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

Wednesday 29 June 2022
Via MS Teams

MINUTES

PRESENT	Mrs C Burgoyne	Non-Executive Director
	Mrs H Foster	Chief People Officer
	Professor A Harris	Chief Medical Officer
	Mrs A Hibbard	Chief Financial Officer
	Professor B Kent	Non-Executive Director
	Mr S Kirby	Non-Executive Director
	Mr A Matthews	Non-Executive Director
	Mrs C Mills	Chief Nursing Officer
	Dame S Morgan	Chair
	Mr T Neal	Non-Executive Director
	Mr K Orford	Non-Executive Director
	Mr J Palmer	Chief Operating Officer
	Mr C Tidman	Deputy Chief Executive
APOLOGIES:	Professor J Kay	Non-Executive Director and Senior Independent Director.
	Mrs S Tracey	Chief Executive Officer
IN ATTENDANCE:	Ms G Garnett-Frizelle	PA to Chairman (for minutes)
	Mrs J Gott	Assistant Director of Governance
	Ms Z Harris	Divisional Director (Observer)

		ACTION
085.22	**CHAIR'S OPENING REMARKS**	
	The Chair welcomed the Board, members of the public, Governors and observers to the meeting. The Chair reminded everyone it was a meeting held in public, not a public meeting, and asked for questions at the end focussed on the agenda. She asked members of the public to only use the 'chat' function within MS Teams at the end to ask any questions and reminded everyone that the meeting was being recorded via MS Teams. **The Chair's remarks were noted.**	
086.22	**APOLOGIES**	
	Apologies were noted for Mrs Tracey and Professor Kay. Professor Kent advised that she would have to leave the meeting at approximately 11:15.	
087.22	**DECLARATIONS OF INTEREST**	
	Mrs Gott informed the Board that the following new declarations for the Board's Register of Interest had been received from Mrs Tracey: Member, NHS Employers Policy Board	

	Member, NHS Assembly	
088.22	**MATTERS TO BE DISCUSSED IN THE CONFIDENTIAL MEETING**	
	The Chair noted that a meeting of the Finance and Operational Committee would take place between the public and confidential Board sessions, and an update on business transacted would be provided in the confidential Board. In addition, the following items were on the Boards' confidential agenda: updates from the Audit Committee, Digital Committee, Governance Committee, the Integration Programme Board, MyCare Programme Board and Our Future Hospitals Programme Board. The Board would be approving the Corporate Governance Statements, reviewing the Annual Remuneration Committee Report and receiving an Endoscopy Business Case.	
089.22	**MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 25 MAY 2022**	
	The minutes of the meeting held on 25 May 2022 were considered and approved as an accurate record.	
090.22	**MATTERS ARISING AND BOARD ACTION SUMMARY CHECK**	
	Action check The actions were noted as per the tracker with the following additional updates: *Action 077.22 (2) – Information to be included in the next IPR to provide an overview of the length of time over 4 hours that patients were waiting in ED*. Mr Palmer informed the Board that for Northern services, there had been 1270 patients waiting over four hours in the reporting period, of which eight became twelve hour waits which provided assurance that even in times of extreme pressure waits were being managed to a reasonable level. For Eastern services in the same reporting period, 4083 patients had waited more than four hours, of which 53 became twelve hour waits. The action was noted as closed. *Action 080.22 – Professor Harris to check with Dr Davies whether the Board could provide assistance to her relating to recruitment of a Guardian of Safe Working for the northern locality*. Professor Harris advised that Dr Davies had been grateful for the offer of assistance. An advert had gone out regarding recruitment of a new Guardian of Safe Working for Northern services with a closing date of 6 July 2022. There had been an offer from Dr Colville, Guardian of Safe Working in Eastern services, to extend his role to encompass the northern locality which had been appreciated, however the view of the medical leadership and the junior doctors was that it would be better if a senior doctor from the north could be found. If the recruitment proved unsuccessful however Dr Colville's offer would be taken up. The action was noted as closed. **The Board of Directors noted the updates.**	
091.22	**CHIEF EXECUTIVE OFFICER'S REPORT**	
	Mr Tidman provided the following updates to the Board.	

National Update

- The Fuller Stocktake Report on Next Steps for Integrating Primary Care was recommended to the Board. The report argued that Primary Care Networks should evolve into Integrated Neighbourhood Teams, with secondary care consultants aligned to them with Commissioners incentivising this.
- The financial position was very challenging as the country exited Covid. Despite additional funding being made available by NHS England for the impact of inflation, it was clear there was still a financial gap which all systems were working hard to close. NHS Providers had noted that some of the efficiency requirements for 2022-23 were very challenging and could lead to some difficult choices for all systems.
- The Secretary of State had recently announced that the Government remained committed to delivery of 48 new hospitals by 2030, despite reported concerns about affordability and delay.
- A review of NHS management commissioned by the Department of Health, and undertaken by Sir Gordon Messenger and Dame Linda Pollard, contained seven key recommendations. These included a single set of core leadership and management standards for NHS managers and a more effective appraisal system. There was also a focus on behaviours, which aligned with the Royal Devon's work on its Corporate Strategy.
- NHS England's Medical Director announced during June that peaks during the recent Omicron wave had been quite severe, but total Covid admissions had fallen. It was noted that whilst admissions had started to rise slightly during June, using international comparators for the latest Covid variants higher levels of hospitalisation were not being seen. This will be kept under review, in particular regarding the impact on staff sickness absence levels.
- NHS England recognised that the NHS does have a lower bed base compared to other health systems and there will be a review of overall bed numbers. It was acknowledged that the NHS had operated in the past at a high level of efficiency and bed occupancy but this didnot afford any head room.
- Two thirds of patients waiting nationally longer than two years for treatment had now been treated. The Government announced that all patients waiting longer than two years would be offered treatment elsewhere in the country and be supported with travel expenses and accommodation.
- A new report from Healthwatch highlighted the impact of long waiting times on health inequalities. The report found that patients were struggling to access information and services when they were waiting for treatment and made a number of recommendations, including publishing waiting list data in a way that includes disparities.

System Issues

- The Devon Integrated Care System (ICS) will become a statutory body from 1 July 2022 and will be known as One Devon. A three-day event was planned during the first week of July to launch the new ICS and its operating model. The Trust is committed to help shape development of the ICS.
- The Devon System submitted its revised operational plan to the regional team last week and feedback was awaited. The plan outlined Devon's improvement trajectories for the coming year and how the system will live within its resources. The plan was not quite at breakeven, but did show significant improvement with the deficit now at £18m, which sits with the Royal Devon, largely as a result of post-Covid funding movements. The revisions to the plan had resulted in pausing of some non-critical spending plans and had left the system with no real

contingency. The Trust is working with the system to strengthen plans and further de-risk the position.

Local issues

- Significant operational pressures were being experienced across the whole of Devon, including at the Royal Devon. Both Emergency Departments and Acute Medical Units were very busy, leading to longer waiting times. This was being managed well, with teams remaining under pressure but continuing to work collaboratively with South West Ambulance service and neighbouring hospitals, with the focus remaining on patient safety.
- Patients fit for discharge remained an issue and the Trust was working closely with Social Care and Mental Health partners to ensure that patients moved through the system in a timely way.
- Good progress had been made on elective recovery, with new facilities operating well. The Trust had been visited by Maria Caulfield MP, Minister of State for Health for Patient Safety and Primary Care and Selaine Saxby MP during which they had been shown the new Jubilee Ward created to help clear the Orthopaedic backlog. In addition, the South West Ambulatory Centre at the Exeter Nightingale Hospital continued to increase its activity having treated 267 patients needing hip or knee replacement surgery by 28 June, with 60% able to return home on the same day following surgery.
- Preparations for Go Live of MyCare in North Devon on 9 July were continuing.
- Work continued to support staff wellbeing, in particular supporting those affected by cost of living challenges.
- A leadership away day was held on 17 June with leaders from both eastern and northern services. The sessions were used to talk about the organisation's vision for the next three to five years and values.
- The Executive Team and Non-Executive Directors had joined the Extraordinary People Awards ceremony held at Sandy Park in Exeter on 21 June. Over 300 staff had been nominated for awards and attended the event.

Ms Morgan informed the Board that she, together with Mrs Hibbard, had visited the Emergency Department at the Department's request so that they could better understand the pressures being experienced by staff. They were told at that visit that there were 89 patients in beds but ready for discharge if a care package had been available for them, which highlighted the importance of finding a way of increasing patient flow and tackling the difficult issues around patient discharges.

Mr Kirby noted the recognition that the NHS in general is under bedded, adding that it is known within the system that Devon is particularly under bedded. He suggested that the Board should consider how it could feed into the NHS England review of overall bed numbers. Mr Tidman agreed that this would be something that should be done at a Devon system level which could then feed into Board deliberations on this issue. Professor Kent agreed that it was imperative that bed stock was reviewed across the county. Mr Palmer commented that bed stock would be an area of intense focus for the winter plan to find a way to increase bed base appropriately, in particular step-down beds.

Mr Palmer advised that operational pressure had built over the preceding 20 days, in part due to a slight sharpening of Covid presentation, as well more general pressures. This increase had presented through minors' pressure from a primary care function that was struggling, difficulties with social care discharges and the number of complex mental health presentations in ED which required a great deal

	of handling to be either admitted as inpatients or required significant navigation through local services. These issues had been discussed by the Executive Team and the Chief Executive had asked Mr Palmer to formally write to the ICS how to performance manage these situations, not all of which are completely within the Royal Devon's gift. **The Board of Directors noted the Chief Executive's update.**	
092.22	**PATIENT STORY**	
	Mrs Mills presented the Patient Story video to the Board which was from the Maternity Voices representative for eastern services. Maternity Voices is an independent organisation focussed on giving every woman on the maternity pathway the opportunity to have their voice heard, championing those voices at national level. They work on five key principles: coproduction of solutions as equal partners, to seek out and listen to the voices of women, birthing people, their families and carers, champion service users' experience within review of services, to look at interdependencies between staff satisfaction and birthing people's experiences and pursuing continuous quality improvement with a focus on equality. The story presented focussed on the 15 Step Challenge, which is a way of looking at services through the user's eye, which was commissioned by the local Maternity and Neonatal Services part of the Commissioners Assurance Review relating to the Ockenden Report. As it was quite a complex narrative regarding what the people who had undertaken the review of eastern services had seen, their full report would be circulated to the Board after the meeting, together with a similar report for northern services. **Action.** Mrs Mills advised that the story clearly linked to the patient experience priority in the Patient Experience Strategy and the ongoing work with the Patient Experience Committee to deliver the Strategy, as well as the priorities around maternity services. Ms Morgan commented that the story was a good reminder of how it feels as a patient to be coming to a place that you are not familiar with, where patients may notice things that staff may have become desensitised to, such as the screen saver mentioned in the video that was showing information about the Red Alert for Covid on every computer screen that patients had to walk past. Professor Kent agreed that it was an excellent reminder for staff of how they become so used to seeing things in a certain way, that they no longer see how they may be interpreted by someone not familiar with them. Mr Neal said that he had been particularly struck by the comment about patients feeling that they belong in the space. In addition, he had noted the comments about inclusion and getting a diversity of view and asked what was being done to get that wider view in terms of feedback from service users. Mrs Mills responded with regard to this particular visit by the Maternity Voices representatives, they had acknowledged that whilst it had been an important lens to look at services through, both participants had been white women and could not cover the totality of service users' views on services. She added that more broadly one of the key tenets of the Patient Experience Strategy was to proactively engage with communities representing the seldom heard voices within feedback, with a number of actions in place which it is hoped will start to deliver this, including broadening the reach of the Patient Involvement Group currently based in North Devon across the wider	

	Royal Devon footprint. Through this, it is hoped to build relationships with leaders of hard to reach groups. Mrs Burgoyne asked whether a Maternity Voices representative would be included in the membership of the Patient Experience Committee and whether the wider information gathered through exercises such as the 15 Steps programme would be brought to the Patient Experience Committee for consideration. Mrs Mills advised that membership of the Patient Experience Committee had been discussed with the Chair of the organisation in Devon who had agreed that a representative would be provided to attend meetings. In addition, Mrs Mills advised that the 15 Steps are included in one of the quality assessments of wards, which also look at other more quantitative measures of quality as well as patient experience; it would therefore be necessary to consider how to disaggregate the patient experience material from these assessments for presentation to the Patient Experience Committee. Mrs Mills agreed to discuss this with Andrea Bell. **Action.** Mr Kirby noted the comment about the number of paper signs that were observed on the walkround of the maternity department and suggested that this should perhaps be looked at, as it creates the wrong impression for visitors to the department. In addition, Mr Kirby informed the Board that he had recently, in his role as Maternity Champion, been advised that new mothers are often approached to give feedback about their experience of care shortly after giving birth, but more useful feedback may be gained at a later date once the new mother has had time to recover and settle into her new role as a parent. He suggested that the Patient Experience Committee may wish to consider, both in the context of maternity but also more widely across other services, on how to get feedback from service users at a later stage when they may have had time to reflect on their experience. Mr Tidman commented that with regard to paper notices and posters, work is in hand to address this and refresh all information that is made available across all sites. He commented that the statement in the video that you can get a feel for a place within 15 minutes of arriving was very true and advised that related to this, the Facilities Team were encouraged to walk around the site to look with fresh eyes at areas, to actively look for things that stood out and could be easily fixed. An update on changes made through these Facilities Team walkrounds would be provided to the Patient Experience Committee later in the year. **The Board of Directors noted the Patient Story.**	
093.22	**INTEGRATED PERFORMANCE REPORT**	

	Mr Palmer presented the Integrated Performance Report (IPR) for activity and performance for May 2022 with the following key points highlighted:
	
	• Whilst May had been a good month in general terms, it was noted that high pressure had started to be seen during June.
	• Covid-19 data had been scaled back in the report due to the reduction in numbers and expected trajectory in the reporting period, however this will be kept under review as new variants develop.
	• Recovering the future:
	  ○ Urgent care flow remains challenging with recent weekends experiencing extremely busy days.
	  ○ Significant work is ongoing regarding 104 week waits.	

- There had been Executive escalation during the past week due to the continued system pressures in Primary Care, Social Care and Mental Health services.

- Collaborations and partnerships:
  - The Winter plan is an area of focus both for the organisation and the system as a whole.
  - There has been strong delivery on complex long-stay patient placement work, led by Tracey Reeves with system partners. Of ten very complex patients with up to 12-month lengths of stay, three had been found placements within the last week.
- Excellence, Innovation and Patient Care:
  - Stroke performance in northern services had stabilised and relatively good performance had continued for eastern services.
- Successes
  - Datix and the ESR system have been integrated across the organisation.
  - Close to delivering on 104 week wait targets. Following work with the NHSE/I Intensive Support Team, approximately 100 patients who had not previously flagged in Epic waiting lists had been validated and they were being absorbed into activity plans.
  - The Jubilee Ward had completed its first month of operation since opening.
  - Key appointments had been made to the Cancer leadership team.
- Opportunities
  - Discussions are underway with Ramsay Healthcare regarding Orthopaedic capability for the future.
  - Discussions were also ongoing with NHSE/I on the potential for seven day working in theatres at the Nightingale and Wonford sites to help support system elective recovery.
  - A business case was on the agenda for the confidential Board meeting for the Endoscopy service.
- Priorities
  - System sign-off of the Financial and Operational Plan.
  - Work with the divisions on improvements to Delivering Best Value.
- Risks
  - The roll out of MyCare in northern services with go live scheduled for 9 July.
  - The potential of increasing Covid pressures and the impact on staffing. Professor Harris informed the Board that there were currently two new Covid variants prevalent in the United Kingdom, BA.4 and BA.5. BA.5 is growing 35.1% faster than Omicron BA.2 and BA.4 is growing at 19.1% faster. This will mean that BA.5 will become the dominant strain in the UK. This is being reflected in patient numbers, with 41 currently at the RD&E and 11 at NDDH. There was no evidence that this variation is any more dangerous than previous variants; whilst there have been an increased number of admissions, increased severe illness or death was not being seen. The organisation will need to continue to be vigilant whilst accepting that Covid will continue to be with us for the foreseeable future and the NHS will continue to develop ways of working with Covid. There is debate on the best ways of doing this, both nationally and globally.
  - System flow pressures.

Mr Orford posed the following question:

1. RTT numbers looked better in the east than in the north. Was the MyCare roll out a factor in this variation?

Mr Palmer responded that MyCare roll out was a factor to a degree, but mutual aid was also impacting northern performance. With the opening of the Jubilee Ward in NDDH, the northern team have been supporting eastern services in chasing down long wait activity, with the majority of this activity in northern services currently supporting eastern services. This will be negotiated carefully over the coming months to ensure that an inequity in northern services does not become embedded. Mr Orford asked if this was likely to continue and whether there was any intervention that the Board could agree that could help turn this around. Mr Palmer responded that, as previously mentioned, there had been a suggestion from NHSE/I in discussions around 104 week waits, that the Trust should bring forward a potential revenue package to bring theatres at the Wonford and Nightingale sites to seven-day working. It may be that once this has been worked through with a potential trajectory for the next six-months, the Board will be able to assist with the negotiations with NHSE/I.

With regard to the impact of the MyCare roll out, there had been a planned reduction of around 15% in activity either side of the My Care implementation date to provide head room and free up resource to assist with implementation.

Mr Matthews asked the following questions:

1. The level of diverts was mentioned in the IPR; what was the volume of these diverts and what was the likely impact on the Trust's performance.

   Mr Palmer responded that the Trust was currently in system conversations every few days about offering divert support to either University Hospitals Plymouth (UHP) or Torbay and South Devon, although northern services have also required support at times. Although there had been the beginnings of a reduction in diverts, as would be expected at this time of year, these had started to increase again, with 18 diverts over the course of one weekend recently, four of which were forecourt diverts from UHP. One of these was a trauma patient who subsequently had to be sent back to Derriford and this had been escalated with a request for formal documentation of the events and the learning. Mr Palmer added that trends on this would be drawn out in the IPR going forward.

   Ms Morgan said that she would welcome seeing whatever information was available for a defined period on the number, source and complexity of divert cases, as she believed divert had been intended as an emergency measure, but it appeared to be increasingly becoming a standard procedure. This would provide the Board with a view on the additional requirements being placed on the Trust. Mr Palmer agreed that this could be drawn out in the next IPR.

2. He was concerned at seeing staff turnover continuing at high levels and asked if the level of vacancies was known. In addition, if the high level of turnover continued what was being planned in terms of recruitment for key staffing groups, for example newly qualified nurses, to address this going into winter.

   Mrs Foster responded that as previously noted at Board there were two different views of turnover that had not been reviewed for some time and this had now been undertaken, with the way turnover is looked at now being aligned with vacancy and finance to look at the average for the last 12 months. Turnover at the Royal Devon is lower than elsewhere in the system, but higher than the organisation would have been previously used to. In terms of vacancy

numbers, whilst the intention will be to share this information with the Board, there had not been confidence that the vacancy position was fully understood; however now that the Operational Plan is nearing sign-off, this would be reviewed. Mrs Foster added that it was likely that some recruitment would have to be accelerated to get ahead of the potential vacancy number. Mrs Mills commented that any risks identified from the realignment of the turnover data sets were being mitigated. Mr Matthews responded that it would be helpful if the data could be converted into something simpler that gave the Board a view of what turnover and vacancy rates were expected to look like in six or nine months and what was being done to manage any risks. Mr Palmer agreed that this would be worked on over the coming months in future iterations of the IPR to provide trajectories for the Board.

3. There had been discussion at the May Board meeting around why the Trust was flagging in the margins of the expected ranges for mortality data, which was attributed to a coding issue. Had these issues now been worked through and was coding found to be the cause as suspected?

   Professor Harris advised that mortality data is retrospective, with current data reflecting the February position, with the coding position still being recovered. Assurance for the Board was that the data point, SSMR, is unaffected by coding, with the RD&E's SSMR data remaining low. In addition, to provide further assurance, he advised that the Structured Judgement Reviews (SJR) continued to improve, with the backlog being reduced, surgeons being recruited to undertake SJRs and the narrative data providing assurance regarding mortality. There would continue to be a correction of the SSMR data over the coming months; it was noted that whilst the supposition was still that this was a coding issue, this could not be confirmed until the issue had been completely worked through.

4. The summary noted that there had been no significant movement in the measures around quality, however the level of 30-minute waits for ambulance handovers had doubled and there had been an increase in issues noted with infection control which would both impact on quality.

5. The concern around delivery of best value had been flagged in the summary of challenges and he would appreciate the opportunity to understand this in more detail.

   Mrs Hibbard responded that this would be covered in detail in the Finance and Operational Committee meeting later that day, but that it was recognised that the Delivering Best Value target for the year of £33.5m was heavily predicated on productivity and benefits through the ERF funding, which make up about half of the total and are at greatest risk. More will be known once the first cut of the ERF funding results is received from the national team which will be released after the quarter 1 position and will inform the Trust of where it is in relation to this and what needs to be done to drive it further.

Mrs Burgoyne asked the following questions:

1. Noting the earlier comments in the Chief Executive's report about bed numbers, where was modelling being undertaken both for bed numbers needed in the Trust and the equivalent in the community in terms of the wide

range of services needed, such as care home beds, step down beds, sheltered housing, that would provide places for green to go patients.

Mr Palmer commented that as part of this year's Winter plan work, available bed modelling would be refreshed. It was known that the Devon system had approximately 500 fewer beds than it was believed were needed, although these did not necessarily need to all be acute hospital beds. It would be important in the Winter cycle to have a blended approach with notification just received that further funding would be made available to continue development of the virtual ward model, to look at how to blend the skill mix and have more of a multi-disciplinary team approach. Discussions are also taking place on a possible model for Care Hotels.

2. The overview commented on the need to make escalations relating to primary care, social care and mental health. What specifically needs to happen to improve those areas?

   Mr Palmer said that the Royal Devon was raising with system partners key areas where they could help the Trust, with clarity being sought for Mental Health Services on what will be available in community services and crisis services for the coming Winter. In addition, some model of Mental Health Assessment Unit will be explored, although Mr Palmer added that it was recognised this might not be the best model but could provide a coping strategy for the Winter cycle.

3. What is the next stage of the vaccination programme for Covid?

   Professor Harris advised that the purpose of the Autumn vaccination programme will be to increase population immunity and protection against severe illness, hospitalisation and possible death from Covid. The current intention of the Joint Committee on Vaccination and Immunisation (JCVI) was to vaccinate the following groups: residents in Care Homes for older adults and their staff, frontline health and social care workers, all those over 65 years of age, adults aged between 16 – 64 in the clinical risk group. This may change depending on the epidemiology of current variants and other variants that come to prominence before the Autumn, as the JCVI may update guidance depending on the severity of the disease.

Mr Neal posed the following questions to the Executives:

1. Virtual outpatient percentages were noted as 22% and 27% against the notional target of 25% and asked what assurance there was that use of virtual clinics was appropriate to patients.

   Professor Harris commented that ideally a Test of Change would be undertaken and feedback sought on every virtual clinic, however there was not sufficient resource to make this feasible. However, feedback is sought and has been received and has shown whilst some patients do not like virtual clinics, the vast majority are very happy with the service. Professor Harris assured the Board that there is no compulsion on patients to attend virtual clinics, all patients are offered a choice and he was therefore reassured that no patients were being disadvantaged. He reminded the Board that Dr Stuart Kyle, who has been leading this transformation work, was due to attend the October

Board meeting to provide an update and suggested that he be asked to specifically address this issue in his update. **Action.**

2. The number of incidents reported relating to long waits was recorded as quite low. Where there had been an incident of harm due to long waiting was the Duty of Candour being fulfilled?

   Mr Palmer responded that the teams were in regular contact with every long-waiting patient in the system as part of the waiting well work being undertaken. In addition, the Trust is expected focus on this as part of the conditions of being in Tier 1. He advised that as of 24 June 2022, 28 patients on the list had proven uncontactable with all other long waiting patients having been contacted. Mr Palmer confirmed that Duty of Candour was being observed.

3. Staff sickness data for northern services over the last few months showed a significant number of absences related to respiratory illness and he asked if there was any particular reason noted for this increase? In addition, he asked if the sickness absence data excluded cases of Long Covid?

   Mrs Foster commented that the arc of respiratory illness in both Trusts was very similar which related in part to an increase in colds and coughs as the country came out of lockdown in the Spring of 2022. With regard to Long Covid, there were 19 cases recorded across both Trusts. The Occupational Health Team are supporting staff diagnosed with Long Covid and as the country moves into living with Covid, consideration will be given on how to support those staff long-term. Mrs Foster added that planning will need to be undertaken on sickness absence trajectories for the coming Winter.

Mr Kirby agreed with other Non-Executive comments that the IPR report was more focussed and forward looking, although he suggested that the use of the South West to benchmark the Trust against in the report should be reconsidered, in particular as the South West does not benchmark well against the rest of England. Mr Kirby also welcomed the inclusion of the cultural dashboard in the IPR, although noting that care would be needed in interpretation of the information as culture could not be compared month on month. He welcomed Mr Palmer's comments on less traditional ways of addressing green to go issues. He noted Mr Neal's comments about outpatients and added that some of the numbers seemed to be off, with no outpatient follow-up numbers for east, but northern figures showing a rapid increase and he asked whether there was a routine review of follow-ups to ask patients whether they still needed review. Mr Palmer responded that he shared some of the concerns on how data for outpatients was coming through, but advised that the NHSE/I team had been at the Trust over the last couple of months to work with the organisation as part of Tier 1 arrangements and will continue to work with the Trust on validation, including of outpatient data. In addition, independent work had been commissioned to help validate outpatient work. Mrs Hibbard advised that if there is a conversation about additional beds in the eastern and northern system, additional revenue would be required and there would need to be an assessment of the availability of workforce to ensure plans are credible.

Mrs Foster commented that the development of the cultural dashboard would continue as a system piece of work which will allow the Trust to see how it compares to other organisations within the system. Progress on cultural development will be measured through reports to the People, Workforce Planning

	and Wellbeing Committee and the six-month update report on the People Plan will also contain an update. Professor Kent commented that it was good to see improvements in diagnostics, but noted that it was being impacted by staff availability and asked whether this needed some scrutiny, particularly regarding service design, to establish whether there were any mitigations that could be put in place. In addition, she noted that there still appeared to be an issue with visas for overseas staff and asked whether there was anything more the Trust could do to help speed the process up. Mrs Foster said that there was a very challenging recruitment market, with the recruitment process not helped by not having the automation in place that was needed. A new system was due to launch on 27 July at the Trust which should help to start to address some of the delays in the current process. She added that with regard to visas work was being undertaken by the IR Hub in Devon. An area of greater challenge was finding accommodation and improvements have been made in signposting and pre-information provided to potential candidates. Mr Palmer added that the pressure on staffing remains acute, with medical staffing in particular over the last three weeks being particularly challenged due to a combination of recruitment coming on-stream, planned leave and unplanned leave and there was constant focus on managing the position. **No further questions were raised and the Board of Directors noted the IPR.**	
094.22	**AUDIT COMMITTEE REPORT**	

	Mr Matthews provided an update on the Audit Committee meeting held on 1 June 2022 with the following key points noted
	
	• Following an initial review at the Audit Committee meeting held in May 2022, the final drafts of the annual accounts, annual reports and quality reports were reviewed and signed off for presentation to the Extraordinary Board meeting held on 8 June 2022.
	• The External Auditors reports on their audits of both organisations were presented with no significant matters arising from either. Mr Matthews had previously raised a point for further exploration by the Auditors, where they had highlighted a potentially increased risk of medium-term financial sustainability in the Value for Money Opinion. It was noted that upon undertaking further work around this, the Auditors had concluded that there was no control issue to be raised.
	• The Committee received the Head of Internal Audit Opinion which gave significant assurance for both organisations, which was an increase for NDHT.
	• The Audit Committee recommended to the Extraordinary Board:
	  ○ approval of the accounts for both organisations;
	  ○ approval of the annual reports for both organisations; and
	  ○ following receipt of additional assurance regarding the data for the NDHT Quality Account, approval of quality reports.
	
	Mr Matthews noted the Committee's thanks to everyone involved in delivering two sets of each of the reports on time to what had been a challenging timetable and during a period when the two organisations had just merged.	

	The Board of Directors noted the Audit Committee update.	
095.22	**GOVERNANCE COMMITTEE REPORT**	
	Mr Kirby presented an update from the Governance Committee meeting held on 24 June 2022 drawing the Board's attention to the following points: • The Committee received a sub-committee report from the Clinical Effectiveness Committees which reported good progress was being made on integrated working of the eastern and northern Committees. • A Safety and Risk update report was presented which covered the five quality priorities, in particular the work that was being undertaken on the new patient safety regime due to be introduced in April 2023. • Two Never Event reports were received and the learning that had been identified was acknowledged. • Updates were provided medical staffing risks in the north and cardiology risks in the east, with assurance that the risks were being managed appropriately. • A summary of changes to the Corporate Risk Register was received. • The Committee received an update on progress against the Ockenden action plan, noting good progress was being made. • The Committee noted good progress on compliance work undertaken to ensure alignment with the maternity incentive scheme. • The Serious Incidents and Never Events Annual Report 2021-22 was received. • There was an update from the Patient Experience Committee; excellent work on the Patient Experience Strategy was acknowledged and the Committee received the workplan to accompany the Strategy. It was noted that progress was being made regarding the issues with delays in response times to complaints. • The Committee received the Head of Internal Audit Opinion, noting the excellent improvement in the north to significant assurance. • The Committee had a detailed discussion on end of life issues, with updates provided for northern and eastern service. The main issue related to Care Quality Commission compliance; it was noted that good progress was being made on actions related to this and a dashboard was being developed to provide a better line of sight on metrics used relating to end of life care. • An update was provided by the Medical Services Division governance team, with assurance provided that governance procedures have held up strongly, notwithstanding operational pressures. • The Committee received the bi-annual legal report, which included data about the increased number of inquests across the South West. No trend relating specifically to the Royal Devon was identified; this was a general trend across the peninsula. • The Freedom to Speak Up Guardian report was received. Good progress on awareness raising was noted now that the Freedom to Speak Up lead is in post. • The Committee discussed conducting a self-assessment, which is deemed good practice and consideration is being given on the best way to complete this. • The Committee approved the quality impact assessment process, which is of particular importance in the current financial context to ensure that safety and quality are prioritised above financial considerations. **The Board of Directors noted the Governance Committee update.**	

096.22	**ITEMS FOR ESCALATION TO THE NDHT & RD&E BOARD ASSURANCE FRAMEWORKS**	
	Ms Morgan asked whether Board members had identified any new risks or anything to add to existing risks from their discussions. Mrs Hibbard reminded the Board that there was review of the financial risks on the Board Assurance Framework (BAF) on the agenda for the confidential Board session later that day. Mr Tidman advised that Mrs Holley had undertaken an initial review of the BAF with a view to bringing the two BAF's together into one new BAF for the Royal Devon. This will be discussed by the Executive Team before being presented to the Board. The new BAF will be based on risks assessed against the Corporate Strategy. **No new risks were identified.**	
097.22	**ANY OTHER BUSINESS**	
	There was no other business raised for discussion. Ms Morgan informed the Board that this would be Mr Orford's last Board meeting for the Royal Devon and thanked him on behalf of the Board of Directors for his contribution to the work of the Trust. She added that the Board had valued his rigour, his commitment and his personal integrity and the challenge he had brought to Board on diversity and she looked forward to continuing to work with him in his new role for the Devon Integrated Care Board.	
098.22	**PUBLIC QUESTIONS**	
	The Chair invited questions from members of the public, staff and Governors in attendance at the meeting. Mrs Matthews said that Professor Harris had mentioned the potential for opening elective facilities at the Nightingale Hospital and possibly also the new Jubilee Ward to provide services over seven days and asked what was the plan to recruit the nursing staff that would be needed for this extended service, bearing in mind the very challenging recruitment market. Professor Harris responded that it had been Mr Palmer who had raised this point, but he recognised that recruiting nursing staff was extremely challenging but there were ways of incentivising recruitment. Mr Palmer commented that the new Jubilee Ward in North Devon District Hospital was allowing ring fencing of beds so that theatres could be used without interruption. With regard to the Nightingale, it had recently been possible to move to five day operating for the two Orthopaedic Theatres and there had been some weeks where it had been possible to extend to six day working. The Trust had been encouraged by NHSEI to formulate a proposal to seek revenue funding for two additional days at the Nightingale Hospital, but the issue will be, as Mrs Matthews pointed out, staffing the additional days. However, the revenue funding would seek to bring an insourced capability to the Nightingale which would mean bringing in staff from outside the area as a fully funded approach. He acknowledged that the broader issue around nurse staffing remained very challenging and the organisation will continue to explore ways of training its own staff or incentivising. There being no further questions, the meeting was closed.	

099.22	**DATE OF NEXT MEETING**	
	The date of the next meeting was announced as taking place at 9.30am on Wednesday 31 August 2022 via MS Teams.	