Royal Devon University Healthcare NHS Foundation Trust

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

At 09.30 on Wednesday 27 April 2022 via MS Teams

AGENDA

This meeting will be recorded via MS Teams

Item	Title	Presented by	Item for approval, information, noting, action or discussion	Time Est.
1.	**Chair's Opening Remarks**	Shan Morgan, Chair	Information	09.30 2
2.	**Apologies**	Melanie Holley, Director of Governance	Information	09.32 1
3.	**Declaration of Interests and Annual Review of the Board's Register of Interests**	Melanie Holley, Director of Governance	Information	09.33 2
4.	**Matters to be discussed in the confidential Board**	Shan Morgan, Chair	Noting	09.35 2
5.	**Minutes of the Meeting of the Boards held 30 March 2022**	Shan Morgan, Chair	Approval (Paper)	09.37 5
6.	**Matters Arising and Board Actions Summary Check**	Shan Morgan, Chair	Information (Paper/Verbal)	09.42 5
7.	**Chief Executive's Report**	Suzanne Tracey, Chief Executive	Information (Verbal)	09.47 20
8.	**Patient Story NDHT**	Carolyn Mills, Chief Nursing Officer	Information (Verbal/paper)	10:07 15
9.	**Performance**			
9.1	**Integrated Performance Report RD&E & NDHT**	Adrian Harris, Chief Medical Officer	Information (Paper)	10:22 60
	BREAK			11:22 10
10.	**Policy and Strategy**			
10.1	**5 Year Corporate Strategy**	Chris Tidman, Deputy Chief Executive	Approval	11:32 10
10.2	**Towards Inclusion Update –**	Suzanne Tracey, Chief Executive Officer	Information (Verbal)	11.42 10
11.	**Assurance**			

11.1	**Governance Committee Report**	Carole Burgoyne, Non-Executive Director	Information	11:52 5
11.2	**Staff Survey Results NDHT & RD&E**	Hannah Foster, Chief People Officer	Information	11:57 20
11.3	**People Plan Update**	Hannah Foster, Chief People Officer	Information	12:17 10
11.4	**Review of the Board Schedule of Reports**	Melanie Holley, Director of Governance	Discussion	12:27 5
11.5	**Charity Sub-Committee Report**	Alastair Matthews, Non-Executive Director & Sub-Committee Chair	Information	12:32 2
12.	**Information**			
12.1	**Ockenden Report**	Carolyn Mills, Chief Nursing Officer	Discussion?	12:34 10
12.2	**Items for Escalation to the NDHT & RD&E Board Assurance Frameworks**	Shan Morgan, Chair	Discussion (Verbal)	12:44 1
13.	**Any Other Business**			**12:44**
	At the conclusion of the formal part of the agenda, there will be an opportunity for members of the public gallery to ask questions on the meeting's agenda. Where possible, questions should be notified to members of the Corporate Affairs team before the meeting. Every effort will be made to give a full verbal answer to the question but where this cannot be done, the Chairman will ask a director to make a written response as soon as possible.			
14.	**Date of Next Meeting:** The next meeting of the Board of Directors will be held at 9:30 am on **Wednesday 25 May 2022**			
15	The Chairman will propose that, under the provisions of section 1(2) of the Admission to Public Meetings Act 1960, the public and press should be excluded from the meeting on the grounds of the confidential nature of the business to be discussed.			

Meeting close at 13:00

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Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	3.0, Public Board meeting		**Date:** 27 April 2022	
Title:	Annual Review of the Board of Directors' Register of Interests			
Prepared by:	Melanie Holley, Director of Governance			
Presented by:	Melanie Holley, Director of Governance			
Responsible Executive:	Suzanne Tracey, Chief Executive			
Summary:	An update to the Royal Devon Board of Directors' Register of Interests.			
Actions required:	The Board is required to review and approve the Register of Interests.			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
		x		
History:	The Board's Register of Interests is reviewed in full annually.			
Link to strategy/ Assurance framework:	Relates to the Board's overall assurance and to the Board Assurance Framework			

Monitoring Information

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

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

1. Purpose of paper

To present an updated Board of Directors' Register of Interests for review and approval by the Board.

2. Background

The Trust is required to keep a Register of Board members interests and to undertake an annual review as part of the production of the Annual Report. At each Board meeting members are invited to declare any interests and may also amend their formal declaration at any time.

3. Analysis

The attached Register has been updated following an annual review of declarations of interest.

4. Resource/legal/financial/reputation implications

The Register of Board Interests is a document available for public inspection, it is posted on the trust website and additionally a copy is held in the Trust Secretary's Office for inspection by any member of the public.

5. Link to BAF/Key Risks

None.

6. Proposals

The Board is asked to review and approve the revised Board Register of Interests.

Royal Devon University Healthcare NHS Foundation Trust

ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST

The following is the current register, as at 19/0422, of the Board of Directors of the Royal Devon University Healthcare NHS Foundation Trust and their declared interests. It is available for inspection on the Trust's website (www.royaldevon.nhs.uk).

Name	Role	Interest
Burgoyne, Carole Mrs	Non-Executive Director	• Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust • Trustee & Co-Vice-Chair Transforming Futures Multi-Academy Trust • Co-opted Governor, Thornbury Primary School, Plymouth • Member of Health, Safety & Wellbeing Committee, University of Plymouth • Member, Plymouth Together Fund Sub-Committee
Foster, Hannah Mrs	Chief People Officer	• Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust • Partner, Scorlinch Farm • Member of Political Party (non-active) • Church Warden, St Lawrence, Clyst St Lawrence
Harris, Adrian Professor	Chief Medical Officer	• Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust • Director of Menegai Medical Limited (Medical Consulting), company number 13192153 • Director of Chudleigh Chapel Court Management Company Limited • Member of Political Party • Partner is a local General Practitioner
Hibbard, Angela Mrs	Chief Finance Officer	• Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust
Kay, Janice Professor	Senior Independent Director	• Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust • Provost, University of Exeter • Board Director, Advance Higher Education • Chair, Subject Level Pilot
Kent, Bridie Professor	Non-Executive Director	• Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust • Professor of Leadership in Nursing & Director of University of Plymouth Centre for Innovations in Health & Social Care: A JBI Centre of Excellence

		• Honorary Contract with University Hospitals Plymouth NHS Trust as Professor and Staff Nurse • Honorary Contract with Royal Cornwall Hospitals NHS Trust as Honorary Associate Director of Nursing • Plymouth University Member Representative on the Board of the South West Academic Health Sciences Network • Member of the Royal College of Nursing • Steering Committee Member of the Royal College of Nursing Research Society • Sub-Committee Lead for Clinical Academic Roles Implementation Network (CARIN); a network of the Council of Deans of Health
Kirby, Steve Mr	Non-Executive Director	• Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust • Director of St Giles Court (Bristol) Management
Matthews, Alastair Mr	Non-Executive Director	• Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust
Mills, Carolyn Mrs	Chief Nursing Officer	• Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust
Morgan, Shan Dame	Chair	• Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust • Member of the Advisory Council of the Bennett Institute for Public Policy • Spouse is General Practitioner in Somerset
Neal, Tony Mr	Non-Executive Director	• Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust • Governor, Bow Community Primary School
Orford, Kevin Mr	Non-Executive Director	• Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust • Non-Executive Director, Intellectual Property Office • Owner & Managing Director of Kevin Orford & Associates Limited • Non-Executive Director on the Devon ICB from 1 July 2022; supporting shadow ICB in unremunerated capacity until 1 July on development of governance arrangements
Palmer, John Mr	Chief Operating Officer	• Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust • Worked as an independent Management Consultant for PRISM Improvement between December 2020-April 2021 providing North West Anglia NHSFT with executive leadership for winter and COVID-19. The Trust has procured PRISM to provide interim site leadership from November 2021 to January 2022.

		• Director & Owner of JC Palmer Ltd
Tidman, Chris Mr	Deputy Chief Executive	• Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust • Company Director of Exeter City Futures Community Interest Company (as representative of RDUH) • Independent Advisor, Performance & Audit Committee, Exeter City Football Club • Son member of the RDUH Staff Admin Bank
Tracey, Suzanne Mrs	Chief Executive	• Committee Member, General Charity of the Royal Devon University Healthcare NHS Foundation Trust • Chair of HFMA Provider Faculty • Member of the Devon County Council Health & Wellbeing Board

Northern Devon Healthcare NHS Trust
Royal Devon and Exeter NHS Foundation Trust

JOINT MEETING IN PUBLIC OF THE BOARD OF DIRECTORS OF THE ROYAL DEVON AND EXETER NHS TRUST AND THE TRUST BOARD OF NORTHERN DEVON HEALTHCARE NHS TRUST

Wednesday 30 March 2022
Via MS Teams

MINUTES

PRESENT RD&E:	Mr J Brent	Chairman
	Mrs C Burgoyne	Non-Executive Director
	Mr P Dillon	Vice Chair
	Mrs H Foster	Chief People Officer
	Professor A Harris	Chief Medical Officer
	Mrs A Hibbard	Chief Financial Officer
	Professor J Kay	Non-Executive Director & Senior Independent Director RD&E (from 10:00 am)
	Mr S Kirby	Non-Executive Director
	Mr A Matthews	Non-Executive Director
	Mrs C Mills	Chief Nursing Officer
	Mr K Orford	Non-Executive Director
	Mr J Palmer	Chief Operating Officer
	Mr C Tidman	Deputy Chief Executive
	Mrs S Tracey	Chief Executive
PRESENT NDHT:	Mr J Brent	Chairman
	Dr T Douglas-Riley	Non-Executive Director & Senior Independent Director NDHT
	Mrs H Foster	Chief People Officer (non-voting NDHT Board member)
	Mrs P Geen	Non-Executive Director
	Professor A Harris	Chief Medical Officer
	Mrs A Hibbard	Chief Financial Officer
	Mr S Kirby	Non-Executive Director (non-voting NDHT Board member)
	Mrs C Mills	Chief Nursing Officer
	Mr T Neal	Non-Executive Director
	Mr K Orford	Non-Executive Director
	Mr J Palmer	Chief Operating Officer
	Mr C Tidman	Deputy Chief Executive (non-voting NDHT Board member)
	Mrs S Tracey	Chief Executive
APOLOGIES:	Mr R Down	Non-Executive Director
	Professor B Kent	Non-Executive Director
IN ATTENDANCE:	Mrs K Allen	Director of Strategy
	Dr A Colville	Guardian of Safe Working (for item 042.22)
	Dr M Dineen	F2 Doctor and President of the Junior Doctor Mess, RD&E (for item 042.22)
	Ms G Garnett-Frizelle	PA to Chairman (for minutes)
	Dr A Hemsley	Medical Director, RD&E
	Mrs M Holley	Director of Governance
	Dame S Morgan	Chair Elect

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		ACTION
034.22	**CHAIRMAN'S OPENING REMARKS**	
	The Chairman welcomed the Boards, members of the public, Governors and observers to the meeting. He reminded everyone it was a meeting in public, not a public meeting, and asked for questions at the end of the meeting and for them to be focussed upon the agenda. He asked members of the public to only use the 'chat' function within MS Teams at the end to ask any questions. He reminded everyone that the meeting was being recorded via MS Teams. **The Chairman's remarks were noted.**	
035.22	**APOLOGIES**	
	Apologies were noted for Mr Down and Professor Kent. The Boards were advised that Professor Kay would join the meeting shortly after 10:00 am.	
036.22	**DECLARATIONS OF INTEREST**	
	The Boards noted the following new declaration: Dr Douglas-Riley was no longer Director of the Yelverton Golf Club.	
037.21	**MATTERS TO BE DISCUSSED IN THE CONFIDENTIAL MEETING**	
	Mr Brent noted the following items on the Boards' confidential agenda: updates from Joint Digital Committee including EPIC Benefits Realisation Update, the Integration Programme Board, MyCare Programme Board (NDHT), and Our Future Hospitals Programme Board, an Operational and Financial Planning Update including approval of the Budget for the next financial year, and a business case for the Community Diagnostics Hub.	
038.22	**MINUTES OF THE MEETING OF THE JOINT NDHT & RD&E BOARD HELD ON 23 February 2022**	
	The minutes of the meeting held on 23 February 2022 were approved as an accurate record.	
039.22	**MATTERS ARISING AND BOARD ACTION SUMMARY CHECK**	
	Action check The actions were noted as per the tracker with the following revisions: *Minute 008.22(1) Update on diagnostics briefing and business case to be presented at March public Board meeting.* It was noted that a paper had been included for discussion on the confidential Board agenda and it had been proposed that this action should be closed. However, it was noted that the feedback from NHSE/I on the submitted business case was not expected until the Summer of 2022 and it was agreed that the action should remain open until this feedback had been received at the July Board meeting. *Minute 008.22(4) – Mr Palmer to look at whether children and young people's data in IPR could be separated out.* The Board noted that the action had transferred to Mrs Mills and the update she had provided that discussions are	

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	ongoing to agree how the Board can receive the oversight and assurance requested but that it was unlikely this would be through the IPR. Mrs Mills added that she was in the process of establishing a Governance Committee for Children and Young People which would report into Joint Governance Committee and then onward to Board, as this was felt to be a more robust solution. Mr Brent said that it would be important to try and ensure that both physical and mental health for children and young people were brought together in this new Committee. **The Boards noted the updates.**	
040.22	**CHIEF EXECUTIVE OFFICER'S REPORT**	
	Mrs Tracey provided the following updates to the Board. <u>National Update</u> • The National Audit Office have been looking at what happened through the pandemic and had produced a report on the roll out of the vaccination programme in England finding that it operated at unprecedented pace, scale and complexity and in conditions of uncertainty to support the objectives of creating the vaccine, securing access to them and administering them to the population as quickly as possible. The report acknowledged the collective efforts of many that had contributed to this programme of work that had saved lives and reduced major illness and hospitalisation, however it also recognised that staff burnout was a major risk to the future success of the programme, together with a lack of surplus capacity within the health system. • The terms of reference for the United Kingdom Covid Public Inquiry had been drafted which set out the aims of the Inquiry. These are firstly to examine the Covid response and the impact of the pandemic in the UK and to produce a factual narrative account focussing on the decisions taken and their consequences involving all sectors that were involved in the pandemic response including healthcare. The second objective was to identify lessons that could be learned which could inform the UK's preparation for future pandemics. The Inquiry will listen to the experiences of bereaved families and others who had suffered hardship or loss as a result of the pandemic, highlight where lessons may be applicable to other civil emergencies, consider the experience of and impact on health, social care and other key workers and ensure that any disparities that are evident including relating to protected characteristics are considered. • The Public Accounts Committee has had a final report on NHS backlogs and waiting times and has said that the Department for Health and Social Care has overseen years of decline in the NHS' cancer and elective waiting time performance and even before the pandemic had not increased capacity sufficiently to meet growing demand. The report states that any transparent and realistic assessment of what the Department and NHSEI expect elective and cancer services to achieve by 2024-25 must include an assessment of how many staff will be available and how staff who have been working under consistent and intense pressure will be supported. • The Secretary of State has outlined plans for NHS reform, including paying to send patients on waiting lists to less busy hospitals or being referred to private hospitals. In addition, he has said that the Government will publish its plans for the NHS workforce by end of the year, emphasised the need for more focus on prevention, on health disparities and ways to enhance the patient voice. He also focussed on how the NHS could become more	

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personalised through the use of digital and AI and stressed the importance of partnerships.

- In terms of elective recovery, the number one indicator will be how NHS providers can respond to reducing the number of 104 week waits, with the aim of getting all to zero by the end of June 2022. For Devon, this would mean having to treat four times the number of patients compared to what had been achieved in quarter 4 2021-22.
- There have been severe pressures nationally on urgent and emergency care and the representatives from the region had been asked to attend a briefing with the national NHSE/I where there was a focus on hospital handovers. There were four requests to providers and systems from this meeting; (i) to have a system plan to manage the risk of urgent and emergency care, particularly ambulance handovers; (ii) once patients are in the emergency department and ready to admit, that this is done as quickly as possible but with recognition of the pressure on beds; (iii) equalise the level of discharges at weekends; (iv) that all Trust Boards are aware of and monitoring ambulance handover times.
- There had been an announcement in the media on 29 March 2022 regarding the reintroduction of staff car parking charges. The organisations have been exploring for some weeks what this means for both Trusts, bearing in mind issues raised by staff relating to concerns about increases in fuel costs, and reimbursement for travel expenses and the organisations' measure for alternative methods of transport outlined in their Green Plan, to ensure that a balanced set of recommendations is put forward.

<u>System Issues</u>

- Part of the requirement for the Devon system to exit the SOF4 criteria is the production of a strategy for acute trust, secondary and tertiary services, which would sit in an overarching strategy for the Devon ICS. The first stage due to take place at the end of March 2022 is to review all the work done as part of the Acute Services Review and the Peninsula Services Strategy to ensure that this is all brought together and that account is taken of any changes since these pieces of work were completed. A Clinical Strategy will then be produced by the autumn of 2022. A paper called "The Way We Do Things in Devon" will be presented at the April Board meeting. This sets out how organisations expect to work differently as partners in the Devon ICS and the changes required in the culture and behaviours as a system.

<u>Local issues</u>

- There has been another period of unprecedented operational pressure across both Trusts, with the number of Covid patients, Covid contacts and patients on the Green to Go list. This has been particularly challenging for NDHT due to Devon being impacted by a very transmissible Covid variant. Whilst it is not proving to be as significant as the primary need for hospitalisation, patients are being admitted also have Covid or were getting Covid once admitted. All measures possible are in place to minimise the impact of this.
- The South West Ambulatory Orthopaedic Centre opened on 14 March 2022 at the Nightingale Hospital with approximately eight patients a day now receiving their treatment at the centre.
- The Board had previously given delegated authority to the Chief Operating Officer and a number of Executive and Non-Executive colleagues to review the final Estates handover report for the Nightingale Hospital. All work has now been completed with regard to the estate, site leadership is in place and approval has been received from the Care Quality Commission for surgical

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	activity at the site, quality and equality impact statements had been completed and clinical and operational protocols are being developed. Recruitment is progressing for the site and work continues across the system to ensure that the best use is made of the facility with an ambition to move to seven day working by the end of the next financial year. • Mrs Tracey shared that she had led a ceremony during the course of March 2022 to remember the life of an Advanced Critical Care Practitioner in Intensive Care at the RD&E, Louise Houslip, who had been missing since going on a diving trip in November 2021. A tree has been planted in her memory. Mr Brent asked if there was any update on the latest position regarding the merger of the two organisations. Mrs Tracey advised that a great deal of work had been undertaken over the last month to finalise the integration, including a number of key meetings held to consider the proposals and approve them; these included a number of meetings with NHSE/I, the two Boards and the Council of Governors. The letter of approval from the Secretary of State was due to be received that day and subject to receipt of that approval, a communication is planned for staff, patients and external stakeholders to confirm that the two organisations will be moving into a new era as one organisation from 1 April 2022. The new organisation will be known as the Royal Devon University Healthcare NHS Foundation Trust. The next milestone for the organisation will be the go live of the Epic system in North Devon in July 2022. Mr Brent asked if Mrs Mills could provide an update following publication of the final Ockenden Report on maternity services. Mrs Mills informed the Boards that the original Ockenden Report had been commissioned in 2017 by the Secretary of State prompted by concerns raised by two families regarding maternity services at the Shrewsbury and Telford Hospital NHS Trust, although since the launch of the review many more families had come forward with concerns about their care at that organisation. The report identifies two areas of particular focus – staffing levels and care of neonates. There will be a high level of peer review of the report against the expectations for organisations to assess the position for the RD&E and NDHT, with a system approach being coordinated through the ICS. Mrs Mills advised that she would bring a more detailed update to a future Joint Governance Committee meeting once a review had been completed. Mr Kirby asked Mrs Tracey if there was an opportunity in the current unprecedented circumstances to look at whether there was a different way of tackling the Green to Go problem, and given the severity of the issue perhaps in a more risk-taking way than would usually be considered. Mrs Tracey said that this was a helpful reflection and she said that in the Boards' work on the Corporate Strategy for the next five years it had been acknowledged that different approaches would need to be considered to tackle some of the issues in Devon. This included the role of the organisations in the wider care sector issue looking at how to strengthen work with partners and possibly take a more active role. **The Boards noted the Chief Executive's update.**	
041.22	**NDHT & RD&E INTEGRATED PERFORMANCE REPORTS**	
	Mrs Hibbard presented the Integrated Performance Report (IPR) for February's activity and performance. Key highlights noted included:	

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	• There were increasing operational pressures across both Trusts during February which had continued into March. • Although there had been a decline in Covid numbers during February, that number had reversed with numbers of inpatients currently at the highest level since the start of the pandemic, with 110 Covid inpatients at NDHT during the preceding weekend. There had been a slight improvement since then, with numbers reducing to 80 at NDHT and 133 at the RD&E. There had been a corresponding significant impact on staff sickness absence with very high levels at both organisations. Ward areas were being risk assessed for every shift to manage safety levels. • Despite these pressures, progress had been made during February on activity delivered, with the Nightingale Hospital taking its first day cases at the end of February with all services up and running by mid-March, which will contribute to further improvement in the trajectories going forward. Dyball Ward at the RD&E which had been used for medical patients during the current operational pressures had now been transferred back to elective orthopaedic which will help to address orthopaedic inpatient waits. The new modular ward is now onsite at the RD&E with work due to be completed by the end of March which will provide protected orthopaedic capacity. • During February NDHT had declared Opel 4 due to pressures on flow, but there had been a very good response and it had been stood down to Opel 3 within 24 hours. The ongoing pressure is having an impact on ambulance handovers and trolley breaches. The community teams are supporting the acute pressures with the Community Urgent Care Response Team supporting discharge and reductions in community bed length of stay to help with flow out of the acute trusts. • Waiting list pressures across 104, 78 and 52 week waits continued and there had also been dips in the cancer 62-day referral performance, although two week waits and 28-day faster diagnosis had improved at both sites. These are all areas of focus for teams as they work through the impact that measures will have on trajectories. • No worsening trend has been identified in quality data, although stroke performance continued to be impacted by bed pressures on both sites. • In terms of the financial position, the overall impact of the operational pressures had evened out enabling forecasting of delivery of the revenue plan for this financial year. There was still some way to go to deliver capital spend for the year, but with a high degree of confidence. The focus for the teams was now on completing the operational and planning round for 2022-23. Mrs Geen asked when the current Covid wave would peak. Professor Harris responded that whilst in previous waves there had been well-modelled information that could be used, this is not available for the current wave as it has happened so rapidly and the variant has an extremely high R number. It was noted however that whilst this variant is extremely infectious, due to the level of vaccination uptake and the level of previous infection within the community, the outcomes for many patients are not as severe in terms of mortality and morbidity. Professor Harris advised that it was believed that this variant would peak quickly and then decline quickly by the end of April. Mr Palmer added that events in France where a new variant has emerged are being tracked carefully. Mr Orford posed the following three questions: 1. There had been a question posed at the last Council of Governors meeting regarding whether Waiting Well applied across every specialty consistently	

and asked if this could be confirmed. Mr Palmer confirmed that it does, although there had been a more comprehensive roll out initially at NDHT with the RD&E now catching up.

2. The Our Future Hospital Programme at NDHT was looking at how some of the staffing issues could be addressed and asked if it would be possible to build into those discussions any themes that were arising from exit interviews that might help inform the debate and to help understand the increased turnover numbers for NDHT. He agreed to discuss this further with Mrs Foster outside the meeting. **Action.**
3. The national ambition was that 104 week waits should reduce to zero by June 2022 and Mrs Tracey had noted that for Devon achievement of this would entail doing four times the amount of elective activity based on clinical prioritisation. Mr Orford asked if there was assurance that clinical prioritisation being undertaken was consistent with the rest of the UK where there are fewer long waiters and review of the process was needed to help address the two-year waiters. Professor Harris responded that there was assurance that waiting lists were being scanned and decisions made in terms of clinical priority, but added that it was not straightforward in terms of harm, as the impact of potential psychological harm is also a factor. He advised that he did not know whether this was being applied in the same way locally as elsewhere in the country. Mrs Tracey said that she could provide assurance, in her role as Senior Responsible Officer for the Planned Care Board for Devon, that the categorisation of patients on waiting lists was being looked at to allow an assessment of whether there is consistency across Devon. There will also be a check on whether patients were being treated in date order once assigned to a category, other than where most efficient use of theatre time is a factor and a patient may be pulled forward if their procedure could fill a shorter theatre slot. Mr Palmer added that given the level of exposure the organisations were in weekly oversight meetings with NHSE/I where the clinical prioritisation approach had been reviewed in detail and they were very happy with the process in place. It was noted that the standing up of Dyball Ward and the Nightingale will make a material impact for 104 week waits over the coming months.

Dr Douglas-Riley asked if there was any data on the vaccination status and age of the majority of the patients currently in hospital who had tested positive for Covid and whether it was known if annual tailored vaccination against Covid would be the norm. Professor Harris said that in general the majority of patients who had either come into hospital with Covid as their primary diagnosis or secondary to other conditions on admittance or had acquired Covid whilst an inpatient were elderly, although there were still some young, unvaccinated patients being admitted. He added that it was not possible to state with certainty at this time whether annual vaccination would become the standard, however he anticipated that vulnerable people will be vaccinated against Covid for years to come. This may be tailored, as the flu vaccine is, each year but this will depend on what happens with the virus over time.

Mr Matthews posed the following questions:

1. He noted from the IPR that whilst outpatients were doing well on the number of patients being seen, this seemed to be biased towards follow-ups but not achieving to the same degree for new patients. Whilst he recognised that these patients would be picked up by the waiting well approach, he assumed less would be known about their health status as they had not been seen at all and asked whether there might need to be a change of emphasis to see more of those patients. Mrs Hibbard noted that follow-up activity did include

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community follow-up, so was not a like for like comparison with new patient activity. Mr Kirby agreed that he had also noted this anomaly. Mr Palmer agreed and said that he could send Mr Matthews and Mr Kirby a breakdown of how this balances out between outpatients in the acute and follow-up in the community. **Action.**

2. There appeared to an issue with fill rates for care staff during the day which did not seem to directly correlate with Covid peaks and asked for clarification on what was being done to address this. Mrs Foster agreed that there was an issue with retention of healthcare assistants following a recruitment campaign last year, some of which related to staff recruited not necessarily being right for the post. Additional funding had been provided for pastoral care and support for the latest intake and there is a national ambition to get to zero vacancies by the end of April 2022. It was noted that it was a very competitive market for staff at that banding level and it was important to be able to offer long term career prospects to those staff. Mrs Mills added that there had been a significant decline in the safe unregistered clinical staffing fill rates at the RD&E for the reasons outlined as well as sickness absence, although wards have done significant work to make the wards as safe as they can be. It was noted there were also recruitment and retention issues related to other non-clinical staff at lower bandings for example in estates and facilities.
3. There appeared to be differences in the way data was being reported between the RD&E and NDHT, for example on the urgent care diagnostic some aspects where improvements were being seen were rated as red despite being better than the same areas in NDHT which were rated green. A specific example was 111 call abandonment which was rated red in Exeter, but green in NDHT where there was a higher rate of call abandonment. Mr Palmer advised that the RAG threshold was incorrectly applied and, should have been highlighted as grey rather than green. The NDHT diagnostic is still developing compared to the RD&Es and grey indicates where there are still discussions to be concluded with local providers concerning where the thresholds will be for red, green and amber.
4. The year to date deficit was reported as £2.8m but would worsen to £6.2m over the next month which seemed to be out of line with the trend and Mr Matthews asked for clarification of the reasons for this. Mrs Hibbard said that there were two aspects to this; firstly, accounting judgements that would not play in until month 12, for example annual leave accrual and secondly areas of additional spend brought forward from next year's plans where there was an opportunity to do so, such as works on the estate that would be revenue based where most of the invoices would not be reflected until March 2022.

Mr Kirby said that it appeared that what happens with the waiting well once they had been contacted looked very different at the two organisations, with the number of patients removed from the list very high at the RD&E compared to NDHT, and patients being referred to lifestyle support at NDHT but not at the RD&E and percentages of referral to clinician also looking very different. Mr Palmer said that the RD&E was still in the early days of rolling out waiting well, with NDHT about six months ahead of them. In addition, the RD&E had used the private sector support for triage. It was expected that the data would start to normalise over the next quarter, although there would always be a volume discussion.

Mr Kirby said that there was quite a disparity between the two Trusts in a number of areas reported on in the People Pulse survey and it would be helpful to

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understand this more fully. In addition, he asked whether the plan for the new organisation would be to continue with the site-based surveys or move to a whole organisation survey. Mrs Foster said that the technology used for the People Pulse surveys meant that the data could be analysed in a number of different ways. The new cultural dashboard will help to achieve a position over time where the data can be presented to include demography and location as well as other factors.

Mr Brent posed the following three questions:

1. Ambulance call response times had been pushed out considerably, with door-to-needle time for stroke patients also extended materially. Whilst Mr Brent acknowledged that ambulance waits were a much bigger issue that could not easily be resolved in the immediate future, he asked whether, where there were time critical interventions needed such as for stroke patients, was there anything further that could be done to change the approach to this pathway across the system. Professor Harris said that whenever a system is under the amount of pressure that currently prevailed in Devon flow becomes an issue but he provided assurance that patients continued to be prioritised appropriately with a high consultant workforce presence in ED in both Trusts. With regard to interventions for stroke, it would not be possible for these to be undertaken with patients before they had arrived at the ED because both treatments require the patient to have a head CT scan before administering. However, he added that the ambulance crews deliver everything to patients that can be at the scene. Mr Palmer added that the organisations would do everything they could to maintain their excellent record on ambulance handovers, although this was difficult under the current pressures. He added that through his work with the Winter Taskforce and other system groups, he could provide assurance that SWAST had a constant focus on stroke.
2. Access for cancer patients was very different between the two Trusts and Mr Brent asked what will be done to reduce time to treatment at NDHT to align this to the RD&E levels. Mr Palmer confirmed that this was an issue that had been identified during the recent NHSE/I virtual visits. He advised that there had been three areas of particular concern with 62-day cancer performance at NDHT, namely colorectal, breast and skin. There are good recovery plans in place for breast and skin, with more work needed for the colorectal service. Overall, the ambition is to drive more activity that is shared across that two sites and the joint Cancer Cabinet will pick this up to look at this as a single organisation going forward. Mr Brent said that as the organisations merge into a single Trust it becomes even less acceptable to have significant variation and it would be useful to have an indicator on the core data relating to variance to drive the questions on why it was the case and what was being done to address it. Mr Palmer commented, as previously advised at Board, there were issues about the strength and depth of the team particularly where there is sickness absence but there are options to be explored on how to strengthen the team.
3. Whilst he acknowledged that there was an element of catch-up in the turnover numbers where staff had previously deferred retirement during the height of the pandemic, he felt that it was important to have a better understanding of the reasons for turnover in order to better understand the risk, understand what recruitment is needed and look at ways to ameliorate the concerns of staff that leave prematurely. Mrs Foster agreed that it was difficult to differentiate from the data presented on turnover between what might be catch up and what might be new turnover. She added that the

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	organisations were not ahead of most others within the system in terms of turnover numbers. It was noted that operational pressures create pressures on the workforce team as well, for example through increased sickness absence reporting and this in turn impacts on other work that they can do, for example greater analysis of reasons for people leaving. Mrs Foster informed the Boards that the team was engaged in a system project to understand to understand how staff feel. The cultural dashboard will give a greater understanding of the drivers behind turnover. With regard to Exit Interviews, currently the highest category of reason stated is "Other" and this is another area for improvement of the Exit Interview going forward. Finally, she advised that in terms of Band 2 and 3 staff a significant issue was that the salary was not competitive in the current market and this has been escalated at regional and national level. Mr Neal recognised and thanked colleagues for the significant amount of work that had been done over the last month to manage the pressures in the system and asked the following specific questions: 1. What had been the impact of Covid in community hospitals over the past few months. Mr Palmer responded that the time to transfer across all three community pathways had been holding well, with community hospitals essential to the ability to hold the position. However, they had also experienced the same staffing sickness absence levels due to Covid as the acute sites and community transfers had become less efficient. 2. There had been a significant rise in the number of family not agreement with discharge plans for a patient at NDHT and asked if there were identifiable reasons for this and what could be done to support families. Mr Palmer advised that the patient choice for discharge position at NDHT remained challenging and efforts had been made to make greater use of family grants to help families care for patients at home. It is hoped that if Covid continues to be as much of an issue as it is currently more flexibility will be given to organisations around patient choice. 3. There are different ways of reporting on neonates between the two Trusts, with one reporting on head count and one reporting as percentage of births and it would be helpful if this could be aligned. In addition, Mr Neal asked if this could be triangulated with other areas of the maternity data. Mrs Mills agreed with the difficulty of interpreting the data in its current format and confirmed that there is work ongoing to look at how it can be aligned going forward and to provide some context around the numbers. She added that it was likely that following the publication of the final Ockenden report, the reporting requirements will be reviewed and possibly changed. Mrs Burgoyne said that the Boards had been informed of system wide work at the last few meetings and asked if there was any feedback from this on suggestions of what could be done differently that will assist the position once the current Covid wave has started to abate. Mr Palmer said that the additional coordination put in place through the Winter Taskforce Group had served the system well during the winter and this coordination has been played into the orthopaedic restart which has helped get Dyball Ward and the Nightingale up and running and pathways for all other Trusts to bring on elective operating over the course of the next six weeks. There is an infrastructure challenge with more protected elective capacity needed for Devon and system support will be needed for this, including support going beyond the Devon ICS. **There were no further questions raised and the Boards noted the IPR.**	

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042.22	**GENDER PAY GAP REPORTS NDHT & RD&E**	
	Mrs Foster presented the Gender Pay Gap Reports for NDHT and RD&E, noting that the reports were created looking at data in arrears from April 2021. She advised it was important to bear in mind that much of staff pay is dictated by national terms and conditions and that there are significant gender biases in the make-up of professional workforces which both contribute to the gender pay gap in the system. It was noted that this is in part due to the impact of Covid and the organisations' ability to influence elements that do play a part in the gender pay gap, such as the Clinical Excellence Awards, had been limited. The gap had widened slightly in Northern Devon since the last report and this was attributed predominantly to the consultant workforce becoming slightly more male dominated. However, it was noted that the work done at the RD&E three years ago to improve inclusion in the Clinical Excellence Awards had started to pay dividends, with the RD&E now above average for the healthcare sector for gender pay gap. Mrs Foster informed the Boards that a discussion had recently taken place at the Joint Governance Committee on what could be done to further improve the Clinical Excellence Awards process particularly in North Devon, however it has subsequently become clear that there will be no changes to the award scheme nationally this year, which will limit the scope of what can be done at local level. Finally, Mrs Foster advised that the run of data for next year's Gender Pay Gap report was due to take place and it was proposed that for this year a report would be produced for both RD&E and NDHT separately, as well as a joint report. Professor Kay said that it was clear from looking at the NDHT data that the differences were at the top and in the lowest quartile and said that there was a question of whether male staff were being appointed on higher grades in the top quartile, and whether faster progression for males was evident across all groups. She added that whilst she was sure that this would be looked at, she felt that a more forensic approach to the data would be helpful and offered her assistance to provide challenge on the detail. Shan Morgan agreed with Professor Kay and added that she would be keen to work with Professor Kay and Mrs Foster on the challenges of tackling the gender pay gap and wider issues of diversity and inclusion. Mrs Foster responded that it was difficult to get accurate progression data across all groups, not just gender, adding that ways of addressing this were planned as part of the development of the cultural dashboard. It was noted that integration of the two organisations would go some way to helping to start closing the gap in the North as a consistent appointment process is put in place. Mrs Foster added that gender pay gap was also being looked at through the Remuneration Committee when looking at senior manager pay. Mr Brent commented that he fully supported doing as much as could be done at an organisational level to improve the Clinical Excellence Awards process whilst the national changes were still awaited, such as changing the terms of reference, changes to the make-up of the Committee and changes to the way that female colleagues are encouraged to apply for the awards. He added that one of the key issues was that not enough young women were entering surgical roles in the volumes that would be needed to start addressing the gender pay gap for this specialty area and said that he would support encouraging the Royal Colleges to start changing the perspective of surgical roles now. Mrs Tracey noted that there were some changes becoming apparent in terms of the gender of applicants presenting for interview. She added that she had recently spent time with junior doctors where she had been approached by a	

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	female junior who was interested in a career in clinical management and wanted to arrange to shadow the Chief Executive to find out more about this pathway. Mrs Tracey said that these were heartening indications that the work that has been undertaken on the inclusion agenda at the Trust is making progress, whilst acknowledging that there was more to do. Mr Tidman commented that there was more balance in the doctors in training now coming through. In addition, he said that as well as ensuring there was gender balance on recruitment panels, it was important for teams to think about language used in adverts placed to recruit staff, for example including references to the organisation being family friendly and offering flexible opportunities, as this may help to remove some of the perceived barriers to application for some candidates. Mrs Foster agreed and said that work had already been started on this and a change in the applicant base was starting to be evident. Professor Kay said that it was important to emphasise that this area did not relate to an equal pay gap in the organisations – there was already equal pay for equal jobs in place. She reiterated that it was vital to look at the data to establish what salaries new appointees were being brought in at and the progression data. **The Boards approved the reports, noting that their approval was not indicative that they found the level of gap acceptable, but approving the report as presented as required. In addition, the Boards agreed the proposal for the next cycle of reporting that separate reports should be produced, together with a joint report.**	
042.22	**GUARDIAN OF SAFE WORKING HOURS REPORT NDHT & RD&E**	
	Dr Colville and Dr Dineen attended to present the Guardian of Safe Working Hours Report for NDHT and the RD&E. Key issues noted were: • The report presented had been deferred from presentation at the February meeting of the Boards and related to data for Quarter 3. • It had not been possible to include rota gaps for February, so it was proposed to include this information for both Quarter 3 and Quarter 4 in the next report. • It had been noted during the current quarter that the ongoing trend of exception reporting noted during Quarter 3 had continued, with three exception reports received over the preceding three to four weeks raising issues of safety. All had been raised by F2 doctors working on wards such as Wynard that had been created for cohorting of patients with Covid. The theme from these exception reports was that junior doctors were being asked to work on their own on these wards at very short notice and with significant numbers of patients to manage. Dr Colville advised that he had spoken to the junior doctors who had raised the reports as soon as possible, and the following points were noted: although they were working on their own, all agreed that they had excellent support available to them at consultant level and the junior doctors reported that whilst they had felt stressed at the time of the event, they had recovered well and did not report any ongoing impact on them. Dr Dineen said that there was significant anxiety and concern amongst junior doctors regarding covering outlier wards, as there are multiple wards involved meaning more juniors are being pulled at short notice and patients are not as medically stable as they might have been in the past on an outlier ward. She	

	noted that the doctors concerned in the three safety concerns raised had not reported ongoing issues for them from this, but added that stress and anxiety will build over time if the situation continues. Mr Brent commented that timely communication was an issue, but noted that the speed of the current Covid wave may have been a contributory factor. Mr Palmer advised that there had recently been sign off for Wynards Ward as a permanently staffed ward, which should hopefully over time mean that juniors being pulled at short notice will become less of an issue, as staff are recruited to the permanent ward structure. Dr Hemsley thanked Dr Colville and Dr Dineen for raising this concern and advised that he would look at this more closely to see what could be done to improve the communication and support that is in place for junior doctors where they are asked to cover outlier wards. He added that a policy is in place, approved through the governance system at the RD&E and with the Deanery, to support the decision-making relating to the redeployment of junior medical staff in times of extreme operational pressure. A step wise approach should be taken to ensure that only staff who have the requisite competencies and skills are drawn on and trying to ensure that the same group of staff are not repeatedly asked to undertake this cover. It was noted that it was likely that increasing staff sickness absence had compounded the issues noted over the last few weeks. Professor Harris agreed with Dr Hemsley and added that there was no doubt that junior doctors, in common with other staff, were under enormous pressure under the current unprecedented circumstances, but that communication and support available should be looked at to ensure that it was optimised. He added that he was optimistic that the current Covid position should have improved significantly over the next month which in turn should improve the position relating to the need to redeploy junior doctors to outlier wards. Mr Kirby asked Dr Dineen whether junior doctors were being put in the position of having to look after patients that they felt they did not have the appropriate level of experience for and if this was the case, how did this fit in with the process described for supporting decision-making when redeploying junior medical staff. Dr Dineen said that she had been involved in the development of the redeployment policy and it did provide a very good framework, however the issue was that the reality on the ground for some junior doctors was that there was not always a named consultant or supervisor available for them to meet with before they were moved to a new area. She added that there was also a responsibility for junior doctors to speak up if they were asked to do something that was outside their competence. Mr Kirby agreed that it was key for both staff, but also for patients, that the culture encouraged junior staff to speak up in these circumstances. Mr Palmer added that there is generally a healthy culture of speaking up in place with staff encouraged to feel empowered to escalate where things are not OK. Mr Dillon said that he was confident that was a good culture that encouraged staff to raise issues, but added that this was only sustainable if staff are confident that something will then be done about the issue raised. Mr Brent asked Dr Dineen if the organisation was supporting junior doctors as much as possible during this challenging period or was it felt that there was more that could be done. Dr Dineen responded that she felt there was a great deal of support in place and the increase in exception reporting was due in part to the message getting out to junior doctors that it was “ok not to be ok”, but there was more work to do to ensure that juniors were aware of all the support that is available to them.	

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	Dr Colville informed the Boards that Dr Griffith-Jones had now stood down as Guardian for NDHT and he suggested, if there were no suitable candidate identified to take on this role in NDHT, he would be happy to take on the task of providing data going forward for both sites and would endeavour to ensure that he visited NDHT when possible. Mr Brent thanked Dr Colville for his offer and agreed that this would be considered. In addition, it was noted that the possibility of developing a joint Junior Doctor Forum across both sites was being discussed and either a joint Mess or very close liaison between the Mess on each site. **The Boards thanked Dr Colville and Dr Dineen for attending the meeting and noted the report.**	
043.22	**ITEMS FOR ESCALATION TO THE NDHT & RD&E BOARD ASSURANCE FRAMEWORKS**	
	The Boards agreed that there had been nothing new raised at the meeting for escalation to the Board Assurance Frameworks.	
044.22	**ANY OTHER BUSINESS**	
	Mr Brent said that he would like to take the opportunity to thank departing Non-Executive Director colleagues for their support and for extending their Terms of Office to help facilitate the merger between the two organisations. The Boards extended their thanks to Mr Dillon, Mr Down, Dr Douglas-Riley and Mrs Geen for their commitment, energy and drive to improving healthcare for the local populations in Devon. Mr Brent added that he and other colleagues leaving the organisations were confident that they were leaving the Trust and local communities in the hands of excellent custodians with the continuing members of the Boards. He thanked Mrs Tracey for her excellent leadership as Chief Executive Officer and commended the choice of Dame Shan Morgan as incoming Chair. Thanks were also extended to the Boards support staff and all staff, both back office and front line staff who provided care to people when they were at their most vulnerable, to Governors both past and present who gave their support to the organisation and to colleagues and members of the public who had regularly attended Board meetings to support, question and challenge. Mr Brent said that his final advice to Board colleagues would be to continue to give their best, not to be distracted by demands to deliver the impossible and to take pride in delivering the best that is possible. Mrs Tracey thanked Mr Brent for his kind words and said that she would also like to take the opportunity to thank Mr Brent for his 10 years of service to the NHS as Chair over a period where there had been significant changes. These encompassed not only latterly with the global pandemic and the integration of the two Trusts, but previous significant developments such as the opening of the new RILD building at the RD&E, the building of a new partnership with University of Exeter and the introduction of MyCare electronic patient record. Throughout all, Mr Brent had been a consistently steadfast and thoughtful Chair, always ready to challenge on what mattered the most with clarity, humility and patience. Mr Brent was also thanked for his work with and championing of the Council of Governors. Mrs Tracey also thanked Mr Brent for his support, wisdom and advice to her since she became Chief Executive and wished him well for his new ventures on behalf of the Boards, staff, Governors, patients and the local communities.	

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	Mrs Foxall thanked Mr Brent on behalf of the Council of Governors for his service as Chair and also extended thanks to all the Non-Executive Directors for their contributions to the work of the Board, noting that their willingness to challenge and question at Board demonstrated their commitment to what matters most to patients and communities. Shan Morgan echoed the thanks of colleagues to Mr Brent and departing Non-Executive Directors. She informed the Boards that it had been a conversation with Mr Brent that had both inspired and convinced her to apply for the role of Chair, as his passion for the role and commitment to public service had been so apparent. She thanked him for the significant legacy he was leaving and said that she was committed to endeavouring to live up to the high standards and values that were embodied at the organisation. Mrs Tracey informed the Boards that she had received confirmation from the Secretary of State for Health for the integration and that with this final stage now completed, the integration of the RD&E and NDHT would proceed on 1 April 2022 as planned. Mr Brent congratulated the Executive Team, the Integration Programme Board and the Council of Governors for all the work that they had undertaken which helped lead to this successful outcome for both organisations.	
045.22	**PUBLIC QUESTIONS**	
	Mrs Matthews advised that she had emailed a question regarding an item on the agenda and would be happy to receive a written response. She added her thanks to Mr Brent for his chairing of the Board over the last four years, and for his encouragement of greater engagement with the North Devon community. Ms Haworth-Booth endorsed the thanks to Mr Brent. She advised that she had two questions that she wished to address to the Boards. 1. Mr Palmer had said that protected elective care was need, but surely this could only be achieved with more staff which is a fundamental problem for the organisations. What other course of action could be proposed that would work with current staffing levels? Mr Palmer responded that, even in the current climate of increased pressure on staffing, it had been possible to generate some ring-fenced capacity including Dyball Ward at the RD&E and the new Nightingale provision. In addition, from 23 May 2022 following delivery of the modular ward at NDDH, ring-fenced capacity will be in place in Northern Devon. Mr Palmer added that for the future, given the large volume of patients on waiting lists, system level action will be needed. 2. There is currently no creche available at North Devon District Hospital. Are there any plans to introduce one? Mr Tidman responded that there is a very successful creche in operation at the RD&E and ways of running something equivalent at NDDH are being explored, with a view to bringing a proposal back to a future Board meeting. There being no further questions, the meeting was closed.	
046.22	**DATE OF NEXT MEETING**	
	The date of the next meeting was announced as taking place at 9.30am on Wednesday 27 April 2022 via MS Teams.	

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PUBLIC MEETING OF THE BOARD OF DIRECTORS AND TRUST BOARD
30 March 2022
ACTIONS SUMMARY

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

PUBLIC AGENDA					
Minute No.	**Month raised**	**Description**	**By**	**Target date**	**Remarks**
174.21 (1)	November 2021	CM to circulate an explanation to the Board on why there is an anomaly between the data presented in the Safe Staffing Report on cost per care hour, care hours per patient day & cost per patient day at the RDE.	CM	May 2022	**Update January 2022** – will include an explanation of any significant variances in data between RDE and NDHT in the next 6 monthly staffing report which is due for presentation in May 2022. **Action complete.** **Update 26.01.22** – The Board agreed to keep this action and action 174.21 (3) on the tracker until the May Board meeting. **Action ongoing.**
174.21 (3)	November 2021	Nursing and medical safe staffing reports to be merged for next six-monthly update to Board.	CM/Aha	May 2022	**Update January 2022** – Plans in place to create merged report for next presentation in May 2022. **Action complete.** **Update 26.01.22 -** as per action 174.21 (1) above. **Action ongoing.**
008.22 (1)	January 2022	Update on diagnostics briefing and business case to be presented at March public Board meeting.	JP	~~March 2022~~ ~~April 2022~~ July 2022	**Update February 2022** – Preparation of the business case is in progress. Presentation of the 2-5 year draft strategy expected for March confidential Board and then presentation at the public Board in April 2022. **Action ongoing** **Update March 2022** – Paper on agenda for discussion at Confidential Board and proposed discussion at public Board following receipt of NHSEI feedback, now anticipated in Summer 2022. **Update March 2022** – The business case would be submitted following presentation at

					the March Confidential Board meeting with feedback following the conclusion of the decision-making process expected from NHSE/I in July 2022. To be updated at the July Public Board meeting. **Action ongoing.**
008.22 (4)	January 2022	Mr Palmer to look at whether children and young people's data in IPR could be separated out.	~~JP~~ CM	~~March 2022~~ April 2022	**Update February 2022** – Under review by Executive Team. An eight week run in to break out some of the data would be needed and move of target date to April was agreed. **Action ongoing.** **Update March 2022** – Following discussion at Execs, it was agreed that this action would transfer to CM. CM provided the following update – discussions are ongoing with relevant stakeholders to agree how the Board can receive the oversight/assurances requested in relation to CYP. It is unlikely that this will be through the IPR. **Action ongoing.** **Update March 2022** – CM advised that preliminary discussions with CB had centred around establishing a Governance Committee for CYP which would report into JGC. As requested by JB, consideration to be given to bringing together physical and mental health issues for CYP in this new Committee. **Action ongoing.** **Update April 2022** – CM has confirmed that an agreement has been reached with the relevant stakeholders and the Board will receive assurances, in relation to CYP, through a 6-monthly report to Governance Committee. This report has been included within the Governance Committee's agenda cycle and will be discussed at August's committee. **Action complete & proposal to close.**
014.22	January 2022	Dr Kyle to attend Board three months after Epic Go Live in NDHT to provide a further update on O/P transformation work, in particular relating to provide an update on the inequities work at system level.	Ski	October 2022	**Next update due October 2022. Action ongoing.**

024.22	February 2022	A session to be arranged for the Board during 2022-23 to receive an update on progress on work both at Trust and system level on transforming services, what outcomes are being looked for and how pathways can be changed.	MH	September 2022	**Update to be provided at September Board. Action ongoing.**
026.22	February 2022	A number of actions as detailed in the minutes of 23.02.22 to be taken account of for future iterations of the IPR over the next three months.	JP	May 2022	**Update March 2022 –** Refinements will continue to be made over the next three month period and a formal update provided at the May Board. **Action ongoing.**
026.22	February 2022	For areas where the Trusts were significantly off target where there was a potential patient consequence, eg stroke, it would be important to have a recovery plan trajectory and challenge against it at Board meetings.	CM/Aha	April 2022	**Update March 2022** – Update due for April meeting. **Action ongoing.** **Update April 2022** – CM in discussion with JP & have agreed that recovery plan trajectory & any required improvements will be included within the IPR, when required. **Action complete & proposal to close.**
041.22(1)	March 2022	Mr Orford and Mrs Foster to discuss themes emerging from Exit Interviews for ND with a view to this information helping to inform the Our Future Hospital Programme work to address some staffing issues.	KO/HF	May 2022	**Update April 2022**- Mr Orford advised that the Programme Board for the North Devon Future Hospital has asked that reports on our ongoing staff interface re staff priorities for the re-development should include any site-relevant themes highlighted in exit interviews. Staff views will be incorporated into the development of the Outline Business Case. **Action complete and proposal to close.**
041.22(2)	March 2022	Mr Palmer to send Mr Kirby and Mr Matthews a breakdown of the balance between acute outpatients and community follow-up outpatient patients to show the balance between new and follow-up appointments in more detail.	JP	April 2022	**Update April 2022** – Mr Palmer will provide an update at the April Board meeting. **Action complete.**

Signed:

Shan Morgan
Chair

Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	8, Public Board meeting		**Date:** 27 April 2022	
Title:	Patient story: first orthopaedic patients of the NHS Nightingale Hospital Exeter			
Prepared by:	Sarah Delbridge, Engagement Manager			
Presented by:	Carolyn Mills, Chief Nursing Officer			
Responsible Executive:	Carolyn Mills, Chief Nursing Officer			
Summary:	Patient stories reveal a great deal about the quality of our service provision, the opportunities we have for learning and the effectiveness of systems and processes to manage, improve and assure service quality. The purpose of presenting a patient story to Board members is to: • Set a patient focussed context to the meeting, bringing patient experience to life and making patient's stories accessible to a wider audience • Support Board members to triangulate patient experience with reported data and information • Enable Board members to reflect on the impact of the lived experience for these patient(s) and its relevance to the strategic objectives of the Board.			
Actions required:	The Board of Directors is asked to reflect on the implications of this story for patients and to reflect on its relevance to the strategic objectives of the Board. Link to status below and set out clearly the expectations of the Board when considering the paper.			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
			X	
History:	In this story we hear about the experience of two patients who have had hip replacement surgery at the NHS Nightingale Hospital Exeter - South West Ambulatory Orthopaedic Centre. One of the priorities outlined in NHS England's 2022/23 operational planning guidance is to deliver significantly more elective care to tackle the elective backlog and reduce long waits. Orthopaedics remains one of the biggest challenges for surgical recovery – not just across Northern and Eastern services, but also across Devon. The Nightingale was initially part of the national response to the first wave of the pandemic, providing emergency in-patient care for nearly 250 patients with COVID-19 from across Devon, Somerset and Dorset. After being decommissioned as a COVID-19 hospital in March 2021, the Nightingale was purchased by the Royal Devon University Healthcare NHS Foundation Trust on behalf of NHS organisations across Devon and the South West region with the aim of it being repurposed towards specialties that would have a major impact on post COVID recovery. Following a clinically-led redesign programme, the Nightingale is now able to			

	offer a range of orthopaedic, ophthalmology, diagnostic and rheumatology services to local people, helping to further reduce waiting times. The first services to become operational on the site last year were diagnostics, followed by ophthalmology, rheumatology and then orthopaedics most recently on the 14.3.2022. The diagnostics capability on site (both MRI and CT) has already helped to stabilise our waiting lists; and ophthalmology service development has already had a significant impact on outpatient waiting times with a "surgicube" to follow for high volume cataract surgery. If the recent submission of the Community Diagnostic Centre business case made to NHSEI is signed off in July 2022, then we will be able to commit to a greatly improved diagnostics recovery trajectory over the next 18 months. In terms of orthopaedics the two theatres in the Nightingale have already successfully operated on more than 60 people, with more than half of those people having hip or knee surgey as a day case; and all of them having a length of stay less than 24 hours. This initial period of operating shows us as perhaps the most efficient day case unit in the UK and it offers real insight into how we might improve our approach to patient management on the Wonford and other Hospital sites across Devon. The two patient stories explore how our first orthopaedic patients have experienced the orthopaedic service in the Nightingale, including positive views on the facilities, staff, after-care and travel. The first patient, Paul, lives in Fremington in North Devon and was the first patient to have a hip replacement at the Nightingale. He went home on the same day as his surgery. Deb, who is Paul's wife, also features in the interview. Deb drove Paul to and from the Nightingale and has helped with his recovery at home. The second patient, Pat, lives in Teignmouth, South Devon. He is also one of the first patients to have a hip replacement at the Nightingale. Due to having his operation towards the end of the day, Pat stayed overnight at the Nightingale and went home the following morning, collected by his wife Gaynor. The Nightingale will continue to provide significant support to our elective recovery programme over the next few years; and it has much to teach us about productivity, patient management, System working and collaboration – and could point the way to how best to develop and manage future Protected Elective capacity on a Devon or regional footprint.
Link to strategy/ Assurance framework:=	The issues discussed are key to the Trust achieving its strategic objectives

Monitoring Information

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

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

Agenda item:	9.1		Date: 27 April 2022	
Title:	Integrated Performance Report – incorporating COVID-19 related performance and spanning both Northern and Eastern Services within Royal Devon University Healthcare NHS Foundation Trust			
Prepared by:	Hannah Foster, Chief People Officer Adrian Harris, Chief Medical Officer Angela Hibbard, Chief Finance Officer Carolyn Mills, Chief Nursing Officer John Palmer, Chief Operating Officer Chris Tidman, Deputy Chief Executive			
Presented by:	Adrian Harris, Chief Medical Officer			
Responsible Executive:	Hannah Foster, Chief People Officer Adrian Harris, Chief Medical Officer Angela Hibbard, Chief Finance Officer Carolyn Mills, Chief Nursing Officer John Palmer, Chief Operating Officer Chris Tidman, Deputy Chief Executive			
Summary:	To advise the Board of the Trust's performance against key performance standards and targets; and progress on the implementation of the Trust Strategy and key supporting projects.			
Actions required:	The Board is asked to receive the Performance Report and note the current risks and the proposed action plans to mitigate the risks against performance delivery.			
Status (*):	Decision	Approval	Discussion	Information
				X
History:	This is a standing agenda item at each meeting of the Board of Directors.			
Link to strategy/ Assurance framework:	This paper details the Trust's performance in respect of key performance standards and targets. Achievement of these performance standards and targets is a key objective within the Trust's Strategy.			

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

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Overview – Executive Themes and Actions to Raise at Board

The IPR for March illustrates the pressures experienced across both sites as a consequence of the most significant COVID surge, from both a capacity and staffing availability point of view, since the start of the Pandemic in March 2020. This is coupled with an increase in non-COVID related non-elective activity, which has risen to a level greater than that seen in the pre-pandemic year. Concomitantly the Trust has, as far as possible, continued its push for elective recovery, increasing activity levels across a range of elective inpatient, daycase and diagnostic specialities.

Flow and operational performance
In March both sites saw significant increases in the number of COVID positive inpatients, far outweighing the numbers seen at the peak of previous COVID waves. This challenge was more acute at the Northern Devon site due to the overall inpatient beds capacity, moving from 8 COVID inpatients on 2nd March, to 110 on 28th March; In parallel, however, there was also a significant increase in COVID inpatients in the Eastern site across March 2022, starting at 50 on 1st March and peaking at 160 on 4th April 2022.

Despite this challenging position, an improvement in the overall levels of activity has been achieved across all points of delivery, with the exception of elective inpatient activity at North Devon (due to the requirement to stand down orthopaedic and other surgical activity to accommodate the significant COVID escalation position).

This position has been supported by the positive impacts of;
• the Nightingale Hospital
• the re-designation of Dyball ward for Orthopaedics at the RD&E

In March all Trusts across Devon have seen a significant spike in COVID inpatients, surpassing all previous waves. The high rate of transmission has exacerbated the position with an increase in nosocomial infection, contact patients and therefore beds which cannot be used due to infection risk impacting on flow through the hospitals.

The increasing pressures in urgent care have also contributed towards a further escalated bed state and this alongside the associated staffing challenges and staff absence during the peak of the COVID wave in March, have all had an adverse impact on flow and operational performance.

Internal Critical Incidents have been declared across both sites during March and an increase in elective cancellations to support the bed positions have been seen. Both sites experienced an increase in 12 hour trolley breaches and unprecedented levels of ambulance handover delays for the two sites which have previously performed at the highest level in this domain. Significant investment has already been approved to support the urgent care pathway at both sites and progress is being made on recruitment which will help to manage the demand we are facing in the acute Trust. In the East, the number of patients on the 'Green to Go' list has reduced again to 83 in March, from 93 in February and from 105 in January. In the North, the Trust saw a peak of 78 patients waiting and ready for discharge on the 30th and 31st March, which represents a significant proportion of the overall available bed capacity.

Elective referrals have now been consistently higher than 2019/20 at North Devon for 5 months and as the site has not yet returned to full elective capacity this has had an impact on the increased incomplete pathways position. The number of patients waiting 104 weeks has reduced but there has been a further deterioration for over 78 and 52 weeks. Referrals to RD&E have increased significantly in March by 1522 to 10330, well above the position seen in March 19/20. As such, this significant increase has meant only a minor reduction in the Incomplete pathways position, even with additional capacity coming on stream. RD&E have seen reduction in 104+ waiters largely attributed towards the return of the Dyball Orthopaedic ward and treatment of orthopaedic patients but an increase in 78 and 52 week waits. Both sites are managing patients on the list through the waiting well process.

Overview – Executive Themes and Actions to Raise at Board

Cancer performance in RD&E saw a reduction in 2WW position compared to February but achieved the 28 Day Faster Diagnosis target albeit a slight reduction on February's position. A significant improvement in 62 Day performance has been seen in March increasing to 75% compared to 61% in February. Cancer performance in the North saw a slight improvement in 2WW position compared to February but a slight reduction in the 28 Day Faster Diagnosis target achieving 59.6% against the target of 75%. Several tumour sites are still struggling to achieve the 28 day faster diagnosis target and actions to support these services will be monitored as part of the Trusts Cancer Recovery Action Plan.

Diagnostics has held a fairly steady position in RD&E with increases in activity seen across a wide range of modalities but with ongoing challenges in other areas exacerbated by the peak of COVID in March. Significant increases in activity have been seen at NDHT, particularly in CT and MRI, overall performance has stabilised in relation to the 6 week target, albeit it below the H2 Trajectory.

Quality
Overall the quality data does not show a significant shift in trend as a result of the challenging operational position. However, there are a couple of areas to note such as performance against the stroke indicators as a result of the bed pressures impacting on the time taken to admit to the stroke unit for both RD&E and NDHT and overall time spent on the stroke unit; this has been impacted by the need to move COVID positive stroke patients away from the Stroke unit into COVID wards. The position regarding RD&E SHMI has deteriorated; however initial analysis has shown this to be down to a coding issue, which is currently being reviewed and actions identified. The SHMI position in NDHT has improved and remains in line with the "as expected range". There have been two incidents at NDHT and one at RD&E of medication incidents and one serious incident reported at NDSHT and three at RD&E. All are under investigations and will be reported through the normal governance routes. There were no Never Events recorded in March.

Workforce
The operational pressure and current COVID situation is impacting significantly on workforce. The non COVID related sickness has continued to show an increase in the IPR and during March the COVID related sickness has increased beyond levels seen previously. This has put incredible stress on staffing levels with continuous review needed of safe staffing levels and support requested from non-clinical staff to support wards with supporting work such as answering phones, housekeeping duties and supporting patients with food and drink. Sickness absence rates have started to fall within April as the peak of the most recent wave of COVID has started to retreat. The focus remains on staff health and wellbeing at work is continuing with teams to identify further support needed. Turnover of staff remains at high levels an has increased across both sites on a rolling 12 month basis.

Finance
RD&E has ended the financial year with a surplus of £6.2m, £14.8m better than budget. RD&E had forecast a £6.3m deficit in month 11 however additional unexpected income of £12.5m was received in month 12 relating to ERF funding largely due to improved data validation. The remaining benefit was due to the underspend already reported in the first half of the year. For NDHT the Board approved a deficit plan for 21/22 of £2.9m. The NDHT year end position resulted in a deficit of £1.4m which is £1.2m favourable to the plan also driven by additional ERF income.

The capital programme for both Trusts ended the year in line with the revised forecast demonstrating delivery of the BAU capital programme and additional schemes funded nationally in year. There was a significant level of capital spend in the last quarter due to the late receipt of national funding and teams are thanked for the tremendous work in ensuring all capital resources were utilised to best value.

Northern Services Operational Performance Dashboard

Domain	Measure/metric	Definition	Last month Feb-22	This month Mar-22	Vs prior month	vs Phase 4 planned	vs National target
ELECTIVE ACTIVITY	Referrals	*Vs baseline (2019/20)*	111.7%	**150.9%**	35.1%	N/A	N/A
	Outpatient activity (New)	*Vs baseline (2019/20)*	103.8%	**144.8%**	39.5%	32.9%	75%
	Outpatient activity (FU)	*Vs baseline (2019/20)*	88.9%	**107.9%**	21.4%	17.6%	75%
	Outpatient virtual (% of total)	*% of total OP activity*	30.40%	**28.5%**	-6.3%	-10.0%	25%
	Elective inpatient activity	*Vs baseline (2019/20)*	66.70%	**59.9%**	-10.19%	43.4%	75%
	Elective daycase activity	*Vs baseline (2019/20)*	90.60%	**103.8%**	14.57%	15.3%	75%
	RTT 18 week performance	*Patients seen <18 weeks vs total incomplete pathways*	58.2%	**57.3%**	-0.9%		92%
	Incomplete pathways	*Total count*	18093	**19995**	10.5%		
	RTT 52+ weeks waited	*Total count*	1367	**1655**	21.1%		
CANCER	2 week referrals	*Performance*	75.14%	**76.17%**	1.0%		
	28 day faster diagnosis standard	*Performance*	60.6%	**59.6%**	-1.0%		75%
	Urgent GP referral 62 day	*Performance*	50.0%	**62.7%**	12.7%		85%

Domain	Measure/metric	Definition	Last month Feb-22	This month Mar-22	Vs prior month	vs Phase 4 planned	vs National target
URGENT CARE	Non-elective Inpatient activity +1LOS	*Vs baseline (2019/20)*	87.7%	**101.9%**	16.19%	11.0%	
	A&E attendances	*Total count*	3643	**4279**	17.5%	-1.5%	
	4 hour wait performance	*Patients seen <4 hours vs total attendances*	71.8%	**71.5%**	-0.3%		95%
	Ambulance handover delays >30 minutes	*Total count*	155	**186**	20.0%		
	Average daily number of patients waiting and ready for discharge	*Total count*	14.38	**18.56**	29.1%		
	Average daily number of patients delayed as awaiting community assessment / referral / bed	*Total count*	12	**8.4**	-30.0%		
	Average daily number of patients delayed as awaiting resource / assessment to start care at home	*Total count*	17	**8.2**	-51.8%		
	Average daily number of patients delayed as awaiting residential / nursing home bed	*Total count*	6.3	**1.4**	-77.8%		
DIAGNOSTICS	6 week wait referral to diagnostic test	*% of diagnostic tests completed in 6 weeks*	44.0%	**44.1%**	0.1%	N/A	99%
	MRI activity	*Total count*	610	**885**	45.1%	48.7%	
	CT activity	*Total count*	1319	**1685**	27.7%	-0.5%	
	Medical Endoscopy activity	*Total count*	303	**346**	14.2%	-30.0%	
	Non-obstetric ultrasound activity	*Total count*	1349	**1512**	12.1%	13.6%	
	Echocardiography activity	*Total count*	323	**341**	5.6%	-25.2%	

Positive value

Negative value < 5%

Negative value > 5%

Eastern Services Executive Summary

Eastern Services Operational Performance Dashboard

Domain	Measure/Metric	Definition	Last Month Feb-22	This Month Mar-22	vs Prior month	vs Phase 4 planned	vs National target
ELECTIVE ACTIVITY	Referrals	vs baseline (2019/20)	93.1%	**106.7%**	13.6%		
	Outpatient Activity (NEW)	vs baseline (2019/20)	79.3%	**87.5%**	8.2%	63%	75%
	Outpatient Activity (FOLLOW-UP)	vs baseline (2019/20)	128.4%	**136.8%**	8.3%	128%	75%
	Outpatient Virtual (% of total)	% of OP activity	30.5%	**30.1%**	-0.4%		25%
	Elective Inpatient Activity	vs baseline (2019/20)	55.1%	**68.8%**	13.7%	79%	75%
	Elective Daycase Activity	vs baseline (2019/20)	87.9%	**90.0%**	2.1%	79%	75%
	RTT 18 Week performance	Patients seen <18 weeks vs total incomplete pathways	49.6%	**47.0%**	-2.6%		92%
	Incomplete Pathways	Total count	63653	**63323**	-0.5%		
	RTT 52 Weeks waited	Total count	5802	**6173**	6.4%		
CANCER	2 week referrals	Total count	2271	2542	12%		
	28 day faster diagnosis standard	Total count	88.8%	76.5%	-12.3%		75%
	Urgent GP referral 62 day	Total count	61.2%	75.1%	13.9%		85%

Domain	Measure/Metric	Definition	Last Month Feb-22	This Month Mar-22	vs Prior month	vs Phase 4 planned	vs National target
URGENT CARE	Non-elective Inpatient activity +1 LOS	Vs baseline (2019/20)	100.1%	**103.6%**	3.6%	93.1%	
	A&E attendances	Total count	9675	**10898**	12.6%	94.7%	
	4 hour wait performance	Patients seen <4hrs vs total attendances	67.2%	**65.7%**	-1.5%		95%
	Ambulance handover delays >30 mins	Total count	132	**152**	13.2%		
	Daily Average Green (Medically Fit) Transfer List	Total count	93	**83**	-12.0%		
	Volume of Average Daily Completed Transfers	Total count	11.5	**12.9**	10.9%		
	Average Time to Transfer (Medically Fit to Discharge) – All Transfers	Total count	5.2	**4.3**	-20.9%		
	Average Weekly Hours Requiring Personal Care Backfill	Total count	1225	**1171**	-4.4%		
	UCR: Referrals	Total count	673	**718**	6.3%		
	UCR: Length of Stay on Caseload	Total count	15.0	**14.0**	-6.7%		
DIAGNOSTICS	6 week wait referral to diagnostic test	% of diagnostic tests completed in 6 weeks	62.1%	60.5%	-1.6%		99%
	MRI activity	Total count	1789	1964	9.8%	90.0%	
	CT activity	Total count	3779	3992	5.6%	100.7%	
	Medical Endoscopy activity	Total count	932	957	2.7%	107.0%	
	Non-obstetric ultrasound activity	Total count	2836	3289	16.0%	117.1%	
	Echocardiography activity	Total count	661	827	25.1%	135.6%	

Positive value

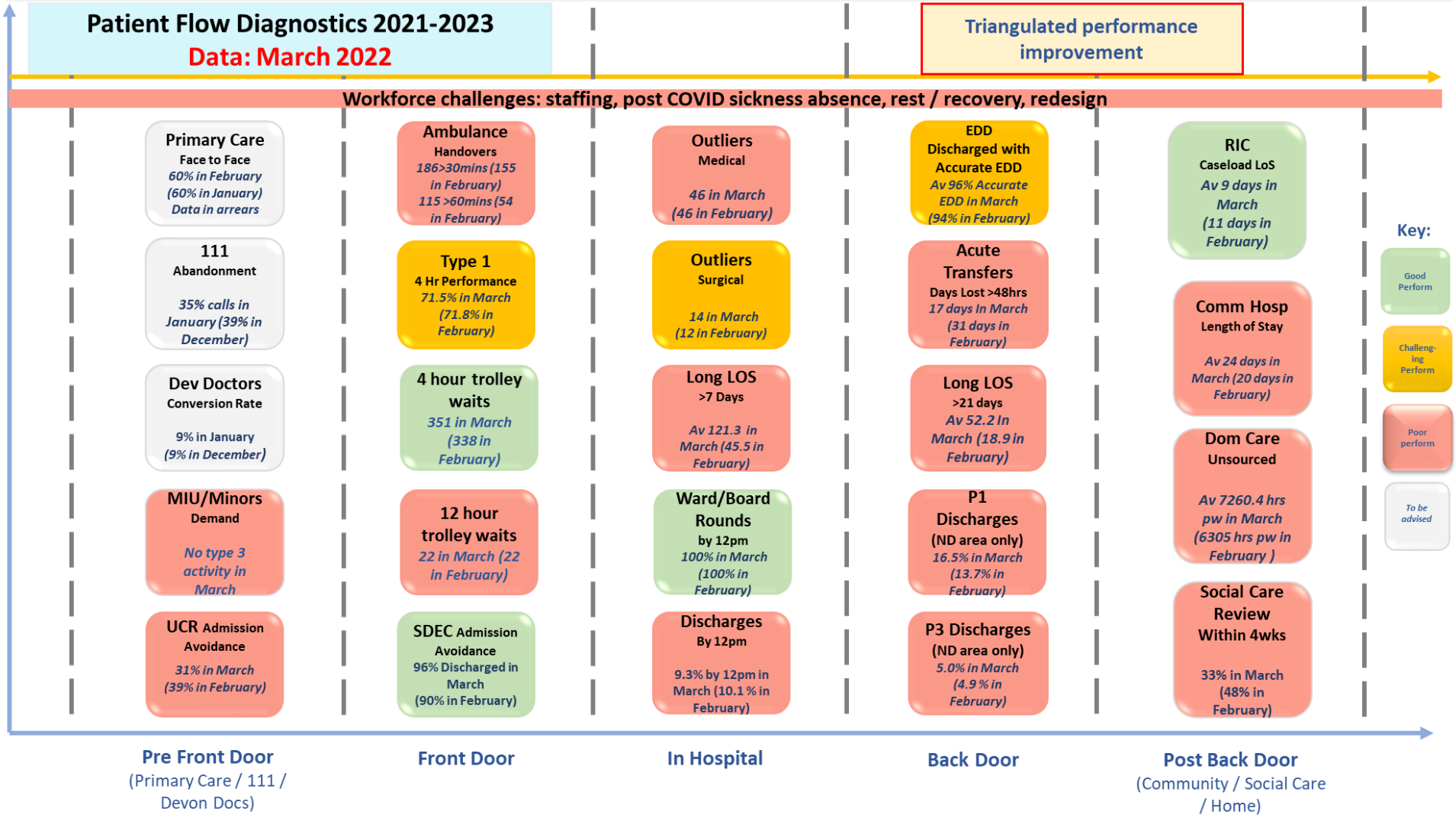
Negative value < 5%

Negative value > 5%

Due to the significance of the impact of the start of the COVID pandemic in March 2020 upon both elective and non elective activity levels, March 2020 activity has been recalculated to be an average of the period from April 2019 to February 2020, when used as a comparator to March 2022. This is also reflected in the Eastern activity charts within this report.

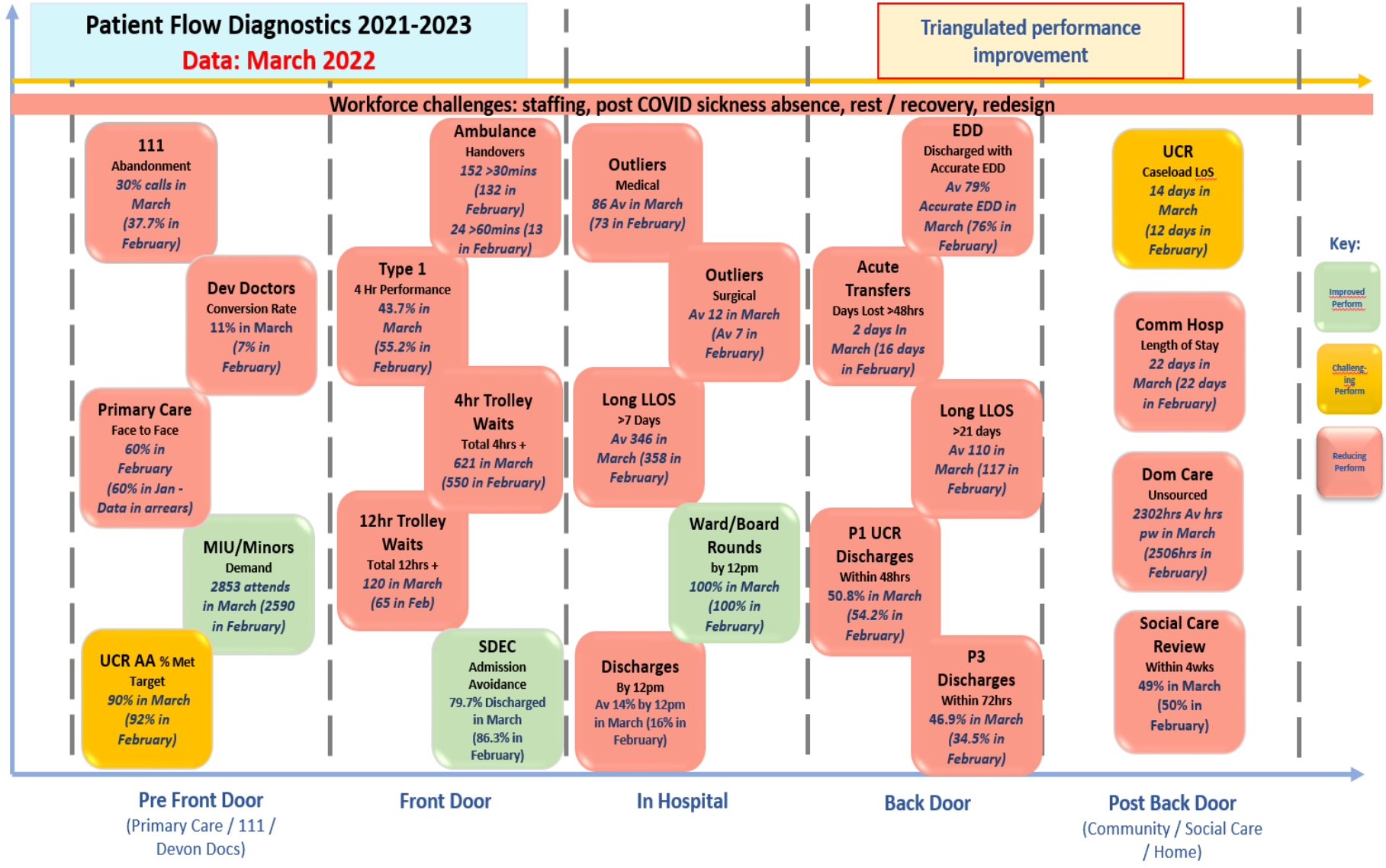
Executive Summary

Northern Services Patient Flow Diagnostic

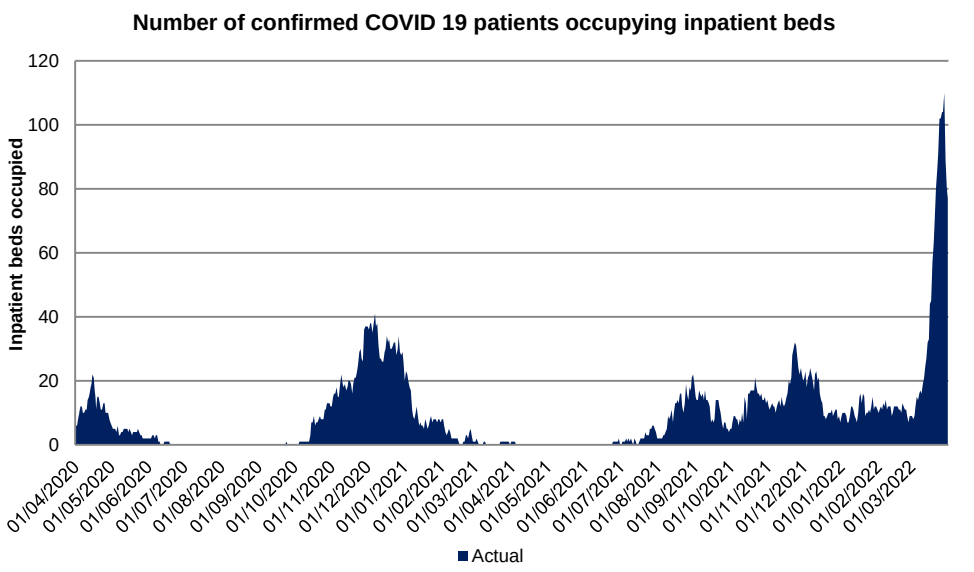


Eastern Services Executive Summary

Eastern Services Patient Flow Diagnostic



Northern Services COVID-19 Inpatient Activity – *Overview of inpatient activity in relation to caring for patients with COVID-19*



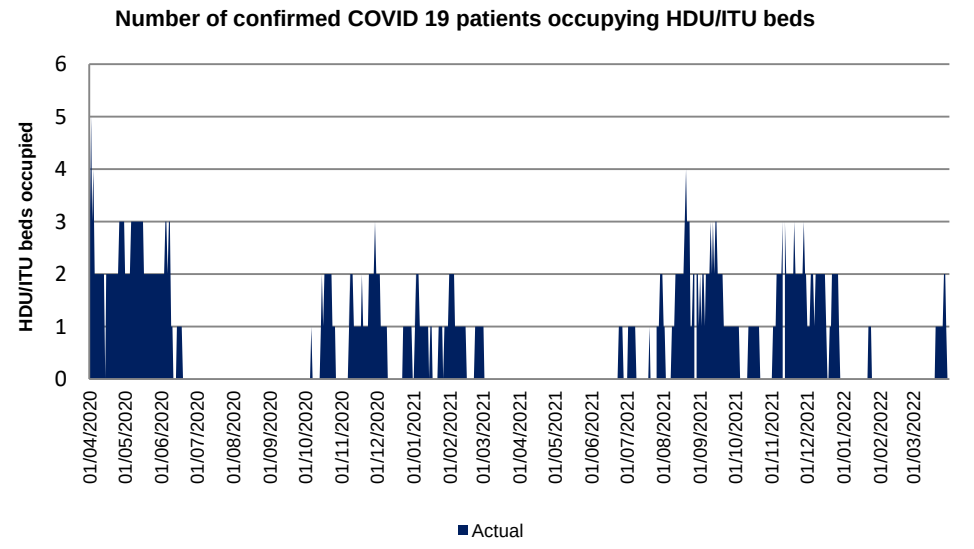
Inpatients

- In March the Trust saw COVID inpatient numbers increase dramatically. The largest inpatient numbers of 110 were seen on the 28th March compared to the lowest seen, a total of 8 patients on the 2nd March. Following the surge in COVID positive patients the Trust entered critical incident twice in March. 4 inpatient wards were used to cohort COVID positive patients and COVID contacts resulting in the need to reduce elective surgery.

Update on the nMABs Service (Neutralising Monoclonal Antibodies).

- To date the Trust has received 586 referrals, carried out 83 intravenous treatments and 68 oral medication treatment. The rest were triaged as either not eligible for treatment as didn't meet strict criteria or did not want to receive the treatment.

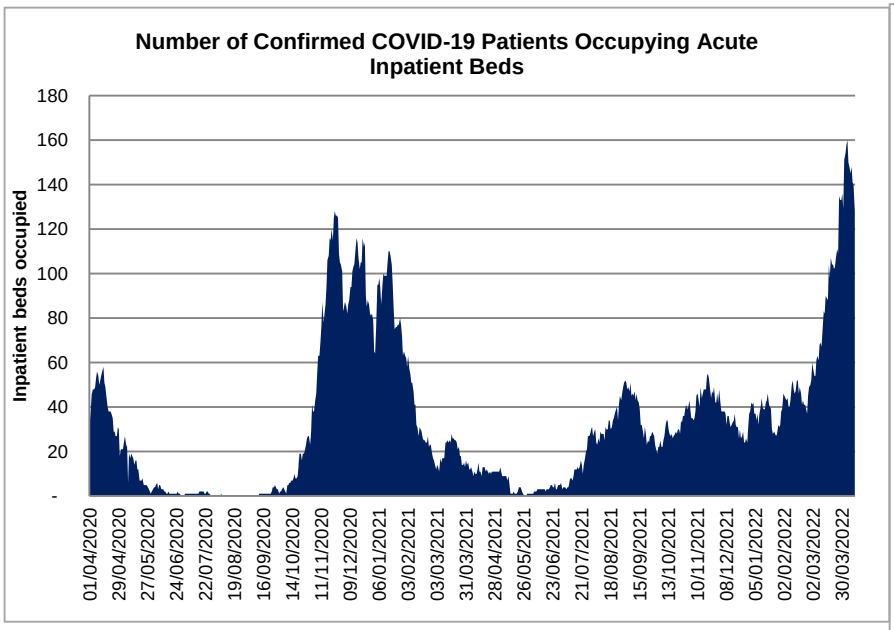
Northern Services Critical Care – *Overview of critical care activity in relation to caring for patients with COVID-19*

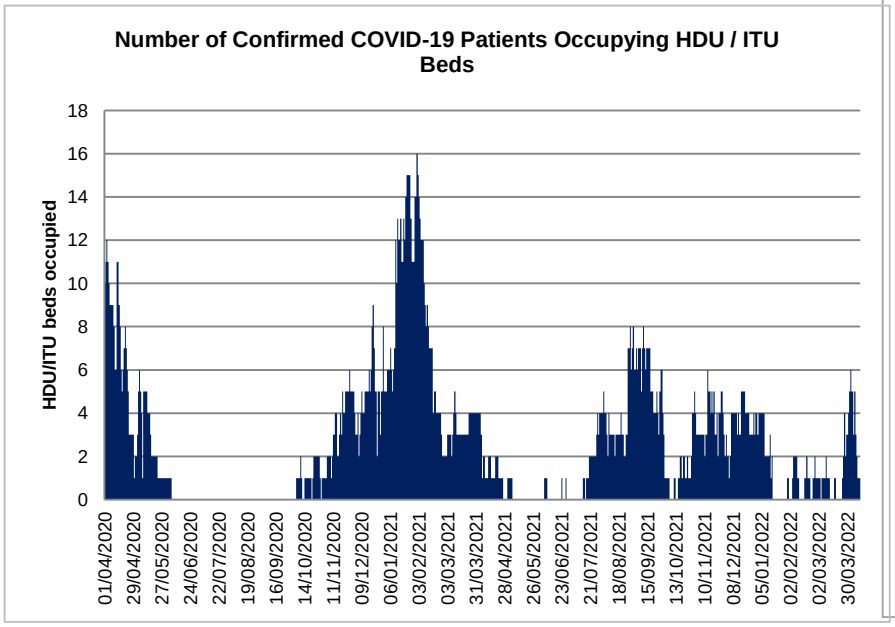


COVID patients in Critical Care beds

Following the vast increase in COVID positive patients seen in March, patients utilised ICU beds for 9 days, including two patients being treated. Although there was an increase in positive patients in ICU, COVID was not the reason for admission or critical care admission for these patients.

Eastern Services COVID-19 Inpatient Activity – *Overview of inpatient activity in relation to caring for patients with COVID-19*





Inpatients

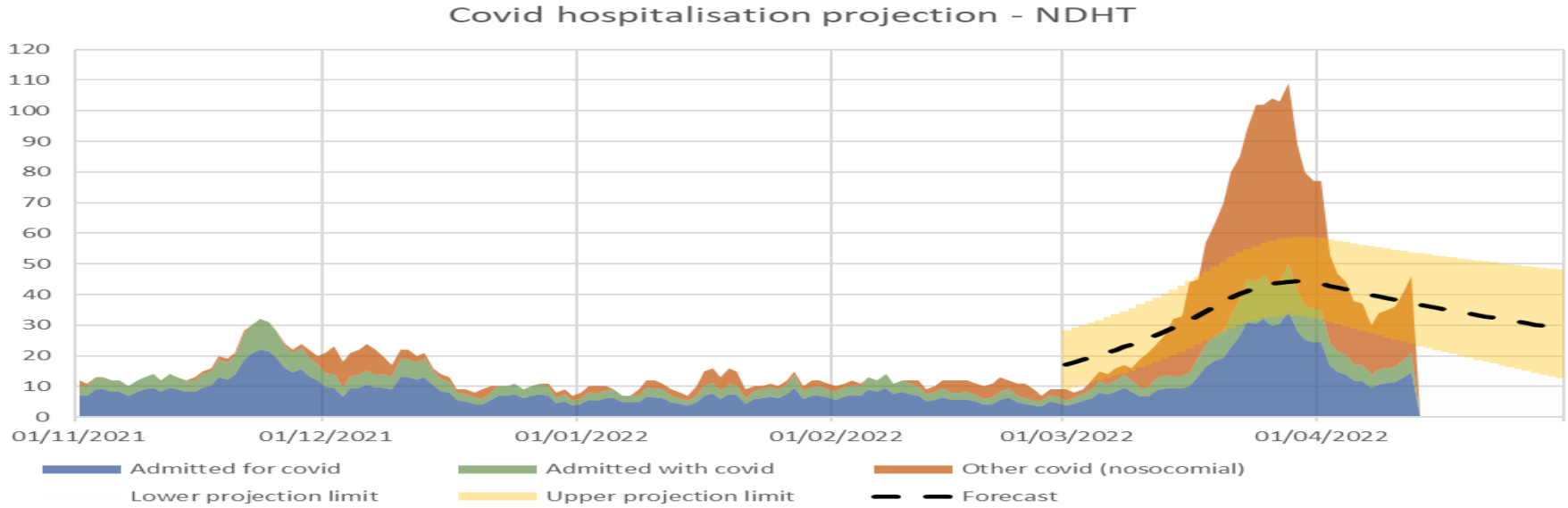
The Trust's Eastern Services have seen numbers increase to the highest level of the pandemic, peaking at 160 on 4th April 2022. Dedicated COVID bed capacity was increased to accommodate this with the conversion of 6 medical and surgical acute and community wards. On the same day COVID contacts peaked at 89 and closed and empty beds were 28.

Very tight management of COVID capacity and closed and empty beds has been required to mitigate adverse impacts on flow.

It is pleasing to note that COVID inpatient numbers are now decreasing, at 104 on 12th April. COVID contacts have reduced to 48 and closed and empty beds reduced to 12. The number of dedicated COVID wards will gradually be reduced as volumes of COVID inpatients allow.

COVID Patients in Critical Care Beds

There has been an increase in patients in critical care beds in the last month. This is a mixture of patients who have COVID and require higher acuity care, and patients who require critical care but have incidental COVID. ITU has 5 dedicated COVID beds available and for a brief time reserve escalated COVID capacity was available through conversion of a theatre. This reserve was not used and is now stood down.

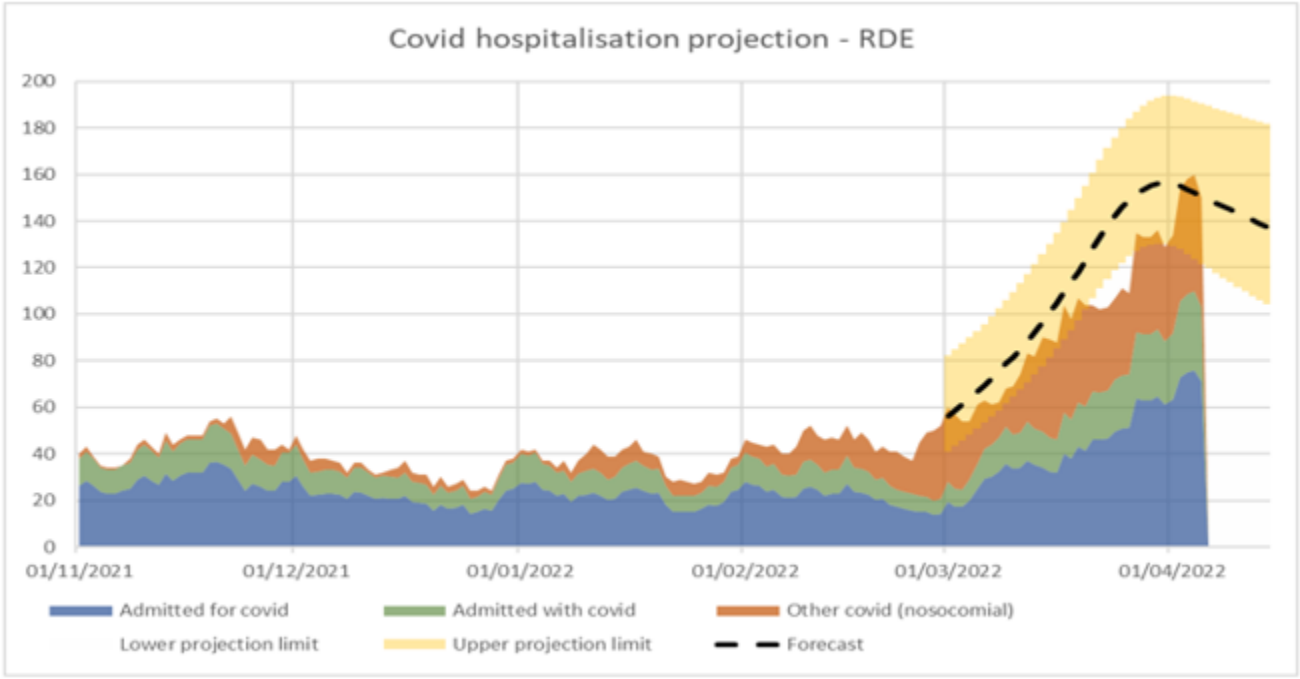


Continuation of COVID Wave 3

- Rates per 100,000 on the 14th April = 1090.
- Rates in all age groups are now decreasing.
- COVID inpatient numbers are now tracking above the central scenario.
- In March the Trust had 8 wards in active outbreak.
- New modelling suggests that by mid to late April the Trust could expect to see between 30 and 65 COVID inpatients.

- COVID patients are monitored daily through the daily forum meeting.
- Inpatient numbers are continuing to fluctuate and remain high, following the relaxing of COVID restrictions in the community and a new variant of COVID-19.
- 2899 inpatient swabs were performed in March.
- The number of staff tests increased in March to 2762, however 690 of these staff members tested positive, the largest figure seen since the start of the pandemic.
- Visiting was stopped in March due to the increase in COVID numbers.
- The high numbers of COVID patients led to an increase in delayed discharge of patients on pathways 2 and 3.
- In addition to the elective orthopaedic ward being repurposed to support urgent care demand and high numbers of COVID patients, DSU has also been used for inpatients.

Eastern Services COVID-19 Inpatient Activity – *Overview of inpatient activity in relation to caring for patients with COVID-19*



The reduction in inpatients with COVID and staff absence due to COVID reflects the CCG modelling above.

The rates per 100,000 were 696.9 in East Devon and 664.5 in Exeter on 8th April 2022. It is unclear whether the change in access to lateral flow devices for the general public will have affected these figures.

Eastern Services COVID-19 Admission Avoidance Activity

Eastern Services COVID-19 Admission Avoidance Activity

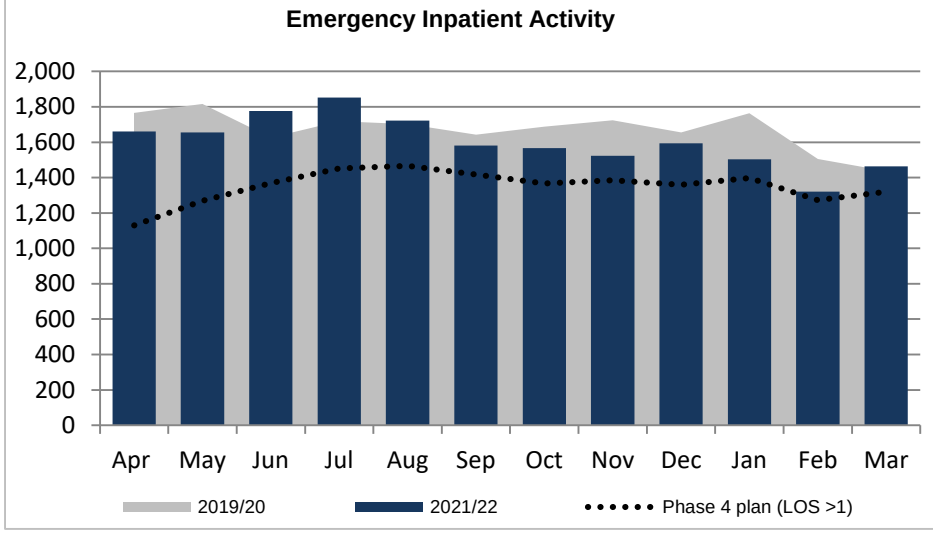
The COVID Medicines Delivery Unit was established on 20/12/21 with less than 7 days notice

- Run by team of Physicians Associates with support from Consultants, Pharmacy, Infection Prevention and Control (IP&C), Specialist Nurses, EPR and E-referral team

At the end of March:

- 1,018 patients referred
- All patients receive phone call as per national guidance (total calls have exceeded 3,000)
- 735 not appropriate (72%)
- Remainder prescribed Molnupiravir (7.5%), Paxlovid (0.5%), Sotrovimab (20%)
- **Approximately 60 admissions prevented with a 400 bed day saving (likely underestimate)**

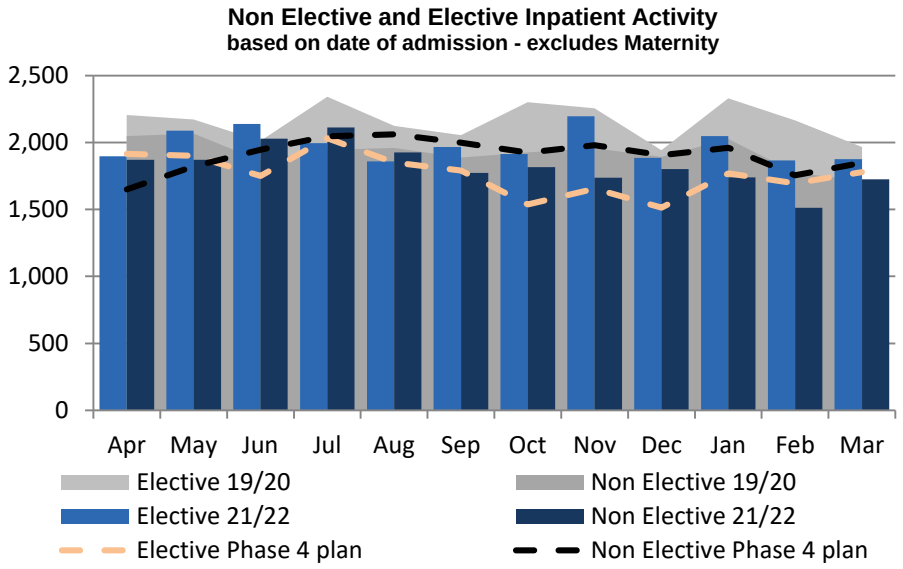
Northern Services Emergency Inpatient Activity



Emergency inpatient activity :
Emergency activity at NDDH remains extremely challenging. In March the Trust saw an increase in attendances. Delays in discharges where care packages and residential/nursing homes are required continue to adversely impacting patient flow, at the end of March 78 beds were being utilised by green to go patients.

- 1725 patients were admitted via ED in March.
- The Emergency Department has been impacted by patient flow with high green to go numbers causing a high number of beds being utilised by patients not requiring a hospital bed. This is then being impacted further due to staff either testing positive or unwell isolating due to COVID symptoms.
- Collaborative system working is ongoing to address pressures including establishment of a Winter Taskforce with membership from system partners in both Health and Social care.

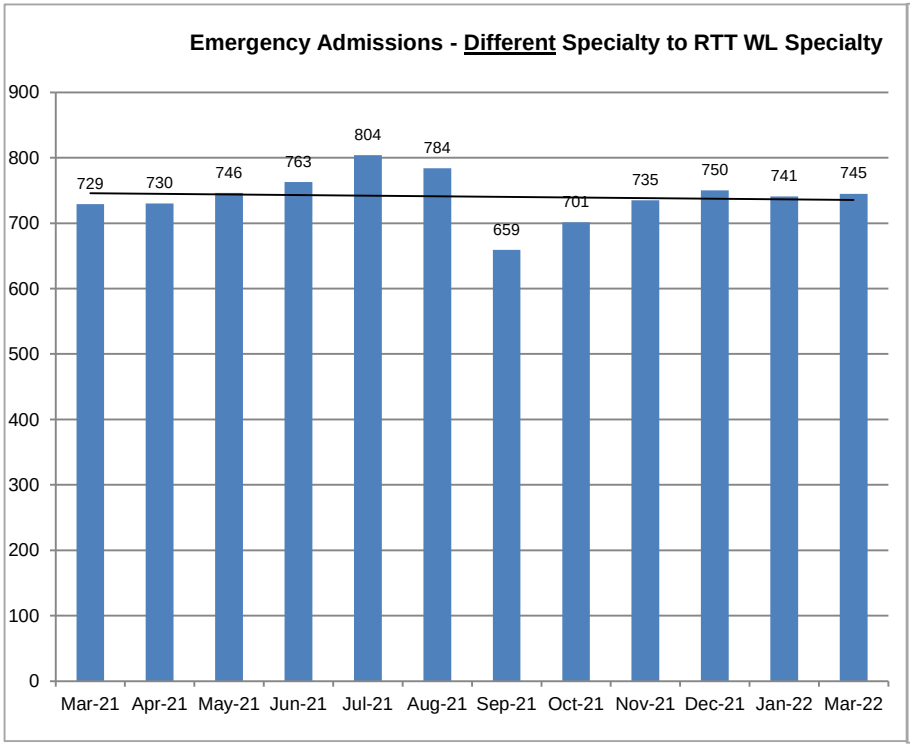
Northern Services Overall Inpatient Activity

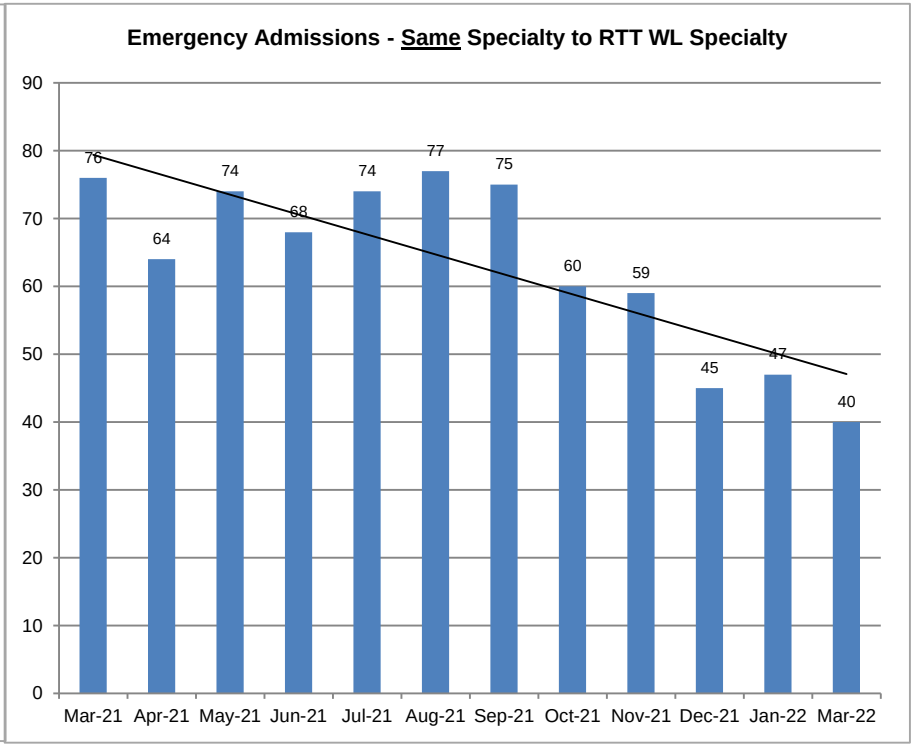


Inpatient activity :

- The percentage split between emergency and elective care in March was 52% elective and 48% emergency.
- Of the 52% elective, 1646 of these were day cases.
- Elective activity remains above the Phase 4 Plan.

Northern Services Emergency Admissions – *key metrics relating to activity & performance in urgent & emergency care services*

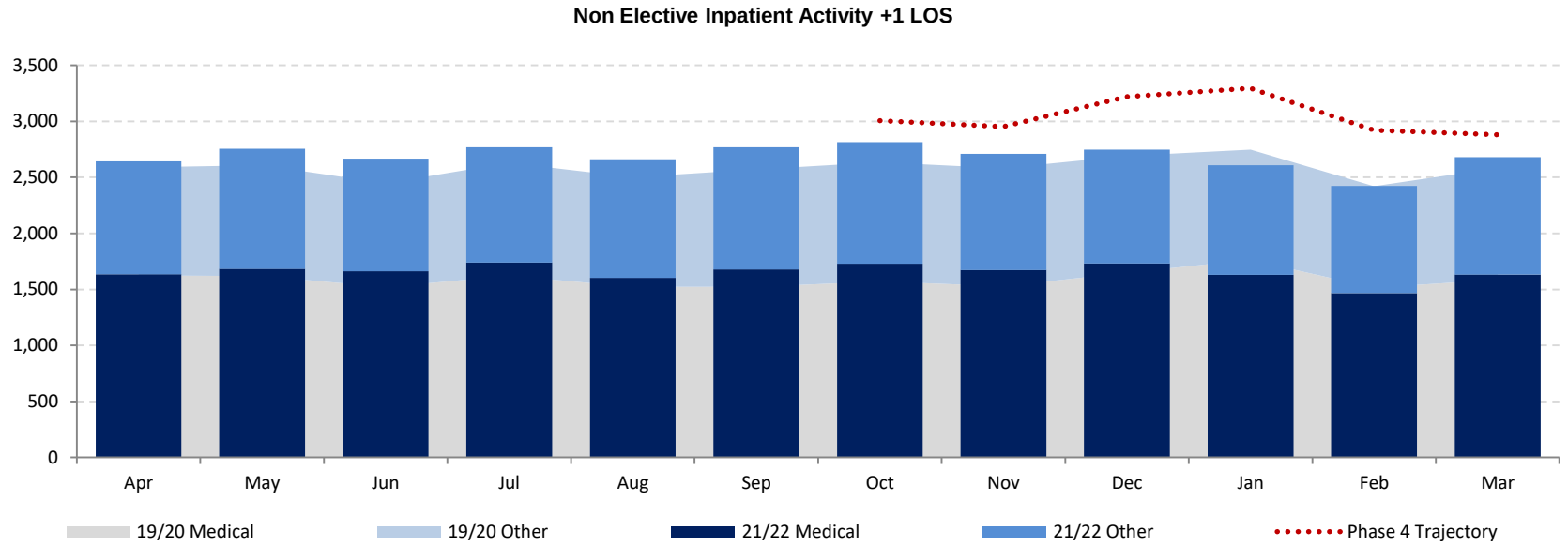




In March the number of emergency admissions of patients on a different speciality waiting list declined significantly. A slight increase was seen on patients being admitted via ED on the same speciality waiting list. General Surgery, Urology and Gynaecology saw the highest numbers in Emergency Admissions on the same specialty pathway.

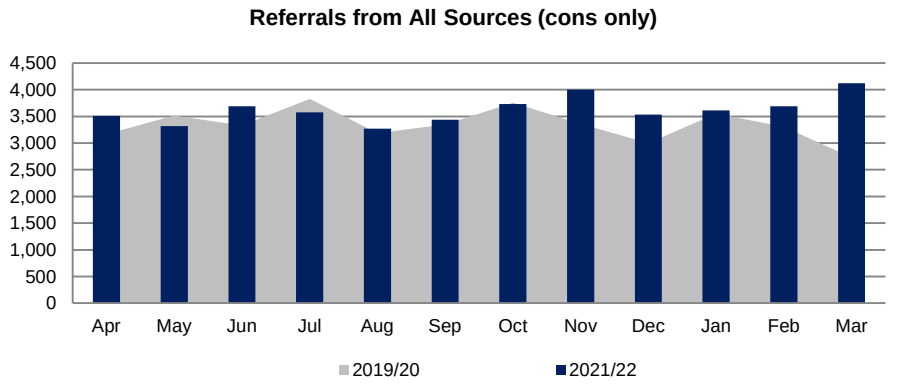
Review of patient pathways and access into services continue to be undertaken by clinical teams to identify any areas for service transformation or development.

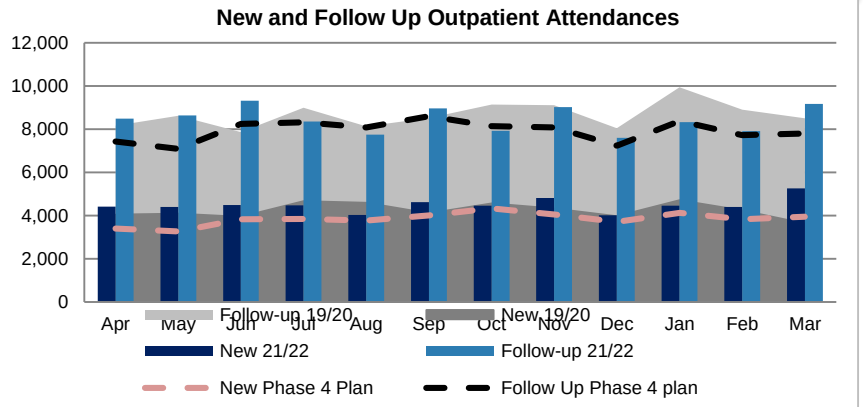
Eastern Services Non-Elective Activity

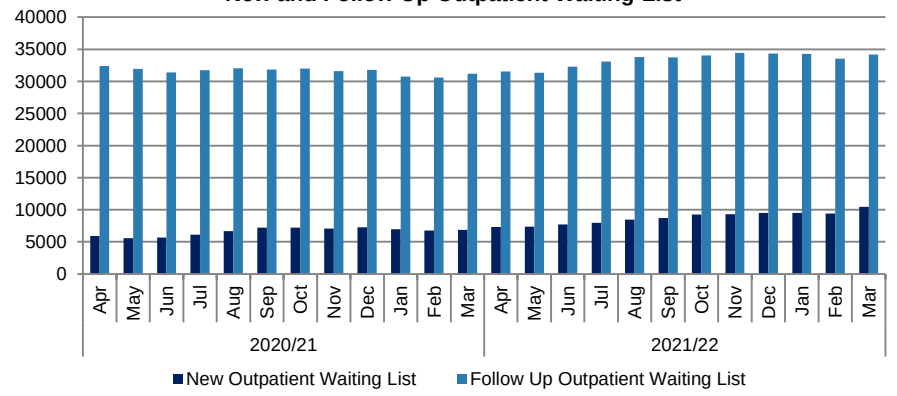


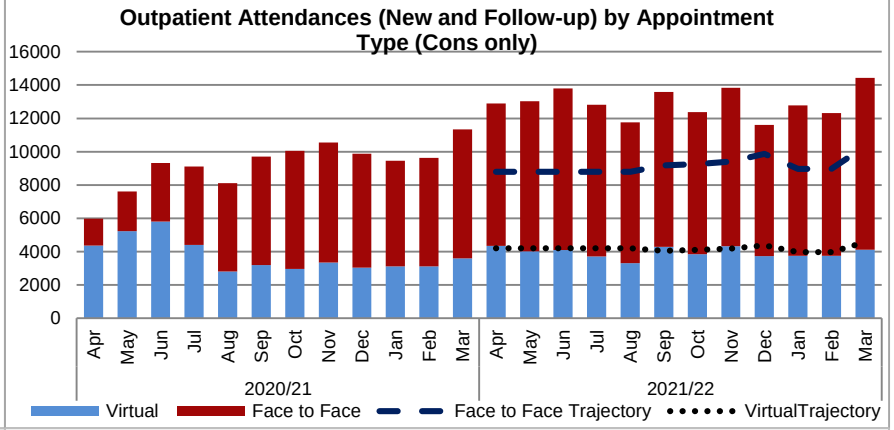
Non elective admissions with a stay greater than 1 day increased between February and March as a proportion of 2019/20 activity, with activity in March 2022 being equivalent to 103.6% of average April 2019 – February 2020 activity levels, whereas in February activity was 100.1% of February 2020. Non elective pressures have continued across the hospital with 106 medical outliers at the time of writing, and an average of 91 medically fit for discharge patients for the most recent week.

Northern Services Elective Activity - Referrals and Outpatients

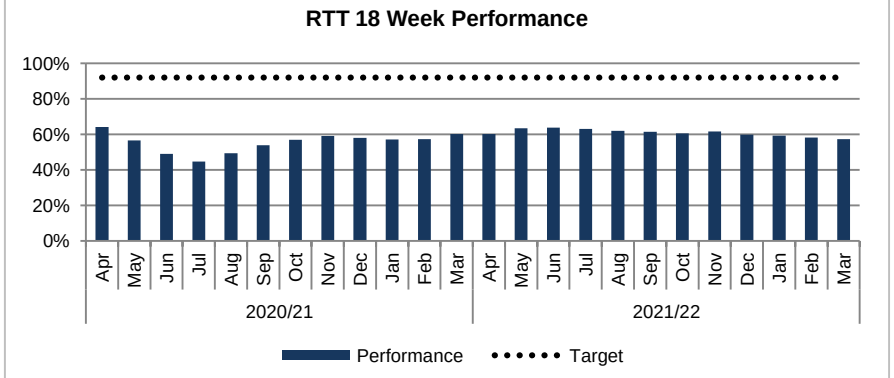




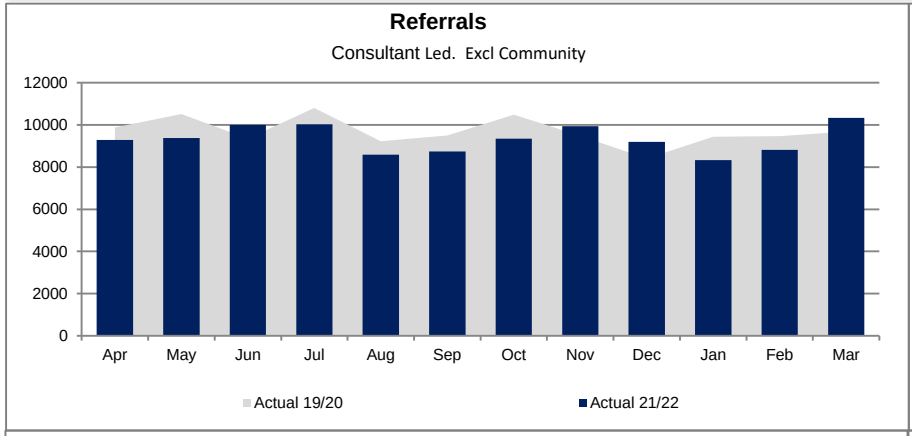


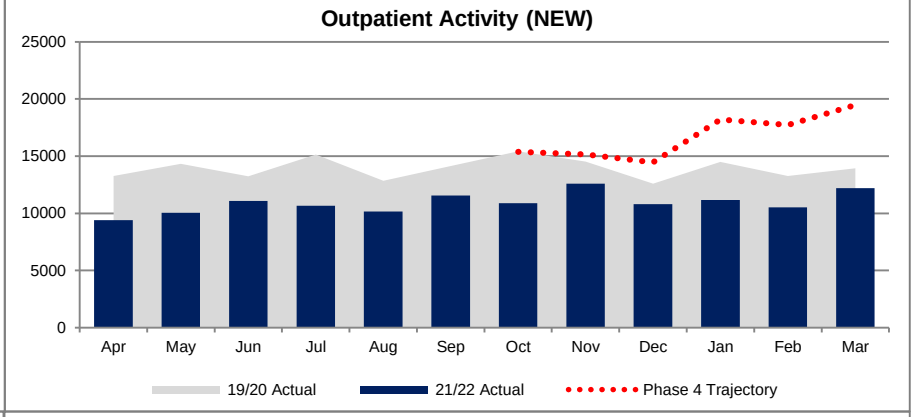


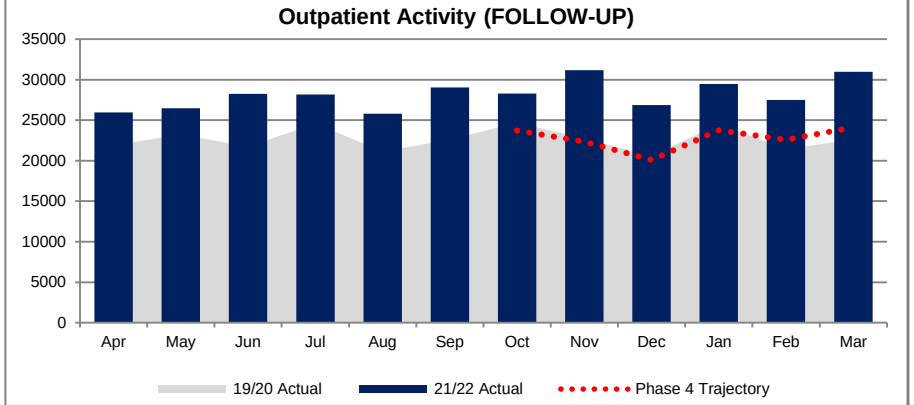
- The volume of referrals increased in March by 428, this is 10.4% higher than February.
- In March 14424 patients were seen in an outpatient setting, 10313 of these were seen face to face. The amount of patients being seen in virtual appointments increased in March with 4111 patients seen virtually. The split percentage shows 29% virtual and 71% face to face.
- At the end of March the Trust had a total of 19,995 pathways, with a trajectory of 12,993. The cancellation of elective surgery and use of the elective orthopaedic ward has contributed to this increase.
- At the end of March 57.3% of patients on an incomplete waiting list were seen and treated within 18 weeks decreasing by 0.9% from February. This is currently below the Trusts trajectory at 92%.

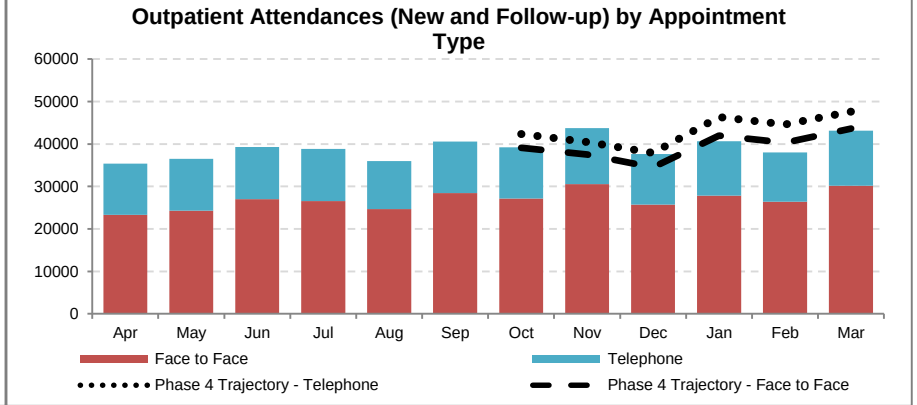


Eastern Services Elective Activity - Referrals and Outpatients







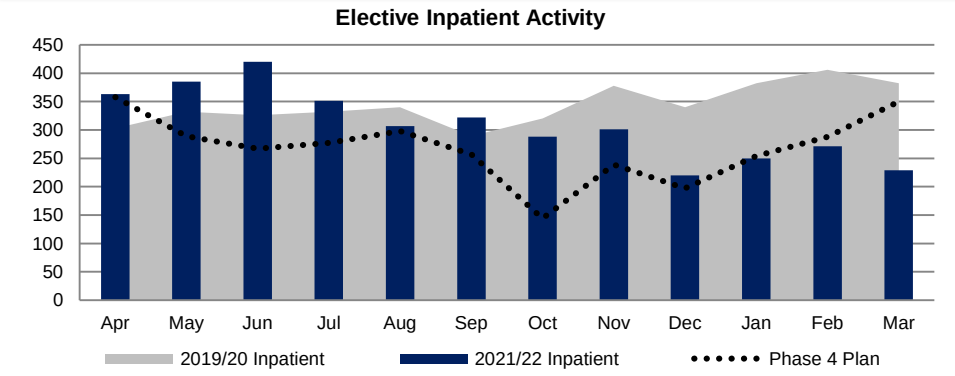


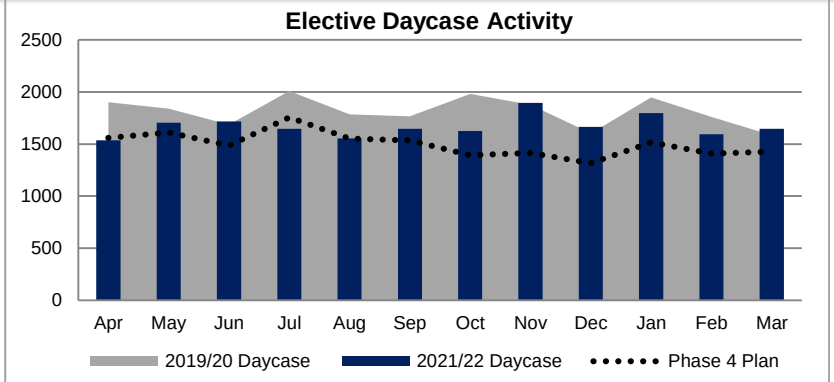
Outpatient new: In March activity new outpatient activity was 88% of average April 2019 – February 2020 new outpatient activity levels. This represents a 9% increase on February 2022 (as a proportion of activity undertaken in February 2020), and suggests a positive position moving into the 2022/23 financial year.

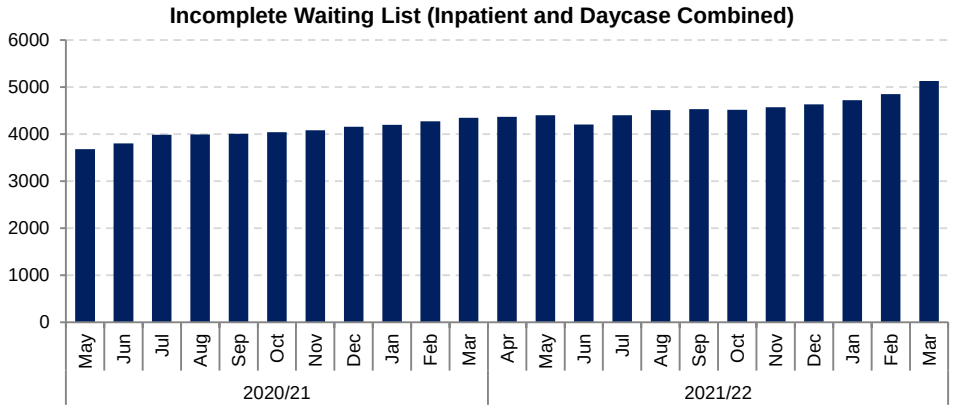
Outpatient follow-up: In March follow up outpatient activity was 137% of average April 2019 – February 2020 follow up outpatient activity levels. This represents a 9% increase on February 2022 levels.)as a proportion of activity undertaken in February 2020). This is positive in terms of addressing the high-volume of patients on a follow-up waiting list, but presents a challenging position in the context of the national planning requirement for 2022/23 to reduce the volumes of outpatient follow-ups.

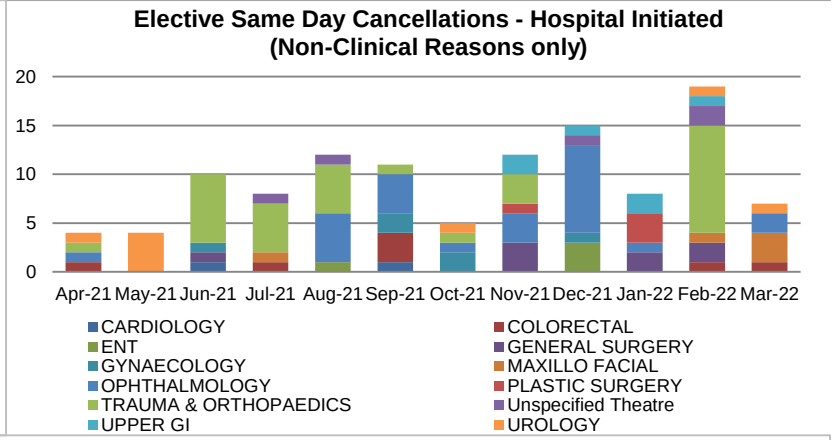
Virtual outpatient activity: performance has been maintained at 30% compared to the national target of 25%.

Northern Services Elective Activity - Inpatient and Daycase







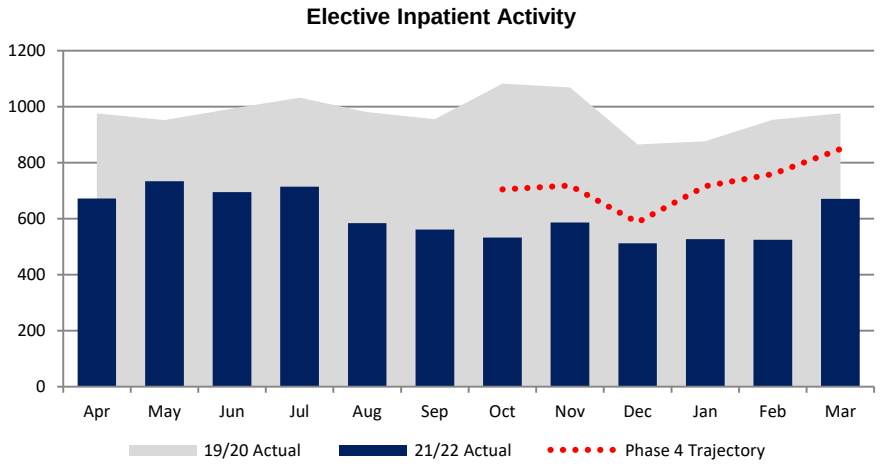


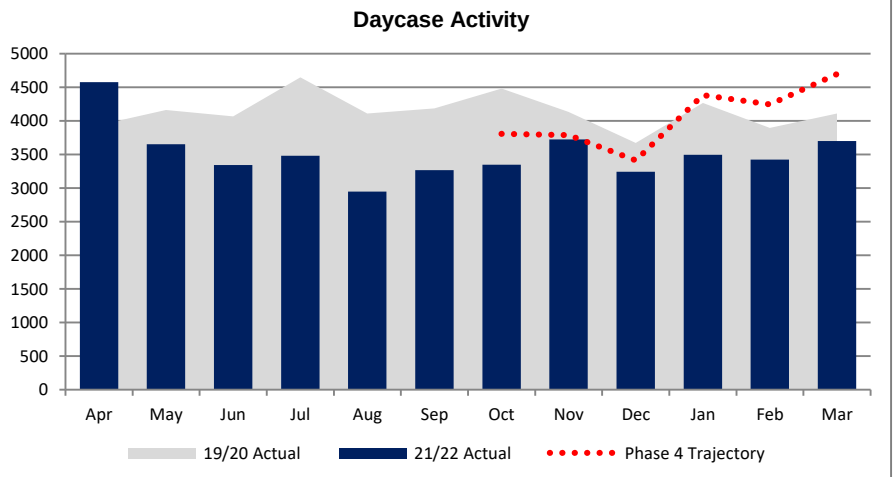
- Elective inpatient activity decreased in March, however 133 orthopaedic patients were cancelled due to COVID inpatient and urgent emergency bed pressures in March, activity levels have not returned to full capacity.
- The Trust also cancelled another 154 surgical patients due to the COVID inpatient pressure on beds.
- Highest clinical priority patients and long waiting patients continue to be monitored weekly via the Patient Tracking Meeting (PTL).
- Whilst bed pressures have been sustained, cancelling Orthopaedic operating has been enacted in advance to give patients notice and avoid cancelling on the day of or day before surgery.

Elective Same Day Cancellations:

- 150 patients were cancelled on the same day in March, for the following reasons:
  - 7 patients were cancelled on the day of surgery by the hospital, for non-clinical reasons.
  - 39 were cancelled 1 day prior to surgery mainly due to lack of beds, but a small number of these were cancelled due to COVID related absence of a clinician.

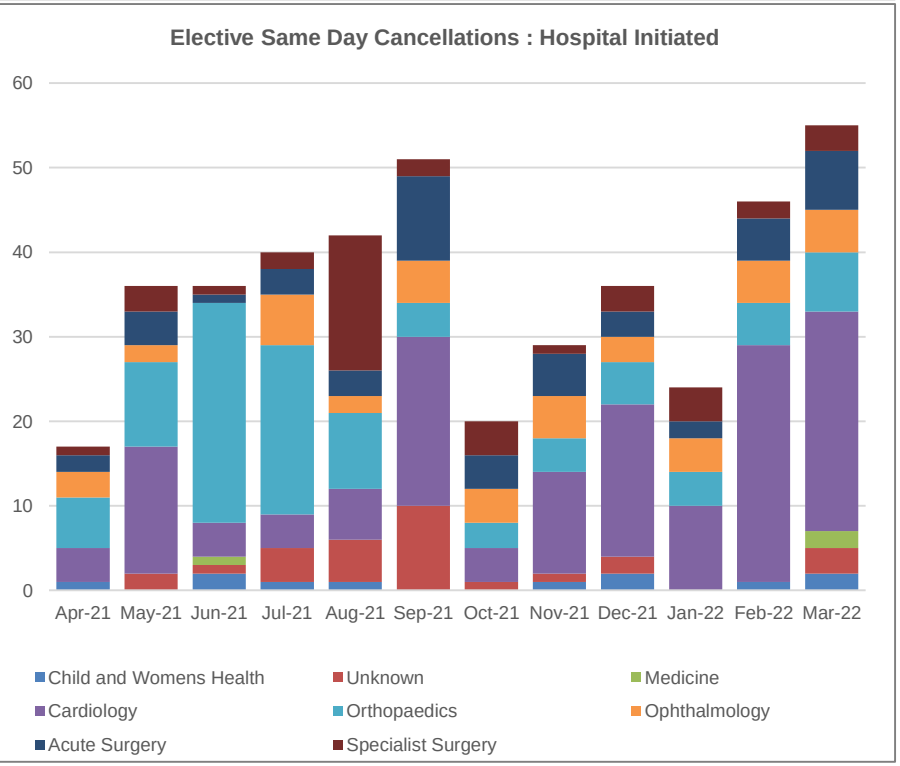
Eastern Services Elective Activity - Inpatient and Daycase



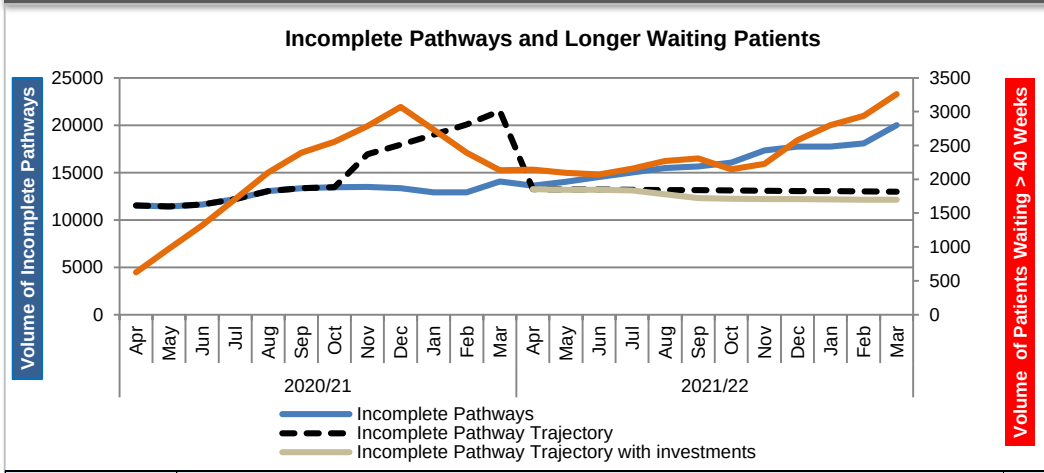


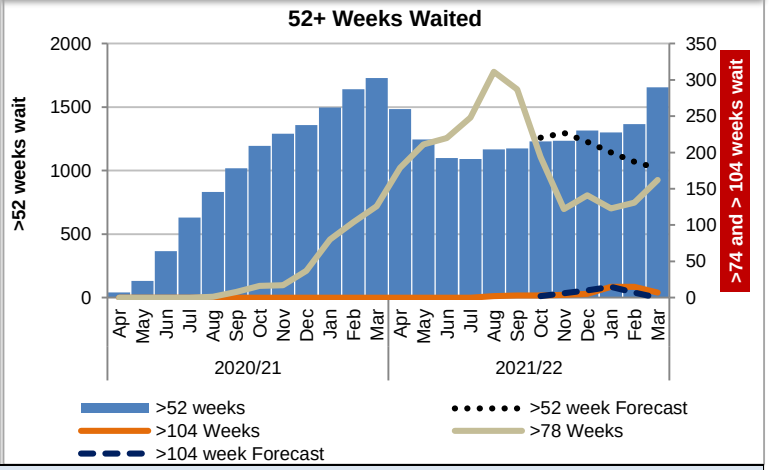
In March 2022, elective inpatient activity was equivalent to 69% of average April 2019 – February 2020 activity volumes. This represents a 14% increase on February 2022 activity levels compared to February 2020. The increase in activity is largely attributable to the re-provision of the Dyball ward for elective orthopaedics.

The volumes of elective daycase activity undertaken in March 2022 was equivalent to 90% of average activity undertaken between April 2019 and February 2020. This represents a 2% increase on the volumes of activity undertaken in February 2022 levels when compared to February 2020 activity volumes).



Northern Services Elective Activity - Long Waiting Patients





Specialty		2020/21												2021/22											
		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
> 40 weeks	T & O	215	315	450	586	675	715	723	751	815	726	622	540	525	457	426	459	478	480	415	482	525	599	600	675
	General Surgery	16	23	36	35	45	49	46	55	35	28	29	32	39	51	51	56	71	78	71	74	75	81	80	102
	Dermatology	9	16	18	21	30	36	44	57	67	60	55	57	56	62	58	71	97	126	133	151	186	215	232	277
	Gynaecology	24	38	54	83	104	130	157	153	171	182	165	162	160	159	170	187	198	192	191	180	203	203	207	210
	Neurology	16	22	16	12	32	55	82	96	97	72	70	83	95	114	125	119	89	67	54	75	94	114	125	131
	Colorectal	2	8	13	15	23	26	31	37	49	51	43	48	63	58	61	57	70	73	60	57	66	54	57	52
	Cardiology	24	32	24	34	29	29	33	35	30	25	20	14	16	20	16	10	12	14	17	21	25	30	43	49
	Ophthalmology	228	381	534	667	810	944	975	1031	1091	917	772	632	605	613	620	654	694	709	690	657	798	838	897	977
	Other	42	68	84	134	250	238	288	390	496	465	404	342	345	323	309	307	304	314	286	293	338	379	390	446
	Upper GI	9	12	17	34	44	47	54	55	67	59	51	53	64	54	52	51	58	59	58	52	60	67	63	52
	Urology	40	62	73	89	111	123	122	129	155	152	162	172	176	186	184	188	201	198	174	187	208	220	244	290
	Grand Total	**625**	**977**	**1319**	**1710**	**2153**	**2392**	**2555**	**2789**	**3073**	**2737**	**2393**	**2135**	**2144**	**2097**	**2072**	**2159**	**2272**	**2310**	**2149**	**2229**	**2578**	**2800**	**2938**	**3261**

- In March the Trust saw an increase of 323 patients waiting over 40 weeks.
- Long waiters by specialty:
  - Ophthalmology – Increased capacity hasn't been utilized due to COVID sickness impacting the team. The team has also seen an increase in urgent referrals, which has resulted in routine patient waits increasing.
  - T&O increased showing the impact hospital pressures are having on elective operating.

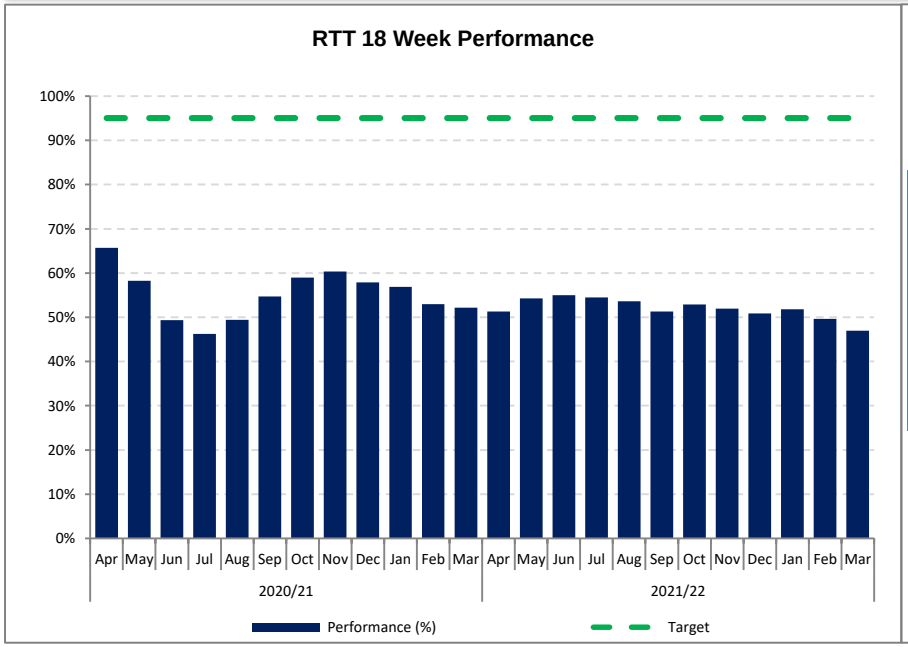
Northern Services Elective Activity - Long Waiting Patients Continued

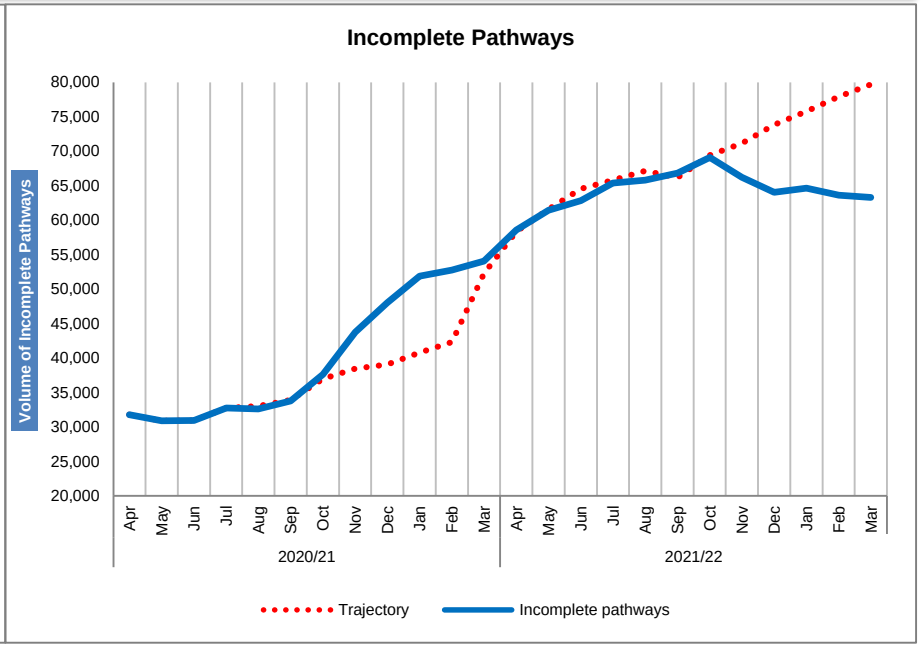
Specialty		2020/21												2021/22											
		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
> 52 weeks	T & O	10	56	139	218	257	307	381	408	413	455	457	467	416	327	260	225	221	222	225	244	267	312	344	391
	Neurology	1	2	3	5	5	5	8	17	23	17	25	35	35	44	52	55	44	32	31	36	29	28	40	43
	Cardiology	6	9	10	15	13	13	12	9	7	12	14	10	8	6	5	1	2	7	12	12	10	10	11	15
	Ophthalmology	11	34	137	252	349	447	515	532	552	547	584	578	492	393	311	323	458	373	371	367	401	390	336	459
	Other	11	23	57	100	158	187	204	239	274	374	477	534	425	352	353	366	315	414	438	454	490	436	504	594
	Urology	2	7	20	40	54	60	76	86	90	93	97	106	108	122	118	124	127	134	120	126	119	125	132	153
	Grand Total	**41**	**131**	**366**	**630**	**836**	**1019**	**1196**	**1291**	**1359**	**1504**	**1654**	**1730**	**1484**	**1244**	**1099**	**1091**	**1167**	**1174**	**1230**	**1235**	**1316**	**1301**	**1367**	**1655**

Specialty		2020/21												2021/22											
		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
> 78 weeks	T & O	0	0	0	0	0	2	6	10	18	38	43	26	47	49	55	51	63	62	42	23	22	41	21	33
	Neurology	0	0	0	0	0	1	1	1	1	0	0	0	0	2	1	1	3	9	5	3	2	3	3	3
	Cardiology	0	0	0	0	0	1	1	1	2	1	0	0	0	0	0	1	0	1	0	0	0	0	0	0
	Ophthalmology	0	0	0	0	0	1	5	2	7	15	22	20	72	82	78	93	106	86	45	18	16	19	17	27
	Other	0	0	0	0	0	2	2	2	5	13	23	69	39	50	58	69	98	90	79	49	72	28	58	62
	Urology	0	0	0	0	1	1	1	1	4	13	16	11	21	28	28	33	41	39	23	29	29	32	32	37
	Grand Total	**0**	**0**	**0**	**0**	**1**	**8**	**16**	**17**	**37**	**80**	**104**	**126**	**179**	**211**	**220**	**248**	**311**	**287**	**194**	**122**	**141**	**123**	**131**	**162**
> 104 weeks	T & O	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	3
	Neurology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	1
	Cardiology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Ophthalmology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	5	4	0
	Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	3	2	3	9	10	3
	Urology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0
	Grand Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**3**	**3**	**4**	**5**	**15**	**15**	**7**

- March saw an increase of 288 patients waiting over 52 weeks and remains higher than the forecast of 1,017.
- There was an increase of 31 patients waiting over 78 weeks for treatment, due to COVID inpatient numbers and emergency pressures 133 elective Orthopedic operating patients were cancelled in March and further orthopaedic operating was not booked.
- At the end of March the Trust had 7 patients waiting over 104 weeks, which remains higher than the Trust forecast of 0. This was largely due to the Trust supporting other Devon hospital patient transfers for earlier treatment.

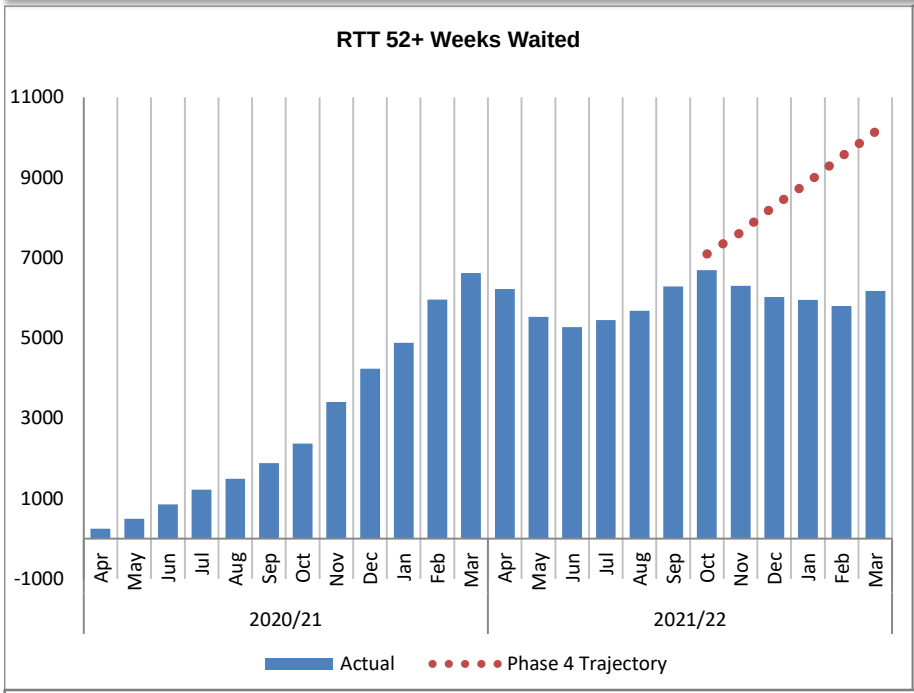
Eastern Services Elective Activity - Inpatient and Daycase

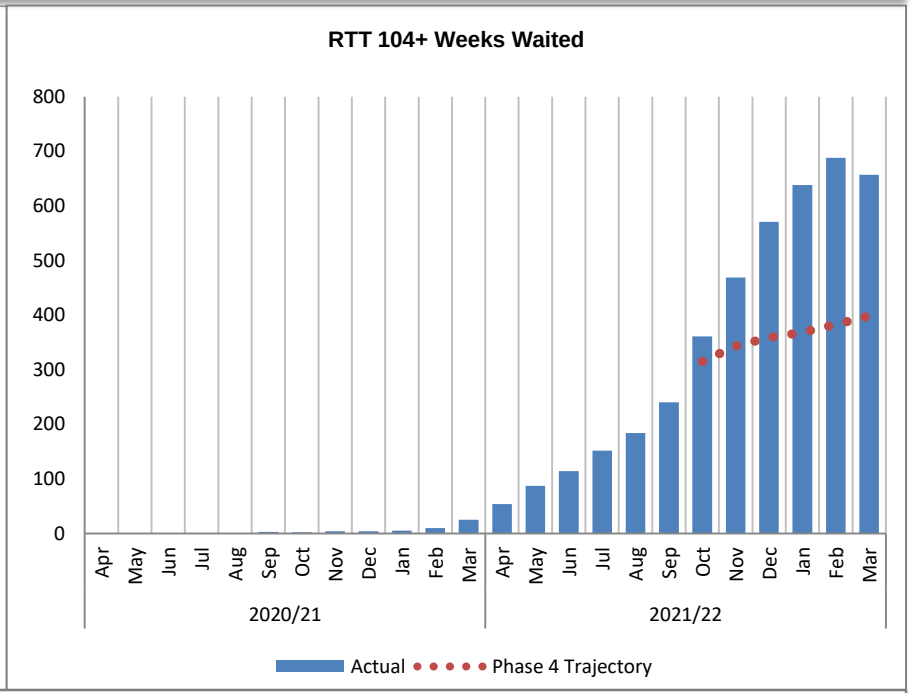




- Incomplete pathways continued to reduce between February and March, which continues towards a positive recovery trajectory.

Eastern Services Elective Activity - Long Waiting Patients





- 104 week waits reduced for the first time between February and March. This is largely attributed towards the return of the Dyball Orthopaedic ward and treatment of orthopaedic patients.

Eastern Services Elective Activity - Long Waiting Patients

	Specialty	2020/21												2021/22											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
40+ weeks	Orthopaedics	599	877	1128	1458	1679	1870	2031	2459	2725	2577	2386	2372	2344	2347	2296	2216	2195	2130	2081	2065	2153	2161	2166	2306
	Cardiology	282	335	371	396	417	434	435	581	709	681	615	563	616	625	679	751	838	894	880	770	758	751	786	873
	General surgery	206	288	352	462	582	727	523	738	872	955	927	816	909	916	860	912	791	845	663	555	405	350	277	208
	Ophthalmology	53	114	349	652	912	1182	1345	1832	2462	2261	2038	1768	1728	1756	1906	2163	2486	2660	2622	2461	2652	2818	2901	3158
	ENT	36	55	78	124	153	217	214	385	608	454	432	445	395	369	390	340	323	374	464	465	454	402	382	383
	Gastroenterology	46	35	34	52	83	134	132	207	280	246	213	247	338	337	393	579	637	855	857	974	862	969	850	804
	Plastic Surgery	39	45	61	88	105	132	127	172	238	190	204	199	214	254	265	306	321	322	317	306	300	301	311	297
	Respiratory Med	13	27	33	60	92	2	2	44	70	104	98	113	238	249	267	297	291	296	278	238	220	201	200	224
	Urology	81	104	148	176	191	205	203	261	245	277	267	265	283	276	318	278	251	242	286	265	298	293	298	303
	Other	158	241	286	357	445	602	1152	1490	1844	1663	1566	1728	1787	1902	1991	2707	3293	3813	3526	3079	3110	3274	3367	3555
	Total	1513	2121	2840	3825	4659	5505	6164	8169	10053	9408	8746	8516	8852	9031	9365	10549	11426	12431	11974	11178	11212	11520	11538	12111
52+ weeks	Orthopaedics	96	196	374	609	738	882	1048	1347	1519	1686	1849	2020	1859	1720	1628	1535	1482	1533	1595	1617	1610	1537	1492	1568
	Cardiology	54	90	138	155	183	199	199	260	313	363	423	418	414	399	417	407	418	491	530	484	442	414	377	416
	General surgery	58	95	137	174	220	260	142	232	318	460	624	574	594	555	539	627	621	788	629	517	368	312	233	167
	Ophthalmology	3	7	20	45	69	175	321	621	890	1006	1354	1483	1315	1013	941	1046	1212	1399	1489	1456	1610	1404	1365	1608
	ENT	5	15	26	30	39	55	78	79	104	142	239	307	276	222	211	183	191	200	222	201	215	220	211	226
	Gastroenterology	3	1	7	14	17	28	41	71	111	111	118	153	178	130	97	143	132	240	323	326	283	298	319	374
	Plastic Surgery	7	16	17	29	37	53	67	79	93	103	133	155	145	154	158	160	186	208	253	228	199	194	195	199
	Respiratory Med	0	0	1	8	18	23	0	19	39	65	70	83	159	134	126	127	147	156	164	124	127	127	121	140
	Urology	15	40	62	72	65	72	87	127	127	154	189	190	198	186	204	170	156	152	162	110	116	124	138	169
	Other	12	34	77	86	106	140	390	575	724	789	963	1240	1086	1018	951	1047	1137	1117	1324	1236	1051	1322	1351	1306
	Total	253	494	859	1222	1492	1887	2373	3410	4238	4879	5962	6623	6224	5531	5272	5445	5682	6284	6691	6299	6021	5952	5802	6173
104+ Weeks	Orthopaedics						0	0	0	1	2	3	8	23	35	47	65	81	114	178	252	340	397	437	445
	Cardiology						0	0	0	0	0	0	1	6	12	23	28	25	27	46	51	49	59	63	57
	General surgery						3	1	0	0	1	3	1	2	4	4	7	7	25	11	10	14	16	12	11
	Ophthalmology						0	0	1	1	1	1	0	0	0	0	0	1	4	6	12	18	18	30	24
	Other						0	1	3	2	1	3	15	23	36	40	52	70	70	120	144	150	148	146	120
	Total						3	2	4	4	5	10	25	54	87	114	152	184	240	361	469	571	638	688	657

Patient survey support key aims

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

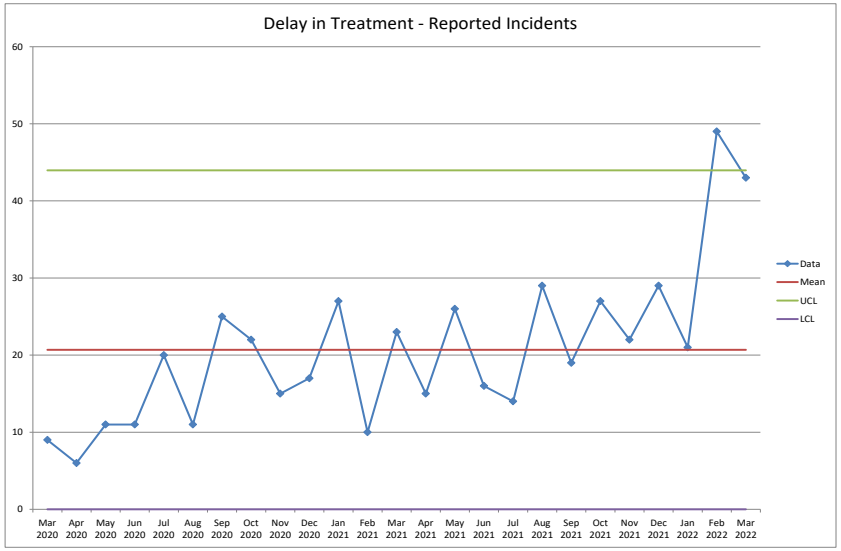
Patients contacted	12,864
Completed survey	7,133
Removed from WL	435
Referred for lifestyle support and advice	-
Escalated to clinician	1,675
WIP	656

Next Steps

- Continuation of communicating with patients on outpatient waiting lists with oversight from Outpatient Recovery and Redesign for assurance
- Continue clinical reviews of patients escalated to clinicians
- Use of Doctor Doctor to re-do patient contacts on admitted waiting lists in line with new national guidance
- Continue alignment our internal and external communications with the RD&E. This includes potential use of doctor, creation of generic waiting letter and redesign of information on Trust website
- Join CCG waiting well programme utilising DRSS and Living Options to support patients awaiting first appointments.

Across the same time period at the NDHT, 43 incidents related to delays in receiving treatment were reported, of which one has been initially graded as major. This incident has been escalated for a 72-hour report due to a delay in access to services in Ophthalmology. This will be managed and reported through regular governance processes, including review of the appropriateness of the initial grading applied. Investigation of each incident including commitment to Duty of Candour, is being managed in line with Trust policy. The outcomes of each investigation will be reported through the Trust's Governance Framework. It is important to note that due to the way this data is collected, not all of these incidents will be related to patients on elective pathways waiting for treatment.

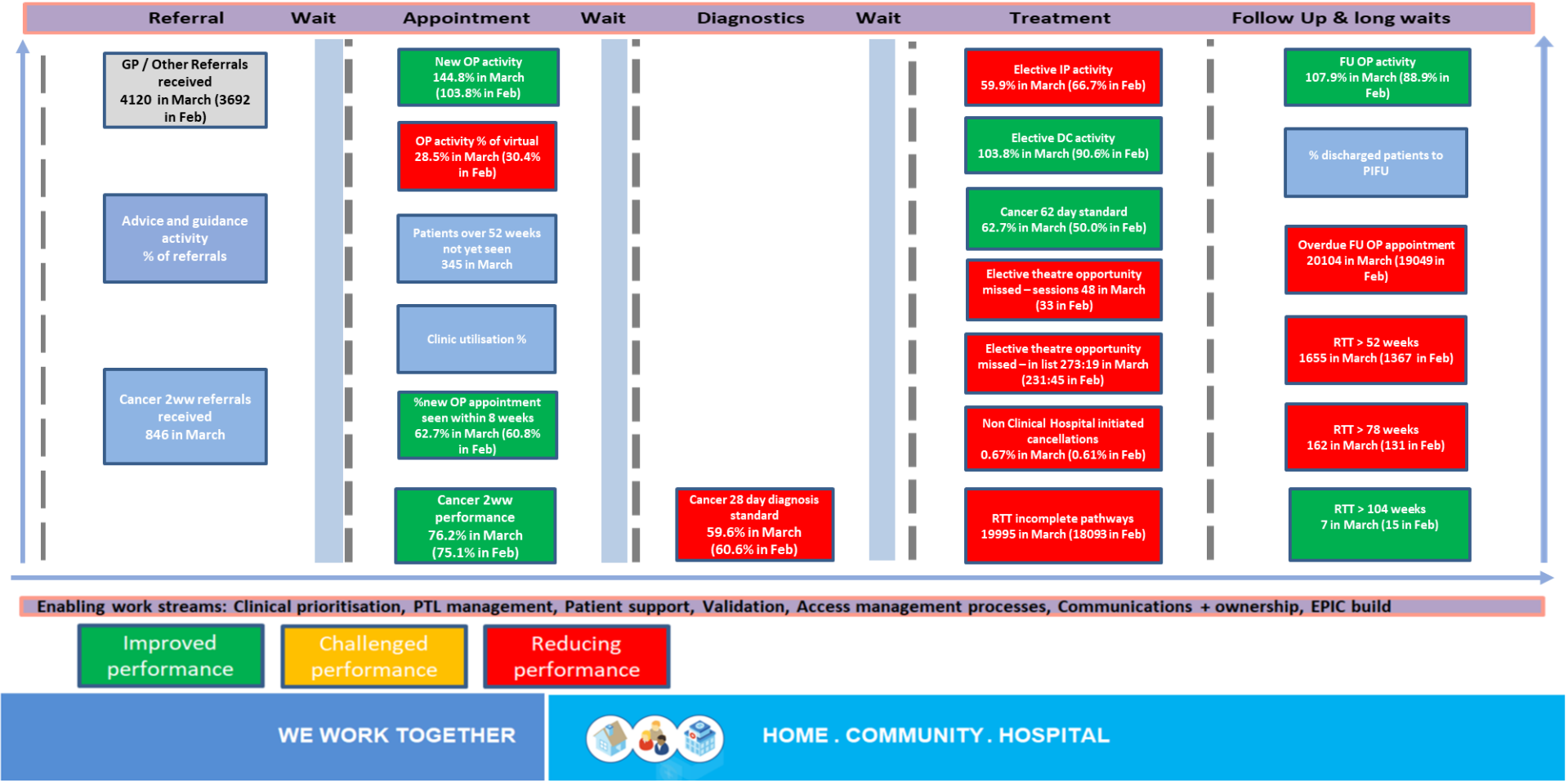
NB: There was an increase in number of incidents reported during 2019 as Clinical Harm Reviews were being undertaken for all patients waiting greater than 52 weeks for treatment.



March 2022 Delay in Treatment Incidents	NONE	MINOR	MAJOR	Total
>12 hour breach (trolley wait)	14	1	0	15
Access - delay/ failure in access to hospital/ care	8	6	1	15
Access/ Appointment/ Referral - other	1	0	0	1
Appointment - delay/ failure	1	0	0	1
Breach - Appointment / Waiting Time	1	0	0	1
Lack of/ delayed availability of beds (general)	5	0	0	5
Referral - delay/ failure	4	1	0	5
Total	**34**	**8**	**1**	**43**

Executive Summary

Planned Care Metrics 2021-2022
Data: March 2022



WE WORK TOGETHER

HOME . COMMUNITY . HOSPITAL

Patient survey support key aims

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

Patients contacted	2357
Completed survey	1169
Removed from WL	359
Referred for lifestyle support and advice	172
Escalated to clinician	255
No response	367
WIP	821

Independent Sector

- Since June 2021 6095 patients have been contacted, reviewed, and offered transfer as part of the Independent Sector process

Progress in Month

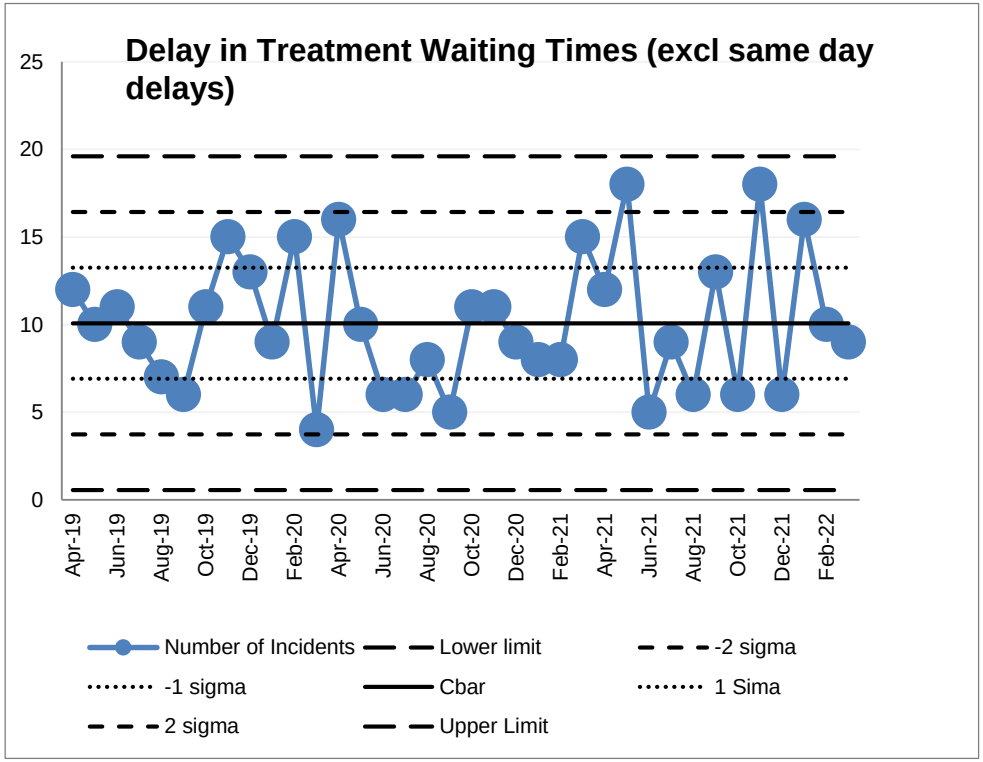
- Direct access community support line went live
- Administration staff training developed to support them with managing and supporting long waiting patients
- Letters sent to long waiting surgical patients

Next Steps

- Waiting times widget pending go live approval from NHSI
- Analysis of patients unable to contact
- Increase survey to 500 patients per month mid April, this will be 250 outpatient and 250 surgical patients per week

Eastern Services Waiting Well

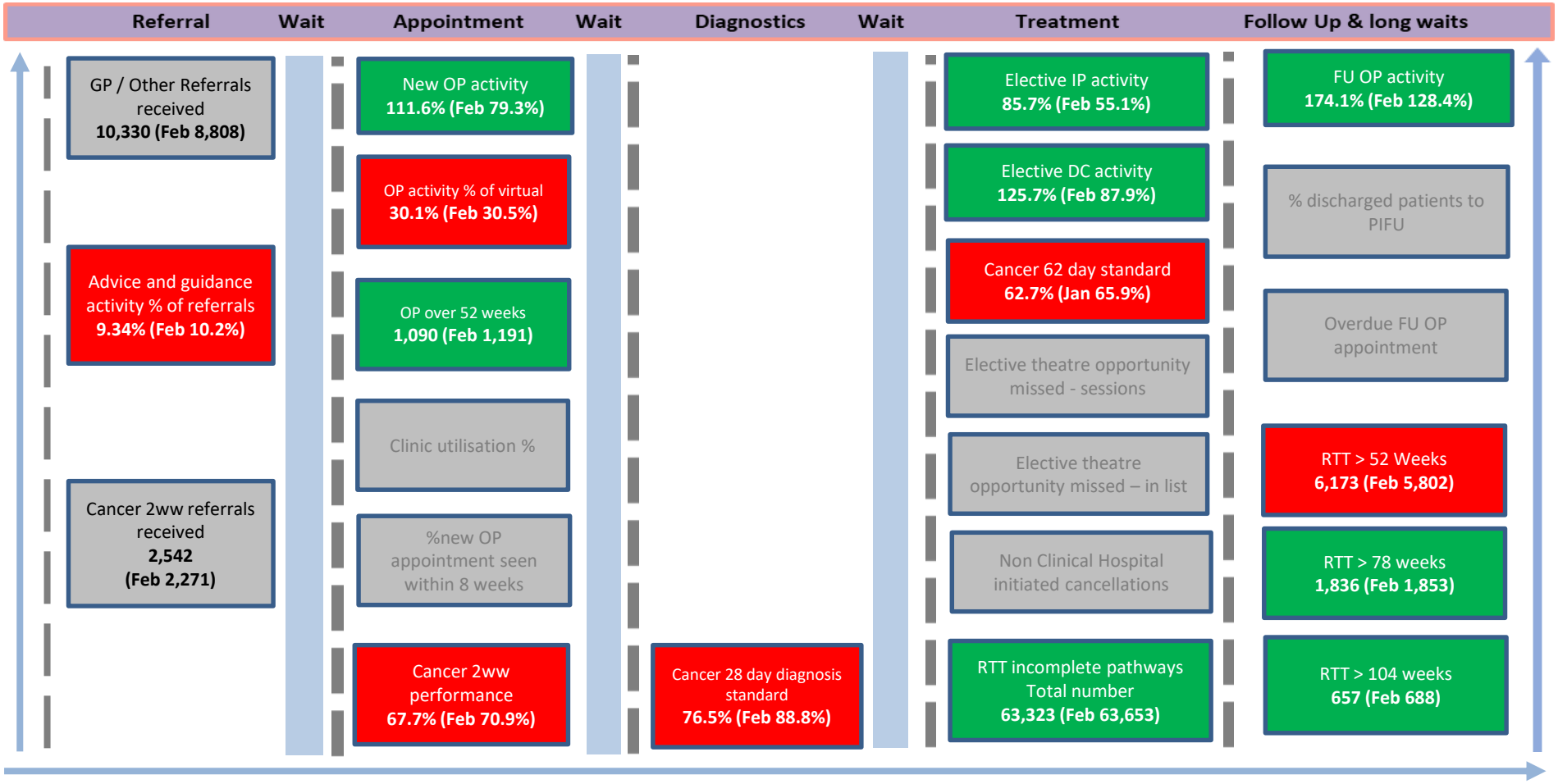
Across the same time period in Eastern 9 incidents were reported for March 2022, these are broken down by the level of harm against stage of pathway below.



	None	Minor	Moderate	Major	Catastophic	Total
Follow up delay	1	3				4
Surgery	2	0				2
New	1	1				2
Diagnostic request delay	1	0				1
Total	5	4	0	0	0	9

Planned Care Metrics 2021-2022
Data: March 2022

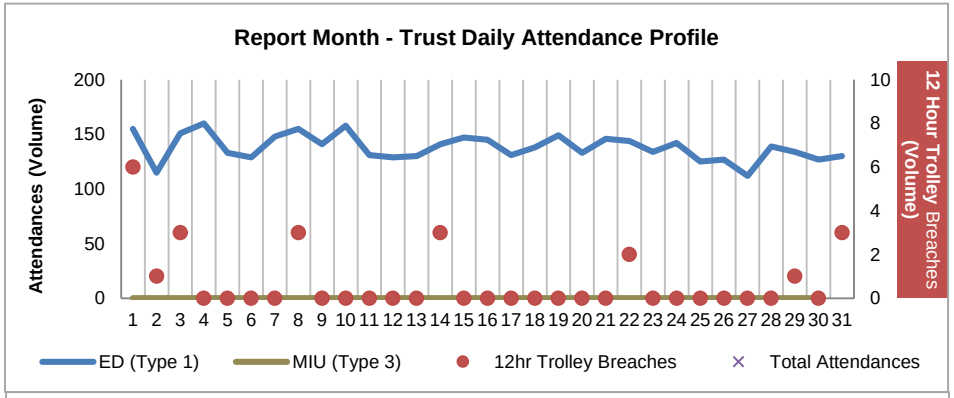
Eastern Services

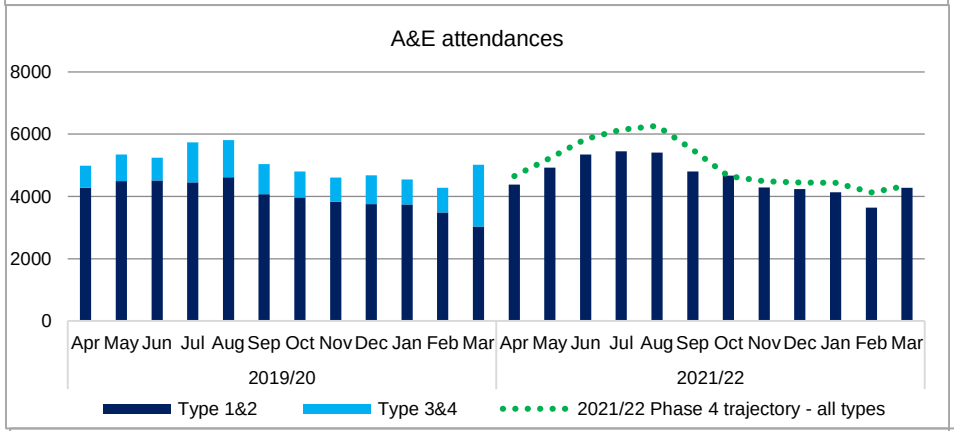


Enabling work streams: Clinical prioritisation, PTL management, Patient support, Validation, Access management processes, Communications + ownership, EPIC build

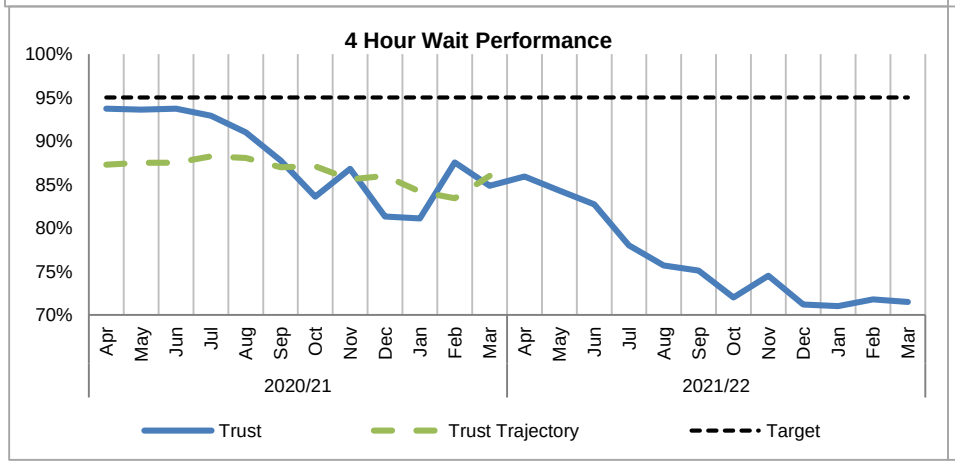
Improved performance | Challenged performance | Reducing performance

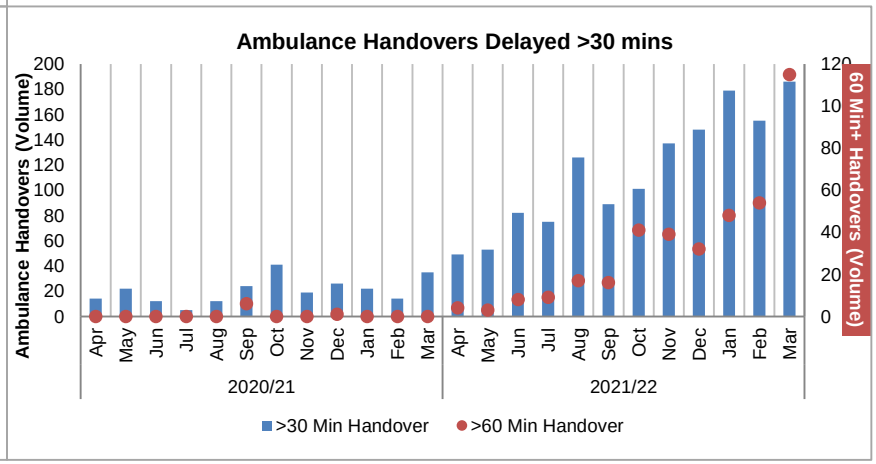
Northern Services Emergency Department – *key metrics relating to activity & performance in urgent & emergency care services*



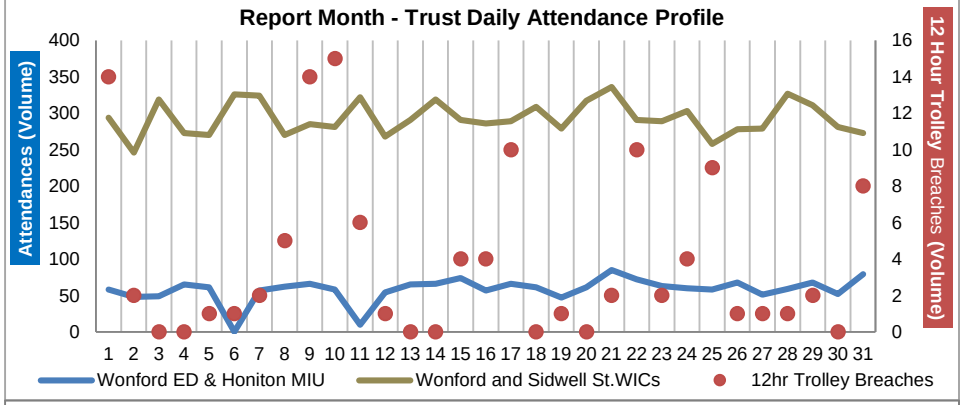


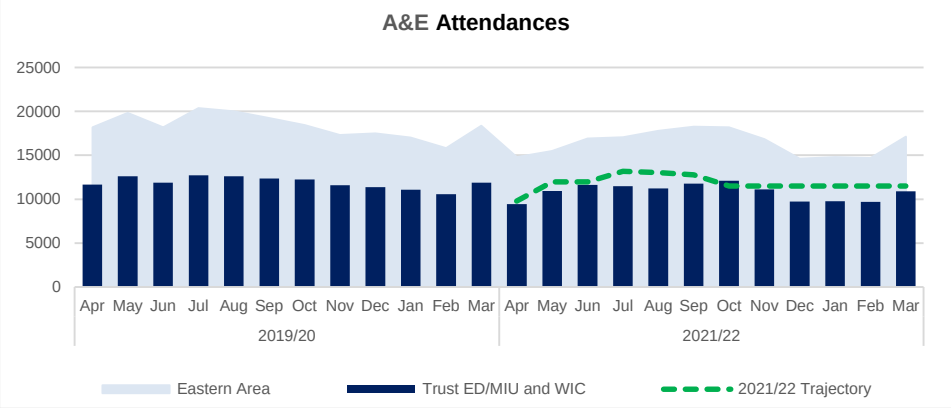
- The Trust achieved 71.5% 4 hour flow performance in March 2022. Two critical incidents were declared in March.
- There were a total of 4279 all type attendances in March, this is a decrease of 636 attendances from the previous month. On average there were 138 attendances per day.
- The Trust incurred 22, 12 hour breach in March, 2x mental health breaches and 20x awaiting medical beds.
- Highest attendances were 160 on the 4th March. Lowest attendances were 112 on the 27th March.
- In March the Trust saw an increase in both >30 minute and >60 minute handover breaches, with 60 minute breaches more than double those in February:
  - 186 >30 minute handovers.
  - 115 >60 minute handovers.
- 522hrs 29mins ambulance handover total time lost (highest ever recorded at NDUH North).
- Average handover time 27 mins 2 secs
- MIU's (Type 3+4) continue to be closed due to staff shortages. The Trust are engaging with Leagues of Friends and local councilors in conjunction with the CCG, in affected local areas.

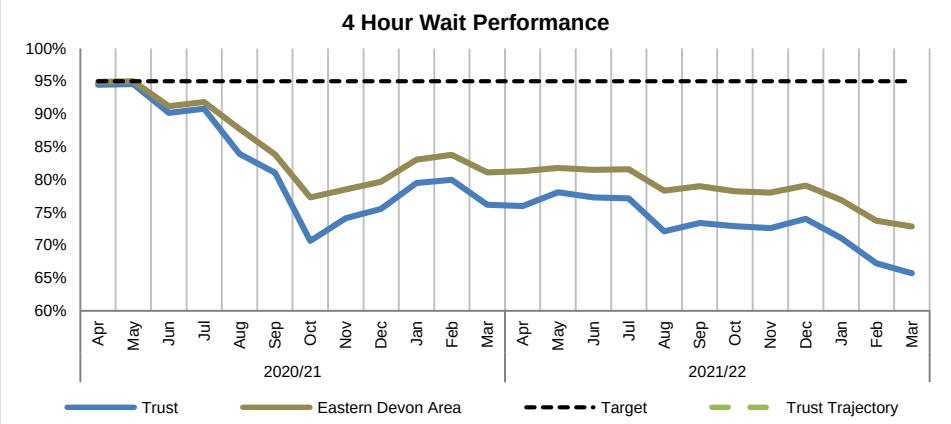




Eastern Services Emergency Department – *key metrics relating to activity & performance in urgent & emergency care services*







Overall Performance:
Type 1 ED performance was 52.99% in March (55.24% in February), Trust performance was 65.38% in March (67.25% in February) and across the Eastern System, including Minor Injury Units and Walk in Centres was 72.63% in March (73.72% in February). The national position for March was 58.6% for Type 1 (60.8% in February) and 71.6% for Types 1-3 in March (73.3% for February).

Type of Activity	Denominator	Patients > 4 Hours	% Performance
ED Only	7945	3735	52.99%
All RD&E Delivered Activity (including Honiton MIU and the WICs)	10798	3738	65.38%
Total System Performance (including MIUs)	13973	3825	72.63%

The Urgent Care System continued to experience significant challenges throughout March. The Patient Flow Diagnostic illustrates the on-going challenges for 111 call abandonment and primary care and domiciliary care capacity. Ambulance handovers averaged 93 per day continuing to reflect the high acuity of patients arriving to the Trust.

High numbers of unplanned escalation beds remained open to support non-COVID and COVID capacity, significantly impacting on patient flow. The total number of patients waiting in excess of 4 hours for an inpatient admission was 620, including 2 transfers to Derriford (548 for Feb and 529 for Jan).

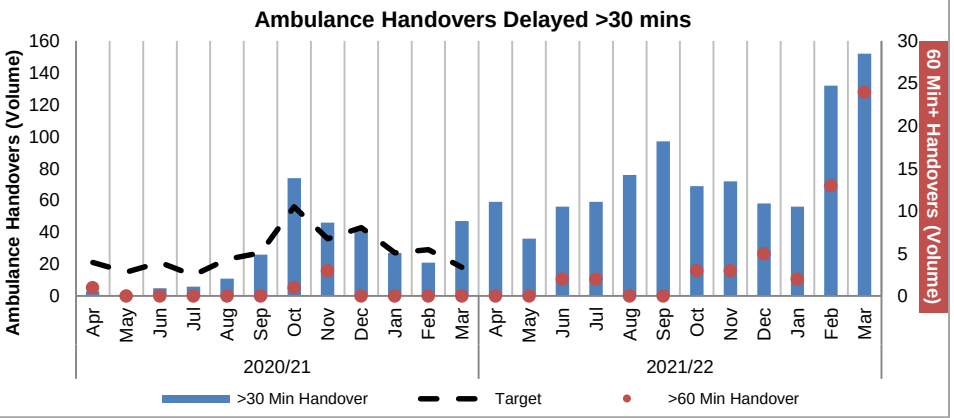
100 patients waited longer than 12 hours for an inpatient admission (compared with 65 patients in Feb and only 6 patients in Jan) of which:

Inpatient mental health bed – 7 patients (6 patients in Feb and 3 in Jan)
Inpatient bed at the RD&E – 93 patients (59 in Feb and 3 in Jan)

Performance and patient flow continued to be impacted by workforce challenges resulting from vacancies and COVID sickness, both within ED and across the Trust, with >12 hour waits for inpatient admissions especially affected. To couple this, at the Trust's lowest bed capacity due to COVID, cold bed capacity was at less than 2/3 total capacity. These days coincided with ED's lowest 4-hour performance.

Following Trust Board approval for Urgent Care investment in October 2021, the additional recruitment to these recurrently funded ED posts continues to progress well. Appointments have been made to the Nurse Practitioner establishment and Support Worker positions and recruitment to the new nursing establishment continues (which includes the Urgent Care investment and ED FBC investment). Following further consultant interviews, 3 more ED Consultants have been appointed, bringing the total to 8 overall, which is the full additional WTE funded in the Urgent Care Paper. 3 locums will move to substantive posts, 1 post will commence in July and 1 in September.

Eastern Services Emergency Department – *key metrics relating to activity & performance in urgent & emergency care services*



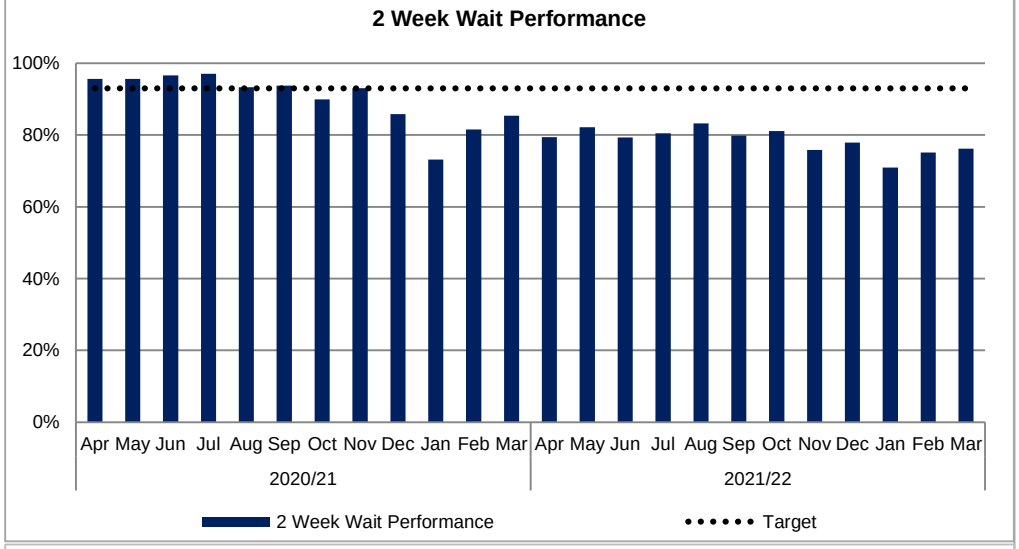
Overall Performance:

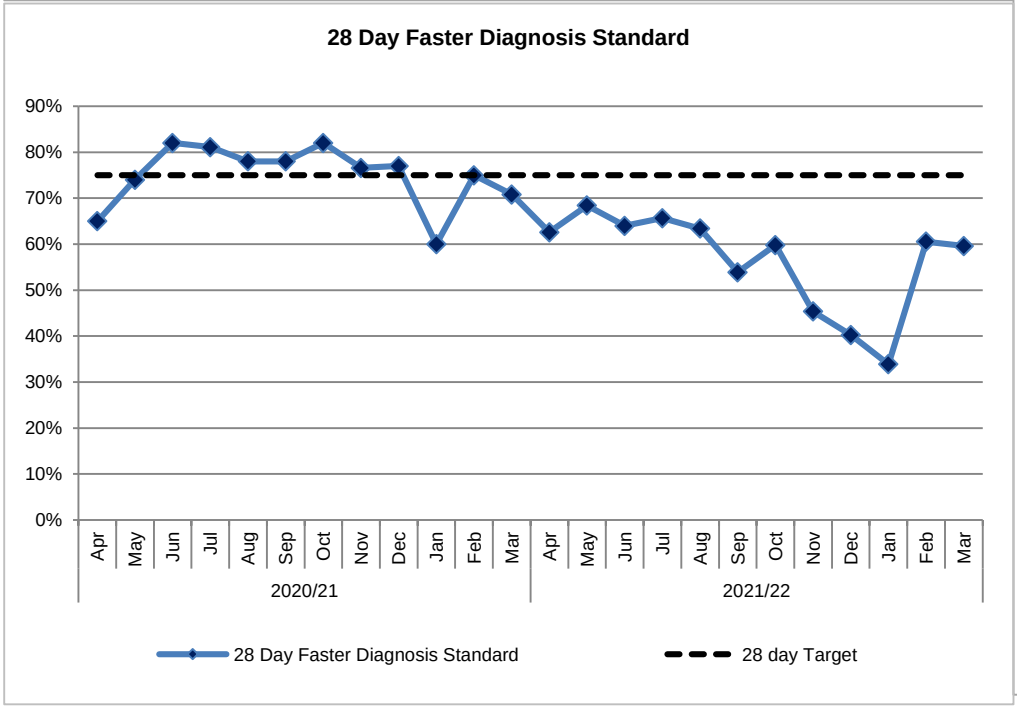
There were 2639 ambulance arrivals in March, 85 on average per day, with 2 days being >100 handovers (2612 in February, 93 on average per day and 2929 in January, 94 on average per day). Handover delays:

- 15 – 30 minutes – 726 unvalidated (643 in February, 724 in January)
- 30 – 60 minutes – 152 validated (132 in February, 56 in January)
- Over 60 minutes – 24 validated (13 in February, 2 in January)

Total unvalidated handover time lost was 225.58 hours in March, up from 201.71 hours in February and 143.5 hours in January, as a result of ongoing patient flow issues relating to the impacts of COVID escalation and associated staffing challenges. Average handover performance below 15 minutes was 63.64% (68.08% in February and 73.49% in January).

Northern Services Cancer 14 and 28 Day





2 Week Wait Performance

- The Trust received 846 2ww referrals, compared to 464 received in the same period in 19/20. The reason for the low referrals in 19/20 was a result of the start of the COVID pandemic.
- In March the Trust saw 79% 2ww referrals within target (un-validated). Whilst most specialties met this standard, waits longer than 14 days in breast surgery lowered the Trusts overall performance.
- 2WW breast (symptomatic) performance decreased to 2.63%.
- Waiting times in breast surgery are expected to reduce when newly appointed consultants are in post.

28 Day Faster Diagnosis Standard

The Trust didn't meet the 28 day faster target, this has been mainly impacted by Colorectal and Urology.

Several tumour sites are still struggling to achieve the 28 day faster diagnosis target and actions to support these services will be monitored as part of the Trusts Cancer Recovery Action Plan.

In colorectal surgery, this is largely due to waiting times for endoscopy.

In urology this has been largely due to waiting for prostate template biopsy.

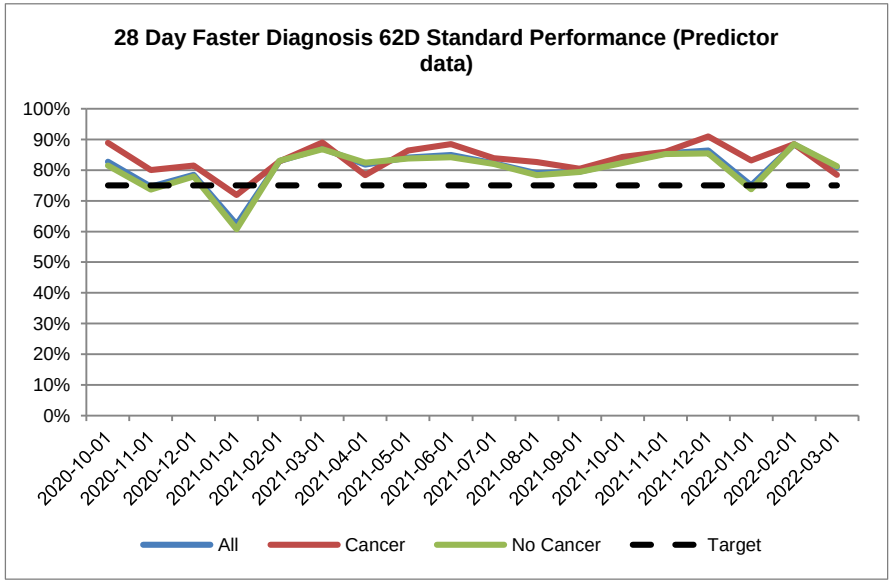
Eastern Services Cancer 14 and 28 Day

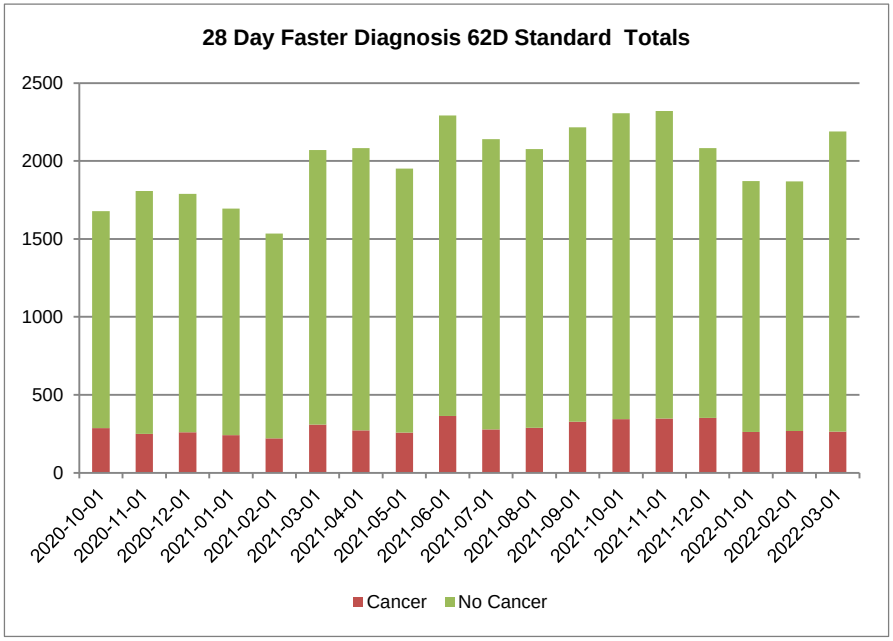
2 Week Wait Referrals
All Specialties across the Trust have seen an increase in 2WW Referrals since December. There is an increase in 2WW breaches for March and therefore a reduction in performance (66.03% in March which is a deterioration on February's position of 69.93%) As indicated in previous IPR reports, 2WW is being phased out nationally and replaced with 28 Day Faster Diagnostic Standard, 31 Day and 62 Day standards.

28 Day Faster Diagnosis
Overall the Trust met the target by achieving 79.5% (481 breaches) in March, a deterioration from 86.3% (274 breaches) in February (however still within Target). There are some tumour sites who are particularly challenged with an increase of breaches; Colorectal (46.8%, 210 breaches – a deterioration from February), Gynaecology (64.8%, 69 breaches), Sarcoma (65.8%, 25 breaches), Urology (65.9%, 31 breaches) and Testicular (73.3%, 4 breaches).

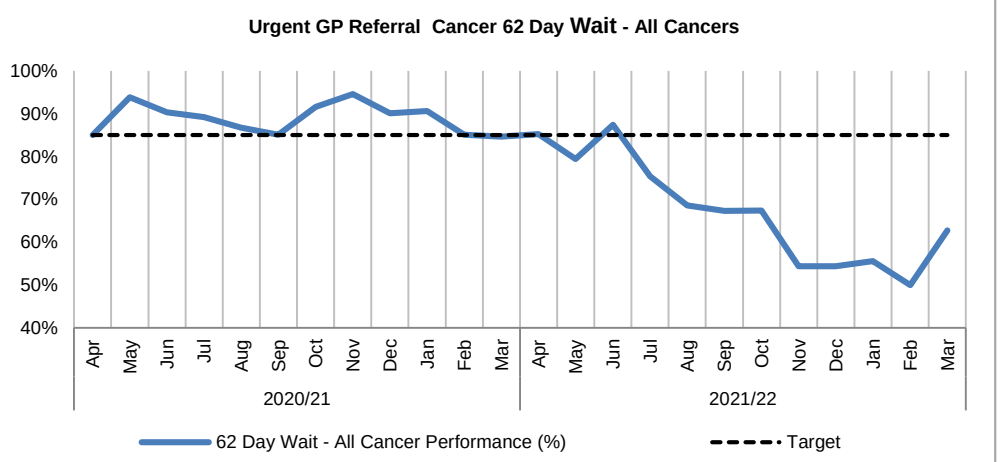
<u>The following actions will support improvements in the above tumour site pathways;</u>
- Cancer Services have recently undertaken a project, working jointly with pathology, to understand the current pathway challenges and look at recommendations in order to achieve the milestones as laid out within the Rapid Diagnostic Service (RDS) pathways (75% of patients hitting the milestones on the national timed pathways).
- Tumour site pathways have been reviewed and mapped against national timed pathways, identifying opportunities for improvement and integrating these into speciality action plans
- The Trust has begun a review of the breach validation process to ensure it is as proactive and effective as possible, using thematic analysis to improve patient experience and access to treatment

104+ Harm/No Harm review
At the end of February there were 64 patients over 104+ Days on their 62 Day Pathway. Following a pathway review with Clinicians – this was reduced to 49 patients (Bowel Cancer Screening excluded), with the majority of patients within the Colorectal and Urology tumour sites. All of these patients have had their pathways expedited (where possible) and a thematic analysis is being undertaken to understand any potential harm. The Trust is in the process of reviewing how this is reported to relevant patients.





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



- The Trust did not achieve the 62 day target in February, final position was 52%.
- March will be finalised on the 10th May, the current forecasted range 60.3% - 64.9%.

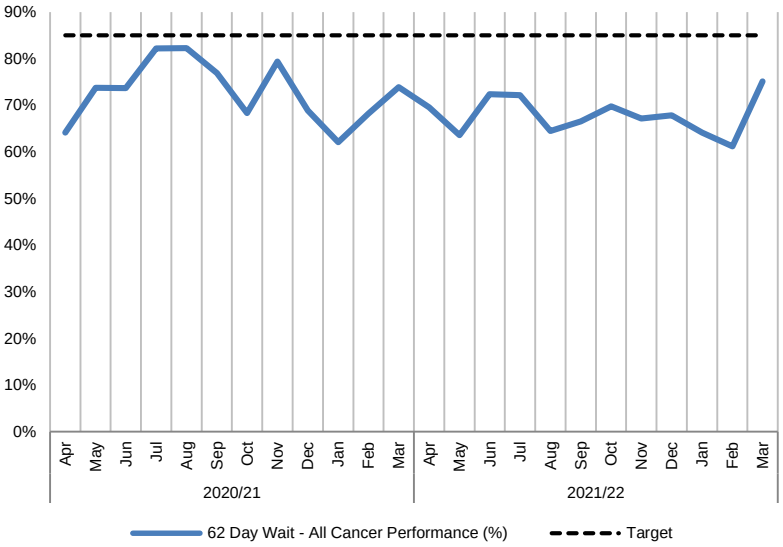
Of the 22 breaches in February 2022, 16 came from 3x tumour sites:

- Breast – In March breast performance increased to 30% and further improvements are expected in future months.
- Urology – Delays continue due to the wait for radiology and LATP (4-5 week waiting time). A new service specific PTL process has been developed to identify areas of improvement.
- Skin – Data input has improved to more accurately capture treatment time.

Cancer - 14,31 & 62 Day Wait

	Performance(%) and Number of Breaches	Target	2020/21 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
14 Day	All Urgent (%)	93%	95.60%	95.60%	96.60%	97.09%	93.30%	93.72%	89.96%	93.08%	85.83%	73.16%	81.56%	84.50%	79.44%	82.20%	79.29%	80.49%	83.25%	79.84%	81.06%	75.82%	77.89%	70.96%	75.14%	76.17%
	All Urgent (N)		8	14	15	14	36	37	57	32	90	106	90	93	120	105	148	133	103	150	132	163	159	183	172	191
	Symptomatic Breast (%)	93%	75.00%	100.00%	92.80%	95.06%	83.00%	94.44%	59.26%	99%	63%	1.10%	10.10%	5.50%	6.56%	1.56%	0.00%	8.16%	0.00%	2.17%	0.00%	3.6%	1.75%	3.64%	7.58%	2.63%
	Symptomatic Breast (N)		2	0	1	1	4	1	5	1	10	41	63	49	57	64	40	45	16	46	11	54	56	53	61	73
31 Day	All Decision To Treat (%)	96%	100.00%	100.00%	100.00%	98.80%	97.40%	100.00%	99.03%	97.90%	98%	100%	99%	90%	94.10%	98.98%	94.70%	96.11%	89.36%	86.59%	88.00%	82.22%	88.09%	83.65%	87.25%	82.10%
	All Decision To Treat (N)		0	0	0	1	2	0	1	2	2	0	1	10	6	2	4	3	6	11	9	16	10	17	13	17
	Subsequent - Surgery (%)	94%	100.00%	100.00%	77.70%	100.00%	100.00%	100.00%	100.00%	89.40%	79%	92.30%	100%	100.00%	91.60%	94.11%	100.00%	90.00%	66.66%	60.00%	66.66%	91.66%	55.55%	41.66%	75%	71.42%
	Subsequent – Surgery (N)		0	0	2	0	0	0	0	2	2	1	0	0	2	1	0	1	4	4	3	1	4	4	2	2
	Subsequent - Anti-Cancer Drug %	98%	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	100%	100%	100%	100%	96%	83%	97%	92.59%	100.00%	95.83%	82.60%	90.32%	94.73%
	Subsequent - Anti-Cancer Drug		0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	5	1	2	0	1	4	4	1
62 Day	All Screening Service (%)	90%	N/A	N/A	N/A	N/A	N/A	N/A	100.00%	100%	0%	50%	100%	50%	33%	0%	33%	33.3	50%	44.44%	100%	66.6%	100%	33.00%	100%	28.57%
	All Screening Service (N)		N/A	N/A	N/A	N/A	N/A	N/A	0	0	3	1	0	1	2	1	2	1	1	2.5	0	1	0.5	1	3	2.5
	Consultant upgrade (%)	90%	93.30%	81.60%	90.00%	77.90%	86.04%	83.33%	81.92%	80.20%	91.78%	93.80%	75%	76.40%	72.05%	87.20%	96.25%	89.65%	76.74%	83.60%	67.34%	76.71%	78.73%	73.23%	80%	60.41%
	Consultant upgrade (N)		5.5	4.5	3.5	7.5	3	7.5	7.5	9	6	3.5	7.5	8	9.5	5.5	1.5	4.5	10	5	8	8.5	6.5	8.5	11	9.5
28 day	28 Ref to diagnosis (%)	N/A	65.00%	74.00%	82.00%	81.10%	78.00%	78.00%	82.00%	76.60%	77.00%	60.00%	72.00%	68.00%	62.60%	68.42%	63.98%	65.65%	63.38%	53.89%	59.82%	45.36%	40.26%	33.89%	60.55%	59.59%
	28 day Ref to diagnosis (N)		78.00	71.00	65	85	98	125	89	140	118	205	155	179	236	204	242	237	229	321	233	394	413	491	288	315

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



Performance

- Performance of the 62 Day Cancer Target has improved to 75.14% (62.7% in February); with Brain/CNS, Lung and Skin the only tumour sites to meet the target. Urology have seen an increase in tertiary referrals for patients requiring Robotically Assisted Laparoscopic Prostatectomy (RALP) and Cystectomy (27 in January, 16 in February and 24 in March) – This is anticipated to maintain and possibly increase over the next few months due to the position in the wider Peninsula. The National Prostate campaign is underway adding to an increase in 2WW Prostate Referrals. Urology are also supporting a mutual aid request from Torbay, accepting 5 x 2WW Prostate Referrals per week – this will have a negative effect on eastern Services performance against this metric, whilst providing access to required treatment for this specific pathway across a wider geographical patient population.
- Colorectal Theatre Capacity remains a significant challenge – however this monitored on a weekly basis within the Specialty and Division.
- Head & Neck are in an increasingly challenged position due to 2WW capacity and challenges in sustaining access to Ultrasound/Radiology (Straight to test – which is the optimum pathway).
- Performance of the 31 Day Cancer Targets remains at 88.96% (89.5% in February) with Brain/CNS, Breast, Haematology, Head & Neck, Lung and Thyroid the only tumour sites to meet the target.
- Gynaecology hysteroscopy capacity remains an issue, and the team is currently using Waiting List Initiatives (WLIs) and converting any stood down activity to provide additional capacity. The Trust is currently training another nurse in hysteroscopy which is near completion, and it is hoped that ERF will also provide additional resource in this area. Histology waiting times are also impacting pathways.

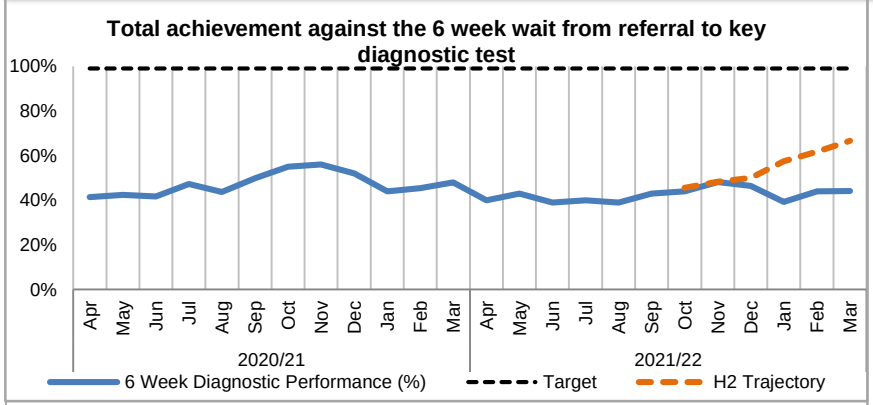
Improvements

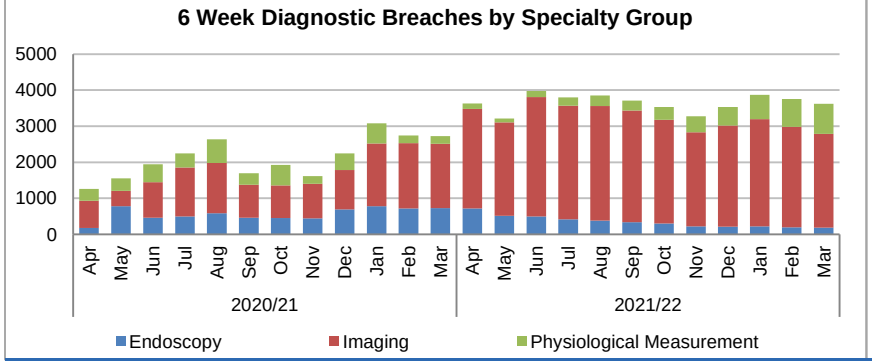
- The Non Site Specific is pathway went live on 28th of March and is now receiving referrals. The pathway is running in close collaboration with AMU and Oncology to provide a rapid diagnostic pathway for patients who have a high probability of cancer but do not fit the referral criteria for any other services. This pathway has currently received 5 referrals, 1 of which has been accepted (this is also the only 2WW service which can reject referrals).
  A Clinical Director role for Cancer is being advertised to cover both the RD&E and NDHT which will bring 16 hours per week of clinical leadership to the cancer agenda, to work alongside the Lead Nurse for Cancer and Programme Director for Cancer.

Cancer - 14, 31, 62 & 104 Day Wait

	Performance(%) and Number of Breaches	TARGET	2020/21 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
14 Day	All Urgent (%)	93%	82.2%	94.2%	90.7%	89.2%	89.9%	74.8%	70.1%	53.4%	61.3%	62.4%	69.7%	67.1%	68.9%	70.4%	65.9%	76.3%	68.6%	62.5%	68.0%	68.2%	70.5%	67.1%	70.9%	67.7%
	All Urgent		153	59	135	191	168	450	531	842	734	579	485	714	650	600	833	514	665	841	702	723	642	622	580	773
	Symptomatic Breast (%)	93%	50.0%	100.0%	100.0%	100.0%	100.0%	31.6%	50.0%	4.5%	2.1%	2.8%	0.0%	11.0%	3.7%	14.9%	8.7%	42.0%	30.4%	8.1%	29.0%	11.3%	7.9%	15.8%	35.8%	13.2%
	Symptomatic Breast		3	0	0	0	0	39	1	64	47	70	54	65	52	57	63	29	32	57	49	47	58	48	34	66
31 Day	All Decision To Treat (%)	96%	98.3%	97.1%	93.9%	94.9%	95.7%	95.7%	94.9%	95.6%	97.4%	93.0%	98.4%	96.8%	96.8%	97.4%	94.2%	94.0%	93.1%	91.5%	95.2%	91.0%	93.2%	92.0%	92.4%	90.3%
	All Decision To Treat		4	6	14	12	11	12	13	12	8	18	4	9	9	7	18	18	19	24	14	29	22	23	19	31
	Subsequent - Surgery (%)	94%	100.0%	90.0%	75.6%	76.6%	86.0%	87.5%	94.3%	93.2%	91.4%	85.1%	83.9%	81.4%	83.1%	81.9%	77.3%	88.5%	76.5%	87.5%	85.4%	79.5%	72.7%	75.6%	76.5%	55.8%
	Subsequent - Surgery		0	7	20	18	7	8	3	4	6	7	9	13	12	15	17	9	16	11	12	16	24	19	19	34
	Subsequent - Radiotherapy (%)	94%	98.2%	98.4%	97.3%	98.6%	97.0%	99.2%	99.2%	94.8%	99.1%	96.0%	98.6%	97.0%	99.3%	100.0%	97.1%	99.2%	98.3%	99.2%	100.0%	97.1%	100.0%	97.7%	99.2%	98.4%
	Subsequent - Radiotherapy		2	2	4	2	3	1	1	6	1	4	2	4	1	0	4	1	2	1	0	4	0	3	1	2
	Subsequent - Anti-Cancer Drug (%)	98%	100.0%	100.0%	100.0%	99.4%	100.0%	100.0%	97.3%	98.4%	98.6%	98.0%	99.0%	94.9%	96.8%	98.5%	100.0%	100.0%	100.0%	100.0%	98.7%	98.9%	98.6%	97.2%	100.0%	98.9%
	Subsequent - Anti-Cancer Drug		0	0	0	1	0	0	3	1	1	1	1	3	3	1	0	0	0	0	1	1	1	2	0	1
62 Day	All Screening Service (%)	90%	75.0%	75.0%	0.0%	100.0%	50.0%	80.0%		0.0%		0.0%	50.0%	66.7%	0.0%	16.7%	0.0%	0.0%	15.4%	50.0%	100.0%	15.4%	14.3%	33.3%	0.0%	56.3%
	All Screening Service		4	1	1	0	1	1	0	1.5	0	1	1.5	2	2	5	5.5	3	5.5	4	0	5.5	6	2	5	7
104 days	Volume of Patients Waiting Longer than 104 Days at Month End		59	89	117	48	34	24	35	33	44	88	48	53	33	42	42	32	45	36	36	38	46	39	37	40

Northern Services Diagnostics - *Fifteen key diagnostic tests*





Performance in respect of the diagnostics waiting times standard improved in March to 44.1%.

Key changes at modality level:

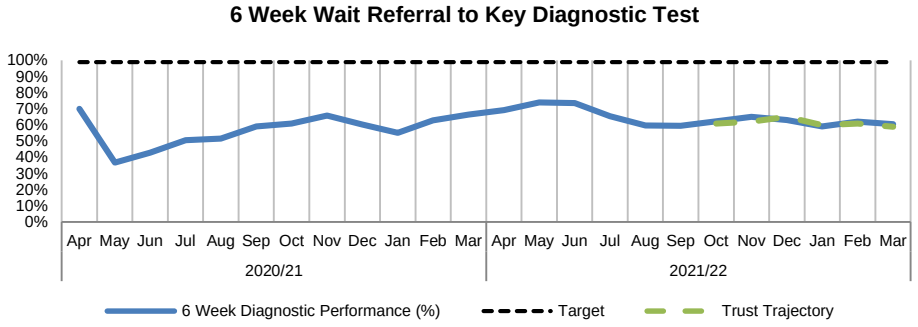
- DXA – New scanner is now operational on site, discussions with other sites and possibilities for recovery are underway.
- Sleep studies – Activity decreased due to a retirement within the team. Recruitment is on going, team are exploring bank staff in the meantime.
- CT and MRI have both improved dramatically. Mobile MRI van on site increasing capacity. Talks with the nightingale ongoing to explore non-contrast scans.
- Neurophysiology – continues to improve.

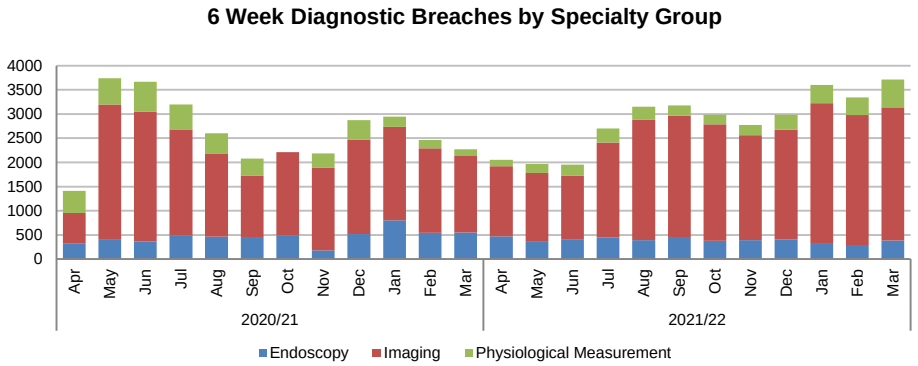
Patients are monitored bi–weekly via the diagnostic PTL meeting chaired by the Group Manager of Clinical Support and Specialist Services. Demand and Capacity work has been carried out to inform planning for 2022/23.

Achievement against the 6 week wait from referral to key diagnostic test

Area	Diagnostics by Specialty	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Imaging	Magnetic Resonance Imaging	78.4%	68.6%	72.3%	62.3%	70.3%	63.3%	73.1%	94.9%	98.1%	78.2%	74.4%	61.5%	52.2%	62.2%	47.4%	55.4%	54.8%	59.6%	64.9%	69.5%	62.2%	51.8%	69.1%	74.9%
	Computed Tomography	50.9%	52.4%	30.9%	44.7%	47.7%	55.0%	59.9%	73.3%	66.0%	61.4%	55.9%	59.7%	61.3%	68.9%	66.1%	62.2%	64.2%	64.5%	66.1%	61.4%	60.4%	48.0%	56.8%	53.0%
	Non-obstetric ultrasound	27.7%	38.0%	38.2%	44.1%	42.7%	50.9%	63.0%	58.7%	59.9%	46.4%	44.1%	53.6%	32.2%	29.6%	24.1%	25.2%	25.4%	28.9%	27.0%	37.6%	35.4%	32.1%	36.1%	40.1%
	Barium Enema		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	DEXA Scan	35.1%	42.4%	40.3%	44.1%	23.8%	26.1%	22.2%	21.6%	15.0%	14.1%	11.9%	8.7%	12.0%	15.3%	15.5%	12.2%	14.5%	14.6%	12.5%	11.7%	11.9%	10.0%	12.6%	12.4%
Physiological Measurement	Audiology - Audiology Assessments	27.9%	1.0%	48.0%	64.0%	72.9%	79.7%	83.4%	92.8%	93.9%	92.1%	94.9%	95.5%	89.9%	97.5%	98.3%	98.3%	99.2%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Cardiology - echocardiography	67.6%	49.2%	51.8%	64.8%	49.5%	73.5%	81.0%	92.5%	92.3%	67.6%	84.8%	81.4%	96.0%	99.6%	96.7%	84.8%	67.6%	67.9%	58.6%	57.5%	53.2%	37.1%	37.6%	36.2%
	Cardiology - electrophysiology		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Neurophysiology - peripheral neurophysiology	24.7%	3.4%	13.5%	14.3%	75.5%	80.4%	82.0%	81.0%	85.1%	86.2%	87.9%	90.3%	90.5%	95.5%	71.2%	56.3%	48.1%	70.2%	86.6%	94.3%	95.5%	81.6%	90.5%	96.4%
	Respiratory physiology - sleep studies	24.5%	88.9%	19.1%	40.2%	26.4%	25.0%	22.5%	23.9%	29.7%	21.4%	27.3%	37.9%	47.5%	57.7%	41.0%	73.9%	89.3%	68.8%	57.8%	50.9%	49.0%	50.4%	32.4%	29.3%
	Urodynamics - pressures & flows	18.3%	83.3%	12.9%	18.3%	7.8%	15.8%	24.4%	19.5%	19.6%	24.5%	26.7%	27.0%	23.1%	36.2%	30.4%	21.9%	18.6%	37.7%	49.4%	51.4%	45.1%	44.6%	35.8%	25.9%
Endoscopy	Colonoscopy	55.3%	39.7%	37.2%	35.3%	26.9%	31.8%	40.7%	38.5%	38.3%	38.6%	38.1%	44.3%	42.9%	38.2%	32.5%	38.7%	35.8%	47.1%	54.7%	51.5%	61.6%	72.3%	85.0%	72.0%
	Flexi sigmoidoscopy	57.4%	40.4%	37.6%	48.4%	41.2%	37.6%	55.1%	58.4%	48.0%	34.2%	44.3%	49.0%	46.6%	42.1%	39.3%	40.7%	42.9%	52.5%	55.7%	64.6%	74.4%	70.4%	84.2%	74.6%
	Cystoscopy	49.1%	54.9%	52.1%	54.7%	48.5%	53.2%	56.9%	73.7%	37.2%	30.6%	35.4%	37.5%	28.7%	42.4%	41.7%	46.6%	43.8%	55.5%	51.1%	62.6%	59.1%	51.8%	51.9%	63.9%
	Gastroscopy	47.9%	38.4%	37.5%	43.4%	30.9%	40.4%	38.2%	38.2%	37.3%	28.1%	31.3%	35.1%	37.3%	41.4%	39.7%	56.9%	49.2%	61.0%	65.9%	81.8%	86.4%	83.7%	87.4%	82.0%
Total		41.4%	42.4%	41.6%	47.2%	43.6%	49.8%	54.8%	55.9%	52.2%	43.9%	45.4%	47.7%	38.9%	43.2%	39.4%	40.3%	39.1%	42.7%	43.9%	48.2%	46.4%	39.2%	43.9%	41.1%

Eastern Services Diagnostics - *volumes of patients waiting longer than 6 weeks for one of fifteen key diagnostics tests*

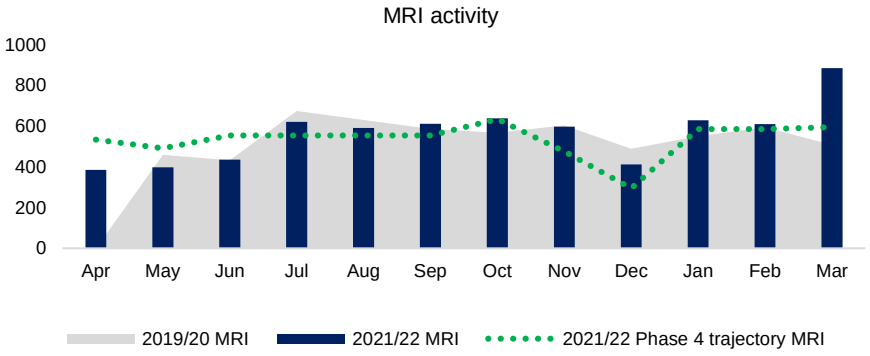


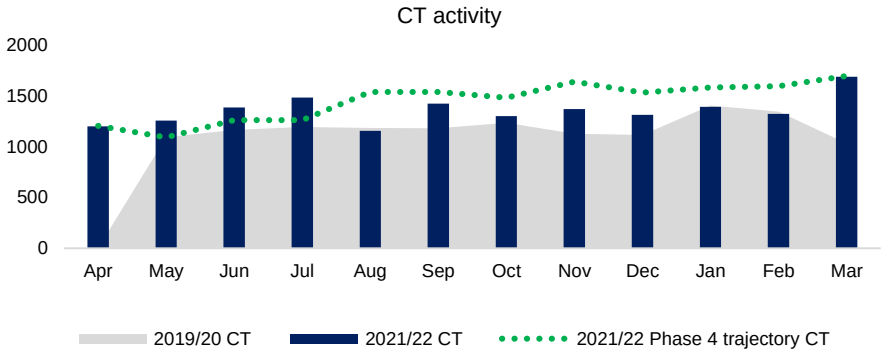


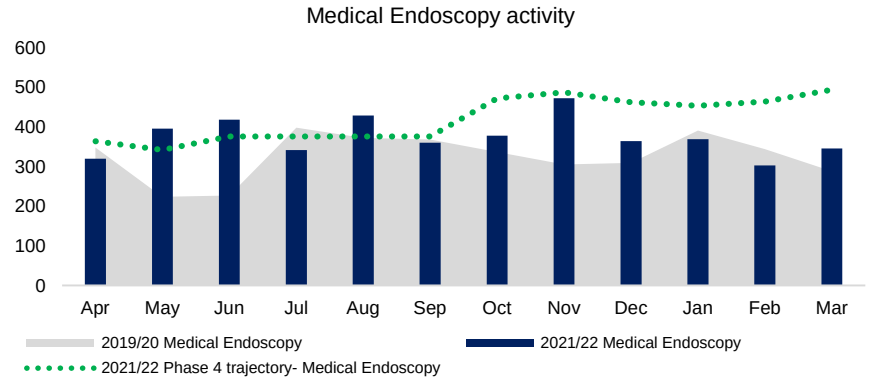
Diagnostic waiting times performance decreased by 1.6% to 60.5% in March, representing a further 376 patients waiting longer than 6 weeks at the end of the month compared to the end of February.

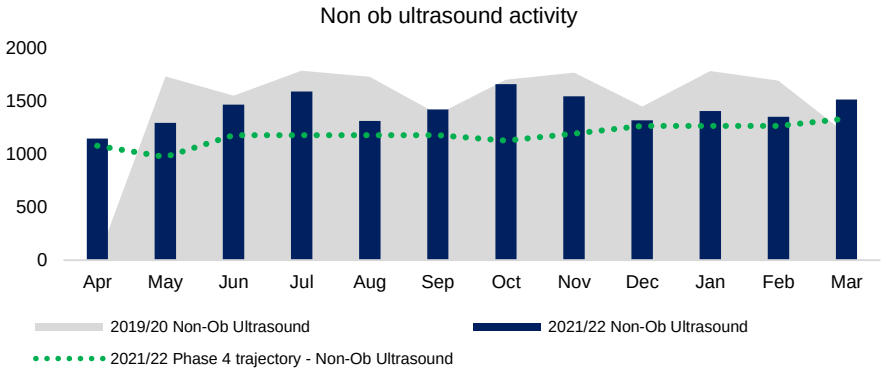
Area	Diagnostics By Specialty	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Endoscopy	Colonoscopy	54.5%	68.4%	66.1%	63.4%	67.5%	68.0%	64.8%	54.3%	52.0%	66.9%	73.3%	67.0%
	Cystoscopy	67.5%	65.9%	44.6%	55.4%	61.3%	37.5%	62.5%	67.1%	86.3%	86.0%	71.9%	88.6%
	Flexi Sigmoidoscopy	58.3%	65.5%	59.2%	46.0%	54.7%	59.0%	61.6%	61.4%	50.0%	59.1%	74.8%	61.6%
	Gastroscopy	67.0%	78.7%	80.1%	70.1%	59.4%	68.4%	75.1%	75.7%	73.1%	70.5%	76.8%	61.7%
Imaging	Barium Enema	-	-	-	-	-	-	-	-	-	-	-	-
	Computed Tomography	53.3%	56.6%	57.8%	52.6%	49.5%	48.5%	42.0%	51.5%	50.2%	53.8%	48.7%	58.0%
	DEXA Scan	73.1%	95.0%	96.2%	76.3%	62.7%	58.9%	66.0%	84.8%	93.7%	96.0%	99.2%	88.0%
	Magnetic Resonance Imaging	64.8%	66.8%	67.9%	60.2%	53.2%	50.9%	57.4%	61.9%	58.0%	58.1%	65.8%	64.9%
	Non-obstetric Ultrasound	85.0%	87.7%	89.3%	76.4%	66.2%	64.7%	66.2%	67.3%	66.0%	51.6%	56.9%	53.3%
Physiological Measurement	Cardiology - Echocardiography	88.9%	89.8%	88.8%	83.6%	84.9%	87.4%	81.2%	79.6%	75.8%	82.9%	84.1%	88.3%
	Cardiology - Electrophysiology	-	-	-	-	-	-	-	-	-	-	-	-
	Neurophysiology - peripheral neurophysiology	88.5%	63.4%	56.0%	39.2%	47.8%	67.3%	84.0%	84.2%	68.9%	63.9%	71.9%	54.5%
	Respiratory physiology - sleep studies	79.7%	75.1%	74.6%	65.3%	64.4%	60.5%	86.0%	81.9%	71.8%	57.7%	60.5%	65.5%
	Urodynamics - pressures & flows	52.8%	84.4%	79.4%	79.4%	75.0%	80.6%	93.3%	84.8%	76.7%	38.3%	35.2%	29.6%
Total		69.3%	73.9%	73.6%	65.4%	59.8%	59.5%	62.3%	65.1%	63.0%	59.0%	62.1%	60.5%

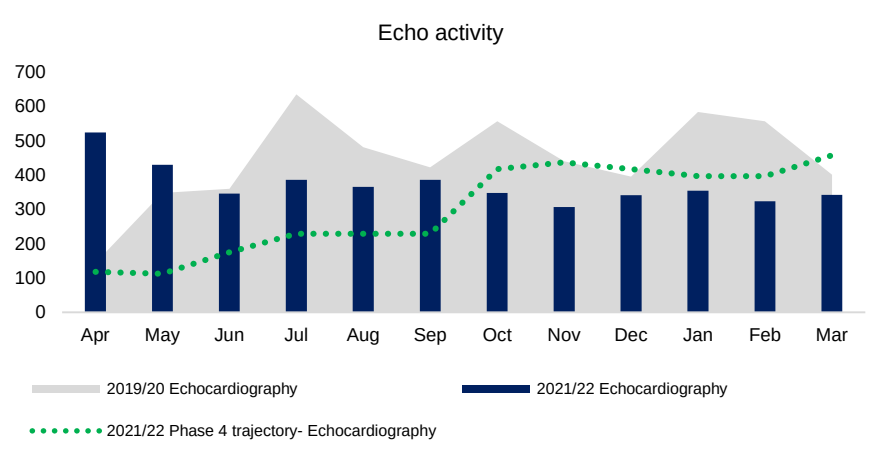
Northern Services Diagnostics - *Diagnostic activity compared to plan across key diagnostics modalities*









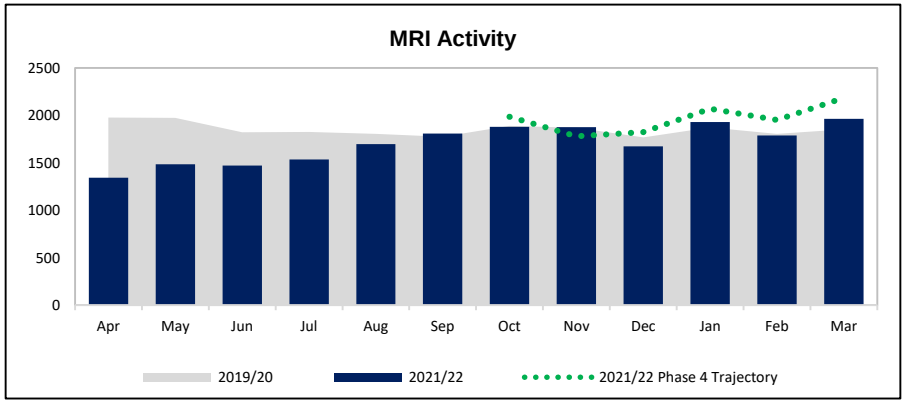


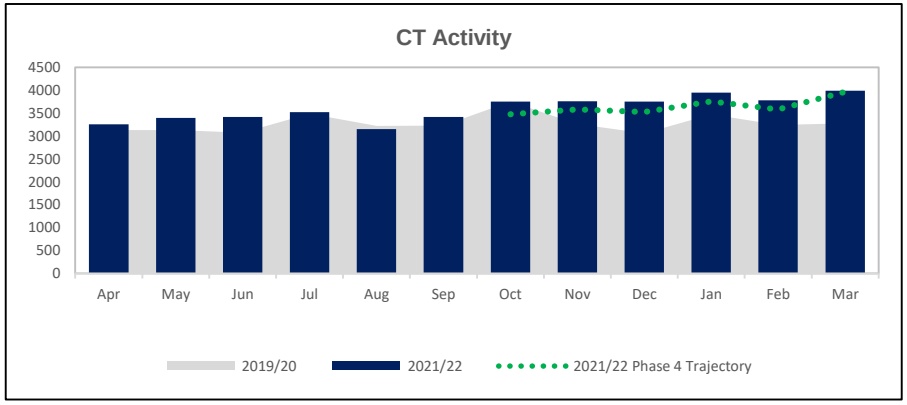
ECHO –The team continue to prioritize the wards, resulting in the cancellation of outpatient clinics. An ERF submission has been placed to double weekend clinic capacity, the team are awaiting approval. Staffing levels have increased, however the team still have 1 vacancy.

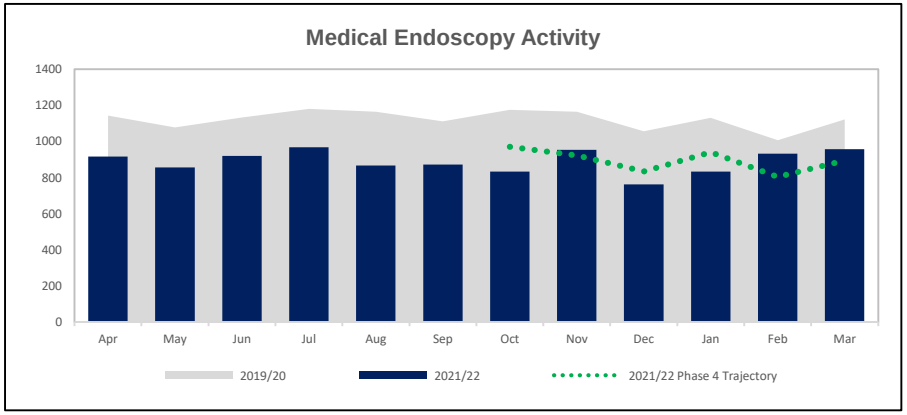
Endoscopy – In February performance dropped as storm Eunice lead to the cancellation of insourcing lists. Performance has improved in March, however COVID has impacted staffing levels. The team have submitted a risk around staffing levels in March, currently 3-4 lists are being cancelled every week.

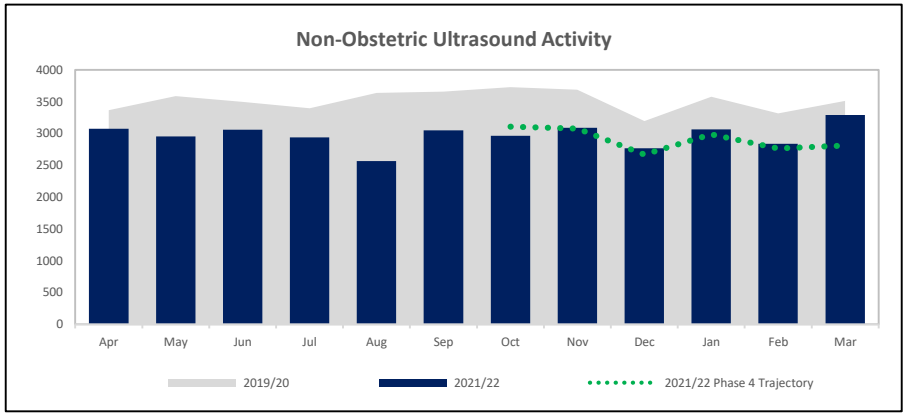
Cardiac CT – In house are doing lists every other weekend. Lists are planned for the next 3 months however these are reliant on staff taking on additional hours.

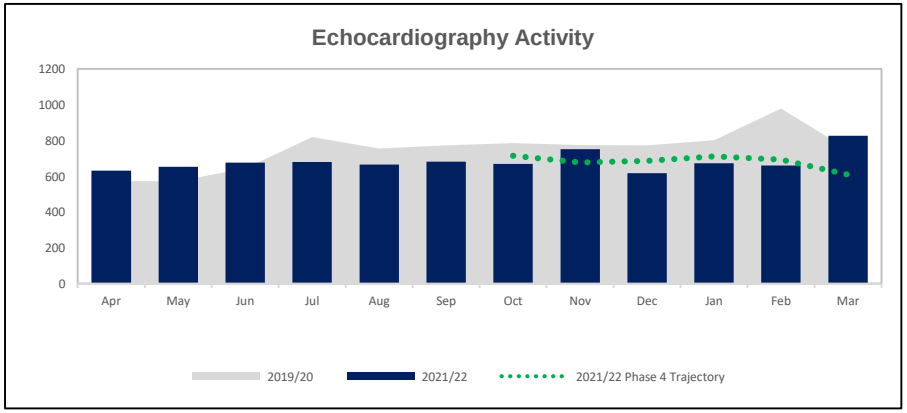
Eastern Services Diagnostics - *volumes of patients waiting longer than 6 weeks for one of fifteen key diagnostics tests*











Eastern Services Diagnostics - *volumes of patients waiting longer than 6 weeks for one of fifteen key diagnostics tests*

Imaging [2752 breaches]

CT

- March has seen an improved breach position, with planned patients now being managed as part of the active waiting list
- This position is expected to improve as Orthopaedics increase use of NHE facilities which in turn means the number of contrast slots can be increased at NHE as there will be greater resus cover for the scanners
- Over the Easter period, in order to fully utilise all the available NHE slots, Torbay and Plymouth have been offered additional non-contrast slots

MRI

- March has slightly deteriorated due to all mobile services being impacted by COVID related sickness and unplanned downtime due to equipment failure (now resolved)
- Assistants have been used to support the mobiles, where possible, when unexpected sickness may have otherwise resulted in cancelled mobile lists
- Planning with Northern Services continues for them to begin scanning at the NHE

Non Obstetric Ultrasound

- March sees a deteriorating position due to increased inpatient activity during the month at the RD&E, the team having to reallocate un-booked outpatient slots to inpatient bookings to support patient flow within the Trust
- Patients waiting longer than 10 weeks for an MSK ultrasound are being sent letters during April in line with the Trust waiting well process
- The Trust is currently exploring alternative third-party providers as an option to secure additional capacity as Peninsula US are unable to increase their weekly provision and due to the Community Diagnostic Centre funding delays recruitment and establishment of the increased capacity at NHE is not expected to come on line until September/October 2022.

DEXA

- The breach position has declined but this has been directly as a result of COVID related sickness. The position is expected to improve over the coming month.

Endoscopy [388 breaches]

- Performance worsened in March, with 388 breaches at end February, representing an increase of 111 from the end of February
- An issue with the script reporting overdue planned procedures has come to light and breach numbers have increased significantly as a result. BI have now confirmed that this is not expected to result in further significant increases in future months.
- Activity increased in March to 957, compared to a trajectory of 894, despite an increase in the number of unused available sessions as a result of staff absence (more than 50% of the Consultant team have had COVID in the past 7 weeks) and additional requirement to provide support to NDHT and to increase ward cover. Average points per list fell below 9 in some weeks due in part to short notice cancellations (patient and hospital)
- Nine super weekend lists were delivered in March and a further 11 are planned for April
- There is still a requirement for additional Endoscopy rooms to meet current and projected demand. A business case is being prepared to present to the Board (deferred until outcome of bid for external capital funding is known) to develop additional Endoscopy capacity.
- ERF bids for additional posts/resources have been submitted and a funding decision is awaited

Physiological measurements [576 breaches]

Echocardiography

- Echo performance improved again in March, with breaches reducing to 93 , compared to 123 at the end of February (2022). This represents the lowest number of breaches since September 2021.
- Activity in month was 827 – well above the trajectory of 610, despite the continued need to divert activity to support inpatient demand
- Plans for weekend WLI sessions in March and April are on track and expected to reduce breaches further, with 3 weekend sessions held in March and 3 planned so far for April 2022.

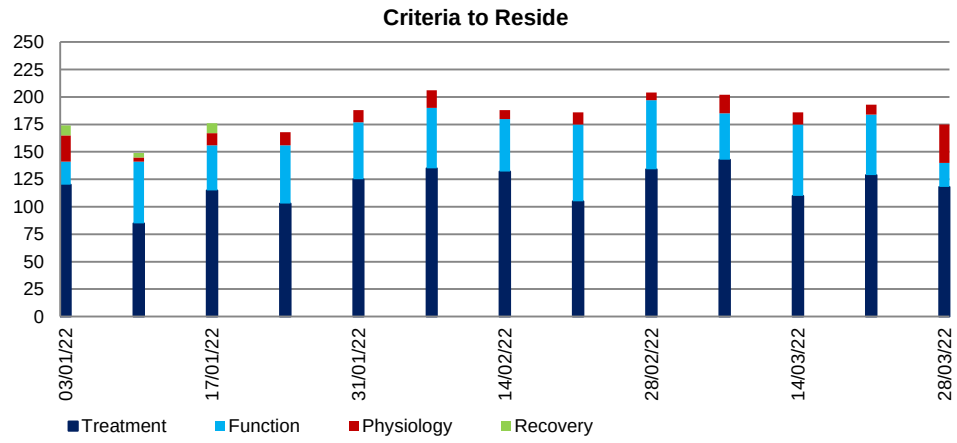
Respiratory Physiology

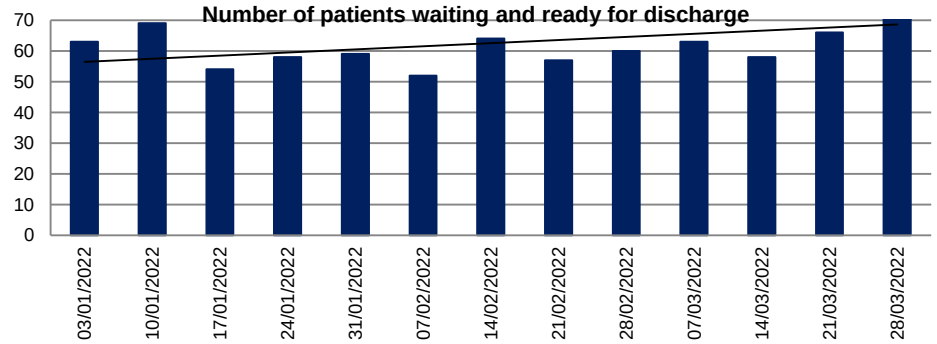
- The number of patients waiting in excess of 6 weeks increased again from 79 at end February to 140 in March.
- The department continues to try to manage the impact of a vacant post, which is affecting capacity, and have also experienced additional absence through COVID related sickness/isolation and maternity related absence.
- The team continues to try to recruit a locum to support recovery of pulmonary function and sleep study performance and is exploring opportunities to extend the roles of existing team members through internal development
- Breach numbers are expected to increase further until the department is able to either recruit substantively or secure agency resource
- ERF bids for additional posts/resource have been submitted and await a funding decision

Neurophysiology

- The number of patients waiting in excess of 6 weeks increased from 56 at end February to 105 at end March.
- Two vacant consultant posts are partly filled with agency support but there remains a capacity gap, particularly in reporting. In addition, some agency clinics were cancelled at short notice in March and the agency were unable to provide cover.
- The service are working with the Specialist HR recruitment team to target international candidates
- An ongoing vacancy in the physiologist team also remains unfilled, and there have been increased sickness absence levels within the team. The service is working to expand internal training and development opportunities in the longer term to fill these specialist posts
- The team are continuing to try identify additional agency resource and have managed to arrange a few additional Consultant sessions in April/May, so hope to stabilise and reduce waits again over this period.

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





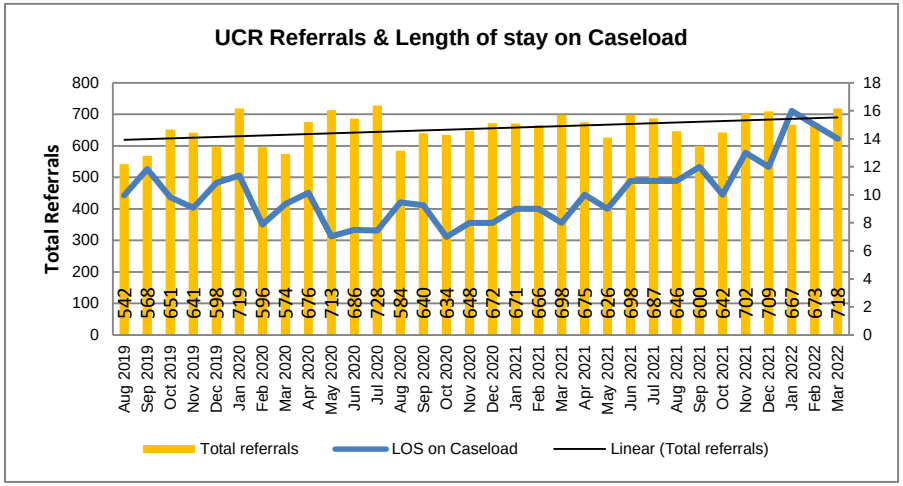
- In March patients categorized as other/ awaiting resource/ assessment/referral/bed resulted in the greatest number of delays.
- The Trust saw a peak of 78 patients waiting and ready for discharge on the 30th and 31st March.
- Limited nursing/residential care places and packages of care are resulting in a peak in patients waiting, resulting in limited bed capacity alongside an increase in admissions/COVID. As a result 133 patients had their elective activity cancelled in March, impacting long waiting patients and leading to poor patient experience.

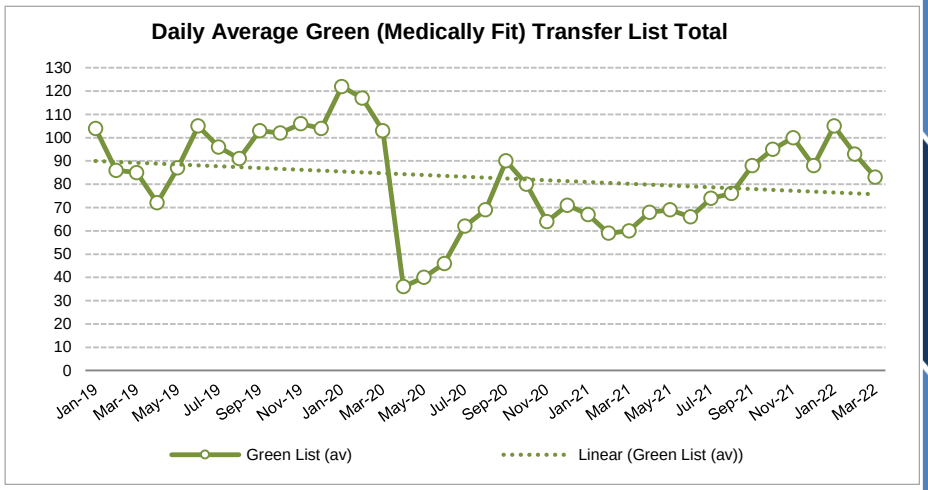
Modular Ward Update

In November 2021 an ERF scheme was approved to enable a 10 bed Modular Ward to be built at NDDH, this will provide the Trust with ring-fenced beds for elective surgery. The modular ward is now on site and work is being undertaken to complete the internal fit out. Completion for all works is 23rd May 2022, which is when the unit will run its first Orthopaedic lists.

	Delay Reason	03/01/2022	10/01/2022	17/01/2022	24/01/2022	31/01/2022	07/02/2022	14/02/2022	21/02/2022	28/02/2022	07/03/2022	14/03/2022	21/03/2022	28/03/2022
Delay Reason	Awaiting Med decision/written dc summary	0	0	0	0	3	2	1	0	0	0	0	0	1
	Awaiting community assessment / referral / bed	25	32	24	25	13	2	3	8	9	9	14	13	15
	Awaiting therapy decision	1	0	1	2	0	2	0	0	0	6	0	0	5
	awaiting resource / assessment to start care at home	26	28	22	18	8	26	6	4	6	15	18	12	18
	Awaiting residential / nursing home bed	8	5	6	5	19	2	17	15	12	2	3	1	4
	Repatriation / Transfer to another acute Trust	0	3	0	4	5	2	5	1	0	2	0	9	4
	Patient/family not in agreement with discharge plans	0	1	0	1	0	2	3	0	0	0	1	1	1
	Others	3	0	1	3	11	14	29	29	33	29	22	30	42

Eastern Services Urgent Community Response – *Admission Avoidance and Discharge*





UCR Demand

- There was a 6.7% increase in referrals to Urgent Community Response (UCR) in March with a 19% increase in referrals to support discharge on Pathway 1.
- UCR continues to respond to high levels of admission avoidance activity (325 in March) amounting to 47.9% of the total referrals. 53% of the total admission avoidance referrals requiring a two hour response came from primary care, 31% from within Community Services and 7% from Hospice.
- The daily average Green to Go list continues to reduce as a result of the increased focus on flow.

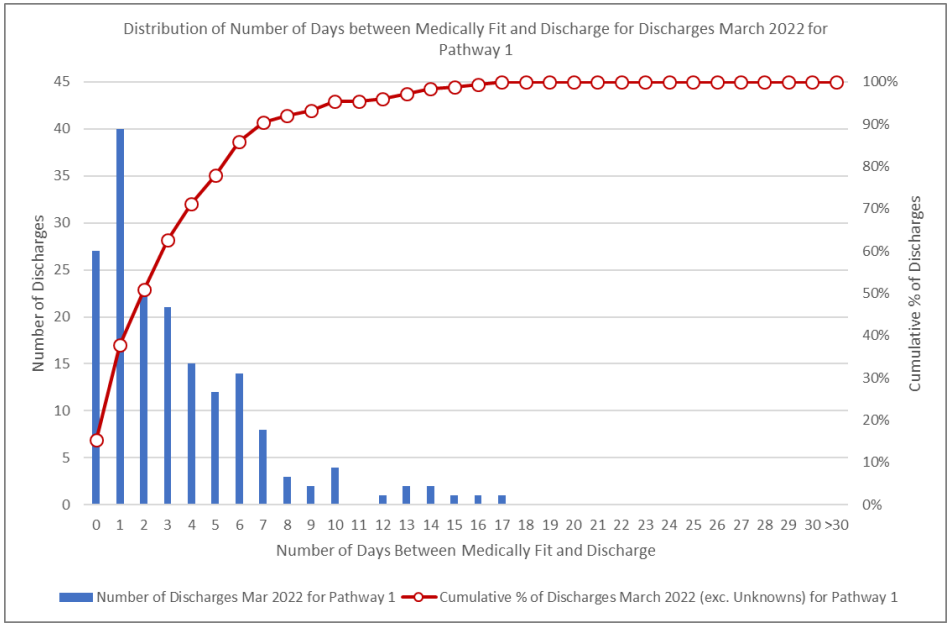
UCR Performance

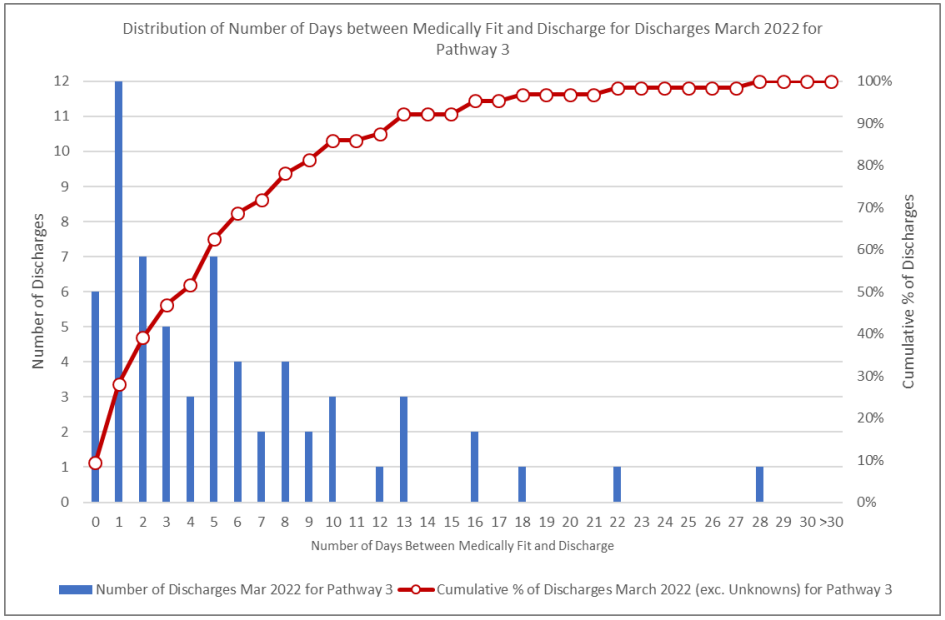
- 89% of clinically triaged admission avoidance referrals requiring an urgent response were seen within 2 hours (national target) which represents a dip from 93% the previous month which is attributed to high levels of COVID sickness and an increase in activity to support discharge from acute and community sites.
- Time to transfer for patients being medically ready to leave hospital to receiving UCR in the community setting was on average 3.7 days, up from 3.2 days in Feb.
- For admission avoidance referrals, at the point of discharge from the UCR service, 82% of people remained in their home environment.
- A reduction in the number of discharges from the UCR caseload to 627 in March compared with 637 in February and 663 in January is demonstrative of the complexity of the caseload and the high numbers of people requiring backfilled care.

Actions to improve performance and outcomes:

1. Successfully implemented Ageing Well (national programme) commitment of delivering UCR function 7 days per week from 8–20.00. This went live on 1st April 2022 in all areas of the Eastern Locality. This was delivered following a consultation with staff to extend the hours of cover and a recruitment campaign. Working collaboratively with the system group to further develop the service including receiving referrals from 999 and 111 and reviewing the reablement function of UCR.
2. Structure in place to give senior clinical and operational scrutiny of all patients medically fit for discharge. Emerging dataset on delays to arranging social care placements enabling greater problem solving for patients on pathways 2 and 3.
3. Working with commissioners to extend provision of agency social care provision beyond the end of April which has up to now been funded via winter allocation.

Eastern Services Flow Out Of Hospital – *Demand for and Performance of Discharge Pathways*





Pathway 1 Discharge Performance

- Average time to transfer for patients medically fit for discharge on Pathway 1 was 3.7 days, an increase from 3.2 days in February.
- 50.8% (90) of patients being discharged on Pathway 1 in the Eastern locality were transferred within 48 hours of being medically ready to leave hospital, which is an improvement from 46% in February.
- A further 36 patients were discharged within four days of being medically fit for discharge.
- 8 patients were outliers and against this target and were discharged between 12 and 17 days of being medically fit for discharge. These outliers are typically due to complex packages of care that are difficult to source.

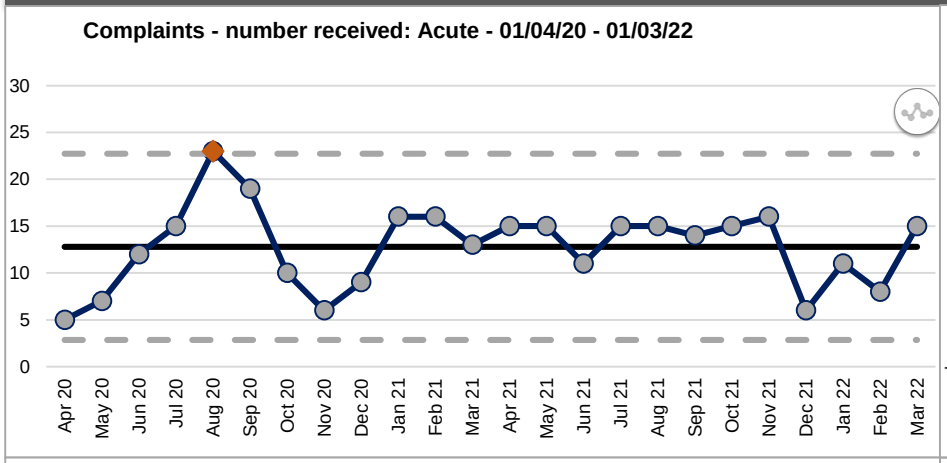
Pathway 2 Discharge performance

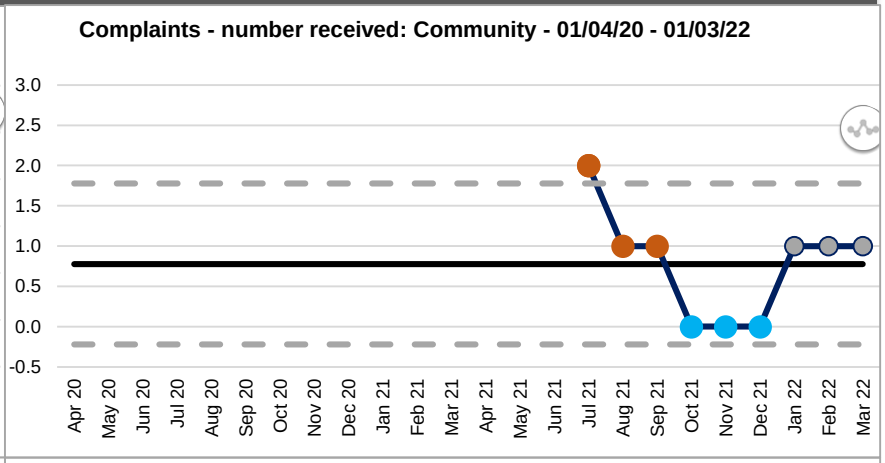
- The majority of **Pathway 2** discharge demand translates into internal transfers to community hospitals, and therefore not considered a discharge. The Trust is currently refining the data to include a position from April IPR onwards.
- Pathway 2 discharges from the acute hospital into short stay care home capacity is better resourced with the community rehabilitation teams who are increasing their visits per patient in order to drive the length of stay down and improve clinical outcomes and care needs longer term. From May IPR we will be reporting performance on 'keeping people well at home'

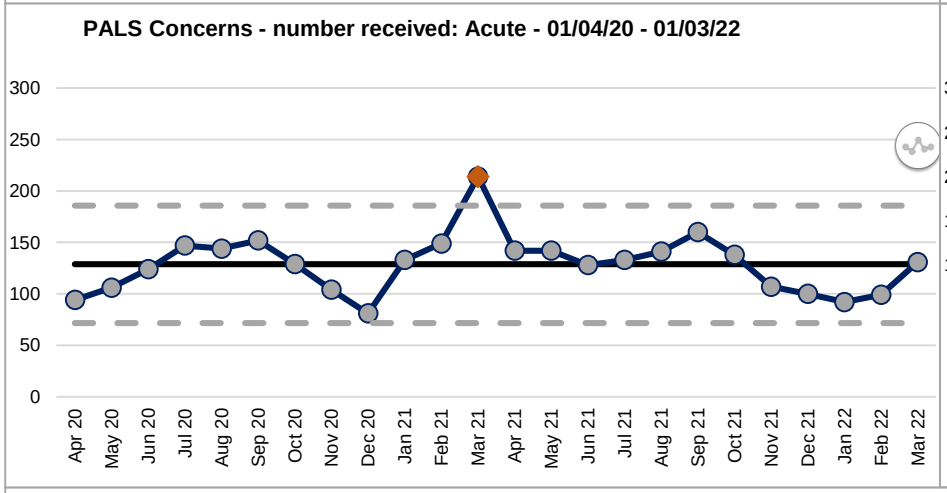
Pathway 3 Discharge Performance

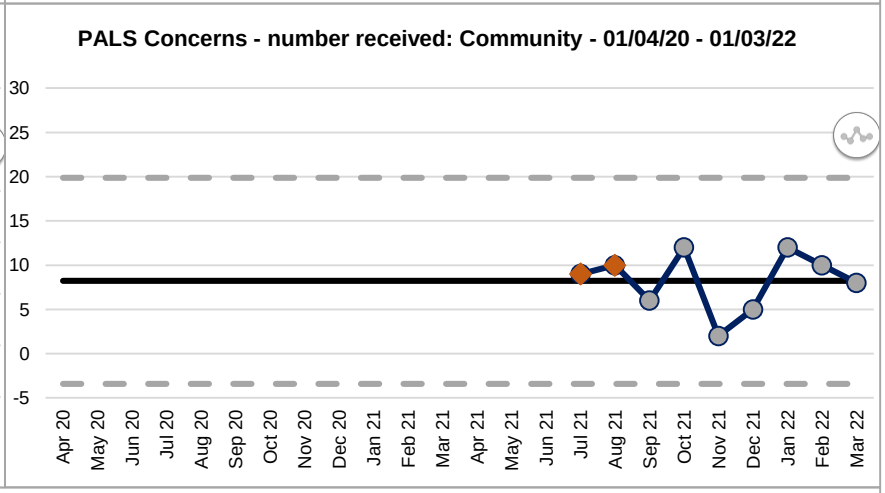
- Average time to transfer for patients medically fit for discharge on Pathway 3 was 5.6, a significant improvement from 9.5 days in February.
- 64 people were discharged from the acute into long term placement within a care homes. 39% of patients were discharged within 3 days and a further 23% were discharged within 6 days of being medically fit for discharge.
- COVID outbreaks in care homes continues to be a significant issue in the availability of care home beds.

Northern Services Patient Experience



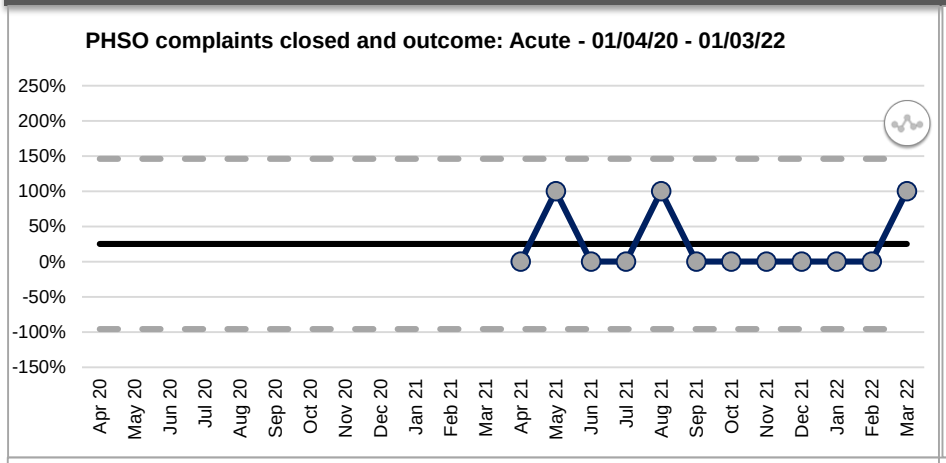


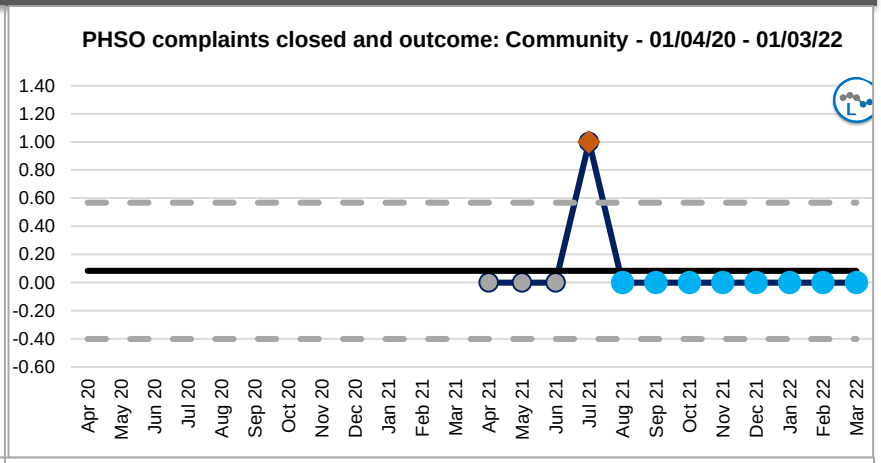


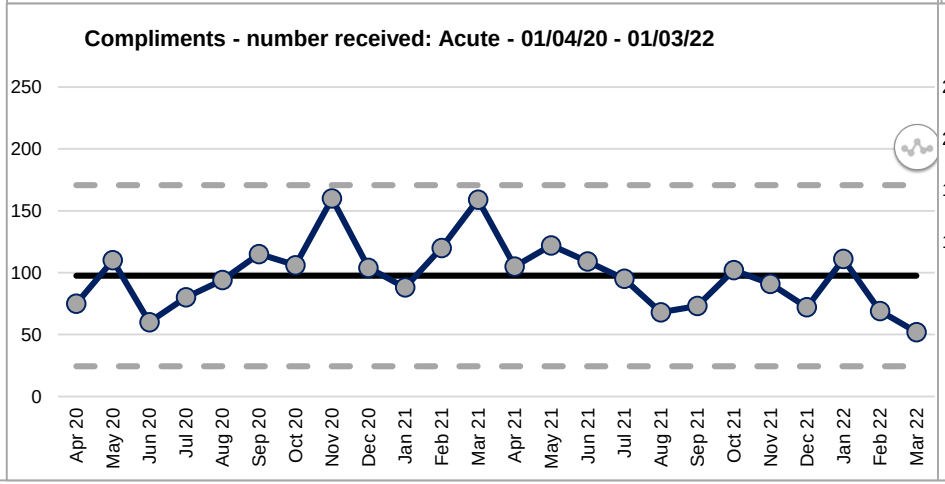


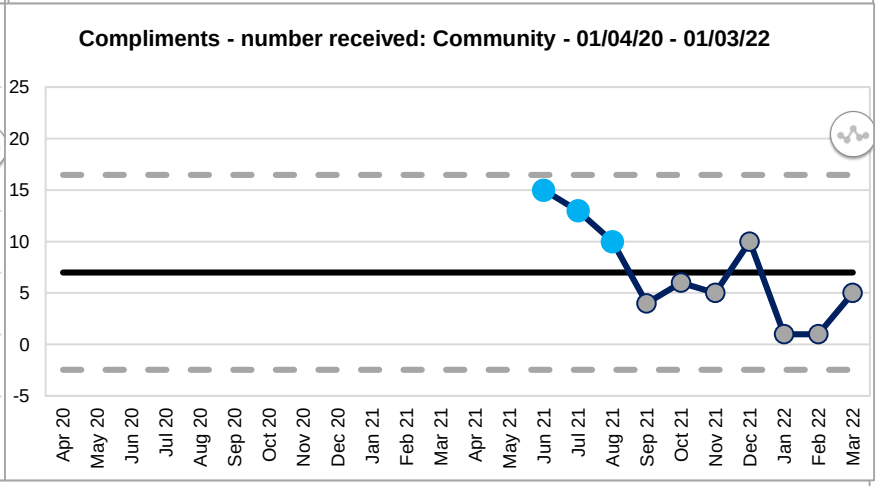
- The number of complaints and PALs concerns remain within normal variation .
- At the end of March there were 40 open complaints. The average number of days a complaint has been open is 56. Extended timeframes were agreed and complainants were kept fully informed of any delays in receiving their formal response
- 20 complaints were closed during March - 4 of the closed complaints were converted to a clinical incident investigation, 3 were coded as partially upheld, 6 were coded as not upheld, the remaining 7 complaints were either withdrawn by complainant , resolved with local resolution or required no further action.
- Significant staffing issues in both clinical and the patient experience team have attributed to the low number of complaints closed. Actions are underway to resolve staffing challenges, however the position is likely to be reflected in the timeliness of response rates in the next 2 – 3 months. The team are continuing to offer local resolution at the outset to improve complainant experience .

Northern Services Patient Experience



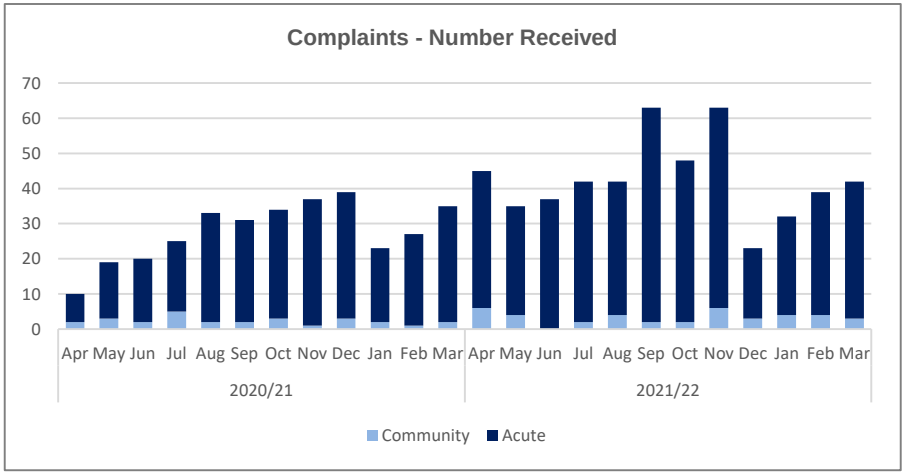


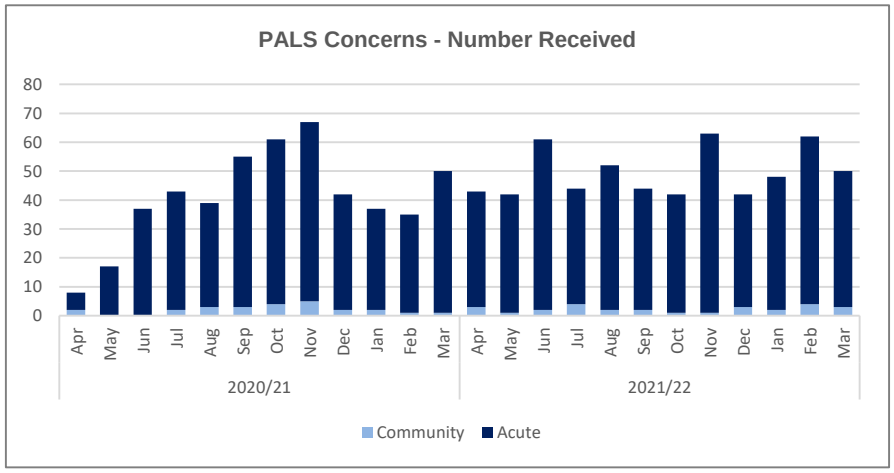


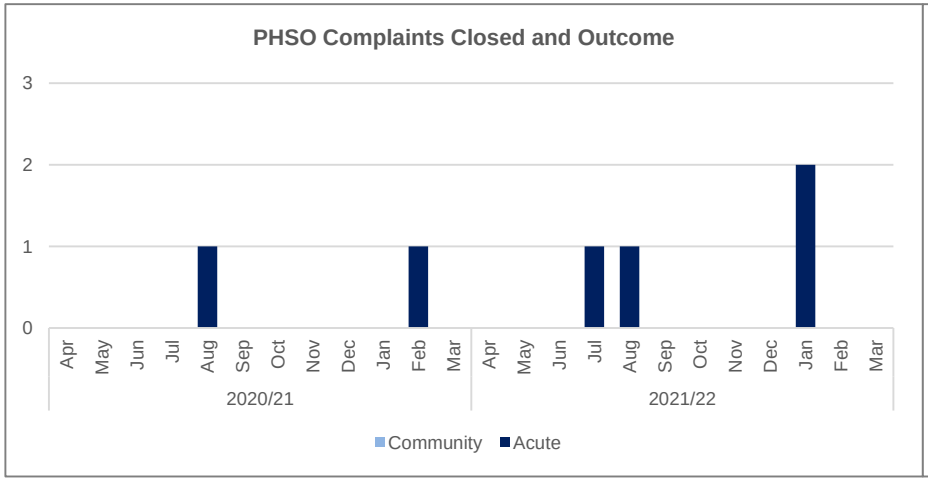


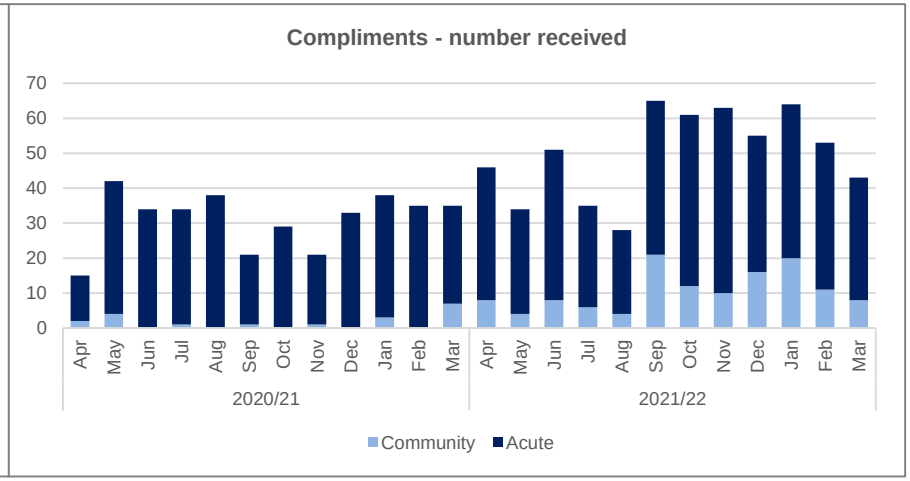
- During March one PHSO case was closed following assessment with no further action for the Trust.
- The total number of compliments recorded decreased slightly during March.
- Less than1% of the overall compliments recorded related to community services and work is underway to increase the capture of compliments in community settings.
- During March the top 5 areas for compliment reporting by location were:
  - A&E
  - Central Delivery Suite / Labour Ward
  - Leg Clinic (Community)
  - Hugh Squire and Victoria Ward

Eastern Services Patient Experience



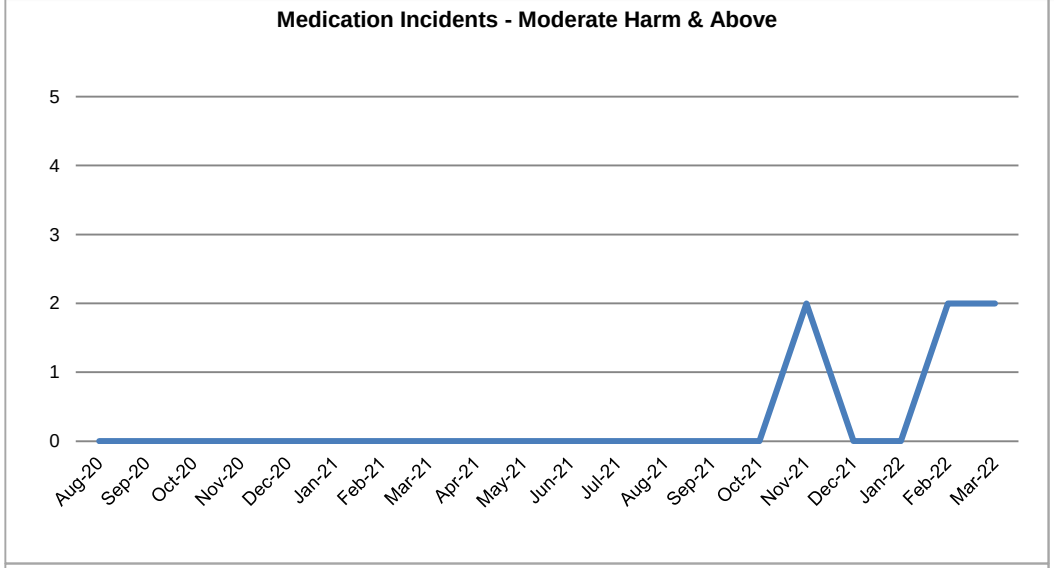




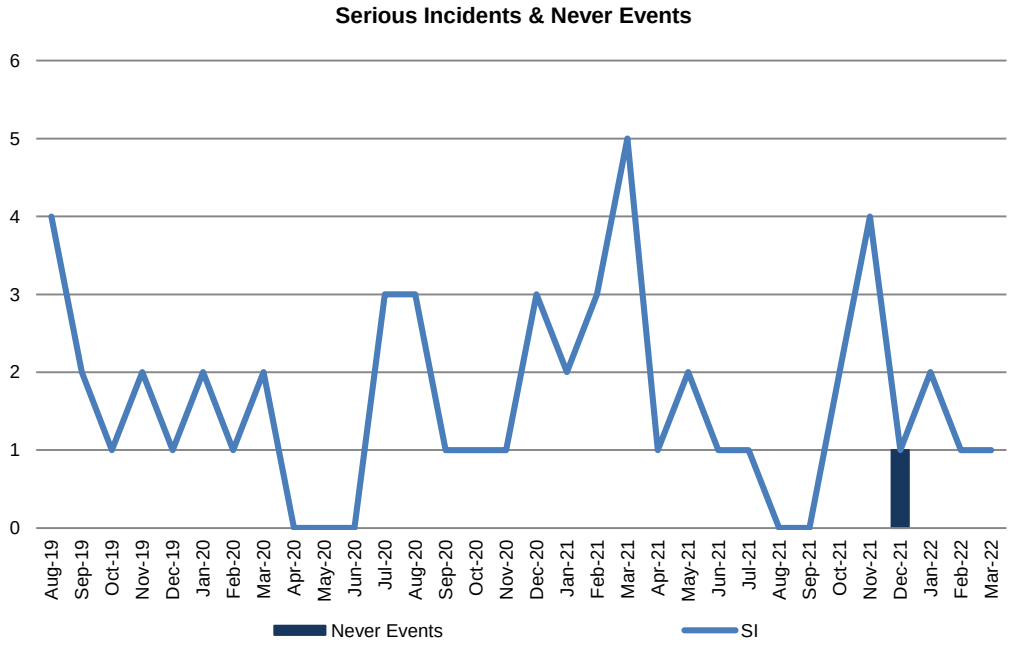


- 42 complaints and 50 concerns were received during March.
- At the end of March there are 169 open complaints, 101 of which are overdue. 106 complaints and concerns were closed during March, 63 of which were in excess of 45 days.
- Compliments received in March are on a downward trajectory. The top 2 locations for compliment recording are Medicine, and Children's and Women's Health.

Northern Services Incidents

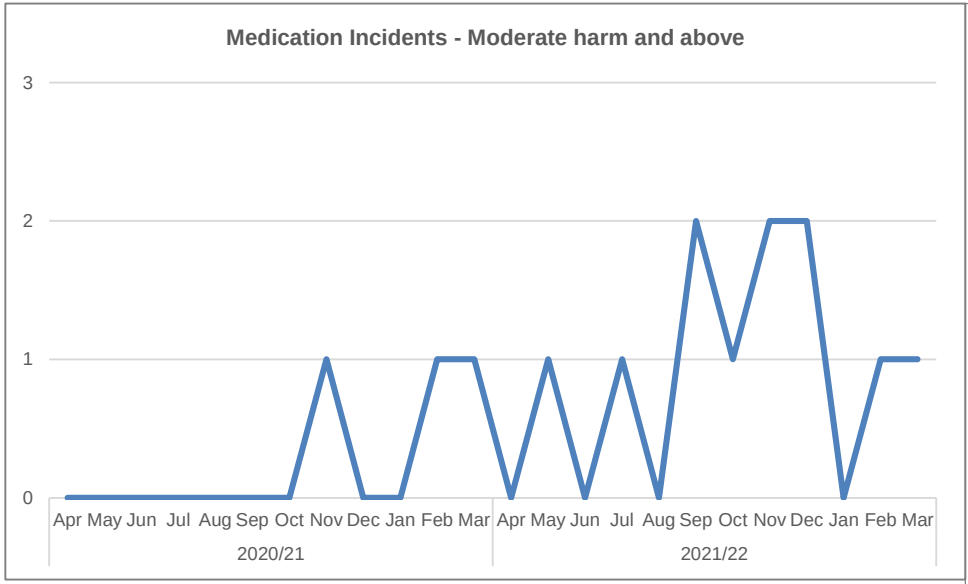


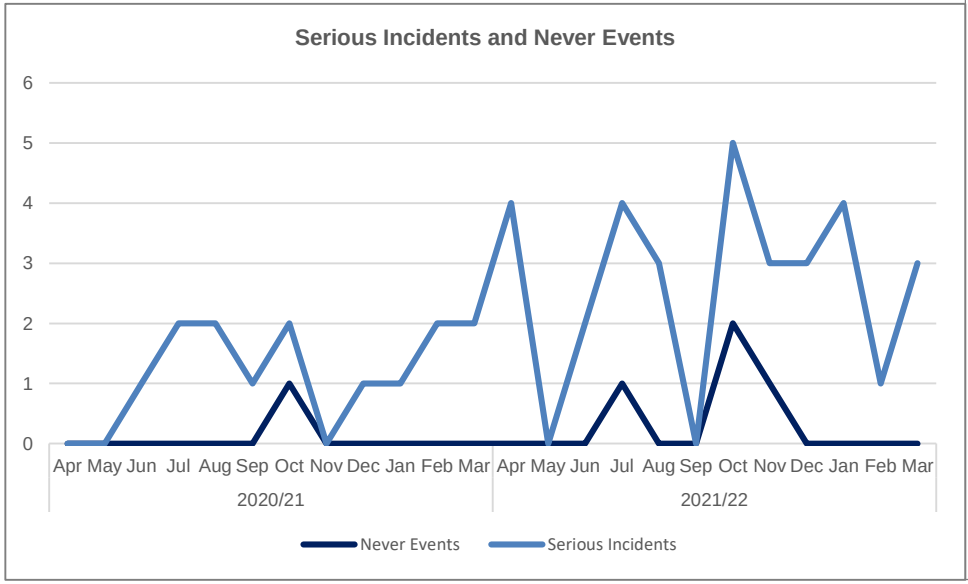
- In March 2022 there were 2 reported incidents of moderate harm or above. Both have been escalated for investigation.



- There was 1 incident reported as meeting SI criteria during March which is being investigated.

Eastern Services Incidents





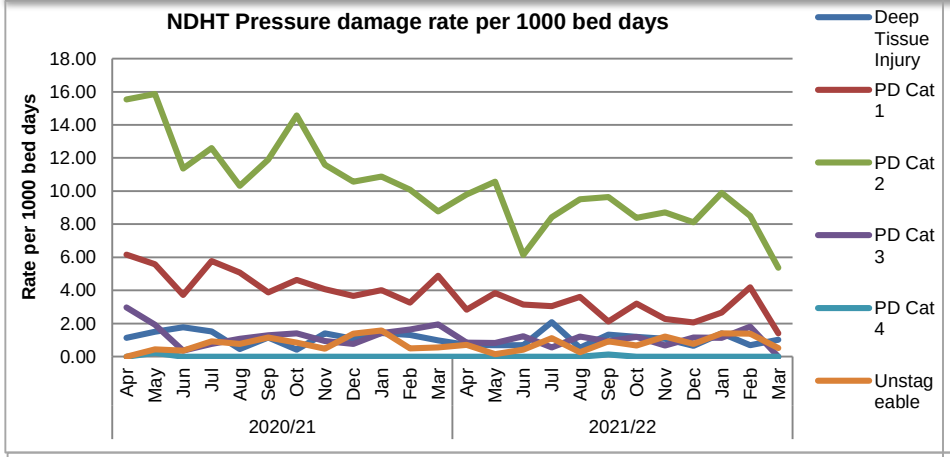
There was one moderate harm medication incident in March relating to a patient with type 2 diabetes where insulin was increased on addition, and they subsequently experienced hypoglycaemia. They responded to administration of Glucagon and a full diabetes review was triggered. An amber investigation has been commenced.

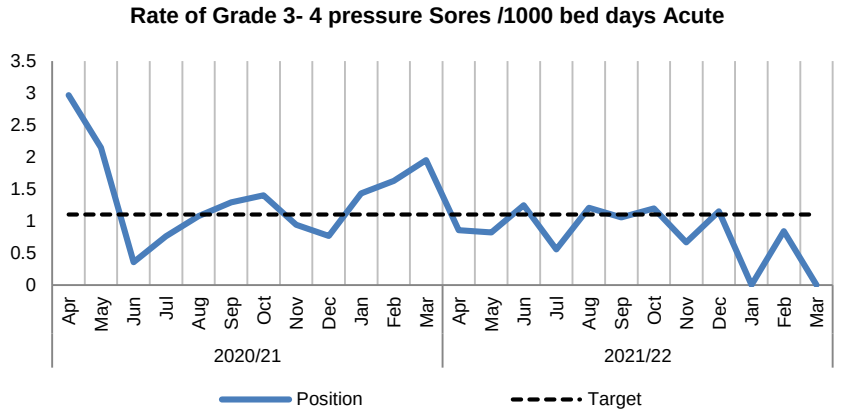
Three Serious Incidents were reported on StEIS:

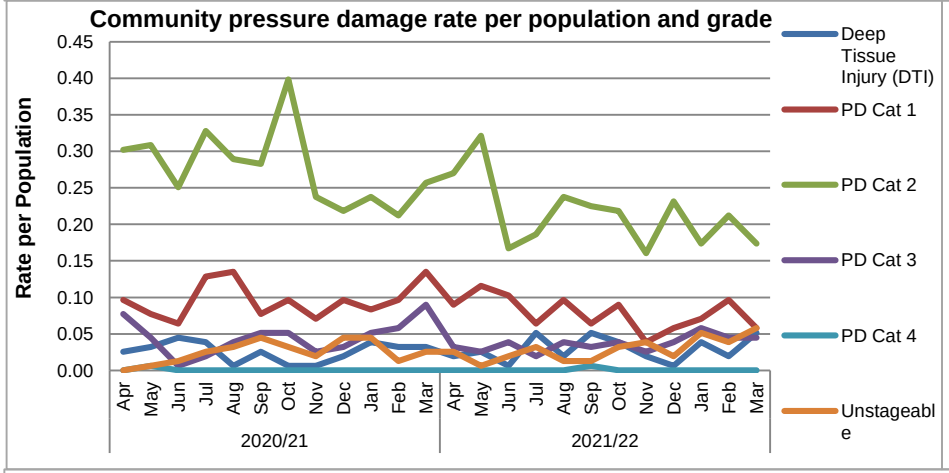
- HSIB reportable incident: a baby was transferred for therapeutic cooling.
- Chemotherapy incident: possible complication leading to hepatitis
- Patient's anticoagulant omitted on discharge, patent subsequently readmitted following stroke.

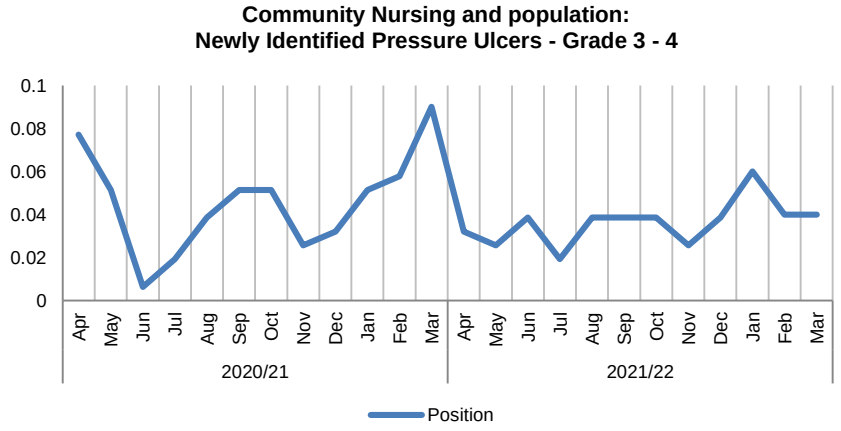
The Medication Safety Officer is providing an article on anticoagulation for a future issue of iBulletin to support learning from incidents relating to this type of medication.

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









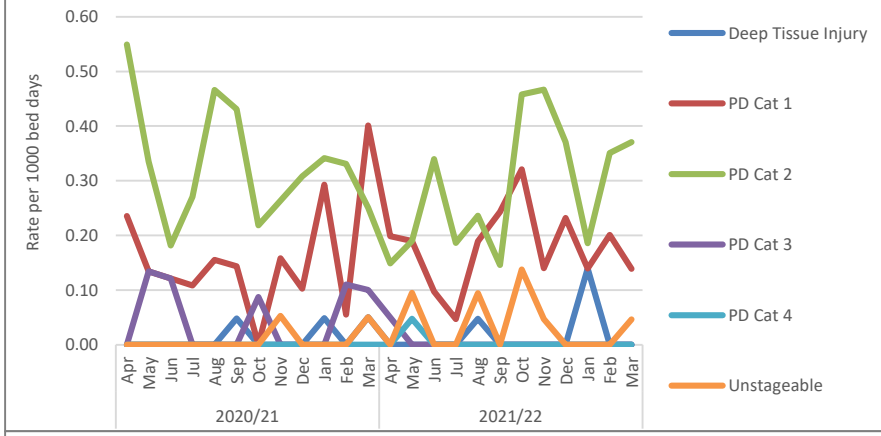
ACUTE –

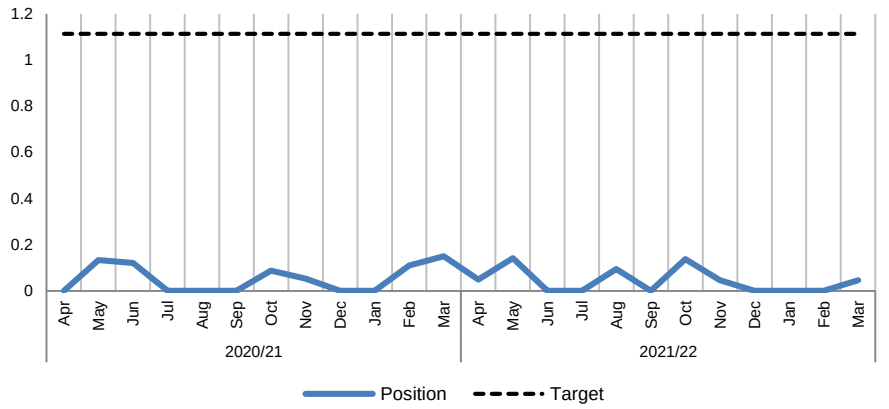
Overall there appears to have been an increase in the number of healthcare acquired pressure ulcers reported in March 2022 (65) compared to February 2022 (45), with no healthcare acquired category 3 or 4 pressure ulcers. This data has not been validated this month due to staffing absences so commentary on the final validated data set will be included in next month's report.

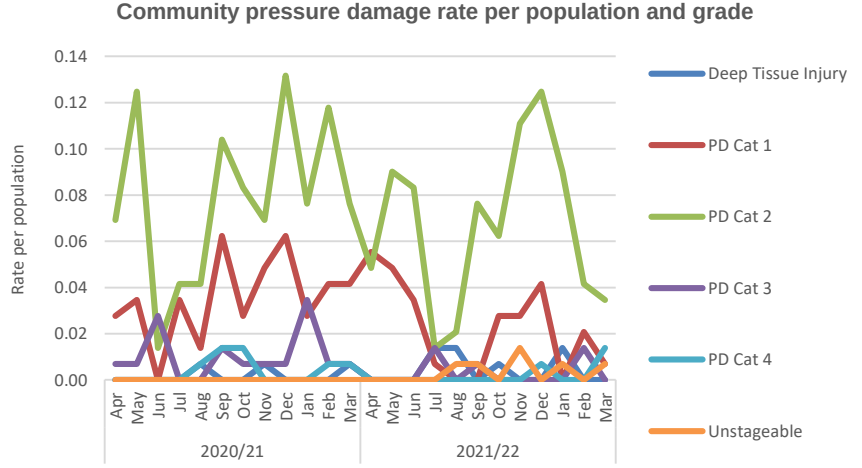
COMMUNITY –

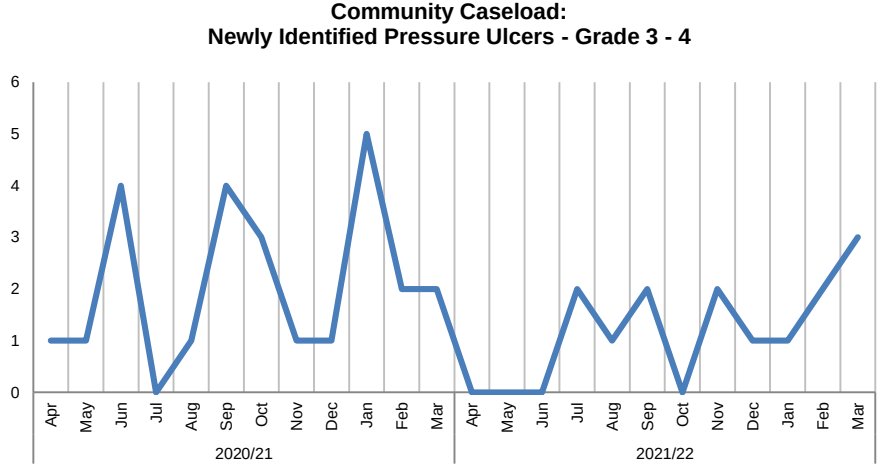
Overall there has been a decrease in the number of healthcare acquired pressure ulcers in March 2022 (60) compared to February 2022 (70). There has been 7 category 3 pressure ulcers reported in March. There were zero category 4 reported pressure ulcers. This data has not been validated this month due to staffing absences so commentary on the final validated data set will be included in next month's report.

Eastern Services Pressure Ulcers – *Rate of pressure ulceration experienced whilst in Trust care*



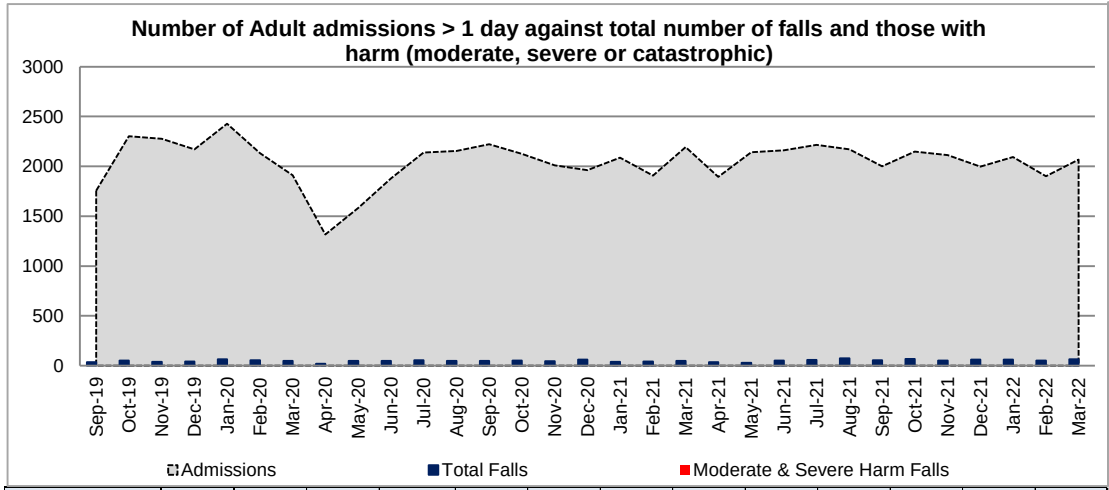




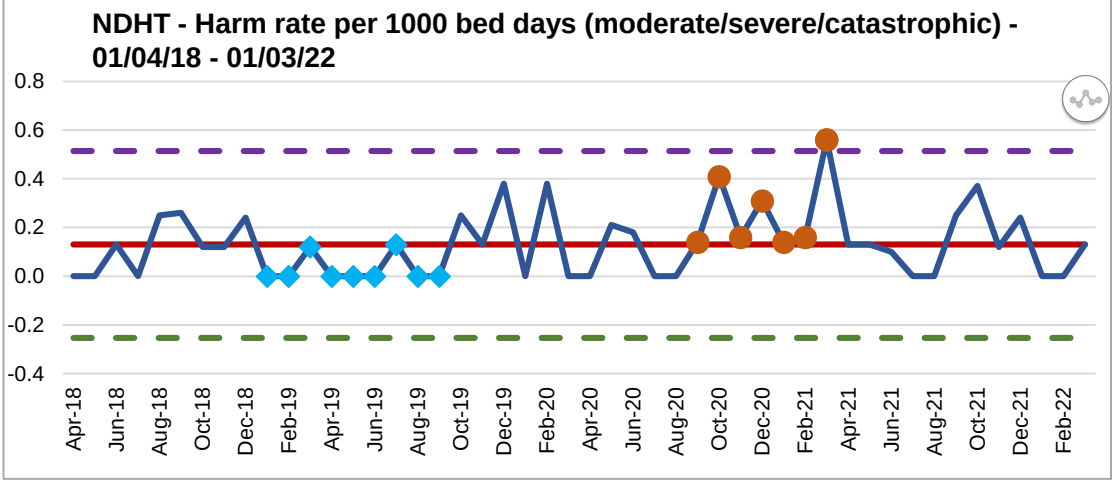


There is a normal variation in the pressure ulcers figures for March 2022 with no unexpected trends identified.
In March 2022, in the hospital setting there has been one patient develop unstageable pressure damage and an investigation is underway. In the community 2 patients developed category 4 pressure damage, both patients were non concordant with the advice, and there are no lapses of care identified. One community patient developed unstable pressure damage which is currently under further investigation. Once these investigations are complete learning will be cascaded via the newsletter and individual action plans.

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



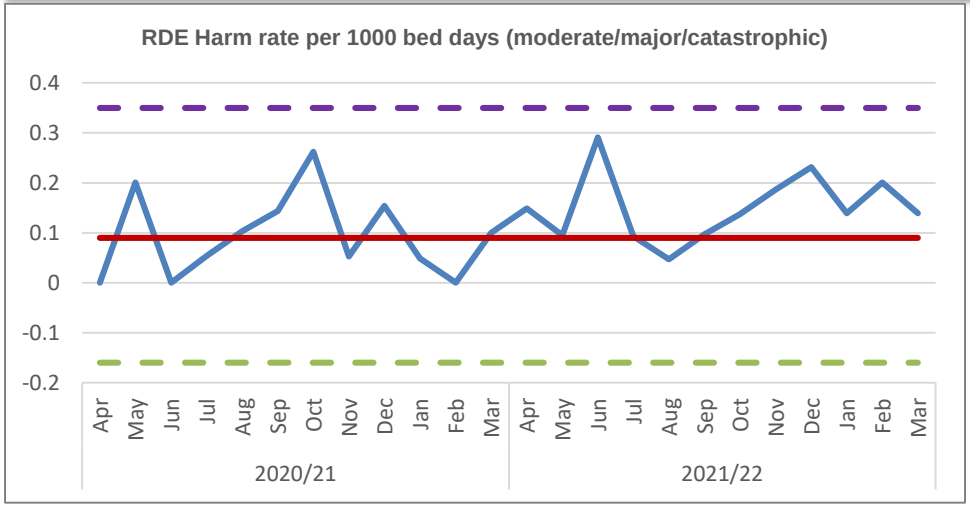
Month	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Admissions	2192	1896	2141	2162	2216	2170	2000	2148	2112	1998	2093	1900	2068
Total Falls	47	37	29	52	57	75	56	67	51	60	60	53	66
Moderate & Severe Harm Falls	4	1	1	0	0	0	2	3	1	2	0	0	1



In March 2022:

- 96.8% of patients admitted did not fall whilst within our care.
- There was one fall of moderate harm which is being investigated.
- Collaborative working continues with Eastern Services colleagues and the My Care team to design and build the new, shared falls assessments and post falls assessments. The Falls Policy is also being merged.

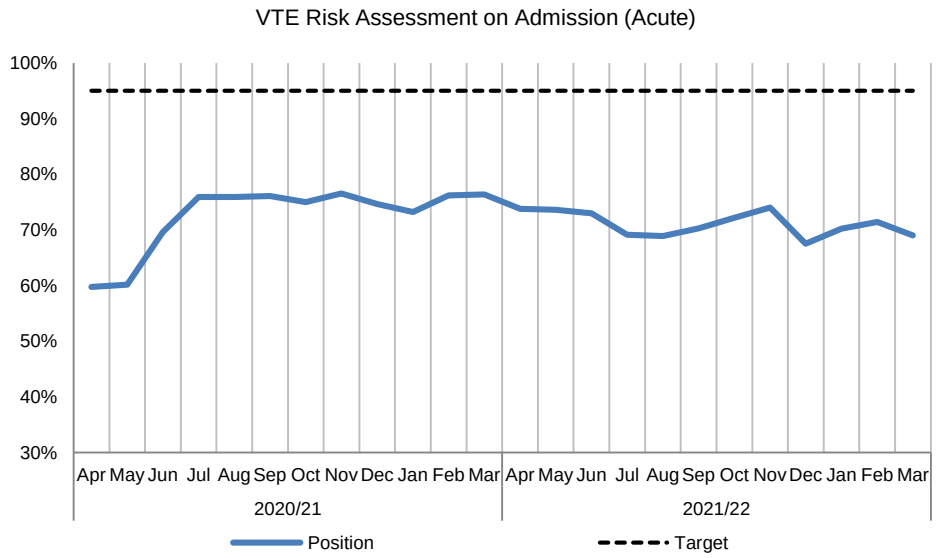
Eastern Services Slip, Trips & Falls – *Rate of incidence of slips, trips & falls amongst inpatients and categorisation of patient impact*



Month	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Admissions																								
Falls	96	104	108	95	102	97	143	132	160	139	96	130	116	112	120	110	129	133	161	160	177	143	152	206
Moderate & Severe Falls	0	3	0	1	2	3	6	1	3	1	0	2	3	2	6	2	1	2	3	4	7	3	4	3

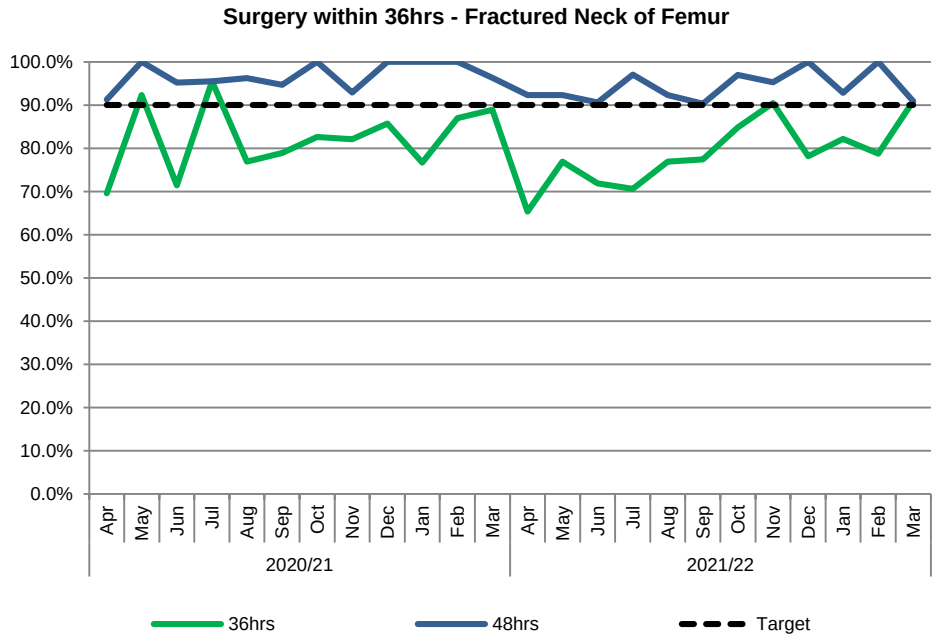
- Two patients experienced falls resulting in fracture to pubic rami and a further patient dislocated their hip following a fall.
- All three falls involved patients who were mobilising independently at the time of the fall, and no lapses in care were identified within reporting. Moderate investigation reports have been completed.

Northern Services Efficiency of Care – *Patients risk assessed for VTE*



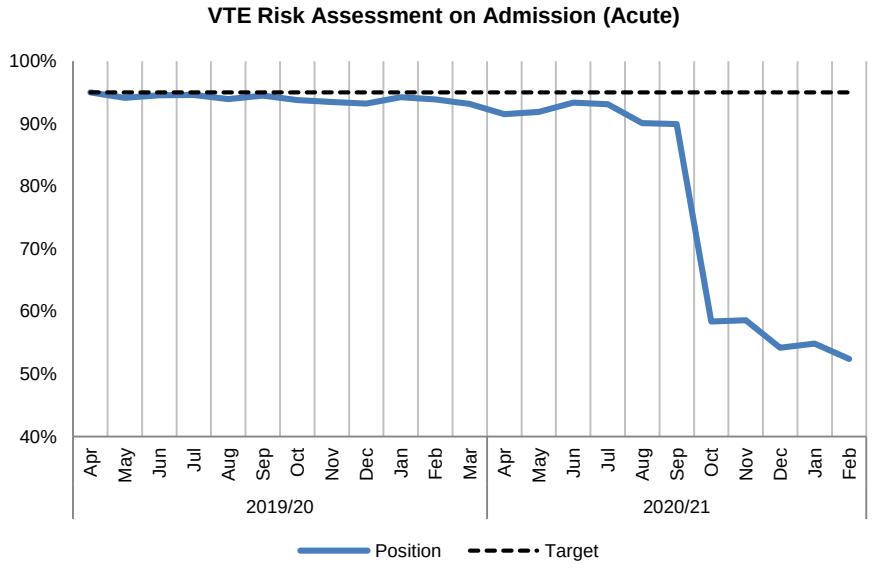
There remains challenges in the transfer of data regarding VTE assessments onto the electronic system.

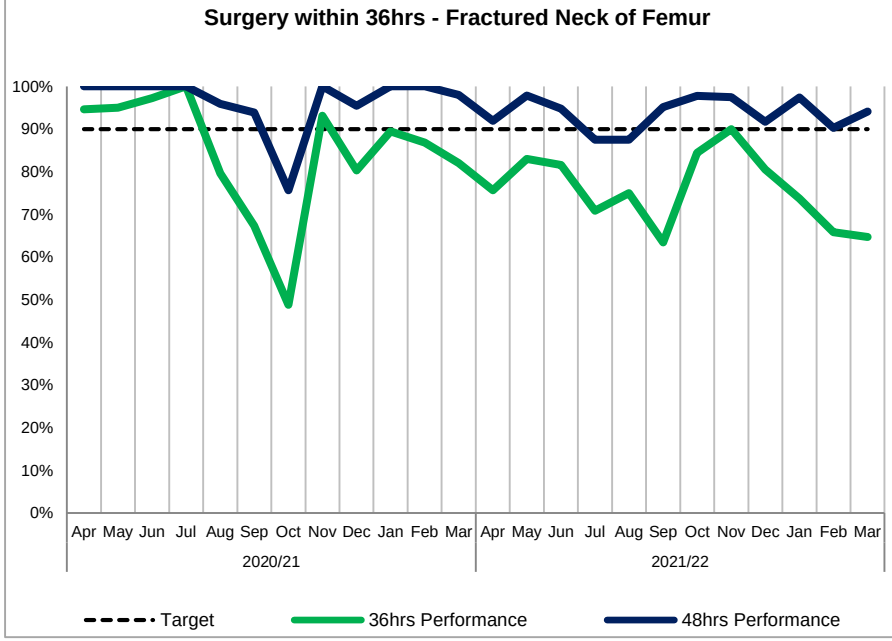
There was a spot audit in March 2022 and it will be presented at the Patient Safety meeting. There remains no evidence that patients are being harmed i.e. appropriate patients continue to receive prophylaxis and there has been no apparent increase in readmissions due to VTE or PE following discharge from hospital.



In March 2022, 91% of medically fit patients with a fractured neck of femur (NOF) received surgery within 36 hours. The Trust admitted a total of 22 patients with a fractured neck of femur in that month who were medically fit for surgery from the outset and of these 20 patients received surgery within 36 hours. The 2 patients in total that breached 36 hours were due to lack of theatre time and awaiting space on theatre lists.

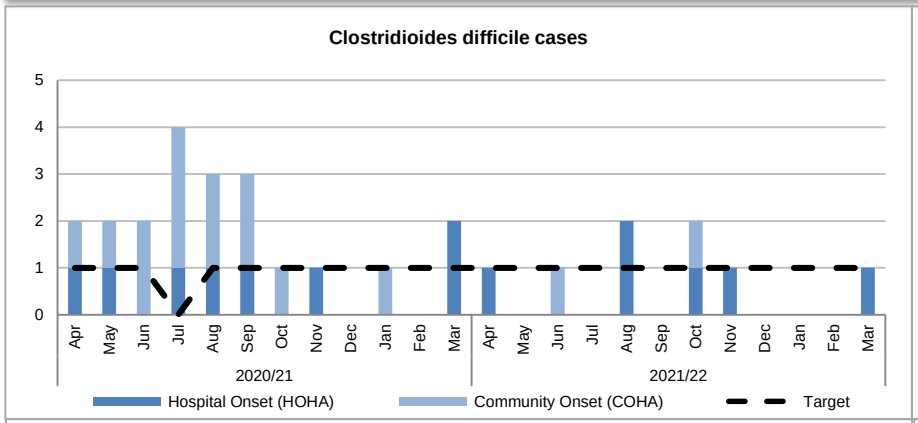
Eastern Services Efficiency of Care – *Patients risk assessed for VTE, given prophylaxis, & operated in 36 hours for a fractured hip*

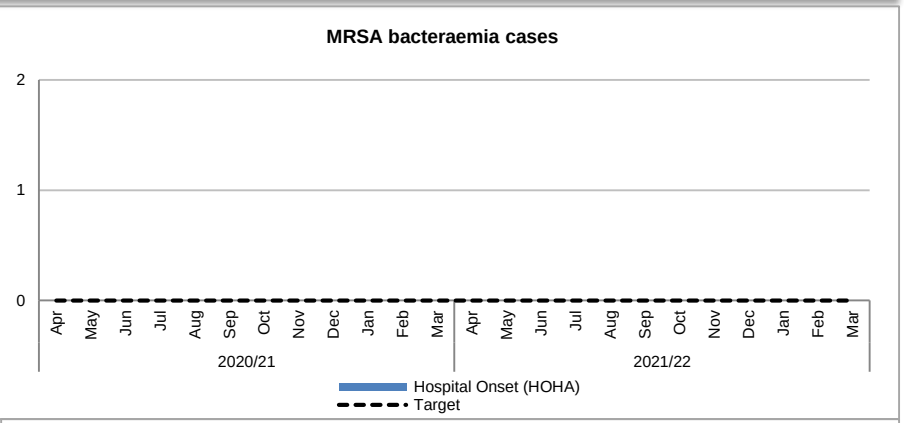


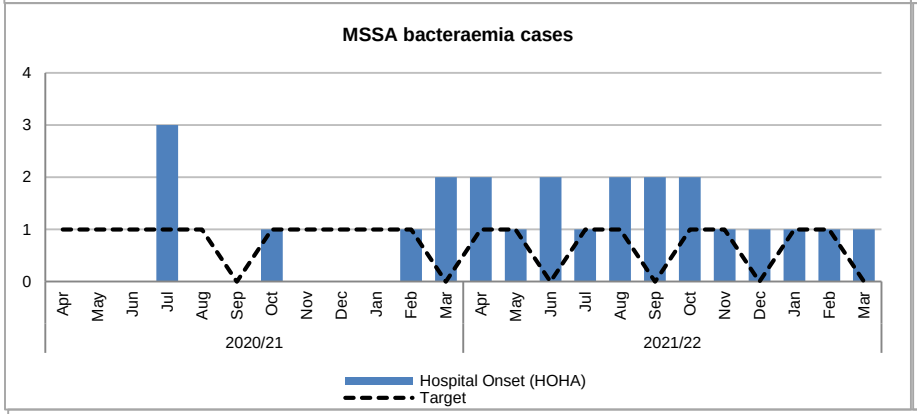


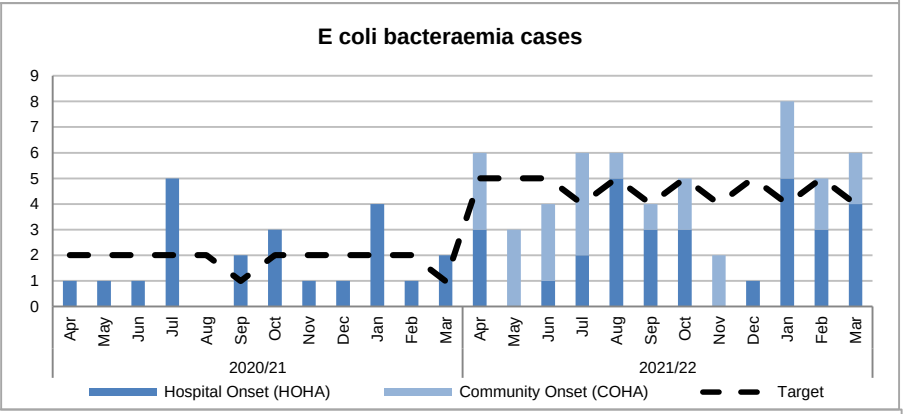
- In March 2022, 65% of medically fit patients with a fractured neck of femur (NOF) received surgery within 36 hours. The Trust admitted a total of 45 patients with a type of femoral hip fracture in that month, of which 40 patients with a FNOF. 34 of these patients were medically fit for surgery from the outset and 22 patients received surgery within 36 hours. The 12 patients in total that breached 36 hours were due to lack of theatre time and awaiting space on theatre lists. Two Medically Fit patients waited more than 48 hours for their surgery due to awaiting space on theatre lists, or were cancelled due to theatre over-run of previous cases. In March there were a total of 138 Trauma admissions. The average number of trauma admissions per day is 4 patients - within March on five days of the month, trauma admissions were greater than 8, with two occasions of 9 Trauma admissions per day.
- PEOC Theatres are predominately used for 'Priority two' cases, plus Spinal Trauma lists, which would not be usable capacity for any FNOF cases. Where clinically appropriate all FNOF cases are given priority in theatres over elective patients.
- The Hip Fracture Lead has reviewed all cases during the month and is confident that the quality of the clinical care remains high and the patients who breached 36 hours, did not come to any harm due to a slightly longer wait for surgery.

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









Healthcare associated infections remain within normal variation

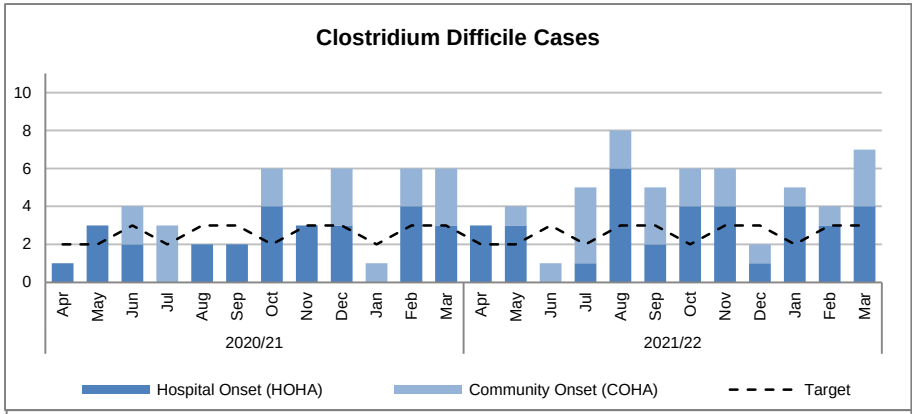
***Clostridioides difficile* (C dif):** There was 1 case of Trust attributed C dif in March 2022. No lapses in care were identified during IP&C review of the case.

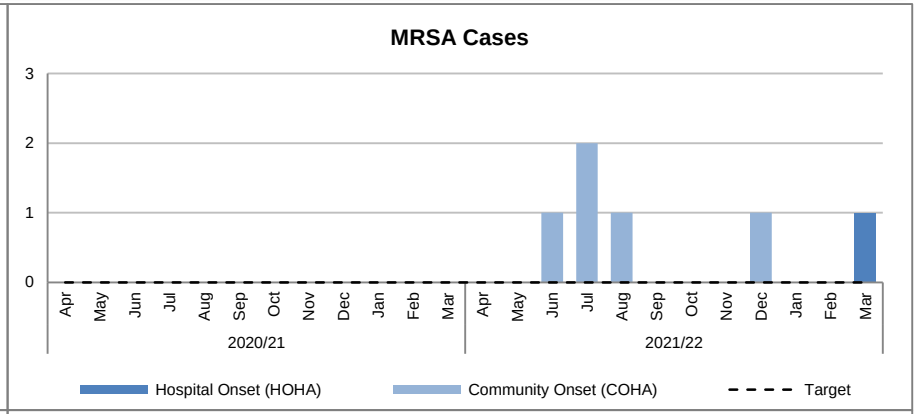
Methicillin resistant *Staphylococcus aureus* (MRSA): There have been no cases of Trust attributed MRSA bacteraemia since February 2015

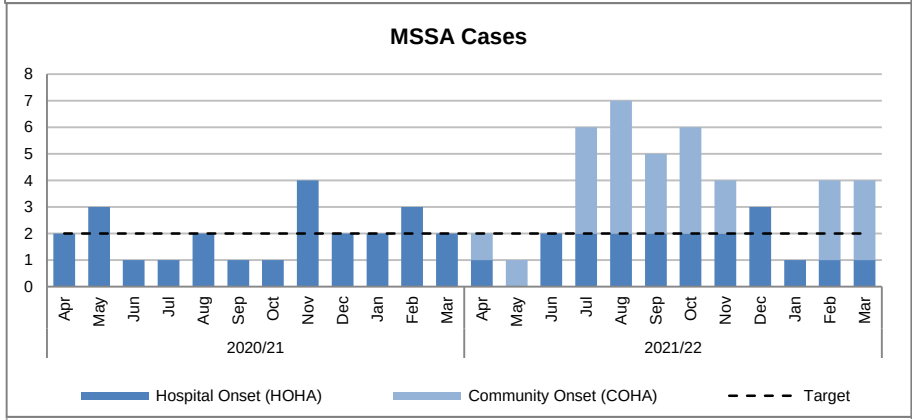
Methicillin sensitive *Staphylococcus aureus* (MSSA): There was 1 case of Trust attributed MSSA bacteraemia in March 2022. The directorate are undertaking a review into this central line related bacteraemia.

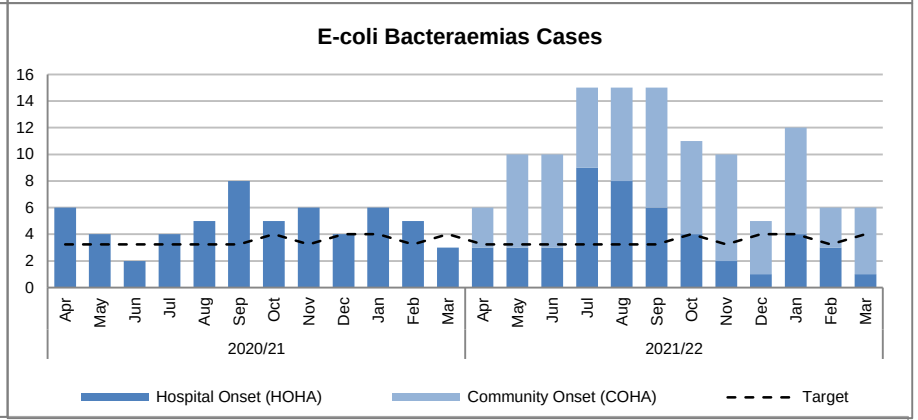
***Escherichia coli* (E coli):** There were 6 cases of Trust attributed E coli bacteraemias in March 2022. No lapses in care were identified during IP&C review of the cases.

Eastern Services Healthcare Associated Infection –*Volume of patients with Trust apportioned laboratory confirmed infection*









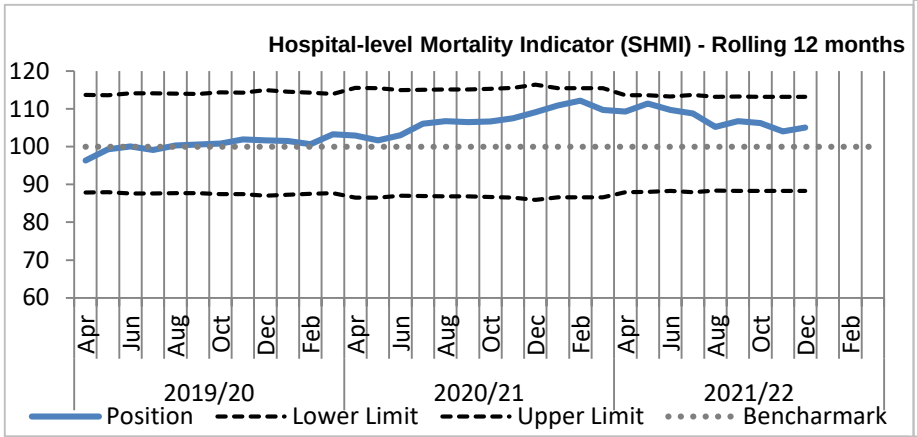
Clostridium Difficile Cases (C.Diff): Four cases were classified as Hospital Acquired (according to national definitions). All incidents resulted in minor harm to the patients affected. Investigations are complete for two cases; both were unavoidable infections, with no significant lapses in care.

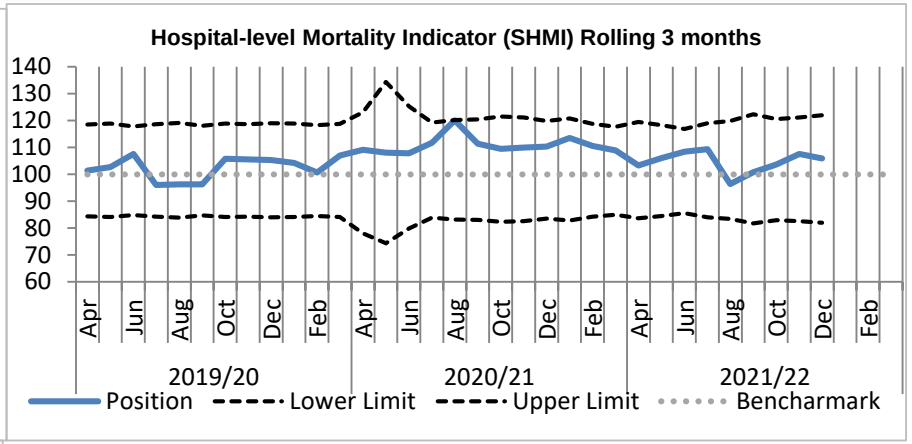
Methicillin Resistant Staphylococcus aureus (MRSA): One HOHA case reported for March. Post Infection Review (PIR) determined the case was unavoidable, unknown source. This is the first HOHA case since 2018. Incidental learning identified practice drift with MRSA screening techniques within haematology. No COHA cases reported since Dec'21.

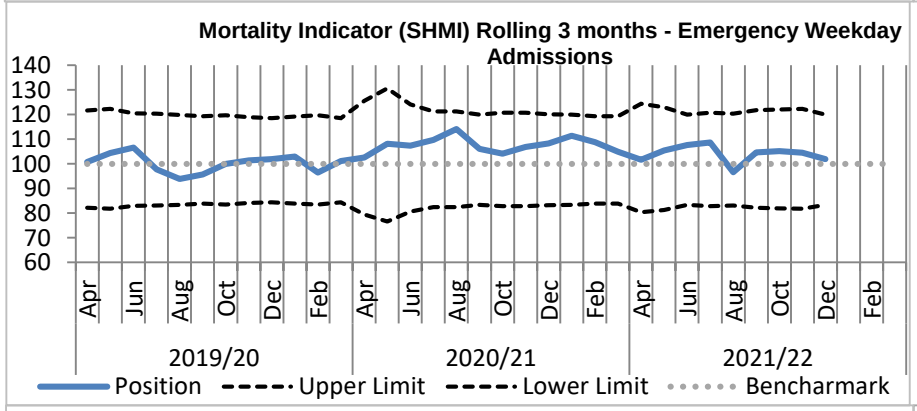
Methicillin Sensitive Staphylococcus aureus (MSSA): In depth review of the hospital associated MSSA cases revealed no Trust learning that would have prevented the bacteraemia. Incidental learning highlighted gaps in intravascular line care and documentation.

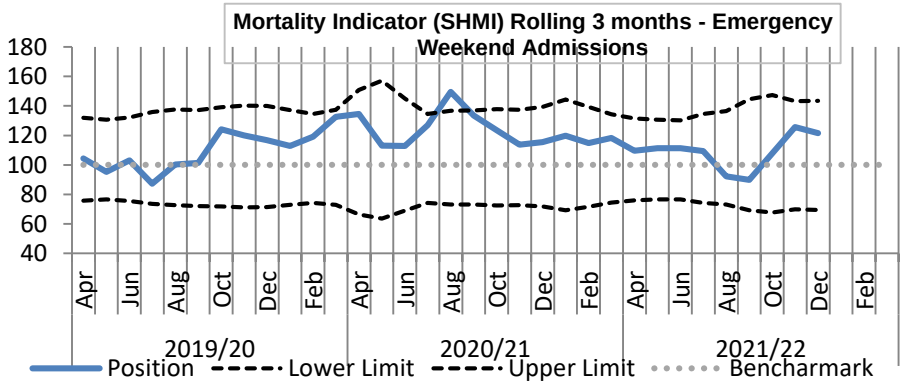
Escherichia coli (E.coli): Individual case review of gram negative bacteraemia ceased in Apr'21 following a review of limited IPC resource vs the benefits accrued. A huge amount of work had gone into in depth review of the majority of Gram negative bacteraemia (GNB) in the preceding 3 yrs. The aetiological causes had not altered significantly, nor the overall numbers despite this knowledge and with limited ways of altering this. Ongoing reviews were deemed unlikely to provide new knowledge to change practice which led to a step down of data collection nearer to the national minimum standard. IPC resource has, instead, switched to case review of HOHA & COHA S.aureus cases plus 'line' associated infection. We continue to review the overall trends in primary foci for GNB, along with some other local demographics which exceeds our mandatory surveillance requirement and have the option to reinstate further enhanced voluntary surveillance if necessary. We have reported 121 HOHA/COHA E.coli cases against the 2021/22 NHS standard contract threshold of 107. Of note, the complete data required to determine gram negative thresholds nationally was not available at the point at which those thresholds were set.

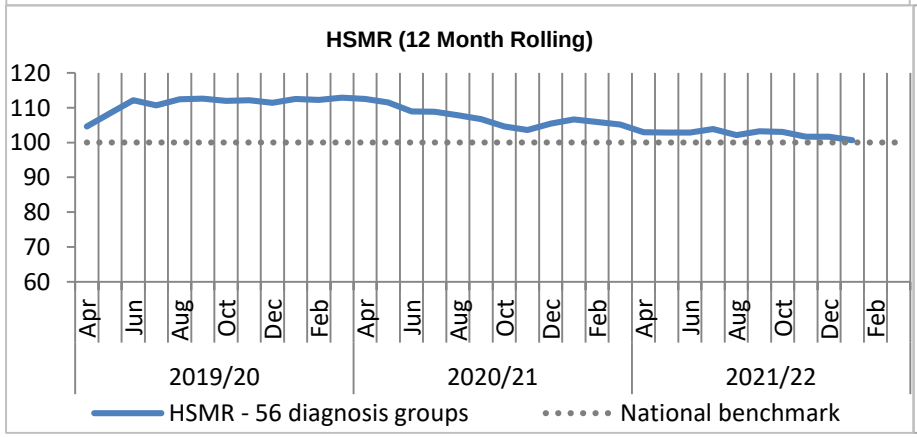
Northern Services Mortality Rates – SHMI & HSMR – *Rate of mortality adjusted for case mix and patient demographics*





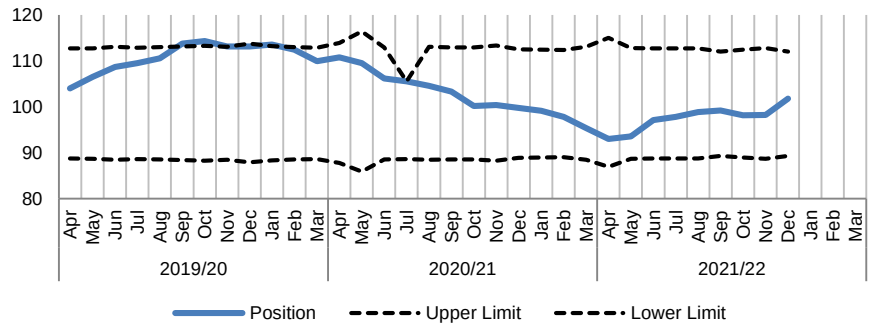


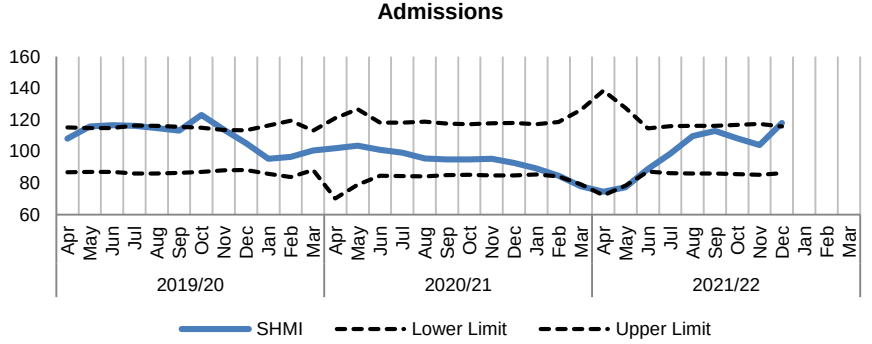


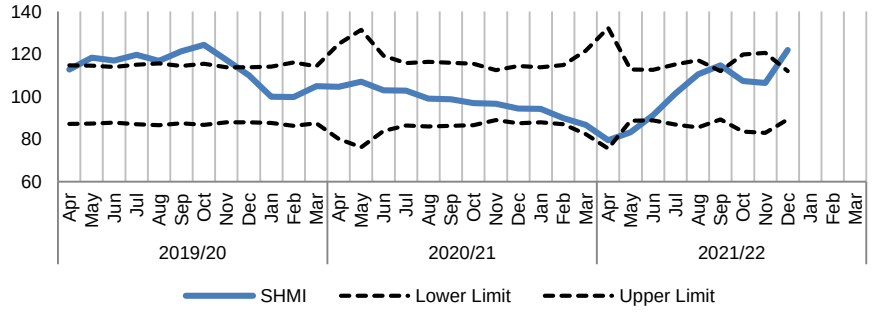


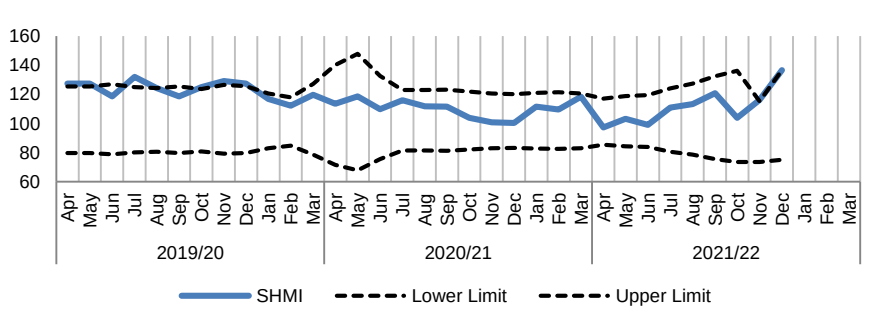
- The position in relation to HSMR has reduced again and is now in line with the 'as expected' range at 100 on a rolling 12 month basis as of January 2022
- The SHMI Mortality rates all remain within the 'as expected' range with reductions seen in the three rolling three month positions.
- The Medical Examiner's Service continues to provide 100% scrutiny of all relevant deaths, with escalation of cases for Structured Judgement Review, or incident reporting undertaken as required.
- Further detail will be provided as part of the 'Responding To and Learning From Deaths' quarterly reporting to the Board of Directors.

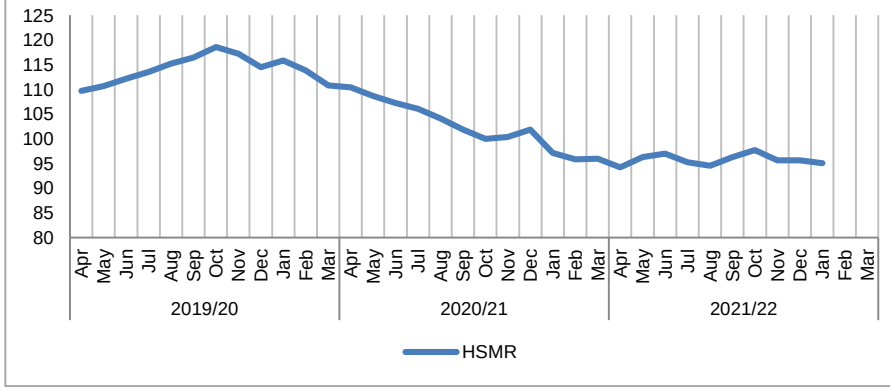
Eastern Services Mortality Rates – SHMI & HSMR – *Rate of mortality adjusted for case mix and patient demographics*





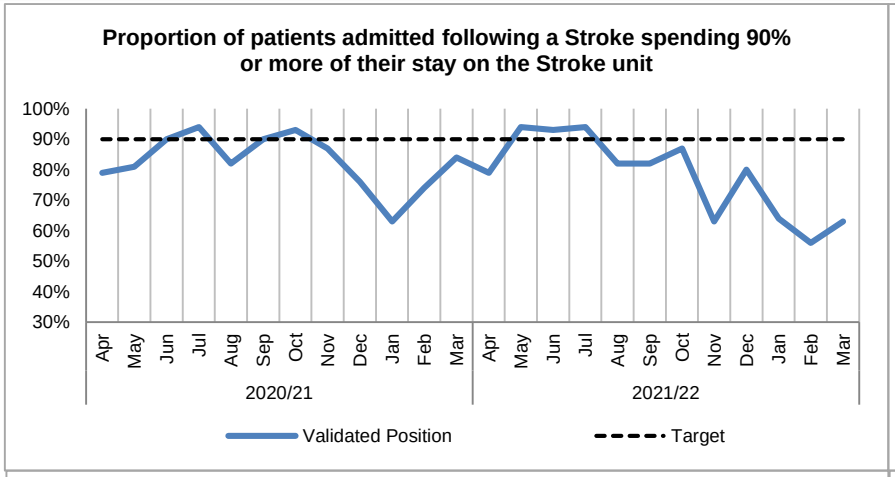


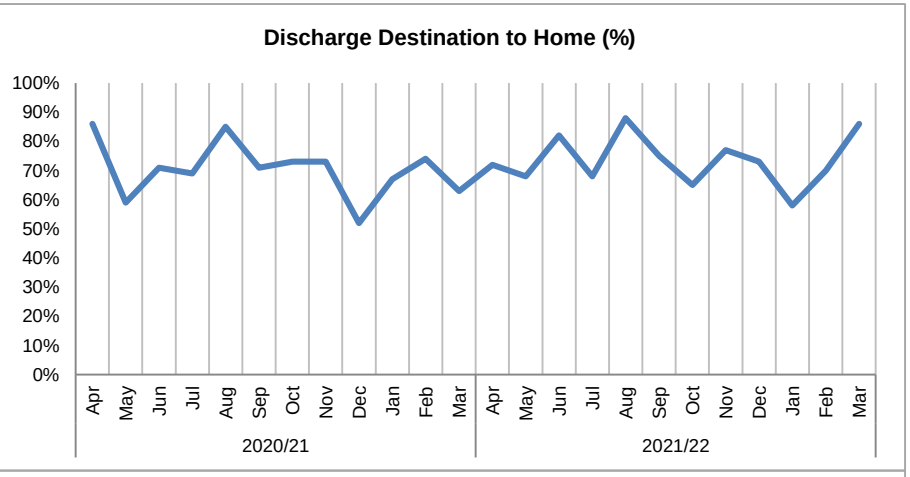


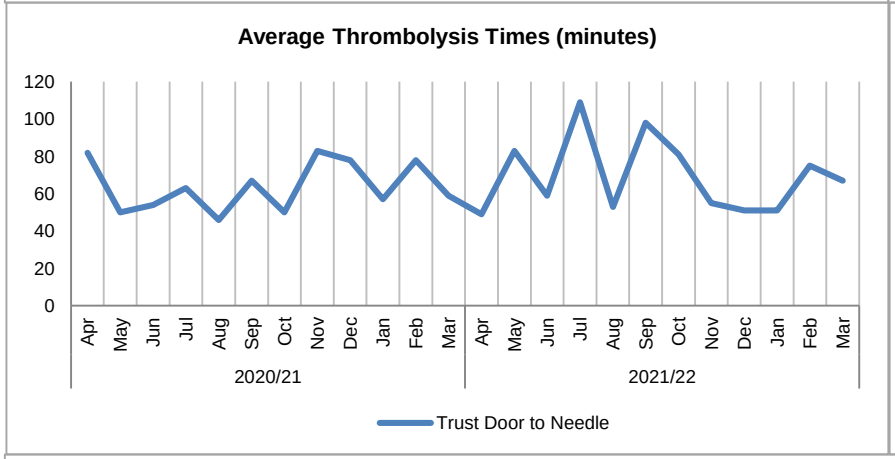


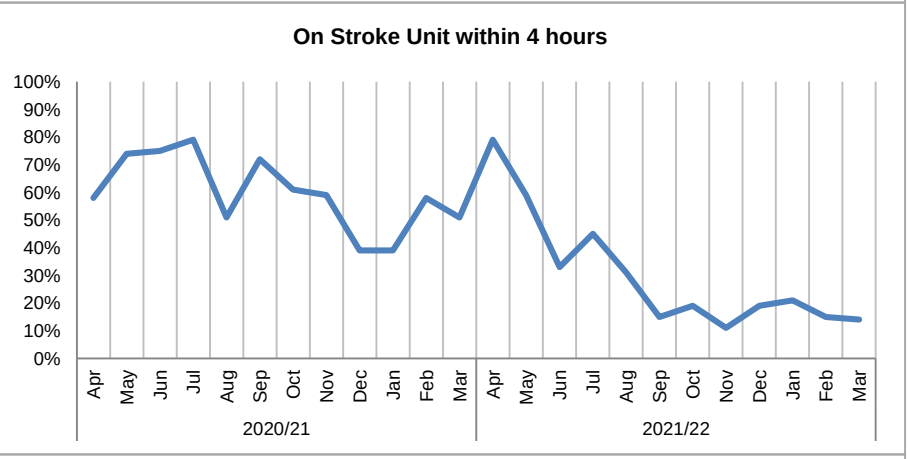
- The position in relation to HSMR remains below the 'as expected' range at 95.04 on a rolling 12 month basis as of January 2022
- The SHMI Mortality rates have shown an increase in the recent position. This is considered due to coding issues, which is being addressed. The SSMR (simplified standardised mortality ratio) which is not affected by coding issues, demonstrates that RD&E data has been lower than the national average for acute trusts over the last year, supporting the assumption that the SHMI increase is coding related.
- There has also been a significant improvement in the Structured Judgement Review activity levels and performance is significantly above demand, enabling a reduction in the backlog from previous quarters.
- The Medical Examiner's Service continues to provide 100% scrutiny of deaths occurring within the Acute and Community sites, as well as Exeter Hospice, with escalation of cases for Structured Judgement Review, or incident reporting as required.

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









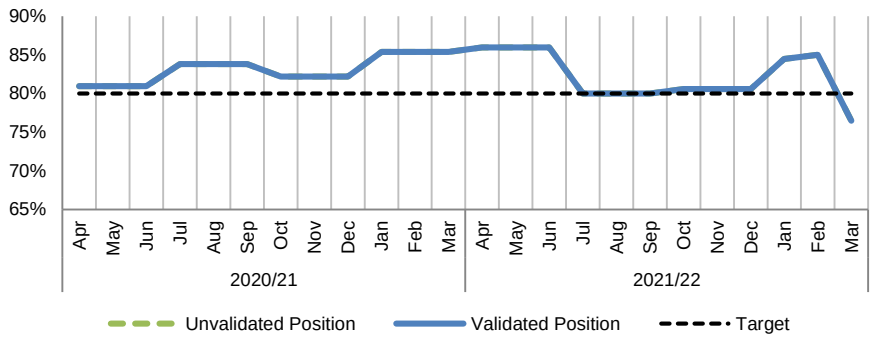
90% stay: Performance against this indicator has slightly improved in March despite ongoing challenges with patient flow and sustained OPEL 3 status. The clinical teams work to expedite patients being cared for on the stroke unit and provide outreach to outlying wards to ensure patients are receiving appropriate stroke care.

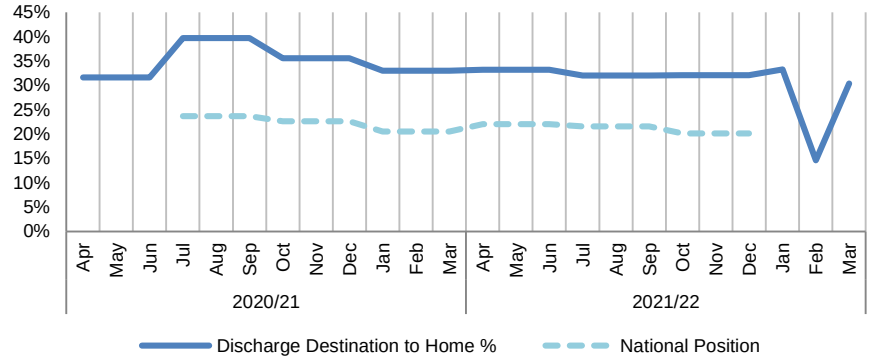
Discharge destination: This metric remains variable but above the national average and has been on an upward trajectory for the last three months.

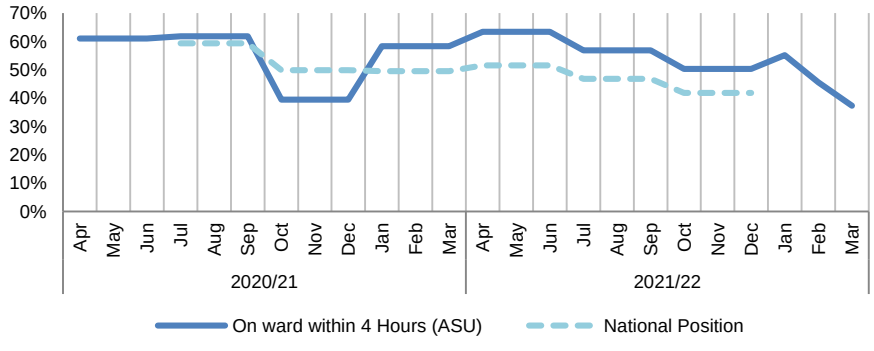
ASU in 4 hours: This position has declined in March and this directly relates to the continued and significant operational pressures in March highlighted in the 90% stay narrative above. Work is underway to ensure the protection of a ring-fenced stroke bed to ensure timely access to the Stroke Unit.

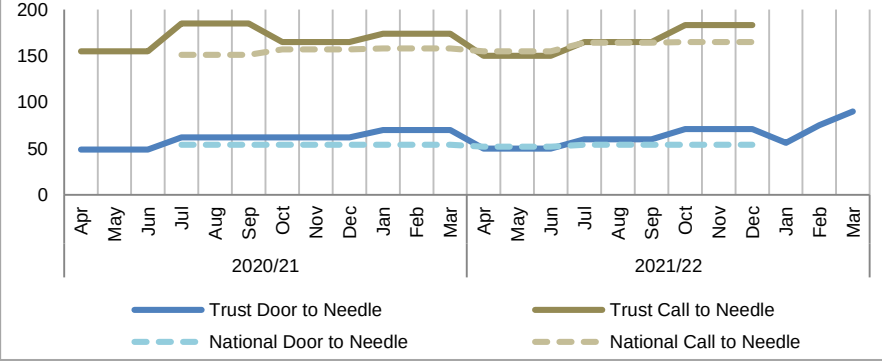
Thrombolysis times: This remains variable, the ED team are continuing working to improve this position.

Eastern Services Stroke Performance – *Quality of care metrics for patients admitted following a stroke*





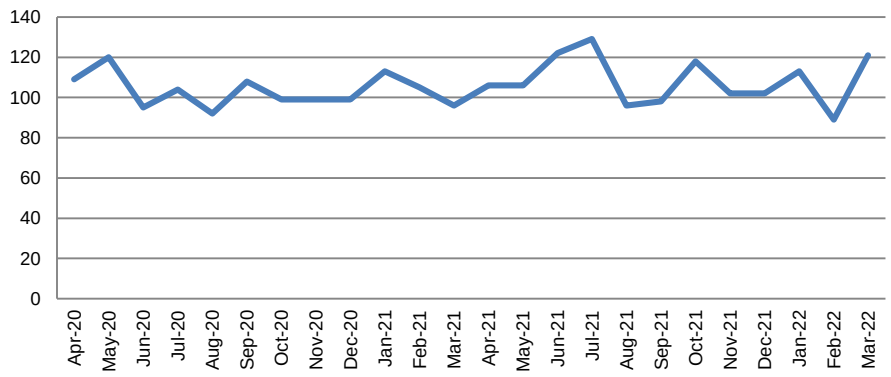




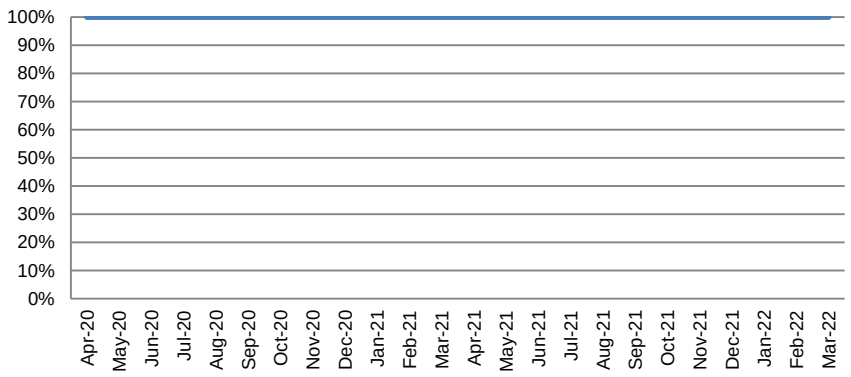
- 90% stay has dipped below the 80% target in March due to ongoing challenges to transfer patients to the ward within 4 hours and for patients to remain on a stroke unit if they develop COVID. This reflects the National position. Recent metrics show a consistent fall in LOS in the Stroke Rehabilitation Unit, which corresponds with a rise in the numbers of referrals to our stroke ESD team (Stroke Support Team).
- In March 37.3% of patients with a confirmed diagnosis of stroke arrived on the stroke unit as their first ward within the 4 hour target. 50% of all of the breaches were due to no available beds in the stroke unit (and no beds elsewhere to transfer patients to and create a bed) and was the predominant problem both in the normal working day and out of hours. This is a significant rise from previous years and also corresponds to a national trend.
- Discharge to home percentage has increased in March to within the ~~normal~~ expected range following the reduction seen in February. There continues to be a rise in the patients discharged home with stroke ESD (Stroke Support Team) and further analysis has shown that the stroke severity and complexity of patients accepted by ESD has risen significantly compared to pre-COVID data.
- There has been an increase in the door to needle times and is showing as greater than the national target and above the national average times although more people are thrombolysed in RD&E than the average nationally. This has been discussed within local audit and governance meetings and the reasons are multifactorial. There was a slight increase in the number of patients presenting after midnight when there is reduced specialist nurse support, there has been a significant decrease in ambulance pre-alerts, with more patients presenting as "walk-ins" due to difficulty/reluctance to call an ambulance and there have been more patients thrombolysed outside of ED resus due to lack of capacity in resus. Walk-in patients are typically slower to be triaged than those arriving via Ambulance and at least one potential thrombolysis patient via walk-in has been missed. ED reception staff are now alerting the triage team if someone has any stroke symptoms. Delivering thrombolysis outside of ED resus is a slower process, due to the environment and lower staffing ratios.
- March has been a month of significant challenge from a medical and general staffing, and bed capacity perspective as a consequence of a significant COVID surge and as such the deterioration in position reflects these challenges. Patients who have had a stroke and are on COVID wards have continued to receive specialist therapy. Despite the necessary ward moves related to COVID positive stroke patients, the staffing and capacity challenges outlined and the consequential difficulty this presents in providing a peripatetic therapies service to patients not located on the stroke units, access for stroke patients to this relevant specialist therapy support has continued to be provided.

Northern Services Maternity – *Metrics relating to the provision of quality maternity care*

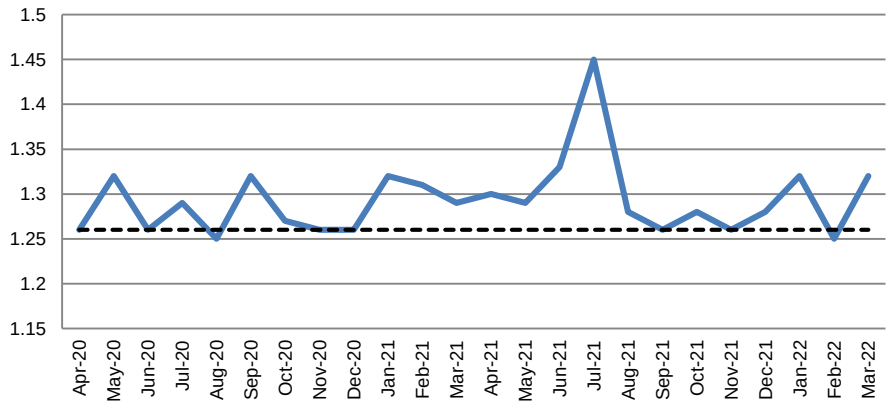
Birth Rate (Number of babies born)



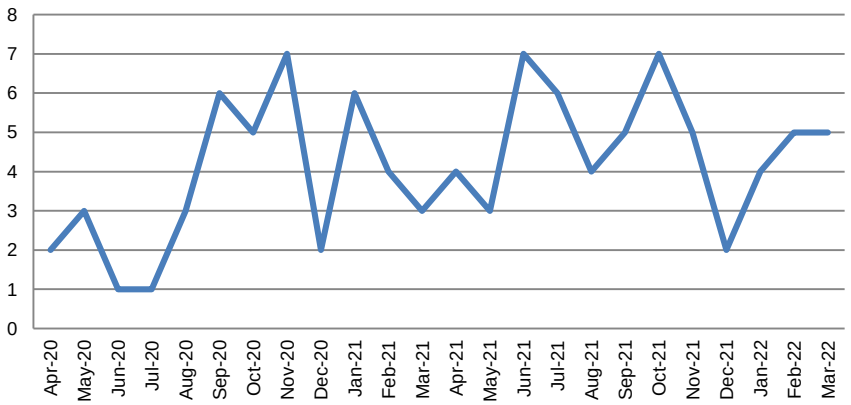
1:1 Care in Labour



Midwife to delivery ratio

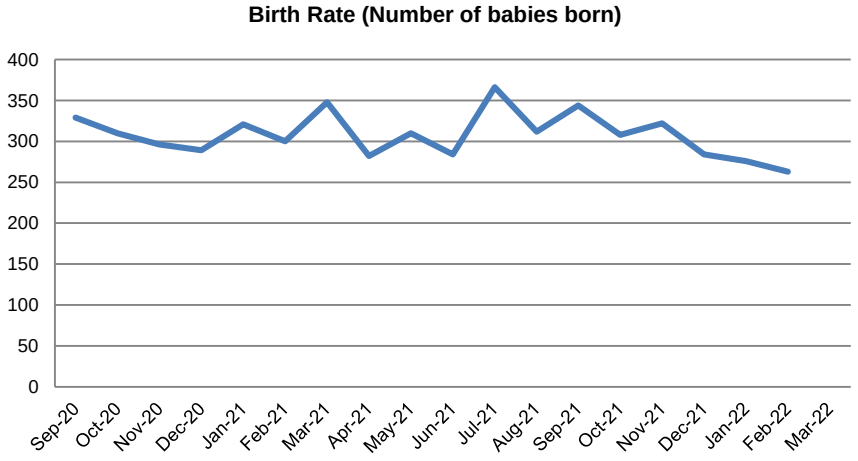


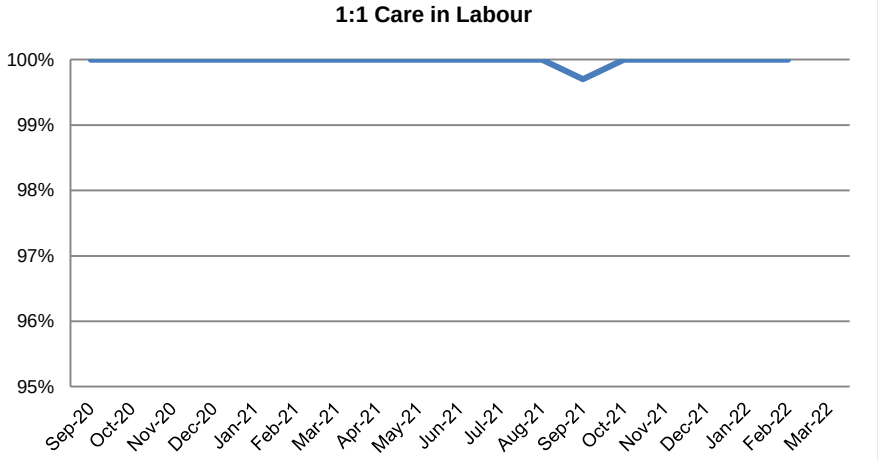
Admissions of (term babies) to NNU

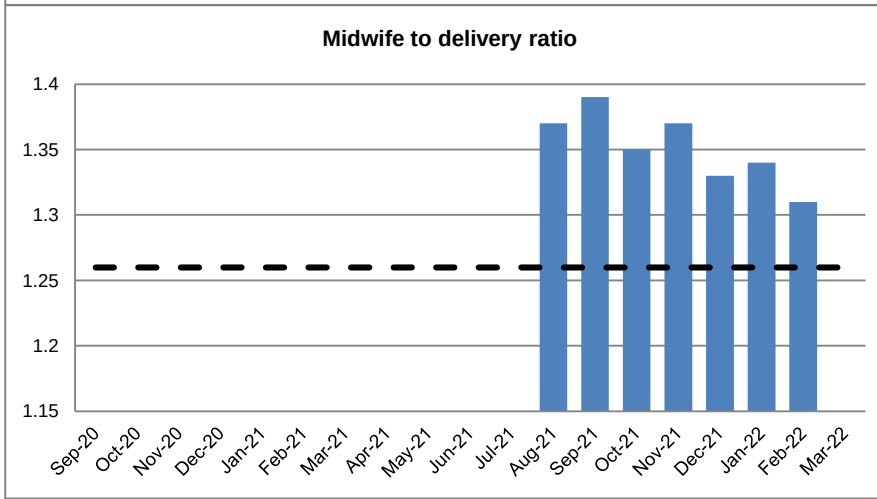


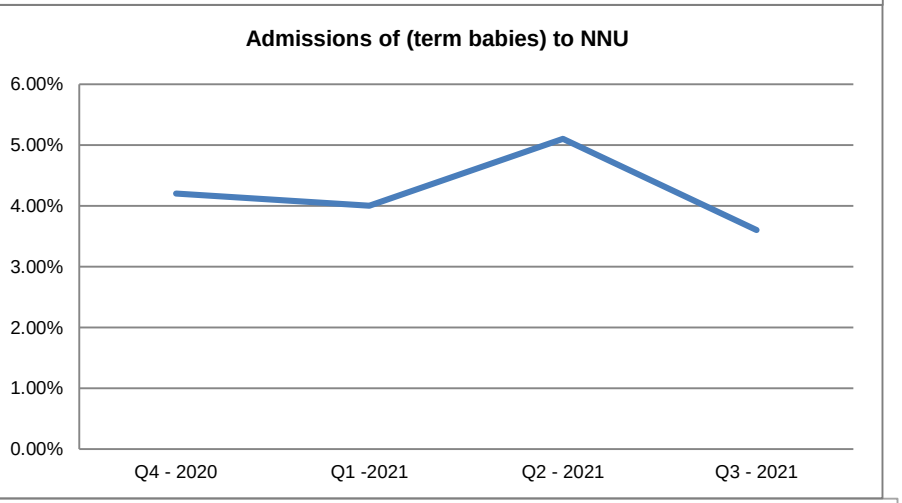
- The number of births remains within normal variation.
- 1:1 Care in Labour is usually 100% and the IPR will exception report any incidents where this standard could not be met
- Midwife to delivery ratio has increased in month due to staffing challenges related to vacancy and sickness. A maternity workforce plan is under development to address the ongoing recruitment challenges. This includes aligning with the Eastern service and the development of cross site roles. It is important to note that birth ratios are no longer considered a holistic review of staffing levels and must be viewed in line with other metrics to determine safe staffing.
- Admissions to NNU is being presented in a differing format to the Eastern Service. The team are working to present this data aligned to the ATAIN project and an agreed timescale for completion of this work will be provided in next months narrative. Reassuringly this data remains within natural variation, when viewed via the ATAIN data.

Eastern Services Maternity – *Metrics relating to the provision of quality maternity care*



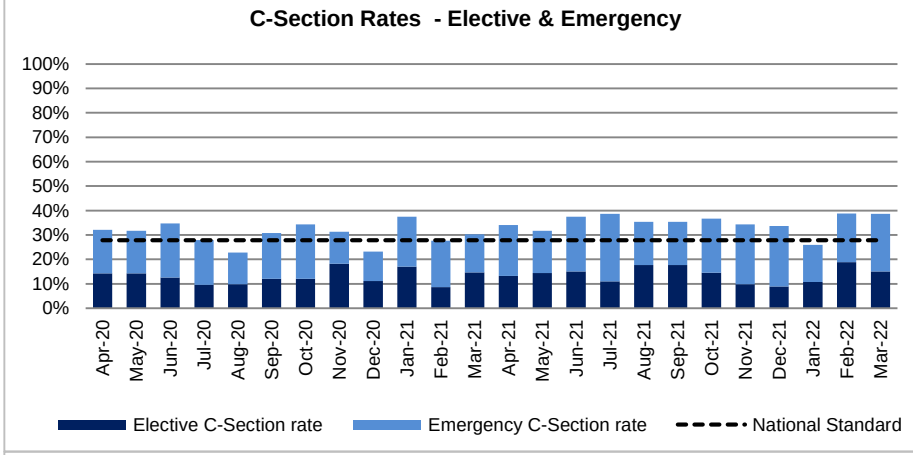


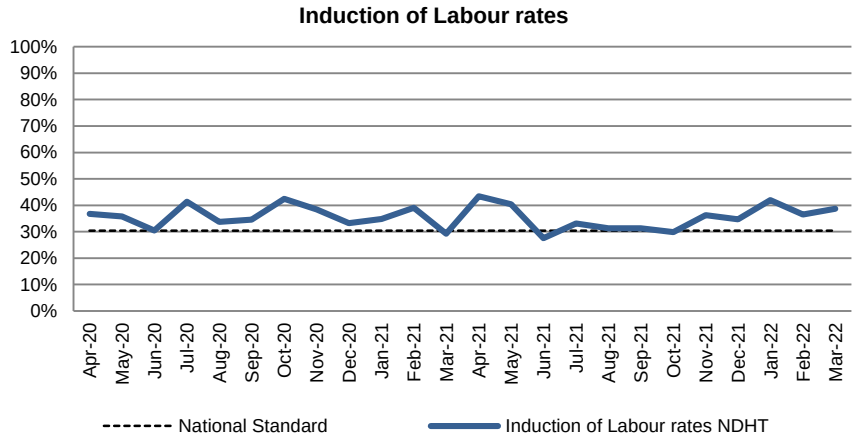


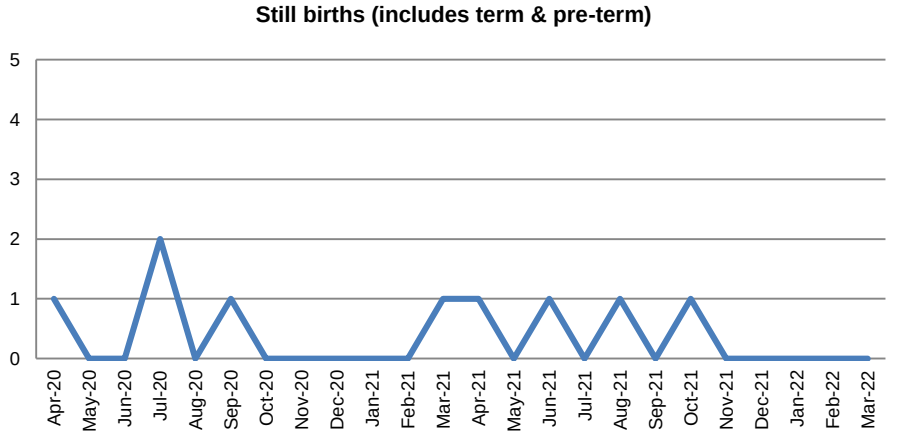


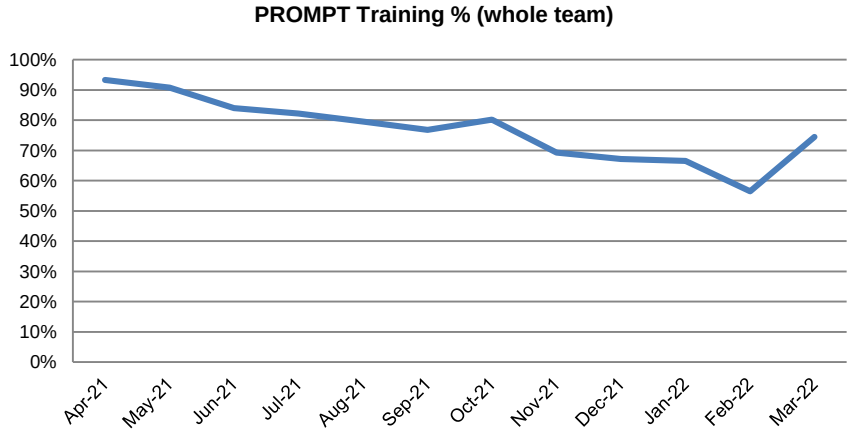
- The midwife to delivery ratio has reduced, this indicates improved performance.

Northern Services Maternity – *Metrics relating to the provision of quality maternity care*



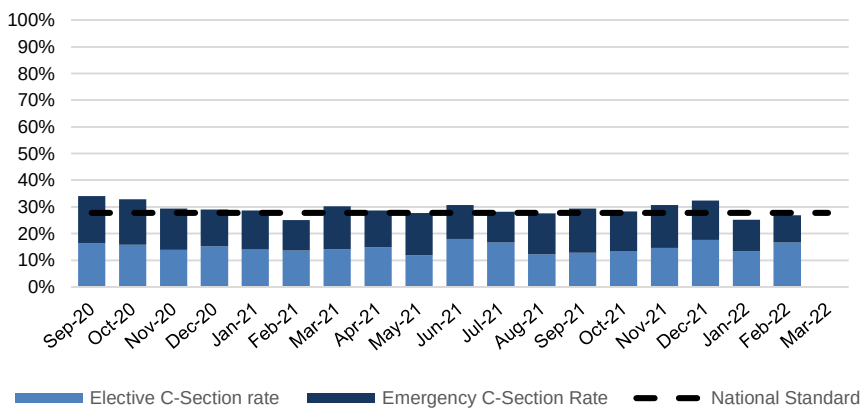


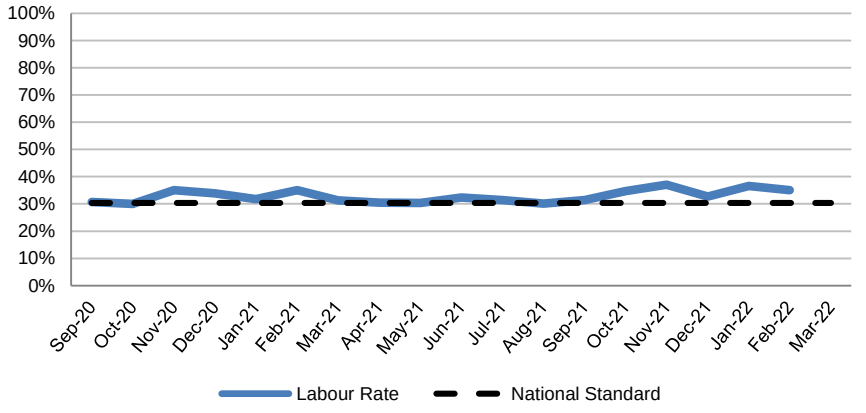


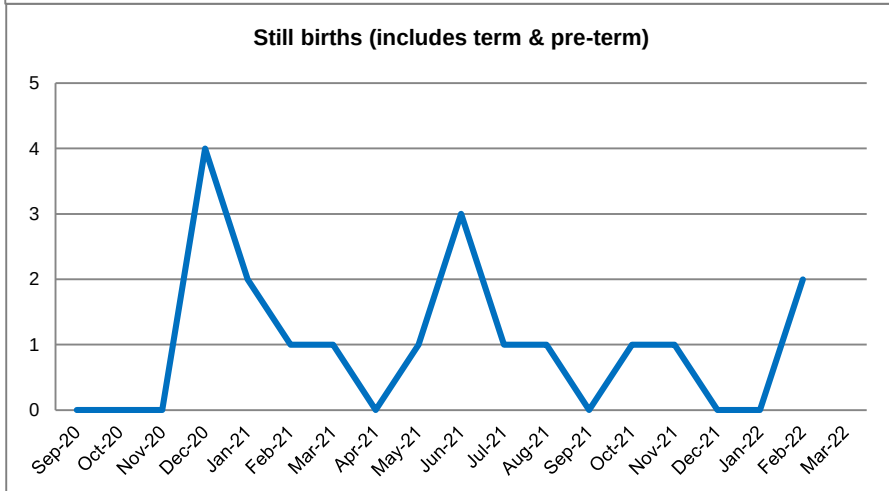


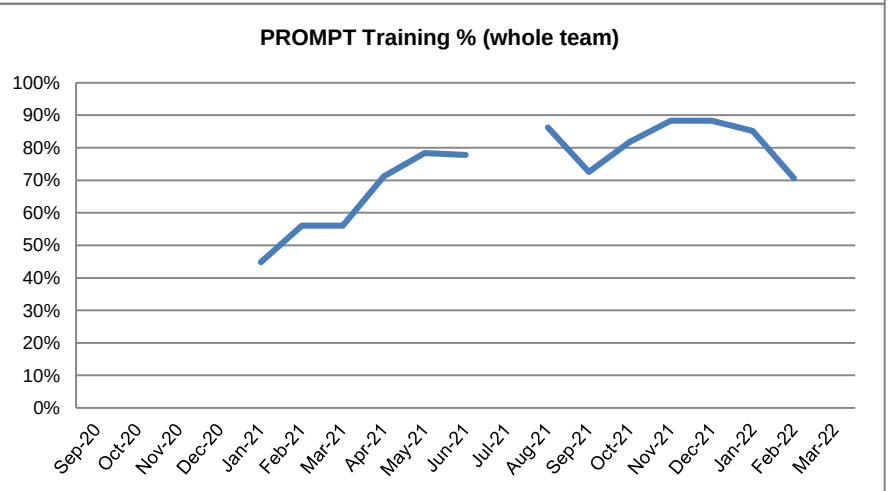
- C-section rates and induction of labour are slightly above the expected rates and the clinical teams are reviewing this data monthly. The elective C-Section follow national guidance. N.B: Trusts are asked to ensure that C/S rates are no longer used as a performance management metric.
- Still births remain within normal variation - with no flags being seen as part of the mortality data.
- PROMPT training compliance has improved. The team are working proactively on a recovery action plan in line with CNST targets and the recovery trajectory will be presented in next months IPR.

Eastern Services Maternity – *Metrics relating to the provision of quality maternity care*





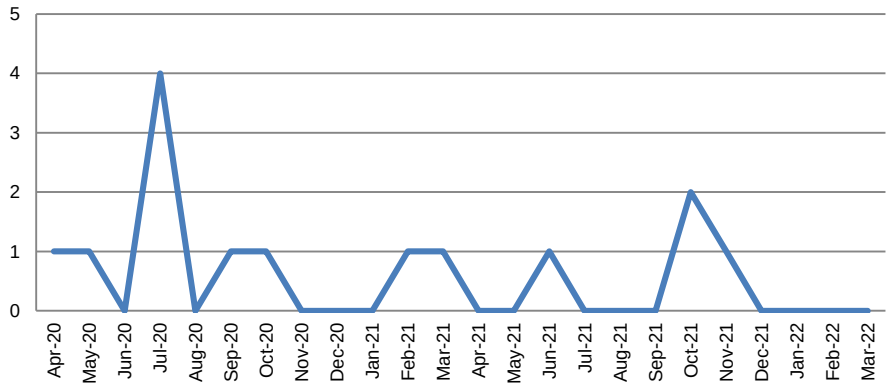




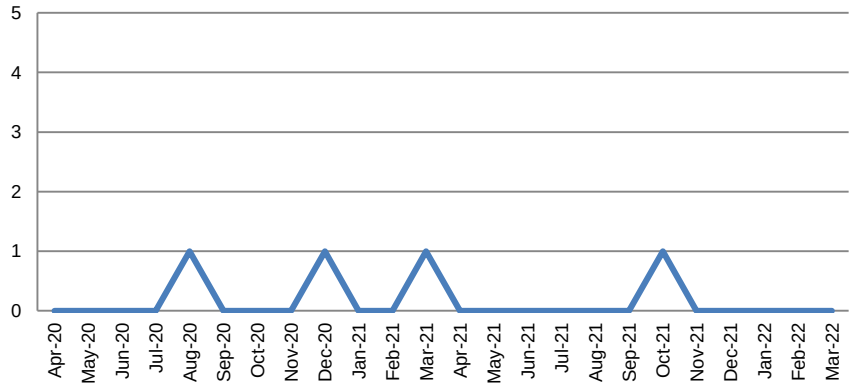
- NHSEI have written to Trust's regarding monitoring of total number of C-Sections following learning from the publication of Ockenden 2. This may require revision to current IPR metrics.
- PROMPT training: robust action plan in place to address deteriorating compliance

Northern Services Maternity – *Metrics relating to the provision of quality maternity care*

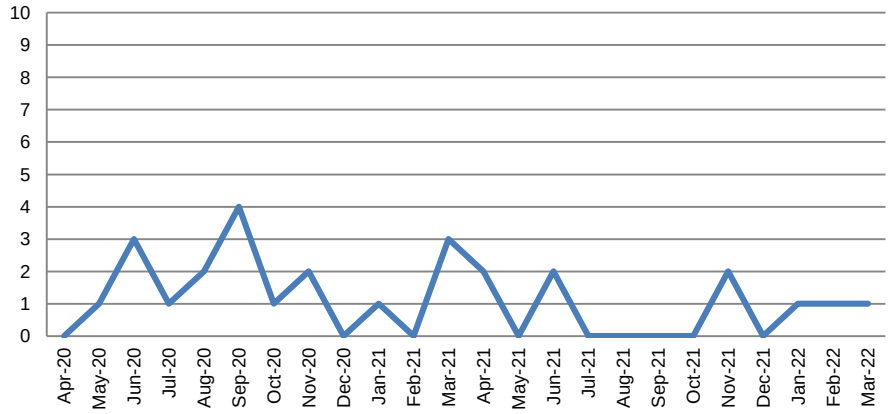
Incidents in current month (moderate and above) (run chart)



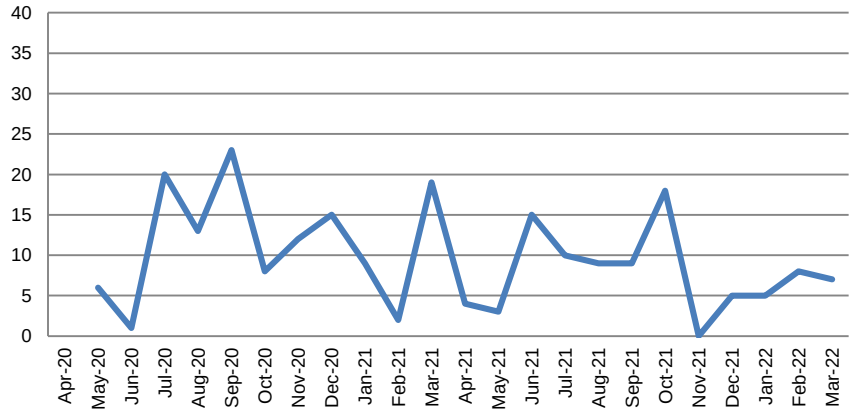
Serious Incidents (run chart)



Complaints Maternity

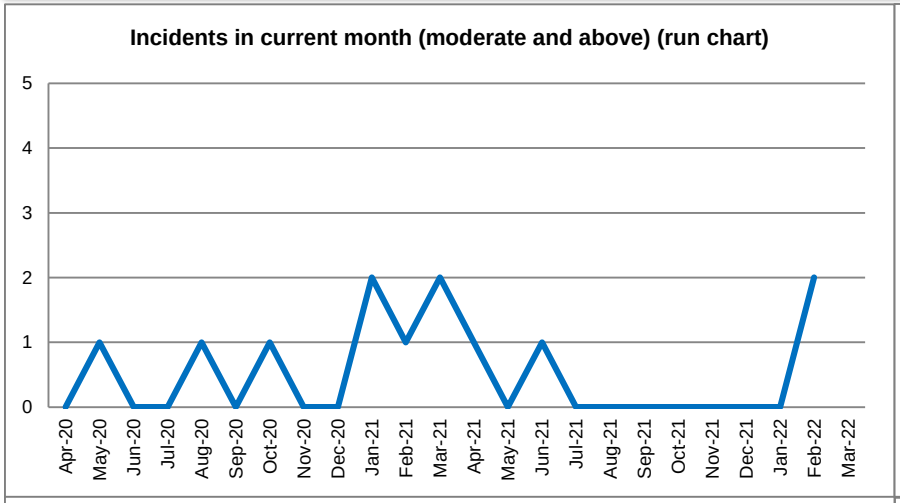


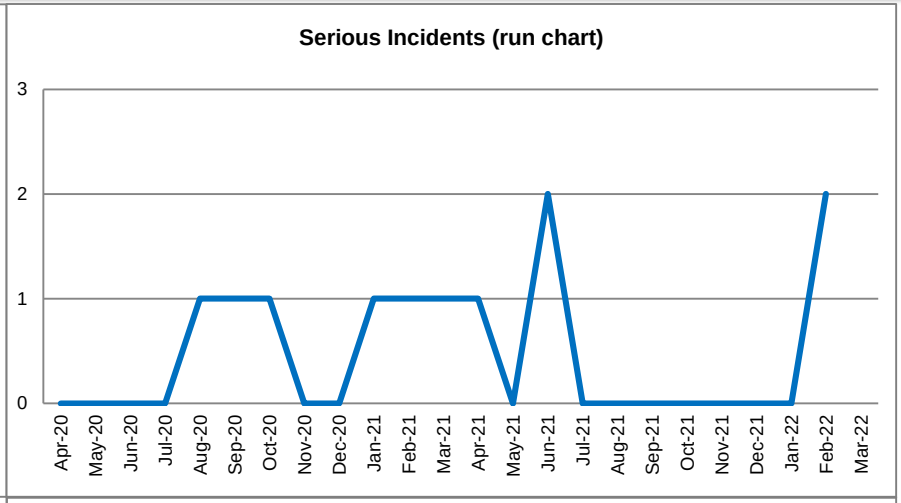
Compliments Maternity

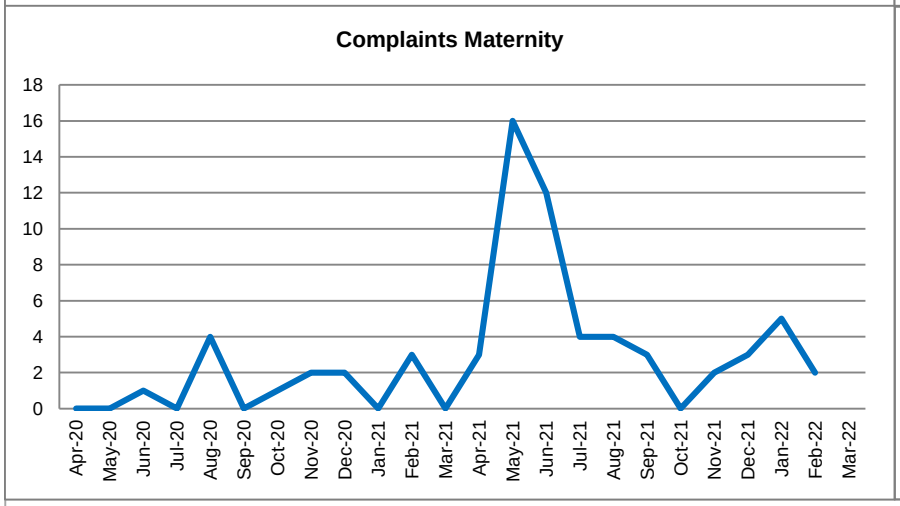


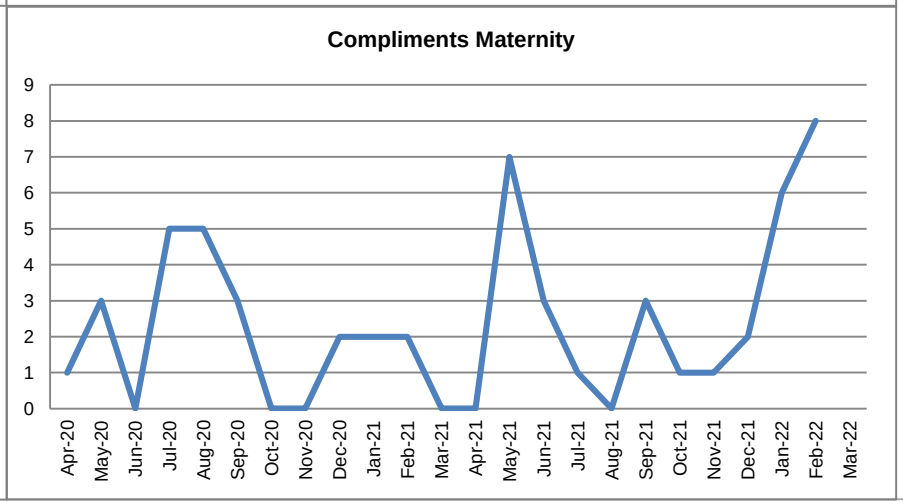
- There have been no moderate or above incidents reported during March.
- There has been one complaint received during March which is currently under investigation.
- Service compliments have reduced slightly in March.

Eastern Services Maternity – *Metrics relating to the provision of quality maternity care*



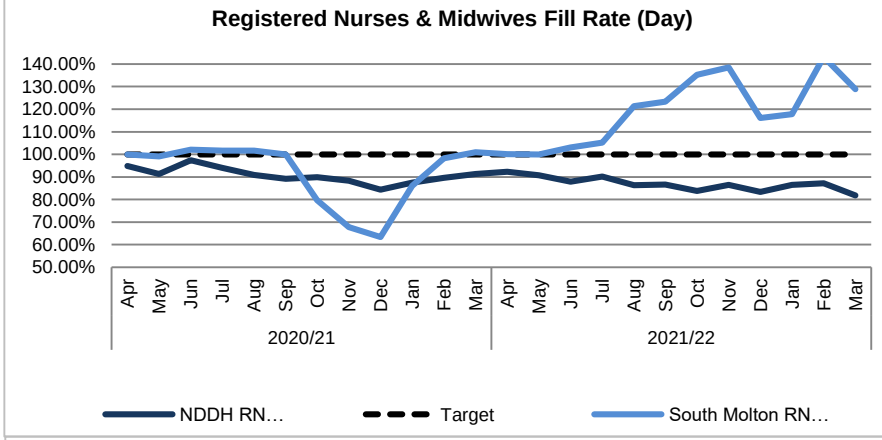


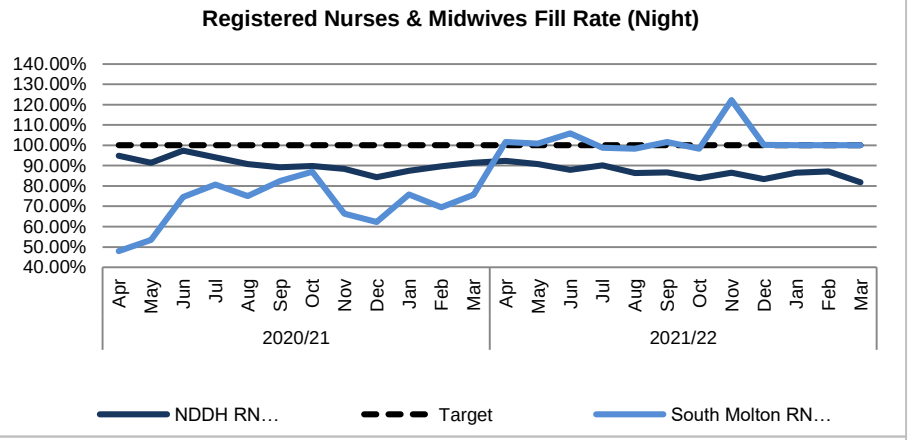


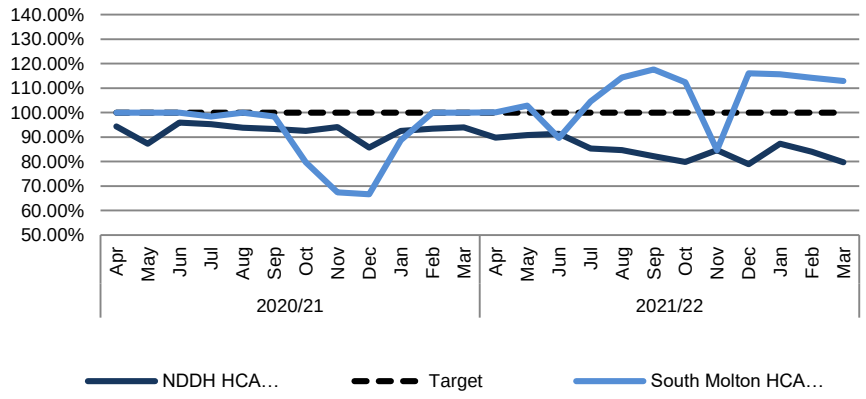


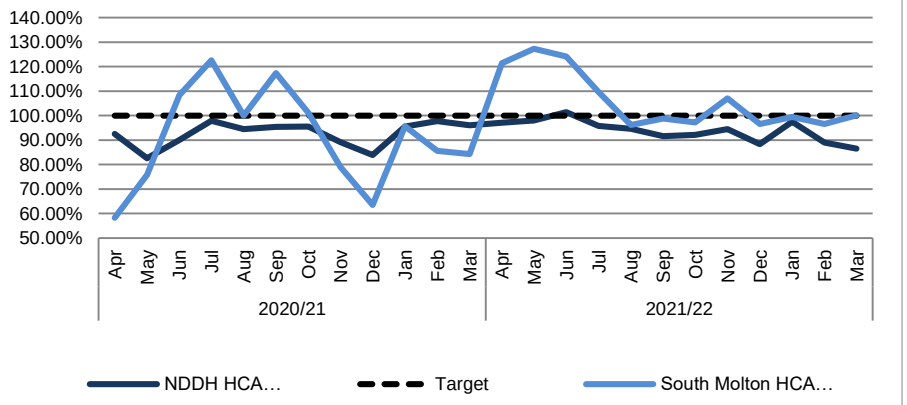
- The serious incidents were reported due to meeting the HSIB criteria.

Northern Services Safe Clinical Staffing Fill Rates



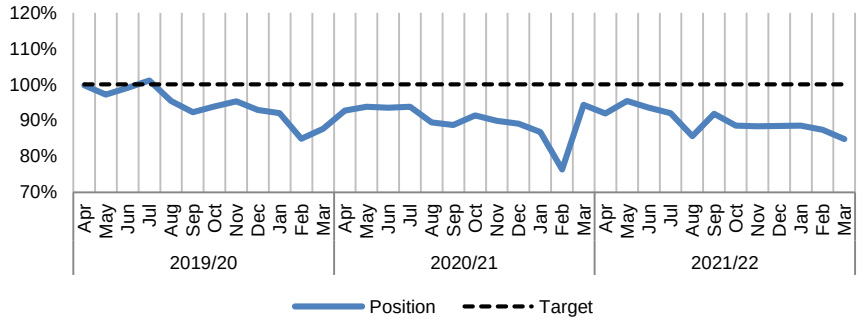


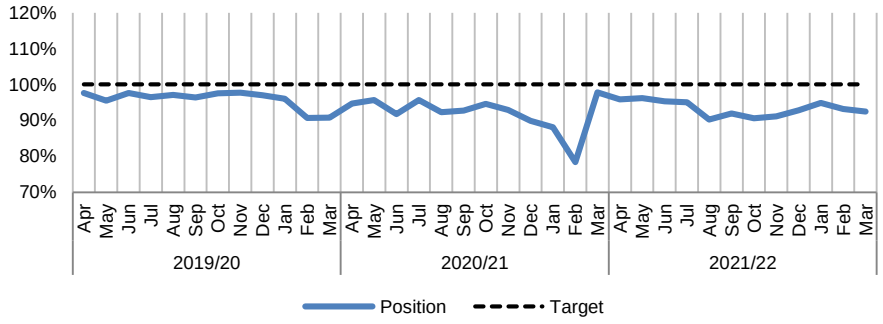


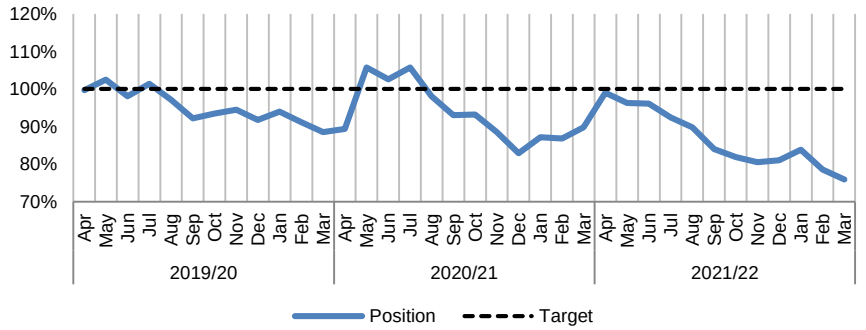


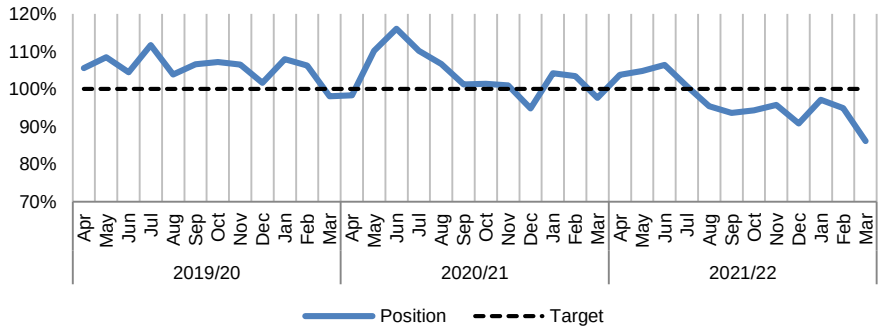
- There has been an overall decline in both Registered Nurse and Health Care Assistant fill rates for both day and night shifts during March.
- This reflects the staffing challenges seen in March caused by a significant increase in both COVID-19 and general sickness.
- All fill rates remain 80% or greater.
- Robust processes are in place daily with senior nurse oversight to ensure safe redeployment of staff to maximise overall patient and workforce safety across all clinical areas.
- South Molton fill rates remain 100% or higher due to the utilisation of additional bed capacity requiring additional staff.

Eastern Services Safe Clinical Staffing – Fill Rate – *Proportion of rostered nursing and care staff hours worked, against plan*



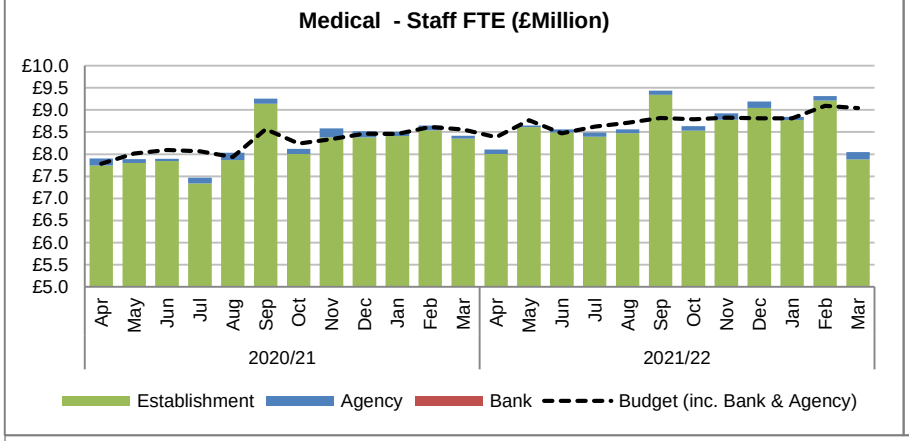


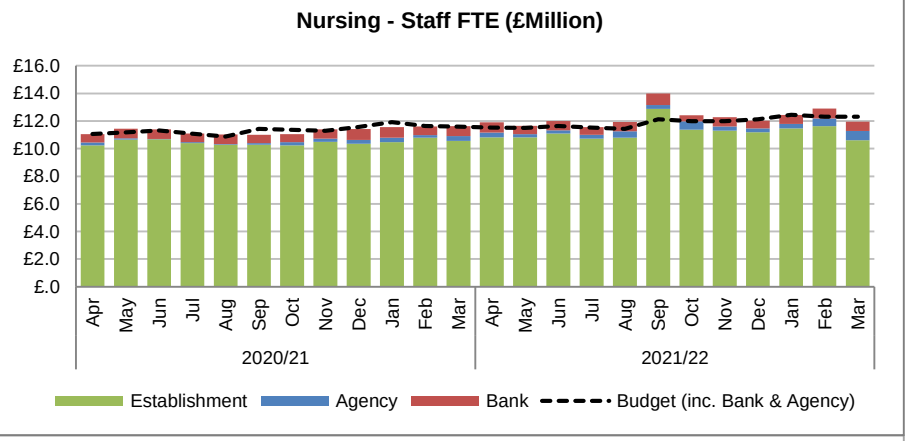


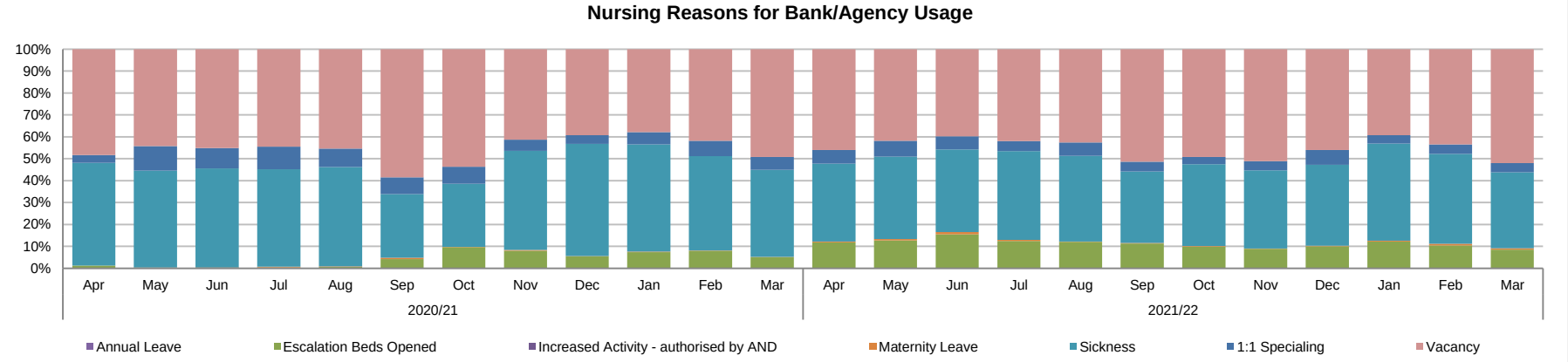


- The overall average fill rate for was 84.8%.
- The most significant shortfalls were for care staff with an average day fill rate of 76%. Medicine was most severely affected with an average day fill rate of 72.81% for care staff.
- The staffing hub continues to maximise safe clinical staffing; and changes to self isolation guidance for staff with family contacts should promote swifter return to work for affected colleagues.
- The Senior Nursing team prioritise staffing to address the highest risks for each shift, to minimise patient the patient safety impact of reduced fill rates.
- There is a rolling recruitment programme in place to meet the demand for care staff, and on-boarding is currently in process.
- No moderate (or greater) harm incidents were reported which cited staffing levels as a causal or contributory factor.
- 22 incidents were reported with minor (14) or no harm (8). 18 of these incidents reported inadequate staffing levels impacting on quality of care, and increased pressure on ward staff.

Eastern Services Safe Clinical Staffing -*Cost of Medical & Nursing Staffing by month against Budget & reasons for temporary staff*

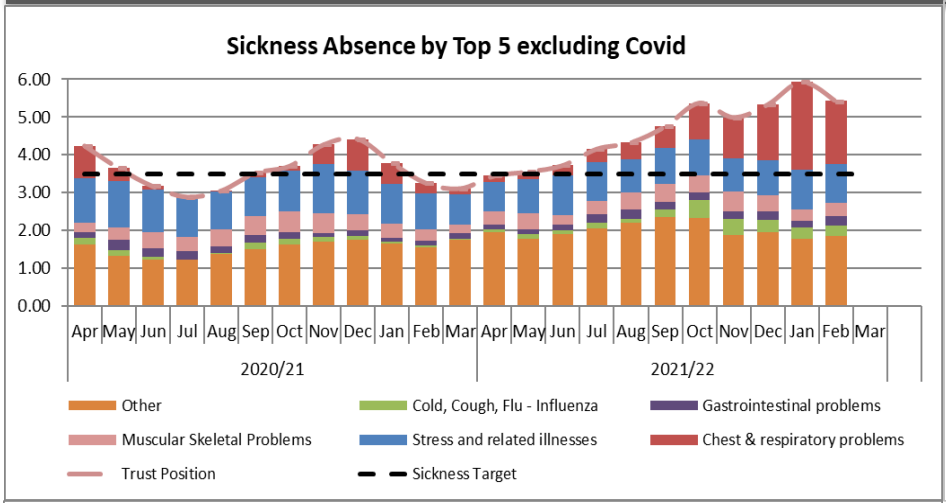


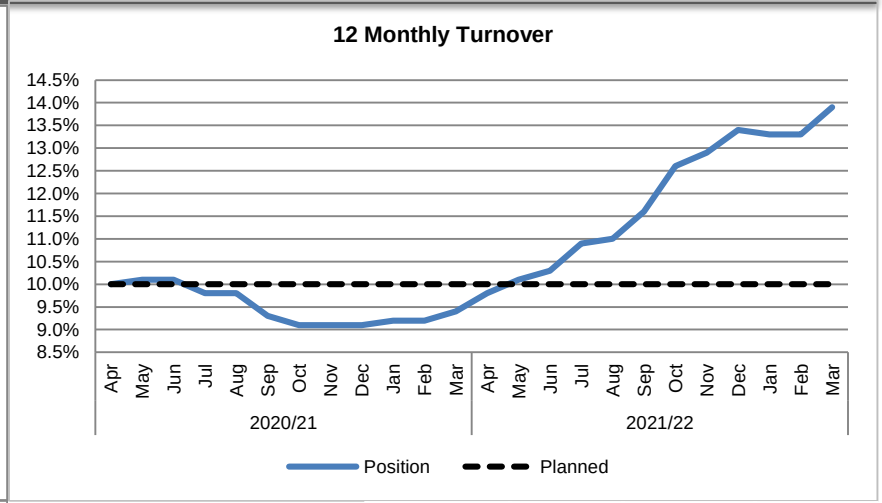


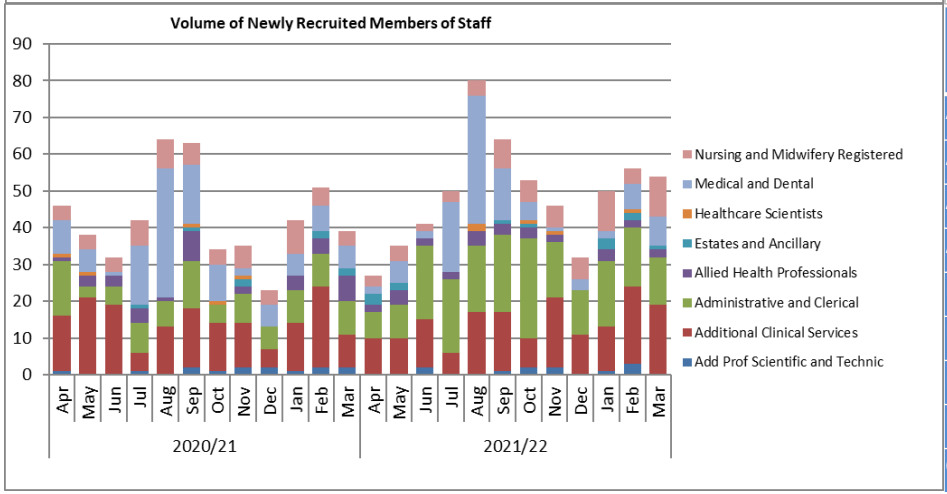


- There was significant impact upon nursing staffing due to absence either with COVID-19 or due to self isolation.
- Operational pressures saw a continued demand for escalation beds which added to patient facing staffing pressure.

Northern Services Other Workforce Indicators







Turnover for 12 months ending 31st March 2022	Avg FTE	Starters FTE	Leavers FTE	Turnover FTE %
Add Prof Scientific and Technic	75.00	4.60	11.99	16.0%
Additional Clinical Services	545.63	125.40	85.88	15.7%
Administrative and Clerical	791.64	84.49	104.97	13.3%
Allied Health Professionals	290.40	24.68	32.19	11.1%
Estates and Ancillary	64.92	6.42	9.57	14.7%
Healthcare Scientists	58.67	4.60	11.50	19.6%
Medical and Dental	168.61	14.80	11.75	7.0%
Nursing and Midwifery Registered	759.03	44.97	114.92	15.1%
Grand Total	2,753.89	309.96	382.76	13.9%

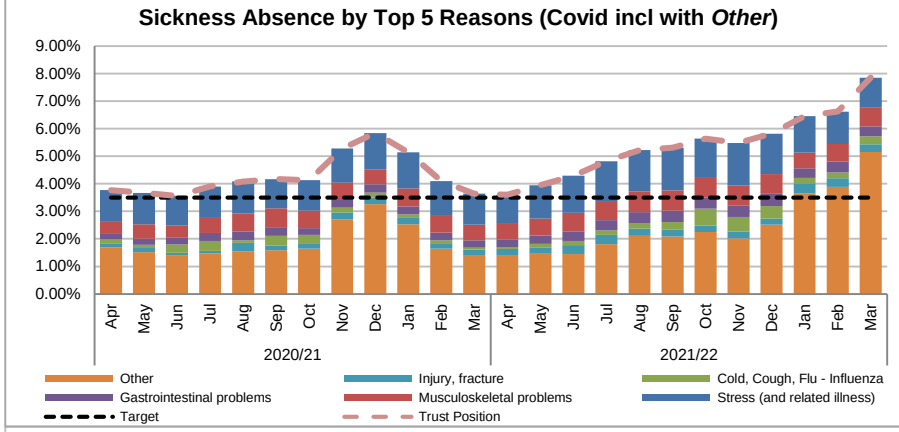
Sickness and Absence

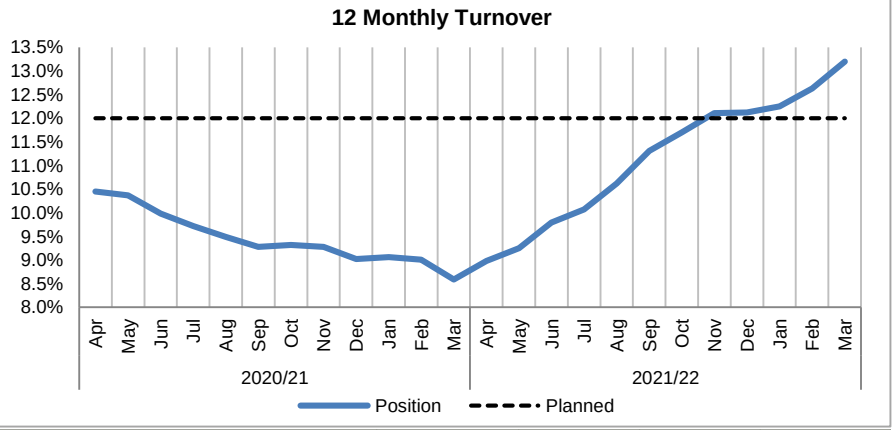
- The number of COVID infections remained high in March, but is now showing signs of reducing. In addition to COVID related sickness, the trust also experienced an increase in non-COVID related sickness. Since January 2022, sickness absence started being tracked daily as part of trust preparations on surge planning, and has continued to present day. Overall, non-COVID sickness has remained relatively stable. COVID sickness absence is detailed in the next slide.
- Absence categorised as stress, anxiety, depression and other psychiatric illness remains one of the primary reason for sickness, accounting for 19% of sickness days. The primary reason for sickness absence was recorded as respiratory illness, accounting for 30.9% of all trust sickness, a reduction on the previous month.

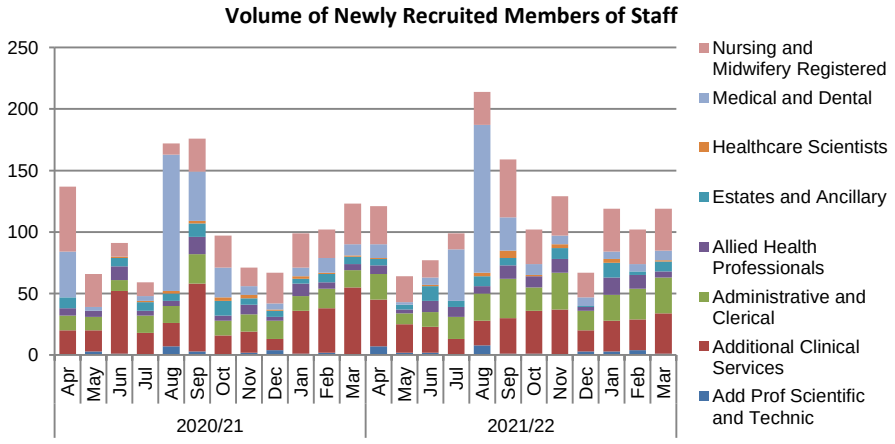
Turnover

- The in-month staff turnover rate has continued to remain stable, although the 12-monthly rolling staff turnover has increased, and currently sits at 13.9% in March. This is likely to continue to rise as the lower turnover figures from 2020/21 are replaced by higher figures.
- An analysis of leavers is currently being undertaken and will be reported back through the Our Future Hospital Programme Board in May 2022..

Eastern Services Other Workforce Indicators







Turnover for the 12 months ending 31st March 2022	Avg FTE	Starters FTE	Leavers FTE	Turnover %
Add Prof Scientific and Technic	194.37	16.18	25.45	13.1%
Additional Clinical Services	1477.59	259.75	259.29	17.5%
Administrative and Clerical	1634.87	156.29	240.44	14.7%
Allied Health Professionals	569.37	73.71	63.53	11.2%
Estates and Ancillary	630.48	64.32	92.28	14.6%
Healthcare Scientists	214.33	15.69	25.95	12.1%
Medical and Dental	416.56	17.63	20.93	5.0%
Nursing and Midwifery Registered	2082.53	268.77	227.46	10.9%
Students	11.30	0.00	1.00	8.8%
Total	**7231.38**	**872.34**	**956.33**	**13.2%**

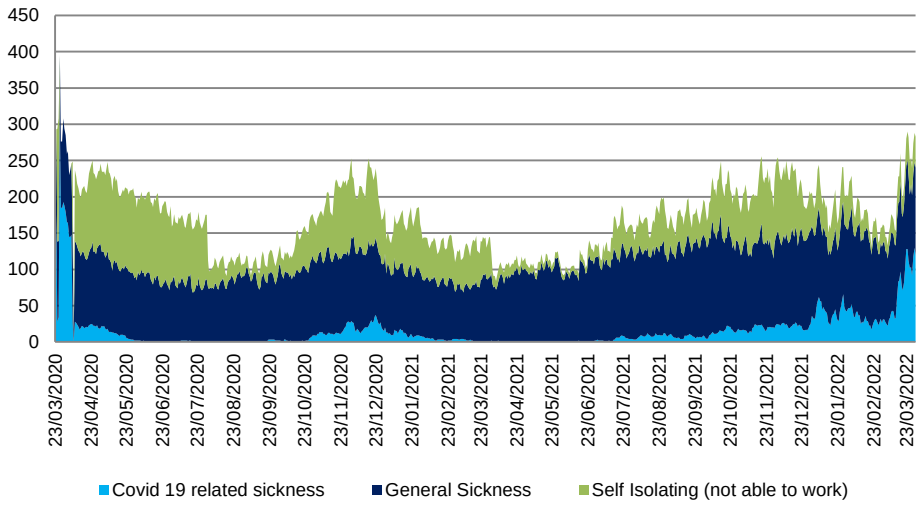
Turnover

- The overall rate continues to rise, mirrored by increases across all workforce groups over March, with the exception of Medical and Dental.
- The rates for Additional Clinical Services (ACS), A&C and Ancillary have climbed unabated of late, though actions focussed at growing our Healthcare Support Worker numbers, plus the work commissioned by NHSIE to reduce nursing vacancies at Band 2 and 3, should begin to see an easing of the staffing pressures exacerbated by high turnover and absences.
- From a Divisional perspective, Medical and Surgical Services remain below the planned turnover threshold, with highest rates in the Specialist Services and Community at 13.8%; the non-clinical divisions are also continuing to show a deteriorating position.

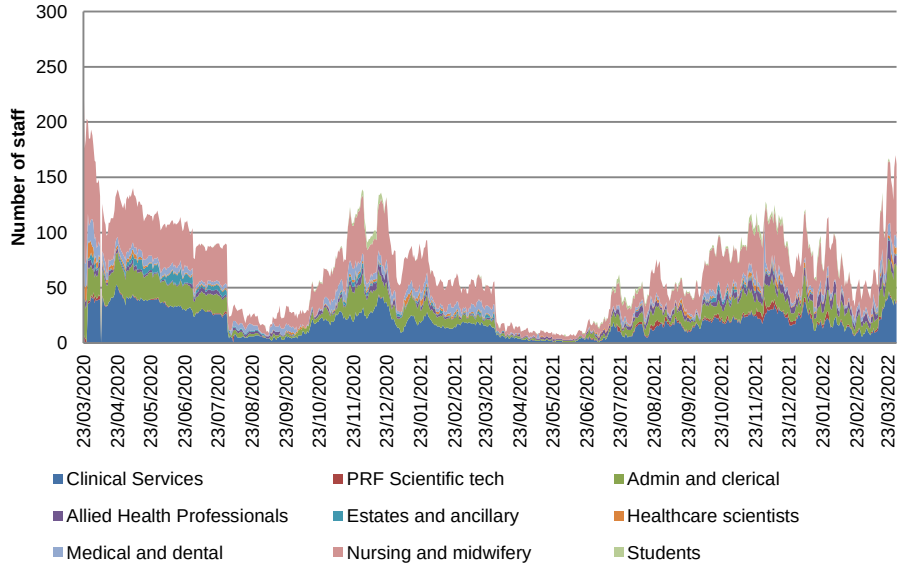
Sickness

- The month of March saw the highest number of COVID infections recorded to date, accounting for nearly half of all sickness absence recorded in the month.
- That volume of positive cases, pushed the Trustwide sickness rate to another unprecedented monthly high of 7.9% .
- Again, the ACS and Ancillary groups were proportionally the worst affected, but the magnitude of absences impacted our workforce across all areas of service.
- With positive cases driving the very high sickness rates seen over this quarter, it is notable that the days lost to Stress and other mental health related illnesses has fallen by 25% compared to December.
- The change in guidance to allow staff that are contacts of a positive case to continue working provided they are healthy and testing daily, will provide some relief to staffing - over a hundred staff were absent due to this status prior to the change in policy.

Staff sickness and self isolating



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



Sickness

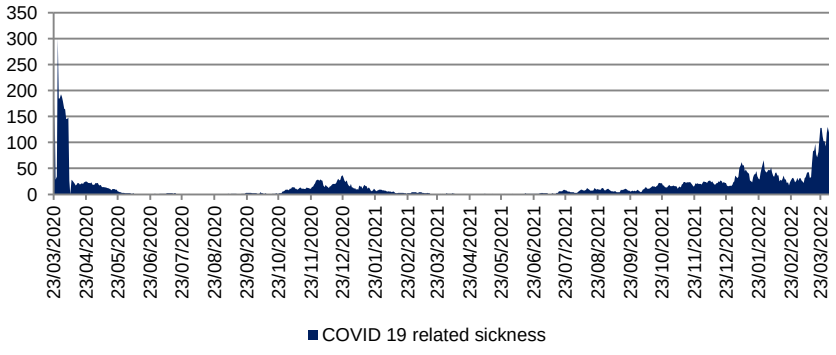
Staff Absence and Self Isolation

As at 19th April 2022, the total number of staff with COVID related absence has shown a decrease from the peak experienced in March 2022, with a total of 78 employees either off sick or not working in any capacity.

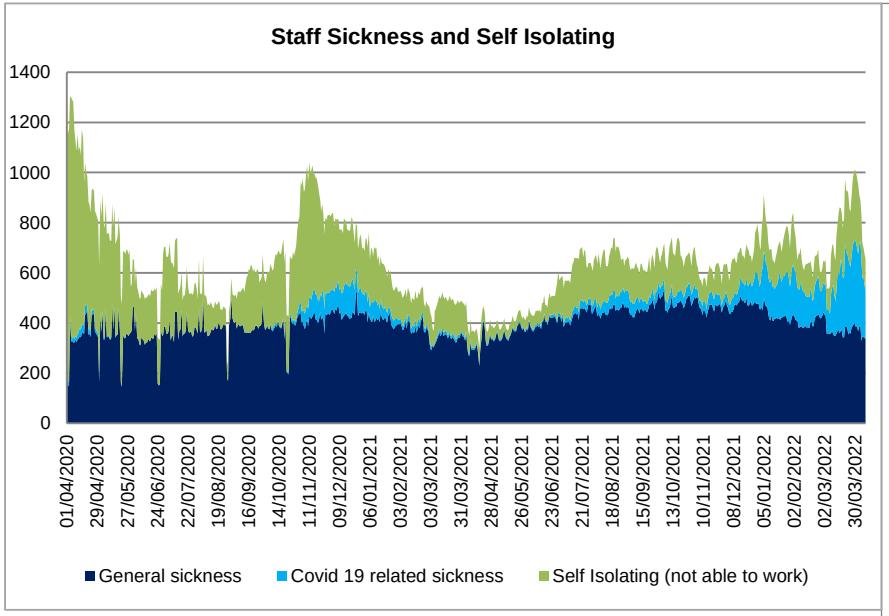
Sickness absence continues to be tracked on a daily basis and is currently broken down as at 19th April 2022, as follows:

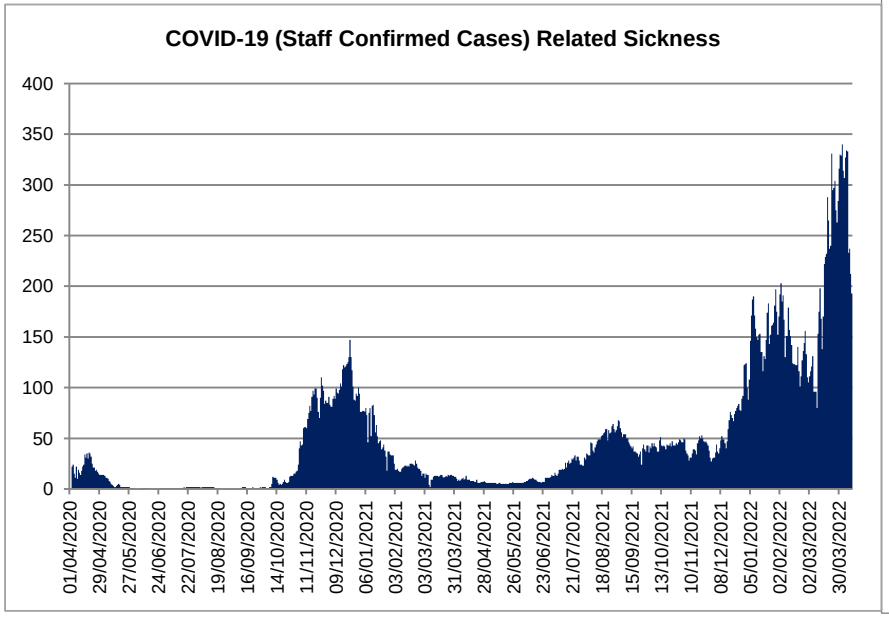
- % Staff Sickness – COVID Confirmed 1.01%
- % Staff Sickness – COVID Incl Isolation 2.25%
- % Staff Sickness – Other (Non COVID) 3.17%
- Total % Sickness 5.42%

COVID 19 related sickness



Eastern Services Workforce



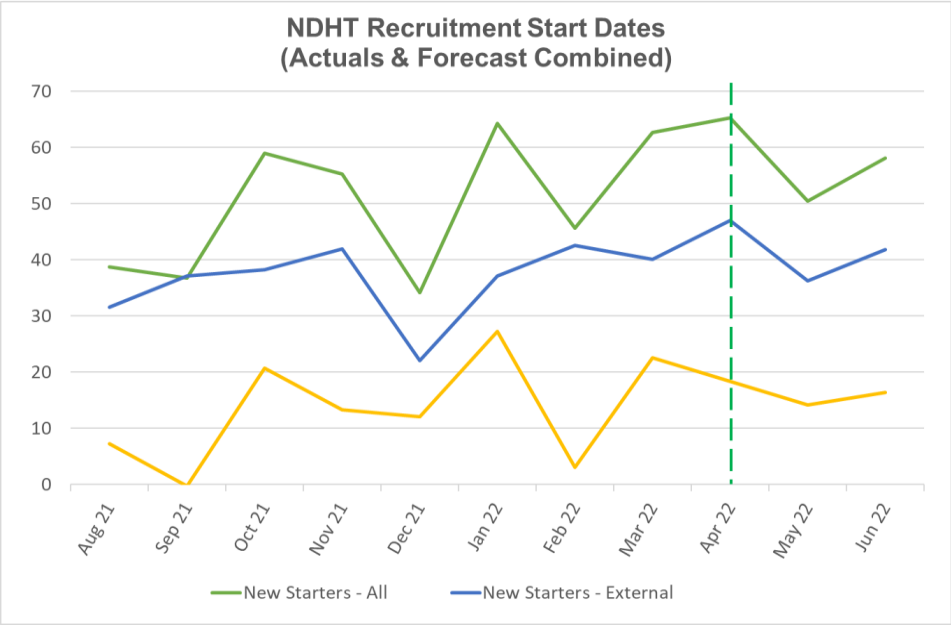


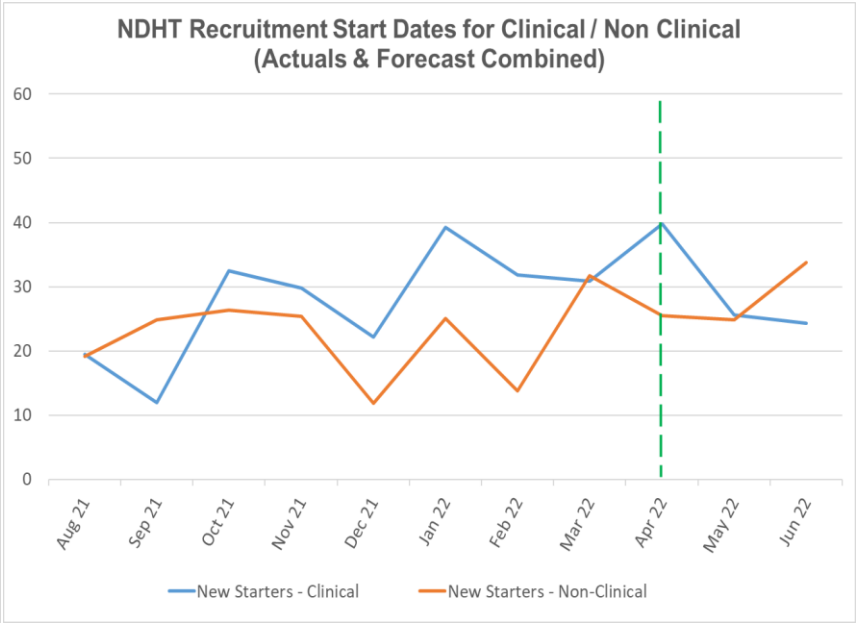
As at 13th April, the total number of staff with COVID related absence has decreased from 420 one month ago to 306 and this is due in part to revised national guidance relaxing the self isolating rules around track and trace and household members being COVID positive. Despite this overall reduction the staffing situation continues to be extremely challenging when factoring in general sickness on top of COVID related absences with non COVID related sickness cases only reducing slightly from 367 to 359 over the same period. At the time of writing 7.2% of the workforce are absent due to general sickness and COVID related absence although this peaked at 10.9% on one occasion in the last month. In addition staff are taking longer to recover from COVID thereby not returning to work as quickly as previously seen adding to the staffing challenges for the Trust.

In the past month we have reported an average of 58 new cases of self isolating a day and this is contributing to a continuing high level of absence which peaked at 619 COVID related absence and 398 general sickness episodes.

Staff Group	General Sickness	Sickness - Covid19	Self Isolating - Symptomatic (includes Self & Household)	Self Isolating - Vulnerable Groups (Includes Pregnant and High Risk)	Total
Add Prof Scientific and Technic	6	8	3	0	**17**
Additional Clinical Services	125	44	19	5	**193**
Administrative and Clerical	61	44	10	0	**115**
Allied Health Professionals	23	20	7	0	**50**
Estates and Ancillary	42	13	8	0	**63**
Healthcare Scientists	3	5	0	0	**8**
Medical and Dental	5	23	9	0	**37**
Nursing and Midwifery Registered	94	62	25	0	**181**
Students			1	0	**1**
Total	**359**	**219**	**82**	**5**	**665**

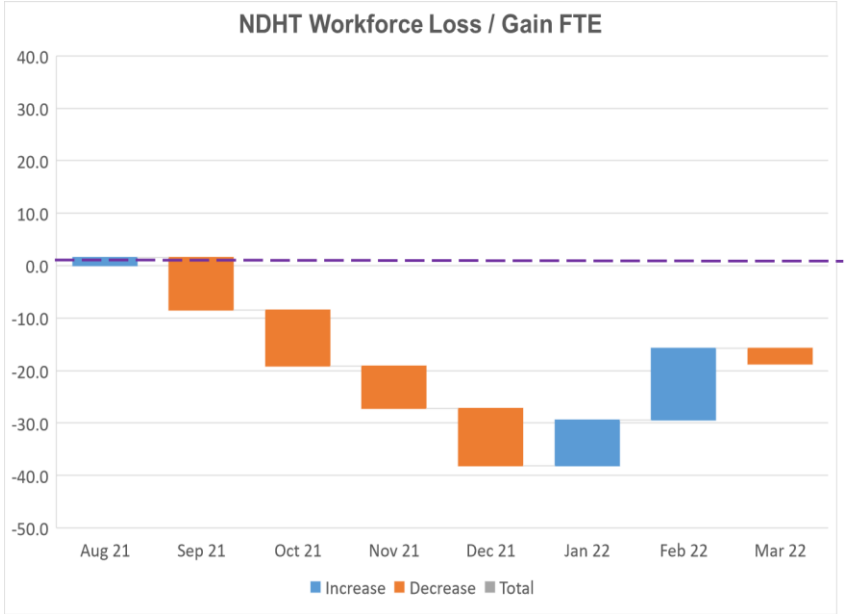
Northern Services Other Workforce Indicators



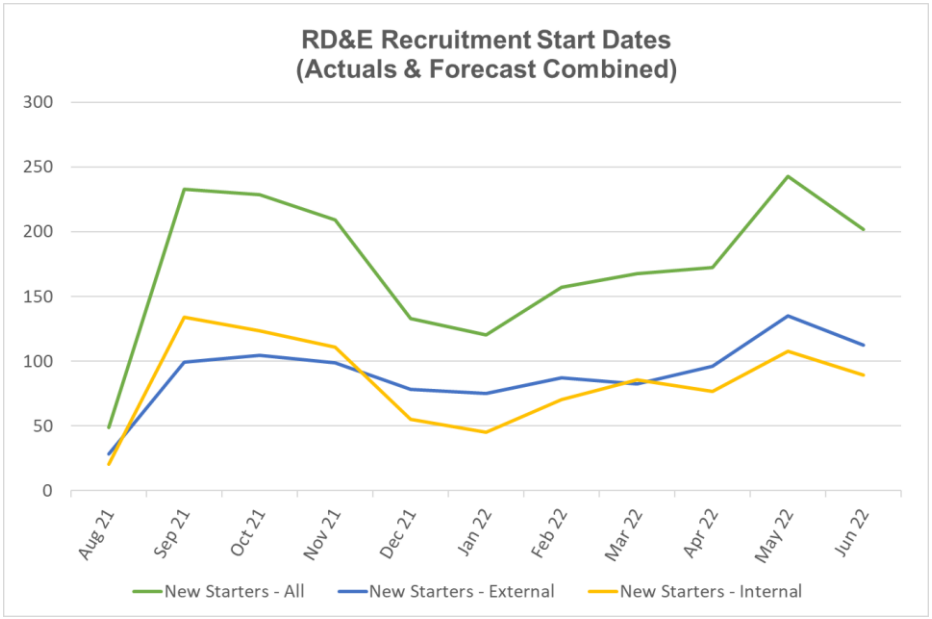


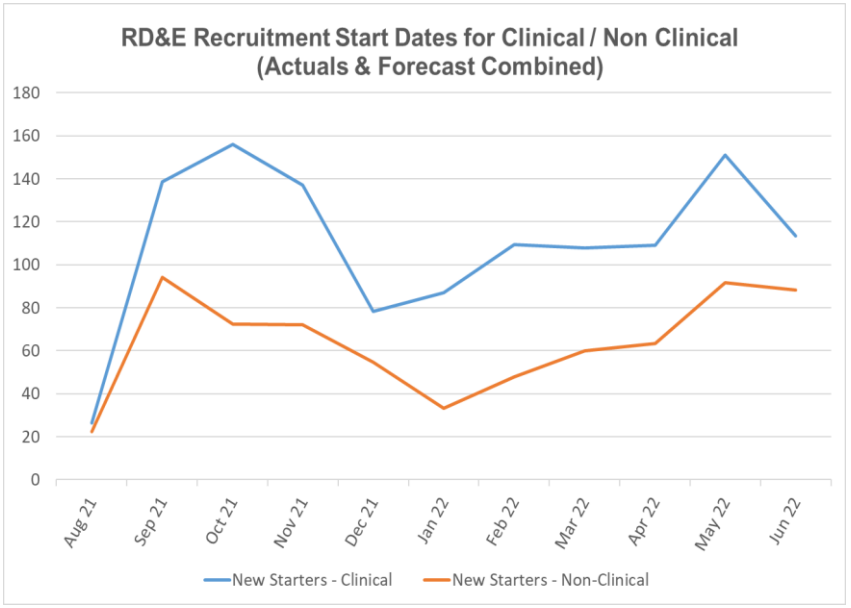
These charts have been developed in order to gain an understanding of the historic actual numbers of non medical and dental staff recruited on a weekly basis, alongside a prediction of the number of staff who will have start dates in the future. This is a forecast based on assumptions and as we develop this data further actual predictions should improve. Data is expressed as FTE and includes permanent and fixed term contract employees

The charts illustrating workforce loss / gain is illustrated as a bridge of net gain and loss of staff against the start point of August 2021. This is not an indication of gain and loss against budgets or establishment headcounts, but seeks to answer the Board's question about the net impact of recruitment and attrition.



Eastern Services Other Workforce Indicators





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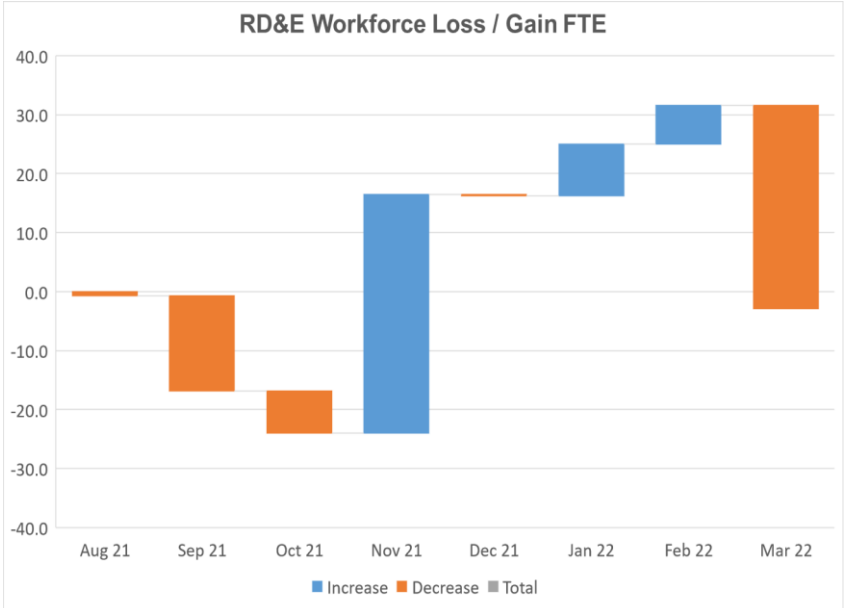
Healthcare Assistant recruitment activity continues with the aim of reaching a zero vacancy position to support the wards. However it should be noted that the recruitment market for band 2s and 3s all round is proving much more challenging against external opportunities paying higher wages. Engagement strategies have been developed to try to address retention issues and to present the career opportunities in these roles.

Registered nurse recruitment from overseas continues with 182 anticipated to start between April and December. Of these 45 will be deployed in Northern Services with the remainder split between Eastern Services and Nightingale .



Northern Services Workforce – *COVID related and general sickness information*

Staff Group	Headcount	1st Vaccination	2nd vaccination	3rd/Booster	1st Vaccination %	2nd Vaccination %	3rd /Booster Vaccination %
Add Prof Scientific and Technic	96	92	88	78	95.8%	91.7%	81.3%
Additional Clinical Services	693	629	615	541	90.8%	88.7%	78.1%
Administrative and Clerical	1047	994	982	900	94.9%	93.8%	86.0%
Allied Health Professionals	346	336	332	309	97.1%	96.0%	89.3%
Estates and Ancillary	91	85	84	72	93.4%	92.3%	79.1%
Healthcare Scientists	67	67	67	65	100.0%	100.0%	97.0%
Medical and Dental	396	378	374	344	95.5%	94.4%	86.9%
Nursing and Midwifery Registered	931	904	893	805	97.1%	95.9%	86.5%
Grand Total	3668	3486	3436	3115	95.0%	93.7%	84.9%

Division	Headcount	1st Vaccination	2nd vaccination	3rd/Booster	1st Vaccination %	2nd Vaccination %	3rd /Booster Vaccination %
415 Clinical Support & Specialist	1452	1384	1367	1242	95.3%	94.1%	85.5%
415 Corporate	731	692	687	625	94.7%	94.0%	85.5%
415 Medicine	722	683	668	597	94.6%	92.5%	82.7%
415 Surgery	763	727	714	651	95.3%	93.6%	85.3%
Grand Total	3668	3486	3436	3115	95.0%	93.7%	84.9%

COVID Statistics at 31st March 2022 for all contracted staff.

Eastern Services Workforce – *COVID related and general sickness information*

Staff Group	Headcount	1st Vaccination	2nd Vaccination	3rd/Booster	1st Vaccination %	2nd Vaccination %	3rd/Booster %
Add Prof Scientific and Technic	220	216	215	196	98.2%	97.7%	89.1%
Additional Clinical Services	1678	1643	1620	1367	97.9%	96.5%	81.5%
Administrative and Clerical	1936	1902	1888	1664	98.2%	97.5%	86.0%
Allied Health Professionals	714	705	694	620	98.7%	97.2%	86.8%
Estates and Ancillary	684	645	626	508	94.3%	91.5%	74.3%
Healthcare Scientists	241	239	238	227	99.2%	98.8%	94.2%
Medical and Dental	988	982	975	907	99.4%	98.7%	91.8%
Nursing and Midwifery Registered	2416	2382	2350	2044	98.6%	97.3%	84.6%
Students	8	8	8	7	100.0%	100.0%	87.5%
Grand Total	8885	8722	8614	7540	98.2%	96.9%	84.9%

Division	Headcount	1st Vaccination	2nd Vaccination	3rd/Booster	1st Vaccination %	2nd Vaccination %	3rd/Booster %
185 Community Services Division	1239	1223	1205	958	98.7%	97.3%	77.3%
185 Corporate Services Division	804	792	789	697	98.5%	98.1%	86.7%
185 Covid Vaccination Division	33	33	33	25	100.0%	100.0%	75.8%
185 Estates and Facilities Division	788	746	723	588	94.7%	91.8%	74.6%
185 Medical Service Division	1932	1902	1882	1659	98.4%	97.4%	85.9%
185 Nightingale Division	26	26	26	21	100.0%	100.0%	80.8%
185 Operational Services Division	49	47	47	45	95.9%	95.9%	91.8%
185 Research & Development Division	149	147	147	128	98.7%	98.7%	85.9%
185 Specialist Services Division	2061	2027	2006	1839	98.4%	97.3%	89.2%
185 Surgical Services Division	1804	1779	1756	1580	98.6%	97.3%	87.6%
Grand Total	8885	8722	8614	7540	98.2%	96.9%	84.9%

All data as at 13th April 2022

Efforts are being concentrated on ensuring all employees have received the first and second vaccine. Currently there are 281 substantive staff and a further 181 active bank workers without the first 2 doses. However since the recent advice on implementing the legislation regarding mandatory vaccination of staff we have seen a decrease in the number of these employees being vaccinated. These employees have been written to and asked to provide evidence of vaccination or confirmation they do not wish to be vaccinated. Work continues to confirm the vaccination status of anyone with an honorary contract.

Support continues to be offered by HR and Occupational Health to those employees who are undecided about being vaccinated.

Finance Overview

Financial Performance - key performance indicators

Domain	Measure / Metric	Unit of Measure	North Devon Healthcare NHS Trust			Royal Devon and Exeter NHS Trust		
			Last Month Feb-22	This Month Mar-22		Last Month Feb-22	This Month Mar-22	
Income and Expenditure	**I&E Surplus / (Deficit) - Total**	£'000	-2,161	-1,439		-2,824	6,185	
	I&E Surplus / (Deficit) v budget	£'000	106	1,282		3,353	14,846	
	Income variance to budget - Total	£'000	633	13,380	Detail provided in income categories below.	-1,585	10,807	
	Income variance to budget - Total	%	0.27%	5.27%		-0.26%	1.58%	
	Income variance to budget - Patient Care	£'000	2,081	11,880	NHSE - additional £6.4m income to off-set substantive pay costs for centrally funded pension contributions. Additional £1.8m income from pass-through drugs and devices. CCG's - additional £5.3m variation orders agreed. Local Authorities - reduced £1.5m with Domiciliary Care services ceased earlier than anticipated.	-245	-221	Please note that £17.1m of income for centrally funded pension contributions was provided for and therefore does not present as a variance
	Income variance to budget - Commercial & R&D	£'000	775	2,502	HEE income, pass-through Covid costs and contributions to funded establishment expected.	28	-6	
	Income variance to budget - Elective Recovery Fund (EFR)	£'000	-2,223	-1,002	H2 ERF below plan - covers the costs of delivering ERF so neutral impact as off set by reduced expenditure. £1.3m EFR additional funding received in Month 12 has improved the prior month adverse variance.	-1,368	10,843	£12.5m EFR additional funding received in Month 12 offset with reduced ERF scheme income on ERF schemes inline with reduced ERF scheme expenditure(£1. 7m).
	Pay variance to budget - Total	£'000	-143	-8,395	Detail provided in pay categories below.	2,324	2,532	Pay - overspends on Nursing (£849k) and Medical Staffing (£466k) are offset with underspends on Admin & Managers (£1.7m) and Other staff (£2.1m).
	Pay variance to budget - Total	%	-0.10%	-5.19%		0.65%	0.62%	
	Pay variance to budget - Substantive	£'000	851	-6,569	£6.4m pension contributions off-set by income received from NHSE.	9,698	10,973	Please note that costs of £17.1m for centrally funded pension contributions was provided for and therefore does not present as a variance.
	Pay variance to budget - Bank	£'000	-624	-1,175	Expenditure incurred covering vacancies and Covid.	-3,054	-3,326	Bank staff not budgeted for / offset with substantive vacancies/ sickness cover. Slightly higher bank spend than previous year.
	Pay variance to budget - Agency	£'000	-370	-651	Nursing and Medical agency expenditure covering vacancies.	-4,319	-5,115	Agency staff not budgeted for / offset with substantive vacancies/ sickness cover - lower levels to 2019/20 year despite COVID-19 expenditure.
	Agency expenditure (inc COVID expenditure) variance to Cap	£'000	-1,973	-2,439	Whilst above cap, agency expenditure is 7% lower than M12 2019/20.	-1,125	-1,900	Small overspend against agency cap (£725k per month) however COVID-19 agency costs amount to £211k per month out of the average monthly expenditure of £884k.
						Please note: M11 originally showed per month, now cumulative figures have been used.		
	Non Pay variance to budget	£'000	579	-2,793	Compensating adjustments within non-pay with excluded drugs and devices materially driving the variance.	-2,675	-3,370	YTD overspends on Services Received (£1.8m - mainly related to NHS property services and contracted out services in Cardiology), Drugs (£1.9m - mainly Pass through drugs £1.4m) and Misc Expenditure (£935k) offset with an underspend on clinical supplies (£1.2m).
	Non Pay variance to budget	%	0.72%	-3.23%		-1.47%	-1.63%	
	PDC, Depreciation, Profit/Loss on asset disposal, Interest Paid / Received variance to budget	£'000	-1,056	-1,195	Calculations based on final balance sheet position and capital programme.	-366	-563	Depreciation higher than budget due to enlarged capital programme, and PDC charge higher than budget based on year end balance sheet position
	Depreciation, Interest Paid / Received variance to budget	%	-13.81%	-14.40%		-1.36%	-1.96%	
	Donated Asset, Depreciation & Impairments variance to budget	£'000	93	285	Technical adjustment to reflect recognised loss on return of COVID assets to DHSC. Net neutral to reported financial position.	-418	-10,532	Includes building impairment £9.8m, movement in donated stock £420k and donated asset depreciation less donated asset additions £336k.
	Cost Improvement Programme - Total Current Year achievement	£'000	1,899	2,229		4,690	4,797	
	Cost Improvement Programme - Total Full Year / Recurrent delivery	£'000	1195	1452		2,841	2,859	
	Cost Improvement Programme - Total Non Recurrent delivery of current year	£'000	704	777		2,627	2,949	
	Cost Improvement Programme - Current Year variance to budget	£'000	0	0		-2,749	-2,641	See report narrative
Capital & Cash	Cash balance	£'000	18,213	20,345		58,812	68,575	
	Cash variance to budget - above / (below)	£'000	8,213	12,345	£5.7m capital creditors at year end reflecting value of capital programme delivered in month. £2.3m timing of increased level of trade debtors due to value of income received in month. £4.3m timing of increased levels of payables - not impacting on suppliers as demonstrated by the payment of 97% of payments within 30 days.	7,132	10,973	
	Better Payment Practice v 95% target - volume	%	97%	97%		92%	92%	
	Better Payment Practice v 95% target - value	%	97%	97%		93%	93%	
	Capital Expenditure variance to budget - Total above / (below)	£'000	-8,714	-6,807	YTD: Variance due to delays with the capital programme, see below for details. FOT: Plans in place to deliver the FOT that achieves planned levels of CDEL and PDC allocations.	7,706	28,421	The capital programme is now higher than the initial planned programme, mainly due to additional funding being awarded from NHSEI.
	Capital Expenditure variance to budget - CDEL above / (below)	£'000	-1,471	-519	£605k reduction in expected donations - £500k from South Molton League of Friends re-profiled to 2022/23 to support re-profiled expenditure. £90k benefit from disposal of CT scanner.	-7,310	-356	The £356k underspend relates to the £1,647k PDC funding received that we were asked not to reutilise by NHSEI, less the programme being increased from the revaluation of properties prior to their disposal of £1.0m and donated additions of £173k, leaving a £100k overspend on CDEL.
	Capital Expenditure variance to budget - PDC above / (below)	£'000	-7,243	-6,288	-£6.0m MYCARE re-profile to 22/23 agreed with DH. Other FOT: -£2.1m OFH OBC assumed PDC funding re-profiled to 22/23. £1.8m Elective TIF PDC notified not in original plan.	15,016	28,777	Programme higher than plan, due to additional schemes now included in the programme that are funded by NHSEI.

Key

Total value
Positive variance value
Negative variance value <5%
Negative variance value >5%

Northern Services Summary Finance Position

Commentary

Month 12 Summary Finance Position

- The Board has approved a £2.9m unadjusted deficit plan for 21/22.
- Cumulative deficit of £1,439k is £1,282k favourable to plan driven predominantly by additional ERF income notified in month The Board is referred to the SOCI appendix which sets out the narrative for variance against the H2 plan for months 7 to 12.

The Board is aware of the reasons for H1 variance and the commentary refers to performance against the H2 plan cumulative variances at month 12:

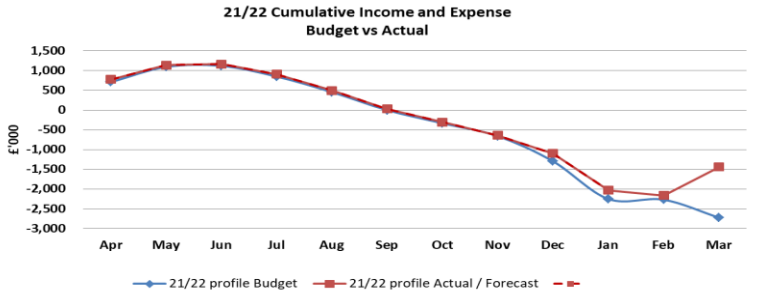
- The net favourable movement in Patient Care income is attributable to the following material variances:
- Specialised Commissioning patient care income £6.5m favourable YTD due to £6.4m income contribution to pension costs reflected in substantive pay in month 12 (this is a regular month 12 transaction).
- CCG patient care income £4.6m favourable to plan. £3.3m attributable to service variation orders and £1.3m additional ERF notified as earned in month 12.
- Private patient and Injury Cost Recovery income has not recovered to planned levels with £0.2m adverse variance.
- Commercial income has over-recovered £2.5m favourable to plan from increased training income (£1.6m) and contributions to workforce establishment (£0.7m) that will off-set adverse pay expenditure variance.
- Overall £9.3m adverse variance on pay after reflecting £6.4m pension costs off-set by income, £1.6m Covid impact increasing the annual leave accrual, £0.7m off-set by additional income, £0.4m pay award for Bank staff, £0.2m covering vacancies and sickness. Whilst agency expenditure is above cap, it is 7% (£0.5m) lower than M12 2019/20.
- £2.5m adverse variance on non-pay arises from increased drugs costs, utilities, Telephony and software maintenance, travel, training and hosting One Northern Devon expenditure. this is off-set by £2.0m income above.
- Depreciation and PDC calculations are based on the balance sheet position.

CIP

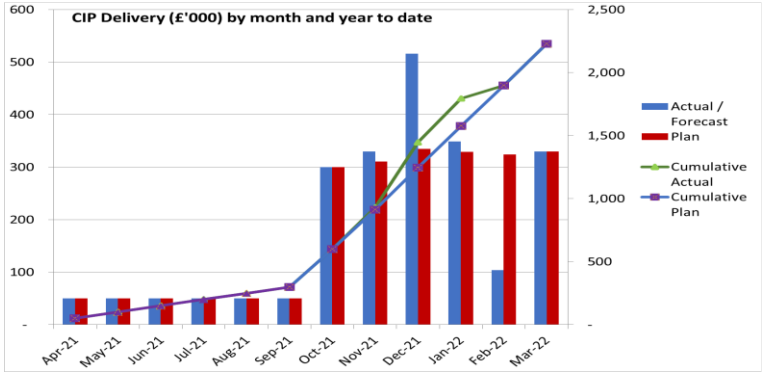
- The CIP achieved year to date is £2.2m being achievement of plan (£1.9m relates to H2). It should be noted that H1 CIP (£0.3m) has been delivered non-recurrently as there was no recurrent route to cash for productivity under the H1 funding regime.

Income & Expenditure Variance by Division	M12 YTD Fav/(Adv) £'000
Clinical Support	12
Corporate	1,269
Medicine	(81)
Surgery	82
Total	**1,282**

Data



NDHCT Month 12 2021/22 Summary Income & Expenditure	H1 Actual £,000	H1 Budget £,000	H1 Variance Fav / (Adv) £,000	H2 to Date Actual £,000	H2 to Date Budget £,000	H2 to Date Variance Fav / (Adv) £,000	Year to Date (H1 + H2) Actual £,000	Year to Date (H1 + H2) Budget £,000	Year to Date (H1 + H2) Variance Fav / (Adv) £,000
Patient Income	121,508	121,643	(135)	127,003	115,990	11,013	248,511	237,633	10,878
Commercial Income	7,803	7,605	198	10,782	8,478	2,304	18,585	16,083	2,502
Total Income	**129,311**	**129,248**	**63**	**137,785**	**124,468**	**13,317**	**267,096**	**253,716**	**13,380**
Pay	(79,825)	(80,765)	940	(90,400)	(81,065)	(9,335)	(170,225)	(161,830)	(8,395)
Non Pay	(44,965)	(44,685)	(280)	(44,323)	(41,810)	(2,513)	(89,288)	(86,495)	(2,793)
Total Expenditure	**(124,790)**	**(125,450)**	**660**	**(134,723)**	**(122,875)**	**(11,848)**	**(259,513)**	**(248,325)**	**(11,188)**
EBITDA	**4,521**	**3,798**	**723**	**3,062**	**1,593**	**1,469**	**7,583**	**5,391**	**2,192**
Depreciation / interest paid / received	(4,648)	(3,930)	(718)	(4,843)	(4,366)	(477)	(9,491)	(8,296)	(1,195)
Net Surplus / (Deficit)	**(127)**	**(132)**	**5**	**(1,781)**	**(2,773)**	**992**	**(1,908)**	**(2,905)**	**997**
Donated Asset Income & Depreciation	157	132	25	312	52	260	469	184	285
Net Surplus / (Deficit) after Donated Asset Income	**30**	**0**	**30**	**(1,469)**	**(2,721)**	**1,252**	**(1,439)**	**(2,721)**	**1,282**



Northern Services Financial Tables

Northern Devon Healthcare NHS Trust Cost Improvement Programme Period ending 31/03/2022 Month 12	Year to Date - Achieved			Recurrent - Achieved			Recurrent - Forecast			CY Target	FY Target
	Actual	Target	Variance to Budget Fav./(Adv.)	Actual	Target	Variance to Budget Fav./(Adv.)	Actual	Target	Variance to Budget Fav./(Adv.)	Forecast Rating	Forecast Rating
	£000	£000	£000	£000	£000	£000	£000	£000	£000	R/A/G	R/A/G
Business As Usual											
Medicine	99	107	(8)	46	46	0	38	38	0	G	G
Clinical Support and Specialist Services	1,109	1,047	62	510	510	0	770	770	0	G	G
Surgery	516	571	(55)	363	363	0	571	571	0	G	G
Corporate	205	204	1	25	25	0	73	73	0	G	G
	1,929	**1929**	**0**	**944**	**944**	**0**	**1,452**	**1452**	**0**		
Trustwide Projects											
Elective Recovery Productivity	300	300	0	0	0	0	0	0	0	G	G
	300	**300**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		
Total CIP	**2,229**	**2,229**	**0**	**944**	**944**	**0**	**1,452**	**1,452**	**0**		

CIP plan achieved with on-going review of Recurrent benefits to inform 22/23 planning.

Northern Services Financial Tables

Northern Devon Healthcare NHS Trust Income Statement Period ending 31/03/2022 Month 12	H1			H2 to Date				Year to Date (H1 + YTD H2)			Outturn		
	Actual £'000	Budget £'000	Actual Variance to Budget Fav / (Adv) £'000	Actual £'000	Budget £'000	Actual Variance to Budget Fav / (Adv) £'000		Actual £'000	Budget £'000	Actual Variance to Budget Fav / (Adv) £'000	Actual £'000	Budget £'000	Actual Variance to Budget Fav / (Adv) £'000
Income													
Patient Income - NHS	113,188	111,806	1,382	122,381	111,090	11,291	1	235,569	222,896	12,673	224,614	222,896	1,718
Patient Income - Local Authority	7,756	9,180	(1,424)	4,318	4,380	(62)		12,074	13,560	(1,486)	12,132	13,560	(1,428)
Other Patient Income	564	657	(93)	304	520	(216)	2	868	1,177	(309)	937	1,177	(240)
Operating Income	7,803	7,605	198	10,782	8,478	2,304	3	18,585	16,083	2,502	17,699	16,083	1,616
Total Income	**129,311**	**129,248**	**63**	**137,785**	**124,468**	**13,317**		**267,096**	**253,716**	**13,380**	**255,383**	**253,716**	**1,667**
Employee Benefits Expenses	(79,825)	(80,765)	940	(90,400)	(81,065)	(9,335)	4	(170,225)	(161,830)	(8,395)	(162,747)	(161,830)	(917)
Drugs	(11,724)	(9,198)	(2,526)	(12,092)	(11,532)	(560)	5	(23,816)	(20,730)	(3,086)	(23,235)	(20,730)	(2,505)
Clinical Supplies	(8,756)	(9,918)	1,162	(9,771)	(10,742)	971	6	(18,527)	(20,660)	2,133	(17,903)	(20,660)	2,757
Non-Clinical Supplies	(4,904)	(5,076)	172	(5,452)	(4,932)	(520)	7	(10,356)	(10,008)	(348)	(10,049)	(10,008)	(41)
Purchase of Social Care	(3,342)	(4,888)	1,546	0	0	0		(3,342)	(4,888)	1,546	(3,342)	(4,888)	1,546
Misc Other Operating Expenses	(13,110)	(12,917)	(193)	(14,329)	(11,211)	(3,118)	8	(27,439)	(24,128)	(3,311)	(26,110)	(24,128)	(1,982)
Services Received	(3,129)	(2,688)	(441)	(2,679)	(3,393)	714	9	(5,808)	(6,081)	273	(6,011)	(6,081)	70
Total Costs	**(124,790)**	**(125,450)**	**660**	**(134,723)**	**(122,875)**	**(11,848)**		**(259,513)**	**(248,325)**	**(11,188)**	**(249,397)**	**(248,325)**	**(1,072)**
EBITDA	**4,521**	**3,798**	**723**	**3,062**	**1,593**	**1,469**		**7,583**	**5,391**	**2,192**	**5,986**	**5,391**	**595**
Profit / (Loss) on asset disposals	11	0	11	(62)	168	(230)	10	(51)	168	(219)	99	168	(69)
Total Depreciation	(3,259)	(3,120)	(139)	(3,386)	(3,190)	(196)		(6,645)	(6,310)	(335)	(6,621)	(6,310)	(311)
Total Operating Surplus / (Deficit)	**(3,248)**	**(3,120)**	**(128)**	**(3,448)**	**(3,022)**	**(426)**		**(6,696)**	**(6,142)**	**(554)**	**(6,522)**	**(6,142)**	**(380)**
Interest Receivable	0	6	(6)	10	0	10		10	6	4	4	6	(2)
Interest Payable	0	0	0	(1)	0	(1)		(1)	0	(1)	(1)	0	(1)
PDC	(1,400)	(816)	(584)	(1,404)	(1,344)	(60)	11	(2,804)	(2,160)	(644)	(2,746)	(2,160)	(586)
Net Surplus / (Deficit)	**(127)**	**(132)**	**5**	**(1,781)**	**(2,773)**	**992**		**(1,908)**	**(2,905)**	**997**	**(3,279)**	**(2,905)**	**(374)**
Add back SOCI impact of impairments included above	0	0	0	0	0	0		0	0	0	0	0	0
Remove SOCI impact of capital donations/grants	157	132	25	312	52	260	10	469	184	285	558	184	374
Net Surplus/(Deficit) after donated asset & PSF/MRET Income	**30**	**0**	**30**	**(1,469)**	**(2,721)**	**1,252**		**(1,439)**	**(2,721)**	**1,282**	**(2,721)**	**(2,721)**	**(0)**

KEY MOVEMENTS AGAINST H2 PLAN

The Board has been informed of financial performance against H1 plan; this statement maintains a focus on delivery of the H2 financial plan to deliver a £2.7m adjusted planned deficit.

1. £6.4m NHS England - income for pension contributions off-set in substantive pay. adverse from reduced level of pass-through drugs off-set by net reduction in relevant non-pay costs. £3.3m net additional service funding from Devon CCG off-set by increased pay and non-pay expenditure. £1.3m additional ERF income.
2. £0.1m Private Patient income and £0.1m Injury Cost Recovery below covid recovery trajectories.
3. £1.6m favourable Training income and £0.7m favourable contributions to workforce establishment above plan; these contribute to increased pay and non-pay expenditure.
4. £6.4m pension contribtions off-set by NHSE income, £1.6m increase in annual leave, £0.7m income received, £0.4m H1 pay award for NHSP, £0.2m vacancies and sickness.
5. Drugs costs are above plan, though there is a shift from NHSE Spec Comm pass through (increased income above) to CCG block and not recovered through income.
6. Non pay benefit from reduced elective care activity due to Covid and winter pressures.
7. Pay award on contracted out hotel services, protective clothing.
8. Driven by increased utilities, Telephony and software maintenance, travel, training and hosting One Northern Devon expenditure; the latter two categories are off-set by income above off-set by £1.7m of income.
9. Reduced levels of insourced elective activity due to Covid and winter pressures.
10. Technical adjustment to reflect recognised loss on return of COVID assets to DHSC. Net neutral to reported financial position.
11. PDC calculation refreshed against current balance sheet.

Northern Services Financial Tables

Commentary

Capital

- The capital plan for the year was £29.0m with a forecast to deliver £22.2m in line with the reprofiling of the EPIC business case. The Board can be assured that CDEL outturn at £7.7m is aligned with STP limit allocated.

Year to Date expenditure

- With £5.2m in month expenditure the capital expenditure for 2021/22 was £22.2m being £6.8m less than plan. £6.0m is attributable to PDC approved re-phasing of MYCARE expenditure to 2022/23 in accordance with the revised delivery profile. £0.6m reduction in the donated income that is matched by reduced levels of expenditure predominantly from re-phasing commencement of Ophthalmology hub to 2022/23. £0.1m disposal proceeds contribute to the Trust's capital programme.
- The month 12 position delivers against the Trust's allocated CDEL limit and notified national funded schemes.

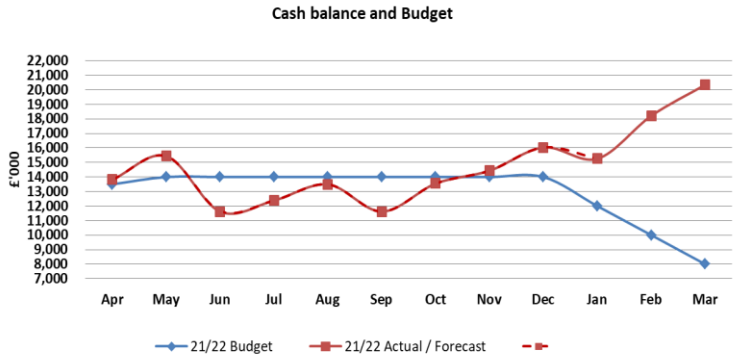
Cash

Year to Date

- £20.3m cash balance is £12.3m favourable to plan predominantly from slippage in the capital programme and the additional income notified in month 12.
- Better Payment Practice of paying 97% of invoices within 30 days exceeds the statutory requirement of 95%.
- Aged debt of £1.8m is £0.3m higher than at the year end. Regular focus on recovery and referral to debt collection including monthly review meeting with Director of Operational Finance (North).
- The majority of aged debt (£1.4m) is between 0 and 30 days. There is no anticipated risk of debt extending beyond settlement terms.

Data

	Year to Date		
	Actual £000	Plan £000	Variance Fav/(Adv) £000
Capital Funding Sources:			
Depreciation - internally generated	6,310	6,310	0
STP CDEL Allocation	1,349	1,349	0
CDEL - Disposal of CT	90	0	90
Donations	96	701	-605
National Funding	14,399	20,687	-6,288
Total Capital Income	**22,244**	**29,047**	**-6,803**
Site Development	-5,001	-6,726	1,725
Estates Project	-5,392	-4,839	-553
Equipment	-1,126	-560	-566
Digital Healthcare	-10,803	-16,372	5,569
Uncommitted	82	-550	632
Total Capital Expenditure	**-22,240**	**-29,047**	**6,807**
Under / (Over) Spend	**4**	**0**	**4**



Northern Services Financial Tables

Northern Devon Healthcare NHS Trust Statement of Financial Position Period ending 31/03/2022 Month 12		Year to Date Actual £'000	Prior Year March 2021 £'000	Actual Movement to Date Fav / (Adv) £'000
Assets, Non-current				
Intangible assets		20,245	16,617	3,628
Property, plant and equipment		94,902	82,920	11,982
Non NHS Trade Receivables, Non-Current		771	774	(3)
Assets, Non-Current, Total		**115,918**	**100,311**	**15,607**
Assets, Current				
Inventories		3,044	3,275	(231)
Trade and other receivables: NHS and DHSC group bodies	1	4,492	1,178	3,314
Trade and other receivables: non-NHS/DHSC Group bodies	1	5,056	4,686	370
Cash and cash equivalents: GBS/NLF		20,336	19,060	1,276
Cash and cash equivalents: commercial / in hand / other		9	9	0
Assets, Current, Total		**32,937**	**28,208**	**4,729**
Liabilities, Current				
Trade and other payables: capital		(5,700)	(1,521)	(4,179)
Trade and other payables: non-capital		(26,503)	(23,574)	(2,929)
Provisions		(9)	(26)	17
Current Tax Payables (VAT and PAYE)		0	(2,889)	2,889
Liabilities, Current, Total		**(35,778)**	**(28,010)**	**(7,768)**
NET CURRENT ASSETS (LIABILITIES)		**(2,841)**	**198**	**(3,039)**
TOTAL ASSETS LESS CURRENT LIABILITIES		**113,077**	**100,509**	**12,568**
Liabilities, Non-current				
Provisions		(51)	(56)	5
Liabilities, Non-current, Total		**(51)**	**(56)**	**5**
TOTAL ASSETS EMPLOYED		**113,026**	**100,453**	**12,573**
TAX PAYERS' EQUITY				
Public dividend capital	2	111,833	97,434	14,399
Retained Earnings (Accumulated Losses)		(8,364)	(6,550)	(1,814)
Revaluation Reserve		9,557	9,569	(12)
Donated Assets Reserve		0	0	0
TOTAL TAX PAYERS' EQUITY		**113,026**	**100,453**	**12,573**

KEY MOVEMENTS

1. Timing of receivables due. Overall level of debtors 'not yet due' assures no risk associated with cash management.

2. Capital PDC received

Northern Services Financial Tables

Northern Devon Healthcare NHS Trust Statement of Cash Flow Period ending 31/03/2022 Month 12	Year to Date Actual £'000	Prior Year March 2021 £'000
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES		
Operating surplus/(deficit)	**929**	**593**
Non-cash income and expense:		
Depreciation and amortisation	6,640	5,550
Impairments and reversals	0	1,522
Income recognised in respect of capital donations (cash and non-cash)	(96)	(452)
(Increase)/decrease in trade and other receivables	(3,705)	9,980
(Increase)/decrease in inventories	231	(106)
Increase/(decrease) in trade and other payables	1,704	4,464
Increase/(decrease) in other liabilities	1,963	501
Increase/(decrease) in provisions	(22)	(2)
Net cash generated from / (used in) operations	**7,644**	**22,050**
Cash flows from investing activities		
Interest received	10	3
Purchase of intangible assets	(4,719)	(10,034)
Purchase of property, plant and equipment and investment property	(13,342)	(13,733)
Proceeds from sales of property, plant and equipment and investment property	110	19
Receipt of cash donations to purchase capital assets	40	95
Net cash generated from/(used in) investing activities	**(17,901)**	**(23,650)**
Cash flows from financing activities		
Public dividend capital received	14,399	39,897
Loans from Department of Health and Social Care- received	0	(930)
Loans from Department of Health and Social Care - repaid	0	(20,003)
Other loans repaid	0	(607)
Interest paid	(1)	(87)
PDC dividend (paid)/refunded	(2,865)	(1,550)
Net cash generated from/(used in) financing activities	**11,533**	**16,720**
Increase/(decrease) in cash and cash equivalents	**1,276**	**15,120**
Cash and cash equivalents at start of period	**19,069**	**3,949**
Cash and cash equivalents at end of period	**20,345**	**19,069**

Northern Services Financial Tables

Northern Devon Healthcare NHS Trust
Capital Expenditure
Period ending 31/03/2022
Month 12

Scheme	Source of Funding		Actual expenditure to date: YTD actual Expenditure £'000	YTD planned expenditure per annual plan* £'000	YTD variance slippage / (higher) £'000	Expected completion date
Schemes >= £500k						
EPIC	PDC	1	10,000	16,000	6,000	22/23
OFH (HIP2) Seed Funding - OBC (subject to SOC approval)	PDC	2	0	2,000	2,000	22/23
Wave 4 - CT Scanner	CDEL/PDC		1,993	1,904	(89)	21/22
OFH (HIP2) Seed Funding - SOC	PDC	3	1,183	1,317	134	21/22
Devonshire House	CDEL		1,373	1,467	94	21/22
General Backlog	CDEL		1,145	1,000	(145)	21/22
Radiology Rooms	CDEL	4	1,221	825	(396)	21/22
Aseptic Unit	CDEL	2	34	720	686	22/23
South Molton Community Hospital - Ophthalmology	CDEL/DON	2	16	600	584	22/23
Water Supply Pipework	CDEL		505	500	(5)	21/22
TIF Bids	PDC	5	1,718	0	(1,718)	21/22
Total schemes >= £500k			**19,188**	**26,333**	**7,145**	
Other schemes < £500k and slippage/contingency			3,052	2,714	(338)	21/22
Total			**22,240**	**29,047**	**6,807**	

1. DH approval to re-phase £6.0m PDC to 2022/23 to reflect revised delivery profile from learning from RDE.
2. Re-phased to 22/23 - SMCH Ophthalmology expenditure will be off-set by donated income from South Molton League of Friends.
3. Final agreed value with DH regarding PDC funding for works appropriate for SOC.
4. Costs of completion pulled forward from 22/23.
5. In year national allocation of Elective Targeted Investment Funding (TIF) PDC approved for modular ward and laminar flow bids.

Eastern Services Summary Finance Position

Commentary

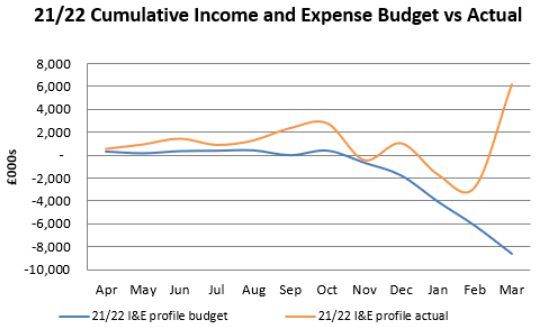
Month 12 Summary Finance position

- The Trust has ended the financial year with a surplus of £6.2m, £14.8m better than budget. The Trust had forecast a £6.3m deficit at month 11 (£2.4m favourable to budget), however additional income of £12.5m was received in month 12 relating to additional ERF funding received.
- The Trust received £8.2m from the Elective Recovery Fund (ERF) in H1 and received a further £4.4m in H2, £1.7m less than planned. The £12.5m EFR additional funding received in Month 12 (with guidance that it should be distributed to Trusts that have earnt it) is offset with reduced ERF scheme income on ERF schemes inline with reduced ERF scheme expenditure(£1.7m), to give an overall benefit to plan of £10.8m
- Excluding the additional £12.5m, the Trust overspent in March by £1.0m. This related to an under-achievement of the Cost Improvement Programme (£521k), an under-recovery of income on the original ERF schemes (£289k, offset with reduction in reserve spend) and overspends on additional PDC dividend costs (£262k) and COVID expenditure (£247k); offset with a underspend on Pay (£208k) and unspent Reserves (£166k).
- In Month 12, cost and income related to additional pension contributions at 6.3% (£17.1m, paid by NHSE/I on providers behalf) have been included as per NHSE/I guidance. The Trust has also amended its accrual for staff leave being carried into the new financial year to £4.9m (from £5.7m at the end of last financial year).
- The Trust has received income for Community Diagnostic HUB (£3.5m) and TIF and ERF+ schemes (£4.7m).
- Pay has underspent by £2.5m for the year, with an underspend in March of £208k. Overspends in the month on Nursing (£389k - mostly due to additional agency/bank staffing costs to cover sickness and vacancies) and Medical Staff (£23k) are offset with underspends on Admin and Managers (£342k) and Other staffing (£278k).
- The planned expenditure on COVID-19 (in envelope funding) was reduced to £792k per month in H2, with additional costs continuing to be funded on a pass through basis e.g. COVID testing and vaccinations. COVID-19 costs for March amounted to £1.9m with £1.0m funded within the STP envelope, £593k related to pass through testing expenditure and £283k for the vaccination programme. Overall COVID expenditure was higher than the envelope funding received for March, mostly relating to additional shifts due to increased COVID sickness/isolation levels of staff. The Trust spent £5.3m in H2 compared to £5.2m in H1.

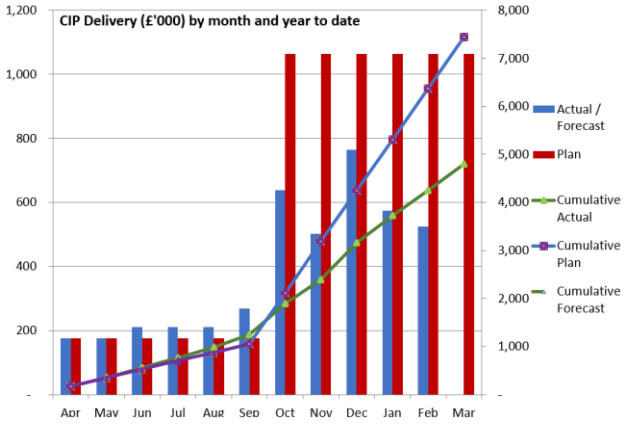
- An impairment of £9.8m has been incurred following capital investment relating to the Nightingale Hospital Site (see capital section).
- Cash as at the end of March was £68.6m, an increase of £5.1m on the value held at the end of the last financial year.

Cost Improvement Programme (CIP)

- The Trust has delivered £4.8m of the £7.4m CIP target for 2021/22 (£6.4m of target related to H2).
- £2.9m has been achieved on a recurrent basis.
- £1.1m of MyCare benefits were achieved in year, £2.2m on a recurrent basis. The slippage for these schemes will be delivered in 22/23.



Royal Devon and Exeter NHS Trust Month 12 2021/22 Summary Income & Expenditure	At Year End 31st March 2022 Actual £m	 Budget £m	 Variance £m
Patient Income	558.3	547.6	10.6
Commercial Income	137.3	137.1	0.2
Total Income	695.6	684.8	10.8
Pay	-404.2	-406.7	2.5
Non-Pay	-255.3	-257.4	2.1
Total Expenditure	-659.5	-664.1	4.6
EBITDA	36.1	20.7	15.4
Depreciation / Interest paid / received	-29.9	-29.4	-0.6
Net Surplus / (Deficit)	6.2	-8.7	14.8
Donated Asset Income & Depreciation	-10.5	0.0	-10.5
Net Surplus after Donated asset Income	-4.3	-8.7	4.3



Income & Expenditure by Division	Year end - variance, + fav/ (adv) Income * £000	 Expense £000	 Total £000
Medicine	293	(3,176)	(2,882)
Surgery	28	2,947	2,974
Specialist	(699)	846	147
Community	(75)	1,632	1,557
Trust wide	11,260	1,788	13,048
Control Total Surplus / (Deficit)	10,807	4,038	14,845

* Due to block contracts only commercial income variance is reported for Divisions

Eastern Services Financial Tables

Royal Devon and Exeter NHS Trust		Year to Date - Achieved			Current Year - Achieved			Full Year - Achieved		
		Actual	Target	Variance to Budget	Actual	Target	Variance to Budget	Actual	Target	Variance to Budget
Cost Improvement Programme				Fav./(Adv.)			Fav./(Adv.)			Fav./(Adv.)
Period ending	31/03/2022									
Month	12	£000	£000	£000	£000	£000	£000	£000	£000	£000
Business As Usual										
	Medical Services	264	79	185	264	79	185	0	260	(260)
	Specialist Services	748	717	31	748	717	31	37	109	(72)
	Surgical Services	314	248	66	314	248	66	297	309	(12)
	Corporate	458	260	198	458	260	198	198	526	(328)
	Community	297	287	10	297	287	10	107	311	(204)
		2081	1591	490	2081	1591	490	639	1,515	(876)
MyCare*										
	MyCare - Medical Records	340	340	0	340	340	0	715	1,360	(645)
	MyCare - Legacy Systems Pay	411	210	201	411	210	201	840	840	0
	MyCare - Legacy Systems Non Pa	245	284	(39)	245	284	(39)	520	284	236
	MyCare - Admin & Clerical Savings	72	262	(190)	72	262	(190)	144	1,535	(1,391)
	MyCare - Postage expenses	0	261	(261)	0	261	(261)	0	261	(261)
	MyCare - Printing	3	251	(248)	3	251	(248)	2	251	(249)
	MyCare - Bed Capacity	0	237	(237)	0	237	(237)	0	956	(956)
		1,070	1,845	(774)	1,070	1,845	(774)	2,220	5,487	(3,267)
Trustwide Projects										
	Trustwide	0	380	(380)	0	380	(380)	0	3,350	(3,350)
	Trustwide - Tariff Efficiency	1,646	1,646	0	1,646	1,646	0	0	0	0
		1,646	2,026	(380)	1,646	2,026	(380)	0	3,350	(3,350)
CIP identified in H1 and H2 plan (agreed by Board)		4,797	5,461	(663)	4,797	5,461	(663)	2,859	10,352	(7,493)
Non identified central mitigations			1,978	(1,978)		1,978	(1,978)	0	2,413	(2,413)
Total CIP		4,797	7,439	(2,641)	4,797	7,439	(2,641)	2,859	12,765	(9,906)

Eastern Services Financial Tables

Royal Devon and Exeter NHS Trust Income Statement Period ending 31/03/2022 Month 12	H1 Actual £000	H1 Budget £000	H1 Actual Variance to Budget Fav./(Adv.) £000	H2 Actual £000	H2 Budget £000	H2 Actual Variance to Budget Fav./(Adv.) £000	Year to 31 March 2021 Actual £000	Year to 31 March 2021 Budget £000	Year to 31 March 2021 Actual Variance to Budget Fav./(Adv.) £000		Prior Yr Mar-21 Actual £000
Income											
NHS Commissioner Block Income	248,682	248,682	0	251,380	251,380	0	500,062	500,062	0	1	462,859
NHS Clinical Income - Other and Private Patients	936	840	96	1,651	1,968	(317)	2,587	2,808	(221)	1	2,609
NHS Top up Income	15,270	15,270	0	15,181	15,181	0	30,451	30,451	0	1	27,507
Elective Recovery Fund	9,016	9,016	0	16,155	5,312	10,843	25,171	14,328	10,843	1	0
Covid-19 related Income	12,787	12,787	0	12,451	12,451	0	25,238	25,238	0	3	26,831
Covid-19 vaccine related Income	2,728	2,728	0	2,573	2,573	0	5,301	5,301	0	3	1,130
Research and Development	9,715	9,715	0	14,230	14,064	166	23,945	23,779	166		20,710
Education and Training	7,973	7,973	0	9,287	9,262	25	17,260	17,235	25		16,354
Other Income	23,385	23,760	(374)	42,198	41,830	368	65,583	65,590	(6)		90,741
Total income	**330,492**	**330,771**	**(278)**	**365,106**	**354,021**	**11,085**	**695,598**	**684,792**	**10,807**		**648,741**
Expense											
Employee Benefits Expenses (Pay)	(191,932)	(192,149)	217	(212,253)	(214,568)	2,315	(404,185)	(406,718)	2,532	2	(384,525)
Drug Costs	(39,152)	(38,363)	(789)	(41,097)	(39,973)	(1,124)	(80,249)	(78,336)	(1,913)		(70,408)
Clinical Supplies	(25,871)	(25,854)	(16)	(27,134)	(28,366)	1,232	(53,004)	(54,220)	1,215		(41,127)
Non Clinical Supplies	(2,814)	(2,891)	78	(3,283)	(3,288)	5	(6,097)	(6,179)	82		(5,061)
Covid-19 related Costs	(8,390)	(10,689)	2,299	(8,540)	(7,965)	(575)	(16,930)	(18,654)	1,724	3	(24,301)
Covid-19 vaccine related Costs	(2,728)	(2,728)	0	(2,573)	(2,573)	0	(5,301)	(5,301)	0	3	(1,130)
Research & Development Expenses	(9,715)	(9,715)	(0)	(13,524)	(13,347)	(177)	(23,239)	(23,062)	(177)		(19,522)
Misc. Other Operating Expenses	(26,567)	(26,414)	(152)	(29,604)	(28,822)	(782)	(56,171)	(55,236)	(935)		(72,799)
Services Received	(6,265)	(4,818)	(1,447)	(8,025)	(7,652)	(373)	(14,290)	(12,470)	(1,820)		(12,267)
Cost Improvement Programme	0	195	(195)	0	2,446	(2,446)	0	2,641	(2,641)		0
Reserves	0	(3,080)	3,080	0	(3,454)	3,454	0	(6,534)	6,534		0
Total Costs	**(313,434)**	**(316,507)**	**3,074**	**(346,034)**	**(347,562)**	**1,528**	**(659,467)**	**(664,069)**	**4,602**		**(631,140)**
EBITDA	**17,059**	**14,263**	**2,796**	**19,072**	**6,459**	**12,613**	**36,131**	**20,723**	**15,409**		**17,601**
Profit / loss on asset disposals	(1)	0	(1)	15	0	15	14	0	14		9
Total Depreciation	(10,035)	(9,680)	(355)	(10,411)	(10,551)	140	(20,446)	(20,231)	(215)		(12,624)
Total operating surplus (deficit)	**7,023**	**4,583**	**2,440**	**8,676**	**(4,092)**	**12,768**	**15,699**	**492**	**15,208**		**4,986**
Total interest receivable/ (payable)	0	0	0	32	0	32	32	0	32		20
Total interest payable on loans and leases	(1,325)	(1,235)	(90)	(1,276)	(1,278)	2	(2,601)	(2,513)	(88)		(756)
PDC Dividend	(3,348)	(3,348)	0	(3,597)	(3,291)	(306)	(6,945)	(6,639)	(306)		(4,289)
Net Surplus/(deficit)	**2,350**	**0**	**2,350**	**3,835**	**(8,661)**	**12,496**	**6,185**	**(8,660)**	**14,846**		**(39)**
Donated asset, depreciation & impairments	(219)	0	(219)	(10,313)	0	(10,313)	(10,532)	0	(10,532)		(16,045)
Net Surplus/(deficit)	**2,131**	**0**	**2,131**	**(6,478)**	**(8,661)**	**2,183**	**(4,347)**	**(8,660)**	**4,314**		**(16,084)**

KEY MOVEMENTS

1 Block contract income with the Trust main commissioners, plus a further top up and Elective Recovery Fund income.

2 Pay - overspends on Nursing (£848k) and Medical Staffing (£466k) are offset with an underspends on Admin & Managers (£1.7m) and Other staff (£2.1m)

3 COVID-19 testing/vaccine costs have been refunded and the Trust has received a block amount of £1.6m per month for other COVID-19 costs incurred

Eastern Services Financial Tables

Commentary

Capital

Year to date expenditure

- The capital programme for the year is £55.9m (planned value was £27.5m). The increase in the annual capital programme mainly relates to additional PDC capital funding being awarded to the Trust of £28.8m, and the revaluation of the properties prior to their disposal enabled the Trust to increase its CDEL programme by £1.1m, offsetting these increases was an underspend of CDEL of £1.4m as additional PDC funding was received for a capital scheme and NHSEI requested that this was not reutilised for further schemes.

Impairment charge

- In 2021/22 the Nightingale Hospital site has been repurposed to provide greater theatre and diagnostics capacity with a further investment of £16.2m being made. The investment relates to changes to the internal configuration of the building and the purchase of new equipment.
- A formal valuation report has been received from Gerald Eve. Costs that have been incurred relating to internal changes to the buildings structure have led to an impairment charge of £9.8m.
- For NHSEI reporting purposes the impairment should be reported below the performance line.

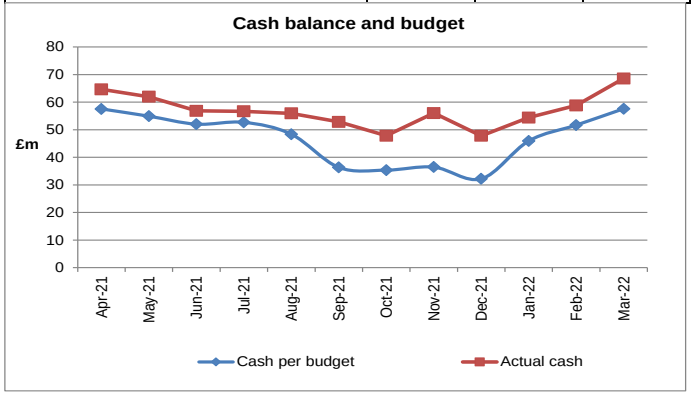
Cash

Year to Date

- Closing cash as at the end of March is £68.6m, a increase of £5.1m on the value held at the year end, with cash being generated by the surplus achieved for the year after adjusting for the all the capital expenditure and PDC funding received. The Cashflow statement provides greater detail of the movements within cash.
- Better Payment Practice of paying 92.5% YTD, of Non-NHS invoices paid within 30 days (target 95%).

Data

	Year to Date		
	Actual £000	Plan £000	Variance Fav/(Adv) £000
Capital Funding Sources:			
Depreciation - internally generated	20,955	19,886	1,069
STP CDEL Allocation	(3,131)	(1,434)	(1,697)
Donations	173	0	173
National Funding - PDC	37,876	9,000	28,876
Total Capital Income	**55,873**	**27,452**	**28,421**
Site Development	31,419	12,467	18,953
Estates Project	3,767	5,338	(1,571)
Equipment	11,357	6,381	4,975
Digital Healthcare	9,330	3,266	6,064
Uncommitted	0	0	0
Total Capital Expenditure	**55,873**	**27,452**	**28,421**
Under / (Over) Spend	**(0)**	**0**	**(0)**



Eastern Services Financial Tables

Royal Devon & Exeter NHS Foundation Trust Statement of Financial Position Period ending 31/03/2022 Month 12	Year to Date Actual £000	Prior Yr March 2021 £000	
Non-current assets			
Intangible assets	37,151	42,135	
Property, Plant and Equipment: other	299,291	270,474	1
Investments in associates and joint ventures	5	5	
Receivables	1,955	2,595	
Total non-current assets	**338,402**	**315,209**	
Current assets			
Inventories	10,231	10,801	
Receivables: due from NHS and DHSC group bodies	25,585	11,393	2
Receivables: due from non-NHS/DHSC group bodies	11,392	13,012	3
Other assets: including assets held for sale & in disposal groups	0	0	
Cash	68,575	63,543	4
Total current assets	**115,783**	**98,749**	
Current liabilities			
Trade and other payables: capital	(15,584)	(11,849)	5
Trade and other payables: non-capital	(58,493)	(57,808)	6
Borrowings	(6,271)	(6,029)	7
Provisions	(191)	(372)	
Other liabilities: deferred income including contract liabilities	(14,082)	(9,009)	8
Total current liabilities	**(94,621)**	**(85,067)**	
Total assets less current liabilities	**359,564**	**328,891**	
Non-current liabilities			
Borrowings	(63,001)	(66,132)	9
Provisions	(919)	(1,617)	
Other liabilities: deferred income including contract liabilities	(1,877)	(1,959)	
Total non-current liabilities	**(65,797)**	**(69,708)**	
Total net assets employed	**293,767**	**259,183**	
Financed by			
Public dividend capital	231,681	193,805	10
Retained Earnings (Accumulated Losses)	22,688	25,036	11
Revaluation Reserve	39,399	40,342	11
Total taxpayers' and others' equity	**293,767**	**259,183**	

KEY MOVEMENTS

1. Property, plant and equipment YTD is £23.8m higher than at 31 March 2021, the movement relates to capital additions of £55.9m less YTD depreciation of £21.0m, building impairment of £9.8m and the disposal of two properties with a book value of £1.3m.
2. NHS Trade receivables are £14.2m higher than at 31 March 2021, the main reason for the increase is the Trust receiving in March 2022 Elective Recovery funding of £14.3m.
3. Non-NHS receivables are £1.4m lower than at 31 March 2021. In particular, VAT receivable is £2.0m lower than at 31 March 2021. This is offset by Non NHS Trade Receivables, which are £1.3m higher than at 31 March 2021, including £0.9m due from Devon County Council.
4. Cash is £5.1m higher than at 31 March 2021. The cash flow statement provides greater analysis of the key variances.
5. Trade and other payables: capital - The value of capital creditors are £3.7m higher than at the previous year end. The increase is due to a significant proportion of the programme (£22.8m - 40.8%) being delivered within the final month of the year.
6. Trade and other payables: non-capital are £0.7m higher than at 31 March 2021, and include £0.3m PDC dividend creditor at 31 March 2022 (£0.3m debtor at 31 March 2021).
7. The increase in loans due in under 1 year relates mainly to interest that has accrued but not yet been paid.
8. Deferred income is £5.0m higher than the value as at 31st March 2021, including deferred Cancer funding of £1.7m and VAT reclaimed but not yet recognised of £1.4m, mostly relating to the reclaim on VAT on the My Care capital investment.
9. The decrease in loans due in over 1 year reflects £4.8m of loan repayments, offset by the receipt of an additional instalment of the Salix loan of £0.7m, and additional EPIC loan and accrued interest of £1.1m.
10. Public dividend capital funding of £37.9m has been received in the year to support capital expenditure initiatives.
11. Retained Earnings and the Revaluation Reserve have decreased by £3.3m in total since 31 March 2021, being the deficit of £4.3m, offset by revaluation gains of £1.1m on two properties that were been identified as surplus and subsequently reclassed and revalued on that basis.

Eastern Services Financial Tables

Royal Devon & Exeter NHS Foundation Trust Cash Flow Statement Period ending 31/03/2022 Month 12	Year to Date Actual £000	Prior Yr March 2021 £000
Cash flows from operating activities		
Operating surplus/(deficit)	5,153	(11,068)
Non-cash income and expense:		
Depreciation and amortisation	20,955	12,959
Impairments and reversals	9,776	18,594
Income recognised in respect of capital donations (cash and non-cash)	(173)	(2,249)
(Increase)/decrease in receivables	(12,242)	9,966
(Increase)/decrease in inventories	570	(2,092)
Increase/(decrease) in trade and other payables	382	10,784
Increase/(decrease) in other liabilities	4,992	3,757
Increase/(decrease) in provisions	(879)	202
Net cash generated from / (used in) operations	**28,534**	**40,853**
Cash flows from investing activities		
Interest received	32	20
Purchase of intangible assets	(1,096)	(25,535)
Purchase of property, plant and equipment and investment property	(51,042)	(44,536)
Proceeds from sales of property, plant and equipment and investment prop	2,332	23
Receipt of cash donations to purchase capital assets	173	110
Net cash generated from/(used in) investing activities	**(49,601)**	**(69,918)**
Cash flows from financing activities		
Public dividend capital received	37,876	32,750
Loans from Department of Health and Social Care - repaid	(1,270)	(1,270)
Other loans received	1,625	10,584
Other loans repaid	(3,575)	(1,744)
Capital element of finance lease rental payments	(172)	0
Interest paid	(1,983)	(2,125)
Interest element of finance lease	(74)	0
PDC dividend (paid)/refunded	(6,328)	(3,668)
Net cash generated from/(used in) financing activities	**26,099**	**34,527**
Increase/(decrease) in cash and cash equivalents	**5,032**	**5,462**
Opening cash and cash equivalents	63,543	58,081
Closing cash and cash equivalents	68,575	63,543

Eastern Services Financial Tables

Royal Devon and Exeter NHS Foundation Trust

Capital Expenditure

Period ending 31/03/2022
Month **12**

Scheme	Approval level	Actual expenditure to date compared to budget on annual plan: YTD actual expenditure £'000	Full year expenditure per annual plan £'000	21/22 forecast slippage / (higher) £'000	Total expected expenditure compared to the value approved by the Exec Group / Board of Directors — Schemes over £500k in progress or planned: Expenditure approved by the Exec Group £'000	Total expenditure forecast for the scheme £'000	Scheme variance under spend / (overspend) £'000	Note	Expected completion date
Nightingale Hospital Accelerator Programme	Board	12,808	0	(12,808)	11,160	12,808	(1,648)		21/22
ED Reconfiguration	FBC	11,169	12,266	1,097	23,740	23,740	0		23/24
Estates Infrastructure 21/22	CRIC	3,898	4,200	302	4,200	3,898	302		21/22
Creating additional theatre and out-patient capacity for Surgical Services	Board	3,850	0	(3,850)	3,805	3,850	(45)		21/22
Community Diagnostics Hub	Board	3,373	0	(3,373)	3,373	3,373	0		21/22
Voice recognition and AI software to improve clinical / administrative productivity - 3M MModal CDI ENGAGE	Board	2,700	0	(2,700)	2,700	2,967	(267)		22/23
LINAC Replacement	Board	2,211	0	(2,211)	3,047	3,047	0		22/23
Replacement of Intuitive Da Vinci Surgical System	CRIC	1,417	0	(1,417)	1,541	1,541	(0)		22/23
Endoscopy PDC Funding	CRIC	1,276	0	(1,276)	1,300	1,276	24		21/22
Diagnostics Digital Capability Programme - Home Reporting	CRIC	1,068	0	(1,068)	1,068	1,068	(0)		22/23
My Care	FBC	1,025	801	(224)	61,484	61,484	0		21/22
Critical Care Capacity Increase	OBC	981	1,250	269	5,881	5,631	250		21/22
Diagnostics Camera Imaging Capture Project	CRIC	800	0	(800)	800	800	(0)		22/23
PC Tech Refresh	CRIC	797	0	(797)	800	800	(0)		21/22
Off-Site Storage for Health Records and Logistics	OBC	770	825	54	2,588	2,534	54		21/22
Catering Equipment Installation	CRIC	644	600	(44)	600	644	(44)		21/22
Replacement of Obsolete Power Tools	CRIC	643	0	(643)	687	643	44		21/22
Containment Level 3 Microbiology Laboratory	CRIC	569	611	42	611	569	42		21/22
Integrated image repository for easier / seamless viewing for clinicians across Radiology / Dental / Dermatology- Non-DICOM and DICOM Imaging Pathways Improvement	Board	525	0	(525)	525	525	(0)		22/23
Replacement of Fluoroscopy Room 2 Siemens Artis Zee dmp	CRIC	0	599	598	599	598	0		22/23
Other schemes < £500k and contingency	CRIC / Unapproved	5,349	6,301	952					
Total 2021/22 Capital Schemes		**55,873**	**27,452**	**(28,421)**					

Approval Level Key

CRIC	Capital and Revenue Investment Case
SOC	Strategic outline case
OBC	Outline business case
FBC	Full business case

Report for all on-going schemes where total scheme value is expected to exceed £0.5m

Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	10.1, Public Board Meeting		**Date:** 27 April2022	
Title:	Royal Devon University Healthcare NHS FT Corporate Strategy and communications plan			
Prepared by:	Jeff Chinnock, Associate Director of Policy & Partnerships and Jess Newton, Head of Communications			
Presented by:	Suzanne Tracey, Chief Executive Officer			
Responsible Executive:	Suzanne Tracey, Chief Executive Officer			
Summary:	This paper sets out the process that the Board followed in the development of the new corporate strategy and shares the final draft of the corporate strategy for approval			
Actions required:	It is requested for this paper to be discussed and accepted along with a recommendation to approve the proposals within this paper.			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
			X	
History:	The Royal Devon University Healthcare NHS FT as a newly merged organisation needs to set out its overall aims and objectives to help steer its course over the next few years built on the strong legacy of the RD&E and NDHT. The strategy has been developed by the predecessor Boards of the two merging organisations talking on board engagement with the Council of Governors and members of staff.			
Link to strategy/ Assurance framework:	Links to a number of BAF risks (detailed in the report)			

Monitoring Information

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

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

1. EXECUTIVE SUMMARY

1.1 Over the last year the predecessor Boards of NDHT and RDE have sought to develop a new corporate strategy for the newly merged Royal Devon University Healthcare NHS Foundation Trust. This work has now been brought together into a draft "long form" version of a new corporate strategy document (attached) which sets out the Trust's mission, values, corporate objectives and priorities over the next 5 years. Alongside the draft strategy, at its April meeting the Board will receive a presentation on the communications and engagement plan to support and embed the corporate strategy.

2. BACKGROUND

2.1 The global pandemic and recovery, the changes in the way the NHS is organised and the ongoing and well-rehearsed challenges impacting on healthcare form the backdrop for the development of the Trust's new corporate strategy. At the same time, digital technologies, artificial intelligence, innovation in healthcare, the clear focus on prevention and population health management and the move to more integrated working, offers significant opportunities for NHS organisations to enhance and improve healthcare.

During the last 12 months, the Boards have sought to better understand the opportunities and key challenges and to use this information and insight to forge a new corporate strategy for the merged organisation that builds on the strengths of both organisations and seeks to navigate a way forward for the Trust over the next five years. Through its own deliberations, and inputs from the council of governors, staff and wider system partners, the Boards have collectively worked on agreeing a clear mission for the organisation, a set of underpinning values, four strategic objectives, and a 'road map' that sets out how the corporate strategy will be delivered.

The Board took the view that once the merger was completed it was appropriate to set out clear plans and priorities to galvanise staff from all parts of the newly formed Foundation Trust on a set of aspirational goals and outcomes which everyone could get behind. Having a clear plan for the next 5 years is even more important given the impact that the pandemic has had on staff. The engagement of staff on the draft objectives and values demonstrated that many colleagues are keen to contribute to collectively shaping a corporate strategy that is both aspirational for the communities and patients we support but is also grounded in the reality of recovering from the pandemic and the other pressures we face both as an organisation and as part of a complex health and care system. The investments we have made and have planned, coupled with our focus on using new digital and related technologies to transform healthcare, whilst retaining the clear focus on patient experience has resonance with staff.

The changes in the way the NHS is organised with the development of Integrated Care Systems and the focus on ever closer partnerships between health and social care, the emergence of place-based partnerships as a key driver for improvement, and the abandonment of competition in the NHS, means that cooperation becomes the organising principle for the way forward. It is therefore important that our new strategy reflects these changes and to ensure ongoing alignment with the priorities set out nationally as well as those being developed by the ICS Devon and to emphasise the importance the Trust places on partnerships to achieve common goals.

3. ANALYSIS

3.1 The document: The discussions held by the Boards have been synthesised into a corporate strategy for the Trust that covers the next five years. The strategy seeks to bring together the strategic direction developed by the Board into a document that, in various ways, sets out our story:

- Where are we now?
- Where do we want to be?

- How will we get there?

The "long-form" version of the corporate strategy document is attached and this is primarily aimed at Board Directors, senior leaders in the Trust, potential senior-level recruits and strategic partners. This is the version that the Joint Strategic Delivery Group and the Board will refer to when considering the progress against the strategy over the coming period. The Executive Directors have reviewed the content and the current draft has been agreed by the Chief Executive Officer as being fit for purpose subject to minor alterations.

A shorter summary version will also be produced drawing on the longer document that will primarily be used on our website, on our intranet and for interested staff. A "plan on a page" - contained in the longer document – will be pulled out to act as the summary for the strategy and this will be aimed at all staff and external stakeholders. This will be professionally produced for digital viewing.

The abridged version and the plan on a page are attached.

The overarching corporate strategy, the enabling strategies and the delivery roadmap will effectively set the strategic direction of the Trust. Following the launch of the corporate strategy, the intention is then to bring forward the enabling strategies in sequence.

Clearly, changes in the external context and unforeseen events, can strongly impact on the course set and that is why it is important to consider the strategy as a "living document" that sets a direction of travel but retains sufficient flexibility to respond strategically as required. As we move forward, the roadmap will change, we will need to regularly review and refocus priorities and we will use the strategy as a decision making tool. It is intended that the Board will review progress against its corporate 'road map' on a quarterly basis.

Designed version: We are working with a company to help produce a designed version of the strategy. The design company will retain the overall feel and approach taken to date but convert this into a professional output that can be used for digital viewing (and printed as necessary). Once approved, we will be making the final changes with the company with the aim of having a final document/s by the 6th May.

Communications & engagement plan: We have developed a plan to launch the new strategy into the organisation and with our external stakeholders and this will be presented at the Board meeting. The launch of the corporate strategy provides an opportunity to:

- Tell a positive story about who we are, what we want to achieve and how we are going to achieve it
- Position and launch the Trust as a leading, digitally-enabled teaching hospital
- Provide reassurance and realism about where we are, and set out our future pathway
- Bring the strategy to life for staff and stakeholders, and engage them in the journey
- Mobilise all staff in the same direction, encouraging ambition, innovation and hope
- Align all Trust activities to the corporate strategy

The plan segments the audiences, sets out clear and measurable objectives, key messages and sets a timeline of activities for the launch and then on how we sustain interest and focus on the strategy over time. Our feedback to staff will include the influence they have had on the plans to date and how they can continue to be involved particularly through the implementation of the support strategies. We also intend, to engage staff in translating the corporate values into a set of behaviours to guide our approach and how we interact with each other, our patients and external stakeholders.

4. RESOURCE / LEGAL / FINANCIAL / REPUTATIONAL IMPLICATIONS

4.1 Delivery of the corporate strategy will require consideration of a number of business cases requiring enabling investment in order to realise the expected benefits. Some of this

investment will require external support and so the timing of delivery will be conditional on the availability of this investment.

5. LINK TO BAF / KEY RISKS

5.1 The corporate strategy sets the overall framework for the BAF and will be used to update/refresh it over the coming months.

6. PROPOSALS

6.1 The corporate strategy document seeks to amalgamate, reflect and bring together a wide range of discussions over a number of months into a coherent document..

With this in mind, the Board is asked to:

- Note the work undertaken to produce this Corporate Strategy
- Endorse the long version of the core corporate document subject to the changes agreed in the Board, providing the Chief Executive officer with the final sign off.
- Comment on the proposals on the communications and engagement plan when presented at the Board meeting

BETTER TOGETHER

NHS
Royal Devon University Healthcare
NHS Foundation Trust

Our Strategy: **Better together**

2022 – 2027

Welcome

Royal Devon University Healthcare NHS Foundation Trust

Welcome to our new Corporate Strategy: **Better together**.

Our new corporate strategy – Better together - sets out our journey to transform care across Northern & Eastern Devon, to enhance staff experience and to cement our position as a leading, digitally-enabled and clinically-led teaching hospital over the next 5 years.

We launch our strategy at a time when we are beginning to emerge from an unprecedented and devastating pandemic. Covid-19 will continue to cast its shadow as we begin to recover and will undoubtedly impact on our plans over the next few years. And yet, our experience over the last two years has shown us that rapid, radical transformation is possible. Our strategy sets out our intention to harness this approach, to build on the foundations we have put in place, and to continue to empower our clinicians to lead the transformation of our services as we recover from the pandemic.

Our new strategy offers a clear sense of our purpose, the way we work and our determination to achieve great care for our population – drawing on our:

- clinical excellence
- cutting-edge research and development
- digital capabilities
- the value we place on partnerships
- Innovation and creativity
- and our amazing staff.

We all know that in healthcare, how you do something is as important as what you do, and that is why our values are writ large in our new plans. Our values underpin everything we do, how we act and behave, and what we hold important.

Our plans build on the legacy and the strengths of the merged RD&E and NDHT. Both Trusts have very special and distinct cultures and histories. Our merger seeks to respect diversity and difference and bring teams together to create stronger services in partnership with each other. Our plans and priorities have been influenced by our staff, our governors and the public. We listened to staff about what values they felt were important, and we listened to colleagues about their ambitions for our services.

All too often a strategy can be something that sits on a shelf – or that area of the intranet you never visit! Our determination is that we live and breathe our new plans – to make them our own – because it is only in this way that we can achieve all we want together.

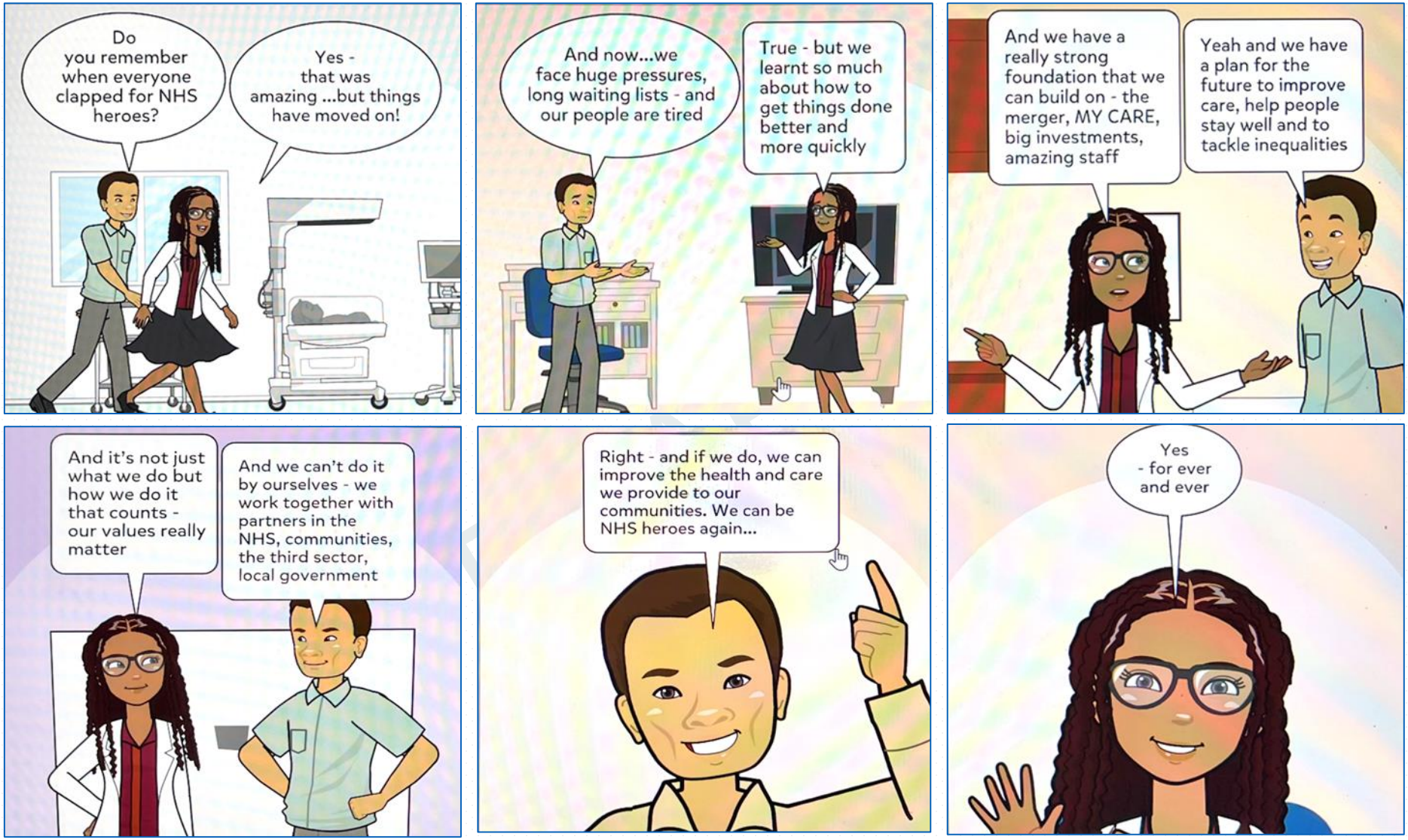
So, I hope you will share our excitement as we look forward over the next few years, as we work together in recovering our services and setting a course which achieves the best possible outcomes for the patients in our care, helps keep people well and supported in their own communities and ensures our staff are valued and supported.

Dame Shan Morgan, Chair

Suzanne Tracey, Chief Executive Officer

DRAFT

Our story: we care Better Together



Where are we now?

Our corporate strategy sets out our journey to transform care across Northern and Eastern Devon as we launch a new Trust from the merger of NDHT and RD&E

Our starting point

The **Royal Devon University Healthcare NHS Foundation** is launching at a time of transition for the NHS.

As we continue to respond to the pandemic and work fast to recover our services and reduce waiting lists, we need to apply the learning we have developed, the innovation we saw, and the use of technology to transform our services. This approach, coupled with the foundations we have in place such as our digital platform and investments in new infrastructure, the merger, and our incredible and caring staff, place us in a strong position to achieve our goals.

We believe that the **Royal Devon**, in partnership with other organisations and as part of the Integrated Care System Devon (ICSD), can make a significant step change in achieving the best possible outcomes for the patients in our care and to keep people well and supported in their own communities.

Why do we need a strategy?

Our strategy is important as we merge two Trusts because it identifies the common purpose all of us who work in the new Trust share, based on bringing together the best of both organisations. It also seeks to ensure we understand the environment in which we operate and the opportunities we have to make a difference.

Our values and strategic objectives offer a clear sense of our purpose, the way we work and our determination to achieve great care for our population. It also sets our priorities for the next 5 years.

As a public benefit corporation, it is also important to set out our plans and priorities openly and transparently.

Our staff are central and that is why we have a clear focus on the careers, and the health and wellbeing of our people, ensuring that **#teamRoyalDevon** are supported in delivering excellent care to our communities in whatever role they have.

We've listened

As we launch our new organisation, we've been listening to our staff, our patients and our stakeholders to help us think through how, as part of the health and care system in Devon, we play our part effectively.

In developing this strategy, we listened to colleagues about their ambitions for our services - our Board took this feedback and used it to influence the development of our future plans and priorities.

As the last few years have shown, a good strategy needs a flexible approach so we will regularly review our plans and adapt accordingly. As we do so, we will continue to listen to our stakeholders and be driven by our clear resolve to help people stay well yet provide the best possible care should they need it.

#wecarebettertogether

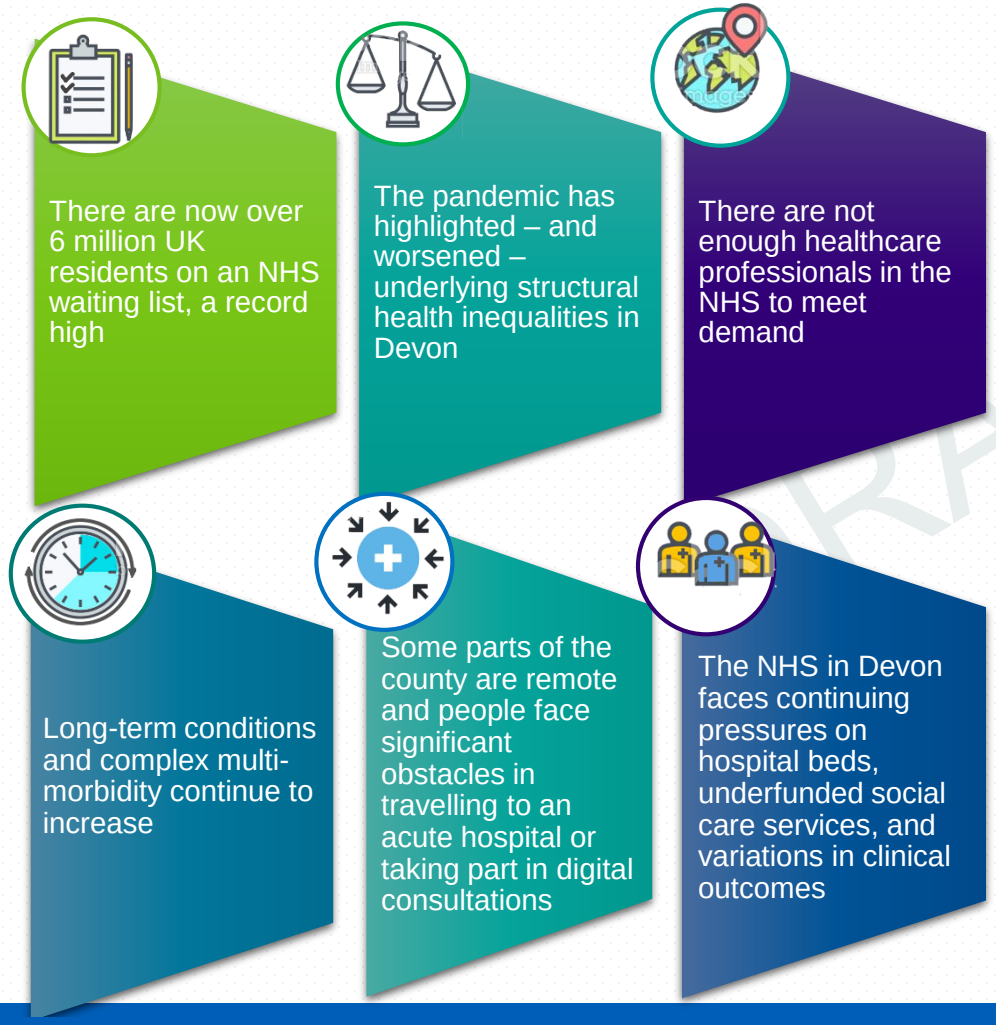
DRAFT

The external context

It is important to recognise that changes in our external context can either negatively impact on our work or provide opportunities to further our agenda including:

- any unprecedented external challenges and opportunities now and into the future
- new policy framework set out by the Government, NHSEI, our regulators and our partners in the Integrated Care System Devon (ICS)
- the views and opinions of the people and communities we serve

Where are we now?



Opportunities

While the context present challenges there are significant opportunities looking ahead including: use of big data, new digital innovations and AI; our status as a University Trust; becoming an integrated health and care organisation; personalised care; reducing operational pressures through effective population health management; our role as an anchor institution.

Policy context

The NHS Long Term Plan (January 2019) sets out a 10-year programme of phased improvements to NHS services and outcomes with an emphasis on partnership working, digital enablement, better co-ordination of care, greater personalisation and reduced health inequalities

Integrated Care Systems

The NHS aims to improve services by establishing integrated care systems (ICS) across the country. ICSs are new partnerships to coordinate services and to plan in a way that improves population health and reduces inequalities. The new ICSs will establish local care partnerships (LCPs) with two – the Northern and the Eastern LCPs – in the geography served by the Trust.

ICS Devon priorities

The Integrated Care System for Devon (ICSD) is a partnership of health and social care organisations working together with local communities across Devon, Plymouth and Torbay to improve people's health, wellbeing and care. The ICSD will:

- improve population health and healthcare
- tackle unequal access, experience and outcomes
- enhance productivity and value for money
- support broader social and economic development

DRAFT

This is us: Better Together

As a merged Trust covering Northern and Eastern Devon we have much to offer our partners, stakeholders and communities across Devon.

The **Royal Devon University Healthcare NHS Foundation Trust** provides acute and community healthcare services to the population of northern and eastern Devon.

The organisation has been formed from the merger of the Northern Devon Healthcare NHS Trust (NDHT) and the Royal Devon and Exeter NHS Foundation Trust (RD&E). Our new strategy will build on the strengths of the legacy of both organisations and the deep partnership that has evolved over several years, to deliver benefits to patients, staff, communities and the Devon NHS system.

Both organisations have a track record of success and for delivering great care for people who we serve.

We have come together as a single organisation, putting us in a strong position to improve patient care quality, resilience and sustainability across Northern and Eastern Devon, and to tackle our most pressing challenges as one.

By combining forces, the new organisation seeks to reap the benefits of:

- operating at a larger scale to overcome the issues faced in delivering healthcare in rural settings
- working collaboratively both within the merged Trust but also with our partners and communities
- seeking to ensure that people and communities have access to high quality healthcare wherever they live
- Improving the quality of and access to care as a result of more resilient services
- stablishing digital-first services to help overcome the issues of rurality and access
- better partnership working enabling the organisation to help address the wider determinants of health with and alongside its statutory and voluntary sector partners
- increased research capability relevant to the Devon population and its demography
- expanding the Foundation Trust model of governor and member representation to develop more accountability to a broader population
- ensuring greater efficiency and releasing resources for reinvestment in clinical services
- developing a more resilient workforce that is motivated, engaged and valued

DRAFT

Better Together

Where do we want to be?

Why?

Our mission

Working together to help you to stay healthy and to care for you expertly and compassionately when you are not

How?

Our values

Compassion

We are compassionate

We are kind and treat our patients, our partners and each other with compassion and courtesy without fail

Integrity

We act with integrity

We are honest and open as individuals and as an organisation. We are creating a culture where people feel respected, valued and included and able to bring their whole selves to work

Inclusion

We are inclusive

We are creating an inclusive culture, which values and celebrates our diversity. We listen and take action to ensure there is equity for everyone. We are a collaborative organisation that partners with others to achieve positive outcomes

Empowerment

We empower people

We are developing a culture in which our patients have greater control over decisions and actions affecting their health, and where staff are able to act independently in the best interests of patient care within a defined framework

What?

Our objectives

Collaboration and partnerships **C**

A great place to work **A**

Recovering for the future **R**

Excellence and innovation in patient care **E**

DRAFT

Our values

Our mission is supported by a clear set of values that we seek to embed into every part of our organisation. These values set out what we stand for and what is most important to us as an organisation. Our values define who we are, what we believe, how we act, the decisions we make, and our relationships with our patients, our community and our colleagues.

Compassion

We are compassionate

We are kind and treat our patients, our partners and each other with compassion and courtesy without fail

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Empowerment

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We are developing a culture in which our patients have greater control over decisions and actions affecting their health, and where staff are able to act independently in the best interests of patient care within a defined framework

In developing our values, we have taken into account the NHS values and the existing values of the two merging organisations. We want to develop a new culture built on the best of both organisations that will enable us to adapt and change what we do to improve our services. We have also reflected the views of our staff and external stakeholders, who have helped define what matters most to them.

DRAFT

Our strategic objectives: CARE

Where do we want to be?

C Collaboration and partnerships

"We will work in partnership to improve the health of our communities and play a key role in prevention and tackling health inequalities in Devon"

Why?

- Outcomes are improved when patients participate and set out what matters most to them
- Partnerships have a critically important role to play in encouraging collaboration between providers, primary care, local government, wider public services, the voluntary sector and citizens to achieve positive outcomes
- We need to bridge the gap between research and practice and collaborate with commercial and academic partners
- Understanding and comparing data and insight is key to addressing health inequalities
- Place-based partnerships are fundamental to addressing health and wellbeing and tackling health inequalities
- The health and social care system contributes around 4–5% of England's total carbon footprint

How?

- Help develop effective partnerships with relevant stakeholders and work as an integral part of ICS Devon
- Increase patients' partnership and participation in care
- Develop effective commercial, academic and research partnerships to improve patient care
- Use data to drive reductions in health inequity
- Ensure we develop effective place-based partnerships to address population health with our primary care, voluntary sector and statutory colleagues
- Reduce our carbon footprint

Outcomes?

- To be a good corporate citizen and partner who plays a key role in prevention and tackling health inequalities in Devon
- To have enabled patients as partners
- To use cutting edge research, data and innovation to improve services
- To deliver health care sustainably minimising the impact on our planet
- To play a key role in the ICS and place based partnerships

DRAFT

Our strategic objectives: CARE

Where do we want to be?

A great place to work

"Creating the culture and environment to retain, develop, support and attract people to work as part of a team to deliver patient centred care"

Why?

- Our values should drive consistent behaviours at all times across our organisation
- The pandemic has had a negative impact on our people's health and wellbeing and has reduced motivation
- We strive to learn but we don't always apply our learning
- We strive to create an inclusive place to work but we don't always get it right
- Our people have the best ideas on innovation and practice change but this is sometimes not harnessed effectively

How?

- Instil a just culture
- Embed our new values and behaviours
- Look after our staff's health and wellbeing
- Develop a culture of learning and development
- Enable inclusion and a sense of belonging
- Support and drive change / innovation in all that we do

Outcomes?

- To be a great employer that values its people, that embraces diversity and is well-led
- To support our people and listen to them
- To demonstrably value difference
- To have developed a new culture built on the best of both organisations that will enable us to adapt and change
- To be a collaborative partners with patients and stakeholders
- To have built a culture of continuous learning and improvement
- To have developed a just culture

DRAFT

Our strategic objectives: CARE

Where do we want to be?

R Recovering for the future

"We will be an integrated organisation that will deliver an equitable recovery and use the opportunity to drive change"

Why?	• Recovering from the pandemic and restoring services will take time • There needs to be fair and equitable access to health and care services • There is need for greater innovation and capacity to improve services and apply learning • There remain unacceptable delays in the flow of patients through and out of our hospitals • Devon remains a financially challenged system • There is a need to work with partners to harness community assets to improve health
How?	• Restore services to meet national waiting time targets and recover from the COVID-19 pandemic • Continuously improve our service offer to patients • Reduce delays in the flow of patients through our sites • Support communities to meet their longer term health needs • Ensure fair access for all and tackle health inequalities • Make a significant improvement to address our financial position
Outcomes?	• To be an integrated organisation that has recovered elective backlogs and used the opportunity to drive change • To make a significant improvement in the financial deficit • To have enhanced patient flow and played a key role in making Devon's wider health and care services resilient • To enhance our facilities to improve patient care • To have supported community development with our partners • To build on the innovative approaches developed through the pandemic and apply them to improve services

DRAFT

Our strategic objectives: CARE

Where do we want to be?

E Excellence and innovation in patient care

"We will embrace new technologies, research and innovation and ways of working to deliver the best possible care and to enable people to stay well"

Why?

- Empowering citizens to take control over their own health and wellbeing can enhance their outcomes
- Our staff have insights and innovative approaches to healthcare which we need to better harness
- Digital health has the potential to prevent disease and lower healthcare costs, while helping patients monitor and manage chronic conditions
- People who are digitally excluded are at risk of worse access to services and worse health outcomes.
- People with protected characteristics are less likely to have access to the internet, and the skills to use it
- Patients' experience of healthcare impacts on their outcomes and contributes to a more positive patient recovery experience which can improve physical and mental wellbeing

How?

- Transform our relationship with patients and empower citizens to have greater control of their care
- Empower staff to take a quality improvement approach
- Empower the organisation through greater integration and the use of digital technologies
- Address digital inclusion with our partners
- Improve patient experience
- Use our data and our research capabilities to transform patient care
- Maximise the use of digital and related technologies to make a step change in patient care

Outcomes?

- To be working together with patients in our care on the outcomes they want to achieve using digital, artificial intelligence and high quality research
- To consistently deliver efficient, effective data driven care based on good practice
- To be recognised as a leading digital health organisation
- To be a leader in genomics
- To integrate a Quality Improvement (QI) approach in all that we do
- To be recognised as a leading teaching hospital

DRAFT

Our “better together” delivery roadmap 2022-25

Our delivery roadmap sets out some of the key milestones over the next three year period based on detailed planning. As we move forward we will adapt our plans and provide further detail for years 4 and 5.

How will we get there?

	2022/23	2023/24	2024/25
C Collaboration and partnerships	• Green plan/sustainability strategy launched • Develop investment plan on social care support • ICS / LCPs governance established • University partnership biomedical research centre begins • ICS Long term plan consultation begins	• Health inequalities / partnership strategy • Continued development of provider network • ICS / LCPs fully operational • Enhanced engagement with primary care • Development of closer ties with social care	• LCPs take on place based commissioning
A A good place to work	• Code of conduct for all staff agreed • Workforce strategy developed and implementation begins • Proposal on key worker housing developed • Work on developing and aligning organisational development / culture work begins • ACP strategy launches	• New training centre at NDDH site proposal submitted • Leadership & management programme commences	• Training and development centre opens • Key worker housing opens
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DRAFT

We care **better together**

Staff Integration Story: Endocrinology and Diabetes

Antonia Brooke (Clinical Lead Endocrinology, Diabetes and Metabolism, RD&E) and Poe Budge (Lead Clinical Nurse Specialist, NDHT) share how the Endocrinology and Diabetes teams have been working together across both main sites.

How long have the teams been working together and how are you currently working?

Antonia: Both teams started to work more closely last year. The situation around COVID-19 meant the team at North Devon needed some extra support and we gradually started to work together on a more formal basis.

Poe and her team carried the department through a really difficult period, and now we have some really good locums in place we are working on a bigger and better vision for both departments.

We have a forum for ideas that we didn't have before, and Northern and Eastern teams are invited to joint case discussion meetings. Together we are looking at best practice, recognising that there are some things we can align and improve, and that some things are right for the local site.

Poe: It was a little bit tricky at first because NDHT didn't have any consultants in Endocrinology and Diabetes. The nursing team had worked without any consultants for a couple of years. Initial conversations with RD&E took a little while to find the right footing as there was an imbalance in terms of roles and power, as to be expected.

We stripped everything back to find our shared priorities and worked together on how to make things better. The team from RD&E are very approachable and we are a very strong nursing team at NDHT which helped in ensuring we were heard!

What future benefits can you see from working more closely?

Poe: We have a lot of positive things about Northern Devon that we don't get to shout about as much as we should. Being part of a larger Trust will give us a louder voice and the chance to show people more about working in Northern Devon.

Antonia: A huge one for both of us is that we instantly increase our population base. This secures availability locally to certain services that are only available to those serving a population of over a million. Being part of a bigger team gives us a stronger voice. Simple things like sharing protocols and governance can instantly half the workload. If we have one way that works, let's do that. No need to do it twice if we don't need to.

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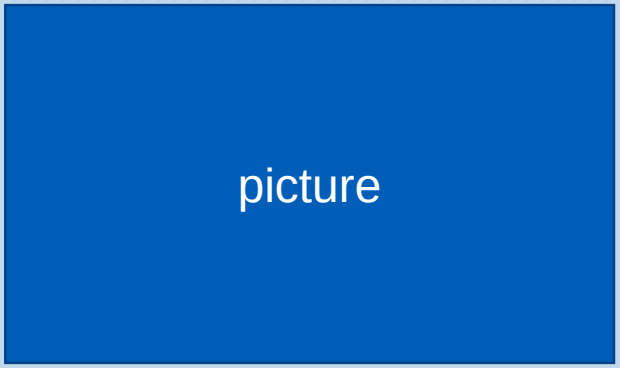

Do you have any advice for other teams who are thinking of working with each other?

Poe: Make sure each side comes with an open mind and is prepared to listen. We all have the same objective and that is to provide the best service we can.

Also, don't be afraid to stand up for your service. We don't always agree on everything straight away, but through mutual respect and listening to each other, we can always find a solution. That's what we did and together we now have a really good relationship.

Antonia: I would say just get on with it! I'm a firm believer in the bigger the pool the better the service. The sooner people get together, the sooner we can find better ways of working.

Delivering our corporate strategy

Our strategy takes into account the current issues that impact on us as we emerge from the pandemic, the significant long term challenges we face as an organisation and as a health and care system, and the policy context in which we operate. Our strategy is designed to meet these challenges and to set ambitions for the organisation and ultimately our patients and the communities we serve. There is much for us to do to strive to be ever better whilst remaining focused on delivering high quality safe care in the here and now.

We are confident that our strategy and our core mission will help us better care for those people who need our services as well as those who need support in their communities to live well.

In order that we can deliver on our corporate objectives, we need to transform how we provide our services – we know that business as usual will not be sufficient. We do not underestimate the scale of the challenge and have developed a transformation programme to support delivery of better together.

We will primarily deliver our corporate strategy:

- through our enabling strategies which will be focused on the outcomes set out in our strategic objectives
- through clinically-led transformation of our services
- by working hand in hand with our health and care partners, local government, academic institutions and the voluntary sector in common cause
- through our most precious resource – our people, who, in whatever role, demonstrate their total commitment to high quality patient care.

Our Board will track the delivery of these milestones to ensure accountability through agreed key performance indicators. Our Council of Governors will ensure that our Board is holding the organisation to account and that our decisions are consistent with our status as a public benefit corporation.

DRAFT

Our enabling strategies

People Will deliver a new culture based on the best of both	**Clinical** Will deliver our new model of care
Transformation Will enable us to change and improve services	**Patient experience** Will improve the involvement and journey experienced by patients
Finance Will make a significant improvement to our financial position	**Digital/data and AI** Will enable patients to manage their health digitally
Green plan Will deliver our carbon reduction target	**Estates** Wil ensure we have the right estate for our clinical needs
Comms and engagement Will help address the wider determinants of ill health with our partners	**Health Inequalities / Partnership** Will inform and involve our stakeholders

What does it mean for you?

Our new strategy sets out our plans and priorities for the future with the aim of having a positive outcome for everyone.

How will we get there?

Our patients/ carers/users

- have access to high quality, seamless and safe care
- receive kind, compassionate, empathetic personalised care and be listened to and treated with dignity and respect
- benefit from research, innovation, digital and artificial intelligence
- able to access their health record records digitally
- empowered to set their own healthcare goals with clinicians
- supported to live well and healthily in their homes and communities
- have equitable access to services and be supported
- expect that carers are recognised and supported
- expect support for children and vulnerable people

Our staff

- recognised, supported and valued and are listened to
- well managed and compassionately led
- expect everyone to uphold our values
- feel positive about their role and that it makes a difference
- benefit from a good working environment and experience
- empowered to act individually and in teams
- benefit from an excellent health and well-being programme
- benefit from training and the harnessing of talents
- work in a culture where people act with civility and kindness
- work within a safe and healthy environment
- belong, where difference is valued and celebrated

Our communities and partners

- work together in collaboration for the common good
- understand that we will use our status as an anchor institution to support economic and social development
- expect the organisation to reduce its carbon footprint
- support community development and the realisation of community strengths and assets
- expect openness, transparency and honesty
- actively partner with our key stakeholders and third sector organisations
- support efforts to address the social determinants of ill health
- listen and engage with citizens
- proactively seek the views of the seldom heard

DRAFT

BETTER TOGETHER

Our mission

Working together to help you to stay healthy and to care for you expertly and compassionately when you are not

Our values: Our **values** will guide *how* we go about achieving our mission

Compassion

Integrity

Inclusion

Empowerment

Our CARE objectives

Collaboration and partnerships

We will work in partnership to improve the health of our communities

A good place to work

We will create a culture which retains, develops, supports and attracts people to work as part of a team to deliver patient centred care

Recovering for the future

We will deliver an equitable recovery and capacity for further change

Excellence and innovation in patient care

We will embrace new technologies and ways of working to deliver the best possible care and to enable people to stay well

Our destination

- A step change in the health and wellbeing of local people
- Patients having more control over their care with seamless digital experiences
- Equal access to care and more care closer to home
- Reducing length of our waiting lists
- Reducing our carbon footprint by 80% by 2030
- Reducing health inequalities through working more closely with our key partners
- Improved our financial position
- Motivated, supported and valued staff in an inclusive culture
- Ensuring our care is more joined up
- Evidence and data-led quality improvement and transformation

The NHS Long Term Plan and the ICS Devon's plan set the context

#onedevon

The following Royal Devon enabling strategies will support our mission

- People
- Clinical
- Transformation
- Patient experience
- Finance
- Digital
- Green plan
- Estates
- Health Inequalities
- Comms and engagement

We will work hand in hand with our partners, social care and the voluntary sector

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For more information …

Website address

Social media etc

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End page

BETTER TOGETHER

NHS
Royal Devon University Healthcare
NHS Foundation Trust

Our Strategy: **Better together**

2022 – 2027

Better Together

Where do we want to be?

Why?

Our mission

Working together to help you to stay healthy and to care for you expertly and compassionately when you are not

How?

Our values

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We are compassionate

We are kind and treat our patients, our partners and each other with compassion and courtesy without fail

Integrity

We act with integrity

We are honest and open as individuals and as an organisation. We are creating a culture where people feel respected, valued and included and able to bring their whole selves to work

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We are inclusive

We are creating an inclusive culture, which values and celebrates our diversity. We listen and take action to ensure there is equity for everyone. We are a collaborative organisation that partners with others to achieve positive outcomes

Empowerment

We empower people

We are developing a culture in which our patients have greater control over decisions and actions affecting their health, and where staff are able to act independently in the best interests of patient care within a defined framework

What?

Our objectives

Collaboration and partnerships **C**

A great place to work **A**

Recovering for the future **R**

Excellence and innovation in patient care **E**

DRAFT

Welcome

Royal Devon University Healthcare NHS Foundation Trust

Welcome to our new Corporate Strategy: **Better together**.

Our new corporate strategy – Better together - sets out our journey to transform care across Northern & Eastern Devon, to enhance staff experience and to cement our position as a leading, digitally-enabled and clinically-led teaching hospital over the next 5 years.

We launch our strategy at a time when we are beginning to emerge from an unprecedented and devastating pandemic. Covid-19 will continue to cast its shadow as we begin to recover and will undoubtedly impact on our plans over the next few years. And yet, our experience over the last two years has shown us that rapid, radical transformation is possible. Our strategy sets out our intention to harness this approach, to build on the foundations we have put in place, and to continue to empower our clinicians to lead the transformation of our services as we recover from the pandemic.

Our new strategy offers a clear sense of our purpose, the way we work and our determination to achieve great care for our population – drawing on our:

- clinical excellence
- cutting-edge research and development
- digital capabilities
- the value we place on partnerships
- Innovation and creativity
- and our amazing staff.

We all know that in healthcare, how you do something is as important as what you do, and that is why our values are writ large in our new plans. Our values underpin everything we do, how we act and behave, and what we hold important.

Our plans build on the legacy and the strengths of the merged RD&E and NDHT. Both Trusts have very special and distinct cultures and histories. Our merger seeks to respect diversity and difference and bring teams together to create stronger services in partnership with each other. Our plans and priorities have been influenced by our staff, our governors and the public. We listened to staff about what values they felt were important, and we listened to colleagues about their ambitions for our services.

All too often a strategy can be something that sits on a shelf – or that area of the intranet you never visit! Our determination is that we live and breathe our new plans – to make them our own – because it is only in this way that we can achieve all we want together.

So, I hope you will share our excitement as we look forward over the next few years, as we work together in recovering our services and setting a course which achieves the best possible outcomes for the patients in our care, helps keep people well and supported in their own communities and ensures our staff are valued and supported.

Dame Shan Morgan, Chair

Suzanne Tracey, Chief Executive Officer

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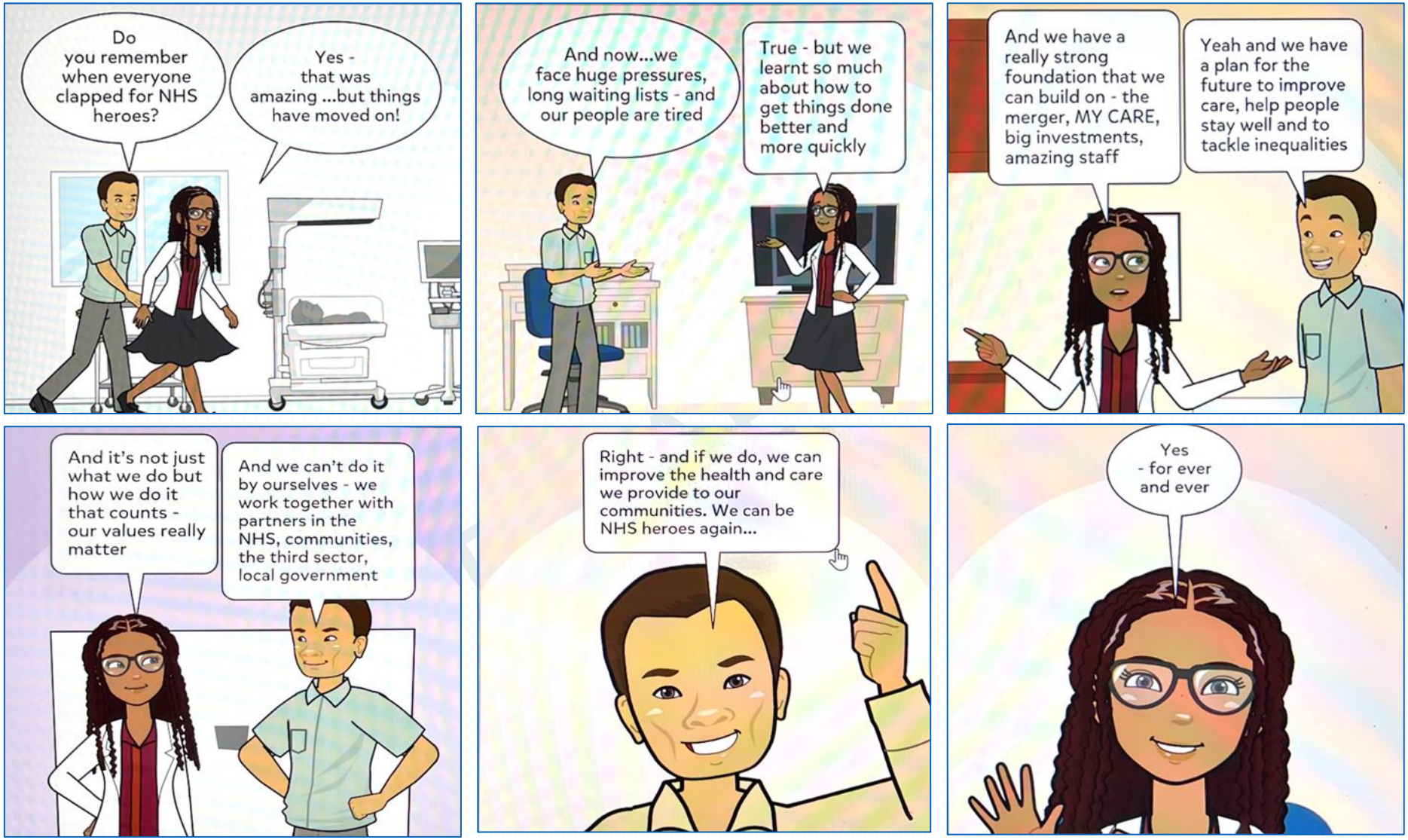
Our story: we care Better Together



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DRAFT

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Will help address the wider determinants of ill health with our partners	Will inform and involve our stakeholders

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DRAFT

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DRAFT

Agenda item:	11.1 Public Board Meeting		**Date:** 27 April 2022	
Title:	Governance Committee (GC) report			
Prepared by:	Jacky Gott, Deputy Head of Governance			
Presented by:	Carole Burgoyne, Non-Executive Director			
Responsible Executive:	Suzanne Tracey, Chief Executive Officer			
Summary:	A report by exception from the Governance Committee.			
Actions required:	For noting			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
				x
History:	The last Governance Committee Report was presented verbally to the Board of Directors on 23 February 2022.			
Link to strategy/ Assurance framework:	The Governance Committee reviews and monitors the Corporate Risk Register and identifies and escalates operational risks which it considers could have strategic significance and which the Board might consider placing on the Board Assurance Framework.			

Monitoring Information

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

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

DRAFT

1. EXECUTIVE SUMMARY

1.1 To provide, as requested by the Board of Directors (Board) a report by exception, from the Governance Committee following the meeting on 8 April 2022.

2. BACKGROUND

2.1 The Governance Committee is responsible for ensuring that effective governance is embedded in the organisation and that risks associated with compliance and legislation and regulatory standards are identified and mitigated. It provides assurance to the Board that the Trust has effective systems of internal control in relation to risk management and governance.

2.2 The Governance Committee Chair, on behalf of the Governance Committee, is responsible for reporting back to the Board, in line with the Board's Schedule of Reports on a quarterly basis, issues by exception.

2.3 A copy of the approved Governance Committee minutes are available for inspection pursuant to the Governance Committee's terms of reference.

3. ANALYSIS

3.1 In line with the schedule of reports, the Governance Committee receives exception reports from the relevant sub committees each time they meet. As of the date of this report, the Governance Committee is assured from the reports that the sub-committees continue to function effectively.

3.2 The Governance Committee (GC) raises the following matters for information with the Board:

a) 'Clinical View from the Bridge':

Adrian Harris provided the GC with a clinical view of the challenges facing the Trust at the current time which related to the level of COVID-19 patients, Delayed Transfers of Care (DToC), and the high operational pressures across both sites. It was cautiously anticipated that COVID-19 numbers would decline in the coming weeks, at which point the focus would move to 'green to go' and DToC which it was acknowledged were issues nationally and not just within Devon. Assurance was provided that a number of inter-agency discussions had already taken place with the independent sectors and social care focussing on addressing the green to go/social care issues over the summer which is pivotal in de-escalating the sites and preparing for next winter.

b) RD&E Commissioned External Invited Service Reviews:

<u>Spinal Services</u>
The GC received an update on progress against the action plan for Spinal Services and it was noted that good improvement had been made with the recommendations/actions with only five actions remaining open which relate to mediation, case selection criteria for M&M discussions, data collection for British Spine Registry, and relationships with the independent sector; revised deadlines for which were approved.

The GC supported the development of a workplan to specify the service ambitions and agreed that further updates should be scheduled for the August and December 2022 meetings, at which point it is anticipated that the action plans would be complete.

<u>Cardiology</u>
The GC received an update on progress against the action plan for Cardiology; four actions were overdue related to MDT, rota for 24/7 care, and implementation of HR policies but updates against these were noted and the revised timescales were approved. The GC

was pleased to note that the Royal College of Physicians had confirmed that no further scrutiny was required of the action plan and this had now been handed back to the Trust to continue to manage. The GC agreed that a final update would be provided in August 2022, at which point it is hoped that the action plan would be complete.

c) Responding to and Learning from Deaths Q3 2021/22:

The JGC scruntinised the reports presented by Mark Daly, Mortality Lead who provided the following assurance to the JGC:

- The frequency of Structured Judgement Review (SJR) Forums for the Eastern Services had been increased and there had also been a significant improvement in the performance of SJRs; it was anticipated that the backlog would be addressed within six months.
- Mortality data relating to emergency weekend admissions continues to be monitored, SMHI data for emergency weekend admissions have fallen to within expected limits.
- There is a focus on shared learning across divisions and sites going forwards, and integration of teams and production of data and reporting.

d) CQC Action Plan Updates:

The GC received an update on the position of the RD&E and NDDH CQC action plans and noted the assurance in terms of the closure of actions and supporting evidence.

e) Clinical Effectiveness Committees (Northern & Eastern Services):

The GC noted that both site CECs continued to focus on COVID related matters, i.e. screening, testing, staff risk matrix, vaccination and alert status. The GC was pleased to note that the first combined CEC meeting, as a single organisation, had been held with positive feedback and collaboration. It was further noted that the plan was to bring together the two site CECs incrementally over the next three months.

f) Joint People Workforce Planning and Wellbeing Committee (JPWPWC):

The GC received a report from the JPWPWC and assurance on the following:

- Guardian of Safe Working report – already scrutinised by the Board on 30th March 2022.
- The backlog of job evaluations and the impact on recruitment was discussed, and although delays of up to nine months were reported, the GC received assurance that there were recovery plans in place and an improvement in the position had been since January. Further assurance was provided that there was focus on the appropriate prioritisation of roles that affect safe delivery of care. A risk assessment has been approved onto the corporate risk register (CRR) which relates to the capacity issues within recruitment and impact on operational services.

g) Joint Safety & Risk Committee (JS&RC):

The JGC received the JS&RC update, presented by Carolyn Mills, Chief Nursing Officer:

- Assurance was provided on the ongoing monitoring and associated actions with the Northern Services medical workforce risks and the Eastern Services Cardiology risks.
- The GC received and noted the update reports for the Maternity Continuity of Care proposal for both sites.
- Two Never Event reports were received and noted.
- Noted the new risks added to the CRR as approved by the S&RC:
    - Northern Services plus sized patients – score 9
    - Northern Services maternity staffing – score 16
    - Eastern Services nursing workforce – score 16

h) Draft Annual Governance Statement:

The draft Annual Governance Statement was received and noted; this will be presented to the Board for final approval, ahead of inclusion and submission within the Annual Report for each site.

i) Quality Priorities Update (NDHT & RD&E):

A 2021-22 Q2 update was received and the progress noted. It was acknowledged that this was now out of date, and the Q4 position would be included within the Quality Account.

j) Whistleblowing Policy:

The GC ratified the Whistleblowing Policy; the only changes being to the logo to reflect that of the new single organisation, and some revised contact details.

k) Policy for Procedural Documents:

The GC ratified the policy which had been revised to align both the policy itself and the process for the single organisation.

l) Governance Committee Terms of Reference:

The revised Terms of Reference (Appendix A) were agreed by the GC and are presented to the Board for ratification. The main changes included the removal of the word 'joint' to reflect a single, integrated Committee.

4. RESOURCE / LEGAL / FINANCIAL / REPUTATIONAL IMPLICATIONS

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

5. LINK TO BAF / KEY RISKS

5.1 The Joint Governance Committee reviews the Corporate Risk Register twice a year and identifies and escalates risks as appropriate to the Board of Directors that the Joint Governance Committee considers may be strategic and therefore the Board of Directors might consider escalating to the Board Assurance Framework.

6. PROPOSALS

6.1 It is proposed that the Board of Directors notes the report from the Joint Governance Committee and approves the revised Terms of Reference (at Appendix A).

Royal Devon University Healthcare NHS Foundation Trust

~~JOINT~~ GOVERNANCE COMMITTEE

Terms of Reference

These Terms of Reference are used as evidence for:	
Care Quality Commission Regulation:	17 Good Governance
Other (*please specify*):	

1. Accountability

1.1 The ~~Joint~~ Governance Committee (~~J~~GC) is accountable to and will report directly to the Board of Directors of the Royal Devon University Healthcare NHS Foundation Trust~~RD&E NHS FT/Trust Board of Northern Devon Healthcare NHS Trust~~.

2. Purpose

2.1 The ~~J~~GC is responsible for ensuring that governance is embedded in the organisation~~s~~; the Trust~~s~~ operate~~s~~ within the law and compli~~esy~~ with its~~their~~ regulators and deliver~~s~~ safe, quality and effective care. It will provide assurance to the Board of Directors~~/Trust Board~~ that the Trust~~s~~ ha~~sve~~ effective systems of internal control in relation to risk management and governance.

3. Membership

3.1 The ~~J~~GC shall be appointed by the Board of Directors~~/Trust Board~~.

The membership shall consist of :

- ~~A~~ A Non-Executive Chair ~~(from each Trust)~~ – appointed by the Board of Directors~~/Trust Board – Thus providing a Chair and Deputy. Chairing of meetings will alternate from meeting to meeting~~
- A Non-Executive Vice-Chair – appointed by the Board of Directors
- At least four~~two~~ Non-Executive Directors ~~(from each Trust)~~ – appointed by the Board of Directors~~/Trust Board~~
- Chairs of all reporting Sub-Committees:
  - Integrated Safeguarding Committee*– ~~Interim Chief Nurse / Interim~~ Chief Nursing Officer~~e~~
  - Clinical Effectiveness~~Reference~~ Committee *- ~~Deputy~~ Medical Director (NDHT) / ~~Deputy~~ Medical Director (RD&E)
  - People, Workforce, Planning and Wellbeing Committee *- Chief People Officer~~Director of People~~
  - Safety and Risk Committee *- Chief Executive Officer

(A nominated deputy must attend in the absence of the Sub-Committee Chair)*

- Medical Staff Committee (MSC) RD&E / Medical Advisor Committee (MAC) NDHT representative
- ~~Joint Professions Committee representative (RD&E only) to rotate every 12 months)~~

- ~~Head~~ Director of Governance ~~(RD&E)~~
- ~~Head of Compliance and Risk (NDHT)~~
- Deputy Head of Governance ~~(RD&E only)~~
- Chief Medical Officer~~Director~~*
- Responsible Officer (Revalidation) (RD&E and NDHT)
- The Co-Chair of the Ethics Committee (as and when the Committee is convened)

**A nominated deputy should attend in the absence of the ~~Interim~~ Chief Nursing Officer~~es~~*

**A nominated deputy should attend in the absence of the Chief Medical ~~Director~~Officer*

Attendees:

- Representation from the Clinical Commissioning Group (one~~1~~ rep to cover both Trusts
- Trust Chair~~man~~

3.2 The Board of Directors~~/Trust Board~~ will review the membership of the ~~Joint~~ Governance Committee annually to ensure that it best reflects the requirements of governance within the Trust~~s~~.

3.3 The Chair~~s~~ will serve not normally for more than three years. The Non-Executive members will serve for three years and be eligible for re-appointment for a further three years.

3.4 Individuals may be co-opted for specific projects.

4. A Quorum

4.1 A quorum will consist of not less than seven members of the Committee with at least the following members present:

- Two non-Executive Directors ~~(one from each Trust)~~, one of whom should Chair the meeting
- The Chairs or Deputies from the reporting Committees so each Committee is represented
- There must be one Executive Director present

4.2 A record of attendance will be maintained, the expected attendance is 80%.

5. Procedures

5.1 The ~~J~~GC shall appoint a secretary to prepare agendas, keep minutes/recordings of meetings and deal with any other matters concerning the administration of the Committee. The secretary will be responsible for maintaining in real time the repository for the Terms of Reference, agenda, minutes and the action and attendance log on the RD&E Trust Governance shared drive.

5.2 Any member of staff may raise an issue with the Chair or Vice-Chair, normally by written submission. The Chair will decide whether or not the issue shall be included in the Committee's business and whether the individual raising the matter be invited to attend.

5.3 Written reports from the reporting sub-committees will be provided to the ~~J~~GC in accordance with the ~~J~~GC Schedule of Reports. The Chair of the sub-committee should ensure that the written report is submitted for circulation in advance of the meeting, or in the event the sub-committee has not met, this should be recorded on

the agenda.

6. Frequency of Meetings

6.1 To be held 6 times a year, every other month.

6.2 The ~~J~~GC may require the attendance of any Director, or member of staff, and the production of any document it considers relevant to Governance / Risk management.

6.3 Any member of the ~~J~~GC can request an Extraordinary meeting by contacting the Chair/Vice Chair of the ~~J~~GC who will consider the request.

7. Duties and Responsibilities

1. To agree a Schedule of Regular Reports and to ensure the schedule is followed and where not, the reason why is recorded in minutes.
2. To receive reports which identify key clinical and corporate risks (including patient experience) and ensure it receives assurance that they are being managed.
3. To monitor and assess the workplans provided by the sub-committees and be the point of escalation for any shortfalls in progress.
4. The ~~J~~GC will receive a bi-annual detailed report on the risks on the Corporate Risk Register (CRR). The ~~J~~GC will request a deep dive into individual risks as appropriate.
5. The ~~J~~GC will receive reports by exception on external visits and accreditation to ensure that highlighted shortcomings in the Trust's~~'~~ outcomes or processes are being understood and addressed effectively. The exception report will highlight any unacceptable delays in addressing areas of concern.
6. To receive reports which identify new areas of legislation, policy or other requirements with which the Trust~~s~~ is~~are~~ required to comply, together with an assessment of the Trust's~~'~~ ability to meet the new requirements, and any further action required.
7. The ~~J~~GC will review the final Internal Audit self-assessment of compliance against the Care Quality Commission (CQC) regulatory framework.
8. The ~~J~~GC will seek to identify any new or emerging risk areas which may need to be added to the Board Assurance Framework~~s~~.
9. The ~~J~~GC will provide quarterly reports to the Board of Directors~~/Trust Board~~ primarily by exception on issues arising at the ~~Joint~~ Governance Committee. The ~~J~~GC minutes will be available to the Board.
10. The ~~J~~GC will provide to the Audit Committee~~s~~ in March (end of financial year) an assurance statement on compliance with the Trust's~~'~~ risk strategy~~ies~~. If the assurance statement is negative, the ~~Joint~~ Governance Committee will provide assurance that a robust action plan is in place.
11. The Chairs ~~and Co-Chairs~~ of both the Audit Committee~~s~~ and ~~Joint~~ Governance Committee will meet twice a year with the Director~~Head~~ of Governance to discuss any areas of concern or improvement in the operation of the ~~Joint~~ Governance Committee and Audit Committee~~s~~.
12. The ~~J~~GC will request the Internal Audit Team to include specific internal audits as required. Any issues will be raised directly with the Audit Committee~~s~~.
13. The ~~J~~GC will monitor timely completion of ~~J~~GC Audits with receipt of a progress report submitted twice a year from the Head of Internal Audit.
14. The ~~J~~GC will confirm that the Trust~~s~~ ha~~s~~ve an annual programme of clinical audit through assurance from the Clinical Effectiveness~~Reference~~ Committee~~s~~.

15. The ~~J~~GC will receive and review the Quality Account on an annual basis.

8. Monitoring the effectiveness of the committee

8.1 The ~~J~~GC will monitor its effectiveness by reviewing its duties and responsibilities bi-annually, supported by the Internal Audit Programme of audit of the Governance Performance System.

8.2 The ~~J~~GC will undertake an effectiveness review annually and report the outcome to the Board

9. Review

9.1 The Board of Directors~~/ Trust Board~~ will review the Terms of Reference of the ~~J~~GC annually to ensure that it remains fit for purpose and is best facilitated to discharge its duties.

DRAFT

Membership

Joint Governance Committee	RD&E	NDHT
Non-Executive Director (Joint Chairs)	Steve Kirby	Tony Neal
Non-Executive Director and Patient Experience Lead	Chris Bones	Tim Douglas-Riley
Chair of Integrated Safeguarding Committee	Carolyn Mills	
Chair of Safety and Risk Committee	Suzanne Tracey	
Chair of People, Workforce Planning and Wellbeing Committee	Hannah Foster	
Chair of Clinical Reference Committee	Anthony Helmsley	Stuart Kyle
Co – Chair Joint Ethics Committee	James Brent/David Mabin/Stuart Kyle To attend as required (i.e. when a meeting has been held)	
Medical Director	Adrian Harris	
Responsible Officer (Revalidation)	David Mabin	Stuart Kyle
Medical Staff Committee (MSC) / Medical Advisory Committee (MAC) representative	Richard Haigh	Karen Davies
Joint Professions Committee representative (RDE only) *to rotate every 12 months*	Zita Martinez	
Head of Governance	Melanie Holley	
Head of Compliance and Risk		Julie Poyner
Deputy Head of Governance	Jacky Gott	
Attendees:		
Representation from the CCG	Darryn Allcorn	
Administration:	Debbie Hancock	Geraldine Garnett-Frizelle

DRAFT

Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	11.2, Public Board Meeting		**Date:** 27 April 2022	
Title:	RD&E and NDHT results from the NHS Staff Survey			
Prepared by:	Vicky Cook, Staff Engagement Officer (NDHT) Anette Grahns, Engagement Manager (RD&E) Hannah Foster, Chief People Officer			
Presented by:	Hannah Foster, Chief People Officer			
Responsible Executive:	Hannah Foster, Chief People Officer			
Summary:	This report analyses the key findings from the 2021 NHS staff survey for both the RD&E and NDHT, highlighting key issues arising and making proposals in response to the identified concerns.			
Actions required:	It is requested for this paper to be discussed and accepted along with a recommendation to approve the proposals within this paper.			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
			x	
History:	The NHS staff survey is completed on an annual basis and is a crucial method of gathering feedback from our people on a wide range of indicators in relation to our organisation.			
Link to strategy/ Assurance framework:	Links to a number of BAF risks (detailed in the report)			

Monitoring Information

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

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

1. EXECUTIVE SUMMARY

1.1 This report has been written to provide the Board with an overview of the results from the 2021 NHS Staff Survey for both NDHT and the RD&E, to include analysis of trends as well as some of the key findings, risks and issues.

The response rates have remained above average at NDHT and have improved at the RD&E; however, historical comparisons across the wider survey have been made more challenging this year, due to the significant changes that the survey has undergone to align with the People Promise.

Where comparisons are available, it is clear that both Trusts have seen a decline in performance, however many of these declines have also been seen at a national level, signifying the challenging conditions in which the NHS continues to operate in during the ongoing pandemic and recovery process.

Overall NDHT performs well regionally, with the RD&E performance being more variable. Nationally there are pockets of variation in performance against the national average, so it is difficult to draw overarching conclusions. Individual themes and questions are however explored in more detail throughout this paper.

This paper reviews the themes and results of individual questions against national averages in the same benchmarking group and makes a number of recommendations for next steps and actions as a result of the key findings.

It is important to note that as we go forward as an integrated organisation, we are moving to a more continuous employee experience measure cycle, with the People Pulse quarterly survey and cultural dashboard (currently in development) providing regular touch points for staff throughout the year. As a result, we are seeking to establish a robust, continuous feedback cycle for staff, with ongoing action planning at both a local and trust wide level, designed to facilitate and initiate visible improvements and changes. The NHS Staff Survey will then provide an annual check-in to evaluate the ongoing actions happening as part of the cyclic employee experience review process.

2. BACKGROUND

2.1 The NHS has experienced a year like no other, with the pandemic continuing to impact each and every one of us. The NHS Staff Survey took place in the third quarter of 2021-2022, during which time each Trust was operating at OPEL 3 or higher alert levels throughout. Alongside the extreme operational pressures and the ongoing pandemic, other key projects such as the continuation of MyCare at RD&E, initial MyCare project initiation at NDHT and the integration should also be considered contributory factors to the overall landscape in which the survey was conducted.

It is important to note that 2021 has seen the most significant changes to the NHS Staff Survey in over a decade, now aligned to the People Promise and increased data collection on participation and inclusivity information, whilst maintaining comparability for key indicators, such as WRES and WDES data. The previous survey themes have been replaced with seven People Promise elements, with the exception of the Staff Engagement and Morale themes which remain. Sub-scores have also been introduced for the majority of the elements and themes to provide further insight. More information on the survey changes can be found in Appendix 1.

Benchmarked results were issued by the Survey Coordination Centre (SCC) on 24 February 2022 and have been used to extract key findings for this paper. Results were embargoed until 30 March 2022; hence this paper being presented to the Board in April 2022.

The SCC benchmarking reports provide an overview of our position compared to 126 English Acute and Acute and Community Trusts. These reports allow us to understand our performance at both a national and local level.

COVID-19 specific questions were included again within the 2021 survey, asking respondents about their experiences throughout the pandemic.

Whilst we have brought together the findings from both Trusts, it is important to note that the demography of the surveys differs in that all staff are asked to complete the survey at the RD&E while in NDHT, certain Facilities groups, for example catering staff are excluded as they are employed by a third party (Sodexo).

3. ANALYSIS

3.1 Response rates

	2020	2021	
	% Response	% Response	Respondents
RD&E	44%	46%	4,144
NDHT	55%	51%	1,797

The national average response rate of 46%, has been exceeded by NDHT, with the RD&E in line with the national average.

NHSE/I has recently advised that the response rate should not be used as an indicator for staff engagement in itself, rather the specific staff engagement theme scores should be used to understand engagement levels within organisations. There is some challenge to this argument, some argue that the number of staff engaging with and completing the survey is still a key indicator of engagement in itself.

3.2 People Promise Elements and Theme Scores

A summary of the theme scores for each Trust, and the benchmarking group (Acute & Acute and Community) can be found in the table below. All scores are out of 10. More detailed information, including sub scores in Appendix 2.

People Promise element / theme	RD&E	NDHT	Average
We are compassionate and inclusive	7.4	7.5	7.2
We are recognised and rewarded	5.9	6.2	5.8
We each have a voice that counts	6.8	7.0	6.7
We are safe and healthy	6.1	6.2	5.9
We are always learning	4.9	5.3	5.2
We work flexibly	6.0	6.4	5.9
We are a team	6.7	6.9	6.6
Staff Engagement	6.9	7.1	6.8
Morale	5.9	6.1	5.7

Due to the introduction of the new People Promise elements, historical trend analysis is only available for the two unchanged themes (Staff Engagement and Morale). We can however review our position against our benchmarking average, and performance overall in relation to all of the 126 trusts to understand where we are now currently, with future

staff survey results providing trend analysis and the ability to gauge delivery against the NHS People Plan.

The existing staff engagement and morale themes have seen a decline at both the RD&E and NDHT, a pattern that is also seen nationally and reflects the challenges that the NHS continues to face; however, both Trusts are above the national average in most areas. One of the contributory factors to the staff engagement score falling, both at local and national level, is the reduction in the advocacy scores. Of particular note is the decline in the number of staff recommending their organisation as a place to work. Further detail on this is provided in section 3.4 of this report.

RD&E

RD&E scores above average for eight of the nine elements / themes, with 'We are always learning' the one element, which is below average (4.9 vs 5.2). For the new sub-scores, we can see that RD&E is on par or above average for 19 of the 21 areas, with 'Appraisals' and 'Autonomy and Control' the sub-scores rated under par. Question level data show that all four appraisal related questions show lower than the average, ranging between 1 - 8% behind similar trusts. For the Autonomy & Control questions

NDHT

All nine of the elements / themes score above average, and also the organisation also performs well when looking at the sub-scores, where 20 out of the 21 scores are above average.

Whilst all themes are above average, the smallest difference (+0.1%) is seen in the 'We are always learning' element, and a deeper dive shows that this is caused by one of the sub-scores 'Appraisals' being below average. Looking at question level data we can see that whilst the quality of appraisals is above average, the number being completed within the previous 12 months is lower than average (76.2% v's 80.1%), contributing to the reduced overall sub-score.

3.3 **Highest and Lowest Scoring Areas**

RD&E

Top scoring questions

The question on 'Staff recommending the Trust to friends and family' scored 11% above similar trusts (78% for RD&E), however there is a downward trajectory from 2018 (then 86%) of staff answering positively to this question.

Questions for People Promise element 'Compassion and Inclusion', score well above the average. High rates also scored for both for speaking up and for having adequate materials and equipment.

Bottom scoring questions

Scores for the four questions covering Appraisals have significantly worsened and are also performing significantly below the comparator group. Staff also score 'Able to make improvements happen in my area of work' 3% under the comparator group.

NDHT

Top scoring questions

The question around recommending the organisation as a place to work shows as top scoring question compared to the average score, despite this question also showing as

one of the most declined questions since 2020. This highlights NDHT's good performance at a national level.

Another question which shows as a top scoring question compared to the average score is satisfaction with recognition for good work, which also appears in the most declined scores. This again shows that NDHT is still performing well nationally despite the declines seen locally when compared to last year's results.

Bottom scoring questions

Three of the bottom 5 scoring questions for NDHT are around appraisals, an area already identified within this report as being the one sub-score that is below average. Appraisal questions were not included within the 2020 survey, and so it is important to note that these comparisons are being made with 2019 pre-pandemic data.

3.4 Most improved / declined scores

RD&E

Most improved questions

Notable improvements for three of the line manager related questions, e.g. 'Immediate manager asks for my opinion before making decisions that affect my work', an increase of 5% are increases that we can celebrate with our managers. Initiatives such as Head of Departments and Staff Briefings may have contributed, alongside development opportunities for managers.

Most declined questions

The single most notable decrease is in the questions around staffing; 'Enough staff at organisation to do my job properly', a drop of under 10% in one year. The pandemic is likely to be one of the reasons, due to staff illness and also the current wait for people to be treated. Decline in motivational questions is also a concern, formerly a strong performing area for the Trust.

NDHT

Most improved questions

The most significant improvement is seen in staff feeling pressure from managers to come to work when not well enough (likely strengthened around the infection prevention and control measures in place and support for staffing provided to managers).

Most declined questions

The most declined questions are similar to the picture presented nationally; not enough staff at the organisation to do their job properly, increased presenteeism, a decline in recommending the organisation as a place to work and declines in the number of staff looking forward to going to work, and feeling valued.

3.5 Staff Sentiment

	RD&E	NDHT	Average	Best
I would recommend my organisation as a place to work	65.0% 2020 – 71.3%	67.7% 2020 – 74.8%	58.4% 2020 – 67.0%	77.6% 2020 – 84.0%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	78.4% 2020 – 84.2%	72.6% 2020 – 78.5%	66.9% 2020 – 74.3%	89.5% 2020 – 91.7%
Care of patients / service users is my organisation's top priority	80.5% 2020 – 83.2%	81.7% 2020 – 84.4%	75.5% 2020 – 79.5%	89.1% 2020 – 90.7%
Thinks the organisation acts on concerns raised by patients / service users	72.5% 2020 – 74.6%	76.9% 2020 – 77.9%	71.0% 2020 – 74.0%	85.9% 2020 – 86.9%

We can see from the above table that all of the staff sentiment scores have seen declines at both national and local level, with the most significant declines seen for RD&E and NDHT in the number of staff recommending their organisation as a place to work.

It is however encouraging to see that both RD&E and NDHT remain above average for all of the staff sentiment scores, and we can see from the below analysis published in the Health Service Journal (HSJ) recently that despite the declines seen, NDHT ranks third in the South West, and RD&E is sixth, when looking at the 'I would recommend my organisation as a place to work" question.

Trust	2016	2017	2018	2019	2020	2021	Change 2020 to 2021
Yeovil District Hospital NHS Foundation Trust	62%	58%	69%	75%	76%	73%	-3.9
Somerset NHS Foundation Trust	-				76%	70%	-6.4
Northern Devon Healthcare NHS Trust	66%	68%	69%	74%	75%	68%	-7.1
Dorset County Hospital NHS Foundation Trust	65%	67%	69%	70%	72%	66%	-5.4
Royal United Hospitals Bath NHS Foundation Trust	67%	64%	65%	65%	74%	66%	-8.0
Royal Devon and Exeter NHS Foundation Trust	-	70%	74%	73%	71%	65%	-6.3
University Hospitals Bristol and Weston NHS Foundation Trust	-				72%	63%	-9.2
North Bristol NHS Trust	53%	54%	60%	69%	72%	63%	-9.5
University Hospitals Dorset NHS Foundation Trust*	69%	73%	73%	73%	76%	62%	-13.6
Torbay and South Devon NHS Foundation Trust	70%	63%	67%	65%	68%	59%	-9.1
Salisbury NHS Foundation Trust	72%	70%	65%	68%	70%	56%	-13.4
University Hospitals Plymouth NHS Trust	57%	57%	61%	62%	66%	55%	-10.8
Royal Cornwall Hospitals NHS Trust	47%	48%	52%	58%	63%	54%	-9.1
Great Western Hospitals NHS Foundation Trust	58%	54%	56%	58%	65%	53%	-11.0
Gloucestershire Hospitals NHS Foundation Trust	56%	52%	56%	59%	64%	53%	-11.7

Source:https://www.hsj.co.uk/workforce/revealed-the-best-and-worst-acute-trusts-to-work-at-according-to-staff/7032196.article

3.6 The Impact of COVID-19 (see Appendix 3)

In the 2021 survey, staff were asked four questions relating to their experience during the COVID-19 pandemic:

YOUR EXPERIENCE DURING THE COVID-19 PANDEMIC	
23. The Covid-19 pandemic	
a. In the past 12 months, have you worked on a Covid-19 specific ward or area at any time?	1 ☐ Yes 2 ☐ No
b. In the past 12 months, have you been redeployed due to the Covid-19 pandemic at any time?	1 ☐ Yes 2 ☐ No
c. In the past 12 months, have you been required to work remotely/from home due to the Covid-19 pandemic?	1 ☐ Yes 2 ☐ No

The results show differing experiences of staff in each group across each element / theme. As can be seen in appendix 3, the scores are consistently higher across all the themes for staff that were working remotely / from home for both NDHT and RD&E.

At both Trusts those working on COVID-19 specific wards, and those deployed showed similar experiences, and scored below the average organisation scores for all elements/themes.

3.7 **Trends on Individual Questions[1]**

RD&E

A combination of significantly improved score in the last year and a higher score vs the average, similar trust:

- Staff reported that they have an improved set of shared objectives, over 2% higher than other that at other trusts and last year.
- Staff report improved scores for experienced harassment, bullying or abuse from managers and colleagues, both vs 2020 and other trusts.
- Staff feel secure raising concerns about unsafe clinical practice and they would feel confident that organisation would address concerns about unsafe clinical practice.

A combination of significantly historical decline and significantly worse score vs the average trusts:

- RD&E staff are 1.5% less satisfied with opportunities for flexible working patterns compared to similar trusts, a decline of -2.2% in the last year and -4% since 2018.

A significantly worse score vs the average trust:

- Colleagues highlight that they are less able to meet all the conflicting demands on their time at work, coupled with a -10% decline vs 2020 in enough staff at organisation to do their job properly.
- Staff score all questions about appraisals as lower than the average acute trust, ranging between 1-8% behind similar trusts across the four questions.
- Staff report 1% less likely to access the right learning and development opportunities, vs scores at similar trusts.
- Team members report their team meets less often to discuss the team's effectiveness, RD&E's score is 2.6% worse score than the average trust.
- Staff report feeling less able to make improvements happen in their area of work, 3% lower score vs national average since 2020 and 9% since 2018.

NDHT

In general NDHT's results are in line with the national trends; however the following exceptions are of note:

[1] Note that the full reports and summary reports detailing the percentages for individual questions can be found here: https://www.nhsstaffsurveyresults.com/

- NDHT shows improvements in staff knowing what their work responsibilities are, despite a decline nationally
- The average scores for staff feeling that their organisation would address their concerns shows a decline, however NDHT has seen a improvement
- Significant uplift in the number of staff reporting harassment and bullying when they experience it, compared to average
- Decrease seen in the number of staff reporting musculoskeletal problems as a result of work, against the increasing trend seen nationally
- A significant improvement seen in staff feeling pressure from managers to come to work, compared to a static position nationally
- Improvements in staff feeling the organisation acts fairly with regard to career progression, whilst a decline is seen nationally
- Staff feeling like their role makes a difference to patients – NDHT has a lower than average score
- NDHT showing sharper decline in staff feeling satisfied with the recognition they get for good work, having been a top scoring trust for the previous 2 years
- A sharper decline seen in staff reporting that they are involved in changes in their work areas, when compared to the national small decline
- Sharp decline seen in staff reporting physical violence incidents at work, despite a smaller decrease seen nationally.
- Significant decline seen in NDHT's scores around teams having shared objectives, whilst the national average remains fairly static.

3.8 **ICS benchmarking**

RD&E generally scores around the middle of the pack both regionally and at ICS level, however shows the lowest scores for the 'We are always learning' element when compared to other South West Trusts and those within the ICS.

NDHT performs well regionally and is consistently within the top range of the scores. When looking at the ICS (excluding Devon Partnership Trust[2]), NDHT is the highest scoring trust for all nine of the elements / themes.

3.9 **Equality, Diversity and Inclusion (see appendix 4)**

The NHS staff survey includes data used in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Some of the key points are listed below, but a full summary of the data can be found in Appendix 4.

RD&E

WRES analysis

- A decrease in harassment and bullying reported by Black, Minority Ethnic (BME) colleagues by colleagues (-6.1%, vs -0.6% nationally), where nationally the equivalent score for harassment by patients was unchanged since 2020.
- BME colleagues (45.7%) report a decrease in equal opportunities for career progression (down 4.7%), nationally this score decreased by 0.6%. There is a gap

[2] Devon Partnership Trust, falls within a different benchmarking group, with other mental health Trusts, so comparisons may not be like for like.

of over 16% to white colleagues, where 62% believe there are career equal opportunities for progression.

- 15.5% of BME staff report discrimination by manager, a drop by -4%. Nationally 17.3% of BME report similar discrimination, while white staff report a 20.4% discrimination by managers, improved from 22% in 2020.

WDES analysis

- A positive trajectory reported by staff with a disability or long-term illness (LTC), experiencing harassment, bullying or abuse from patients or members of the public. Down annually since 2019, now at 26.6%, against a national backdrop of an increase last year (by 1.5%), to 32.4% for this staff group.
- A fairly static position for LTC since 2018 for RD&E staff with a larger decrease last year, in reported harassment or abuse by managers (-2.3%) vs nationally (-1%).
- LTC report a more positive position at RD&E vs the national average (3.8% fewer) LTC colleagues experience harassment and abuse by colleagues in 2021.
- A significant drop in LTC saying they reported harassment (-4.3%) but still lower than national average for this staff group.
- A positive development reported by LTC, over 4% more (55.7%) report that the organisation provides equal opportunities for career progression or promotion where the national average is stable.
- A sharp drop where LTC staff feel less satisfied with the extent to which their organisation values their work, by -6.8%, where staff without LTC report a -2.7% drop.

NDHT

WRES analysis

- BME have reported a 3% rise in bullying and harassment from patients, relatives or the public in 2021, a larger increase than has been seen nationally.
- Decreases have been seen in bullying and harassment from staff across both white and BME staff groups, however there still remains a significant difference in the numbers of white staff experiencing this (20.9%) compared to BME staff (27.9%).
- This same pattern is evident in the % of staff experiencing discrimination from managers / colleagues - 17.3% of BME staff compared to 4.3% of white staff.
- When looking at career progression and promotion opportunities, BME staff figures have remained relatively static (44.7% v's 44.5%) and the gap remains at around 20%.

WDES analysis

- The percentage of staff experiencing bullying or harassment from patients, relatives or the public has decreased for both staff with a LTC (2.2%) and those without (2.5%), a similar increase to that seen at a national level.
- 3.6% less staff with a LTC have experienced harassment, bullying or abuse from other colleagues since last year, whilst the figures for those without a LTC have seen a very small increase (+0.4%).

- A 4.8% increase is seen in the % of staff with a LTC believing that the organisation provides equal opportunities for career progression / promotion, compared to a 0.5% increase for staff without a LTC.
- A drop has been seen both locally and nationally in staff with a LTC reporting that adequate adjustments have been made for them, with NDHT's figures dropping from 82.4% in 2020 to 80.0% in 2021.

3.10 **Key Issues Identified**

RD&E

The key concerns identified are described below:

- Scores for the four questions covering Appraisals have significantly worsened and perform significantly below the comparator group.
- Staffing levels at the Trust are the most declined score (-9.4% benchmarked score) within the 2021 survey, this follows national trend.
- RD&E staff are 1.5% less satisfied with opportunities for flexible working patterns compared to similar trusts, a decline of -2.2% in the last year and -4% since 2018.
- New questions on burnout are included in this survey, with the RD&E score just above average in this sub-theme.
- Improved scores for managers, with all nine questions rated significantly higher vs comparator group (7Qs) or compared to last year (2Qs).
- 83% of Health, Wellbeing & Safety questions scored higher, or significantly higher than the comparator group (20 of 24 questions).

NDHT

The key points of note and concerns are described below:

- Our results tell a similar story to that nationally. Staff are suffering from burnout, experiencing higher stress levels and staffing levels are at a critical level. More staff are reporting there are not enough staff in the organisation for them to do their job properly.
- Despite our burnout scores being better than average, the scores were still low, signifying the intense pressures that staff continue to work under.
- Appraisals are the only sub-score with a below average score. The quality of appraisals was above average, but the number being completed was 4% lower than average.
- Historically NDHT has been one of the highest performers for scores around immediate managers; however, this gap is narrowing and needs review to ensure that further decline is avoided.

There is a need to understand the differing experiences between groups of staff (division / department / staff group etc.) to identify specific areas of focus. Further data analysis will enable deep dives to be undertaken to really understand the key issues in more depth.

The task and finish group that has been formed will look at the results in more detail to establish the key priorities and set actions to address these.

3.11 **People Pulse (Appendix 5)**

Launched in July 2021, the People Pulse is still in its infancy and whilst we can identify changes between Q4 and Q2 results, it should be noted that the dataset captured to date is still relatively limited and full trend analysis is not yet possible. The April 2022 People Pulse will provide a fourth data point and allow for trend analysis to commence (utilising three People Pulse data sets, alongside the NHS Staff Survey).

RD&E

Improvements can be seen across eight (53%) of the 15 questions when compared to the July 2021 People Pulse data, with seven questions showing declines. Of the areas that declined, these relate mainly to motivation and advocacy, while two involvement questions and the health and wellbeing question have increased.

NDHT

Declines can be seen across 13 of the 15 questions (86.7%), when compared to the Q2 People Pulse data.

Whilst we should be cautious in comparing this data with the annual NHS Staff Survey (due to weighting differences), it does appear at a top level, that there may be a continuing downward trend across these questions.

It is however positive to see that staff still view the organisation as supportive towards their health and wellbeing, with this score one of two that has improved.

Benchmarking

Nationally, we can see that despite declines across eight of the nine employee engagement questions, NDHT's scores are still above both the Integrated Care System (ICS) and national averages, however when compared to the employee (staff) engagement score from the NHS Staff Survey, a reduction of 0.2 can be seen.

The RD&E also scores well in relation to its peers; however despite increases in a number of the scores in January 2022, many of the employee engagement questions were declined, and the employee engagement question score therefore remains static when compared to the NHS Staff Survey. Further insight on this will be available following completion of the next People Pulse.

	NDHT	RD&E	STP Average	National Average (Acute and Acute and Community Trusts)
Employee Engagement	6.9	6.9	6.7	6.4
Advocacy	7.1	7.2	6.7	6.5
Involvement	6.7	6.6	6.6	6.2
Motivation	7.0	6.9	6.7	6.5

Source: Model Hospital (NQPS Scores)

People Pulse data is now being included in the Integrated Performance Report (IPR) on a quarterly basis, and forms a key part of the cultural dashboard that is currently being developed at system level.

Detailed dashboards are being built within the survey system Qualtrics, to allow for enhanced demographic breakdowns, providing the ability to perform deep dives and analyse how employee experience changes between different groups of staff, assisting with the identification of targeted actions.

Moving forward the People Pulse will provide frequent touchpoints for staff, and allow for ongoing feedback and action, with the NHS Staff Survey providing a detailed annual check-in.

4. RESOURCE / LEGAL / FINANCIAL / REPUTATIONAL IMPLICATIONS

4.1

- As the results have only recently become available an action plan from these findings is yet to be fully developed; however it is possible that any actions may have financial / resource implications.
- There are elements of the staff survey that highlight room for improvement. The NHS Staff Survey results are in the public domain and any decline in performance could have reputational implications.

5. LINK TO BAF / KEY RISKS

5.1 The staff survey is directly referenced as a control or source of assurance in many of the risks on the current Board Assurance Frameworks (BAF).

6. PROPOSALS

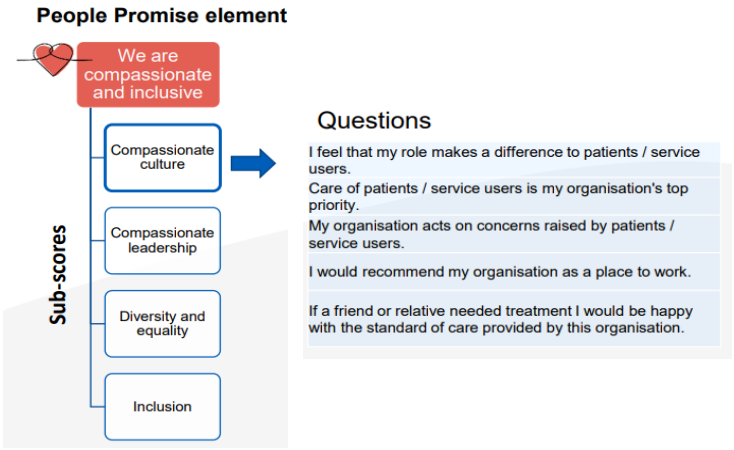
6.1 **Next Steps**

- Recognising the importance of ensuring that the identification of priorities, recommendations and action planning is an inclusive and representative process, a task & finish group has been established. This group will receive a presentation from Picker, of the results from both former organisations side by side (scheduled for 26 April 2022).
- The task & finish group will then split into two separate groups, looking at results for northern and eastern services in more detail and identifying and agreeing priorities for a Trust wide response.
- Trust wide action plans (cross referenced with the NHS People Plan actions and 22/23 inclusion plan on a page) will be created to address key areas of concern / priorities identified by the task and finish group. Plans will be monitored through the task and finish group and additionally through other committees, such as PWPW, Partnership Forum and the Inclusion Steering group.
- Divisional and department level action plans will be created to look at detailed findings in each of these areas, and actions to address these. Divisional Directors will be held accountable for delivery of these plans through Performance Assurance Framework (PAF) meetings.
- Ways in which Trust wide learnings and improvements can be shared will be reviewed to ensure action across the whole Trust where possible, and shared learning for mutual benefit, where applicable, linking key areas together to share best practice.
- Looking ahead, the quarterly People Pulse survey and cultural dashboard will provide a robust, continuous feedback cycle for staff, with ongoing actions for improvement, with the NHS Staff Survey providing an annual check-in.

Appendix 1 – Summary of survey changes

New People Promise elements:

People Promise element	Sub-scores	Questions
Promise 1: *We are compassionate and inclusive*	P1.1: Compassionate culture P1.2: Compassionate leadership P1.3: Diversity and equality P1.4: Inclusion	Q6a, Q21a-d Q9f-i Q15, Q16a-b, Q18 Q7h-i, Q8b-c
Promise 2: *We are recognised and rewarded*	[No sub scores]	Q4a-c, Q8d, Q9e
Promise 3: *We each have a voice that counts*	P3.1: Autonomy and control P3.2: Raising concerns	Q3a-f, Q5b Q17a-b, Q21e-f
Promise 4: *We are safe and healthy*	P4:1 Health and safety climate P4:2 Burnout P4:3 Negative experiences	Q3g-i, Q5a, Q11a, Q13d, Q14d Q12a-g Q11b-d, Q13a-c, Q14a-c
Promise 5: *We are always learning*	P5.1: Development P5.2: Appraisals	Q20a-e Q19a-d
Promise 6: *We work flexibly*	P6.1: Support for work-life balance P6.2: Flexible working	Q6b-d Q4d
Promise 7: *We are a team*	P7.1: Team working P7.2: Line management	Q7a-g, Q8a Q9a-d

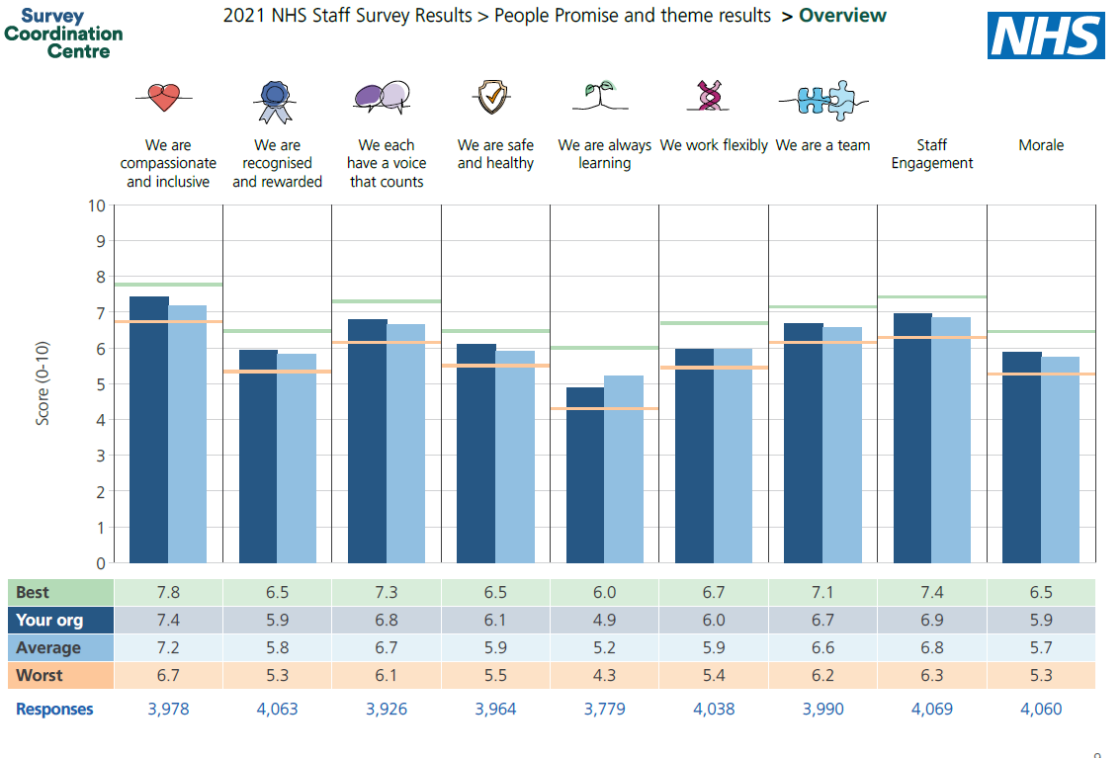


Existing themes:

Themes	Sub-scores	Questions
Staff Engagement	E.1: Motivation	Q2a-c
	E.2: Involvement	Q3c, Q3d, Q3f
	E.3: Advocacy	Q21a, Q21c, Q21d
Morale	M.1: Thinking about leaving	Q22a-c
	M.2: Work pressure	Q3g-i
	M.3: Stressors (HSE index)	Q3a, Q3e, Q5a-c, Q7c, Q9a

Appendix 2 – Element, theme and sub-scores

RD&E element / theme scores



Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.4	5.9	6.8	6.1	4.9	6.0	6.7	6.9	5.9
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	3,978	4,063	3,926	3,964	3,779	4,038	3,990	4,069	4,060

NDHT element / theme scores

Survey Coordination Centre

2021 NHS Staff Survey Results > People Promise and theme results > **Overview**

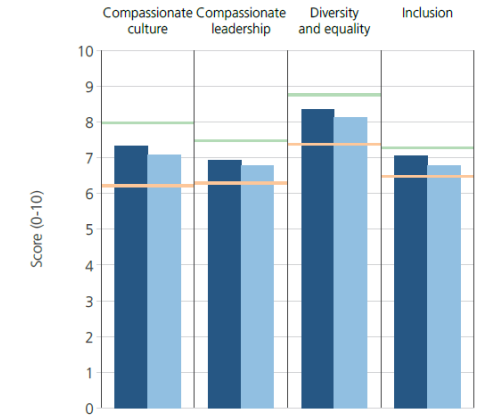
NHS

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.5	6.2	7.0	6.2	5.3	6.4	6.9	7.1	6.1
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	1,796	1,793	1,782	1,788	1,714	1,784	1,790	1,796	1,795

Sub-scores

RD&E

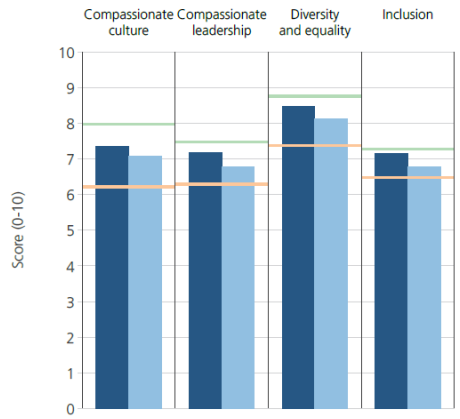
Promise element 1: We are compassionate and inclusive



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Best	8.0	7.5	8.8	7.3
Your org	7.3	6.9	8.3	7.1
Average	7.1	6.8	8.1	6.8
Worst	6.2	6.3	7.4	6.5
Responses	3,942	3,993	3,975	4,021

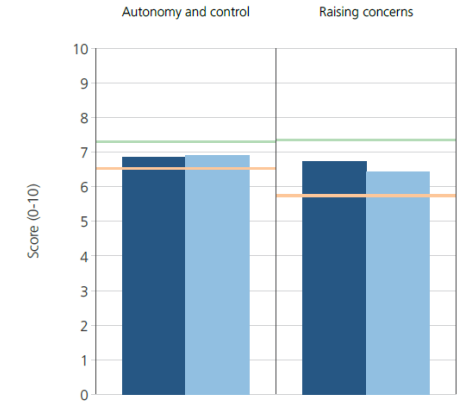
NDHT

Promise element 1: We are compassionate and inclusive



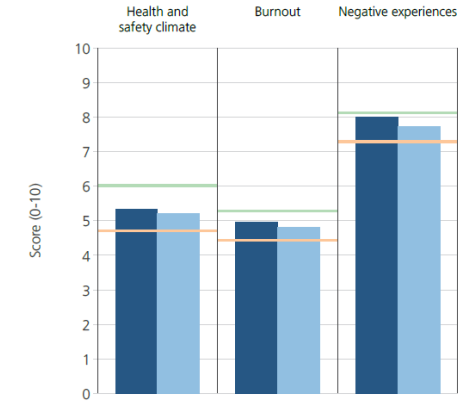
	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Best	8.0	7.5	8.8	7.3
Your org	7.3	7.2	8.5	7.2
Average	7.1	6.8	8.1	6.8
Worst	6.2	6.3	7.4	6.5
Responses	1,793	1,794	1,792	1,790

Promise element 3: We each have a voice that counts



	Autonomy and control	Raising concerns
Best	7.3	7.3
Your org	6.8	6.7
Average	6.9	6.4
Worst	6.5	5.7
Responses	4,069	3,928

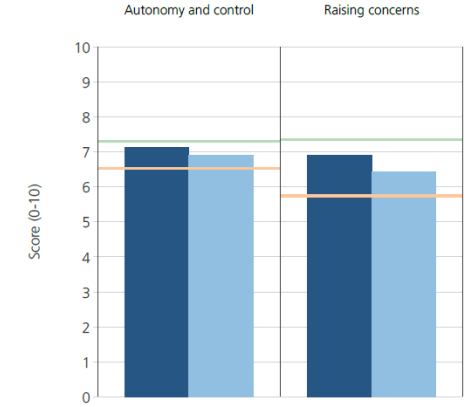
Promise element 4: We are safe and healthy



	Health and safety climate	Burnout	Negative experiences
Best	6.0	5.3	8.1
Your org	5.3	4.9	8.0
Average	5.2	4.8	7.7
Worst	4.7	4.4	7.3
Responses	4,070	3,976	3,973

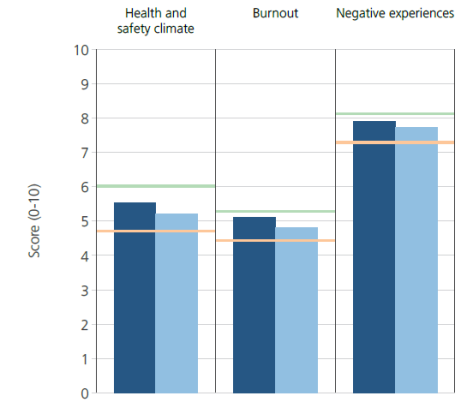
RD&E

Promise element 3: We each have a voice that counts



	Autonomy and control	Raising concerns
Best	7.3	7.3
Your org	7.1	6.9
Average	6.9	6.4
Worst	6.5	5.7
Responses	1,793	1,786

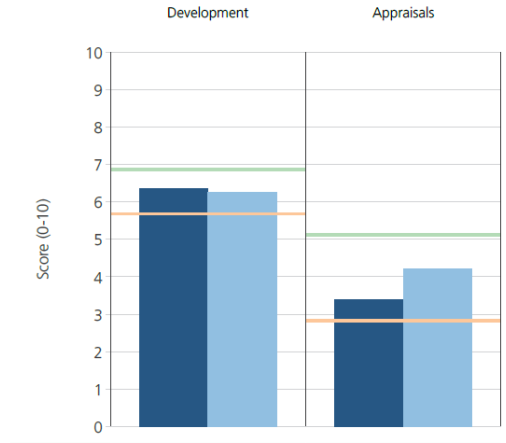
Promise element 4: We are safe and healthy



	Health and safety climate	Burnout	Negative experiences
Best	6.0	5.3	8.1
Your org	5.5	5.1	7.9
Average	5.2	4.8	7.7
Worst	4.7	4.4	7.3
Responses	1,794	1,796	1,790

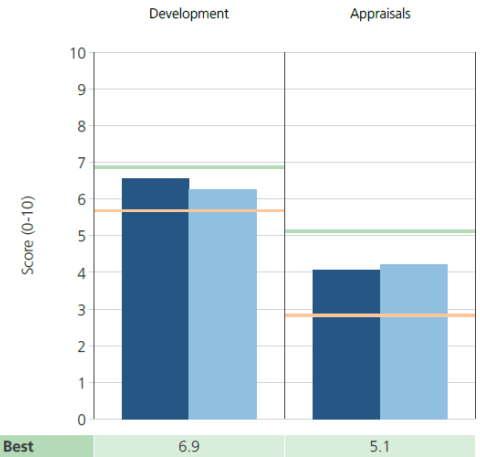
NDHT

Promise element 5: We are always learning



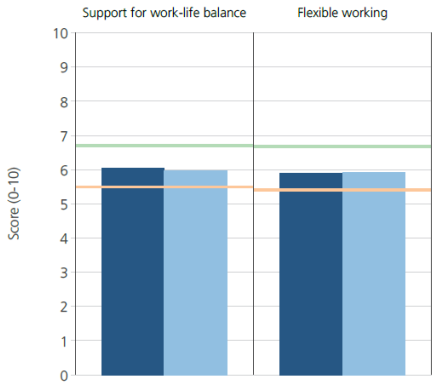
	Development	Appraisals
Best	6.9	5.1
Your org	6.3	3.4
Average	6.3	4.2
Worst	5.7	2.8
Responses	3,956	3,800

Promise element 5: We are always learning



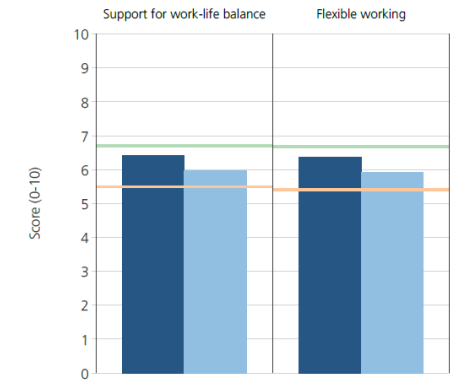
	Development	Appraisals
Best	6.9	5.1
Your org	6.6	4.1
Average	6.3	4.2
Worst	5.7	2.8
Responses	1,789	1,720

Promise element 6: We work flexibly



	Support for work-life balance	Flexible working
Best	6.7	6.7
Your org	6.0	5.9
Average	6.0	5.9
Worst	5.5	5.4
Responses	4,044	4,060

Promise element 6: We work flexibly



	Support for work-life balance	Flexible working
Best	6.7	6.7
Your org	6.4	6.4
Average	6.0	5.9
Worst	5.5	5.4
Responses	1,793	1,786

Promise element 7: We are a team

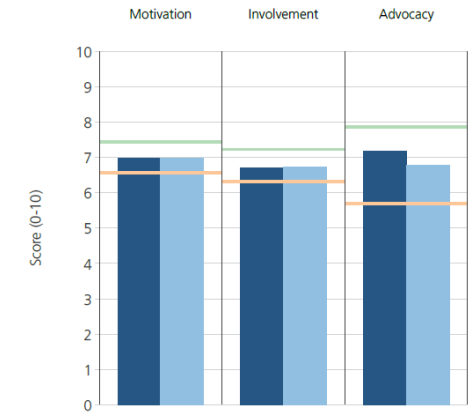
	Team working	Line management
Best	7.0	7.3
Your org	6.7	6.7
Average	6.5	6.6
Worst	6.2	6.2
Responses	4,032	3,992

Promise element 7: We are a team

	Team working	Line management
Best	7.0	7.3
Your org	6.8	7.0
Average	6.5	6.6
Worst	6.2	6.2
Responses	1,792	1,794

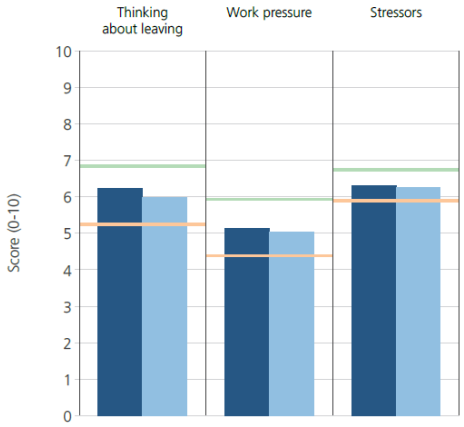
RD&E

Staff Engagement



	Motivation	Involvement	Advocacy
Best	7.4	7.2	7.9
Your org	7.0	6.7	7.2
Average	7.0	6.7	6.8
Worst	6.6	6.3	5.7
Responses	4,092	4,069	3,943

Morale



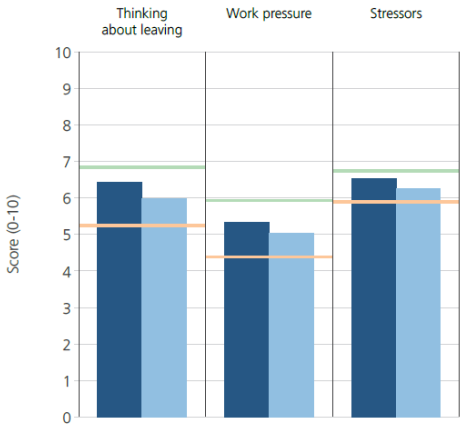
	Thinking about leaving	Work pressure	Stressors
Best	6.8	5.9	6.7
Your org	6.2	5.1	6.3
Average	6.0	5.0	6.2
Worst	5.2	4.4	5.9
Responses	3,918	4,068	4,046

NDHT

Staff Engagement

	Motivation	Involvement	Advocacy
Best	7.4	7.2	7.9
Your org	7.1	7.0	7.2
Average	7.0	6.7	6.8
Worst	6.6	6.3	5.7
Responses	1,782	1,793	1,793

Morale

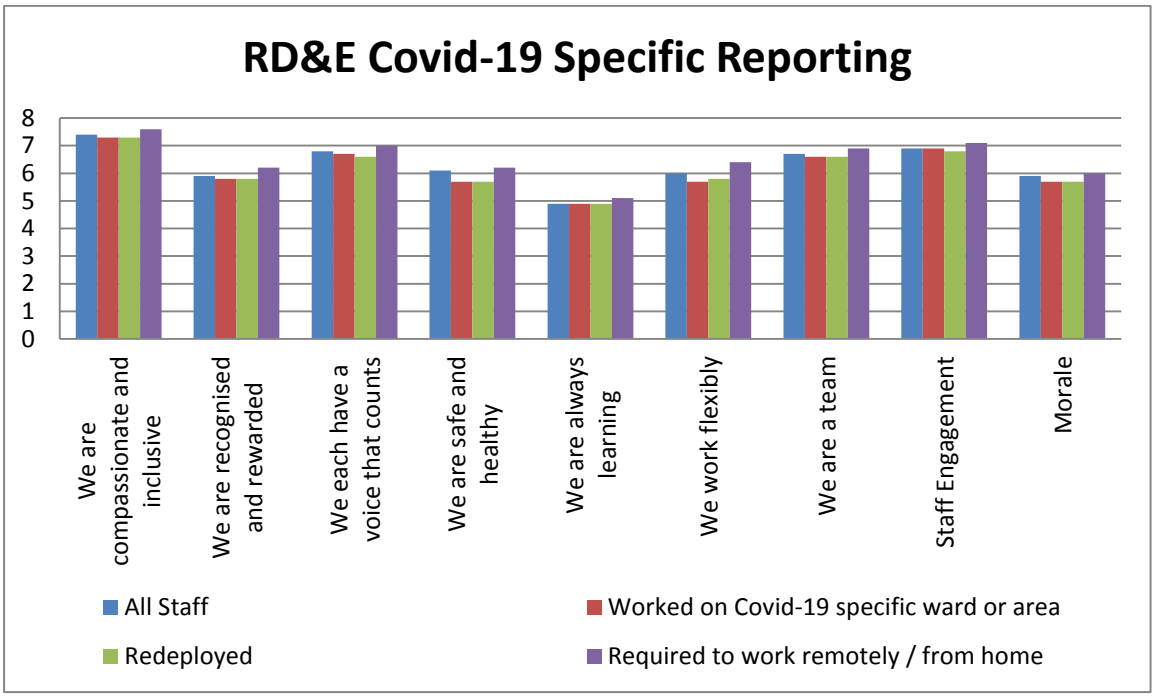


	Thinking about leaving	Work pressure	Stressors
Best	6.8	5.9	6.7
Your org	6.4	5.3	6.5
Average	6.0	5.0	6.2
Worst	5.2	4.4	5.9
Responses	1,794	1,793	1,791

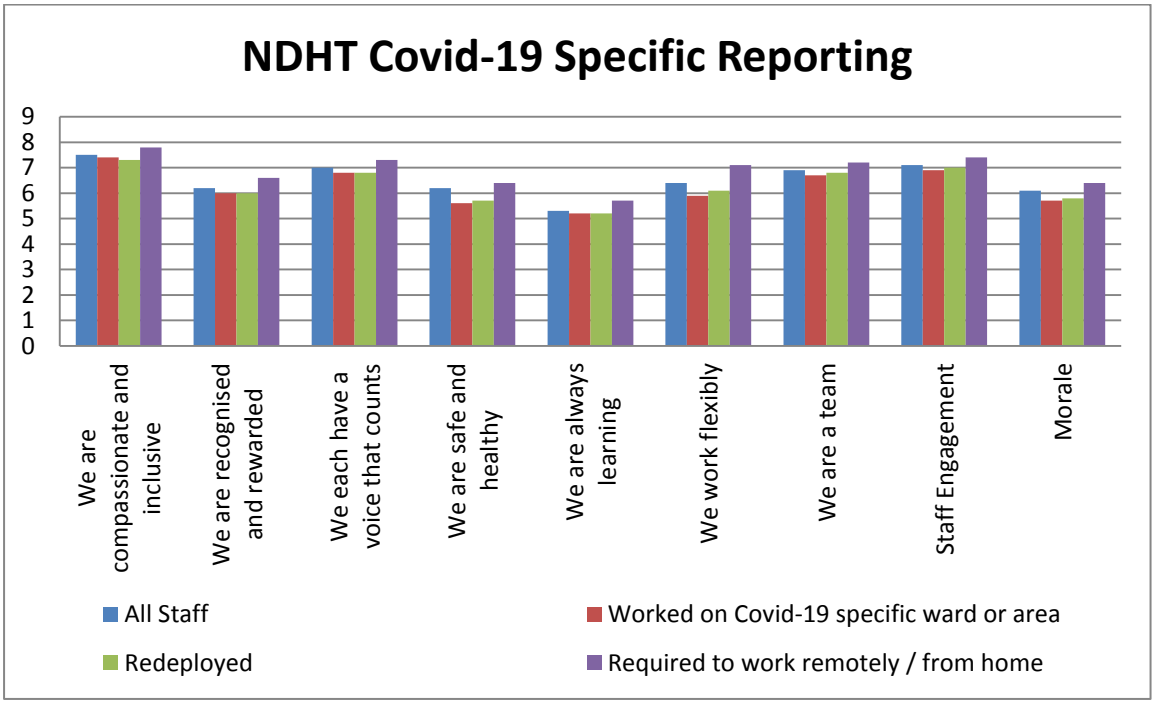
Appendix 3 – COVID-19 specific reporting

See graph below for an overview of the results, showing differing experiences of staff in each classification group across each of the themes.

RD&E



NDHT



Appendix 4 – WRES & WDES information

WRES data

	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months		% of staff experiencing harassment, bullying or abuse from staff in last 12 months		% of staff believing that the organisation provides equal opportunities for career progression or promotion		% of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	
	2020	**2021**	**2020**	**2021**	**2020**	**2021**	**2020**	**2021**
White – RD&E	22.0%	20.4%	21.8%	17.1%	59.4%	62.0%	5.8%	6.1%
White – NDHT	22.2%	25.2%	21.1%	20.9%	61.7%	63.0%	4.7%	4.3%
White – Average	25.4%	26.5%	24.4%	23.6%	59.4%	58.6%	6.1%	6.7%
BME – RD&E	27.6%	27.5%	27.2%	21.1%	50.4%	45.7%	19.5%	15.5%
BAME – NDHT	36.9%	34.8%	33.0%	27.9%	44.7%	44.5%	17.8%	17.3%
BAME – Average	28.0%	28.8%	29.1%	28.5%	45.2%	44.6%	16.8%	17.3%

2020 and 2021 data has been included to indicate the direction of travel for both RD&E, NDHT as well as the average score for the Acute and Acute and Community benchmarking group.

WDES data

	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months		% of staff experiencing harassment, bullying or abuse from manager in last 12 months		% of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months		% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it		% of staff who believe that their organisation provides equal opportunities for career progression or promotion	
	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021
Staff with a LTC or illness – RD&E	27.1%	26.6%	16.1%	13.8%	24.6%	22.8%	48.2%	43.9%	54.0%	55.7%
Staff with a LTC or illness – NDHT	29.4%	31.6%	15.5%	14.5%	25.5%	21.9%	48.2%	47.8%	53.6%	58.4%
Staff with a LTC or illness – Average	30.9%	32.4%	19.3%	18.0%	26.9%	26.6%	47.0%	47.0%	51.6%	51.4%
Staff without a LTC or illness – RD&E	21.1%	19.4%	9.5%	6.5%	14.4%	11.2%	43.8%	45.3%	60.0%	62.0%
Staff without a LTC or illness – NDHT	21.3%	23.8%	7.2%	7.3%	15.3%	15.7%	45.1%	49.9%	62.5%	63.0%
Staff without a LTC or illness – Average	24.5%	25.2%	10.8%	9.8%	17.8%	17.7%	45.8%	46.2%	57.4%	56.8%

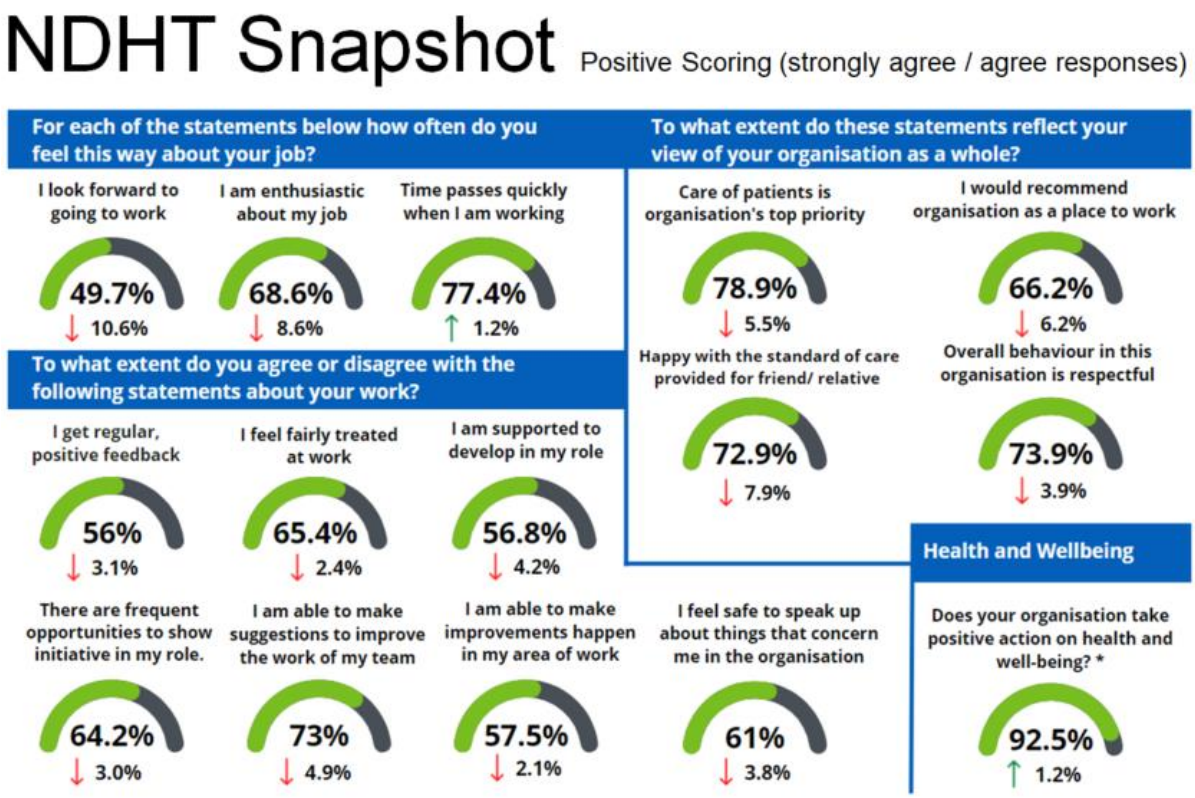
WDES data (cont.)

	% of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties		% of staff satisfied with the extent to which their organisation values their work		% of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work		Staff engagement score (0-10)	
	2020	2021	2020	2021	2020	2021	2020	2021
Staff with a LTC or illness – RD&E	28.3%	28.3%	40.4%	33.6%	81.9%	76.7%	6.9	6.7
Staff with a LTC or illness – NDHT	26.7%	24.2%	44.6%	39.4%	82.4%	80.0%	6.9	6.9
Staff with a LTC or illness – Average	33.0%	32.2%	37.4%	32.6%	75.5%	70.9%	6.7	6.4
Staff without a LTC or illness – RD&E	21.6%	20.3%	46.1%	43.4%	/	/	7.1	7.0
Staff without a LTC or illness – NDHT	20.8%	15.4%	56.1%	48.7%	/	/	7.4	7.2
Staff without a LTC or illness – Average	23.4%	23.7%	49.3%	43.3%	/	/	7.1	7.0

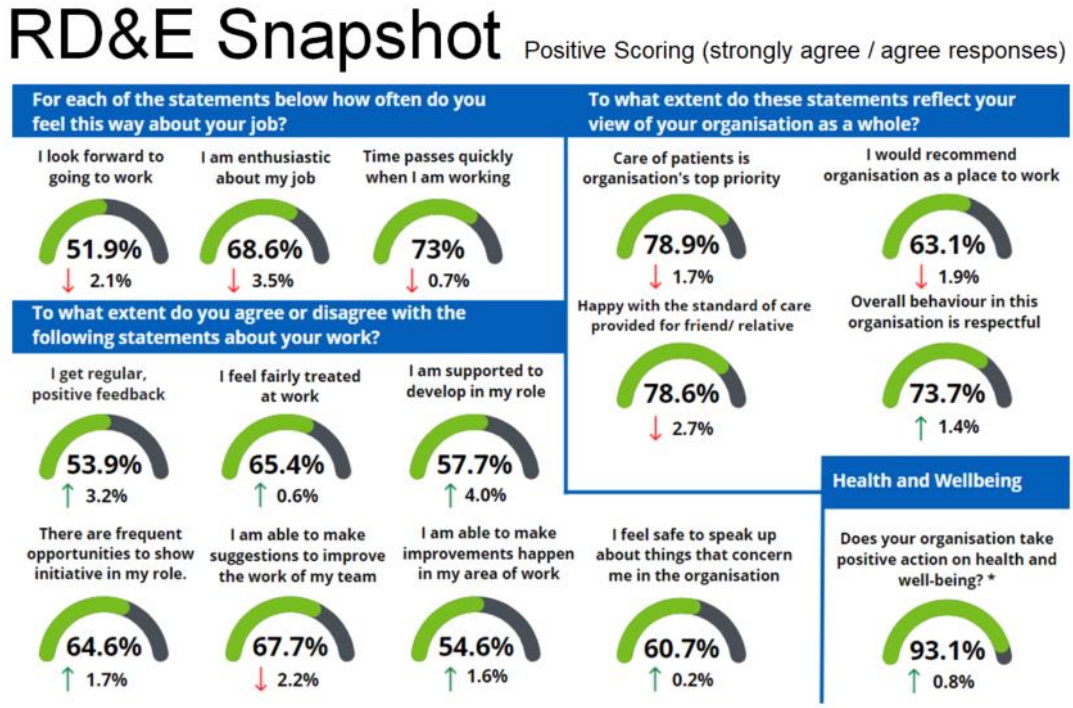
2020 and 2021 data has been included to indicate the direction of travel for both RD&E, NDHT as well as the average score for the Acute and Acute and Community benchmarking group.

Appendix 5 – People Pulse snapshots

NDHT



RD&E



NHS
Royal Devon
University Healthcare
NHS Foundation Trust

NHS Staff Survey Results 2021

Survey changes

- 2021 saw the most significant changes to the NHS Staff Survey within the last decade
- Survey has been aligned to the 7 People Promise elements, whilst maintaining pre-existing Staff Engagement and Morale themes
- Sub-scores have been introduced within the element/theme scores, providing greater depth of insight

NHS People Promise:

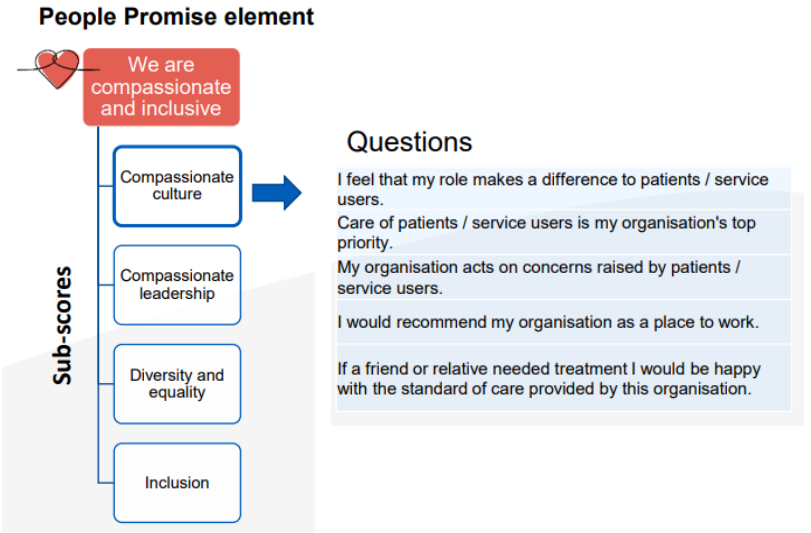
Survey elements / themes

New People Promise elements:

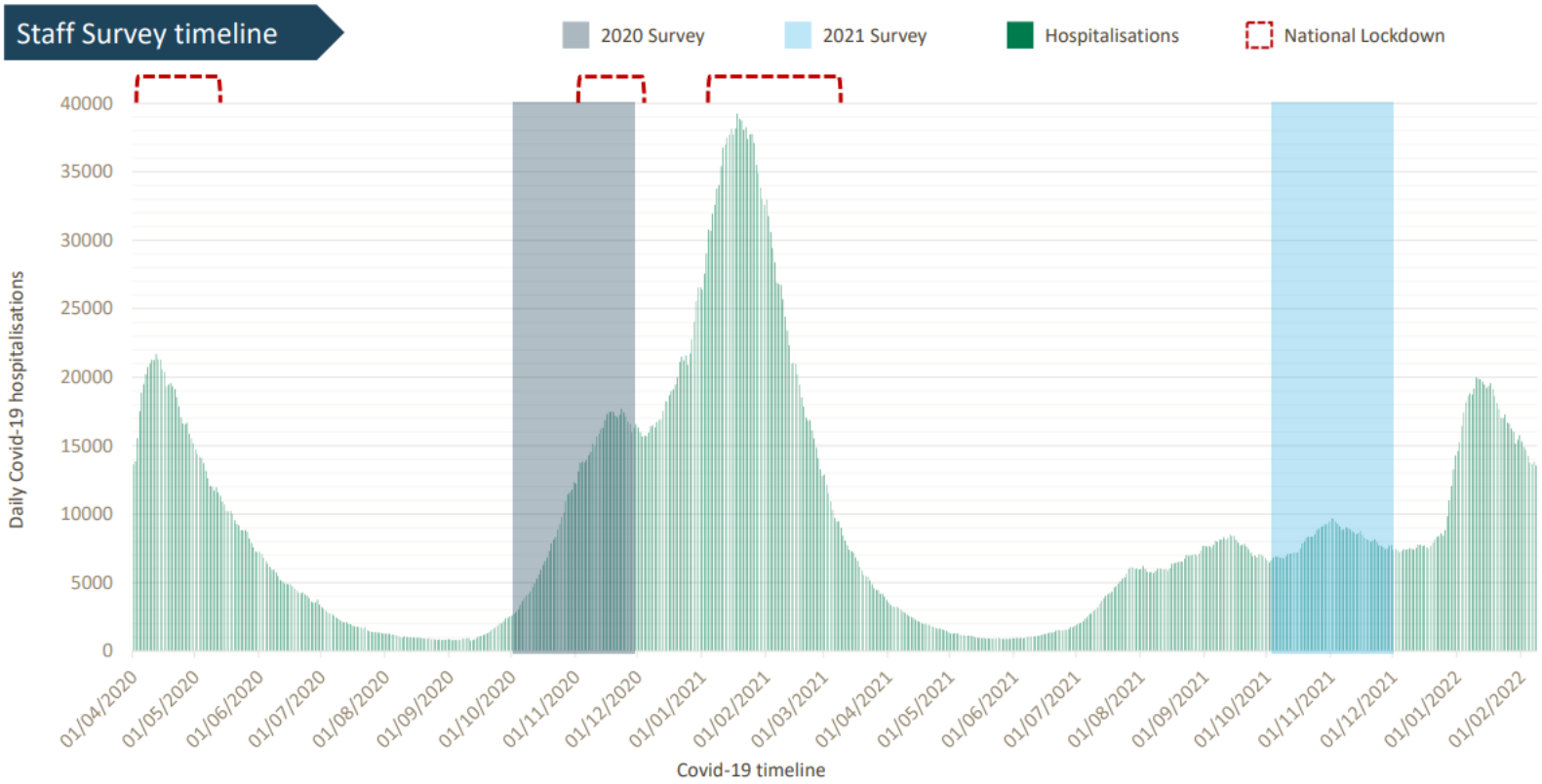
People Promise element	Sub-scores	Questions
Promise 1: *We are compassionate and inclusive*	P1.1: Compassionate culture P1.2: Compassionate leadership P1.3: Diversity and equality P1.4: Inclusion	Q6a, Q21a-d Q9f-i Q15, Q16a-b, Q18 Q7h-i, Q8b-c
Promise 2: *We are recognised and rewarded*	[No sub scores]	Q4a-c, Q8d, Q9e
Promise 3: *We each have a voice that counts*	P3.1: Autonomy and control P3.2: Raising concerns	Q3a-f, Q5b Q17a-b, Q21e-f
Promise 4: *We are safe and healthy*	P4:1 Health and safety climate P4:2 Burnout P4:3 Negative experiences	Q3g-i, Q5a, Q11a, Q13d, Q14d Q12a-g Q11b-d, Q13a-c, Q14a-c
Promise 5: *We are always learning*	P5.1: Development P5.2: Appraisals	Q20a-e Q19a-d
Promise 6: *We work flexibly*	P6.1: Support for work-life balance P6.2: Flexible working	Q6b-d Q4d
Promise 7: *We are a team*	P7.1: Team working P7.2: Line management	Q7a-g, Q8a Q9a-d

Existing themes:

Themes	Sub-scores	Questions
Staff Engagement	E.1: Motivation E.2: Involvement E.3: Advocacy	Q2a-c Q3c, Q3d, Q3f Q21a, Q21c, Q21d
Morale	M.1: Thinking about leaving M.2: Work pressure M.3: Stressors (HSE index)	Q22a-c Q3g-i Q3a, Q3e, Q5a-c, Q7c, Q9a



The Covid-19 pandemic - timeline



UK Covid-19 Hospitalisation data: Healthcare in the UK | Coronavirus in the UK (data.gov.uk) | UK National Lockdown timeline: timeline-lockdown-social (instituteforgovernment.org.uk)

The national picture

The two themes retained within the survey, Morale and Staff Engagement, both worsened nationally.

Staff Engagement has declined nationally for the first time in three years, driven largely by the fall in the advocacy sub theme (% of staff recommending the NHS as a place to work fell from 67% to 60%).

Notable increases in work pressure, negative staff experiences, and a decline in health and wellbeing measures - increases in stress, staff attending work when unwell, and musculoskeletal injury levels rose. The new burnout question also demonstrated high levels of burnout nationally.

Areas of strengths - team working, compassionate leadership.

Saffron Cordery, Deputy Chief Executive of NHS Providers said:

"The last two years have been hugely challenging for NHS staff who have worked tirelessly in the pandemic and continue to work flat out tackling care backlogs and ongoing pressures from COVID-19.

It's no surprise that all of this has affected staff morale and wellbeing, and these factors are compounded by critical staff shortages across the NHS.

It is vital that the government comes up with a fully-costed and funded workforce plan to ensure the NHS has the staff it needs to meet increased demand for services now and in the future…"

Royal Devon University Healthcare NHS Foundation Trust

Survey response rates

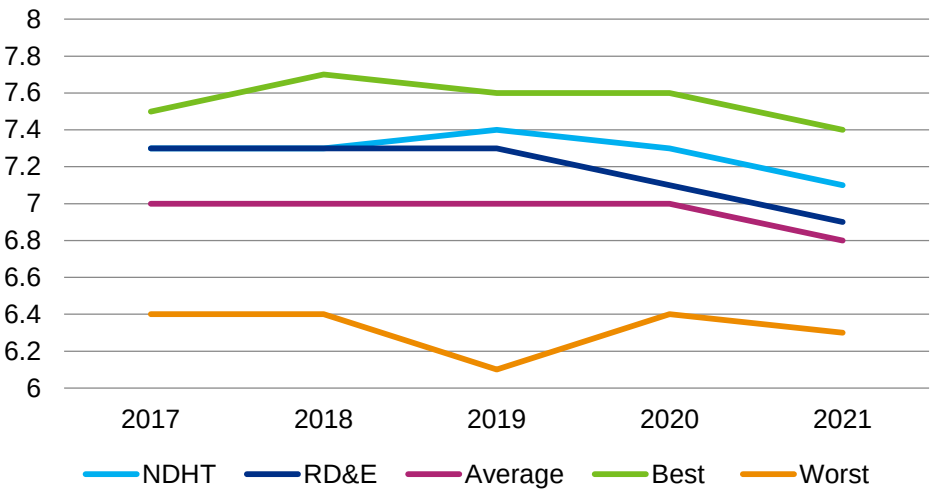
	RD&E	NDHT	Benchmarking group (Acute and Acute and Community Trusts)
Completed questionnaires	4,144	1,797	444,326
Response rate 2021	**46%**	**51%**	**46%**
Response rate 2020	44%	55%	45%
Survey mode	Mixed	Mixed	Variable
Sample type	Census	Census	Census

Royal Devon University Healthcare NHS Foundation Trust

The journey so far

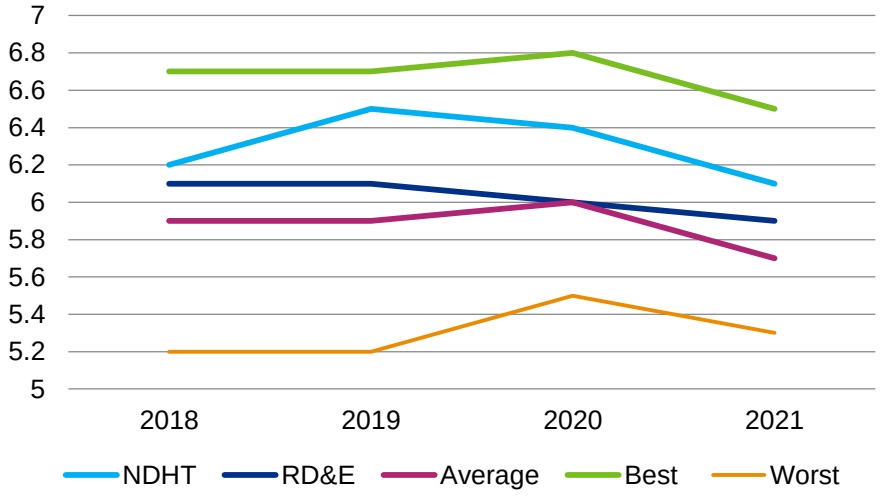
Due to the significant survey changes, and introduction of new People Promise elements, historical comparison is limited. The two themes carried forward, **Staff Engagement** and **Morale**, have trend data available:

Staff Engagement Score 2017 - 2021



The two trusts show a decline in staff engagement scores, in line with the negative trajectory seen nationally.

Morale Score 2018 - 2021



Both trusts show a decline in morale scores, NDHT is in line with the trajectory seen nationally, however RD&E shows a more gradual decline.

Where are we now – RD&E?

Survey Coordination Centre

2021 NHS Staff Survey Results > People Promise and theme results > **Overview**

NHS

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.4	5.9	6.8	6.1	4.9	6.0	6.7	6.9	5.9
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	3,978	4,063	3,926	3,964	3,779	4,038	3,990	4,069	4,060

Scores above average Acute, Acute and Community Trusts for all themes.
8 (of 9) sub-scores increased vs the 19 (of 21) sub-scores.

'We are always learning' shows the only area with lower than average score. Questions scoring below par relates to appraisals and development opportunities.

Where are we now - NDHT?

Survey Coordination Centre

2021 NHS Staff Survey Results > People Promise and theme results > **Overview**

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.5	6.2	7.0	6.2	5.3	6.4	6.9	7.1	6.1
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	1,796	1,793	1,782	1,788	1,714	1,784	1,790	1,796	1,795

Scores are above average for all element/ themes and above average for 20 out of the 21 sub-scores

We are always learning shows the smallest difference (+0.1%) between average and organisation score. Deeper dive shows lower than average scores in the appraisal sub-score

Royal Devon University Healthcare NHS Foundation Trust

National comparisons

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
NDHT	11th	5th	8th	7th	42nd	8th	8th	21st	9th
RD&E	20th	37th	40th	24th	115th	60th	34th	39th	32nd

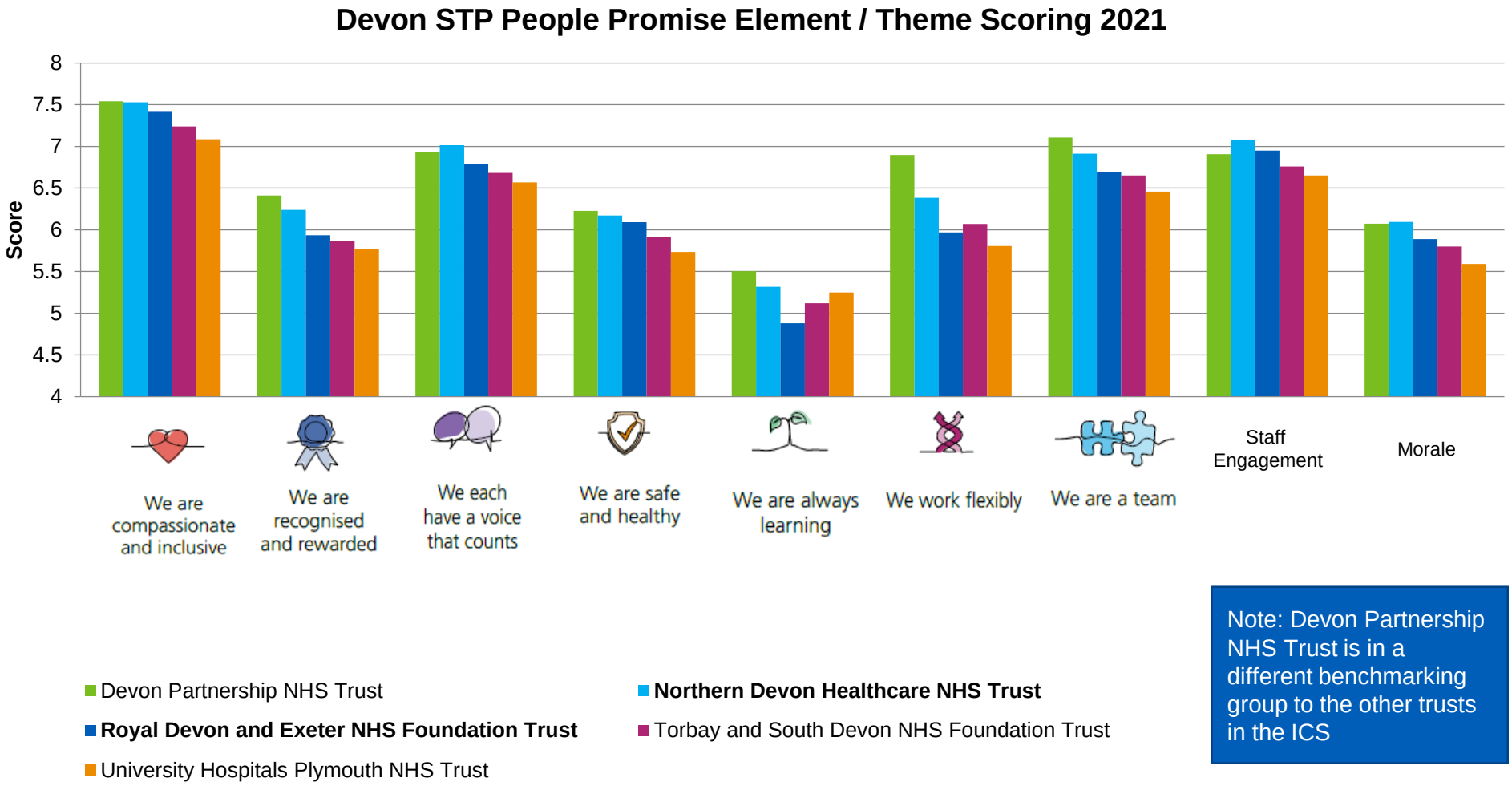
126 Acute and Acute & Community Trusts

NDHT in top 10 for 6 out of the 9 elements / themes

RD&E around top quarter for 1/3 of elements

Clear that work is needed in both trusts on the 'We are always learning' element

Devon ICS results



Note: Devon Partnership NHS Trust is in a different benchmarking group to the other trusts in the ICS

Staff Sentiment

	RD&E	NDHT	Average	Best
I would recommend my organisation as a place to work*	**65.0%** 2020 – 71.3%	**67.7%** 2020 – 74.8%	**58.4%** 2020 – 67.0%	**77.6%** 2020 – 84.0%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	**78.4%** 2020 – 84.2%	**72.6%** 2020 – 78.5%	**66.9%** 2020 – 74.3%	**89.5%** 2020 – 91.7%
Care of patients / service users is my organisation's top priority	**80.5%** 2020 – 83.2%	**81.7%** 2020 – 84.4%	**75.5%** 2020 – 79.5%	**89.1%** 2020 – 90.7%
Thinks the organisation acts on concerns raised by patients / service users	**72.5%** 2020 – 74.6%	**76.9%** 2020 – 77.9%	**71.0%** 2020 – 74.0%	**85.9%** 2020 – 86.9%

***** Largest decline among these Staff Sentiment questions vs 2020 at RD&E (**-6.3**%) and NDHT (-**7.1**%) was for' **I would recommend the trust as a place to work**'.

For **all** Trusts nationally, not just Acute and Acute and Community Trusts, 59.4% of staff would recommend their organisation as a place to work – a decline of more than 7% percentage points from 66.8% in 2020, and lower than at any point in the last five years.

Source: Picker March 2022

Top and bottom question scores

	RD&E top	Trust	Av.
1	If friend/relative needed treatment would be happy with standard of care provided by organisation	78%	67%
2	Have adequate materials, supplies and equipment to do my work	63%	55%
3	Colleagues are understanding and kind to one another	76%	69%
4	Colleagues are polite and treat each other with respect	78%	70%
5	Feel safe to speak up about anything that concerns me in this organisation	68%	61%

	RD&E bottom	Trust	Av.
1	Received appraisal in the past 12 months	69%	80%
2	Appraisal helped me improve how I do my job	14%	20%
3	Appraisal helped me agree clear objectives for my work	25%	30%
4	Able to make improvements happen in my area of work	50%	53%
5	Appraisal left me feeling organisation values my work	27%	29%

	NDHT top	Trust	Av.
1	Have adequate materials, supplies and equipment to do my work	65%	55%
2	Disability: organisation made adequate adjustment(s) to enable me to carry out work	80%	71%
3	Would recommend organisation as place to work	68%	58%
4	Satisfied with recognition for good work	59%	51%
5	Feel safe to speak up about anything that concerns me in this organisation	70%	61%

	NDHT bottom	Trust	Av.
1	Received appraisal in the past 12 months	79%	80%
2	Appraisal helped me improve how I do my job	19%	20%
3	Feel my role makes a difference to patients/service users	86%	88%
4	Always know what work responsibilities are	86%	87%
5	Appraisal helped me agree clear objectives for my work	31%	30%

Most improved and declined scores

RD&E most improved		2020	2021
1	Immediate manager asks for my opinion before making decisions that affect my work	52%	57%
2	Would feel secure raising concerns about unsafe clinical practice	73%	77%
3	Immediate manager gives clear feedback on my work	57%	61%
4	Last experience of physical violence reported	65%	69%
5	Not experienced harassment, bullying or abuse from managers	89%	92%

RD&E most declined		2020	2021
1	Enough staff at organisation to do my job properly	37%	27%
2	In last 3 months, have not come to work when not feeling well enough to perform duties	55%	49%
3	Would recommend organisation as place to work	71%	65%
4	Often/always look forward to going to work	57%	52%
5	If friend/relative needed treatment would be happy with standard of care provided by organisation	84%	79%

NDHT most improved		2020	2021
1	Not felt pressure from manager to come to work when not feeling well enough	77%	81%
2	Last experience of harassment/ bullying/ abuse reported	46%	49%
3	Would feel secure raising concerns about unsafe clinical practice	77%	79%
4	Have not experienced musculoskeletal problems as a result of work activities	69%	71%
5	Confident that organisation would address concerns about unsafe clinical practice	63%	65%

NDHT most declined		2020	2021
1	Enough staff at organisation to do my job properly	41%	32%
2	In last 3 months, have not come to work when not feeling well enough to perform duties	60%	50%
3	Often/always look forward to going to work	64%	55%
4	Satisfied with extent organisation values my work	54%	46%
5	Would recommend organisation as place to work	75%	68%

Against the trends – RD&E

Royal Devon University Healthcare NHS Foundation Trust

A combination of significantly improved score in the last year and a higher score vs the average, similar trust :

- Staff reported that they have an improved set of shared objectives, over 2% higher than other that at other trusts and last year.
- Staff report improved scores for experienced harassment, bullying or abuse from managers and colleagues, both vs 2020 and other trusts.
- Staff feel secure raising concerns about unsafe clinical practice and they would feel confident that organisation would address concerns about unsafe clinical practice.

A combination of significantly historical decline and significantly worse score vs the average trusts :

- RD&E staff are 1.5% less satisfied with opportunities for flexible working patterns compared to similar trusts, a decline of -2.2% in the last year and -4% since 2018.

A significantly worse score vs the average trust:

- Staff report feeling less able to make improvements happen in their area of work, 3% lower score vs national average since 2020 and 9% since 2018.
- Colleagues highlight that they are less able to meet all the conflicting demands on their time at work, coupled with a -10% decline vs 2020 in enough staff at organisation to do their job properly.
- Team members report their team meets less often to discuss the team's effectiveness, RD&E's score is 2.6% worse score than the average trust.
- Staff score all questions about appraisals as lower than the average a/c trust, ranging between 1-8% behind similar trusts across the four questions.
- Staff report 1% less likely to access the right learning and development opportunities, vs scores at similar trusts.

Against the trends - NDHT

- NDHT shows improvements to staff knowing what their work responsibilities are, despite a decline seen nationally
- The average scores for staff feeling that their organisation would address their concerns shows a decline, however NDHT has seen a improvement
- Significant uplift in the number of staff reporting harassment and bullying when they experience it, compared to average
- Decrease seen in the number of staff reporting musculoskeletal problems as a result of work, against the increasing trend seen nationally
- A significant improvement seen in staff feeling pressure from managers to come to work, compared to static position nationally
- Improvements in staff feeling the organisation acts fairly with regard to career progression, whilst a decline is seen nationally
- Staff feeling like their role makes a difference to patients – NDHT showing lower than average score
- NDHT showing sharper decline in staff feeling satisfied with the recognition they get for good work, having been a top scoring trust for the previous 2 years
- A sharper decline seen in staff reporting that they are involved in changes in their work areas, when compared to the national small decline
- Sharp decline seen in staff reporting physical violence incidents at work, despite a smaller decrease seen nationally.
- Significant decline seen in NDHT's scores around teams having shared objectives, whilst the national average remains fairly static

What do we need to think about?

RD&E	NDHT
A better than expected result, post very challenging COVID-19 period. 56 of the 92 questions (60%) significantly higher scores vs similar trusts.	High performing trust nationally, within South West region and Devon ICS
Scores for the four questions covering Appraisals have significantly worsened and performing significantly below the comparator group.	Appraisals was the only sub-score that saw a below average score – the quality of appraisals was above average, but the number being completed was 4% lower than average
Staffing level at Trust the most declined score (-9.4%) within the 2021 survey, this follows national trend.	Despite burnout scores being above average – scores were low across this sector
New questions on burnout included in survey, RD&E score just above average in this sub-theme.	Results tell a similar story to that nationally – staff are suffering from burnout, experiencing higher stress levels and staffing levels are at a critical level
Improved scores for Managers; all nine questions rated significantly higher vs comparator group (7) or last year (2).	Historically trust has been one of the highest performers for scores around immediate managers – this gap is narrowing and needs review
83% of Health, Well-being & Safety questions scored higher, or significantly higher than the comparator group (20 of 24 questions).	A need to understand the differing experiences between groups of staff – division / department / staff group etc, to identify specific areas of focus

Next steps

RD&E & NDHT
A task & finish group has been established and will receive presentation of results for both organisations side by side by Picker (scheduled for 26 April).
Task & finish group will then split into two separate groups, looking at each organisations results in more detail and identifying and agreeing priorities for a cross-organisational response.
Further data analysis will be completed, looking at hotspots and differing experiences of staff groups to understand where specific, targeted actions may be required.
Trust wide action plans will be created to address key areas of concern / priorities identified by the task and finish group. Plans to be monitored through task and finish group and through other committees, i.e. PWPW and Partnership Forum.
Divisional and department level action plans to look in detail at findings in each of these areas, and actions to address. Divisional Directors to be held accountable for delivery of plans through Performance Assurance meetings.
Ways in which cross-organisational learnings and improvements can be shared will be reviewed to ensure joint action where possible, and shared learning for mutual benefit – where applicable, linking key areas together to share best practice.
Looking ahead, the quarterly People Pulse survey and cultural dashboard will provide a robust, continuous feedback cycle for staff, with ongoing actions for improvement, with the NHS Staff Survey providing an annual check-in.

Appendices

- Inclusion
- South West Benchmarking

Inclusion

Organisation provides equal opportunities for career progression/promotion:

- **RD&E: 62% of White Staff and 45.7% of 230 all other ethnic staff**
- **NDHT: 63% of White Staff and 44.5% of 110 all other ethnic staff**

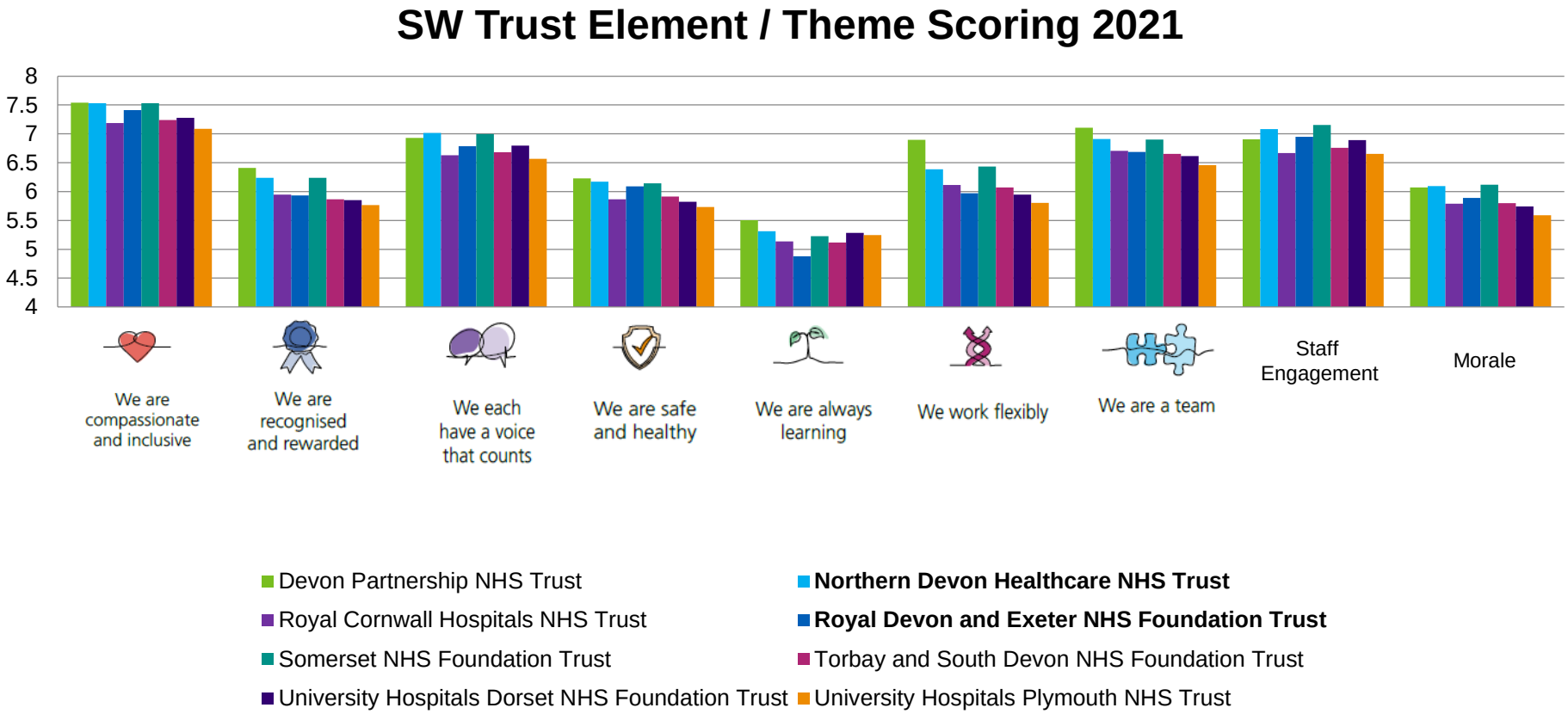
Staff from all other ethnic groups combined – benchmarking average – 44.6%

Personally experienced discrimination from any of the following: Manager / team leader or other colleagues

- **RD&E: 6.1% of White Staff and 15.5% of all other ethnic staff**
- **NDHT: 4.3% of White Staff and 17.3% of all other ethnic staff**

Staff from all other ethnic groups combined – benchmarking average – 17.3%

South West benchmarking



Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	11.3, Public Board Meeting		**Date:** 27 April 2022	
Title:	People Plan Update			
Prepared by:	Alex Tait, Executive Support Manager & Hannah Foster, Chief People Officer			
Presented by:	Hannah Foster, Chief People Officer			
Responsible Executive:	Hannah Foster, Chief People Officer			
Summary:	This paper and appended presentation provide an overview of the work being undertaken on the NHS People Plan focussing on progress at a local level.			
Actions required:	This paper is being presented to ensure the Board are aware of the Trust progress against the People Plan and have the opportunity to feed comments back to the People Function.			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
			X	
History:	A People Plan update is received by the People, Workforce Planning and Wellbeing Committee on a quarterly basis, with the last update having been received at the March 2022 meeting. Going forward it has been agreed that there will be a 6 monthly update to the Board.			
Link to strategy/ Assurance framework:	The issues discussed are key to the Trust and wider system achieving their strategic objectives.			

Monitoring Information

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

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

1. Purpose of Paper

This report has been written to provide an update on the Royal Devon University Healthcare NHS Foundation Trust's progress against the NHS People Plan[1]. Whilst much of the People Plan work is being driven within the Integrated Care System (ICS), this paper focuses primarily on progress being made within our Trust.

2. Background

The NHS People Plan was published in July 2020, setting out actions over a period of four years to support transformation for our people across the whole of the NHS. In November 2020 an overview of the plan was shared with the Board and since then the People, Workforce Planning and Wellbeing Committee (PWPW) have received quarterly progress updates.

This plan has an ambitious and broad set of goals, encompassed in the following headings:

- Looking after our people
- Belonging in the NHS
- New ways of working and delivering care
- Growing for the future

Central to the NHS People Plan is the NHS People Promise (See figure 1). The elements that make up the People Promise are the things all employees should be able to say about working in the NHS by 2024. This may already be the case for many; however, this promise pledges that in the future this will be the case for everyone working in the NHS.

The People Promise gives the Trust and the ICS the Employee Value Proposition (EVP) for the future, which we need to make a reality for our people.

Figure 1 - The NHS People Promise

[1] Link to The NHS People Plan

3. Analysis

Moving forward it has been recognised that it is vital that the NHS People Plan is intrinsically linked to the new Trust Corporate Strategy. In line with this, one of the four key objectives of the new Trust will be to create 'a great place to work' for our people. This objective will be achieved by aligning our goals with the aforementioned four headings of the NHS People Plan.

In order to help organisations to understand where their strengths and weaknesses are against the People Promise; the 2021/22 NHS Staff Survey aligned the questions with each element of the People Promise. This means that as we move forward, any actions agreed as a result of feedback from the Staff Survey will be intrinsically linked with the goals of the People Promise and NHS People Plan.

A PowerPoint presentation has been included (appendix 1) detailing the latest update on our local progress against the NHS People Plan.

4. Resource/legal/financial/reputation implications

Whilst much progress has been made against the NHS People Plan, it is important for the Board to recognise the current workforce and operational pressures, and the potential impact these may have on delivery the People Plan.

From a People Function perspective, these risks will be partially mitigated by the new senior structure, which is now almost fully recruited to (appendix 2). This structure provides centres of expertise in key areas, where historically resource has been minimal, so will enable real progress to be made on our strategic objectives. It is, however, important to note that many of the goals within the NHS People Plan will impact outside of the People Function and will require wider engagement with operational teams. This is the area is likely to be a challenge due to operational pressures.

5. Link to BAF/Key Risks

At present, the NHS People Plan is referenced as a mitigation / potential mitigation on RD&E BAF risks 7 & 9 and NDHT BAF risks 6 & 7.

6. Proposals

It is proposed that this report and appendices are discussed and accepted by the Board, with updates being provided on a bi-annual basis moving forward.

Royal Devon University Healthcare
NHS Foundation Trust

Trust Progress Against the NHS People Plan

Hannah Foster, Chief People Officer

Overview of the People Plan

Royal Devon University Healthcare NHS Foundation Trust

- The NHS People Plan was published in July 2020, setting out actions over a period of four years to support transformation for our people across the whole of the NHS.
- Delivery of the NHS People Plan is being led at a system level; however as a Trust we are working to embed the principles of the People Plan and People Promise throughout the Trust.
- This plan has an ambitious and broad set of goals, encompassed in the following headings, which will form the basis of our Corporate Objective to be ‘a great place to work’:
  - Looking after our people
  - Belonging in the NHS
  - New ways of working and delivering care
  - Growing for the future

What is the 2030 vision for NHS HR and OD?

The 4 strands of the People plan

Commitments in the People Promise

Vision for HR & OD teams

The emerging strategy for the Trust, our People Team vision and its recent People team restructure is completely consistent with this vision

Great Place to Work strategic objective

Royal Devon University Healthcare
NHS Foundation Trust

- Health & wellbeing
- Effective leadership and management
- Understanding and improving our employee experience

- Inclusion
- Retention
- Recognition & values
- Just and Learning Culture
- Freedom to speak up & employee voice

- New ways of working and delivering care
- Digitally enabled
- Mobile & flexible
- New and innovative roles
- Workforce plan
- Data & intelligence

- Development plan
- Local engagement & partnerships
- Recruitment & marketing

How will we measure progress?

Royal Devon University Healthcare NHS Foundation Trust

We have already started to look at more intelligent measurement with improved data collection and reporting to enable an understanding of where our culture is and track movement. We will continue this journey through:

- Delivery of workforce plan
- Cultural & wellbeing dashboards
  - Tracking People pulse, national survey and other metrics
  - Reported quarterly
  - Trend analysis by service area, role, location and demography
- Retention data
  - Improved against system and geography
- Progression data
  - Able to demonstrate we have grown our own
  - Anchor organisation outcomes
- Values feel embedded and understood
- Reflect on achievements and successes regularly

Recent successes

Systems & Data

- New Head of Systems, Data and Insight post recruited to
- Introduction of Qualtrics to measure employee experience and facilitate the People Pulse surveys
- Exit interviews in north now digital via Qualtrics
- Full alignment of IPR data across north and east achieved
- Alignment of regular data sets to ICS and joint working on preparation
- Development of an Employee Relations Dashboard

Recruitment & Retention

- Career webinars developed & used in North, starting to be used in East attracting those new into care as part of HCSW programme
- Continuation of promoting healthcare as a career choice via virtual work experience
- HCSW R&R Task & Finish Group set up
- Monthly Hard to Fill meetings successfully resulting into some key senior appointments being made and good quality recruitment packs (Page Tiger)
- Made link with the Princes Trust to get local people into roles in the NHS (clinical and non clinical)
- Return to some F2F interview days on site and at local events and colleges (subject to IPC approval)
- International Recruitment remains strong – welcomed over 70 RNs across East and North

Recent successes

Wellbeing and Employee Experience

- Assessment against the revised NHS H&WB framework
- Launch of a unified Employee Assistance Programme platform (Vivup)
- Guidance on how our employees can build wellbeing into everyday working has been developed and communicated to managers
- Participation in the national ‘NHS Flex for the Future’ programme
- Established a Joint Staff Wellbeing Group
- Established a Joint Morale Programme Group

Diversity & Inclusion

- Appointment of new Associate Director of Wellbeing, Inclusion & Employee Experience post
- Appointment of new Diversity & Inclusion Analyst post
- Reciprocal mentoring programme underway
- Inclusion action plans have been developed
- Coaching and interview preparation sessions are now in place
- Three staff networks have now been fully established
- Introduction of specialist inclusion training for staff
- Establishment of culture clubs for staff

Recent successes

People Development

- New Learning Management System (Learn+) launched in the north
- New online appraisal process including 1-2-1 meetings launched
- Became a full provider of apprenticeships in the east
- Launched People Development Academy
- Management development support package launched
- Full utilisation of HEE Continuous Professional Development (CPD) funds

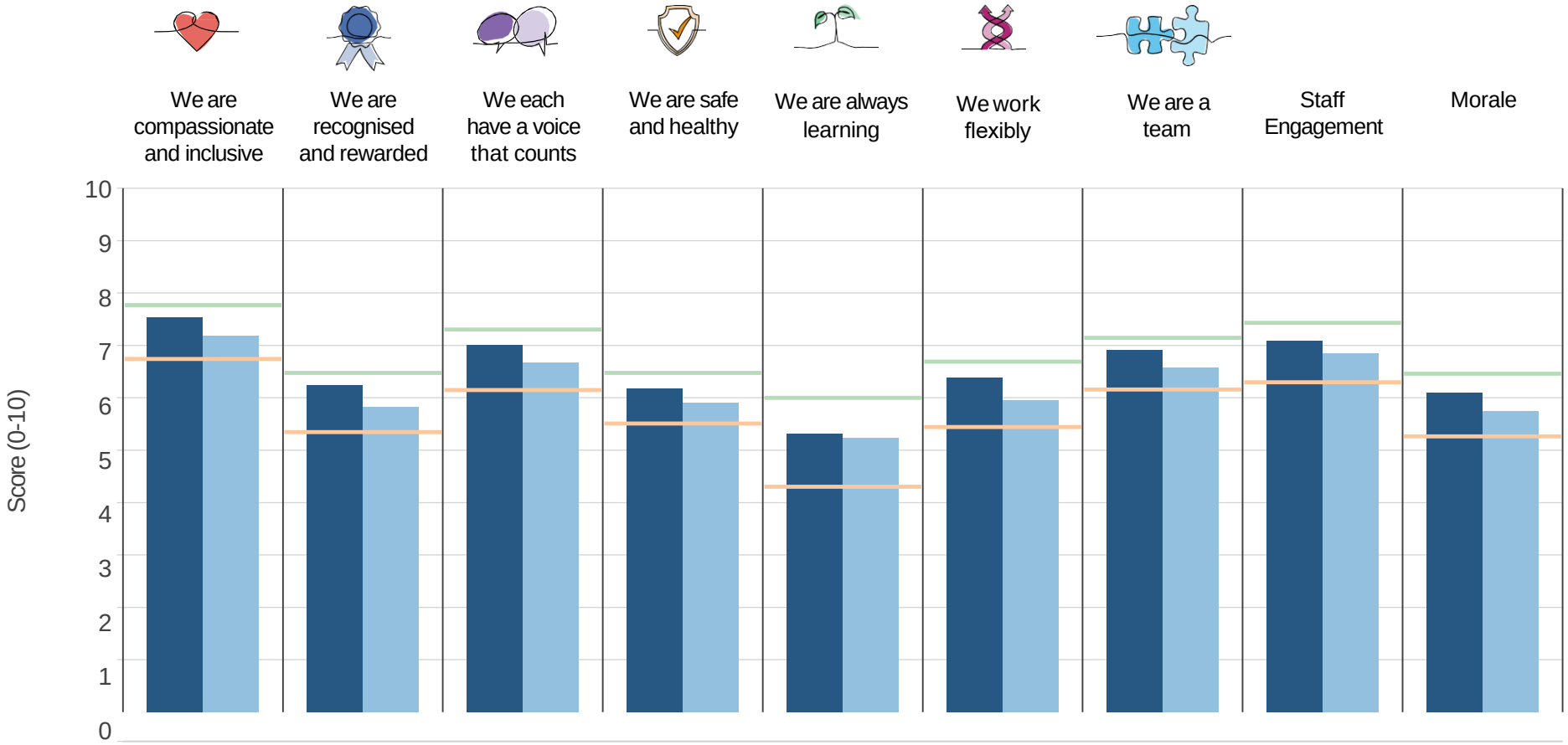
Other Achievements

- Completed the Senior Function Restructure including centres of expertise in People Development and Wellbeing, Inclusion and Employee Experience
- Further cultural work including restorative justice training having been scheduled and surveys to understand staff perception of the current culture and also to understand their vision for the future organisation

Royal Devon
University Healthcare
NHS Foundation Trust

Northern Devon 2021 NHS Staff Survey Results

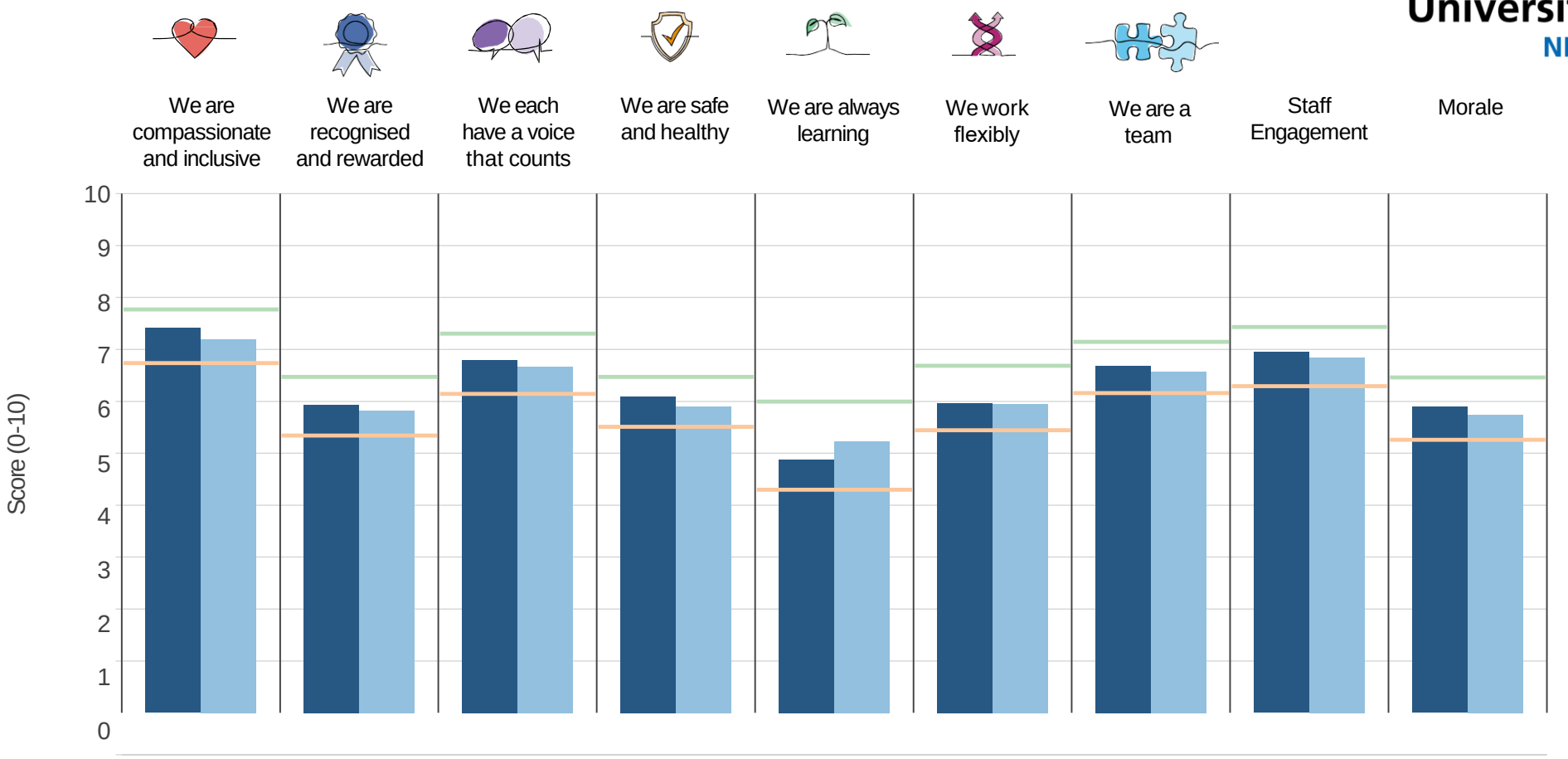
Royal Devon University Healthcare NHS Foundation Trust



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.5	6.2	7.0	6.2	5.3	6.4	6.9	7.1	6.1
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	1,796	1,793	1,782	1,788	1,714	1,784	1,790	1,796	1,795

RD&E 2021 NHS Staff Survey Results

Royal Devon University Healthcare NHS Foundation Trust



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.4	5.9	6.8	6.1	4.9	6.0	6.7	6.9	5.9
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	3,978	4,063	3,926	3,964	3,779	4,038	3,990	4,069	4,060

NHS People Plan - Actions for Employers How Have We Performed?

Royal Devon University Healthcare NHS Foundation Trust

- The NHS People Plan set out a number of actions for employers and systems as well as the national teams.
- The next slides demonstrate progress made against the employer actions and are split into the following categories:
  - Health and wellbeing
  - Flexible working
  - Equality & diversity
  - Culture & leadership
  - New ways of delivering care
  - Growing the workforce
  - Recruitment & retention

Health & Wellbeing Employers Actions

Royal Devon University Healthcare NHS Foundation Trust

Put in place effective infection prevention and control procedures.

Ensure that all staff have access to psychological support.

Support staff to use other modes of transport and identify a cycle-to-work lead.

Make sure line managers and teams actively encourage wellbeing to decrease work-related stress and burnout.

Ensure people have sufficient rests and breaks from work and encourage them to take their annual leave allowance in a managed way

Ensure all staff have access to appropriate personal protective equipment (PPE) and are trained to use it.

Appoint a wellbeing guardian.

Prevent and tackle bullying, harassment and abuse against staff, and a create a culture of civility and respect.

Every member of NHS staff should have a health and wellbeing conversation.

Ensure staff have safe rest spaces to manage and process the physical and psychological demands of the work.

All frontline healthcare workers should have a vaccine provided by their employer.

Complete risk assessments for vulnerable staff, including BAME colleagues and anyone who needs additional support, and take action where needed.

Prevent and control violence in the workplace – in line with existing legislation.

Ensure people working from home can do safely and have support to do so, including having the equipment they need.

Ensure that workplaces offer opportunities to be physically active and that staff are able to access physical activity throughout their working day.

All new starters should have a health and wellbeing induction.

Identify and proactively support staff when they go off sick and support their return to work.

Complete

In Progress

Early Stages / Not Started

Health & Wellbeing Employers Actions

	Action	Progress
1	Put in place effective infection prevention and control procedures.	Complete
2	Ensure all staff have access to appropriate personal protective equipment (PPE) and are trained to use it.	Complete
3	All frontline healthcare workers should have a vaccine provided by their employer.	Complete
4	Complete risk assessments for vulnerable staff, including BAME colleagues and anyone who needs additional support, and take action where needed.	Complete
5	Ensure people working from home can do safely and have support to do so, including having the equipment they need.	Agile working guidance / policy required Long term space review needed including the longer term strategy for staff working remotely
6	Ensure people have sufficient rests and breaks from work and encourage them to take their annual leave allowance in a managed way	Much work complete (i.e. management comms, rest space upgrades etc. but lots still to be done. Operational pressures and staff shortages prevent staff taking breaks and annual leave
7	Prevent and tackle bullying, harassment and abuse against staff, and a create a culture of civility and respect.	Cultural work underway – again much has already been completed (civility sessions for staff, restorative justice, appointment to Lead Freedom to Speak Up Guardian), but this will take time to fully embed.
8	Prevent and control violence in the workplace – in line with existing legislation.	A number of interventions are in place such as zero tolerance posters, breakaway training and conflict resolution training. There is also security presence on the larger sites with processes in place to report and monitor incidents. There has been a reported increase in violence and aggression incidents in some areas of the Trust, so more work needs to be done to reduce these.
9	Appoint a wellbeing guardian.	Complete – CEO is the Wellbeing Guardian for the Trust

Health & Wellbeing Employers Actions Cont.

	Action	Progress
10	Support staff to use other modes of transport and identify a cycle-to-work lead.	Cycle to work lead identified in the East, need to establish if there is a lead in the north. Work has been undertaken to support staff using other modes of transport such as ensuring all staff have completed a personal travel plan to show staff the greener alternatives for travel before applying for a Trust travel pass. There is more still to be done to support staff to use other modes of transport and move away from commuting in private cars. This is exacerbated by the rurality of Devon and a lack of public transport infrastructure in some areas.
11	Ensure staff have safe rest spaces to manage and process the physical and psychological demands of the work.	Some work has been done to improve the quality of many existing rest spaces, but there are still several gaps and an ongoing plan for a 3 year rest space strategy will be key to this.
12	Ensure that all staff have access to psychological support.	Complete – In place and is being delivered by the OH counselling and wellbeing team, the Employee Assistance Programme (EAP) and via Talkworks. During the pandemic this support has been taken to areas of greatest need, recognising staff cannot always leave their role to visit OH team. This support has been very well received by staff.
13	Identify and proactively support staff when they go off sick and support their return to work.	KPI's are monitored on completion of return to work interviews taking place within the eastern services. The Employee Relations Team deliver regular sickness workshops for line managers on sickness management and the associated processes. Involvement of OH can be sought through either the line manager or a self referral where needed, including phased return, temporary redeployment or adjustments required. Whilst lots is already in place, there is still more to be done to proactively support staff returning to work.
14	Ensure that workplaces offer opportunities to be physically active and that staff are able to access physical activity throughout their working day.	There are very limited opportunities i.e. through classes such as yoga, but there are lots of opportunities to improve this further. Ambition has been limited due to Covid restrictions.
15	Make sure line managers and teams actively encourage wellbeing to decrease work-related stress and burnout.	Line managers are encouraging wellbeing initiatives; however, operational pressures and the current staffing levels are a significant barrier to enabling staff to be able to prioritise their wellbeing.
16	Every member of NHS staff should have a health and wellbeing conversation.	A dedicated wellbeing section has been built into the Trust 1-2-1 and annual appraisal process, which gives staff the opportunity to discuss their health & wellbeing as well as any actions to support them. This is relatively new, so data on completion of this will need to be understood to ensure these conversations are happening.
17	All new starters should have a health and wellbeing induction.	Complete - An introduction to the Trust health & wellbeing approach is included in the corporate induction for all staff.

Other Employers Actions

Royal Devon University Healthcare NHS Foundation Trust

Requesting flexibility – whether in hours or location, should (as far as possible) be offered regardless of role, team, organisation or grade.	Encourage our former people to return to practice as a key part of recruitment drives during 2020/21, building on the interest of clinical staff who returned to the NHS to support the COVID-19 response.	Make sure future potential returners, or those who plan to retire and return this financial year, are aware of the ongoing pension flexibilities.	Ensure people have access to continuing professional development, supportive supervision and protected time for training.	Use HEE's e-Learning for Healthcare programme and a new online Learning Hub, which was launched to support learning during COVID-19.	When recruiting temporary staff, prioritise the use of bank staff before more expensive agency and locum options and reducing the use of 'off framework' agency shifts during 2020/21.
Continued focus on developing skills and expanding capabilities to create more flexibility, boost morale and support career progression.	51 per cent of organisations to have eliminated the ethnicity gap when entering into a formal disciplinary processes.	Cover flexible working in standard induction conversations for new starters and in annual appraisals.	Review governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes.	Ensure that staff who are mid-career have a career conversation with their line manager, HR and occupational health.	Publish progress against the Model Employer goals to ensure that the workforce leadership is representative of the overall BAME workforce.
Increase recruitment to roles such as clinical support workers, highlighting the importance of these roles for patients and other healthcare workers as well as potential career pathways to other registered roles.	Employers should fully integrate education into their plans to restart clinical services, releasing time of educators and supervisors; and providing an increased focus on support for students and trainees	Board members must give flexible working their focus and support.	For medical trainees, employers should ensure that training in procedure-based competencies is restored as services resume to sustain the pipeline of new consultants in hospital specialties.	Design roles which make the greatest use of each person's skills and experiences and fit with their needs and preferences.	Discuss equality, diversity and inclusion as part of the health and wellbeing conversations described in the health and wellbeing table.
Offer more apprenticeships, ranging from entry-level jobs through to senior clinical, scientific and managerial roles.	Ensure staff are aware of the increase in the annual allowance pensions tax threshold.	Overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets.	Use guidance on safely redeploying staff, developed in response to COVID-19, alongside the existing tool to support a structured approach to ongoing workforce transformation.	Be open to all clinical and non-clinical permanent roles being flexible.	Roll out the new working carers passport to support people with caring responsibilities.

Flexible Working Employers Actions

	Action	Progress
1	Be open to all clinical and non-clinical permanent roles being flexible.	Have engaged with the national Flex for the Future programme and will be exploring a number of the initiatives from this programme. All jobs are advertised as 'flexible' as standard, however there is work still to be completed in this area
2	Cover flexible working in standard induction conversations for new starters and in annual appraisals.	Health and wellbeing of employees is discussed in both 1-2-1 and the annual appraisal process. This provides an opportunity for flexible working to be discussed in order to support a healthy work life balance, however there are no specific questions in the template. Flexible working is also discussed as part of corporate induction.
3	Requesting flexibility – whether in hours or location, should (as far as possible) be offered regardless of role, team, organisation or grade.	Complete – this is now offered from day one and included in our Flexible Working Policy.
4	Board members must give flexible working their focus and support.	The Chief People Officer acted as the Executive sponsor for the Trust to partake in the NHS flex for the future programme.
5	Roll out the new working carers passport to support people with caring responsibilities.	This action has not yet been completed; however work has taken place to improve the Carers Policy.

Equality & Diversity Employers Actions

	Action	Progress
1	Overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets.	Action plan in place, with some limited progress having been made, i.e. disability confident accreditation in place, positive action steps taken around senior recruitment, introduction of the specialist and executive recruitment team, reciprocal mentoring programme.
2	Discuss equality, diversity and inclusion as part of the health and wellbeing conversations described in the health and wellbeing table.	No specific mention of ED&I as part of 1-2-1 and appraisal, however this is being explored.
3	Publish progress against the Model Employer goals to ensure that the workforce leadership is representative of the overall BAME workforce.	No progress has been published against model employer goals; however some data exists from WRES that can be used to support analysis. Work will be completed to publish progress against the Model Employer goals.
4	51 per cent of organisations to have eliminated the ethnicity gap when entering into a formal disciplinary processes.	Complete - Data reflects that there is no ethnicity gap in our organisation. It is acknowledged that other organisations are out of our control, therefore the status of this action reflects only the areas within our direct control.

Culture & Leadership Employers Actions

	Action	Progress
1	Review governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes.	The Diversity and Inclusion steering group is Chaired by the CEO and regular D&I updates are received by the Board and PWPW. Network Chairs are invited to the D&I steering group to contribute to discussions, however attendance needs to be improved to ensure meaningful discussion and change.

New Ways of Delivering Care Actions

	Action	Progress
1	Use guidance on safely redeploying existing staff and deploying returning staff, developed in response to COVID-19 by NHSEI and key partners, alongside the existing tool to support a structured approach to ongoing workforce transformation.	Dynamic redeployment process for use at daily staffing meetings for staff able to move immediately together with structured redeployment process managed by the Employee Relations Team for staff able to fulfil medium-term assignments e.g. clinical staff joining the Testing Team in OH in the eastern services. The process utilises up-to-date individual COVID risk assessments, OH advice and use of Staff Risk Matrix. Many of our approaches link in with elements of the HEE Star tool, however further work will be progressed to understand how this tool might further support our workforce redesign.
2	Continued focus on developing skills and expanding capabilities to create more flexibility, boost morale and support career progression.	A management development support package has been launched to support managers and their teams with continually developing their skills and support as a result of the challenges presenting over recent years. Career conversations are built into appraisals. Bitesize training has also been developed to provide more flexibility for those who may be unable to be released for a whole day.
3	Use HEE's e-Learning for Healthcare programme and a new online Learning Hub, which was launched to support learning during COVID-19.	Learn+ has been launched in North and due to launch in East over the coming months. HEE e-learning for health is used as part of the online core learning catalogue.

Growing the Workforce Employers Actions

	Action	Progress
1	Employers should fully integrate education and training into their plans to rebuild and restart clinical services, releasing the time of educators and supervisors; supporting expansion of clinical placement capacity during the remainder of 2020/21; and providing an increased focus on support for students and trainees, particularly those deployed during the pandemic response.	Launch of management development support package to supporting managers and their teams with development and support.
2	For medical trainees, employers should ensure that training in procedure-based competencies is restored as services resume and are redesigned to sustain the pipeline of new consultants in hospital specialties.	Training has been restored in procedure based competencies; however at this stage it is not possible to say for sure that all individuals have caught up with training that was missed during the pandemic.
3	Ensure people have access to continuing professional development, supportive supervision and protected time for training.	The Trust offers an extensive catalogue of development opportunities and has maximised the usage of HEE CPD funding for clinical staff; however operational pressures have made it difficult to release staff for training & development. Bitesize training modules have been released to improve the flexibility of the offer.

Recruitment & Retention Employers Actions

	Action	Progress
1	Increase recruitment to roles such as clinical support workers, highlighting the importance of these roles for patients and other healthcare workers as well as potential career pathways to other registered roles.	Complete – Development of recruitment strategy to attract candidates who are 'new into care', career webinars prior to application & interview using clinical staff describing the role of HCSW. Career pathway infographics have also been developed.
2	Offer more apprenticeships, ranging from entry-level jobs through to senior clinical, scientific and managerial roles.	Complete
3	Encourage our former people to return to practice as a key part of recruitment drives during 2020/21, building on the interest of clinical staff who returned to the NHS to support the COVID-19 response.	Complete, but with limited staff returning to practice in this period.
4	When recruiting temporary staff, prioritise the use of bank staff before more expensive agency and locum options and reducing the use of 'off framework' agency shifts during 2020/21.	Work to increase recruitment to Central Bank, including medical, nursing and AHP students, linking with Exeter and Petroc college students & encouraging staff friends and family. Strict controls in place using tiering structure through Bank modules of rostering system. Bank workers are booked in advance and can replace agency workers at any time thereafter. Senior authorisation required for 'off framework' bookings and rule in place to not accept any agency worker who holds a substantive or FTC contract with another Devon Trust.
5	Design roles which make the greatest use of each person's skills and experiences and fit with their needs and preferences.	Roles determined by service need and managed through formal job matching process. Reasonable adjustments made where needed involving OH as necessary. Flexible working policy in place and encouraged to use including annual review of any flexible working arrangement to ensure working well for both parties. Internal Expressions of Interest and secondment opportunities regularly advertised to utilise known internal skills and experience prior to any external adverts.
6	Ensure that staff who are mid-career have a career conversation with their line manager, HR and occupational health.	All staff will have a detailed conversation about career progression and their aspirations for the future at their annual appraisal with their line manager; however this would not currently include HR and Occupational Heath. Further understanding of this is required and options can then be considered.
7	Ensure staff are aware of the increase in the annual allowance pensions tax threshold.	Complete - Staff have been made aware of this through all staff comms and writing to individuals most likely affected. This information is also published on the pension pages on staff intranet.
8	Make sure future potential returners, or those who plan to retire and return this financial year, are aware of the ongoing pension flexibilities.	Complete - Staff have been made aware of this through all staff comms and writing to individuals most likely affected. This information is also published on the pension pages on staff intranet.

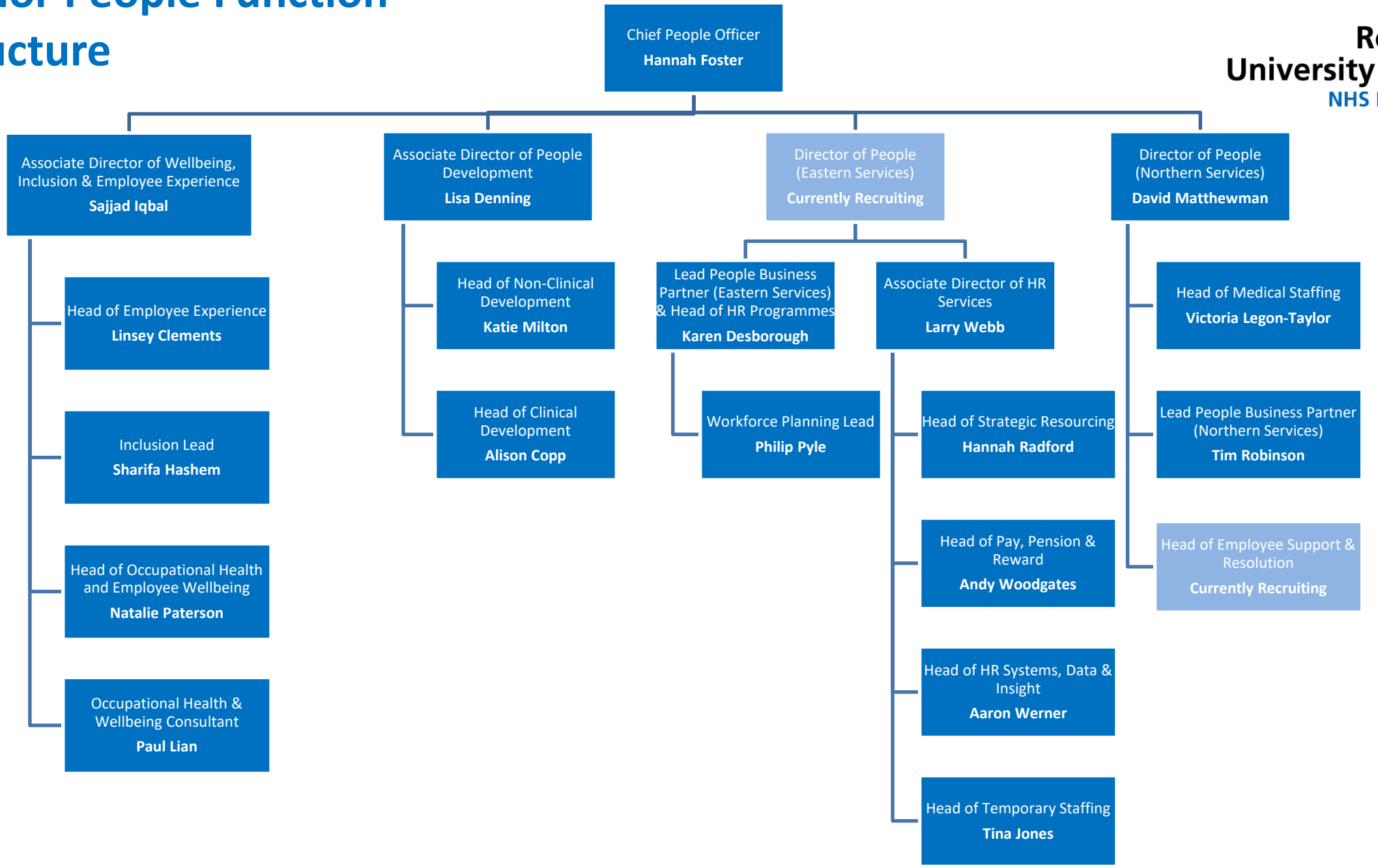
Next Steps

Royal Devon University Healthcare NHS Foundation Trust

- Working to embed the new senior People Function structure
- Work ongoing on key streams of work that are already in progress, i.e. workforce plan, integration of systems and processes, code of conduct etc.
- Development of individual roadmaps for each part of the People Function
- ‘Great Place to Work’ 5 year roadmap to be developed as part of the Corporate Strategy, encompassing delivery of the People Plan
- Royal Devon University Hospitals NHS Foundation Trust People Strategy to be fully developed
- All of the above to be in line with the Trust Corporate Strategy & NHS People Plan

Senior People Function Structure

Royal Devon University Healthcare NHS Foundation Trust



Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	11.4, Public Board meeting		**Date:** 27 April 2022	
Title:	Annual Review of the Board Schedule of Reports			
Prepared by:	Melanie Holley, Director of Governance			
Presented by:	Melanie Holley, Director of Governance			
Responsible Executive:	Suzanne Tracey, Chief Executive			
Summary:	The Board is asked to review and approve the Schedule of Reports for 2022/23 to ensure it receives the correct reports at the right time during the course of the year in order to conduct its business effectively.			
Actions required:	For the Board to review and approve the Board Schedule of Reports 2022/23.			
Status (*):	**Decision**	**Approval**	**Discussion**	**Information**
		x		
History:	The Board Schedule of Reports is reviewed annually.			
Link to strategy/ Assurance framework:				

Monitoring Information

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

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

1. Purpose of paper

The purpose of this paper is for the Board to review and approve the Schedule of Reports for 2022/23 to ensure it receives the correct reports at the right time during the course of the year in order to conduct its business effectively.

2. Background

The Schedule of Reports is reviewed annually.

3. Analysis

The Schedule of Reports is attached. The Board is asked to consider the following:

- Proposal to replace List of Outstanding Business Cases with either quarterly or six-monthly Corporate Roadmap Update
- Any other changes to the schedule it may deem necessary to ensure it remains fit for purpose for 2022/23

4. Resource/legal/financial/reputation implications

None.

5. Link to BAF/Key risks

None.

6. Proposals

The Board is asked to consider and approve the draft Schedule of Reports for 2022/23.

Apr-22

BOARD OF DIRECTORS REPORTS SCHEDULE FOR 2022/23

	April	May	June	July	August	Sept	October	November	December	January	February	March	Frequency	Responsible Exec - are these still correct?	Comment
Policy & Strategy															
Annual Report & Quality Report update	✓												*Annually, as required - C*	*Chief Executive / Chief Nursing Officer*	
Annual Accounts - Draft	✓												*Annually, as required - C*	*Chief Finance Officer*	
Annual Report & Quality Report - Approval		✓											*Annually, as required - C*	*Chief Executive / Chief Nursing Officer*	
Annual Accounts - Approval		✓											*Annually, as required - C*	*Chief Finance Officer*	
Budget Setting Update											✓		*Annually, as required - C*	*Chief Finance Officer*	
Budget												✓	*Annually, as required - C*	*Chief Finance Officer*	
Operational Plan - approval of draft											✓		*Annually, as required - C*	*Chief Finance Officer*	
Operational Plan - approval of final												✓	*Annually, as required - C*	*Chief Finance Officer*	
Operational Capacity & Resilience Plan							✓						*Annually for approval -P*	*Chief Operating Officer*	
Strategy Update - IPR 6 monthly report							✓						*6 monthly after sign off - P*	*Chief Executive*	
Towards Inclusion	✓			✓			✓			✓			*Quarterly - P*	*Chief Executive*	
Treasury Management Policy approval								✓					*Bi-Annually (next due Nov 2021) - C*	*Chief Finance Officer*	Approved November 2021 - date of next review November 2023
Performance															
Integrated Performance Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	*Every Month - P*	*All*	
NIHR CRN SWP Annual Report and Annual Plans				✓									*Annually as required - P*	*Chief Medical Officer*	
Assurance															
~~Annual Clinical Staffing Review (was establishment review).~~ Six Monthly Safe Staffing Review		✓								✓			*Annually- P*	*Executivce Medical Director and Chief Nurse*	This was presented as Six Monthly Safe Staffing Report at Nov 21 Board with next update due May 2022, so will change to twice a year Nov & May
Annual Complaints Report to the Board										✓			*Annually - P*	*Chief Nursing Officer*	
Annual Review of Register of Directors Interests	✓												*Annually, ahead of production of Annual Report - P*	*Chief Executive / Head of Governance*	
Annual Sustainability & Development Plan										✓			*Annually - P*	*Deputy Chief Executive*	
Audit Committee Report		✓	✓	✓				✓			✓		*Quarterly - P*	*Chief Financial Officer / Chair of AC*	Propose to have an update to each Board meeting following a Committee meeting: so Feb, May, July, November plus possible additional meeting June if needed for Ann Accts
Board Assurance Framework	✓			✓			✓			✓			*Four times a year - C*	*Chief Executive/Director of Governance*	
Corporate Risk Register	✓												*Annuallly (to coincide with the last quarterly review of the BAF)-C*	*Chief Executive/Director of Governance*	
Corporate Governance Statement			✓										*Annually C (required by NHSI)*	*Chief Executive/Director of Governance*	To be approved by Board by 30 June each year
Corporate Roadmap Update													*Either quarterly or half yearly - C*	*Deputy Chief Executive*	Email 24.03.22 asking for this to replace previous annual presentation of list of outstanding business cases
Corporate Trustee meeting								✓					*Annually - separate mtg*	*n/a*	
Digital Committee	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	*After each meeting - TBC*	*Non-Executive Director Chair*	
F1 Quality Improvement Academy Presentation				✓									*Annual - P*	*Chief Medical Officer*	
Governance Committee Report	✓		✓		✓	✓	✓		✓	✓	✓		*Quarterly - P*	*Chief Executive/Chair of GC*	Update to each Board meeting following a Committee meeting: so Feb, April, June, August (or Sept if no August Board), Oct, Dec (or Jan if no Dec Board)
Guardian of Safe Working Hours quarterly report		Q4 & Annual Report				Q1		Q2			Q3		*Quarterly - P (schedule for this report updated in Jan 2021 at AH/AC request)*	*Chief Medical Officer*	Report to move to a joint report from Q2 (Nov Board) as agreed at September Board
Infection Control Annual Programme				✓									*Annually - P*	*Chief Medical Officer*	
Infection Control Annual Report				✓									*Annually - P*	*Chief Medical Officer*	
Integration Programme Board reports	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	*Monthly - C*	*Chair, IPB*	Added as a monthly report
Items for escalation to the BAF	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	*Monthly - P & C*	*All*	
~~*List of outstanding business cases*~~													*Annually-C*		*To be removed from the schedule going forward as per email CT 24.03.22 advising that it will be replaced by a quarterly / half yearly report to Board on the Corporate Road Map which will encompass a tracking function*
Operational Plan - Condition G6 and Condition CoS7 self-certs		✓											*Annually - C*	*Chief Financial Officer*	To be approved by Board by 31 May each year
My Care Programme update	✓	✓	✓	✓	✓								*Monthly - C*	*Chief Medical Officer*	ND MyCare Programme Board meeting monthly until Sept 2022 - Go Live July 2022
~~Medical Appraisal & Revalidation Report~~						✓							*Annually - P*	*Chief Medical Officer*	From 2022 will no longer come direct to Board - instead presentation to JGC then reported to Board through JGC report September (email J Hobbs 12.10.21)
Our Future Hospitals Programme Board	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	*Monthly as required - C*	*NED Committee Chair*	Report to Board after each meeting
People Plan Update	✓						✓						*Bi-Annually (April & October) - P*	*Chief People Officer*	Added as a bi-annual report as requested at HF appraisal 2021 & email AT 10.03.22
Remuneration Committee Report			✓										*Annually, as required - C*	*Chair of Rem Comm*	
Research & Development Annual Report						✓							*Annually - P*	*Chief Medical Officer*	
Staff Survey Results												✓	*Annually - P*	*Director of People*	
Information															
Review of schedule of reports	✓												*Annually - P*	*Chief Executive/Director of Governance*	

Royal Devon University Healthcare
NHS Foundation Trust

Agenda item:	9.7, Confidential Board Meeting		**Date:** 27 April 2022	
Title:	Report from the 24 March 2022 Charity Sub-Committee meeting			
Prepared by:	Clare Degenhardt, Financial Accounts Manager			
Presented by:	Alastair Matthews, Non-Executive Director (Chair of the Charity Sub-Committee)			
Responsible Executive:	Angela Hibbard, Chief Financial Officer			
Summary:	The purpose of this document is to provide the Corporate Trustee with an overview of the matters discussed at the 24 March 2022 Charity Sub-Committee meeting.			
Actions required:	The Corporate Trustee is asked to acknowledge the matters discussed at the Charity Sub-Committee meetings.			
Status (*):	**Decision**	**Approval**	**Discussion**	**Information**
			Yes	**Yes**
History:				
Link to strategy/ Assurance framework:				

Monitoring Information

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

Care Quality Commission Standards	Outcomes		
NHSI		Finance	✓
Service Development Strategy		Performance Management	
Local Delivery Plan		Business Planning	
Assurance Framework		Complaints	
Equality, diversity, human rights implications assessed			
Other *(please specify)*			

1. Purpose of paper

The purpose of this document is to provide the Corporate Trustee with an overview of the matters discussed at the recent Charity Sub-Committee meeting.

2. Background

2.1 The Charity Sub-Committee's purpose is:

- To oversee the operation of the Charity on behalf of the Trustee;
- To give assurance to the Trustee that charitable funds are managed and operated in accordance with the governing documents and comply with relevant legislation and guidance from the Charity Commission for England and Wales; and
- To make recommendations, as agreed at its meetings, to the Trustee, for its approval or otherwise.

2.2 Copies of the Minutes of the 24 March 2022 Charity Sub-Committee meetings together with the supporting papers are available from the Financial Accounts Department if required.

2.3 Section 3 below provides an overview of the matters discussed at the Sub-Committee meeting.

3. Analysis

3.1 Fundraising Update

Ian Roome (IR) presented an update on fundraising. The Fundraising team have adopted a 'hybrid' model of fundraising for 2022, combining a mix of physical and virtual events as the country emerges from the pandemic.

The requirement for the Charity to have a fundraising ambition and objectives was discussed, and it was noted that the Fundraising Team needed a campaign to be approved, in order to formulate a longer-term plan. It was agreed that a three-year plan for the combined Charity be brought to the October 2022 meeting of the Sub-Committee, which would then go to the Corporate Trustee for approval.

3.2 Financial update

The Charity Sub-Committee received a financial update for the ten months to 31st January 2022 The financial performance of the Charity was discussed and noted by the Charity Sub-Committee.

3.3 Charity Integration

At the time of the meeting, the actions to be undertaken before the two charities could merge on 1st April 2022 were all on track. The on-line form to formally advise the Charity Commission (CC) of the merger, the closure of the ND Charity and its linked charities, and the Charity's new name and objectives would be submitted once the Grant of Acquisition letter was received from NHSEI. (Post meeting update: the form and accompanying documentation were submitted to the CC on 31st March 2022).

Further work is scheduled to take place over the following months to fully integrate the Charity.

3.4 Creating the Environment – using the grants made to the Trust

Paul Honey (PH) presented the next stages of the Creating the Environment scheme. The plans to incur this capital expenditure over the next three years were discussed. It was noted that this expenditure would come from the Trust's allocated capital, and therefore put a strain on the capital programme, but the members of the Sub-Committee confirmed that they did want the granted funds to be spent over the next three years as planned, and asked for assurance on this point.

3.5 Methodology for apportioning the Fundraising Department costs and utilising unrealised investment gains

A paper setting out the considerations for charging the Fundraising Department costs to the Charity, and for using some of the unrealised gains, was discussed. The Sub-Committee agreed that for 2022/23 onwards, Fundraising Department costs would be recharged to the Charity, and would be apportioned across campaigns and other funds, including the unrealised gain control funds. The proportion to be charged to campaigns would be based on the Fundraising Department pay costs for campaigns. This proportion, once agreed, would not be expected to fluctuate year on year. Any direct fundraising costs are to be charged to the appropriate campaign.

Historically, the RD&E charitable funds administration costs have been offset by investment income, with any excess costs being charged against the unrealised gain control funds. The ND funds have been charged administration and fundraising costs. The proposal is for funds to bear any excess of allocated costs in excess of allocated investment income.

The forthcoming change will be communicated to Fund Holders. This may come as an unwelcome surprise, but the communication will stress the benefits that the Fundraising Department will provide for all funds, as well as for the Charity more widely.

4. Resource/legal/financial/reputation implications

It is the Board of Directors' responsibility to ensure that the NHS Body fulfils its duties as the Corporate Trustee when it manages the charitable funds.

5. Link to BAF/Key risks

There are no additional risks identified.

6. Proposals

The Board is asked to note the matters discussed at the Charity Sub-Committee meeting.

Royal Devon University Healthcare NHS Foundation Trust

Agenda item:	12.1, Public Board meeting		**Date:** 27 April 2022	
Title:	Ockenden Report			
Prepared by:	Carolyn Mills, Chief Nursing Officer			
Presented by:	Carolyn Mills, Chief Nursing Officer & Adrian Harris, Chief Medical Officer			
Responsible Executive:	Carolyn Mills, Chief Nursing Officer & Adrian Harris, Chief Medical Officer			
Summary:	The Ockenden – Final report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust (SaTH) was published on 30 March 2022 following a five year review of maternity care at Shrewsbury and Telford Hospital NHS Trust. The review found "significant or major concerns" around maternity care provided by SaTH between 2000-2019 which resulted in 201 deaths, 131 still births and 70 deaths during the neonatal period. The Board of Directors has a duty to prevent the failings found at Shrewsbury and Telford Hospital NHS Trust happening in our organisation.			
Actions required:	The Board of Directors are asked to review the contents of this report, to note the immediate action taken following the receipt of the final Ockenden report and the process for undertaking a full assessment against the fifteen essential and immediate actions identified.			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
			x	
History:	Since the publication of the first report from the inquiry in December 2020, the Board of Directors in Public Board or in Board sub committees has received assurance regarding the Trust's delivery against the identified seven immediate and essential actions to improve quality and patient safety across maternity services nationally. In addition: • The Board assurance process for providing a clear line of sight of maternity services has been reviewed and strengthened. • Ockenden suggests multidisciplinary teams will work better together and there has been investment in training. • To support multidisciplinary team working culture, a development programme for leaders in Northern location was commissioned. • A further review of the workforce establishment and skill mix was undertaken and investment made to deliver on the consultant-led ward rounds & to meet the full midwife requirements of birth rate plus.			
Link to strategy/ Assurance framework:	Strategic objective 1: Listen to people to build on and continually improve what we do.			

Monitoring Information

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

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

1. Purpose of paper

The purpose of this paper is to provide the Board with an overview position of findings, conclusions and essential actions from the independent review of maternity services at SaTH – the final Ockenden report. This final report paints a tragic and harrowing picture of repeated failures in maternity care which has led to unimaginable trauma for so many families.

The final report builds upon the first Ockenden report in that all the immediate and essential actions (IEAs) within that initial report remain important and must be progressed. The final report identifies a number of new themes and 15 areas as IEAs that should be considered by all trusts in England providing maternity services. Some of these include:

- the need for significant investment in the maternity workforce and multi-professional training
- suspension of the midwifery continuity of carer model until – and unless – safe staffing is shown to be present
- strengthened accountability for improvements in care among senior maternity staff, with timely implementation of changes in practice and improved investigations involving families
- Listening to families
- Creating a culture where all staff feel able to speak up.

2. Background

The Ockenden – Final report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust (SaTH) was published on 30 March following a five year review of maternity care at Shrewsbury and Telford Hospital NHS Trust. The review found “significant or major concerns” around maternity care provided by SaTH between 2000-2019 which resulted in 201 deaths, 131 still births and 70 deaths during the neonatal period.

The report paints a tragic and harrowing picture of repeated failures in maternity care which has led to unimaginable trauma for so many families. The Board has a duty to prevent the failings found at Shrewsbury and Telford Hospital NHS Trust happening in Royal Devon University Healthcare NHS Foundation Trust.

3. Analysis

Maternity services (Northern and Eastern locations) have undertaken an initial review of the 15 areas identified for immediate and essential actions. This review is ongoing and will be supported by using an overarching assessment National Health Service England (NHSE) designated toolkit devised to support providers to assess their current position & provide assurance of effective implementation to their boards. The

Local Maternity System, NHS England and NHS Improvement regional teams will be part of this review.

The Eastern location took the decision to not go live with the planned implementation of the Midwifery Continuity of Carer (MCoC) model in April 2022. This was as a result of the current staffing resource identified as needed to implement MCoC which included the use of preceptee midwives, the use of which to support this care delivery model appears to be contraindicated in the final Ockenden report. This pause will enable a full review of the proposed staffing position to ensure that all the building blocks needed for a sustainable model are in place.

4. Resource/legal/financial/reputation implications

Nil at this time

5. Link to BAF/Key risks

BAF risk no. 5 & 4 – the Trust suffers from significant workforce supply issues/clinical capacity and capability to deliver, transform and sustain services.

6. Proposals

Nil