Royal Devon University Healthcare NHS Foundation Trust

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

At 09:30 on Wednesday 1 November 2023
Boardroom, Noy Scott House, Royal Devon & Exeter Hospital

AGENDA

Item	Title	Presented by	Item for approval, information, noting, action or discussion	Time Est.
1.	**Chair's Opening Remarks**	Shan Morgan, Chair	Information	09:30 2
2.	**Apologies**	Shan Morgan, Chair	Information	09:32 1
3.	**Declaration of Interests**	Melanie Holley, Director of Governance	Information	09:33 2
4.	**Matters to be discussed in the confidential Board**	Shan Morgan, Chair	Noting	09:35 2
5.	**Minutes of the Meeting of the Board held 27 September 2023**	Shan Morgan, Chair	Approval (Paper)	09:37 5
6.	**Matters Arising and Board Actions Summary Check** - Review of Occupational Health Data re percentage of work related versus non-work related stress/other mental health issues	Shan Morgan, Chair Hannah Foster, Chief People Officer	Information (Paper/Verbal)	09:42 5
7.	**Chief Executive's Report**	Paul Roberts, Interim Chief Executive Officer	Information (Verbal)	09:47 20
8.	**Patient Story**	Carolyn Mills, Chief Nursing Officer	Information (Paper)	10:07 15
9.	**Operational Capacity & Resilience Plan**	John Palmer, Chief Operating Officer	Approval (Paper)	10:22 45
	COMFORT BREAK			11:07
10.	**Performance**			
10.1	**Integrated Performance Report**	Adrian Harris, Chief Medical Officer	Information (Paper)	11:17 45
11.	**Policy & Strategy**			
11.1	**Update on the work of the Peninsula Acute Provider Collaborative**	Chris Tidman, Deputy Chief Executive Officer	Information (Paper)	12:02 5
11.2	**Corporate Roadmap Update** –	Chris Tidman, Deputy Chief Executive	Information (Paper)	12:07 10

11.3	**Review of Board Assurance Framework**	Melanie Holley, Director of Governance	Information (Paper)	12:17 10
12.	**Assurance**			
12.1	**Survey Reports** • **Inpatient Survey (2022) –** • **Urgent & Emergency Care Survey**	Carolyn Mills, Chief Nursing Officer	Information (paper)	12:27 10
12.2	**Digital Committee Update**	Tony Neal, Non-Executive Director & Committee Chair	Information (Paper)	12:37 5
12.3	**Finance and Operational Committee**	Steve Kirby, Non-Executive Director & Committee Chair	Information (Paper)	12:42 15
12.4	**Governance Committee**	Martin Marshall, Non-Executive Director & Committee Chair	Information (Paper)	12:57 5
12.5	**Response to the Verdict in the Trial of Lucy Letby**	Melanie Holley, Director of Governance	Information (Paper)	13:02 10
13.	**Information**			13:12
13.1	**Items for Escalation to the Board Assurance Framework**	Shan Morgan, Chair	Discussion (Verbal)	13:12 1
14.	**Any Other Business**			13:13
	At the conclusion of the formal part of the agenda, there will be an opportunity for members of the public gallery to ask questions on the meeting's agenda. Where possible, questions should be notified to members of the Corporate Affairs team before the meeting. Every effort will be made to give a full verbal answer to the question but where this cannot be done, the Chair will ask a director to make a written response as soon as possible.			
15.	**Date of Next Meeting:** The next meeting of the Board of Directors will be held at 09:30 on Wednesday 29 November 2023.			
16.	The Chair will propose that, under the provisions of section 1(2) of the Admission to Public Meetings Act 1960, the public and press should be excluded from the meeting on the grounds of the confidential nature of the business to be discussed.			

Meeting close at 13:23

Royal Devon University Healthcare NHS Foundation Trust

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

Wednesday 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	

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	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.	

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- 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.

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	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	

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	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.	

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- 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

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	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 below 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.	

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- 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.

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	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	

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	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.**	

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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	

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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

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	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	

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	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.	

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	• 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.	

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	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	

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	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.	

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PUBLIC MEETING OF THE BOARD OF DIRECTORS
27 September 2023
ACTIONS SUMMARY

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

PUBLIC AGENDA					
Minute No.	**Month raised**	**Description**	**By**	**Target date**	**Remarks**
043.23(2)	March 2023	Mrs Foster to look at inclusion of absolute establishment data in the IPR in future iterations.	HF	~~April 2023~~ ~~May 2023~~ ~~July 2023~~ October 2023	**Update 21.04.23**- 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. **Action ongoing.** **Update 23.05.23** – Work is continuing on this. Next update to July Board. **Action ongoing.** **Update 19.07.23** – As verbally reported at the June Board, there are some delays to the redevelopment of the Our People report within the IPR, particularly in relation to vacancy & establishment data due to some of the Unit 4 implementation issues. We are expecting this work to be completed in September 2023, so can be included in the IPR the following month. **Action ongoing.**
060.23	April 2023	A discussion to take place at a future Board meeting regarding acceptable levels of vacancy and what the expected vacancy rate would be if the expectation was not to be at 100% recruitment. (Action added after May Board meeting as it had been missed initially).	HF	~~July 2023~~ ~~September 2023~~ ~~October 2023~~ November 2023	**Update 19.07.23** – Further work is required to understand acceptable vacancy levels, due to the multifaceted nature of this area that requires balancing of operational & financial plans. It would also be helpful to understand thresholds used in other organisations & their rationale to make an

					informed decision. It is proposed that a paper is presented to the next Board meeting to propose a recommendation based on the above factors, with a view that maximum & minimum tolerated vacancy levels could be reflected in the relevant IPR charts. **Action ongoing.** **Update 21.09.23** – Due to close links with the long term workforce plan, this is going to be included in the wider strategic update in October 2023, along with our gap analysis against the Long Term Workforce Plan. **Action ongoing.** **Update October 2023** – strategic update deferred from October to November Board. Due date changed. **Action ongoing.**
077.23(1)	May 2023	~~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.~~ Updated action added following Board meeting in September 2023 to give thought to the national allocation formula given the increase in demand for Northern Services noted in the briefing paper circulated.	~~JP~~ Execs	~~September 2023~~ November 2023	**Update 20.07.23** – Initial analysis indicates comparable patterns of growth in type 1 ED attendances in other coastal healthcare systems, at levels in excess of type 1 growth observed nationally. Opportunities for learning from other systems being explored. **Action complete.** **Update 26.07.23 –** Following a further update at the July Board from Mr Palmer, it was agreed that the information with a breakdown of ED attendances and any coastal implications should be circulated to the Board and the ICS for information. **Action ongoing** **Update 21.09.23** – Updated briefing paper incorporating ED attendance trend data to August 2023 circulated. **Action complete.** **Update 27.09.23** – Following discussion at September Board, it was agreed that Mr Palmer would provide wording for an additional action to be added following

					feedback from Board members that thought would need to be given to formula given the increase in demand for Northern Services in particular noted in the briefing paper circulated. **Action ongoing.** **Update 25.10.23** – Executive consideration in train about next available opportunity to submit representation for recognition of increased demand within the national allocation formula. **Action ongoing.**
077.23(2)	May 2023	~~Following a question from Professor Marshall, Mrs Foster to look at the category for stress for sickness absence in terms of how this was broken down into work-related and other stress/mental health issues and provide an update.~~ Updated Action: HF to review OH data to see if it provided more detail on the percentage of work-related vs non-work related stress/other mental health problems.	HF	~~July 2023~~ October 2023	**Update 28.06.23** – HF advised this had been covered in the meeting, in that it was difficult to break down the category unless staff had indicated what the particular issue was. HF suggested that she took an action to review OH data to see if it provided more detail on the percentage of work-related vs non-work related stress/other mental health problems. Extend due date to October 2023. **Action ongoing.** **Update 23.10.23** – Review of Occupational Health Data re percentage of work related versus non-work related stress/other mental health issues included under Matters Arising on public Board Agenda for October. **Action complete.**
077.23(4)	May 2023	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.	JP	~~June 2023~~ ~~July 2023~~ ~~September 2023~~ October 2023	**Update 21.06.23** – Update included in the IPR. **Action ongoing.** **Update 28.06.23** – Although clarification had been received on BCF and iBCF funding, there remained an outstanding issue regarding UEC funding. A further letter would be sent to ask for a final position on this funding. **Action ongoing.** **Update 26.07.23** – A further meeting was scheduled with the ICS to consider the outstanding funding bids. **Action ongoing.**

					Update 21.09.23 – A verbal update will be given at the September Board meeting. **Action ongoing.** **Update 27.09.23** – JP informed the Board that assurance had been received that BCF funding was in place, but clarity on UEC funding was still awaited. Disparity regarding fair shares between Trusts had been raised through a number of channels including the System Recovery Board, but a final view of settlement was still awaited. **Action ongoing.** **Update 25.10.23** – Devon ICB has confirmed the Trust as receiving £2.8m of the £13.8m available for the Devon System through ICB Winter Funding. Of this £1.5m is allocated to schemes across both sites, with a further £1.2m allocated to Northern Services and £224k for schemes affecting Eastern Services. A suite of further schemes that would help to mitigate the gap in beds identified as part of the Winter Capacity & Demand modelling and which could be implemented at pace, has been identified. Details of the schemes (with an aggregate bed impact of 66 beds) have been shared with the ICB in the event that slippage of other schemes within the system means that further monies become available. A response from the ICB is awaited. A verbal update will be given to October Board. **Action ongoing.**
080.23(2)	May 2023	Mr Neal asked if more detail around the exact number of incidents being reported could be included in future Safe Staffing Reports to Board.	CM/Aha	November 2023	**Update 13.06.23** – Detail regarding the exact number of incidents will be included within the next six-monthly Safe Staffing reports to Board. **Action ongoing.**

					Update 28.06.23 – The Board agreed that this action should be kept open until presentation of the next six-monthly report in November 2023 to ensure that it was completed. **Action ongoing.**
099.23(1)	June 2023	Following a discussion about length of stay for stroke patients and whether delay in admission to the Acute Stroke Unit impacted length of stay and further impacted where patients were discharged to in the community, the Board was advised that the Acute Peninsula Sustainability review was looking at this and this could be brought to a future meeting.	CT	~~September 2023~~ ~~October 2023~~ November 2023	**Update 19.07.23** – Briefing note to be distributed by September 2023. **Action ongoing.** **Update 21.09.23** – The Acute Provider Collaborative has identified stroke as a fragile service and data/KPIs are being collected on all peninsula services. A briefing on stroke will be contained within this in due course. A briefing note on RDUH's North and East stroke performance is being prepared for the Board. **Action ongoing.** **Update 26.10.23** – Delayed due to operational pressures on stroke team. Briefing note to be circulated during November. **Action ongoing.**
116.23	July 2023	Following discussion about the possibility of industrial action by GPs, Mr Tidman advised that the Executive Team would develop a contingency plan with a briefing note to share with the Board and should GP industrial action be announced, a further discussion would be tabled for a future Board meeting.	CT	November 2023	**Update due to November 2023** – Action due date moved to November, as no indications of additional industrial action have been received. **Action ongoing.** **Update 26.10.23** – CT advised that still no indication received and suggests that action be closed. **Propose to close.**
118.23(5)	July 2023	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.	AHA	~~September 2023~~ October 2023	**Update 27.09.23 -** 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 ongoing.** **Update 26.10.23 –** Validation work has been undertaken & responses received from the majority of relevant areas. It has been agreed that a finalised list of exclusions will be confirmed by 1 November & then Epic will be updated., as required, to incorporate these agreed exclusions & enable reporting for subsequent IPRs. **Action ongoing.**
120.23	July 2023	Any changes to the Clinical Strategy/enabling strategies to be copied to the Chair for information.	AHA	September 2023	**Update 23.08.23** – All updates to the Clinical Strategy to be approved as appropriate with Adrian Harris & Carolyn Mills (as accountable officers), & shared with the Chair for information. **Action ongoing.** **Update 27.09.23** – It was noted that final checks were being undertaken. **Action ongoing.** **Update 26.10.23 –** No further updates received. Clinical Strategy is now live with a range of 'launch events' planned across both Eastern and Northern Services. **Action complete.**
121.23	July 2023	Following discussion about whether risks and mitigations could be more closely aligned in the BAF and the suggestion that the graph at the top of the table in the BAF could be used to show forecast rates, which should help to address this, it was agreed that this would be followed up to make sure there was more consistency in the way the table was used for each risk.	MH	October 2023	**Update October 2023** – Included in the BAF report for October Board, agenda item 11.2. **Action complete.**
121.23	July 2023	More detail on actions and due dates to be provided in the BAF, so that this information could be flagged in the BAF summary which would help ensure they were progressed.	MH	October 2023	**Update October 2023** – Included in the BAF report for October Board, agenda item 11.2. **Action complete.**

121.23	July 2023	Mr Palmer asked if the direction of travel of individual risks could be included in the BAF summary.	BAF Risk owners	October 2023	**Update due to next Board on 01.11.23 –** BAF on the agenda for October Board meeting, agenda item 11.2.
136.23	September 2023	Amendment to minute number 116.23 requested.	GGF	October 2023	**Update 28.09.23** – Requested amendment made. **Action complete.**
139.23	September 2023	Mrs Mills to follow up with the PALS team to ensure that feedback is provided to the family featured in the patient story on what would/had changed with the ED rebuild since their experiences.	CM	October 2023	**Update 23.10.23** – Confirmation has been received from the Engagement team that they will provide feedback regarding the new build ED/PAU unit to the family featured in September's story. **Action complete.**
140.23	September 2023	Following presentation of the Outpatient Transformation update, it was agreed that a further update should be scheduled for 6 months time.	AHA	March 2024	**Update 28.09.23** – Added to the draft Board agenda for March 2024.
140.23	September 2023	The Board had discussed during the Outpatient Transformation update the possible benefits of investing more in EPIC to get some of the builds fixed more quickly and agreed that this should be covered in more detail in the EPIC seminar planned in November 2023.	AHA	October 2023	**Update October 2023** – EPIC seminar in diaries for 07.11.23.
141.23(1)	September 2023	The value of the IPR, what is missing, what might be removed to be added to list of Board Development Day topics for a future meeting.	MH	October 2023	**Update 28.09.23** – added to the list. **Action complete.**
141.23(2)	September 2023	Professor Kent noted that the Northern midwife to delivery ratio was trending upwards and asked what mitigations were in place. Mrs Mills agreed to follow this up with the Head of Midwifery and feedback to Professor Kent.	CM	October 2023	**Update 25.10.23** – It has been confirmed that the variation in the Northern midwife to delivery trend is attributable to the Birth rate reducing & the positive increase in no. of midwives at our Northern Maternity services. The division will continue to monitor any deviations or variations of trend with their Divisional Performance & Governance meetings. **Action complete.**
141.23(3)	September 2023	Mr Kirby raised a question about whether improvements in waiting lists were as a result of productivity and efficiency or from in- or outsourcing and was advised it was both. It was agreed that it would be helpful to understand the balance between the two and Mr Tidman agreed to look at this in more detail outside the meeting.	CT	October 2023	**Update 26.10.23** – Work to be undertaken as part of the income workstream of the financial recovery plan, & reported through to FOC. **Propose action closed.**
141.23(4)	September 2023	Finance and Operational Committee asked to look at the increase in agency use against the other factors such as the reduction in vacancy	AHI	October 2023	**Update 18.10.23 –** looking for a deep dive to be taken to the Delivering Best Value Board

		rates not making sense in more detail and report back to Board in a FOC update.			which can be used to feedback to the FOC for assurance. Will also link to urgent action needed on financial recovery as part of FOC November update. **Action ongoing.**
141.23(5)	September 2023	Mrs Mills to ask the team to look at the potential for a future patient story relating to how patients and families are communicated with regarding being discharged in a way that they felt did not meet either their needs or expectations (there was particular reference to patients with mental health needs).	CM	November 2023	**Update 23.10.23** – As requested at September's Board, October's Patient Story will focus on Patient led discharge. **Action complete.**
142.23(1)	September 2023	Mr Neal had noted that distractions were noted in the themes in the Never Events report, but there was no action to look at whether there were specific distraction in particular settings that could be addressed. Professor Harris agreed to look at this outside the meeting.	AHA	October 2023	**Update 26.10.23** – A 'Never Events Summit' is being held on 31 October comprising SLT attendance & senior clinical attendance, this is one of the themes that is incorporated within this face to face session. A subsequent action plan will be developed & monitored via the Safety & Risk Committee & will report back through Governance Committee & onwards to Board of Directors. **Propose action closed.**
142.23(2)	September 2023	Mr Palmer suggested that Schwartz rounds were a good model for routinising group reflection on safety and policy and suggested they be added to the action plan for Never Events as a supportive intervention	AHA	October 2023	**Update 26.10.23** – A 'Never Events Summit' is being held on 31 October comprising SLT attendance & senior clinical attendance, this is one of the themes that is incorporated within this face to face session. A subsequent action plan will be developed & monitored via the Safety & Risk Committee & will report back through Governance Committee & onwards to Board of Directors. **Propose action closed.**
143.23	September 2023	Detailed discussion of the Annual Complaints Report to be included under the Patient Experience item on the agenda at the next Joint Board and CoG Development Day.	CM	8th November 2023	**Update 23.10.23** – An overview of complaints, including the Annual Complaints Report, has been included within the Patient Experience Overview presentation for the next Joint Board and CoG Development Day (due to take place on 08.11.23). **Proposal to close.**

144.23	September 2023	Mr Kirby to check the wording in the recommendations relating to the MTFP, to ensure that it made clear that the Trust's view is that this is a model rather than a plan as delivery plans were not yet in place.	AHI/SKI	October 2023	**Update 26.10.23** – This was given as feedback to the ICB as part of the Trust Board's response. Unfortunately, the wording of Plan is set by NHSE & is not within the ICBs control to change. However, the narrative that was submitted to NHSE included each Trust Board's feedback which consistently recognised this as a model rather than a plan & therefore this is formally noted. **Proposal to close.**

Signed:

Shan Morgan
Chair

Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	6, Public Board Meeting		**Date: 1** November 2023	
Title:	Work Related Sickness Absence with a Focus on Mental Health Conditions			
Prepared by:	Paul Lian, Consultant Occupational Health & Wellbeing Physician, Natalie Paterson, Head of Occupational Health & Wellbeing, Richard Dinsdale, Business and Clinical Support Manager and Alex Tait, Executive Support Manager			
Presented by:	Hannah Foster, Chief People Officer			
Responsible Executive:	Hannah Foster, Chief People Officer			
Summary:	A detailed report on work related sickness absence, with a specific focus on mental health conditions and stress.			
Actions required:	Link to status below and set out clearly the expectations of the Board when considering the paper.			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
				X
History:	This paper has been written for Board as requested in action 077.23(2) on the Public Board action tracker.			
Link to strategy/ Assurance framework:	The issues discussed are key to the Trust achieving its strategic objectives, notably being a great place to work.			

Monitoring Information

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

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

1. Purpose of paper

The purpose of this paper is to provide a detailed understanding of work related sickness, with a particular focus on work related stress and other mental health related conditions.

2. Background

In the Integrated Performance Report discussion at the May 2023 Public Board, a question was raised as to how the Trust compared to others in terms of sickness absence in relation to stress. During this conversation it was clarified that this category of sickness absence included all stress and mental health conditions whether to not related to or resulting from work. As a result of this discussion it was agreed that further analysis would be undertaken to explore the information available to provide a greater understanding of work related mental health issues in our workforce.

This analysis follows several detailed reports that have been presented to Board in recent years, with an in depth report having been seen by Board in February 2021. This concluded that there was a national issue with mental health sickness rates across the NHS and provided assurance that compared to other Trusts, mental health sickness rates within the Trust were at a low level. Much of the background context presented within this previous report will remain similar, however, whilst the previous report acknowledged that work and non-work related conditions were included in the sickness figures, at that time a further breakdown was not provided.

Ongoing assurance has been provided through employee experience surveys (i.e. the NHS Staff Survey and People Pulse Surveys) that staff believe the organisation takes positive action on their health and wellbeing, with the July 2023 People Pulse results confirming that 90.1% of respondents agree or strongly agree with this statement.

This report seeks to provide a more recent update on our local position as well as some of specific information about the proportion of work related stress, based on referrals to our Occupational Health and Wellbeing (OH&WB) service.

3. Analysis

National Trends

Statistics from Mental Health First Aid England confirm that in 2015/16 stress was responsible for 37% of all cases of work-related ill health and 45% of all working days lost due to Health issues in Great Britain. Whilst this data is now a few years old, more recent data confirms an increase in recorded mental health conditions in the wider population since the COVID-19 pandemic, with evidence suggesting that depression showed an increase of 7% when comparing pre-pandemic to 2021[1]. This suggests that the aforementioned percentage will likely have increased since these statistics were released, but also confirms what we already believed, that this is a longstanding issue within the wider population.

Within healthcare nationally, it has been a reported 29% increase in staff sickness absences amongst healthcare staff since 2019, with NHS sickness rates at the highest levels since 2010 when records began.[2] It is reported that the main reasons for sickness are mental health conditions, musculoskeletal conditions then respiratory illnesses, trends that have been seen for an extended period of time.

A report by the HSE[3] confirmed that in 2021/22, approx. 1,800 workers per 100,000 (around 1.8%) suffered with work-related stress, depression or anxiety, however for healthcare workers, this rate significantly increased to just below 3,500 workers per 100,000 (around 3.5%). On initial review of our occupational health data, this demonstrates that we are not an outlier when compared to other Trusts, however, it must be acknowledged that this data only accounts for

[1] Mind Up - https://www.myndup.com/blog/mental-health-statistics-2023#:~:text=Since%20the%202020%20pandemic%2C%20poor,each%20year%20in%20the%20UK.
[2] BBC News June 2023 NHS staff sickness hits record high in England - https://www.bbc.co.uk/news/health-66047270
[3] HSE Summary Statistics for Great Britain 2022 - Health and safety statistics 2022 (hse.gov.uk)

those referred to the OH&WB team. This national information also confirm that our industry as a whole has some of the highest levels of work related stress, depression or anxiety across various industries, something that we should be working to reduce on a local, system and national basis.

Overview of Referrals to OH&WB

In line with the above national trends, the OH&WB department have experienced a continual increase in the volume of referrals with an 18% increase year to date and a 7% increase in referrals in the last quarter alone. Historic data shows that referrals have increased by 29% between 2020 and 2023, something that has triggered the need for a demand and capacity review of the service. It should be noted that sickness data for the 2022/23 financial year does not reflect this upward trend, indicating that more people are seeking support, rather than more people being unwell.

In recognition that some absences are due to work related matters, the Royal Devon OH&WB department produces quarterly reports outlining the presenting health issues of staff referred to Occupational Health as part of the service line reporting. This data is broken down into the following categories:

- **Caused by work** – referral for a condition that would not have occurred without the workplace exposure and is reportable to the Health & Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).
- **Work related** – referral for a condition where work exposure made a substantial difference to the severity of the condition but criteria for RIDDOR reporting is not met.
- **Non-work related** – referrals where the condition does not relate to work.
- **Unsure** – where it is not immediately clear of whether the condition is work related or not.

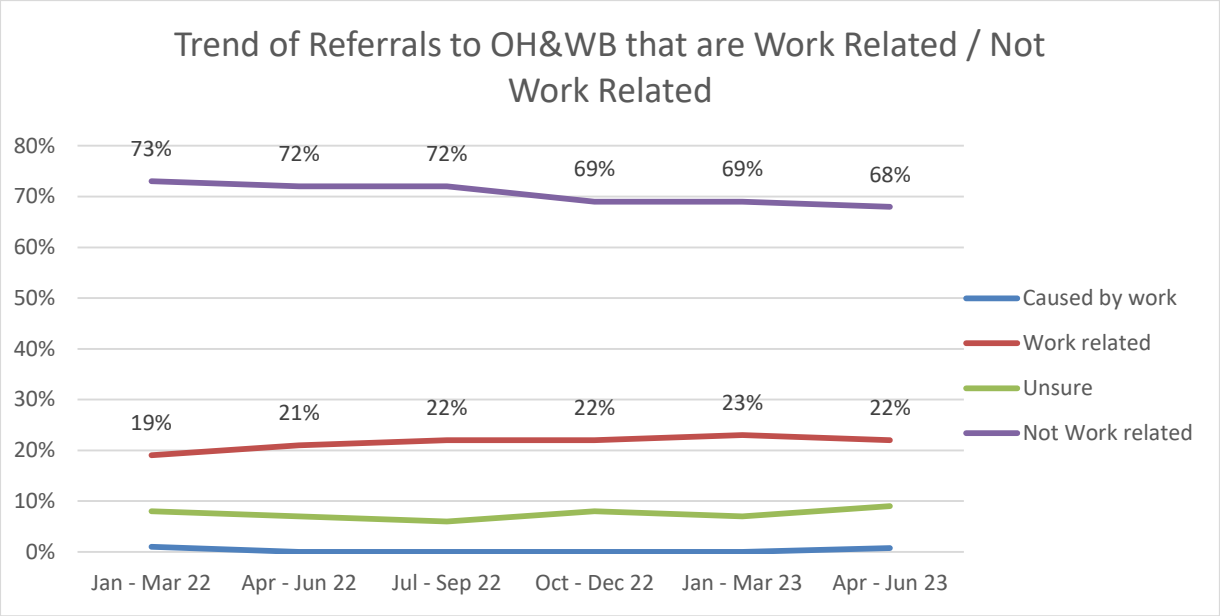
An exert of the quarterly report showing the most common reasons for work related referrals to OH&WB, covering the period from April to June 2023 is provided below. The category 'other' includes all other conditions:

	Unsure	Caused by Work	Work Related	Not Work Related	% Caused by Work / Work Related
Skin	3		7	3	53.85%
Psychological	28		96	95	43.84%
Short-term sickness issue	2		15	22	38.46%
Musculoskeletal (back)	8		19	62	21.35%
Neurological	2		10	36	20.83%
Endocrine			2	9	18.18%
Eyes			1	5	16.67%
Musculoskeletal (arm/neck)	13	2	9	52	14.47%
Ear Nose Throat			1	6	14.29%
Musculoskeletal (other)	4	4	7	87	10.78%
Other	9	0	12	169	6.32%
Grand Total	**69**	**6**	**179**	**546**	
% total of new referrals	**8.63%**	**0.75%**	**22.38%**	**68.25%**	

The above data confirms that when looking at overall referral data, 23.13% are work related or caused by work. By comparison, 43.84% of referrals for staff with psychological conditions are

recorded as having been caused by work or work related, an increase on the previous quarter. Whilst this paper primarily focuses on work related psychological conditions, it is important to note that other areas, including musculoskeletal (MSK) conditions also make up a significant proportion of work related conditions.

When looking at all work related or caused by work referrals 96 out of 179 (52%) were psychological. In the previous quarter this figure was 47%. This is significantly higher than the national average. The percentage of non-work-related referrals has shown a slow gradual decrease in the period from January 2022 to June 2023 from 73% to 68%, with both work related and unsure very slightly increasing. This represents a proportional increase in referrals for work related conditions overall due to the aforementioned 29% increase in referrals between 2020 and 2023.



Work Related Psychological & MSK Conditions

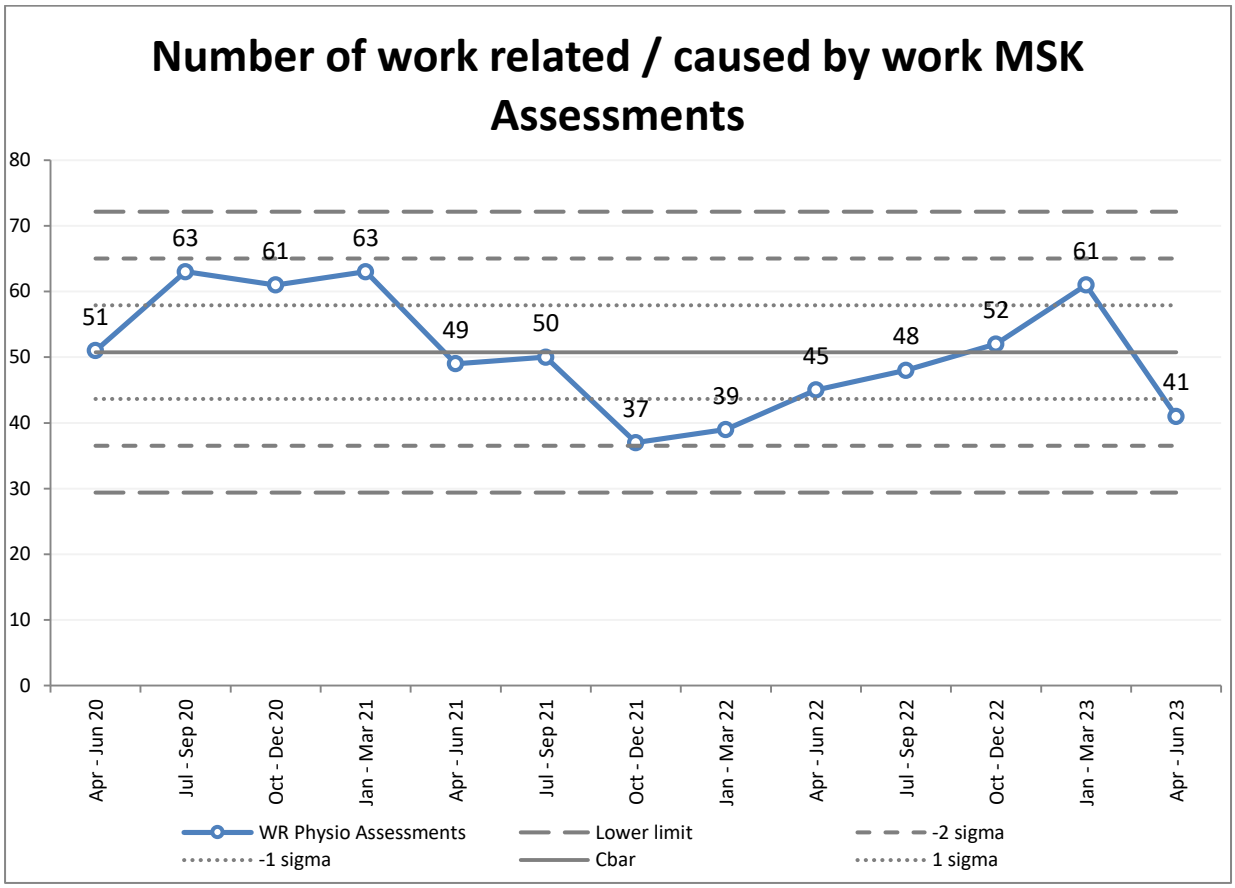
More detailed analysis of the data available is undertaken for the two most common reasons for work related referrals in the form of a stress dashboard and a musculoskeletal dashboard (see appendix 1), each of which are split by northern and eastern services. Some analysis of the trends within these dashboards is provided below.

Stress Dashboard

The stress dashboard includes trends in work related and caused by work by quarter, presented in a Statistical Process Chart (SPC). This allows oversight of excess changes beyond two standard deviations. The data is also split by staff group, division and cluster. In eastern the percentage of work related stress have not breached two standard deviations in this period, however, cases referred to OH&WB have increased due to an overall increase in referrals. In northern services, an increase can be seen in the lead up to and including the first quarter of 2022/23. It is possible that this could have been linked with integration, however the numbers have since stabilised. It should be noted that there is no longer seasonal dip in referred cases over the summer months with referrals remaining high all year. This illustrates that pressures on the health service are no longer constrained to winter pressures as in the pre-Covid years.

MSK Dashboard

A similar MSK dashboard is produced for work related and caused by work musculoskeletal referrals to OH&WB, with a breakdown by division and staff groups. Additionally, the below shows the number of MSK assessments that have taken place trustwide for work related / caused by work conditions, showing a gradual increase between October 2021 and March 2023; however, still within acceptable tolerance levels. This data should be treated with caution as assessment numbers are dependent on capacity, therefore increased capacity in a given quarter could cause a spike in assessments.



Current Management of Work Related Sickness

The Trust is already doing an enormous amount of work to positively impact the holistic wellbeing of our staff, much of which should positively influence both physical and psychological wellbeing. Some examples of positive work being done to improve wellbeing and to provide assurance in this area include:

- Cultural development, including the launch of the Trust values and Trust strategic objectives, including to be a great place to work.
- Increased staffing levels through reduced vacancy levels.
- Governance structure including Workforce Planning and Wellbeing Committee (PWPW), Health & Safety Group, Staff Health & Wellbeing Group, Work Related Conditions Group, Staff Incident Review Group and Violence and Aggression Task and Finish Working Group.
- Governance processes including policies, guidance and procedures (such as DATIX and RIDDOR reporting) in place for management of work related illness.
- A range of training, including Manual Handling, Burnout, Stress Awareness, Health and Wellbeing Conversations etc.
- A network of Health and Wellbeing Champions, Mental Health Champions, Trauma Risk Incident Management (TRiM) practitioners and Mental Health First Aiders.
- Employee Assistance Programme (EAP) and signposting for staff to other services such as the Devon Wellbeing Hub, Talkworks, national practitioner health programmes and the national NHS helpline.
- In-house support, including physiotherapy, meditation, counselling, menopause support, back care team and chaplaincy support.

A summary of this support, including contact details for each service can be found on the Staff intranet (HUB).

It should be noted that the data presented in this report reflects the number of referrals to OH&WB, however, will not capture information about those who have not been referred. Previously, concerns have been raised about staff not accessing the support on offer. The increased referral levels do not appear to be reflected as higher levels of sickness in the data available in the financial year 2022/23, so this could indicate that more people are accessing the support available than previously, a positive change.

Next Steps

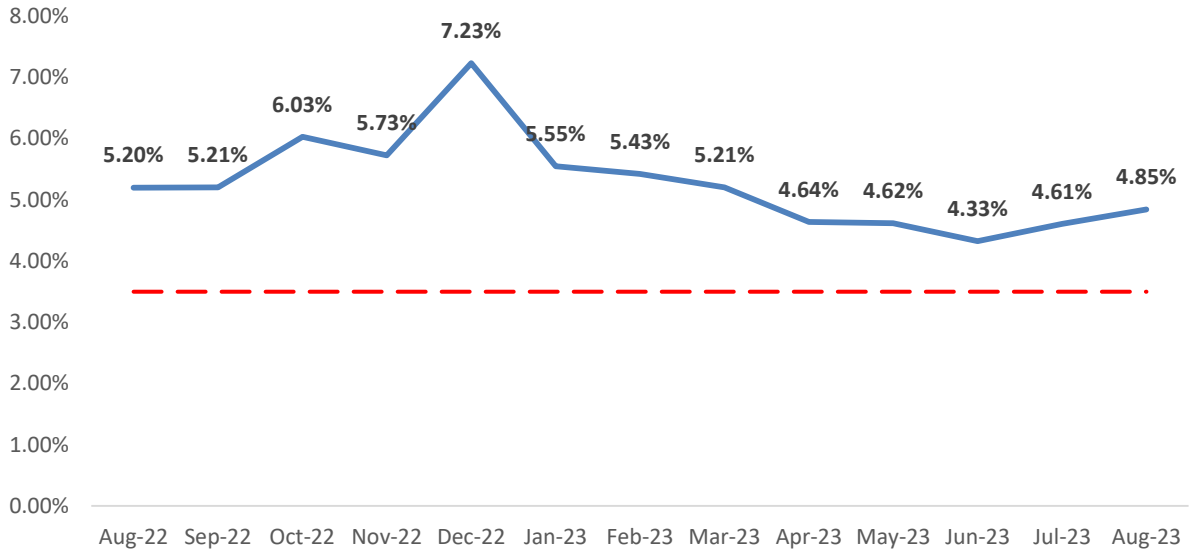
Whilst much work is already being undertaken in this space there are areas that could potentially be reviewed. These include:

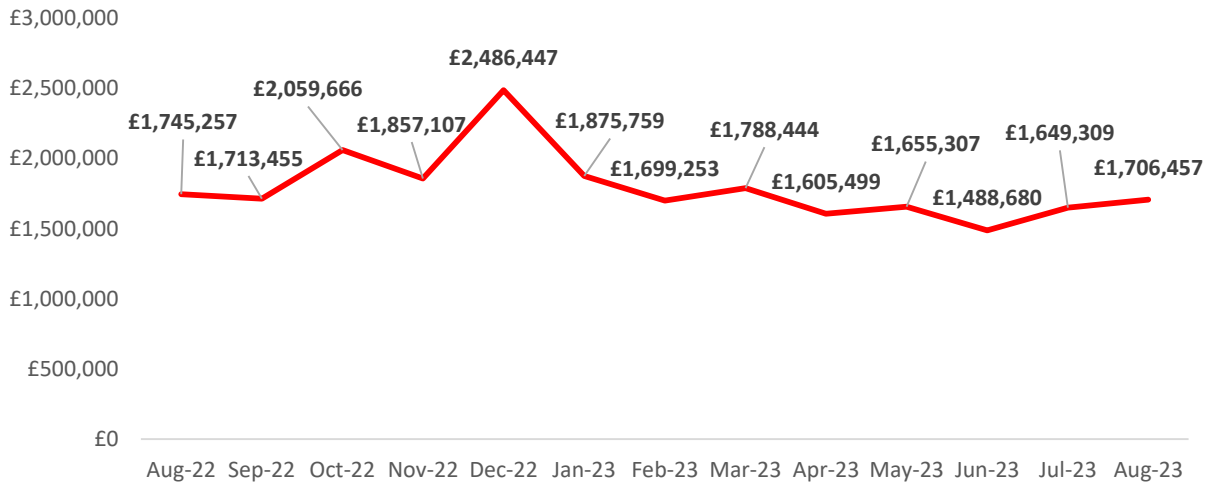
- A review of reporting needs to be undertaken to ensure that all relevant information is being captured, triangulated and reported on appropriately and disseminated to the right groups of people to be able to take-action and provide assurance.
- Work is ongoing to review the way in which moving and handling training is delivered. It will be essential to continue to prevent work related MSK conditions to understand the impact of any changes to provision.
- Review of how data collection could be improved in ESR to capture when sickness absence is work related, in scenarios where a member of staff is not referred to occupational health.
- Violence and aggression continues to be a concern and source of trauma for our staff when adverse events occur. Work is ongoing to further improve physical and psychological support for our staff and to prevent violence and aggression in the workplace.
- New standards for OH&WB services are expected to be launched following a Department for Work and Pensions consultation entitled “Occupational Health: Working Better”. This will provide a steer on the national direction for support. It will be important that any changes or proposals are well aligned with the wider system conversations in relation to wellbeing.
- In light of the significant increased levels of referrals to OH&WB and the amount of work related sickness, a full demand and capacity review has been requested to take place. The need for this review has been escalated through a number of forums, including Health and Safety Group.

Whilst the above may assist in supporting the Trust in managing work related sickness, it is important to consider the context in which our staff are working which is reflected in the absence of a seasonal trend in stress related referrals to OH&WB. In recent years pressures within the Trust have been continuous and prolonged in a way that has not been previously seen in the Trust or wider NHS. Whilst there is work we can and are doing to support our staff, there are many factors in the external environment that will continue to increase workload and potential stressors within the workplace for our staff now and into the future.

4. Resource/legal/financial/reputation implications

Sickness absence has a significant impact on the Trust, especially in terms of resource and financial impact. Financially, the cost of losing staff to sickness absence is significant, so anything the Trust can do to support staff wellbeing not only helps us to be a great place to work, but also has a positive impact on staffing levels, with a significant financial saving. Please see a 12-month summary of total sickness absence and associated cost below:





5. Link to BAF/Key risks

These issues directly link to the following Board Assurance Framework risks, both of which can have a direct impact on staff wellbeing, particularly levels of stress in the workplace:

- Our people do not feel looked after or valued. Employee experience is poor and people feel their health and wellbeing is not prioritised.
- Failure to recruit, retain and train to ensure the right number of staff with the right skills in the right location.

6. Proposals

It is proposed that the Board discuss and note this report and agree to close action 077.23(2) on the action tracker.

NHS
Royal Devon
University Healthcare
NHS Foundation Trust

Agenda item:	8, Public Board Meeting	**Date:** 1 November 2023
Title:	Patient story: Patient discharge	
Prepared by:	Bethany Hoile, Communications and Engagement Coordinator	
Presented by:	Carolyn Mills, Chief Nursing Officer	
Responsible Executive:	Carolyn Mills, Chief Nursing Officer	
Summary:	Patient stories reveal a great deal about the quality of our service provision, the opportunities we have for learning and the effectiveness of systems and processes to manage, improve and assure service quality. The purpose of presenting a patient story to Board members is to: • Set a patient focussed context to the meeting, bringing patient experience to life and making patient's stories accessible to a wider audience • To support Board members to triangulate patient experience with reported data and information • For Board members to reflect on the impact of the lived experience for these patient(s) and carer(s) and its relevance to the strategic objectives of the Board.	
Actions required:	The Board of Directors is asked to reflect on the implications of this story for patients and carers and to reflect on its relevance to the strategic objectives of the Board.	

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

History:	The Royal Devon University Healthcare NHS Foundation Trust's 2022-27 Trust strategy and 2022-25 Patient Experience strategy articulate the Trust's ambition to collaborate and work in partnership with patients, carers, stakeholders and the local community to develop accessible, high-quality and patient-centric services and facilities. This patient story examines the experience of waiting to be discharged. Georgina was admitted to the Emergency Department at the RD&E (Wonford) with severe abdominal pain in February 2023. After being operated on successfully, Georgina was transferred to a ward for a further four days. Georgina was keen to be discharged from hospital as soon as possible and felt that once she was told that she would be discharged there was a significant delay in her being able to leave the Trust, partly due to waiting for medication. The discharge lounge was mentioned to Georgina, but she was not sent there before going home.

	To create efficient, safe and effective discharge, the Trust's practice is to identify an expected date of discharge (EDD) within 24 hours of admission. Accurate EDDs allows clinicians to plan for discharge and achieve a morning discharge time (where safe to do so). These also support early conversations with patients about their expected length of stay in hospital and their anticipated date and time of discharge. The Trust has a discharge improvement plan as part of its ongoing improvement work to support the timely flow of patients through inpatient services. This has two key areas for improvement: • Increasing the number of discharges from the hospital before midday (to close the gap between predicted and actual discharges each day). • Increasing the number of discharges over the weekend Timely discharge is supported by the use of discharge lounges on both sites; the details of which have been presented to the Board in a previous patient story (April 2023).
Link to strategy/ Assurance framework:	**BAF Risk 8** - Risk of a significant deterioration in quality and safety of care

Monitoring Information

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

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

Agenda item:	9, Public Board Meeting		**Date:** 1 November 2023	
Title:	Winter Plan 2023/24			
Prepared by:	Heather Brazier, Director of Operations (Northern Services) Phil Luke, Interim Director of Operations (Eastern Services) Leigh Mansfield, Associate Director of Operations & Patient Flow (Eastern Services) Ellie Johnston, Operations Projects Support Coordinator (Eastern Services)			
Presented by:	John Palmer, Chief Operating Officer			
Responsible Executive:	John Palmer, Chief Operating Officer			
Summary:	The Winter Plan sets out detailed modelling describing the size of the baseline bed capacity shortfall, the position following funded interventions, the remaining gap and recommendations for further action.			
Actions required:	The Board of Directors is asked to: • Approve the Winter Plan 2023/24 for the Royal Devon University Healthcare NHS Foundation Trust and • Note the proposed additional actions to manage the capacity shortfall described within the Winter Plan, and the approach to the pursuit of further funding outlined in section two of the covering paper.			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
		X		
History:	The Winter Plan is presented to the Board of Directors annually. Since 2022/23 the plan has been integrated, covering both acute sites of the RDUH. It has been developed in line with NHS Devon Integrated Care System Winter Planning and national guidance, and has been discussed and considered by the Trust's Delivery Group.			
Link to strategy/ Assurance framework:	The issues discussed are key to the Trust achieving its strategic objectives, in particular the delivery of an equitable recovery and capacity for further change.			

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

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

1. Purpose of paper

The Winter Plan (attached at **appendix 1**) is presented to Board in order to:

- Provide assurance regarding the robustness of the planning process underpinning the Winter Plan.
- Provide a clear plan to reassure staff that measures are in place to keep patients safe over the forthcoming winter period.
- Gain approval for the funded interventions set out in the plan.
- Support a discussion at the Board of Directors' meeting regarding options for addressing the bed capacity gap after the funded interventions are implemented.

2. Background

The plan has been prepared by the respective site operational management teams, in consultation with clinical and managerial colleagues, prior to review by the Trust Delivery Group (TDG). The TDG supported the actions set out in the Winter Plan, as well as the proposal to seek funding to implement additional schemes for Winter in order to manage the capacity gap.

Modelling and plan

Detailed modelling described in the Winter Plan shows the following:

- Without any intervention, an average bed capacity shortfall for RDUH of 121 beds, 84 in the East and 37 in the North. Modelling also shows daily variation on top of this average of upwards to an additional 46 beds in the East and a further 21 in the North, which must be taken into consideration.
- RDUH has been supported by ICB winter funding, receiving £2.8m of the £13.8m available (£1.4m for both sites, £1.2m for the North and £224K for the East.) Through these funds, a number of interventions have been established, which partially mitigate this, providing the equivalent of 88 additional bed capacity (60 in the East, 28 in the North).
- This leaves an average working gap of 33 beds, after interventions, against the average demand, but this could increase to as much as 100 on our most challenged days.
- The Trust has identified additional measures that could be implemented at pace over the next few weeks in order to mitigate this gap, however, they would require additional funding.
- The above numbers are summarised in **figure 1** below.

Figure 1

	Demand		Capacity	The gap		Additional measures	
	Average gap without interventions	Upper control limit gap (accounting for daily variation)	Funded mitigations in place	Remaining gap against average	Remaining gap against average and UCL level	Additional mitigation proposed	Cost of additional mitigation £000s
East	84	46	60	-24	-70	52.5	£1,204
North	37	21	28	-9	-30	13.5	£888
Total	121	67	88	-33	-100	66	£2,092

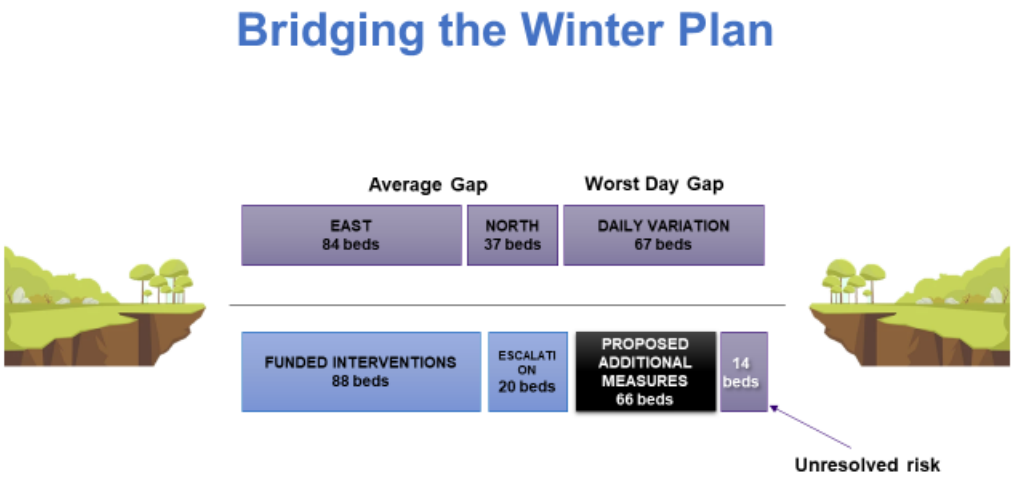
Approach to closing the remaining gap

Whilst we are grateful for the funding made available at system level and the capacity and capability it will provide during the Winter period, the remaining challenge for the Winter Plan is to address the bed gaps that could be caused by daily variation (as described in **figure 2** below).

Operational and clinical teams have undertaken an accelerated piece of work over the last few weeks to examine the potential for scaling up some elements of the plan and also purely additional measures. In broad terms these cover:

- the further **scaling of the Virtual Ward bed base**;
- A **spoke proposal for the Care Coordination Hub** that seeks to complement the putative ICB proposal;
- The purchasing of **additional P1 care hours** which builds on the short term measure that has been put in place for our services over the last month and has stabilised NCTR (if not yet turned back towards an improvement trajectory);
- **Expansion of our Same Day Emergency Care** services;
- **Expansion of our escalation bed base**, discharge coordinators and pathfinder activities; and
- A recognition of our demographic challenge and the Deloitte analysis that seeks to **increase outpatients capacity for Healthcare for Older People and Stroke and Orthogeriatrician** support; and
- A **strengthened capability for elective ringfencing** in cardiology, general surgery and orthopaedics.

Figure 2



The interim Chief Executive has written to ICB and NHSE colleagues in order to propose this approach with a request for access to slippage funding from the UEC ICS allocation. It is important to underline that is doing so we are underlining the importance of our organisational resilience in providing ongoing system support.

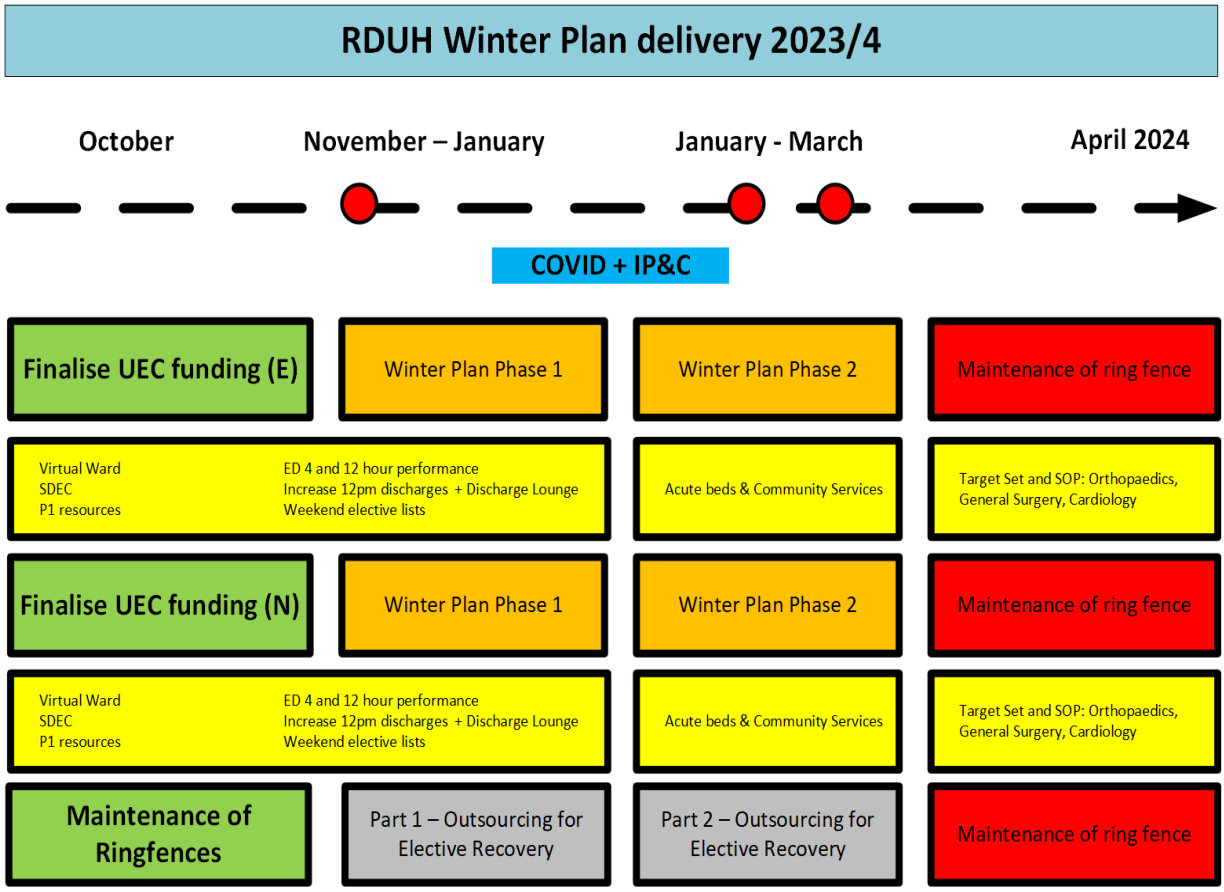
Implementation

In the meantime, operational and clinical teams will press ahead with implementation of the Winter Plan against the outline implementation plan at **figure 3** and make preparations for implementation of the further measures if further funding becomes available.

In terms of Winter Plan deployment, several measures from within the plan are already well

underway and the first stages of wider communications with our leadership teams have been undertaken. Over the coming few weeks we will be disseminating the Winter Plan with further communications and organisational engagement emphasising the importance of preparation before Christmas, delivery thereafter and maintenance of our commitments to elective as well as emergency activity.

Figure 3



3. Resource/legal/financial/reputation implications

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

Delivery of the Trust's Financial & Operational Plan commitments in relation to both finance and performance, are fundamental to the Trust's exit from NOF4 and from Tier 1. In addition, NHSE has advised that access to a £150m capital fund in 20-24/255 will be available to those Trusts who achieve both 80% A&E 4 Hour performance across Q4 2023/24, and 90% of ambulance handovers within 30 minutes across Q3 and Q4 2023/24.

4. Link to BAF/Key risks

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

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

5. Proposals

The Board of Directors is asked to:

- Approve the Winter Plan for 2023/24.
- Note the proposed additional actions to manage the capacity shortfall described within the Winter Plan, and the approach to the pursuit of further funding outlined in section two of the covering paper.

Royal Devon University Healthcare NHS Foundation Trust

Winter Plan 2023-24

To be used in conjunction with: NHS England Operational Pressures Escalation Levels Framework
In consultation with: Divisional Teams Eastern Services Urgent and Emergency Care Taskforce Northern Urgent and Emergency Care Board Joint Operations Board **Approval required from:** Trust Delivery Group Royal Devon University Healthcare NHS Foundation Trust Board of Directors
Contact for Review: Heather Brazier, Director of Operations – Northern Services Phil Luke, Interim Director of Operations and Transformation – Eastern Services

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1. INTRODUCTION

1.1 As a result of a broad range of pressures, 2023/24 has so far proved to be an unrelentingly challenging year for urgent care services nationally, within the Devon system, and here at the Royal Devon University Hospital (RDUH). Despite record levels of investment, waiting times in our emergency departments have risen to unprecedented levels and our ability to accept timely handover from paramedic crews to enable them to respond to emergency calls has been compromised. This winter plan sets out the scale of the challenge facing the Trust this winter and the actions planned and in place to provide the best outcomes for our patients and to support the wellbeing of our staff.

The 2023/24 Winter Plan has been developed based on the current understanding of demand, implementation of schemes that have been successful in previous winters and an evidence base for new schemes.

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

The Operational Planning process for 2023/24 and the UEC Recovery Plan, launched in January 2023, which provided UEC funding, has also supported the plan development.

The Winter Plan sets out the following:

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

The objectives are as follows:

- Ensure that the Trust has sufficient urgent and emergency care (UEC) capacity to provide high quality and safe care for patients, including those with respiratory infections.
- Optimise cancer and elective care by reducing cancellations of elective procedures.
- Support staff health and wellbeing and build confidence in operational plans.
- Minimise ambulance handover delays and optimise 4-hour performance and 12-hour waits in the Emergency Department (ED).
- Work collaboratively across the Devon system to prevent inappropriate attendance and admission and support timely discharge.
- Deliver operational resilience in the most cost-effective way possible.

1.2 **Ownership and Governance**

Executive Director Lead
John Palmer, Chief Operating Officer

Operational Delivery Leads
Heather Brazier, Director of Operations – Northern Services
Phil Luke, Interim Director of Operations and Transformation – Eastern Service

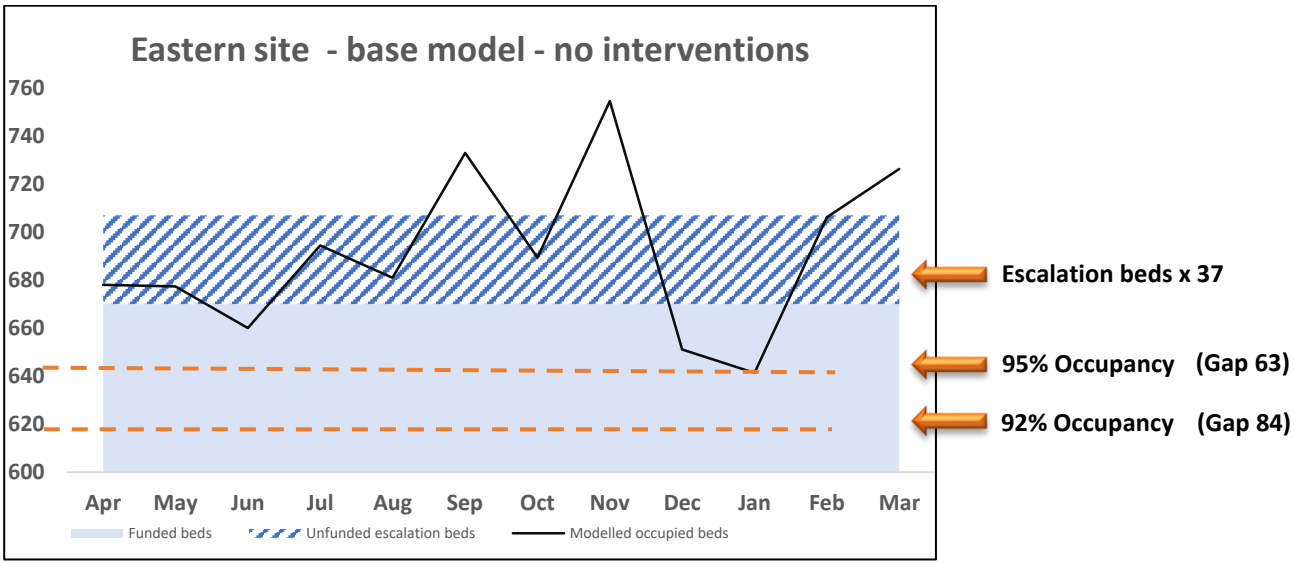
[1] PRN00645-delivering-operational-resilience-across-the-nhs-this-winter-270723.pdf (england.nhs.uk)

- The Trust Delivery Group has overall responsibility and oversight of the plan, which it carries out through the Eastern Services Urgent and Emergency Care Taskforce and Northern Services Urgent and Emergency Care (UEC) Board, both of which report to the Joint Operations Board.
- Version control and governance of the Winter Plan will remain the responsibility of the Eastern Services Operations Support Unit.
- Following approval by the Trust's Board of Directors, this plan will be distributed to the Trust's Executive Team, to individuals on the Director, Manager and Senior Nurse on-call rotas and the Site Management Offices. The approved plan will also be made available on the Trusts' Intranet.
- In addition, this plan will also be distributed to partner organisations in the local healthcare community including NHS Devon ICB.
- Divisions have the responsibility for communicating and adhering to their specific plans.

2. THE SCALE OF THE CHALLENGE

2.1 The Trust uses a comprehensive bed modelling tool, which collates actual data from our most recent lengths of stay, at specialty level, factoring seasonal variation, including the anticipated impact of flu and COVID-19. These data are matched with anticipated patient volumes for non-elective and elective demand to create a picture of the overall bed demand in certain bed pools such as Medicine, Surgery, Trauma and Orthopaedics etc. The demand data are then compared to our existing capacity to provide a starting point showing the deficit or surplus in bed capacity if no interventions are made. The baseline positions are set out in the graphs and narrative below.

Eastern position



The graph above shows funded bed capacity and modelled demand, as well as dotted lines marking 95% and 92% occupancy. It is commonly accepted that to achieve optimum flow from the Emergency Department and enable the right patients to be placed in the right specialty bed, an occupancy level of 85% is desirable. Unfortunately, such a position is not achievable and the Trust generally aims to run at 92% occupancy in order to balance operational efficiency with affordability and workforce availability.

Over the winter months, the above model shows an average bed requirement of 700 beds, compared to funded capacity of 670 beds, of which 637 would represent 95% occupancy and

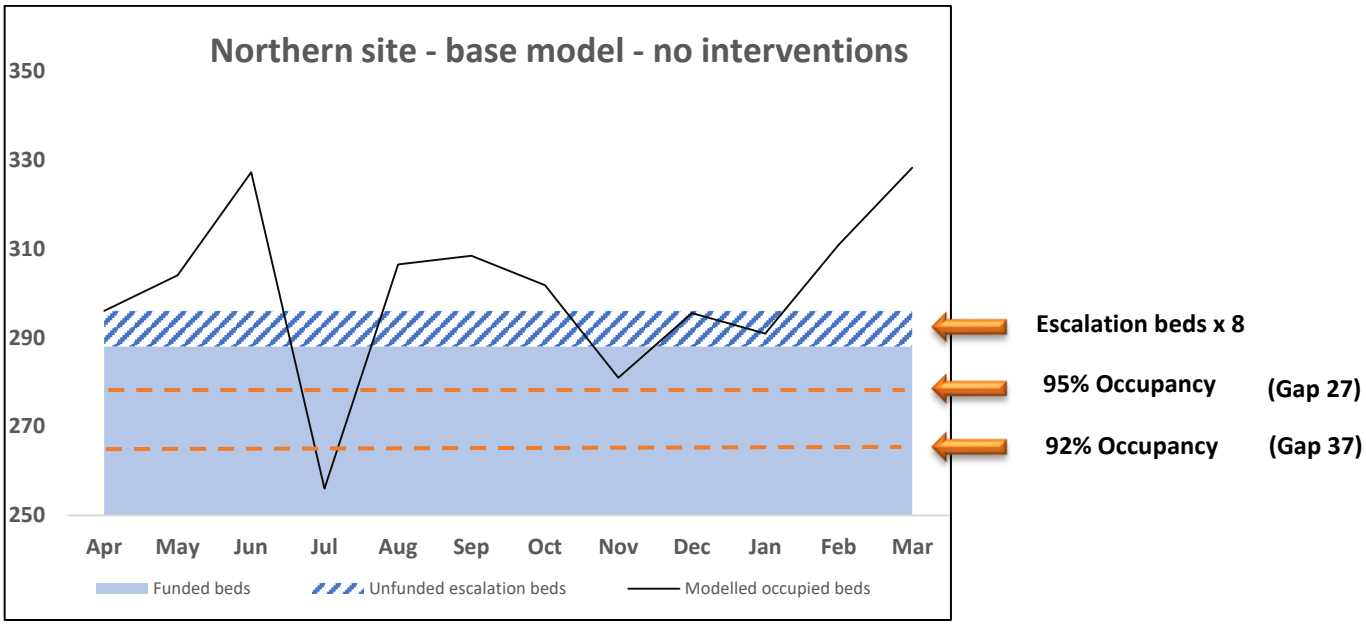
616 would represent a 92% occupancy level. The annotations to the right of the graph show the gap in bed capacity to achieve 95% and 92%, which are 63 and 84 beds respectively. Importantly, the model also shows significant monthly variation, with November showing the greatest demand and the largest deficit of 138 beds required in order to achieve a 92% occupancy level.

It is important to note that for simplicity, the above graph shows the monthly average, which masks daily variation. The more detailed modelling shows upper control limits, which, in the case of the Eastern position, show that, on some days, demand will be up to 46 beds higher than the monthly average shown by the modelled occupied beds line. It is important that our winter plan is sufficient to account for this variation.

The graph also shows escalation bed capacity on top of funded beds of 37 beds. It is not desirable to occupy these beds as it invariably places pressure on the smooth running of other key elements of the Trust, such as elective throughput, trauma flow from the ED etc, however, the beds are a commonly used and important feature of the Trust's operational resilience.

In summary of the Eastern position, with no interventions, the Trust is likely to operate in excess of 100% of its bed capacity throughout winter, with the need for additional bed capacity even above our escalation capacity for long periods of time. **The average shortfall in bed capacity to operate at 92% bed occupancy is 84 beds**. It could be anticipated that this would lead to frequent declarations of OPEL 4, with periods of time where the Trust was unable to effect timely discharge from the ED or receive rapid handover from paramedic crews, leading to significant patient risk. There would also be an increased risk of cancellation of elective procedures which would have significant patient impact.

Northern position



Over the winter months, the above model shows an average bed requirement of 302 beds, at our Northern site compared to funded capacity of 288 beds, of which 274 would represent 95% occupancy and 265 would represent a 92% occupancy level. The annotations to the right of the graph show the gap in bed capacity to achieve 95% and 92%, which are 27 and 37 beds respectively. As with the Eastern model, the modelled occupied beds line shows the average monthly occupancy, which masks daily variation. For the Northern site, this variation is as much as 21 beds above the monthly average line.

At our Northern site, there are just eight escalation beds, which significantly impact on operational flow when utilised.

In summary of the Northern position, with no interventions the Trust is likely to operate in excess of 100% of its bed capacity throughout winter, with the need for additional bed capacity even above our escalation capacity for long periods of time. **The average shortfall in bed capacity to operate at 92% bed occupancy is 37 beds**. It could be anticipated that this would lead to frequent declarations of OPEL 4, with periods of time where the Trust was unable to effect timely discharge from the ED or receive rapid handover from paramedic crews, leading to significant patient risk.

Trust baseline position without interventions

The combined position across our two acute sites is shown in the table below. The data show an average shortfall over winter, to operate at 92% occupancy, of 121 beds, but with some monthly variation. March 2024 is showing as the most challenging month, with a shortfall of 173 beds. The average shortfall in bed capacity as a proportion of overall funded beds is remarkably similar across the two sites, at 12.5% for our Eastern site and 12.8% for the Northern site.

		Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Winter average
Eastern	Funded beds	670	670	670	670	670	670	670
	Modelled demand	689	755	651	641	706	726	700
	Shortfall to achieve 92% occupancy	-73	-138	-35	-25	-90	-110	-84
Northern	Funded beds	288	288	288	288	288	288	288
	Modelled demand	302	281	295	291	311	328	302
	Shortfall to achieve 92% occupancy	-37	-16	-31	-26	-46	-63	-37
RDUH	Funded beds	958	958	958	958	958	958	958
	Modelled demand	991	1036	947	932	1017	1055	1002
	Shortfall to achieve 92% occupancy	**-110**	**-154**	**-65**	**-51**	**-136**	**-173**	**-121**

3. THE WINTER PLAN - INTERVENTIONS TO MANAGE DEMAND

3.1 This section sets out the plan to manage the significant bed capacity gaps on both sites described in section two. The approach taken will be broken down into four elements as follows:

- Strategic context regarding operational resilience
- Funded interventions on each site to mitigate the bed capacity shortfall
- The anticipated impact of these actions
- Additional steps proposed in order to provide greater resilience

3.3 Strategic context regarding operational resilience

Firstly, in October 2021 the Board of Directors approved a significant package of investment spanning the breadth of urgent care and both the Northern and Eastern sites. This funding addressed a critical shortfall in the ED staffing levels on both sites, as well as adding an additional ward on the Eastern site, increasing the bed pool by 20 beds. As anticipated, it has taken time for these posts to be recruited to and for people to commence in role. Whilst the challenge we face this winter is daunting, the Trust is in a much-improved position as a result of the additional resilience provided from this investment.

Secondly, in addition to the above funding, at the Northern site, funding has been approved to strengthen acute medical services. This follows the Safer Patient Care paper and is a long term business case phased over 3 years to recruit senior medical staff to build resilience in medical services. Progress has been rapid, with the appointment of three consultants as at the end of September 2023, which will increase resilience in Cardiology and Gastroenterology.

Thirdly, throughout the year, the Trust has worked as part of a wider system to balance emergency demand across Devon. Since June 2023, this has involved accepting circa 300 additional ambulances from the Plymouth and South Devon catchment areas. This has led to circa 200 inpatient admissions, with an approximate average of 14 patients occupying RDUH beds at any time. Our teams have been proud to help colleagues from other Trusts and protect patients with emergency needs, however, the psychological impact on our staff of repeatedly being asked to go above and beyond to support system pressures has at times been considerable. We continue to play a daily role in supporting other Trusts, however, supporting the Devon ICB to develop a larger solution remains an important challenge.

43.3 Funded interventions to mitigate the capacity shortfall

In order to maximise operational resilience, the Trust has utilised external funding to enable additional measures to be implemented, which are set out below.

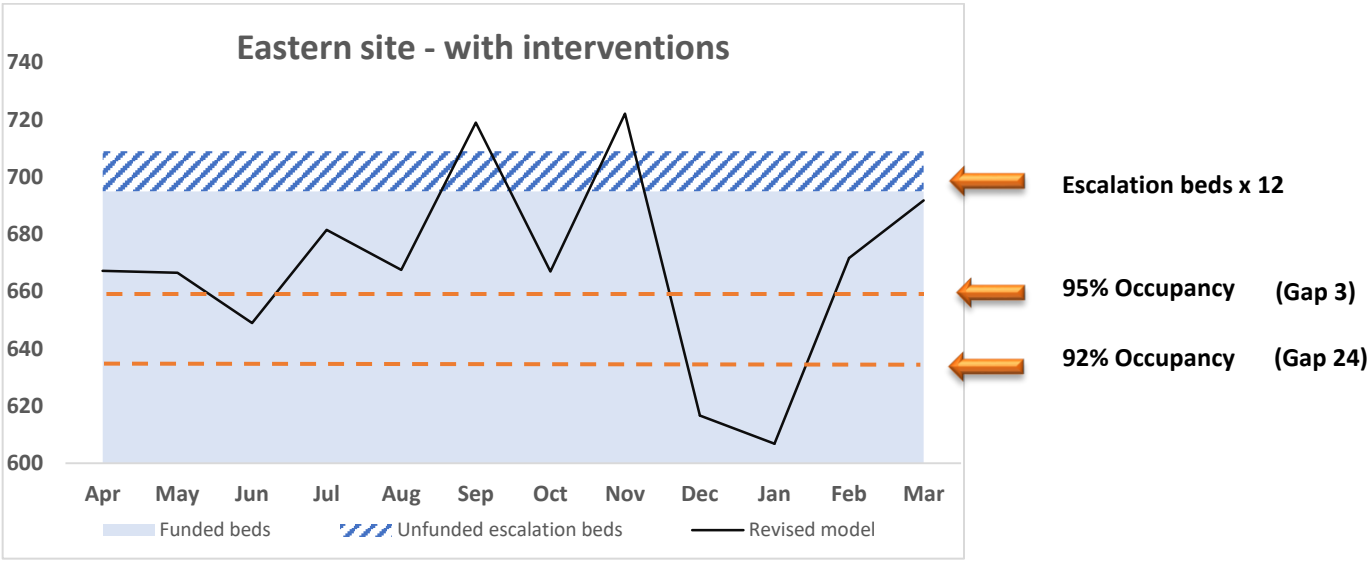
Eastern site

The winter actions for the Eastern site are set out in the table below

No	Brief narrative	Key modelling assumptions	Bed impact
1	**Virtual Ward** – patients whose admissions were avoided or discharge expedited by being cared for at home with remote support from our clinical team.	50% of VW patients would have occupied an acute bed. Target 39 VR beds over winter.	**20**
2	**Recurrently funding existing escalation beds** Capener 7, Yealm 4, Wynard Medical 2, Sidmouth 1	None required. 100% of bed capacity added to funded bed capacity.	**14**
3	**Review of commonly used remaining escalation beds Durbin 4, Otter 2, Wynard 5** - Incorporate escalation beds which are commonly used into the bed pool based on a realistic assessment of likelihood. It is not desirable to use these escalation beds, however pragmatically accepting their use will support better long-term planning.	That these beds will continue to be utilised over winter.	**11**
4	**Reduce "no criteria to reside" patients** • Discharge Coordinators – to support discharge from wards • Out of Hours District Nursing Call Handling Service	Bed capacity gains for new interventions only have been set.	15

No	Brief narrative	Key modelling assumptions	Bed impact
	• Provision of Primary Care Medical Cover for all Pathway 2 patients placed in Care Homes • Tactical Provider Support Team (TPST) 1:1 Hospital Discharge to Care Home Support • Live-in Carers Support • Hospice care Nurse within SPOA – Focus on EOL Care, Hospice and P3 discharge • Virtual ward Night Sits • Help People Home Without Delay programme		
5	**Actions to help flow that will not increase bed capacity** • Discharge lounge - weekend opening - to improve patient flow at weekends • GP streaming in ED • Support for frequent attenders to avoid ED attendance and admission	NA	0
	Total		60

Eastern Site - Impact of funded interventions



The impact of the interventions set out in the table above is significant, amounting to the equivalent of 60 beds, compared to the shortfall of 84 beds to achieve an average occupancy of 92%. Based on this modelling, the average occupancy would be around 95.5%, and **the shortfall to achieve an occupancy of 92% would be 24 beds**.

Whilst this does represent a significant improvement on the unmitigated position, this level of occupancy would likely lead to high levels of congestion and almost continuous patient flow challenges. It should also be noted that the shortfall of 24 beds to achieve a 92% occupancy level is based on a **monthly average**, which masks monthly and daily variation of up to 46 beds above the average demand. There remains therefore a challenging picture facing the Trust over the forthcoming winter, which we will be seeking to further mitigate through the additional actions described in the next section.

Will we be able to keep patients safe?

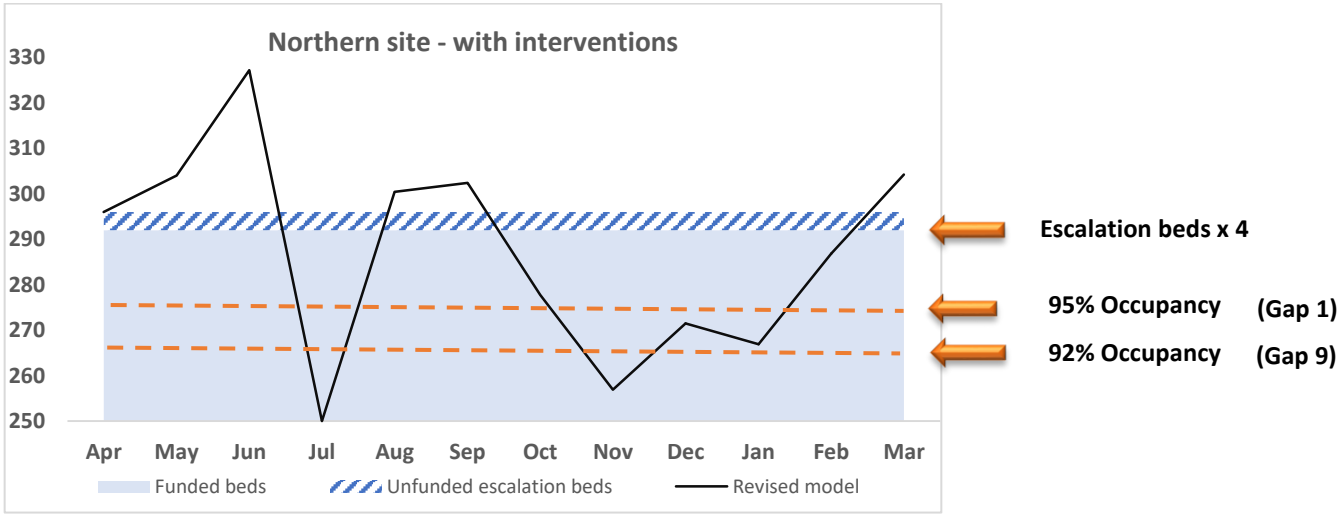
Whilst much improved, the above position does show a significant element of risk over the forthcoming winter months. In the event that emergency demand overruns our capacity, the Trust is able to implement the following measures to maintain safe emergency care.

- Implement the OPEL 4 incident management framework, which will direct resources from elective care and other activities to creating bed capacity. In extremis, this has always proved to be effective.
- Utilise elective bed capacity in order to accommodate emergency patients as a short-term measure. Not included in the escalation bed figures shown in the data so far are the use of Knapp (20 beds) and Dyball (26 bed) wards. These beds would only be used in extremis, however, they do provide a back-up in the event of a surge of emergency patients.

Northern site

No	Brief narrative	Key modelling assumptions	Bed impact
1	**Virtual Ward** – patients whose admissions were avoided or discharge expedited by being cared for at home with remote support from our clinical team.	50% of VW patients would have occupied an acute bed. Target 21 VR beds over winter.	**11**
2	**Recurrently funding existing escalation beds** South Molton 4	None required. 100% of bed capacity added to funded bed capacity.	**4**
3	**Reduce "no criteria to reside" patients** • Discharge Coordinators - to support discharge from wards • Out of Hours District Nursing Call Handling Service • Provision of Primary Care Medical Cover for all Pathway 2 patients placed in Care Homes • Tactical Provider Support Team (TPST) 1:1 Hospital Discharge to Care Home Support • Live-in Carers Support • Hospice care Nurse within SPOA - Focus on EOL Care, Hospice and P3 discharge • Virtual ward Night Sits • Help People Home Without Delay programme	Bed capacity gains for new interventions only have been set.	**13**
4	**Actions to help flow that will not increase bed capacity** • Northern discharge hub • Increased GP streaming in ED • Support for frequent attenders to avoid ED attendance and admission • Discharge Liaison Officer and clinical admin support to clinical site team	NA	0
	Total		28

Northern site – impact of interventions



The impact of the interventions set out in the table above is significant, amounting to the equivalent of 28 beds, compared to the shortfall of 37 beds to achieve an average occupancy of 92%. Based on this modelling, the average occupancy would be around 94.5%, and **the shortfall to achieve an occupancy of 92% would be 9 beds**.

Whilst this does represent a significant improvement on the unmitigated position, this level of occupancy would likely lead to high levels of congestion and almost continuous patient flow challenges. It should also be noted that the shortfall of 9 beds to achieve a 92% occupancy level is based on a **monthly average**, which masks monthly and daily variation of up to 21 beds above the average demand. There remains therefore a challenging picture facing the Trust over the forthcoming winter, which we will be seeking to further mitigate through the additional actions described in the next section.

As noted for the Eastern site, in the event that emergency demand were to exceed capacity, the Trust would operate the OPEL 4 capacity framework actions, utilise elective bed capacity and would be able to maintain safe care for emergency patients.

Trust-wide position after funded interventions

		Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Winter average
Eastern	Funded beds	695	695	695	695	695	695	695
	Modelled demand	667	722	617	607	672	692	663
	Shortfall to achieve 92% occupancy	-28	-83	22	32	-33	-53	**-24**
Northern	Funded beds	292	292	292	292	292	292	292
	Modelled demand	278	257	271	267	287	304	277
	Shortfall to achieve 92% occupancy	-9	12	-3	2	-18	-36	**-9**
RDUH	Funded beds	987	987	987	987	987	987	987
	Modelled demand	945	979	888	874	959	996	940
	Shortfall to achieve 92% occupancy	**-37**	**-71**	**20**	**34**	**-51**	**-88**	**-33**

On both sites, the funded interventions considerably mitigate the baseline shortfall in bed capacity over winter. Unfortunately, however, there remains a capacity deficit to achieve an average 92% bed occupancy. In addition, there is monthly variation to account for, as well as daily fluctuations in demand, which will result in there being sustained periods of significant operational pressure on both sites over winter.

53.3 Additional interventions that could be implemented with further funding

Given the likelihood of this sustained pressure, the Trust has identified additional measures which could be implemented at pace if funding to support them were in place. These measures are summarised in the table below.

Site	Division	Scheme description	Bed capacity impact once fully implemented	Total revenue cost 2023/24 (£'000)
RDUH North & East	Medicine	**Virtual Ward Expansion** emergency winter expansion of AHAH and SDEC space within current model, but enable increased flow through SDEC, ambulatory HOT clinics and ECU beds. rate - add in VW matron post top up £20k required)	14	£ 250
Eastern	Community	**Care Coordination Hub** Avoid 8 admissions per day (ave LoS 4 days) Open 7/7 10:00-20:00 Staff costs ~£760k per annum, adjust for 17 weeks Dec-March	14	£ 250
Eastern	Community	**Escalation beds in Tiverton and Sidmouth Community Hospitals** 1 x additional HCA needed @ 4.5 WTE for Tiverton beds, Sidmouth bed already funded via UEC	5	£ 45
Eastern	Medicine	**Yealm Beds x 4** Dec-March @ 1 x RN and 1 x HCA day and 1 x HCA night	4	£ 30
Eastern	Operations/Central	**SDEC Expansion** to open at 08:00 December '23-March '24 - predict one avoided admission every other day. 2.5 hours x 17 weeks @ x 1 Consultant, x 1 B6 RN and x 1 HCA	3.5	£ 45
Eastern	Operations/Central	**Discharge Coordinators** - to support discharge from wards to support flow and enable extended cover in to weekends and beyond 4pm. Additional 4.8 WTE B3 to bring establishment to 12 WTE and provide cover to all wards	3	£ 144
Eastern	Medicine	**Weekend Cardiology Lists** Weekend white board list to reduce waits from 3 days to 2, thereby saving 3 bed days. Running Saturday and Sunday lists for 14 weeks from Dec '23 to March '24. Staffing @ 1 x Consultant, 2 x B6, 1 x B7, 1 x B3 HCA	3	£ 159
Eastern	Community	**Additional P1 hours** - further capacity for P1 care @ 262 hours pw for 21 week November - March inc	3	£ 166
Eastern	Specialist/ Medicine	**Pharmacy input to Acute Hospital at Home (Virtual Ward)** 1.0 WTE medicines management pharmacy technician at band 5 to work with the AHAH pharmacist linking with community services pharmacy team to ensure best care for patients 12 mth FTC	1	£ 35
Eastern	Medicine	**Therapy Cover Knapp** 1 x B5 PT, 1 x B5 OT and pharmacy tech @ 17 weeks	1	£ 50
Eastern	Medicine	**Junior Doctor cover for escalation beds (**Kenn, Bovey, Capener, Dart)	1	£ 30
Eastern total			**52.5**	**£ 1,204**
Northern	Community	**Escalation beds in South Molton** 5.07 WTE RN, 5.07 WTE HCA, 1.0 WTE Discharge co-ordinator, 1.0 WTE Activities co-ordinator, 1.07 WTE Ward Clerk, 0.60 WTE SAS Doctor, 1.84 WTE Generic worker, 4.31 WTE Therapies and 1.42 WTE Pharmacy £73k per month Dec-March	8	£ 292
Northern	Medicine	**Enhanced pathfinder support in ED and MAU for admission avoidance** 1 WTE band 7 for ED, 1.6 WTE band 6 for ED. 2.6. WTE for MAU, 2 WTE band 3 support workers covering ED/MAU ***1 year FTC***	2	£ 298
Northern	Medicine	**Increase OP capacity for HFoP and Stroke** Healthcare for older people: Additional clinic slots to prevent patients being readmitted Additional 16 patients per clinic - one per month. Per additional clinic - insourcing costs plus 8hrs B5 Nurse and B3 Admin Stroke: Additional 16 patients per clinic - two per month to prevent admission or readmission	1.5	£ 136
Northern	Medicine	**Additional clerical support in ED** Additional ED Board Co-ordinators to provide 24/7 cover to facilitate patient flow from ED. Additional 2.48 WTE band 3	1	£ 98
Northern	Medicine	**Ortho-geriatrician support to trauma** Dedicated Senior doctor to medically optimise trauma patients. 1.0 WTE middle grade @£100 ph x 17 weeks	1	£ 64
Northern	Community	**Increase P1 offer**		
Northern total			**13.5**	**£ 888**
TOTAL			**66**	**£ 2,092**

All of the above measures could be implemented by the end of 2023. It should be noted that the Virtual Ward expansion and Care Co-ordination Hub are linked schemes, which will require feasibility work by the Estates team to ascertain if there are capital costs relating to the provision of a platform for two mobile outpatient units, which would provide space for clinical staff. This rapid feasibility study has been commissioned to enable these additional measures to be implemented at pace, if funding can be identified.

As is shown in the table, the benefit of the schemes would be a gain of 66 beds, 52.5 in the eastern site and 13.5 on the North. These additional capacity gains would significantly improve operational resilience on both sites, reducing the average bed occupancy on the eastern site to under 90% and thereby enabling capacity for fluctuations in demand.

The Trust will seek additional funding from the slippage in the Devon ICB winter funding allocation and the Board of Directors will consider further approaches to funding these additional winter resilience measures.

4. OTHER CONSIDERATIONS

4.1 Risks and Impact

The following risks have been identified which, if materialised, could impact on delivery of both the plan and also upon patient care and service delivery:

- Failure to successfully deliver all elements of the plan, including difficulty in recruiting fixed term staff Risk that some mitigations will not receive funding from UEC business cases
- Risk that additional intervention schemes will not receive funding from UEC slippage and further risk of additional exposure to financial expenditure risk as a result.
- Increase in Emergency Department demand above forecast levels and subsequent impact on performance and delayed ambulance handover times
- Increase in non-elective admissions above predicted numbers, putting pressure on paediatric, intensive care and medical beds particularly.
- Risk to elective activity due to UEC demand and cancellation of elective admissions, including oncology and haematology treatments, due to the number of emergency admissions and/or delays in patients waiting for onward care, therefore reducing ability to meet cancer and referral to treatment waiting times.
- IPC Outbreaks
    - Increased demand impacting on bed availability
    - Exceeding ITU and respiratory support capacity
    - Loss of workforce due to unplanned absence
    - Loss of domiciliary care hours and care home beds
    - Exceeding mortuary capacity
- Further impacts of Industrial Action, resulting in minimal staffing numbers, cancellations of planned activity and increased pressures within UEC
- Adverse weather conditions, such as snow and ice, flood and high winds.
- Partner agencies, such as GPs, social care, acute providers, unable to cope with increased demand resulting in patients diverting to the Trust.
- High numbers of patients who are waiting for onward care with no criteria to reside.
- Patient transport resilience is compromised.
- Increased costs, for instance through providing additional staff, accommodation, transport
- Reassigning staff to work in unfamiliar areas at times of staffing shortage.

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An Urgent and Emergency Care Risk Assessment has been signed off at the August 2023 Safety and Risk Committee for inclusion on the Corporate Risk Register.

4.2 Workforce and Wellbeing

Staffing

A key impact on staff well-being is the level of safe staffing levels and this is an area that has been and will continue to be challenging as a result of many factors including Industrial Action (IA) by various staff groups. With the number of strikes already having taken place the Trust is well versed and prepared with a good structure in place for planning and constant review through its Gold Command structure. It does not, however, remove the fact that backlogs of work build as a result.

Despite the challenges of IA the Trust's vacancy level has positively exceeded its target of 7% currently standing at 4.94% demonstrating good progress in filling key roles particularly in our nursing workforce group. The successful recruitment of nurses from overseas has allowed a reduced reliance of bank and agency workers although some skill mix balances still need some temporary workforce support.

The Trust has managed its unregistered nurse vacancy down to a good level and introduced a robust retention plan to maintain turnover levels. Key successes in the recruitment of some long standing hard to fill medical roles is also helping vacancy levels. The overall Trust turnover has seen a drop to 10.7%.

Staff sickness has fluctuated in recent months but currently stands in a better position than has been seen in the previous few years at 4.61%. COVID-19 sickness continues to be present and again a fluctuation in the number of staff off sick with COVID-19 symptoms has been seen in recent months. Anxiety/stress/depression/other psychiatric illnesses contribute to over a quarter (27.4%) of all sickness absence, with this being more prevalent in staff working in UEC areas. When the Trust is in an escalated position for any length of time it impacts on staff, as they are asked to move within the hospital to maintain overall safe staffing numbers. Staff moves impact on staff morale and ultimately absence.

The high level of escalation beds constantly having to open with no funding to staff them impacts the overall staffing position. This is coupled with also having to care for patients with complex mental health needs over and above what would have been their required length of stay as care settings are unable to accept them back into their placement. A higher level of acuity of patients and changes to the ward base for some specialties has also led to an increased establishment requirement.

The Trust has a number of controls in place to ensure that overall safe staffing levels are maintained. This includes daily staffing meetings led by our Assistant Directors of Nursing, monthly workforce group meetings for the core staffing groups (Nursing, Midwifery, AHPs and doctors) and collaborative system meetings focused on the usage and management of temporary workforce.

Wellbeing

There has been an increase in violence and aggression, particularly within areas of UEC, and this is contributing to staff fatigue. To mitigate this, the Devon system is launching a campaign to reduce the incidence of violence and aggression towards healthcare staff, in addition to a robust wellbeing focus at senior leadership events within the Trust. It is acknowledged that an element of the workforce strategy is to offer overtime, and staff are already tired. A winter health and wellbeing paper is in train and will be added when complete, but some support structures include;

- Sleep physiologist support
- Financial management support and advice
- Trauma support
- Stress & burnout messages
- Commitment to ongoing investment in rest and wellbeing facilities

Remote Working

In order to support work-life balance, the Trust continues to support remote working. Staff are able to work flexibly, in agreement with their manager, with many staff working a hybrid model of some days on site and some at home each week. Appropriate IT equipment has been made available and a set of Home Working principles developed and communicated. A need to have a formal working from home policy will follow in response to recent guideline updates, and will be included once completed.

4.3 **Infection Prevention & Control (IPC)**

There are escalation plans in suit for both northern and eastern sites regarding bed demand in the event of increased IPC demand. This is managed dynamically and tailored according to operational circumstances.

Seasonal Flu Plan

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

Influenza Pandemic Plan

Whilst influenza pandemics have been relatively infrequent, a new pandemic could emerge at any time. The Trust's response to an influenza pandemic will be based on this Framework and the Trust's Pandemic Management Plan. Reference should also be made to the Trust Business Continuity Management Policy (approved in September 2023), Eastern Services' Business Continuity Strategic Response and Recovery Plan and individual Service Continuity Plans.

Seasonal Vaccination Programme

The autumn 23/24 vaccination programme commenced on 11th September 2023 for COVID-19 vaccinations and will start week commencing 9th October 2023 for the 'flu campaign. Frontline health and social care staff are eligible for both vaccinations, as per Joint Committee on Vaccination and Immunisation (JCVI) guidelines. For the Eastern services, there will be provision at Exeter Vaccination Centre, Greendale Farm Shop and all hospital sites. This includes community hospitals, Wonford and Heavitree, as well as a roving offer to our satellite sites. For Northern services, the vaccination unit has returned to Barnstaple Tesco Extra and all hospital sites. There is an offer at NDDH and community hospitals. Staff communication will be updated regularly to facilitate easy access, and HUB will show venues, dates and times of the vaccination offer. In addition, the flu vaccination is supported by an extensive peer vaccination programme, making vaccination easily accessible, The aim is to facilitate increased uptake and minimise absence as a result of seasonal illnesses.

Viral Gastroenteritis

Within the general community, circulation of Viral Gastroenteritis (Norovirus) is common, causing sporadic or small clusters of cases. Norovirus has a considerable propensity to spread within hospitals resulting in ward or hospital-wide outbreaks. Success in limiting outbreaks depends heavily on early recognition of those who may be infected in order that appropriate action can be taken. The Trust's (Eastern) Viral Gastroenteritis Policy is currently being reviewed to produce a Trust wide document. It is based on National guidance and when reviewed, incorporates any learning from previous outbreaks.

Domestic Services Specialist Cleaning

The Domestic Services team and Sodexo will provide an enhanced cleaning service in response to the winter pressures. Upon request additional staff will be requested via the staff bank or Sodexo helpdesk to support this increase in demand, undertaking both social cleans and deep cleans where necessary. A member of the Domestic Services Operational Team attends the daily bed/patient flow meetings and will attend the Gold Command meeting as requested to ensure that patient moves and changes to ward usage are appropriately supported.

4.4 Elective and Cancer Care

The Trust has backlogs of patients waiting for treatment, in part due to the reduction in surgical bed capacity due to non-elective admissions during the pandemic. Where possible elective beds will be ring-fenced to support elective recovery and oncology and haematology beds ring-fenced for critical treatments. The Trust has an improvement board to oversee the work to increase activity. Patients are reviewed and priority status reassessed, in order that treatment can be expedited if indicated. A Joint Cancer Cabinet for the Trust is in place, jointly chaired by the Chief Medical Officer and Chief Operating Officer, and a detailed action plan is in place.

Funding has been received through the Elective Recovery Fund, Accelerator Programme and Community Diagnostic Hub programme to increase elective diagnostic and treatment capacity each of which will bring benefit for both urgent and routinely referred patients.

Following the completion of the reconfiguration on the Nightingale Hospital, Exeter (NHE) the unit has been providing short stay ambulatory orthopaedics at South West Ambulatory Orthopaedic Centre, cataract surgery through Centre of Excellence for Eyes, diagnostic imaging, and rheumatology services, with almost 100,000 additional patient episodes across the services achieved in its first year. In 2023 the NHE was one of the first eight Getting it Right First Time accredited elective surgical hubs, and is providing national exemplar ringfenced elective services for RDUH Eastern, Northern and Torbay South Devon. During 2023/24, the diagnostic centre will be expanded to introduce further off-site physiological measurement services, to increase elective diagnostic capacity for the system.

4.5 Emergency Preparedness and Business Continuity

The arrangements for responding to any major incident are contained with the Eastern Services Emergency Preparedness Plan and the Northern Incident Response Plan. The Trust has Business Continuity Management Policy, a Strategic Business Continuity and Recovery Plan for Eastern Services and a Business Continuity Plan for Northern Services. The plans are made available on the Trust's intranet site.

4.6 Adverse Weather Conditions

The Trust receives warnings of adverse weather from the Met Office and health warnings from the UKHSA. The Trust also receives additional information from a Met Office Adviser via the Local Resilience Forum if forecast weather has the potential to cause disruption. The Trust has an adverse weather plan which can be found on the Emergency Preparedness page of the Trust intranet and covers all types of weather including heatwave and snow/ice. The plan is reviewed each year against national guidance which corresponds to Met Office Cold Weather Alert and Heat Health Watch periods.

4.7 Communication of the Plan

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

- A series of internal communications and engagement activities to support staff health and wellbeing and build confidence in the plan, including senior leader 'talking heads' videos, a winter plan visual, regular internal updates across all channels, screensavers, targeted communications to line mangers, heads of departments and senior leaders.
- Working with ICS Devon partners to implement an external-facing, targeted communications campaign which aims to shape public behaviour and promote healthier life choices.
- Working with system partners, and in particular primary care, to help ease pressures across the Royal Devon.
- Aligning to several pre-existing campaigns and programmes already underway, including the staff morale and wellbeing interventions programmes.

A copy of the winter 2023/24 communication strategy has been provided in Appendix 1.

The key elements comprising the 2023/24 winter plan have been outlined under page 6.

APPENDIX 1: WINTER 2023/24 COMMUNICATION PLAN

INTRODUCTION

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

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

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

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

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

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

BACKGROUND

Capacity planning

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

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

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

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

We want to ensure:

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

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

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

Help Us Help You / Think 111 First

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

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

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

More detail about the One Devon external-facing winter communications campaign, which begins in October 2023, can be found in part 4 below.

OBJECTIVES

The winter plan objectives fall under the Trust's first strategic objectives to both deliver an equitable recovery and to use to the opportunity to drive change, and the objective to create the culture and environment to retain, develop, support attract people to work as part of a team to deliver patient centred care. The objectives have been adapted in response to the COVID-19 pandemic and are as follows:

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

Winter plan objective	**Communication and engagement objectives**
Support staff health and wellbeing and build confidence in operational plans	• Continue to support the development, implementation and/or marketing of the interventions set out in the staff morale and wellbeing paper (led by the Trust's Chief People Officer). • Support the wellbeing, inclusion and employee experience teams to promote the services and support available to staff. • Develop a feedback loop for staff to flag what's working well and any new ideas for supporting wellness over the winter months. • Provide regular and timely updates on the winter plan to ensure staff understand the plan, the part they play in it and feel motivated to support it.
Ensure that the Trust has sufficient urgent and emergency care capacity to care for patients, including those with COVID-19	• Provide regular, timely and accurate operational updates (ie OPEL level, surge planning, hospital reconfiguration, COVID-19). • Roll out updated discharge campaign linked to national 'Home First' campaign across Trust and use 'Home for Lunch' messaging to communicate the importance of a safe, timely discharge to patients and their family/carers, and the actions they can take to facilitate this. • Promote the discharge lounge(s) to staff through regular updates about their use and success, and case studies. • Carefully worded updates to primary care. • Promote messages about staying home if an infectious disease (flu, COVID-19, norovirus etc.) is suspected, and to call 111/999 if urgent care is needed. • Promote flu vaccines/COVID-19 vaccine for staff.
Optimise cancer and elective care to	• Continue to provide information to patients on waiting lists and updates to staff (part of the 'Waiting Well' programme).

reduce waiting times for our patients.	• Continue to support the Outpatient Transformation and Recovery Programme (separate communications and engagement plan developed). • Continue to support the System Asset Programme at the NHS Nightingale Hospital Exeter (separate communications and engagement strategy developed).
Work collaboratively across the Devon system to prevent inappropriate attendance and admission and support discharge	• Support and promote the winter communications campaign for Devon, developed by Devon ICS members to help prevent inappropriate attendance and admission through: o encouraging the public to get their flu and COVID-19 vaccinations o supporting people to make informed decisions to manage their health and get prepared for winter o giving people the information, they need to access the right care in an urgent or emergency situation. • Align discharge messaging across system partners
Deliver operational resilience in the most cost-effective way possible	• Share learning and innovation across staff groups and services • Support promotion of integrated working across Eastern and Northern services to avoid duplication and improve efficiency. • Focus on schemes and initiatives which promote people to return home and to stay well at home, by focussing resource and efforts on prevention, working collaboratively and sharing skills to empower people to live as independently as possible at home

Audiences/stakeholders

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

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

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

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

Audience/stakeholder	Influence	Importance to campaign objectives	Communications aims
Royal Devon staff	High, direct	High	Understand our plan for winter and what they can do to help Understand the impact of the decisions they make

Audience/stakeholder	Influence	Importance to campaign objectives	Communications aims
			Support the culture of promoting independence Support staff health and wellbeing
GPs	High, direct	High	Understand our plan and what they can do to help
Domiciliary care partner agencies and care homes	High, direct	High	Understand our plan, awareness of OPEL, and what they can do to help Understand how to help us prevent admissions and facilitate timely discharges
NHS Devon ICB	High, indirect	High	Understand our plan and support our conversations with referrers Understand how they can help us promote our key messages with the public
Other providers within the system	Medium, indirect	Medium	Understand our plan and work with us to develop opportunities to share communications resources and key messages
National bodies NHSE	High, indirect	Medium	Understand our plan and gain assurance of care system management
Voluntary sector	Medium, indirect	Medium	Understand our drive to promoting independence and the detrimental impact of a hospital stay can have on someone's independence Understand our approach and how they can help
Inpatients, carers and families	Direct, high influence	High	Understand what they can expect from us and what we ask of from them Understand that a shorter stay in hospital is better for the patient

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

Key messages

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

Sub-messages – staff

- Your health and wellbeing is our priority, please access the support and resources available
- We have a robust plan and we have implemented a number of changes this year to support us to manage winter pressures alongside the continued challenge of COVID-19, flu and industrial. Whatever your role, it is essential that you understand the plan and how you can contribute.
- We're doing all we can to support you, your teams and your services over the next few months – take a look at our winter plan to find out more.
- It's vital that everyone follows COVID-19 IPC, staff testing and patient testing guidance that is in place
- Maintaining patient flow is everybody's business.
- Delays at the emergency department for ambulance crews' impact on the availability of ambulances to deal with life threatening emergencies.
- Think Home First when it comes to discharges and work to get patients 'Home for lunch'
- Please be prepared to start conversations about discharge early on with patients and their families, and think about how to address any potential delays caused by patients and their families.
- Consider where patients can be moved to a virtual ward and use AHAH as much as possible.
- We want to embed a culture across the Trust in which we promote independence in everything we do.
- We know that this winter will be challenging - there is a range of free resources and advice available to help support you and your wellbeing.
- Thank you for everything you are doing to help us deliver excellent patient care at this time.
- Please get the flu vaccine and COVID-19 booster to protect yourself, your patients and your colleagues.

Line managers and HoDs

- Help us to make sure your team know about the winter plan and the role we all play in maintaining patient flow across the Trust.
- Support your teams to make the right decisions when it comes to discharging patients efficiently
- Please continue to check in with your teams and support their wellbeing, signposting to available resources.

Sub-messages - patients/visitors/general public

- Our services will be extremely busy over the winter period. You can help us by 'Thinking 111 First' and only attending the emergency department if you have an urgent or life-threatening illness or injury and by using the alternatives for less urgent needs.
- HUHY national messaging
- We will do everything we can to help you/your loved one maintain their independence.
- Staying in a hospital bed for longer than is necessary can cause more harm than good. Think Home First when you come into hospital.
- Help us get you or someone you care for home by lunch
- Please help us by staying well this winter - if you are eligible for a free flu or COVID-19 booster vaccine, it is because you need it, so please get it to protect yourself.
- If you are unwell and displaying symptoms of COVID-19, flu, a stomach virus or cold like symptoms please don't visit the hospital.

Sub-messages - system partners and wider stakeholders

- We have a robust plan to help us manage winter pressures, but we will need your support.
- Please consider what you can do in your role/organisation to help us provide the best possible care for people this winter, whether that's through supporting us to prevent admissions or helping us to discharge our patients in a timely way.
- Please help us by continuing to only refer patients to our emergency department when necessary.
- If you need support with a patient please call the relevant team at Royal Devon for advice if you can.
- Please consider how you can support us to encourage people to use our services appropriately.

APPROACH

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

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

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

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

- Develop communications for staff outlining what we are planning and when changes may happen:
    - Topics – bed escalation / 111 First / infection control guidance
    - Slide-set for use at key meetings outlining key elements of the plan and roles of staff.
- Work alongside staff health and wellbeing colleagues to develop the winter wellbeing campaign. This interactive campaign will focus on engaging staff in staying safe and well, and boosting morale as much as possible throughout the challenging winter period.

- Support other staff morale and wellbeing interventions as supported by the Trust Delivery Group. A detailed intervention action plan has been developed outside the scope of this plan, so while not directly linked, the winter communications plan aligns too and enhances this ongoing work.
- Waiting well external communication refresh – update external message to support those on waiting lists
- Develop seasonal communications to public which support them to make the best choices when in need of care.

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

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

The key actions are outlined below.

- Provide regular, timely and accurate operational updates alongside opportunities for staff to feedback
- Remind people of 'Think Home First' and early discharge campaign 'Home for lunch'
- Promote use of discharge lounge(s) as key part of maximising flow
- Promote use of virtual wards and remote monitoring in appropriate pathways to support capacity.
- Promote culture of supporting people to maintain independence.
- Carefully worded updates to primary care around e-referrals for advice and guidance.
- Promote use of Think 111 First to support appropriate use of the emergency department.
- Continue to promote national HUHY messaging and system comms
- Promote importance of not attending hospital if showing symptoms of certain illnesses – COVID-19. Flu, Norovirus
- Internal comms to acknowledge staff and say thank you – encourage looking after each other.

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

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

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

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

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

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

1. **Think 111 First** – choose well and behaviour change campaign to encourage contacting 111 before attending ED, or visit 111 online
2. **Flu and COVID-19 booster vaccination** – increase uptake in all groups and added messaging on measure in place to keep people safe, limit exposure, etc.
3. **GP access** – promotion of enhanced access, different models of care
4. Digital offer – online and video consultations, NHS app, ORCHA health and wellbeing app library, HANDi paediatric app and links with RSV
5. **Mental health** - support available for people, especially as we approach Christmas and New Year, and launch of 24/7 crisis lines, as well as crisis cafes and IAPT services
6. **Pharmacy and self-care** – promoting the GP community pharmacy consultation service (CPCS) for minor illness, raising awareness of pharmacy services, and the new local self-care campaign "Treatment starts at home"
7. **Inequalities** – focus on seldom heard groups working with local communities and community champions to undertake engagement and insight work, ensuring services are inclusive, translated, and easy read documentation. Support to access services and information outside of digital platforms, particularly for people with learning and/or physical disabilities.
8. **Early discharge** – system-wide campaign to support early discharge from hospital and improve flow

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

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

The communications team will work with operational leads to understand how best to capture and share learning and innovation to support operational resilience.

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

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

On-going/reactive

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

- Establish dedicated communications capacity at all times in-hours to support teams to get messages out quickly and in the most effective way.
- Ensure the communications team on call function supports teams with preparation for anticipated out of hours communications needs and is available to support out of hours when required.
- Ensure communications team proactively monitors local developments, as well as information and campaigns from NHS England and UK Heath Security Agency.
- Work with partners across the system to respond to reputational risks relating to performance and winter pressures in a timely, coordinated and credible way, which also recognises the efforts of staff.

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

Phase	Completed by	What	Audience	Outcome

MEASURES OF SUCCESS AND EVALUATION

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

Agenda item:		Date: 01 November 2023		
Title:	Integrated Performance Report – spanning both Northern and Eastern services within Royal Devon University Healthcare NHS Foundation Trust			
Prepared by:	Hannah Foster, Chief People Officer Adrian Harris, Chief Medical Officer Angela Hibbard, Chief Finance Officer Carolyn Mills, Chief Nursing Officer John Palmer, Chief Operating Officer Chris Tidman, Deputy Chief Executive			
Presented by:	Adrian Harris, Chief Medical Officer			
Responsible Executive:	Hannah Foster, Chief People Officer Adrian Harris, Chief Medical Officer Angela Hibbard, Chief Finance Officer Carolyn Mills, Chief Nursing Officer John Palmer, Chief Operating Officer Chris Tidman, Deputy Chief Executive			
Summary:	To advise the Board of the Trust's performance against key performance standards and targets; and progress on the implementation of the Trust Strategy and key supporting projects.			
Actions required:	The Board is asked to receive the Performance Report and note the current risks and the proposed action plans to mitigate the risks against performance delivery.			
Status (*):	Decision	Approval	Discussion	Information
				X
History:	This is a standing agenda item at each meeting of the Board of Directors.			
Link to strategy/ Assurance framework:	This paper details the Trust's performance in respect of key performance standards and targets. Achievement of these performance standards and targets is a key objective within the Trust's Strategy.			

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

Royal Devon University Healthcare NHS Foundation Trust

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Overview – Executive Themes and Actions to Raise at Board

This IPR covers the period of September 2023 which saw further Industrial Action (IA) from the BMA for consultant action between the 19th and 20th followed by junior doctors between the 20th and 23rd of the month. These periods of IA were even more exceptional given that during this period we had consultant and junior doctor action overlapping, a pattern then repeated between the 2-4th October. Once again these periods generated further disruption and delays to service provision. Our staffing body has continued to show immense respect to colleagues exercising their rights of representation and despite the more challenging nature of these rounds of action, remarkably we have still been able to staff most of our shifts safely throughout this period with rostered staff and volunteers. We noted in the last IPR the significant challenge we have to recover our Financial and Operational plan delivery against trajectories as we implement the Winter Plan and whilst this certainly remains the case, we have restored activity levels in September and October that have avoided precipitous worsening of our elective trajectories over the last month. The IPR in this cycle includes the now familiar visualisation of activity lost to Industrial Action and also an overview of our relative position against **National Operating Framework exit criteria**, which will receive even greater scrutiny over the next six months as we move into monthly **System Improvement Assessment Groups** chaired by the NHSE South West Regional Director. The NOF process and the balanced scorecard reflect the need for us to continue triangulating between our grip on **financial recovery**; **tier 1 processes**, our applied work on **never events**; and our **continued support for the system in terms of UEC and elective capability**, including the Nightingale.

Recovering for the Future

The financial position continues to show a **deterioration in month** with an adverse variance of £11.3m for plan. This takes the **year to date deficit to £28.9m**. Within this position are the costs of the impact of industrial action being £2.8m expenditure and £2.5m lost income. The national guidance is that this is still being negotiated and a resolution is expected. Once confirmed this will be backdated and improve the current position. The Finance Committee considered the national guidance on the forecast change proposal and agreed there was not enough certainty on a number of issues to adhere to the protocol and move the forecast position at this time. It was therefore agreed that the forecast position would be held to plan until more certainty can be given. There are a number of pressures being seen within the current run rate which are not associated with industrial action and although a number of recovery actions were agreed in month 4 these are not yet impacting on the level of spend. **A call to action on financial recovery has therefore been launched** to help drive a reduction in current levels of spend to improve the deficit for the last half of the year. The impact of this will need to be quantified as part of the certainty around the yearend forecast and although the Trust is wholly committed to doing all it can to improve the finances without compromising the safety of care to our patients it is anticipated that a forecast change will be enacted in the future.

Urgent care performance saw the Trust sitting behind the planned trajectory for both Type 1 and Types 1-3 targets but with an improvement month on month to 52.3% and 61.8% respectively. It is notable that both sites saw a reduction in attendances, which will have contributed to performance improvement (breaking the pattern of escalating demand over the previous six months). We continue to maintain a forensic drive on flow improvement through **UEC tier 1** by focusing on daily discharge by 12pm, discharge lounge optimisation, minors performance and overnight breaching and we are maintaining a strong focus on out of hospital activity. In this context No Criteria to Reside (particularly Eastern position) has deteriorated against trajectory (and funding mitigation for P1 pathway has been secured); Urgent Community Response continues to outperform national target by c. 20%; unallocated hours post social care assessment continue to reduce; and 205 admissions flowed into our 55 Virtual Ward beds in September (moving to 100 beds by year end). These will all be **essential elements of our Winter Plan** which is on the agenda today – and **the Community Strategy** which will come to November Board. As part of our drive on a large number of mitigations to improve our UEC flow position, over the next few weeks we are aiming to achieve a very strong alignment between the Integrated Care System's Winter Plan and our own, particularly coalescing around the **Care Coordinating Hub, the Strategic Control Centre and Virtual Ward**. Board members will be aware that we have written under separate cover to our system colleagues suggesting additional interventions that we feel will make an even contribution to closing both system and local bed gaps for Winter.

Overview – Executive Themes and Actions to Raise at Board

The Trust wide operational performance dashboard for September shows that our hopes for **increased elective activity levels** have been realised which is just about offsetting the worst impacts of Industrial Action in order to maintain an improvement trajectory month on month against each of our long waiting targets. We did declare two complex 104 ww patients ("pop ons") at the end of September as indicated was possible in the last round of the IPR. As a result of these late presentations we have commissioned a **final validation of our long waiting patient cohorts** and a check of our clinical outcoming processes with the support of NHSE and the ICB. The terms of this review have been reported through our Financial and Operational Committee this month. We are also now generating detailed weekly data for Elective Recovery tier 1 covering outpatients recovery. In addition we are also now driving a significant amount of collaborative activity through the **One Devon Assurance Board and GIRFT** which will mean in future IPR cycles we will be reflecting detailed operational working and further planning for collaboration with Torbay and South Devon NHS Foundation Trust in relation to cardiology; additional weekend activity at the Nightingale to support orthopaedic long wait demand in University Hospitals Plymouth; and proposals for Spinal Services to support the whole system – all in very close step with GIRFT colleagues through the ***further, faster*** programme.

For **cancer services**, we saw small deteriorations in month in relation to our 62 day waiting target (to 7.9%) and maintained a static position against the Faster Diagnosis Standard where we sit just off national compliance. These positions have regularised month to date in October, however we remain vulnerable on our 2 week wait performance which is principally driven by the huge demand spike in dermatology over the last six months and our regionally agreed support to colleagues in Taunton. This arrangement will shortly come to an end and we will seek to regularise. Our overall improvements resulting in our exit from cancer tiering were recognised by Dame Cally Palmer in a national session conducted with cancer charities last week, where we were presented as an exemplar for successful tier working.

Outside of the financial and operational plan targets, **Diagnostics performance** has deteriorated by just under 5% in Northern Services against the 6 week DMO1 target (despite some good modality performance) and Eastern's position has marginally improved. The improvement team continue to work on a detailed forward trajectory for these services to match those in our other prioritised domains. This trajectory should reflect the welcome initiation of the modular endoscopy function in future IPR cycles.

Collaborating in Partnership

The Board will receive an update on the **community strategy in the November Board cycle** following the strategic paper reviewed in July and the **Winter Plan** at Board today will once again be fundamentally underpinned by the partnership working inherent in the Help People Home Without Delay programme. Meanwhile, the Trust's Interim Chief Executive has written to the ICB with a proposal to build further on our Winter Plan with a range of potential further commitments that will continue to grow our most successful in and out of hospital services such as Virtual Ward, Same Day Emergency Care as well as seeking to support system interventions like the Care Coordinating Hub. We continue to provide significant UEC support to the system as it has suffered several periods of OPEL System 4 over the last six weeks and we are looking to fully understand the learning from the 17 weeks of postcode catchment change which completed on the 10th October 2023. We are hugely grateful to our lead clinicians whom absorbed c. 150 patient attendances and 80 additional admissions during that period in addition to our normal levels of support. This can only be seen as a significant contribution to the safety of the Devon system.

Overview – Executive Themes and Actions to Raise at Board

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 the last IPR we indicated that the CMO and CNO would be undertaking **harm reviews of four never events**, the result of which has been no harm in three cases and minor harm in one case. **One serious incident** occurred in the Trust in September in Northern Services in relation to ophthalmology; and a learning review and duty of candour process has been completed. **Three moderate harm medication incidents** took place with two relating to medicines reconciliation issues for a patient at different stages of their pathway, where they received a medication no longer prescribed. Again, these harms are under review. It is also important to note that **19 patient safety incidents** were reported relating to staffing shortages – all of which were assessed as either no harm or minor harm, but we should balance this against current nursing fill rates of 97.25% for Northern and 93.5% for Eastern Services. We also received **notification from the PHSO on two new primary investigations** which will determine whether a full investigation is required.

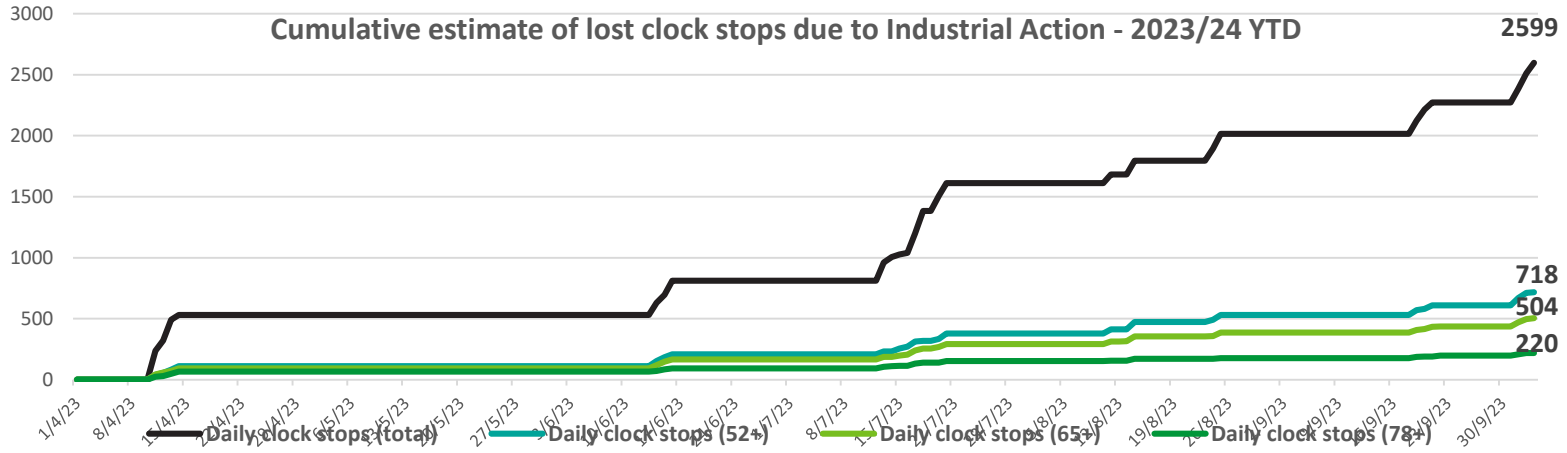
The CNO and CMO are undertaking a series of review activities to ensure that reflection, learning and training are taken from never events and the next leadership event for our senior teams across the organisation will be entirely given over to reflection, learning and follow up activities to provide further assurance.

In this IPR we have expanded the data relating to patient experience; and we note the sustained improvement in volume of complaints closed by early resolution driven by new complaints investigation process. In month we should also note that HSMR remains stable and reducing on a rolling 12 month basis; SMHI remains within expected range; and pressure ulcer and falls incidence remains within normal variation.

A Great Place to Work

Our people intelligence continues to reflect a largely positive picture, with vacancy rate and turnover continuing to fall. The **reduction in vacancies** is now starting to be reflected in the recruitment pipeline data, with reduction of recruitment activities in all stages of the recruitment process. The **sustained reduction in turnover** is positive and will be providing greater stability to the trust, with no staff groups now exceeding the planned rate of 13.5%. Whilst all of this is very positive, it is unfortunate that the levels of temporary staffing usage have not fallen in line with the reduced vacancy rate, with agency spend currently above plan despite rigorous controls being in place. This indicates that whilst vacancies are low, additional staff are still seen as a necessity in some areas. This is likely reflective of a multitude of factors, not least the sustained Industrial Action the Trust has seen in recent months, combined with sickness levels beginning to show signs of increasing. There continues to be a significant focus on reducing temporary staffing usage to support the delivery of the operational plan.

Industrial Action Impact – Local Analysis



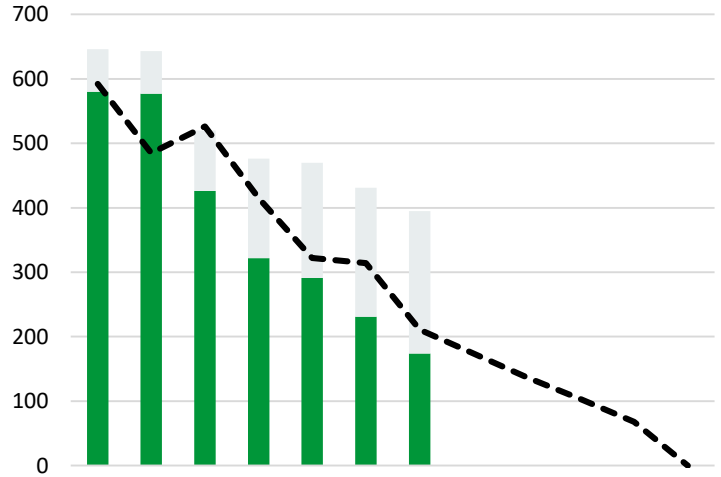
Cumulatively, 2599 clock stops estimated to be *lost* due to Industrial this financial YTD. Of these:
718 x 52+ weeks, 504 x 65+ weeks & 220 x 78+ weeks.

Month	All clock stops	52+ clock stops	65+ clock stops	78+ clock stops	Industrial Action
Apr-23	530	110	92	66	Junior Doctors 11-14th
May-23	0	0	0	0	RCN 1st May
Jun-23	282	99	75	28	Junior Doctors 14-16th
Jul-23	800	170	125	60	Jr Dr's 13-18th, Dr's 20-21st
Aug-23	404	153	96	25	Junior Doctors 11-14th, Dr's 24-25th
Sep-23	256	79	49	21	Junior Doctors 20-23rd, Dr's 19-21st
Oct-23	328	107	67	21	Junior Doctors & Dr's 2-4th
Total	**2599**	**718**	**504**	**220**	

Data source: Local BI data on daily clock stops

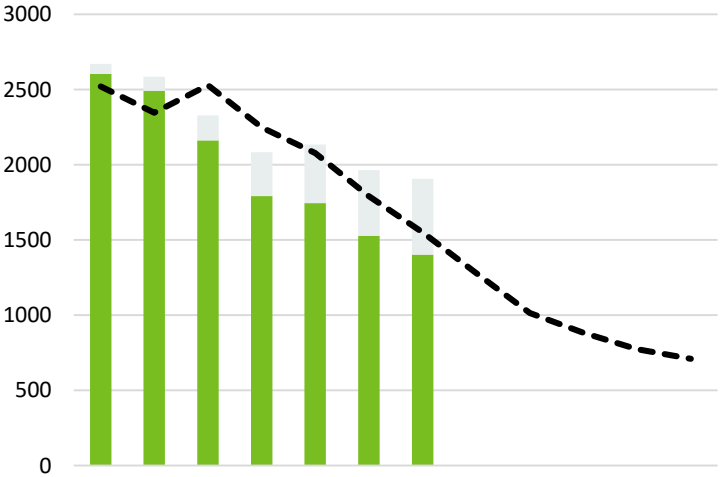
Industrial Action Impact – Local Trajectory Analysis

78+ week waiters - Estimate of Trust position without IA



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
IA Lost Activity	66	66	94	154	179	200	221					
Position without IA	580	577	426	322	291	231	174					
Plan	592	485	526	415	322	314	211	174	137	103	68	0

65+ week waiters - Estimate of Trust position without IA



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
IA Lost Activity	66	92	167	292	388	437	504					
Position without IA	2606	2493	2162	1791	1746	1528	1402					
Plan	2520	2346	2530	2249	2078	1790	1550	1280	1014	881	774	710

Data source: Month end RTT performance and local BI data on daily clock stops

Balanced Scorecard – Looking to the Future

Successes

- Well led and managed Industrial Action periods (despite dual running)
- Recruitment & retention plans continue to show positive results in relation to vacancies
- Completion of provision of a postcode catchment change to support neighbouring Trusts
- Embedding of the Improvement Director to drive performance against financial and operational plan
- Maintenance of elective recovery and quartile 1 level performance from Nightingale SWAOC, CDC and CEE
- Initiation of elective collaboration through GIRFT on cardiology, spinal and orthopaedic services
- National Cancer session as tier 1 exemplar

Opportunities

- Delivery of the 2023/4 financial and operational plan
- Progressive offer to ICB to go further on Winter Plan measures.
- TIF bid for elective infrastructure to resubmit
- GIRFT bid for cardiology 7 day working in development
- Rapid implementation of the Northern Services Acute Medicine Model
- Initiation of the Management of Change consultation in support of OSIG in November
- Development of UEC tier 1 plan / Winter Plan / Community Strategy
- Continuation of Elective Recovery tier 1 plan to clear 78 and 65ww patients
- GIRFT further and faster programme – cardiology, spinal and orthopaedics
- Primary Care Risk Assessment with the ICS
- Learning from Never Events programme of activity.

Priorities

- Safety of our services with a focus on ED and overall flow
- Staff Health and Wellbeing
- Improvement of approach to Devon UEC and its funding streams
- Delivery of the 2023/4 financial and operational plan and focus on NOF exit criteria
- Delivering our financial recovery programme
- Reducing the number of NCTR patients through ICB/Region/National escalation (particularly Northern)
- Completion of our detailed Business Informatics plan and data layer
- Standardisation of job planning and leave planning.

Risk/Threats

- Continued Industrial action (new balloting process underway)
- Balancing Devon System support with demands of UEC Tier 1 performance
- Access to UEC funding slippage to support Devon Winter Plan.
- Potential loss of confidence in reporting due to continued data quality issues (though improving confidence)
- Staffing Resilience in Northern Services – Medical, Nursing, HCA and Ancillary
- Staff Morale with constant pressure and cost of living challenges
- Inability to balance delivery across financial and operational plan
- Primary care fragility
- Challenge of taking and applying learning from Never Events.

Financial & Operational Exit Criteria Measures

UEC	Improvements in line with agreed baseline and plan, over two quarters, in ambulance handover delays (>15 minutes & > 3 hours)
	Improvements in line with agreed baseline and plan, over two quarters, in ambulance response times for Category 2 incidents to 30 minutes on average over 23/24, with plan for further improvements in 24/25
	Improvements in line with agreed baseline and plan, over two quarters, in total average time in ED & 12 hour breaches. (Trajectory to achieve 76% by 23/24)
	Month on month improvements, over one quarter, in pre-midday Discharges against agreed baseline and trajectories
	Achieve and sustain for two quarters a reduction in number of patients who no longer meet the "criteria to reside in hospital" to no more than 5%
	Achieve and sustain for two quarters a reduction in number of patients who no longer meet the "criteria to reside in hospital" to no more than 2019 levels by end of 23/24
	CQC confirmation of UHP compliance with Conditions on the trust's Licence
Elective Recovery	Reduction in waits over 104 weeks and 78 weeks, inline with agreed plan, against agreed baseline
	Significant reduction in 65 weeks by March 2024, inline with agreed plan, against agreed baseline
	75% of GP referred patients diagnosed within 28 days
	To exit Tier 1: The percentage of patients waiting over 62 days to start cancer treatment across the system is less than double the requirement for March 2023 (≤12.8%) and working towards achieving the national target.
	To exit Tier 1: The weekly number of patients waiting over 62 days decreases over 4 consecutive weeks and remains stable, or improving for 2 out of 3 months for the quarter
Finance	There is confirmation of the underlying run rate from 2022/23 and an improvement in the actual recurrent run rate in the 2023/24 plan
	The 2023/24 plan shows an improvement in productivity compared to 2022/23
	A system-wide shared services programme is developed that has all back office functions within scope and includes accompanying timelines and delivery plans
	The system delivers the financial plan for 2023/24 recurrently for two successive quarters
	The system delivers improvements in productivity in 2023/24 for two successive quarters

Off track against trajectory with concerns regarding delivery
Off track against trajectory, but plans in place to recover
Delivering against criteria or trajectory
Does not apply to RDUH

One Devon

Trust Executive Summary

Trust wide — Operational Performance Dashboard

Domain	Measure/Metric	Definition	Last Month Aug-23	This Month Sep-23	FOP Trajectory	Planned Trajectory	National target	FOP EOY Target
Trust Operational Plan Metrics	RTT 65 Weeks waited	Total count	2134	1965	-169	1790		710
	RTT 78 Weeks waited	Total count	470	431	-39	313		0
	RTT 104 Weeks waited	Total count	2	2	0	0		0
	Cancer - Over 62 day waiters	Total count	255	291	36	294		198
	Cancer - % 62 day waiters against total open pathways	% patients over 62 days against open pathway	7.0%	7.9%	0.9%			6.4%
	Cancer - 28 day faster diagnosis	% patients receiving diagnosis in 28-days	71.6%	71.1%	-0.5%	71.8%	75%	75.1%
	A&E - Type 1 - 4 hr performance	% patients seen in Type 1 sites in 4-hrs	50.3%	52.3%	2.0%	61.9%		70.2%
	A&E - All 4-hr performance	% patients seen in All sites in 4-hrs	59.2%	61.8%	2.6%	68.1%	95%	76.0%
	No criteria to reside	Average daily count	102	117	15	72		50
	No criteria to reside	NCTR as a % of occupied beds	10.0%	11.2%	1.2%	6.7%		4.9%
Trust Financial Plan	Financial Performance : I&E surplus / (Deficit)	Year to date position £000	(19,282)	(28,956)		(17,635)		(28,035)
	Delivering Best Value financial savings delivery	Year to date position £000	17,552	21,067		16,128		60,300

Positive Value | Negative Value < 5% | Negative Value > 5%

Northern Services Executive Summary

Northern Services Operational Performance Dashboard

Domain	Measure/metric	Definition	Last Month Aug-23	This Month Sep-23	Vs prior month	Planned	National target
ELECTIVE ACTIVITY	Outpatient activity (New)	*Vs baseline (2019/20)*	**101.8%**	**120.2%**	18.4%	137.4%	104%
	Outpatient activity (FU)	*Vs baseline (2019/20)*	**134.2%**	**142.6%**	8.5%	111.8%	75%
	Outpatient procedures	*Vs baseline (2022/23)*	**220.5%**	**190.5%**	-30.0%	169.7%	
	Elective inpatient activity	*Vs baseline (2019/20)*	**60.3%**	**62.6%**	2.3%	91.5%	104%
	Elective daycase activity	*Vs baseline (2019/20)*	**113.6%**	**118.1%**	4.5%	117.4%	104%
	RTT 18 week performance	*Patients seen <18 weeks vs total Incomplete pathways*	**51.2%**	**51.6%**	0.4%		92%
	Incomplete pathways	*Total count*	**24407**	**23971**	-1.8%	23187	
	RTT 52+ weeks waited	*Total count*	**2856**	**2538**	-11.1%	2746	
	RTT 65+ weeks waited	*Total count*	**1061**	**967**	-8.9%	939	
	RTT 78+ weeks waited	*Total count*	**210**	**190**	-9.5%	123	
	RTT 104+ weeks waited	*Total count*	**0**	**0**	100.0%	0	
CANCER	2 week referrals	*Performance*	**93.1%**	**86.2%**	-6.9%		93%
	28 day faster diagnosis standard	*Performance*	**75.4%**	**74.8%**	-0.6%	60.4%	75%
	Urgent GP referral 62 day	*Performance*	**100.0%**	**76.4%**	-23.6%		85%
	Cancer - Over 62 day waiters	*Total count*	**43**	**47**	9.3%	97	
	Cancer - % 62 day waiters against total open pathways	*% patients over 62 days against open pathway*	**5.4%**	**6.2%**	0.8%		

Domain	Measure/metric	Definition	Last Month Aug-23	This Month Sep-23	Vs prior month	Planned	National target
URGENT CARE	Non-elective Inpatient activity +1 LOS	*Vs baseline (2019/20)*	**107.7%**	**107.5%**	-0.3%	79.5%	
	A&E attendances	*Vs baseline (2019/20)*	**121.1%**	**124.5%**	3.4%	86.8%	
	4 hour wait performance	*Patients seen <4 hours vs total attendances*	**57.0%**	**59.6%**	2.6%	69%	95%
	Ambulance handover delays >30 minutes	*Total count*	**352**	**371**	5.4%		
	Residual no criteria to reside	*Average daily count*	**41**	**39**	-4.9%	32	
	Residual no criteria to reside	*NCTR as a % of occupied beds*	**14.0%**	**13.3%**	-0.8%	10.9%	
DIAGNOSTICS	6 week wait referral to diagnostic test	*% of diagnostic tests completed in 6 weeks*	*60.0%*	*55.5%*	-4.6%	*N/A*	99%
	MRI activity	*Vs baseline (2019/20)*	*116.6%*	*116.9%*	0.3%	104.5%	
	CT activity	*Vs baseline (2019/20)*	*149.5%*	*137.1%*	-12.4%	137.6%	
	Medical Endoscopy activity	*Vs baseline (2019/20)*	*123.9%*	*133.7%*	9.8%	114.1%	
	Non-obstetric ultrasound activity	*Vs baseline (2019/20)*	*98.3%*	*116.9%*	18.6%	112.8%	
	Echocardiography activity	*Vs baseline (2019/20)*	*106.7%*	*116.4%*	9.7%	109.7%	

Positive value

Negative value < 5%

Negative value > 5%

Eastern Services Executive Summary

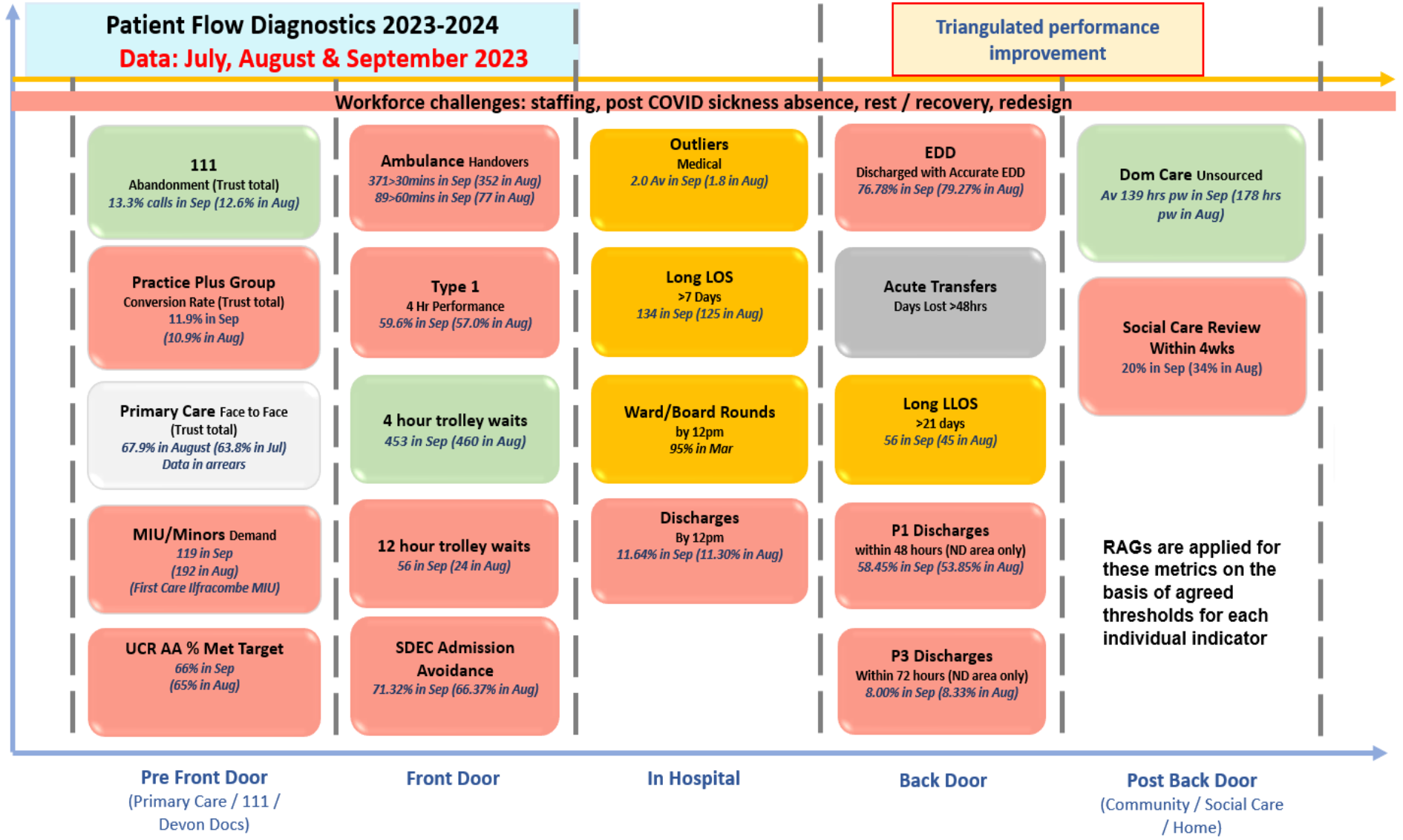
Eastern Services Operational Performance Dashboard

Domain	Measure/Metric	Definition	Last Month Aug-23	This Month Sep-23	vs Prior month	Planned	National target
ELECTIVE ACTIVITY	Outpatient Attendances (NEW)	vs baseline (2019/20)	108.6%	**97.2%**	-11.4%	95.5%	104%
	Outpatient Attendances (FOLLOW-UP)	vs baseline (2019/20)	135.9%	**126.8%**	-9.1%	127.6%	75%
	Outpatient Procedures	vs baseline (2019/20)	131.4%	**115.8%**	-15.6%	110.2%	
	Elective Inpatient Activity	vs baseline (2019/20)	64.3%	**59.7%**	-4.5%	88.4%	104%
	Elective Daycase Activity	vs baseline (2019/20)	107.4%	**114.5%**	7.2%	121.6%	104%
	RTT 18 Week performance	Patients seen <18 weeks vs total incomplete pathways	56.1%	**56.4%**	0.3%		92%
	Incomplete Pathways	Total count	54758	**55103**	0.6%	57758	
	RTT 52 Weeks waited	Total count	3084	**2883**	-6.5%	1997	
	RTT 65 Weeks waited	Total count	1073	**998**	-7.0%	851	
	RTT 78 Weeks waited	Total count	260	**241**	-7.3%	190	
	RTT 104 Weeks waited	Total count	2	**2**	0.0%	0	
CANCER	14 Day Urgent	Performance	62.7%	46.9%	-15.9%		93%
	28 day faster diagnosis standard	Performance	70.3%	69.7%	-0.6%	75.2%	75%
	Urgent GP referral 62 day	Performance	65.0%	67.6%	2.7%		85%
	% 62 day waiters against total open pathways	62 day waits as a % of total pathways	7.5%	8.4%	0.9%		
	Count of open pathways over 62 days	Total count	212	244	15.1%	197	

Domain	Measure/Metric	Definition	Last Month Aug-23	This Month Sep-23	vs Prior month	Planned	National target
URGENT CARE	Non-elective Inpatient activity +1 LOS	Vs baseline (2019/20)	109.3%	**104.1%**	-5.2%	97.0%	
	A&E attendances	vs 19/20 baseline	87.3%	**88.9%**	1.7%	76.5%	
	4 hour wait performance Type 1 only	Patients seen <4hrs vs total attendances	45.6%	**47.4%**	1.8%	57.0%	95%
	4 hour wait performance Type 1-3	Patients seen <4hrs vs total attendances	60.3%	**62.7%**	2.5%	67.3%	95%
	Ambulance handover delays >30 mins	Total count	558	**434**	-28.6%		
	Residual : No Criteria to Reside count	Average Daily count	61.0	**78.0**	21.8%	50	
	Residual : No Criteria to Reside proportion	As a % of occupied beds	8.4%	**10.4%**	2.0%	6.5%	
DIAGNOSTICS	6 week wait referral to diagnostic test	% of diagnostic tests completed in 6 weeks	60.6%	61.2%	0.7%		99%
	MRI activity	vs 19/20 baseline	111.9%	108.6%	-3.3%	107.4%	
	CT activity	vs 19/20 baseline	132.3%	127.6%	-4.6%	115.1%	
	Medical Endoscopy activity	vs 19/20 baseline	79.6%	81.9%	2.3%	94.3%	
	Non-obstetric ultrasound activity	vs 19/20 baseline	103.6%	99.1%	-4.6%	92.3%	
	Echocardiography activity	vs 19/20 baseline	150.7%	151.6%	0.9%	155.4%	

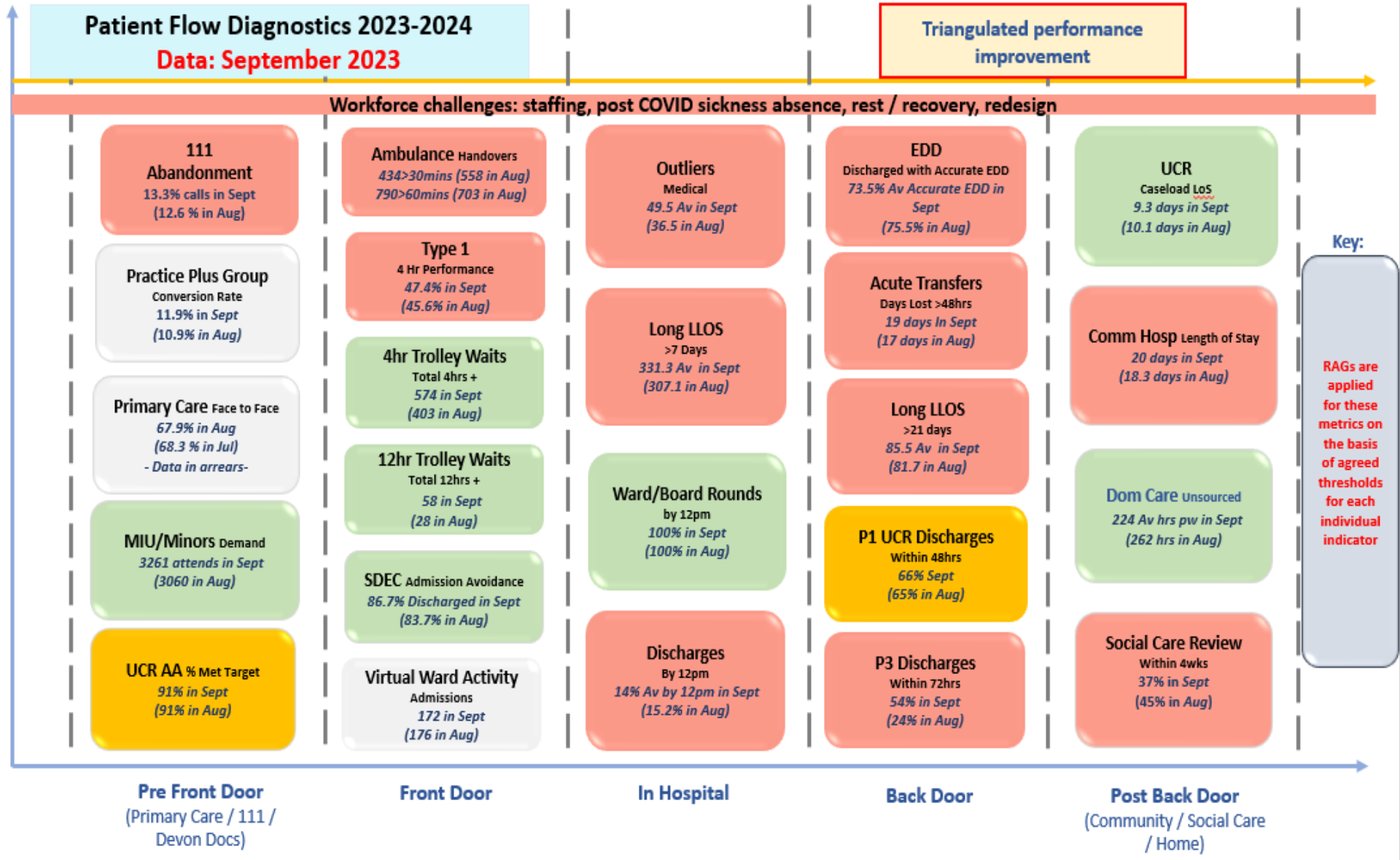
Positive Value | Negative Value < 5% | Negative Value > 5%

Northern Services Patient Flow Diagnostic

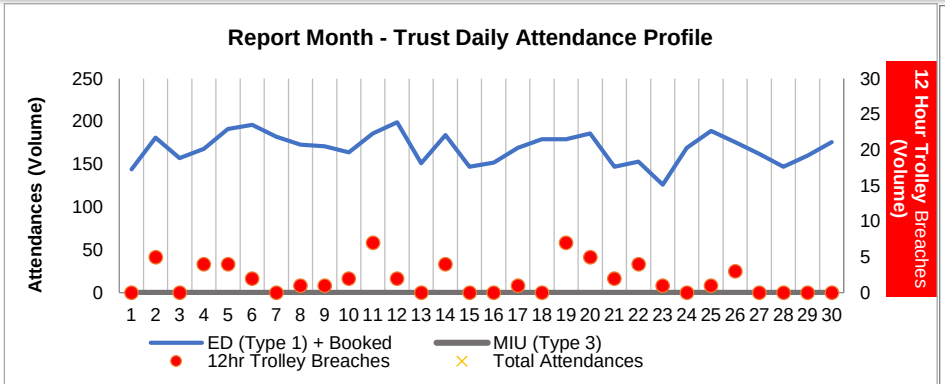


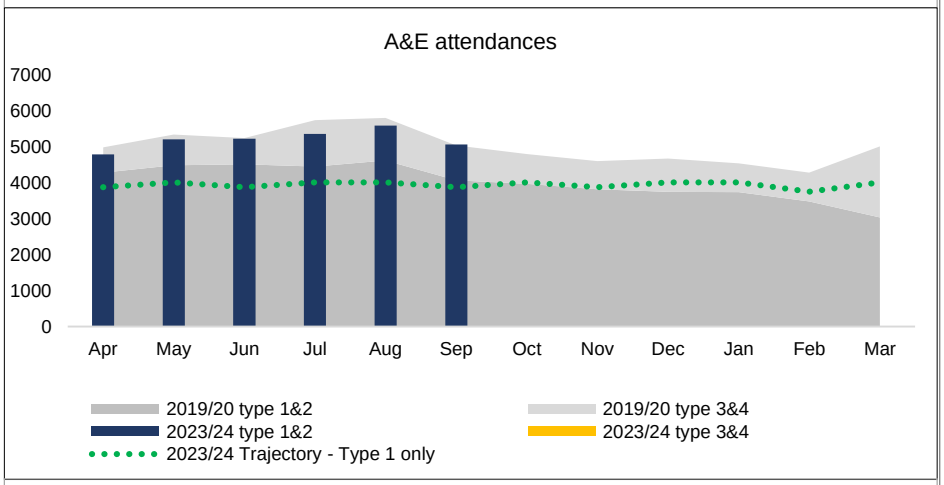
Eastern Services Executive Summary

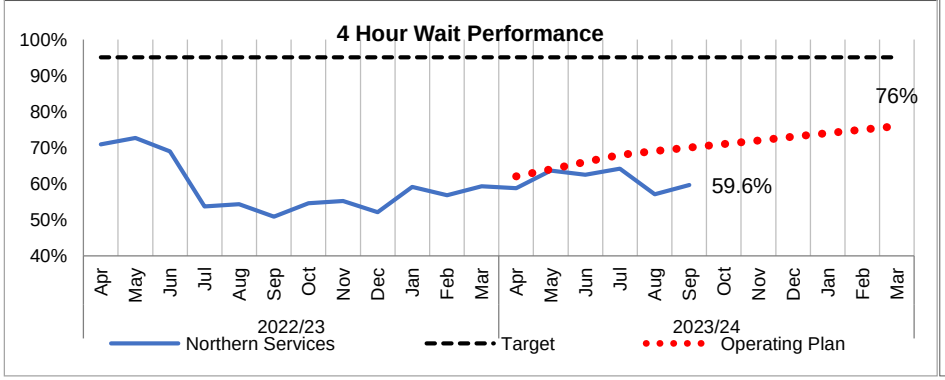
Eastern Services Patient Flow Diagnostic



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



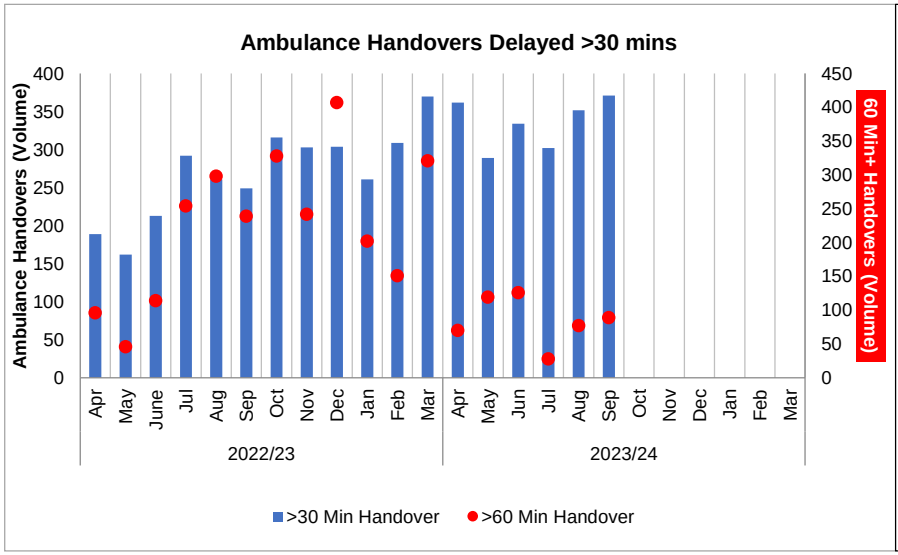


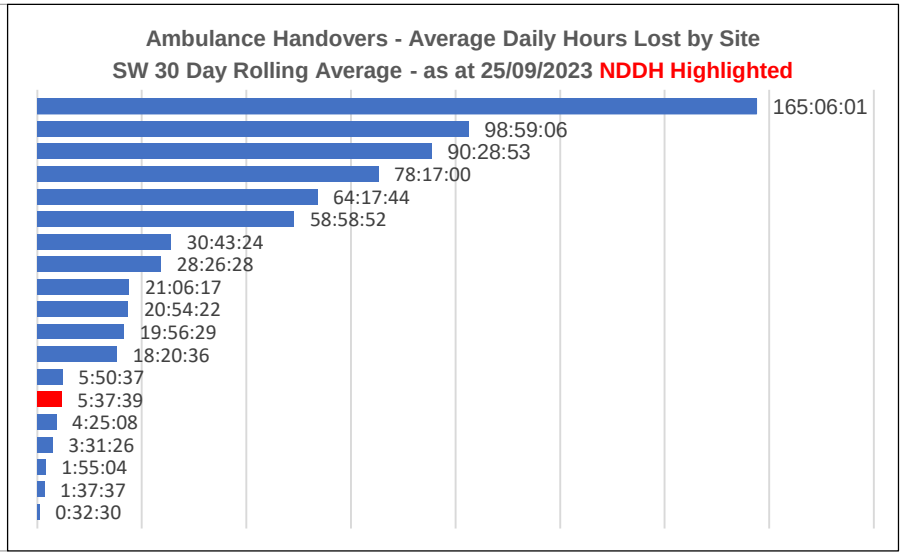


Type of Activity	Denominator	Patients > 4 Hours	% Performance
ED Only	5064	2044	59.6%

- There was a decrease of 527 attendances in September compared to August. However, this was still a 15.88% increase against attendances in September 2022.
- The service reported a 2.6% increase in performance in September against the 4 hour waiting times target.
- The number of 4-Hour breaches decreased from 2403 in August to 2044 in September.
- ED saw a decrease in attendances in September with a peak of 199 attendances on the 12th September.
- An action plan is in place with actions to support improvement in 4 hour performance.

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

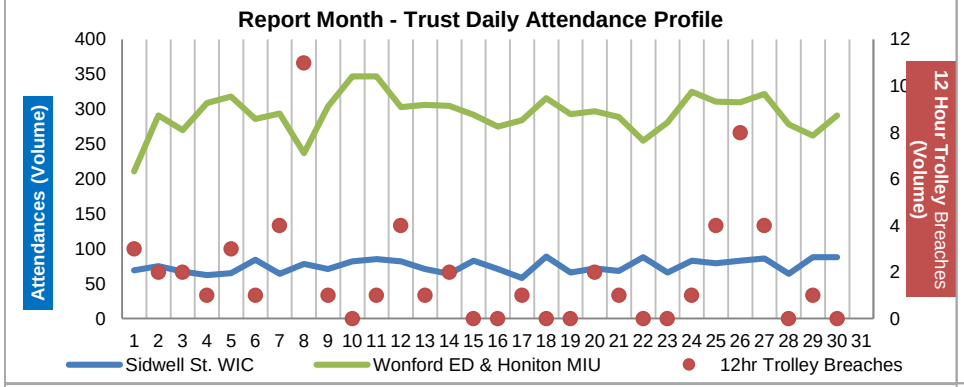


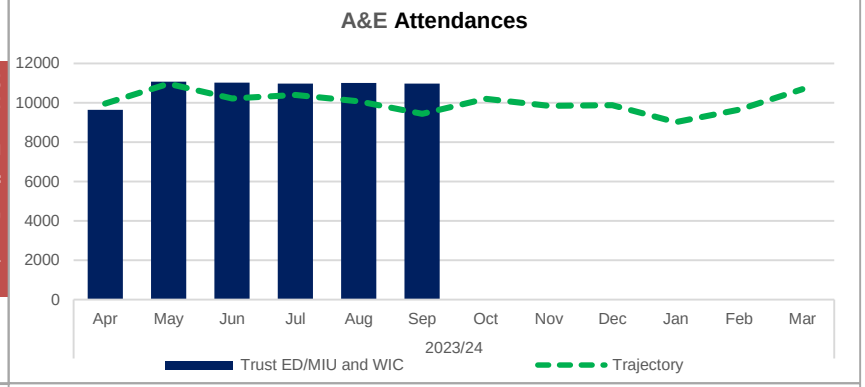


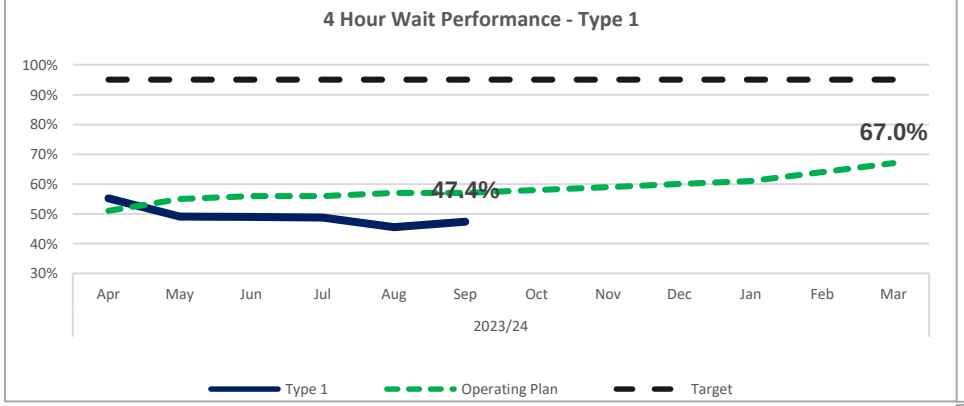
- Ambulance handover delays greater than 60 minutes increased by 12 in September and 30 minute handover delays increased by 19.

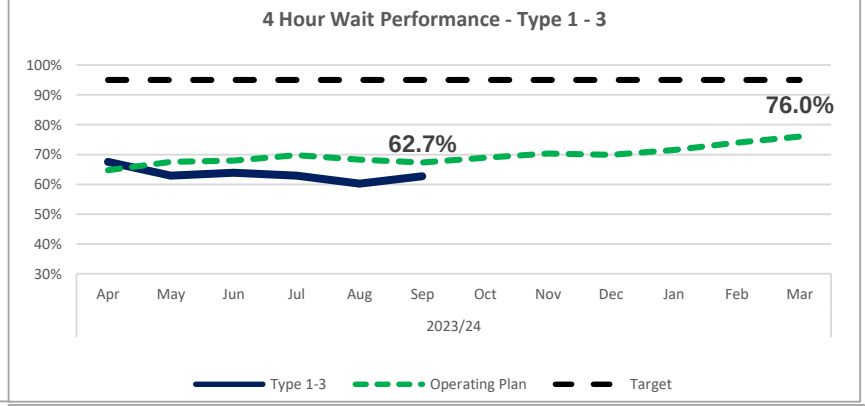
Eastern Services Emergency Department

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









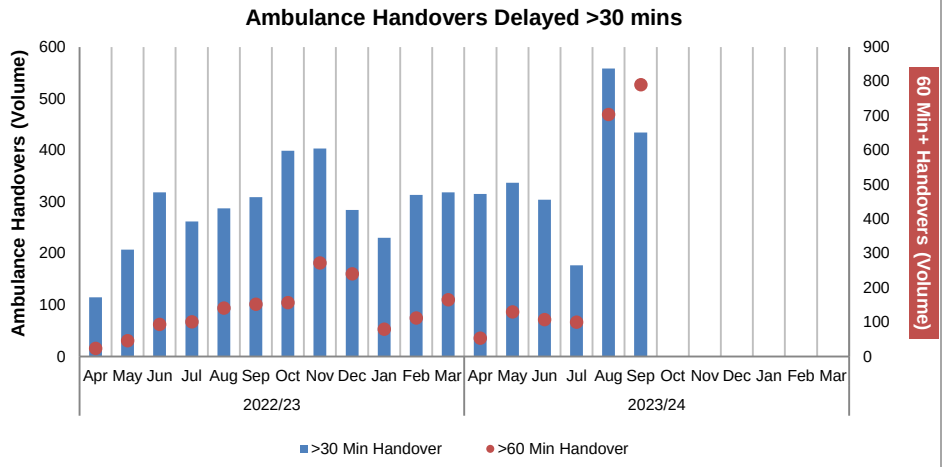
Type of Activity	Denominator	Patients > 4 Hours	% Performance
ED Only	7705	4053	47.40%
All RD&E Delivered Activity (including Honiton MIU and the WICs)	10966	4086	62.74%
Total System Performance (including MIUs)	13525	4263	68.48%

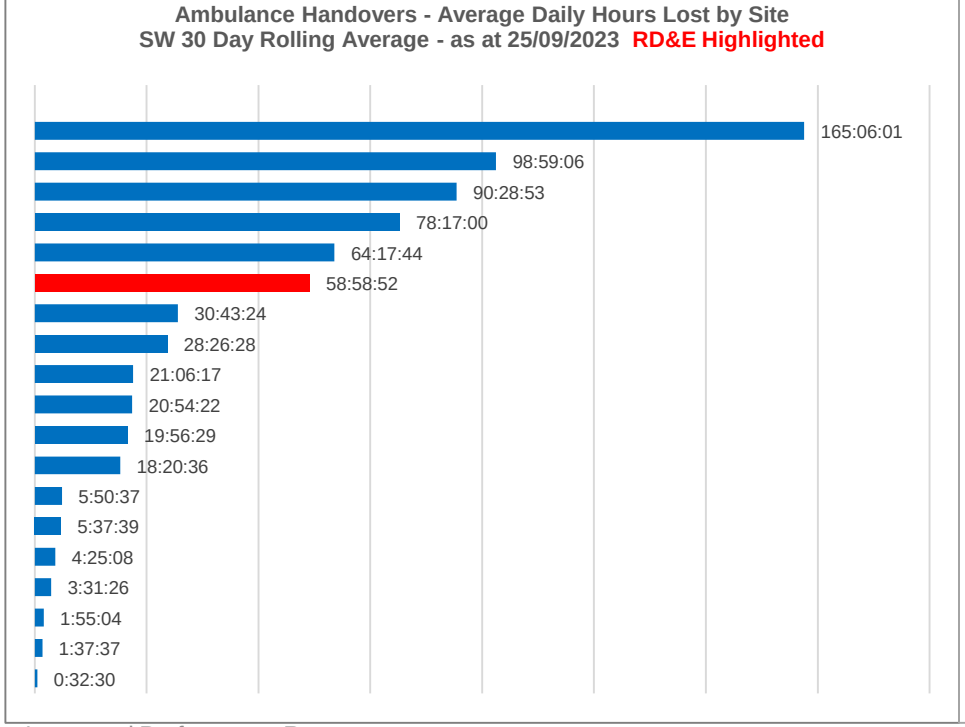
Overall Performance:

- All Type – 4 hour performance increased from 60.26% in August to 62.74% in September (Eastern All Type trajectory for September 67.28%).
- ED Type 1- 4 hour performance increased from 45.56% in August to 47.40% in September (Eastern Type 1 trajectory for September 57.0%).
- Type 1 daily attendance figures were on average 257 per day, representing continued high demand.

Eastern Services Emergency Department

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





Overall Performance:

- SDEC activity saw a slight increase in September, up 10.7% from August with a weekday average of 20 attendances per day.
- Admissions from SDEC decreased from 16.3% in August to 13.3% in September.
- The virtual ward saw 205 admissions (172 Eastern and 33 Northern) with a peak number of patients of 51, the daily average was 32. A plan has been agreed to accelerate virtual ward bed capacity by December 2023.

- **Actions being taken to improve performance**

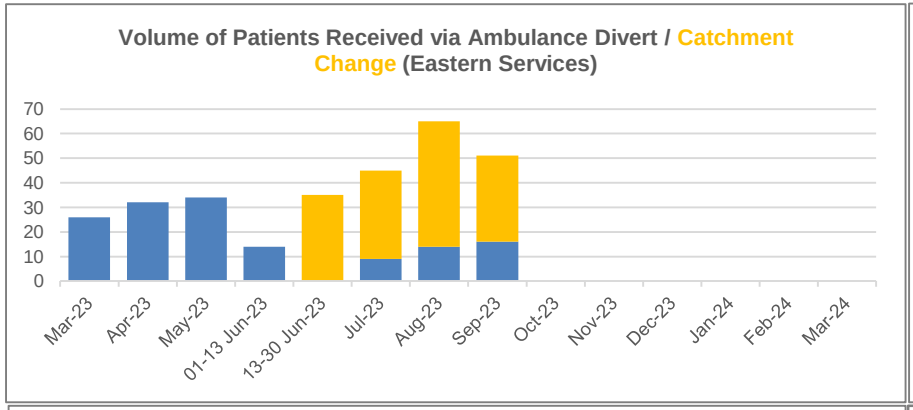
- UEC Simulation Modelling being undertaken with Deloittes.
- ECIST onsite audit of ambulance handovers.
- Task and finish group to reduce attendances of specialty expected patients to ED.
- Focus on improvements to initial time to triage (proportion of patients assessed within 15 minutes of arrival for ambulance arrivals and walk ins).
- Implementation of Trust Internal Professional Standards.
- GP Streaming to reduce minors' attendances and improve performance.
- Focus on mental health patient pathways.
- Extension of Safety Huddles to include evening review

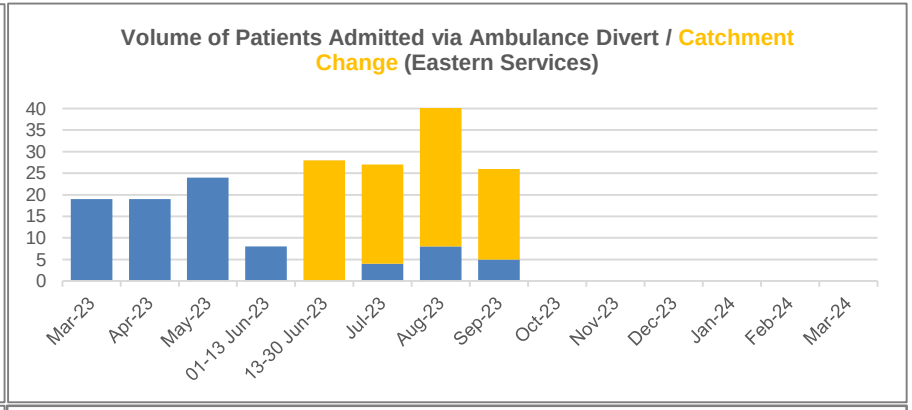
- **Focus on ambulance reporting**

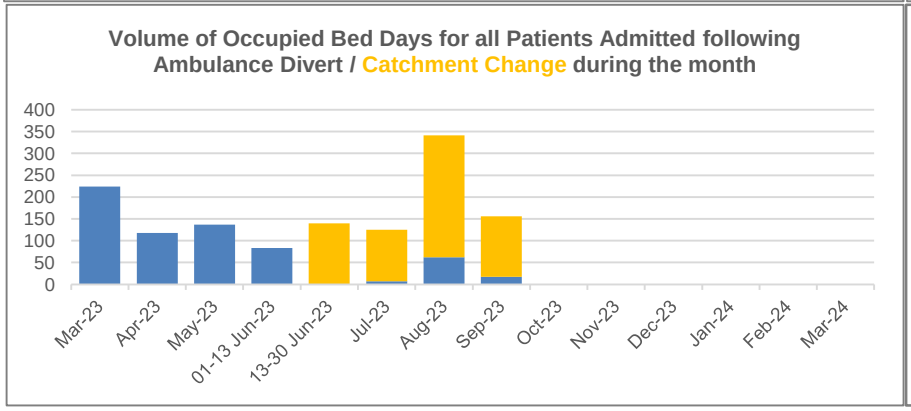
- Monthly ambulance handover meetings established with SWAST to review processes and improvements.
- Regional Hospital Handover Data Quality Task & Finish Group.
- Devon Ambulance Cell and ICB Eastern locality top 5 system priorities to improve ambulance handover delays; MH pathways, specialty expected patients to ED, GP streaming, ED e-triage and ambulance handover data validation.
- ICB/SWAST implementation of X-CAD hospital ambulance arrivals screens and scoping the possibility of reactivating the dual pin sign off to improve accuracy of ambulance handover times.

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	27	21	6	21	2	4
April 2023	19	18	1	14	4	1
May 2023	29	20	9	18	11	0
June 2023	7	2	5	4	2	1
July 2023	0	0	0	0	0	0
August 2023	11	8	3	4	4	3
September 2023	8	5	3	2	0	6







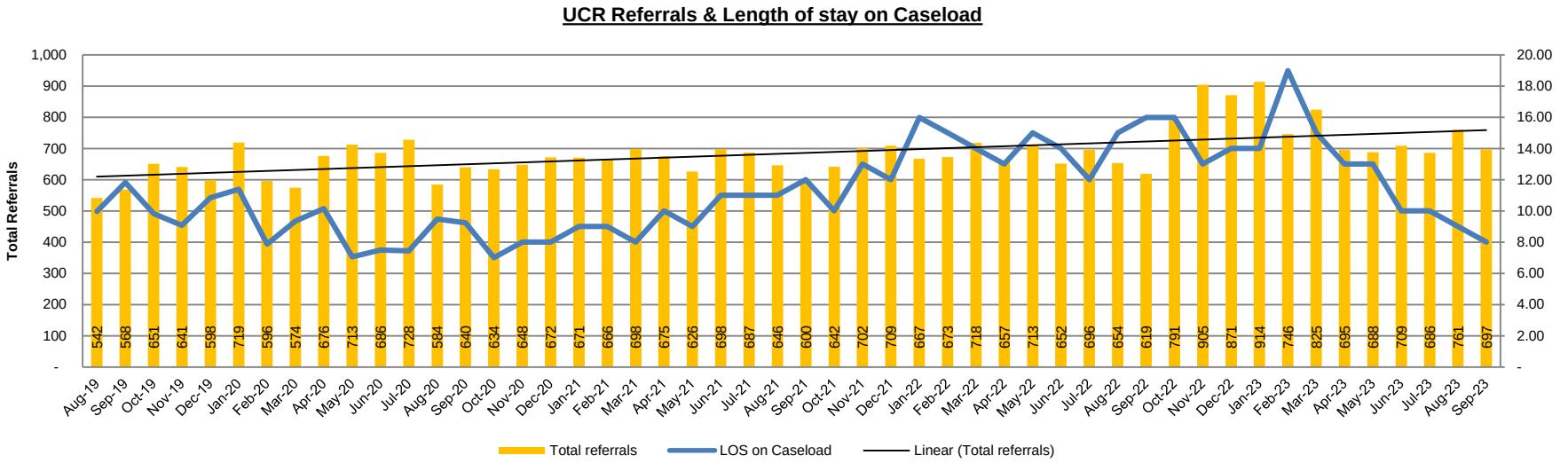
Trust – Provision of System Support for Planned Care

Number of Mutual Aid Requests received by RDUH					
	Received	Completed	Declined	Ongoing	Under Consideration
Apr-23	2		2		
May-23	3		2	1	
Jun-23	2			1	1
Jul-23	1		1		
Aug-23	3		2		1
Sep-23	2			1	1

Number of Mutual Aid Requests made by RDUH					
	Made	Completed	Declined	Ongoing	Under Consideration
Apr-23	1				1
May-23	0				
Jun-23	0				
Jul-23	0				
Aug-23	0				
Sep-23	0				

Trust Urgent Community Response

Admission avoidance and discharge



Urgent Community Response (UCR) Demand and Performance

- Demand for UCR (admission avoidance and supporting discharge) slightly decreased from August to September.
- For September, there were 336 community admission avoidance referrals. We continue to surpass the national target (75%) with 96% of the urgent referrals being responded to within 2 hours.
- Length of stay on the caseload has significantly improved and this is largely down to improved market capacity for domiciliary care which enables UCR teams to discharge patients onto long term care providers in a more timely way.
- Increased senior clinical and operational support to teams has also supported a reduction in length of stay on the caseload, as the teams are more supported to take proportionate risk appetite is being taken.

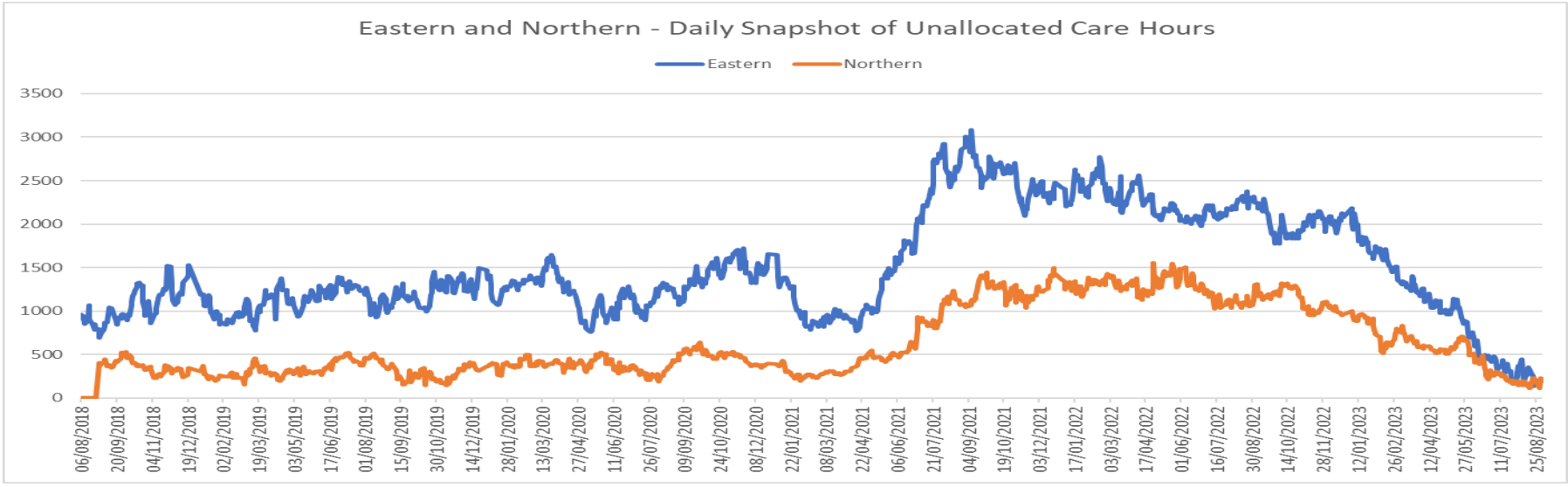
Future developments for UCR

- Increasing demand for UCR from SWAST – currently we respond to an average of 35-40 'SWAST level 1 and level 2 fallers' referrals each month.
- The Care Coordination Hub pilot over winter will support more effective use of existing pathways and greater integration of UCR and Virtual Ward pathways.
- UCR will be open to accept self referrals and respond to Appello pendant alarm referrals from the end of November.

Northern and Eastern Community Services Unallocated and Backfill

Unallocated domiciliary care hours, and backfill position

Unallocated Hours - Post Care Act

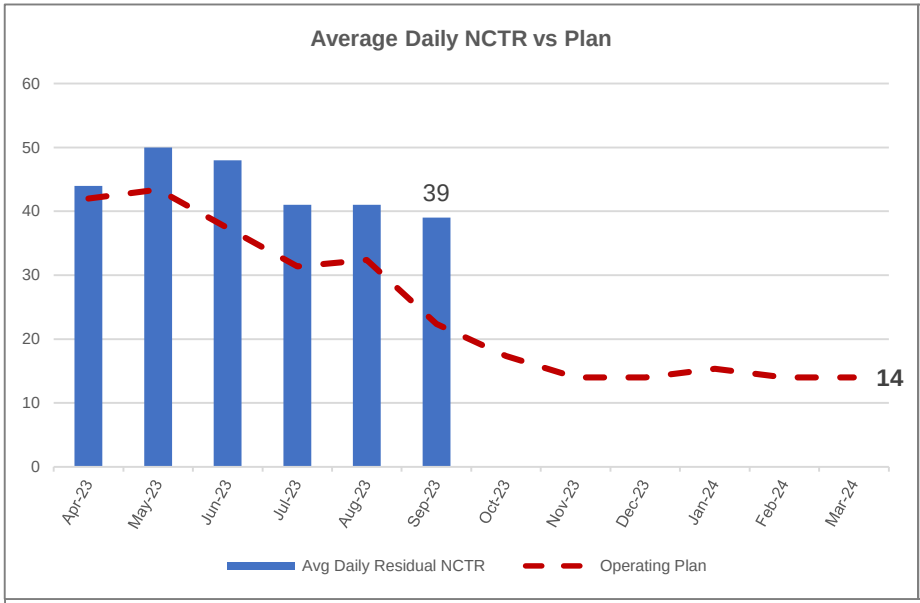


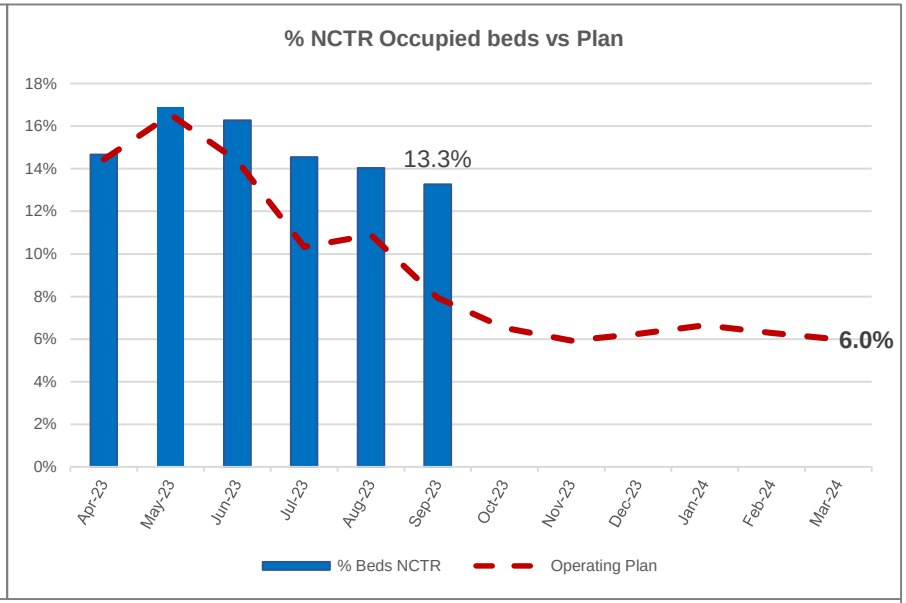
Overall - Unallocated Hours

- Unallocated hours are the number of care hours yet to be provided for in the market after the social care assessment (patients awaiting package of care).
- Total unallocated care continued its downward trend and is a significantly improving position; this is due to effective stimulation of the domiciliary care market with new care agencies coming online and international recruitment.

Northern Services No Criteria to Reside

Patients with no criteria to reside as a proportion of occupied beds





<u>Pathway 0</u> - Actions to Improve Performance

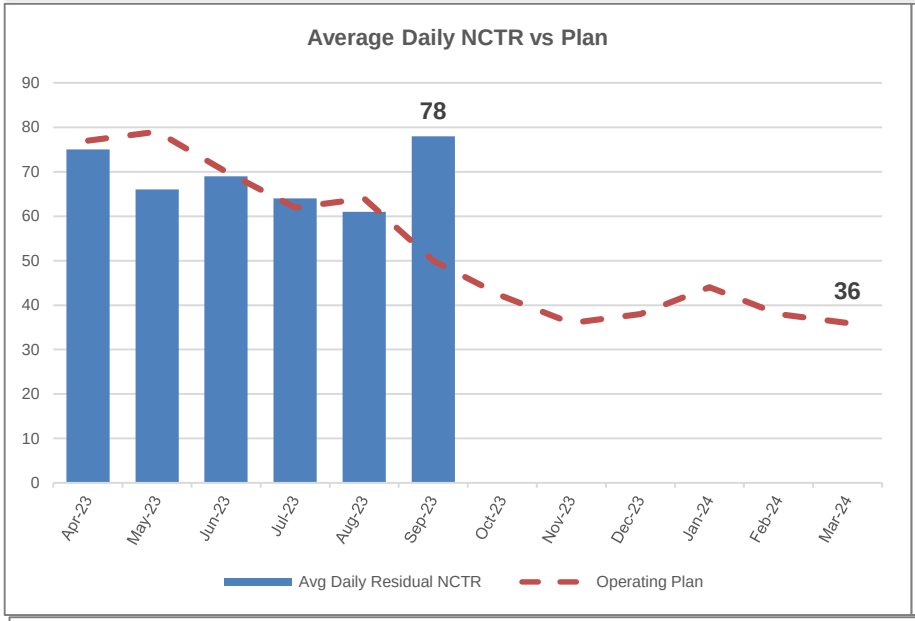
- Medically optimised part of board rounds and updated daily, alongside Expected Date of Discharge (EDDs) and criteria led discharges
- Discharge Lounge open 7 days a week and utilisation is increasing, saving 50 bed days in August and supporting 33% before midday for discharges from core beds
- Discharge pathway mapping in partnership with ICB now completed and system work underway to improve Pathway 0.
- Acute Hospital at Home (Virtual Ward) supporting admission avoidance in the Emergency Department (ED).

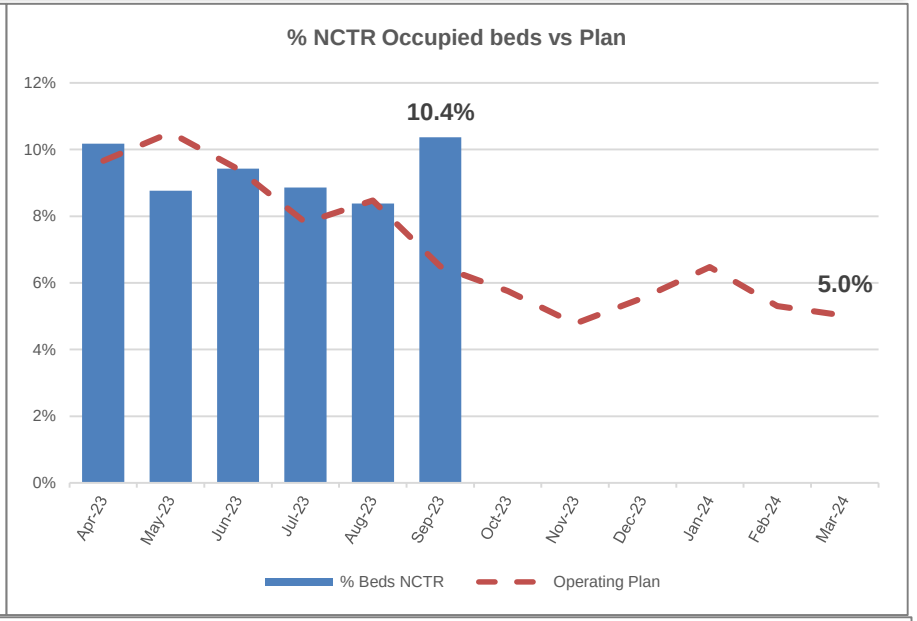
<u>Pathway 1-3</u> - Actions to Improve Performance

- 4 weeks additional 182hrs domiciliary care agency support commenced w/c 2/10/23
- UEC funded 24 hr care live in care model commenced w/c 2/10/23. This will enable more complex patients to be supported at home who otherwise may have required a Pathway 2 or Pathway 3 bed.
- UEC funded 1:1 support in care homes will be starting from w/c 16/10/23 to support care homes in supporting more complex patients on discharge.
- Daily huddle to review performance against discharge targets for each cluster.

Eastern Services No Criteria to Reside

Patients with no criteria to reside as a proportion of occupied beds





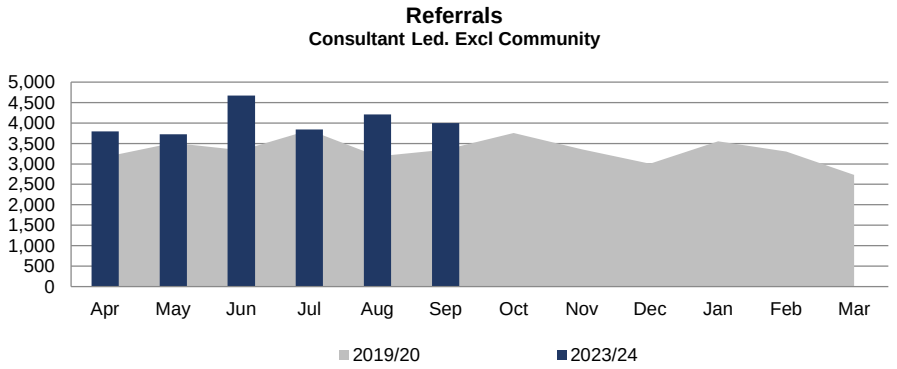
<u>Pathway 0</u> - Actions to Improve Performance

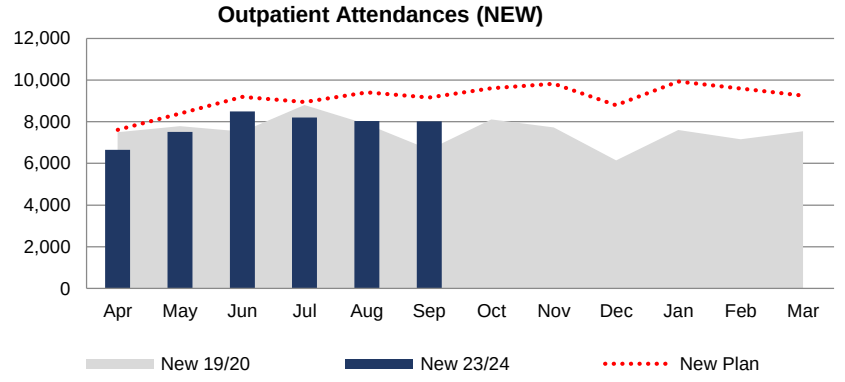
- Criteria Led Discharge utilising the EPR is now in place on a number of wards across Eastern Hospitals. Roll out continues.
- EPR workflow, based on Frimley Park workflow went live Trust wide 25th September. Workshops and floor support continues to encourage regular updates to EDD and appropriate delay reporting for NCTR and medically optimised
- Increased use of discharge lounge for Pathway 0 patients – highest use to date in September (906 patients) of whom 34% were before midday
- Trust wide discharge programme plan in train – planned launch in November.

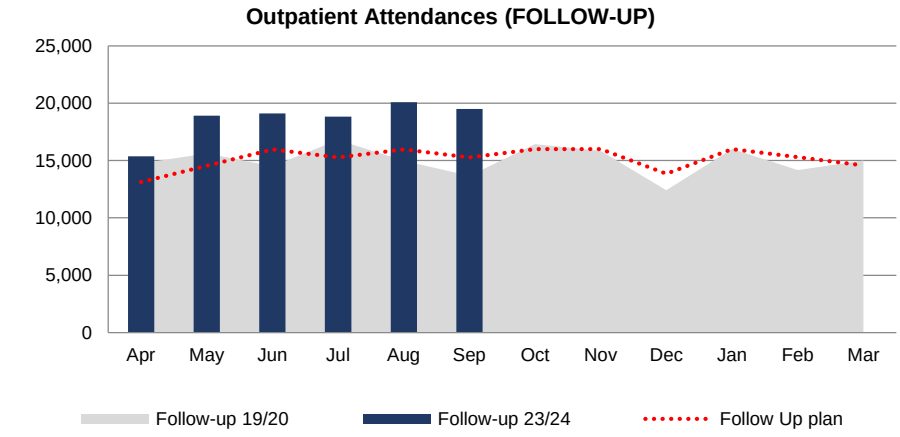
<u>Pathways 1-3</u> - Actions to Improve Performance

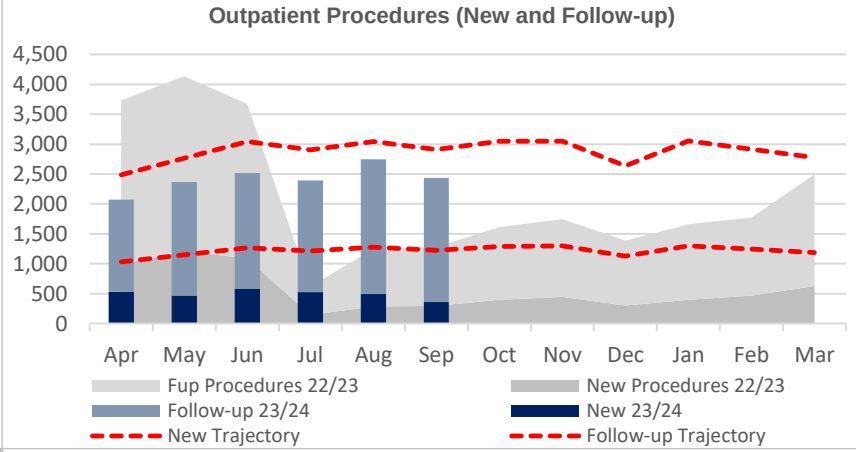
- 4 weeks additional 290hrs domiciliary care agency support commenced w/c 2/10/23
- UEC funded 24 hr care live in care model commenced w/c 2/10/23. This will enable more complex patients to be supported at home who otherwise may have required a Pathway 2 or Pathway 3 bed.
- UEC funded 1:1 support in care homes will be starting from w/c 16/10/23 to support care homes in supporting more complex patients on discharge.
- Daily huddle to review performance against discharge targets for each cluster.

Northern Services Elective Activity- Referrals and Outpatients



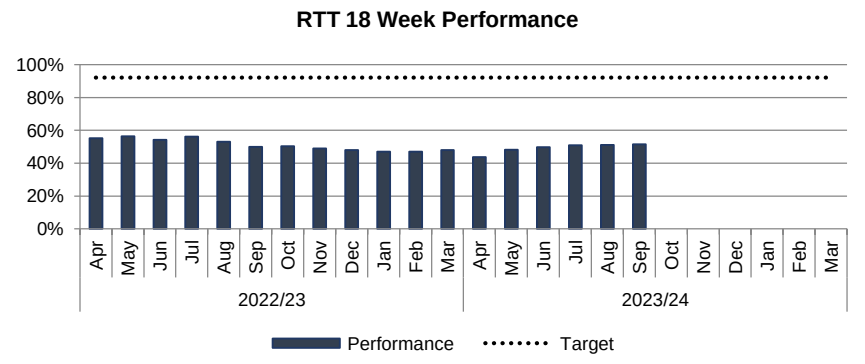




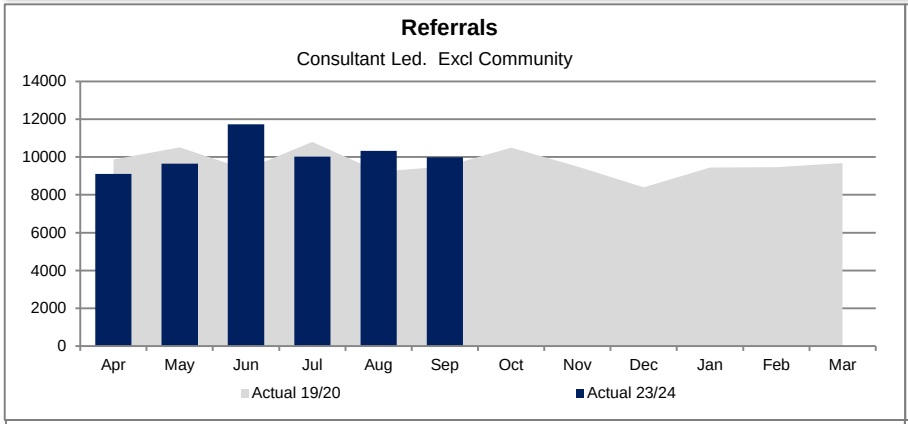


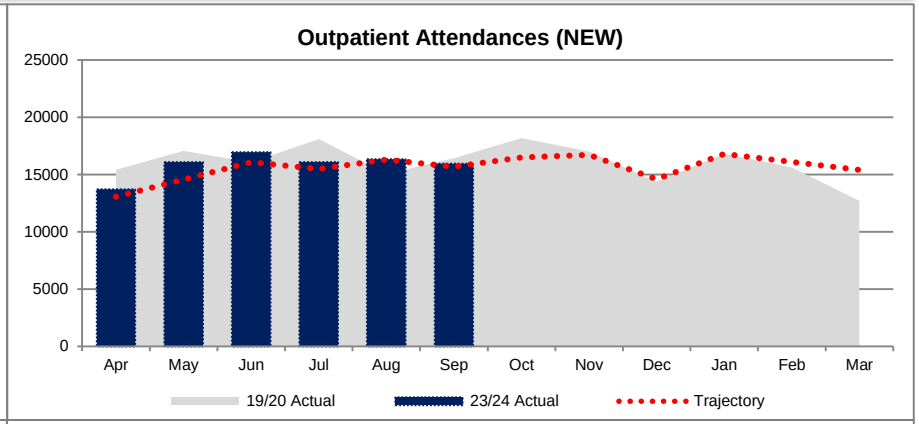
Note: the outpatient activity charts have been amended to show outpatient procedures separately, where as previously outpatient procedure activity was incorporated within the Outpatient New and Follow up charts respectively. This change has been made to provide greater visibility over outpatient procedures. As reported previously, in order to align with national ERF reporting, some specialties are excluded.

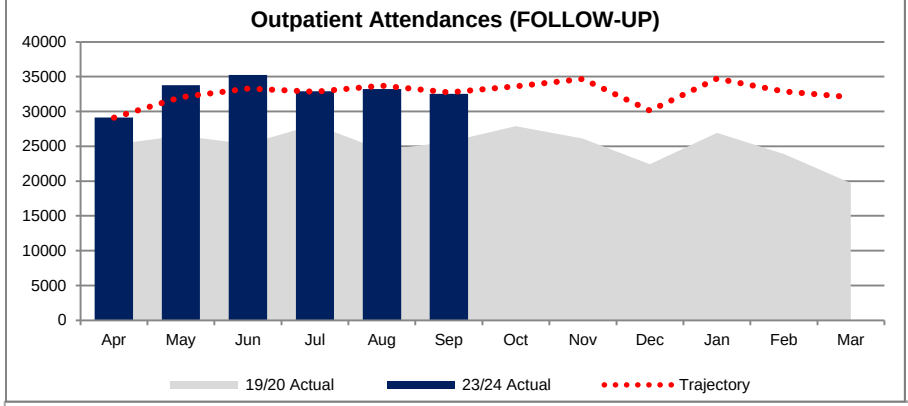
- There were a total of 27,508 Outpatients appointments in September. Of this 8,022 were New appointments and 19,486 were Follow-up appointments. Work is underway to reduce follow-up activity.
- 78.6% of appointments were held Face to Face and 21.4% were Virtual appointments in September.
- There was a slight increase in RTT 18 week performance again in September.
- **Outpatient follow-up**: activity was above 2019/20 volumes and in line with planned volumes for September. Explanations for the higher volume of activity vs 2019/20 have been provided in previous board reporting, but in summary relates to the differences in activity data capture relating to the implementation of a new electronic patient record since 2019/20.

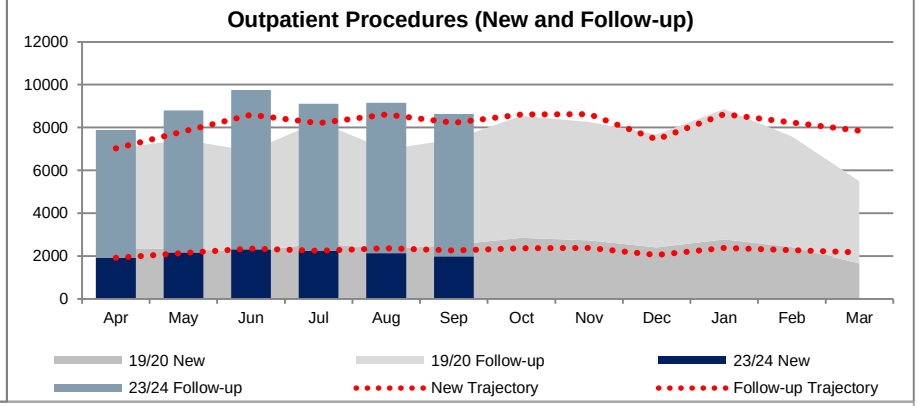


Eastern Services Elective Activity- Referrals and Outpatients









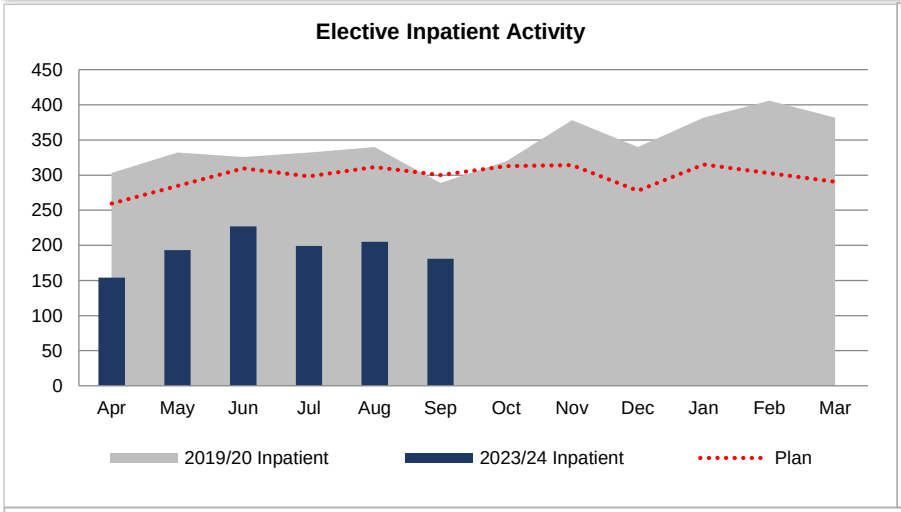
Note: the outpatient activity charts have been amended to show outpatient procedures separately, where as previously outpatient procedure activity was incorporated within the Outpatient New and Follow up charts respectively. This change has been made to provide greater visibility over outpatient procedures. As reported previously, in order to align with national ERF reporting, some specialties are excluded.

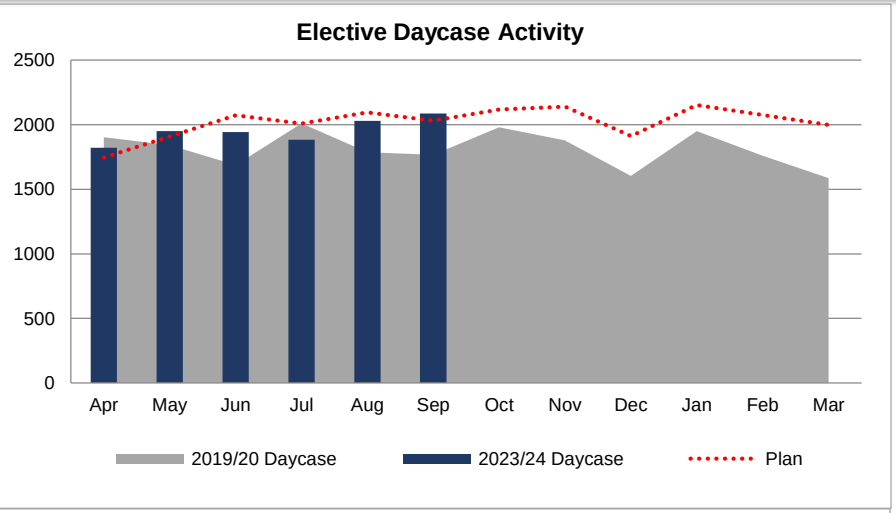
Outpatient attendances (new): was 97% of 2019/20 levels but in line with plan, which is a slight deterioration on the August position. Industrial action continued into September for consultants and junior doctors and so will represent the biggest driver of the variance.

Outpatient attendances (follow ups): was 127% of 2019/20 levels and 99% of planned levels. As previously reported, one of the biggest drivers of the increase on 2019/20 is the recording and reporting of community activity, which has been reviewed and considered appropriate to be counted, but has been raised with NHSE for an external formal view. If any changes are made as a result of this they will be reported in forthcoming IPRs.

Outpatient procedures (new and follow up): was 116% of 2019/20 and 105% of plan. The improvement of recording all outpatient procedures that are performed across the Trust is a key element of the Trustwide Delivering Best Value programme, with plans for further improvement to the end of the financial year.

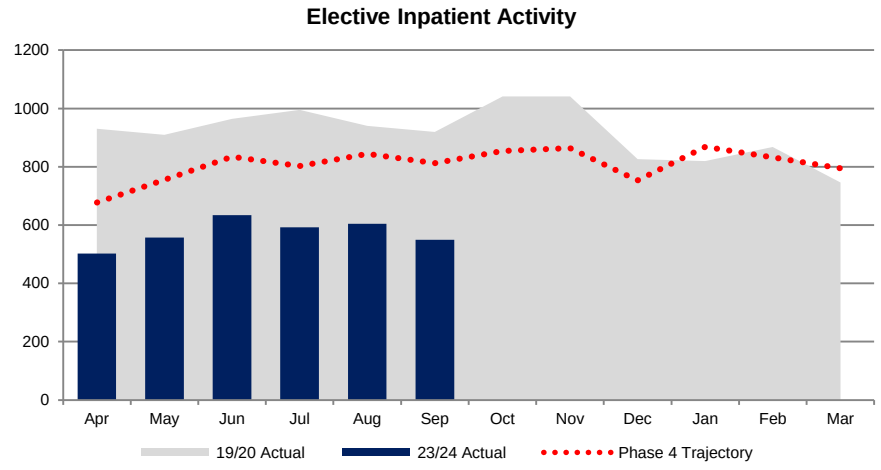
Northern Services Elective Activity- Inpatient and Daycase

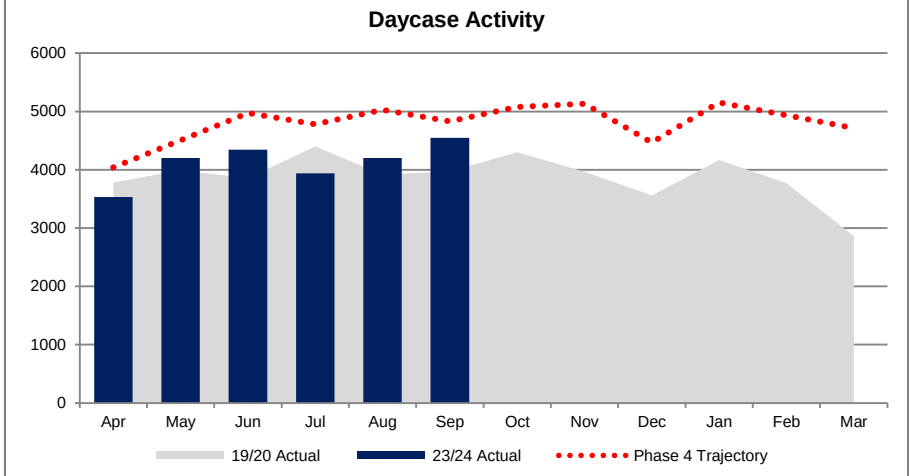




- Highest clinical priority patients and long waiting patients continue to be monitored weekly via the Patient Tracking Meeting (PTL).
- Elective Inpatient activity decreased during September by 24 and Daycase activity increased during September by 59.
- A period of Industrial Action in September resulted in a higher number of cancellations for elective activity than in previous periods of industrial action.

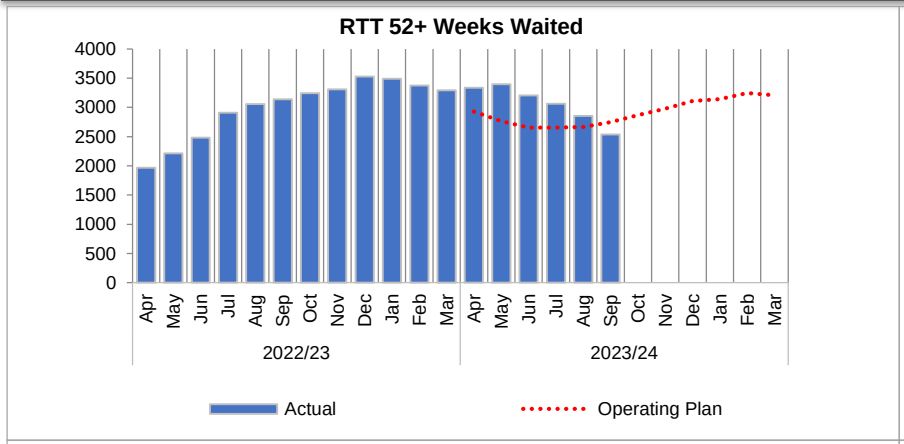
Eastern Services Elective Activity- Inpatient and Daycase

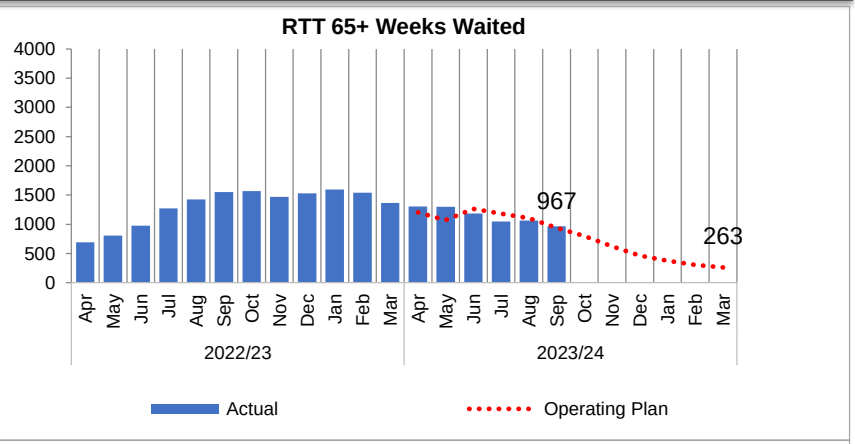


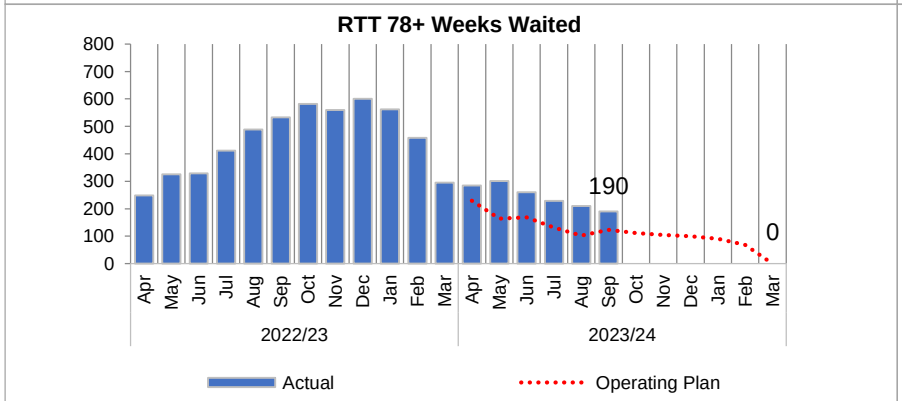


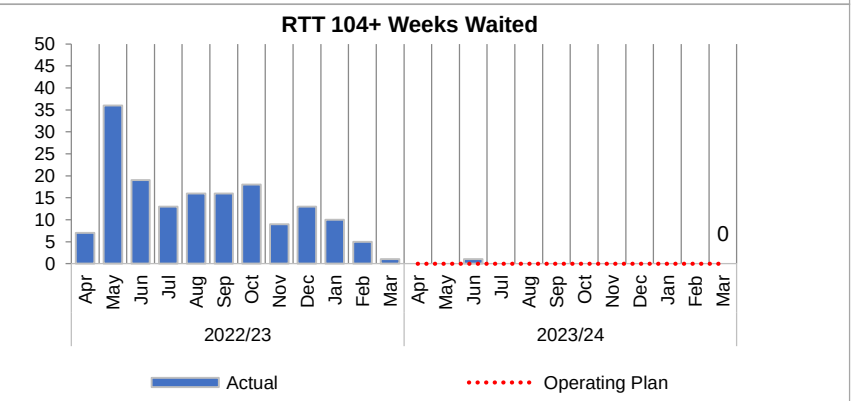
- **Elective Inpatient activity** in September was equivalent to 60% of 2019/20 activity and 68% of planned 23/24 levels.
- **Elective Daycase activity** in September was equivalent to 115% of 2019/20 activity and 94% of planned 23/24 levels.
- The ongoing industrial action impact into September represents the most significant driver of the variance to plan. However, ERF planned activity is also under planned levels at month 6, including Nightingale activity. The charts show an improving run rate here, but a detailed review of ERF activity year to date by scheme is currently under way in order to improve performance for the second half of the year.

Northern Services Elective Activity- Long Waiting Patients



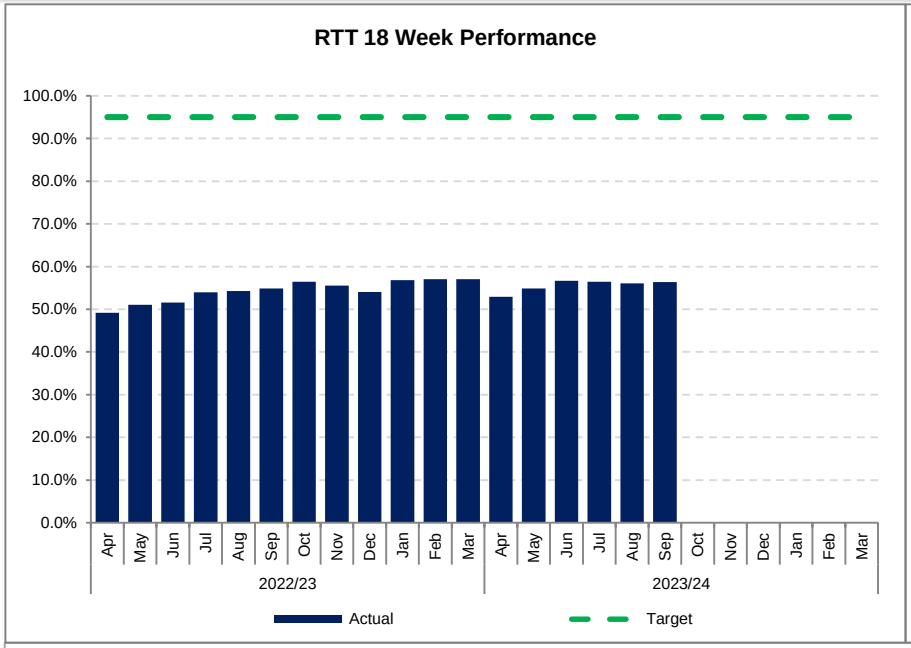


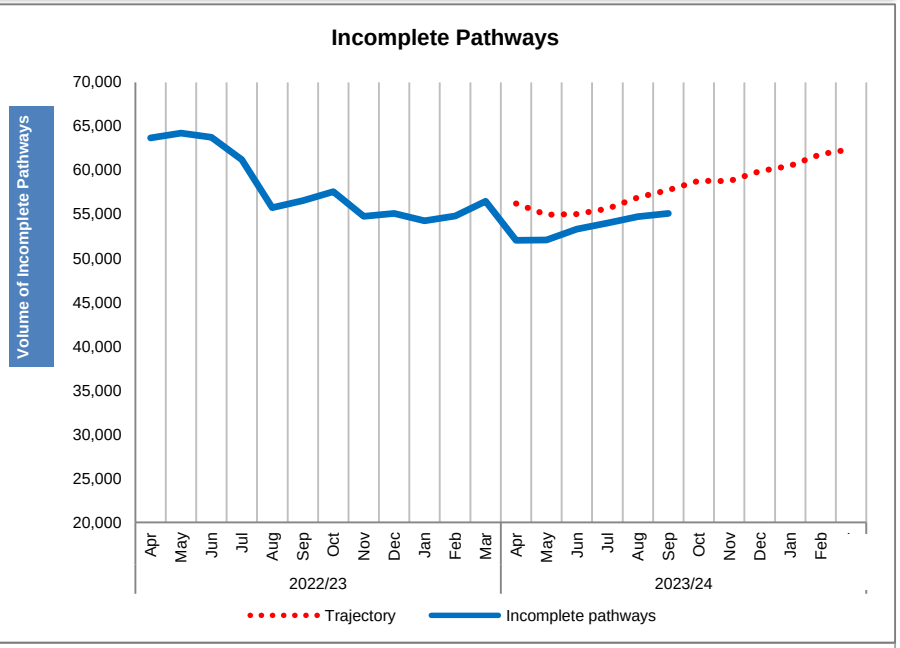




- Regular meetings are being held to ensure that the focus remains on the number of patients waiting 78, 52 and 43 weeks for a first appointment. In addition to focus on treating the longest waiting patients, additional capacity for earlier first appointments is being sought to support longer term and sustainable reductions in waiting times.
- We continue to achieve the target of 0 patients waiting 104 weeks or longer.
- Having had a similar number of patients waiting over 78 weeks since March, the impact of these efforts is beginning to be seen as the number of patients waiting over 78 weeks at the end of September reduced to 190 despite ongoing industrial action by junior doctors and consultants staff.

Eastern Services Elective Activity- Inpatient and Daycase

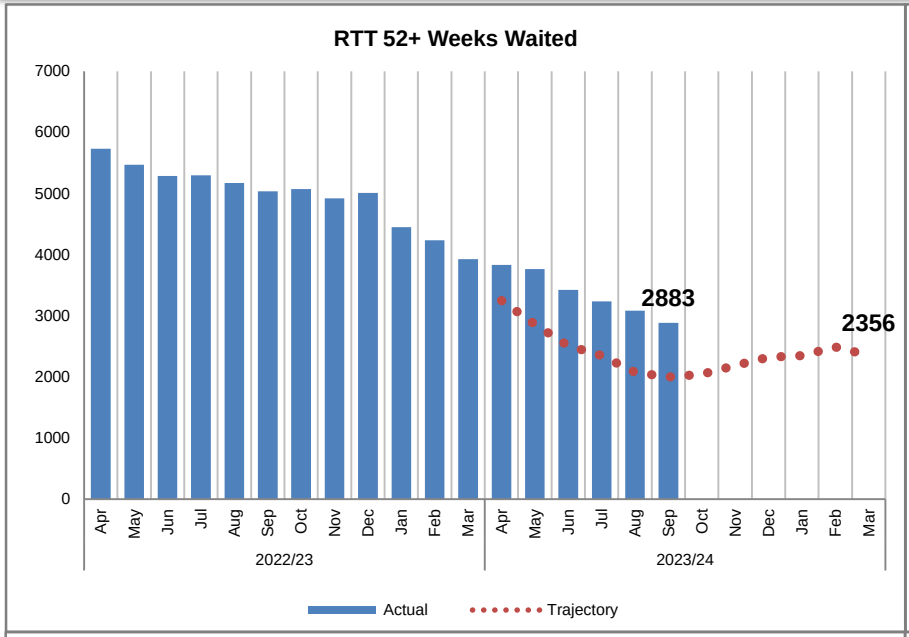


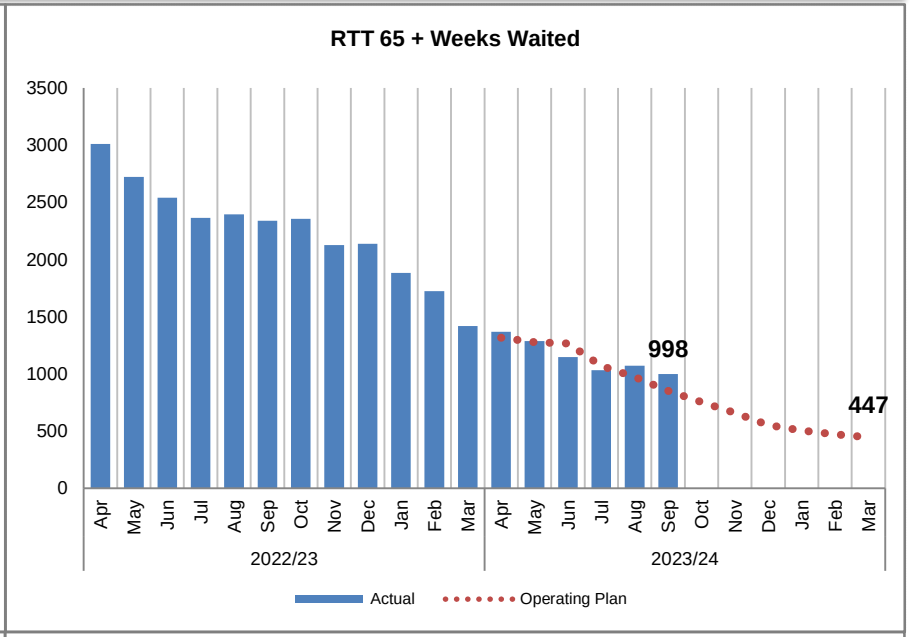


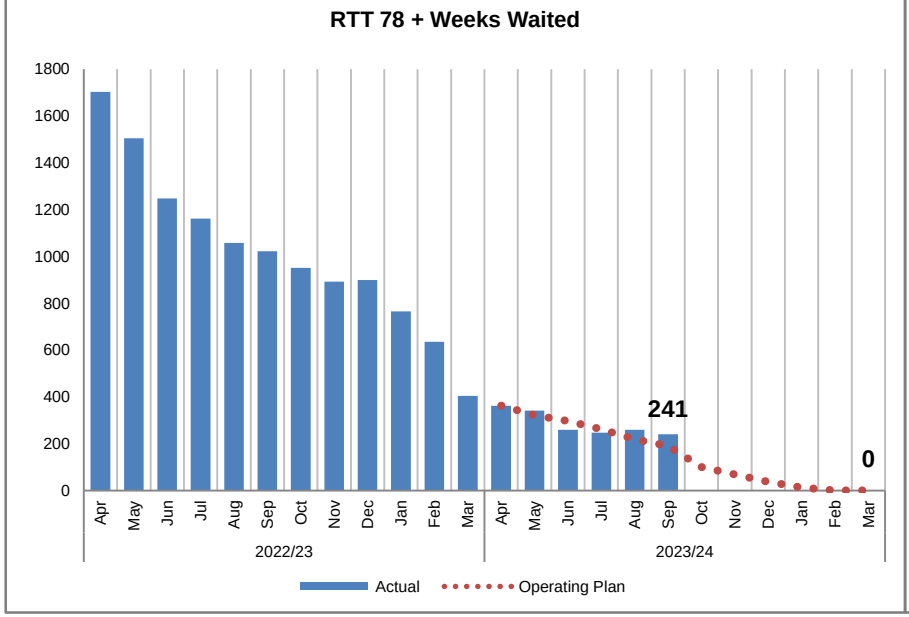
Incomplete pathways: after a period of steady improvement, incomplete pathways continue to rise for the 4th consecutive month. This is line with trajectory, and also in line with the regional and national trend, but is a concern in relation to long-term elective recovery as it shows demand continues to exceed capacity. The work referenced in relation to the review of current ERF schemes will support improvement plans in this area.

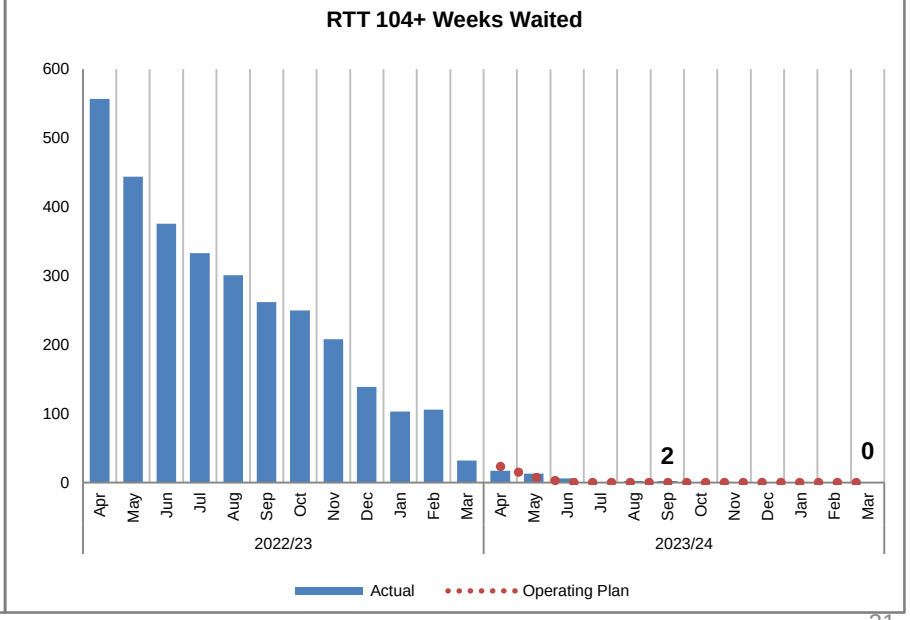
Long waits: despite the continued and sustained impact of industrial action, long waits continue to reduce (improve) month on month. All long wait positions are above (behind) plan, but detailed review has shown that if the direct impact of industrial action is taken into consideration, then the trust would be ahead of plan for all long-wait categories.

Eastern Services Elective Activity – Long Waiting Patients



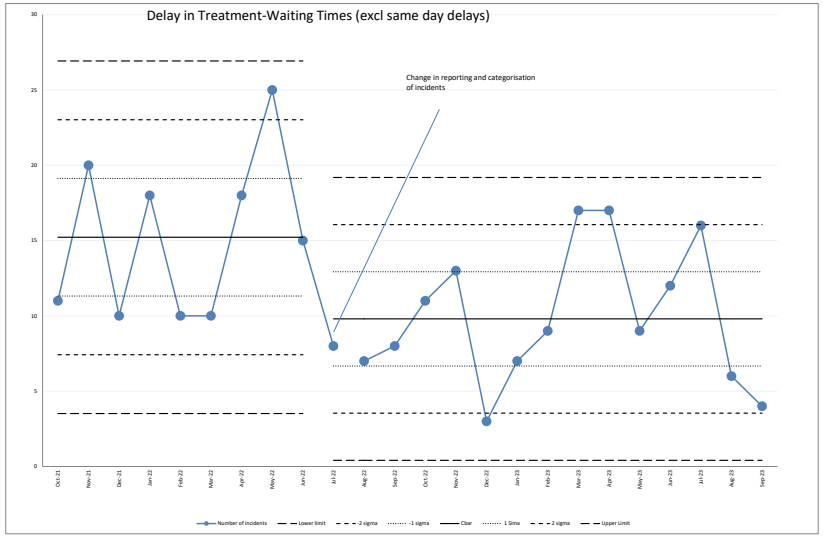






Northern Services - Waiting Well

Northern services reported four incidents for September 2023. None of these incidents resulted in moderate or greater harm.

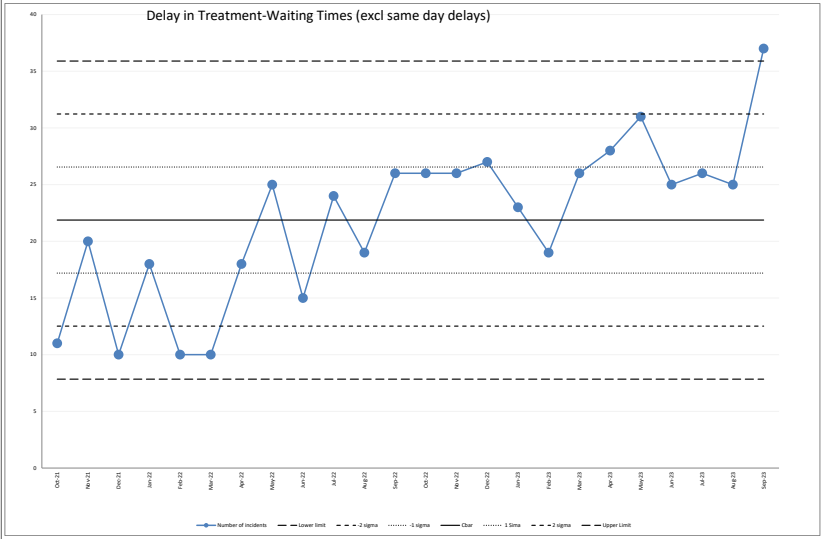


September 2023

	None	Minor	Moderate	Major	Catastrophic	Total
New	2	0				2
Diagnostic request delay	0	1				1
Follow up delay	0	1				1
Total	2	2	0	0	0	4

Eastern Services Waiting Well

Eastern services reported 37 incidents for September 2023, eleven incidents have been initially graded as moderate harm, but ten are awaiting validation.



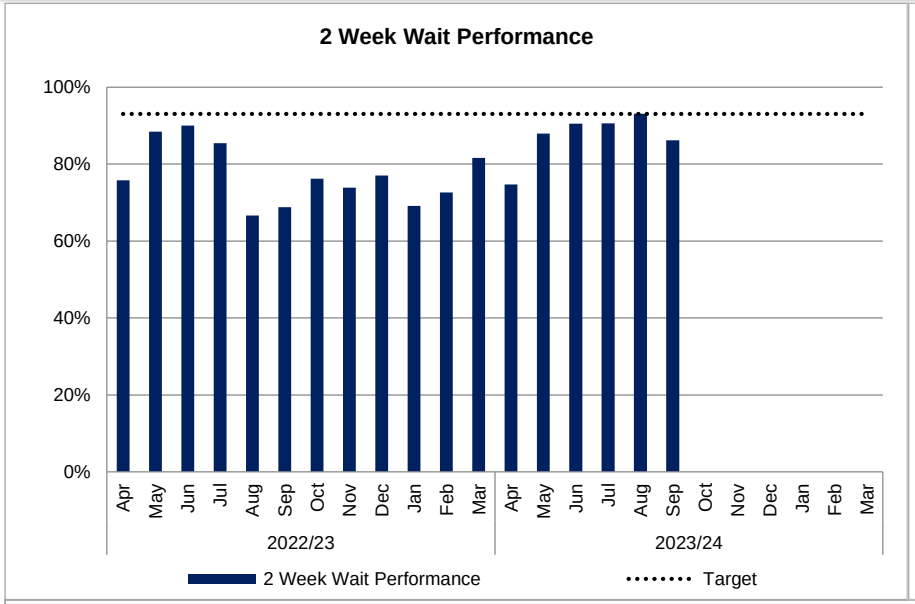
September 2023

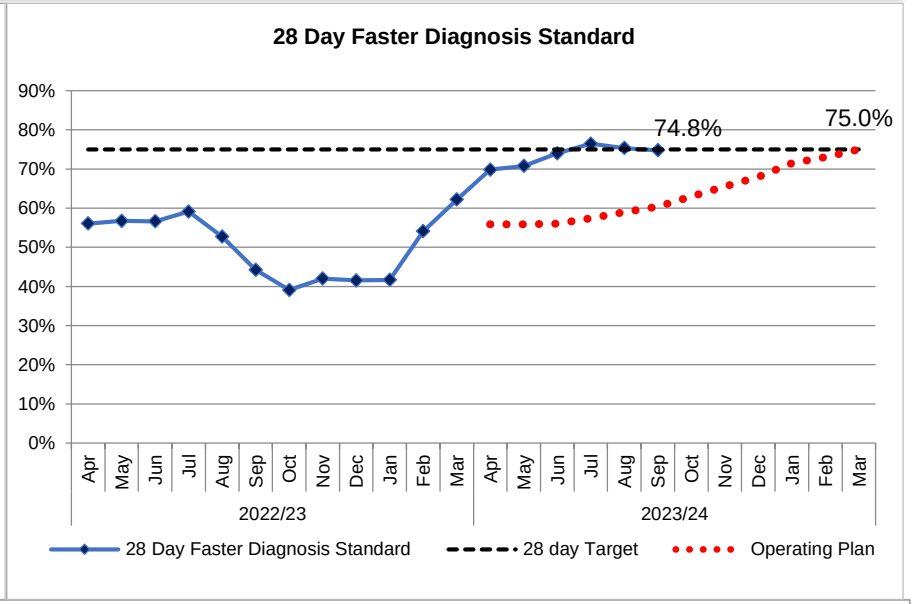
	None	Minor	Moderate	Major	Catastrophic	Total
New	7	3	11			21
Follow up delay	3	4	0			7
Surgery	1	3	1			5
Diagnostic request delay	3	1	0			4
Total	14	11	12	0	0	37

Moderate harm incident:
Patient had surgical appointment cancelled, this is the second cancellation this patient has experienced. Division has contacted patient directly to check on well being and provide advice. Operation to be rescheduled

Ten incidents were reported which were highlighted through the cardiology waiting list review process. Incidents identified through this process are entered onto Datix as moderate, pending clinical review, and the grading is then adjusted as appropriate.

Northern Services Cancer 14 and 28 Day





2 Week Wait Performance

Performance demonstrates an improving trajectory with August submitted position being reported at 93.05% which is above target for the first time in over a year. Unfortunately unvalidated performance for September show a deterioration in performance to 86.2% as a result of capacity pressures in skin. 2WW performance remains challenged in some tumour sites. The highest volumes of breaches in August are observed in Skin and lower GI, however both of these areas achieved in excess of 93%. The specialty that was most challenged in August was the Non-site specific pathway at 61% (where 8 of the 15 patients referred waited longer than 2 weeks for their appointment) :

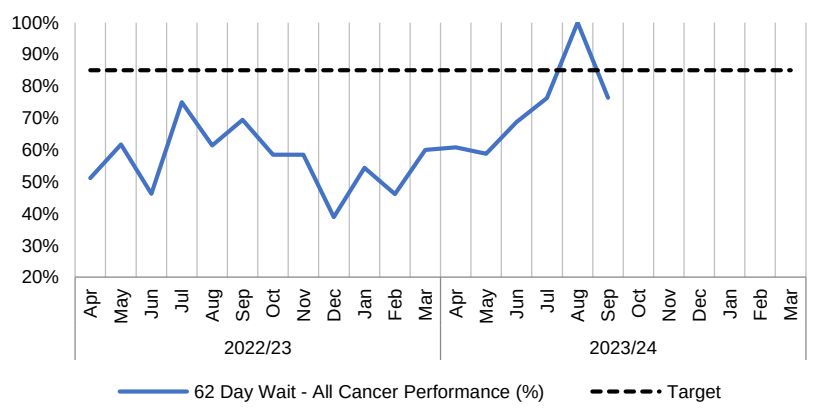
Average waiting times for 1st outpatient appointment were 8 days as an average across all tumour sites. All services are working to reduce first out patient waiting times to 7 days.

28 Day Faster Diagnosis Standard

FDS performance is also improving with significant increase in performance over the last 6 months from 42% in January to 76.5% in July. August performance deteriorated slightly to 75.4%. Unvalidated FDS performance for September has deteriorated further to 74.8% which is just below the 75% threshold. This position is above the year end improvement threshold and the submitted improvement trajectory. 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 with specific actions to improve waiting times for first outpatient appointments and diagnostic turn around times. The highest volumes of breaches in August are observed in:

- Lower GI, 63 breaches (56.85%) This reflects service pressures and endoscopy waiting times, significant additional clinical activity including endoscopy insourcing is currently being delivered to maintain delivery. TNE service is now live and will improve waiting times going forward.
- Urology, 38 breaches (50.65%). Performance has improved significantly over the last few months from 23% in February due to pathway improvements, which are ongoing. Performance has deteriorated in August due to staffing pressures and increases in diagnostic turnaround times
- Gynae, 28 breaches (58.33%), service pressures for 2ww OPA and hysteroscopy impact on 28 day delivery for gynae, additional capacity and staffing plans are in place.

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



- Performance against the 62 day target is generally improving in line with an improved backlog position. Provisional data for September indicates a position of 76.4%. The majority of pathway delays are within the diagnostic and staging phase, particularly for Urology which accounts for 8 of 15 breaches in August. Recent delays in PSMA PET scans have contributed to a higher number of breaches in Urology.
- 62 day performance will improve with actions aligned to deliver 28 FDS, 2WW performance and maintaining a PTL backlog below 6.4%.
- Capacity remains a challenge across some specialties including Oncology for both 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. These are monitored at the Northern Cancer Steering Group.

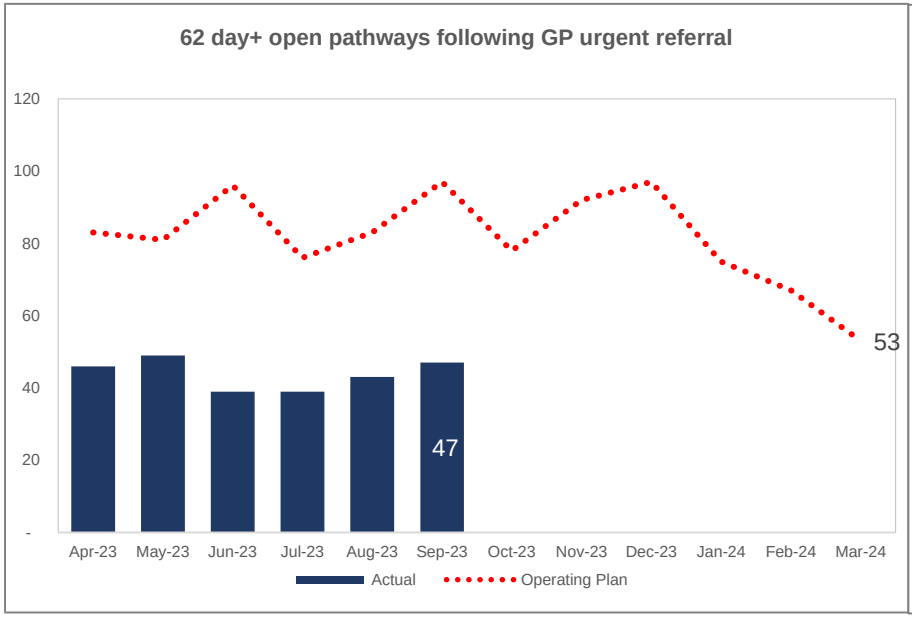
Please note for all 2 week, 28 day, 31 day, and 62 day cancer waiting times indicators, the most recent month's position is unvalidated, and reflects data that are not yet submitted nationally. These data will be refreshed in next month's report.

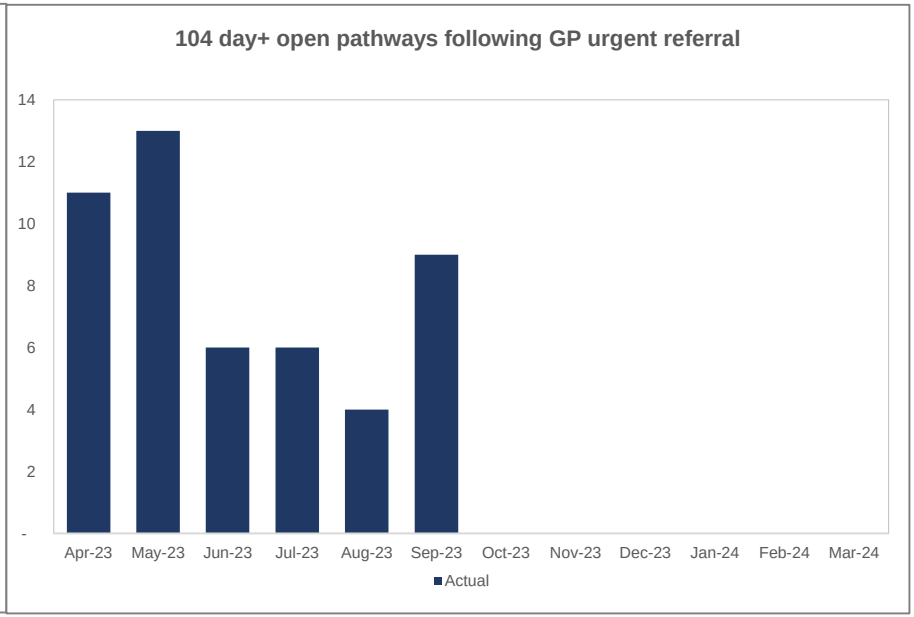
Cancer - 14,31 & 62 Day Wait

	Performance(%) and Number of Breaches	Target	2022/23 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023/24 Apr	May	Jun	Jul	Aug	Sep
14 Day	All Urgent (%)	93%	75.75%	88.40%	90.01%	85.38%	66.59%	68.77%	76.15%	73.84%	77.04%	69.09%	72.62%	81.61%	74.67%	87.88%	90.50%	90.58%	93.05%	86.19%
	All Urgent (N)		154.0	98.0	90.0	76.0	294.0	282	186	214	138	217	190	146	193.0	103.0	84.0	79.0	60.0	111
	Symptomatic Breast (%)	93%	8.70%	71.74%	80.33%	100.00%	0.00%	100.00%	100.00%	81.33%	75.00%	35.71%	42.86%	58.62%	67.86%	88.89%	90.48%	53.33%	72.22%	53.33%
	Symptomatic Breast (N)		42.0	13.0	12.0	0	1	0	0	2	4	9	12	12	9.0	2.0	2.0	7	5	7
31 Day	All Decision To Treat (%)	96%	84.42%	86.67%	75.76%	83.72%	78.72%	90.00%	87.14%	90.00%	78.33%	82.61%	92.86%	89.04%	91.36%	90.54%	97.53%	88.57%	95.56%	80.00%
	All Decision To Treat (N)		12.0	10.0	16.0	7	10	6	9	6	13	12	4	8	7.0	7.0	2.0	8	2	24
	Subsequent - Surgery (%)	94%	60.00%	33.30%	33.30%	1.00%	100.00%	100.00%	50.00%	60.00%	76.92%	60.00%	38.46%	68.75%	71.43%	35.71%	82.35%	58.33%	87.50%	58.33%
	Subsequent – Surgery (N)		4.0	2.0	4.0	0	0	0	3	4	3	6	8	5	4.0	9.0	3.0	5	1	5
	Subsequent - Anti-Cancer Drug %	98%	60.00%	33.30%	33.30%	100%	100%	97%	88%	77%	93%	78%	100%	96.15%	89.47%	90.00%	100.00%	84.21%	100.00%	93.75%
	Subsequent - Anti-Cancer Drug		4.0	2.0	4.0	0	0	1	3	13	3	8	0	1	2.0	1.0	0.0	3	0	1
62 Day	All Screening Service (%)	90%	100.00%	66.67%	100.00%	100%	0%	100%	0%	100%	N/A	N/A	N/A	N/A	N/A	33.30%	0.00%	20%	0%	57%
	All Screening Service (N)		0.0	1.0	0.0	0	0	0	0	0	0	0	0	0	0.0	2.0	2.0	2	0.5	3
	Consultant upgrade (%)	90%	62.79%	60.00%	75.47%	54.17%	72.22%	55.56%	76.92%	61.54%	72.97%	64.29%	74.00%	69.70%	64.86%	76.47%	82.14%	86.11%	100.00%	80.26%
	Consultant upgrade (N)		8.0	11.0	6.5	5.5	5	8	6	5	5	5	3.5	5	6.5	4.0	5.0	2.5	0	7.5
28 day	28 Ref to diagnosis (%)	N/A	56.04%	56.76%	56.61%	59.11%	52.68%	44.25%	39.08%	42.00%	41.54%	41.66%	54.10%	62.17%	69.81%	70.76%	74.00%	76.46%	75.35%	74.75%
	28 day Ref to diagnosis (N)		244.0	275.0	256.0	119.0	212.0	344	452	551	380	451	358	317	224.0	262.0	240.0	186.0	211.0	199

Northern Services Cancer 62 Day Backlog

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



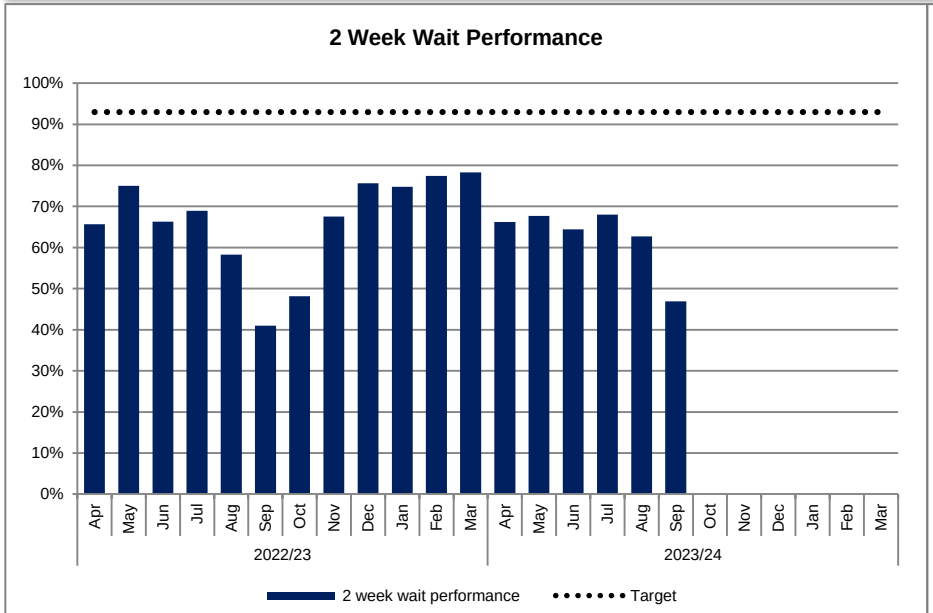


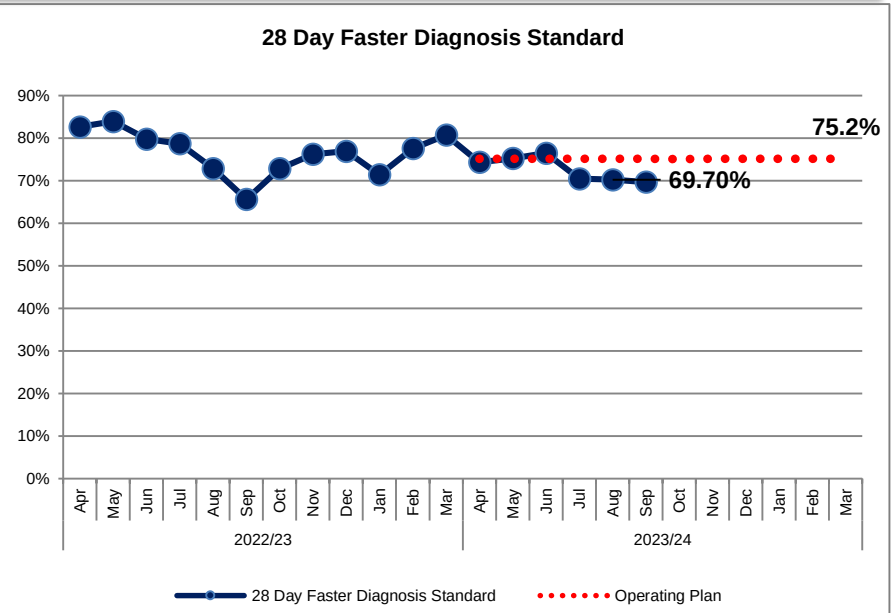
- The number of patients on active cancer pathways waiting more than 62 days has reduced from 395 (29.3%) at the start of September 2022 to 47 (6.2%) at the most recent weekly PTL (02/10/2023) which is significantly better than trajectory and remains under the nationally recommended backlog threshold of 6.4%.
- Performance has slowly been deteriorating over the last 2 months due to capacity pressures within some specialties and increases in some turnaround times.
- The tumour sites with the largest number of patients waiting over 62 days are Colorectal (16 – 7.5%); Urology (12 – 13.8%).
- There are 9 patients (02/10/2023) that remain on a cancer pathway over 104 days, this volume has increased slowly over the last month in line with the increasing number of patients over 62 days.

Key actions:

- Weekly PTL meetings in place for all tumour sites with action logs and formal escalation process in place.
- Colorectal - Substantive consultant appointed with start date agreed in February 2024
- Endoscopy
    - insourcing/weekend lists remain in place.
    - TNE service has commenced.
    - Endoscopy unit expansion awaiting approval.
    - The first cohort of patients have been booked in to the Tiverton mobile unit for procedures in October.
- Urology - Revised prostate pathway commenced in February and under regular review, further work underway to streamline staging investigations.
- Work to improve Radiology and Pathology waiting times has been initiated.

Eastern Services Cancer 14 and 28 Day



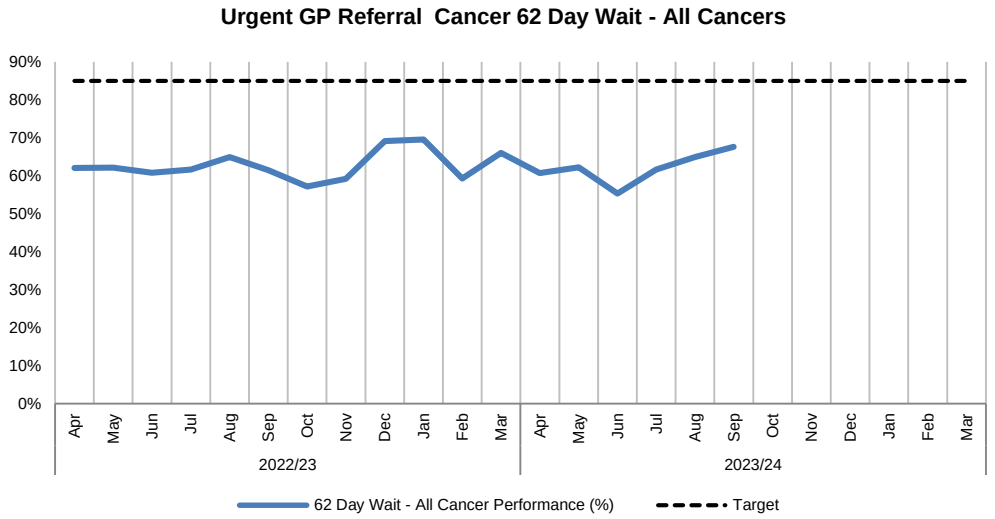


Performance across the East continues to decline – due to both Bank Holidays and Industrial Action, combined with an increase in 2WW referrals. Where possible additional clinics have been sought to mitigate these challenges.

- **Endoscopy** – Interim mobile unit has been delivered to Tiverton. A 7 days a week colonoscopy service will be going live on 16th October to run for 12 months. An independent sector provider will provide 12 point lists equating to 24 points per day. The service will cover both Eastern and Northern Services' longest waits. The permanent new build solution of 3 endoscopy suites at Tiverton will then take over in August 2024. There is a risk to the timescales for delivery of the plan in relation to the Tiverton site (PFI, flood risk and contamination risk) and the financial deliverability. The introduction of postal booking will ensure full capacity is utilised across all sites.
- **Gynaecology** – Significant workforce challenges are expected in the coming months. A gynae-oncology consultant has been appointed and will join the team by April 2024. Waiting list initiatives (WLIs) are being undertaken to minimise the impact on performance.
- **Urology** – A third Robotic Assisted Laparoscopic Prostatectomy (RALP) surgeon has been signed off within the Team. Currently experiencing an increase of RARC's which impacts the RALP capacity. Plans in place to operationally respond to the impact of the storyline within a popular BBC soap opera regarding a character's experience of prostatectomy – no increase in referrals noted yet.
- **Upper GI** – Currently holding 3 consultant vacancies and out to advert for 1wte. 3 registrars will rotate into an acting up consultant role for 12 months to support gaps in the rota. This will start on 23rd October with the first registrar on a 3 month rotation.
- **Upper G**I outpatient capacity is improving. Unfortunately OGD capacity remains challenged. Due to advertise 3 consultant vacancies in October/November 2023. Maternity leave will be covered with a registrar acting up from October 2023.
- **Skin** – The service is challenged by increased seasonal referrals at an unprecedented level, as well reduced capacity due to consultant sickness.. WLIs are being undertaken to counter this. Clinics have started for the AI pilot, and although they have yet to have the intended impact on demand it is anticipated that this will develop as use of the service increases over the trial period. Of note, the service is also providing mutual aid to Taunton until end of October 23.

Eastern Services Cancer 62 Day

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



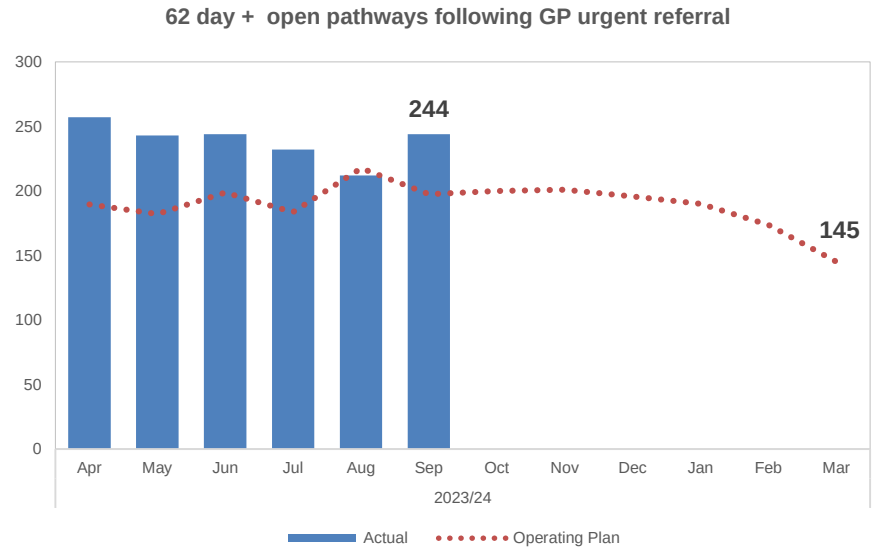
- Oncology appointment capacity across most specialities is constrained, particularly in Lung where there is a 3 week wait for an outpatient appointment pre-treatment due to Consultant vacancies.
- Theatre capacity remains challenged as does Theatre staffing, which will impact the ability to deliver extra sessions.
- The ERF request for 2 substantive Colorectal consultants, which would support On Call Rota and provide additional theatre capacity through cover, has been approved and recruitment is in progress.
- A combination of the impact of industrial action and bank holidays, alongside a volume of patient choice consistent with previous years has contributed to the increase in breaches within 62 day pathways.

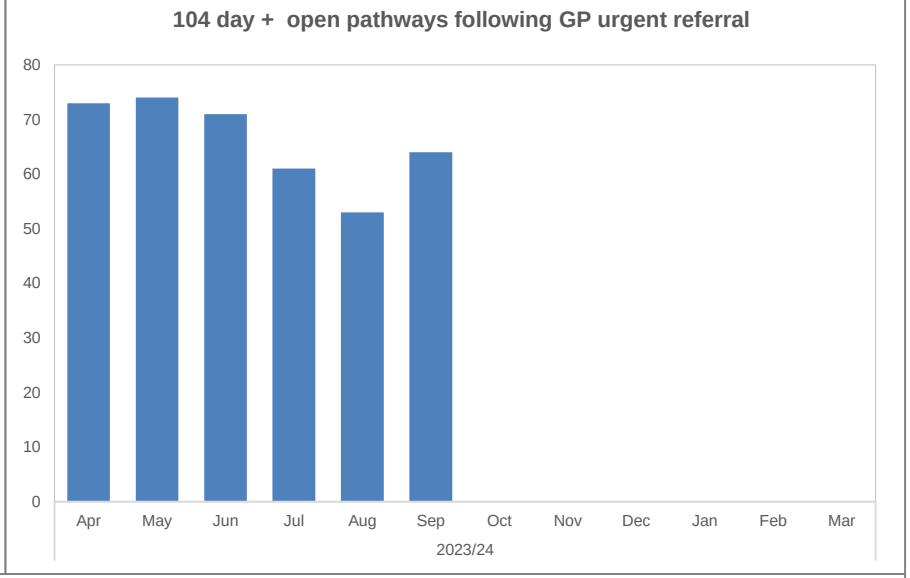
Cancer - 14, 31, 62 & 104 Day Wait

	Performance(%) and Number of Breaches	TARGET	2022/23 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023/24 Apr	May	Jun	Jul	Aug	Sep
14 Day	All Urgent (%)	93%	65.6%	75.0%	66.3%	69.0%	58.3%	41.0%	48.2%	67.6%	75.6%	74.8%	77.4%	78.3%	66.2%	67.7%	64.5%	68.0%	62.7%	46.9%
	All Urgent		760	605	762	763	1027	1434	1253	818	488	559	470	550	734	758	969	853	923	1301
	Symptomatic Breast (%)	93%	20.9%	35.2%	58.1%	57.4%	62.9%	16.7%	40.5%	72.5%	95.8%	93.9%	100.0%	91.4%	92.1%	91.2%	79.3%	78.8%	52.3%	78.1%
	Symptomatic Breast		34	46	18	20	13	30	25	14	1	2	0	5	3	3	6	7	21	7
31 Day	All Decision To Treat (%)	96%	88.5%	86.9%	87.9%	85.4%	89.8%	89.5%	92.2%	87.7%	89.4%	78.5%	86.7%	88.7%	87.3%	85.2%	89.7%	89.2%	85.4%	70.0%
	All Decision To Treat		31	41	34	37	22	21	18	31	25	72	40	34	35	47	34	37	52	97
	Subsequent - Surgery (%)	94%	64.2%	67.1%	76.0%	75.3%	71.2%	61.1%	78.3%	88.3%	82.1%	63.9%	73.0%	66.7%	76.2%	68.9%	67.9%	84.5%	67.5%	73.8%
	Subsequent - Surgery		29	26	25	21	17	28	18	11	14	44	30	34	20	32	35	16	27	27
	Subsequent - Radiotherapy (%)	94%	100.0%	99.2%	95.9%	98.8%	97.6%	98.6%	99.3%	99.3%	99.1%	100.0%	98.3%	99.3%	97.6%	97.9%	96.8%	97.7%	99.1%	99.2%
	Subsequent - Radiotherapy		0	1	4	1	2	1	1	1	1	0	2	1	3	3	4	3	1	1
	Subsequent - Anti-Cancer Drug (%)	98%	100.0%	98.6%	100.0%	100.0%	97.5%	100.0%	100.0%	100.0%	100.0%	98.9%	97.6%	96.8%	100.0%	100.0%	100.0%	100.0%	98.9%	98.6%
	Subsequent - Anti-Cancer Drug		0	1	0	0	2	0	0	0	0	1	3	4	0	0	0	0	1	1
62 Day	All Screening Service (%)	90%	12.5%	28.6%	33.3%	0.0%	0.0%	0.0%	0.0%	20.0%	33.3%	0.0%	28.6%	12.5%	0.0%	15.0%	22.2%	37.5%	0.0%	24.0%
	All Screening Service		3.5	2.5	2	2	4	1	2	4	2	2.5	5	7	3	8.5	7	7.5	13	9.5
104 days	Volume of Patients Waiting Longer than 104 Days at Month End		52	53	70	68	58	59	54	84	81	84	81	62	73	74	71	61	53	64

Eastern Services Cancer 62 Day Backlog

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





- Histology – Turnaround times have been static. Two new recruits will join the department in January. Two dissection practitioners are about to qualify to practice independently and will bring further improvements in turnaround times in early autumn.
- Radiology – CT and MRI turnaround times have deteriorated over the last few weeks following industrial action and summer leave. Continued outsourced reporting capacity is being employed to support recovery of turnaround times, and funding has been secured to continue to support additional activity throughout the year. For CT-guided biopsy, Interventional radiology mitigations include a new consultant in post this month and a further consultant starting in coming months.

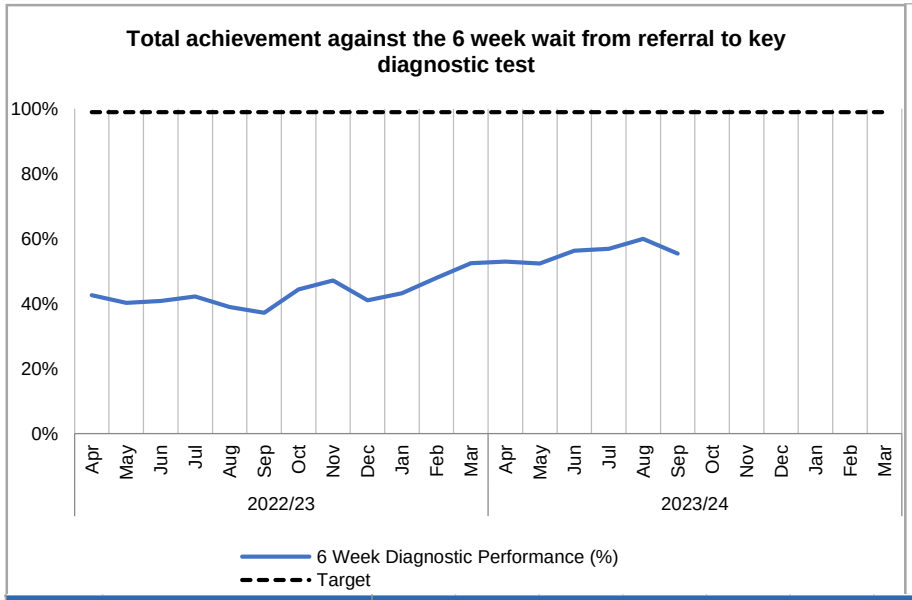
Off trajectory;

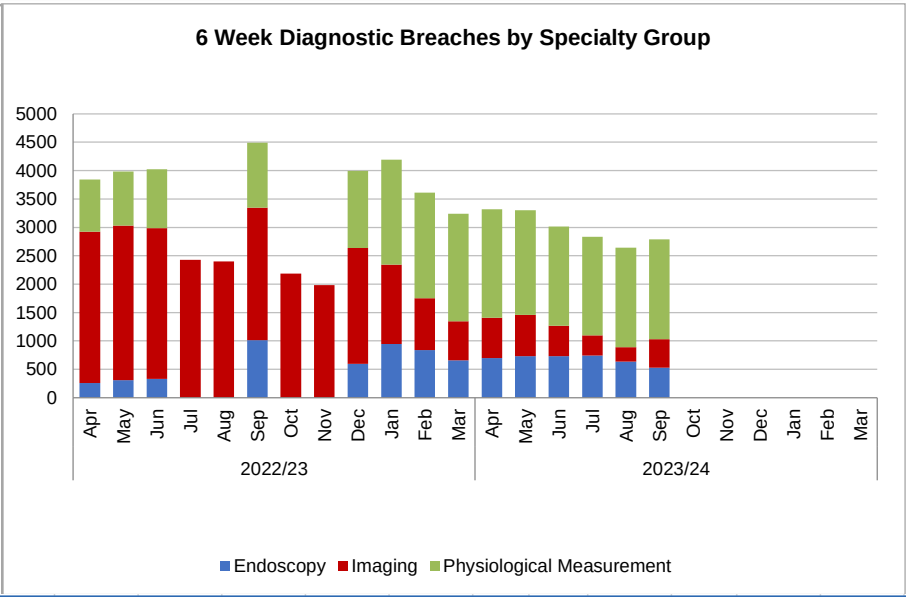
- Urology – Challenged due to a cluster of RALP referrals and late tertiary transfers. Third RALP surgeon was signed off at the end of August 2023. It was decided not to proceed with the insourcing company, however further requests for Mutual Aid may be made later in the year when required.
- Colorectal – remains challenged with long waiting patients due to delays in Endoscopy (plans in place) and theatre capacity (plans in place).
- Gynaecology – Significant workforce challenges are expected in the coming months. However, Gynae-Oncology Consultant has been recruited. WLI's are being undertaken to minimise the impact on performance.
- Skin – higher than expected seasonal increase in 2WW referrals has put significant pressure on the service, combined with annual leave/industrial action and Consultant sickness has led to an imbalance of demand/capacity. WLI is already in action. Also providing mutual aid to Taunton

Key Actions;

- ***Upper GI –*** *Substantive 1 WTE consultant Gastroenterologist post out to advert in October/November (3 WTE Vacancy)*
- ***Gynaecology –*** *Substantive consultant recruited.*
- ***Histology/Radiology –*** *WLI to continue to support multiple pathways*
- ***Skin –*** *WLI to achieve previous 2WW performance. GPSI to work with team for 12 months*

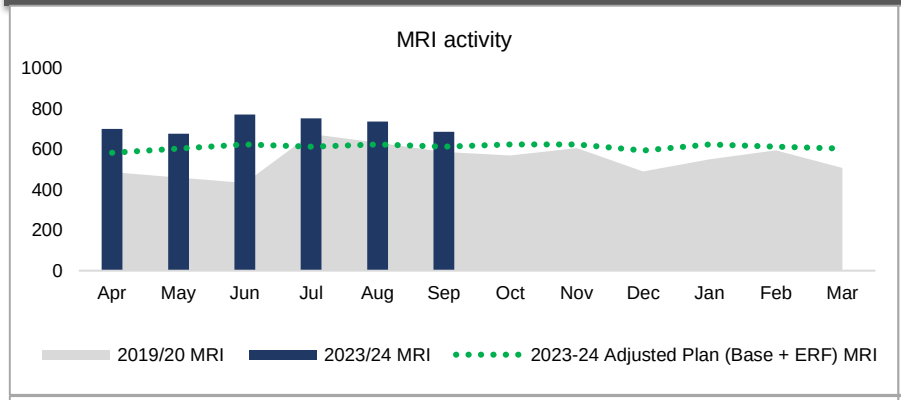
Northern Services Diagnostics - *Fifteen key diagnostic tests*

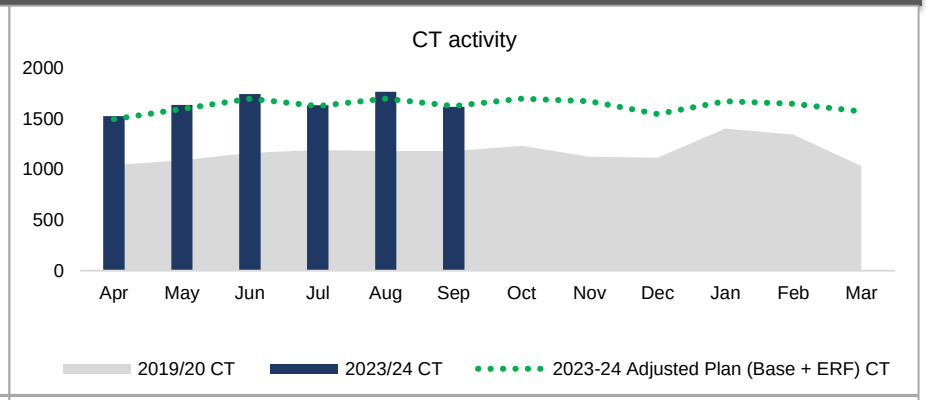


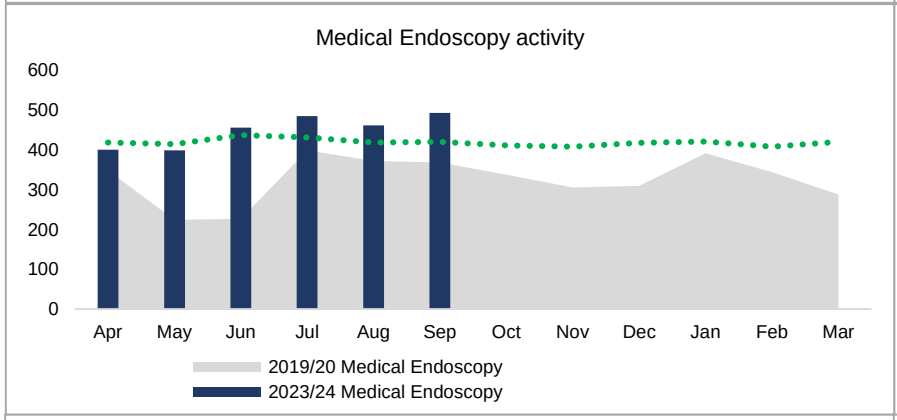


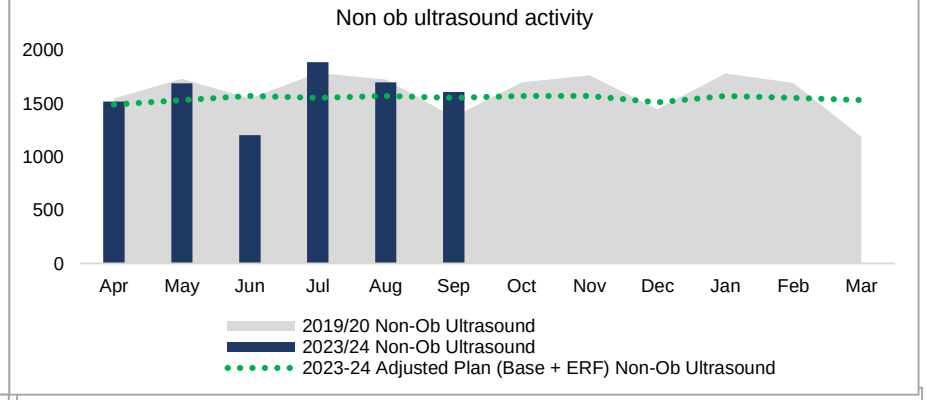
		Achievement against the 6 week wait from referral to key diagnostic test																	
Area	Diagnostics by Specialty	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Imaging	Magnetic Resonance Imaging	96.5%	96.7%	94.6%	97.7%	100.0%	100.0%	99.4%	99.7%	99.7%	96.9%	97.6%	98.4%	97.7%	98.5%	98.9%	99.2%	99.4%	99.1%
	Computed Tomography	55.6%	55.2%	64.7%	65.2%	56.1%	66.8%	81.9%	76.3%	75.2%	78.4%	87.6%	95.3%	95.6%	94.3%	95.9%	93.2%	90.9%	83.1%
	Non-obstetric ultrasound	35.2%	32.9%	30.9%	33.1%	35.2%	35.2%	35.8%	40.9%	36.2%	54.9%	86.1%	88.1%	85.9%	80.6%	85.7%	92.0%	96.1%	76.7%
	Barium Enema	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	DEXA Scan	11.6%	10.7%	10.5%	11.5%	14.6%	13.8%	14.5%	17.9%	14.3%	15.7%	19.8%	27.8%	29.2%	27.9%	37.0%	49.5%	60.3%	49.8%
Physiological Measurement	Audiology - Audiology Assessments	100.0%	100.0%	100.0%							100.0%	100.0%	99.1%	97.3%	94.8%	97.7%	93.5%	94.7%	98.6%
	Cardiology - echocardiography	31.4%	26.6%	28.3%						27.9%	18.6%	23.0%	23.4%	25.2%	24.4%	28.2%	27.4%	27.8%	22.5%
	Cardiology - electrophysiology	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Neurophysiology - peripheral neurophysiology	96.3%	96.8%	92.5%			88.5%			97.9%	93.8%	99.1%	96.3%	91.2%	97.2%	98.9%	93.2%	96.8%	72.2%
	Respiratory physiology - sleep studies	22.5%	34.3%	30.8%			17.4%			64.8%	52.3%	42.5%	26.4%	28.6%	41.7%	42.9%	39.1%	31.0%	32.8%
	Urodynamics - pressures & flows	20.4%	25.4%	23.3%			1.4%			39.4%	30.8%	46.2%	35.7%	27.9%	51.5%	37.5%	53.8%	47.7%	24.2%
Endoscopy	Colonoscopy	62.3%	48.6%	43.8%			27.6%			30.6%	32.7%	34.2%	39.5%	37.7%	36.8%	34.6%	27.9%	32.4%	34.1%
	Flexi sigmoidoscopy	64.8%	71.8%	70.3%			28.5%			42.9%	30.9%	29.7%	40.1%	42.8%	39.0%	44.9%	34.7%	44.3%	42.5%
	Cystoscopy	67.0%	75.6%	73.3%			59.8%			74.4%	42.6%	48.4%	83.3%	81.3%	88.9%	91.8%	80.2%	86.7%	85.0%
	Gastroscopy	70.9%	61.9%	60.8%			53.1%			44.9%	39.1%	41.3%	48.2%	41.9%	37.6%	40.9%	40.7%	45.7%	41.5%
Total		42.6%	40.2%	40.8%	42.2%	39.0%	37.2%	44.4%	47.2%	41.0%	43.2%	48.0%	52.5%	53.0%	52.4%	56.3%	56.9%	59.8%	55.5%

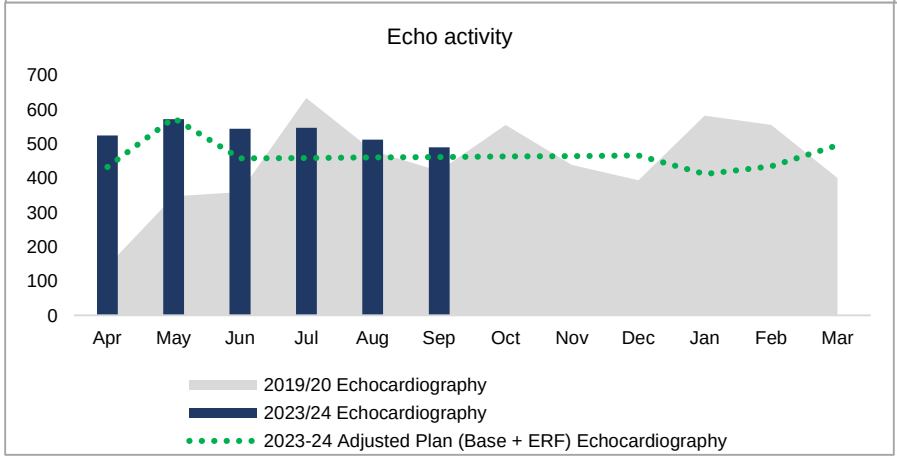
Northern Services Diagnostics - *Diagnostic activity compared to plan across key diagnostics modalities*









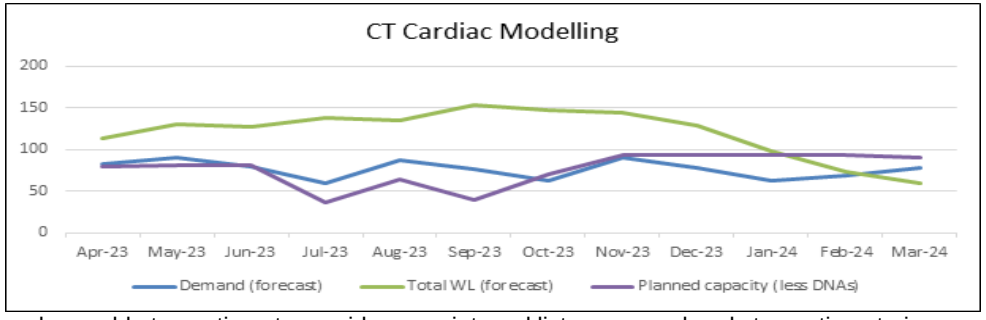


Northern Services Diagnostics

- **MRI –** MRI activity is above plan and performance is being maintained. The MRI scanner experienced a failure in September and was out of action for approximately 1 week although patients have been able to be rebooked (in the mobile unit).

- **CT – Non-Cardiac CT –** We have increased capacity in planning for 23/24 to meet demand and currently at 95% of patients seen within 6 weeks.

- **Cardiac CT** - CT cardiac lists were agreed at RD&E providing an additional 14 scans per session, 3-4 sessions per month. As a result of this increase in capacity, the number of patients receiving their Cardiac CT scan had improved significantly from 39.1% at the end of January to 86.5% in May 2023. Due to a decline in Eastern performance, Northern capacity for cardiac CT at RD&E has been reduced. We continue to work with our colleagues across site to align resources and monitor performance to ensure equality for our patients but this reduction in capacity will result in a decline in performance for Northern CT cardiac scans. We have moved from 89% at the beginning of July to 64% beginning of October. Extra cardiac CT lists on the mobile CT van are in the process of planning but should enable a further 7 weekend lists from November 2023 to March 2024 which is potentially capacity for up to 144 patients.



- **U/S-** We have been able to continue to provide some internal lists over weekends to continue to improve performance. Some capacity at the Eastern CDC has been requested and we are waiting to hear. This has been delayed slightly by sickness absence in the Eastern team impacting on U/S services. Outsourcing was sourced for September and will continue in October for Soft tissue scans, which will reduce the longer waiters. Longer term we have a sonographer who will be training in this area, course commencing February 2024.

- **Endoscopy** -Consultant Gastroenterologist vacancies remains a key constraint, one new consultant started in-post in early October. 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. To further increase capacity an additional of trans-nasal Endoscopy has been identified and this additional capacity was expected to be in place in early August but this was unfortunately delayed until September. This has increased gastroscopy capacity and has indirectly supported improvement in colonoscopy and sigmoidoscopy as regular lists will be preserved for these diagnostic procedures.

- **Echocardiogram** – Despite increasing the capacity the Inpatient demand for ECG continues to outstrip capacity. Funding has been secured from NHS England which will be used to recruit an additional Echo-cardiographer to carry out Inpatient Echos.

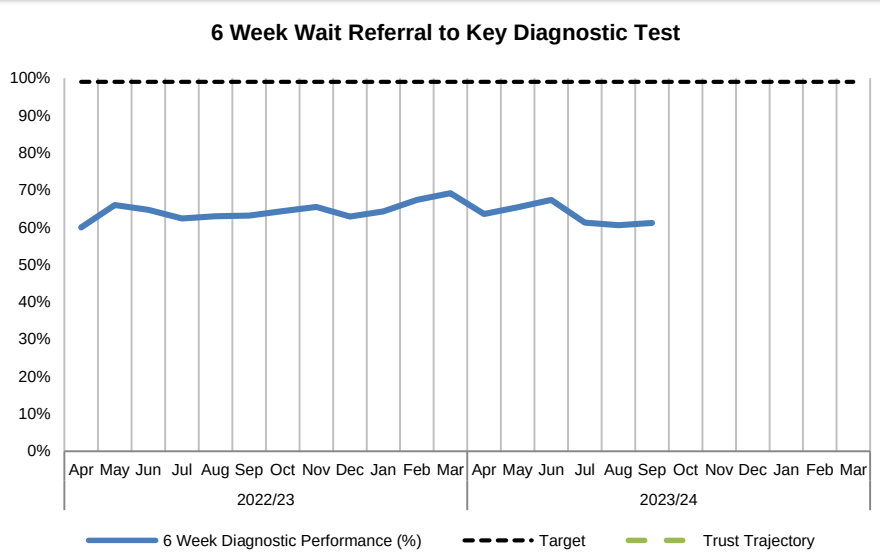
- **Sleep studies –** Additional capacity has been identified across clinics, nurses will carry out additional lists and a new member of staff will be joining in October, when capacity is expected to increase.

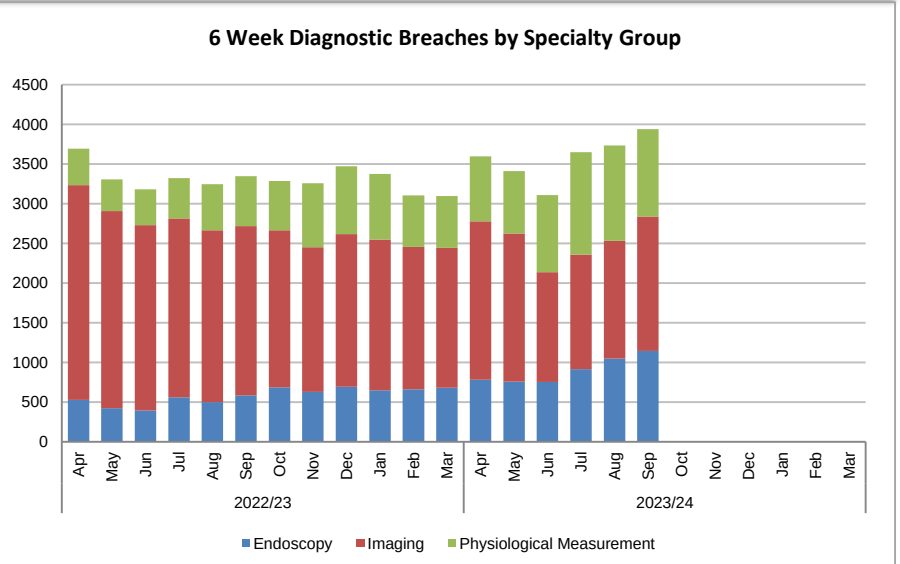
- **DXA –** DXA improvement continues in line with although this is still reliant on 2 individual staff members. The contract with Taunton for one list per month continues for 23/24.

- As part of the Trust's Improvement Programme, a diagnostic improvement workstream has been commenced.

Eastern Services Diagnostics

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

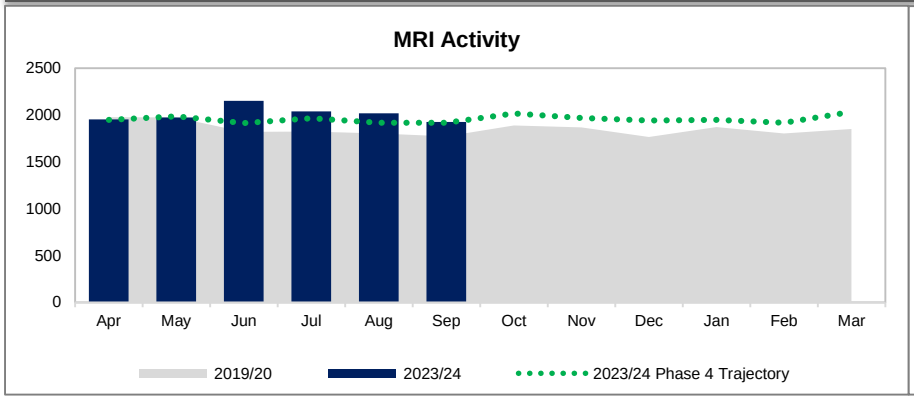


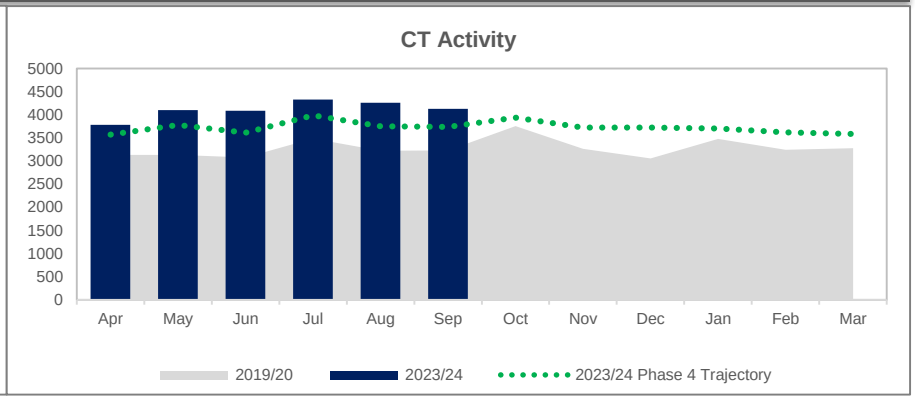


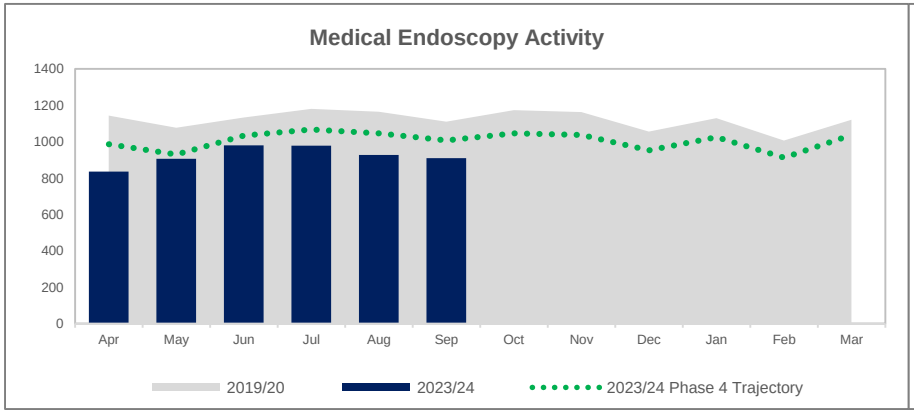
Area	Diagnostics By Specialty	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Endoscopy	Colonoscopy	51.6%	54.9%	53.9%	53.9%	51.2%	53.0%	50.1%	49.2%	53.1%	41.9%	48.2%	38.1%
	Cystoscopy	87.4%	83.5%	88.1%	47.8%	83.1%	83.2%	75.2%	73.6%	73.5%	76.5%	57.9%	59.4%
	Flexi Sigmoidoscopy	51.3%	49.6%	44.8%	82.1%	41.7%	50.4%	51.1%	54.5%	51.4%	43.4%	42.6%	33.7%
	Gastroscopy	69.8%	78.3%	74.8%	74.7%	73.9%	73.5%	66.3%	70.3%	97.4%	69.8%	66.3%	57.9%
Imaging	Barium Enema	-	-	-	-	-	-	-	-	-	-	-	-
	Computed Tomography	89.5%	92.3%	86.2%	87.9%	83.3%	84.6%	82.5%	79.5%	77.4%	76.5%	81.5%	99.8%
	DEXA Scan	99.2%	98.4%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	100.0%	99.3%	100.0%
	Magnetic Resonance Imaging	73.7%	75.6%	68.5%	70.7%	76.5%	73.4%	66.6%	68.8%	72.8%	69.8%	69.3%	72.0%
	Non-obstetric Ultrasound	54.5%	56.7%	56.8%	56.6%	60.1%	66.4%	59.9%	63.8%	70.9%	70.4%	66.6%	70.2%
Physiological Measurement	Cardiology - Echocardiography	75.2%	65.0%	66.6%	66.9%	72.6%	66.3%	61.7%	66.1%	58.8%	43.2%	44.7%	48.0%
	Cardiology - Electrophysiology	-	-	-	-	-	-	-	-	-	-	-	-
	Neurophysiology - peripheral neurophysiology	55.4%	65.4%	43.2%	49.4%	61.2%	75.1%	59.3%	62.1%	67.6%	41.5%	37.5%	78.5%
	Respiratory physiology - sleep studies	61.4%	63.1%	60.6%	57.8%	57.7%	66.4%	65.5%	60.7%	61.4%	53.9%	47.0%	44.4%
	Urodynamics - pressures & flows	25.7%	33.7%	28.8%	38.5%	32.2%	37.8%	36.8%	36.8%	27.3%	29.2%	21.3%	20.0%
Total		64.4%	65.5%	63.0%	64.3%	67.4%	69.2%	63.6%	65.4%	67.4%	61.3%	60.6%	61.2%

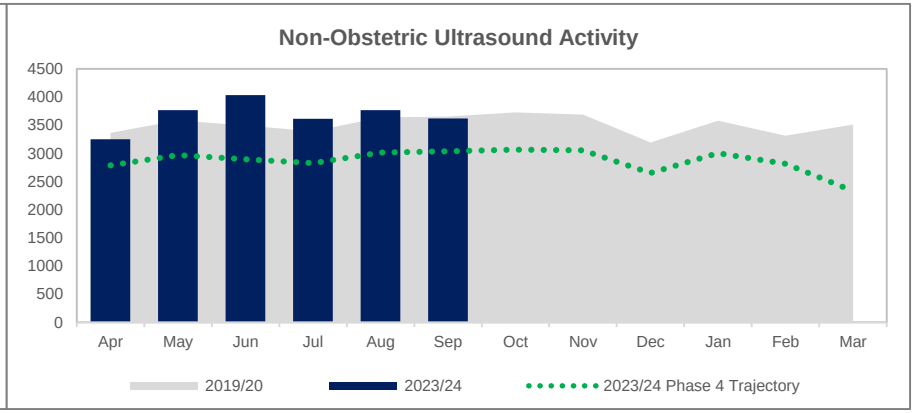
Eastern Services Diagnostics

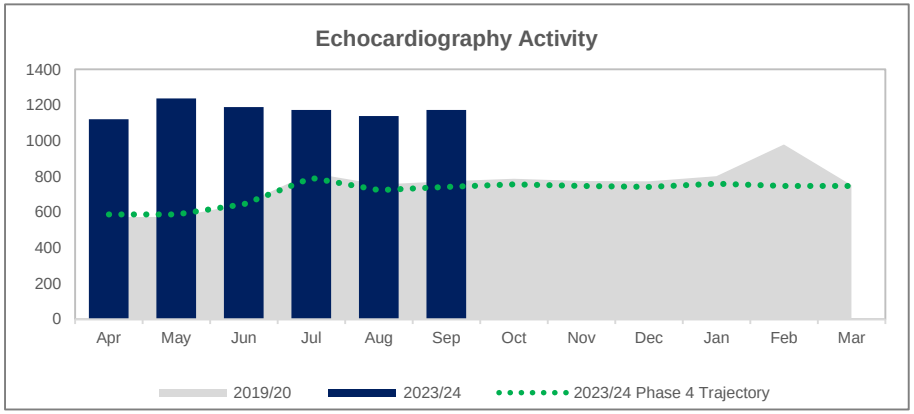
Volumes of patients waiting longer than 6 weeks for one of fifteen key diagnostics tests











Eastern Services Diagnostics

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

At the end of September 61.2% of patients were waiting less than 6 weeks – an improvement of 0.6% since the end of August.

CT

- September saw a return to normal capacity however the sustained impact of industrial action continues. All patients whose wait is longer than circa 6 weeks require CT cardiac imaging.
- Breaches over 6 weeks continues to decrease, reducing by 61% since mid August.

MRI

- Cardiac MRI continues to be challenged, although activity has been maintained throughout the Industrial Action. The imaging team have worked with Cardiology to support a new list every Friday and additional lists where cardiologists and cardiac nursing teams timetables permit during weekends
- Non-Cardiac MRI breaches have more notably deteriorated, mainly as a result of industrial action as well as the transfer of capacity to Cardiac MRI. The longest waiting patients for a non-cardiac procedure are currently waiting up to 22 weeks. The team is working through options to address this as a priority.

Non Obstetric Ultrasound

- The ultrasound waiting list remains stable following industrial action
- Musculoskeletal ultrasound continues to encounter capacity issues which the Imaging Team are working with the MSK Radiologists on, seeking to identify opportunities to increase capacity.

Dexa

- Dexa waits remain within target, with the small number of breaches resulting from patient choice.

Endoscopy

- Endoscopy mobile unit operational from 16 October and running well. Patients being booked from both Eastern and Northern Services.
- Highest number of points in a week delivered at the start of October – 594.5 points. Increasing volume will be seen with the additional mobile capacity
- Reduced waiting time for 2WW patients waiting for OGD (16 days at start of October down to 9 days at end October)

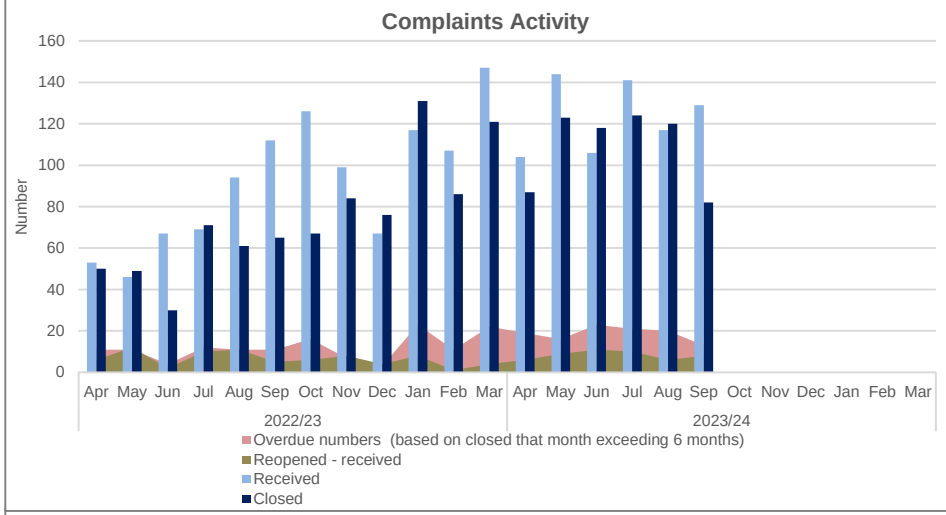
Echocardiography

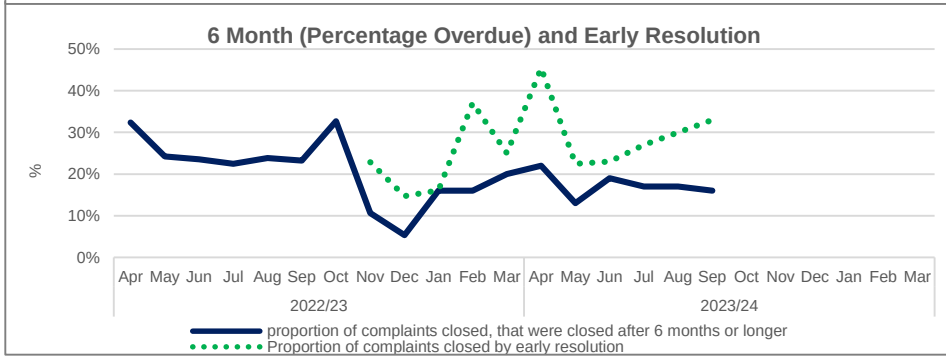
- Demand has increased further on a previously high level with performance remaining challenged. Despite ongoing weekend physiologist clinics, the number of breaches has increased.
- Three band 6 posts were recruited to, with postholders commencing in the New Year. A Business Case is being developed to increase the resource in Cardiology; this includes an increase in the number of echo physiologists.
- An echo task and finish group, led by a member of the consultant team, is working on both protocols to better support the service through more efficient triage, and workflows in Epic to enable this. Additionally, clinical advice for valve surveillance intervals at the outpatient Epic request is being explored.

Respiratory Physiology

- Equipment assistant recruited to release more clinical time to report tests. Capital approval to replace broken equipment – order placed.

Trust Patient Experience





During September, 27 complaints were closed by early resolution (33% of total closed). There has been sustained improvement in the volume of complaints being closed over the last two quarters. The recent development of a new complaints investigation process has a primary driver of improving the quality of complaints responses for the service user, the secondary driver will promote opportunities to resolve complaints within 14 days. This service improvement is currently being rolled out across the Trust and is due to be completed by the end of March 2024.

There was an increase in complaints received in August and a decrease in complaints closed when compared to the previous month. The percentage of complaints closed after 6 months or longer in month has decreased to 16%, this is in part due to the very complex nature of the complaints being received and the resource required by clinicians to contribute to complaint investigations. Overdue complaints are monitored through the divisional PAF meetings, and at weekly complaints huddles between divisions and corporate services.

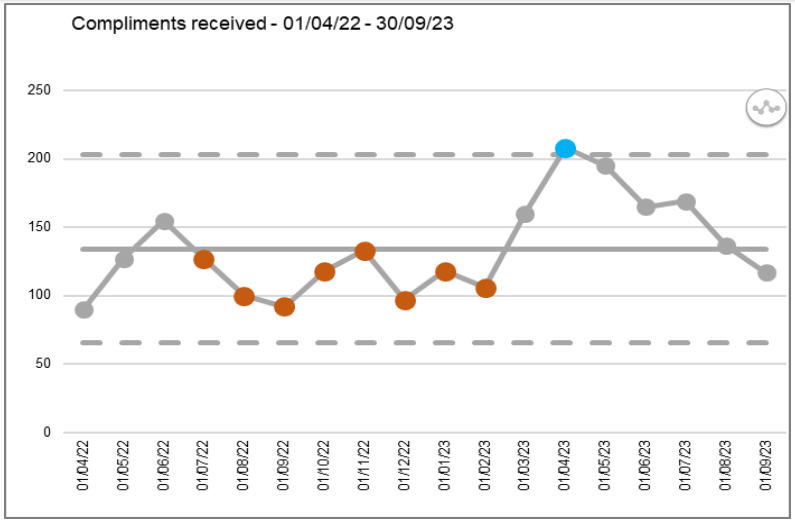
Two new primary investigations were received from the PHSO during September, the primary review will determine whether further investigation is required, and one investigation was closed.

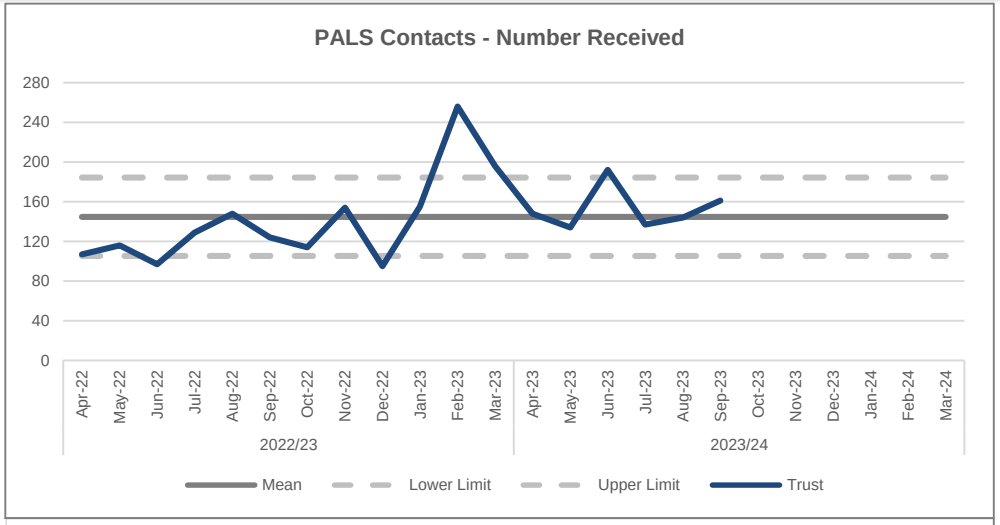
Analysing the main themes from September remain consistent with themes reported in previous months, and wider patient experience metrics. Communication remains the main theme throughout complaints. Values and behaviors of staff is the second most reported theme, which triangulates with PALS and Care Opinion data received.

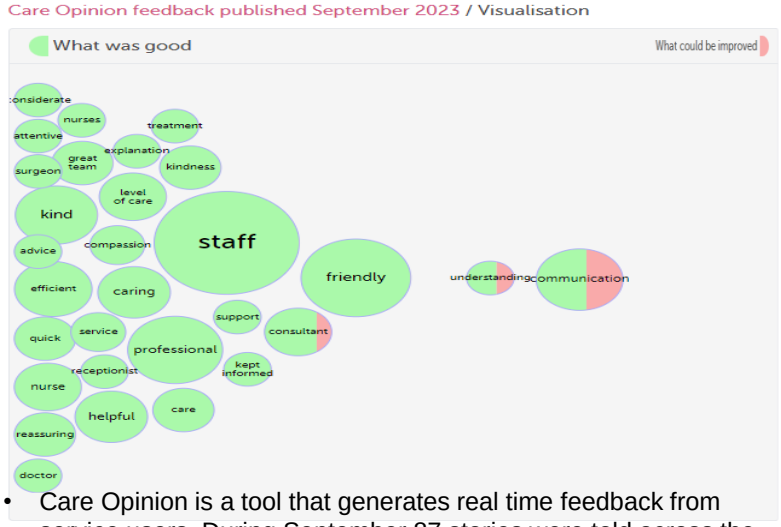
Number of new PHSO investigations received during month	Primary investigations currently open	Detailed investigations currently open	Number of PHSO investigations closed during month
2	15	3	1

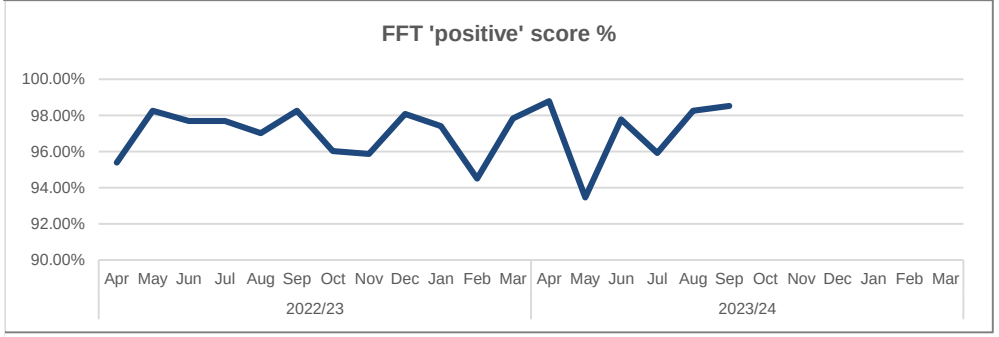
	2022/23												2023/24					
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Complaint received and acknowledged within 3 days	88.89%	84.79%	67.27%	93.50%	96.51%	85.00%	87.00%	93.34%	90.29%	90.00%	90.50%	88.00%	90.00%	91.00%	98.00%	92.00%	91.00%	95.00%
Over 6 months (no of complaints open at end of month)	12	16	4	12	11	13	16	7	3	22	14	23	13	20	18	14	15	22
Complaints closed in month by early resolution								27	15	21	32	31	36	26	27	33	36	27
Over 6 months (%)	32.35%	24.24%	23.53%	22.45%	23.81%	23.26%	32.65%	10.61%	5.36%	16.00%	16.00%	20.00%	22.00%	13.00%	19.00%	17.00%	17.00%	16.00%

Trust Patient Experience





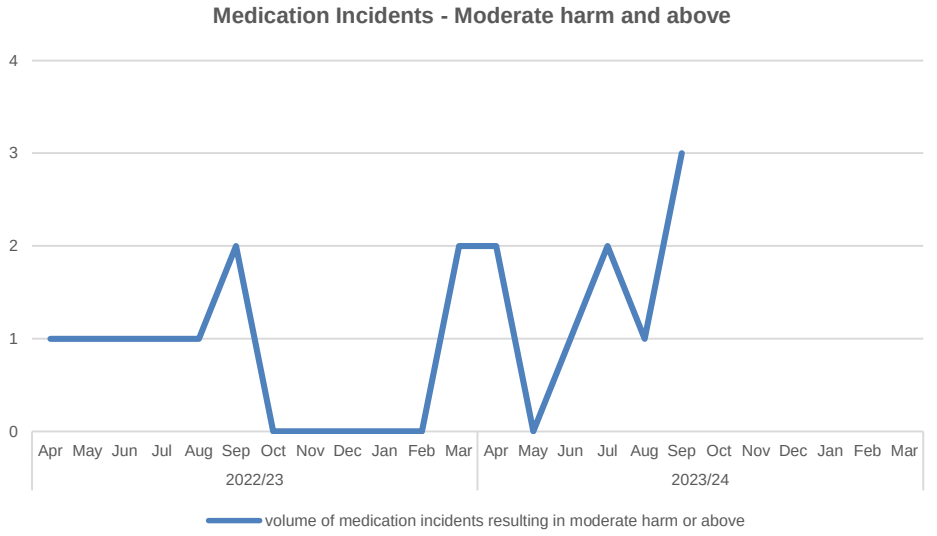


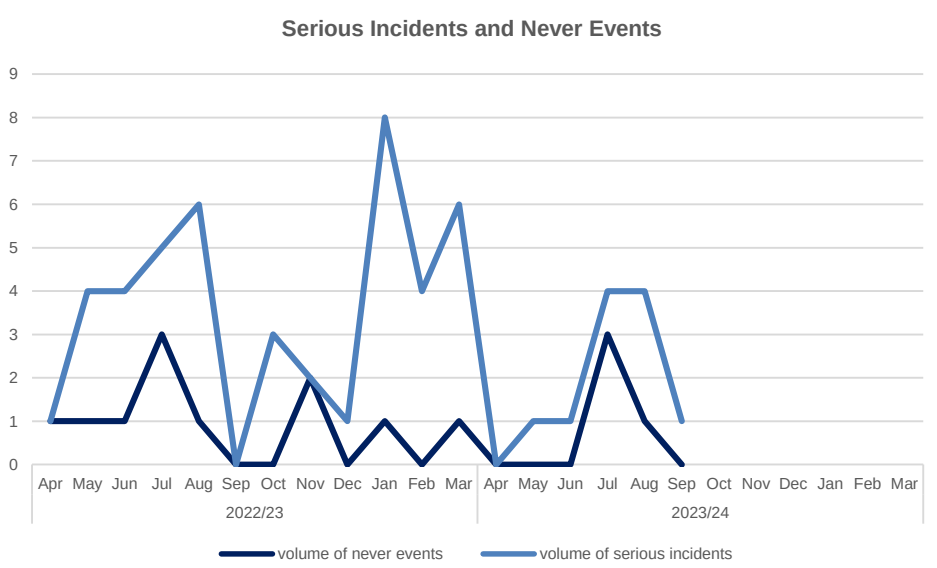


- Care Opinion is a tool that generates real time feedback from service users. During September 87 stories were told across the Trust, of those 14 had a critical element, 5 were not rated as received through NHS choices, 68 (78%) were positive stories. The system is planned to be rolled out (advanced subscription) by end of March 2024 across the trust which will connect staff with service users in real time. Usage of Care Opinion across the trust may explain the declining numbers of compliments logged and recorded.

- Top 5 PALs themes for September were communications, appointments, Trust admins / policies / procedures, values & behaviours & facilities. These themes align with themes arising from Care Opinion feedback with communication, understanding & consultant behaviour (values & behaviours) being the top 2 themes.
- The Trust has an extensive Urgent and Emergency Care programme within which waiting times and flow through emergency settings are monitored, with work ongoing both locally and nationally to improve. The Patient Experience Team are leading a trustwide project with an aim to improve how we communicate with service users, and the People team continue to lead extensive work to deliver the cultural roadmap for Trust colleagues.

Trust Incidents





Three moderate harm medication incidents were reported.

Two incidents relate to the same medicines reconciliation issue for a patient, reported at different stages of their pathway. Summary care record was unavailable for medicine reconciliation resulting in patient receiving a medication no longer prescribed.

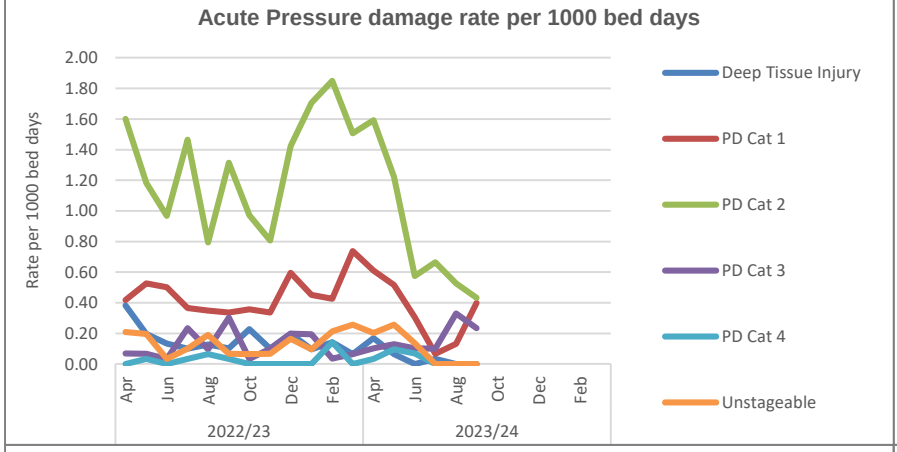
The third incident related to issues with shared care prescriptions. Dosage changes for a rheumatology patient were not being processed in a timely way, which resulted in a rheumatology patient receiving inappropriate dosing.

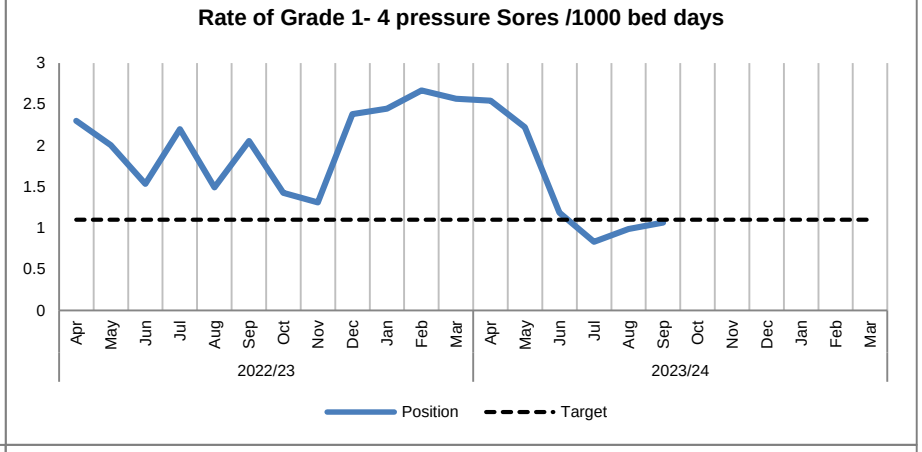
Issues for both patients have now been resolved

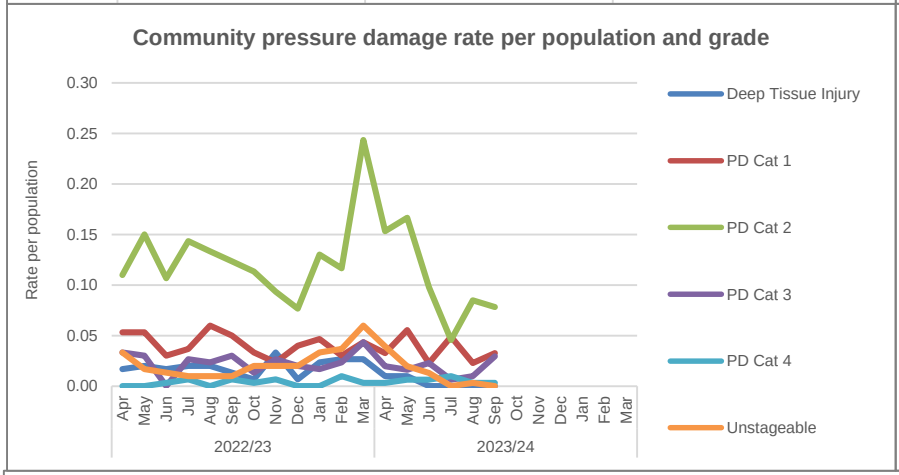
There was one Serious Incident StEIS reported in September 2023. This was a treatment delay in Northern Ophthalmology Services. This incident was highlighted in the August 2023 Waiting Well component of the IPR. A concise learning review has been commissioned for this incident and Duty of Candour has been completed.

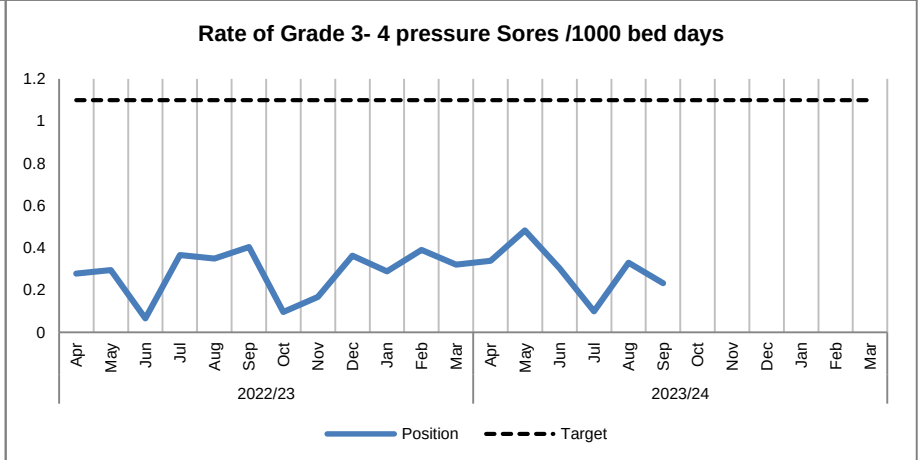
Trust Pressure Ulcers

Rate of pressure ulceration experienced whilst in Trust care





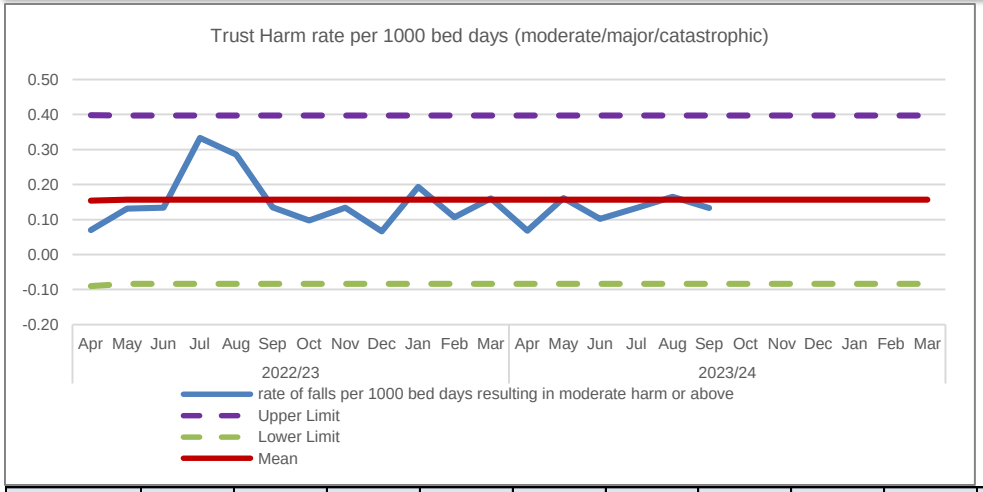




- Healthcare acquired pressure damage remains low and within normal variation. The pressure ulcer prevention strategy appears to be a significant factor in improvements across the Trust.
- In Northern services a targeted programme of improvement work has seen a reduction in both the number of pressure ulcers and the degree of harm. Eastern services reported one category 3 pressure ulcer. This will be subject to investigation as initial review indicated that potential lapses of care contributed to the tissue damage.

Trust Slip, Trips & Falls

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

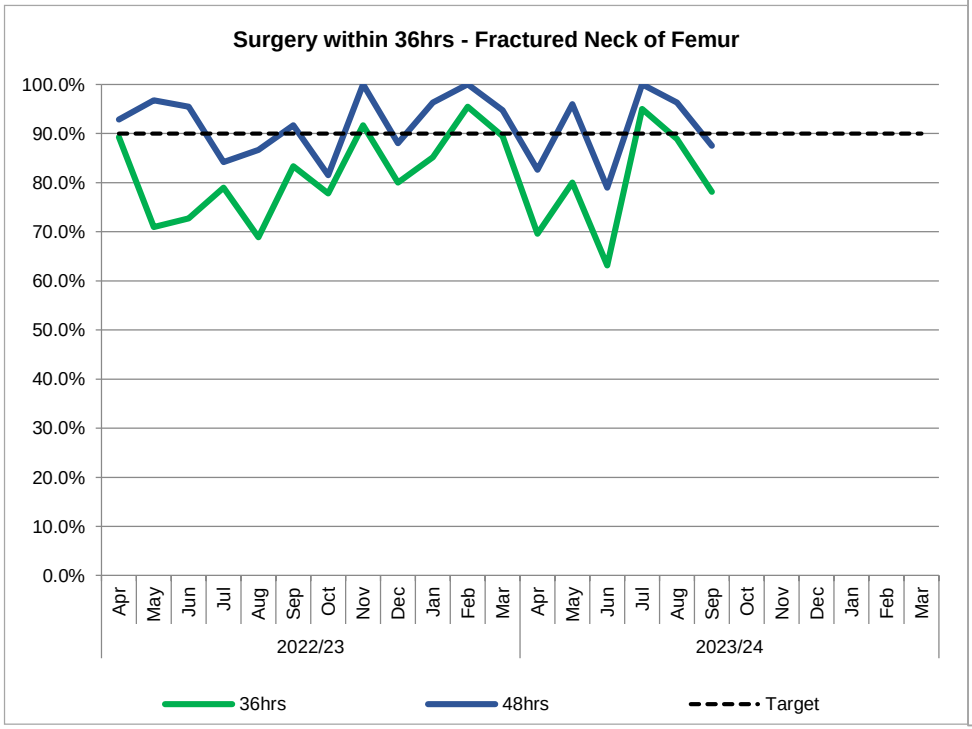


Month	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Falls	232	200	226	236	194	203	228	206	204	221	203	227	186	184	167	196	188	197
Moderate & Severe Falls	2	4	4	10	9	4	3	4	2	6	3	5	2	5	3	4	5	4

- Falls remain within normal variation.
- Four moderate harm falls were reported which resulted in patients experiencing fractures; two falls were witnessed; two were not directly witnessed. Post fall huddles or reviews are completed for all cases; initial review demonstrates that no suboptimal care issues are associated with the falls.

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

Northern Services	Oct-22	Nov-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Aug-23	Sep-23
NDDH	65%	81%	76%	82%	78%	77%	76%	71%	82%	82%



- 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 September 2023, 78.1% of medically fit patients with a fractured neck of femur (NOF) received surgery within 36 hours. The Trust admitted a total of 32 patients with a fractured neck of femur in that month who were medically fit for surgery from the outset and of these, 25 patients received surgery within 36 hours.

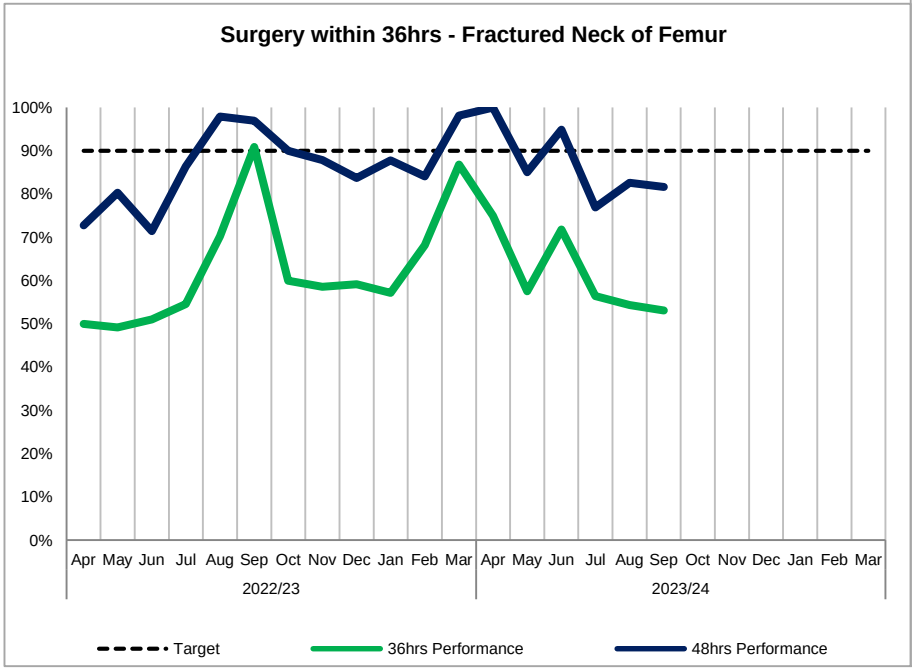
- The seven patients in total that breached 36 hours were due to lack of theatre time and awaiting space on theatre lists. There is an increasing volume of Trauma admissions being seen impacting on capacity. Four patients waited longer than 48 hours; therefore 87.5% of patients received their surgery 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	Oct-22	Nov-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Aug-23	Sep-23
RDE Wonford	73%	72%	81%	88%	87%	82%	79%	87%	83%	83%

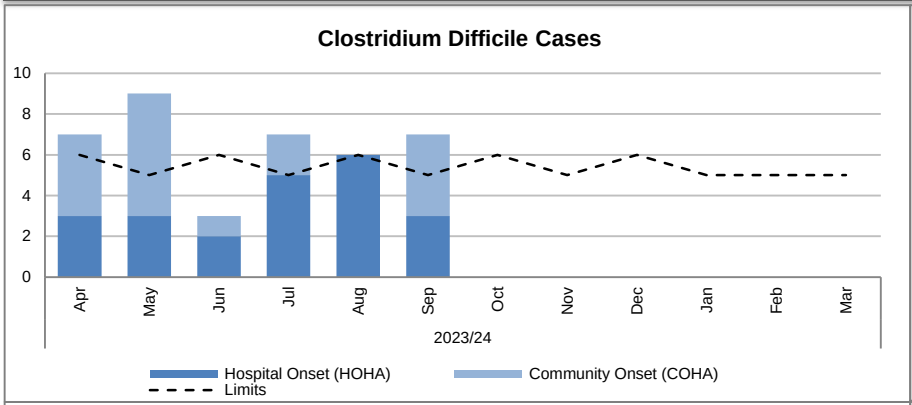
- The snapshot position taken from the Epic system in relation to the proportion of patients risk assessed for VTE on admission, demonstrates a stable position.

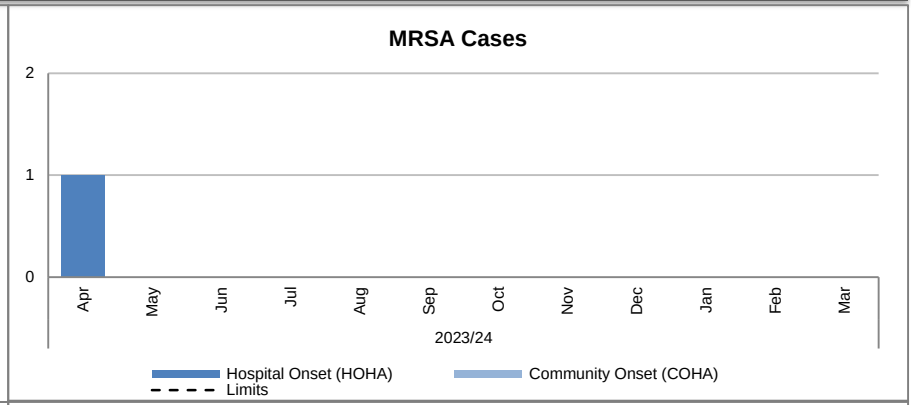


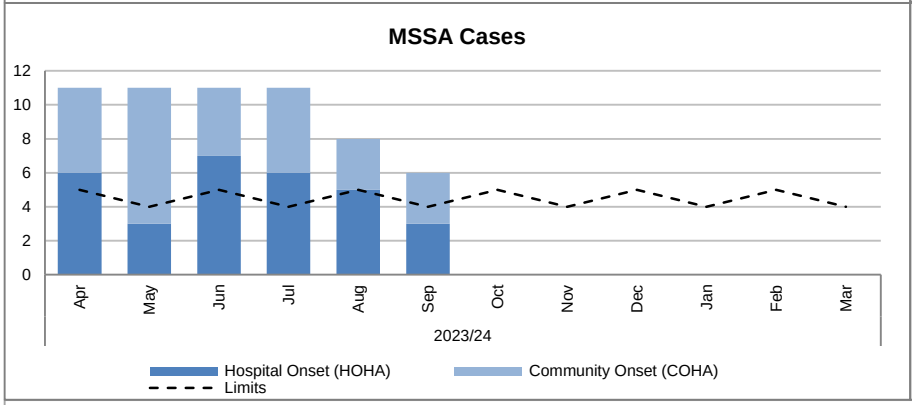
- In September 2023, 53% of medically fit patients with a fractured neck of femur (FNOF) received surgery within 36 hours. There were a total of 59 patients admitted with a FNOF, 46 of these patients were medically fit for surgery from the outset and 26 patients received surgery within 36 hours.
- Nine medically fit patients had to wait longer than 48 hours for surgery. The reason for delay was awaiting space on theatre lists.
- There were a total of 180 trauma patients admitted in September, with two days seeing 11 and 12 trauma patients being admitted, which is extremely high.
- Where clinically appropriate all FNOF cases are given priority in theatres over elective patients. 55 Trauma Patients had their surgery during September in PEOC Theatres, which was to the detriment of elective activity. The high trauma numbers in September resulted in a significant number of elective cancellations. 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 an extended wait for surgery.
- Additional elective work has now moved to SWAOC for Foot and Ankle, Soft Tissue Knees and in October Spinal – this is additional work and therefore has not freed up any additional specific trauma space within PEOC. Within PEOC Theatres there are lists designated to accommodate trauma patients, however, due to the peaks of trauma admissions and the inability to predict demand, elective patients do get cancelled to accommodate trauma patients.

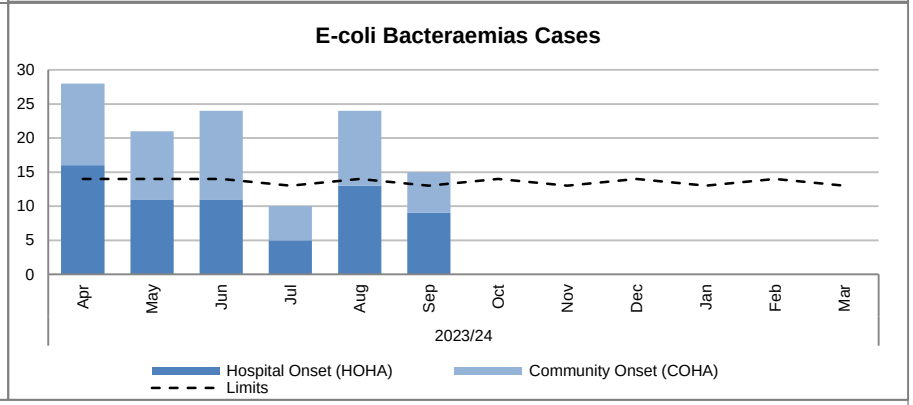
Trust - Healthcare Associated Infection

Volume of patients with Trust apportioned laboratory confirmed infection







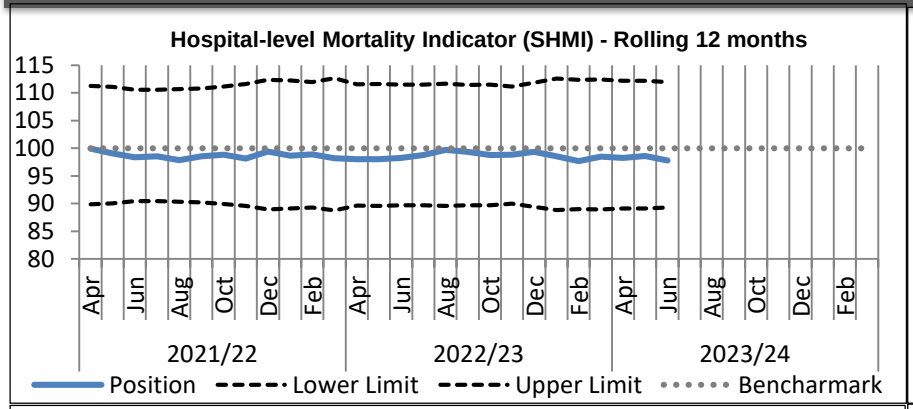


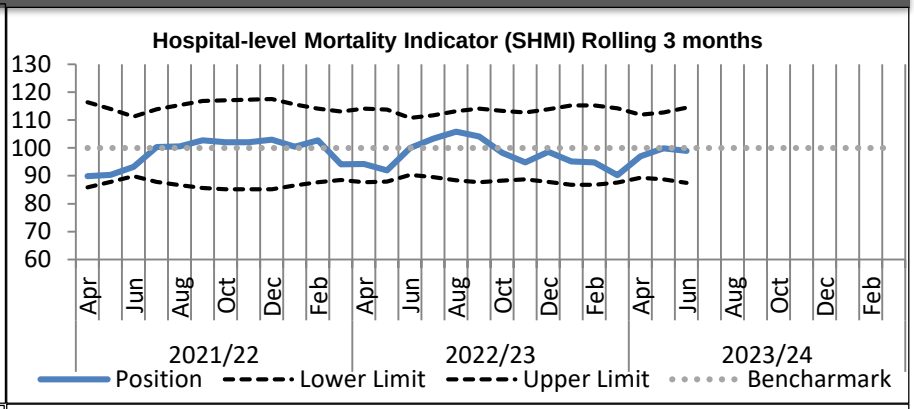
C.Diff – All cases investigated and deemed unavoidable. No Trust learning identified.
MRSA – Nil
MSSA – HCAI incidence remains above trajectory. Healthcare associated cases are investigated in full to establish preventable learning, with feedback where identified to enable improvement action planning. IPC team improvement projects that have been specifically targeted at reducing intravascular device associated infection in 2023 – 24 are underway throughout Eastern services.
E.Coli – September HCAI volume is on par with trajectory for this month. Gram negative bacteraemia rates remain consistently high this year. Urinary foci continues to be the highest causative factor with a significant urinary catheter association for HOHA cases in September. No Trust learning identified.

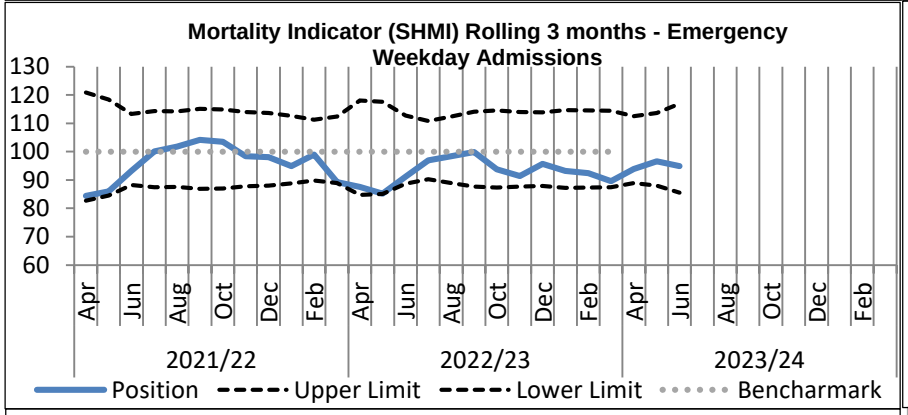
Work to align IPC with the patient safety incident response framework (PSIRF) has begun. A proportionate response to healthcare associated infection, rather than routine case by case review is proposed. This will not impact current mandatory reporting requirements and includes the continuous identification and feedback of trends and infection prevention themes in real time. New PSIRF pathways, in the process of being established, will further enable prompt feedback within divisional emerging safety event review groups and aid contribution to clinical improvement forums.

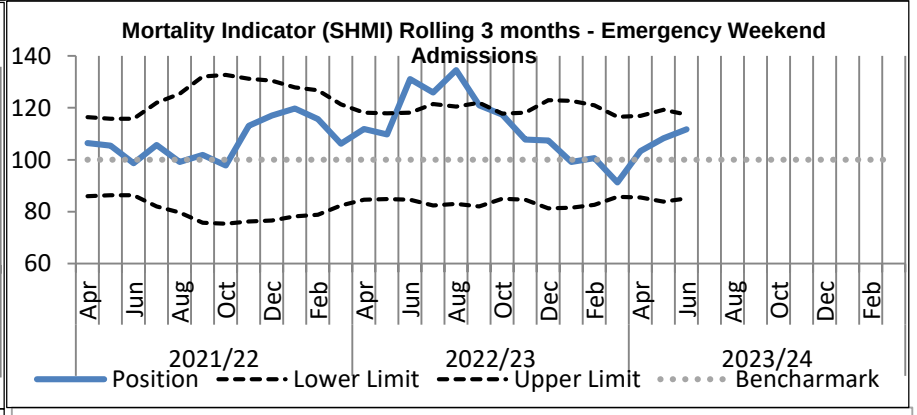
2023-24 trajectories have been agreed to include Northern and Eastern site expectations alongside those set for the Trust as a whole.

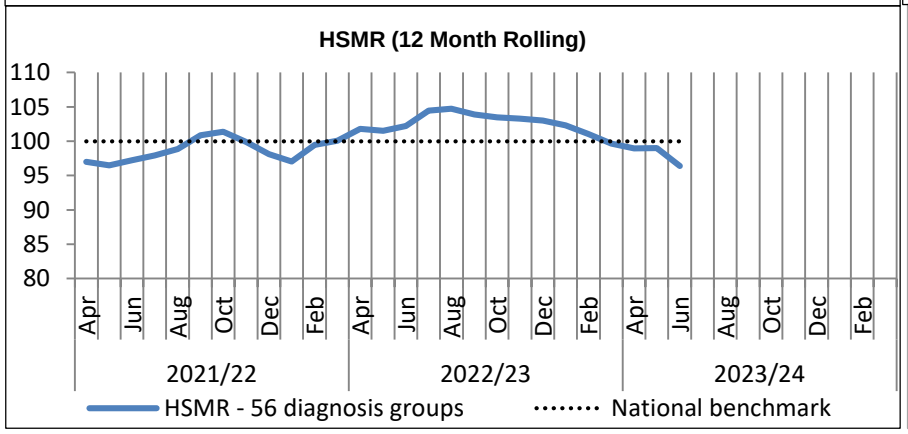
Northern Services Mortality Rates – SHMI & HSMR – *Rate of mortality adjusted for case mix and patient demographics*









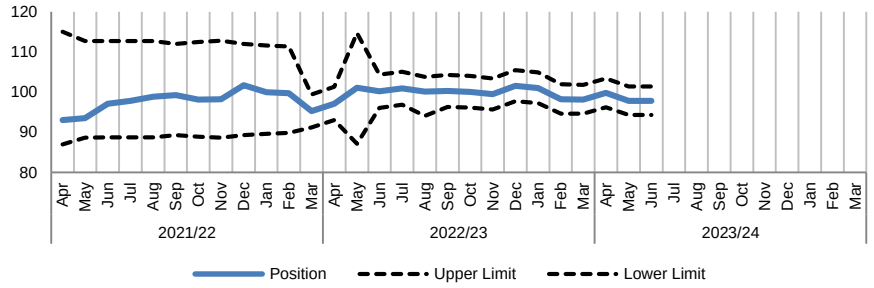


- The SHMI position remains within the expected range for all metrics
- The HSMR position remains stable and reducing on a rolling 12 month basis to June 2023
- The Medical Examiners continue to give independent scrutiny of all hospital deaths raising areas of concern to the mortality review process, governance/Datix, and clinicians where appropriate. No new emergent themes are currently being identified through this process.

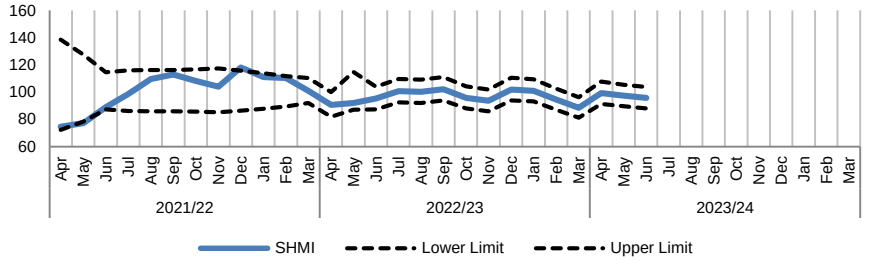
Eastern Services Mortality Rates – SHMI & HSMR

Rate of mortality adjusted for case mix and patient demographics

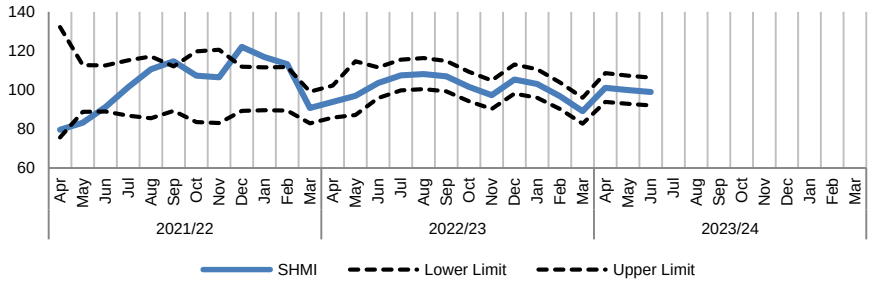
Hospital-level Mortality Indicator (SHMI) - Rolling 12 months



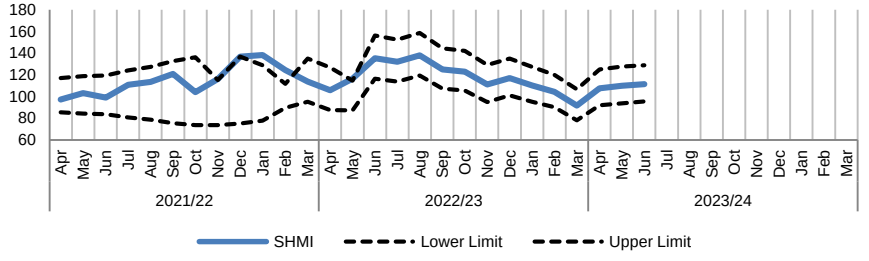
Mortality Indicator (SHMI) Rolling 3 months - Weekday Admissions



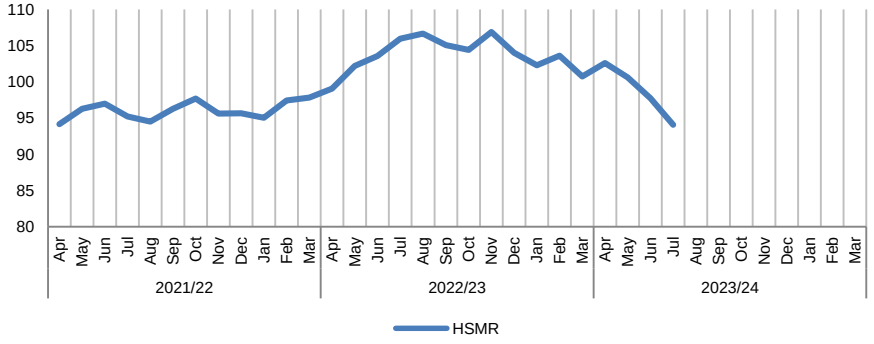
Hospital-level Mortality Indicator (SHMI) Rolling 3 months



Mortality Indicator (SHMI) Rolling 3 months - Weekend Admissions



HSMR (12 Month Rolling)



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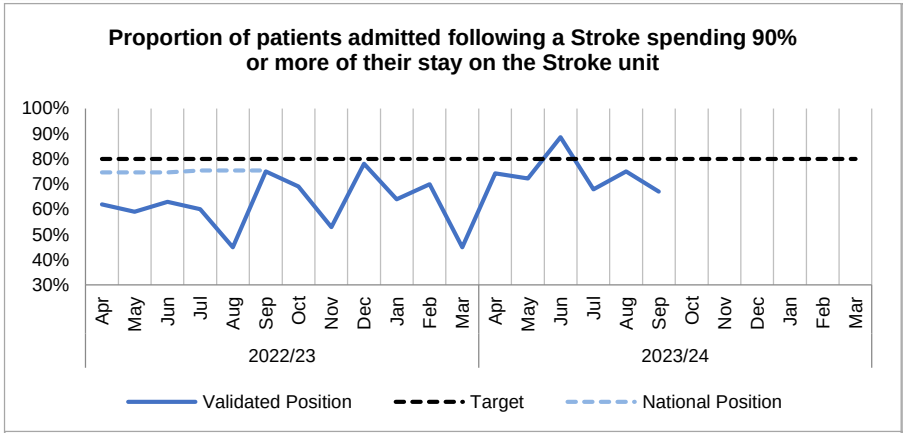
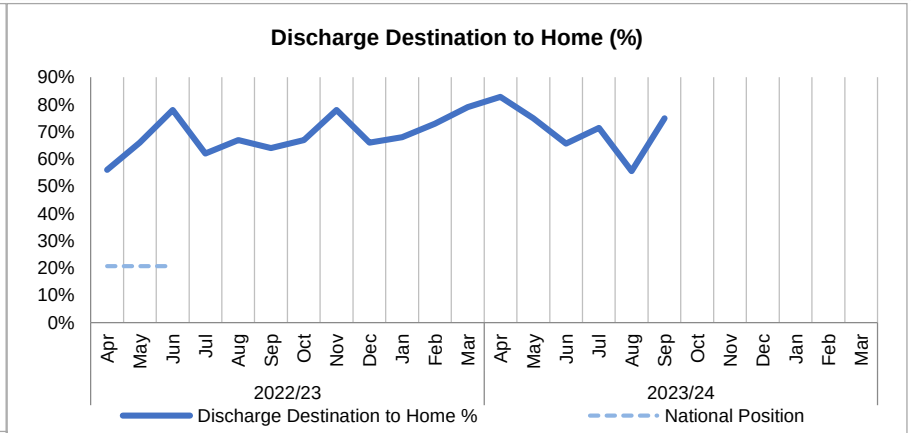
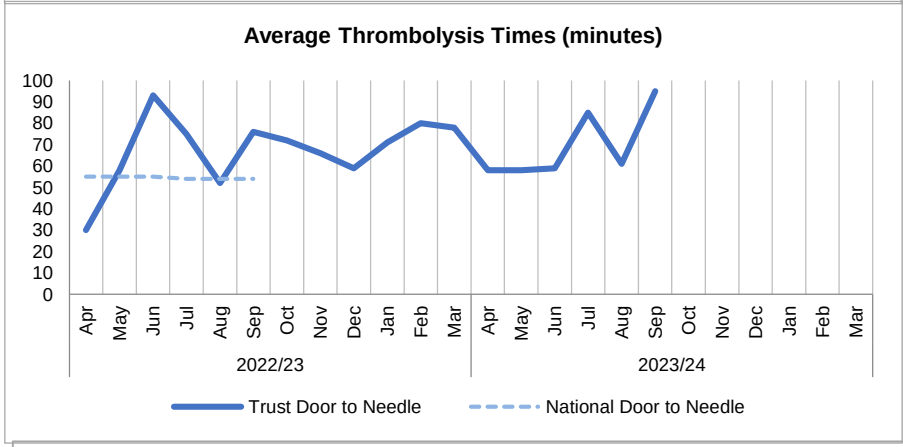
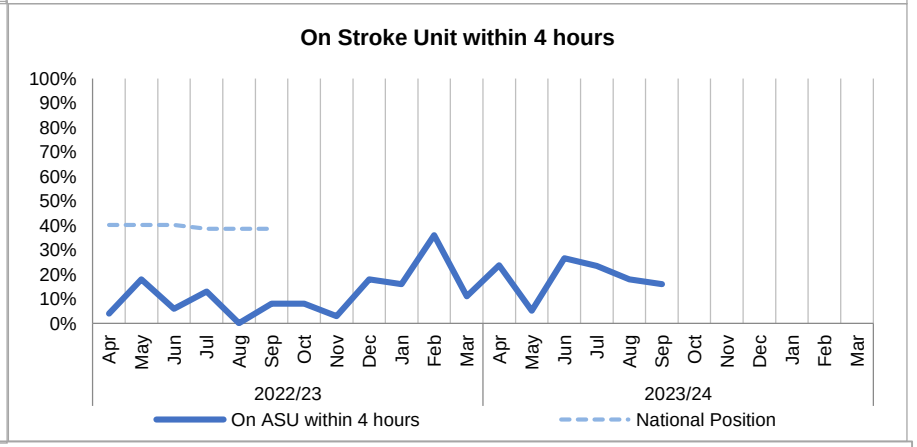
- The Medical Examiners continue to give independent scrutiny of all hospital deaths raising areas of concern to the mortality review process, governance/Datix, and clinicians where appropriate. No new emergent themes are currently being identified through this process.

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





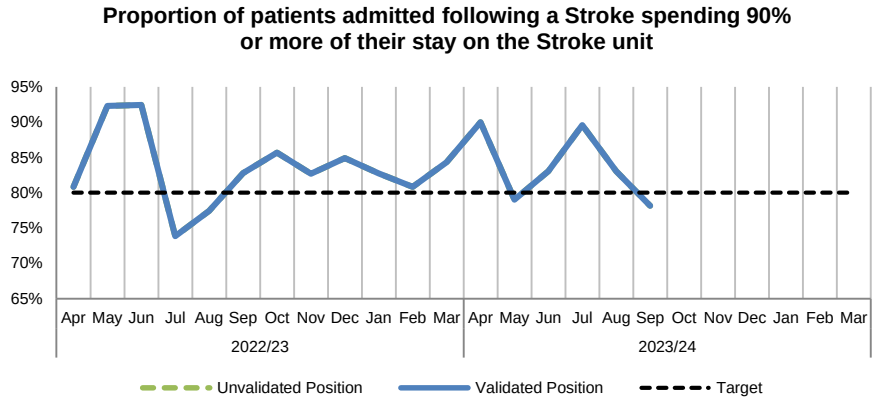


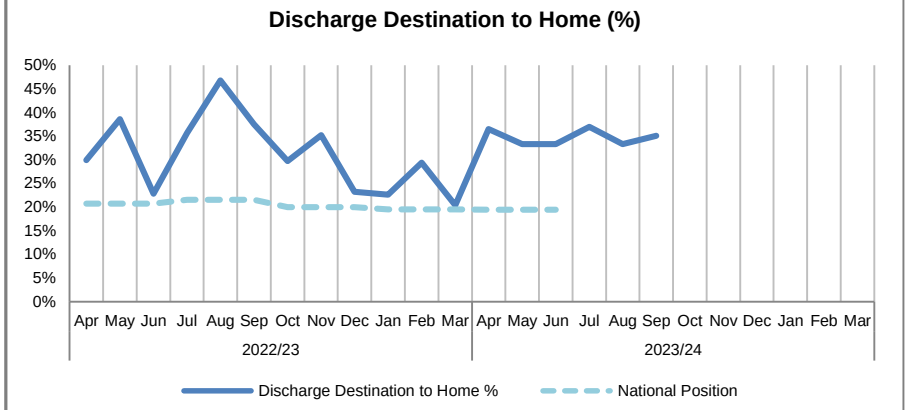


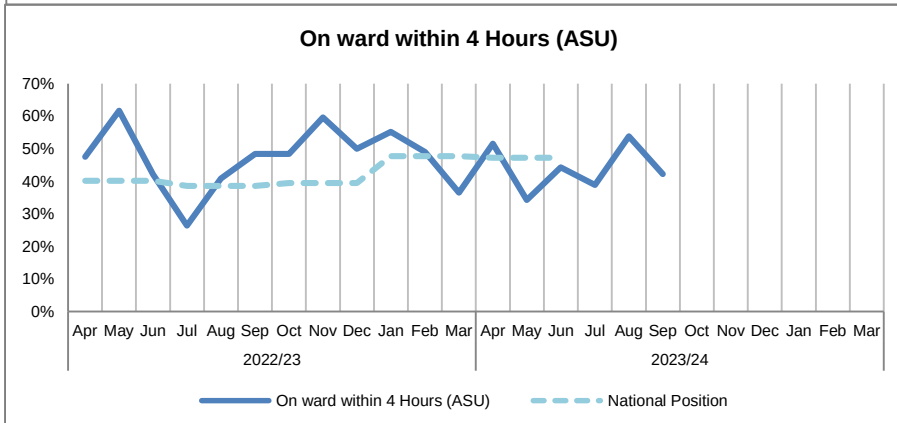
- **90% stay:** Performance against this indicator continues to show a more stable position across the last five months, achieving 67% in September. The Stroke clinical teams continue to provide outreach to outlying wards to ensure stroke patients are receiving appropriate stroke care. The Patient Flow Improvement Group continue to focus on reviewing the ringfencing processes with the site management team.
- **Discharge destination:** This metric is relatively stable and is above the national average.
- **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.

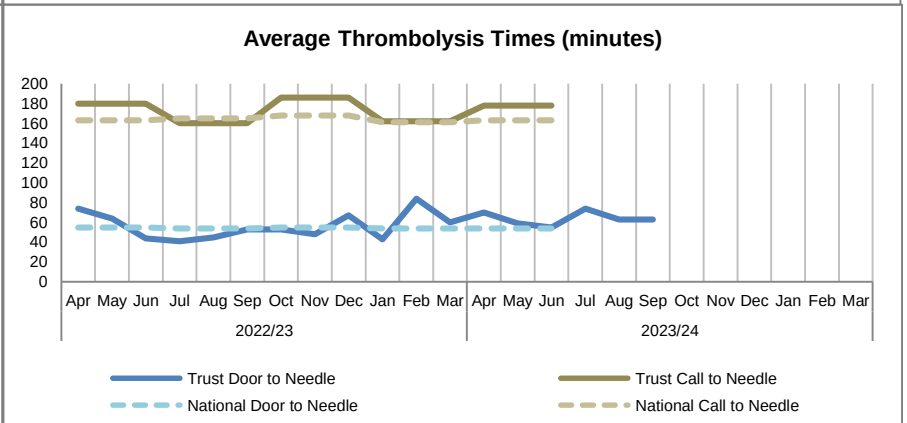
Eastern Services Stroke Performance

Quality of care metrics for patients admitted following a stroke



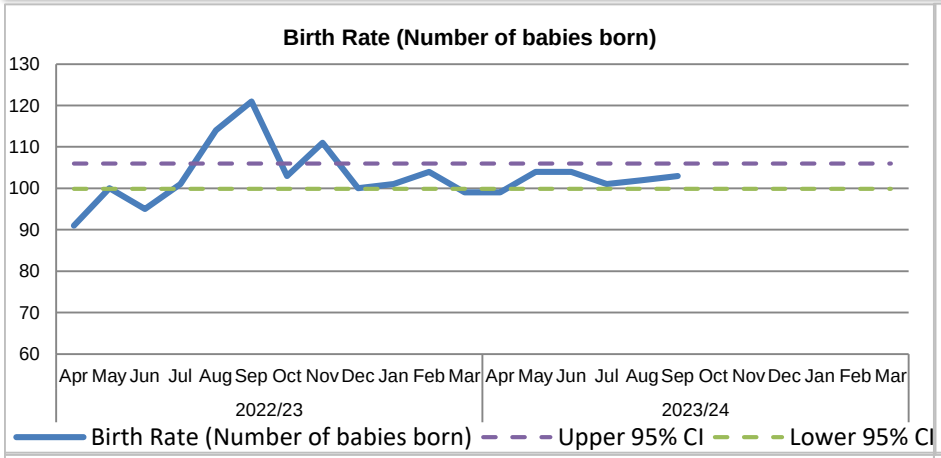


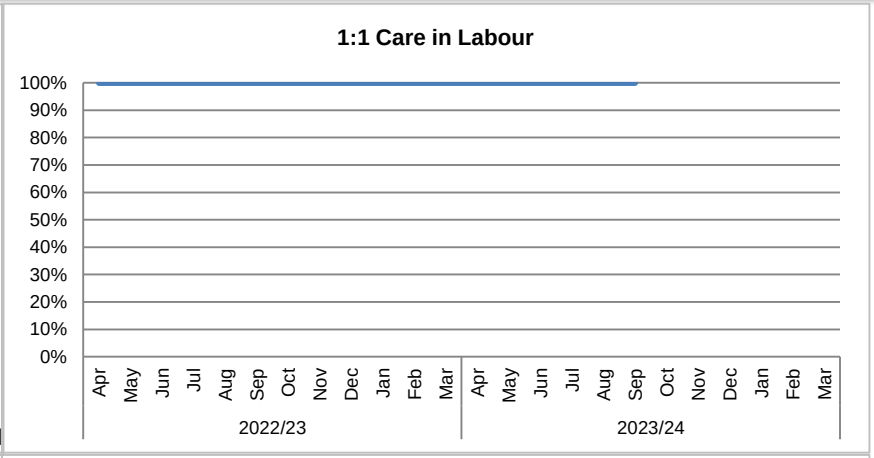


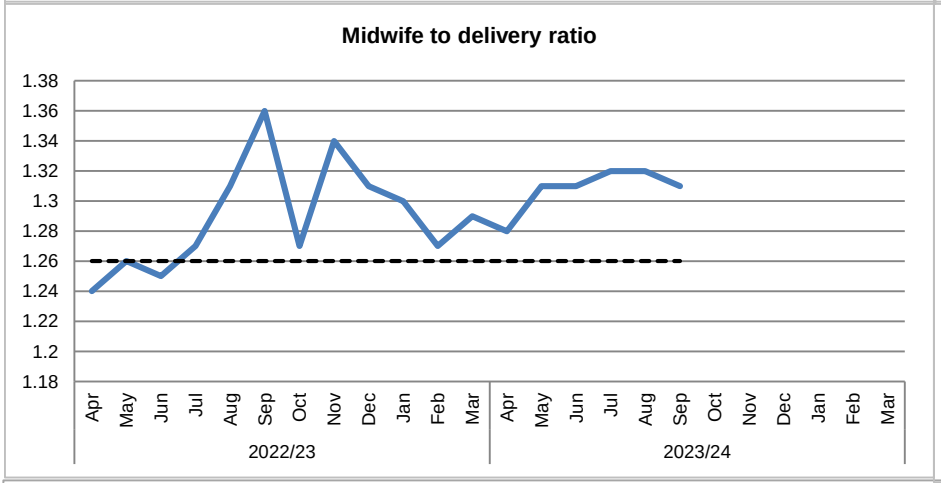


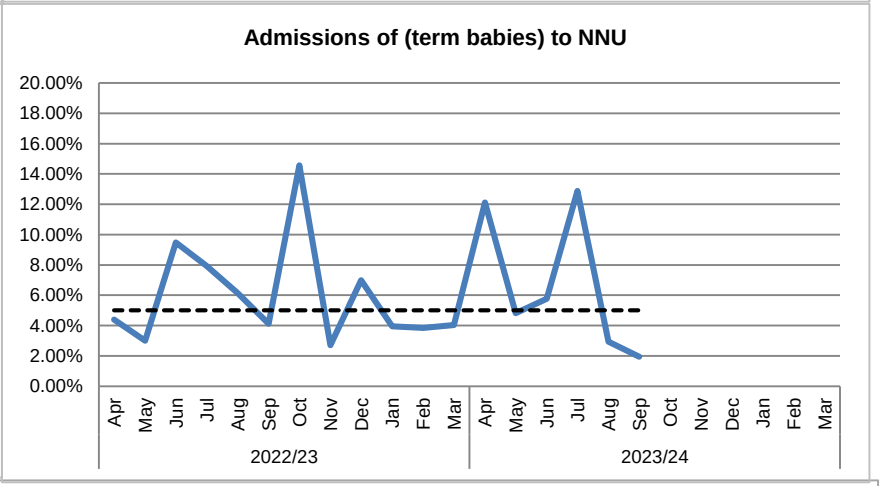
- **90% stay -** The proportion of patients admitted spending 90% of their stay on the stroke unit has dipped just below the target position in September and this corresponds with a reduction in the percentage achieved against the on ward within 4 hours target indicator, this in part is due to the period of operational pressures experienced as a consequence of the industrial action for both Consultants and Junior Doctors for an extended period of time in the month.
- The proportion of patients for whom their discharge destination is home remains stable.
- **Average Thrombolysis times** remain stable and in line with the national position.

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



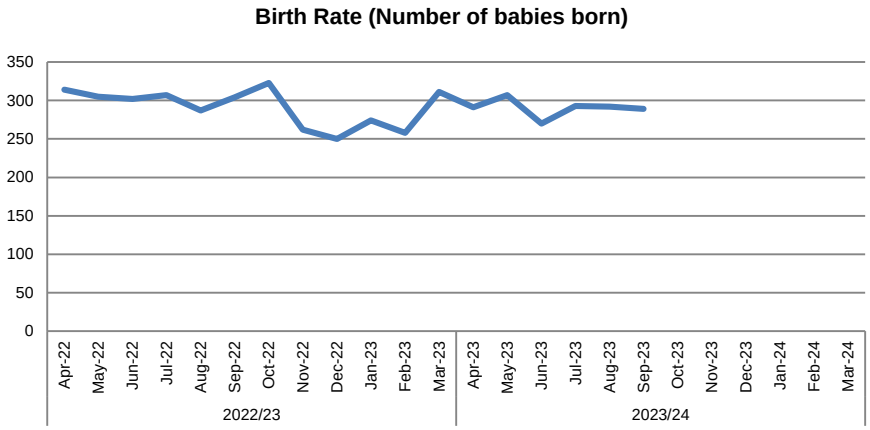


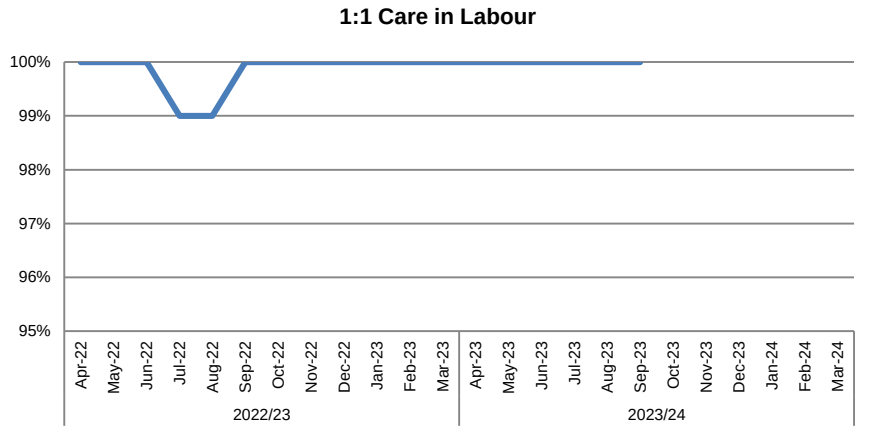


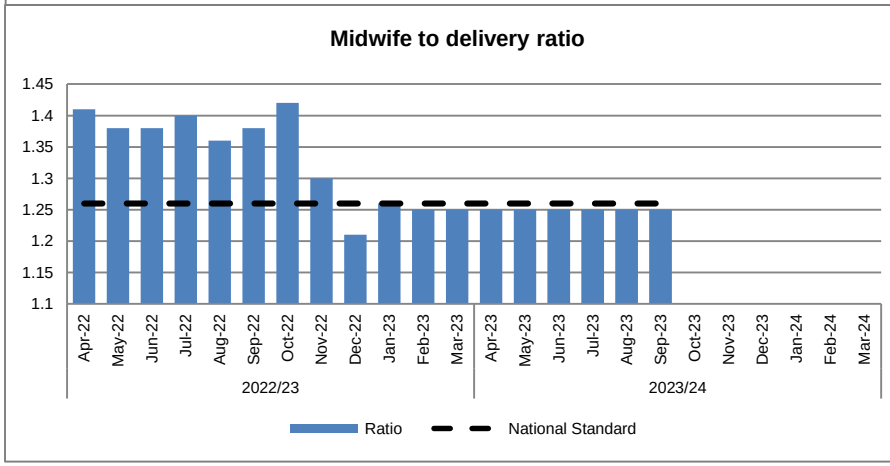


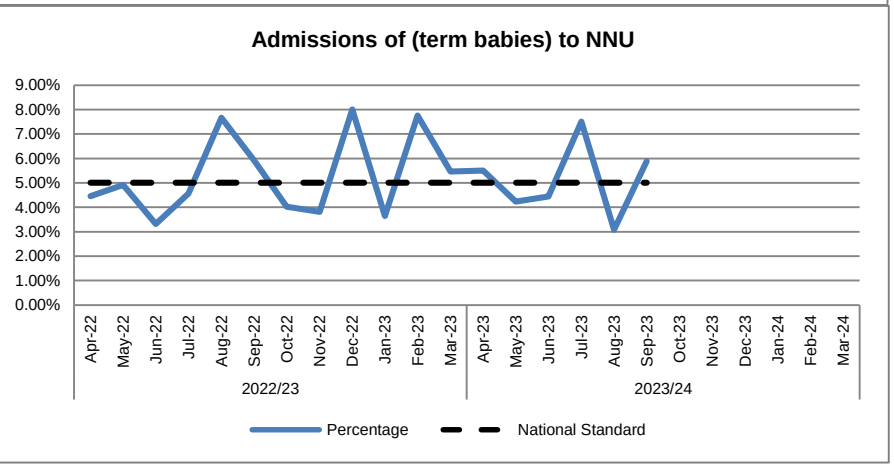
Eastern Services Maternity

Metrics relating to the provision of quality maternity care

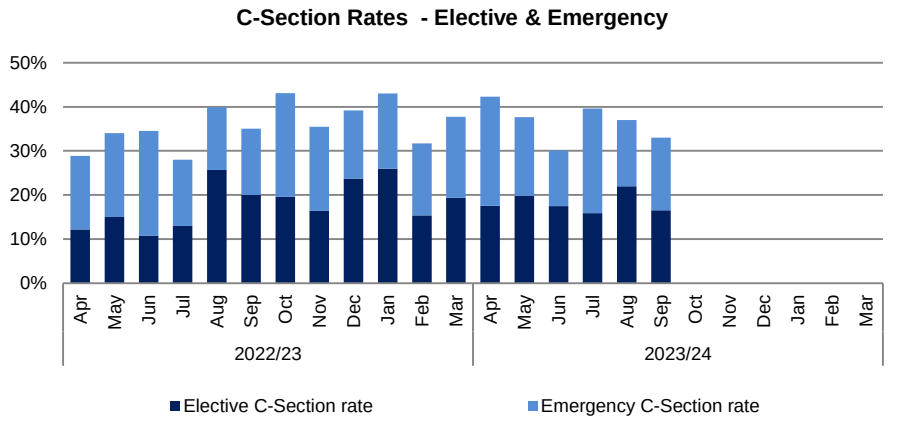


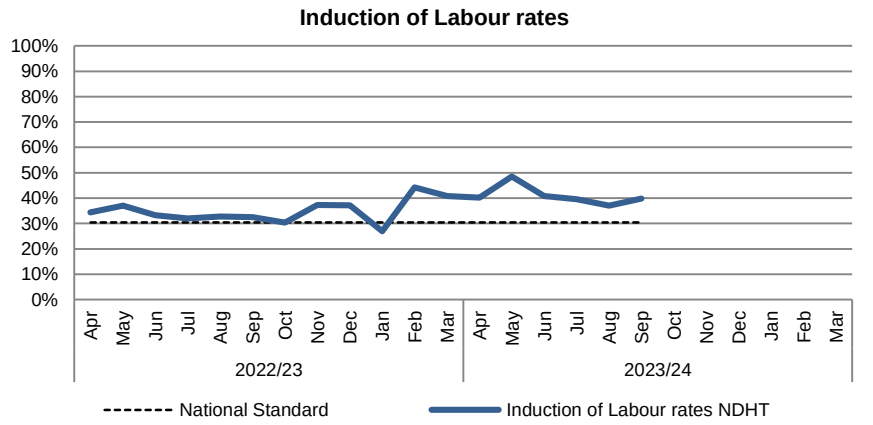


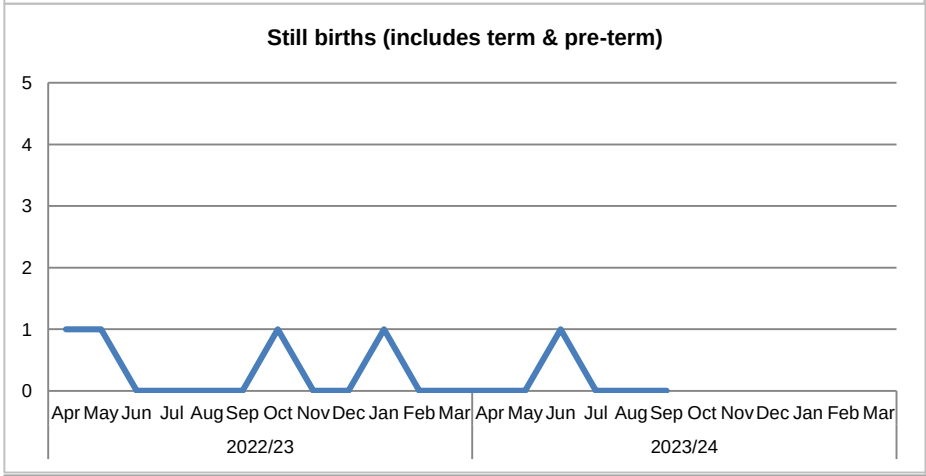


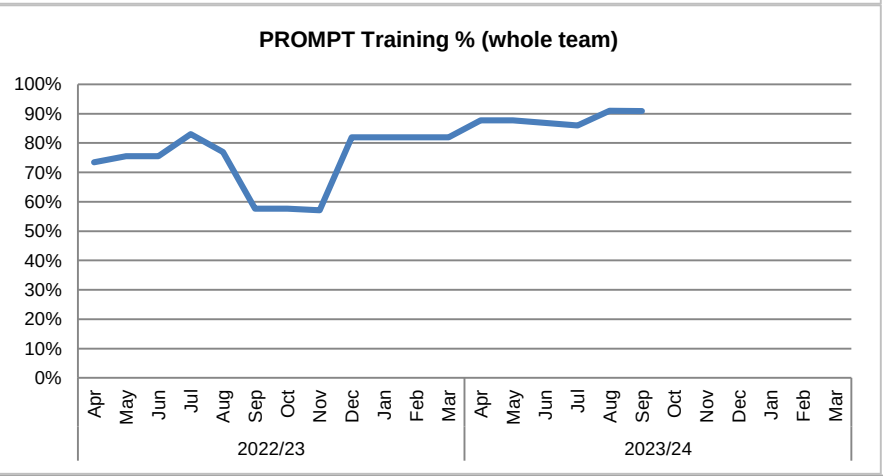


Northern Services Maternity – *Metrics relating to the provision of quality maternity care*





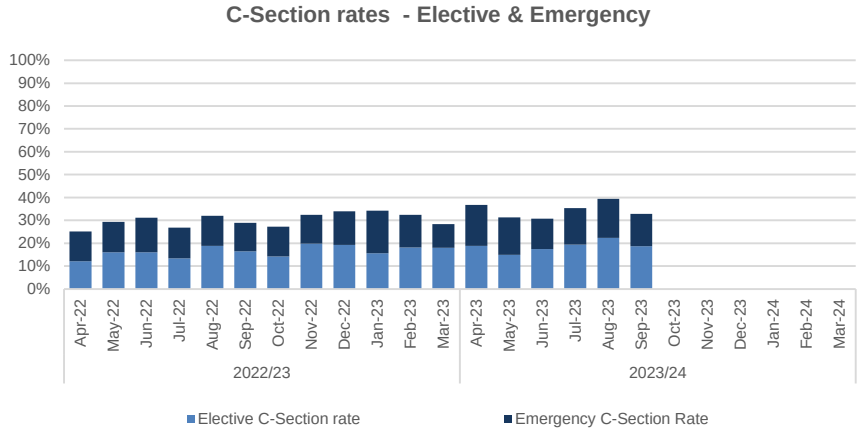


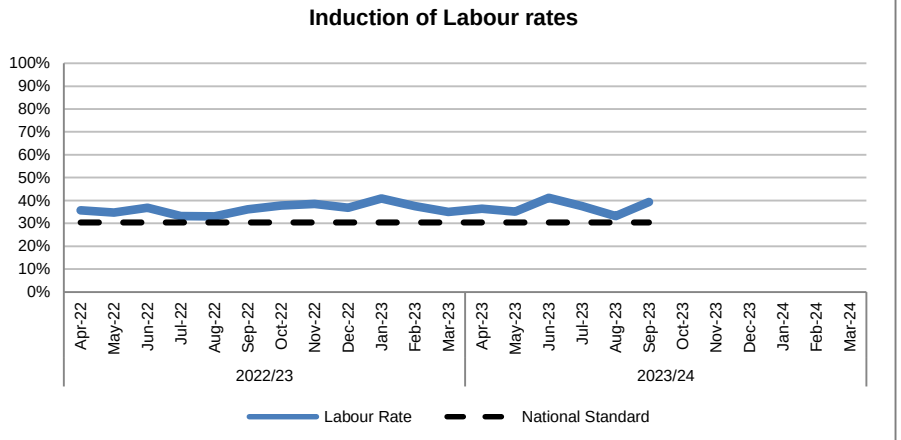


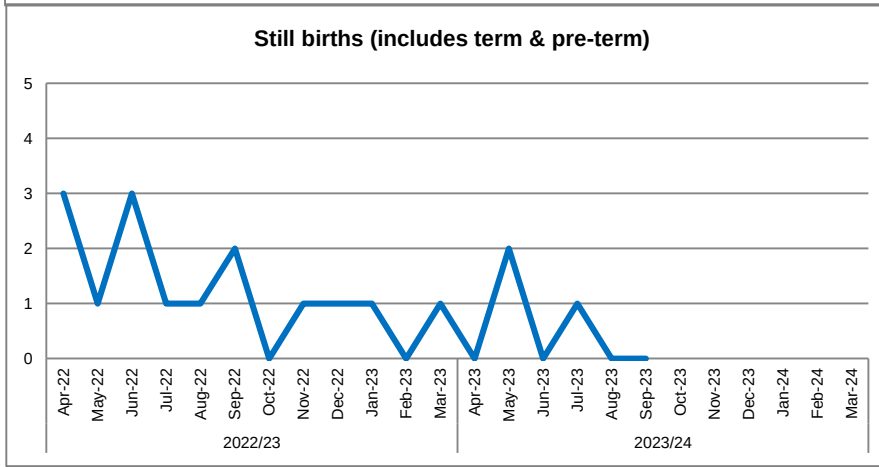
- All induction of labour care in August and September reviewed by speciality governance team. Safe and effective care planning identified in all cases.
- The service continues to prioritise PROMPT training as part of CNST Year 5 compliance evidence.

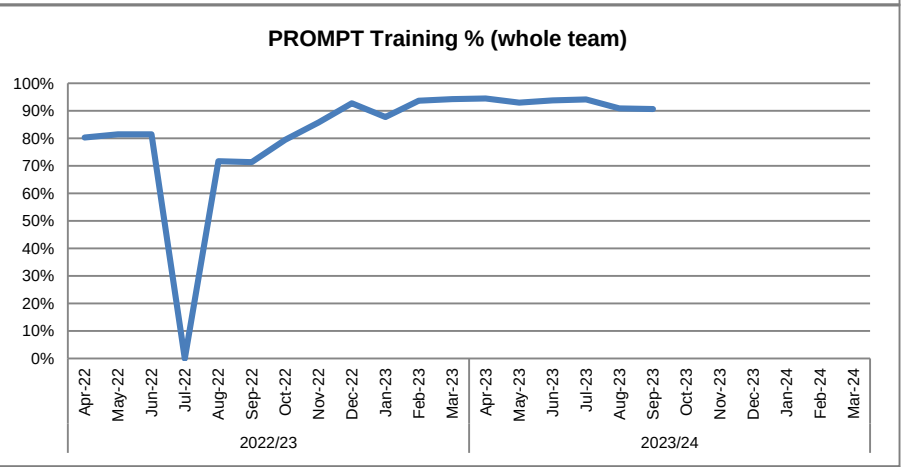
Eastern Services Maternity

Metrics relating to the provision of quality maternity care





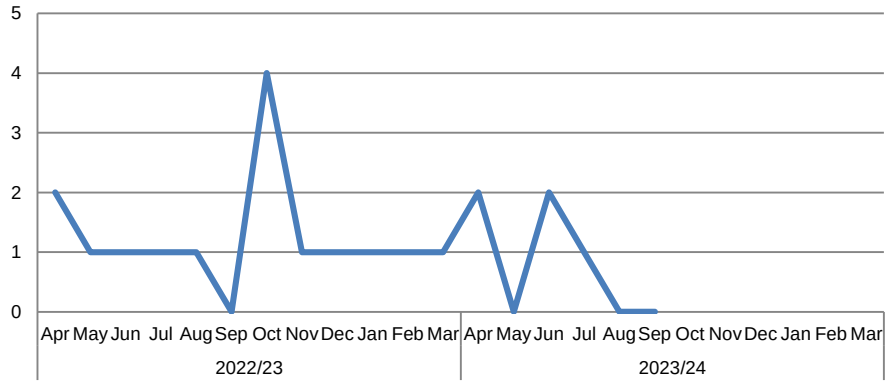




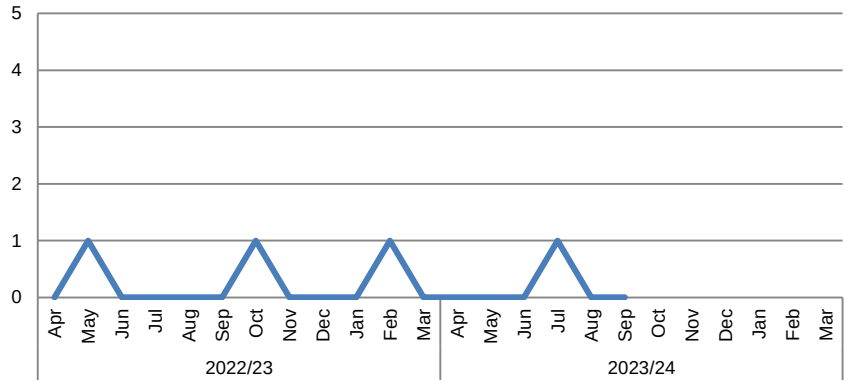
- The service continues to prioritise PROMPT training as part of CNST Year 5 compliance evidence.

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

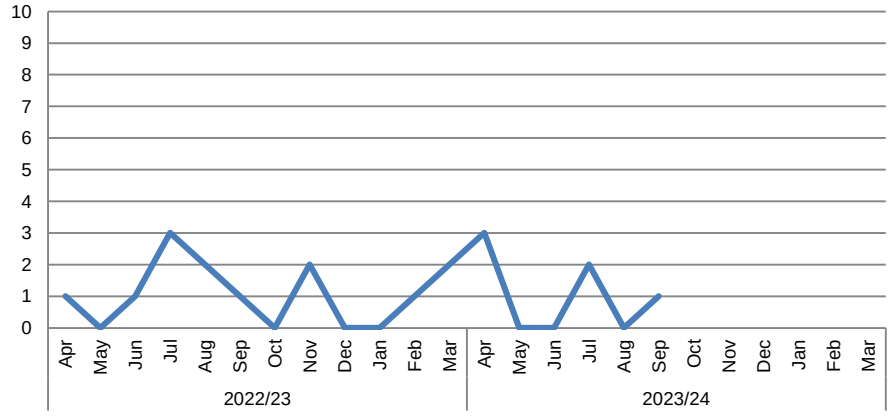
Incidents in current month (moderate and above) (run chart)



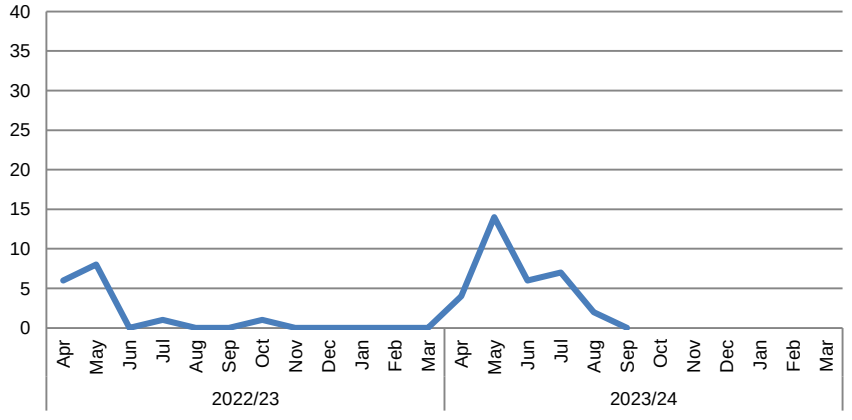
Serious Incidents (run chart)



Complaints Maternity



Compliments Maternity

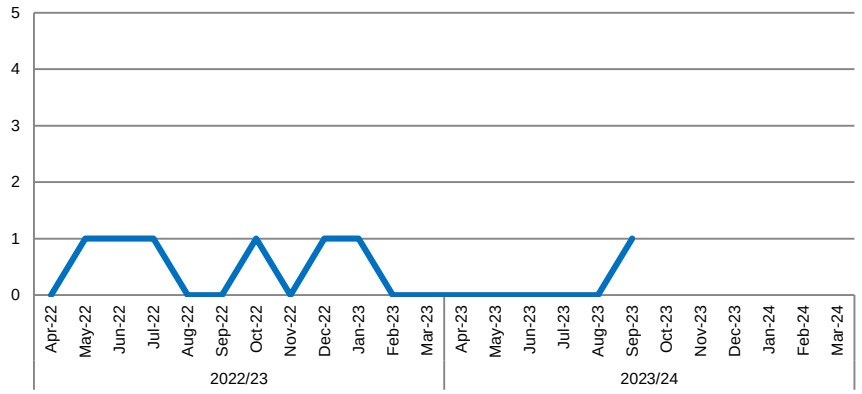


- The service has commenced a service user feedback campaign to promote engagement from service users and help to inform service developments

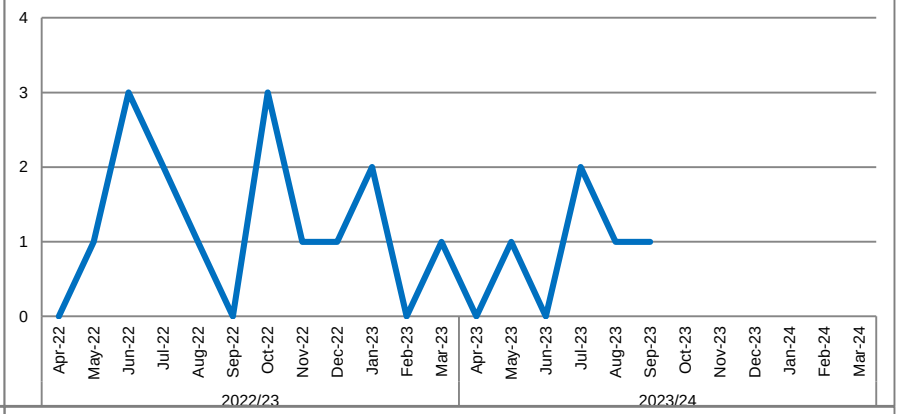
Eastern Services Maternity

Metrics relating to the provision of quality maternity care

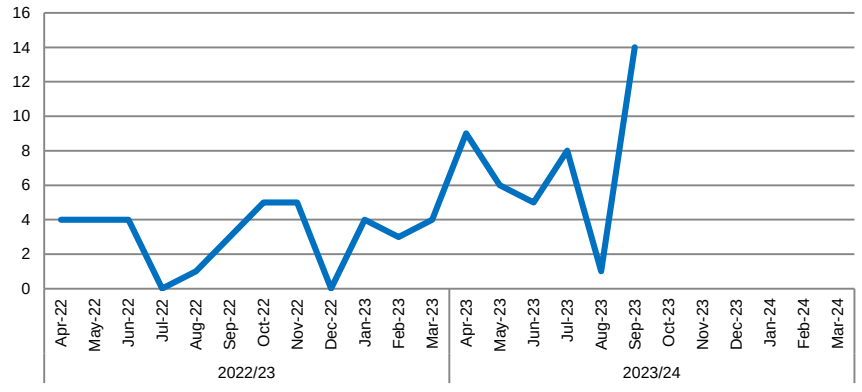
Incidents in current month (moderate and above) (run chart)



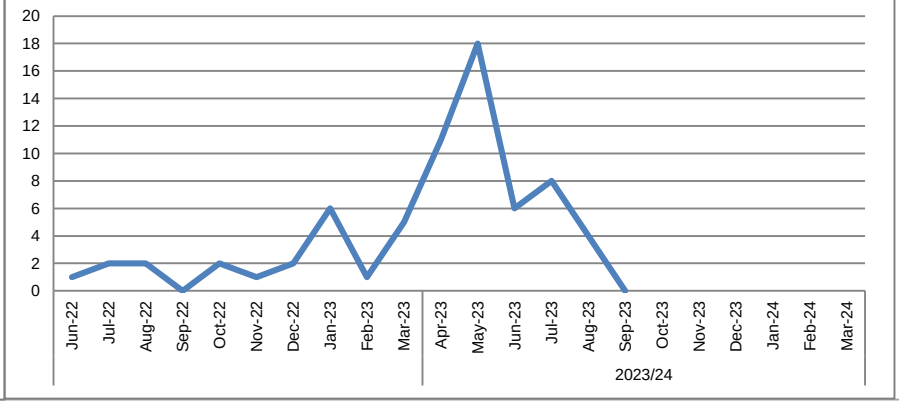
Serious Incidents (run chart)



Complaints Maternity

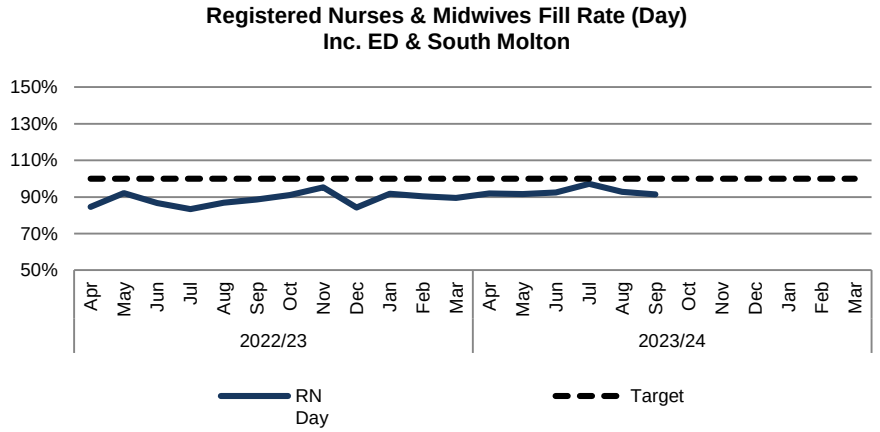


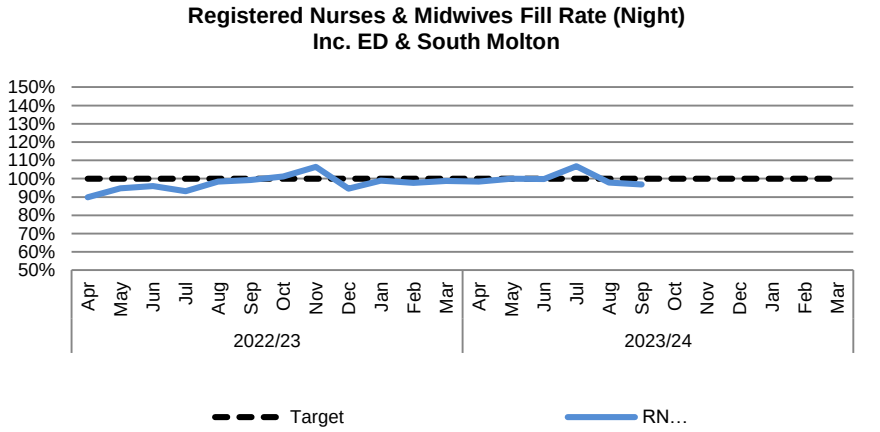
Compliments Maternity

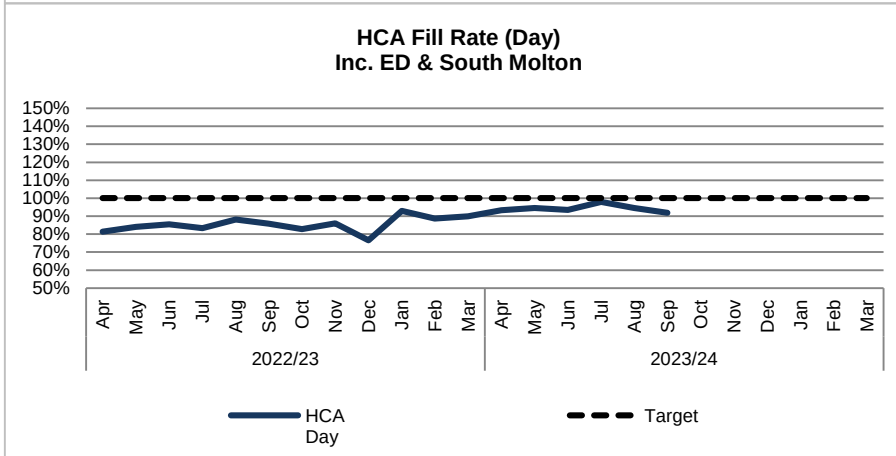


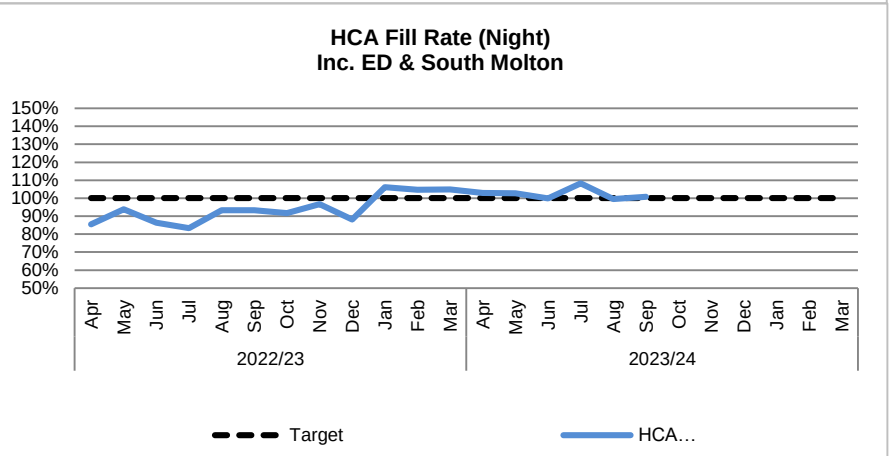
- There was one moderate or above incident in month: Postnatal mother delivered at RD&E collapsed in other SW hospital. Care under MDT review.
- There was one Serious Incident reported in month: HSIB reportable and under review process.

Northern Services Safe Clinical Staffing Fill Rates





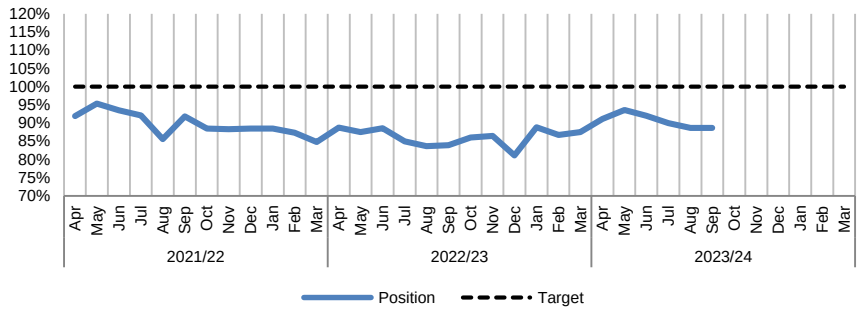


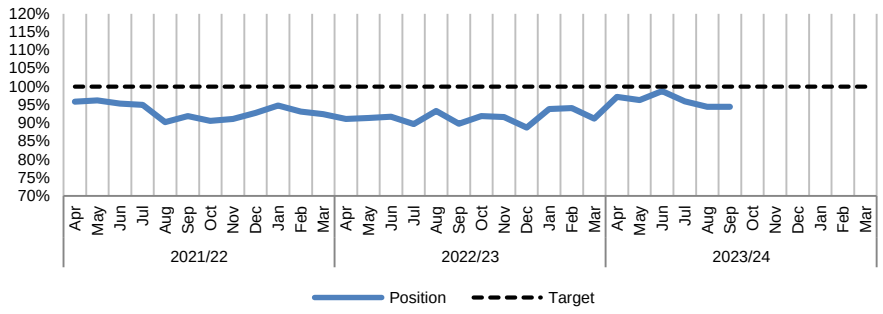


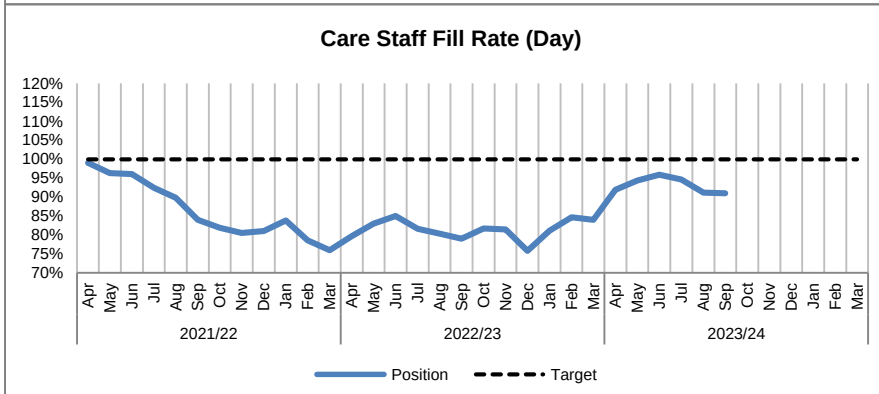
- The fill rate for Northern services was 97.25%
- Five patient safety incidents were reported related to staffing shortages. Three of these were no harm, and the remaining 2 incidents were minor harm
- All patient safety incidents which were graded as moderate harm or greater were reviewed; none of these cite staffing as a causal or contributory factor.

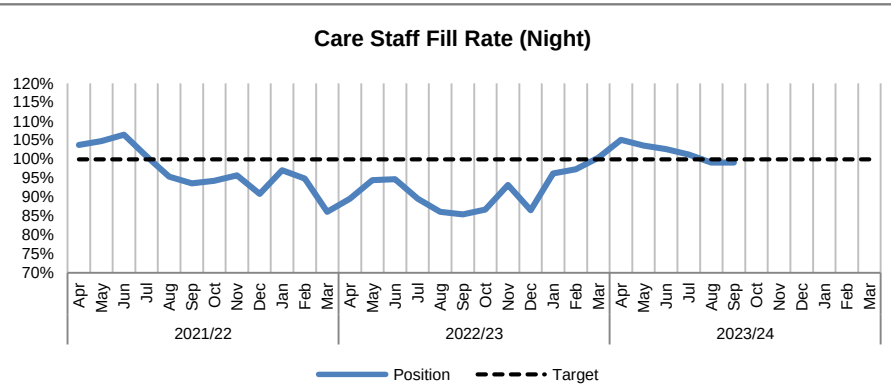
Eastern Services Safe Clinical Staffing – Fill Rate

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



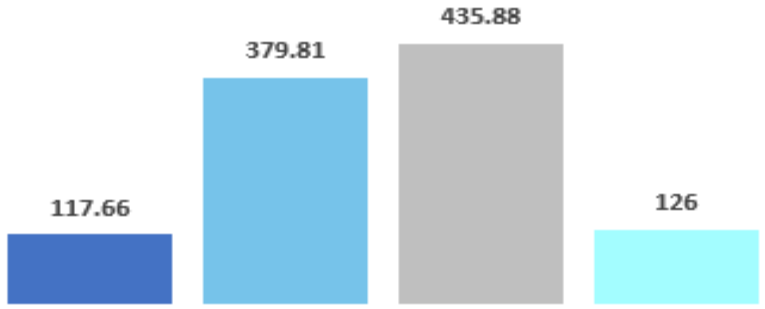


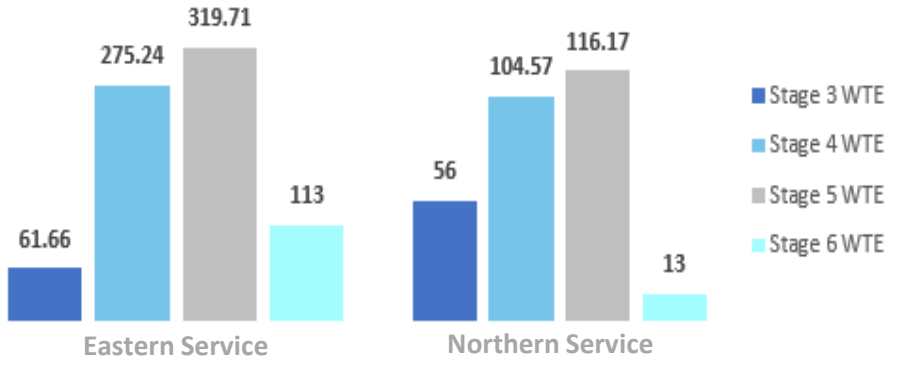




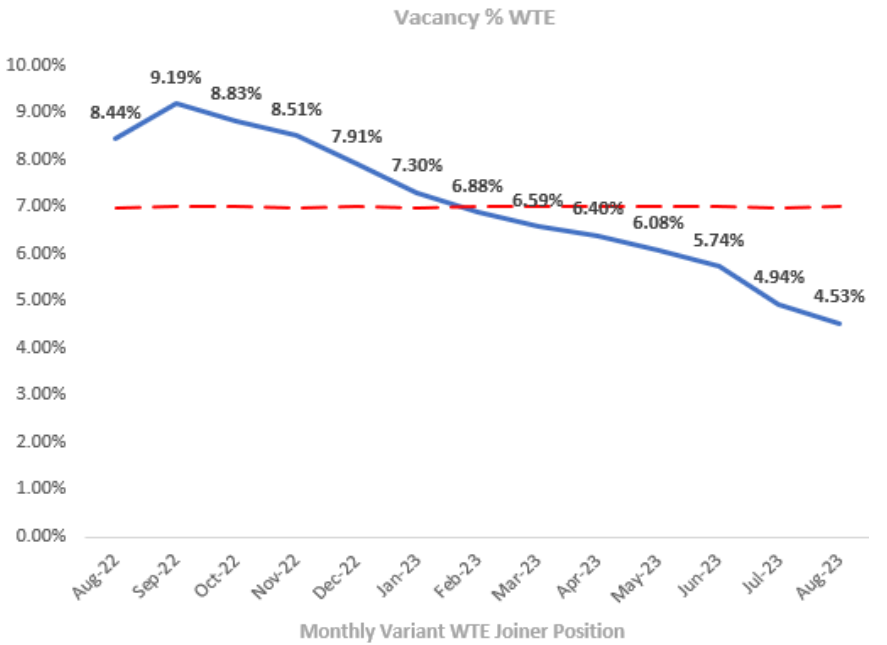
- The fill rate for Eastern services was 93.5%
- Fourteen patient safety incidents were reported related to staffing shortages 12 of these were no harm, and the remaining 2 incidents were minor harm
- All incidents which were graded as moderate harm or greater were reviewed; none of these cite staffing as a causal or contributory factor.

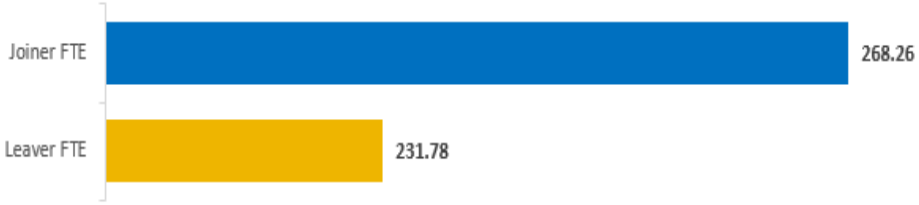
Trust Recruitment Update



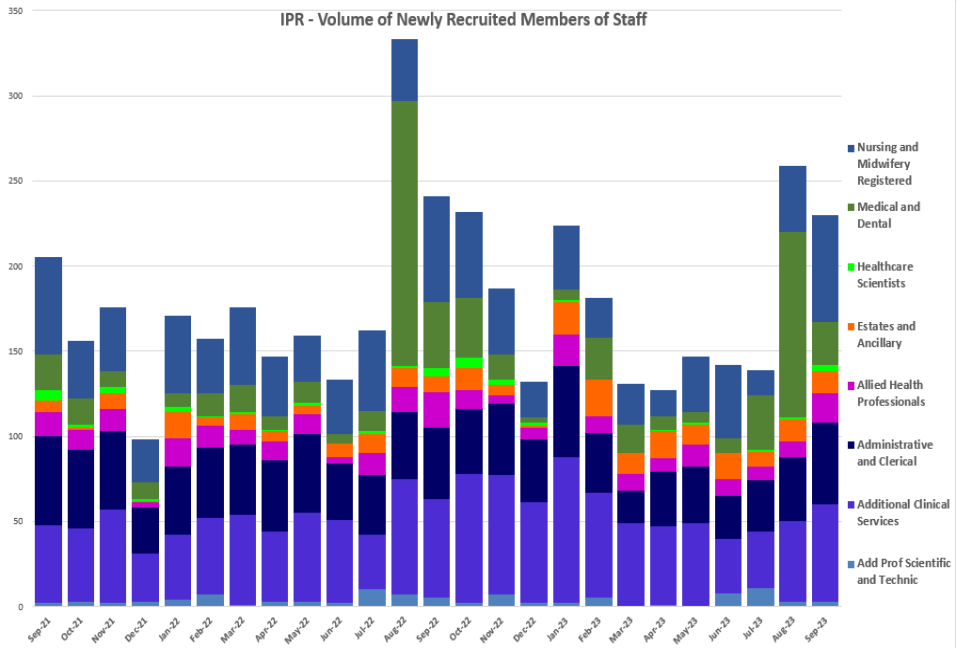


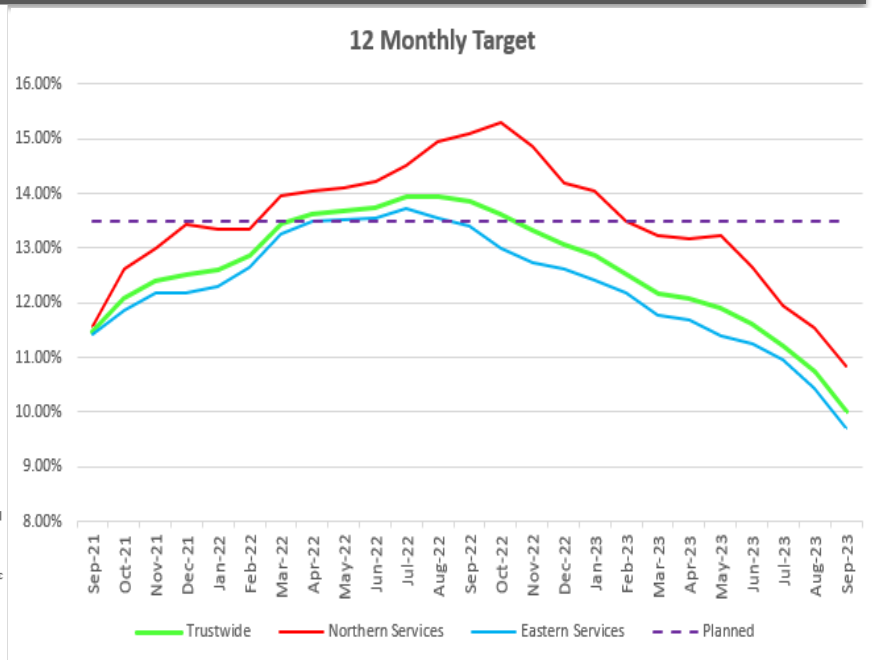
- Stage 3 vacancies have once again seen another decrease from 131 posts out to market in August, to 103 in September. This decrease is also reflected in the WTE from 148.26 down to 117.66 in September.
- Stage 4 (Shortlisting and Interviews) has seen a decrease in both individuals and WTEs sitting at 308 Individuals and 379.81 WTEs at the end of September. The closing in difference between the headcount and WTEs in Stage 4 is also a positive as we are seeing a lower number not being filled and having to be advertised for again demonstrating we are attracting the right people to our roles.
- Stage 5 (Contract and Pre-Employment stage) is continuing to see decreases month on month with a headcount figure of 511 from August's 586. This continues to get closer to the manageable threshold of 500 staff in stage 5.
- Stage 6 (people on induction) has seen a decrease to 126 after the expected high numbers throughout August and September with newly qualified staff and doctors in training joining the Trust.
- Average TTH see's an increase at the end of September from 66.1 in August to 71.8 days partly attributable to having to wait for an available induction slot – this was highlighted as a risk related to impact from industrial action.
- Most of the staff groups have seen increases in time to hire with the largest increase in days occurring in Additional Clinical Services and Estates having an increase of 17 days. Healthcare scientists also see an increase of 11 days.
- Additional Clinical Services returns to being one of the highest applied for staff groups in September sitting at 926 applications from August's 467.
- Medical and Dental falls out of the top 5 applied for Staff groups with AHP returning to the top 5 with 236 applications in September
- The Trust welcomed a further 17 IR nurses at the end of September with a further 17 due to arrive in October.
- Trustwide Vacancy figure continues to decrease from 4.94% in July to 4.53% in August



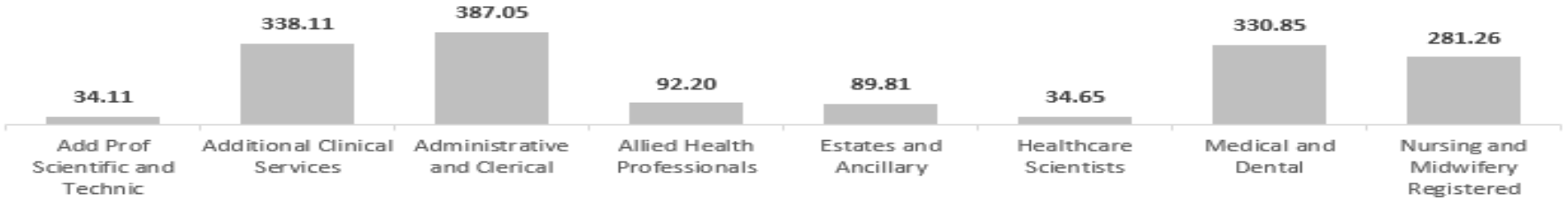


Trust Turnover





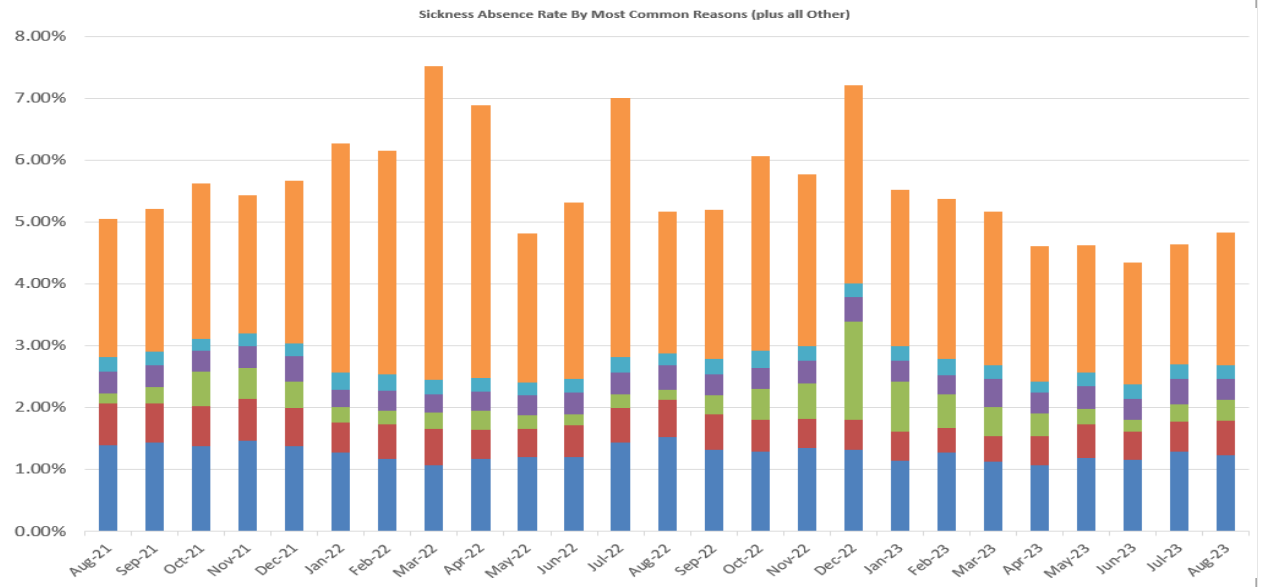
Leavers (FTE) for 12 months to 30th September 2023 – Permanent and FTC Contracts

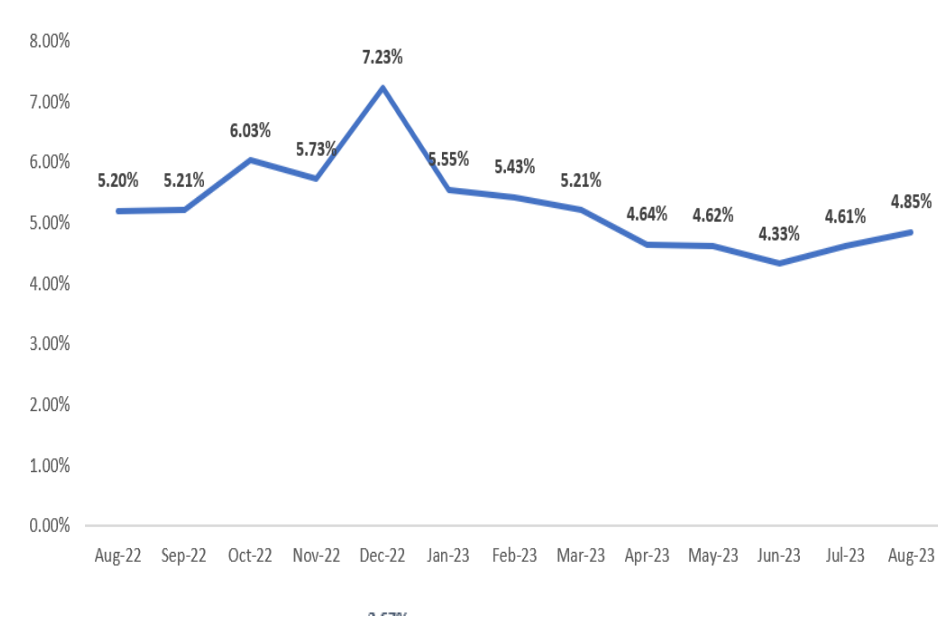


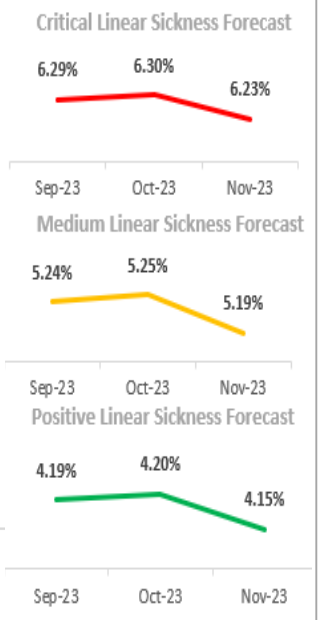
Turnover (data as at end-September 2023)

- Trustwide turnover continues to decrease, now 10% at the end of September from the 10.7% at the end of August providing more stability in our workforce numbers although sickness is impacting this to be fully taken advantage of. This decrease also supports the trajectory to meet the new targets set within the Long Term Workforce plan.
- Eastern Service falls once again from 10.4% in August to 9.7% in September.
- Northern service is also continuing its trend of decreasing from 11.55% to 10.84%
- Additional Clinical Services turnover falls below the Planned rate of 13.5% after being the only staff group above planned rate in the last months
- All remaining staff groups continue to sit below the 13.5% planned rate, each decreasing once again in line with the total decreases across the Trust.

Trust Sickness Absence







Sickness Absence (Data shown for latest complete month: August-23)

- The sickness rate for August has seen an increase from July's 4.61% rising to 4.85% making this the third month increase in a row.
- The Trustwide increase is reflected in the Northern service increasing to 4.04% in August from July's 3.84%
- Eastern Service also shows an increase from July rising from 4.89% to 5.15% in August
- Anxiety/stress/depression/other psychiatric illnesses continue to be the highest sickness reason in August making up 23.27%. This however is a decrease from July's sickness reason of 27.4%
- Infectious Diseases has a rise in Sickness reason from July in August sitting at 10.41% of sickness being attributed to this, where previously this was at 5.4%
- Due to the overall trust sickness increasing, this is mirrored in the majority of the staff groups also seeing rises in percentages. The highest areas of increases are Estates with over 1% increase, and Additional Clinical Services increasing by 0.80% from July.
- Additional Clinical Services and Estates continue to be the two highest sick rates at 7.4% and 8.43% respectively. The other staff groups sit around 4% with HCS and Medical staff being below the threshold at 2.05% and 1.68%
- The increase in sickness % is also shown in the cost of sickness which once again increases in August from £1,649,309 in July to **£1,706,457** in August.

Trust Summary Finance Position

Financial Performance - key performance indicators

Consolidated Metrics							
Domain	Measure / Metric	Unit of Measure	This Month Aug-23	This Month Sep-23	Narrative	Forecast Mar-24	Narrative
Income and Expenditure	**I&E Surplus / (Deficit) - Total**	£'000	**-19,282**	**-28,956**	Deficit is £11.3m adverse to plan and continues to be driven by the impact of industrial action on pay costs, under delivery of savings plan, other pay cost pressures, underachievement of ERF income and net increase in drugs costs above plan. The due diligence on the drugs position has been completed that supports the level of costs incurred - although there was a reduction in run-rate compared to the previous month. The Finance and Operational Committee has been assured the key drivers in the worsening position were understood. The year to date position includes the cost of industrial action with the national assumption this will be funded nationally. If resolved this will be backdated, improving the position.	**-28,035**	Due to ongoing discussions nationally regarding the financial impact of Industrial Action on 23/24 plans, the current forecast outturn remains as per plan. There remains ongoing review to inform quantifying risks, mitigations and the potential impact of the financial recovery plan actions implemented to determine the value of any future adverse movement from plan. A call to action has been launched on financial recovery to ensure other cost drivers can be managed to reduce the overall rate of spend for the remainder of the year without compromising patient safety or operational recovery.
	I&E Surplus / (Deficit) v budget	£'000	**-3,886**	**-11,321**		**0**	
	Income variance to budget - Total	£'000	**6,158**	**6,238**	See below	**13,136**	
	Income variance to budget - Total	%	**1.46%**	**1.23%**		**1.30%**	
	Income variance to budget - Patient Care	£'000	**2,390**	**-461**	Correction of the level of ERF income year to date based on the latest NHSE calculations that are subject to a significant time lag receiving the information. The impact fell in one month (£1.8m) as there was no earlier validation methodology available. This is attributable to loss of activity due to industrial action. This adverse position is being mitigated year to date though additional income of £8.4m received in relation to the variable high cost drugs expenditure which offsets the drugs spend within non pay.	**4,349**	Improvement in the forecast relates to an increase in pass through drugs extrapolated from the year to date position. This is offset with an increase in expenditure.
	Income variance to budget - Operating income	£'000	**3,768**	**6,699**	Overachievement of income recovery under DBV workstreams, including non recurrent income benefits offsetting under recovery of Research & Development, Education income contributions to staff costs below planned levels, with corresponding decrease in expenditure to offset. Under recovery of non patient care services also within overall position.	**8,787**	Year to date values expected to continue for the year (adjusted for in month one off benefits) that will be validated as part of the ongoing detailed forecast due diligence.
	Pay variance to budget - Total	£'000	**-4,508**	**-8,431**	Overall impact of £8.4m adverse to plan - £2.8m strike action, pay impact of DBV slippage and £1.5m unfunded pay award costs all falling in month 6. Additional pressures attributable to stretch ERF and additional costs and specialling 1:1 NHSE returns have been completed to collect cost and activity impacts of strike action. Income recovery is not reflected in the YTD position. If resolved nationally this will be backdated and improve the overall position.	**-4,169**	Overall impact of £4.2m adverse to plan includes the impact of future months DBV and Financial Recovery Plan off-set by the impact of strike action. The overall Trust wide forecast is held to plan assuming these cost pressures will be mitigated nationally.
	Pay variance to budget - Total	%	**-1.64%**	**-2.56%**		**-0.64%**	
	Agency expenditure variance to Plan	£'000	**-3,593**	**-4,187**	Increased usage to cover vacancies, sickness, strike support and specialling of highly complex patients awaiting discharge - further work being undertaken to ensure compliance with agency controls and identify high users of agency, including non clinical areas	**-4,526**	Agency plan for the year is £15.1m. £19.7m FOT expenditure is £4.4m less than month 12 2022/23. Focus on understanding agency usage and actions to reduce through the financial recovery plan pay workstream; reporting through monthly performance meetings.
	Agency expenditure variance to agency limit	£'000	**-1,004**	**-1,076**	Agency limit YTD is £10.7m and showing a negative variance due to increased use above plan	**1,698**	Agency limit for the full year is £21.4m
	Non Pay variance to budget	£'000	**-6,107**	**-10,174**	Non pay underspends due to activity levels being slightly behind plan partly due to impact of strike action are off-set by increases in drugs expenditure - though month 6 cost was lower than the previous month. In month £3.0m adverse movement on R&D expenditure is off-set by corresponding income favourable variance above. Overall non pay controls are being implemented as part of the financial recovery plan. However, £8.7m is recovered through additional income and therefore net unplanned for drugs growth is £4m	**-8,089**	Overall impact of £8.1m adverse to plan includes the impact of future months DBV and Financial Recovery Plan off-set by increased drugs expenditure offset by additional HCD income. Net impact of drugs growth is forecast at £8m prior to the impact of the call to action on financial recovery.
	Non Pay variance to budget	%	**-3.86%**	**-5.36%**		**-2.20%**	
	PDC, Interest Paid / Received variance to budget	£'000	**518**	**577**		**962**	
	PDC, Interest Paid / Received variance to budget	%	**9.68%**	**8.91%**		**7.12%**	
	Capital Donations variance to plan - technical reversal	£'000	**53**	**469**	Neutral adjustment when calculating reported financial position.	**-1,840**	Neutral adjustment when calculating reported financial position.
	Delivering Best Value Programme - Total Current Year achievement	£'000	**17,552**	**20,559**	Strong start to the year in terms of savings programme though slippage on recurrent delivery has been off-set by non-recurrent over-delivery. YTD adverse variances continue to be largely driven by non-delivery against digital programme and shortfall in income data capture. Accelerating delivery is part of the financial recovery plan to de-risk forecast and scope additional ideas	**60,296**	Full year internal requirement of £44.7m with £15.6m required from ICB schemes. There is an £8.6m risk to internal forecast position - £3.1m unidentified and £5.5m from risk of double count against ICB schemes.
	Delivering Best Value Programme - Year to date/ Current Year variance to budget	£'000	**4,515**	**4,428**	DBV schemes variance to plan: £5.4m Income favourable (£1.8m) Pay adverse £0.8m Non pay favourable	**0**	

Trust Summary Finance Position

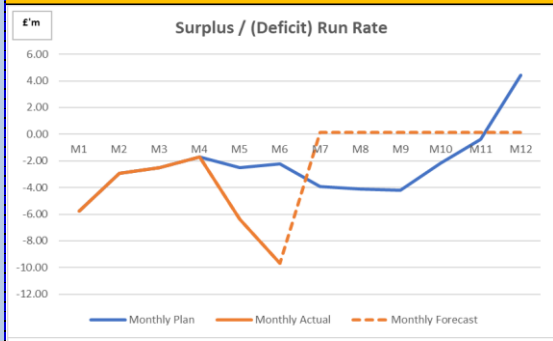
Financial Performance - key performance indicators

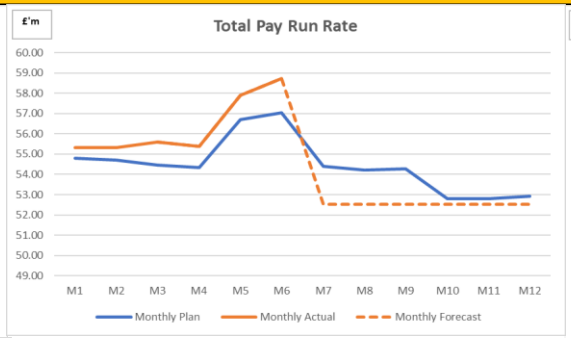
Consolidated Metrics							
Domain	Measure / Metric	Unit of Measure	This Month Aug-23	This Month Sep-23	Narrative	Forecast Mar-24	Narrative
Capital & Cash	Cash balance	£'000	22,010	19,406	(£12.9m) adverse impact of year to date financial position offset in part by improvements in working capital; £7.7m favourable from slippage in the capital programme and net interest received; (£7.9m) adverse slippage on the receipt of capital PDC compared to plan; (£2.7m) adverse opening cash position lower than plan.	19,973	Cash flow currently being assessed to take into account risk and mitigation scenarios and will be reported via the Finance and Operations Committee.
	Cash variance to budget - above / (below)	£'000	-22,909	-15,754		5,479	
	Better Payment Practice v 95% cumulative target - volume	%	75%	75%	Continued improvement in cumulative value of invoices paid within target; volume reduction reflects catch up of invoices of relatively low value In month 87.4% of invoices by value were paid within 30 days and actions to recover performance are positive and continues to include focus on sufficient authoriser capacity; daily bank runs, support to pharmacy and increased finance capacity to address post-implementation vacancies.	90%	All endeavours will be targeted to minimise the impact on suppliers. Recovery to **90% cumulatively** remains the aspiration with assurance being reported through the Audit Committee.
	Better Payment Practice v 95% cumulative target - value	%	81%	82%		90%	
	Capital Expenditure variance to plan - Total above / (below)	£'000	-7,372	-22,633	Capital expenditure to M6 was £13.1m being £22.6m less than assumed in plan. Of the variance, £13.5m is due to profiling - all lease expenditure was planned to be fully incurred at M06. Excluding leases, the programme is £9.1m behind plan though £12.6m of open orders gives confidence the slippage will recover Whilst the programme is behind plan, there is confidence the slippage will recover and the respective Capital Programme Groups are actively monitoring risks and mitigations to ensure delivery.	1,874	Forecast capital expenditure of £75.0m fully utilises the CDEL and PDC allocations forecast in 2023/24.
	Capital Expenditure variance to plan - CDEL above / (below)	£'000	-2,822	-2,145	Slippage on commencing schemes with expectation to recover supported by the value of orders placed.	1,957	£0.2m additional system CDEL allocation and £1.8m donated income off-sets variance in operating income. Donated income is a neutral adjustment when calculating reported financial position.
	Capital Expenditure variance to plan - PDC and Leasing above / (below)	£'000	-4,550	-20,488	Slippage on commencing schemes with expectation to recover: £13.5m lease profiling (IFRS16) £4.4m Endoscopy capacity £0.9m Cardiology Day case Unit £2.1m Community Diagnostics	-83	Net adjustment in PDC - fully utilises the 2323/24 allocations.

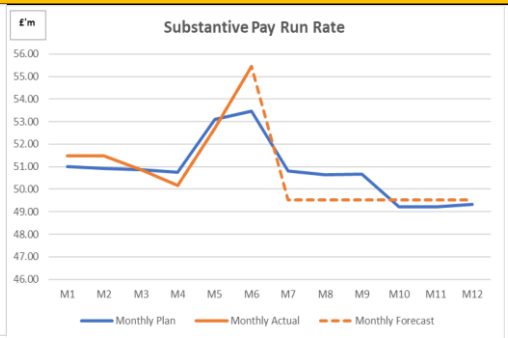
Key
- Total value
- Positive variance value
- Negative variance value <5%
- Negative variance value >5%

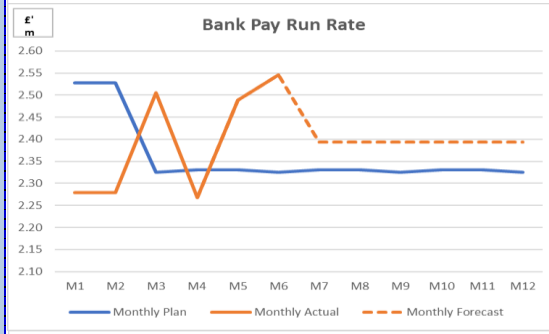
Trust Financial Tables

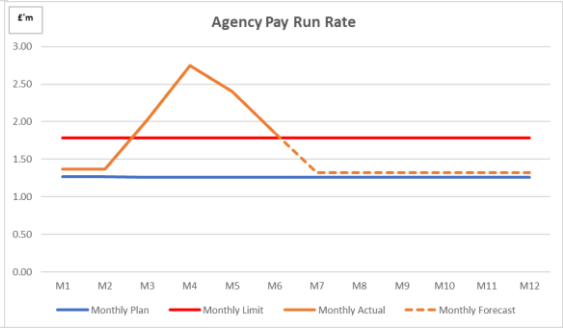
Royal Devon University Healthcare NHS Foundation Trust
Charts
Period ending 30/09/2023
Month 6

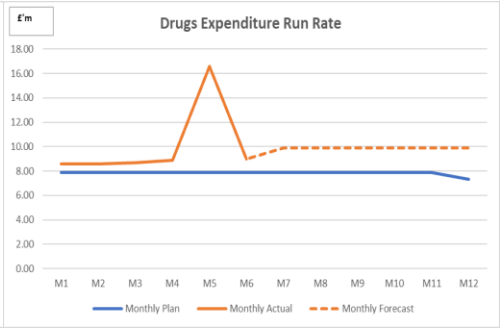


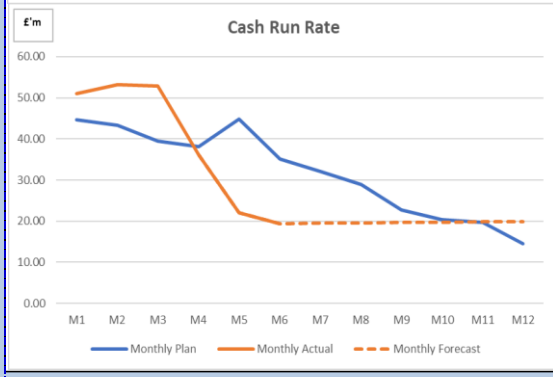


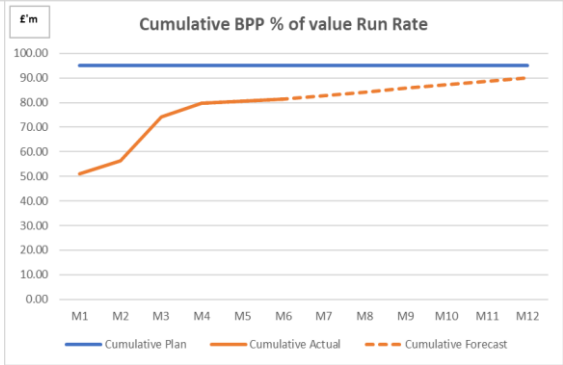












BPP
Continued improvement in cumulative value of invoices paid within target - with actions to recover performance remaining positive and continues to include focus on sufficient authoriser capacity; daily bank runs, support to pharmacy and increased finance capacity to address post-implementation vacancies. Recovery to **90% cumulatively** remains the aspiration with assurance being reported through the Audit Committee.

Income and Expenditure
Call to action focusing on exec level work streams to target run rate imporvement across all domains to bring the run rate back towards planned levels. Runrate charts demosnatrte the scale of the challenge to achieve this.

Trust Financial Tables

Royal Devon University Healthcare NHS Foundation Trust Income Statement Period ending 30/09/2023 Month 6	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Actual Variance to Budget Fav / (Adv) £'000		Outturn Plan £'000	Outturn Actual £'000	Outturn Actual Variance to Budget Fav / (Adv) £'000
Income							
Patient Care Income	451,643	451,182	(461)	2	890,984	895,333	4,349
Operating Income	56,766	63,465	6,699	3	116,417	125,204	8,787
Total Income	**508,409**	**514,647**	**6,238**		**1,007,401**	**1,020,537**	**13,136**
Employee Benefits Expenses	(329,693)	(338,124)	(8,431)	4	(653,488)	(657,657)	(4,169)
Services Received	(17,984)	(15,362)	2,622		(35,963)	(26,024)	9,939
Clinical Supplies	(45,099)	(42,117)	2,982		(90,000)	(74,160)	15,840
Non-Clinical Supplies	(8,706)	(8,004)	702		(15,428)	(14,408)	1,020
Drugs	(47,386)	(60,256)	(12,870)	1	(94,212)	(119,630)	(25,418)
Establishment	(7,401)	(8,363)	(962)		(13,141)	(15,526)	(2,385)
Premises	(12,951)	(12,306)	645		(25,538)	(24,612)	926
Depreciation & Amortisation	(20,267)	(20,227)	40		(42,010)	(42,010)	0
Impairments (reverse below the line)	0	0	0		0	0	0
Clinical Negligence	(15,912)	(15,912)	0		(26,520)	(26,520)	0
Research & Development	(4,993)	(9,347)	(4,354)	5	(9,012)	(18,694)	(9,682)
Operating lease expenditure	(935)	(911)	24		(1,690)	(1,822)	(132)
Other Operating Expenses	(8,159)	(7,162)	997		(14,847)	(13,044)	1,803
Total Costs	**(519,486)**	**(538,091)**	**(18,605)**		**(1,021,849)**	**(1,034,107)**	**(12,258)**
EBITDA	**(11,077)**	**(23,444)**	**(12,367)**		**(14,448)**	**(13,570)**	**878**
Profit / (Loss) on asset disposals	0	0	0		0	0	0
Interest Receivable	1,045	1,676	631		1,431	2,393	962
Interest Payable	(1,362)	(1,430)	(68)		(2,642)	(2,642)	0
PDC	(6,156)	(6,142)	14		(12,308)	(12,308)	0
Net Surplus / (Deficit)	**(17,550)**	**(29,340)**	**(11,790)**		**(27,967)**	**(26,127)**	**1,840**
Remove donated asset income & depreciation, AME impairment and gain from transfer by absorption	(85)	384	469		(68)	(1,908)	(1,840)
Net Surplus/(Deficit) after donated asset & PSF/MRET Income	**(17,635)**	**(28,956)**	**(11,321)**	1	**(28,035)**	**(28,035)**	**0**

KEY MOVEMENTS AGAINST BUDGET

1. Deficit is £11.3m adverse to plan and continues to be driven by the impact of industrial action on pay costs and net increase in drugs costs above plan. The due diligence on the drugs position has been completed that supports the level of costs incurred - although there was a reduction in run-rate compared to the previous month.

2. Patient care income impacted by the overachievement of the DBV programme offsetting the correction of the level of ERF income year to date based on the latest NHSE calculations that are subject to a significant time lag receiving the information. The impact fell in one month as there was no earlier validation methodology available.

3. Additional income under DBV offsetting Research and Development, Education and income contributions to staff costs below planned levels, with corresponding decrease in expenditure to offset. Also offsetting non patient care services provided including in year NR benefits released through DBV.

4. Overall impact of £8.4m adverse to plan - £2.8m strike action, pay impact of DBV slippage, £1.5m unfunded pay award costs and additional pressures attributable to stretch ERF and additional costs and specialling 1:1. DBV pay shortfall off-set by additional non recurrent income above plan.

5. In month £3.0m adverse movement on R&D expenditure is off-set by corresponding R&D income.

Trust Financial Tables

Royal Devon University Healthcare NHS Foundation Trust Statement of Financial Position Period ending 30/09/2023 Month 6	Year to Date				Outturn			Prior Year	
	Plan £000	Actual £000	Actual Variance Over / (Under) £000		Plan £000	Actual £000	Actual Variance Over / (Under) £000	Mar-23 £000	Actual YTD Movement Incr. / (Dec.) £000
Non-current assets									
Intangible assets	55,625	54,170	(1,455)	1	53,333	52,837	(496)	58,621	(4,451)
Other property, plant and equipment (excludes leases)	428,995	420,199	(8,796)	1	451,271	452,575	1,304	421,298	(1,099)
Right of use assets - leased assets for lessee (excludes PFI/LIFT)	65,481	52,977	(12,504)	2	61,184	62,142	958	54,580	(1,603)
Other investments / financial assets	5	5	0		5	5	0	5	0
Receivables	2,726	3,549	823	2	2,726	3,303	577	3,303	246
Credit Loss Allowances	0	(228)	(228)	2	0	(228)	(228)	(228)	
Total non-current assets	**552,832**	**530,672**	**(22,160)**		**568,519**	**570,634**	**2,115**	**537,579**	**(6,907)**
Current assets									
Inventories	13,550	15,955	2,405	2	13,550	13,550	0	15,624	331
Receivables: due from NHS and DHSC group bodies	17,810	27,068	9,258	2	17,810	17,810	0	39,891	(12,823)
Receivables: due from non-NHS/DHSC group bodies	16,000	26,525	10,525	2	16,000	16,796	796	21,090	5,435
Credit Loss Allowances	0	(889)	(889)	2	0	(796)	(796)	(796)	(93)
Other assets: including assets held for sale & in disposal groups	0	0	0		0	0	0	0	0
Cash	35,160	19,406	(15,754)		14,494	19,973	5,479	46,033	(26,627)
Total current assets	**82,520**	**88,065**	**5,545**		**61,854**	**67,333**	**5,479**	**121,842**	**(33,777)**
Current liabilities									
Trade and other payables: capital	(11,000)	(5,021)	5,979	2	(11,000)	(11,000)	0	(6,615)	1,594
Trade and other payables: non-capital	(79,849)	(94,979)	(15,130)	2	(79,850)	(79,848)	2	(96,708)	1,729
Borrowings	(14,643)	(18,672)	(4,029)	2	(15,000)	(18,567)	(3,567)	(16,676)	(1,996)
Provisions	(200)	(296)	(96)	2	(200)	(295)	(95)	(295)	(1)
Other liabilities: deferred income including contract liabilities	(10,500)	(12,012)	(1,512)		(10,500)	(10,500)	0	(17,892)	5,880
Total current liabilities	**(116,192)**	**(130,980)**	**(14,788)**		**(116,550)**	**(120,210)**	**(3,660)**	**(138,186)**	**7,206**
Total assets less current liabilities	**519,160**	**487,757**	**(31,403)**		**513,823**	**517,757**	**3,934**	**521,235**	**(33,478)**
Non-current liabilities									
Borrowings	(112,663)	(96,298)	16,365	1	(102,440)	(99,682)	2,758	(102,694)	6,396
Provisions	(970)	(1,264)	(294)	2	(970)	(1,276)	(306)	(1,276)	12
Other liabilities: deferred income including contract liabilities	0	0	0		0	0	0	0	0
Total non-current liabilities	**(113,633)**	**(97,562)**	**16,071**		**(103,410)**	**(100,958)**	**2,452**	**(103,970)**	**6,408**
Total net assets employed	**405,527**	**390,195**	**(15,332)**		**410,413**	**416,799**	**6,386**	**417,265**	**(27,070)**
Financed by									
Public dividend capital	367,341	363,874	(3,467)	2	382,645	387,264	4,619	361,604	2,270
Revaluation reserve	63,956	52,385	(11,571)	2	63,956	52,385	(11,571)	52,385	0
Income and expenditure reserve	(25,770)	(26,064)	(294)	2	(36,188)	(22,850)	13,338	3,277	(29,341)
Total taxpayers' and others' equity	**405,527**	**390,195**	**(15,332)**		**410,413**	**416,799**	**6,386**	**417,266**	**(27,071)**

KEY MOVEMENTS

1 Slippage on capital programme forecast to recover by year end

2 The plan was based on a forecast outturn balance sheet at month 7 2022/23 that was significantly different at year end as shown; the YTD balance sheet being more reflective of outturn than plan.

Trust Financial Tables

Royal Devon University Healthcare NHS Foundation Trust Cash Flow Statement Period ending 30/09/2023 Month 6	Year to Date Plan £000	Year to Date Actual £000	Year to Date Actual Variance Fav. / (Adv.) £000		Outturn Plan £000	Outturn Actual £000	Outturn Actual Variance Fav. / (Adv.) £000
Cash flows from operating activities							
Operating surplus/(deficit)	(11,077)	(23,443)	(12,366)		(14,448)	(13,570)	878
Non-cash income and expense:							
Depreciation and amortisation	20,267	20,227	(40)		42,010	42,010	0
Impairments and reversals	0	0	0		0	0	0
Income recognised in respect of capital donations (cash and non-cash)	(469)	0	469		(842)	(2,682)	(1,840)
(Increase)/decrease in receivables	0	7,183	7,183		0	26,323	26,323
(Increase)/decrease in inventories	0	(331)	(331)		0	2,074	2,074
Increase/(decrease) in trade and other payables	220	(1,717)	(1,937)	1	222	(16,860)	(17,082)
Increase/(decrease) in other liabilities	0	(5,880)	(5,880)		0	(7,392)	(7,392)
Increase/(decrease) in provisions	0	(11)	(11)		0	0	0
Net cash generated from / (used in) operations	**8,941**	**(3,972)**	**(12,913)**		**26,942**	**29,903**	**2,961**
Cash flows from investing activities							
Interest received	1,045	1,676	631		1,431	2,393	962
Purchase of intangible assets	(900)	0	900		(3,000)	(3,000)	0
Purchase of property, plant and equipment and investment property	(19,331)	(12,654)	6,677		(54,660)	(52,192)	2,468
Proceeds from sales of property, plant and equipment and investment property	0	0	0		0	0	0
Receipt of cash donations to purchase capital assets	469	0	(469)		842	2,682	1,840
Net cash generated from/(used in) investing activities	**(18,717)**	**(10,978)**	**7,739**		**(55,387)**	**(50,117)**	**5,270**
Cash flows from financing activities							
Public dividend capital received	10,439	2,270	(8,169)		25,743	25,660	(83)
Loans from Department of Health and Social Care - repaid	(635)	(635)	0		(1,270)	(1,270)	0
Other loans received	0	0	0		0	0	0
Other loans repaid	(2,353)	(2,353)	0		(5,174)	(5,174)	0
Other capital receipts	0	0	0		0	0	0
Capital element of finance lease rental payments	(3,692)	(3,367)	325		(8,828)	(8,828)	0
Interest paid	(1,424)	(1,177)	247		(3,978)	(3,457)	521
Interest element of finance lease	0	(312)	(312)		0	(521)	(521)
PDC dividend (paid)/refunded	(6,154)	(6,102)	52		(12,308)	(12,256)	52
Net cash generated from/(used in) financing activities	**(3,819)**	**(11,676)**	**(7,857)**		**(5,815)**	**(5,846)**	**(31)**
Increase/(decrease) in cash and cash equivalents	**(13,595)**	**(26,626)**	**(13,031)**		**(34,260)**	**(26,060)**	**8,200**
Cash and cash equivalents at start of period	**48,754**	**46,033**	**(2,721)**		**48,754**	**46,033**	**(2,721)**
Cash and cash equivalents at end of period	**35,159**	**19,407**	**(15,752)**		**14,494**	**19,973**	**5,479**

KEY MOVEMENTS

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

Trust Financial Tables

Royal Devon University Healthcare NHS Foundation Trust Capital Expenditure Period ending 30/09/2023 Month 6	Year to Date				Full Year Forecast		
Scheme	**Plan £'000**	**Actual £'000**	**Variance slippage / (higher) £'000**	**Open Orders £'000**	**Plan £'000**	**Actual £'000**	**Variance slippage / (higher) £'000**
Capital Funding:							
Internally funded	9,324	6,369	2,955		31,074	31,191	(117)
PDC	10,439	3,449	6,990		25,743	25,660	83
Donations/Grants	469	1,279	(810)		842	2,682	(1,840)
IFRS 16	15,488	1,990	13,498		15,488	15,488	0
Total Capital Funding	**35,720**	**13,087**	**22,633**		**73,147**	**75,021**	**(1,874)**
Expenditure:							
Equipment	9,559	2,161	7,398	1,588	15,528	15,577	(49)
Estates Backlog/EIP	2,195	1,137	1,059	3,962	7,371	6,953	418
Estates Developments	6,298	2,540	3,758	1,077	10,047	9,114	933
Digital	1,249	934	315	1,142	4,162	7,629	(3,467)
Our Future Hospital	0	437	(437)	0	0	2,397	(2,397)
ED	1,849	1,688	161	1,320	6,165	4,000	2,165
Cardiology Day Case	3,871	2,705	1,166	169	7,432	7,439	(7)
CDC Nightingale	2,200	79	2,121	1,801	4,400	4,416	(16)
Endoscopy	6,499	203	6,296	378	11,122	12,895	(1,773)
Diagnostics - Northern Schemes	0	0	0	0	3,797	0	3,797
Digital Capability Programme	0	25	(25)	209	1,123	1,123	0
Other	0	1,178	(1,178)	985	0	2,859	(2,859)
Unallocated	2,000	0	2,000	0	2,000	618	1,382
Total Capital Expenditure	**35,720**	**13,087**	**22,633**	**12,632**	**73,147**	**75,021**	**(1,874)**
Under/(Over) Spend	**0**	**0**	**0**		**0**	**0**	**0**

Capital expenditure to M06 was £13.1m; £22.6m less than assumed in plan. Of the variance, £13.5m is due to profiling - all lease expenditure was planned to be fully incurred at M06. Excluding leases, the programme is £9.1m behind plan but £12.6m of open orders give confidence the slippage will recover. The respective Capital Programme Groups are actively monitoring risks and mitigations to ensure delivery.

Forecast capital expenditure of £75.0m fully utilises the CDEL and PDC allocations forecast in 2023/24.

Trust Financial Tables

Royal Devon University Healthcare NHS Foundation Trust
Delivering Best value
Period ending 30/09/2023
Month 6

Delivering Best Value Finance Report Month 6		RAG	Year to Date Plan £000s	Year to Date Actuals £000s	Year to Date Variance £000s	Forecast Plan £000s	Forecast Delivery £000s	Forecast Variance £000s	Narrative
Internal Recurrent DBV									
Clinical Activity	Clinical Productivity - Activity		4,323	4,323	0	13,100	13,100	0	
	Data quality, coding & capture		2,500	1,492	-1,008	5,000	5,000	0	Slippage due to phasing differences between programme plan & identified phasing.
Corporate Services	Corporate Services - Integration		498	129	-369	2,000	1,158	-842	
Other Income Opportunities	Overseas visitor income		67	100	33	200	200	0	
	Other Trustwide Income		0	0	0	0	200	200	
Estate Review	Leased Estate DBV		0	20	20	200	200	0	Work ongoing to identify potential opportunity, full confidence of estates team to deliver target in year, remit expanded to include all estate usage costs
Workforce	Temporary Workforce		2,403	1,471	-932	5,200	1,471	-3,729	Agency spend currently above plan, any future agency spend reduction will be cost avoidance not DBV
	Supporting colleagues return to work		0	0	0	500	0	-500	Route to cash is cost avoidance rather than DBV
Epic	Epic Optimisation		1,521	227	-1,294	3,101	1,073	-2,028	Detailed review of opportunities presented to DBV Governance process, expected delivery relates to admin benefit and stationary. Eastern admin delivery £239k below expectation, admin delivery includes £232k delivered non recurrently to date
	Epic Optimisation - Digital		1,367	0	-1,367	2,699	395	-2,304	Expected delivery relates to legacy systems, work ongoing to enable savings to be transacted by month 6. £396k adverse variance to expected delivery due to eastern healthcare records MOC on pause as requested by CT
Procurement	Procurement		250	75	-175	500	461	-39	Detailed review of forecast undertaken by Head of Procurement
Pharmacy	Medicines		150	150	0	300	991	691	Over delivery to be recognised against system strategic programme
Transformation	Transformation		0	0	0	400	148	-252	
Covid	Covid Costs		1,300	1,300	0	2,600	2,600	0	
Finance Adjustments	Release previous commitments made not yet drawn down		1,000	1,000	0	2,000	2,000	0	
Other Divisional DBV	Other Divisional DBV		0	93	93	0	175	175	ENT savings identified in northern surgery division
	Total Recurrent DBV		**15,379**	**10,380**	**-4,999**	**37,800**	**29,172**	**-8,628**	
Internal Non recurrent DBV									
Corporate Services	Corporate Services - Integration		2	282	280	0	581	581	
Other Income Opportunities	Other Trustwide Income		0	1,450	1,450	0	2,900	2,900	Capital charges income
Estate Review	Profit on disposal		0	0	0	500	0	-500	Update to DBV Board reflected no delivery expected
Estate Review	Leased Estate DBV		0	889	889	0	130	130	Non recurrent NHS Property Services adjustment
Workforce	Non clinical vacancy controls		500	500	0	1,000	1,000	0	
Epic	Epic Optimisation		0	342	342	0	0	0	
Procurement	Procurement		0	46	46	0	39	39	
Pharmacy	Medicines		0	0	0	0	320	320	Over delivery to be recognised against system strategic programme
Transformation	Transformation		0	0	0	0	0	0	Genomics non recurrent benefit due to new analyser
Finance Adjustments	NR Balance Sheet		0	6,344	6,344	4,500	6,296	1,796	Detailed review of accruals and deferred income
	Capital charges review		0	0	0	400	400	0	
	Funding arrangements for transfer of care		250	0	-250	500	436	-64	Forecast based on projections of activity delivered to date
Other Divisional DBV	Other Divisional DBV		0	326	326	0	297	297	Trauma product credit eastern surgery
	Total Non-Recurrent DBV		**752**	**10,179**	**9,427**	**6,900**	**12,399**	**5,499**	
	System Double Count Risk						**-5,511**		
	Total Internal DBV		**16,131**	**20,559**	**4,428**	**44,700**	**36,060**	**-8,640**	

- Year to date position showing plan £16.1m and achievement of £20.1m being £4.4m favourable variance (M5 £4.5m favourable). Movement in position due to pharmacy over delivery now allocated against system strategic schemes being partly offset by an additional NR benefit on rates.
- Full year position showing a shortfall of £8.6m against the plan being a deterioration of £5.5m from M5 reflecting the potential to double count savings from system strategic schemes.

Trust Financial Tables

Royal Devon University Healthcare NHS Foundation Trust
System Savings
Period ending 30/09/2023
Month 6

Delivering Best Value Finance Report Month 6		RAG	Year to Date Plan £000s	Actuals £000s	Variance £000s	Forecast Plan £000s	Delivery £000s	Variance £000s
System Strategic DBV								
Clinical Support	High Cost Drugs & Devices/Pharmacy		0	508	508	1,700	1,130	-570
Clinical Support	Imaging		0	0	0	850	456	-394
Clinical Support	Pathology		0	0	0	850	882	32
Corporate Services	Corporate Services		0	0	0	1,100	133	-967
Estates	Estates		0	0	0	800	901	101
People Services	Workforce		0	0	0	1,600	500	-1,100
New Models of Care	New Models of Care		0	0	0	4,000	0	-4,000
Procurement	Procurement		0	0	0	3,000	1,509	-1,491
Digital	Digital		0	0	0	1,700	0	-1,700
	Total System DBV		**0**	**508**	**508**	**15,600**	**5,511**	**-10,089**
	Total DBV Delivery		**16,131**	**21,067**	**4,936**	**60,300**	**41,571**	**-18,729**

Forecast delivery of RDUH share of system stretch is £5.5m although further work underway to validate through a series of route to cash meetings. Risk off double count mitigated through offsetting against the internal DBV programme as same spend categories targeted. Although schemes are forecasting under delivery this is in part due to timing of delivery in key strategic work programmes and delivery is assumed with a greater impact in 2024/25.

Phasing of the system plan was for Q4. Impact is reflected in overall Trust forecast which remains on plan as mitigations are being explored through the Financial Recovery call to action.

Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	11.1, Public Board Meeting		**Date: 1 November 2023**	
Title:	Update on the work of the Peninsula Acute Provider Collaborative			
Prepared by:	Peninsula Acute Provider Collaborative (PAPC)			
Presented by:	Chris Tidman, Deputy CEO			
Responsible Executive:	Chris Tidman, Deputy CEO			
Summary:	The report sets out the progress made by the PAPC and in particular the clinical case for change and the work delivered to date through the Peninsula Acute Sustainability Programme and the immediate areas for focus.			
Actions required:	Link to status below and set out clearly the expectations of the Board when considering the paper.			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
		x	x	
History:	The Board has previously received updates via the CEO report.			
Link to strategy/ Assurance framework:	Links to Clinical Strategy and 'Better Together' road map			

Monitoring Information

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

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

1. Purpose of paper

In January 2022 a paper was presented to the Boards of acute Provider Trusts in Devon seeking a mandate to establish an Acute Provider Collaborative (APC).

The overall aim of the Collaborative was to develop a mechanism that bound leaders and organisations together, as equal partners, to improve the delivery of acute healthcare for the whole of the population of Devon.

The primary focus of the APC was outlined as focusing on system-wide transformation of acute services. It would not cut across or replace the place-based partnership arrangements which are designed to inform the planning and delivery of integrated health and care services at a local level and would have no responsibility for direct delivery of acute services.

The functions of the APC were agreed by Boards to include:

- Identifying the opportunities for joint working (operationally and strategically)
- Agreeing the acute services transformational priorities and delivery plan
- Commissioning specific pieces of work
- Receiving recommendations and/or business cases
- Making joint decisions within any delegated authority; and
- Making joint decisions to be endorsed by Trust Boards and ICB.

It quickly became apparent that to achieve the best outcomes and fulfil the ambition of driving equity across the population that the remit of the APC needed to extend across *the whole Peninsula*. On that basis the acute provider in Cornwall and Isles of Scilly accepted the invitation to be a full member of the APC which was renamed the Peninsula Acute Provider Collaborative (PAPC).

Membership of the PAPC includes the Chair, Chief Executive and Chief Medical Officers of:

- Royal Cornwall Hospitals Trust (RCH)
- Royal Devon University Healthcare NHS Foundation Trust (RDUH)
- Torbay and South Devon NHS Foundation Trust (TSD)
- University Hospitals Plymouth NHS Trust (UHP)

The Chief Medical Officers of both Devon and Cornwall and Isles of Scilly ICBs are also members of the PAPC.

Since its inception the PAPC has made considerable progress. This has included the launch of the Peninsula Acute Sustainable Programme (PASP) in October 2022. The PAPC has delegated its authority to a PASP Board to scope a sustainability programme for several key Acute Trust services. The PAPC remains accountable for the work of PASP. This programme focuses on the fact that our hospital services must be transformed to address:

- Services that are struggling to meet the increasing demand and needs of patients.
- A population which is growing older.
- Existing (and worsening) inequalities in access and experience of services.
- Challenges in recruiting and retaining staff.

We need to:

- Support staff to deliver safe and high-quality care.
- Ensure services conform to national and professional standards.
- Provide safe and high-quality services across the whole Peninsula.
- Meet demand now and in the future.
- Make the best use of our limited resources.

Wider context

The work of the Peninsula Acute Provider Collaborative sits within a wider context for both NHS Devon and NHS Cornwall and Isles of Scilly. Both have unique and shared challenges. The challenges facing Acute Trusts, and the need for change have been articulated by our respective Chief Medical Officers in this video: **https://www.youtube.com/watch?v=gW-AU0cXlgw**

Within Devon:

- Over the next three years, the NHS in Devon will be making changes and improvements to reduce waiting times for treatment, improve access and get spending back under control.
- Too many people in Devon are waiting too long to get the NHS care they need – this includes waiting times for ambulances and treatment in Emergency Departments as well as for planned operations like knee replacements and for support for mental health care. This is impacting on the physical and mental health of people in Devon.
- And for many years, Devon has consistently spent more money on health services than it has been given to meet the needs of the 1.2 million people it serves, placing the county into unacceptable levels of financial deficit.
- Devon's financial and performance challenges mean it is among a small number of systems placed in 'special measures' (sometimes known as segment four of the NHS Oversight Framework) by NHS England as part of a

national improvement programme. This means extra reporting requirements and strict financial controls which limit decision-making powers. It also means Devon has to make improvements to avoid losing further decision-making powers.

- Devon is managing this via a System Recovery Programme. The System Recovery Programme aims to deliver the improvements needed that would NHS Devon to meet the targets to improve waiting times and deliver best value, which will allow Devon to move out of segment four/special measures in the first quarter of the 2024/2025 financial year.
- In performance terms, System Recovery Programme is about improving two key areas in the first instance:
    - Urgent and emergency care; and
    - Planned/elective care.
- The provision of safe and timely care that is affordable and sustainable is our number one priority – if Devon achieves this, makes the improvements expected, it will move out of special measures.
- To do this, Devon will have to make major improvements to:
    - The way care is delivered; and
    - The way money is managed.
- In financial terms, recovery means being able to set a balanced budget each year and, in the longer term, starting to address the NHS Devon underlying deficit.
- In performance terms, NHS Devon wants to do more than 'recover' services – in many areas the system needs to make best use of its people and talent, and take opportunities created by the latest technology to deliver the best care equably across Devon. In the short term, Devon needs to reduce long waits for care and look after more people closer to home, rather than send them out of Devon for treatment.

The Peninsula Acute Provider Collaborative's immediate focus

In May 2023 a new Chair was appointed to the PAPC on a 12-month fixed term contract: Stephanie Elsy, currently Chair of NHSE Bath & Northeast Somerset, Swindon & Wiltshire ICB. The PAPC is maturing and is in the process of reviewing its scope so that it is well placed to address the challenges ahead. Given the context and respective priorities of NHS Devon and NHS Cornwall and Isle of Scilly, the Peninsula Acute Provider Collaborative in intend to:

- **Prioritise fragile services** where patient access needs to be improved and we need ensure that we have right workforce in the right place to deliver good quality care. Currently we are targeting the following fragile services: Urology, Interventional Radiology, Stroke, Histopathology, Microbiology and Oncology. A service is determined to be "fragile" against an agreed set of access, quality, safety, and workforce criteria. Given these criteria, we anticipate that more

services will be added to this initial list for immediate attention to ensure their ongoing stability.

- **Look at opportunities for improving productivity and performance** by working towards the delivery of single services across the full portfolio of our sites by ensuring we make the best use of our building infrastructure, technology, and transport services.

- **Agree which services need to be transformed**. We will involve and engage with patients, the public and our workforce to identify and agree new service models and design a programme and supporting plans which align with other programmes and plans being developed within the wider Devon, Cornwall and Isles of Scilly integrated care context, for example, primary care, mental health, social care and community services.

- **Involve and engage with our stakeholders.** We want to hear the ideas of our teams on how our services and processes could be improved. We want to be open and honest about what is happening and why and so we will be working and engaging with local people, our staff and our partners to explain more about the challenges we face and how we are rising to them.

We will provide regular reports to Acute Trust Boards on the work programme, progress and achievements of the Peninsula Acute Provider Collaborative.

Recommendation
The Board is asked to note the report

NHS
Royal Devon
University Healthcare
NHS Foundation Trust

Agenda item:	11.2 Public Board Meeting	Date:	1 November 2023
Title:	Royal Devon "Better Together" Strategy Roadmap 2022-27 – report period July - September 2023 (Q2 23/24)		
Prepared by:	Katherine Allen, Director of Strategy		
Presented by:	Chris Tidman, Deputy CEO		
Responsible Executive:	Chris Tidman, Deputy CEO		
Summary	This paper presents the Royal Devon Strategy roadmap progress report for Quarter 2 23/24, a forward look for 6 months and suggested next steps around plans for 2024.		
Actions required:	The TDG is asked to note this paper		

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

History:	Every quarter TDG and Trust Board of Directors receive a report presenting the progress in delivering the Royal Devon "Better Together" Strategy and six-month look ahead.
Link to Strategy / Assurance Framework	Royal Devon Strategy

Monitoring information

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

Care Quality Commission Standards			
NHS Improvement		Finance	
Service Development Strategy	x	Performance Management	
Local Delivery Plan	x	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: 2023/24 quarter 2 (Q2) progress report (covering the period 1 July to 30 September 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 Q2, with some milestones being slipped due to competing operational priorities.

1.4 Following the approval of all of the enabling strategies in July 2023 (clinical, estates, people, digital, data, finance) the strategy leads have collaborated to ensure implementation plans were developed which aligned to the clinical strategy.

1.5 The enabling strategies were launched on 24th October, with a number of events lined up for staff to find out more about what this means for the Trust.

1.6 The milestones from each strategy implementation plans have been plotted. The next phase of work is to take the likely 2024/25 operational plan, DBV and improvement priorities and pre-populate aspects of the 2024 operational plan with relevant strategy milestones.

1.7 Following feedback from TDG, the strategy roadmap will be presented to the Board of Directors for their approval in November 2023. The revised roadmap will then support the development and pre-population of the RDUH operating plan for 2024/25.

2. Royal Devon Strategy and Roadmap: Q2 23/24 progress report

The following section takes the key highlights from the achievements from July – September 2023 (Q2 2023/24):

2.1 **Merged Charity launched**
The Royal Devon hospitals charity merged in July 2023. Milestone completed.

2.2 **ICS PASP scenarios**
The Acute Provider Collaborative (APC) is overseeing the programme. The programme has been delayed due to disruption from industrial action, but good progress has been made. Milestone completed.

2.3 **Enabling Strategies**
The six enabling strategies were approved by the Board of Directors in July 2023. Milestone completed.

2.4 **OSIG: Agree divisional structure options**
To ensure all options for the future operating model are considered this milestone was deferred from July to September 23. The draft structure options were agreed in September

2023 and subject to some final revisions, we expect to move into the consultation phase during November. Milestone completed.

2.5 **Improvement Programme Plan**
The RDUH Improvement Programme plan is in place and being monitored through the Improvement Working Group, with assurance provided via Finance and Operations Committee. Milestone completed.

2.6 **Health Inequalities Strategy**
This milestone was added following the publication of the Joint Forward Plan and emerging national policy on prevention. The strategy and health inequalities report is due at TDG and Board in November 2023. Milestone deferred from September to November 2023.

2.7 **East & North key worker housing OBC**
The OBC draft for internal Trust circulation was completed in September 2023. Internal and external discussions regarding OBC route and next steps will take place in November 2023. The progression of the OBC requires HMT approval for the accounting treatment of the commercial model. NHSE/HMT are conducting a 'pilot' short-form (OBC/FBC combined) business case with North Bristol Trust and they have advised other Trusts with OBCs to pause pending the HMT outcome. RDUH in dialogue with NHSE SW about being a fast follower Milestone deferred from September to December 2023, where it is planned to take the business case to Finance and Operations Committee.

2.8 **OFH progress update on the options submitted**
Options have been submitted to the NHP team and response awaited. Milestone completed.

2.9 **Tiverton Endoscopy Unit**
The Tiverton mobile unit went live date on 16 October 2023 following a 6 week delay associated with getting a letter of indemnity from the PFI owner, and having to source a separate power source. Issue escalated via NHSE SW. The milestone was therefore moved from September to October 23.

2.10 **Breast Unit engagement starts**
Following approval of the SOC in September 2022, a working group was established to develop an OBC. Estates will commence a feasibility study for the Cluster and Divisional preferred options. Engagement has started. Milestone completed

2.11 **Enabling strategies implementation plans**
Workshops were held in August and September 2023 to develop the enabling strategy implementation plans. As the strategy roadmap is being presented to the Board of Directors for approval in November 2023 this milestone is moved from September 2023 to November 2023.

2.12 **Monitoring of strategy roadma**p
This milestone has moved from September 2023 to March 2024 to align with the strategy roadmap being presented to the Board of Directors for approval in November 2023 and subsequent quarterly reporting schedule.

2.14 Table 1 shows the milestones that were achieved in Q2 2023/24 of the Royal Devon corporate roadmap (1 July – 30 September 2023).

Table 1: Q2 2023/24 H2 Royal Devon strategy roadmap

			2023		
			H1, Q2		
		Strategic Objectives	Jul	Aug	Sept
Board Programme	Overall Corporate Strategy Roadmap - Year 2 of 5	Collaboration & Partnership	Merged Charity launched (Royal Devon hospitals charity)		Health Inequalities Strategy
			ICS: PASP scenarios developed		
		A great place to work	Workforce Strategy		
		Recovering for the future	Estates Strategy and site development plans	Improvement Programme Plan	OFH progress update on the options submitted
			Financial Strategy		OSIG: Agree divisional structure options
			Information & BI Strategy		
		Excellence & Innovation in patient care	Clinical Strategy		Breast Unit engagement starts
			Digital Strategy		

Key

Completed
In progress
Off-track

2.15 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.

2.16 Those change controls which are relevant to the Q2 period because they are off-track are listed below. The detail is reported in Appendix 1, table 3.

- OSIG: Agree divisional structure options
- East & North key worker housing OBC approved
- Health inequality strategy
- Tiverton Endoscopy Unit
- Enabling strategies implementation plans
- Monitoring of enabling strategies

3. Royal Devon Corporate Roadmap in H2 Q3 and Q4 2023/4

Table 2 shows the look ahead to the milestones proposed for the next six months from 1 October 2023 – 31 March 2024.

Table 2: October 2023 – March 2024 Royal Devon strategy roadmap

			2023			2024		
			H2, Q3			H2, Q4		
		Strategic Objectives	Oct	Nov	Dec	Jan	Feb	Mar
Board Programme	Overall Corporate Strategy Roadmap - Year 2 of 5	Collaboration & Partnership						ICB to implement BAU Acute Collaborative Operation
								ICB to mobilise contribution model for LCPs
		A great place to work	Longterm Workforce Plan					
		Recovering for the future	RD&E paed ED work commences	Pre-populate operating plan	Vascular Hybrid Theatre FBC		OSIG: divisional structure implemented	Cardiology Day Care Unit (CDCU) opens
			Tiverton Endoscopy Unit	Enabling strategies implementation plans				OFH OBC Plan commences
								Monitoring of enabling strategies via Corporate roadmap
		Excellence & Innovation in patient care	EPIC Risk assessment TSD - to BoD					

4. Recommendations

The Board is asked to note:

4.1 the progress made during July - September 2023 (Q2 23/24) and the achievement of the majority of milestones.

4.2 the current roadmap milestones for the next 6 months and that the next Corporate Roadmap report will be prepared once the 2024/25 strategy roadmap has been signed-off by the Board of Directors.

4.3 that further or amended milestones will be contained in the next strategy roadmap report in March 2024.

4.4 Note that a process to monitor delivery of enabling strategies will be agreed with the leads and likely to involve the relevant committees, i.e CSDG, digital committee etc. The agreed governance will be presented in the next update for information and assurance.

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 April 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 Q2 2023/24 milestones

Commitment	Original date due	Proposed new date	Reason for change
OSIG: Agree divisional structure options	July 2023	August 2023	To enable time for engagement and ensure all options for the future operating model are considered.
Health inequality strategy	October 2023	November 2023	The strategy and health inequality waiting list report need to be presented together. The data was delayed.
East & North key worker housing OBC approved	September 2023	December 2023	To enable internal discussions regarding OBC route and next steps in October 2023 and SEDG presentation in November 2023.
Tiverton Endoscopy Unit	September 2023	October 2023	A standalone connection to water by South West Water on 22 September. Water testing will then commence. A provisional go-live date of 9 October 2023.
Enabling Strategies implementation plans	September 2023	November 2023	To align with the enabling strategy roadmap being presented to the Board of Directors for approval in November 2023.
Monitoring of enabling strategies	September 2023	March 2024	To align with the enabling strategy roadmap being presented to the Board of Directors for approval in November 2023 and subsequent quarterly reporting schedule.

Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	11.3 Public Board Meeting		**Date:** 1 November 2023	
Title:	Quarterly review of the Board Assurance Framework			
Prepared by:	Melanie Holley Director of Governance			
Presented by:	Melanie Holley Director of Governance			
Responsible Executive:	Paul Roberts Chief Executive Officer			
Summary:	To present to the Board of Directors the Board Assurance Framework for the Royal Devon.			
Actions required:	Link to status below and set out clearly the expectations of the Board when considering the paper.			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
		x	**x**	
History:	The BAF was last presented to the Board of Directors on 26 July 2023. In line with the Boards schedule of reports, the BAF is presented quarterly for review.			
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		
NHS Improvement		Finance	
Service Development Strategy		Performance Management	
Local Delivery Plan		Business Planning	
Assurance Framework		Complaints	
Equality, diversity, human rights implications assessed			
Other *(please specify)*			

1. Purpose of paper

To present to the Board of Directors (BoD), the quarterly review of the Board Assurance Framework (BAF) for the Royal Devon University Healthcare NHS Foundation Trust.

2. Background

On 1 April 2022, the Royal Devon & Exeter NHS Foundation Trust integrated with Northern Devon NHS Trust and was renamed the Royal Devon University Healthcare NHS Foundation Trust (Royal Devon). Prior to April 2022 a BAF existed for both Trusts and was reviewed quarterly at the Joint Board Meetings.

The BoD approved a Corporate Strategy for Royal Devon on 27 April 2022. A new BAF was created which outlined the risks of the Trust not achieving the strategic objectives which are detailed within the Corproate Strategy.

The BAF was reviewed in April 2023 alongside the Trusts Corporate Risk Register. The BoD agreed that as part of the operational planning process and in line with good governance, the BAF should once again undergo a review to ensure it accurately updates the risks to the Trust not achieving the strategic objectives. The BoD approved the proposed revised BAF in July 2023 as part of the routine quarterly review.

Individiual BAF risks were last reviewed during September/October 2023 by the Board Committees.

The list of BAF risks is detailed in Appendix A.

3. Analysis

Summary of current and target assessments of risks

Risk ID	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Position ↔ ↓ ↑	Target
1	16	16	16	16	16		↔	8
2	16	16	16	16	16		↔	8
3	20	20	20	16	16		↔	12
4	25	25	25	20	25		↑	12
5	25	25	25	20	20		↔	9
6	New risk			20	20		↔	8
7	9	9	9	9	9		↔	4
8	12	16	16	16	16		↔	4
9	16	16	Not reviewed	16	16		↔	8
10	New risk			25	25		↔	4

Summary of current risk scores heat map

Impact	Likelihood				
	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Very Likely				5,6	4,10
4 Likely				1,2,3,8,9	
3 Possible			7		
2 Unlikely					
1 Rare					

Points for the BoD to note:

Risk 1 – Degree and complexity of change impacts on leadership resilience and capacity to deliver
Cumulative impact of industrial action added as a further risk factor, but risk held at 16.
Plans to strengthen controls include greater system ownership of NHSE improvement interventions and a request for a Board Development session to focus on the Corporate Road map priorities to risk assess deliverability and capacity in the face of current pressures.
Also, suggested review of workforce/people governance to ensure it has full Board visibility.

Risk 2 - Failure to recruit, retain and train the required to ensure the right no. of staff with the right skills in the right location
A number of amendments have been made, assurance was provided to the PWPW that the right actions are being planned, but the risk remains high. Consideration was given to reducing the likelihood score from 4 to 3 however PWP felt that whilst vacancy levels had reduced, the current position remained vulnerable with many ares of high risk. It was therefore agreed that the score would remain unchanged.

Risk 3 – Finance Capital Risks
No changes recommended to the narrative or the score.

Risk 4 - Non delivery of the financial plan (Trust and system)
Narrative updated to reflect the progress on the Devon ICS Medium Term Financial Plan (MTFP) but reflecting gaps in this process as it is a financial model and not supported by detailed delivery plans. Also updated to reflect the progress on the Trust Financial Strategy but recognising that this also lacks detailed delivery plans behind the level of savings required to provide assurance on turnaround of the financial position.Final amendments are the recognition of the financial recovery plan to reduce the run-rate of spend and gaps in assurance due to lack of route to cash on the system savings plans.

Change in risk score, from 20 to 25.

Although there is a deterioration in the financial position this is already reflected in the highest level of likelihood of 5 within the overall risk score. The biggest impact on the change in risk of delivery is on the consequences due to the worsening cash position. The Trust will need to request cash support from NHS England to cover the deficit position as cash balances have

been depleted. With this request comes a significant level of additional scrutiny with daily cash forecasting and analysis of cash requirements. Whilst there is a plan to improve the working capital (debtors and creditors) to reduce the financial support required there is a risk of challenge against the Trust's capital programme.

With the change in cash position there will also be a consequence to the EPIC loan with a potential increase in interest rate under the current agreement due to the perceived increase risk to the lenders.

Risk 5 - Operational Risk in relation to Elective Demand and Waiting Lists
The narrative has been updated to reflect the progression of the investment and development programmes, including in relation to Cardiology, Endoscopy and Diagnostics, and to reflect the recent positive change in the Trust's Tiering Status as an additional source of assurance.

Risk 6 - Our people do not feel looked after or valued. Employee experience is poor and people feel their health and wellbeing is not prioritised
A number of amendments have been made, assurance was provided to the PWPW that the right actions are being planned, but the risk remains high. It was therefore agreed that the risk score would remain unchanged.

Risk 7 - Risk of not maximising EPIC benefits (Trust and system)
BAF risk 7 has been reviewed by the relevant risk owners and has been updated accordingly. There have been further discussions regarding the current scoring of the risk but it has been agreed to remain at the existing level; however, this BAF risk is due to be reviewed again in November by the relevant governance group and Digital Committee, with a view to adding a further emerging strategic threat, which will likely have a bearing on the existing risk scoring. This will be reflected in the next iteration, pending the outcomes of these further discussions and as additional information emerges over the coming weeks.

Risk 8 - Risk of a significant deterioration in quality and safety of care
BAF Risk 8 was reviewed at September's Safety and Risk Committee (28.09.23) and remains at a current Risk score of 16. Minimal changes were made to the Risk; primarily the inclusion of timeframes for completion of plans to improve control as requested by the Board.

Risk 9 – Our Future Hospitals- Delays in funding/ failure to deliver clinical strategy for North Devon

No changes recommended to the risk score, controls or assurance.

Risk 10 – Operational Risk in relation to UEC Targets
Minor revisions are proposed to the narrative to reflect the likelihood of the discontinuation of the temporary adjustment to postcode catchments, and the re-instigation of dynamic conveyancing in order to support neighbouring Provider acute Trusts including as part of System Winter Plan arrangements. In addition, the risk incorporates reference to Trust's Urgent and Emergency Care Improvement Plan.

4. Resource/legal/financial/reputation implications

None

5. Link to BAF/Key risks

In addition to being an incredibly useful management tool, regulators require BoDs to have a robust BAF in place as part of the Boards assurance and risk management process.

6. Proposals

For the Board of Directors to:

- Review the current 10 BAF risks, asking questions and providing challenge to ensure that mitigations and actions are progressing timely and ensuring that the scores accurately reflect the current position of the risks.
- To identify any further risks which are not listed.
- To note that in addition to this report, the Board will receive regular updates from the Sub Committees of the Board for the BAF risks that have been delegated for review by Sub Committees.

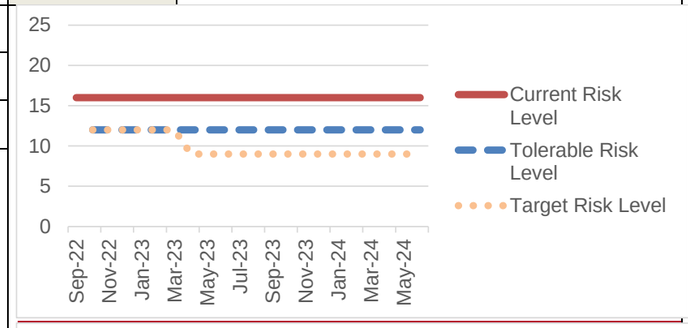
APPENDIX A
Summary of BAF Risks July 2023

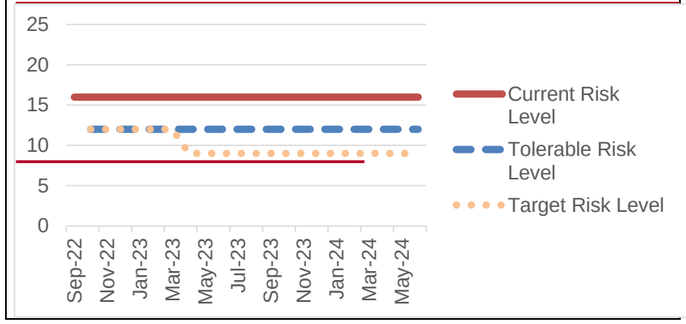
	Strategic Risk (High level version)	SRO	Committee	Current	Target
1	**Degree & complexity of change impacts on leadership resilience & capacity to deliver**	CEO	Board	16	8
2	**Failure to recruit, retain and train the required to ensure the right no. of staff with the right skills in the right location**	HF	GC (via PWPW)	16	8
3	**Trust unable to invest in its capital plans**	AHi	FOC	16	12
4	**Non delivery of the financial plan** (Trust and system)	AHi	FOC	20	12
5	**Elective demand and waiting list backlogs are not delivered**	JP	FOC	20	9
6	**Our people do not feel looked after/valued, employee experience is poor and people feel health and wellbeing are not prioritised**	HF	GC (via PWPW)	20	8
7	**Risk of not maximising EPIC benefits** (Trust and system)	AHa	Digital	9	4
8	**Risk of a significant deterioration in quality and safety of care**	CM	GC (via S&RC)	16	4
9	**Our Future Hospitals – Delays in Funding/failure to deliver clinical strategy for Northern services**	CT	OFH	16	8
10	**UEC targets are not delivered**	JP	FOC	25	4

Royal Devon University Healthcare NHS Foundation Trust

Risk 1 Degree & Complexity of Change Impacts on Leadership Resilience & Capacity to Deliver

Principal risk (what could prevent us achieving this strategic priority)	There is a risk that the degree and complexity of internal and external demands (and the scale of operational change) has a significant negative impact on leadership and senior management capacity, morale and therefore capability.					**Strategic priority**	A great place to work
Lead Committee	~~TBC~~Board	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Our People
Executive lead	~~Hannah Foster~~CEO / Deputy CEO	**Likelihood**	4 – Likely	3 – Possible	2 – Unlikely	**Risk appetite**	Minimal
Initial date of assessment	14/09/2022	**Consequence**	4 – Major	4 – Major	4 – Major	**Risk treatment strategy**	Modify
Last reviewed	10/01/2023 17/04/2023 18/07/2023 26/10/23	**Risk rating**	**16 – Significant**	**12 – Medium**	**8 – Low**		
Last changed	10/01/2023 17/04/2023 18/07/2023 26/10/2023						





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Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating** (assured or inconclusive with further actions required)
• Increased complexity of internal and external demands as we recover services post COVID • Financial constraints preventing solutions being implemented. • Significant strategic and operational change- both within the Trust and across the Devon system. • Heightened regulatory scrutiny in relation to the NHS System Oversight Framework (SOF4) criteria. • Ongoing impact of managing and mitigating the impact of industrial action on leadership resilience	• Corporate Road Map in place to manage pace of strategic change and to ensure capacity & capability is in place to deliver/ use of Board Development Sessions to ensure capacity is in place • Trustwide Executive and site management structure to support the broader leadership teams. • Trust Delivery Group in place for Trustwide operational matters and Operations Boards set up for each site to ensure agile decision making • Leadership Group established for progression, support and development of senior managers, to provide resilience. • Active Board role input supporting System Recovery Board to ensure proportionate and triangulated across all domains • Executive coaching and mentoring support in place for Executive Directors. • Executive led Leadership Group meetings / engagement events focussed on delivery of operational and strategic priorities • Inclusive Leadership training set up and being delivered to senior leadership team. • Specialist and executive resourcing team in place substantively to support executive, specialist and hard to fill roles. • Management Support Programme launched. • Leadership ~~Academy launched~~development programme based on 'Controlling the Controllables'. • Cycle of risk and succession planning for the leadership group commenced, including identification of plans to eliminate single points of failure. • Extensive comms plan based on authenticity and gratitude – naming challenges but celebrating success	• Limited ability to control demands that originate outside of the organisation.	• ~~Leadership development programme based on 'Controlling the Controllables'~~ • . • Working with partner organisations to streamline reporting and improvement interventions to/with regulators. • Ensuring that improvement interventions requested go through a consistent system governance process. • Board Development session to be held on determining timing of road map priorities based on available capacity and urgent demands.	• ~~Board~~ Performance Assurance Framework (PAF). • Performance and Governance System around delivery. • Intelligence from the quarterly People Pulse surveys and the annual staff survey. • Successful recruitment to senior leadership posts. • Monthly workforce reports on turnover/ sickness • Appraisal and 360 feedback • Feedback from Trust and system leaders • Regular reporting of annual leave usage for the senior leadership team (March 2023) • Data from health & wellbeing conversations (May 2023) • Intelligence on flexible working requests including approval rates (October 2023) • Information on completion of stress risk assessments (December 2023) • Internal progression metrics (October 2023) • Metrics in relation to leadership competency (May 2023) • Reports on attrition/vacancy levels for 8a+ (July 2023)	• ~~Regular reporting of annual leave usage for the senior leadership team (March 2023).~~ • ~~Data from health & wellbeing conversations (May 2023).~~ • ~~Intelligence on flexible working requests including approval rates (October 2023).~~ • ~~Information on completion of stress risk assessments (December 2023).~~ • ~~Internal progression metrics (October 2023)~~ • ~~Metrics in relation to leadership competency (May 2023).~~ • ~~Reports on attrition/vacancy levels for 8a+ (July 2023).~~ • PWPW operates at a level below Governance Committee – Board to consider greater visibility of workforce metrics through Board and sub-committee reporting.	There are a number of actions in place to provide further assurance and to understand the impact of this risk; however, there is a limited amount that can be done to control the external environment and the demands outside of the organisation. Whilst there is assurance that the right actions are included on this plan, it is unlikely that the demands are going to ease and therefore it is expected that the risk score will remain at the current level.

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Royal Devon University Healthcare NHS Foundation Trust

Risk 2 Failure to Recruit, Retain and Train the Required to Ensure the Right No. of Staff with the Right Skills in the Right Location

Principal risk (what could prevent us achieving this strategic priority)	Failure to recruit, retain and train the required to ensure the right number of staff with the right skills in the right location					**Strategic objective**	A great place to work
Lead Committee	Governance Committee (via People, Workforce Planning & Wellbeing Committee)	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Our People
Executive lead	Hannah Foster	**Likelihood**	4 – Likely	3 – Possible	2 – Likely	**Risk appetite**	Minimal
Initial date of assessment	14/09/2022	**Consequence**	4 – Major	4 – Major	4 – Major	**Risk treatment strategy**	Modify
Last reviewed	~~20/07/2023 -~~ _ ~~PWPW~~10/08/23 - GC	**Risk rating**	**16 – Significant**	**12 – Medium**	**8 – Low**		
Last changed	~~20/07/2023 -~~ _ ~~PWPW~~10/08/23 - GC						

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Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating** (assured or inconclusive with further actions required)
• National shortages. • Competitive recruitment market. • Inability to attract candidates in certain staff groups. • Inability to retain existing staff. • Not fully utilising digital capability. • Challenging financial climate with headcount reduction for non-clinical roles. • Potential for increasing GP numbers to adversely impact recruitment and retention of doctors	• Trust strategy including great place to work objective and Trust values, to create an effective, healthy and inclusive working environment with a just and learning culture to support recruitment and retention • Growing our own workforce with links to key educational providers and own academy status to provide apprenticeships. • Successful international recruitment campaigns. • Sharing of resources Trustwide i.e. clinical / medical staff working across northern and eastern services. • Specialist and executive resourcing team ~~in place substantively to~~ supporting executive, specialist and hard to fill roles. • Career Gateway system ~~in place.~~ • Recruitment fairs scheduled for next 12-months. • ~~Strategic workforce lead for nursing and midwifery and AHP's and~~Dedicated workforce planning ~~team in post.~~capacity • Delivering Best Value retention -stream. • New recruitment branding delivered. • Stay conversations piloted and in place.	• Lack of strategic workforce plan for the Devon ICS. • Inability to convert temporary workforce to permanent posts. • ~~Inability to recruit to enough posts to meet demand within current financial envelope.~~ • Sustainable finance solution for pipeline of apprentices sufficient to support retention and transformation. • Staff do not always feel empowered to make changes to mitigate this risk.	• Automated ID & DBS checks for new starters. • Further use of Career Gateway to develop workflows and improve automation. • Development of local 5-year workforce plan. • ~~Standardise candidate feedback reporting to inform process improvement and recruitment marketing strategy.~~ • Position management to move to ESR to provide clear articulation of vacancies at position level (September 2023). • Automate new starter checklist for managers. • Implement discounts and special offers for new starters as part of their welcome. • Prioritise staff accommodation improvement 'must-dos' e.g. rest areas. • Apprenticeship pay and reporting proposal. • Survey new starters in week one, month one and month three, then use the results to improve the new starter experience and drive improvements. • Completion of actions within the NHS Long Term Workforce Plan 2023	• Regular monitoring of a range of metrics, including those linked to recruitment and retention at PWPW. • Strategic Workforce Planning Hub • Metrics in the Integrated Performance Report (IPR). • Benchmarking through the ICS Cultural Dashboard. • Employee experience intelligence including quarterly People Pulse surveys and the annual staff survey including measurement of people promise. • Reporting of progress against the NHS People Plan. • Reporting on recruitment pipelines. • Survey ~~currently out to understand~~results about induction process experience from new starters and recruiting managers. • Weekly workforce infographic data,	• ~~Fully analysed exit interview data following the new digital exit survey launch (May 2023).~~ • Candidate experience information to be able to inform improvements. (July 2023) • ~~Development and learning dashboard to illustrate progression and apprenticeship pipeline (May 2023)~~ • Improved ~~H~~health and wellbeing dashboard to be launched (~~June~~ Dec 2023) • Further insight into apprenticeship	**Assured** – The PWPW was assured that the right actions are planned to mitigate this risk. Whilst good progress is being made in terms of vacancy rates, the Committee noted that there are still areas of high risk and that this position is vulnerable and could change. It was therefore agreed that the

in the acute setting. • The impact of continued industrial action.	• Candidates can access helpful information and resources prior to their start date on Learn+. • Strategic resourcing group ~~in place~~ to ~~prioritise~~ support recruitment to posts. • ~~Approved a~~Northern medical workforce business case approved, to increase substantive medical capacity. • Proactive health and wellbeing offer in place. • Career Gateway & Learn+ interface including autoenrollment of new starters onto mandatory training and reporting to other key stakeholders. • Interface ~~has been created~~ between Career Gateway and ESR, reducing manual data entry. • Healthcare Support Worker band 2 to 3 process enacted. • Step into health launched to encourage former military candidates to apply for roles across the trust. • Improvements in recruitment and retention have led to a reduced vacancy rate.			showing workforce loss / gain and details of the pipeline. • Monthly Workforce dashboard in place. • Vacancy Control Process (VCP) ~~process~~ including recruiting to turnover for some roles. • Recruitment risks regularly escalated to Senior Responsible Officers (SRO)s • Proactive retirement age profiling in place. • Single strategic resourcing role list with risk based prioritisation, that is regularly reported to the Divisions. • Attraction intelligence available to understand why people are joining the organisation. • Development and learning dashboard in place and presented regularly at People Development Group • Digitalised exit surveys now launched with two months of data collected • Health and wellbeing metrics	pipeline to be included in development dashboard (Dec 2023) • Information about progression metrics to be added to development dashboard (Mar 2024) • Analysis of exit survey data once enough information has been collected (Dec 2023)	risk score should remain the same.

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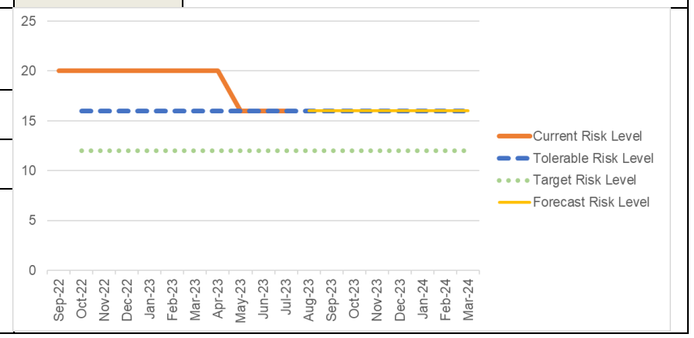
Risk 3 Trust unable to invest in its Capital Plans

Principal risk (what could prevent us achieving this strategic priority)	Risk 3 - The Trust is unable to invest in capital plans that support delivery of its operation or strategic objectives							**Strategic priority** Recovering for the future
Lead Committee	Finance and Operational Committee	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Financial	
Executive lead	Angela Hibbard	**Likelihood**	4	4	3	**Risk appetite**	Moderate	
Initial date of assessment	July 2021	**Consequence**	4	4	4	**Risk treatment strategy**	Mitigate	
Last reviewed	~~July 2023~~Oct 2023	**Risk rating**	**16**	**16**	**12**			
Last changed	May 2023			Given current financial climate				



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Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
The new NHS Capital regime is managed under ICS level CDEL limits, reducing the ability for Foundation Trusts to invest above a set limit. In addition, capital sources are becoming more constrained at a time that backlog maintenance costs are increasing. The ability to carve out strategic capital form internal CDEL limits is therefore challenging. Additional national capital is made available during the year but as a System with a deficit financial plan and in SOF4 restrictions on assessing this capital are likely. In addition, the national hospital programme (a source of future funding for the North) is over subscribed and plans are likely to be reduced within an affordability envelope. The strategic threat is therefore that capital is insufficient to manage the growing BAU capital needs and strategic capital development will be limited impacting on the delivery of our corporate strategy	**External** Engagement with the ICS & Regional Capital funding process to ensure fair share allocation of ICS CDEL Engage with ICS prioritisation process for national tranches of funding to ensure ICS process reflects priority of Royal Devon strategic capital needs Link to financial revenue risk and the controls around development of a financial recovery trajectory **Internal** Internal Strategic capital prioritisation process Oversight meetings: Research, Innovation and Commercial Opportunities Group, Strategic Estates Development Group	**External** Evidence of link of strategic capital requests to the financial recovery trajectory NHSEI approved financial plan – link to risk 2 Approved SOC for Northern Services development programme though NHP Robust prioritisation process of ICS capital needs linked to OCS LTP/Strategy **Internal** Alignment of capacity and elective recovery with capital investment need Alignment of external funding bids to strategic capital priorities due to the short-term nature of turn around against national funds Evidence of contribution of capital plans to financial recovery trajectory	**External** Refresh of ICS capital prioritisation process with visibility of outputs to ICS leaders Continued engagement with NHP team to set out need to progress Northern Services OFH Refresh of ICS NHP direction of travel following outputs from ICS strategic work programmes (i.e. acute services sustainability) Liaison with NHSEI to communicate importance of strategic capital for Devon ICS and link to operational recovery **Internal** Link to financial revenue risk on financial recovery trajectory Specific evidence of high priority strategic capital schemes such as PEC for Royal Devon on how they will contribute to financial recovery. Strategic Estates plan – being developed across North and East	**External** **Internal** IPR reporting on board capital programme spend Board meeting minutes Board updates and Business Cases Reporting of progress against 5 Year Financial Strategy through SEDG	**External** Capital prioritisation signed off by ICS leaders **Internal** Visibility of risk on capital restrictions through clinical governance/ Safety and risk	

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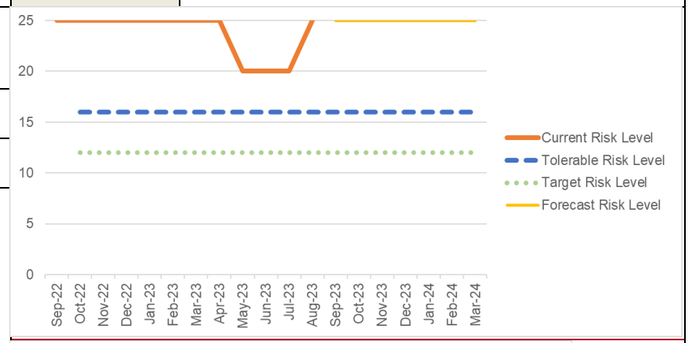
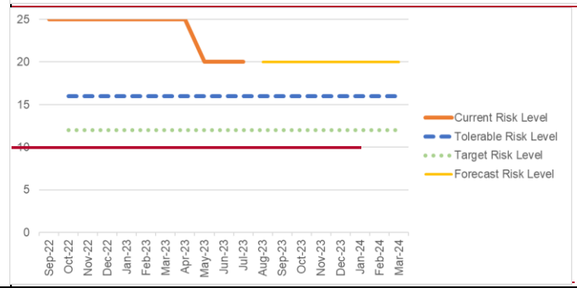
Risk 4 Non Delivery of the Financial Plan (Trust and System)

Principal risk (what could prevent us achieving this strategic priority)	Risk 4 - The Trust and wider Devon ICS have ambitious deficit plans with a challenging level of savings required, which are at risk of non-delivery						
Lead Committee	Finance and Operational Committee	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Finance
Executive lead	Angela Hibbard CFO	**Likelihood**	5	4	3	**Risk appetite**	Moderate
Initial date of assessment	July 2021	**Consequence**	~~4~~5	4	4	**Risk treatment strategy**	Mitigate
Last reviewed	~~July 2023~~October 2023	**Risk rating**	**~~20~~ 25**	**16**	**12**		
Last changed	May 2023			Given current financial climate			

Strategic priority	Recovering for the future





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Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
The Trust and Devon system have been placed in NSOF4 due to the financial and operational performance which places us in the highest tier of national intensive support and additional regulatory scrutiny. The approved financial plan for 2023/24 is extremely challenging due to the underlying deficit across the Devon system and convergence of income towards the national formula. The three year trajectory of financial recovery is also likely to require a continuous high level of savings delivery to reach financial sustainability. The scale and pace of savings required to be delivered results in a real risk that the target cannot be met in year with the consequence of failing to deliver the overall financial plan internally and across Devon and the regulatory consequences of non delivery including staying in the NSOF4 regulatory oversight. The inevitable strategic threat is that the balance between financial and operational recovery is lost and decisions are driven in a way that do not align with our Trust values and may be taken outside of the Trust's control.	**External** Active Executive engagement within ICS work programmes and System Recovery Board Direct Trust engagement with the region through established finance networks. ICS Financial Principles framework including how growth funding is allocated and risk share agreed under the new aligned payment incentive guidance Continued work across the ICS strategic work programmes to ~~to~~ improve the financial plan run-rate to a more beneficial position into 2024/25 Common system narrative due to the ~~ch~~ Deloittes drivers of the deficit work System improvement plan aligned to NSOF4 exit criteria to focus on delivery Devin ICS MFTP which models the financial trajectory over the 3-5 year period **Internal** Finance and Operational Committee refocused to a core group to enable detailed assurance to be given to the Trust Board. Comprehensive improvement plan for RDUH aligned to the NSOF4 exit criteria joining financial, elective and UEC recovery Enhanced budgetary control and ownership of delivery through use of performance assurance framework to hold to account for delivery ~~Refresh of LTFM post merger evidencing~~RDUH finance strategy linked to clinical strategy and contribution to corporate strategy on longer term financial recovery which sets out the financial modelling assumptions aligned to the Devon ICS LTFM. This includes an investment appraisal criteria to support prioritisation of funding~~.~~ Central governance around delivering best value programme in year and longer-term strengthened	**External** Agreement on next steps to take forward inequities work as a system once a trajectory for financial balance is achieved ~~Devon ICS LTFM which demonstrates deliverable financial sustainability within a 3 year time frame~~Delivery plans behind the MTFP which evidences how the MTFP will be delivered **Internal** ~~RDUH LTFM aligned to the Devon ICS model and internal enabling strategies~~ ~~transformation~~Delivery plan behind the level of savings set out in the RDUH finance strategy	**External** ICS workplan on financial recovery linked to strategy need for transformation and key enablers to unlock potential - supported through the work of Deloittes Refresh of the Devon ICS LTFM **Internal** ~~Refresh of LTFM linked to clinical and corporate strategy which needs to demonstrate trajectory of improvement~~Development of multi-year savings / transformation programme to evidence how the finance strategy will be delivered link to benchmarking information	**External** Minuted "View from the Bridge" Updates including: ICS updates on Devon financial position NHSEI updates Updates to inform Board debate from other system committees and meetings Recognition of NDHT subsidy by CCG/ICS subject to NSOF 4 approach Feedback from System recovery Board into RDUH finance and operational committee **Internal** Oversight of financial position provided to the Board through the IPR and to Finance and Operational Committee for exceptional items Finance and Operational Committee scrutiny of the Improvement Plan and in particular Delivering Best Value Sub-committee reports to Board Integrated Performance Report Audit committee assurance on grip and control actions Financial Recovery Plan actions to reduce run rate of spend in year	Detailed risk mitigation plan for non-delivery of system workstreams Detailed route to cash for system stretch savings to provide assurance on delivery of the forecast position	

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	and embedded froorm start of the financial year Review of HFMA getting the basics right checklist and action plan being delivered and assured through the audit committee					

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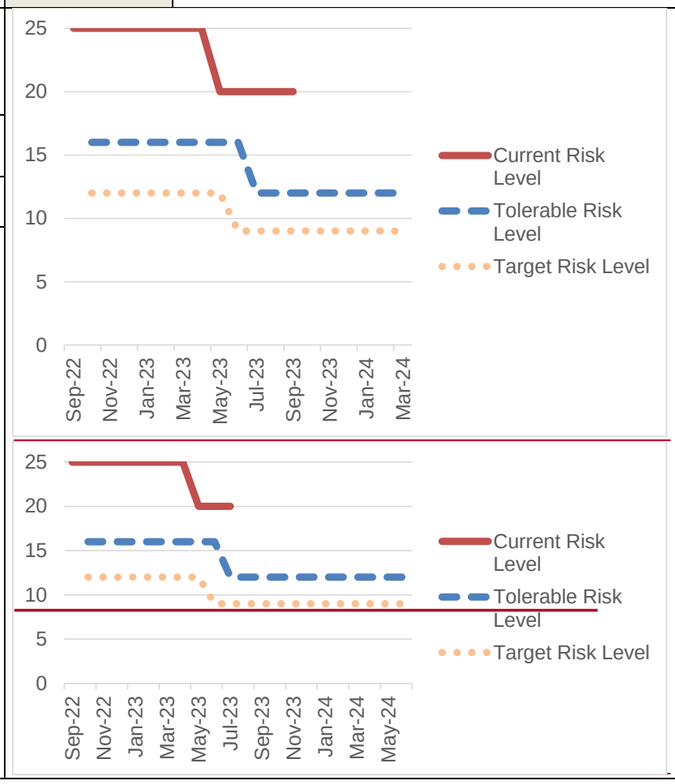
Risk 5 Elective Demand and Waiting-List Backlogs are not delivered

Principal risk (what could prevent us achieving this strategic priority)	Risk 5 - There is a risk of the Trust being unable to meet new demand for elective services (including cancer) and / or to provide required levels of activity to either address the waiting list backlog or to deliver the commitment contained within the Trust's Financial & Operational Plan							**Strategic priority**	Recovering for the Future
Lead Committee	Finance & Operational Committee	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	~~System~~ Regulatory, Quality, Reputational		
Executive lead	Chief Operating Officer	**Likelihood**	4–likely	4 – likely	3 – possible	**Risk appetite**	~~[leave blank]~~minimal		
Initial date of assessment	October 2022	**Consequence**	5 – catastrophic	3 – moderate	3 – moderate	**Risk treatment strategy**	Avoid		
Last reviewed	July 2023	**Risk rating**	**20 – high**	**12 – moderate**	**9 – moderate**				
Last changed	~~July~~ October 2023								



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Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
A widespread and sustained organisational insufficiency of clinical service capacity for patients needing elective care including cancer care as a result of • Wworkforce fragility and shortages including as a result of industrial action, • inability to sufficiently invest in infrastructure to either increase capacity or replace equipment, • inability to control increased demand for care services, • inability to deliver productivity and efficiency commitments inherent within the Trust's Financial & Operational Plan	Detailed annual planning cycle, Access to Elective Recovery Fund (ERF) and Targeted Investment Fund (TIF) Regular data led reporting to Trust Board, ICS and, NHSEI (region and nationally) on progress against elective recovery trajectory Use of Nightingale Hospital Exeter to provide additional diagnostic and procedure capacity to aid recovery Proactive development of Strategic and Outline Business Cases, to enable timely and detailed responses to national funding when advised as available Active participation in and response to recommendations of One Devon Elective Pilot, and in Further Faster programme Development of effective relationships with ICB ~~/ STP~~and NHSE (both regionally and nationally, including senior attendance at a wide range of system led meetings including Chief Operating Officer / Director of Performance update meetings, System Delivery & Improvement Group, Devon System Planned Care Board, Provider Performance Oversight Meeting, and Nightingale Hospital Programme Board, and in welcoming best practice visits to the Trust	Awaiting decisions following finance and capital investment requests to support changes to existing estate and clinical models Workforce constraints remain – including recruitment of consultants and other specialist posts in some areas and inability to recruit sufficient nursing staff to open planned escalation areas over the winter period. Co-dependency on STP partners particularly with regards to strength and sufficiency of capacity of respective elective care service provision Pace of development of clinical innovation programme to enable shortfalls in capacity to be overcome Understanding of inequalities of access to care, and associated healthcare impacts amongst different population groups	• Expansion of procedures able to be offered from Nightingale, and increased utilisation of Nightingale (December 2022 and ongoing) • Assurance is being sought from the Devon system regarding underwriting of NHE to support continued service delivery • Optimisation work to reduce the impact of MY CARE on outpatient throughput is progressing, and preparations made for the mandating of personalisation in EPIC. • ERF investment across multiple programmes • Potential further non recurrent investment in outsourcing in Q4 • ~~Capital and revenue investments confirmed in Community Diagnostic Centre, Tiverton Endoscopy Unit (phase 1), and Cardiology Day Case Unit~~ • ~~Funding secured for purchase of a robot for Northern Services, and lease of an additional robot for Eastern Services,~~	Performance metrics • IPR • PAF • RTT Data • Cancer Metrics • Activity and Referrals data Volume, value and aggregate activity impact of approved Elective Recovery Fund (ERF) bids Internal investment & external sponsorship Changes in Trust's Tiering Status (September 2023) Bed modelling Ability to increase utilisation of independent sector ToRs / Minutes and Action Logs of internal meetings strengthened as part of Operational Governance Framework • Delivery Group • PAF • Operations Boards • Access meeting ToRs/Minutes of external/STP meetings: • Devon Planned Care Board • System Asset Programme Board • Cancer Cabinet • Hospital Escalation status • System Delivery & Improvement Group Programme of and feedback from external visits Completion of NHSEI 10-week challenge (Winter 2022) Capital and revenue investments confirmed in Community Diagnostic Centre, Tiverton Endoscopy Unit (phase 10, and Cardiology Day Case Unit Funding secured for purchase of a robot for Northern Services, and lease of an additional robot for Eastern Services (Summer 2023) Development of a TIF bid for a vascular hybrid and / or trauma theatre capacity, admissions ward and revenue investment in orthopaedics (September 2023)	Current operational and financial planning cycle focuses on 1-2 year plan delivery. Lack of available capital and recurrent revenue funding to support required service changes, and timeliness of regional/ national decision making Sporadic and short notice timeframes in which capital funding is indicated as potentially available and applications are required to be submitted Timeframe for delivery of MY CARE optimisation Local model of care agreed but no agreed Devon ICB future model of care Lack of ICB agreed approach to community engagement, and engagement of wider system partners	

			• Continued pursuit of protected elective capacity both in-house and as part of new ventures with Independent Sector partners • ~~Completion of NHSEI 10-week challenge~~ • Development of Tier 1 Funding proposal to support continued usage of insourcing and outsourcing arrangements on a time-limited basis whilst ERF schemes for 23/24 are optimised to maintain current run rate of delivery • ~~Development of a TIF bid for a~~Securing of funding for a vascular hybrid and / or trauma theatre capacity, admissions ward and revenue investment in orthopaedics *Please note: all actions are ongoing unless otherwise indicated*			

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Royal Devon University Healthcare NHS Foundation Trust

Risk 6 Our People do not feel looked after/valued, employee experience is poor and people feel health and wellbeing are not prioritised

Principal risk (what could prevent us achieving this strategic priority)	Our people do not feel looked after or valued. Employee experience is poor and people feel their health and wellbeing is not prioritised.					**Strategic objective**	A great place to work
Lead Committee	Governance Committee (via People, Workforce Planning & Wellbeing Committee)	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Our People
Executive lead	Hannah Foster	**Likelihood**	4 - Almost Certain	3 - Possible	2 - Likely	**Risk appetite**	Minimal
Initial date of assessment	12/07/2023	**Consequence**	4 - Major	4 - Major	4 - Major	**Risk treatment strategy**	Modify
Last reviewed	~~20/07/2023 –~~ ~~PWPW~~21/09/23 – PWPW 10/08/23 - GC	**Risk rating**	**16 – Significant**	**12 – Medium**	**8 – Low**		
Last changed	~~20/07/2023 –~~ ~~PWPW~~21/09/23 – PWPW 10/08/23 - GC						

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating** (assured or inconclusive with further actions required)

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• Demand for services exceeds capacity, increasing workload, ~~and the~~ potential for burnout, moral injury or/and work related stress. • Not fully utilising digital capability, ~~thus~~ increasing workload for staff. • Challenging financial climate with headcount reduction for non-clinical roles. • Working excessive hours is becoming a cultural norm within the NHS leading to burnout. • Integration c~~C~~hange fatigue, long waits and public criticism impacting morale. • Increasing levels of violence and aggression towards our people. • Insufficient psychologically safety/inclusion culture. • Insufficient supportive line management to provide positive employee experience and enable wellbeing. • Lack of management time/capacity to support respecting, welcoming, valuing and developing people. • Operational and financial pressures preventing career development, progression and fulfilment. • Capital constraints preventing quality working environment and/or staff accommodation. • Ongoing Industrial Action impacting rest, leave, operational and leadership capacity. • Lack of integrated ways of working and collaboration, leading to silo working and poorer employee experience.	• Trust strategy including great place to work objective and Trust values, to create an effective, healthy and inclusive working environment with a just and learning culture to support recruitment and retention. • Proactive health and wellbeing offer ~~in place~~. • Our Charter ~~is in place~~. • Promoting a~~nd~~ Positive Working Environment Policy and subsequent documentation created with a focus on just and learning culture. • Staff Incident Review Group ~~now established~~. • Managing Incivility: becoming a responsible bystander and other strategies training ~~launched~~. • Pastoral support ~~for all staff~~, including dedicated role for international recruits. • Freedom to Speak Up Guardians ~~in place~~. • Enhanced development offer for existing staff. • P~~Continued p~~rotection and promotion of taking of annual leave. • Staff recognition schemes. • Focus and resources in place for inclusion, employee experience and culture work. • Significant comms and engagement activity with staff via various channels. • Investment in recruitment and retention activity. • Dedicated Staff Rest Space Group ~~in place~~. • Line manager induction workshops. • Extraordinary People Awards • Executive inclusion commitments	• ~~Inability to recruit to enough posts to meet demand within current financial envelope.~~ • Process streamlining and automation are not happening quickly enough to reduce workload of staff. • Not all processes and policies support the desired cultural direction. • Training to prevent violence and aggression is not always undertaken by all relevant staff. • Evidence that staff can take breaks. • ~~Ensuring p~~Protection of management time. • On call arrangements that support work life balance. • Impact of ambitious ICS operational plan. • Impact of NHS Long T~~t~~erm W~~w~~orkforce P~~p~~lan. • Staff do not always feel empowered to make changes to mitigate this risk.	• Completion of the actions within the Cultural Development Roadmap. • Single Trustwide violence and aggression lead. • Completion of all stages of project simplify. • ~~Line manager induction to be introduced to enable them to support their teams.~~ • Line managers and leaders programme to be introduced, including an option to complete individual modules. • Masterclass to help staff to understand and uphold our values being developed. • Systemwide launch of campaign to prevent violence and aggression. • Launch of a revised approach to reward and recognition. • #TeamRoyalDevon week. • ~~Relaunch of staff awards.~~ • ~~Improved data on learning, employee experience to understand progression and demographic difference.~~ • Improve flexible working options for all groups. • New flexible retirement options. • ~~Executive activity to drive further inclusion work~~Inclusion to be included in future Board Development Day • Phase 1 of the new hospital programme to develop new staff accommodation. • Management of Change (MoC) through Operational Services Integration Group (OSIG)	• Regular monitoring of a range of metrics, including ~~those within~~ the Integrated Performance Report (IPR). • Benchmarking through the ICS Cultural Dashboard. • Employee experience intelligence, including quarterly People Pulse surveys and the annual staff survey including measurement of people promise. • Reporting on progress against the cultural development roadmap. • Reporting to the Staff Health & Wellbeing Group and sub-groups. • Health & Wellbeing metrics are available, but will be consolidated into a more comprehensive dashboard (see gap). • ~~Staff~~ Feedback to the Inclusion Steering Group from staff inclusion networks ~~established and provide feedback to Inclusion Steering Group.~~ • National Guardians Office statistics on Freedom to Speak Up reporting. • Employee Experience and Survey action plan delivery monitored at PAF meetings. • Development and learning dashboard in place and presented regularly at People Development Group. • Digitalised exit surveys now launched with two months of data collected. • Health and wellbeing metrics.	• ~~Fully analysed exit interview data following the new digital exit survey launch.~~ • Candidate experience information to be able to inform improvements. • Improved h~~H~~ealth and wellbeing dashboard to be launched (Dec 2023). • Further insight into apprenticeship pipeline to be included in development dashboard (Dec 2023) • Information about progression metrics to be added to development dashboard (Mar 2024) • Analysis of exit survey data once enough information has been collected (Dec 2023)	**Assured** – The PWPW was assured that the right actions are planned to mitigate this risk. The PWPW received assurance that employee experience scores are increasing, however in the current context, including industrial action and ongoing operational pressures, it was agreed for this risk to remain the same.

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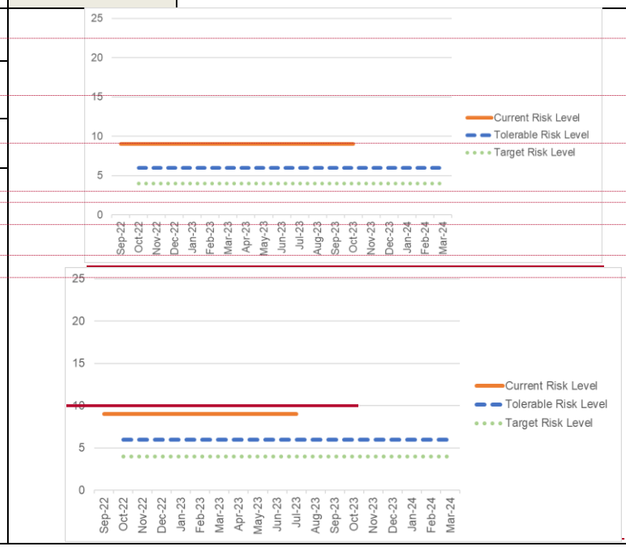
Risk 7 Risk of not maximising EPIC benefits (Trust and System)

Principal risk (what could prevent us achieving this strategic priority)	There is a risk of not realising/maximising the financial benefits from IT/Digital implementation, as a result of lack of skills and confidence of staff and patients.							**Strategic priority**	Excellence and Innovation in patient care
Lead Committee	Digital Committee	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	~~IMT~~Clinical Digital Services		
Executive lead	Adrian Harris, Chief Medical Officer	**Likelihood**	~~3 - Possible~~	~~2 - Unlikely~~	~~2 – Unlikely~~	**Risk appetite**	TBC		
Initial date of assessment	~~14 October 2022~~	**Consequence**	~~3 - Moderate~~	~~3 - Moderate~~	~~2 - Minor~~	**Risk treatment strategy**	Modify		
Last reviewed	~~July 2023~~25 October 2023	**Risk rating**	~~9 - Medium~~	~~6 – Low~~	~~4 - Low~~				
Last changed	~~July 2023~~25 October 2023								

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Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
There is a risk that staff across the Trust are resistant to change, particularly integration and EPIC/EPR There is a risk that patients and staff (technical, clinical, and managerial) lack the skills and confidence to implement and exploit digital technology meaning that the benefit of investment could be lost or not maximised Staff are at risk of change fatigue due to the number of significant programmes and staff have raised concerns particularly in relation to being able to effectively deliver across both geographies with limited capacity	**Trust committee/governance & clinical service structures including:** Assigned Executive/ Site Director portfolios/accountabilities including relevant statutory roles Single clinical digital services structure in place from April 2023 across RDUH. Single governance process for digital improvement- Series of eight advisory groups ~~with oversight group active from May 2023.~~ reporting to the Clinical Digital & Operational Oversight Group active (as of May 2023) Digital Committee in place across Eastern and Northern Services as a direct Sub-Committee of the Board of Directors Reporting to the Board of Directors via the Digital Committee Appointment of RDUH (cross site) Director of Service Improvement and sub structure to support benefit delivery and integration with transformation programme Clinical Digital services governance meeting commences July 2023 Management of change policy Admin Transformation Programme Manager Role in post Full time comms lead appointed within Transformation to support trust wide engagement on all transformation Projects and Programmes **Support & resources for users/patients:** • Additional 2.5 WTE posts in place focusing on development of MYCARE (patient portal). • MyCare m~~M~~arketing campaign launched to increase sign up to 100,000 patient users • Epic IT helpdesk supporting end users/staff with enquiries/issues • Epic training/personalisation sessions to support confidence and efficiency in the use of Epic at a collective and individual level	Secure integrated structure across Eastern and Northern Services not yet agreed and in place in all areas. Digital and Clinical strategies still to be completed as enabling strategies. Two Advisory Groups yet to be set up (ETA Nov 23) Continued use of paper letters (appointment) whilst encouraging patient sign up to MYCARE comms referring to reduced carbon footprint leading to Patient complaints	Substantive, integrated CDS structure in place but others still to follow. Tightening links between finance and digital committee on benefits identification and realisation process to be implemented between digital, operations and finance Refresher training to commence December 2023 for all Eastern staff, blending delivery modalities to include self-guided tip sheets, ad-hoc 'video tip sheets', online learning master classes and face to face training. Improved Comms and transparency around functionality of MYCARE & reasons behind paper appt letters – transparency with patients	Monthly reporting to the Board of Directors from the Digital Committee. Clinical digital services updates monthly to operations boards (N&E) with further updates alt-months to Digital committee. Clinical digital advisory group and oversight group governance structure in place escalating to CEC if required. Benefits realisation progress reporting to Board of Directors / FOC Reporting of benefits – DBV working groups and board. Ongoing recruitment is in progress subject to approval working trust wide as a joint team. Monthly digital focus EPR benefits realisation group (Trustwide) Admin benefit delivery agreed July 2023 with no further EPIC admin benefits expected. Ongoing EPIC training / personalisation sessions to support confidence and efficiency in the use of Epic at a collective and individual level. Refresher training to commence September 2023 for all Eastern staff, blending delivery modalities to include self-guided tip sheets, ad hoc 'video tip-sheets', online learning, master classes and face to face training. Combined with Hyperdrive upgrade to simplify use/ interaction with Epic Patient portal – MYCARE – continuing to drive engagement and comms to increase levels of sign up, currently 80,000 users with 5% (avg) increase per month. Target 100,000 by December 2023 and 120,000 by March 2024. Through transformation comms lead, commencing a programme of 'non-financial' EPIC benefits capture to support engagement with Epic and transformation. Clinical and Digital enabling strategies underway	Single structure agreed and implemented July 2023. Substantive funding shortage for full EPR analyst and training capacity required which may contribute to change fatigue for some staff. Benefits- FBC assumptions not fully realisable in some areas. Limited alternative savings available but still being scoped. Engagement with Age UK to support engagement with the use of Patient Portal – they have a digital champion programme to increase older people's engagement and support with digital systems, for those particularly digitally 'excluded'	

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	• Tip sheets created and readily available on the EPR system/dashboard to support staff • IO Team (NMAHP & MIO Teams) supporting end users across the Trust Other —Stakeholder & staff Communication & Engagement Plan — —Partnership Agreement with Staffside and Trade Union partners — • Active engagement of staff in key programmes • Clinical (medical) leadership capacity strengthened • Health & Wellbeing support for our people • Transformation Strategy launched Jan 2023					

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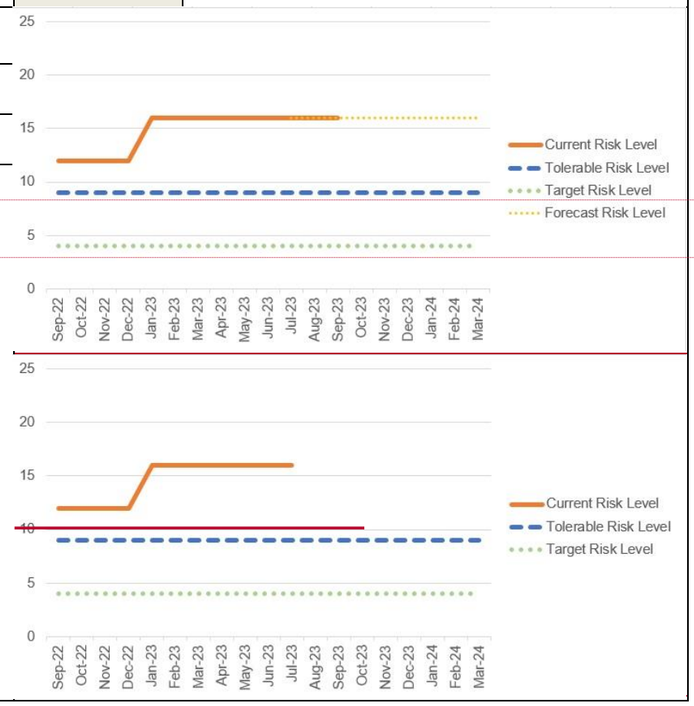
Royal Devon University Healthcare NHS Foundation Trust

Risk 8 Risk of a significant deterioration in quality and safety of care July 2023

Principal risk (what could prevent us achieving this strategic priority)	Significant deterioration in standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm, poor clinical outcomes and delivery of sub-optimal patient care.						**Strategic priority**	Excellence & innovation in patient care
Lead Committee	Safety and Risk Committee	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient Safety	
Executive lead	Chief Nursing Officer	**Likelihood**	4 - Likely	3 - Possible	2 - Unlikely	**Risk appetite**	Low	
Initial date of assessment	18th October 2022	**Consequence**	4 - Major	3 - Moderate	2 - Minor	**Risk treatment strategy**	Modify	
Last reviewed	~~10th July 202~~ 15th September 2023~~3~~	**Risk rating**	**16 - Significant**	**9 - Moderate**	**4 - Low**			
Last changed	~~10th July 2023~~23rd October 2023							



Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap ~~and issues relating to COVID-19~~** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**

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Widespread loss of organisational ability to focus on quality of care, including patient safety processes due to workforce gaps/staff, Industrial Action, working under pressure to deliver flow & covid recovery, and a failure to engage patients and carers in care leading to: - an increased incidence of avoidable harm; - an increased exposure to 'Never Events'; - higher than expected mortality; - a failure to escalate, report and learn from quality incidents.	**Trust committee/governance & clinical service structures including:** • Assigned Executive & Site Director portfolios/accountabilities • Monthly meeting of Safety & Risk Committee & reporting sub groups (IPC/H&S/Patient safety etc.) • Patient Experience Committee • Clinical Effectiveness Committee • Safeguarding Committee **Strategies, policies and procedures:** • Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems • Risk management framework and policy • Performance management framework **Systems and monitoring:** • Incident Reporting investigation process, SIs/Never Event Reports, Claims • Lessons learned from Never Events • Quality Priorities • Retrospective EPIC dashboards • CQUINs & contract monitoring • Recording of escalation systems NEWS etc • Medicines Management • National Surveys • NICE, NSF and Clinical Audit • Capital Programme • Maternity CNST/Ockenden • Performance reporting and accountability/ performance reviews/ performance dashboards • Clinical audit programme & monitoring arrangements local and national • External audit of quality/patient safety e.g. GIRFT/Royal college reviews • Defined safe medical & nurse/midwifery staffing levels for all wards & departments • Ward assurance/ metrics & accreditation programme • Triangulation of insight from: • Patients and carers – complaints/PAL's/ Health Watch, other stakeholders • Dialogue with regulators to get feedback on local and benchmarked status re quality standards **People:**	Regular Divisional risk reports to S&RC/GC The trust has had a high number of never events, these are serious incidents which are wholly preventable. Trust wide safety oversight Community services were not well represented within the board service and performance measure	Strengthen the reporting of medical and clinical education through PWPW report to GC *(Action ~~ongoing with Chief People Officer)~~ will be delivered through the creation of a Board Committee for People which will include the reporting of clinical and medical education January 2024 Trust Secretary / Chief Executive* Implementation of National Patient Safety Strategy (inc. PSIRF) Completion by November 2023 – Chief Nursing Officer & Chief Medical Officer Formation of new Royal Devon Safety Committee (in line with National Patient Safety Strategy requirements) and new Royal Devon Risk Management Committee Completion by January 2024 – Chief Nursing Officer & Chief Medical Officer To review/change/expand the current IPR metrics & other governance and performance meetings to better represent the breadth of services the Trust is accountable for. Completion by Autumn 2024 – Chief Operating Officer	**External Independent Inspections** • CQC • Royal Colleges • GIRFT reviews • Commissioning/network reviews • Audit SW Assurance **Internal Audit programme** • Clinical audit outcomes • Ward assurance/ metrics & accreditation programme **Statutory reporting** • Learning from deaths report • Guardian of Safe Working report • Six monthly safe staffing reports – Medical and NMAHP • SHMI • Annual complaints report • Annual IPC report • Board integrated performance report • Quality report (incl. quality priorities) NHS England Three Year Delivery Plan for Maternity and Neonatal Services **Other reporting** • Regular board sub-committee performance/progress reports to GC (patient experience, safeguarding, safety and risk, clinical effectiveness) • Maternity Safety Champion activities • Mandatory training reporting • Health & safety reporting • Claims, inquest reports • Freedom to speak up reports • Whistle blowing reports • Ad-hoc requested specialist specific reports e.g. End of Life • Progress report cultural development • National Patient Safety Alerts compliance reports • HSIB **Screening Quality Assurance Services assessments and reports of:** • Antenatal and New-born screening • Breast Cancer Screening Services • Bowel Cancer Screening Services • Cervical Screening Services **Accreditation/Regulation annual assessments and reports of**; • Pathology (UKAS) • Endoscopy Services (JAG) • Medical Equipment and Medical Devices (BSI) - - Blood Transfusion Annual Compliance Report	Comprehensive systems approach to Patient Safety Management; delivered through implementation of the National Patient Safety Strategy (PSIRF)	

	• Processes in place for staff to raise quality and other related concerns e.g. freedom to speak up guardian, whistle blowing policy • Maintenance of competent clinical staff through recruitment, induction, mandatory training, registration, supervision & re-validation **Industrial Action:** • Gold, Silver, EPPR plans in place to manage business continuity			• PLACE **Action Plans** • National survey action plans • Performance recovery plans **QIA outcomes related to operational planning and Delivering Best Value 2023/24**		

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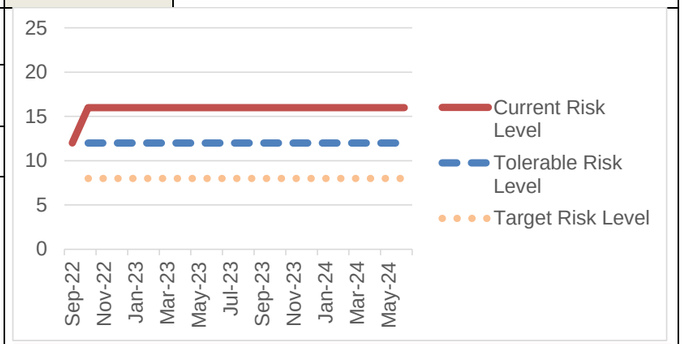
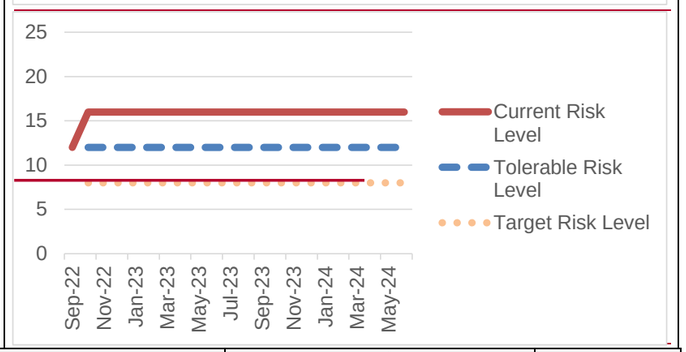
Risk 9 Our Future Hospitals – Delays in Funding/Failure to Deliver Clinical Strategy for Northern Services

Principal risk (what could prevent us achieving this strategic priority)	Continued delay of a positive decision on the Our Future Hospital Strategic Outline Case, resulting in planning blight, a reliance on short term sub optimal investment and a deleterious impact on the recruitment and retention of staff to North Devon						
Lead Committee	OFH Programme Board	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Workforce/ Estate
Executive lead	Chris Tidman, Deputy Chief Executive	**Likelihood**	4 Likely	3 Possible	2 Unlikely	**Risk appetite**	Minimal
Initial date of assessment	18/10/2022	**Consequence**	4 Major	4 Major	4 Major	**Risk treatment strategy**	Modify
Last reviewed	18/07/2023 26/10/2023	**Risk rating**	**16**	**12**	**8**		
Last changed	18/07/2023 26/10/2023						

Strategic priority	Recovering for the future / Great Place to Work





Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**

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Next phase of the national NHP results in NDDH scheme being pushed back until post 2030 due to complexities of ambition for complete hospital rebuild compared to more deliverable part rebuild/ part refurb. Leading to risk around critical backlog maintenance and lack of confidence amongst clinical staff of scheme delivery. Underlying financial deficit of the Devon system leads to a more radical Acute Sustainability review of hospital configuration, meaning a detailed Pre Consultation Business Case, slowing down decision making	**Trust Committee / Board Governance** OFH Programme Board meets monthly and reports progress to Board of Directors, including developing options around phase 1 enabling works and deliverability / affordability of various options from part rebuild/refurb to full rebuild Early enabling work starting on accommodation blocks to demonstrate progress. Phase 1 OBC being completed and importance socialised with DHSC and NHSE. **System Governance** Trust active participant in Peninsula New Hospital Programme Board. SOC supported by the Devon CCG/ICS are clinically necessary and affordable. NHPs now part of ToR of the ICS Finance Committee and agreement to review OBCs in light of Peninsula Acute Sustainability Programme **Stakeholder Management** Robust internal comms approach with senior clinical staff around understanding process and approach to options Proactive engagement with NHP Executive and political stakeholders to stress the importance of early enabling works to demonstrate progress, risks of extended delay and having a deliverable scheme that can pass HM Treasury tests. NHP roadshow visit to North Devon on 2nd August	Risk of delay by NHP & ICB/Region may not be understood Risk of delay may not be fully understood by national politicians	Critical Backlog maintenance and mitigation plans to be assessed and shared with NHP team & ICB, so impact of any delay on capacity or capital funding is understood ~~Further lobbying using local politicians and NHSE to outline the risks of delay.~~Visits from politicians and NHSE to outline the risks of delay. Letters to DHSC to confirm	SOC, Board and Committee reports Internal Gateway Assurance Letters from NHP outlining funding for Phase 1 OBC Political statements supporting the early investment in staff accommodation in North Devon & commitments to maintaining momentum		Whilst we now have a government announcement, it is still too soon to say whether it is possible to reduce the current risk score back down to a 4 x 3. Much will depend on the release of the capital funding for the phase 1 enabling works on accommodation and the confirmation around the timing of the preferred option.

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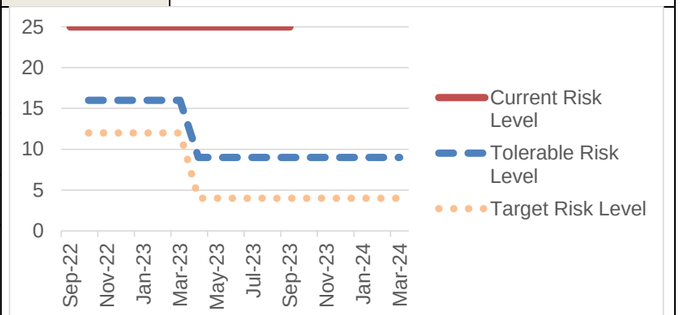
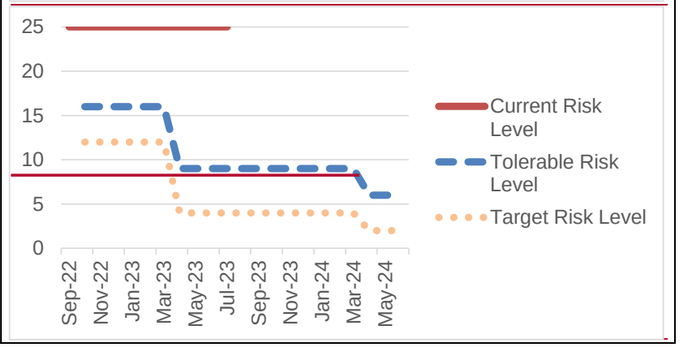
Risk 10 UEC Targets are not delivered

Principal risk (what could prevent us achieving this strategic priority)	Risk 10 - There is a risk of the Trust being unable to deliver the urgent & emergency care commitments contained within the Trust's Financial & Operational Plan due to unscheduled care demands and capacity						
Lead Committee	Finance & Operational Committee	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	~~System~~ Regulatory, Quality, Reputational
Executive lead	Chief Operating Officer	**Likelihood**	5 – very likely	3 – possible	2 – unlikely	**Risk appetite**	~~[leave blank]~~Minimal
Initial date of assessment	October 2022	**Consequence**	5 – catastrophic	3 – moderate	2– minor	**Risk treatment strategy**	Avoid
Last reviewed	July 2023	**Risk rating**	**25 – high**	**9– moderate**	**4 – low**		
Last changed	~~May~~ October 2023						

Strategic priority	Recovering for the Future





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Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in assurance / action to address gap and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
A widespread and sustained organisational insufficiency of clinical service capacity for patients needing urgent care due to unscheduled care demands and capacity, as a result of • System and care partners' failure to deliver necessary improvements to support achievement of 5% No Criteria to Reside • workforce shortages including as a result of industrial action, • inability to control increased demand for care services, including demand for urgent and emergency care • inability to deliver productivity and efficiency commitments inherent within the Trust's Financial & Operational Plan • wider system demand/support for urgent & emergency care through ambulance diverts	Detailed annual planning cycle, including development of operational capacity and resilience plan (Winter plan), Regular data led reporting to Trust Board, ICS and, NHSEI (region and nationally) on progress against urgent & emergency care improvement trajectories Development of effective relationships with ICB and DCC, including senior attendance at a wide range of system led meetings including Chief Operating Officer / Director of Performance update meetings, System Delivery & Improvement Group, Devon System Urgent Care Board, Provider Performance Oversight Meeting, and active participation in and escalation into Devon System SOF4 Improvement Programme Detailed system wide and organisational winter planning Four week pilot undertaken October to November 2022 with adjusted postcode catchments to support TSDT and UHP Trusts. Further ten week adjustment to postcode catchments to support TSDT and UHP agreed. Discussions ongoing as to the most sustainable basis by which any ambulance activity might be diverted to RDUH going forward	Co-dependency on system partners particularly with regards to strength, sufficiency of capacity and availability of urgent care including out of hours services within primary care, and social care Lack of visibility of and volatility in funding decisions of system partners, particularly with regards to social care Workforce constraints remain – including recruitment of consultants and other specialist posts in some areas and inability to recruit and / or retain sufficient nursing staff to maintain WIC service delivery or to open planned escalation areas over the winter period. Continuing workforce fragility for external care providers (e.g. domiciliary care and nursing home care) Ability of neighbouring Trusts to respond to equivalent UEC pressures and demand, and to maintain delivery of identified fragile services Continuation of ambulance catchment change, alongside ongoing requests for further ambulance diverts to support Devon system	Infrastructure for emergency patients has progressed throughout 2022/23 including. • Continued progress of the ED Redevelopment programme, and inclusion of a Paediatric ED element to the programme. Securing of necessary further funding release by system partners by end Q1 23/24. Refresh of the Operational Capacity and Resilience Plan (Winter Plan) approved by Board in October 2022. Further refresh to be undertaken in Autumn 2023 as an integral part of the Trust UEC plan Implementation at pace of Trust's UEC Improvement Plan through Autumn and Winter 2023 *Please note: all actions are ongoing unless otherwise indicated*	Performance metrics • IPR (monthly) • PAF (monthly) • Activity and Referrals data (IPR monthly) ~~Monitoring of adjustment to postcode catchments to understand volume of diverted patients and associated impact~~ Likelihood of discontinuation of adjustment to postcode catchments 10/10/2023 and potential for Winter Director appointment for Devon, and instigation of dynamic conveyancing ~~Internal investment & external sponsorship~~Anticipated update on UEC funding (Community £3.2m vs £5.2m fair share) Winter Plan (Autumn 2023) Bed modelling (Autumn 2023) ToRs / Minutes and Action Logs of internal meetings strengthened as part of Operational Governance Framework • Trust Delivery Group • PAF • Operations Boards ToRs/Minutes of external/STP meetings: • Devon Urgent Care Board • Hospital Escalation status • System Delivery & Improvement Group Schedule of 1:1s with Devon County Council Director of Integrated Adult Social Care	Current health operational and financial planning cycle focuses on 1-2 year plan delivery. Lack of visibility of funding availability and funding decisions of social care system partners ~~Timeframe for delivery of MY CARE optimisation~~ Local model of care agreed but no agreed Devon ICB future model of care Lack of ICB agreed approach to engagement of wider system partners	

		Pace of development of clinical innovation programme to enable shortfalls in capacity to be overcome				

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Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	12.1a, Public Board Meeting		Date: 1 November 2023	
Title:	Care Quality Commission – 2022 National NHS Adult Inpatient Survey			
Prepared by:	Will Denford, Executive Support Officer Andrea Bell, Deputy Director of Nursing (Patient Experience)			
Presented by:	Carolyn Mills, Chief Nursing Officer			
Responsible Executive:	Carolyn Mills, Chief Nursing Officer			
Summary:	The 2022 National NHS Adult Inpatient Survey, commissioned by the Care Quality Commission as part of the NHS Patient Survey Programme, is an annual survey that all eligible NHS organisations in England are required to conduct to assess the experiences of people who stayed at least one night as an inpatient. The 2022 survey, formally published by the CQC in September 2023, is the first time the Royal Devon Trust has been surveyed as a single organisation.			
Actions required:	The Board is asked to note the content of the 2022 National NHS Adult Inpatient Survey paper.			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
				X
History:	The full 2022 Adult Inpatient Survey and detailed analysis will be presented at the Patient Experience Operational Group on 27 October 2023, and subsequently at the Patient Experience Committee on 15 November 2023.			
Link to strategy/ Assurance framework:	The issues discussed are key to the Trust achieving its strategic objectives; **BAF Risk 8** – *Risk of a significant deterioration in quality and safety of care*			

Monitoring Information

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

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

1. Purpose of paper

1.1 The purpose of this paper is to present to the Board of Directors the summary of the Royal Devon University Healthcare (RDUH) Care Quality Commission 2022 National NHS Adult Inpatient Survey.

1.2 The Trust ranked joint second nationally for inpatient satisfaction alongside three other acute and general combined NHS Trusts. This ranking is based on the mean averages of questions from the 2022 survey.

1.3 The results of this survey also need to be considered in the context of the IPR and other reports that the Board and the Board sub-committee for patient experience receives related to patient feedback, patient engagement & patient experience to provide further triangulation.

2. Background

2.1 The NHS Patient Survey Programme (NPSP), commissioned by the Care Quality Commission (CQC) collects national patient feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

2.2 As part of the NPSP, the National NHS Adult Inpatient Survey has been conducted annually since 2002; with the 2022 survey assessing the experiences of people over 16 years of age who stayed in hospital for at least one night as an inpatient in November 2022.

2.3 The 2022 survey results, which were formally published by the CQC in September 2023, were combined for the first time following Royal Devon's integration in April 2022.

2.4 Please refer to Appendix 1 for the full 2022 National NHS Adult Inpatient Survey.

3. Summary of 2022 National NHS Adult Inpatient Survey

3.1 For RDUH in total, 591 responses were received, with a response rate of 49%, compared to the national average of 40%.

3.2 RDUH performed well with an overall experience score of 8.5 out of 10, and out of the total 45 questions:

- 1 result achieved rating of 'better than expected'
    - *Were you offered food that met any dietary needs or requirement you had?*
- 3 results achieved rating of 'somewhat better than expected'
    - *Did you have confidence in and trust in the doctors treating you?*
    - *After the operations or procedures, how well did hospital staff explain how the operation or procedure had gone?*
    - *Overall, did you feel you were treated with respect and dignity while you were in hospital?*
- 1 result was rated as 'somewhat worse than expected'

- *How did you feel about the length of time you were on the waiting list before your admission to hospital?*

- And the remaining 40 questions were rated as 'stayed the same' in line with the national benchmark.

4. Analysis of 2022 National NHS Adult Inpatient Survey

4.1 The survey highlighted that patients rated the Trust highly in the following areas:

- Food outside set meal times: *patients being able to get hospital food outside of set meal times, if needed*
- Help with eating: *patients being given enough help from staff to eat meals, if needed*
- Dietary needs or requirements: *patients being offered food that met any dietary needs or requirements they had*
- After the operation or procedure: *patients being given an explanation from staff of how their operation or procedure went*
- Changing wards during the night: *staff explaining the reason for patients needing to change wards during the night*

4.2 Although the Trust scored highly within expected ranges, themes have still been identified within the survey report highlighting the following areas in which patient experience could improve:

- Waiting to be admitted: *patients feeling that they waited the right amount of time on the waiting list before being admitted to hospital*
- Noise from other patients: *patients not being bothered by noise at night from other patients*
- Feedback on care: *patients being asked to give their views on the quality of their care*
- Further health or social care services: *patients being given information about further health or social care services they may need after leaving hospital*
- Support from health or social care services: *patients being given enough support from health or social care services to help them recover or manage their condition after leaving hospital*

4.3 The Patient Experience Operational Group, overseen by the Patient Experience Committee, will focus in on the themes raised from the survey (4.2) and will develop a plan to improve in these areas for any items identified that are not already included within pre-existing patient experience workplans, by November 2023.

5. Resource/legal/financial/reputation implications

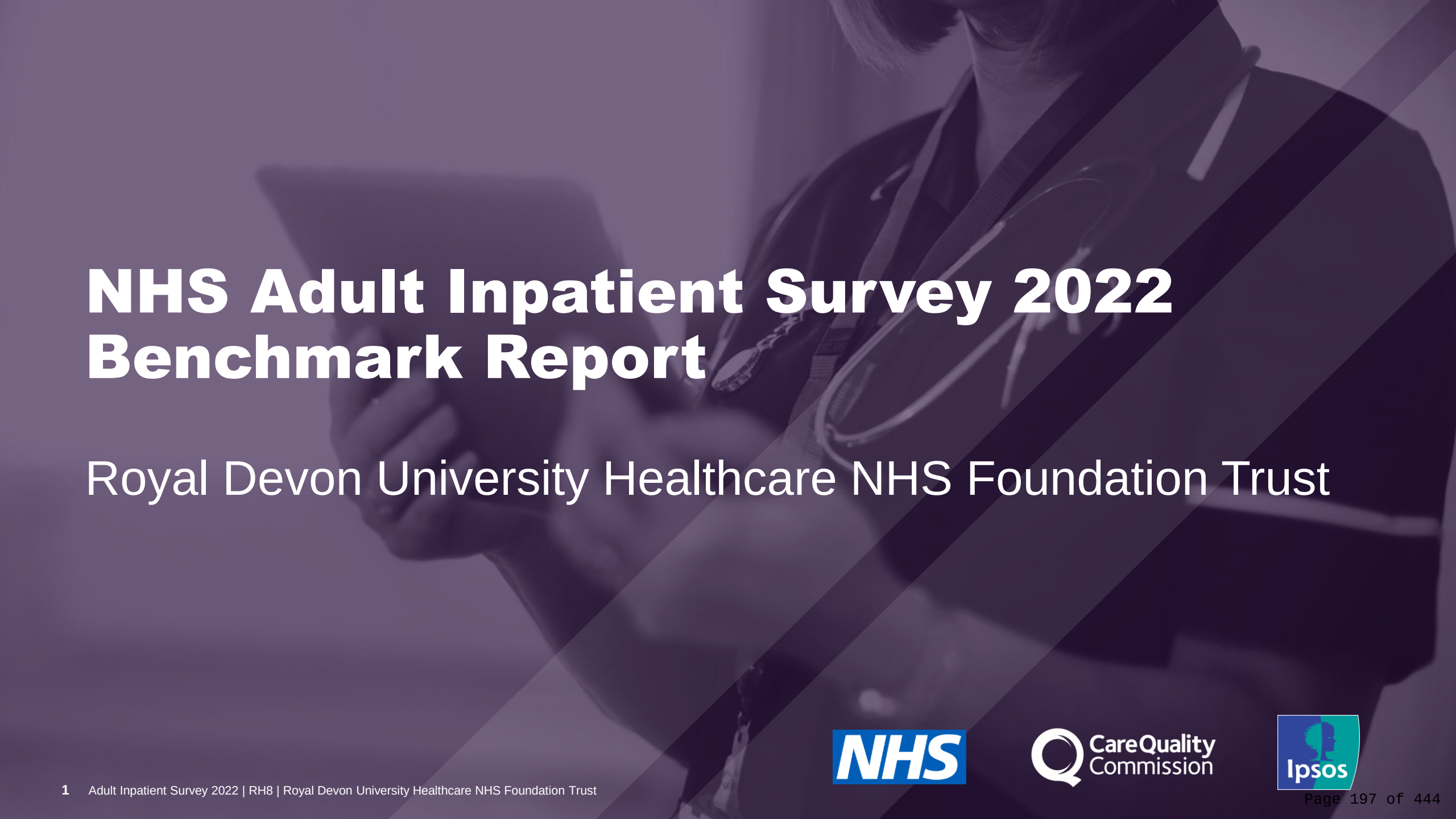
5.1 Nil

6. Link to BAF/Key risks

6.1 No links to BAF or risks have been identified.

7. Proposals

7.1 The Board of Directors is asked to **note** the Royal Devon University Healthcare 2022 National NHS Adult Inpatient Survey.



NHS Adult Inpatient Survey 2022 Benchmark Report

Royal Devon University Healthcare NHS Foundation Trust

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Background and methodology

This section includes:

- an explanation of the NHS Patient Survey Programme
- information on the Adult Inpatient 2022 survey
- a description of key terms used in this report
- navigating the report

Background and methodology

The NHS Patient Survey Programme

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

The NPSP is commissioned by the Care Quality Commission (CQC); the independent regulator of health and adult social care in England.

As part of the NPSP, the Adult Inpatient Survey has been conducted annually since 2002. CQC will use results from the survey to build an understanding of the risk and quality of services and those who organise care across an area.

To find out more about the survey programme and to see the results from previous surveys, please refer to the section on further information on this page.

The Adult Inpatient Survey 2022

The survey was administered by the Coordination Centre for Mixed Methods (CCMM) at Ipsos. A total of 165,181 patients were invited to participate in the survey across 133 acute and specialist NHS trusts. Completed responses were received from 63,224 patients, an adjusted response rate of 40.2%.

Patients were eligible to participate in the survey if they were aged 16 years or over, had spent at least one night in hospital, and were not admitted to maternity or psychiatric units. A full list of eligibility criteria can be found in the survey sampling instructions.

Trusts sampled patients who met the eligibility criteria and were discharged from hospital during November 2022. Trusts counted back from the last day of November 2022, sampling every consecutively discharged patient until they had selected 1,250 patients. Some smaller trusts, which treat fewer patients, included patients who were treated in hospital earlier than November 2022 (as far back as April 2022), to achieve a large enough sample.

Fieldwork took place between January and April 2023.

Trend data

The Adult Inpatient 2022 survey was conducted using a push-to-web methodology (offering both online and paper completion). There were minor questionnaire changes, including three new questions and changes to question wording. The 2022 results are comparable with data from the Adult Inpatient 2020 and 2021 surveys, unless a question has changed or there are other reasons for lack of comparability such as changes in organisation structure of a trust. Where results are comparable, a section on historical trends has been included.

Further information about the survey

- For published results for other surveys in the NPSP, and for information to help trusts implement the surveys across the NPSP, please visit the NHS Surveys website.
- To learn more about CQC's survey programme, please visit the CQC website.

Key terms used in this report

The ‘expected range’ technique

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts. This is designed to help understand the performance of individual trusts and identify areas for improvement.

This report also includes site level benchmarking. This allows you to compare the results for sites within your trust with all other sites across trusts. It is important to note that the performance ratings presented here may differ from that presented in the trust level benchmarking.

More information can be found in the Appendix.

Standardisation

Demographic characteristics, such as age and gender, can influence patients’ experience of care and the way they report it. For example, research shows that men tend to report more positive experiences than women, and older people more so than younger people.

Since trusts have differing profiles of patients, this could make fair trust comparisons difficult. To account for this, we ‘standardise’ the results, which means we apply a weight to individual patient responses to account for differences in demographic profile between trusts.

For each trust, results have been standardised by the age, sex and method of admission (emergency or elective) of respondents to reflect the ‘national’ age, sex, and method of admission distribution (based on all respondents to the survey).This helps ensure that no trust will appear better or worse than another because of its profile of service users, and enables a fairer and more useful comparison of results across trusts. In most cases this standardisation will not have a large impact on trust results. Site level results are standardised in the same way.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale of 0 to 10. A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the trust is performing. Only evaluative questions in the questionnaire are scored. Some questions are descriptive (for example Q1) and others are ‘routing questions’, which are designed to filter out respondents to whom the following questions do not apply (for example Q6). These questions are not scored. Section scoring is computed as the arithmetic mean of question scores for the section after weighting is applied.

Trust average

The ‘trust average’ mentioned in this report is the arithmetic mean of all trusts’ scores after weighting or standardisation is applied.

Suppressed data

If fewer than 30 respondents have answered a question, no score will be displayed for that question (or the corresponding section the question contributes to).

Further information about the methods

For further information about the statistical methods used in this report, please refer to the survey technical document.

Using the survey results

Navigating this report

This report is split into six sections:

- **Background and methodology** – provides information about the survey programme, how the survey is run, and how to interpret the data.
- **Headline results** – includes key trust-level findings relating to the patients who took part in the survey, benchmarking, and top and bottom scores. This section provides an overview of results for your trust, identifying areas where your organisation performs better than the average and where you may wish to focus improvement activities.
- **Benchmarking** – shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part; using the 'expected range' analysis technique. This allows you to see the range of scores achieved and compare yourself with the other organisations that took part in the survey. Benchmarking can provide you with an indication of where you perform better than the average, and what you should aim for in areas where you may wish to improve. Section score slides also include a comparison with other trusts in your region. It may be helpful to compare yourself with regional trusts, so you can learn from and share learnings with trusts in your area who care for similar populations.
- **Trust results** – includes the score for your trust and breakdown of scores across sites within your trust. Internal benchmarking may be helpful so you can compare sites within your organisation, sharing best practice within the trust and identifying any sites that may need attention.
- **Trends over time** – includes your trust's mean score for each evaluative question in the survey shown in a significance test table, comparing it to your 2020 and 2021 mean score. This allows you to see if your trust has made statistically significant improvements between survey years.
- **Appendix** – includes additional data for your trust; further information on the survey methodology; interpretation of graphs in this report.

How to interpret the graphs in this report

There are several types of graphs in this report which show how the score for your trust compares to the scores achieved by all trusts that took part in the survey.

The two chart types used in the section 'benchmarking' use the 'expected range' technique to show results. For information on how to interpret these graphs, please refer to the Appendix.

Other data sources

More information is available about the following topics at their respective websites, listed below:

- Full national results; link to view the results for each trust; technical document: www.cqc.org.uk/inpatientsurvey
- National and trust-level data for all trusts who took part in the Adult Inpatient 2022 survey: https://nhssurveys.org/surveys/survey/02-adults-inpatients/year/2022/. Full details of the methodology for the survey, instructions for trusts and contractors to carry out the survey, and the survey development report can also be found on the NHS Surveys website.
- Information on the NHS Patient Survey Programme, including results from other surveys: www.cqc.org.uk/content/surveys
- Information about how the CQC monitors hospitals: www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-nhs-acute-hospitals

Headline results

This section includes:

- information about your trust population
- an overview of benchmarking for your trust
- the top and bottom scores for your trust

Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of patients who took part in the survey.

1,250 invited to take part

591 completed

69% urgent/emergency admission

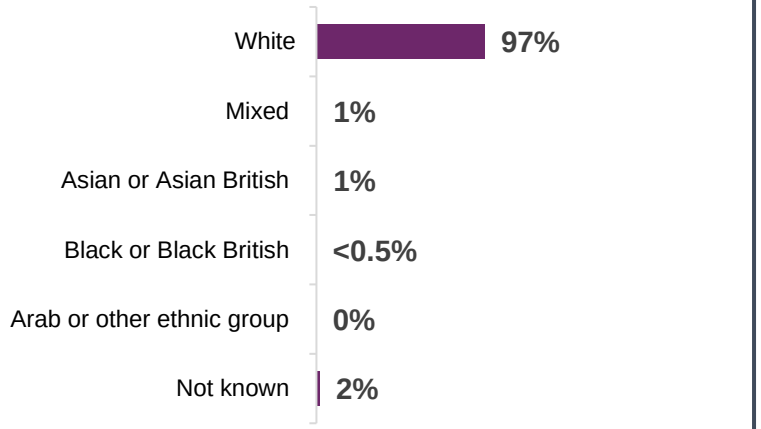
31% planned admission

49% response rate

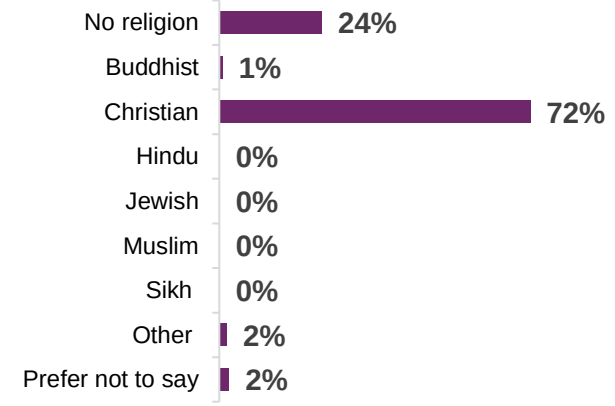
40% average response rate for all trusts

N/A response rate for your trust last year

Ethnicity



Religion

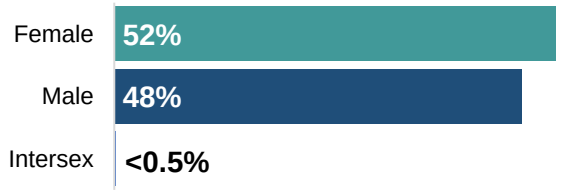


Long-term conditions

of participants said they have **physical or mental health conditions, disabilities or illnesses** that have lasted or are expected to last 12 months or more (excluding those who selected "I would prefer not to say").

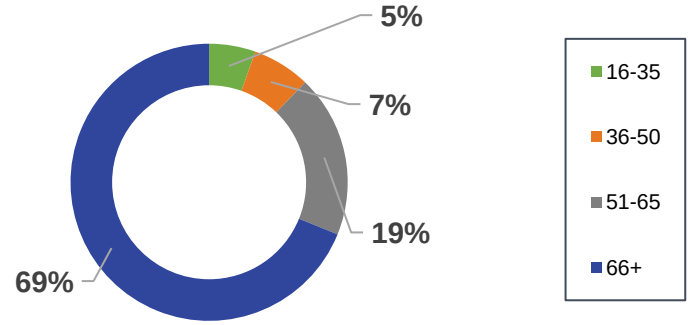
Sex

At birth were you registered as…



1% of participants said their gender is different from the sex they were registered with at birth.

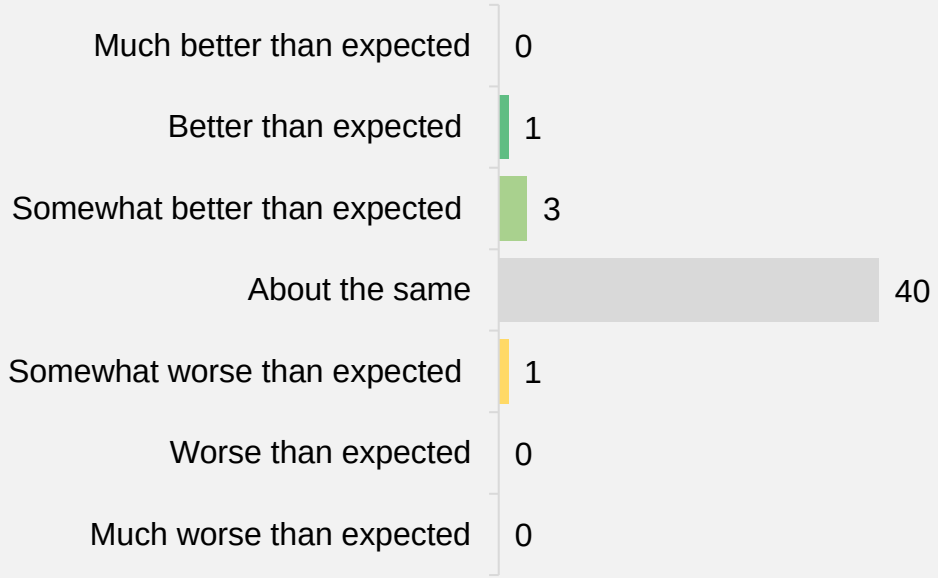
Age



Summary of findings for your trust

Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

The **number of questions** in this report where your trust showed a statistically significant increase, decrease, or no change in scores compared to 2021 results.

This information is not available for your trust.

Data for trusts which have undergone significant restructuring (i.e. mergers and closures) should not be compared with previous survey results.

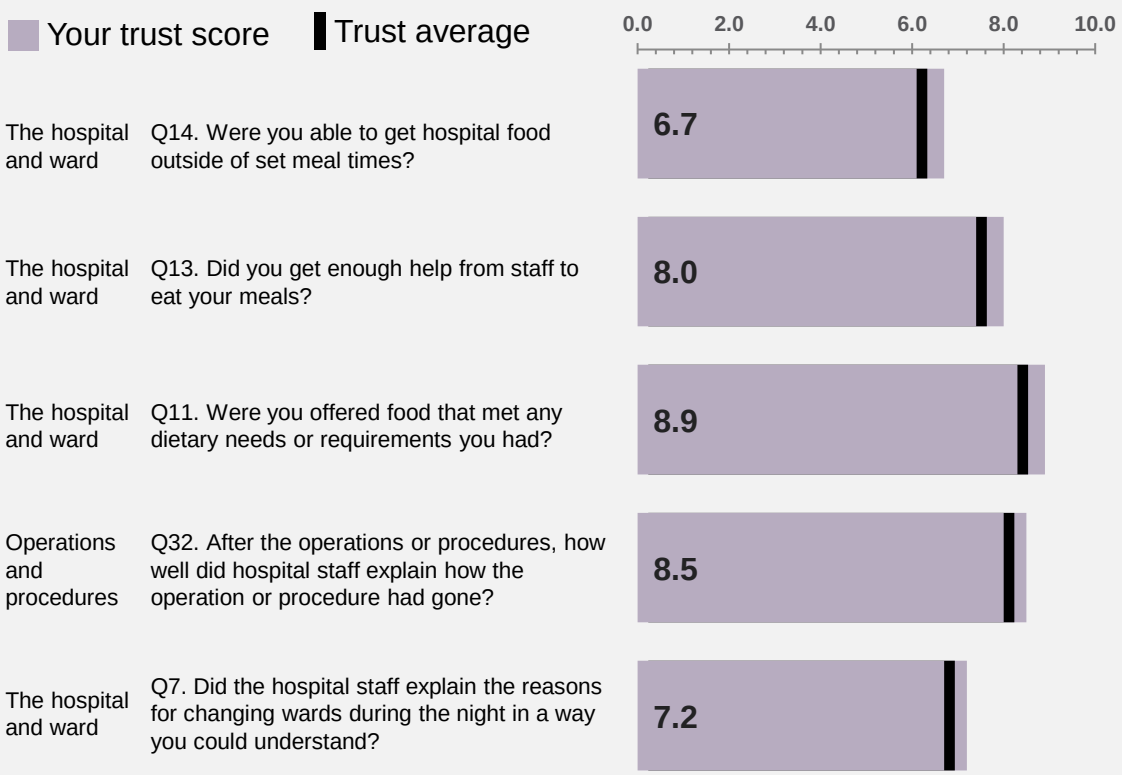
For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the appendix section "comparison to other trusts".

Best and worst performance relative to the trust average

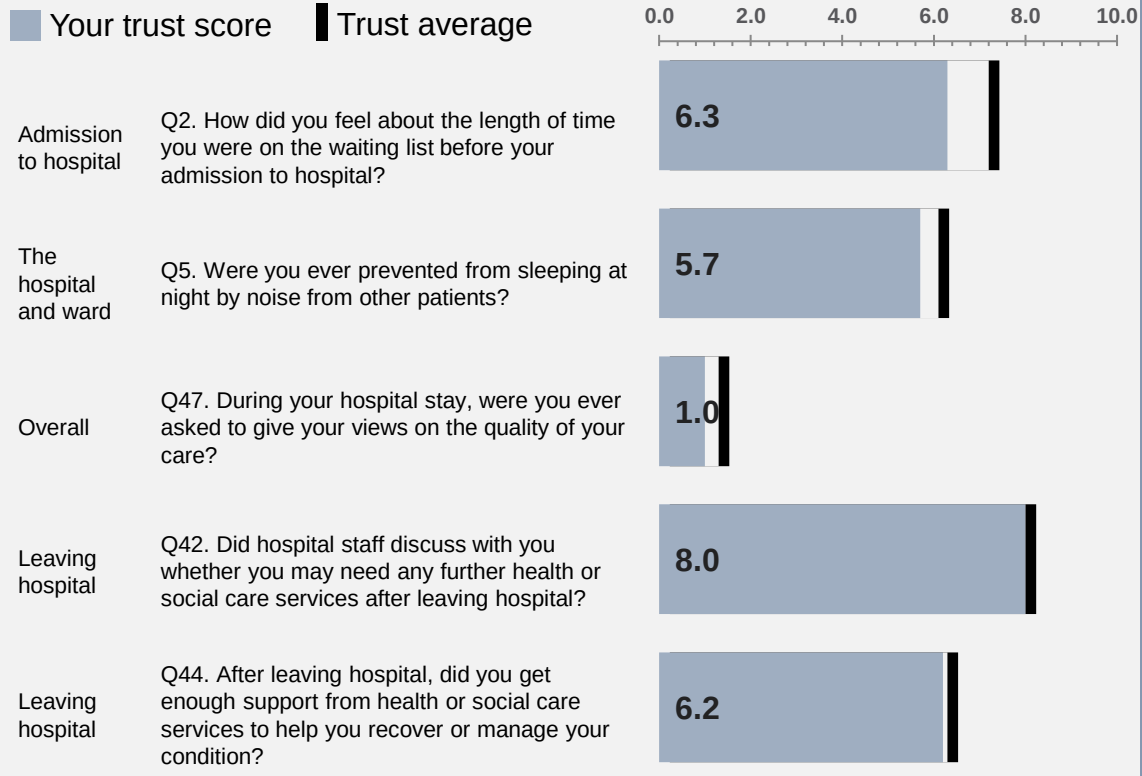
These five questions are calculated by comparing your trust's results to the trust average (the average trust score across England).

- **Top five scores**: These are the five results for your trust that are highest compared with the trust average. If none of the results for your trust are above the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's best performance may be worse than the trust average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the trust average. If none of the results for your trust are below the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's worst performance may be better than the trust average.

Top five scores (compared with trust average)



Bottom five scores (compared with trust average)



Benchmarking

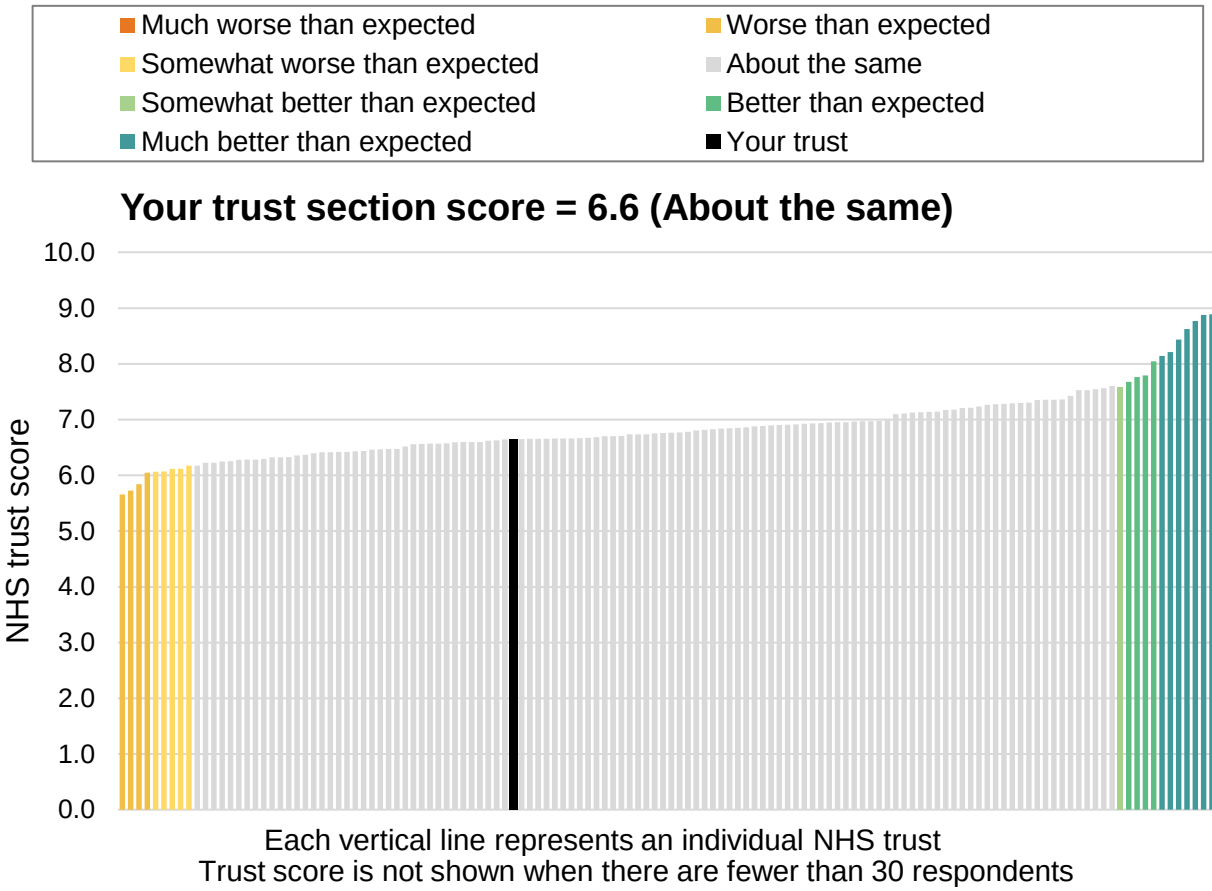
This section includes:

- how your trust scored for each evaluative question in the survey, compared with other trusts that took part
- an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts
- a comparison of section scores with other trusts in your region

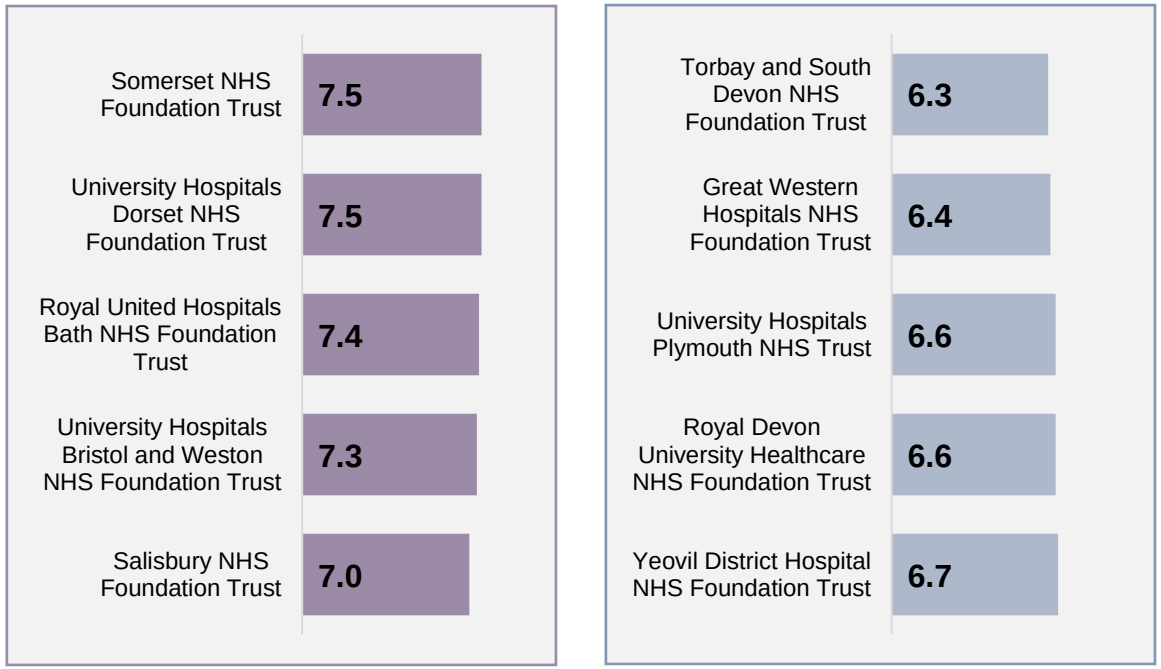
Section 1. Admission to hospital

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



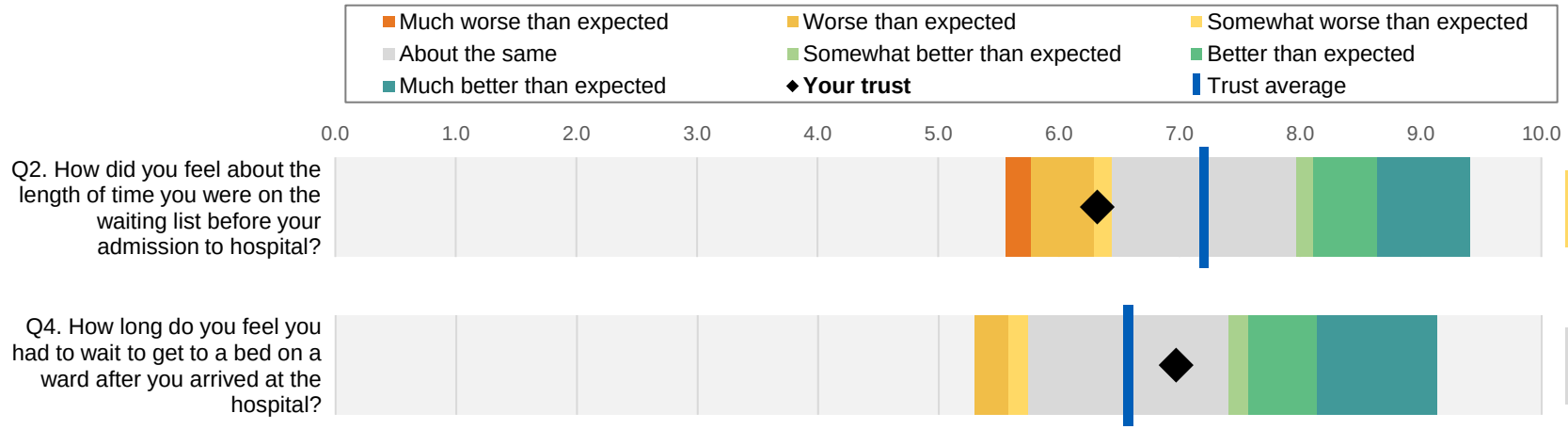
Comparison with other trusts within your region



Section 1. Admission to hospital (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

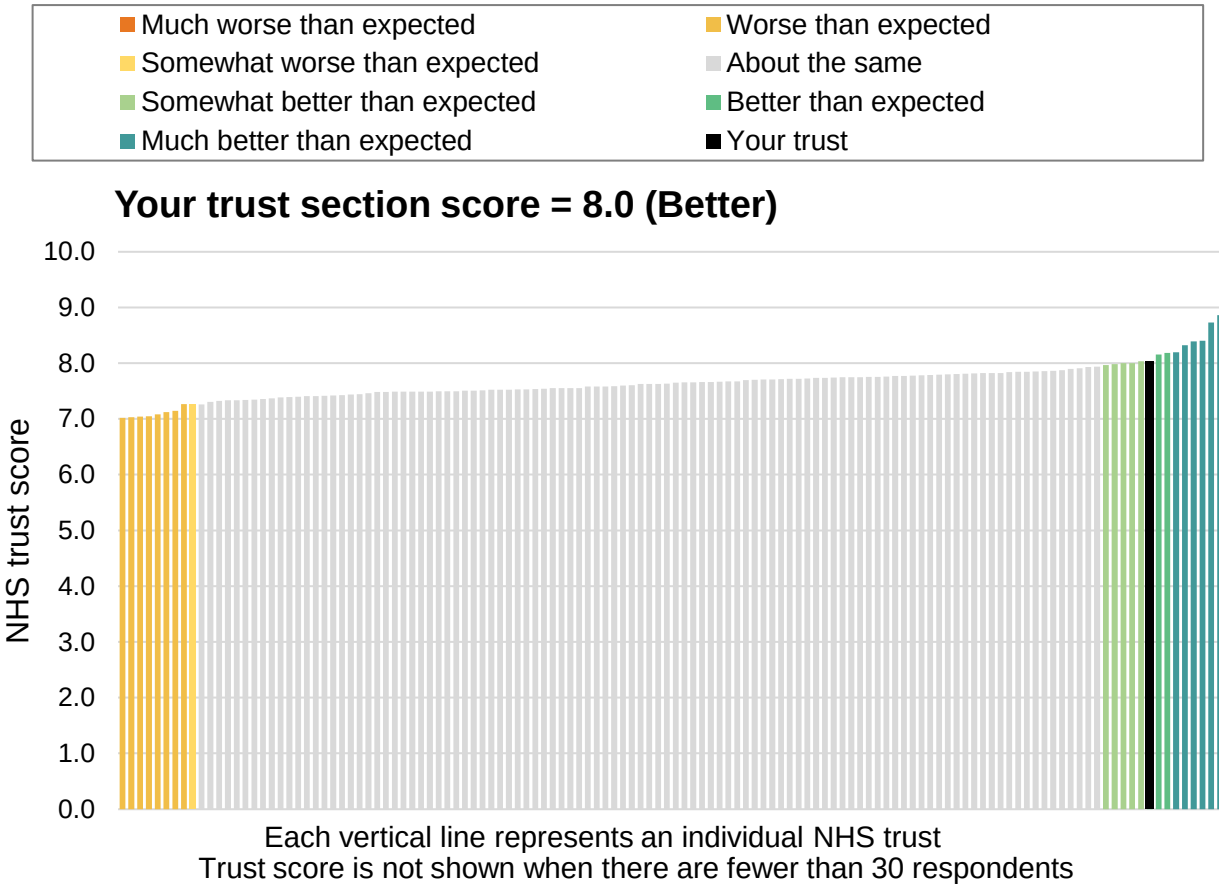


			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
Somewhat worse	183	6.3	7.2	5.6	9.4
About the same	556	7.0	6.6	5.3	9.1

Section 2. The hospital and ward

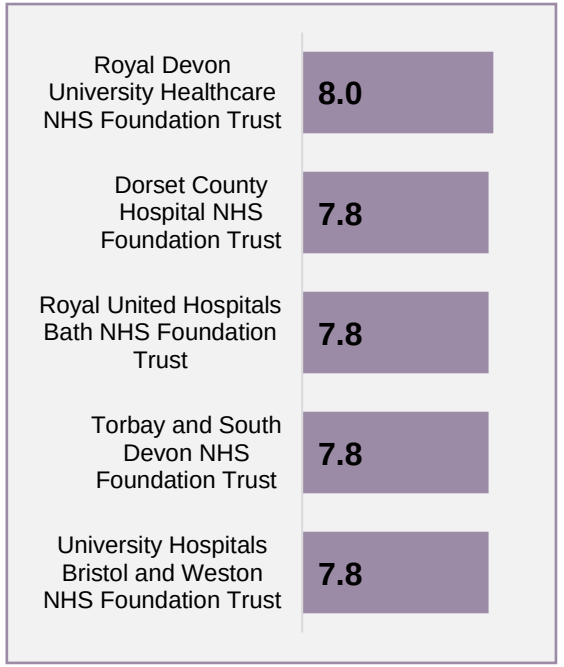
Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

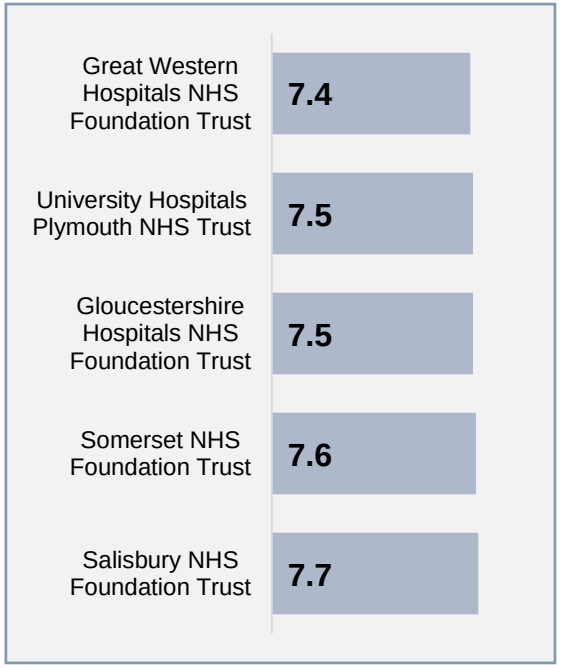


Comparison with other trusts within your region

Trusts with the highest scores



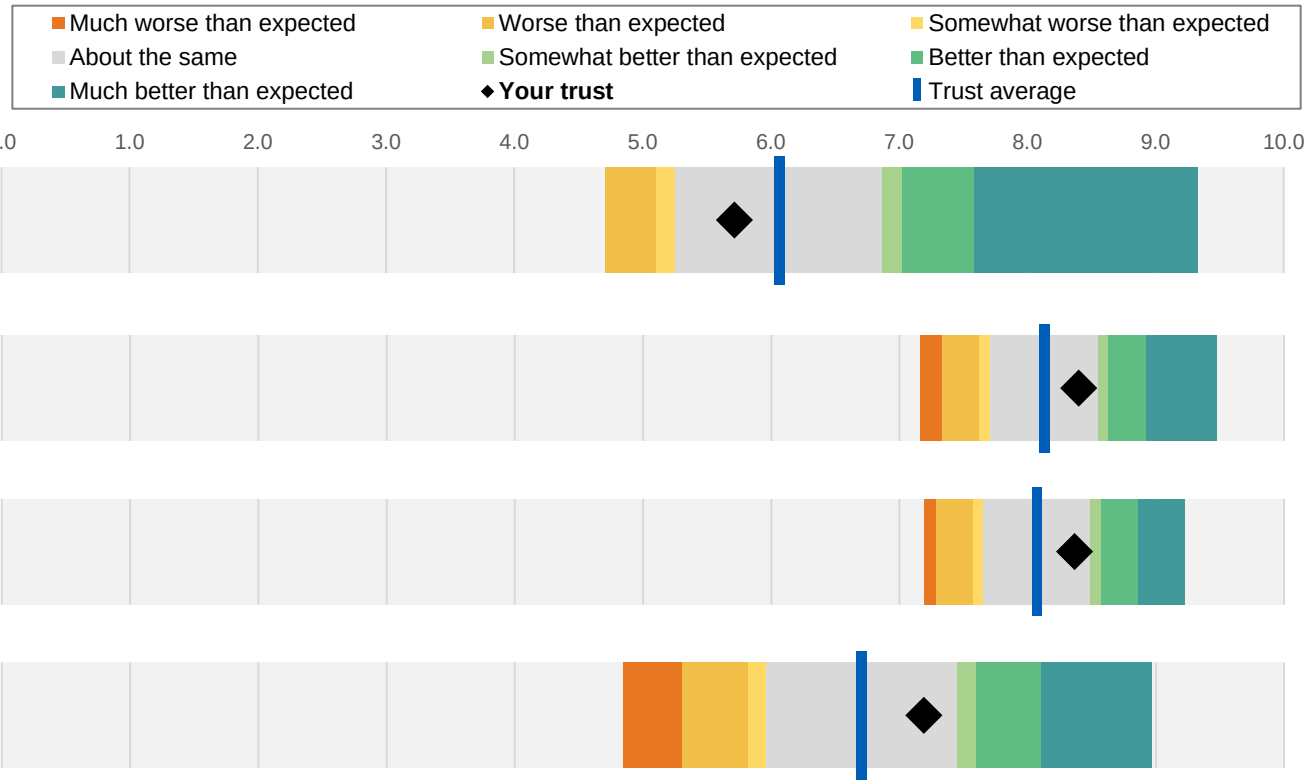
Trusts with the lowest scores



Section 2. The hospital and ward (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



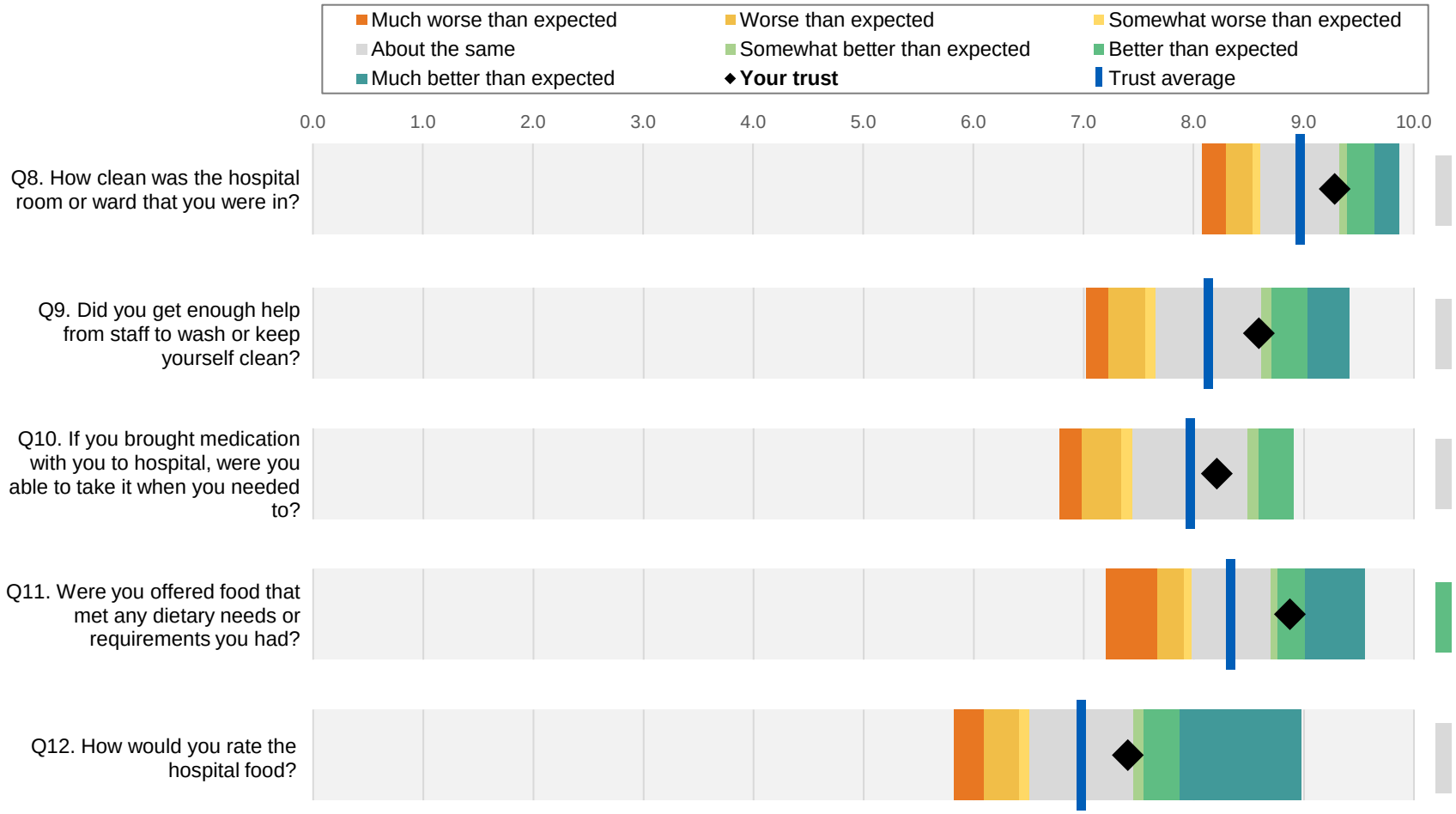
			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
Q5. Were you ever prevented from sleeping at night by noise from other patients?	520	5.7	6.1	4.7	9.3
Q5. Were you ever prevented from sleeping at night by noise from staff?	520	8.4	8.1	7.2	9.5
Q5. Were you ever prevented from sleeping at night by hospital lighting?	520	8.4	8.1	7.2	9.2
Q7. Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?	135	7.2	6.7	4.8	9.0

About the same

Section 2. The hospital and ward (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

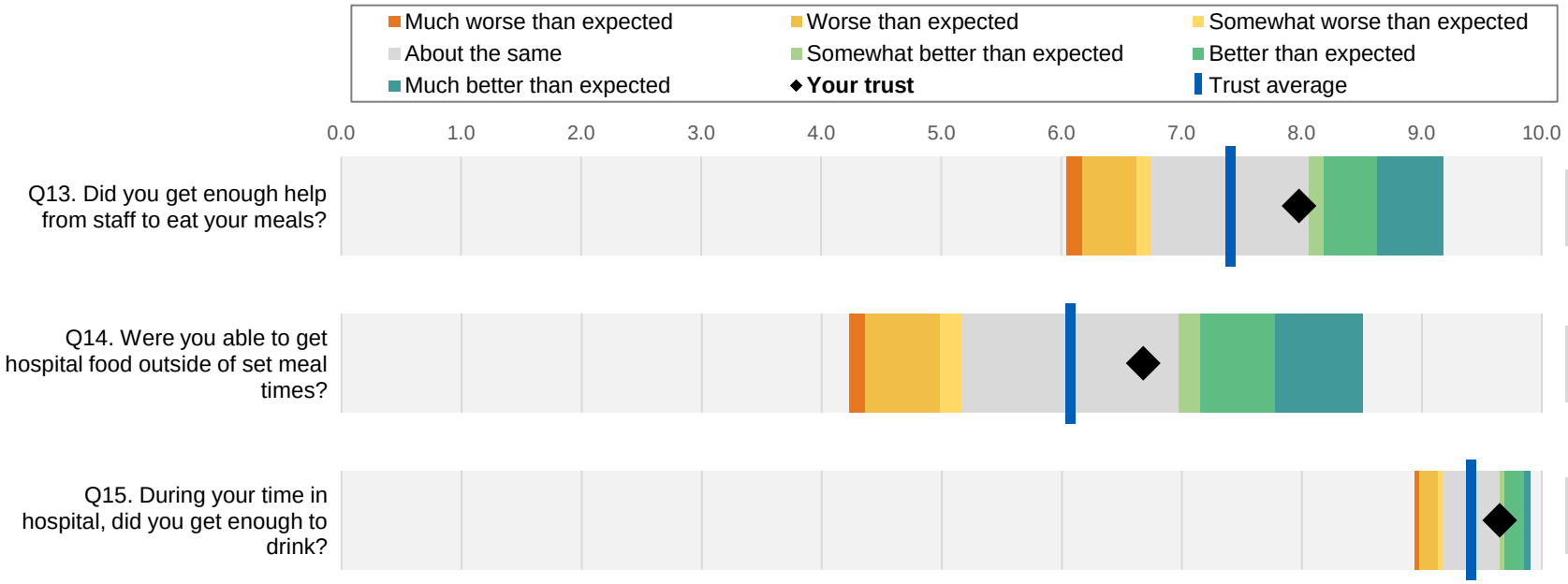


			All trusts in England			
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score	
Q8. How clean was the hospital room or ward that you were in?	572	9.3	9.0	8.1	9.9	About the same
Q9. Did you get enough help from staff to wash or keep yourself clean?	437	8.6	8.1	7.0	9.4	About the same
Q10. If you brought medication with you to hospital, were you able to take it when you needed to?	339	8.2	8.0	6.8	8.9	About the same
Q11. Were you offered food that met any dietary needs or requirements you had?	293	8.9	8.3	7.2	9.5	Better
Q12. How would you rate the hospital food?	562	7.4	7.0	5.8	9.0	About the same

Section 2. The hospital and ward (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

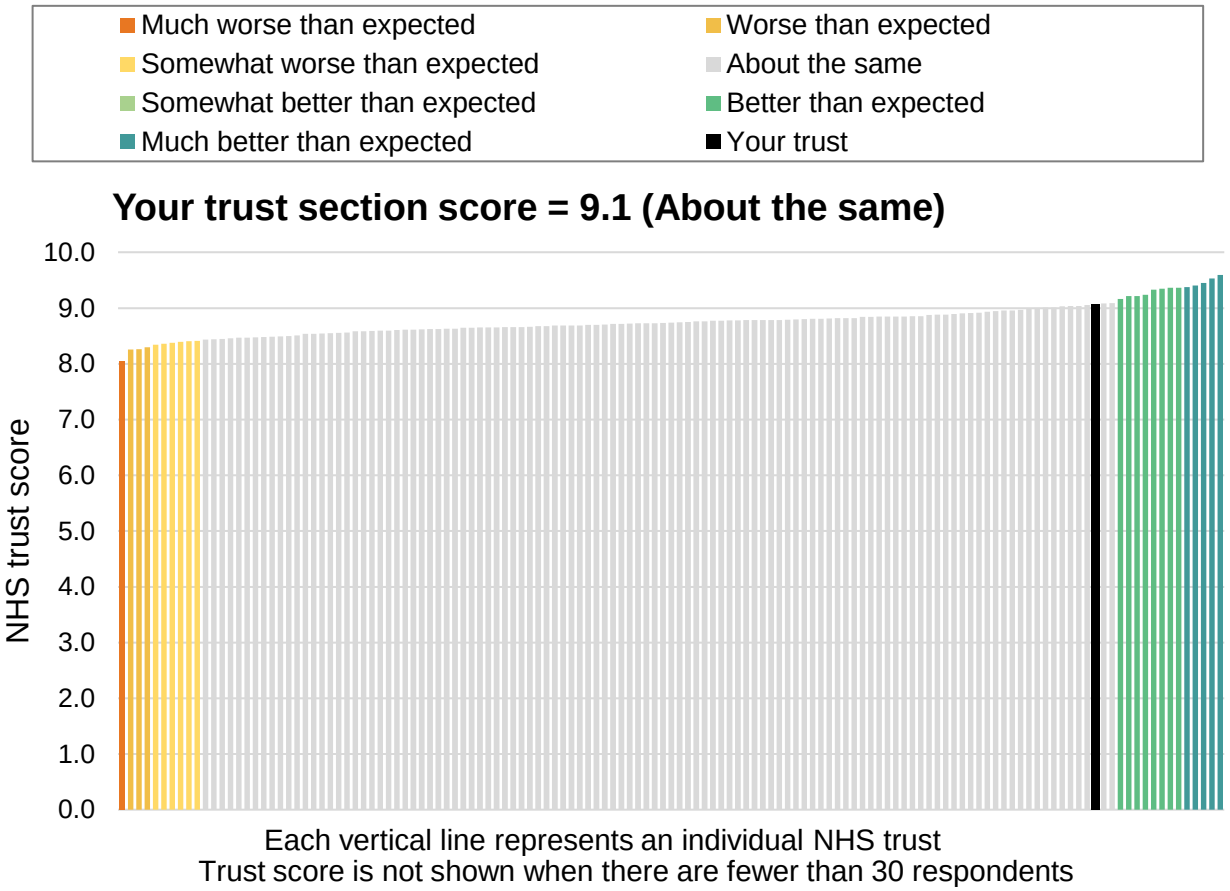


	Number of respondents (your trust)	Your trust score	All trusts in England: Trust average score	All trusts in England: Lowest score	All trusts in England: Highest score
Q13. Did you get enough help from staff to eat your meals?	142	8.0	7.4	6.0	9.2
Q14. Were you able to get hospital food outside of set meal times?	218	6.7	6.1	4.2	8.5
Q15. During your time in hospital, did you get enough to drink?	544	9.6	9.4	8.9	9.9

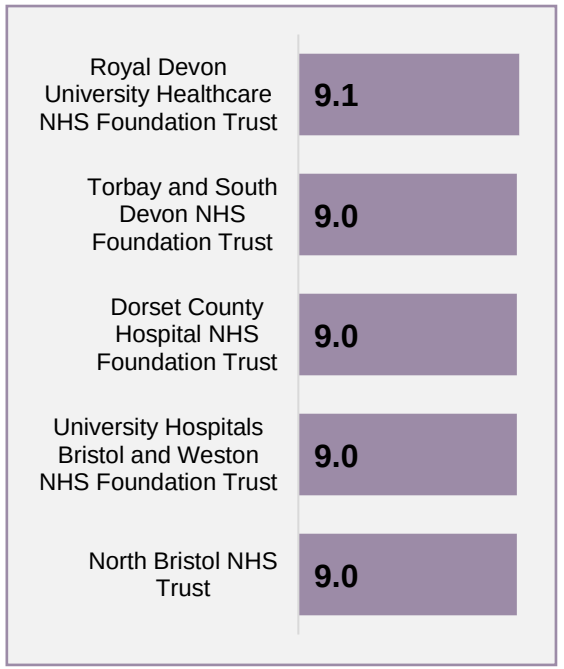
Section 3. Doctors

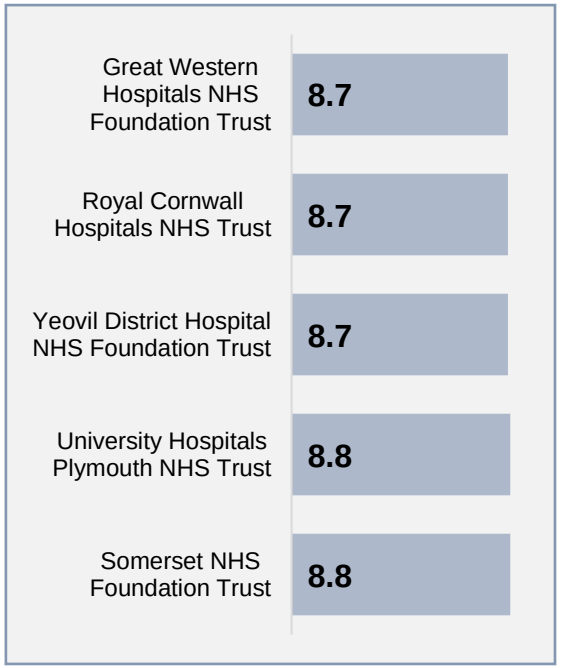
Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Comparison with other trusts within your region





Section 3. Doctors (continued)

Question scores

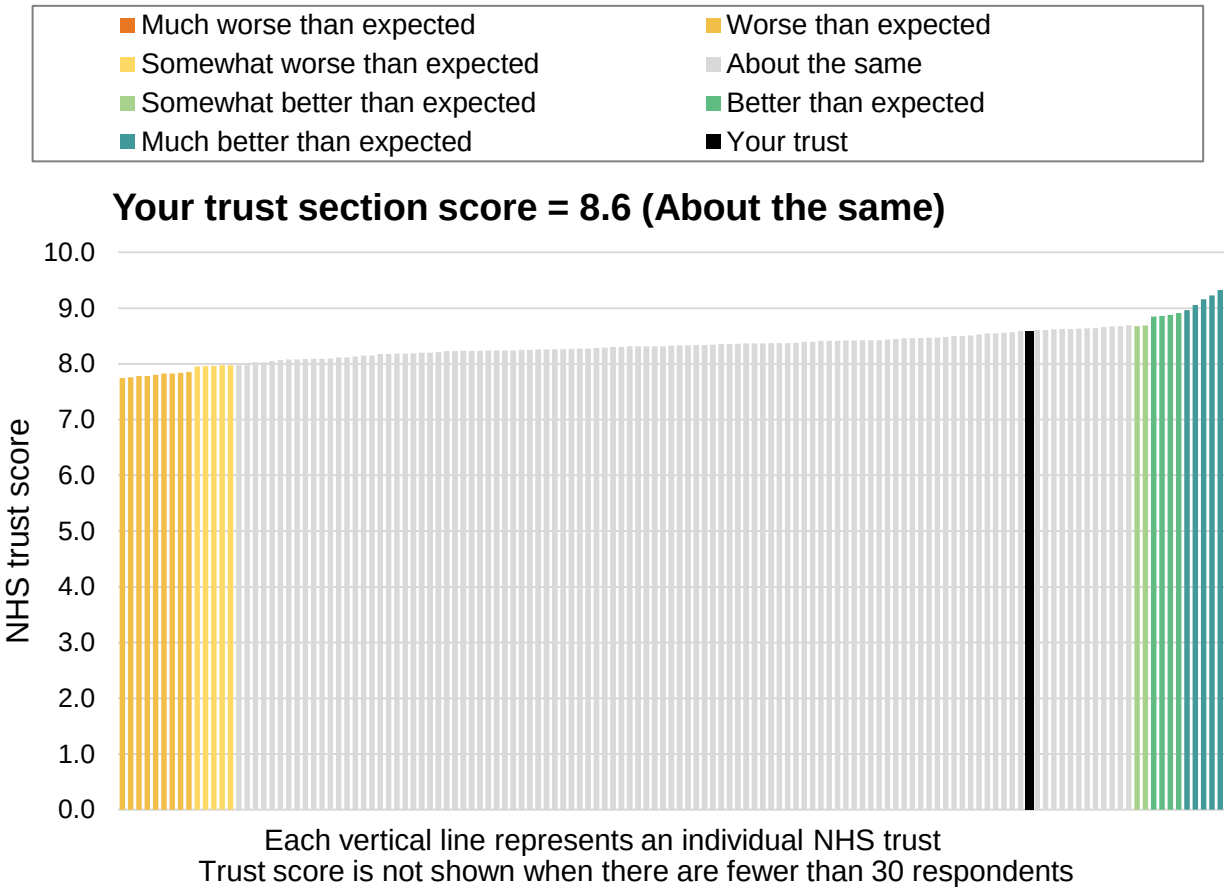
Trust score is not shown when there are fewer than 30 respondents.

			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
Q16. When you asked doctors questions, did you get answers you could understand?	532	8.9	8.6	7.9	9.5
Q17. Did you have confidence and trust in the doctors treating you?	584	9.4	9.1	8.4	9.8
Q18. When doctors spoke about your care in front of you, were you included in the conversation?	582	8.9	8.6	7.9	9.7

Section 4. Nurses

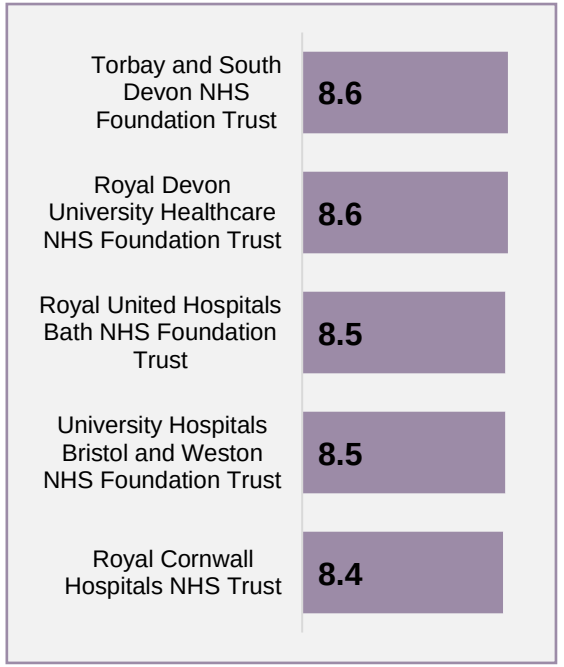
Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

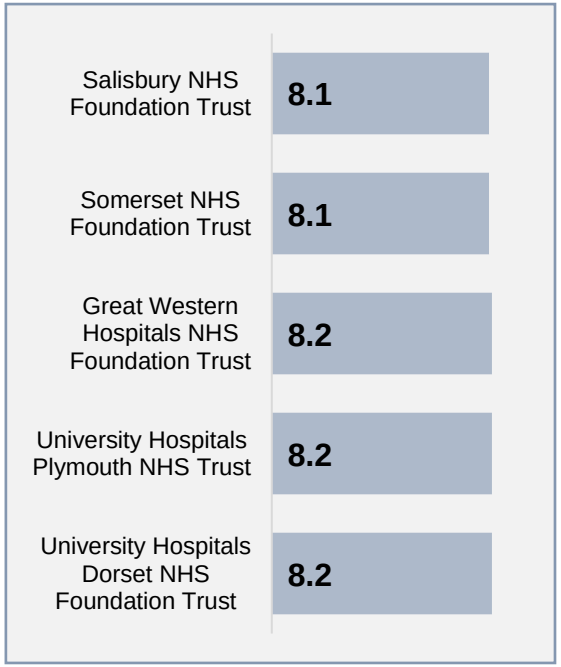


Comparison with other trusts within your region

Trusts with the highest scores



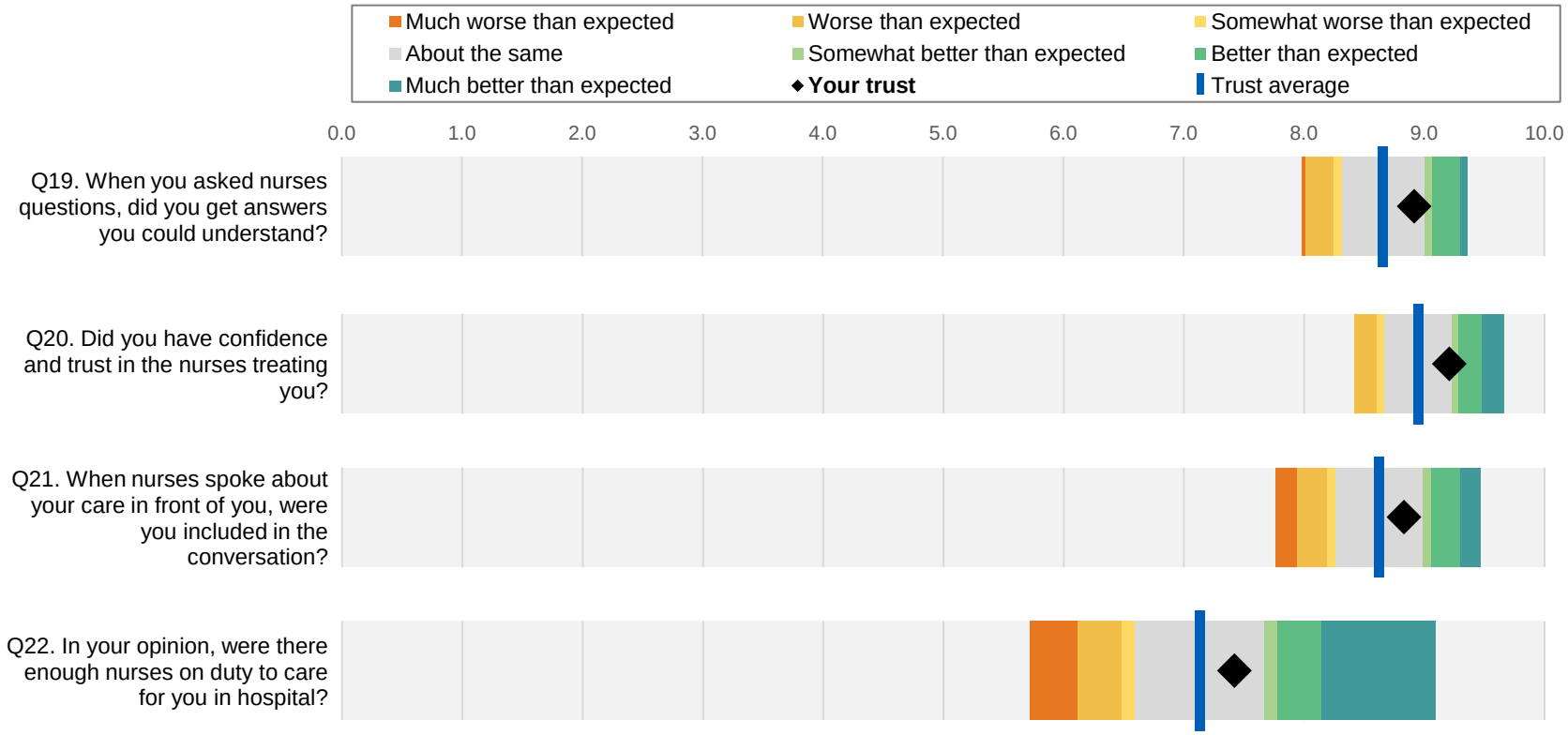
Trusts with the lowest scores



Section 4. Nurses (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

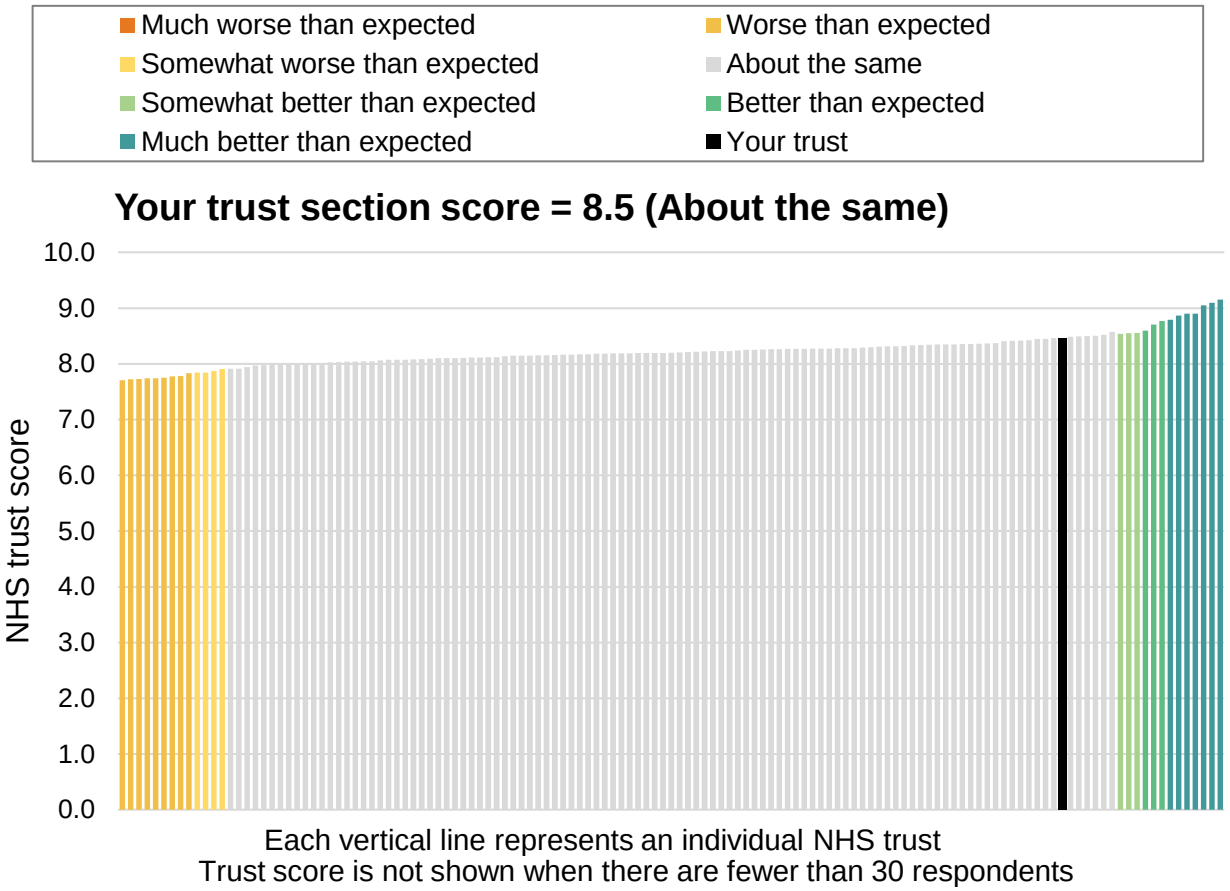


			About the same	All trusts in England		
	Number of respondents (your trust)	Your trust score		Trust average score	Lowest score	Highest score
Q19. When you asked nurses questions, did you get answers you could understand?	540	8.9	About the same	8.7	8.0	9.4
Q20. Did you have confidence and trust in the nurses treating you?	582	9.2	About the same	8.9	8.4	9.7
Q21. When nurses spoke about your care in front of you, were you included in the conversation?	580	8.8	About the same	8.6	7.8	9.5
Q22. In your opinion, were there enough nurses on duty to care for you in hospital?	584	7.4	About the same	7.1	5.7	9.1

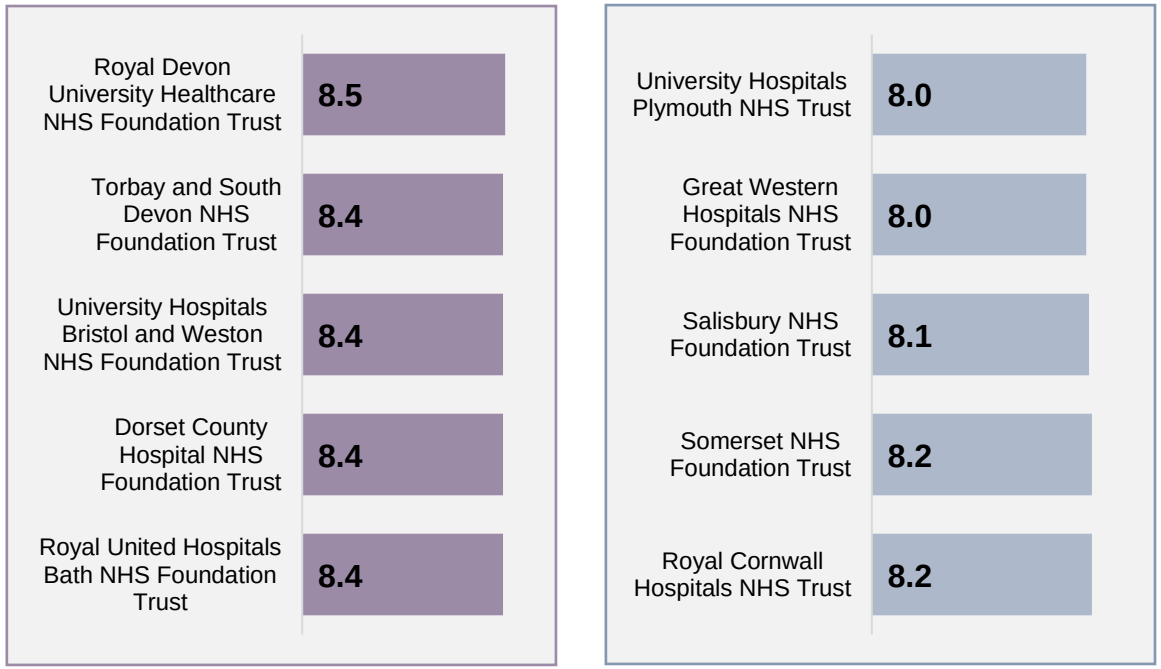
Section 5. Your care and treatment

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



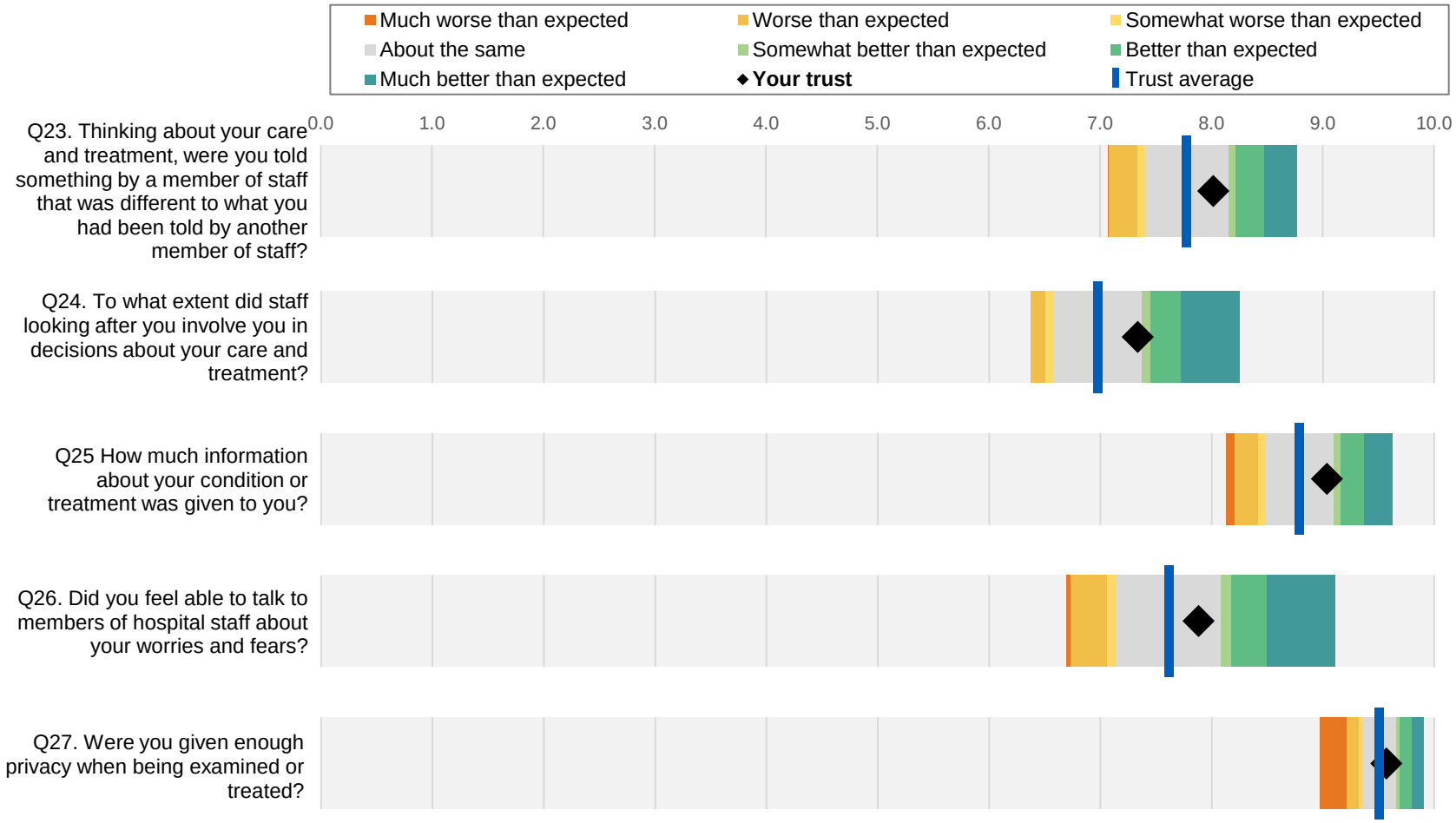
Comparison with other trusts within your region



Section 5. Your care and treatment (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

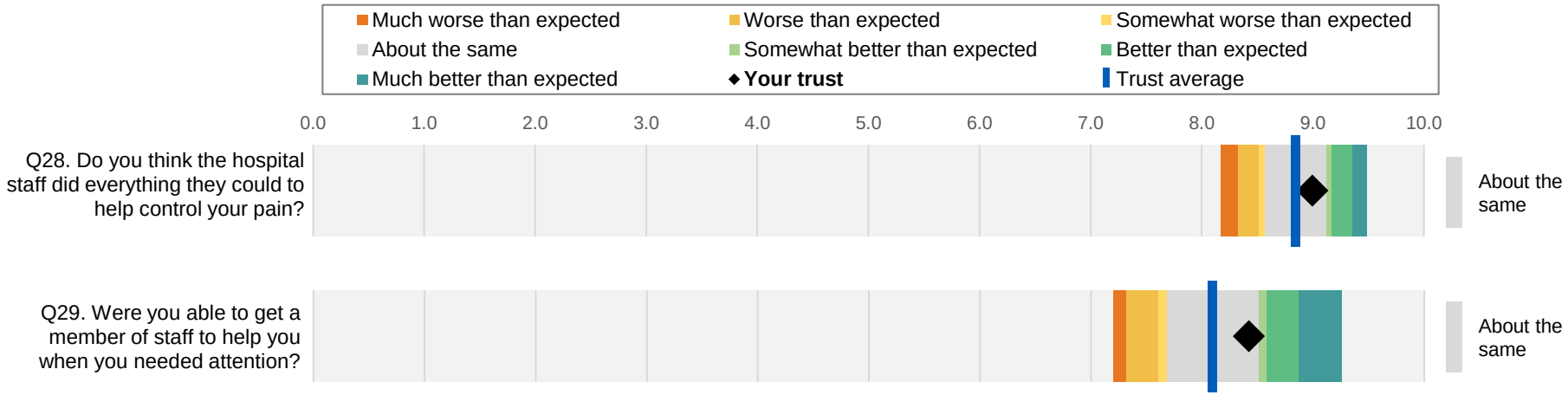


		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
514	8.0	7.8	7.1	8.8
549	7.3	7.0	6.4	8.2
568	9.0	8.8	8.1	9.6
485	7.9	7.6	6.7	9.1
576	9.6	9.5	9.0	9.9

Section 5. Your care and treatment (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

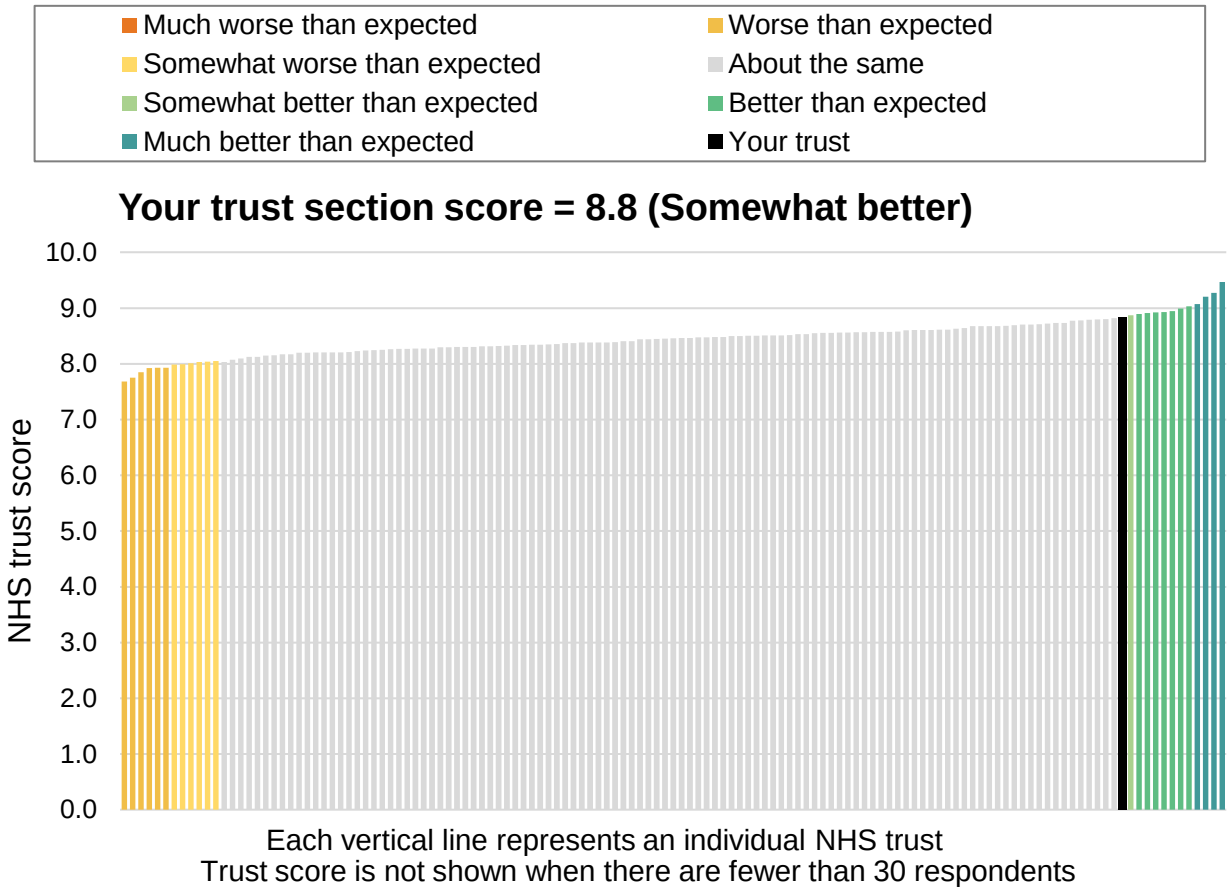


		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
473	9.0	8.8	8.2	9.5
528	8.4	8.1	7.2	9.3

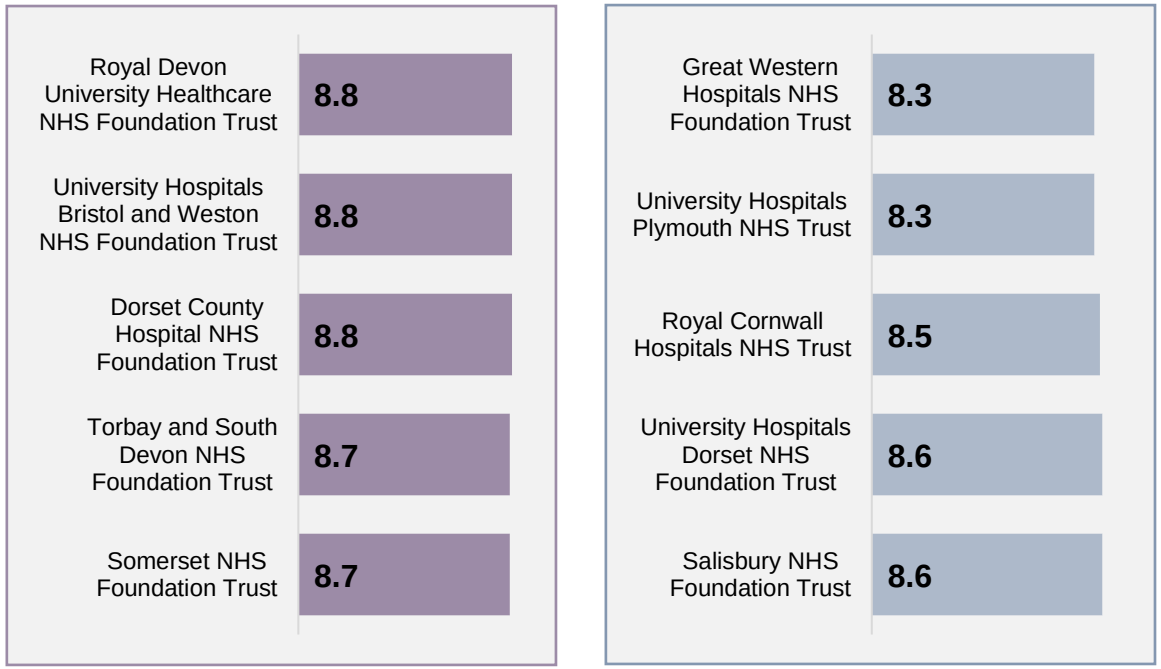
Section 6. Operations and procedures

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



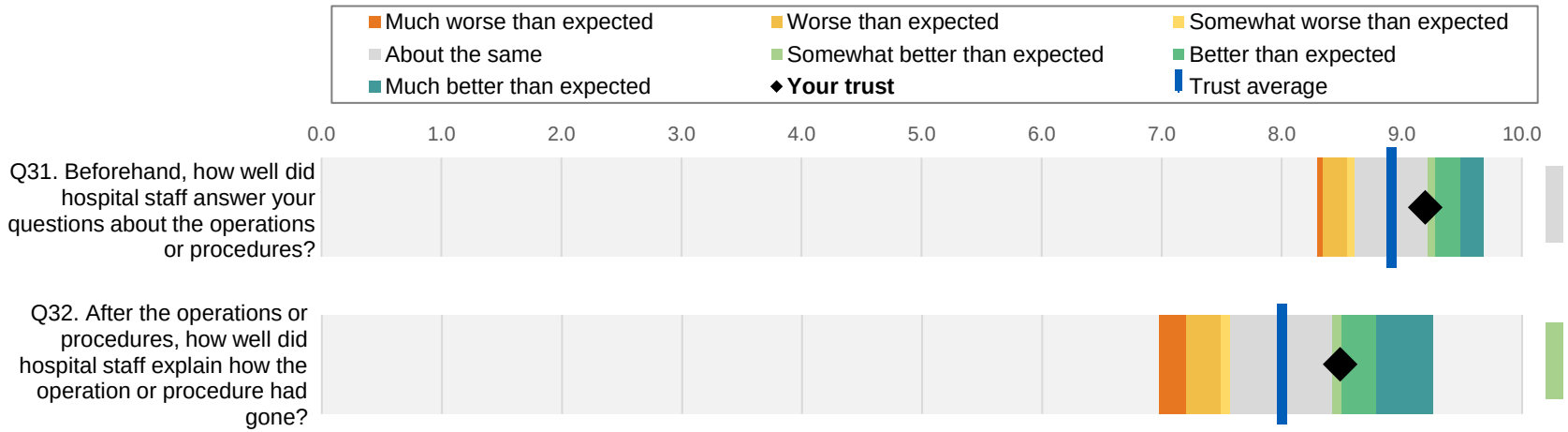
Comparison with other trusts within your region



Section 6. Operations and procedures (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

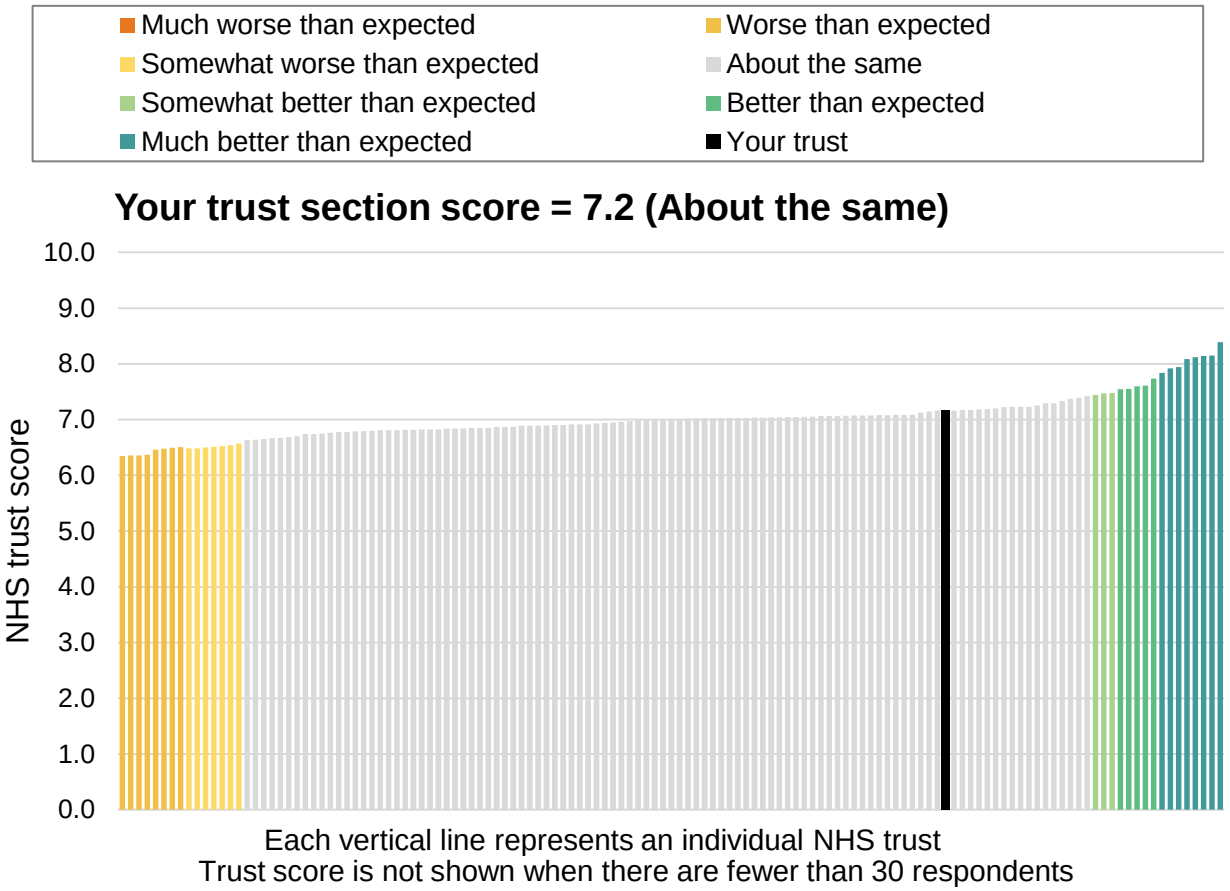


		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
293	9.2	8.9	8.3	9.7
314	8.5	8.0	7.0	9.3

Section 7. Leaving hospital

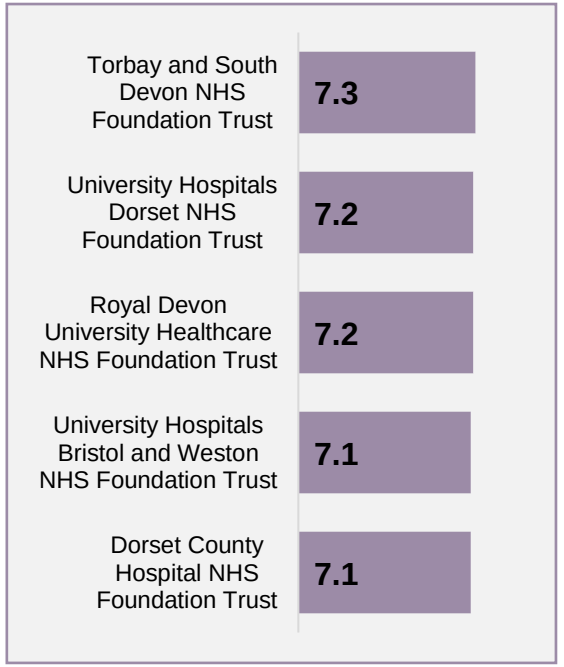
Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

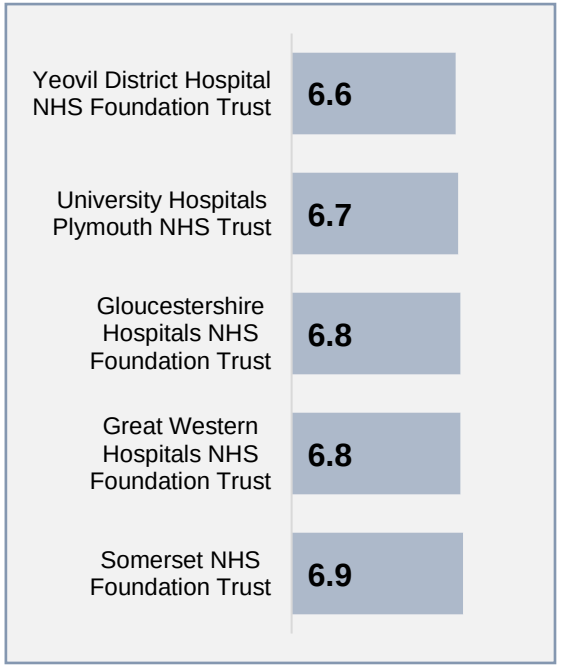


Comparison with other trusts within your region

Trusts with the highest scores



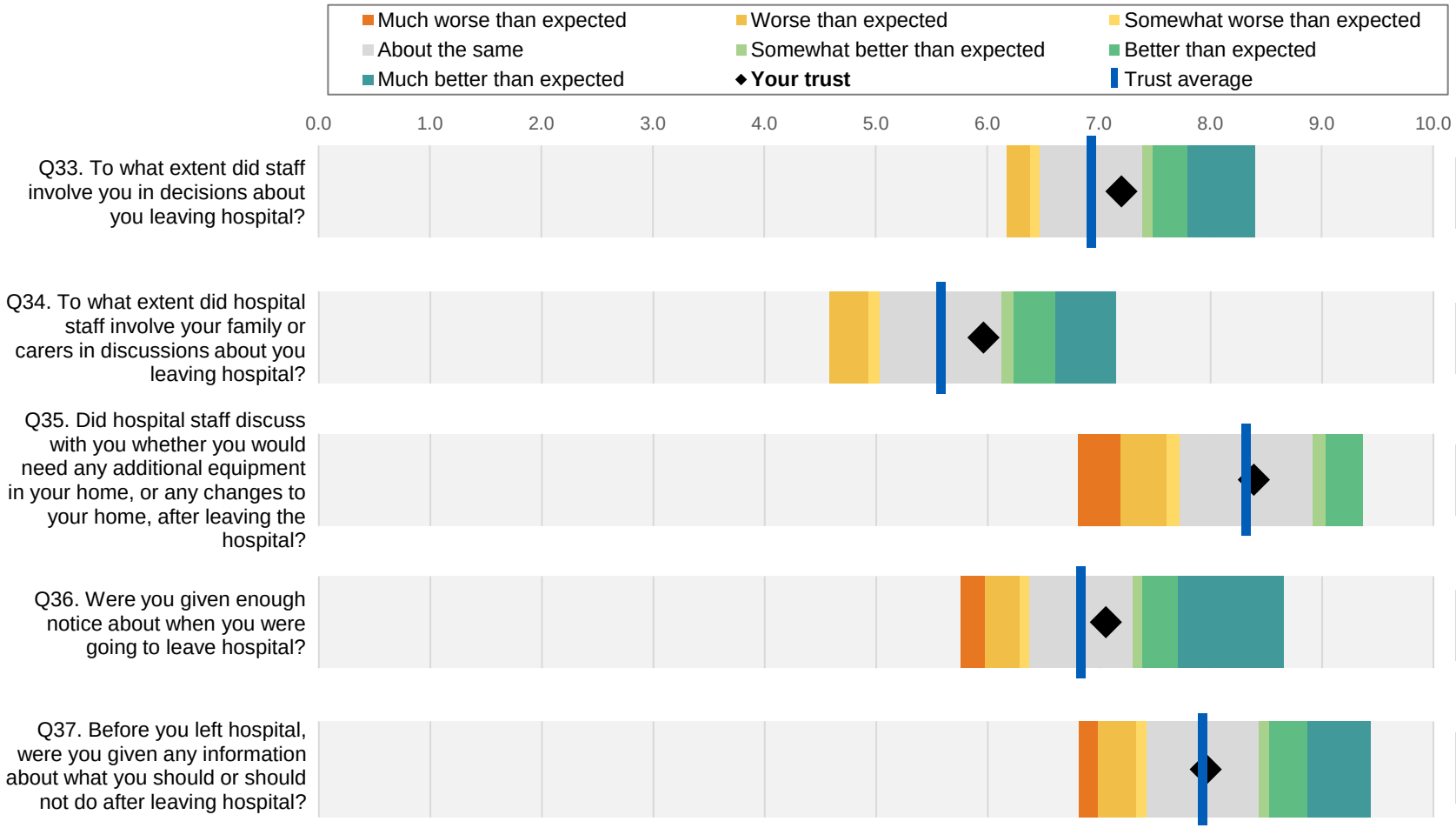
Trusts with the lowest scores



Section 7. Leaving hospital (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

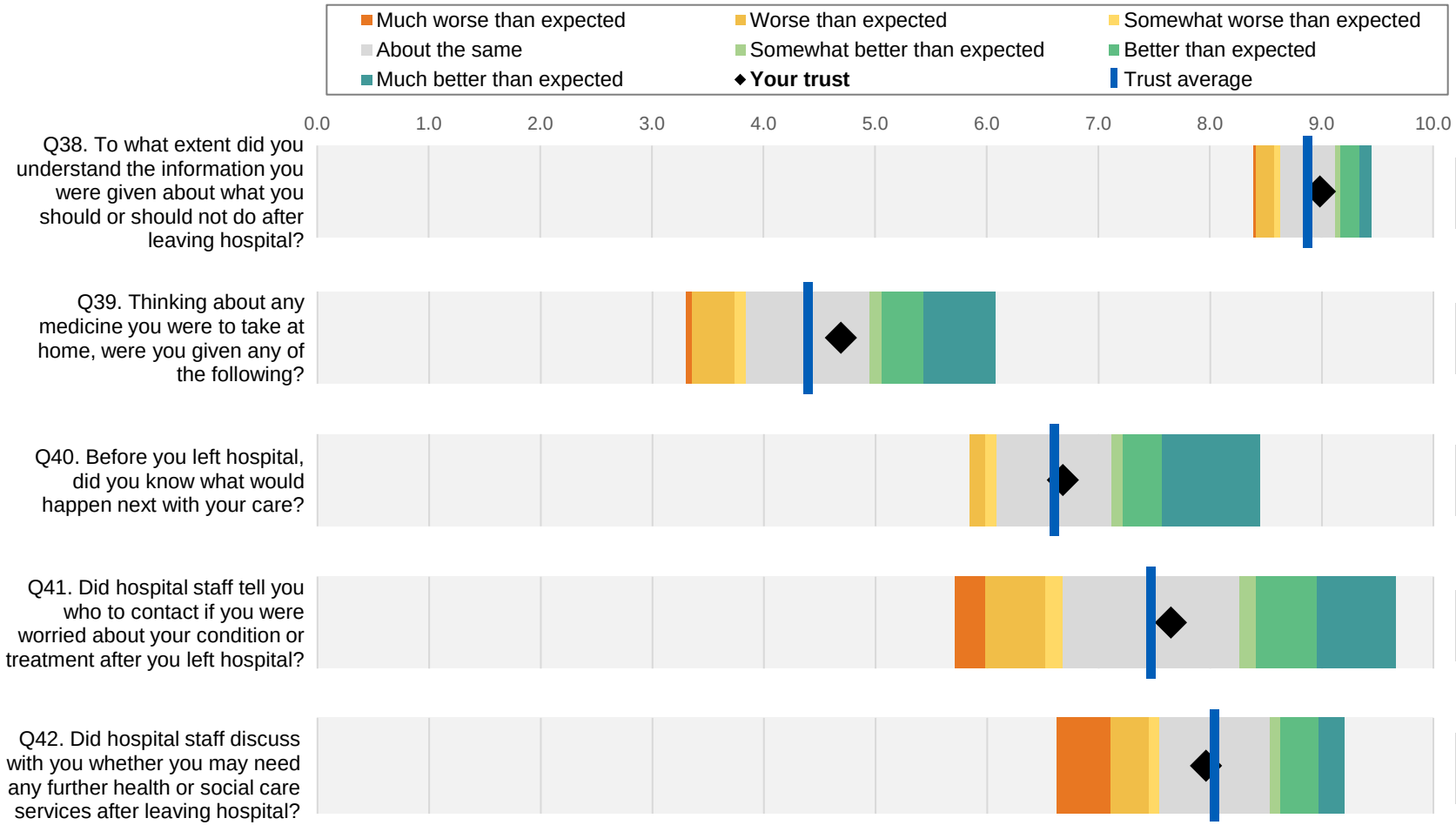


			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
Q33. To what extent did staff involve you in decisions about you leaving hospital?	572	7.2	6.9	6.2	8.4
Q34. To what extent did hospital staff involve your family or carers in discussions about you leaving hospital?	389	6.0	5.6	4.6	7.2
Q35. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?	232	8.4	8.3	6.8	9.4
Q36. Were you given enough notice about when you were going to leave hospital?	588	7.1	6.8	5.8	8.7
Q37. Before you left hospital, were you given any information about what you should or should not do after leaving hospital?	540	8.0	7.9	6.8	9.4

Section 7. Leaving hospital (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

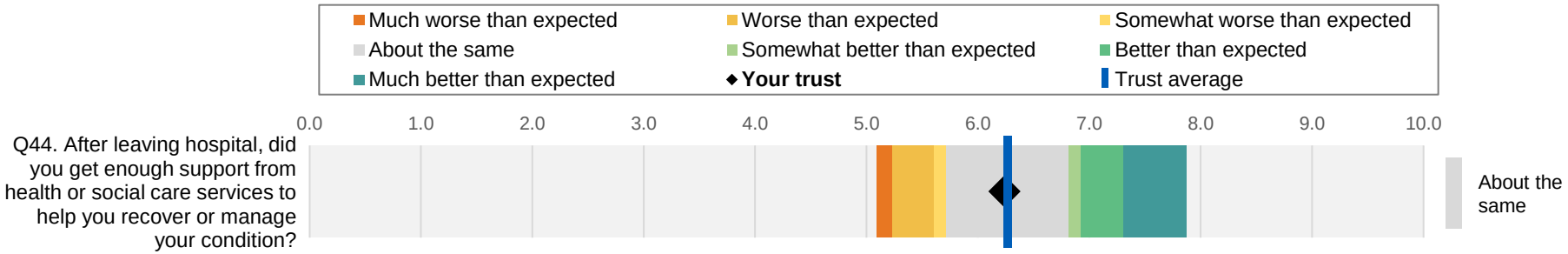


	Number of respondents (your trust)	Your trust score	All trusts in England: Trust average score	All trusts in England: Lowest score	All trusts in England: Highest score
Q38. To what extent did you understand the information you were given about what you should or should not do after leaving hospital?	412	9.0	8.9	8.4	9.4
Q39. Thinking about any medicine you were to take at home, were you given any of the following?	436	4.7	4.4	3.3	6.1
Q40. Before you left hospital, did you know what would happen next with your care?	501	6.7	6.6	5.8	8.4
Q41. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	518	7.6	7.5	5.7	9.7
Q42. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	318	8.0	8.0	6.6	9.2

Section 7. Leaving hospital (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

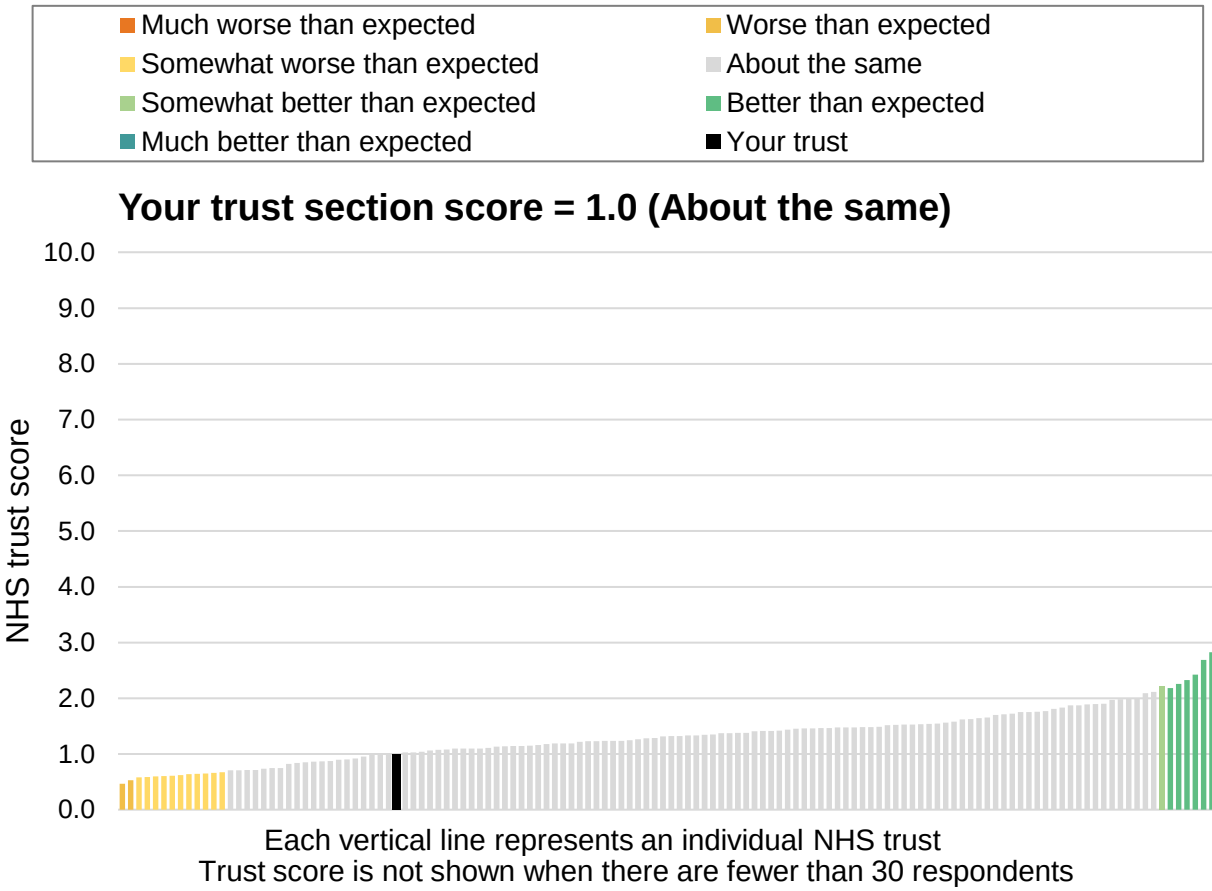


		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
311	6.2	6.3	5.1	7.9

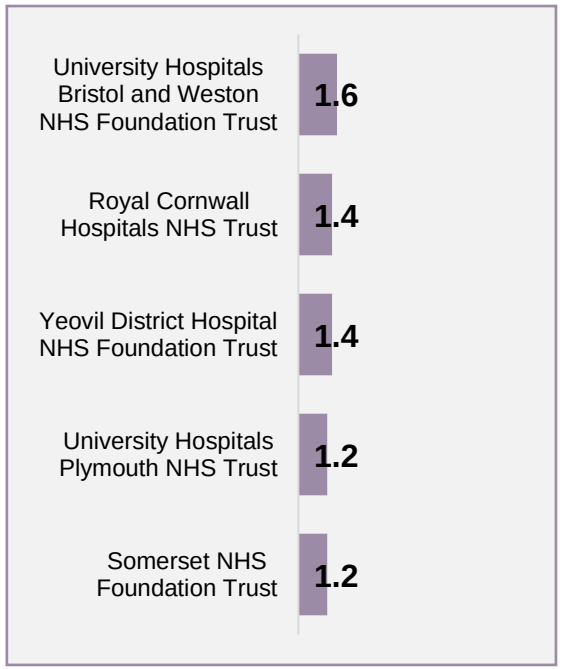
Section 8. Feedback on the quality of your care

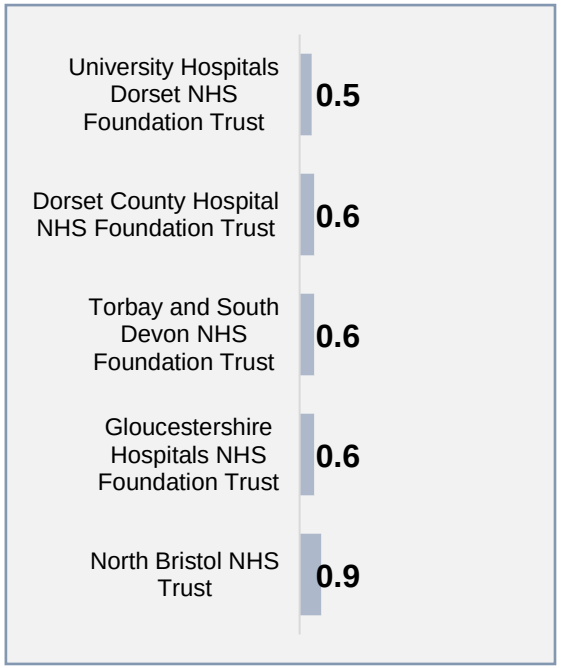
Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Comparison with other trusts within your region

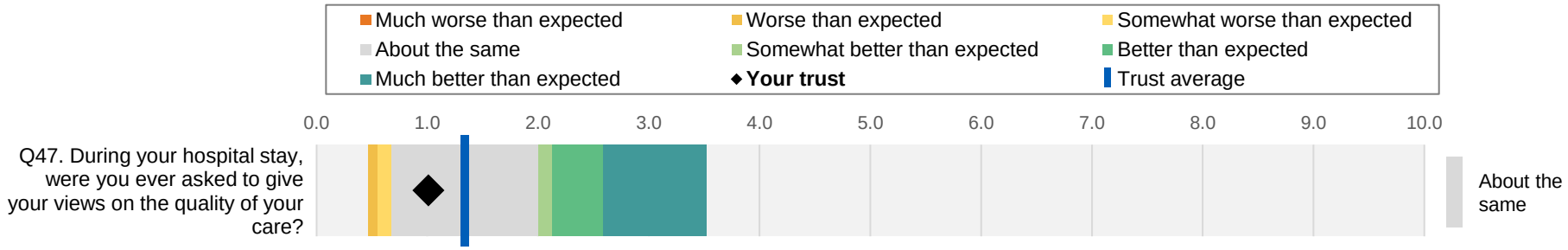




Section 8. Feedback on the quality of your care (continued)

Question score

Trust score is not shown when there are fewer than 30 respondents.

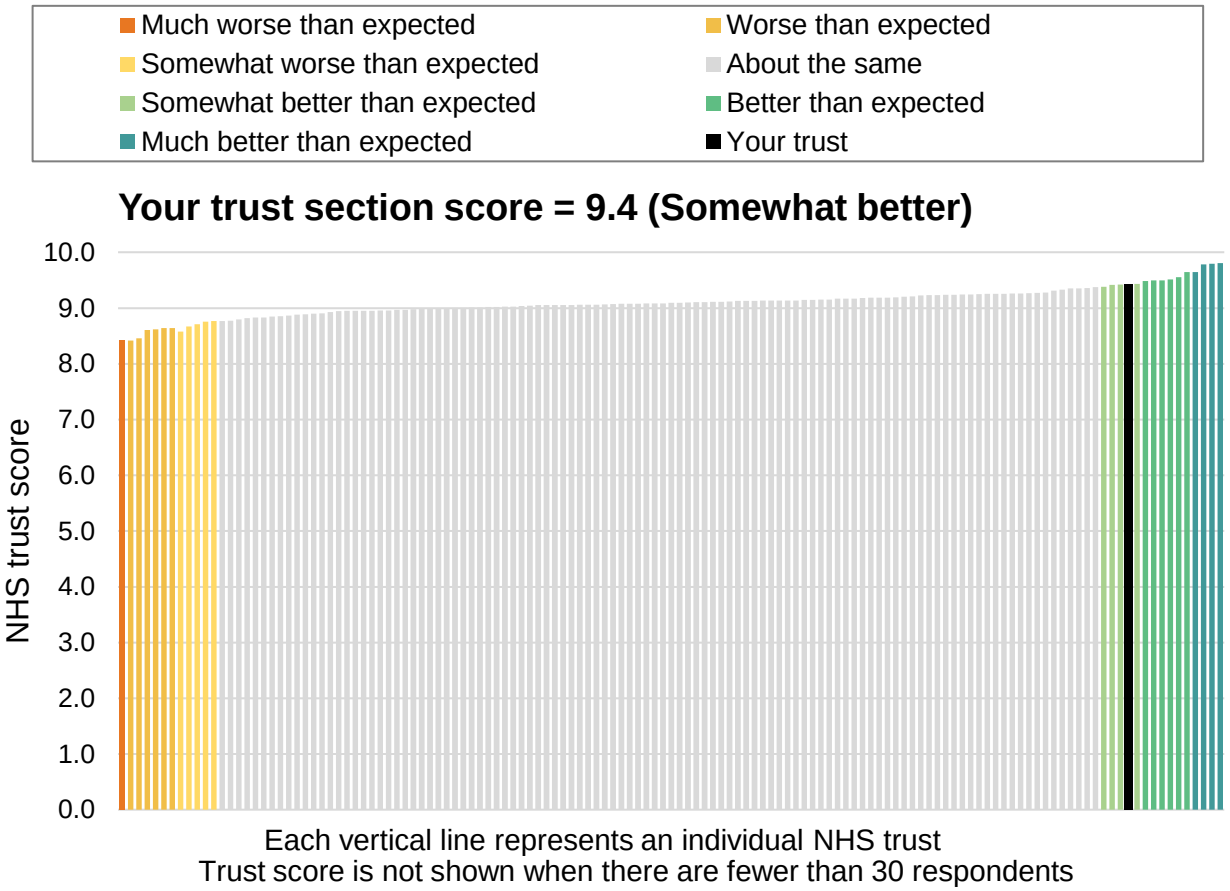


		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
510	1.0	1.3	0.5	3.5

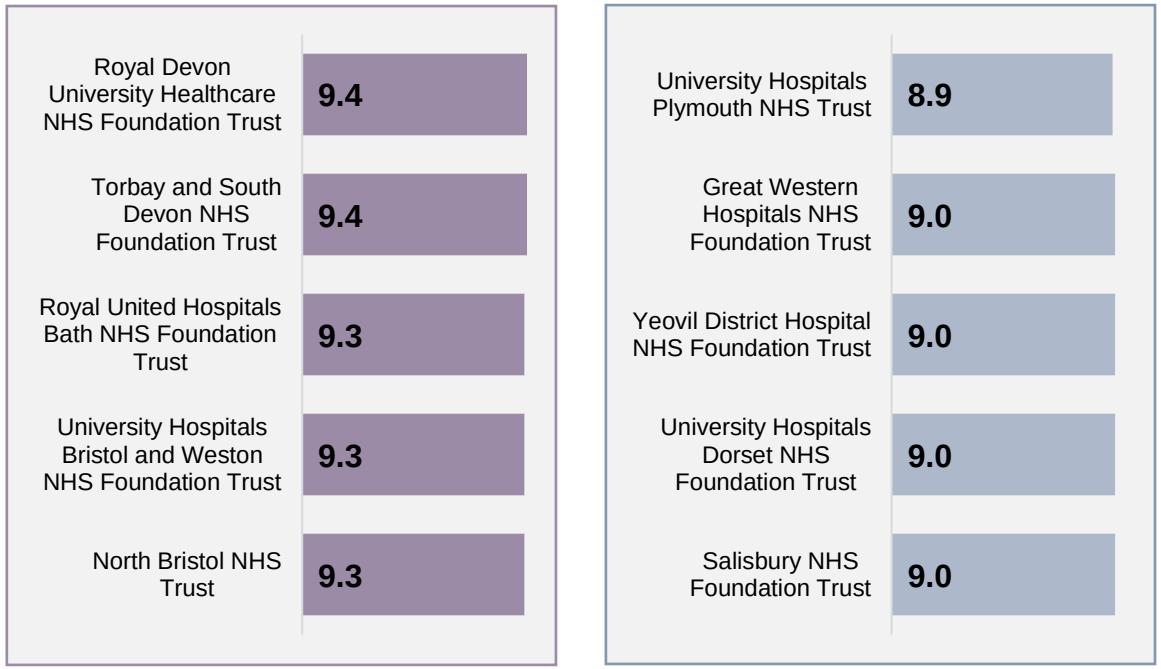
Section 9. Respect and dignity

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



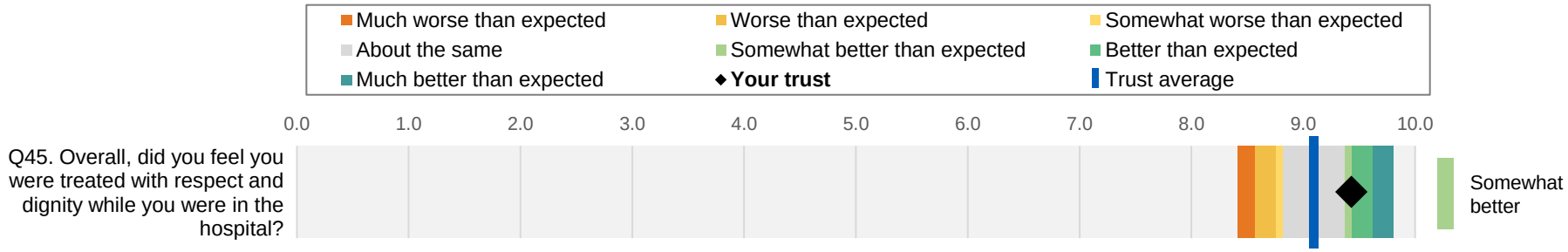
Comparison with other trusts within your region



Section 9. Respect and dignity (continued)

Question score

Trust score is not shown when there are fewer than 30 respondents.

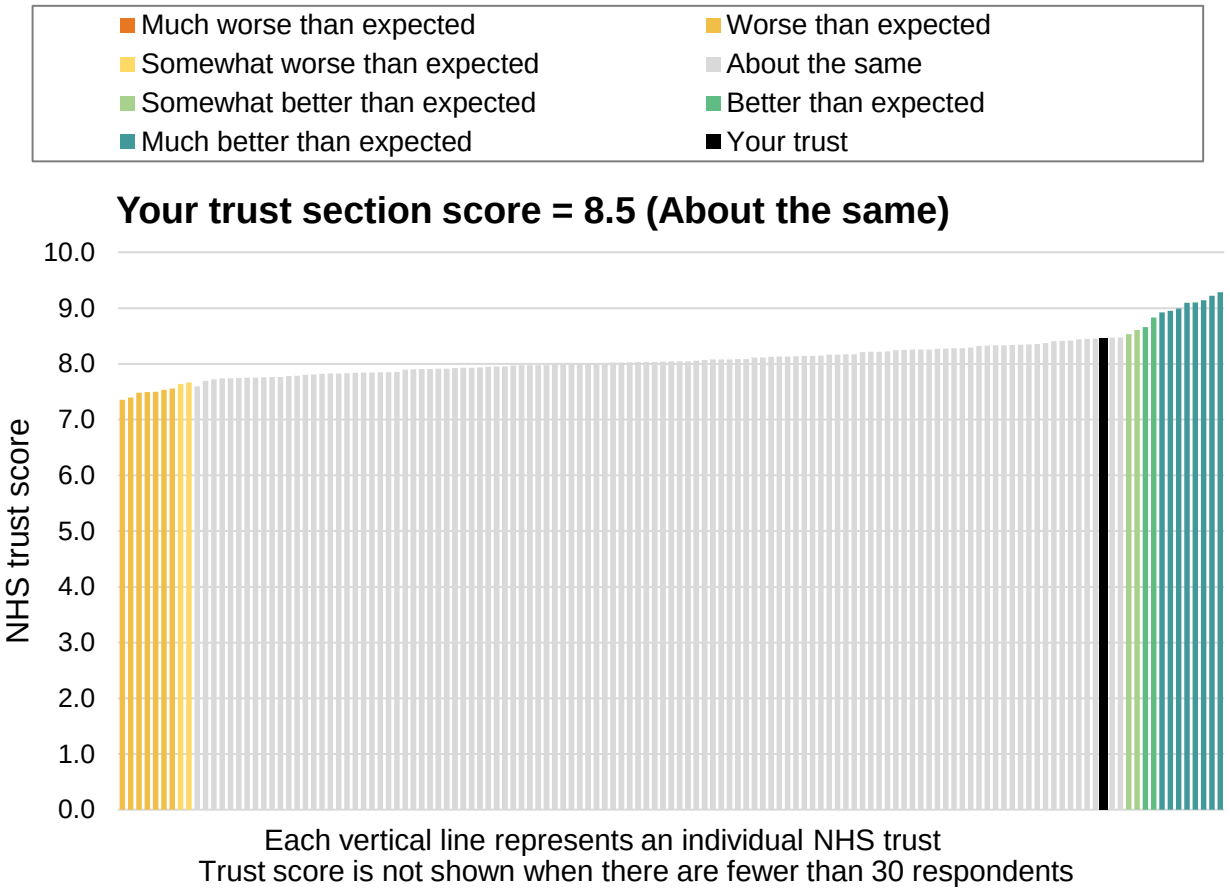


		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
587	9.4	9.1	8.4	9.8

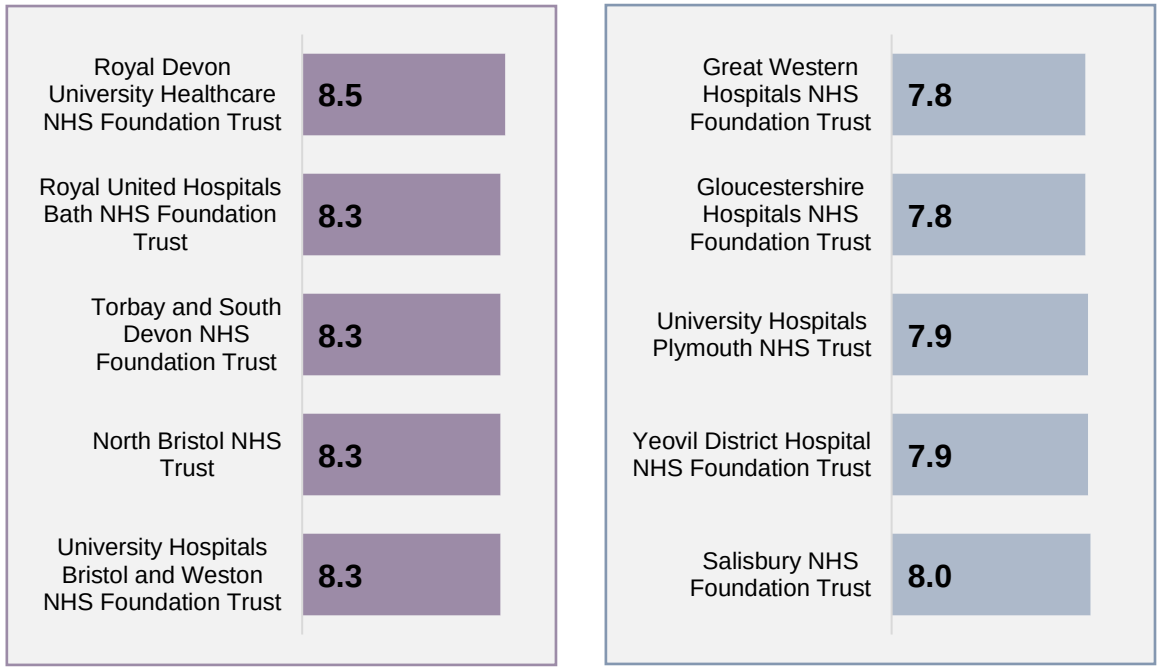
Section 10. Overall experience

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



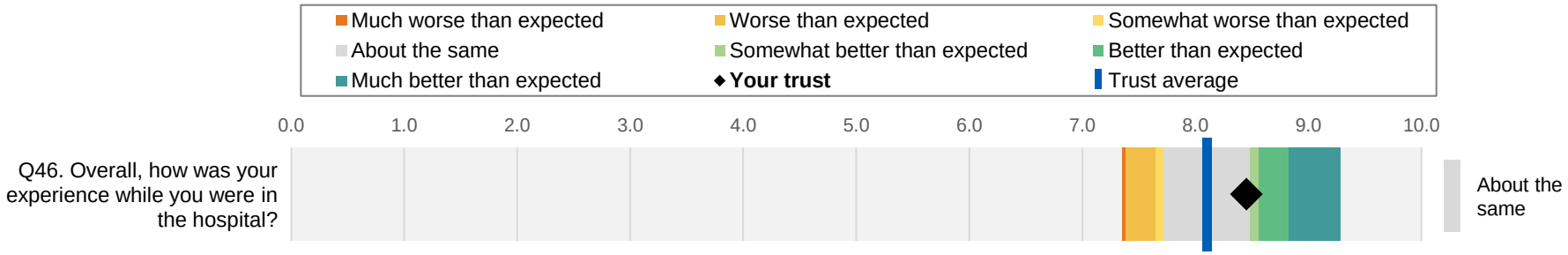
Comparison with other trusts within your region



Section 10. Overall experience (continued)

Question score

Trust score is not shown when there are fewer than 30 respondents.

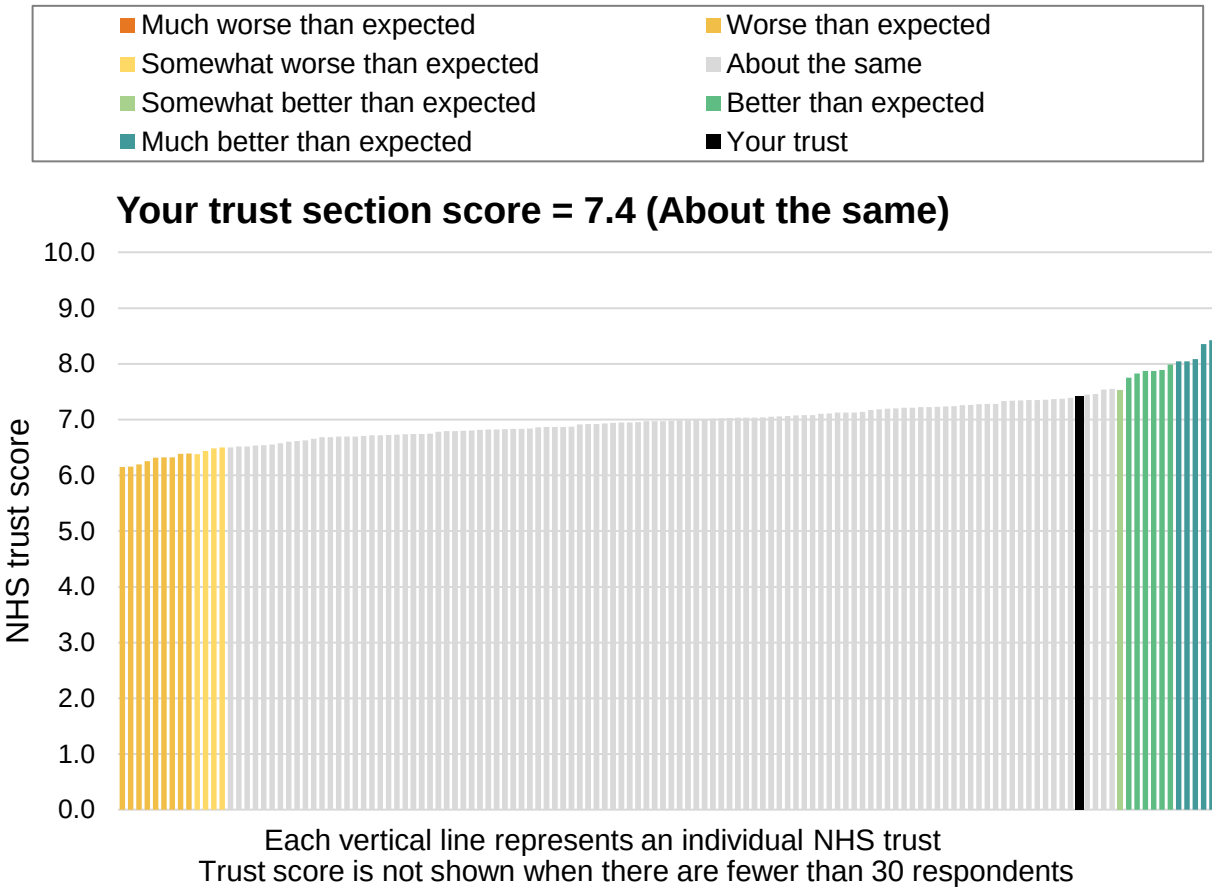


		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
584	8.5	8.1	7.4	9.3

Section 11. Long-term condition

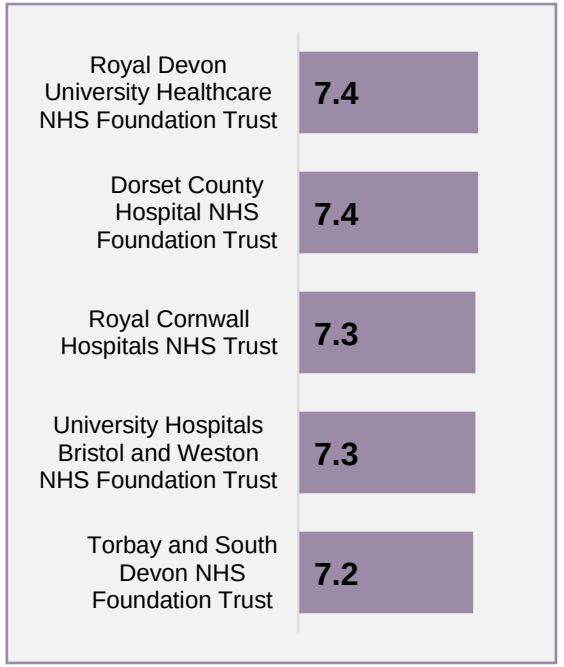
Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

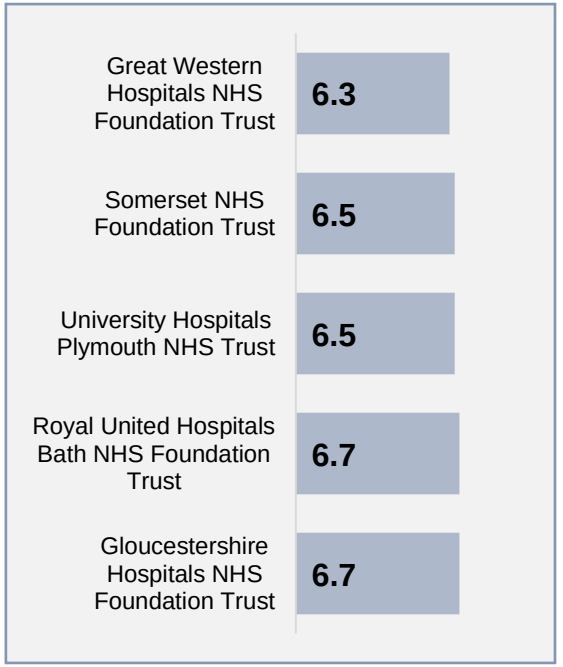


Comparison with other trusts within your region

Trusts with the highest scores



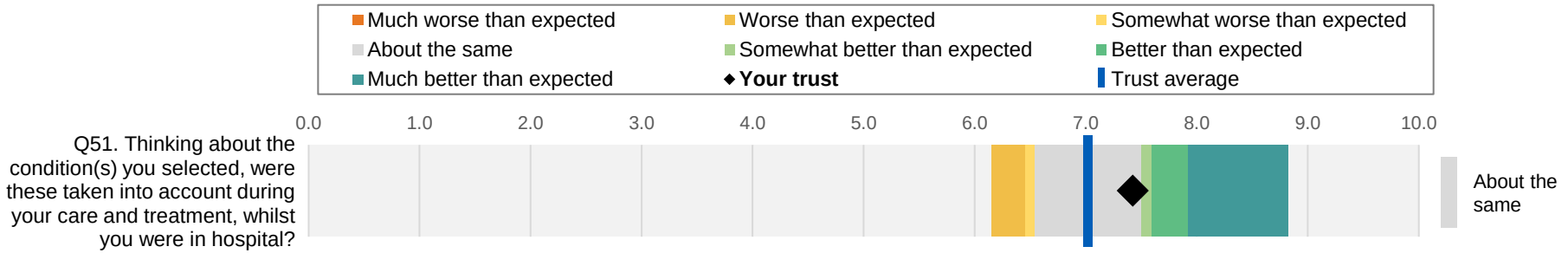
Trusts with the lowest scores



Section 11. Long term condition (continued)

Question score

Trust score is not shown when there are fewer than 30 respondents.



		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
387	7.4	7.0	6.2	8.8

Trust results

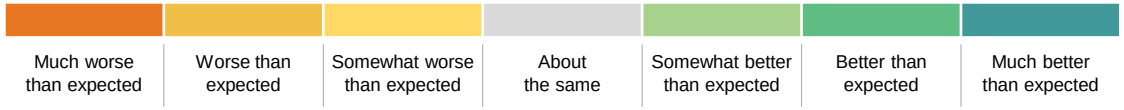
This section includes:

- an overview of results for your trust for each question, including:
  - the score for your trust
  - a breakdown of scores across sites within your trust
- if fewer than 30 responses were received from patients discharged from a site, no scores will be displayed for that site

Admission to hospital

Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?

Results for your trust

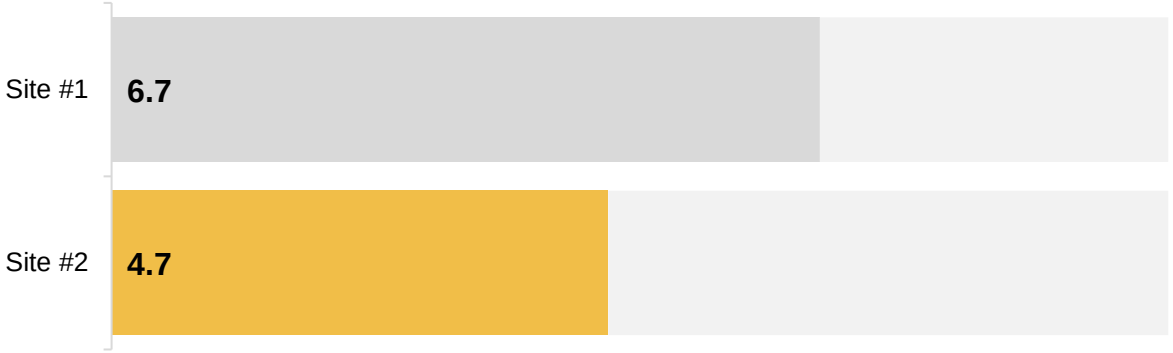


Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (142)

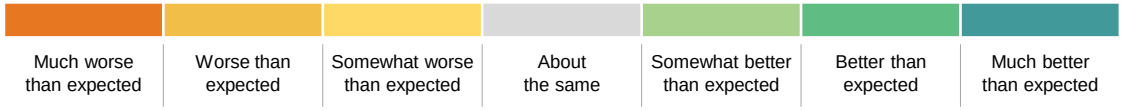
Site 2

NORTH DEVON DISTRICT HOSPITAL (38)

Admission to hospital

Q4. How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (413)

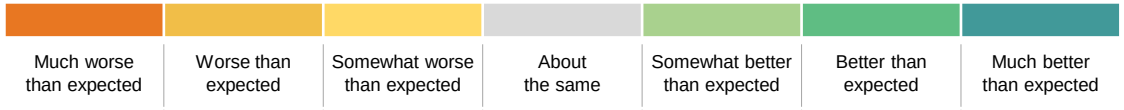
Site 2

NORTH DEVON DISTRICT HOSPITAL (131)

The hospital and ward

Q5. Were you ever prevented from sleeping at night by noise from other patients?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (391)

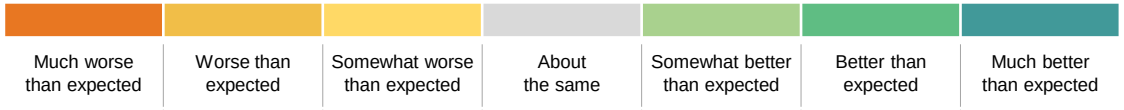
Site 2

NORTH DEVON DISTRICT HOSPITAL (118)

The hospital and ward

Q5. Were you ever prevented from sleeping at night by noise from staff?

Results for your trust



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Breakdown of scores for sites within your trust:

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Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (391)

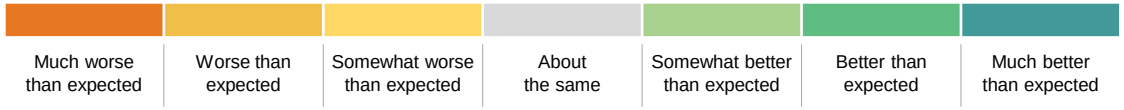
Site 2

NORTH DEVON DISTRICT HOSPITAL (118)

The hospital and ward

Q5. Were you ever prevented from sleeping at night by hospital lighting?

Results for your trust



Your trust score compared with all other trusts:

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Breakdown of scores for sites within your trust:

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Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (391)

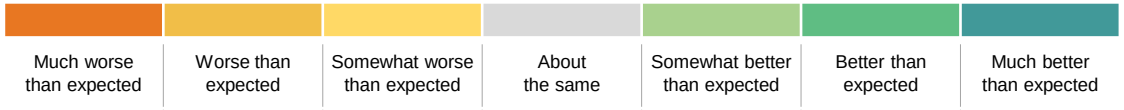
Site 2

NORTH DEVON DISTRICT HOSPITAL (118)

The hospital and ward

Q7. Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?

Results for your trust



Your trust score compared with all other trusts:

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Breakdown of scores for sites within your trust:

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Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (102)

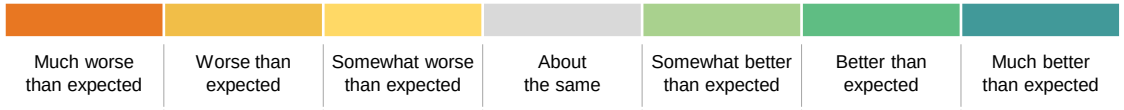
Site 2

NORTH DEVON DISTRICT HOSPITAL (32)

The hospital and ward

Q8. How clean was the hospital room or ward that you were in?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

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Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (424)

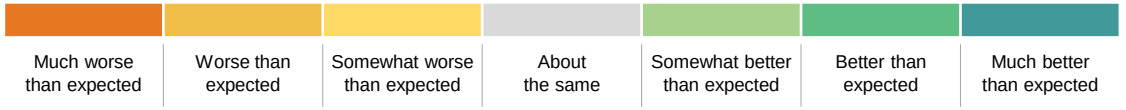
Site 2

NORTH DEVON DISTRICT HOSPITAL (137)

The hospital and ward

Q9. Did you get enough help from staff to wash or keep yourself clean?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

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Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (320)

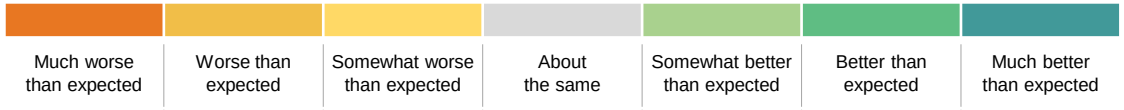
Site 2

NORTH DEVON DISTRICT HOSPITAL (107)

The hospital and ward

Q10. If you brought medication with you to hospital, were you able to take it when you needed to?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

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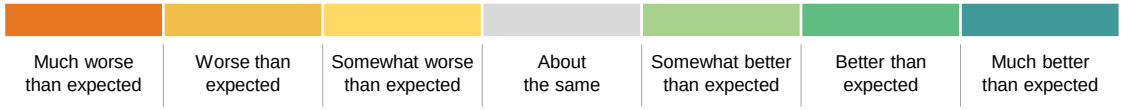
Site 1	Site 2
ROYAL DEVON & EXETER HOSPITAL (WONFORD) (243)	NORTH DEVON DISTRICT HOSPITAL (88)

The hospital and ward

Q11. Were you offered food that met any dietary needs or requirements you had?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

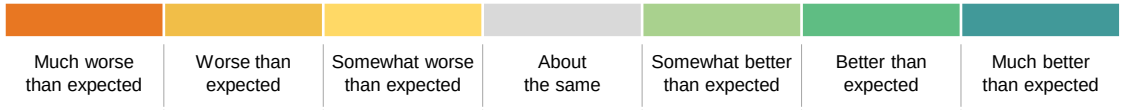
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1	Site 2
ROYAL DEVON & EXETER HOSPITAL (WONFORD) (221)	NORTH DEVON DISTRICT HOSPITAL (64)

The hospital and ward

Q12. How would you rate the hospital food?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (416)

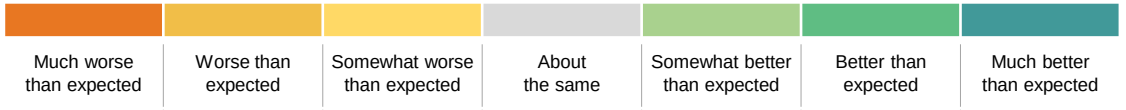
Site 2

NORTH DEVON DISTRICT HOSPITAL (134)

The hospital and ward

Q13. Did you get enough help from staff to eat your meals?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (99)

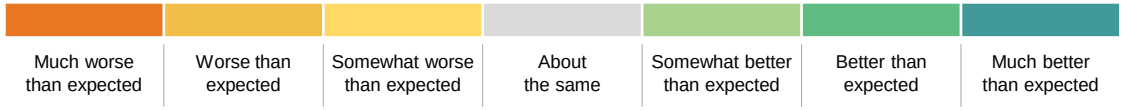
Site 2

NORTH DEVON DISTRICT HOSPITAL (37)

The hospital and ward

Q14. Were you able to get hospital food outside of set meal times?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (157)

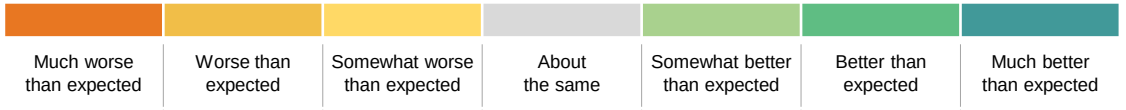
Site 2

NORTH DEVON DISTRICT HOSPITAL (58)

The hospital and ward

Q15. During your time in hospital, did you get enough to drink?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (406)

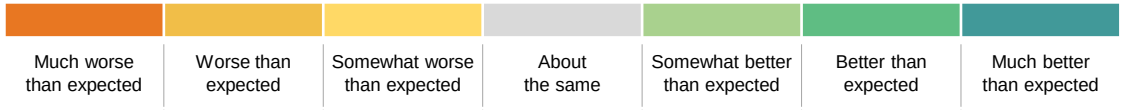
Site 2

NORTH DEVON DISTRICT HOSPITAL (127)

Doctors

Q16. When you asked doctors questions, did you get answers you could understand?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

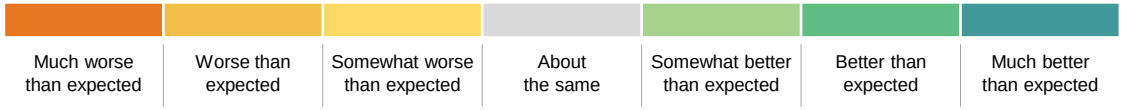
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1	Site 2
ROYAL DEVON & EXETER HOSPITAL (WONFORD) (396)	NORTH DEVON DISTRICT HOSPITAL (125)

Doctors

Q17. Did you have confidence and trust in the doctors treating you?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

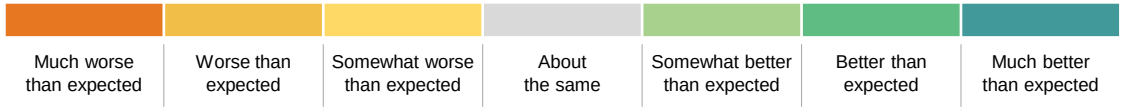
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1	Site 2
ROYAL DEVON & EXETER HOSPITAL (WONFORD) (431)	NORTH DEVON DISTRICT HOSPITAL (141)

Doctors

Q18. When doctors spoke about your care in front of you, were you included in the conversation?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (429)

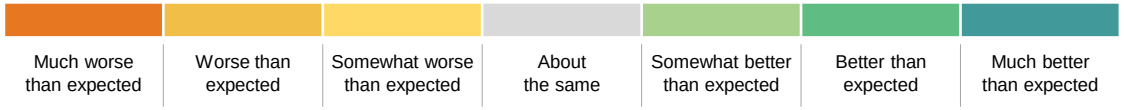
Site 2

NORTH DEVON DISTRICT HOSPITAL (141)

Nurses

Q19. When you asked nurses questions, did you get answers you could understand?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

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Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (401)

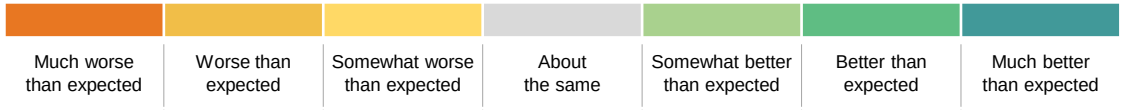
Site 2

NORTH DEVON DISTRICT HOSPITAL (129)

Nurses

Q20. Did you have confidence and trust in the nurses treating you?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (428)

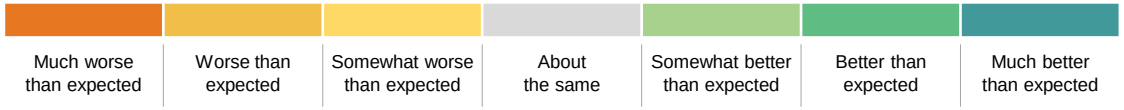
Site 2

NORTH DEVON DISTRICT HOSPITAL (143)

Nurses

Q21. When nurses spoke about your care in front of you, were you included in the conversation?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

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Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (427)

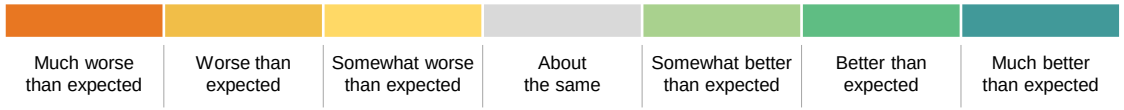
Site 2

NORTH DEVON DISTRICT HOSPITAL (142)

Nurses

Q22. In your opinion, were there enough nurses on duty to care for you in hospital?

Results for your trust



Your trust score compared with all other trusts:

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Breakdown of scores for sites within your trust:

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Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (430)

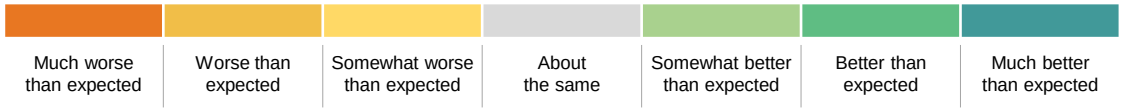
Site 2

NORTH DEVON DISTRICT HOSPITAL (142)

Your care and treatment

Q23. Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?

Results for your trust



Your trust score compared with all other trusts:

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Breakdown of scores for sites within your trust:

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Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (382)

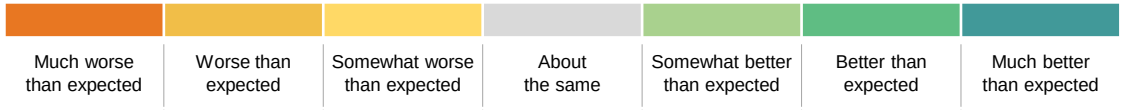
Site 2

NORTH DEVON DISTRICT HOSPITAL (122)

Your care and treatment

Q24. To what extent did staff looking after you involve you in decisions about your care and treatment?

Results for your trust



Your trust score compared with all other trusts:

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Breakdown of scores for sites within your trust:

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Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (404)

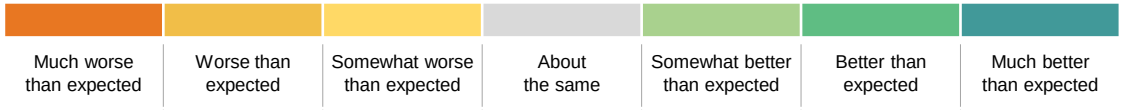
Site 2

NORTH DEVON DISTRICT HOSPITAL (133)

Your care and treatment

Q25. How much information about your condition or treatment was given to you?

Results for your trust



Your trust score compared with all other trusts:

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Breakdown of scores for sites within your trust:

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Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (420)

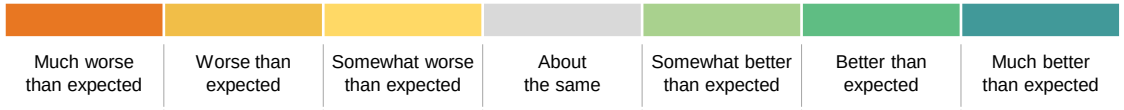
Site 2

NORTH DEVON DISTRICT HOSPITAL (137)

Your care and treatment

Q26. Did you feel able to talk to members of hospital staff about your worries and fears?

Results for your trust



Your trust score compared with all other trusts:

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Breakdown of scores for sites within your trust:

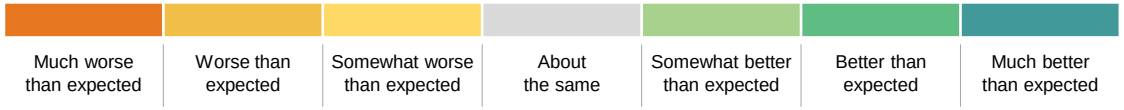
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1	Site 2
ROYAL DEVON & EXETER HOSPITAL (WONFORD) (357)	NORTH DEVON DISTRICT HOSPITAL (117)

Your care and treatment

Q27. Were you given enough privacy when being examined or treated?

Results for your trust



Your trust score compared with all other trusts:

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Breakdown of scores for sites within your trust:

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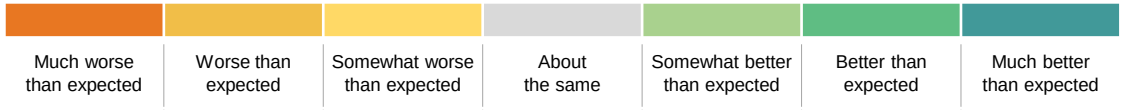
Site 1	Site 2
ROYAL DEVON & EXETER HOSPITAL (WONFORD) (425)	NORTH DEVON DISTRICT HOSPITAL (138)

Your care and treatment

Q28. Do you think the hospital staff did everything they could to help control your pain?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

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Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (343)

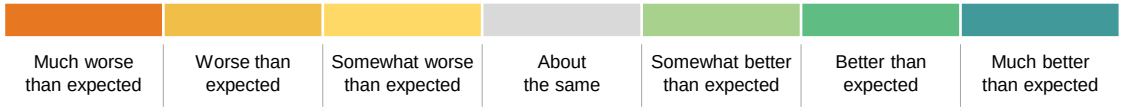
Site 2

NORTH DEVON DISTRICT HOSPITAL (120)

Your care and treatment

Q29. Were you able to get a member of staff to help you when you needed attention?

Results for your trust



Your trust score compared with all other trusts:

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Breakdown of scores for sites within your trust:

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Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (382)

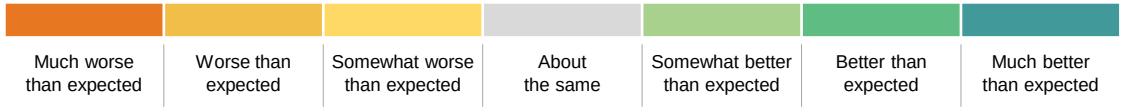
Site 2

NORTH DEVON DISTRICT HOSPITAL (133)

Operations and procedures

Q31. Beforehand, how well did hospital staff answer your questions about the operations or procedures?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

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Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (227)

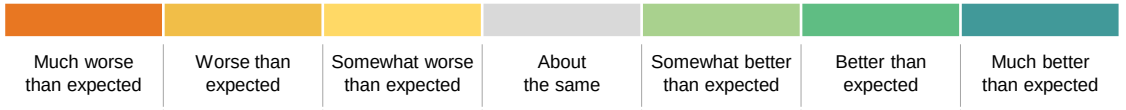
Site 2

NORTH DEVON DISTRICT HOSPITAL (64)

Operations and procedures

Q32. After the operations or procedures, how well did hospital staff explain how the operation or procedure had gone?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

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Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (240)

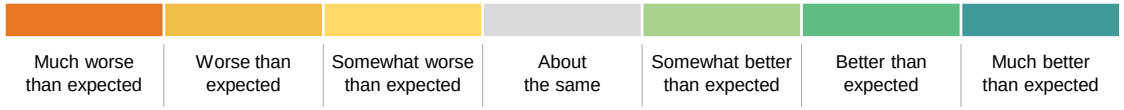
Site 2

NORTH DEVON DISTRICT HOSPITAL (70)

Leaving hospital

Q33. To what extent did staff involve you in decisions about you leaving hospital?

Results for your trust



Your trust score compared with all other trusts:

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Breakdown of scores for sites within your trust:

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Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (419)

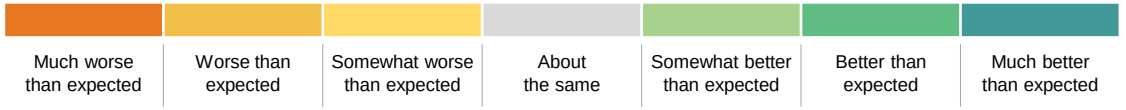
Site 2

NORTH DEVON DISTRICT HOSPITAL (140)

Leaving hospital

Q34. To what extent did hospital staff involve your family or carers in discussions about you leaving hospital?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (279)

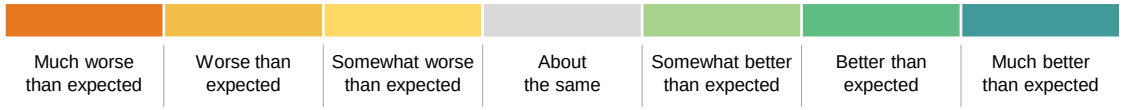
Site 2

NORTH DEVON DISTRICT HOSPITAL (101)

Leaving hospital

Q35. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (161)

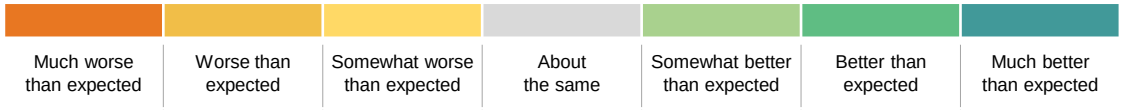
Site 2

NORTH DEVON DISTRICT HOSPITAL (63)

Leaving hospital

Q36. Were you given enough notice about when you were going to leave hospital?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (431)

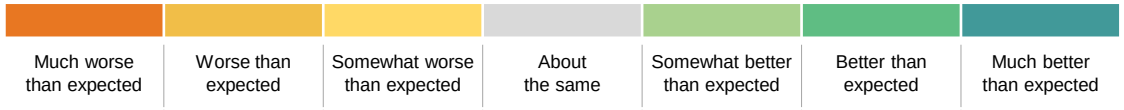
Site 2

NORTH DEVON DISTRICT HOSPITAL (144)

Leaving hospital

Q37. Before you left hospital, were you given any information about what you should or should not do after leaving hospital?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (403)

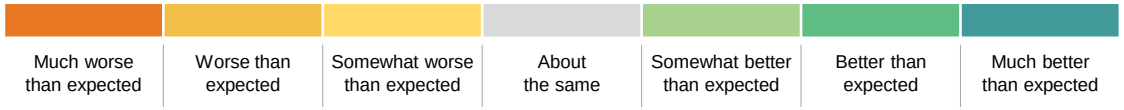
Site 2

NORTH DEVON DISTRICT HOSPITAL (127)

Leaving hospital

Q38. To what extent did you understand the information you were given about what you should or should not do after leaving hospital?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (314)

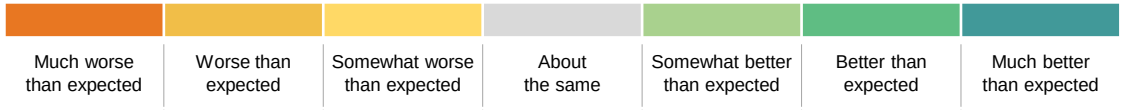
Site 2

NORTH DEVON DISTRICT HOSPITAL (92)

Leaving hospital

Q39. Thinking about any medicine you were to take at home, were you given any of the following?

Results for your trust

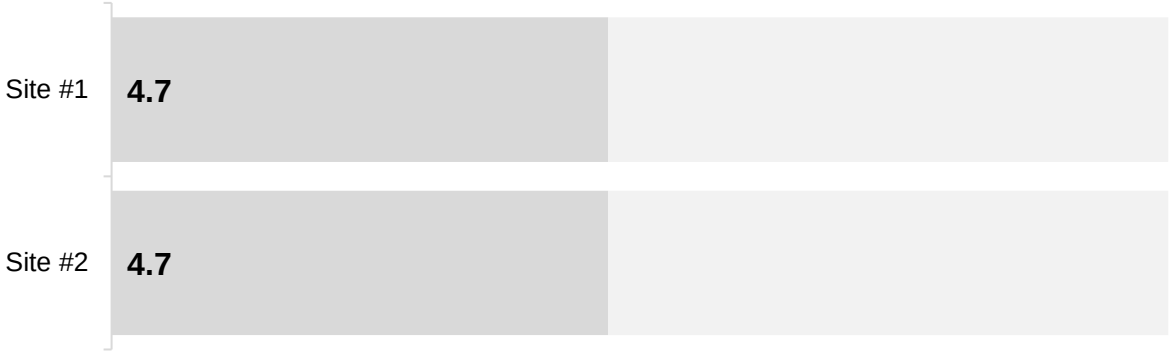


Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (312)

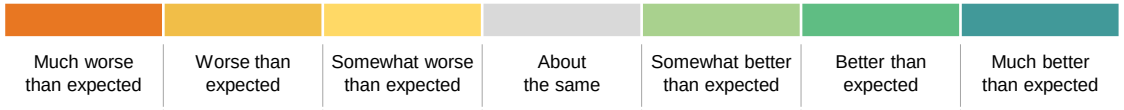
Site 2

NORTH DEVON DISTRICT HOSPITAL (114)

Leaving hospital

Q40. Before you left hospital, did you know what would happen next with your care?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (369)

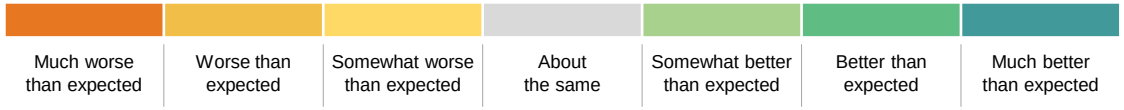
Site 2

NORTH DEVON DISTRICT HOSPITAL (121)

Leaving hospital

Q41. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (380)

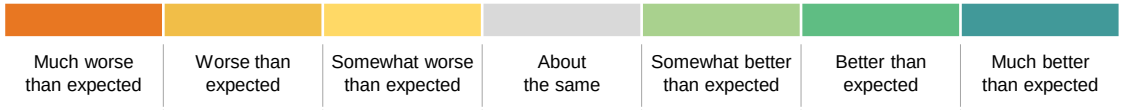
Site 2

NORTH DEVON DISTRICT HOSPITAL (130)

Leaving hospital

Q42. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (227)

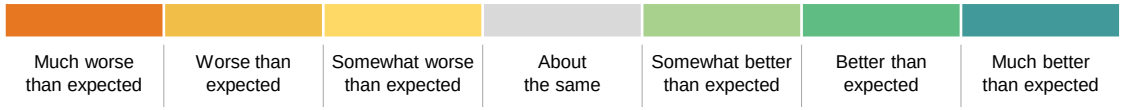
Site 2

NORTH DEVON DISTRICT HOSPITAL (81)

Leaving hospital

Q44. After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (222)

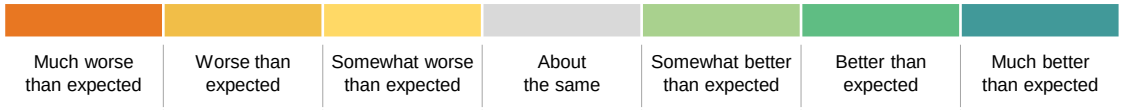
Site 2

NORTH DEVON DISTRICT HOSPITAL (79)

Feedback on care

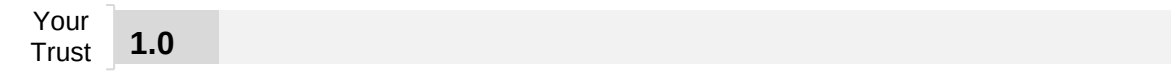
Q47. During your hospital stay, were you ever asked to give your views on the quality of your care?

Results for your trust



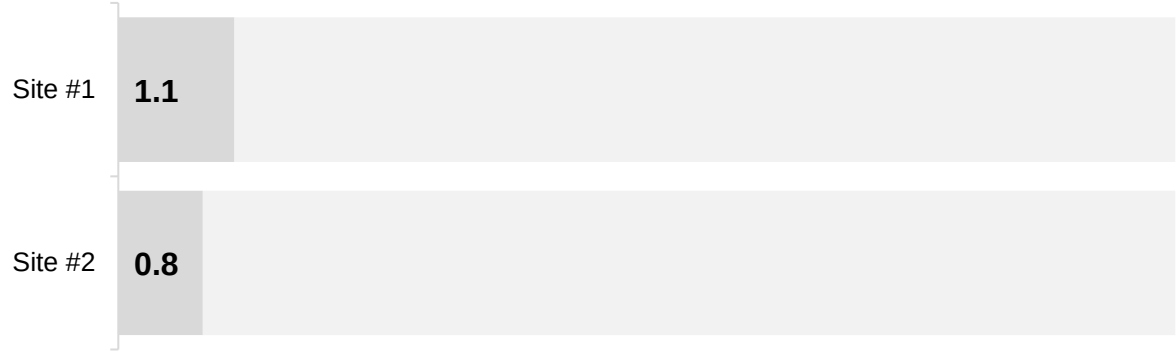
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (376)

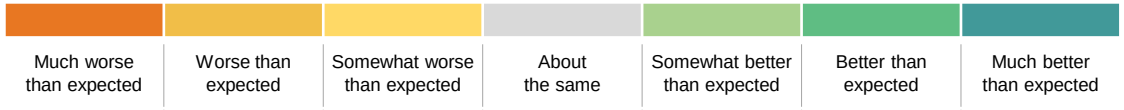
Site 2

NORTH DEVON DISTRICT HOSPITAL (123)

Respect and dignity

Q45. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (431)

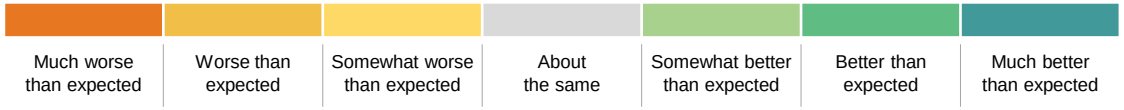
Site 2

NORTH DEVON DISTRICT HOSPITAL (143)

Overall experience

Q46. Overall, how was your experience while you were in the hospital?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

ROYAL DEVON & EXETER HOSPITAL (WONFORD) (428)

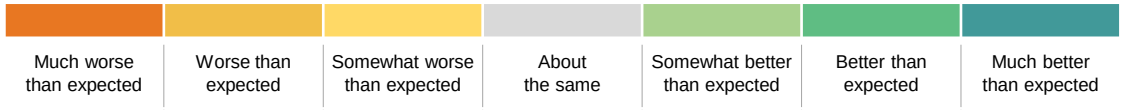
Site 2

NORTH DEVON DISTRICT HOSPITAL (143)

Long term condition

Q51. Thinking about the condition(s) you selected, were these taken into account during your care and treatment, whilst you were in hospital?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1	Site 2
ROYAL DEVON & EXETER HOSPITAL (WONFORD) (287)	NORTH DEVON DISTRICT HOSPITAL (92)

Trends over time

This section is not available for your trust.

Data for trusts which have undergone significant restructuring (i.e. mergers and closures) should not be compared with previous survey results.

For further information

Please contact the Coordination Centre for Mixed Methods:
InpatientCoordination@ipsos.com

Appendix

Comparison to other trusts

The questions at which your trust has performed much worse or worse compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much worse than expected	Worse than expected
• Your trust has not performed “much worse than expected” for any questions.	• Your trust has not performed “worse than expected” for any questions.

Comparison to other trusts

The questions at which your trust has performed somewhat worse or somewhat better compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat worse than expected	Somewhat better than expected
• Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?	• Q17. Did you have confidence and trust in the doctors treating you? • Q32. After the operations or procedures, how well did hospital staff explain how the operation or procedure had gone? • Q45. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Comparison to other trusts

The questions at which your trust has performed better or much better compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Better than expected	Much better than expected
• Q11. Were you offered food that met any dietary needs or requirements you had?	• Your trust has not performed “much better than expected” for any questions.

NHS Adult Inpatient Survey 2022

Results for Royal Devon University Healthcare NHS Foundation Trust

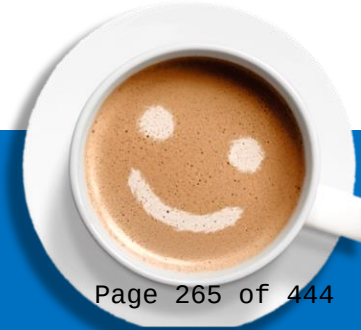
Where patient experience is best

- ✓ Food outside set meal times: patients being able to get hospital food outside of set meal times, if needed
- ✓ Help with eating: patients being given enough help from staff to eat meals, if needed
- ✓ Dietary needs or requirements: patients being offered food that met any dietary needs or requirements they had
- ✓ After the operation or procedure: patients being given an explanation from staff of how their operation or procedure went
- ✓ Changing wards during the night: staff explaining the reason for patients needing to change wards during the night

Where patient experience could improve

- Waiting to be admitted: patients feeling that they waited the right amount of time on the waiting list before being admitted to hospital
- Noise from other patients: patients not being bothered by noise at night from other patients
- Feedback on care: patients being asked to give their views on the quality of their care
- Further health or social care services: patients being given information about further health or social care services they may need after leaving hospital
- Support from health or social care services: patients being given enough support from health or social care services to help them recover or manage their condition after leaving hospital

These topics are calculated by comparing your trust's results to the average of all trusts. "Where patient experience is best": These are the five results for your trust that are highest compared with the average of all trusts. "Where patient experience could improve": These are the five results for your trust that are lowest compared with the average of all trusts.



This survey looked at the experiences of people who were discharged from an NHS acute hospital in November 2022. Between January 2023 and April 2023, a questionnaire was sent to 1250 inpatients at Royal Devon University Healthcare NHS Foundation Trust who had attended in late 2022. Responses were received from 591 patients at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

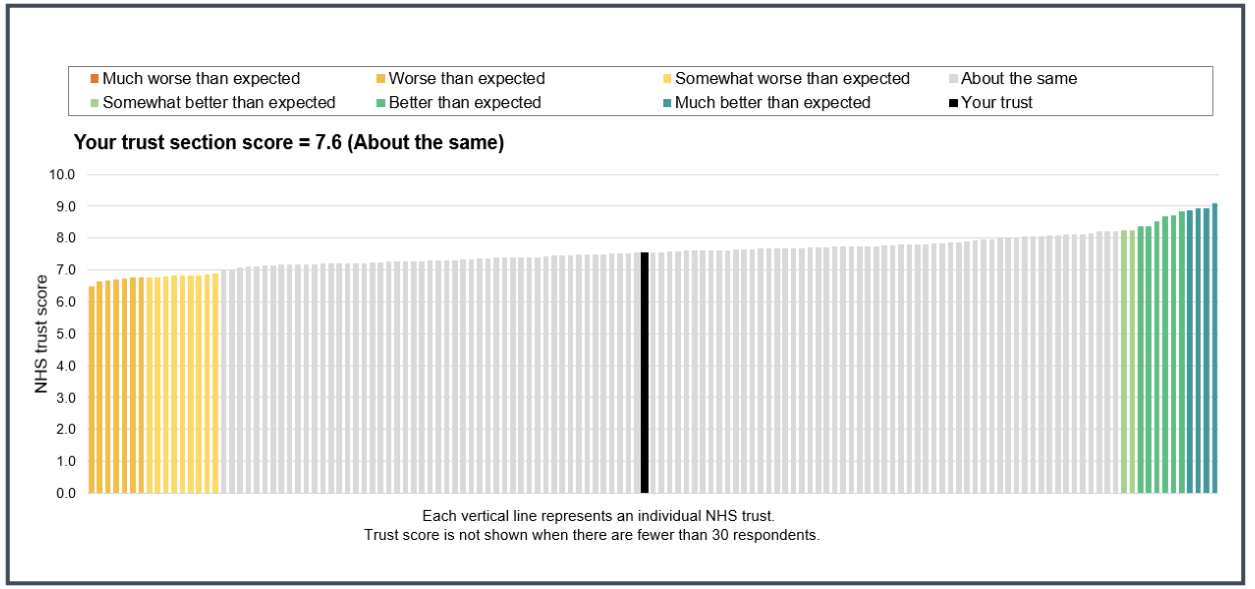
How to interpret benchmarking in this report

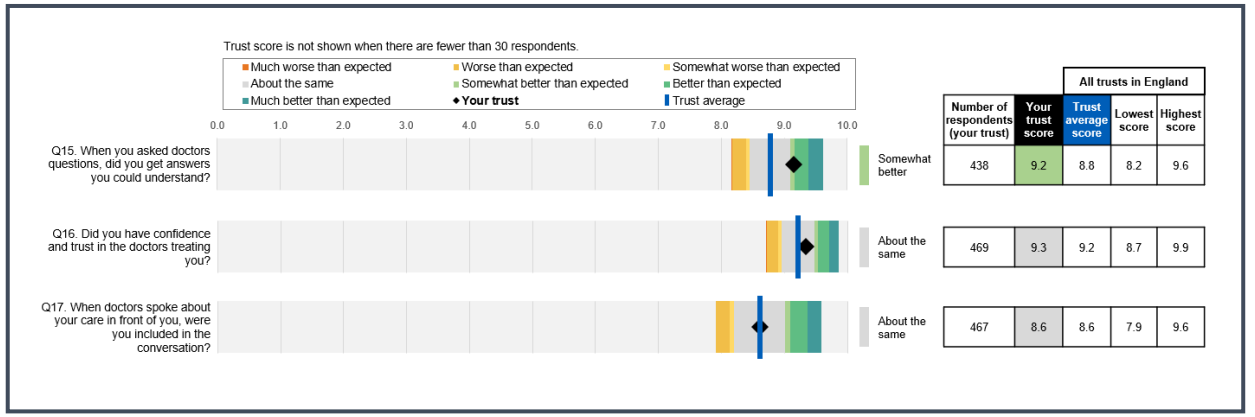
Trust level benchmarking

The charts in the 'benchmarking' section show how the score for your trust compares to the range of scores achieved by all trusts taking part in the survey. The black line shows the score for your trust. The graphs are divided into seven sections, comparing the score for your trust to most other trusts in the survey:

- If your trust's score lies in the **dark green section** of the graph, its result is 'Much better than expected'.
- If your trust's score lies in the **mid-green section** of the graph, its result is 'Better than expected'.
- If your trust's score lies in the **light green section** of the graph, its result is 'Somewhat better than expected'.
- If your trust's score lies in the **grey section** of the graph, its result is 'About the same'.
- If your trust's score lies in the **yellow section** of the graph, its result is 'Somewhat worse than expected'.
- If your trust's score lies in the **light orange** section of the graph, its result is 'Worse than expected'.
- If your trust's score lies in the **dark orange** section of the graph, its result is 'Much worse than expected'.

These groupings are based on a rigorous statistical analysis of the data termed the 'expected range' technique.





How to interpret benchmarking in this report (continued)

Trust level benchmarking

The ‘much better than expected,’ ‘better than expected’, ‘somewhat better than expected’, ‘about the same’, ‘somewhat worse than expected’, ‘worse than expected’ and ‘much worse than expected’ categories are based on an analysis technique called the ‘expected range’. Expected range determines the range within which a trust’s score could fall without differing significantly from the average, taking into account the number of respondents for each trust, to indicate whether the trust has performed significantly above or below what would be expected.

If it is within this expected range, we say that the trust’s performance is ‘about the same’ as other trusts. Where a trust is identified as performing ‘better’ or ‘worse’ than the majority of other trusts, the result is unlikely to have occurred by chance.

The question score charts show the trust scores compared to the minimum and maximum scores achieved by any trust. In some cases this minimum or maximum limit will mean that one or more of the bands are not visible – because the range of other bands is broad enough to include the highest or lowest score achieved by a trust this year. This could be because there were few respondents, meaning the confidence intervals around your data are slightly larger, or because there was limited variation between trusts for this question this year.

In some cases, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust. This occurs as the bandings are calculated through standard error rather than standard deviation. Standard error takes into account the number of responses achieved by a trust, and therefore the banding may differ for a trust with a low numbers of responses.

Site level benchmarking

The charts in the ‘trust results’ section present site level benchmarking. This allows you to compare the results for sites within your trust with all other sites across trusts. It is important to note that there may be differences between the average score of the sites provided and the overall score for the trust. This may be related to the size of the sites, results for suppressed sites or weighting, as sites and trusts are weighted separately. In addition, if a single site result is presented for a trust, the ‘expected range’ category may differ: although the score achieved will be the same for both the site and for the trust, the upper and lower boundary levels will differ between the two due to them being calculated differently in each case.

If fewer than 30 responses were received from patients discharged from a site, no scores will be displayed for that site.

Additional information on the ‘expected range’ analysis technique can be found in the survey technical report on the NHS Surveys website.

An example of scoring

Each evaluative question is scored on a scale from 0 to 10. The scores represent the extent to which the patient's experience could be improved. A score of 0 is assigned to all responses that reflect considerable scope for improvement, whereas a score of 10 refers to the most positive patient experience possible. Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. Where options were provided that did not have any bearing on the trust's performance in terms of patient experience, the responses are classified as "not applicable" and a score is not given. Similarly, where respondents stated they could not remember or did not know the answer to a question, a score is not given.

Calculating an individual respondent's score

The following provides an example for the scoring system applied for each respondent. For question 15 "When you asked doctors questions, did you get answers you could understand":

- The answer code "Yes, always" would be given a score of 10, as this refers to the most positive patient experience possible.
- The answer code "Sometimes" would be given a score of 5, as it is placed at an equal interval along the scale.
- The answer code "No, never" would be given a score of 0, as this response reflects considerable scope for improvement.
- The answer codes "I did not have any questions" and "I did not feel able to ask questions" would not be scored, as they do not have a clear bearing on the trust's performance in terms of patient experience.

Calculating the trust score for each question

The weighted mean score for each trust, for each question, is calculated by dividing the sum of the weighted scores for a question by the weighted sum of all eligible respondents to the question for each trust. An example of this is provided in the survey technical document.

Calculating the section score

An arithmetic mean of each trust's question scores is taken to provide a score for each section.

Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	12.1b, Public Board Meeting	Date: 1 November 2023
Title:	Care Quality Commission – 2022 National NHS Urgent and Emergency Care Survey	
Prepared by:	Will Denford, Executive Support Officer Andrea Bell, Deputy Director of Nursing (Patient Experience)	
Presented by:	Carolyn Mills, Chief Nursing Officer	
Responsible Executive:	Carolyn Mills, Chief Nursing Officer	
Summary:	The 2022 National NHS Urgent and Emergency Care (UEC) Survey, commissioned by the Care Quality Commission, collects national feedback on the experiences of adults using Emergency Departments (Type 1 services) and Urgent Treatment Services (Type 3 services). The 2022 UEC survey, formally published in August 2023, is the first time the Royal Devon was surveyed as a single organisation with no disaggregation of data provided.	
Actions required:	The Board is asked to note the content of the 2022 National NHS Urgent and Emergency Care Survey paper.	

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

History:	The full UEC survey and analysis were presented, discussed and reviewed at the Patient Experience Committee on 16 August 2023.
Link to strategy/ Assurance framework:	The issues discussed are key to the Trust achieving its strategic objectives; **BAF Risk 8** – *Risk of a significant deterioration in quality and safety of care* **BAF Risk 10** – *UEC targets are not delivered*

Monitoring Information

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

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

1. Purpose of paper

1.1 The purpose of this paper is to present to the Board of Directors the summary of the Royal Devon University Healthcare (RDUH) Care Quality Commission 2022 National NHS Urgent and Emergency Care (UEC) survey.

1.2 The 2022 survey summarises the results for our Northern and Eastern Emergency Departments (Type 1 services) and the Minor Injuries Unit at Honiton (Type 3 services).

1.3 The results of the 2022 UEC survey need to be considered in the context of the IPR and other reports that the Board and the Board sub-committee for patient experience receives related to patient feedback, patient engagement & patient experience to support further triangulation.

2. Background

2.1 The NHS Patient Survey Programme (NPSP), commissioned by the Care Quality Commission (CQC) collects national patient feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

2.2 As part of the NPSP, the Urgent & Emergency Care survey's first iteration was in 2003, and since 2012 it has been a biannual survey across all eligible NHS organisations in England.

2.3 The 2022 UEC survey, formally published by the CQC in August 2023, was the first time the Trust was surveyed as a single organisation post-integration with no disaggregation of data by site.

2.4 Please refer to Appendix 1 for full survey on Type 1 services and Appendix 2 for full survey on Type 3 services.

3. 2022 CQC Urgent and Emergency Care survey – Type 1 services

3.1 In total, 295 patients who attended the Trust's Emergency Departments (ED) responded to the survey, with a response rate of 32%, compared to the national average of 23%.

3.2 RDUH performed well on Type 1 services with an average score of 7.9 out of 10; not scoring lower than the national average in any metric and scoring better than the national average for 13 metrics.

3.3 While the Trust's average score is down by 4.8% from 2020, the survey results do showcase areas of positive improvement within our Emergency Departments.

The survey highlighted that patients rated the Trust highly in the following areas:

- Waiting: *Patients being informed of how long the wait to be examined will be*
- Staff responsiveness: *Patient being able to get help from staff if they needed attention*
- Information sharing: *Health or social care staff having information about patients' visit to ED*

- Symptoms: *Staff telling patients what symptoms of their illness to watch out for when they are home*
- Medication: *Staff members explaining purpose of medications in a way the patient can understand*

3.4 The survey also highlighted the following areas in which patient experience could improve:

- Privacy: *Patients being given enough privacy when discussing their condition with receptionists*
- Communication needs: *Staff helping patients with any communication needs they have*
- Family involvement: *Family members, friends or carers having enough opportunity to talk to health professionals*
- Transport when leaving A&E: *Staff discussing patients' transport arrangements before they leave ED*
- Length of visit: *Length of patients' ED visit*

4. 2022 CQC Urgent and Emergency Care survey – Type 3 services

4.1 In total, 225 patients who attended the Trust's Minor Injuries Unit at Honiton (referenced as urgent treatment centre (UTC) in the survey) responded to the survey, with a response rate of 39%, compared to the national average of 22%.

4.2 RDUH performed very well with an average score of 8.7 out of 10; not scoring lower than the national average on any metrics and scoring better than the national average for 9 metrics.

4.3 Though in line with the national average, the average score for questions regarding the Trust's Minor Injuries Unit is down by 2.1% since 2020, with these results also showing a similar decline in scores around waiting times.

4.4 The survey highlighted that patients rated the Trust highly in the following areas:

- Waiting: *Patients being informed on how long wait to be examined will be*
- Transport when leaving urgent treatment centre: *Staff discussing patients' transport arrangements before they leave the UTC*
- Length of visit: *Length of patients' urgent treatment centre visit*
- Information: *Staff giving patients enough information to help them care for their condition at home*
- Information sharing: *Health or social care staff having information about patients' visit to the UTC*

4.5 The survey also highlighted the following areas in which patient experience could improve:

- Food and drink: *Availability of suitable food or drink*
- Waiting: *Length of wait before patients first speak to a health professional*
- Communication needs: *Staff helping patients with any communication needs they have*

- Pain management: *Staff doing everything they can to help control patients' pain*
- Confidence and trust: *Patients having confidence and trust in health professionals treating them*

5. Learning from 2022 UEC survey results

5.1 The 2022 UEC survey identifies that waiting times within both types of services remains a real concern for patients, yet matches the national picture. The Trust has an extensive Urgent and Emergency Care programme within which waiting times and flow through emergency settings are monitored, with work ongoing both locally and nationally to improve. However, any new improvements identified as part of this survey will be integrated within these programmes of work.

5.2 Discharge processes form part of our existing Discharge and Flow programme and the findings from this survey will be fed back through this route by the Northern and Eastern Associate Directors of Nursing.

5.3 The survey also notes further work is required to improve our approach to pain control for patients attending our UEC settings. This is being monitored through specialty governance routes across both Northern and Eastern sites.

5.4 It is also important to recognise the significant operational challenges the Trust has faced over the last 12 months and to both celebrate and recognise the positive achievements detailed in this report:

- Patients felt listened to and communicated with
- Patients felt involved in decisions
- Patients felt safe in our care
- Patients had confidence in our staff and felt supported
- Patients felt respected and treated with dignity

5.5 The Patient Experience Operational Group, overseen by the Patient Experience Committee, will focus in on the themes raised from the survey (3.4 & 4.5) and will develop a plan to improve in these areas for any items identified that are not already included within pre-existing patient experience workplans, by November 2023.

6. Resource/legal/financial/reputation implications

6.1 Nil

7. Link to BAF/Key risks

7.1 No links to BAF or risks have been identified.

8. Proposals

8.1 The Board of Directors is asked to **note** the Royal Devon University Healthcare 2022 National NHS Urgent and Emergency Care Survey.

2022 Urgent and Emergency Care Survey Benchmark Report for A&E Departments (Type 1 services)

Royal Devon University Healthcare NHS Foundation Trust

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6. Appendix

- Comparison to other trusts
- Trust results poster
- How to interpret benchmarking in this report
- How to interpret change over time in this report
- An example of scoring

This work was carried out in accordance with the requirements of the international standard for organisations conducting social research (accreditation to ISO27001:2013; certificate number GB10/80275).

Background and methodology

This section includes:

- an explanation of the NHS Patient Survey Programme
- information on the Urgent and Emergency Care Survey
- a description of key terms used in this report
- navigating the report

Background and methodology

The NHS Patient Survey Programme

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

The NPSP is commissioned by the Care Quality Commission (CQC); the independent regulator of health and adult social care in England.

As part of the NPSP, the Urgent & Emergency Care (UEC) Survey first iteration was in 2003, and since 2012 it has been a biannual survey. To find out more about the survey programme and to see the results from previous surveys, please refer to the section on further information on this page.

Urgent and Emergency Care Survey

The survey was administered by the Survey Coordination Centre for Existing Methods (SCCEM) at Picker Institute.

The 2022 survey of people who used UEC services involved 122 NHS trusts with A&E departments (Type 1 service). Fifty-nine of these trusts had direct responsibility for running an Urgent Treatment Centre, Urgent Care Centre or Minor Injuries Unit (Type 3 service) and will therefore also receive benchmarked results for their Type 3 services. Two separate questionnaires were used, one for Type 1 services and one for Type 3 services. To access the questionnaires please see the 'Further Information about the survey' section below.

Responses were received from 29,357 people who attended a Type 1 department, this is a response rate of 22.6%.

Patients were eligible for the survey if they were aged 16 years or older and had attended UEC services during September 2022. Full sampling criteria can be found in the sampling instructions manual (see 'Further Information about the survey' section).

Trusts responsible for Type 1 departments only created a random sample of 1,250 patients. Trusts that also directly run Type 3 departments sampled 950 patients from Type 1 departments and 580 patients from Type 3 departments totalling 1,530 patients. Questionnaires and reminders were sent to patients between November 2022 and March 2023.

Trend data

The Urgent & Emergency Care Survey is comparable back to the 2016 survey. Redevelopment work carried out ahead of the 2016 survey means that the results for 2022 are only comparable with 2020, 2018 and 2016 and not with earlier surveys. Trend data is presented in this report for questions that have been asked in previous survey years.

This report is for Type 1 accident and emergency (A&E) departments only.

Further information about the survey

- For published results and for more information on the Urgent & Emergency Care Survey please visit the UEC page on the NHS Surveys website.
- For published results for other surveys in the NPSP, and for information to help trusts implement the surveys across the NPSP, please visit the NHS Surveys website.
- To learn more about the CQC's survey programme, please visit the CQC website.

Key terms used in this report

The ‘expected range’ technique

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts. This is designed to help understand the performance of individual trusts and identify areas for improvement. More information can be found in the Appendix.

Standardisation

Demographic characteristics, such as age and sex, can influence patients’ experience of care and the way they report it. For example, research shows that older people report more positive experiences of care than younger people. Since trusts have differing profiles of patients, this could make fair trust comparisons difficult. To account for this, we ‘standardise’ the results, which means we apply a weight to individual patient responses to account for differences in demographic profile between trusts. For each trust, results have been standardised by the age and sex of respondents to reflect the ‘national’ age-sex type distribution (based on all respondents to the survey).

This helps ensure that no trust will appear better or worse than another because of its profile, and enables a fairer and more useful comparison of results across trusts. In most cases this standardisation will not have a large impact on trust results.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale of 0 to 10. A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the trust is performing. Only evaluative questions in the questionnaire are scored. Some questions are descriptive (for example Q1) and others are ‘routing questions’, which are designed to filter out respondents to whom the following questions do not apply (for example Q19). These questions are not scored. Section scoring is computed as the arithmetic mean of question scores for the section after weighting is applied.

National average

The ‘national average’ mentioned in this report is the arithmetic mean of all trusts’ scores after weighting is applied.

Suppressed data

If fewer than 30 respondents have answered a question, no score will be displayed for that question (or the corresponding section the question contributes to).

Further information about the methods

For further information about the statistical methods used in this report, please refer to the survey technical document which is on the 'Analysis and Reporting' section of the UEC22 webpage on the NHS surveys website.

Using the survey results

Navigating this report

This report is split into five sections:

- **Background and methodology** – provides information about the survey programme, how the survey is run, and how to interpret the data.
- **Headline results** – includes key trust-level findings relating to the patients who took part in the survey, benchmarking, and top and bottom scores. This section provides an overview of results for your trust, identifying areas where your organisation performs better than the average and where you may wish to focus improvement activities.
- **Benchmarking** – shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part; using the 'expected range' analysis technique. This allows you to see the range of scores achieved and compare yourself with the other organisations that took part in the survey. Benchmarking can provide you with an indication of where you perform better than the average, and what you should aim for in areas where you may wish to improve.
- **Trust results** – includes the score for your trust and breakdown of scores across sites within your trust. Internal benchmarking may be helpful so you can compare sites within your organisation, sharing best practice within the trust and identifying any sites that may need attention.
- **Change over time** – displays your trust score for each survey year. Where available, trend data will be shown from 2016 to 2022. Questions are displayed in a line chart with the trust mean plotted alongside the national average. Statistical significance testing is also shown between survey years 2022 vs 2020. This section highlights areas your trust has improved on or declined in over time.
- **Appendix** – includes additional data for your trust; further information on the survey methodology; and interpretation of graphs in this report.

How to interpret the graphs in this report

There are several types of graphs in this report which show how the score for your trust compares to the scores achieved by all trusts that took part in the survey.

The two chart types used in the section 'Benchmarking' use the 'expected range' technique to show results. For information on how to interpret these graphs, please refer to the Appendix.

Other data sources

More information is available about the following topics at their respective websites, listed below:

- Full national results; technical document: https://www.cqc.org.uk/uecsurvey
- National and trust-level data for all trusts who took part in the 2022 Urgent & Emergency Care Survey https://nhssurveys.org/surveys/survey/03-urgent-emergency-care/. Full details of the methodology for the survey, instructions for trusts and contractors to carry out the survey, and the survey development report can also be found on the NHS Surveys website.
- Information on the NHS Patient Survey Programme, including results from other surveys: www.cqc.org.uk/content/surveys
- Information about how the CQC monitors hospitals: https://www.cqc.org.uk/what-we-do/how-we-use-information/using-data-monitor-services

Headline results

This section includes:

- information about your trust population
- an overview of benchmarking for your trust
- the best and worst scores for your trust

Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of patients who took part in the survey.

950 invited to take part

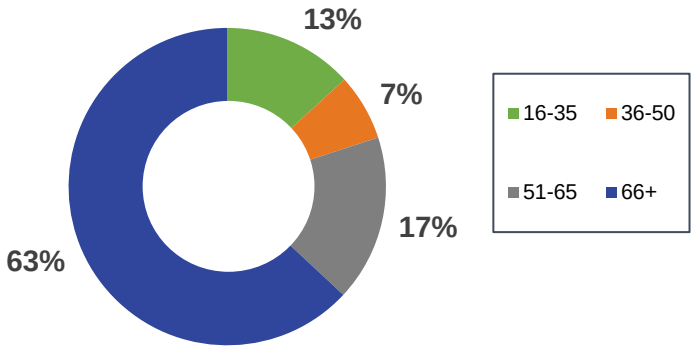
295 completed

32% response rate

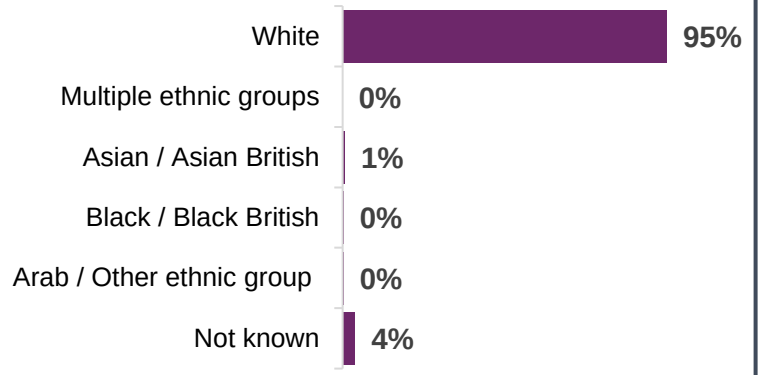
23% average response rate for all trusts

-% response rate for your trust last year

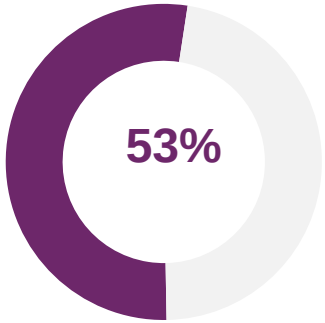
AGE



ETHNICITY



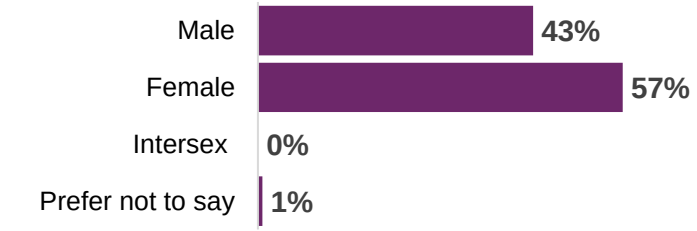
LONG-TERM CONDITIONS



of patients have a **physical or mental health condition or illness** that has lasted or is expected to last for 12 months or more.

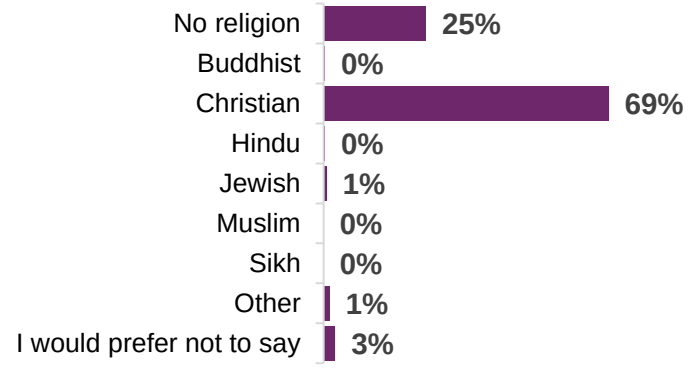
SEX

At birth were you registered as…



0% of patients said their **gender is different from the sex they were registered with at birth**.

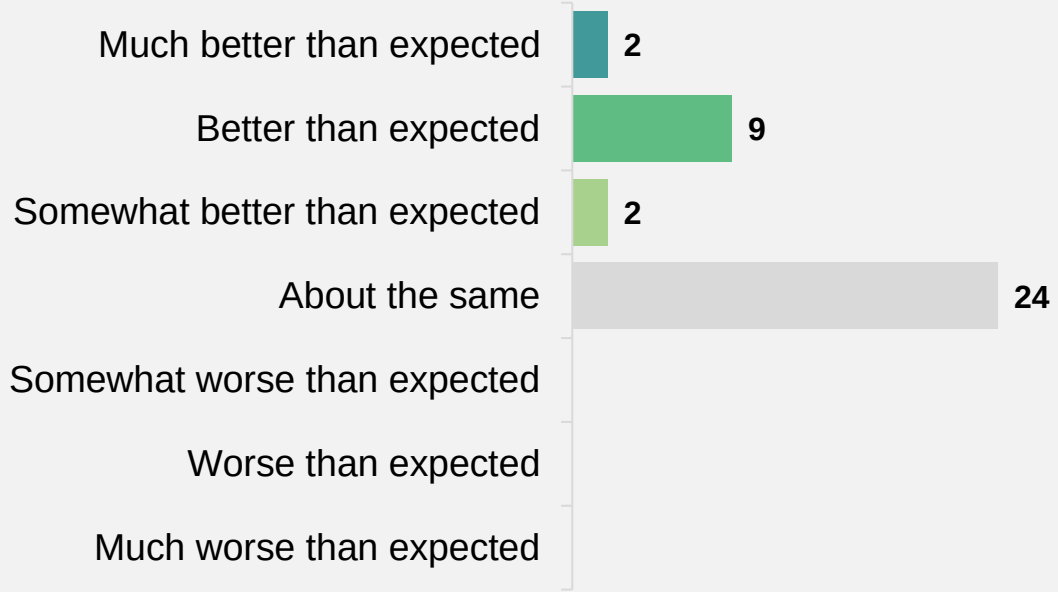
RELIGION



Summary of findings for your trust

Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

The **number of questions** at which your trust has performed statistically significantly better, significantly worse, or no different than your result from the previous year, 2022 vs 2020.

This information is not available for your trust.

Data for trusts which have undergone significant restructuring (i.e. mergers and closures) or experienced sampling errors should not be compared with previous survey results.

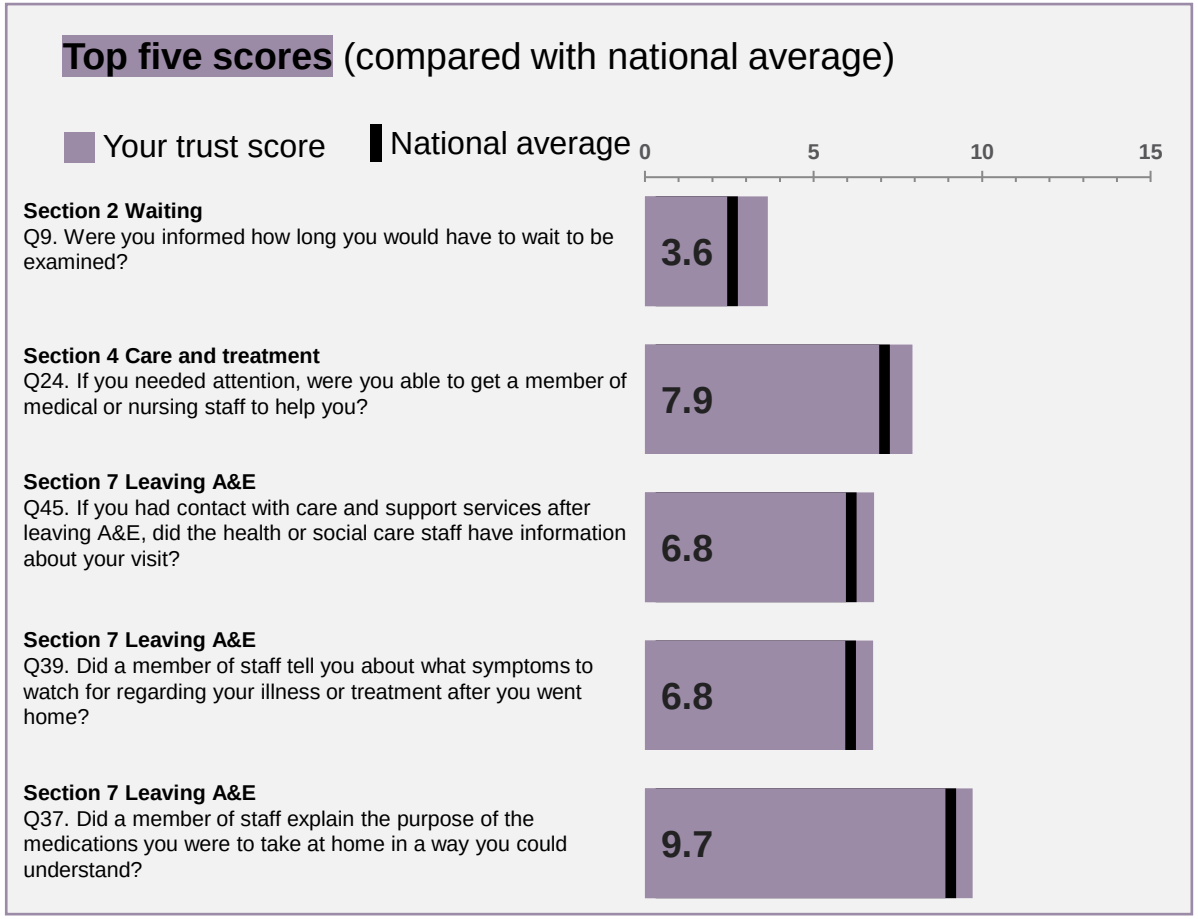
For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the appendix section "your trust has performed much worse" , "your trust has performed worse" , "your trust has performed somewhat worse", "your trust has performed somewhat better", "your trust has performed better", "your trust has performed much better" .

Best and worst performance relative to the national average

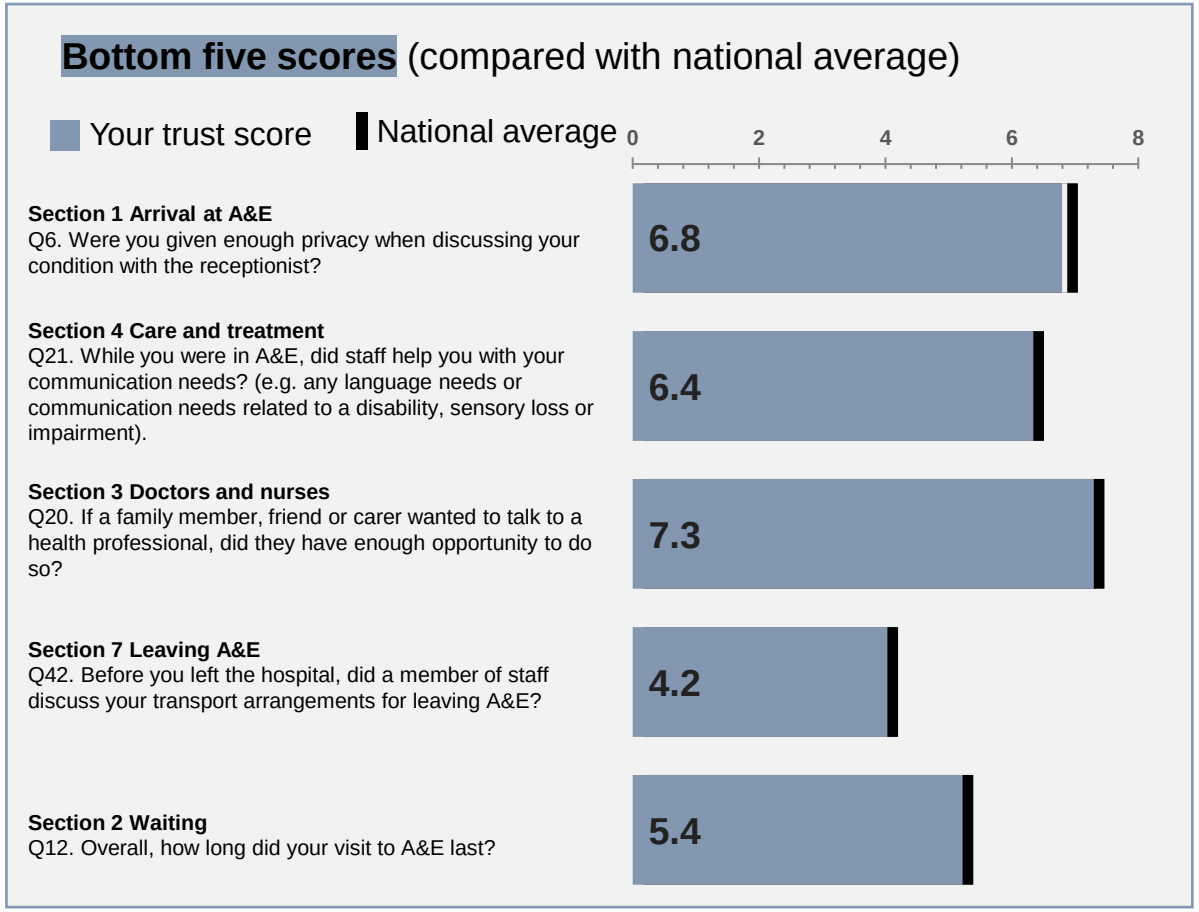
These five questions are calculated by comparing your trust's results to the national average.

- **Top five scores**: These are the five results for your trust that are highest compared with the national average. If none of the results for your trust are above the national average, then the results that are closest to the national average have been chosen, meaning a trust's best performance may be worse than the national average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the national average. If none of the results for your trust are below the national average, then the results that are closest to the national average have been chosen, meaning a trust's worst performance may be better than the national average.

Top five scores (compared with national average)



Bottom five scores (compared with national average)



Benchmarking

This section includes:

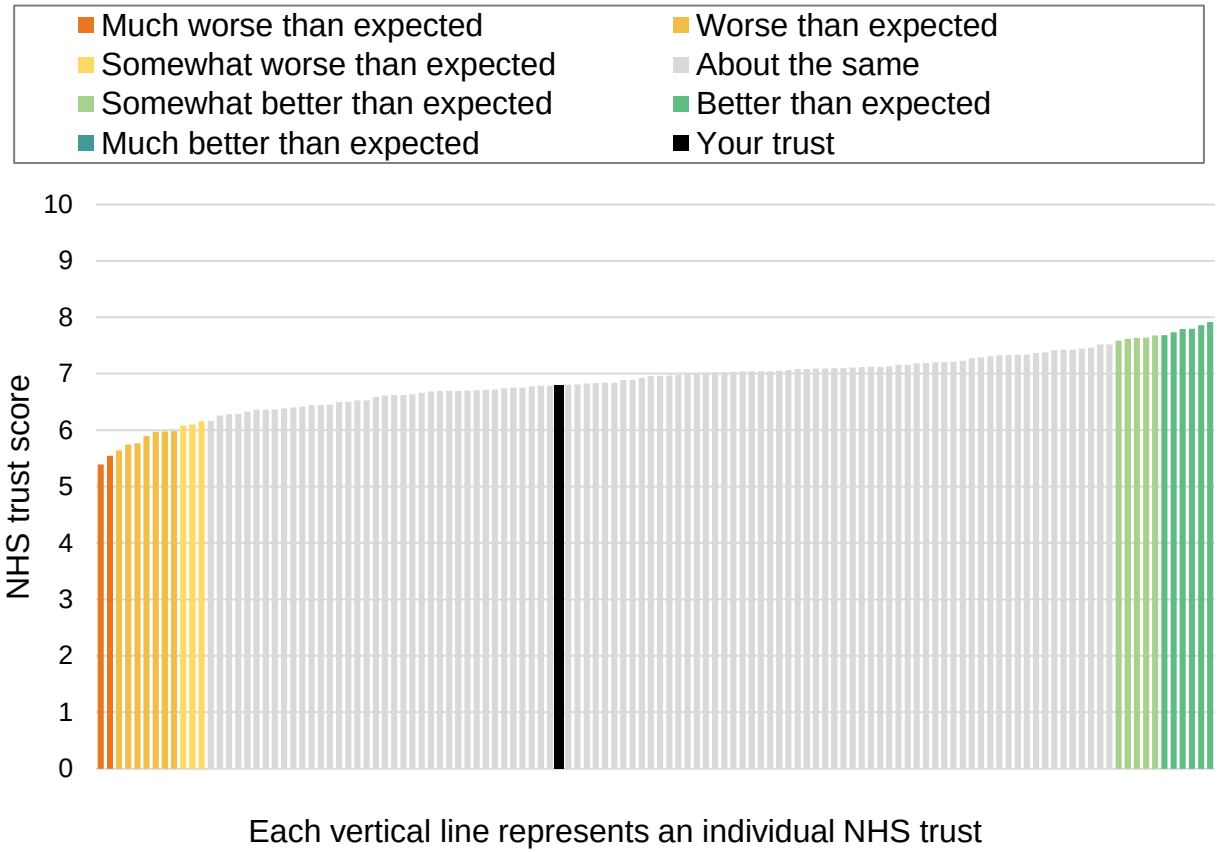
- how your trust scored for each evaluative question in the survey, compared with other trusts that took part.
- an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts.

Please note, Q29 has been supressed as there are fewer than 30 respondents for all trusts.

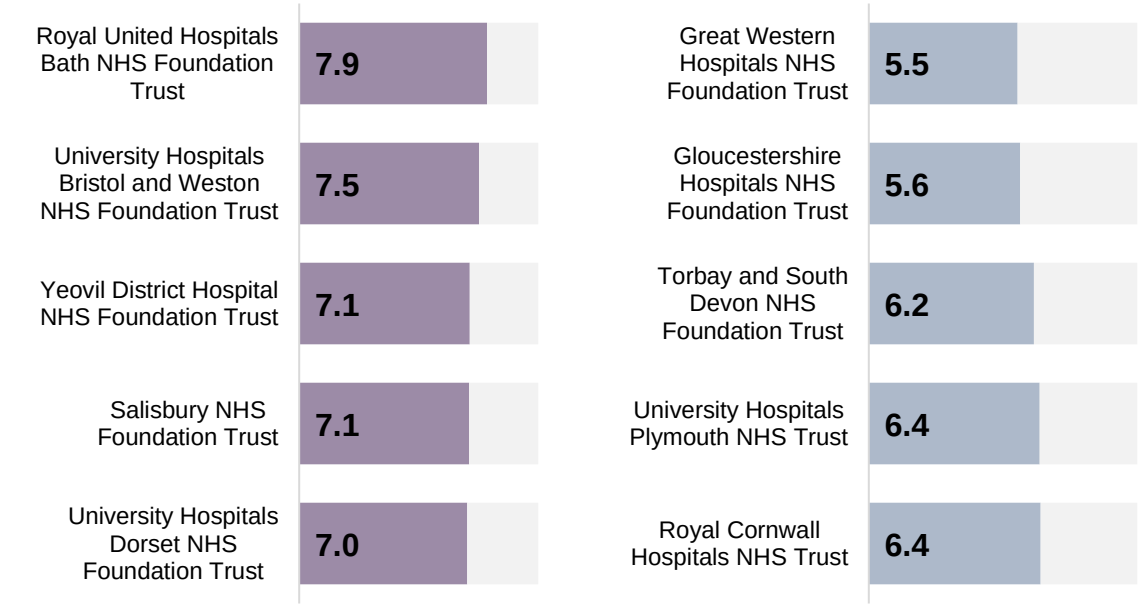
Section 1. Arrival at A&E

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 6.8 About the same

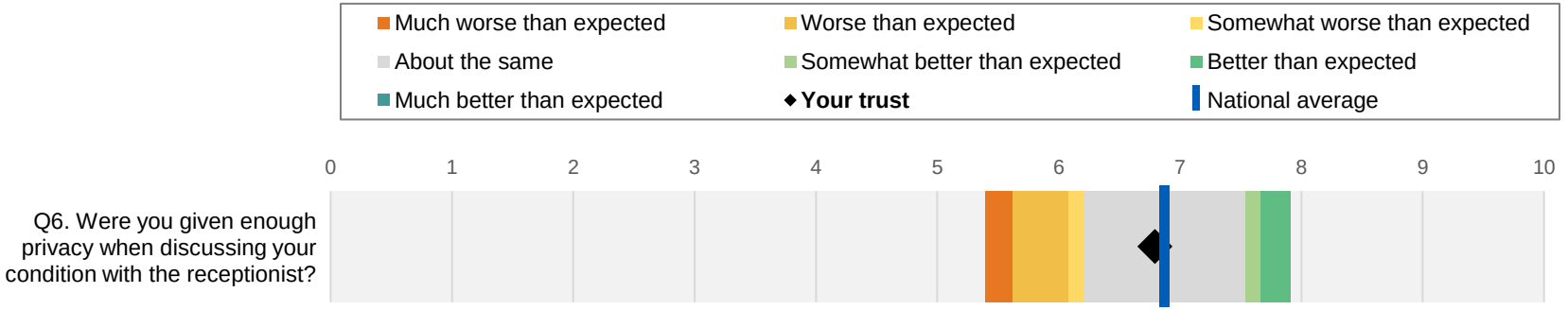


Comparison with other trusts within your region



Section 1. Arrival at A&E

Question scores

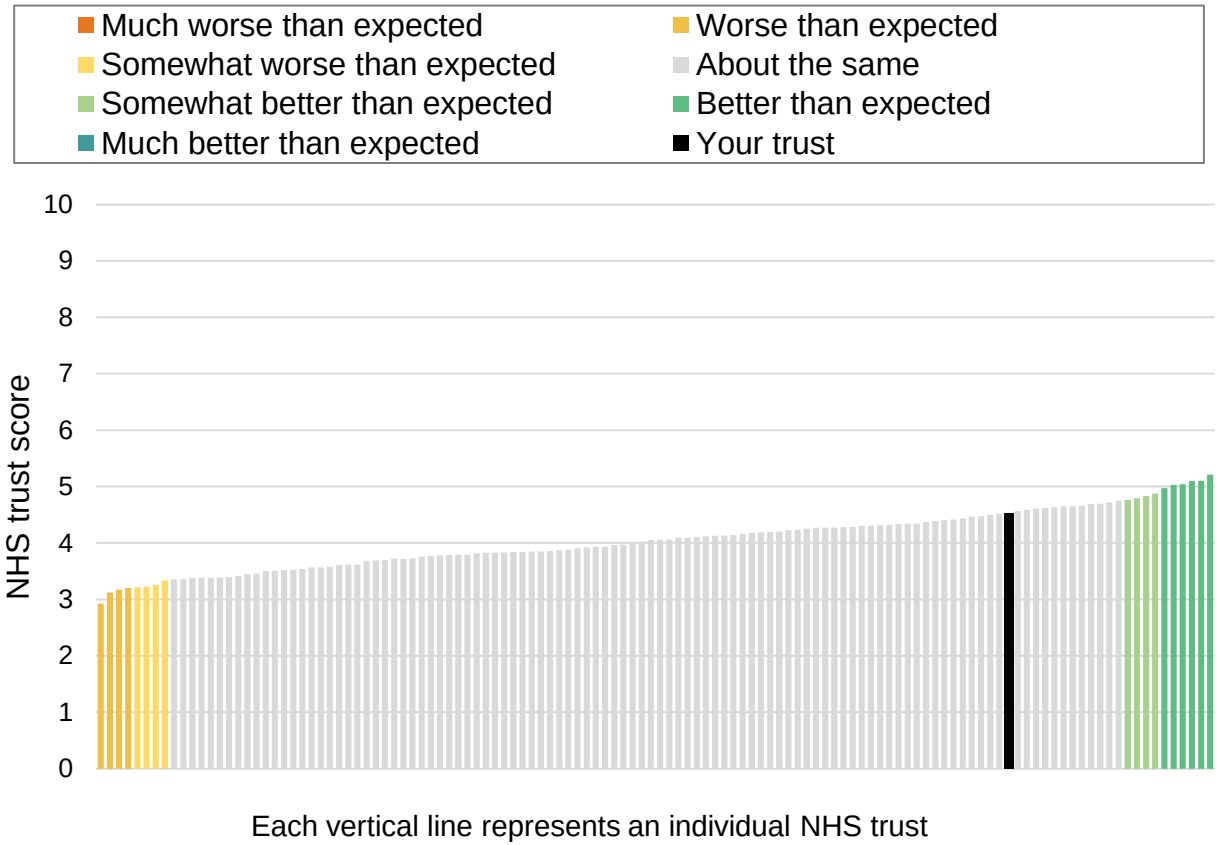


All trusts in England				
Number of respondents	Your trust	National average	Lowest score	Highest score
225	6.8	6.9	5.4	7.9

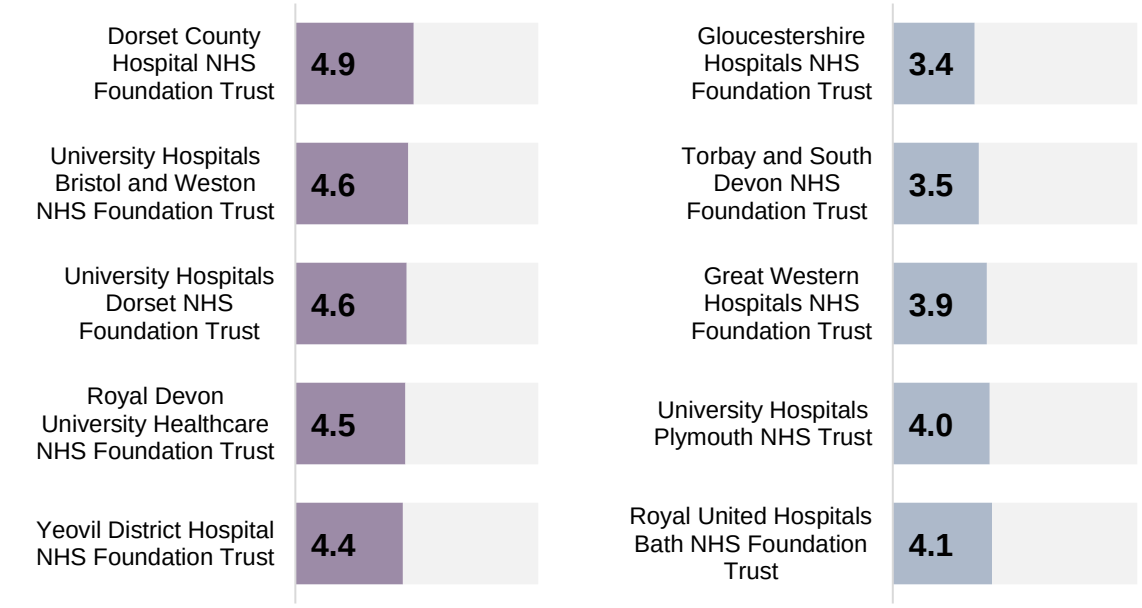
Section 2. Waiting

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 4.5 About the same

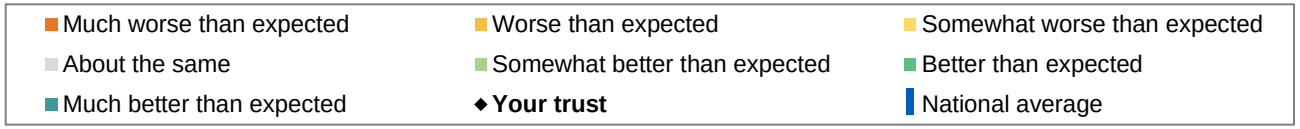


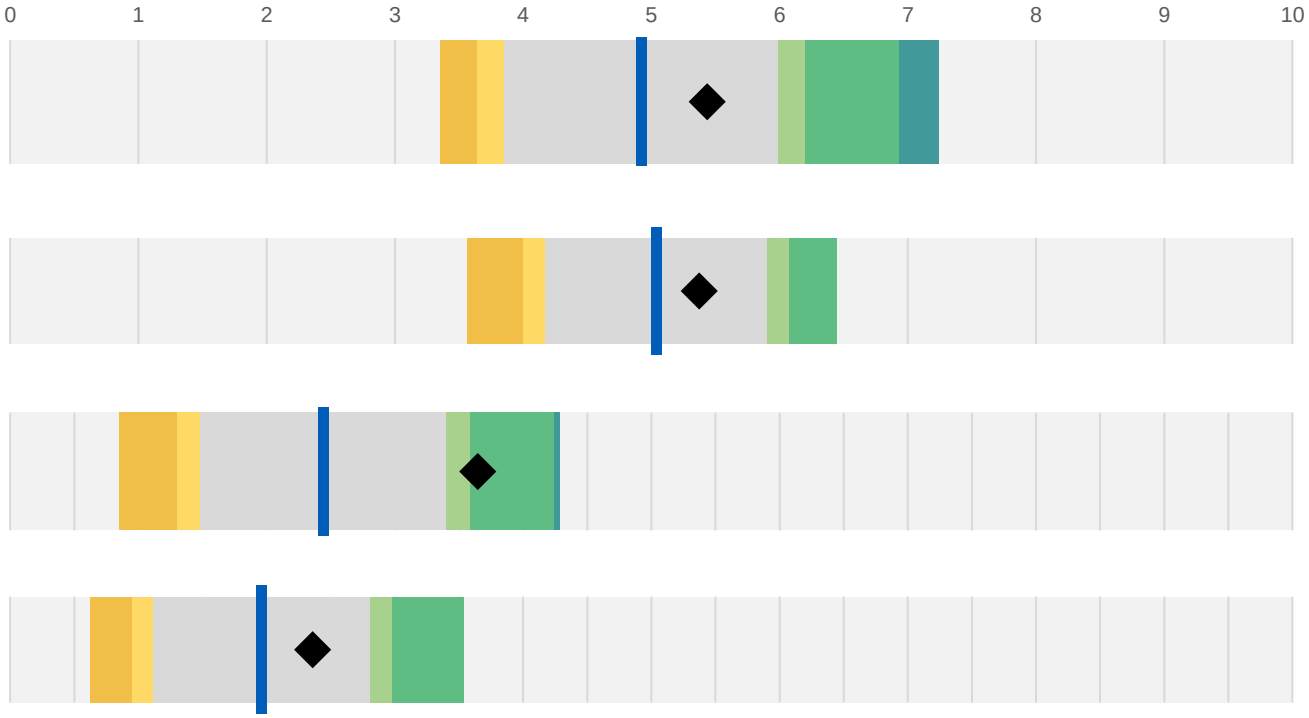
Comparison with other trusts within your region



Section 2. Waiting (continued)

Question scores

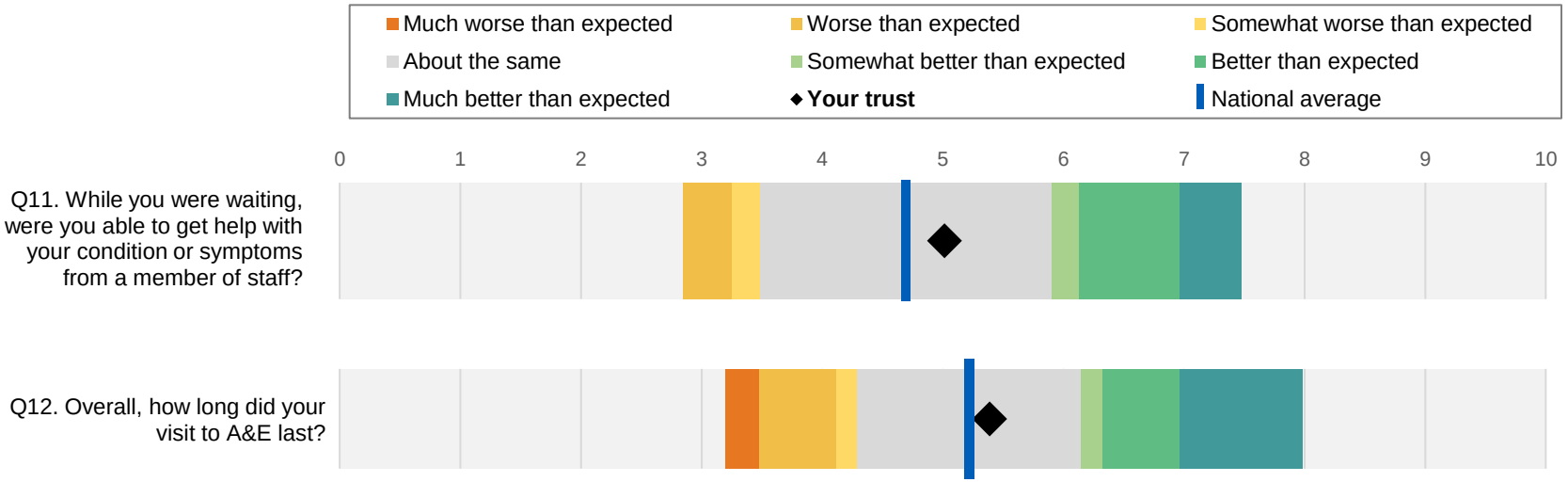




	All trusts in England				
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	271	5.4	4.9	3.4	7.2
About the same	274	5.4	5.0	3.6	6.4
Better than expected	227	3.6	2.4	0.9	4.3
About the same	205	2.4	2.0	0.6	3.5

Section 2. Waiting (continued)

Question scores

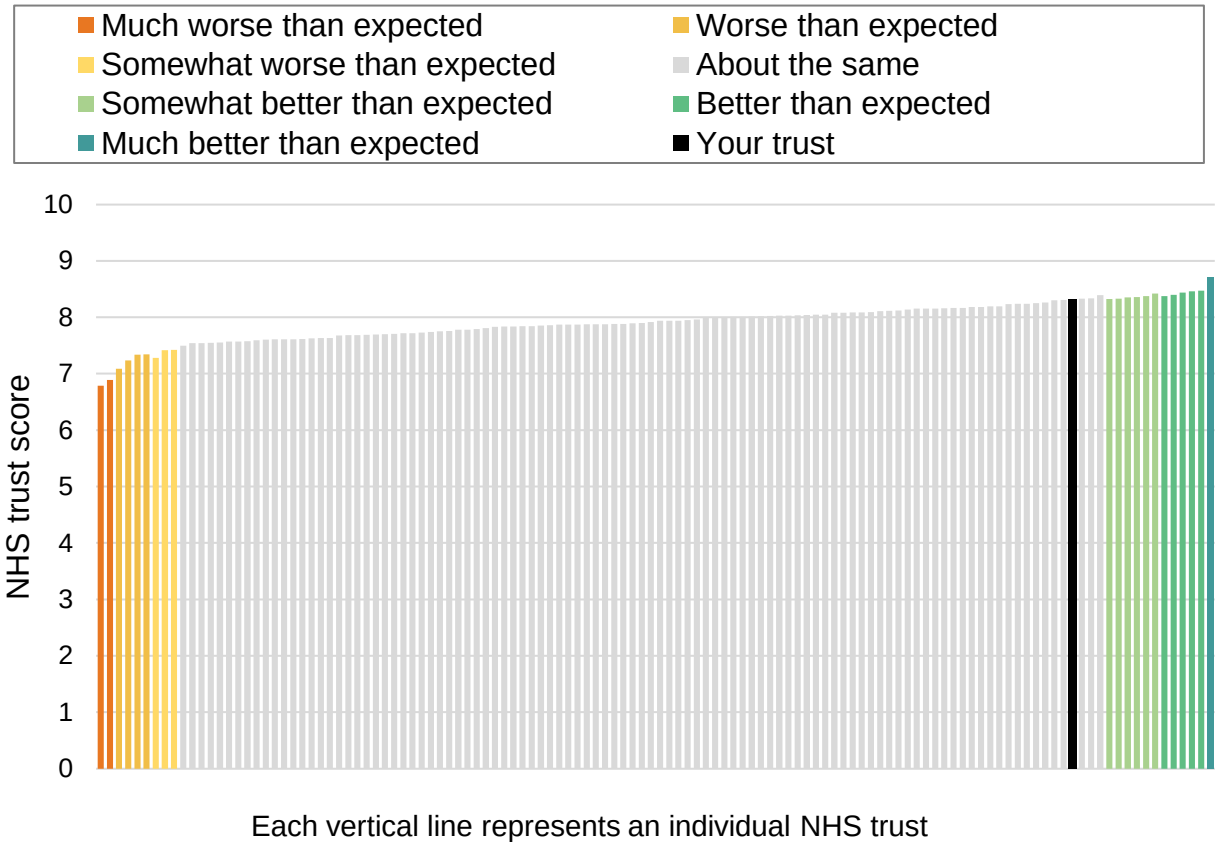


	All trusts in England				
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	153	5.0	4.7	2.8	7.5
About the same	276	5.4	5.2	3.2	8.0

Section 3. Doctors and nurses

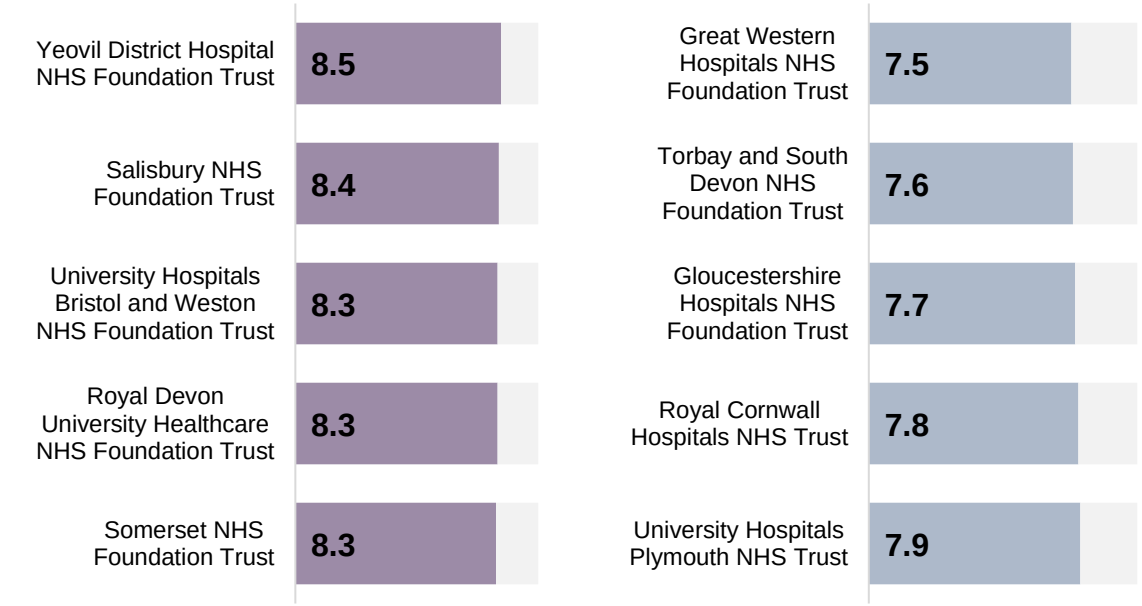
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.3 About the same



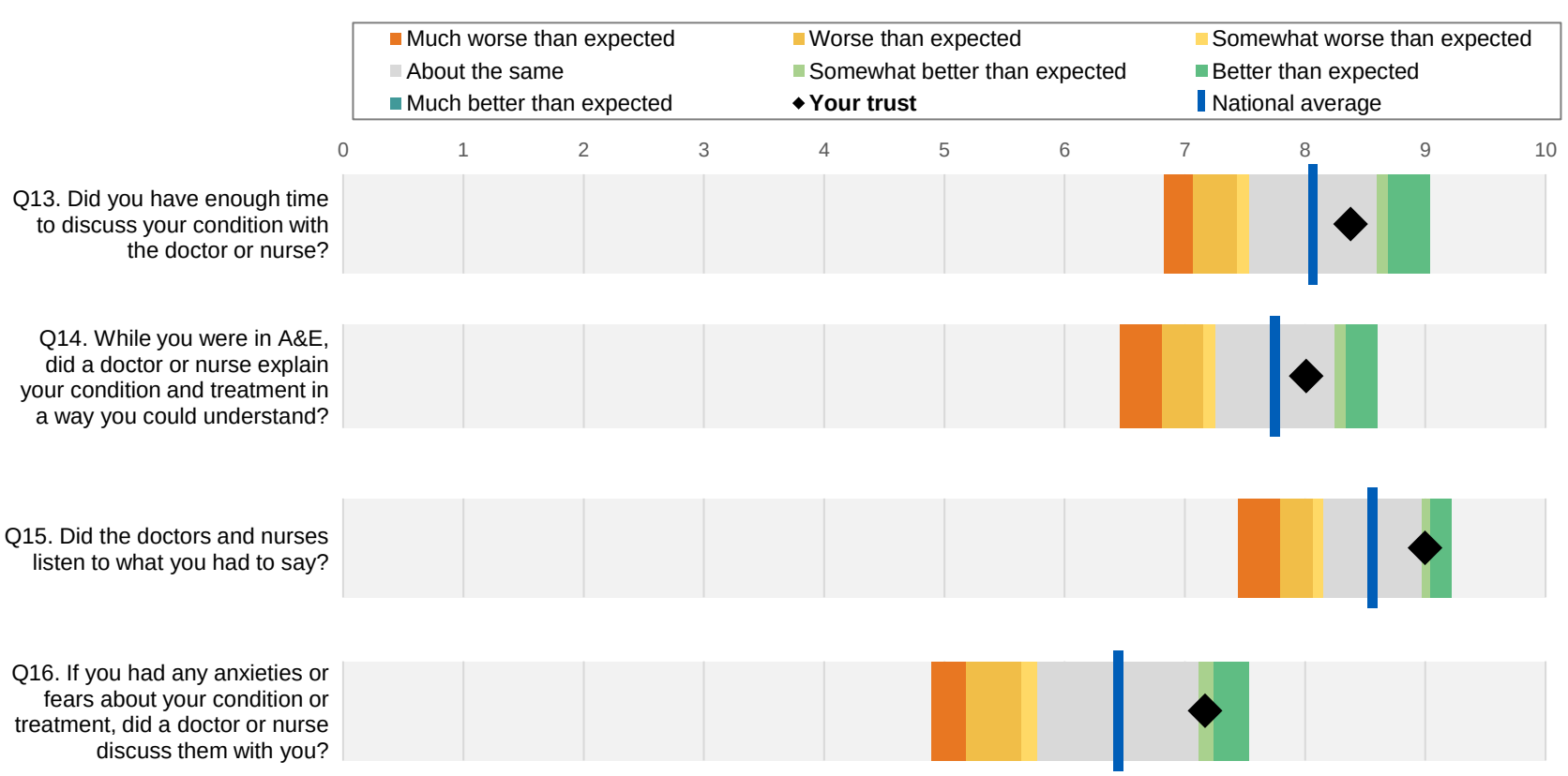
Each vertical line represents an individual NHS trust

Comparison with other trusts within your region



Section 3. Doctors and nurses (continued)

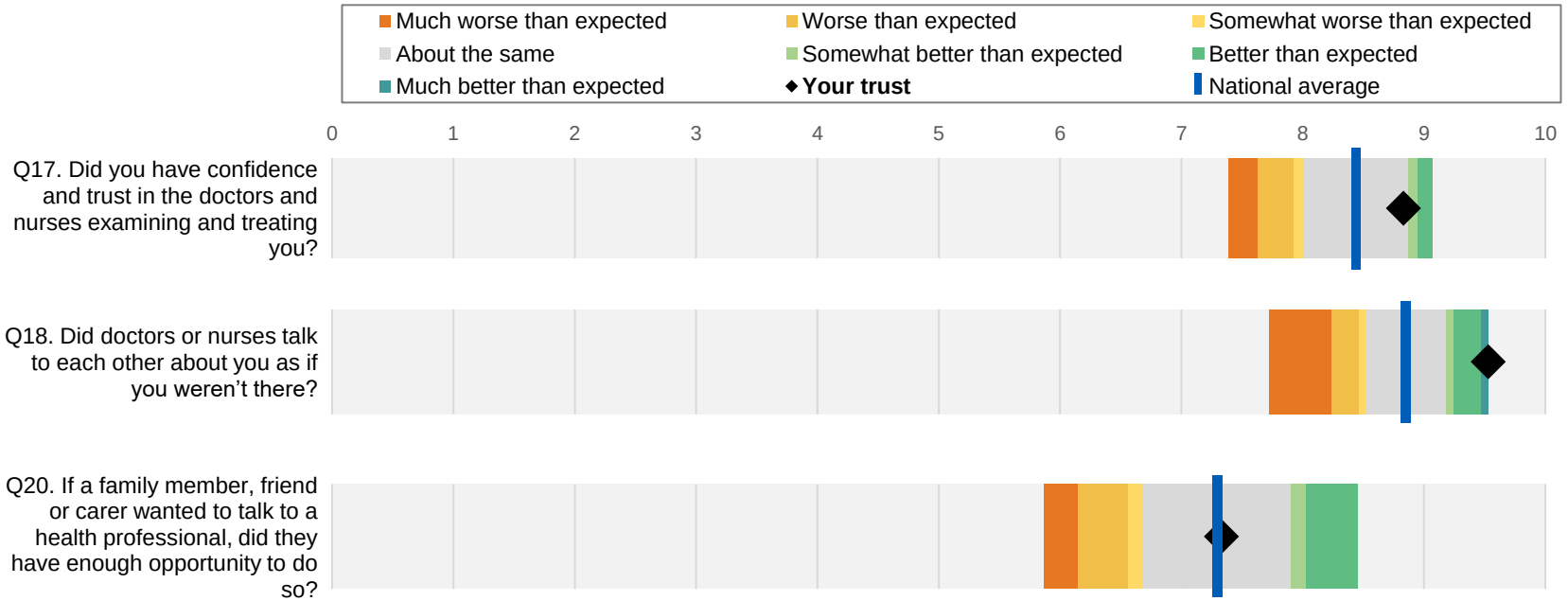
Question scores



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
About the same: 288	8.4	8.1	6.8	9.0
About the same: 275	8.0	7.7	6.5	8.6
Somewhat better than expected: 289	9.0	8.6	7.4	9.2
Somewhat better than expected: 189	7.2	6.4	4.9	7.5

Section 3. Doctors and nurses (continued)

Question scores

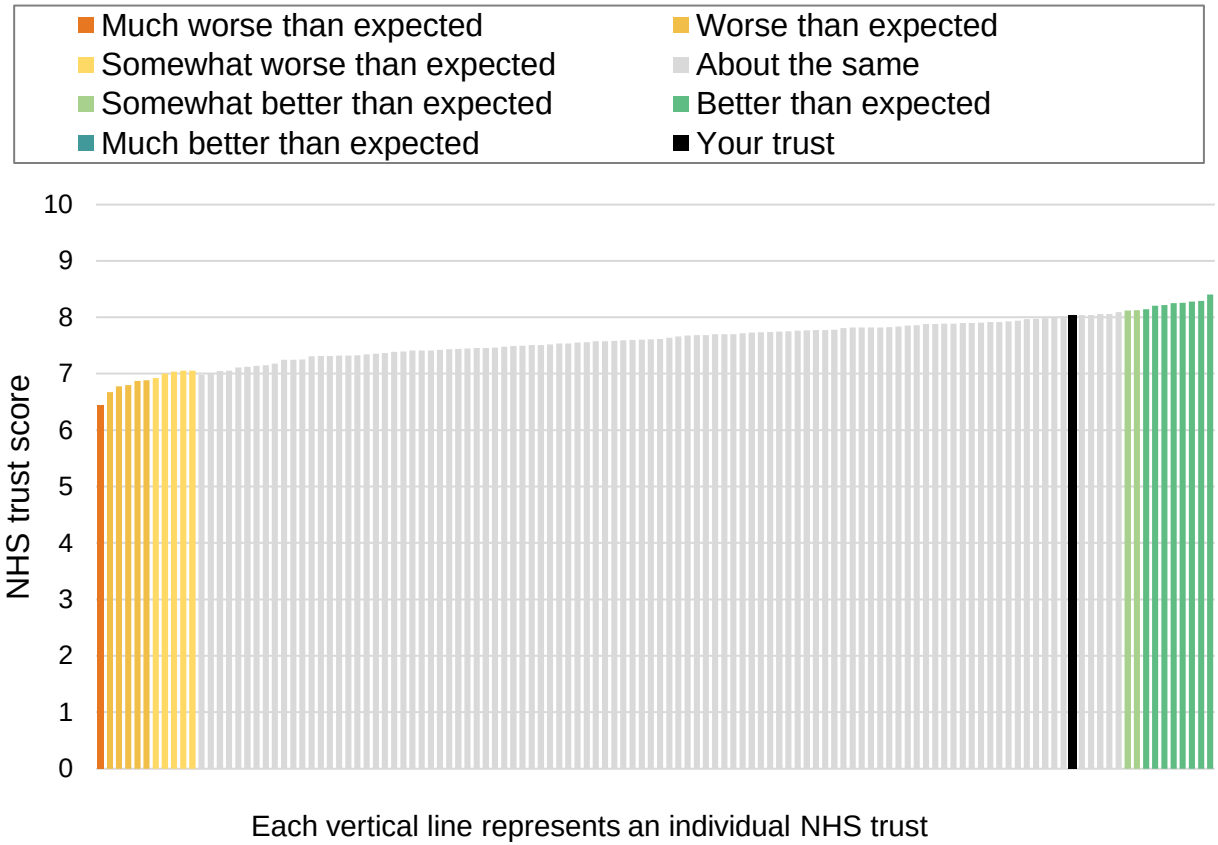


			All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	293	8.8	8.4	7.4	9.1
Much better than expected	290	9.5	8.9	7.7	9.5
About the same	133	7.3	7.3	5.9	8.4

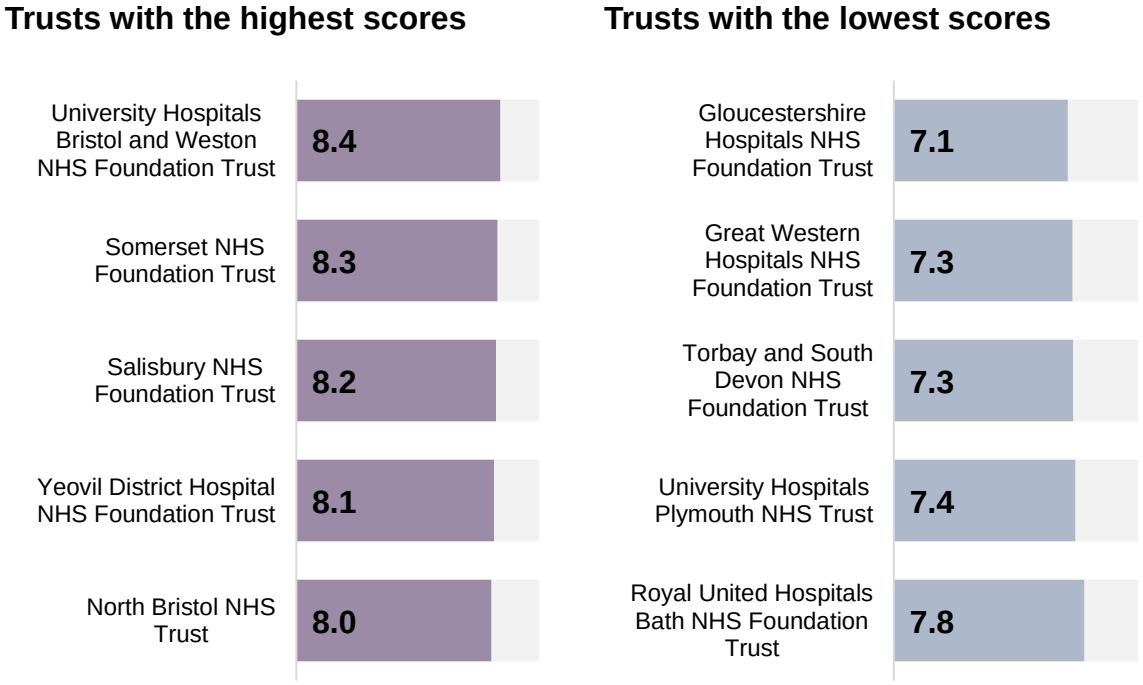
Section 4. Care and treatment

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.0 About the same

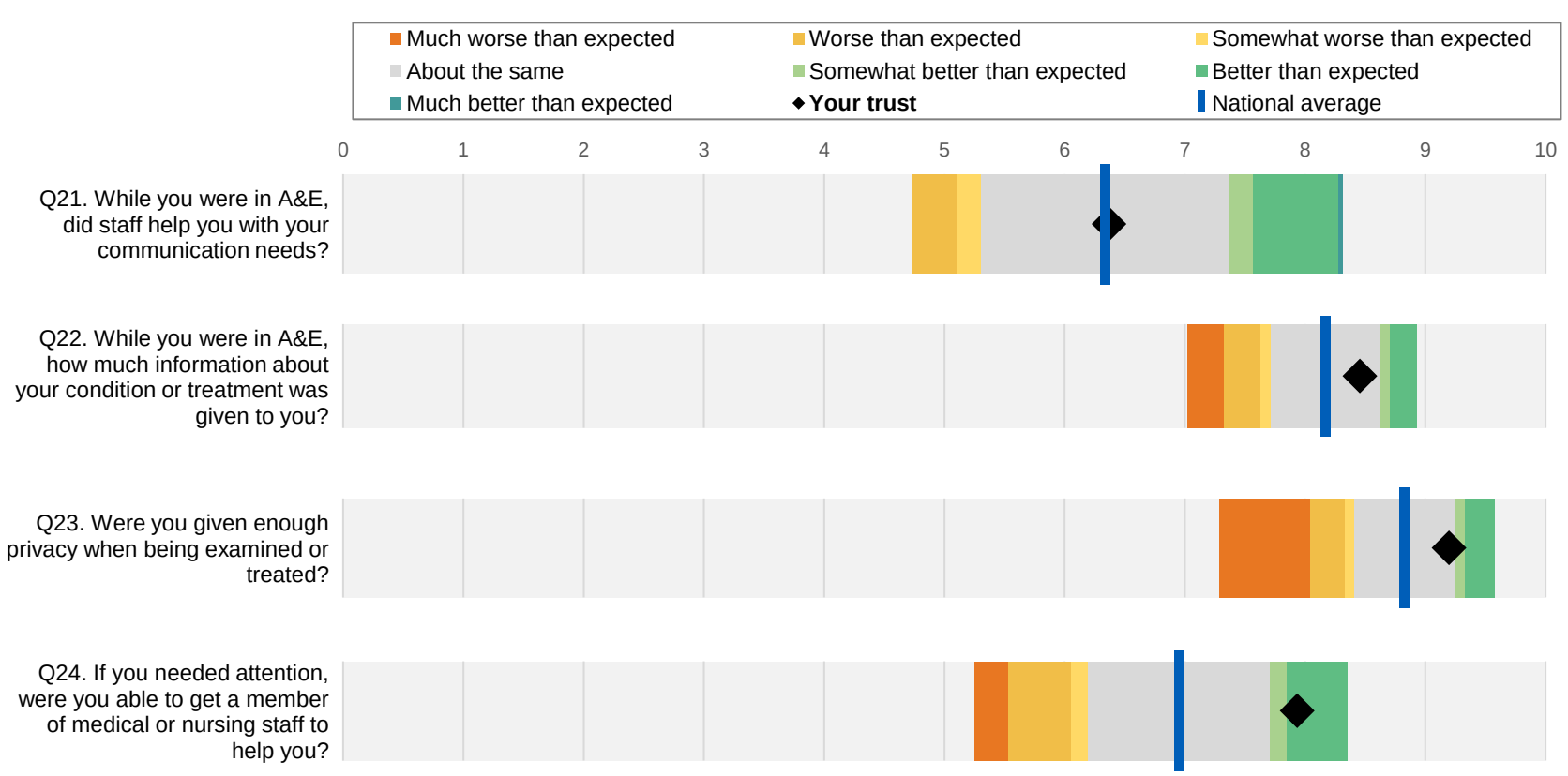


Comparison with other trusts within your region



Section 4. Care and treatment (continued)

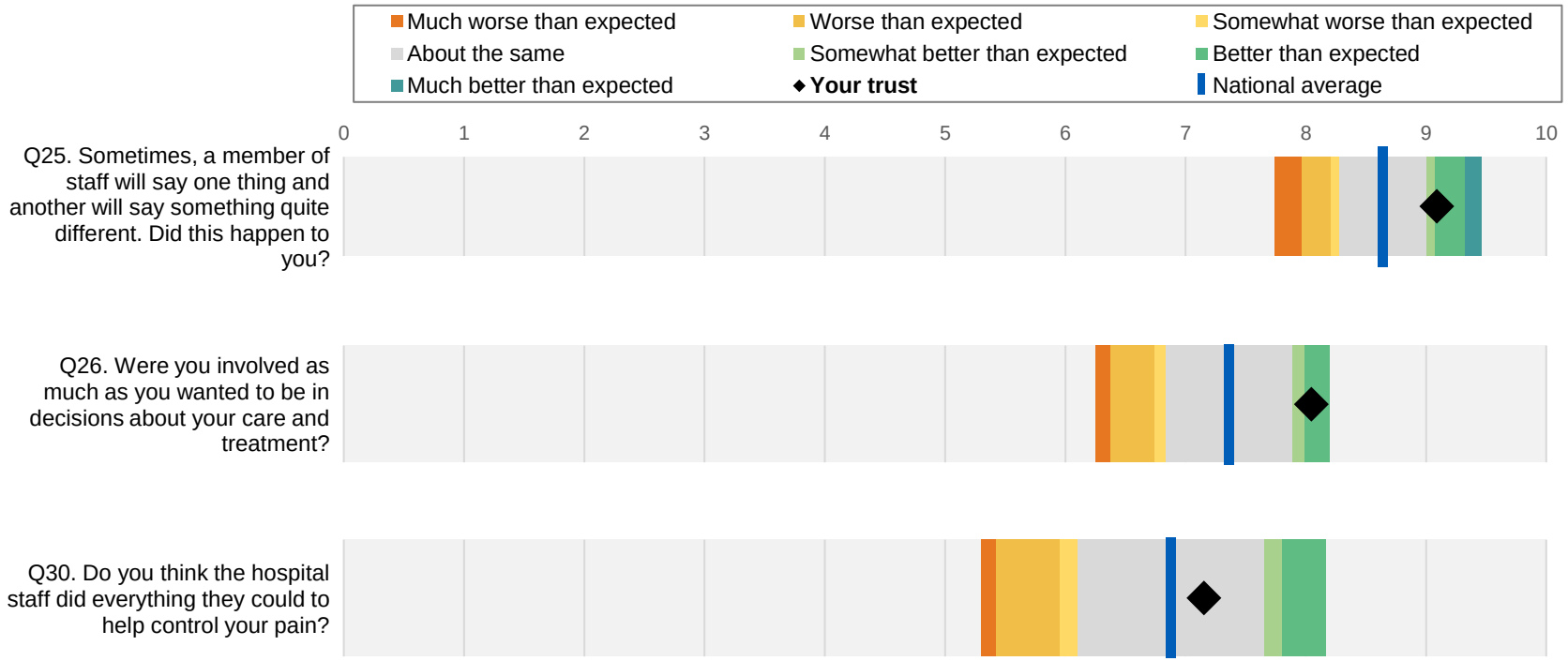
Question scores



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
About the same: 60	6.4	6.3	4.7	8.3
About the same: 285	8.5	8.2	7.0	8.9
About the same: 288	9.2	8.8	7.3	9.6
Better than expected: 169	7.9	7.0	5.3	8.4

Section 4. Care and treatment (continued)

Question scores

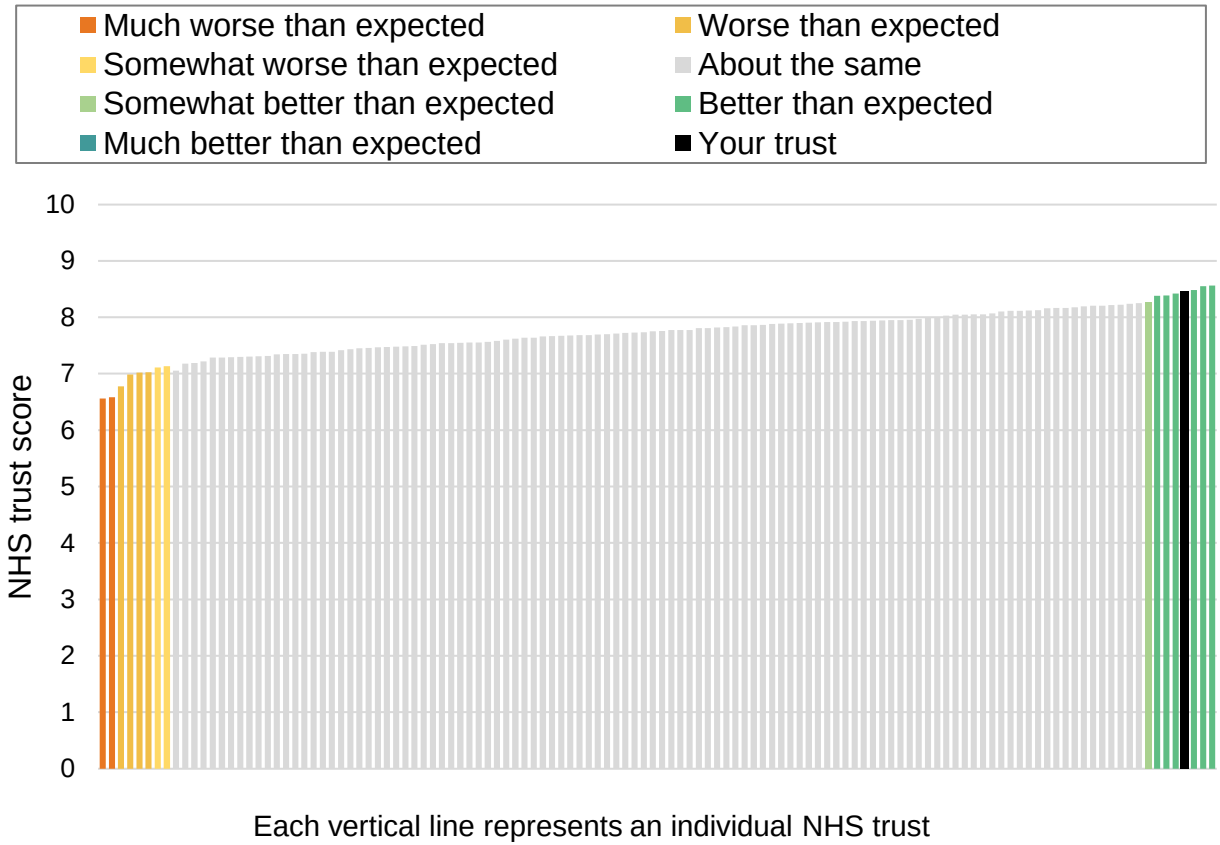


		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
Better than expected: 286	9.1	8.6	7.7	9.5
Better than expected: 268	8.0	7.4	6.2	8.2
About the same: 199	7.2	6.9	5.3	8.2

Section 5. Tests

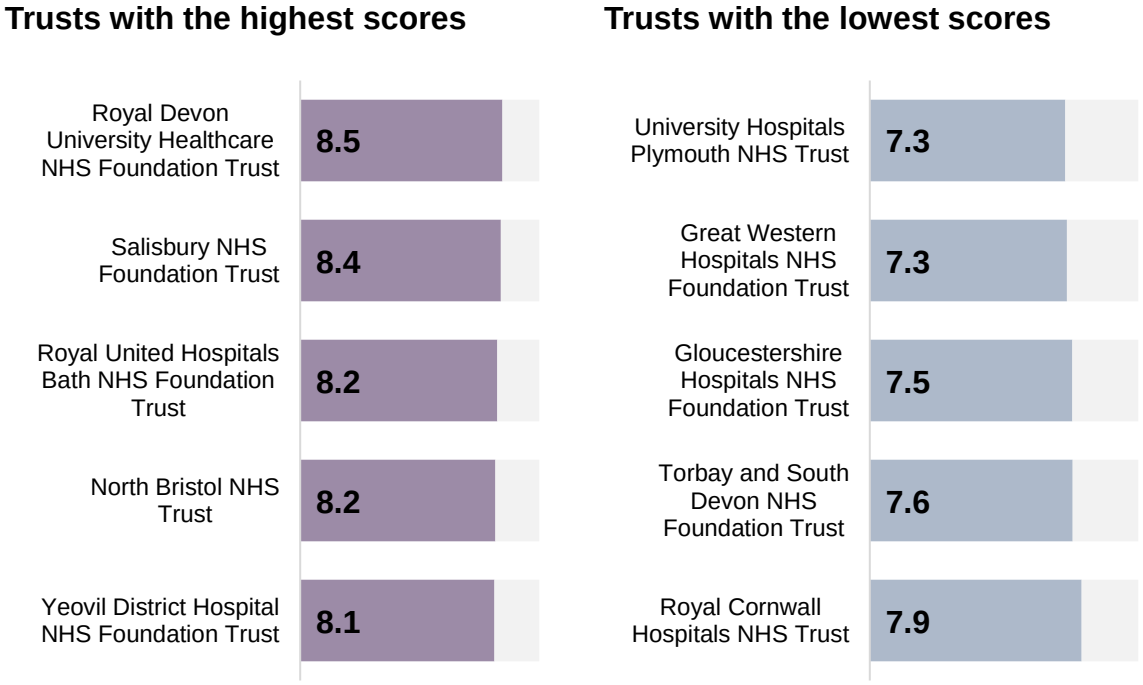
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.5 Better than expected



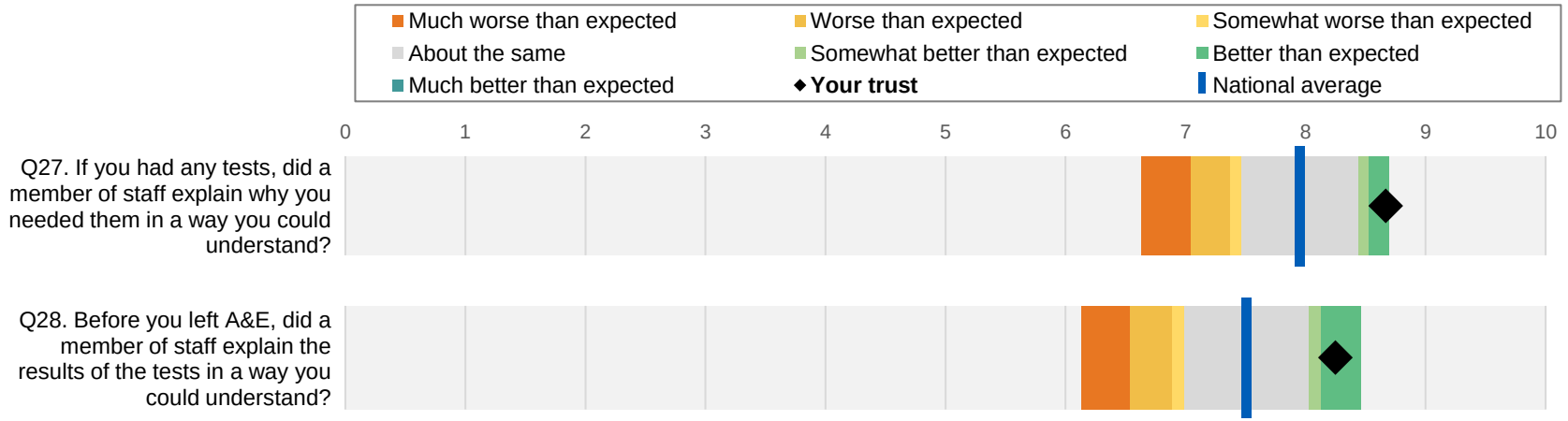
Each vertical line represents an individual NHS trust

Comparison with other trusts within your region



Section 5. Tests (continued)

Question scores



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
Q27. If you had any tests, did a member of staff explain why you needed them in a way you could understand?				
226	8.7	8.0	6.6	8.7
Q28. Before you left A&E, did a member of staff explain the results of the tests in a way you could understand?				
200	8.2	7.5	6.1	8.5

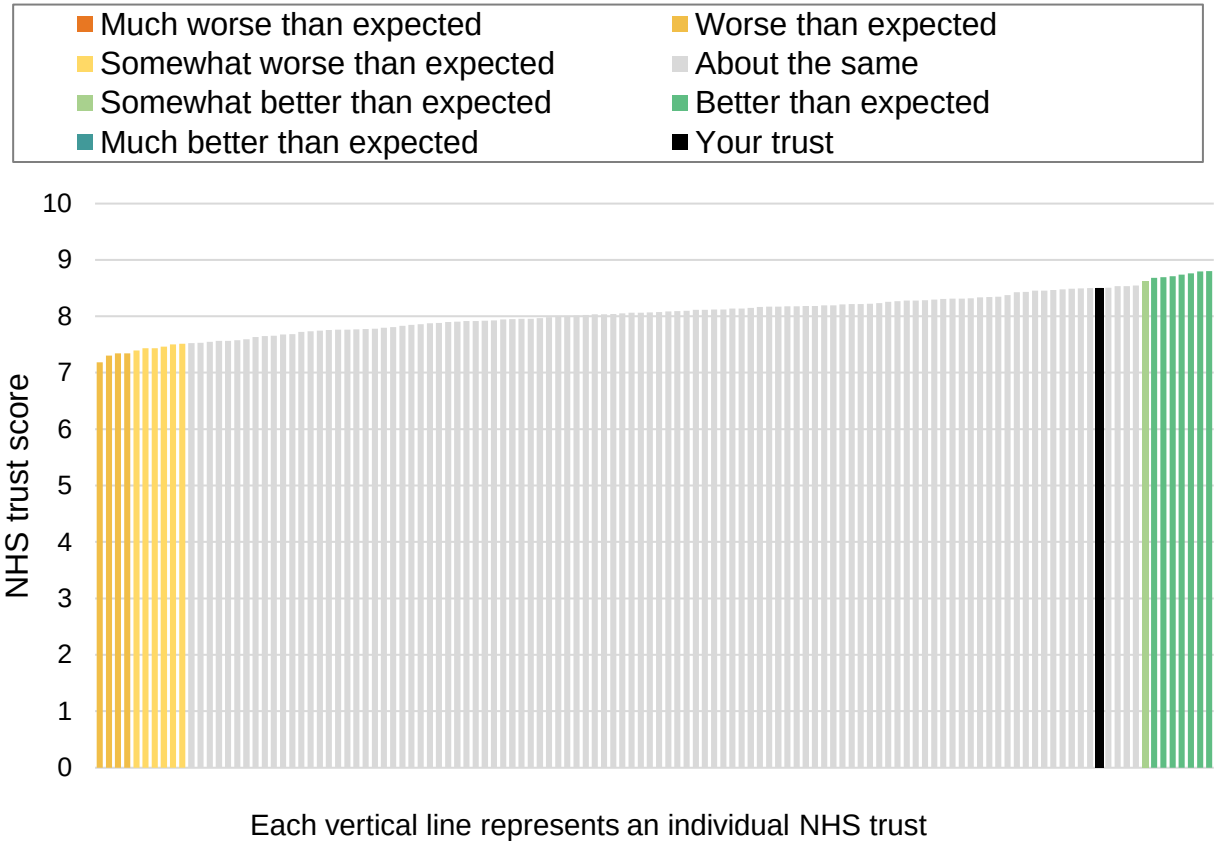
Better than expected

Better than expected

Section 6. Environment and facilities

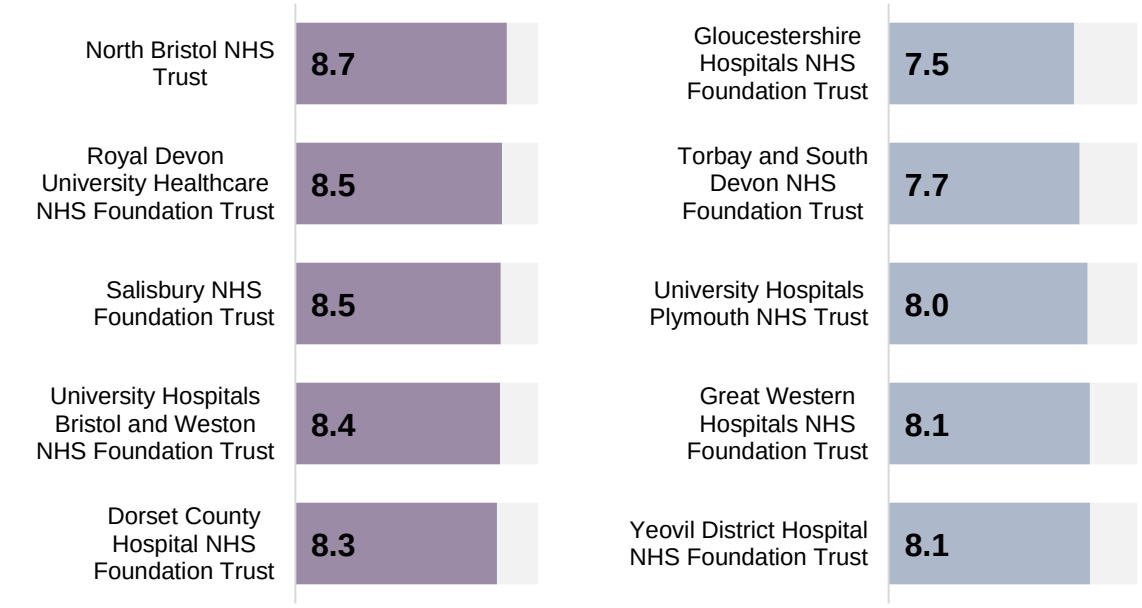
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.5 About the same



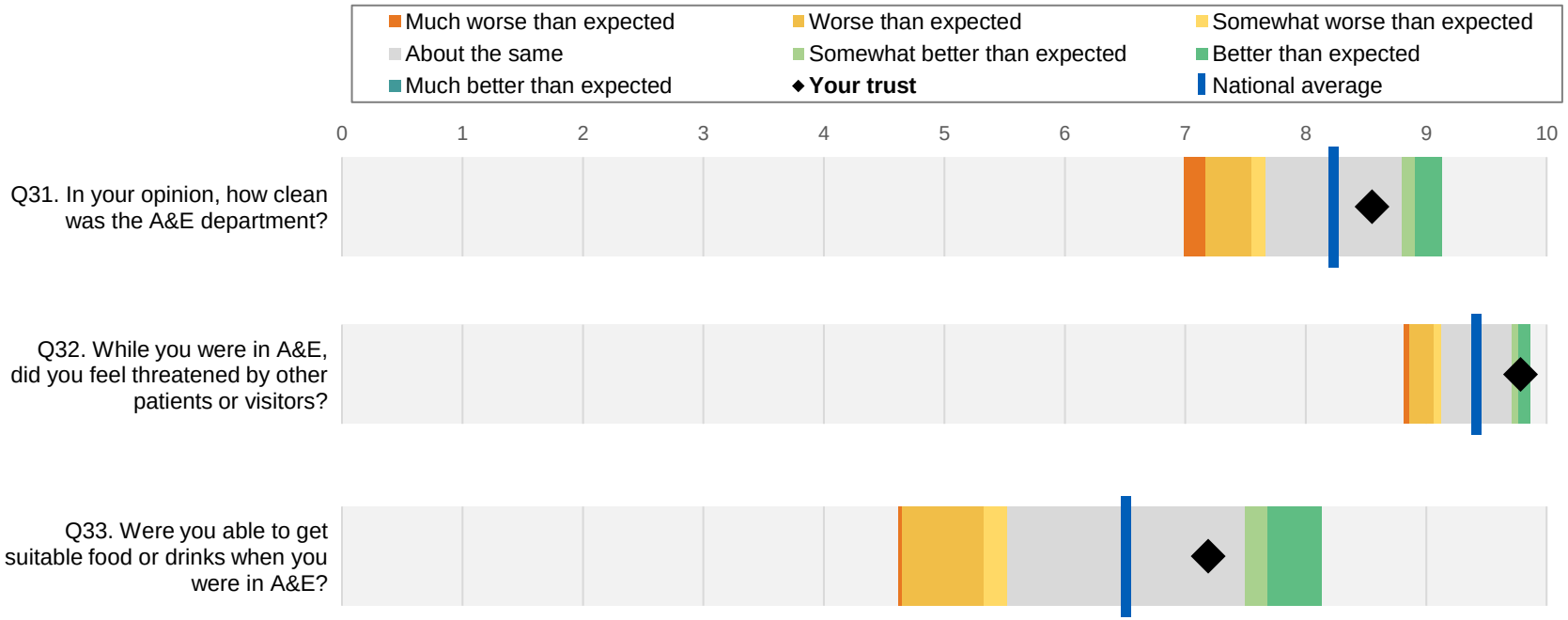
Each vertical line represents an individual NHS trust

Comparison with other trusts within your region



Section 6. Environment and facilities (continued)

Question scores

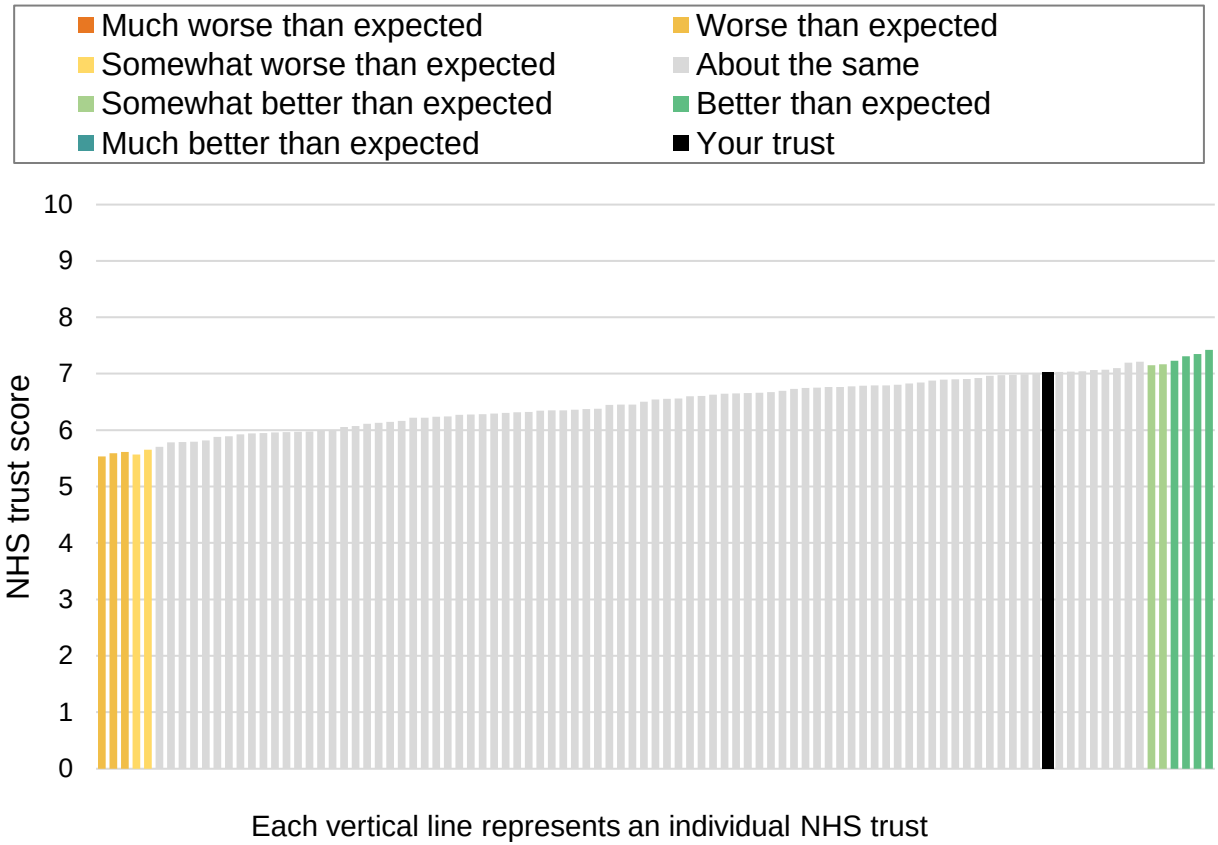


			All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	278	8.5	8.2	7.0	9.1
Better than expected	291	9.8	9.4	8.8	9.9
About the same	173	7.2	6.5	4.6	8.1

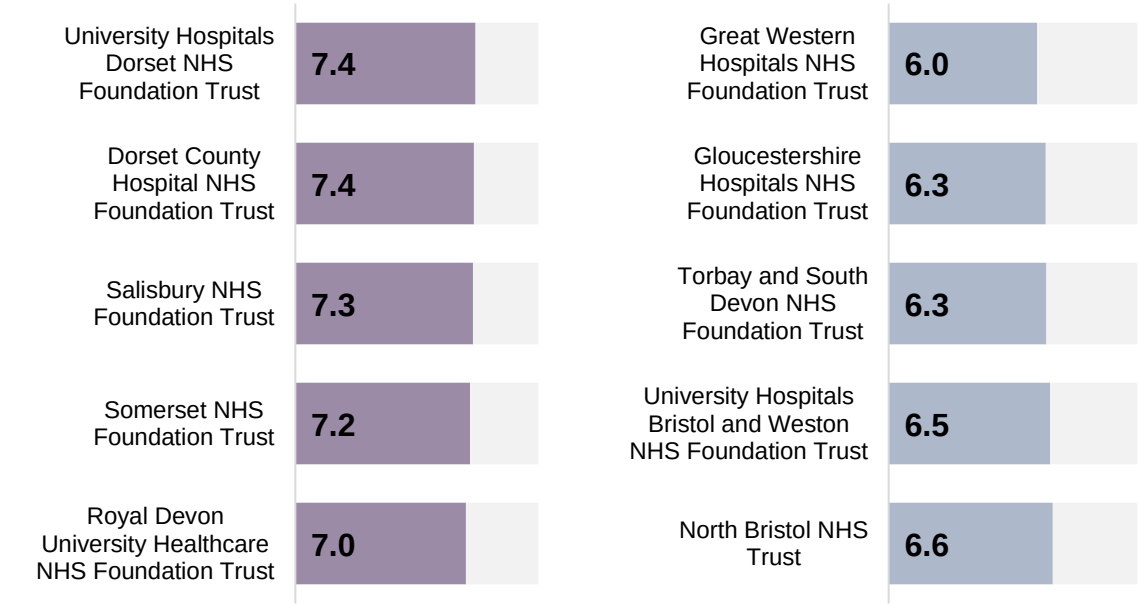
Section 7. Leaving A&E

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.0 About the same

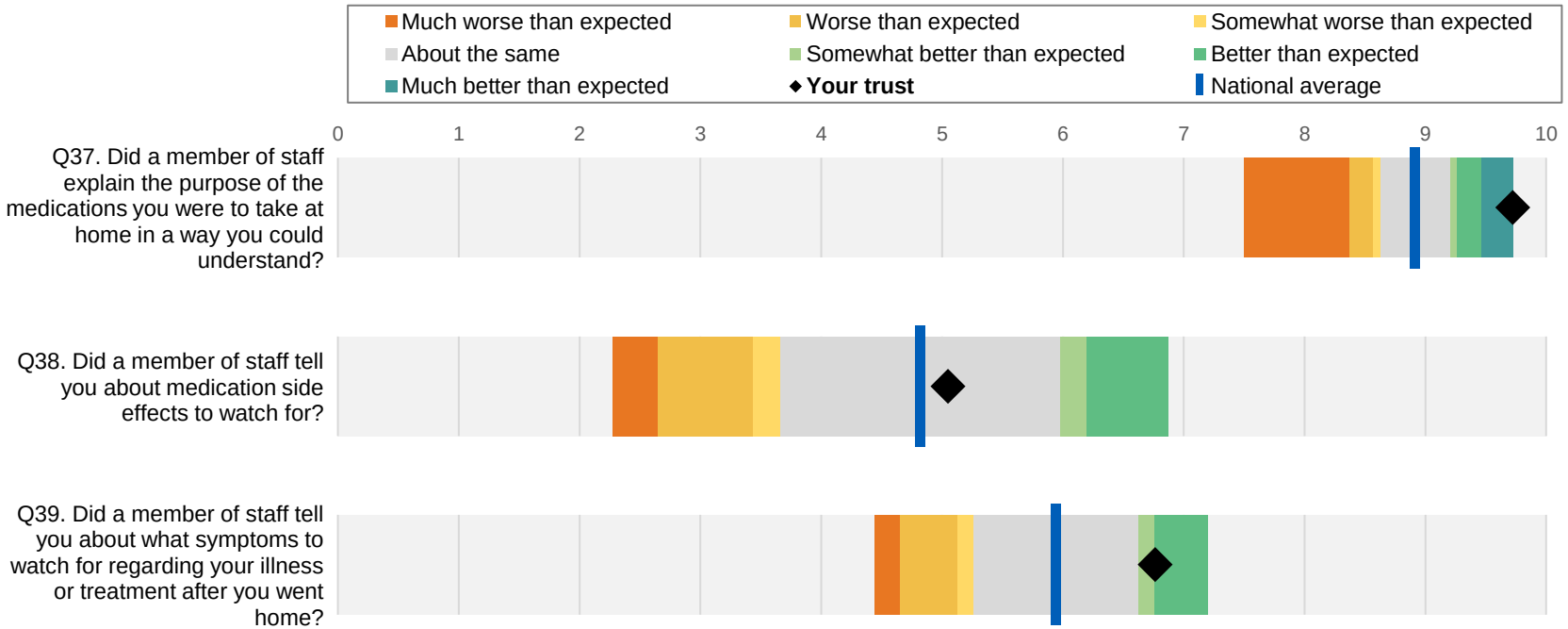


Comparison with other trusts within your region



Section 7. Leaving A&E (continued)

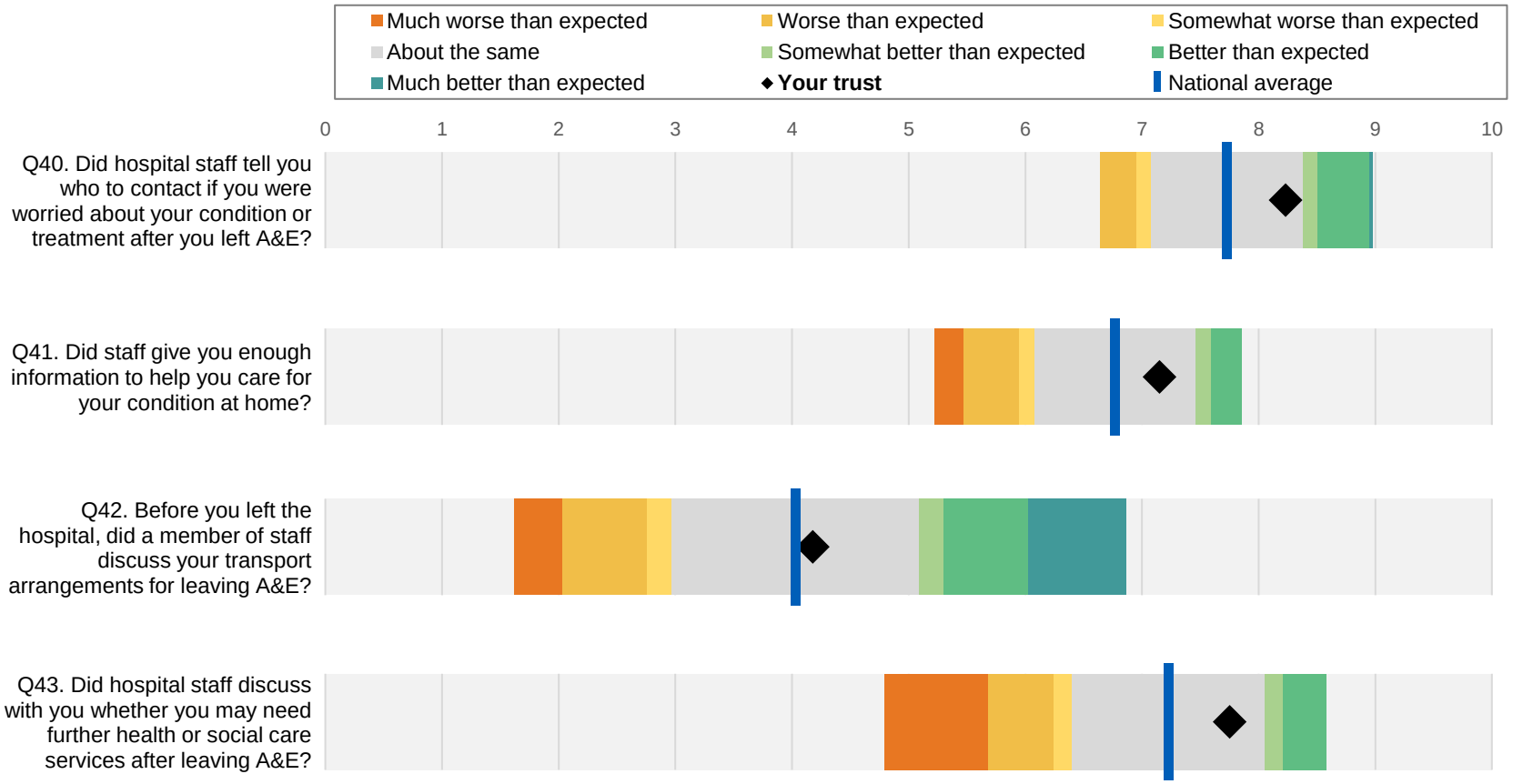
Question scores



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
Much better than expected	58	9.7	8.9	7.5	9.7
About the same	48	5.0	4.8	2.3	6.9
Better than expected	152	6.8	5.9	4.4	7.2

Section 7. Leaving A&E (continued)

Question scores

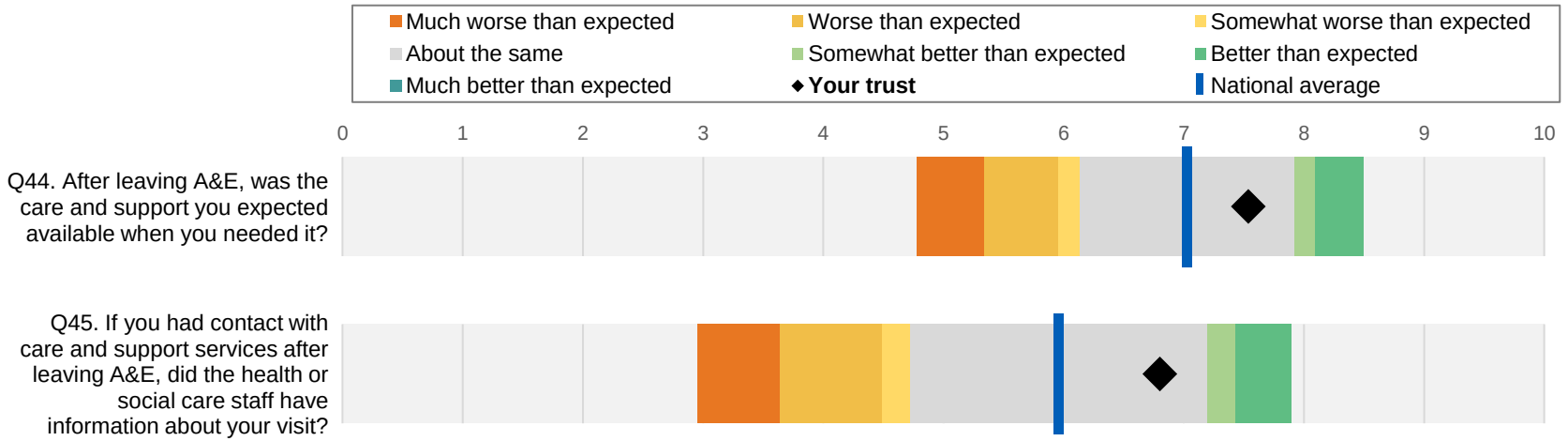


		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
180	8.2	7.7	6.6	9.0
167	7.1	6.8	5.2	7.9
94	4.2	4.0	1.6	6.9
87	7.8	7.2	4.8	8.6

About the same

Section 7. Leaving A&E (continued)

Question scores

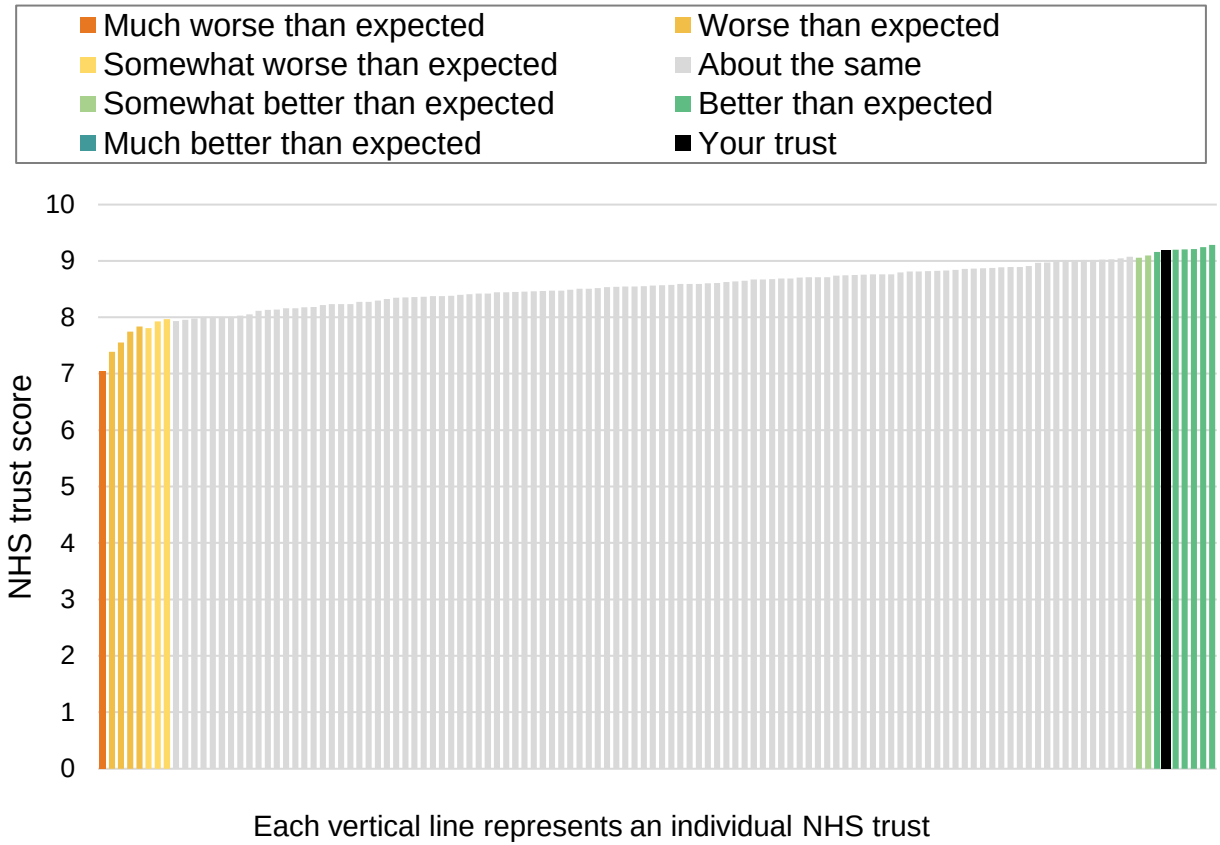


			All trusts in England			
	Number of respondents	Your trust	National average	Lowest score	Highest score	
Q44. After leaving A&E, was the care and support you expected available when you needed it?	93	7.5	7.0	4.8	8.5	About the same
Q45. If you had contact with care and support services after leaving A&E, did the health or social care staff have information about your visit?	56	6.8	6.0	3.0	7.9	About the same

Section 8. Respect and dignity

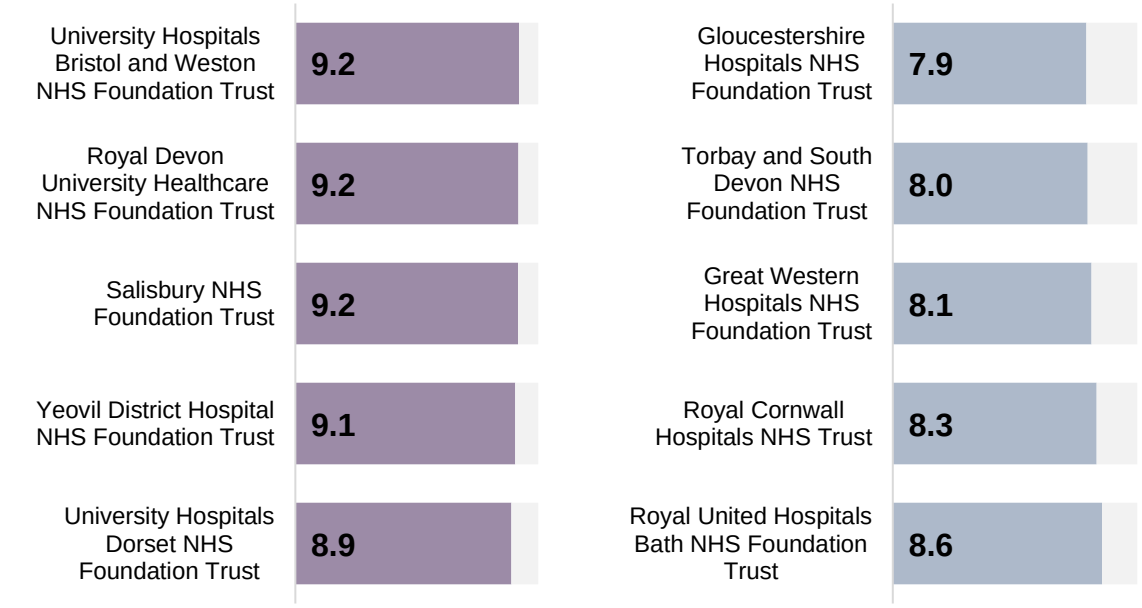
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 9.2 Better than expected



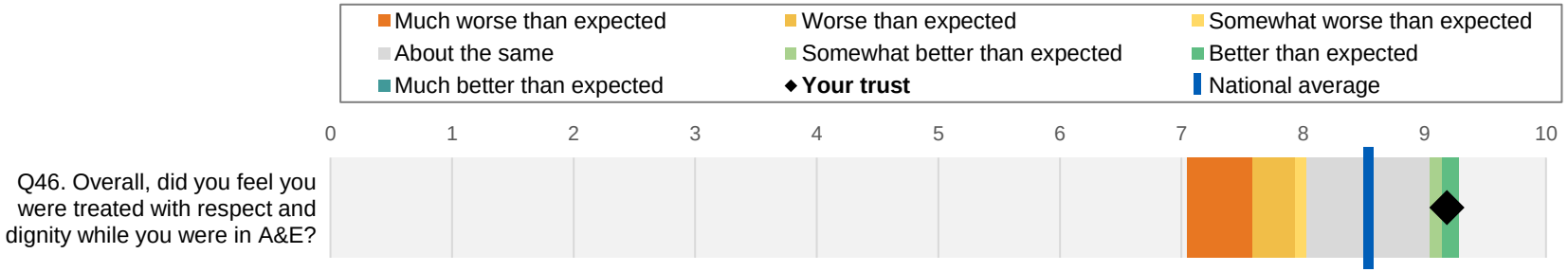
Each vertical line represents an individual NHS trust

Comparison with other trusts within your region



Section 8. Respect and dignity (continued)

Question scores



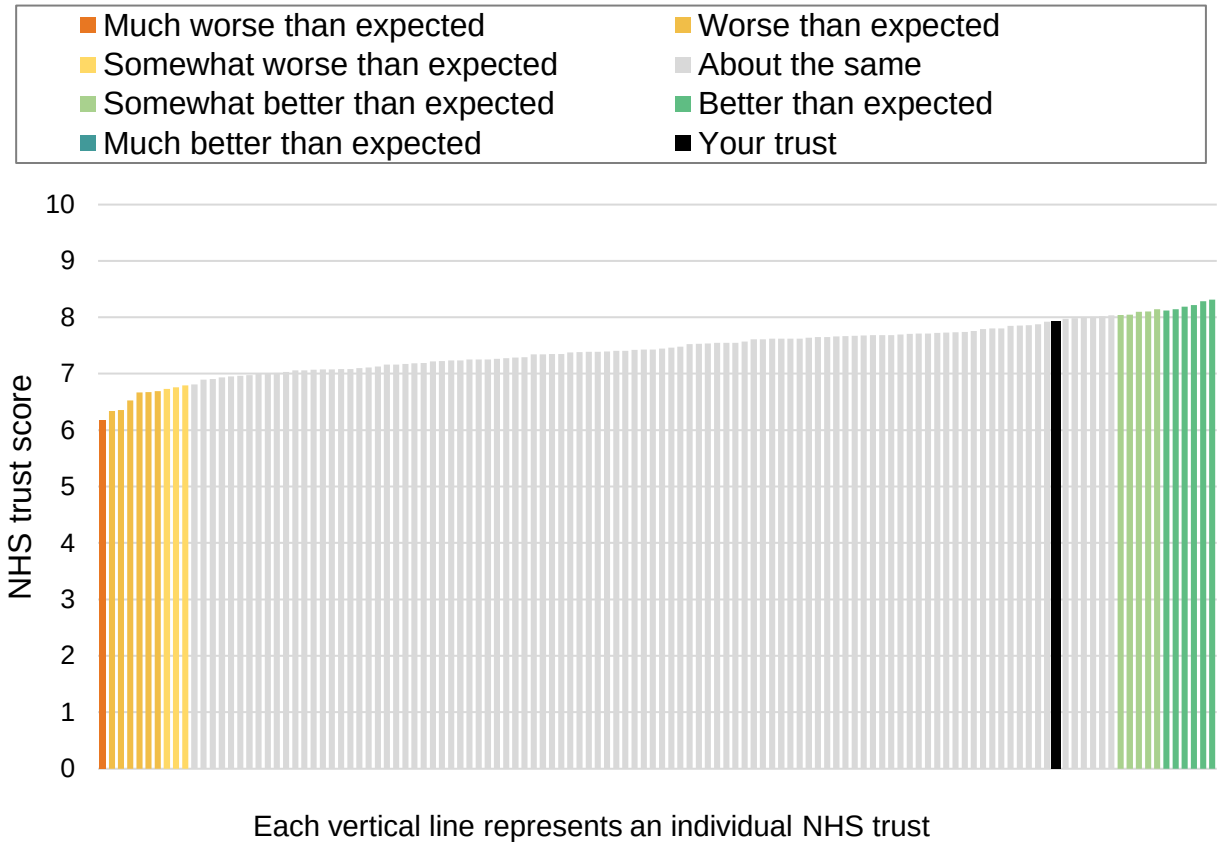
Better than expected

	All trusts in England			
Number of respondents	Your trust	National average	Lowest score	Highest score
285	9.2	8.5	7.0	9.3

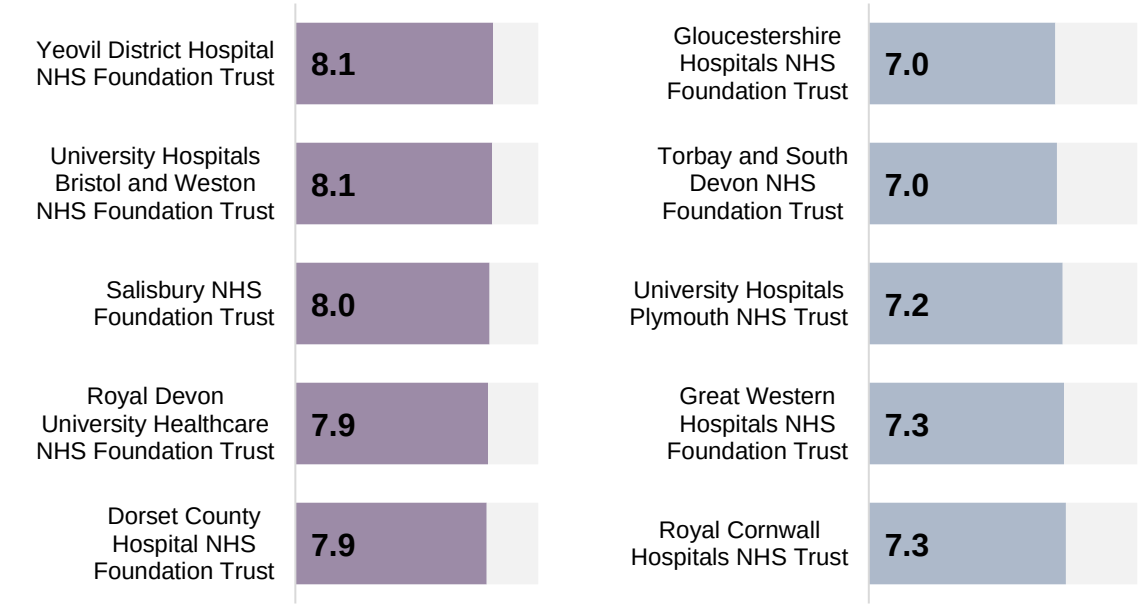
Section 9. Experience overall

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.9 About the same

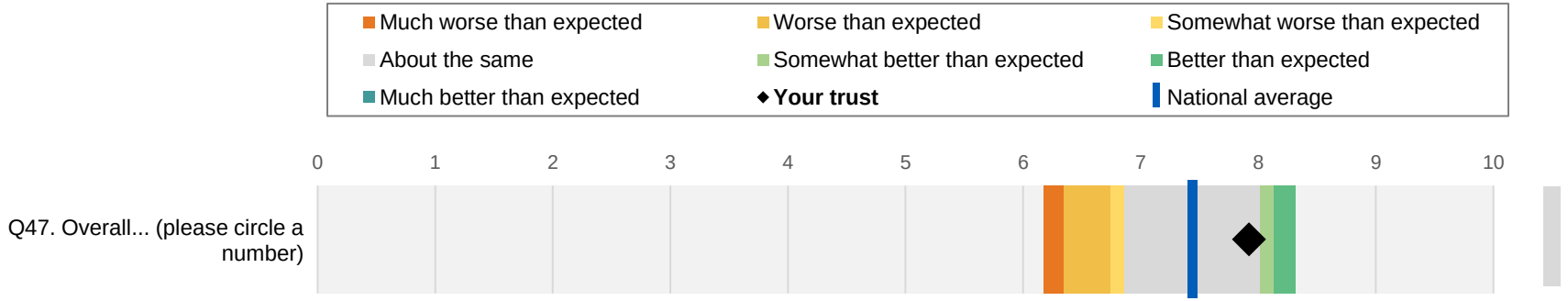


Comparison with other trusts within your region



Section 9. Experience overall (continued)

Question scores



All trusts in England				
Number of respondents	Your trust	National average	Lowest score	Highest score
278	7.9	7.4	6.2	8.3

Please note, Q29 and Q35 have been supressed as there are fewer than 30 respondents.

Trust and site-level results

This section includes:

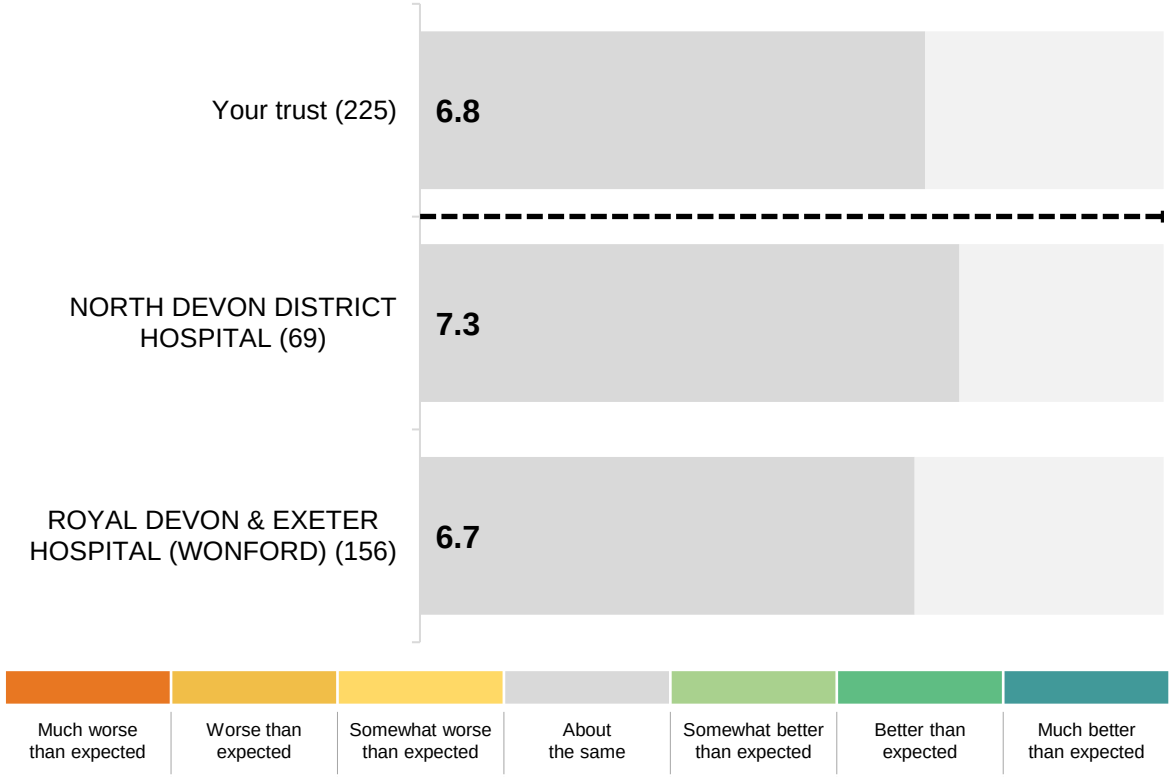
- an overview of results for your trust for each question, including:
  - the score for your trust
  - a breakdown of scores across sites within your trust
- if fewer than 30 responses were received from patients discharged from a site, no scores will be displayed for that site

Section 1. Arrival at A&E

Q6. Were you given enough privacy when discussing your condition with the receptionist?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



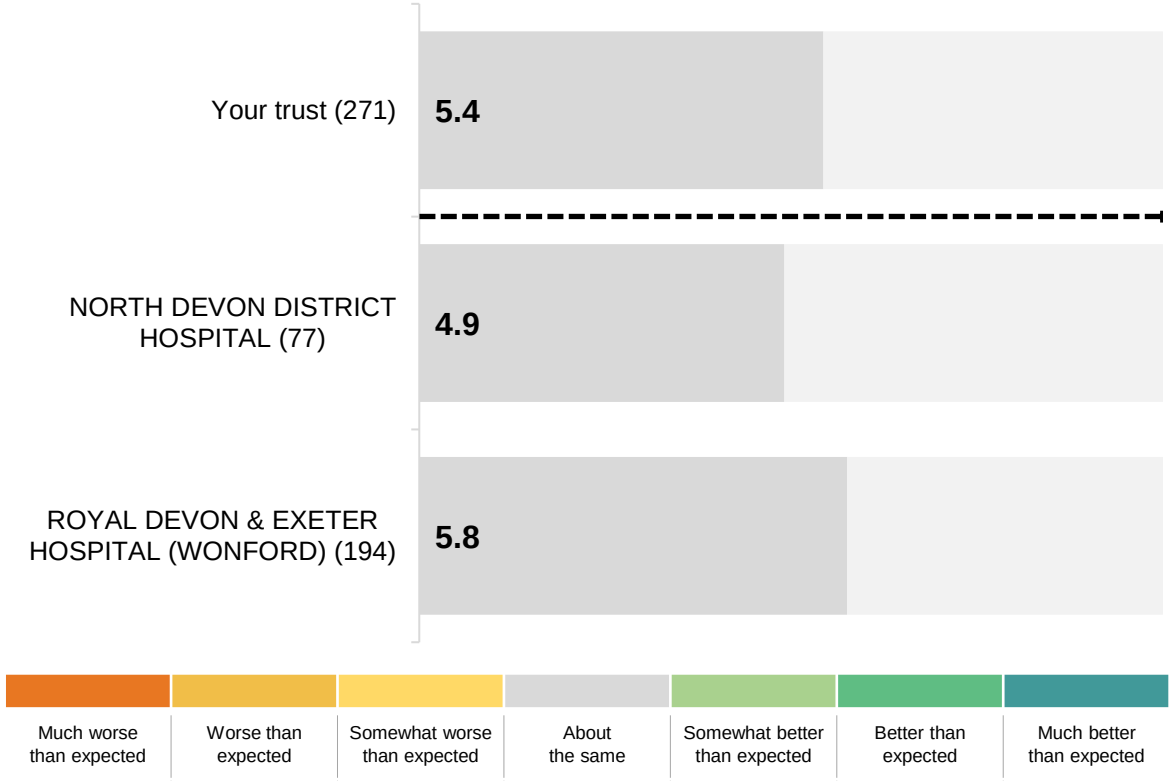
Please note: the number of respondents is shown in brackets next to the site name

Section 2. Waiting

Q7. How long did you wait before you first spoke to a nurse or doctor?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



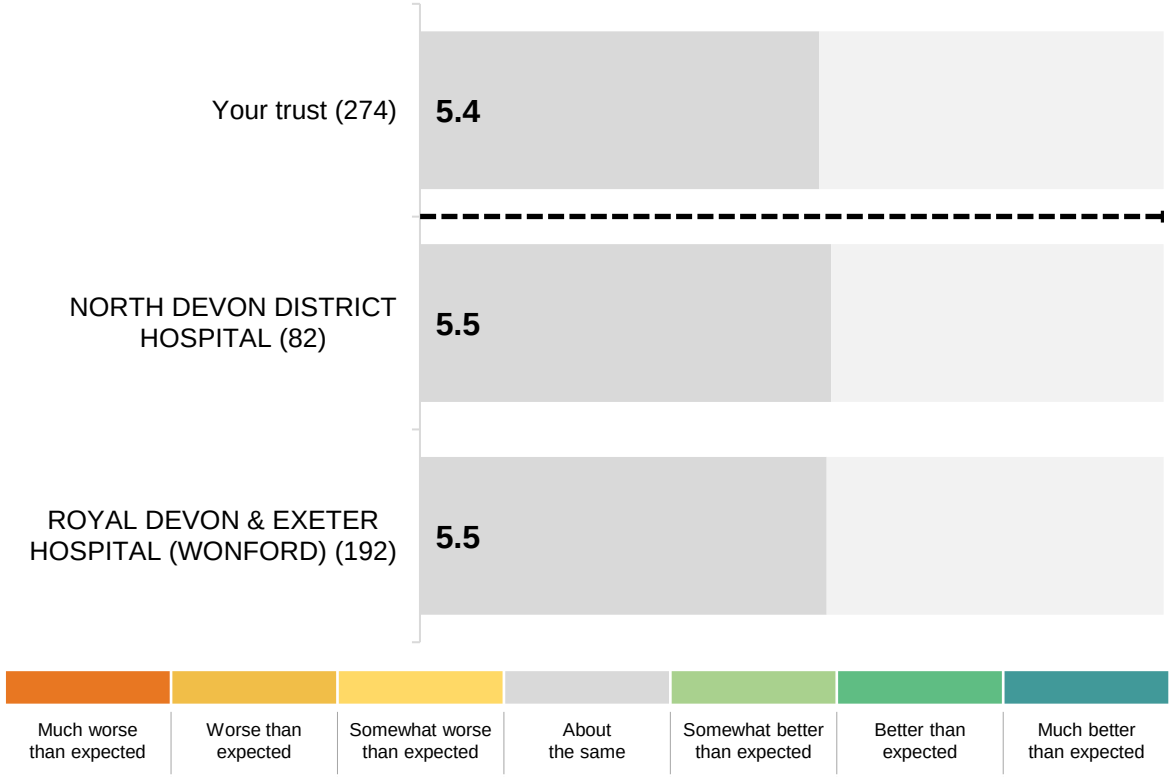
Please note: the number of respondents is shown in brackets next to the site name

Section 2. Waiting

Q8. Sometimes, people will first talk to a doctor or nurse and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



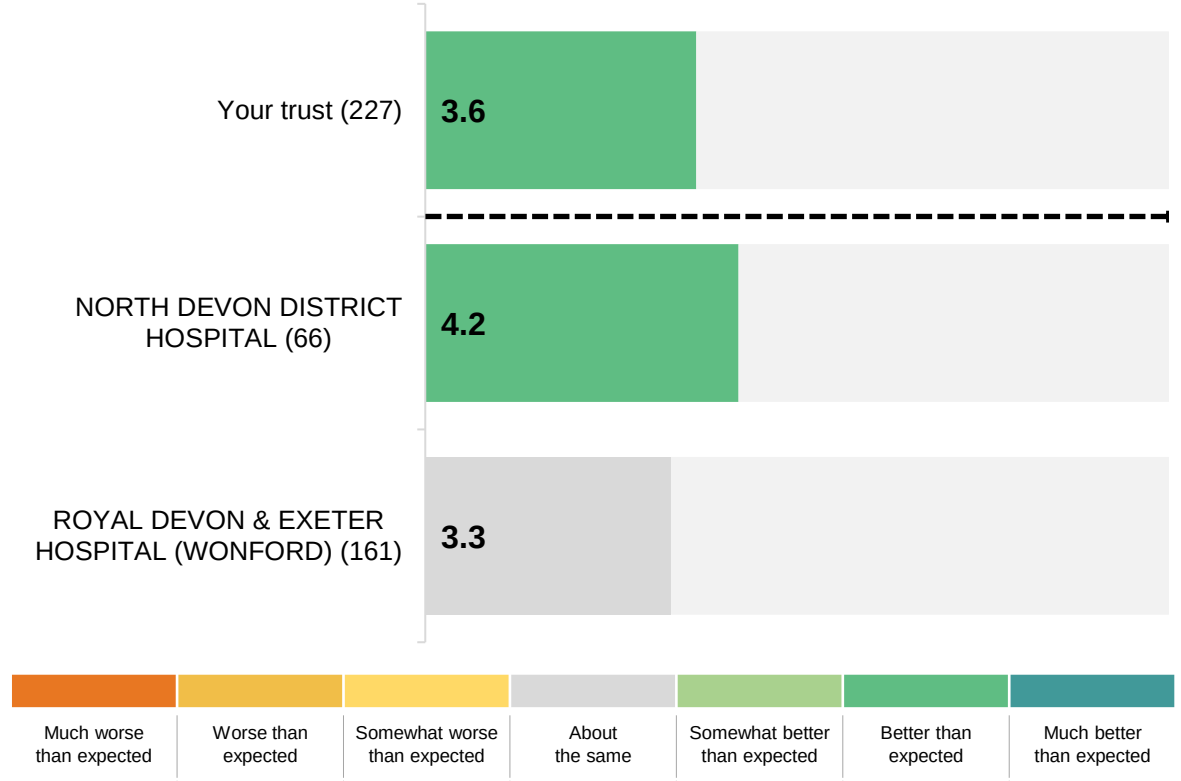
Please note: the number of respondents is shown in brackets next to the site name

Section 2. Waiting

Q9. Were you informed how long you would have to wait to be examined?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



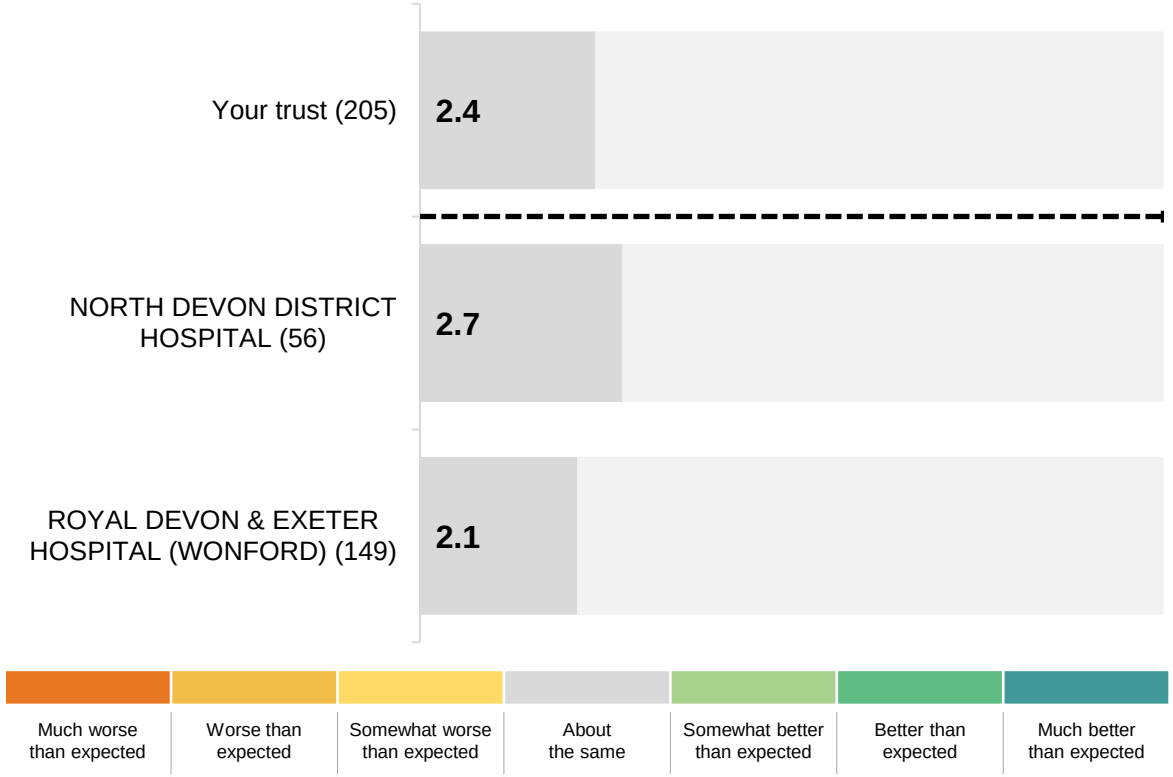
Please note: the number of respondents is shown in brackets next to the site name

Section 2. Waiting

Q10. Were you kept updated on how long your wait would be?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



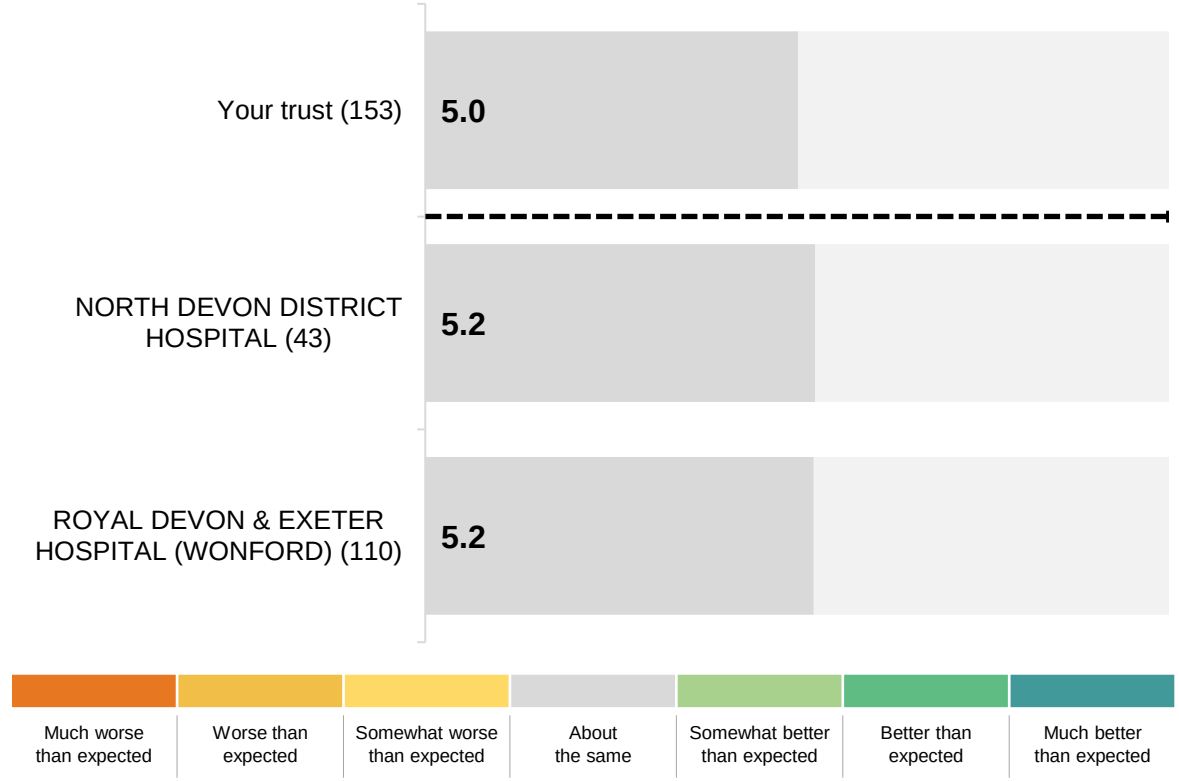
Please note: the number of respondents is shown in brackets next to the site name

Section 2. Waiting

Q11. While you were waiting, were you able to get help with your condition or symptoms from a member of staff?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



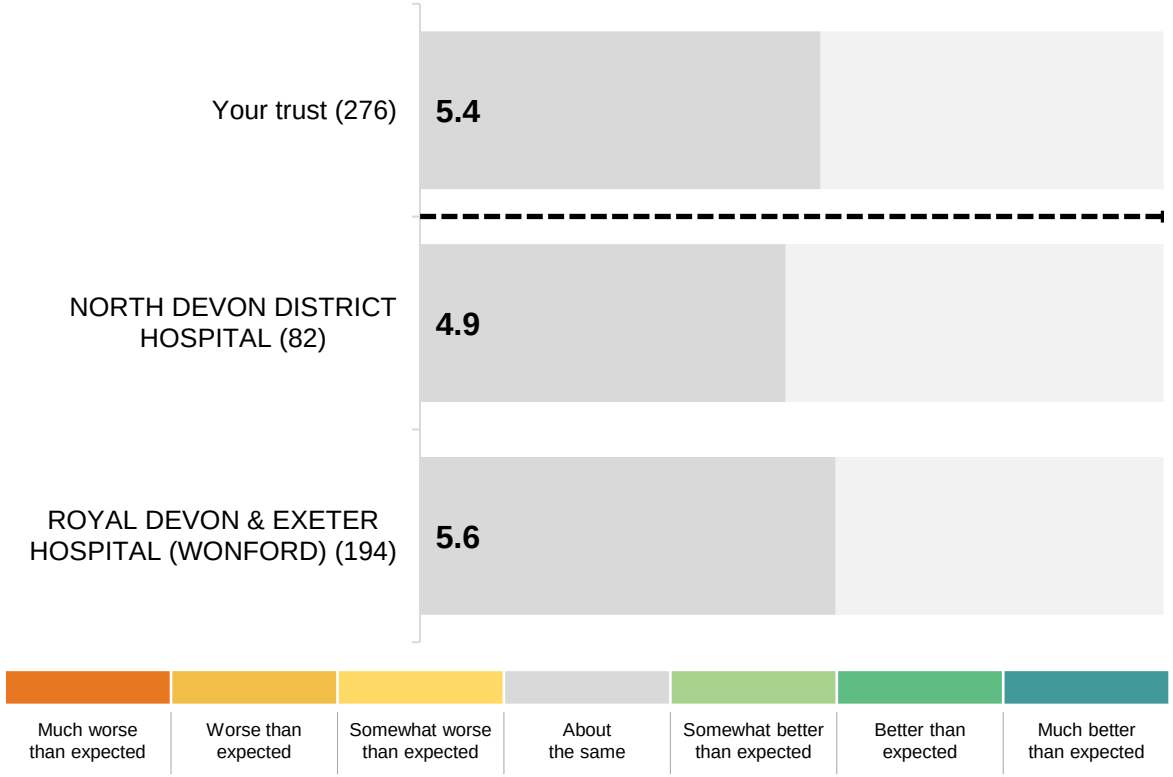
Please note: the number of respondents is shown in brackets next to the site name

Section 2. Waiting

Q12. Overall, how long did your visit to A&E last?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



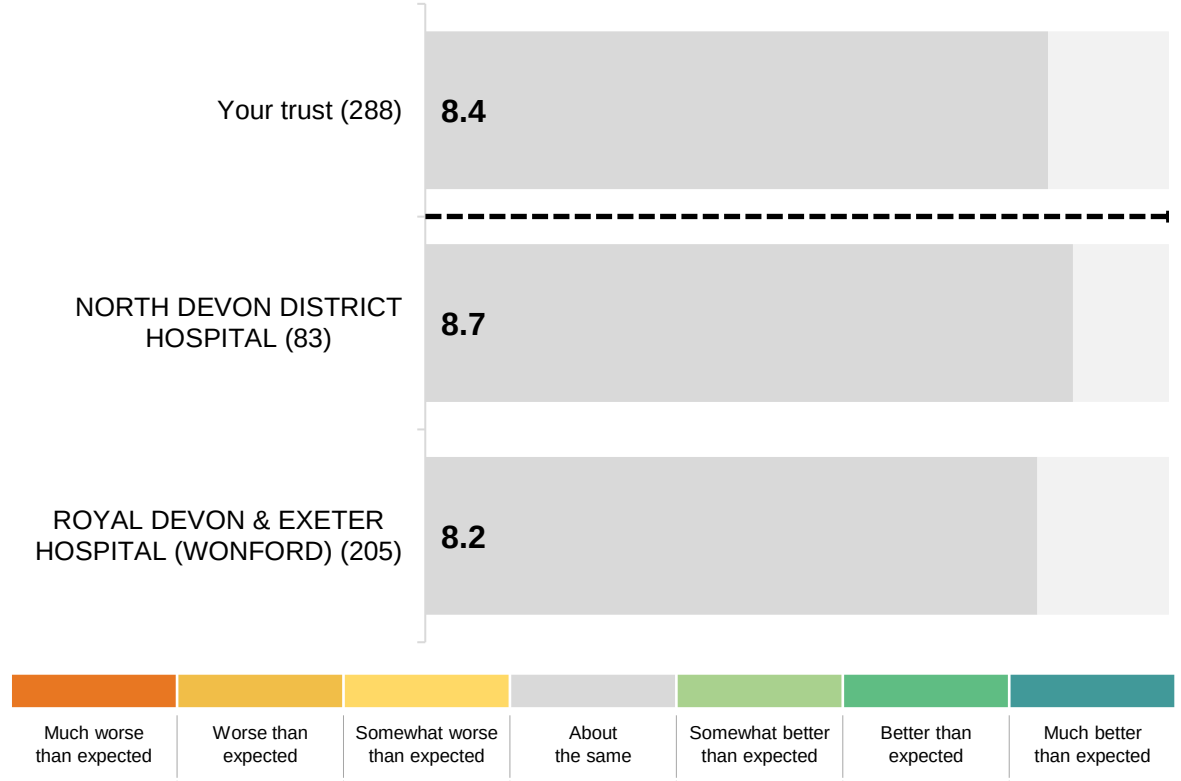
Please note: the number of respondents is shown in brackets next to the site name

Section 3. Doctors and nurses

Q13. Did you have enough time to discuss your condition with the doctor or nurse?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



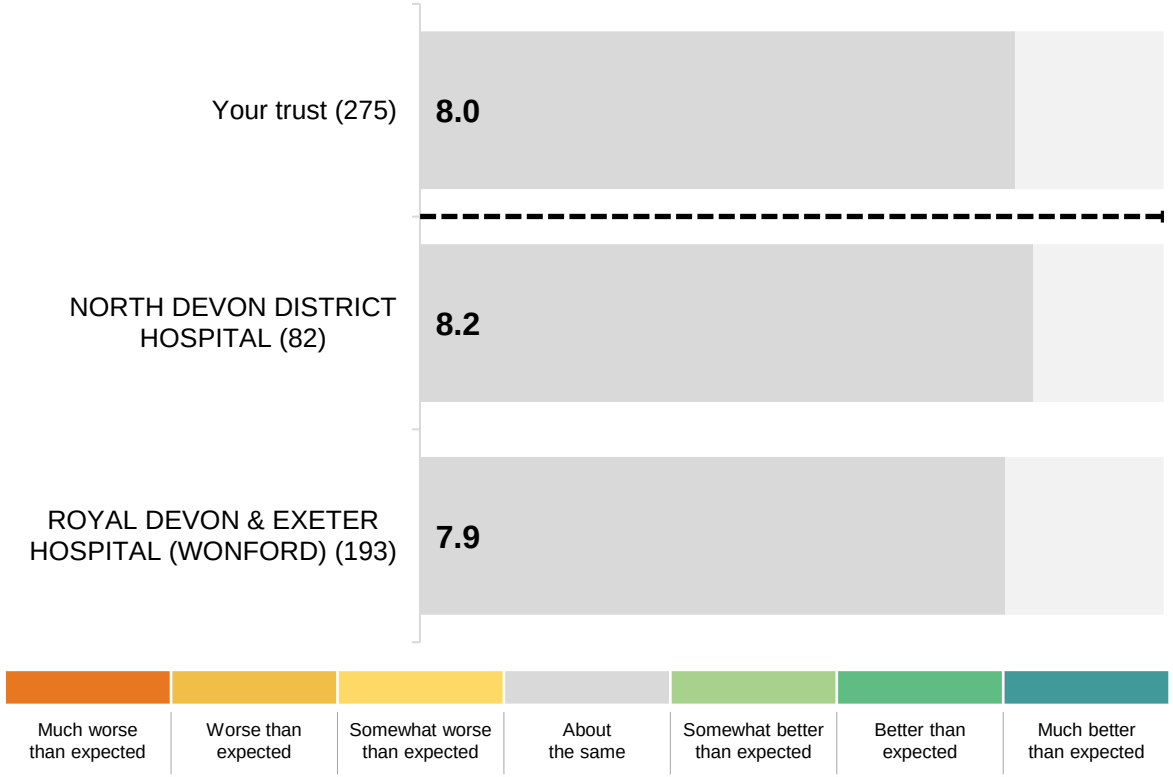
Please note: the number of respondents is shown in brackets next to the site name

Section 3. Doctors and nurses

Q14. While you were in A&E, did a doctor or nurse explain your condition and treatment in a way you could understand?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



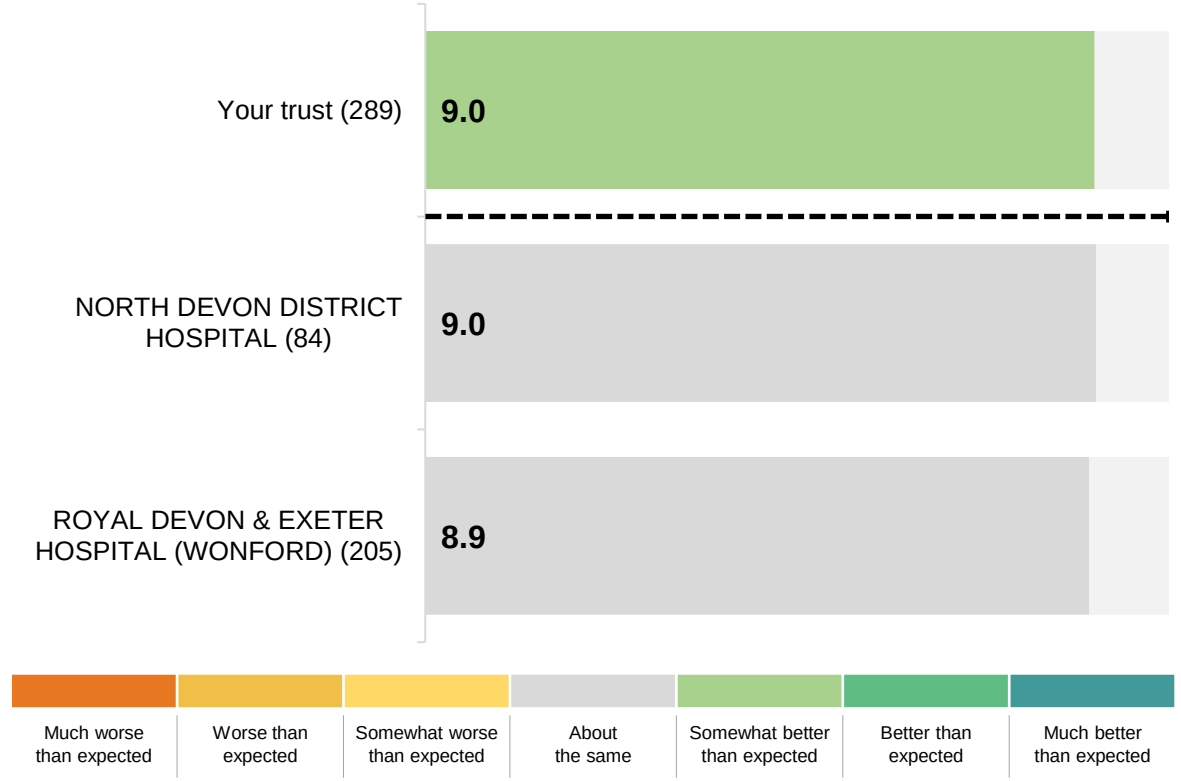
Please note: the number of respondents is shown in brackets next to the site name

Section 3. Doctors and nurses

Q15. Did the doctors and nurses listen to what you had to say?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



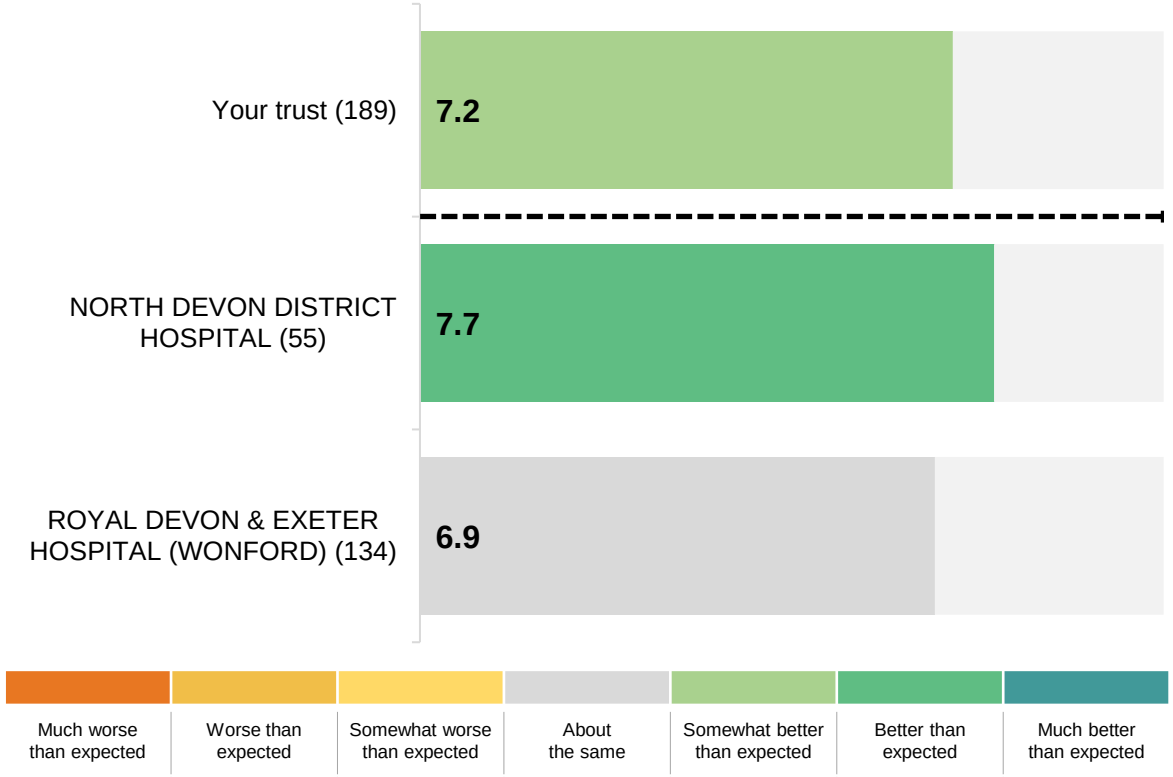
Please note: the number of respondents is shown in brackets next to the site name

Section 3. Doctors and nurses

Q16. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



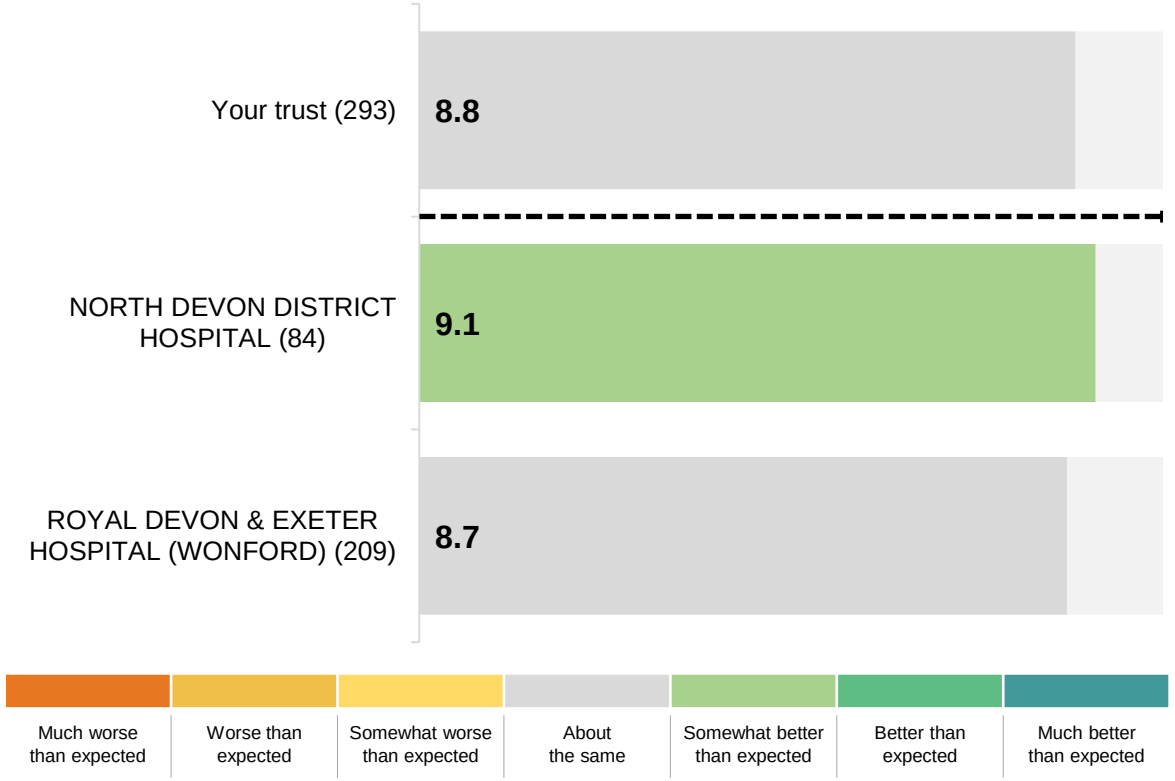
Please note: the number of respondents is shown in brackets next to the site name

Section 3. Doctors and nurses

Q17. Did you have confidence and trust in the doctors and nurses examining and treating you?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



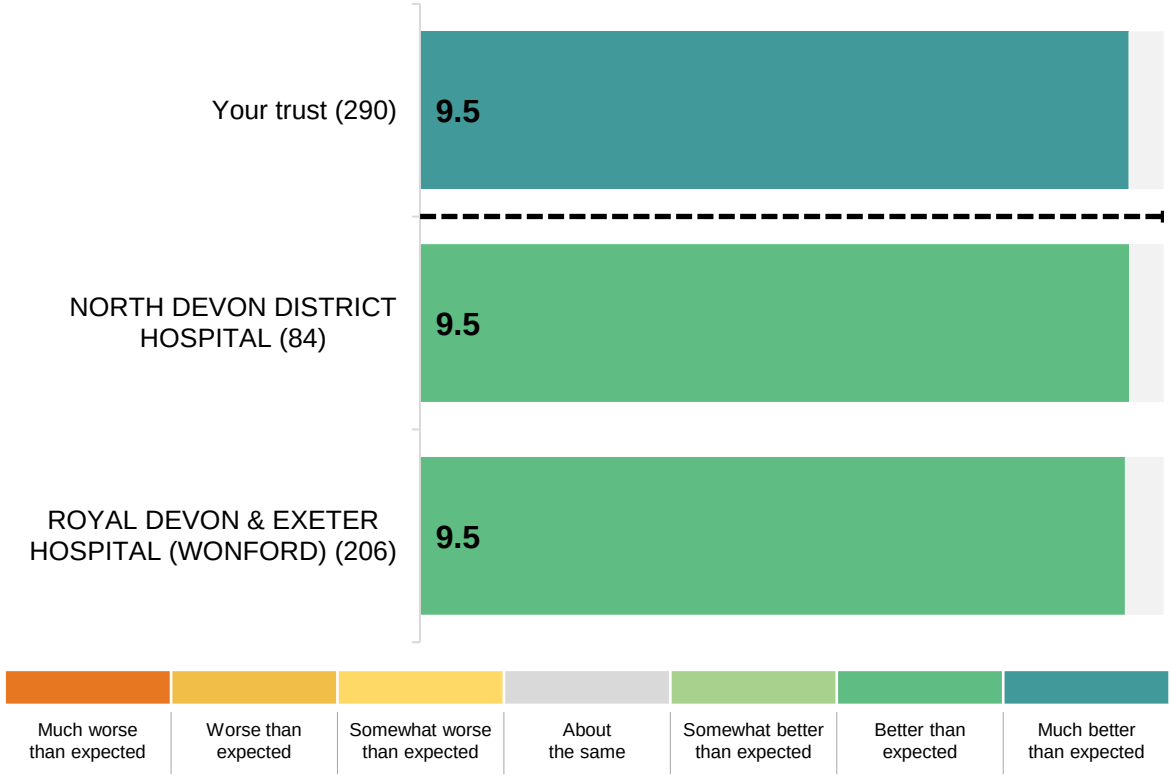
Please note: the number of respondents is shown in brackets next to the site name

Section 3. Doctors and nurses

Q18. Did doctors or nurses talk to each other about you as if you weren't there?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



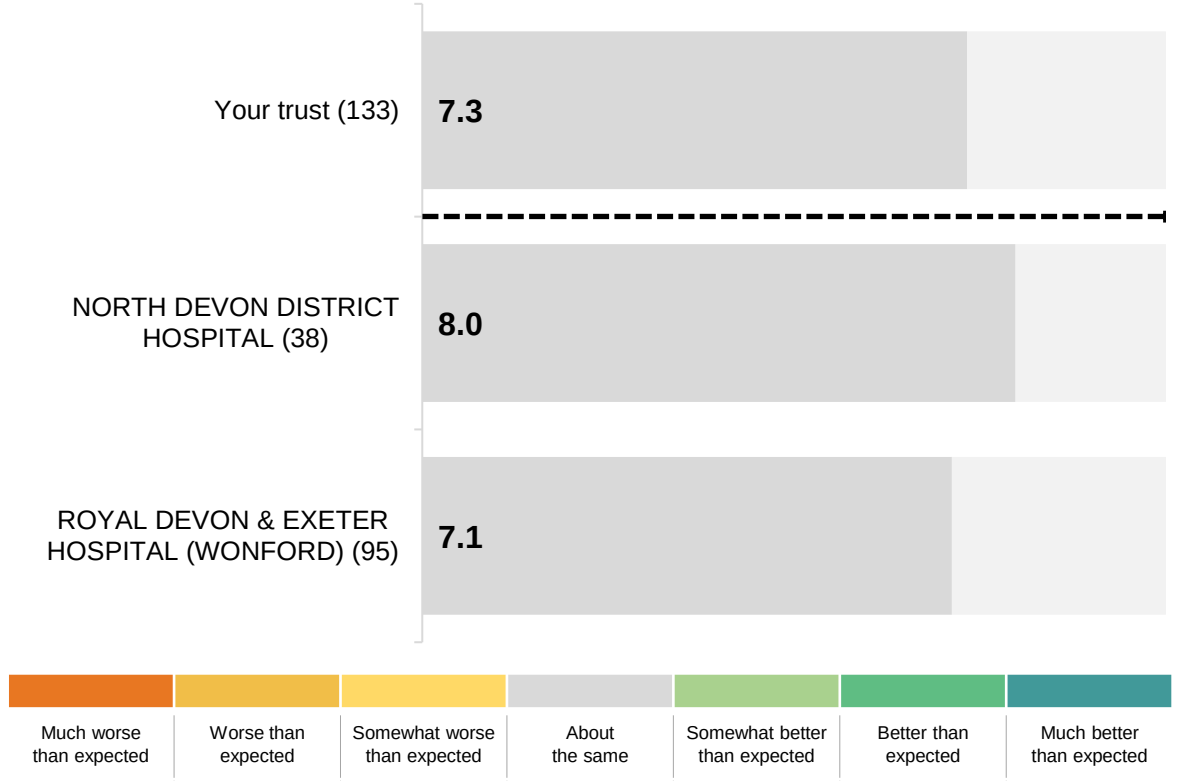
Please note: the number of respondents is shown in brackets next to the site name

Section 3. Doctors and nurses

Q20. If a family member, friend or carer wanted to talk to a health professional, did they have enough opportunity to do so?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



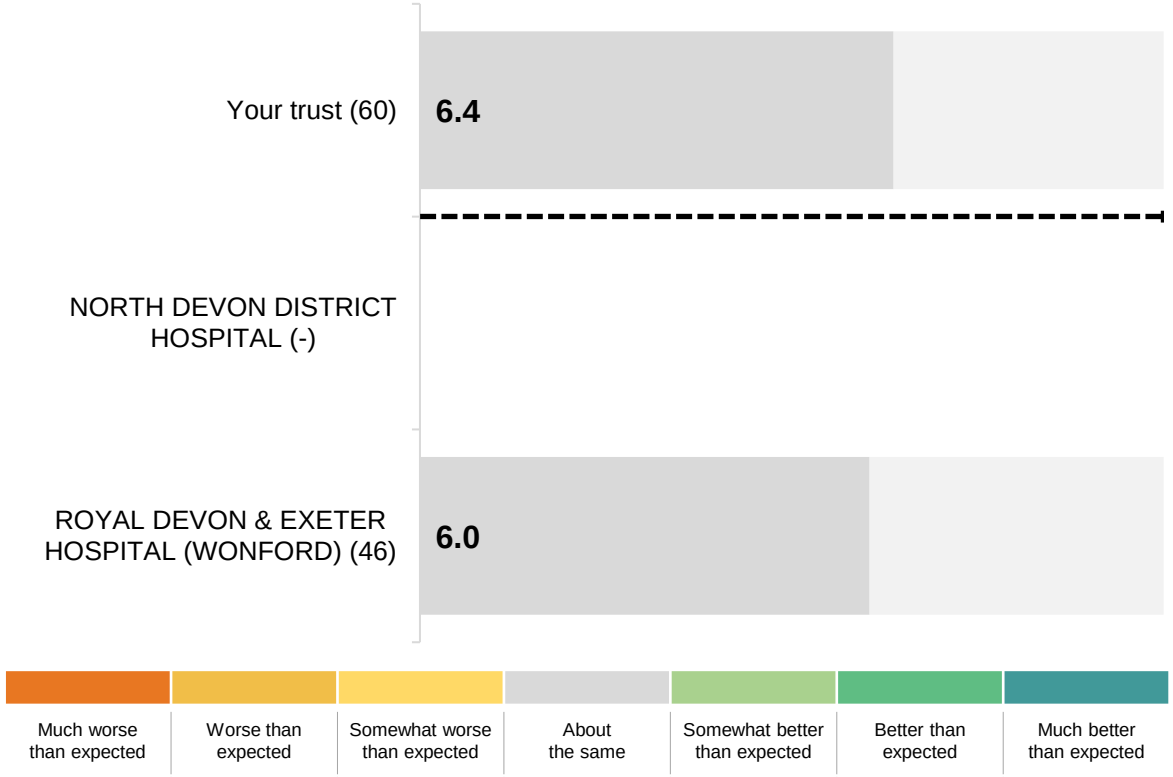
Please note: the number of respondents is shown in brackets next to the site name

Section 4. Care and treatment

Q21. While you were in A&E, did staff help you with your communication needs?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



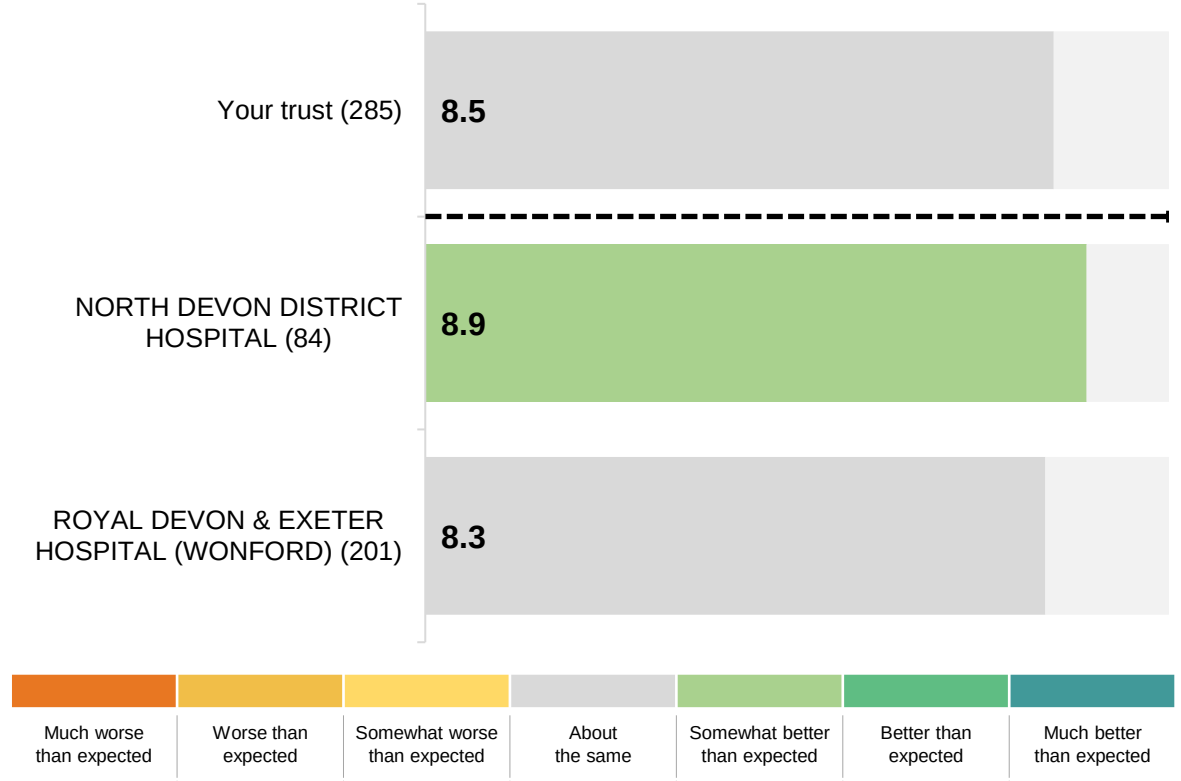
Please note: the number of respondents is shown in brackets next to the site name

Section 4. Care and treatment

Q22. While you were in A&E, how much information about your condition or treatment was given to you?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



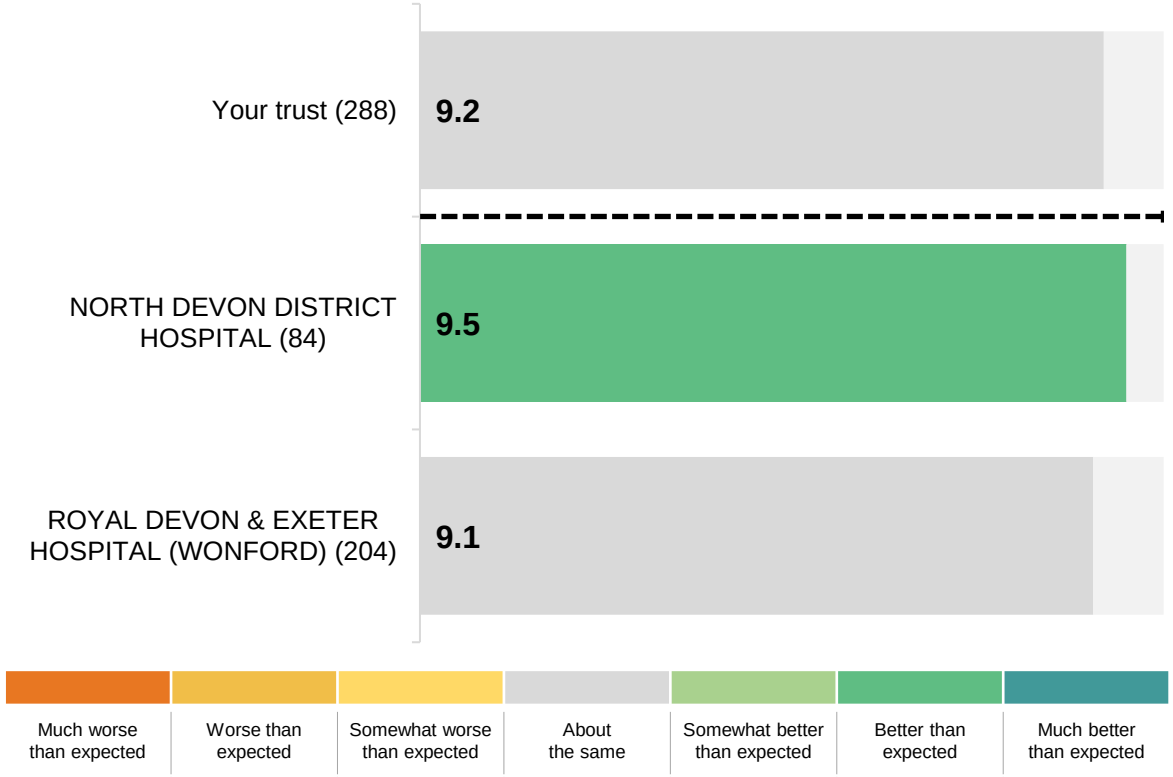
Please note: the number of respondents is shown in brackets next to the site name

Section 4. Care and treatment

Q23. Were you given enough privacy when being examined or treated?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



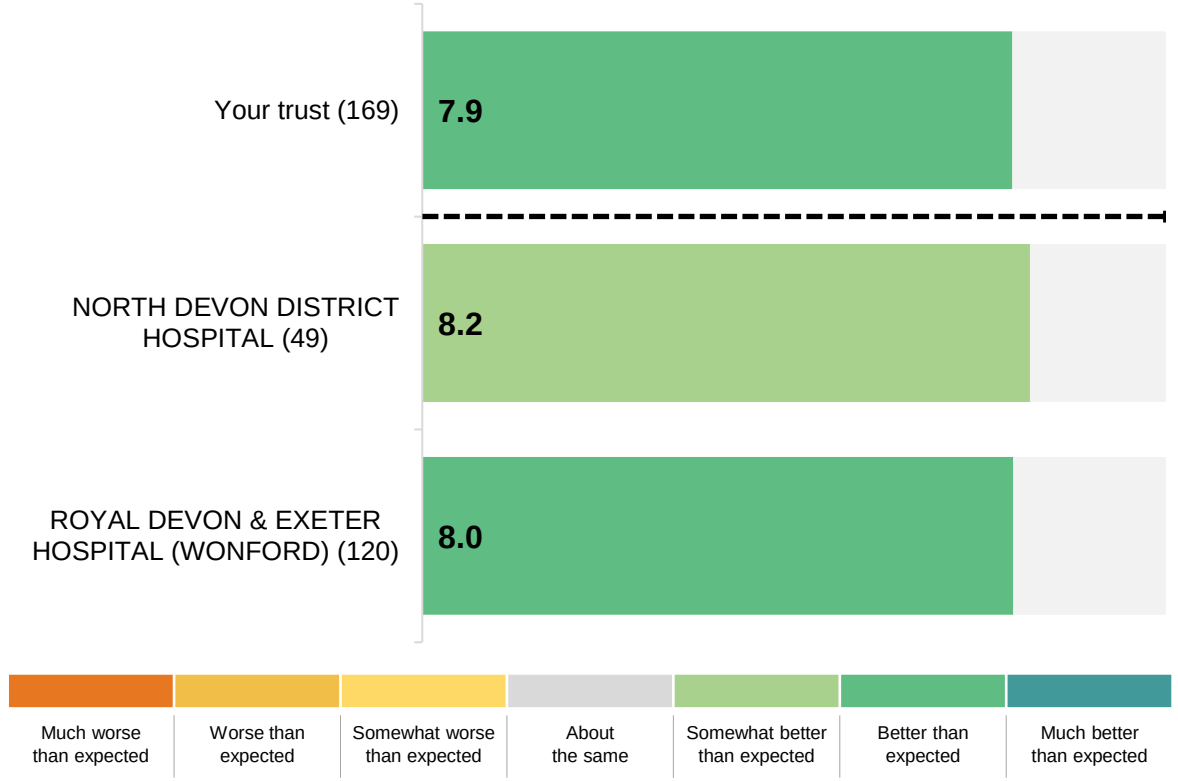
Please note: the number of respondents is shown in brackets next to the site name

Section 4. Care and treatment

Q24. If you needed attention, were you able to get a member of medical or nursing staff to help you?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



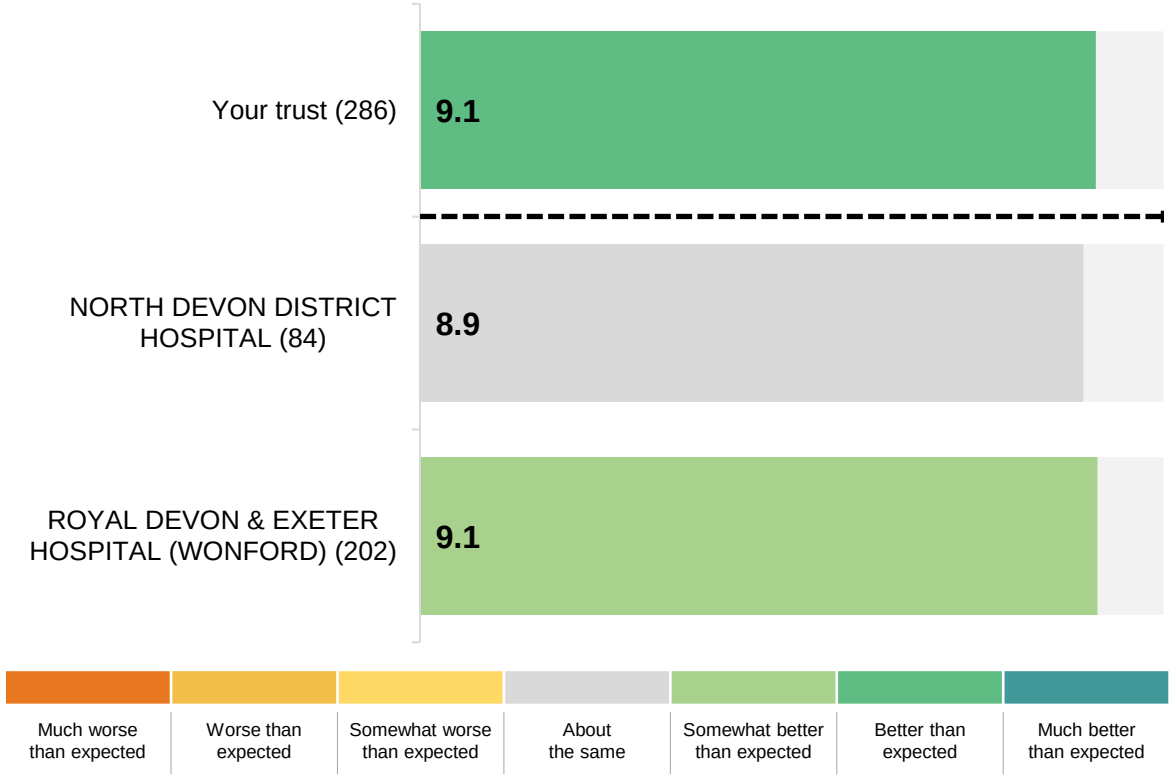
Please note: the number of respondents is shown in brackets next to the site name

Section 4. Care and treatment

Q25. Sometimes, a member of staff will say one thing and another will say something quite different. Did this happen to you?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



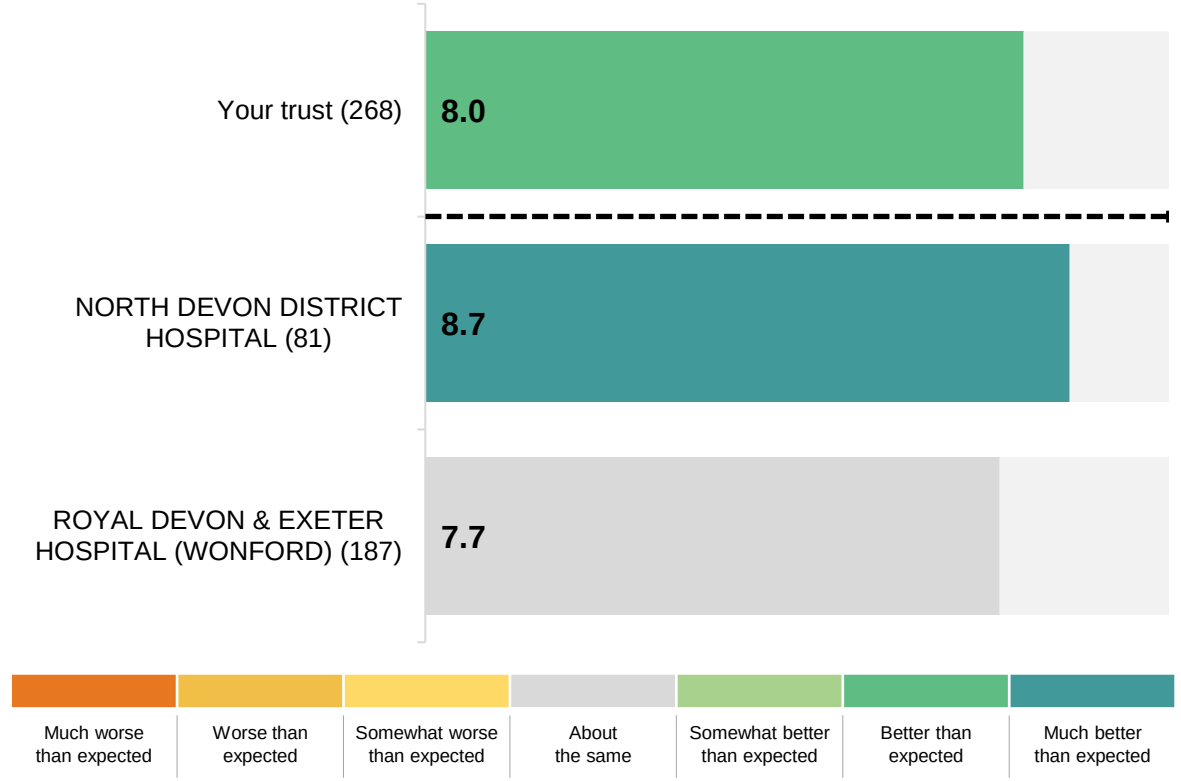
Please note: the number of respondents is shown in brackets next to the site name

Section 4. Care and treatment

Q26. Were you involved as much as you wanted to be in decisions about your care and treatment?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



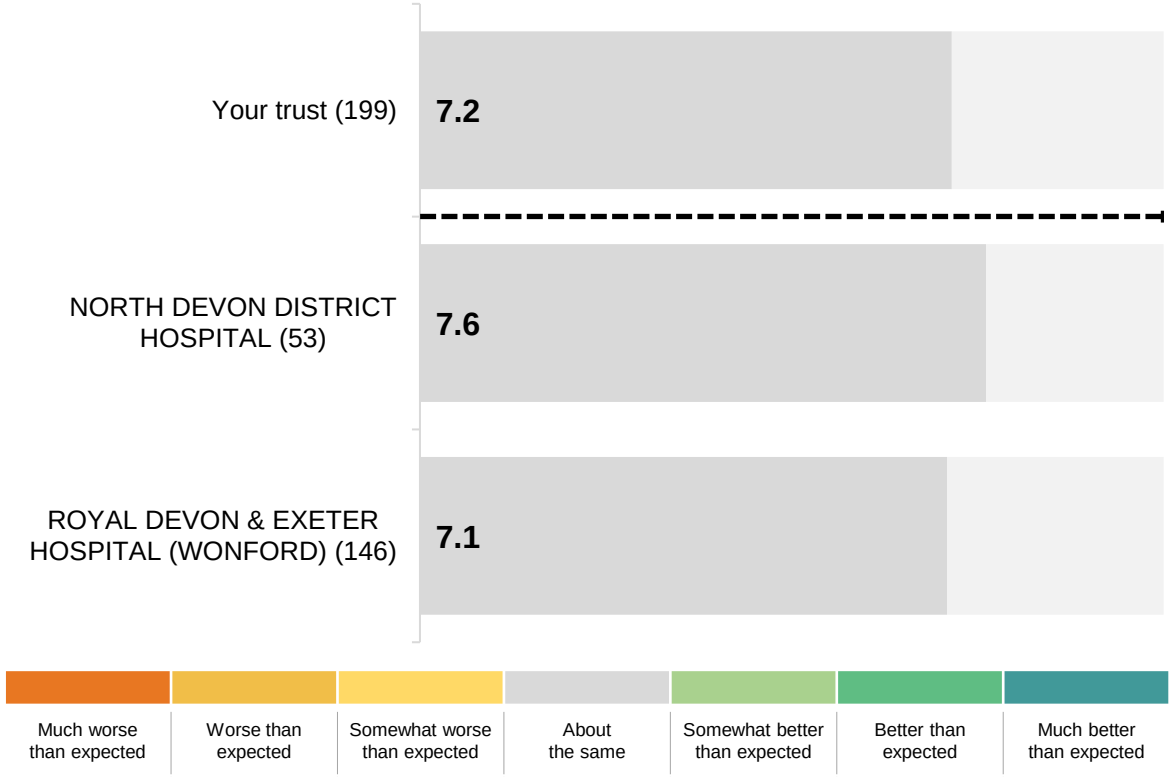
Please note: the number of respondents is shown in brackets next to the site name

Section 4. Care and treatment

Q30. Do you think the hospital staff did everything they could to help control your pain?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



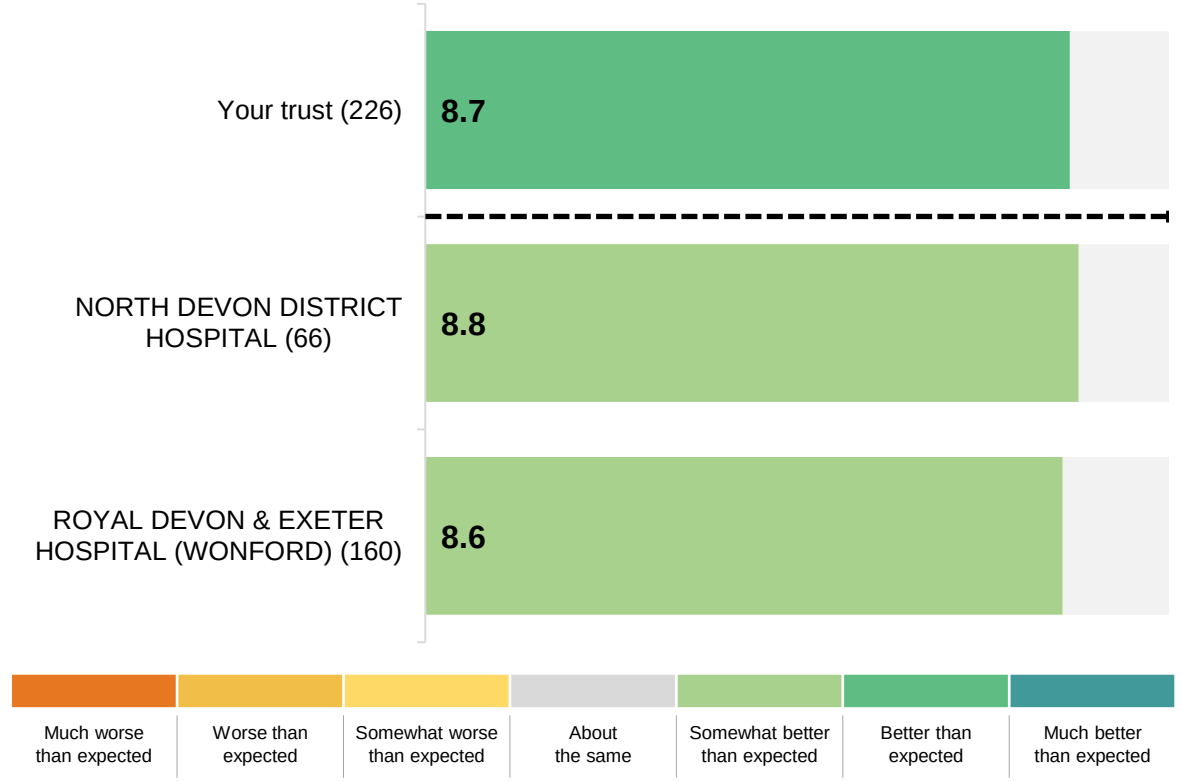
Please note: the number of respondents is shown in brackets next to the site name

Section 5. Tests

Q27. If you had any tests, did a member of staff explain why you needed them in a way you could understand?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



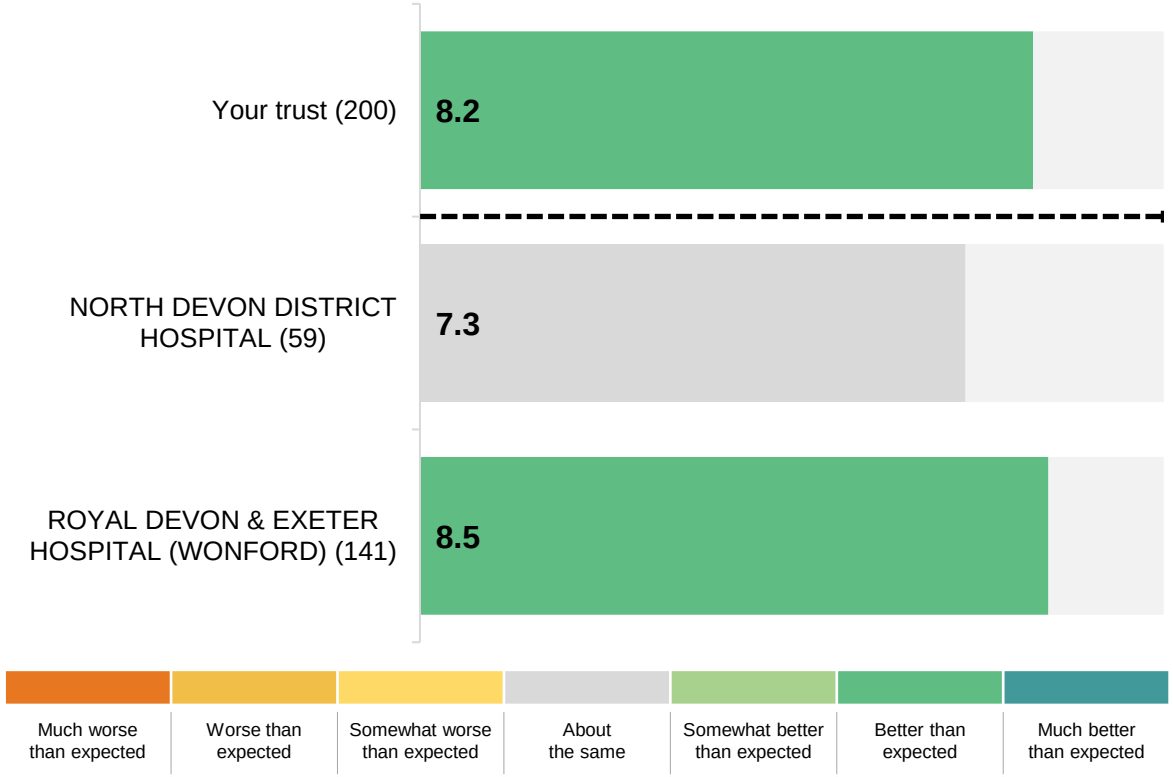
Please note: the number of respondents is shown in brackets next to the site name

Section 5. Tests

Q28. Before you left A&E, did a member of staff explain the results of the tests in a way you could understand?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



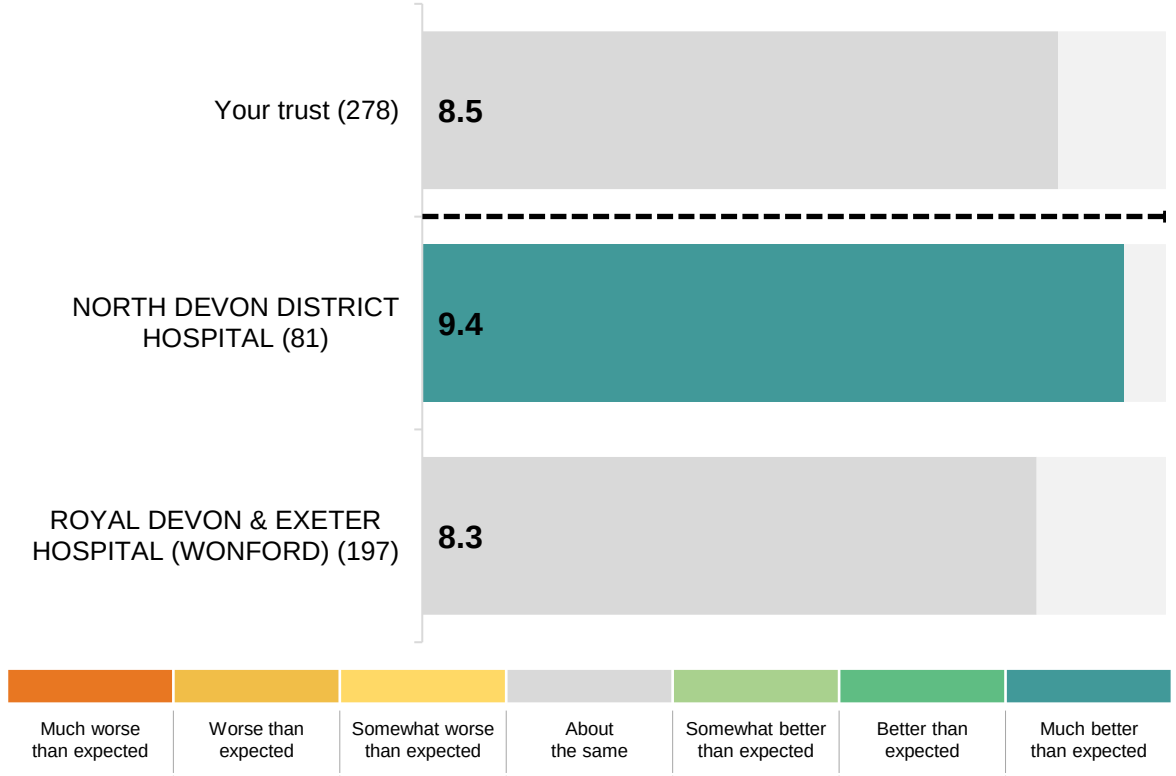
Please note: the number of respondents is shown in brackets next to the site name

Section 6. Environment and facilities

Q31. In your opinion, how clean was the A&E department?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



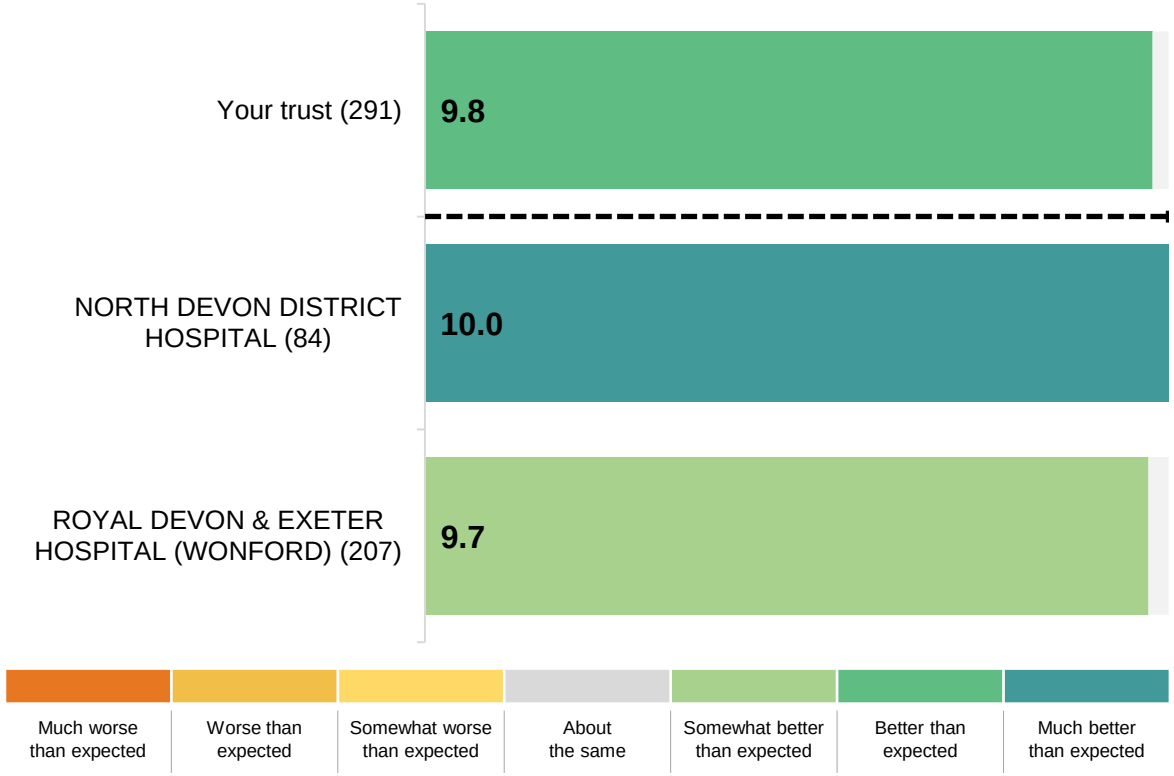
Please note: the number of respondents is shown in brackets next to the site name

Section 6. Environment and facilities

Q32. While you were in A&E, did you feel threatened by other patients or visitors?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



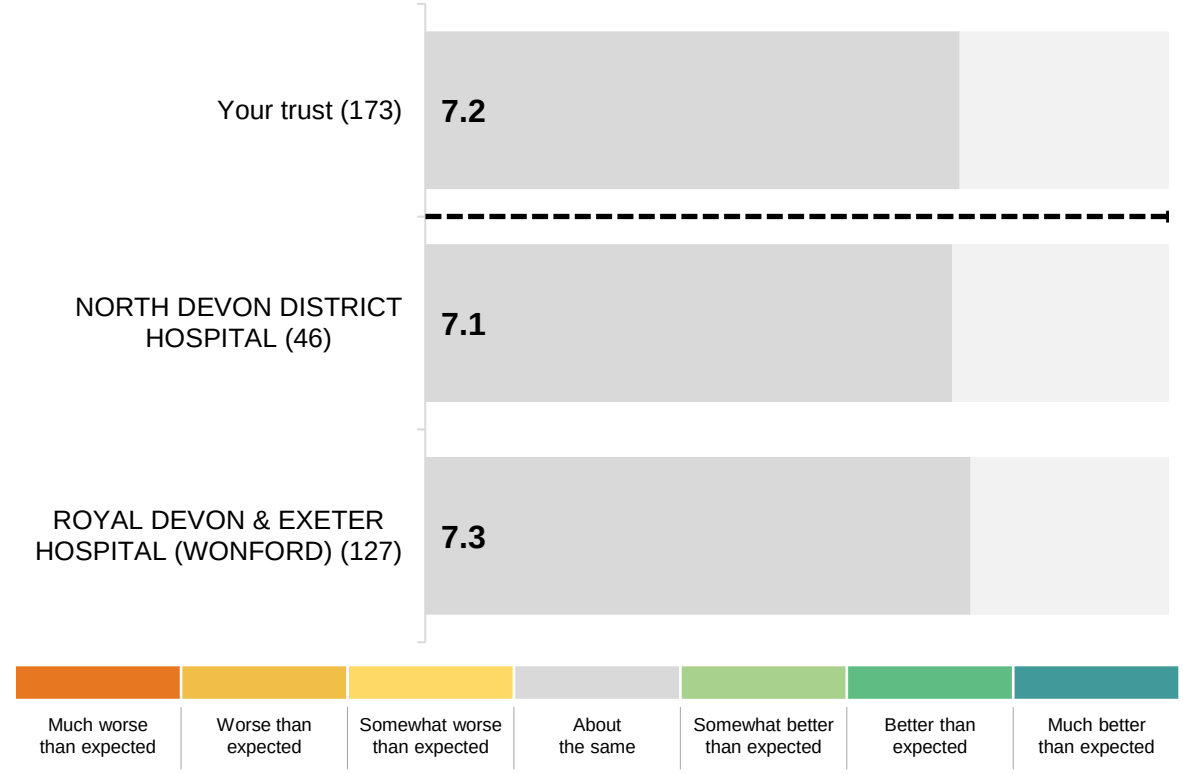
Please note: the number of respondents is shown in brackets next to the site name

Section 6. Environment and facilities

Q33. Were you able to get suitable food or drinks when you were in A&E?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



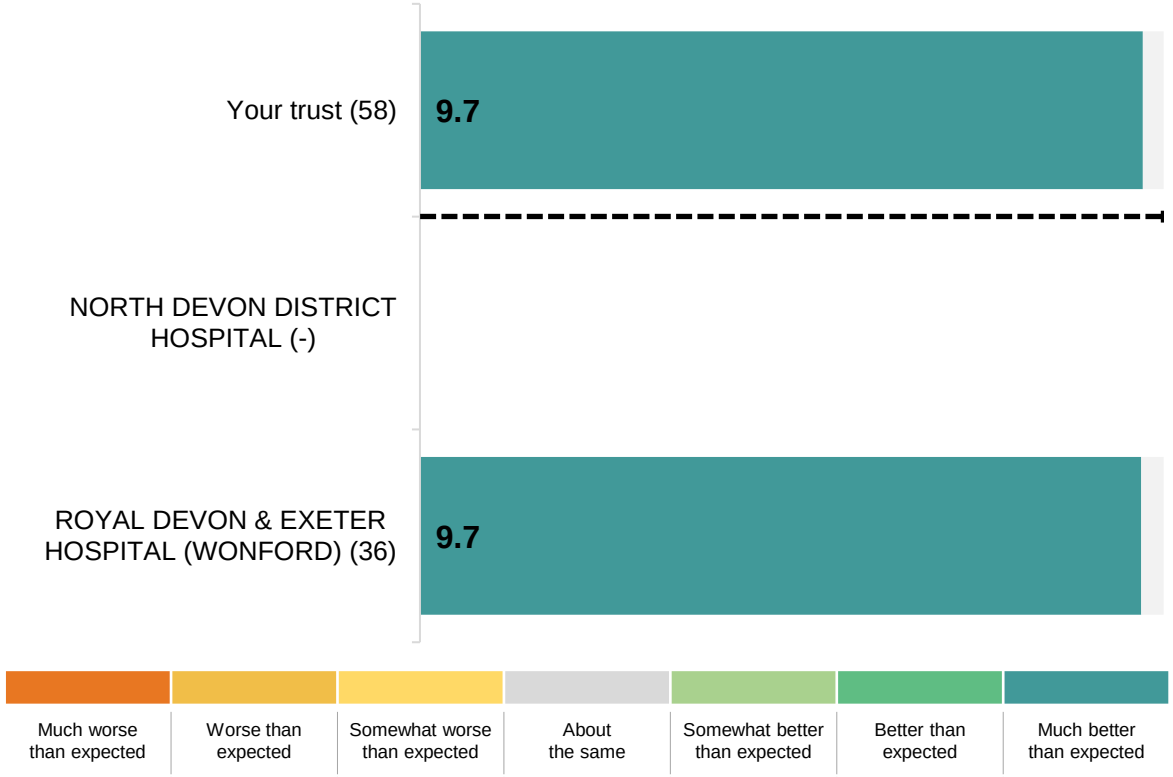
Please note: the number of respondents is shown in brackets next to the site name

Section 7. Leaving A&E

Q37. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



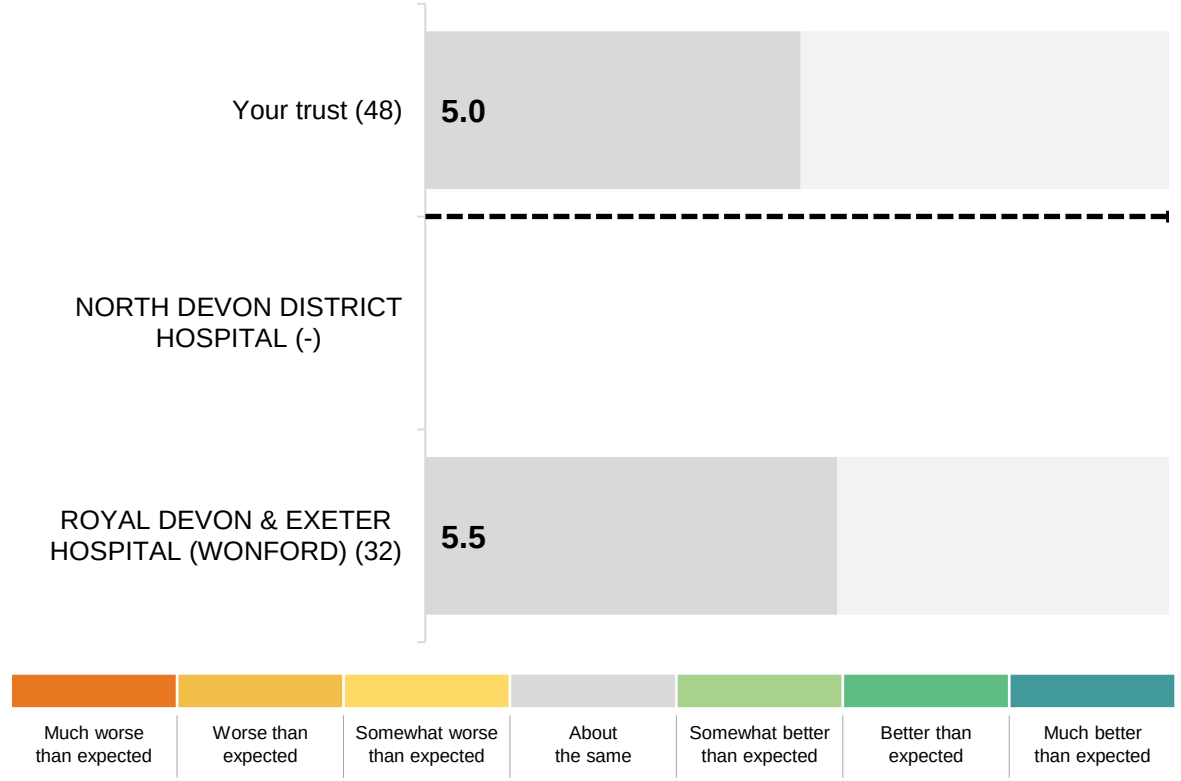
Please note: the number of respondents is shown in brackets next to the site name

Section 7. Leaving A&E

Q38. Did a member of staff tell you about medication side effects to watch for?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



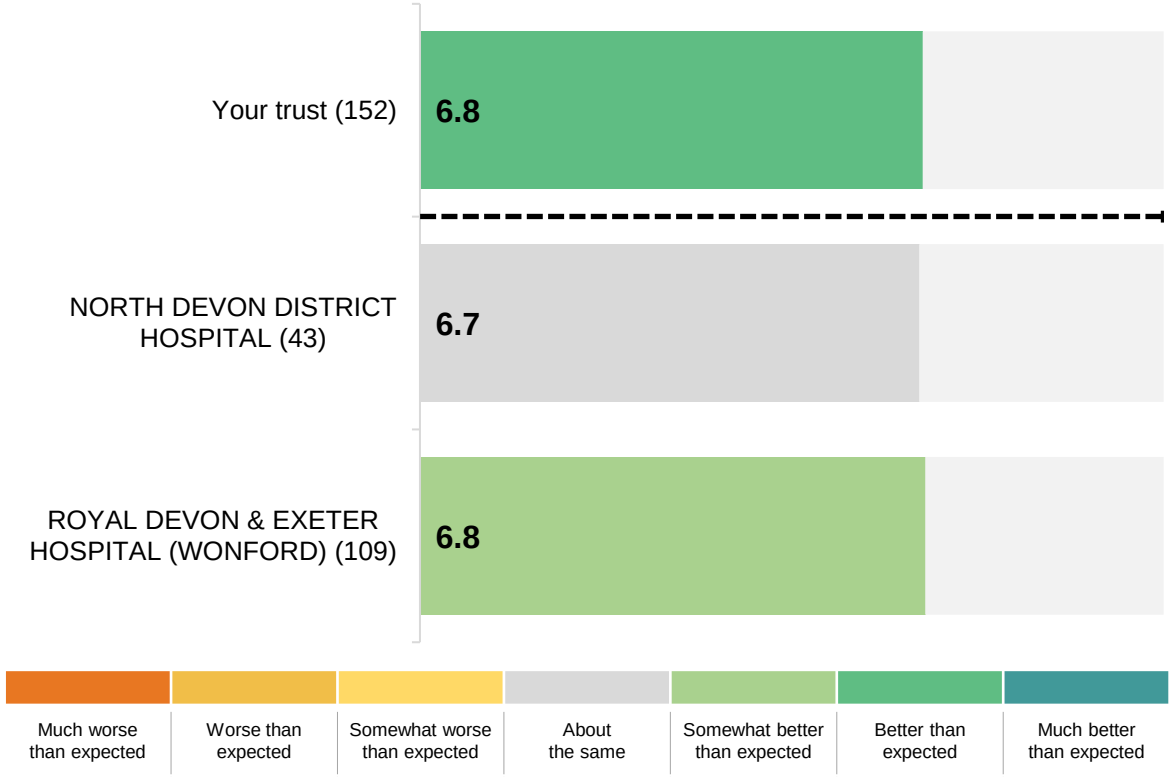
Please note: the number of respondents is shown in brackets next to the site name

Section 7. Leaving A&E

Q39. Did a member of staff tell you about what symptoms to watch for regarding your illness or treatment after you went home?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



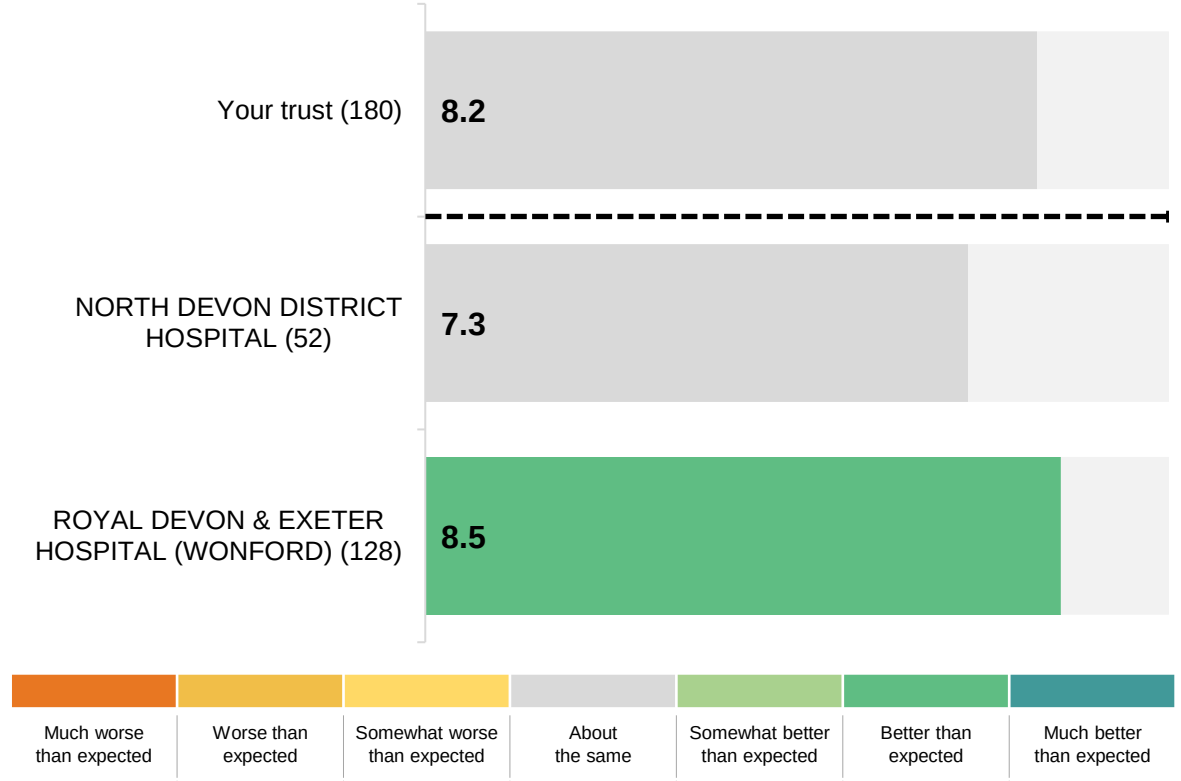
Please note: the number of respondents is shown in brackets next to the site name

Section 7. Leaving A&E

Q40. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left A&E?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



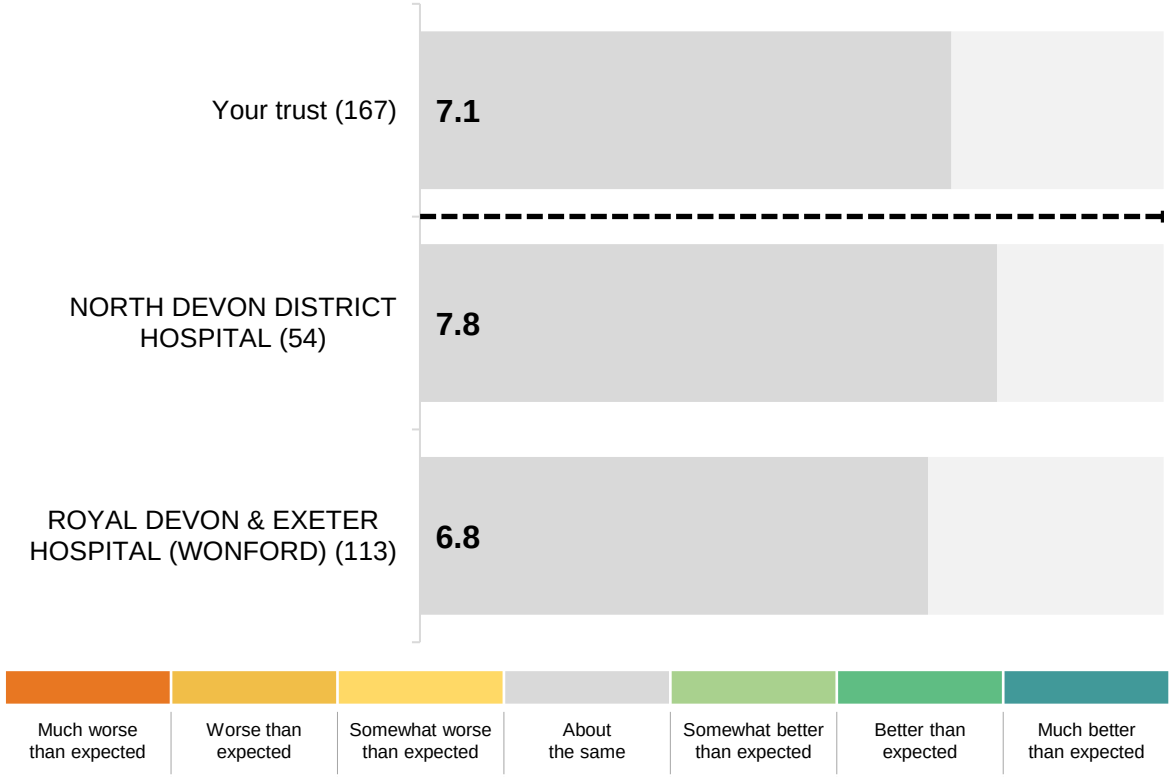
Please note: the number of respondents is shown in brackets next to the site name

Section 7. Leaving A&E

Q41. Did staff give you enough information to help you care for your condition at home?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



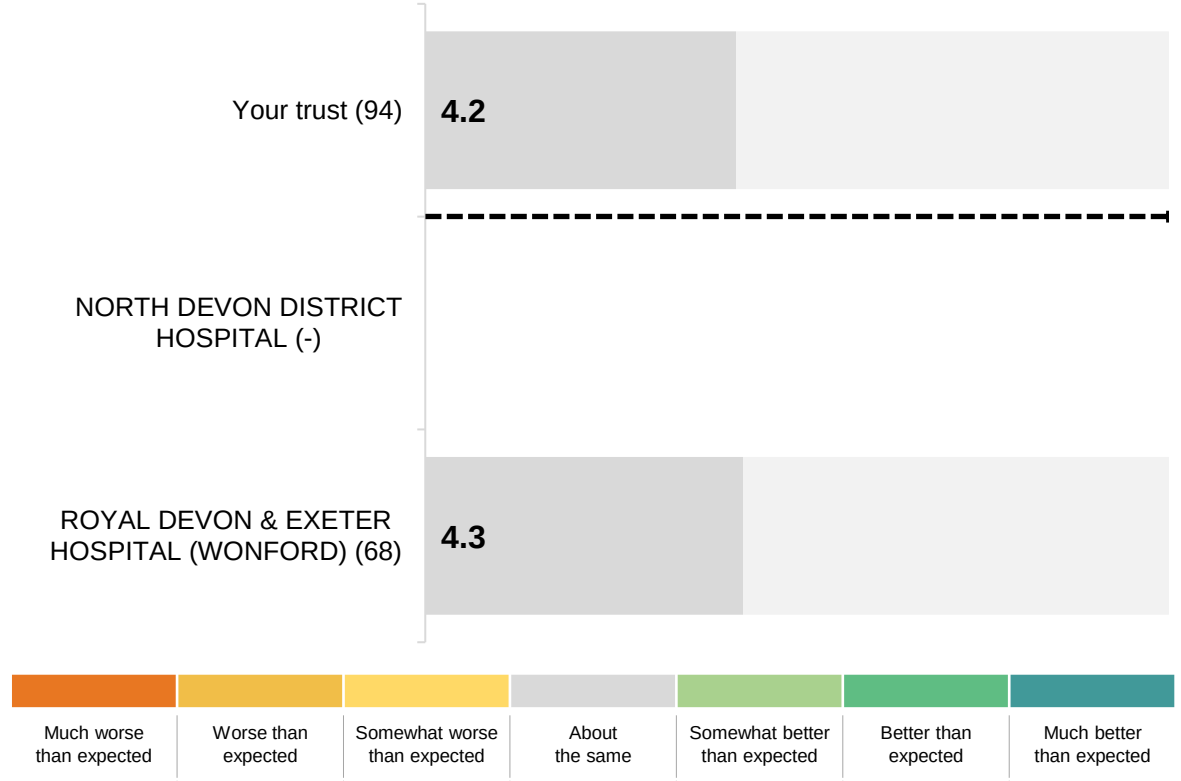
Please note: the number of respondents is shown in brackets next to the site name

Section 7. Leaving A&E

Q42. Before you left the hospital, did a member of staff discuss your transport arrangements for leaving A&E?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



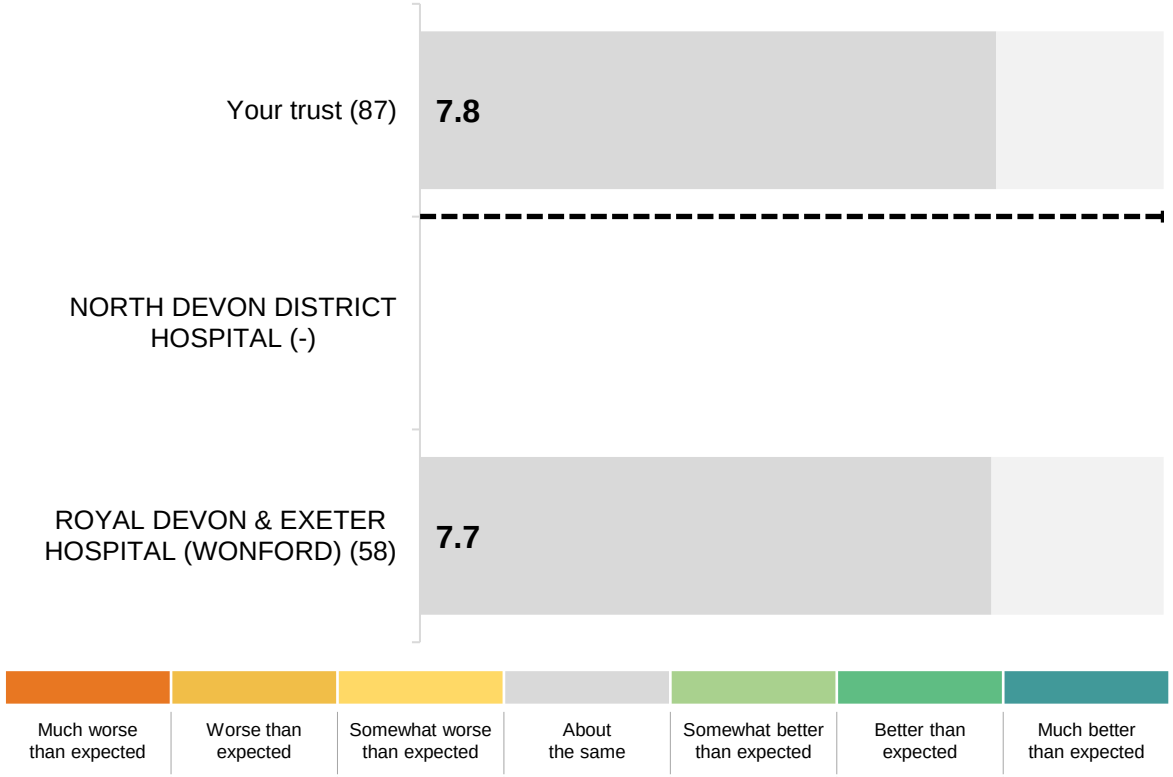
Please note: the number of respondents is shown in brackets next to the site name

Section 7. Leaving A&E

Q43. Did hospital staff discuss with you whether you may need further health or social care services after leaving A&E?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



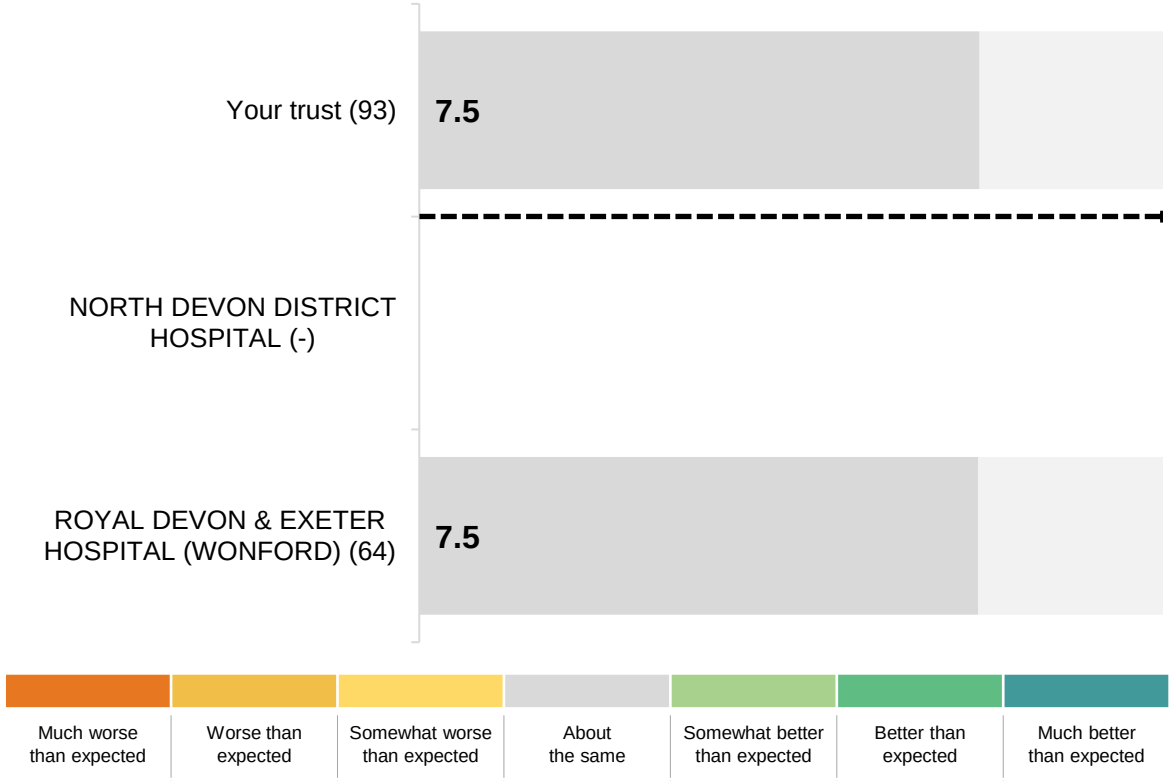
Please note: the number of respondents is shown in brackets next to the site name

Section 7. Leaving A&E

Q44. After leaving A&E, was the care and support you expected available when you needed it?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



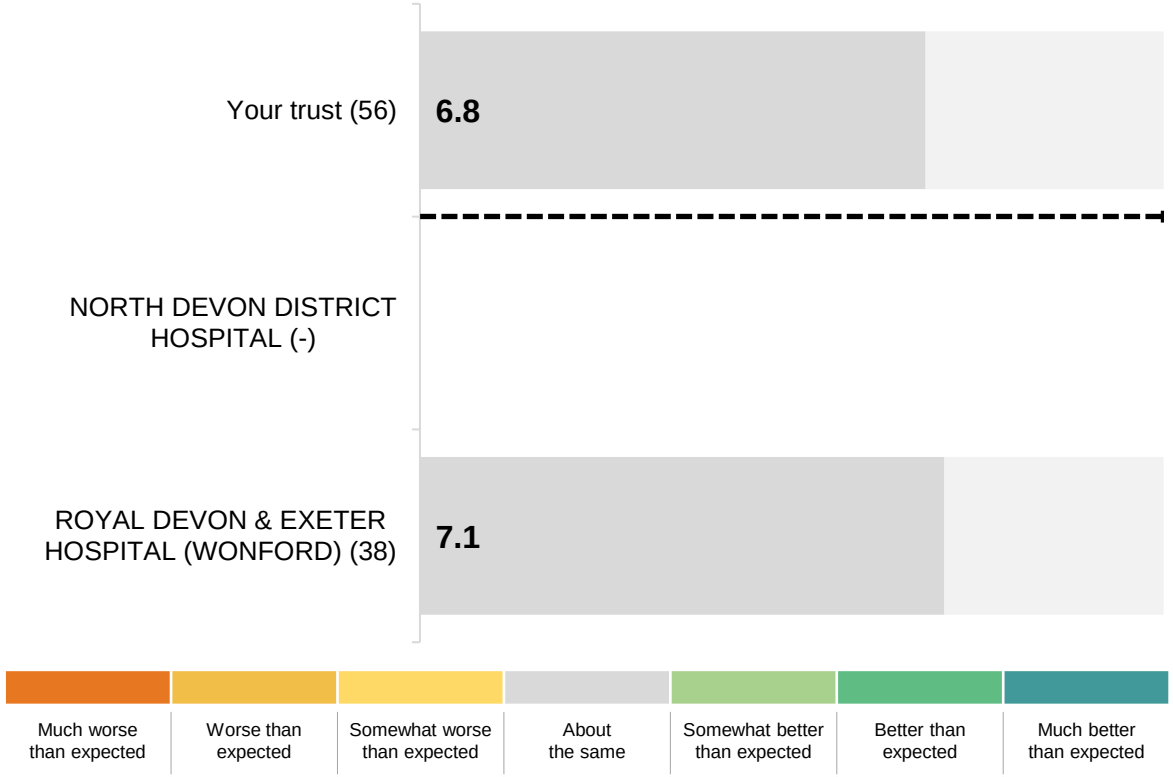
Please note: the number of respondents is shown in brackets next to the site name

Section 7. Leaving A&E

Q45. If you had contact with care and support services after leaving A&E, did the health or social care staff have information about your visit?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



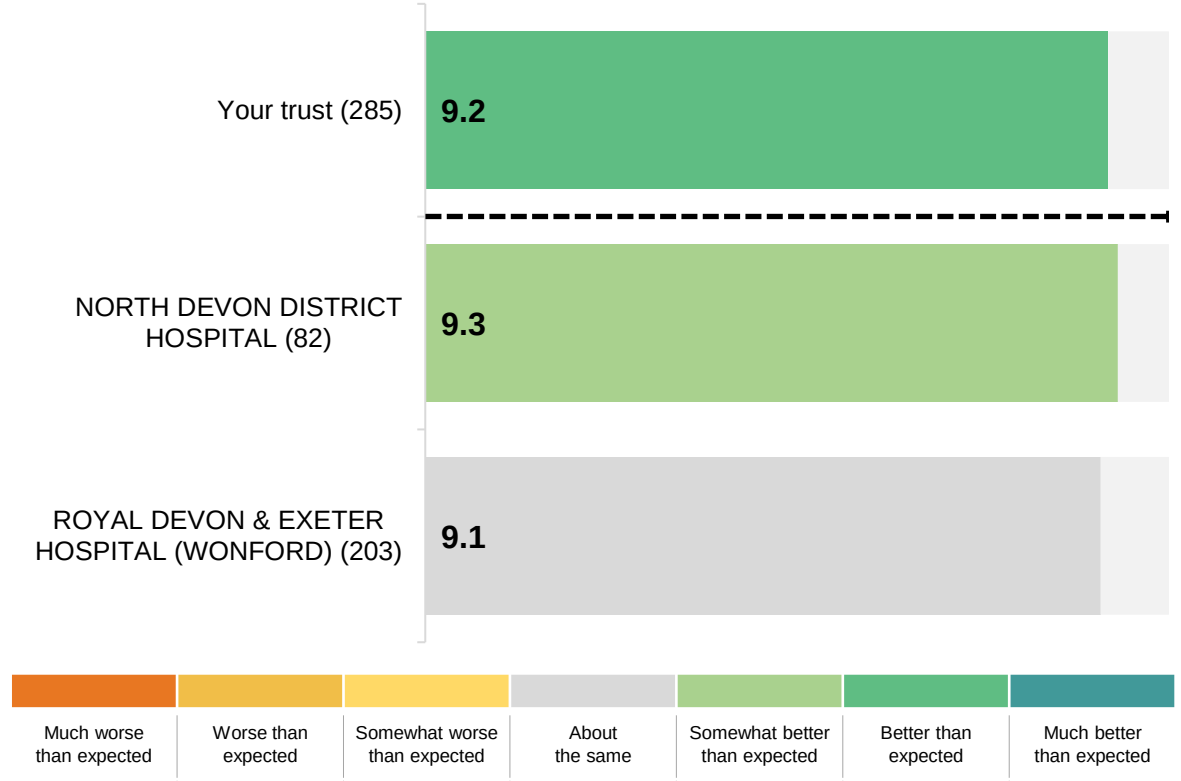
Please note: the number of respondents is shown in brackets next to the site name

Section 8. Respect and dignity

Q46. Overall, did you feel you were treated with respect and dignity while you were in A&E?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



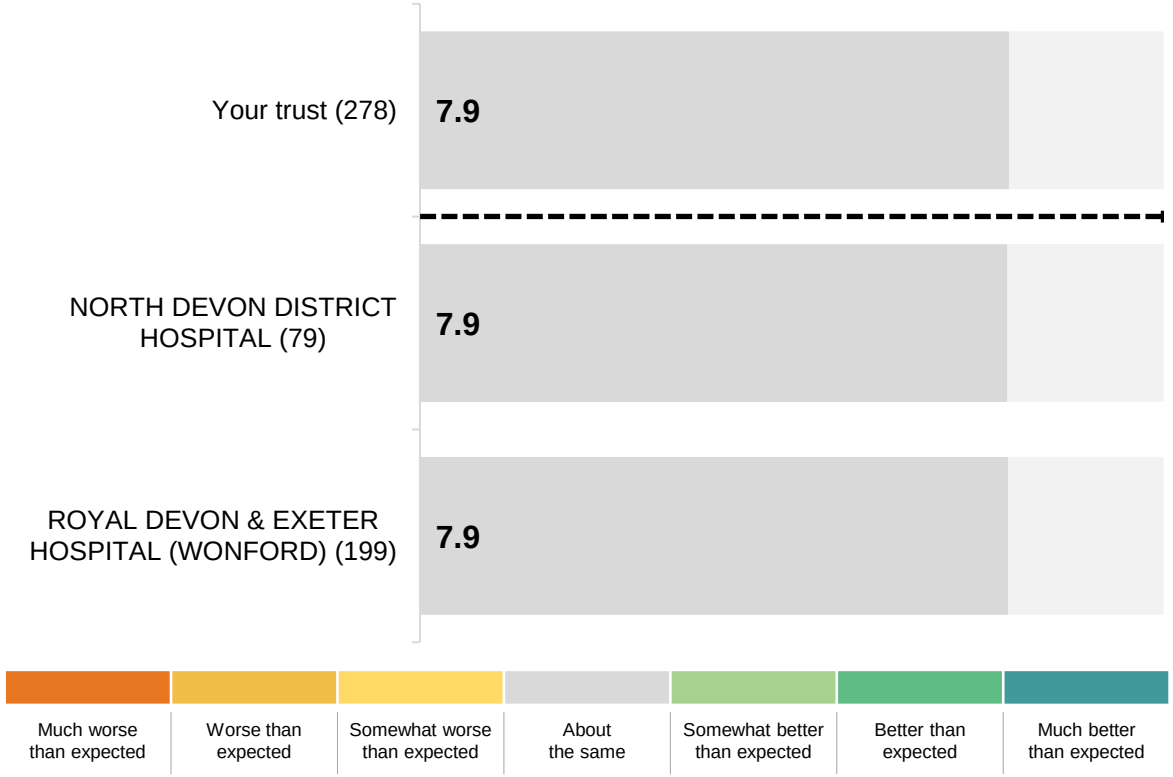
Please note: the number of respondents is shown in brackets next to the site name

Section 9. Experience overall

Q47. Overall... (please circle a number)

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



Please note: the number of respondents is shown in brackets next to the site name

Change over time

This section includes:

- a comparison to previous survey years scores for your trust for each question, including:
  - your trust's 2022 score compared with its scores from 2016 to 2020.

Please note:

- If data is missing for a survey year, this is due to a low number of responses, or because the trust data was not included in the survey that year, due to sampling errors or ineligibility.

RH8 Royal Devon University Healthcare NHS Foundation Trust does not have any historical comparisons.

Appendix

Comparison to other trusts: where your trust has performed much better

The questions at which your trust has performed much better when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much better than expected

- Q18. Did doctors or nurses talk to each other about you as if you weren't there?
- Q37. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?

Comparison to other trusts: where your trust has performed better

The questions at which your trust has performed better than compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Better than expected

- Q9. Were you informed how long you would have to wait to be examined?
- Q24. If you needed attention, were you able to get a member of medical or nursing staff to help you?
- Q25. Sometimes, a member of staff will say one thing and another will say something quite different. Did this happen to you?
- Q26. Were you involved as much as you wanted to be in decisions about your care and treatment?
- Q27. If you had any tests, did a member of staff explain why you needed them in a way you could understand?
- Q28. Before you left A&E, did a member of staff explain the results of the tests in a way you could understand?
- Q32. While you were in A&E, did you feel threatened by other patients or visitors?
- Q39. Did a member of staff tell you about what symptoms to watch for regarding your illness or treatment after you went home?
- Q46. Overall, did you feel you were treated with respect and dignity while you were in A&E?

Comparison to other trusts: where your trust has performed somewhat better

The questions at which your trust has performed somewhat better when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat better than expected

- Q15. Did the doctors and nurses listen to what you had to say?
- Q16. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?

Comparison to other trusts: where your trust has performed somewhat worse

The questions at which your trust has performed somewhat worse when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat worse than expected

- No questions for your trust fall within this banding.

Comparison to other trusts: where your trust has performed worse

The questions at which your trust has performed worse compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Worse than expected

- No questions for your trust fall within this banding.

Comparison to other trusts: where your trust has performed much worse

The questions at which your trust has performed much worse when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much worse than expected

- No questions for your trust fall within this banding.

2022 Urgent and Emergency Care Survey

A&E Departments (Type 1 services) results for Royal Devon University Healthcare NHS Foundation Trust

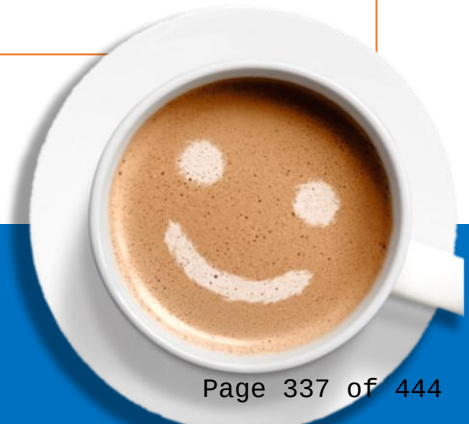
Where patient experience is best

- ✓ **Waiting:** Patients being informed of how long wait to be examined will be
- ✓ **Staff responsiveness:** Patient being able to get help from staff if they needed attention
- ✓ **Information sharing:** Health or social care staff having information about patients' visit to A&E
- ✓ **Symptoms:** Staff telling patients what symptoms of their illness to watch out for when they are home
- ✓ **Medication:** Staff members explaining purpose of medications in a way patients can understand

Where patient experience could improve

- ○ **Privacy:** Patients being given enough privacy when discussing their condition with receptionist
- ○ **Communication needs:** Staff helping patients with any communication needs they have
- ○ **Family involvement:** Family members, friends or carers having enough opportunity to talk to health professionals
- ○ **Transport when leaving A&E:** Staff discussing patients' transport arrangements before they leave A&E
- ○ **Length of visit:** Length of patients' A&E visit

These questions are calculated by comparing your trust's results to the national average. "Where patient experience is best": These are the five results for your trust that are highest compared with the national average. "Where patient experience could improve": These are the five results for your trust that are lowest compared with the national average.



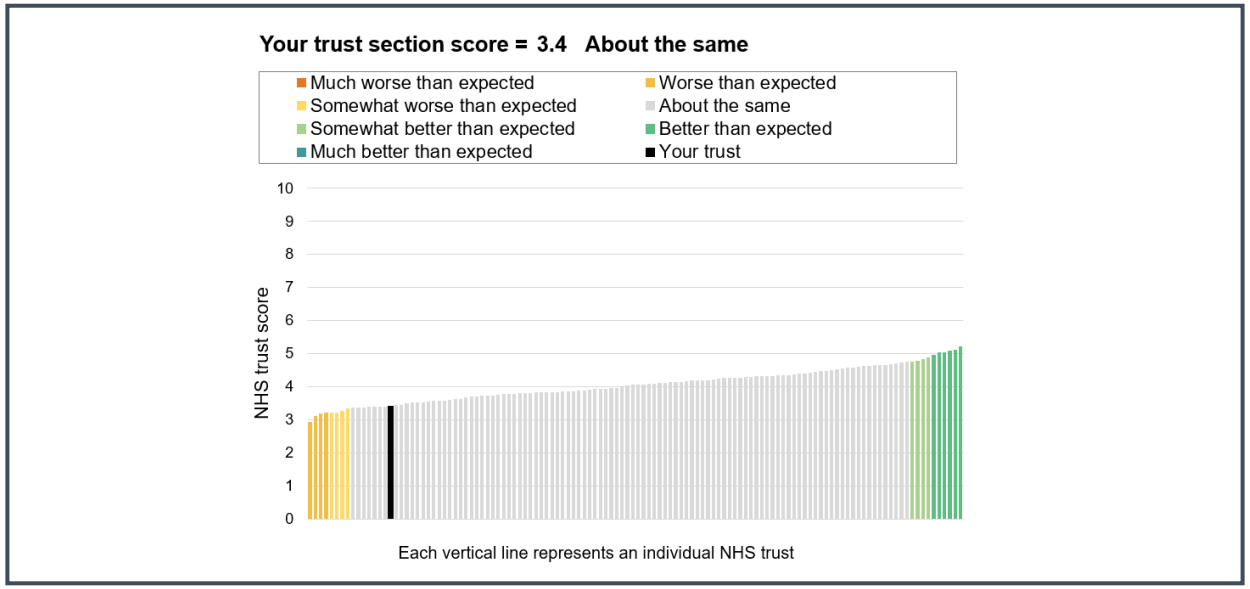
This survey looked at the experiences of people who were receiving care or treatment in a Type 1 accident and emergency (A&E) department and had been treated by the trust between 1st and 30th September 2022. Between November 2022 and March 2023, a questionnaire was sent to 950 recent patients. Responses were received from 295 patients at this trust. If you have any questions about the survey and our results, please contact [INSERT TRUST CONTACT DETAILS].

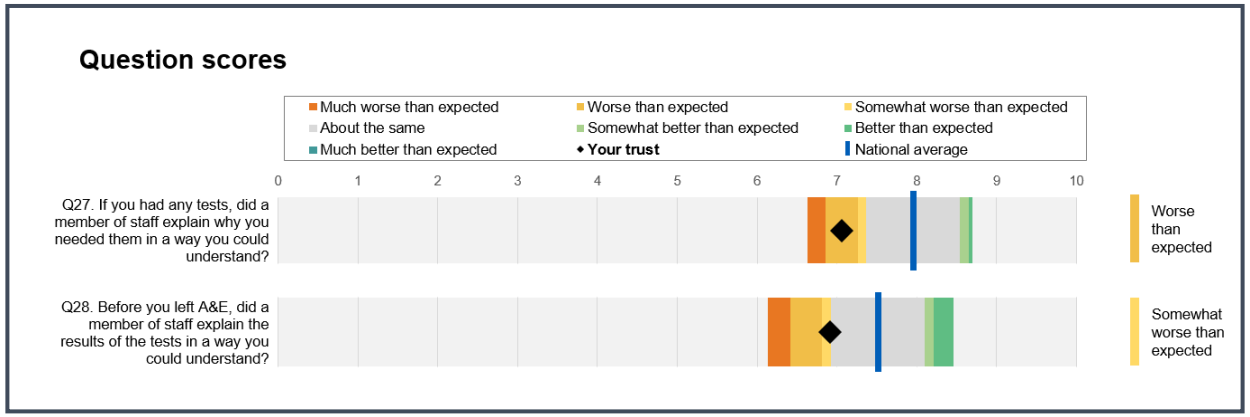
How to interpret benchmarking in this report

The charts in the 'benchmarking' section show how the score for your trust compares to the range of scores achieved by all trusts taking part in the survey. The black line shows the score for your trust. The graphs are divided into seven sections, comparing the score for your trust to most other trusts in the survey:

- If your trust's score lies in the **dark green section** of the graph, its result is 'Much better than expected'.
- If your trust's score lies in the **mid-green section** of the graph, its result is 'Better than expected'.
- If your trust's score lies in the **light green section** of the graph, its result is 'Somewhat better than expected'.
- If your trust's score lies in the **grey section** of the graph, its result is 'About the same'.
- If your trust's score lies in the **yellow section** of the graph, its result is 'Somewhat worse than expected'.
- If your trust's score lies in the **light orange** section of the graph, its result is 'Worse than expected'.
- If your trust's score lies in the **dark orange** section of the graph, its result is 'Much worse than expected'.

These groupings are based on a rigorous statistical analysis of the data termed the 'expected range' technique.





How to interpret benchmarking in this report (continued)

The ‘much better than expected,’ ‘better than expected’, ‘somewhat better than expected’, ‘about the same’, ‘somewhat worse than expected’, ‘worse than expected’ and ‘much worse than expected’ categories are based on an analysis technique called the ‘expected range’. Expected range determines the range within which a trust’s score could fall without differing significantly from the average, taking into account the number of respondents for each trust, to indicate whether the trust has performed significantly above or below what would be expected.

If it is within this expected range, we say that the trust’s performance is ‘about the same’ as other trusts. Where a trust is identified as performing ‘better’ or ‘worse’ than the majority of other trusts, the result is unlikely to have occurred by chance.

In some cases, there will be no shades of orange and/or green area in the graph. This happens when the expected range for your trust is so broad that it encompasses either the highest possible score for all trusts (no green section) or the lowest possible score for all trusts (no orange section). This could be because there were few respondents and/or a lot of variation in their answers.

In some cases, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

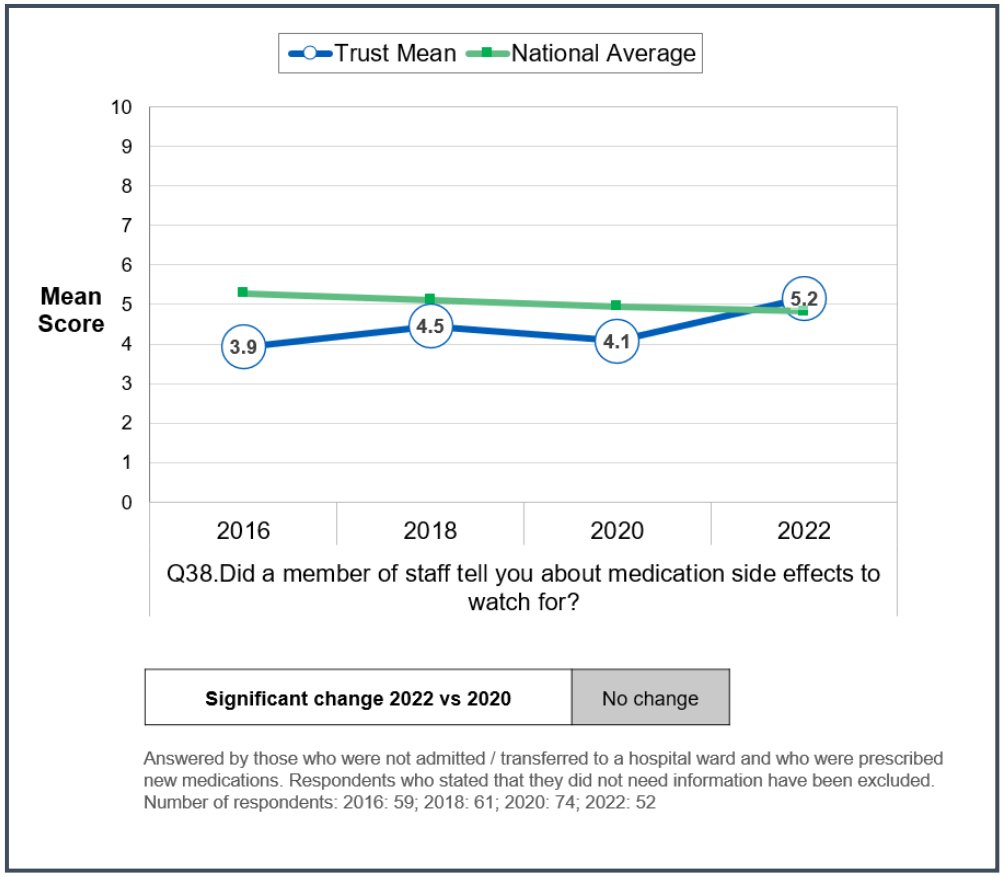
Additional information on the ‘expected range’ analysis technique can be found in the survey technical report on the NHS Surveys website.

How to interpret change over time in this report

The charts in the 'change over time' section show how your trust scored in each Urgent & Emergency Care survey iteration. Where available, trend data from 2016 to 2022 is shown. If a question only has one data point, this question is not shown. Questions that are not historically comparable, are also not shown.

Each question is displayed in a line chart. These charts show your trust mean score for each survey year (blue line). The national average is also shown across survey years, this is the average score for that question across all NHS trusts with a Type 1 accident and emergency (A&E) department in England (green line). This enables you to see how your trust compares to the national average. If there is data missing for a survey year, this may be due to either a low number of responses, because the trust was not included in the survey that year, sampling errors or ineligibility.

Statistically significant changes are also displayed in tables underneath the charts, showing significant differences between this year (2022) and the previous year (2020). Z-tests set to 95% significance were used to compare data between the two years (2022 vs 2020). A statistically significant difference means it is unlikely we would have obtained this result if there was no real difference.



An example of scoring

Each evaluative question is scored on a scale from 0 to 10. The scores represent the extent to which the patient's experience could be improved. A score of 0 is assigned to all responses that reflect considerable scope for improvement, whereas a score of 10 refers to the most positive patient experience possible. Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. Where options were provided that did not have any bearing on the trust's performance in terms of patient experience, the responses are classified as "not applicable" and a score is not given. Similarly, where respondents stated they could not remember or did not know the answer to a question, a score is not given.

Calculating an individual respondent's score

The following provides an example for the scoring system applied for each respondent. For question 6 "Were you given enough privacy when discussing your condition with the receptionist?":

- The answer code "Yes, definitely" would be given a score of 10, as this refers to the most positive patient experience possible.
- The answer code "Yes, to some extent" would be given a score of 5, as it is placed at an equal interval along the scale.
- The answer code "No" would be given a score of 0, as this response reflects considerable scope for improvement.
- The answer code "I did not discuss my condition with a receptionist" would not be scored, as they do not have a clear bearing on the trust's performance in terms of patient experience.

Calculating the trust score for each question

The weighted mean score for each trust, for each question, is calculated by dividing the sum of the weighted scores for a question by the weighted sum of all eligible respondents to the question for each trust. An example of this is provided in the survey technical document.

Calculating the section score

An arithmetic mean of each trust's question scores is taken to provide a score for each section.

Thank you.

For further information, please contact the Survey Coordination Centre for Existing Methods:

emergency@surveycoordination.com

2022 Urgent and Emergency Care Survey Benchmark Report for Urgent Treatment Centres (Type 3 services)

Royal Devon University Healthcare NHS Foundation Trust

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6. Appendix

- Comparison to other trusts
- Trust results poster
- How to interpret benchmarking in this report
- How to interpret change over time in this report
- An example of scoring

This work was carried out in accordance with the requirements of the international standard for organisations conducting social research (accreditation to ISO27001:2013; certificate number GB10/80275).

Background and methodology

This section includes:

- an explanation of the NHS Patient Survey Programme
- information on the Urgent and Emergency Care Survey
- a description of key terms used in this report
- navigating the report

Background and methodology

The NHS Patient Survey Programme

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

The NPSP is commissioned by the Care Quality Commission (CQC); the independent regulator of health and adult social care in England.

As part of the NPSP, the Urgent & Emergency Care (UEC) Survey first iteration was in 2003, and since 2012 it has been a biannual survey. To find out more about the survey programme and to see the results from previous surveys, please refer to the section on further information on this page.

Urgent and Emergency Care Survey

The survey was administered by the Survey Coordination Centre for Existing Methods (SCCEM) at Picker Institute.

The 2022 survey of people who used UEC services involved 122 NHS trusts with A&E departments (Type 1 service). Fifty-nine of these trusts had direct responsibility for running an Urgent Treatment Centre, Urgent Care Centre or Minor Injuries Unit (Type 3 service) and will therefore also receive benchmarked results for their Type 3 services. Two separate questionnaires were used, one for Type 1 services and one for Type 3 services. To access the questionnaires please see the 'Further Information about the survey' section below.

Responses were received from 7,418 people who attended a Type 3 department, this is a response rate of 22.1%.

Patients were eligible for the survey if they were aged 16 years or older and had attended UEC services during September 2022. Full sampling criteria can be found in the sampling instructions manual (see 'Further Information about the survey' section).

Trusts responsible for Type 1 departments only created a random sample of 1,250 patients. Trusts that also directly run Type 3 departments sampled 950 patients from Type 1 departments and 580 patients from Type 3 departments totalling 1,530 patients. Questionnaires and reminders were sent to patients between November 2022 and March 2023.

Trend data

The Urgent & Emergency Care Survey is comparable back to the 2016 survey. Redevelopment work carried out ahead of the 2016 survey means that the results for 2022 are only comparable with 2020 and 2018 and not with earlier surveys. Trend data is presented in this report for questions that have been asked in previous survey years.

This report is for Urgent Treatment Centres (Type 3 services) only.

Further information about the survey

- For published results and for more information on the Urgent & Emergency Care Survey please visit the UEC page on the NHS Surveys website.
- For published results for other surveys in the NPSP, and for information to help trusts implement the surveys across the NPSP, please visit the NHS Surveys website.
- To learn more about the CQC's survey programme, please visit the CQC website.

Key terms used in this report

The ‘expected range’ technique

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts. This is designed to help understand the performance of individual trusts and identify areas for improvement. More information can be found in the Appendix.

Standardisation

Demographic characteristics, such as age and sex, can influence patients’ experience of care and the way they report it. For example, research shows that older people report more positive experiences of care than younger people. Since trusts have differing profiles of patients, this could make fair trust comparisons difficult. To account for this, we ‘standardise’ the results, which means we apply a weight to individual patient responses to account for differences in demographic profile between trusts. For each trust, results have been standardised by the age and sex of respondents to reflect the ‘national’ age-sex type distribution (based on all respondents to the survey).

This helps ensure that no trust will appear better or worse than another because of its profile, and enables a fairer and more useful comparison of results across trusts. In most cases this standardisation will not have a large impact on trust results.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale of 0 to 10. A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the trust is performing. Only evaluative questions in the questionnaire are scored. Some questions are descriptive (for example Q1) and others are ‘routing questions’, which are designed to filter out respondents to whom the following questions do not apply (for example Q19). These questions are not scored. Section scoring is computed as the arithmetic mean of question scores for the section after weighting is applied.

National average

The ‘national average’ mentioned in this report is the arithmetic mean of all trusts’ scores after weighting is applied.

Suppressed data

If fewer than 30 respondents have answered a question, no score will be displayed for that question (or the corresponding section the question contributes to).

Further information about the methods

For further information about the statistical methods used in this report, please refer to the survey technical document which is on the 'Analysis and Reporting' section of the UEC22 webpage on the NHS surveys website.

Using the survey results

Navigating this report

This report is split into five sections:

- **Background and methodology** – provides information about the survey programme, how the survey is run, and how to interpret the data.
- **Headline results** – includes key trust-level findings relating to the patients who took part in the survey, benchmarking, and top and bottom scores. This section provides an overview of results for your trust, identifying areas where your organisation performs better than the average and where you may wish to focus improvement activities.
- **Benchmarking** – shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part; using the 'expected range' analysis technique. This allows you to see the range of scores achieved and compare yourself with the other organisations that took part in the survey. Benchmarking can provide you with an indication of where you perform better than the average, and what you should aim for in areas where you may wish to improve.
- **Change over time** – displays your trust score for each survey year. Where available, trend data will be shown from 2018 to 2022. Questions are displayed in a line chart with the trust mean plotted alongside the national average. Statistical significance testing is also shown between survey years 2022 vs 2020. This section highlights areas your trust has improved on or declined in over time.
- **Appendix** – includes additional data for your trust; further information on the survey methodology; and interpretation of graphs in this report.

How to interpret the graphs in this report

There are several types of graphs in this report which show how the score for your trust compares to the scores achieved by all trusts that took part in the survey.

The two chart types used in the section 'Benchmarking' use the 'expected range' technique to show results. For information on how to interpret these graphs, please refer to the Appendix.

Other data sources

More information is available about the following topics at their respective websites, listed below:

- Full national results; technical document: https://www.cqc.org.uk/uecsurvey
- National and trust-level data for all trusts who took part in the 2022 Urgent & Emergency Care Survey https://nhssurveys.org/surveys/survey/03-urgent-emergency-care/. Full details of the methodology for the survey, instructions for trusts and contractors to carry out the survey, and the survey development report can also be found on the NHS Surveys website.
- Information on the NHS Patient Survey Programme, including results from other surveys: www.cqc.org.uk/content/surveys
- Information about how the CQC monitors hospitals: https://www.cqc.org.uk/what-we-do/how-we-use-information/using-data-monitor-services

Headline results

This section includes:

- information about your trust population
- an overview of benchmarking for your trust
- the best and worst scores for your trust

Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of patients who took part in the survey.

580 invited to take part

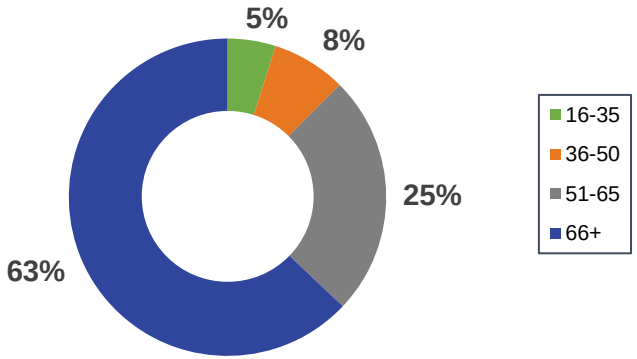
224 completed

39% response rate

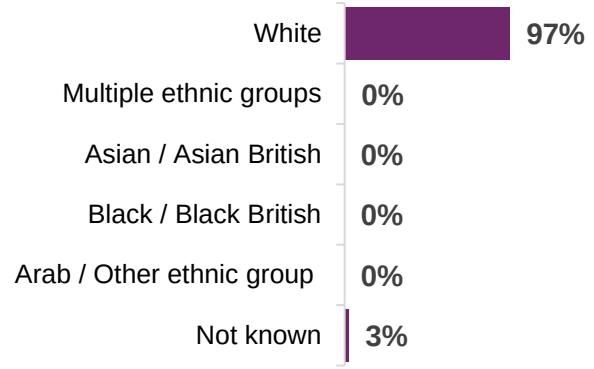
22% average response rate for all trusts

-% response rate for your trust last year

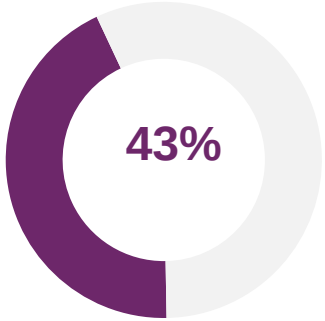
AGE



ETHNICITY



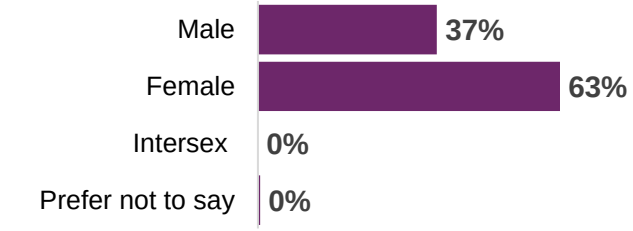
LONG-TERM CONDITIONS



of patients have a **physical or mental health condition or illness** that has lasted or is expected to last for 12 months or more.

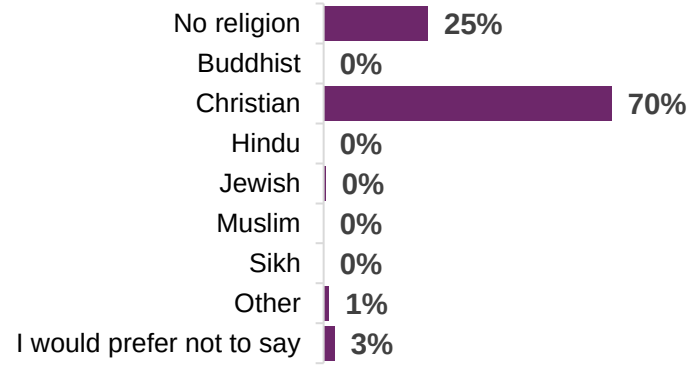
SEX

At birth were you registered as…



0% of patients said their **gender is different from the sex they were registered with at birth**.

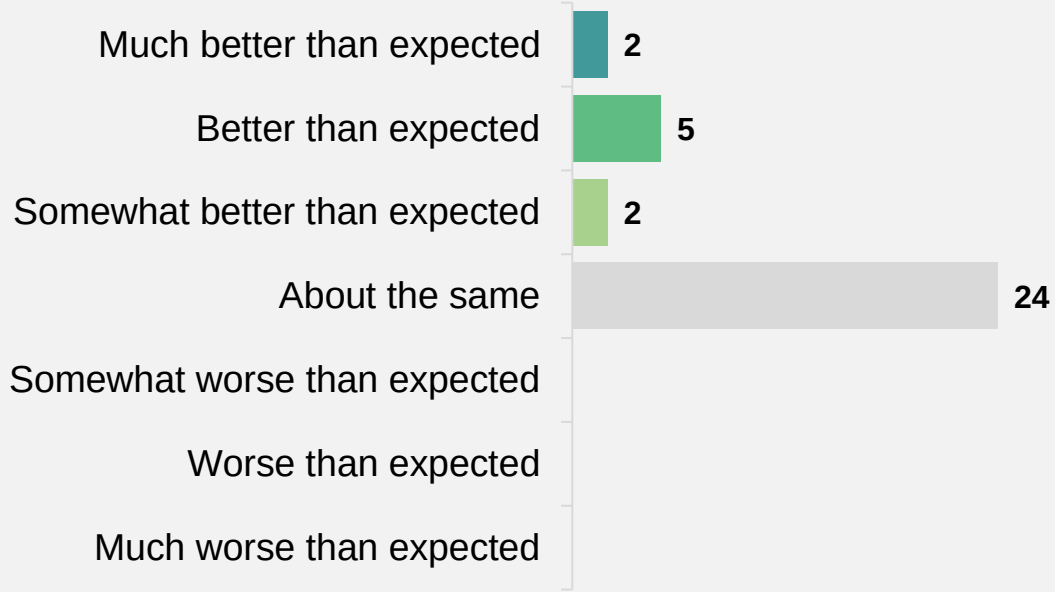
RELIGION



Summary of findings for your trust

Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

The **number of questions** at which your trust has performed statistically significantly better, significantly worse, or no different than your result from the previous year, 2022 vs 2020.

This information is not available for your trust.

Data for trusts which have undergone significant restructuring (i.e. mergers and closures) or experienced sampling errors should not be compared with previous survey results.

For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the appendix section "your trust has performed much worse" , "your trust has performed worse" , "your trust has performed somewhat worse", "your trust has performed somewhat better", "your trust has performed better", "your trust has performed much better" .

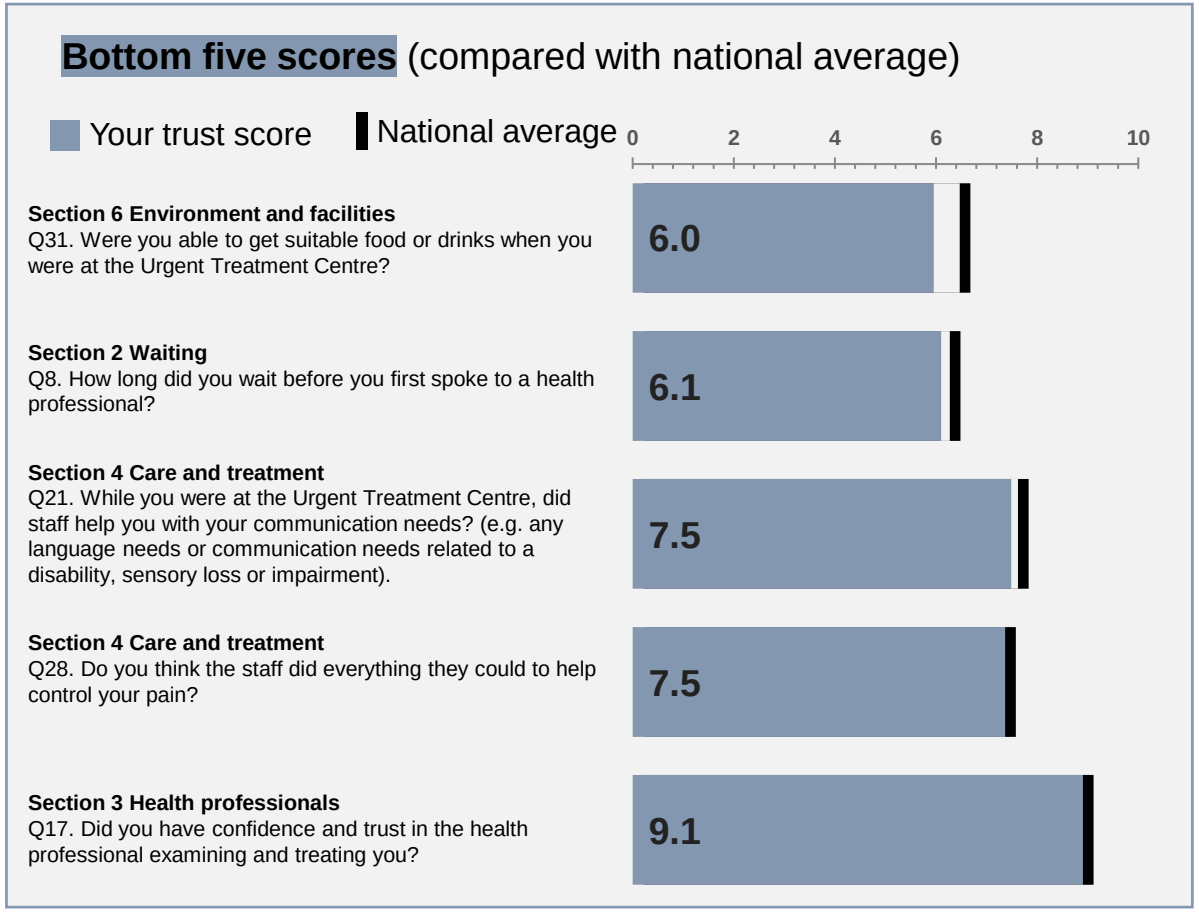
Best and worst performance relative to the national average

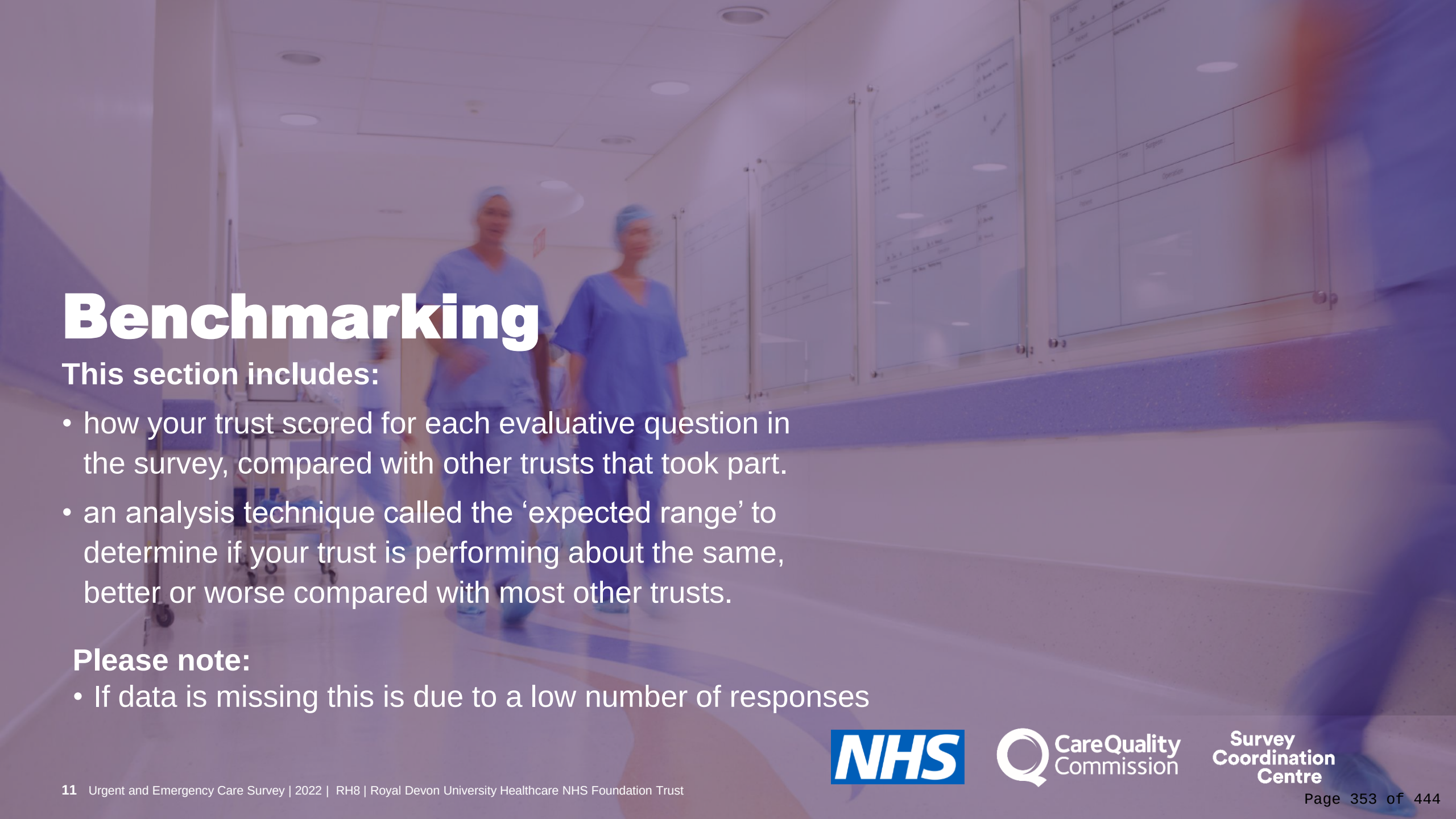
These five questions are calculated by comparing your trust's results to the national average.

- **Top five scores**: These are the five results for your trust that are highest compared with the national average. If none of the results for your trust are above the national average, then the results that are closest to the national average have been chosen, meaning a trust's best performance may be worse than the national average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the national average. If none of the results for your trust are below the national average, then the results that are closest to the national average have been chosen, meaning a trust's worst performance may be better than the national average.

Top five scores (compared with national average)

Bottom five scores (compared with national average)





Benchmarking

This section includes:

- how your trust scored for each evaluative question in the survey, compared with other trusts that took part.
- an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts.

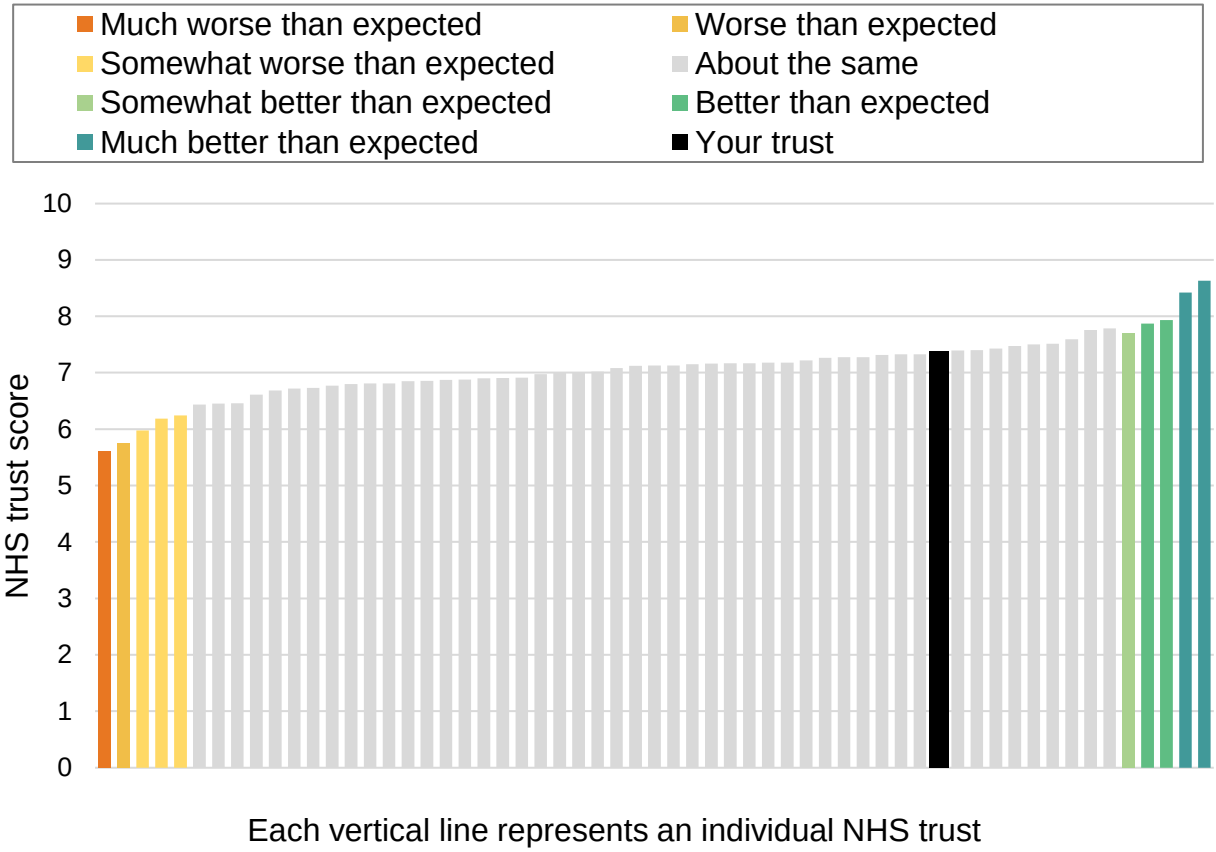
Please note:

- If data is missing this is due to a low number of responses

Section 1. Arrival at the Urgent Treatment Centre

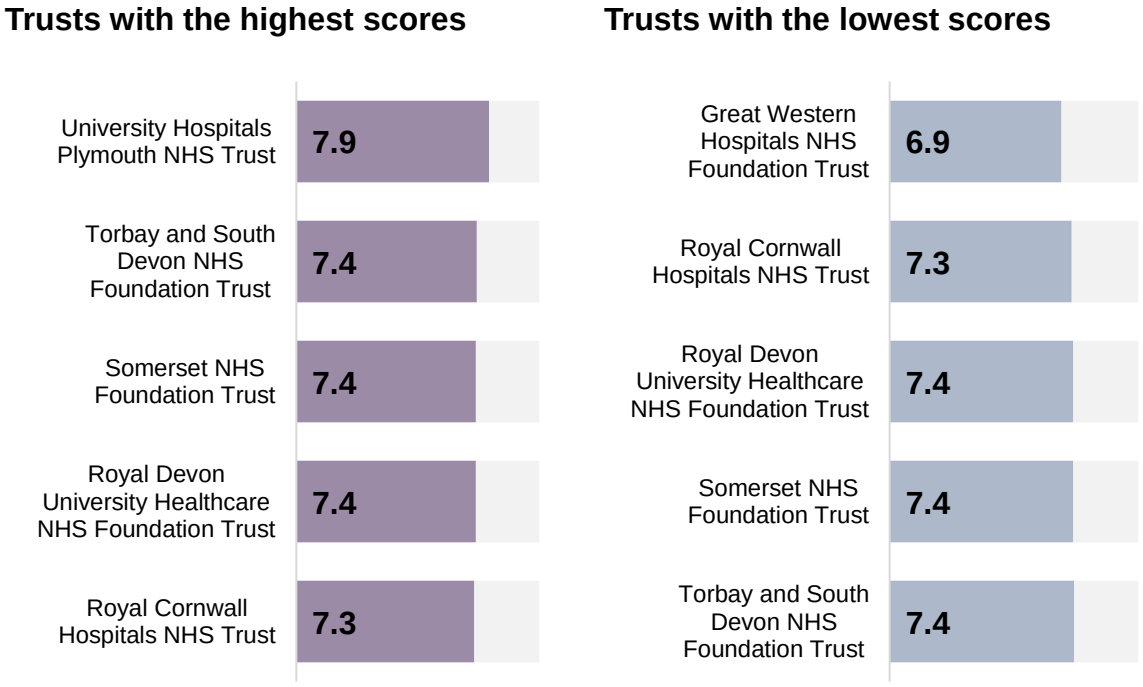
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.4 About the same



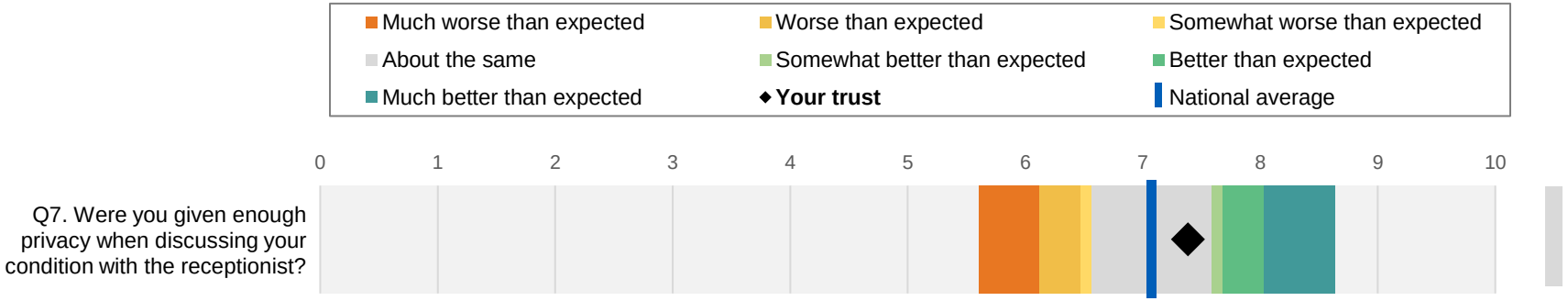
Each vertical line represents an individual NHS trust

Comparison with other trusts within your region



Section 1. Arrival at the Urgent Treatment Centre

Question scores

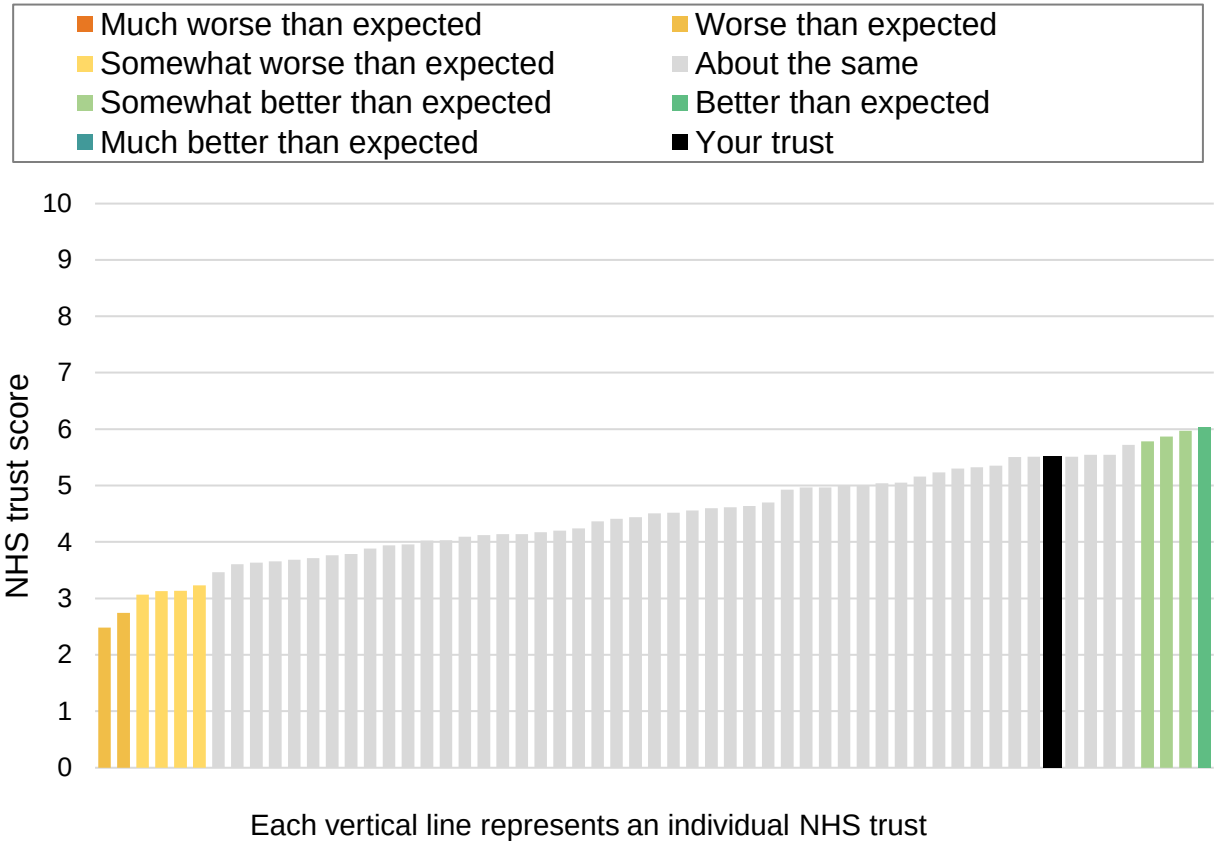


All trusts in England				
Number of respondents	Your trust	National average	Lowest score	Highest score
206	7.4	7.1	5.6	8.6

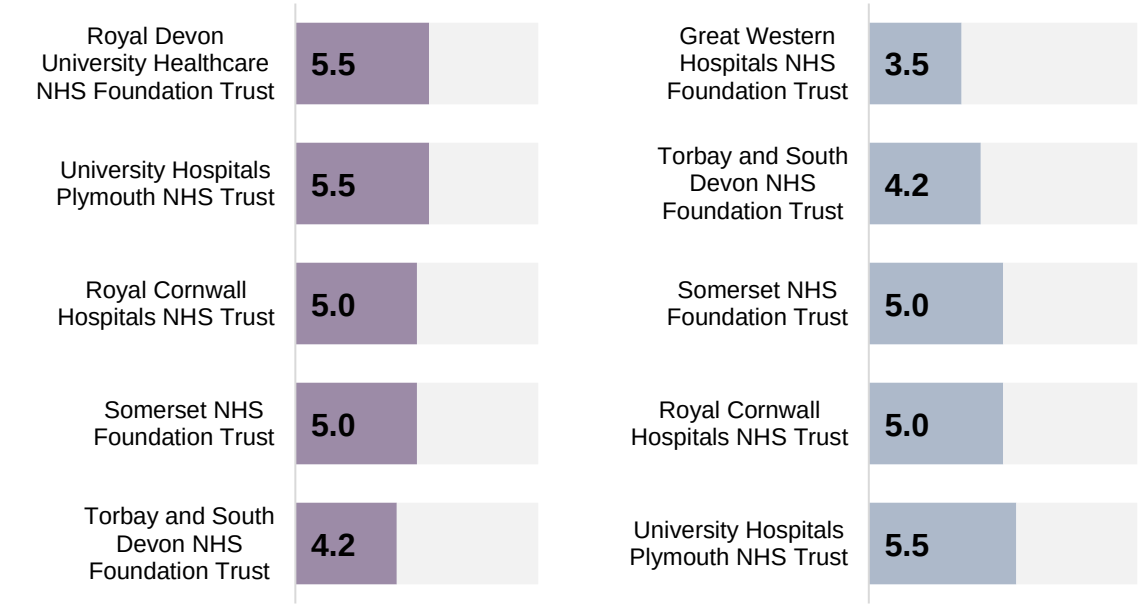
Section 2. Waiting

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 5.5 About the same

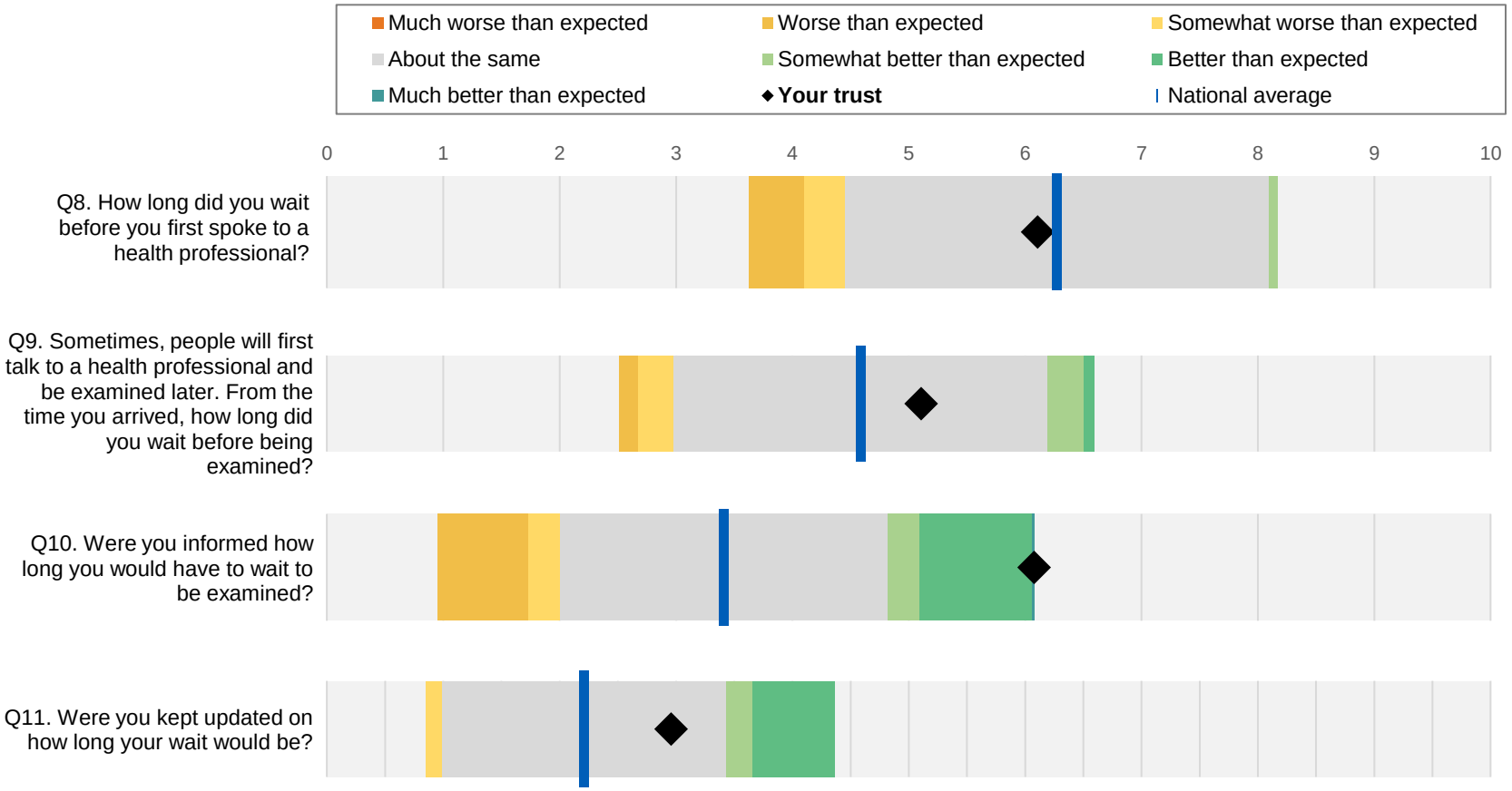


Comparison with other trusts within your region



Section 2. Waiting (continued)

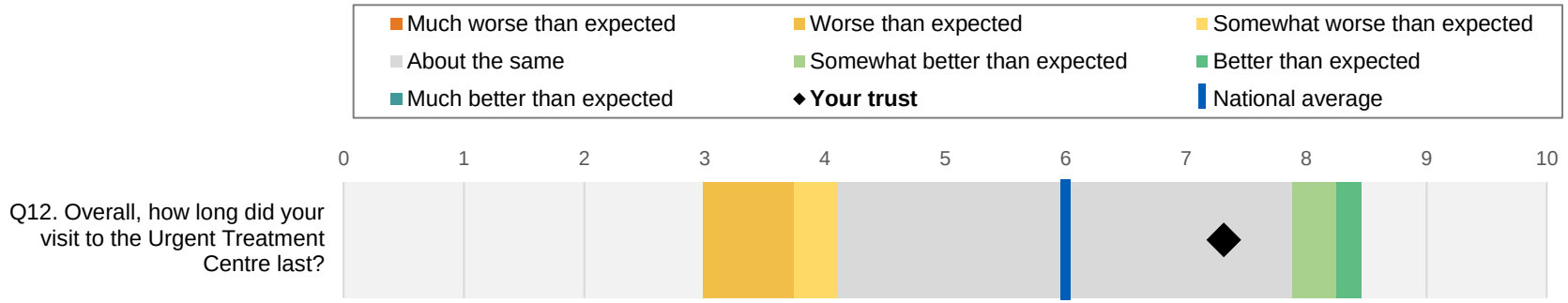
Question scores



	All trusts in England				
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	197	6.1	6.3	3.6	8.2
About the same	192	5.1	4.6	2.5	6.6
Much better than expected	173	6.1	3.4	1.0	6.1
About the same	125	3.0	2.2	0.9	4.4

Section 2. Waiting (continued)

Question scores



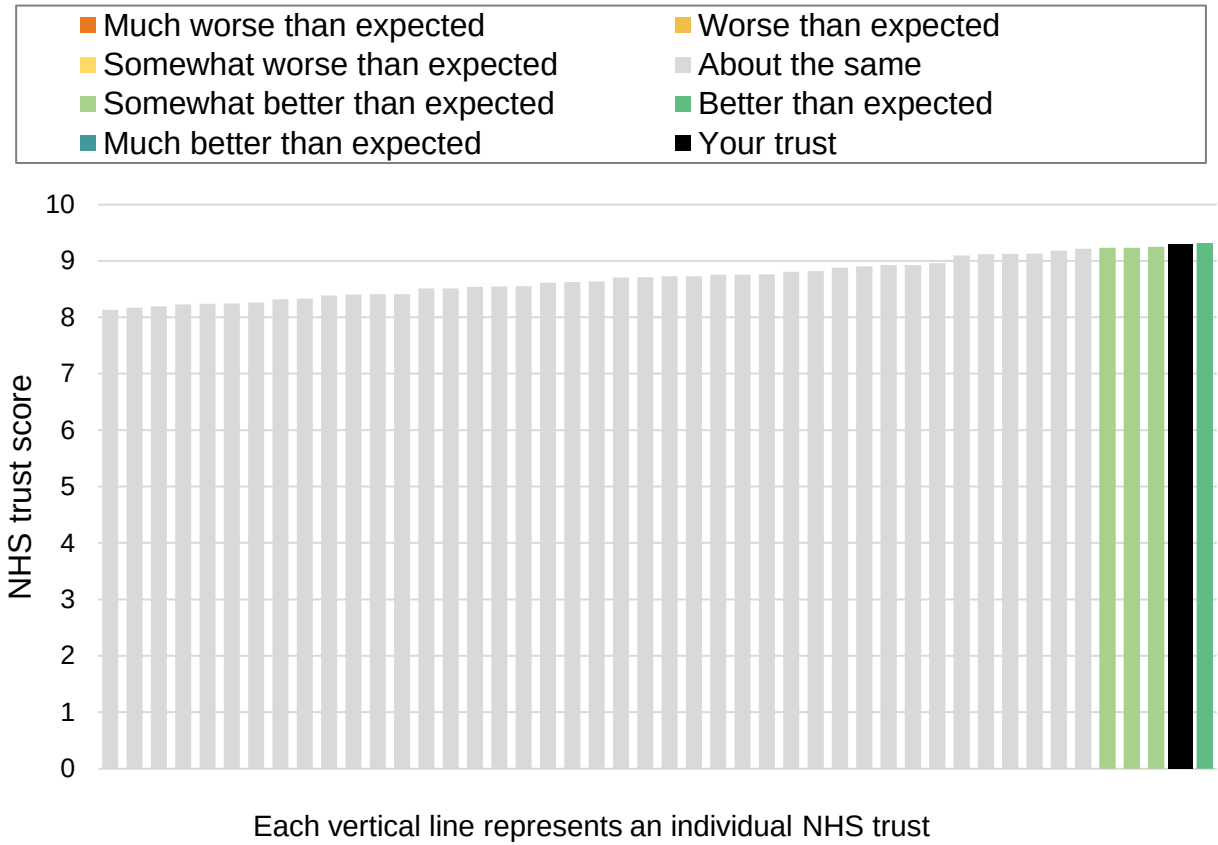
All trusts in England

Number of respondents	Your trust	National average	Lowest score	Highest score
219	7.3	6.0	3.0	8.5

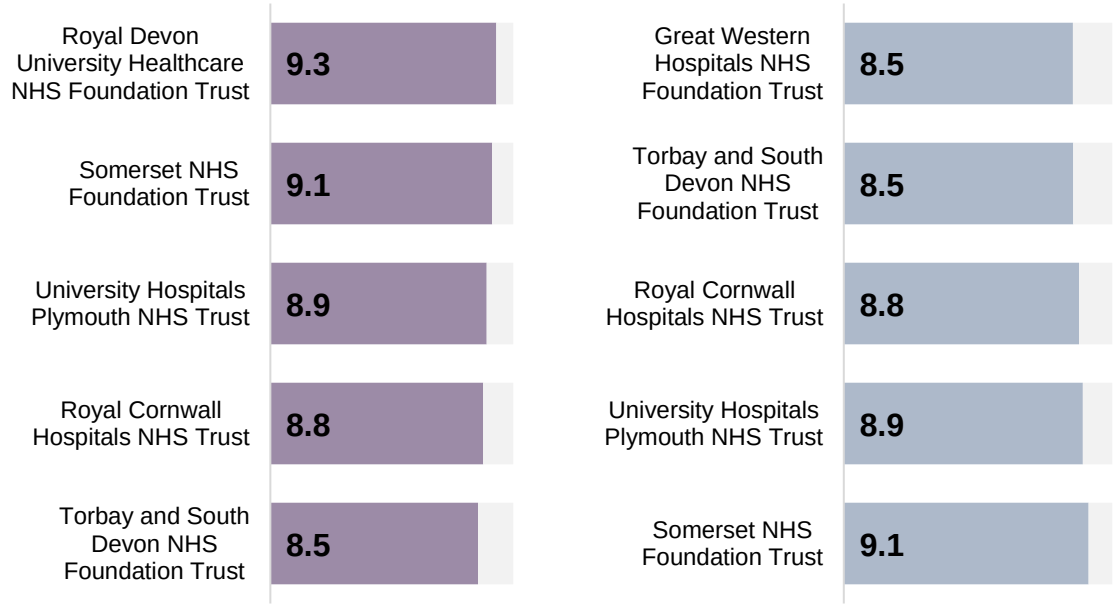
Section 3. Health professionals

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 9.3 Better than expected

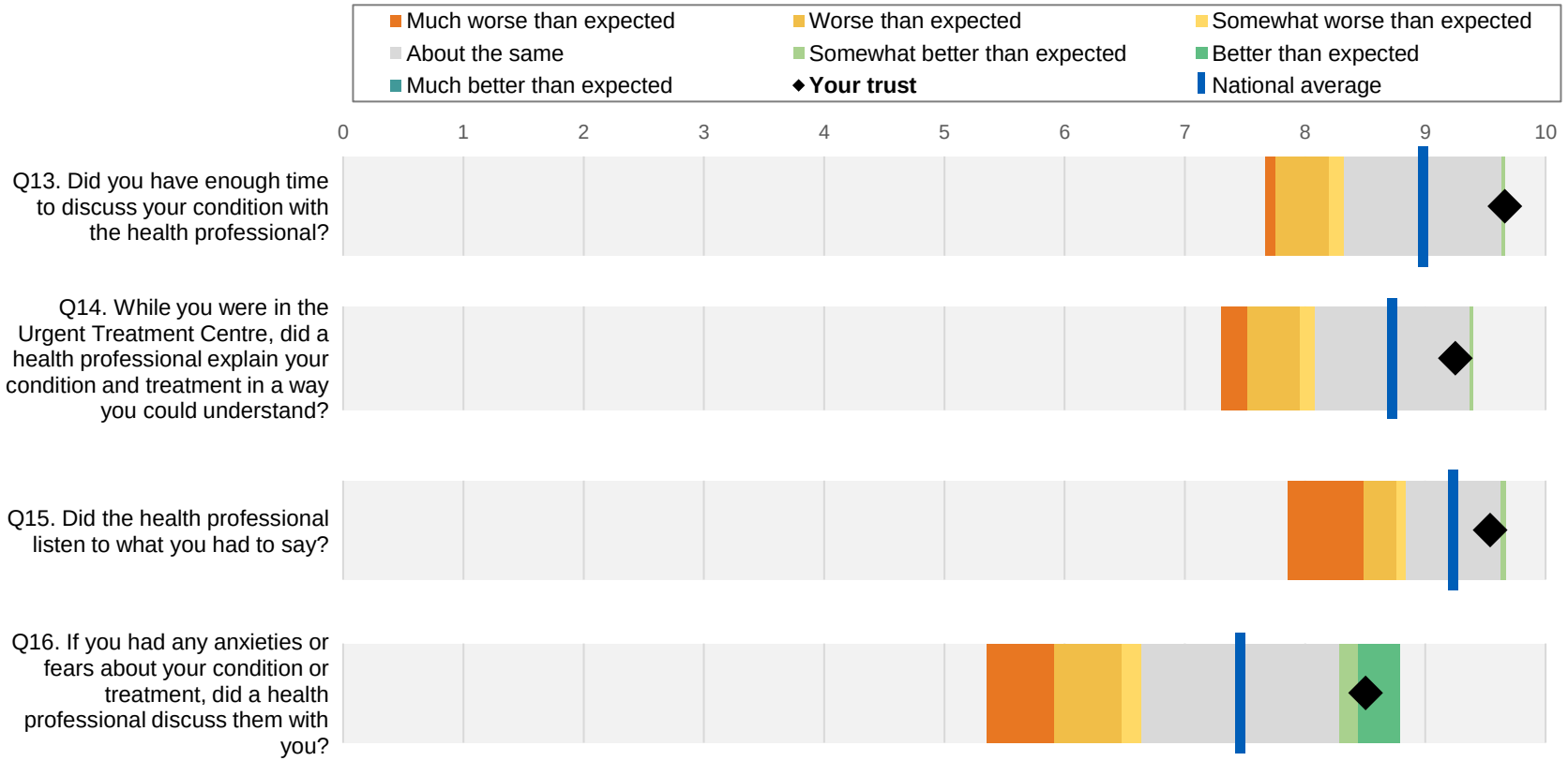


Comparison with other trusts within your region



Section 3. Health professionals (continued)

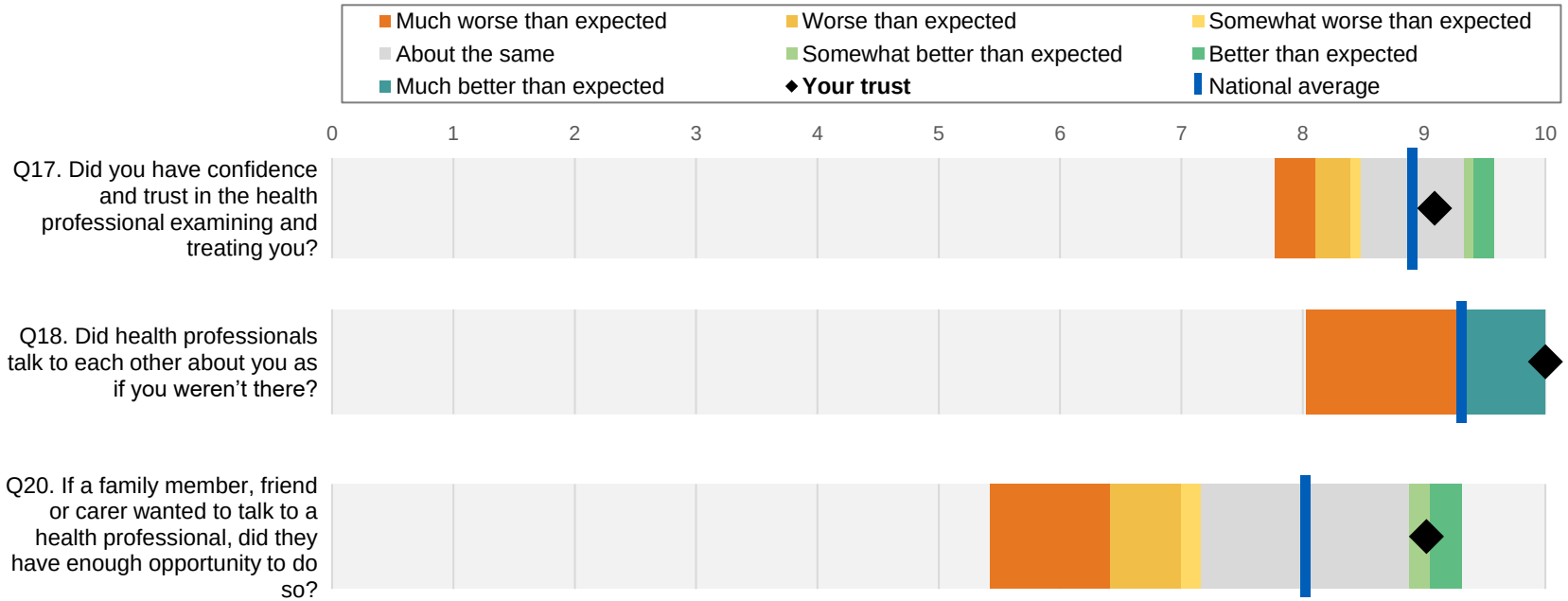
Question scores



		All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
Somewhat better than expected	224	9.7	9.0	7.7	9.7
About the same	216	9.2	8.7	7.3	9.4
About the same	224	9.5	9.2	7.9	9.7
Better than expected	122	8.5	7.5	5.4	8.8

Section 3. Health professionals (continued)

Question scores

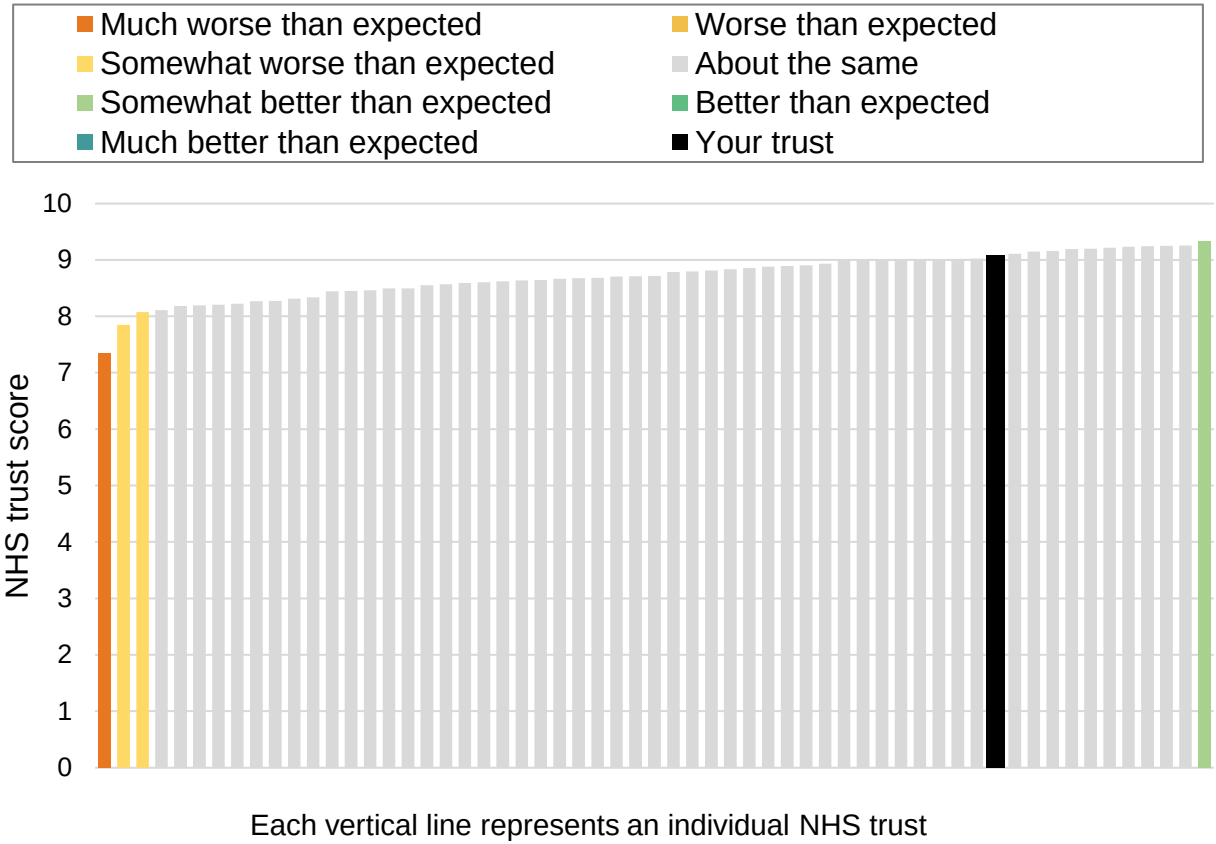


	Number of respondents	Your trust	All trusts in England: National average	Lowest score	Highest score
About the same	220	9.1	8.9	7.8	9.6
Much better than expected	149	10.0	9.3	8.0	10.0
Somewhat better than expected	93	9.0	8.0	5.4	9.3

Section 4. Care and treatment

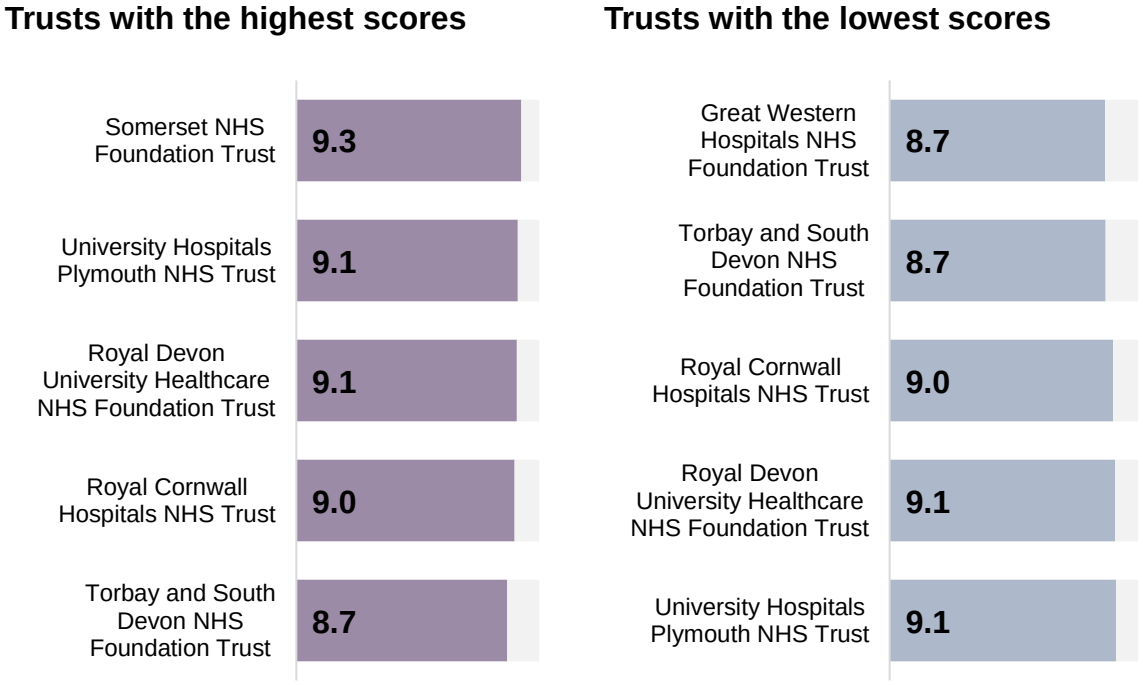
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 9.1 About the same



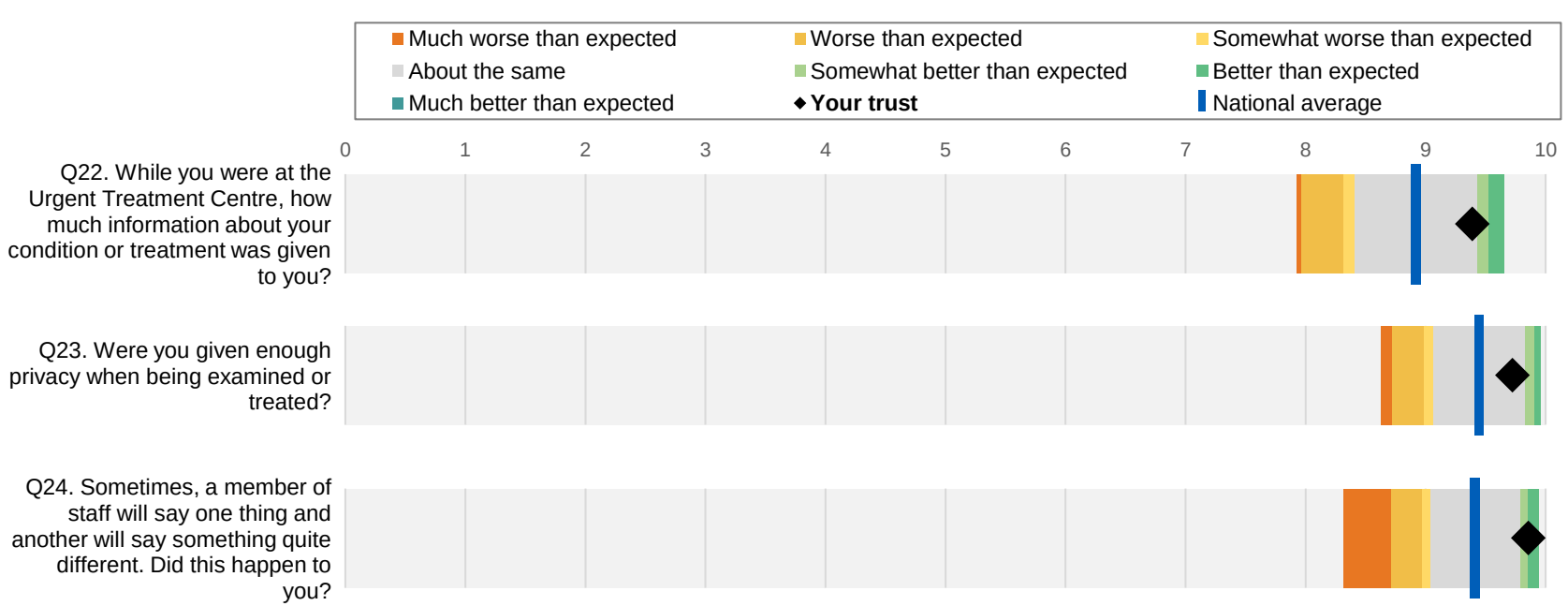
Each vertical line represents an individual NHS trust

Comparison with other trusts within your region



Section 4. Care and treatment (continued)

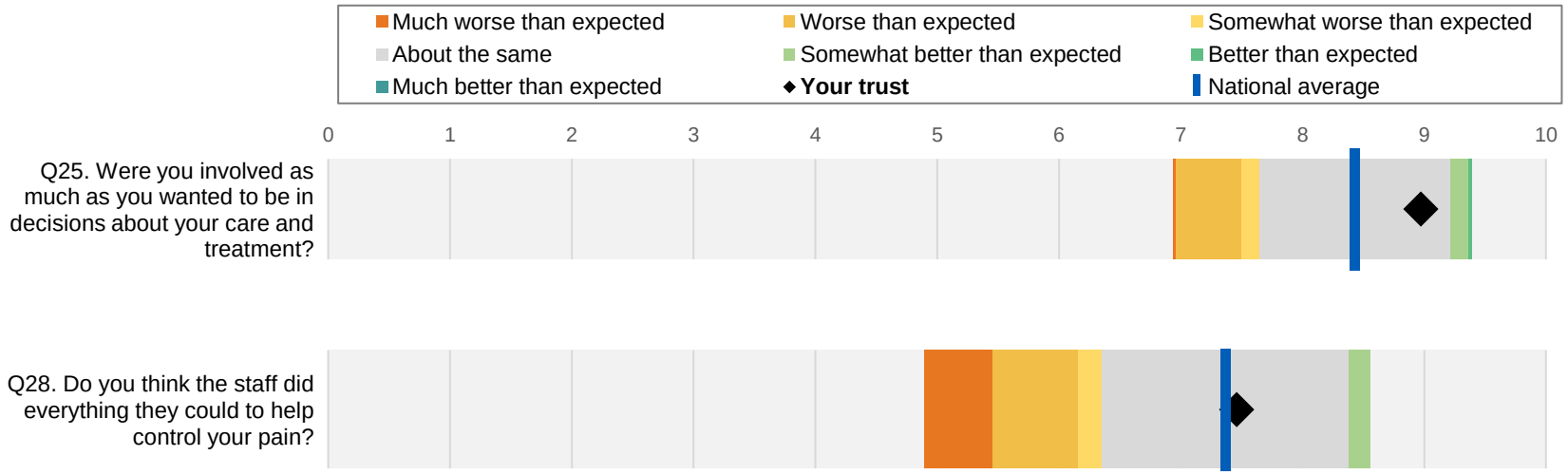
Question scores



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
About the same: 219	9.4	8.9	7.9	9.7
About the same: 220	9.7	9.4	8.6	10.0
Better than expected: 218	9.9	9.4	8.3	9.9

Section 4. Care and treatment (continued)

Question scores

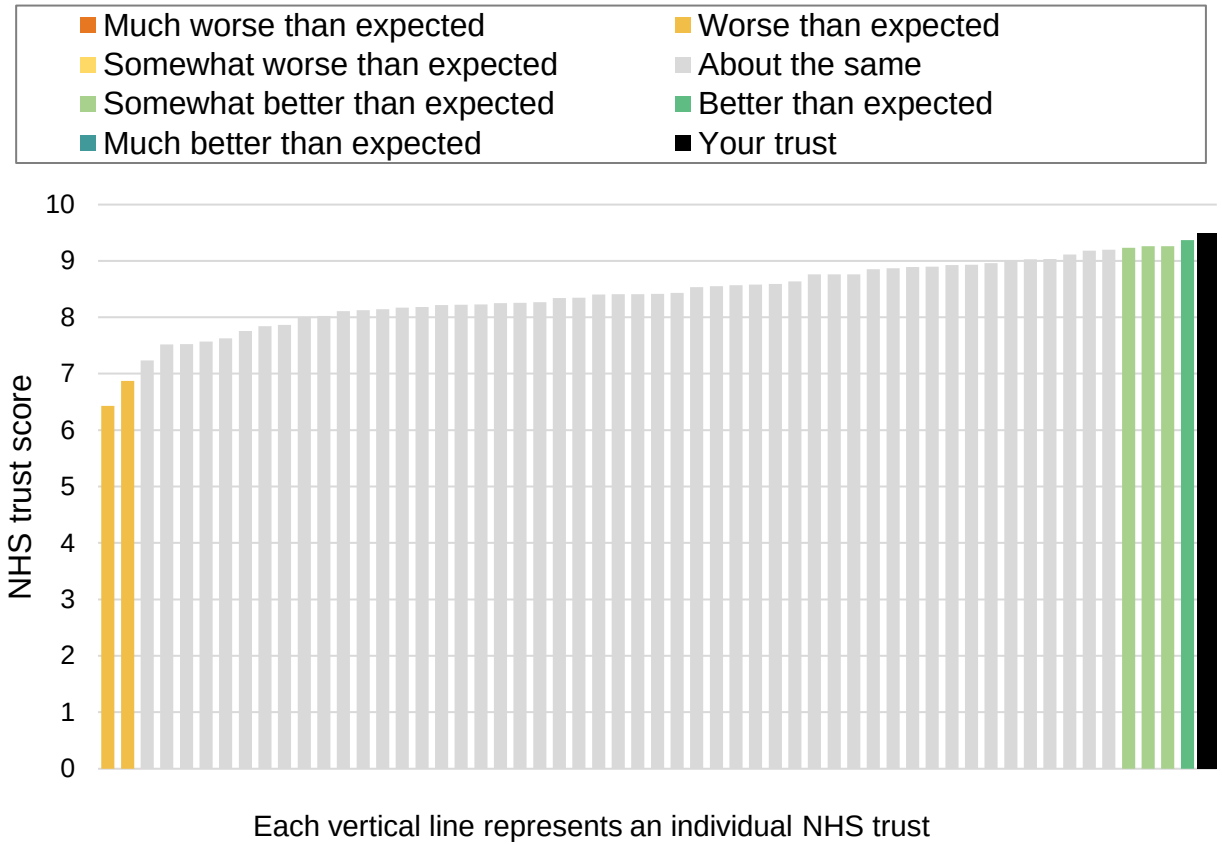


		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
About the same				
216	9.0	8.4	6.9	9.4
About the same				
152	7.5	7.4	4.9	8.6

Section 5. Tests

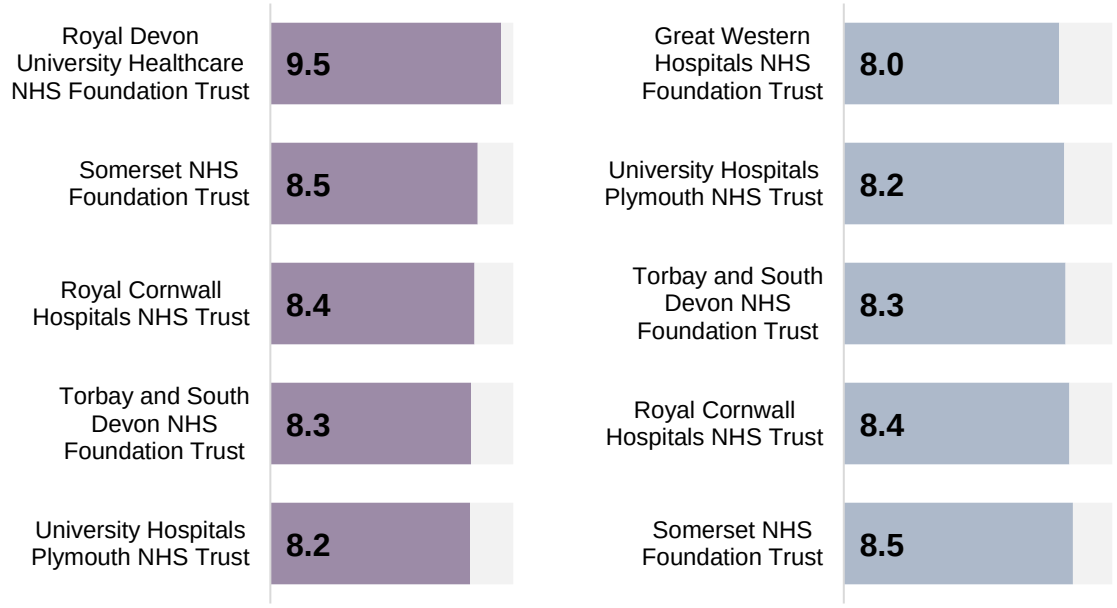
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 9.5 Better than expected



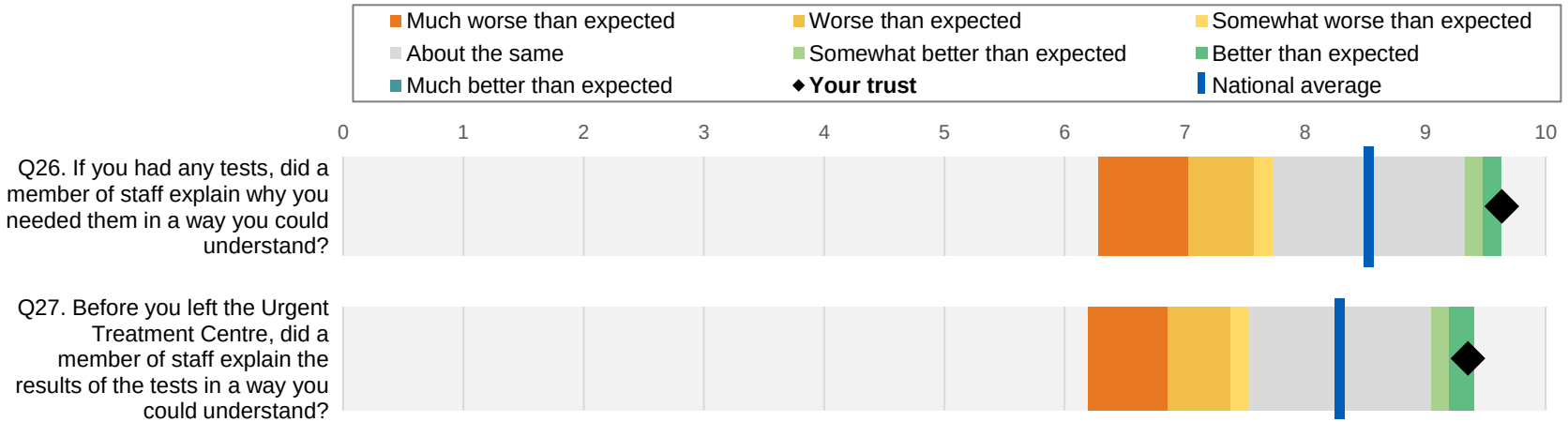
Each vertical line represents an individual NHS trust

Comparison with other trusts within your region



Section 5. Tests (continued)

Question scores



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
75	9.6	8.5	6.3	9.6
75	9.4	8.3	6.2	9.4

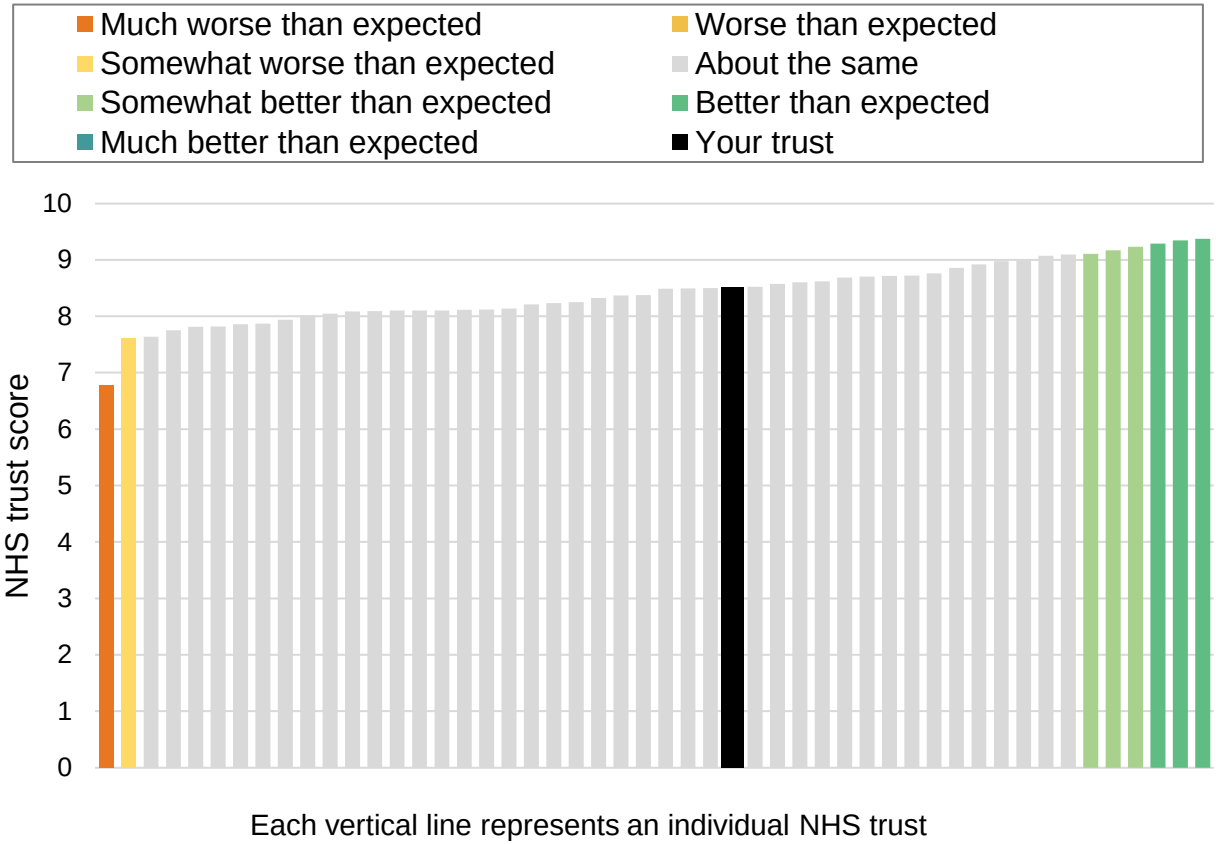
Better than expected

Better than expected

Section 6. Environment and facilities

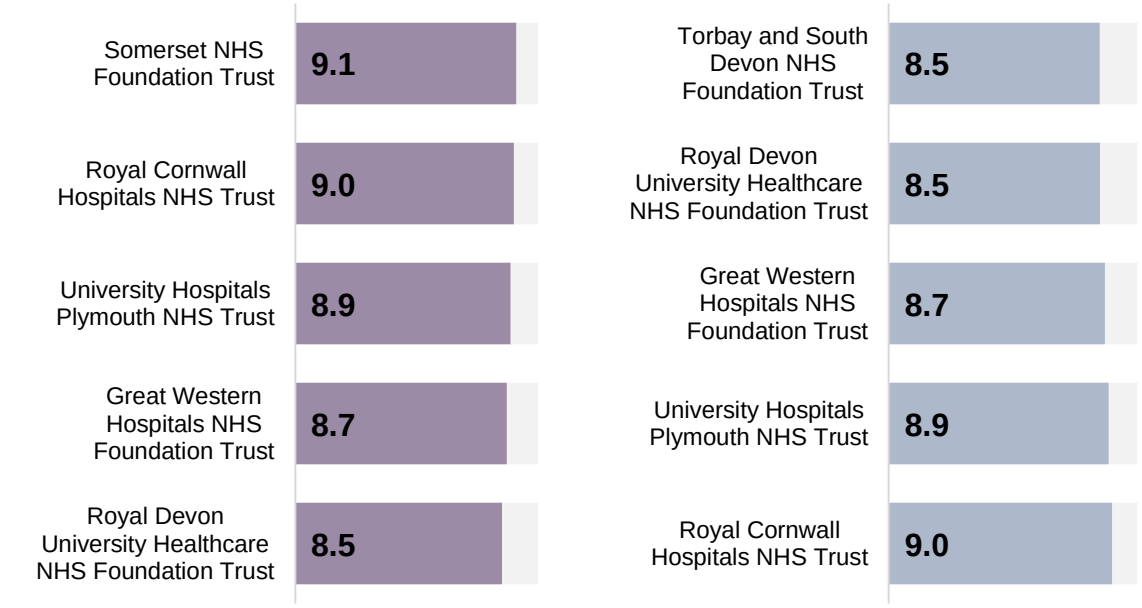
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.5 About the same



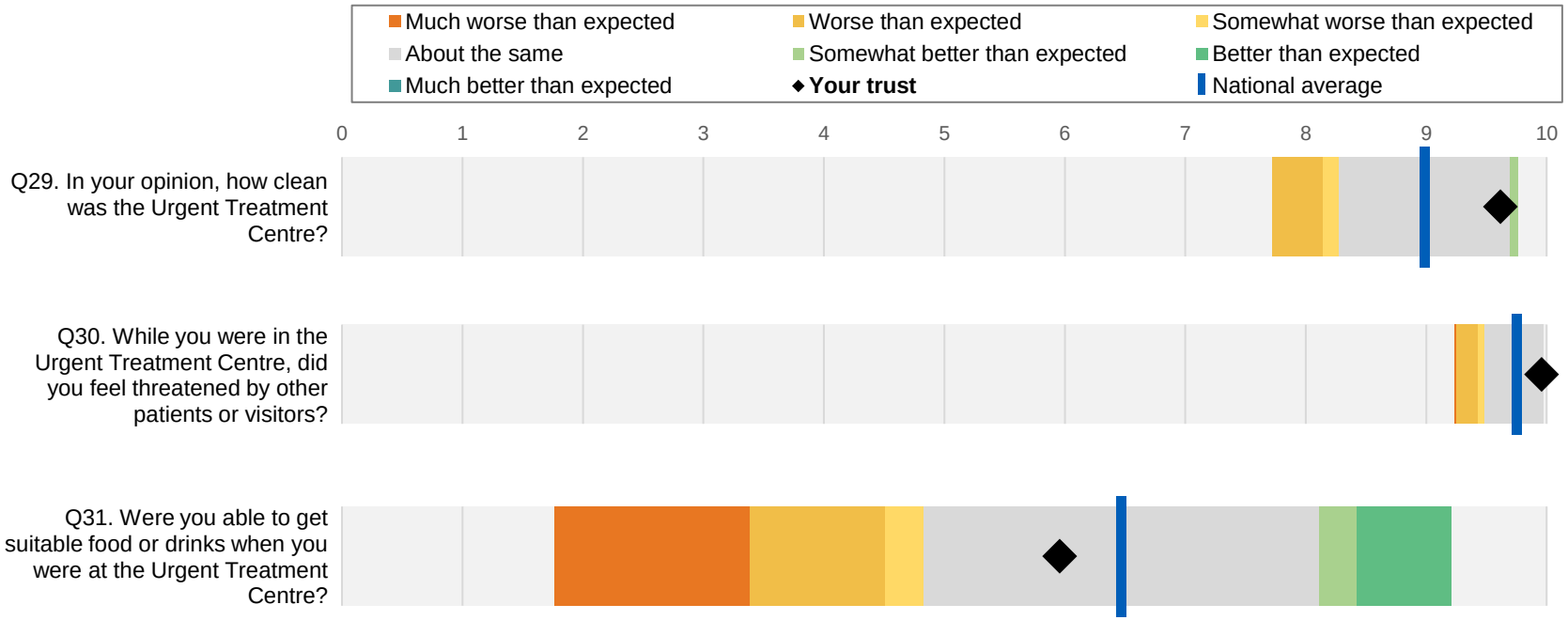
Each vertical line represents an individual NHS trust

Comparison with other trusts within your region



Section 6. Environment and facilities (continued)

Question scores



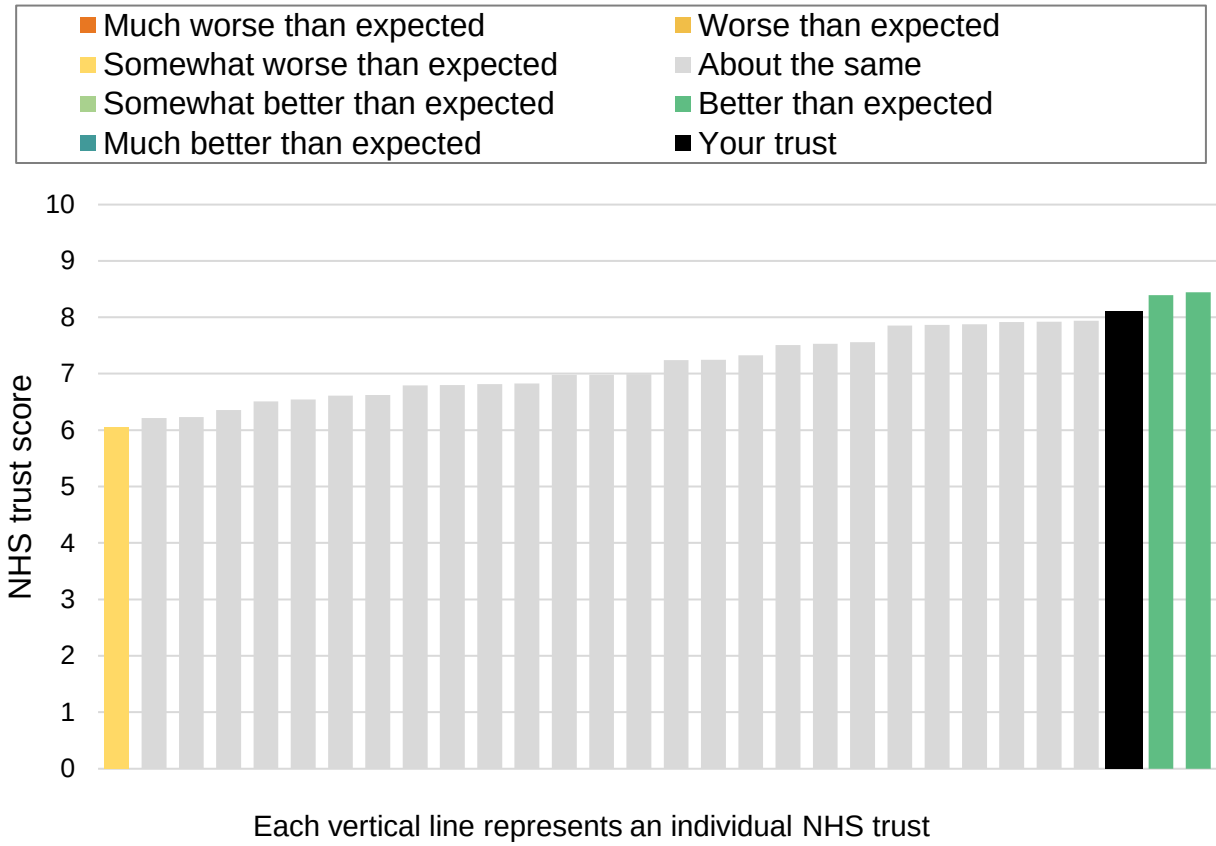
			All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
Q29. In your opinion, how clean was the Urgent Treatment Centre?	221	9.6	9.0	7.7	9.8
Q30. While you were in the Urgent Treatment Centre, did you feel threatened by other patients or visitors?	223	10.0	9.8	9.2	10.0
Q31. Were you able to get suitable food or drinks when you were at the Urgent Treatment Centre?	65	6.0	6.5	1.8	9.2

About the same

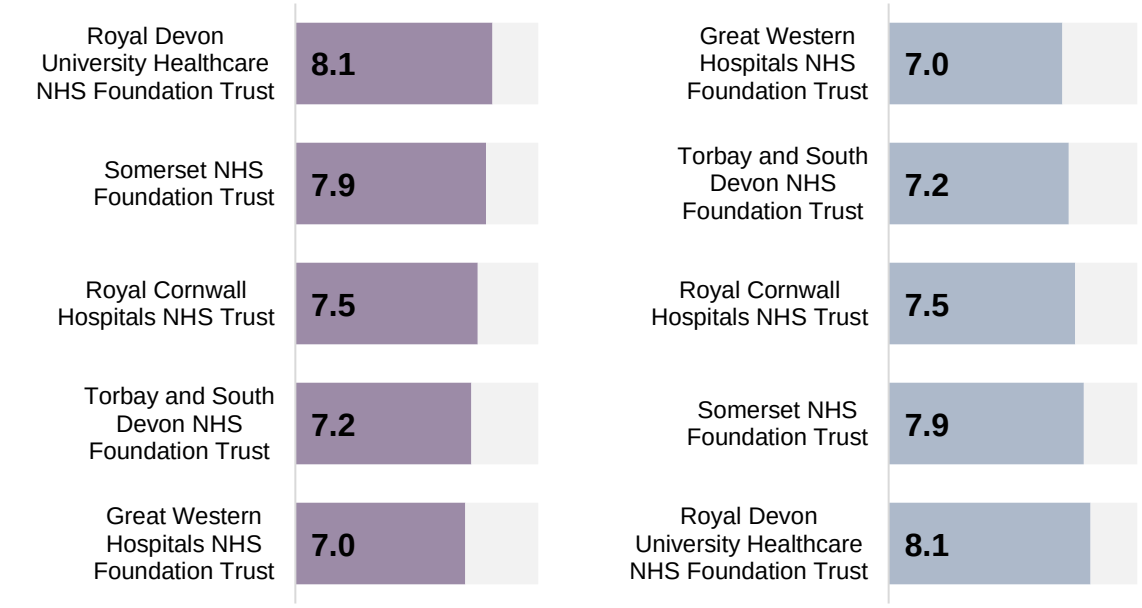
Section 7. Leaving the Urgent Treatment Centre

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.1 Somewhat better than expected

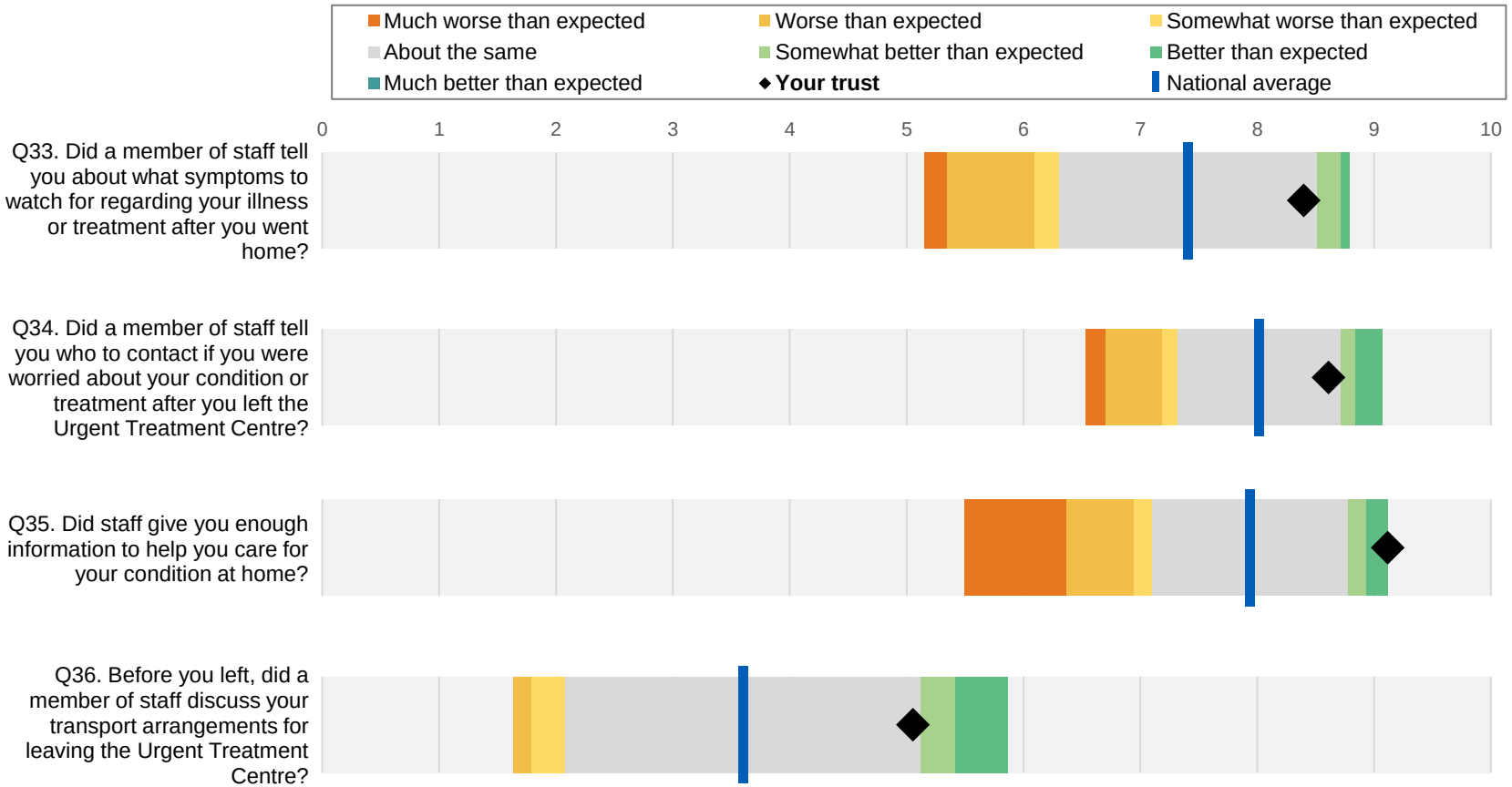


Comparison with other trusts within your region



Section 7. Leaving the Urgent Treatment Centre (continued)

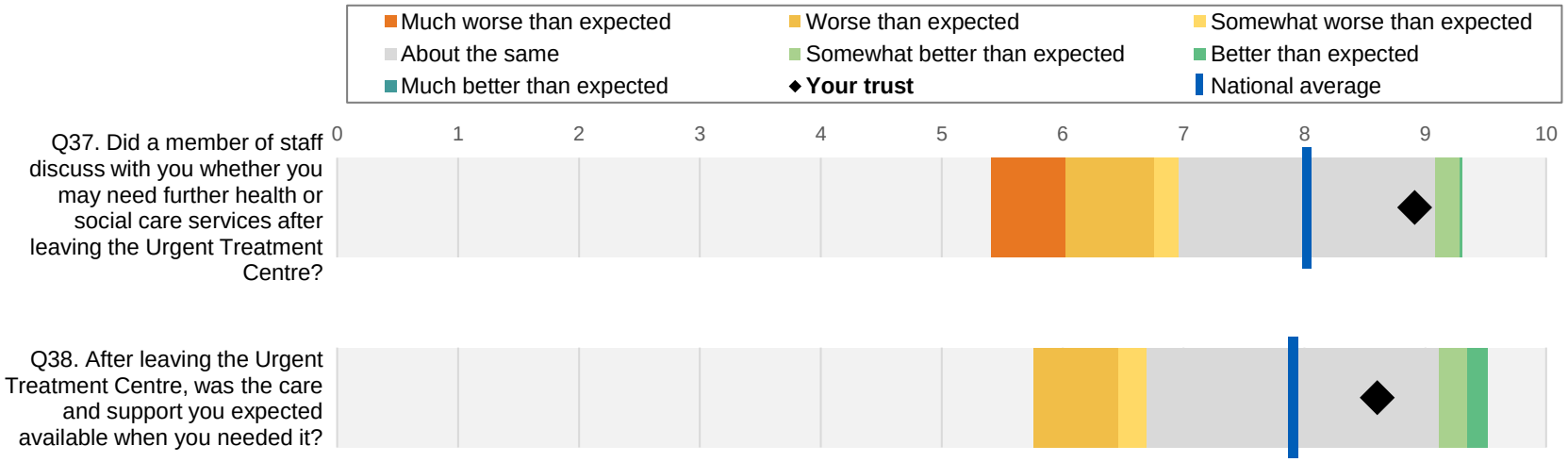
Question scores



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score	
166	8.4	7.4	5.1	8.8	About the same
174	8.6	8.0	6.5	9.1	About the same
183	9.1	7.9	5.5	9.1	Better than expected
53	5.1	3.6	1.6	5.9	About the same

Section 7. Leaving the Urgent Treatment Centre (continued)

Question scores

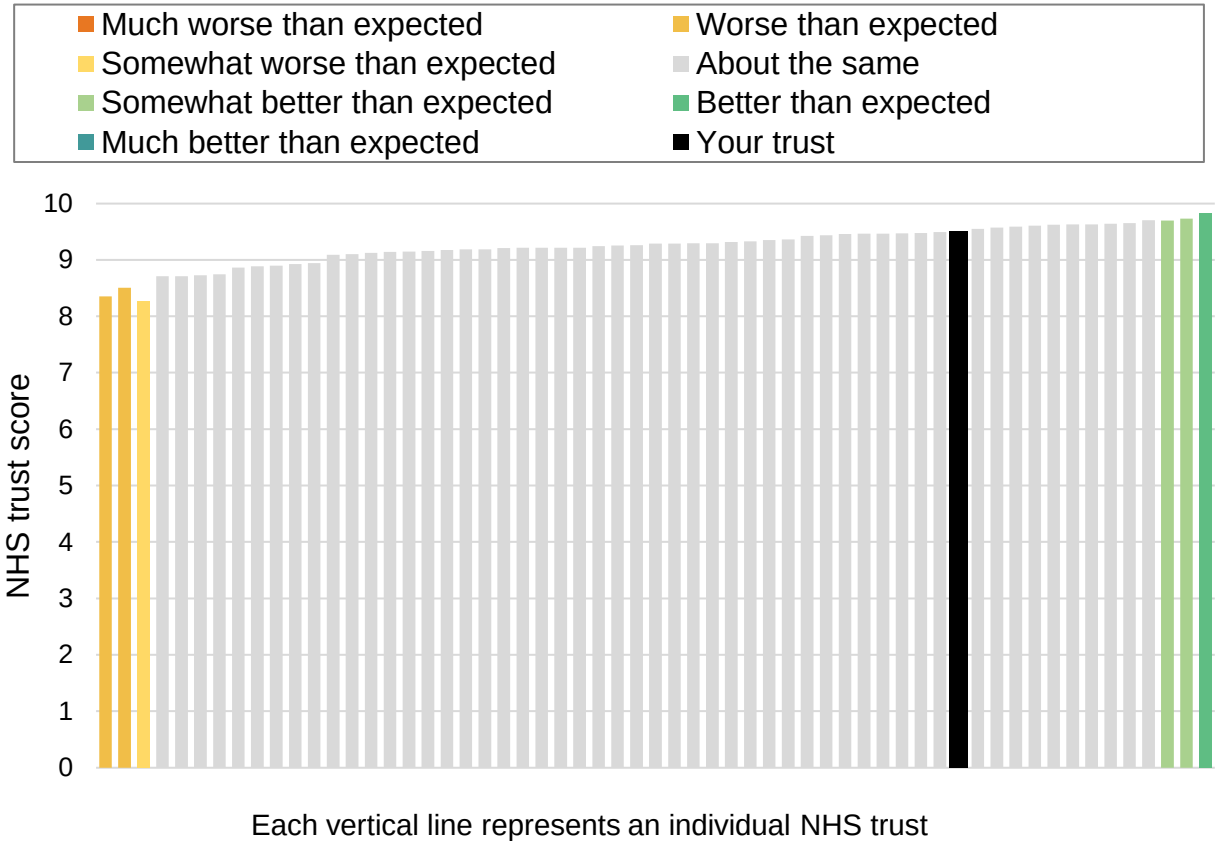


			All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	71	8.9	8.0	5.4	9.3
About the same	78	8.6	7.9	5.8	9.5

Section 8. Respect and dignity

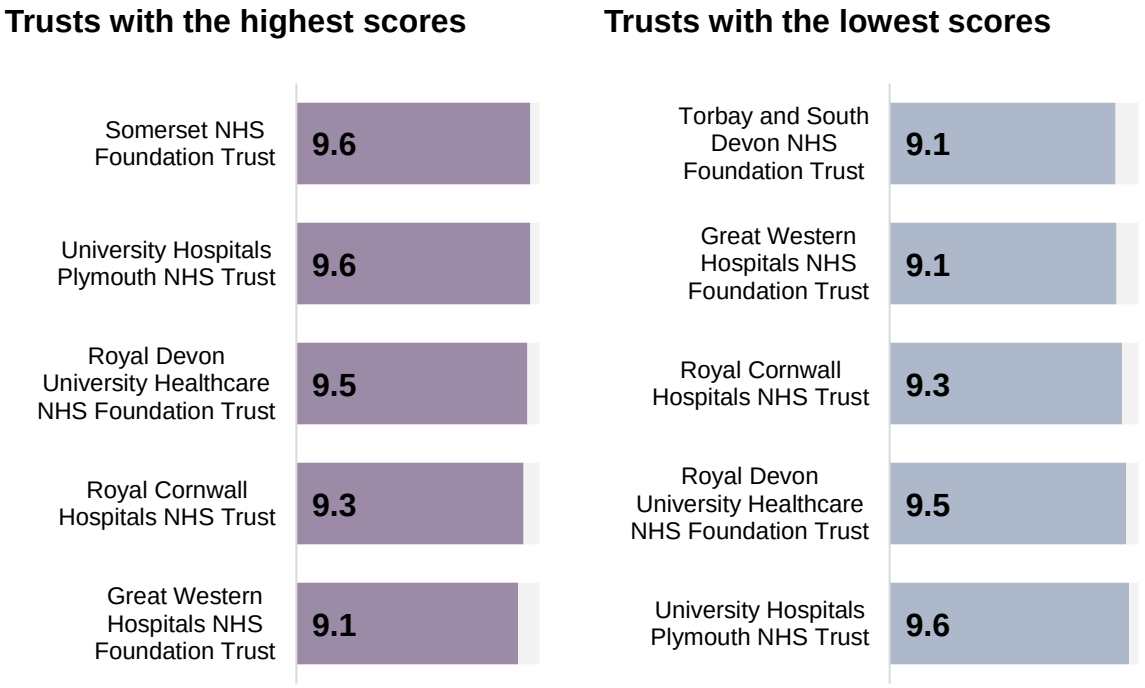
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 9.5 About the same



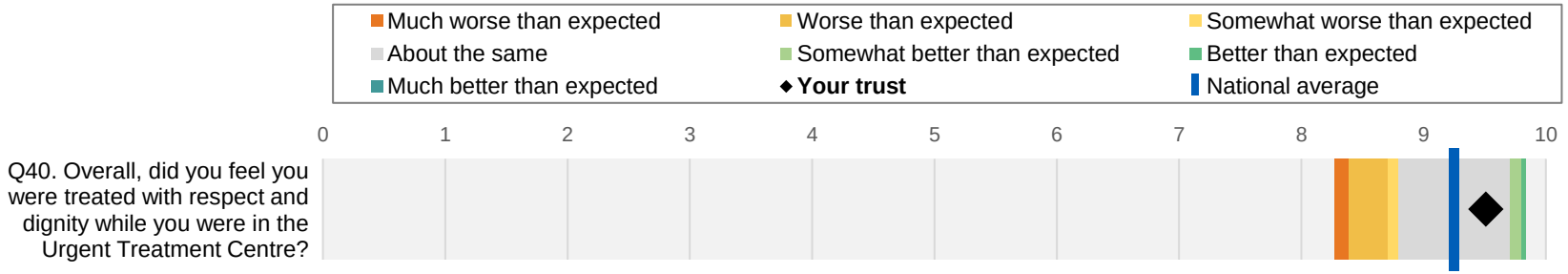
Each vertical line represents an individual NHS trust

Comparison with other trusts within your region



Section 8. Respect and dignity (continued)

Question scores

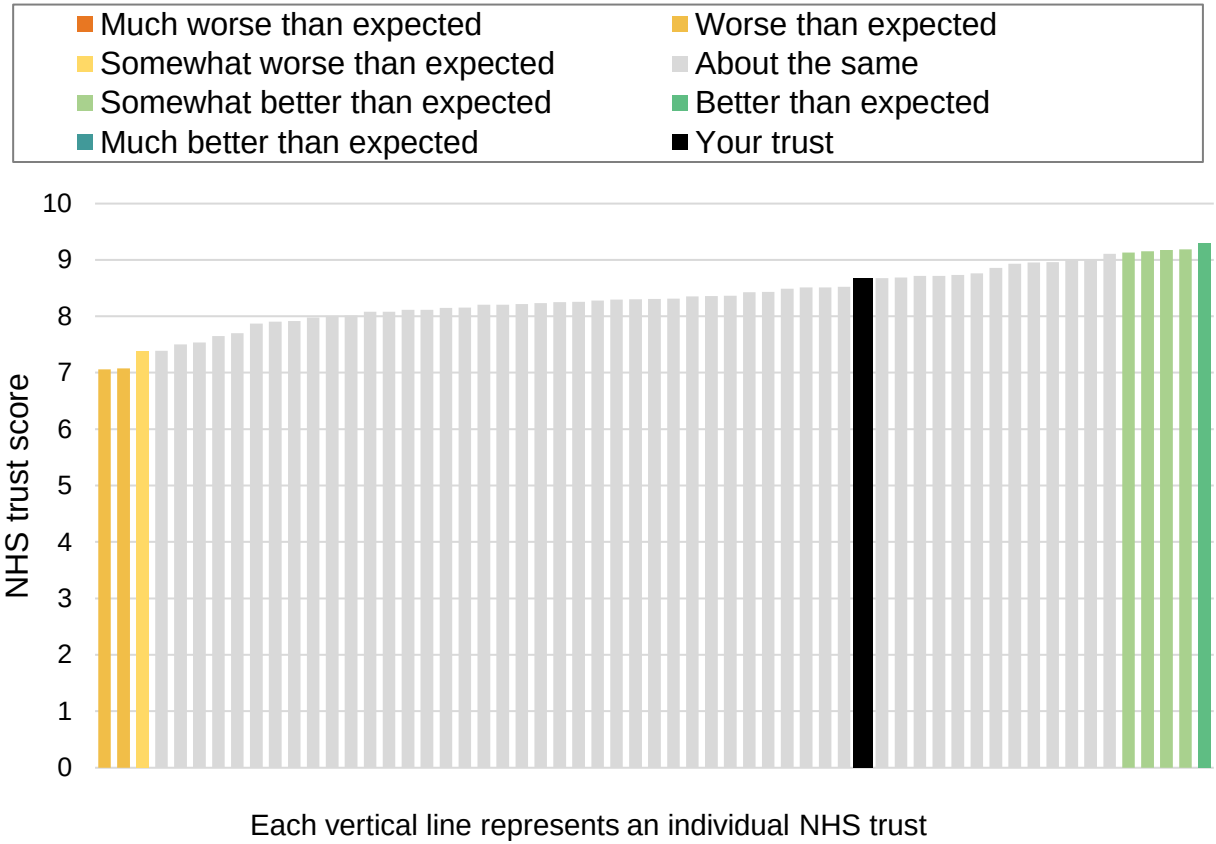


		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
219	9.5	9.3	8.3	9.8

Section 9. Experience overall

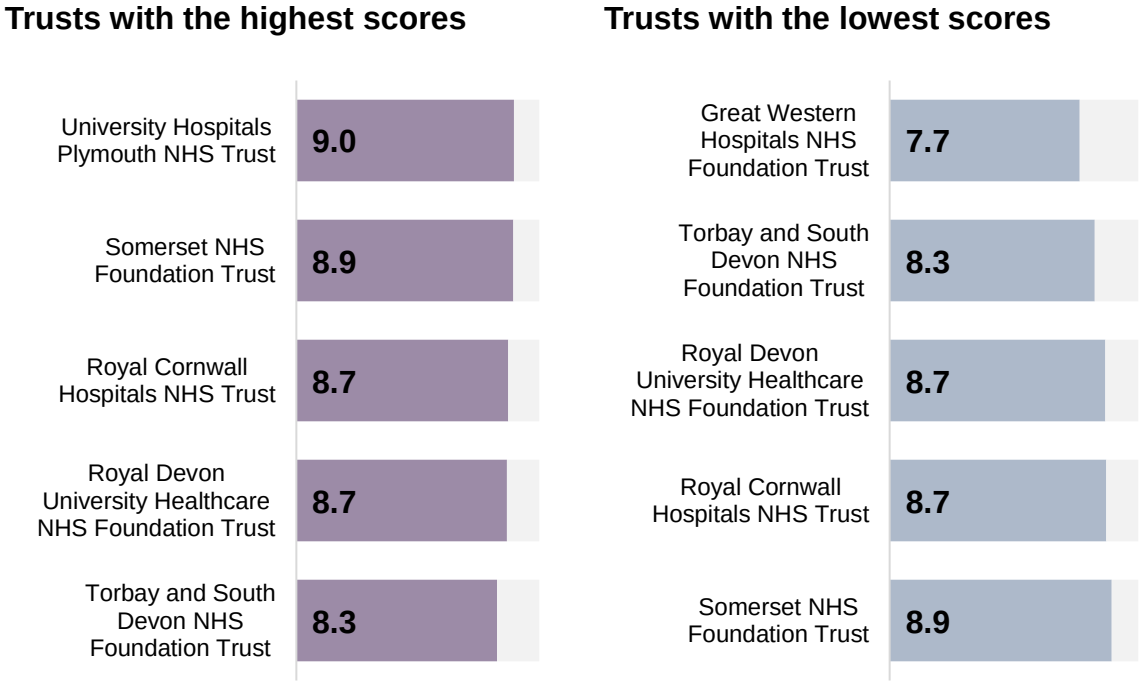
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.7 About the same



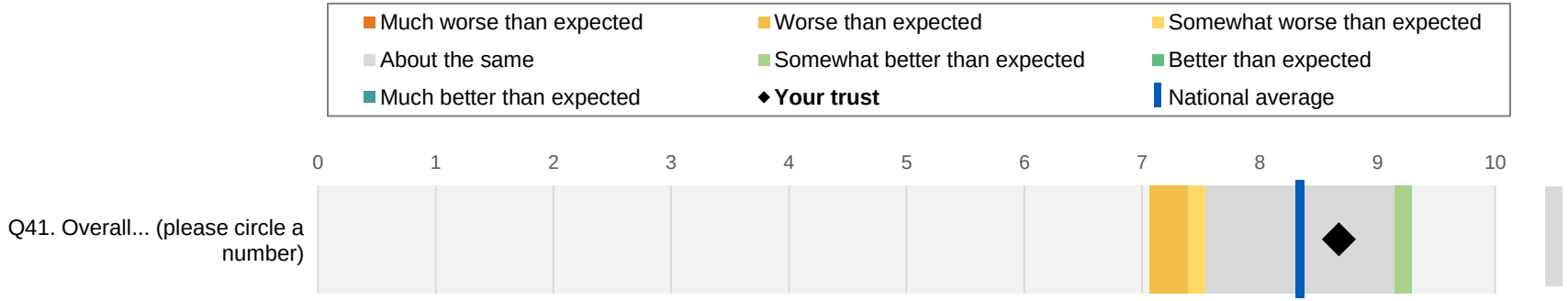
Each vertical line represents an individual NHS trust

Comparison with other trusts within your region



Section 9. Experience overall (continued)

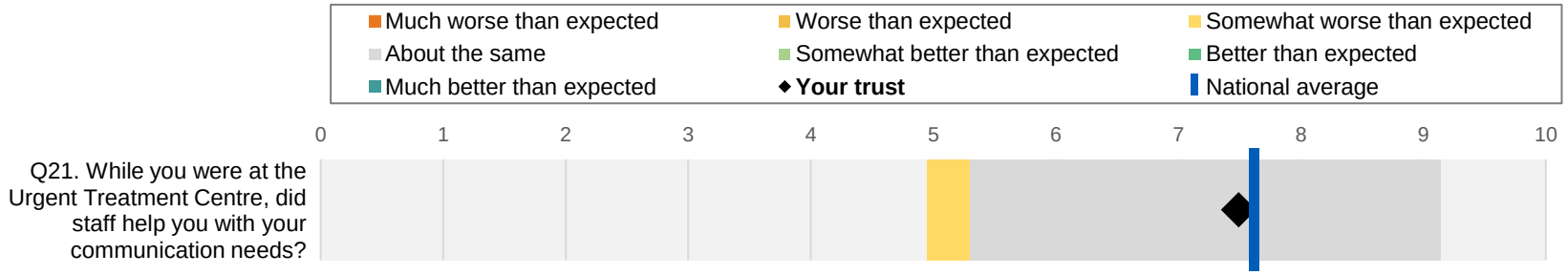
Question scores



All trusts in England				
Number of respondents	Your trust	National average	Lowest score	Highest score
214	8.7	8.3	7.1	9.3

Q21. While you were at the Urgent Treatment Centre, did staff help you with your communication needs?

Question scores

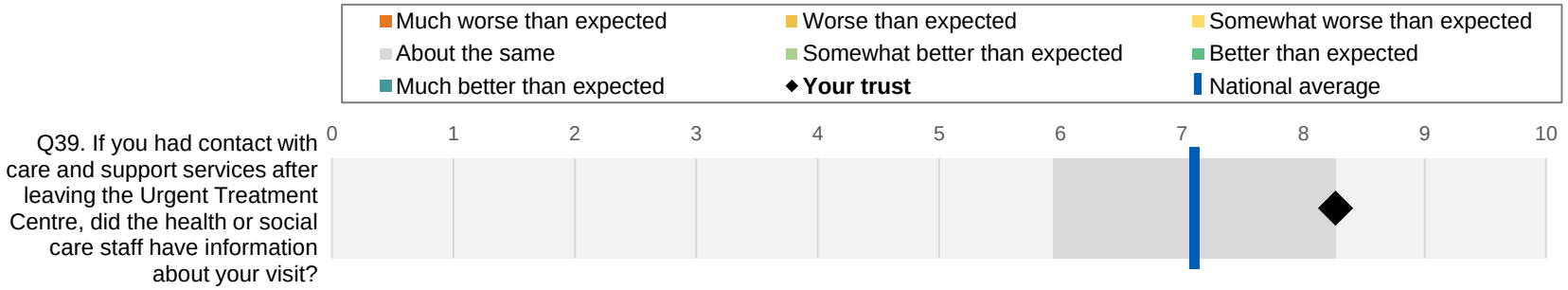


		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
40	7.5	7.6	5.0	9.1

Please note this question is not included in a section score due to high levels of suppression.

Q39. If you had contact with care and support services after leaving the Urgent Treatment Centre, did the health or social care staff have information about your visit?

Question scores



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
46	8.3	7.1	5.9	8.3

Please note this question is not included in a section score due to high levels of suppression.

Change over time

This section includes:

- a comparison to previous survey years scores for your trust for each question, including:
  - your trust's 2022 score compared with its scores from 2018 to 2020.

Please note:

- If data is missing for a survey year, this is due to a low number of responses, or because the trust data was not included in the survey that year, due to sampling errors or ineligibility.

RH8 Royal Devon University Healthcare NHS Foundation Trust does not have any historical comparisons.

Appendix

Comparison to other trusts: where your trust has performed much better

The questions at which your trust has performed much better when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much better than expected

- Q10. Were you informed how long you would have to wait to be examined?
- Q18. Did health professionals talk to each other about you as if you weren't there?

Comparison to other trusts: where your trust has performed better

The questions at which your trust has performed better than compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Better than expected

- Q16. If you had any anxieties or fears about your condition or treatment, did a health professional discuss them with you?
- Q24. Sometimes, a member of staff will say one thing and another will say something quite different. Did this happen to you?
- Q26. If you had any tests, did a member of staff explain why you needed them in a way you could understand?
- Q27. Before you left the Urgent Treatment Centre, did a member of staff explain the results of the tests in a way you could understand?
- Q35. Did staff give you enough information to help you care for your condition at home?

Comparison to other trusts: where your trust has performed somewhat better

The questions at which your trust has performed somewhat better when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat better than expected

- Q13. Did you have enough time to discuss your condition with the health professional?
- Q20. If a family member, friend or carer wanted to talk to a health professional, did they have enough opportunity to do so?

Comparison to other trusts: where your trust has performed somewhat worse

The questions at which your trust has performed somewhat worse when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat worse than expected

- No questions for your trust fall within this banding.

Comparison to other trusts: where your trust has performed worse

The questions at which your trust has performed worse compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Worse than expected

- No questions for your trust fall within this banding.

Comparison to other trusts: where your trust has performed much worse

The questions at which your trust has performed much worse when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much worse than expected

- No questions for your trust fall within this banding.

2022 Urgent and Emergency Care Survey

Urgent Treatment Centres (Type 3 services) results for Royal Devon University Healthcare NHS Foundation Trust

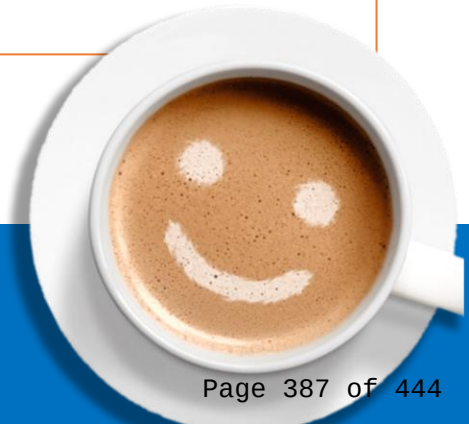
Where patient experience is best

- ✓ **Waiting:** Patients being informed on how long wait to be examined will be
- ✓ **Transport when leaving UTC:** Staff discussing patients' transport arrangements before they leave the UTC
- ✓ **Length of visit:** Length of patients' Urgent Treatment Centre visit
- ✓ **Information:** Staff giving patients enough information to help them care for their condition at home
- ✓ **Information sharing:** Health or social care staff having information about patients' visit to the UTC

Where patient experience could improve

- **Food & drink:** Availability of suitable food or drink
- **Waiting:** Length of wait before patients first speak to a health professional
- **Communication needs:** Staff helping patients with any communication needs they have
- **Pain management:** Staff doing everything they can to help control patients' pain
- **Confidence and trust:** Patients having confidence and trust in health professionals treating them

These questions are calculated by comparing your trust's results to the national average. "Where patient experience is best": These are the five results for your trust that are highest compared with the national average. "Where patient experience could improve": These are the five results for your trust that are lowest compared with the national average.



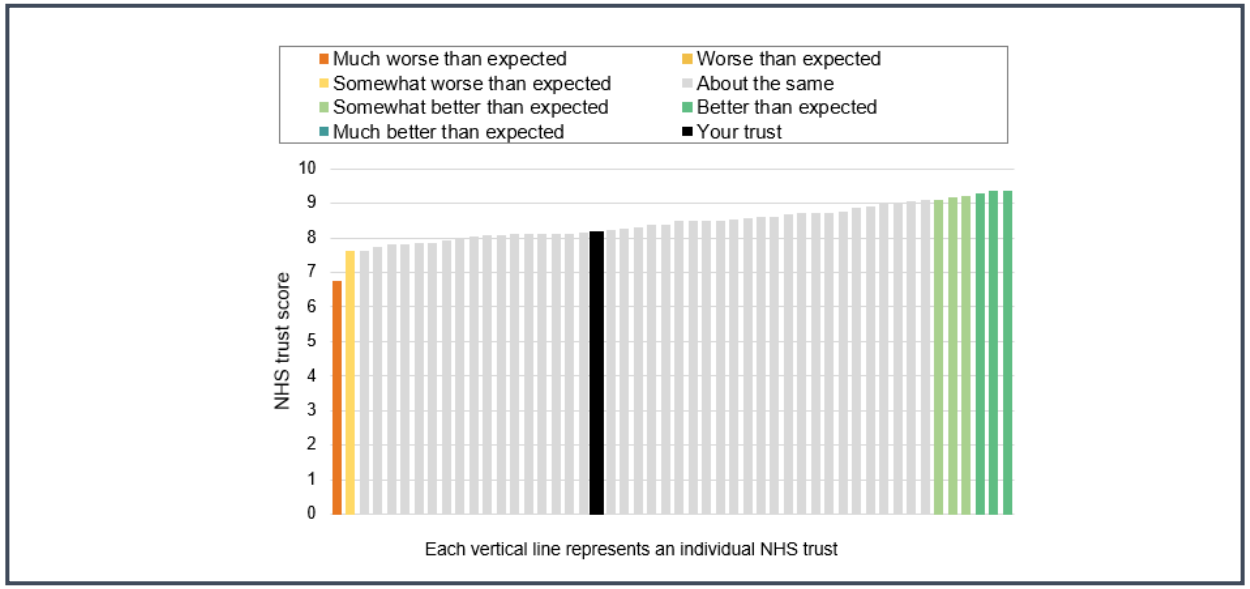
This survey looked at the experiences of people who were receiving care or treatment in a Type 3 Urgent Treatment Centre (UTC) and had been treated by the trust between 1st and 30th September 2022. Between November 2022 and March 2023, a questionnaire was sent to 580 recent patients. Responses were received from 224 patients at this trust. If you have any questions about the survey and our results, please contact [INSERT TRUST CONTACT DETAILS].

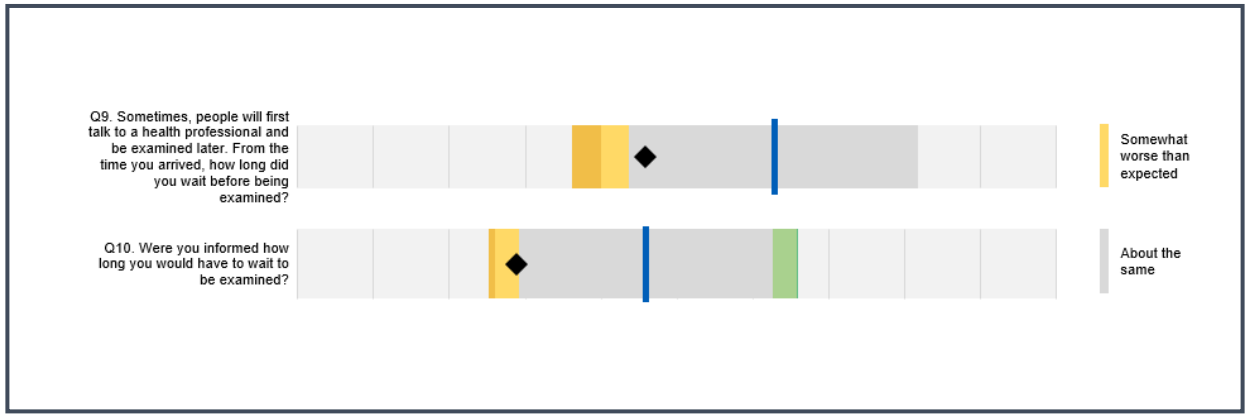
How to interpret benchmarking in this report

The charts in the 'benchmarking' section show how the score for your trust compares to the range of scores achieved by all trusts taking part in the survey. The black line shows the score for your trust. The graphs are divided into seven sections, comparing the score for your trust to most other trusts in the survey:

- If your trust's score lies in the **dark green section** of the graph, its result is 'Much better than expected'.
- If your trust's score lies in the **mid-green section** of the graph, its result is 'Better than expected'.
- If your trust's score lies in the **light green section** of the graph, its result is 'Somewhat better than expected'.
- If your trust's score lies in the **grey section** of the graph, its result is 'About the same'.
- If your trust's score lies in the **yellow section** of the graph, its result is 'Somewhat worse than expected'.
- If your trust's score lies in the **light orange** section of the graph, its result is 'Worse than expected'.
- If your trust's score lies in the **dark orange** section of the graph, its result is 'Much worse than expected'.

These groupings are based on a rigorous statistical analysis of the data termed the 'expected range' technique.





How to interpret benchmarking in this report (continued)

The ‘much better than expected,’ ‘better than expected’, ‘somewhat better than expected’, ‘about the same’, ‘somewhat worse than expected’, ‘worse than expected’ and ‘much worse than expected’ categories are based on an analysis technique called the ‘expected range’. Expected range determines the range within which a trust’s score could fall without differing significantly from the average, taking into account the number of respondents for each trust, to indicate whether the trust has performed significantly above or below what would be expected.

If it is within this expected range, we say that the trust’s performance is ‘about the same’ as other trusts. Where a trust is identified as performing ‘better’ or ‘worse’ than the majority of other trusts, the result is unlikely to have occurred by chance.

In some cases, there will be no shades of orange and/or green area in the graph. This happens when the expected range for your trust is so broad that it encompasses either the highest possible score for all trusts (no green section) or the lowest possible score for all trusts (no orange section). This could be because there were few respondents and/or a lot of variation in their answers.

In some cases, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

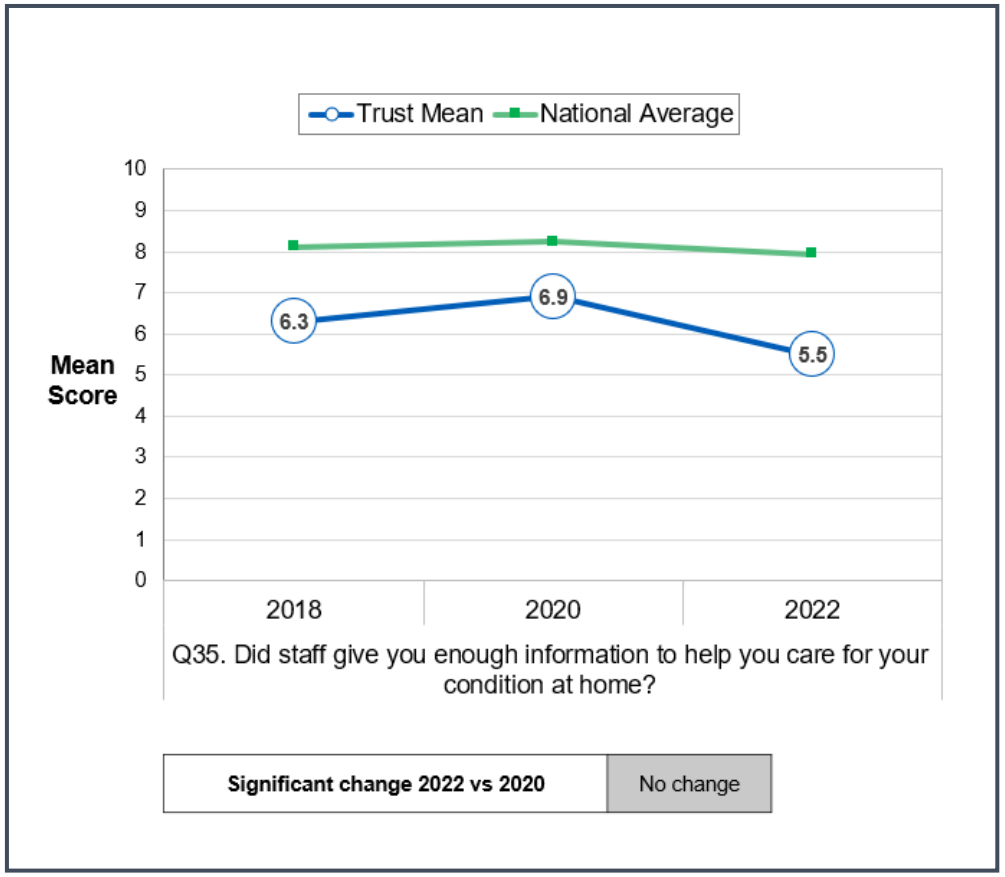
Additional information on the ‘expected range’ analysis technique can be found in the survey technical report on the NHS Surveys website.

How to interpret change over time in this report

The charts in the ‘change over time’ section show how your trust scored in each Urgent & Emergency Care survey iteration. Where available, trend data from 2018 to 2022 is shown. If a question only has one data point, this question is not shown. Questions that are not historically comparable, are also not shown.

Each question is displayed in a line chart. These charts show your trust mean score for each survey year (blue line). The national average is also shown across survey years, this is the average score for that question across all NHS trusts with a Type 3 Urgent Treatment Centre (UTC) in England (green line). This enables you to see how your trust compares to the national average. If there is data missing for a survey year, this may be due to either a low number of responses, because the trust was not included in the survey that year, sampling errors or ineligibility.

Statistically significant changes are also displayed in tables underneath the charts, showing significant differences between this year (2022) and the previous year (2020). Z-tests set to 95% significance were used to compare data between the two years (2022 vs 2020). A statistically significant difference means it is unlikely we would have obtained this result if there was no real difference.



An example of scoring

Each evaluative question is scored on a scale from 0 to 10. The scores represent the extent to which the patient's experience could be improved. A score of 0 is assigned to all responses that reflect considerable scope for improvement, whereas a score of 10 refers to the most positive patient experience possible. Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. Where options were provided that did not have any bearing on the trust's performance in terms of patient experience, the responses are classified as "not applicable" and a score is not given. Similarly, where respondents stated they could not remember or did not know the answer to a question, a score is not given.

Calculating an individual respondent's score

The following provides an example for the scoring system applied for each respondent. For question 7 "Were you given enough privacy when discussing your condition with the receptionist?":

- The answer code "Yes, definitely" would be given a score of 10, as this refers to the most positive patient experience possible.
- The answer code "Yes, to some extent" would be given a score of 5, as it is placed at an equal interval along the scale.
- The answer code "No" would be given a score of 0, as this response reflects considerable scope for improvement.
- The answer code "I did not discuss my condition with a receptionist" would not be scored, as they do not have a clear bearing on the trust's performance in terms of patient experience.

Calculating the trust score for each question

The weighted mean score for each trust, for each question, is calculated by dividing the sum of the weighted scores for a question by the weighted sum of all eligible respondents to the question for each trust. An example of this is provided in the survey technical document.

Calculating the section score

An arithmetic mean of each trust's question scores is taken to provide a score for each section.

Thank you.

For further information, please contact the Survey Coordination Centre for Existing Methods:

emergency@surveycoordination.com

Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	12.2, Public Board Meeting		**Date: 1 November 2023**	
Title:	Digital Committee Update			
Prepared by:	Colin Garforth, Programme Support Manager			
Presented by:	Tony Neal, Non-Executive Director and Committee Chair			
Responsible Executive:	Adrian Harris, Chief Medical Officer			
Summary:	Briefing of items discussed at Digital Committee held on 5 October 2023			
Actions required:	Link to status below and set out clearly the expectations of the Board when considering the paper.			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
				X
History:	The last Digital Committee update was presented to the Board of Directors in Sep 2023.			
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		
NHS Improvement		Finance	
Service Development Strategy		Performance Management	
Local Delivery Plan		Business Planning	
Assurance Framework		Complaints	
Equality, diversity, human rights implications assessed			
Other *(please specify)*			

1. Purpose of paper

To provide a briefing on the Digital Committee (DC) held on 5 Oct 2023.

2. Background

The DC provides a direct feed into the Board of Directors and senior/corporate oversight to assure that:

- a robust, effective fit-for-purpose framework is in place for the technical, clinical and operational delivery of the digital agenda and digital maturity aspirations;
- the digital agenda contributes to the Trust operating within the law and compliance with statutory and regulatory requirements whilst concurrently delivering safe, quality and effective, digitally enabled sustainable care.
- the Trust has effective systems of internal control in relation to the digital agenda and associated governance arrangements and
- the digital agenda is aligned to overall direction of the Trust, the Integration Programme and the wider ICS.
- innovative use of technology supports the delivery of service transformation to ensure we continue to improve at all levels
- Oversee the development and delivery of the Digital Strategy Implementation Plan, noting interdependencies, risks and milestone achievements.

The Digital Committee Chair, on behalf of the DC, is responsible for reporting back to the Board of Directors on a monthly basis.

3. Analysis

The DC receives status reports from the relevant sub committees each month. The DC is assured from the reports that these sub committees function effectively.

The DC raises the following matters for information with the Board of Directors:

3.1 Digital Strategy

- Enabling strategies sub-group continuing to develop strategy roadmap
- Work is underway to identify the resource requirements across the teams in Digital Services to deliver the strategy
- Support given for proposed Patient Reference Group to be set up to bring together the different fields of digital, clinical digital, transformation and sustainability to develop a strategic narrative around how we are transforming our services digitally. This will allow us to shift focus to a digital model of care and move away from siloed working. Further discussion required with Executives to agree governance route.

3.2 People Systems

- HF presented an update on the national and regional work around workforce systems, looking at scaling People Services to see how we can collaborate across system to achieve efficiencies.

- Business cases are being developed for the 'employee experience layer' and 'digital service layer'; scheduled for approval end of calendar year.
- Alignment with Enabling Strategies prioritisation required.

3.3 ICS Shared Services Model

- Channel 3 have produced Outline Business Cases (OBC) on the following:
  - Target Operatiing Model (TOM)
  - Shared Service Desk
- Finances require further interrogation; this is being picked up through various planned workshops.
- OBCs will need approval by each Trust Board across the system.
- Board discussion is required around the overall shared services model to obtain assurances as the business cases progress.
- Committee agreed it is right to explore these scenarios; need to ensure there are safeguards are built e.g. around hosting.

3.4 DSPT

- Work continues to address action identified from 2022/23 DSPT submission.
- Work commenced with on 2023/24 DSPT activity, some evidence collected.
- Unlikely to achive 'standard met' by Dec 23; significant risk remains regarding achieving 95% Training Compliance.

3.5 Clinical Coding

- Coding team are managing a backlog of uncoded activity.
- All trainees now in place.
- Training takes 2 years to complete.
- September baseline figures already showing improvement.
- Uncoded activity metrics will be produced for future Digital Committees

4. Link to BAF/Key risks

4.1 BAF Risks

- Epic Benefits Realisation risk – Updated risk is being submitted through local Clincial Governance meeting before presenting to Digital Committee in Dec 2023.

4.2 Divisional Risks

- There are currently 3 risk scored 16:
  - DSPT compliance
  - (New) Network Core Out of Support (North) – Programme in place to replace out of support network equipment
  - (New) Migration of Critical Servers (North) – Critical servers are being migrated.

  - New business cases need to consider impact on digital services capacity to support delivery
- New risks to be evaluated for:
  - Medical Record storage
  - Rollout of Epic across the system
  - Devon System to host Epic outside of Royal Devon.
  - Patient letters in Epic (following recent incident at Newcastle Hospital)

5. Proposals

It is proposed that the Board of Directors notes the report from the Digital Committee and to approve the revised Terms of Reference.

Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	12.3 Public Board Meeting		Date: 1 November 2023	
Title:	Finance and Operational Committee Board Update			
Prepared by:	Angela Hibbard, Chief Finance Officer			
Presented by:	Steve Kirby, Non-Executive Director & Finance & Operational Committee Chair			
Responsible Executive:	Angela Hibbard, Chief Finance Officer John Palmer, Chief Operating Officer			
Summary:	This is an update paper to give the Board of Directors assurance on the financial and operational business undertaken through the Finance Committee and to recommend any decisions for full board approval			
Actions required:	The Finance and Operational Committee makes the following recommendations to the Trust Board of Directors: • To approve the recommended increase in BAF risk score 4 due to the increased consequences on non-delivery of the financial plan. All other updates are for noting.			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
		X		**X**
History:	The Finance and operational Committee was held on 17 October 2023 with a detailed meeting pack to support agenda items. The meeting was quorate.			
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		
NHS Improvement		Finance	X
Service Development Strategy		Performance Management	X
Local Delivery Plan		Business Planning	X
Assurance Framework		Complaints	
Equality, diversity, human rights implications assessed			
Other *(please specify)*			

1. Purpose of paper

To provide, as requested by the Board of Directors, a report on matters arising from the Finance and Operational Committee (FOC) at the meeting held on 17 October 2023. A full copy of the approved FOC minutes is available upon request.

2. Background

The role of FOC is to provide additional assurance to the Trust Board of Directors through the public and confidential Board meetings on financial and operational matters. The committee is for assurance only and there is no decision-making authority in the terms of reference. However, the committee scrutinise any issues to enable clear recommendation to be made to the Board of Directors.
Items received for information are by exception to enable a greater level of assurance behind the financial, data quality and operational issues reported in the IPR.

3. Updates

3.1 Assurance Updates

2023/24 financial position by exception

Two by exception items were raised, recognising that the detail on the month 6 position was covered by a separate agenda item:

Drugs position – concern had been raised at a previous meeting on the level of drugs overspend to plan and whether we were assured on the accuracy of the reported position. A task and finish group has been established to review the financial position and to look at the reporting to highlight areas of growth that could be influenced. Validation of the reported value had been provided through a review of the financial ledger to provide assurance on any duplicates, a review of the drugs flagged as outside of tariff and a partial stock take targeted at the high stock holding areas. In all instances no concerns were identified.

A review of the contract position demonstrated that there is an over performance to the variable contract elements and therefore part of the drugs overspend is mitigated. This level of spend was not recognised at plan stage as the plan was based on the contract offer by specialist commissioning.

Once taken into consideration, the net unrecovered drugs overspend year to date reduces from £13m to £4m. From a forecast perspective the likely net unrecovered overspend is estimated to be £8-10m. From this £3m excess growth risk was recognised at planning stage. In addition, £3m of this overspend is in relation to pass through drugs not recovered as they are part of the ICB block contract rather than variable. Work on understanding how this overspend can be further mitigated is ongoing.

Commissioner Income	Terms	Year to date contract value	Year to date actual income value	variance	Full year contract value	Full year forecast	variance
Devon ICB	Block	12,552	12,552	0	25,104	25,104	0
Spec Com	Variable	27,865	35,000	7,135	55,730	70,000	14,270
Other	Variable		1,519	1,519		3,039	3,039
Total		40,417	49,071	8,654	80,834	98,143	17,309

Expenditure	Year to date plan value	Year to date actual	variance	Full year plan	Full year forecast	variance
Devon ICB	-12,552	-13,895	-1,343	-25,104	-27,791	-2,687
Spec Com	-27,865	-35,000	-7,135	-35,729	-70,000	-34,271
Other (including non PbR)	-6,984	-11,373	-4,389	-34,136	-22,746	11,390
Total	-47,401	-60,269	-12,868	-94,969	-120,537	-25,568
Net Drugs Position	-6,984	-11,197	-4,213	-14,135	-22,394	-8,259

Reflected in FOT Assessment	-10,000
Improvement	**1,741**

Endoscopy activity Tiverton – the Trust board had previously approved a business case for mobile endoscopy activity in Tiverton as a temporary solution until the permanent build was completed. This was part of a system response to the diagnostic improvement ask to be funded through the Community Diagnostic Fund. At the point of board approval there remained some ambiguity about the funding flows and the maximum exposure was presented as £0.4m. Since this time the revenue funding streams have been changed again and recovery will now be through ERF which is funded at tariff. Since this is outsourced activity the service is now loss making under a tariff arrangement and the exposure this financial year is £0.9m. The cost pressure is approximately £150k per month and will continue into 2024/25 until the in-house development is completed.

The Trust will continue to make representation to NHS England to fund in line with the original intention of the programme to try to mitigate this impact.

The committee noted the escalations.

2023/24 Operational performance by exception

An update was provided on the latest performance position which continued to demonstrate good progress but recognised the impact that industrial action was having with over 2,599 clock stops lost during the year to date. The committee was presented with a performance scenario which stripped out this lost activitwhich demonstrated a better than plan counter factual position.

No other escalations presented as brought through other agenda items.

Month 6 Financial Position and Impact on Forecast

The committee received a report from the CFO detailing the year to date adverse variance to plan of £11.3m taking the overall year to date deficit position to £28m. A number of areas are not yet clarified from NHS England which will improve this position but as these have not yet been resolved they cannot be reflected in the year to date position. These are:

- Costs of industrial action
- Lost ERF income due to impact of industrial action
- Shortfall in pay award funding

In addition to these unknown issues, discussions continue with the ICB on additional income to cover the high cost drugs pressures and the urgent and emergency care pathway funding.

As these outstanding issues will significantly improve the level of variance, the forecast outturn position is being held as at month 5 to allow time for resolution. This aligns with the NHS England change protocol of only moving the forecast position once and when enough certainty exists. It is recognised that there are other pressures outside of these key issues which may require further mitigation and if all issues are not successfully resolved a change in forecast in future months is likely.

Further detail will be taken into the confidential board on next steps under the NHSE protocol.

The committee noted the report

Improvement Plan delivery

The Director of Improvement provided an update on the work of the operational improvement plan. It was recognised that the response on the elective recovery was going well with many successes but still lots to achieve as we remain off trajectory against plan for long waits. Action is being placed on clinical outcoming and a video message from the CMO being put together to support engagement across all clinicians.

The main focus of the update was UEC with feedback on numerous national visits which have helped provide good external feedback. The improvement director has also spent time in ED across different shift patterns to look for any causal factors on performance with an independent view. It was acknowledged that a process needs to be mapped out to support the development of the paediatric assessment area as part of the final phase of the ED build to ensure it fits the service needs. A test of change has been agreed in minors and ambulatory majors starting the second week of November. Positive feedback was reported against the safety huddles that have been introduced at intervals across the day.

The committee noted the report.

Delivering Best Value savings Plan

The month 6 report was noted as read with the key messages being month 6 delivery is reporting a £4.9m positive variance year to date (£4.5m in month 5). However, the positive movement is through identification of further non-recurrent benefits to manage the in-year adverse financial position which, although above the non-recurrent DBV plan, is masking the under delivery of the recurrent savings required.

From a forecast perspective there remains £3.3m of unidentified savings. However, RDUH's share of the Devon stretch savings as at month 6 is forecast to be £5.5m. As there is a significant risk of double count this has been netted off the internal savings plan to take a prudent position, ensuring the savings are only counted once across the system. Further due diligence will be undertaken to establish whether any savings will be additional which may improve the forecast position.

The committee noted the report.

Devon System Productivity Analysis

The deputy CEO presented the national implied productivity analysis for the Devon system which is a measure that looks at the relative weighted activity increase against the cost growth year on year (adjusted for inflation). The month 2 analysis demonstrates across the Devon system there is a significant challenge of returning to 2019/20 pre covid levels of activity with significant cost growth across the period resulting in an overall negative implied productivity position of -0.3% comparing to month 3 in 2022/23. However, for RDUH this is a positive 4.9% meaning that a greater level of additional activity is being delivered through a smaller cost base increase.

Comparison to 2019/20 shows a more negative position with a -17.5% decline in implied productivity (adjusted for service transfers) of which RDUH equates to -13.5%.

It was agreed that this gives a good measure on the relative progress across activity and cost collectively and shows that, whilst there is a lot more still to do to return to 2019/20 levels, the Trust is making good inroads into the challenge. However, it should not be forgotten that we are measured in absolute terms to the level of deficit we hold and therefore this should not remove from the financial challenge we continue to be faced with.

3.2 Other Items for Trust Board of Directors approval

BAF review
A formal review was undertaken of the 4 risks reportable to the committee being :

Risk 3 - The Trust is unable to invest in capital plans that support delivery of its operation or strategic objectives
Risk 4 - The Trust and wider Devon ICS have ambitious deficit plans with a challenging level of savings required, which are at risk of non-delivery
Risk 5 - There is a risk of the Trust being unable to meet new demand for elective services (including cancer) and / or to provide required levels of activity to either address the waiting list backlog or to deliver the commitment contained within the Trust's Financial & Operational Plan
Risk 10 - There is a risk of the Trust being unable to deliver the urgent & emergency care commitments contained within the Trust's Financial & Operational Plan due to unscheduled care demands and capacity

Some amendments were agreed to the narrative which will be visible to the wider board upon the next detailed review of BAF risks.

One change of scoring was recommended on risk 3 due to the potential to change the FOT in a future reporting period if all outstanding issues could not be resolved with a positive outcome. The likelihood of this is a 5 but the consequence was recommended to increase to a 5 due to the impact this will have reputationally and on the cash forecast regime that we will likely enter into.

A debate was had on the scoring of the capital risk and whether the increasing deficit would impact on capital programmes. Although there was a risk it was not felt the likelihood increases as NHSE rarely call on trusts to reduce capital programmes due to the clinical and operational impact.

The committee recommend to the board for approval of the change of risk score 4.

4. Resource/legal/financial/reputation implications

The Trust as well as the wider Devon ICS has set out a challenging operational and financial plan for delivery in 2023/24. The risks of this were set out at planning stage but with a commitment to the high level of ambition.

5. Link to BAF/Key risks

A detailed review was undertaken and a recommendation made to increase the risk score of risk 4. All other scores held at present.

6. Recommendations

The Finance and Operational Committee makes the following recommendations to the Trust Board of Directors:

- To approve the recommended increase in BAF risk score 4 due to the increased consequences on non-delivery of the financial plan.

All other updates are for noting

Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	12.4, Public Board Meeting		**Date: 1 November 2023**	
Title:	Governance Committee (GC) Report			
Prepared by:	Jacky Gott, Assistant Director of Governance			
Presented by:	Martin Marshall, Non-Executive Director & Chair of the GC			
Responsible Executive:	Paul Roberts, Chief Executive Officer			
Summary:	A report by exception from the Governance Committee			
Actions required:	For noting			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
				x
History:	The last Governance Committee Report was presented to the Board of Directors on 27 September 2023.			
Link to strategy/ Assurance framework:	The Governance Committee reviews and monitors the Corporate Risk Register and identifies and escalates operational risks which it considers could have strategic significance and which the Board might consider placing on the Board Assurance Framework.			

Monitoring Information

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

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

1.	**EXECUTIVE SUMMARY**
1.1	To provide, as requested by the Board of Directors (Board) a report by exception, from the Governance Committee following the meeting on 19 October 2023.
2.	**BACKGROUND**
2.1	The Governance Committee is responsible for ensuring that effective governance is embedded in the organisation and that risks associated with compliance and legislation and regulatory standards are identified and mitigated. It provides assurance to the Board that the Trust has effective systems of internal control in relation to risk management and governance.
2.2	The Governance Committee Chair, on behalf of the Governance Committee, is responsible for reporting back to the Board, in line with the Board's Schedule of Reports after each meeting of the GC, issues by exception.
2.3	A copy of the approved Governance Committee minutes is available for inspection pursuant to the Governance Committee's terms of reference.
3.	**ANALYSIS**
3.1	In line with the schedule of reports, the Governance Committee receives exception reports from the relevant sub committees each time they meet. As of the date of this report, the Governance Committee is assured from the reports that the sub-committees continue to function effectively.

3.2	The Governance Committee (GC) raises the following matters for information with the Board:
	• **Clinical 'View from the Bridge':** Carolyn Mills, Chief Nursing Officer (CNO) provided an update on the ongoing periods of industrial action (IA) and increased operational activity which continue to have a significant impact on the whole of the organisation. In particular the detrimental effect on waiting lists, financial recovery plans and significantly, staff fatigue and morale. Assurance was provided to the GC that safety remains the Trust's priority and that all reasonable steps are being taken to support staff during periods of IA and increased operational pressures.
	• **Surgical Services Divisional Governance Updates:**
	  • **Northern Services** – The GC received an update from Karen Donaldson, Divisional Director, and Mel Hucker, Assistant Director of Nursing, Surgical Services. The GC noted that governance meetings continued to take place across the Division despite the operational challenges resulting in periods of OPEL 4. The nursing workforce staffing issues on Jubilee ward and within the Critical Care team were noted, however, assurance was provided that this is monitored closely by the senior nursing team and via the Nursing and Midwifery Assurance and Productivity Group. The GC was also informed that the annual nurse staffing review was due to commence which would pick up these issues. The GC noted the good progress with addressing the backlog of complaints with no complaints now overdue, and the positive feedback from the public received via Care Opinion.
	  • **Eastern services** – Nicola Du'Gay, Divisional Director, and Lynn Goss, Lead Nurse for Safety and Quality, Surgical Services presented the report from Eastern Services, and highlighted the relaunch of governance processes in response to the Patient Safety Incident Response Framework (PSIRF) and to encourage greater engagement with clinical specialities. The GC were informed of the focus on immediate and long-term learning from Never Events, in particular human factors

training, and how the Division are aligning with the wider Trust wide programme of work for National Safety Standards for Invasive Procedures (NatSSIPs2).

The GC noted the collaborative work across the two separate Divisions and the efforts to develop joint governance processes and shared learning and practice. The GC therefore requested that the Surgical Division provides a combined annual report in October 2024.

- **Sexual Misconduct Reports –** the GC discussed in depth the following reports:
  - The Working Party on Sexual Misconduct in Surgery (WPSMS) report 'Breaking the Silence: Addressing Sexual Misconduct in Healthcare' *(An independent report on sexual misconduct by colleagues in the surgical workforce, Professor Carrie Newlands, Miss Philippa Jackson & Ms Tamzin Cumming)*
  - WPSMS Research study article 'Sexual Harassment, sexual assault and rape by colleagues in the surgical workforce'
  - Lessons Learned – review of the process of a sexual misconduct case – an external report undertaken by Dr Helen Smith.

  The GC acknowledged the importance of the findings from the studies/reports and supported the following proposals:

  - The Trust will commit to reviewing and signing up to the NHS England Sexual Safety in Healthcare Charter, with the intention of delivering the ten commandments by July 2024
  - To establish a sexual safety in the workplace task and finish group, and the GC approved the Terms of Reference
  - For the GC to provide ongoing oversight and scrutiny of the progress of the recommendations in the external review, and the commandments within the Charter.

- **Controls and Assurances in response to the Letby case** – The GC received confirmation from Melanie Holley, Director of Governance, that following the Letby case, a letter from NHS England detailing five questions for the Board of Directors has been received. This letter has been reviewed and a separate paper is due to be presented to the October Board meeting for further consideration and discussion.

- **Clinical Effectiveness Committee:** Cheryl Baldwick, Consultant Orthopaedic Surgeon, deputising for the Chair of the CEC, presented the report to the GC, providing updates on the following key areas of work by the CEC:
  - The annual report of Organ Donation activity demonstrated excellent performance, resulting in the Trust being reassessed and moving from a Level 4 to a Level 2 rating (Level 1 being the highest rating and Level 4 being the lowest), with a resultant increase in Specialist Nurse for Organ Donation (SNOD) resourcing in 2023.
  - Continued collaboration across Eastern and Northern services in relation to key clinical effectiveness components including procedural documents, and national clinical audits. Significant progress has been made in aligning and integrating the Clinical Audit function, including the implementation of a new Datix module which will allow real time reporting on audit reports and actions.

- **People, Workforce Planning & Wellbeing Committee:** David Matthewman, Director of People at Northern Services provided the GC with a report on the work of the PWPW, and highlighted:
  - In August 2023, NHS England published a strengthened Fit and Proper Person Test (FPPT) Framework for Board members. The GC received assurance that

there was a robust action plan in place to implement the changes which will be monitored through to completion by the PWPW.

- The PWPW had reviewed and updated the BAF risks relating to 'Our people do not feel looked after or valued' and 'Failure to recruit, retain and train'. The GC noted and approved the amends (as outlined in the BAF report, item 11.2 on the Board agenda).
- The GC received and approved the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports and action plans from PWPW. It was noted that due to the requirement to publish these before the 31st October, the reports had been circulated to the Board members by email seeking approval before the meeting on the 1st November.
- The Guardian of Safe Working Hours Q1 report was received and noted. The GC discussed the impact of IA on safe working hours and educational opportunities for junior doctors and whether medical staff were exception reporting this impact.
- The GC were advised that the Trust has received a formal dispute from staffside on behalf of Band 2 and 3 healthcare workers relating to the uplift in pay award and the appropriate backpay period. No national agreement has been reached and therefore this has been formally escalated to the ICB for a consistent systemwide response.

- **Safety & Risk Committee:** Carolyn Mills, Chief Nursing Officer, presented the report and the GC noted the following items for information:
  - The S&RC approved two risks onto the CRR –
    - Patient Flow/Urgent & Emergency Care capacity (score 16) which articulates the operational challenges associated with increased activity levels and urgent care capacity
    - Never Event/ National safety standards for invasive procedures (NatSIPPs) compliance (score 9) which describes the risks of patient safety events occurring if safety processes are not embedded in practice.
  - An update on the National safety standards for invasive procedures (NatSIPPs) Task and Finish Group was provided and the areas of priority noted.
  - An update on the PSIRF implementation was provided, with confirmation that the Learning from patient Safety events (LFPSE) reporting platform will go live on the 1st November, and the PSIR Plan (PSIRP) has been circulated for consultation. The GC noted the significant changes due and requested that the Non-Executive Directors are provided with a briefing on how incident information and assurances will be provided and sought in the new framework.
  - The GC received an update on the Maternity and Neonatal Services 3-year delivery action plan, noting the good progress.
  - The Committee noted the Q1 update on the Quality Priorities for 2023/2024.
- **Patient Experience Committee (PEC):** Carole Burgoyne, Non-Executive Director and Chair of the PEC provided the GC with an update from the PEC.
  - The new complaint standards were launched in April 2023 and aim to provide a quicker, simpler and streamlined complaints handling process with a focus on early resolution for complainants, and shared learning. The GC were advised that the Trust has successfully implemented the standards and revised policy. The Trust is also in the first pilot group to test the new complaint training modules.
  - The GC noted the feedback from a deep dive into complaints relating to 'communication' which remains the most common theme. The deep dive identified factors relating to provision of information to patients and some areas where negative feedback is disproportionally coded. Further review was commissioned via the Performance Assurance Framework (PAF) meetings and any actions would be taken forward by the Patient Experience Operational Group.

  The GC noted the report and approved the PEC Terms of Reference.

	• **Safeguarding Committee (SC):** Carolyn Mills, Chief Nursing Officer, presented the report and the GC discussed the following items:
	  • Safeguarding training compliance continues to improve but challenges remain for some key areas such as the Emergency Department. Assurance was provided that staff have a basic level of training, and all reasonable steps were being taken to prioritise provision of training in these areas despite the significant operational pressures.
	  • The increase in allegation against staff was notable however this is considered to be in part due to increased awareness and training on how to raise concerns. The GC were assured that there are no apparent themes or trends of concern and that the Trust HR and Safeguarding teams are involved to ensure any causal links or risks are identified.
	  • There has been a significant increase in Deprivation of Liberty Safeguards (DoLs) applications to the Local Authority over the past 12 months and this is attributable to the improved understanding across the Trust of the requirements and process.
	The GC noted the report and approved the Terms of Reference.

4	**RESOURCE / LEGAL / FINANCIAL / REPUTATIONAL IMPLICATIONS**
4.1	No resource/legal/financial or reputation implications were identified in this report.
5.	**LINK TO BAF / KEY RISKS**
5.1	The Governance Committee reviews the Corporate Risk Register twice a year and identifies and escalates risks as appropriate to the Board of Directors that the Joint Governance Committee considers may be strategic and therefore the Board of Directors might consider escalating to the Board Assurance Framework.
6.	**PROPOSALS**
6.1	It is proposed that the Board of Directors notes the report from the Governance Committee.

Appendix One: Maternity and Neonatal Services 3 Year Delivery Action Plan Update

The purpose of this paper is to define key trust actions and to introduce the Royal Devon University Healthcare (RDUH) Maternity and Neonatal Action plan developed to support the delivery of the Trust objectives set out in the NHS England Three Year Delivery Plan.

SUMMARY OF KEY ACTIONS:

1) Listening to women and families with compassion which promotes safer care

All women will be offered personalised care and support plans. By 2024, every area in England will have specialist care including pelvic health services and bereavement care when needed; and, by 2025, improved neonatal cot capacity.

During 2023/24, Integrated care systems (ICSs) will publish equity and equality plans and take action to reduce inequalities in experience and outcomes.

From 2023/24, Integrated care boards (ICBs) will be funded to involve service users. National policy will be co-produced, keeping service users at the heart of our work.

KEY TRUST ACTIONS

Care and support plan is in place for every pregnant person which takes account of their physical health, mental health, social complexities, and choices. The plan includes a risk assessment updated at every contact, including when the woman is in early or established labour.

Improve personalised care in most vulnerable groups evidenced by outcome metrics and service user feedback satisfaction.

Evidenced progress toward the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding as set out in IF strategy.

Involve service users in quality, governance and co-production when designing and planning delivery of maternity and neonatal services.

2) Supporting our workforce to develop skills and capacity to provide high-quality care

Trusts will meet establishment set by midwifery staffing tools and achieve fill rates by 2027/28, with new tools to guide safe staffing for other professions from 2023/24.

During 2023/24, trusts will implement local evidence-based retention action plans to positively impact job satisfaction and retention.

From 2023, NHS England, ICBs, and trusts will ensure all staff have the training, supervision, and support they need to perform to the best of their ability.

KEY TRUST ACTIONS

Undertake regular local workforce planning, using nationally standardised tools where available, to establish the workforce required for each profession at every stage of care.

Develop and implement a local plan to fill vacancies, which should include support for newly qualified staff and midwives who wish to return to practice.

Provide administrative support to free up pressured clinical time.

Identify and address local retention issues affecting the maternity and neonatal workforce in a retention improvement action plan.

Implement equity and equality plan actions to reduce workforce inequalities.

Create an anti-racist workplace, acting on the principles set out in the combatting racial discrimination against minority ethnic nurses, midwives and nursing associates' resource.

Identify and address issues highlighted in student and trainee feedback surveys, such as the National Education and Training Survey.

Newly appointed Band 7 and 8 midwives should be supported by a mentor.

Develop future leaders via succession planning, ensuring this pipeline reflects the ethnic background of the wider workforce.

Ensure junior and SAS obstetricians and neonatal medical staff have appropriate clinical support and supervision in line with RCOG guidance and BAPM guidance, respectively.

Ensure temporary medical staff covering middle grade rotas in obstetric units for two weeks or less possess an RCOG certificate of eligibility for short-term locums.

3) Developing and sustaining a culture of safety to benefit everyone

Throughout 2023, effectively implement the NHS-wide "PSIRF" approach to support learning and a compassionate response to families following any incidents.

By 2024, NHS England will offer a development programme to all maternity and neonatal leadership teams to promote positive culture and leadership.

NHS England, ICBs, and trusts will strengthen their support and oversight of services to ensure concerns are identified early and addressed.

KEY TRUST ACTIONS

Make sure maternity and neonatal leads have the time, access to training and development, and lines of accountability to deliver the ambition above. Including time to engage stakeholders, including Maternity and Neonatal Voice Partnership (MNVP) leads.

At Board level, regularly review progress and support implementation of a focused plan to improve and sustain maternity and neonatal culture.

Understand 'what good looks like' to meet the needs of their local populations and learn from when things go well and when they do not.

Involve the MNVP in developing the trust's complaints process, and in the quality safety and surveillance group that monitors and acts on trends.

At Board level listen to and act on Freedom to Speak Up data, concerns raised and suggested innovations in line with the FTSU Guide and improvement tool.

4) Meeting and improving standards and structures that underpin national ambition.
Trusts will implement best practice consistently, including the updated Saving Babies Lives Care Bundle by 2024 and new "MEWS" and "NEWTT-2" tools by 2025.

In 2023, NHS England's new taskforce will report on how to better detect and act sooner on safety issues, arising from relevant data, in local services.

By 2024, NHS England will publish digital maternity standards; services will progress work to enable women to access their records and interact with their digital plans.

KEY TRUST ACTIONS
Implement version 3 of the Saving Babies' Lives Care Bundle and adopt the national MEWS and NEWTT-2 tools by March 2025.

Ensure high-quality submissions to the Maternity Services Data Set and report information on incidents to NHS Resolution, the Healthcare Safety Investigation Branch and National Perinatal Epidemiology Unit.

Have and be implementing a digital maternity strategy and digital roadmap in line with the NHS England What Good Looks Like Framework.

Aim to ensure that any neonatal module specifications include standardised collection and extraction of neonatal national audit programme data and the neonatal critical care minimum data set.

Royal Devon University Healthcare NHS Foundation Trust

People, Workforce Planning & Wellbeing Committee (PWPW)

Date:	Thursday 21 September 2023
Agenda item:	Item 18
Title:	Employment check standards updated in line with new FPPT framework
Prepared by:	Hannah Radford, Head of Strategic Resourcing
Presented by:	Hannah Radford, Head of Strategic Resourcing

1. CONCERNS / RISKS / GAPS IN ASSURANCE FOR ESCALATION TO PWPW

1.1. Context

On 2 August 2023, NHS England published the Fit and Proper Person Test (FPPT) Framework for Board Members in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review). This also takes into account the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles.

The framework will introduce a means of:

- retaining information relating to testing the requirements of the FPPT for individual directors,
- a set of standard competencies for all board directors
- a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC.

The purpose is to strengthen/reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS.

The Framework is effective from 30 September 2023 and should be implemented by all boards going forward from that date.

NHS organisations are not expected to collect historic information to populate ESR or local records, but to use the Framework for all new board level appointments or promotions and for annual assessments going forward.

Full details of the framework can be found here NHS England Fit and Proper Person Test Framework for board members

1.2. Scope of the FPPT Framework

The FPPT applies to all board members of NHS Organisations

- both executive directors and non-executive directors (NEDs), irrespective of voting rights;
- interim (all contractual forms) as well as permanent appointments;
- those individuals who are called 'directors' within Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

1.3. Key Principles

The FPPT Framework has been designed to deliver on the following:

- Patient safety and good leadership in organisations, and this should be recognised by all board members; and poorly performing managers and directors are prevented from moving between health organisations.
- Improving care for patients (recognising that the boards of NHS organisations include highly committed and hard-working people)
- Fairness and proportionality (not be a bureaucratic burden on organisations or individuals).
- Ensuring that board members are demonstrating the right behaviours will help the NHS drive its cultural initiatives: namely, to foster a culture of compassion, respect and inclusion, and a feeling of belonging; as well as setting the tone at the top to encourage a listening and speaking up culture.
- Ultimate accountability for adhering to this framework will reside with the chair of an NHS organisation.
- A commitment from NHSE to review of the FPPT Framework within 18 months.

1.4. Data

The launch of the FPPT Framework will involve NHS England and participating data controllers (NHS trusts, foundation trusts and integrated care boards) communicating to all board members in their organisation whose details will be included in ESR, in advance of the FPPT Framework (and standard reference tools) going live on 30 September 2023.

Information collected will be retained in ESR. More detail of this can be found in the Privacy Statement in Appendix One of this document.

By doing so directors will be afforded the opportunity to object if they have concerns regarding the proposed use of their data, and NHS England and participating data controllers will be able to consider these concerns and amend their approach if necessary.

1.5. Roles and responsibilities

The FPPT Framework describes the following roles and responsibilities:

Chairs or NHS organisations	Overall accountability for arrangements in their organisation • Ensure assessments carried out for board members on appointment and annually, and at any time that something new comes to light. • Ensure that the Board Member Reference (BMR) is completed for any board member who leaves the board for whatever reason, whether or not a reference has been requested. • Conclude on assessments for the whole board (executive and non-executive, permanent or temporary, voting or non-voting) and update ESR. • Submit annual summary to relevant regional director
Senior Independent Director	Carry out FPPT assessment of the Chair
Chief People Officer/Company Secretary	Support Chair in establishing arrangements for the FPPT and specifically for: • Accessing and entering information into ESR • Testing elements of FPPT assessment and recording outcome and evidence for Chair to review and conclude • Completing the annual submission form
Chief Executive	• Carry out initial assessment of the FPPT for executive board members and share with the Chair for overall assessment of board member FPP status • Support the Chair
Governors	Take the annual Trust submission and other information relating to FPPT into account as part of their role in appointment and removal of Chairs and Non-Executive Directors and their role in receiving information about the performance appraisal process.
NHS Regional Directors	Oversight role covering elements of: • Appointment and initial FPPT assessment • Receipt of the annual FPPT submission forms • Where required, in relation to disputes and appeals (although local resolution expected)
NHSE Central Team	A central team is being established to support the process going forward • England.karkimplementationteam@nhs.net

1.6. Strengthened FPPT Assessment

The FPPT Framework strengthens the checks required. A summary of these, with comments on actions, can be found below:

Workstream	Comments on Framework	Actions for Royal Devon
Training and Development – checked and recorded at recruitment and updated annually	• Organisations should assure themselves that the information provided by the applicant is correct and reasonable for the requirements of the role	• Test application against Person Specification and undertake verification checks to confirm.
	• Key qualifications required for the role should be in the person specification (e.g. professional qualifications)	• Person Specification to be agreed at the start of the recruitment campaign, clearly setting out requirements
	• It is suggested that a training history of no less than 6 years should be the minimum plus any role specific qualifications/training if that was more than 6 years ago.	• Test application against Person Specification and undertake verification checks to confirm. • Further detail to be extracted from candidate during shortlisting to ensure full period covered, plus additional relevant/specific qualifications/training if more than 6 years ago.

Last Appraisal and date	• There will be further guidance from NHSE before 31 March 2024 relating to board appraisals	
	• Appraisals should consider both performance objectives and development towards the standard competencies within the LCF. Guidance on minimum standards will be provided and organisations should conclude on whether the appraisal outcome is satisfactory	• Review appraisal template to incorporate all appropriate elements for FPPT.
Disciplinary findings relevant to the FPPT assessment, including those arising from: • Grievance(s) and complaint(s) • Speak up(s)	• The NHS Standard Reference requests information about upheld and ongoing investigations. The new BMR requests information about investigations (relevant to FPPT) that have been concluded and the matter upheld; ongoing at the time of the reference; or discontinued and the reason for this	• Consider appropriateness of clauses that relate to confidentiality in settlement agreements going forward.
Behaviour not in accordance with Trust values and behaviours or local policy	• Board behaviours are considered in 'Our Leadership way' which is referred to in the 'People Promise'. This in turn, is linked to the competencies within the LCF and should be considered as part of an FPPT assessment.	• Assessed annually and on as 'as when' basis.
Employment Tribunal judgement check	• An additional check of ET judgements where a specific board member (rather than the organisation as a whole) was implicated and which related to FPPT.	• Add check to recruitment FPPT checklist. • A register is available at: https://www.gov.uk/employment-tribunal-decisions
Board Member Reference (BMR)	• The new BMR template should be used from 1 October 2023 to request references and also for any board member leaving the organisation for whatever reason – whether or not a references has been requested.	• Add BMR to recruitment FPPT checklist. • Ensure recruitment agencies are aware of requirement for new template. • Add BMR to leaver checklist. • CCJ to be added to the checklist: https://www.trustonline.org.uk/
	• This should be retained for the career of the board member or up until their 75th birthday.	• Ensure appropriate storage and records destroyed at appropriate time period.
Settlement Agreements	• The Chair's guidance document describes this in more detail. It is acknowledged that details may not be known described where there are confidentiality agreements in place.	• Consider appropriateness of clauses that relate to confidentiality in settlement agreements going forward.
Letter of confirmation	• This should be used in relation to joint appointments, the host employing organisation should carry out the FPPT assessments having sought information/commentary from the 'other organisation'.	• To be reviewed and considered when/if applicable.
Annual submission form	• Annual summary of outcome of FPPT assessments for all board members to be sent to the Regional Director.	• Review of the template and ensure gap analysis completed.
Sign off by Chair	• The Chair has the ultimate accountability for ensuring that effective arrangements are in place in their organisation to meet the FPPT Framework standards.	• Ensure this is captured in the responsibilities of the Role Description. • Ensure the Chair is appropriately briefed and aware of the FPPT and associated responsibilities.

1.7. Timeline

The FPPT Framework becomes effective from September 2023. Work prior to the effective date is the sharing of the updated privacy statement (Appendix One) with existing board members.

From **30 September 2023**

- Use the new Board Member Reference template for references of all new board appointments.
- Complete and retain locally the new BMR for any board member who leaves the board for whatever reason and whether or not a reference has been requested.
- Use the Leadership Competency Framework as part of the assessment process when recruitment to all board roles
- Update the recruitment checklist to include the strengthened FPPT assessment, including Employment Tribunal outcomes, CCJ, BMR etc, as listed in section 1.6 of this paper.

By **31 March 2024**, fully implement the FPPT Framework incorporating the Leadership Competency Framework, including:

- First full FPPT annual review of all board members
- Individual self-attestations completed for all board members
- Annual submission form completed to go to the relevant regional director
- ESR database updated

By the end of Q1 2024/25, incorporate the forthcoming Leadership Competency Framework into annual appraisals of board directors for 2023/24, using the board appraisal framework. In future years, the appraisal/Leadership Competency Framework and FPPT assessment should all align.

The Royal Devon's internal process document has been reviewed in light of the recommendations and has been amended to support compliance. This can be found in Appendix Two.

The updated Self-Attestation is Form can be found in Appendix Three.

A list of actions which are required to be undertaken to support compliance with the framework can be found in Appendix Four.

2. RECOMMENDATIONS TO THE PWPW COMMITTEE

This document, along with appendices, are intended to provide assurance to the PWPW committee that the changes have been noted and a comprehensive action plan is in place. It is recommended that the PWPW monitors the action plan through to completion.

Royal Devon University Healthcare NHS Foundation Trust

Board Member Privacy Notice

Royal Devon University Healthcare NHS Foundation Trust is required to provide you with details on the type of personal information which we collect and process. In addition to any other privacy notice which we may have provided to you, this notice relates to the information collected and processed in relation to the Fit and Proper Persons Test (FPPT).

The FPPT in the Electronic Staff Record (ESR) is commissioned by NHS England.

Contact:	**Professor Adrian Harris**, Chief Medical Officer & Senior Information Risk Owner (SIRO)
Address:	Royal Devon and Exeter Hospital (Wonford), Barrack Road, Exeter. EX2 5DW
Phone Number	01392 411611
E-mail:	rduh.cmooffice@nhs.net

The type of personal information we collect is in relation to the FPPT for board members and is described below, much of which is already collected and processed for other purposes than the FPPT:

1. Name, position title (unless this changes).
2. Employment history – This would include detail of all job titles, organisation, departments, dates, and role descriptions.
3. References.
4. Job description and person specification in their previous role.
5. Date of medical clearance.
6. Qualifications.
7. Record of training and development in application/CV.
8. Training and development in the last year.

9. Appraisal incorporating the leadership competency framework has been completed.

10. Record of any upheld, ongoing or discontinued disciplinary, complaint, grievance, adverse employee behaviour or whistle-blow findings.

11. DBS status.

12. Registration/revalidation status where required.

13. Insolvency check.

14. A search of the Companies House register to ensure that no board member is disqualified as a director.

15. A search of the Charity Commission's register of removed trustees.

16. A check with the CQC, NHS England and relevant professional bodies where appropriate.

17. Social media check.

18. Employment tribunal judgement check.

19. Exit reference completed (where applicable).

20. Annual self-attestation signed, including confirmation (as appropriate) that there have been no changes.

Processing of this data is necessary on the lawful basis set out in Article 6(1)(e) UK GDPR as the foundation for the database. This is because it relates to the processing of personal data which is necessary for the performance of the fit and proper person test which is carried out in the public interest and/or in the exercise of official authority vested in the controller.

For CQC-registered providers, ensuring directors are fit and proper is a legal requirement for the purposes of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and organisations are required to make information available connected with compliance to the CQC.

APPENDIX ONE

How we get the personal information and why we have it

Most of the personal information we process is provided to us directly by you as part of your application form and recruitment to satisfy recruitment checks and the FPPT requirements.

We may also receive personal information indirectly, from the following sources in the following scenarios:

- References when we have made a conditional offer to you.
- Publicly accessible registers and websites for our FPPT.
- Professional bodies for FPPT to test registration and or any other 'fitness' matters shared between organisations.
- Regulatory bodies, eg CQC and NHS England.

We use the information that you have given us to:

- conclude whether or not you are fit and proper to carry out the role of board director
- inform the regulators of our assessment outcome.

We may share this information with NHS England, CQC, future employers (particularly where they themselves are subject to the FPP requirements), and professional bodies.

Under the UK General Data Protection Regulation (UK GDPR), the lawful bases we rely on for processing this information are:

- We need it to perform a public task.

How we store your personal information

Your information is securely stored. We keep the ESR FPPT information including the board member reference, for a career long period. We will then dispose of your information in accordance with our Records Management Policy.

Your data protection rights

Under data protection law, you have rights including:

- Your right of access – You have the right to ask us for copies of your personal information.

- Your right to rectification – You have the right to ask us to rectify personal information you think is inaccurate. You also have the right to ask us to complete information you think is incomplete.
- Your right to erasure – You have the right to ask us to erase your personal information in certain circumstances.
- Your right to restriction of processing – You have the right to ask us to restrict the processing of your personal information in certain circumstances.
- Your right to object to processing – You have the right to object to the processing of your personal information in certain circumstances.
- Your right to data portability – You have the right to ask that we transfer the personal information you gave us to another organisation, or to you, in certain circumstances.
- You are not required to pay any charge for exercising your rights. If you make a request, we have one month to respond to you.

Please contact us at rduh.assesstorecords-eastern@nhs.net if you wish to make a request.

How to complain

If you have any concerns about our use of your personal information, you can make a complaint to us at rduh.dpo@nhs.net. You can also complain to the ICO if you are unhappy with how we have used your data.

The ICO's address

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF
Helpline number: 0303 123 1113 ICO website: https://www.ico.org.uk

Fit and Proper Persons Procedure

Directors - Executive Director and Non-Executive Director level positions

This document outlines the processes the appropriate teams should follow for Board positions, as defined above.
This document has been updated to reflect the updates in the Fit and Proper Persons Test (FPPT) Framework, published by NHS England on 2 August 2023 - NHS England Fit and Proper Person Test Framework for board members.
This document will make reference to the FPPT Framework.
The sections of the checklist are detailed below and should be used for collation of evidence as detailed below:
Part A – At recruitment stage (internal or external) (by the recruitment team)
Part B – Annually at appraisal (by the manager/Director of Governance on behalf of the Chair)
Part C – Upon re-appointment – Non-Executive Directors

In the event of a self-disclosure issue and/or issue arising from any check, the Chair*, supported by the Director of Governance and/or board member will:

1) Meet with the individual to gather circumstances and full details;

2) Evaluate collected information and decide whether the individual is to be appointed/remain in post;

3) If serious enough refer to appropriate body and terminate contract (following any applicable procedures and/or contractual terms such as the Disciplinary Procedure for Executive Directors or Service Agreement for Non-Executive Directors).

* In the circumstance where the self-disclosure issue and/or issue arising from any check relates to the Chair, the Senior Independent Director will undertake this role instead of the Chair.

APPENDIX TWO

Part A – At recruitment stage ('internal' or 'external' appointment)

(to be completed by the recruitment team and passed to the Director of Governance, with details of the checks, once completed. Some/all of these checks may be provided by a 3rd party verification organisation such as Capita or Verifile, on our behalf. Where applicable, checks are in line with NHS Employers employment standards and regulation - https://www.nhsemployers.org/topics-0/employment-standards-and-regulation).

Name of person for which checks are required:	
Job title of person for which checks are required:	
Date checks initiated:	

No.	Check	Actions to take	Evidence recorded	Tick if complete
1	DBS – standard (or enhanced with adults/children's safeguarding barred list, if applicable by role)	DBS forms to be completed by candidate and relevant ID documents supplied for recruitment to initiate the DBS checks. DBS checks must be completed on a 3 year cycle.	If cleared, record outcome, certificate number and date of issue in ESR/Career Gateway. If issues have been reported, share with Director of Governance and recruiting manager for review and agreement on next steps.	☐
2	Occupational health clearance	Send candidate link to the occupational health portal with details on how to complete in full.	When cleared, put occupational health fitness form on personal file /Career Gateway and update details in ESR. If issues have been reported, share with recruiting manager for review and agreement on next steps.	☐
3	References	In line with NHS employment checks standard. Previous 6 consecutive years history. At least 2 references from different employers, where possible to be obtained – see clarification on references to be collected here: NHS England Fit and Proper Person Test Framework for board members. (Page 37) At least one Board Member Reference (BMR) to be collected using the BMR template, or, where joining the NHS for the first time, as near to the BMR requirements as possible.	When obtained, recruitment manager to agree that they are satisfactory and file in personal file and update details in Career Gateway/ESR. If issues have been reported, share with Director of Governance and recruiting manager for review and agreement on next steps.	☐
4	Professional qualifications and current registration	It is suggested that a training history of no less than 6 years should be the minimum, plus any role specific qualifications/training if that was more than 6 years ago. Request original documents. Or, where available, check online database.	Take copies of original certificates provided and file in personal file. Update details on Career Gateway/ESR. Take a screen shot of the online registration details and file in personal file. Update details on Career Gateway/ESR.	☐
5	Educational qualifications	As above (point 4 and undertaken as part of point 7 below)	As above (point 4)	☐
6	Identity and right to work checks	In line with NHS employment checks standard and Home Office right to work checklist.	Take copies of original documents provided and file in personal file. Update details on Career Gateway/ESR.	☐
7	Additional checks	Verifile form to be completed and sent to Verifile for clearance. Verifile checks, in addition to the above: • UK Credit Check – Equifax • Media Search • Social Media Search • Internet Search • UK Company Credit Check – limited or non-limited – if applicable	When cleared, record on ESR and put top copy of the report in personal file. If issues have been reported, share with Director of Governance and recruiting manager for review and agreement on next steps.	☐

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APPENDIX TWO

		• Academic Qualification/s • Global Fraud and Sanctions Search • UK Investigative Directorship Search		
8	Charity Trustees check	Check name against the following online database. http://apps.charitycommission.gov.uk/trustee register/	If no entry recorded, record outcome with screenshot on file. If issues have been reported, share with Director of Governance and recruiting manager for review and agreement on next steps.	☐
9.	Employment Tribunal Decisions/Judgements	Check of ET judgements where a specific board member (rather than the organisation as a whole) was implicated and which related to FPPT. Check details online: https://www.gov.uk/employment-tribunal-decisions	If no entry recorded, record outcome with screenshot on file. If issues have been reported, share with Director of Governance and recruiting manager for review and agreement on next steps.	☐
10	County Court Judgements (CCJ)	A search of the insolvency and bankruptcy register and checks over county court judgement (CCJ) or high court judgement for debt.	If no entry recorded, record outcome with screenshot on file. If issues have been reported, share with Director of Governance and recruiting manager for review and agreement on next steps.	☐

When all checks are complete, share file with Director of Governance for record keeping and with the recruiting manager for information. Ensure ESR is fully completed/updated.

APPENDIX TWO

Part B – Annually at appraisal

(to be initiated by the manager/Director of Governance with the support from the recruitment team on completing the checks. Some/all of these checks may be provided by a 3rd party verification organisation such as Capita or Verifile, on our behalf)

Name of person for which checks are required:	
Job title of person for which checks are required:	
Date checks initiated:	

No.	Check	Actions to take	Evidence recorded	Tick if complete
1	Assessment of continued fitness	Manager/Director of Governance to issue self-attestation form to be completed and signed by individual.	File completed self-attestation form in personal file.	☐
2	Additional checks	Manager/Director of Governance to initiate the process by advising recruitment of the timeline checks need to be initiated. Recruitment will oversee the checks with Verifile. Verifile form to be completed and sent to Verifile for clearance. Verifile checks: • UK Credit Check – Equifax • Media Search • Social media search • Internet search • UK Company Credit Check – limited or non-limited – if applicable • Global Fraud and Sanctions Search • UK Investigative Directorship Search	When cleared, record on ESR and put top copy of the report in personal file. If issues have been reported, share with Director of Governance and recruiting manager for review and agreement on next steps.	☐
3	Charity Trustees check	Manager/Director of Governance to initiate the process by advising recruitment of the timeline checks need to be initiated. Recruitment will undertake the check. Check name against the following online database. http://apps.charitycommission.gov.uk/trusteeregister/	If no entry recorded, record outcome with screenshot on file. If issues have been reported, share with Director of Governance and recruiting manager for review and agreement on next steps.	☐
4	Occupational health self-declaration	Manager sends a self-declaration to be completed. If required, then the link in with occupational health as appropriate.	Put occupational health fitness form on personnel file. If issues have been reported, follow instructions on self-declaration.	☐
5	DBS – standard (or enhanced with adults/children's safeguarding barred list, if applicable by role)	DBS forms to be completed by candidate and relevant ID documents supplied for recruitment to initiate the DBS checks. DBS checks must be completed on a **3 year cycle.**	If cleared, record outcome, certificate number and date of issue in ESR/Career Gateway. If issues have been reported, share with Director of Governance and recruiting manager for review and agreement on next steps.	☐
9.	Employment Tribunal Decisions/Judgements	Check of ET judgements where a specific board member (rather than the organisation as a whole) was implicated and which related to FPPT. Check details online: https://www.gov.uk/employment-tribunal-decisions	If no entry recorded, record outcome with screenshot on file. If issues have been reported, share with Director of Governance and recruiting manager for review and agreement on next steps.	☐

10	County Court Judgements (CCJ)	A search of the insolvency and bankruptcy register and checks over county court judgement (CCJ) or high court judgement for debt.	If no entry recorded, record outcome with screenshot on file. If issues have been reported, share with Director of Governance and recruiting manager for review and agreement on next steps.	☐

When all checks are complete, share file with Director of Governance for record keeping and with the recruiting manager for information. Ensure ESR is fully completed/updated.

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Part C – Upon re-appointment (Non-Executive Director)

(to be completed by the recruitment team. Some/all of these checks may be provided by a 3rd party verification organisation such as Capita or Verifile, on our behalf)

Name of person for which checks are required:	
Job title of person for which checks are required:	
Date checks initiated:	

No.	Check	Actions to take	Evidence recorded	Tick if complete
1	Assessment of continued fitness	Manager/Director of Governance to issue self-attestation form to be completed and signed by individual .	File completed self-declaration form in personal file.	☐
2	Occupational health self-declaration	Send candidate a self-declaration to complete. If required, then the link in with occupational health as appropriate.	When cleared, put occupational health fitness form on personnel file. If issues have been reported, share with recruiting manager for review and agreement on next steps.	☐
3	Additional checks	Verifile form to be completed and sent to Verifile for clearance. Verifile checks, in addition to the above: • UK Credit Check – Equifax • Media Search • Social media search • Internet search • UK Company Credit Check – limited or non-limited – if applicable • Global Fraud and Sanctions Search • UK Investigative Directorship Search	When cleared, record on ESR and put top copy of the report in personal file. If issues have been reported, share with Director of Governance and recruiting manager for review and agreement on next steps.	☐
4	Charity Trustees check	Check name against the following online database. http://apps.charitycommission.gov.uk/trusteeregister/	If no entry recorded, record outcome with screenshot on file. If issues have been reported, share with Director of Governance and recruiting manager for review and agreement on next steps.	☐
5	DBS – standard (or enhanced with adults/children's safeguarding barred list, if applicable by role)	DBS forms to be completed by candidate and relevant ID documents supplied for recruitment to initiate the DBS checks. DBS checks must be completed on a **3 year cycle.**	If cleared, record outcome, certificate number and date of issue in ESR/Career Gateway. If issues have been reported, share with Director of Governance and recruiting manager for review and agreement on next steps.	☐
6.	Employment Tribunal Decisions/Judgements	Check of ET judgements where a specific board member (rather than the organisation as a whole) was implicated and which related to FPPT. Check details online: https://www.gov.uk/employment-tribunal-decisions	If no entry recorded, record outcome with screenshot on file. If issues have been reported, share with Director of Governance and recruiting manager for review and agreement on next steps.	☐
7.	County Court Judgements (CCJ)	A search of the insolvency and bankruptcy register and checks over county court judgement (CCJ) or high court judgement for debt.	If no entry recorded, record outcome with screenshot on file. If issues have been reported, share with Director of Governance and recruiting manager for review and agreement on next steps.	☐

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Royal Devon University Healthcare NHS Foundation Trust

New starter/annual NHS FPPT self-attestation

1. Executive and Non-executive Director roles in the NHS are positions of significant public responsibility and it is important that those appointed can maintain the confidence of the public, patients and NHS staff. Royal Devon University Healthcare NHS Foundation Trust has a duty to ensure that those appointed to serve on the Trust Board are of good character and comply with the "Fit and Proper Person" requirements as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and the Fit and Proper Persons Test (FPPT) Framework document, available here: NHS England Fit and Proper Person Test Framework for board members

2. By signing the declaration, you are confirming that you are a "fit and proper person" as defined by the list provided on the following page, and that you are not aware of any pending proceedings or matters which may call such a declaration into question in the future.

3. The information that you provide in this declaration form will be processed in accordance with the privacy statement available here <add link or attach a copy if not yet available on website>

APPENDIX THREE

Fit and Proper Person Test annual/new starter* self-attestation

ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST

I declare that I am a fit and proper person to carry out my role. I:

- am of good character
- have the qualifications, competence, skills and experience which are necessary for me to carry out my duties
- where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals
- am capable by reason of health of properly performing tasks which are intrinsic to the position
- am not prohibited from holding office (eg directors disqualification order)
- within the last five years:
  - I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more
  - been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged
  - nor is on any 'barred' list.
- have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, any if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Signature:	
Date of last appraisal, by whom:	
Signature of board member:	
Date of signature of board member:	
For chair to complete	
Signature of chair to confirm receipt:	
Date of signature of chair:	

*Delete as appropriate

APPENDIX THREE

FPPT Framework Review Action List

Ref	Action title	Summary	Responsible	Status	Notes
DATA PROCESSING					
1.1	Complete privacy statements	Ensure appropriate policy document is in place in relation to special category data - Page 7, #6	Hannah / Rhiannon / Ade	Complete	HMR to review and draft
1.2	Advise SIRO of process	Adrian informed	Rhiannon / Ade	Complete	
1.3	Define scope of framework	See 1.3, page 4 - green highlight #1 Includes those at board level with professional registration (i.e. GMC and NMC) - Page 5, #2 **There are 2 groups that may fall in to FTTP, (1) Board members as defined above, and (2) 'other key roles...who may regularly attend board meetings or otherwise have significant influence on board decisions'** - Page 5, #3 The annual submission requirement does not apply to group (2) - Page 5, #4 '**FPPT ... applies to directors and those performing the functions of, or functions equivalent or similar to the functions of, a director...**" - Page 7, #7 "Where an individual is appointed as a temporary/interim cover and is not already assessed as fit and proper, the NHS organisation should ensure appropriate supervision by an existing board member" - Page 21, #15	Mel Holley		HMR - Note that the temporary arrangements of up to 6 weeks do not require full FPPT checks and so may influence the thinking about including site directors in the scope if BCP was a consideration for widening scope.
1.4	Send Privacy Statement to those in scope	To be sent to all board members by 30 September 2023 so they have an opportunity to object - Page 7, #5	Mel Holley	In progress	HMR to review and draft. Mel to issue.
1.5	Retention of data	IG to review 1.4 (Personal Data) so that they are aware of the changes and to flag any concerns to Hannah Radford.	Rhiannon / Ade	Complete	HMR met with Rhiannon and Ade and shared FPPT Framwork with the team.
1.6	Ongoing review of the data held in ESR	Should be able to "consistently demonstrate on an annualised basis that a formal assessment of fitness and properness for each board member has been undertaken. NHS organisations should consider carrying out the assessment alongside an annual appraisal" - Page 14, #9	Mel Holley		

Ref	Action title	Summary	Responsible	Status	Notes
RECRUITMENT OF NEW STARTERS					
2.1	Regulation 5	starts P8. No changes to regulation 5, but strengthened FPPT assessment in place. Review and update FPPT recruitment checklist to include BMR, CCJ and ET judgements etc.	Hannah Radford	Complete	HMR - a register of ET judgements - https://www.gov.uk/employment-tribunal-decisions
2.2	Reference process (BMR)	See page 16 - adapt for local version (for new appointments that have been promoted, temporary appointments (including secondments) involving acting up, existing NHS board members moving to a different organisation as a board member - but NOT for individuals who join the NHS from an organisation outside of the NHS - Page 18, #12) "A**t least one board member reference should be obtained when an NHS organisation is appointing a board member**" - Page 38	Hannah Radford	In progress	Updating the BMR template
2.3	Approval from NHSE Appointments Team	"FPPT approval should be sought from the NHS England Appointments Team before they commence their role." - Page 19, #14 -- Create a SOP for the process to ensure the correct process is followed each time	Mel Holley		
2.4	Occupational Health	**NHS organisations should undertake occupational health assessments (OHA) for potential new board member appointments, in circumstances where the individual in question has indicated a physical or mental health condition as part of pre-employment checks (eg medical assessment questionnaire)** - Page 31	Hannah Radford	Complete	HMR - part of existing FPPT process
2.5	Financial soundness	Robust processes should be in place to assess board members in relation to bankruptcy, sequestration, insolvency and arrangements with creditors. This, as a minimum, will include search of the insolvency and bankruptcy register and checks over county court judgement (CCJ) or high court judgement for debt - Page 31	Hannah Radford	Complete	HMR - see action 2.1 CCJ review - https://www.trustonline.org.uk/
2.6	Person Specification	Ensure that for future recruitment rounds, that the description of the role and the person specification adequately sets out the requirements for the role, and that "key qualifications required for the role are in the person specification". (Mel Holley) Also ensure that "training history of no less than 6 years" plus any specific qualifications are captured during shortlisting process, and verified at onboarding. Ensure onboarding checklist reflects this (HMR)	Mel Holley Hannah Radford	Ongoing requirement	HMR - noted for future recruitment.

Ref	Action title	Summary	Responsible	Status	Notes
INDUCTION					
3.1	Gap analysis on current process to ensure LCF incorporated	Chairs should ensure that their NHS organisation can show evidence that appropriate systems and processes are in place to ensure that all new and existing board members are, and continue to be, fit and proper ...Such systems and processes include (but are not limited to) recruitment, induction, training, development, performance appraisal, governance committees, disciplinary and dismissal processes.	Mel Holley		

Ref	Action title	Summary	Responsible	Status	Notes
TRAINING AND DEVELOPMENT					

4.1	Gap analysis on current process	NHS organisations should ensure any necessary training is undertaken by board members where gaps in competency have been identified. – As such, a tailored learning development plan and training framework should support board members. - Page 30 - Training constitutes continued development for board members - Page 30	Mel Holley		
4.2	Frequency of review	– Both the development plan and training should be updated and delivered respectively with an appropriate frequency. - Page 30	Mel Holley		
4.3	Development plans	"The annual attestation by board members is expected to be undertaken at the same time as the annual appraisal process and assessment of competence against the s**ix competency domains will also be used to guide the board member's development plan for the coming year**" - P35	Mel Holley		
4.4	Failure to complete	Those consistently failing to undergo required training in a timely manner should be deemed to have missed an important obligation, and appropriate action should be taken in line with the NHS organisation's policies and procedures. In turn, this may mean that a board member is not fit and proper. - Page 30 Does this need incorporating in policy/process/person specification?	Mel Holley	In progress	HMR - I have done a search on the current PS document for "train, training and development" and it does not return any relevant results. Perhaps consider inclusion in future document versions in terms of expectation against FPPT.

Ref	Action title	Summary	Responsible	Status	Notes
ANNUAL APPRAISAL/PROCESS					
5.1	Annual self-attestation	"Every board member will need to make an **annual self-attestation**" - Page 18, #13 "Board level leaders will be asked to attest to whether they have the requisite experience and skills to fulfil minimum standards against the six competency domains." - P35 "The attestation record will be captured on ESR" - P35 "The annual attestation by board members is expected to be undertaken at the same time as the annual appraisal process and assessment of competence against the six competency domains will also be used to guide the board member's development plan for the coming year" - P35 - make recommendations for changes	Hannah Radford (to prepare draft)/ Mel Holley (to review)	Complete	HMR - Saved new version in local folder.
5.2	Process flow of steps	See page 15 of FPPT Framework document - adapt for local version	Mel Holley		
5.3	Occupational Health	While the OHA will not form part of the annual FPPT, it is an integral component of the recruitment process - Page 31 Should we continue to use the annual health declaration as part of current process?	Mel Holley		HMR - note that OH concerns should be raised as and when rather than annual intervals. Mel H to consider and confirm.
5.4	BMR note	"The annual appraisals of the past three years will then be used to guide the board member's reference." - P35	N/A	N/A	
5.5	SID annual review	"Annually, the SID or deputy chair will review and ensure that the Chair is meeting the requirements of the FPPT" - Page 23, #17 Ensure this is incorporated into local process	Mel Holley		
5.6	Appraisal template	Review annual appraisal template to incorporate elements for FPPT, including but not limited to: LCF, BMR requests. Outcome of FPPT assessments for all board members to be sent to the Regional NHSE director.	Mel Holley		
5.7	DBS Checks	Whilst not an annual requirement, there is a 3-yearly requirement to check DBS. The recruitment team can undertake this check once initiated by the Chair (or appointed deputy).	Mel Holley		

Ref	Action title	Summary	Responsible	Status	Notes
GOVERNANCE COMMITTEE					
6.1	Gap analysis on current process	No proposed changes to council of Governors as not in scope. Chairs annual appraisals are presented to the CoG for information and FPPT for NEDs. - Page 23, 18 Ensure process aligns with this requirement, if not already in place.	Mel Holley		

Ref	Action title	Summary	Responsible	Status	Notes
DISCIPLINARY AND DISMISSAL					
7.1	Failure of duty	Those consistently failing to undergo required training in a timely manner should be deemed to have missed an important obligation, and appropriate action should be taken in line with the NHS organisation's policies and procedures. In turn, this may mean that a board member is not fit and proper. - Page 30	Mel Holley		HMR - See 4.4
7.2	Settlement agreements	"Going forward, NHS organisations should consider inclusion of a [confidentiality] term in any proposed settlement agreement to state that information about the settlement agreement can be included in ESR, and in doing so will not be a breach of confidence." - P35	Mel Holley		

Ref	Action title	Summary	Responsible	Status	Notes
LEAVER PROCESS					
8.1	Process flow of steps	See page 17. Adapt for local version.	Mel Holley		

8.2	Board Member Reference	"NHS organisations should maintain complete and accurate board member references at the point where the board member departs, irrespective of whether there has been a request from another NHS employer and including in circumstances of retirement. Both the initial and board member references should be retained locally." - P35 BMRs should be retained for the career of the board member or up to their 75th birthday - ensure appropriate storage and records destroyed at appropriate time period. Incorporate into local process SOP.	Mel Holley		
8.3	Settlement agreements	"Going forward, NHS organisations should consider inclusion of a [confidentiality] term in any proposed settlement agreement to state that information about the settlement agreement can be included in ESR, and in doing so will not be a breach of confidence." - P35	Mel Holley		HMR - see 7.2

Ref	Action title	Summary	Responsible	Status	Notes
THE ROLE OF THE CHAIR					
9.1	NHSE Regional Team	Once the annual checks have been completed of the chair, the annual FPPT submission (including results of all FPPT board members is then sent to the relevant NHS England regional director - Page 23, #19 Ensure this is incorporated into local process	Mel Holley		
9.2	Accountability for FPPT	Ultimate accountability for adhering to this framework will reside with the chair of an NHS organisation' - Page 13, #8 Ensure the Chair is fully briefed and aware of requirements.	Mel Holley		
9.3	Evidence of process	"Chairs should ensure [the Trust] can show evidence that appropriate systems and processes are in place to ensure that all new and existing board members are, and continue to be, fit and proper" - Page 14, #10 "Such systems and processes include (but not limited to) recruitment, induction, training, development, performance appraisal, governance committees, disciplinary and dismissal processes" - Page 14, #11 Ensure local process documents reflect this.	Hannah Radford - recruitment FPPT documents to be updated and reflective of new process. Mel Holley - ensure other elements are adapted.	HMR - Complete Mel Holley - TBC	HMR - As listed on this page.
9.4	Reporting	"It is good practice for the chair to present a report on completion of the annual FPPT in accordancy with local policy, to the board in a public meeting and, where applicable, to the CoG for NEDS, for information." - Page 22, #16 Review and incorporate into local process, as appropriate.	Mel Holley		
9.5	Role description of Chair	Consider review and update of the Role Description to incorporate FPPT role and responsibilities	Mel Holley		

Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	12.5, Public Board Meeting		**Date: 1st November 2023**	
Title:	Response to the Verdict in the trial of Lucy Letby			
Prepared by:	Melanie Holley Director of Governance			
Presented by:	Melanie Holley Director of Governance			
Responsible Executive:	Paul Roberts Chief Executive Officer			
Summary:	To share with the Board of Directors the Trust's approach to Speaking Up and provide a status position in relation to the five questions raised by NHS England.			
Actions required:	For the Board of Directors to note the content, specifically the response to the five questions raised by NHS England and to consider any further assurances the Board of Directors would like to receive.			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
			x	
History:	N/A			
Link to strategy/ Assurance framework:				

Monitoring Information

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

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

1. Purpose of paper

The purpose of the paper is to present to the Board of Directors (BoD) the Trust's response to the five questions contained in a letter received on 18th August 2023 from NHS England relating to the verdict in the trial of Lucy Letby.

To share with the BoD an outline of the Freedom to Speak Up Service which is available to all Trust staff and the further work planned to enhance the service.

2. Background

Speaking Up

On 18th August 2023, following the outcome of the trial of Lucy Letby, NHS England wrote to all Trusts and Primary Care Networks (Appendix A).

The letter sets out NHS England's commitment to doing everything possible to prevent anything like the Lucy Letby case happening again and advises that steps towards patient safety monitoring are already being strengthened.

The letter specifically states that NHS leaders and Boards **must** ensure proper implementation and oversight of Freedom to Speak Up (FTSU) and requests that Boards should urgently request a response to five key questions, outlined below in section 3.

The Trust launched its FTSU service in 2016 in line with the recommendations set down by Sir Robert Francis in his report into the failings at Mid Staffordshire.

The Director of Governance, on behalf of the Chief Executive Officer manages both the FTSU service and Whistleblowing.

The Trust currently has 9 volunteer FTSU Guardians (2 northern based and 7 eastern based) representing Nursing, Medical, AHPs, Facilities, People Function, House Keeping, Finance and a Care Assistant who works in the community. The Trust has recently secured funding for a dedicated Lead FTSU Guardian, following a 12 month pilot which was funded through Charitable Funds.

The FTSUGs are supported by two Non Executive Director FTSUG champions, as well as the Director of Governance.

In addition to the FTSUG service there are a number of alternative routes that are available to staff to raise concerns (as outlined in Appendix B). In line with the Trust's Raising Concerns (Whistleblowing Policy), staff are encouraged first and foremost, where appropriate, to raise concerns through their normal line management.

Fit and Proper Person Requirements

The letter from NHSE also reminds Trusts of their obligations under the Fit and Proper Person (F&PP) Requirements which is regulated by the Care Quality Commission (CQC) and relates to Members of the Board.

The Trust has a Fit and Proper Persons process in place which was reviewed by the CQC during the Well Led Inspection in May this year.

NHS England recently strengthened the F&PP framework which came into effect from 30th September 2023. Details of the new framework, which essentially requires additional background checks, clearer accountability of the Chair and a new reference and appraisal template were presented to the Trust's People, Workforce Planning and Wellbeing Committee (a sub-committee of the Governance Committee (GC) on 21st September 2023. A robust action plan is in place which will be monitored through to completion by the GC (as outlined in the GC report to the Board, agenda item 12.5).

Appointments made to the Trust since September 2023 are being managed in line with the new framework. Board members have been provided with privacy notices for their review and agreement.

3. Analysis

Listed below are the five questions requested by NHSE for Boards to consider. The responses below detail the Trust's position.

Question 1 – All staff have access to information on how to speak up

Trust staff are provided with a wide range of information on how to speak up both formally via the Trust's How to Raise a Concern (Whistleblowing) Policy which can be found on the Trust's Intranet, together with Intranet pages on the Freedom to Speak Up Services, screen savers on all Trust computers, posters and leaflets.

Promotion of the service is via weekly walkarounds of the Lead FTSUG and monthly site visits which are planned to recommence in November (a timetable of site visits will shortly be uploaded to the Trust's Intranet site). In addition to clinical areas, there will be a focus on visiting non clinical areas, large staff groups and areas where staff may not have access to the Trust's Intranet, such as Housekeeping, Laundry, Facilities and Estates to name a few. The continued and constant visible presence of the Lead FTSUG will (as evidenced during the 12 month pilot) help make speaking up be discussed regularly throughout the Trust.

Following the success of the pilot of the Lead FTSUG, there was a direct correlation to walkarounds/site visits with an increase in the number of contacts made by staff. The newly appointed Lead FTSUG is working closely with the Communications Team to look at how the profile of the service can be raised further through regular routine comms.

In terms of priorities going forward, the Lead FTSUG is planning on increasing the number of FTSU Champions throughout the Trust so that all areas have access to a Champion in their own work area/department. It is known that staff will speak more readily to their peers and so multiple Champions in areas/departments will hopefully

allow speaking up to become a normal occurance. Champions will signpost staff to Guardians if they deem the concern requires escalation.

Question 2 – Relevant departments such as Human Resources and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme

The FTSU Team and senior colleagues in the People Function have confimed that they are awa re of the National Speaking Up Support Scheme. No referrals have been made to date.

All concerns raised via the FTSUG team and through the Whistleblowing process have been resolved, to the best of our knowledge, to the individual's satisfaction (there is an appeals process within the Trust's WB Policy).

The FTSUG's follow up all contacts to ensure that the member of staff is ok and that the concerns/issues have been resolved satisfactorily. Similarly the FTSUG's are aware that no one should suffer a detriment as a result of raising a concern and the process that should be followed (ie escalation to the Director of Governance) should this be raised as a concern.

Question 3 – Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speak up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthly and supporting cultures where everyone feels safe to speak up should also be put in place

All staff have a number of routes available to them for raising concerns, as outlined in Appendix B and detailed within the Trust's Whistleblowing Policy.

In terms of FTSUG, staff can contact the Guardians by email, either personal or through the generic email account and by phone (all Guardians have a mobile phone). All emails, including the generic email box are checked daily by both the Guardians and the Lead FTSUG – the expectation is that the member of staff will receive a response within 24 hours (often much sooner). Staff can, and do, raise concens directly to the Lead FTSUG during walkarounds and site visits.

Training materials have been designed that are used to promote speaking up – regular training sessions with student nurses and junior doctors are routinely held. It is planned with the newly appointed Lead FTSUG to extend these to training sessions throughout the Trust over a 12 month period to medical students, overseas recruits (both nursing, medical and AHP's), and newly qualified nurses, midwives and AHP's as part of the Trust's Preceptorship programme.

Whilst there is evidence that staff from different cultures have accessed the service, more work is required to enhance this and to test that all staff have equal access.

Considerable promotional work has been undertaken during the pilot of the Lead FTSUG, which will continue with the newly appointed Lead FTSUG focusing on new starters, via the Trusts Corporate Induction, Preceptorship, Diversity networks and

induction of overseas staff. This will be underpinned through close working with our colleagues in the People Function, Diversity and Inclusion and Staff Side.

Plans are in place to increase the numbers of FTSUG's in the Trust specifically targeting Northern, Community, Children's and Neonatal and LGBTQ community and ensuring that all key staff groups are represented.

As mentioned previously the Lead FTSUG is planning on increasing the number of FTSU Champions throughout the Trust so that all areas have access to a Champion in their own work area/department. Staff from these staff groups are going to be actively encouraged to become Champions to further enable staff to speak up from these staff groups.

A highly experienced FTSUG professional working in another Trust has agreed to mentor the newly appointed Lead FTSUG. In addition to the mentoring there will be opportunities to explore how other Trusts have taken forward their FTSUG services – for example some Trusts appoint Champions for "sign posting" only, whereas other Trusts, like Royal Devon, have taken the approach to appoint Guardians who carry a caseload.

Question 4 – Boards seek assurance that staff can speak up with confidence and Whistleblowers are treated well

The Board currently seeks assurance that staff can speak up through assurances received by the Governance Committee (which are reported onwards to the Board).

Evidence, obtained through the National Freedom to Speak Up Guardian Office (NGO) details a steady increase in the number of cases of staff speaking up over the year for Royal Devon, compared with other organisations who appear to have relatively static numbers per quarter. Nationally the Trust is within the top quarter of Trusts reporting to the NGO (ie when compared with all Trusts) and similarly in the top quarter of Trusts of similar size to Royal Devon. Although benchmarking data is helpful it should not be reviewed in isolation, due to the number of other routes available for staff to speak up (Appendix B).

Going forward reporting to the GC will include data in terms of numbers and themes using the FTSUG, but also numbers and themes using the alternative routes and also the formal route of Whistleblowing.

All staff who speak up either through the FTSUG service or via the Whistleblowing route are provided with information at the outset that they should not suffer a detriment by doing so, and are provided with information on what they should do if they believe they have – any such cases will be thoroughly investigated. To date there has only been one reported case where an individual perceived they had suffered a detriment. This was thoroughly investigated by an external, independent investigator who could find no evidence to uphold the claim. The detriment, as it was perceived by the individual, occurred prior to concerns being raised.

The newly appointed Lead FTSUG has received assurance from the Chair of the Trust, the CEO and the Executive Directors that no staff member should experience any detriment if they have the courage to speak up. The Lead FTSUG is making this

part of every discussion he has when speaking to staff, delivering training or speaking to any person raising a concern.

All Whistleblowing cases are jointly managed by an Executive Director and the Director of Governance, with agreement/decisions being taken by the Chair of the Trust, Chief Executive and the two NED FTSU Champions (in line with the Raising Concerns, (Whistleblowing Policy). This process has been in place for many years and ensures that all concerns raised through this route are taken seriously and appropriate action is undertaken.

In line with the Trusts annual Internal Audit Programme, Audit South West (the Trusts Internal Auditors) will shortly be commencing an audit on the FTSU and Whistleblowing, the results of which will be presented to both the Audit Committee and GC.

In spite of the above, there is clearly more that can be done to both encourage staff to speak up and to do so openly and transparently. The newly appointed Lead FTSUG has objectives and a workplan in place to progress this and has already reached out to other Lead FTSUG's within the Regional and National Guardian networks in order to learn from others.

Question 5 – Boards are regularly reporting, reviewing and acting upon available data

Assurance reporting of speaking up and Whistleblowing is undertaken by the GC on behalf of the Board. To date all Whistleblowing concerns are routinely reported to the GC, providing a summary of the concern, action taken (ie investigation or fact finding), outcome (concerns upheld or not) and learning identified. Where learning is identified an action plan is put in place which is monitored by the GC through to completion. In addition, an annual report is presented to the GC summarising all WB concerns raised with a thematic review undertaken both of the concerns and of the actions.

In terms of FTSUG, the GC has been receiving reports twice a year from the Lead FTSUG. Reports detail number of contacts with staff, themes, national benchmarking and work being undertaken to strengthen the service.

During the last annual review of Whistlbelowing, the GC agreed that going forward reports need to bring together all aspects of speaking up and Whistelblowing, along with data from the other routes which can be used for speaking up – the rationale being for the GC to see the totality of numbers, and themes throughout the Trust, together with a single action plan and a single learning from approach.

The BoD is asked to consider the frequency of such reports and whether these should continue to be presented through the GC or direct to the Board.

In addition to assurance reporting to the GC, the FTSUG's and Director of Governance have met twice a year with the Chair of the Trust and the CEO. The frequency of these meetings have changed to quarterly and will be attended by the Lead FTSUG, representing both himself and indeed the Guardians and Champions.

4. Resource/legal/financial/reputation implications

None identified.

5. Link to BAF/Key risks

In terms of F&PP – BAF risk 2, Failure to recruit, retain and train people to ensure the right number of staff with the right skills in the right location.

In terms of FTSUG/Whistleblowing – BAF risk 6, Our people do not feel looked after/valued; employee experience is poor and people feel health and wellbeing are not prioritised.

6. Proposals

It is proposed that the BoD considers the Trust's position in terms of the Fit and Proper Persons Test and the FTSUG/Whistleblowing services available to staff in relation to the Lucy Letby Verdict; the BoD is asked to consider any further assurances it requires at this stage, whilst awaiting further direction from NHS England.

Appendix A

Letter from NHS England

Appendix B

Routes available to staff for speaking up / raising concerns

Internal
Line Managers
Freedom to Speak Up Guardians
Freedom to Speak Up Champions
Chair, Chief Executive and other Executive Directors
Director of Governance (Whistleblowing)
People Function (Human Resource Team)
Counter Fraud
Safeguarding Team
Patient Safety Team
Medical Examiners
Datix (through incident reporting)
Staff Side and Union Representative
Equality Diversity and Inclusion Leads
Guardian of Safeworking

External
Professional Bodies, NMC, GMC etc
Regulators – Care Quality Committee / NHS England
Police
Coroner

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

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

18 August 2023

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for

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communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England

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