaiting confirmation of whether permanent or one year only move
Annual Review of Register of Directors Interests	<b>P</b>												Annually, ahead of production of Annual Report - P	Chief Executive / Director of Governance	
Annual Sustainability & Development Plan										<b>P</b>			Annually - P	Deputy Chief Executive	
Audit Committee Report		<b>P</b>	<b>P</b>	<b>P</b>				<b>P</b>				<b>P</b>	Quarterly - P	Chief Finance Officer / Chair of AC	update to each Board meeting following a Committee meeting: so Feb, May, July, November plus possible additional meeting June if needed for Ann Accts
Board Assurance Framework	<b>P</b>			<b>P</b>				<b>P</b>		<b>P</b>			Four times a year - C	Chief Executive/Director of Governance	Presentation of BAF updates & Corporate Roadmap updates aligned: to be presented quarterly. (As agreed at Board Oct 22)
Clinical Negligence Scheme for Trusts for Maternity return to NHS Resolution		<b>P</b>											Annually - P	Chief Nursing Officer	
Corporate Risk Register	<b>P</b>												Annually (to coincide with the last quarterly review of the BAF)-C	Chief Executive/Director of Governance	
Corporate Governance Statement			<b>P</b>										Annually C (required by NHSI)	Chief Executive/Director of Governance	To be approved by Board by 30 June each year
Corporate Roadmap Update	<b>P</b>			<b>P</b>				<b>P</b>		<b>P</b>			Quarterly - C	Deputy Chief Executive	Presentation of Corporate Roadmap updates & BAF updates aligned: to be presented quarterly. (As agreed at Board Oct 22)
Corporate Trustee meeting								<b>P</b>					Annually - separate mtg	n/a	
Digital Committee	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	After each meeting - TBC	Non-Executive Director Chair	
Finance & Operational Committee	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>	Monthly - C	Non-Executive Director Chair	FOC changed to monthly meeting
Gender Pay Gap Report												<b>P</b>	Annually - P	Chief People Officer	
Governance Committee Report	<b>P</b>		<b>P</b>		<b>P</b>		<b>P</b>		<b>P</b>	<b>P</b>	<b>P</b>		Quarterly - P	Non-Executive Director Chair	Update to each Board meeting following a Committee meeting: so Feb, April, June, August (or Sept if no August Board), Oct, Dec (or Jan if no Dec Board)
Guardian of Safe Working Hours quarterly report														Chief Medical Officer	Removed from Board Schedule of Reports after May Board meeting (25.05.22). Going forward to be presented to PWP/W & twice annually Alaric/James Hobbs to provide information to be included in the Safe Staffing Report for Board
Infection Control Annual Programme				<b>P</b>									Annually - P	Chief Nursing Officer	
Infection Control Annual Report				<b>P</b>									Annually - P	Chief Nursing Officer	
Integration Programme Board reports	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>		<b>P</b>	<b>P</b>	<b>P</b>		<b>P</b>	<b>P</b>	<b>P</b>	Monthly - C	Non-Executive Director Chair	Added as a monthly report
Items for escalation to the BAF	<b>P</b>	<b>P</b>	<b>P</b>	<b>P</b>		<b>P</b>	<b>P</b>	<b>P</b>		<b>P</b>	<b>P</b>	<b>P</b>	Monthly - P & C	All	
Operational Plan - Condition G6 and Condition CoS7 self-certs		<b>P</b>											Annually - C	Chief Finance Officer	To be approved by Board by 31 May each year
My Care Programme update													Monthly - C	Chief Medical Officer	ND MyCare Programme Board meeting monthly until Sept 2022 - Go Live July 2022. Last formal update to Sept Board, after which it will be reported through Digital Committee.
Medical Appraisal & Revalidation Report													Annually - P	Chief Medical Officer	From 2022 will no longer come direct to Board - instead presentation to JGC then reported to Board through JGC report September (email J Hobbs 12.10.21)
Our Future Hospitals Programme Board	<b>P</b>		<b>P</b>		<b>P</b>		<b>P</b>		<b>P</b>			<b>P</b>	Bi-monthly as required - C	NED Committee Chair	-Updated March 2023 - meetings changed to bi-monthly
People Plan Update	<b>P</b>						<b>P</b>						Bi-Annually (April & October) - P	Chief People Officer	October presentation to include Annual Partnership Working & Staff Voice Presentation
Remuneration Committee Report			<b>P</b>										Annually, as required - C	Non-Executive Director Chair	
Research & Development Annual Report						<b>P</b>							Annually - P	Chief Medical Officer	
Staff Survey Results												<b>P</b>	Annually - P	Chief People Officer	
WRES/WDES Reports Information		<b>P</b>											Annually P	Chief People Officer	
Review of schedule of reports	<b>P</b>												Annually - P	Chief Executive/Director of Governance	

