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

Wednesday 27 September 2023
Petroc Tiverton Campus, Bolham Road, Tiverton EX16 6SH

MINUTES

PRESENT	Mrs C Burgoyne	Non-Executive Director
	Mrs H Foster	Chief People Officer
	Professor A Harris	Chief Medical Officer
	Mrs A Hibbard	Chief Financial Officer
	Professor B Kent	Non-Executive Director
	Mr S Kirby	Non-Executive Director
	Professor M Marshall	Non-Executive Director
	Mr A Matthews	Non-Executive Director
	Mrs C Mills	Chief Nursing Officer
	Dame S Morgan	Chair
	Mr T Neal	Non-Executive Director
	Mr J Palmer	Chief Operating Officer
	Mr P Roberts	Interim Chief Executive Officer
	Mr C Tidman	Deputy Chief Executive Officer
APOLOGIES:	None	
IN ATTENDANCE:	Mr M Browning	Programme Director Outpatient Transformation (for Item 140.23)
	Ms G Garnett-Frizelle	PA to Chair (for minutes)
	Mrs M Holley	Director of Governance
	Dr S Kyle	Clinical Lead for Outpatient Transformation (for Item 140.23)
	Professor H Quinn	Research & Development Director (for Item 150.23)

132.23	**CHAIR'S OPENING REMARKS**	
	The Chair welcomed the Board, Governors and observers to the meeting and Mr Roberts, Interim Chief Executive to his first Board of Directors meeting. Ms Morgan reminded everyone it was a meeting held in public, not a public meeting and asked members of the public to only use the 'chat' function in MS Teams at the end to ask questions focussed on the agenda and reminded everyone that the meeting was being recorded via MS Teams. Ms Morgan thanked all the Governors attending, both in person and via Teams. **The Chair's remarks were noted.**	
133.23	**APOLOGIES**	
	There were no apologies to note.	
134.23	**DECLARATIONS OF INTEREST**	
	Mrs Holley informed the Board that the following declarations had been received for Mr Roberts: • Member of a political party • Mr Roberts' wife is a clinician at Torbay and South Devon NHS Foundation Trust **The Board of Directors noted the declarations.**	

135.23	**MATTERS DISCUSSED TO BE DISCUSSED IN THE CONFIDENTIAL MEETING**	
	The Chair noted that the Board would receive at its confidential meeting updates on Finance and Operational Committee, Integration Programme Board and Our Future Hospitals Programme Board.	
136.23	**MINUTES OF THE MEETING HELD ON 26 JULY 2023**	
	The minutes of the meeting held on 26 July 2023 were considered and approved subject to the following amendment: Minute number 116.23, Chief Executives Update, p6 of 23, paragraph 3, to be amended to read "Mrs Hibbard informed the Board that there was a ~~proscribed~~ prescribed collection nationally of data…"	
137.23	**MATTERS ARISING AND BOARD ACTION SUMMARY CHECK**	
	The Board of Directors noted and agreed the updates to actions. The following further updates to actions were noted: Action 077.23(1) "Data regarding ED attendances in other coastal areas to be reviewed, to see if similar increases in attendances had been seen and if there was any learning for the Trust from their experiences". Mr Palmer advised that he had received feedback from a number of Board members following circulation of a briefing paper containing ED attendance trend data. He advised that more thought would need to be given to formula given the increase in demand noted, especially for Northern services. It was agreed that Mr Palmer would provide wording for an additional action relating to this for the action tracker. **Action.** Action 077.23(4) "A letter had been sent to DCC and the ICB requesting clarity on all funding streams (including the main hospital discharge fund) to support discharge and social care and the June IPR would contain an update on this". Mr Palmer reminded the Board that it was agreed at the July Board meeting that this action should remain open. Assurance had been received that Better Care Funding was in place but that absolute clarity on Urgent and Emergency Care funding was still awaited and this was still the case. There was a disparity regarding fair shares between Trusts which had been raised through a number of channels, including the System Recovery Board, but a final view of settlement was still awaited. Action 115.23 "Mrs Holley had informed the Board that she had been asked to share the Trust's BAF with the ICB some months ago as part of the alignment work on BAFs that was being undertaken at system level, which she had done. She had requested that someone from RDUH be involved with this, but had not had a response. Mr Tidman agreed to follow this up with the ICB." Mr Tidman informed the Board that he had contacted the ICB who had agreed that the intent was to have one consolidated Board Assurance Framework. Mrs Holley confirmed that she had now been contacted by the ICB regarding this and it was agreed that this action could therefore be closed. Action 118.25(4) " Mr Matthews noted that induction of labour was above target on both sites and asked for clarification of whether this was a concern and if there were any implications for the Trust. Professor Harris and Mrs Mills agreed to review the data outside the meeting to understand any possible implications." The Board noted the update to the action that had been provided. Mrs Mills further advised that the Devon system was looking	

	at a dataset for maternity and neonatal services and once agreed the information provided in the IPR could be changed to be aligned with the agreed position for the system. **Action.** Action 118.23(5) " Mr Matthews noted that VTE monitoring in both Northern and Eastern services was below where it had been previously and asked what implications this might have for patient safety. Professor Harris advised that there was a group of patients that were not included in the data, but agreed that more granularity on the data would provide assurance and this would be reviewed." Professor Harris advised that a drill down had been undertaken to understand what was happening and this related to the exclusion of some patients under certain specific circumstances which had been part of the system prior to the implementation of EPIC, but which had been removed and not re-added to the system. A list of exclusions had been generated and circulated to clinicians for validation following which they would be signed off by Professor Harris before being added into EPIC which should then provide the true position by the next Board meeting. Action 118.23(6) "Following a question raised by Mr Matthews regarding the impact of inpatient and day cases being 10-20% below plan in terms of earning additional income, it was agreed that this should be discussed in more detail by the Finance and Operational Committee" Mrs Hibbard advised that a detailed paper had been presented to the September Finance and Operational Committee meeting in September 2023 and it was agreed that this action could therefore be closed. Action 120.23 "Any changes to the Clinical Strategy/enabling strategies to be copied to the Chair for information". It was noted that at the time of presentation some feedback from partner organisations was still awaited and that once the document had been finalised, any changes would be shared with the Chair. **The Board of Directors noted the updates.**	
138.23	**CHIEF EXECUTIVE OFFICER'S REPORT**	
	Mr Tidman provided the following updates to the Board. <u>National Update</u> • Industrial action by the BMA continued, with the first day of joint industrial action by consultants and junior doctors and a further period of joint action planned for the next week. Nationally, the impact on patients of industrial action had topped over 1m cancelled appointments causing continued pressure on staff and the Trust was continuing to provide as much support as possible. The Trust would continue to escalate nationally the need for a mutually agreed settlement to be agreed speedily. • The national winter vaccination campaign for Covid boosters and flu had started and the Trust would be rolling out vaccination clinics for frontline staff and eligible patients. • The use of Reinforced Autoclaved Aerated Concrete (RAAC) had been reported extensively in the news in recent weeks. All trusts had been asked to assess their estate and report back to NHS England (NHSE) on whether RAAC was in place. All of the Trust's sites were surveyed in 2019 and following a reassessment the Trust reported that a small amount of RAAC was present in a wall panel in the link corridor in North Devon District Hospital. This had been inspected with NHSE's technical experts who had confirmed it was in good condition and not load bearing. NHSE were satisfied that this was a manageable risk at the moment, but this would need to be replaced in the future.	

- A new framework for the Fit and Proper Persons Test for Board members, which is regulated by the Care Quality Commission (CQC), was due to come into effect at the end of September 2023. Chairs would have overall responsibility for arrangements.
- Mr Tidman and Professor Marshall had attended a national Chairs' and Chief Executives' event on 6 September 2023 to discuss and reflect on the lessons from the Lucy Letby verdict. It would be important for the learning to be taken into the Trust's governance processes and Board discussions to be assured that it was satisfied that processes were robust and that the Trust had the right culture to encourage listening to staff and following up on concerns.

<u>System Issues</u>

- The Devon system remained strongly focussed on financial and performance recovery, with the Executive Team playing their part in system design and improvement. Given the focus on winter preparedness, the ICS was invited to a deep dive event with the NHSE Regional Team during August 2023 to review the ICB's out of hospital proposal. The consolidated Winter Plan due to be presented to the October Board meeting should show not only what the Trust would be doing, but all the support that could be expected outside of hospital.
- Risks remained regarding delivery of the 2023-24 operational and financial plan. Industrial action had had a major impact, including financially due to double running costs. The Trust had however now virtually eliminated its 104 week waits and had also received a letter from the national team recognising the significant improvements.
- A letter had been received from Professor Tim Briggs, National Director for Clinical Improvement and Elective Recovery, thanking staff in Devon for their efforts and progress made on reducing waiting times. Professor Briggs had visited both the Centre for Excellence at the Nightingale Hospital and the South Molton Eye Centre and had cited some of the transformed services he had seen as exemplars.

<u>Local issues</u>

- The results of the most recent CQC Inpatient Survey had recently been released and the Trust had been ranked joint second nationally for inpatient satisfaction.
- The Trust had appointed a new Lead Freedom to Speak Up Guardian, Simon Domoney, to lead the team of volunteer Freedom to Speak Up Guardians.
- The Extraordinary People Awards event is due to take place in November 2023. 550 nominations had been received from colleagues and patients; shortlisting and judging would take place over the coming weeks.
- The Trust had taken delivery of a new £2m genetic sequencer which enables a full series of genetic tests to be undertaken within 24 hours. The National Institute for Health Research had supported the Trust with funding to take this forward.
- Mr Phil Luke would be covering as Director of Operations (Eastern) for a period whilst Ms Dootson was away from work and Ms Leigh Mansfield had been appointed to the role of Divisional Director of Operations.

Mr Kirby commented that the Winter Plan had been presented for approval at a recent ICB Finance Committee meeting he had attended and he had received assurance that the Trust had had input to this. Mr Palmer advised that whilst there had been a degree of engagement through data collection and a meeting had been arranged for all organisations to pull the threads together, more work would be needed to ensure the plan properly reflected the acute provider positions. Mr Tidman added that it had been made clear that even if there was a national requirement for templates to be submitted by a deadline, there would have to be engagement events and each organisation would have to go through its own assurance process.

	Mr Matthews asked if there was anything further the Trust and the system should be doing with regard to escalating concerns relating to industrial action. Mr Tidman advised that the regional and national teams had been open in asking for feedback so that they could be transparent with politicians about the cumulative impact of continuing industrial action. Mr Roberts added that there were other issues relating to the general work experience of doctors and that the Trust's duty as an employer was to ensure that it kept a good relationship with its clinicians and to have a focus on all the other issues that would make doctors' experience of working life better. Mrs Foster commented that wellbeing for doctors was being looked at with a letter planned from Professor Harris to all doctors to reinforce the importance of wellbeing and rest. Professor Marshall asked if there was a way of measuring longer term harm as a result of cancellations due to industrial action and Professor Harris responded that every postponed procedure or operation carried a degree of psychological harm and risk with patients experiencing greater pain and discomfort, and whilst the aggregate of what this meant was understood, undertaking work to look at this in greater detail would require time from consultants which would mean time taken away from catching up on lists. Ms Morgan thanked Board members for their comments, adding that the Board had agreed that it would have a session at a future development day to look at lessons learned from how the Trust had responded to industrial action **The Board of Directors noted the Chief Executive's update.**	
139.23	**PATIENT STORY**	
	Mrs Mills presented the Patient Story video to the Board which related to the experience of a parent with a sick child brought to the ED in Eastern Services reflecting the challenges relating to the time they spent waiting in ED and the environment in the waiting area that was not suitable for a child. Ms Morgan noted that there were plans in place that would help to resolve some of the issues experienced by this family in terms of the location of the paediatric service and that communication had been noted as an issue with the family relying on paramedics to keep them informed on how long they would have to wait. This linked to the Annual Report for Complaints where communication was identified as a significant issue in complaints. Mr Tidman confirmed that the final phase of the Trust's ED build was a combined Paediatric ED and Paediatric Assessment Unit, as the pathways and relationships between the two were very important. The work was due to start over the coming weeks and the combined service should be up and running in 2024. Mr Neal noted that there would be other areas across both sites where there was no separate paediatric waiting space, such as outpatients, adding that there would also be adult patients who would find some of the experiences described in the story equally traumatic, such as patients with anxiety. He suggested that it would be helpful to look at this through the patient experience lens periodically. Mrs Burgoyne asked whether arrangements would be put in place for a child or young person presenting with high anxiety or a mental health issue to ensure that they were not spending long periods in the general ED area. In addition, she asked whether the voice of the child and the carer had been considered for the rebuild of ED. Finally, Mrs Burgoyne suggested that it would be helpful to go back to this family to inform them of what would	

	change with the ED rebuild. Mrs Mills advised that she would follow this up with the PALS team to ensure that they had been in contact with the carer. **Action.** Professor Harris commented that the description in the story of being triaged at the end of a corridor was because the ED was at that time in the rebuilding phase, but acknowledged this was not in any way acceptable. Wherever possible children with high anxiety or mental health issues would be placed in an assessment room, however if the ED was at capacity this could not always happen. Professor Harris advised that he had discussed with the Paediatric Emergency Medicine Lead and the Lead Clinician for Paediatrics the need for the patient voice in developing the integrated unit and work had been undertaken with patients and the Trust's charity to make the environment child friendly. Professor Kent suggested that the Trust could make more use of the Ark which had a Patient Public Involvement Group. Mr Palmer informed the Board that internal professional standards for ED had recently been launched on both sites. Mr Matthews commented that it had taken three hours to triage the patient, noting that this was an important measure but did not appear to be tracked anywhere in information presented to the Board. Professor Harris responded that cohorted patients in ED were held in a queue and remained under the care of ambulance staff, but verbal triage would be undertaken by the ambulance staff discussing the needs of the patient with the senior clinician. Professor Marshall commented that one of the most common concerns expressed by advocates for children and young people was that children were treated as second class citizens and asked whether the Trust was in a better place in terms of the priority given to children in the new development. Professor Harris responded that whilst there had always been the intention to have a fit for purpose centre; the most pressing priority had related to resus capacity, but paediatrics had been prioritised. Ms Morgan thanked the Team for the story which she noted had generated a helpful discussion. **The Board of Directors noted the Patient Story.**	
140.23	**OUTPATIENT TRANSFORMATION UPDATE**	
	Mr Browning shared a powerpoint presentation with the Board, the highlights of which included: • Governance for the Joint Strategic Outpatient Transformation Group had been changed to align with the new Improvement Board, with six key workstreams which reported monthly to the Transformation Group. There was also now a Digital Outpatient Advisory Group. The structure brings together key people to share best practice and provide support to implement changes where there are opportunities. • There is a nationally set target to reduce follow-up activity of 25% on 2019/20 volumes. This was challenging for the Trust as the implementation of EPIC since 19/20 had created issues with the presentation of like for like data in relation to outpatient activity, for example community and midwifery activity, which had not been recorded previously but was now recorded on EPIC. It has been agreed with the National Director for Elective to draw a line from 2022 when EPIC had been fully implemented across both sites.	

- There are a significant number of patients waiting for follow-up and overdue follow-ups with varying risks across specialties. This backlog would need to be addressed before any reduction in activity will be seen in the figures from changes in the patient pathways.
- There are three key elements to the follow-up improvement programme:
  - Deep dives were underway in the national Further Faster system using GIRFT methodology to produce best practice guides for each specialty. Key data has been shared with all specialties and they have been provided with a checklist to undertake a gap analysis to identify opportunities to improve. 16 specialties are involved, with three teams having completed and one awaiting confirmation of a meeting to discuss. Meetings are being arranged with the remainder. At the end of this process it is hoped to have specialty level action plans to take forward.
  - Patient Initiated Follow-Up (PIFU) – the national target was to move 5% of patients onto PIFU and the Trust was moving in a positive direction towards this target with the current position being 3.3%. This equates to 30,000 patients on an active PIFU pathway. Gap analysis is being undertaken and key workstreams with a number of specialities. Patient Stratified Follow-Up was being utilised across cancer services using a combination of remote monitoring and PIFU.
  - Follow-Up Validation Plan – a contract is in place with an external digital provider. There are two platforms in place; firstly an SMS message asking patients if they still need to be on the waiting list which had been piloted in Pain Management. Secondly, there is a more complex integrated process that is being built in EPIC that will go live in mid-October, consisting of a multi-layered assessment questionnaire which will either lead to removal from the pathway with clinical validation, moving to a PIFU if stable or remaining on the list.
- In order to help with monitoring clinical risk on the Waiting List, percentage overdue is now built in.
- The Trust is 6th best nationally for its Did Not Attend (DNA) position. This effective management of DNAs enables the Trust to see approximately 2,500 patients per month or over 31,000 more patients each year. There are a number of high performing specialties and learning has been taken from these. Short notice cancellations were an area of opportunity where two-way text messaging could be used.
- The Trust is in the top quartile for utilisation rate for advice and guidance, although the conversion rate for appointments was in the 3rd quartile.
- The Chief Medical Officer had led a series of meetings with clinical leads and service managers across both sites to discuss opportunities to maximise use of digital technology, EPIC and voice recognition to increase the number of patients seen in Outpatient Clinics with action plans in place to support clinical staff to take forward.
- A workstream was established to focus on accurately capturing activity already being delivered by teams, for example unscheduled appointments, and this had now been built into EPIC. There was also an opportunity being explored around outpatient procedures that were not being recorded.

Ms Morgan asked when a further update on this would be brought to the Board and Professor Harris suggested that an update in six months' time should be scheduled. **Action.** Professor Harris added that whilst there had been a shift in the way that clinicians work, job planning did not reflect this which would be looked at.

Professor Marshall noted that no reference had been made to the importance of outpatient departments for teaching for health professionals and that it was important that education was a component of productivity, as if it was not, this would damage future generations of clinicians. Dr Kyle said that this was a difficult area – how to train the clinical workforce in outpatients – when there is limited estate capacity and those being trained are less

	productive. The responsibility lies with the clinical leaders in each specialty to ensure that they escalate to the Outpatient Team where they are not able to provide education opportunities so that support can be provided. Mr Kirby noted that EPIC build had been mentioned as an issue in a number of areas and asked whether there might be a payback in investing more in EPIC to get some of the builds fixed. Professor Harris responded that the Outpatient EPIC build had progressed significantly. Dr Kyle agreed that on the whole there had been a definite shift, although there were sometimes issues where it would be helpful if builds happened quicker but builds were complex. Ms Morgan suggested that this could picked up in the EPIC seminar that Professor Harris was arranging for the Board. **Action.** Mrs Hibbard said that the Finance and Operational Committee had received a paper relating to income, ERF, counting and coding and a resource package to support accelerating some of the work to ensure that income benefit was being maximised. **The Board of Directors noted the update.**	
141.23	**INTEGRATED PERFORMANCE REPORT**	
	Mrs Hibbard presented the Integrated Performance Report for August 2023 with the following points highlighted: • Industrial action by both junior doctors and consultants took place during August 2023 which had impacted on performance, as well as on leadership, management and support services capacity to ensure services continued to run safely. • The Trust was able to declare zero 104 week waits at the end of August subject to two retrospective reviews from the national team, and the Trust moved out of national tiering for cancer with effect from 20 September 2023. • Loss of activity was having an impact on overall recovery with a slowing of clearance rates on 78 and 65 week wait targets, with concerns on the Trust's ability to deliver against the plan. • The urgent care position remained challenging, behind the planned improvement trajectory for ED performance both type 1 and type 1 to 3, although some improvement in overall ED performance had been seen in recent weeks. Northern services were in the seventh month of consecutive growth. However, both sites had retained strong ambulance handover performance. • Urgent community response performance continued to surpass the national target by 20%. There had also been improvements in social care assessments, care allocation and the use of the virtual ward which were leading to improvements in discharge and flow, although it was recognised that No Criteria to Reside (NCTR) remained above where it needed to be. • There was significant financial challenge with the organisation having moved off plan for the first time this year. The drivers of this are recognised and a number of additional actions have been set out in the financial recovery plan, however overall delivery looks to be high risk. Detailed work was ongoing on the likely trajectory and conversations were taking place with the wider system on financial recovery. • There was an increasing trend on never events with work led by Professor Harris and Mrs Mills including reflection, learning and training events. • The vacancy rate had fallen below 5% and turnover was also showing positive movement. However, this had not flowed through to a reduction in the use of agency which is one of the driving factors in the financial position and was being further scrutinised in the financial recovery plan. It was important to recognise that there were pockets of fragility, particularly in Northern services.	

- There was agreement of continuation of the postcode catchment change which supports ambulance pressures in other parts of the system.
- Staff morale continued to be a concern as the Trust moves into winter.
- The Trust is seeking funding for additional capacity, but this was very much speculative at this time awaiting a funding route.

Mr Neal asked what the trajectory was for NCTR and was it expected that it could be achieved, particularly for the North. Mr Palmer responded that NCTR was currently at 10% on both sites and needed to reduce to 5%. He added that the work that the ICS had been doing particularly around Northern services had stalled and it was hoped that the new initiatives to optimise home care which were due to start in late October 2023 were well resourced and should make a difference. It was noted that during each period of industrial action acute discharge was strongly driven but this then had an impact on NCTR. In terms of meeting the trajectory, Mr Palmer said that there would be a great deal of work to be done over the coming six weeks. Mr Tidman added that the financial pressures that Devon County Council were under needed to be recognised and continued dialogue and open relationships with social care colleagues would be very important. Early sight of any plans that the Council may have would be vital.

Mr Matthews noted that oncology appointments across most specialties were struggling for capacity and asked how serious a concern that was. Mr Palmer noted that this had been declared as a risk over the last couple of years and investment had been made into oncology. However, despite this there were still concerns with an immediate concern around workforce to balance capacity.

Mr Matthews noted the significant improvements to the 65-week waiting list and beyond, but that there appeared to be a significant bow wave of 52 week waits and asked how this was being managed. Mr Palmer commented that there was significant oversight of both long waits and outpatient activity, with the challenge being to keep focus on managing long waits as well as on outpatients.

Mr Matthews asked for clarification of the rise in August in pay which had then come down again. Mrs Hibbard replied that a significant amount of annual leave was booked during August, so usage of agency did increase. She added that it was hoped that the actions put in place in the financial recovery plan, such as increased vacancy control, would help to address the overall increase in the use of agency in Month 6.

Mr Matthews commented the IPR did not show full year effect and recurrent effect of delivering better value, although this was presented to the Finance and Operational Committee and suggested that this might be included on the one-page summary in the IPR. In addition, he asked whether information about weighted activity should be included. Ms Morgan acknowledged that there was always more information that could be added to the IPR, her view was that it should be kept as streamlined and focused as possible. Mrs Hibbard commented that she had asked for weighted activity to be added to the balanced scorecard going forward. Following discussion, it was agreed that a review of what Board members most value in the IPR, what might be missing, deleted or added should be added to the list of topics for a future Board Development Day. **Action.**

Professor Kent asked for clarification of steps being undertaken with SWAST and hospital at home to integrate services. Mr Palmer responded that over the last two years the Trust had run pilots with SWAST for a direct pathway from the ambulance stack into Urgent Community Response and utilisation had been poor. This was a target for improvement this year and it was hoped to build a different approach for SWAST for Devon.

	Professor Kent noted that the Northern midwife to delivery ratio was trending upwards and asked what mitigations were in place. Mrs Mills advised that she would follow this up with the Head of Midwifery and come back to Professor Kent. **Action.** Mr Kirby said that Michael Wilson had challenged the system on whether improvements in waiting lists were as a result of productivity and efficiency or from in or outsourcing. Mr Tidman had responded that it was both. Mr Kirby commented that it would be useful to understand the balance between the two. Mr Tidman agreed that he would look at this in more detail outside the meeting. **Action.** Mr Kirby said that it was difficult to understand the increase in agency use when looking at the other factors, such as the reduction in vacancy rates. Mrs Hibbard responded that a fortnightly Understanding Pay Task and Finish Group would be looking at this in more detail. She added that infrastructure was one of the driving forces between Month 4 and Month 5. Ms Morgan suggested that this should be discussed at the Finance and Operational Committee and reported back to the Board. **Action.** Mrs Burgoyne asked what assurance there was that some of the changes relating to domiciliary care would be in place early enough to make an impact during winter. Mr Palmer advised that the programme that had been put in place last year, "help people home without delay", was being put in place again for this year with some additional investment which would increase one to one activity. It was noted that the Winter Plan would be presented to the October Board together with the updated Community Strategy. This would try to balance the short-term measures needed for winter with the medium to long term activities to facilitate a three to five year shift. Mrs Burgoyne commented that work had been undertaken to look at how many beds were used in hospital for patients with dementia and linked to mental health patients and which was being used to help look at what needed to be done to reduce those numbers. Mr Palmer said that this related to intensive work that had been undertaken with the Chief Medical Officer and Chief Operating Officer at Devon Partnership Trust to look at common issues around the delays for mental health patients. Mrs Hibbard informed the Board that a workshop was planned in the coming week for all parties across Devon to look at key strategic pieces of work that would help collectively. Mrs Mills commented that it was very important to get communication with patients and their families right to combat the impression that they were being "pushed out" in a way that did not meet their needs or expectations. Ms Morgan suggested that this would make a good subject for a future patient story and it was agreed that this would be looked at. **Action.** **The Board of Directors noted the Integrated Performance Report.**	
142.23	**NEVER EVENTS AT RDUH**	
	Professor Harris said that whilst it was encouraging that no significant harm had been seen from the Never Events reported, however if there were failures in processes insignificant harm could become significant. He added that these types of incident were rarely about one failure or one individual, but rather came about through an aggregation of a number of things. He believed there was a coherent plan in place, but he would welcome test and challenge of this in the best interests of keeping patients safe. Mrs Mills added that the balance between improving safety and personal accountability, as well as the principles of a just culture had been borne in mind in developing all actions. Professor Harris and Mrs Mills and the Teams had worked with the ICB and the South West NHSE Safety Team to check and balance the Trust's interpretation of the events and to understand if there was	

	any learning for both the Trust and the Devon system. This had informed the development of the actions. Ms Morgan noted that inconsistent implementation of both local and national safety checklists was noted as one of the most frequent themes and asked for clarification of why this was happening. Professor Harris responded that there were local checklists in place for certain procedures undertaken by different teams in the Trust, for example for a spinal block procedure, and one of the priorities would be to have a standardised approach across all teams, although this was an extensive piece of work as many of the processes were procedure specific and there were thousands of site-specific procedures. He advised that it was important to get the right balance with checklists to make them robust but not overly complex. He added that the ability for staff to speak up if they felt that a process was not being followed or an error had occurred was built into all safety processes, but there was work to be done on improving psychological safety for staff to encourage them to speak up. Ms Morgan noted that the top recurring theme was people operating under pressure. Mr Roberts said that it was important to be clear that staff had the time to work safely, regardless of pressures they were operating under. He added that it was important that staff understood that the Trust appreciate reporting of incidents as something that was valuable to the organisation. Professor Harris agreed and said that the New Patient Safety Incident Response Framework supported this. Mr Neal noted the work to be undertaken on consolidating checklists and asked whether there would be a process in place on completion of this work to check whether it had made a difference in terms of them being completed. In addition, Mr Neal noted that distractions were noted in the themes, but there did not appear to be an action to look at whether there were specific distractions in particular settings that could be addressed. Professor Harris agreed to look at that. **Action.** Professor Kent asked whether there was a potential for risks to increase with cross site working and asked whether there were mitigations that needed to be put in place to address this. Professor Harris agreed that there was a potential risk and said that the long term solution was to standardise completely, but there was also a focus on the opportunity to move whole teams rather than just a medic. Professor Marshall noted that pressure was a significant factor and asked whether pressure was coming from clinicians themselves or from elsewhere and Professor Harris said that soft intelligence indicated that much of this pressure was coming from individual clinicians themselves. Mrs Mills added that one of the themes that had come out of the latter reviews undertaken was the perceived risk of doing the wrong thing versus the benefit of expediting rapid treatment, particularly in relation to pain relief. Mr Palmer said that Schwartz rounds were a good model for routinising group reflection on safety and policy and thought should be given to adding them as a supportive intervention. **Action.** Ms Morgan said that this had been an important discussion and one that the Board should return to both at Board and Board Development Days to look at in more detail. She added that it would be important for the Trust to learn from good practice from other organisations. **The Board of Directors noted the report on Never Events at RDUH.**	

143.23	**ANNUAL COMPLAINTS REPORT**	
	Mrs Mills presented the Annual Complaints Report, the format of which used a balanced scorecard approach to patient experience. She highlighted the following areas for the Board's attention: • Significant progress had been made in managing the backlog of complaints, particularly in Eastern services. • The Trust had been an early adopter of the standards that had been developed nationally for managing complaints. • There had been some complexities in aligning data for the new merged organisation which had been achieved partway through the current financial year. • The most common theme related to communication and a deep dive had been undertaken on this which had been shared with the Patient Experience Committee. The deep dive had looked at whether there were any themes relating to specific teams, locations and content. • A detailed piece of work was undertaken to look at complaints that had been reopened to understand why this had happened. The most common feedback received was that people did not feel their questions had been answered. • As part of being in the national pilot for complaints standards, the Trust is about to launch a new template which should help to ensure there are more robust checks and balances in place. • Complainants who are unhappy with the Trust's response have the option to contact the Parliamentary and Health Service Ombudsman (PHSO) to have their complaint reviewed. During the period reported the PHSO closed 17 cases, 2 were partly upheld and 2 were upheld. The Trust complied with all of the recommendations from upheld and partly upheld investigations which were monitored to completion by the Trust's governance process. Ms Morgan said that she was grateful for the Patient Experience Committee in reviewing this report in detail. It was noted that a session was planned for the next Joint Board and Council of Governors Development Day to look at patient experience in detail and Ms Morgan suggested that a detailed discussion on the report should be saved for that event. **Action.** **The Board of Directors the Annual Complaints Report.**	
144.23	**FINANCE AND OPERATIONAL COMMITTEE**	
	Mr Kirby informed the Board that the Finance and Operational Committee had met in August due to the pressure that both the Trust and the whole system was under. He advised that it was clear that financial pressure was intense and not showing signs of easing in the near future. Mrs Hibbard provided the following combined update from the meetings held in August and September: • The Trust had remained on plan in Month 4 but recognised the risk profile evidence that it was increasingly likely the organisation would move off plan at some point, and that had happened in Month 5. Recognising this as part of the Month 4 position had triggered the financial recovery plan with a number of actions that were being delivered across workstreams, including understanding pay and non-pay, accelerating the delivering best value programme and maximising income, which aligned to the work referred to in the Outpatients Transformation update about data capture. Communications had been shared with the organisation regarding the pressures that	

	the Trust was under. Additional spend controls had been put in place but had not yet impacted. • As outlined in the IPR, the Month 5 position was a £3.9m adverse variance from plan. • Operational performance exceptions were also highlighted in both meetings which had been covered in the IPR discussion. • The Committee had also received updates on the Operational Improvement Plan, with a focus on ED performance and the delivering best value savings plan which linked to financial recovery. • The Committee received lessons learned on the major build programme for the ED configuration. • ERF performance was discussed, setting out current performance under the current rules, but recognising that there may be further changes to these. These were aligned to opportunities that may align to the financial recovery plan. • Presentations were given at both meetings on the Medium-Term Financial Plan (MTFP), which the Committee were required to recommend to the Board. Mrs Hibbard highlighted the feedback that the Committee had given; it recognised that this was a financial model rather than a plan and that the system was working on how to translate the model into a deliverable plan. The modelling with an agreed set of assumptions should give a trajectory of financial improvement as a system. At this stage, individual organisation positions were not expected to be signed off but the overall system position was. • The Committee had also provided feedback on the National Hospital Programme feedback on the scenarios of under delivery in 2023/24 which it was felt needed to be drawn out much more strongly in the model as a potential worsening of position in that plan. • It was also noted that this was described as an ICS plan but there was no mention of the local authority position within it. • The ICB had provided a form of words to be used included in the report to Board so that all organisations were consistent in the ask of Boards in signing this off. • The Committee received the MBI data validation outcome and the self-assessment against the national protecting and expanding activity which had subsequently been amended following detailed review by Mr Matthews to better reflect the current position. • The second draft of a speculative case for hybrid theatre capacity was also presented recognising the impact the extra capacity could have on waiting lists, but being clear that both a capital and revenue source of funding would be needed to take that forward. He added that the consequence of approving the MTFP would be that it would commit the Trust and the system to the numbers in the original plan, ie £43m deficit this year and £30m next year going into surplus in years 3, 4 and 5. Mr Kirby said that the Board's endorsement was not of the numbers, but related more to the system having common principles and ways of working, including principle of financial improvement. Ms Morgan reminded the Board that when the plan was originally submitted a letter had been sent from herself and Mr Tidman which set out the caveats around the assumptions that had been made, which had included that success depended on reducing NCTR to 5% which had not happened. She suggested that it would be helpful to review the list of caveats. Mr Tidman asked whether, if the system reforecast the position to year end based on not all of the assumptions coming through, there would be an opportunity to refresh the MTFP. Mrs Hibbard responded that understanding of what the true exit rate for 2023/24 had been included in the response as part of the scenarios and this formed part of the submission that had gone to NHSE. There had been no feedback in terms of the process going forward, so it was not possible to say at this time whether NHSE would expect or accept a new submission based on the outturn for 2023/24. It was also noted that the trajectory of	

	improvement would go against the national expectation for breakeven for next year and the system would need to understand if any further deterioration was recoverable in year one of the forward model or would it change the overall trajectory. Mr Tidman said that when the system considered what its yearend run rate was going to be it would be important to cross-reference this back. Mr Kirby advised this had been discussed in detail at the ICB Finance Committee and he had had a conversation with the Chair of that Committee to ensure that he was clear on the Trust's stance on this. Mr Kirby further advised that Deloitte had undertaken work to understand non-recurring bolstering of the number for this year and the extent to which this could "right shift" with recurring planning for next year and beyond. The ICB Finance Committee had noted that the strategic, longer-term transformation work flowing out of the Acute Provider Collaborative was not built into the model, and it was recognised that the model was very fluid currently. Mr Neal noted that in the recommendations about the MTFP it is still referred to as a plan, although the recommendations start by saying that it was a model rather than a plan. He suggested it would be important to make clear that the Trust's view is that this is a model as delivery plans are not there yet. Mr Kirby agreed that he would check this wording. **Action.** Mr Matthews said that the model makes a number of assumptions about the strategic benefits that there were currently no details for. Mr Kirby responded that there was ongoing work to validate routes to cash etc for the strategic CIPs, which were system CIPs built into the model. Longer term strategic transformation was an overarching line on the model which was currently showing no financial benefit; it was acknowledged that this might relate to pace and politics. Mrs Hibbard commented that there was already a set of assumptions around a targeted savings programme and once these are quantified, they would start to make those targets, rather than additional savings. Ms Morgan advised the Board of Directors that the Finance and Operational Committee had recommended the following three items for approval: i. Investment criteria to be built into business case and prioritisation processes in line with the approved financial strategy. ii. To approve the national Protecting and Expanding Elective Capacity (Outpatient Capacity) 2023/24 return for submission to NHS England by 30 September 2023. iii. To approve the MTFP wording to be agreed and to give delegated authority to the Chief Finance Officer to approve any minor changes prior to final submission. If there are any material changes, the Board would be asked to give delegated authority to the Chief Finance Officer, Chair of Finance and Operational Committee and Deputy Chief Executive. NB – it was noted that the ICS Finance Committee had approved the MTFP with the caveats noted included. Ms Morgan commented that there could be disruption to plans in the future depending on wider peninsula issues and Mr Kirby said that he anticipated that there would need to be full Board discussion on the reforecast. **The Board of Directors noted the Finance and Operational Committee update and approved the recommendations of the Committee.**	
145.23	**AUDIT COMMITTEE**	
	Mr Matthews presented the Audit Committee update from the meeting held on 9 August 2023. It was noted that the Committee had discussed the IM&T Business Continuity Disaster Recovery audit noting that there was a split opinion with East rated satisfactory	

	and North rated limited. The Committee was informed that the report was on the agenda for detailed review and tracking of actions by the Digital Committee. **The Board of Directors noted the Audit Committee update.**	
146.23	**DIGITAL COMMITTEE**	
	Mr Neal presented the Digital Committee update from the meeting held on 3 August 2023 with the following points highlighted: • Work was continuing on development of the Digital Strategy. • Development of the Shared Service Desk Business Case was underway. • The Committee discussed the Data Centre Failover Exercise noting that work was being undertaken to engage with all impacted stakeholders to ensure mitigations were fully understood, as the test would trigger Trustwide outage of Epic and some Tier 1/2 systems. • Minor changes to the Committee's Terms of Reference were discussed and approved for presentation to the Board of Directors. Mrs Foster noted that the Committee had discussed recruitment to Digital Teams and noted that this was a challenging area to recruit to and be competitive for the NHS. **The Board of Directors noted the update and agreed the revised Terms of Reference.**	
147.23	**GOVERNANCE COMMITTEE**	
	Professor Marshall presented the Governance Committee update from the meeting held on 10 August 2023 noting that: • The Committee had approved a number of minor changes to the Reporting Schedule. • The Committee had received the Children and Young Persons Bi-Annual Report which had highlighted a significant increase in the number of children and young people presenting with eating disorders across both inpatient and outpatient services with no commissioned services in place for these. **The Board of Directors noted the update.**	
148.23	**INTEGRATION PROGRAMME BOARD**	
	Mr Matthews presented the Integration Programme Board update from the meetings held on 22 August and 19 September 2023. It was noted that the paper provided an update on progress of the Operational Services Integration Group and that a more detailed discussion on this was planned for the confidential Board session. **The Board of Directors noted the update.**	
149.23	**OUR FUTURE HOSPITAL PROGRAMME BOARD**	
	Mr Kirby presented the Our Future Hospital Programme Board update from the meeting held on 14 September 2023. The Board noted: • Health Minister, Lord Markham, visited North Devon District Hospital together the national New Hospital Programme Team on 2 August 2023 to meet with colleagues, patients and stakeholders. As part of the visit, Lord Markham toured the estate and learned more about the Trust's ambitions as part of the New Hospital Programme. • Nicola Brewer, Programme Manager, would be managing work to complete the short form business case for the residences.	

	• A key focus had been on refining the business case from the original preferred way forward. It was believed that a smaller and more nimble case, such as the Trust's, may be more favourable for early adoption by the New Hospitals Programme Ms Morgan noted that Lord Markham's visit had enabled the Trust to provide him with a good perspective of the issues and the Trust's ability to respond quickly and within budget. Ms Morgan expressed her thanks to the Team who had organised the visit and to Governors and staff who had attended the discussions. **The Board of Directors noted the update.**	
150.23	**RESEARCH AND DEVELOPMENT ANNUAL REPORT**	
	Professor Quinn joined the meeting. Professor Harris welcomed Professor Quinn to the meeting to present the Annual Report. Professor Quinn highlighted the following points from the Annual Report: • A significant amount of research activity had stopped during the pandemic, but progress had been made over the last year through the reset programme led by the Department of Health with recovering activity, as well as expanding the breadth of what the Trust was able to offer patients. • Improvement had been seen across multiple specialty areas, with particular success noted in commercial activity which was bucking the national trend. • There are significant issues with delays with the medicine's regulator, with 18 trials currently awaiting approval. Despite this the Trust did very well recruiting in the last year compared to other similar organisations, due to the breadth of offer within the organisation, including the Clinical Research Facility and the Patient Recruitment Centre, one of only five in the NHS in England. • Non-commercial trials were helping to change ways of working at the Trust. Of note was the Boost trial at North Devon District Hospital which was evaluating a 12-week strength and conditioning programme to see if it is more effective than standard treatment for people with spinal stenosis. The Team are also supporting delivery of research to help prevent admissions. • Over £4m of grant funding was achieved in the last financial year which was attributed to the good collaboration of the Trust with University partners and other institutions. • The Trust had successfully bid for £1.6m capital funding for a new genomics analyser which was already on site. • The Biomedical Research Centre had been a great achievement for the Trust and its partners. • Additional investment in pharmacy had allowed the appointment of an additional Senior Clinical Trials Pharmacist. Eight senior research investigators had been awarded Biomedical Research Centre Senior Investigative fellowships. • The Trust has a Nursing, Midwifery, Allied Healthcare Professional and Healthcare Science Strategy, the first organisation in the region to do so. The Trust worked closely with the University of Plymouth to develop the strategy and is now working with the Chief Nurse for NHSE to roll out learning from this to other Trusts across the region. • The Patient Recruitment Centre is a test bed for innovation, for example through work currently underway to maximise the potential of EPIC through extracting data directly from EPIC directly into life science partners electronic data capture systems which is likely to reduce the amount of data entering by 40-50%. • Work was also being undertaken with the Patient Improvement Centre on remote and digital trials.	

	Ms Morgan offered congratulations on behalf of the Board for all that the Team had achieved. Professor Kent asked whether some of the successes of the past year were attributable to the Joint Research Office and was advised that this had provided the opportunity for Teams to formally work together better. Professor Kent noted that the Research Design Service South West had been unsuccessful in its bid to host the new structure for this service and asked what support the Trust would have to support developing grants etc. Professor Quinn responded that this was one of three services that were not recommissioned and the National Institute for Health Research (NIHR) had taken the decision to move to a national service which was due to start very shortly. It was not yet known how researchers would be able to access this new service. A meeting had been agreed for the Deputy Head of NIHR Infrastructure with research active Trusts, and the Universities of Plymouth, Bristol and Exeter, to discuss what Key Performance Indicators they will be putting in place to ensure that researchers in the South West would continue to be supported. Mr Neal noted that the Trust was bucking the national trend in terms of commercial research and asked why this was. Professor Quinn responded that the Trust had maximised the use of the Patient Recruitment Centre, with GPs who come in to work in the Centre and the Team also worked very effectively with Trust based consultants, GPs, clinical research nurses and other staff. Mrs Foster asked what aspirations there were for research into workforce. Professor Quinn responded that the Team did not have the expertise to undertake research into workforce but would collaborate with others on this. She added for many staff research was not their main role, but the Team helped them bridge the gap. It was noted that there were currently 1100 vacancies for research nurses across the South West at Bands 5 and 6 and the Team were working with non-registered colleagues to up-skill them, but there were trials where registered nurses were essential, and the Trust was involved with a programme to promote research roles. Mr Matthews asked whether there was confidence that the Trust could attract funding for the underlying infrastructure needed for research. Professor Quinn responded that the Biomedical Research Centre would provide a significant amount of infrastructure funding, approximately £15m over the next 5 years. In addition, the Clinical Research Facility had some infrastructure funding and upfront funding for non-billable commercial activity had been provided for the Patient Recruitment Centre. Whilst rapid expansion could be difficult to manage, it was felt that the Trust had done quite well, although the workforce issues previously mentioned were of concern. Mr Kirby asked if there was specific research being undertaken looking at productivity and Professor Quinn advised that there was, citing an implementation project that was about to be started with the Applied Research Collaboration to use research they had done to improve patient flow between community and acute providers. The ambition was to have more professional managers become involved in research over the next few years. Mr Tidman commented that key drivers for integration had been equity of access to research for patients and the potential for a good research offer to help recruit and retain staff. He asked what ambitions there were for developing more opportunities in North Devon. Professor Quinn responded that the first academic department was now established in North Devon which had helped with recruitment into some commercial trails	

	in the northern site. In addition, some trials have now been opened across both sites and there are more Allied Health Professionals as lead investigators in North than in East. A disadvantage on the northern site is that there was no dedicated research clinic space and a bid was to be submitted to the Clerks Foundation for this. Ms Morgan congratulated the Research Team for a successful year. **The Board of Directors noted the Research and Development Annual Report.**	
151.23	**ITEMS FOR ESCALATION TO THE BOARD ASSURANCE FRAMEWORK**	
	No issues were noted for escalation to the Board Assurance Framework.	
152.23	**ANY OTHER BUSINESS**	
	Professor Kent informed the Board that Organ Donation Awareness Week had recently been celebrated and the Trust had come second in the region in the Race for Recipients. She expressed her thanks to the Team leading on Organ Donation across both sites.	
153.23	**PUBLIC QUESTIONS**	
	No questions had been submitted in writing in advance of the meeting. Mrs Sweeney noted that the patient voice had been discussed under several agenda items, adding that the patient voice was a key role for Governors. She added that the Trust did not currently have a very strong Patient and Public Involvement Group and asked whether that could be looked at, as patient involvement was very important in co-design of services. Mrs Sweeney added that the Council of Governors recognised the stress that staff continued to experience and appreciated the wellbeing initiatives that the Trust had in place to support staff. She noted that it was important to always remind staff that patients were at the centre of everything the organisation does. Ms Morgan thanked Mrs Sweeney for her comments and noted that it would be Mrs Sweeney's last attendance as Lead Governor. She expressed her thanks on behalf of the Board for Mrs Sweeney's work on the Council of Governors, adding that she would also be expressing her thanks to Mrs Sweeney and other Governors who were completing their terms of office at the Annual Members Meeting later that day.	
154.23	**DATE OF NEXT MEETING**	
	The date of the next meeting was announced as taking place on 1 November 2023.	