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 31 August 2022
Via MS Teams

MINUTES

PRESENT	Mrs C Burgoyne	Non-Executive Director
	Dr K Davies	Medical Director (deputy for Chief Medical Officer)
	Mrs H Foster	Chief People Officer
	Mrs A Hibbard	Chief Financial Officer
	Professor J Kay	Non-Executive Director & Senior Independent Director
	Mr S Kirby	Non-Executive Director
	Mr A Matthews	Non-Executive Director
	Mrs C Mills	Chief Nursing Officer
	Dame S Morgan	Chair
	Mr T Neal	Non-Executive Director
	Mr J Palmer	Chief Operating Officer
	Mr C Tidman	Deputy Chief Executive
APOLOGIES:	Professor A Harris	Chief Medical Officer
	Professor B Kent	Non-Executive Director
IN ATTENDANCE:	Ms G Garnett-Frizelle	PA to Chairman (for minutes)
	Mrs M Holley	Director of Governance
	Mr S Iqbal	Associate Director of Wellbeing, Inclusion & Employee Experience (for Item 110.22)
	Ms D McMurray	Director of People, Eastern Services (Observer)
	Ms J Newton	Head of Communications (Observer)

		ACTION
100.22	**CHAIR'S OPENING REMARKS**	
	The Chair welcomed the Board, members of the public, Governors and observers to the meeting. The Chair reminded everyone it was a meeting held in public, not a public meeting, and asked for questions at the end focussed on the agenda. She asked members of the public to only use the 'chat' function within MS Teams at the end to ask any questions and reminded everyone that the meeting was being recorded via MS Teams. Ms Morgan informed the Board that a recent Council of Governors meeting had been held face-to-face at Sandy Park Conference Centre with a hybrid option available for people to attend virtually if they wished. Overall, the event had worked well although there was some learning to be explored on how to improve some aspects of the hybrid model, with the hope that the formal Board of Directors meetings would return to face-to-face with a similar hybrid option very soon. **The Chair's remarks were noted.**	
101.22	**APOLOGIES**	

	Apologies were noted for Professor Harris and Professor Kent. It was noted that Dr Davies was deputising for Professor Harris.	
102.22	**DECLARATIONS OF INTEREST**	
	No new declarations were noted.	
103.22	**MATTERS DISCUSSED IN THE CONFIDENTIAL MEETING**	
	The Chair noted that a meeting of the Finance and Operational Committee had taken place that morning and in addition updates from the Audit Committee, Digital Committee, the Integration Programme Board, MyCare Programme Board and Our Future Hospitals Programme Board were received. The Board also received a review of the Trust's Board Assurance Framework and a presentation on health inequalities in coastal areas from Professor Asthana; the presentation had built on the outcomes of the Chris Whitty report on this topic published in 2021.	
104.22	**MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 29 JUNE 2022**	
	The minutes of the meeting held on 29 June 2022 were considered and approved as an accurate record subject to the following amendment: *Minute number 093.22, page 12, paragraph 3* "Mrs Foster said that there was a very challenging recruitment market, with the recruitment process not helped by not having the automation in place that was needed." **Action.**	
105.22	**MATTERS ARISING AND BOARD ACTION SUMMARY CHECK**	
	Action check The actions were noted as per the tracker with the following additional updates: *Action 008.22 "Update on diagnostics briefing and business case to be presented at March public Board meeting."* Mr Palmer confirmed that the latest briefing from NHSE/I was that a decision was expected in September 2022. He added that decisions were still awaited with regard to the Endoscopy and Cardiology Business Cases, however a release of £500k had been received for design costs. *Action 074.22 "Mr Neal asked how the increased risk to the health of the local population from the impact of the cost of living increases, noted in the work commissioned by the Royal College of Physicians, was being tracked and responded to by the Devon ICS. Mrs Tracey agreed to raise with the ICS Lead."* The Board noted the update provided and agreed that as this had been followed up, the action should be closed noting that whilst there had been no formal response as yet from the ICS, this issue would continue to be addressed through other items as part of the Board's business. **The Board of Directors noted the updates.**	
106.22	**CHIEF EXECUTIVE OFFICER'S REPORT**	

Mrs Tracey provided the following updates to the Board.

National Update

- A new Secretary of State for Health and Social Care, Mr Steve Barclay, had been appointed, however it was possible that this could change following the election of a new Prime Minister at the beginning of September.
- Challenging operational pressures had continued over the summer months; not just locally but nationally too.
- Following the continued fall in case numbers over recent weeks, routine symptomatic testing for Covid was being paused from 31 August 2022. Testing for individuals with Covid symptoms would continue, as would testing for immune-compromised patients and patients admitted to Care Homes.
- The NHS would be the first healthcare system globally to use the new bivalent Covid vaccination, with the next phase of the vaccination programme due to start at the beginning of September for residents in care homes and the housebound in the first instance. The national booking service would open that week ahead of the wider roll-out of the vaccine on 12 September for those most susceptible to serious illness and those aged 75 and over.
- Plans had been set out by the Government on how to better support people with long Covid.
- A letter had been issued by NHS England outlining the next steps for planning for Winter 2022-23 which included a Board Assurance Framework and ensuring sufficient capacity and resilience to meet pressures of a busy Winter period. The plans included preparing local services for additional pressure by creation of the equivalent of an extra 7000 beds, through a mix of actual new physical beds, virtual ward spaces and initiatives to improve patient flow over coming months. In addition, more call handlers would be recruited across the country to deal with higher demand.
- Hospitals would be encouraged to continue use of mutual aid through the Winter, including through NHS 111. It is hoped to improve response times by automatically diverting calls between Trusts to improve core waits for patients.
- The Secretary of State had recently brought together Chief Executive Officers from six Trusts, which included University Hospitals Plymouth and Royal Cornwall Hospital, to understand and tackle ambulance handover delays. NHS England has been working with the six Trusts for the last month, with intensive support at both national and regional level being provided.
- The NHS elective recovery plan set out how the backlogs that had built up during the pandemic would be addressed, with first steps being to focus on patients waiting two or more years by the end of July 2022, with the exception of patients who did not want to be seen sooner, did not want to travel to be seen sooner and some very complex cases requiring specialist treatment. There were more than 22,500 patients waiting more than two years at the start of the year, with a further 51,000 who would breach the two-year mark by the end of July. The majority had now been treated, with the exceptions as already noted. The Trust's focus was on the totality of the problem, irrespective of patient choice; significant improvements had been seen locally.
- The NHS and social care were facing an unprecedented workforce crisis, compounded by the absence of a credible government strategy to tackle the issue according to a new report by the Health and Social Care Committee. The Committee had published a new recruitment, training and retention report outlining the scale of the workforce crisis. New research suggested a shortfall of around 12,000 hospital doctors and more than 50,000 nurses and midwives. Evidence on workforce projections suggested that an additional 450,000 jobs

would be needed in health and 490,000 in social care by the early part of the next decade. Despite progress on hospital waiting lists, a record high of nearly 6.5 million was reached in April 2022. The report found that the Government had shown a marked reluctance to act decisively and concluded that a refusal to undertake proper workforce planning posed risks to plans to tackle the Covid backlog. Serious understaffing posed risks to staff and patient safety in routine and emergency care.

- NHS leaders continued to warn of the potential for rising numbers of worsening health outcomes across the country unless the Government took urgent action to limit further energy price increases.
- Given the challenging situation outlined, the Board might want to consider when looking at performance against national targets that they had been set outside of the prevailing operating context and to ask how the Trust could hold itself to account in this extraordinary environment.

<u>System Issues</u>

- ICS update - key headlines on the scale of the challenge for Devon, implications of the operating plan and approach to supporting changes had been set out in the July ICS update which had been circulated to the Board.
- Devon had welcomed the new Chair and some of the Non-Executive Directors from NHS England on a visit to organisations in the county, which had provided an opportunity to provide a realistic view of the challenges and opportunities in Devon and showcase good work and future plans. NHS England Board members were able to visit the NHS Nightingale Hospital and hear about East Devon's voluntary, community and social enterprise sector work, in particular supporting refugees and asylum seekers.
- Elected members from county and district councils had taken part in a webinar in July for development of the eastern Local Care Partnership. Over 200 elected members from six authorities were invited to hear from a panel consisting of representatives from One Devon and the eastern Local Care Partnership. Over 130 attended with 20 questions submitted through the event and speakers including Jane Milligan, Chief Executive of the ICS and Councillor James McInnes, Interim Joint Chair of the One Devon Partnership Board, as well as voluntary sector colleagues.

<u>Local issues</u>

- Through late June and July, both eastern and northern services had been impacted by the latest Omicron wave. Whilst the new variant was milder in acuity, it was fast spreading and led to an increase in staff sickness absence. The number of patients in hospital who had Covid rose quite quickly and flow was also impacted by nursing homes seeing the effect of the outbreak.
- The Executives and Trust Directors met to look at everything being done for Winter and what were the key things that would have the biggest impact. The conclusion was that the focus should be on recruitment and creation of capacity, in particular improving the efficiency of the Green to Go list.
- The national pay award was announced, with all NHS staff in England to receive an award of at least £1400 for 2022-23. The Trust was working to national timescales to ensure that staff received this at the end of September.
- Additional advice and support for staff had been put in place during the current cost of living crisis. A decision had been taken to delay implementation of the reintroduction of car parking charges for staff for the rest of the financial year meaning there would be a significant challenge particularly on the eastern site for staff car parking. An interim arrangement had been put in place to

	encourage better use of all options. From 8 September staff in non-patient facing roles would be limited to parking on site two days a week, using either the park and ride, park and walk or alternative methods of transport, such as cycling, walking or bus services to the hospital on the other three days. • Essential maintenance work including fire work was planned in Exmouth Community Hospital and as a result the 16 beds from the Doris Heard inpatient ward were being transferred to Honiton Hospital for a period of at least eight weeks. Stakeholder engagement had taken place to ensure that it was clear that this was not an expansion of the community bed base, but rather a temporary measure whilst necessary works were completed. • The Trust had been awarded Employer of Year at Petroc's annual awards ceremony with the award collected by representatives of the Northern Devon Learning and Development team. The work of Gail Richards and Lucy Warner through the pandemic to support apprentices, Project Search and work experience students was recognised. • The latest intake for Project Search for this year had commenced. The Project Search work programme, which is committed to transforming the lives of young people with learning disabilities and autism through providing work experience, had been running in North Devon since 2013 and had seen 69 students undertake work experience at Northern Devon. Of those 69 students, only 6 had left the programme altogether and 8 had been unable to find employment. The remaining students had found employment following completion of the programme, with 20 of them still employed at Northern Devon. This year 22 students will take part in the programme across both sites. Ms Morgan thanked Mrs Tracey for her comprehensive overview of issues. She commented that the update had referred to the importance of tackling Green to Go patients and she had been struck in the overview of the Integrated Performance Report that the figure of Green to Go patients as a percentage of bed base was 33% in northern. This combined with the historic low bed base in Devon overall had serious implications for tackling the elective care backlog. She noted the new programme being set up, "Help People Home without Delay" and asked Mrs Tracey the priorities for action at Trust and system level to reduce overall length of stay and increase patient flow. Mrs Tracey agreed that this was probably the most significant issue faced by the Trust at this time. She added that whilst the numbers of patients coming through were not significantly higher, there was an impact on efficiency as patients could not be contained within the established medical base, and were outlying into other wards. Average length of stay over the last few years had increased by about two days per patient. Improving flow, particularly with regard to Green to Go patients was the priority, as creating extra capacity could not be done at scale. **The Board of Directors noted the Chief Executive's update.**	
107.22	**PATIENT STORY**	
	Mrs Mills presented the Patient Story video to the Board which was linked to a research item later on the agenda. The story related to the Trust's strategic objective of Excellence and Innovation in Patient Care and highlighted the benefits to patients and their families of participation in research, with the opportunity offered for a different route to treatment and the possibility of enhanced recovery.	

	Following viewing of the video, Mr Neal asked whether feed back was provided to research participants on the overall outcome of the research they had been involved in was. Mrs Mills responded that she was unsure whether this did happen and agreed to find out and let Mr Neal know. It was noted that many trials are randomised with some participants receiving a placebo and there could be sensitivities around providing detailed feedback, however there was confidence that there would be opportunities for patients to access wider outcomes of studies they had participated in. **Action.** Mr Kirby asked whether uptake of the opportunity to participate in research was audited and further asked whether it was up to clinicians to identify appropriate candidates or would all patients be routinely offered the opportunity to take part. Mrs Mills responded that many of the studies were national studies with specific criteria for patients taking part. She agreed that whilst there may be some inequity of opportunity for some patients being able to take part, this could relate to where patients accessed care and the nature of the specialty providing their care; it was noted however that research contributed to improving care for all patients. Mr Kirby asked whether the Trust carried out its own research, for example to test out hypotheses for local issues and circumstances, and Mrs Mills responded that research undertaken was a mixture of national studies and more local-based research much of which would be through use of evidence-based practice, rather than pure research. Dr Davies commented that for many specialties participation in national trials forms part of what clinicians are peer reviewed on, adding that there is increasingly uniformity of patients being offered participation in appropriate clinical trials. She advised the Board that in her own experience feedback was provided to patients that they had taken part in a national trial and quite often trials that had been hard to recruit to nationally. Mrs Foster said that the story provided a good demonstration of the Trust's strategy at work, as it described empowerment of not only a patient and their carer, but also of a staff member to work differently to help with the recovery of the patient. **The Board of Directors noted the Patient Story.**	
108.22	**INTEGRATED PERFORMANCE REPORT**	
	Mr Tidman presented the Integrated Performance Report (IPR) for activity and performance for July 2022 with the following key points highlighted: • The report presented covered June and July. It was noted that there were still some incomplete data sets due to the Go Live of Epic at the beginning of July. • The Go Live had had an impact on elective throughput and ability to transition. • As noted in the Chief Executive's report, the Omicron variant was less acute, but had had a major impact on staff absence which had coincided with the start of the holiday period. • Additional focus had been provided in the report this month on data quality. • As part of close working with social care clear metrics will be used to help hold each other to account going in to Winter.	

- A high level Board scorecard was included showing successes over the period, a look forward to the next period outlining the main opportunities and risks, and where to prioritise as a Board and Executive Team.
- A great deal of work had been done by the Finance and HR teams over the last few weeks to crystallise the vacancy position and trajectories for key staff categories. From September, the IPR will provide a vacancy snapshot for both sites together with a workforce trajectory.

Ms Morgan invited Non-Executive Directors to pose questions on the report.

Mr Kirby asked the following questions:

1. Was there an assumption that there was likely to be industrial action and were contingency plans being considered should this happen?

   Mr Tidman responded that this was being flagged at national level in terms of planning contingencies. Conversations were ongoing and the Trust had good relationships with Staffside on both sites. Mrs Foster added that this was been carefully tracked, but to date none of the Unions had formally notified the Trust that they were balloting on industrial action. Preparations were underway to ensure that should there be industrial action, plans would be in place under the Trust's emergency preparedness, resilience and response processes. Mr Tidman said that whilst there would be contingency plans that would be put in place, there would be an impact on the Trust's ability to deliver timely patient care and the recovery plan.

2. The IPR contained a statement that there was an additional £23m for the ICS for Winter capacity, with the Trust's share of this £3.5m and an assumption that a good proportion will go to social care. How will other parties be held accountable for delivery of this?

   Mr Palmer said that there was now a rough proposition from the ICS that there would be some investment into care hotel provision, some to pathway 1 agency support, some investment to pathway 2 which would provide bed equivalence around care homes, and some smaller investments around complex dementia. There would also need to be conversations around domiciliary care incentives during Winter. There was virtual ward provision building on the capability that had been put in place over the preceding six months and an 18 bed and an 11 bed acute bed provision. All of these could generate measurables and discussions were taking place with the ICS on how this will be done. Given the absolute dependency between the success of the Trust's and social care for the local population, there was agreement that there had to be a way of holding to account with a number of ways this will happen, including through the weekly SDEG meetings and at a higher level within the ICB. A discussion is currently being had on whether the funding should be held within the ICS rather than being divided out to organisations. Mr Tidman added that there will be a gateway process for deliverability, with schemes progressing through the gateway held to account, if not delivering stopped and funds diverted elsewhere to contingent schemes.
3. The report mentioned, under the Best Value programme section, that Mrs Hibbard and Mr Palmer would be undertaking a round of site leadership team meetings to understand why some of the programmes are behind on delivery.

Could feedback on how these discussions were progressing be provided to the Board?

Mrs Hibbard responded that she and Mr Palmer had met with the divisional leadership teams last weeks and there was absolute commitment from the teams to this agenda, recognition of what the current ask was and willingness to do what they could to support it, but acknowledging the reality of operational pressures. She advised that she was confident everything was being done to manage non-recurrently, whilst recognising that this needed to be turned into recurrent savings. There had been a change in the way teams managed cost pressures and thinking differently about using resources more flexibly. There was agreement to focus on the productivity agenda and on where the opportunities were. There was resource coming into the Finance Team through recruitment to a vacant post to help with this. The divisional teams had also asked for help on a trust-wide basis on a number of actions to help achieve consistency of process and approach to help them look at opportunities in their services and the Finance Team were looking at the best way to take this forward through programmes of work. The teams had also asked that the conversation be brought back to the triumvirate meetings so that there is shared ownership across clinical, operational and corporate teams.

Mr Palmer commented that the focus had been agreed as prioritising workforce planning beyond the short-term. The teams had also asked for focus on medical workforce and Mr Palmer advised that there was going to be direct Executive sponsorship of these two areas to follow through.

Mrs Burgoyne posed the following questions:

1. The report noted that 105 patients had been treated in the new Jubilee Ward up to June. How could the impact of this new resource be maximised?

   Mr Tidman said that the Jubilee Ward was a wider system asset for both populations across northern and eastern and had enabled building of linkage across clinical teams. He added that an update would be provided every 6-12 months particularly around innovation.

2. A successful recruitment campaign had led to eight consultants being recruited to ED. Was there learning from this that could be shared with other areas struggling to recruit?

   Mr Tidman agreed that the recruitment campaign had been very successful, but noted that it was easier to recruit to a service where there was already a position of strength, as was the case for both ED teams. It was much harder to recruit to already fragile services, but branding and marketing were being looked at, as well as how to target people considering joining the Trust and he reminded the Board that there were long lead times for these campaigns. Mrs Foster added that it was important to have an attractive job plan for the role.

3. Was modelling available on how long Covid may affect the organisation going forward?

   Mr Palmer advised that it was still early days for long Covid modelling to say for certain how far this service would develop. In addition, it was noted that it

was expected that there would be further Covid surges over the Winter months with further modelling was needed on this.

4. The Patient Experience Committee had received an escalation report on complaints and it was noted that whilst there was still a backlog, it was starting to reduce. Could Mrs Mills provide a further update to the Board?

   Mrs Mills informed the Board that two new slides were included in the IPR which would help ensure that the Trust complies with statutory requirements regarding transparency around managing complaints. There was a significant backlog of complaints, particularly in eastern services, compounded by a halt on responding to complaints during Covid and a subsequent increase in complaints related to delayed treatment and pressures in ED. There was recognition that delays in responding to complaints could impact on patients' and their families' trust and confidence in the organisation, with a clear plan in place on how this will be managed going forward, with a trajectory for improvement presented to the Patient Experience Committee. There was a caveat that this may need revision if numbers continued to increase. Additional agency resource was being put into the divisions in the eastern services with the greatest backlog to assist. Mrs Burgoyne, as Chair of the Patient Experience Committee, would provide updates to the Board.

5. Was the money for social care noted in the report for the whole county or was it broken down across the three areas? Is it known what the gap would be if pressures continue as they are and how would that gap be addressed? Is there any indication of how money will be used in primary care?

   Mr Palmer responded that of the £23m funding allocated, £10m was for social care Devon-wide. Winter modelling was well underway with an additional exercise undertaken this year to validate the bed model, working with statisticians from NHS England/Improvement, which had shown that there was a decent planning assumption. The baseline for this year was showing that running up to Christmas there would be a shortfall of between 30-50 beds across both sites compared to where the organisation would wish to be and between January and March 2023 there would be a shortfall of approximately 100 beds per site. The difference for this year going into Winter was that it was known that the baseline position for Green to Go was more vulnerable than in previous years. Further work would take place over the coming weeks to consolidate Winter plans which would be brought to the October Board meeting. There were transitionary funds within the allocation for the out of hours service which was changing provider in October. In addition, dependent on the outcome of negotiations, there might potentially be a Spring access fund.

Mr Matthews posed the following questions:

1. Cancer performance in the North continued to concern him. Whilst he understood the analysis of the problem would there be a trajectory for improvement provided?

   Mr Palmer advised that the PTL had been swollen following implementation of Epic in northern services in July as it is now utterly comprehensive. Work was underway to validate down to a more normal position. There were three areas of particular concern with a great deal of remedial work – gynaecology, colo-rectal and dermatology. Plans were in place for gynaecology and colo-rectal

that would recover the position over the coming weeks, although dermatology remained an exposed position. Conversations had taken place about outsourcing for dermatology which should come to fruition over the next few weeks to help start the recovery. Colo-rectal was connected to the diagnostic position and would need some of the work at the Nightingale Hospital on MRI, sonography appointments and increase in ultrasound to come into play quickly. Dr Davies confirmed that plans were in place for all three areas, however Go Live had impacted the ability to be clear about data and had also meant a reduction in capacity. For dermatology where there were already large numbers, this had had a greater knock on effect. There would be a recovery period for lost capacity and to pin down data. Mr Matthews commented that there did appear to be a very significant disparity between the North and the East. Dr Davies responded that there were cross site conversations taking place to provide support. Mr Palmer added that a new Joint Clinical Director was due to start which would help with this and the Joint Cancer Cabinet had also recommenced meeting.

2. The report indicated that there were 843 new recruits who were awaiting pre-employment checks before starting work and asked if this was within the control of the Trust or was it dependent on external agencies completing these checks before new staff could take up their positions?

   Mr Tidman advised that modelling of where staff were coming through the pipeline was taking place and where recruitment could be automated or fast-tracked this was being done, particularly for some of the ancillary positions. He added that approximately a third of the 843 recruits were internal candidates, but there was also a higher than normal amount of onboarding to do so consideration needed to be given to ensure the team was properly resourced as well as to induction processes. Mrs Foster said that the launch of the new recruitment portal had gone well. Indicative reporting was showing that there were approximately 1100 vacancies and there were offers out to over 950 people. Whilst there was more to do on automation of checks, these could not be compromised. She added that support was continuing on accommodation efforts and ensuring that staff were given a good welcome to the Trust when they start.

Mr Neal asked the following questions:

1. National targets had been set a long time ago. Was there confidence where the Trust set targets that they were realistic?

   Mr Tidman responded that the Board had always been clear that it would not sign up to any target, whether operational performance or financial, that it did not believe was deliverable.

2. The report referenced a significant increase in trolley waits in ED during July in the North but offered no explanation. Could the Executives provide some assurance regarding this?

   Mr Palmer responded that this was one of the areas that remained unvalidated due to the Epic implementation. However, he acknowledged that there had been some worsening of the position during the period, but not to the extent within the report. It was noted that there were a number

	of areas that would need further revision to be accurate which would be worked on over the coming weeks. **No further questions were raised and the Board of Directors noted the IPR.**	
109.22	**TOWARDS INCLUSION**	
	Mrs Tracey presented the quarterly update report on progress of the inclusion work highlighting the following key points: • Whilst the initial focus of inclusion actions had been on staff, the focus this year had been widened to include priorities for patients and the community. • Staff priorities continued to relate to awareness training, recruitment and career progression. In terms of training, a pilot was running through August and September 2022 with a target of between 75-100 leaders due to receive the training. An update on progress would be provided in the next quarterly report to the October Board meeting. As part of the awareness raising work, an inclusion calendar had been developed. Mrs Tracey informed the Board that whilst there had been progress on the driving your career programme, it had been anticipated that only two cohorts would go through the programme by the end of the financial year and she would be requesting, at the next meeting of the Inclusion Steering Group that those numbers should be increased. • Patient priorities were focused on communication with development and implementation of a Patient Communication Framework due to be completed by March 2023 ensuring there is training in place to improve communication access skills. This work was at an earlier stage than the staff priorities, but Mrs Tracey advised that the next quarterly update would provide more detail on how development of the Framework was progressing. • Community priorities were focussed on improving health inequalities, in particular looking at the impact of this on management of waiting lists, as well as building the baseline in conjunction with the Trust's work with the Local Care Partnerships on identifying the key issues and the Trust's role. One Northern Devon had been leading work on refreshing the health inequalities strategy which would inform the priorities for the Northern Local Care Partnership. A workshop had been held in June 2022 with over 100 stakeholders to identify and discuss key issues based on a set of data analysis and public engagement and the outcomes from this would help develop the new strategy by November 2022. The Eastern Local Care Partnership is working with the voluntary care sector on three prevention priorities viewed through the inequalities lens. The Trust was working with colleagues on the Integrated Care Board on the waiting well project to help understand whether there were differences in waiting lists that could be attributed to factors such as social deprivation. Whilst the focus was on cancer waiting lists currently, it was hoped to extend this to other pathways in the future. It was agreed that the slides would be circulated to the Board of Directors for information. **Action.** Professor Kay noted that gender pay had been included as an indicator but there were no actions. Mrs Tracey responded that the measurement on staffing was not around gender pay gap and the work was not focussed on this. **The Board of Directors noted the update.**	

110.22	**WORKFORCE RACE QUALITY STANDARD & WORKFORCE DISABILITY EQUALITY STANDARD REPORTS 2021-22**	
	The Board of Directors was advised that the two reports had already been presented to and scrutinised by the Governance Committee, but there was a requirement for the Board to receive them for review as well. Mrs Foster summarised the following key points for Board members: • The reports were retrospective. • There were some positive results which reinforced outcomes of the Staff Survey, for example improvements in staff feeling able to speak out and improvements in management scores. • As outlined in Mrs Tracey's report previously, significant areas of focus were career development in underrepresented groups, ensuring inclusive recruitment and leadership training, safe and effective mechanisms for speaking up and accessibility. • There had been good progress on the development of staff networks and work was continuing on developing these further. • Separate reports for the Northern Devon and Royal Devon and Exeter, as well as a combined report were presented for 2021-22, but from next year one combined report would be submitted. Ms Morgan noted that a decrease in feeling valued was reported in the race equality standard. Mrs Foster responded that this had reflected to some degree what had been reported in the staff survey, which was due in part to the operational context of the last year. Mr Iqbal added that there was engagement through the staff networks to try and better understand what some of the issues impacting this might be so that they could be addressed. Professor Kay noted that harassment experienced by staff from members of the public for both the race and disability standards were quite high and asked how this was being addressed. Mrs Foster agreed this was a concern, which had also been picked up in the wider system with public campaigning planned and the Trust was also working on violence and aggression, adding that staff were provided with support to go to the police when appropriate and there was a robust process in place to make sure that incidents were fully investigated. Professor Kay suggested that it would be good to understand in more detail what such incidents meant for staff and Mrs Foster agreed, adding that some work was already underway in this regard which would be taken forward through the governance system. Professor Kay commented on the very positive work Mr Iqbal and Ms Hashem were engaged in for the Trust, adding that the University, which had just been awarded the Race Equality Charter Mark, was also working closely with their new Inclusion Manager and hoped that this good work would continue across Exeter as part of the developing culture. Mr Matthews advised that there was an error in the disability standard report for Northern Devon, section 1, first sentence the percentage noted is incorrect. Mrs Foster agreed this would be corrected before submission. **The Board of Directors approved the reports presented for submission, with the amendment noted.**	
111.22	**AUDIT COMMITTEE REPORT**	

	Mr Matthews provided an update on the Audit Committee meeting held on 25 July 2022. No questions were raised by Board members. **The Board of Directors noted the Audit Committee update.**	
112.22	**GOVERNANCE COMMITTEE REPORT**	
	Mr Neal presented an update from the Governance Committee meeting held on 12 August 2022 drawing the Board's attention to the following points: • The Committee received a clinical safety paper from Mrs Mills, which had been requested by the Board. • The Committee had received an update on a place of death audit from the Community Division Update. The findings from the audit would be shared with the End of Life Working Group, as well as across the system. • The Committee received an update on the thematic review of Never events during the period June 2021 to May 2022. Human factors had been identified as the main theme, covering broadly three areas – stress and busyness of the environment for staff and the risk that posed in terms of stress and distraction; communication and making sure checklists were implemented and followed. The review recommended a number of actions which were underway and these would be monitored through the Safety and Risk Committee with progress reported to the Governance Committee. Ms Morgan thanked Mr Neal for the report and for the excellent presentation he had given to Governors at a recent joint Council of Governors and Board Development Day on governance. It was noted that Mr Matthews had agreed to give a similar presentation to Governors at a future event on audit controls. **The Board of Directors noted the Governance Committee update.**	
113.22	**NATIONAL INSTITUTE FOR HEALTH & CARE RESEARCH NETWORK, SOUTH WEST PENINSULA ANNUAL REPORT & ANNUAL PLAN**	
	Ms Morgan welcomed Mr Visick and Mr Gibbons to the meeting to present the National Institute for Health and Care Research (NIHR) Network Annual Report and Plan. Mr Visick informed the Board that the Clinical Research Network in the South West Peninsula was one of 15 across the country and was formed in 2015 and hosted by the Royal Devon and Exeter since that date. Key highlights for the year were noted as: • Just over 44,500 people had taken part in clinical trials across the peninsula during the course of 2021-22, an increase in the number of studies open to recruitment of 45% compared to 2020-21. • 63% of commercial recruitment was to non-Covid studies. • Recruitment to time and target for clinical trials was very good at 75% against a national average of 66%. • Radiotherapy research grew by 127% over the previous year, leading to the South West being top in the country for radiotherapy research. A major contributory factor to this outcome had been the success of the cancer lead in	

	getting £250k of additional funding from NHS England for partner organisations to help support radiology research. • There was also focus on Covid research during the year, with 22,5000 participants recruited to Covid trials in the South West. • The Network received funding from the Department of Health to transform research delivery outside of the hospital setting. The funding was used to build a new team to deliver the strategy, with successes including appointing into local authorities and public health positions. In addition, 38 care homes across the South West took part in clinical trials for the first time. • Primary care research also did well, with just over 8,000 participants recruited last year which was the third highest in England. 68% of GPs in the South West are research active compared to the national average of 51%. • Professor Jason Smith from University Hospitals Plymouth was named as the NIHR principal investigator of the year. • There had been one annual plan produced across all 15 networks this year and submitted to the Department of Health. The South West Peninsula Network also produced its own local plan, aligned with the principal of Chris Whitty's paper "Best Research for Best Health, as it was felt that it was important to give strong direction for the Network and its partners across the South West. • The Network received a budget of approximately £12m and there was strong guidance on how this is distributed. The main remit for the Network both last year and going forward was to help maintain stability in partner organisations, although this would be challenging in particular as there was a flat funding model last year and this will also be the case next year. Ms Morgan thanked Mr Visick for the overview of the nature and scope of the work of the Network, as well as the challenges it faced. Mr Matthews asked whether the enormous operational pressures being experienced across Devon were impacting on staff ability to participate in research. Mr Visick responded that operational pressures were a threat to research participation as clinicians were working very hard to recover waiting lists, and this in turn could impact capacity for those clinicians to conduct research trials. He added that this was being discussed at national level and, locally, Mr Gibbons was engaging with the ICS to make sure that research remained on the agenda. Mr Gibbons said that there would be challenges, although much of the research done in the NHS was by staff who were enthusiastic about research, but not always job planned to do it. There were also opportunities working with the ICS to integrate research more into clinical pathways. Mr Kirby noted that whilst the Network in the South West consistently overachieved against the national average, it still received the lowest amount of funding and asked if there was more that could be done to highlight the prominence of the work in the peninsula. In addition, he asked whether there might be an opportunity to approach Epic for some funding to demonstrate through research the benefits of the electronic patient record system now in use at both Eastern and Northern sites. Mr Visick responded that funding had been in part based on activity. This had now changed, with a new contract planned for 2024 and an opportunity to change the funding history for a possible uplift. He agreed that reaching out to Epic would be a good idea. Mr Gibbons added that the Network was very good at commercial research which provided the opportunity to bring in additional income. Professor Kay asked for clarification of the sentence in the report relating to the ability to generate supportive income. Mr Gibbons explained that the Patient Recruitment Centre was a mechanism for increasing high throughput commercial	

	studies and whilst the South West consistently performed well, there was more that could be done. A major limitation to this was clinicians having time in job plans for commercial research and the Network would like to work with partner organisations to find ways of developing commercial research further. Mr Visick added that there were pockets of excellence in the region in commercial research and there was a real opportunity to grow this portfolio, but there would be a challenge as commercial research needs significant capacity and resource from support services. Mrs Hibbard said that she had visited research departments on both Northern and Eastern sites and staff at both had articulated that capacity issues were a significant pinch point for imaging, chemotherapy and pharmacy and those were all areas where it is acknowledged that the Trust has recruitment issues. It was therefore not always just funding that could be a restraint on research. Ms Morgan thanked Mr Visick and Mr Gibbons for their presentation and suggested that the research potential of Epic be explored further outside the meeting. **Action.** **The Board of Directors noted the Annual Report and Annual Workplan.**	
114.22	**INFECTION CONTROL ANNUAL REPORTS 2021-22**	
	Mrs Mills presented the Infection Control Annual Reports for the former Royal Devon and Exeter NHS Foundation Trust and the Northern Devon Healthcare NHS Trust for 2021-22. It was noted that the reports had been presented to the Governance Committee where they had been discussed in detail and where it had been agreed that they presented a true and accurate reflection of infection control activity over the reporting period. In addition, it was noted that no issues of concern had been identified in either report regarding the Trust meeting its statutory duties. **No questions were raised and the Board of Directors approved the Infection Control Annual Reports for 2021-22.**	
115.22	**ITEMS FOR ESCALATION TO THE NDHT & RD&E BOARD ASSURANCE FRAMEWORKS**	
	Ms Morgan asked whether Board members had identified any new risks or anything to add to existing risks from their discussions and nothing was raised.	
116.22	**ANY OTHER BUSINESS**	
	There was no other business raised for discussion.	
117.22	**PUBLIC QUESTIONS**	
	The Chair invited questions from members of the public, staff and Governors in attendance at the meeting. Mrs Haworth-Booth asked whether it would be possible for members of the public to receive a copy of the Inclusion and Equality slides that the Chief Executive had shared with the Board and Mrs Tracey confirmed that the slides presented would be added to the public website. **Action.**	

	Mrs Kay Foster noted the number of patients Green to Go but waiting for discharge and asked whether the change of the model of discharge to "home is best" was contributing to discharge difficulties for Green to Go patients. She asked whether a contributory factor might be that more staff might be needed to look after patients discharged home than would have been the case if they had been discharged to a Community Hospital bed. She added that the problem may become worse in the current financial climate, with relatives who in the past may have taken time away from work to help look after an elderly relative upon discharge from hospital no longer able to do so. Mr Palmer responded that the particular issue that Ms Morgan had referred to earlier in the meeting had been that on a bed base of 240 beds in Northern Devon, there had been times when 33% and above of beds had been used for Green to Go patients. He added that the issue that had to be considered was how many beds to put into acute and how many into the community hospitals, primary care or virtual wards and this would form part of the planning for winter over the coming weeks with partners in primary care, the voluntary sector and social care. The winter plan would be on the agenda for the October Board meeting and it will outline how to make the best use of all the bed availability across the Devon system. Mrs Tracey added that whilst there might be staffing issues to address, the priority for the Trust had to be to ensure that patients were in the right place for them and for most patients being able to rehabilitate in their own home was the best outcome. There being no further questions, the meeting was closed.	
118.22	**DATE OF NEXT MEETING**	
	The date of the next meeting was announced as taking place on the afternoon of Wednesday 28 September 2022.	