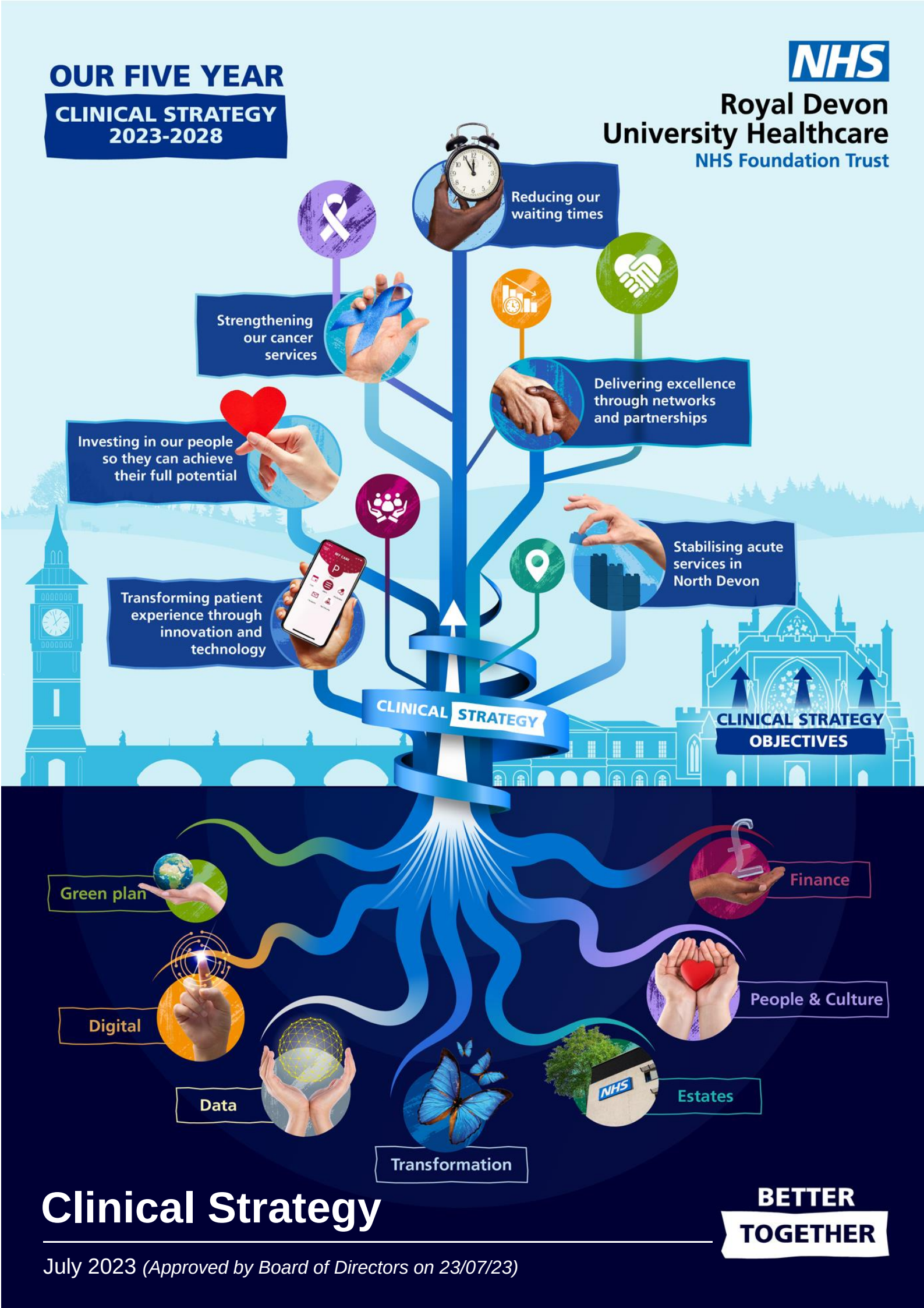


Clinical Strategy

July 2023 *(Approved by Board of Directors on 23/07/23)*

Clinical Strategy:

Vision

Recovering our services whilst supporting clinical excellence and improved outcomes for our community, through working with system partners and the application of technology, research and innovation.

Objectives

- **Stabilising and developing acute medical services at North Devon**
- **Recovering our waiting times**
- **Reducing acute admissions and lengths of stay**
- **Increasing the separation between elective capacity and urgent care**
- **Strengthening cancer services**
- **Working with local partners to optimise community pathways**

Strategic priorities

- **Invest in staffing to support Acute Medicine in North Devon**
- **Improve safe alternatives to acute admission**
- **Build community capacity in care home and domiciliary care support**
- **Increase clinical productivity through transformation**
- **Build outpatient and diagnostic capacity**
- **Increase utilisation of MY CARE**
- **Reduce outpatient demand through patient initiated follow-up (PIFU) and increased virtual care**
- **Protect our elective bed capacity**
- **Support the Peninsula Acute Sustainability Programme (PASP)**
- **Use the power of Epic to transform services**

Contents

Foreword

Our clinical services touch the lives of patients at times of basic human need, when care and compassion are what matter most. Over the course of the COVID-19 pandemic, our ability to deliver the kind, compassionate and expert patient care, to which we all aspire, was tested, with services stretched and many staff feeling fatigued by the continuous pressures. In response to these challenges, the efforts of staff at Royal Devon have been nothing short of heroic.

This five-year Clinical Strategy provides a blueprint for recovering our services whilst supporting clinical excellence and improving outcomes for our community, through working with system partners and the application of technology, research and innovation. In addition to providing a comprehensive set of practical approaches, this strategy aims to transmit a message of hope and optimism for a brighter future for our patients and our amazing staff.

Underpinning this Clinical Strategy is a suite of enabling strategies, covering key areas, including our Workforce, Estates, Digital, Data and Finance. The co-production of each of these strategies simultaneously, signals a bold intention that clinical and managerial leadership teams from across the Trust will work in concert to deliver the necessary improvements in patient care, whist addressing our financial challenges by making services streamlined and efficient.

We would like to thank our clinical chairs, Professors Bruce Campbell and David Sanders, whose experience, skill and commitment has ensured that this Clinical Strategy embodies the aspirations, judgement and expertise of hundreds of clinical and non-clinical staff from across the Trust, as well as patients and colleagues from our wider health and social care system.

Delivering this ambitious plan will be challenging: however, work to deliver this strategy is already well underway and tremendous progress is already being made so far in 2023/24. The redevelopment of our Emergency Department and the commencement of a much-needed Cardiology Day Case Unit for our eastern services, allocation of significant funding to stabilise and develop acute medicine in the north, and the procurement of an additional surgical robot for both sites, are some of many examples of our strategy being delivered.

We have every confidence that staff at Royal Devon will show the dedication, compassion and innovation we saw during the pandemic and before, in getting behind this collective vision, and the actions set out in this strategy, to make it our reality, in service of our staff and our patients.

Professor Adrian Harris

Chief Medical Officer

Carolyn Mills

Chief Nursing Officer

Introduction and Executive Summary

Overview

This Clinical Strategy describes the vision of the Royal Devon University Healthcare NHS Foundation Trust for provision and development of clinical services to the population of Northern and Eastern Devon, to deliver high-quality, sustainable emergency, elective and specialist care, covering the next five years and beyond. It is underpinned by a set of Trust principles, which are aligned with the NHS Long Term Plan and the principles of One Devon.

Our challenges

Many people believe that healthcare providers are facing the most challenging time in the history of the NHS. The impact of COVID-19 has stretched to every element of our services, and our staff have invariably felt fatigued and apprehensive in the face of the prolonged nature of the pandemic and the scale of challenges it has presented. In particular, there has been an unprecedented impact on urgent care services, with extremely long ambulance and emergency department (ED) waiting times widely reported in the media.

The local Devon system is not only experiencing all the issues relating to the pandemic seen nationally, but in addition, has a more geographically dispersed and older population than the national average. Detailed background information about the Trust, its partner organisations and the challenges and context of this strategy can be found in Appendix 1.

A further and important consideration for our Clinical Strategy is the long waiting times at Royal Devon, relative to other parts of the country. At the start of 2023/24 the Devon Integrated Care Board (ICB) had more than triple the number of patients waiting over 52 weeks for treatment compared to the average for the South West, with Royal Devon accounting for 49% of those patients. Thanks to the hard work of our staff, the Trust is making excellent progress in reducing waiting times. Continuing this trend, including for patients on cancer pathways, is a key priority within this strategy.

A further critical element for consideration has been the extremely challenging financial context both for Royal Devon and the wider ICB. In order to gradually address this, our services must capitalise upon opportunities presented through integration, partnership working, technology and innovation, to become more efficient and deliver the best value for the available resources.

Developing our strategy

In order to respond to the challenging context and to ensure delivery of high standards of care and equity of access for our patients, our Clinical Strategy, developed in close consultation with our staff, is both comprehensive and ambitious. In developing this strategy, we engaged extensively with clinicians and managers throughout the Trust and worked with patient and public representatives and partners across Devon. Consequently, there is strong alignment between this Clinical Strategy and the wider system approach to the challenges we collectively face. More detailed information regarding the development of the strategy, its structure and our guiding principles, is provided in section one of this document.

Of particular note is the approach taken to develop the Clinical Strategy whilst simultaneously refreshing our key enabling strategies. This bold and complex undertaking aims to ensure that the aspirations set out in this

document, as our primary strategy, are underpinned by further detail of *how* things will be delivered in our Estates, Digital, Data, Finance, and People & Culture strategies.

Services for children and young people

The nature of children and young people's (CYP) illness has changed over the last decade. Presentations of CYP with eating disorders, self-harm and complex mental health needs have increased significantly. In addition, some of our longest waiting times for elective care include key services for children, and addressing these and other challenges is an important element of the Clinical Strategy. Many of the proposed developments, across all four clinical domains, will impact upon both adults and CYP. Where our key actions are specifically relevant for CYP services, such as for neurodisability and neurodevelopmental conditions, this has been identified, however, it can be assumed that, with some obvious exceptions, our "strategic approaches" apply to both adults and CYP services.

Key elements of the Clinical Strategy

Our strategy is broken down into four "domains", namely;

- **Local Acute and Emergency Care,**
- **Community and Primary Care Led Services,**
- **Elective Care,**
- **Tertiary Care & Areas of National Clinical and Academic Excellence.**

In each domain the challenges faced by the relevant services are described. To support operational teams in developing local plans to deliver this strategy, examples of good practice for each of the domains are included in Appendix 2. Each domain then presents a series of key objectives and "strategic approaches" which will be undertaken in order to achieve them. A graphical overview of the domains, key objectives and strategic approaches to achieve them is provided in section one. As a planning aid for operational teams, a tabular summary is also provided in Appendix 3.

In total, over the four domains, there are 13 objectives and 51 strategic approaches. Whilst they are all important for service delivery, key objectives include;

- **Stabilising and developing acute medical services at NDDH,**
- **Recovering our waiting times,**
- **Reducing acute admissions and lengths of stay,**
- **Increasing the separation between elective capacity and urgent care,**
- **Strengthening cancer services.**

Strategic approaches to achieving these aims include investment in acute medicine staffing in northern Devon, increasing domiciliary care capacity, optimising the use of Epic and virtual care, as well as the development of new facilities, such as a hybrid operating theatre. Increasing capacity in our services will require external capital investment, and proactive planning will be necessary to take advantage of funding opportunities when they arise.

Whilst the strategy is grouped into the domains set out above, there are a number of golden threads running throughout. These include using technology, particularly the tremendous power of Epic to transform our services, working in partnership with others, promoting research to improve clinical care and building capacity and capability in our workforce, who are the bedrock of our clinical services.

Other considerations of the Clinical Strategy

Delivery of a five-year strategy as complex as this one will require leadership and proactive identification and mitigation of potential barriers and risks, as well as excellent communication to engage staff from across the Trust. Further detail on implementation of the strategy and risk management is provided in section three of this document. Once approved by the Board of Directors, delivery of the Clinical Strategy and the enabling strategies will be overseen by the Trust Delivery Group, chaired by the Chief Operating Officer.

Final word

This Strategy sets out a blueprint for recovering our services and supporting clinical excellence through open and honest partnership working, and the application of technology, research and innovation. Like all strategies it will need to flex and adapt to socioeconomic and political changes over the five-year period, however, if successful, it will be transformative. Delivery of the objectives set out in this document will enable more patients to be treated, more quickly and efficiently, and ensure that emergency services can provide the level of safe, high-quality care we would all wish for ourselves or our families.

Finally, we hope that this Clinical Strategy provides a joint sense of purpose and optimism that Royal Devon will overcome the challenges we face together, in pursuit of excellence for patients and the communities we serve.

Section One

01

SECTION ONE

Developing our Strategy

Developing a five-year strategy covering all of our acute and community services is a complex undertaking. This section describes the key elements underpinning our strategy, namely;

- **Our guiding principles,**
- **The structure of the strategy,**
- **The engagement process undertaken with staff, patients and our partners in other organisations.**

Guiding principles

In April 2021, the Trust Clinical Leadership Team agreed eight principles which would be used to inform the development of the Clinical Strategy. These are listed below.

	Principles of the Clinical Strategy
1	Delivering safe and effective care which reduces clinical variation, improves process efficiency and improves clinical outcomes
2	Collaborating as system partners to deliver integrated healthcare and wellbeing services
3	Reducing health inequalities for all our people
4	Fully exploiting digital, scientific and technological innovation in healthcare
5	Investing in our people so they can work to their full potential, feeling supported to provide the best quality care
6	Getting the best value for our population from our finite resource
7	Empowering people to access personalised holistic care which we will provide closer to home wherever possible
8	Championing the environment to reduce our carbon footprint

Figure 1. The principles which underpin the Clinical Strategy

Structure of the Clinical Strategy

The Clinical Strategy is grouped into four domains, under which the challenges, key objectives and strategic approaches we will undertake to achieve them are set out. To support operational teams in developing local plans to deliver this strategy, examples of good practice for each of the domains are included in Appendix 2.

An overview of the domains, objectives and underpinning strategic approaches is provided below in Figure 2.

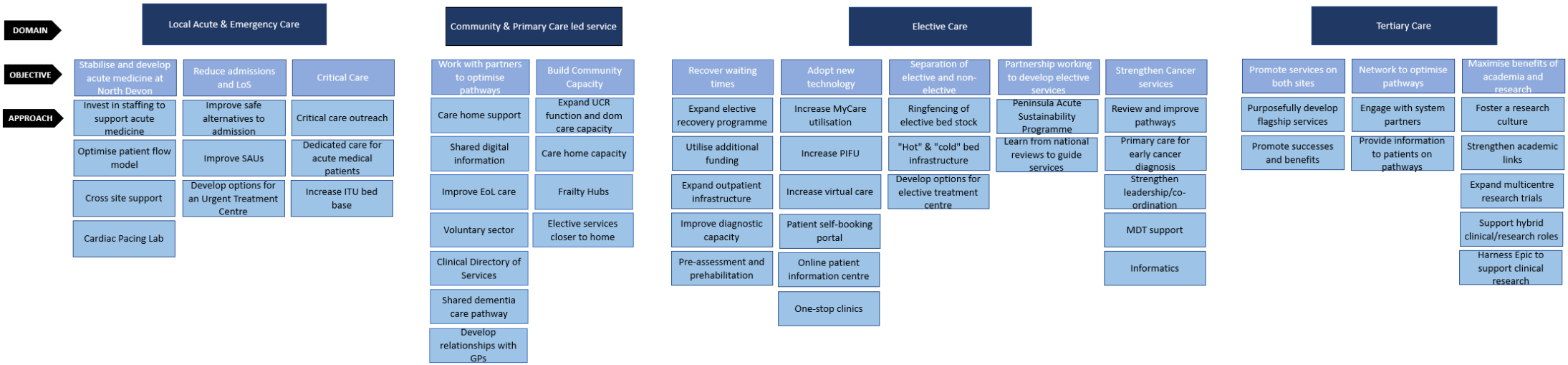


Figure 2. Clinical Strategy, a visual overview

Engagement with our staff, patients and key local partners

This document is called our “Clinical Strategy” for two important reasons. Firstly, as it sets out a blueprint for recovery and transformation of our clinical services. Secondly, this strategy is intended to represent the voice of clinical teams from across the Trust, regarding our key challenges and our collective judgement as to the best way to address them. The process throughout has been open and inclusive, with different perspectives and opinions being sought so that our staff rightly feel that this document is *their* Clinical Strategy.

In developing this strategy, we engaged extensively with clinicians and managers throughout the Trust, as well as in primary care and mental health services. We also worked with patient and public representatives, as well as commissioners, to get their perspective on the challenges and how we can collectively overcome them. The process of engagement to develop this strategy is summarised in figure 3 below.

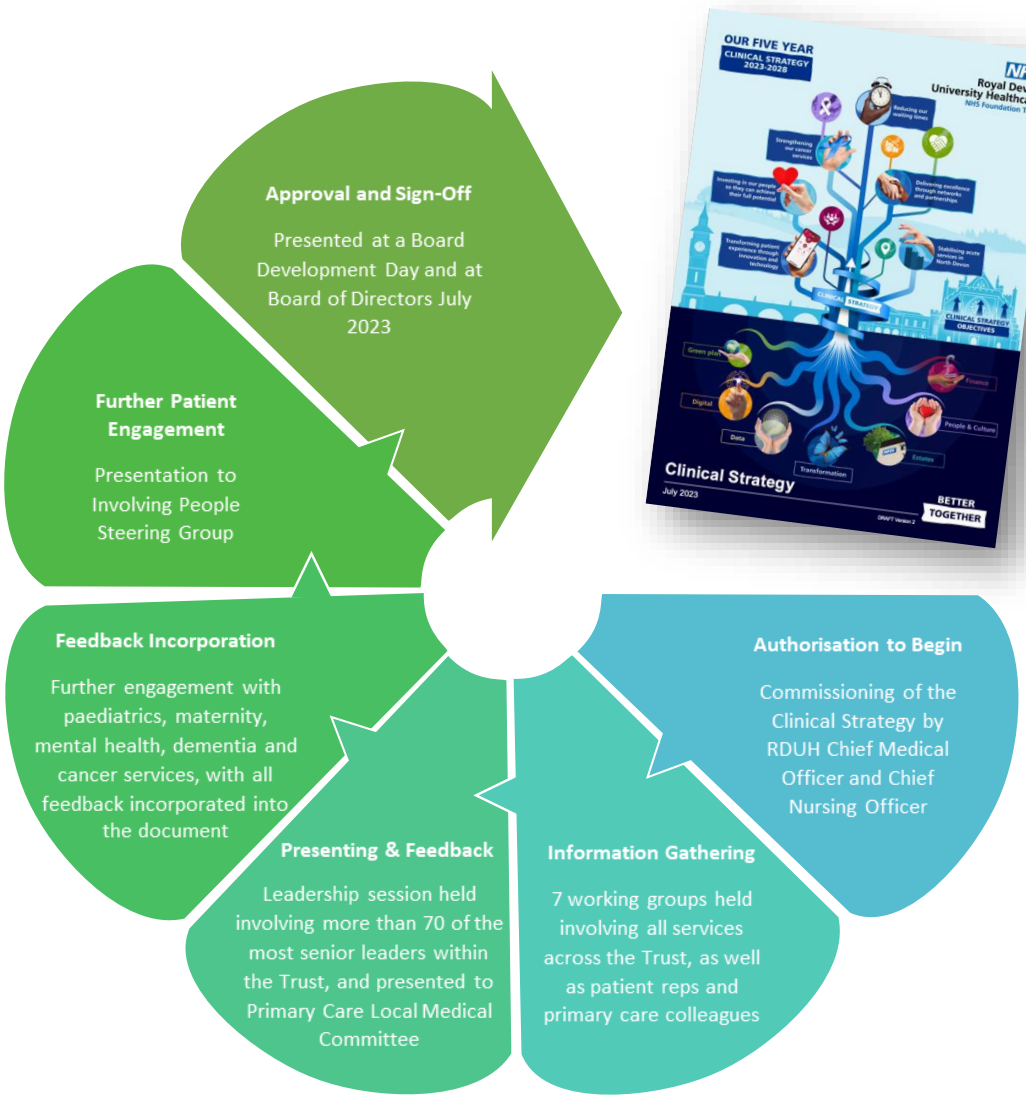


Figure 3. The engagement process in developing the Clinical strategy.

Section Two

02

SECTION TWO

Domain 1 – Local Acute and Emergency Care

Goal

We will provide prompt, high-quality acute urgent and emergency care to patients. We will seek to make pathways as efficient as possible, improve patient experience, reduce unnecessary ED attendances and acute hospital admissions, and minimise length of stay.

Main Challenges

- **Increasing demand (numbers of acute admissions) -** Acute admissions compromise the capacity for planned care at both the RD&E and at NDDH, causing cancellation of planned procedures and impacting on outpatient work. The number of acute admissions is rising due to an increasing and aging population, which is exceeding the capacity of primary and community care services. This results in our EDs and acute medicine receiving many patients whose attendances could potentially have been avoided, including children and young people. These pressures adversely affect both patient care and the experience of patients and their families and carers.

- **The impact of the COVID-19 pandemic** - COVID-19 has been the defining feature of the recent history of the NHS and has been arguably the largest emergency to affect the NHS in its history. In addition to this, seasonal influenza and other infectious diseases, such as Mpox, can have profound impacts on patients and cause significant disruption to service provision. Over the course of the five years of this Clinical Strategy, we will continuously strengthen our infection control readiness, ensuring our estates infrastructure, training, pandemic planning and stock levels of important equipment, such as powered respirators, enable us to respond effectively to future outbreaks or pandemics.

- **Potentially avoidable attendances -** These include unusually high admission numbers for substance related conditions in under 18s and a misconception among many people about when it is appropriate to attend the ED.

- **Shortages in workforce required for emergency care -** Delivery of effective urgent care requires continued focus on the staff, who are the bedrock of our services. The People & Culture Strategy, developed to support the delivery of this Clinical Strategy, contains detail on the workforce challenges and solutions, and plans to implement them. In particular, these will include recruitment and retention of clinical and other staff, as well as how we will further develop innovative roles already working effectively, to support our consultant led services. These include physician associates, practice educators, advanced clinical practitioners and others. A robust framework will be developed, clarifying the roles of all staff, and setting out support for training, development and supervision.

- **Patients with mental health conditions** - Many patients admitted to acute hospitals also have mental health needs during their visit or admission, but there are increasing numbers of patients presenting with acute physical health conditions who primarily require specialist mental health support, rather than

attention solely to their physical conditions. Our EDs will continue to forge strong clinical links with our co-located partner, Devon Partnership NHS Trust, to ensure we support patients with co-ordinated care in a place of safety.

- **Patients with acute delirium and dementia** - A large proportion of acute and emergency admissions in patients over 65 have acute delirium, often on a background of progressive dementia. These patients are highly complex, and present the greatest challenge to patient flow. We will review our Dementia Strategy, with a focus on specific aspects of good practice, such as early conversations with families and use of the "this is me" approach. We will also ensure that upgrades to ward environments are "dementia friendly", for example through the use of handrails contrasting with wall colour and clear floor marking.

- **The distance that some patients have to travel for acute care is considerable** - This means that some urgent treatments (e.g. acute heart conditions requiring cardiac catheterisation) can be unduly prolonged.

Strategic Approaches

This section sets out three objectives the Trust aims to achieve in relation to urgent and emergency care, underpinned by the "strategic approaches" that will be taken to deliver them over the next five years.

Objective 1. Stabilise and develop acute medicine at North Devon

A fundamental principle underpinning our service delivery is that patients should have equitable access to high-quality emergency services no matter where they live in our catchment area. We recognise that for some specialised services patients may have to travel, but both NDDH and the RD&E require a bedrock of acute medical capacity and capability to support the needs of patients who attend as emergencies. NDDH has long experienced diseconomies of scale due to its smaller size and remoteness, making it harder to recruit and retain specialist staff and constraining investment. We will address the challenges for both sites in the following ways:

i. **Invest in staffing to support acute medicine** – We will increase medical and non-medical staffing levels in acute medicine to provide more resilient services. This will strengthen service provision, support alternatives to acute admission and reduce length of stay. In turn, this will result in less need for future growth in our bed stock and less frequent use of expensive escalation beds, thereby making the investment required cost-neutral over time.

ii. **Optimise the patient flow model** – We will clinically review the pathways through which patients are reviewed and admitted, ensuring that physical infrastructure of facilities, such as Acute Medical Unit (AMU) and Same Day Emergency Care (SDEC), are fit for purpose. Leveraging the information within Epic, we will strive to improve our response to differing levels of demand, and also optimise how we manage flow through our various care settings. This requires us to make more intelligent use of our information, aided by automation where possible.

iii. **Increase support from our eastern services in acute medicine** – Since the merger in April 2022 much progress has been made in providing support from eastern services to the north and in integrating key urgent care services, but there remains work to do. We will continuously support our clinical and operational teams to maximise the benefits of being part of a larger trust, particularly with regard to medical cover and specialised services.

iv. **Provide a cardiac pacing lab** – We will explore the feasibility of providing a cardiac pacing lab at NDDH. This would save around one hundred non-elective patients travelling to Exeter each year, as well as hundreds of elective patients, and would shorten their length of stay. It would also make cardiology consultant roles at NDDH more appealing, thereby supporting recruitment of high calibre staff.

Objective 2. Reduce acute admissions and length of stay (LOS)

Lengths of inpatient stay have important implications both for the wellbeing of patients and for the efficiency of the Trust. For patients, there is good evidence that staying longer than clinically appropriate brings significant disbenefits, including muscle atrophy and loss of independence. For the efficiency of the Trust, lowering LOS or avoiding admissions altogether is essential to provide the capacity required to admit acutely unwell patients. The Trust treats over 40,000 non-elective inpatients each year in approximately 1000 beds. A reduction in LOS of one day per patient would create the capacity equivalent to over 100 beds. There are many workstreams focused on delivering this objective, but our strategic approaches below set out those changes which are most significant at an organisational level. This approach is closely aligned to the Integrated Care Board (ICB) strategy.

i. **Improve safe alternatives to admission** - We will continuously strengthen services to support patients by providing safe, high-quality alternatives to admission to an acute hospital bed. These will include:
   - SDEC running 7 days a week across both sites
   - A greater number and availability of “hot clinics” for urgent patients
   - Expansion of the Trust’s “virtual ward” so that up to 100 suitable patients can be safely monitored at home without the need for admission by the end of 2023
   - Following the completion of a dedicated children’s area as part of the refurbishment of our eastern ED, we will upgrade the physical infrastructure and review the service model of the short stay Paediatric Assessment Unit (PAU)
   - Further enhance the Urgent Community Response (UCR) functions in the community, to increase admission avoidance activity and outcomes
   - Working with our Primary Care Networks (PCNs) and NHS 111 to stream patients more appropriately into the above services to reduce ED attendance and acute admission
   - Working with UCR teams to develop a community-based Delirium Pathway to provide skilled assessment, treatment, and support for patients with delirium and progressive dementia to help prevent avoidable admissions

ii. **Improve Surgical Assessment Units (SAU)** – We will improve the infrastructure of our SAUs on both sites to ensure that non-elective surgical patients have access to high-quality assessment, and alternatives to acute admission. Alongside this, day case and ambulatory pathways for non-elective surgical patients will be continuously enhanced.

iii. **Develop options for an Urgent Treatment Centre (UTC)** – Urgent Treatment Centres are GP led urgent care facilities, open at least 12 hours a day, every day, offering appointments that can be booked through NHS 111 or through a GP referral, and are equipped to diagnose and deal with many of the most common ailments people attend ED for. We will work with system partners to explore the feasibility of implementing UTCs, which are coterminous with the EDs on the northern and eastern sites. The units would stream less acutely unwell patients and will also offer support for patients with mental health and social issues, both of which should reduce congestion and manage future growth in demand in our EDs.

Objective 3. Increase facilities and arrangements for critical care

Critical care facilities and staffing levels underpin the Trust's ability to care for acutely unwell non-elective patients, as well as safe and timely delivery of care for our highest risk elective patients.

i. **Develop critical care outreach** - We will further develop critical care outreach delivery models, which will support the care of critically ill patients and complement existing community models, in areas remote from the Intensive Treatment Unit (ITU).

ii. **Provide dedicated critical / high dependency care for acute medical patients** - Additional dedicated facilities for the care of critically ill patients in the area of the Acute Medical Unit at our eastern site will also be considered as an approach to caring for the increasing numbers of very sick medical patients who are admitted acutely.

iii. **Increase Intensive Treatment Unit (ITU) bed base** – at both the RD&E and NDDH our ITU bed base is considerably lower than the national average of 7.3 per hundred thousand people. We will seek capital funding to increase our ITU bed numbers on both the RD&E and NDDH sites.

Domain 2 - Community & Primary Care-led Service

Goal

We will work with our partners to provide joined-up, high-quality care to help keep people well at home and reduce the need for hospital admission.

Main Challenges

- **An ageing population** with multiple co-morbidities, which creates a high demand for community services, both in terms of referrals and complex need.
- **A widely dispersed rural population**, which means prolonged distances and travelling time for community staff and in some cases limited infrastructure (including domiciliary care agencies) to support people to stay well at home.
- **Staff shortages,** which affect the ability to deliver community care and impact on workforce resilience and retention.
- **A lack of community facilities and space** in which to offer enough clinics for patients, for example in physiotherapy, maternity services, community dental services and podiatry.
- **A lack of domiciliary care and private provision of home care**, which increases demand for community services in order to keep people safe and slows discharge from acute hospital beds.
- A lack of knowledge among both patients and healthcare providers about what services are available and how to access them, in order to ensure our community services are used to their maximum skill and expertise.
- **Deficiencies in recognition and support for people living with dementia.** Low rates of early diagnosis and shortfalls provision of carer and patient support cause unplanned preventable crisis admissions.
- **Shortfalls in End of Life Care.** A lack of coordination and arrangements for holistic and individualised care by system partners, which often results in avoidable hospital admissions and patients not being able to die at home, as they would wish.
- **Inadequate linkage of digital systems** between community services, secondary care (Epic) and primary care.

Strategic Approaches

Our excellent community service teams play a critical role in supporting people within their homes, working closely with colleagues in primary care, social care, care agencies and the voluntary sector at a truly local level. Due to its dispersed nature, much of the work they undertake is less visible than for our acute services, although it is vital to keeping people safe and well in their own communities. Each year our teams undertake approximately 240,000 community nursing visits and 85,000 therapy visits within patients' homes. In addition, our teams provide approximately 100,000 therapy and podiatry appointments and operate 92 community

hospital beds in Tiverton, Exmouth, Sidmouth and South Molton. Our community midwifery teams provide antenatal and postnatal care and support home birth in the community across the Royal Devon geography.

This section sets out two objectives the Trust aims to achieve in relation to community and primary care-led services, underpinned by the "strategic approaches" that will be taken to deliver them over the next five years.

Objective 1. Work with local partners to optimise pathways of care

Our acute and community services are part of the broader health and social care network which is necessary to support people in living healthy lives and to care for them when they need help. In the Royal Devon catchment area, there are 65 GP practices and approximately 136 care homes, in which around 4000 people live. There is also a network of acute and community mental health services provided by Devon Partnership Trust (DPT), working alongside our teams to provide care for some of our most complex and vulnerable patients. Other critical partners include South Western Ambulance Foundation Trust (SWASFT) and the broad range of voluntary sector groups supporting people across the breadth of health and social care. Fostering a culture of strong partnership working, where we strive towards seamless care for our patients, is a cornerstone of this Clinical Strategy.

i. **Improve care home support** - Over 1500 acute admissions per year are of people resident in care homes. Recent audits have shown approximately 30% of these admissions are avoidable. Building on the existing Enhanced Health in Care Homes Framework, we will enhance the support our acute and community services provide to care homes within our catchment area. This will include therapy support, specialist advice and increased participation in multidisciplinary teams.

ii. **Improve use of shared digital information** - Communication and sharing of patient information provides clear advantages in connecting clinical services from across the health and social care system, (including mental health services) and in making the whole system simpler and easier to navigate for patients, their families and carers. Our Clinical Digital team will be expanded and will work closely with our clinical teams to continuously improve the ways in which Epic can make patient care, safer, easier and more effective. There is a multitude of examples of this work, but within urgent care they include the creation of dashboards to identify COVID-19 patients, tools to streamline the discharge process and refinements to make prescribing safer. We will also support the implementation of the Devon & Cornwall Care Record and integration with our services and the NHS app.

iii. **Improve End of Life Care** – Building on the Trust-wide end of life work plan, which has already delivered nurse led Treatment Escalation Plans (TEPs) in the community, we will improve End of Life Care through targeted investment in staff, proactive planning with patients and families to reduce avoidable hospital admissions and ensuring excellent liaison across the acute, community and wider system teams.

iv. **Work more closely with voluntary sector organisations** – Local charitable groups, such as Help the Aged, Dementia UK, Alzheimer's society and the British Red Cross can play critical roles in supporting patients' wellbeing at home and reducing social isolation, which is often a precursor to acute hospital admission and discharge. We will pilot the introduction of a volunteer coordinator role to liaise with these voluntary sector organisations, as well as patients, carers and patient families. This will expand the range of our collaboration and compliment the work of our community teams.

v. **Update the clinical Directory of Services (DOS)** - The DOS will be updated and promoted for use by clinical teams and patients through a range of publicity and media, to help all potential users navigate the care system and more easily find the support they need. The updated DOS will include information about waiting times for our ED, walk-in centres (WICs) and minor injury units (MIUs).

vi. **Shared dementia care pathway** – We will work in partnership with Social Care teams, Devon Partnership Trust, community groups, and volunteers to deliver innovative, community-based, personalised care for people living with dementia. Our dementia and delirium pathways will promote health and independence at home and prevent illness and unplanned admissions. We will share processes and information, and ensure there is open communication between the Acute Trust and partners in the community, ensuring that people living with dementia get the best care in the most appropriate place, including care at the end of life in their own home.

vii. **Continue to promote and develop local relationships between our community teams and GP practices,** to work together and deliver the Fuller Report recommendations, which promote improved collaboration to maximise the capacity of local 'neighbourhood teams'.

Objective 2. Build community capacity to reduce acute bed occupancy

Our services commonly operate with around 170 patients who are "green to go" but cannot leave hospital due to delays in care home placement, packages of care in their own homes or other social circumstances. Some of the key solutions to this are not within the direct control of Royal Devon but through partnership working with Devon County Council and the Devon ICB, we can enhance existing approaches and develop innovative new services to provide greater capacity.

i. **Expand the Urgent Care Response (UCR) function and domiciliary care capacity within the Community Division** – Our teams provide immediate support to people in their own homes to prevent the need for hospital admission or offer support immediately post discharge. These teams will be developed in order to help mitigate the shortfall in the domiciliary care market, with consideration also being given to widening their scope, capitalising upon the opportunities for support from our acute and community services and the virtual ward. Our teams in the East and the North will standardise their approaches, enhancing their ability to work in concert.

ii. **Provide care home capacity** – We will explore the feasibility of providing a care home or intermediate care facility, managed by the Trust or with a third-party partner, taking patients exclusively from acute and community beds. This facility would be well supported by rehabilitation services with the aim of most patients being discharged safely home within a period of 1-2 months. The service would require commissioning from either Devon ICB or Devon County Council (DCC) as part of the feasibility process.

iii. **Develop frailty hubs** – Working closely with colleagues in primary care and mental health services, we will support the development of frailty hubs. These will bring several disciplines together to enhance the care for frail patients. An example of this is proactively reviewing the 4000 patients in care homes and colour-coding them, based upon their wishes and clinical need, as to whether they should be admitted to an acute hospital in the event they become unwell. Introduction of this work in other localities has been shown to reduce admissions to acute hospital beds by 80%.

iv. **Expand the range of elective care services which can be delivered closer to people's homes** - Royal Devon currently undertakes elective surgery on four community operating sites and provides thousands of clinic appointments across the range of our 17 community hospitals. We will continue to develop these, to make care more convenient to patients, and to preserve precious resources on our acute sites. An example of this is the development of the Urology Investigations Unit in Ottery St Mary, which now provides new and follow-up outpatient services and cystoscopy and we are seeking to expand this further with the addition of a platform for a mobile MRI scanner to provide one-stop cancer clinics.

Domain 3 - Elective Care

Goal

We will provide elective care of the highest quality for our patients in a timely and predictable way, by utilising the most up-to-date technology. We will reduce our waiting times by maximising the capacity of elective care within the resources available and provide it as close to home as possible.

Main Challenges

- **The number of patients needing elective care is increasing,** as is the complexity of their conditions. This applies to both medical and surgical services.
- **There is insufficient operating theatre capacity at both RD&E and NDDH,** and use of this capacity is frequently obstructed by the numbers of acute admissions, which cause cancellation of planned procedures. Intensive care facilities are also sometimes a limiting factor.
- **Lack of protected elective capacity.** Elective beds (including day surgery beds) are commonly occupied by acute medical patients at both sites.
- **Epic offers tremendous opportunities** to streamline care however it is a complex and time-consuming process.
- **There is lack of standardisation of care pathways** between our northern and eastern services, resulting in variability of the quality of care in some areas.
- **Units remote from the RD&E and NDDH are sometimes unable to provide up-to-date treatments** because of inadequate equipment (for example, no laparoscopic equipment at Tiverton hospital for our hernia service).

Strategic Approaches

This section sets out five objectives the Trust aims to achieve in relation to elective care, underpinned by the "strategic approaches" that will be taken to deliver them over the next five years.

Objective 1. Recover our waiting times through maximising elective activity

Across the NHS waiting times have increased significantly as a result of the COVID-19 pandemic, with thousands of patients waiting in excess of two years for treatment during 2022/23. Elective activity has been constrained by a number of factors in recent years, notably the impact of the COVID-19 pandemic, and workforce challenges. Royal Devon currently has some of the longest waiting times in the country, including key services for children, such as neurodisability and neurodevelopmental conditions, resulting in stress, discomfort and in some cases, harm to our patients. Recovering our waiting times to acceptable levels is our top priority for elective care. We will achieve this in the following ways:

i. **Expand the elective productivity programme.** Increasing our clinics by just one patient per clinic, for example, would result in over 40,000 additional slots per year. The additional income generated by this

activity would also tackle the challenging financial context in which the Trust is operating. Our Transformation Team will continue to support clinical teams to remove barriers to efficiency, such as Epic interfaces, staffing levels or booking processes, to make clinics and operating lists run more smoothly.

ii. **Utilise additional external revenue funding, where available, to deliver additional activity.** In 2022/23, the Elective Recovery Fund (ERF) programme supported the delivery of thousands of additional cases through locum staff and ad hoc additional activity from existing teams. But the funding mechanism varies from year to year and is invariably non-recurrent, which makes recruitment of clinical staff difficult. We will proactively plan measures to increase activity, so that we can react in an agile way to opportunities for injections of additional capacity through short notice funding when it becomes available.

iii. **Expand and improve outpatient physical infrastructure.** Some key areas require improvements to their physical infrastructure as the current facilities do not meet the needs of patients or staff. For example, our Breast Care patients have to walk considerable distances during their appointment and get dressed and undressed multiple times during an already stressful process. We will proactively prepare business cases to address these, such that we are in a position to quickly take advantage of national capital funding, which periodically becomes available at short notice. In the past three years, this approach has resulted in tens of millions of external funding to support developments within the Trust, such as the ED refurbishment, additional MRI and CT scanners, and an additional inpatient ward in NDDH.

iv. **Improve diagnostic capacity** through productivity improvements and transformation, furthering the work being done by our diagnostic community hubs and the Nightingale Hospital's Devon Diagnostic Centre.

v. **Develop improved pre-assessment and prehabilitation for elective care –** We will develop improved pre-assessment pathways with due consideration of the level of physical frailty and cognitive risk, so that we can provide appropriate medical optimisation and prehabilitation when needed, or alternatives to overly-burdensome procedures when these are no longer clinically appropriate.

Objective 2. Improve patient experience, particularly through adoption of new technology

The digitisation of patient information enabled by Epic opens up a broad range of opportunities to make care more personal, convenient and safe for patients. MY CARE in particular, offers an opportunity for patients and carers to have greater control and to access care in novel ways, such as through apps or wearable devices. We will improve patient experience in the following ways:

i. **Increase utilisation of MY CARE**– We will greatly expand the usage of MY CARE through targeted patient communication via a range of media. There will be further development of training for key staff involved in signing patients up to MY CARE. By the end of 2023/24 we aim to have enrolled 100,000 patients on the system, increasing to 250,000 within three years. Help will be provided for patients who are inexperienced with digital systems, for example, in virtual consultations, and there will be support for patients who are unable to access the internet in their homes.

ii. **Increase use of patient initiated follow-up (PIFU)** – We will continuously increase the use of PIFU (when a patient initiates an appointment when they need one, based on their symptoms and individual circumstances, as opposed to simply being booked for an appointment in the future, which may or may not add value). If one in twenty follow-up appointments were saved through this approach, there would be an additional 22,000 slots available per year in which to see other patients, which would help reduce backlogs.

iii. **Increase virtual care** - We will maximise the use of virtual care, including virtual clinics, pre-assessment, prehabilitation and remote monitoring using hand-held or wearable devices. This not only enables care closer to patients' homes, but it also has important environmental benefits. The reduction in physical outpatient attendances is likely to mean that around 3.5 million fewer miles are being driven by patients each year, reducing carbon emissions by approximately 650 tonnes. For patients, this

results in savings of approximately £500k in petrol costs and £600k in parking charges. This approach also supports a reduction in cross-site working for staff, making best use of valuable clinical time and further contributing to the environmental benefits because of reduced staff travel.

iv. **Introduce a patient self-booking portal** – The current system of booking patients over the phone requires a large number of administrative staff working to match patients with available clinic slots. We will develop a patient portal to enable patients to book and cancel their own appointments safely and securely, such that such that approximately 400,000 appointments (50%) will be booked by patients themselves. This will be more convenient for patients, reduce DNAs and free up administrative staff to support clinical care in other areas.

v. **Create an online patient information centre** – Each year the Trust sends over two million letters to patients, many of which include leaflets (patients frequently receive the same leaflet multiple times) and other documentation, which could be more easily made available online. In addition to this, our admin staff field thousands of phone calls from anxious patients and relatives seeking to establish how long they will wait for their procedure and what to do if they experience various symptoms. The ICB has developed an excellent online tool to provide patients with much of this information. We will link with system colleagues to develop an online information centre, providing patients with up-to-date support and information. This will also provide opportunities to signpost patients with chronic conditions to appropriate emotional wellbeing support in the community and relevant psychoeducation workshops; such as our Irritable Bowel Syndrome service, provided jointly with DPT.

vi. **Increase the provision of one-stop multidisciplinary clinics** – Additional one-stop services will be introduced This will involve changes in pathways and practices, but will reduce numbers of hospital attendances, which will boost efficiency, improve patient experience and reduce the effect of travel on the environment. We will incorporate mental health professionals into our pathways where appropriate, to recognise comorbid complexity and deliver integrated management plans for our patients.

Objective 3. Increase separation of non-elective and elective capacity

Over many years, the Trust has endeavoured to protect elective capacity but despite considerable support and commitment, has been unsuccessful due to growing urgent care pressures. Only around 8% of the Trust's bed capacity is for elective activity, which is why small shifts in the urgent care bed capacity (the other 92%) have such a significant impact. Over the five years covered by this Clinical Strategy, we aim to materially increase the separation or protection of elective care capacity across the Trust. Ideally, this will be through the development of elective activity that is geographically separate to our urgent capacity, through the provision of an elective treatment centre for example, but some elective services work hand in hand with urgent care, such as ITU, and cannot easily be relocated. Our approach to strengthening protection of elective capacity will therefore involve thoughtful use and expansion of elective care facilities in order to create resilient capacity for patients. We will focus investment and service redesign on protecting our elective capacity in the following ways:

i. **Ensure ringfencing of elective bed stock** - We will prioritise ringfencing elective bed capacity for Cardiology, Orthopaedics, Gynaecology and General Surgery across the Trust. This work will be incorporated into the urgent care agenda described in domain one of this strategy as a key measure of success.

ii. **Develop our existing infrastructure to support separation of "hot" and "cold" activity** – In the longer term, more theatre, catheterisation laboratory and endoscopy capacity will be needed, which will require changes in use of existing facilities and will be supported by the Estates Strategy, which is an enabler to this Clinical Strategy. Any new developments will be specifically considered to assess the extent to which they further the protection of our elective capacity. The development of the Cardiology Day Case Unit at the RD&E due in 2023/24 is an example of capital projects to support protected elective capacity. The "Our Future Hospital" Programme in NDDH, is an enabler for the protection of elective capacity.

iii. **Develop options for an elective treatment centre** - In addition to the above approaches, which strengthen our existing services, we will also strongly make the case for national funding to develop an elective treatment centre. This would comprise multiple theatres undertaking orthopaedic, plastic and other surgery, with the supporting outpatient and diagnostic capacity to enable first class delivery of elective care, uninterrupted by urgent care pressures. This would result in more predictable, higher throughput operating lists which, as with outpatient productivity, would also materially improve the challenging financial position.

Objective 4. Work with other organisations to develop elective services in the best way for patients

The elective services we provide are part of a wider network of care provided to patients. Acute care provided by neighbouring Trusts in Devon, Taunton and Cornwall can have a significant influence on the shape of services provided at Royal Devon. In addition, best practice and innovation from Trusts across the NHS, as well as shifts in national policies and priorities, are important factors to continuously consider. We will ensure that Royal Devon plays a leadership and partnership role, alongside other local acute providers and that an outward-looking, learning culture informs development of our elective services. Key strategic approaches to delivering this objective are as follows:

i. **Actively engage with, shape and implement the Peninsula Acute Sustainability Programme (PASP) outcomes –** Our clinical and managerial teams will play a leading role in working with other organisations to shape the outcomes of the PASP for adult and children's services to develop and implement the best service models for our teams and our patients across Devon. At the time of writing this Clinical Strategy, the PASP process is at an early stage however, it is likely that this will be a significant programme of work shaping service provision over the next five years.

ii. **Increase our focus on learning from benchmarking, good practice and national reviews to guide development of our services** – In many areas, Epic is now providing excellent data and outcome measures to help inform service development. In addition, benchmarking from external sources, such as the Model Healthcare System, peer reviews, Getting It Right First Time (GIRFT) visits and Royal College reviews are becoming increasingly powerful, as tools for driving service improvement. We will incorporate the inclusion and analysis of such information into our routine informatics and provide training for our clinical and managerial leaders to support improvement of our elective (and other) services.

Objective 5. Strengthen our cancer services

Cancer care is subject to the same challenges as other elective services, including the increasing impact of demographic pressures on demand, workforce constraints, and the impingement of urgent care on bed capacity. In addition, our cancer services face some specific challenges, such as the impact of increasing survivorship of first and subsequent cancers, the increasing complexity of available and recommended treatments, and the upscaling of National Institute for Health and Care Excellence (NICE) mandated oncology treatments.

As a result of these pressures, delays in cancer treatment have increased. Only around 40% of cancer patients undergo their first treatment within 62 days, compared to the national target of 85%. Only 73% see a specialist within two weeks compared to the target of 93%, and less than half are diagnosed within 28 days compared to a national target of 75%. NICE guidance on cancer services (2004) highlighted that at diagnosis, approximately half of all patients report severe levels of anxiety and depression that negatively affect their quality of life. In the year following diagnosis, approximately one in ten patients would benefit from intervention by specialist psychological services due to the severity of their symptoms.

We will strengthen our cancer services in the following ways:

i. **Review and improve cancer pathways** – Over the course of the five years of this Clinical Strategy, we will review all our cancer pathways and introduce measures to improve them wherever possible. These improvements will include shortening the pathway, for example, though more one-stop services; building capacity through additional staff or facilities, such as a dedicated Breast Care Unit; and integrating emerging diagnostic and treatment options, such as genomics, to make care as effective as possible. We will address psychological distress by having an embedded psychological service to meet patient needs across cancer pathways. Working with partner agencies including FORCE Cancer Charity and Exeter Leukaemia Fund (ELF) will also help patients deal with psychological issues they may be experiencing relating to their cancer care.

ii. **Support primary care in early diagnosis of cancer** – We will support and encourage elements of cancer pathways being provided by primary care, including expansion of the provision of direct access diagnostics, enabling GPs to expedite cancer care.

iii. **Strengthen leadership, oversight and coordination of cancer services** – We will improve the visibility, direction and oversight of cancer services by ensuring there is senior clinical and managerial leadership dedicated solely to cancer services. Job-planned time for clinicians involved in cancer leadership positions will be provided to avoid clashes with other priorities. Governance systems for cancer will also be reviewed to ensure there is robust sharing of cancer incident reporting between clinical and divisional teams, oversight of complaints relating to cancer services and drive and momentum in conducting our reviews of cancer pathways.

iv. **Provide additional support for cancer Multidisciplinary Teams (MDTs)** – Cancer MDTs will be reviewed, to ensure there is sufficient administrative and Allied Health Profession (AHP) resource to manage the volume and complexity of the workload; together with job-planned MDT leadership, to enable regular updating of protocols and membership. We will harness Epic to make MDTs run as smoothly as possible and to increase interoperability between MDTs, to support effective transfers of care.

v. **Increase the use of informatics to improve services** – As an early adopter of Epic, Royal Devon has a significant opportunity to capitalise on informatics to improve services. We will develop a bespoke cancer informatics system providing accurate, real time data, trend analysis, and easy-to-use reports and dashboards to facilitate improvements in cancer care.

Domain 4 – Tertiary Care & Areas of National Clinical and Academic Excellence

Goal

We will work with our system partner organisations to ensure that the Royal Devon offers specialist tertiary care based on the expertise of our services, aligned with and supported by academic activities. Alongside other acute service providers, this will support the optimum care for patients, make best use of the limited capacity across the region, and provide stability for each hospital.

Tertiary services are those provided beyond a Trust's normal geographical area due to their highly specialist nature and the particular expertise located elsewhere.

The main tertiary centre in the Peninsula is University Hospitals Plymouth, which is the Major Trauma Centre and provides neurosurgery, resectional hepatobiliary and oesophagogastric surgery. The Royal Devon also provides a number of tertiary services across Devon, Cornwall and Somerset, as outlined below.

Examples of services where patients travel outside of our catchment area for specialist care not provided by Royal Devon	Examples of services provided by Royal Devon to which patients travel from outside our normal catchment area for specialist care

• **Services provided by University Hospitals Plymouth**
  ○ Cardiac surgery
  ○ Upper gastrointestinal cancer surgery (provided by UHP)
  ○ Major trauma UHP
  ○ Stroke thrombectomy
  ○ Renal transplantation
  ○ Neurosurgery
  ○ Neonatal Intensive Care (NICU Tier 3)
  ○ Immunology
• **Services provided by specialist Bristol Children's Hospital**
  ○ Specialist children's surgery
	• **Scoliosis surgery**
	• **Spinal trauma**
	• **Abdominal wall reconstruction**
	• **Robotically assisted laparoscopic prostatectomy**
	• **Complex hip and knee revision surgery**
	• **Genomics**
	• **Renal dialysis**

Table 1. Examples of Tertiary care services

Main Challenges

- **Providing an equitable service** for patients who live in localities distant from the hospital which offers the specialist care that they need. Public transport links are poor in many areas, journeys can take a long time. This requires consideration of the difficult balance between the benefits of centralised specialist care and the inconvenience of travel, which discourages or prevents some patients from accessing care.
- **Vascular services** at NDDH are currently linked with Taunton, rather than our own services in the RD&E, despite Royal Devon being the arterial centre for East Devon and Torbay.
- **Data linkages** are currently a problem for ready access to patient records because of inadequate links between different hospitals involved in tertiary specialist care, and between hospitals and primary / community services. For example, it can even be difficult to see blood test results of patients referred from other localities, or repatriated from them.
- **Pursuit of research activities and academic excellence** can be challenging for clinical staff. They need encouragement, time, and infrastructure to pursue these activities.

Strategic Approaches

Objective 1. Promote and invest in our flagship services on both sites

Our flagship services include Orthopaedics, Renal, Genomics and Cystic Fibrosis in the RD&E and complex abdominal wall surgery, and the Comprehensive Hernia Service at NDDH. These specialties represent enormous opportunities for Royal Devon, and have implications which extend beyond their specialty team or the patients they serve. They can:

- **bring a sense of pride to staff across the organisation, boosting morale and recruitment,**
- **bring innovation and investment from industry, such as funded fellowships who undertake clinical work and commercial research,**
- **foster the reputation of the Trust nationally, through recognition of its centres of excellence,**
- **materially help address the financial position through additional income.**

It is important that each hospital has its own defined area(s) of specialist practice, which offer the best possible tertiary care for patients. We will support our flagship services in the following ways:

i. **Purposefully develop flagship services** – We will provide support to key services to identify challenges they may be experiencing and provide support from either operational management or the Transformation Team to address them. In addition, we will make the right support available to these services to evaluate and take forward opportunities for further service development, including investment in key infrastructure where required.

   All investment cases will be required to demonstrate value for money, as well as clear benefits for our patients. However, we will support our tertiary services to creatively explore how investment can be identified from national or regional funds wherever appropriate. Examples of current key investment priorities include:

   - the introduction of a robot at NDDH for abdominal wall surgery,
   - the addition of a hybrid theatre for vascular surgery at the RD&E,
   - additional operating theatre capacity within orthopaedics and
   - upgrading the infrastructure of our renal services.

Expansion of robotic surgery into clinical specialties, such as gynaecology and other services, is also likely to be required over the five years of this Clinical Strategy.

ii. **Promote the successes and benefits of our flagship services to others** – With support from our Comms Team and senior operational and clinical colleagues, we will more effectively promote our flagship services. This will be through highlighting their work on social media, showcasing significant research and nominating our tertiary (and other) services for various awards as a way of thanking our staff and drawing attention to their excellent work.

Objective 2. Network with other hospitals to optimise pathways for patients and staff

Networked services, which mean that patients may travel between organisations during a single pathway, require collaboration, teamworking and strong clinical relationships, underpinned by effective digital and physical infrastructure. Getting this right can be time consuming and complex. Navigating a care pathway between organisations can be confusing and daunting for patients, particularly those on cancer pathways. We will support our clinical teams to develop networked services in a way which makes care as uncomplicated as possible for our patients, and which makes best use of our precious resources. To achieve the delivery of this objective we will:

i. **Actively engage with system partners** – We will work with other organisations collaboratively to optimise networked pathways of care. Regional and wider clinical networks that currently work well, such as within Radiology and Pathology, will be supported, and may be used as exemplars for the development of other networked services.

ii. **Provide clear information for patients on pathways and where to get help** – We will link our tertiary services with the planned online Patient Information Centre to ensure that patients can get up-to-date information about pathways for services crossing organisational boundaries. Our administration teams will provide support for patients who have difficulty accessing digital information, helping them navigate pathways and connecting them to a clinician when they have questions or concerns.

Objective 3. Maximise the potential benefits of academia and research

A focus on academia and research goes hand-in-hand with the training and development opportunities that this offers, which can boost morale and improve both recruitment and retention of staff. Involvement in multicentre research trials, for example, improves the generality of care, by advancing our knowledge, and also provides care of a particularly high quality to patients involved in the studies. The Trust will actively support research and academia as a core element of clinical care in the following ways:

i. **Foster a research culture across the Trust** – Areas of research, development, and publication within the Trust, which include nationally and internationally recognised services, such as genomics, diabetes, inflammatory bowel disease, and hip replacement surgery (the Exeter Hip), will be supported in their further research and academic ambitions.

ii. **Strengthen our links with academic institutions** - The established close links between the Trust and the University of Exeter Medical School and the University of Plymouth will be supported and developed further.

iii. **Expand multicentre research trials** – We will actively support our clinicians' participation in multicentre research trials, recognising that this benefits patients who become involved in trials, and future patients who will benefit from their outputs. Patients who are not themselves enrolled in trials have also been shown to have better medical outcomes in research active organisations. We aim to ensure equity of access to research participation for currently under-served populations, including people with learning disabilities, cognitive disability, and people from rural and economically-deprived areas.

iv. **Support hybrid clinical / research roles** - We will nurture and develop clinical posts with an academic component, in disciplines across the Trust, as part of our strategy to make posts attractive to dynamic and high-quality applicants. This will raise the profile of specialties with good research track records.

v. **Harness the capacity of Epic and other digital systems to support clinical research** – Our clinical and Clinical Digital teams will work together to ensure that information from digital information systems is utilised as fully as possible, not only for service improvement, but also for research. The wealth of data that these systems gather offers great potential for both clinical and epidemiological research. The adoption of Epic offers important research opportunities and we will strive to be an organisation known for excellent research facilitated by the application of clinical data.

Section Three

SECTION THREE

Further considerations in delivering the Clinical Strategy

How the Clinical Strategy will be supported by other Trust strategies

Delivering a five-year Clinical Strategy of the scale set out in this document is a complex undertaking, which will require coordinated leadership and planning in Estates, People & Culture, Digital, Data, Finance and Transformation, in addition to the close involvement of our clinical teams. We are taking a bold approach in revising the strategies for all these areas, alongside the development of the Clinical Strategy. This will ensure cross-fertilisation of innovation and will minimise risks in areas such as recruitment and capital availability.

Detailed work has been completed, reviewing all the strategic approaches described in this document for their links with the other Trust strategies. This will ensure a coordinated approach, so that these other strategies will support and enable implementation of the actions required to deliver the Clinical Strategy.

Links to the key Trust strategies are available in Table 2 below. Links to each of the other strategy documents will also be available on the Trust's website.

Strategy	Link
People & Culture	*To be added when final documents are approved in summer 2023*
Estates	*To be added when final documents are approved in summer 2023*
Data	*To be added when final documents are approved in summer 2023*
Finance	*To be added when final documents are approved in summer 2023*
Digital	*To be added when final documents are approved in summer 2023*
Transformation	https://www.royaldevon.nhs.uk/media/2hbfvayn/transformation-strategy-doc-v14.pdf
Green Plan	https://www.royaldevon.nhs.uk/media/deud4j3w/royal-devon-our-green-plan-2022-2025.pdf

Table 2. Supporting strategies

Risk Management

Coordination of the clinical and associated enabling strategies described above will optimise our approach, but there remain important factors that the Trust can influence but not fully control. These include; funding at national or regional level, national policy shifts, demand and capacity shortfalls in professional training, as well as patient factors, such as growth in demand exceeding forecast levels, difficulties in recruitment, and unplanned macro events such as the COVID-19 pandemic. The matrix below sets out the risks considered to be the most significant, alongside the controls put in place to best mitigate them.

No	Risk area	Risk and effect	Mitigating actions
1	People & Culture	Unable to recruit general and specialist staff or provide level of professional training required to meet strategy ambitions.	• Co-production of the People & Culture Strategy alongside the Clinical Strategy will align work of HR team to support recruitment of specialist staff. • The Trust has recently invested in additional support in this area and vacancies are reducing at a Trust level.
2	Digital	Due to lack of funding, technical limitations, complexity, lack of clinical buy-in or lack of technical and leadership capability the Trust is unable to capitalise upon digital opportunities to improve services.	• Co-production of the Digital Strategy alongside the Clinical Strategy will align work of digital teams to support necessary developments. • Approved investment in transformation capability includes additional resource in digital expertise. • The Trust's Digital Services are overseen by the Chief Medical Officer (CMO) to ensure the work of the digital team is prioritised according to clinical needs of the organisation. • An operational group, chaired by the Director of Transformation is being established to continuously align the work of the digital teams with operational priorities.
3	Estates/ Finance	Funding constraints limit the Trust's ability to deliver the aims of the Clinical Strategy.	• Co-production of the Estates Strategy alongside the Clinical Strategy will align work of Estates team to support necessary developments. • The Clinical Strategy document is clear throughout that the Trust will seek funding for new developments but does not commit funding beyond current resources. In order to be open and transparent with our staff, this will be clearly articulated to our staff in the communication strategy. • In order to maximise our ability to successfully bid for external funding when it becomes available, we will proactively develop cases to support the capital developments set out in the Clinical Strategy. Business cases must include transformation of services, as opposed to simply creating "more of the same" capacity. • The Executive Team is working at system and regional level to gain support for capital investment to deliver change. This has so far gained support for the Nightingale Hospital Community Diagnostics Hub, the ED development, two surgical robots and the development of the Cardiology Day Case Unit.
4	Engagement with staff	Failure to secure the necessary support, drive and engagement with staff to deliver the strategy.	• Extensive engagement with clinical and leadership staff in the development of the Clinical Strategy. • An comms plan accompanies this strategy to inform, engage and inspire staff in all areas and secure their support.

No	Risk area	Risk and effect	Mitigating actions
5	Leadership	Insufficient leadership capacity and capability to deliver the strategy.	• The Trust Delivery Group (TDG), led by the Chief Operating Officer (COO), will oversee the delivery of the plan. (see **Delivering the Strategy**) • A development programme aimed at operational and clinical leaders is being launched in Q1 2023/24. This should support leadership staff in many of the key areas required to deliver change on this scale. • The Trust has invested in expanding the Transformation Team so that there is significant, senior operational and strategic experience and expertise to support change management.
6	National Policy shifts	Could impact positively or negatively on delivering the strategy in a number of ways including funding shifts, new initiatives etc.	• The Director of Strategy will work with senior colleagues to gain early knowledge of any proposed changes to allow the maximum time to plan and adapt to changing circumstances. • The ownership of the Clinical Strategy by the TDG aims to support agility and responsiveness in the face of any changes going forwards.
7	Unplanned macro events	Global events such as pandemics, conflict and macro-economic forces may impact upon service delivery.	• The ownership of the Clinical Strategy by the TDG aims to support agility and responsiveness in the face of any changes going forwards.

Table 3. Risk Management matrix

Delivering the strategy

Once approved by the Board of Directors, the Trust Delivery Group (TDG), led by the Chief Operating Officer (COO) will be tasked with the delivery of the Clinical Strategy. This group comprises the Executive Team, Trust Directors and a number of other senior managerial and clinical staff, so it is well placed to coordinate and prioritise resources to ensure delivery, as well as to respond effectively to any future changes in the strategic and political landscape.

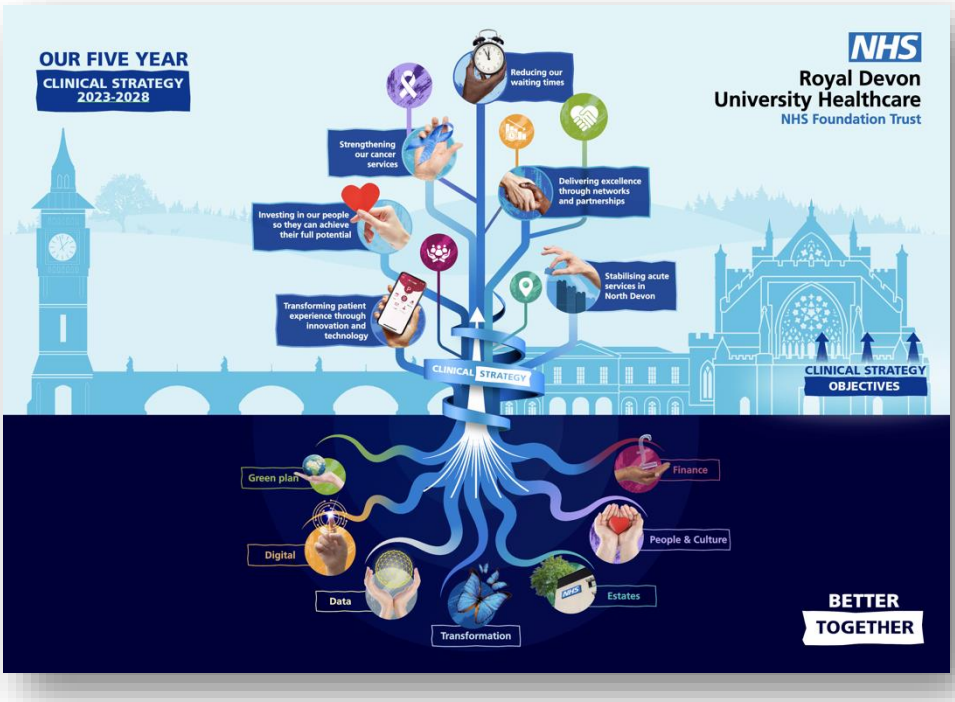
Under the direction of the TDG, divisional and specialty teams will be responsible for developing operational plans as part of their annual planning process, which will describe the steps each service will take to progress their delivery of the strategy. These operational plans take account of emerging national guidance and robust local data. The plans will have clear, measurable outcomes so that success can be quantified, and steps can be taken to support any teams struggling to progress individual strategic approaches.

Six monthly reports will be provided for the Board of Directors, aimed at ensuring Board-level support for delivering the strategy and overcoming any barriers to its implementation.

Communicating the strategy

This strategy provides the Royal Devon with a blueprint for service improvement, which, in addition to providing a sound basis for operational planning, also offers our staff a vision for the future which is both hopeful and optimistic. It is important that the key elements of the strategy are communicated effectively to staff across the Trust, as well as patients, and other organisations with which Royal Devon works in partnership. To achieve this aim, our Communications Team will deliver a segmented approach, offering key stakeholders a range of media through which to understand the strategy, including access to this document, summarised versions, graphic illustrations and animations describing the strategy and the key strategic approaches.

A sample of the illustrations for the strategy, including the relationship with both the Better Together and supporting strategies, is provided below.



Acknowledgements

The document was developed and overseen with support and engagement from the North and East Clinical Strategy Decision Groups. Details of the members are shown in the table below.

Eastern Clinical Strategy Decision Group (task & finish – clinical integration)

Name	Role
Bruce Campbell	Chair
Nolwenn Luke	Assistant Director of Nursing
Lynsey Webb	Clinical Director for Medical Services; Governance, Consultant in Nephology and Acute Medicine
Sisse Olsen	Consultant Oncoplastic Breast Surgeon (Clinical Lead), Training Programme Director for General Surgery
Sophie Markevics	Assistant Director of Therapy - Community Services
Ali Macefield	Deputy Head of Midwifery and Gynaecology
Chris Mulgrew	Clinical Chief Information Officer - Eastern
Richard Haigh	Consultant Rheumatologist
James Bayliss	Lead Nurse Quality

Northern Clinical Strategy Decision Group (part of Our Future Hospital programme)

Name	Role
David Sanders	Chair
Lucy Miller	Consultant in Anaesthesia; Persistent Pain Lead
Rebecca Rub	Consultant Paediatrician
Naomi Clatworthy	Nurse Consultant, Acute Oncology Service
James Rogers	AHP Physiotherapy Consultant
Alison Moody	Clinical Chief Information Officer - Northern

Other staff acknowledged as involved in the development of the strategy:

Name	Role
Carolyn Mills	Chief Nursing Officer
Adrian Harris	Chief Medical Officer
Phil Luke	Director of Transformation
Zahara Hyde	Our Future Hospital Programme Director
Laura Harrison	Executive Support Coordinator
Dominic Page	Project & Service Change Manager

Appendices

Appendix 1 – Background information about the Trust, its partner organisations, and the challenges and context of this strategy

This section describes the population health needs for North and East Devon that the Royal Devon serves through its community services and two acute hospitals that are a long distance apart. It outlines the merger of the North and East parts of the Trust, and the partner organisations with which the Trust works, to provide a full range of health and care services for patients. It describes some of the challenges facing the Trust and summarises important aspects of the national and regional strategic context within which this Clinical Strategy will sit. The initial perspective of the strategy is the next five years, but its intention is to guide the development of sustainable services in the long term.

Background

The Trust comprises the Royal Devon and Exeter Hospital (RD&E) in Exeter, the North Devon District Hospital (NDDH) in Barnstaple and their associated community services, which have traditionally served the populations of East and North Devon, respectively. The two acute hospitals are a distance of 53 miles, and 1.5 hours apart, making NDDH one of the most remote acute hospitals in England from its nearest neighbour. The Trust serves a distributed and dispersed rural population, meaning that travel and access to care are recurrent themes for many patients, especially in North Devon where travel time to the next nearest acute hospital is up to two hours (and often longer in the summer months, due to volume of holiday traffic). The map below shows the geography of the area and the locations of the Trust's facilities.

Figure 1. Map of hospital sites in Devon.

Acute Hospital Services

NDDH, built in 1978, is a 298-bedded district general and is the major care provider for acute and specialist care for the population of North Devon and East Cornwall. The core population of 165,000 served by NDDH is boosted in summer to an estimated 320,000, which manifests in a ~25% surge in ED attendances. The hospital provides 24/7 emergency services and some specialist services to the population, with an emergency department, intensive care unit, maternity, neonatal, children's services, and full diagnostic, surgery and outpatient services. It has excelled in the provision of some surgical services for which it is a national exemplar and receives referrals from around the region. In 2019, NDDH was named as one of 40 sites identified by the government's New Hospital Programme for investment to redevelop and expand the facilities to provide appropriate sustainable future healthcare for the population it will serve.

The RD&E is an 843-bedded large acute hospital, which was largely rebuilt in the years immediately preceding 1992, and has since been expanded. It serves a core population of 450,000, providing a full range of acute and elective services, with the important exceptions of some specialist cancer surgery, cardiac surgery and neurosurgery. Some of its services are nationally recognised to be exceptional (for example orthopaedics, genomics, clinical genetics and cystic fibrosis). It has a strong record of nationally and internationally recognised research and publication in a number of clinical areas.

Community Services

The community health and social care services of the Trust are supporting patients in their homes when needed, and provide a variety of day treatment, outpatient, health and wellbeing and inpatient services at the 17 community hospitals throughout East and North Devon.

There are 12 community hospitals in Eastern Devon, three of which have established inpatient beds. There are five community hospitals in North Devon, one of which has inpatient beds, and a health centre located in the town centre of Barnstaple.

Across Devon a diverse mix of services have developed in our community facilities, offering local population access to minor injury, sexual health, maternity and day case services, as well as the Exeter Nightingale Hospital, developed in Exeter during the COVID-19 pandemic and now serving the population with access to orthopaedics and ophthalmology elective services, and diagnostic services.

Table 1 gives some details of the capacity and activity of the Trust, and the staff they employ.

Metric	Eastern Site	Northern Site
Core population served	450,000	165,000
Inpatient beds	843	298
ED attendances: (Source: Annual Reports 2021/22)	ED: 90,906 MIU: 11,039 Walk in Centre: 22,360	ED: 59,349 NB – Northern Devon MIUs closed since April 2020
Inpatients total (Source: Annual Reports 2021/22)	106,855	25,619

Day case patients (Source: Annual Reports 2021/22)	42608	20024
Births (Source: Annual Reports 2021/22)	4,018	1,302
Average number of Employees WTE (Source: Annual reports 2021-22)	8,534	3,663
Operating surplus/(deficit)	(£6.0m)	(£0.6m)
Overall CQC (Source CQC)	Good	Requires improvement

Table 1. Capacity and activity of RDUH

The merger between the Royal Devon & Exeter NHS Foundation Trust and Northern Devon Healthcare NHS Trust in 2022 followed three years of increasing collaboration between the Trusts as teams worked to secure the sustainability of local healthcare services for the North Devon area.

As a small remote hospital, NDDH has faced historic challenges around economies of scale, workforce and clinical sustainability in key services, exacerbated by high living costs and low availability of workforce accommodation, and old infrastructure that has not been modernised in keeping with other hospitals in the region. Before the merger, the two Trusts worked together under a collaboration agreement to deliver obstetrics and maternity, haematology and oncology services. The merger has supported the development and delivery of joint clinical service delivery plans for some of the most challenged acute medical services in North Devon, including gastroenterology, stroke, healthcare for older people, diabetes and acute medicine.

System partner organisations

Patients served by the Trust's acute and community health and care services also depend on other organisations, with which the Trust works in close partnership. These include primary care networks (PCNs), mental health services (Devon Partnership Trust), South West Ambulance Service NHS Foundation Trust (SWASFT), Devon County Council (DCC), Child and Family Health Devon (CFHD), district councils and local community and voluntary sector organisations, University Hospitals Plymouth NHS Trust, and Torbay & South Devon NHS Foundation Trust

There are strong links for the Trust with the University of Exeter, and it is the lead partner for the University of Exeter Medical School (UEMS). Both the RD&E and NDDH are teaching hospitals for medical students and both have clinical academic units, which partner with UEMS. There are also strong links with Exeter, Plymouth and Bristol universities for undergraduate training for the Nursing and Allied Health Professionals.

UEMS and the Royal Devon are one of twenty Biomedical Research Centres in England, created with the ambition over the next five years to drive innovation in the diagnosis and treatment of illness across a variety of high-priority disease areas including cancer, mental health and dementia.

Main Challenges

These can be summarised as growing numbers of people, an increasingly aged population with rising disease prevalence, varying degrees of deprivation, changing nature of child and young people's health and long waiting times.

Population Growth

North and East Devon have rapidly expanding populations. Alongside significant population growth, people are choosing to relocate out of major cities where they are able to work remotely and / or retire in Devon. Non-demographic growth is anticipated to have a significant impact with an ageing population living longer with more co-morbidities. Between 2011 and 2021 the South West had the second highest population growth in England and Wales (Figure 1), making it home to an additional 412,000 people.

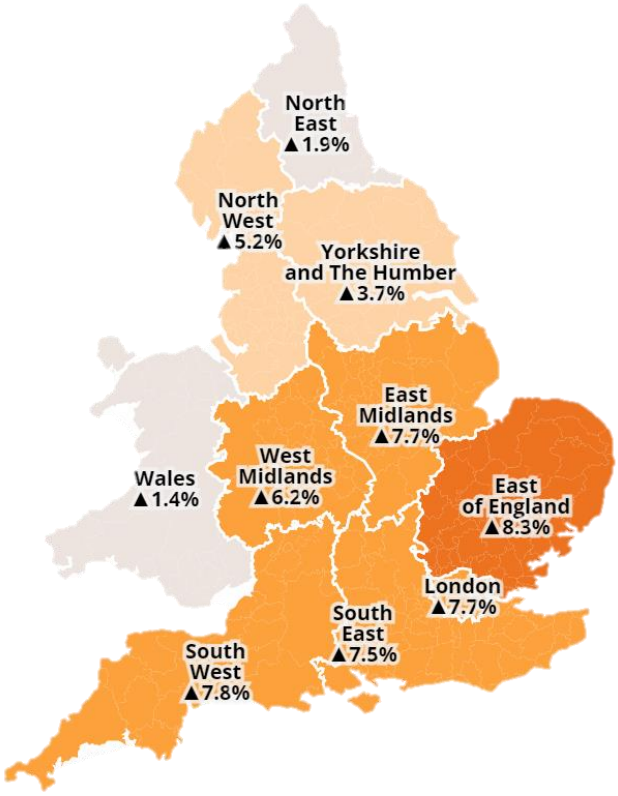


Figure 2. Population change (%) in English regions and Wales between 2011 and 2021 (Source: ONS Census 2021).

For England as a whole in 2021, the largest increase was in the 30-34-year age group (Figure 2) but for the South West it was in those aged 55-59 years (Figure 3), with an increase of 24% in people aged 65 years and over. In mid-2020 the median age in the South West was 44.1 years compared to 40.4 across the UK.

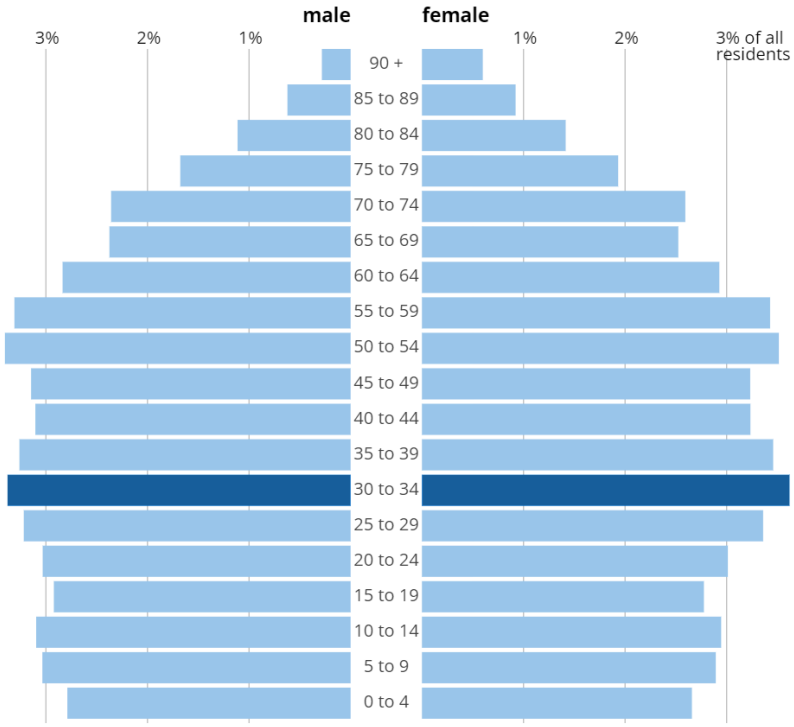


Figure 3. The age and sex distribution of the population of England in 2021 (Source: ONS Census 2021).

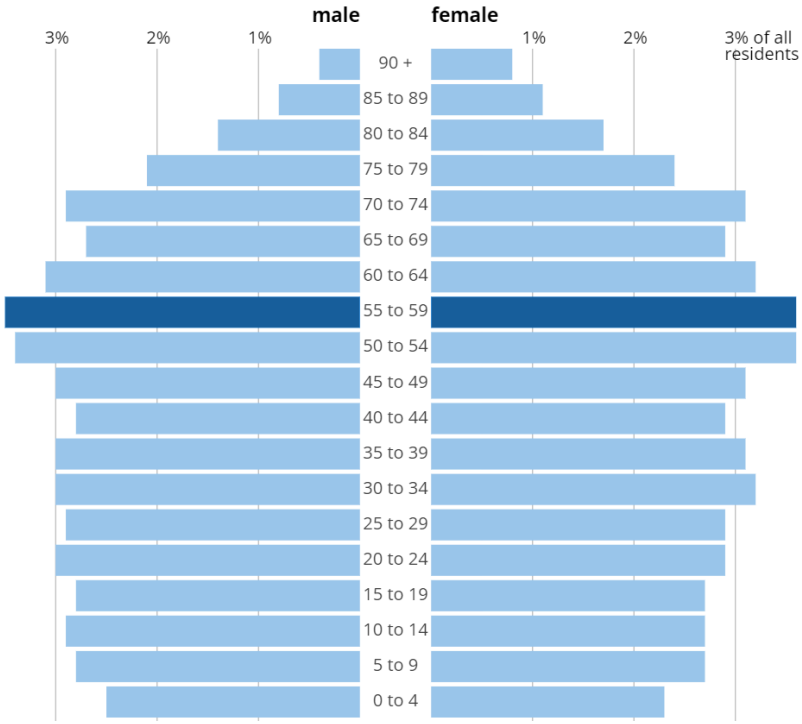


Figure 4. The age and sex distribution of the population of the South West in 2021 (Source: ONS Census 2021).

Deprivation

The Indices of Deprivation were last released in 2019. These deprivation statistics include metrics for income, employment, education, health, crime, barriers to housing and services and living environment. Figure 5 highlights deprivation across Devon (most deprived is dark blue) and is broken down by Lower-level Super Output Areas (LSOAs), which are made up of roughly the same population numbers which is a standard way of dividing England and Wales.

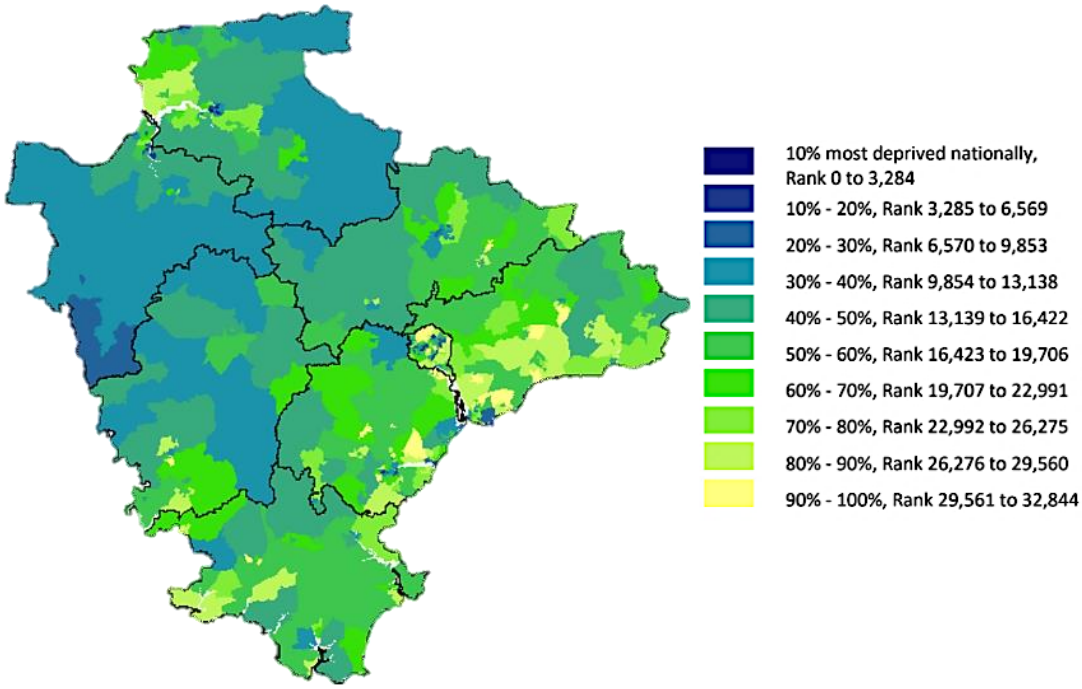


Figure 5. Deprivation of Devon by national decile (Source: ONS 2019, cited in Deprivation facts & figures, Devon County Council 2019)

There is a 10-year life expectancy difference across Devon. Infant mortality and alcohol-related admissions are relatively high in the most deprived areas.

The most deprived areas in Devon are in the wards of Ilfracombe Central, Barnstaple Central Town and Forches & Whiddon Valley in North Devon. These three areas are in the most deprived 10% of all areas in England. Around 4800 people live in these areas. Torbay and the city of Plymouth should also be noted, as these areas both experience deprivation rates higher than the national average. The equivalent of 27% of the Torbay population is considered deprived, with 14 wards in the most deprived 1% nationally (figure 6). In Plymouth, inequalities occur across the city, the most deprived areas being to the west. The ward of Stonehouse falls within the most deprived 1% (figure 7).

Devon's sparse rural and coastal communities contribute to the challenges of deprivation and inequality. This is the focus of the Chief Medical Officer's annual report (2020/21) (CMO annual report, 2021).

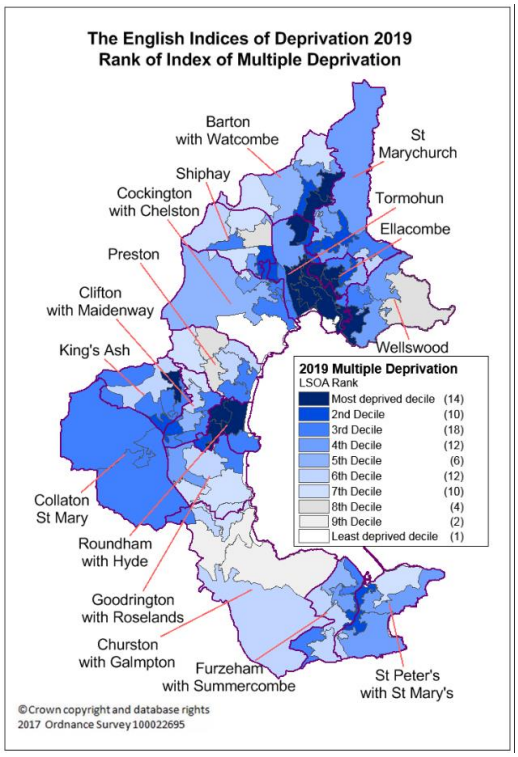


Figure 6. Deprivation of Torbay by national decile (Source: Index of Multiple Deprivation, cited in Torbay Joint Strategic Needs Assessment, Torbay Health and Wellbeing Board 2022)

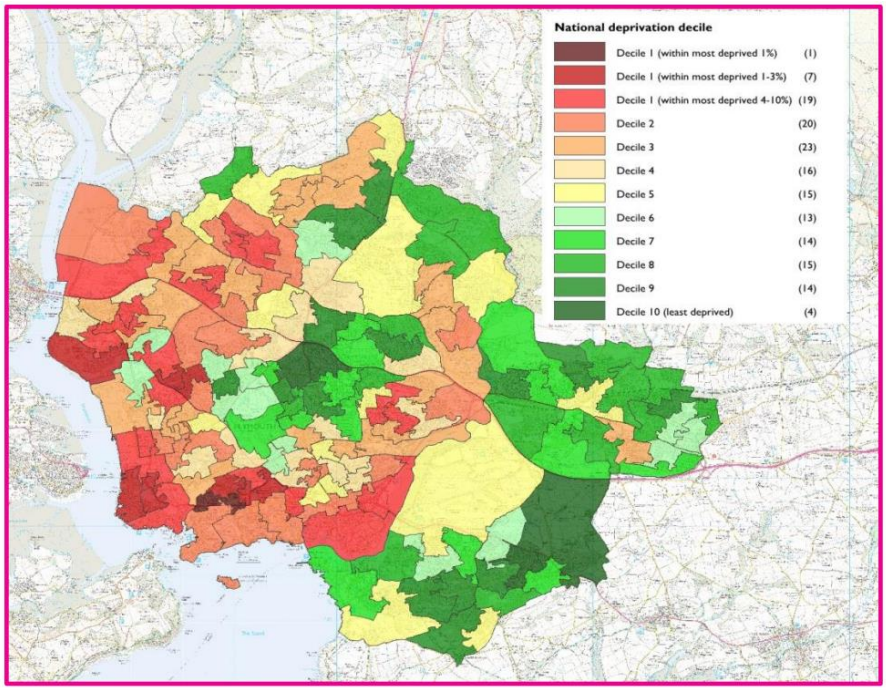


Figure 7. Deprivation of Plymouth by national decile (Source: Index of Multiple Deprivation 2015, cited in Plymouth Report, Plymouth City Council 2019)

Child health

The nature of children and young people's (CYP) illness has changed over the last decade. Presentations of CYP with eating disorders, self-harm and complex mental health needs have increased significantly. Coupled with this has been a change in the epidemiology of infectious disease (including Flu A, RSV and Group A Streptococcus) and an increase in chronic diseases such as diabetes, and some novel post COVID-19 syndromes.

CYP are seen in various services across the Trust, including medical and surgical specialties. They continue to represent 25% of the ED caseload. A team of dedicated acute and community paediatricians and nurses manage children who require specialist care, with support from paediatric tertiary centres in Bristol. Our neonatal units continue to manage 6000 births each year.

Smoking in pregnancy is more prevalent in our locality than nationally. This habit can be linked with miscarriage, prematurity, complications during labour, and sudden infant death syndrome.

Rates of probable mental disorders have increased since 2017 from 11.6% to 17.4% for 6 to 16-year olds, and 10.1% to 17.4% for 17 to 19-year olds.[1]

Other challenges include increasing numbers of children in relatively low-income families, significant childhood obesity rates, and higher than average rates of dental decay, leading to dental related hospital treatment.

This Clinical Strategy aims to improve care for CYP across the spectrum of emergency, community, elective and tertiary services.

Disease Prevalence

A review by the Office for Health Improvement and Disparities published December 2021 showed that Devon has a high prevalence of a range of chronic conditions which place particular demands on health services. Table 2 shows some of these:

	Devon CCG	England
Coronary Heart Disease (CHD) prevalence	3.9%	3.0%
Heart failure prevalence	1.1%	0.9%
Observed prevalence of chronic kidney disease (CKD)	4.9%	4.0%
Proportion of patients receiving home dialysis (Home HD and PD combined)	19.5%	17.5%

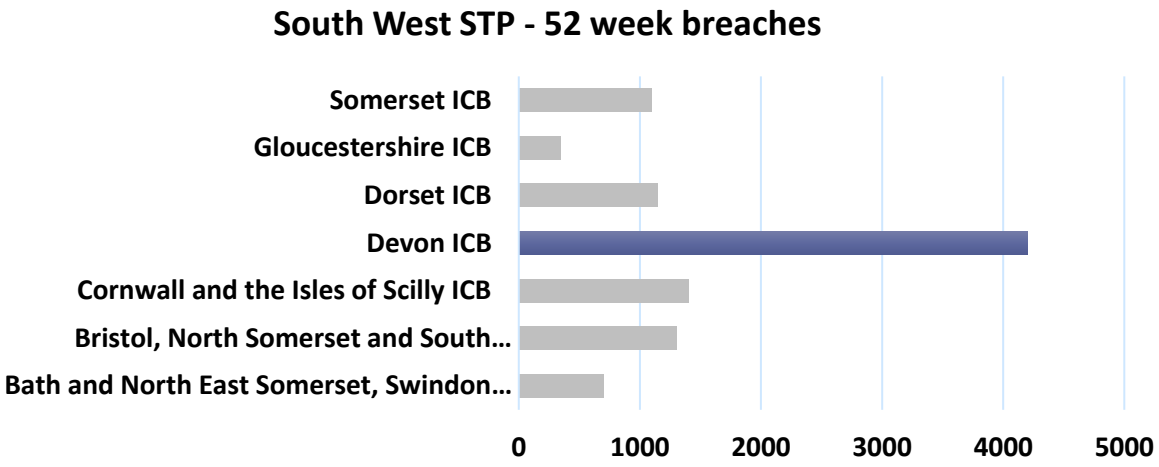
[1] Mental Health of Children and Young People in England 2021 - wave 2 follow up to the 2017survey – NHS Digital, 29/04/21

Stroke: QOF prevalence	2.5%	1.8%
Atrial fibrillation: QOF prevalence	2.8%	2.0%

Table 2. Prevalence of chronic conditions in Devon (Office for Health Improvement and Disparities, 2021)

Elective Care Waiting Times

A further and important consideration for the Clinical Strategy is the long waiting times at Royal Devon, relative to other parts of the country. Devon Integrated Care Board (ICB) had more than triple the number of patients waiting over 52 weeks for treatment, compared with the average for the South West as a whole, as shown in the graph below.



Graph showing number of patients waiting more than 52 weeks for procedure in South West ICBs

In addition to this, within the Devon ICB system, Royal Devon has the greatest total number of patients waiting over 52 weeks for treatment. As a result of the efforts of our staff, work already underway to reduce waiting times is taking effect and the numbers are beginning to fall. The approaches outlined in this strategy will further this effort, hopefully expediting the decline in waiting times, whilst still ensuring the high-quality and compassionate care that our patients rightly expect.

Appendix 2 - Examples of initiatives which have helped to integrate and develop services at the Royal Devon

Examples of Initiatives that have Improved Acute and Urgent Care:

- **An urgent community response team** has been developed, which operates across North and East Devon, providing a 90% response rate to 2-hour admission avoidance referrals for the eastern service.
- **A Same Day Emergency Care (SDEC) unit** has been introduced, during the hours of 1000 – 2200 at the RD&E, and this model is now being expanded to NDDH. Patients referred from primary care are seen and treated by SDEC clinicians, and discharged back to the community on the same day. The service is provided in a large part by Advanced Clinical Practitioners (ACPs) working with medical supervision.
- **An ambulatory assessment area** for general surgery has been introduced at NDDH. There is also a hot gallbladder pathway, which accounts for almost a third of all acute general surgical admissions at NDDH, which is a national exemplar.
- **Paediatric Assessment Unit (PAU)** offers alternative review of children and young people who would otherwise present to the Emergency Department (ED). 80% of children and young people are discharged from PAU without admission.
- **"Hot clinics"** in some specialties, such as neurology and vascular surgery (at the RD&E), and GI surgery (at NDDH), reducing acute admissions. Rheumatology has not only established a hot clinic, but also an urgent outpatient pathway for suspected giant cell arteritis, which has resolved a longstanding problem with referrals for urgent temporal artery biopsies.
- **Virtual wards.** Virtual wards have been introduced, both in the North and in the East, aimed at delivering care at home, including remote monitoring, daily contact, and, for example, intravenous antibiotic treatment, which improve patient experience and enable an easy route for them to return for review.
- **Nurse and Allied Health Professional led services,** including heart failure, acute oncology, dementia and spasticity service at NDDH. The North Devon paediatric community nurses are working with the ED and the paediatric team to support admission avoidance and earlier hospital discharges.
- **Front door frailty models** are supporting admission avoidance, with expert decision makers present at the front door to direct patients promptly and appropriately. These involve bringing several disciplines together to make plans and provide care for frail patients.
- **Specialty support for acute medicine.** At the RD&E and NDDH there is daily provision of specialty input, for example Cardiology, Gastroenterology, and Respiratory, into the Acute Medical Unit and Medical Assessment Unit wards, to streamline care.
- **Accelerated discharge.** For eastern acute medical patients who are fit for home, 5/7 days a week access to therapists and liaison with community teams for care at home has reduced hospital stays. Work is being done in the northern acute to realise the full benefit this provides.
- **Recruitment of medical staff** to the ED and acute medicine service at the RD&E has a good track record, as a result of a flexible and supportive approach to developing sustainable job plans, and allowing individuals to develop their specialist interests.

Examples of Initiatives that have Improved Community and Primary Care-led Services

- **GP support for care homes,** through regular ward rounds and care planning.
- **The use of First Contact Practitioners** to take pressure off primary care. For example, musculoskeletal first contact practitioners provide access to direct primary care physiotherapy assessment and referral.
- **The Community Podiatry service** provides patient education and early referral of diabetic foot problems to the hospital foot care team.
- **Community-based optometrists** based in Axminster, Crediton, Tiverton and Seaton support recovery of patients after elective eye procedures, who would normally have been seen by acute ophthalmology team.
- **Highly regarded community services with national recognition.** For example, the sexual assault referral centre and the sexual health service, with its links to the GP training scheme and the medical school. Another example is in community paediatrics, where the CQC highlighted evidence of outstanding collaborative working with community paediatric nurses for children and young people.
- **Our care home teams (Northern and Eastern)** have enhanced links with care homes supporting with additional training and education to reduce unnecessary hospital admissions for care home residents.
- **Integrated and flexible working across Community Core Services**. For example, the Urgent Community Response work collaboratively with the Community Rehabilitation and Community Nursing services, as well as Primary Care and Social Care colleagues enabling a creative and coordinated response to meet people's needs and to keep people well at home.
- **One-stop urology cancer service** at Ottery St Mary Community Hospital delivering outpatient appointments, cystoscopy, and biopsies.
- **Innovative routes into professions,** for example student apprenticeship opportunities across a range of AHP groups and rotational Band 5 placements in Occupational Therapy and Physiotherapy.
- **Development of a community Midwifery HUB** in central Barnstaple, delivering enhanced midwifery care to improve health outcomes and reduce health inequalities.

Examples of Initiatives that have Improved Elective Care

- **Using capacity remote from the RD&E and NDDH** – For example the Nightingale Hospital, for Ophthalmology, Orthopaedics, and Rheumatology; including the introduction of the Devon Diagnostic Centre as an external extension of the Medical Imaging Department at the RD&E, which provides diagnostic services to patients across the whole of Devon, and has seen over 50,000 patients imaged as additional activity in the 2022/23 year.
- **The introduction of virtual care in many services,** driven in part by COVID-19, has increased efficiency and offered selected patient care in or close to their homes. This includes 'virtual' consultations in most specialties, preoperative assessments, postoperative follow-up, and remote monitoring. The renal transplant service is an example, with its virtual appointments to discuss results with patients, following blood tests taken at its "roving phlebotomy clinics".
- **The introduction of 'one-stop' clinics** – For example, the chronic post inguinal hernia pain (CPIP) clinic at NDDH with imaging and interventional procedures on the day and the early arthritis clinic in rheumatology at the RD&E.
- **The introduction of patient-initiated follow-ups (PIFU)** in some specialties has improved patient experience and made workloads more sustainable whilst contributing to personalised care. Examples in surgery include breast surgery, orthopaedics, and in medicine PIFU for patients with epilepsy and bronchiectasis.

- **Certain services have achieved widely recognised levels of excellence** in the ways in which they are delivering care - For example the North Devon Comprehensive Hernia Service (which receives a high volume of regional and national referrals and has a number of one stop multidisciplinary clinics) and day case orthopaedic hip and knee arthroplasty in the North with well-defined pathways facilitating early discharge. In the East the Renal Service has been rated as "outstanding" by CQC, based on its collaborative working between Multidisciplinary Teams (MDT) members and tailoring care to meet the individual needs of patients.
- **Collaborative pathways between hospital and community services** – For example between Ophthalmology, and optometrists in the community, and in the area of audiology.
- **Collaborative pathways with mental health input** into physical specialities to allow earlier screening and joint management of mental health comorbidities. There is good evidence that this approach improves recovery across both physical and mental health domains. Examples of current work include gastroenterology (winner of a Patient Safety National Award in 2021) diabetes, ICU oncology, neurology and stroke.
- **Extended Therapy Hours** – to provide early rehabilitation and optimise Day 0 discharges.

Examples of Tertiary Care Provided by the Trust

- **Clinical Genetics,** based at the RD&E, provides care for patients from Devon, Cornwall and the Isles of Scilly. The service is one of three providers in England for endocrine tests, and it is the national centre for monogenic diabetes.
- **Exeter Genomics Laboratory** work in partnership with the Bristol Genetics Laboratory to deliver genomic testing for patients with rare disease and cancer throughout the South West of England
- The **Cystic Fibrosis team** at the RD&E provide one of the UK's specialist cystic fibrosis centres and it forms part of the Peninsula network.
- The **Renal Service** at the RD&E provides care for patients from the Torbay area, Taunton and a large area of Somerset, as well as our local population.
- **North Devon Comprehensive Hernia Service** runs an academic unit based at NDDH, receiving referrals for complex hernias, abdominal wall reconstruction and complex post herniorrhaphy pain from across the region and elsewhere in England.
- **Plastic Surgery** provides specialist care including free flap breast reconstruction for patients from Torbay and parts of Dorset and Cornwall, as well as our local population.
- **Orthopaedics and the RD&E**, with the use of the Exeter hip, worldwide.
- **Sexual health services and sexual assault referral centres (SARCs**) for Devon and Cornwall
- **Paediatric specialist surgical services** utilise a networked model with Bristol Children's Hospital. There is also a special urgent transport system for critically ill children (WATch service).
- **Upper gastrointestinal cancer** surgery is centralised to Plymouth, but surgeons, gastroenterologists, radiologists, oncologists and pathologists at the RD&E and at NDDH have video linked MDTs with the specialists in Plymouth to plan the care of each individual patient.

Academia and research:

- The RD&E has a very strong track record of clinical research and development. Examples include its research into clinical genetics and diabetes, and development of the Exeter Hip prosthesis.
- There are many close links with the University of Exeter Medical School. The combined facility of the Postgraduate Education Centre, the Wellcome Wolfson Medical Research Centre, and the *NIHR Exeter*

Clinical Research Facility, in Exeter was established to increase understanding of the mechanisms of disease and treatment by studying patients. The Trust's National Institute for Health and Care Research (NIHR) is one of only five NIHR funded Patient Recruitment Centres and the only NIHR infrastructure dedicated to the delivery of commercial contract research.

- The Research Innovation Learning and Development (RILD) building on the RD&E site is a centre for these activities for all Trust staff.
- There are joint clinical/university posts (both substantive and honorary) and a range of academic departments across the Trust.

Recently (October 2022) nearly £790 million was awarded to 20 NIHR biomedical research centres (BRCs) across England. These include including a new centre in Exeter, committed to drive innovation in the diagnosis and treatment of illness across a variety of high-priority disease areas including rehabilitation, mycology, diabetes, mental health and dementia over the next five years.

Appendix 3 - List of Objectives and Approaches of the Clinical Strategy

No	Domain	Objective	Approach	Links to Enabling Strategy: Division	Trust	System	Estates	Digital	People & Culture
1.1.1	Local Acute & Emergency Care	Stabilise and develop acute medicine at North Devon	Invest in staffing to support acute medicine		Yes		Yes		Yes
1.1.2			Optimise the patient flow model			Yes	Yes	Yes	Yes
1.1.3			Increase support from our eastern services in acute medicine	Yes					Yes
1.1.4			Provide a cardiac pacing lab	Yes			Yes	Yes	Yes
1.2.1		Reduce acute admissions and length of stay (LOS)	Improve safe alternatives to admission	Yes	Yes		Yes	Yes	Yes
1.2.2			Improve Surgical Assessment Units (SAU)		Yes		Yes	Yes	Yes
1.2.3			Develop options for an (UTC)			Yes			Yes
1.3.1		Increased facilities and arrangements for critical care	Develop critical care outreach	Yes				Yes	Yes
1.3.2			Provide dedicated critical/high dependency care for AMU	Yes	Yes		Yes		Yes
1.3.3			Increase Intensive Treatment Unit (ITU) bed base	Yes			Yes	Yes	Yes
2.1.1	Community & Primary Care-led Service	Work with local partners to optimise pathways of care	Improve care home support			Yes		Yes	Yes
2.1.2			Improve use of shared digital information		Yes			Yes	
2.1.3			Improve End of Life Care		Yes			Yes	Yes
2.1.4			Work more closely with voluntary sector organisations		Yes		Yes		Yes
2.1.5			Update the clinical Directory of services (DOS)		Yes			Yes	
2.1.6			Shared dementia care pathway		Yes	Yes		Yes	
2.1.7			Continue to promote and develop local relationships between our community teams and GP practices			Yes			
2.2.1		Build community capacity to reduce acute bed occupancy	Expand the Urgent Care Response (UCR) function and domiciliary care capacity within the Community Division			Yes			Yes

No	Domain	Objective	Approach	Division	Trust	Links to Enabling Strategy: System	Estates	Digital	People & Culture
2.2.2			Provide care home capacity			Yes	Yes	Yes	Yes
2.2.3			Develop frailty hubs	Yes					
2.2.4			Expand the range of elective care services which can be delivered closer to people's homes			Yes	Yes	Yes	Yes
3.1.1	Elective Care	Recover our waiting times through maximising elective activity	Expand the elective recovery programme	Yes	Yes				
3.1.2			Utilise additional external revenue funding, where available, to deliver additional activity	Yes	Yes				
3.1.3			Expand and improve outpatient physical infrastructure	Yes	Yes		Yes		
3.1.4			Improve diagnostic capacity	Yes	Yes		Yes		
3.1.5			Develop improved pre-assessment and prehabilitation for elective care	Yes	Yes			Yes	
3.2.1		Improve patient experience, particularly through adoption of new technology	Increase utilisation of MY CARE			Yes		Yes	
3.2.2			Increase use of patient initiated follow-up (PIFU)	Yes			Yes	Yes	
3.2.3			Increase virtual care	Yes	Yes		Yes	Yes	
3.2.4			Introduce a patient self-booking portal		Yes			Yes	
3.2.5			Create an online patient information centre		Yes			Yes	
3.2.6			Increase the provision of one-stop multidisciplinary clinics				Yes	Yes	
3.3.1		Increase separation of non-elective and elective capacity	Ensure ringfencing of elective bed stock		Yes				
3.3.2			Develop our existing infrastructure to support separation of "hot" and "cold" activity		Yes		Yes		
3.3.3			Develop options for an elective treatment centre			Yes	Yes	Yes	Yes
3.4.1		Work with other organisations to	Actively engage with, shape and implement the Peninsula Acute Sustainability Programme (PASP) outcomes			Yes		Yes	Yes

No	Domain	Objective	Approach	Division	Trust	System	Links to Enabling Strategy: Estates	Digital	People & Culture
3.4.2		develop elective services	Increase our focus on learning from benchmarking, good practice and national reviews to guide development of our services	Yes	Yes			Yes	
3.5.1		Strengthen our cancer services	Review and improve cancer pathways		Yes			Yes	
3.5.2			Support primary care in early diagnosis of cancer			Yes			
3.5.3			Strengthen leadership, oversight and coordination of cancer services	Yes	Yes				
3.5.4			Provide additional support for cancer Multidisciplinary Teams (MDTs)	Yes				Yes	
3.5.5			Increase the use of informatics to improve services	Yes	Yes			Yes	
4.1.1	Tertiary Care & Areas of National Clinical and Academic Excellence	Promote and invest in our flagship services on both sites	Purposefully develop flagship services		Yes		Yes	Yes	
4.1.2			Promote the successes and benefits of our flagship services to others		Yes				
4.2.1		Network with other hospitals to optimise pathways for patients and staff	Actively engage with system partners			Yes			
4.2.2			Provide clear information for patients on pathways and where to get help	Yes					
4.3.1		Maximise the potential benefits of academia and research	Foster a research culture across the Trust		Yes				
4.3.2			Strengthen our links with academic institutions		Yes				Yes
4.3.3			Expand multicentre research trials		Yes				
4.3.4			Support hybrid clinical / research roles		Yes				Yes
4.3.5			Harness the capacity of EPIC and other digital systems to support clinical research		Yes			Yes	

Appendix 4 – Glossary of Terms

Term	Definition
Acute care	Acute care is the provision of active, short-term treatment for a specific condition (hospital care).
Acute Medical Unit (AMU)	An Acute Medical Unit (AMU) is an area of an acute hospital site which provides rapid assessment, investigation, diagnosis, and treatment for adult patients (over the age of 16) who have been referred directly to the team by a GP or the Emergency Department because they have an urgent medical problem that needs specialist assessment.
Ambulatory Assessment Area	An Ambulatory Assessment Area is an area for assessing patients who may not need admission to hospital.
"Call before convey"	Call before convey refers to an initiative launched by South Western Ambulance Service (SWASFT) to avoid bringing people into hospital, through paramedics linking in with other healthcare professionals.
Chronic condition	A chronic condition is a persistent or long-lasting illness or health condition that is lived with, that cannot be cured but can usually be managed with medicines, treatments, care and ongoing support.
Comorbidity	Comorbidity occurs when a person has more than one disease or condition at the same time. Conditions described as comorbidities are often chronic or long-term conditions.
Elective care	Elective care refers to non-urgent care which is planned in advance rather than is urgently necessary. This refers to diagnostic testing, scans, outpatient care and surgery.
Electronic Patient Record	An Electronic Patient Record is an electronic record of healthcare information for an individual. The Royal Devon launched its electronic patient record system (Epic) in October 2020.
Epic	The electronic health records system used by the Royal Devon.
Genomics	Genomics is a branch of molecular biology concerning structure, function, evolution and mapping of genomes.
Green to Go	Patients are referred to as Green to Go at the point at which they are medically fit for discharge. Discharge of Green to Go patients may be delayed due to other factors such as waiting for domiciliary care or a care home placement.
Health Inequalities	Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society.
Health outcomes	Health outcomes are an interrelated set of attributes that describe the consequences of a disease or impact of an intervention by a healthcare provider.
Hot Clinics	Outpatient appointments available to patients at very short notice (1-2 days) to avoid hospital admission are called hot clinics.
Integrated Care Board (ICB)	An Integrated Care Board (or ICB) is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area. The

	Devon ICB serves a population of around 1.2 million people across eight district councils in the county.
Integrated Care System (ICS)	An Integrated Care System (ICS) is an organisation that brings together different health and care services – such as a hospital, a clinical commissioning group, a council, an ambulance service, local GPs, local mental health services and other things – in a specific local area. The aim is to work together to make better use of public money and provide better care for people who live in the area.
Intensive Treatment Unit (ITU)/Intensive Care Unit (ICU)	Intensive Treatment Units (ITU)/Intensive Care Units (ICU) are specialist hospital wards that provide treatment and monitoring for people who are very ill. They are staffed with specially trained healthcare professionals and contain sophisticated monitoring equipment.
Length of Stay (LOS)	Length of stay (LOS) is the duration of a single episode of hospitalisation, usually measured in days.
MY CARE	MY CARE is an electronic portal through which patients can access their healthcare information and manage their health. For further information, visit NHS Royal Devon | MY CARE.
NDDH	North Devon District Hospital – Royal Devon University Healthcare NHS Foundation Trust's northern acute provider.
Paediatric Assessment Unit (PAU)	A Paediatric Assessment Unit (PAU) is an acute unit where children are assessed for emergency admission. From here patients may be discharged home, asked to attend a day unit, or transferred straight to a bed on a ward for immediate treatment.
Patient Initiated Follow-up (PIFU)	Patient Initiated Follow-up (PIFU) is when a patient initiates an appointment when they need one, based on their symptoms and circumstances. It is designed to empower patients to manage their own condition, and supports shared decision making, to deliver more personalised care.
Peninsula Acute Sustainability Programme (PASP)	The Peninsula Acute Sustainability Programme (PASP) is designed to lead the planning and delivery of transformational change for acute services across Devon and Cornwall. The aim is to deliver a high quality, joined-up and sustainable health care service for the peninsula.
Primary Care Network (PCN)	A Primary Care Network (PCN) is a group of GP practices in an area that work together, and with hospitals, social care, pharmacies and other services, to care for people with long-term conditions and prevent people becoming ill.
Primary care	Primary care is considered the first contact of healthcare for patients, including GPs, pharmacy, dental and optometry.
Provider (Healthcare)	A Healthcare provider is a legal entity that provides healthcare under NHS service agreements. Care from all providers is free at the point of use in England. Providers are split into Primary, Secondary and Tertiary Care. Primary refers to the first point of contact (GP, dentists and pharmacies), Secondary refers to hospital and community care which is either planned or urgent, and Tertiary refers to highly specialised treatment (transplants, neurosurgery).
RD&E	Royal Devon and Exeter Hospital - Royal Devon University Healthcare NHS Foundation Trust's eastern acute provider.
Same Day Emergency Care (SDEC)	Same Day Emergency Care (SDEC) is the provision of same day care for emergency patients who would otherwise be admitted to hospital. Under this care model, patients presenting at hospital with relevant conditions can be rapidly assessed, diagnosed and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided.

Social care	Social care refers to all forms of personal care and practical assistance for children, young people and adults to help them support their independence, dignity and live comfortably.
Surgical Assessment Unit (SAU)	A Surgical Assessment Unit (SAU) is an acute unit where patients are assessed for emergency surgical admission. From here patients may be discharged home, asked to attend a day unit, or transferred straight to a bed on a ward for immediate treatment.
System	Royal Devon is part of a wider 'system' of partner organisations. In the context of this strategy document, 'system' refers to the wider network which includes Devon County Council, Devon Partnership Trust, Livewell, other acute hospitals, Primary Care providers, voluntary sector organisations and other partners.
Tertiary care	Tertiary care is highly specialist health care requiring particular expertise and equipment, that is available only in specialist hospitals in certain parts of the country.
Third sector	The Third sector refers to non-governmental and non-profit-making organisations including charities, voluntary and community groups etc.
Urgent care	Urgent care involves an illness or injury which needs urgent attention by medical professionals.
Urgent Community Response (UCR)	Urgent Community Response (UCR) refers to the provision of urgent care to people in their own home to help them avoid hospital admission and enable them to live independently for longer.
Virtual Ward	A Virtual Ward is a way of providing support outside hospital to people with long-term conditions who may need extra care to avoid being admitted to hospital. The 'ward' is run by the hospital, and treatment and care is provided virtually by nurses and other health professionals.