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

MINUTES

PRESENT	Mrs H Foster	Chief People Officer
	Professor A Harris	Chief Medical Officer
	Mrs A Hibbard	Chief Financial Officer
	Professor B Kent	Non-Executive Director
	Mr S Kirby	Non-Executive Director
	Professor M Marshall	Non-Executive Director
	Mr A Matthews	Non-Executive Director
	Mrs C Mills	Chief Nursing Officer
	Dame S Morgan	Chair
	Mr T Neal	Non-Executive Director
	Mr J Palmer	Chief Operating Officer
	Mr C Tidman	Deputy Chief Executive Officer
APOLOGIES:	Mrs C Burgoyne	Non-Executive Director
	Mrs S Tracey	Chief Executive Officer
IN ATTENDANCE:	Ms G Garnett-Frizelle	PA to Chair (for minutes)
	Dr A Hemsley	Medical Director (for item 098.23)
	Mrs B Hoile	Engagement Officer (via Teams for item 097.23)
	Mrs M Holley	Director of Governance
	Mrs Z Harris	Divisional Director, Community Services (for item 0.98.23)

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

093.23	**MATTERS DISCUSSED TO BE DISCUSSED IN THE CONFIDENTIAL MEETING**	
	The Chair noted that the Board would receive at its confidential meeting the annual report, annual accounts and quality report, a finance and operations committee update and an update from the system recovery board. The Chair noted that the majority of the business of the Board was on the public agenda and that going forward she would ensure that this continued to be the case.	
094.23	**MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 31 MAY 2023**	
	The minutes of the meeting held on 31 May 2023 were considered and approved subject to the following amendments: Minute number 079.23, page 11 of 20, first bullet point to be amended to read "LGBTQ+ and other protected characteristic data was also included at the Board's request".	
095.23	**MATTERS ARISING AND BOARD ACTION SUMMARY CHECK**	
	The Board of Directors noted and agreed the updates to actions. The following further updates to actions were noted: Action 066.23, April 2023 "A paper to be presented at a future Board meeting outlining items that were presented at Board meetings but did not have a mandated timing to review and therefore currently sat outside the Board Schedule of Reports". Mrs Holley informed the Board that the Board Schedule of Reports had been reviewed and was on the agenda for approval. In addition, Mrs Holley had shared a list of items presented to Board during 2022/23 that were not on the Schedule with the Chair and Deputy Chief Executive. These were mainly business cases and deep dives requested by the Board. It was noted that there had been discussion about business cases going to the Finance and Operational Committee (FOC) going forward with FOC then making a recommendation to the Board to avoid duplication. The action was agreed as complete and closed. Action 077.23(2), May 2023 "Following a question from Professor Marshall, Mrs Foster to look at the category for stress for sickness absence in terms of how this was broken down into work-related and other stress/mental health issues and provide an update". Mrs Foster said that she believed this had been covered in the meeting as she had advised that it was difficult to break this down unless staff had specifically indicated what the particular issue was for them. Mrs Foster suggested that she could take a different action to review Occupational Health data to see if this provided more detail on the percentage of work-related versus non-work-related stress and other mental health problems, with an agreed extension of the due date to September 2023. The Board agreed with this suggestion. **Action.** Action 077.23(4), May 2023 "A letter had been sent to Devon County Council (DCC) and the Integrated Care Board (ICB) requesting clarity on all funding streams (including the main hospital discharge fund) to support discharge and social care and the June IPR would contain an update on this". Mr Palmer proposed that this action should be kept open, as although he and Mr Tidman had received a letter that clarified Better Care Funding (BCF) and iBCF (Improved	

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

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

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

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

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

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

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

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

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

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

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

- Work had been done on the format of the IPR for this month to try to make it less dense, more aligned with finance and to pare down the Executive Introduction.
- Almost all trajectories had continued to improve, despite impact from industrial action.
- There had been some data quality issues which although not major were potential reputational risks; the Trust had been transparent with NHSE about these.
- There were some opportunities, including the vascular hybrid as well as the opportunity to fit a data layer on top of EPIC which would make EPIC more reportable which were both broadly supported by NHSE to bring forward and routes to funding were being explored.
- 4-hour performance in Urgent and Emergency Care had improved over the last week for Eastern Services.
- Trajectories for 104-week waits were holding with the hope that these would be cleared on 18 July 2023. 78-week waits were also holding, however 65-week waits remained exposed with additional solutions pursued including insourcing and outsourcing with funding to be rolled out between July and December. This should underpin continued improvement to get back to trajectory.

Ms Morgan noted that the successes on the balanced scorecard highlighted that recruitment and retention plans showed positive results in relation to vacancy, sickness absence and turnover and asked what this was attributed to. Mrs Foster said that the accelerating vacancies programme started last year had contributed to improvements in the process for recruitment which were showing benefits. In addition, there had been improvements in marketing and more engagement with divisions around recruitment events and work undertaken on retention was starting to embed.

Mr Kirby commented that the ratio of face-to-face versus virtual outpatients appeared to be going in the wrong direction with follow-up appointments very high and unused below target and asked what was being done to address these points. Mr Palmer responded that Dr Kyle would be attending a future Board meeting to provide a full update on Outpatient Transformation where these points would be addressed. With regard to follow-ups, data cleansing work was being undertaken that should provide a benefit. Mr Palmer added that Professor Harris was leading conversations on how to restore or get ahead of where patient lists were pre-Covid. Professor Harris added that the methodology employed working with Teams was to use benchmark data of their previous position and the current position and having the conversations with the Teams on how to get back to template. Mr Palmer advised that auditing of the level of follow-ups would be needed.

Mr Kirby said that it appeared that the 36 and 48-hour time lapse issues with fractured neck of femur did not appear to be improving despite the advent of the Nightingale Hospital and asked if there was a reason for this. Professor Harris said that fractured neck of femur was treated as part of trauma surgery list along with other trauma but the hybrid theatre would unlock capacity to do trauma which would help with this.

Mr Kirby noted that the drugs cost remained consistently high. Professor Harris responded that there was a workstream aimed at this area, adding that as more Consultants worked in Northern Services with their range of expertise and skills, this was driving up drug spend in North.

Professor Kent noted that there had been clear improvements in diagnostics, but that there was no trajectory for the 6-week wait from referral to key diagnostic test and asked what plans were in place to get to the target of 100%. Mr Palmer said that on areas targeted considerable improvement was coming through. A commitment had been made that all targets should have a trajectory and this would come back in the IPR through the course of the year.

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

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

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

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

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

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

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

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

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

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