Royal Devon University Healthcare NHS Foundation Trust

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

Wednesday 29 November2023
Boardroom, Noy Scott House, Royal Devon & Exeter Hospital

MINUTES

PRESENT	Mrs H Brazier	Trust Director (deputy for Chief Operating Officer)
	Mrs H Foster	Chief People Officer
	Professor A Harris	Chief Medical Officer
	Mrs A Hibbard	Chief Financial Officer
	Professor M Marshall	Non-Executive Director
	Mr A Matthews	Non-Executive Director
	Professor T McIntyre-Bhatty	Non-Executive Director
	Mrs C Mills	Chief Nursing Officer
	Dame S Morgan	Chair
	Mr T Neal	Non-Executive Director
	Mr P Roberts	Interim Chief Executive Officer
	Mr C Tidman	Deputy Chief Executive Officer
APOLOGIES:	Mrs C Burgoyne	Non-Executive Director
	Professor B Kent	Non-Executive Director
	Mr S Kirby	Non-Executive Director
	Mr J Palmer	Chief Operating Officer
IN ATTENDANCE:	Ms G Garnett-Frizelle	PA to Chair (for minutes)
	Mrs K Allen	Director of Strategy (for item 187.23)
	Ms C Baldwick	Deputy Medical Director, Eastern & Northern (for item 189.23)
	Mrs Z Harris	Divisional Director Community Services (for item 184.23)
	Mrs M Holley	Director of Governance
	Dr L Webb	Associate Medical Director Community Services (for item 184.23)

178.23	**CHAIR'S OPENING REMARKS**	
	The Chair welcomed the Board, Governors, staff and members of the public to the meeting. Ms Morgan reminded everyone it was a meeting held in public, not a public meeting and asked members of the public to only use the 'chat' function in MS Teams at the end to ask questions focussed on the agenda and reminded everyone that the meeting was being recorded via MS Teams. Ms Morgan thanked all the Governors attending, both in person and via Teams. **The Chair's remarks were noted.**	
179.23	**APOLOGIES**	
	Apologies were noted for Mrs Burgoyne, Professor Kent and Mr Palmer, noting that Mrs Brazier was attending on his behalf.	
180.23	**DECLARATIONS OF INTEREST**	
	Mrs Holley informed the Board that the following declaration had been received for Professor McIntyre-Bhatty: • Non-Executive Member, NHS Hampshire & Isle of Wight Integrated Care Board	

	• Governor, University for the Creative Arts • Chair, AIM Community Ltd (an educational charity) • Independent Reviewer, European Association for Quality Assurance in Higher Education (ENQA) **The Board of Directors noted the declaration.**	
181.23	**MATTERS DISCUSSED TO BE DISCUSSED IN THE CONFIDENTIAL MEETING**	
	The Chair noted that the Board would receive at its confidential meeting updates on Finance and Operational Committee and Cash Draw Down submission to NHS England.	
182.23	**MINUTES OF THE MEETING HELD ON 1 November 2023**	
	The minutes of the meeting held on 1 November 2023 were considered and approved.	
183.23	**MATTERS ARISING AND BOARD ACTION SUMMARY CHECK**	
	The Board of Directors noted and agreed the updates to actions.	
184.23	**CHIEF EXECUTIVE OFFICER'S REPORT**	
	Mr Roberts acknowledged the continued pressures in Urgent and Emergency Care (UEC), as well as in other services, adding that whilst there had been some days of good performance, No Criteria to Reside (NCTR) remained a significant issue blocking system flow. There had been discussion within the system on what could be done to boost capacity and a decision was still awaited on whether there was support for some of the additional things that had been suggested that would be outside the Winter Plan. There had also been discussions on how to reduce ambulance waiting times across the system. There had been good progress made on elective care, particularly considering the periods of industrial action. The Trust had had an invited visit from the regional cancer team on 28 November to look at progress on cancer services and an update on outcomes from that visit would be shared with the Board once received, although initial feedback was believed to be positive. Month 7 had been challenging for the organisation financially with a further move off plan from £11.3m to £17m. NHSE had required resubmission of reprofiled financial plans together with profiles of the impact of getting closer to the financial plan on Urgent and Emergency Care and Elective Care. Significant work was being undertaken to ensure there was better control over vacancy, better discipline around agency usage, programmes of work on non-pay expenditure and drug expenditure and to maximise recovery of income earned by the Trust, all of which would provide the potential to get closer to the original plan. There had been a good level of engagement with staff to understand the impact of the focus on financial management. <u>National Update</u> • Following the Government reshuffle, a new ministerial team was in place at the Department of Health. • The second round of public hearings in the Covid inquiry were underway with experts and Government officials giving evidence, with a focus on examining Government decision-making throughout the pandemic.	

	• The Terms of Reference for the Thirlwall Public Inquiry following the Lucy Letby case had been made public. The Inquiry was looking at the case and wider questions regarding NHS management, governance and culture. • This year's vaccination campaign for flu and Covid was well underway with 42% uptake of the flu vaccination and 35.8% for the Covid vaccination to date. • An announcement had been made by the British Medical Association that it would go out to ballot consultants on the possible pay deal. <u>System Issues</u> • NHS Devon had announced the appointment of Mr Steve Moore as its new Chief Executive Officer with a start date of February 2024. • Professor Harris attended the Devon Health and Care Scrutiny Committee on 9 November 2023 to present the Trust's recent Care Quality Commission (CQC) report and improvement plan which were well received. <u>Local issues</u> • The two hospital charities would be merging from 4 December 2023 to become the Royal Devon Hospitals Charity. Staff have worked to develop a new identity for the charity that will make it more relevant and recognisable. • It was announced in November 2023 that the Trust is the host organisation for the peninsula Research Delivery Network and, working together with the University of Exeter, £3m investment had been received to open a Centre for Healthcare Technology. • Three teams of staff at the Royal Devon were nominated for national Health Service Journal awards. The team which had led a project to reduce the use of gases in anaesthetics that are harmful to the environment won the Toward Net Zero award. • The CQC were currently on site to undertake an inspection of maternity services, with Eastern services being inspected on 29 November and Northern on 30 November. Professor Marshall asked whether it was thought consultants would accept the proposed pay deal and was informed that local feeling was that they would accept. Mrs Mills noted that there were a number of communications coming through from the Royal College of Nursing on the disequity of the proposed settlement for consultants compared to the settlement for staff on Agenda for Change. **The Board of Directors noted the Chief Executive's update.**	
185.23	**COMMUNITY STRATEGY**	
	Mrs Harris and Dr Webb joined the meeting. Mrs Harris summarised the following key points on work since the last Board discussion on community at the June meeting: • Clear divisional priorities included focus on end of life, falls and frailty • The Division had been closely involved in winter planning, with good progress on UEC funded schemes, urgent community response development, virtual ward and admission avoidance, complex discharge pathways, demand and capacity modelling with relevant escalations to the Integrated Care Board (ICB). • There were some areas that were still a work in progress, including primary care, Devon Partnership Trust and mental health, and social care. • There were six key asks of the Board contained within the paper. Board support would be very important to help the cultural shift that would be needed.	

	Ms Morgan noted that the ICB had funded primary care to oversee patients in short stay Care Home rehabilitation beds, but were not providing funding for community services for these patients and asked for clarification of what that meant for the Trust. It was noted that the pathway 2 short stay Care Home rehabilitation beds were not additional beds, but were block booked, with 8 short stay beds in one Care Home enabling more effective support of those patients. The ICB had led a demand and capacity modelling exercise for pathways 1-3, with modelling for pathway 2 showing a need for an additional 56 short stay Care Home beds across North and East. The Local Negotiating Committee had advised on behalf of Primary Care that the additional work would be undertaken providing that Primary Care were paid for it and funding was made available for this, but the same had not been made available to the Trust and a risk assessment had been completed which clearly articulated that if existing community staff were redirected from rehabilitation to supporting the patients in short stay beds, there would be a significant impact on other patients in the community. This had been formally escalated to the ICB, but to date no formal response had been received. Ms Morgan advised she would be happy to raise this with the Chair of the ICB at their next one to one if this would be helpful. **Action.** Mrs Foster asked whether the Trust was strategically partnered with the Third Sector, as there were many younger retirees in Devon who could be significant enablers if they were engaged with. Mrs Harris confirmed that the Trust worked with the voluntary sector at place level based in clusters, but that the voluntary sector had always had non-recurrent funding that they could rely on which was decreasing year on year so that the sector was no longer able to provide the help they would have previously. Professor Marshall asked what the priorities were that would demonstrate community adding value to the whole system. In addition, he noted that the focus on the recommendation on place based multidisciplinary teams would require a significant change in working patterns with protected time to work in the community and working in partnership with consultants would be key. Ms Morgan agreed, adding that this would be a good topic for further discussion at a Board Development Day. **Action.** Professor Marshall suggested that the Trust should be more explicit about its attitude to working with General Practice. Dr Webb advised that there was a significant piece of interface work being undertaken to look at how primary and secondary care communicate with an ambition to save up to 15% of primary appointments through improved communication, but relationship building would take time. Dr Webb was working with Castle Place Practice to use them to test and pilot initiatives. It would be important to include primary care in the strategy and to get more support from the ICB on dynamic risk assessment. Mrs Harris noted that the tender for GP provision for homeless people had come up recently and the Trust have been contacted about this. Mrs Harris advised that there were six proposals in the report presented, with more support being requested for some, including on investment and finding creative ways of shifting resource and investment in additional geriatrician time. A further priority would be the new rehabilitation model to support people to focus on prevention. Mr Neal noted the work on the virtual ward and asked how much further this could be developed. He also noted the work on end of life and asked what was being done to support patients who had expressed their wish to die at home. Mrs Harris responded that there had been a focus on training and upskilling staff across all community teams to support early identification of end of life in the last 12 months of life and provide support to patients and their families and carers to have advanced care planning conversations.	

	The virtual ward had primarily been used for patients who had had contact with the acute trust and gone home with virtual ward support, but the model was changing and would become part of the Care Coordination Hub. In addition, a proposal was being taken through governance processes to look at Urgent Community Response being able to feed into the virtual ward, so that Teams would have more confidence to keep people at home with access to consultants and medical teams through the virtual ward. There was also work to be done with GPs on how they could use the virtual ward and there was an opportunity for it to be used in palliative care. Mr Matthews commented that the report referenced an independent review by NHS Confederation of NHS spend which noted that on average systems that invested more in community care saw a 15% reduction in non-elective admission rates and 10% lower ambulance conveyance rates. He asked where the Trust would benchmark in this regard compared to the region and nationally and whether the Integrated Care System (ICS) would be looking at this. Mrs Harris agreed this would need quantifying; she had discussed with Business Intelligence colleagues who needed support to allow them capacity to work with the division on this. Mrs Hibbard reminded the Board that it had previously received a proposal on creating a shared business intelligence service, initially between the Trust and the ICB and that the management of change process was underway with the hope to TUPE ICB staff in February 2024, which would give access to their skill set, and in turn increase the capacity for Business Intelligence support to divisions. Mr Matthews asked what challenges there were to having the capacity to retrain and attract the right skill mix of staff to deliver the vision outlined in the strategy and was advised that there were some staffing challenges due to rurality with some areas where it was more difficult to recruit and retain staff. However, bringing support workers in through apprenticeship schemes worked well, giving those staff training to support developing competencies. The model of care suggested required staff with a different skill set requirement, as they would need to be more experienced and competent to make difficult, quick decisions around risk appetite to keep patients at home. Teams have creative ideas regarding how to bring in staff to meet these needs, rather than continuing to recruit in the same way. Mr Matthews asked what could be changed in the Integrated Performance Report to ensure focus on this, including where investment was needed. Ms Morgan suggested that metrics could be included for review on a six-monthly basis. **Action.** Mrs Harris said that she would continue to look at how to make information included in the IPR more useful and reflective. Mr Tidman said that the community strategy aligned with the corporate strategy ambition to intervene early to avoid health inequalities, adding that a good economic evidence base was needed to show that long term investment in prevention could lead to reduction in admissions. This could be used to help build an independently verified business case to help support a shift within the system. Dr Webb said that there had been a shift in the culture but there was more that could be done, particularly on virtual ward take up in North. Mrs Hibbard said that there had been a commitment in the financial strategy regarding guaranteeing flow of funding year on year, but the impact of 2023-24 on numbers was not yet known. She added that she had reflected on how to support community to be more visible in the system and she said that she believed the disadvantage of being an integrated Trust was that the ICB did not have to negotiate the funding for community. A full contract rebase for 2024-25 had been requested with a suggestion of community as a separate	

	area for negotiation. The Team had been asked to do a detailed breakdown of cost for community services to provide a strong baseline for that negotiation. Mr Roberts said that there was a significant allocative efficiency argument to be made about community services, with a clear link to health inequalities work. In terms of NHS productivity, primary care was most successful and primary care should be a very strong feature of what was being proposed. Professor McIntyre-Bhatty agreed that the inequalities issue was critical and added that it would be worth looking at some elements of this area sooner to understand how to better integrate with primary care. It would also be important to mainstream what was happening with the voluntary sector and community to ensure everything was being done that could be. He noted comments about working with the ICB on investment in community and said that it would be important for the Trust to quantify what it wanted to do in terms of allocation. Mrs Hibbard agreed, adding that the Trust needed to be more assertive with the ICB on being paid for services that it delivered and to encourage the ICB to use surplus to support deficit organisations to make investments that will make a difference. Professor Harris noted the comments regarding a culture of non-admission and discharge that needed to be developed and said that this was not just to challenge with staff, but would also need to addressed with patients and families, as many would see the hospital as a place of safety. He added that this would need leadership and courage to take this forward and acknowledgement that it will be a time for learning and to do everything possible to make sure the right thing was done for patients and their families. Professor Marshall noted that there were benefits for the organisation as an integration Trust, adding that there was already evidence in existence to show that investment in primary and community services lead to good outcomes at lower cost. Ms Morgan thanked Mrs Harris and Dr Webb for their presentation and the discussion generated. The Board supported the vision, the need for a change in culture and being clear about what is the right place for patients, and the outline proposals subject to more detail and modelling. The Board had agreed that an evidence base would need to be drawn together and noted the role of the ICB and funding. A session would be scheduled for a future Board Development Day to discuss in more detail, including what the strategy would mean in practice, and a timescale for this would be agreed outside the meeting and a further presentation to a future Board meeting would arranged to look at next steps. **Action.** Mrs Harris and Dr Webb left the meeting.	
186.23	**PATIENT STORY**	
	Mrs Mills presented the Patient Story video to the Board which related to the Trust's strategic objective to strengthen Cancer Services and continue to deliver improvements in cancer pathways and diagnostic waiting times. The video featured a patient diagnosed with primary breast cancer in June 2021 and outlined her experience from various services, the benefits of being able to access results, reports and appointment through EPIC for patients and areas that the patient had found difficult. The patient had explained that it would have helped her if it had been explained at the start of the pathway that the proposed treatment might evolve and change over time. It had also been daunting after having had very close contact with clinicians for over a year during her to treatment to be discharged and she was not prepared for the sense of loss that she felt.	

	The patient's comments on areas where she felt things had not worked as well for her as they could have been were noted and it was suggested that the issue around changes in patient pathways could be explained in initial consultations, so that patients were aware that things may change. In addition, it was suggested that more signposting of services, such as those provided by the Force charity, could help patients feel less alone once discharged at the end of treatment. Mrs Mills said that the story would be shared with the Team to reinforce messages, noting that it reflected the findings in the National Cancer Survey which was on the agenda. **The Board of Directors noted the Patient Story.**	
187.23	**INTEGRATED PERFORMANCE REPORT**	
	Mrs Foster presented the Integrated Performance Report for October 2023 with the following points highlighted: • There had been further industrial action during the early part of October 2023, however the trajectory for elective had remained on track. • The position in urgent care remained challenging, with attendances at the highest level for the year to date. • GP streaming had been reinstated on both sites. • The Trust had written to the ICS to advise that NCTR had not improved as much as expected in the plan, with lack of confirmation of funding a concern. • Cancer remained challenging. Diagnostics were ahead of plan, however there was a long way to go to achieve the target of 85% by the end of the year. Work had been undertaken to look at length of wait across both sites to see what could be done to equalise this, which would mean patients travelling. • There was continued focus on safety and finance and balancing risks. • There had been significant improvement in closing complaints, with the highest number closed since April 22. • Finance remained off track in month 7, and the deficit position and risk had increased as a result. A financial recovery programme had been put in place at the end of October, with further additional controls being put in place since then. • Recruitment and retention figures remained good, although some new recruits had taken longer to settle into roles, meaning agency had not reduced as much as hoped. However, there were now additional, very robust controls in place around agency and recruitment. Patients with additional needs, including mental health patients needing specialling, had contributed to increased agency spend. • Focus remained on wellbeing for staff. Ms Morgan asked if there were any trends noted about the kind of complaints being received and was advised that there was a general rise in complaints but no particular trends had been noted for the month, with the main theme remaining communication. Professor McIntyre-Bhatty asked whether the data regarding complaints would be looked at in detail by the Patient Experience Committee, including whether there were any particular clusters of complaints about particular areas, departments or individuals. Mrs Mills responded that the Board had previously discussed how it could be sighted on the level of detail and membership of the Patient Experience Committee had been reviewed to include three Non-Executive Directors. In addition, a quarterly report would be circulated to Board members outside formal Board meetings to provide assurance that the detailed review was taking place.	

	Ms Morgan noted that one of the risks/threats on the Balanced Scorecard was "Balancing Devon System support with the demands of Urgent and Emergency Care and Elective Recovery Tier 1 performance" and asked whether this related to the support being provided to the wider system for ambulance diverts. Mr Roberts responded that discussions were taking place regarding this and that there was an acceptance that there would almost certainly be reallocation of ambulance conveyancing due to the position in Plymouth and Torbay. The aim was to find an agreed way of looking at relative risk between the acute Trusts within the system, as this was not currently in place with judgements being made by the ambulance Trust based on how many ambulances were outside, rather than what was happening inside the hospital. There needed to be better understanding of what progress was being made in Plymouth and Torbay on some of the fundamental issues that were impacting this. Finance would be part of the equation, with the proposals that had previously been forward to close the bed gap in the Winter Plan, but a response had not yet been received relating to this. Mr Matthews noted that the bed gap to be closed in the Winter Plan assumed getting to 5% on NCTR, however this remained off track. If this was not resolved, the consequence appeared to be loss of elective capacity and income and he asked whether thought needed to be given to proactively reprioritising some elective activity. Mrs Brazier said that efforts were underway to ringfence elective Orthopaedic wards and increase day surgery rates and the additional funding that was being sought for investment in other schemes would help with this. An action plan had been developed with the support of the ICB on NCTR, and although time to transfer had improved, demand continued to increase. Daily review was undertaken. Mrs Hibbard said that in terms of loss of income, the comparison was to 2019-20 threshold where elective activity would also have been cancelled to a significant degree as this was before ringfences were in place. Therefore, the challenge to earn the income was less because of this profiling. Mr Tidman suggested that a follow-up should be sent to the system advising that there was a concern that the 60-bed gap was probably understated in terms of where NCTR was to add more weight to the request. **Action.** Professor McIntrye-Bhatty said that although there were a lot of actions outlined with the ICS, they would not necessarily have the impact wanted. Mrs Brazier said that although there were actions to try and improve NCTR which could have an impact, a decision had not yet been given on whether funding would be available. Mr Roberts added that a set of proposals for further investment had previously been circulated for information and they could be recirculated. **Action.** Mr Matthews noted that there had been a plan to undertake around 5000 inpatient operations by this point with only around 60% completed and asked what the plan was for managing this, as there could be a build-up of more complex patients that needed to be inpatients rather than managed through Day Case. Mr Tidman said that the vast majority of elective work was day case; there was regular review and there was no evidence that complex cases were building up. Mr Matthews noted that the IPR stated that the clinical lead in East looked at all fractured neck of femur cases that were not done within 36 hours to review the clinical impact but did not state that this was also done in North and asked for clarification. Mrs Brazier confirmed that this was also undertaken in Northern services. There was discussion of agency and locum usage and Mrs Foster advised that there were actions in place but there was often a long tail on recruitment. Mrs Hibbard added that the Trust was currently over the agency cap. She added that linkages between the workforce trajectory and planning were being looked at for 2024-25 planning.	

	Mr Neal noted the continued increase in Accident and Emergency (A&E) attendances and asked if there were steps in place to challenge the formula. Mrs Hibbard confirmed that the Trust was on block contract for this year for A&E attendances for 2023-24. She added that the contract rebase she had previously mentioned needed to be done across all activity with growing appetite to do this across the ICB, however the difficulty would be projecting what growth to put into the contract for the upcoming year. Mr Neal noted that there had been an incident of major harm from delay in follow-up relating to Ophthalmology Services which was being investigated and asked whether a review of triage of the waiting-well list was needed. Professor Harris advised that investigation of this case was ongoing, however there were Failsafe Officers whose role it was to scrutinise the Ophthalmology waiting list to ensure that errors of this kind were not made. There had been a system error, with the individuals being asked to take on some additional work leading them to not scrutinise the lists to the level that would be expected and they had now been retasked to do this. Professor Marshall asked how improvements in recruitment had been achieved, whether improvements had been seen across the whole of the NHS and whether the Government's immigration policy might impact this going forward. Mrs Foster said that the Trust had put in work to accelerate recruitment processes the previous summer which had paid dividends in reducing time to hire etc. Retention had improved across the NHS due to a number of reasons, including the pay settlement and changes in the wider economy, as well better recruitment from within the local economy. International recruitment was reducing, as there was a clearer idea of the pipeline for future requirements. Mrs Mills added that international recruitment had formed an important part of recruitment for the year, with a further cohort arriving in December 2023 and one planned for 2024. Work was being undertaken to look at options for strategic workforce planning for nurses, midwives and allied health professionals. She added that international recruitment, even taking account of supernumerary time, was cheaper than apprenticeships/developing our own staff. It was noted that the nursing and midwifery vacancy position was broadly aligned with both Plymouth and Torbay. Mrs Foster commented that the long-term workforce plan was on the agenda for discussion at the next Board Development Day on 6 December 2023. Professor Marshall noted that there was reference in the IPR to dermatology, oncology and urology being the most fragile services, but outside of formal meetings he believed that cardiology was discussed as the most fragile. He asked if that was correct and how the Board held itself to account for that if specific data was not presented. Professor Harris said that the Trust was very aware of the length of waiting lists for cardiology and that the term fragile was unhelpful in this domain, as cardiology was very robust, with the issue relating to waiting times for a range of procedures. A Cardiology Transformation Meeting was held fortnightly chaired by the Chief Operating Officer and progress was making progress. Professor Marshall asked whether this was an area for a deep dive. Mrs Mills commented that all these areas were on the Corporate Risk Register and were subject to regular review in terms of risk and mitigations. Harm events were also reviewed and reported through the IPR. Mr Roberts suggested that a specific update on Cardiology should be added to the January Board agenda. **Action.** In addition, thought should be given to how the Board could get assurance on areas of concern. Ms Morgan noted that the "Challenge of taking and applying learning from Never Events" was listed under Risks and Threats on the balanced scorecard and asked for clarification on how these challenges were seen and responded to. Professor Harris said that a number of things had been put in place, most notably clinical leadership, to address the challenges. Detailed work had been undertaken to understand where the problem lies and the Clinical	

	Lead was working with teams to educate them on the risks. There has been a change in approach to National Safety Standards for Invasive Procedures (NatSSIPS) NHS wide and the Trust was adapting its processes in line with this. However, it was clear that irrespective of checking processes, the issues related to human factors and human factor training was due to start in December, with multidisciplinary leaders who will be taught how to mitigate for human factors and who will then cascade this onwards to teams. Professor Harris advised that EPIC provided a number of "hard stops" where a button has to be pressed when a pathway is moved, but this can be distracting for clinicians and there is a fear that this may inadvertently be contributing to the problem. The Team have been asked to visit other sites using EPIC to see how they have streamlined this process. Mrs Hibbard commented that it was important to note that the Board had recently held an Extraordinary meeting where it had received and discussed a detailed financial recovery plan, which meant there were no specific financial questions that were raised at this meeting. **The Board of Directors noted the Integrated Performance Report.**	
188.23	**HEALTH INEQUALITIES PROGRAMME UPDATE**	
	Mrs Allen joined the meeting. Mr Tidman reminded the Board that a Task and Finish Group had been set up a year ago which looked at how the Trust performed against the NHSE reporting requirements on health inequalities which were specific to the recovery programme, ensuring that waiting lists were being reduced in a measured way to ensure that patients were not being left behind. The Group had also looked at the broader health inequalities agenda. It had been agreed that a progress report on health inequalities should be presented to the Board twice a year and the report presented provided a level of assurance against the NHSE requirements. However, Mr Tidman advised that he felt this was a fairly narrow focus and there was more data that the Trust could look at and this would be addressed in more detail in the Health Inequality Strategy that would be presented to the January meeting of the Board. The report presented also provided an update on work that the Trust was doing in partnership, particularly with Local Care Partnerships (LCPs), including progress in North Devon through the work of One Northern Devon and other small pilot programmes. It would be key going forward to take learning from the pilots to inform the Trust's strategy to do things at a bigger scale. Mrs Allen highlighted the key point from the report: • There was work undertaken on the three areas covered in the report – the Trust's role as a healthcare provider to look at barriers to accessing healthcare, its role as a partner to look at how it can help tackle housing, fuel poverty and other elements that impact people's health and its role as an anchor institution in Devon which has a significant impact on the economy, society and environment of the county. Ms Morgan commented that she had attended two meetings of One Northern Devon and had been impressed on the depth of knowledge there was on a small group of the most disadvantaged members of the community, adding that work in East Devon was starting to catch-up with North. She asked the best way for the Trust to link in with these initiatives. Mrs Allen said that it was important to "go where the energy was" and that learning from North had shown that partners come with different priorities which did link with areas of commonality which needed to be understood and forming a habit of partnership working was vital.	

	Professor Marshall noted that with regard to the priority on restoring services inclusively, the data did not show a significant social-economic difference and asked if the data on this was trusted. Whilst he supported the suggestion in the report regarding social prescribers, they did need a lot of support and supervision to be successful and this would need to be built into the plan of work. Finally, Professor Marshall commented that the report did not contain much detail on the Trust's role as an anchor organisation. Mr Tidman advised that he was confident in the data, however it provided a narrow lens view to answer specific questions from NHSE. Mrs Allen advised that there were two models of social prescribing community networks being used, with some having peer support and some not. Those with peer support generally worked better and there was less burn-out amongst the social prescribers. Ms Morgan suggested that this should be included in the follow-up discussion that the Board would have on community services. **Action.** Mr Neal asked for further comment on the digital deprivation data. Mrs Allen said that the Trust had to make sure that services were accessible and inclusive, taking account of people's ability to access services digitally. Mr Tidman said that this would be covered in the Health Inequalities Strategy. Mrs Foster noted the ICB funding allocations to Northern and Eastern LCPs which were allocated in small amounts across a number of initiatives and asked whether this would provide value for money. Mrs Allen responded that notification of funding had been received in August 2023 with the objective being to spend the allocation by the end of the year. It had been decided to use this funding to supplement and build up projects already in place in the workplan, prioritising projects required looking at the root cause for repeat attendance through Emergency Care. Approximately £34k had been set aside for evaluation to ensure impact of work was understood. Ms Morgan asked if there was a sense of the areas where the Trust was likely to make the biggest difference with the resources available. Mr Tidman said that he believed that early intervention in targeted areas would have an impact, as well as targeting smoking. Mrs Allen added that the conditions with deprivation markers, such as respiratory, cardiovascular, mental health were more prevalent in deprived areas and these were where the biggest impact could be made. **The Board of Directors noted the Health Inequalities Progress Report.**	
189.23	**SURVEYS**	
	Mrs Mills presented the NHS England National Cancer Patient Experience Survey 2022 to the Board of Directors noting that it had previously been discussed at the Patient Experience Committee. There were a number of very high-level actions in the report which would be reviewed by the Teams. The report showed really strong performance for the Cancer service. Mr Neal noted that there were some comments in the survey relating to primary care and asked if these would be shared with primary care. Mrs Mills responded that she did not know if the results had been shared with primary care but would find out and if not would make sure they were shared. **Action.** Mr Neal asked whether there was anything unexpected in the report and was advised that the Teams would be looking at the outcomes to see whether the work they had done had made an impact and for any areas where improvements could be made.	

	Professor Marshall noted that patients being able to get a second opinion was covered in the report, adding that whilst he was sure that many patients would want this it may be quite expensive and asked for clarification on the position at the Trust. Mrs Brazier said that clinicians would always cater for a second opinion when requested by a patient. Professor Marshall noted that the report was very long and questioned whether the full report needed to be presented to the Board, in particular as it had already been discussed at the Patient Experience Committee. The Board of Directors discussed the question of the length of papers presented to the Board generally and Ms Morgan agreed that shorter and more focussed papers would be helpful. She advised that there was an item on the agenda regarding how the Board could work more effectively and this would be an element to be considered. **The Board of Directors noted the NHS England National Cancer Patient Experience Survey 2022.**	
190.23	**SIX MONTHLY SAFE STAFFING REVIEW**	
	Mrs Mills reminded the Board that there was a statutory requirement to present a safe staffing report for nursing, midwifery and allied health professionals on a six-monthly basis. Key issues were noted as: • The impact of delivery of 2023-24 recruitment and retention plans were evident in the report across professional groups. Focus going forward will be on ensuring that the controls in place for vacancies and on agency use, for example for enhanced observation, to ensure that reasons for use are legitimate in the context of wards now being generally fully staffed. • No changes in establishment, either in terms of numbers or skill-mix, were reported. • There had been no regulatory interest in staffing over the reporting period and the Trust was compliant with regulatory requirements and related standards. • There are no risks on the Corporate Risk Register related to nursing, midwifery or allied health professionals, with several having been removed during the reporting period because of progress made. • Data had been included in the report regarding the total number of incidents reported over the last six months, 18,053 of which 236 related to staffing incidents, a decrease since the last reporting period of October 2022-March 2023. Some themes had been noted from these incidents, including the inability to get one to one care for patients on occasion. • A new safer care nursing tool had been launched nationally which will allow organisations to benchmark skill mix and establishment, as well as acuity and dependency of patients. The tool is quite subjective and the outcomes needed to be triangulated with professional judgement and external benchmarking. • The review of community nursing had shown that there should be a refocus on skill mix and establishment for both registered and unregistered staff. In addition, it was demonstrated that there was a differential in skill mix and establishment across North and East that would be looked at in greater detail. Ms Morgan asked for clarification of the difference in skill mix between North and East noted in the report and was informed that this related only to community nursing, with a higher level of registered nurses compared to unregistered staff in Northern services than in Eastern. It was noted that this had come out of the first use of the new national safe care nursing tool for community and more work would be undertaken to fully understand this result.	

	Mr Matthews noted that 27 maternity Red Flags had been raised in the last six months which all related to supernumerary status of the labour ward co-ordinator in Eastern services and asked for clarification of what this meant. It was noted that it was a requirement that the Labour Ward co-ordinator must have supernumerary status. Whilst this would always be rostered for, there were 27 occasions during the reporting period where this was not possible due to a number of reasons, for example occasions where specific clinical needs meant that the staff member was required to work clinically and it was deemed to be a lesser risk to redeploy the staff member. It was noted that 27 occasions were a very low percentage of total shifts over a six-month period. Professor McIntyre-Bhatty asked whether staff understood the improvements in recruitment and retention. Mrs Mills commented that there were still some areas where there were exceptions with specific challenges on staffing remained, but the feeling on the ground reported was that staff feel more settled and feel more confident that they will be working with teams they know and will not be redeployed frequently as a result of vacancies in other areas. Professor Marshall commented that whilst safe staffing related to headcount, it would also relate to experience and expertise of staff and asked how this was considered and whether there was any evidence that new clinicians were less ready for practice because of the changing nature of training and the impact of the pandemic on training. Mrs Mills responded that experience and expertise was taken account of in terms of recruitment of staff and where apprenticeships would be located, so that newly qualified and apprentices where spread across areas as much as possible. It was noted that some international recruits had taken longer than the 12-week supernumerary period agreed across the South West to settle into their new roles, adding that there had been a decrease in quality of some of the international recruits through the International Recruitment Hub and the Trust had a higher level of scrutiny of candidates than it would be prepared to take through this route. With regard to nurses coming from UK Universities, they were generally of high calibre. Mrs Foster commented that the amount of international recruitment into countries had reduced the experience level by default. She added that in terms of whether staff felt the impact of improved recruitment and retention, she was hopeful that this would be demonstrated in responses to the recent national Staff Survey. Ms Baldwick joined the meeting for presentation of the medical safe staffing report. Professor Harris reminded the Board that there was no statutory obligation regarding medical safe staffing meaning there was no benchmark data for this. As a result, the medical safe staffing report was not comparable to that produced for nursing, although the ambition was to continue to improve the data over time. He highlighted the following points: • There had been periods of industrial action by consultants and junior doctors during the six-month reporting period which had been challenging. However, they had been managed well and patients had been kept safe. • As there was little safe staffing data available generally for medical staffing, the report looked at incidents reported together with data from the Guardian of Safe Working report. • Risk scores for most specialties had reduced over the reporting period, with the exception of two for Northern services. • With the assistance of the HR Team, it was now possible to start generating data to demonstrate how many doctors and their equivalents there were on each site and within areas on each site. The intention for future reports would be to try and benchmark but this would be internal benchmarking, as there was no external benchmarking data available.	

	Ms Morgan asked if there were any areas of particular concern to Professor Harris and he advised that medicine in North Devon was still a concern, although there had been some progress. He added that work would continue to incrementally improve the position, but this would be episodic and dependent on finding the right individual who fits the role and wants to join the organisation. Ms Morgan asked whether this issue was reflected adequately in the risk assessment and Professor Harris advised that he believed it was although there were difficulties in mitigating the risk with reliance on long-term locums., He added that there was also a very good incident reporting culture in the Trust which helped to highlight incidents around safety. **The Board of Directors noted the Six Monthly Safe Staffing Review**	
191.23	**AUDIT COMMITTEE**	
	Mr Matthews presented an update from the Audit Committee meeting held on 6 November 2023 with the following key issue noted by the Board of Directors: • Delivery of the internal audit plan had been challenging due to a number of staffing issues and an issue with a sub-contract at Internal Audit South West. It had been agreed that a catch-up with Internal Audit would be scheduled for December 2023 to check on progress for recovery of the plan, as it will be important to ensure than any reprioritisation of audits is undertaken in good time. Professor McIntyre-Bhatty noted that the Committee had received one final report and three draft reports with limited assurance and asked whether that was an unusually large number. Mr Matthews agreed that this was more than would normal, however, he felt the strength of the audit plan was that the Executive Team would ask for areas that were of concern to be audited, so to an extent it was unsurprising that some of these areas would then receive a limited assurance report. It was noted that the Audit Committee was aware that there had been a slight drift downward overall of ratings and would be monitoring this for the rest of the year. Mrs Hibbard added that the Trust had improved the way it linked the Audit Plan to key risks using the Governance Committee and she would expect to see a decline for this reason. Ms Morgan asked for clarification on section 3.7 of the report which mentioned governance across the Integrated Care Board and the Integrated Care System as an emerging issue. Mrs Hibbard advised that as shared services were expanded across Devon there was a question regarding what assurance organisations and Audit Committees would need for a service provided by another organisation and if the Trust were to host a service, what level of assurance would it need to provide to others. Mr Matthews added that the Committee had discussed how it might involve Internal Audit South West in this process. Ms Morgan further noted the Counter Fraud Progress Report presented to the Audit Committee and that the Committee had escalated the issue of secondary jobs and working whilst on sick leave to the Chief People Officer and asked for an idea of the scale of this. Mr Matthews advised that the Internal Audit Team had informed the Committee that nationally there had been a significant number of cases of secondary jobs and working whilst on sick leave and had given an example of a successful prosecution of a case involving a relatively small sum, which would not normally have been pursued. **The Board of Directors noted the Audit Committee update.**	
192.23	**FINANCE & OPERATIONAL COMMITTEE**	

	Mrs Hibbard presented the Finance and Operational Committee update from the meeting held on 24 November 2023. The Board of Directors noted: • The Committee received a draft of the internal planning process and a detailed workplan of the programme of work already underway. The Trust was due to launch planning guidance internally which would be subject to any national guidance issued over the coming weeks. An ICS planning day was scheduled for Monday 4 December 2023 to help get as much consistency as possible with planning across the system. The Trust would be focussing on lessons learned from 2023-24 which had been particularly challenging in terms of planning, particularly when bringing planning together for the two former organisations onto one ledger. • The Committee received a business case for Spinal Surgery at the Nightingale Hospital which was a really good example of collaborative working across the system, as it would not only benefit patients within the Trust's catchment area, but would also offer support to University Hospitals Plymouth. The financial flows would allow a transfer of activity from the independent sector to the NHS and there was assurance of underwriting from the ICB that no organisation would be financially disadvantaged if that did not happen. It was noted that the business case had already gone through the triple lock process. The Committee recommended approval of the business case to the Board of Directors. **The Board of Directors noted the update and:** • **Approved the Spinal Business Case** • **Noted the recommendation of no change to the Board Assurance Framework risk scores**	
193.23	**INTEGRATION PROGRAMME BOARD**	
	Mr Matthews presented an update from the Integration Programme Board meeting held on 21 November 2023 and highlighted the following: • The Operational Services Integration Group (OSIG) process had started as the next step in driving full integration. The process will be divided into two phases, with Phase 1 underway and due to complete in the early Spring of 2024. Ms Morgan asked what were the issues of most concern and the risks within the OSIG programme of work. Mr Matthews responded that the major risks had been mitigated by the work that had been completed leading up to going out to consultation and he did not anticipate any major risks during Phase 1. The challenge would be moving to Phase 2 in a way that ensured that clinical integration and benefits for patients came to the fore and were not out of step with the managerial integration. In addition, it was important to achieve the integration at the right cost which would also have challenges. Mr Roberts commented that there was an inherent risk within this process to people feeling valued and supported and this would need to be closely monitored to ensure that vulnerabilities and concerns were understood and that staff felt listened to. Ms Morgan asked what an appropriate timescale was for when progress on this work could be considered by the Board and Mr Matthews advised that he believed a Board discussion should be scheduled for the early Spring as Phase 1 was completed and the move to Phase 2 was due, probably to the February Board meeting. **Action.** **The Board of Directors noted the Integration Programme Board update.**	
194.23	**OUR FUTURE HOSPITAL PROGRAMME BOARD**	

	Mr Tidman presented the Our Future Hospital Programme Board update from the meeting held on 16 November 2023. The Board noted the two key issues discussed which were: • Assurance had been received on funding for the onsite staff accommodation and the Trust was currently going out for a design and build contractor for this work. Work was underway to coordinate the staff moves that would be needed as part of this. • Representation had been made to the National Team to advise that the Trust was in a position where it could proceed and have an outline business case within the next two years ready to go. It was still difficult to say at this stage when the first builds would start nationally, but the Trust would want to be in a position to proceed with a phased build. Engagement with local stakeholders continued to ensure their support. The National Team still needed to get the Programme Business Case signed off by the Treasury in March 2024. Ms Morgan asked when it was expected that the Trust would be in a position to get "spades in the ground" for the residential accommodation. Mr Tidman said that he would expect that a business case could be brought to the Board in February 2024. It would then need to be submitted to the National Team with the hope that it would be signed off by April 2024, which would mean "spades in the ground" by the early Autumn of 2024. **The Board of Directors noted the Our Future Hospitals Programme Board update.**	
195.23	**APPROVAL OF CHANGES TO STANDING ORDERS**	
	Ms Morgan informed the Board that she had been concerned for some time about the amount of time taken up at Board meetings to receive and agree routine reports and other items. Mrs Holley had undertaken to look at best practice in other organisations, including frequency of Board meetings, with many organisations holding bi-monthly Board meetings together with Development and Strategy days. As a result of that Ms Morgan would like to propose a change of frequency of Board meetings from ten per annum to six per annum, with a review of this approach at the end of six months. Before changes were finalised and agreed at the January Board, it was proposed that further research would be undertaken by Mrs Holley on best practice elsewhere including how to make best use of sub-committees of the Board. In addition, consideration would be given to how the best way to manage routine papers currently presented to the Board and a review would be undertaken of the list of statutory reports, in order that, by streamlining, the Board could be more effective in how it operates whilst remaining publicly accountable. Ms Morgan would also discuss the proposed changes with the Council of Governors. **The Board of Directors noted the direction of travel with regard to future arrangements for Board meetings based on best practice.**	
196.23	**ITEMS FOR ESCALATION TO THE BOARD ASSURANCE FRAMEWORK**	
	The Board of Directors agreed that nothing had been discussed that needed to be added as a new risk to the Board Assurance Framework or further points to be added to existing risks.	
197.23	**ANY OTHER BUSINESS**	
	No other business was raised for discussion.	
198.23	**PUBLIC QUESTIONS**	

	Mrs Matthews had submitted a question in advance which related to a point she had raised at the October Board regarding whether there was any evidence of impact on mental health patients from the proposals by Devon County Council (DCC) to close mental health Link Centres, in particular whether there had an increase in attendance at ED. She had been informed that Devon Partnership Trust (DPT) had attended a recent Council of Governors meeting where this question was asked and had undertaken to provide a response. Mrs Holley advised that the Deputy Chief Executive of DPT, Mr Mantay had attended the Council of Governors meeting and advised that Link Centres were commissioned by DCC who were currently undertaking a consultation on areas of this service. DPT would be responding to this consultation to say that they did not support the proposal, but they recognised that local authorities were also under significant financial pressure. Mrs Matthews asked whether any impact on staff and services had been seen from the closure of the Link Centres and Mrs Brazier responded that this would be hard to measure, but she was not aware of any feedback from the Team directly relating to this. Ms Bearfield submitted the following question: "The importance of data sharing in managing services in the Trust is well understood now, but there is considerable concern among the public and relevant agencies, British Medical Association included, about NHSE awarding the Federated Data Platform contract to Palantir and, given its history, scepticism regarding NHSE's insistence that there will be no breach of confidentiality or monetisation. What are the implications of the Palantir contract for the RD&E and EPIC, and will the Trust have any local control? What will the Trust be saying to NHSE about this?" Professor Harris responded that detail relating to the Federated Data Platform contract was not yet available, so implications relating to Trust data were not yet known. He advised that what was not currently known was whether the data would remain in the UK data warehouse or whether it would be taken outside the UK by Palantir, however currently no personal data that would enable identifying an individual was shared with any institution. It was acknowledged that this was a potential risk which would be discussed at the Digital Committee. **Action.** Mr Richards said that Mr Tidman had estimated (at the last Council of Governors' meeting) the cost of NCTR at £12m per annum, therefore achieving the target of 5% would save £8m per annum having a sizeable impact on the budget overspend. There was recognition nationally that not all delays were as a result of issues in social care, with some of them relating to NHS delays, with a national ratio of 60% of delayed discharge attributable to the NHS and 40% to local authorities. Mr Richards asked for clarification of the Trust's ratio of NHS versus social care delays and as DCC was not under Level 4 scrutiny, why did the Trust not put them under more pressure. In addition, Mr Richards asked whatever the Trust's equivalent ratio relating to delayed discharges, what was the action plan to improve the process. Mr Tidman responded that when this had previously been discussed both at Board and the Council of Governors, it had been in the spirit of acknowledging this was a collective endeavour for the NHS and social care to try and do better for patient. He added that DCC partners had been very supportive of looking at the totality of what was spent and seeing if there was anything proactive that could be done through early intervention. A piece of work was being undertaken within the ICB looking at the cost of placements and what could be done by sharing the risks. Mrs Hibbard added that there was no payment mechanism in place that would allow the Trust to recharge DCC for delays caused by social care. The Trust was paid for a patient's episode of care whilst in a hospital setting but this was based on an average length of stay.	

	Ms Hallett said that investing in prevention and community services had been a long-held intention within the NHS and asked what would be different this time. In addition, Ms Hallett said that having worked in SDEC and Hospital at Home, the more you personalised care in the community the less throughput you could get, whereas having patients coming to a setting was more effective as you could see more through batching. She asked how the Trust would find the financial resources for more personalised care given the current financial environment. Professor Harris said that for the hospital at home initiative, the Trust tried to identify those patients who needed interventions but did not need to be in a hospital setting for this. He added that it was known that home was safer for many patients in terms of mental health, reablement, and infection. Costs were well within the range for patients being admitted, but it was acknowledged that as the complexity of patients using the hospital at home model increased this may change. Mr Tidman added the digital capability now available, for example through wearables, could contribute to breaking the cycle. Mrs Kay Foster asked for clarification of the comment earlier in the meeting that it was cheaper to recruit nurses from abroad than to train nursing apprentices. Mrs Mills said that from a Trust's perspective, the cost difference for training nursing apprentices as opposed to recruiting international nurses was significant because of the "off the job" element of the apprenticeship. Apprentices were paid a full salary, but did not work full hours due to the classroom training that was part of their apprenticeship. Mrs Kay Foster asked if international recruits could bring their families with them, as this would add additional financial cost through provision of services. Mrs H Foster said that this would depend on the circumstances, but there could be benefits where both partners were working. She added that the reality was that for international recruits, the Trust would lose 12 – 16 weeks whilst they were supernumerary, but following that they would be working full time, whereas for apprentices the Trust would be paying them a full-time salary for three years but would lose 40% of their time whilst they were studying. Mrs H Foster added that this was a topic of discussion nationally in relation to the long-term workforce plan for the NHS. Mr Cox commented that with regard to the exit criteria for the National Operational Framework, the last IRP mentioned productivity under the finance section and noted that this did not seem to be referenced often in Board papers. Mrs Hibbard advised that productivity sat in the finance section of the IPR because it was the measure of how the organisation increased its output at a relative beneficial rate to the increase in cost base to demonstrate delivery of more for the same or less. This was reported through the Finance and Operational Committee which had received at its October meeting a report on relative productivity across the whole of Devon and how the Trust benchmarked against that. Mrs Hibbard and Mr Palmer worked closely together to build in what they consider to be productivity benefits as part of activity planning which then flowed through to financial planning. The value in the Delivering Best Value was the same for plan and real, as some of the growth funding was set aside into the Delivering Best Value programme. Mr Cox asked how frequently anaesthetists in Northern were required for transfer of patients off site, leaving emergency surgery unable to take place during their absence. Professor Harris responded that this happened on average once a month or less, and added that there was now a retrieval service in the South West which had alleviated this issue to a degree.	
199.23	**DATE OF NEXT MEETING**	
	The date of the next meeting was announced as taking place on 31 January 2024.	