



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

At 09:30 on Wednesday 30 November 2022  
Via MS Team

### AGENDA

*This meeting will be recorded via MS Teams7*

Item	Title	Presented by	Item for approval, information, noting, action or discussion	Time Est.
1.	<b>Chair's Opening Remarks</b>	Shan Morgan, Chair	Information	09:30 2
2.	<b>Apologies</b>	Melanie Holley, Director of Governance	Information	09:32 1
3.	<b>Declaration of Interests</b>	Melanie Holley, Director of Governance	Information	09:33 2
4.	<b>Matters discussed in the confidential Board</b>	Shan Morgan, Chair	Noting	09:35 2
5.	<b>Minutes of the Meeting of the Board held 26 October 2022</b>	Shan Morgan, Chair	Approval (Paper)	09:37 5
6.	<b>Matters Arising and Board Actions Summary Check</b>	Melanie Holley, Director of Governance	Information (Paper/Verbal)	09:42 5
7.	<b>Chief Executive's Report</b>	Suzanne Tracey, Chief Executive Officer	Information (Verbal)	09:47 20
8.	<b>Patient Story</b>	Jason Lugg, Director of Nursing (Northern)	Information (Verbal/paper)	10:07 15
9.	<b>Outpatients Transformation Update (Deep Dive)</b>	Stuart Kyle, Clinical Lead Outpatient Transformation Mike Browning, Programme Director Outpatient Transformation	Information (Presentation)	10:22 30
	<b>COMFORT BREAK</b>			10:52 10
10.	<b>Performance</b>			
10.1	<b>Integrated Performance Report</b>	Chris Tidman, Deputy Chief Executive	Information (Paper)	11:02 30
11.	<b>Policy and Strategy -NO ITEMS</b>			

<b>12.</b>	<b>Assurance</b>			
<b>12.1</b>	<b>Audit Committee Report</b>	Alastair Matthews, Non-Executive Director & Committee Chair	Information (Paper)	<b>11:32</b> 5
<b>12.2</b>	<b>Six Monthly Safe Staffing Report</b>	Jason Lugg, Director of Nursing (Northern) & Adrian Harris, Chief Medical Officer	Information (Paper)	<b>11:37</b> 15
<b>13.</b>	<b>Information</b>			
<b>13.1</b>	<b>Items for Escalation to the Board Assurance Framework</b>	Shan Morgan, Chair	Discussion (Verbal)	<b>11:52</b> 1
<b>14.</b>	<b>Any Other Business</b>			<b>11:53</b>
	At the conclusion of the formal part of the agenda, there will be an opportunity for members of the public gallery to ask questions on the meeting's agenda. Where possible, questions should be notified to members of the Corporate Affairs team before the meeting. Every effort will be made to give a full verbal answer to the question but where this cannot be done, the Chair will ask a director to make a written response as soon as possible.			
<b>15.</b>	<b>Date of Next Meeting:</b> The next meeting of the Board of Directors will be held at 09:30 on Wednesday 25 January 2023.			
<b>16.</b>	The Chair will propose that, under the provisions of section 1(2) of the Admission to Public Meetings Act 1960, the public and press should be excluded from the meeting on the grounds of the confidential nature of the business to be discussed.			

**Meeting close at 12:03**

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

Wednesday 26 October 2022 via MS Teams

### MINUTES

<b>PRESENT</b>	Mrs H Foster	Chief People Officer
	Professor A Harris	Chief Medical Officer
	Mrs A Hibbard	Chief Financial Officer
	Professor J Kay	Senior Independent Director (from item 143.22)
	Professor B Kent	Non-Executive Director
	Mr S Kirby	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
	Mrs S Tracey	Chief Executive Officer
	Mr C Tidman	Deputy Chief Executive
<b>APOLOGIES:</b>	Mrs C Burgoyne	Non-Executive Director
<b>IN ATTENDANCE:</b>	Ms S Delbridge	Communications Officer (for item 141.22)
	Ms G Garnett-Frizelle	PA to Chairman (for minutes)
	Mrs M Holley	Director of Governance

		ACTION
<b>134.22</b>	<b>CHAIR'S OPENING REMARKS</b>	
	<p>The Chair welcomed the Board, members of the public, Governors and observers to the meeting, and 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.</p> <p><b>The Chair's remarks were noted.</b></p>	
<b>135.22</b>	<b>APOLOGIES</b>	
	Apologies were noted for Mrs Burgoyne	
<b>136.22</b>	<b>DECLARATIONS OF INTEREST</b>	
	There were no new declarations of interests raised for noting.	
<b>137.22</b>	<b>MATTERS DISCUSSED IN THE CONFIDENTIAL MEETING</b>	
	The Chair noted that a meeting of the Finance and Operational Committee had taken place that morning. The Board had received updates at its confidential meeting from the Digital Committee, Governance Committee, Integration	

	Programme Board and Our Future Hospitals Programme Board, as well as updates on the Corporate Strategy Roadmap and the revised Board Assurance Framework.	
138.22	<b>MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 28 SEPTEMBER 2022</b>	
	The minutes of the meeting held on 28 September 2022 were considered and approved as an accurate record.	
139.22	<b>MATTERS ARISING AND BOARD ACTION SUMMARY CHECK</b>	
	<p><b>Action check</b></p> <p>The actions were noted as per the tracker with the following additional update: <i>008.22(1) Update on diagnostics briefing and business case to be presented at March 2022 public Board meeting.</i> Mr Palmer advised that the Community Diagnostics Centre bid had been approved by the region to go forward to the final national panel which it was believed would meet on 3 November 2022. Mr Palmer extended his thanks to the Team who continued to focus on moving this forward.</p> <p><b>The Board of Directors noted the updates.</b></p>	
140.22	<b>CHIEF EXECUTIVE OFFICER'S REPORT</b>	
	<p>Mrs Tracey provided the following updates to the Board.</p> <p><u>National Update</u></p> <ul style="list-style-type: none"> <li>• The new Prime Minister had appointed Mr Steve Barclay as Secretary of State for Health, a position he had previously held for a short period during the Summer of 2022.</li> <li>• The Treasury had confirmed that the NHS would not receive additional funding to cover inflation costs, increasing the prospect of further real term pay cuts for staff in coming years as the NHS will have to find funding for pay increases of above 3% from existing budgets. Julian Kelly, Chief Financial Officer, advised that increases in inflation would force the NHS to scale back services unless the Government provided extra funding, adding that the NHS in England would have to find an additional £20bn in efficiency savings over the next three years due to the increased cost of goods and services.</li> <li>• The new Chancellor, Jeremy Hunt, had indicated that all departments including Health and Social Care, would face a round of difficult spending cuts, despite assurances that reverses in the Health and Social Care levy would not result in reductions to the NHS budget. This was despite a recent report from the NHS Confederation which demonstrated direct correlation between investment in the NHS and growth in the UK's economy, with analysis showing that for every £1 invested in the NHS, £4 made its way back into the economy through increased productivity and boosted participation.</li> <li>• Latest NHS workforce figures showed that a record number of staff voluntarily resigned during the first quarter of 2022-23; almost 35,000 staff voluntarily resigned, up from 28,000 during the same period in 2020-21 and just over 19,000 in 2019-20. The most common reason stated was work life balance.</li> <li>• There were almost 7 million patients on the waiting list nationally in August, up from 6.8 million in July. In addition, breaches of a year plus increased to approximately 388,000 in month. The month on month reduction in 18-month</li> </ul>	

waiters had slowed, with the position standing at 50,888 at the end of August. The number of patients waiting more than 12 hours in A&E for a decision to admit jumped to new record of 32,776 in September.

- NHS Blood and Transplant had raised its alert level to Amber following several months of low stock levels warning that this might result in cancellation of non-urgent operations by some hospitals. Stocks of O type blood had dropped nationally to less than 2 days' worth. Members of the public had been encouraged to come forward in high numbers to donate blood.
- The National Audit Office (NAO) had highlighted in a report on integrated care systems (ICS) the apparent tension between meeting national targets and addressing local needs. Challenging financial savings targets, longstanding workforce issues and wider pressures on the system particularly in social care contributed to the higher risk that ICS's would find it challenging to fulfil the hopes that stakeholders had for them. The NAO has called on the Department of Health and NHSE to clarify a realistic set of medium-term objectives to ensure that ICS's can make progress on prevention and local priorities.
- All Trusts had received a letter from the National Team with support for the expansion of operational resilience measures for Winter. Over 8 million people had their autumn booster in just over a month, but given the challenges already noted and the possibility of a high prevalence of flu this year, it would be important to make sure that best practice from across the country was included in plans. The letter also outlined better supporting people in the community, including putting in place a community-based falls response service in all systems, maximising the use of virtual wards and active consideration of the establishment of an acute respiratory infection hub for same day assessment, and providing additional support for care homes through reducing unwarranted variation in ambulance conveyance rates. Trusts were encouraged to deliver ambitions to maximise bed capacity and support the ambulance service by ensuring timely discharges. There had also been a recent announcement of £500m to support social care to speed up the discharge process across mental and physical health pathways, with details of how this will be allocated awaited.
- The new Winter Improvement Collaborative should be in place by the end of October 2022 focussing on the root cause of delays for ambulance handovers. There is also support for elective recovery and a request for Boards to review relevant performance data and delivery plans to establish whether assurance mechanisms were effective and in line with the elective recovery plan
- Urgent cancer referrals were at 118% of pre-pandemic levels, whilst cancer treatment and diagnostic levels across the country were nearer to 100% of pre-pandemic levels. The focus was on trying to resolve the mismatch between demand and capacity.
- Trusts have been asked to self-assess against the UK HSA Guidance on the Management of Covid-19 patients and the Infection Prevention Control (IPC) Manual, using the IPC Framework.
- The report from Bill Kirkup in relation to baby deaths in East Kent had been received the previous week and was being worked through.

#### System Issues

- A meeting had taken place as part of the Exeter Civic University agreement agreed by the Board last year. The purpose of the agreement was to use the influence of the University of Exeter, working in partnership with other anchor organisations across Exeter, to ensure a thriving and sustainable economy, happy and healthy people and a vibrant culture. The meeting reviewed the first

year of progress with particular interest on the work being undertaken to enhance the health and wellbeing of citizens and reduce health inequalities.

- Work was underway across the ICS on the Devon Operating Model with a number of meetings arranged for leaders to socialise and sense check the proposed way forward to achieve a system-based approach. ICS governance was continuing to develop, with key appointments of a Chief Financial Officer and a Chief Delivery Officer now made.
- The Board had a paper from the Acute Provider Collaborative on the agenda for consideration. The Collaborative was a key part of the work underway to ensure that the system had sustainable care models based on pathways, medical, surgical and paediatric assessment in the first instance. The Trust will ensure that this aligned with the work it is undertaking on developing its clinical strategy.
- One Northern Devon and the Eastern Local Care Partnership had provided information on plans in place for statutory and voluntary bodies to help mitigate the impact of the cost of living crisis following concerns about the impact on people's physical and mental health and wellbeing. Information provided locally will be fed into a system level summit planned for early November to take stock of plans and work with partners to address any significant gaps.
- Over the last month because of pressures across the whole system the decision had been taken to make some planned, temporary changes to ambulance catchment boundaries to provide support to University Hospitals Plymouth and Torbay and South Devon. The arrangements will be in place from 10 October until 7 November 2022 and will see patients from two additional postcodes brought to the Wonford site with the hope that this will avoid unscheduled divers to Exeter from other Trusts. It is estimated this will be 4-5 patients per day.

#### Local issues

- The Trust had recently undertaken a Reset Week as a focus for resetting the position going into the Winter period. 67 beds were freed up across both sites, Emergency Department hours reduced by 556 and lunchtime discharges improved by 75%. As a result, there were also 33 fewer complex long stay patients at the end of the week and it had allowed ring-fences to be maintained around elective work and a conversation about securing the entirety of the cardiology ring fence in Eastern services. There had also been improvements in the Green to Go position through the Executive sponsored "help people home without delay" programme and the anticipated recruitment improvements would be integral to overall delivery of the plan.
- There had been increasing rates of Covid-19 and the Trust's Joint Clinical Effectiveness Committee had agreed that from Friday 21 October all clinical areas had to revert to wearing fluid resistant surgical masks. Patients who had had previous vaccinations but not the latest booster were not as protected against the two new variants of Covid-19 and as uptake of booster vaccinations has been low across the UK, there had been a sharp rise in admissions.
- The Trust had held its first Team Royal Devon week from 17–23 October 2022 which linked to the Trust's strategy objective of making the organisation a great place to work. The week featured events, staff discounts and giveaways and inclusion offers, with a focus on how all staff work together across the organisation to do their best for patients, communities and each other.
- October had also been Freedom to Speak Month, with the theme for 2022 freedom to speak up for everyone with the Trust focussing on speak up for safety, civility, inclusion and everyone.
- The Trust had received the results of the National Cancer Experience Survey which had been outstanding, with outcomes demonstrating that patients were

well-supported from diagnosis to treatment. The survey had been completed by 1300 patients on both Northern and Eastern sites who had received a diagnosis and treatment between April – June 2021.

- Mrs Tracey had attended the first National Genomics summit earlier in October, at which a world first national genetic testing service developed by the Trust in collaboration with the genomics researchers at the University of Exeter and clinicians and academics worldwide was launched. The service provides rapid processing of DNA samples of babies and children with rare diseases and would benefit about 1000 babies and young children with results and diagnosis now possible within a much shorter timeframe than previously.
- The National Institute for Healthcare Research had awarded £800m to 20 new biomedical research centres across the country, one of which is in Exeter. The award will allow the Centres to translate scientific discoveries into new treatments, diagnostic tests and medical technologies to improve patients' lives. The bid had been led in partnership by the Trust and the University of Exeter, together with health partners across the peninsula and the Centre would be the first in the South West. £15m had been awarded to translate scientific discoveries into tangible benefits for patients, with a focus on neurodegeneration, rehabilitation, diabetes, genetics and clinical mycology.

Ms Morgan asked whether there were any lessons from the Reset Week that could be adopted for the longer term. Mr Palmer said that the week formed part of the kick start of the Winter plan pre-Christmas. A number of workforce initiatives had been put in place to drive 7-day working, including ward clerking at weekends, and leadership posts in nursing and medical teams which had led to similar discharge levels being achieved on Saturday and Sunday as during the week. This had also helped with refining of some of the resource allocation in the Winter plan.

Professor Kent asked whether there had been any positive or negative impact on services at the RD&E noted following the temporary ambulance boundary changes. Mrs Tracey responded that any change would have an impact and whilst this might only involve 4 patients per day, average length of stay could be up to 9 days with the cumulative effect of this impacting 20-25 beds. She added that it was a concern that the good work undertaken during the Reset Week to create capacity and protect ring-fencing may be impacted by this, although it was being managed at present. Professor Harris commented that whilst this was the right thing to do for the system, it had involved a number of compromises for the Royal Devon. It was also a less than ideal solution for individual patients involved, as it can be harder to repatriate them as there is less understanding of their local health and social care environment and this can lead to increased length of stay. Mr Palmer added that the Trust had done the right thing to provide support to the system and help ensure that patients were cared for appropriately and the solution, whilst not ideal was better than the Trust receiving emergency ambulance divers, as it had allowed a more planned approach to be taken.

Professor Kent said that the impact of this on patients and their families was important and asked whether there were plans to get feedback from these patients. Mr Palmer responded that this would be done and reflected in a future iteration of the IPR. Mrs Tracey suggested that the Patient Experience Committee could commission a piece of work to look at this in more detail. **Action.**

Mr Kirby commented that whilst the Trust would want to play its part in supporting the wider community in terms of mutual aid, he had a concern that there was a



	<p>possibility that it would be a net loser and suggested that it was important for the Trust to keep a record of the support it provides. Mrs Tracey agreed that it was important to strike the right balance. Mrs Hibbard confirmed that data was being collected so that conversations could be had within the system. Mr Palmer added that the agreement to take this on had been carefully crafted with discussions taking place about access to University of Plymouth's independent sector elective capacity to make sure that the Trust's position does not deteriorate to an unacceptable level during this period. In addition, there had been sign off at regional level that there would be a suitable financial adjustment to reflect the data.</p> <p><b>The Board of Directors noted the Chief Executive's update.</b></p>	
<p><b>141.22</b></p>	<p><b>PATIENT STORY</b></p>	
	<p style="text-align: right;"><i>Ms Delbridge joined the meeting.</i></p> <p>Mrs Mills presented the Patient Story video to the Board which was related to the virtual ward and was an important part of services offered to patients and in managing bed pressures. The story presented offered perspectives from two patients describing the benefits of technology for those who would otherwise have had to be either an inpatient to receive the level of monitoring required for diagnosis or had regular outpatient attendances. Mrs Mills added that the virtual ward had had a positive impact on each of the patient's experience, including on their ability to manage their day to day life and reduction in trips to the hospital.</p> <p>Ms Morgan said that she had been struck by one patient saying they felt respected and "in the loop" and the other commenting that it had made a difference in terms of her childcare responsibilities, the process had been very easy and had given her peace of mind. Professor Kent said that the story had provided a good illustration of the impressive use of technology to transform care, enabling it to be provided to patients where it was most suitable for them. Mr Matthews commented that, in addition to the improved patient experience, one of the patients had said that they had finally been able to receive a diagnosis and treatment which had not been possible in the past.</p> <p>Mr Neal asked whether there was work being undertaken to build a vision of how the Trust wanted to build on this provision going forward. Professor Harris responded that this was an evolving process, with the Trust having an ambition to maximise Epic and the use of wearables. Currently, clinicians were trying to find the clinical conditions to fit the technology but this would change over time as they become more familiar with the technology and the development of the Trust's digital strategy would also provide pointers on new directions to explore.</p> <p>Mrs Foster said that it would be important in the future to also correlate staff experience of using the new technologies which could then be used to feedback to the wider staff body to demonstrate the positives from a workforce perspective.</p> <p>Mr Palmer said that a focus for the Trust was helping people home and a challenge over the coming years for the Trust to develop in concert with social care would be how more could be done to help stabilise people at home. One of the areas being trialled over the Winter was further development of the virtual ward and he believed that connecting virtual wards into community and primary care would be the next stage. Working with social care to stabilise patients at home and proactively manage their conditions would have further benefits for the organisation.</p>	

	<p><b>The Board of Directors noted the Patient Story.</b></p> <p><i>Ms Delbridge left the meeting.</i></p>	
<p>142.22</p>	<p><b>WINTER PLAN 2022-23</b></p>	
	<p>Mr Palmer presented the Winter Plan for 2022-23 to the Board of Directors, noting his thanks to Gill Heathcote and Nicol Cleverdon for their work on the integrated plan presented.</p> <p>Key highlights from the presentation were noted as:</p> <ul style="list-style-type: none"> <li>• Whilst there were still some gaps over the next six months that would have to be taken on by additional efficiencies or <i>in extremis</i> cancellations of activity or movements to additional beds in the community, the plan presented was manageable.</li> <li>• A great deal of partnership work had gone into the plan. Where there were headings that showed bed equivalents of 64 across the system, this had been achieved with intensive work with social care partners.</li> <li>• There had been a number of phases of work over the last few months:             <ul style="list-style-type: none"> <li>○ Executive commitment to the recruitment pipeline and Green to Go.</li> <li>○ The reset programme of work which had had a positive impact on both sites, creating a sense of acceleration.</li> <li>○ Phase 1 of the plan – drive through the learning from the reset programme and make sure that elective ring fences hold with Standard Operating Procedures in place.</li> </ul> </li> <li>• It is expected that further bed base interventions would be needed between January and March 2023.</li> <li>• Findings from the Reset Week included the importance of investment in transport over the whole week, staff for seven days with leadership in place, ensuring that ancillary services were held at the right level, and holding the focus on ring fencing. The reset programme scoped out and delivered an intended improvement.</li> <li>• Winter Plan Phase 1 would run through to the end of December 2022, embedding all the improvements in processes.</li> <li>• Phase 2 would run from January to March 2023 bringing in the additional beds that had been identified and funded across Eastern and Northern Services. Maintenance of ring fencing would remain an area of significant focus.</li> <li>• The plan could only be delivered with significant partnership, engagement and involvement and once signed off by the Board, further Comms work was planned with partners in the system and within the organisation.</li> </ul> <p>Ms Morgan thanked Mr Palmer for the presentation, noting that it was a complex and ambitious plan and the Reset Week had provided a good start for the implementation of the subsequent phases. She asked what was his greatest concern about the success of the plan. Mr Palmer responded that this would be ensuring delivery on holding ring fences and delivering balanced healthcare over the course of the winter months, in particular as it is recognised that this had been a significant challenge for the Trust for the last five years.</p> <p>Professor Kent asked how much collaboration there had been with patient and community groups on developing the plan to ensure there was “buy in” from the start. Mr Palmer said that engagement on the Winter Plan takes place across the year, and there had been a debrief with partners on last year’s plan to inform the learning for this year’s planning. Local Care Partnerships, which include voluntary</p>	

sector partners, had reviewed the plan and provided feedback. He agreed that delivery of the plan was reliant on local groups and organisations being part of the solutions, in particular where they provide the “wrap around” for patients that cannot always be provided by statutory bodies.

Mr Kirby asked the following questions:

1. When would recruitment start? Mr Palmer advised that recruitment had started some months ago, with the challenge of ensuring that recruits stay. The Recruitment Team were generating data for the Executive Team on pinch points and how appointments can be accelerated where possible.
2. If it becomes necessary to go out to the private sector for outsourcing, how are those relationships managed, i.e. is this done at a strategic level or at an *ad hoc* spot purchase level? Mr Palmer said the organisation had some advantages from its current position on Tier 1 for elective recovery, with wide access to independent sector discussions. If emergency activity was needed, the ICB would usually negotiate that for the Trust, although the Royal Devon also has EPRR powers.
3. Are there any novel ways that could be used to encourage all staff to take up their booster vaccinations? Mrs Mills confirmed that there was a very targeted approach on the Eastern site to approach staff directly to invite them to attend for boosters. She added that there had been greater uptake for Covid-19 booster than for the seasonal flu vaccination amongst staff and advised that she and other Executives were recording some short videos to remind staff of the importance of uptake of both boosters and flu vaccinations this year. Mrs Mills agreed to circulate data regarding uptake of both booster and flu vaccination outside the meeting. **Action.**
4. Is the organisation fully sighted on the potential impact of works in ED at the RD&E site and how ED flow would be managed? Mr Palmer said that it was anticipated there would be a period of 5-6 weeks that would be most disrupted during the work, with the ED corridor being out of use from 7 November. This had all been planned for, including the ceasing on 7 November of the additional ambulance catchment area work previously noted by the Board.

Mr Matthews noted that the plan states there would be bed deficits of 57 and 76 in January and February but that ring fences would be maintained and asked whether there were realistic opportunities for mitigation of the position. Mr Palmer responded that this was a fair challenge, with February in particular predicted to be a very challenging month. There were two opportunities to try and close the worst gaps: the first would be to enact bed escalation *in extremis* which there was funding for, in the first instance on the acute site but possibly also moving into the community if staffing can be arranged. Secondly, the reset programme had demonstrated that with concerted effort it was possible to get back within bed base, and it might therefore be necessary to hold further reset weeks over the coming months.

Ms Morgan said that there had been a long-standing concern expressed at Board meetings of the impact on flow of delayed discharge and asked if there were any early lessons from the Reset Week on improving discharges. Mr Palmer responded that there had been more social care staff on site during the Reset Week working with ward staff on discharges which had had a positive impact. Further plans are being looked at to use some of the additional resources allocated to Social Care and Integrated Care for similar work. In addition, some of the actions tested in the Executive sponsored “help people home without delay” initiative had

	<p>worked well and had been accelerated, for example referring patients from the ambulance stack straight to the urgent response service. The enhanced care support to aid the care home transfers programme was due to start two weeks ahead of time and there were four of the beds intended for the live in carer model already on stream.</p> <p>Mr Neal asked whether anything was being planned to enhance staff wellbeing, particularly during January and February. Mr Palmer said that significant work had been undertaken during the summer period to ensure that key leads had taken leave. In addition, during the Reset Week there had been daily Comms messages to staff to ensure they understood what the organisation was trying to do and felt supported and this had been followed directly by the Team Royal Devon week. He confirmed however that there was more work to do. Mrs Foster added that the intention was to take the learning from Team Royal Devon week on what had gone well to see what could be built into business as usual going forward and to support managers to create a good environment with positive team engagement. This would be fed into the Winter Plan. Charitable Funds would also be made available to the Operations Team for activities and support during the Winter period.</p> <p>Mr Kirby asked if there was any information available on the rate of readmissions following the Reset Week. Mr Palmer advised this was not yet available but would be checked.</p> <p>Ms Morgan asked how the Trust's plan compared to others in the system. Mr Palmer said that key features would be very similar, but the Trust's plan would be distinguished by the level of detailed work to create the bed model. In addition, the way that the Trust had planned in elective elements, potential percentage resulting from two or three further Covid waves and flu over the coming months would set the organisation apart in terms of the level of detail. Whilst the modelling distinguishes the Trust from others, the plan would not be dramatically different. Ms Morgan commented that it might be worth reviewing the value of the input made into modelling by the Trust compared to other local Trusts.</p> <p><b>The Board of Directors approved the Winter Plan for 2022-23..</b></p>	
<p><b>143.22</b></p>	<p><b>INTEGRATED PERFORMANCE REPORT</b></p>	
	<p>Mrs Hibbard presented the Integrated Performance Report (IPR) for activity and performance for September 2022 with the following key points highlighted:</p> <ul style="list-style-type: none"> <li>• Urgent and ED care pressures continued to increase during September, with the continued high level of green to go patients and rising Covid numbers impacting both staff and beds. The Trust continued to provide support to the system during this period with ambulance diverts.</li> <li>• Elective recovery remained an area of focus, but was still behind trajectory. Pressures on the urgent care pathway had a significant impact on elective capacity, as well as continuing staffing pressures.</li> <li>• Improvement had continued in both the 78-week and 104-week waits, with more to do and ring-fenced capacity a priority in the Winter Plan. The Trust is receiving support from NHSEI in the 10-week challenge, helping to maintain focus on the position of long-waiting patients.</li> <li>• Additional capacity put in place at both the Nightingale Hospital and the Jubilee Ward was helping to improve the position. The Board of Directors noted that</li> </ul>	

the South West Elective Orthopaedic Team had won a prestigious award for partnership and innovation.

- Cancer performance was challenged across all targets, with some improvements expected with the provision of additional support in the East and a plan to stabilise the position in the North.
- Diagnostics performance was benefiting from the additional capacity that had been put in place in the East, although there was a less positive picture in the North; work continued to address this as part of the Winter and Elective Recovery Plan.
- Complaints had increased during September and work was underway to understand any themes and learning.
- There had also been an increase in pressure ulcer damage which the Tissue Viability Team were reviewing to ensure actions were put in place.
- Although there were no new Never Events reported during September, this remained a key area of learning.
- Workforce measures continued to indicate the pressures on staffing, with high sickness absence levels and reliance on agency staffing. Although turnover appeared to be plateauing, it remained higher than would be wished.
- Recruitment and retention remained a focus. As previously reported, the first Team Royal Devon event took place in October, with learning to be taken into future events.
- The cultural dashboard had not been included as there were a number of ICS metrics within the data that required ratification.
- The finance position remained challenging, with a continued level of scrutiny of the Trust's financial plan. The Trust was managing a number of issues where guidance or the economic outlook were having an impact, resulting in a remaining risk of delivering the financial position. The position remained dynamic, with focus on areas the Trust does have control over to evidence it had delivered what the Trust said it would and continuing discussions with the Regulators on areas where the Trust has less control.
- Approval of the cardiology day case unit on the Eastern site was a significant step forward, although there had been a challenge on the Trust's delivery times. In addition, seed funding for endoscopy in Tiverton had been approved.

Mr Matthews asked if it would be possible to get an idea of what trajectory for cancer performance it was hoped would be achieved by the actions that were being put in place. Mr Palmer said that the position had not changed over the last few months. Dermatology had revealed a difficult position post-Epic implementation and this, combined with a demand and capacity mismatch, had thrown the entire cancer position out of kilter. A reduction in the overall PCR for cancer for Northern services was emerging which had started to have an impact on overall reduction for the organisation. The Trust was being tracked at the highest level on the proportion of the waiting list that is 62 days and over which was close to 15% at its peak in August. Rapid work to validate the PTL and a demand and capacity plan for Dermatology, Gynaecology and Colo-Rectal for Northern had helped to stabilise the position, which was currently about 13%. Work was continuing on the delivery plan for Northern and Eastern with good support now in place with the new Joint Lead for Cancer. The trajectory for the 62-day waits would be included in the next IPR to provide assurance.

Mr Matthews said that the Board had discussed at Finance Committee its concerns about delivery of the cost improvements in the better value programme and asked whether there was confidence that changes made for the future would provide a

better handle on delivery. Mrs Hibbard responded that delivery of the best value programme was contributing to the risk of delivering the £18m deficit. Non-delivery could be mitigated through non-recurrent means which if not recovered over time would create further pressures. Although it was difficult to add further pressures onto operational teams currently to look at this, the Finance Team are looking forward to how to improve governance on delivering better value, support that can be given to teams and education and training that can be put in place.

Mr Matthews noted that both in the paper presented and in Mrs Hibbard's introduction, the Board was advised that 78-week waits were improving, but the data provided did not support this, but rather indicated it was getting worse. Mr Palmer said that the Team are continuing to work through the validation of the PTL for Northern services for 78-week waits and Eastern services have seen a significantly improving position. There may however be a lag in the data from the September report.

Mr Kirby asked the following two questions:

1. Is there a threshold at which Covid patients are admitted or was there an admission avoidance option that ought to be explored? Professor Harris responded that Covid was treated as any other disease with patients with a primary diagnosis of Covid who are deemed ill enough admitted and decisions physiologically driven. Although mortality and morbidity from Covid had improved, significant numbers of patients who were admitted with another condition also had Covid, although it was difficult to disaggregate how much of a contribution this was making to their morbidity. He confirmed that no patients were being admitted inappropriately.
2. Weekend SHMI mortality rates in both Northern and Eastern sites had taken a sharp upward turn – was there further comment on reasons for this? Professor Harris said that the baseline had dropped off nationally although the reason was not yet fully understood. The upturn locally was of concern, and although Professor Harris had looked at other metrics to see if there was any evidence to support concerns around weekends; nothing had been found at this point but work to understand would continue.

Mr Neal asked the following two questions:

1. Is there a view on what ratio of stress to harm is normal in the system or nationally, and if so where the Trust stands in relation to this? Mrs Mills responded that nothing was statistically available linking the ratio of stress to adverse effects. There was however a great deal of information available, supported by publications from the CQC for example, about the overall impact of high stress environments on staff's ability to function as they otherwise might.
2. Where can the Board get snapshots of where Trust performance is a worry compared to the national picture? Mrs Tracey responded that she had attended a national leadership session recently where it had been noted that national dashboards should be available within the next few weeks. The intention once received would be to look at how these could be used on key areas of performance to help provide a national and regional context.

Professor Kent said that whilst it was good to see that the career gateway appears to be effective, with over 1000 vacancies was the investment in recruitment

	<p>providing as much benefit as could be expected. Mrs Foster said that the Trust was being successful in the market, with recent recruitment events held in North and East and 100 job offers made on the day. Whilst some people are lost in the pipeline, there were already 130 new staff booked into induction days over the next three weeks. Current figures show that the Trust was recruiting 1.3 staff for every 1 staff member leaving the organisation. It was noted that time for checks for new members of staff had been reduced by 30% over a two-month period. Mrs Foster added that Comms messaging to staff on the progress being made was a vital part of the ongoing work. Mrs Tracey added that the Executive Team were looking at different routes to get Comms messages out to staff including trialling infographics around recruitment and bed capacity. In addition, there was a broader piece of work looking at best ways to communicate on a two-way basis.</p> <p>Professor Kay commented that much of the recruitment and retention data continued to be backward looking and asked if there were key indicators that could be included that were red flags or early warning signs relating to turnover, sickness and retention. Mrs Foster said that she felt it would be helpful to include information on vaccine uptake for the next few months. With regard to other data, this is being worked on as part of the new workforce dashboard.</p> <p><b>No further questions were raised and the Board of Directors noted the IPR.</b></p>	
<p><b>144.22</b></p>	<p><b>PEOPLE PLAN UPDATE</b></p>	
	<p>Mrs Foster shared a presentation on local progress against the NHS People Plan. The Board noted that:</p> <ul style="list-style-type: none"> <li>• The NHS People Plan was published in July 2020 with a significant number of actions. There had not been updates to the People Plan since that time, however much of the Trust’s strategy is aligned to it. Delivery of the People Plan is being monitored at ICS level.</li> <li>• There are four strands to the People Plan and the People Promise with seven commitments. The Plan also contained the vision for HR and OD teams.</li> <li>• The Trust’s great place to work objective was its interpretation of how it would develop the culture and environment and have the reporting and methodology in place to support staff to work to the best of their ability.</li> <li>• Internal work had been done to agree what would be measured and how, and what was expected to be achieved by 2027.</li> <li>• With regard to the Employee Value Proposition, work done at system level and work done to develop the Trust’s strategy had shown that the People Promise is the same as the Employee Value Proposition.</li> <li>• Since the last update to the Board, there had been some significant key achievements including the launch of the Trust’s Charter, the Career Gateway, introduction of Learn Plus across Eastern services, the Culture Club, involvement in the Booker Prize, work with the Leadership Academy and confirmation of accreditation with the Veterans Covenant Health Alliance.</li> <li>• Key measurable achievements included the Vivup Salary Sacrifice Scheme, apprenticeships which are at 10%, just and learning culture including use of mediation to prevent formal grievance processes and the new Career Gateway.</li> <li>• Expected progress over the next six months included draft of the 5-year strategic workforce plan in January 2023, further automation of pre-employment checks, delivery of high priority actions in the vacancies programme, new leadership and management programme to be in place, people function policies delivered, improved management information and</li> </ul>	

reporting and further progress towards greater digital enablement within the People function.

Professor Kay asked for clarification on what the apprenticeships were in and Mrs Foster responded that there were apprenticeship schemes across many staff groups in the organisation. Professor Kay asked what was planned around data upskilling and data analysts and Mrs Foster advised that whilst there were some apprenticeships in IT, this would need to be developed further as part of the overall Digital Strategy. Mrs Hibbard added that a review of the Trust's Business Intelligence Service was being undertaken, part of which would look at the Data Strategy linked to the Digital Strategy with one of the clear deliverables being understanding future workforce needs and mapping what needed to be done in the short, medium and longer term.

Professor Kent noted the improvement in timescales for pre-employment checks and asked how difficult it had been to get some of the checks, particularly those relating to safety, automated. Mrs Foster said that whilst processes were automated to an extent, there was further work ongoing to look at automating ID checks for example.

Mrs Foster presented an early draft update on workforce planning and the retirement trajectory which would be presented back to the Board of Directors at their January meeting. The draft workforce plan would be informed by the Clinical Strategy and the ICS workforce plan expected in April 2023.

Key points highlighted included:

- Turnover had increased over the last two years, in line with much of the system.
- Leaver insights – retirement is the highest reason for leaving across all staff groups.
- Average age of retirement is 61 years. Highest risk groups for retirement are Admin and Clerical, Estates and Ancillary staff.
- The Trust had a slightly larger younger cohort of staff compared to other Trusts in Devon. The system overall has 21% of staff over 55 years of age.
- Some validation of data was still needed before the next presentation of this work in January 2023.

Ms Morgan noted that in the chart showing reasons for leaving, the bar for the Other category was nearly as high as that for retirement and asked if this could be explored further. In addition, she commented that the highest risk staff groups for retirement were groups where the organisation would face strong competition to recruit from the retail and hospitality sectors. Mrs Foster said that exit data was an area of focus in both Northern and Eastern services. Some qualitative work undertaken gave more detail on reasons for leaving with flexibility being an issue. With regard to Admin and Clerical and Estates and Ancillary staff, focus had been on Nursing and Healthcare Assistant recruitment over the last few months with some good outcomes, but there was work now underway looking at other groups.

Professor Kent asked whether there were any steps that could be taken to try and delay the decision to retire. Mrs Foster said that there was a great deal of work going on at national level on nurse retention, with the difficulty being how to do things that were operationally sustainable. Mrs Mills commented that the Trust was taking part in a self-assessment against the NHSEI retention best practice guidance and a workplan will be developed from this. Maternity services were also



	<p>part of a national NHS Wellbeing Pilot looking at how to maximise the wellbeing of staff including those nearing potential retirements.</p> <p>Mr Matthews asked whether there was anything related to pensions that acted as a disincentive or could be used as an incentive and whether any changes could be made. Mrs Foster responded that a new flexible pension option was due to be launched in April 2023, but overall there was too little flexibility in the NHS Pension Scheme.</p> <p><b>The Board of Directors noted the update.</b></p>	
<p><b>145.22</b></p>	<p><b>ACUTE PROVIDER COLLABORATIVE UPDATE &amp; TERMS OF REFERENCE</b></p>	
	<p>Mrs Tracey advised the Board that the paper presented provided a summary of progress of the work of the Peninsula Acute Provider Collaborative established earlier in 2022 and was asked to endorse the proposals included in the report.</p> <p>Mr Matthews asked how the work with the Acute Provider Collaborative impacted on the Trust's Memorandum of Understanding with Torbay and South Devon NHS Foundation Trust. Mrs Tracey responded that the Trust had received notification from Torbay that whilst the work of the Acute Provider Collaborative was ongoing, the work of the SEND network would be paused.</p> <p>Mr Matthews said that the report stated that Plymouth was the only tertiary centre and asked whether it was not the case that the Trust was delivering some tertiary services. Mrs Tracey said that it was clear that this referred to the major trauma centre in Plymouth and there was no proposal at this stage of any changes to specialist services already delivered by the Royal Devon.</p> <p>Mr Kirby asked how this fitted with the Devon long term plan and, noting that previous attempts to bring organisations together had not been successful, what was different this time that would make this successful. Mrs Tracey responded that the Acute Provider Collaborative was a key component of the Devon long term plan and strategy; which would be demonstrated when the Operating Model is presented to the Board. With regard to why the Collaborative would work when previous attempts had not gained traction, Mrs Tracey said that there had been some outcomes from the work that had been undertaken as the forerunner to this on decisions about Emergency Departments meaning that the Collaborative was not starting from scratch. In addition, there seemed to be greater impetus in this group with more leadership capacity devoted to it and support for it across One Devon. Professor Harris added that he felt there had been a fundamental change since the last time this had been attempted, with a willingness to be honest and for vested parties being prepared to give things up and contemplate difficult decisions. He said that there was some question for him of whether the Collaborative could get to where it wanted to be within the very ambitious timeframe but there was a necessity to push forward. Ms Morgan said that this was very strongly supported by the ICS as a way forward for the system as a whole.</p> <p>Mr Kirby commented that it would be disappointing if the Collaborative were side-tracked by the inclusion of Cornwall in the group, as he felt that the issues relating to Cornwall were an almost intractable problem unless Devon were sorted out. Professor Kay said that whilst she did think it was good to see this operating across the peninsula, it did seem a little counter-cultural as this was one system of many</p>	

	<p>which was looking to be integrated through the ICS. She added that she did have concerns about the additional workload for the same group of people already involved in many other important and time-consuming projects. Mrs Tracey agreed that there was an increasing pull to system work, but that the intention was to try and keep the system focussed on a few key issues and make good progress on them. She said that this runs parallel to the work the Trust was doing on the clinical strategy, so the focus was on doing the work once and doing it effectively.</p> <p>The Board agreed the Terms of Reference presented and the proposals outlined in the document, with the caveat of the time constraints this might impose.</p> <p><b>The Board of Directors noted the update and approved the Acute Provider Collaborative Terms of Reference.</b></p>	
<p><b>146.22</b></p>	<p><b>GOVERNANCE COMMITTEE UPDATE</b></p>	
	<p>Mr Neal provided an update from the Governance Committee meeting held on 14 October 2022 with the following key issues highlighted to the Board:</p> <ul style="list-style-type: none"> <li>• Very positive survey results, including from the National Inpatient Survey for 2021 and the National Cancer Patient Experience Survey for 2021, were noted in the Patient Experience Committee update.</li> <li>• A comprehensive report had been received from the Safety and Risk Committee, including an update on cardiology waiting times. Further work was commissioned by the Committee regarding the improvement trajectory and the associated actions required to mitigate the risk within a reasonable timescale.</li> <li>• The Chief Nursing Officer had provided an update on progress on the Ockenden Action Plan, which it was noted had been included in the meeting papers for Board members.</li> </ul> <p><b>The Board of Directors noted the Governance Committee update.</b></p>	
<p><b>147.22</b></p>	<p><b>TOWARDS INCLUSION</b></p>	
	<p>Mrs Tracey provided a verbal update on progress on the Towards Inclusion agenda, advising that no written report was available at this time due to a delay in the Inclusion Steering Group meeting. A full written update would be provided for the next quarterly report to the Board of Directors.</p> <p>Highlights noted were:</p> <ul style="list-style-type: none"> <li>• Staff Development – as noted in the Chief Executive’s report, the Trust had recently held its first Team Royal Devon week. There were two parts of the staff development objective – raising awareness and helping to develop staff’s careers – and sessions were offered linked to this, including Let’s Talk about Race and Bystander Awareness, as well as a number of other sessions supportive of the inclusion agenda.</li> <li>• Leadership training – the pilot session had now been completed with a group of 15 leaders and feedback from this group would be reviewed and any changes needed made to the training. It was then hoped to roll this out to a wider group of leaders across the remainder of this year.</li> <li>• Delivery of inclusion training had continued across the organisation, including to apprentices, students, physiotherapy and occupational therapy teams, the NIHR Clinical Research Network South West team, the transformation team and the clinical research team.</li> </ul>	

	<ul style="list-style-type: none"> <li>As part of Black History Month in October 2022 the Trust had released its first resource pack to accompany the inclusion calendar. The pack included resources to support learning, helpful information about the month, staff comments and signposting to further resources and support.</li> <li>The Trust planned to run a programme called Driving Your Career aimed at helping to improve the current disparity between groups who may not progress as readily through the career structure.</li> </ul> <p><b>The Board of Directors noted the verbal update on inclusion.</b></p>	
148.22	<b>ITEMS FOR ESCALATION TO THE NDHT &amp; RD&amp;E BOARD ASSURANCE FRAMEWORKS</b>	
	Ms Morgan asked whether Board members had identified any new risks or anything to add to existing risks from their discussions. None were raised.	
149.22	<b>ANY OTHER BUSINESS</b>	
	No other business was raised by Board members.	
150.22	<b>PUBLIC QUESTIONS</b>	
	<p>The Chair invited questions from members of the public, staff and Governors in attendance at the meeting.</p> <p>Ms Bearfield asked what happened to patients removed from the ambulance stack, as reported in the IPR update and whether there was a pathway for mental health patients and a pathway for other medical problems. Mr Palmer responded that there was a shared analysis between the Ambulance Service and the Urgent Care Response Team on how patient disposition is measured. If the Ambulance Service identified a patient that met the criteria, a telephone call was made to have a clinical conversation following which a referral was emailed to the Urgent Care Team. This provided an admission avoidance approach not previously available.</p> <p>Dr McElderry asked what assurances could be given regarding the Trust's cyber security and also on heat resilience of servers, particularly in light of the protracted debilitating effect of the breakdown of IT systems reported at Guy's and St Thomas' during the heatwave in the summer months due to servers overheating. Professor Harris responded that the Trust takes cyber security very seriously with a dedicated Cyber Security Officer in post and by ensuring that everyone understood their responsibility in ensuring the organisation was as safe as possible from cyber threat. Cyber security was reported through the Trust's Digital Committee. With regard to the resilience of data centres, they consumed significant amounts of power getting very hot, so were vulnerable to significant swings in ambient temperatures. The Trust has four data centres, with the bulk of the work taking place through the data centres on the Eastern site. Adequate cooling was in place and although it was always possible that a combination of scenarios could lead to overheating, it was unlikely. However, the Trust has robust business continuity plans in place, with every clinical area having a USB device available that has its own battery power available should overall power be lost with work undertaken on a regular basis in clinical areas to ensure these devices were looked after and kept up to date on data.</p>	

	<p>Ms Haworth-Booth noted Mr Kirby's comment earlier in the meeting regarding keeping a record of how much mutual aid is provided by the Trust, and asked whether it was the case that Plymouth had Devon-wide responsibility for tertiary care which might impact on their need for more mutual aid. Mrs Tracey thanked Ms Haworth-Booth for her question and clarified that whilst Plymouth was the provider for major trauma, neurosurgery and cardiac surgery, specialist services were delivered across the peninsula including at the Royal Devon. Plymouth had significant contracts with specialist services and their capacity on the basis of that extra payment should be considered, however, over the last 12 months there had been increasing reliance on mutual aid for a number of reasons. There is an expectation that each organisation will do its part to deliver its responsibilities. Mr Palmer added that delivering the additional catchment coverage for ambulances during this period is very exceptional and was being done to help provide the right support to the Devon system. It was hoped that going forward there would be a more planned approach possible with improved planning through the Integrated Care Board. Mrs Kay Foster suggested that there must be a knock-on effect of this extension of the Trust's catchment area on the local community and the Trust's waiting list which needed to be considered.</p> <p>Mrs Kay Foster noted the update from the Chief Executive on the Team Royal Devon week and informed the Board that she had received a thank you from a member of the Board for her work as a Governor as part of this initiative which she had very much appreciated.</p> <p>Mrs Matthews advised that she had recently been involved in discussions around the clinical strategies in Eastern services regarding urgent and emergency care and cancer services and asked how the work from these consultations sat with the peninsula acute sustainability programme. Professor Harris responded that Plymouth and Torbay were also developing their clinical strategies, however many of the people involved would be the same across organisations; he explained that, for example, he was responsible for one element of urgent care work for the ICS and Mark Hamilton, Chief Medical Officer at UHP, was responsible for the surgical side of this. There was overall oversight of the various work going on, and there would almost certainly be some incongruities but he expected these to be ironed out over time as the work progressed. This would not however be easy as difficult decisions would need to be made.</p> <p>There being no further questions, the meeting was closed.</p>	
<p><b>151.22</b></p>	<p><b>DATE OF NEXT MEETING</b></p>	
	<p><b>The date of the next meeting was announced as taking place on the afternoon of Wednesday 30 November 2022.</b></p>	

**PUBLIC MEETING OF THE BOARD OF DIRECTORS**  
**26 October 2022**  
**ACTIONS SUMMARY**

This checklist provides a status of those actions placed on Board members in the Board minutes, and will be updated and attached to the minutes each month.

PUBLIC AGENDA					
Minute No.	Month raised	Description	By	Target date	Remarks
008.22 (1)	January 2022	Update on diagnostics briefing and business case to be presented at March public Board meeting.	JP	<del>March 2022</del> <del>April 2022</del> <del>July 2022</del> <del>August 2022</del> <del>September 2022</del> <del>October 2022</del> November 2022	<p><b>Update February 2022</b> – Preparation of the business case is in progress. Presentation of the 2-5 year draft strategy expected for March confidential Board and then presentation at the public Board in April 2022. <b>Action ongoing</b></p> <p><b>Update March 2022</b> – Paper on agenda for discussion at Confidential Board and proposed discussion at public Board following receipt of NHSEI feedback, now anticipated in Summer 2022.</p> <p><b>Update March 2022</b> – The business case would be submitted following presentation at the March Confidential Board meeting with feedback following the conclusion of the decision-making process expected from NHSE/I in July 2022. To be updated at the July Public Board meeting. <b>Action ongoing.</b></p> <p><b>Update May 2022</b> – The business case has been submitted to NHSEI, reflecting the revised revenue funding for 22/23. Feedback remains awaited &amp; an outcome from the decision-making process is expected from NHSEI in July 2022. An update will be provided at the August Public Board meeting. <b>Action ongoing.</b></p> <p><b>Update August 2022</b> – Formal confirmation has been received from NHSEI of £9.8m</p>

				<p>revenue funding for 2022/23. An outcome as to consideration of the request for capital funding for 2022/23 and revenue funding in 2023/24 remains awaited with the last indication from NHSEI being a likely decision in September, against the original expectation of a July decision. <b>Action ongoing.</b></p> <p><b>Update September 2022</b> – An outcome of the formal consideration of the request for capital funding for 2022/23 &amp; revenue funding in 2023/24 remains awaited. <b>Action ongoing.</b></p> <p><b>Update September 2022</b> – Mr Palmer informed the Board that the Trust was in advanced discussions with NHSE/I regarding the business case, with the clinical measurements proposition being worked through. <b>Action ongoing.</b></p> <p><b>Update October 2022</b> – NHSE regional team process is now at final stages of review. Notification of outcome of regional review anticipated in next week, ahead of formal consideration by NHSE national team. <b>Action ongoing.</b></p> <p><b>Update to Board 26.10.22</b> – Mr Palmer advised that the region had confirmed it had approved the Community Diagnostics Bid to be put forward to the final national panel for consideration. National panel due to meet on 03.11.22. <b>Action ongoing.</b></p> <p><b>Update November 2022</b> – Formal approval of business case received from national NHSEI team including formal confirmation of capital funding of £10m, alongside acknowledgement and notional approval of</p>
--	--	--	--	--

					revenue funding of £37m over the next five years. <b>Action complete.</b>
014.22	January 2022	Dr Kyle to attend Board three months after Epic Go Live in NDHT to provide a further update on O/P transformation work, in particular relating to provide an update on the inequities work at system level.	Ski	October 2022 November 2022	<b>Next update due October 2022. Action ongoing.</b> <b>Update September 2022</b> – due to the significant agenda for the October Board meeting, it was agreed that this action be carried forward to the November meeting. <b>Action ongoing.</b> <b>Update November 2022</b> -On the agenda for November Board. <b>Action complete.</b>
024.22	February 2022	A session to be arranged for the Board during 2022-23 to receive an update on progress on work both at Trust and system level on transforming services, what outcomes are being looked for and how pathways can be changed.	MH	September 2022 November 2022	<b>Update to be provided at September Board. Action ongoing.</b> <b>Update September 2022</b> – This will be added to the programme for a future Board Development Day. <b>Action ongoing.</b>
140.22	October 2022	The Board discussed the possible impact on patients and their families of the temporary expansion of the Trust's ambulance catchment area during October/November 2022, i.e. patients being in hospital out of area, difficulties with repatriating and possible increased length of stay. It was agreed that PEC should consider commissioning a piece of work to look at feedback from these patients/families to understand what impact had been.	CB/CM	November 2022	<b>Update November 2022</b> – to be considered at a future meeting of the Patient Experience Committee. <b>Action complete.</b>
142.22	October 2022	Mrs Mills to circulate data on staff uptake of both Covid-19 booster and flu vaccination.	CM	November 2022	<b>Update November 2022</b> – Data on staff uptake of both Covid-19 booster and flu vaccinations distributed to Board of Directors. <b>Action complete.</b>

**Signed:**

**Shan Morgan**  
**Chair**

<b>Agenda item:</b>	8, Public Board meeting	<b>Date:</b> 30 November 2022		
<b>Title:</b>	Patient story: Partnership working in the Community to keep people well at home.			
<b>Prepared by:</b>	Bethany Hoile, Comms & Engagement Coordinator			
<b>Presented by:</b>	Carolyn Mills, Chief Nursing Officer			
<b>Responsible Executive:</b>	Carolyn Mills, Chief Nursing Officer			
<b>Summary:</b>	<p>Patient stories reveal a great deal about the quality of our service provision, the opportunities we have for learning and the effectiveness of systems and processes to manage, improve and assure service quality.</p> <p>The purpose of presenting a patient story to Board members is to:</p> <ul style="list-style-type: none"> <li>• Set a patient focussed context to the meeting, bringing patient experience to life and making patient's stories accessible to a wider audience</li> <li>• To support Board members to triangulate patient experience with reported data and information</li> <li>• For Board members to reflect on the impact of the lived experience for these patient(s) and its relevance to the strategic objectives of the Board.</li> </ul>			
<b>Actions required:</b>	<p>The Board of Directors is asked to reflect on the implications of this story for patients and to reflect on its relevance to the strategic objectives of the Board.</p> <p>Link to status below and set out clearly the expectations of the Board when considering the paper.</p>			
<b>Status (x):</b>	<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Information</b>
			<b>X</b>	
<b>History:</b>	<p>The Royal Devon University Healthcare NHS Foundation Trust's 2022-27 Trust strategy and 2022-25 Patient Experience strategy articulate the Trust's ambition to collaborate and work in partnership with patients, carers, stakeholders and the local community to develop accessible, high-quality and patient-centric services and facilities.</p> <p>This patient story is set within the context of the Trust's strategic objectives: to develop place-based partnerships and encourage collaboration between providers, primary care, local government, wider public services and the voluntary sector to improve the health of our communities and achieve positive outcomes for our patients.</p> <p>Safe and effective discharge from hospital remains a current priority for the Trust and in preparation for a challenging winter period with significant pressure on bed capacity; our community teams will play a crucial role in supporting this.</p> <p>This patient story serves to bring to life an example of partnership working delivered by one of our community matrons in Seaton, Axminster and Sidmouth.</p>			



	<p>The Trust's community matron role supports a number of aims within our Trust strategy, focusing on what matters to the patient, treating patients and carers as partners in delivering care, and delivering in partnership with primary care and social care colleagues.</p> <p>This approach helped the patient maintain independence at home, and whilst he was admitted to a care home for a short period, he avoided hospital admission. The Standardised Admission Ratio for Seaton, Sidmouth and Axminster is often the lowest in Devon. This is, in part, due to the expertise of our community matrons.</p> <p>In this story, the patient's daughter and carer describes her experience of caring for her father and the significant difference the community matron made to both her as carer, and to her father. The patient had experienced congestive heart failure and consequently was suffering from edema. He was not taking prescribed medication consistently when the community matron was called in.</p> <p>Through effective communication, our community matron took time to understand the complexity of the patient's needs and build trust with them. She assessed the deteriorating clinical picture and led a coordinated intervention, using a multi-disciplinary team approach to the patient's care. She liaised with the GP regularly, coordinated with social services and directed the carers to home adaptations and funding available (including attendance allowance). After initial resistance and fear she was able to reassure and re-educate the patient about his perception of care.</p> <p>The community matron's knowledge of local services and approach of empowering the patient and carer, played a crucial part in admission avoidance.</p>
Link to strategy/ Assurance framework:	The issues discussed are key to the Trust achieving its strategic objectives

**Monitoring Information**

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

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

<b>Agenda item:</b>	Public, 10.1	Date: 30 November 2022		
<b>Title:</b>	Integrated Performance Report detailing October 2022 – spanning both Northern and Eastern services within Royal Devon University Healthcare NHS Foundation Trust			
<b>Prepared by:</b>	Hannah Foster, Chief People Officer Adrian Harris, Chief Medical Officer Angela Hibbard, Chief Finance Officer Carolyn Mills, Chief Nursing Officer John Palmer, Chief Operating Officer Chris Tidman, Deputy Chief Executive			
<b>Presented by:</b>	Carolyn Mills, Chief Nursing Officer			
<b>Responsible Executive:</b>	Hannah Foster, Chief People Officer Adrian Harris, Chief Medical Officer Angela Hibbard, Chief Finance Officer Carolyn Mills, Chief Nursing Officer John Palmer, Chief Operating Officer Chris Tidman, Deputy Chief Executive			
<b>Summary:</b>	To advise the Board of the Trust’s performance against key performance standards and targets; and progress on the implementation of the Trust Strategy and key supporting projects.			
<b>Actions required:</b>	The Board is asked to receive the Performance Report and note the current risks and the proposed action plans to mitigate the risks against performance delivery.			
<b>Status (*):</b>	Decision	Approval	Discussion	Information
				X
<b>History:</b>	This is a standing agenda item at each meeting of the Board of Directors.			
<b>Link to strategy/ Assurance framework:</b>	This paper details the Trust’s performance in respect of key performance standards and targets. Achievement of these performance standards and targets is a key objective within the Trust’s Strategy.			

Monitoring Information		Please specify CQC standard numbers and tick ✓ other boxes as appropriate	
Care Quality Commission Standards	Outcomes		
NHS Improvement / England	✓	Finance	✓
Service Development Strategy		Performance Management	✓
Local Delivery Plan		Business Planning	
Assurance Framework		Complaints	
Equality, diversity, human rights implications assessed			
Other (please specify)			

## Contents

Section	Page
Overview	3 – 7
Activity & Flow, and Operational Performance	8 – 43
Patient Experience	44 – 45
Quality & Safety	46 – 69
Our People	70 – 77
Finance	78 – 85

# Overview – Executive Themes and Actions to Raise at Board

## Forward look

This report focuses on the reporting month of October which remained challenging for the Trust (as it proved for the whole of the NHS in England). However, it was also a month when the organisation: continued to make significant steps forward on long waits activity through the initiation of the NHSEI 10 week challenge; provided mutual aid to our Trust neighbours through a change to catchment area; and achieved an improvement in unscheduled care performance through our “reset programme”. In November, the acceleration of long wait activity sees us at the time of writing with less than 200 patients waiting over 2 years for surgery (from 950 patients in February); continuing to hold our ambulance waits at lower than peer average despite catchment adjustment; and for the most part strengthening our approach to holding our elective ringfences by maintaining hospital flow.

Despite our improvements, we remain as a Tier 1 Trust for Elective Recovery and we have received a significant set of challenges from NHSEI to improve our data validation and reporting across key service domains including Cancer services. The data and quality section of the IPR demonstrates a commitment to providing robust assurance as we transition from EPR implementation to BAU data management and reporting. The need for this robust approach has been underlined by the Board self-assessment of its governance for elective and cancer recovery.

## Recovering for the Future

In terms of **urgent and emergency care** the organisation continued to face significant pressure in October. Despite the increase in attendances on both sites and the 72 diverts provided to neighbouring Trusts, **four hour performance improved** across both sites. Ambulance handover worsened for both sites in month, which was to be expected given the support provided to neighbouring Trusts, but actually still remained better than peer average. Part of the reason for maintaining this relatively positive position was that the **reset programme** freed 67 beds across the two sites; reduced ED hours waited by 556; improved lunchtime discharges by 75%; and saw 33 fewer complex long stay patients. This allowed **elective ring fences** to be maintained on both sites – a fundamental enabler for the **Winter Plan** as it initiates. The operational and transformation teams collaborated strongly to deliver the reset and the intention is that this discipline be repeated at key points during Winter.

**Elective recovery** continues to be a huge focus and this increased further in October with the establishment of the NHSEI supported **10 week challenge and long term elective recovery plan**. The Finance and Operational Committee will receive detailed updates on the development and delivery of the plan, but all elements of the plan are currently green or amber rated for both sites. The combined trajectory for 104 week waits should result in **179 patients over 104 weeks waiting at end of November**; and the completion of MBI validation in Northern Services will enable a further improvement trajectory to year end from its current combined position of **1518 (against a planned position of 1650) patients waiting over 78 weeks**. Whilst we have a challenging starting position, the organisation clearly now has momentum in tackling the backlog position and a commitment to achieving 0 104 week waiting patients by end of March '23. The Nightingale continues to provide an important complement to both sites in terms of Trauma and Orthopaedics which is at the heart of our challenge. The first foot and ankle surgeries have taken place in November and by the **end of December the Nightingale site will be at 75% utilisation on behalf of the Devon System**.

# Overview – Executive Themes and Actions to Raise at Board

**Cancer performance** also remains an area for distinct focus and whilst the majority of key indicators show a small performance improvement in month, the IPR sets out the **urgent recovery plans** in place for dermatology, colorectal, urology, gynaecology and oncology which will require significant cross site and Trust working. As referenced in the data quality section, the **reporting issues that we have encountered in Northern and Eastern Cancer Services will require an external review of our Cancer Patient Tracking List** and this has now been commissioned from MBI with independent support and oversight also to be provided by NHSEI IST. To support us in this work we will receive the formal report from our **invited national Cancer Services review** which took place on the 14/15<sup>th</sup> November. A notable opportunity for us to continue improving Cancer performance is through the national approval received of the business case for **Nightingale Community Diagnostic Centre (£37m revenue and £10m capital)**.

The pressure on the **finance position** of both the Trust and the wider Devon ICS remains equally as challenging with a number of cost pressures having to be absorbed into the position such as rising energy prices, shortfalls on pay inflation funding and changes in the funding regime which negate our ability to earn additional income for cohorts of activity. Alongside this there is a **shortfall in delivering the savings programme** for the year – the majority of which is due to loss of productivity improvement relating to the operational challenges set out, but also a shortfall in the expected annual cost efficiencies. As the Trust's implied productivity is benchmarking in line with the SW regional average, it can be seen that these pressures are being seen across the country. Cost pressures are currently being managed through non recurrent means in the year to date position, **and after noting a number of risks that now total £3m, our current forecast outturn remains at a £18m deficit, in line with our 22/23 plan**. The senior leadership team remain committed to achieve our financial plan over the next five months through to year-end.

## Collaborating in Partnership

The **Help People Home Without Delay** programme continued to drive at improving patient discharge to home with social care support throughout October. Whilst demand pressure continued to increase during the course of the month, it is clear that the **programme was beginning to grip** with bed availability slowly increasing and the UCR/SWAST pathway showing promising signs of progress. As we have entered November, the average daily number of medically fit to discharge patient numbers has started to reduce on both sites and we intend that our time to transfer will continue to improve as we have brought the community teams under a single integrated Division as a prioritised Winter pilot.

We have invited social care colleagues to join our Board Development session in December to explore how we can improve our joint planning processes, in the light of the recently announced NHS and social care settlement as part of the Autumn statement.

# Overview – Executive Themes and Actions to Raise at Board

## Excellence and Innovation in Patient Care

It is important to triangulate the performance with the quality metrics to identify any trends that may show a consequence of the continued pressures the Trust is facing. **There has been an increase in complaints during October** for both sites, but the introduction of a new action plan has started to improve response times at the end of Q2. There were three Serious Incidents reported in Northern Services and **two Never Events in Eastern Services** which are now under investigative review (initial review does not suggest that there has been a pattern from previous incidents). Follow up reporting will be provided in relation to the Never Events in the next Board cycle.

**Whilst Infection control data is above target**, it is not outside tolerances for this time of year; and **SHMI data is also within expected range**.

## A Great Place to Work

The **workforce metrics** continue to indicate the pressures being felt by our people. **General sickness continued to increase across both sites in October** in line with seasonal trends, although notably COVID related absence on both sites remained low. The impact of this alongside operational pressures on clinical services resulted in an increased reliance on bank and agency staff.

**Recruitment events** are proving successful in recruiting high volumes of staff, particularly in the areas most challenged by high turnover. Overseas recruitment is also making a significant contribution to our nursing numbers. Welcome, onboarding and retention activity is included as part of accelerating filling our vacancies programme and it is expected that this targeted work will reduce attrition over time. It is encouraging to see the reduction in turnover rates for Eastern services.

This IPR also includes the second **Cultural Dashboard for Royal Devon**, which is still an evolving data set both in our Trust and the wider ICS – further scrutiny will be applied to this dataset as it develops.

Finally, we should register that during the week of 17<sup>th</sup> October the organisation held **Team Royal Devon week** which celebrated and engaged our staff through nearly 60 online and in-person events, workshops and information sessions – over 550 staff attended. We learnt a great deal from the week and it was a great opportunity to thank our staff for everything that they are doing for our patients on a daily basis during these exceptional times. Alongside these thoughts for our staff, we note with concern the **potential for industrial action** in December and are therefore diligently preparing our contingency plans for December.

## Data Quality and reporting

**Diagnostics (Northern):** As reported previously, the implementation of the new EPR for Northern services in July resulted in some reporting issues, which have affected both external reporting and inclusion within the IPR. A number of these issues have been resolved but there is a remaining issue relating to elements of Diagnostic reporting. Concerns remain in relation to Cardio-respiratory, audiology and Endoscopy activity and waiting list position regarding the capture of all relevant activity. Specific modality task and finish groups are in operation and making progress, but this is not yet resolved.

**Cancer waiting times (both sites):** a technical adjustment was implemented in-month to support cancer reporting, which automatically closed cancer pathways if a specific outcome was selected by the user. It has subsequently been identified that a small number (c.1%) of these pathway closures were incorrect, which has resulted in the pathways affected being re-opened and manually validated. The root cause of this issue has been identified and a remedial plan was immediately implemented, but this issue has created a fluctuation in weekly cancer reporting at a time when performance is under particular scrutiny. Whilst this specific issue is being actively resolved through validation, external assurance is being planned to perform a detailed assurance review of the Cancer PTL.

**RTT / waiting list reporting (both sites):** the Board will be aware of recent issues with RTT reporting and the capture / completeness of incomplete pathways, which prompted a detailed review / support from the NHS Elective Support Team, followed by external validation support focusing on long waits in May '22. This work has been successful at gaining assurance over the reported position of long waits and processes to identify further data quality issues at source. Whilst the recent focus has been on validation of the longest waiting patients, work has now moved to focus on the algorithms for patients on multiple pathways and the removal of duplicate pathways. Specific groups have been tasked with addressing these actions, and there is confidence of positive resolution by the end of the calendar year. In order to ensure complete confidence with external stakeholders the IST team from NHSEI will provide some oversight on the final approach to data extraction from our EPR.

There is recognition from the Executive team that improvements are required in relation to **end-to-end data quality, from user input, to EPR configuration, through to reporting extracts**. The Trust has recently engaged external support from HCI with a focus on both immediate improvements that can be made and the development of a comprehensive data strategy. Data infrastructure and data quality are integral to this programme of work and the outcomes will be reported in the coming iteration. Given the important moment that we are at in moving from post EPIC implementation to business as usual the following arrangements will be in place over the next few months:

- An **Executive led task and finish** (CFO, CMO, COO) to provide oversight on all major data activities in order to assure the Board and external stakeholders that we are on track from EPRR implementation to BAU reporting and performance;
- A **COO led set of activities** that build on NHSEI IST and MBI ongoing work in elective activity and ensure the completion of the original plan; and a similar roll out of actions in cancer services through a further commission with NHSEI IST and MBI; and
- An **Executive led (CFO, CMO, COO) continuation to point of delivery of the HCI review** and real time improvement activities as commissioned to provide medium to long term improvement of whole organisation data management and reporting.

# Board Scorecard – Looking to the Future

## Successes

- Approval given for the £10m capital and £37m revenue investment in Community Diagnostic Centre at the Nightingale Hospital.
- Continued recognition of the Devon system partnership work at the Nightingale Hospital.
- Recruitment plans are showing positive results.
- Mutual aid offered to neighbouring Trusts, whilst maintaining ambulance handover and elective ringfences.
- Retrospective WLMDS cancer submission made for Northern Services back to point of EPIC implementation.

## Opportunities

- Insourcing & outsourcing and mutual aid capacity to further reduce long waiters in October and through to March '23.
- Initiation of the Winter Plan.
- Integration of 8 high priority services at our Northern services and development of our integrated Medicine business case.
- Elective recovery 10 week challenge to provide extra support/impetus coupled with national GIRFT programme; and development of long term elective recovery plan.
- Board assurance oversight on elective and cancer recovery.
- Invited national cancer visit report before Christmas.
- Maximising the use of the protected elective care at the Nightingale through theatre staffing, insourcing and new services.

## Priorities

- Staff Health and Wellbeing.
- Urgent validation work on long elective and cancer waits with NHSEI IST / MBI and continued focus on 104 ww.
- Industrial action contingency plan.
- Winter Plan and Help People Home Without Delay (social care partnership).
- Pipeline for recruitment processes to fast-track new starters.
- Delivering Best Value to meet financial plan.
- Launching the Trust's transformation approach.

## Risk/Threats

- Staff Morale with constant pressure and cost of living challenges.
- Loss of national/regional confidence in reporting due to data quality issues following EPIC installation.
- Potential Industrial action.
- Staffing resilience – Medical Staff (Northern) / nursing / HCA / ancillary.
- Further COVID waves anticipated.
- Green to Go Patient delays to placement.
- Clearing the Northern Services Dermatology Cancer backlog and ensuring overall plan for 62 day waits delivers sustained improvement.
- Inability to hit Board agreed financial target.

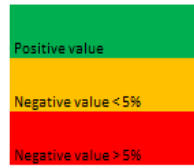


# Northern Services Executive Summary

## Northern Services Operational Performance Dashboard

Domain	Measure/metric	Definition	Last Month Sep-22	This Month Oct-22	Vs prior month	Planned %	National target
ELECTIVE ACTIVITY	Referrals	<i>Vs baseline (2019/20)</i>				N/A	N/A
	Outpatient activity (New)	<i>Vs baseline (2019/20)</i>	114.0%	110.0%	-4.0%	73.4%	104%
	Outpatient activity (FU)	<i>Vs baseline (2019/20)</i>	109.3%	102.9%	-6.3%	71.8%	75%
	Outpatient virtual (% of total)	% of total OP activity					25%
	Elective inpatient activity	<i>Vs baseline (2019/20)</i>	58.1%	51.3%	-6.9%	115.6%	104%
	Elective daycase activity	<i>Vs baseline (2019/20)</i>	81.7%	79.4%	-2.3%	89.5%	104%
	RTT 18 week performance	<i>Patients seen &lt; 18 weeks vs total incomplete pathways</i>	49.9%	50.4%	0.5%		92%
	Incomplete pathways	<i>Total count</i>	25205	25698	2.0%		
	RTT 52+ weeks waited	<i>Total count</i>	3137	3246	3.5%		
	RTT 78+ weeks waited	<i>Total count</i>	533	582	9.2%		
RTT 104+ weeks waited	<i>Total count</i>	16	18	12.5%			
CANCER	2 week referrals	<i>Performance</i>	63.23%	63.50%	0.3%		
	28 day faster diagnosis standard	<i>Performance</i>	34.31%	41.83%	7.5%		75%
	Urgent GP referral 62 day	<i>Performance</i>					85%

Domain	Measure/metric	Definition	Last Month Sep-22	This Month Oct-22	Vs prior month	Planned %	National target
URGENT CARE	Non-elective inpatient activity +LOS	<i>Vs baseline (2019/20)</i>	96.1%	89.1%	-7.0%	96.7%	
	A&E attendances	<i>Total count</i>	4370	4507	2.9%	99.3%	
	4 hour wait performance	<i>Patients seen &lt; 4 hours vs total attendances</i>	50.9%	54.4%	3.5%		95%
	Ambulance handover delays >30 minutes	<i>Total count</i>	249	316	26.9%		
	Average daily number of patients waiting and ready for discharge	<i>Total count</i>					
	Average daily number of patients delayed as awaiting community assessment / referral / bed	<i>Total count</i>					
	Average daily number of patients delayed as awaiting resource / assessment to start care at home	<i>Total count</i>					
	Average daily number of patients delayed as awaiting residential / nursing home bed	<i>Total count</i>					
	6 week wait referral to diagnostic test	<i>Referral diagnostic tests completed in 6 weeks</i>	38.0%	44.0%	6.0%	N/A	99%
	MRI activity	<i>Vs baseline (2019/20)</i>	96.9%	100.9%	4.0%	110.6%	
DIAGNOSTICS	CT activity	<i>Vs baseline (2019/20)</i>	113.9%	110.3%	-3.6%	120.1%	
	Medical Endoscopy activity	<i>Vs baseline (2019/20)</i>	110.3%	102.4%	-8.0%	154.0%	
	Non-obstetric ultrasound activity	<i>Vs baseline (2019/20)</i>	108.2%	93.8%	-14.3%	109.4%	
	Echocardiography activity	<i>Vs baseline (2019/20)</i>	43.0%	54.1%	11.1%	18.7%	



# Eastern Services Executive Summary

## Eastern Services

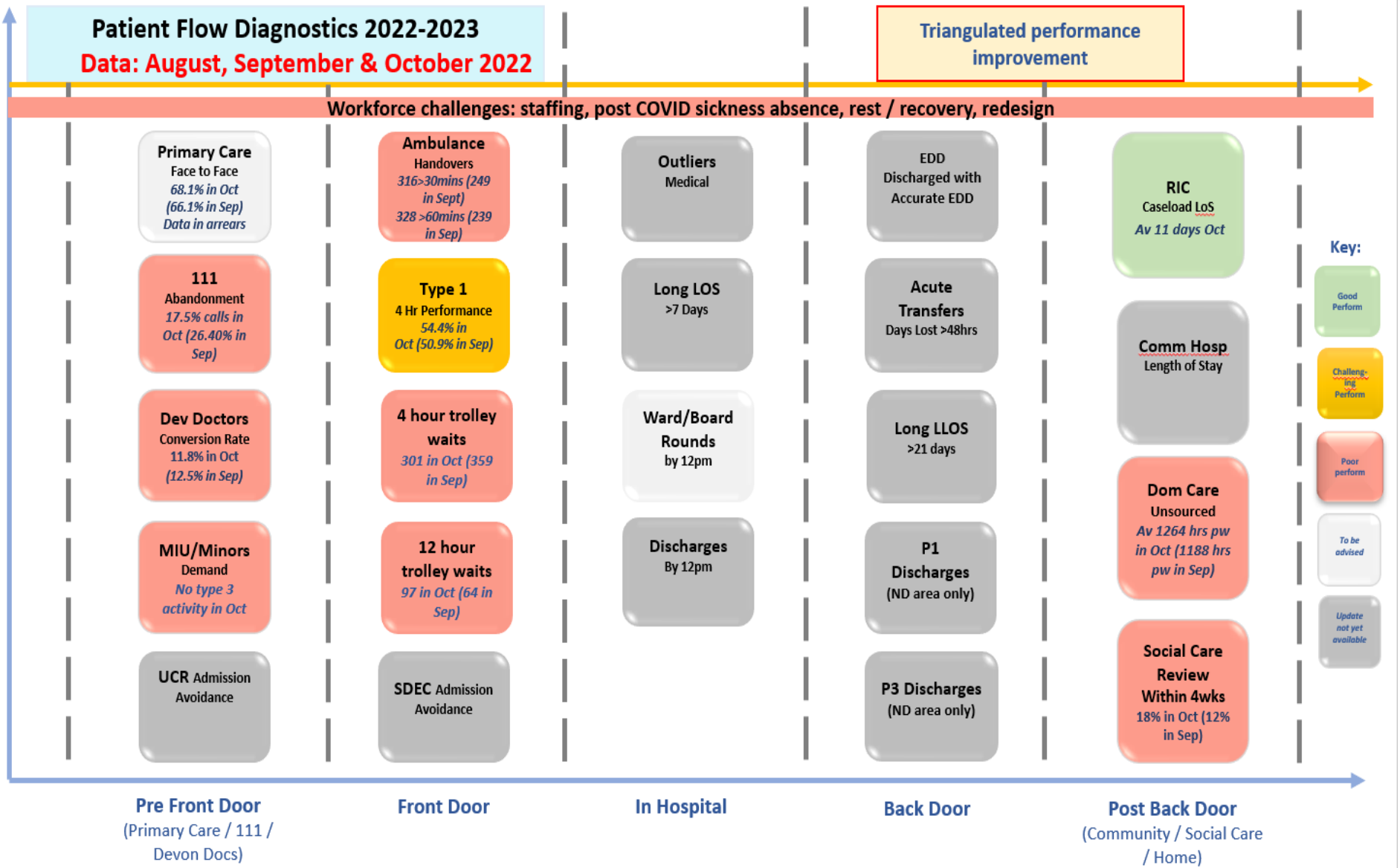
## Operational Performance Dashboard

Domain	Measure/Metric	Definition	Last Month Sep-22	This Month Oct-22	vs Prior month	Planned %	National target
ELECTIVE ACTIVITY	Outpatient Activity (NEW)	vs baseline (2019/20)	81.6%	<b>77.3%</b>	-4.3%	100.0%	104%
	Outpatient Activity (FOLLOW-UP)	vs baseline (2019/20)	139.9%	<b>129.5%</b>	-10.4%	88.3%	75%
	Elective Inpatient Activity	vs baseline (2019/20)	75.8%	<b>67.3%</b>	-8.5%	110.1%	104%
	Elective Daycase Activity	vs baseline (2019/20)	92.9%	<b>91.6%</b>	-1.4%	117.0%	104%
	RTT 18 Week performance	Patients seen < 18 weeks vs total incomplete pathways	54.9%	<b>56.4%</b>	1.5%		92%
	Incomplete Pathways	Total count	56556	<b>57579</b>	1.8%		
	RTT 52 Weeks waited	Total count	5034	<b>5074</b>	0.8%		
	RTT 78 Weeks waited	Total count	1023	<b>952</b>	-6.9%		
	RTT 104 Weeks waited	Total count	262	<b>250</b>	-4.6%		
CANCER	14 Day Urgent	Performance	40.9%	48.3%	7.4%		93%
	28 day faster diagnosis standard	Performance	65.0%	59.4%	-5.7%		75%
	Urgent GP referral 62 day	Performance	58.9%	73.5%	14.6%		85%

Positive value
Negative value < 5%
Negative value > 5%

Domain	Measure/Metric	Definition	Last Month Sep-22	This Month Oct-22	vs Prior month	Planned %	National target
URGENT CARE	Non-elective Inpatient activity +1LDS	Vs baseline (2019/20)	98.2%	<b>97.7%</b>	-0.5%	106.60%	
	A&E attendances	Total count	9800	<b>10832</b>	10.5%	110.6%	
	4 hour wait performance	Patients seen < 4hrs vs total attendances	59.1%	<b>59.6%</b>	0.5%		95%
	Ambulance handover delays > 30 mins	Total count	309	<b>399</b>	22.6%		
	Daily Average Green (Medically Fit) Transfer List	Total count	98	<b>98</b>	0.0%		
	Volume of Average Daily Completed Transfers	Total count	10.2	<b>11.4</b>	10.5%		
	Average Time to Transfer (Medically Fit to Discharge) - All Transfers	Total count	5.4	<b>5.2</b>	-3.8%		
	Average Weekly Hours Requiring Personal Care Backfill	Total count	1082	<b>1005</b>	-7.1%		
	UCR: Referrals	Total count	619	<b>791</b>	21.7%		
	UCR: Length of Stay on Caseload	Total count	16.0	<b>16.0</b>	0.0%		
DIAGNOSTICS	6 week wait referral to diagnostic test	% of diagnostic tests completed in 6 weeks	63.2%	64.4%	1.2%		99%
	MRI activity	vs 19/20 baseline	105.5%	101.4%	-4.0%	107.4%	
	CT activity	vs 19/20 baseline	106.7%	103.1%	-3.6%	105.1%	
	Medical Endoscopy activity	vs 19/20 baseline	115.4%	122.1%	6.7%	125.7%	
	Non-obstetric ultrasound activity	vs 19/20 baseline	110.7%	115.4%	4.7%	103.5%	
	Echocardiography activity	vs 19/20 baseline	176.4%	175.5%	-0.8%	112.7%	

## Northern Services Patient Flow Diagnostic



# Eastern Services Executive Summary

## Eastern Services

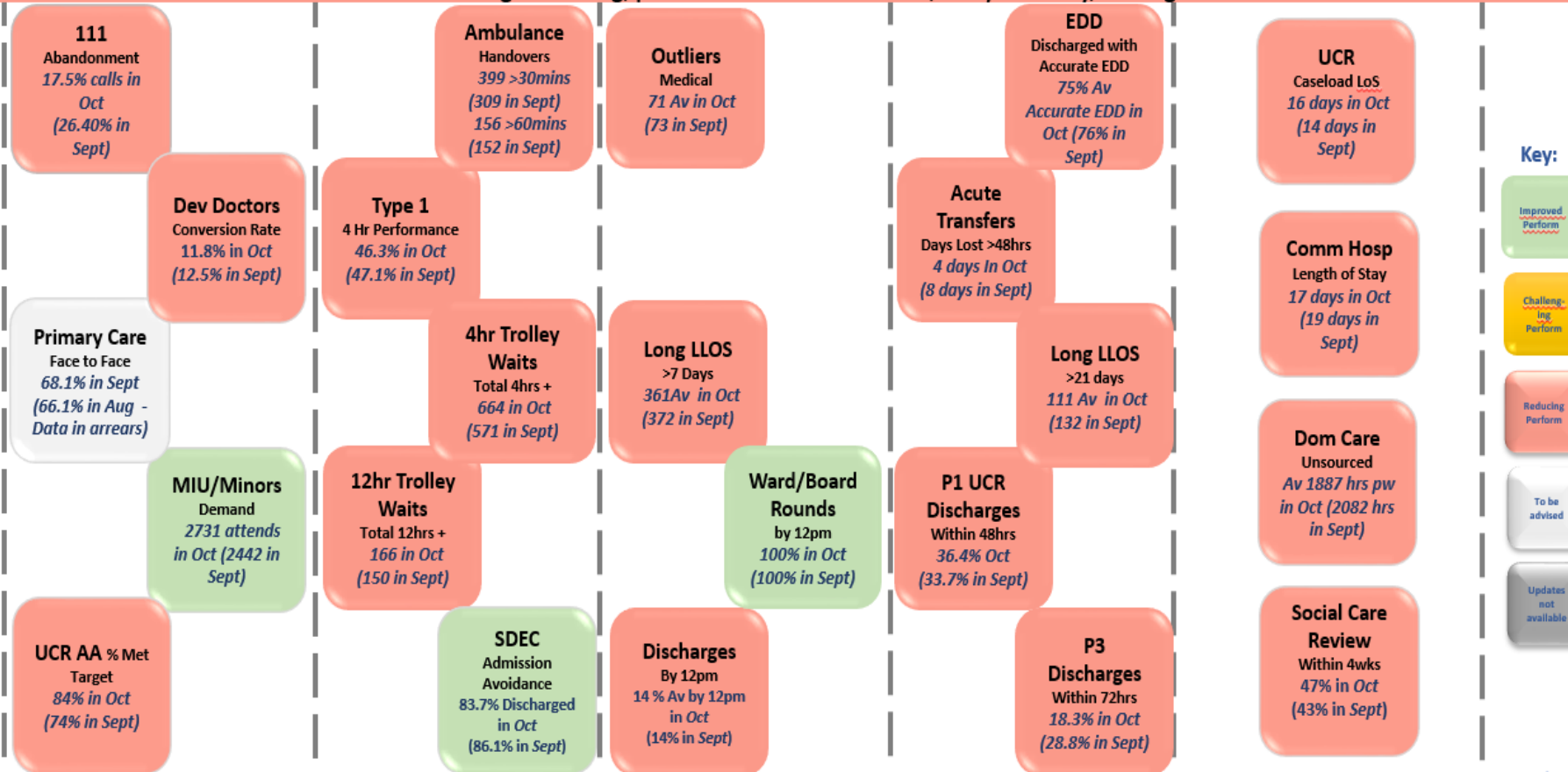
## Patient Flow Diagnostic

### Patient Flow Diagnostics 2021-2023

Data: October 2022

Triangulated performance improvement

Workforce challenges: staffing, post COVID sickness absence, rest / recovery, redesign



- Key:**
- Improved Perform
  - Challenging Perform
  - Reducing Perform
  - To be advised
  - Updates not available

Pre Front Door  
(Primary Care / 111 / Devon Docs)

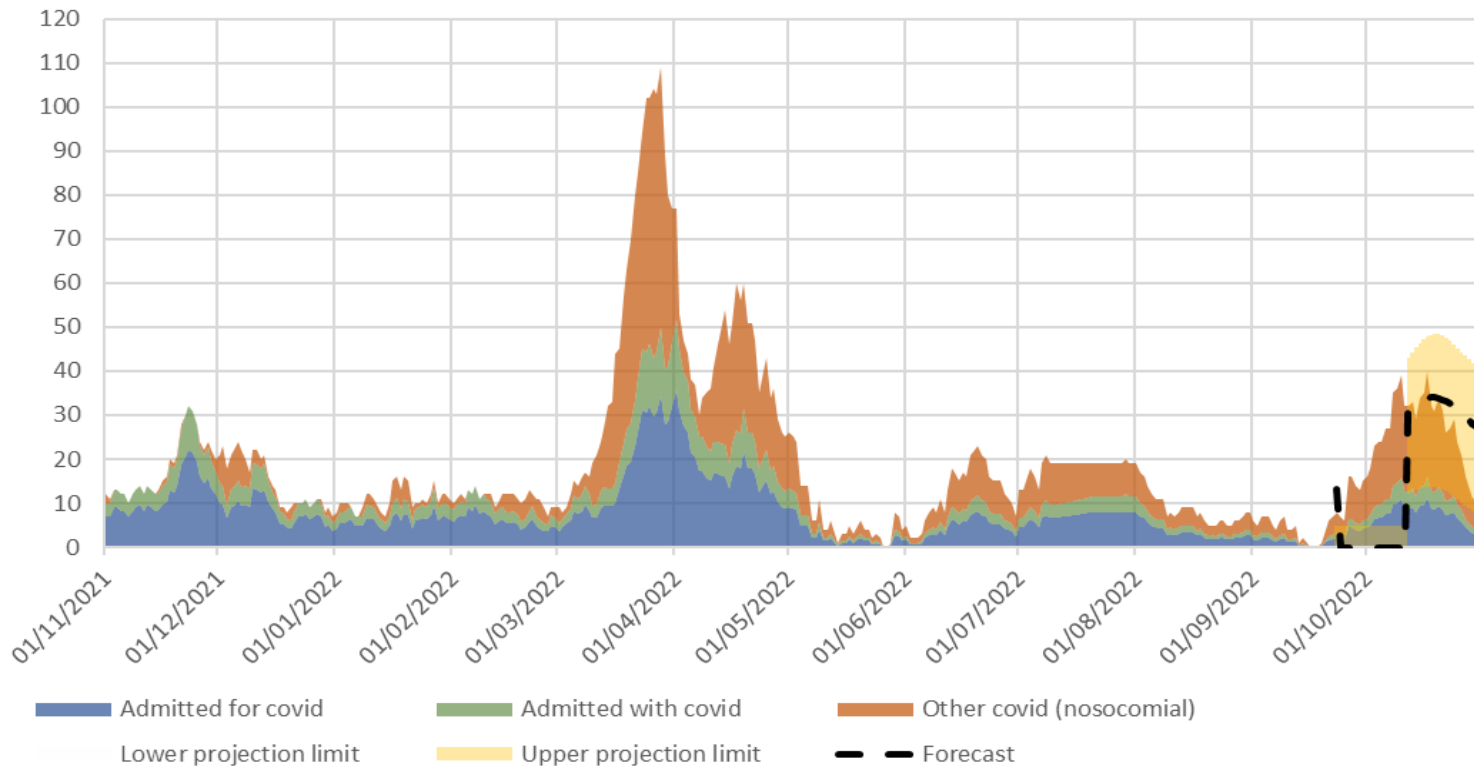
Front Door

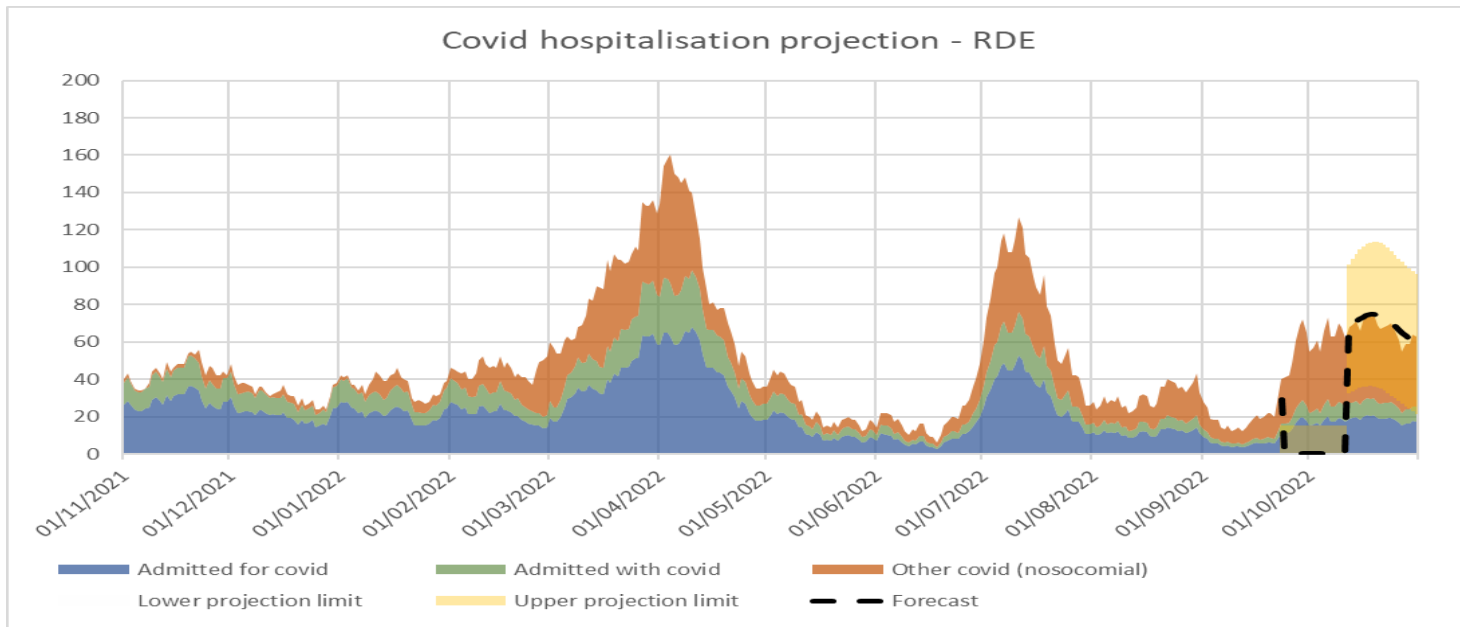
In Hospital

Back Door

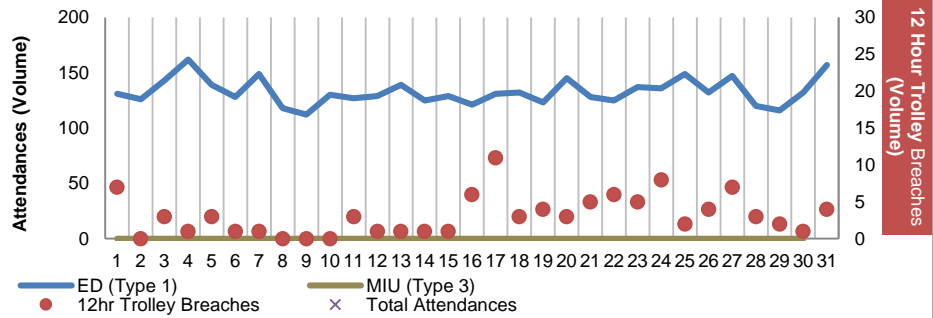
Post Back Door  
(Community / Social Care / Home)

## Covid hospitalisation projection - NDDH



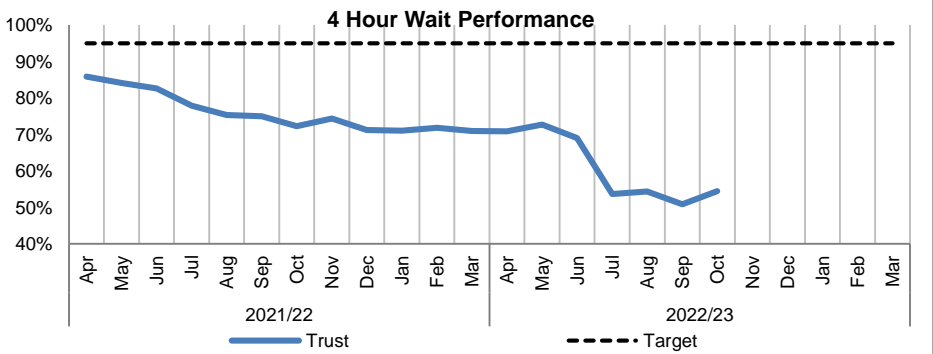
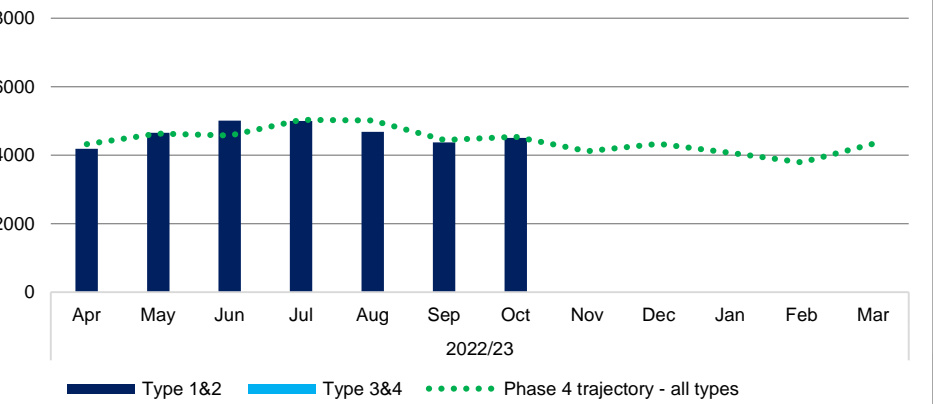


### Report Month - Trust Daily Attendance Profile

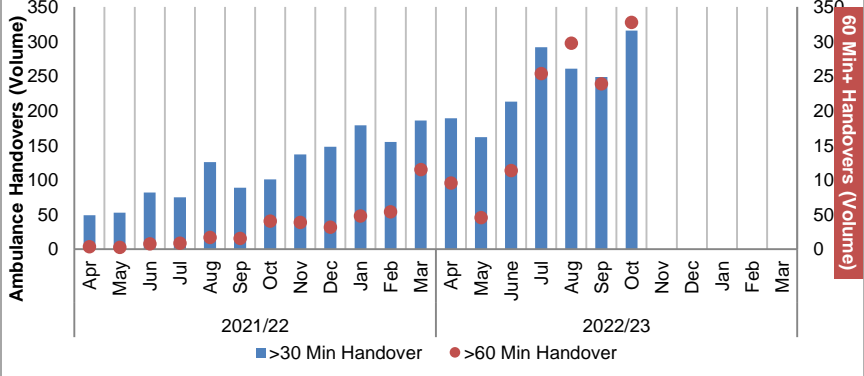


- ED remained escalated throughout October as the number of Green to go patients remained high with longer length of stay. The total unvalidated time lost in ambulance handover delays was 742 hours. This is a significant increase of 29.3% compared to September.
- Despite the pressure, the service did report a 3.5% improvement against the 4 hour target in M7.
- Bideford MIU (Type 3+4) remains closed and in Ilfracombe First Care continue to provide minor injury services on Fridays, Saturdays, Sundays and Mondays between the hours of 10am-6pm and this will remain in place until the end of the financial year. A group has been set up by the ICB in conjunction with key stakeholders to review short term and longer term provision of MIUs/UTC provision across Devon.
- Urgent Care Response (UCR) teams began to receive Category 3 and 4 SWAST referrals from early November with the aim of reducing hospital attendances. The team are currently finalising a joint dashboard to track demand and outcomes that are being achieved.
- From November a designated Hospital Ambulance Liaison Officer (HALO) will be in place at North Devon to support cohorting, handover and offloading reducing handover delays and releasing ambulances.
- Plans are in place to ringfence and enhance SDEC capacity as part of the patient flow improvement programme.

### A&E attendances



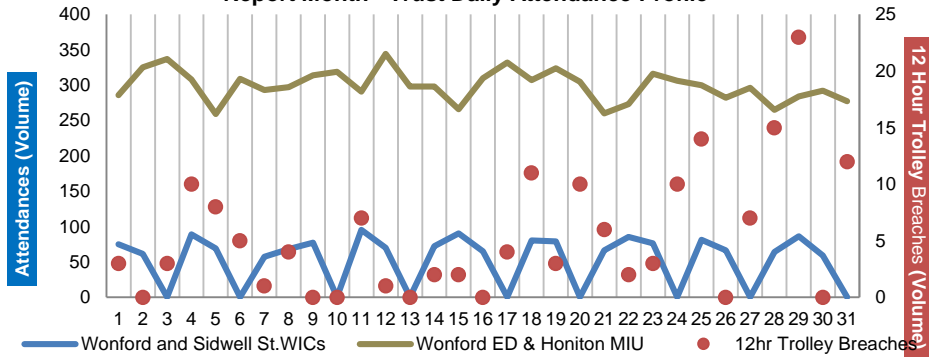
### Ambulance Handovers Delayed >30 mins



# Eastern Services Emergency Department

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

### Report Month - Trust Daily Attendance Profile



### Overall Performance:

Type of Activity	Denominator	Patients > 4 Hours	% Performance
ED Only	8101	4352	46.28%
All RD&E Delivered Activity (including Honiton MIU and the WICs)	10832	4378	59.58%
Total System Performance (including MIUs)	12092	4378	63.79%

All type performance against the 4 hour wait target remains static at around 60%. Ambulance handover delays continue to be challenged, albeit not an outlier against national averages. 12 hour wait for a bed remains high -164 incidences in October

### Key Drivers:

- Bed capacity pressure and restricted flow to beds in the hospital
- 111 call abandonment and lack of primary care streaming
- Reduced capacity at Sidwell Street WIC –closed on Monday and Thursday – will continue until at least Feb 23
- Current vacancies and sickness in Medical and Nursing teams

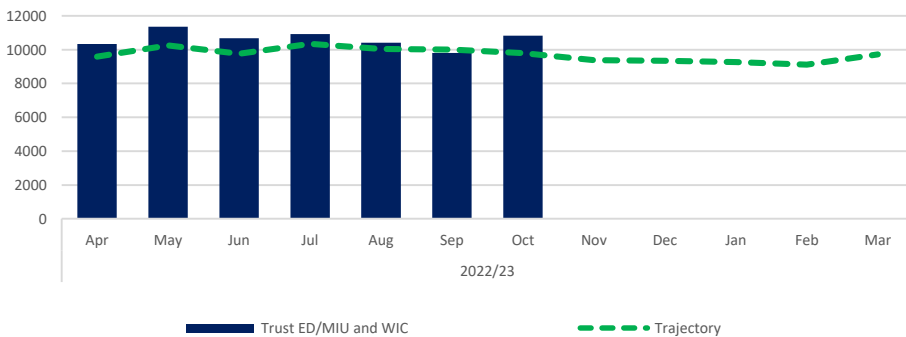
### To note:

- The temporary adjusted ambulance catchment area resulted in an additional 59 ambulance arrivals in October- this was due to reverse on 7<sup>th</sup> November
- The 'knock through' of the new ED build happened on 7<sup>th</sup> November, impacting on the ability to manage corridor care- mitigations have been put in place to minimise delays.

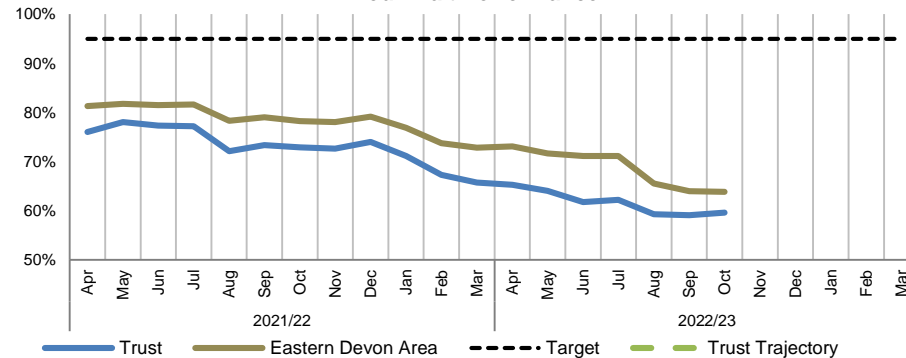
### Actions

Clinical Lead in communication with Practice Plus to re-introduce streaming to GP out of hours service. The service has focussed on improving the 15 min to triage performance. Work to streamline the process was undertaken and performance is being monitored via daily briefings and weekly meetings.

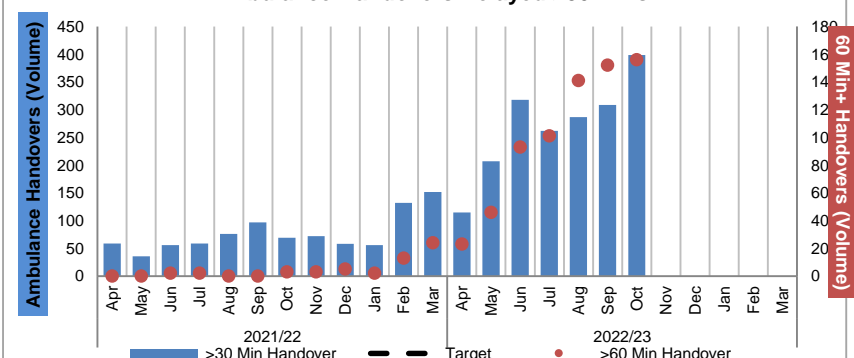
### A&E Attendances



### 4 Hour Wait Performance



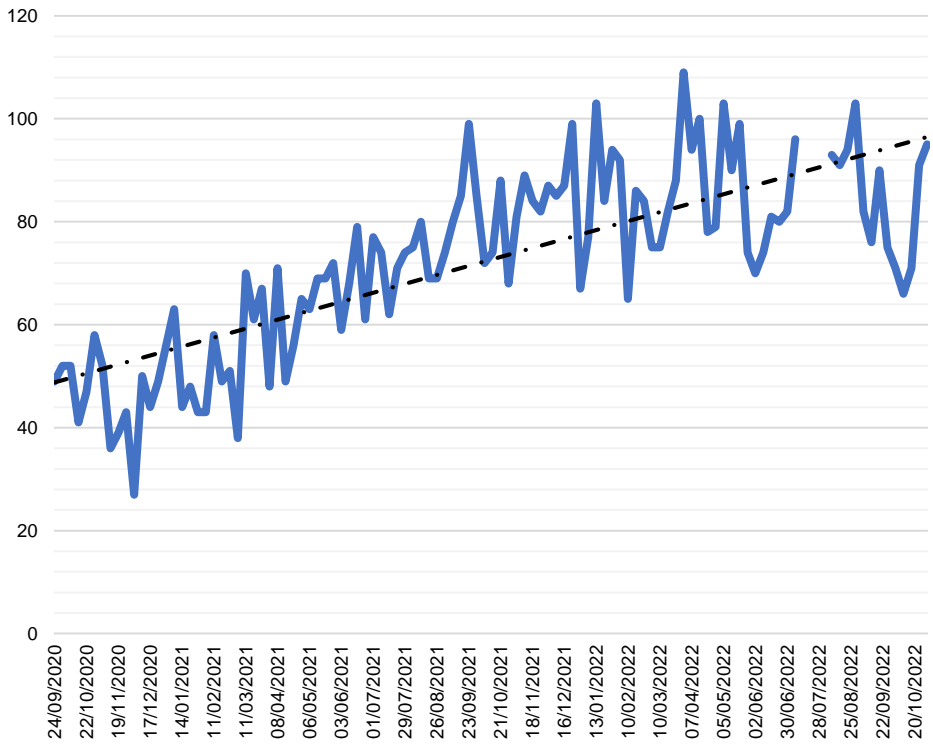
### Ambulance Handovers Delayed >30 mins





# Northern Services Discharge – Volumes of Patients Identified as Clinically Ready for Discharge

**Weekly Snapshot of Patients who do not meet Criteria to Reside (Gap reflects introduction of Epic affecting Reporting)**



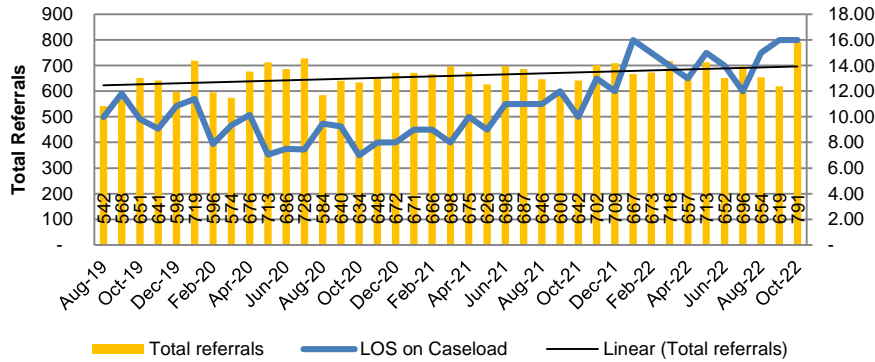
- The number of Green to Go patients have remained high during October. A number of actions are being taken as part of winter planning which is expected to have a positive impact. Eight additional P2 (short term rehabilitation) beds have been commissioned and work is continuing with the ICB and DCC market management to source a further 6 additional P2 beds.
- Northern and Eastern Community teams are to integrate from 14th November for 6 months as a temporary measure to support the delivery of the winter plan which will enable a common approach to discharge processes.

Delay Reason	06/06/2022	13/06/2022	20/06/2022	27/06/2022	04/07/2022	11/07/2022	18/07/2022	25/07/2022	01/08/2022	Data unavailable due to go live												
										08/08/2022	15/08/2022	22/08/2022	29/08/2022	05/09/2022	12/09/2022	19/09/2022	26/09/2022	03/10/2022	10/10/2022	17/10/2022	24/10/2022	31/10/2022
Awaiting Med decision/written dc summary	0	0	0	0	0	0				0	0	1	0	0	0	0	0	0	0	0	5	0
Awaiting community assessment / referral / bed	8	8	9	23	13	13				23	18	23	23	21	17	21	21	20	20	24	15	23
Awaiting therapy decision	4	0	1	0	1	1				0	0	0	0	0	0	0	0	1	0	0	1	0
Pathway 1 awaiting resource / assessment to start care at home	10	17	17	21	18	18				15	23	22	24	16	19	20	11	9	6	9	16	21
Pathway 3 Awaiting residential / nursing home bed	6	9	7	8	15	15				13	16	18	13	11	11	15	11	14	12	15	13	11
Repatriation / Transfer to another acute Trust	0	3	0	1	2	2				11	8	8	4	3	7	6	5	6	4	4	0	12
Patient/family not in agreement with discharge plans	0	0	0	1	1	1				1	0	0	0	0	0	0	0	0	0	1	0	2
Others	2	3	5	3	2	2				7	3	0	0	2	2	2	1	3	5	2	1	3

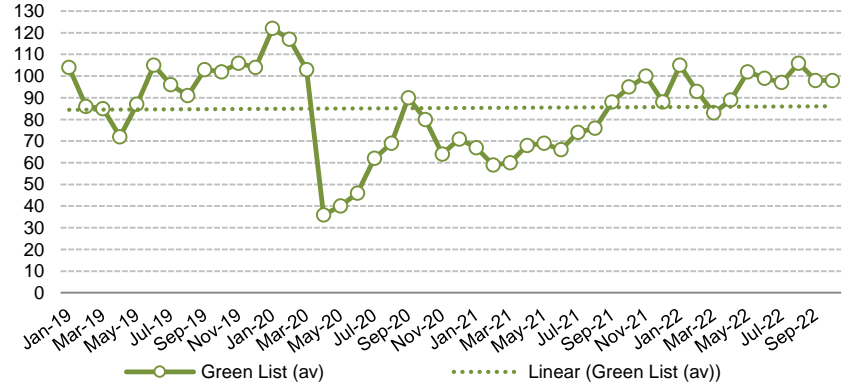
# Eastern Services Urgent Community Response

Admission avoidance and discharge

UCR Referrals & Length of stay on Caseload



Daily Average Green (Medically Fit) Transfer List Total



## UCR Demand and Flow Performance

- There was a 27.8% increase in referrals to UCR from September to October, coupled with an increase in length of stay on the caseload due to delays in assessment for long term care.
- There were 295 referrals to UCR for admission avoidance in October, 62 required a two hour response of which 90% met that target.
- The average number of patients on the green to go list in October was 98 and in the three months to October, compared with the same period last year, has increased by 16%.
- Number of patients discharged with a need for onward packages of care increased by 7% from September to October. From January IPR, we will start to report on the percentages of patients discharged within the agreed targets, in-line with ED performance reporting.

## Actions to improve performance and outcomes

- Actions being taken to improve this position are part of the Help People Home without Delay Programme. This is expected to improve the position from November, aligned with extra capacity coming on line within social care.
- Following successful pilot in reset week, teams will proactively refer patients for onward care and discharge from caseload.
- An additional six agency workers are coming online in November to provide live-in care (6 beds in total for complex patients).
- On 1<sup>st</sup> November a new 1:1 agency support for Pathway 2 & 3 placements is being implemented providing additional circa 5 beds through winter.
- One additional winter bed opened in Sidmouth Hospital in October, and four additional winter beds have been identified in Tiverton.
- A weekly audit across North and East on the Best Practice Discharge Pathways is proactively identifying opportunities to improve efficiencies across services.
- Vacancy position (Community Services) in October was 11.1% and local recruitment events are planned in November.

Activity & Flow

Operational Performance

Patient Experience

Quality & Safety

Our People

Finance

# Eastern and Northern Services Social Care

Unallocated domiciliary care hours, and waiting list position

Activity & Flow

Operational Performance

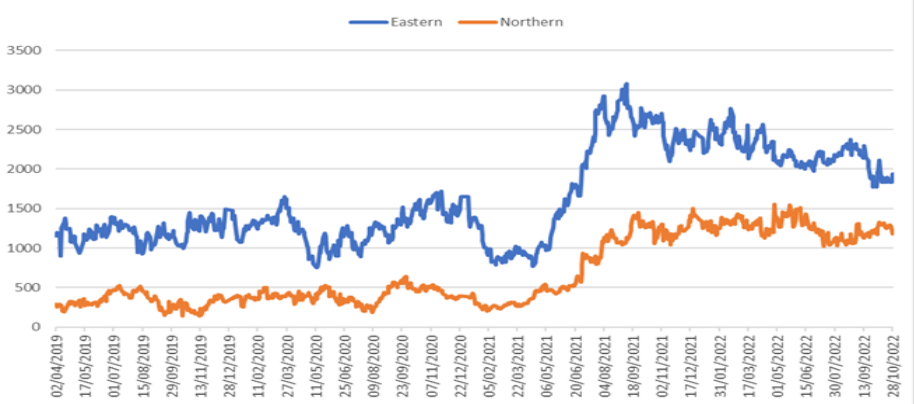
Patient Experience

Quality & Safety

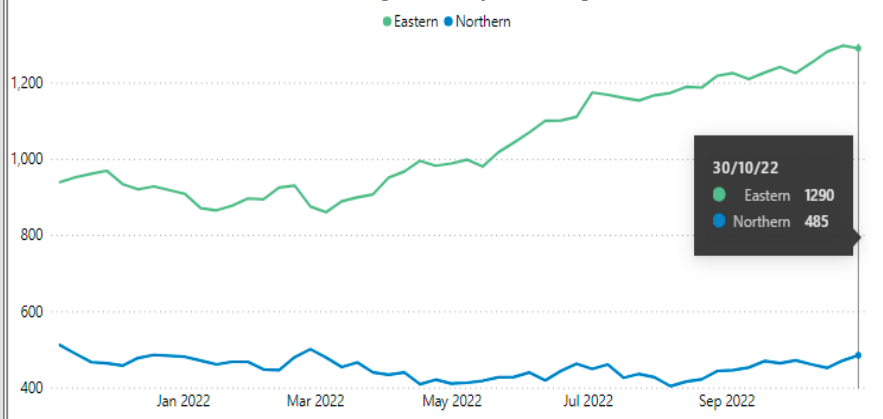
Our People

Finance

Eastern and Northern - Daily Snapshot of Unallocated Care Hours



All Waiting List trend by week ending



## Unallocated Care Hours:

- Whilst reducing slightly, this position remains of significant concern as it represents the level of social care hours that will need to be picked up either by agency or backfilled by UCR teams. DCC are progressing international recruitment within the domiciliary care market, however we are yet to understand the impact of this on market provision.
- Through Help People Home Without Delay programme Clusters for Eastern are now managing Pathway 1 patients directly with a greater influence over the care package prescribed. Also, good progress has been made during November in reducing backfill by around 25%.

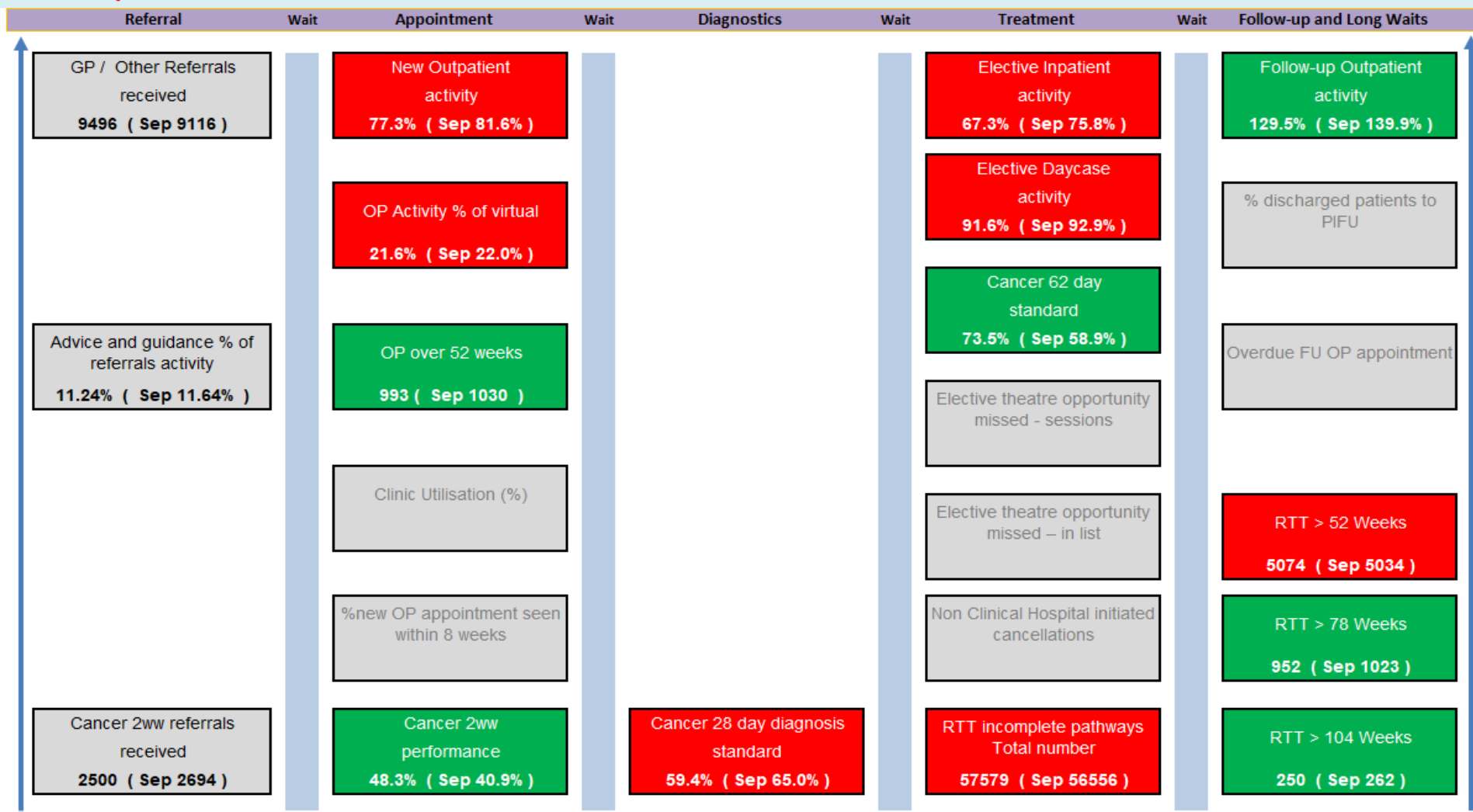
Devon was notified of its £10.4m share of the national £500m Hospital Discharge Fund, which is expected to be made recurrent. Work is now underway at ICS level to jointly plan how best to use this funding to reduce delayed discharge.

A diagnostic has been produced for both the Trust CEO and Director of Adult Social Care which sets out some options for strengthening partnership working. This will be reviewed in more detail at the December Board Development session.

# Planned Care Metrics 2022-2023

## Eastern Services

Data : September 2022



Enabling work streams: Clinical prioritisation, PTL management, Patient support, Validation, Access management processes, Communications + ownership, EPIC build

Improved performance

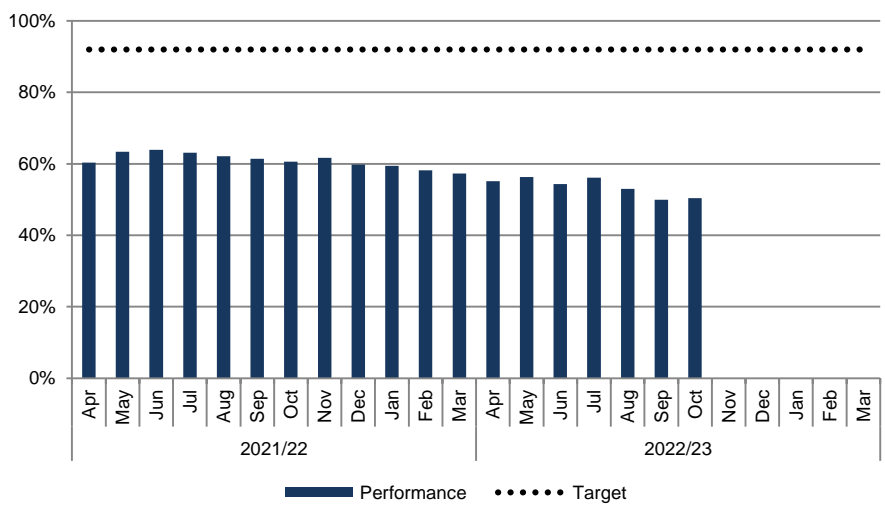
Challenged performance

Reducing performance

Note – Northern dashboard under construction

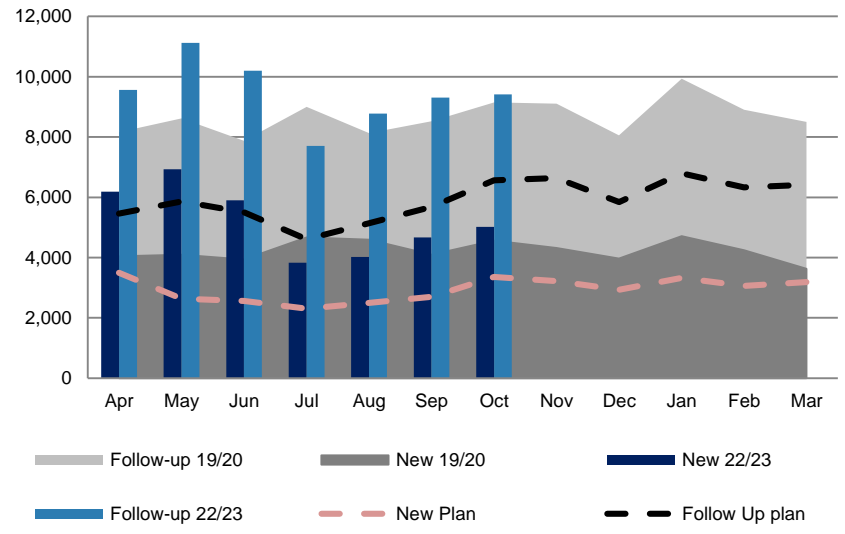
# Northern Services Elective Activity- Referrals and Outpatients

RTT 18 Week Performance

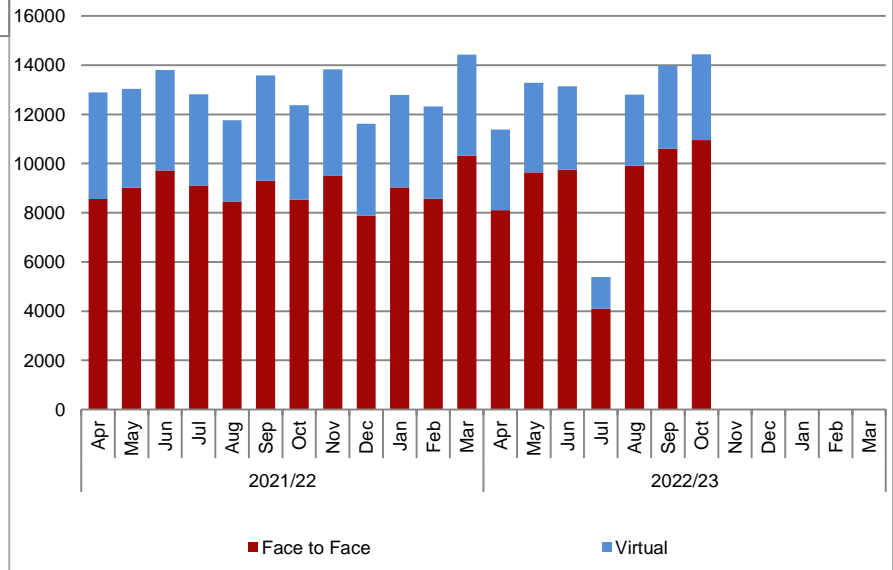


- External support is in place to support validation of the PTL. A modest reduction in the size of the PTL is anticipated on completion of this exercise at the end of November.

New and Follow Up Outpatient Attendances

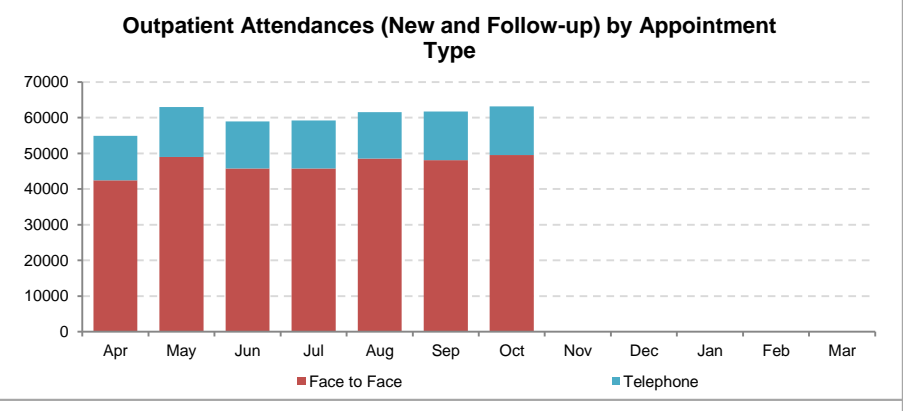
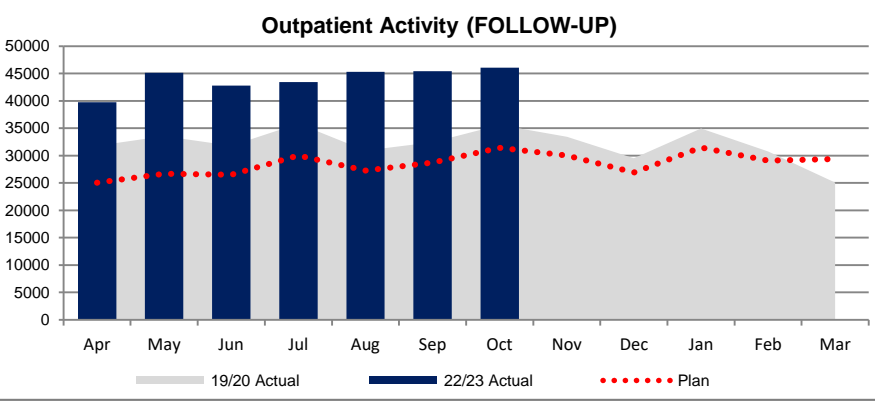
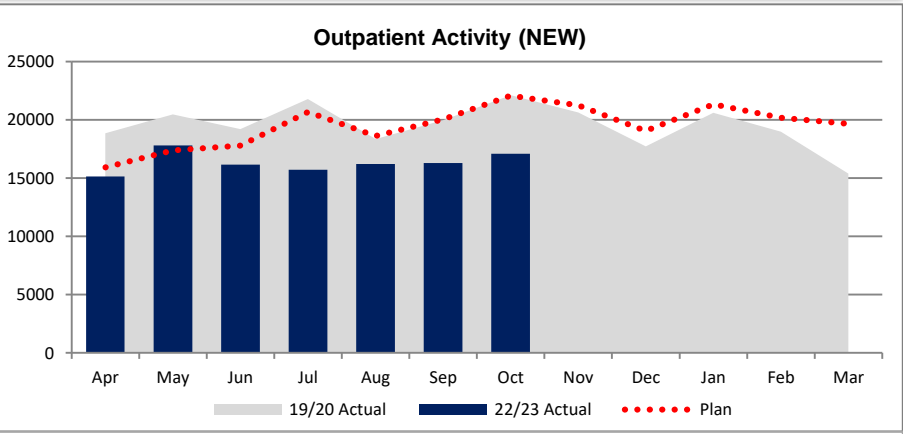
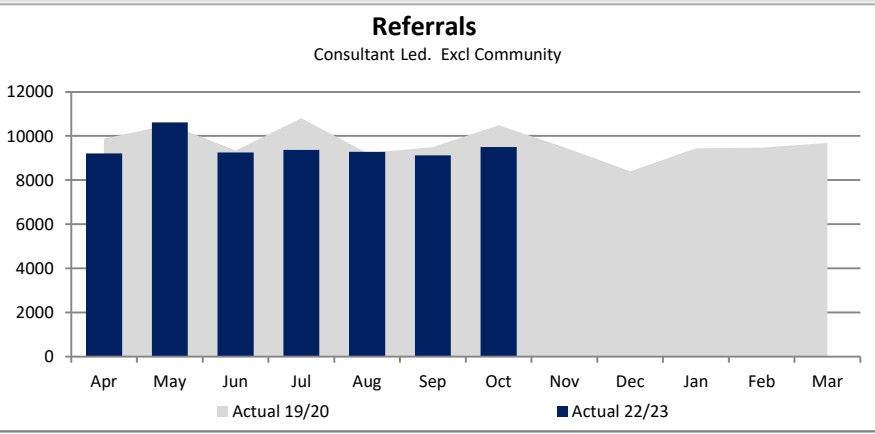


Outpatient Attendances (New and Follow-up) by Appointment Type (Cons only)



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

# Eastern Services Elective Activity- Referrals and Outpatients



**Outpatient activity (new):** this was expected to increase in relation to Ophthalmology expansion at Axminster and through the Nightingale. These services have now commenced but baseline activity is lower than plan due to a more graduated start linked to staffing. Other attributable factors for the under-performance against plan, and the corresponding actions for improvement include:

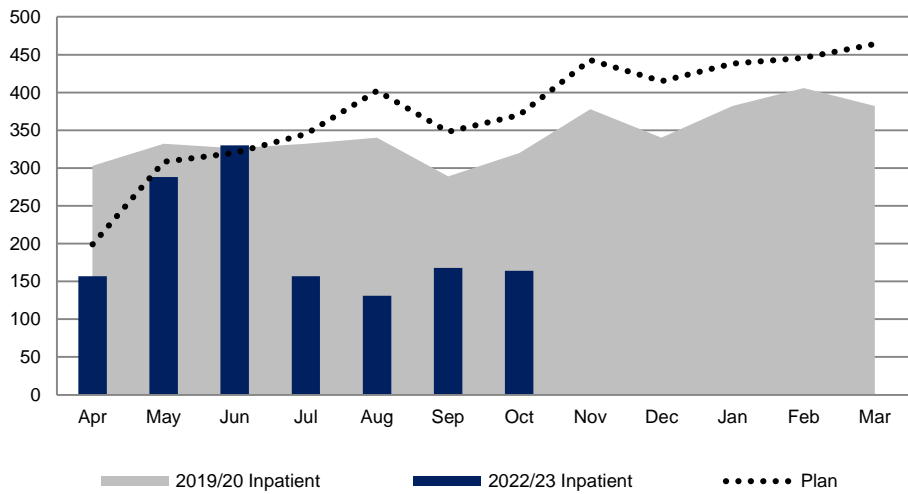
- Volume of staff vacancies placing pressure on running clinics – specific focus on recruitment and retention
- Clinic utilisation (fewer patients per clinic) – Service improvement team now in place and focussing on specific specialties ( deep dive on the November Board agenda)
- Data quality (not capturing all activity that is undertaken) – focus of contracting team working with operational teams

**Outpatient activity (follow up):** was 130% of 2019/20 activity compared to 140% in September. Data quality work continues to ensure the correct activity is reflected in the correct point of delivery (e.g. new / follow ups) with a specific focus on Ophthalmology, Cardiology and Midwifery.

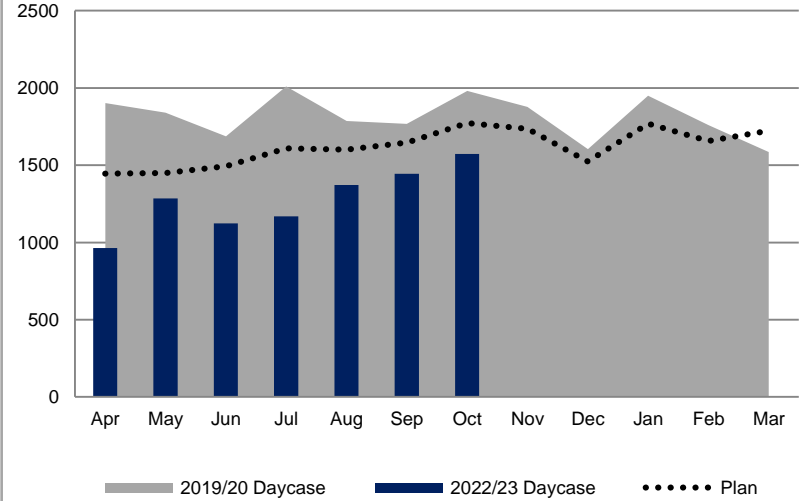
**Virtual outpatient activity:** was 22% in October, which is consistent with previous months.

# Northern Services Elective Activity- Inpatient and Daycase

### Elective Inpatient Activity



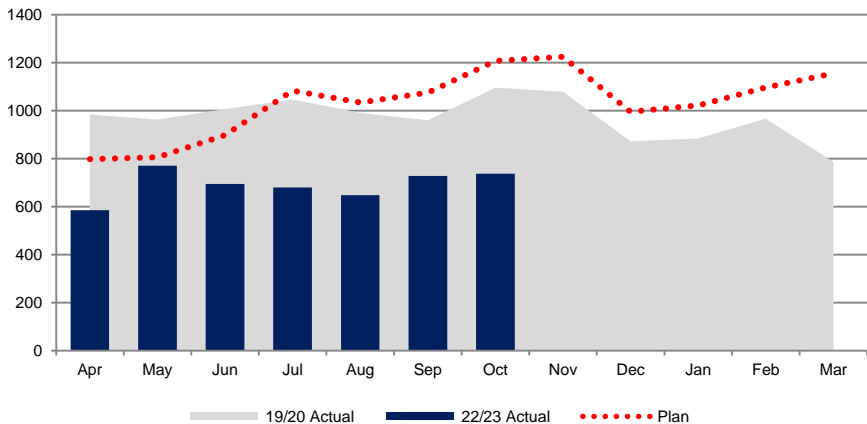
### Elective Daycase Activity



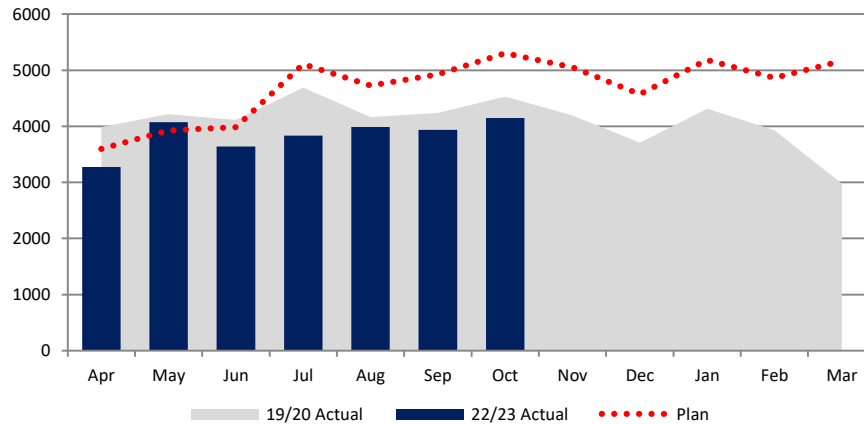
- During October, efforts have been made to reduce the use of the Day Surgery Unit for emergency escalation beds, which has led to an increase in day case activity.
- Highest clinical priority patients and long waiting patients continue to be monitored weekly via the Patient Tracking Meeting (PTL).
- Elective Same Day Cancellation data is still a work in progress. However, in October, fewer patients had their planned surgery cancelled due to unavailability of beds and this continues into November.
- The October reset week was largely successful in re-establishing elective throughput. A 10 week challenge has been set to reduce the number of 104 and 78 week waits between now and year end.

# Eastern Services Elective Activity- Inpatient and Daycase

### Elective Inpatient Activity



### Daycase Activity

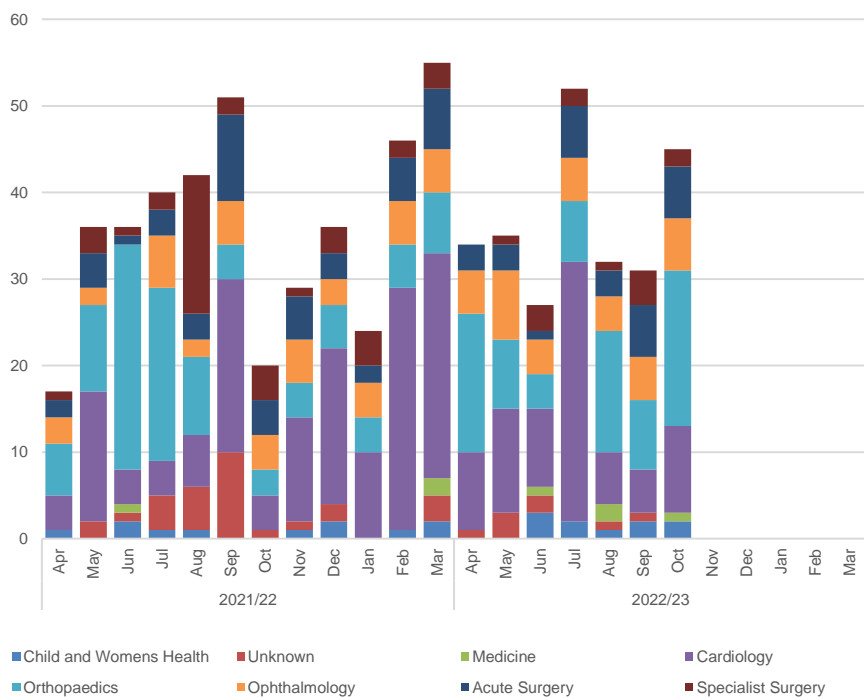


**Elective and Day Case activity: the charts show a slight increase in October but still significantly below 19/20 levels.**

The major contributory factors include:

- Theatre staffing: theatre recruitment / capacity has been improving but not yet at full capacity due to staffing constraints.
- Nightingale shortfall against plan: utilisation is expected to further improve from November as a result of further recruitment and an expansion of services to include foot and ankle surgery.
- Ringfencing of elective beds: UEC pressures and high numbers of delayed discharges continue to place pressure on elective beds, particular across surgery and cardiology.

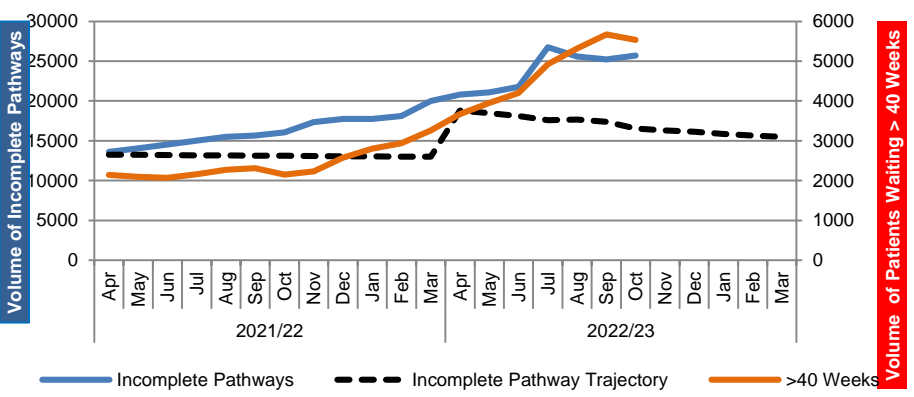
### Elective Same Day Cancellations : Hospital



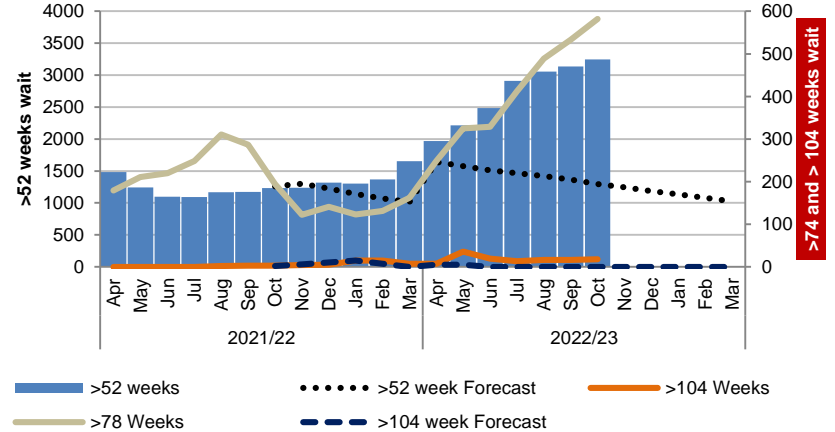


# Northern Services Elective Activity- Long Waiting Patients

### Incomplete Pathways and Longer Waiting Patients



### >52, >78, >104 Weeks Waited



Specialty		2022/23														
		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
> 40 weeks	T & O	478	480	415	482	525	599	600	675	765	812	814	951	1008	1075	1018
	General Surgery	71	78	71	74	75	81	80	102	117	115	126	141	146	146	144
	Dermatology	97	126	133	151	186	215	232	277	316	335	349	387	406	413	385
	Gynaecology	198	192	191	180	203	203	207	210	227	263	312	381	465	501	500
	Neurology	89	67	54	75	94	114	125	131	154	169	158	192	193	189	158
	Colorectal	70	73	60	57	66	54	57	52	52	49	50	-	-	-	-
	Cardiology	12	14	17	21	25	30	43	49	54	69	92	144	174	225	236
	Ophthalmology	694	709	690	657	798	838	897	977	1088	1102	1149	1255	1252	1252	1239
	Other	304	314	286	293	338	379	390	446	510	627	699	1043	1233	1413	1423
	Upper GI	58	59	58	52	60	67	63	52	61	64	74	-	-	-	-
	Urology	201	198	174	187	208	220	244	290	329	344	376	428	443	462	431
<b>Grand Total</b>	<b>2272</b>	<b>2310</b>	<b>2149</b>	<b>2229</b>	<b>2578</b>	<b>2800</b>	<b>2938</b>	<b>3261</b>	<b>3673</b>	<b>3949</b>	<b>4199</b>	<b>4922</b>	<b>5320</b>	<b>5676</b>	<b>5534</b>	

An administrative validation of all patients waiting over 40 weeks is being done and is due to be completed by the end of November.



# Northern Services Elective Activity- Long Waiting Patients Continued

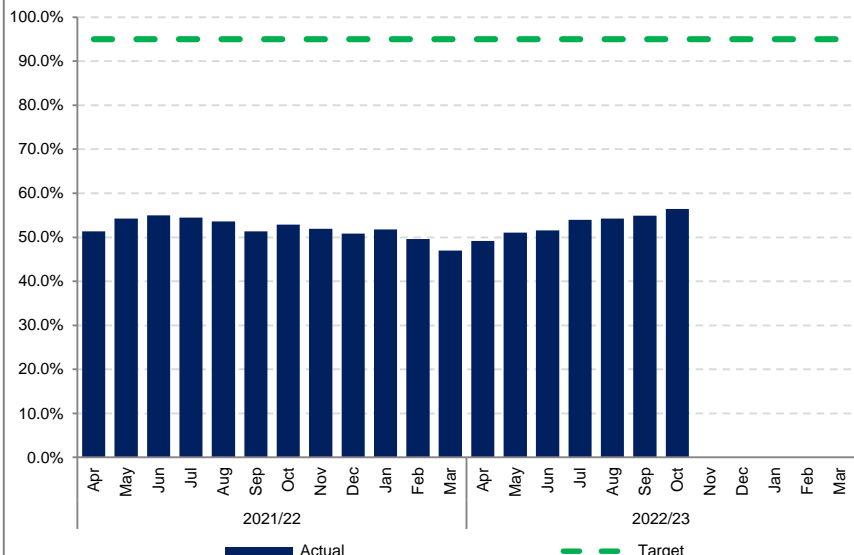
Specialty		2022/23														
		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
> 52 weeks	T & O	221	222	225	244	267	312	344	391	460	522	529	594	590	594	596
	Neurology	44	32	31	36	29	28	40	43	57	74	69	93	110	116	117
	Cardiology	2	7	12	12	10	10	11	15	13	23	27	37	42	72	92
	Ophthalmology	458	373	371	367	401	390	336	459	561	632	720	865	824	823	831
	Other	315	414	438	454	490	436	504	594	694	757	903	1055	1208	1248	1331
	Urology	127	134	120	126	119	125	132	153	182	204	235	268	284	284	279
	<b>Grand Total</b>	<b>1167</b>	<b>1174</b>	<b>1230</b>	<b>1235</b>	<b>1316</b>	<b>1301</b>	<b>1367</b>	<b>1655</b>	<b>1967</b>	<b>2212</b>	<b>2483</b>	<b>2912</b>	<b>3058</b>	<b>3137</b>	<b>3246</b>

Specialty		2022/23														
		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
> 78 weeks	T & O	63	62	42	23	22	41	21	33	65	126	97	114	137	140	130
	Neurology	3	9	5	3	2	3	3	3	5	6	5	7	10	7	15
	Cardiology	0	1	0	0	0	0	0	0	2	1	0	0	1	1	4
	Ophthalmology	106	86	45	18	16	19	17	27	44	33	43	58	54	85	116
	Other	98	90	79	49	72	28	58	62	89	106	134	170	204	238	251
	Urology	41	39	23	29	29	32	32	37	43	53	50	63	65	62	66
	<b>Grand Total</b>	<b>311</b>	<b>287</b>	<b>194</b>	<b>122</b>	<b>141</b>	<b>123</b>	<b>131</b>	<b>162</b>	<b>248</b>	<b>325</b>	<b>329</b>	<b>412</b>	<b>471</b>	<b>533</b>	<b>582</b>
> 104 weeks	T & O	0	1	0	0	0	1	0	3	2	28	13	5	6	5	5
	Neurology	0	0	0	1	1	0	0	1	1	1	1	1	1	0	1
	Cardiology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Ophthalmology	0	0	0	1	1	5	4	0	1	0	0	1	2	2	1
	Other	2	1	3	2	3	9	10	3	3	4	1	2	2	4	8
	Urology	0	1	0	0	0	0	1	0	0	3	4	4	4	5	3
	<b>Grand Total</b>	<b>2</b>	<b>3</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>15</b>	<b>15</b>	<b>7</b>	<b>7</b>	<b>36</b>	<b>19</b>	<b>13</b>	<b>15</b>	<b>16</b>	<b>18</b>

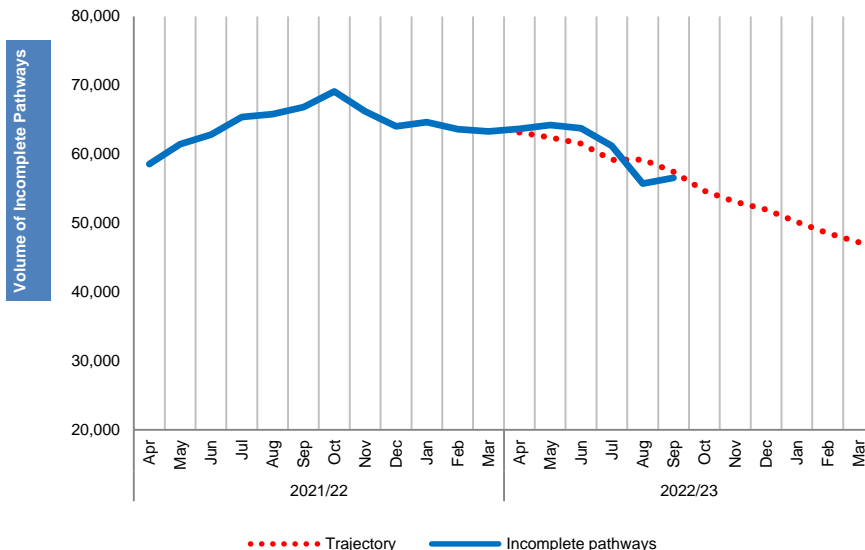
- By the end of November the expectation is that there will be a reduction to 8 patients waiting in excess of 104 weeks for treatment.

# Eastern Services Elective Activity- Inpatient and Daycase

### RTT 18 Week Performance



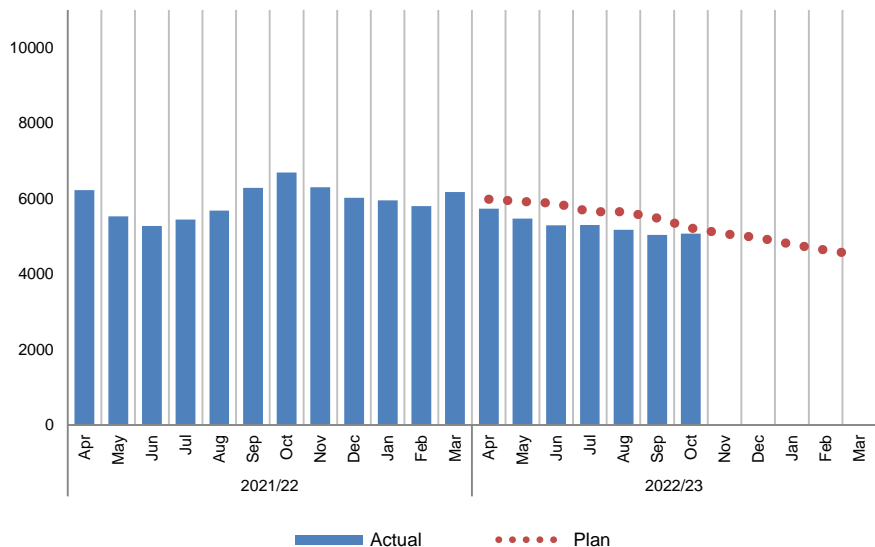
### Incomplete Pathways



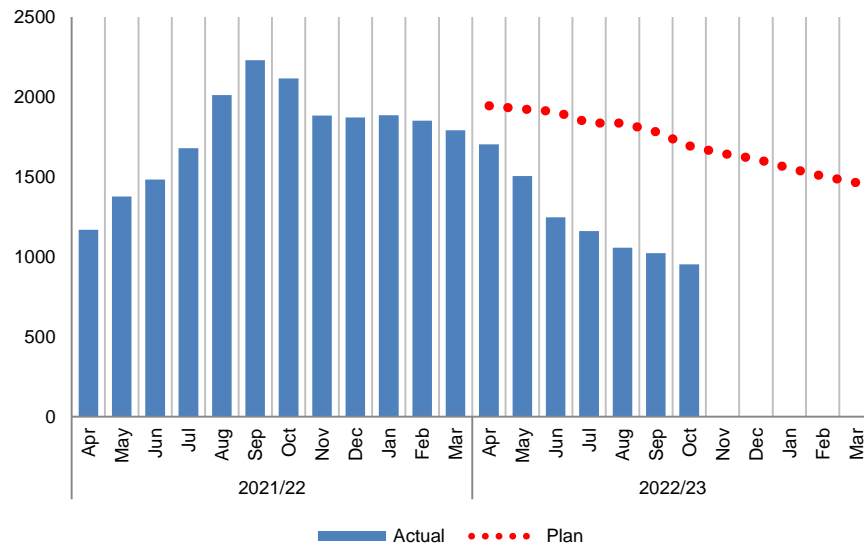
Incomplete pathways continue to track in line with the overall trajectory, although there was a month on month increase between September and October, mainly attributed to General Surgery, which is currently behind plan due to capacity issues. Additional pathway validation work has now largely been completed. The support has been focusing on Eastern incomplete pathways but has now been re-attributed to Northern services as the Eastern project moves to completion.

# Eastern Services Elective Activity – Long Waiting Patients

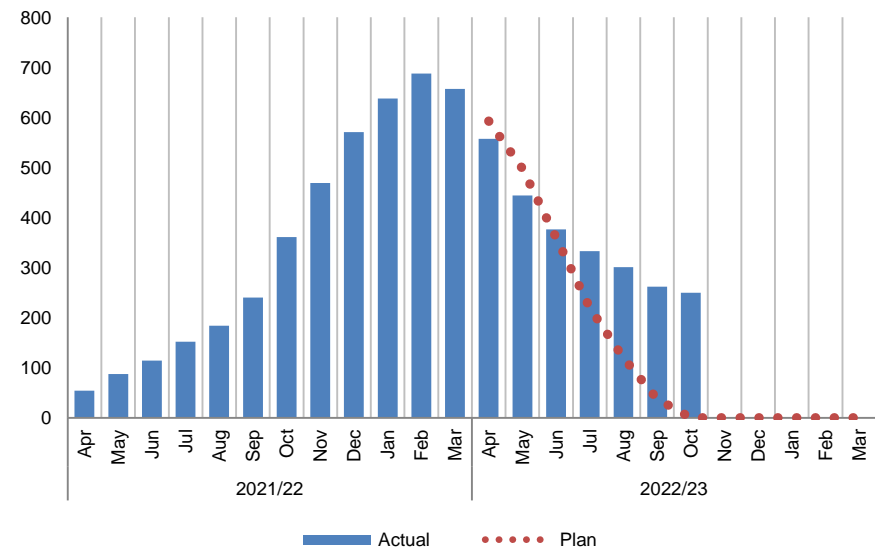
### RTT 52+ Weeks Waited



### RTT 78 + Weeks Waited



### RTT 104+ Weeks Waited



**78+:** the position improved slightly between September and October, mainly attributed to Orthopaedics (additional targeted support at NHE) and Cardiology (additional external targeted support).

**104+:** the position continues to improve from 262 to 250 at the end of October. Challenges remain with General Surgery and maintaining the positive run rate for Orthopaedics.

Work continues with the '10 week challenge' programme of intensive work with support from NHSE colleagues, with a focus on securing additional mutual aid opportunities and maintain the ringfence of elective capacity. Good progress is being made and the ambition remains to eliminate all 104+ week waiters by March 31<sup>st</sup> 2023.

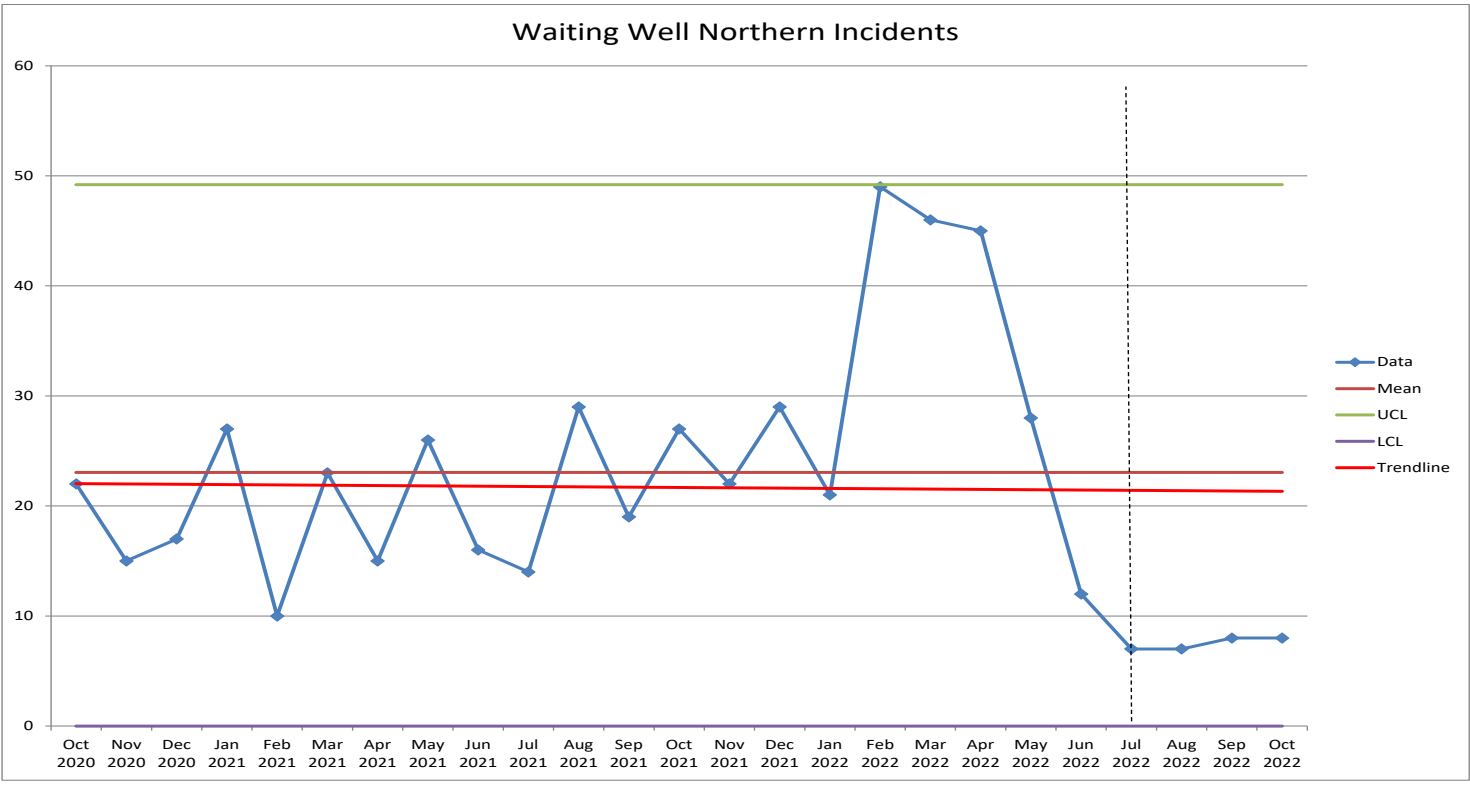
# Eastern Services Elective Activity- Long Waiting Patients

Specialty	2021/22												2022/23							
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	
40+ weeks	Orthopaedics	2344	2347	2296	2216	2195	2130	2081	2065	2153	2161	2166	2306	2281	2181	2061	2248	2268	2311	2224
	Cardiology	616	625	679	751	838	894	880	770	758	751	786	873	827	854	875	801	840	771	681
	General surgery	909	916	860	912	791	845	663	555	405	350	277	208	187	141	125	124	100	123	121
	Ophthalmology	1728	1756	1906	2163	2486	2660	2622	2461	2652	2818	2901	3158	2804	2961	2350	1507	1186	1024	946
	ENT	395	369	390	340	323	374	464	465	454	402	382	383	449	471	448	370	392	394	381
	Gastroenterology	338	337	393	579	637	855	857	974	862	969	850	804	640	714	521	760	319	228	223
	Plastic Surgery	214	254	265	306	321	322	317	306	300	301	311	297	299	318	268	253	248	216	228
	Respiratory Med	238	249	267	297	291	296	278	238	220	201	200	224	264	318	334	304	293	298	262
	Urology	283	276	318	278	251	242	286	265	298	293	298	303	271	232	180	195	167	185	169
	Colorectal Surgery	592	587	559	571	626	627	697	720	733	782	816	845	885	936	919	910	851	834	845
	Upper GI	115	123	117	136	150	145	170	159	154	161	176	182	190	178	167	183	175	176	175
	Other	1080	1192	1315	2000	2517	3041	2659	2200	2223	2331	2375	2528	2673	2753	2770	2885	3034	3305	3143
	Total	8852	9031	9365	10549	11426	12431	11974	11178	11212	11520	11538	12111	11770	12057	11018	10540	9873	9865	9398
52+ weeks	Orthopaedics	1859	1720	1628	1535	1482	1533	1595	1617	1610	1537	1492	1568	1499	1416	1364	1419	1374	1436	1487
	Cardiology	414	399	417	407	418	491	530	484	442	414	377	416	429	457	487	520	545	482	428
	General surgery	594	555	539	627	621	788	629	517	368	312	233	167	137	106	95	91	66	78	92
	Ophthalmology	1315	1013	941	1046	1212	1399	1489	1456	1610	1404	1365	1608	1345	1164	929	858	688	578	546
	ENT	276	222	211	183	191	200	222	201	215	220	211	226	228	226	221	204	199	170	162
	Gastroenterology	178	130	97	143	132	240	323	326	283	298	319	374	222	163	157	108	96	51	93
	Plastic Surgery	145	154	158	160	186	208	253	228	199	194	195	199	205	208	177	168	158	138	129
	Respiratory Med	159	134	126	127	147	156	164	124	127	127	121	140	154	134	130	143	162	174	145
	Urology	198	186	204	170	156	152	162	110	116	124	138	169	163	142	126	129	94	86	91
	Colorectal Surgery	445	437	437	448	455	451	498	514	526	553	517	523	526	593	609	618	546	508	513
	Upper GI	80	86	76	81	94	95	114	99	102	107	106	104	104	109	113	101	101	127	
	Other	561	495	438	518	588	571	712	623	434	667	727	677	719	760	885	927	1144	1232	1261
	Total	6224	5531	5272	5445	5682	6284	6691	6299	6021	5952	5802	6173	5731	5473	5289	5298	5173	5034	5074
78+ weeks	Orthopaedics	581	654	697	698	761	810	782	775	843	846	827	820	773	684	584	528	472	457	417
	Cardiology	108	111	120	126	152	165	175	137	121	134	138	133	153	149	134	129	130	121	94
	General surgery	36	49	74	132	205	340	253	185	141	109	95	98	68	43	38	37	24	28	23
	Ophthalmology	61	70	91	137	279	384	343	264	246	307	325	331	271	223	155	140	94	77	80
	ENT	44	50	57	68	79	69	75	64	64	51	36	27	26	21	24	32	37	42	40
	Gastroenterology	14	19	17	17	10	12	10	13	8	12	14	33	19	18	13	6	7	5	4
	Plastic Surgery	30	36	34	40	56	75	76	78	58	54	50	58	58	55	37	31	38	41	37
	Respiratory Med	12	18	25	28	34	35	20	6	10	9	17	20	32	26	26	22	24	19	5
	Urology	48	61	64	48	52	43	44	23	24	21	18	18	21	13	14	13	12	13	17
	Colorectal Surgery	128	172	175	195	219	233	250	252	260	248	221	183	188	183	149	153	127	119	120
	Upper GI	23	22	21	23	34	34	35	29	22	19	21	22	30	22	19	28	22	22	29
	Other	85	115	108	167	132	31	54	58	76	77	91	48	65	68	55	43	71	79	86
	Total	1170	1377	1483	1679	2013	2231	2117	1884	1873	1887	1853	1791	1704	1505	1248	1162	1058	1023	952
104+ Weeks	Orthopaedics	23	35	47	65	81	114	178	252	340	397	437	445	364	299	261	230	191	162	153
	Cardiology	6	12	23	28	25	27	46	51	49	59	63	57	58	45	32	31	22	16	12
	General surgery	2	4	4	7	7	25	11	10	14	16	12	11	15	7	8	9	6	7	5
	Ophthalmology	0	0	0	0	1	4	6	12	18	18	30	24	13	8	2	6	9	8	5
	Colorectal Surgery	19	23	28	34	38	41	54	64	75	87	80	75	67	63	46	42	45	42	48
	Upper GI	1	2	0	2	3	3	7	4	4	2	2	3	2	4	1	1	1	0	0
	Other	3	11	12	16	29	26	59	76	71	59	64	42	38	18	26	14	27	27	27
	Total	54	87	114	152	184	240	361	469	571	638	688	657	557	444	376	333	301	262	250

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

# Northern Services Waiting Well

October 2022 Waiting Well Northern Incidents	None	Minor	Moderate	Total
New	1	4	0	5
Diagnostic request delay	2	0	1	3
<b>Total</b>	<b>3</b>	<b>4</b>	<b>1</b>	<b>8</b>



A moderate harm incident had been reported in relation to delays for lung biopsies in Radiology. A Nursing workforce review is currently taking place and a risk assessment form to be completed based on Nursing shortages has been requested.

The other incidents that have been reported relate to urgent care rather than to patients on waiting lists awaiting planned care issues, and include patients experiencing delays in contacting 111 or receiving a call back from 111, this is then leading to a delay in receiving treatment from care services at NDDH.

## Patient survey support key aims

- Identify any patients who no longer want or need to be on a waiting list (patient validation)
- Ensure patients are empowered to seek appropriate help from the health system when needed
- Refer any identified patients that need further community support to local voluntary sector organisation(s)

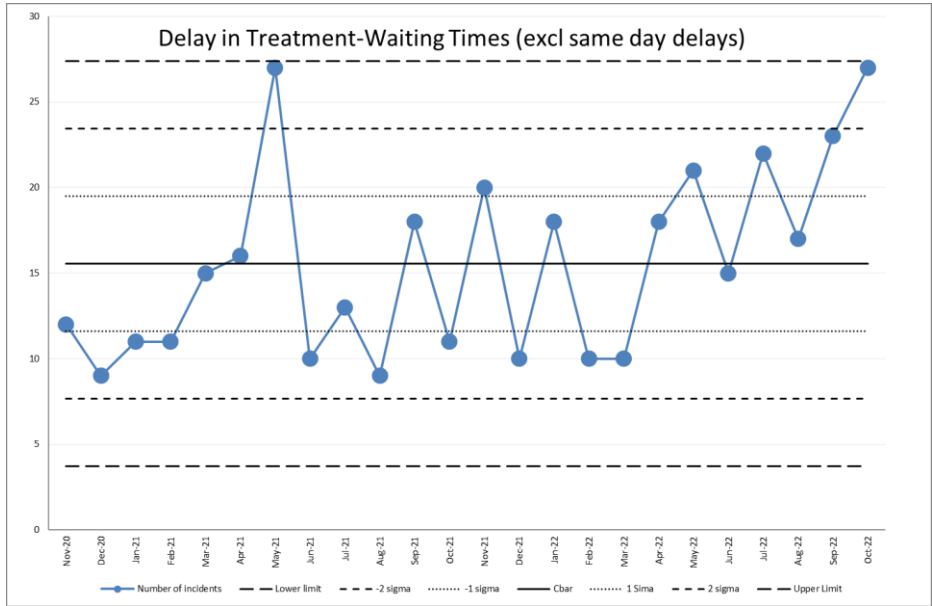
<b>Patients Contacted</b>	<b>11160</b>
Completed Survey	8276
No response	1708
Work In Progress	1176
Escalated to clinician for review	2682
Referred for lifestyle support and advice	1203
Removed from WL	1491

Current Survey is focussed on not yet seen patients, and patients on a surgical WL. Work is ongoing to develop a system to support validation of patients on follow up pending lists. Work is underway with the ICB to develop the current survey to support with Mutual aid validation.

Scoping is underway to support regular review of patients every 12 weeks following guidance from NHSI.

# Eastern Services Waiting Well

Across the same time period in Eastern 27 incidents were reported for October 2022, these are broken down by the level of harm against stage of pathway below.

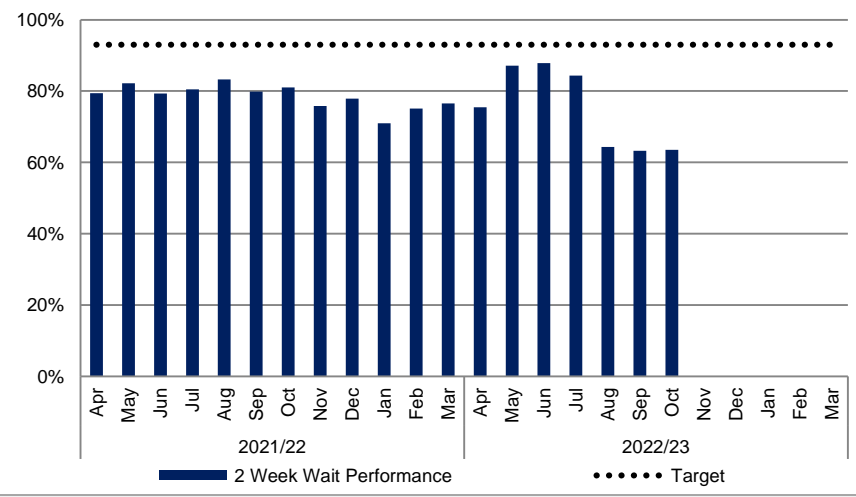


	None	Minor	Moderate	Major	Catastrophic	Total
New	8	2				10
Surgery	5	2				7
Follow up delay	5	2				7
Diagnostic request delay	1	1	1			3
<b>Total</b>	<b>19</b>	<b>7</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>27</b>

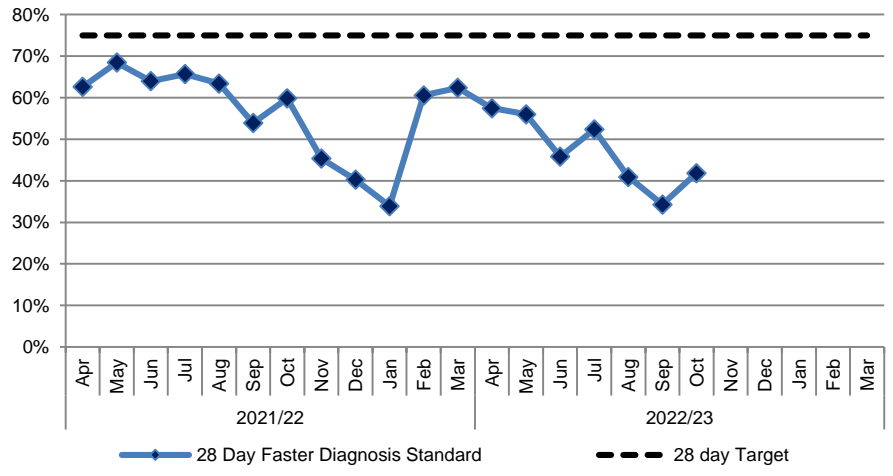
All incidents that occurred in the period were reported by 08/11/2022.



### 2 Week Wait Performance



### 28 Day Faster Diagnosis Standard



## 2 Week Wait Performance

Following challenges with data quality, cancer waiting time data will be re-submitted for Quarter 2 during November.

The significant challenges in the high volume speciality of Dermatology as a result of transition from System1 to Epic have been the main contributor towards the drop in 2 week wait performance since August. Additional capacity including insourcing has been put in place to address this backlog and booking is currently within 4 weeks in Dermatology.

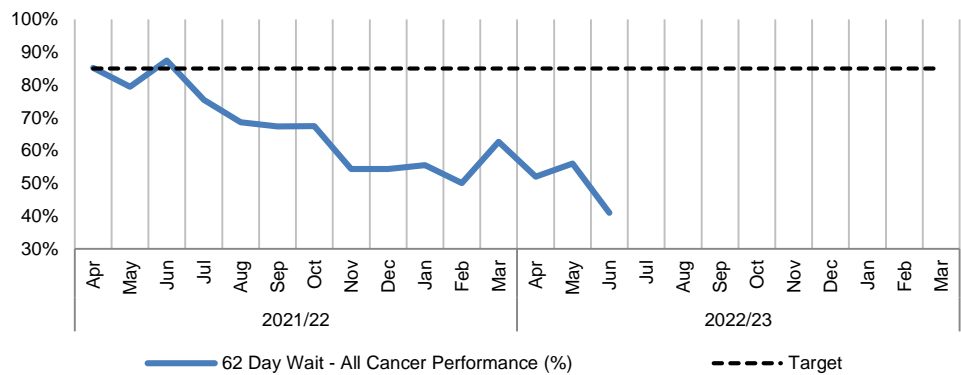
- Gynaecology have also run additional 2WW clinics in September, October and November and further additional capacity is planned throughout December.

## 28 Day Faster Diagnosis Standard

- The 2ww performance is directly impacting on ability to confirm diagnosis within 28 days.
- Several tumour sites are still struggling to achieve the 28 day faster diagnosis target and actions to support these services are being monitored as part of the Trust's Cancer Recovery Action Plan.
- Colorectal faster diagnosis breaches have significantly increased as a result of challenges with consultant and clinical nurse specialist appointment availability and access to endoscopy for colonoscopy diagnosis. A newly appointed Patient Navigator started in post on 1<sup>st</sup> September, providing dedicated support in tracking and escalating pathway delays in colorectal.
- Urology performance remains below target, however work has been completed to ensure that TURBT have been prioritised.
- Skin performance is expected to improve once the 2 week backlog has been cleared.
- Hysteroscopy capacity continues to be the main challenge in achieving 28 day FDS performance in Gynaecology. Additional activity is being put in place to support this.

# Northern Services Cancer 62 Day – Proportion of patients treated within 62 days following referral by a GP for suspected cancer

**Urgent GP Referral Cancer 62 Day Wait - All Cancers**

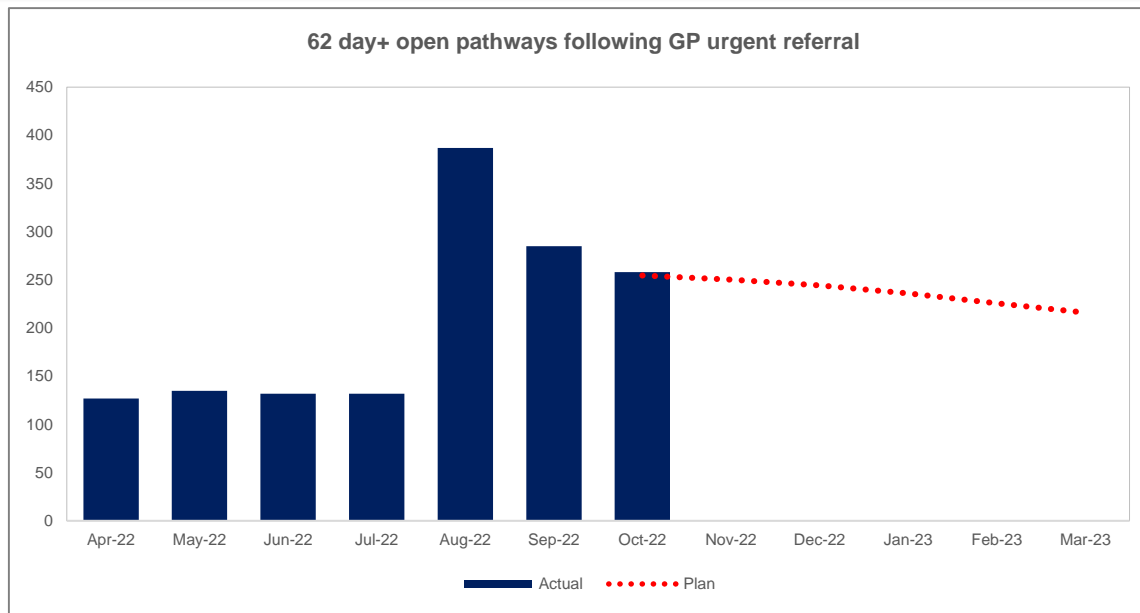


- Work has progressed to resolve data quality issues following the transition to Epic. The Trust will be re-submitting Quarter 2 submissions by the end of November and it is expected that 31 and 62 day performance will be routinely reported thereafter.
- Reports have been developed that identify pathology results and first chemotherapy treatments which now allows the Cancer Services team to identify more treatments for validation and reporting.
- Weekly meetings continue to review recovery in Dermatology and the number of patients waiting over 62 days has continued to reduce.
- Actions to recover the urology and colorectal positions are in place as part of the Cancer Recovery Action Plan and are monitored at the Northern Cancer Steering Group.

Cancer - 14,31 & 62 Day Wait		Target	2021/22												2022/23							
Performance(%) and Number of Breaches			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	
14 Day	All Urgent (%)	93%	79.44%	82.20%	79.29%	80.49%	83.25%	79.84%	81.06%	75.82%	77.89%	70.96%	75.14%	76.57%	75.44%	87.12%	87.89%	84.31%	64.36%	63.23%	63.50%	
	All Urgent (N)		120.0	105.0	148.0	133.0	103.0	150.0	132.0	163.0	159.0	183.0	172.0	190.0	154.0	102.0	86.0	83.0	299.0	285	254	
	Symptomatic Breast (%)	93%	6.56%	1.56%	0.00%	8.16%	0.00%	2.17%	0.00%	3.57%	1.75%	3.64%	7.58%	2.67%	8.70%	71.74%	79.31%					
	Symptomatic Breast (N)		57.0	64.0	40.0	45.0	16.0	46.0	11.0	54.0	56.0	53.0	61.0	73.0	42.0	13.0	12.0					
31 Day	All Decision To Treat (%)	96%	94.10%	98.98%	94.70%	96.11%	89.36%	86.59%	88.00%	82.22%	88.09%	83.65%	87.25%	84.11%	83.54%	81.80%	76.90%					
	All Decision To Treat (N)		6.0	2.0	4.0	3.0	6.0	11.0	9.0	16.0	10.0	17.0	13.0	17.0	12.0	17.0	15.0					
	Subsequent - Surgery (%)	94%	91.60%	94.11%	100.00%	90.00%	66.66%	60.00%	66.66%	91.66%	55.55%	41.66%	75.00%	71.42%	54.54%	20.00%	40.00%					
	Subsequent - Surgery (N)		2.0	1.0	0.0	1.0	4.0	4.0	3.0	1.0	4.0	4.0	2.0	4.0	5.0	4.0	3.0					
	Subsequent - Anti-Cancer Drug %	98%	100.00%	100.00%	100.00%	95.65%	83.33%	96.60%	92.59%	100.00%	95.83%	82.60%	90.32%	96.29%	96.15%	92.60%	94.40%					
Subsequent - Anti-Lancer Drug		0.0	0.0	0.0	1.0	5.0	1.0	2.0	0.0	1.0	4.0	4.0	1.0	1.0	2.0	1.0						
62 Day	All Screening Service (%)	90%	33.30%	0.00%	33.30%	33.30%	50.00%	44.44%	100.00%	66.60%	100.00%	33.00%	100.00%	28.57%	100.00%	75.00%	100.00%	100%				
	All Screening Service (N)		2.0	1.0	2.0	1.0	1.0	2.5	0.0	1.0	0.5	1.0	3.0	2.5	0.0	1.0	0.0	0				
	Consultant upgrade (%)	90%	72.05%	87.20%	96.25%	89.65%	76.74%	83.60%	67.34%	76.71%	78.73%	73.23%	80.00%	62.00%	57.44%	60.00%	74.50%					
	Consultant upgrade (N)		9.5	5.5	15	4.5	10.0	5.0	8.0	8.5	6.5	8.5	11.0	10.0	10.0	11.0	7.0					
28 day	28 Ref to diagnosis (%)	NA	62.60%	68.42%	63.98%	65.65%	63.38%	53.89%	59.82%	45.36%	40.26%	33.89%	60.55%	62.34%	57.47%	56.00%	45.80%	52.34%	40.90%	34.31%	41.83%	
	28 day Ref to diagnosis (N)		236.0	204.0	242.0	237.0	229.0	321.0	233.0	394.0	413.0	492.0	292.0	329.0	254.0	268.0	241.0	173.0	263.0	270	395	

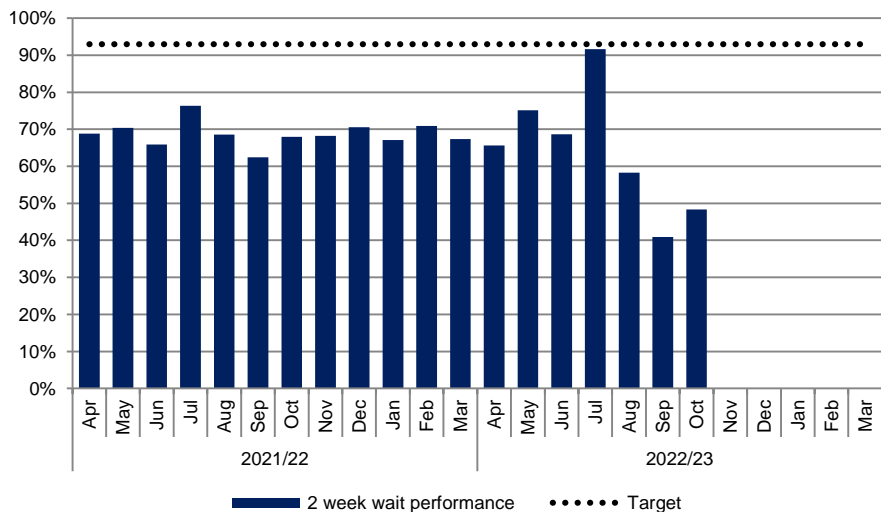
# Northern Services Cancer Long Waits

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

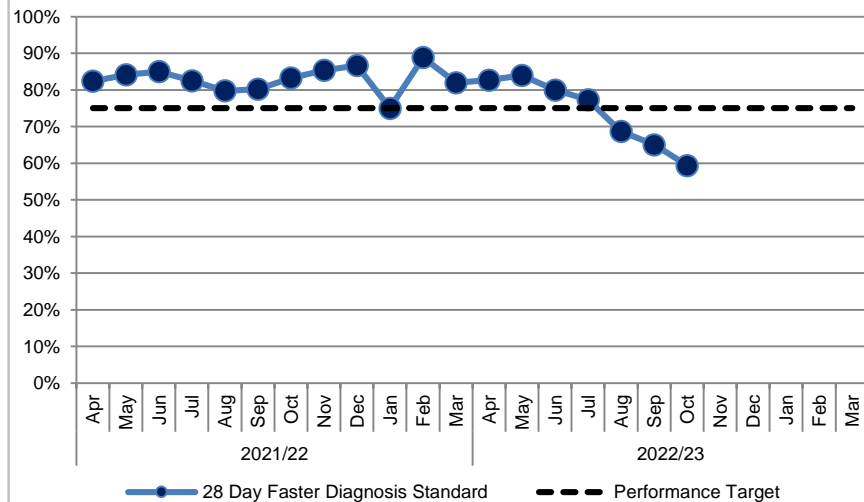


- The number of patients on active cancer pathways waiting more than 62 days has reduced from 415 at the start of September to 258 at the end of October. The tumour sites with the largest number of patients waiting over 62 days are Dermatology, Urology and Colorectal. It is worth noting that Breast had no patients waiting over 62 days which represents good progress.
- Weekly meetings continue to review recovery in Dermatology and as a result of extra insourced capacity, the number of patients waiting over 62 days is forecast to reduce from 270 in September to 68 by the end of November.
- Colorectal, Urology and Upper GI continue to be areas of concern due to challenges at all stages of the patient pathway: endoscopy capacity remains the most significant challenge for colorectal and upper GI tumour sites. Additional endoscopy capacity through the use of additional insourcing is being planned. Actions to recover the urology and colorectal and Upper GI positions are in place as part of the Cancer Recovery Action Plan and are monitored at the Northern Cancer Steering Group.

### 2 Week Wait Performance



### 28 Day Faster Diagnosis Standard



## 2 Week Wait Performance

- Performance has reduced since August due largely to increased demand. Support has been requested from the Cancer Alliance with Primary Care with regards to insuring FIT Tests are completed pre-referral. The Triage Team are in the process of identifying GP Practices who need additional education and support and will offer targeted training session.
- Bids have been submitted for additional support at Referral/triage stage of the pathway. Exploration of additional mutual aid is underway.
- There has been a significant improvement in Breast 2WW Performance in October – this is expected to continue into November.
- Head & Neck pathway remains challenged, scope underway to identify opportunity for work to move from Medical to Nursing staff to free Medical capacity. Capital has been secured to support additional capacity within the Thyroid Pathway – currently looking at additional ways to resource Cytology.
- Skin 2WW referrals by financial year details a 42% increase in demand over 3 years – Plans have been submitted to convert space in Heavitree for additional clinic rooms. Specialist Pharmacist has been appointed in October with the plan to release Medical capacity within the 2WW pathway.

## 28 Day Faster Diagnosis Standard

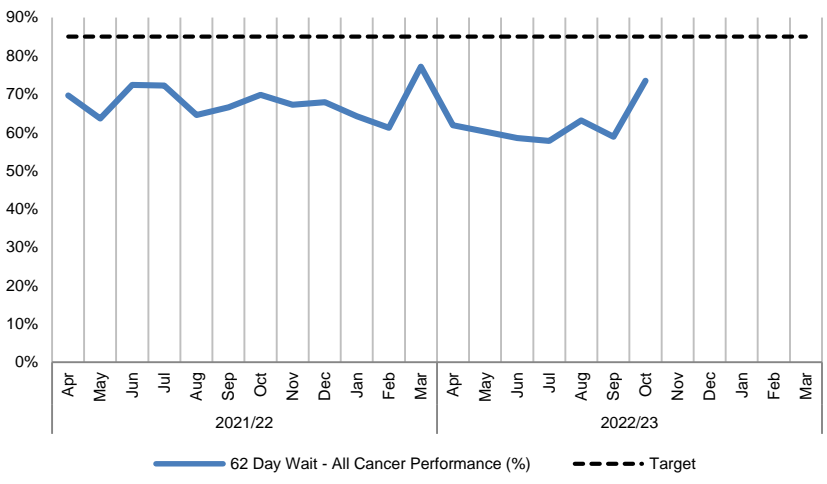
- Performance for September and October reported above is likely to under-represent the true position due to delays in validating the pathways. It is anticipated that in the next report, performance over these months will be shown to have improved back to nearer 70%.
- Colorectal is impacted by a current 4-5 week wait for 2WW colonoscopy. Currently working on a process map of the entire Colorectal pathway to review and understand where small gains in waiting time improvement can be achieved. The regional NHSEI Cancer Improvement Lead has offered support to map the pathways and identify improvements with the clinical team.
- Capacity in Gynaecology has increased, however, demand has increased at a greater rate since August. There is potential for increasing hysteroscopy capacity through externally provided resource from the Cancer Alliance. It is anticipated that this may become available in November.

# Eastern Services Cancer 62 Day

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

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

**Urgent GP Referral Cancer 62 Day Wait - All Cancers**



Performance against the 62 Day Cancer Target improved by 8.1% to 72.92% in October.

**Risks & mitigations**

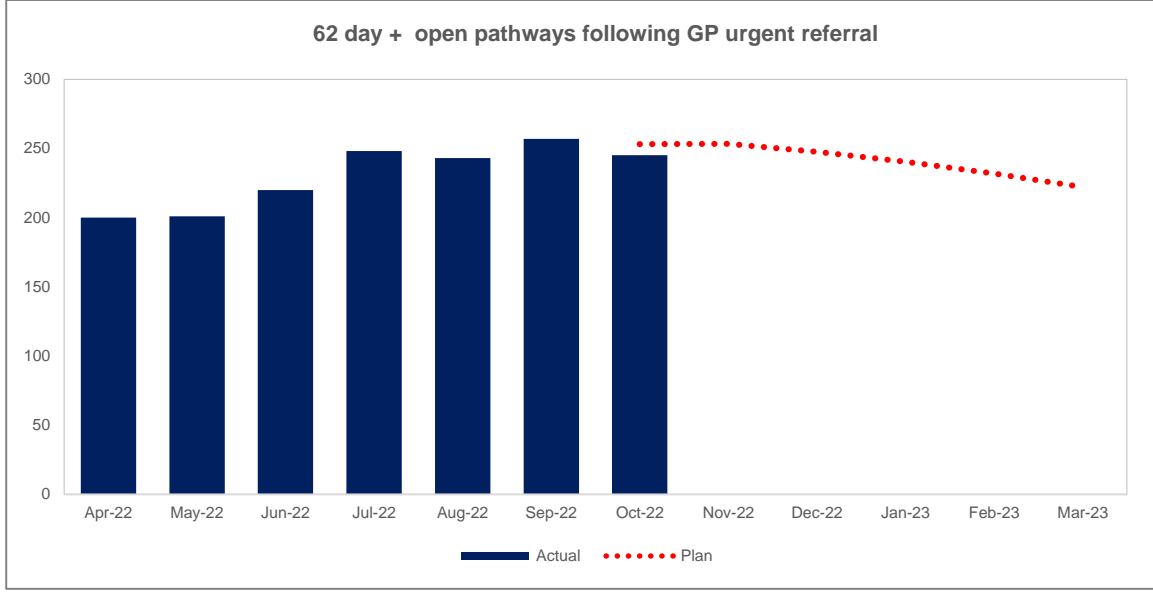
- Radiology and Histology waits: Histopathologist posts increase in early 2023/24
- Increased demand for US/CT guided biopsy causing some delays, for which mitigation has been put in place.
- Delays in Urology are due to insufficient clinic and RALP capacity to match the increase in demand, including tertiary referrals. Various staffing solutions are planned including additional registrars starting mid-October, use of CNS capacity to undertake biopsies and triage as well as reimplementing the Health and Wellbeing clinics. An additional robot has been requested as part of the end of year capital.
- New theatre timetable has been implemented which will increase theatre capacity for GI services.
- Oncology - no longer able to absorb capacity required to implement new statutory NICE guidance for patients when this is released. Since April 2021 there have been 59 new NICE TAGs released in Oncology and Haematology with a further 11 currently in consultation. Designated Oncology meetings being set up across the Peninsula to agree mitigations.

**Cancer - 14, 31, 62 & 104 Day Wait**

Performance(%) and Number of Breaches	TARGET	2021/22												2022/23							
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	
14 Day	All Urgent (%)	93%	68.9%	70.4%	65.9%	76.3%	68.6%	62.5%	68.0%	68.2%	70.5%	67.1%	70.9%	67.3%	65.6%	75.1%	68.7%	91.7%	58.3%	40.9%	48.3%
	All Urgent		650	600	833	514	665	841	702	723	642	622	580	781	759	601	677	151	1019	1430	1236
	Symptomatic Breast (%)	93%	3.7%	14.9%	8.7%	42.0%	30.4%	8.1%	29.0%	11.3%	7.9%	15.8%	35.8%	13.3%	20.9%	36.8%	86.2%	93.1%	62.9%	16.7%	41.5%
	Symptomatic Breast		52	57	63	29	32	57	49	47	58	48	34	65	34	43	4	2	13	30	24
31 Day	All Decision To Treat (%)	96%	96.8%	97.4%	94.2%	94.0%	93.1%	91.5%	95.2%	91.0%	93.2%	92.0%	92.4%	92.9%	88.5%	87.2%	87.4%	84.7%	89.6%	87.5%	93.5%
	All Decision To Treat		9	7	18	18	19	24	14	29	22	23	19	19	31	40	35	36	19	22	23
	Subsequent - Surgery (%)	94%	83.1%	81.9%	77.3%	88.5%	76.5%	87.5%	85.4%	79.5%	72.7%	75.6%	76.5%	62.8%	63.8%	67.1%	76.0%	75.9%	68.6%	62.9%	79.1%
	Subsequent - Surgery		12	15	17	9	16	11	12	16	24	19	19	29	29	26	25	20	16	26	18
	Subsequent - Radiotherapy (%)	94%	99.3%	100.0%	97.1%	99.2%	98.3%	99.2%	100.0%	97.1%	100.0%	97.7%	99.2%	99.1%	100.0%	99.2%	95.8%	98.8%	97.4%	98.5%	99.4%
	Subsequent - Radiotherapy		1	0	4	1	2	1	0	4	0	3	1	1	0	1	4	1	2	1	1
62 Day	All Screening Service (%)	90%	96.8%	98.5%	100.0%	100.0%	100.0%	100.0%	98.7%	98.9%	98.6%	97.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.1%	100.0%	98.7%
	All Screening Service		3	1	0	0	0	0	1	1	1	2	0	0	0	0	0	0	2	0	1
104 days	All Screening Service (%)		0.0%	16.7%	0.0%	0.0%	15.4%	50.0%	100.0%	15.4%	14.3%	33.3%	0.0%	0.0%	12.5%	16.7%	33.3%	0.0%	0.0%	0.0%	21.7%
	All Screening Service		2	5	5.5	3	5.5	4	0	5.5	6	2	5	3	3.5	2.5	2	2	2	1	9
104 days	Volume of Patients Waiting Longer than 104 Days at Month End		33	42	42	32	45	36	36	38	46	39	37	40	52	53	70	68	58	69	54

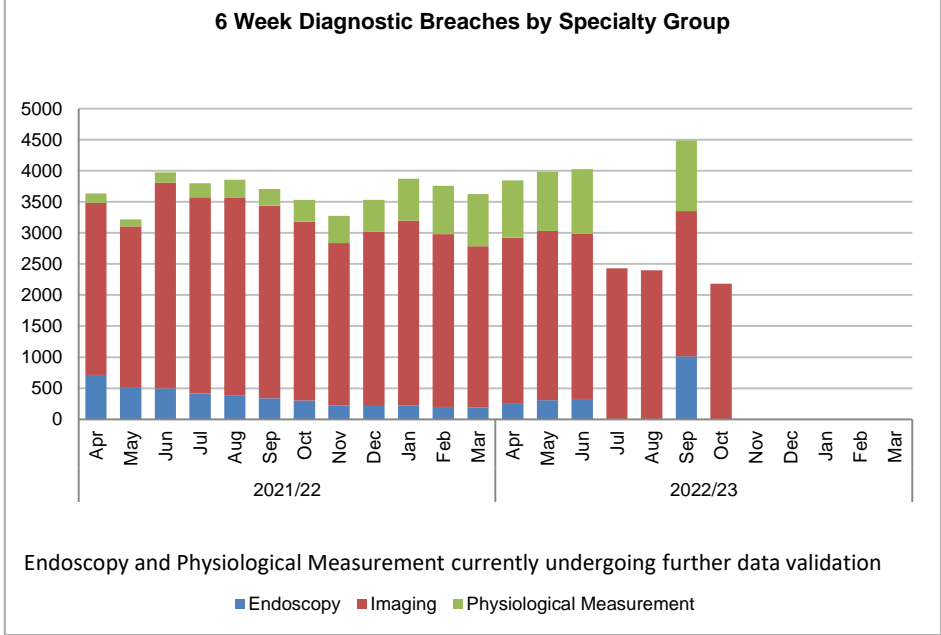
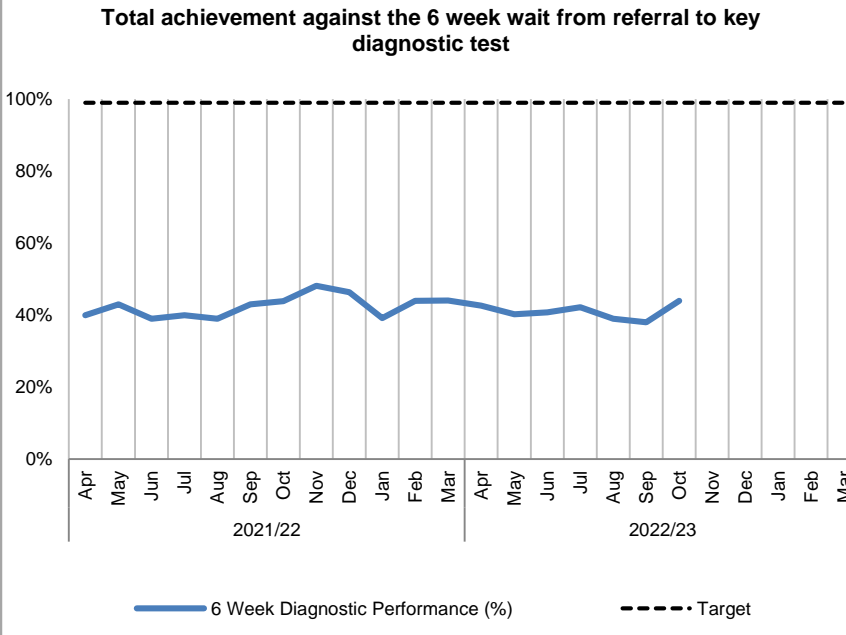
# Eastern Services Cancer Long Waits

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



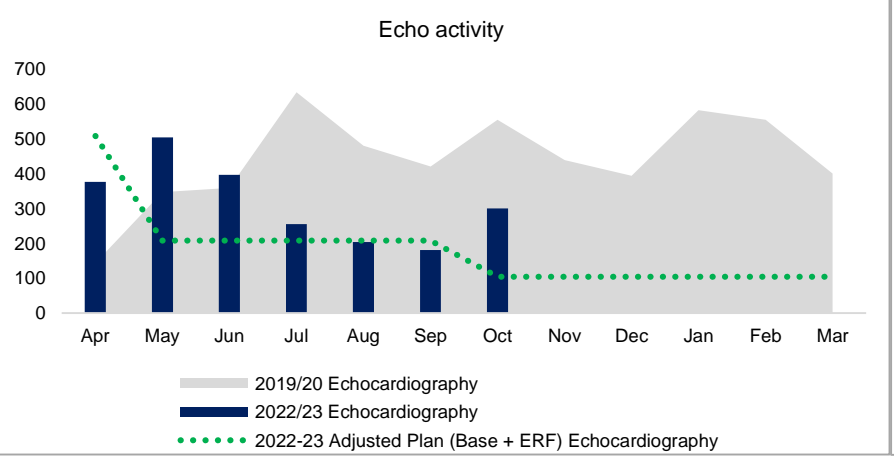
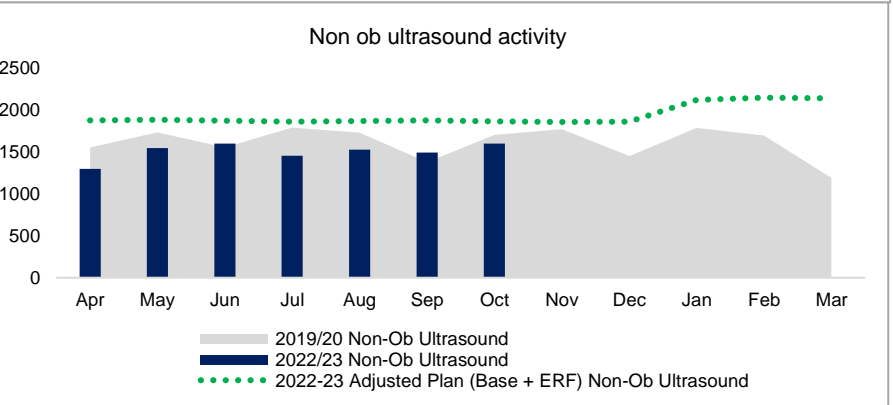
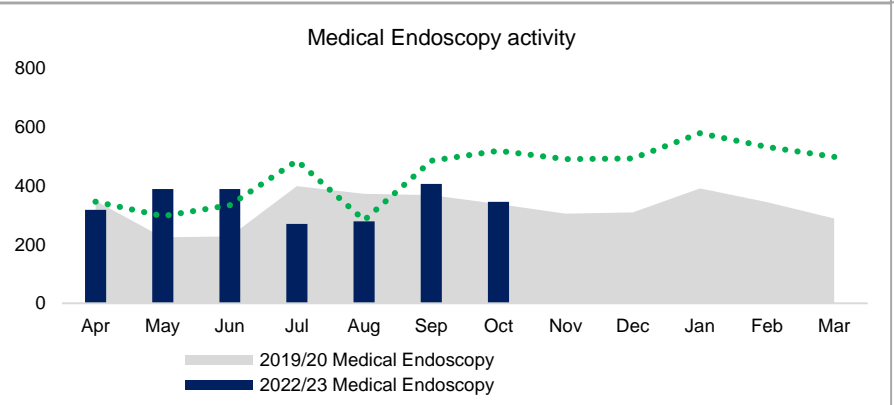
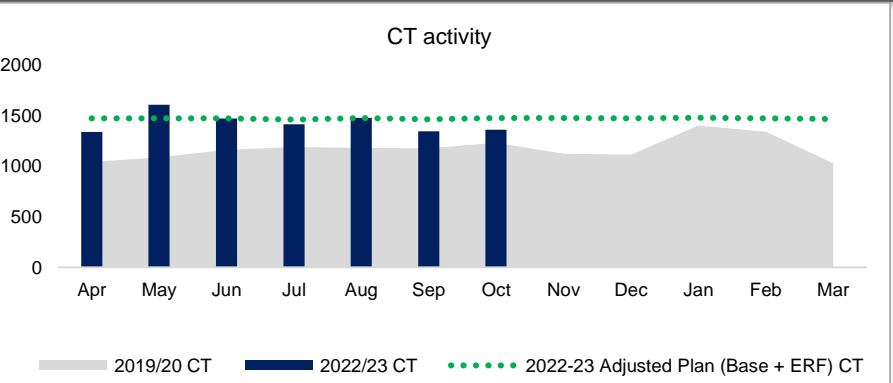
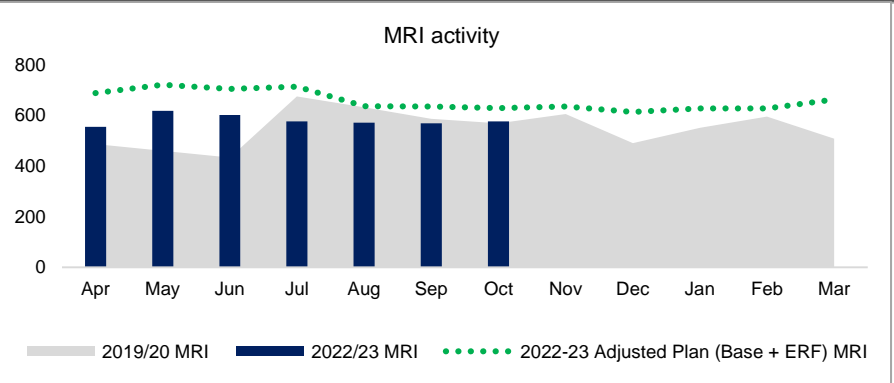
- 9.8% of cancer patients waiting for treatment at the end of October had waited longer than 62 days ( NHSE benchmark 6.4%; peninsula performance 11.2%).
- The number of patients waiting for treatment is significantly higher than plan reflecting the impact of increased demand
- In addition a reporting issue during November resulted in the overall PTL and those >62 days showing a stepped increase – intensive validation is in progress and will be complete by 4<sup>th</sup> December. Early results show less than 1% of cases actually needed to be added back to the list. Reviews for potential harm have not identified any issues to date.
- Actions to resolve:
  - Additional support and scrutiny to PTLs to ensure every opportunity is taken to resolve or escalate delays
  - Additional Director of operations close oversight of long waiters and data quality processes

# Northern Services Diagnostics - Fifteen key diagnostic tests



		Achievement against the 6 week wait from referral to key diagnostic test																			
Area	Diagnostics by Specialty	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	
Imaging	Magnetic Resonance Imaging	52.2%	62.2%	47.4%	55.4%	54.8%	59.6%	64.9%	69.5%	62.2%	51.8%	69.1%	74.9%	96.5%	96.7%	94.6%	97.7%	100.0%	100.0%	99.4%	
	Computed Tomography	61.3%	68.9%	66.1%	62.2%	64.2%	64.5%	66.1%	61.4%	60.4%	48.0%	56.8%	53.0%	55.6%	55.2%	64.7%	65.2%	56.1%	66.8%	81.9%	
	Non-obstetric ultrasound	32.2%	29.6%	24.1%	25.2%	25.4%	28.9%	27.0%	37.6%	35.4%	32.1%	36.1%	40.1%	35.2%	32.9%	30.9%	33.1%	35.2%	35.2%	35.8%	
	Barium Enema	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	DEXA Scan	12.0%	15.3%	15.5%	12.2%	14.5%	14.6%	12.5%	11.7%	11.9%	10.0%	12.6%	12.4%	11.6%	10.7%	10.5%	11.5%	14.6%	13.8%	14.5%	
Physiological Measurement	Audiology - Audiology Assessments	89.9%	97.5%	98.3%	98.3%	99.2%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-	-	-	-	-
	Cardiology - echocardiography	96.0%	99.6%	96.7%	84.8%	67.6%	67.9%	58.6%	57.5%	53.2%	37.1%	37.6%	36.2%	31.4%	26.6%	28.3%	-	-	-	-	-
	Cardiology - electrophysiology	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Neurophysiology - peripheral neurophysiology	90.5%	95.5%	71.2%	56.3%	48.1%	70.2%	86.6%	94.3%	95.5%	81.6%	90.5%	96.4%	96.3%	96.8%	92.5%	-	-	-	88.5%	-
	Respiratory physiology - sleep studies	47.5%	57.7%	41.0%	73.9%	89.3%	68.8%	57.8%	50.9%	49.0%	50.4%	32.4%	29.3%	22.5%	34.3%	30.8%	-	-	-	17.4%	-
Urodynamics - pressures & flows	23.1%	36.2%	30.4%	21.9%	18.6%	37.7%	49.4%	51.4%	45.1%	44.6%	35.8%	25.9%	20.4%	25.4%	23.3%	-	-	-	1.4%	-	
Endoscopy	Colonoscopy	42.9%	38.2%	32.5%	38.7%	35.8%	47.1%	54.7%	51.5%	61.6%	72.3%	85.0%	72.0%	62.3%	48.6%	43.8%	-	-	-	27.6%	-
	Flexi sigmoidoscopy	46.6%	42.1%	39.3%	40.7%	42.9%	52.5%	55.7%	64.6%	74.4%	70.4%	84.2%	74.6%	64.8%	71.8%	70.3%	-	-	-	28.5%	-
	Cystoscopy	28.7%	42.4%	41.7%	46.6%	43.8%	55.5%	51.1%	62.6%	59.1%	51.8%	51.9%	63.9%	67.0%	75.6%	73.3%	-	-	-	59.8%	-
	Gastroscopy	37.3%	41.4%	39.7%	56.9%	49.2%	61.0%	65.9%	81.8%	86.4%	83.7%	87.4%	82.0%	70.9%	61.9%	60.8%	-	-	-	53.1%	-
<b>Total</b>		38.9%	43.2%	39.4%	40.3%	39.1%	42.7%	43.9%	48.2%	46.4%	39.2%	43.9%	41.1%	42.6%	40.2%	40.8%	42.2%	39.0%	38.0%	44.0%	

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





Although all modalities other than hearing assessments and echocardiograms were included in reporting in October, subsequent to this data quality issues were identified. As a result this month's report has reverted to a snapshot for non-radiological modalities whilst these data quality issues are corrected.

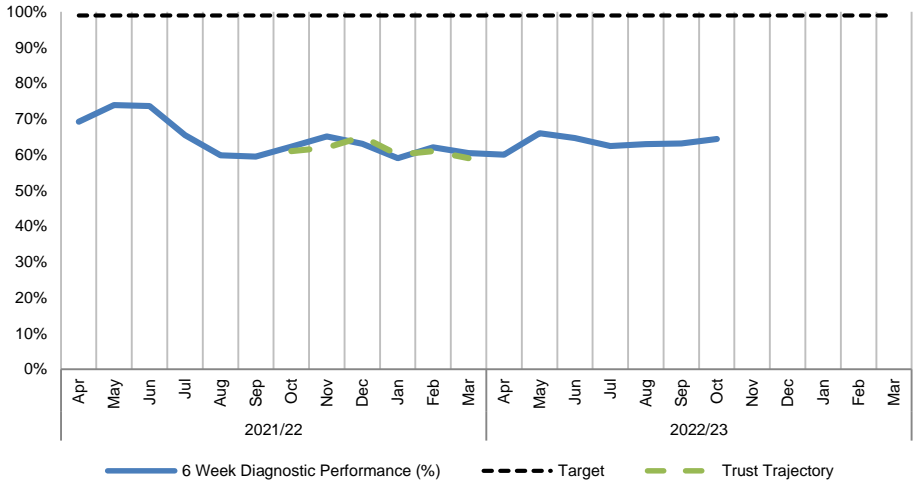
Key issues at modality level:

- **MRI** – Whilst activity is below plan, demand is being met and patients are being offered scans within 3-4 weeks.
- **CT – Non-Cardiac CT** – Whilst activity is below plan it is meeting demand with patients being offered scans within 6 weeks. In October how there has been an increase in 2 week wait referrals which will affect this position. As a result, increased capacity through mobile services and the Nightingale is also being explored. Additional cardiac CT lists have been taking place in October and November providing additional capacity of 100 scans and a further day is scheduled in December. CT cardiac lists at RD&E have been agreed, providing an additional 14 scans per session commencing in early December and continuing until the end of March 2023
- **U/S**- Outsourcing capacity is currently being explored and funding has been sourced for 1200 scans to be used before end of March 2023
- **DXA** – An SLA is in place with Taunton for one list per month only due to the difficulties in sourcing patients who are able to agree to travel to attend these clinics. Discussions are also taking place with Eastern Services who could potentially offer scan in Exeter.
- **Endoscopy** - Consultant Gastroenterologist vacancies and nursing sickness remains a key constraint. A bi-weekly Task and Finish Group has been set up to review ongoing data quality post Epic implementation and to review utilisation of lists. Current capacity is ringfenced for cancer and urgent cases only with a further 2 insourcing weekends per month booked until the end of December 2022.
- **Cystoscopies** – Capacity remains a challenge due to the increasing levels of referrals to service. Additional support has been sought from radiology delivering an additional 5 slots a week to bring the service back to booking within 2 weeks and sustaining performance. Service is also investigating insourcing to support an additional weekend a month scanning list which will equate to 44 additional patients per weekend , reducing backlog and maintaining demand.
- **Echocardiogram** – Inpatient demand for ECG continues to outstrip capacity. Service currently supporting 13 additional lists per month with a total of 11 patients per session. A data cleanse of 1130 patients is being undertaken to rationalize testing following a recent review of inappropriate and duplicate requests throughout Reset week.

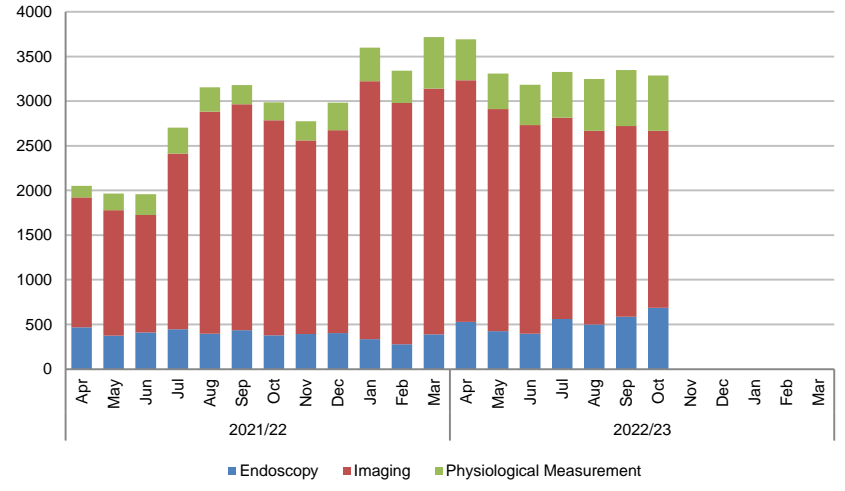
# Eastern Services Diagnostics

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

### 6 Week Wait Referral to Key Diagnostic Test



### 6 Week Diagnostic Breaches by Specialty Group



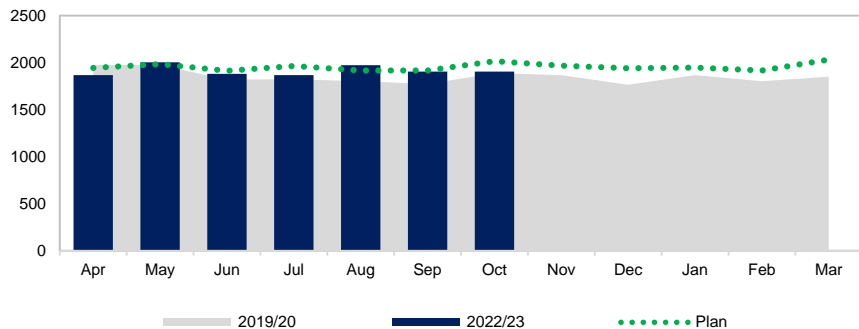
Area	Diagnostics By Specialty	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Endoscopy	Colonoscopy	54.3%	52.0%	66.9%	73.3%	67.0%	57.1%	64.7%	66.5%	64.0%	63.5%	58.3%	51.6%
	Cystoscopy	67.1%	86.3%	86.0%	71.9%	88.6%	83.1%	82.8%	95.2%	91.5%	88.9%	93.2%	87.4%
	Flexi Sigmoidoscopy	61.4%	50.0%	59.1%	74.8%	61.6%	59.6%	73.0%	76.2%	74.6%	74.5%	62.2%	51.3%
	Gastroscopy	75.7%	73.1%	70.5%	76.8%	61.7%	57.2%	68.0%	72.4%	56.7%	68.7%	68.0%	69.8%
Imaging	Barium Enema	-	-	-	-	-	-	-	-	-	-	-	-
	Computed Tomography	51.5%	50.2%	53.8%	48.7%	58.0%	64.3%	73.2%	76.8%	77.1%	81.3%	85.4%	89.5%
	DEXA Scan	84.8%	93.7%	96.0%	99.2%	88.0%	97.8%	97.1%	98.9%	98.4%	98.2%	99.4%	99.2%
	Magnetic Resonance Imaging	61.9%	58.0%	58.1%	65.8%	64.9%	66.3%	73.9%	74.3%	69.6%	69.1%	72.9%	73.7%
	Non-obstetric Ultrasound	67.3%	66.0%	51.6%	56.9%	53.3%	51.6%	55.1%	51.6%	53.1%	52.7%	51.2%	54.5%
Physiological Measurement	Cardiology - Echocardiography	79.6%	75.8%	82.9%	84.1%	88.3%	82.1%	86.2%	80.9%	74.5%	71.4%	72.7%	75.2%
	Cardiology - Electrophysiology	-	-	-	-	-	-	-	-	-	-	-	-
	Neurophysiology - peripheral neurophysiology	84.2%	68.9%	63.9%	71.9%	54.5%	52.9%	73.2%	69.6%	72.5%	67.1%	61.2%	55.4%
	Respiratory physiology - sleep studies	81.9%	71.8%	57.7%	60.5%	65.5%	60.6%	67.6%	68.3%	60.0%	58.6%	65.8%	61.4%
	Urodynamics - pressures & flows	84.8%	76.7%	38.3%	35.2%	29.6%	26.0%	30.1%	30.3%	34.5%	28.6%	26.9%	25.7%
<b>Total</b>		65.1%	63.0%	59.0%	62.1%	60.5%	60.0%	66.0%	64.7%	62.4%	63.0%	63.2%	64.4%

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

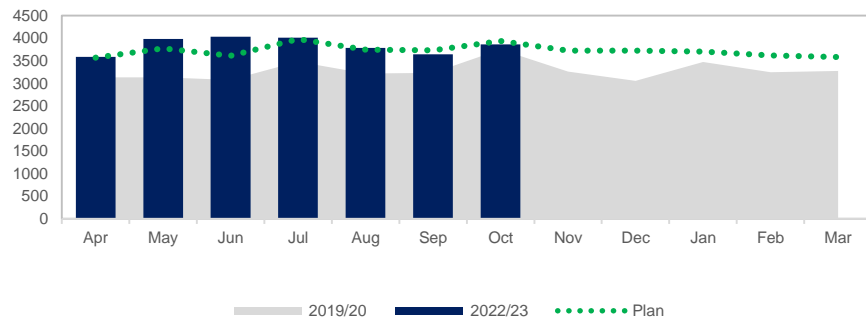
# Eastern Services Diagnostics

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

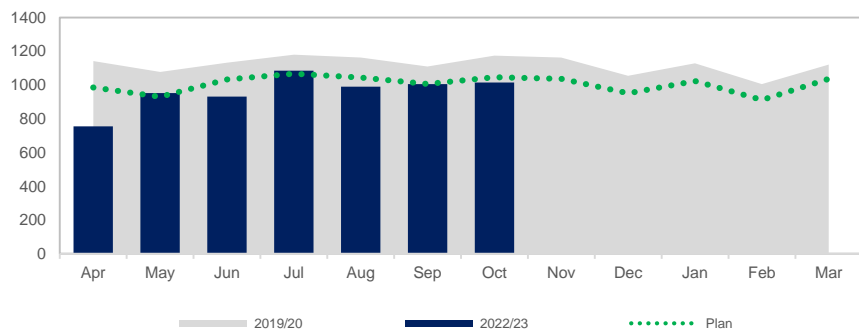
### MRI Activity



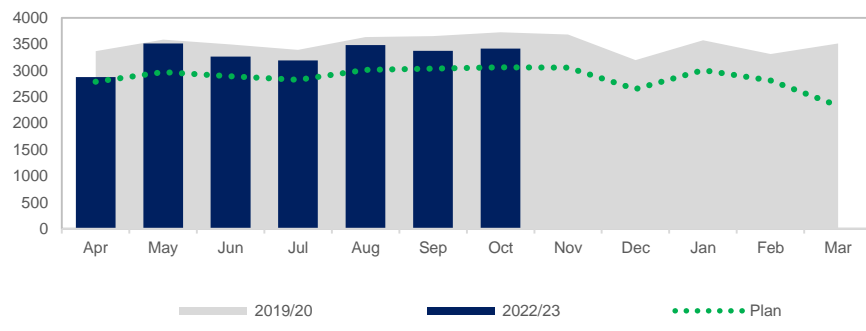
### CT Activity



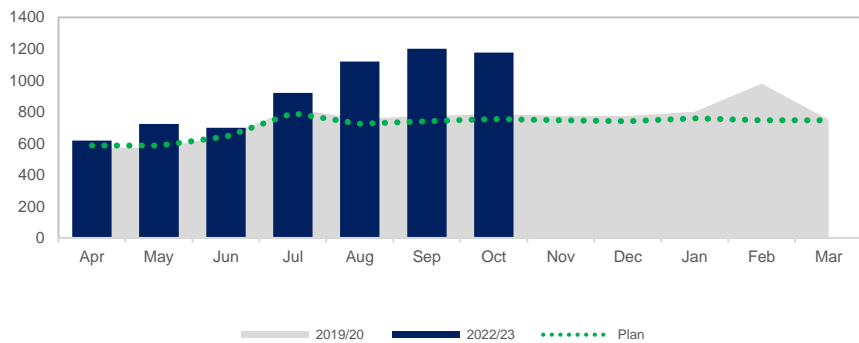
### Medical Endoscopy Activity



### Non-Obstetric Ultrasound Activity



### Echocardiography Activity



# Eastern Services Diagnostics

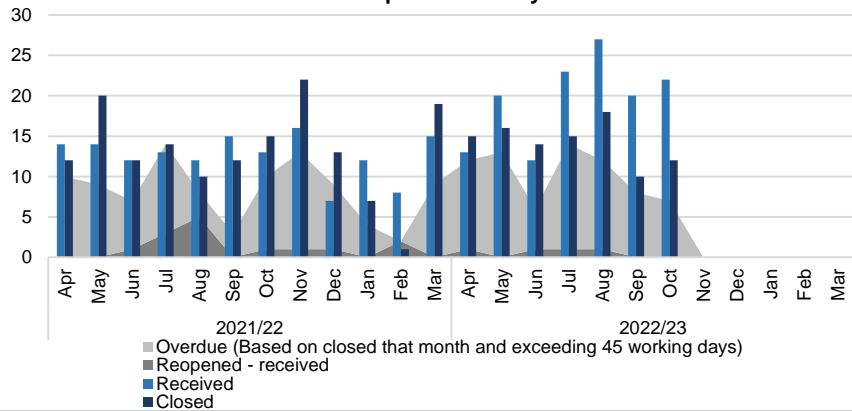
Volumes of patients waiting longer than 6 weeks for one of fifteen key diagnostics tests

At the end of October, 64.4% of patients on the diagnostic waiting list had waited less than 6 weeks, an improvement of 1.2% from September.

- **CT** - Projected activity levels suggest a deteriorating breach picture during November and December resulting from reduced OP activity during the earlier months. This is expected to peak in December with recovery then projected week by week
- **MRI** –recovery plans include taking up Torbay’s underutilised capacity at the CDC & optimising weekend capacity
- **Non Obstetric US** – key issue MSK. NHSEI approved funding for all CDC equipment which will provide additional capacity during Q4. Plan also to convert some reporting sessions to MSK US lists.
- **Endoscopy** – super weekends continue to deliver additional activity. Longer term plans are progressing for the expansion of rooms at Tiverton.
- **Echo** – ERF will fund outsource 260 additional outsourced echo which will improve the DM01 position from November
- **Neuro** – workforce redesign to utilise additional physical capacity underway.

# Northern Services Patient Experience

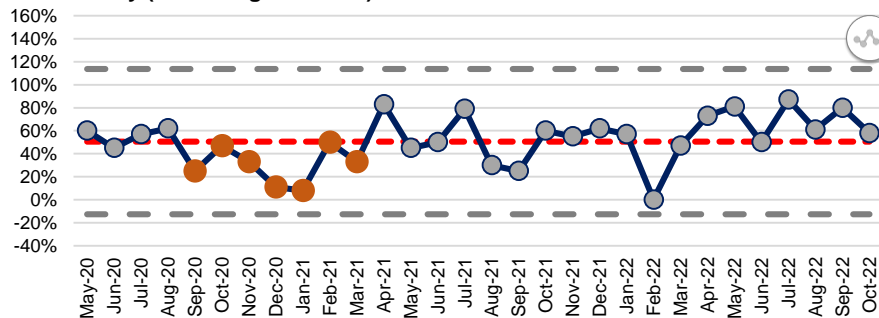
Complaints Activity



**Standards:**

- Performance against the improvement trajectory for complaints had deteriorated slightly at the end of Q2, with the number of complaints open over 45 working days more than expected. This is attributed to the ongoing complexity of the complaints currently open, and the increase in numbers of complaints received.
- A complaints action plan has been developed to address the backlog of overdue complaints and to ensure actions are in place to support ongoing improvement work.
- During Q2, the top 5 themes for complaints received in Northern were:
  - Communications
  - Patient care
  - Clinical treatment – surgical group
  - Admissions and discharges
  - Values and behaviours
- The complaints action plan, alongside trends and themes of complaints, are monitored through the Patient Experience Committee.

45 Day (Percentage overdue) - 01/05/20 - 01/10/22



Oct-22

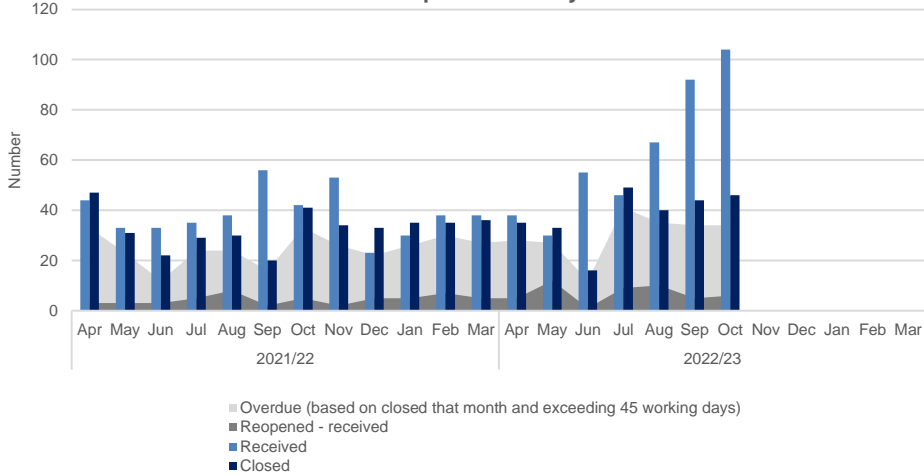
Current stage			Closed
Primary investigations currently open	Dispute resolutions requested	Detailed investigations currently open	Number of PHSO investigations closed during Aug 22
Northern	4*	1	1

\* one case is joint with Eastern services

		2021/22												2022/23						
Month		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Complaints Timeliness	Complaint received acknowledged within 3 Day	92%	100%	100%	93%	100%	100%	100%	100%	92%	100%	100%	95%	93%	100%	100%	96%	100%	100%	100%
	45 Day (Percentage overdue)	83%	45%	50%	79%	30%	25%	60%	55%	62%	57%	0%	47%	73%	81%	50%	87%	61%	80%	58%
	Over 6 Months	17%	0%	0%	7%	0%	0%	7%	9%	8%	0%	0%	5%	7%	25%	0%	0%	0%	20%	0%

# Eastern Services Patient Experience

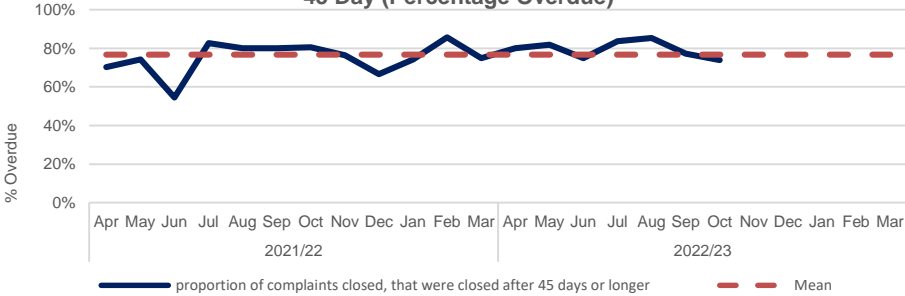
Complaints Activity



**Standards:**

- Due to a change in process (to bring Royal Devon in line with the new complaints standard) implemented on 1 September 2022, all concerns received by the patient experience department are logged as a complaint. This has resulted in a continued rise in the numbers of complaints logged.
- It has been recognised nationally, through the Parliamentary & Health Service Ombudsman (PHSO), that this change in process will result in a rise in complaints.
- A complaints action plan has been developed to address the backlog of overdue complaints and to ensure actions are in place to support ongoing improvement work.
- During Q2, the top 5 themes for complaints received in Eastern were:
  - Communication with patient
  - Appointment delay (Inc. length of wait)
  - Communication with relatives/carers
  - Care needs not adequately met
  - Wait for operation/procedure
- The complaints action plan, alongside trends and themes of complaints, are monitored through the Patient Experience Committee.
- By end of Q2, good initial progress has been made with reducing the most overdue complaints with outcomes tracking above the expected improvement trajectory.

45 Day (Percentage Overdue)

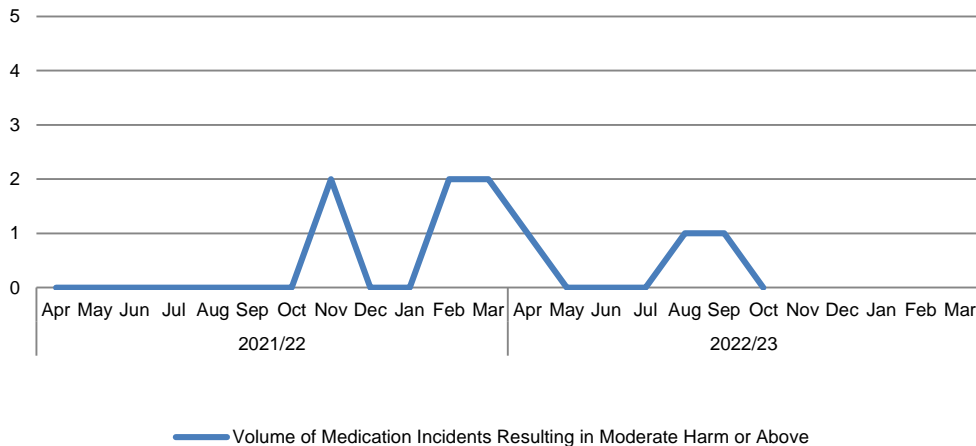


Number of new PHSO investigations received during month	Primary investigations currently open	Detailed investigations currently open	Number of PHSO investigations closed during month
2	4	0	2

Month	2021/22												2022/23						
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Complaint received and acknowledged within 3 days	93.88%	94.87%	94.44%	100.00%	96.08%	95.31%	94.12%	96.55%	89.66%	94.59%	95.83%	88.00%	84.78%	69.57%	67.27%	86.99%	97.01%	70.00%	74.00%
45 Day (Percentage overdue)	70.21%	74.19%	54.55%	82.76%	80.00%	80.00%	80.49%	76.47%	66.67%	74.29%	85.71%	75.00%	80.00%	81.82%	75.00%	83.67%	85.37%	77.27%	73.91%
Over 6 months	2	2	0	4	1	1	4	3	3	6	3	5	11	8	4	12	10	10	16

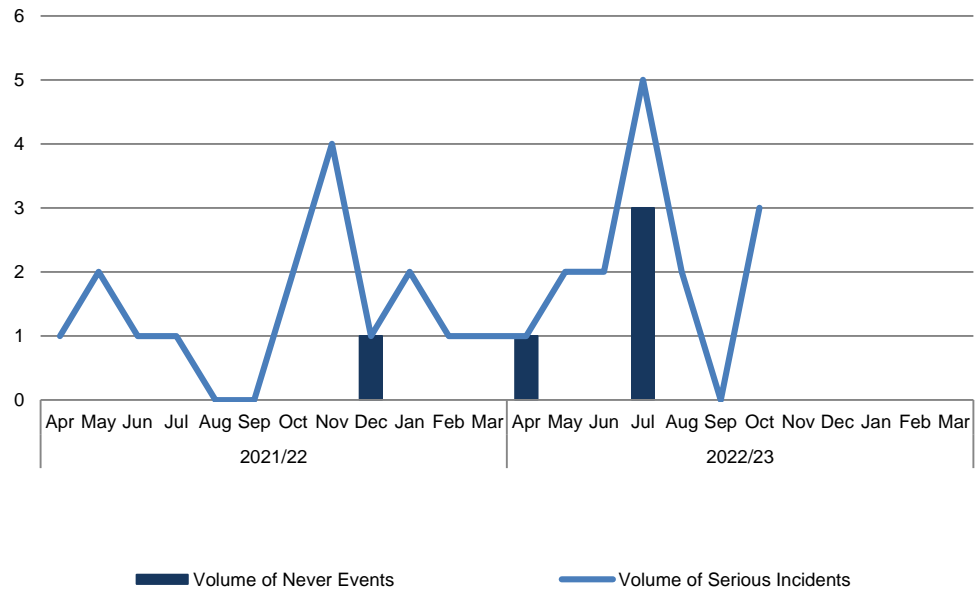
# Northern Services Incidents

### Medication Incidents - Moderate Harm & Above



In October 2022 there were no medication errors reported.

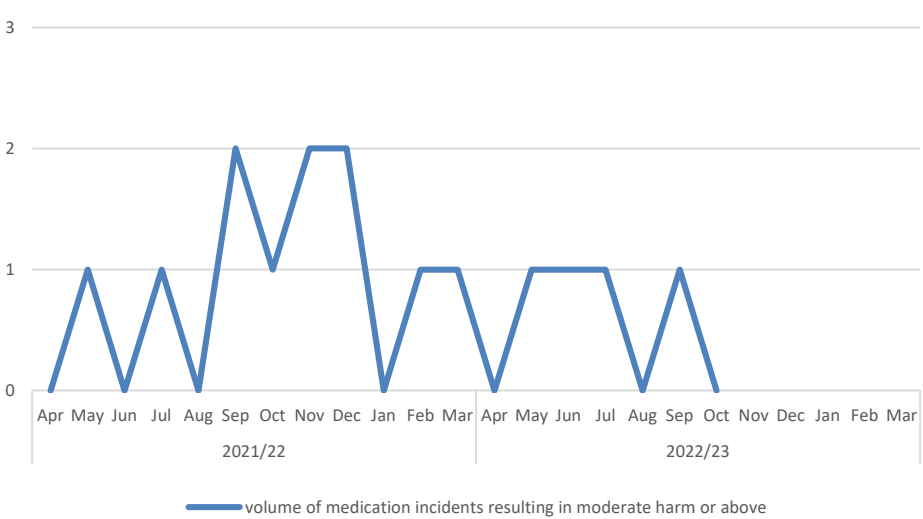
### Serious Incidents & Never Events



In October 2022 there were three incidents escalated for investigation as Serious Incidents.

# Eastern Services Incidents

Medication Incidents - Moderate harm and above

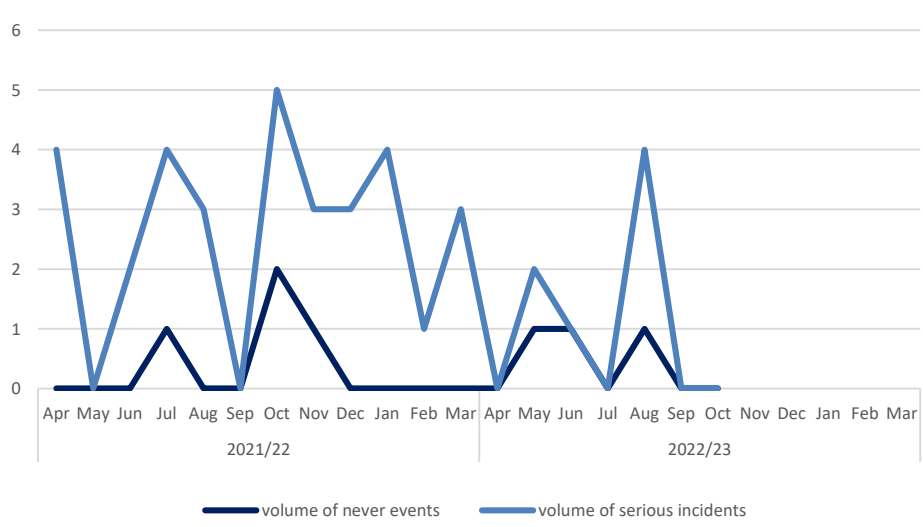


Although no Serious Incidents or Never Events were reported on the Strategic Executive Information System (StEIS) in October 2022 this was due to an issue on the StEIS Platform which prevented successful upload of data.

There were two Serious Incidents, both of which were Never Events in October 2022:

Type of Never Event	Patient Harm	Patient Outcome	Comments
Retained Swab	No Harm	Discharged as planned	Dental procedure. No failures of any previously identified actions from Never Events contributed to the incident.
Wrong Site Surgery	Low Harm	Discharged as planned	Urology Procedure. No failures of any previously identified actions from Never Events contributed to the incident.

Serious Incidents and Never Events



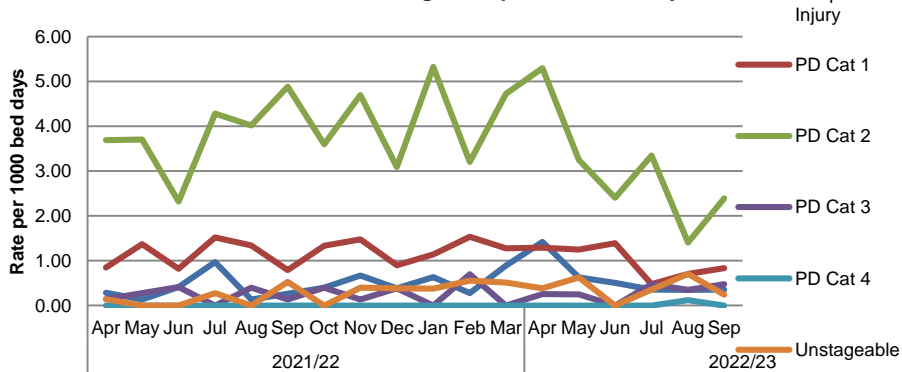
The Trust has worked in partnership with NHS England to resolve the StEIS platform issues and the Never Events listed above will display as reported in next months IPR.



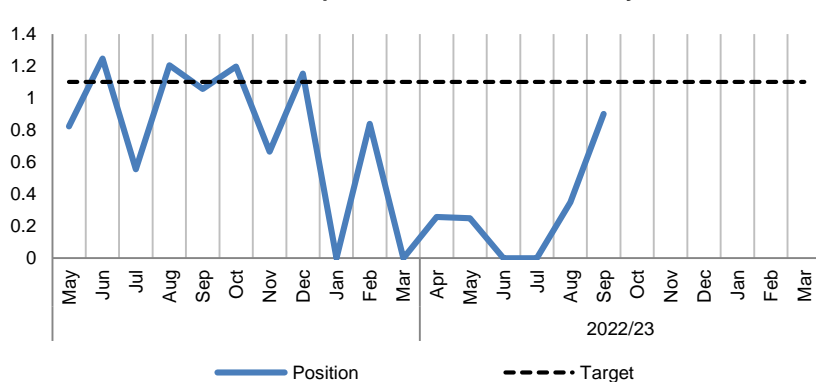
# Northern Services Pressure Ulcers – Rate of pressure ulceration experienced whilst in Trust care



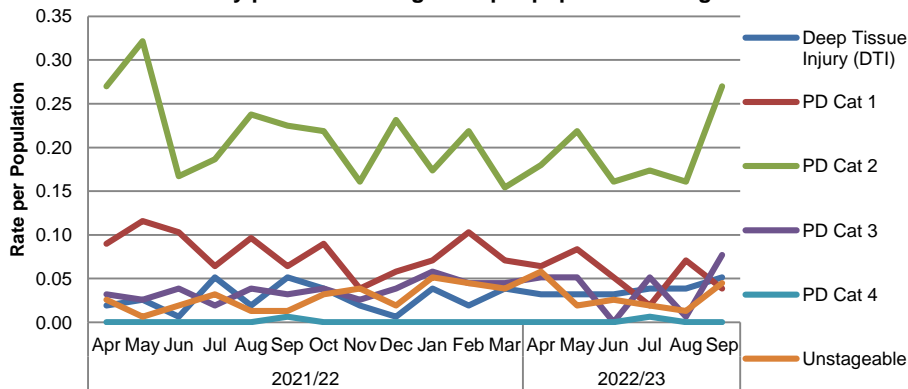
**NDHT Pressure damage rate per 1000 bed days**



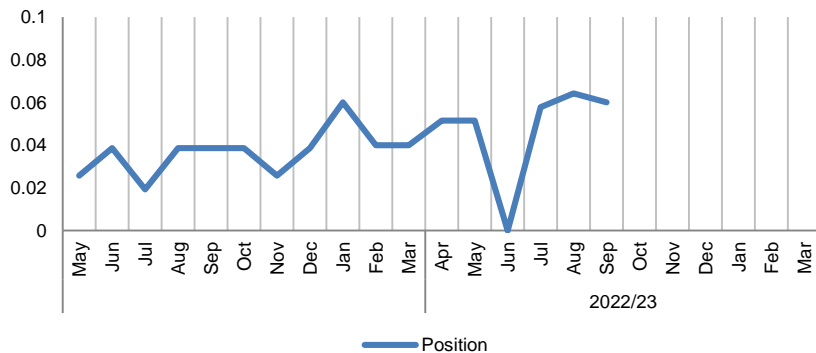
**Rate of Grade 3- 4 pressure Sores /1000 bed days Acute**



**Community pressure damage rate per population and grade**



**Community Nursing and population: Newly Identified Pressure Ulcers - Grade 3 - 4**



**Acute** – in September there was an increase in the total number of health acquired pressure ulcers reported. There was an increase in healthcare acquired category 3 pressure ulcers in September which are subject to investigation. No common themes have been identified to date.

**Community** – in September 2022 the number of total health acquired pressure ulcers within the community remained the same and also saw an increase in category 3 pressure ulcers reported.

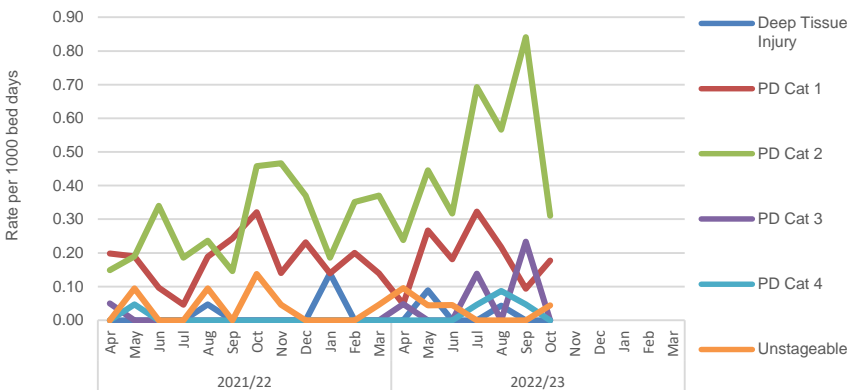
The Tissue Viability team are keen to improve identification and increase reporting of category 1 pressure ulcers through teaching and supporting staff on wards. The team are also trying to support staff with the completion of risk assessments and care planning on EPIC.

*NB The October data is unvalidated and will be subject to amendment following review.*

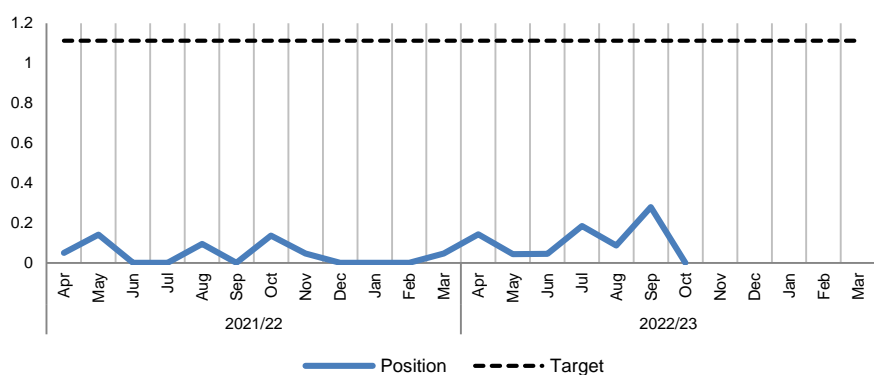
# Eastern Services Pressure Ulcers

Rate of pressure ulceration experienced whilst in Trust care

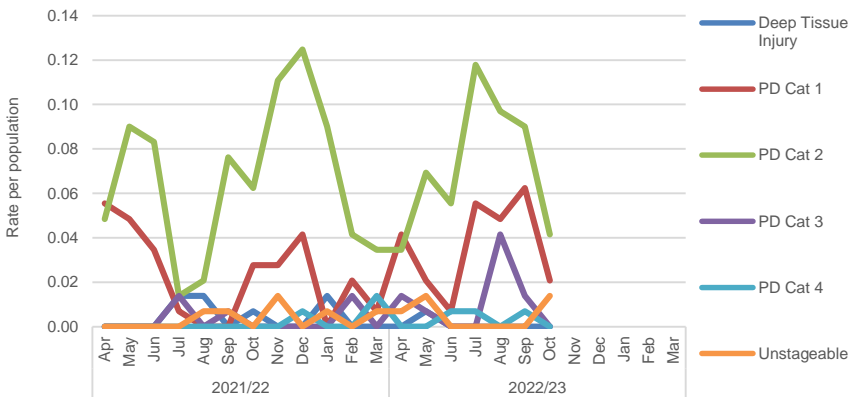
### Acute Pressure damage rate per 1000 bed days



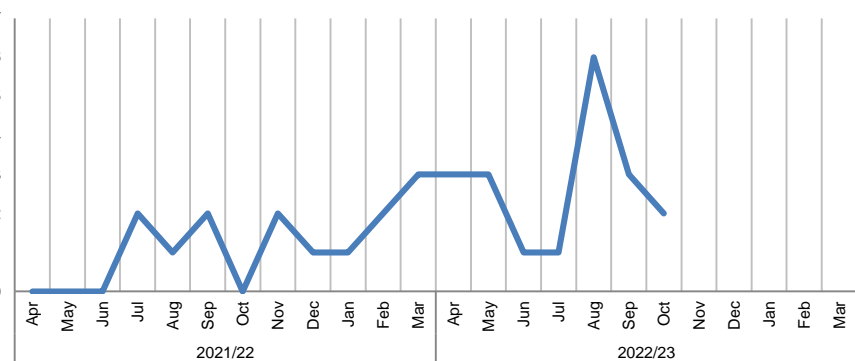
### Rate of Grade 1 - 4 pressure Sores /1000 bed days



### Community pressure damage rate per population and grade



### Community Caseload: Newly Identified Pressure Ulcers - Grade 3 - 4

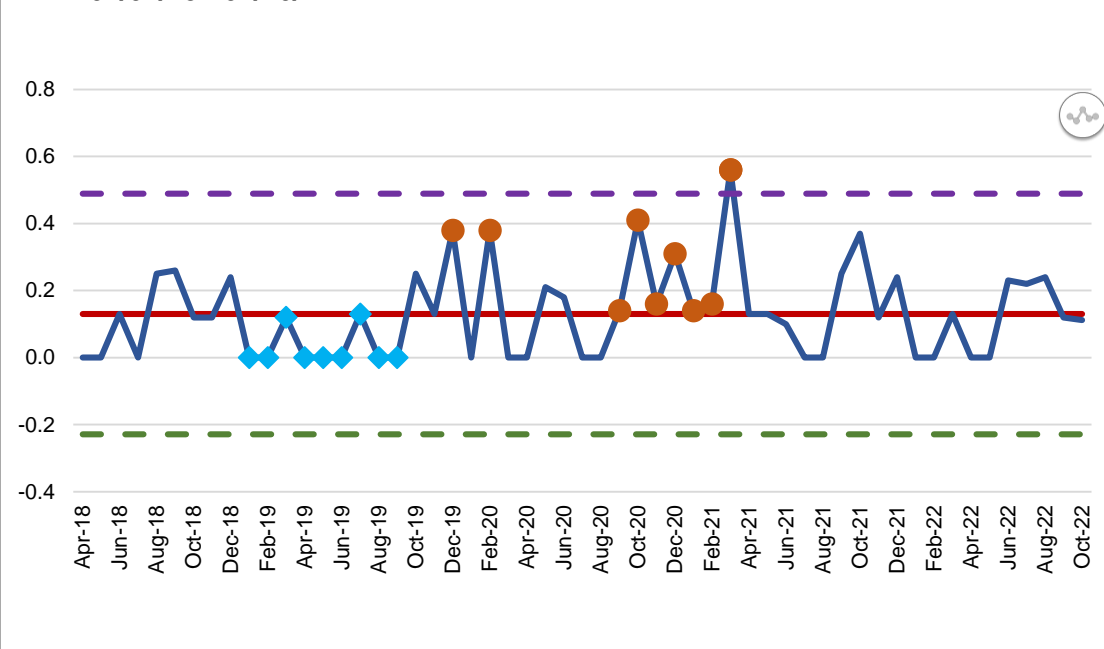


- Across all areas, the incidents of pressure damage have reduced to expected levels. The Tissue Viability Team has delivered targeted education to areas of concern.
- There have been some changes to the data going back to June 2022: suspected deep tissue injuries and unstageable pressure damage in both the acute and community setting have been amended as these had not been categorised correctly.
- There was a category 4 in the acute setting which occurred on ITU in September to a very unwell patient. The remaining incidents have been escalated as a moderate incidents to obtain any learning and change of practice required.

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

Month	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Admissions	2000	2148	2112	1916	1978	1819	2012	1866	2026	2024				
Total Falls	56	67	51	60	60	49	66	65	59	55	74	49	48	66
Moderate & Severe Harm Falls	2	3	1	2	0	0	1	0	0	1	2	3	1	1

**NDHT - Harm rate per 1000 bed days (moderate/severe/catastrophic) - 01/04/18 - 01/10/22**



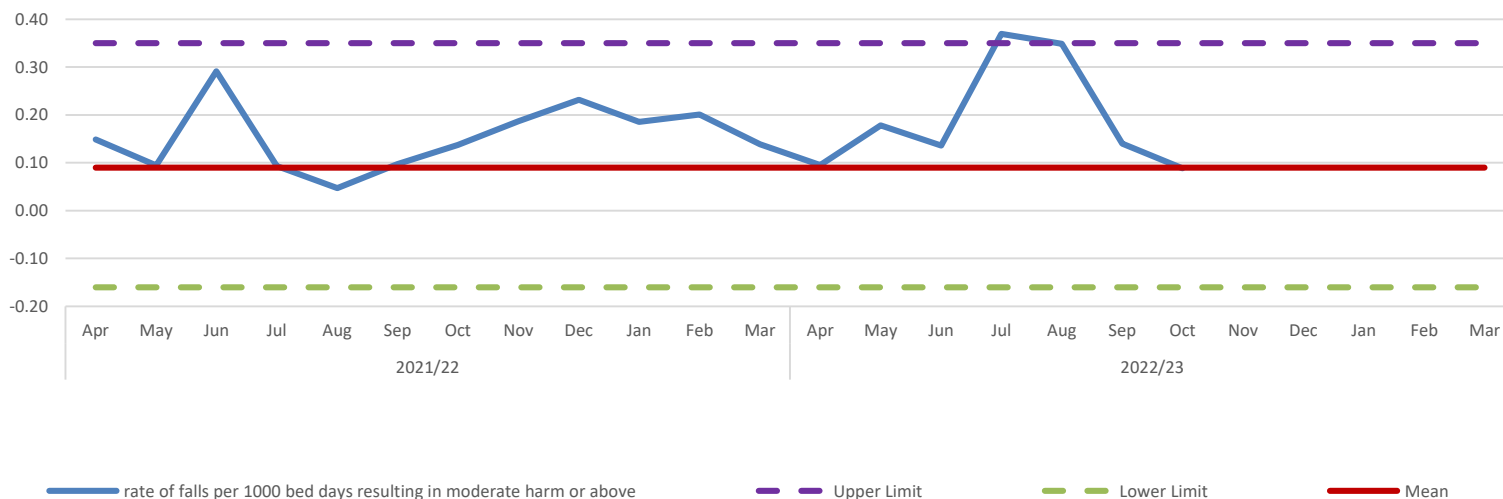
In October 2022:

- 94% of patients admitted did not fall.
- There was 1 fall which has been escalated for further investigation.
- Work continues to align policies. Our current priority is recognising that staff require support with using EPIC regarding falls risk assessments, care plans and post falls management. We have created a post falls tip sheet and will be going to all ward areas to support and share with staff in November.

# Eastern Services Slip, Trips & Falls

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

RDE Harm rate per 1000 bed days (moderate/major/catastrophic)



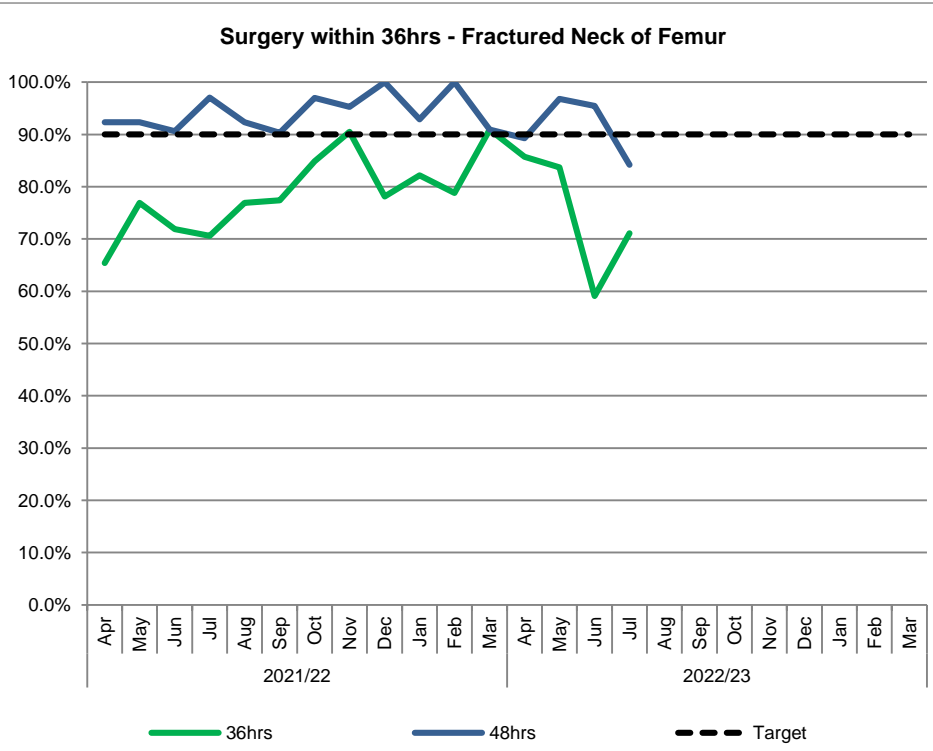
Month	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Admissions																			
Falls	116	112	120	110	129	132	162	160	179	143	152	206	167	141	167	269	222	190	225
Moderate & Severe Falls	3	2	6	2	1	2	3	4	5	4	4	3	2	4	3	8	8	3	2

- Falls remain within normal variation.
- There were two falls which resulted in Moderate Harm. From the initial review of these incidents, no sub-optimal care issues have been identified and investigations have commenced.
- Eastern services have published a new falls prevention page on Hub, sharing best practice, national guidance and resources. This went live in November 2022.



VTE Risk Assessment				
	Aug-22	Sep-22	Oct-22	Nov-22
<b>Northern Services</b>	73%	60%	65%	81%

- In October 2022
- A larger spot audit was completed and reviewed for a completed VTE assessment. It covered 181 patients (normally 55 patients) over 8 adult inpatient wards.
    - There was 81.21% compliance which is an improvement, as staff become more familiar with completing the assessment via EPIC.
  - Ongoing monthly spot audits will continue whilst Epic reporting of VTE compliance is optimised



Data in relation to the Fractured Neck of Femur position is currently being validated post Epic Go-Live to ensure the figures derived from this are consistent with the previous methodology. The clinical team are undertaking a review and this will be completed by the next IPR with backdated figures and updated narrative included.

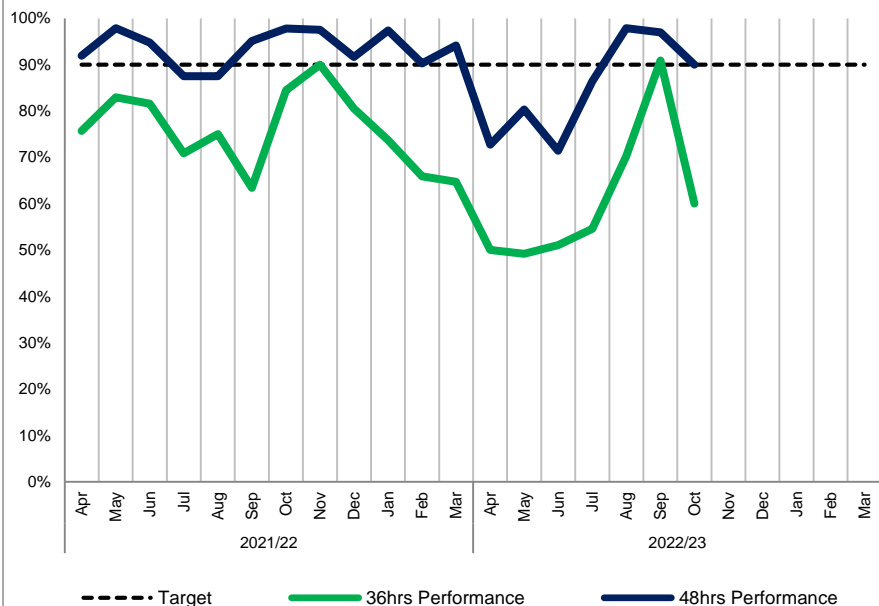
# Eastern Services Efficiency of Care

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

VTE Risk Assessment				
Eastern Services	Aug-22	Sep-22	Oct-22	Nov-22
RDE Wonford	76%	75%	73%	72%

- The snapshot position taken from the Epic system in relation to the % of patients risk assessed for VTE on admission, demonstrates a stable position.

Surgery within 36hrs - Fractured Neck of Femur



- In October, 60% of medically fit patients with a fractured neck of femur (FNOF) received surgery within 36 hours. There were a total of 46 patients admitted, 40 of these patients were medically fit for surgery from the outset and 24 patients received surgery within 36 hours.
- Where clinically appropriate all FNOF cases are given priority in theatres over elective patients.
- The Hip Fracture Lead has reviewed all cases during the month and is confident that the quality of the clinical care remains high and the patients who breached 36 hours, did not come to any harm due to a slightly longer wait for surgery.
- Work is being actively progressed to increase the volume of Orthopaedic and Spinal activity that can be redistributed to the Nightingale Hospital, to free up theatre capacity on the Wonford site - it is anticipated this could be enacted in the new year;

Activity & Flow

Operational Performance

Patient Experience

Quality & Safety

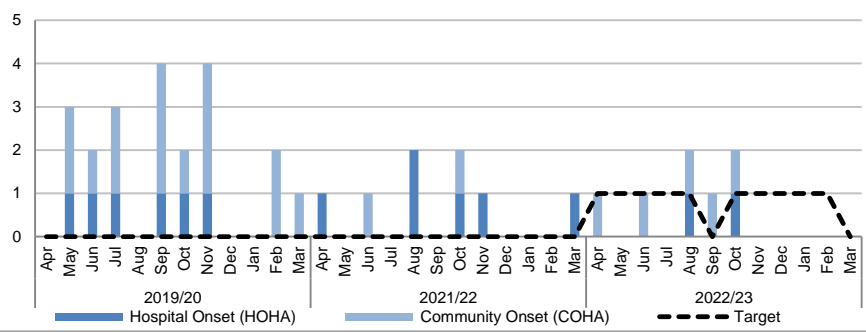
Our People

Finance

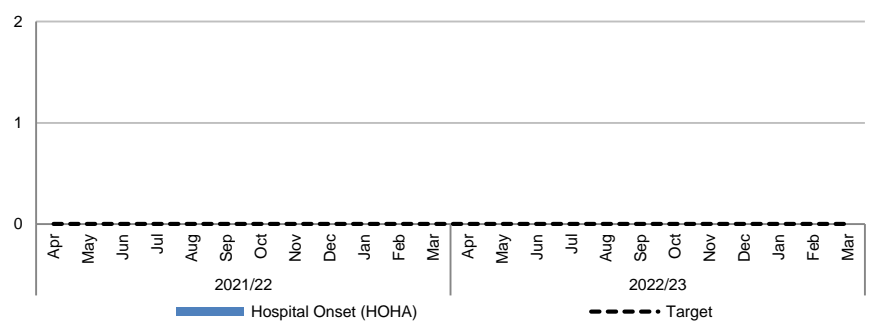
# Northern Services Healthcare Associated Infection – Volume of patients with Trust apportioned laboratory confirmed infection



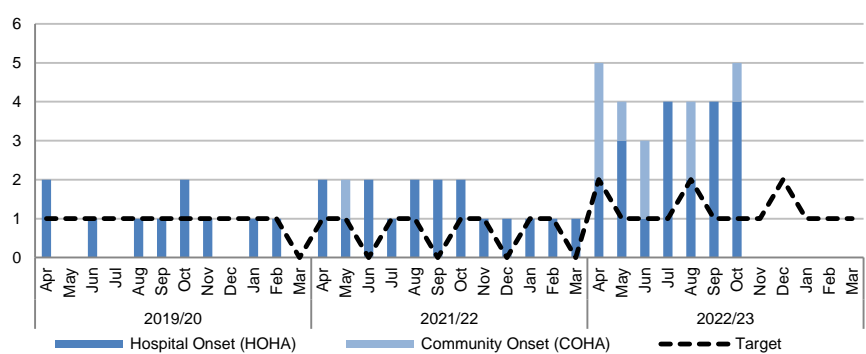
**Clostridioides difficile cases**



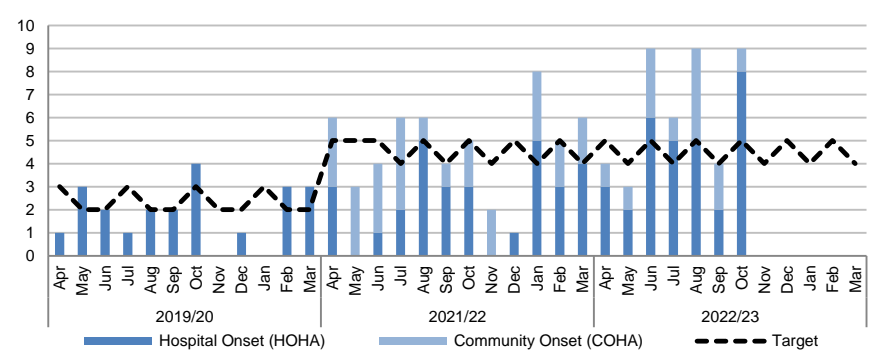
**MRSA bacteraemia cases**



**MSSA bacteraemia cases**



**E coli bacteraemia cases**



**Escherichia coli (E coli):** There were 9 cases of Trust attributed *E coli* bacteraemias in October 2022 and the Northern locality remains above the target trajectory. 7 of the cases this month were related to the urinary tract with 5 of these catheter related. No lapses in care were identified during IP&C review of the cases. Since April 22 there has been a normal distribution of cases both by cause (the majority are urinary) and by location.

**Methicillin sensitive Staphylococcus aureus (MSSA):** Trust attributed MSSA bacteraemia remain above the self-imposed target. No common cause has been found to explain these higher numbers and there is no obvious link in location or cause of infection. No lapses in care were identified during IP&C review of the cases.

These healthcare associated infections remain within normal variation:

**Methicillin resistant Staphylococcus aureus (MRSA)**

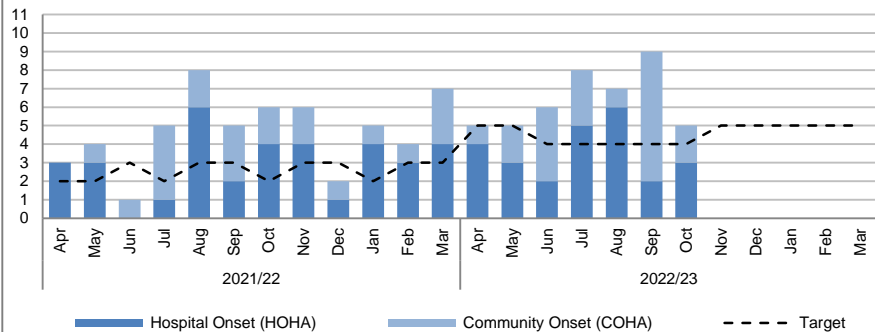
**Clostridioides difficile (C dif):**

Bacteraemia and C difficile cases are reviewed and discussed at the Infection Prevention and Decontamination Assurance Group.

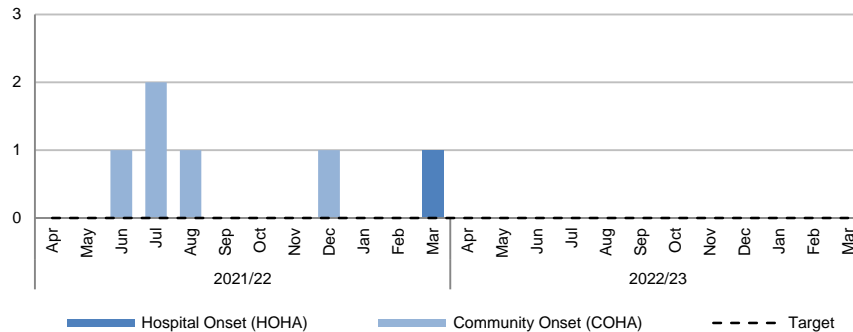
# Eastern Services Healthcare Associated Infection

Volume of patients with Trust apportioned laboratory confirmed infection

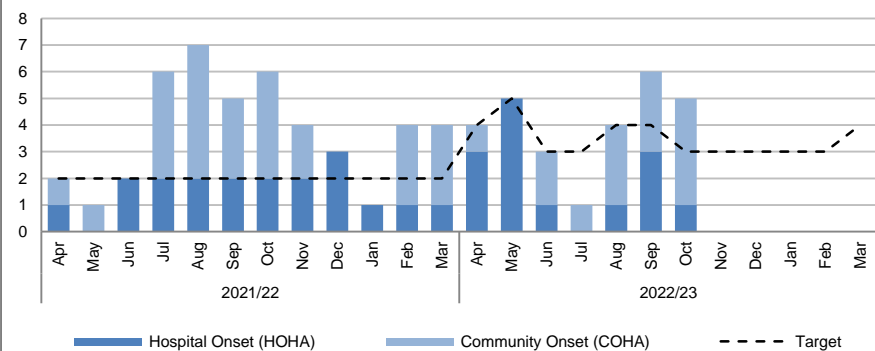
### Clostridioides difficile cases



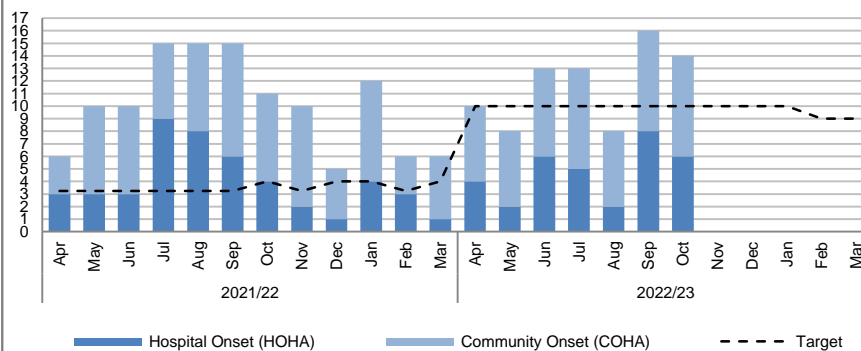
### MRSA bacteraemia Cases



### MSSA bacteraemia cases



### E-coli bacteraemias Cases



#### Clostridioides difficile:

HOHA - The investigation for one HOHA cases is complete and no lapses in care were identified. The investigations for the remaining HOHA cases are not yet complete but no apparent lapses in care identified at this stage. All three associated with appropriate and necessary antibiotic use.

COHA - Both of the COHA cases were relapses having tested positive in September. No new learning identified.

**MSSA bacteraemia:** All cases investigated as part of enhanced surveillance process.

HOHA -No lapses in care were identified.

COHA - Three cases were associated with central venous catheters. No Trust learning was identified that would have prevented these infections although incidental learning related to documentation of the management of the lines and patients after blood stream infection identified have been fed back to the relevant clinical teams.

**E.Coli bacteraemia:** Enhanced surveillance of E.coli bacteraemias was paused during COVID and has not yet recommenced to allow time for COVID post infection reviews.

However, sources of infection are identified, where it is possible to determine source, and are as follows:

HOHA - Three were unknown sources. Of those where a source could be identified one is associated with the hepatobiliary tract; one with urinary tract; and one with gastrointestinal tract i.e. no common theme.

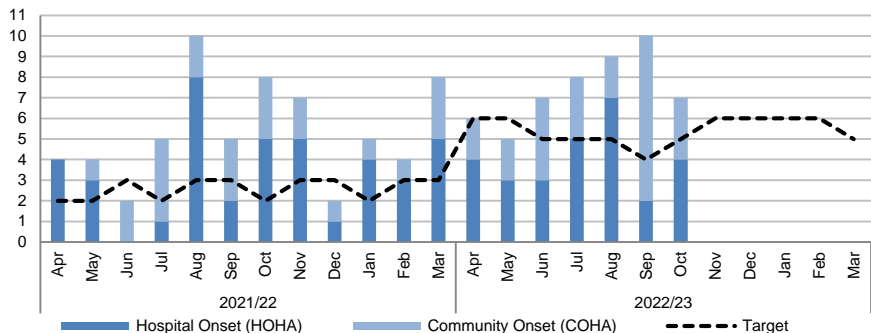
COHA - One was from an unknown source. Three associated with the urinary tract and one of these patients had a necessary long term catheter. Four associated with the gastrointestinal tract and one unknown.



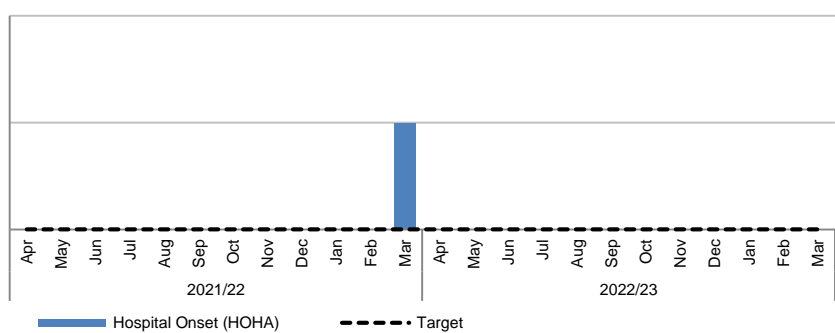
# Trust Level Healthcare Associated Infection – Volume of patients with Trust apportioned laboratory confirmed infection

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

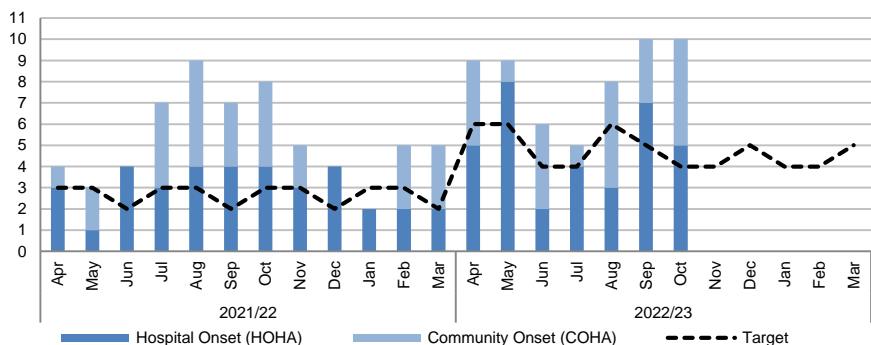
### Clostridioides difficile cases



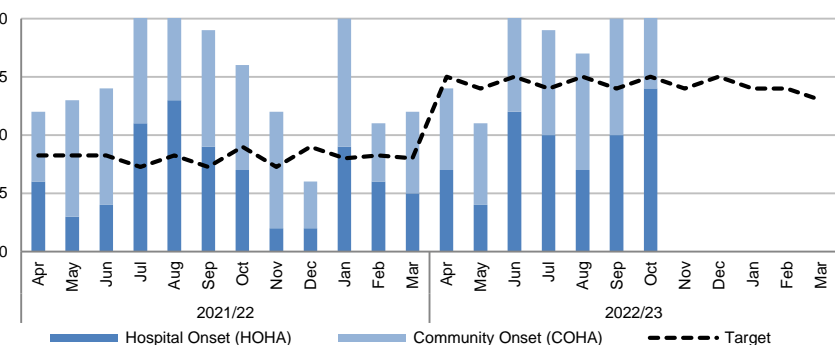
### MRSA bacteraemia cases



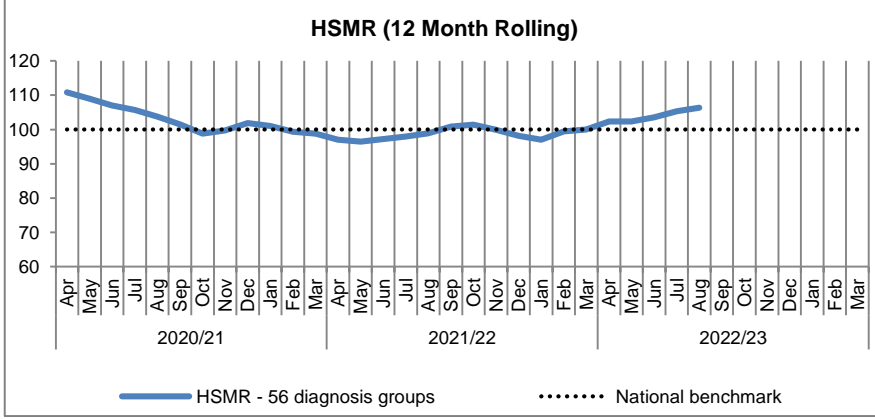
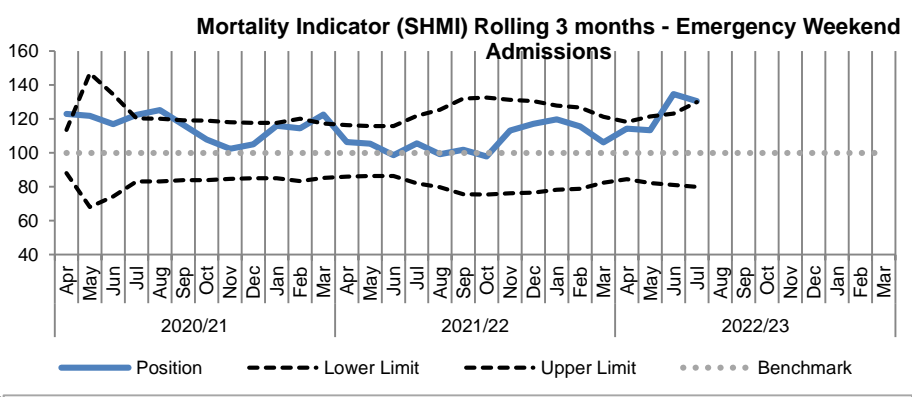
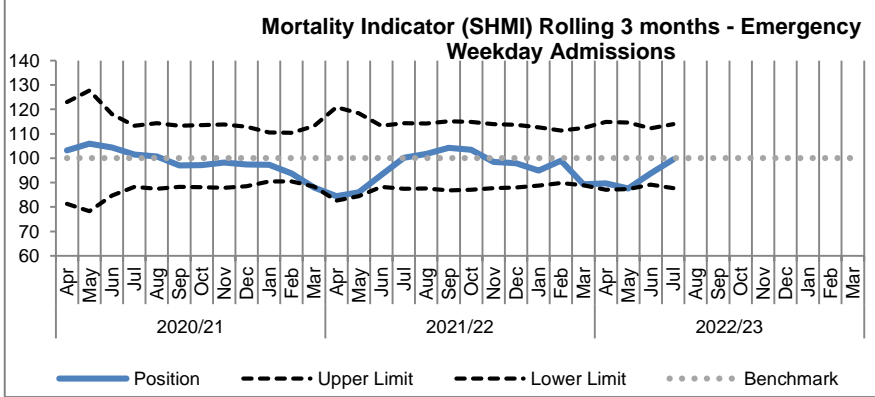
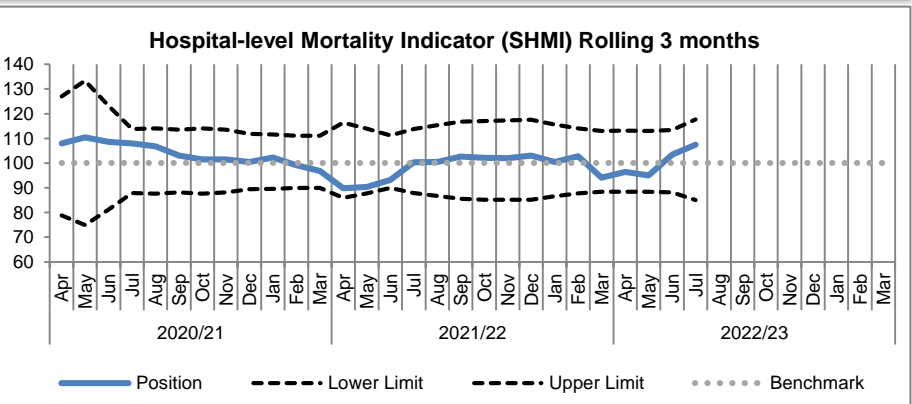
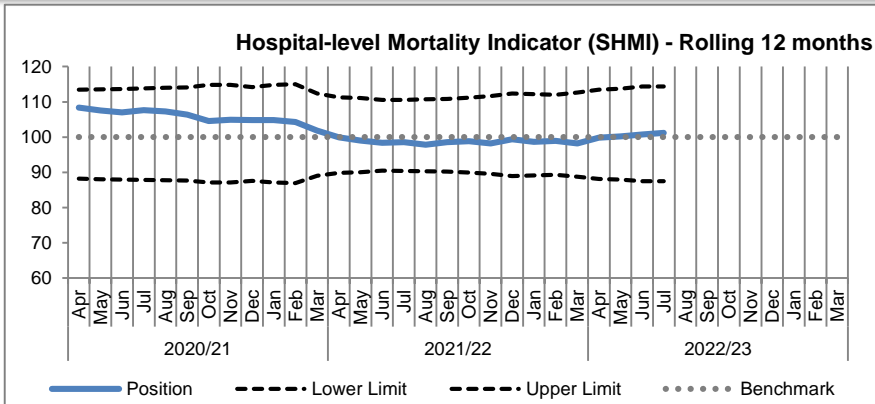
### MSSA bacteraemia cases



### E coli bacteraemia cases



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

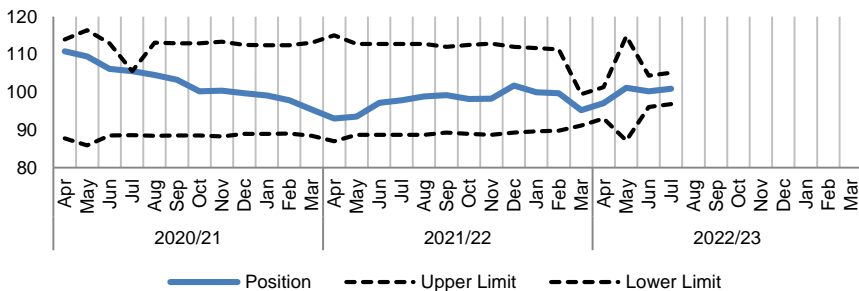


- The SHMI position, remains within the expected range with the exception of Emergency Weekend Admissions, which has dipped but remains just outside the upper control limit. Emergency admissions at the weekend show a higher frailty score when benchmarked nationally.
- A detailed report is being provided to the next Mortality Group meeting. Initial indications show issues with coding may be driving the elevated position.
- The Medical Examiners continue to give independent scrutiny of all hospital deaths raising areas of concern to the mortality review process, governance/Datix, and clinicians where appropriate. No new emergent themes are being identified through this process.

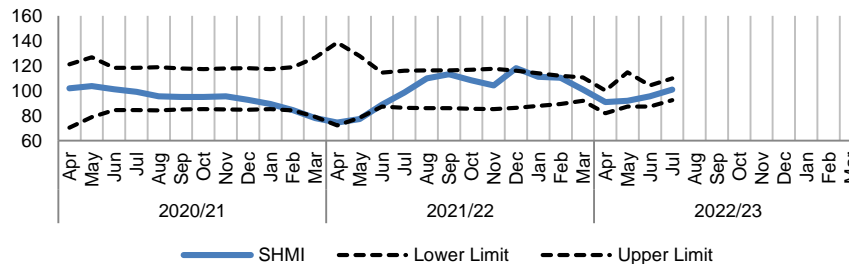
# Eastern Services Mortality Rates – SHMI & HSMR

Rate of mortality adjusted for case mix and patient demographics

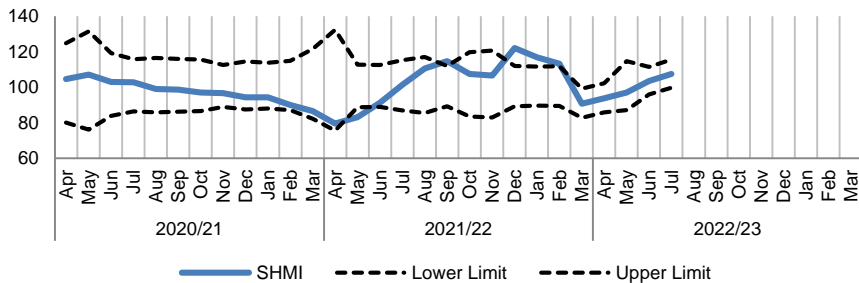
**Hospital-level Mortality Indicator (SHMI) - Rolling 12 months**



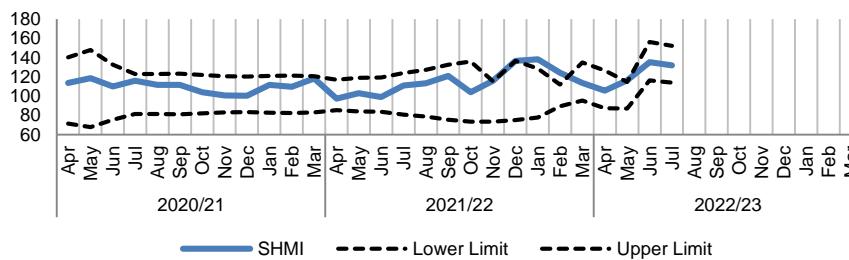
**Mortality Indicator (SHMI) Rolling 3 months - Weekday Admissions**



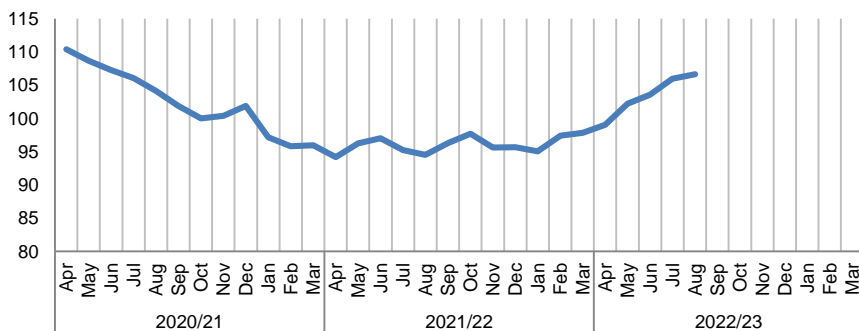
**Hospital-level Mortality Indicator (SHMI) Rolling 3 months**



**Mortality Indicator (SHMI) Rolling 3 months - Weekend Admissions**



**HSMR (12 Month Rolling)**

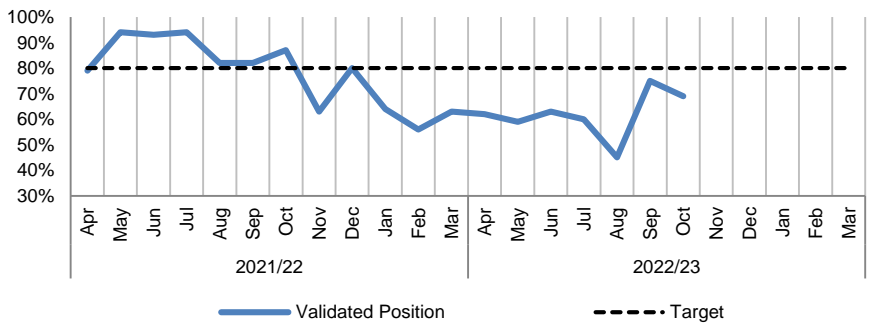


- Trust data has been merged since integration and the charts show the combined positions within the RDU (Northern and Eastern Services) from April 2022.
- The SHMI Position remains within the 'as expected' levels for all measures included within the IPR.
- The rise in HSMR is driven principally by the aggregation of Northern Services data since April 2022.
- A detailed report is being provided to the next Mortality Group meeting. Initial indications show issues with coding may be driving the elevated position.
- The Medical Examiners continue to give independent scrutiny of all hospital deaths raising areas of concern to the mortality review process, governance/Datix, and clinicians where appropriate. No new emergent themes are being identified through this process.

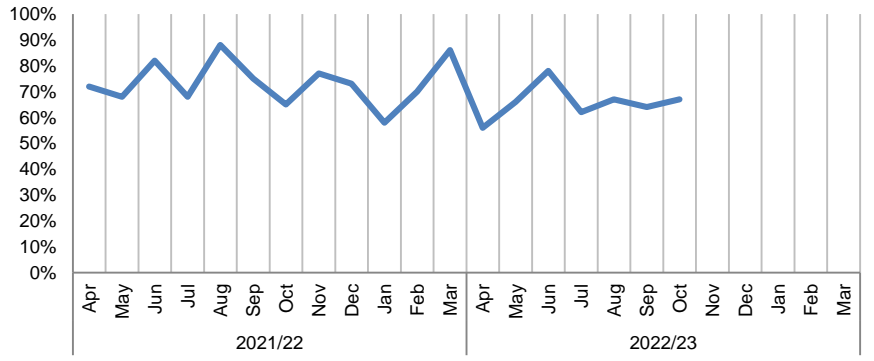
# Northern Services Stroke Performance – Quality of care metrics for patients admitted following a stroke



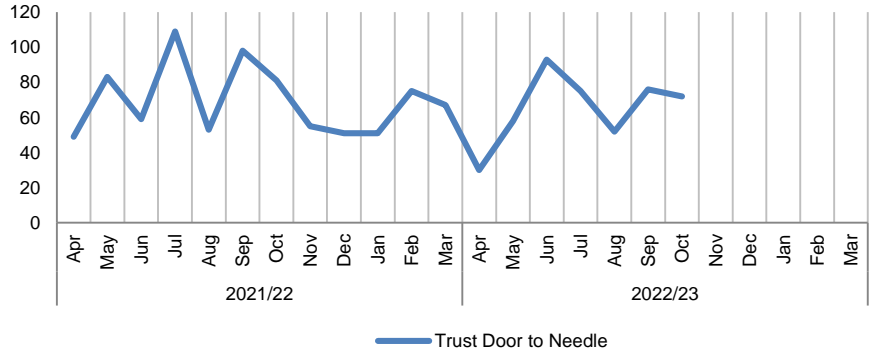
**Proportion of patients admitted following a Stroke spending 90% or more of their stay on the Stroke unit**



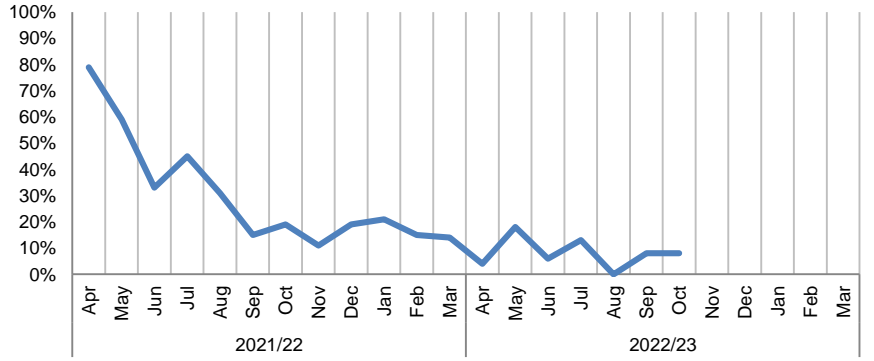
**Discharge Destination to Home (%)**



**Average Thrombolysis Times (minutes)**



**On Stroke Unit within 4 hours**



**90% stay:** Performance against this indicator has remained stable in October, despite ongoing challenges with patient flow. The Stroke clinical teams provide outreach to outlying wards to ensure stroke patients are receiving appropriate stroke care. The Patient Flow Improvement Group are reviewing the ringfencing processes with the site management team.

**Discharge destination:** This metric is relatively stable and is above the national average.

**ASU in 4 hours:** This target remains challenging due to the high level of occupancy and inability to ringfencing stroke beds.

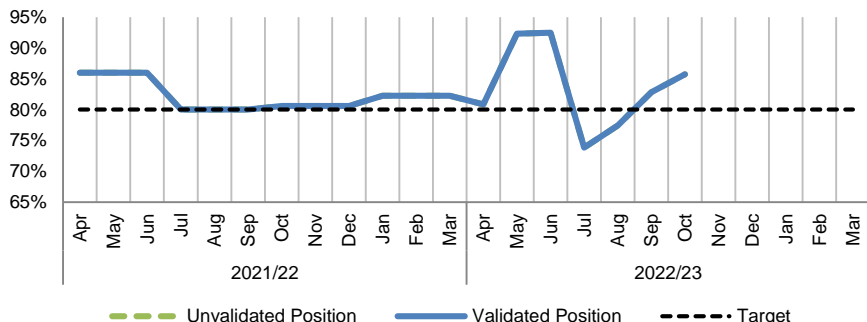
**Thrombolysis times:** Thrombolysis time is broadly stable over time. Overall the number of eligible stroke patients for thrombolysis is low.

# Eastern Services Stroke Performance

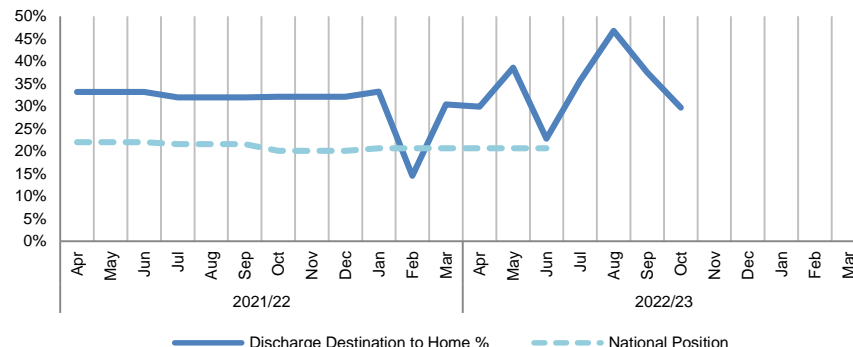
Quality of care metrics for patients admitted following a stroke



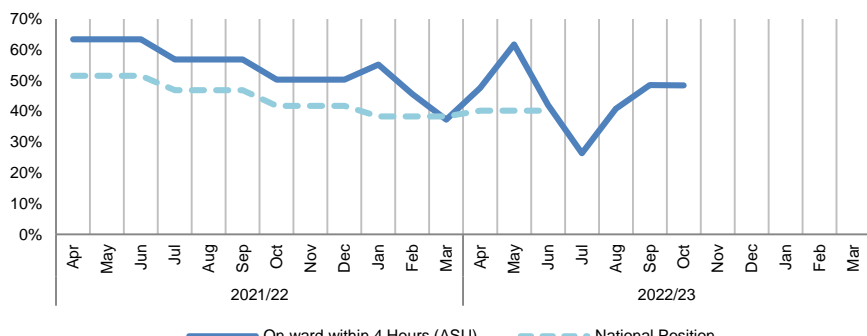
**Proportion of patients admitted following a Stroke spending 90% or more of their stay on the Stroke unit**



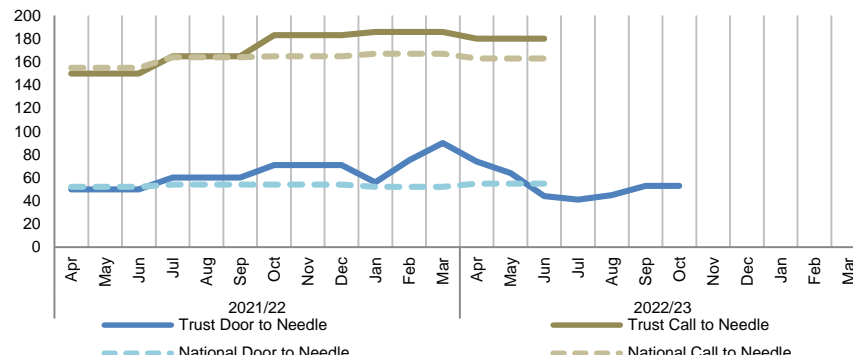
**Discharge Destination to Home (%)**



**On ward within 4 Hours (ASU)**

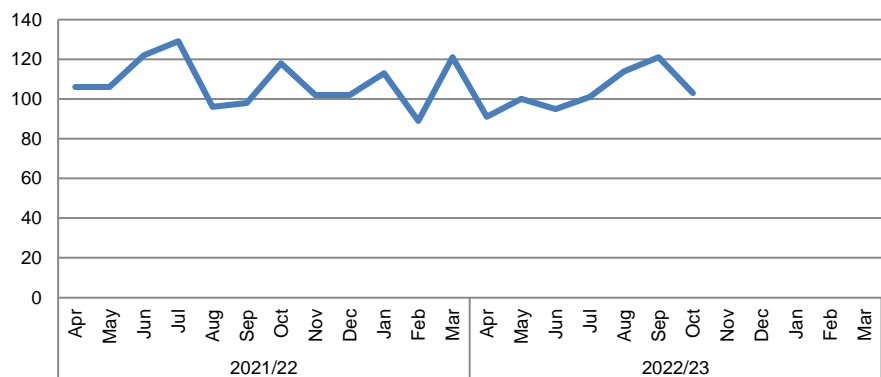


**Average Thrombolysis Times (minutes)**

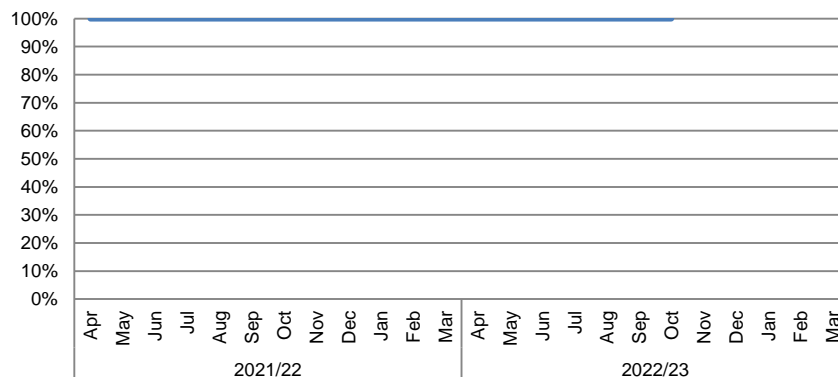


- 90% stay - The proportion of patients admitted spending 90% of their stay on the stroke unit has increased and is above target. This has been due to the continued concerted effort to try and transfer patients more quickly to the ward. In October 85.7% was achieved against the 90% stay indicator and 48.4% of stroke patients were transferred to the unit within 4 hours, which is above the national position.
- Other indicators remain positive.

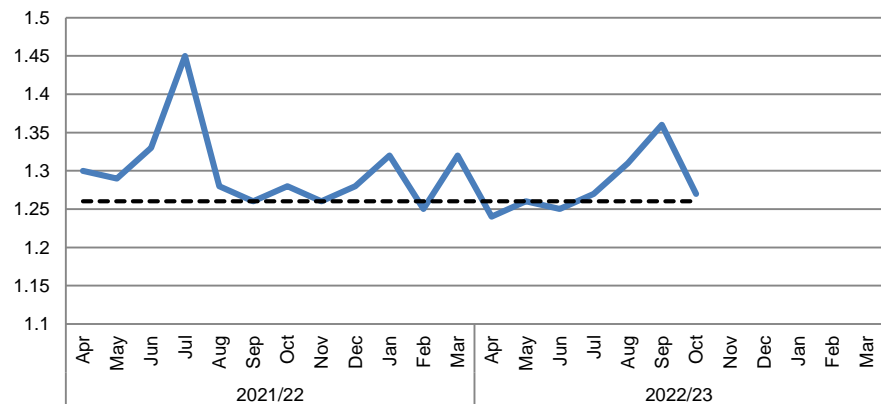
### Birth Rate (Number of babies born)



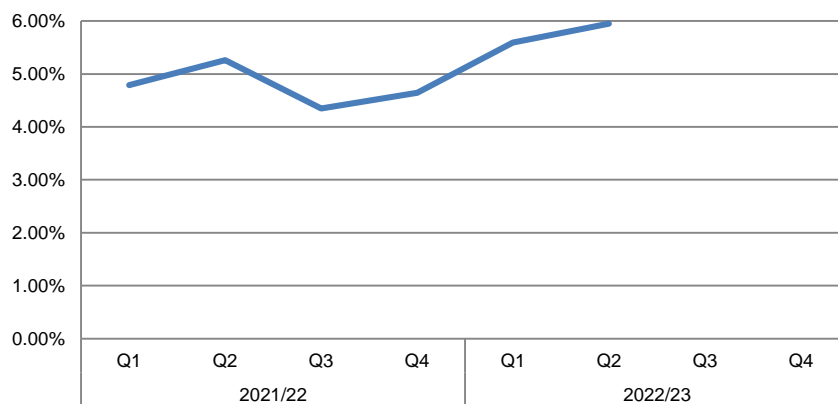
### 1:1 Care in Labour



### Midwife to delivery ratio



### Admissions of (term babies) to NNU

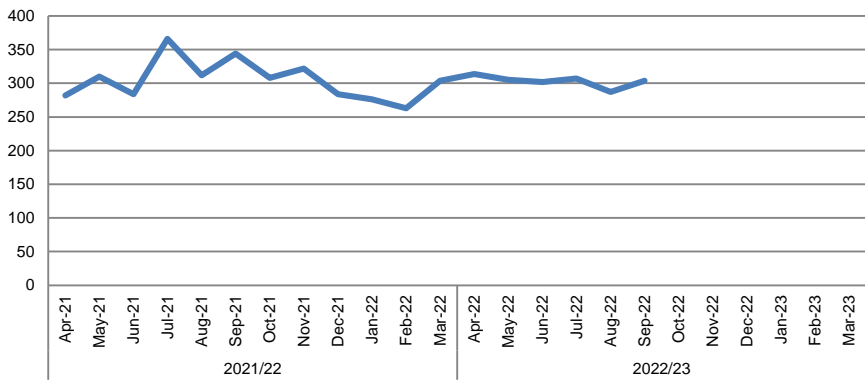


- The number of births remains within normal variation
- The number of term babies admitted to NNU has exceeded national target (5%) for the month and is noted to have increased steadily. All cases are reviewed using the ATAIN (avoiding term admissions into neonatal units) programme to identify any areas for escalation and learning however, this review and associated quarterly audit has been delayed due to significant staffing challenges. This is now being prioritised in preparation for CNST evidence submission. The maternity service intend to work with the neonatal team to ensure ATAIN audits are completed in a timely manner moving forward.

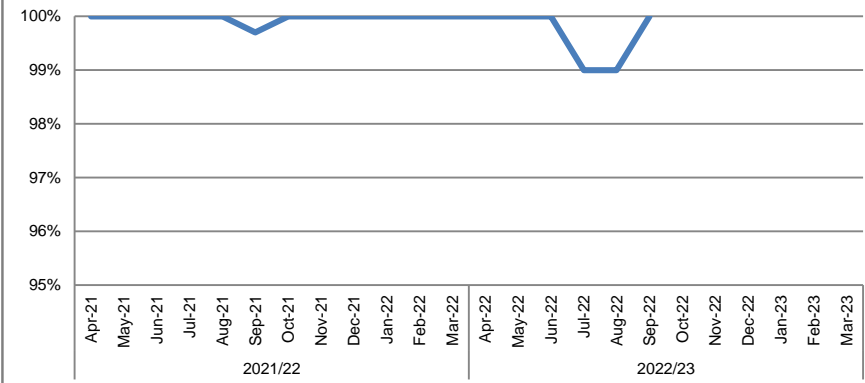
# Eastern Services Maternity

Metrics relating to the provision of quality maternity care

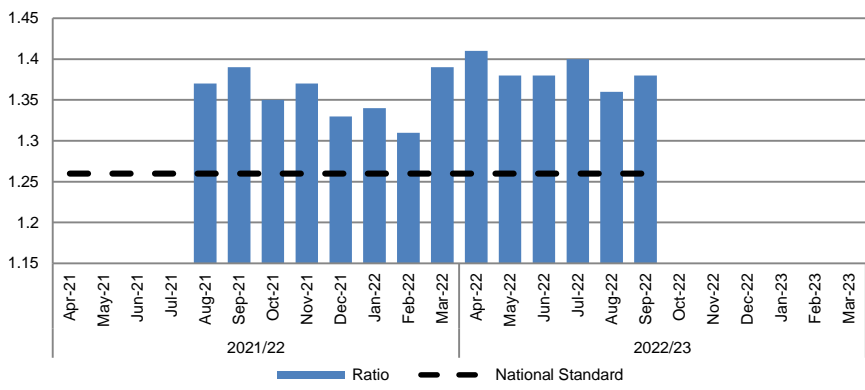
### Birth Rate (Number of babies born)



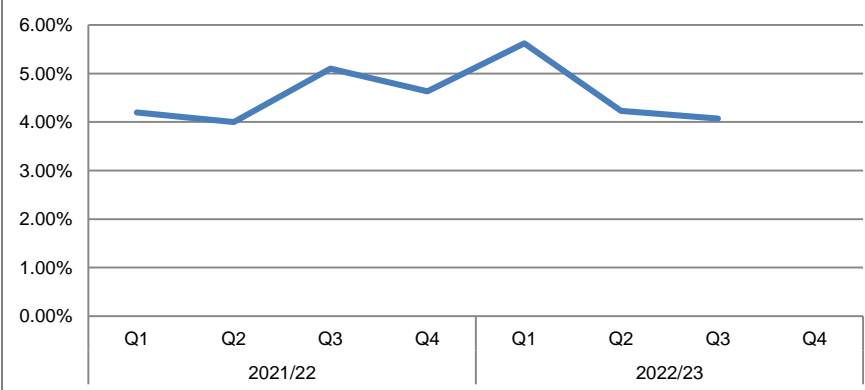
### 1:1 Care in Labour



### Midwife to delivery ratio



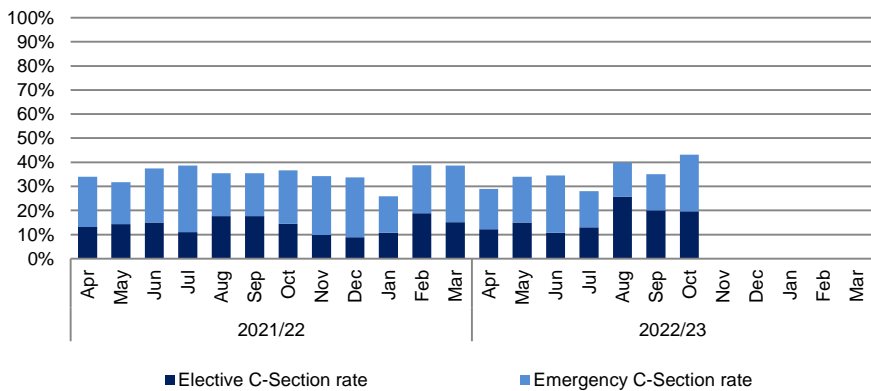
### Admissions of (term babies) to NNU



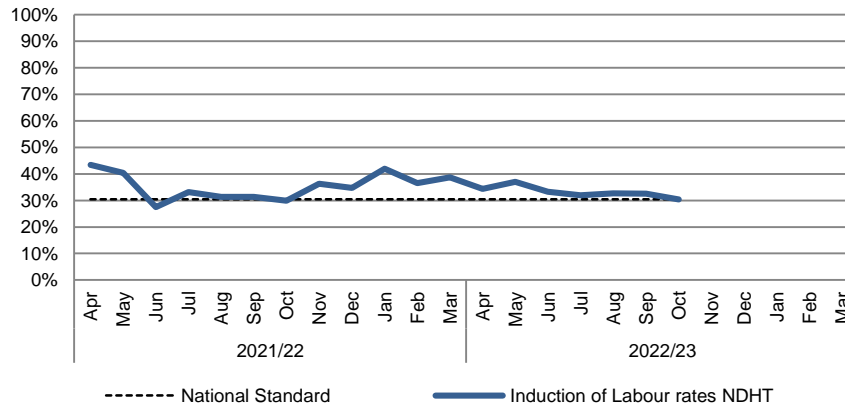
- Birth rate has remained consistent in September.
- Acuity has been high with an increase in induction of labour due to a change in national guidance.
- Term admissions to the neonatal unit has seen a reduction despite the high acuity. RDUH East remains below the national average.

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

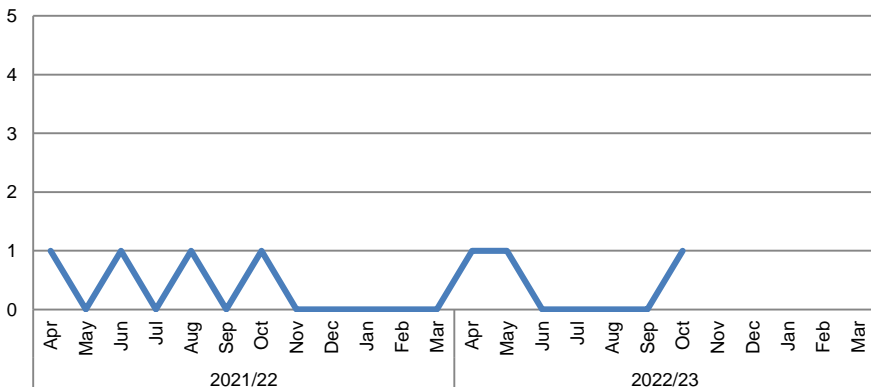
### C-Section Rates - Elective & Emergency



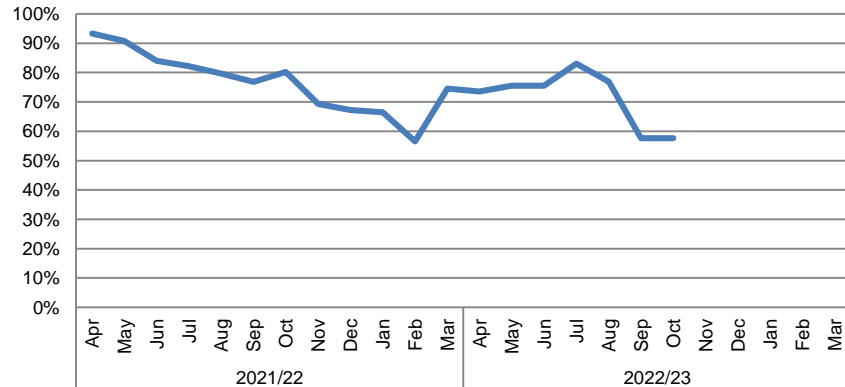
### Induction of Labour rates



### Still births (includes term & pre-term)



### PROMPT Training % (whole team)



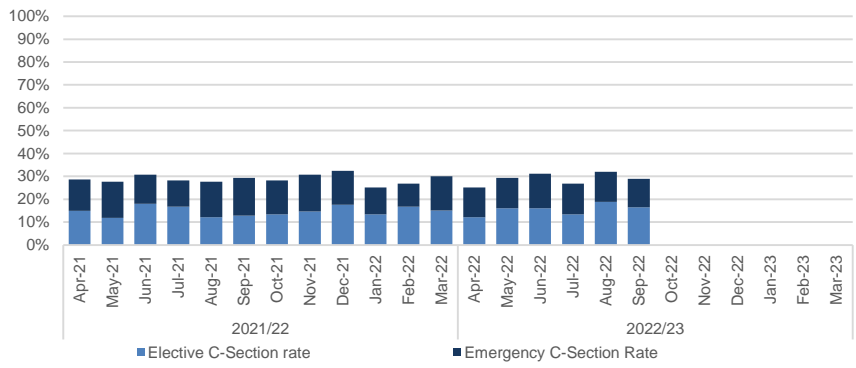
- Emergency and elective caesarean section rates, and induction of labour are aligned with the national standard for the month.
- PROMPT training compliance has dipped due to an increase in short term sickness however the service is working to a robust recovery trajectory to reach the 90% target for CNST compliance. The service has been addressing compliance with innovative training programmes including PROMPT for the community setting. The recovery trajectory is being monitored by the Trust Directors through the monthly Performance Assurance Meetings.



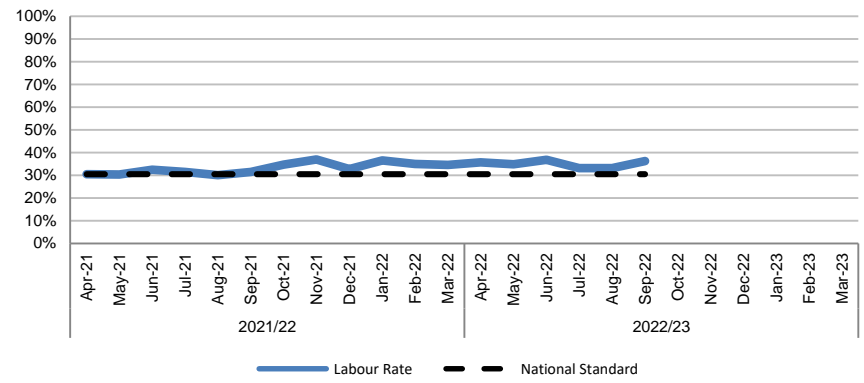
# Eastern Services Maternity

Metrics relating to the provision of quality maternity care

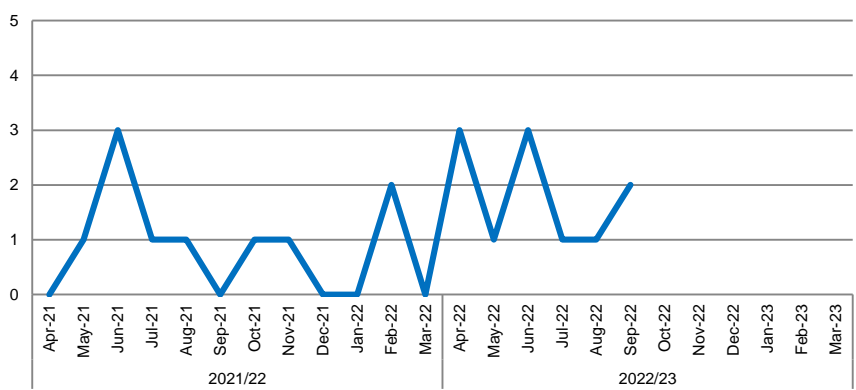
C-Section rates - Elective & Emergency



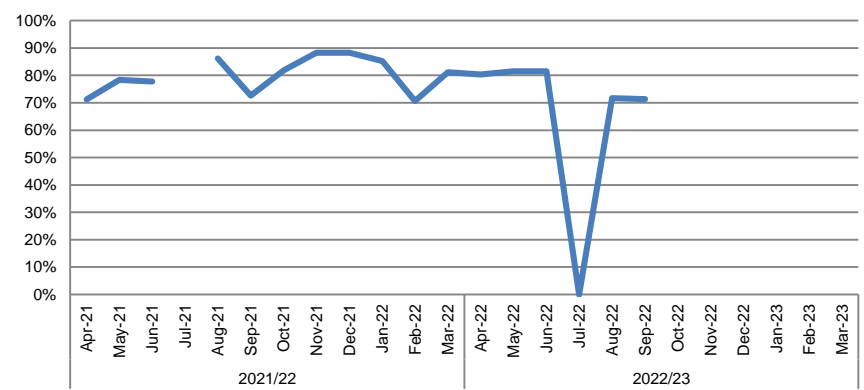
Induction of Labour rates



Still births (includes term & pre-term)

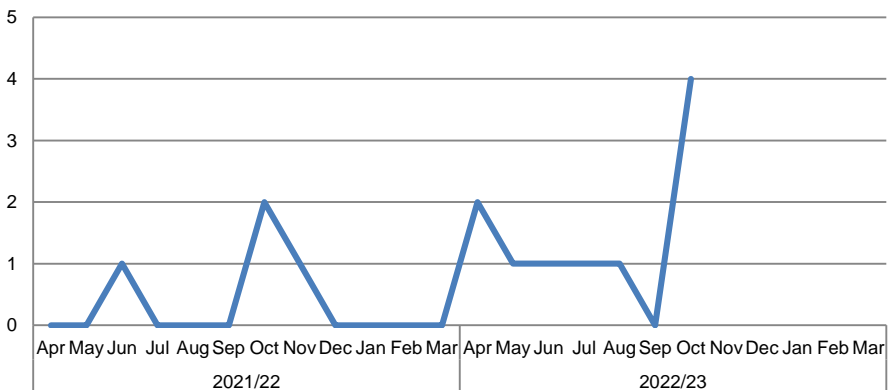


PROMPT Training % (whole team)

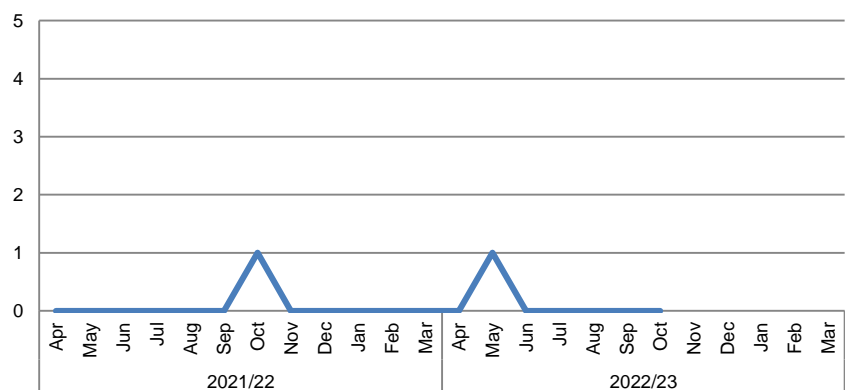


- Induction of labour rates are steadily increasing in line with the national trend.
- Stillbirths continue to be monitored closely via the PMRT review process and other external bodies.
- PROMPT training has seen an uphill trajectory and will continue to be on target for December CNST requirements.

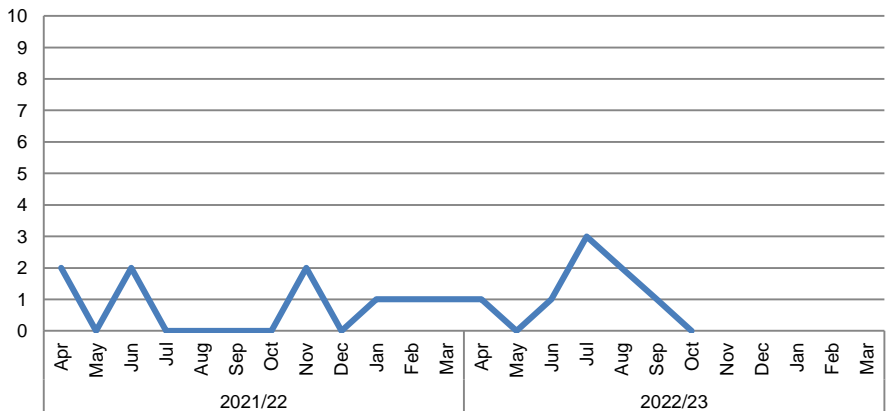
**Incidents in current month (moderate and above) (run chart)**



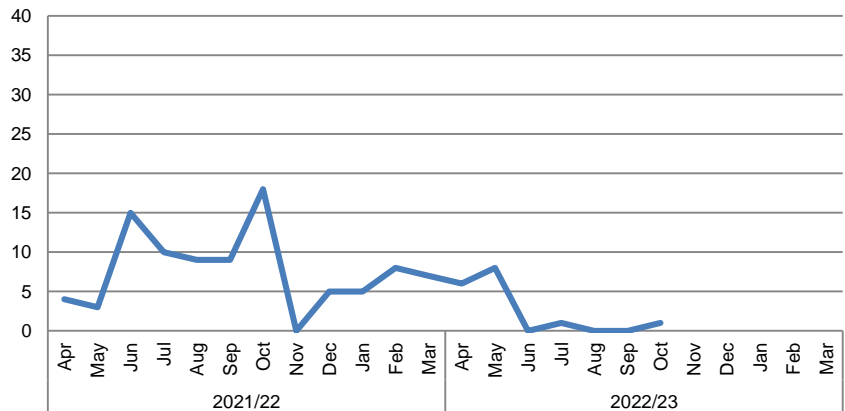
**Serious Incidents (run chart)**



**Complaints Maternity**



**Compliments Maternity**

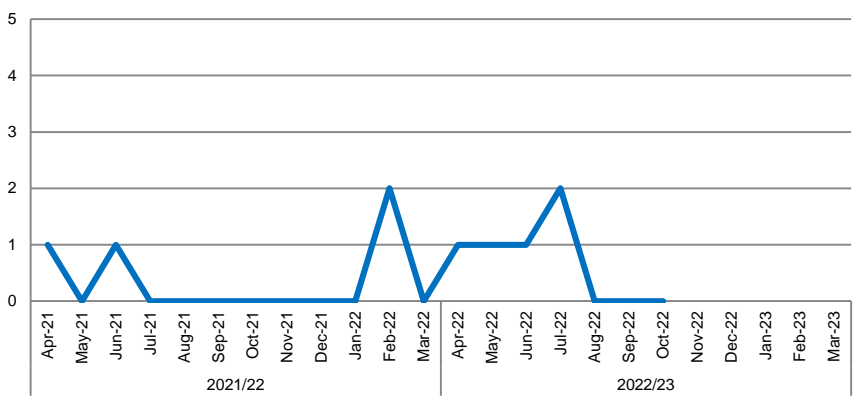


- There were 4 moderate or above incidents reported for the month; 1 of which has been downgraded to minor following review:
  - 1: Transfer to tertiary unit for therapeutic cooling (does not meet HSIB criteria)
  - 2: term IUD placental abruption
  - 3: Neonatal hypoglycaemia & seizures possible hyperinsulinaemia
- There is no specialty specific complaints data available in month.

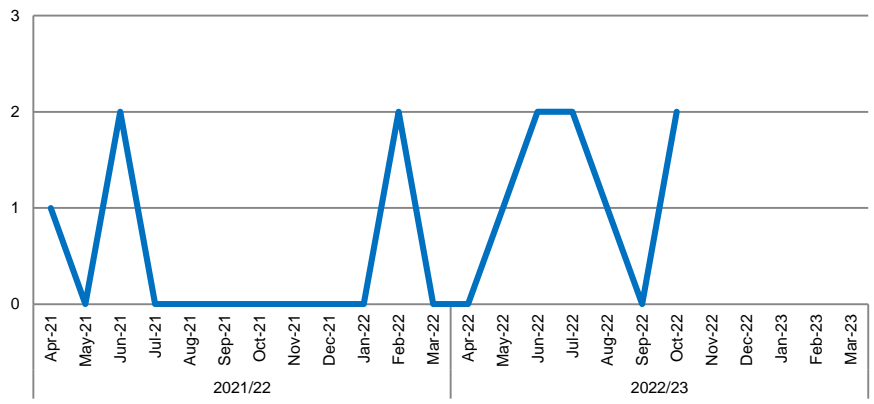
# Eastern Services Maternity

Metrics relating to the provision of quality maternity care

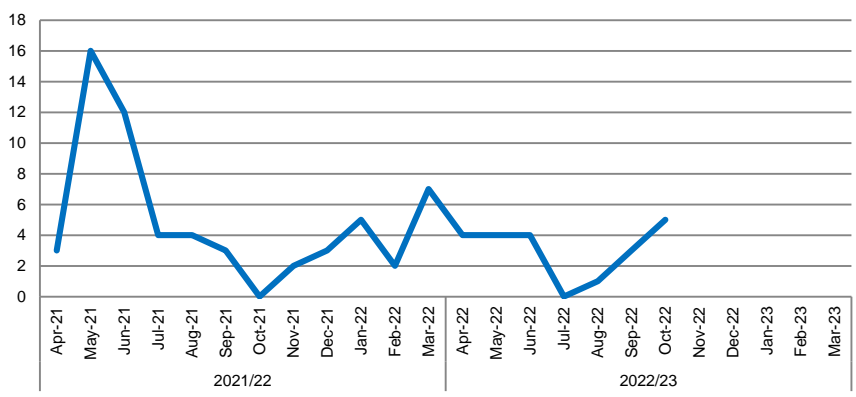
**Incidents in current month (moderate and above) (run chart)**



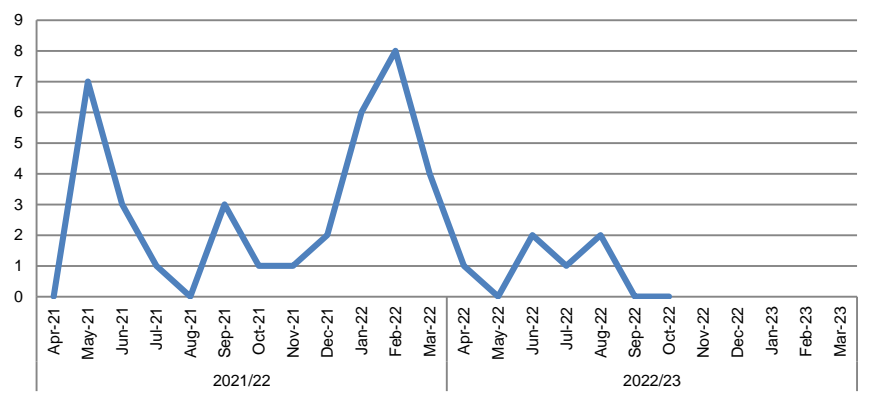
**Serious Incidents (run chart)**



**Complaints Maternity**



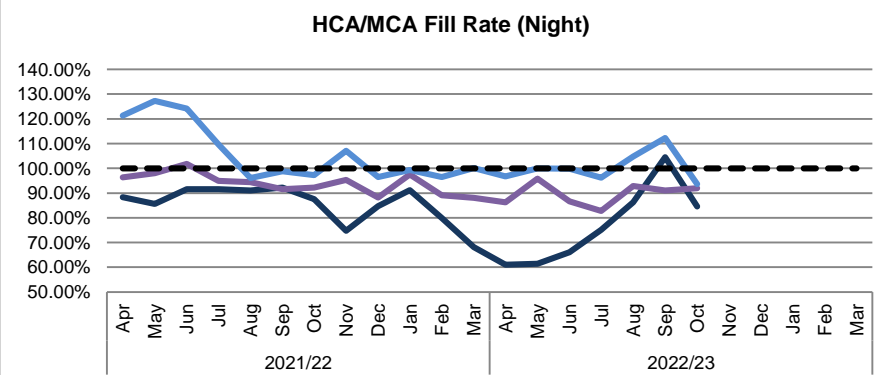
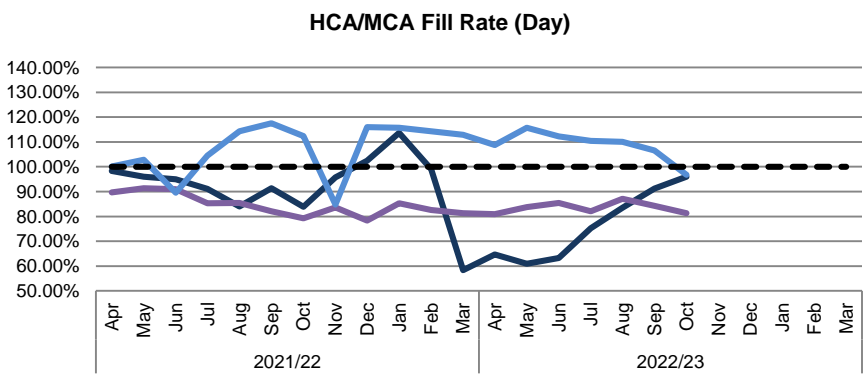
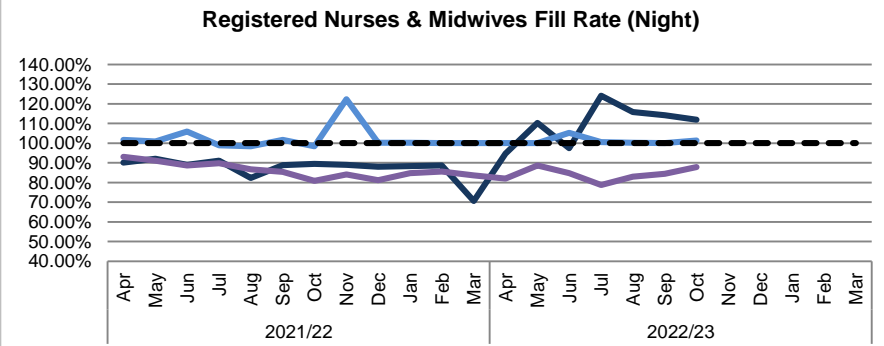
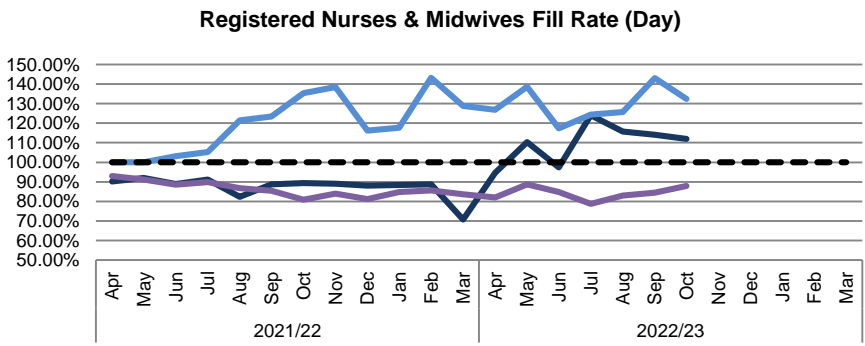
**Compliments Maternity**



- There has been an overall reduction in complaints, these continue to be processed in a timely manner despite staffing pressures.

# Northern Services Safe Clinical Staffing Fill Rates

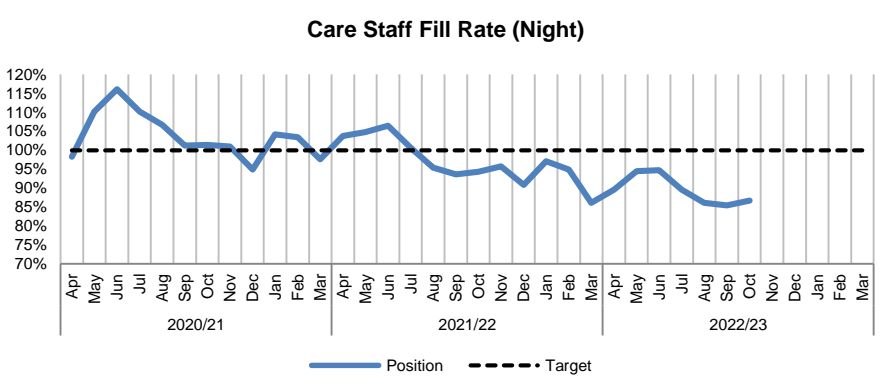
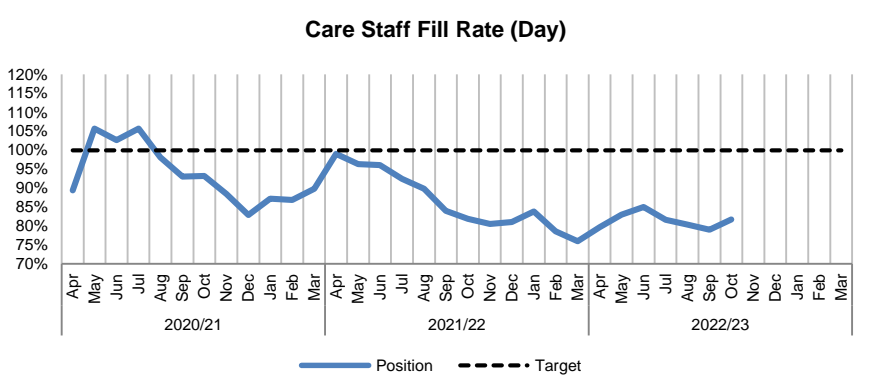
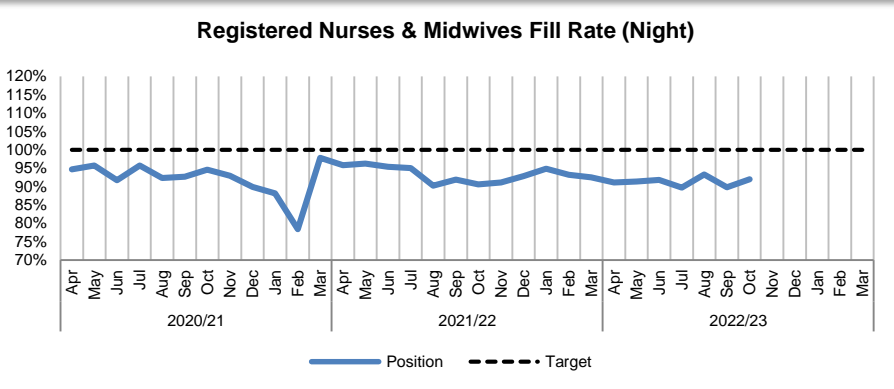
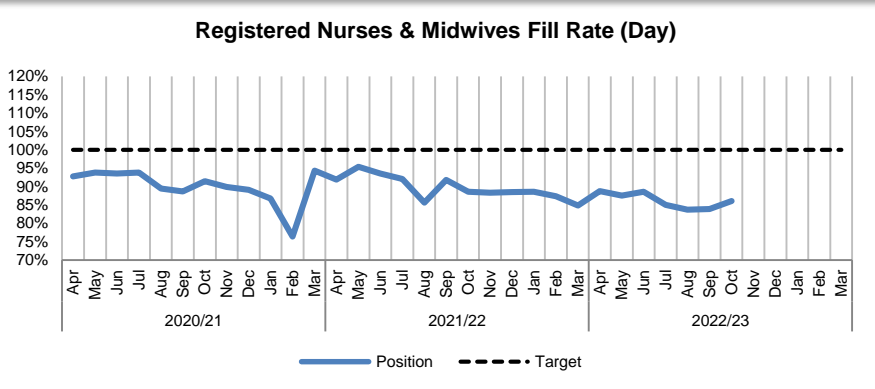
Activity & Flow  
Operational Performance  
Patient Experience  
Quality & Safety  
Our People  
Finance



- The overall fill rate for October 2022 remains > 85%.
- Midwifery - Registered staff: 89.09% in the Day and 89.19% at Night. Unregistered Staff: 79.02% in the Day and 73.09% at Night. Trials of Long shifts and additional externally funded specialist posts are adversely affecting the data currently. Midwifery services are currently working with the e-rostering and finance teams to cleanse the fill rate data. A more accurate midwifery fill rate will be submitted for the next IPR.
- South Molton - Fill rates for both RN & HCA shifts remain high due to the utilisation of additional bed capacity requiring additional staff which artificially improves the overall fill rate; this is being addressed.
- All incidents are reviewed, the main theme being unfilled shifts. There were three incidents reported as “staff shortage, all of which resulted in minor (2) or no harm (1).

# Eastern Services Safe Clinical Staffing – Fill Rate

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

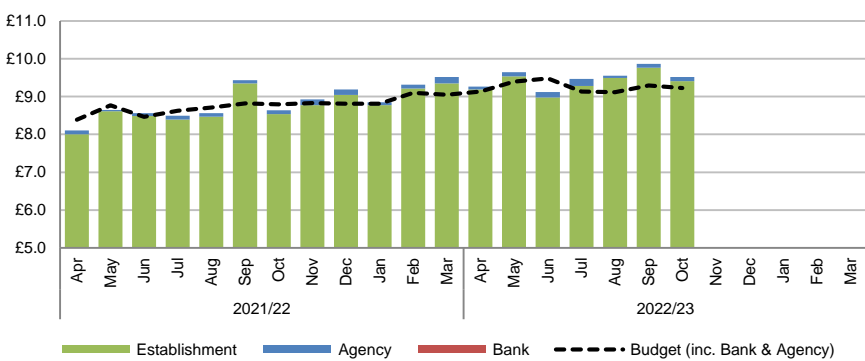


- The overall fill rate for October 2022 was 86.6%.
- The day fill rate for care staff was at 81.8%; with Medicine at 77.5%. Medicine has a number of vacancies for health care assistants, and active recruitment is in place. Staffing risks are mitigated through the twice daily staffing meetings and clinical matrons support the wards to ensure that safety of patients is not compromised.
- There were 14 incidents reported relating to staffing (staff shortages). These were reported as either minor harm (4) or no harm (10).
- All incidents resulting in moderate or greater patient harm have been reviewed and none of these incident reports identify staffing as a causal or contributory factor.
- RN & RM fill rates will be separated within future IPR cycles.

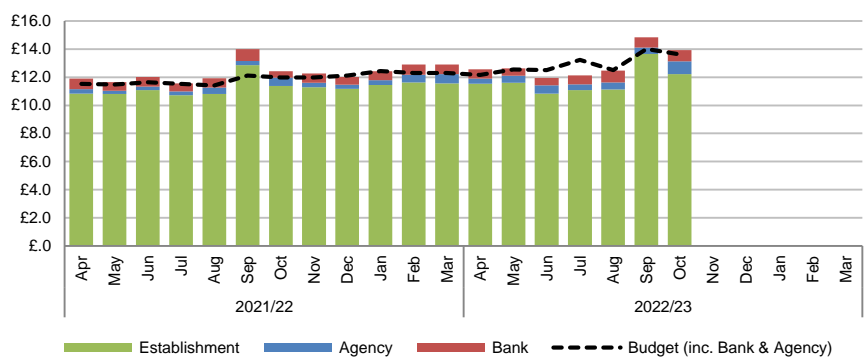
# Eastern Services Safe Clinical Staffing

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

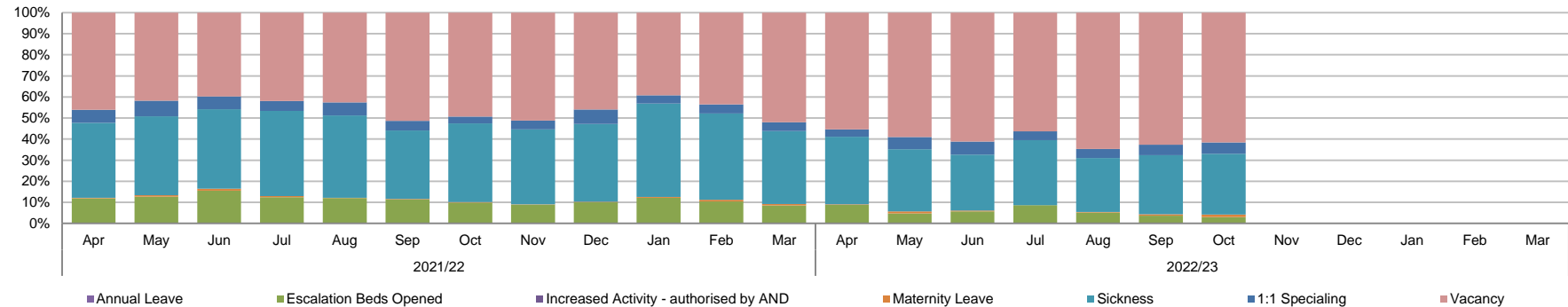
### Medical - Staff FTE (£Million)



### Nursing - Staff FTE (£Million)



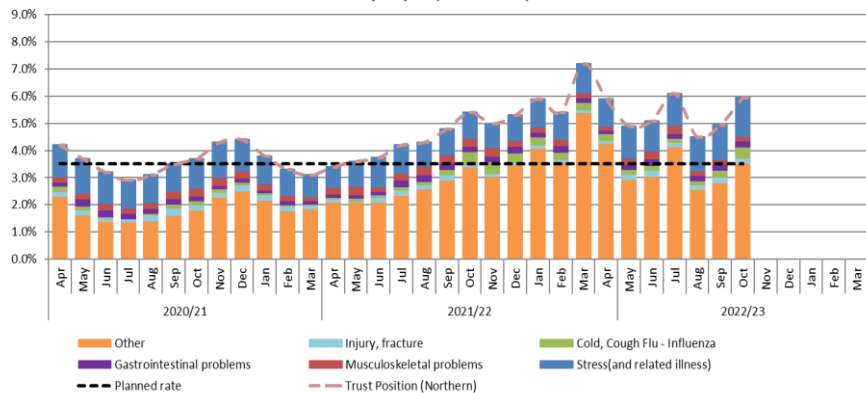
### Nursing Reasons for Bank/Agency Usage



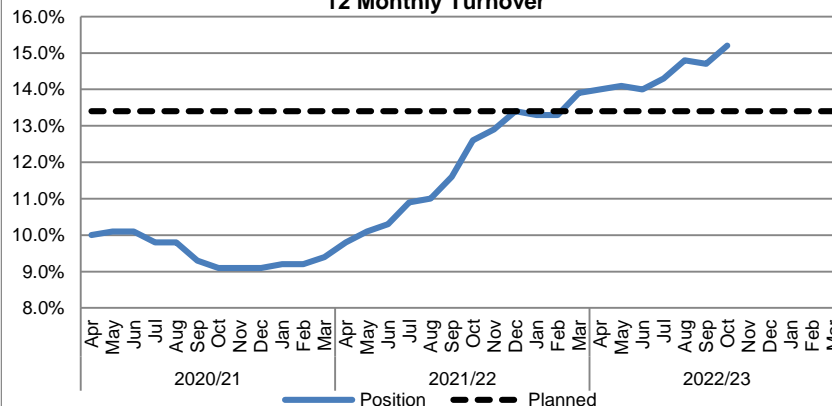
- Pressure on services due to high demand remains an issue, with OPEL 4 declared 30/09/2022 – 03/10/2022 and 21/10/2022 – 24/10/2022.

# Northern Services Workforce Indicators

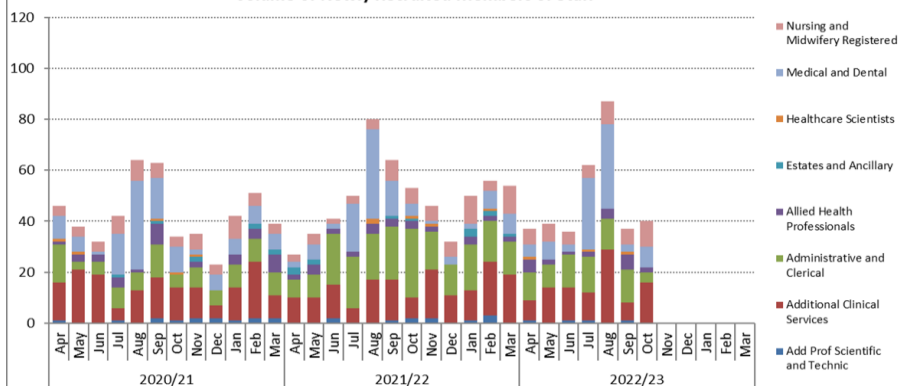
Sickness Absence by Top 5 (inc. Other)



12 Monthly Turnover



Volume of Newly Recruited Members of Staff



Turnover for 12 months ending 31st October 2022	Avg FTE	Starters FTE	Leavers FTE	Turnover FTE %
Add Prof Scientific and Technic	72.7	3.3	15.0	20.7%
Additional Clinical Services	553.9	151.0	97.6	17.6%
Administrative and Clerical	776.1	68.1	115.7	14.9%
Allied Health Professionals	291.1	20.0	29.9	10.3%
Estates and Ancillary	65.0	7.9	8.8	13.6%
Healthcare Scientists	59.0	4.6	8.9	15.1%
Medical and Dental	172.0	14.9	21.1	12.3%
Nursing and Midwifery Registered	764.2	56.5	121.9	16.0%
<b>Grand Total</b>	<b>2,753.86</b>	<b>326.38</b>	<b>419.11</b>	<b>15.2%</b>

## Sickness and Absence

- An increase in the month on month sickness rate is partly attributable to the rise in cold, coughs and flu episodes which we experience during the winter months. The flu and COVID booster programmes are well underway and will provide some mitigation, however it is expected that this usual seasonal trend will continue.
- Days lost to stress related sickness absence (and other related illnesses) continues to remain static for the last 6 months, which given operational pressures is better than might have been expected and may be indicative of the Health & Wellbeing support that is in place. Other related sickness is showing an increase. Further analysis will be undertaken to understand this further and any findings will be shared in the January 2023 IPR.

## Turnover

- The overall rate for Northern Services has increased again, following a short period of stability. The accelerating filling our vacancies programme is underway and is already helping to improve staffing levels. It is expected that this will continue as those in the pipeline start in post.
- There have been small increases across most staff groups, with the exception of Additional Professional Scientific & Technical (stabilised) and estates and Ancillary and Healthcare Scientists which have recorded a slight decrease.
- Those groups most challenged by high turnover – Additional Clinical Services (which primarily include Healthcare Support Workers) and Nursing & Midwifery remain the top three areas of concern. Recruitment events for northern services have been running since September and are proving successful in recruiting high volumes of staff in these areas, however it will take some time for these numbers to show in the new starter figures, in the IPR.
- Welcome, onboarding and retention activity is included as part of accelerating filling our vacancies programme and it is expected that this targeted work will reduce attrition over time.

Activity & Flow

Operational Performance

Patient Experience

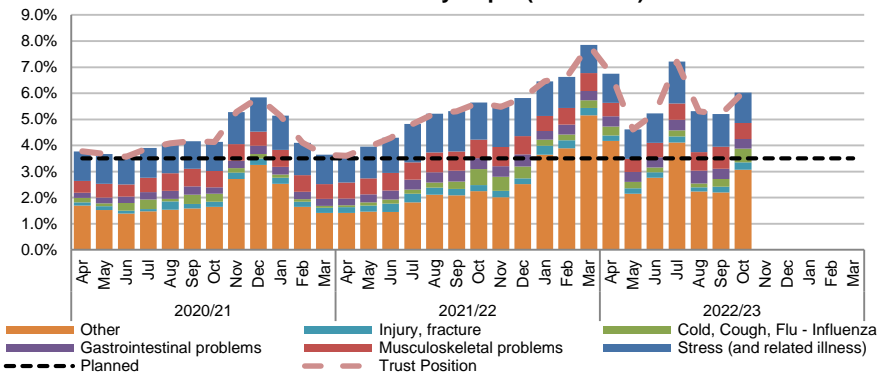
Quality & Safety

Our People

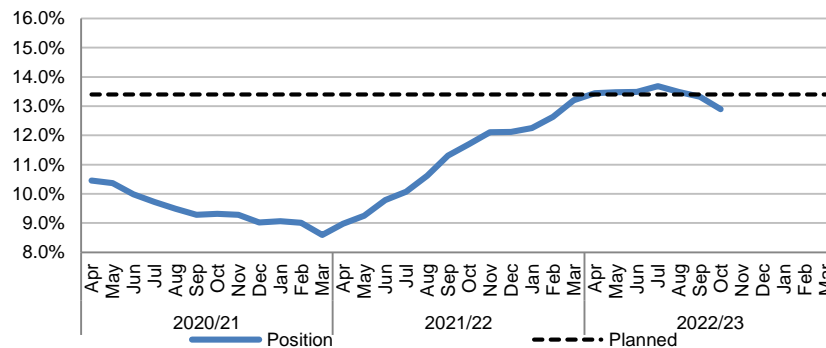
Finance

# Eastern Services Workforce Indicators

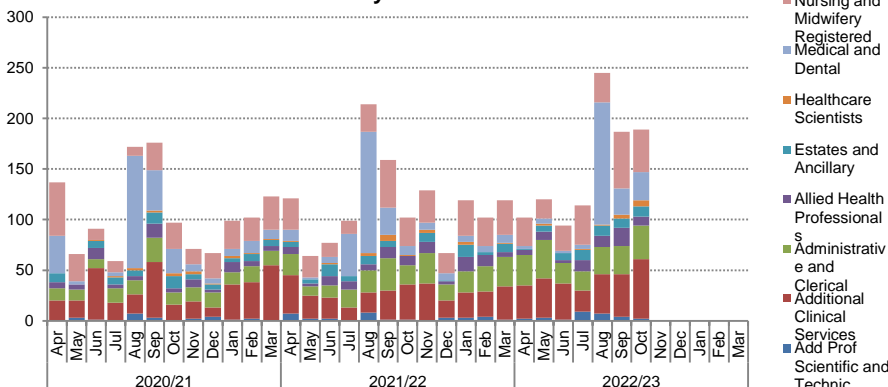
### Sickness Absence by Top 5 (Inc. Other)



### 12 Monthly Turnover



### Volume of Newly Recruited Members of Staff



Turnover for 12 months ending 31st October 2022	Avg FTE	Starters FTE	Leavers FTE	LTR FTE %
Add Prof Scientific and Technic	208.6	27.9	27.5	13.3%
Additional Clinical Services	1484.6	331.9	254.5	16.9%
Administrative and Clerical	1663.2	229.3	229.9	13.8%
Allied Health Professionals	583.1	89.0	69.6	12.0%
Estates and Ancillary	614.4	77.6	90.4	14.7%
Healthcare Scientists	212.2	17.2	21.6	10.3%
Medical and Dental	430.6	17.5	14.0	3.3%
Nursing and Midwifery Registered	2148.5	316.8	244.5	11.2%
Students	15.1	0.0	0.4	2.6%
<b>Grand Total</b>	<b>7360.3</b>	<b>1107.2</b>	<b>952.5</b>	<b>12.9%</b>

## Sickness and Absence

- An increase in the month on month sickness rate is partly attributable to the rise in cold, coughs and flu episodes, which we experience during the winter months. The flu and COVID booster programmes are well underway and will provide some mitigation, however it is expected that this usual seasonal trend will continue.
- Days lost to stress related sickness absence (and other related illnesses) continues to reduce and is at the lowest level for 6 months. This is partly attributed to the intensive support going into divisions to support staff and manager in return to work meetings.
- When looking at the rolling 12 month trend, the Nursing workforce groups have increased marginally and continue to show a rate of over 6% for RN and Midwives, and 9% for Support to Nursing (i.e. HealthCare Support Workers). Estates and Ancillary staff remain at over 9% for the past year. These small increases are to be expected given the rise in seasonal illness.

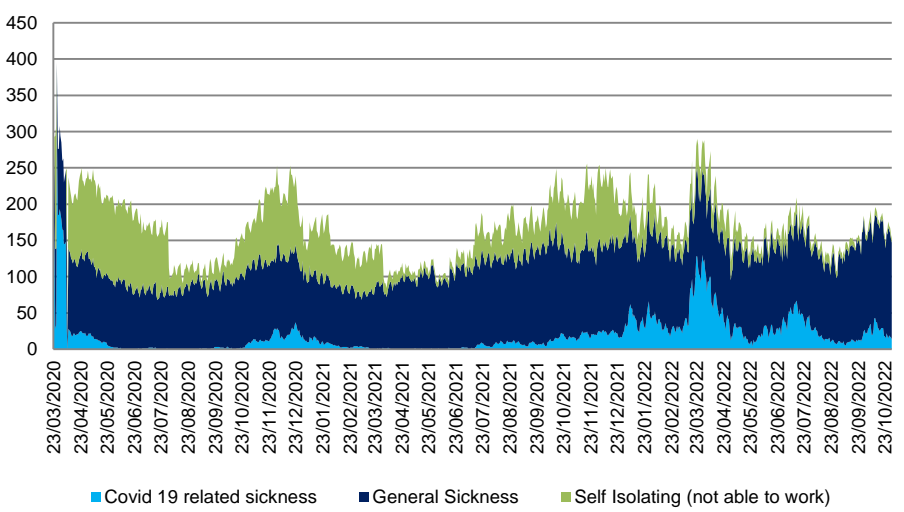
## Turnover

- The overall rate for Eastern Services continues to reduce and is now below 13%, the lowest reported since March. With the exception of AHP, all of our major workforce groups showed a decreased from September 2022.
- Those groups most challenged by high turnover – Additional Clinical Services (which primarily include Healthcare Support Workers) and Estates & Ancillary – have both recorded a further positive drop this month to 16.9% and 14.7% respectively and are the lowest rates reported since March 2022





### Staff sickness and self isolating



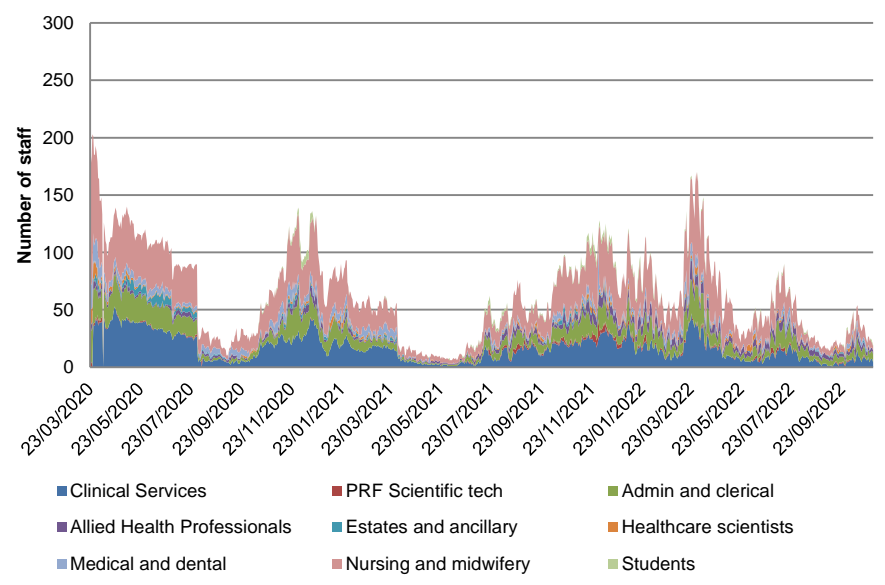
### Staff Absence and Self Isolation

Whilst there has been an increase in general sickness, COVID absence remains low

The programme of flu and Covid autumn booster vaccinations continues with sessions for both being offered across trust sites. The NHS Digital Foundry system collects vaccination data for our workforce and includes attendances at non trust sites such as primary care/pharmacy settings. The percentage of staff receiving the Covid booster stands at 49% with 37% recorded as having the flu vaccination. These rates are for the RDUH as a whole and cannot be split by north/east. The table below shows 2022 rates for RDUH but 2021 rates for northern services only.

Flu vaccinations are lower this year by 26% and Covid by 3% but the Trust continues to encourage uptake through a range of comms messages.

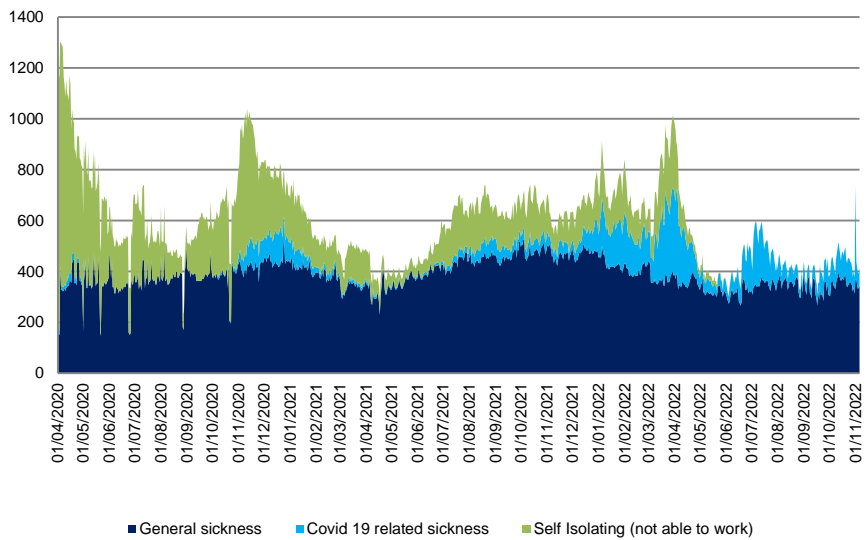
### COVID 19 related sickness and self isolating (not able to work) by staff category



	2022 FLU RDUH Total	2021 FLU ND only	2022 Flu Variance	2022 COVID RDUH Total	2021 COVID ND Only	2022 Covid Variance
<b>Medical and Dental</b>	35%	60%	-25%	53%	56%	-3%
<b>Nursing and Midwifery Registered</b>	36%	65%	-29%	46%	52%	-6%
<b>All other prof qual clinical staff</b>	36%	67%	-31%	53%	55%	-2%
<b>Support to Clinical Staff</b>	37%	60%	-23%	46%	49%	-3%
<b>No direct patient care</b>	37%	59%	-22%	54%	54%	0%
<b>TOTAL</b>	37%	63%	-26%	49%	52%	-3%

# Eastern Services Workforce – Covid related and general sickness information

**Staff Sickness and Self Isolating**

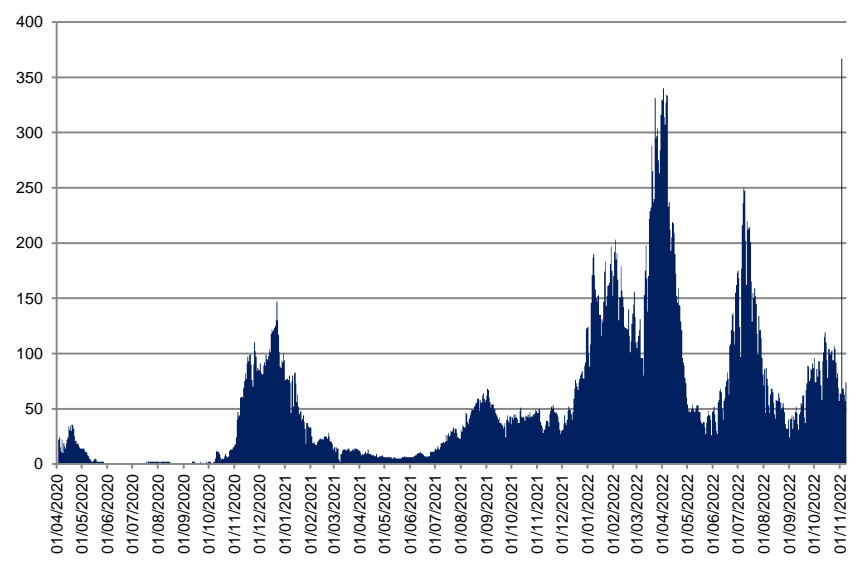


**Staff Absence and Self Isolation**

As at 21st November, the total number of staff with Covid related absence has decreased from 101 one month ago to 48 and reflects the decrease in Covid cases being seen in the general population over the last month. At the time of writing 4.4% of the workforce are absent due to general sickness and Covid related absence and is a positive decrease on the 5% reported last month

The programme of flu and Covid autumn booster vaccinations continues with sessions for both being offered across trust sites. The percentage of staff receiving the Covid booster stands at 49% with 37% recorded as having the flu vaccination. These rates are for the RDUH as a whole and cannot be split by north/east. The table below shows 2022 rates for RDUH but 2021 rates for eastern services only.

**COVID-19 (Staff Confirmed Cases) Related Sickness**

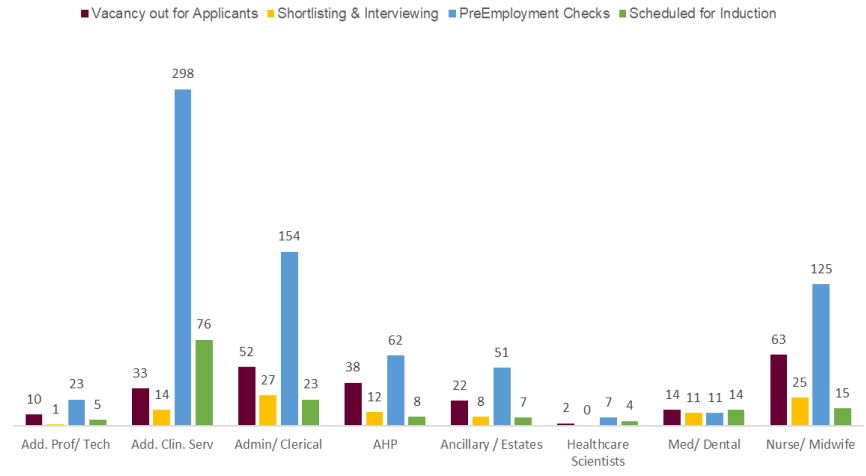


	2022 FLU RDUH Total	2021 FLU RDE only	2022 Flu Variance	2022 COVID RDUH Total	2021 COVID RDE Only	2022 Covid Variance
<b>Medical and Dental</b>	35%	59%	<b>-24%</b>	53%	59%	<b>-6%</b>
<b>Nursing and Midwifery Registered</b>	36%	57%	<b>-21%</b>	46%	47%	<b>-1%</b>
<b>All other prof qual clinical staff</b>	36%	74%	<b>-38%</b>	53%	64%	<b>-11%</b>
<b>Support to Clinical Staff</b>	37%	51%	<b>-14%</b>	46%	40%	<b>6%</b>
<b>No direct patient care</b>	37%	27%	<b>10%</b>	54%	56%	<b>-2%</b>
<b>TOTAL</b>	37%	50%	<b>-13%</b>	49%	49%	<b>0%</b>

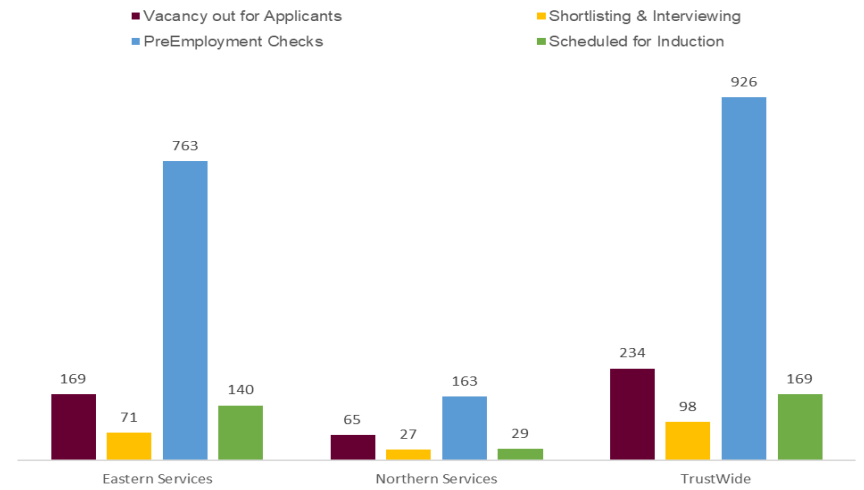


# Trust Other Workforce Indicators

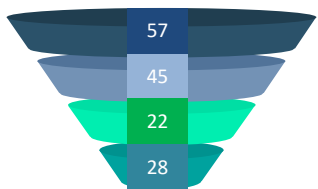
### Recruitment Update - Staff Group



### Recruitment Update - Service Level



Candidate numbers booked for Induction as at 14<sup>th</sup> November 2022



- 14<sup>th</sup> November 2022
- 21<sup>st</sup> November 2022
- 28<sup>th</sup> November 2022
- 5<sup>th</sup> December 2022

NB: Vacancy data is reported in WTE whilst recruitment pipeline is reported in headcount as 1.00 WTE may be filled by more than one person in the actual recruitment.

We have seen an improvement since the launch of Career Gateway though we are still experiencing backlogs in our pipeline due to the high numbers of offers.. Those already in the pre-employment stage are anticipated to start within the next 3 months taking into account notice periods vary between 1-3 months. A full action plan for recruitment is in place and is being monitored at each PWPW Committee.

Work is ongoing via 'Accelerating getting vacancies filled' to look at reducing time to onboard people and ensure sufficient induction capacity and retention activity is in place to sustain progress.

International recruitment continues successfully with 18 registered nurses arriving in the East before the end of December 2022. A further 12 will be starting in the North over the same period. In January/February/March 2023 we are expecting a further 30 in the East and 15 in the North. 2 radiographers have also been recruited directly – one starting in December and the other in January. Further recruitment is ongoing to target specific AHPs with NHSEI funding: Radiographers, Occupational Therapists and Podiatrists (a total of 18).

	Aug-22	Sep-22	Oct-22		
<b>Total Vacancy (ESR/Finance)</b>	<b>Vacancies</b>	<b>Vacancies</b>	<b>Budgeted</b>	<b>Contracted</b>	<b>Vacancies</b>
Add Prof Scientific and Technic	29.4	26.1	245.0	218.4	26.5
Additional Clinical Services	278.4	284.8	2488.2	2197.8	290.4
Administrative and Clerical	156.6	168.4	2736.3	2564.7	171.7
Allied Health Professionals	123.4	118.3	1079.6	960.1	119.6
Estates and Ancillary	131.6	147.0	819.0	651.3	167.8
Healthcare Scientists	24.5	21.3	347.0	318.3	28.7
Medical and Dental	17.0	3.1	1281.5	1278.0	3.5
Nursing and Midwifery Registered	274.4	273.3	3121.2	2866.5	254.7
<b>Total</b>	<b>1035.3</b>	<b>1042.2</b>	<b>12117.9</b>	<b>11055.1</b>	<b>1062.8</b>

# RDUH Cultural Dashboard Executive Summary

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

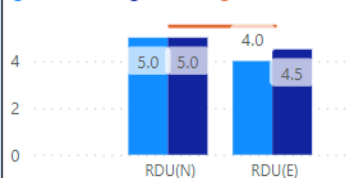
Latest Pulse Survey Questions

Provider ● RDU(E) ● RDU(N)

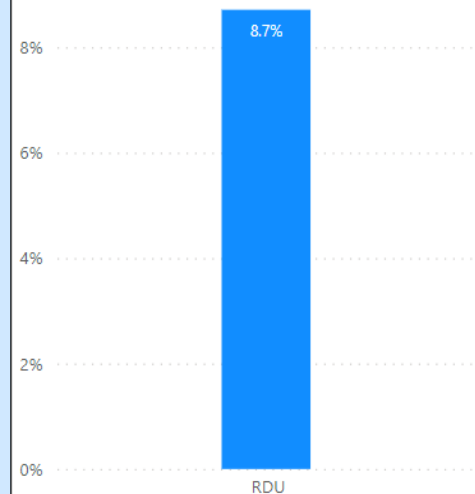


Latest Agency Spend as % of Total (Model Hospital)

ProviderValue PeerValue BenchmarkValue

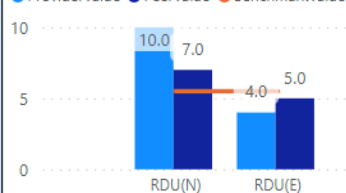


Latest Vacancy Rate by Provider



Latest Bank Spend as % of Total (Model Hospital)

ProviderValue PeerValue BenchmarkValue



Latest Vacancy numbers by Staff Group

Overall subs... Registered ... Health care ... Allied healt... Consultants (...)

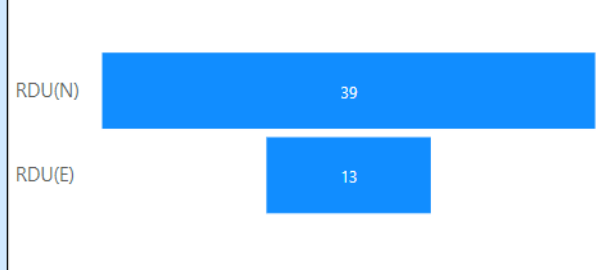


Latest Rolling 12 Month Absence Rate

provider ◆ RDU



12 Month Average: Cases Reported to FTSU Guardians (Model Hospital)



Some data for northern and eastern services is still separate, however it is expected that metrics will become combined over time. This information provides an insight into our performance as a Trust in these areas as well as allowing us to understand where we may be an outlier compared to our system partners. Key points have been noted below:

- The data indicates that around half of the vacancies in the Devon ICS are sitting with the Royal Devon, which is reflective of the size of the organisation. There is a dedicated programme of work ongoing to accelerate filling our vacancies, so it is expected that this number will reduce in the coming months.
- The Royal Devon absence rate has increased since May 2022, however this is currently the lowest absence rate in the system
- The latest vacancy rate in Royal Devon is higher than other acute hospitals in the region, however the vacancy rate shown is from September 2022. The 'accelerating filling our vacancies' programme has started to reduce our net vacancy levels and will continue as candidates in the pipeline start in post. It is expected that this will be reflected in our vacancy rate in future months.
- Agency spend for Royal Devon as a % of the total is the same or lower than the peer value.
- Eastern services is showing a very low number of cases reported to FTSUG's in the last 12 months. It is believed that the lower levels of reporting could in part be due to under-reporting and also due to the lack of a lead FTSUG in post at the point this data was submitted. It has been confirmed that reported referral numbers have since increased substantially. In Q1 of 2022/23 alone 44 cases were reported to the National Guardian's Office for the new organisation.

The cultural dashboard is still evolving, with a task and finish group having been set up, so it is expected that metrics will continue to develop in the coming quarters.

## Northern Services

Period Quarter ● 2022/23 Q1 ● 2022/23 Q2

Care of patients / service users is my organisation's top priority

I am able to make suggestions to improve the work of my team / department

Time passes quickly when I am working

Overall behaviour in this organisation is respectful

I feel fairly treated at work

There are frequent opportunities for me to show initiative in my role

If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation

I am enthusiastic about my job

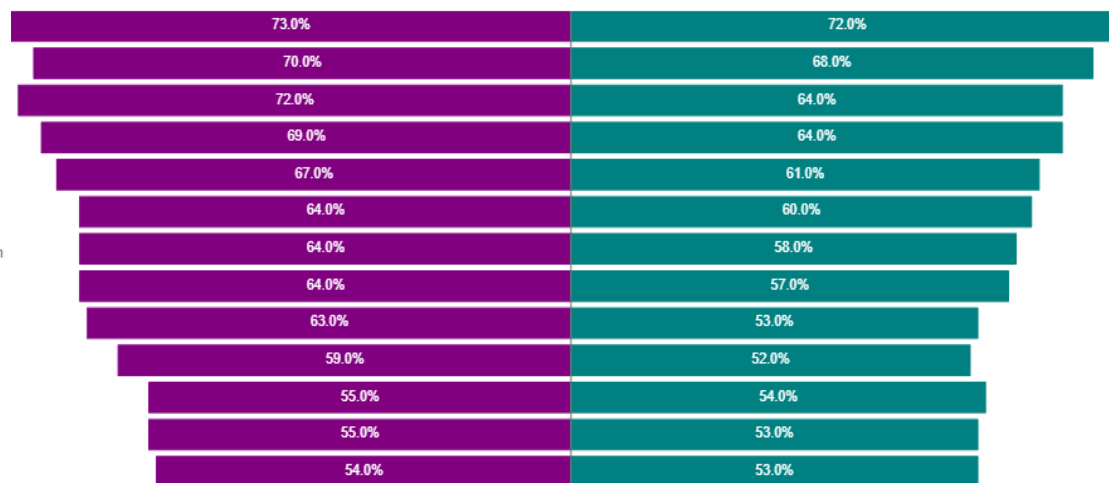
I feel safe to speak up about things that concern me in the organisation

I would recommend my organisation as a place to work

I get regular positive feedback

I am able to make improvements happen in my area of work

I am supported to develop my role



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

In northern services the latest People Pulse showed a decline in all nine questions, with the three most significant declines as follows:

- I feel safe to speak up about things in this organisation (-10%)
- Time passes quickly when I am working (-8%)
- I am enthusiastic about my job (-7%).

The time period in which this survey was conducted (ending in August 2022) was a time of significant pressure across the whole Trust, with integration having recently taken place a couple of months earlier and EPIC had gone live in northern services. Some of the overall decline in scores could reflect these ongoing pressures, with lower staffing levels due to annual leave during the summer holidays.

It is important to note that the majority of organisations in the ICS for Devon also saw a drop in score for the question 'I feel safe to speak up about things in this organisation'. The decline in this question will be escalated to the Lead Freedom to Speak Up Guardian to see if any further local insight can be gained.

The three areas showing significant decline will be further analysed to understand if this is the case in particular areas or divisions within northern services, or if this is a theme across all services. This data will also be reviewed against the next quarters results and should there be no improvement, more concentrated work will be undertaken within these areas.

Currently this dashboard does not include comparative response rate, however it is expected that this will be included moving forward.

## Eastern Services

Period Quarter ● 2022/23 Q1 ● 2022/23 Q2

Care of patients / service users is my organisation's top priority

If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation

Overall behaviour in this organisation is respectful

Time passes quickly when I am working

I am able to make suggestions to improve the work of my team / department

I feel fairly treated at work

I am enthusiastic about my job

There are frequent opportunities for me to show initiative in my role

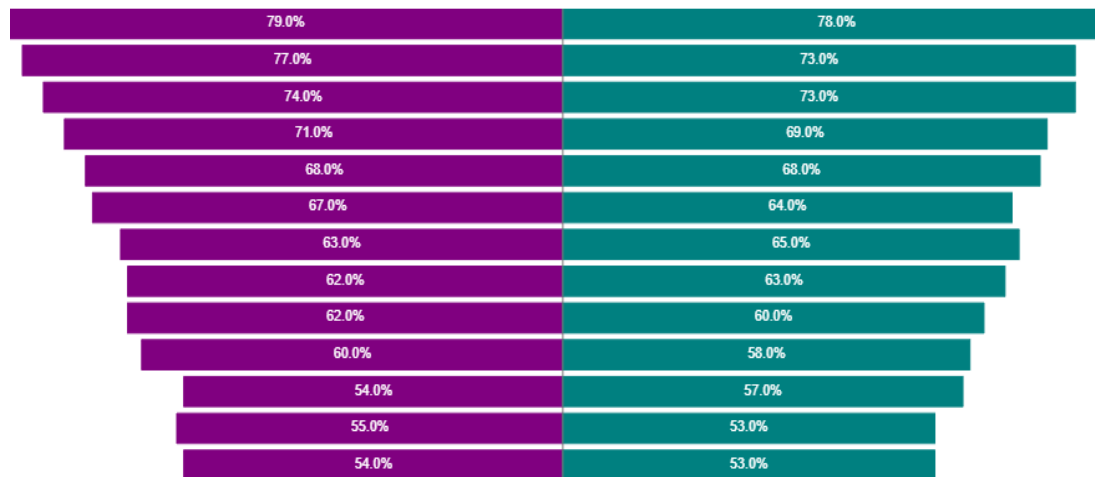
I feel safe to speak up about things that concern me in the organisation

I would recommend my organisation as a place to work

I am supported to develop my role

I am able to make improvements happen in my area of work

I get regular positive feedback



In eastern services the quarter 2 People Pulse Survey showed a decline in six out of nine questions asked, of which the two most significant declines were noted for the following questions:

- If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (-4%)
- I feel fairly treated work (-3%)

Despite these declines, eastern services still remained as the highest 'scorer' in the ICS for Devon in these questions, so whilst not scoring as well as the previous quarter, was still scoring well comparatively.

The following two questions showed an increase in scores:

- I am enthusiastic about my job (+2%)
- There are frequent opportunities for me to show initiative in this role (+1%)

The score for 'I am able to make suggestions to improve the work of my team or department' remained static.

The time period in which this survey was conducted (ending in August 2022) was a time of significant pressure across the whole Trust, with integration having recently taken place a couple of months earlier. The overall decline in some of the scores could reflect these ongoing pressures, with lower staffing levels due to annual leave during the summer holidays.

Currently this dashboard does not include comparative response rate, however it is expected that this will be included moving forward.

# RDUH Finance Overview

Activity & Flow

Operational Performance

Patient Experience

Quality & Safety

Our People

Finance

## Financial Performance - key performance indicators

Consolidated Metrics						
Domain	Measure / Metric	Unit of Measure	Last Month Sep-22	This Month Oct-22	Year End Mar-23	
Income and Expenditure	<b>I&amp;E Surplus / (Deficit) - Total</b>	£'000	-6,108	-8,433	-18,263	
	I&E Surplus / (Deficit) v budget	£'000	0	3	0	
	<b>Income variance to budget - Total</b>	£'000	-287	324	555	Mostly related to commercial income(see below).
	<b>Income variance to budget - Total</b>	%	-0.06%	0.06%	0.06%	
	Income variance to budget - Patient Care	£'000	797	332	518	
	Income variance to budget - Commercial income	£'000	-1,084	2	37	Commercial activities are under-recovered mostly due to car parking, nursery, fertility and catering. Increasing education income now reflected in YTD and FOT budgets off-setting prior month and FOT adverse variances.
	<b>Pay variance to budget - Total</b>	£'000	-433	-313	323	Impact of productivity CIP under delivery removed from pay variance and reported within the CIP to show true position on pay (pre CIP)
	<b>Pay variance to budget - Total</b>	%	-0.14%	-0.09%	0.05%	
	Agency expenditure (Inc. COVID expenditure) variance to Plan	£'000	-3,842	-5,142	-10,116	Usage particularly in nursing and medical workforce reflecting vacancies, sickness, Covid impact and ESRF delivery.
	<b>Non Pay variance to budget</b>	£'000	837	-214	-791	Increased drugs expenditure YTD and FOT not recoverable above block contract income.
	<b>Non Pay variance to budget</b>	%	0.54%	-0.12%	-0.25%	
	<b>PDC, Depreciation, Interest Paid / Received variance to budget</b>	£'000	-117	206	-87	
	<b>PDC, Depreciation, Interest Paid / Received variance to budget</b>	%	-0.48%	0.72%	-0.18%	
	<b>Cost Improvement Programme - Total Current Year achievement</b>	£'000	15,530	18,415	33,935	
Cost Improvement Programme - Year to date/ Current Year variance to budget	£'000	-7,500	-9,168	-18,745	See report narrative	
Capital & Cash	Cash balance	£'000	71,541	55,577	48,754	<b>YTD:</b> Timing of settlement of net working capital, particularly payments to suppliers, capital programme slippage and the impact of late changes to the June plan that was not reflected in the Balance Sheet (£11.4m) <b>FOT:</b> The balance sheet was not updated for the late revenue changes made to the final Annual Plan.
	Cash variance to budget - above / (below)	£'000	29,309	15,409	19,198	
	Better Payment Practice v 95% target - volume	%	91%	91%	95%	
	Better Payment Practice v 95% target - value	%	94%	93%	95%	
	<b>Capital Expenditure variance to budget - Total above / (below)</b>	£'000	-4,971	-6,601	0	See report narrative. There is confidence the programme will recover based on the value of open orders.
	Capital Expenditure variance to budget - CDEL above / (below)	£'000	-4,479	-5,722	0	As above
Capital Expenditure variance to budget - PDC above / (below)	£'000	-492	-879	0	Slippage on planned commencement of Diagnostics CDC in East that is awaiting approval.	

### Key

Total value

Positive variance value

Negative variance value <5%

Negative variance value >5%

# RDUH Summary Finance position

## Trust Commentary

### Month 7 Summary Finance Position - YTD

- The Board has approved a deficit plan of £18.3m
- Cumulative deficit of £8.3m achieves plan predominantly by Delivering Best Value slippage on pay off-set by lower non-pay expenditure.
- Favourable non-pay arises from the reduced levels of elective activity.
- Depreciation and PDC calculations are based on the balance sheet position.

### Month 7 Summary Finance Position - FOT

- The planned deficit of £18.3m is forecast to be achieved.

### Risks and Mitigations

- The table opposite sets out the current assessment of risk and mitigation opportunities that exist in months 8 to 12 to the current planned deficit.
- Gross risk and mitigation opportunities have been consolidated and assessed on likelihood of materialising.
- Unmitigated risk of £2.0m to £3.1m has been identified with the main mitigation opportunities being further non recurrent benefits expected of continued expenditure underspends and other technical benefits. Work is ongoing to identify ways of mitigating this net risk position by year end.

### Delivering Best Value (DBV) Programme

- The DBV programme for the year is £33.9m
- £9.2m has been achieved YTD against £18.4m target being £9.2m adverse to plan. The shortfall was covered through other NR slippage as set out above.
- Current assessment is of delivering £15.2m of the total programme being £18.7m adverse to plan and is reflected in the risks and mitigations table for months 8-12 (with month 1-7 being mitigated within the YTD overall position). Of the forecast shortfall £14.6m for the year relates to productivity opportunity that is affected by current pressures in Urgent and Emergency Care impacting the ability to deliver the elective activity plan.

Delivering Best Value Programme £m	FY Plan	Year to date plan	Year to date actual	Year to date variance	True Forecast	Forecast Variance
Divisional CIP	5.5	3.6	3.0	-0.6	4.5	-1.0
Mycare benefits	1.9	1.0	0.4	-0.6	0.9	-1.0
Productivity	14.6	6.8	0.0	-6.8	0.0	-14.6
Covid Cost Reductior	6.5	3.6	2.9	-0.7	5.3	-1.2
Further Stretch	5.4	3.4	2.9	-0.5	4.5	-0.9
<b>Total</b>	<b>33.9</b>	<b>18.4</b>	<b>9.2</b>	<b>-9.2</b>	<b>15.2</b>	<b>-18.7</b>

### Consistency with reporting to NHSEI and the Integrated Care System for Devon

- The reporting to NHSEI via the ICS has now brought a renewed focus on consistency of reporting.
- The Board has historically received financial information comparing actual to budget being a flexed version of the plan submitted to NHSEI for the financial year. Whilst this gives the Board assurance of consistency with information provided to internal budget managers, system and national reporting requirements compare actual to fixed plan and when taken in isolation can give the appearance of differential reporting to Boards and Regulator.
- The appendices include a reconciliation of the YTD fixed plan to budget and transparency on the variances reported against fixed plan and budget.

## Data

### Trust

	Year to Date			Year End Forecast		
	Actual £,000	Budget £,000	Variance Fav / (Adv) £,000	Actual £,000	Budget £,000	Variance Fav / (Adv) £,000
<b>Month 7 2022/23</b>						
<b>Summary Income &amp; Expenditure</b>						
Patient Income	491,212	490,890	322	845,325	844,807	518
Commercial Income	65,525	65,523	2	110,828	110,791	37
<b>Total Income</b>	<b>556,737</b>	<b>556,413</b>	<b>324</b>	<b>956,153</b>	<b>955,598</b>	<b>555</b>
Pay	(351,177)	(350,864)	(313)	(605,650)	(605,973)	323
Non Pay	(185,516)	(185,302)	(214)	(319,150)	(318,359)	(791)
<b>Total Expenditure</b>	<b>(536,693)</b>	<b>(536,166)</b>	<b>(527)</b>	<b>(924,800)</b>	<b>(924,332)</b>	<b>(468)</b>
<b>EBITDA</b>	<b>20,044</b>	<b>20,247</b>	<b>(203)</b>	<b>31,353</b>	<b>31,266</b>	<b>87</b>
PDC, Depreciation, Interest & gain from absorption	84,129	83,972	157	59,417	58,876	541
<b>Net Surplus / (Deficit)</b>	<b>104,173</b>	<b>104,219</b>	<b>(46)</b>	<b>90,770</b>	<b>90,142</b>	<b>628</b>
Removal of exceptional items	(112,603)	(112,652)	49	(109,033)	(108,405)	(628)
<b>Net Surplus / (Deficit) after exceptional items</b>	<b>(8,430)</b>	<b>(8,433)</b>	<b>3</b>	<b>(18,263)</b>	<b>(18,263)</b>	<b>0</b>

Delivery Risk	Most Likely £m	Best Case £m
<b>Deficit plan</b>	<b>-18.3</b>	<b>-18.3</b>
<b>Risks months 1 - 8</b>		
Overall DBV shortfall	-18.8	-18.8
ERF cost risk - additional 104wk schemes	-1.5	-1.5
Additional costs of energy not funded	-2.0	-2.0
Overspend issues	-5.7	-5.7
Contractual risk	-1.0	-1.0
Other issues	-0.8	-0.8
<b>Gross Risk</b>	<b>-29.8</b>	<b>-29.8</b>
<b>Mitigations months 1 - 8</b>		
Underspending areas	14.0	15.2
Balance Sheet mitigations	6.0	6.0
Slippage	4.1	4.1
Funding / contractual negotiations	2.5	2.5
<b>Total Mitigations</b>	<b>26.7</b>	<b>27.8</b>
<b>Net delivery risk on top of planned deficit</b>	<b>-3.1</b>	<b>-2.0</b>



# RDUH Summary Finance position

## Consolidated - Commentary

### Capital

- The capital programme for the year is £53.9m and is forecast to be £2.4m higher than plan due to additional CDEL required to cover new leases and additional Donations.
- Confirmation has been received that the 2021/22 and 2022/23 IFRS16 impact of leases meeting the criteria will be covered by a central allocation. Whilst minimising the risk to Trust CDEL there remains detail to work through with NHSEI.
- Capital expenditure to M7 was £21.2m; whilst the programme is behind plan, there is confidence the programme will recover based on the value of open orders.

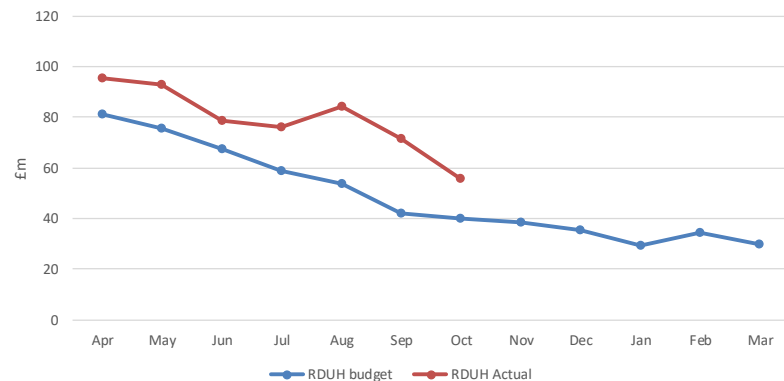
### Cash

- Closing cash as at the end of October is £55.6m and is £15.4m higher than plan due to timing of settlement of net working capital, slippage in the capital programme and the impact of late changes to the June plan that was not reflected in the Balance Sheet (£11.4m).
- Forecast cash balance of £48.8m at the end of the year.
- Better Payment Practice of paying 92.2% YTD, of Non-NHS invoices paid within 30 days (target 95%) - this remains challenging due to the level of invoicing within pharmacy and the resourcing needed to reconcile and approve within the pharmacy team. Plans are progressing.
- Aged debt stands at £37.3m with £31.3m being not due at month end.

## Data

	Year to Date			Full Year Forecast		
	Actual £'000	Plan £'000	Variance Fav/(Adv)	Actual £'000	Plan £'000	Variance Fav/(Adv)
<b>Capital Funding Sources:</b>						
CDEL	17,448	17,448	0	33,306	33,306	0
Donated	892	892	0	1,316	892	424
Leases	1,219	1,219	0	4,887	2,303	2,584
PDC	8,282	8,282	0	14,366	14,953	(587)
<b>Total Capital Income</b>	<b>27,841</b>	<b>27,841</b>	<b>0</b>	<b>53,875</b>	<b>51,454</b>	<b>2,421</b>
<b>Expenditure:</b>						
Developments	5,920	7,608	1,688	15,076	14,737	(339)
Equipment	2,044	4,887	1,244	15,738	14,918	(820)
Estates projects	1,349	2,552	2,843	5,062	6,050	988
Digital	11,928	12,794	825	16,396	15,191	(1,205)
Unallocated	0	0	0	1,603	558	(1,045)
<b>Total Capital Expenditure</b>	<b>21,241</b>	<b>27,841</b>	<b>6,600</b>	<b>53,875</b>	<b>51,454</b>	<b>(2,421)</b>
<b>Under / (Over) Spend</b>	<b>6,600</b>	<b>0</b>	<b>6,600</b>	<b>0</b>	<b>0</b>	<b>0</b>

Cash balance and Budget



**Royal Devon University Healthcare NHS Foundation Trust**  
**Income Statement - Consolidated**  
 Period ending 31/10/2022  
 Month 7

<b>Income</b>
Patient Care Income
Operating Income
<b>Total Income</b>
Employee Benefits Expenses
Drugs
Clinical Supplies
Non-Clinical Supplies
Misc Other Operating Expenses
Services Received
<b>Total Costs</b>
<b>EBITDA</b>
Profit / (Loss) on asset disposals
Total Depreciation
<b>Total Operating Surplus / (Deficit)</b>
Interest Receivable
Interest Payable
PDC
Gain from Transfer by Absorption
<b>Net Surplus / (Deficit)</b>
Remove donated asset income & depreciation, AME impairment and gain from transfer by absorption
<b>Net Surplus/(Deficit) after donated asset &amp; PSF/MRET Income</b>

Year to Date		
Actual	Budget	Actual Variance to Budget Fav / (Adv)
£'000	£'000	£'000
491,212	490,890	322
65,525	65,523	2
<b>556,737</b>	<b>556,413</b>	<b>324</b>
(351,177)	(350,864)	(313)
(58,309)	(57,913)	(396)
(45,848)	(46,641)	793
(9,279)	(9,473)	194
(59,201)	(59,034)	(167)
(12,879)	(12,241)	(638)
<b>(536,693)</b>	<b>(536,166)</b>	<b>(527)</b>
<b>20,044</b>	<b>20,247</b>	<b>(203)</b>
3	0	3
(21,688)	(21,844)	156
<b>(1,641)</b>	<b>(1,597)</b>	<b>(44)</b>
648	648	0
(1,668)	(1,660)	(8)
(6,192)	(6,198)	6
113,026	113,026	0
<b>104,173</b>	<b>104,219</b>	<b>(46)</b>
(112,603)	(112,652)	49
<b>(8,430)</b>	<b>(8,433)</b>	<b>3</b>

Outturn		
Actual	Budget	Actual Variance to Budget Fav / (Adv)
£'000	£'000	£'000
845,325	844,807	518
110,828	110,791	37
<b>956,153</b>	<b>955,598</b>	<b>555</b>
(605,650)	(605,973)	323
(98,238)	(97,306)	(932)
(82,390)	(83,074)	684
(15,587)	(16,014)	427
(99,598)	(99,189)	(409)
(23,337)	(22,776)	(561)
<b>(924,800)</b>	<b>(924,332)</b>	<b>(468)</b>
<b>31,353</b>	<b>31,266</b>	<b>87</b>
3	0	3
(41,319)	(41,857)	538
<b>(9,963)</b>	<b>(10,591)</b>	<b>628</b>
1,325	1,325	0
(2,803)	(2,803)	0
(10,815)	(10,815)	0
113,026	113,026	0
<b>90,770</b>	<b>90,142</b>	<b>628</b>
(109,033)	(108,405)	(628)
<b>(18,263)</b>	<b>(18,263)</b>	<b>0</b>

**KEY MOVEMENTS AGAINST BUDGET**  
**Overall achievement against plan**  
 1. NR pay underspends off-set by slippage on Delivering Best Value and reserves.  
 2. Drugs expenditure not recoverable above block contract income.  
 3. Under spends linked to low er levels of elective activity and classification w ithin non-pay categories.

Royal Devon University Healthcare NHS Foundation Trust Statement of Financial Position - Consolidated	Year to Date			Outturn			Prior Year			
	Actual	Annual Plan	Actual Variance Fav. / (Adv.)	Actual	Annual Plan	Actual Variance Fav. / (Adv.)	Mar-22	Actual YTD Movement Incr. / (Dec.)		
	£000	£000	£000	£000	£000	£000	£000	£000		
Period ending 31/10/2022 Month 07										
<b>Non-current assets</b>										
Intangible assets	60,668	62,694	(2,026)	1	59,117	58,263	854	57,500	3,168	
Other property, plant and equipment (excludes leases)	392,540	395,841	(3,301)	1	422,196	423,476	(1,280)	392,293	247	
Right of use assets - leased assets for lessee (excludes PF/LIFT)	54,373	55,650	(1,277)	2	53,622	52,915	707	1,840	52,533	
Other investments / financial assets	5	5	0		5	5	0	5	0	
Receivables	2,816	2,726	90		2,726	2,726	0	2,725	91	
<b>Total non-current assets</b>	<b>510,402</b>	<b>516,916</b>	<b>(6,514)</b>		<b>537,666</b>	<b>537,385</b>	<b>281</b>	<b>454,363</b>	<b>56,039</b>	
<b>Current assets</b>										
Inventories	14,996	13,550	1,446	3	13,550	13,550	0	13,275	1,721	
Receivables: due from NHS and DHSC group bodies	34,520	19,310	15,210	4	17,810	17,810	0	29,931	4,589	
Receivables: due from non-NHS/DHSC group bodies	25,099	20,850	4,249	4	16,000	16,000	0	16,575	8,524	
Other assets: including assets held for sale & in disposal groups	0	0	0		0	0	0	0	0	
Cash	55,577	40,170	15,407	5	48,754	29,556	19,198	10	88,920	(33,343)
<b>Total current assets</b>	<b>130,192</b>	<b>93,880</b>	<b>36,312</b>		<b>96,114</b>	<b>76,916</b>	<b>19,198</b>	<b>148,701</b>	<b>(18,509)</b>	
<b>Current liabilities</b>										
Trade and other payables: capital	(5,702)	(5,000)	(702)		(11,000)	(11,000)	0	(21,284)	15,582	
Trade and other payables: non-capital	(82,551)	(82,008)	(543)		(80,229)	(80,061)	(168)	(84,970)	2,419	
Borrowings	(14,398)	(12,013)	(2,385)	6	(13,042)	(11,763)	(1,279)	(6,277)	(8,121)	
Provisions	(217)	(200)	(17)		(200)	(200)	0	(200)	(17)	
Other liabilities: deferred income including contract liabilities	(25,991)	(12,100)	(13,891)	7	(10,500)	(10,500)	0	(17,649)	(8,342)	
<b>Total current liabilities</b>	<b>(128,859)</b>	<b>(111,321)</b>	<b>(17,538)</b>		<b>(114,971)</b>	<b>(113,524)</b>	<b>(1,447)</b>	<b>(130,380)</b>	<b>1,521</b>	
<b>Total assets less current liabilities</b>	<b>511,735</b>	<b>499,475</b>	<b>12,260</b>		<b>518,809</b>	<b>500,777</b>	<b>18,032</b>	<b>472,684</b>	<b>39,051</b>	
<b>Non-current liabilities</b>										
Borrowings	(106,861)	(107,406)	545		(105,295)	(103,136)	(2,159)	(63,038)	(43,823)	
Provisions	(941)	(970)	29		(970)	(970)	0	(970)	29	
Other liabilities: deferred income including contract liabilities	0	(1,877)	1,877	8	0	(1,877)	1,877	(1,877)	1,877	
<b>Total non-current liabilities</b>	<b>(107,802)</b>	<b>(110,253)</b>	<b>2,451</b>		<b>(106,265)</b>	<b>(105,983)</b>	<b>(282)</b>	<b>(65,885)</b>	<b>(41,917)</b>	
<b>Total net assets employed</b>	<b>403,933</b>	<b>389,222</b>	<b>14,711</b>		<b>412,544</b>	<b>394,794</b>	<b>17,750</b>	<b>406,799</b>	<b>(2,866)</b>	
<b>Financed by</b>										
Public dividend capital	349,514	350,132	(618)		357,188	358,468	(1,280)	343,514	6,000	
Revaluation reserve	49,894	48,957	937		63,956	63,956	0	49,900	(6)	
Income and expenditure reserve	4,525	(9,867)	14,392		(8,600)	(27,630)	19,030	10	13,386	(8,861)
<b>Total taxpayers' and others' equity</b>	<b>403,933</b>	<b>389,222</b>	<b>14,711</b>	9	<b>412,544</b>	<b>394,794</b>	<b>17,750</b>	<b>406,799</b>	<b>(2,866)</b>	

**KEY MOVEMENTS**

- Timing of MYCARE Asset Under Construction (Intangible) and slippage on capital programme (PP&E) forecast to recover by year end
- Variance to budget includes £2.0m lease premium adjustment (previously held in deferred income) reducing the lease assets and £1.0m of higher than budget assets largely due to the value of community property leases being higher
- Pharmacy and theatre stock level increases
- Timing issue - no bad debt risk.
- Cash £15.4m higher than plan due to timing of settlement of net working capital and the impact of late changes to the June plan that was not reflected in the Balance Sheet (£11.4m) and slippage on the capital programme.
- Loans and Leases due in 1 year primarily due to YTD accrued loan interest, a re-analysis of lease liability splits and the value of community property leases being higher than planned.
- Deferred income is £10.2m higher than budget and will be released over the course of H2.
- Non-current deferred income of £1.9m relating to the lease premium for Bowmoor House and Noy Scott House that has now been released against the right-of-use asset values for those properties within property, plant and equipment (as per IFRS-16 national guidance).
- Reserves are £14.7m higher than plan due to the plan not being updated for the late revenue changes made - £11.4m is the cash benefit.
- The FOT cash balance is £19.0m higher than plan. It has been identified that the balance sheet was not updated for the late revenue changes made to the final Annual Plan.

Royal Devon University Healthcare NHS Foundation Trust Cash Flow Statement - Consolidated Period ending 31/10/2022 Month 07	Year to Date			Outturn		
	Actual	Annual Plan	Actual Variance Fav. / (Adv.)	Actual	Annual Plan	Actual Variance Fav. / (Adv.)
	£000	£000	£000	£000	£000	£000
<b>Cash flows from operating activities</b>						
<b>Operating surplus/(deficit)</b>	(1,645)	(4,912)	3,267	(9,963)	(9,561)	(402)
Non-cash income and expense:						
Depreciation and amortisation	21,689	22,126	(437)	37,619	39,665	(2,046)
Impairments and reversals	0	3,700	(3,700)	3,700	3,700	0
Income recognised in respect of capital donations (cash and non-cash)	(45)	(154)	109	(454)	(268)	(186)
(Increase)/decrease in receivables	(13,204)	2,427	(15,631)	12,695	8,777	3,918
(Increase)/decrease in inventories	(1,721)	(269)	(1,452)	(275)	(269)	(6)
Increase/(decrease) in trade and other payables	(2,940)	(27,196)	24,256	(4,377)	(27,801)	23,424
Increase/(decrease) in other liabilities	8,424	(5,801)	14,225	(7,148)	(7,488)	340
Increase/(decrease) in provisions	(12)	0	(12)	0	0	0
<b>Net cash generated from / (used in) operations</b>	<b>10,546</b>	<b>(10,079)</b>	<b>20,625</b>	<b>31,797</b>	<b>6,755</b>	<b>25,042</b>
<b>Cash flows from investing activities</b>						
Interest received	648	148	500	1,207	203	1,004
Purchase of intangible assets	(8,003)	(12,687)	4,684	(12,494)	(13,389)	895
Purchase of property, plant and equipment and investment property	(28,805)	(18,939)	(9,866)	(49,703)	(43,892)	(5,811)
Proceeds from sales of property, plant and equipment and investment property	3	0	3	3	0	3
Receipt of cash donations to purchase capital assets	15	356	(341)	1,174	850	324
<b>Net cash generated from/(used in) investing activities</b>	<b>(36,142)</b>	<b>(31,122)</b>	<b>(5,020)</b>	<b>(59,813)</b>	<b>(56,228)</b>	<b>(3,585)</b>
<b>Cash flows from financing activities</b>						
Public dividend capital received	6,000	6,618	(618)	13,675	14,954	(1,279)
Loans from Department of Health and Social Care - repaid	(635)	(635)	0	(1,270)	(1,270)	0
Other loans received	854	0	854	854	0	854
Other loans repaid	(2,279)	(2,280)	1	(4,606)	(4,606)	0
Other capital receipts	0	93	(93)	174	174	0
Capital element of finance lease rental payments	(4,729)	(4,282)	(447)	(7,493)	(5,796)	(1,697)
Interest paid	(962)	(1,192)	230	(1,998)	(1,995)	(3)
Interest element of finance lease	(329)	(290)	(39)	(513)	(513)	0
PDC dividend (paid)/refunded	(5,667)	(5,572)	(95)	(10,973)	(10,830)	(143)
<b>Net cash generated from/(used in) financing activities</b>	<b>(7,747)</b>	<b>(7,540)</b>	<b>(207)</b>	<b>(12,150)</b>	<b>(9,882)</b>	<b>(2,268)</b>
<b>Increase/(decrease) in cash and cash equivalents</b>	<b>(33,343)</b>	<b>(48,741)</b>	<b>15,398</b>	<b>(40,166)</b>	<b>(59,355)</b>	<b>19,189</b>
<b>Cash and cash equivalents at start of period</b>	<b>88,920</b>	<b>88,911</b>	<b>9</b>	<b>88,911</b>	<b>88,920</b>	<b>(9)</b>
<b>Cash and cash equivalents at end of period</b>	<b>55,577</b>	<b>40,170</b>	<b>15,407</b>	<b>48,754</b>	<b>29,556</b>	<b>19,198</b>

**Royal Devon University Healthcare NHS Foundation Trust**  
**Capital Expenditure - Consolidated**  
**Period ending 31/10/2022**  
**Month 7**

Scheme	Source of Funding	Actual expenditure to date			Total expenditure forecast for the year				Expected Completion Date
		Actual £'000	Plan £'000	Variance slippage / (higher) £'000	Forecast future £'000	Forecast £'000	Plan £'000	Variance slippage / (higher) £'000	
<b>Schemes &gt;= £500k</b>									
MYCARE (Northern)	N CDEL/PDC	10,061	10,057	(4)	400	10,461	10,061	(400)	22/23
ED Reconfiguration	E CDEL	4,151	4,285	134	620	4,771	6,871	2,100	23/24
Estates Infrastructure 22/23	E CDEL	1,138	1,441	303	3,104	4,242	4,520	278	22/23
Diagnostics CDC	E PDC	0	1,664	1,664	2,604	2,604	4,110	1,506	24/25
Cardiology Day Case Unit	E PDC/DON	0	0	0	1,599	1,599	2,500	901	24/25
Operating leases renewed in 2022/23	N&E CDEL	0	1,219	1,219	4,887	4,887	2,303	(2,584)	22/23
Backlog Maintenance	N CDEL	232	535	303	1,048	1,280	1,840	560	22/23
Aseptic Unit	N CDEL	0	700	700	0	0	1,700	1,700	22/23
Ophthalmology Hub	N CDEL/DON	70	431	361	1,343	1,413	1,249	(164)	22/23
Equipment	N CDEL	324	355	31	1,507	1,831	1,105	(726)	22/23
NHP - OBC Funding	N PDC	608	618	10	694	1,302	1,060	(242)	22/23
R14 Genetics NovaSeq 6000	E PDC	795	0	(795)	168	963	0	(963)	22/23
Digital Histopathology (Eastern)	E CDEL/PDC	0	0	0	905	905	905	0	22/23
LINAC Replacement	E CDEL	581	553	(28)	255	836	836	(0)	22/23
Mortuary	N CDEL	10	350	340	790	800	800	0	22/23
Nightingale Hospital Accelerator Programme	E CDEL	778	765	(13)	0	778	765	(13)	22/23
MYCARE (Eastern)	E CDEL	1,059	806	(254)	2	1,061	714	(347)	22/23
Replacement of Fluoroscopy Room 2 Siemens Artis Zee	E CDEL	12	136	124	586	598	598	0	22/23
Room 9 - Xray Replacement	E CDEL	0	0	0	540	540	0	(540)	22/23
General Space Moves	N CDEL	47	0	(47)	83	130	689	559	22/23
Endoscopy Expansion	E PDC	0	0	0	502	502	0	(502)	23/24
Wi-Fi Refresh	N CDEL	0	0	0	450	450	500	50	22/23
<b>Total Schemes &gt;= £500k</b>		<b>19,867</b>	<b>23,915</b>	<b>4,047</b>	<b>22,086</b>	<b>41,954</b>	<b>43,126</b>	<b>1,173</b>	
Schemes <= £500k	N&E CDEL	1,373	3,927	2,554	10,043	11,416	7,822	(3,594)	22/23
Schemes <= £500k	N&E PDC	0	0	0	406	406	406	0	22/23
Schemes <= £500k	N&E DON	0	0	0	100	100	100	0	22/23
<b>Total Capital Expenditure</b>		<b>21,240</b>	<b>27,841</b>	<b>6,601</b>	<b>32,635</b>	<b>53,875</b>	<b>51,454</b>	<b>(2,421)</b>	

Year to date slippage planned to recover by year end.

£2.4m additional expenditure is off-set by additional CDEL allocation for IFRS16 leases and donations.

Reconciliation of movements in SOCI Plan to Budget	YTD Fixed Plan (NHSEI reporting)	Adjustments to Plan	YTD Flexed Plan (Board Reporting)	YTD Actual	Actual v Plan Variance (NHSEI Reporting)	Actual v Budget Variance (Board Reporting)	Explanation of adjustments to plan
	£'000	£'000	£'000	£'000	£'000	£'000	
<b>Statement of comprehensive income</b>							
Operating income from patient care activities	474,150	16,740	490,890	491,212	17,062	322	NHSEI pass-through drugs & devices exceeding plan off-sets additional expenditure
Other operating income	59,060	6,463	65,523	65,526	6,466	3	£0.8m R&D income - off-sets additional expenditure £1.8m services provided - off-sets additional expenditure £1.7m training income - off-sets additional expenditure £1.4m income in advance released £0.5m contributions to staff costs £0.2m charitable contributions to expenditure
<b>Total Income</b>	<b>533,210</b>	<b>23,203</b>	<b>556,413</b>	<b>556,738</b>	<b>23,528</b>	<b>325</b>	
Employee expenses - Total	(331,084)	(19,780)	(350,864)	(351,177)	(20,093)	(313)	For the purposes of internal accountability corresponding expenditure budget has been released to ensure appropriate reporting. These adjustments distort variances that are reported through NHSEI and ICS reporting compared to information presented to the Board and it is important the differences are understood.
Operating expenses excluding employee expenses	(207,038)	(108)	(207,146)	(207,206)	(168)	(60)	
<b>Total Expenses</b>	<b>(538,122)</b>	<b>(19,888)</b>	<b>(558,010)</b>	<b>(558,383)</b>	<b>(20,261)</b>	<b>(373)</b>	
<b>OPERATING SURPLUS/(DEFICIT)</b>	<b>(4,912)</b>	<b>3,315</b>	<b>(1,597)</b>	<b>(1,645)</b>	<b>3,267</b>	<b>(48)</b>	
<b>FINANCE COSTS</b>						<b>0</b>	
Finance income	148	500	648	648	500	0	
Finance expense	(1,650)	(10)	(1,660)	(1,668)	(18)	(8)	
PDC dividends payable/refundable	(6,188)	(10)	(6,198)	(6,192)	(4)	6	
<b>NET FINANCE COSTS</b>	<b>(7,690)</b>	<b>480</b>	<b>(7,210)</b>	<b>(7,212)</b>	<b>478</b>	<b>(2)</b>	
Other gains/(losses) including disposal of assets	0	0	0	3	3	3	
Share of profit/(loss) of associates/joint ventures	0	0	0	0	0	0	
Gains/(losses) from transfers by absorption	113,026	0	113,026	113,026	0	0	
Movements in fair value of investments, investment property and financial liabilities	0	0	0	0	0	0	
Corporation tax expense	0	0	0	0	0	0	
<b>SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR</b>	<b>100,424</b>	<b>3,795</b>	<b>104,219</b>	<b>104,172</b>	<b>3,748</b>	<b>(47)</b>	
<b>Adjusted financial performance</b>							
<b>Surplus/(deficit) for the period/year</b>	<b>100,424</b>	<b>3,795</b>	<b>104,219</b>	<b>104,172</b>	<b>3,748</b>	<b>(47)</b>	
Add back all I&E impairments/(reversals)	3,700	(3,700)	0	0	(3,700)	0	
Adjust (gains)/losses on transfers by absorption	(113,026)	0	(113,026)	(113,026)	0	0	
<b>Surplus/(deficit) before impairments and transfers</b>	<b>(8,902)</b>	<b>95</b>	<b>(8,807)</b>	<b>(8,854)</b>	<b>48</b>	<b>(47)</b>	
Remove capital donations/grants/peppercorn lease I&E impact	469	(95)	374	424	(45)	50	
<b>Adjusted financial performance surplus/(deficit)</b>	<b>(8,433)</b>	<b>0</b>	<b>(8,433)</b>	<b>(8,430)</b>	<b>3</b>	<b>3</b>	

<b>Agenda item:</b>	12.1, Public Board Meeting	Date: 30 November 2022		
<b>Title:</b>	Audit Committee Report			
<b>Prepared by:</b>	Colin Dart, Director of Operational Finance (Northern)			
<b>Presented by:</b>	Alastair Matthews, Chair of Audit Committee			
<b>Responsible Executive:</b>	Angela Hibbard, Chief Financial Officer			
<b>Summary:</b>	A report from the Audit Committee on the key issues arising from the meeting on 7 November 2022.			
<b>Actions required:</b>	It is proposed that the Board of Directors: (i) note the report from the Audit Committee			
<b>Status (*):</b>	<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Information</b>
		<b>X</b>		<b>x</b>
<b>History:</b>	The Terms of Reference were last approved at the 25 May 2022 Board to reflect the needs of the new merged Trust.			
<b>Link to strategy/ Assurance framework:</b>	The primary role of the Audit Committee is to conclude upon the adequacy and effective operation of the organisation's overall internal control system. In setting the Internal Audit plan for the year, the Audit Committee seeks to ensure that a programme of work has been put in place to review the risks of the Trust on a regular basis.			

<b>Monitoring Information</b>	Please <i>specify</i> CQC standard numbers and tick ✓ other boxes as appropriate		
Care Quality Commission Standards			
Monitor		Finance	
Service Development Strategy		Performance Management	
Local Delivery Plan		Business Planning	
Assurance Framework	X	Complaints	
Equality, diversity, human rights implications assessed			
Other ( <i>please specify</i> )			

## **1. Purpose of Paper**

- 1.1 To provide, as requested by Board of Directors (Board), a report on the key matters arising from the Audit Committee (AC) at its 7 November 2022 meeting. A copy of the approved AC minutes is available for inspection.

## **2. Background**

- 2.1 The primary role of the AC is to conclude upon the adequacy and effective operation of the overall internal control system in both organisations. It is responsible for providing assurance to the Board in relation to the financial systems and controls of the Trusts. The Annual Governance Statements which are included in the Annual Reports review the effectiveness of the systems of internal control. By concurring with this statement and recommending its adoption to the Board, the AC also gives its assurance on the effectiveness of the overarching systems of integrated governance, risk management and internal control.

The meeting initially was not quorate and the AC agreed a revised running order so those items requiring a decision were presented to a quorate Committee. All decisions were made with the required quoracy under the Terms of Reference.

## **3. Analysis**

### **3.1 Counter Fraud Interim Report**

The AC **noted**:

- The update on Bank Mandate Fraud and the support being given to the Finance and Payroll teams together with actions to continue to manage the ongoing risks.
- Counter Fraud e-learning has now been rolled out across the eastern site and reporting will be visible through future reporting to AC.
- Following evaluation and feedback on the Counter Fraud e-learning module a more comprehensive package is being introduced that will strengthen evidence of knowledge acquired.
- Contribution to the Trust Risk Management Policy by ensuring the risk assessment methodology complies with component 3 of the Functional Standard.
- A local proactive exercise reviewing vulnerability to fraud as a result of large organisational change found no evidence of duplicate payments after testing 100% of invoices in both finance systems during a test period from 1 February 2022 to 8 July 2022.
- Improvements in a number of amber rated Counter Fraud Functional Standard components from 2021/22 (East 5, North 1) are predicted that would result in green ratings across all components in 2022/23.



### 3.2 **Reports on RD&E Procurement by the NHS Counter Fraud Authority**

The AC received a report from the Director of Operational Finance (East) regarding 2 reviews relating to the former RDE NHSFT.

The AC **noted** that for post-assurance Covid-19 emergency expenditure:

- Due diligence controls were evidenced in tendering, new supplier process, purchase order controls, payments in arrears and Gold Command structure.
- The report referenced a new supplier that was not subject to due diligence. For the sole supplier the AC received assurance that whilst not in the format expected by the CFA, due diligence had taken place.
- Planned improvements in holding verifiable evidence of supplier due diligence.

The AC **noted** that for non-purchase order (PO) expenditure in 2019/20:

- Improvements seen in PO compliance.
- 4 areas of non-PO compliance were identified and the AC was assured these were Estates and Hotel Services related orders separate from the EROS order system and were covered by contracts as opposed to PO's.
- Planned improvements via the new integrated finance and procurement system should address these issues and incorporate improvements across the North site.

### 3.3 **ASW Assurance Annual Report 2021/22**

The AC received the annual report and **noted**:

- Compliance with Public Sector Internal Audit Standards, with the next self-assessment due to be subject to external assurance with reporting expected in February 2023.
- Developing a system focus over short to medium term.
- Consideration how learning opportunities from others are taken forwards so local best practice can be shared in a live environment.

### 3.4 **External Audit Progress Report**

The AC **noted**:

- Finalised the audit of both Charities to report to the November Charity Committee;
- Attended the Trust's Annual Members meeting in September 2022;
- A training session to be provided to Governors on 23 November 2022;
- Technical updates impacting the annual audit of accounts regarding earlier assurance of risk assessment; and
- 2022/23 annual accounts timetable expected to be published by the end of the calendar year

### 3.5 **Audit Committee Effectiveness Review.**

The AC has undertaken an effectiveness review that was deferred in 2021 as the Committee transitioned from a Joint AC to the Royal Devon Audit Committee following the merger. Questionnaires were sent to the 5 NED members, regular AC attendees and the remaining Board members who were not AC members. The questions were scored from 1 to 3 and the majority of responses received were '3'. There were responses for examples of 'what went well' and also suggestions of 'even better if'.

AC has **identified** the following areas to explore for improvement

- Improving the perception of the AC and its role in assurance and control processes to the wider organisation seeking help from Executive Directors to support that through other Committees;
- 'Horizon-scanning' when considering the needs of the 2023/24 internal audit plan; and
- Consider improvements for embedding Internal Audit recommendations.

### 3.6 **Internal Audit Interim Report**

The AC received the Internal Audit Interim Report at 27th October 2022 covering final work for the predecessor organisations, the Audit and Assurance Plan for the Royal Devon University Healthcare NHS Foundation Trust, final audit reports issued, audit reports pending, the status of work in progress/planning and detail of outstanding recommendations.

The AC **noted**:

- Delivery of 426 (40%) days of the total 1,065 planned days for the 2022/2023 Audit and Assurance Plan
- 4 final reports presented to the Committee (3 satisfactory, 1 limited assurance)
- 6 reports at draft report stage (2 significant, 2 satisfactory, 1 limited assurance, 1 N/A - Management review)
- Proposed development of enhanced reporting of progressing recommendations to support the AC assurance process.
- Proposed review pre-2021 open recommendations to ensure they remain valid.
- 2023/24 Audit and Assurance plan to be presented in February 2023.

The AC **approved** two changes to the 2022/2023 Plan:

- 40 days to support Covid review reallocated from management reviews
- 10 days to support Nightingale Hospital Expenditure taken from contingency

The AC approved the Internal Audit Charter

### 3.7 North Devon GDPR Compliance Update

The AC received an update on progress delivering the IA recommendations and **noted:**

- The action plan is monitored by the Digital Committee
- Actions to date had been delivered and the plan was on track for future dates;
- Actions had been linked to the Information Governance Toolkit meaning resources could be ring-fenced to deliver the required actions by 31 March 2023.

The AC **agreed** to continue to monitor progress over the next 6 months.

### 3.8 Consultant Payments Limited Assurance Draft Report

The AC received an update on progress on the delayed draft report and **noted:**

- The CMO and IA were due to meet to clarify and finalise outstanding elements of the report

Due to the time between meetings, the AC **agreed** the Chair is to receive a copy of the final report ahead of the next scheduled meeting.

### 3.9 NDHT Data Quality Review Report – Limited Assurance

The AC received an update on the limited assurance report from the CMO and **noted:**

- 3 actions had been closed – 8 remained open and within due date of extended milestones.
- Assurance is through the Digital Committee with a collective policy to be in place by 31 March 2023 that was linked to the establishment of a Business Intelligence Steering Group.
- Discussions on potential interim solution for a Deputy SIRO.

### 3.10 Review of Volunteers (Lampard Report Principles) Report – Limited Assurance

The AC received an update on the limited assurance report from the CNO and **noted:**

- The review was commissioned by the CNO regarding assurance concerns across process and governance.
- The CNO fully supported the report and recommendations and an action plan was in place delivering actions by or before 31 March 2023.

### Review of the Standards of Business Conduct Policy

3.11

The AC received and reviewed the revised Standards of Business Conduct Policy following a comprehensive review bringing together the two legacy organisation's policies plus best practice and guidance from Counter Fraud.

The AC **noted**:

- The revised policy incorporates actions arising from a focussed quality assessment of compliance against the NHS Counter Fraud Authority standards.
- Once approved there was planned communication to staff ahead of December 2022 go-live. Given the length of the policy it was considered key that the policy was communicated effectively and the AC Chair requested the Committee see the plan before the policy went live.

The AC **approved** the policy subject to:

- Communications plan being shared with the Committee
- Financial values stated confirmed to be consistent with the Scheme of Delegation

### Self-Assessment against the HFMA 'Getting the Basic Right' Checklist

3.12

Following presentation of the self-assessment checklist to the Finance and Operational Committee in September 2022, the AC was presented with a detailed and prioritised action plan for improvements in the Royal Devon financial control environment.

The AC **noted**:

- The self-assessment covered 72 questions across 8 domains.
- Duplication resulted in 34 actions to be delivered. The timeframe for delivery of the actions is ambitious with key dependencies and the plan was deliverable and aligned with the needs of the organisation.
- IA were in the process of reporting on 12 specific areas by the end of November in accordance with NHSE requirements.

The Committee **agreed** to receive a progress update at its next meeting in February 2023.

### Compliance Review of Audit Committee Terms of Reference

3.13

The AC undertook its annual review of compliance and **assessed and agreed** its compliance with its Terms of Reference.

### Review of Audit Committee Schedule of Reports

3.14

The AC **reviewed and updated** its Schedule of Reports.

**4. Representation to the Board**

- 4.1 The AC confirms to the Board that it is compliant with its Terms of Reference and that it continues to review the adequacy and effective operation of the Trust's overall internal control system. This report highlights to the Board the key issues from the most recent AC meeting on 7 November 2022.

**5. Resource/legal/financial/reputation implications**

- 5.1 No resource/legal/financial or reputation implications were identified in this report.

**6 Link to BAF/Key risks**

- 6.1 None identified

**7. Proposals**

- 7.1 It is proposed that the Board of Directors **note** the report from the AC.

<b>Agenda item:</b>	12.2, Public Board meeting	Date: 30 November 2022		
<b>Title:</b>	Royal Devon University Healthcare NHS Foundation Trust Safe Staffing Report for Nursing, Midwifery and Allied Health Professionals (AHPs) (April 2022 to September 2022)			
<b>Prepared by:</b>	Bev Allingham, Strategic Workforce Lead - Nursing, Midwifery, AHPs			
<b>Presented by:</b>	Carolyn Mills, Chief Nursing Officer			
<b>Responsible Executive:</b>	Carolyn Mills, Chief Nursing Officer			
<b>Summary:</b>	<p>The National Quality Board (NQB) guidance (2013) requires Trusts' to undertake a full nursing and midwifery safe staffing review annually, and at least every six months to review nursing, midwifery and care staffing capacity and report this to a Public Board meeting.</p> <p>This paper provides a six-month review of the Trust's provision of nursing, midwifery and AHP staffing. It provides information on strategic and day to day work to try and ensure safe staffing levels have been maintained over the last six months (April 2022 to September 2022) and on risks related to staffing &amp; their mitigating actions.</p> <p>This report provides Trust wide and Eastern &amp; Northern data sets to present an overall picture and to highlight specific variations in Northern and Eastern locations.</p> <p>There have been no significant changes to nursing and midwifery establishments or skill mix for the period of this report and no substantive changes to the principles of staffing ratios for inpatient areas. There have been no significant or recurrent changes in AHP establishments or skill mix for the period of this report.</p> <p>The last six months have seen a consistent deficit position in the number of nursing and HCSW hours required and the number of hours available. This gap has frequently left wards and departments staffing no's or skill mix in a position that has required close monitoring to support safe care delivery and mitigate the risk of any adverse patient/staff outcomes.</p>			
<b>Actions required:</b>	<p>The Board are asked to note the content of the report; the work being undertaken to ensure compliance wherever possible with local safe staffing standards, with national guidance and the mitigating actions in place to manage risks associated with staffing gaps (day to day &amp; strategic).</p> <p>To confirm if any further information/assurance is required.</p>			
<b>Status (x):</b>	<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Information</b>
				<b>X</b>

<b>History:</b>	<p>The full paper was presented, discussed and reviewed at People, Workforce Planning and Wellbeing Committee (PWPW) on 17 November 2022.</p> <p>There is a programme of ongoing recruitment and retention activities to support the provision of safe staffing and improve the vacancy and turnover position and these are reported to Board through the IPR and the PWPW report to Governance Committee.</p>
<b>Link to strategy/ Assurance framework:</b>	<p>The issues discussed are key to the Trust achieving its strategic objectives;</p> <p><b>BAF Risk 2:</b> There is a risk that workforce levels will be insufficient to deliver the required capacity and care model.</p> <p><b>BAF Risk 5:</b> There is a risk of the Trust being unable to meet new demand for elective services (including cancer) and / or to provide required levels of activity to address the waiting list backlog due to unscheduled care demands and capacity</p> <p><b>BAF Risk 8:</b> Significant deterioration in standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes</p>

### Monitoring Information

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

Care Quality Commission Standards	Outcomes	18	
NHS Improvement	X	Finance	
Service Development Strategy		Performance Management	X
Local Delivery Plan	X	Business Planning	X
Assurance Framework	X	Complaints	
Equality, diversity, human rights implications assessed			X
Other ( <i>please specify</i> )			

## 1. Purpose of paper

The purpose of this paper is to provide assurance on work to ensure safe staffing levels over the last six months (April 2022 to September 2022). This report also provides the Board of Directors with the terms of reference ([Appendix 1](#)) for the next Nursing, Midwifery and Allied Health Professions (AHP) (NMAHP) Annual Staffing Review (ASR) to be undertaken through December 22/January 23.

This paper needs to be considered in the context of other reports that the Board receives related to staffing and reports on serious incidents, patients' outcomes, patient feedback and clinical risk management to support triangulation with staffing reports.

## 2. Background

The Trust is required to demonstrate ongoing compliance with the National Quality Board (NQB) improvement guidance "How to ensure the right people, with the right skills are in the right place at the right time" (November 2013), the subsequent resource "Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time" (July 2016); NICE Safer Staffing Guidance, Developing workforce safeguards NHSE/I 2018.

The above documents set expectations for Trusts on the delivery of the commitments associated with publishing staffing data on nursing, midwifery, AHP and care staff. These include:

- Report and publish a monthly return to NHS England indicating planned and actual nursing staffing by ward. This is published on the NHS Choices website;
- Publish information with the planned and actual registered & unregistered nurse staffing for each shift;
- Provide a 6-monthly report on nursing and midwifery & AHP staffing to the Public Board.

It is important to note the last six months has seen the challenges associated with the ongoing COVID-19 pandemic in managing daily staffing, improved slightly. However, the long-term effect of the pandemic continues to impact on the wider recruitment and retention position which in turn affects the daily staffing situation, and the ability to ensure levels and skill mix are at the correct levels in order to provide a quality service for our patients at all times.

Data sources used in this report are continuing to be developed and there are still areas of data that will not have been validated at the time of report production.

## 3. Nursing and Midwifery & AHP Staffing

There have been no significant changes to nursing and midwifery establishments or skill mix for the period of this report and no substantive changes to the principles of staffing ratios for inpatient areas. There have been no significant or recurrent changes in AHP establishments or skill mix for the period of this report.



There have been no regulatory requests for information relating to safe staffing for nursing, midwifery and AHP's in the last 6 months.

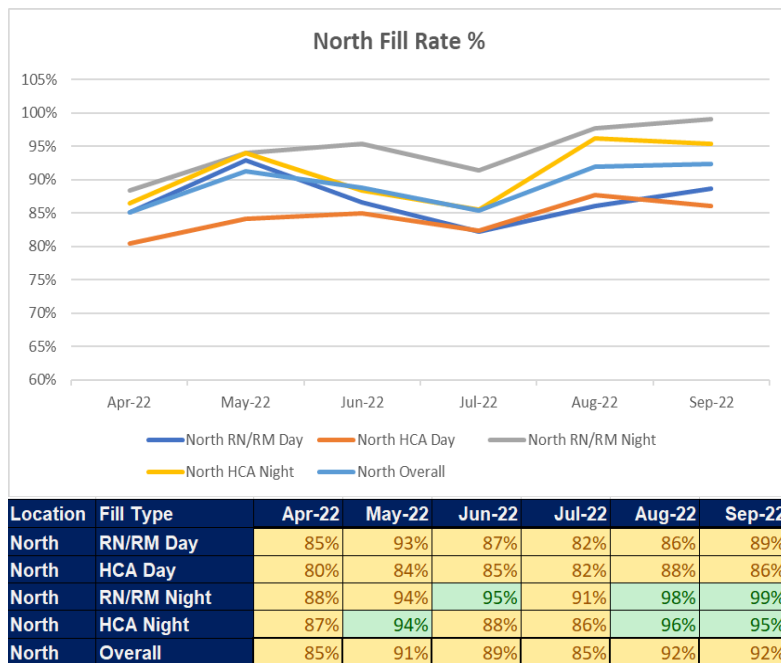
### 3.1 Staffing planned versus actual - Nursing & Midwifery

The Trust continues to submit monthly returns to the Department of Health via the NHS national staffing return (Unify). This return details the overall Trust position on actual hours worked versus expected hours worked for all inpatient areas, the percentage fill rate for Registered Nurses (RN), Registered Midwives and Health Care Assistants (HCA) for day and night shifts, together with the overall Trust percentage fill rate. There is ongoing discussion with the national team around including Registered Nursing Associates (RNAs) within the RN part of this return but this has not yet been confirmed. This return also includes the Care Hours Per Patient Day (CHPPD).

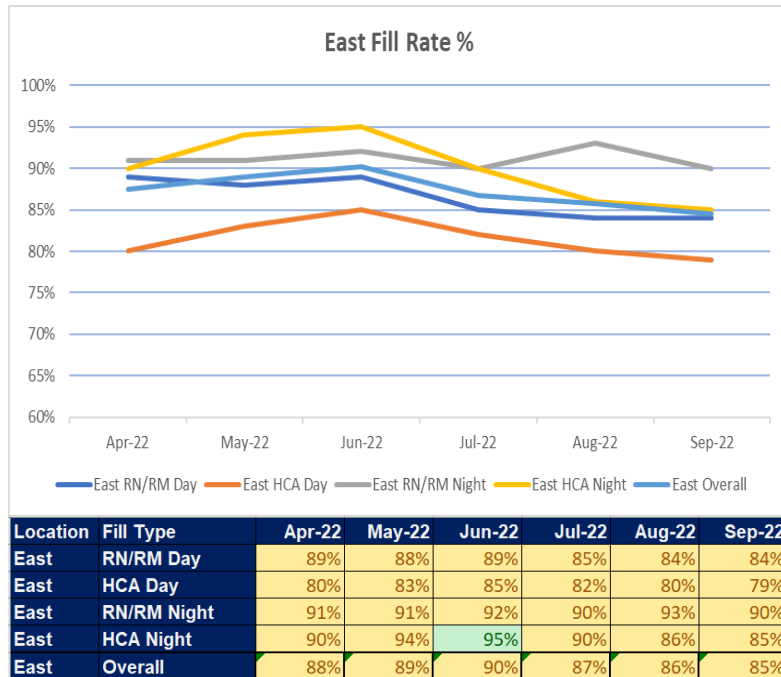
Nursing & midwifery staffing fill rates & other staffing data is reviewed at the monthly Divisional Performance Reviews and the Trust Operations Board. Figures 1-3 display the 6 monthly staffing fill rates for inpatient ward areas for both registered and unregistered staff (in acute and community hospitals).

Nursing and midwifery staffing data will be reported separately in the IPR report and 6-monthly safer staffing report going forward.

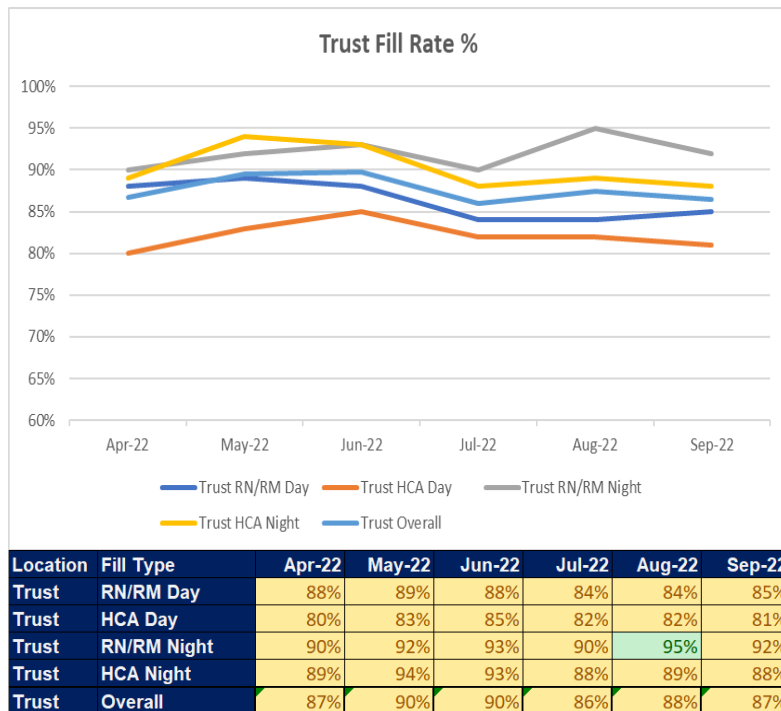
**Figure 1. Northern - Staffing versus actual**



**Figure 2. Eastern - Staffing versus actual**



**Figure 3. Trust wide - Staffing versus actual**



	Over 100 % Staffing
	95 - 100 % Staffing
	75 - 95 % Staffing
	0 - 74 % Staffing

Overall fill rates for RNs, RMs, and HCAs continue to show a fluctuating position for both days and nights in both Trusts. This corresponds with the peaks and troughs in activity, the accompanying fluctuating levels of Covid and non-Covid related absence and additional escalation beds in operation.

The data broadly aligns to how the daily staffing picture presents and to the staff feedback that we receive and the overall staffing position continues to be amber overall.

The data returns do not reflect daily changes in bed complement due to escalation and revised staffing numbers needed as a result of this. This data needs to be viewed in this context & therefore will be at times presenting a staffing view that looks better than has been the reality.

Confirmed planned escalation beds for winter capacity with any associated changes in staffing will be reflected in future reporting.

### 3.2 **Staffing planned versus actual – AHPs**

As set out in previous reports there is currently no national guidance or evidence-based tools to help clinical leaders understand the AHP workforce skills and capacity required to meet patient need and deliver safe high-quality care.

In 2019, work commissioned by NHSI to test whether the Safer Nursing Care Tool could be adapted to support AHP deployment, found the methodology was not transferrable to the peripatetic practice of AHPs. Further work to create tools that predict AHP workforce demand is ongoing at a National level with promising results coming from a recent proof of concept project.

AHP staffing levels have historically been determined using capacity and demand data, patient complexity, acuity, need and patient outcomes. In addition, some national guidance is available for specific clinical settings or groups, for example theatres, breast screening, stroke services and critical care.

The majority of AHP professions provide a Mon-Fri service with weekend cover and on-call provision. Available staff are already undertaking their rostered shifts. There is not a large pool of un-rostered staff to call on and bank and agency staff are in limited supply. For most services if staffing is low the only option is to prioritise acuity and severity and reduce routine appointments. Complex patients require an appropriate skill mix to ensure the safety of patients and staff.

The AHP workforce team having been working alongside therapy colleagues to develop an AHP effective staffing tool for Royal Devon to allow for daily reporting of staffing levels across Northern and Eastern Services that will reflect planned versus actual in a similar way to nursing. The project is in a pilot phase and will be trialed initially across therapy teams with a wider roll out once effectiveness of tool is shown. The matrix uses a RAG status to measure staffing levels, mitigating actions and achievable activity levels for each category.

In the early stages the data will be recorded and pulled manually from spreadsheets.

- Collect data from the beginning of November for OT and Physio only (acute and community) with data for the May Safer Staffing report.
- If tool is effective, add data collection for SLT and dietetics, from beginning of Jan
- Add to all other AHP groups from April
- If tool is successful approach IT for development of succinct reporting tool or app
- Share findings with NHSEI

### 3.3 Red Flag reporting Nursing and Midwifery

The purpose of the red flag system set out within national safe staffing guidance is to have a consistent approach to reporting a shortage of registered nurse time. These are incorporated into a staff RAG rating for each location & each inpatient area with a set of defined actions associated with the rating. If an area is red RAG rated, this should prompt an immediate escalation response and mitigating actions.

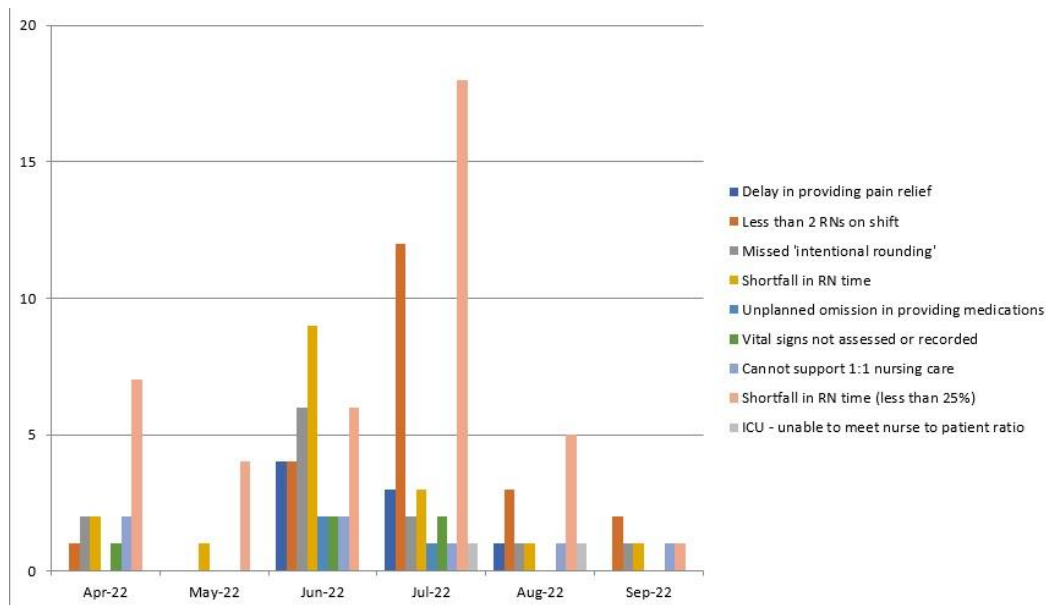
A system to ensure red flags are reported and reviewed as per national guidance for nursing and midwifery is in place. It is still not fully utilised to maximum effect except in maternity services where the use of red flags is well established. Further training and education around Red Flags is underway to support staff.

Monthly reports are being generated which require validation of reported red flags and actions that have been taken to mitigate them. An annual review of red flags will be incorporated into the next Annual Staffing Review.

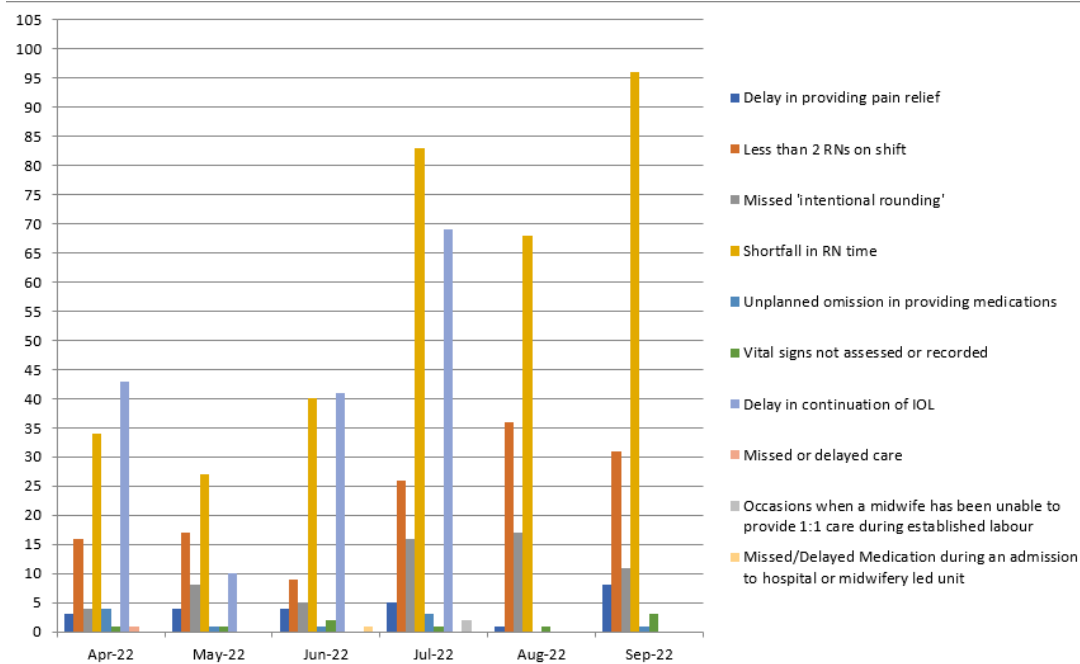
RN shortfall is the most common reason for raising a red flag in both Northern and Eastern services which aligns with the daily staffing position. The data presented below at the time of this report had not been validated.

Figures 4 & 5 below show the types and numbers of red flags raised.

**Figure 4. Northern SafeCare Red Flags Raised**



**Figure 5. Eastern SafeCare Red Flags Raised**



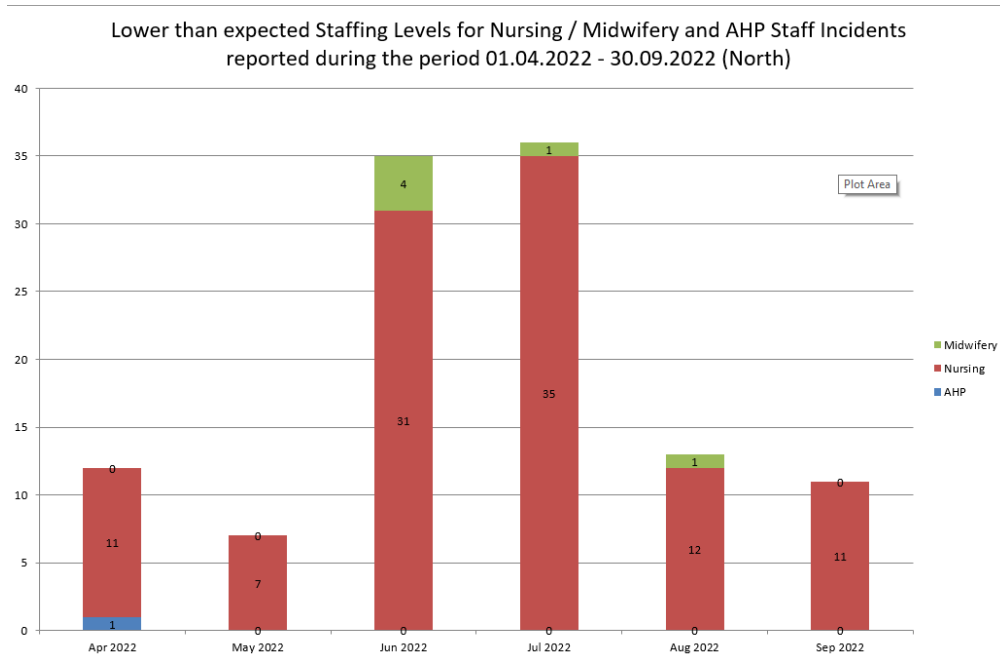
### 3.4 Staffing incidents Nursing, Midwifery and AHP's

All staffing related incidents are reviewed by line managers and appropriate action taken both in response to the incident and in any possible proactive preventative measures that can be put in place going forward. These are also reviewed in divisional governance and performance meetings.

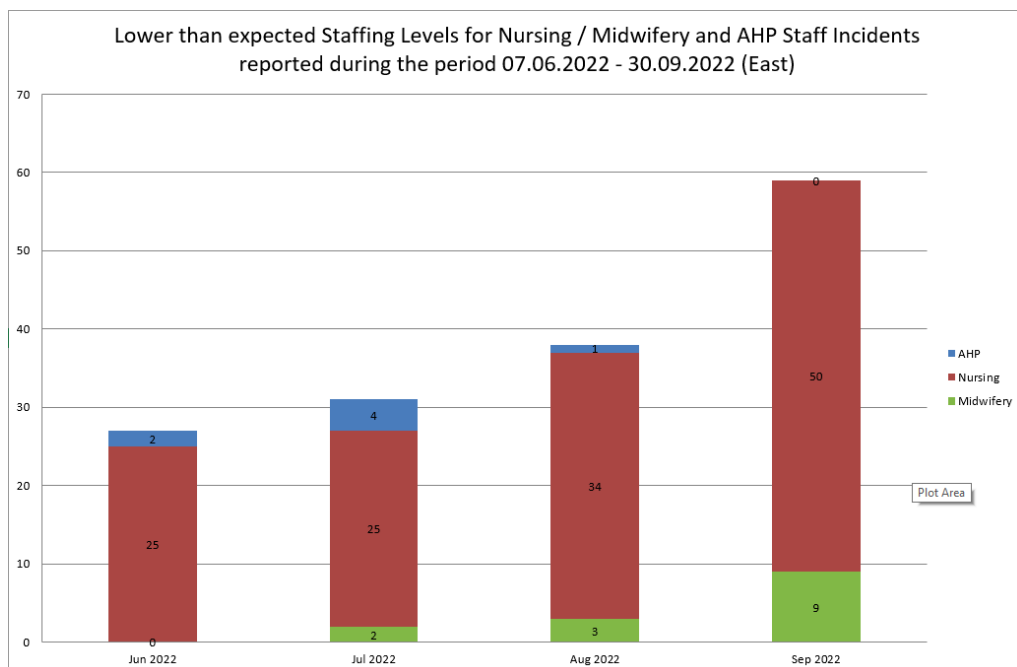
Staffing incident reporting has been strengthened in line with the Datix upgrade and alignment of reporting since becoming Royal Devon. Professional bi-monthly reports are produced with themes and trends.

The data below shows some improvement in the lower than expected staffing levels reported in North but an increase in East. Due to the Datix system upgrade there is no historical data for East before June.

**Figure 6. Northern - Lower than expected Staffing Levels for Nursing / Midwifery and AHP Staff Incidents**



**Figure 7. Eastern - Lower than expected Staffing Levels for Nursing / Midwifery and AHP Staff Incidents**



### 3.5 National Benchmarking

Weighted Activity Unit (WAU) and Care Hours per Patient Day (CHpPD) are the main source of benchmarking on the NHS Model Health and Hospital system. There are no staffing risks identified through benchmarking data for nursing, midwifery or AHPs.

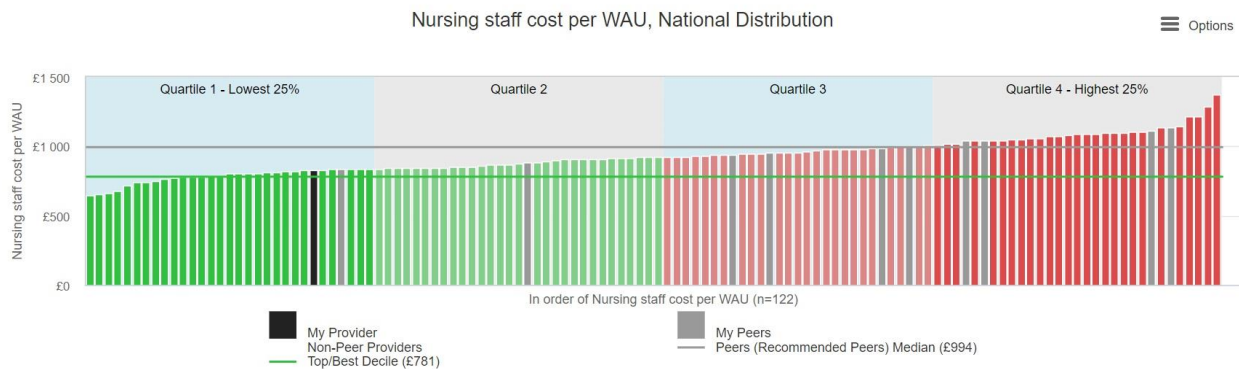
### 3.6 WAU

The Weighted Activity Unit (WAU) is a case mix-adjusted measure of the clinical output of each organisation. It is the primary output measure used within the Model Health system and used as a denominator when assessing organisation's productivity.

WAU is a measure of efficiency; more productive Trusts will have a lower cost per WAU and less productive Trusts will have a higher cost per WAU. The WAU metric does not directly correlate to the quality of care.

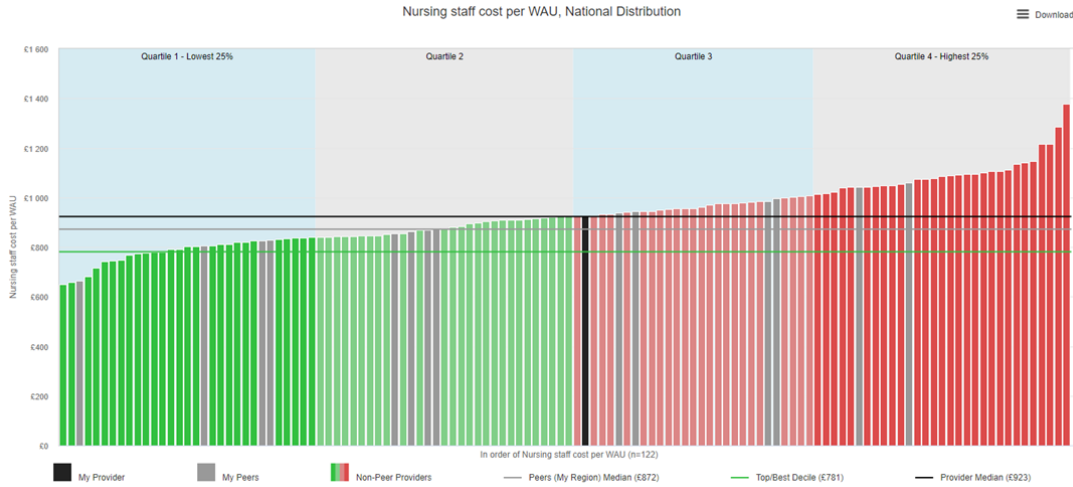
There is a lag in the Model Health system and still being reported as NDHT and RD&E currently, this is anticipated to be correct for future reporting.

**Figure 8. Northern – Nursing staff cost per WAU**



This data has not changed since the last report. The cost per WAU data in figure 8 displays NDHT sitting within quartile 1 which is the same as when last reported. Nursing staff cost per WAU is £827 and NDHT shows a positive picture against peer trusts.

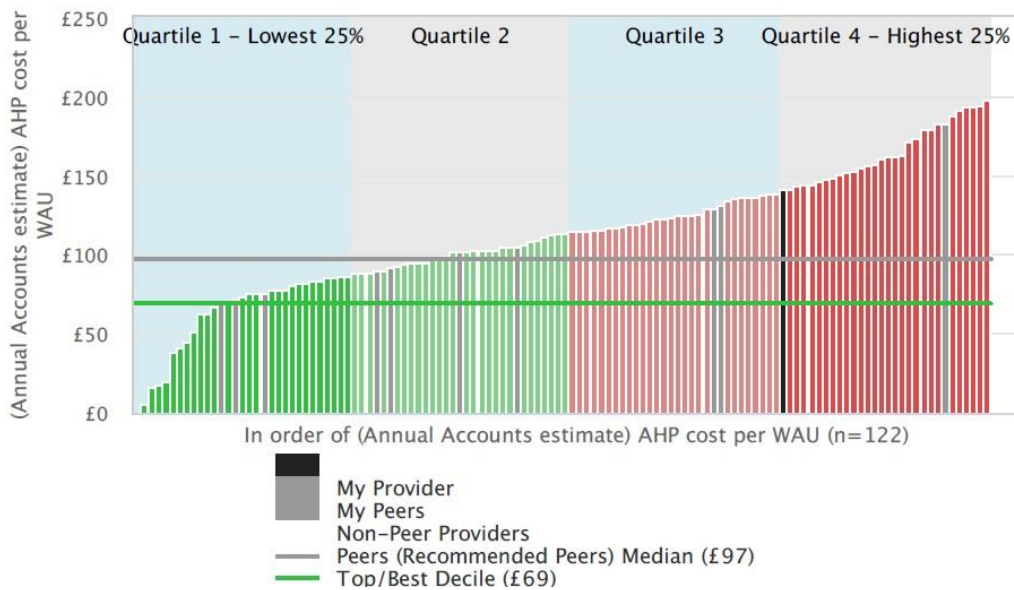
**Figure 9. Eastern – Nursing staff cost per WAU**



The data has not changed since the last report. The cost per WAU data in figure 9 displays RD&E currently sitting within the same quartile 3 when last reported. Nursing staff cost per WAU is £925 and RD&E remains slightly above peer trusts.

**Figure 10. Northern – AHP staff cost per WAU**

(Annual Accounts estimate) AHP cost per WAU, National Distribution

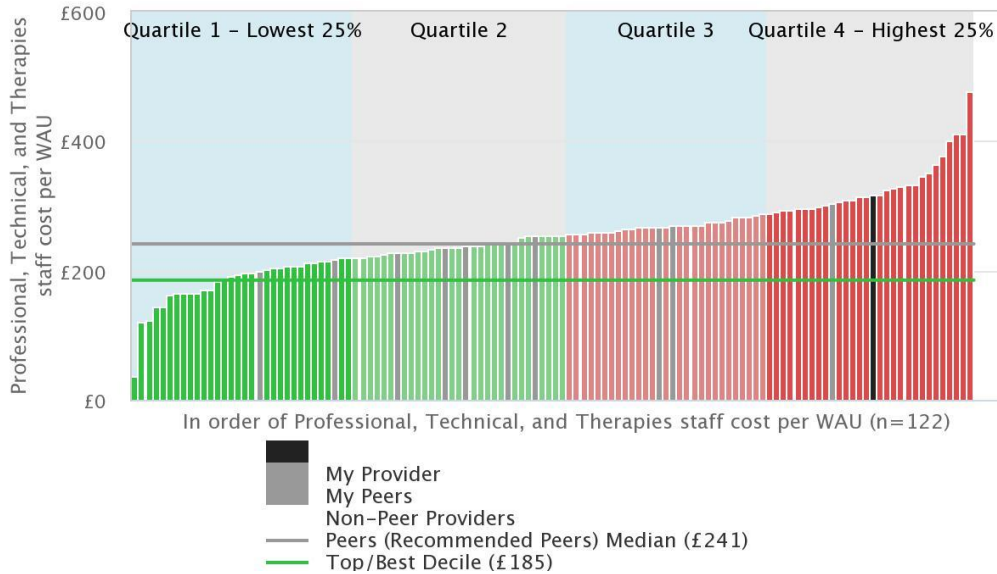


The cost per WAU data in figures 10 & 11 display NDHT and RD&E in quartile 4, with RD&E slightly higher. This is the latest data but notably is for the period 2020/21 so more recent data is needed to form an accurate assessment. This does cover all AHP professions (14 single professions under the AHP umbrella term).



**Figure 11. Eastern – AHP staff cost per WAU**

Professional, Technical, and Therapies staff cost per WAU, National Distribution



### 3.7 CHpPD – Nursing and Midwifery inpatient areas

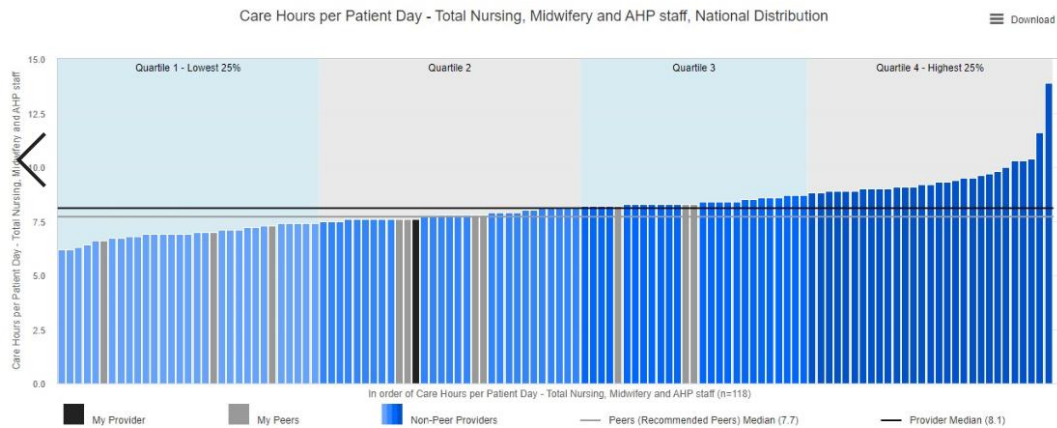
The CHpPD is a measure of actual daily nursing and midwifery staffing levels in relation to daily patient numbers on inpatient wards.

There is additional CHpPD figure which is reviewed internally which is the *required* CHpPD which considers acuity & dependency data, this is then mapped against the planned and actual CHpPD; the *required* CHpPD regularly exceeds the planned and actual which is further evidence towards a detailed safe staffing assessment. The *required* CHpPD is not reported externally or on the Model Hospital dashboard.

There is no set standard of what good looks like for CHpPD; it should reflect the activity, acuity and dependency of the clinical ward and the hospital services.

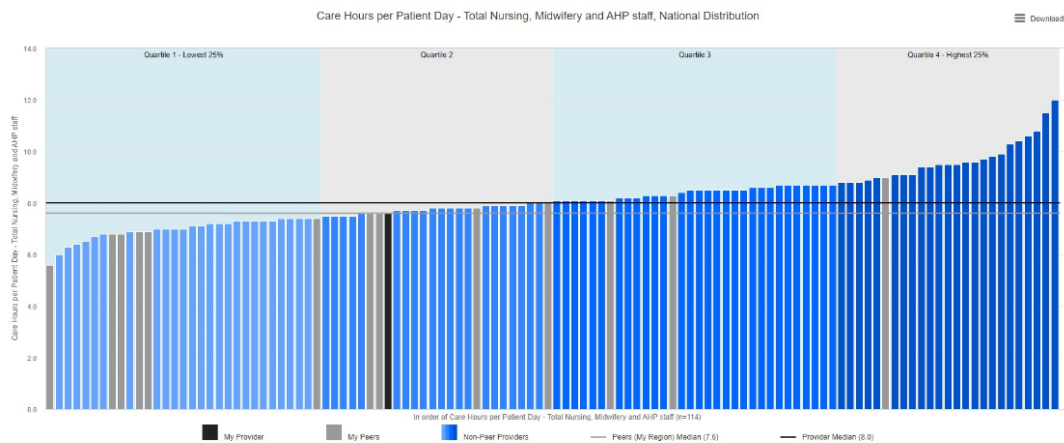
Work is continuing to ensure accurate and timely acuity and dependency data entry with further training and education to support this.

**Figure 12. Northern - Care Hours per Patient Day**



Data for North in figure 12 shows the trust remaining in the middle of quartile 2 and average within peer trusts with a CHpPD of 7.2 compared to a peer median of 7.7.

**Figure 13. Eastern – Care Hours per Patient Day**



Data for East in figure 13 shows movement from the last report from quartile 1 to quartile 2 and average within peer trusts with a CHpPD of 7.6 which aligns with the Peer median of 7.6.

#### 4. Sickness

Sickness data is a key part of safe staffing assurance and monitoring, and also a gauge to staff wellbeing; particularly in this sustained and challenging period through the Covid pandemic and beyond alongside continued workforce pressures.

Combining sickness absence with vacancies gives a picture of total absence that needs to be covered by temporary staffing and aligns with planned versus actual staffing numbers.

Figures 14 and 15 below for Northern and Eastern services show a similar sickness picture. There is an overall improvement in the last 6 months from 6.83% to 6.4% in North and 7.25% to 6.82% in East which is encouraging. The AHP data is now split between registered and unregistered. North has seen a slight increase since the last

6 months overall, East has seen an increase in unregistered and slight decrease in registered. It remains notably higher for the HCSW group which reflects what is seen in the daily staffing position; this is managed according to sickness and wellbeing policies & procedures. Any relevant learning related to absence forms part of the specific HCSW/HCA recruitment and retention workplan.

There is a range of organisational and national well-being services for staff to access.

**Figure 14. Northern - Sickness rate by month, by staff group**

	2022 / 04	2022 / 05	2022 / 06	2022 / 07	2022 / 08	2022 / 09	6-month rate
<b>HCSW</b>	13.18%	8.30%	8.61%	10.68%	6.45%	7.03%	<b>9.01%</b>
<b>Unregistered AHP</b>	6.78%	4.42%	4.43%	7.68%	3.64%	4.96%	<b>5.31%</b>
<b>Registered AHP</b>	5.72%	4.20%	5.29%	5.54%	4.91%	5.94%	<b>5.26%</b>
<b>Registered Nurses &amp; Midwives</b>	8.67%	5.13%	5.00%	5.90%	5.13%	5.72%	<b>5.92%</b>
<b>Total</b>	<b>8.85%</b>	<b>5.59%</b>	<b>5.78%</b>	<b>6.97%</b>	<b>5.28%</b>	<b>6.01%</b>	<b>6.40%</b>

**Figure 15. Eastern - Sickness rate by month, by staff group**

	2022 / 04	2022 / 05	2022 / 06	2022 / 07	2022 / 08	2022 / 09	6-month rate
<b>HCSW</b>	9.34%	7.58%	8.09%	11.49%	9.69%	9.45%	9.28%
<b>Unregistered AHP</b>	10.95%	6.16%	6.72%	7.54%	5.95%	6.64%	7.32%
<b>Registered AHP</b>	5.60%	3.77%	4.99%	5.75%	4.37%	3.75%	4.70%
<b>Registered Nurses &amp; Midwives</b>	7.21%	5.07%	5.87%	7.42%	5.41%	5.68%	6.11%
<b>Total</b>	<b>7.69%</b>	<b>5.58%</b>	<b>6.36%</b>	<b>8.32%</b>	<b>6.46%</b>	<b>6.52%</b>	<b>6.82%</b>

## 5. Vacancies

The vacancy position for Northern is set out below in figure 16. There is a deterioration with RNs/RMs and HCSWs from the position reported in the last report in May 22. This is largely due to FTE Budgeted increases in Staff Group Nursing and Midwifery in May 2022. This came from a mixture of large and small increases (1-2 FTEs) in different areas.

The AHP (14 professions) dataset is new as previously only therapies (4 professions within AHP) was provided so no accurate comparisons can be done at this stage. The AHP support worker vacancy positive position in North will reflect the increase in apprenticeships to grow registrants and these will sit in the unregistered workforce figures whilst on training programmes. Increasing AHP support workers will also

support ongoing hard to fill AHP registered post vacancies whilst recruitment is ongoing.

The vacancy position for Eastern is set out below in figure 17 and there is a similar deterioration with RNs/RMs and HCSWs from the position reported in the last report in May 22. There were also significant additions to the FTE budgets in April 2022 where historical non-recurrent establishment increases were substantively confirmed in budgets.

Registered Nursing Associates (RNAs) are included in the RN/RM dataset and Trainee Nursing Associates (TNAs) are included within the HCSW vacancies. The RN/RM dataset includes Band 5 – 8 positions and the HCSW includes Band 2 & 3 positions.

There have been active HCSW recruitment campaigns with monthly recruitment days resulting in significant offers with 160 in the recruitment pipeline for Eastern and 60 for Northern which will have a positive impact on the vacancy position even allowing for 15% attrition.

For RNs/RMs in Northern there is a total of 23 confirmed offers of which 12 are Internationally recruited Nurses (IRNs), 2 with start dates and 9 in the pre-employment check phase. RNs/RMs in Eastern there is a total of 43 confirmed offers of which 18 are IRNs, 9 with start dates and 16 in the recruitment pre-employment check phase.

There continues to be challenges with the recruitment timeline with delays from interview to start date but there have been improvements and the timeline KPIs are monitored closely.

There is a robust programme of recruitment for clinical nursing apprenticeships to support sustainable growth locally of RNs and Nursing Associates (NAs) alongside an ambitious international recruitment (IR) campaign; bringing in a total of 182 nurses by December 2022 across Royal Devon (including Nightingale) and a further 45 between January and March 2023. There is increased recruitment of IR nurses (IRNs) who live locally over the coming months; these are overseas nurses with a registration who are already in the country and working with us as HCSWs, this plays to our focus on local sustainable recruitment and is cost effective. Finally, there is a new Return to Practice (RtP) campaign due to start shortly across nursing, midwifery and AHPs.

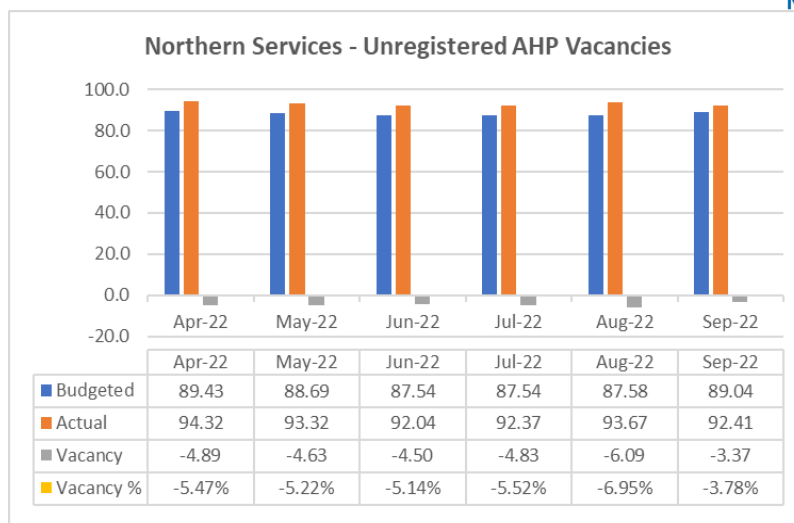
A nursing and midwifery retention gap analysis has been undertaken with a resultant action plan in line with NHSEI requirements. This supports the wider nursing, midwifery and AHP retention programme of work as part of the Trust's Accelerating Filling Our Vacancies workstreams which all focus on filling vacancies and reducing turnover and retaining our staff.

There was incentive funding towards AHPs to support an AHP workforce supply project lead in Eastern and Northern to undertake a workforce gap analysis and 3-year workforce strategy with a focus on leadership, apprenticeships and support workers. These posts have been extended until the end of March 2023 and are shining a light on the importance and needs of our AHP workforce.

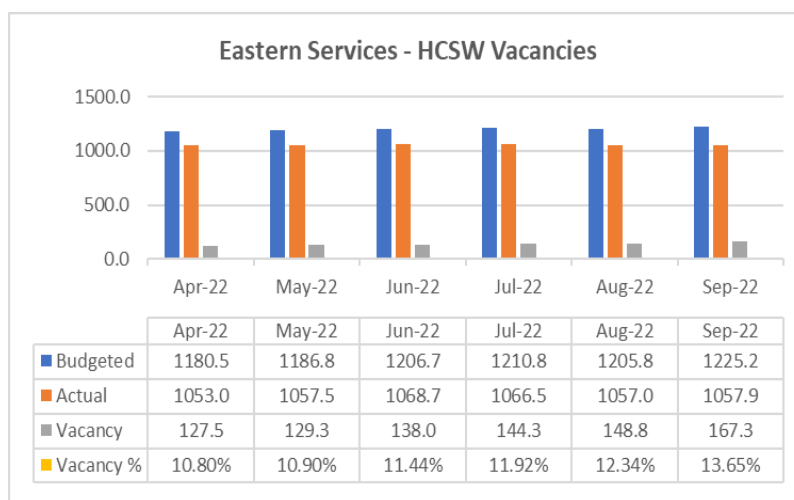
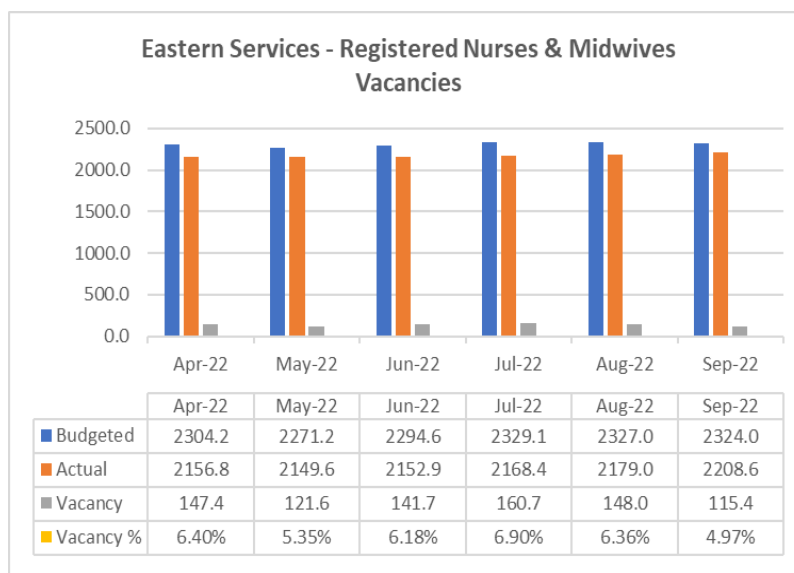
The Trust engages in all National, regional and local programmes of recruitment and retention work and accesses all external incentive funding that is available.

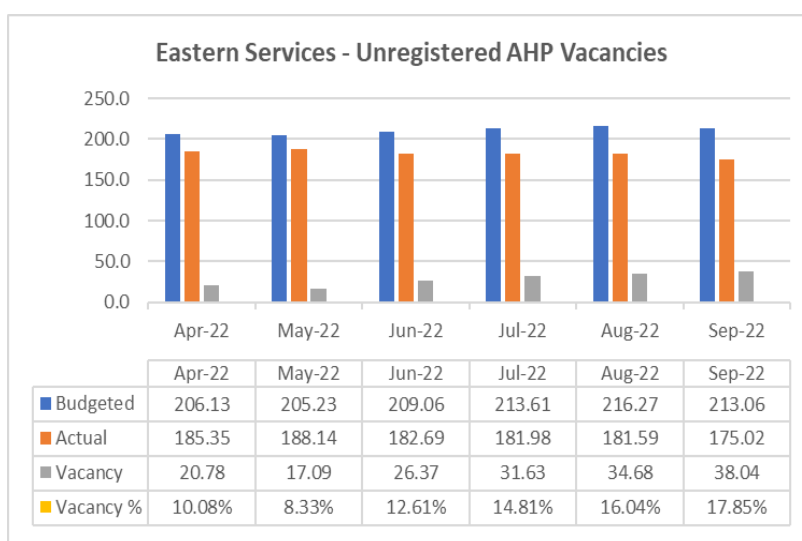
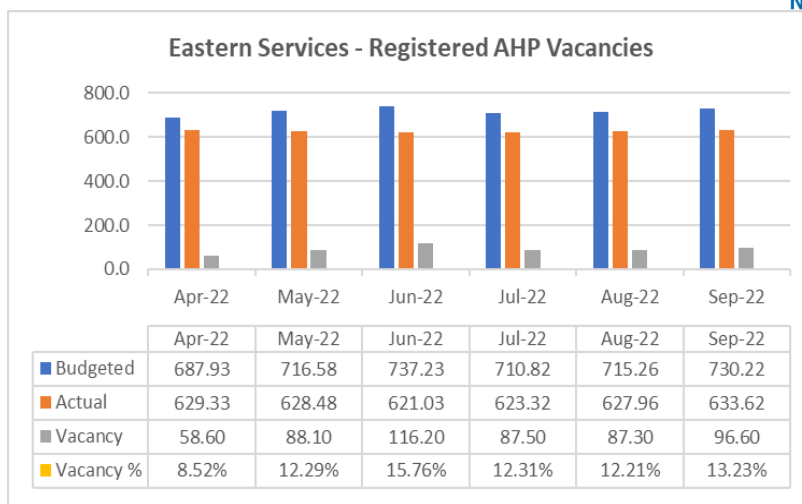
**Figure 16. Northern – RN, HCSW and AHP Vacancies**





**Figure 17. Eastern – RN, HCSW and AHP Vacancies**

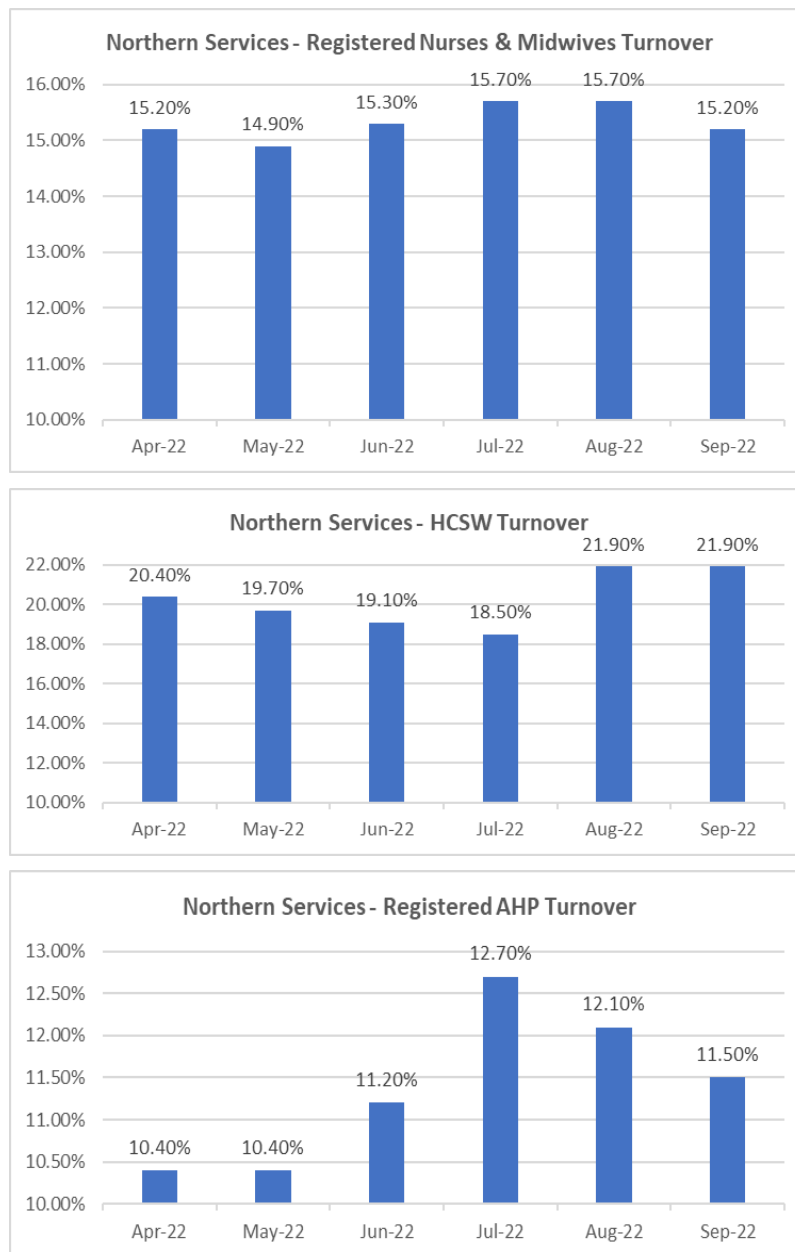




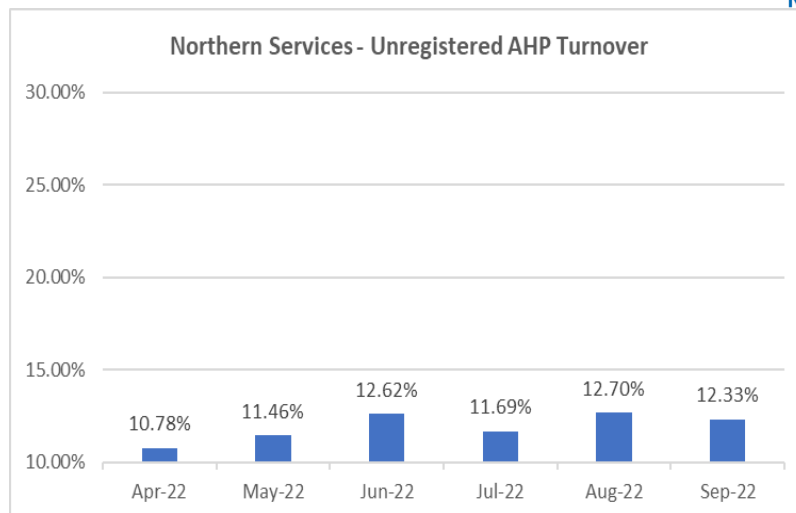
## 6. Turnover

**North and East** - Turnover currently for all groups (figure 18 & 19) is higher than the Trust target of 10%. The figures fluctuate and remains broadly within a 2% range with no significant change since the last report. As noted in section 6 there is an active recruitment and retention programme.

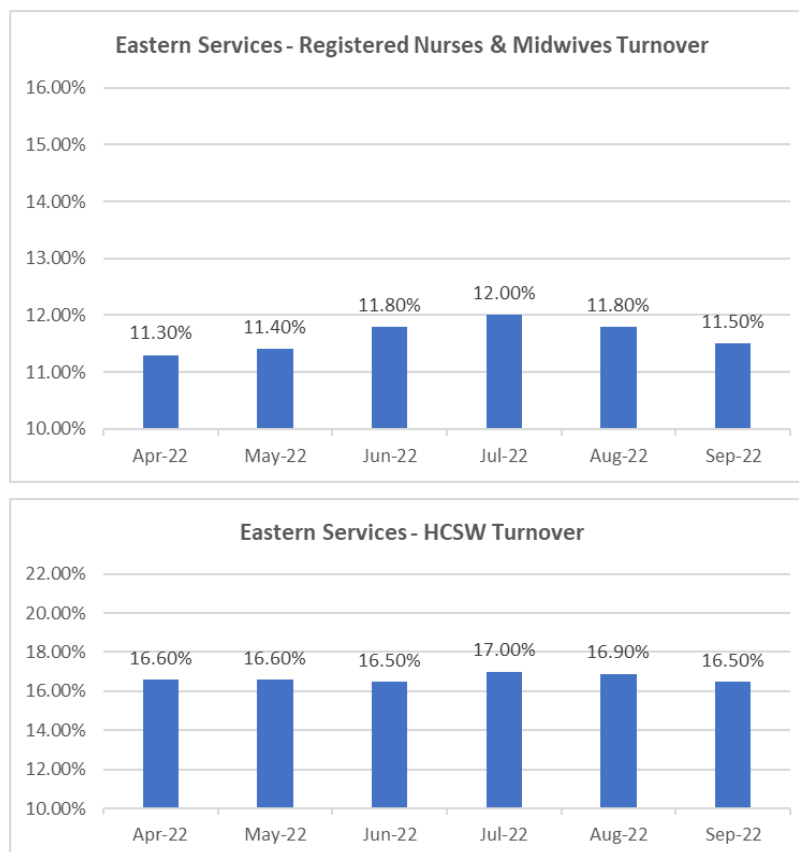
**Figure 18. Northern – RN, HCSW and AHP Turnover**

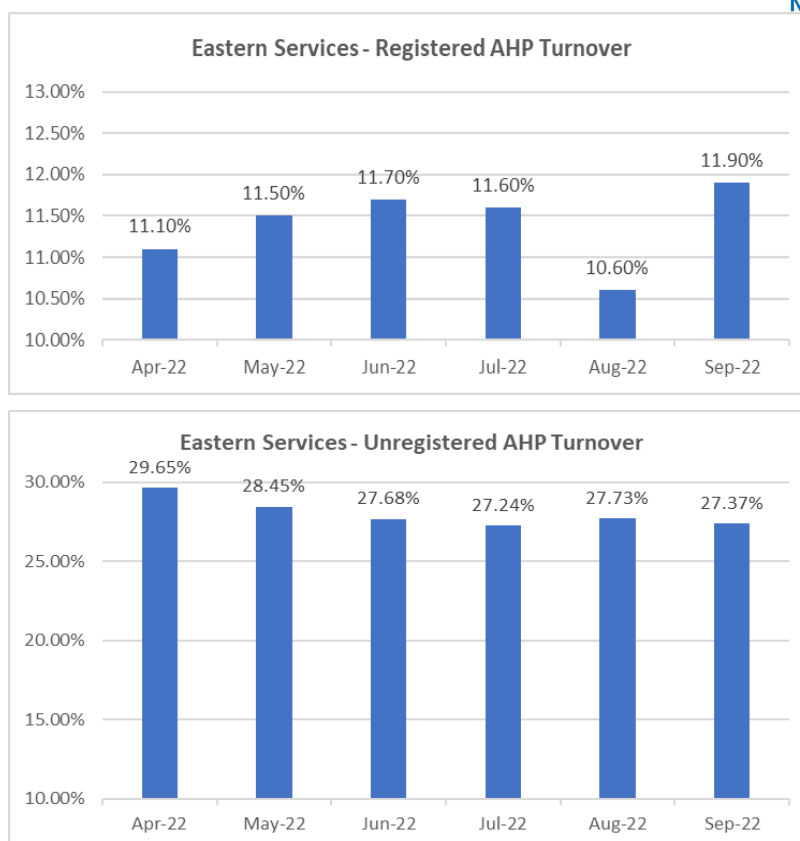






**Figure 19. – Eastern – RN, HCSW and AHP Turnover**





## 7. Performance against key quality metrics

The organisational quality performance for the last six months indicates that overall the standard of patient care during this period was safe.

There is ongoing work planned undertaking a more detailed analysis of staffing levels against specific patient quality, safety and experience metrics, national patient survey, local feedback sources and staff well-being metrics through the national staff survey and this will be reflected in the next report to the Board of Directors in May 2023.

## 8. Staffing Risks, Nursing, Midwifery and AHP on the Corporate Risk Register (CRR)

### 9.1 Northern and Eastern

New Risks included on the CRR during the period of April 2022 to September 2022:

- **Risk ID 690:** Nursing and Healthcare Support Worker (HCSW) Workforce. A number of risks in relation to Nursing and HCSW staffing continue to be held within Divisional Risk Registers across Northern and Eastern services; with the primary focus of risks on vacancy levels, as a result of turnover and difficulties in recruiting to posts related to national and local factors i.e. national shortage of nurses & HCSWs, competitive labour market, and falling unemployment rates.

A previous Eastern specific Nursing workforce risk (*Nursing workforce – Risk ID: 468*) was created and added to the Corporate Risk Register in June 2022. This risk

has been revised to articulate the Nursing and HCSW workforce risk across both Northern and Eastern services. (Risk score of 20).

Previous risks currently on the CRR include:

- Risk ID 14: *Management of Chemotherapy Nursing establishment within Cancer Services* (Remains at a score of 16).
- Risk ID 165: *Northern Midwifery Staffing Levels* (Remains at a score of 16).

## 10. Annual Staffing Review (ASR)

The next ASR is being undertaken through December 22/January 23 to inform 2023/23 Operating Plans. Specific Terms of Reference (ToR) are attached in [appendix 1](#).

The key outcomes of this review will be in the next 6 monthly report on Safe Staffing to the Board of Directors in May 2023.


Delivery of the 2021/22 trust wide ASR action plan has been governed through the year and will be reviewed within the 2022/23 ASR. Any outstanding actions will be progressed onwards via the resultant new ASR action plan.

## 11. Conclusion

This report provides a range of data and information that provides assurance to the Board of Directors that staffing has been safe at the Royal Devon University Healthcare NHS Foundation Trust across both the Northern and Eastern locations.

It is important to note the last six months has seen the challenges associated with the ongoing COVID-19 pandemic in managing daily staffing, improved slightly. However, the long-term effect of the pandemic continues to impact on the wider recruitment and retention position which in turn affects the daily staffing situation, and the ability to ensure levels and skill mix are at the correct levels in order to provide a quality service for our patients at all times.

## APPENDIX 1 – Annual Staffing Review 2022 Terms of Reference

Terms of Reference	 <b>Royal Devon</b> <b>University Healthcare</b> <small>NHS Foundation Trust</small>
<b>Nursing, Midwifery &amp; AHP Annual Staffing Review (ASR) (2022)</b>	
<b>Purpose and scope</b>	
<p>Provide the Strategic Workforce Lead (NMAHP), DoNs and CNO through to the Board of Directors with assurance of the current position relating to staffing levels in the trust; notably the key risks and actions being taken in relation to delivery of safe and effective care.</p> <p><u>In scope:</u></p> <ul style="list-style-type: none"> <li>• Adult, Paediatric and Maternity Inpatient wards;</li> <li>• Out-patient &amp; Non-Inpatient departments (i.e. Endoscopy, Interventional Radiology)</li> <li>• Emergency Department/MIUs, Medical Assessment Units &amp; SDECs</li> <li>• Intensive Care Units/High Dependency Units</li> <li>• Theatres (all);</li> <li>• Community Inpatient Settings and Community Nursing</li> <li>• Acute and Community AHP services</li> </ul> <p><u>Out of scope:</u></p> <ul style="list-style-type: none"> <li>• Clinical Educator roles – separate Terms of Reference and review already underway;</li> <li>• Clinical Nurse Specialists, Advanced Clinical Practitioner (ACP) and Nurse Consultant roles.</li> </ul>	
<b>Core Principles and Objectives</b>	
<p>The core principle of safe staffing levels is to have an appropriate number and mix of registered nurses, health care support workers, midwives and AHPs to deliver quality care, keep patients safe from avoidable harm and promote a positive patient experience whilst managing effectively within a financial envelope.</p> <p>The main objectives of this review are:</p> <ul style="list-style-type: none"> <li>• A divisional review of ward/department and service establishments to provide assurance that the staffing is fit for purpose and complies with regulatory and specialist requirements</li> <li>• Measure delivery against the 21/22 ASR review outcomes and integrate outstanding actions into this review;</li> <li>• Provide assurance through Divisional planning that registered nursing associates and assistant practitioners are being formally integrated into ward and department establishments and templates;</li> <li>• Provide assurance through Divisional planning that clinical apprenticeship training posts (TNAs, Nurse Degree Top ups, 4-year Nurse Degree programme and AHP programmes) are being formally integrated into establishments and templates;</li> <li>• AHPs – review registrant to support worker ratio and consider increasing support worker roles;</li> <li>• Review rostering practice compliance including assurance that ward/department roster templates match the funded establishment;</li> <li>• Assess compliance against national and specialist regulations and guidance (if compliant in 2021 ASR and nothing has changed then an assurance statement is sufficient)</li> </ul>	
<b>Specific data sources to be included and referenced</b>	<b>Key members of the review group</b>
Safer Nursing Care Tool (SNCT- Shelford Group) & specific local staffing tools such as BAPM and Birth Rate Plus – links & information provided; Use of Red Flags; Professional Judgement; Benchmarking using Model Hospital and other similar hospitals/wards; Rostering policy and productivity – optimum use of contracted hours; Incidents and Risks; Workforce data: Vacancies and recruitment, sickness, other leave; Use of Temporary workforce (NHSP/Bank/Agency);	<ul style="list-style-type: none"> <li>• Chief Nursing Officer;</li> <li>• Directors of Nursing;</li> <li>• Strategic Workforce Lead – Nursing, Midwifery and AHPs;</li> <li>• Associate/Assistant Directors of Nursing</li> <li>• Heads of Midwifery</li> <li>• AHP leads</li> <li>• Finance Business Partners</li> <li>• People Business Partners (PBPs)</li> <li>• Rostering Leads</li> </ul>
<b>Accountability, Reporting &amp; Review Arrangements</b>	
Divisional ASR Meetings; Trust wide Nursing, Midwifery & AHP Strategy Meeting; People, Workforce, Planning & Workforce Committee; Board of Directors.	

<b>Agenda item:</b>	12.2, Public Board	<b>Date: 30 November 2022</b>
<b>Title:</b>	Six-Month Safe Staffing Report – Medical Staffing – Royal Devon University Healthcare Trust – Eastern and Northern Services	
<b>Prepared by:</b>	Cheryl Baldwick – Deputy Medical Director – Eastern and Northern Services (RDUH)	
<b>Presented by:</b>	Professor Adrian Harris – Chief Medical Officer (RDUH)	
<b>Responsible Executive:</b>	Professor Adrian Harris – Chief Medical Officer (RDUH)	
<b>Summary:</b>	<p>This report provides a six-month review of the Trust’s position for the provision of Medical staffing. The report details any significant changes that have occurred in Medical staffing arrangements in the last six months and any risks on the corporate risk register related to Medical staffing.</p> <p>Staffing within General Medicine and medical specialties remains the biggest challenge across both acute sites with continued pressure on services to provide emergency care for acute admissions and substantial shortfall of staff, particularly in Northern Services.</p> <p>Medical staffing in the Divisions of Surgery and Clinical Support Services is more robust, although some challenges remain, particularly with regard to adequate staffing to provide timely care for cancer and long-waiting patients. Medical staffing in these areas cannot be taken in isolation as many of the challenges to increasing activity also rely on additional nursing and AHP staff being available.</p> <p>As there are limited national metrics for medical staffing levels, Trust-defined valid metrics for safe medical staffing are in development and will be submitted to the newly re-established and now cross-site Medical Workforce Strategy Group for comment and agreement. A number of safety and quality metrics are already in place for the Medical Services Division of Northern Services, which are reported on a monthly basis to the Safety and Risk Committee. Additional revised and cross site comparative Safety and Quality Metrics for the Medical Workforce have now been identified and approved by the Safety and Risk Committee. Further work is planned via Medical Workforce Strategy Group to add to these metrics, which includes Trust-defined minimum staffing levels to provide satisfactory care for emergency patients, urgent cancer treatment, long-waiting patients and routine patients. They incorporate aspects of various national targets and clinical standards, such as seven-day services. Performance against these metrics will form part of this report in future – a dashboard will be produced and revised on an iterative basis, reporting to the Medical Workforce Strategy Group to supplement this paper.</p>	
<b>Actions required:</b>	For the Board of Directors to note this Six-Month Safe Staffing Report for Medical Staffing. To note the range of challenges across the organisation and across specialities, and to note the mitigating actions already in place, underway or being further developed (short term, medium term and longer term), to ensure safe levels of medical staffing can continue to be provided and further	

	enhanced.			
<b>Status (x):</b>	<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Information</b>
				<b>X</b>
<b>History:</b>	This is the third Six Month Safe Staffing Report for Medical Staffing to the Board of Directors. The Safe Medical Staffing report continues to be refined and adapted over future reports, to ensure it provides sufficient information to meet the additional 'recommendations' from NHSI in relation to 'developing workforce standards', and the expectations / requirements of the Boards of Directors.			
<b>Link to strategy/ Assurance framework:</b>	<p>The issues discussed are key to the Trust achieving its strategic objectives;</p> <p><b>BAF Risk 2:</b> There is a risk that workforce levels will be insufficient to deliver the required capacity and care model.</p> <p><b>BAF Risk 5:</b> There is a risk of the Trust being unable to meet new demand for elective services (including cancer) and / or to provide required levels of activity to address the waiting list backlog due to unscheduled care demands and capacity</p> <p><b>BAF Risk 8:</b> Significant deterioration in standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes</p>			

**Monitoring Information**

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

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

## 1. Purpose of paper

To update the Board of Directors in relation to Safe Staffing for the Medical Workforce across both Eastern and Northern Services. This accompanies the report provided to the Board of Directors, by the Chief Nursing Officer, in relation to Nursing, Midwifery and AHP safe staffing.

## 2. Background

Following publication of the Francis Report 2013 and the subsequent “Hard Truths” (2014) document, NHS England and the Care Quality Commission issued joint guidance to Trusts on the delivery of the commitments associated with publishing staffing data on nursing, midwifery and care staff levels. These include:

- Report and publish a monthly return to NHS England indicating planned and actual nurse staffing by ward. This is published on the NHS Choices website.
- Publish information with the planned and actual registered and unregistered nurse staffing for each shift
- Provide a 6-monthly report on nurse staffing to the Board of Directors.

The NHS Improvement “Developing Workforce Safeguards” (October 2018) recommends that Trust reports include safe staffing information for Allied Healthcare Professionals (AHPs) and **Medical staff** as well as nursing and midwifery staff.

Additional guidance was also provided in 2018 by the Royal College of Physicians in relation to Medical Staffing of inpatient areas, for Physicians. This guidance was used previously to develop minimum doctor numbers for the Medical wards and has informed previous increases in medical workforce numbers.

It is important to note the last six months has continued to see challenges associated with the ongoing COVID-19 pandemic in managing daily staffing, improved slightly. However, the long-term effect of the pandemic continues to impact on the wider recruitment and retention position which in turn affects the daily staffing situation, and the ability to ensure levels and skill mix are at the correct levels in order to provide a quality service for our patients at all times.

Data sources mentioned within this report are in the process of validation or indeed development, to provide a useful and robust set of metrics to support the definition of ‘safe medical staffing’.

### 3. Summary

Staffing within General Medicine and medical specialties remains the biggest challenge across both acute sites with continued pressure on services to provide emergency care for acute admissions and substantial shortfall of staff, particularly in Northern Services.

Medical staffing in the Divisions of Surgery and Clinical Support Services is more robust, although some challenges remain, particularly with regard to adequate staffing to provide timely care for cancer and long-waiting patients. Medical staffing in these areas cannot be taken in isolation as many of the challenges to increasing activity also rely on additional nursing and AHP staff being available.

As there are limited national metrics for medical staffing levels, Trust-defined valid metrics for safe medical staffing are in development and will be submitted to the newly re-established and now cross-site Medical Workforce Strategy Group for comment and agreement. A number of safety and quality metrics are already in place for the Medical Services Division of Northern Services, which are reported on a monthly basis to the Safety and Risk Committee. Additional revised and cross site comparative Safety and Quality Metrics for the Medical Workforce have now been identified and approved by the Safety and Risk Committee. Further work is planned via Medical Workforce Strategy Group to add to these metrics, which includes Trust-defined minimum staffing levels to provide satisfactory care for emergency patients, urgent cancer treatment, long-waiting patients and routine patients. They incorporate aspects of various national targets and clinical standards, such as seven-day services. Performance against these metrics will form part of this report in future – a dashboard will be produced and revised on an iterative basis, reporting to the Medical Workforce Strategy Group to supplement this paper.

### 4. Key Risks

There are six high-level risks in the Medical Division (Northern Services) on the Trust Corporate Risk Register at present. These are governed through the Safety & Risk Committee. All relate to shortages of medical staff. They are:

- Acute Medicine – risk score 20
- Healthcare for Older People – risk score 20
- Gastroenterology – risk score 20
- Stroke Medicine – risk score 20
- Junior doctors – risk score 16

The recent paper submitted to the Safety & Risk Committee in September reports five incidents in the previous 18 months, where insufficient staffing was found to be a contributory factor, three of which have been upgraded to Serious Incidents. The division has developed draft metrics relating to safety and quality, which are reported



to the Safety and Risk Committee on a monthly basis. Particular issues highlighted include lack of capacity for senior weekend reviews of patients on wards and continued reliance on locum doctors to staff the Medical Assessment Unit and inpatient wards.

A comprehensive business case has been developed, outlining the need for an increase in the number of senior and junior staff within Medicine. This is due to be presented to the Board of Directors in December and builds on the case provided to the Trust Delivery Group earlier this year.

Medicine in Eastern Services is also challenged, particularly within Respiratory Medicine, which has been added to the Corporate Risk Register with a risk score of 16, acknowledging the risk of harm for patients waiting for initial assessment for potential lung cancer and delays to diagnosis.

The division also holds three risks with scores of 12:

- Junior doctors
- Neurophysiology
- Emergency Medicine middle-tier doctors

In the last six months there have been a total of seven incidents recorded on Datix relating to medical staffing shortages in Eastern Services. Four of these were reported as ‘no impact’ and three reported as ‘minor impact’. All of these incidents were raised as a result of short notice sickness absence, requiring last minute cover to be sought or working on minimum, albeit ‘safe’ levels of cover for a short period of time. Three of these incidents were within the Medical Services Division, three within the Specialist Services Division and one within the Surgical Services Division. All have been investigated, with one investigation ongoing.

## 5. Establishment and Vacancies

Comprehensive work undertaken recently within Medicine on both acute sites has highlighted discrepancies between the budgeted medical workforce establishment and that required to safely deliver emergency and contracted elective work across the Trust. In addition, there has been divisional restructuring with the creation of the Community Division across both sites and budgets do not all follow clinical practice.

Based on the current budgeted establishment in the ESR system, there are numerous medical vacancies as outlined below. It is not clear that all medical vacancies are visible within ESR and further manual revalidation is required to ensure accuracy of the vacancy position across the Trust as a whole. We anticipate that this will be completed in advance of the next report to Board.

Division		Vacancies (WTE)
Eastern Services	Medicine	16.8
	Surgery	8.7
	Clinical Support Services	7.5

Northern Services	Medicine*	6.4
	Surgery	6.4
	Clinical Support Services	7.2
Community Services		1.4

\* This figure does not consider the proposals in the impending business case for an increase in the establishment in the department of Medicine in Northern Services. It is also below the number expected with the current acknowledged establishment, which suggests that there are 16 vacancies within the department of Medicine.

## 6. Recruitment

There has been successful substantive senior doctor recruitment in Eastern services, including posts that have been consistently hard to fill in Haematology, Oncology and Radiology, although these services remain under pressure to staff safe rosters. In addition, there has been successful recruitment in some specialties where there are national recruitment challenges, including Histopathology and Urology.

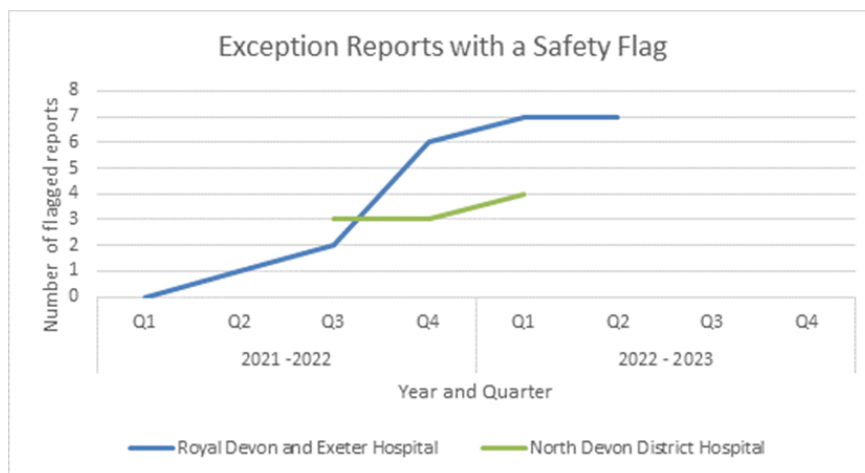
In Northern services, there has also been successful recruitment, concentrated in the Surgical Division, predominantly within Anaesthetics and Breast Surgery. The latter will have a positive effect on the safe provision of breast cancer services.

Division		Starting Date			
		April to September 2022		September to date	
		Consultant	SAS	Consultant	SAS
Eastern Services	Medicine			2	
	Surgery	2	1	3	1
	Clinical Support Services	2	1	4	
Northern Services	Medicine		3		
	Surgery	5	5	1	2
	Clinical Support Services		1		1
Community Services					4

## 7. Junior Doctor Exception Reports with Immediate Safety Concern

Between April and September 2022, there has been a trend to an increase in exception reports flagged as an immediate safety concern across both acute sites, although Quarter 2 data for Northern Devon were not available at the time of writing. In addition, we know that there is significant under-reporting by junior doctors so it is

difficult to know if this reflects increasing pressure on services, a change in reporting behaviour or a combination of the two.



Further detail is provided in reports by the Guardian of Safe Working but, in brief, these largely relate to junior staff who feel they have too many patients to cover safely and insufficient senior cover, predominantly but not exclusively within General Medicine. No harm to patients was noted or reported. However, this causes worry and anxiety amongst junior staff.

There have been three reports in surgery in Eastern Services during the current quarter from October 2022. These all relate to one weekend period where there was very high demand and all senior doctors were committed in theatres over a prolonged period, leaving the junior team feeling exposed and over-stretched.

## 8. Future View

There is a lack of resilience in several services, particularly those with small total numbers of doctors and national recruitment shortages.

Following a consultant resignation in Urology in Northern Services, we anticipate that this service will experience significant senior staffing challenges over the coming six months, which is likely to impact on the emergency and out of hours service that can be provided on the Northern Service site. Work is in progress between the Urology departments on the two sites to mitigate this and ensure that appropriate arrangements are in place for emergency urology patients at all times.

As outlined previously in this paper a number of key tasks are being developed / progressed;

- Validation of Medical Workforce data, to ensure that reported establishments and vacancies are accurately recorded, to support future reporting and workforce planning.

- Development of a robust and consistent annual establishment review process for the Medical Workforce across all divisions and sites. This will include non-medical roles, such as Physicians Associates (PAs) and Advanced Care Practitioners (ACPs) in conjunction with the Nursing, Midwifery and AHP Workforce Strategy Group.
- Identification across all specialities of 'minimum safe staffing levels' for the Medical Workforce and a process to consistently record and report where these levels are breached / challenged
- Agreement of key supporting 'safety and quality' metrics for the Medical Workforce and to build these in to the development work list for business intelligence and epic to enable both real time and retrospective reporting.
- Establishment of ongoing reporting of safe medical staffing from divisional teams through to the Medical Workforce Strategy Group, supported by the above actions.
- Presentation of the Northern Services Medical Staffing Business Case to the December Board of Directors for approval

