MEETING OF THE BOARD OF DIRECTORS OF THE
ROYAL DEVON AND EXETER NHS FOUNDATION TRUST

28 June 2017
Held at Boardroom, Noy Scott House, RD&E Hospital

MINUTES

PRESENT:
Mr J Brent Chairman
Mr P Adey Chief Operating Officer
Mrs J Ashman Non-Executive Director
Mr P Dillon Non-Executive Director
Professor J Kay Non-Executive Director
Mr D Robertson Non-Executive Director
Ms M Romaine Non-Executive Director
Mr P Southard Acting Chief Financial Officer
Mrs E Wilkins-Brice Deputy Chief Executive/Chief Nurse

APOLOGIES:
Mrs T Cottam Executive Director of Transformation & Organisational Development
Mr A Harris Executive Medical Director
Mrs S Tracey Chief Executive

IN ATTENDANCE:
Mr J Chinnock Head of Stakeholder Engagement & Communications
Miss B Coates Governance Coordinator
Dr M Daly Deputy Medical Director/Associate Medical Director – Surgical Services
Mrs M Holley Head of Governance
Mr P Luke Divisional Director – Operations
Mr P Oliver Deputy Director of Transformation & Organisational Development
Miss L Vine Executive Support Officer

68.17 CHAIRMAN’S OPENING REMARKS

Mr Brent welcomed Governors and members of the public to the meeting and in particular Dr Daly, deputising for Mr Harris, Mr Oliver who was deputising for Mrs Cottam and also presenting the Integrated Performance Report (IPR), and Mr Luke who was providing a presentation in relation to Referral To Treatment (RTT). Mr Brent reminded the meeting that it was a meeting held in public, but was not a public meeting. Questions would be welcome from members of the public at the end of the meeting and he reminded the public that the questions should relate to the meeting agenda.

69.17 APOLOGIES

Apologies had been received from Mrs Cottam, Mr Harris and Mrs Tracey.
### DECLARATION OF INTERESTS

There were no new declarations of interest. Mr Brent reminded Board members to flag any interests if they arose during the course of the meeting.

### MATTERS TO BE DISCUSSED IN THE CONFIDENTIAL MEETING AND TO BE DISCUSSED IN THE BOARD SESSION

Mr Brent informed the meeting that the Board would be discussing in its confidential meeting the Board Assurance Framework (BAF), the routine return to NHS Improvement (NHSI) of the Corporate Governance Statement, a Memorandum of Understanding with the University of Exeter, the annual Executive Director Remuneration Committee (EDRC) report to Board and a key strategic issues discussion which was a standing item on the agenda. Mr Brent also reminded the Board and members of the public that the Extraordinary People Awards would take place during lunchtime. He said was pleased that the number of nominations had increased again this quarter with a number of wonderful stories about how staff had contributed over and above what was considered to be standard.

### MINUTES OF THE LAST MEETING HELD ON 24 MAY 2017

The minutes of the meeting held on 24 May 2017 were agreed as a correct record subject to the following amendments:

- Minute 61.17, page 5, first sentence of last paragraph to read ‘…that the Trust had an unprecedented 37 responses in the top 20% but one in the bottom 20% which reflected continuous improvement in patient experience.’
- Minute 62.17, page 9, eighth paragraph to read ‘…reported incidents per 100 admissions…’, ‘…position had been affected by incident numbers which now included those reported by Community based teams for which there had been no admissions.’
- Minute 62.17, page 10, last paragraph to read ‘…note that the four hour trajectory…’, ‘…to focus more on staffing…’
- Minute 62.17, page 11, fifth sentence of third paragraph to read ‘…Ms Romaine asked if…’
- Minute 62.17, page 11, last paragraph to read ‘…negative patient experience impact which would exacerbate the time lag linked with…’
- Minute 62.17, page 12, first sentence to read ‘…further commented that the handover performance trajectory…’
- Minute 63.17, page 13, first bullet point to read ‘…difference to the ability of the Trust to cope.’

### MATTERS ARISING AND BOARD ACTION SUMMARY CHECK

**Action check**

The actions were as per the tracker with the following additions

- Minute 62.17 (A metric detailing patients who have a DTOC of more than 10
days to be included in the Integrated Performance Report): The Board approved the requested extension to September 2017.

**Matters Arising**

Minute 61.17 (Deep dive into staff experiencing violence at work to assess whether this is deteriorating further and address the issue): Mrs Wilkinson-Brice said that following a discussion with Mrs Cottam, Mrs Wilkinson-Brice agreed to assume responsibility for this action.

Minute 62.17, additional action to be added: Ms Romaine proposed that an action be added to the May 2017 minutes in relation to Mr Harris providing assurance to the Board in relation to when all Consultant job plans would be completed. This was agreed.

**ACTION: An action regarding the completion of Consultant job plans to be added to the May 2017 public Board minutes.**

Mr Robertson enquired as to the outcome of the consensual audit of the Trust by the Information Commissioner’s Office (ICO). Mrs Holley informed the Board that the Trust had not yet received the report from the ICO. This was due in July 2017 and would be taken through the governance system. Mr Robertson asked if the establishment review that Mrs Wilkinson-Brice had referred to at the May 2017 Board meeting was complete and whether there was an action for this to be reported back to Board. Mrs Wilkinson-Brice confirmed that this would be reported back in September 2017.

**CHIEF EXECUTIVE’S REPORT**

In Mrs Tracey’s absence, Mrs Wilkinson-Brice raised the following with the Board:

1) Mrs Wilkinson-Brice reported that, in light of the recent tragic events at Grenfell Tower, NHSI had requested urgent completion of a cladding and fire improvement questionnaire as well as urgent reviews of fire risk assessments. Further to this, Mrs Wilkinson-Brice said that an additional urgent request had been received from NHSI over the weekend, for local fire and rescue services to complete an inspection of all properties to ensure there were no urgent fire safety risks. Mrs Wilkinson-Brice confirmed that Mr Adey and Mark Hawken (Deputy Director of Strategic Capital Planning) had completed visual assessments on Saturday 24 June 2017 of all inpatient buildings with cladding; visual assessments of administration buildings were carried out by the Trust’s on call estates officer and the local Fire and Rescue services Command Contact Officer. Mrs Wilkinson-Brice said that NHSI had categorised various Trusts according to whether cladding was in use and the number of floors and she confirmed that the Trust was classed as category one because of a number of inpatient buildings with external cladding. Mrs Wilkinson-Brice highlighted these as being the modular wards (Ashburn and Yealm), the Centre for Women’s Health, a modular theatre, the Paediatric Assessment Unit (PAU) and Heavitree hospital. She assured the Board that visual and fire safety checks had been completed in respect of these areas with the following findings:

- There were alternative means of escape in all areas
- There was adequate fire compartment provision supported by good quality fire doors
- There was a programme of planned testing and regular
maintenance

- The Trust had a modern fire alarm system
- There was regular staff training and a fire safety programme run by the Trust Fire Advisor team
- Fire risk assessments, as carried out by the hospital Fire Officers, were in date
- The Trust had a robust on call process and on call teams had been briefed on increased vigilance.

Mrs Wilkinson-Brice said that further information was expected from NHSI which had announced earlier that day that additional support would be provided to nine Trusts requiring more rapid and intensive support in the shorter term to complete essential safety checks; the Trust was not one of these.

Mrs Wilkinson-Brice also noted that assurance had been received that morning from NHS Property Services that they were taking swift action to review their estate and check fire safety in all of their buildings. Mrs Wilkinson-Brice invited questions at this point and Professor Kay asked that the fire safety checks of the Research, Innovation, Learning and Development (RILD) building be shared with the University, although she confirmed that the University had also completed its own checks.

**ACTION:** Fire safety checks of the RILD building to be shared with the University of Exeter.

2) Mrs Wilkinson-Brice was pleased to report that the ‘Your Road to Wellbeing’ campaign that had been launched the previous week had been a great success. She said it focused on empowering patients, supported by staff, to improve their wellbeing and promote independence whilst in hospital. Mrs Wilkinson-Brice said that the campaign had focussed on five key elements over the week; one per day:

- Get up, get dressed and keep mobile
- Eat and drink well
- Get the most of your medicines
- Communication matters/keep in mind your mental health
- Make your going home plan as soon as possible

Mrs Wilkinson-Brice said the highlight of the week was the marathon relay which took place on Wednesday 21 June 2017 with a number of staff and patients, including an octogenarian, taking turns to run laps around the hospital. She added that the campaign would continue to run throughout the year with a different theme each month. Mrs Wilkinson-Brice paid particular thanks to Nolwenn Luke (Executive Support Manager) and Lisa Martin (Senior Physiotherapist) for their dedication and support with this innovative campaign.

3) Mrs Wilkinson-Brice reminded the Board that the outcomes of the Acute Services Review (ASR), part of the STP, had been published the previous week. She said that three main service areas had been under review; urgent and emergency care which had been led by Mr Harris, maternity, paediatrics and neonatology which had been led by Rob Dyer (Medical Director – Torbay and South Devon (TSD)) and Stroke which had been led by George Thomson (Medical Director – Northern Devon Healthcare Trust (NDHT)).

Mrs Wilkinson-Brice said that a briefing had been released to staff and the public which detailed that all four main acute hospitals (RD&E, NDHT, TSD, PS)
and Derriford Hospital) would continue to provide urgent care services but that collaborative working was required to build resilience.

In relation to urgent and emergency care services, Mrs Wilkinson-Brice said that the report noted that each of these main sites would need to enhance the way in which they operate in a sustainable way.

For stroke services, Mrs Wilkinson-Brice informed the Board that first-line emergency response would continue and would be supported by ‘Acute Stroke Units’ at all four sites. She added that two specialist ‘Hyperacute Stroke Units’ (HASUs) would be developed in Exeter and Plymouth providing 24/7 immediate, expert care from highly specialist staff.

Mrs Wilkinson-Brice said that Consultant-led maternity services would be retained at all four main hospital sites and further work would be carried out to look at the community midwifery-led units in line with the national strategy ‘Better Births’. Mrs Wilkinson-Brice said that there was strong evidence which implied that midwifery-led units worked better when co-located with Consultant-led units.

Overall, Mrs Wilkinson-Brice said that the emphasis had been on access and clinical sustainability from a clinical perspective and that further conversations were needed to establish timetables and the second phase of this work. Mrs Wilkinson-Brice invited questions from the Board.

Ms Ashman noted that the ASR appeared to be low risk in terms of disruption to the Trust but high risk when looking at the overall strategy for Devon. Mr Robertson echoed this and said there did not appear to be much change except for the development of the HASU and he commented that the outcome did little to address the financial deficit. Mrs Wilkinson-Brice said that this was a clinical recommendation and this only the first stage of the review. Mr Brent agreed the changes proposed were very modest and did not address the financial challenge. Dr Daly acknowledged that all four main sites were working efficiently already and in order to move services, significant capital investment would be required. Mr Brent replied citing the recent Naylor Report which said the NHS estate was £5bn underinvested and required an additional £5bn invested in order to improve; however if the use of the estate was more efficient, savings of £6bn could also be made. He said it was his view that capital expenditure should not be used as an excuse for not making changes.

Mr Adey said that stage two would look at the workforce and financial implications of the clinical proposals. Mr Southard said the primary reason that the ASR was undertaken was to review the resources available in order to get the best use of them. Dr Daly said that addressing the staffing challenges would be the biggest achievement possible.

Mr Brent said he was very grateful to those that had completed the work so far and he looked forward to further work to address the financial sustainability.

Professor Kay noted that she had not been able to get a sense of the journey of this piece of work. Ms Romaine said she was concerned that a huge amount of clinicians’ time had been committed to this work, which was particularly true of Mr Harris, and that she did not believe it had achieved a great overall gain. She said this was largely because the parameters had not been clear from the start and what was expected of those involved had not been defined.

Mrs Wilkinson-Brice said that Mrs Tracey would no doubt provide the
Board’s feedback to the Programme Delivery Executive Group (PDEG).

4) Mrs Wilkinson-Brice said that, as the Board was aware, the General Election had resulted in a hung Parliament with the Conservative Party being the largest party. She said that Jeremy Hunt had remained as Secretary of State for Health and the Board should have received the recent communication which listed the more junior positions. Mrs Wilkinson-Brice said that all local Members of Parliament (MPs) had retained their seats and that the Government had agreed a ‘Confidence and Supply’ arrangement with the Democratic Unionist Party (DUP).

Mrs Wilkinson-Brice invited further questions from the Board.

Ms Ashman asked if the Trust had been affected by the backlog of unprocessed clinical correspondence reported the previous day by NHS Shared Business Services. Mrs Holley confirmed that the Trust had not been involved and she believed it to be mainly primary care that had been affected.

The Board noted the Report from the Chief Executive.

75.17 INTEGRATED PERFORMANCE REPORT

Mr Oliver highlighted to the Board the correction circulated yesterday by email that confirmed that non-elective medical admissions for the month were 2.4% above planned levels, with 43 more medical admissions than anticipated across the month and not 7.9% as previously reported. Mr Oliver said that patient flow throughout May 2017 had been good with 30 days rated Operational Pressure Escalation Level (OPEL) Level 1 and one day rated OPEL 2. Mr Oliver reported that the Trust’s performance against the four hour Emergency Department (ED) target had improved to 92.83%, exceeding the Sustainability and Transformation Funding (STF) trajectory of 92.05% for May 2017.

Moving on to Patient Safety and Experience, Mr Oliver said that 90 complaints and concerns had been received for acute services and five for Community services during May 2017. The top theme for acute services related to the attitude of ED staff which Mr Oliver said accounted for approximately 40% of these complaints. Mr Oliver said that all complaints were being actively investigated and would form part of the quarterly report to the Patient Experience Committee (PEC) in due course.

Mr Oliver said that specialising requirements across the four Divisions totalled 85.50 whole time equivalents (WTE) in May 2017; an increase of 25.79 WTE from last month. More than 60% of this increase was attributable to a single surgical patient with significant mental health needs requiring Registered Mental Nurse support and Mr Oliver referred the Board to the report which detailed further information on the specialising needs.

Mr Oliver informed the Board that the first hospital acquired MRSA bacteraemia for almost six years had been identified from blood cultures taken from a patient with Acute Myeloid Leukaemia. Mr Oliver confirmed that this had been reported to Public Health England (PHE) and that at the time of writing the IPR, the post-infection review was in progress and no lapses in care had been identified.

Mr Oliver said that there were a further three Clostridium difficile cases in May 2017 totalling six cases against a trajectory of four in the first two months of the year. Mr Oliver said that one of the cases identified in April 2017 was found to be associated with lapses in care; an action plan was in place and
investigations into all cases were on-going.

Mr Oliver reported that Trust-wide figures for antimicrobial prescribing compliance had improved to 89.7% for inclusion of a duration on the drug chart but showed a deterioration to 88.7% of an indication on the drug chart and 91.5% for guideline compliance. Mr Oliver said that actions to further improve the situation were summarised within the report.

In May 2017, Mr Oliver said that the volume of National Reporting and Learning System (NRMLS) reportable incidents had increased from 176 to 209 incidents within the Community; the reasons for this increase were being investigated.

Mr Oliver said that the apparent increase in pressure ulceration shown in the Ward to Board dashboard in appendix five of the report reflected the inclusion of data relating to patients within the Community hospitals from April 2017 rather than any increase in occurrence. Mr Oliver said that each individual incidence of a pressure ulcer was being investigated and opportunities for learning were being identified.

In May 2017, Mr Oliver reported that only 50% of patients with a fractured Neck of Femur (NoF) underwent surgery within the contractual 36 hours of admission. He assured the Board that the Clinical Lead was confident that the quality of the clinical care remained high and benchmarked well against national data. Mr Oliver said that 42 out of the 44 patients underwent surgery within the National Hip Fracture Database standard of 48 hours. Mr Oliver referred the Board to the IPR which included a detailed exception report showing more data as well as an action plan to address this.

Mr Oliver said that the proportion of stroke patients spending 90% or more of their admission on the Stroke Unit had been sustained for three consecutive quarters by maintaining availability of admissions beds on the Acute Stroke Unit.

Mr Oliver reported that there had been a number of Demonstrating Difference examples in May 2017. In particular, Mr Oliver drew the Board’s attention to an example of excellent teamwork, the Urgent Community Response Team in Exeter, where acute and community teams, health and social care and other care providers had demonstrated how inappropriate admissions to the acute hospital could be reduced by working together.

In terms of operational delivery, Mr Oliver said that performance against the four hour ED target in May 2017 was 92.83%. Mr Oliver said that this represented an improvement on the April 2017 position of 91.9% and was sufficient to both achieve the STF trajectory of 92.05% for May 2017 and recover the shortfall of 12 patients below the required STF level in April 2017.

Mr Oliver reported that three patients had waited longer than 12 hours for admission during May 2017, all of whom were complex psychiatric patients requiring admission to a psychiatric inpatient bed.

Referring to ambulance handover delays, Mr Oliver said there had been 36 which were greater than 30 minutes in May 2017 against a trajectory of 25 but he confirmed that none had exceeded 60 minutes in duration.

Mr Oliver informed the Board that combining medical staffing posts with University postgraduate study within the ED had been successful, resulting in the middle grade rota being fully staffed from August 2017. He added that interviews to appoint two additional ED Consultants were due to take place at the beginning of July 2017 to increase the Consultant establishment to 12 WTE and significantly extend Consultant cover out of hours. Mr Oliver also
reported that two internally trained nurse practitioners would help provide cover across the week and these had also been recruited.

In terms of Cancer performance, Mr Oliver was pleased to report that the draft position showed that the Trust had achieved eight of the nine cancer targets in May 2017. Mr Oliver said that performance against the 62 day wait from GP referral was at 81.55%, missing the target of 85% by just eight patients. Mr Oliver said this was primarily as a consequence of current workforce challenges within Urology. Mr Oliver reported that the team were reviewing the national pathway work that had recently been completed for the prostate pathway in order to identify any further improvements that could be made.

Mr Oliver reported that performance also continued to be challenged within lung, upper GI and lower GI. Mr Oliver said that these tumour sites had been identified as key areas for improvement by NHS England (NHSE) and over the coming months the Trust would be working with NHSE and the Cancer Alliance to continue to further refine the pathways for lung and prostate patients.

Mr Oliver informed the Board that the Trust was on track to achieve the Q1 STF trajectory for the 62 day cancer target of 80% with performance against the RTT target at 90.42% against the national target of 92% and the Q1 trajectory of 90.4%. Mr Oliver reminded the Board that a detailed presentation in relation to RTT would be provided later in the meeting.

Moving on to diagnostics, Mr Oliver said that as a result of continuing challenges relating predominantly to CT scans, the Trust had not achieved the 99% target for patients receiving tests within six weeks. He added that 3.73%, or 217 of the 5816 patients, had waited longer than six weeks. Mr Oliver said that opportunities to increase the use of external suppliers and to appropriately control demand were being explored. He also noted that the CT position was not expected to be sustainably resolved until Q3 2017/18 due to the capital replacement programme which covered a range of imaging equipment.

Mr Oliver reported that only one patient had waited longer than 52 weeks for treatment; this patient required a complex spinal operation and the patient was taking time to consider the decision as to whether or not to undergo the surgical procedure.

Referring to workforce measures, Mr Oliver reported that there had been a small reduction in the annual staff turnover rate for acute services from 12.9% to 12.7% and the estimated turnover in Community services had increased marginally to 13.7%. Mr Oliver said that the predominant staff groups driving high turnover levels continued to be registered nurses and midwives, unregistered nurses and unregistered Allied Health Professional (AHP) staff; he said that further details were provided in the report.

Mr Oliver reported that extensive work had been undertaken to understand staff turnover within the Trust, including an analysis of exit interview data. He said that the causes were multifactorial and included opportunities for development, flexible working, opportunities for career progression and car parking. Mr Oliver said that these factors were consistent with recent NHS Employers’ research and this was being addressed through a wide range of retention initiatives at both Trust and Divisional levels; examples of which were summarised within the report.

Mr Oliver said that registered nurse recruitment remained challenging and vacancy numbers were increasing. He added that the Trust was currently exploring potential recruitment opportunities in Ireland, Philippines, India, Dubai and through the use of agencies in the UK. Mr Oliver said that of the 149 registered nursing and midwifery vacancies currently being recruited to,
56% had been given a conditional offer with the remaining 44% at advert stage.

In terms of sickness, Mr Oliver said that the aggregate Trust absence due to sickness was 3.48% for May 2017 equating to a further £490k which excluded any additional costs for replacement cover. Mr Oliver drew the Board’s attention to the report which provided a breakdown showing the top five reasons for sickness absence.

Mr Oliver said that sickness attributed to anxiety, stress, depression and other psychiatric illness accounted for 25.5% of all absences and involved 118 members of staff in May 2017. Of these, Mr Oliver said that 75 (64%) were absent for less than one month, 103 (88%) for less than three months and just four staff (3%) were absent for more than six months.

Mr Oliver reported that requests for temporary cover for nursing and midwifery shifts had increased in both acute and community services but that the Trust had successfully filled 83% of acute and 82% of community shifts with Trust bank workers. This, Mr Oliver said, was another record since the transfer of community services in October 2016.

In relation to pay, Mr Oliver reported an underspend of £534k year to date and he said that the Trust was forecast to underspend £593k at year end. Mr Oliver said that total agency spend for the Trust amounted to £623k in May 2017; this was a favourable position compared to the NHSI ceiling of £775k per month (£9.3m for the financial year) and the internal Trust target which Mr Oliver said was now confirmed as £6.9m for the financial year.

Mr Oliver informed the Board that at the end of May 2017, a deficit of £747k was incurred in comparison to a budgeted deficit of £778k; a deterioration of £31k compared to last month’s report. Mr Oliver said that the deterioration was due to an in month adverse income position of £559k which had been offset with a favourable pay position of £311k and an overachieved Cost Improvement Programme (CIP) saving of £241k for the month.

Mr Oliver said that the Trust was currently forecasting a deficit of £0.5m in line with both the budget and Operational Plan. Mr Oliver added that all three STF performance trajectories were currently being met and the Trust expected to receive £8.7m of STF funding later in the year.

To date, Mr Oliver said that £5.6m of the £21.6m current year CIP target had been achieved with £312k being achieved in month two. Mr Oliver said that plans were in place for £13.9m of the remaining balance and £2.1m was currently unidentified. Mr Oliver reported that recurrent schemes totalling £3.8m had been achieved and plans were in place for a further £13.2m through Divisional and Trust wide schemes with a remaining balance unidentified of £4.5m.

Referring to leadership and governance, Mr Oliver said that between 1 January 2017 and 31 March 2017 there were 18 incidents which involved patients graded with an actual impact of moderate, major or catastrophic closed. In all 18 instances, the Duty of Candour requirements were met in full.

Mr Oliver said that the total income penalty risk for month two was £10k; this was incurred as a result of the MRSA bacteraemia previously described.

In summary, Mr Oliver said that operational and financial performance to date had been positive with good patient flow being maintained. Mr Oliver invited questions from the Board.

Mr Brent noted that a deep dive into Cancer Strategy would be presented in
the confidential section of the Board meeting that day and suggested that a summary should be provided to the July 2017 public Board meeting. This was agreed.

**ACTION:** Summary of the deep dive into Cancer Strategy to be provided at the July 2017 public Board meeting

Mr Robertson noted that the number of pressure ulcers had increased since the inclusion of data relating to patients within the community hospitals. With the number of patients in the community hospitals being less than in the acute, he said the number of pressure ulcers appeared disproportionate and asked if there was an issue within the community hospitals. Mrs Wilkinson-Brice said the cases were being reviewed and reminded the Board that patients admitted into the community hospitals are often admitted from home and therefore some already had pressure ulcers prior to admission. She added that, upon visiting the community teams, she had witnessed patients who had chosen not to adopt methods to alleviate and prevent pressure ulcers.

Referring to patients with a fractured NoF and the target of 36 hours in which to undergo surgery, Mr Robertson said this had been a focus for Governors at a recent Council of Governors meeting. He asked why this particular fracture was focused on rather than any other. Dr Daly said that patients with a fractured NoF had the highest mortality rate and the most prolonged recovery time. He said that with each hour in which surgery was delayed, the rate at which muscle mass was lost increased. Dr Daly reiterated that 42 out of the 44 patients underwent surgery within 48 hours and he assured the Board that this was a high achievement and better than the average rate. Dr Daly also said that clinicians recognised that emergency patients were more vulnerable than elective patients and he reminded the Board of the investments and developments within the ED and Acute Medical Unit. He said that trauma work was being prioritised over elective work and that clinicians were passionate to improve upon this target in particular. Mr Dillon suggested, as the Trust has repeatedly failed this target, that perhaps it should be amended to 48 hours instead of 36. Both Dr Daly and Mr Brent said that there was no good evidence for an arbitrary target. Mr Dillon challenged this and said the National Hip Fracture Database must have evidence behind its 48 hour target. Mr Brent commented that the target should be changed or the Trust change its actions to reach the target. Mrs Wilkinson-Brice replied the fractured NoF target performance should be looked at alongside the number of emergency trauma patients that arrived and were treated at the trauma centre. The recovery plan for the target did improve performance but this was then effected by an increase in trauma cases. She said that if no other variables were to change, an action plan would address the issues; however as the number of trauma patients fluctuated, the Trust was constantly trying to balance the risk. Mr Adey agreed that trauma capacity was key to the performance against the target. He assured the Board that it was a clinically-led process and he confirmed that the patients were regularly reviewed. Ms Ashman reminded the Board that the target of 36 hours had been introduced to prevent patients, particularly those that were elderly, having their treatment continually delayed due to trauma patients. She added that she was reassured by the clinical reviews of these patients and did not feel that the target should be altered.

Mr Dillon said it was his view that it was not acceptable for the Board to receive exception reports month after month. Dr Daly acknowledged this but said the direction of travel within the Surgical Division was to increase capacity to deal with variation, in particular variation within trauma. Cultural and system changes were required and where these had been made, for example within
Plastic Surgery, targets were being met. He added that management of inappropriate demand was also in place. Consultants were able to have conversations with patients who then chose not to have surgery.

Mrs Wilkinson-Brice suggested that a Consultant Orthopaedic Geriatrician should be invited to give the Board further detail in relation to this target, so that a balanced decision could be made as to the potential revision of it. The Board agreed with this suggestion and Professor Kay added that detailed data would also be helpful for the Board to see variation.

**ACTION:** Deep dive into fractured Neck of Femur to be scheduled and a Consultant Orthopaedic Geriatrician to be invited

Mr Robertson said that he had recently visited both the Acute Paediatric Unit and the Acute Medical Unit and commented that it appeared that both were deemed as ‘safe places’ for mental health patients whilst staff noted they were not trained to treat such patients. He asked how the pathway for mental health patients was progressing. Mr Brent confirmed that a session with the Board and Devon Partnership Trust (DPT) was due to be scheduled. Mr Robertson suggested that Virgin Care, responsible for child mental health care, should also be included as it was not just a problem within adult care.

**ACTION:** Virgin Care to be invited to attend the Board session being scheduled with the RD&E and DPT to look at the pathway for mental health patients

Professor Kay was pleased to note the developments within Gynaecology Oncology due to the purchase of a laparoscopic stack system and asked firstly how this was affecting patient outcomes and secondly how the continual use would be monitored to realise and identify benefits. Mr Adey said that the performance would be monitored at Divisional level and suggested that John Renninson would be able to advise as to the effect on patient outcomes in the cancer strategy session later.

Mr Dillon noted that the number of complaints received over the last three months totalled 281 against the typical average of approximately 210. He confirmed that he had asked Bernadette George, Lead Nurse for Patient Safety, Risk and Patient Experience, to look into this and to provide assurance at the next Patient Experience Committee meeting.

Mr Dillon said that, upon reading the IPR, it appeared that the Trust was running at a lower level of activity than expected and asked if this was as a result of successful demand management or whether the resources were too limited. Mr Adey said that there were issues in terms of profiling data which was not unusual within the first few months of the financial year due to Easter and the two bank holiday weekends. He added that the sequencing of uploading data had also had an impact and that whilst a reduction in the number of referrals and outpatient appointments was the right direction of travel, the Senior Leadership Team (SLT) had discussed this issue at a meeting the day before. Mrs Wilkinson-Brice said that whilst this was a concern, the SLT had discussed the need to reduce costs proportionate with sustained activity reduction. Mr Southard added that the Trust had also underperformed against contracts, particularly within Urology due to sickness, but reminded the Board that this was only based on one month of data.

Mr Dillon noted the decline in diagnostic performance, particularly within CT, and asked if bringing the capital expenditure forward would help alleviate this. Mr Southard said that unfortunately due to necessary and planned changes to the Cath Lab plan, completion had been delayed and could not be accelerated. Mr Adey added that demand management was being looked into to see how
this could improve the position.

Referring to the high outpatient appointment unavailability, Mr Dillon asked how this would impact on the patient experience and what the Board could do to address this. Mr Adey assured the Board that whilst there were a high number of Appointment Slot Issues (ASIs), this looked only at the particular point in time at which a patient called to make an appointment. He added that junior doctor staffing issues and a shift of patients choosing to be referred to the RD&E from other areas, particularly within Neurology, contributed to this. Mrs Wilkinson-Brice acknowledged there may be an impact on patient experience but added that also part of the patient experience was the ability to choose where they are treated and said that the Trust needed to be aware of any default drift of patient choice rather than a planned change. Referring to the Trust’s continued challenges with staff exit interviews, Ms Romaine welcomed the research carried out by NHS Employers into the factors most likely to make a nurse stay in a role. She said all the factors listed apart from pay were in the gift of the Trust and asked if they applied to the Trust and if so, what course of action was in place to manage them. She said it was important that the Trust’s strategic approach was coherently explained. Mrs Wilkinson-Brice acknowledged Ms Romaine’s view and assured the Board that a significant amount of work was underway in regards to career development and turnover. As an example she said she had commissioned the development of a new Professional Development Strategy covering a 3-5 year period for nurses, midwives and Allied Health Professionals to conclude by the end of the calendar year. She acknowledged that this needed further discussion with Mr Harris to agree whether this should be broadened to include all clinical staff and how the Trust could offer broad career development opportunities. Ms Romaine asked that in the IPR workforce section that planned actions were presented alongside reason for turnover and Mrs Wilkinson-Brice said she would relay this to Mrs Cottam.

ACTION: Mrs Wilkinson-Brice to liaise with Mr Harris to discuss whether the Professional Development Strategy should incorporate all clinical staff so that the Trust can offer broad career development opportunities.

ACTION: Mrs Wilkinson-Brice to relay to Mrs Cottam the request for future workforce detail in the IPR.

Mr Brent commented that, given this had been highlighted for almost six months now, it was his view that the Trust make exit interviews mandatory. Mr Oliver said that whilst there was nothing stopping the Trust from doing so, staff could not be forced to take part in an exit interview if they did not wish to. Mr Brent suggested that a change in culture was required as outside the NHS, he felt staff expected to take part in exit interviews upon leaving employment. Mrs Wilkinson-Brice said that this had been discussed at the SLT meeting the previous day and it had been suggested that exit interviews may be taken up more often if they were carried out by an independent person rather than a line manager and this was being trialled currently. She also said that the number of exit interviews offered should be compared to the number completed. In addition to this, Mrs Wilkinson-Brice said that the SLT had agreed that a conversational approach to exit interviews was important such that exiting staff could describe their reason for leaving in a humanistic way. Ms Romaine asked if any targets had been set regarding exit interviews and Mrs Wilkinson-Brice said she would pick that up with Mrs Cottam. She added that NHSI was offering additional support to Trusts with higher than average nurse turnover and confirmed that the Trust was due to attend a workshop to discuss this in July 2017. She said the Trust was keen to learn from other Trusts’ experience.
ACTION: Mrs Cottam to advise on the target being worked towards in terms of improving the number and quality of exit interviews.

Mr Brent noted that there was clear representation at Board level for both medical and nursing staff but asked, given the particularly high turnover within admin and clerical staff, how focus would be given at Board level to this staff group. Mr Adey confirmed that John Groom, Divisional Director Medical Services, had reinstated the Admin and Clerical Workforce Group which Mr Adey would have oversight of at Board level.

Having attended a recent safety thermometer, Ms Romaine noted that she had had some useful conversations with staff in relation to the nursing ‘transfer window’. However, she said that this had also highlighted the number of wards which were less attractive for staff and she asked if the Trust were aware of this and how it was being managed. Mrs Wilkinson-Brice said that she was aware of the areas which were more difficult to recruit to and highlighted Gastroenterology as an example of a very challenging area to work in. Mrs Wilkinson-Brice assured the Board that Tracey Reeves, Deputy Chief Nurse/Midwife, had an overview of the requests to transfer and often had to speak to individuals to explain that whilst a requested move may not be possible at a given time if it resulted in leaving an area understaffed, it may be possible at a later date. She also added that enhanced training with the security team had taken place a few years ago to enable them to assist the de-escalation of clinical situations; this had made a great improvement on the wards on the whole. The issue raised by Ms Romaine would form part of the thinking in relation to the Professional Development Strategy.

Mrs Wilkinson-Brice referred to the patient who had acquired MRSA bacteraemia within the Trust and reiterated to the Board that no lapses in care had been identified. She stressed that this case had been under stringent scrutiny by the clinical team, led by the Directors of Infection Prevention & Control [DIPCs] and that it was a very unusual case. Mrs Wilkinson-Brice confirmed that contact tracing of other patients and staff had taken place but no source had been discovered. Mrs Wilkinson-Brice said that a thorough and robust investigation was underway but this case was not indicative of an emerging trend.

The Board noted the report.

76.17 REFERRAL TO TREATMENT: ELECTIVE WAITING LIST UPDATE

Mr Luke thanked the Board for inviting him to present at the meeting and reminded them that RTT targets were defined in the NHS Constitution. He said that it gave a pledge to patients that they would be treated within a certain period of time and if this pledge could not be upheld, it required that Commissioners take “reasonable steps” to ensure the patient was offered suitable alternatives.

Mr Luke said that RTT was measured from the first day of referral to the date that patients received their “first definitive treatment.” He said that factors that affected this were demand (GP referrals, number of diagnostics required and ED attendances), capacity and management (balancing the different forces).

Mr Luke reported that when he last presented to the Board, in September 2016, RTT performance had deteriorated from 93.5% to 92%. The main causes of this were winter pressures and the junior doctor industrial action which had taken place. He added that there was an aspiration to improve performance, however, it was not possible to guarantee that this would not
drop below 92% due to a number of risks in the system.

Across the region, Mr Luke said that most Trusts faced challenges in RTT performance as the number of referrals increased but the number of resources was reduced. In this instance, Mr Luke said that demand could be ruled out as the cause because overall the Trust had received 2% less referrals in 2016/17 in comparison to 2015/16, with the exception of Orthopaedic referrals, which increased by approximately 9% in 2016/17.

Mr Luke said that the Trust had been achieving 92% until October 2016 when performance declined just below this. He added that whilst the Trust was currently achieving the STF trajectory of 90.4%, which would increase to 92% over the next year.

Mr Luke highlighted the shape of the ‘admitted waiting list’ to the Board. He said there had been a shift in the 90th percentile of patients from 25 to 28 weeks. Whilst some specialties achieved 100% of the 18 week standard, the size of specialty had to be taken into account and three of the five largest specialities were not meeting the target.

When looking at the total incomplete pathways by specialty, Mr Luke said that there were four key areas to address but Trauma and Orthopaedics (T&O) had the lowest performance. Two years ago there had been 600 patients waiting longer than 18 weeks. This had been reduced to 400 patients; however this had since increased to over 1000 patients. The main causes for this growth were:

- 2015/16 winter bed pressures and industrial action
- Independent Sector (IS) activity ceasing in September/October 2016. This single factor had resulted in 400 patients not being transferred to the Independent Sector, which equates to approximately 1.6% of the fall in the Trust aggregate performance.
- Bed capacity issues during the first two weeks of January 2017, which resulted in the use of an orthopaedic ward as a medical ward meaning approximately 100 orthopaedic cases were postponed
- An 8.8% growth in orthopaedic GP referrals during 2016.

Mr Luke reported that over the last 13 months, 19 patients breached 52 weeks waiting for treatment. He assured the Board that these patients were identified at 40 weeks and were offered a date for treatment, with a minimum of three weeks’ notice. Whilst the majority of patients accepted the date given, Mr Luke said a small number declined them. Mr Luke said that if patients continued to decline appointments over a three month period, they could be referred back to their GP following clinical review and scrutiny to ensure it was safe to do so. He added that this process was monitored through a number of meetings including the Access meeting and Performance Assurance Framework (PAF) meetings.

Mr Luke provided a summary of the analysis and highlighted that Orthopaedics and remain key areas of focus for which there are clear plans, which are closely monitored both within Divisions and via Trust-wide performance management processes. He said that whilst the 52 week breaches risk had increased, it remained a relatively low risk and was limited to four specialities. Additionally, Mr Luke said there was strong performance management in place through Divisional comm cells, triumvirate oversight and review of waiting lists, specialty meetings, Access meeting, Operations Board, Senior Delivery Group, PAF and Board meetings.
Mr Luke said that an orthopaedic action plan had been put in place to address the underlying capacity gap of approximately 350 patients. In order to meet this, Mr Luke said the Trust would need to deliver on its contracted activity and schedule two Saturday lists for 30 weeks of the year. Mr Luke added that the Trust was working with Deloitte and Four-Eyes Insight in relation to a theatre productivity programme with a modest target of 100 cases over 12 months. He also said that demand management was a central element of the STP planned care work stream. Mr Luke informed the Board that a second action plan had been put in place in relation to Cardiology which included some additional evening and weekend lists. He said that once the Cath Lab replacement was complete, the mobile lab would be used for a short time to clear the backlog.

Referring to the action plan for other specialties, Mr Luke said that workforce was a common theme which needed to be addressed. He also highlighted that patients were choosing to be treated at the RD&E, for example in Dermatology and Neurology, which is causing considerable pressure in these specialties.

In terms of future considerations and risks, Mr Luke said that demand management was always challenging and, whilst we should do everything we can as system leaders to progress this work, he was cautious about assuming too great a benefit from this in any plans at this stage. He said that workforce constraints would be a key factor, medical staffing and junior doctors in particular, and that any delays to the Cath Lab replacement could delay the Cardiology recovery. Mr Luke said that whilst the STF trajectory was deliverable, it remained challenging. Mr Luke invited questions from the Board.

Mr Robertson thanked Mr Luke and said it was a very clear presentation. He noted that rather than the number of patients, the acuity should be focussed on and graded. Mr Luke acknowledged that the Trust already prioritised patients depending on acuity.

Mr Brent said that whilst a number of conversations had taken place in relation to the issues within Cardiology, he would value further detail as to how the patients were being managed. Mr Luke said that weekly reviews took place to ensure that patients were being booked according to clinical need and that the longest waiters within each category were booked chronologically. In addition, there was a clear plan to reduce waiting times which Mr Luke and Mr Adey had reviewed and were closely supporting the Division in the delivery of. Mr Adey reminded the Board that Mr Harris had previously explained that Cardiology patients requiring angiograms were prioritised as this was an important diagnostic procedure. Mrs Wilkinson-Brice said the Governance Committee had commissioned the Safety & Risk Committee to undertake a Cardiology deep dive.

Professor Kay asked if any costs were being attached to achieving the actions outlined. Mr Luke confirmed that during the budget setting process, Divisions reviewed whether there were funds available. He said actions have been funded by money not being paid to the independent sector. Mr Adey added that it had also been built into the financial forecast for the next year.

Mr Brent asked that given the potential risks to the recovery plan, had the Trust tested its demand forecasting. Mr Luke confirmed it had and said the Trust had forecast 0% growth as a balanced position between the STP ambition to reduce overall demand compared to the historical experience of steady growth year to year. Mr Brent said it would be helpful to further understand where the risks to performance sat and Mr Luke agreed to provide
further detail.

**ACTION:** Further detail on the future risks to RTT performance to be provided to the Board.

Ms Romaine asked if the delays to treatment for patients with a fractured neck of femur was having an impact on the RTT performance within orthopaedics. Mr Luke said that the average was 35 fractured neck of femurs per month. If there were more than two in one day it could cause an issue and the number received each month led to around 10 elective orthopaedic cancellations a month. It was therefore a factor in RTT performance but a relatively small one.

The Board noted the presentation.

<table>
<thead>
<tr>
<th>77.17</th>
<th>ANY OTHER BUSINESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>No other business was reported.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>78.17</th>
<th>PUBLIC QUESTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Timms, a member of the public, asked if the Trust was reviewing its engagement with local MPs following the result of the General Election in order for them to better understand the pressures within the NHS. Mrs Wilkinson-Brice confirmed that Mrs Tracey met with local MPs on a quarterly basis and she did not have a sense that the issues were not being represented. Mr Chinnock added that the STP would be looking at how it could use the influence within government of the Conservative MPs in the region. Professor Foxall, a Public Governor, commented that she was pleased that the Non-Executive Directors had asked all the questions she would have asked. Referring to the diagnostic delays particularly within CT scanning, she asked the Trust to keep a focus on the wellbeing of staff who were waiting for this equipment. This was noted. Mr Brent took the opportunity to congratulate Professor Foxall on her recent election as Lead Governor, taking over from Richard May when he completed his term of office in September 2017. A member of the public asked if the Board discussed how the Trust used new medicines to meet targets, improve patient outcomes and reduce waiting times and costs. Mrs Wilkinson-Brice explained that the Clinical Effectiveness Committee, largely made up of clinicians and chaired by Mr Harris, was responsible for monitoring and reviewing new practice and treatment. She added that this was reported to Board through the Governance Committee. There being no further questions from the public, the meeting was closed.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE OF NEXT MEETING</th>
</tr>
</thead>
<tbody>
<tr>
<td>The date of the next meeting was announced as taking place at 9.30am on Wednesday 26 July 2017 at the Royal Devon and Exeter Hospital.</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Minute No.</th>
<th>Month raised</th>
<th>Description</th>
<th>By</th>
<th>Target date</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>50.17</td>
<td>April 2017</td>
<td>Maternity Dashboard to be produced on A3 paper in future Ward to Board reports.</td>
<td>EWB</td>
<td>July 2017</td>
<td>This will be completed for its target date of July 2017. Action ongoing</td>
</tr>
<tr>
<td>61.17</td>
<td>May 2017</td>
<td>Deep dive into staff experiencing discrimination at work in order to improve metric</td>
<td>TAC</td>
<td>September 2017</td>
<td>David Matthewman will be leading the deep dive investigation. Action ongoing.</td>
</tr>
<tr>
<td>61.17</td>
<td>May 2017</td>
<td>Deep dive into staff experiencing violence at work to assess whether this is deteriorating further and address the issue</td>
<td>EWB</td>
<td>July 2017, September 2017</td>
<td>This action requires more time than anticipated to be accurately completed. Request that this be deferred to the September meeting. Action ongoing.</td>
</tr>
<tr>
<td>62.17</td>
<td>May 2017</td>
<td>Community services data to be separated further to clearly identify that of bedded inpatients and that of patients cared for at home.</td>
<td>EWB</td>
<td>September 2017</td>
<td></td>
</tr>
<tr>
<td>62.17</td>
<td>May 2017</td>
<td>A metric detailing patients who have a DTOC of more than 10 days to be included in the Integrated Performance Report.</td>
<td>PA</td>
<td>June 2017, September 2017</td>
<td>The reporting of this metric will be considered as part of the IPR review due to be completed in September. Action on-going.</td>
</tr>
<tr>
<td>62.17</td>
<td>May 2017</td>
<td>Mr Harris to provide assurance to the Board in relation to when all Consultant job plans would be completed.</td>
<td>AH</td>
<td>July 2017</td>
<td>AH provided a verbal update to the July 2017 meeting.</td>
</tr>
<tr>
<td>63.17</td>
<td>May 2017</td>
<td>Progress review of the Ambulatory Care Unit to report back to Board in November 2017</td>
<td>PA</td>
<td>November 2017</td>
<td>A progress review will be provided at the November meeting of the Board of Directors. Action on-going</td>
</tr>
</tbody>
</table>
## PUBLIC AGENDA

<table>
<thead>
<tr>
<th>Minute No.</th>
<th>Month raised</th>
<th>Description</th>
<th>By</th>
<th>Target date</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>73.17</td>
<td>June 2017</td>
<td>An action regarding the completion of Consultant job plans to be added to the May 2017 public Board minutes.</td>
<td>MH</td>
<td>July 2017</td>
<td>This action has been added to May 2017 minutes.</td>
</tr>
<tr>
<td>74.17</td>
<td>June 2017</td>
<td>Fire safety checks of the RILD building to be shared with the University of Exeter.</td>
<td>PS</td>
<td>July 2017</td>
<td>July update: Mr Clark confirmed to July Board that this action had been completed.</td>
</tr>
<tr>
<td>75.17</td>
<td>June 2017</td>
<td>Summary of the deep dive into Cancer Strategy to be provided at the September 2017 public Board meeting.</td>
<td>PA</td>
<td>September 2017</td>
<td></td>
</tr>
<tr>
<td>75.17</td>
<td>June 2017</td>
<td>Deep dive into fractured NoF to be scheduled and a Consultant Orthopaedic Geriatrician to be invited</td>
<td>EWB/AH</td>
<td>Autumn 2017</td>
<td>This has been discussed and is being planned for inclusion on the Board Agenda in early autumn. Action on-going.</td>
</tr>
<tr>
<td>75.17</td>
<td>June 2017</td>
<td>Virgin Care to be invited to attend the meeting being scheduled with the RD&amp;E and DPT to look at the pathway for mental health patients</td>
<td>ST/AH</td>
<td>Autumn 2017</td>
<td>This is being progressed and will include attendance from a wider stakeholder group which will include Virgin Care. Action on-going.</td>
</tr>
<tr>
<td>75.17</td>
<td>June 2017</td>
<td>Mrs Wilkinson-Brice to liaise with both Mrs Cottam and Mr Harris to discuss whether the professional development strategy should incorporate all clinical staff so that the Trust can offer broad career development opportunities</td>
<td>EWB / TAC/AH</td>
<td>July 2017</td>
<td>Update July 17: Junior Doctors will also be included in the professional development strategy. Action completed.</td>
</tr>
<tr>
<td>75.17</td>
<td>June 2017</td>
<td>Mrs Cottam to advise on the target being worked towards in terms of improving the number and quality of exit interviews</td>
<td>TAC</td>
<td>July 2017</td>
<td>Update July 2017: This information is included in the IPR.</td>
</tr>
<tr>
<td>76.17</td>
<td>June 2017</td>
<td>Further detail on the future risks to RTT performance to be provided to the Board.</td>
<td>PA/PL</td>
<td>Sept 2017</td>
<td>This is likely to be a paper circulated outside of Board.</td>
</tr>
</tbody>
</table>

Signed: