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

At 09:30 on Wednesday 26 July 2023
Cotie Innovation Area, Petroc, North Devon Campus, Old Sticklepath Hill, Barnstaple EX31 2BQ

AGENDA

As of 20/07/2023

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 28 June 2023**	Shan Morgan, Chair	Approval (Paper)	09:37 5
6.	**Matters Arising and Board Actions Summary Check**	Shan Morgan, Chair	Information (Paper/Verbal)	09:42 5
7.	**Chief Executive's Report**	Chris Tidman, Deputy Chief Executive	Information (Verbal)	09:47 20
8.	**Patient Story**	Carolyn Mills, Chief Nursing Officer	Information (Paper)	10:07 15
9.	**Performance**			
9.1	**Integrated Performance Report**	Carolyn Mills, Chief Nursing Officer	Information (Paper)	10:22 45
	COMFORT BREAK			11:07 10
10.	**Policy & Strategy**			
10.1	**Corporate Roadmap Update –**	Chris Tidman, Deputy Chief Executive	Information (Paper)	11:17 10
10.2	**Clinical Strategy and other Enabling Strategies**	Adrian Harris, Chief Medical Officer	Approval (Paper)	11:27 45
10.3	**Review of Board Assurance Framework**	Melanie Holley, Director of Governance	Information (Paper)	12:12 10
11.	**Assurance**			
11.1	**Staff Survey Analysis and Way Forward**	Hannah Foster, Chief People Officer	Information (Paper)	12:22 45

	BREAK FOR LUNCH			13:07
11.2	**Infection Control Annual Report and Annual Programme**	Carolyn Mills, Chief Nursing Officer	Approval? (Paper)	13:40 10
11.3	**Finance and Operational Committee**	Steve Kirby, Non-Executive Director & Committee Chair	Information (Paper)	13:50 15
11.4	**Digital Committee Update**	Tony Neal, Non-Executive Director & Committee Chair	Information (Paper)	14:05 5
11.5	**Integration Programme Board Update**	Alastair Matthews, Non-Executive Director and Programme Board Chair	Information (Paper)	14:10 5
11.6	**National Institute for Health & Care Research Clinical Research Networks South West Peninsula Annual Report and Annual Plans**	Adrian Harris, Chief Medical Officer	Information (Paper)	14:15 15
12.	**Information**			14:30
12.1	**Items for Escalation to the Board Assurance Framework**	Shan Morgan, Chair	Discussion (Verbal)	14:30 1
13.	**Any Other Business**			14:31
	At the conclusion of the formal part of the agenda, there will be an opportunity for members of the public gallery to ask questions on the meeting's agenda. Where possible, questions should be notified to members of the Corporate Affairs team before the meeting. Every effort will be made to give a full verbal answer to the question but where this cannot be done, the Chair will ask a director to make a written response as soon as possible.			
14.	**Date of Next Meeting:** The next meeting of the Board of Directors will be held at 09:30 on Wednesday 27 September 2023.			
15.	The Chair will propose that, under the provisions of section 1(2) of the Admission to Public Meetings Act 1960, the public and press should be excluded from the meeting on the grounds of the confidential nature of the business to be discussed.			

Meeting close at 14:41

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

Wednesday 28 June 2023
Exeter College Future Skills Centre, Exeter Airport Industrial Estate, EX5 2LJ/via MS Teams

MINUTES

PRESENT	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 C Tidman	Deputy Chief Executive Officer
APOLOGIES:	Mrs C Burgoyne	Non-Executive Director
	Mrs S Tracey	Chief Executive Officer
IN ATTENDANCE:	Ms G Garnett-Frizelle	PA to Chair (for minutes)
	Dr A Hemsley	Medical Director (for item 098.23)
	Mrs B Hoile	Engagement Officer (via Teams for item 097.23)
	Mrs M Holley	Director of Governance
	Mrs Z Harris	Divisional Director, Community Services (for item 0.98.23)

		ACTION
090.23	**CHAIR'S OPENING REMARKS**	
	The Chair welcomed the Board, Governors and observers to the meeting. Ms Morgan reminded everyone it was a meeting held in public, not a public meeting. She asked members of the public to only use the 'chat' function in MS Teams at the end to ask any questions which should be focussed on the agenda and reminded everyone that the meeting was being recorded via MS Teams. Ms Morgan thanked all the Governors attending, both in person and via Teams. **The Chair's remarks were noted.**	
091.23	**APOLOGIES**	
	Apologies were noted for Mrs Burgoyne and Mrs Tracey.	
092.23	**DECLARATIONS OF INTEREST**	
	No new Declarations of Interest were noted.	

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093.23	**MATTERS DISCUSSED TO BE DISCUSSED IN THE CONFIDENTIAL MEETING**	
	The Chair noted that the Board would receive at its confidential meeting the annual report, annual accounts and quality report, a finance and operations committee update and an update from the system recovery board. The Chair noted that the majority of the business of the Board was on the public agenda and that going forward she would ensure that this continued to be the case.	
094.23	**MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 31 MAY 2023**	
	The minutes of the meeting held on 31 May 2023 were considered and approved subject to the following amendments: Minute number 079.23, page 11 of 20, first bullet point to be amended to read "LGBTQ+ and other protected characteristic data was also included at the Board's request".	
095.23	**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 066.23, April 2023 "A paper to be presented at a future Board meeting outlining items that were presented at Board meetings but did not have a mandated timing to review and therefore currently sat outside the Board Schedule of Reports". Mrs Holley informed the Board that the Board Schedule of Reports had been reviewed and was on the agenda for approval. In addition, Mrs Holley had shared a list of items presented to Board during 2022/23 that were not on the Schedule with the Chair and Deputy Chief Executive. These were mainly business cases and deep dives requested by the Board. It was noted that there had been discussion about business cases going to the Finance and Operational Committee (FOC) going forward with FOC then making a recommendation to the Board to avoid duplication. The action was agreed as complete and closed. Action 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". Mrs Foster said that she believed this had been covered in the meeting as she had advised that it was difficult to break this down unless staff had specifically indicated what the particular issue was for them. Mrs Foster suggested that she could take a different action to review Occupational Health data to see if this provided more detail on the percentage of work-related versus non-work-related stress and other mental health problems, with an agreed extension of the due date to September 2023. The Board agreed with this suggestion. **Action.** Action 077.23(4), May 2023 "A letter had been sent to Devon County Council (DCC) and the Integrated Care Board (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 proposed that this action should be kept open, as although he and Mr Tidman had received a letter that clarified Better Care Funding (BCF) and iBCF (Improved	

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	Better Care Funding), however there remained an issue regarding Urgent and Emergency Care Funding (UEC). He advised that a further letter would be sent to ask for a final position on that funding. The Board agreed the action to remain open. Action 080.23(2) "Mr Neal asked if more detail around the exact number of incidents being reported could be included in future Safe Staffing Reports to Board". It was noted that detail regarding exact number of incidents would be included in the next six-monthly report to the Board in November 2023. It was agreed that the action should be kept open until that time to check that it had been covered. **The Board of Directors noted the updates.**	
096.23	**CHIEF EXECUTIVE OFFICER'S REPORT**	
	Mr Tidman provided the following updates to the Board. <u>National Update</u> • Celebrations were planned across the country for the 75th birthday of the NHS on 5 July and the Trust was planning events and competitions throughout that week, as well as sharing staff and patient thank yous and stories. • The Genomics Lab Team were taking part in filming with NHSE to celebrate how their work is transforming care, with a visit to the Genomics Lab by the Chief Executive of NHSE expected in July 2023. The work of the Team would also be featured on local news. • The fifteen Academic Health Science Networks across the country had been renamed "Health Innovation Networks" and will focus more on business development. • The public inquiry into COVID-19 had started hearing evidence in mid-June 2023 and examining how the United Kingdom was prepared for civil emergencies. The Trust expects to work with NHSE to provide any information needed for the inquiry. • A report had been published by The Kings Fund looking at how the NHS compared to health care systems in other countries. It was noted in the report that the UK had below average spending on health as a share of Gross Domestic Product compared to many other countries. There was little evidence to show that any particular system produced better results than others. • The pay dispute was continuing with some professions. Whilst the Royal College of Nursing ballot had received insufficient support to continue industrial action, it had been confirmed by the British Medical Association that Consultants would be taking industrial action on 20 and 21 July 2023. Junior Doctor industrial action had already been confirmed between 13 and 18 July 2023. The Trust was continuing to plan and mitigate for industrial action, but it was acknowledged that these two periods of industrial action would be hugely disruptive. • Publication of the NHS Workforce Plan was expected over the next week. NHSE had expanded its drive to increase overseas recruitment with the introduction of funding for organisations to recruit more categories of health professionals from overseas, including physiotherapists, therapeutic radiographers and operating department practitioners. • The Trust had received a letter from the New Hospital Programme (NHP) team setting out the Trust's indicative funding envelope and the milestones that would need to be met. The Trust was reviewing its plans and developing the	

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	case for staff accommodation in NDDH. Further detail would be provided under the Our Future Hospital Programme Board update. <u>System Issues</u> • The 5 Year Forward View would be published at the end of the month which would set out the medium-term ambitions for improving the health of the population of Devon. • The Trust continued to work with partners across Devon on the operating plan for this year looking on reducing long waits and improving urgent care through working together. System partners were also working together to look at how to improve the financial position. • A letter had been received regarding the operational plan which set out next steps on how the system might be able to go further and faster • As stated by Mr Palmer, clarification had been received from DCC and the ICB on enabling funding to support hospital discharge, although further clarification was awaited on UEC funding. <u>Local issues</u> • The Financial and Operational plans were broadly on track at month 2, although the plan was slightly behind where it should be regarding long waits due to the impact of cancellations as a result of industrial action. • The Trust remained in Tier 1 for cancer with focused support in place from the region and nationally. A letter had been received from NHSE which set out what the Trust needed to achieve to exit Tier 1. • The new surgical robots had been delivered before the end of the financial year and were operational. • The new Discharge Lounge at NDDH was due to open on 3 July 2023 on time and within budget. In addition, development of the new Minors Unit in the Wonford Emergency Department was underway. • The BBC had run an item on local news relating to the Nightingale Hospital, where the 1000th hip and knee operation since opening had recently been performed. • Mr Tidman and Ms Morgan had met with representatives of the Leagues of Friends in both Eastern and Northern Devon over the last month and had committed to developing a new relationship with them to work together to identify improvements they can make for staff and patients in the Trust's community settings. • Work was underway through the Executive Team to take the integration to the next level through development of clinical divisional structures that would enable delivery of the best possible and consistent care across both services. • The Genomics Team had been successful in receiving £1m from NHSE to be the lead for the rare diseases network and had also been successful in receiving funding for a new genomics sequencer. Ms Morgan thanked Mr Tidman for his update and asked if he could give the Board an assessment of the overall impact of industrial action so far and any particular concerns he had regarding future industrial action. Mr Tidman said that there had been a level of anxiety for teams at the start of the period of industrial action, however there was now a level of confidence that the Trust can mitigate patient safety through its plans, although it was not possible to mitigate the impact of cancelling patients who were in pain or who were anxious. He added that the extended period of industrial action was impacting morale, as staff may not feel valued and it was demoralising for staff who were working hard to clear backlogs.	

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	Mr Palmer agreed that morale was a material issue and it would be important for the Trust to manage messaging carefully. He added that the Trust had also allowed a significant amount of Time Off In Lieu to be used by staff to allow these periods to be covered and staff taking this time back over the next few months would conflate with peak annual leave time, leading to a very tight staffing position. Mrs Foster agreed that the "long tail" issue mentioned by Mr Palmer was significant, as well as the amount of capacity needed from leadership during the periods of industrial action and added that the 7 days of strike action by Junior Doctors in July could have a significant impact. Professor Harris commented that in relation to the upcoming strikes by medical staff, the situation on the two sites was very different. In part this was due to size, as the larger size of the RD&E site provided some extra resilience, whilst there was more anxiety about how it would be managed on the smaller site at NDDH. The greater concern was regarding the next junior doctors strike which could cover a longer period than previously. It was noted however that the leadership from Trust Directors had been outstanding. Professor Harris said the news about the genomic sequencer was to be celebrated and added that the Trust's lab was the only centre in the world that was currently doing this genome sequencing test in a collaboration between clinicians, scientists and the University. Mr Matthews asked whether this was being exploited commercially. Professor Harris responded that he had met with the Chief Scientist the previous week to discuss how this could be done. Professor Marshall asked whether the Trust had maximised the relationship with the Academic Health Science Networks. Mr Tidman responded that relationships had not been fully maximised. It was noted that whilst there had been collaborations, there was more that could be done and the Trust welcomed the change of direction to move more towards business innovation. Professor Marshall asked what plans there were for investment in estate outside the main sites, for example Sidwell Street Walk-In Centre. Mr Tidman advised that the quality of estate was variable across the Trust and there was a rolling programme of improvements as part of the Estates Strategy, but choices did have to made on where funding was spent. He added that where the Trust leased premises, such as Sidwell Street, the Trust was at the behest of the Landlord or NHS Property Services. Professor Marshall asked how a balance of investing in the community was addressed and Mr Tidman said that strategic funding that was made available was often for improvements on the acute site, but that the organisation tried to ensure that it was being fair and reasonable with allocation from the rolling programme. Professor Marshall asked whether there were staff in place already trained in using the new robots and if not, what was the impact on productivity of introducing this new way of working. Mr Tidman advised that in the Northern site, surgical staff were receiving training on the robots as they went along by peers, and the same would apply to some of the surgeons in the Eastern site. He added that it was inevitable during the training period that there would be some impact on productivity, but there was a commitment from all of the surgeons to mitigate this. Mr Kirby said that he had attended the ICB Finance and Performance meeting the previous day where it had been stated that the industrial action would not have a significant impact which he queried. He had been informed that there had been differential approaches between the acute trusts in Devon and that Plymouth were	

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	attributing their financial gap to having spent more on maintaining services. Mr Palmer responded that it was still too early to tell what the impact had been as data about cancellations had not come through to organisations positions. However, the Trust had known very quickly when cancelling outpatient appointments due to industrial action, that this was sitting on top of its already large non-admitted position and had declared it immediately in its forecast. The operational response had been to try and recover the position over the last 10 days and it had been possible to absorb quite a lot of the impact. Mr Palmer added that it would be important to mature understanding both within the ICB and regionally of how forecasts were being managed on a weekly and monthly basis. Mrs Hibbard commented that the financial impact of industrial action was twofold, in that agency spend could not be reduced by as much as would be wished and the cost of cover through substantive staff, however the non-pay saving through cancellation had enabled some mitigation. She added that the biggest risk was that if the Trust was not able to recover the trajectory over time, the future assumptions in the plan on additional ERF income would be at risk. Mr Matthews commented that it was important to note that there were patients cancelled who may not be on the 78 week waits list, but cancellation would still have an impact on the Trust's waiting lists. Mr Kirby agreed and said that this had been his point in raising the question at the Finance and Performance meeting. Mr Palmer agreed that the impact was frequently being viewed externally only through the lens of the 78 week wait impact, but assured the Board that in all meetings with NHSE, the Trust was demonstrating the full impact of industrial action. **The Board of Directors noted the Chief Executive's update.**	
097.23	**PATIENT STORY**	
	Mrs Mills presented the Patient Story video to the Board which related to areas for improvement on the RD&E site highlighted by the parent of a child with profound and multiple learning disabilities, in particular regarding the benefits of installing a Changing Places toilet facility. Ms Morgan thanked Mrs Mills for the presentation, and asked when it was expected that the Changing Places facility would be available at the RD&E and was advised that it was hoped this would be available onsite by the end of the calendar year. The Board noted that there was already a Changing Places toilet facility in place in NDDH, which had been developed following a campaign by a patient's family. It was acknowledged that this had been a complicated process in terms of finding the right space that would be accessible and it had taken longer than had been hoped. Mrs Hibbard commented that there was grant funding that could be accessed for projects such as this. Professor Kent informed the Board that she had been shown the new facility in NDDH when she had visited the previous summer and agreed that it was very impressive, although signage could be improved. Mr Neal commented that this was a good example of the Trust working with patients and families when they brought an issue to their attention, however he asked whether this was not something that the Trust should already have been aware of. Mrs Mills said that this had already been in the sights of the Patient Experience	

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	lead in terms of equality of access for patients, but there were complexities in providing the facility. Professor Harris commented that frequently patients, particularly those with chronic conditions, were experts in what they needed. He said that although patients could flag issues up through PALS, it might be helpful to change the narrative with these patients to flag up that the organisation wanted to listen to their needs and making it easier for them to access ways of communicating their needs. Ms Morgan agreed and suggested that this was something that might be addressed at the Annual Members meeting and through seeking advice from Governors using their links into communities. Mrs Mills agreed and said that there were plans through the Patient Experience Committee to improve representation of the voice of the community. Mrs Foster commented that there was a wider inclusion issue arising from the story, where both capital and space were part of the challenge to providing facilities for washing for religious groups and access to breastfeeding facilities for example. MS Morgan suggested that this might be the kind of the project that Leagues of Friends would be interested in being involved with, as there were obvious benefits to patients. Mr Tidman agreed and added that rather than just fundraising for equipment, thought could be given to how to improve the whole experience for patients. Ms Morgan said that an action should be taken from this to look across the Board at the resources that could be tapped into to identify ways of meeting needs through different possible funding streams, including the Leagues of Friends. **Action.** **The Board of Directors noted the Patient Story.**	
098.23	**COMMUNITY DEEP DIVE**	
	Dr Hemsley and Mrs Harris were welcomed to the meeting. Mr Palmer informed Board members that although the Board received some insight into these services through reporting, this was through a very tight lens and performance driven. Community services were very broad across the Trust and involved a large number of staff across both sites. Mr Palmer said that looking at where the organisation and the system wanted to develop strategically, community services were both efficacious and productive investments to help reduce length of stay and be more successful in pathways. The following points were highlighted for the Board: • Over 2000 staff worked in the community across the Trust's geography with over 10,000 patients on their caseloads. • National guidance, including the Community Nursing National Plan which included safer staffing tools, benchmarking and guidance on developing the workforce and national Rehabilitation Guidance expected over the next few months, would build on current focus. • Integrated Health and Social Care Leadership was very important and relationships continued to develop with Health and Social Care, Mental Health and the voluntary sector. • The community service had been working together across North and East Devon for seven months and this had provided much good practice learning for teams.	

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- The insight work from Deloittes had highlighted the priorities that the Trust was already working on: end of life, falls and frailty, no criteria to reside and mental health.
- There were challenges relating to the vacancy position but there was good insight into what hard to fill roles were and how to make progress in filling them. A particular challenge was recruitment of support workers as there were many other options in the current market.
- Help was needed in redressing the balance and getting more parity for community within the organisation, although it was noted that some initiatives, such as the Associate Medical Director recruitment would strengthen the vision for the future.
- Allied Health Professionals (AHPs) were an important staff group who provided holistic healthcare across both acute and community, with rehabilitation playing a key role in prevention, as well as for long term conditions and for more acute conditions. It would be important to grow the Trust's AHP leadership in terms of their visibility and prominence.
- Prevention work in the community has a beneficial impact on how the acute functions. An example of this was work that was being undertaken in enhancing care in Care Homes through teaching and education of care home staff and Trust staff doing advanced care planning with Care Homes, as well as helping with reviewing medications.
- Multi-disciplinary meetings that include GPs and Trust staff were where the most frail patients who are potentially at greatest risk of admission to hospital can be reviewed to look at ways of helping to stabilise them and prevent inappropriate admissions.

Ms Morgan thanked Dr Hemsley and Mrs Harris for their excellent report and the insight it had provided into the breadth and depth of services provided in the community. She asked what, in their view, were the biggest obstacles to successful partnership and delivery of priorities in the community service. Mrs Harris said that at a local level relationships with external stakeholders were very good and teams were able to work together creatively and flexibly to meet the needs of the patients. There were however difficulties at times in getting other organisations to commit, even when there was strong agreement on priorities, due to capacity. There were also challenges with some lack of consistency in primary care, but she believed these could be overcome through building relationships. Mrs Harris noted that the daily pressure within the organisation was on flow and no criteria to reside. The same teams supported admission avoidance and helping patients home, which were adjusted according to demand but it was becoming increasingly more difficult to balance supporting as many discharges as possible with prevention work which would have longer term benefits.

Dr Hemsley said that pre-pandemic there had been good working relationships across organisations in both Eastern and Northern Devon, but not a good legacy of delivering together. Post-pandemic there had been a shift in focus towards the acute element of each organisation's work and primary care was releasing a significant number of contracts for work they would previously have done, with the Royal Devon now picking up some of that work.

Professor Kent noted that there was a national shortage of rehabilitation staff and it would be important for the Trust to protect the resources it had. She asked whether it was believed that there was sufficient capacity and capability within the community to respond to all the initiatives planned and plans to make sure that staff

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	had the skill sets that would be needed. Mrs Harris said that there was good understanding of the competencies of registered and non-registered clinical staff and efforts to think differently about what skills were needed, with help from clinicians to design roles and include career progression. Dr Hemsley commented that when looking at resource, it was important to include infrastructure, for examples beds in the acute. Professor Marshall said that it would be important to shift the culture to think about community services more effectively. He suggested that community might be a standing agenda item for the Board. Ms Morgan asked if data could be included in the IPR in more detail and Mr Palmer agreed that it could to give more depth. Mrs Harris agreed that the team could look at the IPR content to see how it could be made more relevant to community services and added that it would also be important to think about how to relate that to different audiences and why community was important for their agenda. Mr Palmer commented that the first part of the paper provided a three point performance based snapshot, with the second part then outlining the strategic insight that the Trust should be an anchor organisation for Devon in respect of primary and community services and integrated services. He said that there were models that the Trust could learn from regarding how pathways could be integrated and how to repurpose pathways that were acute-dominated, with the virtual wards an example of that direction of travel. Mr Tidman said that it would be important to encourage teams to look beyond acute and community divisions and how they could work together to improve services for patients. Dr Hemsley said that the interface structure had been grown over the last few years and work needed to continue to build on this. Mr Matthews asked how it was planned to ensure that the best would be got from both Eastern and Northern services now that they were working together. Mrs Harris responded that a great deal of work had been undertaken with the teams to look at what was important to them and what they had difficulty with. It was noted that learning and good practice had been taken from both teams, but not everything had to be completely consistent across North and East, as long as local variation could be justified. Mrs Harris added that there was benefit for the teams in being part of a bigger service as they felt they were seen and heard more than they had been before. Mr Neal commented that he would like to see more of the voices of staff and patients, adding that the community sites offered massive potential for the Trust. Mrs Hibbard asked how the Trust could work with the local authority to agree the capacity and pathway needed for rehabilitation. Mrs Harris said there was a Devon wide Discharge Transformation Board which included commissioners looking at how to utilise hospital discharge money to best effect, for best value and with good outcomes, and rehabilitation would be part of this. Mr Kirby asked whether a more strategic shift would be needed to drive prevention more realistically, perhaps through a better career structure. Mr Kirby further noted that the ICB had a very specific objective relating to prevention and asked whether the Trust should work more closely with the ICB linking the work it was doing in a structured and funded way. Dr Hemsley agreed that there was a significant	

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	opportunity relating to prevention, in particular through innovation, for example through linked working with the ambulance service who have a direct link with the Urgent Care Response teams when they attend an incident where an older person has had a fall. Dr Hemsley said it was important to remember that admission to hospital for older people in particular could be the right decision to receive the level of care needed and appropriate until they can safely be returned home. Mrs Harris said that it would be important that the strategy and proposal that would be brought back to the Board of Directors in October 2023 should be innovative and to be explicit about what more integrated pathways around prevention would look like. Mrs Foster commented that with the demographics of the area, the Board had previously discussed its ambition to be the best it could be in end of life provision and suggested that this should be explored in the Strategy. Mrs Harris said that by December 2023 all community staff in both Northern in Eastern would be trained on how to identify people in the last 12 months of life and this would be recorded on EPIC, as well as on advanced care planning conversations and nurse led Treatment Escalation Plans in the community setting. Dr Hemsley added that he and Tracey Reeves had worked over the last few years to build relationships with the Hospice as they also already provided some community services in some areas. Dr Hemsley suggested that it would be helpful to have a Board level champion for end of life and Non-Executive Board members could contact him if they were interested in this. **Action.** Professor Harris said that the division between primary and community care was a key factor with no overarching Devon structure within primary care in place to drive cooperation to integrate pathways. He said that the Board would need to agree its ambition and strategy to address this issue. Mr Palmer said that there were plans to talk to the ICS about risk assessment and primary care, and thought would need to be given to how some mitigations could be put in place without taking on all of the risks of provision within primary care. Mr Palmer said that the plan going forward would be for the strategy which would build out from the Clinical Strategy to be presented to the Board in October 2023. He added that governance was importance in this area and there was an opportunity to establish an Urgent and Emergency Care Board with the ICS which would help in looking at some of the funding discontinuity issues. Mr Palmer added that both Dr Hemsley and Mrs Harris had mentioned parity for community services and said that the discussions had provided confidence that the Board was fully supportive and that community services were agreed as fundamental. Ms Morgan thanked Dr Hemsley and Mrs Harris for their high-quality paper and noted that this was an important topic that the Board would return to at future meetings and through the inclusion of key information in the IPR. The Board had noted that the Community Strategy would be presented to the October Board. **The Board of Directors noted the Community Deep Dive.**	
099.23	**INTEGRATED PERFORMANCE REPORT**	
	Mr Palmer presented the Integrated Performance Report (IPR) for activity and performance for May 2023 noting the following key points: • Work had been done on the format of the IPR for this month to try to make it less dense, more aligned with finance and to pare down the Executive Introduction.	

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	• Almost all trajectories had continued to improve, despite impact from industrial action. • There had been some data quality issues which although not major were potential reputational risks; the Trust had been transparent with NHSE about these. • There were some opportunities, including the vascular hybrid as well as the opportunity to fit a data layer on top of EPIC which would make EPIC more reportable which were both broadly supported by NHSE to bring forward and routes to funding were being explored. • 4-hour performance in Urgent and Emergency Care had improved over the last week for Eastern Services. • Trajectories for 104-week waits were holding with the hope that these would be cleared on 18 July 2023. 78-week waits were also holding, however 65-week waits remained exposed with additional solutions pursued including insourcing and outsourcing with funding to be rolled out between July and December. This should underpin continued improvement to get back to trajectory. Ms Morgan noted that the successes on the balanced scorecard highlighted that recruitment and retention plans showed positive results in relation to vacancy, sickness absence and turnover and asked what this was attributed to. Mrs Foster said that the accelerating vacancies programme started last year had contributed to improvements in the process for recruitment which were showing benefits. In addition, there had been improvements in marketing and more engagement with divisions around recruitment events and work undertaken on retention was starting to embed. Mr Kirby commented that the ratio of face-to-face versus virtual outpatients appeared to be going in the wrong direction with follow-up appointments very high and unused below target and asked what was being done to address these points. Mr Palmer responded that Dr Kyle would be attending a future Board meeting to provide a full update on Outpatient Transformation where these points would be addressed. With regard to follow-ups, data cleansing work was being undertaken that should provide a benefit. Mr Palmer added that Professor Harris was leading conversations on how to restore or get ahead of where patient lists were pre-Covid. Professor Harris added that the methodology employed working with Teams was to use benchmark data of their previous position and the current position and having the conversations with the Teams on how to get back to template. Mr Palmer advised that auditing of the level of follow-ups would be needed. Mr Kirby said that it appeared that the 36 and 48-hour time lapse issues with fractured neck of femur did not appear to be improving despite the advent of the Nightingale Hospital and asked if there was a reason for this. Professor Harris said that fractured neck of femur was treated as part of trauma surgery list along with other trauma but the hybrid theatre would unlock capacity to do trauma which would help with this. Mr Kirby noted that the drugs cost remained consistently high. Professor Harris responded that there was a workstream aimed at this area, adding that as more Consultants worked in Northern Services with their range of expertise and skills, this was driving up drug spend in North. Professor Kent noted that there had been clear improvements in diagnostics, but that there was no trajectory for the 6-week wait from referral to key diagnostic test	

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and asked what plans were in place to get to the target of 100%. Mr Palmer said that on areas targeted considerable improvement was coming through. A commitment had been made that all targets should have a trajectory and this would come back in the IPR through the course of the year.

Professor Kent noted that length of stay for stroke patients was not captured and asked whether or not being able to get patients into the Acute Stroke Unit was impacting length of stay and then further impacting where patients went in the community once discharged. Mr Palmer said that the two services were very differently deployed but it would be possible to look at some comparators. Mr Tidman said that different models for stroke were being looked at as part of the Acute Peninsula Sustainability review and some of that work could be brought to the Board. **Action.**

Mr Neal asked whether there was a protocol in place when requests for mutual aid were declined and was the impact of the decision being reviewed at system level to ensure that the protocol was fair and right. Mr Palmer said that the Trust was capturing the data and being clear about what the impact would be. The Trust Delivery Group received a monthly update on all requests for mutual aid and whether they had been agreed or not. The ICS was finding it challenging to keep an overview of mutual requests made and agreed to and how to run a dispute resolution should it arise. The Trust Delivery Group was trying to connect the mutual aid issues to the Acute Provider Collaborative discussions where more mutual aid would not address the issue and something more fundamental needed to be looked at. Mr Palmer added that there had been a catchment change that had been put in place a few weeks ago, which was being monitored closely. It was noted that there were still some ambulance diverts on top of the catchment change, but Mr Palmer said that some time needed to be allowed for this to settle.

Mr Neal noted the incident with major harm that had been reported in Ophthalmology which might suggest that the triaging of the waiting well in Eastern services was not working quite as well as it should. Mr Palmer said that the data relating to this had probably been included in the IPR too early; a 72-hour review of a missed injection was being undertaken to look at whether this had had a negative impact on the patient's pathway, but it would not be clear until this had been completed what degree of harm had been incurred. Mr Palmer said that this would be treated with all seriousness and investigated thoroughly.

Mr Matthews commented that the IPR frequently reported underperformance on inpatients and overperformance on day cases and asked for clarification of what that meant for patients. Professor Harris said that day cases were predominantly surgery and the rate limiting issue was the lack of beds in the South West and the organisation being in escalation and not having availability of the full complement of beds. Mr Palmer added that there were clear breakdowns of trajectories by specialty and by admitted and non-admitted pathways. In addition, the NHSE intervention support team was currently providing support to the Trust to check demand and capacity values with specialties. Mr Tidman added that it should be also recognised that more and more day case surgery would be undertaken over time.

Mr Matthews commented that the chart for cancer waiting times in Eastern Services appeared to have set a target way below anything that had been achieved

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	in preceding months. Mr Palmer said that he would check this, but that trajectories were overall on track. **Action.** Professor Marshall asked when the broader set of metrics to measure patient views of performance would be developed. Mrs Mills said that data was available, but not all captured in the IPR, although it was reviewed at sub-committee level. She said that the data was quite dense and she was not sure of the value of including it in the IPR. Mr Tidman said there were patient surveys that were presented to the Board that would give more of a feel in this area. Ms Morgan said that this could be added to the agenda for a Joint Board and Council of Governors Development Day. **Action.** Professor Harris commented that work was being undertaken in paediatrics, surgery and general medicine as part of the Acute Peninsula Sustainability work across all four acute sites in the peninsula in the South West with structured interviews with service users to get an overview of experience. **No further questions were raised and the Board of Directors noted the IPR.**	
100.23	**AUDIT COMMITTEE**	
	Mr Matthews presented the Audit Committee update from the meeting held on 7 June 2023. The Board noted the following points: • The Trust continued to receive significant assurance from Internal Audit in the final Head of Internal Opinion, although the Committee had noted that this had been a more marginal decision than in previous years. It was noted that it was a positive outcome to hold that level of assurance through the first year following the merger. • The Committee noted that the Data Quality report was still in draft form at the time of the meeting. This had now been finalised. • The Committee received the Annual Corporate Governance Statement and a number of amendments were requested and additional evidence to be included was noted. Subject to this, the Committee agreed that it would recommend the Annual Corporate Governance Statement to the Board for approval. Ms Morgan thanked Mr Matthews and noted that it would be important to ensure that the organisation was both maintaining and improving the controls in place for the longer-term. Mrs Hibbard informed that the Board that she had followed up with the new Director of Audit South West who had confirmed that one of the key elements of assurance that Internal Audit used was the Internal Audit Programme. She said that the way the Trust proactively targeted Internal Audit into areas where there were concerns would mean that some reports would receive limited or satisfactory assurance, but the Trust was right to target those areas where it needed independent scrutiny. Mr Kirby commented that it was pleasing to see the significant assurance rating for the audit of Delivering Best Value processes, particularly given the significant changes that had been made during the year. **The Board of Directors noted the Audit Committee update.**	
101.23	**CONDITION FT4 (CORPORATE GOVERNANCE STATEMENT)**	

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	Mr Tidman presented the Corporate Governance Statement Condition FT4. The Board was informed that this had, as Mr Matthews advised, been scrutinised by the Audit Committee and amendments had been made to the evidence provided to support the statements. It was noted that submission of the Corporate Governance Statement was due by 30 June 2023. It was noted that there was an error in the first response in the Statement where a sentence from last year's submission relating to the collaborative agreement had been retained and this should be removed. **Action.** **The Board of Directors approved the Condition FT4 (Corporate Governance Statement) subject to a final check and removal of the sentence relating to the collaborative agreement.**	
102.23	**FINANCE & OPERATIONAL COMMITTEE**	
	Mr Kirby presented the Finance and Operational Committee report from the meeting held on 15 June 2023. The Board of Directors noted: • As noted under the Audit Committee report, the significant assurance relating to the Delivering Best Value (DBV) work was welcomed and it was noted that this was by far the best progress made in this area for many years and would give the organisation the best chance of achieving the CIP targets. Mr Kirby had noted at the ICB Finance and Performance Committee meeting that other Trusts in the system were making similar good progress. • An under delivery of DBV had been noted for Month 2, but this had been managed through underspends in non-pay linked to reduced levels of activity. • The Committee received updates on issues relating to the implementation of the new financial ledger and procurement system and data quality issues. It was noted that the Trust had been transparent about the issues with the system and there was robust work underway to move both back on track. Mrs Hibbard added that it was important to note the Better Payment Practice Code which was a key target looked at by NHSE and related to how quickly the Trust paid invoices, with two measures being value of invoices and volume of invoices to ensure that smaller suppliers were not being disadvantaged. There had been a number of system issues with the implementation of the new ledger which had now largely been resolved. Positive progress was noted with the volume of unpaid invoices having fallen by 60% and the value of unpaid invoices fallen by 67% and 37% more invoices paid over the preceding week than had been paid in month 1 and month 2. • The Committee approved under delegated authority the Elective checklist for submission. • The Committee had received a proposal for a 6-month extension to the current insourcing and outsourcing plan which it agreed to recommend to the Board for approval. Mrs Hibbard reminded the Board that any new spend above £50k needed sign-off both internally by the Trust and through the ICS and new spend above £100k needed additional sign-off by NHSE. The proposal for the 6-month extension to insourcing and outsourcing had been taken through this triple-lock process. There had been some concerns about the additional financial risk that this would build into the system, however the Trust was not asking the system to underwrite the risk. The risk was for the Trust, however as it was predicated on earning additional ERF income through the additional activity that it would generate, it was a risk	

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	overall to the system. However, it had on balance been supported through the triple-lock process because of the additionality of the activity which would help the Trust to further recover its waiting list position, particularly with the attention now on 65-week waits. There was a caveat, in that the impact of industrial action was not yet known and how that would be managed nationally. Work was being done with partners post-approval to ensure that the risk the Trust was carrying was fully recognised and how this would play into the overall system position on ERF. **The Board of Directors approved the 6-month extension to insourcing and outsourcing.** Mr Tidman informed the Board that the Committee had agreed, in relation to the issues regarding the ledger, that it would be good governance for a post project evaluation to be undertaken once all issues had been resolved to identify learning for future non-clinical system implementations. Ms Morgan said that this discussion had demonstrated that the Finance and Operational Committee was an indispensable part of the Trust's governance structure and expressed thanks to Mr Kirby and members of the Committee for the time they gave to discussing issues in depth to provide assurance to the Board. **The Board of Directors noted the Finance and Operational Committee report.**	
103.23	**GOVERNANCE COMMITTEE**	
	Mr Neal presented the Governance Committee report from the meeting held on 15 June 2024. He informed the Board that the Committee had received updates on the two external invited service reviews, one of Cardiology Service (Eastern) and the other of Spinal Services (Eastern) noting the significant progress that had been made. The Committee agreed that it would seek further assurance regarding these services through the scheduling of follow-up visits to both departments for Non-Executive Directors. Ms Morgan thanked Mr Neal for his chairing of the Governance Committee and for the assurance that had been provided to the Board. It was noted that Professor Marshall would take over as Chair of the Governance Committee from the next meeting. **The Board noted the Governance Committee update.**	
104.23	**OUR FUTURE HOSPITAL PROGRAMME BOARD**	
	Mr Kirby presented the Our Future Hospital Programme Board report from the meeting held on 15 June 2023 with the following points highlighted: • Since the announcement in May by the Secretary of State confirming the Government's commitment to delivering 40 new hospital building programmes by 2030, a letter had been received from the New Hospital Programme (NHP) confirming that the proposed build at NDDH remained on the programme and that the Trust's allocation of funding had increased. The Trust would be expected to adopt hospital 2.0 principles, reduce refurbishment and bring its proposed solution closer to the minimum viable product. • Work had been undertaken to review what this meant for the Trust's programme in terms of whether the Trust continued with its original programme	

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	or moved to the proposal for a new build. The Chair and Deputy Chief Executive had discussed this with local MPs and the Trust had approval to proceed on a twin track approach. • It had also been made clear that the NHP expected the Trust to progress its enabling works on the re-provision of onsite staff accommodation at NDDH. The Trust submitted its seed funding application to develop the detailed design and financial case by the deadline of 19 June 2023. • There were significant caveats that had to be noted, including the potential for delay, the budget nationally may not stretch to all of the hospitals that were included in the approvals and, if there were a delay, ensuring capital was available to cope with increased capacity demands and backlog maintenance. Ms Morgan commented that she and Mr Tidman had met with Selaine Saxby, MP and Geoffrey Cox, MP to update them on the issues and Mr Tidman had provided an excellent brief which explained the position very well. Mr Tidman informed the Board that two sets of correspondence had been received; the first was confirmation of the potential size of the funding envelope and of the enabling works commitments. The second, more detailed letter, set out the next steps in a 9 month process that all hospitals in the programme will need to go through. This involved data gathering, self-assessment in terms of readiness in terms of how well the organisation complied with hospital 2.0, the standardised model, and where the organisation might potentially move away from that and business case preparation. This would then inform the national team in terms of briefings and sequencing. Professor Kent commented that on her recent visit to NDDH that it was very clear that the facilities, particularly on Level 1 were not fit for purpose with insufficient bathrooms leading to patients having to share and potential for breaching the gender specific requirements for patients. Mr Tidman said that there were a number of risks in the intervening period which had been set out in the briefing. These related partly to backlog maintenance and demand and capacity. Mr Matthews asked for clarification of the additional risk relating to hospital 2.0. Mr Tidman said that the Trust's original proposal was to effectively rebuild the technical block and refurbishment and modernisation of the existing ward block, however it would not be possible within that proposal to adhere to the specification for 100% single rooms for patients. **The Board noted the Our Future Hospital Programme Board report.**	
105.23	**BOARD SCHEDULE OF REPORTS**	
	Mrs Holley presented the reviewed Board Schedule of Reports which she advised was also being checked against items presented to the Board not included on the Schedule to ensure that nothing was being overlooked. It was noted that the frequency of Digital Committee meetings had changed to bi-monthly and that would be updated on the schedule. Mrs Mills said that the National Patient Surveys had been missed off the Schedule and these would be added in. **Action.**	

	The Board of Directors approved the Schedule of Reports subject to the amendments requested.	
106.23	**ITEMS FOR ESCALATION TO THE BOARD ASSURANCE FRAMEWORKS**	
	Ms Morgan asked if Board members had picked up any new risks for escalation to the Board Assurance Framework or current risks that needed to be expanded. None were raised.	
107.23	**ANY OTHER BUSINESS**	
	No other business was raised by Board members.	
108.23	**PUBLIC QUESTIONS**	
	The Chair invited questions from members of the public and Governors in attendance at the meeting. Mr Wilkins asked when the outcomes from the Staff Survey would be presented to the Board and Mrs Holley advised that this item had been carried forward to the July Board agenda, due to the number of items on the agenda for the June meeting. Mr Wilkins asked Mr Tidman to clarify what was meant by Hospital 2.0 and how this differed from what had gone before. He further asked how tentative plans for the development of NDDH differed from Hospital 2.0. Mr Tidman responded that Hospital 2.0 was the Department of Health's approach to standardised specifications for buildings with engagement with the construction industry on how to build the standard hospital as quickly as possible. Hospital 2.0 is a modular construction with a pre-fabricated approach as all the evidence shows that this is the way to build high quality buildings to budget. The intention for NDDH was to build a modular style building for the technical block, with an internal refurbishment of the existing four storey building to retro-fit as many single occupancy rooms as possible and ensure that Health Technical Memoranda were complied with. The Trust now had the opportunity to compare its original plan with the possibility of a new build, looking at considerations such as where it would be sited, how quickly it could be built and most importantly whether a business case could be developed to demonstrate affordability. A value for money, affordability and deliverability test would be needed for both options. Mr Dunster noted the comments during the Community Deep Dive presentation regarding interaction with Primary Care and Secondary Care. He suggested that it would be helpful to talk to those practices which were rated excellent or outstanding by the Care Quality Commission. Mr Palmer said this was a helpful reflection. He added that other areas with mature, integrated systems conducted an annual analysis with full engagement with stakeholders. This analysis identified practices that were struggling and might need intensive support, practices that were doing well and practices that were excelling. A risk-based conversation would then look at whether it was better to provide intensive support or drive best practice. The Trust is asking the ICS to conduct this type of exercise with it, particularly as some practices had asked to engage with the Trust. This would help to understand the entirety of the position in primary care and look at mitigations. Professor Harris agreed that this had to be something that was done as a system.	

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	Mrs Kay Foster said that she had recently attended a meeting about work in the community with SeaChange, which offers a programme of activities and community support to improve health and happiness in the community, where there had been some discussion on what was being done in relation to preventative medicine. She said that she had mentioned this to Dr Hemsley and Mrs Harris who were aware but not linked in to this. She said that she would be keen in her role as a Governor to bring something back to the Council of Governors on what was happening in the community. Mr Kempton asked for clarification on plans for the junior doctor's strike. Professor Harris advised that plans were being worked through. There was confidence that a way would be found to navigate safely through this period, although it was acknowledged that five days of industrial action would be extremely challenging. Mr Palmer commented that the Gold Command structure that had been put in place was well rehearsed and although the five-day strike would be challenging, the approach that was in place was well established to deal with significant operational challenge. There being no further questions, the meeting was closed.	
109.22	**DATE OF NEXT MEETING**	
	The date of the next meeting was announced as taking place on Wednesday 26 July 2023.	

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Royal Devon University Healthcare NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS
28 June 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~~ September 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~~ Request extension to September 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.**
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.	JP	July 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.**
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.**
077.23(3)	May 2023	Work to be commissioned through the Governance Committee to look at readmission rates over time, following a question from Professor Marshall about follow-up for patients discharged with NCTR.	MM/MH	August 2023	**Update due August 2023**
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	**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 20.07.23 – A verbal update as to the latest position will be given at the July Board meeting. **Action ongoing.**
077.23(7)	May 2023	Mrs Burgoyne noted the work that was being done across North and East looking at the increased presentation of patients with mental health problems and what measures were available to keep people safe and suggested that this should also be considered as part of the community response as well. Mr Tidman agreed to take this away for consideration.	CT	July 2023	**Update 19.07.23** – Mental health collaboration is continuing, being jointly led by the RDUH COO & DPT CNO. As part of our winter planning, a joint quality improvement piece of work has been agreed to improve the interface at the emergency 'front door' of our hospitals to ensure our patients experiencing mental ill health are able to access care & support in a more timely way. It is suggested that this might be a potential future topic for a Board Deep dive, to include colleagues from DPT. **Action ongoing.**
079.23	May 2023	Specific follow-up actions from the reports on WRES and WDES to be developed and the Board to receive assurance on progress through the inclusion workplan to which they would be attached. More detail on this would be discussed at the June Board with the presentation of the deep dive into the Staff Survey results.	HF	~~June 2023~~ July 2023	**Update 21.06.23** – Presentation of deep dive into Staff Survey results deferred to July Board. **Action ongoing.** **Update 19.07.23** – An inclusion strategy & delivery plan is in development & a Board Development Day has been held to gain full Board engagement on our plan going forward. This will provide the necessary focus for the Equality Delivery Standard (EDS) that the Trust is required to undertake. The inclusion strategy & delivery plan is due to be presented to Board in Quarter 2. Additionally, the executive team have made a number of inclusion commitments, which are detailed in the Staff Survey paper. **Action complete.**
080.23(1)	May 2023	Mrs Foster to look at what numbers of Trust Grade doctors would fit into the category where they would have an option to move into Primary Care to assess what level of potential risk there may be to the Trusts.	HF	July 2023	**Update 19.07.23** – It has been confirmed that there is a low risk of already employed Trust Grade doctors moving to primary care, due to these individuals ordinarily being on an HEE Training Programme for another

					Specialty (not GPST) but taking time out of training during their programme to undertake a Trust Doctor role. A move into Primary Care would require changing to a different training programme, therefore it is not expected that a move to primary care would be undertaken at this point. The vast majority of employed Trust Grade Doctors are on Fixed Term Contracts before entering back into the Training Programme, so additionally, very fe w are substantive. In the longer term it is expected that this risk will be mitigated by the NHS workforce plan, which includes substantially growing the number of doctors & a renewed focus on retention. **Action complete.**
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.**
086.23(1)	May 2023	Workforce risks on the BAF to be reviewed following discussion about the potential for senior clinicians to exit the Trust to join GP practices	HF	July 2023	**Update 19.07.23** – This strategic threat has been considered & articulated in BAF risk 2 (Failure to recruit, retain & train the required to ensure the right number of staff with the right skills in the right location). See BAF risk for full details. **Action complete.**
086.23(2)	May 2023	Risk 9 to be reviewed once the letter from the centre had been received regarding the Our Future Hospital Programme, to look at consequences for estates, recruitment and other areas if there is a delay for the programme until 2030.	CT	July 2023	**Update 19.07.23** – BAF has been reviewed & updated. **Action complete.**
088.23	May 2023	A written response to be provided to questions submitted to the Board by Mrs Sue Matthews	~~CM~~ HF	~~June 2023~~ July 2023	**Update June 2023** – Responses to two questions answered at the May Board

					meeting sent to Mrs Matthews. The third question being reviewed by Mrs Mills. **Action ongoing.** **Update 10.07.23** – Following review, action transferred to HF for response. **Action ongoing.** **Update 20.07.23** – This has proved more complex than initially thought. Further investigation is being undertaken by CM. **Action ongoing.**
094.23	June 2023	Amendment to minutes of 31 May 2023 requested, minute number 079.23.	GGF	June 2023	**Update 30.06.23** – Amendment made. **Action complete.**
097.23	June 2023	Action to be taken from the Patient Story presentation to look at resources that could be tapped into to identify ways of meeting needs for patients through different possible funding streams, including the Leagues of Friends.	CM/AHi	September 2023	
098.23	June 2023	Non-Executive Board members to contact Dr Hemsley if they would be interested in becoming a champion for End of Life care.	NEDs/MH	July 2023	**Update:** Bridie Kent is the identified NED to attend the End of Life Steering Group and therefore should be considered as the Board Champion. **Action complete.**
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	**Update 19.07.23** – Briefing note to be distributed by September 2023. **Action ongoing.**
099.23(2)	June 2023	Mr Palmer to review the chart for cancer waiting times in Eastern Services in the IPR as the target that was set appeared to be below anything that had been achieved in preceding months.	JP	July 2023	**Update 20.07.23** – Review undertaken & revised trajectory for continued delivery of 28 days Faster Diagnosis Standard in the Trust's Eastern Services in 2023/24 incorporated in this month's IPR. **Action complete.**
099.23(3)	June 2023	An item to be added to the programme for a future Joint Board and Council of Governors Day to look at the metrics used to measure patient views on performance in greater detail.	CT/SM/MH	July 2023	**Update:** added to the list of topics for Joint Board and COG development days . **Action complete.**
101.23	June 2023		GGF	June 2023	

		Condition FT4 (Corporate Governance Statement) – error in first statement to remove sentence included from last year's statement regarding the collaborative agreement.			**Update 30.06.23** – Sentence removed. **Action complete.**
105.23	June 2023	Presentation of National Patient Surveys to be added to the Board Schedule of Reports.	GGF	June 2023	**Update 30.06.23 -** National Patient Surveys added. **Action complete.**

Signed:

Shan Morgan
Chair

<table>
<tr><td>Agenda item:</td><td colspan="2">8, Public Board Meeting</td><td colspan="2">Date: 26 July 2023</td></tr>
<tr><td>Title:</td><td colspan="4">Patient story: Using the MY CARE Patient Portal</td></tr>
<tr><td>Prepared by:</td><td colspan="4">Bethany Hoile, Comms & Engagement Coordinator</td></tr>
<tr><td>Presented by:</td><td colspan="4">Carolyn Mills, Chief Nursing Officer</td></tr>
<tr><td>Responsible Executive:</td><td colspan="4">Carolyn Mills, Chief Nursing Officer</td></tr>
<tr><td>Summary:</td><td colspan="4">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.</td></tr>
<tr><td>Actions required:</td><td colspan="4">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.</td></tr>
<tr><td rowspan="2">Status (x):</td><td>Decision</td><td>Approval</td><td>Discussion</td><td>Information</td></tr>
<tr><td></td><td></td><td>X</td><td></td></tr>
<tr><td>History:</td><td colspan="4">This patient story is set within the context of the Trust’s strategic objective of excellence and innovation in patient care; through embracing new technologies and ways of working to deliver the best possible care, the Trust empowers our patients to take control over their own health.

The launch of the Royal Devon’s electronic patient record system, Epic, has supported our clinicians and patients across our Northern and Eastern sites to collaborate in the provision of care in new and dynamic ways.

In this story, we hear from Tim, who has complex health needs and has received care at a variety of NHS trusts. Tim signed up to the MY CARE patient portal after an admission to the RD&E in 2021.

Tim’s story serves to bring to life the experience of using the MY CARE patient portal, which is the patient-facing component of Epic.

The MY CARE patient portal can be accessed on a variety of devices i.e. phone, tablet; allowing patients access to particular aspects of their medical records, and also providing a communication tool between the Trust and its patients.</td></tr>
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	Through MY CARE, our patients are also able to access test results and clinic letters quickly and conveniently, and receive appointment reminders. The enhanced communication options made available through MY CARE are one of the methods supporting productivity improvement across the Trust. For example, clinicians are able to arrange for patients to share information about their current condition in advance of their scheduled appointment to maximise the time available within consultations. Additionally, some patients are able to communicate directly with their clinical team through its direct messaging function to reduce the need for follow-up outpatient appointments. There is also an ongoing programme of work across the Trust to increase the number of patients and for specialties with long term conditions using the MY CARE patient portal to continue to increase the benefits realised. Tim also describes the benefits of accessing his health records digitally, including receiving appointment reminders, and also shares his concerns relating to digital exclusion and data protection. He also suggests improvements to the portal for users and recommends setting up a feedback mechanism so that patients have a clear route to share their experience of using the MY CARE patient portal and can help to make improvements. The Trust is relaunching it's MY CARE Patient Portal Experience Group, which will continue to have patient representation within it, and will look to approach the areas addressed within Tim's story.
Link to strategy/ Assurance framework:	The issues discussed are key to the Trust achieving its strategic objectives

Monitoring Information

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

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

NHS
Royal Devon
University Healthcare
NHS Foundation Trust

<table>
<tr><td>Agenda item:</td><td colspan="2">9.1, Public</td><td colspan="2">Date: 26 July 2023</td></tr>
<tr><td>Title:</td><td colspan="4">Integrated Performance Report – spanning both Northern and Eastern services within Royal Devon University Healthcare NHS Foundation Trust</td></tr>
<tr><td>Prepared by:</td><td colspan="4">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</td></tr>
<tr><td>Presented by:</td><td colspan="4">Carolyn Mills, Chief Nursing Officer</td></tr>
<tr><td>Responsible Executive:</td><td colspan="4">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</td></tr>
<tr><td>Summary:</td><td colspan="4">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.</td></tr>
<tr><td>Actions required:</td><td colspan="4">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.</td></tr>
<tr><td rowspan="2">Status (*):</td><td>Decision</td><td>Approval</td><td>Discussion</td><td>Information</td></tr>
<tr><td></td><td></td><td></td><td>X</td></tr>
<tr><td>History:</td><td colspan="4">This is a standing agenda item at each meeting of the Board of Directors.</td></tr>
<tr><td>Link to strategy/
Assurance framework:</td><td colspan="4">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.</td></tr>
</table>

<table>
<tr><td colspan="2">Monitoring Information</td><td colspan="2">Please specify CQC standard numbers and tick ✓other boxes as appropriate</td></tr>
<tr><td>Care Quality Commission Standards</td><td>Outcomes</td><td colspan="2"></td></tr>
<tr><td>NHS Improvement / England</td><td>✓</td><td>Finance</td><td>✓</td></tr>
<tr><td>Service Development Strategy</td><td></td><td>Performance Management</td><td>✓</td></tr>
<tr><td>Local Delivery Plan</td><td></td><td>Business Planning</td><td></td></tr>
<tr><td>Assurance Framework</td><td></td><td>Complaints</td><td></td></tr>
<tr><td colspan="3">Equality, diversity, human rights implications assessed</td><td></td></tr>
<tr><td colspan="3">Other (please specify)</td><td></td></tr>
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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 June 2023 which saw further Industrial Action from the BMA between the 14th and 17th of the month. Unfortunately this generated further disruption and delays to service provision and at the time of writing we have just addressed another period of unprecedented back to back BMA junior doctor and consultant actions in the latter half of July (with more dates to follow at the end of August as matters stand). We have to reflect once again on the enormous respect that colleagues have paid to each other during the industrial action periods by maintaining service provision for our patients whilst also supporting colleagues' rights of representation. At the same time, we can only acknowledge the compounding impact of continuous action on our ability to deliver continuous service to our population and on the general morale of our staff. It makes it all the more remarkable therefore, that in terms of overall position against the Financial and Operational Plan trajectories we have maintained relatively good progress against our planned trajectories against our elective recovery targets, alongside a more static position against UEC and NCTR. This gives us a relatively sound performance position as we enter into Quarter 1 reviews of our Devon wide performance over the coming days.

Recovering for the Future

The Trust wide operational performance dashboard for June shows clearly that we continued to make positive progress on **elective recovery**, All three long waiting domains of 65, 78 and 104 week waiting patients improved month on month and we remained close to F&OP trajectory. At the time of writing we are holding a very small number of 104ww risks which relate solely to Industrial Action cancellation of complex all day lists; and we are about to commence detailed demand and capacity reviews of our remaining 78 and 65ww specialties with NHS England's Improvement Support Team. If the 104ww cannot be cleared in July, it will certainly by the end of August – and this will be a major milestone for our recovery.

For **cancer services**, we improved month on month in relation to our 62 day waiting target and also held within F&OP trajectory. Northern Services maintained a nationally compliant position within the overall Trust 62 day waiting position which is also reflected in the wider suite of cancer measures in the IPR. Alongside this we were able to report both a month on month improvement and a compliant position against the national target for the Faster Diagnosis Standard. These improvements have been recognised in recent discussions and there may be a resultant change in tiering as a result following the Q1 review.

Urgent care performance saw the Trust sitting behind the planned trajectory for both Type 1 and Types 1-3 targets and with a relatively static position month on month. The maintenance of performance was achieved despite a growth in attendances against baseline, and ambulance handover improved during the course of the month in Eastern, contributing positively to Devon's overall CAT2 ambulance performance. However, we are aiming for significant improvement on 4hour performance between now and October, so over the course of late June and July we have been building up a deeper analysis of our current underperformance against trajectory and the available mitigations available. This has led to a strong Northern Services focus on optimising the new discharge lounge and in Eastern Services a similar focus on driving ED minors performance in the recently restored ED footprint (which doubles minors capacity). In recent days, the Trust has achieved full compliance against the 70% target and the aim has to be to sustain this level of performance.

Outside of the financial and operational plan targets, **Diagnostics performance** has improved 6ww target overall in June which is a positive move on from the static position of recent months and builds on some of the specialty level improvements noted in last month's IPR. Whilst there is a month on month loss of activity for echocardiography and non-obstetric ultrasound, echocardiography remains significantly above plan and a replacement outsourced provider is being sought for non obstetric ultrasound in the North.

Overview – Executive Themes and Actions to Raise at Board

The month 3 finance position continues to be on plan year to date despite an increase in pay costs and an under delivery of the delivering best value savings plan, both of which are mitigated by the underspend on non-pay. This position is also reflected in the forecast, where the Trust is holding the £28m deficit position but with variations as per the year to date position. There remains a significant risk to delivery of the year-end position. The cost of Industrial Action and loss of ERF income should be mitigated through the national change in ERF regime to recycle funding back to systems to cover this cost pressure, although further guidance is awaited. However, the most significant risk remains the delivery of the savings programme. Mitigations are in place for some degree of forecast local slippage but any movement of the system savings programme is likely to be difficult to manage at local level.

Progress continues to be made on resolving the ledger implementation issues with most system related issues now resolved. The focus is now on clearing the backlog of invoice progressing and authorisation to settle outstanding supplier accounts. Good progress has been made and there is an improvement in the better payment practice code reported for month 3 and a trajectory to return to good performance by month 5. Areas of manual authorisation processes, which were an issue prior to the new system but now exacerbated due to the build up of backlog, are being reviewed to streamline the process.

Collaborating in Partnership

The Board received an excellent presentation from the community team in the last cycle and work has commenced on building the community strategy for discussion in October's Board. The Executive escalations made to the ICB on discontinuity of UEC funding streams are still in progress and whilst a first release of UEC funding has been indicated this week (mainly in relation to community investments), the entirety of available funding and its allocation to projects is still incomplete. On a positive note, the stabilised funding for discharge does seem to be reflected in the continued improvement in the number of care hours (not) lost in June. June's No Criteria to Reside financial and operation plan performance was static against planned trajectory in month, but the further impact of additional Industrial Action has pushed the organisation further behind plan. Despite the recent further round of Industrial Action the current Trust NCTR position is slowly improving – but within that the Northern position remains significant exposed, partly due to the inherent lack of access to P2 rehabilitation beds in Northern Devon. We have escalated this concern internally and externally with the ICS and resolution of UEC funding will have to provide additional activity in the second half of the year.

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 June there was one medication incident across the Trust, one serious incident which is subject to investigation and three falls classified as moderate harm. Overall falls remain within normal variation, as do our reports across mortality indices.

A Great Place to Work

June was a month that saw positives and challenges. Importantly Agenda for Change (AFC) staff received the pay award and the lump sum which resulted in the vast majority of colleagues receiving an adjustment. June also saw the 72 hour Junior Doctors strike, with 402 shifts affected in East and 123 North. The action was well managed, however a significant number of other colleagues, particularly Consultants changed leave and accrued TOIL to keep services safe. The Trust is very appreciative of colleagues stepping in to support services however this will have a delayed impact on capacity through time owed to those that have worked. The Trust has now seen vacancy levels fall for eight consecutive months, with an overall vacancy rate of just above 6%. Simultaneously, successful selection of candidates remains positive with a significant increase in the number of candidates in the pipeline. This is very positive news however higher volumes risk delays in processing although time to hire is also improving. Continued reduction in turnover across the Trust is a sign of improved retention and is also contributing to the positive vacancy position. It is likely this alongside an improved take home pay position as a result of the pay award, is having a positive impact on retention, as filling vacancies reduces pressures on other staff, thus improving their experience.

Overview – Executive Themes and Actions to Raise at Board

Data Quality

RTT

In the May IPR, data quality issues were highlighted with the monthly RTT position that had been reported to Board, and the work that was underway to reconcile this with the validated weekly returns that are made. This was completed and the April, May and June positions reported in the IPR and to NHSE are now using a consistent methodology with the weekly position.

Another change in month was a formal request from NHSE for revised RTT trajectories to update the submissions made in the operational plan. The Trust made no amendments to the 78+ and 104+ trajectories, but did submit an improved trajectory for 65+, which improved the March 2024 position from 868 Trustwide to 710. This improved trajectory was based on improved clock stop activity in the first quarter, excluding the impact of industrial action, and was agreed with operational teams. Further ongoing industrial action would likely have a material impact on the ability of the Trust to meet the new trajectories and so this will be closely monitored. The revised trajectories have been incorporated into the IPR for Trustwide, Eastern and Northern services.

Activity reporting

A proposal was taken to the Finance and Operational Committee to change the way activity is reported in the IPR. The activity reporting has been adjusted to align with the national Elective services Recovery Framework (ESRF), which excludes specific specialties and commissioners from the broader activity dataset. This change does not mean the previous activity reporting was incorrect, but by making the adjustment it aligns the Trust reporting to the national reporting guidance for elective recovery. This change has been reflected in this month's IPR, and applied retrospectively (e.g. previous month's activity reporting has been adjusted to reflect the exclusions applied).

One of the implications of this change is that it reduces the volume of outpatient follow ups as a percentage of 2019/20- this has been an issue for some time with board reporting, as it relates to the EPR implementation in that a broader range of activity (particularly midwifery and community) is now counted and reported as outpatient activity, but was not in 2019/20 pre EPR implementation.

Balanced Scorecard – Looking to the Future

Successes

- Positive engagement with NHSE SW Regional Director on UEC position
- Well led and managed Industrial Action periods
- Recruitment & retention plans continue to show positive results in relation to vacancies
- Provision of a postcode catchment change to support neighbouring Trusts whilst maintaining ambulance handover performance
- 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.

Opportunities

- Delivery of the 2023/4 financial and operational plan
- TIF bid for elective infrastructure to resubmit
- TIF bid for data layer investment to be submitted
- Rapid implementation of the Northern Services Acute Medicine Model
- Driving forward of the integration programme through OSIG and CPIG to achieve phases 1 and 2 implementation
- Development of UEC tier 1 plan / Winter Plan
- Delivery of tier 1 cancer against clarified exit criteria (with potential to move back to tier 2 shortly)
- Delivery of tier 1 elective recovery plan and clearance of patients waiting 104wws
- GIRFT further and faster programme
- Primary Care Risk Assessment.

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 improvement approach
- Delivering Best Value to meet the demands of our financial and productivity plan
- 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 (July 13 – 18th for Junior Doctors and 20-21st now completed, August 24-25th to follow)
- Potential request for extension beyond August 2023 to temporary ambulance catchment change
- Delays in sign off of remaining UEC funding for this year
- Potential loss of confidence in reporting due to continued data quality issues
- Staffing Resilience in Northern Services – Medical, Nursing, HCA and Ancillary
- Staff Morale with constant pressure and cost of living challenges
- Inability to balance delivery across financial and operational plan
- Primary care fragility
- 3 investigations underway which meet Never Event criteria.

Trust Executive Summary

Trust wide — Operational Performance Dashboard

Domain	Measure/Metric	Definition	Last Month May-23	This Month Jun-23	FOP Trajectory	Planned Trajectory	National target	FOP EOY Target
Trust Operational Plan Metrics	RTT 65 Weeks waited	Total count	2585	2329	-256	2530		710
	RTT 78 Weeks waited	Total count	643	520	-123	466		0
	RTT 104 Weeks waited	Total count	13	7	-6	0		0
	Cancer - Over 62 day waiters	Total count	292	283	-9	295		198
	Cancer - % 62 day waiters against total open pathways	% patients over 62 days against open pathway	9.0%	8.4%	-0.6%			6.4%
	Cancer - 28 day faster diagnosis	% patients receiving diagnosis in 28-days	74.4%	77.8%	3.4%	70.8%	75%	75.1%
	A&E - Type 1 - 4 hr performance	% patients seen in Type 1 sites in 4-hrs	54.8%	54.4%	-0.4%	59.9%		70.2%
	A&E - All 4-hr performance	% patients seen in All sites in 4-hrs	63.2%	63.4%	0.3%	67.3%	95%	76.0%
	No criteria to reside	Average daily count	116	117	1	107		50
	No criteria to reside	NCTR as a % of occupied beds	11.1%	11.4%	0.3%	10.7%		5.3%
Trust Financial Plan	Financial Performance : I&E surplus / (Deficit)	Year to date position £000	(8,678)	(11,191)		(11,191)		(28,035)
	Delivering Best Value financial savings delivery	Year to date position £000	3,523	5,413		7,246		60,300

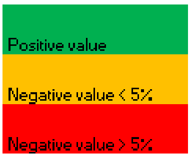
Positive Value | Negative Value < 5% | Negative Value > 5%

Northern Services Executive Summary

Northern Services Operational Performance Dashboard

Domain	Measure/metric	Definition	Last Month May-23	This Month Jun-23	Vs prior month	Planned	National target
ELECTIVE ACTIVITY	Outpatient activity (New)	Vs baseline (2019/20)	94.8%	107.1%	12.3%	122.2%	104%
	Outpatient activity (FU)	Vs baseline (2019/20)	123.2%	125.5%	2.3%	110.1%	75%
	Elective inpatient activity	Vs baseline (2019/20)	57.8%	69.6%	11.8%	95.0%	104%
	Elective daycase activity	Vs baseline (2019/20)	106.0%	115.2%	9.2%	122.9%	104%
	RTT 18 week performance	weeks vs total incomplete pathways	48.1%	49.8%	1.7%		92%
	Incomplete pathways	Total count	23899	24313	1.7%	23663	
	RTT 52+ weeks waited	Total count	3395	3203	-5.7%	2656	
	RTT 65+ weeks waited	Total count	1299	1182	-9.0%	1264	
	RTT 78+ weeks waited	Total count	301	260	-13.6%	169	
	RTT 104+ weeks waited	Total count	0	1	100.0%	0	
CANCER	2 week referrals	Performance	87.9%	90.4%	2.5%		93%
	28 day faster diagnosis standard	Performance	72.7%	76.1%	3.4%	56.0%	75%
	Urgent GP referral 62 day	Performance	58.7%	58.3%	-0.4%		85%
	Cancer - Over 62 day waiters	Total count	49	39	-20.4%	96	
	Cancer - % 62 day waiters against total open pathways	% patients over 62 days against open pathway	6.7%	5.7%	-1.0%		

Domain	Measure/metric	Definition	Last Month May-23	This Month Jun-23	Vs prior month	Planned	National target
URGENT CARE	Non-elective Inpatient activity +1 LOS	Vs baseline (2019/20)	96.8%	110.7%	13.9%	81.5%	
	A&E attendances	Vs baseline (2019/20)	116.0%	116.0%	0.0%	85.9%	
	4 hour wait performance	Patients seen <4 hours vs total attendances	63.6%	62.5%	-1.1%	66%	95%
	Ambulance handover delays >30 minutes	Total count	289	334	15.6%		
	Residual no criteria to reside	Average daily count	50	48	-4.0%	37	
	Residual no criteria to reside	NCTR as a % of occupied beds	16.9%	16.3%	-0.6%	14.4%	
DIAGNOSTICS	6 week wait referral to diagnostic test	% of diagnostic tests completed in 6 weeks	52.4%	56.3%	3.9%	N/A	99%
	MRI activity	Vs baseline (2019/20)	147.3%	178.1%	30.8%	143.7%	
	CT activity	Vs baseline (2019/20)	150.0%	150.0%	0.0%	146.0%	
	Medical Endoscopy activity	Vs baseline (2019/20)	177.7%	200.4%	22.8%	192.2%	
	Non-obstetric ultrasound activity	Vs baseline (2019/20)	97.6%	77.6%	-20.0%	101.5%	
	Echocardiography activity	Vs baseline (2019/20)	164.8%	151.5%	-13.3%	127.4%	



Eastern Services Executive Summary

Eastern Services — Operational Performance Dashboard

Domain	Measure/Metric	Definition	Last Month May-23	This Month Jun-23	vs Prior month	Planned	National target
ELECTIVE ACTIVITY	Outpatient Activity (NEW)	vs baseline (2019/20)	93.9%	**105.5%**	11.5%	131.6%	104%
	Outpatient Activity (FOLLOW-UP)	vs baseline (2019/20)	127.7%	**141.9%**	14.2%	130.6%	75%
	Elective Inpatient Activity	vs baseline (2019/20)	61.4%	**69.2%**	7.8%	92.6%	104%
	Elective Daycase Activity	vs baseline (2019/20)	103.7%	**119.8%**	16.1%	135.1%	104%
	RTT 18 Week performance	Patients seen <18 weeks vs total incomplete pathways	54.9%	**56.6%**	1.8%		92%
	Incomplete Pathways	Total count	52112	**53333**	2.3%	55042	
	RTT 52 Weeks waited	Total count	3764	**3422**	-9.1%	2510	
	RTT 65 Weeks waited	Total count	1286	**1147**	-10.8%	1266	
	RTT 78 Weeks waited	Total count	342	**260**	-24.0%	297	
	RTT 104 Weeks waited	Total count	13	**6**	-53.8%	0	
CANCER	14 Day Urgent	Performance	67.6%	64.3%	-3.3%		93%
	28 day faster diagnosis standard	Performance	77.6%	78.3%	0.8%	75.2%	75%
	Urgent GP referral 62 day	Performance	61.8%	66.6%	4.7%		85%
	% 62 day waiters against total open pathways	62 day waits as a % of total pathways	9.6%	9.1%	-0.5%		
	Count of open pathways over 62 days	Total count	243	244	0.4%	199	

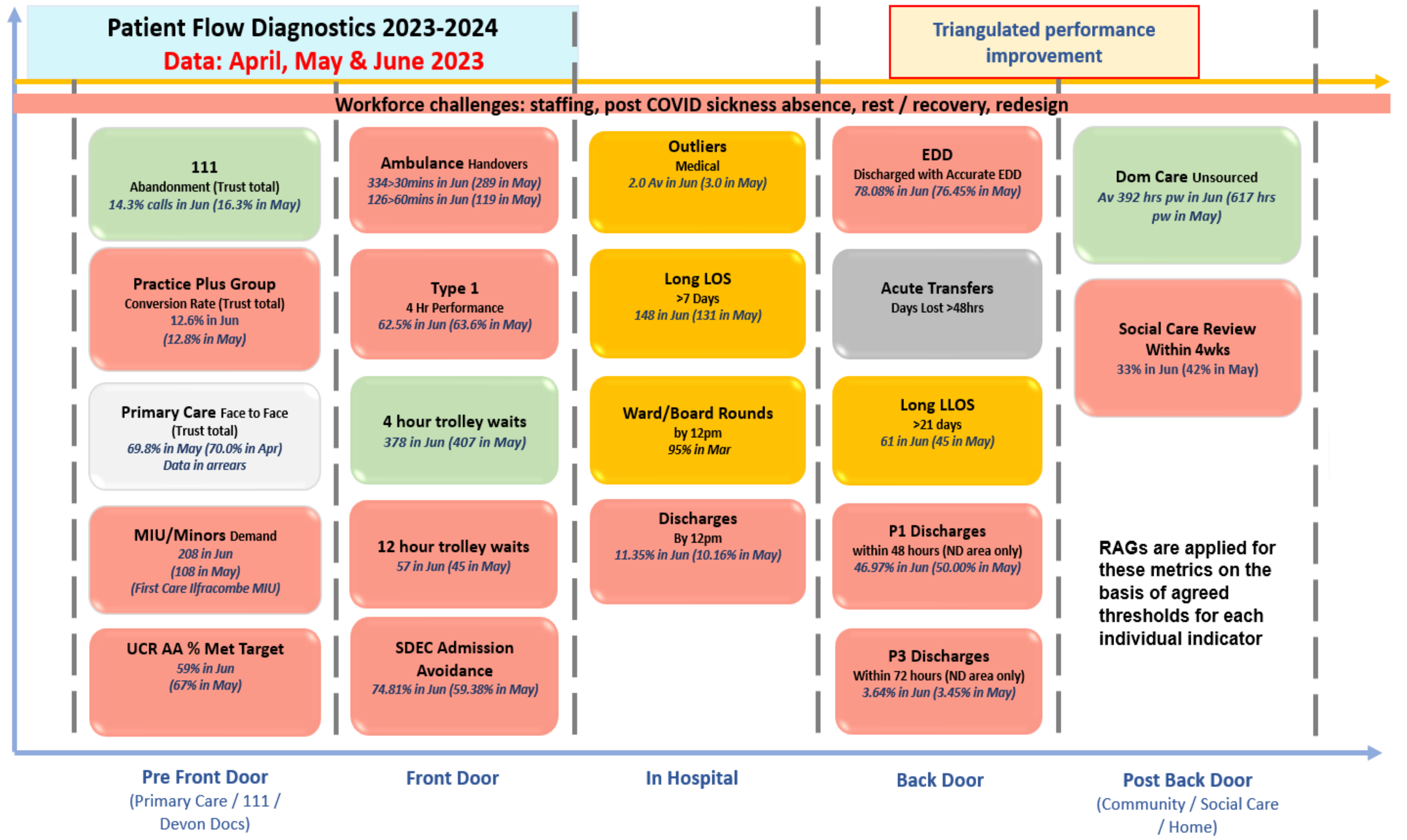
Domain	Measure/Metric	Definition	Last Month May-23	This Month Jun-23	vs Prior month	Planned	National target
URGENT CARE	Non-elective Inpatient activity +1 LOS	Vs baseline (2019/20)	105.5%	**104.6%**	-0.9%	101.4%	
	A&E attendances	vs 19/20 baseline	87.8%	**92.8%**	5.6%	86.0%	
	4 hour wait performance Type 1 only	Patients seen <4hrs vs total attendances	49.1%	**49.0%**	0.0%	56.0%	95%
	4 hour wait performance Type 1-3	Patients seen <4hrs vs total attendances	63.0%	**63.9%**	0.9%	68.0%	95%
	Ambulance handover delays >30 mins	Total count	337	**304**	-10.9%		
	Residual : No Criteria to Reside count	Average Daily count	66.0	**69.0**	4.3%	70	
	Residual : No Criteria to Reside proportion	As a % of occupied beds	8.8%	**9.4%**	0.7%	9.4%	
DIAGNOSTICS	6 week wait referral to diagnostic test	% of diagnostic tests completed in 6 weeks	65.4%	67.4%	2.0%		99%
	MRI activity	vs 19/20 baseline	100.1%	118.2%	18.1%	108.3%	
	CT activity	vs 19/20 baseline	130.8%	132.7%	1.9%	137.2%	
	Medical Endoscopy activity	vs 19/20 baseline	84.0%	86.6%	2.5%	86.2%	
	Non-obstetric ultrasound activity	vs 19/20 baseline	105.1%	115.5%	10.4%	97.8%	
	Echocardiography activity	vs 19/20 baseline	215.7%	184.2%	-31.5%	182.3%	

Positive value

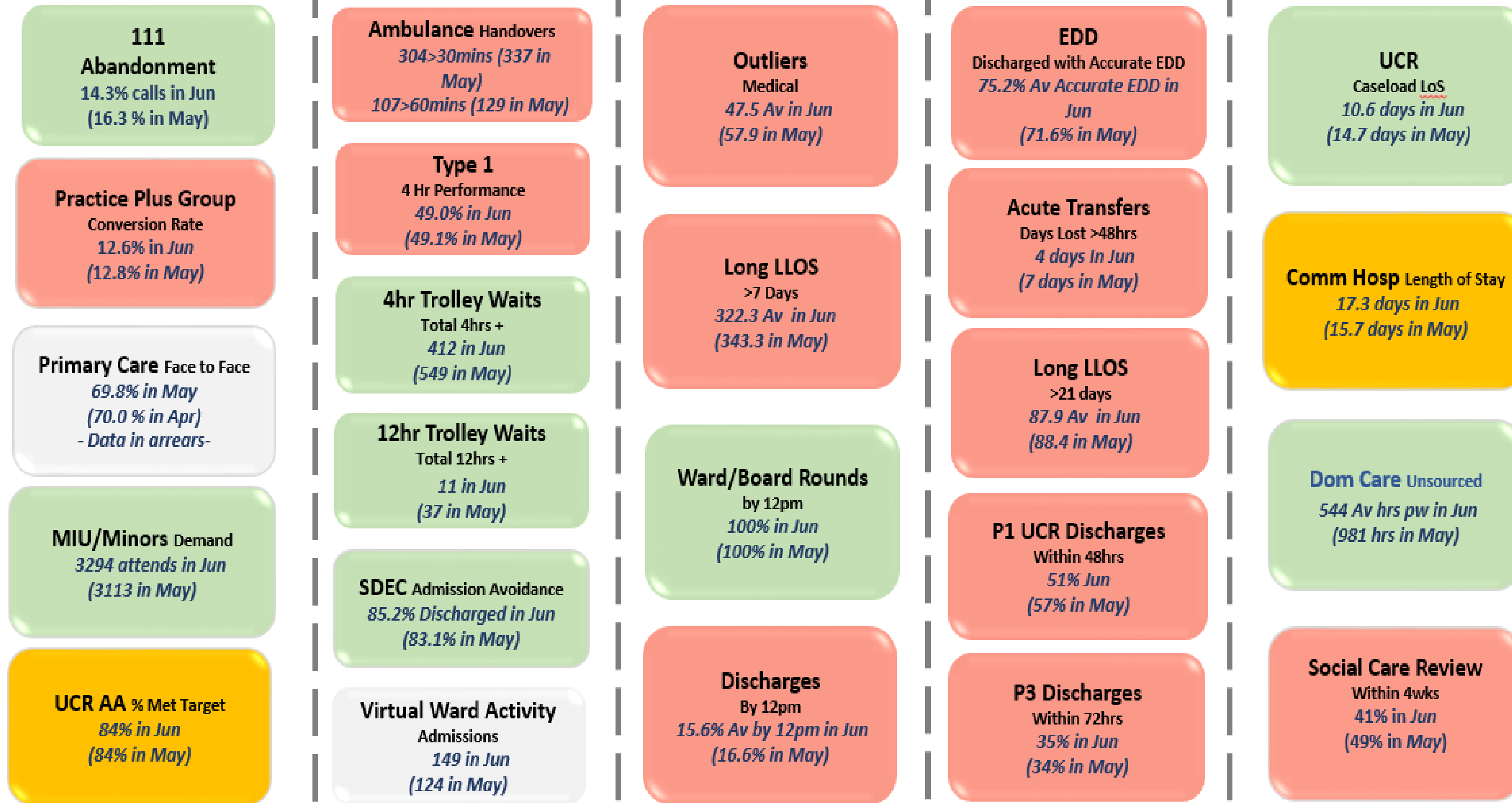
Negative value < 5%

Negative value > 5%

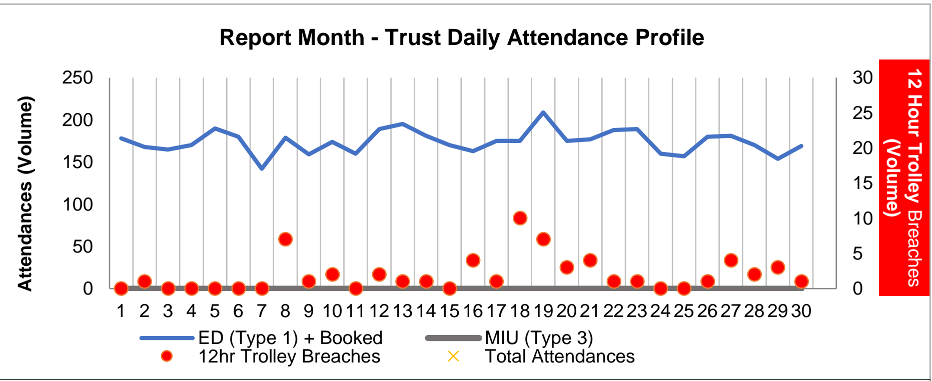
Northern Services Patient Flow Diagnostic

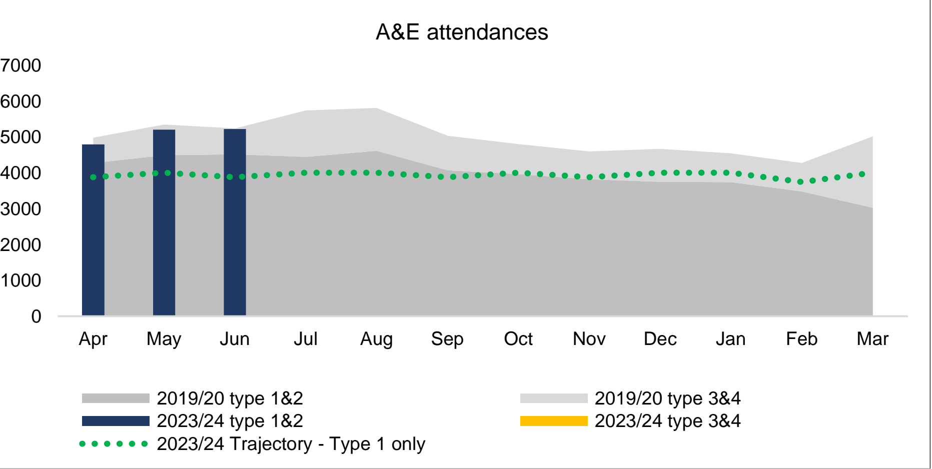


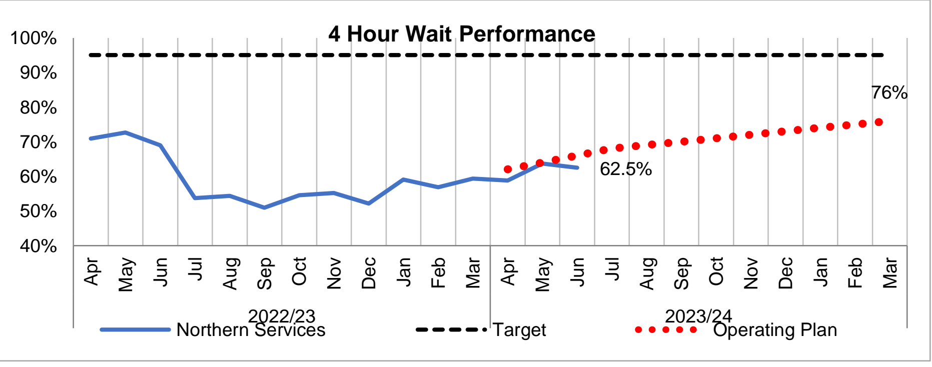
Eastern Services Patient Flow Diagnostic



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





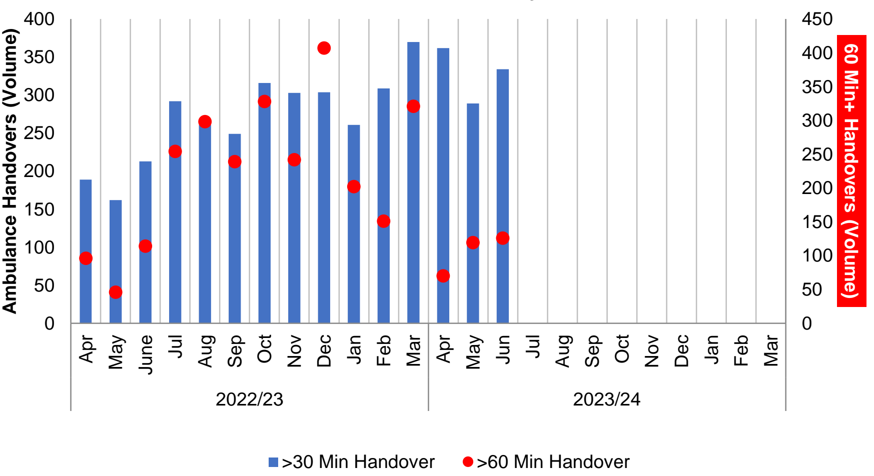


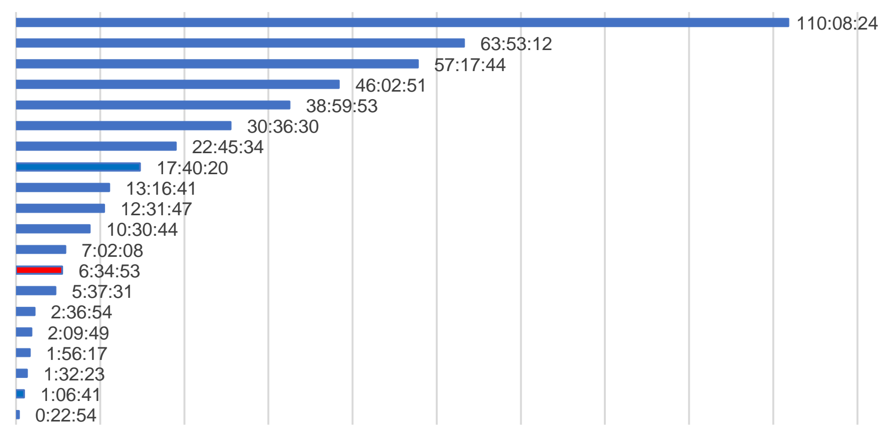
Overall Performance:

Type of Activity	Denominator	Patients > 4 Hours	% Performance
ED Only	5222	1959	62.5%

- ED saw an increase in attendances in June with a peak of 209 attendances on the 19th June.
- In June the total daily hours lost in ambulance handover delays was 375 hours. This is an increase in comparison to the total daily hours lost in May.
- In June the overall number of ED attendances increased by 13 patients against May. It is notable that both ambulance arrivals and self presentations have increased. The service reported a 2.34% decrease in June against the 4 hour target in May
- The number of 4-Hour breaches increased from 1874 in May to 1959 in June.

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





- 60 minute handover delays increased by 45 in June; 30 minute handovers increased by 7.

Activity & Flow

Operational Performance

Patient Experience

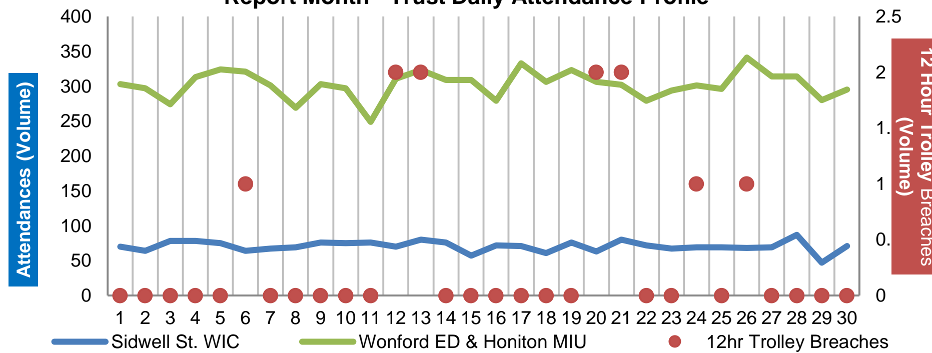
Quality & Safety

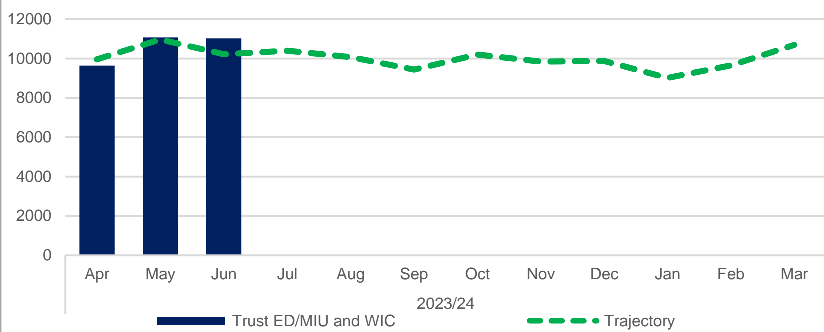
Our People

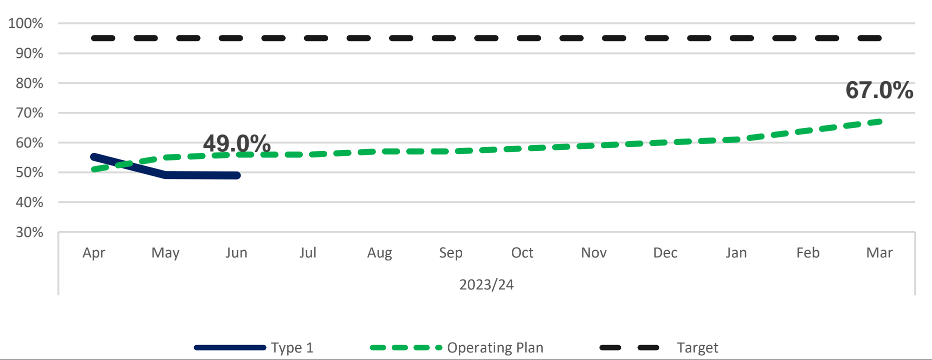
Finance

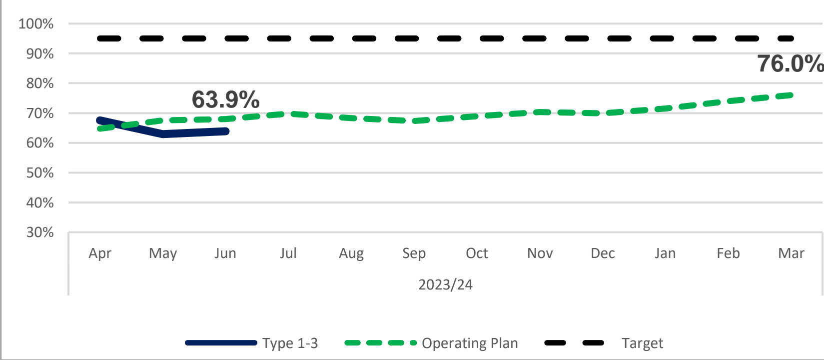
Eastern Services Emergency Department

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









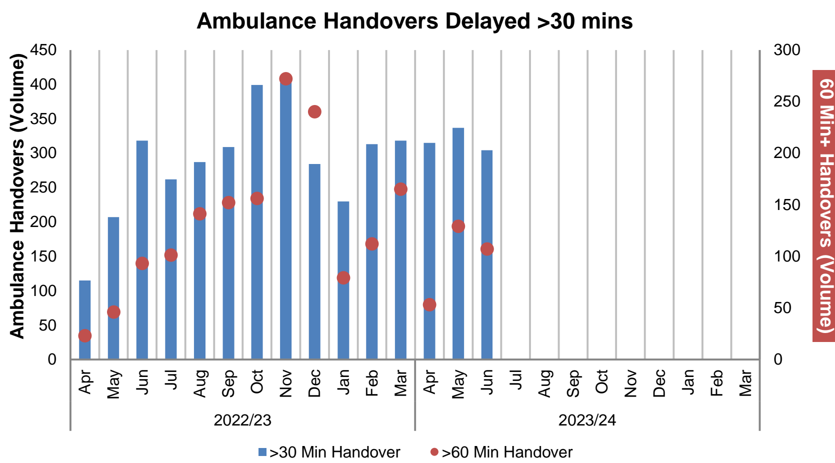
Type of Activity	Denominator	Patients > 4 Hours	% Performance
ED Only	7727	3940	49.01%
All RD&E Delivered Activity (including Honiton MIU and the WICs)	11021	3978	63.91%

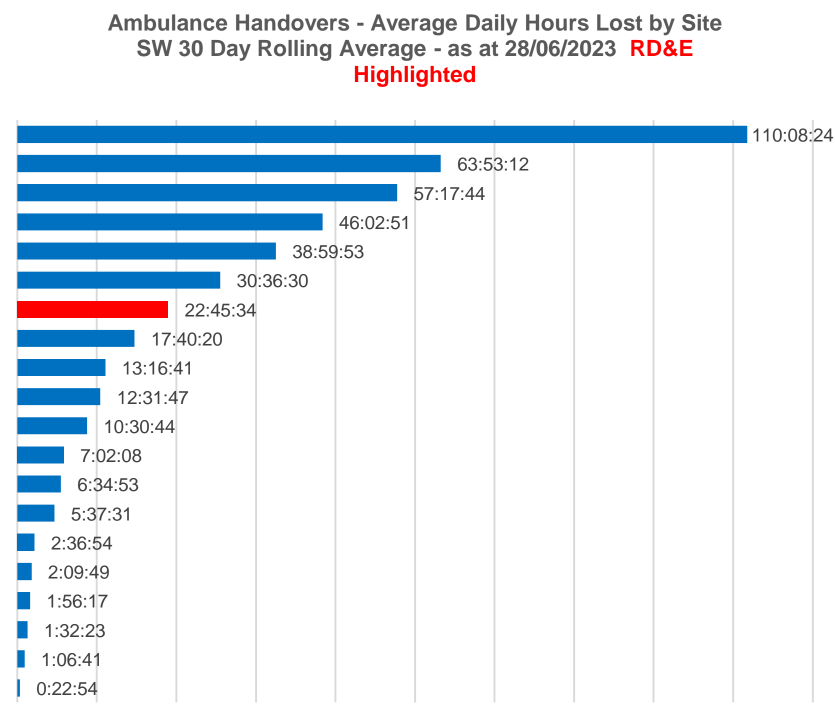
Overall performance

- All Type 4-hour performance improved slightly from **62.96%** in May to **63.91 %** in June.
- ED Type 1 4-hour performance **remained at 49.0% from May to June 2023.** The total accumulative time lost post DTA decreased from 4,169 hours lost from DTA to transfer/discharge in May to 2,553 hours in June 2023.
- The average number of ED attendances per day was 257 across June 2023 representing a high level of demand

Eastern Services Emergency Department

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





SDEC activity continued to increase with June up 4.4% on May with a week day average of 22 attendances per day. Admissions from SDEC reduced to 14.8%. Virtual Ward saw 189 admissions (149 Eastern & 40 Northern), 196 discharges and a peak number of patients of 50. Activity continues to maximise occupancy.

Points for escalation

- CAMHS operating in BCP resulting in no out of hours service provision and increasing numbers of children being directed to ED and increased LoS for children of >24 hours in ED.
- Mental Health demand remain high with limited bed capacity leading to long waits in ED and patients admitted to acute beds waiting for mental health beds
- Catchment resize SOP went live on Tuesday 13 June.

Actions being taken to improve performance

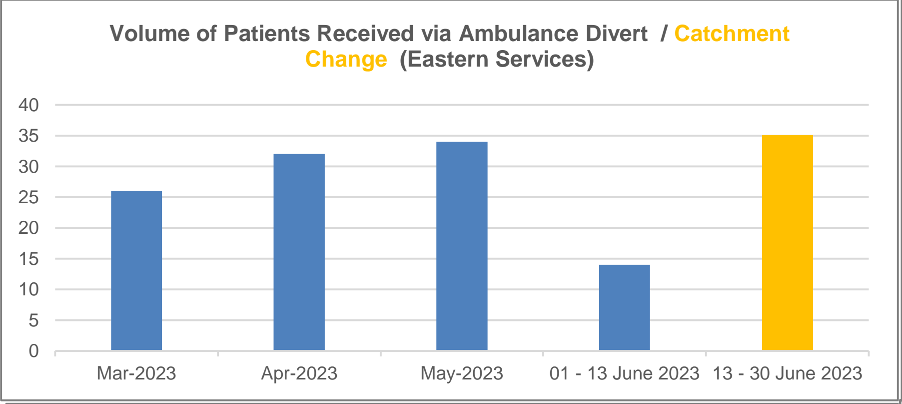
- Review of attendance avoidance opportunities highlighted by Deloitte report
- ED redesign - Minors / LAM Flip work has a revised completion date of the 17 July 2023 which completes the permanent reconfiguration of minors and majors
- Development of a minors stream focus to improve wait time in this patients group
- Awaiting confirmation of UEC funding for UEC schemes for GP Streaming, Low Acuity Attenders and E-triage awaiting
- Task and finish group to reduce attendances of specialty expected patients to ED.
- Implementation of Trust Internal Professional Standards.
- Focus on mental health patients pathways - COO to COO positive discussions on-going
- Renewed focus on target of moving all patients clinically ready to proceed in ED within 1 hour

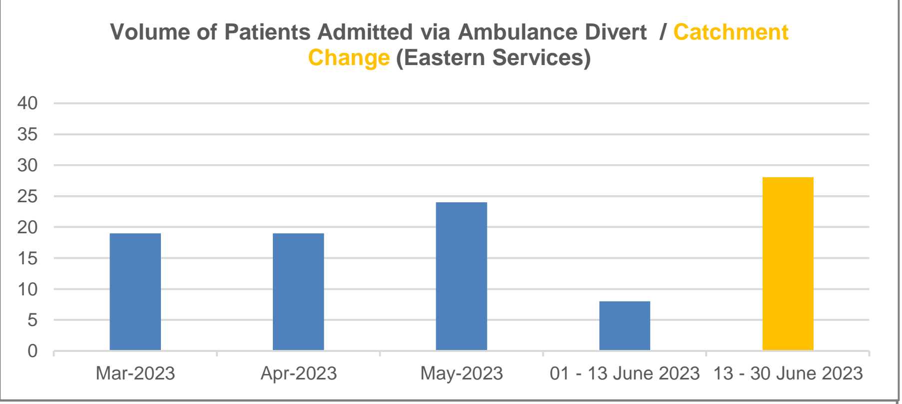
Focus on ambulance reporting

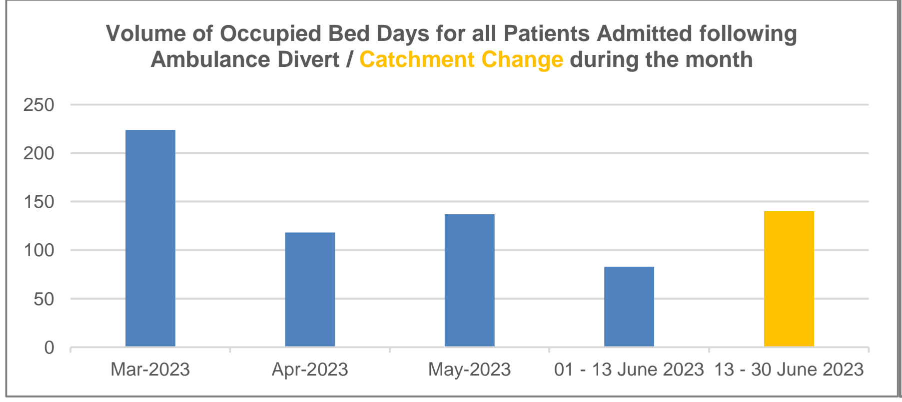
- Monthly ambulance handover meetings established with SWAST to review processes and improvements
- Regional Hospital Handover Data Quality Task & Finish Group
- Devon Ambulance Cell and ICB Eastern locality top 5 system priorities to improve ambulance handover delays; MH pathways, specialty expected patients to ED, GP streaming, ED e-triage and ambulance handover data validation.

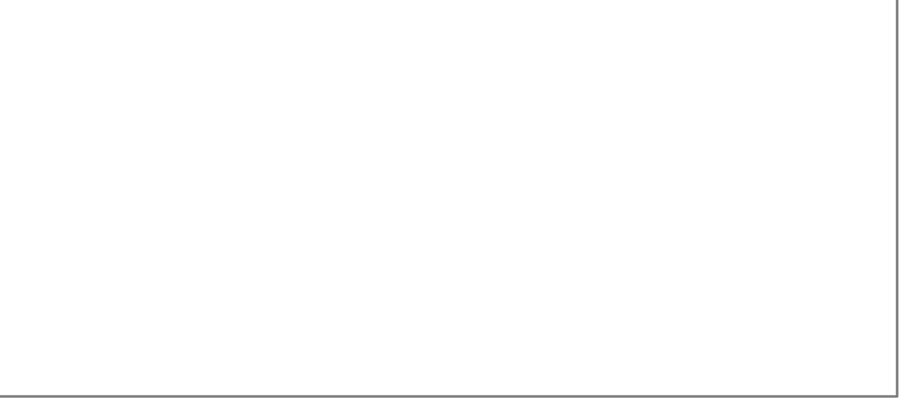
Trust – Provision of System Support for UEC

	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









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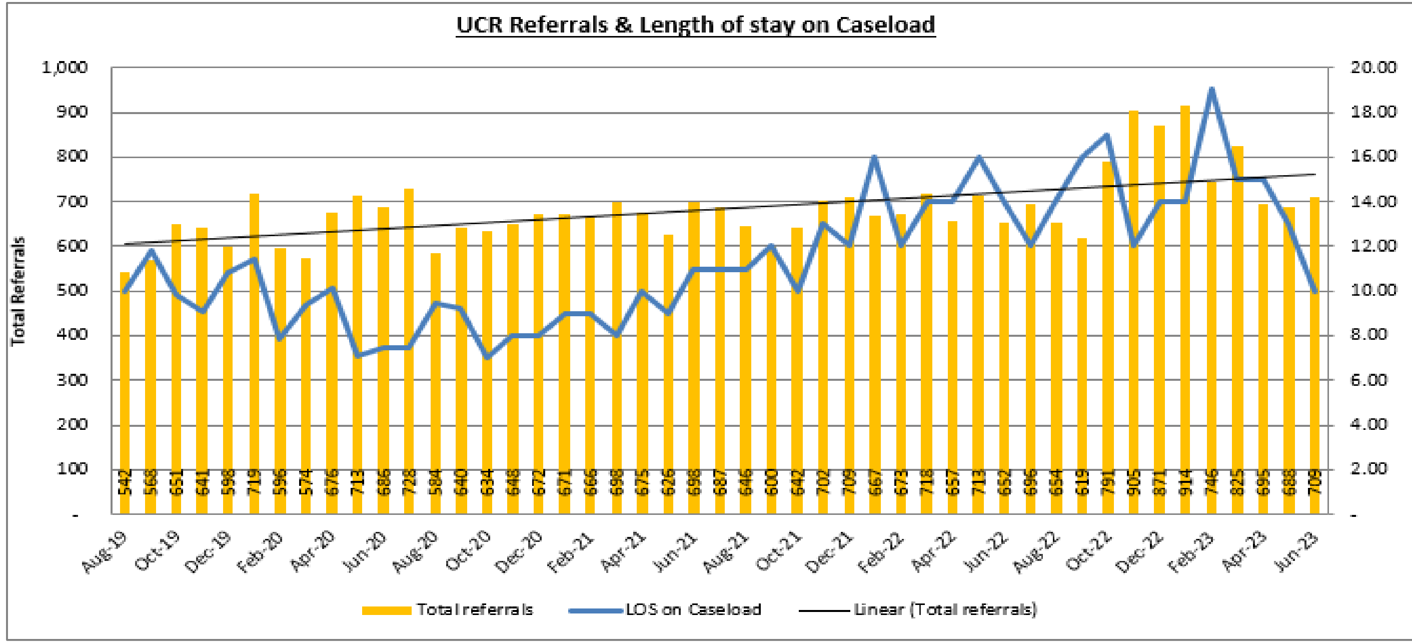
Trust – Provision of System Support for Planned Care

Number of Mutual Aid Requests received by RDUH					
	Received	Completed	Declined	Ongoing	Under Consideration
April 2023	2		2		
May 2023	3		2		1
June 2023	2			1	1

Number of Mutual Aid Requests made by RDUH					
	Made	Completed	Declined	Ongoing	Under Consideration
April 2023	1				1
May 2023	0				
June 2023	0				

Trust Urgent Community Response

Admission avoidance and discharge



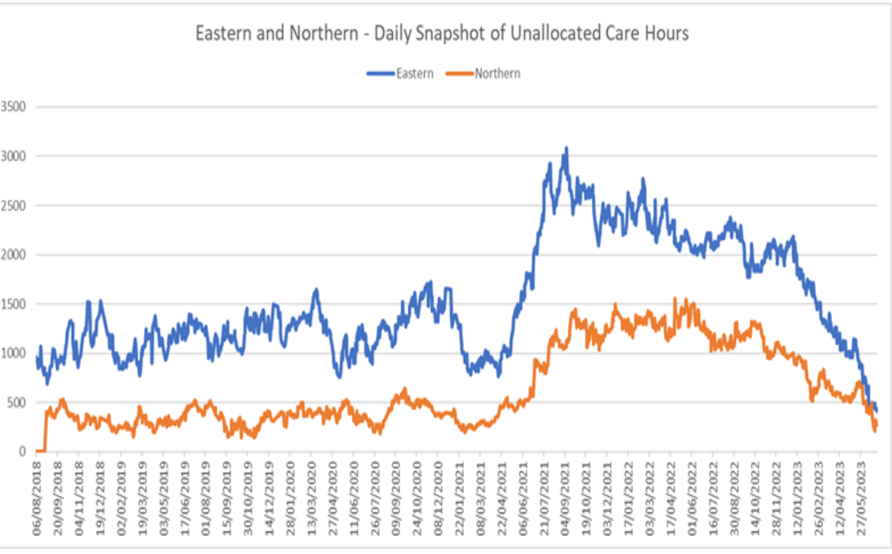
UCR Demand and Performance

- Demand for UCR (admission avoidance and supporting discharge) increased slightly from May into June but remains below the November – January peak in activity.
- Average length of stay has improved to 10 days which peaked in February at 19 days and has been consistently in the mid teens since July 2022. This improvement is due to a significant improvement in backfill due to a number of new providers entering the market with increased capacity to provide ongoing care and supported by 7 day stay reviews for Eastern services. The average number of patients on the caseload has reduced which offers the team more opportunity to complete quicker reviews and plans for discharge.
- There were 277 admission avoidance referrals in June, 56 of which needed a two hour response. 93% of these referrals were responded to within two hours which is commendable against a national target of 70%.
- SWAST referrals into UCR remained the same in June; 17 in total for Northern and Eastern UCR. Royal Devon linked in with system wide meeting with SWAST to ensure a joined up response and action across the system to ensure that this service is being utilised to it's full extent.

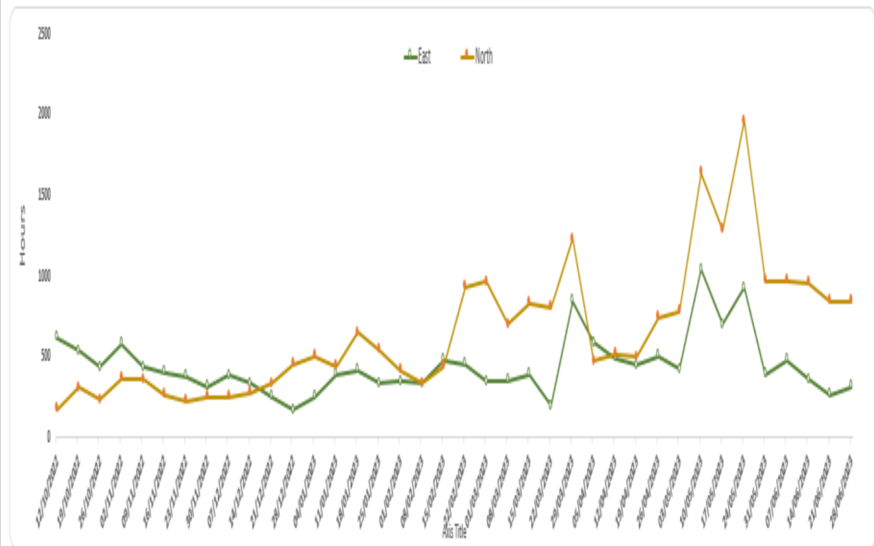
Northern and Eastern Community Services Unallocated and Backfill

Unallocated domiciliary care hours, and backfill position

Unallocated Hours - Post Care Act



Backfill Pre Care Act with onward Referral Not Made



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 continued improvement in the market position across Northern and Eastern due to ongoing work by the DCC market management team to stimulate the market with new care agencies coming online and international recruitment.

Eastern – Pre Care Act Backfill

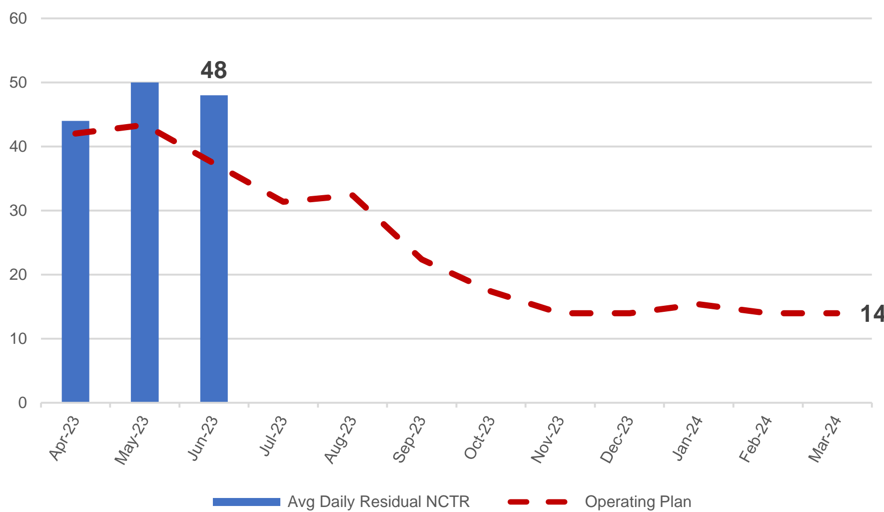
This is the lowest recorded figure in recent years. This is largely due to the impact of new providers and international recruitment improving market capacity. The measures put in place continue to improve the position with daily reviews of the caseload and backfill by UCR Leads, weekly 10 day length of stay meetings, complex hospital social care assessors linked to Community teams and utilisation of Community Service Managers for escalation of issues and weekly review of performance. Working on a trajectory of 200 hours by November 2023.

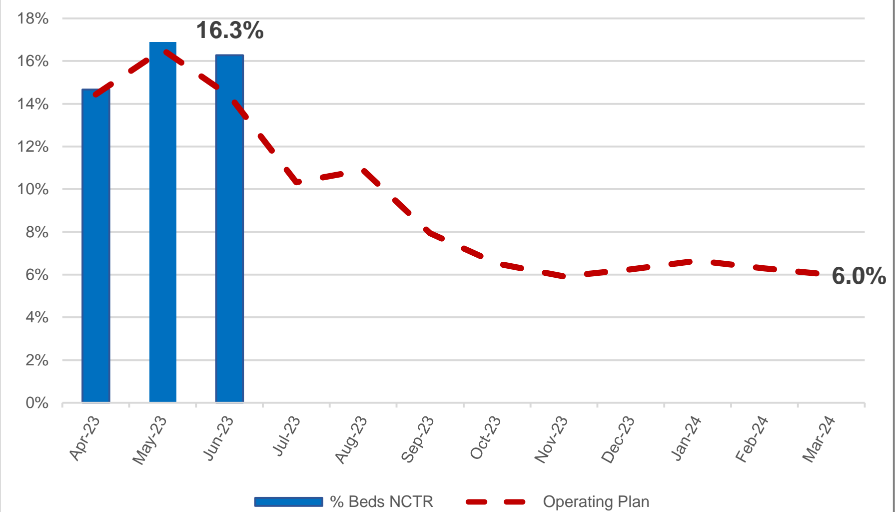
Northern – Pre Care Act Backfill

Northern are showing an improving position with improved market position as noted above. Twice weekly huddles are set up for escalation to CSMs and enables escalation to occur where allocation for a care act assessment exceeds 5 days. An additional short term social worker supporting the hospital discharge team from 09th July will have an initial focus on patient flow to help enable a 36% reduction by the end of July and the team are also looking to change the model for the care act assessment to involve Community teams / Care Direct Plus. Both these actions will look to positively impact the backlog for continuous improvement and work towards the trajectory of 200 hours by November 2023.

Northern Services No Criteria to Reside

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





Pathway 0

P0 position is steadily improving as measures implemented to improve the position take effect.

Actions to Improve Performance

- Training planned for new junior doctor cohort in August to continue Criteria Led Discharge
- New Frimley workflow will facilitate timely discharge and identify any barriers early in the pathway
- Monitoring of a new watchlist with live data to undertake immediate actions where barriers are identified
- The new discharge lounge is facilitating timely discharge with an increase in the number of patients being discharged through the new lounge
- Implementation of recommendations from recent Peer review underway to improve all pathways

NCTR position

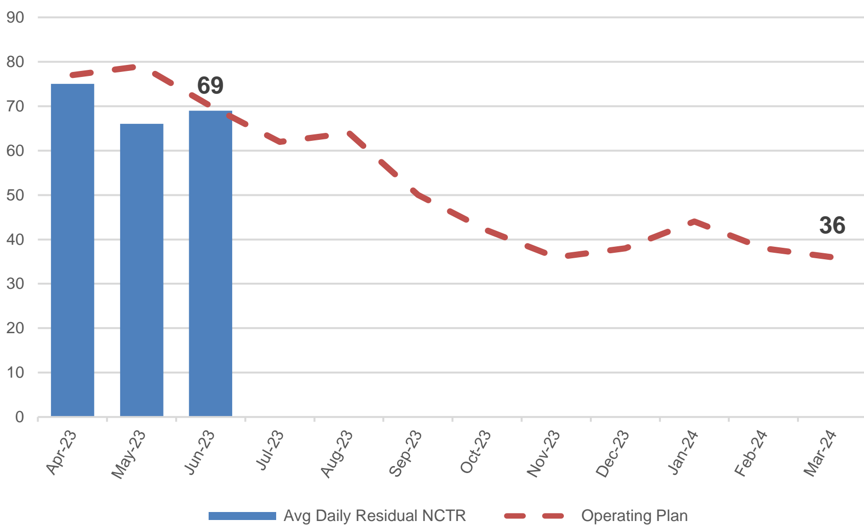
- The overall NCTR position improved slightly in June but is above the trajectory for this month. Time to transfer timings on P1 – 3 are not currently recording accurately but will be provided when new EPIC build goes live in September.

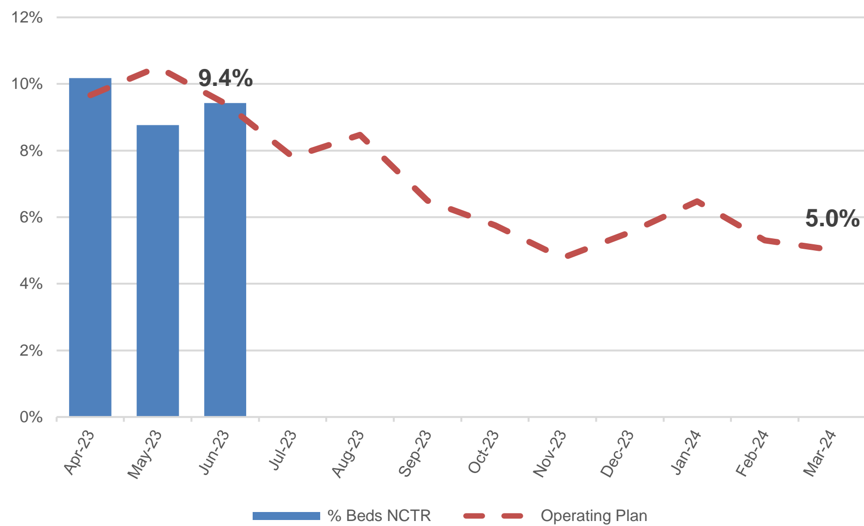
Actions to Improve Performance

- UEC business cases drafted (pending funding decision) for Northern and Eastern services for continuation of live in carer service and additionality of 1:1 support in care homes to enable efficiencies on pathways 2 and 3.
- Improved occupancy (aim 80%) for P2 beds by reviewing extension to short term placements, earlier escalation of delays in completing the care act assessment, increased use of Social Care Reablement to facilitate discharge, identify where admission could have been prevented and ensure standardisation of rehab received.
- Expediting backlog of patients awaiting care act assessment to improve flow with trajectory for improvement set – supported by additional social care role and changing who completes the care act assessments. It should be noted that social care capacity remains an issue.
- Further development of the new Hospital Discharge team – increased involvement and earlier discussion at Board rounds / with wards, improved case management and development of assistant practitioner roles to review goals for earlier release of care capacity
- Targets set to support NCTR trajectory for number of discharges per week and maximum number of patients waiting per pathway 1-3
- NCTR escalation calls set up bi-weekly to monitor targets and take action where required

Eastern Services No Criteria to Reside

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





Pathway 0 (focus on morning discharge)

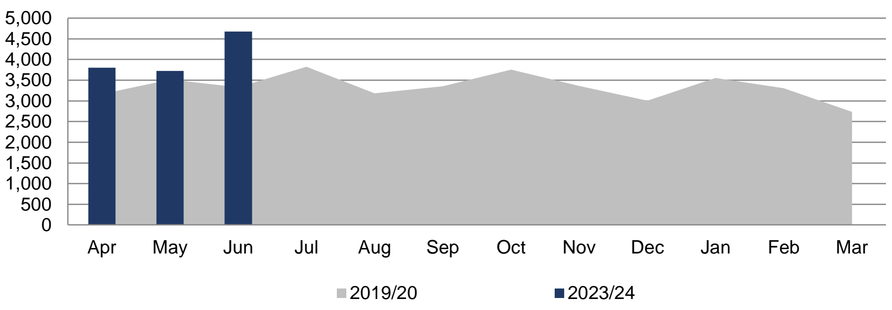
- Criteria Led Discharge utilising the EPR is now in place on a number of wards across Eastern Hospitals. Roll out continues.
- Plan being developed to implement Afternoon Discharge Huddles across all acute and community wards. Pilot wards have seen improvement in morning discharge
- EPR workflow, based on Frimley Park workflow, is being developed, which will facilitate timely discharge and identify any barriers early in the pathway
- Discharge Workshops for ward teams planned for August and September

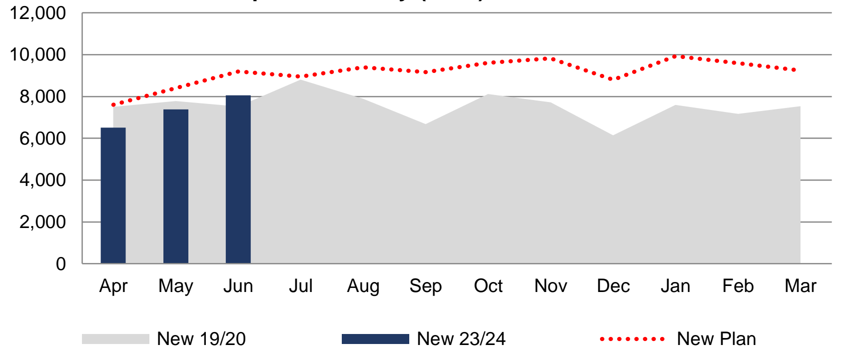
Pathways 1 – 3

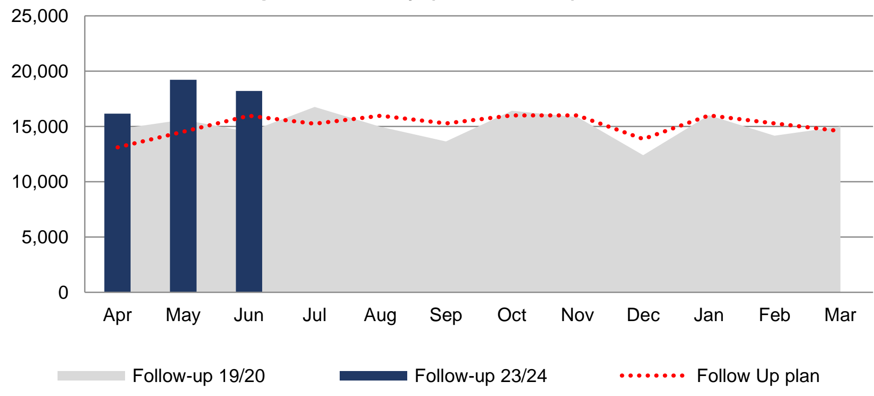
The national target of 2 days time to transfer for Pathway 1 was maintained this month. Time to transfer for Pathway 2 and Pathway 3 remained the same at 6 days and continues to be our focus for improvement.

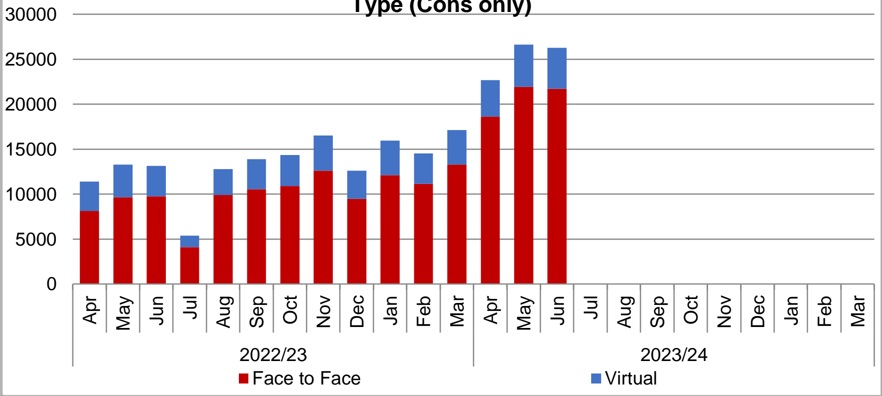
- UEC business cases drafted (pending funding decision) for Northern and Eastern services for continuation of live in carer service and additionality of 1:1 support in care homes to enable efficiencies on pathways 2 and 3.
- Daily rigour through Help Me Home Meetings with a view to change the structure of the meetings to locality led to expedite discharges
- Review of P2 model to align more with Northern services of block book beds with an aim to reduce length of stay

Northern Services Elective Activity- Referrals and Outpatients

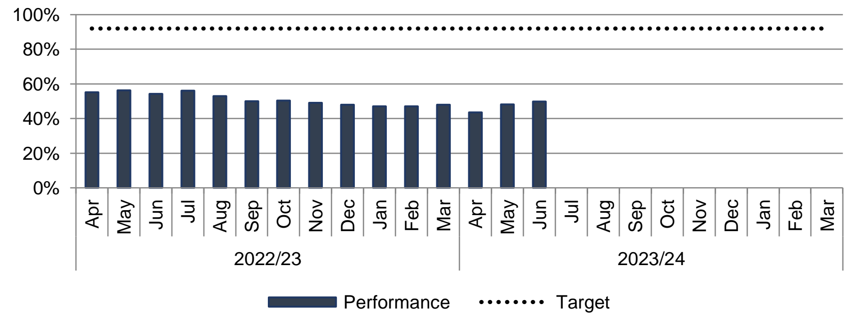








- There were a total of 26,259 Outpatients appointments held in June. Of this 26,259, 8,051 were New appointments and 18,208 were Follow-up appointments.
- 82.75% of appointments were held Face to Face and 17.25% were Virtual appointments.
- There was a slight increase in RTT 18 week performance in June.
- As these numbers reduce focus is moving to 65 weeks wait in line with the national aspiration to have no patients waiting over 65 weeks by March 2024.
- A Three day period of Junior Doctor Industrial Action caused a reduction in Outpatient activity as Consultants rearranged their schedules to provide sufficient inpatient cover on wards.



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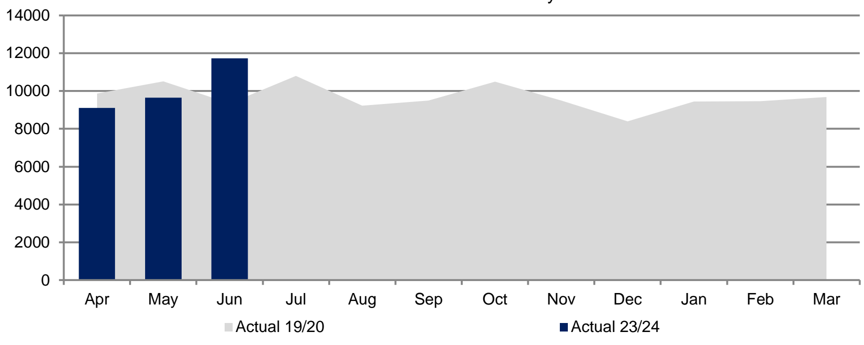
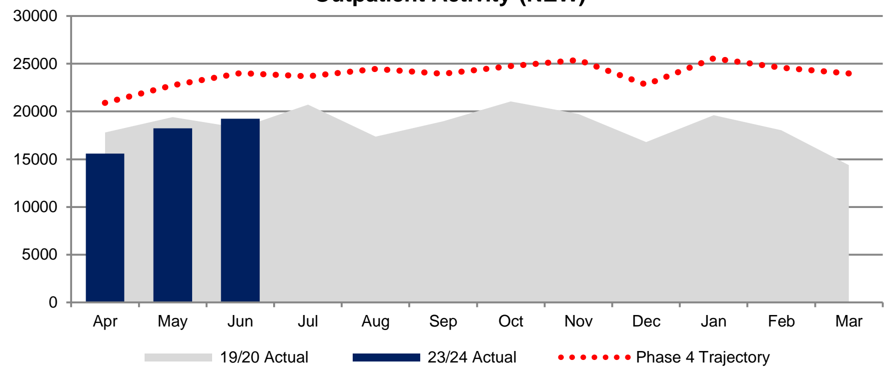
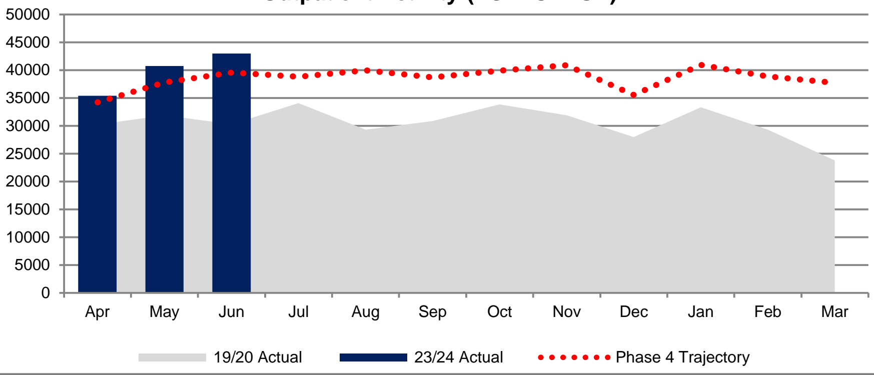
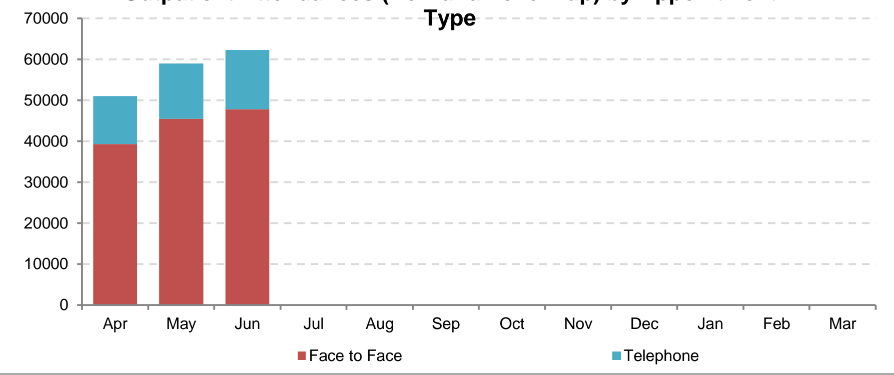
Eastern Services Elective Activity- Referrals and Outpatients







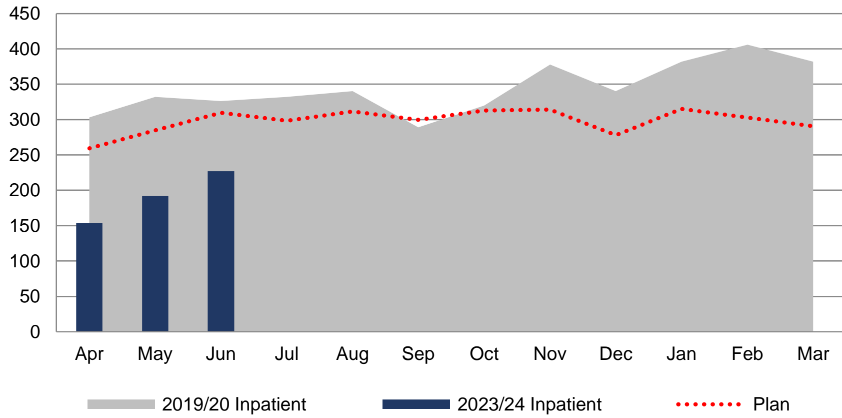


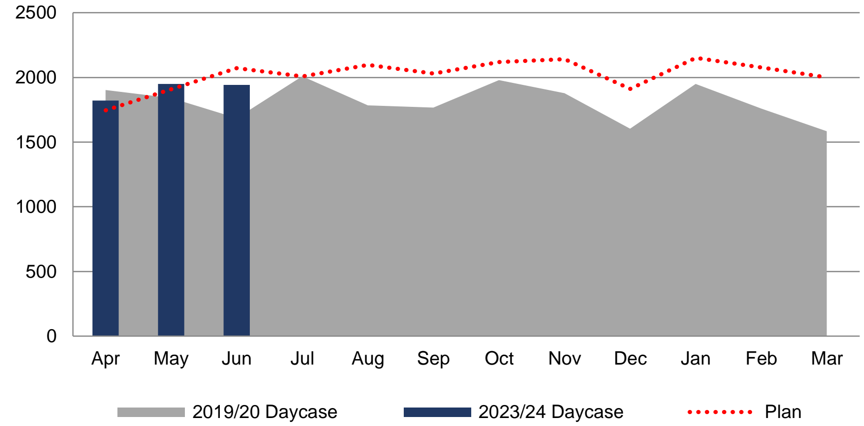
New Outpatient activity: was 105% of 2019/20 volumes, which is an improvement on prior month, and in excess of the NHSE target, but lower than planned activity. Month on month improvements were seen across all specialties, but with the great increase in Ophthalmology where services have expanded through ERF funding. Other notable increases in activity include Cardiology and Dermatology. Despite improvements, planned activity was negatively affected by industrial action, which is expected to continue into July.

Follow up Outpatient activity: was an increase on prior month, and above plan. One of the major drivers of the higher activity than 2019/20 is in community services, where activity is now recorded and reported, but was not in 2019/20. If adjusted, this take activity as a % 2019/20 from 142% to 125%. The major specialties that are showing higher volumes than 2019/20 are Ophthalmology (see above), General surgery and Orthopaedics, and Oncology and Gynaecology. The majority of these specialties either have large outpatient follow up backlogs or are seeing a greater number of patients as follow ups due to length of time between first appointment and surgery. This is expected to improve over time as time to treatment improves.

Outpatient Improvement/Transformation:
PIFU: 3.4%. Current performance is at 3rd Quartile, aiming for top quartile by rolling out to further specialties to improve performance. Gynae and Gastro (Trust wide) & in Breast Northern identified as key opportunities. PIFU also being expanded in 10 services already live. 2929 patients discharged to PIFU in April, Top 5 in the country for numbers on PIFU.
DNA: 3.7%. Current performance puts us in top quartile. Currently developing digital letters and 2 way text message service proposal to improve further.
Productivity: Clinic template review project underway with first 10 meetings completed and key themes identified for further improvement work. 2 specialties so far have agreed increase to templates.

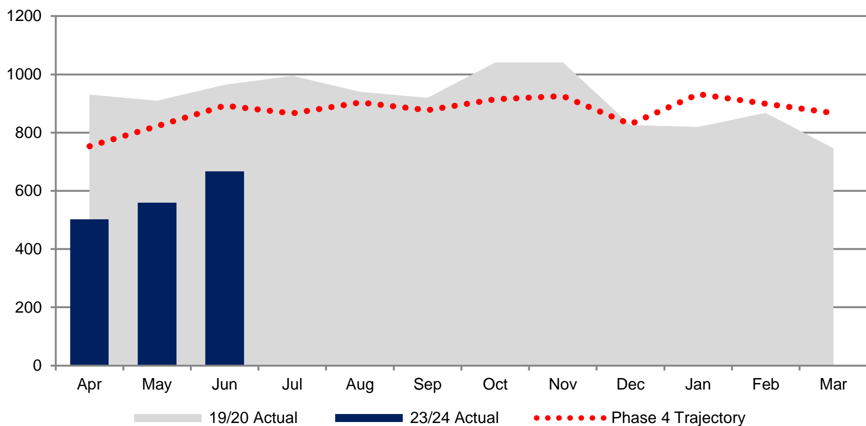
Northern Services Elective Activity- Inpatient and Daycase

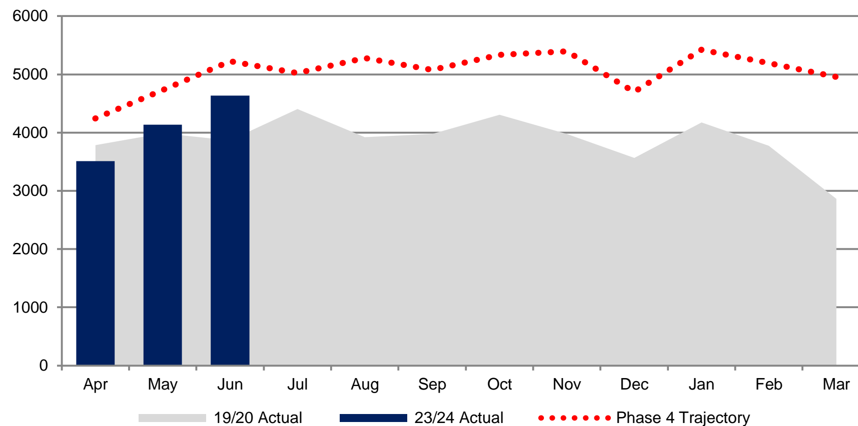




- Highest clinical priority patients and long waiting patients continue to be monitored weekly via the Patient Tracking Meeting (PTL).
- Elective Inpatient increased during June by 35 and Daycase activity decreased slightly during June by 7, this was due to Surgeon and Theatre Staff unavailability.
- A three day period of Industrial action by Junior Doctors between 14 and 17 June caused a reduction in elective activity during the month.

Eastern Services Elective Activity- Inpatient and Daycase

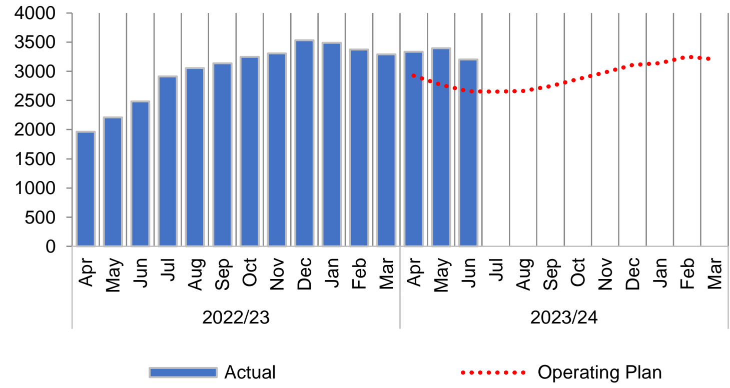


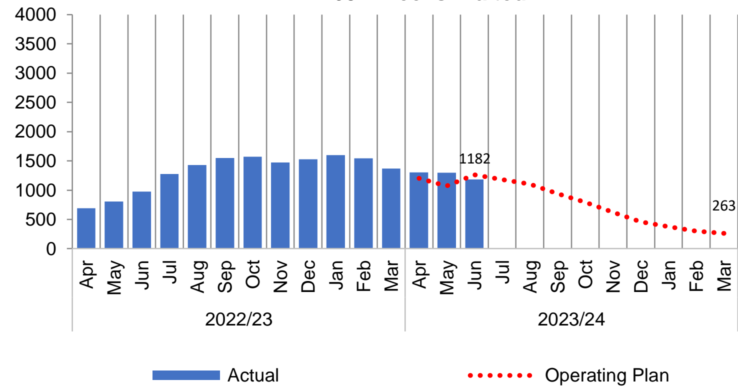


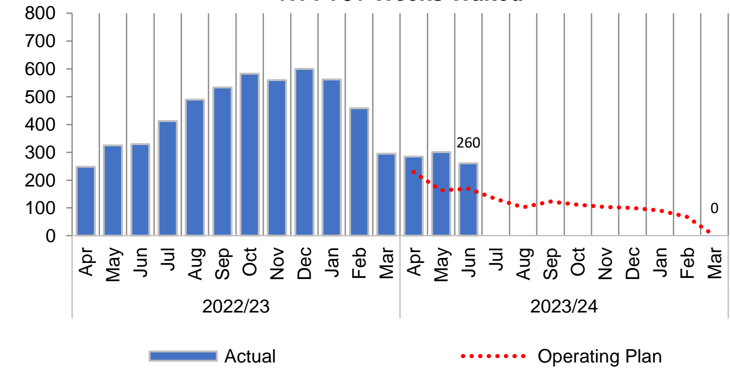
Daycase activity: was 120% of 2019/20, which is an improvement on the prior month, and higher than NHSE target, but still short of planned activity. The improved position was attributed to increases in Ophthalmology (ERF funded expansion at the Nightingale and Axminster), Plastic surgery, and Dermatology.

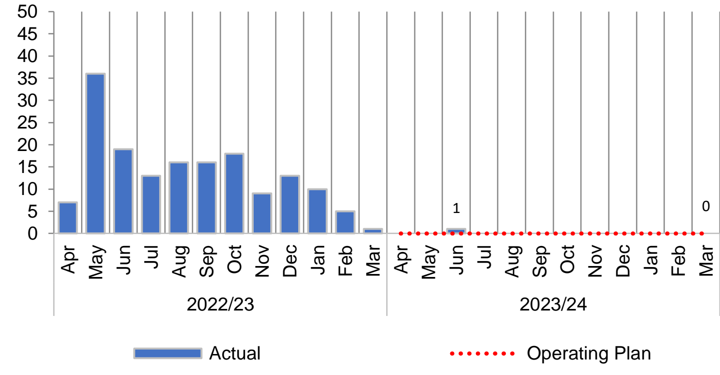
Inpatient activity: was 69% of 2019/20, which is an improvement on the prior month but still short of planned activity. The improved position was attributed to increases in Ophthalmology (ERF funded expansion at the Nightingale and Axminster), Plastic surgery, and Dermatology. The lower inpatient activity was planned for the current year, and is reflective of changes to intended management as a result of the EPR implementation (compared to 2019/20).

Northern Services Elective Activity- Long Waiting Patients



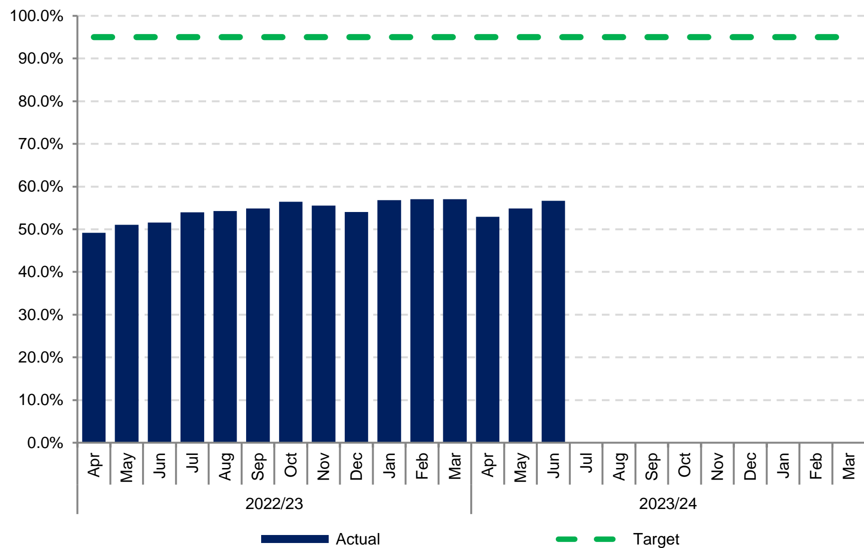


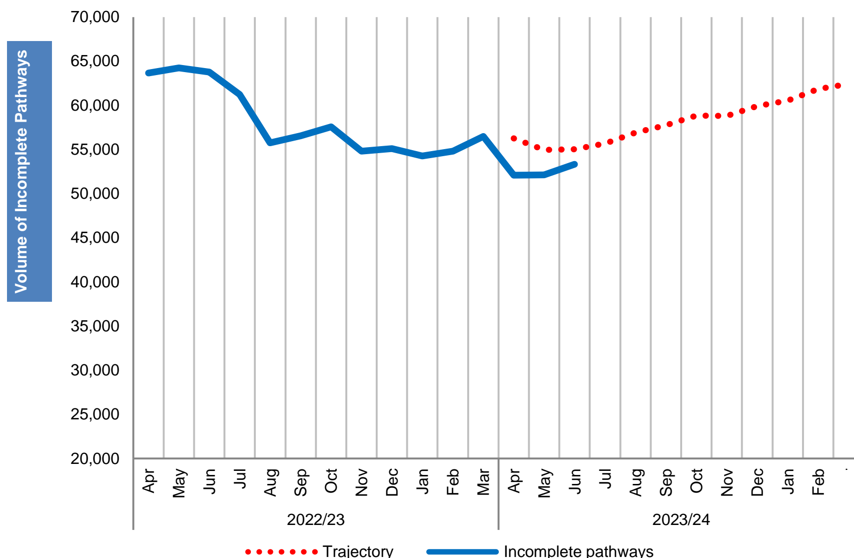




- Regular meetings are being held to ensure that the focus remains on the number of patients waiting longer than 78 and 52 weeks. In addition to focus on treating the longest waiting patients, additional capacity for earlier first appointments is being sought to support longer term and sustainable reductions in waiting times.
- There was one patient waiting 104 days, at the end of June as a result of an incorrect stop of an RTT clock. The patient is due to be treated in July.
- There are significant efforts being made to reduce the number of patients not yet seen by 52 weeks to help reduce the overall pathway. The number of patients waiting 52, 65 and 78 weeks continues to decrease.
- 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 June reduced to 261. This is expected to reduce further in July.

Eastern Services Elective Activity- Inpatient and Daycase

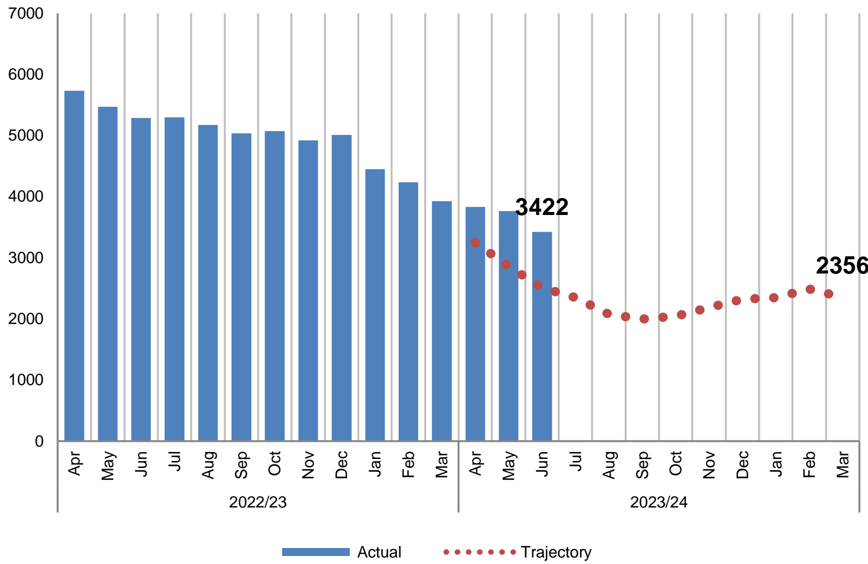


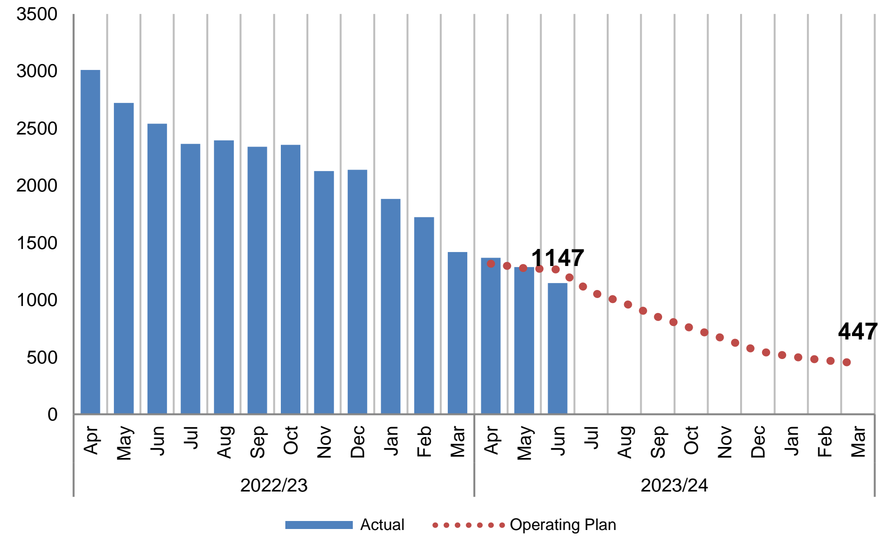


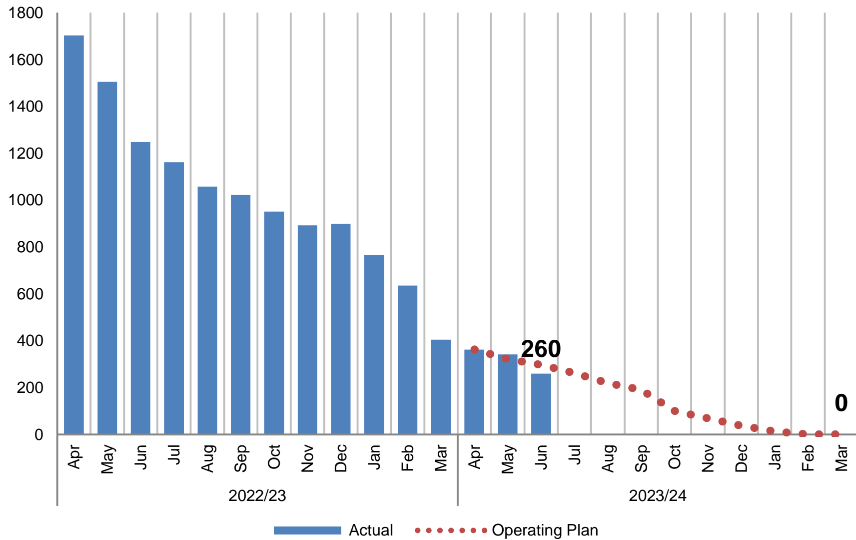
Eastern services incomplete pathways increased between May and June, which is due to clock starts exceeding clock stops, particularly during the weeks when industrial action took place in mid-June. This impact can be expected to continue into July with further industrial action planned.

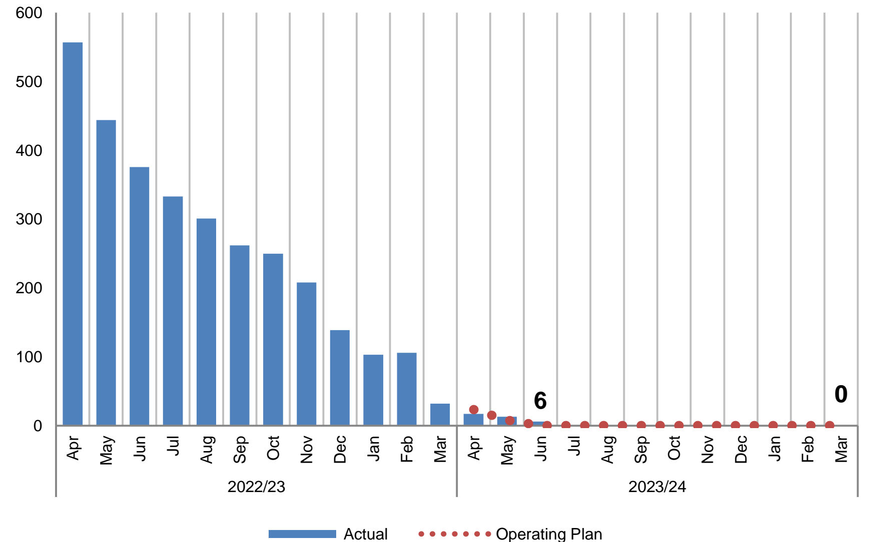
The RTT long waits position continues to improve across all wait categories month on month, but is behind plan in most areas, which is largely attributed to the impact of industrial action since April. The Trust was requested to formally re-submit long wait trajectories for 65+, and has improved the March 2024 plan from 868 to 710 Trust-wide, which equates to 447 for Eastern services.

Eastern Services Elective Activity – Long Waiting Patients









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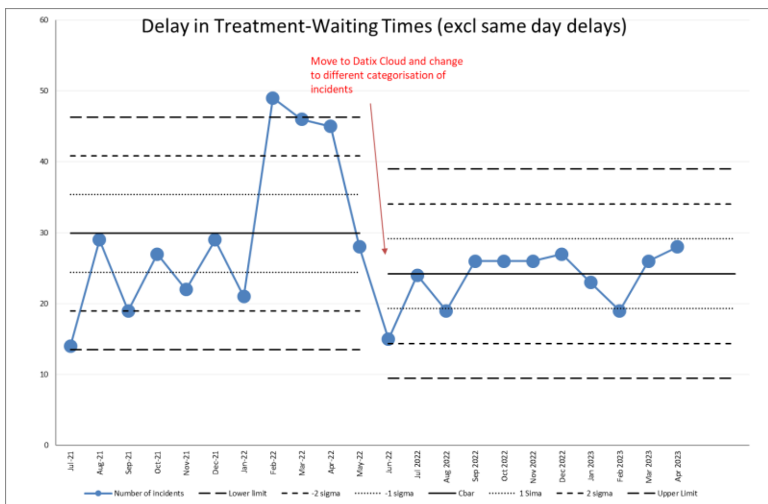
Northern Services Waiting Well

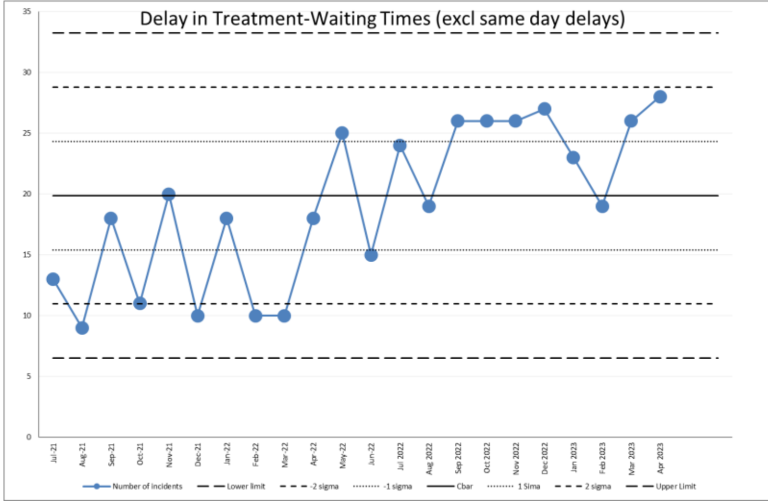
Across the same time period in Northern 12 incidents were reported for June 2023, these are broken down by the level of harm against stage of pathway below.



	None	Minor	Moderate	Major	Catastrophic	Total
New	1	3	2			6
Follow up delay	2	1	2			5
Surgery	1	0				1
Diagnostic request delay						
Total	4	4	4	0	0	12

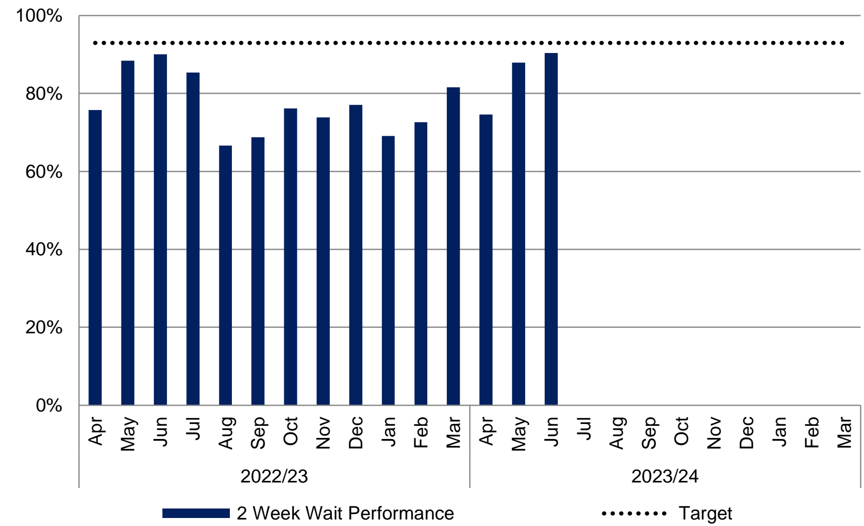
Eastern Services Waiting Well

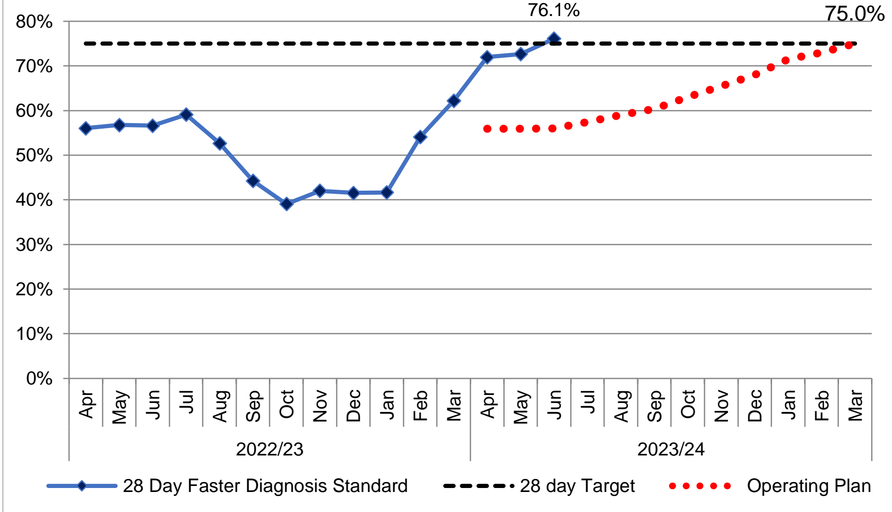
Across the same time period in Eastern Services, 25 incidents were reported for June 2023. These are broken down by the level of harm against stage of pathway below.



	None	Minor	Moderate	Major	Catastrophic	Total
Follow up delay	6	4				10
New	5	2				7
Surgery	5	0				5
Diagnostic request delay		3				3
Total	16	9	0	0	0	25

Northern Services Cancer 14 and 28 Day





2 Week Wait Performance

Performance demonstrates an improving trajectory with provisional performance for June at 90.4% from 87.9% in May. 2WW performance remains challenged in some tumour sites, the highest volumes of breaches in June are observed in:

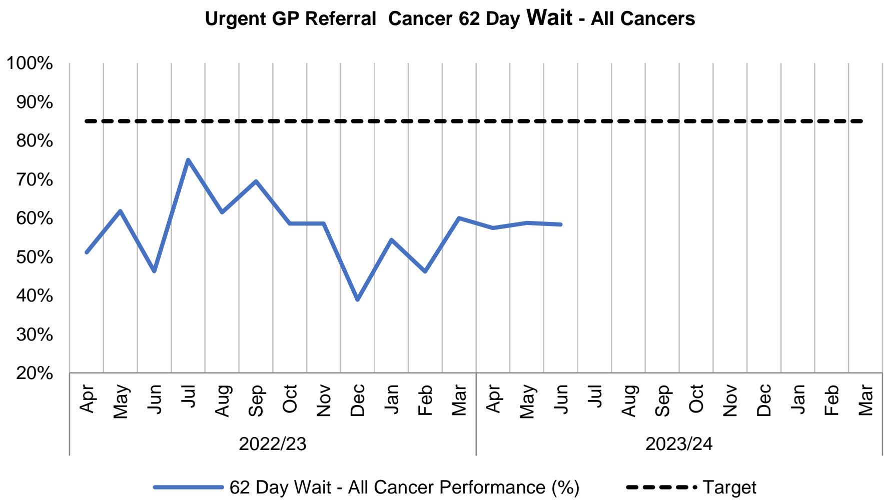
- Lower GI 27 breaches (84.8%) - staffing across the colorectal team remains under significant pressure, this combined with increasing volumes of referrals into the LGI service (20% increase in 2ww referrals since last year) has caused delivery of the 2ww target to be challenging. A significant amount of additional activity is being delivered to mitigate this position on a weekly basis. Locum and substantive consultant posts are out to advert, a provisional interview date for the substantive post is scheduled for early August.
- Gynae 17 breaches (81.3%) – capacity for both 2ww outpatient and hysteroscopy remains stretched, however additional clinics have been scheduled to limit this impact.
- Average waiting times for 1st OPA have improved to 8.4 days in June from 10 days in May across all 2WW tumour sites.

- All services are working to reduce first outpatient 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 75.7% in June. Provisional June performance of 75.7% would be the first month that performance has met the 75% target for over 12 months. 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 June are observed in:
    - Lower GI, 101 breaches (43.6%) This reflects service pressures and endoscopy waiting times, significant additional clinical activity including endoscopy insourcing is currently being delivered to maintain delivery. Transnasal Endoscopy (TNE) service is planned to go live in August which is anticipated to improve endoscopy waiting times.
    - Skin, 27 breaches (90.36%). Performance has significantly improved in recent months and is above target, but a number of patients do breach where diagnostic biopsies are taken prior to excision.
    - Urology, 24 breaches (66.2%). Performance has improved significantly over the last few months from 23% in February due to pathway improvements, which are ongoing.
    - Gynae, 17 breaches (75.4%), 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 improving in line with an improved backlog position, current (unvalidated) performance for June is 58.3% which is in line with the submitted performance for May at 58.7%. The majority of pathway delays are within the diagnostic and staging phase, particularly for Urology and Colorectal tumour sites.
- The largest volume of breaches for June is in Urology (7).
- 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 where currently there are delays for new patient appointments and treatments.
- Patients are monitored throughout their 62 day pathway regularly and weekly site specific PTL meetings are in place for all tumour sites.
- Every service has an up to date Cancer Recovery Action Plan with specific actions against delivery of each of the national CWT indicators where operational standards are not being achieved. These are monitored at the Northern Cancer Steering Group.

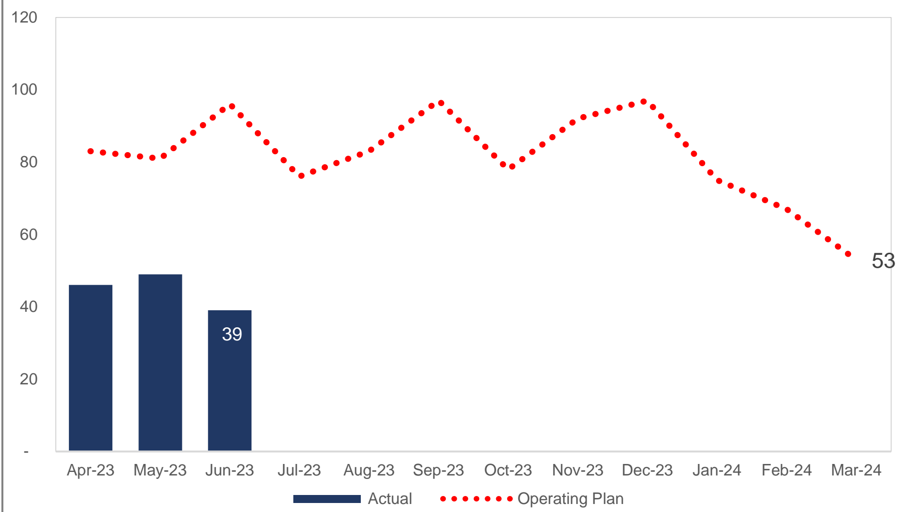
Please note for all 2 week, 28 day, 31 day, and 62 day cancer waiting times indicators, the most recent month's position is unvalidated, and reflects data that are not yet submitted nationally. These data will be refreshed in next month's report.

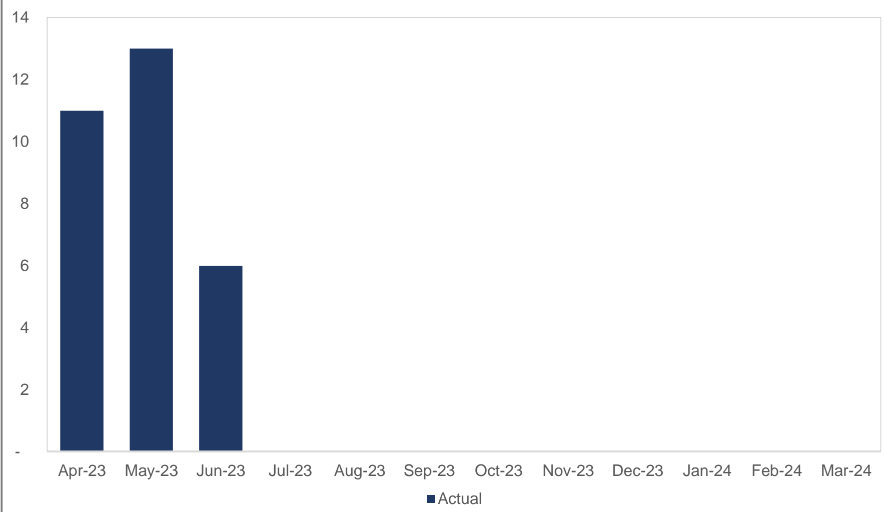
Cancer - 14,31 & 62 Day Wait

	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
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%	74.61%	87.91%	90.35%
	All Urgent (N)		154.0	98.0	90.0	76.0	294.0	282	186	214	138	217	190	146	193.0	102.0	87.0
	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%
	Symptomatic Breast (N)		42.0	13.0	12.0	0	1	0	0	2	4	9	12	12	10.0	2.0	2.0
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%	89.86%	92.54%	92.68%
	All Decision To Treat (N)		12.0	10.0	16.0	7	10	6	9	6	13	12	4	8	7.0	5.0	6.0
	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%	63.64%	30.77%	75.00%
	Subsequent – Surgery (N)		4.0	2.0	4.0	0	0	0	3	4	3	6	8	5	4.0	9.0	3.0
	Subsequent - Anti-Cancer Drug %	98%	60.00%	33.30%	33.30%	100%	100%	97%	88%	77%	93%	78%	100%	96.15%	88.24%	100.00%	90.91%
	Subsequent - Anti-Cancer Drug		4.0	2.0	4.0	0	0	1	3	13	3	8	0	1	2.0	0.0	1.0
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%
	All Screening Service (N)		0.0	1.0	0.0	0	0	0	0	0	0	0	0	0	0.0	2.0	1.0
	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%	64.52%	81.25%	77.50%
	Consultant upgrade (N)		8.0	11.0	6.5	5.5	5	8	6	5	5	5	3.5	5	5.5	3.0	9.0
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%	71.99%	69.41%	76.07%
	28 day Ref to diagnosis (N)		244.0	275.0	256.0	119.0	212.0	344	452	551	380	451	358	317	186.0	227.0	196.0

Northern Services Cancer 62 Day Backlog

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



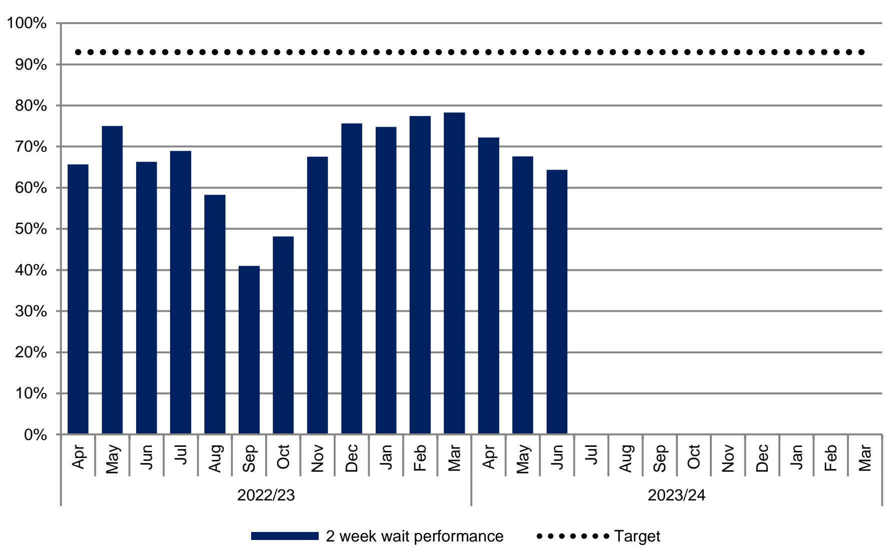


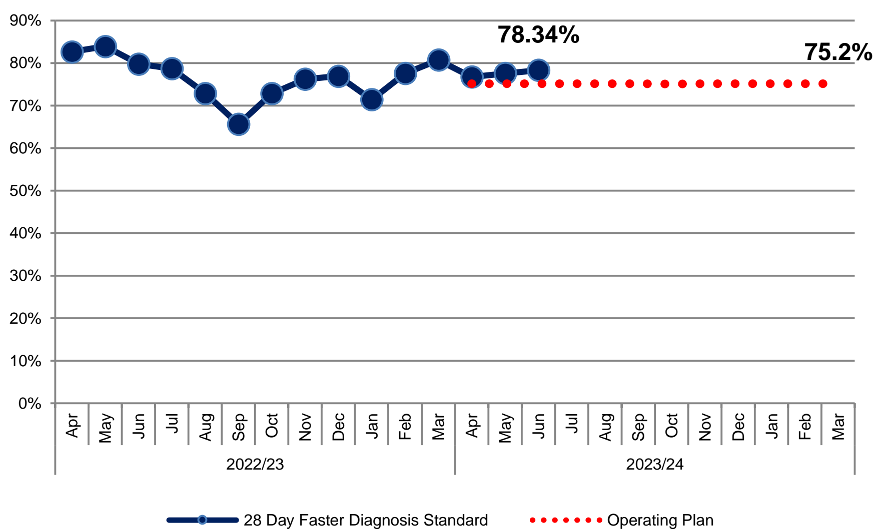
- The number of patients on active cancer pathways waiting more than 62 days has reduced from 395 (29.3%) at the start of September to 40 (5.6%) at the most recent weekly PTL (10/07/23) which is significantly better than trajectory and is now under the nationally recommended backlog threshold of 6.4%.
- The tumour sites with the largest number of patients waiting over 62 days are Colorectal (15 – 7%); Urology (9 – 9.8%). These volumes have been consistently reducing since January (from 72 Urology and 42 Colorectal), although Colorectal volumes have increased slightly over that last few weeks.
- There are 7 patients (10/7/23) that remain on a cancer pathway over 104 days, this volumes has been reducing slowly and reflects complex pathways, patient initiated and medical delays. Next steps are in place for all these patients and increased oversight arrangements are in place .

Key actions:

- Weekly PTL meetings in place for all tumour sites with action logs and formal escalation process in place.
- Colorectal - Substantive and Locum consultant posts out to advert. Interviews for the substantive post are scheduled for early August
- Endoscopy - insourcing/weekend lists remain in place and further insourcing capacity with additional provider has now commenced, TNE service planned to start in August.
- 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





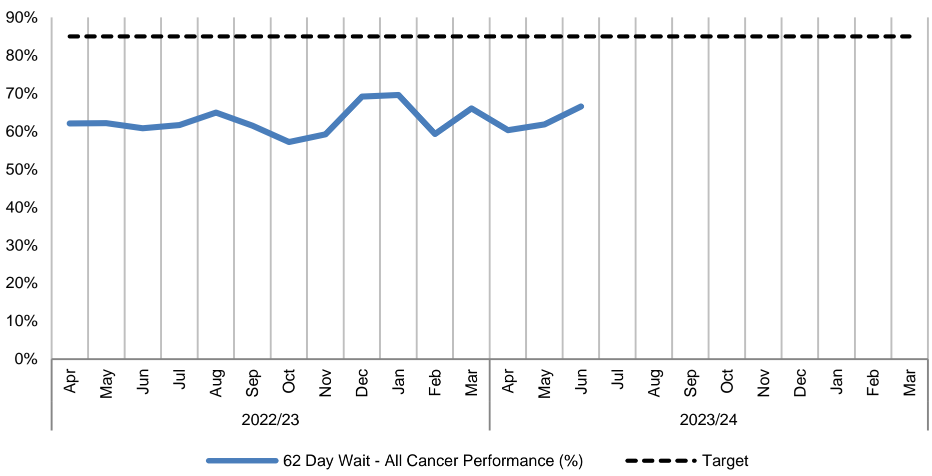
2 Week Wait Performance

Performance across the East has been declining since April – due to both Bank Holidays and Industrial Action, combined with an increase in 2WW Referrals (i.e. approx. 300 for the week of 07/06/2023 for Dermatology). Where possible additional clinics have been sought to mitigate these challenges.

- Endoscopy – Interim mobile unit at Tiverton due for delivery 24th July. Planning is underway for a 7 days a week colonoscopy service to be live towards the end of September 2023 and to run for 12 months. 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).
- Gynaecology 2WW performance remains challenged due to an imbalance of demand/capacity (increased demand during a period of Leave/Absence etc.) however this is being rectified with additional WLI for both PMB and Hysteroscopy clinics. Super Saturdays are planned to continue reducing the current backlog.
- Urology continue to fail to meet the 28 Day target for Prostate. Redesign of process and a workforce restructure within the CNS Team are underway to support this pathway, moving triage to the Clinical Nurse Specialist Team and additional transperineal (TP) Biopsy capacity to be included. Successful recruitment of the Band 8a CNS with a start date in October. It is noted that recovery is reliant on Radiology and Histology and quick turnaround times.
- Breast are currently maintaining performance by cross-covering (due to continued Consultant absence) – however are currently out to recruit for a Locum post to protect the current position as well as the wellbeing of the Team. The Northern team are supporting the service by treating patients on the periphery of the borders.
- Upper GI Outpatient capacity is improving. Unfortunately Oesophagogastro duodenoscopy (OGD) capacity remains challenged.
- Skin performance is currently maintained using WLI and good-will of Consultants. However spikes in referrals (up to 300 per week) have been noticed in June. AI is due to be implemented in August 2023 with one clinic per week currently planned.
- Radiology – CT and MRI turnaround times continue to improve for 2WW patients (11 and 13 days for request to report in June for CT and MR patients respectively). 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 for Sept 2023 with a further advert going live this month.

Eastern Services Cancer 62 Day

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



- Oncology appointments across most Specialities are challenged for capacity, particularly in Lung.
- Theatre capacity remains challenged. Additional Saturday lists have been sought for Urology.
- A proposal for substantive ERF Colorectal Consultants, is being considered
- Histology – Turnaround times are stable and will improve when the new consultant pathologist comes into post in August. The further two consultants 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.

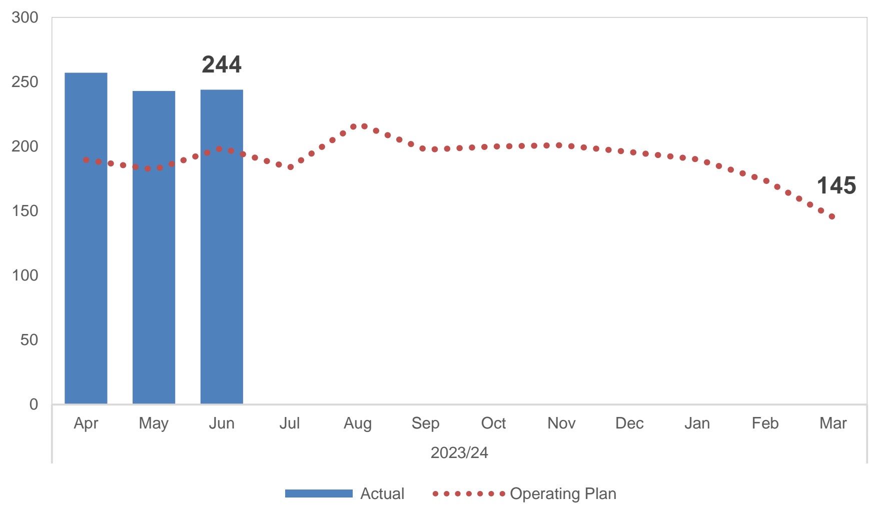
Please note for all 2 week, 28 day, 31 day, and 62 day cancer waiting times indicators, the most recent month's position is unvalidated, and reflects data that are not yet submitted nationally. These data will be refreshed in next month's report.

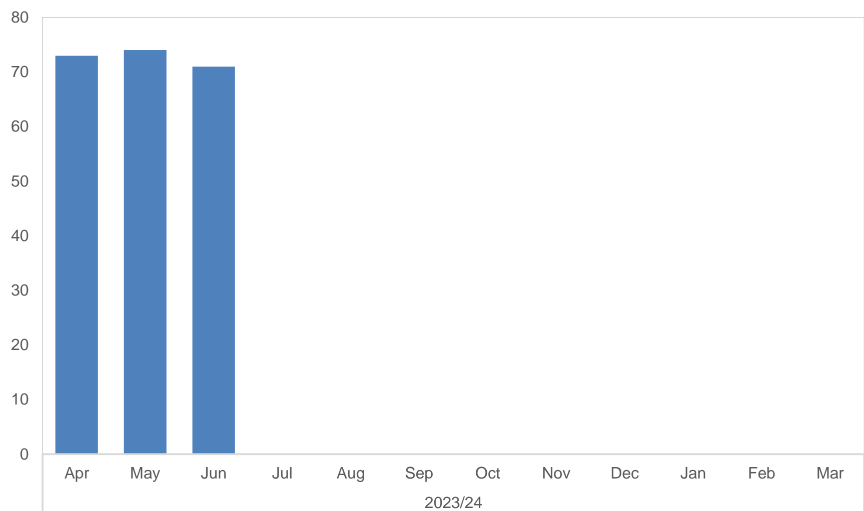
Cancer - 14, 31, 62 & 104 Day Wait

	Performance(%) and Number of Breaches	TARGET	2022/23												2023/24		
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
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%	72.2%	67.6%	64.3%
	All Urgent		760	605	762	763	1027	1434	1253	818	488	559	470	550	552	758	972
	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%	94.6%	91.2%	79.3%
	Symptomatic Breast		34	46	18	20	13	30	25	14	1	2	0	5	2	3	6
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%	86.5%	85.8%	90.3%
	All Decision To Treat		31	41	34	37	22	21	18	31	25	72	40	34	32	41	39
	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%	75.9%	72.5%	59.8%
	Subsequent - Surgery		29	26	25	21	17	28	18	11	14	44	30	34	19	25	41
	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%	98.1%	97.7%	96.0%
	Subsequent - Radiotherapy		0	1	4	1	2	1	1	1	1	0	2	1	2	3	5
	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%
	Subsequent - Anti-Cancer Drug		0	1	0	0	2	0	0	0	0	1	3	4	0	0	0
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%	5.6%	28.9%
	All Screening Service		3.5	2.5	2	2	4	1	2	4	2	2.5	5	7	2	8.5	13.5
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

Eastern Services Cancer 62 Day Backlog

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





Activity & Flow

Operational Performance

Patient Experience

Quality & Safety

Our People

Finance

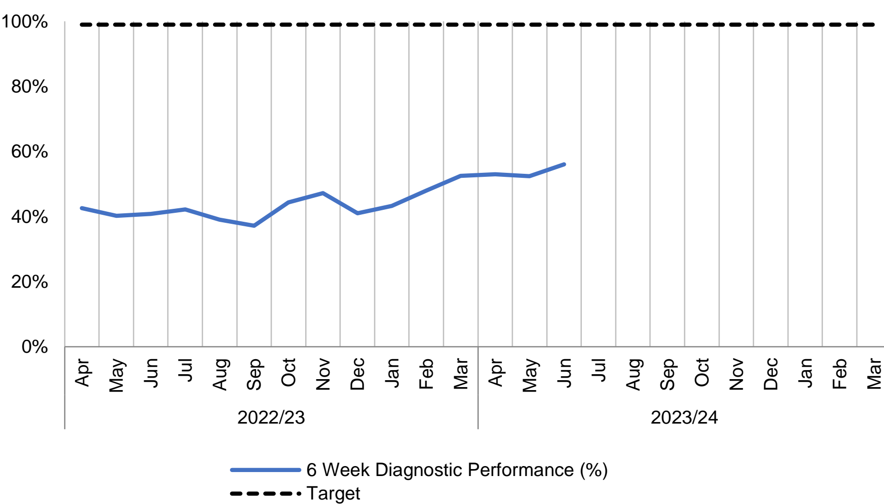
Challenged tumour sites

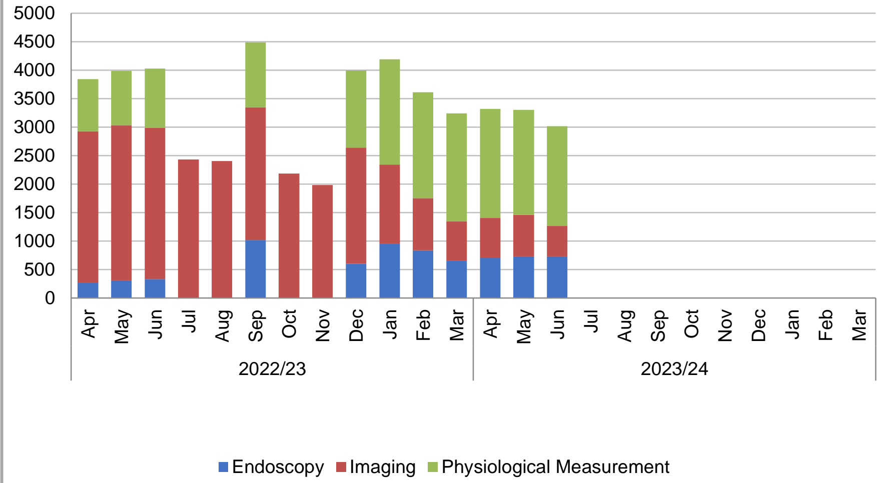
- Urology – challenged due to a group of RALP referrals and late tertiary transfers. A request for Mutual Aid support was unsuccessful. A new clinic has been introduced in a referring centre with an Eastern Consultant to support streamlining of the pathway and review the appropriateness of referrals. Additional capacity (Super Saturdays) will support the reduction of the RALP backlog. Third RALP surgeon is currently in training and is due to have completed their training in Q2 FY 23/24. Consideration for using insourcing company to potentially provide additional capacity
- Lung - Increased number of long waiting patients; reviewing Radiology pathway. There are also delays in Oncology clinic capacity – currently 3 week wait for appointment prior to treatment.
- Upper GI - have a higher than expected number of long waiting patients, in part due to a number of patients waiting approx. 4 weeks for their first OPA. Additional capacity has been sought and performance should improve in the coming months.
- 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. Advertising for Gynae-Oncology Consultant. WLI's are being undertaken to minimise the impact on performance.

Key Actions

- ***Upper GI –*** *Substantive Consultant Gastroenterologist post out to advert (3 WTE Vacancy)*
- ***Gynaecology –*** *Substantive Consultant post out to advert*

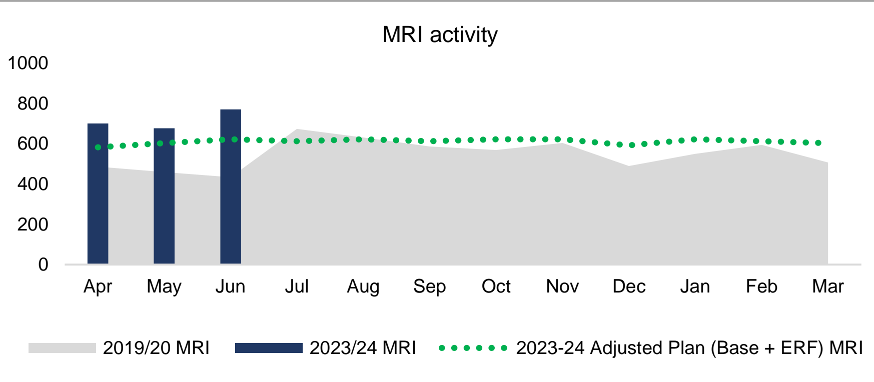
Northern Services Diagnostics - *Fifteen key diagnostic tests*

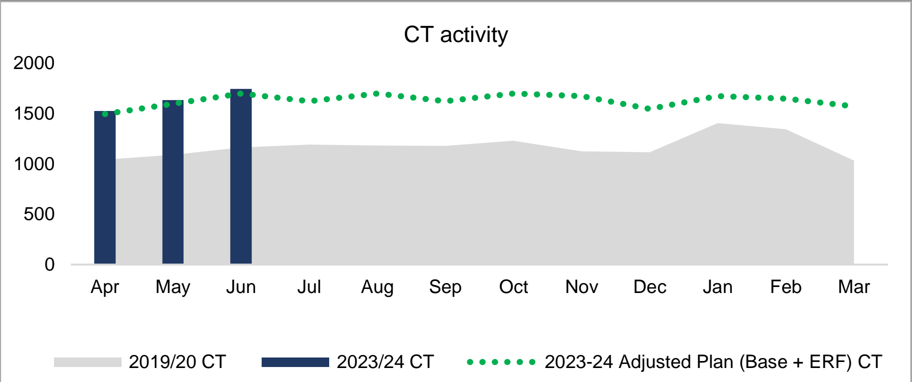


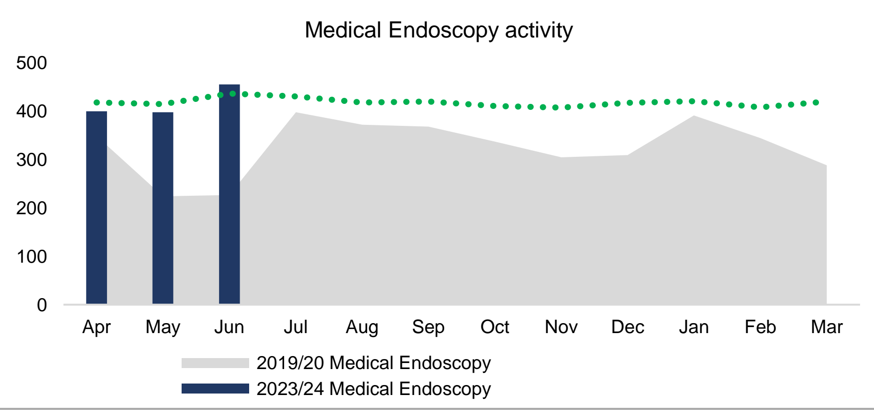


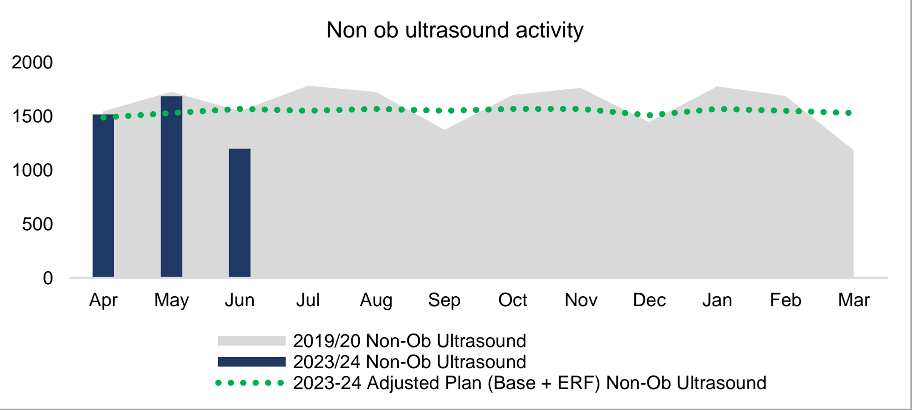
Area	Diagnostics by Specialty	Achievement against the 6 week wait from referral to key diagnostic test														
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Imaging	Magnetic Resonance Imaging	96.5%	96.7%	94.6%	97.7%	100.0%	100.0%	99.4%	99.7%	99.7%	96.9%	97.6%	98.4%	97.7%	98.5%	98.9%
	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%
	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%
	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%
Physiological Measurement	Audiology - Audiology Assessments	100.0%	100.0%	100.0%							100.0%	100.0%	99.1%	97.3%	94.8%	97.7%
	Cardiology - echocardiography	31.4%	26.6%	28.3%						27.9%	18.6%	23.0%	23.4%	25.2%	24.4%	28.2%
	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%
	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%
	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%
Endoscopy	Colonoscopy	62.3%	48.6%	43.8%			27.6%			30.6%	32.7%	34.2%	39.5%	37.7%	36.8%	34.6%
	Flexi sigmoidoscopy	64.8%	71.8%	70.3%			28.5%			42.9%	30.9%	29.7%	40.1%	42.8%	39.0%	44.9%
	Cystoscopy	67.0%	75.6%	73.3%			59.8%			74.4%	42.6%	48.4%	83.3%	81.3%	88.9%	91.8%
	Gastroscopy	70.9%	61.9%	60.8%			53.1%			44.9%	39.1%	41.3%	48.2%	41.9%	37.6%	40.9%
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%

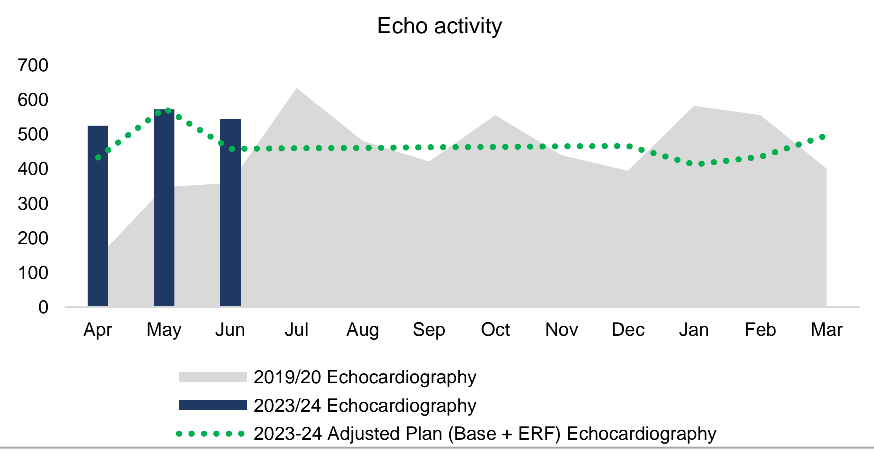
Northern Services Diagnostics - *Diagnostic activity compared to plan across key diagnostics modalities*











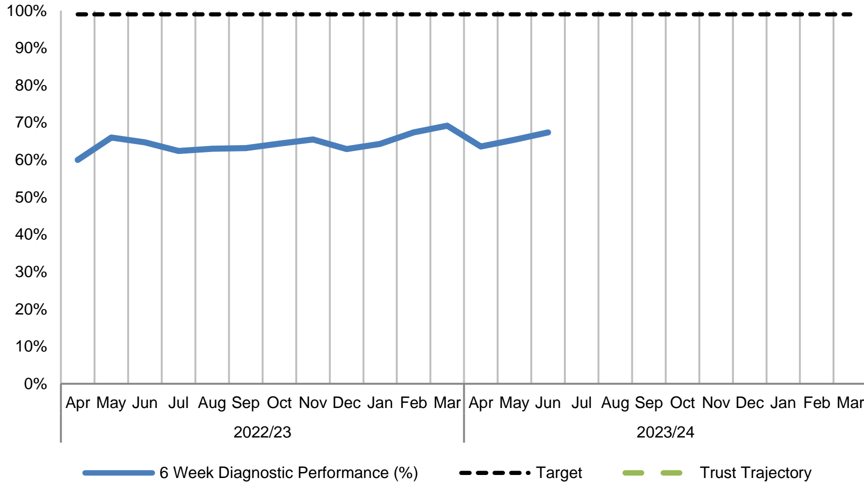
Northern Services Diagnostics

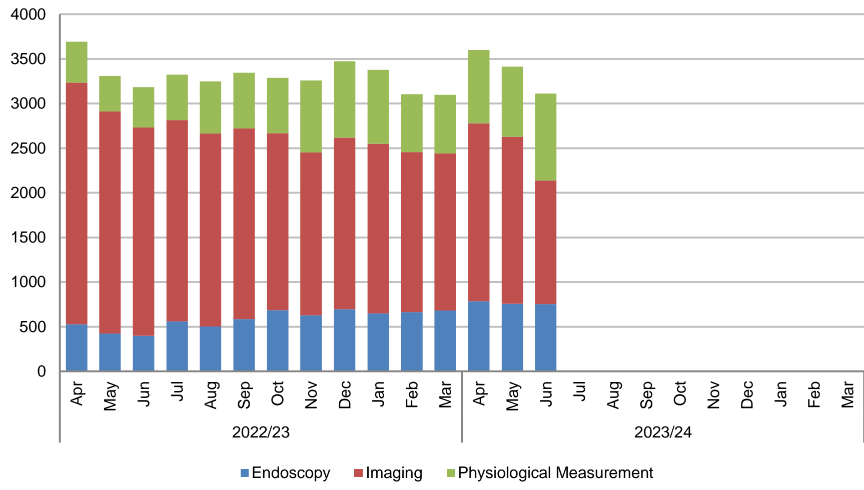
Key issues at modality level:

- **MRI –** MRI activity is above plan and performance is being maintained.
- **CT – Non-Cardiac CT –**We have increased capacity in planning for 23/24 to meet demand and currently at 94% 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 has 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 from 4 sessions in July to 1.5 sessions. This reduction has been extended into September. We continue to work with our colleagues to align resources and monitor performance but this reduction in capacity will result in a decline in performance for Northern CT cardiac scans.
- **U/S-** We have been able to continue to provide some internal lists over weekends to continue to improve performance. We are also looking at outsourcing options available to maintain and continue to improve this position, and have now requested some capacity (initially 200 scans) at the Eastern CDC and await to hear an outcome. Ultrasound has moved from 36% of patients being seen within 6 weeks in January 2023 to 87% in July 2023 but we still have some recovery to achieve.
- **Endoscopy** -Consultant Gastroenterologist vacancies remains a key constraint. Bi-weekly Task and Finish Group has been set up to review ongoing data quality post Epic implementation and to review utilisation of lists. Current capacity is ringfenced for cancer and urgent cases. To further increase capacity an additional of trans-nasal Endoscopy has been identified and this additional capacity will be in place in early August. This will increase gastroscopy capacity and will indirectly support 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 Echo's.
- **Sleep studies –** Additional capacity has been identified across clinics, nurses will carry out additional lists and a Clinical Admin post has now been shortlisted with interviews to be held on the 10th August. Bi weekly Monday clinics will commence from the 17th April seeing an additional 4-5 patients per clinic
- **DXA –** DXA improvement continues with 28% performance in May 2023 to 41% in July 2023. Since the previous IPR; total waits have continued to be reduced in line with the trajectory, this is still reliant on 2 individual staff members. The contract with Taunton for one list per month continues for 23/24.

Eastern Services Diagnostics

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

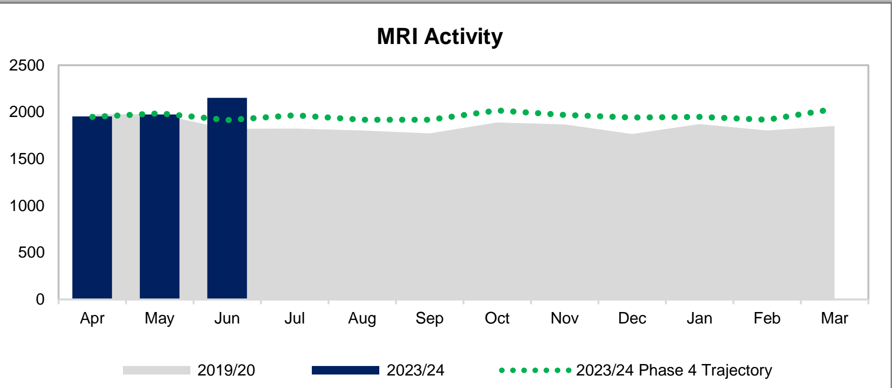


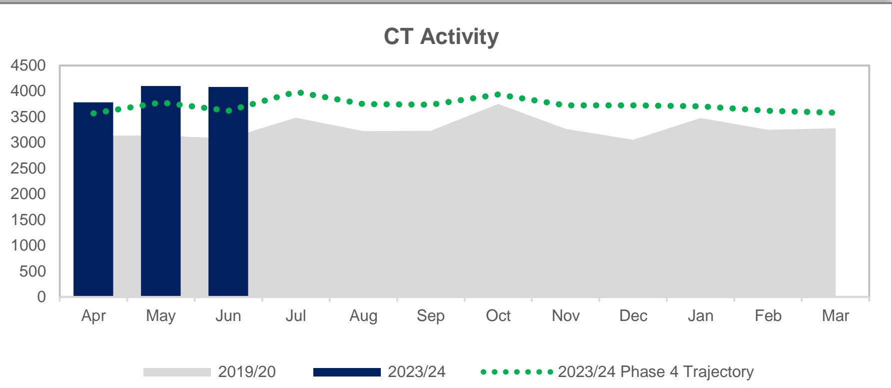


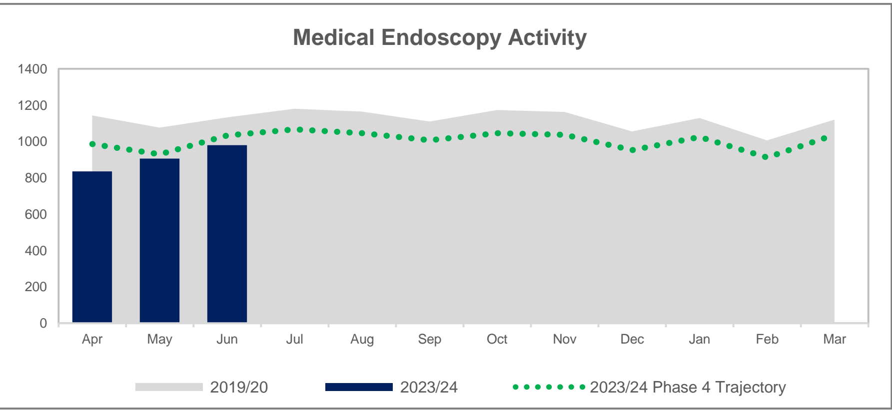
Area	Diagnostics By Specialty	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Endoscopy	Colonoscopy	64.0%	63.5%	58.3%	51.6%	54.9%	53.9%	53.9%	51.2%	53.0%	50.1%	49.2%	53.1%
	Cystoscopy	91.5%	88.9%	93.2%	87.4%	83.5%	88.1%	47.8%	83.1%	83.2%	75.2%	73.6%	73.5%
	Flexi Sigmoidoscopy	74.6%	74.5%	62.2%	51.3%	49.6%	44.8%	82.1%	41.7%	50.4%	51.1%	54.5%	51.4%
	Gastroscopy	56.7%	68.7%	68.0%	69.8%	78.3%	74.8%	74.7%	73.9%	73.5%	66.3%	70.3%	97.4%
Imaging	Barium Enema	-	-	-	-	-	-	-	-	-	-	-	-
	Computed Tomography	77.1%	81.3%	85.4%	89.5%	92.3%	86.2%	87.9%	83.3%	84.6%	82.5%	79.5%	77.4%
	DEXA Scan	98.4%	98.2%	99.4%	99.2%	98.4%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%
	Magnetic Resonance Imaging	69.6%	69.1%	72.9%	73.7%	75.6%	68.5%	70.7%	76.5%	73.4%	66.6%	68.8%	72.8%
	Non-obstetric Ultrasound	53.1%	52.7%	51.2%	54.5%	56.7%	56.8%	56.6%	60.1%	66.4%	59.9%	63.8%	70.9%
Physiological Measurement	Cardiology - Echocardiography	74.5%	71.4%	72.7%	75.2%	65.0%	66.6%	66.9%	72.6%	66.3%	61.7%	66.1%	58.8%
	Cardiology - Electrophysiology	-	-	-	-	-	-	-	-	-	-	-	-
	Neurophysiology - peripheral neurophysiology	72.5%	67.1%	61.2%	55.4%	65.4%	43.2%	49.4%	61.2%	75.1%	59.3%	62.1%	67.6%
	Respiratory physiology - sleep studies	60.0%	58.6%	65.8%	61.4%	63.1%	60.6%	57.8%	57.7%	66.4%	65.5%	60.7%	61.4%
	Urodynamics - pressures & flows	34.5%	28.6%	26.9%	25.7%	33.7%	28.8%	38.5%	32.2%	37.8%	36.8%	36.8%	27.3%
Total		62.4%	63.0%	63.2%	64.4%	65.5%	63.0%	64.3%	67.4%	69.2%	63.6%	65.4%	67.4%

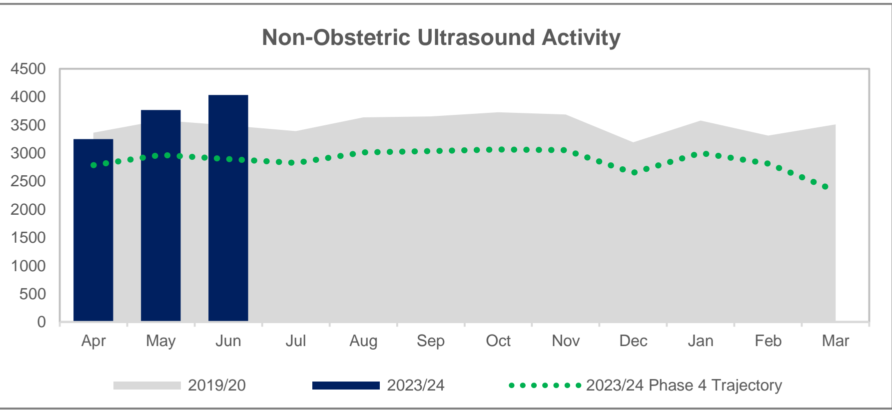
Eastern Services Diagnostics

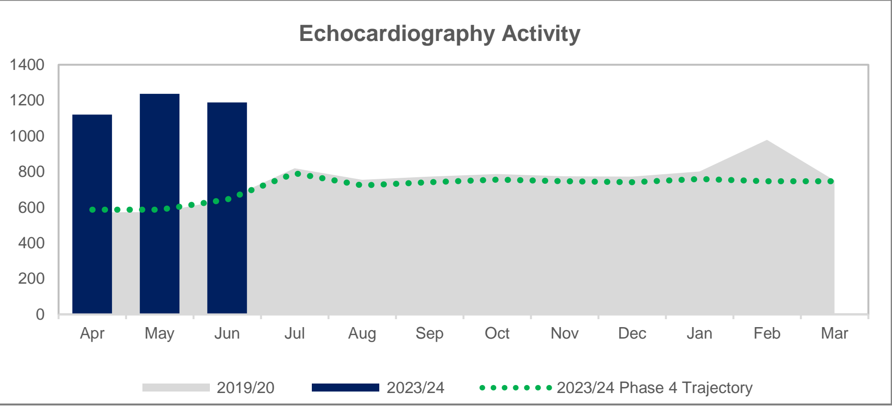
Volumes of patients waiting longer than 6 weeks for one of fifteen key diagnostics tests











Eastern Services Diagnostics

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

At the end of June, 65.4% of patients were waiting less than 6 weeks – an improvement of 1.8% from the end of April, representing 302 fewer patients.

CT

- There has been a continued decrease in performance in June due to
    - a full day's list having to be stood down by one of the 3rd party provider at short notice, this resulted in 10 unused slots
    - unplanned scanner downtime for 1.5 days approximately 16 unused slots
- Northern services continue to use capacity but due to the increase in Cardiac CT for Eastern services the reduced capacity offered during July and August looks likely to continue beyond September to aid recovery of Eastern services' Cardiac CT position, this will be discussed further with Northern services.

MRI

- The position continues to improve during July
- MRI Cardiac continues to be challenged, working with Cardiology exploring how to utilise the MGNC scanner more fully to support a new list every Friday and possible ad hoc additional lists where cardiologists and cardiac nursing teams timetables permit

Non Obstetric Ultrasound

- US waiting list shows significant improvement

Endoscopy

- The endoscopy team continue with super weekends to increase capacity –6 additional lists were delivered in June with 8 planned for July. Along with this, ERF funding is utilised to fill in week gaps in the rota where possible to ensure that maximum activity is achieved. A focus is currently being prioritised on the longest waits, a number of which are likely to be removed or pathway paused. Consultant advert now out to recruit into the 3 x vacancies within the team and there is focus to increase the number of points per list for the nurse endoscopists.
- There has been a delay to the mobile endoscopy unit as this requires a Letter of Indemnity from the PFI provider. There is currently no indication when this LOI will be received. Delivery of the mobile unit is expected on 24 July, however services cannot be connected without the LOI.

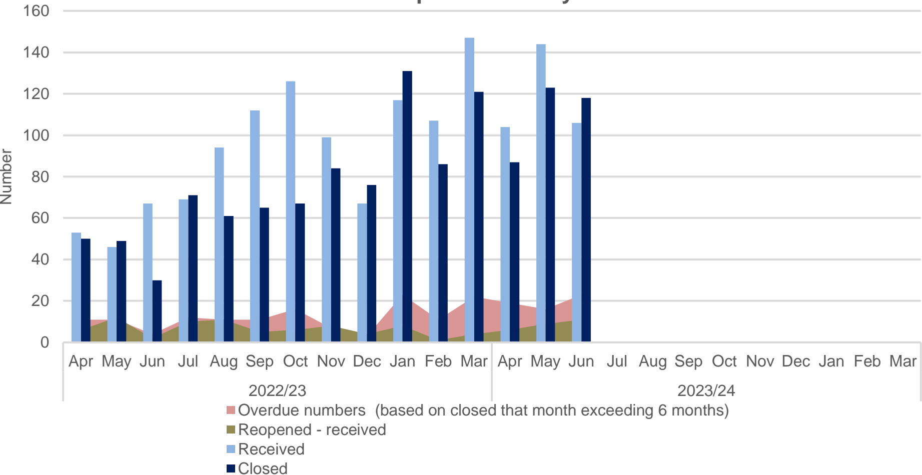
Echocardiography

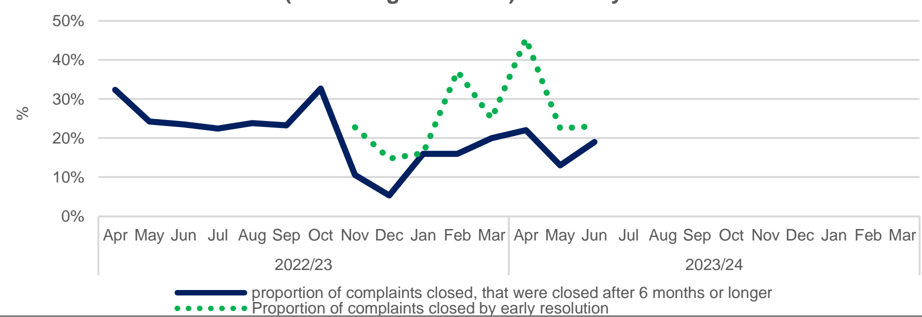
- Demand remains high & therefore performance challenged. Despite ongoing weekend physiologist clinics, the number of breaches has increased in the most recent month (493) compared to the previous position of 417.
- Work on the dashboard continues with BI as well as with the productivity team to optimise test requests.
- Retention of staff remains challenging with four vacancies, currently. There is continued reliance on the use of locum physiologists to support the service both to fill these vacancies and also the increasing demand on the service. However, a recruitment plan is in place with two adverts currently active and a development post commencing in September. A further advert will be placed imminently, for the most-recently received resignation.

Respiratory Physiology

- Neurophysiology - Approval received to recruit an agency staff member and purchase additional reporting equipment to enable additional sleep studies to be delivered (awaiting capital number). Current capacity enables 1 test per week, the interventions will raise this to up to 6 tests per week.
- Respiratory – request being submitted to Capital Planning Group (17/07/23) to replace 2 broken and 1 lost sleep study machines. Currently running at 33% reduced capacity. Tests to return to full capacity when equipment is replaced.

Trust Patient Experience



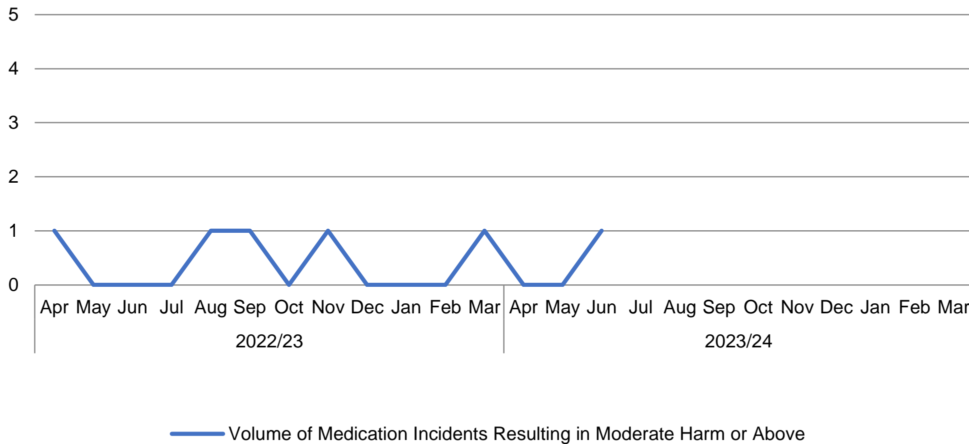


Number of new PHSO investigations received during month	Primary investigations currently open	Detailed investigations currently open	Number of PHSO investigations closed during month
4	15	2	2

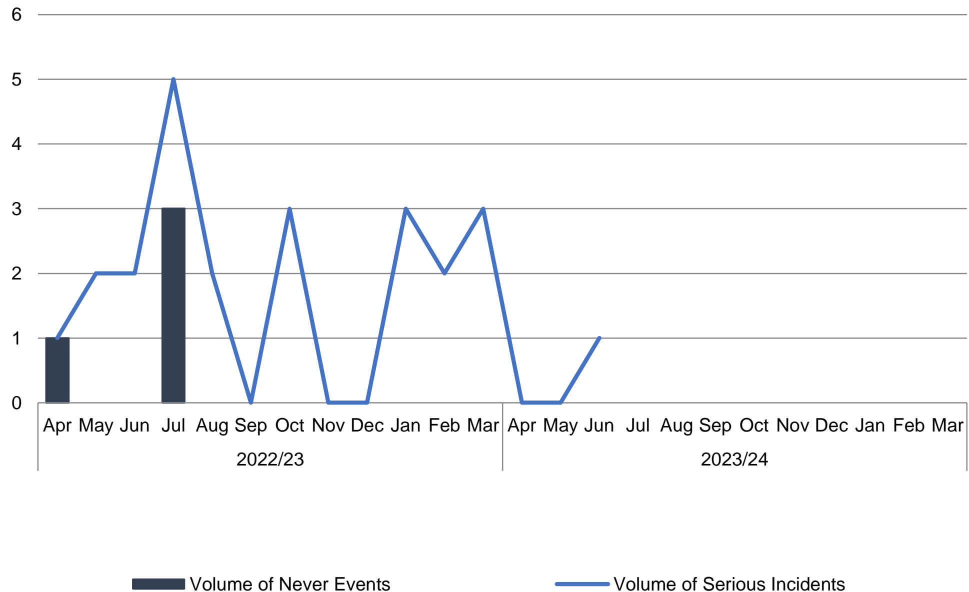
- During June, 27 complaints were closed by early resolution which represents a slight increase compared to the previous month.
- Four new primary investigations were received from the PHSO during June, the primary review will determine whether further investigation is required, and 2 investigations were closed.
- ‘Communication’ remains the main theme throughout complaints and the Patient Experience Committee have commissioned a deep dive into understanding this overarching theme to ensure action and learning.

	2022/23												2023/24		
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
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%
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
Complaints closed in month by early resolution								27	15	21	32	31	36	26	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%

Northern Services Incidents

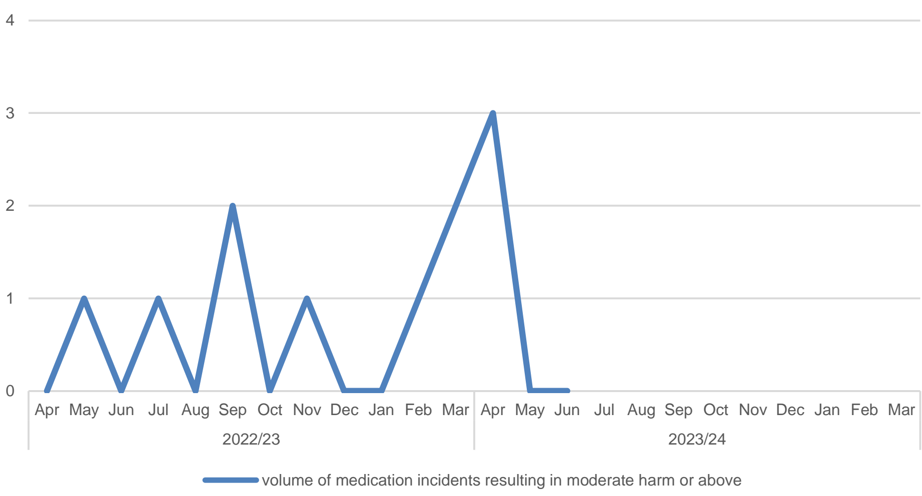


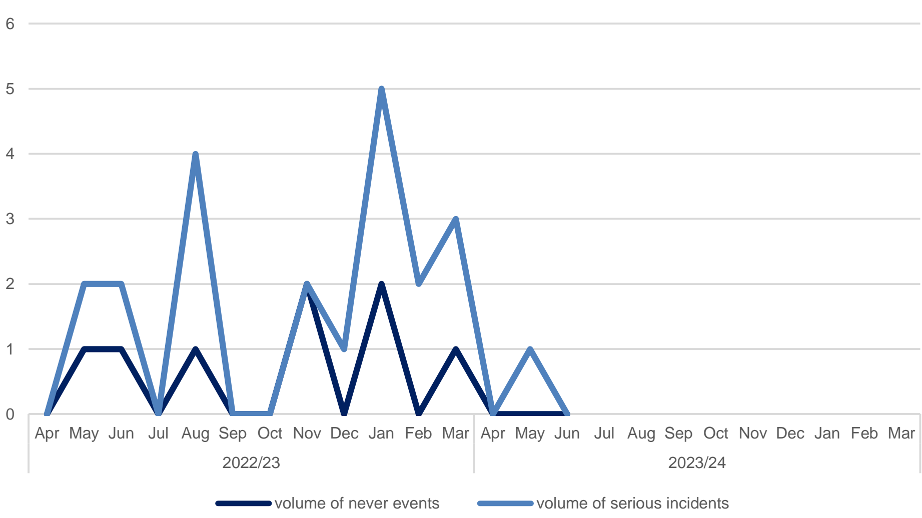
- There was one medication harm incident in June 2023 with moderate harm, involving a chemotherapy drug that was discontinued due to unclear documentation on the discharge summary. This is subject to investigation.



- There was one serious incident in June 2023. This is a late diagnosis of lung cancer. A Serious Incident investigation has commenced.

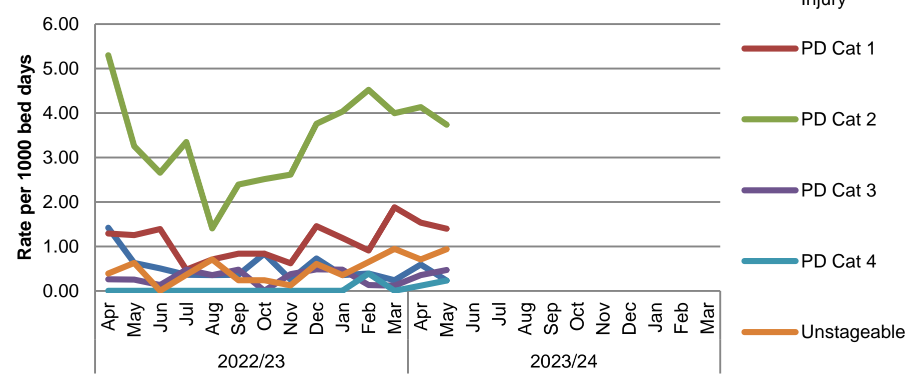
Eastern Services Incidents

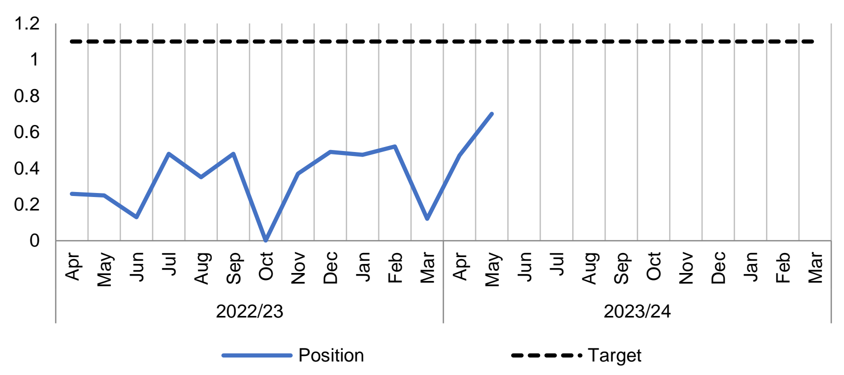


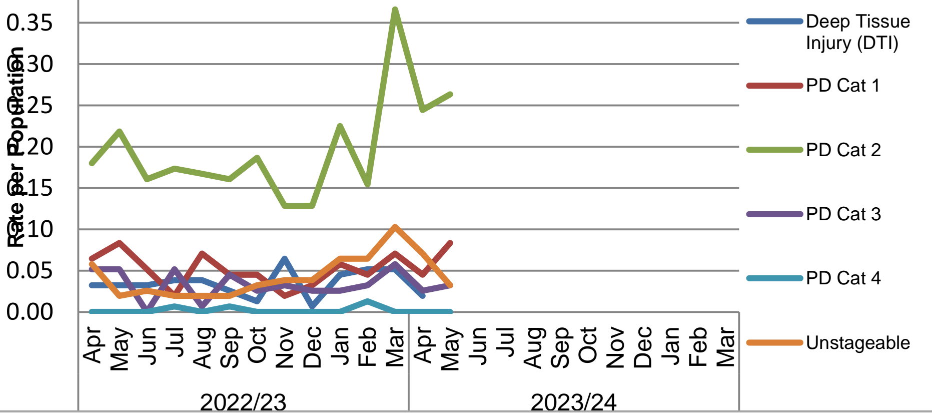


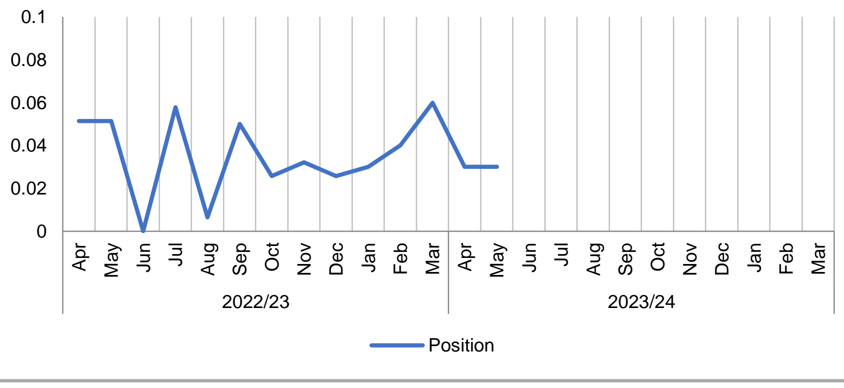
- Patient Safety Incidents remained within normal variation. There were no serious incidents, never events or medication incidents resulting in moderate or greater harm.

Executive Lead : Carolyn Mills





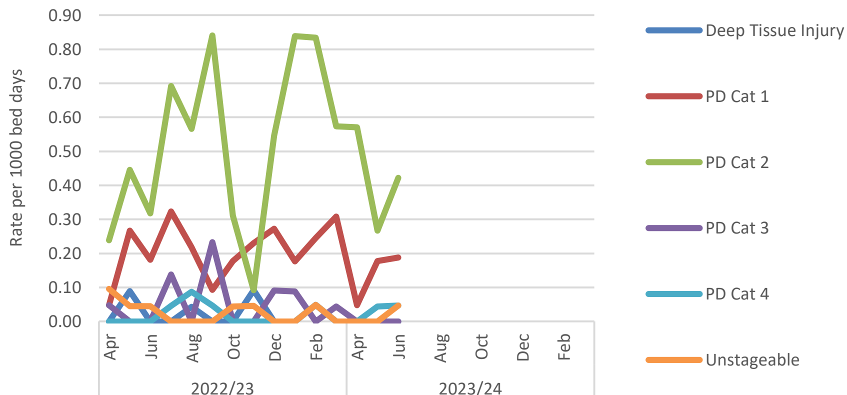


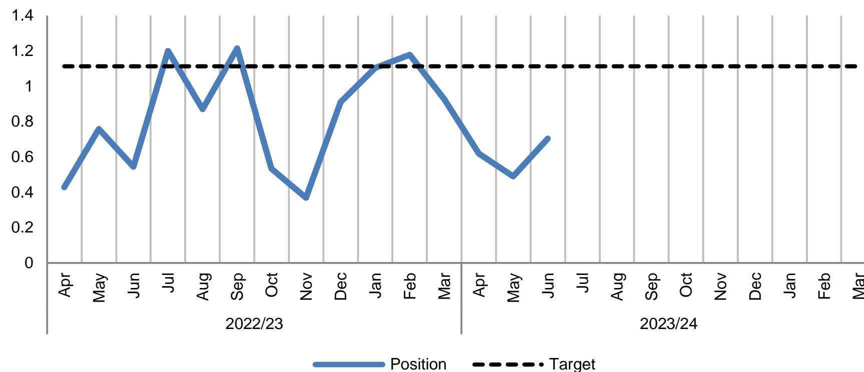


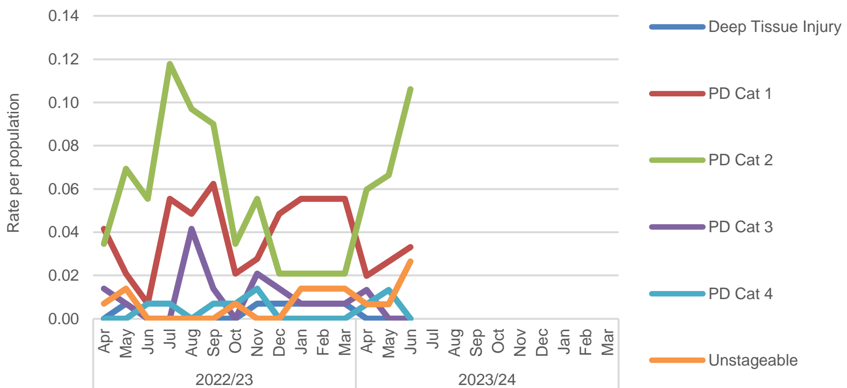
- There has been 2 x category 4 pressure ulcers reported in June. One case relates to a patient wearing a plaster cast and is subject to investigation. The second case is related to a particularly frail and deteriorating patient and is currently being investigated.
- Pressure Ulcer Quality Improvement work continues across inpatient wards. Improvements are being seen in pressure ulcer risk assessment completion and the early identification of category one and category two pressure damage which have both reduced in month.

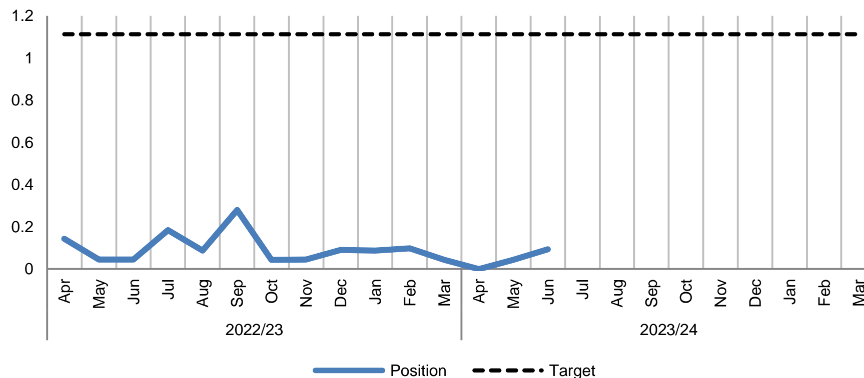
Eastern Services Pressure Ulcers

Rate of pressure ulceration experienced whilst in Trust care







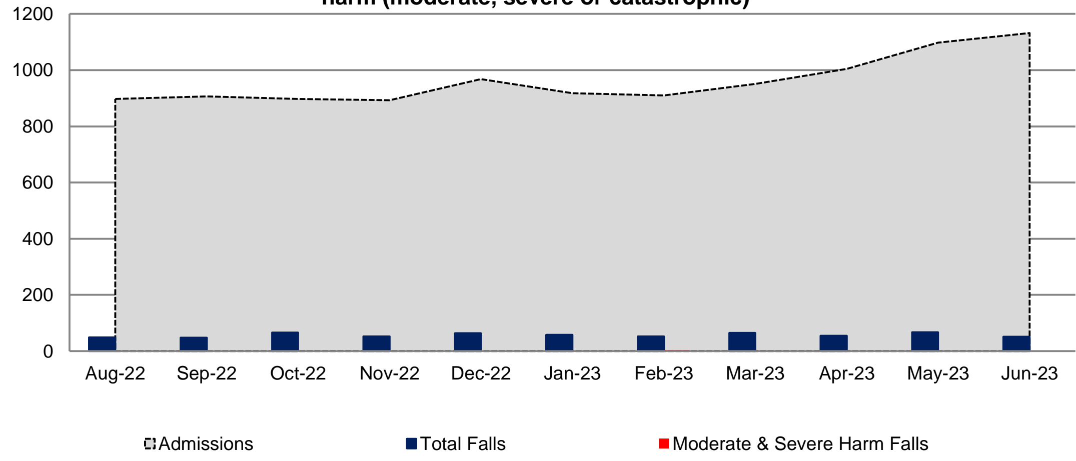


A review of our process' has improved our working practice and all Pressure Ulcers have been validated. Harm from pressure ulcers remains low, with the most significant risk factor being extremes of age (patients aged 90+)

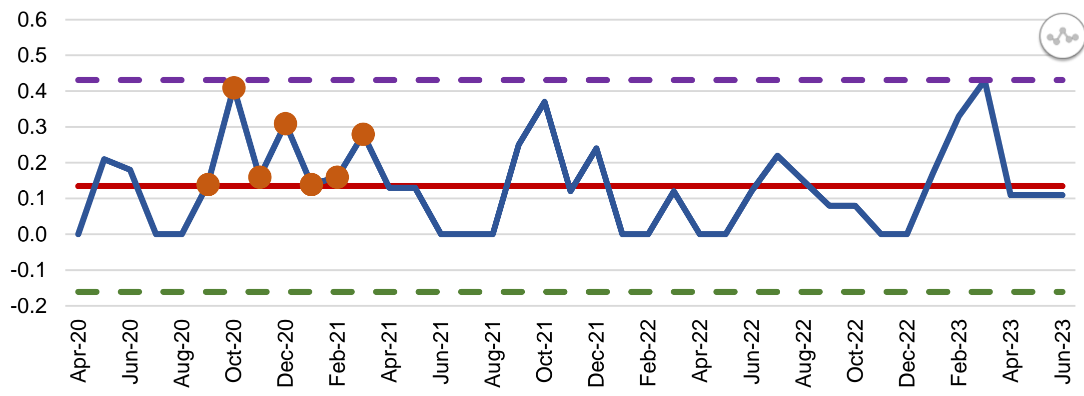
Inpatient setting: An unstageable device related incident in fracture clinic will be reviewed, the thematic review will include previous incidents to ensure our learning processes are robust. The investigation will look at themes and include previous harms to challenge if our processes are sufficiently robust.

Community setting: there has been a rise in the category 2, and unstageable pressure ulcers; this increase is attributed to patients experiencing Skin Changes at Life's End (SCALE).

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



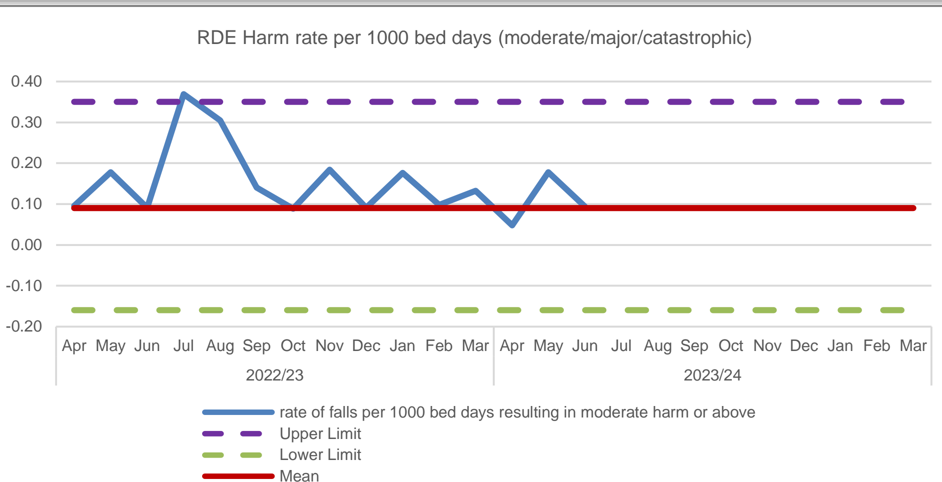
Month	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Admissions	897	907	897	893	968	918	910	951	1004	1098	1132
Total Falls	49	48	66	52	64	58	53	65	55	67	51
Moderate & Severe Harm Falls	2	1	1	0	0	2	3	2	1	1	1



- In June 2023 95% of patients admitted did not fall.
- Falls remain within normal variation
- There was one harmful fall in June, which is subject to an investigation to identify learning.
- The first 'Falls Bootcamp' was completed with Tarka Ward, which was a success and a Tarka Falls Improvement Plan was created. All other wards are scheduled to attend a 'Falls Bootcamp' as part of the Falls Reduction Workstream.

Eastern Services Slip, Trips & Falls

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

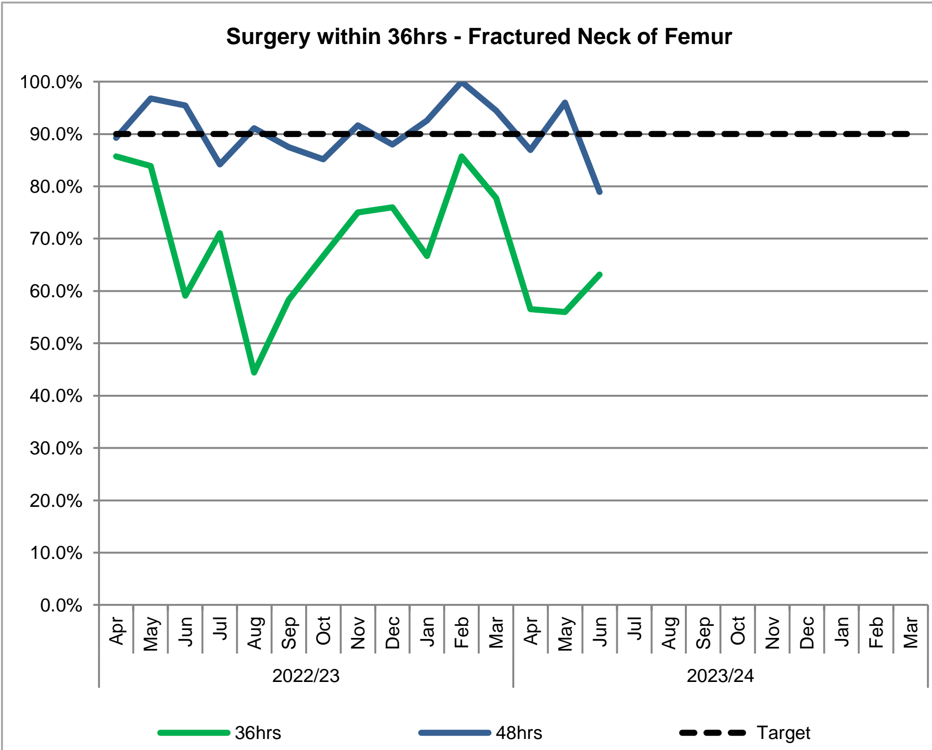


Month	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Falls	167	141	131	160	143	151	160	154	137	157	148	161	134	113	118
Moderate & Severe Falls	2	4	2	8	7	3	2	4	2	4	2	3	1	4	2

Falls remain within normal variation. There were two falls reported as resulting in moderate harm. One patient had an observed slip which resulted in a fractured elbow. The second was an unobserved fall from bed, the actual level of harm from this fall has not been finalised and is likely to be reduced to minor. There were no suboptimal care issues identified

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

Northern Services	Aug-22	Sep-22	Oct-22	Nov-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
NDDH	73%	60%	65%	81%	76%	82%	78%	77%	76%	71%



- 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 June 2023, 63.2% of medically fit patients with a fractured neck of femur (NOF) received surgery within 36 hours. The Trust admitted a total of 19 patients with a fractured neck of femur in that month who were medically fit for surgery from the outset and of these, 12 patients received surgery within 36 hours.

- The 7 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 and there was a particularly high number of Trauma admissions seen in June. Four patients waited longer than 48 hours; therefore 78.9% of patients received their surgery within 48 hours.

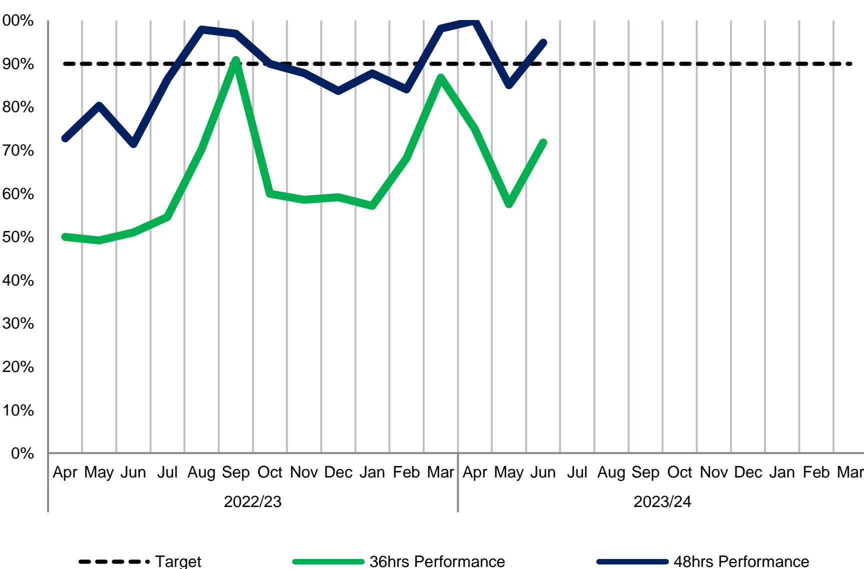
- Validation of the June figures has demonstrated a previous discrepancy in the methodology used to calculate the time to surgery. This have been rectified for June's position and will be retrospectively applied to all months in the next IPR, which will have a positive impact on achievement.

Eastern Services Efficiency of Care

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

Eastern Services	Aug-22	Sep-22	Oct-22	Nov-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
RDE Wonford	76%	75%	73%	72%	81%	88%	87%	82%	79%	87%

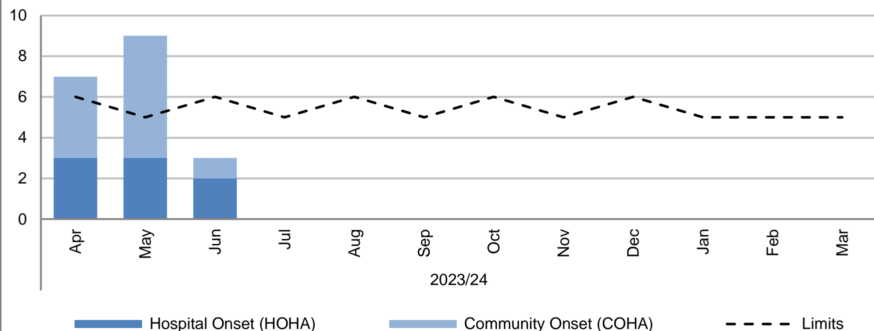
- The snapshot position taken from the Epic system in relation to the proportion of patients risk assessed for VTE on admission, demonstrates a stable position, with improved performance seen in June 2023.

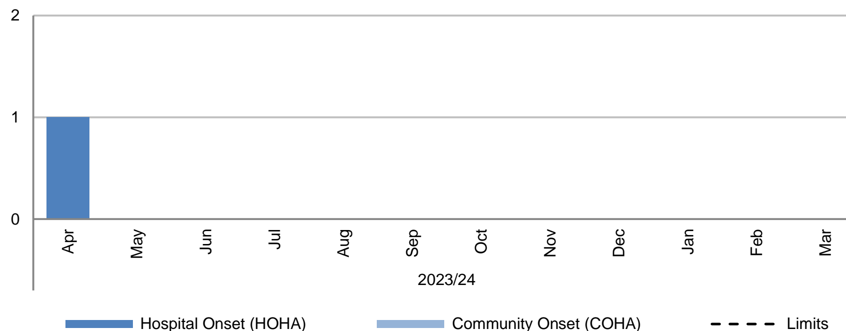


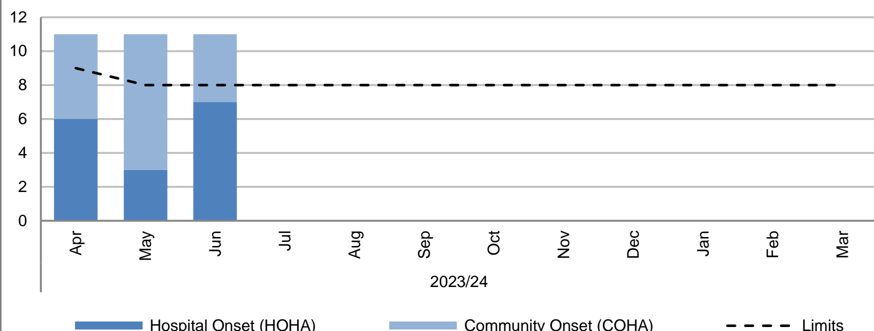
- In June 2023, 71.8% of medically fit patients with a fractured neck of femur (FNOF) received surgery within 36 hours. There were a total of 47 patients admitted with a FNOF, 39 of these patients were medically fit for surgery from the outset and 28 patients received surgery within 36 hours. Two medically fit patients had to wait longer than 48 hours for surgery, therefore 95% of patients received surgery within 48 hours. The main reason for delay was awaiting space on theatre lists.
- There were a total of 187 trauma patients admitted in June, with a spike of 38 Trauma admission across a single three day period between Sunday 18th –Tuesday 20th.
- Where clinically appropriate all FNOF cases are given priority in theatres over elective patients. 49 Trauma Patients had their surgery during June in PEOC Theatres, which was to the detriment of elective activity.
- 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.
- Work is being actively progressed to increase the volume of Orthopaedic and Spinal activity that can be redistributed to the Nightingale Hospital, to free up theatre capacity on the Wonford site.

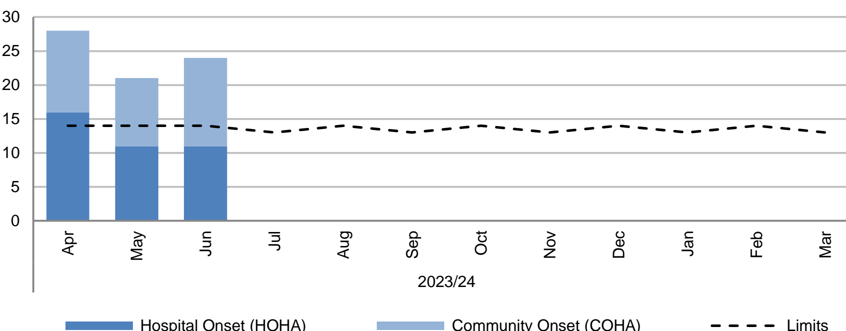
Trust - Healthcare Associated Infection

Volume of patients with Trust apportioned laboratory confirmed infection









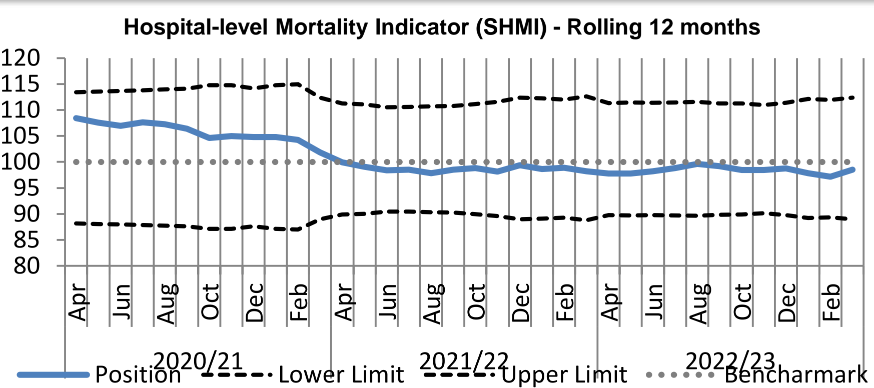
C difficile – Two Hospital Onset (HOHA) and one Community Onset (COHA) cases. No learning identified from investigation of these cases

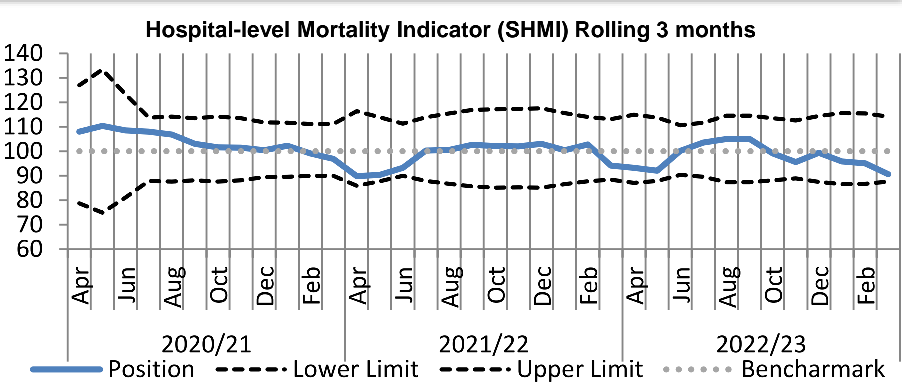
MRSA bacteraemia – Nil

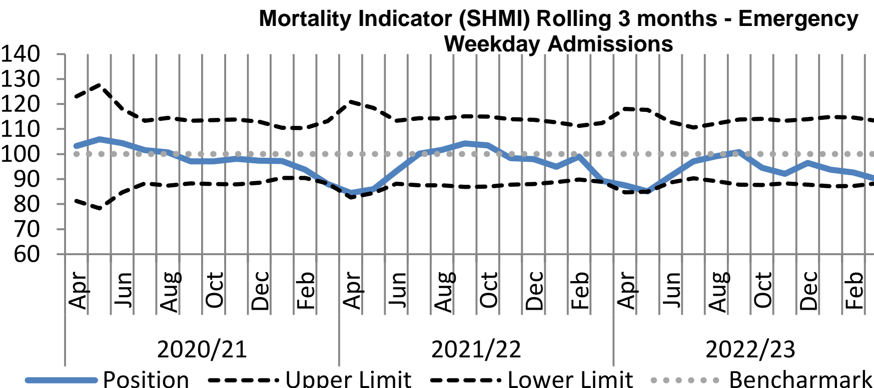
MSSA bacteraemia – Thorough case analysis of the seven HOHA cases and four COHA cases were undertaken. No Trust learning was identified that may have prevented five of the HOHA cases. In one HOHA case, associated with a Peripheral Venous Cannula (PVC), prompt medical review following the identification of pain and erythema at the PVC site may have prevented this bacteraemia. Another of the HOHA cases, also associated with a PVC, may have benefited from the new addition to the VIP (Visual Infusion Phlebitis) scoring chart which is in the process of being updated by the Vascular Access Team; this change will see the requirement to monitor PVC sites for an additional 48hrs after removal following a VIP of 2 or more. No Trust learning was identified for one of the COHA cases. The other COHA case, associated with a CVC, may have been averted if concerns of the line site were escalated as per Trust policy, which may have resulted in a more prompt review of the patient.

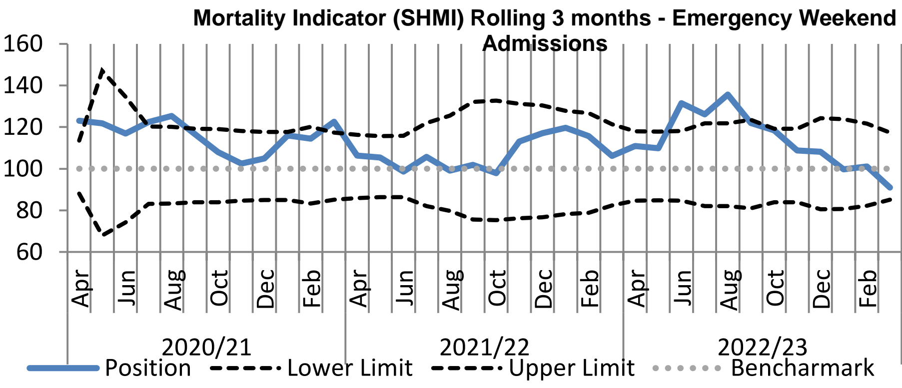
E coli bacteraemia – Of the 11 HOHA cases, one had a gastroenterology source, one a hepatobiliary source, five were urinary source of which four were associated with urinary catheters, one respiratory source and three cases were unknown source. Of the 13 COHA cases, there were four hepatobiliary sources, six urinary sources of which three were associated with a urinary catheter, one gastroenterology source and one source unknown.

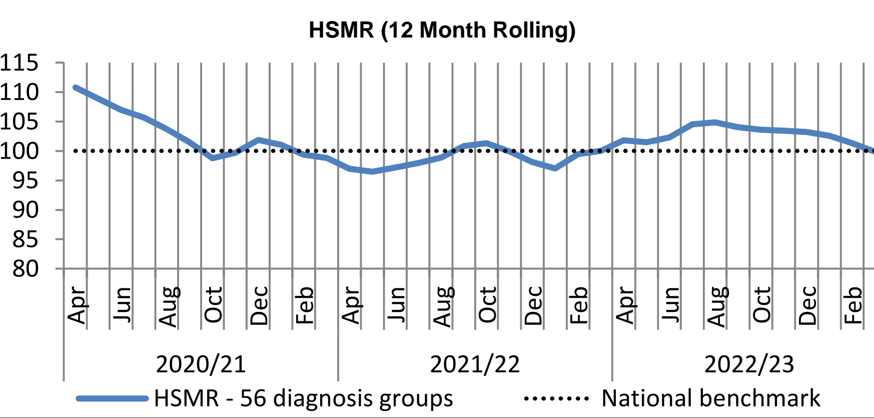
Northern Services Mortality Rates – SHMI & HSMR – *Rate of mortality adjusted for case mix and patient demographics*







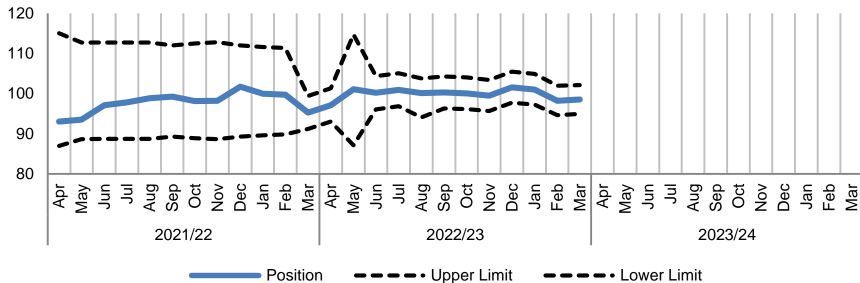


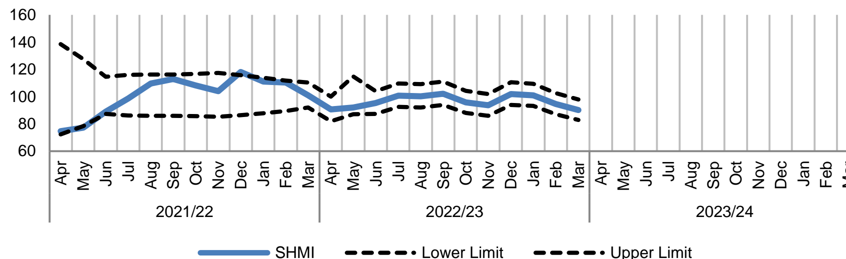


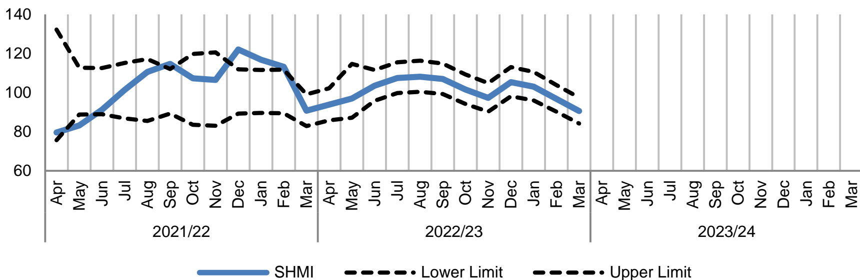
- The overall mortality figures are within national confidence intervals for 12 month and 3 month rolling SHMI and are below all our Peninsula peers. The 12 month HSMR has continued to fall.
- The Medical Examiners continue to give independent scrutiny of all hospital deaths raising areas of concern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

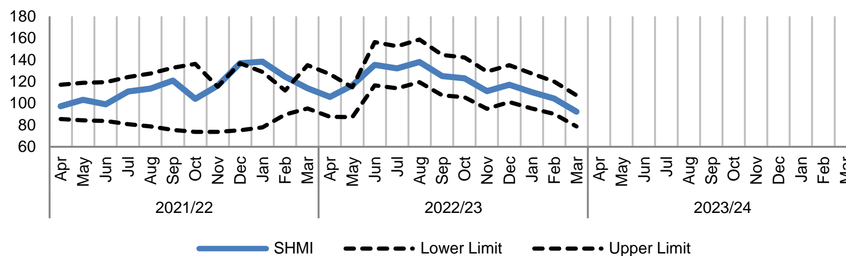
Eastern Services Mortality Rates – SHMI & HSMR

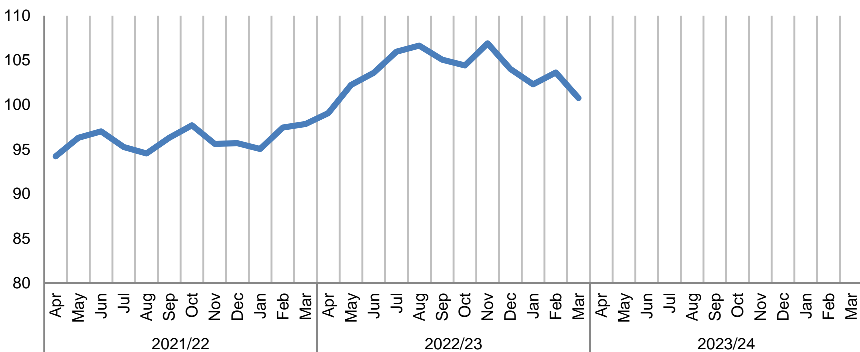
Rate of mortality adjusted for case mix and patient demographics





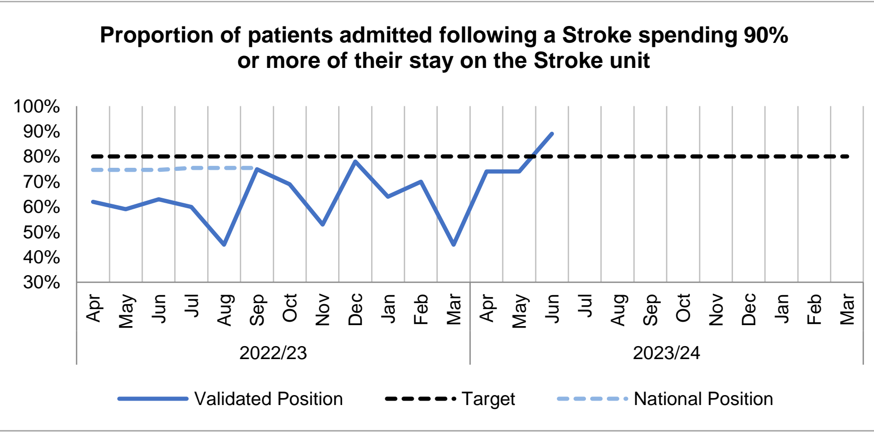


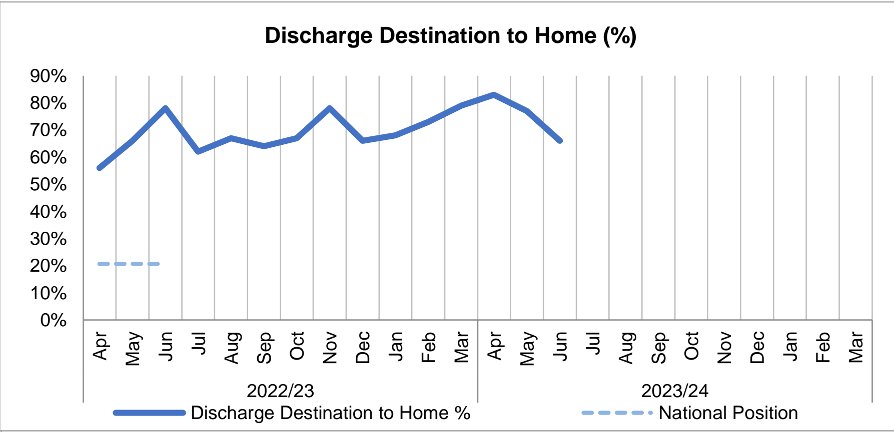


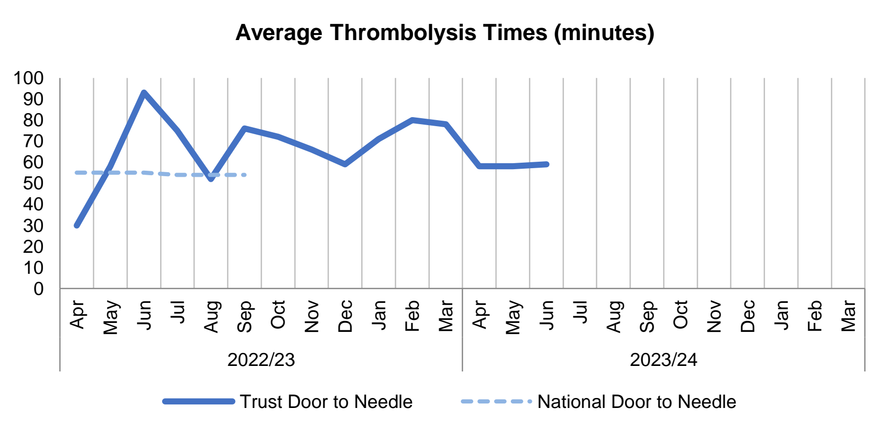


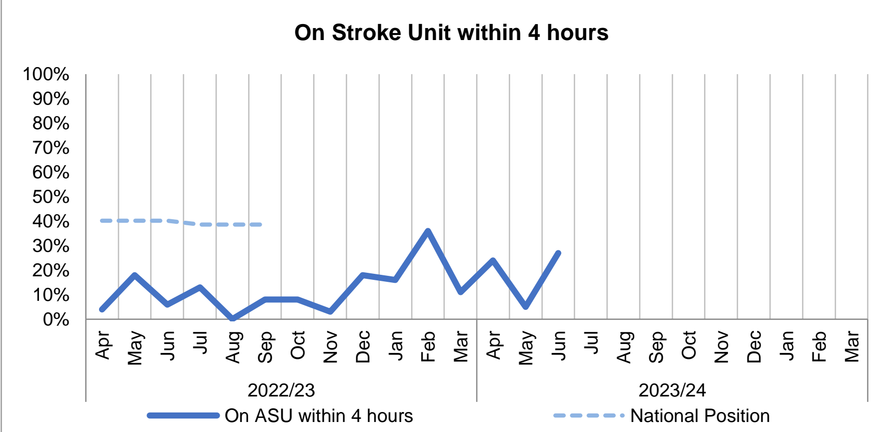
- The SHMI position remains within the expected range for all metrics and demonstrate a continued downward trend.
- The HSMR position remains stable on a rolling 12 month basis to March 2023
- The Medical Examiners continue to give independent scrutiny of all hospital deaths raising areas of concern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

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





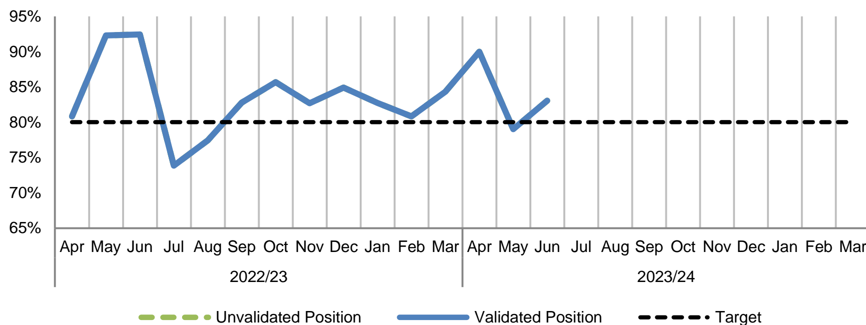


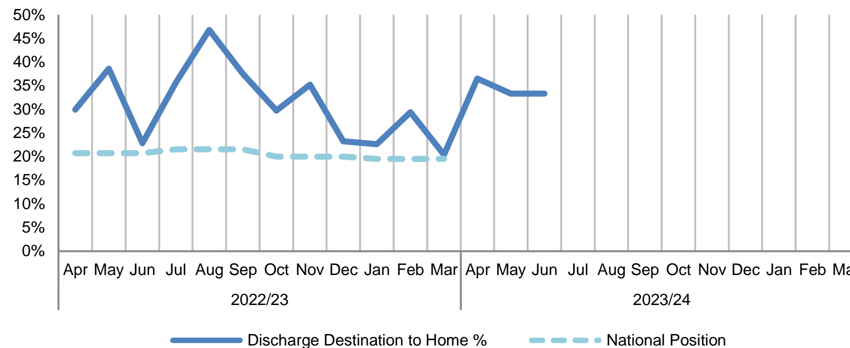


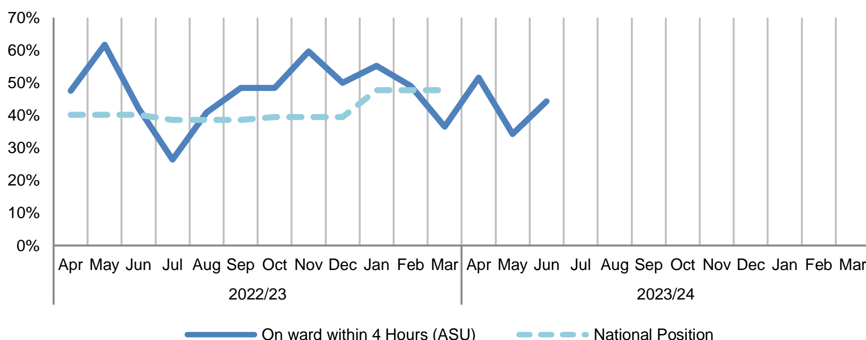
- 90% stay: Performance against this indicator continued to show signs of consistent improvement, with the target being exceeded for the first time since April 2022, achieving 89%. The Stroke clinical teams continue to provide outreach to outlying wards to ensure stroke patients are receiving appropriate 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; however the position has improved in June.

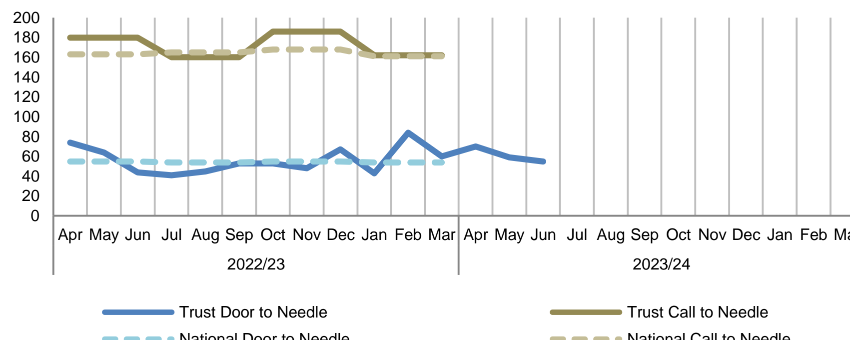
Eastern Services Stroke Performance

Quality of care metrics for patients admitted following a stroke

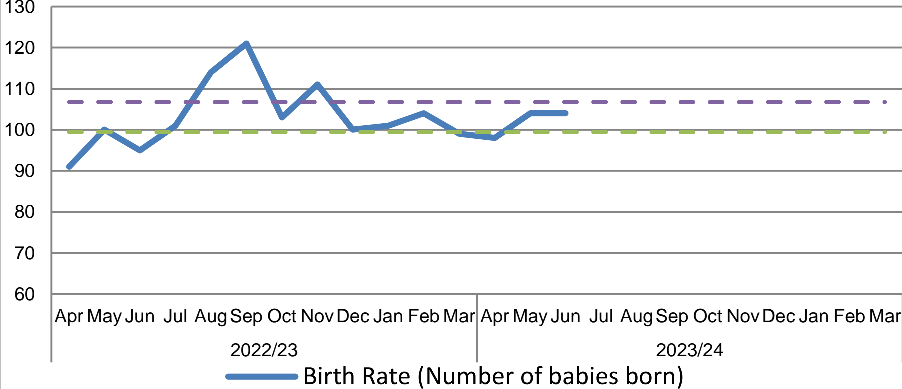


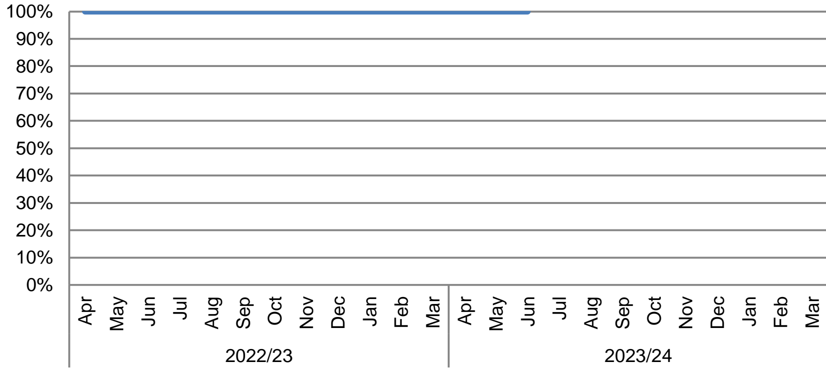


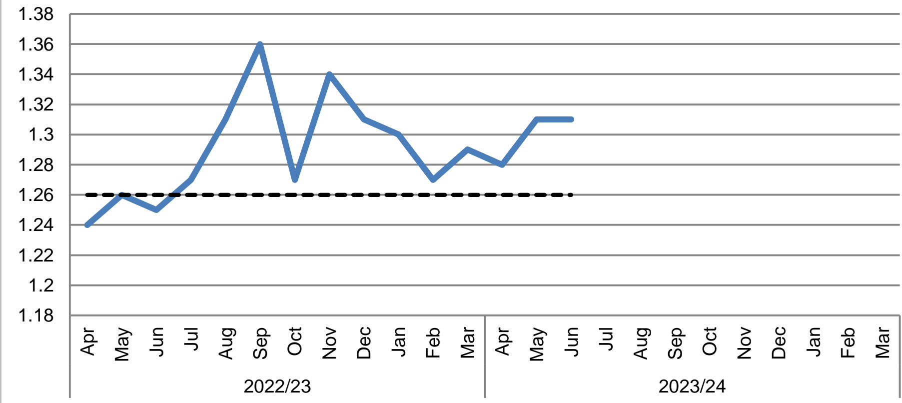


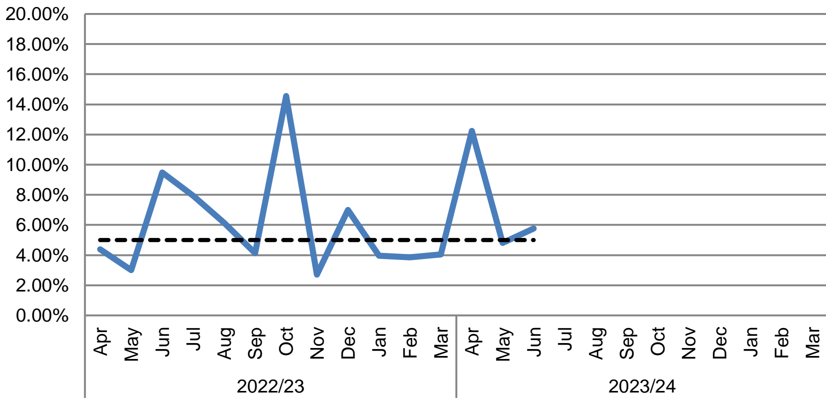


- 90% stay -The proportion of patients admitted spending 90% of their stay on the stroke unit has improved in June and is above target at 83.1%. Also in June 44.3% was achieved against the on ward within 4 hours target indicator, which is in line with the national position
- The proportion of patients for whom their discharge destination is home remains stable.
- Average Thrombolysis times remain stable and in-line with the national position.







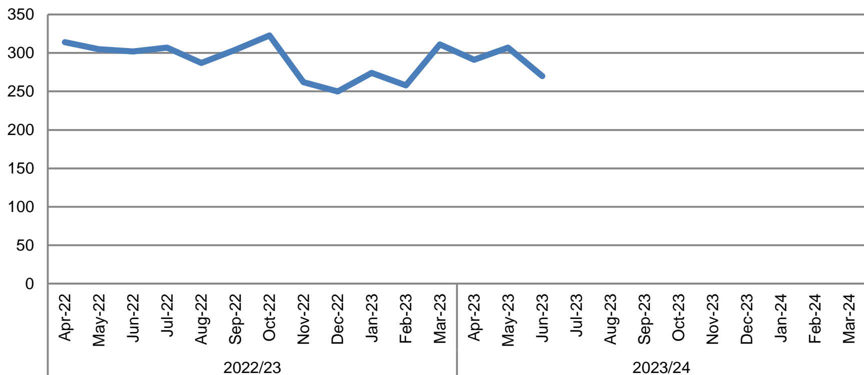


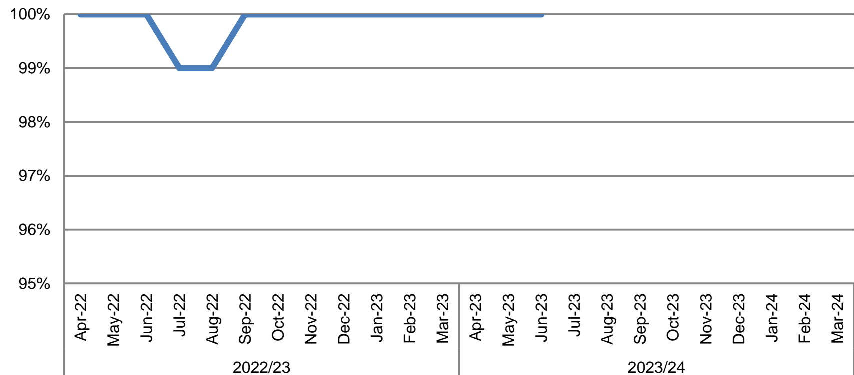
- Term admissions to NNU all reviewed via ATTAIN (Avoiding Term Admission Into Neonatal Units) process and no safety concerns identified.

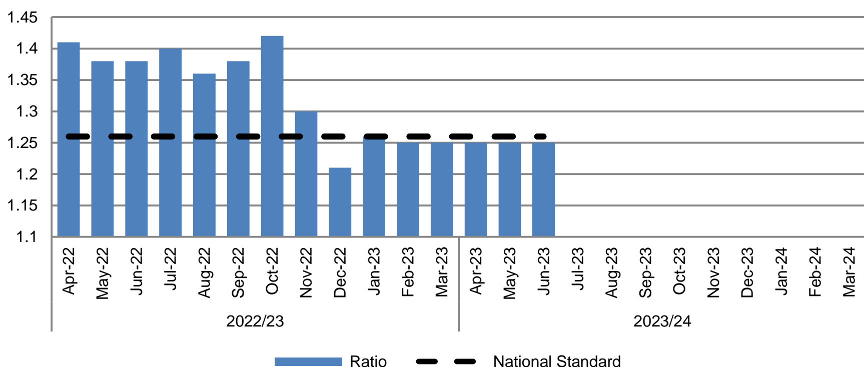
NB Admissions due to lack of dedicated transitional care facility in Northern Services continue to impact on numbers. Services across RDUH continue to explore Transitional care provision as part of integration optimisation.

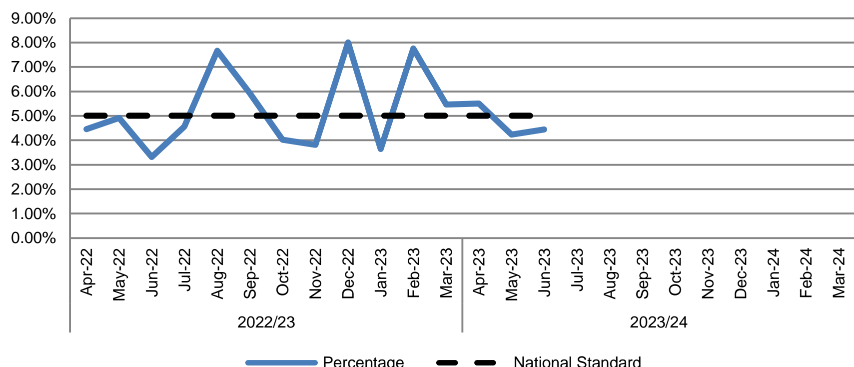
Eastern Services Maternity

Metrics relating to the provision of quality maternity care



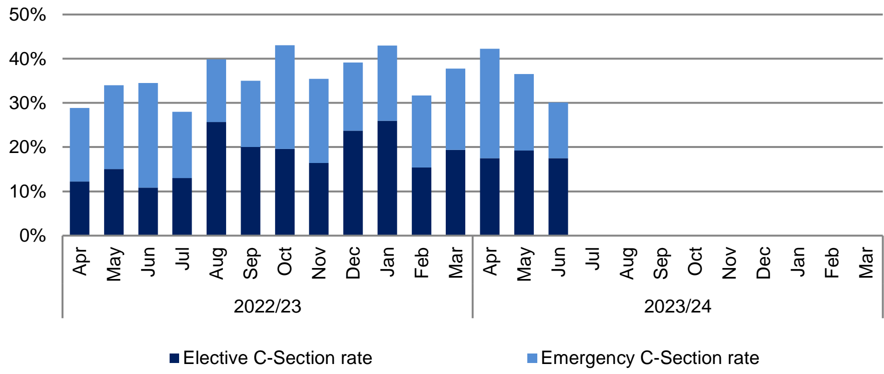


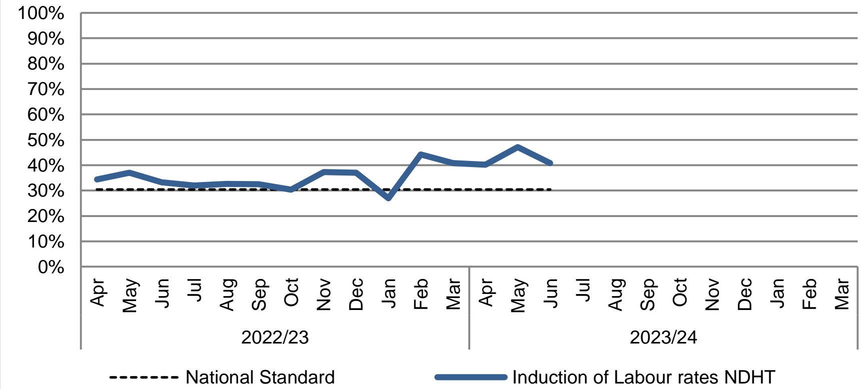


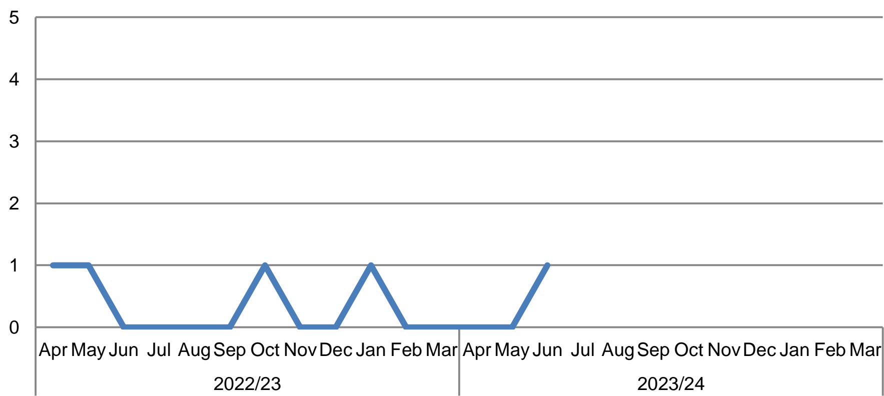


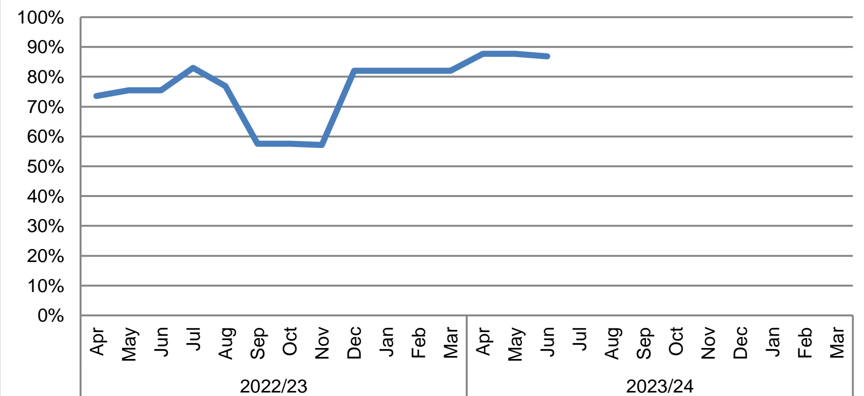
- Term admissions to NNU all reviewed via ATTAIN process. No safety concerns identified. To note, these remain in line with national picture due to the provision of dedicated transitional care facility in East.

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





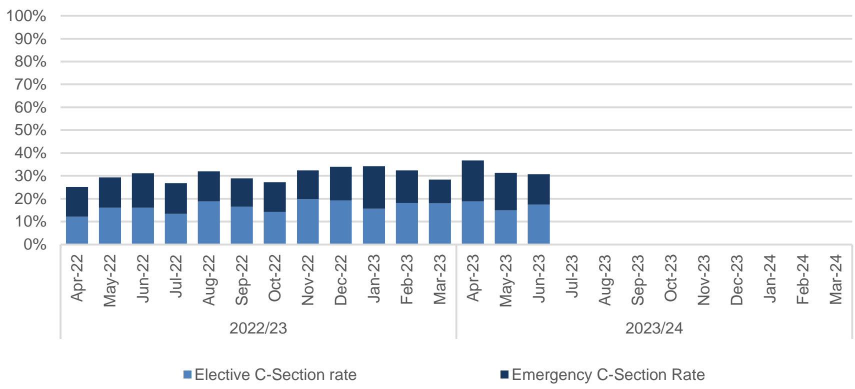


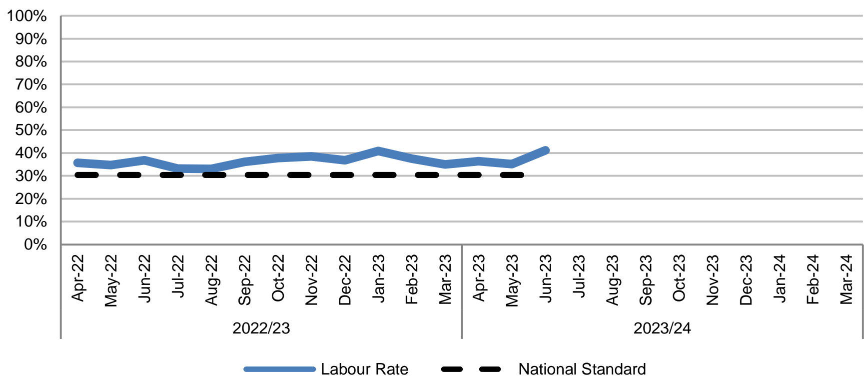


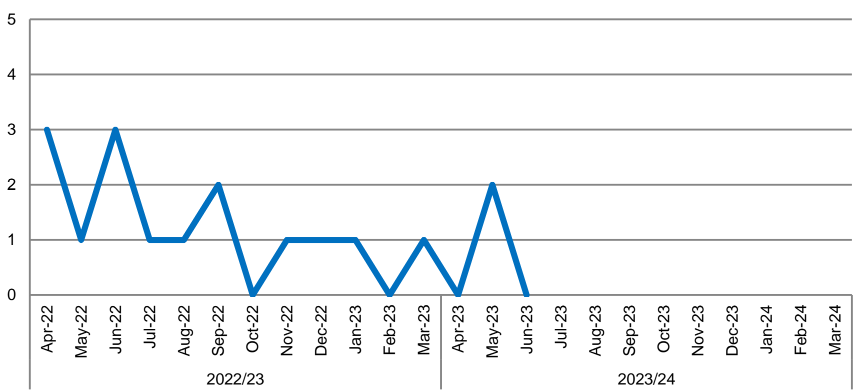
- There was one stillbirth in month which will be fully reviewed via the Perinatal Mortality Review Tool (PMRT) process
- PROMPT (Obstetric Multi-Professional Training) training compliance maintained in month, service continues to prioritise as per CNST Year 5 compliance trajectory

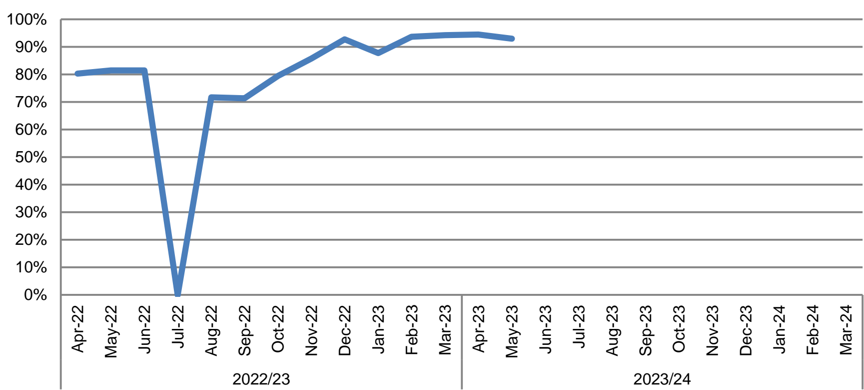
Eastern Services Maternity

Metrics relating to the provision of quality maternity care



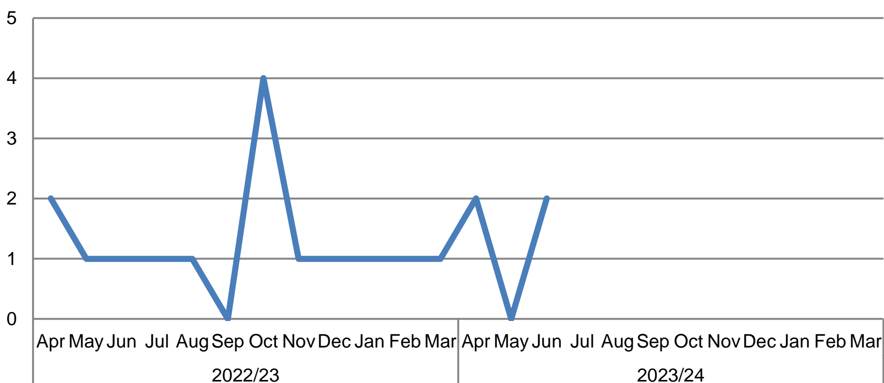


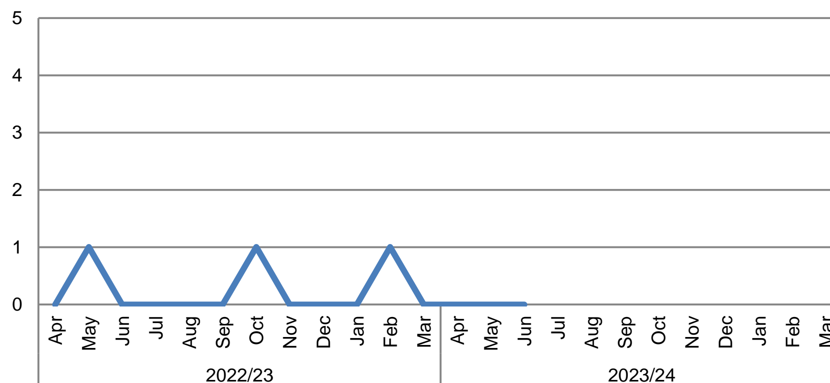


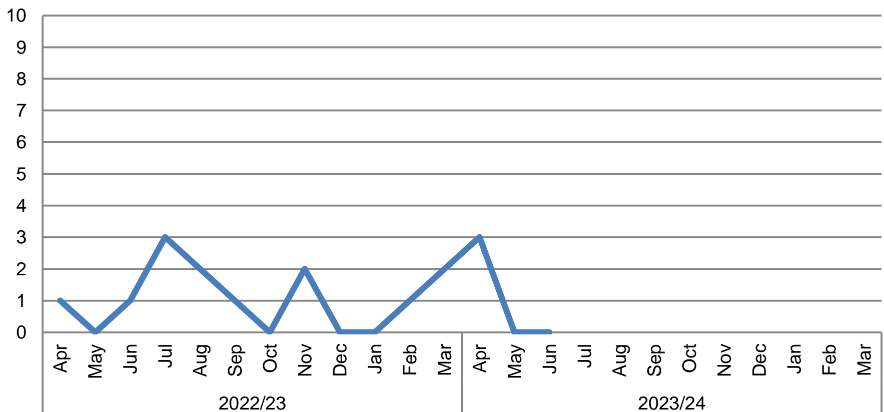


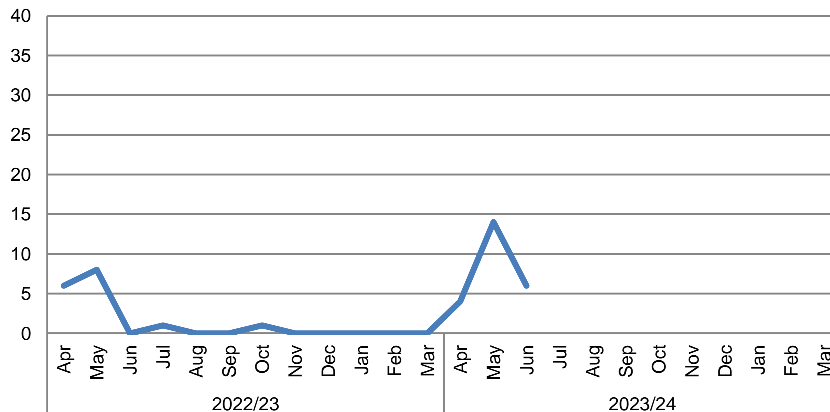
- Induction of labour rates continue to increase in line with the National picture.
- PROMPT training compliance maintained above 90% in month, service continues to prioritise as per CNST Year 5 compliance.

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





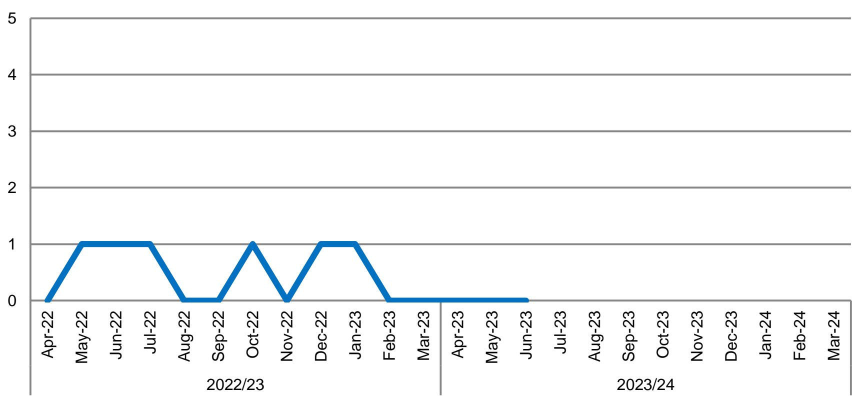


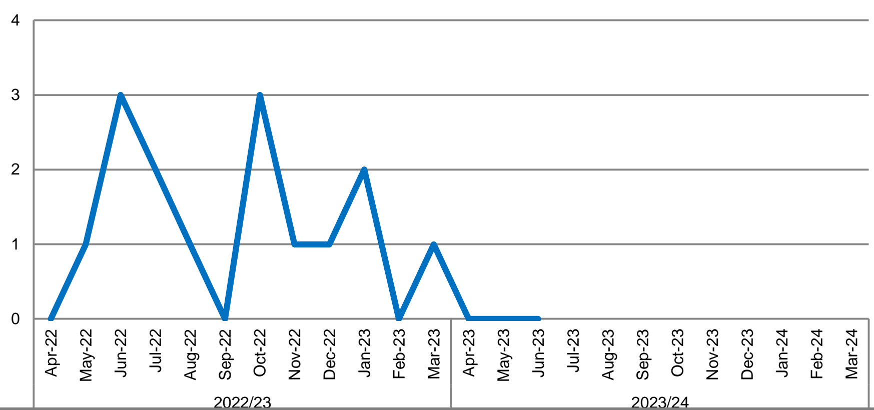


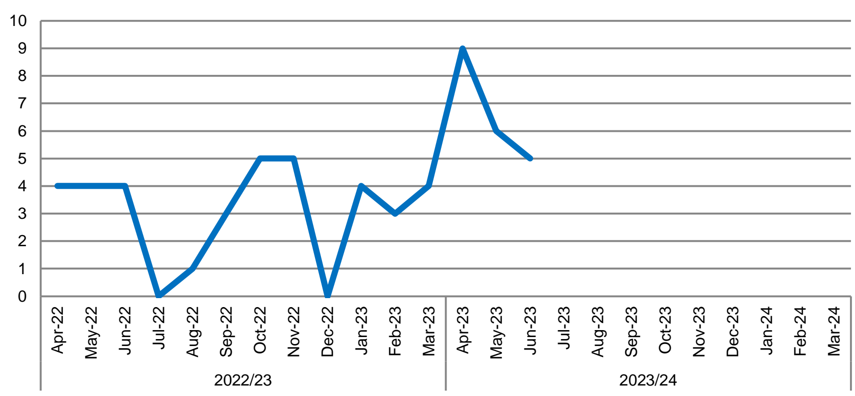
- There were 2 moderate or above incidents in month: 1 stillbirth which will be investigated via the Perinatal Mortality Review Tool (PMRT) process and 1 Term admission to NNU which will be investigated via the Avoiding Term Admission into Neonatal Units (ATTAIN) process.

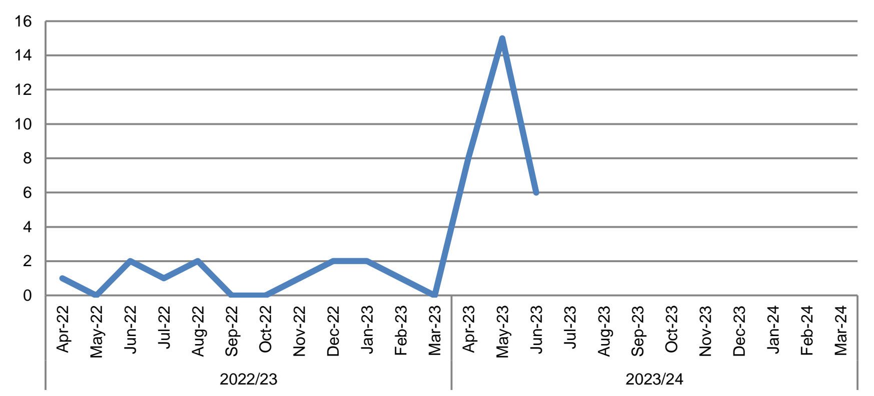
Eastern Services Maternity

Metrics relating to the provision of quality maternity care



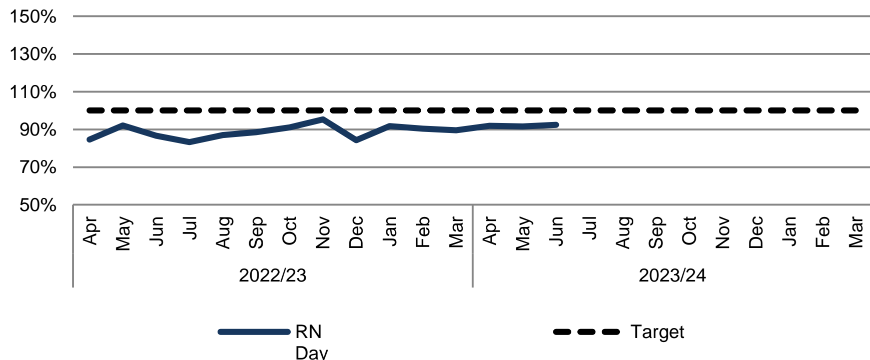


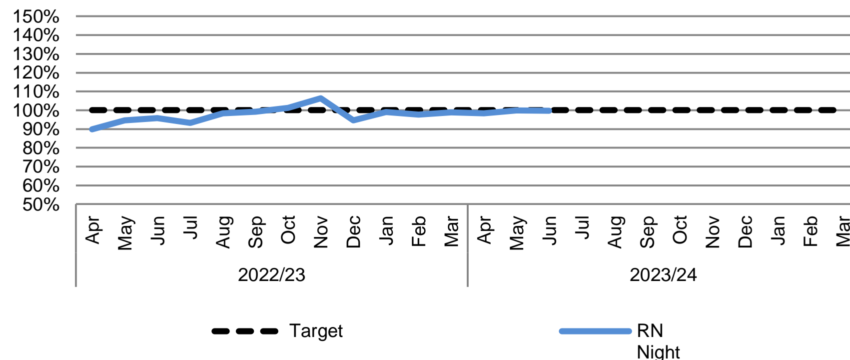


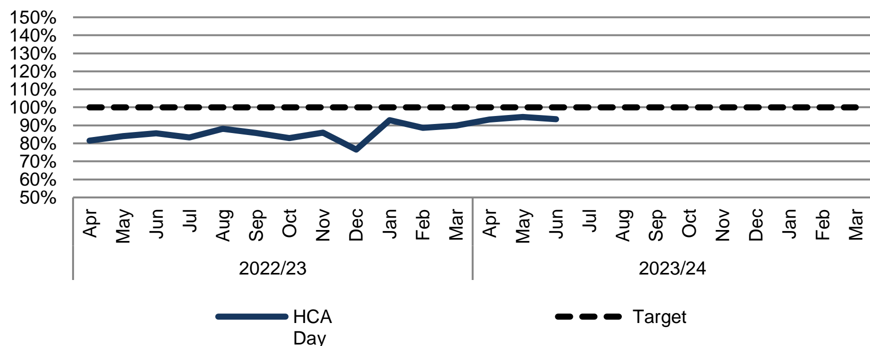


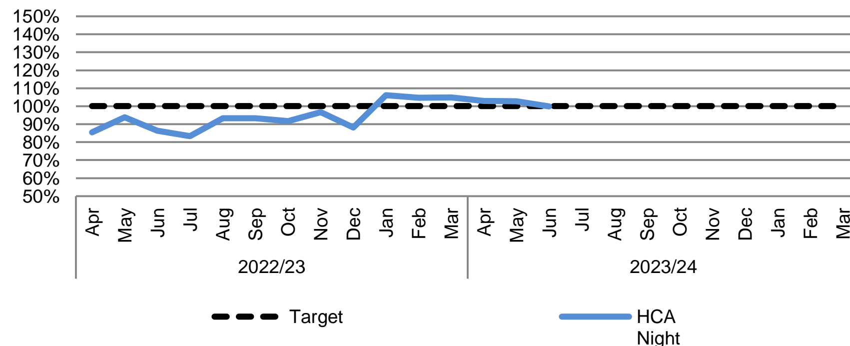
- Service continues to work with the Devon Maternity and Neonatal Voices partnership to encourage service user feedback and provide personalised response in line with Trust early resolution.

Northern Services Safe Clinical Staffing Fill Rates





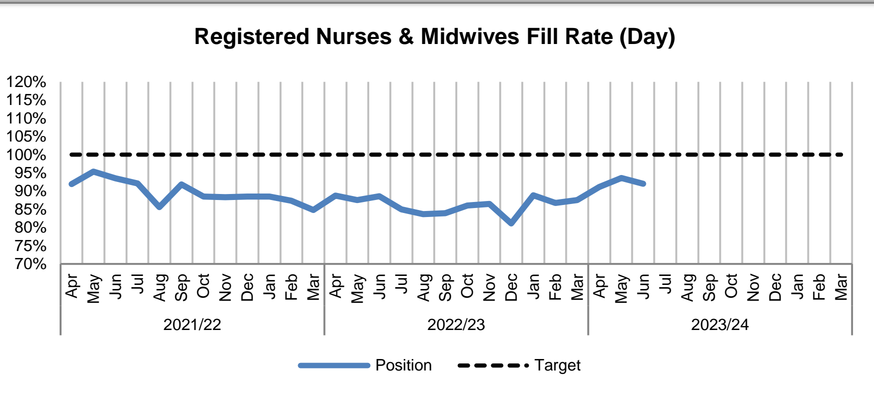


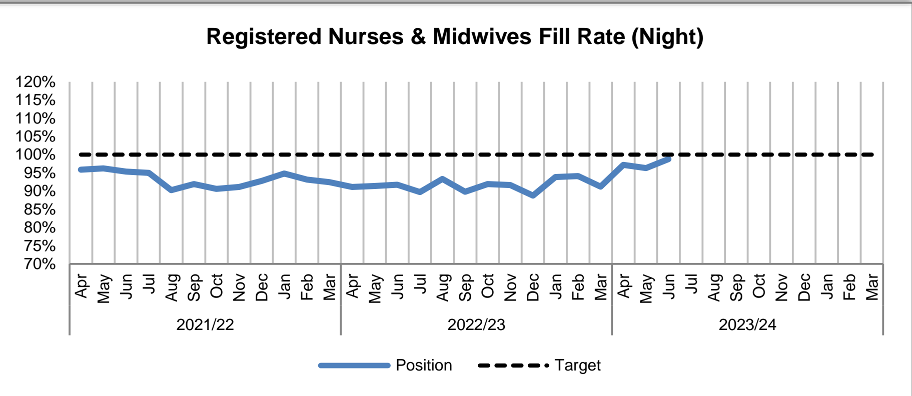


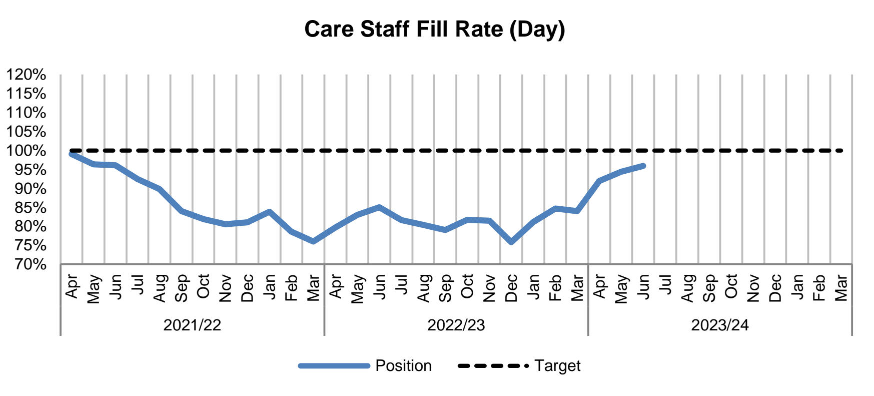
- All staffing fill rates remain 92% or above. Daytime fill rates continue to be more challenging due reduced availability of temporary staff.
- There were 8 reported incidents relating to low nursing and midwifery staffing in April with none scoring moderate or above.
- NB - staffing risks are assessed and mitigated through a number of established processes and strong professional oversight by members of the Senior Nursing and Midwifery teams on a daily basis.

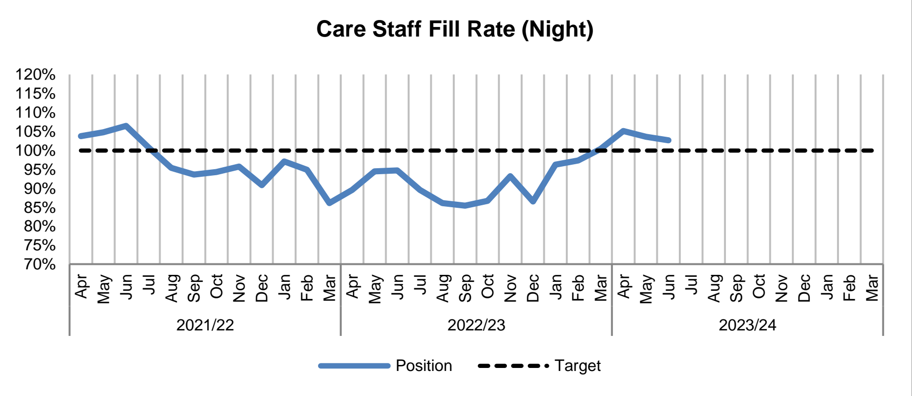
Eastern Services Safe Clinical Staffing – Fill Rate

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







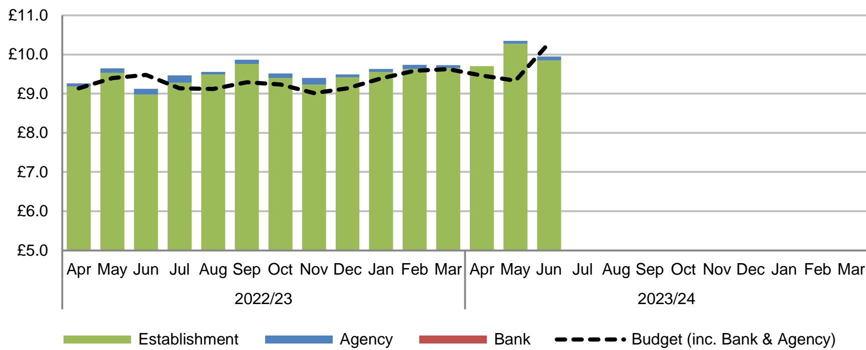


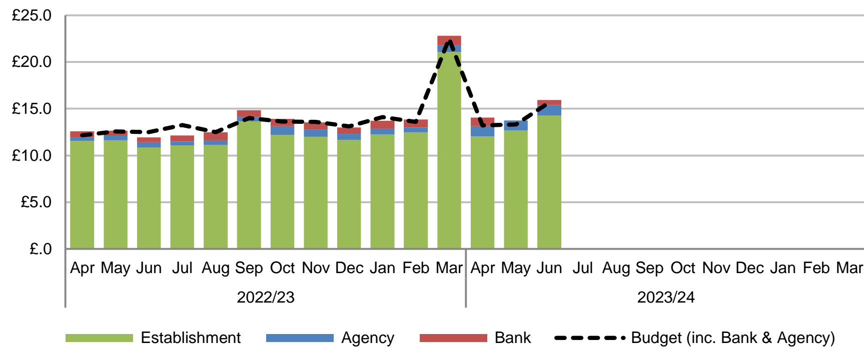
- The fill rate for Eastern services in June 2023 was 97.3%
- There were four patient safety incidents related to staff shortages reported in June 2023. All of these were reported as no harm.
- All patient Safety Incidents which resulted in moderate or greater levels of harm were reviewed. None of these cited staffing issues as either a causative or contributory factor.

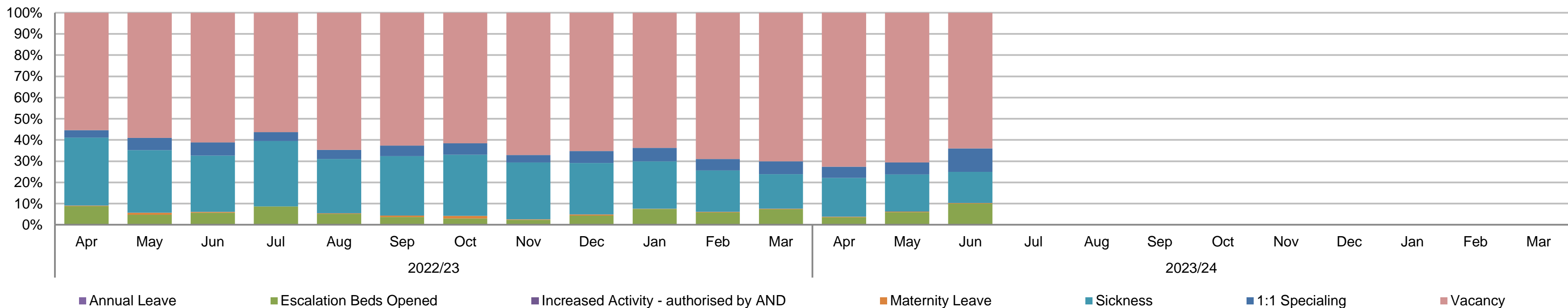
Activity & Flow
Operational Performance
Patient Experience
Quality & Safety
Our People
Finance

Eastern Services Safe Clinical Staffing

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

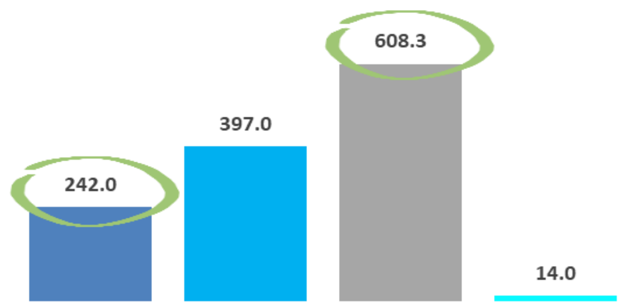


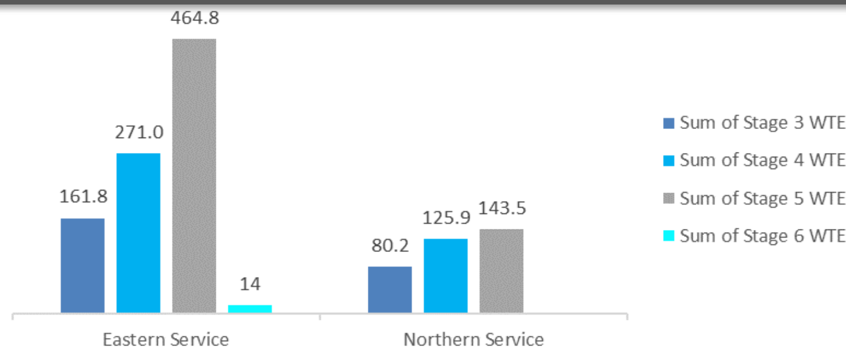




- There was a significant increase in the number of patients who required 1:1 support due to complex mental health presentations or cognitive impairments which created of risk of harm to themselves or others. Over 11% of bank and agency spend was used for 1:1 support. This is the highest proportion of spend noted for this reason. The demand created on services would have been higher, as this spend does not include ward establishment or security staff who are involved in providing 1:1 support.

Trust Recruitment Update





- While the numbers at Stage 3 (194 vacancies out to market) are little changed month on month, there has been significant progression of cases moving from Stage 4 (shortlisting and interview) into Stage 5 pre-employment checks. 705 people are in Stage 5 (up from 594 in May) which exceeds the accepted manageable threshold of caseload volume for these administrative tasks.

- Our Time to Hire (TTH – Time from Advert Published to Contract Offered) reduced to 62.2 for the Trust – following an increase in May which may have been attributable to the three bank holidays that month.
  - Improvements in the TTH can be seen across all of our workforce groups, with notable reductions in the past month to Additional Clinical Services (70 from 82.2), Healthcare Scientists (75.1 from 81.5) and Nursing & Midwifery Registered (70.8 from 79.1)

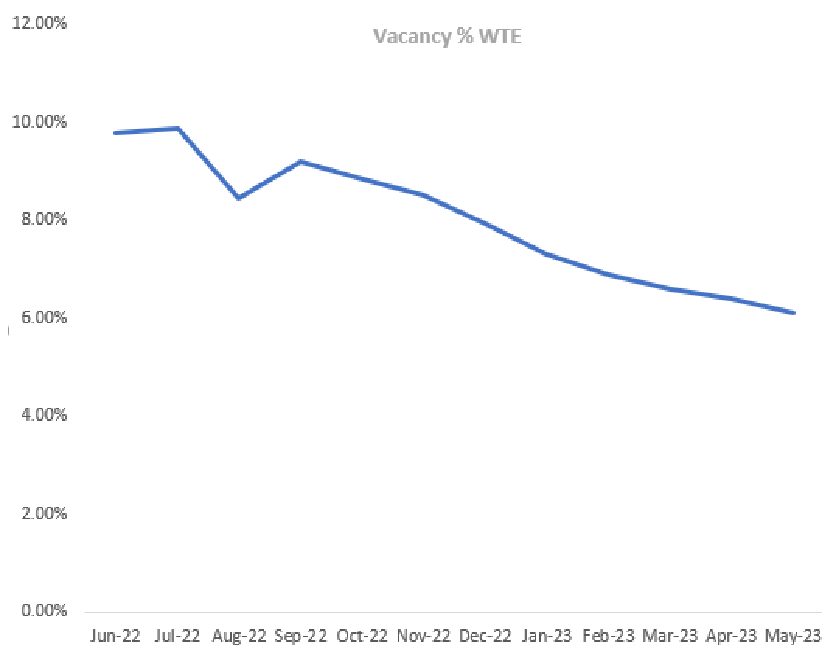
- The staff groups attracting most applications remain Administrative & Clerical, Additional Clinical Services, and Nursing & Midwifery Registered.

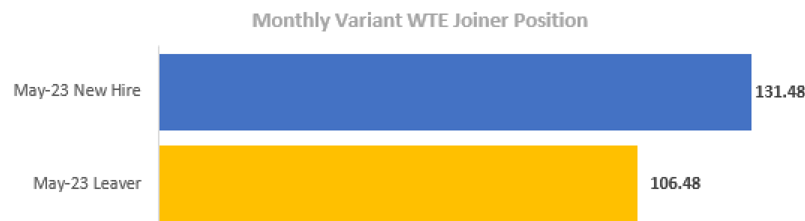
- We have seen an increase in unique visits month on month to Career Gateway
  - Top searches in June by role being Manager (33%), Nurse (27%), Doctor (20%).

- The Royal Devon Website is our greatest recruitment attraction tool with c 50% of applicants coming from this source, NHS Jobs second and Career Gateway Job Alerts third.

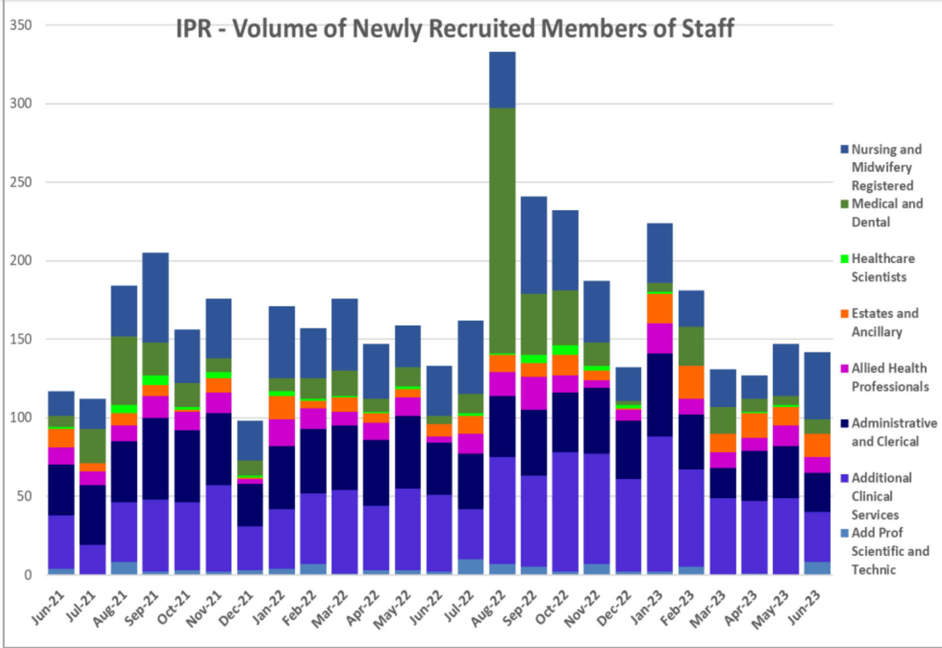
- 37 international nurses arrived in June (25 nurses delayed from May). 20 further nurses are expected to arrive by end of July. We are still experiencing considerable pressure in terms of accommodation across both East and North despite efforts being applied.

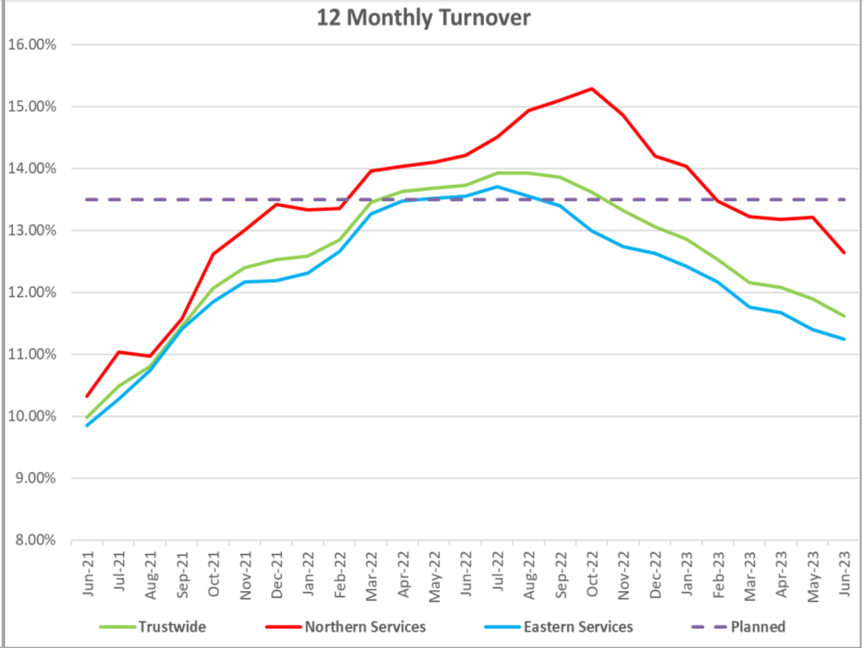
- The vacancy picture remains stable at a Trustwide level, 6.1% and below the planned for 7%.

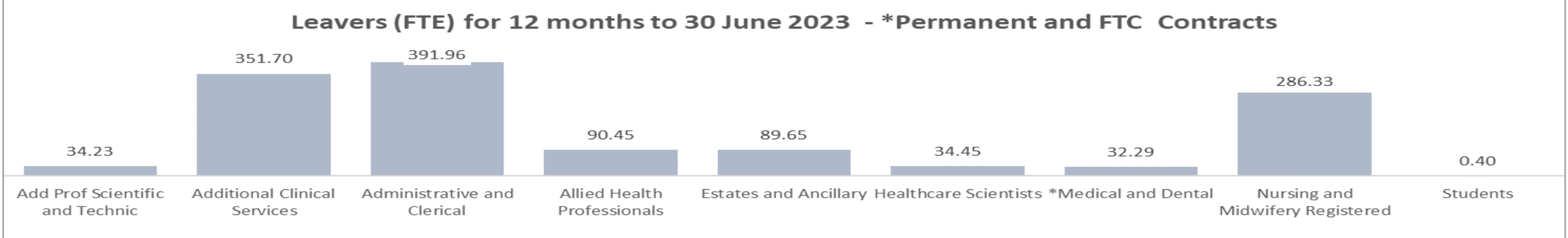




Trust Turnover



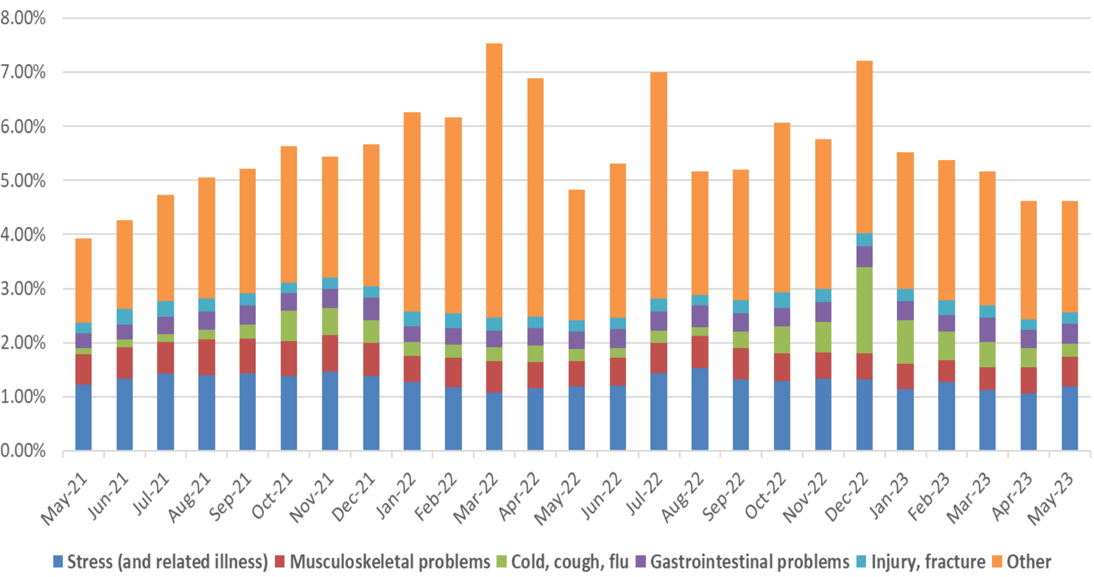


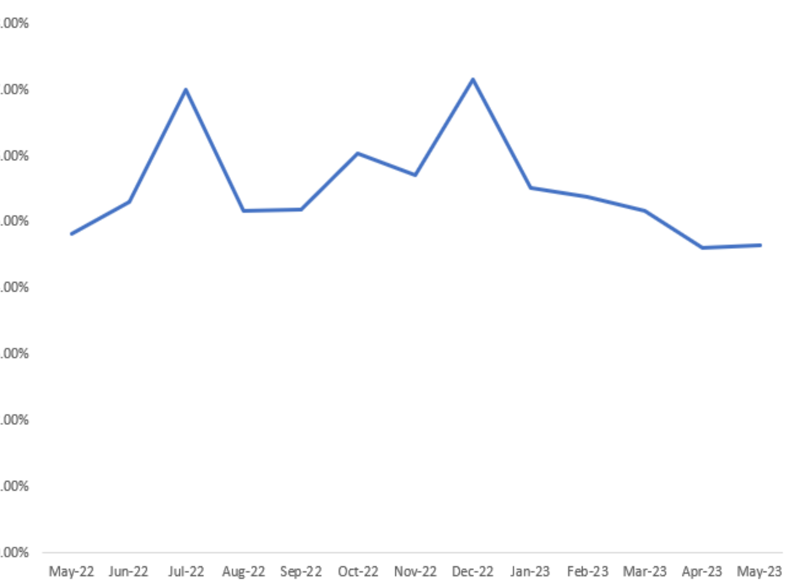


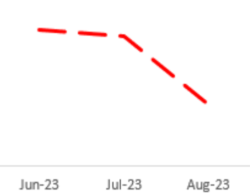
Turnover (data as at end-June 2023)

- Turnover continues to fall Trustwide, now 11.6% at the end of June.
- The decrease in the Eastern rate continues with the rate down to 11.3%.
- After a succession of months in which turnover had plateaued, Northern Services fell from 13.2% to 12.6% in June.
- The Additional Clinical Services and Estates and Ancillary groups remain those most affected by turnover, both seeing month on month increases overall in June to 16% and 13.4% respectively - though this rise was mirrored on the Eastern site only.
- For Admin and Clerical in the North there was 0.7% fall in the rate bringing it back below 14%. In the East A&C remains stable at 12%.

Trust Sickness Absence



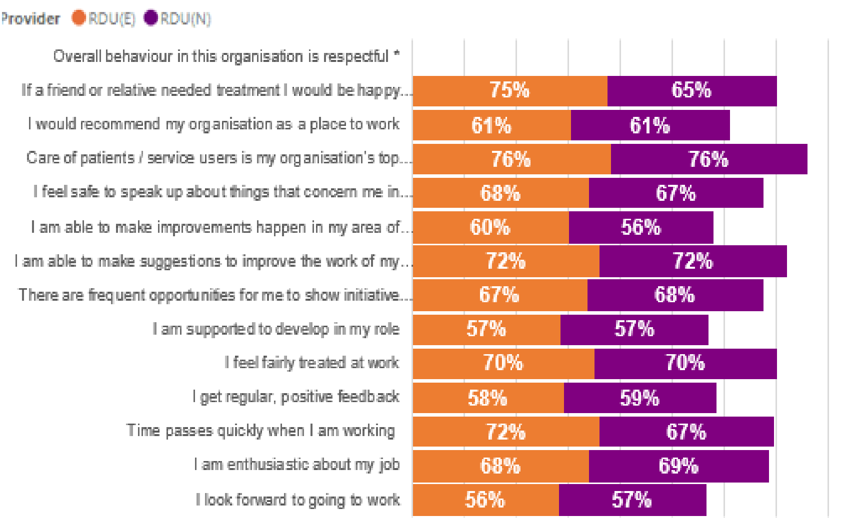


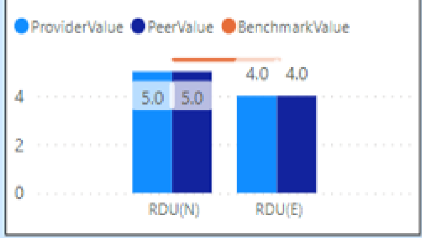


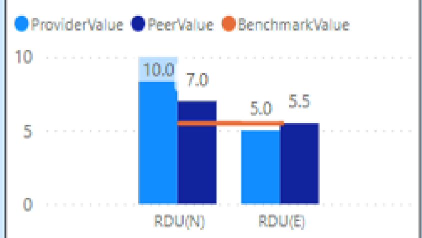
Sickness Absence (Data shown for latest complete month: May-23)

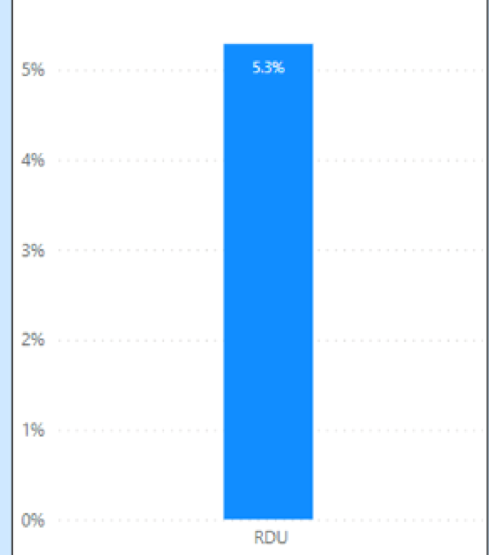
- The sickness rate was little changed in May, with only a minimal increase seen in the overall Trust rate (< 0.1%) to 4.64%.
- By service, a similar picture with our Northern Services showing a further marginal fall (4.38%) and for Eastern Services a minor rise (4.74%).
- In May, Anxiety/stress/depression/other psychiatric illnesses continued to be the predominant cause for sickness absence, with over a quarter of days lost in the month attributed to this reason overall; in Eastern it was a slightly higher proportion at over 26%, while in the North slightly less then a quarter of overall cases (23.6%).
- The continued improvement in sickness absence for our Registered Nursing & Midwifery staff was maintained with a further reduction to below 4.5% overall and similarly reflected on both sites.
- Additional Clinical Services (ACS) however increased overall to 7.41% - an increase most impacting the Eastern site, with the rate for ACS in the North actually falling to the lowest rate (6.35%) recorded in the past 13 months.
- There were further decreases on both sites in May for Estates and Ancillary to below 7% overall – this being the lowest monthly rate recorded for the group since the summer months of 2021.
- The Trust offers a proactive programme of mental health first aid as well as stress management and burnout workshops. The People Function has been actively involved in leadership and management training development to improve managers understanding and ability to utilise the stress risk assessment.
- Single session therapy is available to those who do not need the full six sessions of counselling support and consultative support is offered to teams who are exposed to repeated adversity, e.g. ICU and ED as well as instigating a trauma response (TRiM), where it is deemed appropriate. These services assist in the early identification and subsequent intervention, whilst also supporting a culture shift towards positive mental health action.
- As part of NHS charities funding we have been able to access a psychotherapist for team support.

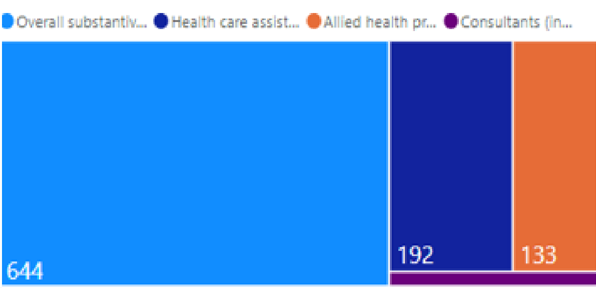
Trust Cultural Dashboard Executive Summary

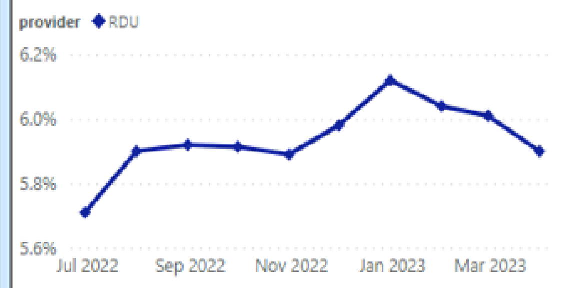


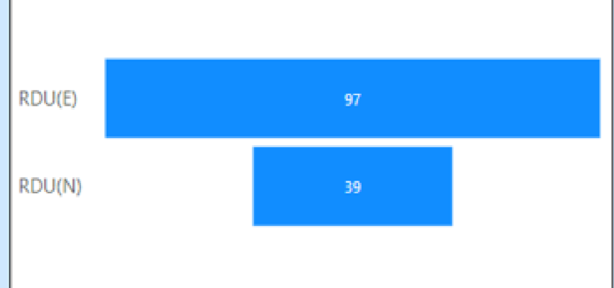












Some data for northern and eastern services is still separate, however it is expected that metrics will become combined over time. This information provides an insight into our performance as a Trust in these areas. Key points have been noted below:

- Responses for 10 of the people pulse questions are broadly comparable for eastern and northern services. For northern services 3 questions have a lower positive response markedly for when answering "if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation" where there is a 10% difference between eastern (75%) and northern (65%) responses.
- The Royal Devon absence rate has continued to decrease in recent months .
- There is no system comparison in this dashboard as there is a significant time lag with data being provided to update the dashboard. This is being fed back to the ICB to understand if anything can be done in future to expedite availability of this data moving forward. Deloitte have been commissioned to develop a systemwide workforce dashboard and this cultural dashboard has been shared to ensure no duplication of effort.
- We are looking to ensure board reporting of this in the IPR in the month after the People Pulse being run to get a more consistent cycle of reporting.

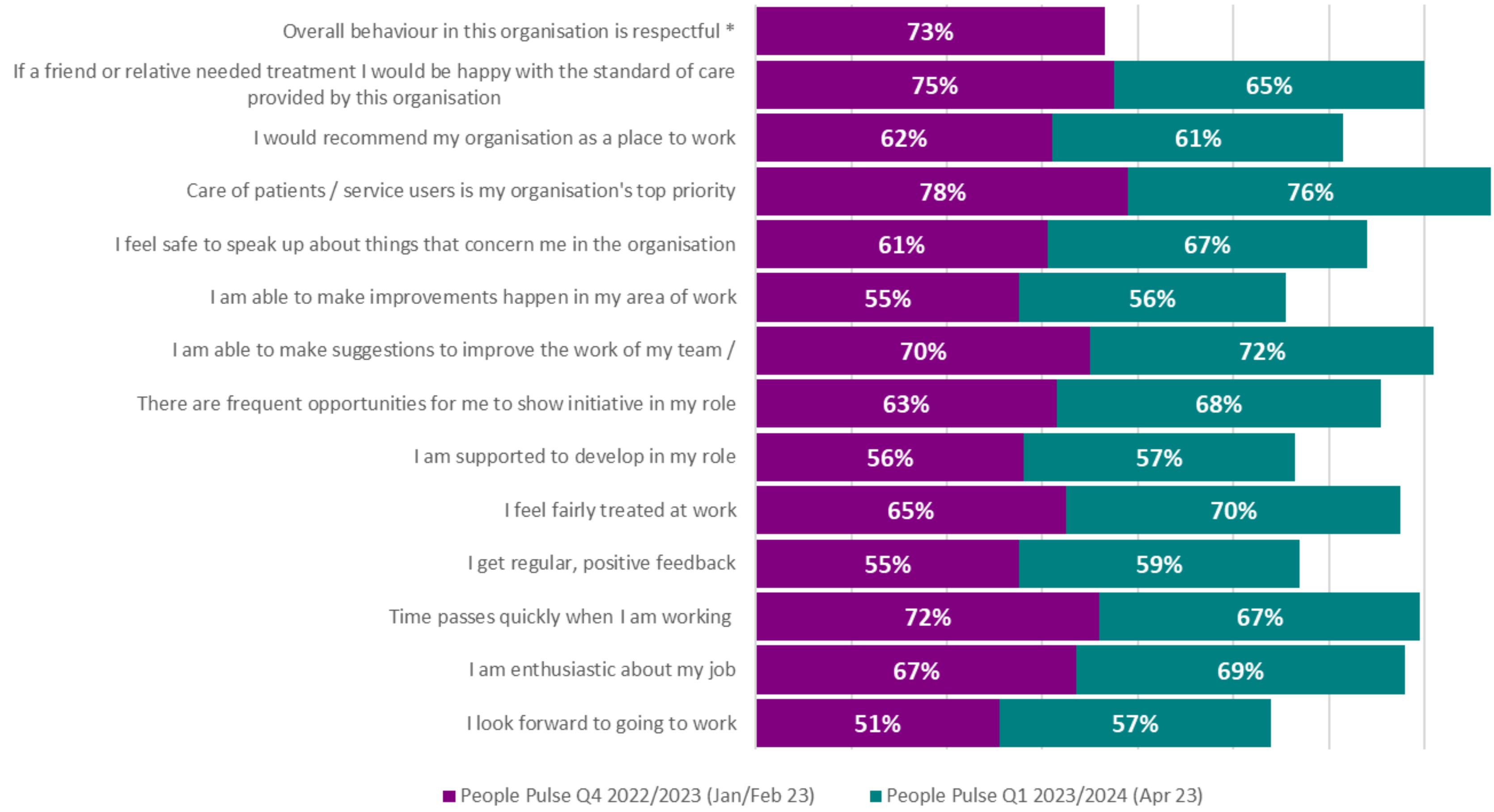
Trust Overview of Survey Response Rates

	Q2 2021/22 People Pule	Q3 2021/22 Staff Survey	Q4 2021/22 People Pulse	Q1 2022/23 People Pulse	Q2 2022/23 People Pulse	Q3 2022/23 Staff Survey	Q4 2022/23 People Pulse	Q1 2023/24 People Pulse
Date range	5th - 21st July 2021	Oct - Nov 2021	19th Jan - 4th Feb 2022	13th - 29th April 2022	13th - 29th July 2022	Oct - Nov 2022	18th Jan - 3rd Feb 2023	17th -28th April 2023
Eastern Response Rate	19.0%	46%	12.5% ↓	10.7% ↓	8.5% ↓	36%	7.5% ↓	10.9% ↑
Northern Response Rate	20.1%	51%	13.0% ↓	11.9% ↓	9.7% ↓	39%	7.9% ↓	11.4% ↑
Overall Response Rate	Not recorded (Pre integration)			10.5%	8.8% ↓	37%	7.6% ↓	10.8% ↑

Notes:

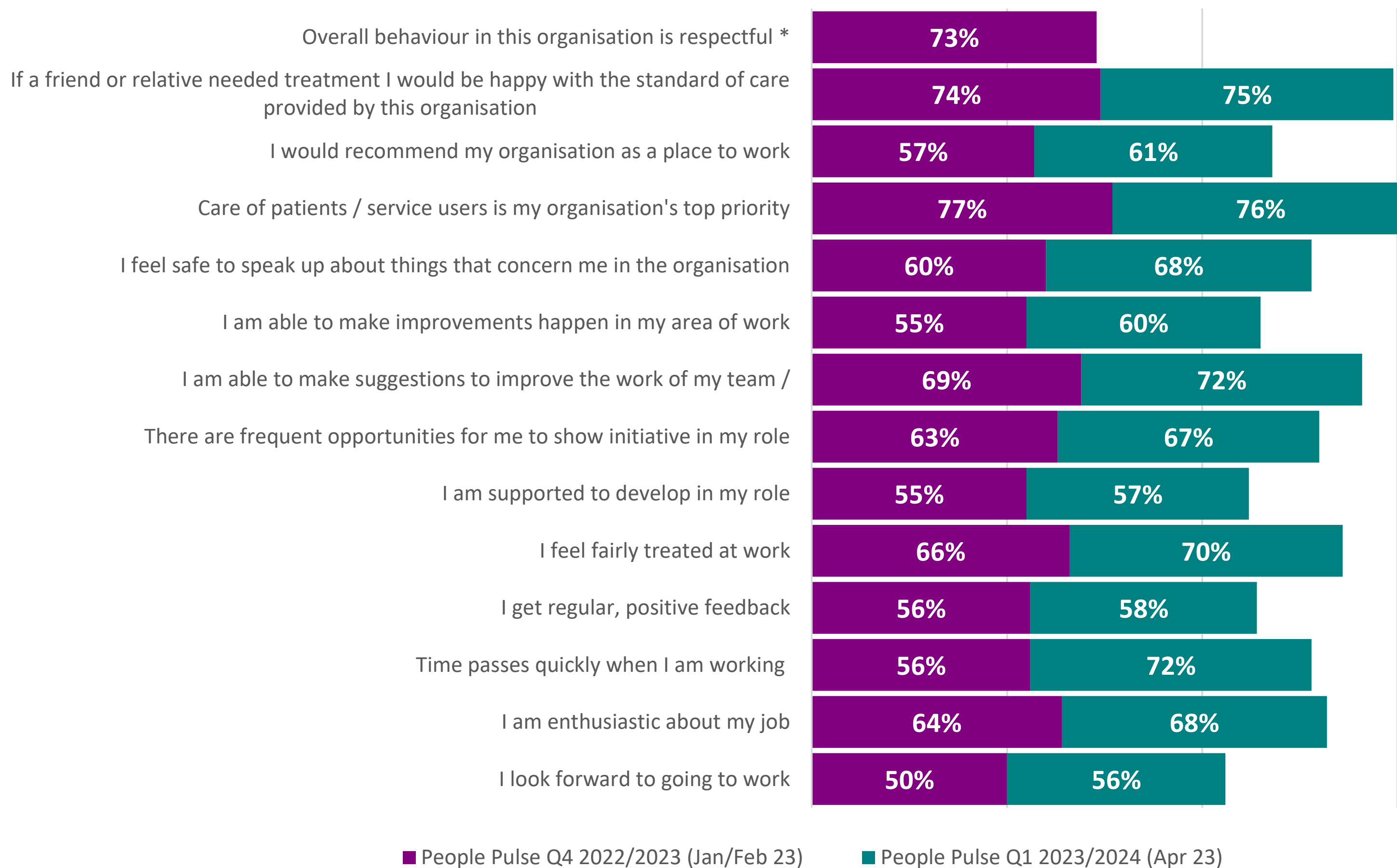
- People pulse includes all bank workers, honorary and locum staff and therefore is sent to a greater number of staff members, when compared to the annual staff survey.
- People pulse runs for a period of between 2 and 2.5 weeks, compared to 8 weeks for the annual staff survey

Northern Services



Across northern services 9 of 13 scores have increased of which 5 scores increased by more than 4%. The positive response to "time passes quickly when I am working has dropped by 5%. Concerningly there has been a 10% drop to the positive response to the question "if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation". Increasing the positive response to this question has been identified as a key executive priority.

Eastern Services



Across eastern services 12 of 13 scores have increased across of which 8 scores increased by more than 4%. The response to “I feel safe to speak up about things that concern me in the organisation” has increased by 8%. In the last quarter there was concern around the drop in positive response to ‘time passes quickly when I am working’, which has seen a decrease in score of 13%, however this quarter the score has increased by 16% suggesting the previous quarter drop may have been an anomaly.

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

Trust Summary Finance Position

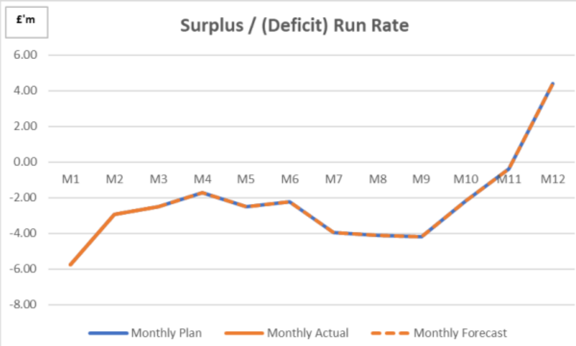
Financial Performance - key performance indicators

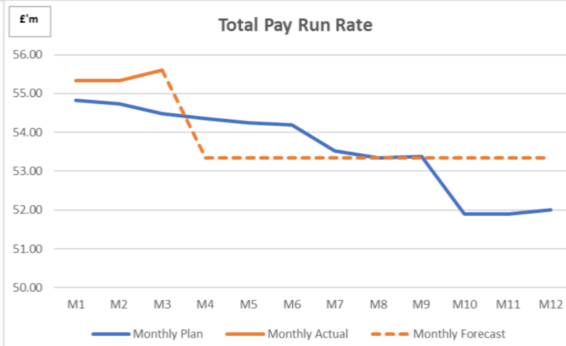
Domain	Measure / Metric (Consolidated Metrics)	Unit of Measure	This Month May-23	This Month Jun-23	Narrative	Forecast Mar-24	Narrative
Income and Expenditure	**I&E Surplus / (Deficit) - Total**	£'000	-8,678	-11,191		-28,035	
	I&E Surplus / (Deficit) v budget	£'000	0	0		0	
	Income variance to budget - Total	£'000	-1,894	-2,517		-4,636	
	Income variance to budget - Total	%	-1.14%	-1.00%		-0.47%	
	Income variance to budget - Patient Care	£'000	-28	-294	NHS England drugs and devices below planned levels.	-870	NHS England drugs and devices below planned levels.
	Income variance to budget - Operating income	£'000	-1,866	-2,223	(£0.7m) Research & Development income (£0.5m) Education and Training (£1.0m) Other Research is being reviewed against planning assumptions; the SOCI highlights underspends on expenditure that are consistent with the reduced income assumptions YTD and FOT.	-3,766	(£1.9m) Research & Development income (£1.0m) Education and Training (£0.9m) Other Reviewing issues and will reflect in future forecasting.
	Pay variance to budget - Total	£'000	-1,126	-2,275	Overall impact of £2.3m adverse to plan (£1.2m strike action, £1.0m DBV slippage) NHSE returns have been completed to collect cost and activity impacts of strike action. Any income recovery is not reflected in the YTD position and would be a future benefit if national funding was available.	-3,517	Overall impact of £3.5m adverse to plan (£2.4m strike action, £1.1m DBV slippage) Any income recovery is not reflected in the YTD position and would be a future benefit if national funding was available.
	Pay variance to budget - Total	%	-1.03%	-1.39%		-0.55%	
	Agency expenditure variance to Plan	£'000	-204	-969	Planned expenditure is net of Delivering Best Value savings target though impacted by usage to cover industrial action. £4.8m YTD expenditure is £0.6m less than month 3 2022/23.	-1,132	Agency plan for the year is £15.1m. £16.1m FOT expenditure is £8.0m less than month 12 2022/23. Focus on understanding agency usage and actions to reduce; reporting through monthly performance meetings.
	Agency expenditure variance to agency limit	£'000	828	586	Agency limit YTD is £5.3m	5,092	Agency limit for the full year is £21.4m
	Non Pay variance to budget	£'000	3,014	4,485	Activity impact of strike action. Review to be undertaken to consider the full year impact.	6,975	Activity impact of strike action.
	Non Pay variance to budget	%	4.76%	4.73%		1.89%	
	PDC, Interest Paid / Received variance to budget	£'000	6	254		1,096	
	PDC, Interest Paid / Received variance to budget	%	0.00%	0.03%		0.00%	
	Capital Donations variance to plan - technical reversal	£'000	0	53		82	Off-sets adverse variance in Capital (CDEL). Neutral adjustment when calculating reported financial position.
	Delivering Best Value Programme - Total Current Year achievement	£'000	3,523	5,413	YTD variance largely driven by non-delivery against Epic benefits (£1.1m), detailed delivery plans finalised and forecast year end under delivery of £4.1m. Scoping of additional ideas underway and a Q1 review being set up with Programme Leads and Divisional Directors to identify further opportunities. DBV schemes variance to plan: (£0.7m) Income adverse (£1.0m) Pay adverse (£0.1m) Non pay adverse	60,296	Full year internal requirement of £44.7m with £15.6mrequired from ICB schemes. £5.8m unidentified is a risk to internal forecast position (£11m prior month). Risk of ICB schemes being quantified.
	Delivering Best Value Programme - Year to date/ Current Year variance to budget	£'000	-1,043	-1,833		0	
Capital & Cash	Cash balance	£'000	53,279	52,864	Trade payables are £6.1m higher than outturn as a consequence of issues following the implementation of the new finance system. The cash benefit is also supported by £5.9m slippage on the capital programme.	20,357	
	Cash variance to budget - above / (below)	£'000	9,906	13,427		5,863	
	Better Payment Practice v 95% cumulative target - volume	%	36%	79%	Issues with the new finance system. Actions to resolve include focus on sufficient authoriser capacity; daily bank runs and support to pharmacy, increase finance capacity to address post-implementation vacancies. Additional capacity is significantly reducing the volume and value of uncoded invoices and is reflected in the improvement.	90%	All endeavours will be targeted to minimise the impact on suppliers. Recovery to 90% **cumulatively** remains the aspiration with the objective for incremental improvement to **recover the in-month 95% of value target by month 5.** Assurance will contine to be reported through the Finance and Operational Committee.
	Better Payment Practice v 95% cumulative target - value	%	56%	74%		90%	
	Capital Expenditure variance to plan - Total above / (below)	£'000	-4,029	-5,876	Capital expenditure to M3 was £2.5m; £5.9m less than assumed in plan. Whilst the programme is behind plan, there is confidence the slippage will recover based on open orders of £8.7m. The respective Capital Programme Groups are actively monitoring risks and mitigations to ensure delivery.	2,368	Forecast capital expenditure of £75.5m fully utilises the CDEL and PDC allocations forecast in 2023/24.
	Capital Expenditure variance to plan - CDEL above / (below)	£'000	-887	-1,053	Slippage across a number of schemes expected to recover.	-82	Off-sets favourable variance in operating income. Neutral adjustment when calculating reported financial position.
	Capital Expenditure variance to plan - PDC above / (below)	£'000	-3,142	-4,823	Slippage on commencing schemes with expectation to recover: £2.3m Endoscopy capacity £1.6m Cardiology Day case Unit £1.0m Community Diagnostics	2,450	£1.4m additional Endoscopy allocation. £1.1m New Hospital Programme allocation.

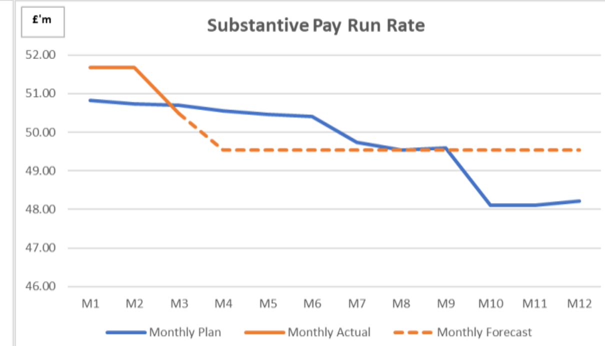
Key
- **Total value**
- **Positive variance value**
- **Negative variance value <5%**
- **Negative variance value >5%**

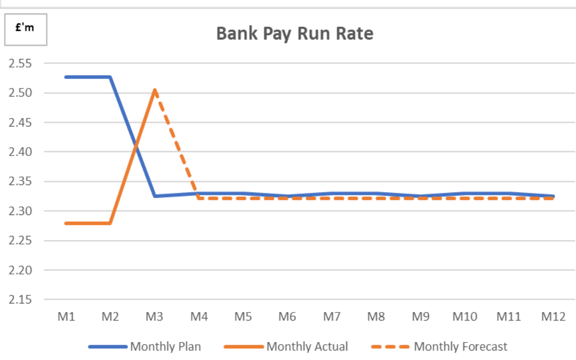
Trust Finance Overview

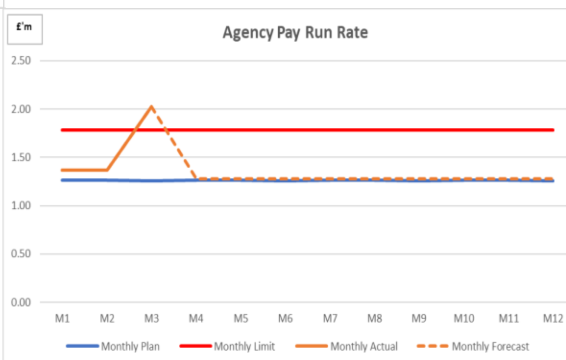
Royal Devon University Healthcare NHS Foundation Trust
Charts
Period ending 30/06/2023
Month 3

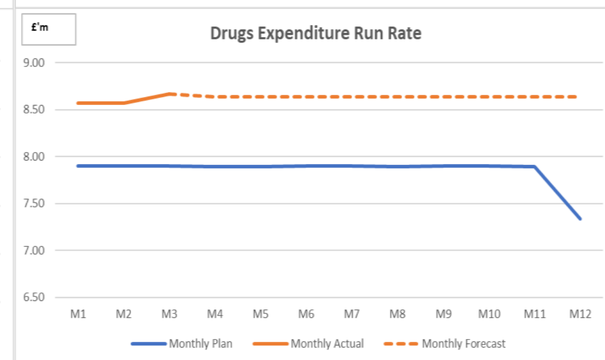


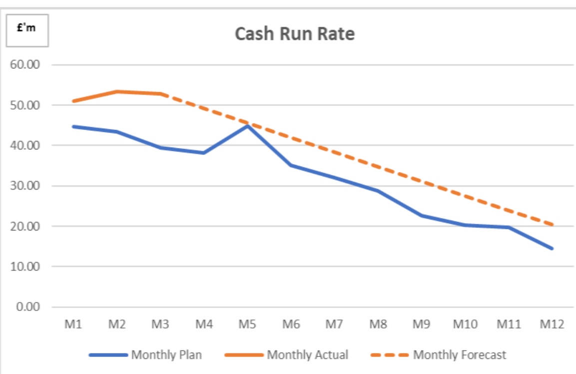


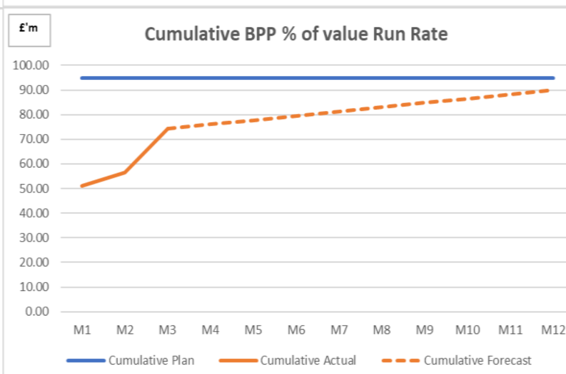












BPP

Issues with the new finance system. Actions to resolve include focus on sufficient authoriser capacity; daily bank runs and support to pharmacy, increase finance capacity to address post-implementation vacancies. Additional capacity is significantly reducing the volume and value of uncoded invoices and is reflected in the improvement.

All endeavours will be targeted to minimise the impact on suppliers. Recovery to **90% cumulatively** remains the aspiration with the objective for incremental improvement to **recover the in-month 95% of value target by month 5**. Assurance is reported through the Finance and Operational Committee.

Deep Dives

Reviews will be undertaken on areas of large variance, particularly pay and drugs, to identify issues and actions; these will be presented to the next Finance and Operational Committee.

Trust Financial Tables

Royal Devon University Healthcare NHS Foundation Trust Income Statement Period ending 30/06/2023 Month 3	Year to Date				Outturn		
	Plan £'000	Actual £'000	Actual Variance to Budget Fav / (Adv) £'000		Plan £'000	Actual £'000	Actual Variance to Budget Fav / (Adv) £'000
Income							
Patient Care Income	222,458	222,164	(294)	1	883,336	882,466	(870)
Operating Income	28,202	25,979	(2,223)	2	113,438	109,672	(3,766)
Total Income	**250,660**	**248,143**	**(2,517)**		**996,774**	**992,138**	**(4,636)**
Employee Benefits Expenses	(163,982)	(166,257)	(2,275)	3	(642,861)	(646,378)	(3,517)
Services Received	(8,973)	(7,384)	1,589	4	(35,963)	(31,468)	4,495
Clinical Supplies	(22,530)	(17,641)	4,889	4	(90,000)	(81,256)	8,744
Non-Clinical Supplies	(4,353)	(3,934)	419	4	(15,428)	(14,736)	692
Drugs	(23,697)	(25,809)	(2,112)	5	(94,212)	(103,519)	(9,307)
Establishment	(3,694)	(4,402)	(708)	5	(13,141)	(13,608)	(467)
Premises	(6,474)	(6,686)	(212)	5	(25,538)	(26,181)	(643)
Depreciation & Amortisation	(10,138)	(10,107)	31		(42,010)	(42,010)	0
Impairments (reverse below the line)	0	0	0		0	0	0
Clinical Negligence	(7,956)	(8,078)	(122)		(26,520)	(26,520)	0
Research & Development	(2,493)	(3,154)	(661)	6	(9,012)	(10,916)	(1,904)
Operating lease expenditure	(467)	(359)	108	5	(1,690)	(1,436)	254
Other Operating Expenses	(4,073)	(2,809)	1,264	5	(14,847)	(9,736)	5,111
Total Costs	**(258,830)**	**(256,620)**	**2,210**		**(1,011,222)**	**(1,007,764)**	**3,458**
EBITDA	**(8,170)**	**(8,477)**	**(307)**		**(14,448)**	**(15,626)**	**(1,178)**
Profit / (Loss) on asset disposals	0	0	0		0	0	0
Interest Receivable	605	879	274		1,431	2,527	1,096
Interest Payable	(687)	(708)	(21)		(2,642)	(2,642)	0
PDC	(3,078)	(3,077)	1		(12,308)	(12,308)	0
Net Surplus / (Deficit)	**(11,330)**	**(11,383)**	**(53)**		**(27,967)**	**(28,049)**	**(82)**
Remove donated asset income & depreciation, AME impairment and gain from transfer by absorption	139	192	53		(68)	14	82
Net Surplus/(Deficit) after donated asset & PSF/MRET Income	**(11,191)**	**(11,191)**	**0**		**(28,035)**	**(28,035)**	**0**

KEY MOVEMENTS AGAINST BUDGET

Overall achievement against plan

1. Patient care income impacted by reduced income expectation on pass-through drugs and devices.

2. (£0.7m) Research & Development income, (£0.5m) Education and Training, (£1.0m).

3. £2.3m Variances across all staff groups on substantive and bank. Medical pay reflects impact of strike action (£1.2m) and slippage on delivering DBV (£1.0m). NHSE returns compiled to collect cost and activity impacts of strike action; recovery is not reflected in the YTD position and would be a future benefit if national funding was available.

4. Activity impact of strike action.

5. Review to be undertaken to consider the comparison with plan run rate at month 7 2022/23 and full year impact.

6. Off sets reduced income from R&D activities.

Trust Financial Tables

Royal Devon University Healthcare NHS Foundation Trust	Year to Date				Outturn			Prior Year	
Statement of Financial Position	Plan	Actual	Actual Variance Over / (Under)		Plan	Actual	Actual Variance Over / (Under)	Mar-23	Actual YTD Movement Incr. / (Dec.)
Period ending 30/06/2023 Month 3	£000	£000	£000		£000	£000	£000	£000	£000
Non-current assets									
Intangible assets	57,221	56,366	(855)	1	53,333	52,837	(496)	58,621	(2,255)
Other property, plant and equipment (excludes leases)	423,894	417,784	(6,110)	1	451,271	453,027	1,756	421,298	(3,514)
Right of use assets - leased assets for lessee (excludes PFI/LIFT)	51,803	52,820	1,017	2	61,184	62,142	958	54,580	(1,760)
Other investments / financial assets	5	5	0		5	5	0	5	0
Receivables	2,726	3,383	657	2	2,726	3,303	577	3,303	80
Credit Loss Allowances	0	(228)	(228)	2	0	(228)	(228)	(228)	
Total non-current assets	**535,649**	**530,130**	**(5,519)**		**568,519**	**571,086**	**2,567**	**537,579**	**(7,449)**
Current assets									
Inventories	13,550	16,929	3,379	2	13,550	13,550	0	15,624	1,305
Receivables: due from NHS and DHSC group bodies	17,810	21,165	3,355	2	17,810	17,810	0	39,891	(18,726)
Receivables: due from non-NHS/DHSC group bodies	16,000	24,566	8,566	2	16,000	16,796	796	21,090	3,476
Credit Loss Allowances	0	(885)	(885)	2	0	(796)	(796)	(796)	(89)
Other assets: including assets held for sale & in disposal groups	0	0	0		0	0	0	0	0
Cash	39,437	52,864	13,427		14,494	20,357	5,863	46,033	6,831
Total current assets	**86,797**	**114,639**	**27,842**		**61,854**	**67,717**	**5,863**	**121,842**	**(7,203)**
Current liabilities									
Trade and other payables: capital	(11,000)	(4,601)	6,399	2	(11,000)	(11,000)	0	(6,615)	2,014
Trade and other payables: non-capital	(79,847)	(102,842)	(22,995)	2	(79,850)	(79,850)	0	(96,708)	(6,134)
Borrowings	(13,968)	(17,730)	(3,762)	2	(15,000)	(18,634)	(3,634)	(16,676)	(1,054)
Provisions	(200)	(295)	(95)	2	(200)	(295)	(95)	(295)	0
Other liabilities: deferred income including contract liabilities	(13,577)	(13,220)	357		(10,500)	(10,500)	0	(17,892)	4,672
Total current liabilities	**(118,592)**	**(138,688)**	**(20,096)**		**(116,550)**	**(120,279)**	**(3,729)**	**(138,186)**	**(502)**
Total assets less current liabilities	**503,854**	**506,081**	**2,227**		**513,823**	**518,524**	**4,701**	**521,235**	**(15,154)**
Non-current liabilities									
Borrowings	(101,576)	(98,928)	2,648	1	(102,440)	(99,839)	2,601	(102,694)	3,766
Provisions	(970)	(1,270)	(300)	2	(970)	(1,276)	(306)	(1,276)	6
Other liabilities: deferred income including contract liabilities	0	0	0		0	0	0	0	0
Total non-current liabilities	**(102,546)**	**(100,198)**	**2,348**		**(103,410)**	**(101,115)**	**2,295**	**(103,970)**	**3,772**
Total net assets employed	**401,308**	**405,883**	**4,575**		**410,413**	**417,409**	**6,996**	**417,265**	**(11,382)**
Financed by									
Public dividend capital	356,902	361,604	4,702	2	382,645	389,797	7,152	361,604	0
Revaluation reserve	63,956	52,385	(11,571)	2	63,956	52,385	(11,571)	52,385	0
Income and expenditure reserve	(19,550)	(8,106)	11,444	2	(36,188)	(24,773)	11,415	3,277	(11,383)
Total taxpayers' and others' equity	**401,308**	**405,883**	**4,575**		**410,413**	**417,409**	**6,996**	**417,266**	**(11,383)**

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.

3 Trade payables are £6.1m higher than outturn as a consequence of issues following the implementation of the new finance system. The cash benefit is also supported by £5.9m slippage on the capital programme.

Trust Financial Tables

Royal Devon University Healthcare NHS Foundation Trust Cash Flow Statement Period ending 30/06/2023 Month 3	Year to Date				Outturn		
	Plan *£000*	Actual *£000*	Actual Variance Fav. / (Adv.) *£000*		Plan *£000*	Actual *£000*	Actual Variance Fav. / (Adv.) *£000*
Cash flows from operating activities							
Operating surplus/(deficit)	(8,170)	(8,477)	(307)		(14,448)	(15,626)	(1,178)
Non-cash income and expense:							
Depreciation and amortisation	10,138	10,107	(31)		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)	(53)	0	53		(842)	(760)	82
(Increase)/decrease in receivables	0	15,207	15,207		0	26,375	26,375
(Increase)/decrease in inventories	0	(1,305)	(1,305)		0	2,074	2,074
Increase/(decrease) in trade and other payables	220	3,109	2,889	[1]	222	(16,858)	(17,080)
Increase/(decrease) in other liabilities	0	(4,672)	(4,672)		0	(7,392)	(7,392)
Increase/(decrease) in provisions	0	(6)	(6)		0	401	401
Net cash generated from / (used in) operations	**2,135**	**13,963**	**11,828**		**26,942**	**30,224**	**3,282**
Cash flows from investing activities							
Interest received	605	879	274		1,431	2,527	1,096
Purchase of intangible assets	(300)	0	300		(3,000)	(3,000)	0
Purchase of property, plant and equipment and investment property	(8,107)	(4,546)	3,561		(54,660)	(52,822)	1,838
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	53	0	(53)		842	760	(82)
Net cash generated from/(used in) investing activities	**(7,749)**	**(3,667)**	**4,082**		**(55,387)**	**(52,535)**	**2,852**
Cash flows from financing activities							
Public dividend capital received	0	0	0		25,743	28,193	2,450
Loans from Department of Health and Social Care - repaid	0	0	0		(1,270)	(1,270)	0
Other loans received	0	0	0		0	0	0
Other loans repaid	0	0	0		(5,174)	(5,174)	0
Other capital receipts	(1,394)	(1,394)	0		0	0	0
Capital element of finance lease rental payments	(1,752)	(1,573)	179		(8,828)	(8,828)	0
Interest paid	(557)	(341)	216		(3,978)	(3,376)	602
Interest element of finance lease	0	(157)	(157)		0	(602)	(602)
PDC dividend (paid)/refunded	0	0	0		(12,308)	(12,308)	0
Net cash generated from/(used in) financing activities	**(3,703)**	**(3,465)**	**238**		**(5,815)**	**(3,365)**	**2,450**
Increase/(decrease) in cash and cash equivalents	**(9,317)**	**6,831**	**16,148**		**(34,260)**	**(25,676)**	**8,584**
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	**39,437**	**52,864**	**13,427**		**14,494**	**20,357**	**5,863**

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 30/06/2023 Month 3	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	3,108	2,108	1,000		31,074	31,074	0
PDC	5,247	424	4,823		25,743	28,193	(2,450)
Donations/Grants	53	0	53		842	760	82
IFRS 16	0	0	0		15,488	15,488	0
Total Capital Funding	**8,408**	**2,532**	**5,876**		**73,147**	**75,515**	**(2,368)**
Expenditure:							
Equipment	853	241	612	230	15,528	13,354	2,174
Estates Backlog/EIP	732	481	251	3,437	7,371	6,948	423
Estates Developments	599	416	182	980	10,047	6,896	3,151
Digital	416	113	303	504	4,162	7,465	(3,303)
Our Future Hospital	0	213	(213)	1	0	1,060	(1,060)
ED	616	594	23	1,640	6,165	5,000	1,165
Cardiology Day Case	1,781	154	1,627	893	7,432	7,439	(7)
CDC Nightingale	1,100	51	1,049	154	4,400	4,400	0
Endoscopy	2,312	6	2,306	222	11,122	12,984	(1,862)
Diagnostics - Northern Schemes	0	0	0	0	3,797	3,797	0
Digital Capability Programme	0	0	(0)	179	1,123	1,123	0
Other	0	263	(263)	488	0	936	(936)
Unallocated	0	0	0	0	2,000	4,113	(2,113)
Total Capital Expenditure	**8,408**	**2,532**	**5,876**	**8,728**	**73,147**	**75,515**	**(2,368)**
Under/(Over) Spend	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Capital expenditure to M03 was £2.5m; £5.9m less than assumed in plan. Whilst the programme is behind plan, there is confidence the slippage will recover based on the value of open orders. The respective Capital Programme Groups are actively monitoring risks and mitigations to ensure delivery.

Forecast capital expenditure of £75.5m 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 30/06/2023
Month 3

Delivering Best Value Finance Report Month 3		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
Recurrent DBV									
	Clinical Productivity - Activity		1,572	1,572	0	13,100	13,100	0	
Clinical Activity	Data quality, coding & capture		1,250	667	-583	5,000	5,000	0	£130k YTD slippage due to under delivery against planned actions largely due to LATPS not being coded correctly. Remainder of variance is caused by phasing differences between programme plan & identified phasing as well as a £600k unidentified, however assurance provided full delivery against target is still expected at year end
Corporate Services	Corporate Services - Integration		250	51	-199	2,000	2,000	0	Further YTD benefit expected in month 4 once new finance ledger has embeded. Identified plans currently £900k short of target. Work ongoing to quantify further opportunities for estates & facilities and operations to mitigate against this
Other Income Opportunities	Overseas visitor income		0	0	0	200	50	-150	Position being reviewed this month to see if further delivery can be expected
	Other Trustwide Income		0	0	0	0	200	200	
Estate Review	Leased Estate DBV		0	0	0	200	200	0	Work ongoing to identify potential opportunity, update on detailed plans expected in July
Workforce	Temporary Workforce		1,005	674	-331	5,200	2,600	-2,600	YTD under delivery due to combination of industrial action and high intensity nursing for specialist patients, cautious approach to this reflected within forecast position
	Supporting colleagues return to work		0	0	0	500	500	0	
Epic	Epic Optimisation		1,444	301	-1,143	5,800	1,653	-4,147	Detailed review of opportunities presented to DBV Governance process, expected delivery relates to admin benefit, non pay legacy systems and stationary
Procurement	Procurement		125	0	-125	500	1,100	600	Current plans suggest a potential over delivery, some opportunities identified by procurement, currently being validated by finance, detailed plans expected delivery to begin from M3
Pharmacy	Medicines		75	173	98	300	1,300	1,000	Value of opportunities being scoped greater than target, potential for over delivery
Transformation	Transformation		0	0	0	400	148	-252	Detailed plans currently suggest in year delivery of £148k
Covid	Covid Costs		650	650	0	2,600	2,600	0	
Finance Adjustments	Release previous commitments made not yet drawn down		500	500	0	2,000	2,000	0	
	Total Recurrent DBV		**6,871**	**4,588**	**-2,283**	**37,800**	**32,451**	**-5,349**	
Non recurrent DBV									
Estate Review	Profit on disposal		0	0	0	500	0	-500	Update from E&F suggest no delivery expected
Workforce	Non clinical vacancy controls		250	250	0	1,000	1,000	0	
Pharmacy	Medicines		0	116	116	0	0	0	
	NR Balance Sheet		0	459	459	4,500	4,500	0	
Finance Adjustments	Capital charges review		0	0	0	400	400	0	
	Funding arrangements for transfer of care		125	0	-125	500	500	0	
	Total Non-Recurrent DBV		**375**	**825**	**450**	**6,900**	**6,400**	**-500**	
	Unidentified					**0**	**5,849**	**5,849**	
	Total DBV		**7,246**	**5,413**	**-1,833**	**44,700**	**44,700**	**0**	

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

NHS
Royal Devon
University Healthcare
NHS Foundation Trust

Agenda item:	10.1 Public Board Meeting		Date:	26 July 2023
Title:	Royal Devon "Better Together" Strategy Roadmap 2022-27 – report period April – June 2023 (Q1 23/24)			
Prepared by:	Katherine Allen, Director of Strategy			
Presented by:	Chris Tidman, Deputy Chief Executive Officer			
Responsible Executive:	Chris Tidman, Deputy Chief Executive Officer			
Summary	This paper presents the Royal Devon Strategy roadmap progress report for Quarter 1 23/24, a forward look for 6 months and suggested next steps around the refresh of the roadmap.			
Actions required:	The Board of Directors 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 2022-27 and six-month look ahead.			
Link to Strategy / Assurance Framework	Royal Devon Corporate Strategy			

Monitoring information

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

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

Royal Devon ‘Better Together’ Strategy Roadmap 2022-23

1. Executive Summary

1.1 In April 2022, the Royal Devon University Healthcare NHS Foundation Trust launched its ‘Better Together’ strategy and five-year delivery roadmap.

1.2 This paper presents the Royal Devon Strategy roadmap: 2023/24 quarter 1 (Q1) progress report (covering the period 1 April to 30 June 2023) and six month look-ahead.

1.3 This quarterly progress update of the Royal Devon ‘Better Together’ strategy reports that the majority of roadmap milestones have been achieved in Q4, with some milestones being slipped due to competing operational priorities.

1.4 The six-month forward look recognises that the clinical strategy and underpinning enabling strategies is being presented to the July 2023 Board of Directors meeting. Between July and September each enabling strategy will develop their implementation plan. Implementation will be mapped across a 5-year horizon, taking into account: interdependencies, achievability and affordability.

1.5 These deliverables will then be collated into a revised corporate roadmap as part of the mid review, which will be presented to the next Board Development session in early October. This review will also take into account other emerging commitments and opportunities. This revised roadmap will then support the development and pre-population of the RDUH operating plan for 2024/25.

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

The following section takes the key highlights from the achievements from April to June 2023 (Q1 2023/24):

2.1 **Social care provision SOC**
This milestone has moved into the system discharge transformation programme following board presentation to ICB.

2.2 **South Molton Ophthalmology Hub opens**
The South Molton Eye Centre opened in mid-April. Patients with eye conditions in North Devon and Torridge will now benefit from reduced waiting times and access to state-of-the-art equipment. Milestone completed.

2.3 **Delivering Best Value (DBV) programme launched**
The CFO and COO co-chair the DBV Board reporting to the Finance and Operational Committee, overseeing the development and delivery of the trust DBV programme.

2.4 **Northern Medical Workforce Business Case**
This business case was approved by the Board of Directors in January 2023. The triple lock support was received in April 2023. Milestone completed.

2.5 **OFH OBC Plan commences**

In a statement in Parliament on Thursday 25 May, Steve Barclay, Secretary of State for Health and Social Care announced that the Government has set aside a significant envelope for the New Hospital programme, with continuous investment beyond 2030. The Government remains committed to North Devon District Hospital as part of the programme, and that we can progress with phase 1 of our scheme, to develop new staff accommodation and to start enabling works to the hospital site.

The OFH OBC plan delivery has not started due to the OFH national programme. The OFH team is working with the national programme team over the next 9 months to build the national programme delivery plan and timeline. Milestone deferred to March 2024.

2.6 **Operational Services Integration Group (OSIG) launch**

The first OSIG meeting took place on 10 May and the Terms of Reference and Target Operating Model were reviewed, with a communications and engagement plan developed. Workshops with senior trust leaders was held on 12 June. Monthly OSIG meetings have been arranged. Milestone completed

2.7 **Discharge Lounge at NDDH operational**

The new discharge lounge, named the Coronation Suite, has been opened at NDDH. Milestone completed.

2.8 **Robotic Surgery commences at NDDH**

DA Vinci XI robots have been delivered to NDDH and will be used predominately for complex abdominal wall service and colorectal surgery with future expansion in gynaecology and other services. Milestone completed.

2.9 **EPIC Risk assessment Torbay & South Devon (TSD) to BoD**

It is expected that TSD will announced their preferred provider in October 2023. Work is ongoing led by the CMO and Deputy CEO with both TSD and UHP around the support required and the proposed delivery model. Milestone for risk assessment deferred from May 2023 to October 2023.

2.10 **ICS: PASP Programme confirms options for scoping & engagement**

Progress update provided to June Boards. Some delays noted to the surgical workshops, in part due to industrial action. The Acute Provider Collaborative (APC) is overseeing the next steps of the programme, to include modelling of potential options for viability, further clinical and patient engagement and focus on delivering shorter term solutions around fragile services. Milestone moved to July 2023 through update from Acute Provider Collaborative.

2.11 **OSIG: Agree divisional structure options**

Engagement with the operational and clinical leaders is on-going led by the COO, supported by CPO, is underway. To ensure all options for the future operating model are considered, this milestone has moved from June to July 23.

2.12 **Vascular Hybrid Theatre FBC**

Vascular Hybrid Theatre was approved as SOC/OBC in May at TDG, with the action that further work was required on developing the FBC and to have it ready for later in the year when a funding opportunity might present from NHSE. Milestone moved to December 2023.

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Royal Devon
University Healthcare
NHS Foundation Trust

2.13 **System Discharge Transformation Programme Launch (new milestone)**
This milestone was the "Social Care OBC" milestone but this action has now moved into the system discharge transformation programme following a Board of Directors presentation to the ICB. Milestone completed.

2.14 Table 1 on the next page shows the milestones that were achieved in Q1 2023/24 of the Royal Devon corporate roadmap (1 April – 30 June 2023).

Table 1: Q1 2023/24 H2 Royal Devon strategy roadmap

			2023		
			H1, Q1		
		Strategic Objectives	Apr	May	Jun
Board Programme	Overall Corporate Strategy Roadmap - Year 2 of 5	Collaboration & Partnership			
		A great place to work			
		Recovering for the future	South Molton Ophthalmology Hub opens	Operational Services Integration Group (OSIG) launch	Discharge Transformation Programme Launch
			Delivering Best Value Launch	Discharge lounge at NDDH operational	Robotic Surgery commences at NDDH
				Vascular Hybrid Theatre OBC	
		Excellence & Innovation in patient care	Northern Medical Workforce Business Case - triple lock		

Key

Key
Completed
In progress

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 Q1 period in this report are below:

- OFH OBC Plan commences
- EPIC Risk EPIC Risk assessment Torbay & South Devon (TSD) to BoD
- OSIG: Agree divisional structure options
- ICS: PASP Programme confirms options for scoping & engagement
- NEW - System Discharge Transformation Programme Launch

3. Royal Devon Corporate Roadmap in H1 Q2 and H2 Q3 2023/4

Table 2 on the next page shows the look ahead to the milestones proposed for the next six months from 1 July to 30 December 2023.

Table 2: July - December 2023 Royal Devon strategy roadmap

Royal Devon University Healthcare NHS Foundation Trust

Board Programme	Overall Corporate Strategy Roadmap - Year 2 of 5	Strategic Objectives	Jul	Aug	Sept	Oct	Nov	Dec
			2023 H1, Q2			2023 H2, Q3		
		Collaboration & Partnership	Merged Charity launched (Royal Devon hospitals charity)		Health inequalities strategy			
		Collaboration & Partnership	ICS: PASP Programme confirms options for scoping & engagement					
		A great place to work	Workforce Strategy		East & North key worker housing OBC approved			
		Recovering for the future	OSIG: Agree divisional structure options		Enabling strateges implementation plans	RD&E paed ED work commences	Pre-populate operating plan	Vascular Hybrid Theatre FBC
		Recovering for the future	Estates Strategy and site development plans		OFH progress update on the options submitted			
		Recovering for the future	Financial Strategy		Tiverton Endoscopy Unit			
		Recovering for the future	Information & BI Strategy					
		Excellence & Innovation in patient care	Clinical Strategy			EPIC Risk assessment TSD - to BoD		
		Excellence & Innovation in patient care	Digital Strategy					

Key
- Completed
- In progress

3.2 Those change controls which are relevant to the Q2 and Q3 period in this report are below. The detail of these changes is reported in table 3 in appendix 1.

- NEW - System Discharge Transformation Programme Launch
- NEW - Merged Charity Launched (Royal Devon hospitals charity)
- NEW - Health inequalities strategy
- NEW - Monitoring of enabling strategies
- NEW – OFH progress update on the options submitted
- NEW – Tiverton Endoscopy Unit
- RD&E Paediatric ED work commences

4. Recommendations

The Board is asked to;

5.1 Note the progress made during April to June 2023 (Q1 23/24) and the current roadmap milestones for the next 6 months.

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

5.3 Note that the next Corporate Roadmap report will be prepared once the enabling strategy implementation plans have been signed-off and after reviewing the emerging commitments and opportunities at the next Board Development session in October.

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 Q1 & Q2/Q3 2023/24 milestones

Commitment	Original date due	Proposed new date	Reason for change
OFH OBC Plan commences	May 23	March 24	The OFH OBC plan delivery has not started due to the national programme. The OFH team is working with the national programme team over the next 9 months to build the national programme delivery plan and timeline
EPIC Risk assessment Torbay & South Devon (TSD) to BoD	May 23	October 23	TSD will announce their preferred supplier in October 2023.
OSIG: Agree divisional structure options	June 23	July 23	Engagement with the operational and clinical leaders is ongoing led by the COO, supported by CPO, is underway. To ensure all options for the future operating model are considered, this milestone has moved from June to July 23.
ICS: PASP Programme confirms options for scoping & engagement	June 23	July 23	This milestone is deferred in part due to the recent industrial action.
NEW - System Discharge Transformation Programme Launch	-	June 23	This milestone was the “Social Care OBC” milestone but this action has now moved into the system discharge transformation programme following a Board of Directors presentation to the ICB. Milestone completed.
NEW - Merged Charity Launched (Royal Devon hospitals charity)	-	July 23	This new July 2023 milestone has been added
NEW - Health inequalities strategy	-	Sept 23	This new milestone has been added as a result of the Joint Forward Plan
NEW – OFH progress update on the options submitted	-	Sept 23	This new Sept 23 milestone has been added
NEW – Tiverton Endoscopy Unit	-	Sept 23	This new Sept 23 milestone has been added

Commitment	Original date due	Proposed new date	Reason for change
RD&E Paediatric ED work commences.	July 23	Oct 23	This milestone has been extended to enable a review of the budget to amend the governance.
NEW - Monitoring of enabling strategies	-	Oct 23	This new October 23 milestone has been added

<table>
<tr><td>Agenda item:</td><td>10.2, Public Board Meeting</td><td colspan="3">Date: Wednesday 26 July 2023</td></tr>
<tr><td>Title:</td><td colspan="4">DRAFT Clinical Strategy and Enabling Strategies</td></tr>
<tr><td>Prepared by:</td><td colspan="4">Katherine Allen, Director of Strategy</td></tr>
<tr><td>Presented by:</td><td colspan="4">Chris Tidman, Deputy Chief Executive
Adrian Harris, Chief Medical Officer</td></tr>
<tr><td>Responsible Executive:</td><td colspan="4">Adrian Harris, Chief Medical Officer</td></tr>
<tr><td>Summary:</td><td colspan="4">Seven draft enabling strategies are presented for approval.

The strategies support the Trust's Better Together strategy and are: clinical, digital, estates, data, finance, people and culture. The Green Plan and Transformation strategy were approved in 2022.

The clinical strategy has primacy amongst the enabling strategies and is presented to Board in full. An executive summary of the others is contained in the pack with the full draft versions available via https://royaldevonstaff.nhs.uk/strategies.

The paper provides a summary briefing on the following:

1. The Devon context and alignment between the Joint Forward Plan and Better Together + enabling strategies
2. Approach to enabling strategy development
3. Development of each strategy
4. Strategy on a page
5. Governance and funding
6. Monitoring delivery of the strategies
7. Communications, engagement and marketing plan</td></tr>
<tr><td>Actions required:</td><td colspan="4">For approval at the July 2023 meeting of the RDUH Board of Directors.</td></tr>
<tr><td rowspan="2">Status (x):</td><td>Decision</td><td>Approval</td><td>Discussion</td><td>Information</td></tr>
<tr><td></td><td>x</td><td></td><td>x</td></tr>
<tr><td>History:</td><td colspan="4">The RDUH Better Together strategy (2022) identified seven enabling strategies required to support achievement of our ambitions and objectives.

Following the launch of Better Together, professional leads across all seven areas commenced the system-wide stakeholder engagement in the development of each enabling strategy.

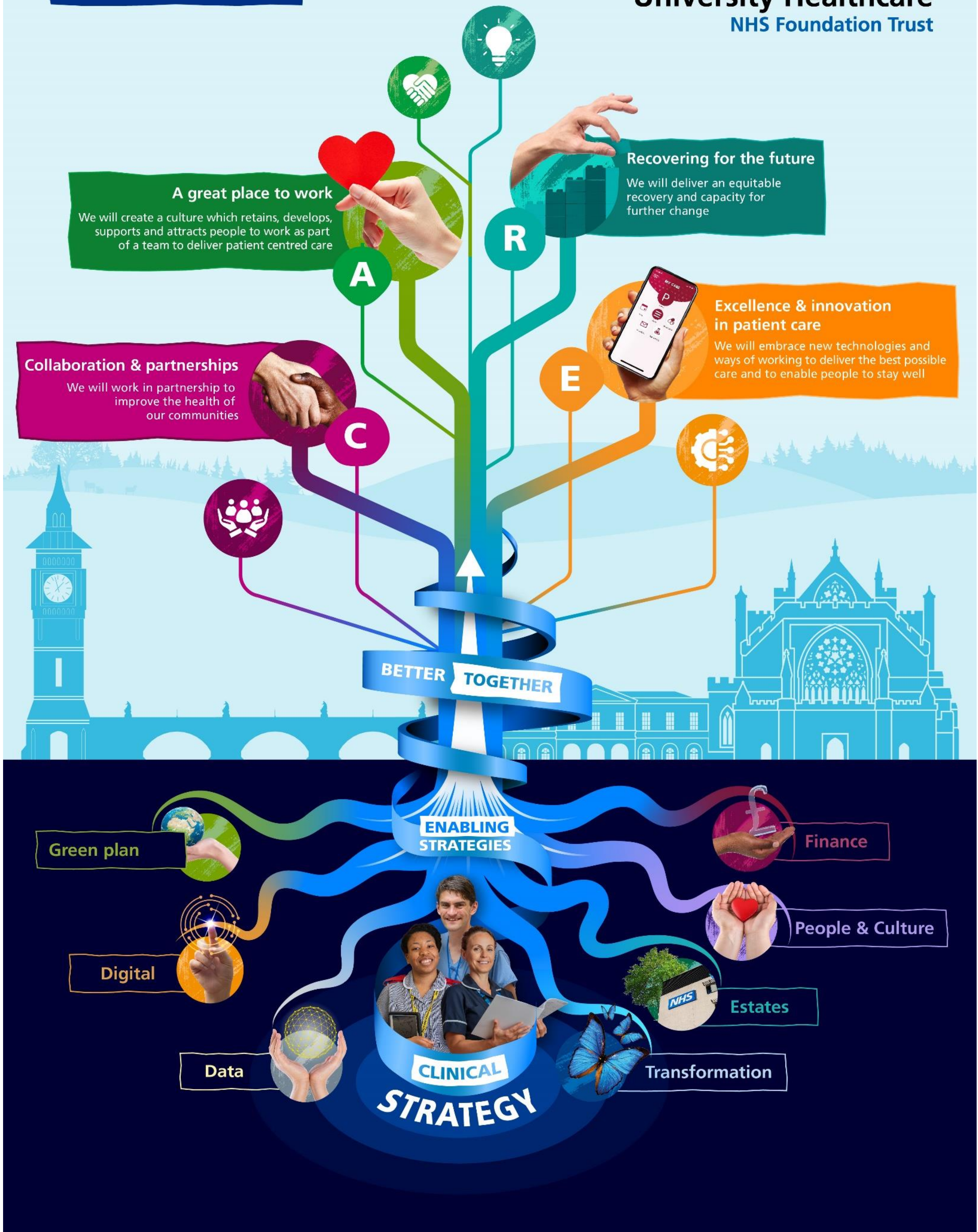
Throughout this process, two additional strategies were added: Data, in response to an emerging business need; and Health Inequalities, in response to a strong theme within the Joint Forward Plan. The former is included for approval in July, the latter will be brought for approval in Q3, 2023/4.</td></tr>
</table>

Link to strategy / Assurance Framework:	The attached 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 England	✓	Finance	✓
Service Development Strategy	✓	Performance Management	✓
Local Delivery Plan	✓	Business Planning	✓
Assurance Framework	✓	Complaints	
Equality, diversity, human rights implications assessed			✓
Other *(please specify)*			


OUR STRATEGY
2023-2028
NHS
Royal Devon
University Healthcare
NHS Foundation Trust
A great place to work
We will create a culture which retains, develops, supports and attracts people to work as part of a team to deliver patient centred care
A
Recovering for the future
We will deliver an equitable recovery and capacity for further change
R
Excellence & innovation in patient care
We will embrace new technologies and ways of working to deliver the best possible care and to enable people to stay well
E
Collaboration & partnerships
We will work in partnership to improve the health of our communities
C
BETTER TOGETHER
ENABLING STRATEGIES
Green plan
Digital
Data
Finance
People & Culture
Estates
Transformation
CLINICAL STRATEGY

1. Purpose of paper

This document presents the process of the development of each enabling strategy and how they articulate a common vision and ambition for the Trust.

It is organised into the following sections:

A. The Devon context and alignment between the Joint Forward Plan and Better Together
B. Approach to enabling strategy development
C. Development of each strategy
D. Strategy on a page
E. Governance and funding
F. Monitoring delivery of the strategies
G. Outline communications, engagement and marketing plan

2. Background

The Trust's Better Together strategy was published as the Royal Devon launched as a merged organisation and set out a mission to "*work together to help you to stay healthy and to care for you expertly and compassionately when you are not".* With four strategic objectives – C A R E – the Better Together strategy, published in June 2022, set out the vision, objectives and values of the Trust as well as identifying the required enabling strategies to support its delivery.

This presented the Trust with a unique opportunity: to simultaneously publish a suite of supporting strategies which aligned our clinical vision to the workforce, financial, digital and estates enablers essential to achieve our aims.

The enabling strategies are: clinical; digital; people; estates; data; finance; transformation and sustainability.

The clinical strategy has primacy amongst all the enabling strategies because it defines a blueprint for delivery of the 'Better Together' strategy, and, by positioning this together with the enabling strategies, provides a clear vision for transforming our services, overcoming our current challenges and delivering the best care to our patients over the next five years.

As data quality emerged as a strategically critical issue during 2022 and health inequalities were identified as a key tenet of recovery and the ICS integrated care strategy both were subsequently identified as required additional enabling strategies. The former is included, but the health inequalities strategy will follow. The Green Plan (sustainability) and Transformation strategies were developed and published earlier in 2022.

Through the development of the suite of strategies, the professional leads have collaborated to consider issues of scheduling, prioritisation, affordability and interdependencies: this indepth exploration will ensure that as the Trust implements these strategies there is already a recognition of the interdependencies and priorities and a sense of how we can present a compelling narrative which will match the investment aims of national funding bodies.

A full suite of the **draft** strategy documents have been posted on Hub here: https://royaldevonstaff.nhs.uk/strategies.

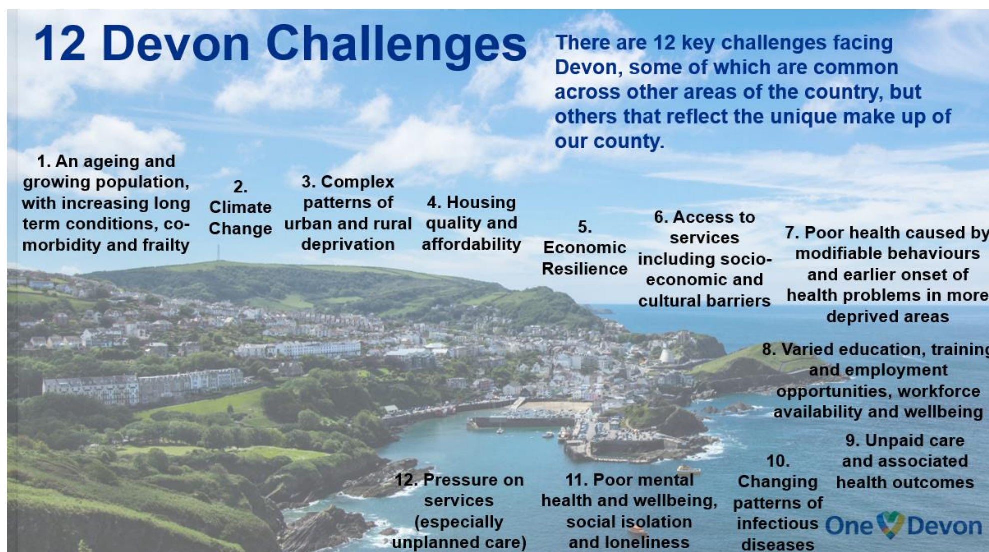
3. Analysis

Section A: The Devon context

This section describes the Devon context and alignment between Better Together and the RDUH's enabling strategies and the Devon Joint Forward Plan and Integrated Care Strategy.

One Devon Integrated Care Strategy: *Equal chances for everyone in Devon to lead long, happy and healthy lives*

In line with national requirements, the Integrated Care System (ICS) in Devon (One Devon) produced an Integrated Care Strategy in December 2022, setting out the 12 key challenges faced in Devon ….



… and identified a set of strategic goals that will help to address the challenges, aligned to the four core purposes of ICSs:

- **Improving outcomes in population health and healthcare**
- **Tackling inequalities in outcomes, experience and access**
- **Enhancing productivity and value for money**
- **Helping the NHS support broader social and economic development**

The Joint Forward Plan is a shared response by partners in Devon to the Devon Integrated Care Strategy and has the following strategic goal around sustainability and financial balance:

> ***One Devon will strengthen its integrated and collaborative working arrangements to deliver better experience and outcomes for the people of Devon and greater value for money.***

RDUH Board of Directors received a briefing on the Joint Forward Plan in May ahead of system-wide approval in June. The table below shows the alignment between the ICS delivery plans and enabling programmes and RDUH's strategies. All areas within the RDUH's service provision and partnership remit are aligned to the Joint Forward Plan.

ICS delivery programme	Better Together strategic objective • **C**ollaboration and Partnership • **A** great place to work • **R**ecovering for the future • **E**xcellence and Innovation	RDUH enabling strategy
Acute service sustainability	C A R E	Clinical strategy Digital strategy People strategy Finance strategy
Housing	C	Health inequalities strategy
Community development and learning	C	Health inequalities strategy
Employment	C A	People strategy Health inequalities strategy
Health protection	E	Clinical strategy
Suicide prevention	C	Health inequalities strategy
Primary and community care	C	Clinical strategy Health inequalities strategy
Mental Health, Learning Disability and Neurodiversity	C R	Clinical strategy Health inequalities strategy
Children and young people	R E	Clinical strategy Health inequalities strategy

ICS enabling programme	Better Together strategic objective	RDUH enabling strategy
Climate Change	C A R E	Green Plan Estates strategy Digital strategy Clinical strategy
Population health	C R E	Clinical strategy Transformation strategy Health inequalities strategy Digital strategy Data strategy
System development	C	Better Together Transformation strategy Digital strategy
Workforce	A R	People strategy
Digital and data	C A R E	Digital strategy Data strategy Clinical strategy
Estates and infrastructure	A R E	Estates strategy Green Plan Clinical strategy Digital strategy
Finance	R	Finance strategy Transformation strategy
Communities and involvement	C R	Health inequalities strategy

		(+ communications, engagement and marketing strategy)
Research, innovation and improvement	R E	Digital strategy Transformation strategy Green Plan
Equality, diversity and inclusion	C A	People strategy Digital strategy

Section B: Approach to enabling strategy development

Following the engagement and approval of the Better Together Trust strategy in June 2022, professional leads across all the enabling strategies commenced development of the following enabling strategies:

The sustainability (Green Plan) and transformation strategies were approved earlier in the cycle: January 2022 and November 2022 respectively. The data strategy and health inequalities strategies were subsequently identified as required enabling strategies due to emerging strategic priorities.

The clinical strategy is the 'lead' enabling strategy to deliver the Trust strategy which means it leads the initial development of annual delivery milestones and prioritisation.

Collaborative and iterative development

An enabling strategy steering group was established which met fortnightly between December 2022 and June 2023.

This group covered the following work:

- Agreeing a common but flexible strategy structure
- Ensuring wide and efficient stakeholder engagement in the strategies
- Reviewing and proof-reading
- Highlighting overlaps and gaps in content
- Reviewing specifications for strategy development supplier contracts
- The development of an initial strategy delivery roadmap
- Creating 'design personalities' of individual strategies
- Facilitating internal and external engagement in strategies
- Checking alignment to Better Together and ICS strategies
- Development of all materials, including exec summary, strategy on a page, full strategy document by the deadline (July Board)

System engagement

- There was significant internal and external stakeholder engagement in each of the strategies. Care was taken to ensure alignment with the JFP which was being developed in parallel with ICB partners.
- The final draft clinical strategy was circulated to all Devon ICB partners for comment in mid-July.

Internal engagement

All of the strategies have been presented to the Trust Delivery Group through formal meetings and engagement sessions with members.

The RDUH Board discussed and approved the Devon Joint Forward Plan in June, which provided the connection to the full draft documents which were discussed at a Board Development session in July.

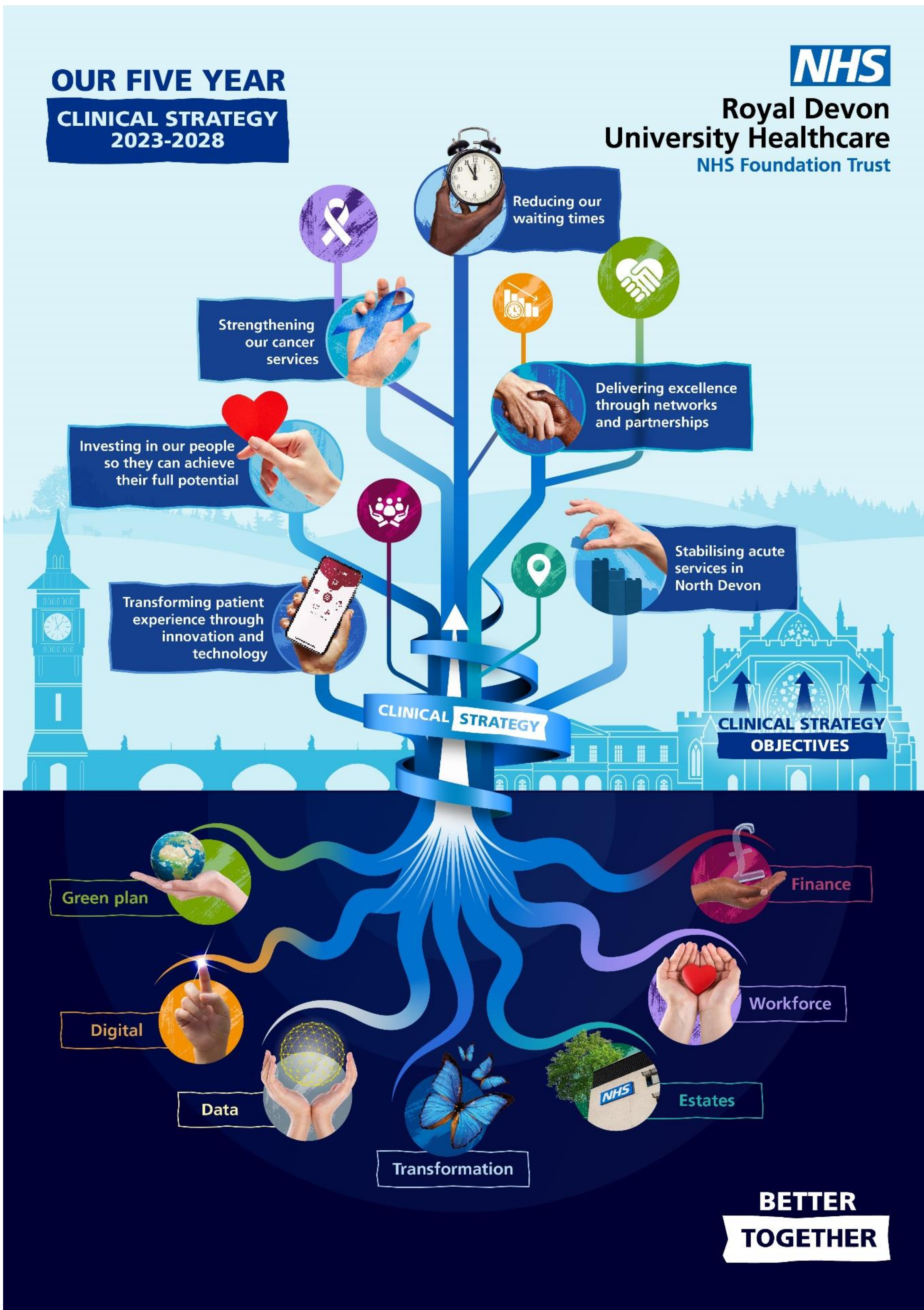
Directors made comments and gave feedback on the drafts which have been incorporated into the final draft versions.

Section C: Development of each strategy

The table below articulates the development route and committee oversight of each strategy.

Professional lead(s)	Board a/o sub-committee	Engagement	Development partner	Current approval status
Clinical strategy				
Bruce Campbell Dave Sanders Zara Hyde Phil Luke	Board of Directors TDG	Extensive internal and external	External supplier	Final draft presented to BoD, July 2023
Digital strategy				
Francis Gillen Phil Milverton	Digital Committee	Extensive internal and external	External supplier	Final draft presented to BoD, July 2023
People strategy				
Denise McMurray	PWPW	Extensive internal and external	Inhouse	Final draft presented to BoD, July 2023
Estates strategy				
Zara Hyde Kevin Ward Paul Honey	SEDG	Extensive internal and external	External supplier	Final draft presented to BoD, July 2023
Finance strategy				
Angela Hibbard Paul Southard	FOC	Internal engagement	Inhouse	Final draft presented to BoD, July 2023
Data strategy				
Sam Maunder	FOC	Internal engagement	External supplier	Final draft presented to BoD, July 2023
Health Inequalities strategy				
Katherine Allen Jeff Chinnock LCP – East and North	TDG	In progress	Inhouse	Draft in progress– due Sept 2023
Transformation strategy				
Phil Luke	Board of Directors	Extensive internal and external	Inhouse	Published
Green Plan				
Dave Tarbet	Board of Directors	Extensive internal and external	Inhouse	Published

Section D: Strategy on a page



Clinical strategy

Vision: Recovering our services whilst supporting clinical excellence and improved outcomes for our community, through working with system partners and the application of technology, research and innovation.

Objectives

1. Stabilising and developing acute medical services at North Devon District Hospital
2. Recovering our waiting times
3. Reducing acute admissions and lengths of stay
4. Increasing the separation between elective capacity and urgent care
5. Strengthening cancer services
6. Working with partners to optimise community pathways

Strategic priorities

- Invest in staffing to support Acute Medicine in North Devon
- Improve safe alternatives to acute admission
- Build community capacity in domiciliary care and care home support
- Increase clinical productivity through transformation
- Build outpatient and diagnostic capacity
- Increase utilisation of the MY CARE patient portal
- Reduce outpatient demand through patient initiated follow-up (PIFU) and increase virtual care
- Protect our elective bed capacity
- Support the Peninsula Acute Sustainability Programme (PASP)
- Use the power of Epic to transform services

Digital strategy

Vision: We will transform and improve patient care by empowering and connecting people and digitising the care and service we provide

Objectives

1. **Empowerment** - We will empower people to use technology to improve their health and wellbeing
2. **Innovation** – We will harness innovation in automation, remote working and Robotic Process Automation in our corporate services to enable more productive services
3. **Data driven decisions** - We will ensure people have access to the data and information they need to deliver modern health and care services

Strategic initiatives

- EPR optimisation and development
- Precision diagnostics, genomics & therapeutics
- Virtual and remote care
- Clinical image exchange
- Cloud-based capability
- Machine learning and AI
- Infrastructure management

People strategy workforce plan

Vision: To become a great place to work by ensuring we have a long-term strategic workforce plan to support and develop our people to deliver high quality, sustainable and transformational future models of care to our patients

Objectives

1. Leadership & Culture
2. Attraction, Recruitment & Retention
3. Developing our People
4. Workforce planning, transformation, Integration & Redesign

Strategic priorities

- Develop a compassionate, inclusive and improvement focussed leadership mindset that supports all staff to give their best and the delivery of wider Trust strategic aims.
- Establish the Trust as an employer of choice that attracts and retains the best talent, by being at the forefront of improvement & innovation and through a shared sense of belonging.
- Equip our workforce with the skills and capacity to deliver future models of care. Staff will be supported with digital upskilling, encouraged to develop and empowered to work to the top of their clinical licence.
- Through system collaboration, development of improved clinical pathways and adoption of technological enablers, ensure the delivery of the clinical strategy is underpinned by a sustainable and fit for purpose workforce model and the plan to deliver it.

Estates strategy

Vision: Our patients will be cared for in a sustainable, flexible and modern and accessible environment. We will achieve this by developing, delivering and operating estate that is fit for purpose, utilising our resources to deliver best value and maximum benefit for patients and staff.

Objectives

1. Site redevelopment enabling future model of care delivery
2. Optimally utilising estate
3. Safe and compliant estate
4. Sustainability in building and estates management

Strategic priorities

- Acute redevelopment:
  - Deliver Our Future Hospital – Northern: enabling works; OBC/FBC
  - Develop eastern site master-plans to inform future development
  - Create the pipeline of capital development projects linked to clinical strategy roadmap
- Prioritise appropriate staff accommodation (OFH Phase 1/KWH)
- Develop and deliver community estates optimization plan
- Implement non-clinical space utilization and management
- Develop clear building and property leasing/management strategy
- Evaluate future Facility Management approach
- Develop energy strategy and de-carbonisation plan to 2030

Data strategy

Vision: Putting data-led insight at the heart of decision-making to improve quality of care and staff experience

Objectives

1. To ensure our workforce has access to timely, complete and reliable data to make evidence-based decisions
2. To create a culture of data-led insight capability to identify needs, allocate resources and prioritise patients appropriately
3. To optimise the data available from the Electronic Patient Record (EPR) and create a linked dataset for a wider set of Trust data to inform joined-up decision making
4. To create a data infrastructure fit for the future including interface with the wider health and care system
5. To develop and support a highly skilled data workforce that makes best use of scarce skillsets and achieve a cost-effective service model

Strategic priorities

Data infrastructure

Delivery of a fit for the future data infrastructure that enables the production of timely and consistent data across different data sets

Data visualisation

Delivery of core suite of dashboards for widespread use across the Trust as well as models allowing more in depth analysis / research where required

Workforce development

Ensuring access to, training, retention and continuous development of the highly skilled workforce required to meet the increasing data needs of a modern organisation

Access and governance

Improving our ways of working so users know how to access the data they need, how to make new requests and how they are prioritised

Finance strategy

Vision: To be financially sustainable across the Trust & System and to enable the continued development of our clinical and supporting strategies

Objectives

1. Work within the Devon ICS to deliver a system wide multi-year financial and operational recovery programme
2. Invest in our workforce through driving recruitment, supporting an affordable long term workforce strategy, investing in well-being and the long-term needs of our Estate
3. Set a sustainable and deliverable recovery trajectory that returns the Trust to recurrent break-even, aligned to the recovery of the waiting list.
4. Develop a financial framework to enable the delivery of the clinical and supporting strategies
5. Investing in New Innovation and Technology, driving the benefits to demonstrate VFM and affordability to the longer-term needs of our population

Strategic priorities

Long Term Financial Model

Finalise the LTFM for the Devon system to give clarity on DBV requirement to achieve financial balance over 3-5 years

Workforce development

Aligning finance, activity and workforce strategic frameworks to ensure clear reconciliation of assumptions and trajectories supporting with a funding strategy that provides the financial support to recovery through ERF and growth – within an overarching affordability framework

Delivering Best Value

Develop a financial recovery plan over 3 years with a challenging but deliverable level of savings aligned to the productivity challenge to restore services and maximise the use of resources

Investment

Develop a multi-year funding approach to support the clinical and supporting developments utilising any opportunities from national programmes

Financial Support

Optimise the new financial ledger with greater reporting capabilities, supporting the finance team skills and enhancing finance training throughout the Trust

Sustainability strategy (Green plan)

Vision: The Trust will embrace the ethos of sustainable development and be leaders in the healthcare field, with sustainability driven continual improvement integrated into its normal business practices.

Objectives

1. Embody sustainable healthcare
2. Staff engagement
3. Carbon reduction

- Reduce our carbon footprint by 80% by 2030
- Achieve carbon net zero by 2040 of emissions directly produced by us
- Achieve carbon net zero by 2045 of emissions associated with products and services purchased by us

Strategic priorities

1. Workforce and system leadership
2. Sustainable models of care
3. Digital transformation
4. Travel and transport
   - Fleet to be zero emissions by 2032
5. Estates and facilities
   - Purchase renewable electricity
6. Medicines
   - Reduce emissions from medicines
7. Supply chain and procurement
   - Reduce single use plastics
   - Key contracts to have sustainability criteria
   - Adopt PPN 06/21 for all contracts (suppliers to be committed to net zero by 2050)
8. Food and nutrition
   - Cease use of single use plastics as far as clinically practicable
9. Adaptation: develop ongoing adaptation plans

Transformation strategy

Vision: Transforming our services through a culture of curiosity in an organisation fuelled by bright ideas, new technology and learning together

Objectives

1. Improved patient care
2. Cost effective care
3. A culture of curiosity
4. Greener healthcare

Strategic priorities

- Your brilliant ideas: Making it easier for staff and patients to share their improvement ideas - transformation cafes, Be more Kevin campaign
- Cutting edge technology: Harnessing the power of Epic; empowering patients to book and monitor their own healthcare; adopting cutting edge medical technology; supporting the development and use of AI
- Learning together: QI academy and hub; improvement training for staff and leaders; fellowships with the Transformation team; working with partners

4. Resource/legal/financial/reputation implications

Section E: Governance and funding

In all cases the strategies were developed with awareness of the following:

Governance - All business cases underpinning a milestone or strategic priority are subject to the appropriate governance. Whilst the strategies set the aspiration, they do not guarantee any business case will be approved if essential criteria, including affordability and system alignment are not met.

Proactivity – Capital, even significant sums, can become available at short notice, with narrow windows for submitting bids. We will proactively develop cases to support the capital developments set out in the strategies to maximise our ability to successfully bid for external funding when it becomes available.

Return on investment – where quantifiable the strategies quantify the expected return on investment.

Section F: Monitoring delivery of the strategies

The first year's delivery milestones of Better Together (2022-23) were translated into a corporate roadmap. Every quarter, TDG and the Trust Board of Directors receive a report detailing the achievements over the last three months and a look ahead to the next 6.

The report also documents reasons for delays or reprioritisation of milestones to reflect the need to operate dynamically in response to changing circumstances.

These reports also gave our teams the opportunity to reflect on and celebrate our successes and achievements.

In preparation for April 2024, the executive directors and leads of each enabling strategy will develop their implementation plan, interdependencies and priorities as a collective and pre-populate the annual operating plan. This will enable the Trust to create an initial schedule of affordable, achievable delivery.

The resulting roadmap of delivery will be presented to Board of Directors in October / November 2023 for approval ahead of the next planning round.

The quarterly roadmap reports will continue to be presented to TDG and Board.

Section G: Communications, engagement and marketing plan

Following Board approval, the enabling strategies will be launched across the Trust's communications channels to all key stakeholders, using a visual and engaging approach.

The communications, engagement and marketing (CEM) approach will be to position and connect all activity to the strategic context of the Trust, demonstrating how everything that is happening links to

the delivery of the enabling strategies, communicating successes and ensuring staff understand how they have contributed to the success of the Trust.

The objectives are to:

- **Communicate the successes**
- **Engage in the delivery**
- **Evidence and position the Trust as a leader and a great place to work**

To support this effectively, the CEM team is undertaking a review of existing communications channels and make improvements to ensure communications output is targeted, effective and relevant for the audiences.

5. Link to BAF/Key risks

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

6. Proposals

The Board of Directors is asked to:

i) Consider the enabling strategies as a collective and advise whether they are sufficiently ambitious and will effectively contribute to the delivery of the Trust's Better Together and clinical strategies

ii) Consider the development process of each strategy and confirm they are assured of sufficient stakeholder engagement

iii) Consider the alignment of both the enabling strategies to deliver Better Together as well as the alignment of the suite of strategies as a whole to the Devon Joint Forward Plan and Integrated Care Strategy

Royal Devon University Healthcare
NHS Foundation Trust

OUR FIVE YEAR CLINICAL STRATEGY 2023-2028

Reducing our waiting times

Strengthening our cancer services

Delivering excellence through networks and partnerships

Investing in our people so they can achieve their full potential

Stabilising acute services in North Devon

Transforming patient experience through innovation and technology

CLINICAL STRATEGY

CLINICAL STRATEGY OBJECTIVES

Clinical Strategy

BETTER TOGETHER

July 2023

DRAFT Version 1.52

Clinical Strategy:

Vision

Recovering our services whilst supporting clinical excellence and improved outcomes for our community, through working with system partners and the application of technology, research and innovation.

Objectives

- **Stabilising and developing acute medical services at North Devon**
- **Recovering our waiting times**
- **Reducing acute admissions and lengths of stay**
- **Increasing the separation between elective capacity and urgent care**
- **Strengthening cancer services**
- **Working with local partners to optimise community pathways**

Strategic priorities

- **Invest in staffing to support Acute Medicine in North Devon**
- **Improve safe alternatives to acute admission**
- **Build community capacity in care home and domiciliary care support**
- **Increase clinical productivity through transformation**
- **Build outpatient and diagnostic capacity**
- **Increase utilisation of the MyCare patient portal**
- **Reduce outpatient demand through patient initiated follow-up (PIFU) and increased virtual care**
- **Protect our elective bed capacity**
- **Support the Peninsula Acute Sustainability Programme (PASP)**
- **Use the power of Epic to transform services**

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Foreword

Our clinical services touch the lives of patients at times of basic human need, when care and compassion are what matter most. Over the course of the COVID-19 pandemic, our ability to deliver the kind, compassionate and expert patient care, to which we all aspire, was tested, with services stretched and many staff feeling fatigued by the continuous pressures. In response to these challenges, the efforts of staff at Royal Devon have been nothing short of heroic.

This five-year Clinical Strategy provides a blueprint for recovering our services whilst supporting clinical excellence and improving outcomes for our community, through working with system partners and the application of technology, research and innovation. In addition to providing a comprehensive set of practical approaches, this strategy aims to transmit a message of hope and optimism for a brighter future for our patients and our amazing staff.

Underpinning this Clinical Strategy is a suite of enabling strategies, covering key areas, including our Workforce, Estates, Digital, Data and Finance. The co-production of each of these strategies simultaneously, signals a bold intention that clinical and managerial leadership teams from across the Trust will work in concert to deliver the necessary improvements in patient care, whist addressing our financial challenges by making services streamlined and efficient.

We would like to thank our clinical chairs, Professors Bruce Campbell and David Sanders, whose experience, skill and commitment has ensured that this Clinical Strategy embodies the aspirations, judgement and expertise of hundreds of clinical and non-clinical staff from across the Trust, as well as patients and colleagues from our wider health and social care system.

Delivering this ambitious plan will be challenging: however, work to deliver this strategy is already well underway and tremendous progress is already being made so far in 2023/24. The redevelopment of our Emergency Department and the commencement of a much-needed Cardiology Day Case Unit for our eastern services, allocation of significant funding to stabilise and develop acute medicine in the north, and the procurement of an additional surgical robot for both sites, are some of many examples of our strategy being delivered.

We have every confidence that staff at Royal Devon will show the dedication, compassion and innovation we saw during the pandemic and before, in getting behind this collective vision, and the actions set out in this strategy, to make it our reality, in service of our staff and our patients.

Professor Adrian Harris

Chief Medical Officer

Carolyn Mills

Chief Nursing Officer

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Introduction and Executive Summary

Overview

This Clinical Strategy describes the vision of the Royal Devon University Healthcare NHS Foundation Trust for provision and development of clinical services to the population of Northern and Eastern Devon, to deliver high-quality, sustainable emergency, elective and specialist care, covering the next five years and beyond. It is underpinned by a set of Trust principles, which are aligned with the NHS Long Term Plan and the principles of One Devon.

Our challenges

Many people believe that healthcare providers are facing the most challenging time in the history of the NHS. The impact of COVID-19 has stretched to every element of our services, and our staff have invariably felt fatigued and apprehensive in the face of the prolonged nature of the pandemic and the scale of challenges it has presented. In particular, there has been an unprecedented impact on urgent care services, with extremely long ambulance and emergency department (ED) waiting times widely reported in the media.

The local Devon system is not only experiencing all the issues relating to the pandemic seen nationally, but in addition, has a more geographically dispersed and older population than the national average. Detailed background information about the Trust, its partner organisations and the challenges and context of this strategy can be found in Appendix 1.

A further and important consideration for our Clinical Strategy is the long waiting times at Royal Devon, relative to other parts of the country. At the start of 2023/24 the Devon Integrated Care Board (ICB) had more than triple the number of patients waiting over 52 weeks for treatment compared to the average for the South West, with Royal Devon accounting for 49% of those patients. Thanks to the hard work of our staff, the Trust is making excellent progress in reducing waiting times. Continuing this trend, including for patients on cancer pathways, is a key priority within this strategy.

A further critical element for consideration has been the extremely challenging financial context both for Royal Devon and the wider ICB. In order to gradually address this, our services must capitalise upon opportunities presented through integration, partnership working, technology and innovation, to become more efficient and deliver the best value for the available resources.

Developing our strategy

In order to respond to the challenging context and to ensure delivery of high standards of care and equity of access for our patients, our Clinical Strategy, developed in close consultation with our staff, is both comprehensive and ambitious. In developing this strategy, we engaged extensively with clinicians and managers throughout the Trust and worked with patient and public representatives and partners across Devon. Consequently, there is strong alignment between this Clinical Strategy and the wider system approach to the challenges we collectively face. More detailed information regarding the development of the strategy, its structure and our guiding principles, is provided in section one of this document.

Of particular note is the approach taken to develop the Clinical Strategy whilst simultaneously refreshing our key enabling strategies. This bold and complex undertaking aims to ensure that the aspirations set out in this

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document, as our primary strategy, are underpinned by further detail of *how* things will be delivered in our Estates, Digital, Data, Finance, and People & Culture strategies.

Services for children and young people

The nature of children and young people's (CYP) illness has changed over the last decade. Presentations of CYP with eating disorders, self-harm and complex mental health needs have increased significantly. In addition, some of our longest waiting times for elective care include key services for children, and addressing these and other challenges is an important element of the Clinical Strategy. Many of the proposed developments, across all four clinical domains, will impact upon both adults and CYP. Where our key actions are specifically relevant for CYP services, such as for neurodisability and neurodevelopmental conditions, this has been identified, however, it can be assumed that, with some obvious exceptions, our "strategic approaches" apply to both adults and CYP services.

Key elements of the Clinical Strategy

Our strategy is broken down into four "domains", namely;

- **Local Acute and Emergency Care,**
- **Community and Primary Care Led Services,**
- **Elective Care,**
- **Tertiary Care & Areas of National Clinical and Academic Excellence.**

In each domain the challenges faced by the relevant services are described. To support operational teams in developing local plans to deliver this strategy, examples of good practice for each of the domains are included in Appendix 2. Each domain then presents a series of key objectives and "strategic approaches" which will be undertaken in order to achieve them. A graphical overview of the domains, key objectives and strategic approaches to achieve them is provided in section one. As a planning aid for operational teams, a tabular summary is also provided in Appendix 3.

In total, over the four domains, there are 13 objectives and 51 strategic approaches. Whilst they are all important for service delivery, key objectives include;

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

Strategic approaches to achieving these aims include investment in acute medicine staffing in northern Devon, increasing domiciliary care capacity, optimising the use of Epic and virtual care, as well as the development of new facilities, such as a hybrid operating theatre. Increasing capacity in our services will require external capital investment, and proactive planning will be necessary to take advantage of funding opportunities when they arise.

Whilst the strategy is grouped into the domains set out above, there are a number of golden threads running throughout. These include using technology, particularly the tremendous power of Epic to transform our services, working in partnership with others, promoting research to improve clinical care and building capacity and capability in our workforce, who are the bedrock of our clinical services.

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Other considerations of the Clinical Strategy

Delivery of a five-year strategy as complex as this one will require leadership and proactive identification and mitigation of potential barriers and risks, as well as excellent communication to engage staff from across the Trust. Further detail on implementation of the strategy and risk management is provided in section three of this document. Once approved by the Board of Directors, delivery of the Clinical Strategy and the enabling strategies will be overseen by the Trust Delivery Group, chaired by the Chief Operating Officer.

Final word

This Strategy sets out a blueprint for recovering our services and supporting clinical excellence through open and honest partnership working, and the application of technology, research and innovation. Like all strategies it will need to flex and adapt to socioeconomic and political changes over the five-year period, however, if successful, it will be transformative. Delivery of the objectives set out in this document will enable more patients to be treated, more quickly and efficiently, and ensure that emergency services can provide the level of safe, high-quality care we would all wish for ourselves or our families.

Finally, we hope that this Clinical Strategy provides a joint sense of purpose and optimism that Royal Devon will overcome the challenges we face together, in pursuit of excellence for patients and the communities we serve.

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Section One

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SECTION ONE

Developing our Strategy

Developing a five-year strategy covering all of our acute and community services is a complex undertaking. This section describes the key elements underpinning our strategy, namely;

- **Our guiding principles,**
- **The structure of the strategy,**
- **The engagement process undertaken with staff, patients and our partners in other organisations.**

Guiding principles

In April 2021, the Trust Clinical Leadership Team agreed eight principles which would be used to inform the development of the Clinical Strategy. These are listed below.

Principles of the Clinical Strategy

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

Figure 1. The principles which underpin the Clinical Strategy

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Structure of the Clinical Strategy

The Clinical Strategy is grouped into four domains, under which the challenges, key objectives and strategic approaches we will undertake to achieve them are set out. To support operational teams in developing local plans to deliver this strategy, examples of good practice for each of the domains are included in Appendix 2.

An overview of the domains, objectives and underpinning strategic approaches is provided below in Figure 2.

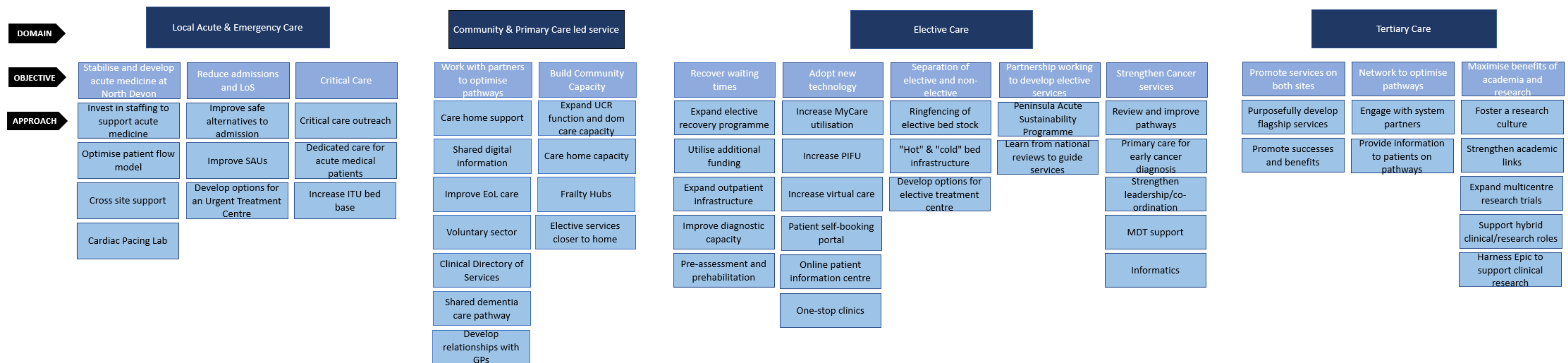

Figure 2. Clinical Strategy, a visual overview

Engagement with our staff, patients and key local partners

This document is called our “Clinical Strategy” for two important reasons. Firstly, as it sets out a blueprint for recovery and transformation of our clinical services. Secondly, this strategy is intended to represent the voice of clinical teams from across the Trust, regarding our key challenges and our collective judgement as to the best way to address them. The process throughout has been open and inclusive, with different perspectives and opinions being sought so that our staff rightly feel that this document is *their* Clinical Strategy.

In developing this strategy, we engaged extensively with clinicians and managers throughout the Trust, as well as in primary care and mental health services. We also worked with patient and public representatives, as well as commissioners, to get their perspective on the challenges and how we can collectively overcome them. The process of engagement to develop this strategy is summarised in figure 3 below.

Figure 3. The engagement process in developing the Clinical strategy.

Section Two

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SECTION TWO

Domain 1 – Local Acute and Emergency Care

Goal

We will provide prompt, high-quality acute urgent and emergency care to patients. We will seek to make pathways as efficient as possible, improve patient experience, reduce unnecessary ED attendances and acute hospital admissions, and minimise length of stay.

Main Challenges

- **Increasing demand (numbers of acute admissions) -** Acute admissions compromise the capacity for planned care at both the RD&E and at NDDH, causing cancellation of planned procedures and impacting on outpatient work. The number of acute admissions is rising due to an increasing and aging population, which is exceeding the capacity of primary and community care services. This results in our EDs and acute medicine receiving many patients whose attendances could potentially have been avoided, including children and young people. These pressures adversely affect both patient care and the experience of patients and their families and carers.

- **The impact of the COVID-19 pandemic** - COVID-19 has been the defining feature of the recent history of the NHS and has been arguably the largest emergency to affect the NHS in its history. In addition to this, seasonal influenza and other infectious diseases, such as Mpox, can have profound impacts on patients and cause significant disruption to service provision. Over the course of the five years of this Clinical Strategy, we will continuously strengthen our infection control readiness, ensuring our estates infrastructure, training, pandemic planning and stock levels of important equipment, such as powered respirators, enable us to respond effectively to future outbreaks or pandemics.

- **Potentially avoidable attendances -** These include unusually high admission numbers for substance related conditions in under 18s and a misconception among many people about when it is appropriate to attend the ED.

- **Shortages in workforce required for emergency care -** Delivery of effective urgent care requires continued focus on the staff, who are the bedrock of our services. The People & Culture Strategy, developed to support the delivery of this Clinical Strategy, contains detail on the workforce challenges and solutions, and plans to implement them. In particular, these will include recruitment and retention of clinical and other staff, as well as how we will further develop innovative roles already working effectively, to support our consultant led services. These include physician associates, practice educators, advanced clinical practitioners and others. A robust framework will be developed, clarifying the roles of all staff, and setting out support for training, development and supervision.

- **Patients with mental health conditions** - Many patients admitted to acute hospitals also have mental health needs during their visit or admission, but there are increasing numbers of patients presenting with acute physical health conditions who primarily require specialist mental health support, rather than

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attention solely to their physical conditions. Our EDs are often used inappropriately, simply as a place of safety for people with mental health conditions, who do not need emergency medical care.

- **Patients with acute delirium and dementia** - A large proportion of acute and emergency admissions in patients over 65 have acute delirium, often on a background of progressive dementia. These patients are highly complex, and present the greatest challenge to patient flow. We will review our Dementia Strategy, with a focus on specific aspects of good practice, such as early conversations with families and use of the "this is me" approach. We will also ensure that upgrades to ward environments are "dementia friendly", for example through the use of handrails contrasting with wall colour and clear floor marking.

- **The distance that some patients have to travel for acute care is considerable** - This means that some urgent treatments (e.g. acute heart conditions requiring cardiac catheterisation) can be unduly prolonged.

Strategic Approaches

This section sets out three objectives the Trust aims to achieve in relation to urgent and emergency care, underpinned by the "strategic approaches" that will be taken to deliver them over the next five years.

Objective 1. Stabilise and develop acute medicine at North Devon

A fundamental principle underpinning our service delivery is that patients should have equitable access to high-quality emergency services no matter where they live in our catchment area. We recognise that for some specialised services patients may have to travel, but both NDDH and the RD&E require a bedrock of acute medical capacity and capability to support the needs of patients who attend as emergencies. NDDH has long experienced diseconomies of scale due to its smaller size and remoteness, making it harder to recruit and retain specialist staff and constraining investment. We will address the challenges for both sites in the following ways:

i. **Invest in staffing to support acute medicine** – We will increase medical and non-medical staffing levels in acute medicine to provide more resilient services. This will strengthen service provision, support alternatives to acute admission and reduce length of stay. In turn, this will result in less need for future growth in our bed stock and less frequent use of expensive escalation beds, thereby making the investment required cost-neutral over time.

ii. **Optimise the patient flow model** – We will clinically review the pathways through which patients are reviewed and admitted, ensuring that physical infrastructure of facilities, such as Acute Medical Unit (AMU) and Same Day Emergency Care (SDEC), are fit for purpose. Leveraging the information within Epic, we will strive to improve our response to differing levels of demand, and also optimise how we manage flow through our various care settings. This requires us to make more intelligent use of our information, aided by automation where possible.

iii. **Increase support from our eastern services in acute medicine** – Since the merger in April 2022 much progress has been made in providing support from eastern services to the north and in integrating key urgent care services, but there remains work to do. We will continuously support our clinical and operational teams to maximise the benefits of being part of a larger trust, particularly with regard to medical cover and specialised services.

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iv. **Provide a cardiac pacing lab** – We will explore the feasibility of providing a cardiac pacing lab at NDDH. This would save around one hundred non-elective patients travelling to Exeter each year, as well as hundreds of elective patients, and would shorten their length of stay. It would also make cardiology consultant roles at NDDH more appealing, thereby supporting recruitment of high calibre staff.

Objective 2. Reduce acute admissions and length of stay (LOS)

Lengths of inpatient stay have important implications both for the wellbeing of patients and for the efficiency of the Trust. For patients, there is good evidence that staying longer than clinically appropriate brings significant disbenefits, including muscle atrophy and loss of independence. For the efficiency of the Trust, lowering LOS or avoiding admissions altogether is essential to provide the capacity required to admit acutely unwell patients. The Trust treats over 40,000 non-elective inpatients each year in approximately 1000 beds. A reduction in LOS of one day per patient would create the capacity equivalent to over 100 beds. There are many workstreams focused on delivering this objective, but our strategic approaches below set out those changes which are most significant at an organisational level. This approach is closely aligned to the Integrated Care Board (ICB) strategy.

i. **Improve safe alternatives to admission** - We will continuously strengthen services to support patients by providing safe, high-quality alternatives to admission to an acute hospital bed. These will include:
    - SDEC running 7 days a week across both sites
    - A greater number and availability of “hot clinics” for urgent patients
    - Expansion of the Trust’s “virtual ward” so that up to 100 suitable patients can be safely monitored at home without the need for admission by the end of 2023
    - Following the completion of a dedicated children’s area as part of the refurbishment of our eastern ED, we will upgrade the physical infrastructure and review the service model of the short stay Paediatric Assessment Unit (PAU)
    - Further enhance the Urgent Community Response (UCR) functions in the community, to increase admission avoidance activity and outcomes
    - Working with our Primary Care Networks (PCNs) and NHS 111 to stream patients more appropriately into the above services to reduce ED attendance and acute admission
    - Working with UCR teams to develop a community-based Delirium Pathway to provide skilled assessment, treatment, and support for patients with delirium and progressive dementia to help prevent avoidable admissions

ii. **Improve Surgical Assessment Units (SAU)** – We will improve the infrastructure of our SAUs on both sites to ensure that non-elective surgical patients have access to high-quality assessment, and alternatives to acute admission. Alongside this, day case and ambulatory pathways for non-elective surgical patients will be continuously enhanced.

iii. **Develop options for an Urgent Treatment Centre (UTC)** – Urgent Treatment Centres are GP led urgent care facilities, open at least 12 hours a day, every day, offering appointments that can be booked through NHS 111 or through a GP referral, and are equipped to diagnose and deal with many of the most common ailments people attend ED for. We will work with system partners to explore the feasibility of implementing UTCs, which are coterminous with the EDs on the northern and eastern sites. The units would stream less acutely unwell patients and will also offer support for patients with mental health and social issues, both of which should reduce congestion and manage future growth in demand in our EDs.

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Objective 3. Increase facilities and arrangements for critical care

Critical care facilities and staffing levels underpin the Trust's ability to care for acutely unwell non-elective patients, as well as safe and timely delivery of care for our highest risk elective patients.

i. **Develop critical care outreach** - We will further develop critical care outreach delivery models, which will support the care of critically ill patients and complement existing community models, in areas remote from the Intensive Treatment Unit (ITU).

ii. **Provide dedicated critical / high dependency care for acute medical patients** - Additional dedicated facilities for the care of critically ill patients in the area of the Acute Medical Unit at our eastern site will also be considered as an approach to caring for the increasing numbers of very sick medical patients who are admitted acutely.

iii. **Increase Intensive Treatment Unit (ITU) bed base** – at both the RD&E and NDDH our ITU bed base is considerably lower than the national average of 7.3 per hundred thousand people. We will seek capital funding to increase our ITU bed numbers on both the RD&E and NDDH sites.

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Domain 2 - Community & Primary Care-led Service

Goal

We will work with our partners to provide joined-up, high-quality care to help keep people well at home and reduce the need for hospital admission.

Main Challenges

- **An ageing population** with multiple co-morbidities, which creates a high demand for community services, both in terms of referrals and complex need.
- **A widely dispersed rural population**, which means prolonged distances and travelling time for community staff and in some cases limited infrastructure (including domiciliary care agencies) to support people to stay well at home.
- **Staff shortages,** which affect the ability to deliver community care and impact on workforce resilience and retention.
- **A lack of community facilities and space** in which to offer enough clinics for patients, for example in physiotherapy, maternity services, community dental services and podiatry.
- **A lack of domiciliary care and private provision of home care**, which increases demand for community services in order to keep people safe and slows discharge from acute hospital beds.
- A lack of knowledge among both patients and healthcare providers about what services are available and how to access them, in order to ensure our community services are used to their maximum skill and expertise.
- **Deficiencies in recognition and support for people living with dementia.** Low rates of early diagnosis and shortfalls provision of carer and patient support cause unplanned preventable crisis admissions.
- **Shortfalls in End of Life Care.** A lack of coordination and arrangements for holistic and individualised care by system partners, which often results in avoidable hospital admissions and patients not being able to die at home, as they would wish.
- **Inadequate linkage of digital systems** between community services, secondary care (Epic) and primary care.

Strategic Approaches

Our excellent community service teams play a critical role in supporting people within their homes, working closely with colleagues in primary care, social care, care agencies and the voluntary sector at a truly local level. Due to its dispersed nature, much of the work they undertake is less visible than for our acute services, although it is vital to keeping people safe and well in their own communities. Each year our teams undertake approximately 240,000 community nursing visits and 85,000 therapy visits within patients' homes. In addition, our teams provide approximately 100,000 therapy and podiatry appointments and operate 92 community

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hospital beds in Tiverton, Exmouth, Sidmouth and South Molton. Our community midwifery teams provide antenatal and postnatal care and support home birth in the community across the Royal Devon geography.

This section sets out two objectives the Trust aims to achieve in relation to community and primary care-led services, underpinned by the “strategic approaches” that will be taken to deliver them over the next five years.

Objective 1. Work with local partners to optimise pathways of care

Our acute and community services are part of the broader health and social care network which is necessary to support people in living healthy lives and to care for them when they need help. In the Royal Devon catchment area, there are 65 GP practices and approximately 136 care homes, in which around 4000 people live. There is also a network of acute and community mental health services provided by Devon Partnership Trust (DPT), working alongside our teams to provide care for some of our most complex and vulnerable patients. Other critical partners include South Western Ambulance Foundation Trust (SWASFT) and the broad range of voluntary sector groups supporting people across the breadth of health and social care. Fostering a culture of strong partnership working, where we strive towards seamless care for our patients, is a cornerstone of this Clinical Strategy.

i. **Improve care home support** - Over 1500 acute admissions per year are of people resident in care homes. Recent audits have shown approximately 30% of these admissions are avoidable. Building on the existing Enhanced Health in Care Homes Framework, we will enhance the support our acute and community services provide to care homes within our catchment area. This will include therapy support, specialist advice and increased participation in multidisciplinary teams.

ii. **Improve use of shared digital information** - Communication and sharing of patient information provides clear advantages in connecting clinical services from across the health and social care system, (including mental health services) and in making the whole system simpler and easier to navigate for patients, their families and carers. Our Clinical Digital team will be expanded and will work closely with our clinical teams to continuously improve the ways in which Epic can make patient care, safer, easier and more effective. There is a multitude of examples of this work, but within urgent care they include the creation of dashboards to identify COVID-19 patients, tools to streamline the discharge process and refinements to make prescribing safer. We will also support the implementation of the Devon & Cornwall Care Record and integration with our services and the NHS app.

iii. **Improve End of Life Care** – Building on the Trust-wide end of life work plan, which has already delivered nurse led Treatment Escalation Plans (TEPs) in the community, we will improve End of Life Care through targeted investment in staff, proactive planning with patients and families to reduce avoidable hospital admissions and ensuring excellent liaison across the acute, community and wider system teams.

iv. **Work more closely with voluntary sector organisations** – Local charitable groups, such as Help the Aged, Dementia UK, Alzheimer’s society and the British Red Cross can play critical roles in supporting patients’ wellbeing at home and reducing social isolation, which is often a precursor to acute hospital admission and discharge. We will pilot the introduction of a volunteer coordinator role to liaise with these voluntary sector organisations, as well as patients, carers and patient families. This will expand the range of our collaboration and compliment the work of our community teams.

v. **Update the clinical Directory of Services (DOS)** - The DOS will be updated and promoted for use by clinical teams and patients through a range of publicity and media, to help all potential users navigate the care system and more easily find the support they need. The updated DOS will include information about waiting times for our ED, walk-in centres (WICs) and minor injury units (MIUs).

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vi. **Shared dementia care pathway** – We will work in partnership with Social Care teams, Devon Partnership Trust, community groups, and volunteers to deliver innovative, community-based, personalised care for people living with dementia. Our dementia and delirium pathways will promote health and independence at home and prevent illness and unplanned admissions. We will share processes and information, and ensure there is open communication between the Acute Trust and partners in the community, ensuring that people living with dementia get the best care in the most appropriate place, including care at the end of life in their own home.

vii. **Continue to promote and develop local relationships between our community teams and GP practices,** to work together and deliver the Fuller Report recommendations, which promote improved collaboration to maximise the capacity of local 'neighbourhood teams'.

Objective 2. Build community capacity to reduce acute bed occupancy

Our services commonly operate with around 170 patients who are "green to go" but cannot leave hospital due to delays in care home placement, packages of care in their own homes or other social circumstances. Some of the key solutions to this are not within the direct control of Royal Devon but through partnership working with Devon County Council and the Devon ICB, we can enhance existing approaches and develop innovative new services to provide greater capacity.

i. **Expand the Urgent Care Response (UCR) function and domiciliary care capacity within the Community Division** – Our teams provide immediate support to people in their own homes to prevent the need for hospital admission or offer support immediately post discharge. These teams will be developed in order to help mitigate the shortfall in the domiciliary care market, with consideration also being given to widening their scope, capitalising upon the opportunities for support from our acute and community services and the virtual ward. Our teams in the East and the North will standardise their approaches, enhancing their ability to work in concert.

ii. **Provide care home capacity** – We will explore the feasibility of providing a care home or intermediate care facility, managed by the Trust or with a third-party partner, taking patients exclusively from acute and community beds. This facility would be well supported by rehabilitation services with the aim of most patients being discharged safely home within a period of 1-2 months. The service would require commissioning from either Devon ICB or Devon County Council (DCC) as part of the feasibility process.

iii. **Develop frailty hubs** – Working closely with colleagues in primary care and mental health services, we will support the development of frailty hubs. These will bring several disciplines together to enhance the care for frail patients. An example of this is proactively reviewing the 4000 patients in care homes and colour-coding them, based upon their wishes and clinical need, as to whether they should be admitted to an acute hospital in the event they become unwell. Introduction of this work in other localities has been shown to reduce admissions to acute hospital beds by 80%.

iv. **Expand the range of elective care services which can be delivered closer to people's homes** - Royal Devon currently undertakes elective surgery on four community operating sites and provides thousands of clinic appointments across the range of our 17 community hospitals. We will continue to develop these, to make care more convenient to patients, and to preserve precious resources on our acute sites. An example of this is the development of the Urology Investigations Unit in Ottery St Mary, which now provides new and follow-up outpatient services and cystoscopy and we are seeking to expand this further with the addition of a platform for a mobile MRI scanner to provide one-stop cancer clinics.

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Domain 3 - Elective Care

Goal

We will provide elective care of the highest quality for our patients in a timely and predictable way, by utilising the most up-to-date technology. We will reduce our waiting times by maximising the capacity of elective care within the resources available and provide it as close to home as possible.

Main Challenges

- **The number of patients needing elective care is increasing,** as is the complexity of their conditions. This applies to both medical and surgical services.
- **There is insufficient operating theatre capacity at both RD&E and NDDH,** and use of this capacity is frequently obstructed by the numbers of acute admissions, which cause cancellation of planned procedures. Intensive care facilities are also sometimes a limiting factor.
- **Lack of protected elective capacity.** Elective beds (including day surgery beds) are commonly occupied by acute medical patients at both sites.
- **Epic offers tremendous opportunities** to streamline care however it is a complex and time-consuming process.
- **There is lack of standardisation of care pathways** between our northern and eastern services, resulting in variability of the quality of care in some areas.
- **Units remote from the RD&E and NDDH are sometimes unable to provide up-to-date treatments** because of inadequate equipment (for example, no laparoscopic equipment at Tiverton hospital for our hernia service).

Strategic Approaches

This section sets out five objectives the Trust aims to achieve in relation to elective care, underpinned by the “strategic approaches” that will be taken to deliver them over the next five years.

Objective 1. Recover our waiting times through maximising elective activity

Across the NHS waiting times have increased significantly as a result of the COVID-19 pandemic, with thousands of patients waiting in excess of two years for treatment during 2022/23. Elective activity has been constrained by a number of factors in recent years, notably the impact of the COVID-19 pandemic, and workforce challenges. Royal Devon currently has some of the longest waiting times in the country, including key services for children, such as neurodisability and neurodevelopmental conditions, resulting in stress, discomfort and in some cases, harm to our patients. Recovering our waiting times to acceptable levels is our top priority for elective care. We will achieve this in the following ways:

i. **Expand the elective productivity programme.** Increasing our clinics by just one patient per clinic, for example, would result in over 40,000 additional slots per year. The additional income generated by this

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activity would also tackle the challenging financial context in which the Trust is operating. Our Transformation Team will continue to support clinical teams to remove barriers to efficiency, such as Epic interfaces, staffing levels or booking processes, to make clinics and operating lists run more smoothly.

ii. **Utilise additional external revenue funding, where available, to deliver additional activity.** In 2022/23, the Elective Recovery Fund (ERF) programme supported the delivery of thousands of additional cases through locum staff and ad hoc additional activity from existing teams. But the funding mechanism varies from year to year and is invariably non-recurrent, which makes recruitment of clinical staff difficult. We will proactively plan measures to increase activity, so that we can react in an agile way to opportunities for injections of additional capacity through short notice funding when it becomes available.

iii. **Expand and improve outpatient physical infrastructure.** Some key areas require improvements to their physical infrastructure as the current facilities do not meet the needs of patients or staff. For example, our Breast Care patients have to walk considerable distances during their appointment and get dressed and undressed multiple times during an already stressful process. We will proactively prepare business cases to address these, such that we are in a position to quickly take advantage of national capital funding, which periodically becomes available at short notice. In the past three years, this approach has resulted in tens of millions of external funding to support developments within the Trust, such as the ED refurbishment, additional MRI and CT scanners, and an additional inpatient ward in NDDH.

iv. **Improve diagnostic capacity** through productivity improvements and transformation, furthering the work being done by our diagnostic community hubs and the Nightingale Hospital's Devon Diagnostic Centre.

v. **Develop improved pre-assessment and prehabilitation for elective care –** We will develop improved pre-assessment pathways with due consideration of the level of physical frailty and cognitive risk, so that we can provide appropriate medical optimisation and prehabilitation when needed, or alternatives to overly-burdensome procedures when these are no longer clinically appropriate.

Objective 2. Improve patient experience, particularly through adoption of new technology

The digitisation of patient information enabled by Epic opens up a broad range of opportunities to make care more personal, convenient and safe for patients. The MyCare patient portal in particular, offers an opportunity for patients and carers to have greater control and to access care in novel ways, such as through apps or wearable devices. We will improve patient experience in the following ways:

i. **Increase utilisation of the MyCare patient portal** – We will greatly expand the usage of MyCare through targeted patient communication via a range of media. There will be further development of training for key staff involved in signing patients up to the MyCare portal. By the end of 2023/24 we aim to have enrolled 100,000 patients on the system, increasing to 250,000 within three years. Help will be provided for patients who are inexperienced with digital systems, for example, in virtual consultations, and there will be support for patients who are unable to access the internet in their homes.

ii. **Increase use of patient initiated follow-up (PIFU)** – We will continuously increase the use of PIFU (when a patient initiates an appointment when they need one, based on their symptoms and individual circumstances, as opposed to simply being booked for an appointment in the future, which may or may not add value). If one in twenty follow-up appointments were saved through this approach, there would be an additional 22,000 slots available per year in which to see other patients, which would help reduce backlogs.

iii. **Increase virtual care** - We will maximise the use of virtual care, including virtual clinics, pre-assessment, prehabilitation and remote monitoring using hand-held or wearable devices. This not only enables care closer to patients' homes, but it also has important environmental benefits. The reduction in physical outpatient attendances is likely to mean that around 3.5 million fewer miles are being driven

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by patients each year, reducing carbon emissions by approximately 650 tonnes. For patients, this results in savings of approximately £500k in petrol costs and £600k in parking charges. This approach also supports a reduction in cross-site working for staff, making best use of valuable clinical time and further contributing to the environmental benefits because of reduced staff travel.

iv. **Introduce a patient self-booking portal** – The current system of booking patients over the phone requires a large number of administrative staff working to match patients with available clinic slots. We will develop a patient portal to enable patients to book and cancel their own appointments safely and securely, such that such that approximately 400,000 appointments (50%) will be booked by patients themselves. This will be more convenient for patients, reduce DNAs and free up administrative staff to support clinical care in other areas.

v. **Create an online patient information centre** – Each year the Trust sends over two million letters to patients, many of which include leaflets (patients frequently receive the same leaflet multiple times) and other documentation, which could be more easily made available online. In addition to this, our admin staff field thousands of phone calls from anxious patients and relatives seeking to establish how long they will wait for their procedure and what to do if they experience various symptoms. The ICB has developed an excellent online tool to provide patients with much of this information. We will link with system colleagues to develop an online information centre, providing patients with up-to-date support and information. This will also provide opportunities to signpost patients with chronic conditions to appropriate emotional wellbeing support in the community and relevant psychoeducation workshops; such as our Irritable Bowel Syndrome service, provided jointly with DPT.

vi. **Increase the provision of one-stop multidisciplinary clinics** – Additional one-stop services will be introduced This will involve changes in pathways and practices, but will reduce numbers of hospital attendances, which will boost efficiency, improve patient experience and reduce the effect of travel on the environment. We will incorporate mental health professionals into our pathways where appropriate, to recognise comorbid complexity and deliver integrated management plans for our patients.

Objective 3. Increase separation of non-elective and elective capacity

Over many years, the Trust has endeavoured to protect elective capacity but despite considerable support and commitment, has been unsuccessful due to growing urgent care pressures. Only around 8% of the Trust's bed capacity is for elective activity, which is why small shifts in the urgent care bed capacity (the other 92%) have such a significant impact. Over the five years covered by this Clinical Strategy, we aim to materially increase the separation or protection of elective care capacity across the Trust. Ideally, this will be through the development of elective activity that is geographically separate to our urgent capacity, through the provision of an elective treatment centre for example, but some elective services work hand in hand with urgent care, such as ITU, and cannot easily be relocated. Our approach to strengthening protection of elective capacity will therefore involve thoughtful use and expansion of elective care facilities in order to create resilient capacity for patients. We will focus investment and service redesign on protecting our elective capacity in the following ways:

i. **Ensure ringfencing of elective bed stock** - We will prioritise ringfencing elective bed capacity for Cardiology, Orthopaedics, Gynaecology and General Surgery across the Trust. This work will be incorporated into the urgent care agenda described in domain one of this strategy as a key measure of success.

ii. **Develop our existing infrastructure to support separation of "hot" and "cold" activity** – In the longer term, more theatre, catheterisation laboratory and endoscopy capacity will be needed, which will require changes in use of existing facilities and will be supported by the Estates Strategy, which is an enabler to this Clinical Strategy. Any new developments will be specifically considered to assess the extent to which they further the protection of our elective capacity. The development of the Cardiology Day Case Unit at the RD&E due in 2023/24 is an example of capital projects to support protected

elective capacity. The “Our Future Hospital” Programme in NDDH, is an enabler for the protection of elective capacity.

iii. **Develop options for an elective treatment centre** - In addition to the above approaches, which strengthen our existing services, we will also strongly make the case for national funding to develop an elective treatment centre. This would comprise multiple theatres undertaking orthopaedic, plastic and other surgery, with the supporting outpatient and diagnostic capacity to enable first class delivery of elective care, uninterrupted by urgent care pressures. This would result in more predictable, higher throughput operating lists which, as with outpatient productivity, would also materially improve the challenging financial position.

Objective 4. Work with other organisations to develop elective services in the best way for patients

The elective services we provide are part of a wider network of care provided to patients. Acute care provided by neighbouring Trusts in Devon, Taunton and Cornwall can have a significant influence on the shape of services provided at Royal Devon. In addition, best practice and innovation from Trusts across the NHS, as well as shifts in national policies and priorities, are important factors to continuously consider. We will ensure that Royal Devon plays a leadership and partnership role, alongside other local acute providers and that an outward-looking, learning culture informs development of our elective services. Key strategic approaches to delivering this objective are as follows:

i. **Actively engage with, shape and implement the Peninsula Acute Sustainability Programme (PASP) outcomes –** Our clinical and managerial teams will play a leading role in working with other organisations to shape the outcomes of the PASP for adult and children’s services to develop and implement the best service models for our teams and our patients across Devon. At the time of writing this Clinical Strategy, the PASP process is at an early stage however, it is likely that this will be a significant programme of work shaping service provision over the next five years.

ii. **Increase our focus on learning from benchmarking, good practice and national reviews to guide development of our services** – In many areas, Epic is now providing excellent data and outcome measures to help inform service development. In addition, benchmarking from external sources, such as the Model Healthcare System, peer reviews, Getting It Right First Time (GIRFT) visits and Royal College reviews are becoming increasingly powerful, as tools for driving service improvement. We will incorporate the inclusion and analysis of such information into our routine informatics and provide training for our clinical and managerial leaders to support improvement of our elective (and other) services.

Objective 5. Strengthen our cancer services

Cancer care is subject to the same challenges as other elective services, including the increasing impact of demographic pressures on demand, workforce constraints, and the impingement of urgent care on bed capacity. In addition, our cancer services face some specific challenges, such as the impact of increasing survivorship of first and subsequent cancers, the increasing complexity of available and recommended treatments, and the upscaling of National Institute for Health and Care Excellence (NICE) mandated oncology treatments.

As a result of these pressures, delays in cancer treatment have increased. Only around 40% of cancer patients undergo their first treatment within 62 days, compared to the national target of 85%. Only 73% see a specialist within two weeks compared to the target of 93%, and less than half are diagnosed within 28 days compared to a national target of 75%. NICE guidance on cancer services (2004) highlighted that at diagnosis, approximately half of all patients report severe levels of anxiety and depression that negatively affect their quality of life. In the

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year following diagnosis, approximately one in ten patients would benefit from intervention by specialist psychological services due to the severity of their symptoms.

We will strengthen our cancer services in the following ways:

i. **Review and improve cancer pathways** – Over the course of the five years of this Clinical Strategy, we will review all our cancer pathways and introduce measures to improve them wherever possible. These improvements will include shortening the pathway, for example, though more one-stop services; building capacity through additional staff or facilities, such as a dedicated Breast Care Unit; and integrating emerging diagnostic and treatment options, such as genomics, to make care as effective as possible. We will address psychological distress by having an embedded psychological service to meet patient needs across cancer pathways. Working with partner agencies including FORCE Cancer Charity and Exeter Leukaemia Fund (ELF) will also help patients deal with psychological issues they may be experiencing relating to their cancer care.

ii. **Support primary care in early diagnosis of cancer** – We will support and encourage elements of cancer pathways being provided by primary care, including expansion of the provision of direct access diagnostics, enabling GPs to expedite cancer care.

iii. **Strengthen leadership, oversight and coordination of cancer services** – We will improve the visibility, direction and oversight of cancer services by ensuring there is senior clinical and managerial leadership dedicated solely to cancer services. Job-planned time for clinicians involved in cancer leadership positions will be provided to avoid clashes with other priorities. Governance systems for cancer will also be reviewed to ensure there is robust sharing of cancer incident reporting between clinical and divisional teams, oversight of complaints relating to cancer services and drive and momentum in conducting our reviews of cancer pathways.

iv. **Provide additional support for cancer Multidisciplinary Teams (MDTs)** – Cancer MDTs will be reviewed, to ensure there is sufficient administrative and Allied Health Profession (AHP) resource to manage the volume and complexity of the workload; together with job-planned MDT leadership, to enable regular updating of protocols and membership. We will harness Epic to make MDTs run as smoothly as possible and to increase interoperability between MDTs, to support effective transfers of care.

v. **Increase the use of informatics to improve services** – As an early adopter of Epic, Royal Devon has a significant opportunity to capitalise on informatics to improve services. We will develop a bespoke cancer informatics system providing accurate, real time data, trend analysis, and easy-to-use reports and dashboards to facilitate improvements in cancer care.

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Domain 4 – Tertiary Care & Areas of National Clinical and Academic Excellence

Goal

We will work with our system partner organisations to ensure that the Royal Devon offers specialist tertiary care based on the expertise of our services, aligned with and supported by academic activities. Alongside other acute service providers, this will support the optimum care for patients, make best use of the limited capacity across the region, and provide stability for each hospital.

Tertiary services are those provided beyond a Trust's normal geographical area due to their highly specialist nature and the particular expertise located elsewhere.

The main tertiary centre in the Peninsula is Derriford Hospital, which is the Major Trauma Centre and provides neurosurgery, resectional hepatobiliary and oesophagogastric surgery. The Royal Devon also provides a number of tertiary services across Devon, Cornwall and Somerset, as outlined below.

Examples of services where patients travel outside of our catchment area for specialist care not provided by Royal Devon	Examples of services provided by Royal Devon to which patients travel from outside our normal catchment area for specialist care
• **Services provided by University Hospitals Plymouth** ○ Cardiac surgery ○ Upper gastrointestinal cancer surgery (provided by UHP) ○ Major trauma UHP ○ Stroke thrombectomy ○ Renal transplantation • **Services provided by specialist Bristol Children's Hospital** ○ Specialist children's surgery	• **Scoliosis surgery** • **Spinal trauma** • **Abdominal wall reconstruction** • **Robotically assisted laparoscopic prostatectomy** • **Complex hip and knee revision surgery** • **Genomics** • **Renal dialysis**

Table 1. Examples of Tertiary care services

Main Challenges

- **Providing an equitable service** for patients who live in localities distant from the hospital which offers the specialist care that they need. Public transport links are poor in many areas, journeys can take a long time. This requires consideration of the difficult balance between the benefits of centralised specialist care and the inconvenience of travel, which discourages or prevents some patients from accessing care.
- **Vascular services** at NDDH are currently linked with Taunton, rather than our own services in the RD&E, despite Royal Devon being the arterial centre for East Devon and Torbay.
- **Data linkages** are currently a problem for ready access to patient records because of inadequate links between different hospitals involved in tertiary specialist care, and between hospitals and primary / community services. For example, it can even be difficult to see blood test results of patients referred from other localities, or repatriated from them.
- **Pursuit of research activities and academic excellence** can be challenging for clinical staff. They need encouragement, time, and infrastructure to pursue these activities.

Strategic Approaches

Objective 1. Promote and invest in our flagship services on both sites

Our flagship services include Orthopaedics, Renal, Genomics and Cystic Fibrosis in the RD&E and complex abdominal wall surgery, and the Comprehensive Hernia Service at NDDH. These specialties represent enormous opportunities for Royal Devon, and have implications which extend beyond their specialty team or the patients they serve. They can:

- **bring a sense of pride to staff across the organisation, boosting morale and recruitment,**
- **bring innovation and investment from industry, such as funded fellowships who undertake clinical work and commercial research,**
- **foster the reputation of the Trust nationally, through recognition of its centres of excellence,**
- **materially help address the financial position through additional income.**

It is important that each hospital has its own defined area(s) of specialist practice, which offer the best possible tertiary care for patients. We will support our flagship services in the following ways:

i. **Purposefully develop flagship services** – We will provide support to key services to identify challenges they may be experiencing and provide support from either operational management or the Transformation Team to address them. In addition, we will make the right support available to these services to evaluate and take forward opportunities for further service development, including investment in key infrastructure where required.

   All investment cases will be required to demonstrate value for money, as well as clear benefits for our patients. However, we will support our tertiary services to creatively explore how investment can be identified from national or regional funds wherever appropriate. Examples of current key investment priorities include:

   - the introduction of a robot at NDDH for abdominal wall surgery,
   - the addition of a hybrid theatre for vascular surgery at the RD&E,
   - additional operating theatre capacity within orthopaedics and
   - upgrading the infrastructure of our renal services.

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Expansion of robotic surgery into clinical specialties, such as gynaecology and other services, is also likely to be required over the five years of this Clinical Strategy.

ii. **Promote the successes and benefits of our flagship services to others** – With support from our Comms Team and senior operational and clinical colleagues, we will more effectively promote our flagship services. This will be through highlighting their work on social media, showcasing significant research and nominating our tertiary (and other) services for various awards as a way of thanking our staff and drawing attention to their excellent work.

Objective 2. Network with other hospitals to optimise pathways for patients and staff

Networked services, which mean that patients may travel between organisations during a single pathway, require collaboration, teamworking and strong clinical relationships, underpinned by effective digital and physical infrastructure. Getting this right can be time consuming and complex. Navigating a care pathway between organisations can be confusing and daunting for patients, particularly those on cancer pathways. We will support our clinical teams to develop networked services in a way which makes care as uncomplicated as possible for our patients, and which makes best use of our precious resources. To achieve the delivery of this objective we will:

i. **Actively engage with system partners** – We will work with other organisations collaboratively to optimise networked pathways of care. Regional and wider clinical networks that currently work well, such as within Radiology and Pathology, will be supported, and may be used as exemplars for the development of other networked services.

ii. **Provide clear information for patients on pathways and where to get help** – We will link our tertiary services with the planned online Patient Information Centre to ensure that patients can get up-to-date information about pathways for services crossing organisational boundaries. Our administration teams will provide support for patients who have difficulty accessing digital information, helping them navigate pathways and connecting them to a clinician when they have questions or concerns.

Objective 3. Maximise the potential benefits of academia and research

A focus on academia and research goes hand-in-hand with the training and development opportunities that this offers, which can boost morale and improve both recruitment and retention of staff. Involvement in multicentre research trials, for example, improves the generality of care, by advancing our knowledge, and also provides care of a particularly high quality to patients involved in the studies. The Trust will actively support research and academia as a core element of clinical care in the following ways:

i. **Foster a research culture across the Trust** – Areas of research, development, and publication within the Trust, which include nationally and internationally recognised services, such as genomics, diabetes, inflammatory bowel disease, and hip replacement surgery (the Exeter Hip), will be supported in their further research and academic ambitions.

ii. **Strengthen our links with academic institutions** - The established close links between the Trust and the University of Exeter Medical School and the University of Plymouth will be supported and developed further.

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iii. **Expand multicentre research trials** – We will actively support our clinicians' participation in multicentre research trials, recognising that this benefits patients who become involved in trials, and future patients who will benefit from their outputs. Patients who are not themselves enrolled in trials have also been shown to have better medical outcomes in research active organisations. We aim to ensure equity of access to research participation for currently under-served populations, including people with learning disabilities, cognitive disability, and people from rural and economically-deprived areas.

iv. **Support hybrid clinical / research roles** - We will nurture and develop clinical posts with an academic component, in disciplines across the Trust, as part of our strategy to make posts attractive to dynamic and high-quality applicants. This will raise the profile of specialties with good research track records.

v. **Harness the capacity of Epic and other digital systems to support clinical research** – Our clinical and Clinical Digital teams will work together to ensure that information from digital information systems is utilised as fully as possible, not only for service improvement, but also for research. The wealth of data that these systems gather offers great potential for both clinical and epidemiological research. The adoption of Epic offers important research opportunities and we will strive to be an organisation known for excellent research facilitated by the application of clinical data.

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Section Three

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SECTION THREE

Further considerations in delivering the Clinical Strategy

How the Clinical Strategy will be supported by other Trust strategies

Delivering a five-year Clinical Strategy of the scale set out in this document is a complex undertaking, which will require coordinated leadership and planning in Estates, People & Culture, Digital, Data, Finance and Transformation, in addition to the close involvement of our clinical teams. We are taking a bold approach in revising the strategies for all these areas, alongside the development of the Clinical Strategy. This will ensure cross-fertilisation of innovation and will minimise risks in areas such as recruitment and capital availability.

Detailed work has been completed, reviewing all the strategic approaches described in this document for their links with the other Trust strategies. This will ensure a coordinated approach, so that these other strategies will support and enable implementation of the actions required to deliver the Clinical Strategy.

Links to the key Trust strategies are available in Table 2 below. Links to each of the other strategy documents will also be available on the Trust's website.

Strategy	Link
People & Culture	*To be added when final documents are approved in summer 2023*
Estates	*To be added when final documents are approved in summer 2023*
Data	*To be added when final documents are approved in summer 2023*
Finance	*To be added when final documents are approved in summer 2023*
Digital	*To be added when final documents are approved in summer 2023*
Transformation	https://www.royaldevon.nhs.uk/media/2hbfvayn/transformation-strategy-doc-v14.pdf
Green Plan	https://www.royaldevon.nhs.uk/media/deud4j3w/royal-devon-our-green-plan-2022-2025.pdf

Table 2. Supporting strategies

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Risk Management

Coordination of the clinical and associated enabling strategies described above will optimise our approach, but there remain important factors that the Trust can influence but not fully control. These include; funding at national or regional level, national policy shifts, demand and capacity shortfalls in professional training, as well as patient factors, such as growth in demand exceeding forecast levels, difficulties in recruitment, and unplanned macro events such as the COVID-19 pandemic. The matrix below sets out the risks considered to be the most significant, alongside the controls put in place to best mitigate them.

No	Risk area	Risk and effect	Mitigating actions
1	People & Culture	Unable to recruit general and specialist staff or provide level of professional training required to meet strategy ambitions.	• Co-production of the People & Culture Strategy alongside the Clinical Strategy will align work of HR team to support recruitment of specialist staff. • The Trust has recently invested in additional support in this area and vacancies are reducing at a Trust level.
2	Digital	Due to lack of funding, technical limitations, complexity, lack of clinical buy-in or lack of technical and leadership capability the Trust is unable to capitalise upon digital opportunities to improve services.	• Co-production of the Digital Strategy alongside the Clinical Strategy will align work of digital teams to support necessary developments. • Approved investment in transformation capability includes additional resource in digital expertise. • The Trust's Digital Services are overseen by the Chief Medical Officer (CMO) to ensure the work of the digital team is prioritised according to clinical needs of the organisation. • An operational group, chaired by the Director of Transformation is being established to continuously align the work of the digital teams with operational priorities.
3	Estates/ Finance	Funding constraints limit the Trust's ability to deliver the aims of the Clinical Strategy.	• Co-production of the Estates Strategy alongside the Clinical Strategy will align work of Estates team to support necessary developments. • The Clinical Strategy document is clear throughout that the Trust will seek funding for new developments but does not commit funding beyond current resources. In order to be open and transparent with our staff, this will be clearly articulated to our staff in the communication strategy. • In order to maximise our ability to successfully bid for external funding when it becomes available, we will proactively develop cases to support the capital developments set out in the Clinical Strategy. Business cases must include transformation of services, as opposed to simply creating "more of the same" capacity. • The Executive Team is working at system and regional level to gain support for capital investment to deliver change. This has so far gained support for the Nightingale Hospital Community Diagnostics Hub, the ED development, two surgical robots and the development of the Cardiology Day Case Unit.
4	Engagement with staff	Failure to secure the necessary support, drive and engagement with staff to deliver the strategy.	• Extensive engagement with clinical and leadership staff in the development of the Clinical Strategy. • An comms plan accompanies this strategy to inform, engage and inspire staff in all areas and secure their support.

No	Risk area	Risk and effect	Mitigating actions
5	Leadership	Insufficient leadership capacity and capability to deliver the strategy.	• The Trust Delivery Group (TDG), led by the Chief Operating Officer (COO), will oversee the delivery of the plan. (see Delivering the Strategy) • A development programme aimed at operational and clinical leaders is being launched in Q1 2023/24. This should support leadership staff in many of the key areas required to deliver change on this scale. • The Trust has invested in expanding the Transformation Team so that there is significant, senior operational and strategic experience and expertise to support change management.
6	National Policy shifts	Could impact positively or negatively on delivering the strategy in a number of ways including funding shifts, new initiatives etc.	• The Director of Strategy will work with senior colleagues to gain early knowledge of any proposed changes to allow the maximum time to plan and adapt to changing circumstances. • The ownership of the Clinical Strategy by the TDG aims to support agility and responsiveness in the face of any changes going forwards.
7	Unplanned macro events	Global events such as pandemics, conflict and macro-economic forces may impact upon service delivery.	• The ownership of the Clinical Strategy by the TDG aims to support agility and responsiveness in the face of any changes going forwards.

Table 3. Risk Management matrix

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Delivering the strategy

Once approved by the Board of Directors, the Trust Delivery Group (TDG), led by the Chief Operating Officer (COO) will be tasked with the delivery of the Clinical Strategy. This group comprises the Executive Team, Trust Directors and a number of other senior managerial and clinical staff, so it is well placed to coordinate and prioritise resources to ensure delivery, as well as to respond effectively to any future changes in the strategic and political landscape.

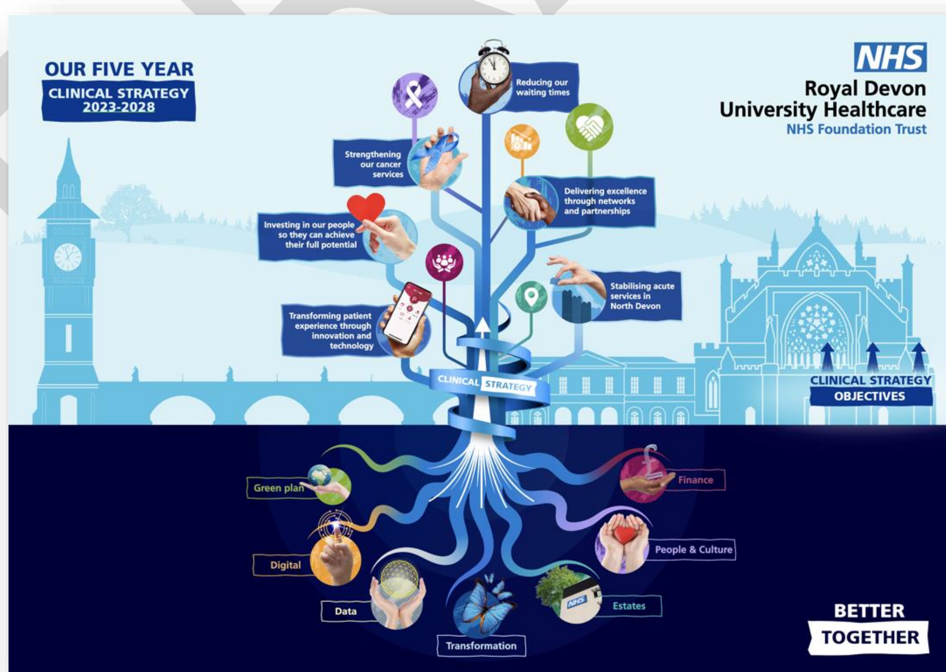
Under the direction of the TDG, divisional and specialty teams will be responsible for developing operational plans as part of their annual planning process, which will describe the steps each service will take to progress their delivery of the strategy. These operational plans take account of emerging national guidance and robust local data. The plans will have clear, measurable outcomes so that success can be quantified, and steps can be taken to support any teams struggling to progress individual strategic approaches.

Six monthly reports will be provided for the Board of Directors, aimed at ensuring Board-level support for delivering the strategy and overcoming any barriers to its implementation.

Communicating the strategy

This strategy provides the Royal Devon with a blueprint for service improvement, which, in addition to providing a sound basis for operational planning, also offers our staff a vision for the future which is both hopeful and optimistic. It is important that the key elements of the strategy are communicated effectively to staff across the Trust, as well as patients, and other organisations with which Royal Devon works in partnership. To achieve this aim, our Communications Team will deliver a segmented approach, offering key stakeholders a range of media through which to understand the strategy, including access to this document, summarised versions, graphic illustrations and animations describing the strategy and the key strategic approaches.

A sample of the illustrations for the strategy, including the relationship with both the Better Together and supporting strategies, is provided below.



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Acknowledgements

The document was developed and overseen with support and engagement from the North and East Clinical Strategy Decision Groups. Details of the members are shown in the table below.

Eastern Clinical Strategy Decision Group (task & finish – clinical integration)

Name	Role
Bruce Campbell	Chair
Nolwenn Luke	Assistant Director of Nursing
Lynsey Webb	Clinical Director for Medical Services; Governance, Consultant in Nephology and Acute Medicine
Sisse Olsen	Consultant Oncoplastic Breast Surgeon (Clinical Lead), Training Programme Director for General Surgery
Sophie Markevics	Assistant Director of Therapy - Community Services
Ali Macefield	Deputy Head of Midwifery and Gynaecology
Chris Mulgrew	Clinical Chief Information Officer - Eastern
Richard Haigh	Consultant Rheumatologist
James Bayliss	Lead Nurse Quality

Northern Clinical Strategy Decision Group (part of Our Future Hospital programme)

Name	Role
David Sanders	Chair
Lucy Miller	Consultant in Anaesthesia; Persistent Pain Lead
Rebecca Rub	Consultant Paediatrician
Naomi Clatworthy	Nurse Consultant, Acute Oncology Service
James Rogers	AHP Physiotherapy Consultant
Alison Moody	Clinical Chief Information Officer - Northern

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Other staff acknowledged as involved in the development of the strategy:

Name	Role
Carolyn Mills	Chief Nursing Officer
Adrian Harris	Chief Medical Officer
Phil Luke	Director of Transformation
Zahara Hyde	Our Future Hospital Programme Director
Laura Harrison	Executive Support Coordinator
Dominic Page	Project & Service Change Manager

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Appendices

Appendix 1 – Background information about the Trust, its partner organisations, and the challenges and context of this strategy

This section describes the population health needs for North and East Devon that the Royal Devon serves through its community services and two acute hospitals that are a long distance apart. It outlines the merger of the North and East parts of the Trust, and the partner organisations with which the Trust works, to provide a full range of health and care services for patients. It describes some of the challenges facing the Trust and summarises important aspects of the national and regional strategic context within which this Clinical Strategy will sit. The initial perspective of the strategy is the next five years, but its intention is to guide the development of sustainable services in the long term.

Background

The Trust comprises the Royal Devon and Exeter Hospital (RD&E) in Exeter, the North Devon District Hospital (NDDH) in Barnstaple and their associated community services, which have traditionally served the populations of East and North Devon, respectively. The two acute hospitals are a distance of 53 miles, and 1.5 hours apart, making NDDH one of the most remote acute hospitals in England from its nearest neighbour. The Trust serves a distributed and dispersed rural population, meaning that travel and access to care are recurrent themes for many patients, especially in North Devon where travel time to the next nearest acute hospital is up to two hours (and often longer in the summer months, due to volume of holiday traffic). The map below shows the geography of the area and the locations of the Trust's facilities.

Figure 1. Map of hospital sites in Devon.

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Acute Hospital Services

NDDH, built in 1978, is a 298-bedded district general and is the major care provider for acute and specialist care for the population of North Devon and East Cornwall. The core population of 165,000 served by NDDH is boosted in summer to an estimated 320,000, which manifests in a ~25% surge in ED attendances. The hospital provides 24/7 emergency services and some specialist services to the population, with an emergency department, intensive care unit, maternity, neonatal, children's services, and full diagnostic, surgery and outpatient services. It has excelled in the provision of some surgical services for which it is a national exemplar and receives referrals from around the region. In 2019, NDDH was named as one of 40 sites identified by the government's New Hospital Programme for investment to redevelop and expand the facilities to provide appropriate sustainable future healthcare for the population it will serve.

The RD&E is an 843-bedded large acute hospital, which was largely rebuilt in the years immediately preceding 1992, and has since been expanded. It serves a core population of 450,000, providing a full range of acute and elective services, with the important exceptions of some specialist cancer surgery, cardiac surgery and neurosurgery. Some of its services are nationally recognised to be exceptional (for example orthopaedics, genomics, clinical genetics and cystic fibrosis). It has a strong record of nationally and internationally recognised research and publication in a number of clinical areas.

Community Services

The community health and social care services of the Trust are supporting patients in their homes when needed, and provide a variety of day treatment, outpatient, health and wellbeing and inpatient services at the 17 community hospitals throughout East and North Devon.

There are 12 community hospitals in Eastern Devon, three of which have established inpatient beds. There are five community hospitals in North Devon, one of which has inpatient beds, and a health centre located in the town centre of Barnstaple.

Across Devon a diverse mix of services have developed in our community facilities, offering local population access to minor injury, sexual health, maternity and day case services, as well as the Exeter Nightingale Hospital, developed in Exeter during the COVID-19 pandemic and now serving the population with access to orthopaedics and ophthalmology elective services, and diagnostic services.

Table 1 gives some details of the capacity and activity of the Trust, and the staff they employ.

Metric	Eastern Site	Northern Site
Core population served	450,000	165,000
Inpatient beds	843	298
ED attendances: (Source: Annual Reports 2021/22)	ED: 90,906 MIU: 11,039 Walk in Centre: 22,360	ED: 59,349 NB – Northern Devon MIUs closed since April 2020
Inpatients total (Source: Annual Reports 2021/22)	106,855	25,619

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Day case patients (Source: Annual Reports 2021/22)	42608	20024
Births (Source: Annual Reports 2021/22)	4,018	1,302
Average number of Employees WTE (Source: Annual reports 2021-22)	8,534	3,663
Operating surplus/(deficit)	(£6.0m)	(£0.6m)
Overall CQC (Source CQC)	Good	Requires improvement

Table 1. Capacity and activity of RDUH

The merger between the Royal Devon & Exeter NHS Foundation Trust and Northern Devon Healthcare NHS Trust in 2022 followed three years of increasing collaboration between the Trusts as teams worked to secure the sustainability of local healthcare services for the North Devon area.

As a small remote hospital, NDDH has faced historic challenges around economies of scale, workforce and clinical sustainability in key services, exacerbated by high living costs and low availability of workforce accommodation, and old infrastructure that has not been modernised in keeping with other hospitals in the region. Before the merger, the two Trusts worked together under a collaboration agreement to deliver obstetrics and maternity, haematology and oncology services. The merger has supported the development and delivery of joint clinical service delivery plans for some of the most challenged acute medical services in North Devon, including gastroenterology, stroke, healthcare for older people, diabetes and acute medicine.

System partner organisations

Patients served by the Trust's acute and community health and care services also depend on other organisations, with which the Trust works in close partnership. These include primary care networks (PCNs), mental health services (Devon Partnership Trust), South West Ambulance Service NHS Foundation Trust (SWASFT), Devon County Council (DCC), Child and Family Health Devon (CFHD), district councils and local community and voluntary sector organisations, University Hospitals Plymouth NHS Trust, and Torbay & South Devon NHS Foundation Trust

There are strong links for the Trust with the University of Exeter, and it is the lead partner for the University of Exeter Medical School (UEMS). Both the RD&E and NDDH are teaching hospitals for medical students and both have clinical academic units, which partner with UEMS. There are also strong links with Exeter, Plymouth and Bristol universities for undergraduate training for the Nursing and Allied Health Professionals.

UEMS and the Royal Devon are one of twenty Biomedical Research Centres in England, created with the ambition over the next five years to drive innovation in the diagnosis and treatment of illness across a variety of high-priority disease areas including cancer, mental health and dementia.

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Main Challenges

These can be summarised as growing numbers of people, an increasingly aged population with rising disease prevalence, varying degrees of deprivation, changing nature of child and young people's health and long waiting times.

Population Growth

North and East Devon have rapidly expanding populations. Alongside significant population growth, people are choosing to relocate out of major cities where they are able to work remotely and / or retire in Devon. Non-demographic growth is anticipated to have a significant impact with an ageing population living longer with more co-morbidities. Between 2011 and 2021 the South West had the second highest population growth in England and Wales (Figure 1), making it home to an additional 412,000 people.

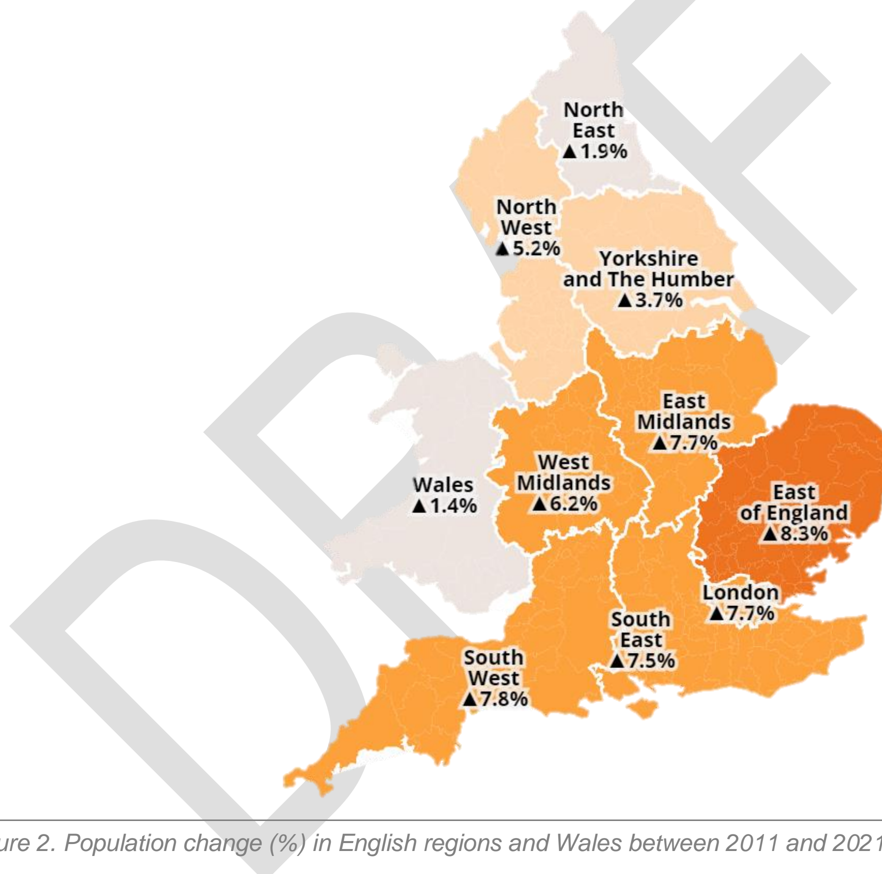

Figure 2. Population change (%) in English regions and Wales between 2011 and 2021 (Source: ONS Census 2021).

For England as a whole in 2021, the largest increase was in the 30-34-year age group (Figure 2) but for the South West it was in those aged 55-59 years (Figure 3), with an increase of 24% in people aged 65 years and over. In mid-2020 the median age in the South West was 44.1 years compared to 40.4 across the UK.

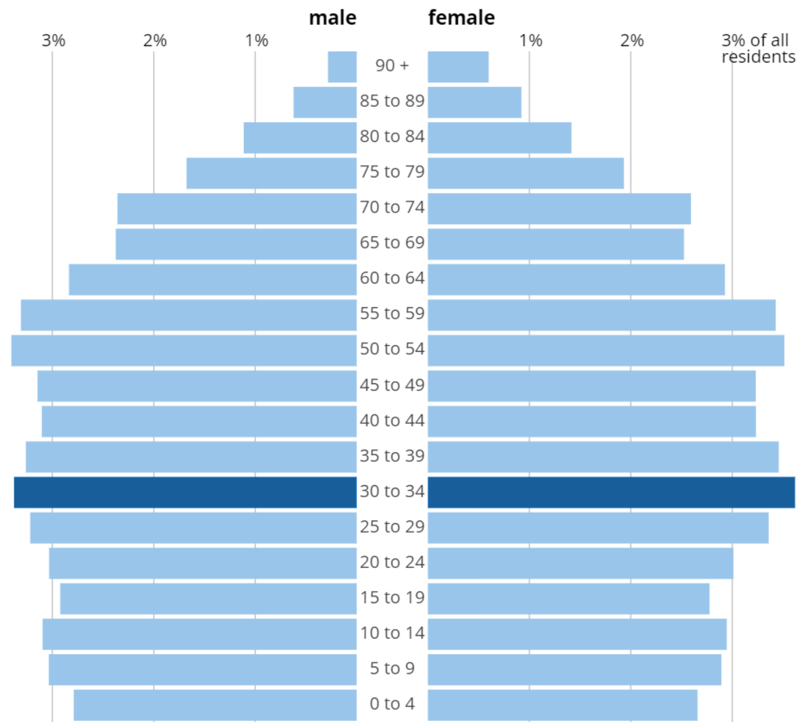

Figure 3. The age and sex distribution of the population of England in 2021 (Source: ONS Census 2021).

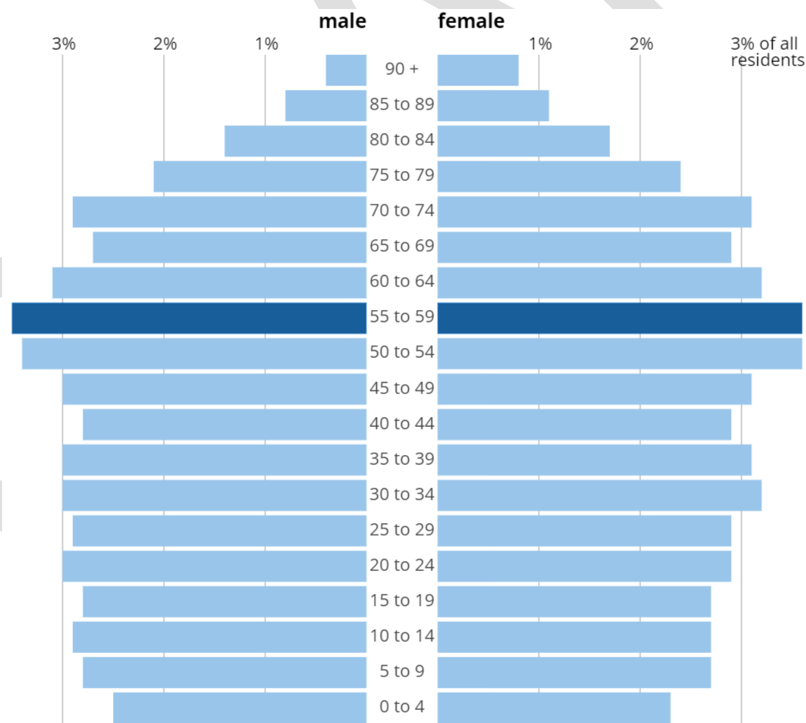

Figure 4. The age and sex distribution of the population of the South West in 2021 (Source: ONS Census 2021).

Deprivation

The Indices of Deprivation were last released in 2019. These deprivation statistics include metrics for income, employment, education, health, crime, barriers to housing and services and living environment. Figure 4 highlights deprivation across Devon (most deprived is dark blue) and is broken down by Lower-level Super Output Areas (LSOAs), which are made up of roughly the same population numbers which is a standard way of dividing England and Wales.

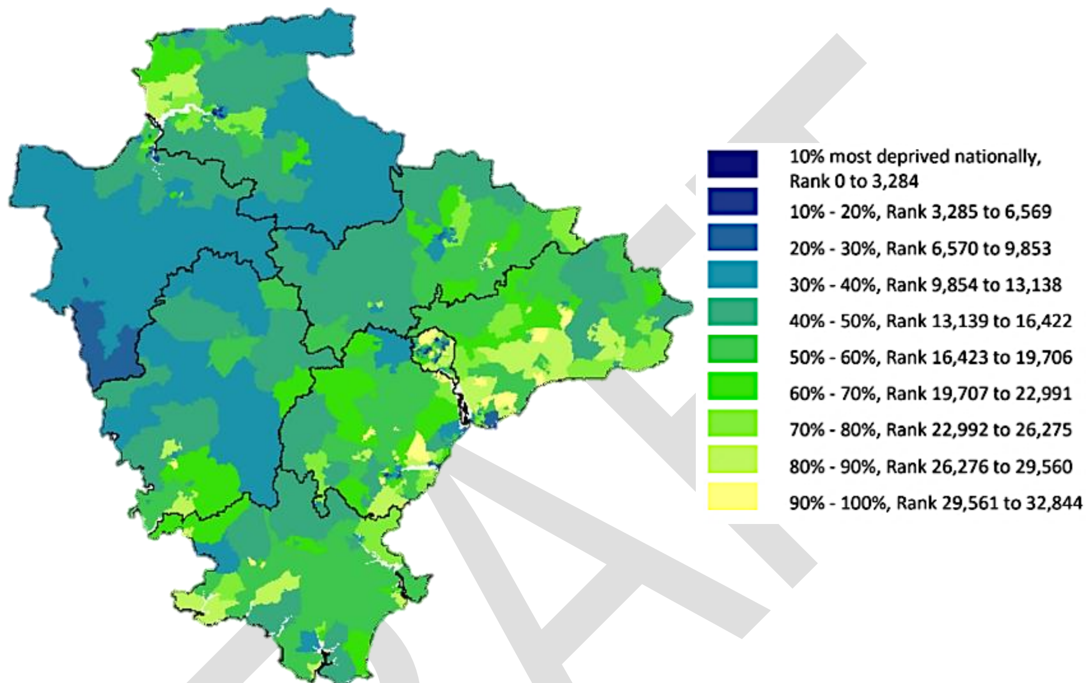

Figure 5. Deprivation of Devon by national decile (Source: ONS 2019, cited in Deprivation facts & figures, Devon County Council 2019)

There is a 10-year life expectancy difference across Devon. Infant mortality and alcohol-related admissions are relatively high in the most deprived areas.

The most deprived areas in Devon are in the wards of Ilfracombe Central, Barnstaple Central Town and Forches & Whiddon Valley in North Devon. These three areas are in the most deprived 10% of all areas in England. Around 4800 people live in these most deprived areas.

There are 18 areas that fall in the broader measure of the most deprived fifth (or quintile) of all areas in England. Around 31,100 people live in these areas. There is a noticeable north-south division with much of East Devon, Exeter, South Hams and Teignbridge being less deprived than North Devon, Torridge and West Devon.

Devon's sparse rural and coastal communities contribute to the challenges of deprivation and inequality. This is the focus of the Chief Medical Officer's annual report (2020/21) (CMO annual report, 2021).

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Child health

The nature of children and young people's (CYP) illness has changed over the last decade. Presentations of CYP with eating disorders, self-harm and complex mental health needs have increased significantly. Coupled with this has been a change in the epidemiology of infectious disease (including Flu A, RSV and Group A Streptococcus) and an increase in chronic diseases such as diabetes, and some novel post COVID-19 syndromes.

CYP are seen in various services across the Trust, including medical and surgical specialties. They continue to represent 25% of the ED caseload. A team of dedicated acute and community paediatricians and nurses manage children who require specialist care, with support from paediatric tertiary centres in Bristol. Our neonatal units continue to manage 6000 births each year.

Smoking in pregnancy is more prevalent in our locality than nationally. This habit can be linked with miscarriage, prematurity, complications during labour, and sudden infant death syndrome.

Rates of probable mental disorders have increased since 2017 from 11.6% to 17.4% for 6 to 16-year olds, and 10.1% to 17.4% for 17 to 19-year olds.[1]

Other challenges include increasing numbers of children in relatively low-income families, significant childhood obesity rates, and higher than average rates of dental decay, leading to dental related hospital treatment.

This Clinical Strategy aims to improve care for CYP across the spectrum of emergency, community, elective and tertiary services.

Disease Prevalence

A review by the Office for Health Improvement and Disparities published December 2021 showed that Devon has a high prevalence of a range of chronic conditions which place particular demands on health services. Table 2 shows some of these:

	Devon CCG	England
Coronary Heart Disease (CHD) prevalence	3.9%	3.0%
Heart failure prevalence	1.1%	0.9%
Observed prevalence of chronic kidney disease (CKD)	4.9%	4.0%
Proportion of patients receiving home dialysis (Home HD and PD combined)	19.5%	17.5%

[1] Mental Health of Children and Young People in England 2021 - wave 2 follow up to the 2017survey – NHS Digital, 29/04/21

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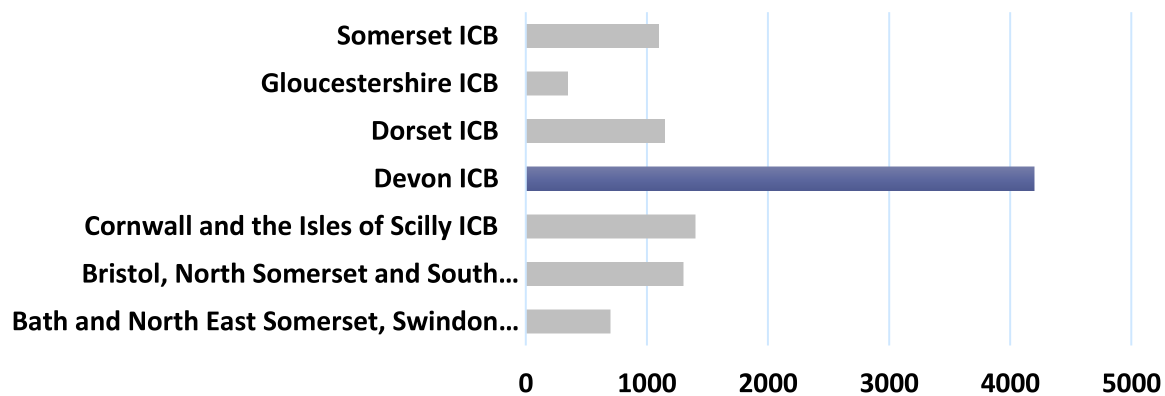
Stroke: QOF prevalence	2.5%	1.8%
Atrial fibrillation: QOF prevalence	2.8%	2.0%

Table 2. Prevalence of chronic conditions in Devon (Office for Health Improvement and Disparities, 2021)

Elective Care Waiting Times

A further and important consideration for the Clinical Strategy is the long waiting times at Royal Devon, relative to other parts of the country. Devon Integrated Care Board (ICB) had more than triple the number of patients waiting over 52 weeks for treatment, compared with the average for the South West as a whole, as shown in the graph below.



Graph showing number of patients waiting more than 52 weeks for procedure in South West ICBs

In addition to this, within the Devon ICB system, Royal Devon has the greatest total number of patients waiting over 52 weeks for treatment. As a result of the efforts of our staff, work already underway to reduce waiting times is taking effect and the numbers are beginning to fall. The approaches outlined in this strategy will further this effort, hopefully expediting the decline in waiting times, whilst still ensuring the high-quality and compassionate care that our patients rightly expect.

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Appendix 2 - Examples of initiatives which have helped to integrate and develop services at the Royal Devon

Examples of Initiatives that have Improved Acute and Urgent Care:

- **An urgent community response team** has been developed, which operates across North and East Devon, providing a 90% response rate to 2-hour admission avoidance referrals for the eastern service.
- **A Same Day Emergency Care (SDEC) unit** has been introduced, during the hours of 1000 – 2200 at the RD&E, and this model is now being expanded to NDDH. Patients referred from primary care are seen and treated by SDEC clinicians, and discharged back to the community on the same day. The service is provided in a large part by Advanced Clinical Practitioners (ACPs) working with medical supervision.
- **An ambulatory assessment area** for general surgery has been introduced at NDDH. There is also a hot gallbladder pathway, which accounts for almost a third of all acute general surgical admissions at NDDH, which is a national exemplar.
- **Review and redevelopment of CAMHS crisis pathways** in the East, to improve flow and support better mental health care at home.
- **Paediatric Assessment Unit (PAU)** offers alternative review of children and young people who would otherwise present to the Emergency Department (ED). 80% of children and young people are discharged from PAU without admission.
- **"Hot clinics"** in some specialties, such as neurology and vascular surgery (at the RD&E), and GI surgery (at NDDH), reducing acute admissions. Rheumatology has not only established a hot clinic, but also an urgent outpatient pathway for suspected giant cell arteritis, which has resolved a longstanding problem with referrals for urgent temporal artery biopsies.
- **Virtual wards.** Virtual wards have been introduced, both in the North and in the East, aimed at delivering care at home, including remote monitoring, daily contact, and, for example, intravenous antibiotic treatment, which improve patient experience and enable an easy route for them to return for review.
- **Nurse and Allied Health Professional led services,** including heart failure, acute oncology, dementia and spasticity service at NDDH. The North Devon paediatric community nurses are working with the ED and the paediatric team to support admission avoidance and earlier hospital discharges.
- **Front door frailty models** are supporting admission avoidance, with expert decision makers present at the front door to direct patients promptly and appropriately. These involve bringing several disciplines together to make plans and provide care for frail patients.
- **Specialty support for acute medicine.** At the RD&E and NDDH there is daily provision of specialty input, for example Cardiology, Gastroenterology, and Respiratory, into the Acute Medical Unit and Medical Assessment Unit wards, to streamline care.
- **Accelerated discharge.** For eastern acute medical patients who are fit for home, 5/7 days a week access to therapists and liaison with community teams for care at home has reduced hospital stays. Work is being done in the northern acute to realise the full benefit this provides.
- **Recruitment of medical staff** to the ED and acute medicine service at the RD&E has a good track record, as a result of a flexible and supportive approach to developing sustainable job plans, and allowing individuals to develop their specialist interests.

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Examples of Initiatives that have Improved Community and Primary Care-led Services

- **GP support for care homes,** through regular ward rounds and care planning.
- **The use of First Contact Practitioners** to take pressure off primary care. For example, musculoskeletal first contact practitioners provide access to direct primary care physiotherapy assessment and referral.
- **The Community Podiatry service** provides patient education and early referral of diabetic foot problems to the hospital foot care team.
- **Community-based optometrists** based in Axminster, Crediton, Tiverton and Seaton support recovery of patients after elective eye procedures, who would normally have been seen by acute ophthalmology team.
- **Highly regarded community services with national recognition.** For example, the sexual assault referral centre and the sexual health service, with its links to the GP training scheme and the medical school. Another example is in community paediatrics, where the CQC highlighted evidence of outstanding collaborative working with community paediatric nurses for children and young people.
- **Our care home teams (Northern and Eastern)** have enhanced links with care homes supporting with additional training and education to reduce unnecessary hospital admissions for care home residents.
- **Integrated and flexible working across Community Core Services**. For example, the Urgent Community Response work collaboratively with the Community Rehabilitation and Community Nursing services, as well as Primary Care and Social Care colleagues enabling a creative and coordinated response to meet people's needs and to keep people well at home.
- **One-stop urology cancer service** at Ottery St Mary Community Hospital delivering outpatient appointments, cystoscopy, and biopsies.
- **Innovative routes into professions,** for example student apprenticeship opportunities across a range of AHP groups and rotational Band 5 placements in Occupational Therapy and Physiotherapy.
- **Development of a community Midwifery HUB** in central Barnstaple, delivering enhanced midwifery care to improve health outcomes and reduce health inequalities.

Examples of Initiatives that have Improved Elective Care

- **Using capacity remote from the RD&E and NDDH** – For example the Nightingale Hospital, for Ophthalmology, Orthopaedics, and Rheumatology; including the introduction of the Devon Diagnostic Centre as an external extension of the Medical Imaging Department at the RD&E, which provides diagnostic services to patients across the whole of Devon, and has seen over 50,000 patients imaged as additional activity in the 2022/23 year.
- **The introduction of virtual care in many services,** driven in part by COVID-19, has increased efficiency and offered selected patient care in or close to their homes. This includes 'virtual' consultations in most specialties, preoperative assessments, postoperative follow-up, and remote monitoring. The renal transplant service is an example, with its virtual appointments to discuss results with patients, following blood tests taken at its "roving phlebotomy clinics".
- **The introduction of 'one-stop' clinics** – For example, the chronic post inguinal hernia pain (CPIP) clinic at NDDH with imaging and interventional procedures on the day and the early arthritis clinic in rheumatology at the RD&E.
- **The introduction of patient-initiated follow-ups (PIFU)** in some specialties has improved patient experience and made workloads more sustainable whilst contributing to personalised care. Examples in surgery include breast surgery, orthopaedics, and in medicine PIFU for patients with epilepsy and bronchiectasis.

- **Certain services have achieved widely recognised levels of excellence** in the ways in which they are delivering care - For example the North Devon Comprehensive Hernia Service (which receives a high volume of regional and national referrals and has a number of one stop multidisciplinary clinics) and day case orthopaedic hip and knee arthroplasty in the North with well-defined pathways facilitating early discharge. In the East the Renal Service has been rated as "outstanding" by CQC, based on its collaborative working between Multidisciplinary Teams (MDT) members and tailoring care to meet the individual needs of patients.
- **Collaborative pathways between hospital and community services** – For example between Ophthalmology, and optometrists in the community, and in the area of audiology.
- **Collaborative pathways with mental health input** into physical specialities to allow earlier screening and joint management of mental health comorbidities. There is good evidence that this approach improves recovery across both physical and mental health domains. Examples of current work include gastroenterology (winner of a Patient Safety National Award in 2021) diabetes, ICU oncology, neurology and stroke.
- **Extended Therapy Hours** – to provide early rehabilitation and optimise Day 0 discharges.

Examples of Tertiary Care Provided by the Trust

- **Clinical Genetics,** based at the RD&E, provides care for patients from Devon, Cornwall and the Isles of Scilly. The service is one of three providers in England for endocrine tests, and it is the national centre for monogenic diabetes.
- **Exeter Genomics Laboratory** work in partnership with the Bristol Genetics Laboratory to deliver genomic testing for patients with rare disease and cancer throughout the South West of England
- The **Cystic Fibrosis team** at the RD&E provide one of the UK's specialist cystic fibrosis centres and it forms part of the Peninsula network.
- The **Renal Service** at the RD&E provides care for patients from the Torbay area, Taunton and a large area of Somerset, as well as our local population.
- **North Devon Comprehensive Hernia Service** runs an academic unit based at NDDH, receiving referrals for complex hernias, abdominal wall reconstruction and complex post herniorrhaphy pain from across the region and elsewhere in England.
- **Plastic Surgery** provides specialist care including free flap breast reconstruction for patients from Torbay and parts of Dorset and Cornwall, as well as our local population.
- **Orthopaedics and the RD&E**, with the use of the Exeter hip, worldwide.
- **Sexual health services and sexual assault referral centres (SARCs**) for Devon and Cornwall
- **Paediatric specialist surgical services** utilise a networked model with Bristol Children's Hospital. There is also a special urgent transport system for critically ill children (WATch service).
- **Upper gastrointestinal cancer** surgery is centralised to Plymouth, but surgeons, gastroenterologists, radiologists, oncologists and pathologists at the RD&E and at NDDH have video linked MDTs with the specialists in Plymouth to plan the care of each individual patient.

Academia and research:

- The RD&E has a very strong track record of clinical research and development. Examples include its research into clinical genetics and diabetes, and development of the Exeter Hip prosthesis.
- There are many close links with the University of Exeter Medical School. The combined facility of the Postgraduate Education Centre, the Wellcome Wolfson Medical Research Centre, and the *NIHR Exeter*

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Clinical Research Facility, in Exeter was established to increase understanding of the mechanisms of disease and treatment by studying patients. The Trust's National Institute for Health and Care Research (NIHR) is one of only five NIHR funded Patient Recruitment Centres and the only NIHR infrastructure dedicated to the delivery of commercial contract research.

- The Research Innovation Learning and Development (RILD) building on the RD&E site is a centre for these activities for all Trust staff.
- There are joint clinical/university posts (both substantive and honorary) and a range of academic departments across the Trust.

Recently (October 2022) nearly £790 million was awarded to 20 NIHR biomedical research centres (BRCs) across England. These include including a new centre in Exeter, committed to drive innovation in the diagnosis and treatment of illness across a variety of high-priority disease areas including rehabilitation, mycology, diabetes, mental health and dementia over the next five years.

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Appendix 3 - List of Objectives and Approaches of the Clinical Strategy

No	Domain	Objective	Approach	Division	Trust	System	Links to Enabling Strategy		
							Estates	Digital	People & Culture
1.1.1	Local Acute & Emergency Care	Stabilise and develop acute medicine at North Devon	Invest in staffing to support acute medicine		Yes		Yes		Yes
1.1.2			Optimise the patient flow model			Yes	Yes	Yes	Yes
1.1.3			Increase support from our eastern services in acute medicine	Yes					Yes
1.1.4			Provide a cardiac pacing lab	Yes			Yes	Yes	Yes
1.2.1		Reduce acute admissions and length of stay (LOS)	Improve safe alternatives to admission	Yes	Yes		Yes	Yes	Yes
1.2.2			Improve Surgical Assessment Units (SAU)		Yes		Yes	Yes	Yes
1.2.3			Develop options for an (UTC)			Yes			Yes
1.3.1		Increased facilities and arrangements for critical care	Develop critical care outreach	Yes				Yes	Yes
1.3.2			Provide dedicated critical/high dependency care for AMU	Yes	Yes		Yes		Yes
1.3.3			Increase Intensive Treatment Unit (ITU) bed base	Yes			Yes	Yes	Yes
2.1.1	Community & Primary Care-led Service	Work with local partners to optimise pathways of care	Improve care home support			Yes		Yes	Yes
2.1.2			Improve use of shared digital information		Yes			Yes	
2.1.3			Improve End of Life Care		Yes			Yes	Yes
2.1.4			Work more closely with voluntary sector organisations		Yes		Yes		Yes
2.1.5			Update the clinical Directory of services (DOS)		Yes			Yes	
2.1.6			Shared dementia care pathway		Yes	Yes		Yes	
2.1.7			Continue to promote and develop local relationships between our community teams and GP practices			Yes			
2.2.1		Build community capacity to reduce acute bed occupancy	Expand the Urgent Care Response (UCR) function and domiciliary care capacity within the Community Division			Yes			Yes

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No	Domain	Objective	Approach	Division	Trust	System	Estates	Digital	People & Culture
						Links to Enabling Strategy			
2.2.2			Provide care home capacity			Yes	Yes	Yes	Yes
2.2.3			Develop frailty hubs	Yes					
2.2.4			Expand the range of elective care services which can be delivered closer to people's homes			Yes	Yes	Yes	Yes
3.1.1		Recover our waiting times through maximising elective activity	Expand the elective recovery programme	Yes	Yes				
3.1.2			Utilise additional external revenue funding, where available, to deliver additional activity	Yes	Yes				
3.1.3			Expand and improve outpatient physical infrastructure	Yes	Yes		Yes		
3.1.4			Improve diagnostic capacity	Yes	Yes		Yes		
3.1.5			Develop improved pre-assessment and prehabilitation for elective care	Yes	Yes			Yes	
3.2.1		Improve patient experience, particularly through adoption of new technology	Increase utilisation of the MyCare patient portal			Yes		Yes	
3.2.2			Increase use of patient initiated follow-up (PIFU)	Yes			Yes	Yes	
3.2.3	Elective Care		Increase virtual care	Yes	Yes		Yes	Yes	
3.2.4			Introduce a patient self-booking portal		Yes			Yes	
3.2.5			Create an online patient information centre		Yes			Yes	
3.2.6			Increase the provision of one-stop multidisciplinary clinics				Yes	Yes	
3.3.1		Increase separation of non-elective and elective capacity	Ensure ringfencing of elective bed stock		Yes				
3.3.2			Develop our existing infrastructure to support separation of "hot" and "cold" activity		Yes		Yes		
3.3.3			Develop options for an elective treatment centre			Yes	Yes	Yes	Yes
3.4.1		Work with other organisations to	Actively engage with, shape and implement the Peninsula Acute Sustainability Programme (PASP) outcomes			Yes		Yes	Yes

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No	Domain	Objective	Approach	Division	Trust	System	Links to Enabling Strategy		
							Estates	Digital	People & Culture
3.4.2		develop elective services	Increase our focus on learning from benchmarking, good practice and national reviews to guide development of our services	Yes	Yes			Yes	
3.5.1		Strengthen our cancer services	Review and improve cancer pathways		Yes			Yes	
3.5.2			Support primary care in early diagnosis of cancer			Yes			
3.5.3			Strengthen leadership, oversight and coordination of cancer services	Yes	Yes				
3.5.4			Provide additional support for cancer Multidisciplinary Teams (MDTs)	Yes				Yes	
3.5.5			Increase the use of informatics to improve services	Yes	Yes			Yes	
4.1.1	Tertiary Care & Areas of National Clinical and Academic Excellence	Promote and invest in our flagship services on both sites	Purposefully develop flagship services		Yes		Yes	Yes	
4.1.2			Promote the successes and benefits of our flagship services to others		Yes				
4.2.1		Network with other hospitals to optimise pathways for patients and staff	Actively engage with system partners			Yes			
4.2.2			Provide clear information for patients on pathways and where to get help	Yes					
4.3.1		Maximise the potential benefits of academia and research	Foster a research culture across the Trust		Yes				
4.3.2			Strengthen our links with academic institutions		Yes				Yes
4.3.3			Expand multicentre research trials		Yes				
4.3.4			Support hybrid clinical / research roles		Yes				Yes
4.3.5			Harness the capacity of EPIC and other digital systems to support clinical research		Yes			Yes	

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Appendix 4 – Glossary of Terms

Term	Definition
Acute care	Acute care is the provision of active, short-term treatment for a specific condition (hospital care).
Acute Medical Unit (AMU)	An Acute Medical Unit (AMU) is an area of an acute hospital site which provides rapid assessment, investigation, diagnosis, and treatment for adult patients (over the age of 16) who have been referred directly to the team by a GP or the Emergency Department because they have an urgent medical problem that needs specialist assessment.
Ambulatory Assessment Area	An Ambulatory Assessment Area is an area for assessing patients who may not need admission to hospital.
"Call before convey"	Call before convey refers to an initiative launched by South Western Ambulance Service (SWASFT) to avoid bringing people into hospital, through paramedics linking in with other healthcare professionals.
Chronic condition	A chronic condition is a persistent or long-lasting illness or health condition that is lived with, that cannot be cured but can usually be managed with medicines, treatments, care and ongoing support.
Comorbidity	Comorbidity occurs when a person has more than one disease or condition at the same time. Conditions described as comorbidities are often chronic or long-term conditions.
Elective care	Elective care refers to non-urgent care which is planned in advance rather than is urgently necessary. This refers to diagnostic testing, scans, outpatient care and surgery.
Electronic Patient Record	An Electronic Patient Record is an electronic record of healthcare information for an individual. The Royal Devon launched its electronic patient record system (Epic) in October 2020.
Epic	The electronic health records system used by the Royal Devon.
Genomics	Genomics is a branch of molecular biology concerning structure, function, evolution and mapping of genomes.
Green to Go	Patients are referred to as Green to Go at the point at which they are medically fit for discharge. Discharge of Green to Go patients may be delayed due to other factors such as waiting for domiciliary care or a care home placement.
Health Inequalities	Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society.
Health outcomes	Health outcomes are an interrelated set of attributes that describe the consequences of a disease or impact of an intervention by a healthcare provider.
Hot Clinics	Outpatient appointments available to patients at very short notice (1-2 days) to avoid hospital admission are called hot clinics.
Integrated Care Board (ICB)	An Integrated Care Board (or ICB) is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area. The

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	Devon ICB serves a population of around 1.2 million people across eight district councils in the county.
Integrated Care System (ICS)	An Integrated Care System (ICS) is an organisation that brings together different health and care services – such as a hospital, a clinical commissioning group, a council, an ambulance service, local GPs, local mental health services and other things – in a specific local area. The aim is to work together to make better use of public money and provide better care for people who live in the area.
Intensive Treatment Unit (ITU)/Intensive Care Unit (ICU)	Intensive Treatment Units (ITU)/Intensive Care Units (ICU) are specialist hospital wards that provide treatment and monitoring for people who are very ill. They are staffed with specially trained healthcare professionals and contain sophisticated monitoring equipment.
Length of Stay (LOS)	Length of stay (LOS) is the duration of a single episode of hospitalisation, usually measured in days.
MY CARE	MY CARE is an electronic portal through which patients can access their healthcare information and manage their health. For further information, visit NHS Royal Devon | MY CARE.
NDDH	North Devon District Hospital – Royal Devon University Healthcare NHS Foundation Trust's northern acute provider.
Paediatric Assessment Unit (PAU)	A Paediatric Assessment Unit (PAU) is an acute unit where children are assessed for emergency admission. From here patients may be discharged home, asked to attend a day unit, or transferred straight to a bed on a ward for immediate treatment.
Patient Initiated Follow-up (PIFU)	Patient Initiated Follow-up (PIFU) is when a patient initiates an appointment when they need one, based on their symptoms and circumstances. It is designed to empower patients to manage their own condition, and supports shared decision making, to deliver more personalised care.
Peninsula Acute Sustainability Programme (PASP)	The Peninsula Acute Sustainability Programme (PASP) is designed to lead the planning and delivery of transformational change for acute services across Devon and Cornwall. The aim is to deliver a high quality, joined-up and sustainable health care service for the peninsula.
Primary Care Network (PCN)	A Primary Care Network (PCN) is a group of GP practices in an area that work together, and with hospitals, social care, pharmacies and other services, to care for people with long-term conditions and prevent people becoming ill.
Primary care	Primary care is considered the first contact of healthcare for patients, including GPs, pharmacy, dental and optometry.
Provider (Healthcare)	A Healthcare provider is a legal entity that provides healthcare under NHS service agreements. Care from all providers is free at the point of use in England. Providers are split into Primary, Secondary and Tertiary Care. Primary refers to the first point of contact (GP, dentists and pharmacies), Secondary refers to hospital and community care which is either planned or urgent, and Tertiary refers to highly specialised treatment (transplants, neurosurgery).
RD&E	Royal Devon and Exeter Hospital - Royal Devon University Healthcare NHS Foundation Trust's eastern acute provider.
Same Day Emergency Care (SDEC)	Same Day Emergency Care (SDEC) is the provision of same day care for emergency patients who would otherwise be admitted to hospital. Under this care model, patients presenting at hospital with relevant conditions can be rapidly assessed, diagnosed and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided.

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Social care	Social care refers to all forms of personal care and practical assistance for children, young people and adults to help them support their independence, dignity and live comfortably.
Surgical Assessment Unit (SAU)	A Surgical Assessment Unit (SAU) is an acute unit where patients are assessed for emergency surgical admission. From here patients may be discharged home, asked to attend a day unit, or transferred straight to a bed on a ward for immediate treatment.
System	Royal Devon is part of a wider 'system' of partner organisations. In the context of this strategy document, 'system' refers to the wider network which includes Devon County Council, Devon Partnership Trust, Livewell, other acute hospitals, Primary Care providers, voluntary sector organisations and other partners.
Tertiary care	Tertiary care is highly specialist health care requiring particular expertise and equipment, that is available only in specialist hospitals in certain parts of the country.
Third sector	The Third sector refers to non-governmental and non-profit-making organisations including charities, voluntary and community groups etc.
Urgent care	Urgent care involves an illness or injury which needs urgent attention by medical professionals.
Urgent Community Response (UCR)	Urgent Community Response (UCR) refers to the provision of urgent care to people in their own home to help them avoid hospital admission and enable them to live independently for longer.
Virtual Ward	A Virtual Ward is a way of providing support outside hospital to people with long-term conditions who may need extra care to avoid being admitted to hospital. The 'ward' is run by the hospital, and treatment and care is provided virtually by nurses and other health professionals.

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Enabling Strategies executive summaries

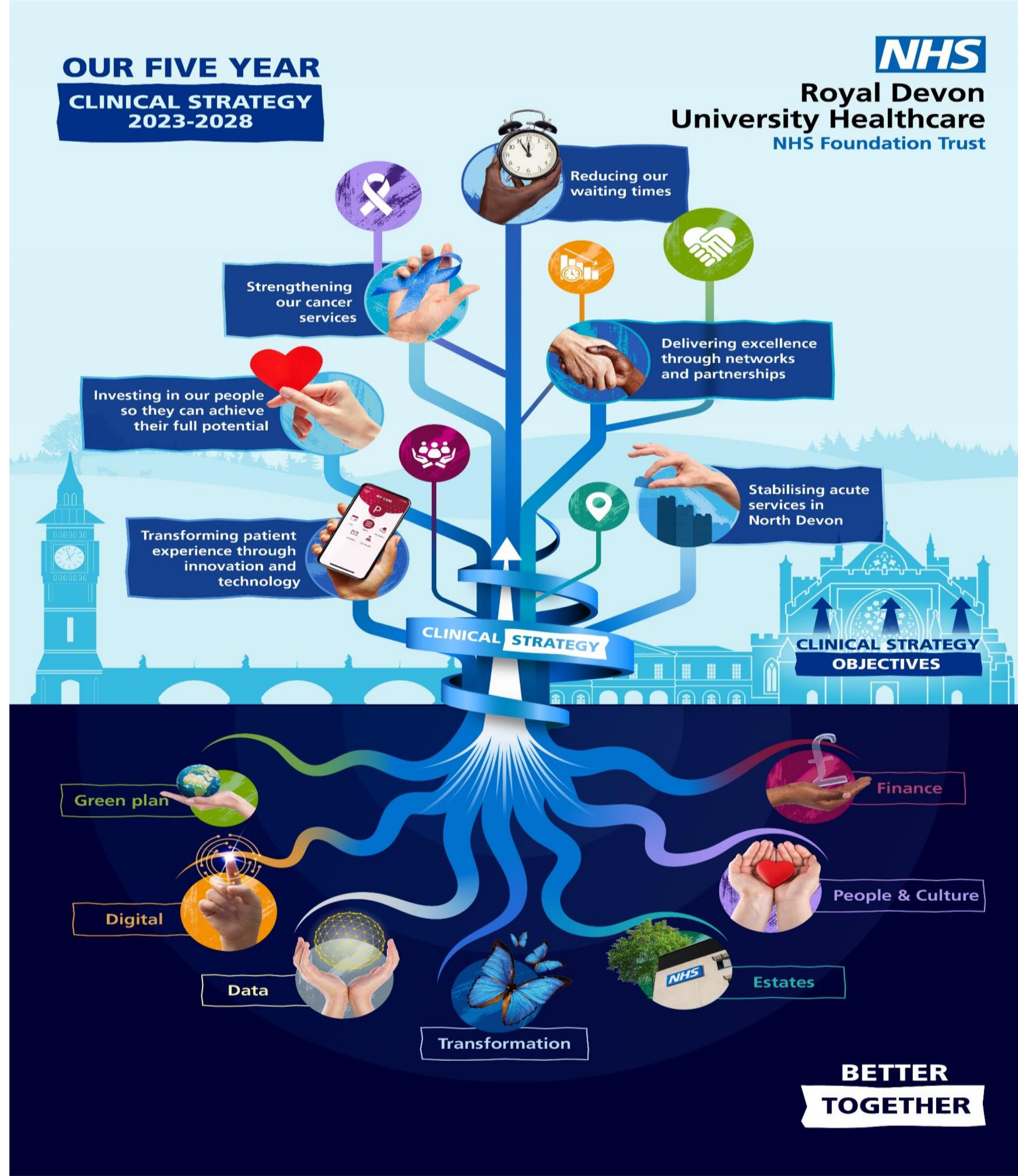
Clinical
Digital
Data
People and Culture
Estates
Finance

July 2023

Introduction

- Better Together + enabling strategies set out an ambitious and shared direction for us all
- Significant engagement with staff and stakeholders in their development
- Checks to ensure alignment with system plans/strategies
- Each strategy supports delivery of clinical strategy

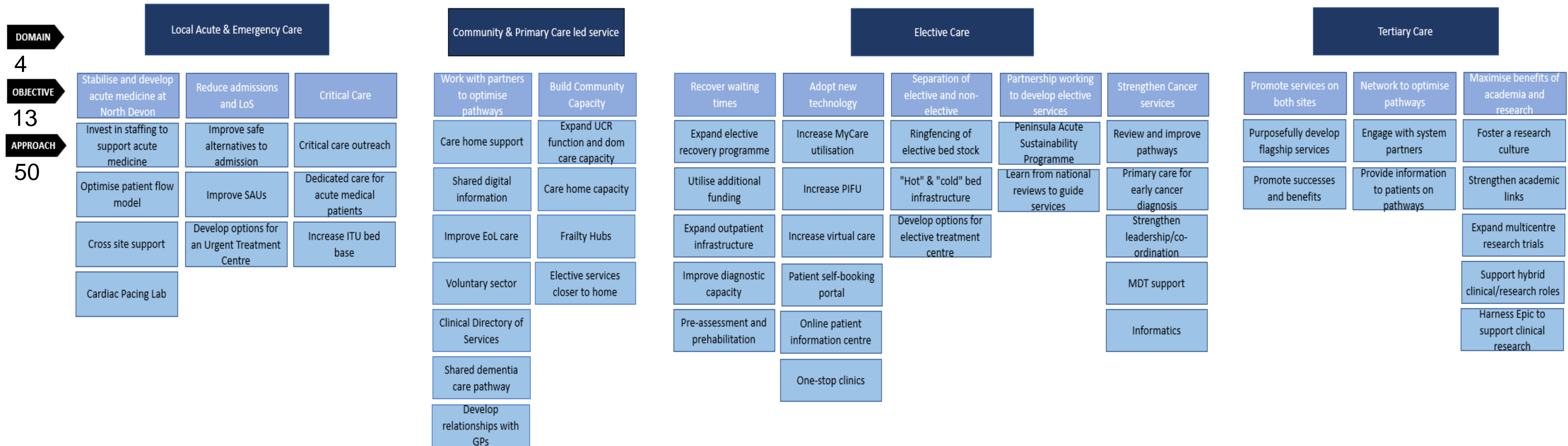
Royal Devon Clinical Strategy



The vision

Recovering our services whilst supporting clinical excellence and improved outcomes for our community, through working with system partners and the application of technology, research and innovation.

Overview

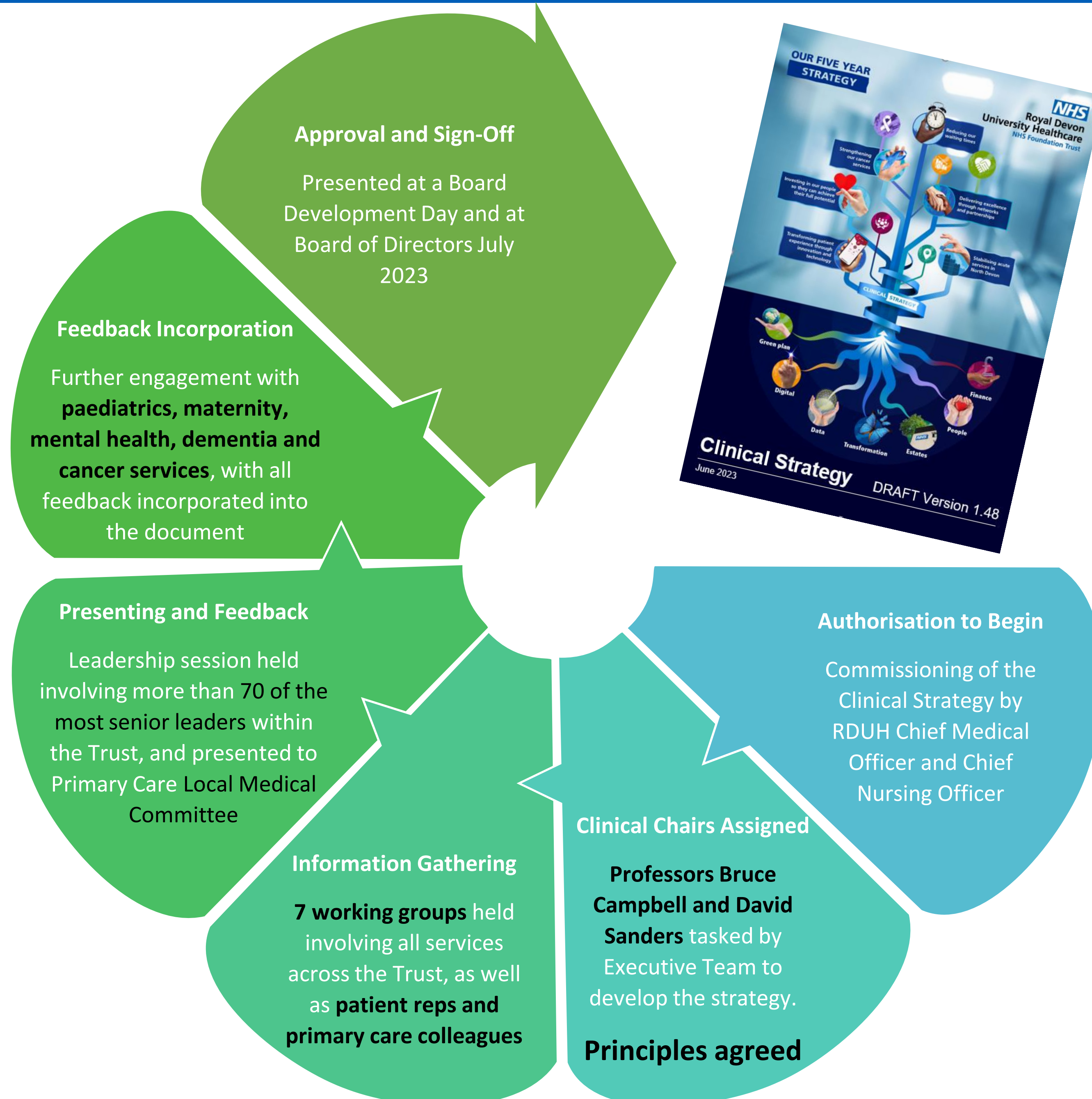


18 Estates transformation

27 Digital transformation

22 Workforce transformation

How did we get there?



Delivering the strategy

- Further alignment to influence annual plans
- Communication & launch
- Corporate Roadmap oversight and delivery

							Links to Enabling Strategy		
No	Domain	Objective	Approach	Division	Trust	System	Estates	Digital	Workforce
1.1.1	Local Acute & Emergency Care	Stabilise and develop acute medicine at North Devon	Invest in staffing to support acute medicine		Yes		Yes		Yes
1.1.2			Optimise the patient flow model			Yes	Yes	Yes	Yes
1.1.3			Increase support from our eastern services in acute medicine	Yes					Yes
1.1.4			Provide a cardiac pacing lab	Yes			Yes	Yes	Yes
1.2.1		Reduce acute admissions and length of stay (LOS)	Improve safe alternatives to admission	Yes	Yes		Yes	Yes	Yes
1.2.2			Improve Surgical Assessment Units (SAU)		Yes		Yes	Yes	Yes
1.2.3			Develop options for an (UTC)			Yes			Yes
1.3.1		Increased facilities and arrangements for critical care	Develop critical care outreach	Yes				Yes	Yes
1.3.2			Provide dedicated critical/high dependency care for AMU	Yes	Yes		Yes		Yes
1.3.3			Increase Intensive Treatment Unit (ITU) bed base	Yes			Yes	Yes	Yes
2.1.1	Community & Primary Care-led Service	Work with local partners to optimise pathways of care	Improve care home support			Yes		Yes	Yes
2.1.2			Improve use of shared digital information		Yes			Yes	
2.1.3			Improve End of Life Care		Yes			Yes	Yes
2.1.4			Work more closely with voluntary sector organisations		Yes		Yes		Yes
2.1.5			Update the clinical Directory of services (DOS)		Yes			Yes	
2.1.6			Shared dementia care pathway		Yes	Yes		Yes	
2.1.7			Continue to promote and develop local relationships between our community teams and GP practices			Yes			
2.2.1		Build community capacity to reduce acute bed occupancy	Expand the Urgent Care Response (UCR) function and domiciliary care capacity within the Community Division			Yes			Yes
2.2.2			Provide care home capacity			Yes	Yes	Yes	Yes

Our strategic choices

- Ambition v affordability
- Delivering Best Value
- Peninsula acute sustainability
- Workforce

Digital Strategy

Our digital strategy journey

Strategy Development

- Developed over the past 12 months
- Led by the Trusts CIO's
- External supplier contracted – to provide experience
- Kings fund – Provided assurance in the early stages re the approach
- Engagement via 1-2-1's – to gather collateral to feed into the strategy
- Workshops – engagement with Senior team

Governance

- Enabling Strategies steering group – Led by Director of Strategies
- Digital Committee – provided guidance, decision making and assurance
- Trust Strategic Delivery Group – Pre Board approval
- Trust Board – Approval and final sign off

Alignment

- National & regional strategies (i.e. OneDevon, WGLL, ICS Digital Strategy etc)
- The Trusts Corporate Strategy (Aligned initiatives with the CARE objectives)
- The Clinical Strategy
- Aligned with the Enabling Strategies

Vision

We will transform and improve patient care by empowering and connecting people and digitising the care and service we provide

The aim to ***transform and improve patient care*** underlines that the Digital Strategy supports clinical and operational practice that delivers care in innovative ways to ultimately lead to better health outcomes for patients

Empowering and connecting people recognises that digital capabilities support staff to be more effective and efficient in delivery through the provision of the digital tools and services they need to perform their role. 'Whom they serve' are the people in the community who are sometimes patients in our care. The role of digital supports people to take greater responsibility for their own health through access to their own health and care information.

Concluding the vision with the statement ***digitising the care and service we provide*** recognises the importance of every aspect of our digital offer takes in to account the lived experience of the people we serve.

Where we want to be by 2028

Fully integrated digital team and systems, ensuring our team has the skills and creativity to support digital adoption and transformation

Optimise the use of EPR, our digital offerings and our resources

Enhanced patient and staff experience via a digitally enabled clinical model

Create time, improve pathways and automate where practical

Connecting patients to clinicians and supporting services

Unified and standardised services and infrastructure aligned to green plan

Empower patients to manage their health and care offerings

Improve data driven decision making and seeking out AI opportunity

Digital Strategy on a Page

Vision

We will transform and improve patient care by empowering and connecting people to their care and digitising the care and service we provide

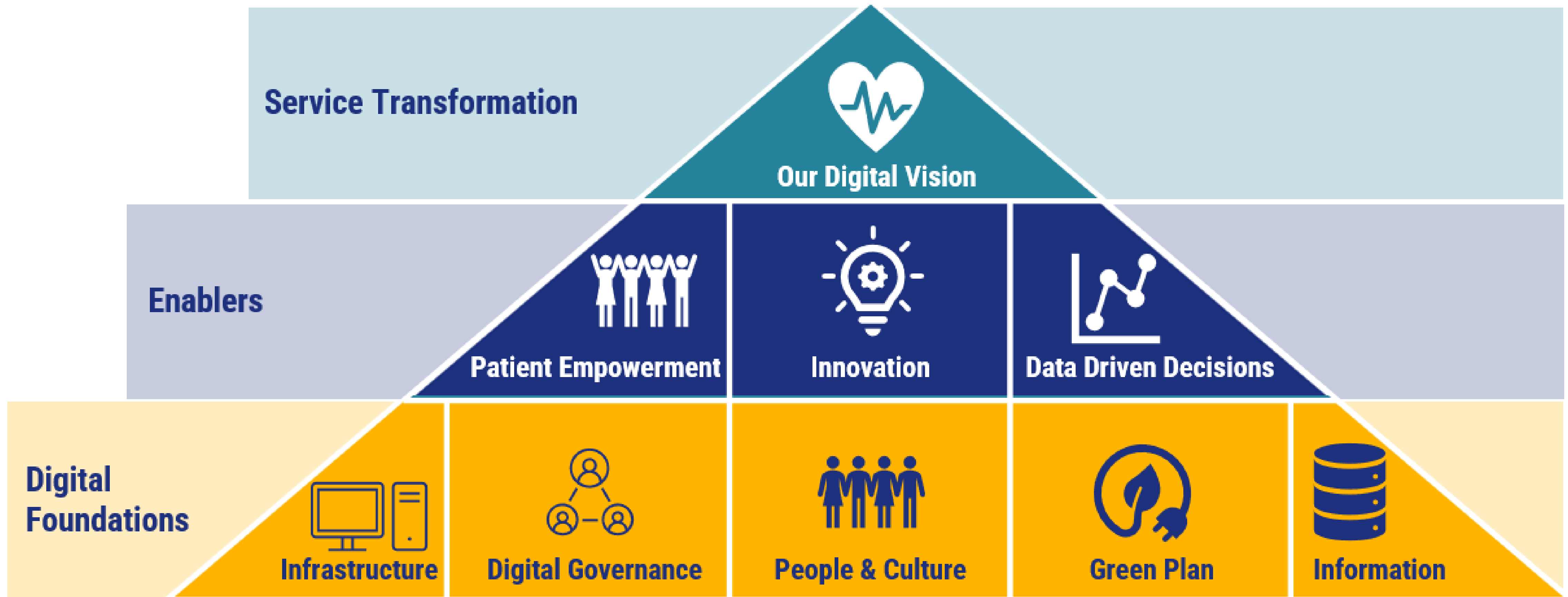
Objectives

1. Empowerment
2. Innovation
3. Data driven decisions

Strategic initiatives

- EPR optimisation and development
- Precision diagnostics, genomics & therapeutics
- Virtual and remote care
- Clinical image exchange
- Cloud-based capability
- Machine learning and AI
- Infrastructure management

Digital Themes



74 Strategic Initiatives

Service Transformation

Our Digital Vision

- EPR Enhancement and Development
- Virtual Consultation
- Shared Patient Record
- Optimised Pathway
- Clinical Decision Support Aids
- System Integration
- Virtual & Remote Care
- Clinical Image Exchange
- Medicine Management
- Demand and Flow Management
- Standardise Best Practice
- Diagnostics and Elective Care

Enablers

Patient Empowerment

- Personal Health Records
- Digital Inclusion - Patient Education
- Research Participation
- Digital Directory of Services
- Patient Portal
- Good Health Promotion

Innovation

- Innovation Pathway
- Links with Research Organisations
- Machine Learning and Artificial Intelligence
- Genomics, Precision Diagnostics, and Therapeutics
- The Learning Health System (LHS)
- Internet of Medical Things

Data Driven Decisions

- Analytics and Reporting
- Data-Driven Decision Making
- Early Intervention/Prevention
- Risk Stratification
- Population Health Management
- Clinical Digital Leadership

Digital Foundations

Infrastructure

- End User Computing
- Communications for All
- Voice Recognition
- Resource Management
- Data Centres
- Technology Refresh
- Cloud Based Capability
- Leading-edge Interoperability Capability
- Single Sign-on
- Internet of Digital Things

Digital Governance

- Engagement and Communications
- Benefits Management
- Digital Support for All Systems
- Agile Delivery Model
- Legacy Systems Removal
- Digital Finance Management
- Prioritisation
- Information Governance
- Service Management
- Enterprise Architecture

People & Culture

- Digital Change Culture
- Integration
- Professional Capability Building & Recruitment
- Shared Digital Future for Staff
- Role Based Training
- Embedding of Digital Staff within Operational / Clinical Areas
- Teaching Links
- Workforce Enablement
- Workforce Management & Rostering
- Demand & Capacity Workforce Model fc Digital
- Ways of Working

Green Plan

- Environmentally Friendly Procurement
- Digital Carbon Footprint
- Responsible Partner Relationships
- Infrastructure Management
- Net Zero
- Energy Reduction

Information

- Data Strategy Enablement
- Security
- Privacy
- Data Quality
- Data Management
- Paper Free
- HIMSS L6/7 (Journey)

Our 7 'Key' Strategic Initiatives

1. **EPR Optimisation and Development:** A real-time and intelligent system that allows for greater efficiency and effectiveness of clinical and operational teams achieving an elevated level of maturity at a national level.

2. **Infrastructure Management:** Utilising estates monitoring equipment and connectivity to allow the effective utilisation of our buildings, locations and related equipment. Matching our ways of working with estate improvements such as hotdesking and role-based access will generate a managed environment that will allow evolution and growth.

3. **Precision diagnostics, genomics and therapeutics:** Improving our digital capabilities within this field of expertise will embed digitally enabled precision diagnostics, genomics and therapeutics services at the point of care. The Royal Devon will improve our presence as a national leader in this field whilst providing more accurate information about patients and their conditions.

4. **Virtual and Remote Care:** Using digital technology, we will increase our remote home care, using virtual wards, in-home monitoring, and patient self-care to develop an environment where patients can remain in their residences of choice with minimal care interactions.

5. **Clinical Image Exchange:** To produce a shared clinical image exchange with availability to all relevant healthcare partners.

6. **Cloud-Based Capability:** Working alongside OneDevon and national guidelines, we will perform assessments of the requirement to choose the right solution for the problem.

7. **Machine Learning and Artificial Intelligence:** Our services will effectively use current and future developments in AI and machine learning to improve efficiency and accuracy and importantly free up clinical time. Growth in this initiative will be key to delivering several key benefits and savings in future years.

Main Digital Challenges

System

- Alignment to the ICS digital strategy may divert resources from RDUH priorities and/or mean restructuring corporate teams
- Funds are often announced with tight turnaround timelines for bids
- Potential system adoption of EPIC will impact RDUH's EPR optimisation

Culture: full achievement of this strategy and our digital ambitions will radically change the way we work and who does that work

- Increased automation may not be embraced by everyone
- Patients may reject the digitisation of their care

Digital exclusion

- Non-digital routes to care have to be provided as an inclusive option to ensure digital inclusion
- This strategy is dependent on digital connectivity throughout Devon

Prioritisation and affordability: There will always be more ambition than we have capacity or funds.

- Astute and dynamic prioritisation needs to be embedded in our planning and business-led
- The infrastructure funding will have to increase to support the digitisation (i.e. cyber security, IG, data, patient portals etc)

Digital skills

- We already have a large number of vacancies that are hard to fill
- Recruiting good quality resources is difficult especially as pay scales do not support the quality required
- Funding is often only available short term (recruiting on short FTC is not sustainable)
- BAU service provision could suffer if funding is short

Data Strategy

Vision

Putting data-led insight at the heart of decision-making to improve quality of care and staff experience

Objectives

- To ensure our workforce has access to **timely, complete and reliable data** to make evidence-based decisions
- To create a culture of **data-led insight** to identify needs, allocate resources and prioritise patients appropriately
- To **optimise the data available from the Electronic Patient Record (EPR)** and create a linked dataset for a wider set of Trust data to inform joined-up decision making
- To create a **data infrastructure fit for the future** including interface with the wider health and care system
- To develop and support a **highly skilled analytical workforce** that makes best use of scarce skillsets and achieve a cost-effective service model

Strategic priorities

- **Data infrastructure:** delivery of a fit for the future data infrastructure that enables the production of timely and consistent data across different datasets
- **Access and governance:** improving our ways of working so users know how to access the data they need, how to make new requests and how they are prioritised
- **Data visualisation:** delivery of core suite of dashboards for widespread use across the Trust as well as models allowing more in depth analysis/research where required
- **Workforce development:** ensuring access to training, retention and continuous development of the highly skilled workforce required to meet the increasing analytical needs of a modern organisation

1. Data infrastructure

Delivery of a fit for the future data infrastructure that enables the production of timely and consistent data across different datasets

What does the end state look like?

Data architecture

- Multi-tenanted data platform to enable access and use of a broad array of data sets across organisations
- Integration of disparate data sets (EPR, other clinical, workforce, costing etc.)
- Production of timely and consistent data (single version of truth)
- Environment to produce more sophisticated output (data science)

Data quality

- High quality, consistent rich data set input by well-trained users
- End to end data quality tools to identify issues at source and clear processes to correct / amend
- Use of automation to identify and improve data quality

How do we get there?

Year	Milestones
1	• Approval of Data architecture business case through Trust and ICB governance • Securing funding for preferred option • Agreeing system-wide technical solutions to create uniform data architecture • Establish Programme governance and resource and commence design • Agreed BI / Cogito Caboodle development plan • Assessment of data quality tools and processes and development plan for improvement
2	• Delivery of data quality improvement plan including development / production of dashboards • Data architecture build
3-5	• Rollout of new architecture (EPR / clinical > Finance / HR > non-trust data set (primary care, social care) • Continuous improvement / development to meet needs and alignment with national plans

2. Access and governance

Improving our ways of working so users know how to access the data they need, how to make new requests and how they are prioritised

What does the end state look like?

New requests and prioritisation

- Standardised templates for new requests and clear processes for prioritisation
- Unified approach between BI, EPR, Digital, users, on prioritisation and objectives
- Clear, regular communication with users on status of requests and prioritisation

Access

- Central repository for all data products and tools that are quality assured, widely accessed and meet users needs

Governance

- Business partners embedded across the Trust delivering insight and enabling evidence-based decisions

How do we get there?

Year	Milestones
1	• Standardised Trust templates for new data / analytical requests • Prioritisation matrix in place and used in prioritising requests • Update to Intranet to provide up to date information on team structure, communication routes, prioritisation process etc. • Development of product catalogue by area (e.g. RTT) and source (e.g. Epic, external) through establishment of internal working groups across BI and EPR • Clarity of ownership and responsibilities between BI and EPR teams • Closer working with BI and Operational teams
2+	• Continuous development of product catalogue covering all major categories • Continuing to develop relationships between end users and BI team

3. Data visualisation

Delivery of core suite of dashboards for widespread use across the Trust as well as models allowing more in depth analysis/research where required

What does the end state look like?

Dashboard suite

- Easily accessible, intuitive, suite of dashboards across recognised core areas, which are constantly evolving and developing to meet users needs

Data science and research

- Bespoke data tools for detailed requests and research
- Active use of advanced data tools and techniques (predictive analytical models, machine learning) to support operational and clinical delivery

How do we get there?

Year	Milestones
1	• Initial suite of dashboards to be made available to end users through a self-service interface • Agreement and procurement of preferred data visualisation software • Collaboration with ICS to enable access to shared dashboards • Development of product catalogue by area (e.g. RTT) and source (e.g. Epic, external) through establishment of internal working groups across BI and EPR • Training for analysts in preferred data visualisation software and end users
2	• Further development of dashboards • Bespoke training for analysts in advanced modelling techniques (role specific) • Re-development of dashboards required for any changes relating to data architecture
3-5	• Appraisal of current data visualisation tools and continuous development of offer

4. Workforce development

Ensuring access to training, retention and continuous development of the highly skilled workforce required to meet the increasing analytical needs of a modern organisation

What does the end state look like?

Shared service to make best use of resources

- Maximising benefits of scarce, highly skilled resource through formal collaboration with ICS

Business intelligence team and skillset

- Highly skilled and respected team with deep technical and operational / clinical knowledge who are recognised experts in their field
- To drive recruitment and retention through more formal collaboration with higher and further education partners

Wider user training and knowledge

- Improved formal and informal training offer to end users to enable higher quality data input and output

How do we get there?

Year	Milestones
1	• ICS shared service review including consideration of benefits of sharing resource across organisations • Engagement with Trust-wide operational training programme • Development of academic programme offers with University of Exeter • Exploration of other ways of engaging with potential future recruits (external and internal) • Further development of automation within BI team to release more time to value-added activity
2+	• Rollout of formal academic offer with University of Exeter • Bespoke training for analysts in advanced modelling techniques (role specific) • Continuous development of automation within BI team to release more time to value-added activity

Risks, challenges and mitigations

Risk / challenge	Proposed mitigation
Funding: insufficient funding to deliver data infrastructure required	• Make best use of existing skilled resources across the system – enabled by shared service approach • Explore available sources of external funding for data infrastructure related to clinical research / commercial opportunities • Explore partnerships with other Trusts in system to share cost • Explore distribution of cost across financial years to make more affordable
Workforce: Inability to recruit and retain skilled BI workforce required to meet current and future demands	• Make best use of existing skilled resources across the system – enabled by shared service approach • Greater collaboration with higher and further education partners on academic programmes • Bespoke training for analysts to develop technical and operational / clinical knowledge
System collaboration: reliance on system cooperation / collaboration for solutions	• System-wide engagement led by ICS BI lead for shared services and data architecture

People and Culture Strategy

Background

- NHS People Plan 20/21 with no further update
- 5 year ICS Workforce strategy in development
- Declining pipeline of staff
- Changes to education pipelines
- Significant challenges with recruitment and retention
- 21/22 development of our values and cultural road map to support Great Place to Work
- The NHS Workforce plan pending publication

Developing the strategy

- Built on the wide range of national research and reports
- Built of the vast number of engagement sessions from developing the cultural road map.
- Linked into the various workforce groups to align plans and focus
- Undertook engagement via the enabling strategy engagement sessions

Goal: Develop a compassionate, inclusive and improvement focussed leadership mindset that supports all staff to give their best and the delivery of wider Trust strategic aims.
Goal: Through system collaboration, development of improved clinical pathways and adoption of technological enablers, ensure the delivery of the clinical strategy is underpinned by a sustainable and fit for purpose workforce model and workforce plan.
Goal: Establish the Trust as an employer of choice that attracts and retains the best talent, by being at the forefront of improvement & innovation and through a shared sense of belonging.
Goal: Equip our people with the skills and capacity to deliver future models of care. We will work with our educational partners to ensure our staff are developed and educated to the highest standards. Staff will be supported with digital and data upskilling, encouraged to develop and empowered to work to the top of their professional scope.
Workforce Strategy – 4 Pillars
Leadership & Culture
▪ Formal development programme
▪ Time to lead
▪ Agile & Compassionate leadership
▪ Empowerment
▪ Just Culture, values & behaviours
Attraction, Recruitment & Retention
▪ Innovation
▪ Legacy mentoring
▪ Pastoral Care
▪ Accelerated programmes for high risk roles
▪ Key worker accommodation and rest facilities
Developing our workforce
▪ Talent Management
▪ New & extended roles*
▪ Career Pathways
▪ Apprenticeships & alternative degree paths*
▪ Digital upskilling
▪ Advanced Practice
Workforce Transformation, Integration & Redesign
▪ New ways of working & use of technology
▪ Integrated health and social care roles & services*
▪ Digital rostering & scheduling
▪ Workforce planning & re-design
Inclusion Strategy
People Promise/ A Great Place to Work / Cultural Roadmap
OUR VISION
As a result of the Workforce Strategy our aim is that all our people will be able to say these things about their experience working with us in five-years' time.
▪ We are known as a great place to work, having delivered the NHS people plan and the People Promise.
▪ We have a just and learning culture, lived and breathed by our people, managers and leaders.
▪ We offer more than a contract of employment – we are innovative about how we attract and retain the best talent.
▪ We involve staff in the planning of their careers, development opportunities, new working practices and new roles.
▪ We have strengthened our in-house training and educational partnerships to equip our people with the skills and capacity needed to support integration, workforce redesign and the Clinical Strategy.

Our Cultural Roadmap

1. Patient Experience and Patient Safety

1a. Embed a patient safety culture
1b. Embed a culture of just and learning
1c. Promote a culture of support, reflection and learning

2. Transformation

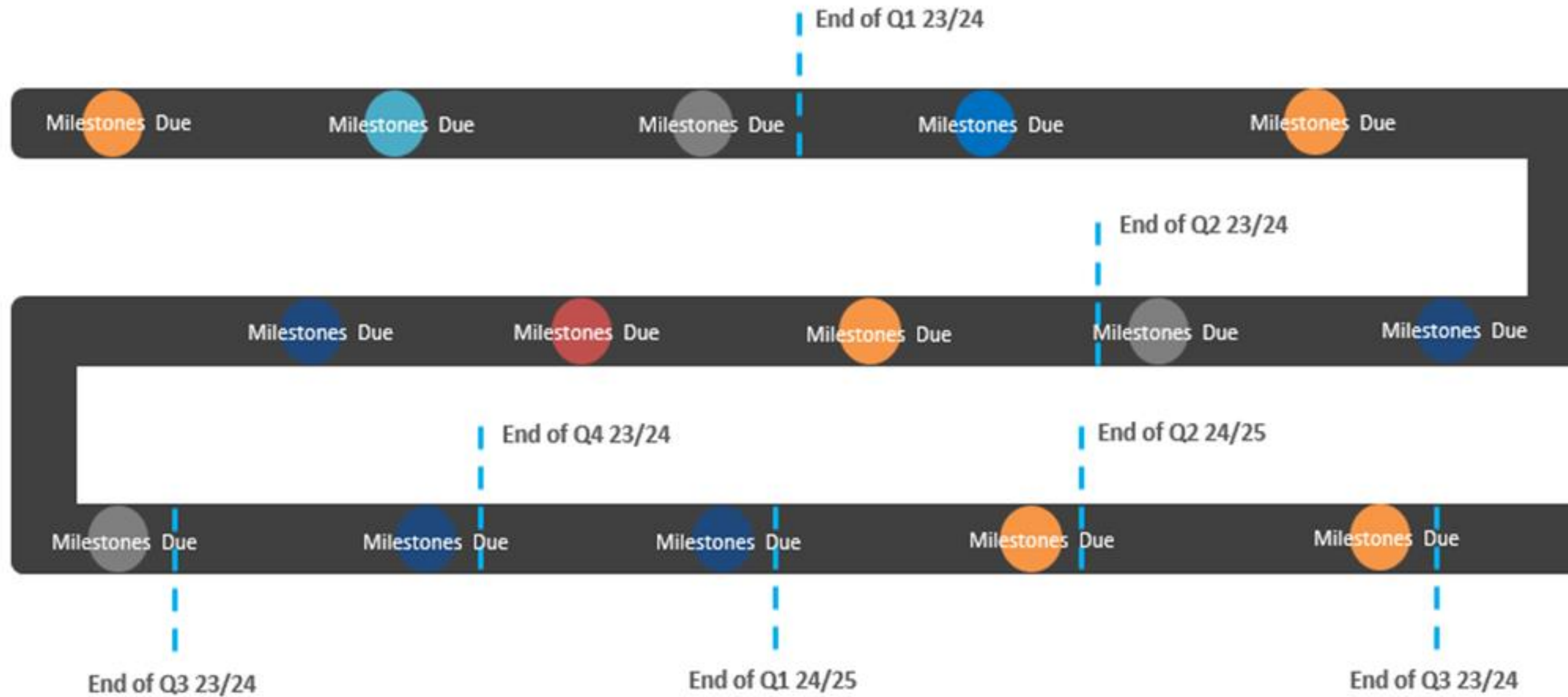
2a. Enabling an agile mindset to change management outside of HR
2b. Improved engagement with employees
2c. Make transformation and innovation an every day topic

3. Employee Experience

3a. Enable improved measurement of employee experience.
3b. Embed a culture of recognition and ensure our staff feel valued.

4. Wellbeing

4a. Decrease work-related stress and burnout
4b. Prevent and control violence in the workplace, in line with existing legislation.
4c. Support financial wellbeing



5. Inclusion

5a. Ensure that everyone has equal access to our services and has a positive experience of the Trust.
5b. Easy access to support available (right time, right place).

6. People Development

6a. Work towards embedding a just and learning culture.
6b. Understand succession in alignment to workforce plans, supporting with strategic resourcing and grow our own.
6c. Identify talent and measure development and progression through the organisation, maximising the skills available.
6d. Develop a coaching culture to support empowerment.
6e. Educate and upskill managers to ensure staff can be supported in a compassionate and inclusive way.
6f. Promote and role model compassionate and inclusive leadership.
6g. Develop a culture of learni

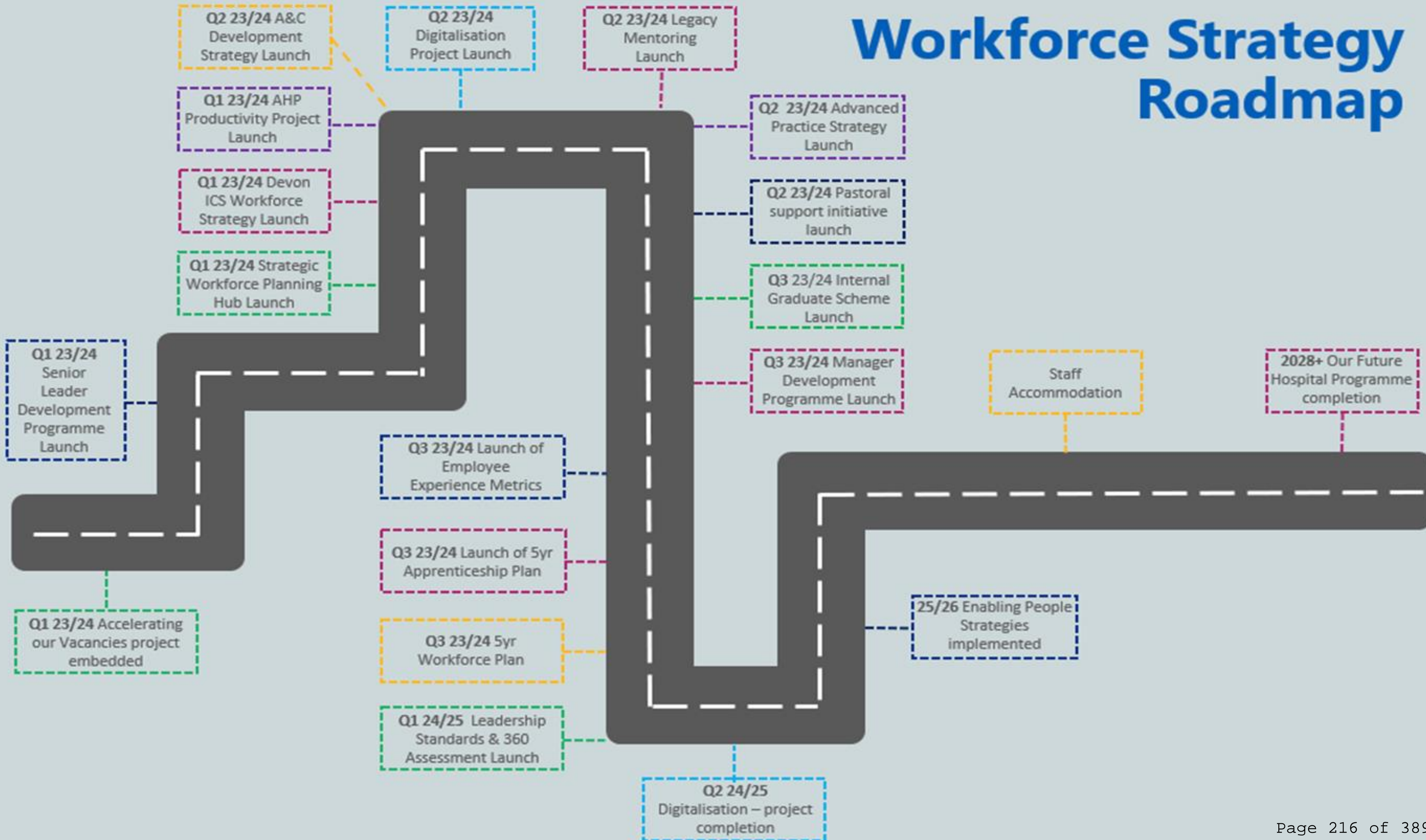
8. Sustainability

8a. Embed sustainable principles
8b. Delivery of our Sustainability Plan

7. Project Simplify & People Practices

7a. To enable HR to review and align local policies to the new principles.
7b. To simplify policies, guidance and resources to improve accessibility and promote a just and learning culture.
7c. Promote a healthy work life balance, while ensuring a sense of belonging for agile working.
7d. Improve hygiene factors and infrastructure to enable other interventions.

Our Workforce Strategy Roadmap



Next Steps – next 3-6 months

- NHS Workforce Plan published 30th June – aligning key outcomes/gap analysis
- Work with partners and teams to ascertain educational pathways and manageable pipelines
- Review our approach to health & well-being and other elements of the National workforce plan
- Align to the One Devon Workforce strategy
- Launch strategic workforce planning rounds to establish needs (Q3) to inform operational planning
- Develop the granular detail of the Trust wide workforce plans 24/25

Challenges & Risks

People

- Aligning strategic clinical objectives to workforce pipeline and supply
- Attracting and retaining our current workforce

Funding

- Funding and support to attract and develop our pipelines and existing workforce

Political context

- NHS Workforce plan – huge ambitions and shifts in workforce design
- Sustainable funding vs vacancy freeze and regulatory conditions

Estate & Facilities Management Strategy

Vision, Mission & Objectives

Our patients will be cared for in a safe, sustainable, flexible, modern, dynamic, inclusive & accessible environment

Our aim is to support delivery of the Better together objectives by developing, delivering and operating estate that is fit for purpose, now and in the future utilising our resources to deliver best value and maximum impact for our patients and staff

Our Objectives

- Site redevelopment enabling future model of care delivery
- Optimally utilising estate
- Safe and compliant estate
- Sustainability in building and estates management

Strategic Priorities

- Acute redevelopment – master-planning, business cases
- Prioritise appropriate staff accommodation (OFH Phase 1/KWH)
- Develop and deliver community estates optimisation plan
- Implement non-clinical space utilisation and management
- Develop clear building and property leasing/management strategy
- Evaluate future Facility Management approach
- Develop energy strategy and de-carbonisation plan to 2030

Where Are We Now – Our starting place

Northern Acute site

- Ageing estate – 70% over 50 years old
- Functional layout does not support future clinical strategy
- Residences are poor quality

	NDDH
Low risk	£3,987,827
Moderate risk	£2,382,916
Significant risk	£28,040,491
High risk	£13,429,293
Total	£47,840,527

Community estate

- Trust community estate serves three main purposes:
  - Providing an administrative hub for community teams
  - A delivery base for rehab and therapy
- Delivery of specific acute pathways(OP)
- Different ownership structures between areas
- Backlog maintenance is comprised of £6.9 million (before on costs)

Eastern Acute sites

- Main Wonford site redeveloped early 1990s; retains some 1970s estate; no master plan
- Heavitree is 1970's and OK but under-utilised
- Backlog maintenance across both sites £113 million (before on-costs)
- The University (UoE) operates on both sites

Non-clinical services

- Non-clinical staff are:
  - in clinical space
  - significantly overcrowded
- Staff accommodation - both residential and rest/work space is poor.
- Opportunity to test hybrid model of FM services

Where Are We Going

Site Redevelopment

- Our Future Hospital plans approved
- Minimise backlog - maximise Hospital 2.0, digital care, new ways working
- Wonford Site master plan developed
- Heavitree potential as elective site maximised
- Future of Nightingale post 2025 determined
- Joint RILD expansion options agreed w/UoE

Optimally Utilising Estates

- Minimise of leased (NHSPS) community estate through efficient & effective space reviews
- Maximise use of Trust own community estate that is still required
- Work collaboratively with provider partners (DCC, DPT, PCNs) and ICB

Safe & Compliant Estate

- Rolling Estates Improvement Programme
- Maintaining critical risk estate at minimum (excluding NDDH)
- Accessible estate - DDA complaint with best practice adopted where possible
- PLACE reviews at or above national standard

Sustainability

- Decarbonisation plan – towards Net Zero Carbon (NZC) to 2030
- Energy strategy implemented
- All new builds to NZC standards
- “Greener” Facilities Management

How Will We Get There

Site Redevelopment

- Aim to accelerate the OFH programme in line with OBC
- Commission master plans for all acute sites guiding investment/development decisions
- Develop staff accommodation and facilities (OFH/KWH)
- Create appropriate mix on-off site admin space
- Create the pipeline of capital development projects

Optimally Utilising Estate

- Different approach to be adopted between owned and leased sites.
- Help shape ICB community strategy
- Get clarity over service provision in community vs acute
- Clear property leasing/management strategy
- Well-embedded space utilisation policy and procedures

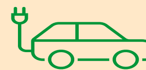
Safe & Compliant Estate

	Wonford	Heavitree	Mardon	NDDH
Low risk	23%	16%	29%	8%
Moderate risk	74%	84%	71%	5%
Significant risk*	3%	0%	0%	59%
High risk*	0%	0%	0%	28%

- Eliminate high risk; minimise significant risk
- Maintain regular reviews and assessments

Sustainability

- Implement the NHS Estates 4 step Net-Zero Carbon Delivery Plan alongside an energy strategy



- Electrify our estate and FM vehicles

- Prepare response for severe climate change impact

Challenges & Risks

People:

- Space culture
- Different work practices

Funding:

- Very limited system capital
- NHP currently northern-focused

Political context:

- Output of Acute Provider Collaborative
- General election (2024)

Finance strategy

The Finance Strategy aims to deliver on the following objectives

- Work with Devon ICS to deliver a system wide multi-year financial and operational recovery programme
- Invest in our workforce through driving recruitment, supporting an affordable long-term workforce strategy, investing in well-being and the long term needs of our Estate
- Set a sustainable and deliverable recovery trajectory that returns the Trust to recurrent break-even, aligned to the recovery of the waiting list.
- Develop a financial framework to enable the delivery of the clinical and supporting strategies
- Investing in New Innovation and Technology, driving the benefits to demonstrate VFM and affordability to the longer term needs of our population

Key Strategic Priorities

- **Long Term Financial Model (LTFM)**

  Finalise the LTFM for the Devon system to give clarity on savings requirements to achieve financial balance over 3-5 years

- **Workforce development**

  Aligning finance, activity and workforce strategic frameworks to ensure clear reconciliation of assumptions and trajectories supporting with a funding strategy that provides the financial support to recovery through ERF and growth – within an overarching affordability framework

- **Delivering Best Value**

  Develop a financial recovery plan over 3 years with a challenging but deliverable level of savings aligned to the productivity challenge to restore services and maximise the use of resources

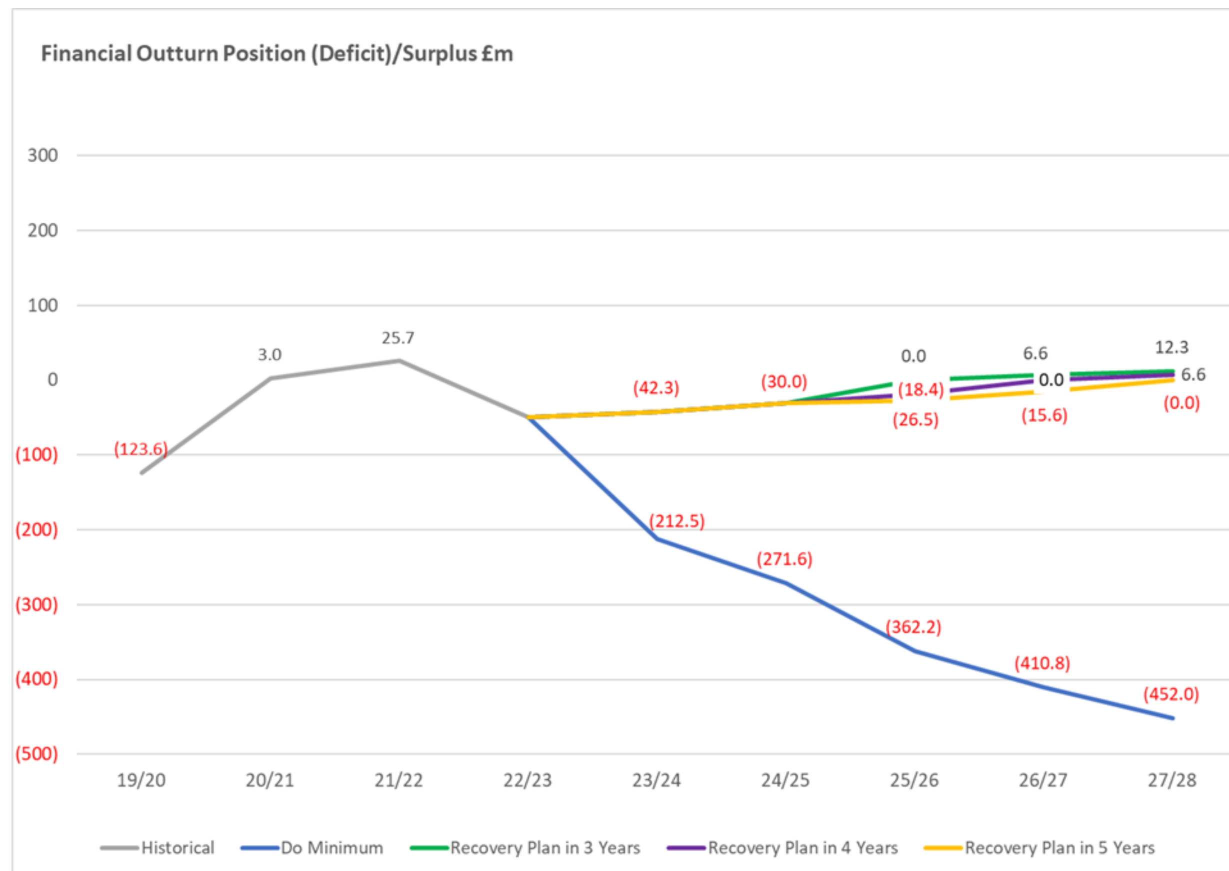
- **Investment**

  Develop a multi-year funding approach to support the clinical and supporting developments utilising any opportunities from national programmes

- **Financial Support**

  Optimise the new financial ledger with greater reporting capabilities, supporting the finance team skills and enhancing finance training throughout the Trust

Alignment to Devon ICS



- Significant financial challenge across Devon ICS
- Deficit plan for 2023/24 but expectation of Medium Term financial recovery across 3 years
- Draft ICS Long Term Financial Model demonstrates this, predicated on significant system savings in 2023/24 plus full year effect into 2024/25.
- Annual programme of savings of £100m-£170m to bring back to recurrent financial balance and manage income convergence

Work on ICS model continuing with NHSE submission due September 2024. The work will need to conclude to inform the final Royal Devon Finance Strategy. Therefore the board in July will be asked to approve the Finance Strategy in principle subject to any changes in the final Devon ICS LTFM

Financial trajectory for Royal Devon

Income and Expenditure position £m	FY23/24	FY24/25	FY25/26	FY26/27	FY27/28
Income	985	999	1,002	1,017	1,035
Pay	-632	-633	-631	-640	-651
Non-Pay	-368	-355	-352	-354	-357
Net Finance Costs	-14	-14	-14	-14	-14
Financial Plan surplus/(deficit)	**-28**	**-2**	**5**	**9**	**14**
Less Non Recurrent Activity	-75	-69	-60	-59	-59
FYE - CIP	33	0	0	0	0
Underlying financial performance surplus/(deficit)	**-71**	**-71**	**-56**	**-50**	**-45**
Of which is NR income - ERF/CDC	50	51	51	52	53
Underlying position adjusted for income	**-21**	**-20**	**-4**	**3**	**8**

- The Royal Devon share of the ICS LTFM demonstrates return to balance in
- Predicated on Signiant Delivering Best Value achievement in 2023/24 of £60m plus £33m FYE - any slippage would need to be recovered in 2024/25 to still achieve trajectory
- Trajectory based on a number of national or ICS assumptions on allocation and convergence of income, growth and inflation assumptions, continue ERF and savings
- These assumptions can be used to set a financial framework by which multi year decision making can be made within the context of a Devon approved model (subject to ICS approval)

Financial Framework

Plan Assumption	Suggested Treatment	Comments
ERF	LTFM assumes continued ERF at 2023/24 plan levels (i.e. fixed allocation plus £8.7m additional stretch) proposal to treat as recurrent cost attracts a further income stretch of £8.6m on top of this. Short term cost pressure in 2024/25 to be funded from growth prior to impact of cost efficiency	Would need system approval as commits further risk against ERF but allows more sustainable solutions to be delivered at lower cost over time – assumes ERF earning above 103% continues
Cost Growth / investment	Cost growth to be contained within overall income growth (and ERF cost pressure). Allocation of growth to be made against key strategic areas of UEC, Community, safety issues, Drugs and Devices, non clinical areas and workforce redesign	Would need to be flexible as part of operational planning as priorities change but allows multi-year decision making to be taken within an expected growth parameter set against the key trust priorities
Savings Programme	To ensure the plan is deliverable a multi year approach is also needed to the savings plan setting out targets and expected areas for delivery	Would enable clear planning on productivity, cost avoidance and cash releasing expectation as a requirement to underpin the multi-year investment proposal

Setting Investment Criteria

- To support the financial framework, investment criteria are proposed to ensure investment decisions align to the overall system recovery and key priorities of the Trust.
- In particular using the enabling strategies including the LTFM to ensure alignment

Investment criteria
The investment is critical to resolve a patient safety/quality issue, as demonstrated through a quality impact assessment (and confirmed by CMO and CNO)
The proposed investment aligns to the Trust Strategy and enabling strategies (Clinical, Digital, Workforce and Estates in particular)
The investment increases capacity in line with the demand and capacity modelling to support the elective recovery programme
The investment supports improved patient flow and the urgent care pathway
Does the revenue model demonstrate a financial contribution to financial recovery under a PBR basis?
Is there a funding source identified for the investment or a likely funding route following a national process?
If no external funding available, is the investment affordable within the 5-year financial framework of the Trust and the ICS?
Is the investment underpinned by a deliverable workforce model?
Does the investment represent value for money?

Capital and cash

Capital

- Use internal CDEL to address key backlog and replacement issues in line with its purpose
- Set Annual budgets across Estates, Equipment and Digital to support multi-year replacement programmes
- Continue to pursue strategic capital through multiple national programmes
- Utilise National Hospital programme for strategic estate solution for Northern Devon
- Link in with NHP for the wider Devon for any significant reconfigurations recommended under the peninsular acute services review

Cash

- Cash resources are depleted in 202324 due to deficit position.
- Any worsening or further deficit in 2024/25 will trigger requirement for cash support through the Department of Health and Social care (DHSC) in the form of additional PDC.
- In subsequent years, the reestablishment of a surplus position will see this need reduce as surpluses rebuild to a sustainable cash balance.

Resultant Position

£'m	FY23/24	FY24/25	FY25/26	FY26/27	FY27/28	Total over 5 years
Financial Plan surplus/(deficit)	-28	-2	5	9	14	-2
ERF Cost base	-36	-47	-50	-51	-51	-235
ERF Income Base	36	46	50	50	51	233
Net ERF impact	-0	-2	-0	-0	-0	-2
Deployment of Growth						
ERF shortfall	0	2	-1	0	0	0
Safey Issues	4	2	2	2	2	13
Drugs and Devices	0	3	3	3	3	12
UEC pathway	0	2	2	2	2	9
Community	0	2	2	2	2	9
Non clincial areas	0	1	2	1	1	6
Workforce redesign	0	1	2	1	1	6
Productivity/Cost avoidance	15	7	8	8	8	46
Total Growth	19	20	20	20	20	99
Savings Plan						
Productivity/Cost avoidance	15	7	8	8	8	46
Cash Releasing	45	23	42	31	26	168
Total Savings	60	31	50	39	34	214

The financial framework sets out:

- Over 5 years we would be planning to:
- Invest £235m in elective recovery
- Deploy £99m of growth including £46m of productivity to the savings plan and £53m of real targeted investment in services in line with the Trust strategy
- Save £214m of savings (plus £33m FYE from 23/24 into 24/25) of which £46m is cost avoidance and £168m is cost reduction
- This enables a balance between elective recovery, investment in non elective services and community and financial recovery to move towards a sustainable financial future within a model aligned to the Devon ICS

Agenda item:	10.3, Public Board Meeting			**Date:** 26 July 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:	Chris Tidman Deputy Chief Exective			
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 April 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 BoD last reviewed the BAF 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, which is being presented today. Risks were reviewed, and new risks articulated during June/July 2023.

It should be noted that following the supportive challenge of whether the proposed additional risk of “The Trust fails to deliver on its ambitions as a merged organisation”, should be added to the BAF, the Deputy Chief Executive has reviewed this with the Execs and concluded that this did not represent a risk to the Trust not achieving the strategic objectives.

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			↔	8
2	16	16	16	16			↔	8
3	20	20	20	16			↓	12
4	25	25	25	20			↓	12
5	25	25	25	20			↓	9
6	New risk			20				8
7	9	9	9	9			↔	4
8	12	16	16	16			↔	4
9	16	16	Not reviewed	16			↔	8
10	New risk			25				4

Summary of current risk scores heat map

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

Points for the BoD to note:

Risk 10 UEC Targets – This is a new risk, with UEC being separated out from risk 5. The narrative has been revised to reflect the agreement to temporarily adjust ambulance postcode catchments, in order to support neighbouring Provider Acute Trusts. It also details the associated monitoring of the impact of this temporary change, and reference to the intention that the refreshing of the Winter Plan in Autumn 2023 will be to form an integral part of the Trust's Urgent and Emergency Care 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.

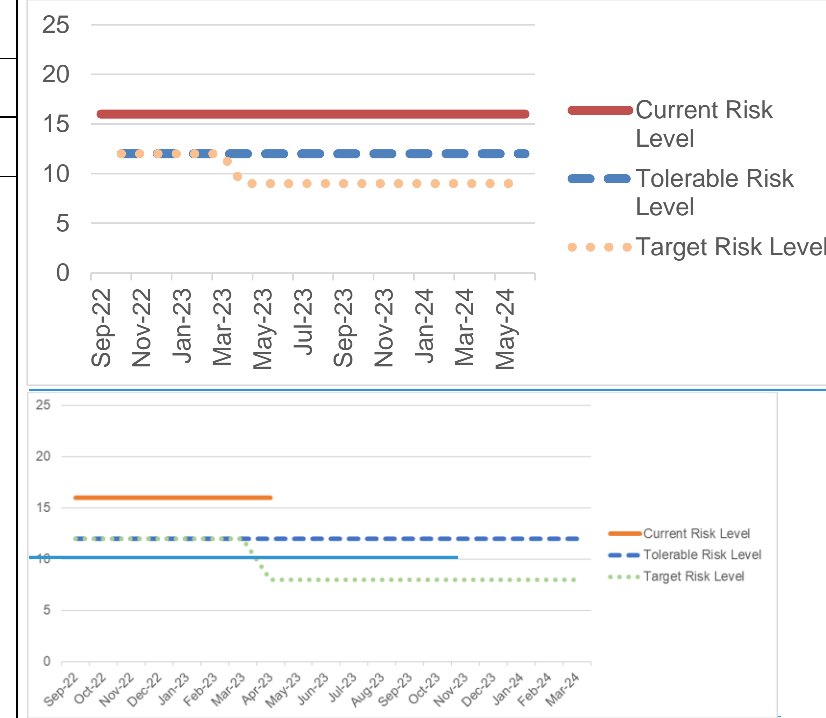
NHS
Royal Devon
University Healthcare
NHS Foundation Trust

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** – (New)	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** - (New)	JP	FOC	25	4

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	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Our People		
Executive lead	Hannah Foster	**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	**Risk rating**	**16 – Significant**	**12 – Medium**	**8 – Low**				
Last changed	10/01/2023 17/04/2023								



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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. ~~Operational pressures due to staffing levels, putting additional pressure on the senior leadership team.~~ • Heightened regulatory scrutiny in relation to the NHS System Oversight Framework (SOF4) criteria.	• 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. • ~~Joint~~ 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 ~~• Stronger strategic relationships at senior levels with non-NHS partners (e.g. One Northern Devon).~~ • 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~~s.~~ • Inclusive Leadership training set up and being delivered to senior leadership team. ~~• Learn+ now in place Trustwide to support with development opportunities and a single appraisal process.~~ • Specialist and executive resourcing team in place substantively to support executive, specialist and hard to fill roles. • Management Support Programme launched. • Leadership Academy launched. • Cycle of risk and succession planning for the leadership group commenced, including identification of plans to eliminate single points of failure.	• Limited ability to control demands that originate outside of the organisation. ~~Limited requirements in place for management / leadership training, prior to entering management roles.~~ • ~~Recruitment volumes and time to hire have improved as a result of accelerating filling our vacancies, which is now being transitioned into the Delivering Best Value programme.~~	• Leadership development programme based on 'Controlling the Controllables'~~.~~ ~~• Plans to explore increasing the uptake of line manager training for aspiring and existing line managers.~~ • Working with partner organisations to streamline reporting and improvement interventions to/with regulators. • ~~Completion of the programme to accelerate filling our vacancies will result in improved staffing levels and therefore reduced escalation to senior management teams.~~	• Board Assurance Framework. • Performance and Governance System around delivery~~including Governance Committee, Programme Reporting Frameworks for HIP2, PAF's etc~~. • ~~Bi-annual~~Monthly people metrics ~~reports to PWPW, looking at the monitoring of working hours.~~ • Intelligence from the quarterly People Pulse surveys and the annual staff survey. ~~• Reporting of progress against the NHS People Plan.~~ • Successful recruitment to senior leadership posts. • ~~Weekly workforce infographic suite~~. • Monthly workforce reports on turnover/ sickness~~.~~ • Appraisal and 360 feedback	• 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).	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~~There is a risk that workforce levels will be insufficient to deliver the required capacity and care model.~~					**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	~~10/01/2023 – PWPW~~ ~~17/04/2023 – Exec Review~~ 20/07/2023 - PWPW	**Risk rating**	**16 – Significant**	**12 – Medium**	**8 – Low**		
Last changed	~~10/01/2023 – PWPW~~ ~~17/04/2023 – Exec Review~~20/07/2023 - PWPW						

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Current Risk Level
Tolerable Risk Level
Target Risk Level

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. • ~~Inability to onboard candidates quickly enough.~~ • 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 in the acute setting.	• Trust strategy including ~~Board~~ 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 support 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 workforce planning team in post. • ~~Trust strategy and values launched.~~ • ~~Accelerating filling our vacancy programme being transitioned to the~~ Delivering Best Value retention stream.~~programme, including activity on retention.~~ • ~~Pilot in place to flex timings of some pre-employment checks, to reduce blockers to start dates.~~ • New recruitment branding delivered. • Stay conversations piloted and in place. • ~~Enhanced corporate induction capacity to meet pipeline.~~ • Candidates can access helpful information and resources prior to their start date on Learn+. • Strategic resourcing group in place to prioritise recruitment to posts. • Approved northern medical workforce business case to increase substantive medical capacity. • Proactive health and wellbeing offer in place.	• Lack of strategic workforce plan for the Devon ICS.~~ning systems and data at all levels of the NHS.~~ • 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.	• 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 ~~C~~clear articulation of ~~target staffing position of key priority roles (registered, unregistered and domestics) including target staff bank numbers~~vacancies at position level (September 2023). • ~~Improve proactive reporting of predicted start dates to give maximum time to IT, people development, security, payroll, to ensure earliest possible start dates.~~ • ~~Automate bulk ESR/payroll onboarding as much as possible, removing manual and singular feeds.~~ • 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. ~~Wi-Fi in eastern services.~~rest areas. • ~~Band 2/3 HCA & HCSW business case.~~ • 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 induction process experience from new starters and recruiting managers. • Weekly workforce infographic data, showing workforce loss / gain and details of the pipeline. • Monthly Workforce dashboard in place. • 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.	• 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) • Health and wellbeing dashboard to be launched (June 2023)	~~**Inconclusive** – Further actions have been completed to provide greater assurance and further controls, however more time for embedding is required before full assurance can be provided. A further update of the BAF is due to be reviewed at PWPW in July 2023.~~

	• 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.					

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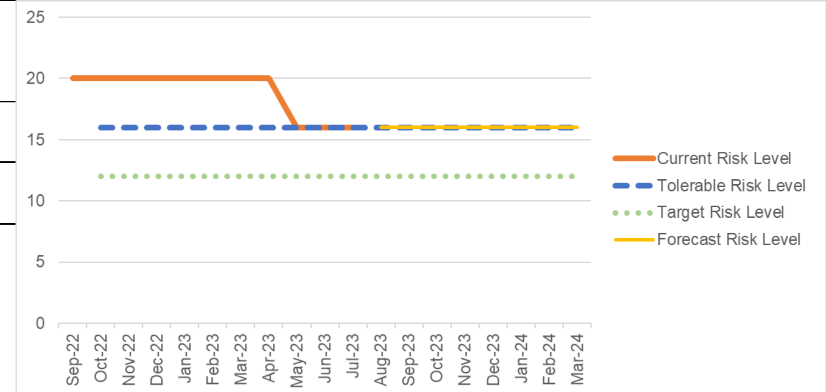
Risk 3 Trust unable to invest in its Capital Plans

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	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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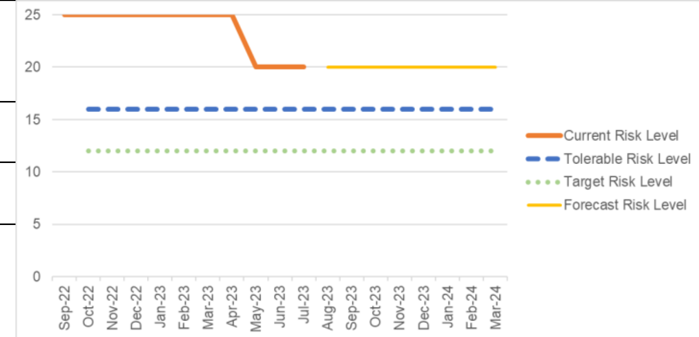
Royal Devon University Healthcare NHS Foundation Trust

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						**Strategic priority**	Recovering for the future
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	4	4	**Risk treatment strategy**	Mitigate	
Last reviewed	July 2023	**Risk rating**	**20**	**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 Trust and Devon system have been placed in SOF4 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 SOF4 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 tot eh Deloittes drivers of the deficit work System improvement plan aligned to SOF4 exit criteria to focus on delivery **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 SOF4 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 link to clinical strategy and contribution to corporate strategy on longer term financial recovery. Central governance around delivering best value programme in year and longer-term strengthened and embedded form start of the financial year Review of HFMA getting the basics right checklist and action plan being delivered and assured through the audit committee	**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 **Internal** RDUH LTFM aligned to the Devon ICS model and internal enabling strategies transformation	**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	**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 SOF 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	Detailed risk mitigation plan for non-delivery of system workstreams	

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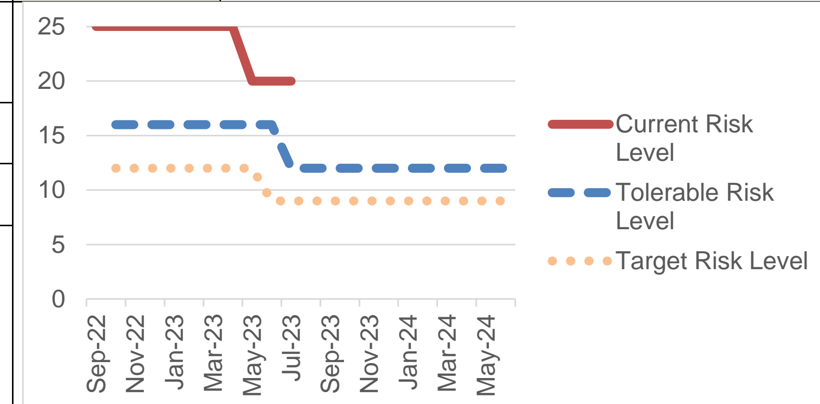
Risk 5 Elective Demand and Waiting-List Backlogs are not delivered

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		
Executive lead	Chief Operating Officer	**Likelihood**	4–likely	4 – likely	3 – possible	**Risk appetite**	[leave blank]		
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	~~May~~ July 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 • workforce 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 Development of effective relationships with ICB / STP, 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	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 • 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, • Continued pursuit of protected elective capacity both in-house and	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 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	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	

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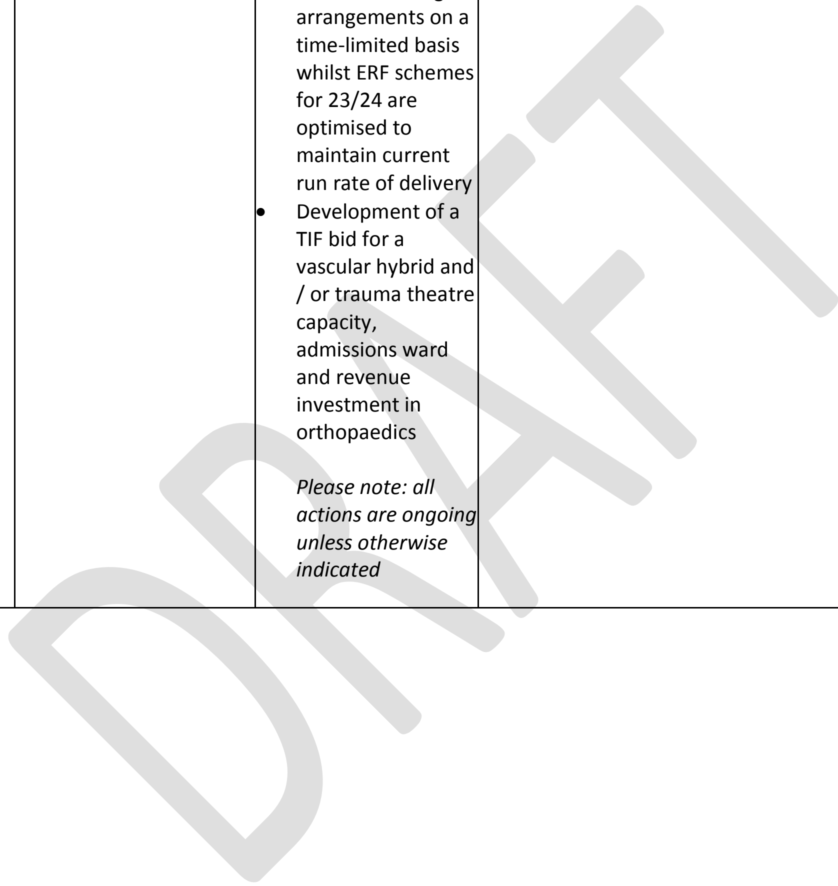
			as part of new ventures with Independent Sector partners • Completion of NHSEI 10-week challenge • Development of Tier 1 Funding proposal to support continued usage of insourcing and outsourcing arrangements on a time-limited basis whilst ERF schemes for 23/24 are optimised to maintain current run rate of delivery • Development of a TIF bid for a 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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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**	5 - 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	**Risk rating**	**20 – Significant**	**12 – Medium**	**8 – Low**		
Last changed	20/07/2023 - PWPW						

Current Risk Level
Tolerable Risk Level
Target Risk Level

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)
• 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. • Change 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.	• 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 and 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. • Continued protection 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.	• 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 protection of management time. • On call arrangements that support work life balance. • Impact of ambitious ICS operational plan. • Impact of NHS Long term workforce plan.	• 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	• 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 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.	• Fully analysed exit interview data following the new digital exit survey launch. • Candidate experience information to be able to inform improvements. • Health and wellbeing dashboard to be launched.	

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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		
Executive lead	Adrian Harris, Chief Medical Officer	**Likelihood**	3 - Possible	2 - Unlikely	2 – Unlikely	**Risk appetite**	TBC		
Initial date of assessment	14th October 2022	**Consequence**	3 - Moderate	3 - Moderate	2 - Minor	**Risk treatment strategy**	Modify		
Last reviewed	July 2023 ~~18 April 2023~~	**Risk rating**	9 - Medium	6 – Low	4 - Low				
Last changed	July 2023 ~~18 April 2023~~								

Royal Devon University Healthcare NHS Foundation Trust

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 ~~MYCARE~~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 ~~There is a risk that staff do not buy in to new ways of working inhibiting transformation of pathways and services.~~ ~~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. 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 ~~Substantive structure in place in Eastern Services for EPIC~~ ~~EPR Benefits Realisation Group – Meeting every other month~~ ~~MYCARE Programme Board in place (Northern Services)~~ 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 Additional ~~3~~2.5 WTE posts in place focusing on ~~implementation~~ development of ~~MYCHART~~MYCARE (patient portal). Marketing campaign launched to increase sign up to 100,000 patient users Stakeholder & staff Communication & Engagement Plan	Secure integrated structure across Eastern and Northern Services not yet agreed and in place in all areas. ~~e~~ Digital and Clinical strategies still to be completed as enabling strategies.	~~Agreement on substantive integrated structure and leadership – November 2023~~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	Monthly reporting to the Board of Directors from the Digital Committee. ~~Monthly reporting of the Northern specific MYCARE Programme Board to the Board of Directors Monthly. EPR reports to Digital Committee and onto Board of Directors bi-monthly.~~ 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 – ~~to digital committee (and onwards to Board of Directors, as requested / required.~~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. ~~Alternate Monthly EPR benefits realisation steering group (east) proposed scheme to achieve CIP requirement from Admin point of view~~ ~~Regular updates on overarching admin under and over spend with anticipated epic benefits to support delivery of savings – Epic benefits realisations – reporting to Ops Board and onwards through to FOC~~ ~~Performance Assurance Framework - reporting around benefit delivery and MYCARE implementation / Optimisation progress~~ Ongoing ~~MYCARE~~ EPIC training / personalisation sessions to support confidence and efficiency in the use of Epic~~/MYCARE~~ 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 ~~Additional MModal support (Voice Recognition) and training~~ 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-	~~Collective session between east and northern teams to identify proposed integrated Clinical / Digital Structure – including Clinical Safety Officer Role and EPR Analyst capacity and Capability~~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 – East optimisation work has recommenced with renewed focus post a brief step down to support Northern Services go-live~~ Benefits- FBC assumptions not fully realisable in some areas. Limited alternative savings available but still being scoped. ~~Northern Services Stabilisation phase continues – view to transitioning to Optimisation phase later this year~~ 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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	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 ~~A single Clinical Digital Services structure is now in place covering both East / North~~ Transformation Strategy launched Jan 2023			financial' EPIC benefits capture to support engagement with Epic and transformation. Clinical and Digital enabling strategies underway		

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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	~~18th April 2023~~ 10th July 2023	**Risk rating**	**16 - Significant**	**9 - Moderate**	**4 - Low**				
Last changed	~~18th April 2023~~ 10th July 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**
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	Regular Divisional risk reports to S&RC/GC Reporting of medical and clinical education to S&RC/GC Trust wide safety oversight	Review of risk management policy/processes *(**Action completed** – Implementation commenced~~s~~ 1st April 2023)* Strengthen the reporting of medical and clinical education through PWPW report to GC *(**Action ongoing with Chief People Officer)*** Joining of the relevant groups across Royal Devon to ensure shared oversight and learning (**Action completed** – Incident Review Group, Mortality Review Group,	**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) • ~~HSIB~~ • NHS England Three Year Delivery Plan for Maternity and Neonatal Services	Assurance that BAU activities of CEC as per terms of reference are being undertaken *(**Action completed** – Agenda for CEC has returned to pre-Covid arrangements and is now chaired by Chief Medical Officer)*	

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	• 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:** • 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	Insight and understanding of patient safety and service delivery issues – connecting leaders with people working at the front line	and Patient Safety Operational Group are all now Trust wide.)(~~***Action ongoing*** – *The review of current governance arrangements has commenced, with the integration of the Trust wide Incident Review Group complete and the proposed Trust wide alignment of the Patient Safety Group in process*~~) Reinstate patient safety walkarounds *(**Action complete** - ~~**Action ongoing** – Plan in place to reinstate~~ Non-Executive patient safety walkarounds have been instigated from May 2023.* Instigation of the safety command structure; including the establishment of a Patient Flow Task Force and identification of key outcomes for it to achieve (i.e. a real time safety data set) *- Led by Chief Operating Officer (**Action completed**)* Development of business case to support an increase in Medical Staffing establishment for Northern location *(**Action complete** ~~**ongoing**~~ – Business case developed and approved through the Triple Lock process)*	**Other reporting** • Regular board sub-committee performance/progress reports to GC (patient experience, safeguarding, safety and risk, clinical effectiveness) • 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 • 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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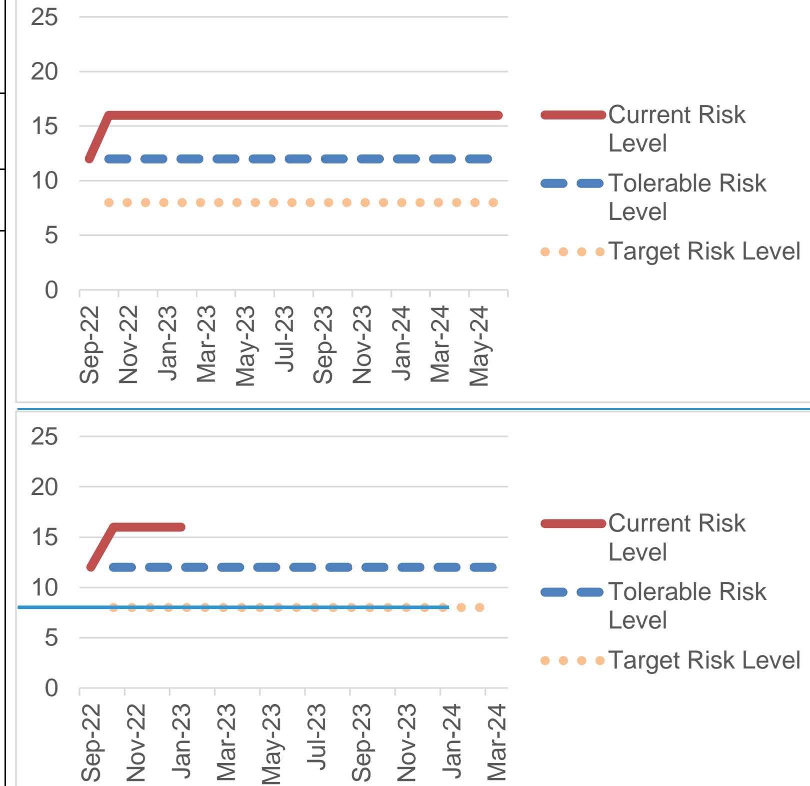
Risk 9 Our Future Hospitals – Delays in Funding/Failure to Deliver Clinical Strategy for Northern Services

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							**Strategic priority**	Recovering for the future / Great Place to Work
Lead Committee	OFH Programme Board	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	~~People/~~ 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		**Risk rating**	**16**	**12**	**8**				
Last changed									



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. Political and Economic instability leads to a re-phasing of the national NHP capital budget or a lack of decision making, meaning that the OFH programme cannot progress to Outline Business Case. 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 scalability which might prove to be attractive to government.deliverability / affordability of various options from part rebuild/refurb to full rebuild Early enabling work starting on accommodation blocks to demonstrate progress SOC to be revised based on review of options. SOC stresses the inflationary costs of delay coupled with the abortive costs of interim backlog maintenance. National decisions expected over Feb/march to coincide with Chancellors statement. **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. Trust volunteered to be one of 5 national pilots in supporting the national programme in designing a minimally viable product NHP roadshow visit to North Devon on 2nd August Meetings arranged between CEOs/ Exec teams to stress readiness and importance to Integration. Political Local MP visits hosted by Chair and ICS Chair	Risk of delay by NHP & ICB/Region may not be understood Risk of delay may not be fully understood by nationallocal 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. Given general election within next 18 months, plans are in place to increase political lobbying and profile	SOC, Board and Committee reports Internal Gateway Assurance 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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Royal Devon University Healthcare NHS Foundation Trust

Risk 10 UEC Targets are not delivered

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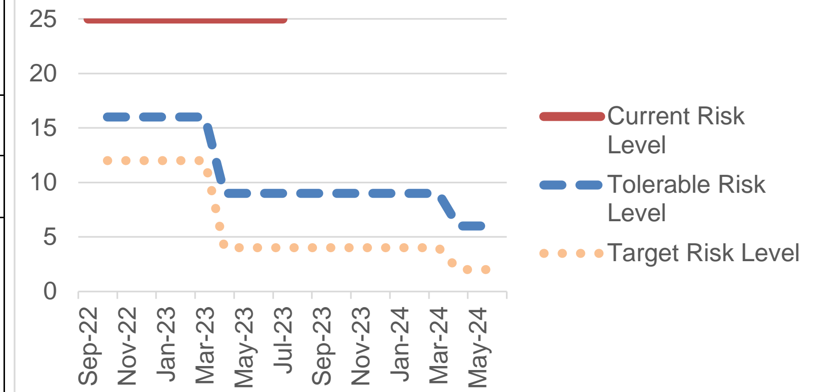
Principal risk (what could prevent us achieving this strategic priority)	Risk 10 - There is a risk of the Trust being unable to deliver the urgent & emergency care commitments contained within the Trust's Financial & Operational Plan due to unscheduled care demands and capacity							**Strategic priority**	Recovering for the Future
Lead Committee	Finance & Operational Committee	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	System		
Executive lead	Chief Operating Officer	**Likelihood**	5 – very likely	3 – possible	2 – unlikely	**Risk appetite**	[leave blank]		
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 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 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 Pace of development of clinical innovation programme to enable shortfalls in capacity to be overcome	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 *Please note: all actions are ongoing unless otherwise indicated*	Performance metrics • IPR • PAF • Activity and Referrals data Monitoring of adjustment to postcode catchments to understand volume of diverted patients and associated impact Internal investment & external sponsorship Winter Plan Bed modelling ToRs / Minutes and Action Logs of internal meetings strengthened as part of Operational Governance Framework • 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	

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Agenda item:	Item 11.1, Public Board Meeting	**Date:** 26 July 2023		
Title:	Follow Up 2022 NHS Staff Survey Report - Summary of Feedback from Listening Events & Trustwide Action Plan			
Prepared by:	Sajjad Iqbal, Associate Director of Wellbeing, Inclusion and Employee Experience and Alex Tait, Executive Support Manager			
Presented by:	Hannah Foster, Chief People Officer			
Responsible Executive:	Hannah Foster, Chief People Officer			
Summary:	This paper has been written to provide further information to the Board, following presentation of the 2022 NHS Staff Survey results in April 2023.			
Actions required:	The Board is asked to review and discuss the further information presented in this paper.			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
			x	
History:	The annual NHS staff survey results were initially discussed in the April 2023 Board. At this time further information was requested, including feedback from the listening events that had commenced, further analysis in some areas and details of the actions being taken. This paper has been written to address these points.			
Link to strategy/ assurance framework:	Our people are an essential part of being able to provide services to our patients. The results of the staff survey are therefore vital in ensuring the Trust can listen to our people and respond appropriately. This is reflected in our 'Great Place to Work' strategic objective, with the NHS Staff Survey also explicitly referenced within the Board Assurance Framework in relation to capacity risks.			

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

1.1 This paper aims to provide an update on questions and matters raised by the Board, following its initial discussion on the National Staff Survey results in April 2023. It also provides an update on the themes and local plans that have resulted from wider organisational engagement since publication, (including the listening events that have taken place across the Trust). The paper also outlines the Trustwide action plan that has been developed to deliver improved scores in the priority areas identified and deliver on our commitment to the 'we are always learning' element of the staff survey. The resulting actions will provide a catalyst for the Trust leadership team to ensure that the Royal Devon is a great place to work.

2. Background

2.1 The 2022 National Staff Survey results were made available to managers in February 2023, prior to the embargo being lifted. A session was then held by Picker to provide managers with an overview of the results on 9 March 2023 (the date the embargo was lifted), along with publishing the results so that they were available to all staff within the Trust.

The Board received its initial presentation of the results in the April 2023 Board meeting, with this further report planned later following organisational engagement. In its initial discussion the Board specifically requested further insight and reporting to be included in the follow up report, in the areas detailed below:

- the 'we are always learning' element of the staff survey, due to it being the only area where the Trust was lower than average;
- the noticeable drop in the northern scores against the year before;
- the areas of colleagues experience of their line management.

Trustwide engagement took place through a number of forums to share findings and to seek feedback. These forums included:

- presentations of the results and analysis at Trustwide meetings;
- meeting with Staffside and senior colleagues at Partnership Forum;
- formal reporting at People, Workforce Planning and Wellbeing Committee (PWPW);
- four Staff Survey listening events in March 2023 (two for managers and two for all staff);
- managers received access to the results to review departmental scores and worked with People Business Partners to develop strategic plans for their areas.

The Executive team also undertook a focused discussion on key areas to determine key strategic level actions in relation to the Survey, which was also triangulated with data from our People Pulse survey.

To enable team/divisional engagement, managers were provided with their local level reports. Divisions were supported to work strategically with their teams to develop staff survey improvement action plans by 16 June 2023. Assurance for the delivery of the action plans will be monitored and reported through the established divisional PAF's and escalation processes.

At a strategic Trust level, assurance and monitoring will be undertaken via PWPW, and established governance processes.

As part of the additional analysis and further actions referenced below It is important to note that the Trust intends to benchmarks itself both within the Devon system and its peers nationally as this will allow for a review of best practice at both a local and national level.

For the purpose of clarity this paper focuses on trustwide strategic actions.

3. Additional Analysis

3.1 Results of wider organisational engagement

As detailed above, Trustwide engagement took place through a number of forums. The listening events primarily focused on gaining feedback in the following areas:

- What has the Trust done really well that needs to continue and be shared more widely?
- What will make the biggest difference for the Trust to improve staff experience and feedback?
- Trustwide; what is the most important aspect to consider? How can this be addressed?
- How can managers and staff become empowered to make changes to improve staff experience at the Trust?
- What will success look like 12-months from now?

The listening events provided many positive stories, themed around caring and compassionate staff, staff following the Trust values, appropriate behaviour, good health and wellbeing support for staff, significant improvements in supporting flexible working, providing excellent patient care remains the priority and the roll out of EPIC.

Staff shared that the areas that would make the biggest positive difference to their staff experience. Key themes that have emerged were:

- **appraisals** – less onerous, protected time to undertake and simplified
- **staffing** – filling vacant posts and improved staffing levels
- **manageable workload -** less project expectations
- **leadership** – empowering managers and making less short notice requests
- **learning and development** – Career pathways for all roles and more classroom based training
- **communication** – listening to staff and reassurance that things change when raised
- **Health and wellbeing** – protected time to support staff health and wellbeing and provide end of shift huddles

Many of these themes are to be expected and most of these themes already have activity and development underway, as they have emerged from wider staff engagement and integration plan. However, hearing this directly from our staff

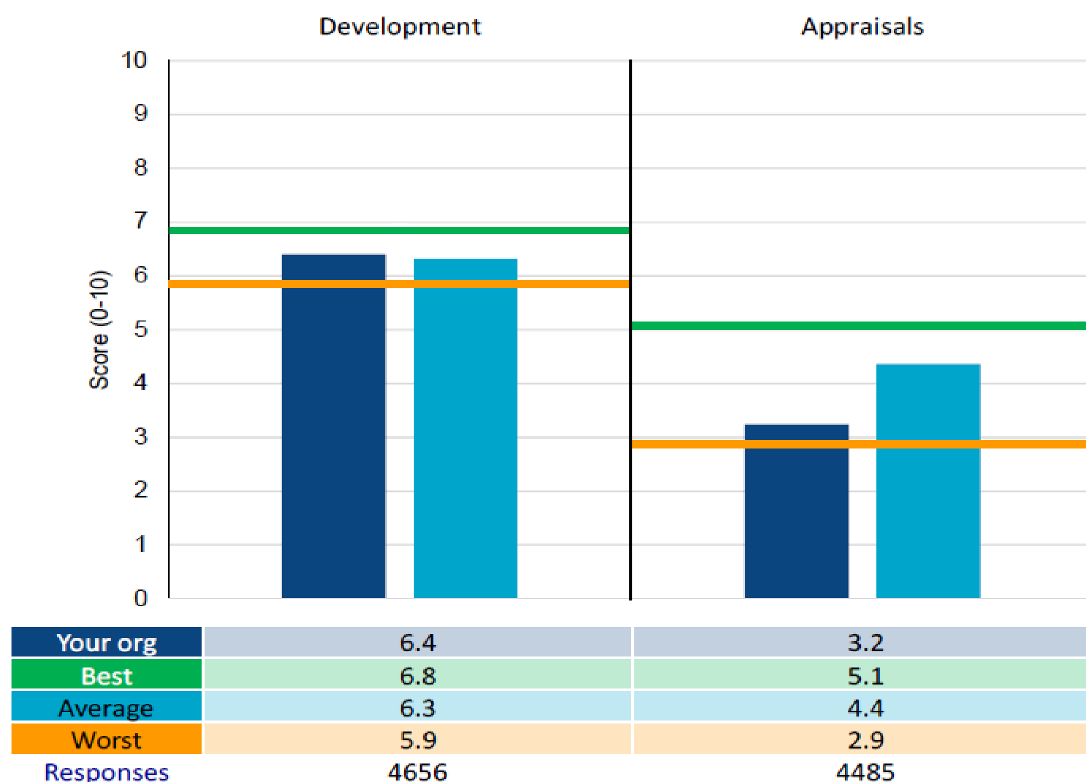
enables us to prioritise and focus on areas that will make a difference. This focus in detailed in 3.5 under the heading of Trustwide actions.

The Trust is now incorporating employee experience data and key workforce reporting metrics into organisational reporting at a team, divisional and trust level with an intent to report this via the cultural dashboard, which is due to go through it first review and update. This enables us to understand employee experience on a more continuous basis and amend plans and focus as new themes and trends emerge. That said it is important that the Trust can see action is undertaken and monitored to ensure that plans are working and that the Trust is actively enabling the 'Great Place to Work objective.

3.2 <u>We are always learning</u>

The initial report showed that the 'we are always learning' metric was the only People Promise area where the Trust scored below average nationally. Further analysis has been undertaken to better understand underlying causes for this.

Within the engagement survey the 'we are always Learning' section is broken into two areas, 'Development' and 'Appraisal'.



	Development	Appraisals
Your org	6.4	3.2
Best	6.8	5.1
Average	6.3	4.4
Worst	5.9	2.9
Responses	4656	4485

As can be seen from the above results, the Trust is slightly above the national average in relation to the development scores; however, is performing significantly below national average in relation to appraisals and only 0.3 points above the worst scoring Trust, impacting our overall 'we are always learning' score.

On further analysis, it is clear that colleagues do not feel current appraisals are supporting them in their everyday roles. This therefore requires significant focused activity to ensure that we are improving this score.

Following the April 2023 Board meeting the Trust reverted the appraisal cycle from 18-months back to 12-months as we believe this may be a contributory factor to the lower score and it is hoped that the change will positively impact the appraisal experience.

There is also a review of the current appraisal and one-to-one process planned in September 2023, which will include consultation and co-production with colleagues. Operational colleagues are also committed to creating more time to improve staff experience under this programme.

Best practice in this area is “little and often”. Evidence from NHS research describes that most organisations have implemented additional activities to enhance the annual appraisal and make a shift towards more meaningful dialogue. The review aims to identify how we take this approach and bring together Health and Wellbeing conversations, 1-2-1’s, objective setting and the traditional appraisal elements over the year. The findings of the review will be reported through the People Development Group up to PWPW.

3.3 Drop in survey scores for Northern Services

When reviewing the initial survey results, it is clear that the year on year annual survey scores in Northern Devon had dropped; however, the May 2023 IPR reported that the Q4 22/23 People Pulse survey did not indicate the same trend. The latest People Pulse survey was run in April and similarly does not show any significant declines in score. This People Pulse will be formally reported in the IPR at Board today; however, the trend analysis is also included in Appendix 1.

Whilst it is important to remember that the national staff survey and the People Pulse will not have the same response base, this would suggest that the timing of the National Staff Survey (November 2022) may have impacted the scores. This survey took place relatively soon after the launch of My Care and at a time when significant operational and staffing pressures were being experienced. So, whilst the complete picture cannot be assumed, there is reason to suspect the decline in experience score may potentially have been impacted by the time in which it was conducted. It is also important to note that the staff survey scores in northern services have historically remained high, reducing the scope for further improvement and making a decline in score more likely.

Whilst timing of the survey might have contributed to the decline in score and an obvious decline is not reflected in the latest people pulse surveys, it is important to recognise that the results from the staff survey and people pulse are not treated in the same way, therefore no assumptions should be made. With integration in mind, ongoing monitoring of the northern survey scores will be critical to ensure we are applying the right activities and interventions to gain improvements in both experience and engagement for our northern colleagues. It will be important to ensure the next staff survey results are measured against this years results, to ensure like for like comparison.

To further enable improvements, the Employee Experience Team will in partnership with People Business Partners and Northern divisional leadership run a programme of targeted engagement events throughout the year to enable staff to give feedback and suggestions on how to make improvements within their areas.

3.4 Staff experience of line managers

The Board requested further analysis to be undertaken in relation to how staff experience their line managers. The deep dive showed that for the majority of questions, there is no difference between how Northern and Eastern colleagues experience their line managers. There is, however, considerable variation in how different elements of the Trust experience their line manager. When looking at data by staff group, division and by demographic analysis the following key findings are apparent:

- Colleagues at band 2, 8d and medical and dental colleagues at all grades report a consistently poorer experience of their line managers, compared to the Trust average. It should be noted that the 8d group represents a relatively small number of individuals , furthermore much work has been undertaken to engage senior leadership, which may have resulted in positive changes since the point this survey was conducted. Colleagues at bands 6, 7, 8b & 8c report a more positive experience in comparison to the Trust average. The bands that are indicated in amber in the staff survey report are scoring in the mid-range for this question (3 percentage points above or below the rest of the organisation). The RAG report by banding can be found in the accompanying presentation.

- In Eastern services, the estates and facilities team shows significantly poorer experience for manager questions. It should be noted that Northern services does not have comparable data for estates and facilities at divisional level due to hierarchy structure; however, staff grouping breakdown shows that this experience is mirrored across the estates and facilities staff group. The northern surgery division is also an outlier, with comparative poor experience across all line management questions.

- In addition to Estates and Facilities (noted above), the following staff groups also scored poorly for management experience: Medical and Dental, Additional Professional, Scientific & Technical and Additional Clinical Services.

- Two age profiles showing the most significant differences and poorest levels of experience in this area are those aged 16-20 and 51-65.

- As reported in the inclusion reports in the May 2023 Board, staff identifying as gay or lesbian show improved staff experience, when compared to the other sexual orientation groups, including heterosexual or straight; however, staff preferring not to say their sexual orientation show less positive staff experience.

The Executive team discussed these themes in detail and explored proposals to address these areas. These are detailed later in this paper.

3.5 Action Plans

A process has been put in place by the Employee Experience team to enable plans and monitoring to operate at all levels within the Trust, from team level, all the way up to Executive Director level. Local engagement plans for individual teams have been created. An example plan is shown in Appendix 2.

Divisional Plans

Divisional leads have developed their plans with support from both staff experience colleagues and People Business Partners. In terms of governance, monitoring and assurance these will be reviewed within the divisional monthly PAF's. During this meeting key survey metrics and actions plans in the division will be shared and monitored for delivery and effectiveness on an ongoing basis.

Trustwide Actions

There are a number of Trustwide actions that have been developed in response to feedback from the Trustwide engagement events, which will be delivered in partnership between Trust SLT and the Employee Experience team and delivery

against these will be monitored through PWPW and will be regularly reported to Board. These are noted in Appendix 3:

Additionally, key areas of work indicated by the survey include:

- promoting a healthy work life balance;
- embedding a culture of recognition and ensuring our staff feel valued;
- preventing and controlling violence and aggression in the workplace.

These elements already form part of the Cultural Development Roadmap. The updated roadmap covering the next two years is in the final stage of development and the Board will have sight of this alongside the People and Culture Strategy. The Cultural Development Roadmap has executive oversight in all the areas covered and assessment of progress will be monitored through PWPW.

Executive Team Actions

Further to the executive discussion, a number of strategic level actions were agreed in relation to the Staff Survey, considering data from the more recent People Pulse survey. Four key areas have been focused on below, with a full action plan in Appendix 4.

- **Focus on areas where employees have had poorer experiences of line management**

  The Executive team will be overseeing progress in the four areas of focus from the deep dive (Northern Surgery, Facilities & Estates, Additional Professional, Scientific & Technical staff and Medical staff). Full details of scores in relation to the line management questions can be found in the accompanying presentation. The executive directors leading these areas will receive additional qualitative data to assess local action plans and to provide assurance that the right action is being taken. Where appropriate they will in August 2023 agree additional key actions with divisional/professional leads and oversee delivery.

- **Inclusion and behaviour**

  The inclusion strategy that is being developed, alongside the work on cultural development should be seeking to drive inclusion in all its forms, enabling improved psychological safety, line management and empowerment at all levels of the organisation, all of which are key to improving employee experience.

  The Board of Directors had committed, at the May 2023 Board inclusion discussion, that a much more focussed approach is needed to positively respond to improving the experience of inclusion within the Trust. An inclusion strategy and delivery plan is in development and a Board Development day has been held to gain full board engagement on our plan going forward. This will provide the necessary focus for the Equality Delivery Standard (EDS) that the Trust is required to undertake. The inclusion strategy and delivery plan is due to be presented to Board in Q2.

  Whilst this work is in development, the existing inclusion plans are continuing; delivering more inclusive processes. Inclusive leadership training is in place, bystander training is in development. Progress against these plans is discussed at the Inclusion Steering Group and will be monitored through PWPW

  Additionally, the executive team have recently discussed and agreed to the following commitments in relation to inclusion:

1. Openly talk about our concerns around exclusion in our work environment and whilst we have made progress, to openly talk about the ‘frozen tier’ and our commitment to address it;

2. Transparently share experiences and stories of exclusion that have been shared with us, use them as a catalyst for change and continue to call out all exclusive behaviour;

3. Name sexual harassment and lack of racial diversity as cultural concerns for our organisation impacting on the psychological safety of our people;

4. Support the violence and aggression work as it develops, recognising its connection to exclusion and psychological safety;

5. Endorse and promote the new inclusion policy statement and use it to inform decision making;

6. Ensure all strategies and integration plans are genuinely reviewed for equity risks and equality impact;

7. Review career progression metrics in our own professional areas, including demographic factors to determine areas where there is a lack of progression;

8. Support embedding the inclusive recruitment objectives into all recruitment process (much of this is in the process but not driven as a necessity);

9. Every executive director to be an executive sponsor of a network and/or a reciprocal mentor;

10. Undertake the Inclusive Leadership Programme and ensure all our reports/senior colleagues do the same.

Additionally, each Executive Director will have an inclusion objective related to their area of responsibility set as part of the annual appraisal cycle.

- **Improving response rates in Survey and People Pulse**

  The executive team were concerned by the significant drop in the response rate, and that the Royal Devon was below the national average. It was agreed that there is a real need to ensure that colleagues know how important their voice is. In response to this, the Executive Directors are committed to leading a campaign (supported by the Communications and Engagement team and the Employee Experience team) on the importance of staff voice. The campaign will run from August 2023 to September 2023. This campaign will actively use managers, staff networks, staffside and engagement channels to:

  - educate our staff on how to easily access all of our surveys;
  - articulate the importance of the staff survey and people pulse surveys, how they are used and how they inform the Board and support activity;
  - articulate the response plan to the staff survey demonstrating that we have listened to contributors’ voices and are taking robust action (details of this can be found further below in the report);
  - promote the anonymity of the survey to give staff confidence that the data is used for positive reasons.

- **Understanding the metric of receiving treatment**

  The Executive team felt that the Trust should aspire to all colleagues feeling confident about receiving treatment in the Trust. We would like this metric to be amongst the best in the country for the Trust. There will be further analysis on this metric, to understand which staff groups areas are reporting negatively and enable the Trust to promote its safety and quality metrics. It has been found previously that these scores are significantly lower in non-clinical groups due to lack of awareness of clinical and safety standards. Therefore, within the scoping of the improvements the Trust will consider how additional education and support can be provided to these groups to create greater understand and thus improve scores within these staff groups.

Trust Priority Areas for improvement

The Board of Directors are committed to being an integral part of improving the experience of the people who work for the Trust. There is an aspiration to improve on all areas of the People Promise year on year, as this is a key indicator of delivering on our 'Great Place to Work' objective. Through delivery of the afore mentioned Trustwide action plan and the Executive led actions, the Board of Directors aim to deliver an improvement through the delivery of the following objectives.

- Increased score on "if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation" (people pulse only. Further analysis of current score breakdown can be found in Appendix 5).
- Improved response rate overall in both people pulse and staff survey.
- Reduced 'do not wish to disclose' response in demographic categories; however, this is challenging to change and may take time to achieve.
- Improved overall experience for lower banded groups.
- Improved 'we are always learning' score.
- Additionally other metrics around wellbeing, attrition and retention should be positively influenced.

Tracking and monitoring of progress

Tracking and monitoring will take place through PAFs and the Employee Experience team. Compliance and themes, triangulated with people pulse results and other staff and patient experience information will be reported through PWPW, Governance Committee and the wider Board.

4. Resource/legal/financial/reputation implications

Clearly, there is a risk that if our employee experience scores reduce, that this will negatively impact our reputation as a desirable employer, which could also have a further impact in terms of capacity. Currently this is not something we are seeing evidence of, with vacancy rates having reduced in recent months and turnover on a downward trajectory.

Whilst this is not an issue that is apparent right now, it will be important to ensure any potential future risk is mitigated. To do this, it is essential that we effectively address the issues highlighted in this report, take meaningful action and ensure our staff are able to see positive change as a result of their feedback.

5. Link to BAF/Key risks

The NHS Staff Survey is explicitly referenced within the Board Assurance Framework in relation to capacity risks; however, also links through to a number of other risks, which would be impacted if levels of retention were to decrease.

6. Proposals

The Board are invited to endorse the approach and actions proposed within this paper.

Appendix 1 – People Pulse Trend Analysis

People Pulse and NHS Staff Survey Results (Q2 2022/2023 – Q1 2023/2024)

Eastern Services

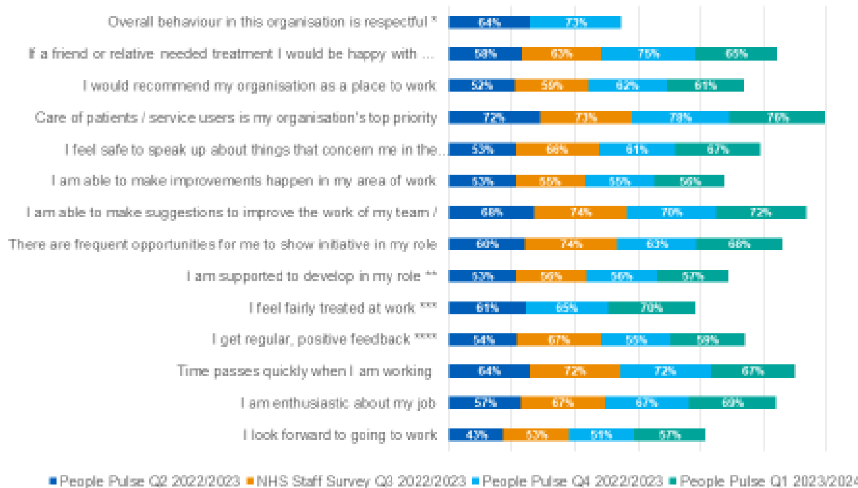
Please note, not all People Pulse questions directly correspond to NHS Staff Survey questions.

These are highlighted in the graph with asterixis, and details listed below:

* No comparable question within NHS Staff Survey
** Data taken from Staff Survey Q22d 'I feel supported to develop my potential'
*** No comparable question within NHS Staff Survey
**** Data taken from Staff Survey Q9b 'My immediate manager gives clear feedback on my work'

People Pulse and NHS Staff Survey Results (Q2 2022/2023 – Q1 2023/2024)

Northern Services



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**** Data taken from Staff Survey Q9b 'My immediate manager gives clear feedback on my work'

Appendix 2 – Example of Local Staff Survey Action Plan

Staff Survey 2022 – Review & Action Plan

Department/Team/Ward:	Responsible:	Date:
Physiotherapy Outpatients	Darren West	6-6-23

Checklist

Share and discuss your results with your team

Explore your results in more depth with your area – e.g. look at previous year's results, are there improvements or declines? How does the team feel about the results – any surprises? Thank team members for the feedback received and demonstrate commitment to making changes.

Celebrate successes

Highlight improvements on calls, during team meetings, post on newsletters/boards etc. Record these in the 'What we do well' section of the plan below.

Identify one or two areas for improvement that you would like to focus on longer term

Record this under the local actions section (additional areas can be included if you/your team are able to deliver the change). Remember to add to the 'We said, we did' section once complete.

Identify any changes made to address feedback

Record these under the 'We said, we did' section.
These can be quick wins – simple small adjustments or improvements to support staff feedback.

Return completed form to the Employee Experience team – by Fri 16 June 2023

Once the form has been completed, please send to the Employee Experience team (or for questions): **rduh.employee.experience@nhs.net**

How to find and use your results

All 2022 Staff Survey reports can be found on the new HUB.

If the breakdown you are looking for, e.g. Team / Department / Division has less than 11 responses, you will not be able to see your data, due to confidentiality rules:
These are represented as white cells with a * within the reports.
If your team / department is not included within a grouped team, please either use the grouped teams, if available (locality 4) or use your cluster or divisional results (locality 5).
For information on how to access and extract your results from the reports, please use this How to guide.

Our 2022 staff survey results

What we do well:	What we could improve:
1. Feel my role makes a difference to patients/service users (100%)	1. For the team to be able to make improvements happen in their area of work (MSK outpatients 44%) (Note that – "Able to make suggestions to improve the work of my team/dept" is 72%).
2. Have opportunities to improve my knowledge and skills (94%)	2. Able to meet conflicting demands on my time at work (MSK outpatients 17% able to meet, organisation 40% able to meet).

Local action plan

Objectives (what do you aim to achieve)	**Activities** (what will you do to achieve your objective)	**Responsibility** (who is responsible)	**Timing** (when will the activity take place and how often)	**Evaluation** (how will you measure success)
Suggestion 1: Cultivate an environment where staff feel the suggestions they make translated to actual service improvements.	Seek to gain a more in depth understanding of why the team do not feel they can make improvements **happen** despite feeling able to make suggestions. To discuss in Senior Team and locality meetings. Create an action plan dependant on results. Possible actions e.g. add team suggestion/improvement items to meeting agenda. Improvement/ suggestion communal white board on teams. Review of how suggestions translate into actions.	Named lead Darren West MSK Team	June 2024	The 2023 NHS Staff Survey, or locally run feedback.

Objectives (what do you aim to achieve)	**Activities** (what will you do to achieve your objective)	**Responsibility** (who is responsible)	**Timing** (when will the activity take place and how often)	**Evaluation** (how will you measure success)
Suggestion 2: To improve the team's ability to meet conflicting demands on my time at work	Seek to gain a more in depth understanding of why the team cannot meet conflicting demands on their time at work. Discuss at team meetings. Ensure we have a culture of trust and openness for people to raise concerns. Ensure the team have appropriate and realistic job plans in line with nationally agreed frameworks. Discuss job plan and staff well-being at supervision and D&R. To ensure that we are actively recruiting into vacancies to reduce pressure on clinical and admin teams.	Darren West MSK Team members.	Starting 1 July 2023	To look at data from the 2024 staff survey. To aim for a minimum of 40% at the next survey. Long term 2 years to aim for 70%?

We said, we did

By identifying the changes / improvements that have happened as a result of your teams' feedback from previous surveys, you can demonstrate that you are listening, and making the changes that truly make a difference.

We said….	We did….
1.	1.
2.	2.

Appendix 3 – Trustwide Action Plan

Trustwide Engagement Colleague Feedback	Action	Responsibility	Timescale
• The appraisal/PDR system does not help me to improve how I do my job, nor make me feel valued. • The appraisal needs to be less onerous – we (both managers and staff) need protected time for completing it	• Review the existing Learn+ Appraisal scheme, with a view to simplifying the tool	• People development team	• September 2023
• We have severe workload and capacity issues in some departments, which means conflicting demands, in some cases a cause of burnout. • We need manageable workloads	• We will continue to ask managers to prioritise filling vacancies in patient facing roles. • We will pilot staff retention initiatives, used at similar Trusts or external organisations	• People team SLT • Employee Experience team	• Ongoing with bimonthly reporting • November 2023
• I am a manager and I want to feel empowered	• Living the value of empowerment will be encouraged and supported by changing how we work and adopting a coaching culture	• Trust SLT	• November 2023
• In order to reset after Covid-19 and projects like MyCare and integration, we need protected time to prioritise our health and wellbeing	• Continued focus on ensuring staff can take regular breaks • Continue programme of rest space improvements • Provide training on wellbeing conversations • Run line manager idea generation sessions	• Trust SLT • Rest space group • People development team & OHWB team • Employee Experience team & OHWB team	• Ongoing with bimonthly reporting • Ongoing with bimonthly reporting • August 2023 • August 2023

Appendix 4 – Executive Level Action Plan

Area of Focus	Action	Responsibility	Timescale
Focus on areas of poorer employee experience	• Review of additional qualitative data in Northern Surgery, Facilities & Estates, Additional Prof Scientific and Technical staff and Medical staff to assess local action plans and provide assurance that the right actions are being taken. • Where appropriate agree additional key actions with divisional/professional leads and oversee delivery.	• Executive team	• August 2023
Inclusion and behaviour	• Inclusion strategy and delivery plan to be discussed and developed at the Board Development Day, including finalising a proposal for the Equality Delivery Standard (EDS). • Approval of inclusion strategy and delivery plan to Board of Directors. • Undertake proactive, frequent and direct engagement on inclusion. Specifically: o Leadership group work o #NHS75 o Heads of Department Forum on an ongoing basis • Adopt the executive inclusion commitments	• Royal Devon Board • Royal Devon Board • Executive team • Executive Team	• July 2023 • September 2023 • July 2023 • July 2023
Improving response rates in Survey and People Pulse	• Lead a campaign on the importance of staff voice.	• Executive team (supported by the Communications and Engagement team and the Employee Experience team)	• August 2023 to September 2023
Understanding the metric of receiving treatment	• Analysis of additional data relating to this metric to understand which staff groups areas are reporting negatively. • Once further analysis has been completed, consideration to be given to potential actions including additional education and support where required.	• Executive Team	• August 2023

Appendix 5 – Further analysis on receiving treatment scoring

YOUR ORGANISATION

q23d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.

	Organisation Overall		Royal Devon - Eastern Services		Royal Devon - Northern Services	
Option	Count	Percent	Count	Percent	Count	Percent
Strongly disagree	109	2%	64	2%	45	3%
Disagree	351	8%	209	6%	142	10%
Neither agree nor disagree	973	21%	643	20%	330	24%
Agree	2430	52%	1747	53%	683	50%
Strongly agree	784	17%	607	19%	177	13%
Total Responses	4647	100%	3270	100%	1377	100%

NHS
Royal Devon
University Healthcare
NHS Foundation Trust

NHS Staff Survey Results 2022

Findings from survey and employee listening sessions

Hannah Foster, Chief People Officer

Board of Directors - July 2023

Background

NHS
Royal Devon
University Healthcare
NHS Foundation Trust

The Board received its initial presentation of the results in April 2023.

In this initial discussion further insight and reporting was requested, to be included in a follow up report. This included feedback from the engagement events as well as the areas detailed below:

- the ‘we are always learning’ element of the staff survey, due to it being the only area where the Trust was lower than average;
- the noticeable drop in the northern scores against the year before;
- colleagues experience of their line management.

Trustwide Engagement

Royal Devon University Healthcare NHS Foundation Trust

Trustwide engagement took place through a number of forums including:

- presentation of results at trustwide meetings;
- engagement with Staffside and Partnership Forum;
- formal reporting at a number of committees;
- listening events in March 2023 for staff and managers;
- divisional level partner meetings;
- focused executive discussion.

Outcomes from Trustwide Engagement

Key themes that have emerged were:

- **appraisals** – less onerous, protected time to undertake and simplified
- **staffing** – filling vacant posts and improved staffing levels
- **manageable workload** - less project expectations
- **leadership** – empowering managers and making less short notice requests
- **learning and development** – Career pathways for all roles and more classroom based training
- **communication** – listening to staff and reassurance that things change when raised
- **health and wellbeing** – protected time to support staff health and wellbeing and provide end of shift huddles.

We Are Always Learning

Royal Devon University Healthcare NHS Foundation Trust

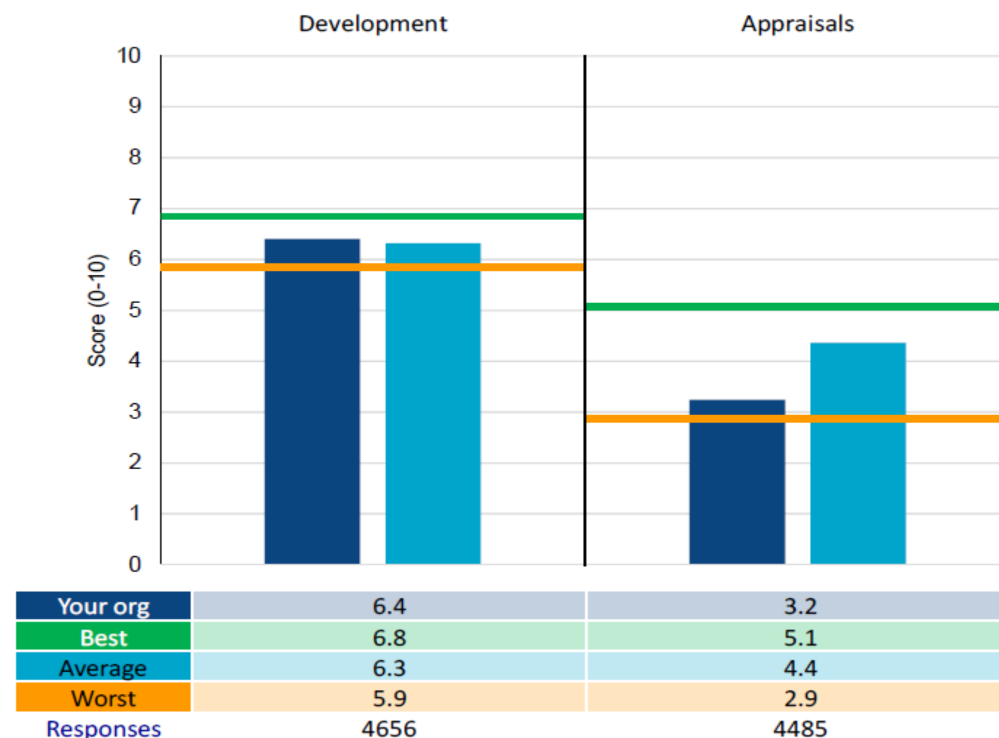
The 'we are always learning' section of the engagement survey is broken into two sections (development and appraisal).

- The Trust is slightly above the national average for development scores.

- However, significantly below national average in relation to appraisals impacting our overall 'we are always learning' score.

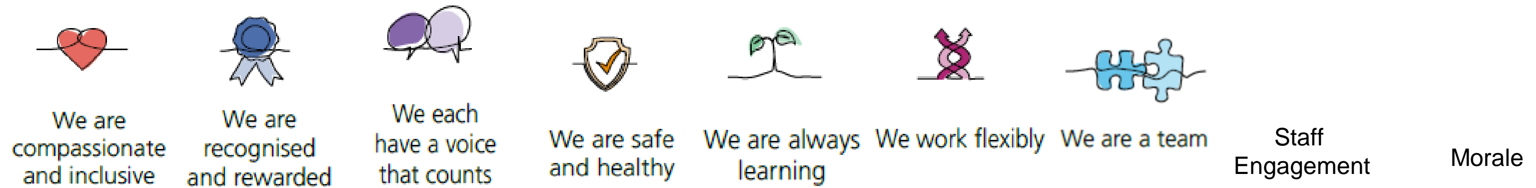
- Following the April 2023 Board, the Trust reverted the appraisal cycle from 18-months back to 12-months, as we believe this may be a contributory factor to the lower score.

- A review of the current appraisal and one-to-one process is planned in September 2023.



	Development	Appraisals
Your org	6.4	3.2
Best	6.8	5.1
Average	6.3	4.4
Worst	5.9	2.9
Responses	4656	4485

People Promise Element / Themes Scores



		We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Northern Services	2021	7.5	6.2	7.0	6.2	5.3	6.4	6.9	7.1	6.1
	2022	**7.4**	**6.1**	**6.7**	**6.0**	**4.9**	**6.3**	**6.8**	**6.8**	**5.9**

Scores for Northern services have declined across all promise elements / themes, with the most significant declines seen in 'we each have a voice that counts', we are always learning' and 'staff engagement' .

People Pulse and NHS Staff Survey Results (Q2 2022/2023 – Q1 2023/2024)

Royal Devon University Healthcare NHS Foundation Trust

Northern Services Analysis

Note, not all People Pulse questions directly correspond to NHS Staff Survey questions.

These are highlighted in the graph with asterixis, and details listed below:

* No comparable question within NHS Staff Survey

** Data taken from Staff Survey Q22d ‘I feel supported to develop my potential’

*** No comparable question within NHS Staff Survey

**** Data taken from Staff Survey Q9b ‘My immediate manager gives clear feedback on my work’

The drops in Staff Survey to Staff Survey are not reflected in the most recent People Pulse surveys; however it is important to note that the data is treated in a different way for the People Pulse and NHS Staff Survey, so it will be important to continue to monitor northern data, including the results of the next NHS Staff Survey to ensure like for like comparison.

Staff Experience of Line Managers - Overview

Further analysis undertaken about how staff experience their line managers showed:

- No significant difference between northern and eastern colleagues.
- Colleagues at band 2, 8d and medical and dental colleagues at all grades report a consistently poorer experience of their line managers, compared to the Trust average.
- Colleagues at bands 6, 7, 8b & 8c report a more positive experience in comparison to the Trust average.
- Significantly poorer experience for manager questions for estates and facilities staff.
- Poor levels of experience for staff aged 16-20 and 51-65.
- Improved experience for staff identifying as gay or lesbian, compared to the other sexual orientation groups, including heterosexual or straight; however, staff preferring not to say their sexual orientation show less positive staff experience.

The Executive team discussed these themes in detail and explored proposals to address these areas. These are detailed later in this presentation.

Staff Experience of Line Managers By Pay Band

NHS
Royal Devon University Healthcare NHS Foundation Trust

Section	Q	Description	Locality 6 Comparator (Organisation Overall) n = 4672	Band 2 n = 640	Band 3 n = 643	Band 4 n = 426	Band 5 n = 750	Band 6 n = 851	Band 7 n = 678	Band 8A n = 221	Band 8B n = 70	Band 8C n = 41	Band 8D n = 13
YOUR MANAGERS	q9a	Immediate manager encourages me at work	72.5%	60.8%	71.9%	72.0%	75.6%	78.4%	78.3%	73.6%	77.1%	82.9%	84.6%
	q9b	Immediate manager gives clear feedback on my work	63.3%	56.0%	65.9%	64.5%	65.7%	67.4%	67.1%	63.6%	68.6%	80.5%	46.2%
	q9c	Immediate manager asks for my opinion before making decisions that affect my work	59.9%	43.5%	59.2%	60.0%	57.9%	65.5%	70.2%	65.0%	72.9%	70.7%	69.2%
	q9d	Immediate manager takes a positive interest in my health & well-being	71.7%	60.3%	72.9%	74.8%	71.6%	77.8%	78.4%	74.5%	72.9%	85.4%	69.2%
	q9e	Immediate manager values my work	73.8%	63.3%	71.7%	73.4%	75.2%	79.1%	79.3%	76.4%	82.9%	87.8%	84.6%
	q9f	Immediate manager works with me to understand problems	70.0%	59.2%	69.0%	69.6%	70.1%	77.3%	76.6%	71.4%	78.6%	73.2%	61.5%
	q9g	Immediate manager listens to challenges I face	73.2%	60.7%	74.0%	72.9%	74.1%	79.0%	80.4%	74.5%	80.0%	82.9%	69.2%
	q9h	Immediate manager cares about my concerns	72.7%	61.8%	72.1%	71.1%	73.3%	78.6%	79.9%	72.6%	79.7%	85.4%	76.9%
	q9i	Immediate manager helps me with problems I face	67.4%	60.5%	70.4%	69.1%	66.3%	73.4%	70.0%	68.2%	69.6%	70.7%	53.8%

Section	Q	Description	Locality 6 Comparator (Organisation Overall) n = 4672	M&D Consultant n = 179	M&D Foundation Dr. n = 26	M&D Junior Doctor n = 72	M&D SAS Doctor n = 38
YOUR MANAGERS	q9a	Immediate manager encourages me at work	72.5%	59.0%	50.0%	60.9%	60.5%
	q9b	Immediate manager gives clear feedback on my work	63.3%	40.3%	46.2%	49.3%	52.6%
	q9c	Immediate manager asks for my opinion before making decisions that affect my work	59.9%	61.2%	42.3%	44.3%	50.0%
	q9d	Immediate manager takes a positive interest in my health & well-being	71.7%	55.1%	57.7%	50.0%	55.3%
	q9e	Immediate manager values my work	73.8%	66.3%	57.7%	65.7%	68.4%
	q9f	Immediate manager works with me to understand problems	70.0%	61.2%	50.0%	50.0%	67.6%
	q9g	Immediate manager listens to challenges I face	73.2%	65.0%	65.4%	52.9%	63.2%
	q9h	Immediate manager cares about my concerns	72.7%	63.5%	61.5%	60.0%	68.4%
	q9i	Immediate manager helps me with problems I face	67.4%	53.4%	53.8%	55.7%	60.5%

Poor experience of line managers for band 2 and medical and dental staff.

Mixed picture for band 8d staff, with significantly lower scores for feedback and support based questions.

Note that band's where staffing levels do not meet minimum threshold for analysis have not been included.

Those in amber reflect the mid range score (up to three percentage points above or below the Trust average).

Staff Experience of Line Managers By Division

NHS
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Section	Description	Comparator (Organisation Overall) n = 4672	185 Community Services Division n = 520	185 Corporate Services Division n = 452	185 Estates and Facilities Division n = 203	185 Medical Service Division n = 554	185 Nightingale Division n = 16	185 Operational Services Division n = 28	185 Research & Development Division n = 91	185 Specialist Services Division n = 855	185 Surgical Services Division n = 557
YOUR MANAGERS	Immediate manager encourages me at work	72.5%	78.4%	77.4%	59.1%	70.6%	75.0%	89.3%	83.5%	68.9%	69.8%
	Immediate manager gives clear feedback on my work	63.3%	68.7%	68.8%	52.2%	56.6%	68.8%	71.4%	68.1%	59.3%	61.1%
	Immediate manager asks for my opinion before making decisions that affect my work	59.9%	60.3%	66.4%	45.3%	56.4%	62.5%	71.4%	63.7%	59.6%	56.6%
	Immediate manager takes a positive interest in my health & well-being	71.7%	77.3%	78.3%	55.7%	68.7%	56.3%	82.1%	73.6%	69.3%	71.0%
	Immediate manager values my work	73.8%	77.2%	79.4%	59.4%	70.4%	68.8%	85.7%	80.2%	71.4%	73.2%
	Immediate manager works with me to understand problems	70.0%	72.1%	73.5%	58.4%	67.8%	68.8%	78.6%	72.5%	67.8%	68.6%
	Immediate manager listens to challenges I face	73.2%	76.1%	78.3%	60.6%	70.8%	68.8%	78.6%	80.2%	71.6%	72.4%
	Immediate manager cares about my concerns	72.7%	76.9%	78.1%	57.6%	70.3%	75.0%	75.0%	78.9%	70.9%	71.7%
	Immediate manager helps me with problems I face	67.4%	70.1%	73.2%	55.2%	67.6%	68.8%	78.6%	72.5%	62.5%	66.6%

Locality 2

Section	Description	Comparator (Organisation Overall) n = 4672	415 Clinical Support & Specialist n = 578	415 Corporate n = 358	415 Medicine n = 204	415 Surgery n = 245
YOUR MANAGERS	Immediate manager encourages me at work	72.5%	74.7%	76.5%	72.9%	66.5%
	Immediate manager gives clear feedback on my work	63.3%	68.8%	70.6%	68.0%	55.5%
	Immediate manager asks for my opinion before making decisions that affect my work	59.9%	64.3%	65.3%	62.1%	52.7%
	Immediate manager takes a positive interest in my health & well-being	71.7%	73.5%	77.2%	72.4%	64.1%
	Immediate manager values my work	73.8%	76.2%	79.6%	74.9%	67.2%
	Immediate manager works with me to understand problems	70.0%	73.5%	76.4%	73.8%	62.4%
	Immediate manager listens to challenges I face	73.2%	76.6%	78.7%	70.9%	63.7%
	Immediate manager cares about my concerns	72.7%	75.4%	76.6%	72.9%	64.5%
	Immediate manager helps me with problems I face	67.4%	71.1%	72.1%	67.0%	63.1%

Locality 2

Poor experience of line managers for eastern estates and facilities staff and northern surgical division.

Mixed picture for eastern clinical divisions (medical, surgical and specialist services),

Generally seeing positive scores across corporate services, operations, research and development, community and clinical support and specialist.

Those in amber reflect the mid range score (up to three percentage points above or below the Trust average).

Staff Experience of Line Managers By Staff Group

NHS
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Section	Description	Comparator (Organisation Overall)	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
	Staff group	n = 4672	n = 123	n = 631	n = 1607	n = 490	n = 173	n = 168	n = 317	n = 1160
YOUR MANAGERS	Immediate manager encourages me at work	72.5%	64.2%	68.7%	74.4%	80.0%	53.2%	71.3%	58.8%	76.3%
	Immediate manager gives clear feedback on my work	63.3%	54.5%	61.5%	66.0%	68.7%	49.7%	64.1%	44.1%	66.4%
	Immediate manager asks for my opinion before making decisions that affect my work	59.9%	52.0%	53.3%	61.8%	68.5%	40.5%	64.1%	54.1%	61.8%
	Immediate manager takes a positive interest in my health & well-being	71.7%	61.0%	68.2%	75.8%	80.1%	50.9%	71.9%	54.1%	73.3%
	Immediate manager values my work	73.8%	65.0%	68.9%	75.9%	80.6%	54.7%	78.3%	65.6%	76.0%
	Immediate manager works with me to understand problems	70.0%	61.0%	65.4%	71.4%	78.5%	56.4%	70.7%	58.5%	73.0%
	Immediate manager listens to challenges I face	73.2%	64.2%	68.9%	75.0%	80.6%	55.2%	79.6%	61.7%	75.7%
	Immediate manager cares about my concerns	72.7%	64.2%	69.0%	74.3%	81.6%	52.9%	75.8%	62.7%	74.7%
	Immediate manager helps me with problems I face	67.4%	60.2%	67.2%	69.7%	76.3%	52.9%	64.5%	54.5%	67.6%

Poor experience of line managers for:

- Estates and Ancillary
- Medical and Dental
- Additional Professional, Scientific and Technical
- Additional Clinical Services

Those in amber reflect the mid range score (up to three percentage points above or below the Trust average).

Staff Experience of Line Managers By Age

Royal Devon University Healthcare NHS Foundation Trust

Section	Description	Comparator (Organisation Overall) n = 4672	16-20 n = 26	21-30 n = 621	31-40 n = 1006	41-50 n = 1174	51-65 n = 1719	66+ n = 90
YOUR MANAGERS	Immediate manager encourages me at work	72.5%	65.4%	75.0%	77.2%	73.1%	68.8%	71.9%
	Immediate manager gives clear feedback on my work	63.3%	61.5%	65.4%	66.2%	64.4%	60.7%	58.4%
	Immediate manager asks for my opinion before making decisions that affect my work	59.9%	57.7%	62.1%	63.8%	62.0%	55.4%	62.9%
	Immediate manager takes a positive interest in my health & well-being	71.7%	69.2%	73.4%	73.7%	73.2%	69.0%	75.3%
	Immediate manager values my work	73.8%	69.2%	77.2%	76.3%	74.9%	70.7%	76.4%
	Immediate manager works with me to understand problems	70.0%	57.7%	72.7%	74.3%	71.8%	65.8%	70.8%
	Immediate manager listens to challenges I face	73.2%	73.1%	75.6%	76.3%	74.2%	69.9%	77.5%
	Immediate manager cares about my concerns	72.7%	80.8%	76.6%	76.0%	73.7%	68.7%	71.9%
	Immediate manager helps me with problems I face	67.4%	61.5%	71.8%	70.4%	68.8%	63.4%	71.6%

Staff Experience of Line Managers By Sexual Orientation

NHS
Royal Devon University Healthcare
NHS Foundation Trust

Section	Description	Comparator (Organisation Overall)	Heterosexual or straight	Gay or Lesbian	Bisexual	Other	I would prefer not to say
	Sexual orientation (q28)	n = 4672	n = 4126	n = 102	n = 89	n = 18	n = 290
YOUR MANAGERS	Immediate manager encourages me at work	72.5%	72.9%	79.4%	71.6%	83.3%	65.2%
	Immediate manager gives clear feedback on my work	63.3%	64.0%	66.7%	60.2%	72.2%	54.0%
	Immediate manager asks for my opinion before making decisions that affect my work	59.9%	61.2%	60.8%	51.7%	44.4%	46.2%
	Immediate manager takes a positive interest in my health & well-being	71.7%	72.7%	75.5%	64.0%	72.2%	59.5%
	Immediate manager values my work	73.8%	74.6%	78.2%	75.3%	77.8%	62.4%
	Immediate manager works with me to understand problems	70.0%	70.9%	76.5%	67.4%	66.7%	57.2%
	Immediate manager listens to challenges I face	73.2%	74.0%	81.4%	74.2%	72.2%	60.3%
	Immediate manager cares about my concerns	72.7%	73.4%	80.4%	74.2%	72.2%	59.9%
	Immediate manager helps me with problems I face	67.4%	68.4%	72.5%	62.9%	72.2%	54.5%

- As reported in the inclusion reports in the May 2023 Board, staff identifying as gay or lesbian show improved staff experience, when compared to the other sexual orientation groups, including heterosexual or straight.
- Staff preferring not to say their sexual orientation show less positive staff experience.

Action Plans

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Action plans are being put in place at all levels of the Trust in response to the results of the staff survey. These are broadly as follows:

Divisional Actions

- Divisional leads have developed their plans
- Monitoring will be through divisional monthly PAF's

Trustwide Actions

- Developed in response to feedback from listening events
- Delivery will be in partnership with leadership team
- Monitoring will be through PWPW and Board

Executive Actions

- Strategic actions with specific areas of focus:
  - Areas of poorer employee experience
  - Inclusion and behaviour*
  - Improving response rates
  - Understanding the metric around receiving treatment

*The Board has development day on inclusion will agree its Board priorities on inclusion for Equality Delivery System (EDS). This will create additional plans.

Executive Inclusion Commitments

NHS
Royal Devon
University Healthcare
NHS Foundation Trust

1. Openly talk about our concerns around exclusion in our work environment and whilst we have made progress, to openly talk about the 'frozen tier' and our commitment to address it;
2. Transparently share experiences and stories of exclusion that have been shared with us, use them as a catalyst for change and continue to call out all exclusive behaviour;
3. Name sexual harassment and lack of racial diversity as cultural concerns for our organisation impacting on the psychological safety of our people;
4. Support the violence and aggression work as it develops, recognising its connection to exclusion and psychological safety;
5. Endorse and promote the new inclusion policy statement and use it to inform decision making;
6. Ensure all strategies and integration plans are genuinely reviewed for equity risks and equality impact;
7. Review career progression metrics in our own professional areas, including demographic factors to determine areas where there is a lack of progression;
8. Support embedding the inclusive recruitment objectives into all recruitment process (much of this is in the process but not driven as a necessity);
9. Every executive director to be an executive sponsor of a network and/or a reciprocal mentor;
10. Undertake the Inclusive Leadership Programme and ensure all our reports/senior colleagues do the same.

Additionally each Exec will have an inclusion objective set as part of the annual appraisal cycle related to their area of accountability.

Trustwide Action Plan Overview

Royal Devon University Healthcare NHS Foundation Trust

Trustwide Engagement Colleague Feedback	Action
The appraisal/PDR system does not help me to improve how I do my job, nor make me feel valued. The appraisal needs to be less onerous – we (both managers and staff) need protected time for completing it.	• Review the existing Learn+ Appraisal scheme, with a view to simplifying the tool
We have severe workload and capacity issues in some departments, which means conflicting demands, in some cases a cause of burnout. We need manageable workloads.	• We will continue to ask managers to prioritise filling vacancies in patient facing roles. • We will pilot staff retention initiatives, used at similar Trusts or external organisations
I am a manager and I want to feel empowered.	• Living the value of empowerment will be encouraged and supported by changing how we work and adopting a coaching culture
In order to reset after Covid-19 and projects like MyCare and integration, we need protected time to prioritise our health and wellbeing.	• Continued focus on ensuring staff can take regular breaks • Continue programme of rest space improvements • Provide training on wellbeing conversations • Run line manager idea generation sessions

Executive Action Plan Overview

Royal Devon University Healthcare NHS Foundation Trust

Area of Focus	Action
Focus on areas of poorer employee experience	• Review of additional qualitative data in Northern Surgery, Facilities & Estates, Additional Prof Scientific and Technical staff and Medical staff to assess local action plans and provide assurance that the right actions are being taken. • Where appropriate agree additional key actions with divisional/professional leads and oversee delivery.

Inclusion and behaviour	• Inclusion strategy and delivery plan to be discussed and developed at the Board Development Day, including finalising a proposal for the Equality Delivery Standard (EDS).
	• Approval of inclusion strategy and delivery plan to Board of Directors.
	• Undertake proactive, frequent and direct engagement on inclusion. Specifically:
	  ○ Leadership group work
	  ○ #NHS75
	  ○ Heads of Department Forum on an ongoing basis

Improving response rates in Survey and People Pulse	• Lead a campaign on the importance of staff voice.
Understanding the metric of receiving treatment	• Analysis of additional data relating to this metric to understand which staff groups areas are reporting negatively. • Once further analysis has been completed, consideration to be given to potential actions including additional education and support where required.

Employee Experience Data Cycle

Royal Devon University Healthcare NHS Foundation Trust

People Pulse Monitoring

- Survey conducted
- Results available much more quickly, as locally available
- Analysis of data to understand any significant changes requiring action
- Data included in cultural dashboard to enable benchmarking
- Cultural dashboard shared with Board and results included in all staff comms

Surveys Conducted

Quantitative information via Workforce dashboards e.g. turnover, attrition, demography, wellbeing, V&A reporting

Qualitative information e.g. FTSU, Staff incident review group, webinars, staffside , staff networks, exit questionnaires

Staff Survey Monitoring

- Survey conducted
- Results released to managers, staff & reviewed by Board
- Action plans developed at all levels of the Trust
- Actions undertaken & monitored through governance structure
- You said, we did to demonstrate the actions taken from previous years survey

Understanding the experience of our people to inform actions

Governance & Monitoring

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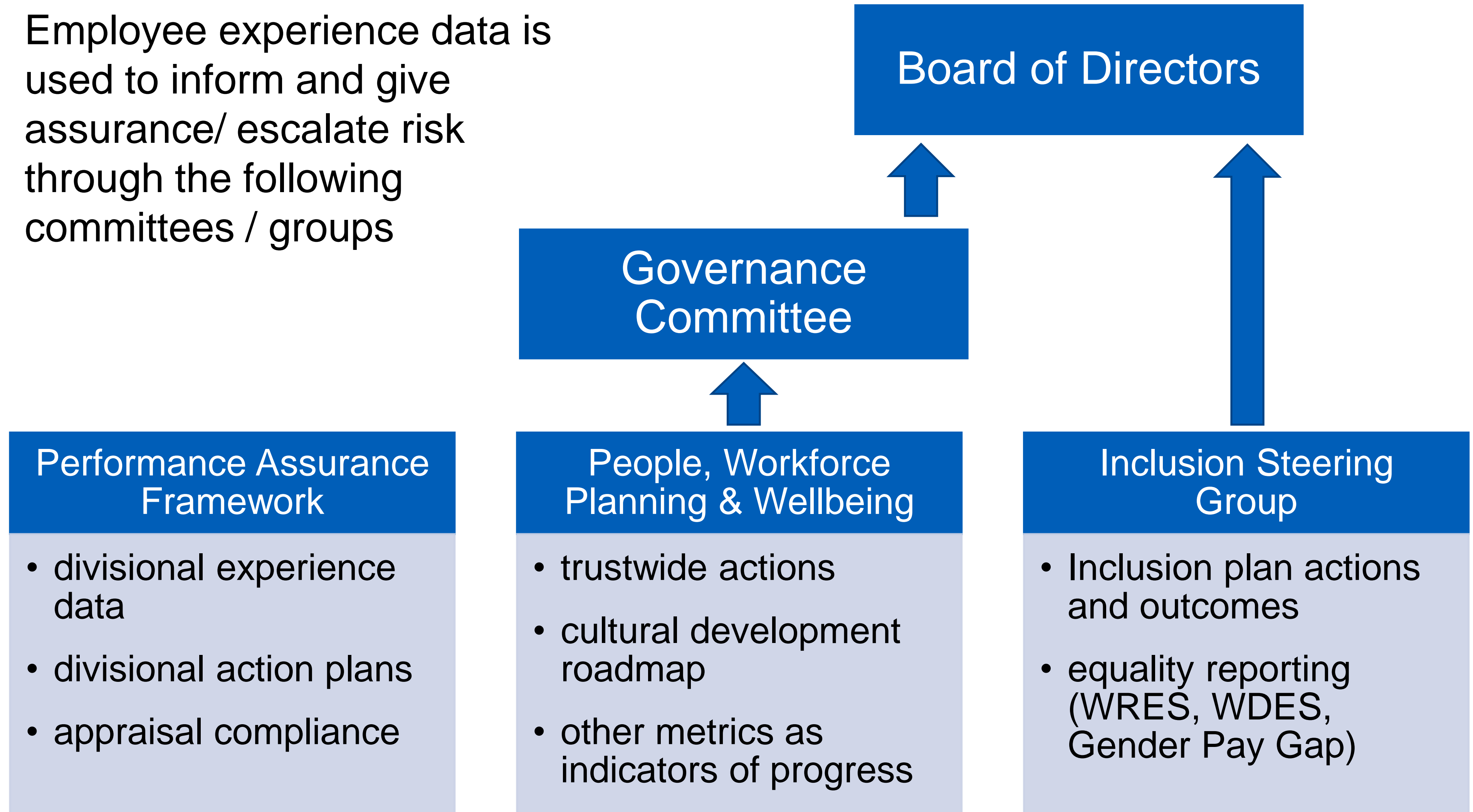

Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	11.2, Public Board Meeting	**Date:** 26 July 2023	
Title:	Directors of Infection Prevention and Control (DIPC) Royal Devon Annual Report 2022-2023		
Prepared by:	Judy Potter, Lead Nurse/Joint DIPC (now retired) – Eastern Services Fiona Baker, Lead Nurse IPC – Northern Services Mel Burden Consultant Nurse and Joint DIPC Eastern Services George Trafford - David Richards -		
Presented by:	Carolyn Mills, Chief Nursing Officer		
Responsible Executive:	Carolyn Mills, Chief Nursing Officer		
Summary:	The publication of the Directors of Infection Prevention and Control (DIPC) Annual Report is a requirement to demonstrate good governance, adherence to Trust values and public accountability. This report informs patients, public, staff, the Board of Directors, Council of Governors and NHS Devon of the infection prevention and control work undertaken in 2022-23, the management arrangements, the state of infection prevention and control within Royal Devon University Healthcare NHS Foundation Trust (RDUH) and progress against performance targets.		
Actions required:	The Board of Directors are asked to note the content of the report, the work being undertaken ensure compliance with the Hygiene Code, consider its relevance to the strategic objectives of the Board and formally approve the 2022-2023 RDUH Annual Report		
Status (x):	Decision	Approval	Discussion	Information
			X	X
History:	This is the first annual report of the Directors of Infection Prevention and Control (DIPC) for RDUH.		
Link to strategy/ Assurance framework:	The issues discussed with the Annual Report are key to the Trust achieving its strategic objectives and compliance with The Health and Social Care Act (2008): Code of Practice on the Prevention and Control of Infections and Related Guidance		

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Monitoring Information

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

Care Quality Commission Standards	Outcomes	Reg 12 and 15	
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)* The Health and Social Care Act (2008): Code of Practice on the Prevention and Control of Infections and Related Guidance			✓

1. Purpose of paper

1.1 The purpose of this paper is to provide assurance to the Board of Directors that the Trust strives to achieve high levels of compliance with The Health and Social Care Act (2008): Code of Practice on the Prevention and Control of Infections and Related Guidance (Department of Health, 2015) and that where gaps exist, that these are highlighted and reasonable mitigations implemented, where practicable to do so.

2. Background

2.1 The Health and Social Care Act (2008): Code of Practice on the Prevention and Control of Infections and Related Guidance (also known as the Hygiene Code) requires Directors of Infection Prevention and Control (DIPC) in organisations which provide health and social care to produce an annual report on the state of healthcare associated infections within their organisation and to release it publicly

3. Analysis

3.1 The DIPC annual report is mapped to the ten criteria associated with the Code and takes the opportunity to celebrate successes, summarise key issues and risks. The Trust is fully compliant with nine of the ten criterion and there are no risks on the Trust corporate risk register related to IPC.

4. Resource/legal/financial/reputation implications

Nil

5. Link to BAF/Key risks

5.1 No links to BAF or risks have been identified.

6. Proposals

6.1 The Board of Directors are asked to note the content of the report, the work being undertaken to ensure compliance with the Hygiene Code, consider its relevance to the strategic objectives of the Board and formally approve the 2022-2023 DIPC Royal Devon Annual Report.

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NHS Foundation Trust

Infection Prevention and Control Annual Report 2022-2023

Royal Devon University Healthcare
NHS Foundation Trust

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EXECUTIVE SUMMARY

This is the first annual report of the Directors of Infection Prevention and Control (DIPC) for the Royal Devon University Healthcare NHS Foundation Trust (RDUH) which was established in April 2022, The publication of the DIPC Annual Report is a requirement to demonstrate good governance, adherence to Trust values and public accountability (Dept. of Health, 2004).

The purpose is to provide assurance that the Trust strives to achieve high levels of compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Department of Health, 2015) and that where gaps exist these are highlighted.

The full report is mapped to the ten criteria associated with the Code and takes the opportunity to celebrate successes and highlight the increasing challenges going forward:

1. COVID-19 has remained a significant issue within healthcare. COVID control measures remained in place for the NHS for much of the year although the success of the COVID-19 vaccination programme, availability of effective COVID treatments and the current prevalence of less virulent strains of COVID-19; allowed small but incremental reductions to control measures. The national direction has been to change the emphasis from 'COVID control' back to a much broader approach of infection prevention and control (IPC) in recognition that all healthcare associated infection must be minimised and this is welcomed. As national guidance has been amended and in response to local prevalence, changes have also been implemented within the Trust.

2. Work commenced during 2022-23 to align arrangements for managing and monitoring the prevention and control of infection within the newly integrated Trust. In particular a Trust wide assurance group, Infection Prevention and Decontamination Assurance Group (IPDAG), has been established and replaces the two separate groups associated with the previous organisations. This is chaired by the Executive lead for healthcare associated infections.

3. The Antimicrobial Stewardship Group, one of the sub groups which report to IPDAG, has also been established as a Trust wide group. Water Safety and Ventilation Group and the Decontamination Operational Group will be merged in 2023.

4. From a clinical perspective, there is evidence of good practice and but also areas for improvement:

   - There have been only two healthcare associated MRSA bacteraemias in 2022-23, one was hospital onset and the other community onset. Both have been determined to be unavoidable via a multi-disciplinary post infection review.
   - The Trust reported seventy eight cases of healthcare associated *Clostridioides difficile* infection giving a rate of infection of 21.5 per 100,000 occupied bed days which is lower than the regional and national rates.
   - Low rates of orthopaedic surgical site infection have been reported for Princess Elizabeth Orthopaedic Centre, South West Ambulatory Orthopaedic Centre and North Devon District Hospital.
   - A voluntary Trust wide point prevalence survey of all healthcare associated infection and antimicrobial usage was undertaken at the end of 2022. The UKHSA protocol from the national survey in 2016 was used to allow comparison with local prevalence rates in 2016. The rate for Northern Services has improved considerably and is now much lower than the 2016 national rate. The rate for Eastern Services has remained below the

national rate and has not changed significantly since 2016.

5. The rate of E. coli blood stream infections which is significantly higher than both the South West and national rates and will be a focus for improvement work included within the 2023/24 IPC programme of work. Advice has already been sought from the Integrated Care Board Infection Prevention and Control Lead and NHSE South West IPC Lead. In correlation with COVID-19 lockdowns and other restrictions in the community in 2020 and 2021 was the reduction in both other respiratory viral infections, in particular influenza, and gastrointestinal viruses such as norovirus. With a return to normality in work and social activities in the community, these viruses have once again taken their place in the population and consequently in our hospitals. This has resulted in outbreaks particularly on the Royal Devon and Exeter site and added to the significant pressures the Trust has experienced particularly over the winter months.

6. Trust Estates and Facilities services continue to work hard to maximise Trust compliance with Criterion 2 of the Code of Practice. The Trust has allocated resources in its 23/24 operating plan ensure meeting t new National Cleaning Standards (2021)

7. Processes for the decontamination of medical devices, reusable invasive instruments and hospital linen are all undertaken to national standards.

8. The Trust has safe water systems at the main sites and in premises administered by the Trust, including the Nightingale. The planned programme of work to ensure that any concerns are identified promptly has been effective and where issues have been identified, they have been resolved efficiently.

9. A review of the delivery of infection prevention and control training to all staff was completed in 2022. This concluded that the National Health Education e-learning programmes at level 1 for non-patient facing staff and level 2 for patient facing staff would be adopted. These have been designed to meet the relevant learning outcomes in the UK Core Skills Training Framework. Some key groups require face to face training in addition to e-learning and this is being addressed following the publication a new national framework for IPC education.

10. Lack of single room facilities is a recognised risk on both sites. This is partly mitigated from an IPC perspective through the use of cohort bays, wards and some portable isolation units for critical care areas.

11. The Trust Occupational Health service remains critical in the delivery of both routine staff health surveillance and vaccination services and has met the additional requirements placed on it in relation to the changes around COVID-19 management.

12. Uptake of influenza immunisation at 61.2% with 6,456 vaccinations administered is lower than last year; this aligns with the wider rate reflective across the NHS.

INTRODUCTION

This is the first annual report of the Directors of Infection Prevention and Control (DIPC) for the Royal Devon University Healthcare NHS Foundation Trust. The publication of the DIPC Annual Report is a requirement to demonstrate good governance, adherence to Trust values and public accountability (Dept of Health, 2004). The purpose is to provide assurance that the Trust maintains high levels of compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Department of Health, 2015) therefore the report is mapped to the ten criteria associated with the Code (refer Table 1).

The establishment of the Royal Devon University Healthcare NHS Foundation Trust in April 2022 brought together the expertise of both the Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as Eastern Services) and Northern Devon Healthcare NHS Trust (hereafter referred to as Northern Services). Both Eastern and Northern Services have separate and experienced Infection Prevention and Control Teams (IPCTs) but they have worked collaboratively, insuring an aligned approach where this has been appropriate. Integration of governance arrangements, training and policies started during 2022 -23 and will continue going forward through the 2023-24 Royal Devon IPC programme of work.

COVID-19 has remained a significant feature within healthcare, particularly for in-patient settings. Although COVID restrictions were removed for the general population, COVID control measures remained place for both patients and staff, including testing, for much of the year. As the year progressed with the success of the COVID-19 vaccination programme, availability of effective COVID treatments and the current prevalence of less virulent strains of COVID-19, multiple small but incremental reductions to control measures were made. Indeed, the national steer has been to change the emphasis from 'COVID control' back to a much broader approach of infection prevention and control (IPC) in recognition that all healthcare associated infection must be minimised.

To that end the first National Infection Prevention and Control Manual in England has been published (NHSE 2022a) and now replaces COVID specific infection prevention guidance. This has been routinely updated since its first publication in April 2022. Similarly, a broader Board Assurance Framework has replaced the COVID specific Board Assurance Framework (NHSE, 2022b).

At the same time as implementation of local changes associated with integration and adopting new national guidance, the Royal Devon has been challenged to restore and recover elective services and reduce backlogs for treatments in line with both system-wide and national NHS expectations. This combination has placed considerable pressure on bed capacity, patient flow and staffing. Increased workload and pressurised staffing is known to impact negatively on infection prevention and control practices and is associated with increased infection rates. Therefore, this report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical who play a vital role in responding to such unprecedented challenges and to minimise infection risk to patients through a difficult year.

The authors would like to express their appreciation and thanks to all those that helped the Trust meet the demands of the last year as well as acknowledging the contribution of other colleagues to this report.

Table 1. The Hygiene Code Compliance Criteria and Trust compliance summary

Fully compliant	Partial compliance	Non-compliant (NC)

No	Criterion	
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them	
2	The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	
3	Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance	
4	The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion..	
5	That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people	
6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	
7	The provision or ability to secure adequate isolation facilities due to limited side room capacity (known risk) *which will only be mitigated by future estates work/New Hospital Programme (North)*	
8	The ability to secure adequate access to laboratory support as appropriate	
9	Registered provider has and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infection	
10	Service providers will have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control..	

1. Systems to manage and monitor the prevention and control of infection.

The Trust has ensured that management and monitoring arrangements are in place following the Trust being established in April 2022, full integration of all aspects of IPC will be delivered through a post transaction implementation plan

1.1 Governance arrangements

1.1.1 The Trust wide Infection Prevention and Decontamination Assurance Group (IPDAG) was established in November 2022; prior to which pre-merger arrangements remained in place with separate assurance groups for Northern and Eastern Services. IPDAG is chaired by the Executive Lead for Healthcare Associated Infection. Membership ensures representation from support services and senior clinical colleagues. The group meets quarterly and reports to the Board of Directors through the Governance Committee via the Safety and Risk Committee sub-group report highlighting concerns, risks and gaps in assurance.

The Trust currently a historical differential arrangement for DIPC across North and East services, this will move to one arrangement in 2023.

1.2 Risk assessment

1.2.1 The Trust has in place suitable and sufficient assessment of risks to patients receiving healthcare with respect of healthcare associated infection (HCAI). These are benchmarked against national best practice, clinical judgment and local risk assessment. The Trust monitors risks of infection through data collection, audit and review of clinical incident reporting. These findings and a review of current risk assessments are reported to the IPDAG and the findings are used to inform future actions and strategy.

1.2.2 Corporate and local HCAI risk assessments are available on the Trust's Corporate Risk Register and the risk rating report for high risks is reviewed on a quarterly basis by the Safety and Risk Committee. Existing control measures and further preventative measures are identified for action and monitored through divisional governance meetings. A Trust wide risk assessment for healthcare associated infection has been completed towards the end of 2022-23 and was approved at IPDAG in April 2023; allowing the closure of historical COVID risk assessments.

1.2.3 The Trust has a robust incident reporting system through which staff can report adverse incidents such as deviation from a clinical guideline or poor practice that may be detrimental to patient care. The IPC teams have oversight of infection prevention incidents reported and provide expert guidance and advice as required to mitigate any further risk or patient harm. Ownership of clinical incidents reported usually remain with the Divisions in which they have occurred and the Divisions provide assurance to IPDAG about significant investigations and share key learning.

1.2.4 Outbreaks are also reported on the incident reporting system. This does not necessarily mean that the outbreak could have been prevented but they are reported in this way because of the impact that outbreak control measures have on bed availability and patient flow. Outbreaks recorded in 2022-23 are summarised in section 1.5.

1.3 Infection Prevention and Control Teams (IPCTs)

1.3.1 Both Northern and Eastern Services have established Infection Prevention and Control Teams with experienced leadership. Since Trust integration, teams have worked collaboratively and will be fully merged in 2023.

1.3.2 Through commissioned arrangements and service level agreements, the IPCTs also deliver services to Devon Partnership Trust and through the Community Infection Management Service to care homes and primary care services. The IPCTs also provide advice and guidance to the Exeter Nightingale Hospital, Sexual Assault Services and the DCC Public Health Nursing Team.

1.3.3 Three of the medical microbiologists work collaboratively to fulfil the role of Infection Control Doctors (ICD) with one based at the North Devon District Hospital site and two at the Royal Devon and Exeter Hospital site. One of the Eastern Services ICDs also provides an ICD role under the service level agreement with DPT.

1.3.4 The antimicrobial stewardship team is led by a Consultant Medical Microbiologist with PAs identified for antimicrobial stewardship activities. Working collaboratively, the Consultant Medical Microbiologist and Antimicrobial Pharmacists provide leadership to influence and promote the safe and effective use of antimicrobials across the Trust, in accordance with local and national guidelines.

1.3.5 The Antimicrobial Stewardship Group (ASG) is tasked with ensuring that antimicrobial drugs are utilised throughout the Trust in a way which results in optimal treatment of infections while minimising the risk of adverse effects, including healthcare associated infections. The group is chaired by a Consultant Medical Microbiologist and reports to Infection Prevention and Decontamination Assurance Group (IPDAG).

1.3.6 Annual programmes of work for 2022-23 were prepared by the IPCTs, and ratified by the Board of Directors. The programmes of work are mapped to the duties of the Code of Practice thus demonstrating the Trust's continued work to maintain compliance with the Code. Programmes included all planned aspects of IPC, including provision of clinical advice, policy development and review, training and audit and surveillance, monitored through a quarterly report to IPDAG.

1.4 Surveillance of Healthcare Associated Infections

1.4.1 Surveillance of infection is more than just monitoring and reporting of infections. The component of surveillance to affect improvement is feedback to clinicians. Surveillance, together with clinical audit, provides invaluable data which highlight good practice and areas for improvement and is a vital component of the IPC programme.

1.4.2 Some surveillance data is only reported internally and other data are reported externally, either as part of mandatory or voluntary surveillance schemes and provides opportunities for benchmarking. Mandatory surveillance data is reported through IPDAG to the Safety and Risk Committee and also directly to the Board of Directors, through the monthly Integrated Performance Report. However, the most important element of surveillance is feedback to clinicians. Feedback prompts review of, and where necessary, planned improvements to clinical practice.

1.4.3 Key components of the surveillance programme are identified in the following sections 1.6-1.8.

1.5. Mandatory Surveillance of Blood stream infections and ***Clostridioides difficile***

1.5.1 Mandatory reports on the following are made to the UK Health Security Agency (UKHSA) utilising web-based surveillance data capture systems:

- *Staphylococcus aureus* blood stream infections
    - Methicillin Resistant *Staphylococcus aureus* (MRSA)
    - Methicillin Sensitive *Staphylococcus aureus* (MSSA)
- *Escherichia coli, Klebsiella and Pseudomonas* blood stream infections (collectively known as Gram negative bloodstream infections (GNBs))
- *Clostridioides difficile* infection

1.5.2 For each type of blood stream infection and *Clostridium difficile* infection, cases are defined as to whether they are healthcare associated or not. For those that are health care associated they may be further defined as being:

Hospital onset healthcare associated (HOHA) - if identified on or after 3 days of admission where day 1 is the day of admission.

Community onset healthcare associated (COHA - not categorised as HOHA but discharged from hospital in the previous 28 days (including day case and Emergency Department visits).

Infections identified that are not healthcare associated are defined as Community onset community associated (COCA)

1.5.3 Under the NHS Standard Contract, requirements are set to minimise *C. difficile* infection and gram negative blood stream infections to threshold levels set by NHS England. Thresholds are based on the number of infections reported not rates of infection. For 2022/23, trust-level thresholds comprise total healthcare-associated cases (i.e. HOHA and COHA). Table 2 shows the threshold counts for this Trust, number of actual cases and rates per 100,000 occupied bed days and comparisons to regional and national rates.

Table 2: Summary of Trust, South West & National cumulative GNB and *c.difficile* data

	Threshold count	No. of cases HOHA + COHA	Royal Devon rate	South West rate	National rate
Clostridioides difficile	65	78	21.05	26.99	23.47
Escherichia coli	172	201	53.97	33.92	31.82
Klebsiella spp.	46	63	16.89	11.09	13.45
Pseudomonas	18	23	6.16	5.05	5.89

Source: Field Epidemiology South West, Public Health England (2023)

1.5.4 Although above the threshold count, it should be noted that the rate of *C. difficile* infection is below the regional and national rate. Of concern is the rate of *E. coli* blood stream infections which is significantly higher than both the South West and national rates and will be a focus for improvement work in 2023/24 monitored through the 2023-24 IPC programme of work, via IPDAG. The IPCTs have already sought advice from the Integrated Care Board IPC lead and NHSE South West IPC lead.

1.5.5 Whilst MSSA surveillance is mandatory, threshold levels are not set by NHS England. Performance and comparison with regional and national rates is shown in Table 3. A zero tolerance approach to MRSA blood stream infections continues and Trust rates are below the regional and national average. However, the MSSA rate is higher than regional and national rates. This requires focused work to achieve improvements and is included in the 2023-24 programme of work.

Table 3: Summary of Trust and South West Staphylococcus aureus data

	2022/23 Threshold count	No. of cases HOHA + COHA	Royal Devon rate	South West rate	National rate
MRSA	Zero	2	0.56	1.0	0.94
MSSA	No nationally set threshold	97	26.12	16.61	13.22

Source: Field Epidemiology South West, Public Health England (2023)

1.6 Orthopaedic Surgical Site Infection (SSI)

1.6.1 It is also a mandatory requirement to conduct surveillance of orthopaedic surgical site infections (SSI), utilising the UK HSA Surgical Site Infection Surveillance Service (SSISS). Surveillance data submitted to SSISS for analysis and reporting is validated against strict protocol to facilitate meaningful comparison between centres within England. Surveillance of implant surgeries requires follow up of patients for 12 months post-surgery. SSI surveillance undertaken within the Trust during 2022-23 is initially reported quarterly by hospital site. However, at the end of 2023 it will be published as a whole Trust by UK HSA. This will resolve any unavoidable increase in hospital site infection rates wholly caused as a result of surgical denominator dilution rather than actual SSI case rise.

1.6.2 The mandatory minimum requirement is to report one quarter of orthopaedic surveillance from one of the following categories:

- Reduction of long bone fracture
- Repair of neck of femur
- Hip replacement
- Knee replacement

1.6.3 This minimum requirement is met in Northern Services, with surveillance following knee replacement surgery undertaken at North Devon in the July to Sept quarter. To date there have been no infections associated with surgeries undertaken in this period.

1.6.4 The minimum requirement is exceeded in Eastern Services in the Princess Elizabeth Orthopaedic Centre (PEOC) and the Southwest Ambulatory Orthopaedic Centre (SWAOC) at the Nightingale Hospital where continuous surveillance is undertaken for both hip and knee surgery.

1.6.5 Since orthopaedic surgery has been undertaken at SWAOC, the case mix in PEOC has changed and includes mainly complex knee and hip cases. This results in a higher

accepted risk for infection and lower numbers within the denominator for the PEOC site. Nevertheless, despite complexity, high risk factors and a smaller denominator infection rates remain low.

1.6.6 Continuous surveillance allows local trend analysis from which to draw comparison. Clinicians have engaged well in receiving surveillance feedback resulting from in depth case analysis for all suspected SSI which enables them to make informed changes to practice within a collectively shared desire to lower rates of infection.

1.6.7 Orthopaedic surgery commenced at the newly opened South West Ambulatory Orthopaedic Centre (SWAOC), at the start of 2022/23. The SWAOC site is utilised by orthopaedic surgeons from other hospitals as well as Royal Devon. The IPC audit & surveillance team work collaboratively with hospital teams across Devon to ensure readmission SSI surveillance is maintained for the 12 months post-surgery in keeping with UK HSA SSI Surveillance Service requirements. To date there have been no SSI reported for the SWAOC site.

1.7 Voluntary Surveillance Point Prevalence Survey

1.7.1 A point prevalence survey utilising UKHSA protocols was undertaken in Eastern and Northern Services at the end of 2022. This was to enable a comparison with results of a national survey in which both Northern and Eastern Services participated as separate organisations in 2016.

1.7.2 Point prevalence surveys are useful in providing data on the proportions of HCAIs and proportions of antimicrobial use at any one point (or period) in time. It gives an understanding of burden of both HCAI and community-acquired infection (CAI) treated with antimicrobials.

1.7.3 In 2016 the national point prevalence rate for HCAI was 6.6%.

1.7.4 It is important to note that in 2016 COVID had not been identified and therefore the point prevalence rate is expressed with COVID excluded to allow comparison with 2016 and also with COVID infections included.

1.7.5 The results for 2016 and 2022 are shown in the tables below:

Eastern Services (inc. Community Hospitals)	2016	2022
Total number of patients reviewed	848 (of which community hospital pts =133)	826 (of which community hospital pts = 44)
Total number of HCAIs	26	34 (incl 9 COVID)
Total percentage of HCAIs	3.1%	4.1% (incl. COVID) 3.1% (excl. COVID)

Northern Services (inc. South Molton)	2016	2022
Total number of patients reviewed	269	298 (Of which community hospital pts = 18)
Total number of HCAIs	23	11 (incl. 2 COVID)
Total percentage of HCAIs	8.2%	3.7% (incl.COVID)

		3% (excl. COVID)

1.7.6 The prevalence rate in Northern Services has decreased significantly since 2016.

1.7.7 The prevalence rate in Eastern Services has increased slightly since 2016 with COVID infections included but remains the same with COVID excluded.

1.7.8 Trust wide rates are 3.1% (COVID excluded) and 4.1% (COVID included) both below the national rate of 6.6% in 2016.

1.8 Outbreaks and Incidents

1.8.1 Early recognition of potential or actual outbreaks is important to reduce unnecessary exposure to patients, staff and visitors. An outbreak can be defined as two or more cases of the same infection related in time and place. However, when a particular infection is very common in the community i.e. two cases in the same time period and place; in hospital does not necessarily mean that they are related and investigation does not always provide conclusive evidence either way.

1.8.2 There have been a large number of outbreaks in the last 12 months which increased when the hospitals were under immense pressure with the volume of patients requiring admission and challenges with delayed discharges.

1.8.3 Outbreak control measures were implemented in accordance with outbreak control policies and that included closing wards or bays to new admissions until the outbreak is at an end. When beds are vacated within a closed bay or ward but cannot be used this is referred to as 'lost bed days'. Whilst this is the most appropriate action to take to minimise the number of patients exposed and the duration of an outbreak, this exacerbates the challenges of managing emergency admissions to hospital and the need to maintain elective services.

1.8.4 Therefore, wherever possible steps were taken to avoid lost bed days by transferring into empty beds patients identified with the same infections or those that had recently recovered from the same infection. This does, however, extend the closure of the ward and delays discharges from the ward to other institutions such as care homes.

1.8.5 Conversely, holding patients in emergency admission areas or in ambulances or postponing elective admissions when sufficient beds are not available also places patients at risk of harm. Senior Managers together with the Directors of Infection Prevention and Control & Infection Prevention and Control Leads approved, when absolutely necessary, deviation from the Outbreak Policy having considered the balance of risk. Decisions of this type were being taken during the Norovirus outbreaks experienced from February through to April 2023.

1.8.6 COVID-19 outbreaks

The requirement to test all patients admitted to hospital for COVID 19 has been significantly reduced during the last year. The revised approach was to mainly test symptomatic patients. Most patients were identified on admission and isolated in single rooms or in COVID cohort bays or a COVID cohort ward depending on prevalence. Some patients admitted to hospital for other reasons developed symptoms of COVID whilst in hospital and this resulted in a number of outbreaks; generally, infections remained mild.

In Eastern Services, 129 small outbreaks were recorded during the year, and in Northern Services, 40 were recorded. These outbreaks were reported internally and via

the national outbreak reporting portal.

1.8.7 Influenza outbreaks

As anticipated, the 2022-2023 influenza (flu) season started early throughout the European region; mirroring the experience in the southern hemisphere. Combined with COVID and other respiratory viruses, this had a high impact on the Royal Devon health services. Despite the greatest number of cases identified in the hospital for several years, the number of outbreaks was minimised by establishing cohort bays in admission wards, prescribing prophylaxis for those patients exposed and having the availability of rapid testing at point of care.

In Eastern Services, there were eleven bay closures due to influenza outbreaks and one full ward closure. In Northern services, there were 9 bay closures due to influenza outbreaks

1.8.8 Norovirus outbreaks

Norovirus is predominantly a winter pathogen but can also cause outbreaks in summer months. Norovirus is extremely easily transmitted between people even with excellent infection control practice, and outbreaks are often seen in semi closed settings such as hospitals, schools, cruise ships, care homes and hotels.

UK Health Security Agency (UKHSA) surveillance data in February 2023 showed that laboratory reports of norovirus were 77% higher than the 5-season average for the same period prior to the coronavirus (COVID-19) pandemic (UKHSA, 2023).

Significant outbreaks were experienced in the acute hospital at Eastern Services. In total, 49 outbreaks were identified at the Royal Devon and Exeter Hospital resulting in whole ward closure on 30 occasions and bay closures on 19 occasions. The impact of norovirus outbreaks on the operational management of the hospital was much more significant than COVID or influenza.

Outbreaks in North Devon were much less significant with only 2 full ward closures and 4 bay closures.

Bed days lost due to ward and bay closures were reported on the Eastern Services dashboard to IPDAG.

1.9 Hospital Hand Hygiene Audit

1.9.1 Audits of compliance with the WHO 5 moments for hand hygiene and compliance with being 'bare below the elbow' are undertaken monthly in clinical areas by clinical staff. Generally, high compliance rates are reported by these auditors however, informal observations and formal validation audits by the IPCTs have identified that hand hygiene compliance has been negatively impacted. There are many causes for this, including increased workload and reduced staffing, but the over use of gloves is perhaps the most significant. This is not limited to just a local issue. Training will focus on improving hand hygiene compliance through emphasising a 'gloves off' approach in 2023-24. Ward based hand hygiene auditors are being retrained to audit with greater scrutiny as monthly audits undertaken at ward level are often not reflecting the observation of the specialist IPC teams.

1.10 Community Hand Hygiene Audit

1.10.1 Engagement of community teams has improved with an improved number of community teams submitting data each month. Compliance data is distributed monthly to designated managers with additional narrative content added to the spreadsheet to support interpretation and response. Compliance with the ‘5 Moments of Hand Hygiene’ remains high, averaging 95.3% across the year from observations collected in home, community clinic settings and of Trust staff supporting patients in residential settings as does compliance with being ‘bare below the elbows’.

1.10.2 Compliance data is presented at IPDAG as part of the Community Division Report and is also discussed through Cluster Governance Meetings, which are periodically attended by members of the IPCT to facilitate interpretation and allow questions to be asked.

1.11. Spot check audits

1.11.1 In Northern services a selection of inpatient and out-patient areas across the hospital and in other off-site locations are “spot check audited” each month by the IPCNs.

1.11.2 The audit tool has been developed by the IP&C team drawing on nationally available resources and designed to check key infection prevention practices, cleanliness standards and identify any common themes.

1.11.3 Any specific areas of non–compliance or good practice are challenged or discussed with staff on wards / in departments at the time. The results are sent to ward / department managers, senior and divisional nurses, Sodexo, Facilities and Estates with a covering email highlighting any issues or good practice.

1.11.5 Many areas of IP&C practice are checked within these audits and some examples are detailed below:

- Hand hygiene and Bare Below Elbows (BBE) compliance and availability of alcohol hand gel and accessibility of hand washing sinks
- On-going care of peripheral IV cannula and urinary catheters,
- Communication about patients on the ward with resistant organisms and MRSA suppression treatment.
- Isolation of patients for infection control reasons
- Storage and management of sharps bins
- Cleanliness of patient equipment some examples include hoists, tourniquets, trolleys, pillows, children’s toys, bedpan shells, and commodes
- Linen and waste management
- Food hygiene and management of water coolers for patient use.

The findings were presented to the Infection Prevention and Decontamination Assurance Group, and there is a plan in place for these to be implemented in Eastern services, and both services will present findings to the Infection Prevention and Decontamination Assurance Group in 2023/24.

2. Provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infection

2.1 Domestic Services (Eastern)

2.1.1 Cleaning services continue to be managed in-house with the management structure remaining unchanged. There have been no new additions to the management team over the last twelve months. The management team continually strive to maintain and deliver a quality service to the Trust.

2.1.2 The Domestic Services Department continues to work closely with Ward Housekeepers. The management team are in regular daily contact and attend a Ward Housekeeper Forum on a monthly basis. A structured plan of visits has been implemented with each ward now having a dedicated point of contact at Supervisory and Management level.

2.1.3 The most significant challenge for the domestic services team in 2022-2023 has been vacancies within the department and difficulties in recruiting to vacancies. It has been necessary at times of particularly high demand to redeploy domestic staff from all non-clinical areas to clinical areas in a bid to keep patient care areas up to standard.

2.1.4 In order to meet the environmental cleaning demands of an increasingly busy hospital during the COVID-19 pandemic and, more recently Norovirus and Influenza seasons, additional resources were added to the Specialist Cleaning Team in a bid to meet the increase in activity. This proved beneficial and helped improve patient flow in key areas such as the Acute Medical Unit and Emergency Department.

2.1.5 As the pandemic and other viral outbreaks have reduced, all domestics assistants have returned to their normal duties and, when there are no deep/outbreak cleans, the Specialist Cleaning Team are assigned to non-clinical areas to deep clean them and bring them back up to standard. Recruitment will be actively undertaken continually until all vacancies are filled.

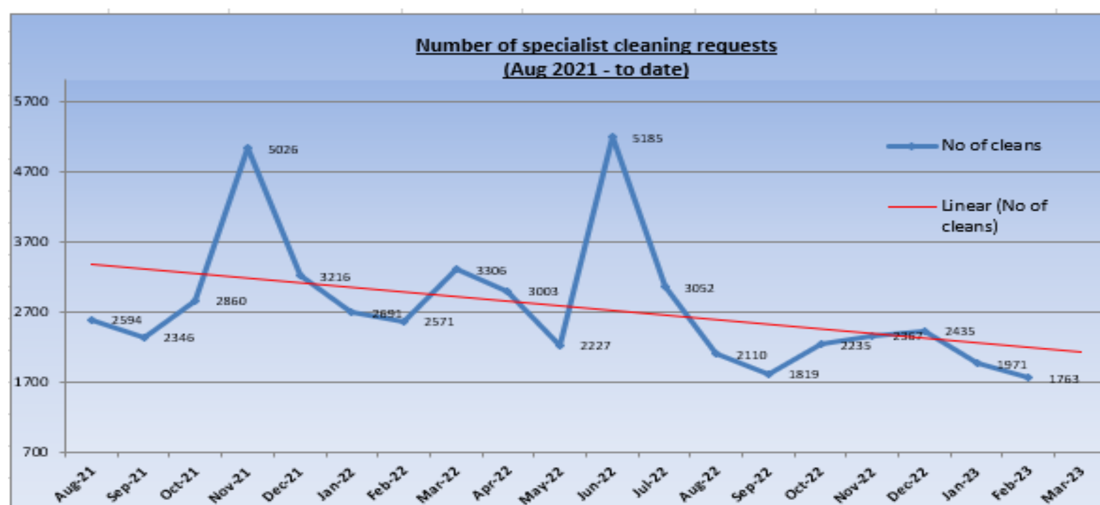
2.1.6 The Audit Team continue to undertake and record technical monitoring on a weekly basis as required by the National Cleaning Standards (2021). The monitoring of waste streams is also included in their daily audits. The monitoring team are supported by the Ward Housekeepers (30 WTE) at ward level and in theatre areas (i.e. Main Theatres and PEOC Theatres), and they undertake technical monitoring of the environment and patient equipment cleaning.

2.1.7 The micad programme is now being successfully utilised and significant amounts of data relating to current resources and the recommended minimum frequency of clean requirements have been recorded. The output data has been used in the re-design of Domestic Services and their delivery in order to meet the ever-changing needs of the Trust. During the course of the next 12 months a full re-evaluation and review of the Domestic Services Department will be undertaken by the Domestic Services Manager in order to ensure all areas are adequately staffed and the Department is in a robust position due to the ever changing size and utilization of areas within the Hospital.

2.1.8 A quarterly management audit is undertaken by a multi-disciplinary team, which includes a Monitoring Officer, a Matron or nominated nursing representative, a member of the Estates Department and an Infection Prevention and Control Nurse Specialist.

2.1.9 In addition to manual environmental cleaning and disinfection methods, the use of hydrogen peroxide vapour (HPV) continues to be used as an effective terminal cleaning regimen for certain types of infection as advised by the Infection Prevention and Control Specialists e.g. spore forming microorganisms such as *Clostridium difficile*, some high consequence infectious diseases, highly significant antimicrobial resistant organisms such as CPE and *Candida auris*. Specialist Cleaning Teams are employed to use HPV decontamination in addition to manual environmental cleaning and disinfection following other types of infections and outbreaks.

2.1.10 The Specialist Cleaning Team has been temporarily increased to twenty-four hours, seven days per week, due to the number of deep/specialist cleans being received to be completed overnight. This will revert back to two dedicated Specialist Cleaning Team members during the night throughout the week within the next two months. The Site Management Team liaise with the temporary overnight Supervisor and this continues to be a positive example of collaborative working. Due to the demand for outbreak cleaning, extra specialist cleaners were recruited by way of agency staff in order to meet the increasing demands. The chart below shows the number of outbreak cleans performed:



2.1.11 The planned annual deep cleaning has not happened as a result of pressure on beds . This does not represent any IPC risk.

2.1.12 Implementation of the National Cleaning Standards (2021) is ongoing following allocation of resources to support implementation.

2.2 Domestic Services (Northern)

2.2.1 Cleaning services continue to be contracted out to Sodexo for the acute hospital site; this will be reviewed before the current contract expires in September 2025. The community sites hotel services are provided by an in-house team that is managed by Sodexo.

2.2.2 North Devon District Hospital is a flagship site for Sodexo due to the successful partnership working model. This was trialled at NDDH in 2001 and has subsequently been embedded in Sodexo's approach when providing their services to other Healthcare providers.

2.2.3 Sodexo maintain and deliver a quality service to the Trust, and continually strive to provide innovation and improvement to the contract. They have recently trialled "Robbie the Robot" – an automated floor cleaner.

2.2.4 Sodexo has performed well with regards to recruitment of staff, and was able to employ an additional 50 staff to support enhanced touch point cleaning in the organisation, and also to support nursing by taking on additional duties. The enhanced touch point cleaning was reduced in September 2022 but the additional support to nursing continues.

2.2.5 At NDDH there is rarely the opportunity to decant wards to facilitate deep cleaning, maintenance or use of HPV decontamination. A deep clean and maintenance function is embedded into Sodexo's routine cleaning schedules (all wards receive this level of service which ensures a deep clean of all areas using a disinfectant over the course of a

week)

2.2.6 In addition to the above cleaning, Sodexo provide a dedicated "bed washing team" to clean beds when they become vacant, whether this is a routine clean (including use of steam cleaners) or a "terminal clean" using a disinfectant. The team also check mattress integrity when they undertake this clean and replace damaged / contaminated mattresses as soon as they are identified.

2.2.7 Monitoring of cleaning is carried out by a Sodexo monitoring officer and there is in house auditing of this monitoring by the facilities department.

2.2.8 Sodexo employ an independent company (Safeguard) to monitor health and safety, training compliance, and food hygiene standards annually

2.2.9 There is also a programme of "aesthetics" monitoring which Sodexo carry out quarterly this identifies environmental issues such as damaged flooring, flaking / damaged paint and plaster, broken furniture / torn seat covers etc that require repair. This enhances the condition and appearance of the environment for visitors, patients and staff, facilitates good cleaning and is a theme that runs throughout the documentation required for the National Patient Led Assessment of the Care Environment (PLACE) inspections

2.3 Patient Led Assessment of the Care Environment (PLACE)

2.3.1 PLACE assessments provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced. The results for cleanliness in 2022 was 97.75%. This is the first inspection since integration of the two previous organisations and therefore comparison cannot be made to previous Trust wide results. The results by site can be seen below:

Victoria Hospital (Sidmouth)	99.00 %
Tiverton & District Hospital	98.63 %
North Devon District Hospital	98.53 %
Royal Devon & Exeter Hospital (Wonford)	97.39 %
South Molton Hospital	96.99 %

2.4 Hospital Sterilisation and Decontamination Unit (HSDU) (Eastern)

2.4.1 The HSDU has seen unprecedented demand for its services following the Covid-19 recovery phase. Theatre activity has risen to the highest rates since 2019 and continues to increase in a bid to tackle the growing patient waiting list. Staff retention and recruitment has proven to be a significant concern during this time for a variety of reasons and the HSDU has had to adapt in a bid to meet the service user demand. This has included expanding the provision of Estates & Facilities bank staff as well as approaching temporary agency cover. A review of the HSDU Technician job role has seen a welcome and much needed banding review, lifting the position up to Band 3.

2.4.2 The Trust has expanded its capabilities and continues to invest in cutting edge technologies, including the provision of an upgraded Xi 'Da Vinci' robot for Urology surgeries to replace the outdated Si model. A second robot was also recently purchased

to expand the benefits into other disciplines including Colorectal, Head & Neck, Prostate surgery and Gynae surgeries. To support this and the growing demand for instrument reprocessing, the HSDU has replaced its aging washer/disinfectors with a suite of new Franke Dekomed D32 Excel machines, whilst increasing its capacity from four to six units. This has further been supported with a new Xi compatible Ultrasonic washer and the addition of a second Sterrad 100NX Hydrogen Peroxide low temperature steriliser, crucial for the reprocessing of robotic endoscopes and newly introduced ultrasound probes among others.

2.4.3 The Trust has effective arrangements for the appropriate decontamination of instruments and other equipment. The Trust is fully compliant with Health Building Note, HBN/13 – Sterile Services Department; operates a quality management system in accordance with ISO 13485:2016 and has registration under the UK Medical Devices Regulation 2002 (as amended). Decontamination processes are undertaken in line with Health Technical Memorandum HTM 01-01 – Decontamination of Surgical Instruments guidance, incorporating ISO 15883, ISO 17665 & ISO 22441 standards as appropriate.

2.4.4 There is a designated decontamination lead with responsibility for ensuring that the decontamination policy is implemented in relation to the organisation and takes account of national guidance. Quarterly meetings are held with the decontamination lead and key stakeholders to review current and best practice and reported via the Decontamination Operational Group & Medical Devices Steering Group.

2.4.5 Appropriate procedures are followed for acquisition and maintenance of decontamination equipment. This includes seeking expert advice from the Trust's appointed Authorised Engineer (Decontamination), AE(D) as well as appropriately skilled Authorised Persons (Decontamination), AP(D) appointed by the Trust.

2.4.6 A monitoring system is in place to ensure decontamination processes remain fit for purpose and meet all required standards:

- Comprehensive Divisional and Departmental Risk assessment to include COSHH review
- Full instrument 'Track & Trace' system in place for surgical instrument trays and supplementary instruments in circulation throughout the Trust and community sites.
- Regular review of NICE compliance (IPG666) in relation to reducing the risk of transmission of Creutzfeldt–Jakob disease (CJD) from surgical instruments used for interventional procedures on high-risk tissues.
- Environmental monitoring of Clean Room and associated processes to include quarterly bioburden testing and staff 'finger dabs' in line with ISO 14644 & BS EN 17141.
- Weekly water testing and feedback of results
- Machine checks, daily, weekly, quarterly & annual control tests and revalidation etc.
- Maintenance programme with available records
- Residual Protein Detection monitoring utilising ProReveal technology to accurately measure protein levels post decontamination to micro levels.
- Independent monitoring systems in place to assure parametric release of decontaminated and sterilised loads.
- External auditing of processes by an independent, approved body to include checks of all equipment and testing validation, staff training competencies etc.

2.5 Hospital Sterilisation and Decontamination Unit (Northern)

2.5.1 In Northern services, decontamination assurance and reporting was via the Infection Prevention and Decontamination Group. The regular monthly meetings were attended

by the Facilities Clinical Services manager who also acted as the decontamination lead and provided updates for the designated agenda item on the IPDG meeting.

2.5.2 There is a plan in place to implement an integrated Trust wide Decontamination Group in 2023/24 that will report into IPDAG.

2.5.3 Decontamination of re-usable medical equipment in the Trust is carried out by the Central Sterile Services Department (CSSD). Staffing comprises; 1 manager, 4 senior technicians and 20 technicians. The CSSD is open 7 days a week with cover for Saturday and Sunday night via an on-call system.

2.5.4 The main unit for reusable instruments is based on level 3 and the flexible endoscope decontamination unit is based on level 0 of NDDH. Current decontamination is carried out utilising 3 instrument washer/disinfectors, 3 endoscope washer/disinfectors and four high-temperature porous load steam sterilisers.

2.5.5 There is a need to replace 2 of the steam sterilisers and 3 of the washer disinfectors which have been in use for some years and this is planned for early 2023/24.

2.5.6 External quality certification for the CSSD is held and is audited by British Standards Institute acting as a notified body for certification to the Medical Device Regulations. The CSSD holds production quality assurance certificate CE02164 and quality system registration certificate MD 78459 from British Standards Institute. The scope of registration covers the sterilisation of theatre trays, procedure packs and single instruments, supply of pre-sterilised devices to end users and high level disinfection of flexible endoscopes.

2.6 Linen Decontamination Unit (Decontamination of Healthcare Textiles)

2.6.1 The Linen Decontamination Unit (LDU) at the Royal Devon University Healthcare NHS Foundation Trust is one of the largest NHS Healthcare laundries in the country and currently boasts some of the most up to date, technological and efficient laundering equipment and monitoring systems used within the UK today.

2.6.2 Following the integration in April 2022, the LDU seamlessly took over the provision of the linen and laundering service to the Northern Devon units from their commercial supplier. This was done whilst continuing to provide the existing Eastern units with their linen service. This equated to an approximate increase of 12% in productivity.

2.6.3 The overriding regulatory documentation for the LDU continues to be the Health Technical Memorandum HTM 01-04 – ‘Decontamination of Linen for Health and Social Care’. HTM 01-04 superseded earlier versions of laundry guidance including HSG (95) 18 and the Choice Framework for local Policy and Procedures (CFPP) series, which was a pilot initiative by the Department of Health.

2.6.4 The Health Act Code of Practice recommends that healthcare organisations comply with the guidance and also outlines the linen handling requirements for laundering establishments who provide linen to the Healthcare and Social Care sectors. These include working to one of two standard requirements, the Essential Quality Requirement (EQR) or Best Practice (BP). EQR is the minimum working standard required but all establishments must have plans in place to attain BP, if they don’t already work to that standard. BP is now the desired requirement for Acute Trusts and other healthcare providers when purchasing new laundering services.

2.6.5 The LDU first achieved the Best Practice standard in October 2017, after successfully being assessed by an external auditor against the requirements of the British Standard BS:EN:14065:2016 – 'Laundry Processed Textiles – Biocontamination Control System'. This assures the provision of the required standard of cleaned, decontaminated linen into the NHS, other public sector customers and the private sector. Registration lasts for 3 years and is maintained by two external annual surveillance visits. The LDU was successfully re-registered in October 2020 and has subsequently successfully passed two further surveillance audits, with the next re-registration audit taking place in October 2023.

2.6.7 In order to achieve and maintain registration, the LDU has implemented a Risk Analysis and Biocontamination Control (RABC) Management System. Part of the RABC system requires the risk assessment of any hazard within the laundering process which could affect the biocontamination quality of textiles. Control measures and process controls have been implemented with the main aim of decontaminating used textiles and controlling the risk of re-contamination, throughout the process until dispatch back to the customer. All control measures and processes are continually monitored and internally audited by in-house staff.

2.6.8 Decontamination of linen is achieved via Critical Control Points (CCP's) during the wash stage adopting the time and temperature standards of HTM 01-04, in order to neutralise the vast majority (99.99% log kill) of bio-contaminants, dangerous substances or germs.

2.6.9 HTM01-04 defines that thermal disinfection occurs with a time/temperature relationship of 65°c held for a minimum of 10 minutes. This is our chosen criteria, however a time/temperature of 71°c held for a minimum of 3 minutes can also suffice.

2.6.10 The CCP's are verified by a real time monitoring system, which will hold the wash process and prevent release of the textiles if the critical temperature is not achieved.

2.6.11 The monitoring system itself is validated using Data Loggers, which are added directly into the wash machines, recording the actual temperature at each stage of the wash process. The process is additionally verified via monthly service visits from the detergent supplier, who audit and correct all aspects of the washing process, including temperatures, water testing and chemical dosing.

2.6.12 The LDU now regularly arranges two further independent tests to validate what scientists say in terms of killing germs within the wash process and to what degree. These are;

- Precision Analysis – this is a destructive test that requires a sample of linen that has been through the decontamination process to be sent off site for testing.
- DES-Controller – the Des (Infection) controller is a simple to use bio indicator for determination and controlling the degree of bacterial reduction.

Both tests are sent off to an independent laboratory in Germany for testing and the results are provided to the LDU.

2.6.13 The RABC system is additionally verified throughout the LDU by a series of Control Points (CP's), where control processes are in place to minimise re-contamination. These are audited and verified by evidence-based systems and document control. These include physical measures such as hygiene controls, protective footwear, KanBan style linen handling systems at the Washer Extractors, dip slide testing and documented evidence such as cleaning schedules, cage sanitisation records and dip slide test results.

2.6.14 The RABC system has an overall main emphasis on the pre-requisites in place, to enable the LDU to implement these controls and systems. A pre-requisite programme identifies

the physical attributes and measures what we already have in place and include such elements as having the correct type of building, having physical barriers between the used and clean linen areas, adequate ventilation systems, hand washing facilities and cleaning regimes. This, along with the biocontamination Risk Plan, helps us implement the control measures required to maintain the system.

2.6.15 The RABC system operates in tandem with the LDU's quality system currently in place, building upon overall standards and includes quality checks at all stages of the finishing section. The LDU has a detailed set of Standard Operating Procedures (SOP) and all staff are trained as per the SOP for the process they are carrying out. This includes carrying out inspection on finished linen, packing and loading in safe quantities and the covering of all cages prior to transit.

2.6.16 All of the above ensures that the LDU receives, decontaminates, cleans, folds and packs over 16.5 million articles per year, for the Royal Devon Eastern and Northern Services, including the Nightingale Hospital Exeter, plus other Acute NHS Trusts, Community Trusts, other Healthcare and Non-healthcare establishments throughout the Southwest Peninsula area.

2.6.17 The LDU led the way during the first COVID-19 pandemic in procuring and purchasing reusable fluid resistant PPE gowns, making the Royal Devon the first Trust in the UK to use reusable PPE gowns in the treatment procedures for COVID-19 infected patients. The use of reusable PPE gowns has continued and they are still in use today.

2.6.18 The LDU has also participated in a recent trial, with NHS England and NHS Impact, along with the Trusts IPCT, to assist in the development and testing of reusable type IIR facemasks for use in all Trusts throughout the country.

2.7 Water Safety

2.7.1 *Legionella* spp. and Pseudomonas *aeruginosa* (P*a*) are the two primary bacteria that are capable of living in hospital water systems, and indeed can be found in almost any water course or feature as they can be found commonly in the environment around us. They have the potential to cause clinically significant infections in patients, especially those with underlying health conditions or immune suppression.

2.7.2 The Water Safety and Ventilation Group (WSVG) meets monthly on a departmental (Estates) level, twice per year on Trust level and as required if an issue or risk with water or ventilation is identified. Among the attendees is an appointed external specialist engineer, known as an Authorising Engineer (AE) who helps to ensure that the Trust is able to follow best practice and ensure continued control of *Legionella* spp. and Pseudomonas *aeruginosa*. A similar role is appointed for the disciplines relating solely to ventilation.

2.7.3 The primary Microbiological control of *Legionella* and Pseudomonas *aeruginosa* is achieved by:

- Temperature; the Trust employs temperature control as the primary method of *Legionella* and P*a* control within the domestic water systems
- This is achieved by maintaining temperatures of:
    - o Cold water at temperatures of < 20°C
    - o Stored hot water at >60°C
    - o Distributed water at >55°C
- The avoidance of stagnation by:
    - o Removing any blind or dead ends on distribution pipework as far back to the origin of supply as possible

- o Ensure all Dead-Legs e.g. low use taps, are either flushed twice weekly or removed including any associated pipework
  o Minimising stored water volumes where possible
  o Ensuring that both existing and new systems ensure a good turnover of any water stored within them, e.g. appropriate tank sizing
- Maintain cleanliness at outlets and follow prescribed cleaning routines to minimise cross contamination from plug holes etc.
- Cold water storage tanks are inspected annually and cleaned as required by specialist contractors

2.7.4 A secondary form of bacterial control is provided by the use of a Copper/Silver (Cu/Ag) Ionisation unit. There are currently four units fitted as below, and each is carefully monitored and regular samples taken to prove its efficacy:

1. Centre for Women's Health
2. Modular Wards Ashburn and Yealm
3. Heavitree Hospital
4. North Devon District Hospital

2.7.5 Historically *Legionella* bacterium have been found in very low numbers in water samples taken from outlets within the Trust. This is not entirely unexpected as the organisms can be found readily in most water supplies, and does clearly illustrate the need to effectively control the environment effectively.

Most recently the Nightingale hospital had issues with Legionella; following a major refurbishment, and after trying a number of chemical disinfection regimes, the decision was taken to install point of use filtration (POU) to every outlet.

This proved highly successful, and allowed the site to open for its intended purpose. A regular temperature monitoring and flushing regime was undertaken during the following months after and following an WSVG agreed process, a series of water samples, taken consecutively over an agreed period of time, indicated no further contamination present and the POU filters could be safely removed.

2.7.6 Pseudomonas *aeruginosa* sampling takes place as per the HTM recommendations; in Augmented Care areas (ICU, HDU, NNU etc.), on a 6 monthly rolling program. Historically positive results have been recorded from both Yarty and Yeo Wards. There was also a positive from a wash hand basin (WHB) near the NNU in CWH and subsequent remedial work and testing indicated that there was no further contamination present.

2.7.7 Remedial action for any outlet testing positive includes immediate isolation of the outlet and removal from use, an urgent review of cleaning processes, the implementation of a regular flushing and sampling regime; engineering works and chemical cleans as required and regular discussion with the WVSG and DIPC, followed by a prescribed sampling regime, which only allows the outlet to be put back into use when 3 consecutive sample results indicate the outlet is clear.

Further works to remove plastic flow straighteners, flexible hoses and corroded pipework or valves also reduces risk, and is undertaken as soon as is practicable.

2.8 Ventilation

2.8.1 Possible risks from ventilation are minimised by the use of contractors to clean the inside of each Air Handling Unit (AHU) on a 3 or 4-month rolling program. This includes

disinfection of areas subject to moisture, such as cooling coils and fins, as well as regular filter changes.

2.8.2 Wall or ceiling mounted cooling units are also subject to regular maintenance and cleans by a specialist contractor, as are portable equipment, where the risk reduced as they are specifically excluded from use in clinical areas.

2.8.3 Other safety precautions include cleaning of ducting and ventilation grills as required and for key areas on a regular PPM program generated by MICAD, the computer aided facility management system.

2.9 Food Hygiene

2.9.1 Environmental Health Officers employed by Exeter City Council for Eastern Services and North Devon Council for Northern Services visit all catering areas on a regular basis to ensure that we are adhering to the required hygiene standards in accordance with Food Safety regulations – this includes cleanliness, completing temperature records for fridges and freezers, stock rotation of all stores, compliance with Hazard analysis and critical control plan. The Trust has been awarded full 5 star ratings for all of our catering areas in Northern and Eastern Services, including the main kitchens.

2.10 NHS Premises Assurance Model (NHS PAM)

2.10.1 The NHS PAM is a management tool that provides NHS organisations with a way of assessing how safely and efficiently they run their estates and facilities services. It is mandatory for all NHS trusts to complete annually from 2020/21. The NHS PAM collection for 2021/22 was submitted online on 9th September 2022.

2.10.2 The assessments are rated on a 5-point scale from Inadequate through Moderate or Minimal improvement to Good or Outstanding. From the applicable assessment criteria, the Trust rated;

- 64% Good & 27% Requiring Minimal Improvement for Eastern Services
- 68% Good & 31.5% Requiring Minimal Improvement for Northern Services

2.10.3 The Assessments are undertaken independently for Northern and Eastern sites. None of the criteria were deemed is inadequate. Areas of improvement identified through the PAM Assessment are recorded and reviewed through the Estates and Facilities Governance Groups.

3. Ensure appropriate antimicrobial use to optimize patient outcomes and reduce the risk of adverse events and antimicrobial resistance

3.1 Antimicrobial stewardship (AMS) optimises the treatment of infection and minimises the collateral damage associated with antimicrobial use such as the emergence of resistant organisms and CDI. It is recognised as one of the key components of IPC. AMS has remained a national priority throughout the COVID-19 pandemic and national targets set within the NHS contract continue to aim to drive down antimicrobial usage.

3.2 Stewardship activities were limited during the pandemic, but there has been a gradual re-introduction since April 2021 including:

- At Eastern sites; stewardship ward rounds scheduled three times a week with a multi -disciplinary team (MDT) including microbiologists, clinicians, infection prevention

and control (IPC) nurses, antimicrobial pharmacists and clinical pharmacists. weekly virtual antimicrobial review round of all vascular speciality patients with MDT including microbiologists, clinician and antimicrobial pharmacists

- Trust wide: weekly antimicrobial review round of all paediatric and NNU patients. MDT includes microbiologists, clinicians, antimicrobial pharmacists, clinical pharmacists and Paediatric liaison and transition nurse.
- At Eastern and Northern sites; weekly *Clostridium difficile* review MDT meeting including microbiologists, clinicians, IPC nurses and antimicrobial pharmacists.
- Trust wide: Provision of educational sessions to junior medical staff and pharmacists.
- Antimicrobial usage between Feb 2022 – Jan 2023. Data pulled from Rx info which has not yet merged Northern and Eastern usage data.
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Antimicrobial Agent	Eastern site usage	Northern site usage
Carbapenem	-49.1%	-34.6%
Tazocin	-18.7% (only Trust to reduce usage)	45.7%
Carbapenem sparing antibiotics	-37.6%	182%
Overall reduction, compared to 2018 baseline	-26.8%	10.6%

- A gap analysis has been completed for Eastern and Northern site antimicrobial guidelines, highlighting all areas that need aligning.
- In November 2022, Eastern and Northern AMS teams took part in the IPC point prevalence survey looking at rates of infections and antimicrobial prescribing
- The Outpatient Parenteral Antimicrobial Therapy (OPAT) Service continues to develop and expend. The OPAT service now includes patients in the Northern sites. There is now a daily review round lead by our OPAT specialist pharmacist and Microbiologist Registrar pro-actively looking for suitable candidates and reviewing all patients in our OPAT virtual ward (AHAH)
- The antimicrobial pharmacists supported the introduction and delivery of the COVID-19 Medicines Delivery Unit (CMDU) based on Torridge ward. Delivery of the service has now been taken on by rotational clinical pharmacists, releasing some work capacity for the antimicrobial specialist pharmacists.
- Continuation of a Quality Improvement Program to improve diagnosis and treatment of Urinary Tract infection with expansion of the program to our Eastern Acute Medical Unit.
- The Antimicrobial Stewardship Group (ASG), which oversees the development and implementation of the Trust annual AMS programme of work met four times over the year, and was quorate on each occasion. ASG now has representation from both Northern and Eastern services.

3.3 There remain a number of challenges which will be addressed through the IPC annual workplan 2023/34.

- Availability of reports from Epic to provide data measuring adherence to key performance indicators for antimicrobial stewardship in the Trust. AMS team are working with Business intelligence to develop.
- Provision of detailed data analysis of infection management, antimicrobial prescribing and breakdown of consumption figures.
- Antimicrobial stewardship activities to provide more frequent stewardship rounds with clinicians and clinical pharmacists.
- Logistical challenges with acquisition of antimicrobial pumps used for our OPAT patients.

- Merger and review of trust antimicrobial guidelines.

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further health and social care support or nursing/medical care in a timely fashion

4.1 Information is provided in a variety of ways for patients, visitors and carers:

- Infection and infection control information is available on the Trust website. This includes information about visiting which has been aligned across Northern and Eastern Services. Visiting information was regularly reviewed by IPC leads in response to changes in prevalence of COVID, Influenza and Norovirus.
- During times of outbreak, a pre-recorded message about visiting restrictions is in place on the hospitals telephony systems.
- Outpatient letters advise patients about any requirements with regard to infection control prior to their visit, however with the frequent changes in relation to COVID management over the last 12 months this may sometimes have been out of date for some patients. Therefore, electronic screens in the hospital and posters were also utilised particularly in relation to the need to wear face protection.
- With regard to specific infectious conditions a range of patient information leaflets are available for patients and their carers.
- Annual reports are published on the external website and reports to the Public Board of Directors.

4.2 Information is also available for those providing further support or care through many of the same methods but also from the Community Infection Management Service (CIMS). The IPCTs are now in the third year of providing a Community Infection Management Service (CIMS), an ICB funded variation to contract. This enables the Trust IPCTs to provide a service to care homes and primary care further enhancing relationship and communication between providers.

4.3 This year CIMS was able pivot away from outbreak support, to a degree, as care home settings became more confident in their own precautions and the requirement for outbreak meetings abated.

4.4 More proactive contact was achieved with a number of educational products, including the following:

- An infection control training session addressing issues associated with antibiotic resistant organisms, antimicrobial stewardship and specimen collection. This was offered through the Eastern Care Services Team, providers of existing training for the social care sector.
- A further session was provided to nominated domiciliary providers including content regarding hand hygiene and the use of personal protective equipment in client homes.
- Working collaboratively with colleagues in Devon County Council, a half day educational event was held in Reed Hall, University of Exeter where topics including oral hygiene, hydration, antimicrobial stewardship and sepsis awareness were taught.
- Workbooks funded by the Integrated Care Board were promoted and supplied to Care Homes which support best practice in infection prevention.

- Link networks were established through distribution lists of links, leads and champions both from care home and primary care settings. The first Primary Care Infection Control Link Network meeting was held through MS Teams in March with an agreement to meet on a quarterly basis.

4.5 Significant service development occurred within primary care with a number of fruitful visits achieved during the year to explore potential work streams and give on-site support to link professionals. The team engaged with regional partners in collaborations to develop support tools for GP practices to meet cleanliness standards and those required for minor procedures and surgery. A regional hydration project was also supported through NHS England.

4.6 The team has established itself in provider networking events where possible and continues to seek opportunities to support these sectors more effectively.

4.7 The team has continued to review toxigenic cases of *C. difficile* arising in the community with feedback, where necessary, being provided to prescribers by Microbiology colleagues. During the year, 43 patients with *C. difficile* infection who had either had an inpatient stay in the Trust longer than 4 weeks prior but within the 12 week period (Community Onset, Indeterminate Associated - COIA) or no inpatient stays within the prior 12 weeks (Community Onset, Community Associated- COCA). Requests for information regarding clinical history and antimicrobial treatments were sent out to GP practices and replies were obtained for 38 demonstrating a high level of engagement. Patients for whom information was not obtainable tended to be from out of the area.

4.8 A scoping process commenced so that further data is gained for cases of Gram-Negative Blood Stream Infections with a urinary source arising in people normally resident in residential settings. Whilst the numbers appear limited, proactive/preventative work is planned with providers in partnership with existing specialists.

4.9 The CIMS team has continued to act as an intermediary, where appropriate, between the RDUH and private providers through submitting content to the Provider Engagement Network Newsletter regarding discharges during outbreak, attending provider forums and relevant meetings and through support to the Single Point of Access Team.

5. Ensure that people who have or are at risk of developing an infection are identified properly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

5.1 Patients are assessed on admission for signs, symptoms and risk factors for infection. The electronic patient records prompt this assessment with inclusion of relevant questions including travel history.

5.2 Northern and Eastern Services had isolation policies in place which during the course of the year were aligned and integrated to provide a single Trust wide policy. This provides guidance on prioritisation for patient placement in single rooms either for their own or others protection.

5.3 The Patient Placement and Movement Policy has also been updated and integrated as a Trust wide policy and this further guides the appropriate placement of patients to reduce risk of infection.

5.4 The movement of patients within the Trust is also included in key policy documents such as the admission and discharge policies. The IPCTs works jointly with bed managers, operations centre staff and with estates and facilities services in planning patient admissions, transfers, discharges and movements between departments and other healthcare facilities.

5.5 Local Trust infection control policies identify the need for information on potential infection hazards to be forwarded to other institutions before patients are transferred out of the Trust. The IPCT liaises with the discharge planning team and infection control information is included in all documentation.

5.6 The use of electronic patient records introduced in October 2020 to Eastern Services and in July 2022 to Northern Services has also played a key role in ensuring that accurate information is available to those engaged in patient care.

6. Systems are in place to ensure that all care workers are aware of and discharge their responsibilities in the process of preventing and controlling infection

6.1 Responsibilities for infection prevention and control is included in job descriptions for all staff within the Trust.

6.2 A review the delivery of infection prevention and control training to all staff was completed in 2022. This concluded that the National Health Education e-learning programmes at level 1 for non-patient facing staff and level 2 for patient facing staff would be adopted. These have been designed to meet the relevant learning outcomes in the UK Core Skills Training Framework.

6.3 The Trust's decision for patient facing staff with certain key roles to also attend face to face training provided by infection prevention specialists remains under review and whilst some face to face training is being delivered; provision is not possible for all patient facing staff, particularly in Eastern Services. This is due to the large numbers of staff requiring training and the limited availability of training venues.

6.4 A new national framework has recently been published (NHSE, 2023) and this will be used to support decision making within the Trust regarding provision of training and will be included in the annual programme for 2023-24.

6.5 In addition to induction and update training, IPC is also included in relation to clinical skills in face-to-face sessions on venepuncture, cannulation and parenteral drug/nutrition administration, link practitioner courses.

6.6 Fit testing and training for use of FFP3 respiratory protective equipment is undertaken for all staff required to use it and this is provided by the fit testing team.

7. The provision or ability to secure adequate isolation facilities

7.1 The Trust recognises the need to maintain and expand facilities for patient isolation for infectious purposes, while recognising the need to provide single room facilities for patients requiring privacy for other reasons. It has been noted for several years that the number of single rooms available and the quality of those single rooms needs to be improved (most single rooms on older wards do not have *en-suite* toilet and shower facilities and are very small; lobbies to negative pressure isolation rooms on Torridge Ward are too small to provide an adequate area for donning and doffing PPE). For this reason, the Trust is partially compliant with this criterion.

7.2 To assist staff, the Trust has an Isolation policy and organism specific policies detailing the need for isolation and the IPCT advise on prioritisation of patients requiring single rooms.

7.3 To mitigate the challenge of the low proportion of single rooms to total beds, when the number of infectious patients exceeds the number of single rooms available, cohorts bays for patients with the same infection are established.

7.4 A small number of portable isolation rooms, known as Redirooms, have also been purchased and are used in clinical settings for patients with infectious conditions where the patient cannot be moved into a cohort e.g. ITU and Respiratory HDU.

7.5 COVID-19 and seasonal viral infections, namely RSV, Norovirus and Influenza have placed tremendous strain on the isolation facilities of all the inpatient services within the Trust. In addition to cohorting patients, other mitigating factors include admission screening of individuals and a low threshold for rapid testing of patients who develop features that could indicate COVID-19 infection (e.g. fever, cough) were implemented.

8. Secure adequate access to laboratory support as appropriate

8.1 Laboratory services are located on both main acute sites and have full UKAS accreditation, which requires the provision of appropriate protocols and standard operating procedures.

8.2 There is provision of seven-day laboratory working and 24 hour access to medical microbiology advice.

8.3 There is a close working relationship with the IPCT; Microbiology Consultants attend weekly meetings between the IPCT, virology and microbiology teams to address on-going and new issues.

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

9.1 A comprehensive range of documents are available, via the Trust's intranet. The IPCT is responsible for the maintenance and updating of the infection control policies, procedures and guidance documents. There are currently a number of infection control documents that are evidence based and reflect national guidance. Approval for such documents arises via IPDAG and ratification of new policies is via the Safety and Risk Committee.

9.2 Currently, two sets of policies remain in use i.e. those associated with the previous organisations prior to integration. Work has commenced to align policies with the aim of having one set only in the next two years; this is included in the 2023-24 IPC programme of work aiming to complete by March 2024.

9.3 Policy integration started with the overarching Infection Prevention and Control Policy. The plan has been to integrate policies at the point when they became due for review and/or when new evidence became available that meant significant changes were required.

9.4 Following the publication of the National Infection Prevention and Control Manual for England, it became clear that integrating two further key policies was necessary and therefore Standard Infection Prevention and Control Precautions Policy and the Source Isolation, Transmission based precautions and Staff Exclusion Policy were also developed for presentation and ratification at IPDAG in April 2023. As mentioned elsewhere in this report, the Patient Placement and Movement Policy has also been aligned.

9.5 The antimicrobial prescribing policy is the joint responsibility of the Consultant Microbiologist and antibiotic pharmacist and is approved by the Antimicrobial Stewardship Group, which reports to IPDAG.

9.6 The decontamination policies and procedures are the responsibility of the decontamination lead.

9.7 All infection control policies carry a three to five yearly review date, or sooner in the light of new evidence. The review schedule is monitored within the annual infection control programme and by the Trust documents administrator. Compliance with key policies is audited according to a schedule included in the annual programme.

9.8 The IPCT also collaborates with others such as the Vascular Access Team in developing guidelines such as the central venous access devices (CVAD) – criteria for referral to the vascular access team.

10. Have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control

10.1 The Occupational Health Service is SEQOHS (Safe Effective Quality Occupational Health Service) accredited. It has been accredited since 2012 and was reaccredited Dec 2022

10.2 The SEQOHS standards are the benchmarks that occupational health services are required to demonstrate they meet to be awarded accreditation and to retain accreditation. Accreditation is a robust process involving self-assessment and external peer assessment against accreditation standards, to establish and promote a culture of continual improvement

10.3 Particularly in a healthcare settings, the occupational health services play a significant role in infection prevention and control. Some of the work they have undertaken in 2022 -23 to support the protection of staff is identified below:

10.3.1 Occupational Health continue to undertake vaccination and blood screening where indicated to reduce the risk of infection in staff at high volumes to tackle the backlog caused by the pandemic and higher levels of recruitment. Table 3 summarises the work carried out in 2022/2023 in comparison to 2021/22.

Table 3: Vaccinations/Bloods

				Jan - Mar 23	Total Apr - Mar 23	Total Apr - Mar 22	Compariso n
Type of Service	J	F	M				
Immunisations							

TB Screening	10	22	14	46	276	695	-60%
Hep B	126	140	180	446	1008	1192	-15%
MMR	146	148	195	489	799	570	40%
Varicella	10	11	17	38	57	46	24%
ACWY				0	14	24	-42%
Dip Tet Polio Booster	34	9	22	65	202	0	
Other vaccinations	2	3	0	5	33	37	-11%
Sub Totals	328	333	428	1089	2389	2564	-7%
Blood Test Screening							
Quantiferon	59	46	61	166	311	154	102%
Varicella	84	61	76	221	362	177	105%
Hep B	164	153	172	489	1068	824	30%
MMR	19	14	22	55	193	144	34%
Hep C	21	25	12	58	168	98	71%
Clinical Chemistry & Haematology	0	0	0	0	4	3	33%
Diphtheria	3	3	0	6	23	16	44%
Inoculation Injury follow up blood test	10	5	6	21	71	47	51%
Victim Inoculation Injury blood test	10	12	11	33	148	151	-2%
HIV	20	25	13	58	170	103	65%
Other/MRSA screening	3	2	10	15	46	49	-6%
Sub Totals	393	346	383	1122	2564	1766	45%
Vaccination Assessment	263	253	292	808	1452	938	55%
EPPs	25	38	24	87	281	269	4%
Total	1009	970	1127	3106	6686	5537	21%

10.3.2 Immunisation and blood test activity (excluding flu) was 21% higher compared to the previous year. Additional capacity was put in place in December with record numbers screened throughout the Jan - Mar quarter. There have been large increases in the number of varicella blood tests and QuantiFERON tests increasing by 105% and 102% respectively. Flu activity recorded on the National Immunisation and Vaccination Systems (NIVS) shows a reduction of 16% for Eastern Services compared with the previous year.

Table 4: COVID-19 Activity

				Jan - Mar 23	Total Apr - Mar 23	Total Apr - Mar 22	Comparison
Type of Service	J	F	M				
Coronavirus advice	141	201	246	588	5322	10862	-51%
Coronavirus risk assessment	33	30	12	75	385	185	108%
Coronavirus medical assessment	3	0	0	3	18	96	-81%
Coronavirus antibody result for storage				0	113	521	-78%
Coronavirus risk assessment for storage	38	18		56	597	7149	-92%
Coronavirus contact tracing				0	72	330	-78%
Total	215	249	258	722	6507	19143	-66%

10.3.3 Table 4 captures the additional COVID-19 activity logged onto the OH database. The overall total is 66% lower than the previous year with falls in all but one category. The number of positives recorded during the year was 4209 compared to 3227 in the previous year; a 30% increase. The COVID-19 work has largely been carried out by COVID-19 funded staff that are not able to be reallocated to other Occupational Health work.

10.3.4 Occupational Health continued to chair the COVID-19 alert status group. This group comprises Northern and Eastern services, DPT, Devon County Council public health and University of Exeter. This group examines the local COVID-19 situation in the various organisations and the Devon COVID-19 prevalence to recommend the relevant COVID-19 alert level. The alert level was used as a guide for PPE used initially (which was subsequently removed) and is still used to determine where staff of higher vulnerability to severe illness and mortality with COVID-19 are able to work.

10.3.5 A collaborative approach to the provision of COVID boosters and Seasonal Influenza vaccinations continued this year with the Infection Control Nursing Leads assigned as Flu Leads. The COVID vaccination working out of Greendale Vaccination Centre provided a roving service in the hospitals and some fixed clinics. They also supported the provision of vaccination for vulnerable patients for both COVID and flu vaccine. Peer vaccinators delivered the majority of flu vaccines to their patient facing colleagues whilst occupational health providing clinic for all staff both on acute and community hospital sites. In keeping with other NHS Trusts, flu vaccination uptake is lower than in previous years at 61.3% against a target of 75%. This is 6,456 vaccinations administered to our staff.

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NHS
Royal Devon University Healthcare
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Agenda item:	11.3, Public Board Meeting		Date: 26 July 2023	
Title:	Finance and Operational Committee Board Update			
Prepared by:	Angela Hibbard, Chief Finance Officer			
Presented by:	Carole Burgoyne, Non-Executive Director & FOC Deputy 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:	To approve the following items as recommended by the Finance and Operational Committee: • RDUH Contractors Framework • DBV board and steering group TOR All other issues raised were for discussion and noting.			
Status (x):	Decision	Approval	Discussion	Information
		X		X
History:	The Finance and operational Committee was held on 17 July 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 July 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

A verbal update was given on the month 3 position which was reported as on plan with variances on other income, pay (due to the cost of covering industrial action) and under delivery of delivering best value savings. These adverse variances were being managed through underspends in non-pay linked to reduced levels of activity. The forecast is still reporting on plan at a deficit of £28m but with material risks on DBV delivery, system stretch savings and additional ERF income recovery.

Concerns were raised on level of mitigation needed to hold the forecast position. It was recognised that the Trust is able to cover slippage in the forecast under performance of the DBV savings plan at present. However, if the system stretch forecast starts to reduce this may start to impact on the Trust wide position unless further mitigation can be found.

National/Regional Finance Regime Developments

The anticipated operational plan closure letter has been received for the Devon system which sets out a number of improvements required on activity trajectories along with a number of additional pay controls to be put in place. A system response is being undertaken to ensure we can comply with the intent of the letter without causing operational disruption. A copy of the system response will be brought to the next meeting.

ERF rules are changing to reduce the threshold of 2019/20 weighted activity levels against which ERF can be earnt by 2%. This will release £360m into systems to account for impact of April's industrial action (cost and lost income). A further negotiation is underway for changes due to subsequent action.

ICB ERF allocations up to threshold are no longer being allocated out at 100% with 16% being held nationally, to be earned on achievement of the new revised trajectories. This is to create a greater incentive for delivery. The remaining 84% will not be subject to any claw back. Providers are being advised to assume that full ERF will be earned despite this change.

Pay awards for 2023/24 have been announced now for agenda for change, junior doctors and some other staff groups at 5-6%. Although providers have been funded in tariff at 2.1% and given assurance that pay awards will be fully funded the department of health and social care is not being given any additional budget and therefore will need to find funding from existing resources. Therefore, there is a risk that other national programmes will be scaled back to fund the difference to systems.

2023/24 Operational performance by exception

An overview was shared on the May performance position in line with the reporting through the Improvement Plan. However, an early view of June data was shared setting out a forecast of six 104 ww with a trajectory of zero by the end of July, 78 weeks being slightly off plan but 65 weeks being better than plan. ED performance has been below plan on type 1 and type 1-3 and is a key area within the improvement plan, with a focus on minors. Progress continues to be made in diagnostics and cancer. Finally, although No Criteria To Reside (NCTR) is on track for eastern sites it remains high and off plan for northern sites. This data will be validated in time for the Month 3 IPR to Board.

Improvement Plan delivery (based on May's operational data)

Showing an improvement from April but ***marginally outside of planned trajectory*** for UEC 4-hour performance, elective recovery long waits targets and cancer 62 day and faster diagnosis targets.

NCTR is ahead of trajectory overall but not across both sites with pressures continuing to be felt in the North.

The committee heard the key areas of focus for recovery being:

- Non-admitted pathway – review of referral process through DRSS (need to align with system workstream) and targeted demand and capacity reviews in key specialties.
- Targeted action on protecting the eastern minors stream recognising new facilities coming on board and requirement to refocus on this end of the pathway to drive up performance.
- Optimise the new northern discharge lounge
- Focused demand and capacity planning on UEC pathways as part of winter planning

The ED improvement plan was tested by the committee in term of what will make the difference to achievement of target and the focus on the eastern minors (and northern to some extent) was felt to be the right area. Overall the Committee felt assured on actions being taken recognising the challenge on delivery.

Delivering Best Value savings Plan (based on June finance data)
The Delivering Best Value savings plan reported that detailed plans are now developed for £33.9m in-year against a £45m target. Month 3 delivery is reporting a £1.8m shortfall with £5.4m delivered against a target of £7.3m which equates to 74% of the target delivered in the first three months (77% as at month 2). The Committee noted areas of forecast under-delivery as follows:

- EPIC cashable benefits – although significant benefits are being seen in patient pathways this is supporting cost avoidance and productivity rather than cost reduction
- Temporary workforce – a significant reduction has been seen in agency spend but it is not quite at planned levels due to the impact of industrial action

The Committee noted the work of the stock take which is focusing on actions to move from red to amber and green delivery to de-risk the plan. It was recognised that although there were some areas of improvement there remain nine headline schemes still classed as RED. A review of Q1 performance is planned to identify areas of further opportunity and to continue to de-risk the existing plans.

Better Payment Practice Code
The committee received an update on the drivers behind the poor BPPC performance in May which was reported at 36% of volume of invoices and 56% of value of invoices paid within agreed payment terms. Performance has now improved to 79.4% in volume and 74.3% in value with a trajectory to return to pre-ledger go live performance by month 5.

There is a pre-existing issue with pharmacy invoices that the new ledger has exacerbated resulting in a significant backlog impacting on supplier accounts. Work is ongoing with the cash management and pharmacy team to resolve the issues and develop a less manual authorisation process. Pharmacy invoices account for around 20% of the Trusts overall invoices received. There are currently 8,000 pharmacy invoices waiting authorisation in the system.

ICS Issues
It was noted that £32.5m of plans have been set out against the £60m stretch with a target to identify the full schemes with support from Deloittes by the end of July. This remains high risk but efforts are being made to develop opportunities and mitigations for slippage. The ICB CMO has agreed to take on the lead of the new models of care work programme.

Data Quality
A paper was received explaining in detail the issue on reporting of outpatient follow ups which has been raised through the IPR. It was recognised that there were legitimate reasons for the increase from 2019/20 volumes due to better data capture. Review of the data has identified that there are specific specialties where a high volume of activity is now recorded but was not previously recorded pre EPR implementation, specifically for midwifery and community home visits. Initial review of the data suggests that the new activity meets the criteria of an outpatient event, (as home visits are designed to avoid the need for an in-hospital appointment), and so is correct to be reported, but was not recorded pre EPR implementation and so results in a misleading / confusing position at trust level when comparing to 2019/20.

The committee considered 3 options on how to improve reporting in the IPR to avoid a misleading position and agreed that undertaking a manual adjustment to exclude specific specialties in line with the ERF guidance would give a better comparison to 2019/20 activity.

The report also set out key reasons for below 2019/20 activity performance in new outpatients and the changes in performance between inpatient and day case activity.

BAF Risks
The BAF risks were reviewed and presented to the Committee with no changes to the scoring but some minor changes to the wording. The committee accepted this position which will be presented to the committee in the July BAF update to Board.

It was noted that the graph data in the risk templates was not being updated and this will be followed up with the governance team.

3.2 Emerging Issues and items for information

NIHR Funding Bid for Healthtech Research Centre
The committee received information on a bid submitted to the NIHR for funding to establish a Health Technology Research Centre (HRC) for the South West in partnership with the University of Exeter. Although the funding is for a 5-year period and presents no financial risk in this timeframe the project needs to be self-funding after 5 years through commercial research funds. The annual value is circa £350k so within the delegated authority of local governance under the scheme of delegation but was presented to the committee due to the strategic importance of the project. The Committee noted the risk from year 5 recognising that this was low due to the commercial opportunities available.

Nightingale Post Project Review
The committee received a paper outlining the implementation, achievements and reflective learning of the Nightingale's first fully operational year. This included reference to other post project evaluations completed and internally commissioned audit reports. The document outlined aspects of What Went Well and Even Better. It was noted that the report was an excellent summary of the programme of work and show cased the excellent innovation that the facility fostered.

RDUH Urgent and Emergency Care Plan Update
A detailed pack supporting the recent urgent care summit with NHS England regional team was shared for information although not reviewed at the meeting.

3.3 Items for Trust Board of Directors approval

RDUH contractors Framework
A paper was presented recommending a local contractor's framework is agreed to help facilitate contracting of local suppliers on estates works to support internal capital projects, particularly those that need to progress at pace. It was recognised that there are national procurement frameworks in place but many local contractors are unable to fulfil the requirements due to size. A local framework will enable a list of approved contractors to be available to the estates team without having to embark on lengthy tender processes.

Feedback was received on strengthening the need to stay within capital budgets as part of the framework and increasing the cost element of the evaluation process as 30% cost and 70% quality felt the wrong balance in the current economic climate. With these amendments the committee was able to recommend approval to the Trust Board.

The committee recommend to the board for approval.

Delivering Best Value Board and Steering Group Terms of Reference
The amended terms of reference were noted by the committee, extending the scope of the governance to incorporate the whole improvement plan alongside the DBV savings.

The committee recommend to the board for approval.

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
The BAF was reviewed this month as part of the quarterly review. No new issues were noted that would impact on the current BAF scores.

6. Recommendations

It is proposed that the Board of Directors approve the following items recommended for approval by the committee

- RDUH Contractors Framework
- DBV board and steering group TOR

All other issues raised were for discussion and noting.

Agenda item:	11.4, Public Board Meeting			**Date: 26 July 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 27 June 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 April 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 held on 27 June 2023.

2. Background

The Digital Committee 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

The Digital Committee Chair, on behalf of the Digital Committee, is responsible for reporting back to the Board of Directors on a monthly basis.

3. Analysis

The Digital Committee (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

- Trust has taken ownership of document from Channel3.
- Version 0.15 of digital strategy presented and approved.
- Overall message has not changed; latest version incorporates feedback from the enabling strategies sessions.
- All enabling strategies to be presented to July Board of Directors.

3.2 Digital Capital Plan 2023/24

- Updated capital plans across Eastern and Northern were presented.
- Revised plan focuses on software legal compliance and essential maintenance in order to maintain service delivery.
- Concern raised regarding focus on maintaining ‘business as usual’, rather than delivery of objectives from the strategy; this is a result of current financial constraints.

3.3 Licensing Growth

- Historically, management of licenses has been reactive, and involved a 'true-up' at the end of the FY.
- Digital Services are moving to a forecasted requirement of licenses going forward.
- This year, there is a new centralised Microsoft licensing model, which has a direct impact on the Trusts bottom line.
- It will be necessary to look at all areas to see where costs can be offset e.g. by rationalising our estate, working collectively with ICS partners and look at leveraging full potential of centralised contract.
- If numbers of staff and devices keep increasing, additional funding will be required.

3.4 Intergrated Care Board Update

- PID validation exervcise ongoing.
- There is recognition that all organisations have signed up to an incredibly ambitious financial and elective recovery plan, the Royal Devon are part of that system and part of the delivery. The system needs to work collectively to come to the right solution that meets the requirements of Devon, rather than an individual trust.

3.5 DSPT Update

- Tooklit submitted at end of June; NHSE has since approved 'status of Approaching Standards'
- There are 10 items identified against the improvement plan (a reduction from the 66 items from last years submission – team thanked for their efforts)
- Aiming to achieve 'Standards Met' by Dec 2023.

3.6 PACS / CRIS Contract Renewals

- Currently liaising with suppliers to extend current contracts which expired 30 June 2023).
- There's not expected to be any interruptions to service whilst new contracts are agreed.

3.7 Imaging GP OCS Business Case

- Paper presented for information; previously presented to TDG.
- Proposal is to implement a GP Order Communications system for imaging across Eastern / Northern Services, in the same way as Pathology tests.
- Referrals would pass into Epic, which then sends an electronic order to CRIS .
- Capital funding has been secured with Peninsula Radiology Network (PenRAD), with a break-even revenue position.

3.8 NHSmail Multi Factor Authentication

- NHSMail will be enforcing MFA for new users from Sep 2023, which will require additional authentication before logging on .
- Trust investigating methods to reduce impact to end users by utilising HSCN connections, where possible.
- Concern was raised regarding requirement to use mobile phones for authentication, as cannot expect staff to use their personal phones. Other options need to be investigated; FIDO tokens not recommended as will incur an additional cost to the trust.
- Session to be scheduled with HR to compile a staff survey; also linking in with NHSE to understand their recommended approach.

4. Link to BAF/Key risks

4.1 BAF Risks

- Digital BAF risks have now been consolidated into a single Epic benefits realisation risk.
- Feedback on updates have been sent to GKD who will update BAF in time for July BoD meeting.

4.2 Divisional Risks

- Work is progressing to consolidate the Northern and Eastern Digital Risk registers, and to ensure that regular risks review are completed and actions to reduce the risk scores are documented on Datix.
- Consolidated risk register to be presented at next meeting.
- Monthly governance and risk meetings are scheduled, and the process was re-iterated at the June meeting:
  - Proposals to close risks are reviewed at Digital Governance & Risk meeting before Datix is updated.
  - High scoring risks (15-25) are reviewed / validated
  - High scoring risks are presented to DC for visibility / assurance and to make decision on escalation to corporate risks register

5. Proposals

It is proposed that the Board of Directors notes the report from the Digital Committee.

Royal Devon University Healthcare
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Agenda item:	11.5, Public Board Meeting			**Date:** 26 July 2023
Title:	July 2023 Integration Programme Board update to the Royal Devon Board of Directors			
Prepared by:	Fran Lowery, Integration Programme Manager			
Presented by:	Alastair Matthews, Non-Executive Director			
Responsible Executive:	Chris Tidman, Deputy Chief Executive Officer			
Summary:	This document provides a written summary of the key areas discussed at the 18 July 2023 Integrated Programme Board, and provides an update on the Integration Programme delivery.			
Actions required:	To note the update.			
Status (x):	Decision	Approval	Discussion	Information
			X	
History:	A monthly report is produced after each IPB to report to the Royal Devon Board of Directors. Note that IPB on 20 June 2023 was cancelled.			
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	X	Finance	
Service Development Strategy		Performance Management	
Local Delivery Plan		Business Planning	X
Assurance Framework	X	Complaints	
Equality, diversity, human rights implications assessed			
Other *(please specify)*			

INTEGRATION PROGRAMME
Programme Exception Report

1. Overview

The IPB met on 18 July 2023 to gain assurance on the progress of the Integration Programme for Year 2 of integration (1 April 2023 to 31 March 2024).

The Integration Programme highlights are:

- The NHSE lessons learnt draft report is due wc 17 July to the DCEO for approval
- The Operational Services Integration Group met on 19 June
- The Clinical Pathway Integration Group met on 22 June and signed off the group's terms of reference
- The Corporate Service Delivery Group is due to meet on 24 July, including the corporate PAF and corporate DBV plan, chaired by the DCEO
- IPB received the terms of refence for CPIG and OSIG, and will receive CSDG ToR in August
- The Royal Devon Clinical Strategy and related five enabling strategies are on the agenda of the Board of Directors in 26 July 2023, following the discussion at the board development session on 6 July.

This exception report presents the main matters arising from the integration programme activities, and summarises key risks and issues across the following headings as discussed at the IPB meeting on 18 July:

- Operational Services Integration Group update
- Clinical Pathway Integration Group update
- Corporate Services PTIP report Q1 Year 2
- Integration programme delivery and governance

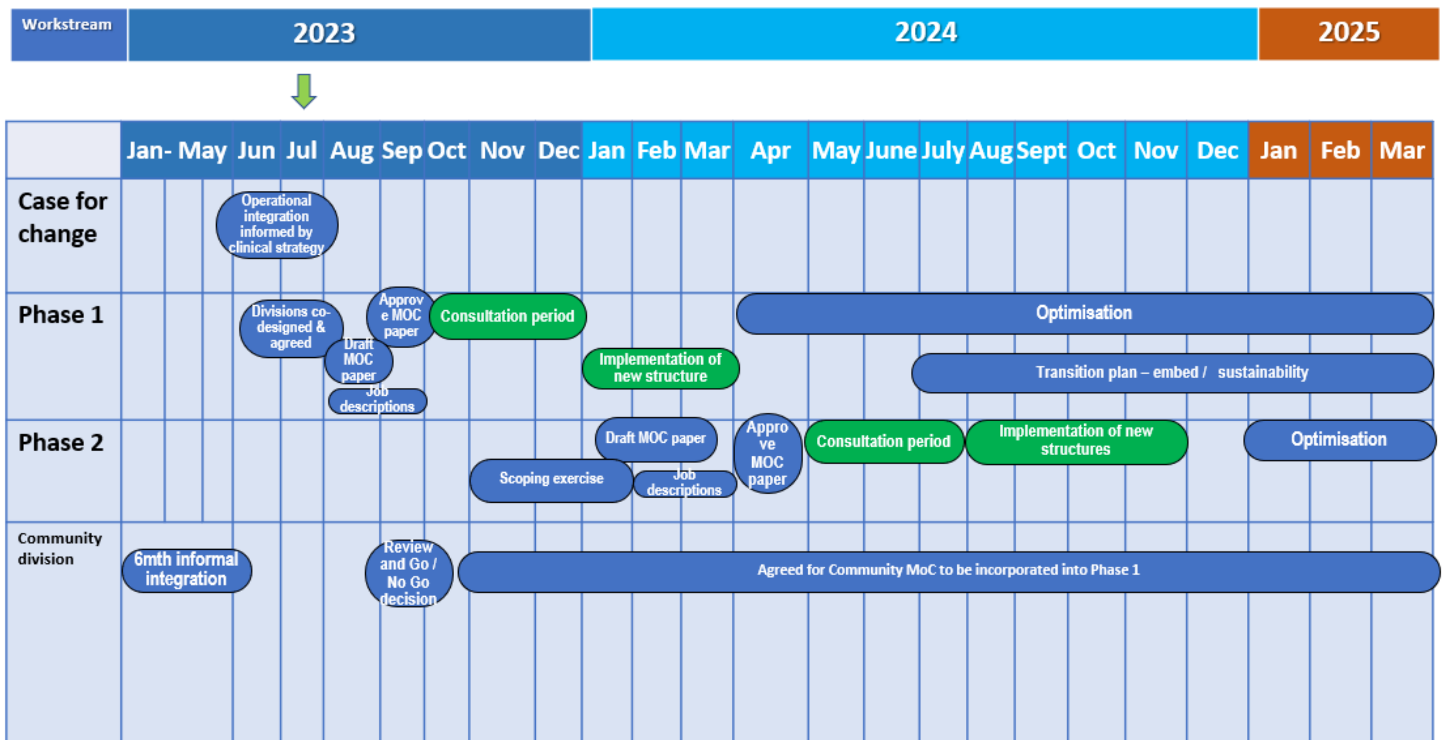
2. Operational Services Integration Group update

The COO gave IPB an update on progress of the Operational Services Integration Group (OSIG). The OSIG steering group met on 18 July, and there were workshops with the trust senior leaders on 19 June and 29 June.

The COO confirmed that the formal Management of Change (MoC) for community, pathology and pharmacy are now within the main MoC, to ensure fairness for our people.

The senior leader's workshop reviewed possible divisional options and there was a consensus for a potential operational structure with maximum integration, pending key further work including: corporate services and professional accountability development, the OD approach, personal development, the validation of the 'as is' detailed data set. Work has been carried out ahead of the next main workshop on 19 July, with several significant decisions to then be agreed such as: medicine and surgery remaining as one or being split, whilst ensuring that divisional sizes are balanced and manageable. It was also noted that trust infrastructure, access to systems including digital will also be resolved ahead of the MoC starting.

The COO then raised the issue of the challenging timeline to ensure that this work continues successfully with engagement and bringing our people with us. It was noted that the original plan had a single phase, and was set to complete in mid-May 2024. However following further detailed work and HR advise, this timeline has now been extended into 2 phases, with a planned completion in November 2024, as shown below:



IPB discussed the reason for this, including the number of staff in phase 1 (100) and phase 2 (up to 1000), the detail and sensitivity of the management of change work required, and recognising the need to complete this before winter 2024, ideally by late summer 2024. Key mitigations were considered to bring this timeframe forward including:

- Merger work which can take place once phase 1 is implemented
- Benchmarking against similar operational mergers
- Looking to deliver phase 1 more rapidly
- Consider reducing the scope of phase 2

- Increasing HR resource and therefore team capacity including job matching panels

A further update will be provided to IPB in August following the workshop and OSIG on 27 July.

3. Clinical Pathway Integration Group (CPIG)

The first CPIG meeting took place on 22 June, co-chaired by the CNO and CMO. The group discussed CPIG's purpose:

- The CPIG is responsible for providing trust executive oversight of the delivery of the clinical service workstream, which includes clinical integration oversight of the original 8 high priority services (haematology, oncology, obs & gynae, acute medicine, gastroenterology, diabetes & endocrine, HfOP, Stroke) plus urology which has recently been added to this category.
- Clinical integration delivery will be overseen through CPIG until new divisional structures are agreed, led by OSIG. This work will then become BAU within the relevant division with oversight through existing governance performance & assurance processes
- The CPIG will meet quarterly, and provide IPB and TDG with quarterly updates on progress, delivery against plan, risk and issue escalation

The group agreed the CPIG terms of reference, recognising the close alignment with OSIG. CPIG will also review the NHSE lesson learnt report once received, recognising the learning from maternity, pathology, and pharmacy, and the need for a clinical lead across both sites to drive integration.

It was also discussed how the governance of the general clinical services might be overseen by CPIG to ensure the correct level of clinical interject to benefit quality of patient care as an integral part of the operation integration of the many other services. It was agreed that the CMO, CNO and COO would review this across both OSIG and CPIG.

CPIG also reviewed progress to date against the high priority service plans (Obs and Gynae, Haem and Onc, Acute medicine, Stroke & HfOP, Diabetes & Endo, Gastro, with urology added - to this group of services). The Trust Directors will ensure that relevant Divisional Directors' at North and East sites review and update the integration plans, and are taken through relevant divisional governance routes and oversight of these are included in Clinical PAF meetings. The next update from CPIG to IPB will include updates on the priority services action plans.

It was agreed that a meeting is set up by end of July with CMO, CNO and Trust MDs initially to discuss HfOP and Stroke to review progress, which lacks pace due to no defined clinical lead in North.

4. Corporate Services PTIP report Q1 Year 2

On 6 December 2021, a Post-Transaction Integration Plan (PTIP) was submitted to NHSE. This included PTIP action plans for corporate services which included pre- and post-merger actions to achieve a successful merger. The pre-merger PTIP actions were all completed ahead of the Royal Devon University Healthcare NHS Foundation Trust (Royal Devon) launch on 1 April 2022.

Since April the Corporate Programme Management Office (CPMO) have worked with the trust corporate leads to support and monitor the delivery of the PTIP actions. Progress of delivery has been monitored and overseen by the Corporate Services Delivery Group (CSDG). Assurance has been provided to the Integration Programme Board (IPB) through exception reporting.

The report provided a review on progress for the second year, first quarter, from 1 April 2023 to 30 June 2023 on the delivery. There are 58 Year 2 corporate services PTIP actions in place for 2023/24, with 35 completed actions as at 30 June 2023.

The corporate PTIP plans for Year 2 are split into the following sections:

Corporate portfolio	Number of PTIP actions	Executive SRO
CMO portfolio	24	CMO
CNO portfolio	9	CNO
Corporate Services	25	DCEO
Total	58	

Overall the year 2 (2023-2024) PTIP corporate action plans have a total of 58 actions. Of these:

- 35 actions have been closed
- 23 actions are planned to be completed in 2023/24

Monthly reviews of progress against plan are led by the CPMO, reporting formally through CSDG, including approval for change controls signed off by execs SROs. There are no issues or risks with the PTIP plans at Q1 and it was confirmed there was no significant slippage in delivery.

5. Integration Programme delivery and management

5.1 Programme governance and risk management

The Head of Corporate PMO met with the Deputy Director of Governance on 13 June to review the year 2 RAID log. There were no new issues identified, and the next risk surgery is planned for 9 August 2023.

It had previously been agreed that the CPIG, OSIG and CSDG terms of reference would be shared with IPB for assurance once they have been signed off by their

groups. The CPIG and OSIG terms of references were on IPB agenda for assurance, and accepted. CSDG will be shared with IPB in August

Progress against four strategic risks from NHSE Amber Transaction Risk rating letter (March 22) continue to be managed:

Risk	Proposed action	Status
Dedicated Finance Committee	Implement Finance Committee (date)	Complete
Royal Devon 3% saving v ICS 5-6%	Best Value Programme developed/ monitored to deliver efficiency savings. Royal Devon now achieving CIP to match system level	Complete
Delay in developing Clinical Strategy impacting on patient benefits	Clinical Strategy (draft) developed in December 22. Clinical Strategy engagement in progress, led by CMO. Final to go to Board of Director for approval July 2023	On track
Clinical integration plans providing assurance to NHSE	Develop and share integration plans with NHSE through agreed milestone to provide assurance. Year 1 lesson learnt process in place with NHSE. Overall trust assurance now provided through SOF4 process	On track

5.2 NHSE Lesson Learnt update

All the NHSE lessons learnt meetings have now taken place. The draft report is expected from NHSE by 19 July to share with the executive directors for an accuracy check. Once the RDUH DCEO confirms the report is accurate from a Trust perspective it will be finalised by NHSE

5.3 Integration Programme delivery – for Quarter 1 (July-Sept 2023)

The high-level programme plan for the delivery of the 1st quarter of year 2 is shown below

Programme delivery for Q2 (July to Sept 23)

Steering Group	Key workstreams	2023 H1, Q2 Jul	Aug	Sept
1. Programme Management IPB	Programme deliverables	Finance, Information & Workforce Strategy to BoD		
	Delivering Best Value			DBV Q2 report
2. Clinical Pathway Integration Group CPIG	CPIG	Clinical and operational pathway integration, informed by Clinical Strategy		
	High risk clinical service integration	High risk services implementation as per plan		
	Key enablers	Clinical Strategy to BoD 26 July	Clinical Strategy delivery plan	
	Clinical MoCs/EoIs			
3. Operational Services Integration Group OSIG	Operational restructure	Consultation and wider agreement		
	OD & Culture	OD workshops, Leadership and engagement events		
	Operational MoCs/EoIs	MoCs phasing planned and approved		
4. Corporate Services Delivery Group CSDG	Corporate PAF			
	Trust Systems/ integration efficiencies			Single payroll- 30 June
	Policies	Year 2 policy alignment, integrated governance processes - Q2		
	Corp MoCs/EoI	Year 2 MoC plan CSDG 24.7.23		Year 2 MoC plan-Q2 review

Key
Completed
In progress
Off track
Not yet started

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Item	11.6, Public Board Meeting		**Date: 26 July 2023**	
Title:	National Institute for Health and Care Research (NIHR) Clinical Research Network South West Peninsula (CRN SWP) One Page Highlight Report 2022-23, Annual Business Plan 2023-24, and Finance Plan 2023-24.			
Prepared by:	Michael Visick - Chief Operating Officer, Clinical Research Network South West Peninsula (CRN SWP)			
Presented by:	Pauline McGlone – Deputy Chief Operating Officer, Clinical Research Network South West Peninsula (CRN SWP)			
Responsible Executive:	Professor Adrian Harris - Chief Medical Officer RDUH			
Summary:	The Royal Devon University Healthcare NHS Foundation Trust (RDUH) Board as contract holder for the NIHR CRN SWP is required to review the annual plan, finance plans and annual report for the network after this has been agreed by the Partnership Group (formed with executive level membership from the SWp NHS Trusts and other providers). This paper outlines the proposed plans and reports including the rationale for determining finance allocations.			
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 (Finance only)	**x**	**x**
History:	The NIHR CRN SWP became operationally live on the 1 April 2014; the Board previously discussed and approved the annual plan/report and finance plans each year.			
Link to strategy/ Assurance framework:	The RDUH is the Host organisation for the NIHR CRN SWP and as such provide the governance infrastructure to manage the contract. CRN SWP activity ensures that the health and social care system and population has access to research opportunity to support that improvement aligned to the corporate strategy over the next 5-10 years. This also links in with objective 3: Innovate and grow the world class specialisms and research with our partners.			

Monitoring Information

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

Care Quality Commission Standards	Outcomes		
NHS Improvement	x	Finance	
Service Development Strategy		Performance Management	
Local Delivery Plan	x	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 information to the Board in its role as Host of the CRN SWP on the annual plan and funding allocations proposed to support the delivery of NIHR portfolio studies by NHS and care providers across the SWP area for 2023-24 and also the annual report for 2022-23.

2. Background

As Host for the CRN SWP it is a requirement of the Department of Health and Social Care (DHSC) contract that the RDUH Host Board approve the network's finance plans however, the requirement for the LCRN's to produce a local business plan has been removed as all 15 LCRN Chief Operating Officers now work together to produce one National annual business plan for DHSC to approve. The requirement to produce an annual report has also been removed and replaced by the requirement to produce a one page impact report that feeds into a National Highlight Report for DHSC. Despite this change the CRN SWP still write a Local annual business plan in order to ensure direction and performance across its service. The annual business plan and one page impact report is shared with the Host board for discussion and review only.

Annual Report 2022-23 (Appendix 1)

In light of the pressures within the NHS system, the national coordinating centre (CC) only requested a one-page highlight / impact annual report to be produced on their provided template format for 2022-23.

The one page highlight report celebrates health and care research success and impact across the SWP. The themes chosen followed the national coordinating centre template. Links are embedded within the report with further information detailed.

- Reset
- Life Science Industry
- Local Initiatives

An annual review meeting was conducted by the national CC in collaboration with West of England, Wessex, Thames Valley and South Midlands and the South West Peniinsula CRNs .

The performance of the 15 Local Clinical Research Networks (LCRN's) for 2022-23 were measured against nine High Level Objectives (HLOs). CRN SWP met eight of the nine metrics.

Annual Plan 2023/24 (Appendix 2)

Again, in recognition of the pressures within the NHS system, the national coordinating centre (CC) had announced that Local CRN annual business plans (ABP) were not required for this financial year. Instead, Chief Operating Officers from across the 15 LCRNs came together to produce one national ABP for submission to the Department of Health and Social Care (DHSC) on behalf of the NIHR CC.

However, a decision was taken locally within the senior management team to write a CRN SWP ABP, which aligned to the NIHR 'Best Research for Best Health: The Next Chapter Best Research for Best Health: The Next Chapter | NIHR, against the NIHR areas of strategic focus.

1. Build on learnings from the research response to COVID-19 and support the recovery of the health and social care system
2. Build capacity and capability in preventative, public health and social care research
3. Improve the lives of people with multiple long-term conditions through research
4. Bring clinical and applied research to under-served regions and communities with major health needs
5. Embed equality, diversity and inclusion (EDI) across NIHR's research, systems and culture
6. Strengthen careers for research delivery staff and underrepresented disciplines and specialisms
7. Expand our work with the life sciences industry to improve health and economic prosperity

Annual Finanace Plan 2023/24 (Appendix 3)

Delivery funding is allocated to the 15 Local Clinical Research Networks (LCRNs) from the NIHR Clinical Research Network National Co-ordinating Centre (CRN CC) to support activities described in the LCRN contract which includes the Performance and Operating Framework (POF). A new contractual requirement was the appointment of a Senior Nursing Midwifery/ Allied Health Professions (NMAHP) leader within the

Senior team to support the NIHR Director of Nursing and Midwifery and to support the delivery of the Chief Nursing Officer strategic plan for research.

The allocation to the CRN SWP to support research delivery across the SWP for 2023-24 was a total of £13,151,317. The total sum included specific funding allocated to strategic workstreams as follows.

- Public Health and Prevention - £77,269
- Transformation of Research Delivery - £833,333
- Targeting underserved communities - £254,829

The budget to all LCRNs remained flat with no applied performance metrics in recognition of current challenges.

No national contingency is held and LCRNs are expected to achieve contractual objectives within their fixed allocation. This includes funding the Host function; Core Leadership team; Study Support Service; clinical sessions and other service support costs; Patient and Public Involvement and Engagement; Training and Education and Continuous Improvement in research delivery.

3. Analysis

The annual report is in Appendix 1.

Performance in relation to the high-level objectives was as follows.

HLO's Summary - SWP & England Summary

High Level Objectives		Ambition FY2223	Actual SWP	Actual England
Efficient Study Delivery Deliver NIHR CRN Portfolio studies to recruitment target	(4) Percentage of closed to recruitment commercial contract studies which have achieved their recruitment target **> This is RTT for commercial studies closed within current FY, at site level**	80%	71% (70/98)	76% (1161/1529)
	(5) Percentage of closed to recruitment non-commercial studies which have achieved their recruitment target **> This is RTT for non-commercial CI studies closed in current FY, at study level**	80%	100% (16/16)	90% (755/838)
	(6) Percentage of open to recruitment commercial contract studies which are predicted to achieve their recruitment target **> This is RTT for commercial open CI studies , at study level**	60%	88% (23/26)	67% (714/1059)
	(7) Percentage of open to recruitment non-commercial studies which are predicted to achieve their recruitment target **> This is RTT for non-commercial open CI studies , at study level**	60%	77% (33/43)	66% (2001/3038)
Provider Participation Widen participation in research by enabling the involvement of a range of health and social care providers	(3) Proportion of General Medical Practices recruiting into NIHR CRN Portfolio studies	45%	48% (116/243)	44% (2875/6541)
	(4) Percentage of NHS Acute trusts with recruitment in NIHR CRN Portfolio studies every quarter	99%	100% (6/6)	100% (137/137)
	(5) Percentage of NHS Acute trusts with recruitment in commercial contract NIHR CRN Portfolio studies every quarter	70%	83% (5/6)	74% (101/137)
	(6) Percentage of NHS Ambulance, Care and Mental Health trusts with recruitment in NIHR CRN Portfolio studies every quarter	95%	100% (3/3)	95% (71/75)
Participant Experience Demonstrate to participants that their contribution is valued	Number of NIHR CRN Portfolio study participants responding to the Participant Research Experience Survey, each year	931	1,600	green

Data is taken from HLO Dashboard in ODP

2

Annual Plan 2023/24 is in Appendix 2

The annual plan was developed, reviewed and amended in collaboration with regional R&D Managers, Lead Research Nurses, core senior management team and the Network Clinical Leads. Objectives and plans were developed to ensure compliance with the Performance and Operating Framework which forms part of the network contract and to also meet the NIHR operational priorities.

Annual Finance Plan 2023-24 is in Appendix 3

A financial break-even position was achieved in 2022/23
A copy of the funding principals and finance plan 2023-24 on the initial allocation is provided as Appendix 3. These were agreed by the Partnership Group in April 2023.

4. Resource/legal/financial/reputation implications

Highlights / Impact Report 2022-23

The one page highlight / impact report provides an important assurance that the NIHR contract is being delivered and that key objectives are achieved. Overall the network achieved the majority of the goals set and did exceptionally well given the pressures currently within the system.

Annual plan and Finance Plan 2023-24
The RDUH is the Host organisation on behalf of all NHS providers in the SWP. If funding is not allocated appropriately the consequence is that the ability of partner organisations to support research will be impaired. This will mean there are fewer opportunities for participants to enter studies which might be of benefit to them.

The annual plan was developed by the CRN SWP senior management team in collaboration with the regional organisations, and clinical leadership of the network. It aligns itself with the NIHR strategic priorities to ensure the SWP remains focused and driven by the national research agenda. The plan was also developed in light of the post COVID recovery in the NHS and the knowledge that the network would be transitioning to a new contract.

The region still receives the lowest amount of funding compared to all other LCRNs. Although the funding model changed in 2019-20 to move away from an activity-based funding (ABF) model, the baseline 80% was still based on a previous ABF model so as the region's activity has proportionately been lower than other LCRNs this makes growth difficult. The recovery of the portfolio post COVID was a key priority and so financial stability was an an agreed principal of the funding model for 2023.24.

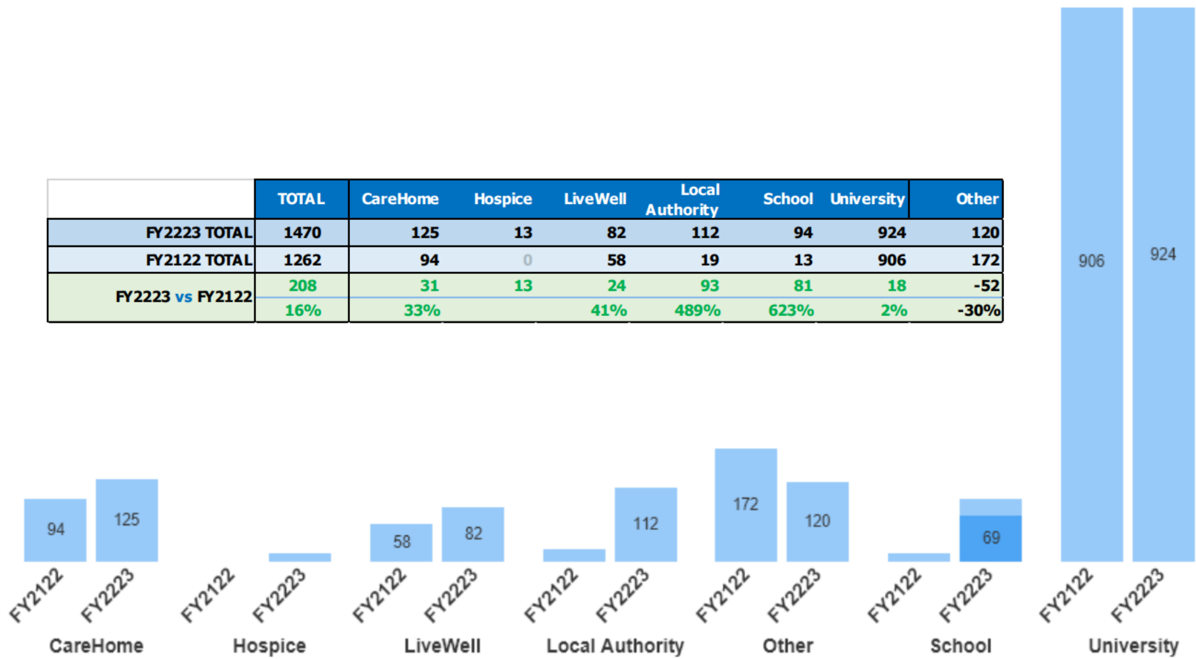
5. Link to BAF/Key risks

Key risks to delivery of the CRN SWP annual plan continue to be linked recovery, pressures of the health and care system and workforce pressures. There are a number of initiatives to support workforce capacity building programmes across the health and care system including the clinical research practitioner (CRP) pathways; collaboration with the Chief Nurse Research Fellows programme; links with Health Education England to support Advanced Clinical Practitioner programmes, Local Authority initiatives through the First Steps programme, access to the new NIHR Academy of Royal Colleges Clinician Researcher programme at the University of Exeter and other universities across the country and local training opportunities supported by the CRN.

The research infrastructure in the region will support a continued pipeline for the CRN to deliver and growth in research across the region. The region has an NIHR School of Primary Care research and School of Public Health Research based at Exeter University; there is also the new Biomedical Research Centre. The RDUH also hosts one of the five NIHR Patient Recruitment Centres (PRC) which are dedicated to delivering commercial research which is additional infrastructure for commercial research. The CRN will continue to work collaboratively with this infrastructure.

Attracting staff to roles within the new 'agile workforce' which is part of the transformation of research delivery is also a challenge; there are strategies to support the placement of staff across the region to support recruitment and targeting of research capacity. This is now in it's second year and this workforce placed across the region has supported research in a wide range of settings including primary care and other out of hospital research. The table below demonstrates our growth in out of hospital research.

Recruitment - Non-NHS



	TOTAL	CareHome	Hospice	LiveWell	Local Authority	School	University	Other
FY2223 TOTAL	1470	125	13	82	112	94	924	120
FY2122 TOTAL	1262	94	0	58	19	13	906	172
FY2223 vs FY2122	208	31	13	24	93	81	18	-52
	16%	33%		41%	489%	623%	2%	-30%

The region continues to have key relationships to support continued commercial pipeline through the IQVIA prime site and Inspire Pfizer status. Regular meetings with ROCHE and PPD take place as well as individual study specific meetings for Chief Investigator commercial trials which the local network now support.

The region continues to receive the lowest amount of Research Capability Funding (RCF) which is linked to NIHR Chief Investigators and NIHR infrastructure. The region is ranked 13/15 for RCF funding receiving £1,357,549 compared to the top region that receives £5,472,401. The CRN continues to fund its Research Associate programme to support growth in Chief Investigators.

The CRN will be transitioning to a new contract which will be completed by the 1st October 2024. There may be risks associated with these changes linked to staff within the core team. A management of change process will be taking place during 23/24 and in to the financial year of 24/25, so appropriate mitigation plans will be put in place as this develops.

6. Proposals

The Board is asked to agree/approve:

I. Agree - The annual report for 2022.23 – Appendix 1
II. Agree - Annual Plan 2023-24 –Appendix 2
III. Approve as ratified by the Partnership Group - Annual finance plans 2023-24

7. Appendices

1. Annual Report
2. Annual Plan
3. Annual Finance Plan (Trust Allocation) and Funding Principles

Appendix 1

CRN SWP Highlight Report 2022/23

Reset

Overall, the Recruitment to time and target (RTT) pass rate for non-commercial was 79% for open studies compared to 68% nationally, and 100% for closed studies compared to 85% nationally. The RTT pass rate for commercial studies was 92% for open studies compared to 71% nationally. Investments were targeted in organisations to support the Reset agenda - UHPNT received £30k to provide out of hours working to target the portfolio. Overall recruitment in 2022/23 was 30% higher than in 2019/20 prior to the pandemic. The number of recruiting studies was 10% higher than in FY2122, and 50% higher than in FY2021. Primary care performance continued to excel with 48% of GPs recruiting to studies. Innovation in trial delivery for the MUCAT study (49795) led to the South West contributing 24% of overall recruitment. The SHAPE study (43731) was brought back on track through close liaison with our Study Support service, opening the study at a local social enterprise and supporting PIC activity and has now led to the study reaching target.

Life Sciences Industry

Organisations across the region recruited to 119 commercial studies. The Harmonie study (51978) saw 9 sites recruit 337 participants to time and target and the Plymouth Mobile Research Unit was used to support delivery and widen participation. The first commercial oral and dental study Progress (49711) recruited to target and was the 3rd highest recruiting site in the UK after adjusted with population. GP practices recruited 138 patients to commercial trials and a practice new to commercial activity was selected to do the LIGHTHOUSE Study (53716). A commercial primary care growth plan has been developed to increase the number of GPs able to support activity. A workshop with regional managers identified actions to support the regional recovery

and growth plan. A new Expression of Interest process has been developed and piloted to drive better return rates. To support a future pipeline a successful decentralised trials event was hosted in collaboration with IQVIA which provided actions to take forward.

Local Initiatives

Support from our Agile workforce has increased the number of out of hospital sites delivering research, with the team supporting 33 recruiting studies across the local authorities, dental practices, schools and hospices. Recruitment of participants from out of hospital settings increased by 16%. 125 participants were recruited into care home research across 5 studies and 29 care homes. The MapMe study (49807) recruited 104 participants supported by the Agile workforce with Devon County council. The LCRN supported the NIHR palliative care network and delivered a regional, then supra regional, supportive and palliative care meeting to support hospice research which included the commissioning of a powerful patient case study. Two hospice sites have since opened and are recruiting to the CHELSEA II study, including one site new to research. The region has appointed a Screening, Prevention and Early Diagnostic Lead (SPED) with 7 studies now opened in a range of settings.

A research inclusion working group has been established with representatives from all Parnter Organisations (POs) to develop a regional action plan to support wider participation in research. Collaboration with the cancer alliance has targeted investment in cancers that disproportionately affect underserved groups leading to a number of studies being opened. Specific projects have targeted rural and coastal, mental health, deprived, and learning disability groups to engage in research. A joint project with population health management has explored the use of a regional data resource for effective targeting of research. GP practices in underserved areas sent text messages to patients encouraging them to sign up to Join Dementia Research (JDR) and saw an increase of 122% in sign-ups. 8 GP practices providing Patient Identification Centres (PICs) support for 2 local CI studies: Help Spot Cancer Early (53191) and Nature on Prescribing (53907). The LCRN's Research Ready Communities project has resulted in a GP practice in an area of significant deprivation becoming research active. The CRN is actively supporting a regional ICB research and innovation strategy in collaboration with POs, Applied Research Collaboration, Higher Education Institutes and Academic Health Science Network to embed research in the health and care system.

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Appendix 2

Clinical Research Network
CRN South West Peninsula

2023/24 Annual Plan

Host Organisation Approval

Confirmation that this Annual Plan has been reviewed and agreed by the LCRN Partnership Group:	Yes/~~No~~
Date of the LCRN Partnership Group meeting at which this Annual Plan was agreed:	
Confirmation that this Annual Plan has been formally approved by the LCRN Host Organisation Board:	Yes/No
Date of the LCRN Host Organisation Board meeting at which this Annual Plan was (or will be) approved:	26/07/2023

Areas of Strategic Focus - CRN SWP Aims and Outcomes				
As part of the NIHR, the CRN SWP has set out objectives in line with Best Research for Best Health: The Next Chapter and other key strategic objectives for 2023.24				
Strategic Focus Area	**CRN SWP Aim**	**Outcome** *(what SWP wants or needs to achieve)*	**Lead**	**Time Frame**
Build on learnings from the research response to COVID-19 and support the recovery of the health and social care system	Implementation of data/ digital support for research	1. Support Pilot with CC on implementation of Find, Recruit and Follow up to support Chief Investigators to utilise digital/data solutions 2. Pilot of Be Part of Research to support clinician referral to research studies 3. Build on IQVIA decentralised trials event and develop further training for staff across the region 4. Embed research feasibility and delivery within the emerging South West Secure Data Environment (SDE) 5. Utilise the one Devon dataset and other integrated care system datasets into the Chief Investigator pathway 6. Implement the regional find a trial tool and pilot within cancer	Study Support Service Lead DCOO Workforce Lead DCOO DCOO RDM	Q1-4
Build capacity and capability in preventative, public health and social care research	Embedded culture of research within the Local Authority (LA)	1. Develop a Comm's campaign within a LA working with the LA comms leads to include- workforce and research opportunities; infographic and messages to Managers to realise research benefits; research opportunities ; your path in research stories 2. Support the open Health Determinants Research Collaboration (HDRC) and future HDRCs with staff research delivery training 3. Ongoing evaluation of the embedded research roles to include survey across all LAs. 4. Continued roll out of research culture survey across all LAs	Communications Lead DCOO	Q1-4

		5. Support the PARC study (54199) roll out in 3 LAs 6. Develop local EDGE attribute for social care research		
	Capacity building programme for LA/voluntary sector staff	1. Develop, implement and evaluate the regional First Steps LA programme - coproduced with the social care/public health and Lay involvement 2. Support at least 2 Research Associates from the Local Authority and continue with the joint ARC/CRN internship programme supporting 2 interns 3. Work in collaboration with University of Plymouth to integrate research delivery into undergraduate and post graduate curriculum	DCOO	Q1-4
	End of Life Care research community Grow end of care research across the SWP	1. Continue to support the South West Peninsula Palliative Care Research Partnership 2. Work with Research Delivery Manager (RDM) colleagues in the West of England and Wessex CRN's to further develop a supra regional community of practice. 3. 3. Open the CHELSEA II hydration study in at least 2 SWP Hospice sites, one of which to be new to NIHR Portfolio research. 4. Scope interest amongst the Supportive & Palliative care community to fund a hospice link nurse.	RDM	Q1-4

Improve the lives of people with multiple long- term conditions (MLTC) through research	Capacity building for supporting MLTC research	1. Develop community of pratice with Clinical MLTC Nurses to support patient identification 2. Supporting researchers to include those with MLTC research as part of recruitment strategy 3. Supra regional MLTC research event 4. Support regional Applied Research Collaboration SEISMIC bid and link with the Secure Data Environment to support CRN activity 5. Create Think tank for cross speciality working for MLTC 6. Support access to chronic disease research for those mental health conditions	RDM	Q1-4
Bring clinical and applied research to underserved regions and communities with major health needs	Data solutions for research targeting	1. Implement national targeting tool within the study support service 2. Build upon CRN SWP Equality Diversity and Inclusion report. a. work with PO's for further analyses; create training resources for PO's b. Further exploration the implementation of aggregating regional primary care data by EDI characteristics 3. Pilot of using population health management work in Devon ICS and one Devon Dataset to target research 4. Develop regional targeting tool to support Chief Investigators and local targeting	DCOO/BIU	Q1-4
	Prevention, screening and early diagnostic research supported by LAs	1. Identify work within the LAs that target uptake of screening with underserved groups and align research opportunities with this work including early diagnostic studies 2. Scope the use of screening contact lists for use in appropriate studies 3. Map out the smoking cessation services in each LA and develop local processes for supporting smoking cessation research	DCOO	Q1-4

	Targeting research - Plan and Place	1. Track all core20plus5 and ICS priority studies across the region and ensure these studies are opened in areas of need2. Develop process for identifying these studies in local EDGE attribute and report quarterly to ICB	BIU/DCOO	Q1-4
	Research ready communities	1. Continue to support research ready communities pilot 2. Build on NHSE/I Research Engagement Network Development (REND) project 3. Develop training/toolkit to support Voluntary Community and Social Enterprise (VCSE) partners support research engagement 4. Target Be Part of Research (BPoR) engagement and signup in rural/coastal communities - Pilot with ONE Cornwall Research and Development (system wide R&D collaboration - LA/primary care/ Acute/ Community) 5. Link in with the Devon ICB creative health project and the mobilising community Assets inequalities programme led by ARC	PPIE Lead	Q1-4
	Life sciences rural and coastal underserved project	1. Develop rural and coastal proposal with Plymouth University Centre for coastal communities in collaboration with ROCHE to explore clincal and research access to care; implement the findings across the region with an action plan to support a coastal and rural research access plan 2. Utilise the videos produced for capturing Index of Multiple Deprivation (IMD) for industry Lead CRN studies to support broadening access	DCOO Business Development Operations Manager	Q1-4
Embed EDI across NIHR research, systems and	To support EDI cultural shift across CRN SWP	1.Implement the regional EDI plan - coproduced with Partner Organisations - thematic areas - research participation and involvement/ workforce/ processes 2. One NIHR strategic group to create/share training resource and tools to	EDI Lead	Q1-4

culture		support EDI in study design and align strategies		
Strengthen careers for research delivery staff and under-represented disciplines and specialisms	Increase the number of NMAP's Supporting research delivery and career development	1. Deliver and evaluate 70@70 legacy project for nursing and midwifery 2. Pilot of ARC / CRN internship programme aimed at mental health/social care and public health early career researchers 3. Deliver the regional CRP strategy - recruit ten registered CRP's 4. Uptake of Research Associate programme targeted at least three NMAP's 5. Engage with the Clinical Scientist programme to promote the value and career opportunities in research. 6. Support the delivery of the AP strategy in collaboration with the University of Plymouth (commissioned by Health Education England) and embed research delivery in programme 7. Develop training and placement opportunities with the School of Dietetics to support the obesity research pipeline	Workforce Lead	Q1-4
Reset and Growth	Develop and deliver a commercial research mentoring scheme for growing commercial research in primary care.	1. Commercial Primary care Growth Project Plan	RDM Cluster 5 /DCOO/Business Development Operations Manager	Q1 - Q4

	Support for high profile programmes	1. Step up regional vaccine hub delivery models 2. Scope and develop hub and spoke models and other implementation plans for the Cancer Vaccine pipeline 3. Develop the delivery model for obesity research	DCOO/ Business Development Operations Manager/ RDM Cluster 1	Q1-4
	Commercial action plan	1. Implement the commercial action plan https://docs.google.com/spreadsheets/d/1Ptd1dklk8nY0PeBzgcy2YYByrJTCl_AcSqDa70kVbJk/edit#gid=0	DCOO/ Business Development Operations Manager	Q1-4
	Reset	1. Implement the regional commercial action plan 2. Develop project to support study set up to help maximise recruitment windows - embed as part of the Performance Review Lead Role for commercial and work with sponsors for non commercial; identify key metrics to support data collection; identify blocks and variation in practice and write up findings with action plan 3. Implement data integrity plan at the set up of each Lead CRN study 4. Robust assessment of deliverability as part of early engagement meeting involving speciality leads for Lead CRN studies	DCOO/ Study Support Service Lead	Q1-4
	Implementation of the National Contract Value Review	1. Implemented across the region 2. Improve adherence 3. Track set up times to maximise recruitment windows	Business Development Operations Manager/Business Intelligence Unit	Q1-4

	Growing capacity to support MedTech and Artifical intelligence research to support the DHSC Medtech strategy	1. Continue working with AHSN on innovation pathway to open at least 3 Medtech studies 2. Joint meetings with AHSN and PenRadiology group to support growth in Artificial Intelligence Imaging Research 3. Produce infographic to market the regional collaboration for Imaging Research 4. Run a join event with National Office for Research Infrastructure (NOCRI)/ UKRI / Small and Medium Enterprises (SMEs) to support submission of grants for MedTech research	DCOO/ Business Development Operations Manager	Q1-4
	Targeted Site ID Process	1. Develop escalation process that meet core priorities 2. Involve SRLs in site ID regional process 3. Evaluate impact the new site process https://docs.google.com/spreadsheets/d/1ii6Jw8J81uCCQxuu7trZ3NHB-S1dqUcU4czEASSVA6M/edit#gid=0https://docs.google.com/spreadsheets/d/1ii6Jw8J81uCCQxuu7trZ3NHB-S1dqUcU4czEASSVA6M/edit#gid=0	Business Development Operations Manager	Q1-4
	Commercial workforce support programme	1. Identify the Commercial Chief Investigators across the region 2. Undertake a survey to identify the requirements of the role 3. Develop support package to support study design and doability assessment 4. Identify future potential PI's/CIs to market to industry	Business Development Operations Manager/Workforce	Q2-3
Embedding research in health and care system	Embedding research in the ICB	1. Support the implementation of the ICBs regional research and innovation strategy 2. Share Impact stories linked to core20plus5/ key priority speciality areas to be shared in ICS communicationss 3. Develop a one ICS communications plan in one ICB area to support better awareness of research and uptake of the public joining Be Part of Research 4. Develop regional reports for ICBs on research participation for the population	COO/CD Engagement Lead	Q1-4

	Embedding research within the LA	1. Attend Association of Directors of Adult Social Services (ADASS) regional meeting to support awareness of research 2. Attend the regional Senior social work meetings 2. Replicate the research week held by Devon County Council across all LAs (see culture of research within the LA)	DCD/ DCOO	Q1-4
	Embedding research in the NHS	1. Reinstate the regional impact library for use by NHS staff 2. Develop slidesets for use by NHS staff for different staff groups 3. Support Research & Development teams use of Best Patient Care, Clinical Research and You	Communications Lead	Q1-4
Community/ primary care strategy	Primary Care Data Project	1. Roll out of robust data systems across primary care to enable accurate feasibility and timely delivery of studies. Proposed systems: Farsite, Clinical Practice Research Data link (CPRD), Primary Care IT solutions (PRIDES) 2. Development of training package for primary care study set up and agile research delivery team about data systems 3. Completing knowledge mapping of primary care and community services in conjunction with AHSN, Devon ICB and CRN SWP. 4. EDGE (local portfolio management systems) revamp in primary care: implementation of quartely EDGE data quality to ensure accurate recruitment records.	RDM Cluster 5	Q1-4
	RSI scheme review	Implementation of a primary care incentivisation programme that meets the health needs of our communities, supported by robust data systems to enable accurate feasibility and efficient delivery of research studies for patient/population benefit.	RDM Cluster 5	Q1-4
	PIC Improvement project	1. Implement EDGE PIC processes in line with national Standard Operating Procedure (SOP) across all health and care settings. 2. Identify affiliated practices for all NHS organisations to support a rapid PIC	DCOO/SSS/RDM Cluster 5	Q1-4

		process 3. Develop mental health specific PIC activity process and clinical coding project		
	PCN research model Pilot	1. Meet with the Primary Care Network (PCN) Clinical Directors who have expressed an interest in delivering research at scale across the PCN. 2. Map out models of delivery that are compliant with HRA guidance and governance requirements. 3. Complete finance modelling based on feedback from PCN's, with support from the finance team. 4. Work with RDM's with out of hospital research portfolios, to scope how system wide research can be delivered and supported with the PCN. 5. Draft PCN pilot proposal for Operational Management Group (OMG) / Clinical Leadership Group (CLG) review and ratification. 6. Subject to OMG/CLG approval, utilise some of the Research Support Initiative (RSI) funding to pilot PCN research between Q2 and Q4 7. End of pilot project report submitted in Q1 of 2024/25.	RDM Cluster 5	Q1 - 4
	Primary Care Commercial Collaboration with PRC	1. Establish robust PRC PIC processes for complex commercial PIC activity 2. Develop work instruction with PIC request form 3. Agree invoicing process	RDM Cluster 5/Primary Care SRL	Q1-4
Direct Delivery Team growth and impact	Governance	1. Primary Care General Data Protection Regulations (GDPR) and Informance Governance process for pre-consent activities. 2. Produce clear guidance of governance process for Direct Delivery Team in non-NHS settings	SRDM	Q1-2

	Ways of working and culture	1. Formalise matrix of responsibilities for out of hospital research studies. 2. Evaluate impact of systemic coaching process for Agile workforce	SRDM	Q3-4
	Agile app	1. Developing an interactive online tool to collect and manage the Agile team's capacity and activity. The information collected from this tool will then automatically feed into the Agile Dashboard. 2. Monitoring the impact of the Agile Team with live real-time information to assist Senior Management Team in timely informed decision-making.	BI Manager	Q1-4
	Care homes	1. Infographic - articulate the benefits of research to care homes, prepare Enabling Research in Care homes (ENRICH) script for staff to use when approaching a research niave care home. 2. Raise awareness for the care home education support team 3. Explore running a ENRICH care home event with Wessex.	RDM Cluster 2	Q2-3
	Agile team Training skills	1. Review and monitor the ARDT mandatory skills training 2. Provide training for interactive Capacity / Activity App 3. Aim to create a practical skills workshop in Primary Care for Agile team 4. Create 30 minute rolling education programme (Breakfast Club)	SRDM	Q1-2

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Section 2: Other Local initiatives for CRN SWP in 2023/24

CRN Key Specialty Areas				
Mental Health	**Increase in Psychedelic research within region**	1. Write a summary paper to share with partner organisations the the use of psychedelics, their applications in specialities and horizon scan for future research 2. Open one study with a schedule 1 license in at least one organisation across the region. 3. Work with SRL to share the learning from the organisation that opened the schedule 1 study to other PO within the region	RDM	Q1-4
	Child and Adolescent mental health services (CAHMS) research participation	1. Work with CAMHS Surge forum team to replicate the work done in Cornwall throughout the SWP. 2. Map out the clinican interested in CAHMs research throughout the SWP, explore using https://mentalhealthresearch.org.uk/mental-health-research-map/ as a repository for interested CAHMs researchers.	RDM	Q1-4
	Schools Network for CAHMS research participation	1. Work with Agile team and Children's RDM to develop a plan to engage with schools in Somerset, Devon and Cornwall with an emphasis on CAHMs research.	RDM	Q1-4

	Addiction	1. Scoping and mapping potential services for addiction 2. Identify potential PIs 3. More-Kare - Collaborate with communications team to ensure rapid recruitment to this difficult to reach group to each sites throughout England and devolved nations. Use targetting tools to support site identification relating to targetting underserved communities.	RDM	Q1-4
Respiratory	**Commercial capacity building**	1. Map respiratory clinicians specialist areas of interest in SWP. 2. Aim to open 1 new study with newly identified PI's from mapping exercise 3. From mapping exercise identify those who are primary care clinicians and work with them to encourage care homes that they work with to participate in AFRI C study	RDM	Q1-4
Dementia	**Increase number of settings promoting and participating in dementia research**	1. Link with dementia care homes and their dementia champions to raise awarness of opportunities. 2. Work with the Care Home Education Support Team to raise awarness of research within the team and the organisations they support	RDM	Q1-4
Cancer	**Find a trial app**	1. Continue work with Business Intelligence Unit (BIU) to pilot the App in 2 acute Trusts (Royal Cornwall Hospitals NHS Trust and Torbay and South Devon NHS trust) as well as at regional Hepatology Multi Disciplinary Team (MDT).	RDM's Cluster 1&6	Q1-4
	Deliver the CHELSEA II study	1. Open the study in at least 2 SWP sites, at least one of which must be a hospice new to Portfolio research.	RDM Cluster 1	Q1-2
	PI Capacity funding	1. Secure ongoing funding to support Principal Investigator (PI) capacity building within our organisations.	RDM Cluster 1	Q1-2

	Increase early diagnostic, screening cancer studies (SPED)	1. Support the Lung health checks study - SCOOT study (52228) at RCHT 2. Early diagnostic centres -relationship building to support the delivery of appropriate SPED studies. 3. SPED collaborations across primary and secondary care to deliver early diagnostic research The LIGHTHOUSE study (CPMS 54864) will help develop and test methods of delivery. 4. Delivery of the GRAIL MCED Galleri Test study (CPMS TBC) at scale across primary care. This is an early cancer diagnostic study. National sample size 33,000	RDM Cluster 1	Q1-2
Maternity and Neonatal	**Research Event**	1. Co-ordinate a Reproductive Health Research Event	RDM Cluster 3	Q1-4
Data and Digital	**Be Part of Research App**	1. Support colleagues in using the Be Part of Research (BPoR) app to for patient referral 2. Support the CRN CC in improving the BPoR app	BI Manager	Q1-4
	EDGE 3 Roll Out	Coordinating EDGE and Partner Organisations to ensure a smooth EDGE 3 roll out and to make the most of the new and improved EDGE functionalities.	BI Manager	Q1-4
	Under-served Community App	Working with National CRN and Partner Organisations to develop effective and sustainable system for collecting and presenting EDI information, possibly as a new Qlik Sense App	BI Manager	Q1-4
Workforce Development and training	**CRP Programme**	1. Develop CRP JD's & Roles within Agile Research Delivery Team 2. Scope number of unregistered Practitioners within PO's	Workforce Lead (WFL)	Q1-4
	PI Development	1. Undertake Regional PI Essentials workshops. Capture profession & speciality data of attendees	WFL	Q1-4

		2. Target audience for areas of need and pipeline growth 3. Evaluate 2022-23 PI Essential attendees. Conversion of attendees into PI's, CI's 4. Provide bespoke PI Essentials sessions in Primary & Community Care		
	Associate PI Scheme	1. Identify key areas of pipeline growth and target specialties in both Primary & secondary care 2. Generate a register of PI mentors for the Associate Principal Investigator (API) scheme 3. Quarterly reporting to OMG 4. API Impact story from both medic & non-medic professions	WFL	Q1-4
	Recruitment & Retention of workforce	1. Explore the option of SWP attendance at National NHS Recruitment Event with Lead Research Nurses/Practitioner 2. Support Health & Wellbeing initiatives for Core Team 3. Support any CRN CC transition initiatives for CoreTeam	WFL	Q1-4
	Early Career Research Programme	1. Support, facilitate & evaluate the Research Associate Programme 2. Evaluation of 70@70 Chief Nurse Fellowship Programme	LCRN Chief Nurse	Q1-4
	Community Nurse / Advanced Clinical Practitioners Engagement Pilot	1. Provide overview of research delivery at SWP General Practice Nurse Post Grad sessions 2. Support Health Education England (HEE/NHSE) meetings and working group sharing opportunities to support research activity	WFL	Q1-4

	Next Steps / DRIVE Training	1. Support & facilitate Regional working group for Next Steps Programme 2. Facilitate and co-ordinate Next Steps sessions within each County	WFL	Q1-4
	Facilitator Community of Practice	1. Facilitate quarterly Face to face meetings for Facilitator Group 2. Provide support for working groups (Induction & Next Steps)	WFL	Q1-4
	EDI Training	1. Establish Regional uptake of NIHR INCLUDE Training 2. Introduce inclusion based surveys 3. Review accessibility of SWP Training offers 4. Roll out the unconscious bias training	WFL	Q1-4
	Induction	1. Support & facilitate Regional Induction working group. 2. Complete Induction recommendation infographic for PO's 3. Complete Induction recommendation inographic for Public Health & Social Care 4. Devise a "Research Ready" induction for non-NHS settings	WFL	Q1-4
Communication and PPIE	**Underserved**	Co-produced comms resources for specific underserved community - pilot roll out in the ICS in Cornwall	Communications Lead	Q1-4
	EDI	Communicatons accessibility training resources for core team and POs	Communications Lead	Q1-4
	Direct Delivery Team	Information packs for different settings eg. schools/local authorities/care homes/prisons	Communications Lead	Q1-4
	JDR	Increase number of people with dementia signed-up to JDR - regional campaign with care homes	Communications Lead	Q1-4
	Be Part of Research (BPOR)	Regional campaign to increase sign ups	Communications Lead	

Business Development	**Site Idenfification (ID) Process**	Evaluate benefits and effectiveness of commerical Site ID MS team platform, facilitate regional roll-out as required.	Business Development Operations Manager (BDOM)	Q1-4
	Commercial Primary Care Growth Strategy	Increase the number of commerically active general practices.	BDOM	Q1-4

Appendix 3

Clinical Research Network
CRN South West Peninsula

CRN SWP Proposed Funding Principles 2023-24

1.1 Funding is allocated to the 15 Local Clinical Research Networks (LCRNs) from the NIHR Clinical Research Network National Co-ordinating Centre (CRN CC) to support activities described in the LCRN contract which includes the Performance and operating Framework (POF).
1.2 Funding is allocated to support all activities outlined in the POF which include all aspects of research delivery, Patient and Public Involvement and Engagement, Workforce development, Communications, Study Support Service, Industry and business development, and continuous improvement in research delivery.

2023/24 Funding Allocations

1.3 NHS trusts with an average CRN funding allocation over £1m in the previous five years have been assured 90% of their 2022/23 initial allocation in the 2023/24 financial year, subject to expected research delivery volume and performance being met. This multi-year funding approach requires the LCRN Leadership team to make an assessment as to whether the LCRN Partner requires the assured funding (i.e. the 90%), as a minimum, in 2023/24. This assessment -i.e. the funding allocation required by the Partner in 2023/24 - should be inherent to the LCRN's ordinary annual local funding distribution model. The local funding distribution model will enable the LCRN Leadership team and LCRN Partnership Group to be assured that the CRN Funding allocation provided to the Partner is proportionate to the planned research activity. This assessment should also consider whether or not the LCRN Partner has contributed to CRN HLOs in the region, proportionate to the level of CRN Funding received.

As the NHS trusts in this group have consistently large portfolios and high levels of research volume, it is a reasonable expectation that all Trusts will require the 90% funding as a

minimum in 2023/24. Should a case arise where the LCRN Leadership team considers that a 2023/24 initial allocation below the 90% value is appropriate, this case should be referred to and discussed with the Coordinating Centre at the proposal stage (i.e. in advance of submission to the LCRN Partnership Group).

1.4 The national model was reviewed in 2019/20 and it was agreed that LCRNs be given an initial allocation, with 80% 'fixed' until 31 March 2023 using the 2018/19 allocations as the baseline. A variable element (20%) was then used to incentivise and reward against performance related to the high-level objectives and CRN speciality objectives in 2019/20 and in 2020/21 linked to an additional objective for research targeting linked to performance in high priority areas – asthma, cancer, COPD, dementia, diabetes, heart failure, mental health common, mental health severe and stroke. Each of these were allocated 4% of the 20%.

1.5 Funding in 2021.22 was allocated in 3 ways. All LCRNs received a flat budget based on their 2020/21 budget which not linked to any performance metrics because of the impact of COVID. Additional funding was then also given to alleviate cost pressures and support retention (£7.46m nationally) and funding to support staff retention where posts were at risk (£10m nationally). This funding was allocated as a percentage of the initial 2020.21 allocation. Additional funding was then given to all LCRNs to support the transformation of research delivery. This funding was ring fenced to support building a new workforce, a CRN Direct Delivery Team which will provide additional capacity and capability to deliver priority research studies in out of hospital settings. This is considered a 3-year initiative.

1.6 DHSC also provided separate funding to the LCRN host organisation for the provision of services related to managing excess treatment costs.

1.7 DHSC also provided funding for Public health prevention research which is a separate allocation.

1.8 No national contingency budget is held and LCRNS are expected to achieve POF objectives within their fixed allocation. This includes funding the host function; core leadership team; study support service; workforce development and training and education; research specialty leads; Industry and business development; communications; business intelligence; finance; information and communications technology; patient and public involvement and engagement; and continuous improvement in research delivery.

1.9 Following national guidance, the main principle of the local allocation is that a pass-through model is not adopted, account will be taken of local knowledge including local and national priorities, to resource flexibly to support continued activity as well as to support an increase in activity. Strategically, allocations will follow a 'necessary and sufficient' approach

with the requirement to maintain capacity, capability and stability.

1.10 Locally there is no imperative to follow the principles of the national model and no expectation that the same methodology is used. In proposing a local model therefore, the local network needs to be cognisant of local issues, use local intelligence to inform allocation, look historically to ascertain which investment has supported excellence in delivery and meet the requirements of the strategic direction of the LCRN.

1.11 The principles being proposed in this local model are informed by what is currently known about changes in the national model.

1.12 In order to develop the SWP proposal a funding model group was again established (Appendix A for membership). The group met between July 2022 to October 2022 to review funding principles, commission options appraisals of elements of the model and review analysis of investment and performance where appropriate.

Proposed Funding Allocation Principles and Rationale 2023-24

2.0 The following are the proposed guiding principles of the funding model:

A. Funding is used for permitted activities as outlined in the Performance and Operating Framework which forms part of the LCRN and Partner Organisation (PO) contracts, investment is monitored to ensure value for money Rationale: LCRNs have contractual obligations to deliver objectives as set out in the POF; these are refreshed annually and funding will therefore need to be allocated to ensure these objectives are met. The majority of funding is allocated at the start of the financial year (FY); as payment is made monthly there is the ability to move funds during year for example if a post is not appointed or if a study does not open or if performance is not as anticipated.

B. The majority of CRN SWP funds are used to support staff costs, stability in this funding to support staff retention is therefore desirable, although this must be balanced with performance. Funding allocations rise and fall and patient pathways change, therefore the CRNSWP may be required to respond to fluctuations in the national allocation, the region's activity, cost pressures and strategic objectives.

C. Consideration is given to the NIHR High Level Objectives (HLO's) as set out in the Performance and Operating Framework. To note the HLOs may not be agreed until after these principles are agreed so it may be necessary to change. Rationale: In order to achieve HLOs it is necessary to target resource to achieve objectives. It is necessary therefore to be cognisant of HLOs when making allocations in order to meet objectives. The HLOs are subject to change so allocations may be reviewed in the context of the finally agreed HLOs.

D. Consideration is given to the NIHR Specialty mandatory requirements as set out in the Performance and Operating Framework. Rationale: In order to achieve the mandatory requirements, it is necessary to review any changes to these once the final POF is released.

E. Consideration is given to the elements identified as informing performance related funding nationally or national strategic funding top slice Rationale: It may be necessary to top slice resource to ensure the ability of the network to gain additional funding for the performance elements is maximised or to demonstrate impact against strategic initiatives such as research targeting.

F. Funding is necessary and sufficient knowledge of the 'actual' requirements to deliver the portfolio are considered. Rationale: The network has good regional oversight of the actual resource requirements for delivery and will use data from multiple sources to inform allocations

G. Any Partner Organisations in receipt of funds >£50k provide a full annual plan outlining proposed use of funds and the plan the organisation has to achieve contractual requirements. Rationale: PO's in receipt of >£50k are category A partners which is the 'step down' contract from the DHSC to Host RDUH. As such they are contractually obliged to support objectives and assurances as set out in the POF. In order to determine that POs have considered the POF and that funds will support POF delivery, a plan is required to provide assurance.

H. Funding is provided to support defined contractual requirements

1. Host Function
2. LCRN Leadership and management
3. Local Speciality Research Leads
4. Cross cutting obligations including Local Portfolio Management System
5. (LPMS); Communications; Continuous Improvement; PPIE; Workforce
6. Development and training; Study Support Service; finance; business
7. Intelligence

Rationale: There are defined allocations for two elements of LCRN funding the Host function, and LCRN Leadership and management. LCRNs are required to have a Clinical Leadership Group within the governance structure formed with Clinical Research Specialty Leads, in CRN SWP there are five and they support a cluster of defined specialty areas or themes, there are also one Lead Research Nurse and one R&D manager on a rotational basis. There is also a requirement for Local Specialty Research Leads (LSRLs) for all 30 specialty areas and sub-specialty leads for some of these specialties. Funding for these roles ranges from 0.25-1.5PA/equivalent determined by required activity for that specialty and linked to strategic investment. There is a requirement to have a LSRL in all 30 specialities, have research champions in a number of others and to support speciality leadership in new areas such as social care. The POF also stipulates defined study support

service, communications, continuous improvement, PPIE and workforce development requirements and that there is an LPMS, staff resource and non-staff funding is reserved for these activities and is set annually based on POF requirements.

I: Top Slice - Clinical Support Team (Primary care/community)
Rationale: The Clinical Support Team (CST) which now form part of the larger Agile workforce is a centrally managed resource with registered and unregistered clinical and non-clinical delivery staff working predominantly in primary and community care, the team can also support all other providers and as the portfolio expands will support public health and social care research. The flexibility of this team in being regionally based enables targeted time limited support with organisations provided with resource, staff, as opposed to funding which is then organisationally bound. This top slice is proposed to remain the same so that the transformational monies provide additional capacity.

J. Top slice Research Site Initiative (RSI) £305K. Rationale: High Level Objective 3c is for 45% of general practices to be recruiting to NIHR studies. To support this objective the Research Site Initiative (RSI) provides funding currently set at three levels to support practices to engage with research (e.g. undertake GCP training, complete EOI). Agile support will be considered when determining the level of RSI. The transformation of research delivery may require additional resource to be assigned to the RSI scheme to support delivery of research in out of hospital settings. This will be carefully managed to ensure that the portfolio reflects the need for this increase.

K. Top slice Primary Care service support costs (SSC) Rationale: SSC are paid to primary care, community providers and non-NHS providers via a triggered payment process based on funding for study set up and then a per patient allocation paid once activity seen in ODP quarterly in arrears. This process is run by the Host for and allows tight budget management; £90k is reserved and released to contingency in year if this level of allocation is not required. Slippage from the service support budget should be initially prioritised for non-nhs settings and primary care.

L. Top slice for Regional Genetics Service £36,750.
Rationale: The RDUH is the regional provider of the genetics service and therefore has an allocation to reflect that this regional team will support recruitment across the region. The levelof funding will be based on actual activity to inform required ongoing funding and the study pipeline.

M. Top slice for South Western Ambulance Service NHS Trust
Rationale: SWASFT is supported with a 0.5 WTE research manager and research paramedic support (£44k) as well as SSC. This is based on actual requirement as opposed to any ABF model which previously would have resulted in disproportionality high allocation. In setting the allocation, activity and the study pipeline will be considered.

N. Strategic funding Underserved

Rationale: One of the NIHR seven areas of strategic focus is bringing clinical and applied research to underserved communities with a requirement that each LCRN supports a 2% top slice of budget to support this agenda. The CRN core team have a number of projects to support this through their plans for PPIE, communications and Business Intelligence and so staff resources are already used to meet part of the 2% requirement. Other strategic initiatives can be aligned to support this agenda whilst also supporting wider remits.

Allocation to all specialty research leads would remain the same for the last year of contract pending a review in line with new contract requirements in 2024.

(i) The Research Associate Programme (£120k) will be top sliced from the budget to support growth in research in defined speciality areas to meet the underserved agenda and it also supports workforce capacity building. The funding allocated by the CRN for the RA programme allows staff to gain portfolio skills whilst also developing their skill base to become PIs and potentially CIs.

(ii) 70@70 legacy project – this project was created last year to support capacity building in the nursing and midwifery workforce and to support embedding research. It is a joint initiative with Trusts and previous 70@70 leaders. It was agreed that this would be increased from £60K to £90K in order to expand on this programme of activity reaching out to community nurses and nurse practitioners within Primary Care.

(iii) First steps – This is a new support programme for research staff in local government and/or voluntary sector. A sum of £40k has been top sliced from the budget. Rationale: The need to build research capacity to support future studies outside of hospital settings in specifically in the local authority/voluntary sector is an important remit of the CRN. This programme allows the SWP to develop capacity to support future studies. Social Work and Public Health will be specifically targeted with an aim to ignite passion and interest in research and enhance motivation, skills and knowledge so that a pathway to a future career in health and social care research can be supported.

P. Contingency £30k
Rationale: To cover unexpected costs. Account will be taken of Trust RCF and commercial activity when considering any contingency applications. All applicants must provide explicit assurance that funds will not be used for CIP.

R. Transformation of Research Delivery £833k
Rationale. The separate budget for transformation of Research Delivery will be ring fenced for this project. There may be opportunities for Partner Organisations to bid for monies to support this transformation agenda. This will be further clarified through the Transformational programme board which will outline the plans for next year. The funding model working group were asked to agree the following to embed in the principles:

Recommendations from the funding model

- Taking into consideration that this is the last year of the current NIHR contract and the pressures experienced across all NHS services, the funding model working group have acknowledged the need for stability in funding for the 2023/24 budget. The pay award increases for core team staff and the POF requirement to appoint a 0.4 wte Chief Nurse as part of the LCRN senior management team will mean that the non-recurrent funding will be reduced but the recurrent funding to all organisations will remain the same.

- Distribution of the non-recurrent funding will be a percentage attributed in line with initial funding allocation. Non-recurrent funding will not be allocated against performance metrics.

- The funding model working group agreed the top slices for the strategic funding and other top slices.

- It was agreed that 'smaller' organisations in receipt of less than £400k would be protected as they are unable to generate commercial activity to offset any decrease.

- Any slippage in Service Support Costs (SSCs) will be used to support non NHS activity. This would be initially reviewed at Quarter 1

2023/24 CRN SWP	TOTAL	Funding	Recurrent	Non-recurrent	SRL	Pan Pen	Core Team	Primary Care	Transform R.Delivery	Contin-gency
TOTAL	£13,151,317		£8,733,275	£416,940	£295,000	£380,750	£2,046,019	£0	£1,249,333	£30,000
CPT	£384,922	3%	£221,450	£25,260	£6,000		£57,496		£74,716	
DPT	£475,679	4%	£360,780	£43,510	£12,000				£59,389	
RCHT	£1,303,783	10%	£1,168,570	£50,680	£24,000		£60,533			
RDUH	£2,502,420	19%	£2,230,910	£96,760	£102,000	£36,750	£36,000			
SFT	£1,391,326	11%	£1,293,790	£56,110	£6,000				£35,426	
TSD	£870,670	7%	£828,730	£35,940	£6,000					
UHPT	£2,060,178	16%	£1,906,010	£82,670	£27,000		£44,498			
YDH	£628,630	5%	£599,620	£26,010	£3,000					
SWA	£44,100	0%	£44,100							
LiveWell	£193,036	1%	£79,315						£113,721	
UoE	£18,000	0.1%			£18,000					
UoP	£15,000	0.1%			£15,000					
ICBs	£438,000	3%			£43,000				£395,000	
Other 'Non-NHS	£18,000	0%			£12,000	£6,000				
HOST	£2,405,824	18%				£92,000	£1,847,492		£466,332	
TBC	£401,749	3%			£21,000	£246,000			£104,749	£30,000

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** – (New)	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** - (New)	JP	FOC	25	4