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 26 July 2023**
**Petroc, North Devon Campus, Old Sticklepath Hill, Barnstaple EX31 2BQ**

**MINUTES**

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| **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 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:** | None | |
| **IN ATTENDANCE:** | Ms M Burden | Consultant Nurse & Joint Director, Infection Prevention & Control (for item 123.23) |
| | Professor B Campbell | Chair of Steering Group (for Item 120.23) |
| | Ms G Garnett-Frizelle | PA to Chair (for minutes) |
| | Mrs M Holley | Director of Governance |
| | Ms P McGlone | Deputy Chief Operating Officer, Clinical Research Network (for item 127.23) |
| | Mr P Luke | Director of Transformation (for item 120.23) |

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| **110.23** | **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.<br><br>**The Chair's remarks were noted.** | |
| **111.23** | **APOLOGIES** | |
| | There were no apologies to note. | |
| **112.23** | **DECLARATIONS OF INTEREST** | |
| | No new Declarations of Interest were noted. | |
| **113.23** | **MATTERS DISCUSSED TO BE DISCUSSED IN THE CONFIDENTIAL MEETING** | |

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| | The Chair noted that the Board would receive at its confidential meeting updates on the Peninsula Acute Provider Collaborative, Future Hospitals work, the Finance and Operational Committee and a discussion on the Trust's Risk Appetite. | |
| **114.23** | **MINUTES OF THE MEETING HELD ON 28 JUNE 2023** | |
| | The minutes of the meeting held on 28 June 2023 were considered and approved subject to the following amendments:<br><br>Minute number 098.23, page 9 of 18, second paragraph. Wording regarding adding community services as a standing agenda item to be amended with the following sentence added "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."<br><br>Minute number 099.23, page 13 of 18, second paragraph. Professor Marshall advised that he remained unconvinced by the argument that patient experience metrics beyond complaints were complicated and were presented and discussed elsewhere in the organisation. He said that he still believed that better metrics should be presented to the Board of Directors. Mrs Burgoyne said that this had been discussed at the last Patient Experience Committee meeting and she would raise it for discussion at the next meeting scheduled for mid-August. It was agreed that Mrs Burgoyne and Professor Marshall would discuss this further outside the meeting so that Professor Marshall could share some of his thoughts on this with Mrs Burgoyne in more detail. | |
| **115.23** | **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:<br><br>Action 077.23(1) "Data regarding ED attendances in other coastal areas to be reviewed to see if similar increases in attendances had been seen and if there was any learning for the Trust from their experiences". Mr Palmer informed the Board that he now had a breakdown of data regarding the Trust's ED attendances and whether there were coastal implications. He said that there was an additional impact from coastal areas, with data for Quarter 4 2022-23, there had been a 34% increase in attendances which related to Northern Services with the overall increase for the organisation as a whole at 20% and this correlated broadly with data from other coastal Trusts. He said that consideration could be given to how to present this data as a group of coastal Trusts that were seeing this raised level of attendances over time. It was agreed that the information should be circulated to the Board and the ICS. **Action.**<br><br>Action 077.23(3) "Work to be commissioned through the Governance Committee to look at readmission rates over time, following a question from Professor Marshall about follow-up for patients discharged with NCTR." It was agreed that work on this should be completed in August 2023 and then reported to the Board of Directors meeting in September 2023.<br><br>Action 077.23(4) "A letter had been sent to DCC and the ICB requesting clarity on all funding streams (including the main hospital discharge fund) to support discharge and social care and the June IPR would contain an update on this". Mr Palmer informed the Board that a further meeting was scheduled with the ICS to consider the outstanding funding bids with work being undertaken on a very detailed business case for every element of the plan which reflected the organisation being in SOF4. He noted that it would | |

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| | be very important to get the remaining funding packages approved and the Trust would be pressing to achieve this.<br><br>Action 077.23(7) "Mrs Burgoyne noted the work that was being done across North and East looking at the increased presentation of patients with mental health problems and what measures were available to keep patients safe and suggested that this should also be considered as part of the community response as well. Mr Tidman agreed to take this away for consideration." The Board noted that this would be added to the list of topics for a future Board Development Day to include colleagues from DPT.<br><br>Mr Kirby informed the Board that at the most recent ICB Finance and Performance Committee meeting that he had attended the ICB BAF had been reviewed where it was clear that there was work to be done to align BAFs across the system which he understood that Mr Shields would be undertaking, although this raised issues about organisational sovereignty. Ms Morgan agreed and said that there needed to be a discussion at system level about the idea of and process for aligning BAFs. Mrs Holley added that she had been asked to share the Trust's BAF with the ICB some months ago for this alignment work and she had requested at the time of sending it that someone from the Trust be involved with this, but she had not heard anything further since that time. Mr Tidman agreed to take an action to follow this up. **Action.**<br><br>**The Board of Directors noted the updates.** | |
| **116.23** | **CHIEF EXECUTIVE OFFICER'S REPORT** | |
| | Mr Tidman provided the following updates to the Board.<br><br><u>National Update</u><br>• 75 years of the NHS was celebrated during July with events across the country including tree planting ceremonies on both acute sites attended by local Mayors, events and competitions and sharing of staff and patient thank you messages.<br>• The first phase of the national Covid inquiry was completed in July with public hearings having heard from a number of witnesses including government officials, scientific advisors, patients and bereavement groups. The second phase will cover governance and decision making during the pandemic.<br>• Further periods of industrial action took place during July, with the junior doctors strike from 13-18 July and the consultants strike action from 20-21 July and teams had gone above and beyond during both periods. Measures were put in place to mitigate risks to patient care, but both periods were very disruptive to planned services. It was important not to normalise the impact of ongoing industrial action on services and the Trust would continue to make representations to local MPs regarding this. The Society of Radiographers had also undertaken industrial action on 25-26 July at a number of Trusts across the country, however the RDUH was not impacted. There was ongoing concern about the amount of leave that staff were deferring to cover additional shifts, the build-up of time off in lieu and the cumulative effect on staff wellbeing.<br>• The NHS had published its 15-year Workforce Plan at the end of June 2023 and the Trust is working with its educational partners on joint planning for growing the workforce for the future.<br>• NHSE had announced changes to funding for the elective recovery fund to allow for the impact of industrial action on waiting time trajectories with the changes being worked through. This would be discussed at the Finance and Operational Committee. In addition, funding changes were signalled for community diagnostic centres which would also be worked through. | |

- The New Hospital Programme national team would be visiting North Devon on 2 August 2023. The visit would provide an opportunity for the national team to meet staff, to understand the importance of a new hospital for North Devon and to discuss the Trust's plans for the staff accommodation rebuild.
- The National Director for Urgent and Emergency Care visited the Royal Devon and Exeter site on 24 July 2023, as part of a visit to the Devon and Cornwall systems. The Trust was able to showcase some of the great work that was being undertaken, as well as set out some of the challenges.

System Issues

- Devon continued to be a challenged system, but there was good engagement across all providers working with the regional and national teams. There was regular reporting on progress against the financial position, urgent and emergency care, cancer and elective performance and progress of the Peninsula Acute Sustainability Programme. Mr Tidman was scheduled to attend an Executive to Executive meeting with the national team in early August to review progress in quarter 1 and plans for quarter 2.
- Devon Partnership Trust was chosen as one of two locations in the South West to benefit from a £40m capital investment subject to business case approval. The investment is for two regional inpatient centres for adult mental health, learning disability and autism for patients whose needs cannot be met on a general mental health ward.
- The Trust's Domestic Abuse and Sexual Violence Teams won the Excellence in Primary and Community Care at this year's Parliamentary Awards. The award was in recognition of the work done by NHS Devon and providers, especially the Royal Devon which hosts the Devon and Cornwall Sexual Assault Referral Centre.
- Professor Tim Briggs, national lead for GiRFT, highlighted the work of the Devon Centre of Excellence for Eyes at the Nightingale in a national presentation on the future of ophthalmology services. The Centre was referenced for its innovative glaucoma pilot and its single point of access for cataracts.
- There were a number of system leadership changes to note, including the appointment of new Chief Operating Officers at both Devon Partnership Trust and Torbay and South Devon NHS Foundation Trust.

Local issues

- Publication of the Care Quality Commission (CQC) Well-Led report and the overall rating for the Trust was expected during August 2023. It is expected that the report would report fairly on the operational challenges faced by the Trust, but that it would also highlight the many positives seen during the CQC visit to the organisation. The report will be used as an opportunity to improve and the action plan will be published on the Trust's public website.
- A new Memorial Garden will be opened at the Royal and Devon Exeter site on 18 August 2023 which will be a remembrance space for those lost to Covid-19, and will also be used as an outdoor therapy space for dementia patients. The Garden was built following a fundraising campaign by one of the Trust's junior doctors, Dr Camilla Stokholm.
- A successful community nursing recruitment campaign was carried out over the last eight months, using both social media and events in community hospitals to promote the rewards of a career in community nursing.
- The new Discharge Lounge at North Devon District Hospital had opened on time and on budget in early July 2023. During its first week of operation 78 patients were discharged earlier due to having access to the Discharge Lounge, which was more than had been achieved during May using the previous much smaller Discharge Lounge. This had made a significant difference to flow on the site.

- The Trust was running a campaign with posters and through social media to promote the MyChart patient portal in an effort to get beyond the 100,000-sign-up mark. Although the patient portal was not without challenges, it gives patients a sense of control, enabling them to access letters, appointment details and test results through the portal and it saves multiple letters being sent out to patients.

Ms Morgan advised that the Board and Council of Governors had recently received an excellent presentation from Professor Harris and the team on MyChart; the Governors had taken an action point to help promote MyChart more widely.

With regard to the CQC Report, Ms Morgan underlined that the Trust would take the outcomes of the report as an opportunity and would engage with it constructively, transparently and positively, using it as a platform for improvement for the future. She added that there was a great deal that was positive that would be fed back to staff.

Ms Morgan asked Mr Tidman what issue was of most concern to him at the moment. Mr Tidman responded that the cumulative impact of pressure on Executive colleagues and the clinical and corporate teams, the pressure to recover and the impact of ongoing industrial action was a significant concern to him.

Mr Matthews asked for clarification of why industrial action by radiographers was not an issue for the Trust. Mrs Foster responded that radiographers were balloted by organisation and the vote at Royal Devon, whilst close, had not been in favour of industrial action.

Professor Marshall asked what plans would be put in place for possible industrial action by GPs, as there would be implications for acute providers. Mr Tidman said that he had not been party to any discussions regarding this, but should industrial action by GPs be confirmed the Trust would work with partners to look at how primary care could be supported and how to manage any peaks and troughs in attendances resulting from a period of action. Professor Harris said it was likely that there would be a reduction in elective activity should GPs go on strike and it would be hoped to move some of that resource across to the Emergency Departments and Minor Injury Units to relieve additional pressures on them. Mr Palmer said there had been some good productive interactions with the ICS on the primary care agenda and there was an opportunity to build risk assessment processes to put in place across the ICS. It was noted that this related to the broader risk around the fragility of primary care that would need to be wrapped into any planning around possible GP industrial action. Mr Tidman said that the Executive Team would develop a contingency plan with a briefing note to share with the Board in the first instance and should GP industrial action be announced for the autumn; a further discussion would be tabled for a future Board meeting. **Action.**

Mr Kirby asked whether the Board needed to be more vocal regarding the significant impact of industrial action, i.e. direct cancellations of activity, the financial impact and the cumulative impact. Mr Tidman said that the Trust had asked for a specific piece of work to be undertaken on the impact of industrial action, including the overall impact on the waiting lists, so that there would be a combined narrative that was clear on what the impact had been. Ms Morgan asked how that would be taken forward and Mr Tidman advised that this had been commissioned by Chief Executives and would be undertaken primarily by the Finance Team and HR.

Mr Palmer informed the Board that a quarter 1 review had been undertaken ahead of the Executive to Executive meeting with Sir David Sloman, Chief Operating Officer for NHS England, which Mr Tidman was due to attend on 2 August 2023. He said that the Trust

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| | had been very transparent about its position, and in particular with regard to impact of industrial action, in regular meetings with NHSE. The Trust had done this earlier than others in the system which had led to questions about whether the organisation was an outlier. He advised that the Trust had lost around 6000 episodes of care overall to industrial action, with around 1800 of these elective episodes. The Trust had asked whether data could be brought together so that it could be comparable for use at the Executive to Executive meeting. Mr Palmer advised that there would be further discussion of the data on impact of industrial action at the Finance and Operational Committee which would then report to the Board to provide assurance.<br><br>Mr Neal suggested that as well as looking at impact on waiting times of industrial action, quality of care, incidents, the patient voice and staff relationships could also be reviewed to see if there was any learning.<br><br>Mrs Hibbard informed the Board that there was a prescribed collection nationally of data on the cost of industrial action that was being undertaken very consistently across the organisations. She added that the ERF changes, which were very complex, had been discussed at the Finance and Operational Committee. Essentially, the threshold was being reduced by 2% which organisations were expected to deliver against.<br><br>Mrs Foster said that it was important not to underestimate the impact on staff morale that ongoing industrial action was having.<br><br>**The Board of Directors noted the Chief Executive's update.** | |
| **177.23** | **PATIENT STORY** | |
| | Mrs Mills presented the Patient Story video to the Board which related to the experience of a patient using the patient portal on EPIC. Mrs Mills informed the Board that the comments and issues raised by the patient have been shared with the Patient User Group.<br><br>Ms Morgan noted that the patient had said that MyCare had not recorded his anaesthetic risk identified some years ago following a procedure at a different organisation in Bristol and asked if it had not been transferred to MyCare because it had been recorded elsewhere. Professor Harris said that this was because of the lack of interoperable systems across the country, with the information regarding this incident recorded by the organisation in Bristol. He added that the advice to patients in instances such as this was to let the Trust know as much detail as possible and the relevant information could then be sought and transcribed to Epic.<br><br>Ms Morgan said that MyCare had been discussed at a recent Council of Governors and Board Development Day, where it was noted that there are patients who will struggle with accessing and using IT. Assurance was given at that meeting that there were alternatives available. Professor Harris said that the organisation was cognisant of both digital poverty and lack of knowledge on how to use technology, adding that the most powerful alternative for these patients would be the use of a proxy to take them through the system.<br><br>Ms Morgan noted that the patient had raised concern about confidentiality and how his data was being treated on MyCare. Professor Harris informed the Board that when a patient signs up to MyChart it is made clear what level of confidentiality they are agreeing to. In addition, he noted that it was his responsibility as the Senior Information Risk Owner for the Trust to ensure that all data was kept safe, adding that data controls in the UK were very rigorous, although this could be at times be a hindrance to pursuing international research collaboration opportunities. | |

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| | Mr Matthews asked if a process was in place to provide support to patients attending appointments who might like to learn more about MyCare, as this might help with sign-up to the Portal. Professor Harris responded that although there was no formal process in place, it was something that staff did frequently with patients on an *ad hoc* basis. Ms Morgan asked if there was information available in the Discharge Lounges about sign up to the Portal and Professor Harris said that there was not, but could be helpful, although he noted that there was a balance to be held between encouraging people to sign up and being perceived as being "big brotherish".<br><br>Mr Neal asked whether reassurance was provided to patients accessing test results to prevent them unnecessarily worrying and whether there was a protocol in place for instances where it might be decided that something would not be made accessible to the patient on MyChart. Professor Harris confirmed there was a protocol in place regarding information made available on MyChart which was reviewed on a regular basis. In addition, he advised that normal ranges for all tests were made available through MyChart alongside blood results. There was also regular review and debate on this but the current consensus was not to add additional information or interpretation of results. He assured the Board that where there was a significant abnormal result, the patient would be contacted by a clinician to discuss.<br><br>Professor Marshall commented that there was an important discussion to be had on opting out and data sharing. He asked whether a patient who opted out of data sharing would still be able to access their own data and Professor Harris confirmed this to be the case.<br><br>Mrs Burgoyne asked for clarification of how primary care view test results etc if they are not using Epic and Professor Harris said that all healthcare workers can be granted complete read only access to all of their patients through Epic including GPs, although most local GPs had not signed up for this.<br><br>Mrs Burgoyne asked whether the community sector and volunteers were involved in helping to promote sign up to MyChart to patients. Professor Harris said that he did not believe that volunteers were currently involved, but this would be a helpful addition to the campaign which he would explore outside the meeting. **Action.**<br><br>Ms Morgan thanked the Board for their questions and the responses provided, adding that the value of Patient Stories was to trigger worthwhile discussions and that it was important that the stories presented were not just positive news but asked serious questions about how the organisation did things. Mrs Mills noted the comments and recorded her thanks to the team for developing the stories for the Board.<br><br>**The Board of Directors noted the Patient Story.** | |
| **118.23** | **INTEGRATED PERFORMANCE REPORT** | |
| | Mrs Mills presented the Integrated Performance Report for June 2023 with the following points highlighted:<br>• As previously noted, there was ongoing impact from continued periods of industrial action and whilst progress on elective recovery had continued to be made, this was not where it would have been.<br>• There had been a continued reduction in vacancies and turnover for the eighth month.<br>• Three investigations into incidents which met the Never Event criteria; it was noted that there had been no harm to patients in any of the incidents. | |

- The Finance Plan was broadly on plan to deliver.

Ms Morgan noted that three incidents were being investigated as they met the Never Event criteria and asked whether there was any learning from these. In addition, Ms Morgan said that previous reviews of Never Events identified that pressure on staff was often a theme and asked whether it was thought that would be the case for these incidents. Mrs Mills responded that it was too early to say at this point what lessons there might be as the investigations had just started, but noted that themes were teams under pressure and staff not following processes. She added that all actions from the previous review undertaken and the individual investigations had been completed, but there was clearly more to be done and work already in train was being expedited. A communications plan was in place, as well as a planned summit with a focus on raising awareness and taking the learning from staff who had been involved in incidents. Mrs Mills, Professor Harris and Mrs Holley would be meeting with the Care Quality Commission to discuss what had been learned from the early review of the incidents and to discuss the plan.

Professor Harris commented that it was important to explore the opportunity and threat provided by Epic and therefore a small team would be identified to visit other sites across the country that were using Epic to look at what they were doing and whether there were any changes that the Trust could make. The team would consist of a lead medic, senior nurse and a member of the clinical audit team. He added that the three Never Events were different, although with some elements of similarity and there did not appear at this point to be a clear theme. It was noted that a report on Never Events would be taken through the Governance Committee following which a presentation should be brought to the Board, together with an update from the team that Professor Harris had described to outline how they were approaching this and their thoughts on what works best. **Action.**

Mr Kirby asked whether some external expertise might be useful regarding the Never Events and Mrs Mills responded that when the previous review had been undertaken advice had been sought from NHSE, who had looked at Never Events more widely across the system and found that other organisations had had similar experiences. A piece of work across the system had started on this with the two leads from the Trust part of the group undertaking the work.

Mr Kirby noted that unallocated hours backfill was looking good, there was very high performance on admission avoidance and new entrants to the market, however No Criteria to Reside (NCTR) was still at the same level and said that the two sets of information did not correlate. Mr Palmer gave assurance that the September IPR would contain improvement trajectories, adding that the Eastern position was improving but he was concerned about the Northern position, with issues regarding access to P2 rehabilitation beds. He would continue to push on the remaining urgent and emergency care funding, as this would provide some opportunities to fill that gap.

Mr Kirby noted that the extension of the temporary ambulance catchment change beyond August 2023 would be a risk and that it had been his understanding that this had been done recognising that this was the right thing for the system. He was therefore unclear why this was identified as a risk. Mr Palmer responded that the risk related to what would happen next. To date, the data showed that the change had had an unremarkable impact, but it would be important for the Trust to finish the period of review so that it would have a body of evidence to understand what was happening. He believed that it would show that there was more work to do in terms of liaison between SWAST and the ICS in order that the catchment was genuinely used, as usage had been quite conservative. He added that there would be a conversation over the next 10 days to agree whether the catchment pilot

should be completed in its entirety or whether to move to dynamic conveyancing immediately; the risk was moving to dynamic conveyancing without adequate preparation or understanding of the impact. Mr Kirby commented that there had been discussion at the ICS Finance Committee on the lack of engagement from senior management at SWAST and Mr Palmer said that there were some issues around making sure that SWAST was represented in the right spaces which the ICS was aware of, but there were excellent relationships with SWAST locally.

Professor Kent noted the increase in Emergency Department (ED) attendances on both sites and asked if there was anything more that could be done to try and understand any trends and try to offset this, particularly over the summer months. Mr Palmer responded that there was an annual cycle for ED attendances and those seen were roughly in line with what would be expected. The briefing which he had mentioned earlier in the meeting would show some of the coastal impact issues. In terms of admission avoidance, the Urgent Care Response was ahead of statutory target, but there remained a question about whether there was a fragility in primary care that was not fully understood. Two meetings had taken place with the ICS, the first relating to single practice issues but the second completely strategic. Fragility in the sector was recognised, and that a strong admission avoidance approach in primary care was needed to ensure that the minor's stream is not overloaded. A joint risk assessment of primary care had been agreed to look at what might be done for the second half of the year.

Professor Kent noted that waiting times for social care reviews were increasing and asked if there was anything more that could be done to improve this. Mr Palmer advised that concerns about funding had been addressed as Better Care Funding had been settled and that there was greater stability in terms of the overall provision of service, but that social care reviews remained an outlier. Sessions had been arranged with Social Care partners where this would be one of the issues discussed. Mr Palmer believed that they would advise there would be a lag between continuity of service and delivering the change, but this would be explored at the planned sessions.

Professor Kent noted the increase in category 2 pressure ulcers in the community and asked whether it was believed end of life could be accounting for this and what mitigations were in place. Mrs Mills advised that she did not have the detail to respond at the meeting but would check and email Professor Kent. **Action.**

Mr Neal asked whether the accrued time off in lieu and annual leave should be noted as a risk on the balanced scorecard.

Mr Neal noted that there had been two moderate harm incidents recorded in Northern services for waiting well but there was no commentary included regarding learning or whether these were an anomaly. It would be helpful to have an historic picture of trend for this. Ms Morgan suggested that rather than add to the IPR, this could be something that the Board could review every 6-12 months. **Action.** Mr Palmer added that narrative would be discussed that would clarify but not add density to the IPR.

Mr Matthews noted that induction of labour was above the target on both sites and asked whether this was a concern and if there were any implications for the Trust. Professor Harris said that there was concern nationally about over-medicalisation of delivery and the target for induction rates was one way of monitoring this. He added that he and Mrs Mills would need to look at the data in more detail outside the meeting to understand any implications. **Action.**

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| | Mr Matthews noted that VTE monitoring had fallen off in the North and was stabilising in the East, with both services below where they had previously been and asked what implications this might have for patient safety. Professor Harris reminded the Board that there was a group of patients that were not included in the data, but agreed that more granularity on the data would provide assurance. **Action.** He added that there was assurance that no harm from thromboembolic disease was being seen.<br><br>Mr Matthews said that the data on inpatient and day cases was 10-20% below plan on both sites and asked what impact this would have in terms of earning additional income. Mrs Hibbard responded that this was not about absolute volumes of activity, but rather about the weighted cost of that activity which would take account of case mix. A 10-20% reduction in overall volume when worked through the formula would not count significantly against the ERF threshold. Mr Tidman suggested that this should be discussed by the Finance and Operational Committee. **Action.**<br><br>Mrs Burgoyne asked for clarification of issues with conversion rates for NHS 111 Practice Plus. Mr Palmer responded that it was a very challenged performance position for the contracted service. Dr Hemsley had done excellent due diligence on the contract and had formally escalated concerns through the Trust Delivery Group and was following up with the ICS.<br><br>Mrs Burgoyne noted that Child and Adolescent Mental Health Services were operating under business continuity plans which was resulting in no out of hours service provision and increasing numbers of children being directed to the ED with increased length of stay for children in ED and asked what was being done to address this. The business continuity plan had been activated due to a recognised staffing deficit for a short period of time, however this had extended over a more prolonged period. This had been escalated to the Commissioners to establish whether there was a timescale for this to be addressed and, if not, what mitigations would be put in place as the current situation was having an impact on treatment for young people, safety and Trust staff.<br><br>**The Board of Directors noted the Integrated Performance Report.** | |
| **119.23** | **CORPORATE ROADMAP UPDATE** | |
| | Mr Tidman presented the quarterly update on the Corporate Roadmap to the Board noting that the Clinical Strategy and enabling strategies were a significant milestone to delivery of the overall Corporate Strategy. He said that the Team would now consider the other milestones that would flow from the Clinical Strategy and enablers and would then set out the plan for the next two years at the Board Development session in October 2023 and get a steer from the Board on priorities.<br><br>Ms Morgan noted that the majority of roadmap milestones had been achieved in quarter 4 which was very positive. She said that it would be important to share with the Council of Governors at a future date.<br><br>Mr Matthews noted that the milestone for the EPIC risk assessment for Torbay and South Devon had deferred to October 2023, as it was expected that Torbay and South Devon would announce their preferred provider in October. He asked if the Board would have an opportunity prior to this to understand the direction of travel and was comfortable with the balance of priorities ahead of October, as he was concerned that if it did not this might become a “fait accompli”. Mr Tidman responded that he and Professor Harris had a meeting scheduled with the Chief Executive of Torbay and South Devon and her team to understand what the ask was. He said that the Board had had an initial discussion on what | |

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| | the opportunities were and he believed that there would be opportunities to make sure that the Board understood what the different options might be ahead to support Torbay.<br><br>**The Board of Directors noted the update.** | |
| **120.23** | **CLINICAL STRATEGY AND ENABLING STRATEGIES** | |
| | Professor Campbell and Mr Luke joined the meeting.<br>Professor Harris informed the Board that it was important to recognise that the Clinical Strategy was co-owned with Mrs Mills and that Professor Campbell was one of the principal authors of the strategy, together with Dave Sanders. The document had been shared with partners, and whilst it reflected the Trust's position it was recognised that as part of the wider system, it would be necessary over time to flex and change it. It would be an iterative document, but the process would be followed that was already in place.<br><br>Professor Campbell informed the Board that he had been asked by Professor Harris to chair meetings to plan the Clinical Strategy which he had agreed to on condition that he and others in the Trust could write the final Strategy rather than an external consultancy, as he wanted it to be specific to North and East Devon. He worked closely with David Sanders in North Devon in developing the Strategy with input from the widest range of people. Although there had been scepticism in the early stages from some clinicians, by the end of the process there had been very helpful involvement from clinicians, managers, other staff groups, as well as representatives of patients and the public. Professor Campbell said that he believed the Strategy presented was a comprehensive, clear, practical and dynamic strategy for the next five years and beyond.<br><br>Mr Luke informed the Board that Mrs Allen had undertaken work to align the enabling strategies and a paper had been included in the pack which detailed progress on the enabling strategies. Mr Luke gave a PowerPoint presentation with key points noted as:<br>• The Finance Strategy was subject to finalisation of the numbers due to system changes.<br>Mrs Hibbard added that the position with the system medium-term financial plan was that this needed to be submitted in September 2023 at which point the Trust would be able to update its Strategy, including the concept in the Finance Strategy around using ERF substantively and using the forward planning on growth and putting provision for investment, as this needed system approval.<br>• The Clinical Strategy was subject to feedback from system partners.<br>• All leads had reviewed the strategies following discussion at the Board Development Day and there had been some minor changes in line with discussions at that meeting.<br>• It was planned to launch the strategies in September 2023 which would include webinars, the documents being made available to staff and patients on the Trust website, managers' briefings and presentation to a range of staff and patient groups.<br>• There will be an interactive version of the Clinical Strategy for staff.<br>• Each strategy has a responsible Executive Lead and have been reviewed and recommended to the Board by the Trust Delivery Group. The strategies are closely aligned with each other, as well as with the Devon Joint Forward Plan.<br>• They will be operationalised through the annual planning rounds going forwards.<br>• Delivery of the strategies will be overseen by the Trust Delivery Group with six monthly updates to the Board of Directors.<br>• The recommendation to the Board is formal sign-off of the 5 Year Clinical and Enabling Strategies and approve delegated authority to the Chief Executive and Executive Leads to make any reasonable adjustments to the strategies as required. | |

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| | Ms Morgan thanked Professor Campbell and Mr Luke for their presentations and for the huge amount of work that had gone into the development of the strategies. She added that whilst she would be happy to give delegated authority for minor changes as requested, she would like to see any changes to be aware of what they were. **Action.**<br><br>Professor Marshall said that this was an excellent piece of work and he had been impressed with the inclusive process followed. The main point he had been struck by was the question of how to protect elective care with the solution of physical separation of elective and emergency care and asked what other approaches were being used to protect elective care given its importance. Mr Palmer responded that the current approach was a set of strong Standard Operating Procedures that built on what had been done with Ophthalmology over the last year which would be applied to General Surgery and Cardiology to hold the position. He added that the process generated through the Nightingale proved that the organisation could be extremely efficient and effective with dedicated sites and workforce. There still needed to be a conversation about what was the right protected elective capacity for Devon over the next 10-15 years using the evidence base that had been generated. If this cannot come from within the NHS, it would be necessary to look at independent partnerships.<br><br>Professor Marshall noted that there was no reference to the Academic Health Science Network in the document, although academic excellence was referenced.<br><br>Professor Marshall commented that there was little reference to general practice/primary care and thought more was needed, in particular regarding more broadly how to support general practice. Professor Harris agreed and said that it was a system problem and solution, with wider engagement as a system needed.<br><br>Professor Marshall advised that he would expect to see a real shift in funding upstream into primary and community care and into patients' homes and this was not reflected in the Finance Strategy. Mrs Hibbard commented that the Trust was not currently funded for primary care and this was why it was not included in the Strategy, with a strategic conversation with the wider ICS around funding needed. The Trust was responsible for community and as part of the financial framework, investment in community had been set out within the limited resourcing over the next 5 years to target what needed to grow in community services.<br><br>Ms Morgan said that she had been struck by repeated references to system and system benefits which was a significant and important change from when she had first started in her role.<br><br>Mr Neal commented that the Devon Forward Plan was relatively new and there was a risk against all of the Trust's plans relating to its stability. It would be important to include measuring benefits and baselines to avoid trying to work out afterwards what the benefits had been after implementation of strategies. He also noted that there were many interdependencies and it would be important to ensure that these were managed, as well as checking against capacity and skills to implement. Mr Tidman suggested that it would be helpful if Mr Neal could offer support to enact the next phase.<br><br>Mr Matthews noted that there was a list of criteria to use to judge future investment decisions in the Finance Strategy and asked whether there would be a way to use that objectively so that when capital projects come forward there would be a way of ranking them across services. Mrs Hibbard responded that the question would be how to operationalise the investment criteria into practice. Ms Morgan asked whether it would be | |

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| | possible to have a template for future decisions on business cases and Mrs Hibbard responded that this was being built into the business case modelling, so it would be very clear how that was evidenced.<br><br>Mr Matthews commented that with regard to elective capacity, the question was also about right sizing it as well as protecting it. In addition, the Clinical Strategy had not mentioned the aspiration to offer a large proportion of patients, particularly cancer patients, the opportunity to participate in clinical trials. Finally, Mr Matthews noted that the Clinical Strategy would be delivered by the Trust Delivery Group led by the Chief Operating Officer and suggested that the Chief Medical Officer and Chief Nursing Officer should jointly lead this with the Chief Operating Officer. Professor Harris advised that Mr Palmer chaired the Trust Delivery Group but that it would be led by all three Executives. It was the Trust's intent to enrol every Oncology patient into a clinical trial, but it was not as mature as Truro yet and the job of the Director of Research and Development was to create the environment for the Team to flourish.<br><br>Mr Kirby noted that there were both internal and external interdependencies and he was not clear on the interface with ICS/ICB strategies, in particular relating to health inequalities and prevention. Those links should be made explicit, as there may be funding streams that the Trust could benefit from and there were also interdependencies with the Acute Provider Collaborative that the Trust might be able to feed into. Mr Kirby suggested that a section on transport could be included in the strategy. Mr Tidman said that this had been discussed with partners and was a prominent feature of the Acute Provider Collaborative work, with a need for all organisations across the peninsula to consider where they go for their Centre of Excellence. He said that transport could be a novel enabler and he would pick this up with Lord Markham when he visited the North Devon site on 2 August 2023. Mr Tidman added that as previously stated, the Strategy was an iterative document that would be changed based on opportunities and challenges over time. Mr Luke said that there was a proposal to bring a paper on health inequalities to the Board of Directors in quarter 3, and added that the focus on digital would help to address some of the issues relating to travel for patients.<br><br>Professor Kent said that there had been some very novel initiatives, but that the Trust did not always have the facilities needed to progress work at the pace wanted and asked how much the various strategies would link together to ensure that this was addressed. Mr Tidman commented that the Director of Estates was looking with her team at co-located services and what could be moved off site to another location in order to expand, as well as looking at what would be possible if there were extra strategic capital. Mr Luke said that there were 51 approaches in the Clinical Strategy and each of these had been gone through with the leads for the enabling strategies to check whether they were covered. They were not perfectly aligned but they were more aligned than previously.<br><br>Mrs Foster commented that a gap analysis on the Workforce Plan would be brought to the October Board.<br><br>Ms Morgan gave approval to proceed, subject to small changes, in response to consultation with stakeholders, but advised that she would like to see the final version to see and understand the changes. Ms Morgan gave thanks and congratulations for the extraordinary work.<br><br>**The Board of Directors approved the Clinical Strategy and enabling strategies subject to the minor amendments discussed and agreed the delegated authority to** | |

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| | **the Chief Executive and Executive Leads to make any reasonable adjustments to the strategies as required, with these being shared with the Chair.** | |
| **121.23** | **REVIEW OF THE BOARD ASSURANCE FRAMEWORK** | |
| | Mrs Holley presented the review of the Board Assurance Framework (BAF), noting that this was the first time it had been presented to the public meeting.<br><br>Ms Morgan asked whether it would be feasible to link together more obviously the risks and mitigations, as it would be helpful if they were more closely aligned. Mr Matthews commented that that should be addressed if the graph at the top of the table was used to show the forecast rates. Mr Tidman asked if this could be followed up to make sure there was more consistency. **Action.** Mrs Mills said that added value could be provided if the actions were pulled out in more detail.<br><br>Mr Kirby commented that the Trust was an outlier in terms of the number of risks that were scored in the major and catastrophic likelihood section of that heat map and suggested that there could be a number of reasons for this including being in NOF4 or the Trust's risk appetite. In addition, Mr Kirby said that he fundamentally disagreed with the score for Risk 7 because of the ongoing risks around Epic. Mr Neal responded that this had been scored as it was in the absence of risk appetite. Mr Tidman commented with regard to Mr Kirby's first point that this may relate to a different appetite because of where the organisation and the system currently are in terms of the scrutiny Devon was under. Mrs Holley said that this would be why it would be helpful for the organisation to be engaged in the review across the system of the BAF. Mr Palmer said that he did think that this related to the organisation being in NOF4 and Tier 1 for every domain, but that the risk should be extrapolated out to acknowledge some of the opportunities that may be available to show a pathway through the rest of the year.<br><br>Mrs Foster said that Risk 1 which sat with the Board and the Chief Executive should be reviewed and Mr Tidman responded that he had reviewed it on behalf of the Executives.<br><br>Mr Neal suggested that if more detail about actions and dates were provided, those that were due could be flagged in the summary which may help to ensure that they were progressed. **Action.**<br><br>Mr Palmer suggested that it would be helpful if the direction of travel of individual risks were included in the summary. **Action.**<br><br>**The Board of Directors noted the review of the BAF.** | |
| **122.23** | **STAFF SURVEY ANALYSIS** | |
| | Mrs Foster presented the Staff Survey analysis that had been undertaken following initial discussion on staff survey results at the April Board meeting. The Board of Directors noted:<br>• There were three specific areas that were looked at in detail. These were the "we are always learning element" where the Trust had scored lower than average, the drop in Northern staff scores and colleagues experience of their line management.<br>• Trustwide engagement had taken place through a number of forums including presentation of results at Trustwide meetings, engagement with Staffside and Partnership Forum, formal reporting at committees, listening events for staff and managers, divisional level partner meetings and focused Executive discussions.<br>• Key themes that emerged from the engagement included improvements needed to the appraisal process to simplify, staffing levels, manageable workloads, empowering | |

managers, career pathways, listening to staff and providing reassurance that things change when raised and health and wellbeing.

- "We are always learning" metric covers a number of areas in the Staff Survey, with the Trust scoring below average in only one area relating to appraisals. The appraisal cycle had been delayed during Covid to every 18 months and it had been agreed at the April Board to accelerate this back to every 12 months. A review of the current appraisal and one-to-one process was planned for September 2023.
- There had been a significant drop in scores for Northern staff since integration across all People Promise elements of the survey, although it was noted that Northern staff had historically scored significantly higher than other organisations. The People Pulse survey results had been reviewed and they did not show the same level of drop, although it was noted that this was a slightly artificial comparison. This would be kept under review.
- Staff experience of line managers – this had been reviewed a few years ago and a further analysis had been undertaken which highlighted a number of themes, which were discussed by the Executive Team and proposals were explored to address the areas identified.
- Action plans were being put in place, with Divisional actions, Trustwide actions and Executive actions.
- Executive Directors had committed to having an inclusion objective set as part of their annual appraisal process related to their area of accountability.
- The ambition is to get constant and iterative plans and measurements to understand whether there is progress being made on areas of concern.
- Employee experience data was used to inform, give assurance and escalate risks through the People, Workforce Planning and Wellbeing Group, the Inclusion Steering Group which report into the Governance Committee, and the Performance Assurance Framework.

Ms Morgan thanked Mrs Foster for the presentation and noted that the themes identified that would make the biggest possible difference to staff experience related to reduction of time pressures. Ms Morgan noted the action plans outlined in the presentation and asked if Mrs Foster could summarise what she would expect to look and feel different for staff in 12 months' time as a result of these plans. Mrs Foster said that there were some early good signs of improvement, including that data was showing that the Trust was becoming more inclusive, but that reducing time pressures was more difficult to measure, but the work on recognition of the pressures and what was outside of the Trust's control should help. Mr Tidman said that the two key metrics that the organisation would want to see a positive change on would be staff recommending the organisation as a place to work and recommending it as a place to receive care.

Mrs Burgoyne noted that one of the themes raised was manageable workload and less project expectations, and asked how business as usual which was very pressured would be balanced with transformational work needed. Mrs Foster noted that the National Workforce Plan referenced this tension and added that there was a shared responsibility to have honest dialogues on this.

Mrs Burgoyne noted that the Executives would have a specific objective regarding inclusion and asked how this would be filtered down for line managers. Mrs Foster agreed that it would be important for the Executive leadership to drive inclusion across the organisation so that staff really understand what is meant.

Mr Neal asked whether, when thinking about cultural development, there was something that needed to be added around communication and setting expectations. With regard to

morale, he suggested that other ways of valuing and recognising people could be explored. In addition, Mr Neal said that he did not feel the poor results for Band 2 staff experience of being managed had been unpicked sufficiently to establish what was behind this. Mrs Foster agreed that thought needed to be given to ensure that everyone felt valued. She added that much of the issue identified with Band 2 staff related to Facilities staff and there was some targeted work to look at this. Mr Tidman added that many of these staff did not have the same access to the Trust's usual communications through digital channels and the Director of Estates was looking at production of Newsletters and holding drop-in sessions for these staff. There was also cultural issues, for example use of clock-in and clock-out cards, which were being addressed.

Mr Kirby commented that he had heard that there was a different partnership and working model with Sodexo, whose staff were not included in the Survey, and suggested that the Trust should talk to Sodexo about their model which may be better for certain groups of staff. Mrs Foster commented that it was important to note that there had been changes to Band 2 and 3 Healthcare Support Workers and that these would play through into the next survey with a different make-up of the Band 2 group. Mr Tidman agreed that there could be learning from Sodexo although the Trust was more constrained in terms of what it could offer through Agenda for Change. He said that Sodexo did have a different way of recruiting and retaining its staff. In terms of the model, this was being strategically reviewed which would be taken through the governance process.

Mr Kirby noted that Mrs Foster had said that there were only 13 people in the 8D group which had had some poor results for feedback and support based questions. Whilst this was a small group they covered a significant area of the Trust, and these scores were concerning. Mrs Foster said that there had been quite a lot of engagement with the leadership group and Mr Tidman added that he believed the areas showing as red for 8Ds related to the pressures on senior managers. It would be for the Executive Team to ensure that they were supporting these staff through their appraisals.

Professor Marshall said that the response to the learning organisation question was concerning, as it was important for staff to believe that the organisation was learning and trying to improve. Work undertaken by the Kings Fund had shown a very clear correlation between staff morale and patient experience and he asked whether it would be helpful for the Trust to do this analysis, and if so whether it had the analytical capacity. Mrs Foster said that the learning organisation question related mainly to whether staff were learning and developing in the organisation, rather than culture. Patient safety and patient experience being part of the culture was included in the cultural development roadmap. Mrs Mills said that if a theme arose that related to a specific area or team through the patient experience data, this would be analysed to try and understand whether there was a specific issue in that team and would be flagged with the relevant manager. She added that whilst it might be possible to undertake a more proactive piece of work on this, she was not sure of the value it might add.

Mr Palmer said that it was important to remember that admin and clerical were an important staffing group who often had to deliver significant activity in a very short time frame. Alongside that, the Trust was modernising as a result of Epic and there were changes in headcount. He suggested that there might be something the Trust could do to emphasise that it valued these staff and was professionalising them. He added that the paper was helpful in putting metrics around the challenge and locating the activity. Finally, Mr Palmer said that the Executive had significant engagement with senior leadership over the last few months and much of the discussions had centred around generating enough headroom to do the right thing for the organisation, with one of the things that had been committed to

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| | being a rationalisation of meetings. Ms Morgan agreed that it was important to give people a sense that the organisation was investing in them for their future.<br><br>Ms Morgan thanked Mrs Foster for her helpful presentation and the discussion that it had generated.<br><br>**The Board of Directors noted the Staff Survey Analysis and Way Forward.** | |
| **123.23** | **INFECTION CONTROL ANNUAL REPORT & ANNUAL PROGRAMME** | |
| | Ms M Burden joined the meeting.<br>Mrs Mills informed the Board that this was a statutory report presented for approval. It was noted that the report would normally have been presented to the Governance Committee but this had not been possible this year because of the timing of meetings. It was noted that the Trust was declaring compliance against all but one of the ten elements of the Code of Practice on the Prevention and Control of Infections and Related Guidance. The Trust was not compliant with criteria 7 which related to the provision of isolation facilities; this was due to limited side room capacity which would only be mitigated through future estates work and the New Hospital Programme in Northern services.<br><br>Mr Neal noted that the higher than expected rate of E. coli blood stream infections and asked for confirmation that this was believed to relate to the spread of viruses as people return to normal working and activities post-pandemic. Mrs Mills confirmed that this was her understanding and Ms Burden added that targeted work was planned for the next 12 months to understand these gram-negative bacteraemia and reduce the incidence.<br><br>It was noted that the report referenced a Conclusion section but this had not been included and Mrs Mills confirmed that it had been removed, but the table of contents had not been updated to reflect this and would be amended. **Action.**<br><br>Mr Kirby asked for clarification on how infection prevention and control worked for virtual wards. Ms Burden advised that the Infection Prevention Control team covered all care provided at home with a community infection management service, which provided training and also surveillance of patients in their own homes.<br><br>Professor Kent asked whether there was a difference between the cleaning services provided in Eastern and Northern services from an Infection Prevention Control perspective. Mr Tidman said that when the two departments were looked at for the last year, Sodexo in Northern services had been much better at recruitment and retention of staff, whereas there had been significant vacancies in the Eastern service. Mr Tidman said that he would look at the specific question in more detail outside the meeting. **Action.**<br><br>Mr Matthews noted that high compliance rates were reported for audits of hand hygiene and bare below the elbows in clinical areas by clinical staff, but that informal observations and formal validation audits by the Infection Control Team had identified that hand hygiene compliance had been negatively impacted. He asked for further clarification of what was behind this disparity. Ms Burden responded that hand hygiene audits had not been as accurate as they could be and when the Team undertook validation audits lower rates of compliance were found than those submitted by wards. Additional hand hygiene training for the auditors is being put in place which will empower them to produce less than satisfactory audit results, so that there will be more accurate information to enable targeted training. Professor Kent said this was a good initiative and she would welcome getting some feedback on impact. | |

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| | Mr Palmer said that it was important to note the themes in the introduction to the report, noting that the preceding Winter had been one of the most complicated in terms of infection control. He said that the Infection Prevention and Control Team had provided excellent advice and had also fed advice into the wider Devon system.<br><br>**The Board approved the Annual Report.** | |
| **124.23** | **FINANCE & OPERATIONAL COMMITEE** | |
| | Mrs Burgoyne presented the update from the meeting held on 13 July 2023 with the following points noted:<br>• The Committee received a detailed update on the Delivering Best Value savings plan, the deep dive that was necessary to ensure that the Trust was on track and was assured that the Team was focussed on getting the information needed to provide a clear position by Month 5.<br>• The Committee had discussed the changes to ERF rules to reduce the threshold of 2019/20 weighted activity levels against which ERF can be earnt by 2% which would release funding into systems to account for the impact of industrial action in April. Further negotiations are ongoing regarding changes due to subsequent periods of action.<br>• The Committee received a detailed paper on No Criteria to Reside.<br>• The Committee noted a bid submitted to the National Institute for Health and Care Research for funding to establish a Health Technology Research Centre for the South West.<br>• The Committee received a recommendation that a local contractors' framework be agreed to facilitate contracting of local suppliers on estates work and, subject to a number of amendments, recommended approval to the Board of Directors.<br>• The Committee noted the amended Terms of Reference for the Delivering Best Value Board and Steering Group and recommended them to the Board of Directors for approval.<br>• The Committee received a post-project review for the Nightingale Hospital following its first fully operational year.<br><br>Mrs Hibbard advised that the finance position was on track at Month 3, but there were two big variances regarding pay and drugs, with pay being the cost of industrial action and non-delivery of the delivering best value programme. It had been agreed that a deep dive on these two areas would be undertaken for the August Finance and Operational Committee meeting to provide assurance on the understanding of the drivers behind these pressures and the actions being taken to bring them back into position. Delivery of the plan at a £28m deficit was still being forecast, whilst recognising a number of very significant risks. There are a number of mitigations in place for these risks, but the unknown factor was how system stretch savings were progressing; it was known that there was a shortfall within the £60m the system was trying to deliver, of which the Trust was holding £15.6m which it was still forecasting delivery against. Mrs Hibbard advised that it was likely that at some point there would be slippage and the system would need to understand what mitigation there would be against the system stretch.<br><br>Mrs Hibbard gave further clarification on the changes to the ERF rules. There was a 2% reduction in the annual threshold trigger to cover in month for April changes for lost activity due to industrial action, with the idea being that systems would change trajectories which would release funding to cover the cost of industrial action. The difficulty was that many systems, including Devon, had already allocated out all ERF funding and it would be challenging to recycle that back in. This was being worked through but was a major risk. | |

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| | In addition, 16% of ERF allocations were being held back until the revised activity threshold had been met. The implications were not known, and providers were strongly advised to assume that they met that threshold so that they would still get 100% as providers. Mrs Hibbard advised that a letter was expected at the end of July 2023 to clarify the detail which would allow the system to model through the implications. Mrs Hibbard noted that there were still negotiations ongoing with the Treasury and government on how the cost of industrial action in June, July and August would be managed.<br><br>Mr Palmer informed the Board that the new Improvement Director had attended the meeting for the first time. She had brought some objective challenge and also some good first cuts of benchmarking, in particular some fair challenge about where the Trust stood across four quartiles across NHSE.<br><br>Professor Marshall asked if it was known how the nationally agreed pay rises would be met. Mrs Hibbard replied that there had been a commitment nationally that frontline services would receive the full amount of funding needed for the pay award, however NHSE would have to find the funding from within existing departmental budgets. In order to fund providers, it would therefore be necessary for NHSE to hold back additional funding that may have been intended for something else, for example digital programme, community diagnostic centres, screening programmes etc.<br><br>Mr Kirby commented that when the clarification on ERF funding was received in late July, an August Finance and Operational Committee would need to be held to discuss this, but that the Board would not receive an update as there was no formal Board meeting in August. Mrs Hibbard said that although the letter had been promised for late July, she did not think it would be received then and it would therefore be unlikely that the work needed to understand the changes would not be ready for an August meeting of the Committee.<br><br>Ms Morgan thanked Mrs Burgoyne and Mrs Hibbard for the update and the assurance that had been provided to the Board of Directors.<br><br>**The Board noted the update and agreed its approval for the two items recommended by the Committee – the local contractors' framework and the Delivering Best Value Board and Steering Group terms of reference.** | |
| **125.23** | **DIGITAL COMMITTEE** | |
| | Mr Neal presented the Digital Committee update from the meeting held on 27 June 2023 with the following items brought to the Board's attention:<br>• The Digital Team were involved in a significant amount of work, in addition to business as usual, and ICS projects were also now starting to come in requiring input from the Team. There were also a number of gaps in the Digital Team. A paper was being prepared for the next meeting of the Committee to look at planning and prioritisation of projects and skills and workforce.<br>• Licence growth was looked at and further work was due to be undertaken to move towards developing a forecasted requirement for licences going forward.<br>• The Committee had discussed the new multi factor authentication requirement for NHS Mail before logging in which will be enforced from September 2023.<br><br>Mrs Foster asked whether the Digital Committee was sighted on what was being signed off and approved in the digital arena at ICS level and Mr Neal responded that the ICS IT Lead had been invited to attend the next Digital Committee meeting to discuss this. | |

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| | **The Board of Directors noted the Digital Committee Update.** | |
| **126.23** | **INTEGRATION PROGRAMME BOARD** | |
| | Mr Matthews presented the Integration Programme Board update from the meeting held on 18 July 2023. The Board noted:<br>• It had become clear that the aspiration to complete operational integration before the summer of 2024 was not realistic. The Programme Board had received an update on a revised timeline for this work which had now been extended into two phases, with a final planned completion date of November 2024, although there was confidence that this could be pulled back to the end of September 2024, with further work was needed to firm plans up and ensure that everyone would have the right opportunities to apply for roles and to conduct the two rounds of consultation that would be needed.<br><br>Ms Morgan asked what the priority areas of focus should be and Mr Matthews responded that it would be important to ensure that the periods of consultation were what they needed to be, for example there was potentially an opportunity to go quite quickly on the first round of consultation as it involved a smaller group of people and could potentially be possible to get aligned more quickly. Mr Palmer added that the hope had been initially that the whole process could be completed within one financial year, although it was then apparent that at least a further six weeks would be needed. He advised that definitive workforce advice had now been received on the need to run two rounds of consultation covered. The challenge, which had been discussed extensively by the Executive Team and in workshops, was whether it would be possible to be very clear on Terms and Conditions upfront in the consultation processes that might then allow a shorter period of consultation. He added that the team were looking at every opportunity to take everyone involved with us in this process, whilst observing due process in order not to trigger misunderstanding or disagreement that would slow the whole process down.<br><br>Ms Morgan noted that the Board would endorse the approach that was being recommended.<br><br>Mr Tidman informed the Board that the report on lessons learned from the merger from the National Review Team had been received on 26 July 2023. It would be checked for factual accuracy and would then be brought back through the Trust's governance processes.<br><br>**The Board of Directors noted the Integration Programme Board report.** | |
| **127.23** | **NATIONAL INSTITUTE FOR HEALTH & CARE RESEARCH CLINICAL RESEARCH NETWORKS SOUTH WEST PENINSULA ANNUAL REPORT & ANNUAL PLANS** | |
| | Pauline McGlone joined the meeting.<br>Professor Harris presented the report to the Board of Directors, noting that the finance plan included with the report was for approval. It had been a successful year for the Network in terms of recruitment and it was noted that there were some opportunities in terms of the commercial vaccine pipeline.<br><br>Mr Kirby commented that it seemed strange that the host Board did not have any involvement in the business plan but was asked to approve the financial plan and Professor Harris agreed that this did appear unusual but this was required.<br><br>Mr Kirby noted that £833k was devoted to transformation of research delivery which appeared to be a very large proportion of the total allocation unless it delivered significant benefit. Ms McGlone responded that this was a top slice that was mandated at national | |

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| | level and started in 2021 relating to transforming research in out of hospital settings. It related to the employment of a workforce across the region that supported primary care, hospice, schools and out of hospital research. The performance of the team is closely monitored.<br><br>Ms Morgan noted that the report stated that the Clinical Research Network would transition to a new contract on 1 October next year with possible risks related to staff in the core team and asked for further clarification of this. Ms McGlone replied that it was not currently known what the new networks would look like and until this was clarified, it was possible that staff may leave with early signs of this already apparent. Professor Harris said that it was known that there would be a greater clinical focus with a slimmed down organisation. A change management process was being introduced but the end point was not yet known.<br><br>Professor Kent asked where the funding was coming from for the requirement to have a local head of nursing and Ms McGlone advised that this was top sliced from the budget; funding of the role was a requirement of the contract but no additional funding was provided.<br><br>Professor Kent asked how the impact of changes to the research design service were being monitored. Ms McGlone responded that this was being actively monitored. The Royal Devon was the host organisation for the current research design service and had applied for an extension. There was a strategic working group in place to ensure that there was support for the new Research Support Service to make sure there would be no impacts at local level.<br><br>**The Board of Directors noted the annual report and approved the finance plan.** | |
| **128.23** | **ITEMS FOR ESCALATION TO THE BOARD ASSURANCE FRAMEWORK** | |
| | 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 reviewed. Mr Kirby suggested that the changes to ERF funding might impact some of the risks and Mrs Hibbard said that this related to the risk of non-delivery of the finance plan. The risk had been reviewed with the consequence reduced but likelihood remaining the same.<br><br>Mrs Hibbard asked whether consideration needed to be given to whether the impact of industrial action needed to be added to the BAF. Mrs Foster commented that this was covered under a number of other risks on the BAF. Mr Tidman said that whilst this was a significant operational risk, he was sure that this would at this point impact on overall achievement of the Trust's strategy, but it would be kept under review. Mr Palmer said that there would be a tipping point where the trajectories for long waits for recovery would become impossible to meet if industrial action continued and this was being watched closely by the centre. He agreed that this should be tracked closely and if the tipping point was reached consideration would need to be given to treating this as a separate risk. Mrs Foster suggested that the original decision recorded on the Corporate Risk Register to cover this risk under a number of strategic risks should be reviewed and Ms Morgan agreed with that, together with continued monitoring, as a way forward. **Action.** | |
| **129.23** | **ANY OTHER BUSINESS** | |
| | Ms Morgan noted that the Board would want to thank Mrs Tracey and celebrate the contribution that she had made to the Trust over many years. Ms Morgan was in touch with Mrs Tracey to discuss finding a suitable date, possibly at the end of a future Board | |

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| | meeting to invite her for an event. The Council of Governors were also keen to hold a similar event with Mrs Tracey at the end of a Council of Governors meeting.<br><br>Ms Morgan informed the Board that the process to recruit a permanent successor for Mrs Tracey had started with the establishment of an Appointments Committee to take this forward. This would be done as quickly as possible, but it was recognised that it could take some time if the successful candidate had to work out a notice period. | |
| **130.23** | **PUBLIC QUESTIONS** | |
| | The Chair invited questions from members of the public and Governors in attendance at the meeting. Mrs Matthews had sent the following question via email which related to the Patient Story, MyChart and access to records and results:<br><br>"When can patients be confident that their MyChart records are complete? At a recent Barnstaple Alliance Primary Care Network (PCN) Patient Participation Group this matter was raised. Ophthalmology and Gastroenterology records appear to be incomplete, e.g. no records accessible for a regular attender at Ophthalmology Glaucoma clinics, and no historical records available for a Gastroenterology patient.<br><br>At the same meeting Barnstaple Alliance PCN Operations Manager promoted a joint Learn Devon scheme to support patients in the community to develop IT skills, log patients into the NHS App, MyChart etc starting a trial run shortly. As per previous meeting, again I requested support in GP surgeries to provide supported IT access for digital appointments with NHS consultations. PCN response was lack of space and staff cited as barriers. Suggestion that library be used rejected on the basis of lack of confidentiality. Has Professor Harris made any progress in this matter?"<br><br>Professor Harris responded that the Trust was struggling to make progress with the idea of having digital help available for patients in GP surgeries due to space constraints. However, a pilot to take place in the community hospital was being explored and, if successful, there may be an opportunity to roll it out more widely. With regard to data migration, at go live of Epic a certain amount of data was migrated across, for example medication, key operations, health conditions and allergies usually covering a two-year historical period and the patient's record would then be populated going forward. Therefore, with regard to the Gastroenterology patient, he would not have expected historical records to be available, but would have expected the records for the regular attender at an Ophthalmology Glaucoma clinic to be available and suggested that if Mrs Matthews were able to identify more detail on where this had happened, Professor Harris would be able to look into this.<br><br>Mrs Penwarden thanked Board members for the comprehensive presentations and discussions and the Non-Executive Directors for their reflections and questions. Mrs Penwarden noted that in the Clinical Strategy presented to the Board there was mention of a Volunteer Coordinator role to liaise with voluntary sector organisations, carers and patient families and asked if more detail could be provided on this. Professor Harris advised that he did not have details regarding this role, but would look at this outside the meeting and provide a response. **Action.**<br><br>Mrs Penwarden noted the list of professionals involved in the development of the Clinical Strategy provided and asked what the Trust philosophy was on consulting, engaging and co-producing clinical strategies and clinical research strategies with people with lived experience. Professor Harris responded that patients were involved in the development of the Clinical Strategy and were also involved in the development of the research strategy. | |

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| | Ms Morgan asked how patients were approached to be involved and Professor Harris said that he was uncertain of the mechanism used, but would look into this and provide an answer outside the meeting. **Action.**<br><br>Dr McElderry thanked the Board for holding the meeting in North Devon and said that the public of North Devon were appreciative of the efforts made to engage with them, and expressed her appreciation particularly to Mrs Tracey for her engagement and communication with the local population. Dr McElderry also paid tribute to the standards of healthcare provided in North Devon. Dr McElderry noted the discussion at the June Board meeting about the plans for a Changing Places toilet facility and asked whether there was any further update and whether the Trust had a named disability champion. Ms Morgan thanked Dr McElderry for her tribute to Mrs Tracey and the services provided in North Devon. Mr Tidman responded that following the presentation at the June Board he had discussed the Changing Places toilet facility with the Director of Estates and Facilities and this would be scoped and if possible built into the capital programme. Mrs Foster said that whilst there was not a specific disability champion, Mrs Tracey had been the Inclusion Champion and that there were a number of different staff networks covering inclusion, including disability.<br><br>Professor Pope noted that there had been examples during the meeting of where the Trust was working effectively with some partners, such as social care, but had highlighted other areas, such as with General Practice, where there were some problems. She asked what the Trust was doing to try to improve partnerships and whether it was believed that Integrated Health Boards would help to improve partnership working in the system. Ms Morgan said that the issue that the Board had discussed with regard to general practice had related to a difference in systems rather than a problem in relationships. She added that the development of the ICS would help to improve system working not only across Devon, but across the peninsula as a whole, but would take time to establish and strengthen. Mr Tidman added that the Trust was working closely with ICB colleagues to look at how to support primary care. There was also work through the locality Boards where primary care colleagues worked with clinicians and managers to plan services at a local level which would develop further over the next few years.<br><br>Mr Wilkins noted that the Staff Survey identified stark differences between how different parts of the workforce experienced line management. The action plan appeared to emphasise the empowerment of managers which appeared to exclude other members of staff and asked whether this was consistent with the Trust's values of inclusion and empowerment for all staff. Mrs Foster responded that this related to feedback from managers who had attended feedback events on being empowered to manage and do their jobs which would in turn help them to empower others.<br><br>Mr Wilkins asked whether the analysis differentiated between hybrid managers who combined professional and managerial roles and general managers who might have more of a corporate viewpoint. Mrs Foster replied that the category would include all staff who had identified themselves as managers.<br><br>Ms Morgan thanked everyone for their questions and for the responses provided. | |
| **109.22** | **DATE OF NEXT MEETING** | |
| | The date of the next meeting was announced as taking place on 27 September 2023. | |