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 25 January 2023 via MS Teams

MINUTES

PRESENT	Mrs C Burgoyne	Non-Executive Director
	Mrs H Foster	Chief People Officer
	Professor A Harris	Chief Medical Officer
	Mrs A Hibbard	Chief Financial Officer
	Professor J Kay	Senior Independent Director (from 10:15)
	Professor B Kent	Non-Executive Director
	Mr S Kirby	Non-Executive Director
	Professor M Marshall	Non-Executive Director
	Mr A Matthews	Non-Executive Director
	Dame S Morgan	Chair
	Mr T Neal	Non-Executive Director
	Mr J Palmer	Chief Operating Officer
	Mrs T Reeves	Director of Nursing, Eastern Services (Deputy for Chief Nurse)
	Mrs S Tracey	Chief Executive Officer
	Mr C Tidman	Deputy Chief Executive Officer
APOLOGIES:	Mrs C Mills	Chief Nursing Officer
IN ATTENDANCE:	Dr K Davies	Medical Director, Northern Services (for item 009.23)
	Ms G Garnett-Frizelle	PA to Chairman (for minutes)
	Mrs B Hoile	Comms & Engagement Coordinator (for item 008.23)
	Mrs M Holley	Director of Corporate Governance

		ACTION
001.23	**CHAIR'S OPENING REMARKS**	
	The Chair welcomed the Board, members of the public, 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. **The Chair's remarks were noted.**	
002.23	**APOLOGIES**	
	Apologies were noted for Mrs Mills; Mrs Reeves was attending as her Deputy.	
003.23	**DECLARATIONS OF INTEREST**	
	The following declaration was noted: Mr Tidman informed the Board of Directors that his daughter was employed as a journalist by the Health Service Journal. **The Board of Directors noted the declaration.**	
004.23	**MATTERS DISCUSSED TO BE DISCUSSED IN THE CONFIDENTIAL MEETING**	

	The Chair noted that the Board would receive updates at its confidential meeting from the Digital Committee, Finance and Operational Committee, Governance Committee and the Integration Programme Board, as well as a Northern Services Medical Staffing Business Case, an update on the Corporate Roadmap, the Board Assurance Framework and a presentation from Matthew Gould on transformation.	
005.23	**MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 30 NOVEMBER 2022**	
	The minutes of the meeting held on 30 November 2022 were considered and approved as an accurate record subject to the following amendments: *Minute 158.22, page 4 of 16, fourth bullet point:* clarification to be added that it was Wynyard Medical Ward that had been renamed. *Minute 159.22, page 5 of 16, third paragraph* change to "Mr Kirby suggested that the Trust could set itself a challenge to look at what would be the payback from placing ~~an eighth~~ some of the resource put into the acute into the community." *Minute 159.22, page 6 of 16* action to be added to the action tracker regarding blister packs no longer being provided for patients to see if anything could be done to reinstate this provision. *Minute 161.22, page 11 of 16, first bullet point, second sentence* change to "Was this an anomaly or had the ~~dialogue changed~~ underlying service improved?"	
006.23	**MATTERS ARISING AND BOARD ACTION SUMMARY CHECK**	
	Action check *158.22, November 2022 Mr Neal asked what the national interpretation was of the ongoing high number of both A&E presentations and Cancer referrals. Mrs Tracey agreed to look into this further and provide a fuller update in her next CEO's report to the January Board meeting.* Mrs Tracey advised the Board that the Cancer part of this action would be covered in her Chief Executive's report and the Deep Dive on Cancer on the Agenda. There was more work done to be done regarding A&E presentations and an update on this would be brought to the February meeting. The Board agreed that actions 163.22(1) and 163.22(2) which both related to the Six-Monthly Safe Staffing report should remain on the tracker until presentation of the next report to the May Board meeting. *166.22, November 2022. Mrs S Matthews raised a question regarding what special provision had been funded to meet the additional needs of people transferred from Marston and other immigration centres to hotels in Ilfracombe. Mr Palmer advised there was a broader discussion with the Local Authority regarding a long-term partnership to ensure provision could continued and agreed to write to Mrs Matthews to provide a detailed response.* Mr Palmer said that no special funding stream had been made available from the ICB or others, but a small amount of reactive services had been made available from Barnstaple including attendance by the Vaccination Outreach Team to this cohort in December 2022 to offer a diphtheria pathway, and the Respiratory Team were offering a clinic for TB screening with paediatric TB screening about to start. The Integrated Care Board (ICB) was about to move to monthly meetings with all partners to have ongoing	

	discussions about support. Mr Palmer said that he would send Mrs Matthews these details and the letter would be published on the Trust's public website. Ms Morgan suggested that a further update should be provided to the Board in due course. *166.22(3), November 2022. Mrs S Matthews suggested that the Trust could consider working with GP Surgeries regarding making a confidential space available to patients to access supported IT for virtual appointments. Professor Harris agreed to look into this further.* Professor Harris said that a pilot was being set up at the Castle Place GP Practice in Tiverton and if effective a conversation would be had with the Integrated Care System (ICS) and Local Care Partnerships (LCP) and non-affiliated GP Practices on how this might be taken forward. **The Board of Directors noted the updates.**	
007.23	**CHIEF EXECUTIVE OFFICER'S REPORT**	
	Mrs Tracey provided the following updates to the Board. <u>National Update</u> • Cancer referrals – it had been a record year for patients receiving cancer treatment, with 320,000 having received treatment between November 2021 and October 2022. More patients had also had cancer checks, with over 2.8m patients seen, up a fifth on numbers before the pandemic. Of these, 6% resulted in a cancer diagnosis. This was important progress for the NHS, as more patients getting checked could impact cancer survival rates. Recent data had also shown that 100,000 patients were diagnosed at stage 1 and 2 when their cancer was easier to treat. Spending on cancer awareness campaigns had doubled and these encouraged people to go for tests, but this formed part of the context for the significant increase in referrals nationally. • A national scheme had been announced, with £200m funding to buy short-term placements to promote swifter transfers out of acute hospitals. This followed an earlier announcement of £5m funding to support adult social care discharge. Guidance for the latest funding advised it should be used to purchase bedded step-down capacity and associated clinical support for patients with no criteria to reside but who could not be discharged with the capacity available. The funding would be held by NHSE and ICBs would claim against it. Plans were being formulated in respect of how this would be utilised. • There was a national focus on waiting lists. The Trust had received a letter from NHSE that set out the expectation that Trusts must issue appointments for all patients who had been waiting over 78 weeks before the end of January and the appointments should be for a date before the end of March 2023. The letter indicated that whilst NHSE would accept some inpatient cancellations, cancelling outpatient appointments even during strike action was less acceptable. • Following a recent ballot, the British Medical Association (BMA) had said that junior doctors would take industrial action in March 2023 for three days. The BMA said that its members had faced a 26% decline in the value of pay over the last 15 years. • The national focus to encourage people to get their flu jabs continued, with latest data showing that 5500 patients were in hospital in the first week of January with flu, as well as a further 9000 with Covid nationally. • NHSE had appointed three new Non-Executive Directors to its Board who were leaders in the fields of nursing, mental health and life sciences.	

- Planning guidance was received in late December 2022, with headlines noted as the inclusion of clarity on the 4-hour target for 2023-24, with Trusts asked to plan on the assumption that they would achieve 76% of all patients being seen or admitted within 4 hours. The guidance also set out core performance and improvement metrics on ambulance handovers, bed occupancy and mental health access and included moving to an activity-based tariff system to support elective recovery. The document indicated a delay in specialised services transferring to ICSs and a target for agency spend of no more than 3.7% of total pay bill.

<u>System Issues</u>

- Work was underway on the One Devon Joint Forward Plan; there was a requirement for all ICBs, with partner Trusts and other system partners to prepare this before 1 April 2023. It would be shared with NHSE and Health and Wellbeing Boards and published on 30 June 2023. Consultation on the draft was expected to commence by 31 March 2023 with those for whom the ICB has core responsibility, including those registered with a GP Practice, unregistered patients who usually resided in the area and Health and Wellbeing Boards. Processes for signing off the plan had to be agreed and the system would be held to account for delivery. The principles would be fully aligned with the system's partnership ambitions. The plan would support subsidiarity by building on existing local strategies and plans, as well as reflecting universal NHS commitments and it should be delivery focussed with specific objectives, trajectories and milestones. Systems had flexibility to determine the scope of the plan and how it would be structured and developed, but there was a minimum requirement that the plan should describe how the ICB and partner Trusts intended to arrange and provide services to meet the population's physical and mental health needs, including the delivery of universal NHS commitments. NHSE will work with systems to ensure there is alignment between the Joint Forward Plan and planning submissions.
- The Trust was committed to taking part in a One Devon elective pilot to support the Devon system to recover the surgical backlog, initially looking at Orthopaedics, Ophthalmology and issues relating to spinal surgical services working closely with acute provider specialty teams. The focus would be to maximise day case activity, standardise pathways, increase efficiencies in theatre utilisation and help support and develop further cross-site working.
- The update from the One Devon Board meeting had been circulated.

<u>Local issues</u>

- There had been two internal critical incidents declared in Eastern services and the NHS in Devon had declared a system incident twice. Both Northern and Eastern services had been at Opel 4 several times during December and January related to significant numbers of patients requiring urgent and emergency care and the acuity of patients presenting, staffing challenges due to sickness, issues with discharge, and increased cases of flu, Covid and Norovirus locally.
- December and January presented a complex infection control position which had added to pressures on services, although the situation appeared to be improving with mask wearing stood down. Focus on encouraging vaccination continued with vaccination centres running a number of outreach clinics. These challenges, together with the impact of industrial action, had led to the postponement of some elective activity which was always a last resort. Work continued to support the health and wellbeing of staff.

	• Industrial action took place during December and January by nursing and ambulance staff, with further RCN strike action planned on 6 and 7 February. The Trust had robust Emergency Preparedness, Resilience and Response plans in place; the work of the senior team to manage the impact of industrial action had been very beneficial. • The organisation remained in a challenging financial environment where it was being requested to recover the waiting list position alongside finances. The Trust had been looking at what it could do to recover the deficit and prevent it from worsening. As a result, the delivering best value programme was being relaunched to ensure that all opportunities were explored to make the best use of resources. • The Care Quality Commission (CQC) undertook an inspection of the Trust in November 2022 and planned the Well-Led part of the inspection in January 2023. This had been postponed following the announcement that all CQC Inspections should be stood down during the current period of intense pressure on services. It will be rearranged for a later date. • As an educational provider for apprenticeships, the Trust had undergone an inspection in December 2022 by OFSTED of the delivery of management apprenticeships and initial feedback was very positive. The final report was expected in February 2023. Professor Kay asked what the criteria for allocation of funding from the national discharge scheme were. Mrs Tracey said the focus was on step-down beds with Trusts encouraged to proceed if it meets the criteria and reclaim the funding through the ICB. Mr Palmer added that the Trust wanted to ensure that it had procured as much agency backfill as possible using this funding. He and Mr Tidman were in discussions to see whether it would be possible to release an after-Christmas domiciliary care incentive to ensure care placements could be resourced sufficiently. He added that the possibility of a mixed workforce with Social Care to create a step-down facility with a higher bedded capacity was being discussed. Professor Marshall noted the update on the increase in cancer referrals and asked to what extent they were appropriate referrals as the increased pressure across the system could be driving some increase in referral rates by GPs and asked whether there had been a reduction in conversion rates. Mrs Tracey said that the national figures showed that only 6% of referrals converted to a cancer being diagnosed, but there was more work to be done on the trends in conversion rates. She added that there had been guidance put in place for tests and arrangements GPs needed to carry out for referrals. **The Board of Directors noted the Chief Executive's update.**	
008.23	**PATIENT STORY**	
	Mrs Hoile joined the meeting. Mrs Reeves presented the Patient Story video to the Board which had been developed to present the lived experience of a carer and events around the care of his mother. She advised that the key areas that came out of the story were: • The story emphasised the importance of carer involvement in the care planning for patients. • The carer had agreed to work with the Trust and had met with the Director of Nursing for Eastern services to discuss how to take a number of initiatives forward.	

	• The story highlighted the importance of planning for discharge from admission with one of the challenges being the need for staff to be permanently based. Ms Morgan commented that this had been a topical story given the extent of delayed discharges. She said that there had been some very constructive feedback provided by the carer and she had been struck by his comment that families and carers should be seen as partners in care by the hospital. Mrs Tracey said that it would be important to look at how to achieve the balance of making care personalised against the operational pressures which may impact this. Professor Kent said that communication was a major factor in the story, as it was in much patient experience feedback received. She added that in the past the process had always been that as soon as a patient was admitted to hospital, staff should start thinking about that patient's discharge plan, but this had perhaps slipped during the pandemic. Messaging on this needed to be reinforced for staff, particularly emphasising the benefit of working on this as an interdisciplinary team rather than in silos. Mr Palmer commented that a lot of work was being undertaken in Northern services on "expect a day of discharge" with all staff across the multi-disciplinary team being up to speed on the expected day of discharge for a patient. He said that the story underlined the importance of getting an identical approach to urgent community response team across both sites which was why a single team for community had been created. He added that the story strengthened the case for the investment the Trust was looking to make in medicine for Northern services, as it highlighted the need for having constancy of purpose and a recognisable rota for medicine populated by substantive staff which would make a difference to the ability to identify discharge potential appropriately. Mr Neal suggested that the impact of the process changes that the carer was contributing to should be looked at in due course through the Patient Experience Committee. **Action.** Professor Kay said that it would be important to get patients and carers involved in their understanding and learning of what is possible, as well as getting the processes right as many people may not be aware of what is possible. Mrs Reeves said that a report on the work that was being undertaken with carers would be presented at the next Patient Experience Committee meeting. She added that as a direct result of the story reinforced communication for clinical teams was being developed to remind them of processes that will help them in planning discharges. Ms Morgan thanked Mrs Reeves for presenting the story and asked for the Board's thanks to be passed on to the carer. **The Board of Directors noted the Patient Story** *Mrs Hoile left the meeting.*	
009.23	**CANCER DEEP DIVE**	
	Dr Davies joined the meeting	

Mr Palmer presented Cancer Deep Dive and advised the Board that there would be a second deep dive update to the Board at the July meeting following completion of the Clinical Strategy. The Board noted the following points:

- The paper described the level of complexity around cancer services, including the demand pressures and the impact of implementation of EPIC, but also the opportunities presented by EPIC for optimisation in a number of key specialties that would be rolled out in coming months.
- There had been demand and capacity mismatch in a number of high-volume services, with the most challenged areas being dermatology and urology.
- There had been some challenges on data quality and work had been undertaken on the health check on the cancer patient tracking list which mirrored the work undertaken on the elective recovery position and had been successful so far.
- The recovery plan outlined how the organisation was responding to challenges, with further improvements noted in the number of patients held on the 62-day waiting list.
- Development of the Strategy was being led by Dr Mike Hanneman, Cross-Site Clinical Director.

Professor Harris informed the Board that the second deep dive would have more of a clinical voice. He said that he agreed that the issues in cancer related to a demand and capacity mismatch which began during the pandemic, although there were already underlying problems. He added that there was real focus on this work and the organisation was on the path to recovery.

Dr Davies, Cancer Lead for Northern Services, added that the increase in demand had been further impacted by ongoing workforce issues, but she was confident that there were sound improvement plans in place. She added that the appointment of Dr Hanneman as the Cross Site Clinical Director had been very beneficial.

Mr Matthews asked how the disparity in performance between Northern and Eastern services would be addressed, giving the example of 62-day waits which were significantly worse in Northern services as were 28-day diagnostics, although 2-week waits were relatively better in Northern. Mr Palmer responded that the current way of presenting the data did make the two services look quite separate and there had been some distinct challenges for Northern services. However, the 62-day validated position was now clear, and pathway management would help to balance demand and capacity. There was also focus on driving through other clinical opportunities, such as outsourcing. There were collaboration opportunities, with discussions currently underway for urology on how. Eastern might support Northern. He noted that the Trust also provided support for urology and other tumour sites to Torbay, which meant any changes to pathways needed to be done in a measured way to minimise the impact.

Dr Davies commented that with regard to Mr Matthew's point about the diagnostics and 2-week wait targets, the 62-day and 28-day targets related to surgical capacity which is more time consuming. With regard to the 2-week wait target, every effort was made to bring that in close to 7 days, as the sooner you can bring that in the more likely you are to catch up on the other pathways. She agreed with Mr Palmer that many of the specialties across Northern and Eastern were actively looking at closer working and this would accelerate over time.

	Mr Kirby noted that around 80% of dermatology referrals were not high risk and asked whether there was more that could be done with GP surgeries to better manage referrals to this service. Professor Harris commented that general practice was under overbearing pressure both locally and nationally and agreed that the acute service needed to find better ways of working with them to help, as when a GP practice is under pressure their threshold for referral dropped which then impacted the acute service. Dr Davies confirmed that there were regular conversations with GP colleagues and added that conversion rates locally for skin cancer referrals were in fact better than elsewhere in the country. It was noted that some of the systems of regular feedback to GPs had been impacted during the pandemic with regular meetings stood down, but these were now restarting. Mr Kirby referred to Mr Palmer's earlier comment about the support that was provided to Torbay, in particular for the urology pathway, and asked what percentage of the total workload this represented and suggested this should be reflected in the Trust's data, as it was otherwise being judged on a far greater catchment area. Professor Harris said that the majority of Torbay's complex cancer patients came to the Royal Devon, but this was part of the territory for the organisation being between a secondary and tertiary centre for cancer. Mr Kirby said that the deep dive highlighted another area where there were reporting issues which were related to the electronic patient record (EPR) and whilst he recognised that there would always be some issues to be resolved when undertaking a major digital transformation, could more be done with EPIC to get senior input to help resolve some of the problems, as there was a danger that people could lose faith in the data. Mrs Hibbard assured Mr Kirby that conversations were taking place with EPIC regarding solutions for the issues he had described and they were working very supportively with the Trust. Mr Palmer added there were two areas being worked through, the first of which related to data quality for which there were weekly meetings at Executive level. The second issue related to build and in the area of greatest challenge, which was dermatology build, there had been full engagement of the EPIC senior team with the Trust in a Task and Finish Group meeting twice a week for two hours. Professor Kent noted that training activity on EPIC for outcoming was outlined in the report and asked if there was an indication that an uptick in performance could be expected following training being provided. Professor Harris responded that it was appropriate for clinicians to outcome on EPIC, but ensuring they completed the training could be difficult due to their other clinical priorities. He was confident that this would work through but would take time. Mr Neal asked whether there was any learning from the process undertaken for the deep dive and whether there was confidence that triage of waiting lists was working effectively. He asked whether the balance of harm would be included in the second part of the deep dive planned for July. Mr Palmer said that it had been very useful to stand back and put the current position in context over a four year period. Mr Palmer advised that some triangulation regarding quality and safety had been drawn out in the paper, but the data was not deep enough at this stage. The Patient Experience Survey had shown whilst there had been a slight deterioration relating to experience and quality, the Trust was still ranking very highly against the national picture. It was noted that the second part of the deep dive would contain data around survival outcomes and any suppression factors that had created a challenging position on harm. Dr Davies gave assurance that when clinicians know	

	that patients would not be seen within two weeks, they automatically triage the referral letters to ensure that those with urgent need were prioritised and seen as soon as possible. . Mrs Burgoyne asked whether there were any plans to look at system wide working around clinical and diagnostic capacity and whether this would be an area that could move into a three-year transformation programme taking all the opportunities that were coming in to look at this in a different way. Mr Palmer responded that system working was being covered by the acute sustainability programme of work. Professor Harris added that there were opportunities to collaborate in the system, with some specialties such as urology already ahead of the curve on this. He further advised that there was a digital opportunity for reducing the dermatology waiting list that was being explored. Full details could not be given at this time in the public meeting as it was still under discussion, but the Board would receive an update in the confidential meeting and it would be shared at a public meeting once discussions had successfully concluded. Professor Kay commented that she did not have a true understanding of some of the data quality issues with EPIC and asked whether there could be a focus on this at Board meetings before the second deep dive was presented in July to help Board members fully understand what the issues were. Professor Harris said that he would be happy to shine a spotlight on EPR to provide a balanced picture of not only the issues but also all the bonuses that had come from the EPR. Ms Morgan said that a number of briefing sessions were being planned for the Non-Executive Directors and the EPR/EPIC would be included. Mrs Tracey reminded the Board that any organisation that implemented an EPR would go through a period of optimisation and resolution of data quality issues. The Trust had a very clear process in place for these data quality issues led by Mrs Hibbard with fortnightly meetings of a Task and Finish Group which was reporting to the Finance and Operational Committee. Mr Tidman said it was important to overlay this with the health inequalities view. He advised that a Task and Finish Group was looking at the impact not just at an aggregate level, but also on different segments of the population. This would be included in the second deep dive to the July Board meeting. Ms Morgan thanked the Executives and Dr Davies for their work on this and the Board for the wide-ranging discussion. **The Board of Directors noted the Cancer Deep Dive** *Dr Davies left the meeting.*	
010.23	**INTEGRATED PERFORMANCE REPORT**	
	Mrs Foster presented the Integrated Performance Report (IPR) for activity and performance for November and December 2022 with the following key points highlighted: • December had been a very challenging month with industrial action, bank holidays, very cold weather and an internal, as well as a system wide critical incident just after Christmas, although the position had improved in January. • Good progress had been made in elective and diagnostics, although there were still some areas of concern such as non-obstetric ultrasound. • There had been positive action on green to go with further progress expected with the additional funding mentioned in the Chief Executive's Report.	

- Reductions in time to hire were evident as a result of the improvements made in the recruitment process.
- It was believed that the Trust would achieve its yearend plan financially, but it would be challenging particularly in the current operational context.

Mr Kirby said that it was commendable that the Trust was the only organisation in Devon that was on track to hit its original finance target for the year. He noted staff attrition rates and asked whether this was a typical NHS profile or related to the Trust's selection and retention processes. Mrs Foster responded that some of this related to new data that the Board were seeing for the first time, adding that she would be bringing a paper on the Workforce Plan baseline to the next Board meeting which would provide greater detail. She said that retention was a key area of focus, with the introduction of buddy systems and funding being sought for pastoral support for new starters.

Mr Kirby said that the organisation had always benchmarked well on infection prevention and control (IPC) measures and asked whether the Trust might potentially take more risk, and if it did would that impact on throughput and productivity. Mrs Reeves said that the approach taken to IPC had been one of creativity and flexibility, balancing risks, for example cohorting contacts of Norovirus in a different way that has allowed maintenance of the flexibility of the bed base without compromising standards. She added that this had been clearly debated through the command structure as it went outside guidance, and she was confident that the organisation was doing everything it should in a safe way.

Professor Marshall noted that there appeared to have been a significant increase in complaints in Eastern services in the Autumn and asked for clarification of reasons for this. Mrs Reeves responded that themes across complaints were access, waiting for procedures and communication. She advised that the analysis of the data for those three months would come through in the next quarterly report to the Patient Experience Committee. She added that there had been renewed focus on promptly resolving complaints, with some additional resource having been allocated to help close some longstanding complaints. Professor Marshall asked what other patient experience indicators were considered. Mrs Reeves said that this was constantly under review, looking at what other organisations were doing but it was difficult to get measures that could be used consistently month on month that would be meaningful and she would welcome suggestions. It was noted this would be followed up when the next six-monthly complaints report was due.

Professor Kent noted that the green to go figures should start to improve with the national discharge scheme, but it would be challenged by the staffing position in social care and close oversight of this would be very important over the coming months. Mr Tidman said there were senior level discussions underway with Health and Social Care and he had recently attended a Health and Wellbeing Board meeting to review plans going forward. He added that a whole system view was needed to find a joint solution.

Professor Kent noted the increase in international recruitment and asked for assurance that there was sufficient resource in place, given the closure of the training area at the Nightingale, to ensure that the quality of the support offered was not impacted. Mrs Foster advised that the international recruits were coming from a greater number of countries meaning that onboarding work with them had

	been quite intense, including pastoral support, help with accommodation etc, as well as new starter surveys and meetings with the Inclusion Lead for the Trust. Mr Matthews noted that, following the previous improvement in 111 call abandonment, this now appeared to have deteriorated again significantly in December with 40% call abandonment reported. He asked for clarification of who would be holding the new provider to account and what impact this had had for the Emergency Department (ED). Mr Palmer responded that this was an expression of staffing levels, with the 111 service drawing from base Trusts to populate its rota and when Trusts were under pressure and prioritising staff into their own services, this had a knock-on effect. This had been escalated to the ICB as commissioner of the service. With regard to impact on ED, there was a lag on data and no huge change in conversion rates or minors demand was evident in the December report, but this would be tracked through January's report. Mr Matthews noted in the stroke reporting for discharge home, the North was reporting 70%, with the East reporting 30%, whilst the national average was 20% and asked whether these figures were correct. Professor Harris advised that he would need to look at this outside the meeting. **Action.** Mr Matthews noted the plan to spend £25m in capital spend in the last three months of the financial year and asked whether the Trust was on course to do this and whether there was confidence that controls could be maintained over this and best value for money achieved. Mrs Hibbard said this happened every year with two contributory factors; firstly, there were always delays in the approval process for national funding through PDC and this impacted spending, however this is built into the timing of plans each year. Secondly, in times when there are very constrained internal capital resources, careful planning with the divisions on use of resource was needed, for example backlog maintenance, and was reassessed each year to look at what cannot be planned for. She said that it was still on track and there was always a plan for contingencies where things may slip, with capital spend that could be brought forward from the next year so that capital limit was not wasted. Mrs Burgoyne said that it was good to hear about conversations that were taking place with the DAS and the Health and Wellbeing Board and asked whether there was a plan that would demonstrate long term aims and short-term measures, in particular whether there were plans similar to those elsewhere in the system, such as the discharge hotel. Mr Tidman said there were three levels to this; firstly to get agreement with social care partners on joint planning for the next three years; secondly to be clear on how they would be held to account; and thirdly there were short term tactical things that could be done, such as extending agency arrangements, the possibility of incentive schemes to encourage the domiciliary workforce to do additional shifts, and whether there could be a bedded solution. A care hotel was not being discussed currently, but all areas would be explored. He added that this would be looked at in more detail at a future Board Development Day. Mrs Burgoyne commented that credit should be given for the excellent communications that had been a feature of the last few months and Mrs Foster commended the work of the Communications Team. She added that a lot of work had gone into getting the right tone and messaging in communications about industrial action.	

	Mrs Burgoyne said that she would welcome input from the Executives on areas of focus for the Patient Experience Committee. Ms Morgan said that the Governors were also considering what contribution they could make to patient experience and would welcome the opportunity to feed into the Committee's considerations. Mr Neal asked whether there was anything that could be considered at local level to empower managers to recognise when wellbeing was being impacted, as pressures could increase very rapidly and although there were good processes in place overall for managing and monitoring wellbeing, it might not be reactive enough in the current climate of rapidly changing pressures. Mrs Foster said that wellbeing was a focus for all Executive and Trust Directors with it being an agenda item for both Gold and Silver Commands. Psychological safety was particularly important in periods of intense pressure. Efforts had been made to ensure that staff counselling sessions were protected as far as possible and there was ongoing monitoring of leave. Mr Neal said that he had been pleased to see emails going out over the last few weeks asking for feedback from staff on any lessons learned over the winter period and asked how this would be captured and fed back. Mr Palmer said that the reason these questions had been asked of the organisation was that two connected things had been done over the last 25 days – the bringing together of strategic Gold Command to provide the best governance to manage the frequent requests for escalation and within that the introduction of the Patient Flow Taskforce to strengthen the clinical voice particularly around safety in real time within the organisation. It was also intended to drive a more innovative conversation on what the Trust's frailty model needed to look like for the coming years. Ms Morgan thanked Mrs Foster and the Executive Team for their responses to a wide range of questions which had provided some important issues to be picked up at future Board and Council of Governors Development Days, including measurement of patient experience and partnership working with social care. **Action.** **No further questions were raised and the Board of Directors noted the IPR.**	
011.23	**TOWARDS INCLUSION**	
	Mrs Tracey advised the Board that, due a change in timing of meetings of the Steering Group for Inclusion, it had not been possible to provide a written report, however this would be addressed going forward. A summary of progress against the plan had been emailed out to Board members at the start of the meeting. Key highlights noted were: • Progress against the three areas of focus: o Staff priorities – there were two areas of focus, promoting inclusive leadership and raising awareness of inclusion issues, and how to debias the recruitment process. Whilst good progress had been made, it had not been at the scale hoped. Five sessions on inclusive leadership had been delivered with 45 leaders attending and a further six were planned during February and March 2023. One of the constraints had been having enough trained staff to deliver the sessions, so a Train the Trainer model was being developed to build in house capacity. With regard to the recruitment process, a new AAC consultant recruitment model would be in place over the coming weeks with	

	feedback from this to be used to help align overall recruitment processes. In addition, further work would be undertaken over the next quarter to roll this out to leadership posts. Work had also been undertaken to create best practice to help people drive their careers with rollout expected from mid-February. The rollout of the programme would start with the Ethnic Minorities Staff Network and then the Disability and LGBTQ+ Network members. • Patient priorities – the focus had been on how to improve access and communication. A key element was co-production of a patient communications framework to ensure that all information would be produced in a better format and take account of issues that some people faced. The Trust is the first in the country to be accredited as communication accessible. It had been planned to launch the framework shortly, however this had been delayed slightly pending the outcome of a national consultation currently underway on the future of accessible information standards. Communication accessible training was underway, with 14% of staff having completed it in Eastern services and 6% in Northern services. • Community priorities – this has been linked in to work on health inequalities at LCP level and the Trust has been very involved in identifying objectives. This work of the LCP should be concluded towards the end of the financial year. The Trust had also been successful in securing virtual ward funding which should help to address health inequalities in relation to heart failure. Ms Morgan thanked Mrs Tracey for the personal leadership she was giving to this area of work which reinforced the values of the Trust. Professor Kay commented that there was a real sense of tangible progress, particularly around the patient priorities and the communications accessible work, and that this, together with the work Mr Tidman was leading on health inequalities through the Task and Finish Group and the work with carers and patients outlined in the Patient Story, were starting to outline a powerful offer for patients. Mrs Tracey agreed that all these key elements needed to be stitched together to make this very real for the local population. **The Board of Directors noted the Towards Inclusion update.**	
012.23	**GOVERNANCE COMMITTEE**	
	Mr Neal presented the update to the Board of Directors highlighting that the overall tone of the meeting had reflected the operational pressures that the organisation was under, managing wellbeing and safety and risk. He emphasised the value of the good quality divisional updates to the Committee. It was noted that the final sub-Committee, the Clinical Effectiveness Committee, was now fully merged across Northern and Eastern and was chaired by Professor Harris. The Committee received the Learning from Deaths report and a follow-up from a deep dive. No questions regarding the Governance Committee update were raised. **The Board of Directors noted the update.**	
013.23	**KIRKUP REPORT**	
	Mrs Reeves presented the Kirkup Report which set out the consequences of failing to meet national standards. The Board noted that the report contained the findings of an investigation into East Kent which had identified that over a period of eleven	

	years clinical care in maternity services had often been sub-optimal. This had led to significant harm and the organisation had failed to listen to families and missed opportunities to bring about improvement in clinical outcomes. The organisation took false assurance with the investigation having concluded that outcomes could have been different in 97 of the 202 care episodes reviewed. The report recommended that Boards remained focussed on delivery of personalised, safe maternity and neonatal care, ensuring that experiences were understood and responded to with respect and compassion. Boards were asked to ensure that the report was presented at a public Board meeting and that the recommendations were taken forward fully. NHS England was focussed on the production of a single delivery plan to bring together the recommendations and actions from a number of different reports. The recommendations covered four areas of focus: identifying poorly performing units, ensuring care was delivered with compassion and kindness, team working with a common purpose and responding with challenge and honesty. The report contained clear next steps and the Trust was working with the local maternity and neonatal system who would lead on oversight of the maternity specific elements. The Board was also asked to think about the assurance it had around its own services. Professor Marshall asked whether patient experience and complaint data could be used to look at broader issues around how staff are feeling about their professional responsibility for how they behave towards patients, which could perhaps help to identify any potential problems at an early stage. Mrs Reeves agreed that there was a real opportunity to think differently about how information could be triangulated differently, not just in maternity services. Mr Palmer said that the Governance Committee had asked for the support of the Royal Colleges for a number of services where there had been concerns. He added that there was increasing confidence in the capability and desire to tackle behaviour in real time if needed. He agreed that more needed to be done in all reporting to triangulate data on quality and safety to make sense of outcome data. Mrs Foster said that much of the report related to poor culture and reminded the Board that the Trust was developing its cultural roadmap as part of its strategy. The work on a just and learning culture would help to enable staff to act with compassion. Mrs Tracey said that organisational behaviour was an important point for the Board to consider. She was assured that despite pressures, the Board's focus was always on what was right for patients but the Board should consider how it could retain this focus under challenging circumstances. She added that empowerment of staff was a core value of the organisation with staff encouraged and supported to do the right thing. Mr Kirby agreed with Mrs Tracey that the risk of this happening increased when organisations were under greater pressure in terms of performance and finance. He reminded the Board that when the Ockenden Report had been published they had agreed that the Governance Committee should have delegated authority to have oversight of the action plan and asked whether that decision should be revisited, particularly in the context of the wider conversation about the safety, quality, performance and finance divide. Mr Kirby said that it was clear from the report that having an open and honest relationship with regulators was vital and he believed that the Board was very open to learn and develop and work with regulators for a joint, common purpose.	

	Mr Matthews noted that the report mentioned that some issues had arisen due to the way that integration of the Trusts involved had occurred and asked whether this was something the organisation should also reflect on given its own recent merger, in particular how the two maternity units had integrated and the culture. He also noted that there was a focus on the importance of the LMNS role and asked whether this role was sufficiently resourced and had the right authority to conduct this role. Mrs Reeves agreed that integration was key and advised that maternity services at the Trust were further along the pathway of integration than some services. The Trust was currently advertising for an Associate Director of Midwifery role which would help to bring both practice and approaches to supporting students together, as well as leading the governance arrangements across the service, which would help to mitigate some of the slight variations between the two units. The teams were already working together on evidence collation and this was a good example of where there could be learning for both services. Professor Kay agreed with Mrs Foster that the culture of an organisation was key and advised the Board of work done by the University of Exeter Medical School, which had looked at student clinicians with increased workloads and pressures. This had found that as these increased, student clinicians began to lose empathy and there might be something for organisations to look at in more depth on how training was provided across groups of clinicians to build resilience and remove compassion fatigue. She added that this could also be part of wider inclusion training for staff to look at how to avoid "othering" and recognise and address compassion fatigue. Mrs Reeves agreed that there was a need for vigilance to identify compassion fatigue. She advised that, together with the work that was underway on culture, there were also civility sessions taking place for staff. Professor Kent welcomed the report and recommendations and said that whilst it was absolutely right to investigate and criticise, it was also important to support all the teams involved in the care of women and newborns, praise where appropriate and support teams to work constructively, to ensure that whilst learning continues and develops, teams feel supported and valued, as otherwise there could be future problems with recruitment and retention in the service. Mrs Reeves agreed and said that the organisation was doing well with recruitment to maternity services across both sites and had recently won an award for the quality of its student midwife programme. Ms Morgan thanked Board members for a constructive discussion on this very important and sobering report. She said that it would be important for the Board to come back at a future date to look at the overall picture on maternity services. **The Board of Directors noted the Kirkup Report**	
014.23	**CLINICAL NEGLIGENCE SCHEME FOR TRUST MATERNITY RETURN**	
	Mrs Reeves presented the Clinical Negligence Scheme for Trusts return for maternity services. The Board of Directors were asked to review the presentation and sign-off the evidence presented for compliance for Year 4. The Board noted that currently there were still two separate returns presented, one for Northern services and one for Eastern, but for Year 5 this will have been amalgamated into one return. The Board were reminded that the maternity incentive scheme had been developed to help improve quality and safety and included 10 safety actions for each of which organisations had to demonstrate evidence. Compliance would lead to some financial benefit for the organisation. The deadline for submission of	

	the return was 2 February 2023. There had been agreement that the Trust could include evidence collected during December 2023 if the Board of Directors were in agreement; the audit report included evidence up to November 2023 and showed 4 out of 10 compliance for one site and 5 out of 10 for the other site, however the further evidence that had been gathered during December demonstrated compliance for the Eastern service, with the 90% target for training having been exceeded and Northern services returning 7 out of 10 compliant with areas of non-compliance relating to training, transitional care facility and the audit of Attain . The return had not been scrutinised through the Audit Committee due to timeframes for reporting. It was proposed that for those areas where there was a gap in assurance in the audit report presented to the Board, the Audit team should scrutinise the additional evidence collated by the maternity team on 31 January 2023 to provide additional assurance that this evidence supported the proposed compliance position. Ms Morgan asked whether Board would be sent copies of the Audit Team's assessment of the additional evidence and Mrs Reeves agreed that that could be done. Mrs Hibbard agreed that this would be vital and asked whether there was confidence that the Trust would act appropriately on the Audit Team's assessment if they concluded that they were not assured of compliance. Mrs Reeves said that whilst the Team were confident in the data collected, they were fully accepting of the need for independent scrutiny by Internal Audit to provide an additional layer of assurance that the evidence supported the submission. Mr Neal suggested that it would be helpful once the final assessment from Internal Audit had been received to review the maternity risks, as some of the scores should have improved. Mr Kirby suggested that there would need to be an additional step in this process for him and Mr Neal to review the outcome of the Internal Audit review and liaise with the Chair and Chief Executive to advise whether they were comfortable with the submission. **Action.** He added that he had been surprised, given discussions at Maternity Safety meetings he had attended, at the drift away from where the organisation had expected to be. The Board agreed Mr Kirby's suggestion, adding that Mr Matthews as Chair of the Audit Committee should also be involved in these discussions and provided that Internal Audit were satisfied with the conclusions around the additional evidence, the return would be signed-off for submission by the deadline.	
015.23	**ITEMS FOR ESCALATION TO THE BOARD ASSURANCE FRAMEWORKS**	
	Ms Morgan asked whether Board members had identified any new risks or anything to add to existing risks from their discussions. Mr Tidman suggested that as review of the Board Assurance Framework (BAF) was linked to review of the Corporate Strategy and Roadmap for next year, this should be taken as part of the planned session at the Board Development Day on 2 March 2023, rather than discussion at this Board meeting. This would enable the Board to undertake an environmental scan and review if the risks in the BAF remained the top 10. Mrs Holley commented that whilst she agreed this would be very helpful, discussion of the BAF should remain on the Board agenda as a standard item as good practice.	

	Mr Kirby asked whether, given that financial pressure was increasing, with the need to be cognisant of the potential impact of that on safety, patient experience and performance, Risks 4 and 8 needed to be added to in terms of increased vigilance to ensure that values are not compromised. Ms Morgan said that the BAF was on the Agenda for discussion at the confidential Board meeting and this could be explored in more detail then. **The Board of Directors noted the comments.**	
016.23	**ANY OTHER BUSINESS**	
	No other business was raised by Board members.	
017.23	**PUBLIC QUESTIONS**	
	The Chair invited questions from members of the public, staff and Governors in attendance at the meeting. Mrs Matthews said that EPIC had been raised several times in the Board's discussions. Data quality issues were clearly important, as were the advances highlighted by Professor Harris in virtual clinical assessment and treatment support. However, she said that patients and staff continued to question the efficacy of EPIC, seeing it as time-consuming and taking the focus from direct patient care to indirect care and may be a contributory element to staff leaving. She suggested that a note could perhaps be included in patient correspondence, prior to admission to explain why nursing staff were clerking patients in at the bedside on tablets as patients had reported frustration that nurses were spending more time on documentation and not "caring" for patients. Professor Harris responded that many staff found EPIC very beneficial and efficient, for example Community Nurses, Allied Health Professionals, Junior Doctors, Intensivists and Anaesthetists and Emergency Physicians. However, he said that with the introduction of any comprehensive EPR there would be some issues and the Trust was working hard to make sure these were ironed out to ensure both patients and staff got the most benefit from it. He advised that entering patients' details directly on to a tablet or other device meant that it needed to be done only once in real time but agreed there could be a perception issue for patients and accepted Mrs Matthews' point that patients needed to be informed about why things were done differently now. Mrs Matthews said that the transfer of Gastroenterology to Exeter was successful for new referrals, and asked whether the same was true for follow-up of existing, longstanding patients in North Devon. Professor Harris said that there was a difficulty in North Devon with the number of Consultants available to treat Gastroenterology patients. He added that the introduction of EPIC meant that patients from North Devon could now be triaged which had not been possible before. Dr McElderry thanked the Board for their discussion on the Kirkup Report. She noted that the report mentioned a lack of team work between different departments within the maternity and neonatal care services at the Trust involved and the difficulties with joint learning days and some training, such as CTG and fetal monitoring training which would be worrying for any organisation. Ms Morgan thanked Dr McElderry for her observations and agreed that joint working was very	

	important. She commented that in continued monitoring of maternity services, it would be important to also make sure that staff were encouraged and supported to work jointly. There being no further questions, the meeting was closed.	
018.22	**DATE OF NEXT MEETING**	
	The date of the next meeting was announced as taking place on Wednesday 22 February 2023.	