Royal Devon and Exeter NHS Foundation Trust

Operational Plan Document for 2016/17

Royal Devon & Exeter NHS Foundation Trust

Approach to activity planning

The health community has a well-established activity planning process. This can be summarised as follows:

- Trust modelling of 3-year activity trend, adjusted for movements in waiting lists to produce an accurate assessment of underlying demand. Model based on specialty and point of delivery casemixed by HRG.
- Clinical and managerial review of the data and outputs to adjust the output for the impact of changes in clinical practice or guidelines. All adjustments documented.
- NEW Devon CCG modelling of primary care referral trends, at specialty level casemixed by HRG, adjusted for demographic growth and QIPP.
- Joint commissioner-provider review and reconciliation of the above components to produce an agreed Indicative Activity Plan (IAP).

Growth rates are noted below and are consistent with the activity templates. Activity figures will change as the discussions across the health economy continue, particularly in relation to the quantification of the impact of QIPP and Success Regime programmes of work.

- A&E 5.9%
- Elective (Day Case) 2.0%
- Elective (Inpatient) 0.3%
- Non-elective Inpatient 2.0%
- Outpatient 0.5%

The work under the Success Regime plans to reduce elective activity (new referrals and follow-ups), length of stay across admitted care (elective and non-elective) and Continuing Health Care requirements.

In parallel there is a clinical and managerial review of capacity and an assessment of any capacity constraints that impact on delivering the IAP and national performance targets. Where capacity constraints require alternative provision, including independent sector capacity, this is agreed between CCG and provider. The current assessment is that the trust's bed capacity to meet the anticipated growth in demand will be sufficient as long as the opportunities presented by the Success Regime and the transfer of community services are realised. Additional theatre capacity has been made available at the Trust's Heavitree site, but theatre capacity beyond this places limits on accommodating any increase in demand beyond that already assumed.

Activity plans are sufficient to achieve the key national targets for cancer. Diagnostic 6-week wait performance will be challenged for the first half of the year, but the Trust will deliver the 99% target from mid-year. There will continue to be some specialty level RTT

challenges, but there is capacity to deliver the aggregate Trust-wide target for 18-week RTT incomplete pathways for our current catchment population. However, the recent closure of the ENT service within Northern Devon Healthcare Trust and the potential closure of the Plymouth Hospitals NHS Trust Neurosurgery service create a significant risk that the Trust's aggregate 18-week RTT incomplete pathways performance will fall below 92% during 2016/7. These service changes are outside the Trust's control and have been reported as risks to NHS Improvement. Further discussions with commissioners, providers and regulators will take place to minimise the risk to performance. The transfer of community services is currently assumed to have no favourable or adverse impact on RTT performance. The A&E 4 hour target will be met for the year on aggregate, but achievement cannot be guaranteed for each individual month.

The Trust works closely with Health Economy partner organisations in the System Resilience Group and Urgent Care Group. As part of this work in 2015/16 the Trust has staffed a ward in a local community hospital to help to provide an alternative to acute admissions and to reduce delayed transfers of care from acute beds. From June 2016 the Trust is anticipated to take over responsibility for local community hospitals and non-bed based community services. This will allow the development of new models of acute-community working in winter 2016/17 to improve system resilience.

The Trust has systems in place to closely monitor demand and capacity. Any unanticipated excess demand or capacity constraints will be managed by an agreed health community process that involves the CCG's 'Planned Care Control Centre' implementing additional demand management initiatives and/or sourcing additional capacity.

Approach to quality planning

Executive Leadership for Quality

The Deputy Chief Executive/Chief Nurse is the lead portfolio holder overall for quality. The responsibility for quality improvement is shared between the Deputy Chief Executive/Chief Nurse, Executive Medical Director and Director of Transformation & Organisational Development.

Approach to Quality Improvement

During 2015/16, the Trust commenced the FutureCare Programme which has been devised and developed to enable the RD&E to provide a sustainable, effective, efficient and personalised care system for the population of eastern Devon and the surrounding areas. The Programme will enable work to deliver a new model of care that focuses as much on wellness and prevention as ill health; that drives the need to see patients as people first and that empowers them to be in control of their own health care. The delivery of the new model of care, in a financially sustainable way, aligns to the direction of travel outlined in the NHS Five Year Forward View, and with the Success Regime work programme.

Specifically within the FutureCare Programme the following 2 quality priorities/programme areas were defined:

- Acute Pathway Transformation
- Integration

Acute Pathway Transformation (APT), enabled by Electronic Patient Record (EPR)

The APT Programme will redesign acute pathways and processes across the Trust in order to reduce variation, improve the safety and quality of care delivered and to increase the accessibility and reliability of information for the population of Devon, the provider partners and our commissioner stakeholders. These changes were planned to be enabled by a comprehensive EPR and IT infrastructure as well as the appropriate organisational structure which will align workforce requirements to the future model of care requirements. Through addressing inefficiencies, the Trust will establish standardised ways of working that improves patient care outcomes and experience. The focus for APT is:

- Outpatient Review and Redesign
- Engaging with the CCG's RightCare programme
- Productivity and Efficiency – Lord Carter Review
- Electronic Patient Record [EPR] business case

Outpatient review and redesign:

Using public and patient feedback data, the plans are in two parts:

- Improve today – e.g. establishing single point of leadership
- Redesign tomorrow

The design of a new model of Outpatient Service is being undertaken by the Care Design Group, a group of >40 people from across the local care economy, from different disciplines, sectors and agencies, paying particular attention to the extensive public/patient engagement/feedback obtained throughout 2015/16.

Right Care:

- Planned workshops completed
- Outputs reviewed and planning underway for 2016/17 implementation

Lord Carter Review

- One of the 32 Trusts to participate
- Received initial feedback – review and next steps being planned for 2016/17

EPR business case:

- The EPR business case has been developed and approved by the Board, and work is underway to secure investment funding required for implementation.

Integration

Community Services Transfer

The community services within the Trust's secondary care catchment area are due to be transferred to the Trust during 2016 (anticipated date 1st June 2016).

The Trust intends to transform the acute and community pathway by developing new models of integrated care, with a particular focus on,

- Single pathways of care between the acute hospital and community services for adults with complex care needs.
- Frailty - improving the co-ordination of services wrapped around frail older people, providing a rapid and integrated response to crisis supported by intensive reablement aimed at minimising the hospital length of stay and maximising rehabilitation potential.
- Long term condition management of "mostly well" and "pre-frail" people. This includes a fundamental review of how, why and where we deliver outpatient services for people with multiple long-term conditions that work to meet the holistic needs of the people (not just their disease management) and pulls on a wider range of service providers, in particular the voluntary sector and local community groups.
- Increased delivery of outpatient services closer to the people they serve, making better use of existing community and social facilities and resources.
- Work with the established social care and mental health teams to develop care co-ordination, system navigation and collaboration of multidisciplinary teams.
- Work with Eastern Devon GPs to identify groups with multiple health conditions and partnering with them to redesign services whilst promoting self-management and control for people e.g. through patients holding their own health and care budgets.

Integrated Care Exeter (ICE)

- Discharge2Assess – 11th Jan 2016 "go live" for patients. A redesigned team approach and philosophy centred on timely discharge to individual's home with wrap around care whilst assessment occurs in the home regarding on going care needs.
- Caring for our homeless – Integrated Health and Wellbeing Team and Hub – March 2016
- Population Risk Stratification – led by Public Health & 2 GP Practices' data stratified to date, moving to further 4 practices
- Prevention & Community Resilience – investment case for social investment in Community Co-ordinators, Connectors, Organisers and Volunteers to form part of the service offer rooted in resilient, local communities.

Quality Priorities

Continuing to build on the 2015/16 priorities, the Trust's 3 Quality Priorities for 2016/17 are:

- Emergency Pathways – reviewing and redesigning the current pathway including all key stakeholders and making the most of the opportunities afforded by the integration of community and acute services for eastern Devon from June 2016.
- Improving discharge processes across local care economy – continuation of the work already underway in line with Integrated Care Exeter and rolled out to the Eastern sector
- Supporting mental health needs for people – supporting the development of the Integrated Psychological Medicines Service with Devon Partnership Trust

Quality - Improvement Methodology, Performance and Assurance

The Trust approach adopts a balanced scorecard approach, represented through the Board Integrated Performance Report. This report includes a range of indicators grouped under the following themes

Governance and Performance is managed via the Governance, Operations and Performance structure and processes which are embedded as part of business as usual within the Trust.

The Governance Committee is chaired by a Non-Executive Director and provides oversight of the risk management process. The Committee takes a comprehensive oversight of the quality and safety of care provided by the Trust and provides assurance to the Board of Directors. The work of the Governance Committee is supported by five key sub committees: Integrated Safeguarding Committee, Clinical Effectiveness Committee, Safety and Risk Committee, Patient Experience Committee and Workforce Governance Committee. These five committees are responsible for monitoring and managing specific types of risk.

In terms of quality the Trust has a Ward/Department accreditation process called Care Quality Assessment Tool (CQAT), this covers all inpatient areas and has recently been extended to include outpatients in 2015/16. In 2016/17 this will be extended further to include Paediatrics, the Emergency Department, Intensive Care Unit and Endoscopy Unit. CQAT forms part of the monthly Ward to Board framework where key quality and safety indicators are reported and monitored. Furthermore a quarterly drill down report is also presented to the Board of Directors where Divisions report by exception any ward/department area that flags on the framework.

In terms of Performance, the Trust uses a Performance Framework which provides assurance that performance including safety & quality indicators will be effectively monitored and reported to support managers and clinicians in delivering the required targets. Chaired by the Operations Director, it also ensures that performance is reported onwards and upwards within the Trust to all appropriate levels and ensures that external performance reporting is consistent with internal reporting.

The Trust has implemented “Connecting Care”; infrastructure and methodology which provides a foundation for innovation and organisational improvement based on standardisation of our core work processes, and is supported by the provision of up-to-date information to monitor and support team performance. Over 2500 staff have been trained in “Connecting Care” and we have implemented a key component, Communication Cells, across 224 clinical and non-clinical teams across the Trust. Over the next year the focus will be on rolling out Communication Cells to community services, following the transfer of clinical services from Northern Devon Healthcare NHS Trust.

In addition the Trust will extend the use of the Strategic Deployment Matrix beyond the Executive Team to the next level of management teams. This tool provides an effective way of prioritising and tracking performance, including quality, against key deliverables and results for the organisation.

Risks to Quality

The Trust has identified the main risk to delivering the quality plan as that outlined on the Trust's Board Assurance Framework, notably the potential impact of financial constraint on ability to maintain quality. The risk mitigation centres on the robust quality assurance framework which is in place, incorporating a balance of hard, empiric data and soft intelligence which alerts relevant levels of clinicians and managers throughout the Trust of any deterioration in quality.

Delayed Transfers of Care continue to represent a significant system quality risk. The Trust is actively engaged in the system work plan, aligned to the NEW Devon Success Regime and FutureCare Programme focused on redesigning the model of care and associated service delivery model required to ensure that citizens are cared for in the right place, at the right time, by the right people.

An additional risk is in relation to any delay beyond 1st June 2016 regarding the transfer of the community services which could negatively impact on the delivery plan and the subsequent quality benefits. The risk mitigation centres on the execution of a robust due diligence process in accordance with Monitor guidance.

Care Quality Commission

The Trust is currently registered without condition with the Care Quality Commission (CQC) and has maintained an Intelligent Monitoring score of 6 (the highest score possible, indicative of low risk) for three consecutive quarters.

The CQC undertook a formal, routine, announced inspection in November 2015. The Trust was rated overall as "Good" but was judged "Outstanding" for caring and for the services provided by the Emergency Department and the Intensive Care Unit. The report praises the Trust's culture as "strongly focused on quality and safety with patients being the absolute priority". The report identifies a number of areas of outstanding practice including, survival rates for patients who have suffered a cardiac arrest are double the national average, that there have been no "never events" for 3 years, no cases of MRSA for almost 5 years and outcomes for patients were good or outstanding.

A small number of actions were identified which the Trust is working through, some of which have already been completed. None of the actions require significant additional investment and the financial plans are consistent with delivery of the required actions.

Safety Priorities 2016/17

The Trust has an annual Patient Safety Programme which is led by the Deputy Chief Executive/Chief Nurse and delivered by the Patient Safety Group (a sub group of the Governance Committee) which is chaired by the Head of Safety, Risk and Patient Experience. Key highlights for 2015/16 have been a focus on reduction of falls and pressure ulcers, Human Factors awareness and training, Acute Kidney Injury (AKI) and Sepsis in our Emergency areas. Key highlights for 2016/17 will be:

- Acute Kidney Injury – implementation of an acute kidney injury care bundle to prevent cases of Acute Kidney Injury developing.

- Medication Safety Thermometer – the traditional NHS Safety Thermometer is firmly embedded within the Trust and performance is consistently in the upper quartile nationally. The aim of the programme this year will be to adopt a Trust wide approach on alternate months to support the improvement in Medication Reconciliation, Allergy Status, Medication Omission, and identifying harm from high risk medicines in line with Domain 5 of the NHS Outcomes Framework.
- Sepsis Care including the use of SBAR- the aim of the work will be to ensure that our ward based areas including maternity rapidly assess and treat patients who develop sepsis through their in-patient admission.
- Safety Culture is of paramount importance. We are in the upper quartile nationally for incident reporting and we plan to work with the AHSN to take some designated teams through safety climate work. Following the transfer of community services the Trust will look to develop an integrated Patient Safety Programme for 2016 / 2017 that will include formal sign up to the Sign Up to Safety Campaign.

Association of Medical Royal Colleges' Responsible Consultant guidance

The Association of Medical Royal Colleges guidance on the Responsible Consultant has been fully taken into account. In the majority of cases the responsible consultant remains the same throughout the patient's stay in hospital. Where care is transferred to a more clinically appropriate team the role is formally handed over to a new Responsible Consultant and a robust and documented handover is undertaken and is appropriately communicated. In a smaller number of cases the role of the Responsible Consultant is transferred within the same clinical team, such as where a week on service is provided, again a transfer of the role is handed over and communicated appropriately. The Responsible consultant's name, along with that of their named nurse, is written on a board next to each patient's bedside. The Responsible Consultants name is also recorded on each ward's patient information / flow board to ensure that all parties are aware of the named responsible consultant.

Seven Day Services

The RD&E has already made significant progress towards the implementation of 7 day services. There has been a significant increase in the number of specialties offering a full 7 day consultant delivered service and an increase in the capacity within diagnostics to provide 7 day access for inpatients admitted as emergencies. We have extended and increased consultant cover / input on the Acute Medical Unit and implemented a Surgical Assessment Unit, operating 7 days per week, to improve our time to first consultant review.

Through our robust mortality review processes, we regularly track mortality rates in a granular level of detail, this shows that we consistently achieve within the expected ranges for patients admitted at both weekends and week days. Our crude mortality rate shows no difference for patients admitted as emergencies on either weekdays or weekends. The changes that have been made in implementing 7 day services are a significant contributory factor to this position

A recent case-note review against the 4 priority clinical standards for 7 day services has shown;

Time to first consultant review

  - At a Trust level 70% of Emergency Admissions are seen by a Consultant within 14 hours of their admission 7 days per week.
  - 52% of patients are seen by a consultant within 6 hours of their Admission 7 days per week
- On-Going Review
  - At a Trust level 84% of patients that are transferred to a base ward are seen once every 24 hours on a consultant delivered ward round 7 days per week
  - 33% of patients admitted to an assessment or High dependency unit are seen twice daily
    - Lower % driven by patients on AMU / StAU – patients are only seen twice daily on the basis on clinic need
    - 100% of patients are seen twice daily on ITU
    - 100% of patients are seen twice daily on Paediatric HDU
    - 60% of patients are seen twice daily on Respiratory HDU

Given the progress already made, 2016/17 will be a year of consolidation rather than extension of 7 day services – we need to ensure that our current 7-day service provision is working as effectively as possible before further developments are implemented. We will continue to monitor our performance against the 4 priority clinical standards - using a specialty level case note review process and to respond to any material changes in performance which require addressing. Through the triangulation of our data we will monitor for any patient safety, clinical outcome and patient experience concerns pertaining to current access to 7 day services, and seek to further mitigate these concerns where changes can be achieved within the existing resources available, or provide an affordable cost-benefit.

In parallel we will continue to work on incremental technical / process changes to support the implementation of the wider clinical standards e.g. creation of a standardised electronic inpatient referral process, the use of summary care records, further improvements to shift handover processes.

Quality impact assessment process

In order to ensure that there are no adverse consequences on patient safety, clinical effectiveness, workforce, patient and staff experience from any CIP schemes, a Quality Impact Assessment (QIA) is carried out for all CIP schemes. The Hospital Operations Board has oversight of the QIA process to ensure that it is complied with. High risk schemes are reviewed by the Deputy Chief Executive/Chief Nurse and Medical Director who make a decision about whether they can proceed.

Triangulation of indicators

The Trust's Performance Framework ensures that performance monitoring and performance are aligned from service line and ward level to Board. The monthly Board Integrated Performance Report includes a wide range of national and local performance indicators grouped by the following themes,

- Clinical Effectiveness
- Workforce
- Patient Experience
- Safety and Safer Staffing
- Operational Effectiveness
- Finance

These are accompanied by RAG ratings of historic and current performance, assessments of future risk, narrative commentary and remedial action plans as required. The integration of these indicators within a single report provides a read-across between indicators and themes that is made explicit within the accompanying narrative. Performance across the majority of targets is consistently good.

An Appendix within the IPR includes the 'Ward to Board' report that displays ward-level safety and quality indicators and thereby provides triangulation at a more granular level, minimising the risk that Trust-wide performance could mask individual areas of concern.

Each Clinical Division meets monthly with the corporate team (Finance, Performance, Workforce, Quality) in a Divisional Performance Meeting to review a set of Divisional and Specialty-level dashboards covering a more detailed set of indicators across all themes. The reports that are prepared for the meeting provides the opportunity for the Clinical Division to undertake its own triangulations and this is tested and challenged in the meetings.

The range of indicators covered by the IPR and the Divisional Performance meetings is extensive. As requested as part of the Operational Planning submission, ten representative local indicators are included in the templates along with trajectories for 2016/17. For three indicators (Proportion of Patients Prescribed Antibiotics for whom Empirical Therapy was Per Guidelines; Median Average Number of Patients "Green to Go" on Community Waiting List at the end of Each Day in Month; Monthly Sickness Absence Rate Amongst all Staff Groups) the trajectories do not show achievement of the local stretch target, based upon performance in 2015/16. This is partly because the local targets are designed to be challenging and some have been made more stretching over time (e.g. antibiotic prescribing), but also because the 2016/17 plans are still in development at the time of submission of this draft Operational Plan.

Approach to workforce planning

During 2015/16 we have embedded an improved annual workforce planning process which quantifies the workforce demand, by role type, together with identifying any different and/or increased requirement that may be driven by the Trust's operational plans (derived from commissioning discussions) and/or to meet our clinical service strategy. During 2016/17 this process will be extended across a wider footprint as a result of the transfer of community services and the redesign of clinical pathways/services via the FutureCare Programme.

The workforce planning process is service line driven and is completed by our service line cluster teams led by a Clinical Lead, Senior Nurse and Operational Manager. Each Cluster

team will submit their workforce plan and these will be collated into a divisional workforce plan for 1st level approval by the Divisional Leadership Team involving Associate Medical Directors, Assistant Directors of Nursing and Divisional Directors. Once approved the divisional workforce plan then forms part of the overall Trust workforce plan which then receives 2nd level approval by the Hospital Operations Board and ratified by the Executive Team.

From a governance perspective, the Trust has robust processes in place to ensure successful delivery against the strategic and operational plans, and the workforce plan is an integral part of this approach.

At the strategic level the Trust Workforce Strategy is owned by the Executive Director of Transformation and Organisational Development ensuring ownership and visibility at the Board and Executive Team level. As described above workforce plans are developed by the clinical divisional teams, reviewed by the Hospital Operations Board and ratified by the Executive Team prior to submission to Health Education South West. As mentioned previously the delivery of the Workforce Strategy is supported by five Sub Groups: Medical; Nursing, Midwifery and AHP; Scientists; Ancillary; Admin & Clerical.

The FutureCare Programme engages staff and external partners and stakeholders in the radical redesign of today's clinical pathways and services, and throughout this work the workforce implications will be identified and managed. This work will involve clinical and non-clinical staff across the acute and community settings to ensure we take a whole end to end pathway approach to the redesign ensuring that interfaces at the 'front' and 'back door' are smooth and effective.

The Workforce Sub Groups, formed to deliver the overall Trust Workforce Strategy, play a key role in ensuring the internal supply of capable resource to meet operational demand as well as being a key interface with external providers such as local universities. Here are some examples of the work the Sub Groups will continue to deliver during 2016/17:

- We are expanding our capacity to take adult nurse training placements and will continue to support & promote the Widening Access initiatives in line with our strategy to promote opportunities for people to work within the care setting.
- We will continue to review and define changes to roles, increased flexibility requirements and changes to delivery of education and training. There are also likely to be operational challenges as the numbers of staff working remotely increases linked to the establishment of a future workforce aligned to the new model of care.
- To address the needs of both today's clinical services, and that of the future, the Sub Groups will continue to have a parallel focus within our Workforce Strategy to improve the external supply of capable workforce and to develop our existing staff.
- Potential investment may be required to support individuals in education and learning activity to ensure new or changing service needs can be met, and to ensure that any redesign of system-wide care pathways can be delivered safely and efficiently.
- We will continue to work with education providers and Health Education South West to inform their plans ensuring workforce supply needs are met for the Trust and

regionally. In reality we have a number of 'hard to fill' roles which require us to take a range of interim steps to ensure continuity of service delivery, for example Allied Health Professional roles such as Occupational Therapists and Radiographers. The interim steps will include international recruitment and a review of skill mix whilst the work with Health Education South West and educational Providers develops longer term solutions.

During 2015/16, we have improved compliance from 70% to 90% for e-rostering processes to ensure consistency of approach and, more importantly, supply of capable resource at the right time. Safe staffing levels have been maintained across the year during which agency usage has been reduced by almost 80% across both registered and unregistered nursing staff primarily through effective recruitment of more than 300 registered nurses during the year.

The Trust workforce plan is submitted to Health Education South West in accordance with their timetable and we continue to build on the success of 2015/16 in strengthening our relationships with them to influence future commissioning of training places. The workforce plan is monitored via the governance approach described below with all changes reflected in the plan to ensure it remains aligned to the needs of the Trust.

Triangulation takes place at every level but is particularly prominent at the Monthly Divisional Performance meetings that incorporate support and challenge in respect of the divisional workforce performance metrics. Metrics are subject to exploration specifically in the context of safety and quality of service delivery include safe staffing, sickness, bank and agency usage, statutory, mandatory and essential training and staff turnover. Every six months there are Divisional Performance Review sessions for each division with the Executive Team.

In addition to the above, the corporate governance approach includes a Workforce Governance Committee that provide assurance to the Trust Governance Committee across the range of workforce related areas of risk.

The Workforce Strategy team has played and will continue to play a leading role in the collaborative work taking place with other Trusts across the region to reduce reliance on agency workers and therefore spend. The common objective is to reduce usage to a minimum and, where agency use is needed, to only use framework agencies and for all Trusts to pay consistent rates within the agreed price caps. A range of strategies have been employed to reduce agency use and staff bank statistics show registered and unregistered nursing shifts being reduced from 1531 shifts in January 2015 to just 318 in January 2016 whilst continuing to deliver safe staffing levels.

In addition, we have had a priority focus on our nursing workforce staff group and, as a result, have recruited 304 FTE registered nurses and 207 FTE unregistered nurses over the last 12 months. At the time of writing we have 30 FTE registered nurse and 10 FTE unregistered nurse vacancies which has been the main contributory factor to reducing our nursing agency spend from £7.6m in 2014/15 to a predicted year end spend of £3.4m for 2015/16.

Workforce Strategy Sub-Group Governance Arrangements

At an operational level, robust reporting mechanisms hold relevant areas (Operational and HR) to account for delivery against a range of metrics, reported monthly through a series of reports and dashboards, and deliver active management of workforce risks. These include:

- Monthly Ward to Board reports
- Monthly Safe Staffing reports
- Monthly Workforce reporting to Hospital Operations Board (HOB)
- Monthly Workforce reporting to Executive Operations Group as part of the HOB update
- Monthly Divisional Performance Meetings

These mechanisms all have either direct access to the Executive Management Group or to the Trust Board.

Approach to financial planning

Financial forecasts and modelling

Context

Since 2013/14 the Trust has experienced an increasing deficit position rising from £3.1m (before impairments) to £11.2m in 2014/15 and a forecast deficit of £20.0m in 2015/16.

The work carried out by the Trust Board in understanding the "Drivers of the Deficit" which was forwarded to Monitor in December 2015, highlighted the key reasons as:-

- Failure to achieve the levels of efficiency required from tariff (£10m); and
- Additional non activity related costs incurred (£8.3m) relating to issues such as additional ward establishment costs to meet required staffing ratios, as well as additional medical staffing costs in part relating to increased waiting list initiatives.
- Additional costs relating to an increase in agency expenditure, the premium for which accounts for £3.6m.

The specific areas that the Trust will be working on to reduce the deficit have been identified as:-

Issues directly in the Trust's control

- Reduce costs (Agency, Admin staffing, Non Pay)
- Improvement in SLR positions (Top 5 priority areas)
- Concentrate on productivity improvements e.g. Lord Carter
- Transfer of community services for Eastern sector (improve efficiency & LOS)

Issues that the Trust will need to influence system wide transformation

- Reduce length of stay (system wide approach to delayed discharges)

- Community Midwifery – Review of service provision
- Deliver opportunities identified by Success Regime

For 2016/17, the Trust is planning for an operational income and expenditure deficit of £6.596m in line with the revised control total identified by Monitor to the Trust on 8th March. The Board of Directors confirmed acceptance of this offer and understands and accepts the conditions attached to this offer. The impact on the Trust is to increase the CIP requirement from £7.9m to £11.5m.

This operational plan has been developed based on traditional operational planning processes, however there has already been a significant amount of work on developing a system wide plan for Devon as part of the Success Regime. The impact of this work on individual organisational plans will become clearer when the final plans are produced, however from work carried out to date it is recognised that the challenge for the Devon health system is to deliver circa £130m of savings in 2016/17 in order to achieve the combined control totals of all the Commissioners/Providers in the system. In order to enable a focus on cost reduction across the Devon Health Economy, it is likely that the RDE, along with other Providers will contract based on a fixed financial value.

The table below highlights the key financial indicators.

	2015/16 forecast outturn £m	2016/17 plan * £m
Patient Income	332.4	399.1
Commercial Income	70.8	76.7
Total Income	403.2	475.8
Expenditure	-423.2	-482.4
Deficit	**-20.0**	**-6.6**
Cash	13.4	6.7
Capital	8.3	12.4
Loan Requirement	0.0	0.0
EBITDA	**0.5%**	**2.7%**
FSRR	**2**	**2**

** Including transfer of Eastern Devon community services*

The key movements from the forecast position for 2015/16 to the 2016/17 plan are additional income and cost for Integration of Community services (£43.9m), Income & expense growth for 2016/17 of £5m, and inflation costs of £11.1m.

Activity

Activity planning is covered on page 2 of this document. The Trust is working closely with the CCG and other providers under the Success Regime to ensure that the Devon Health Economy can achieve financial sustainability and deliver performance targets, quality targets and comply with all other national requirements. Local commissioning intentions are aligned with this collective purpose and there is commitment to jointly manage demand and transform supply, supported by a Right Care methodology. The QIPP plans that will result from this work are not yet fully worked-up

and will be included in the final Operational Plan. More details of the Success Regime work are included in the final section of this draft Operational Plan.

When the 2016/17 Standard Contract and CQUIN Guidance are published the Trust will assess whether any changes to the financial plan are required (e.g. in relation to any changes in the performance sanctions rules).

Cost Assumptions

The key assumptions which impact on cost are inflation, efficiency (CIP), activity growth and strategic expenditure issues, the detailed assumptions for which are set out below:

Inflation

An uplift in cost for 2016/17 has been assumed at £11.1m. This reflects known changes such as CNST, pay and non-pay inflation, pensions and capital charges with the balance relating to reserves which have been set aside for the year (based on the information in the table below) until cost increases are known.

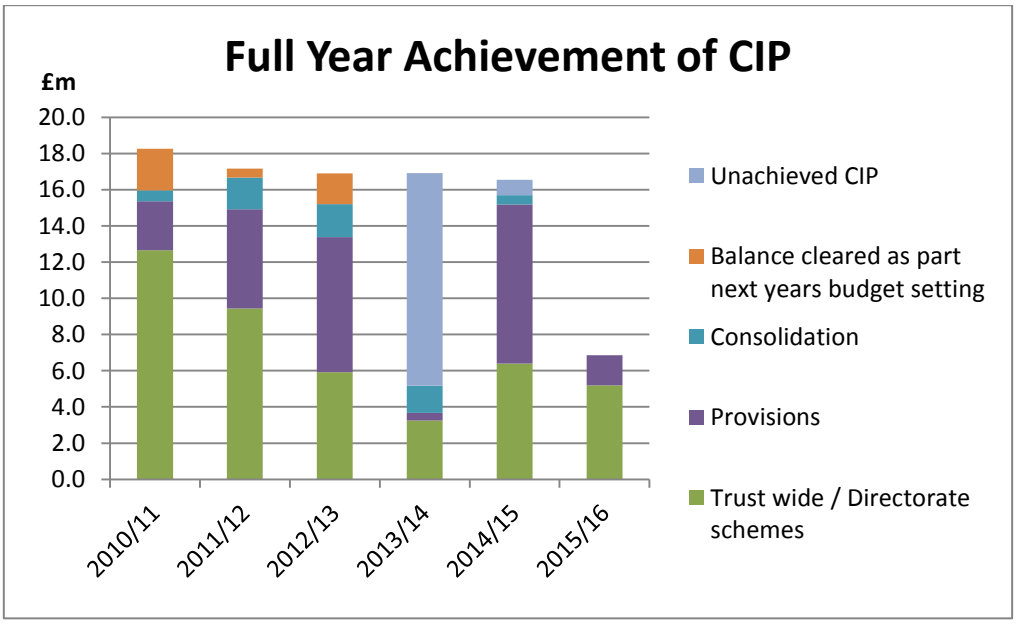
Description	2016/17	£m	Basis of calculation
Pay Inflation/Incremental Uplift	1.22%	3.6	In line with agreed AFC pay settlement.
Pension increase	1.38%	4.0	Revised employers pension contributions in 2016/17 in line with national guidance.
CEA awards / incremental	0.20%	0.6	For 2016/17 Clinical Excellence Awards, derived based on the national calculation for CEAs. Increments are based on expected increase for 2016/17.
Non pay	0.30%	0.9	1.0% of 2015/16 non-pay budget.
Drugs	0.14%	0.4	4.5% of 2015/16 drugs budget excluding pass through drugs recharged to the commissioner.
Capital Charges	-0.27%	-0.8	Forecast capital charge decrease expected for 2016/17.
CNST	0.37%	1.1	Increase as per NHSLA notification.
Other	0.57%	1.6	Anticipated additional expenditure/income reduction changes not currently covered as part of budget setting.
Commercial income	-0.11%	-0.3	1% applied to income from all NHS and non-NHS bodies.
	3.80%	11.1	

Efficiency savings for 2016/17

The CIP target has been set taking into account the 2% efficiency requirement, £2m provision for in-year additional cost pressures and developments and the impact of the Sustainability and Transformation Fund General Element which has allocated £10.0m to the Trust for 2016/17. Following subsequent discussions in January 2016, the Board has agreed to deliver a £6.596m control target which will require an £11.5m CIP target.

The table on pages 22/23 sets out the potential risk of non-delivery of CIP in addition to other factors. The Board recognises that although achievement of the 2% efficiency saving is likely to be challenging, it is thought to be achievable. The risk of delivering the additional £3.6m in order to achieve the control total is however thought to be higher as this will be more dependent on delivery of CIP's through closer working with Success regime partners.

The following chart shows CIP achievement from 2010/11 through to 2015/16. Savings in 2015/16 were delivered through a mixture of trust wide/divisional schemes and provisions.



Lord Carter's provider productivity work programme

The Trust is in the second cohort of providers working with the NHS Productivity and Efficiency programme set up by Lord Carter of Coles. Data has been provided and subsequent reports received have been reviewed for opportunities for saving. Early indications are that the Trust has an Adjusted Treatment Cost (ATC) of 99p and therefore has costs that are less than the mean of the participating providers. The programme has reported our total costs should be in the region of £328m as opposed to our actual costs of £326m. However, the programme has calculated that the Trust's potential ATC savings opportunity is £28.0m compared to the national mean.

Further discussions and meetings with representatives from the Productivity and Efficiency team have taken place regarding the validity of the £28.0m savings. Whilst it has been acknowledged by the Trust that there are some savings opportunities within the work under taken by the Productivity and Efficiency Team, the level of realisable savings will be determined once further information has been received.

The Trust is an active partner in the Northern, Eastern and Western Devon Success Regime and engaged in planning system wide transformation that will significantly impact on the Trust in 2016/17. This will be played into CIP plans and delivery as and when appropriate.

In addition, the Executive Operations Group have considered a range of options for optimising CIP delivery in 2016/17 and have agreed that a small range of high value cost reduction CIP schemes will be the focus in 2016/17.

The high value schemes are:

	16/17 CIP £'000	Full Year CIP £'000
Workforce:	850	1,259
• Agency spend *		
• Medical staff		
• Corporate and Administrative staffing *		
Non-pay:	1,200	2,000
• Estates *		
• Pathology Futures *		
• Procurement - Clinical and non-clinical supplies and services *		
Bed based care:	1,000	2,000
• Productivity in wards • Improved discharge processes		
• Frailty/dementia hubs		
• Enhanced care coordination (e.g. early supported discharge)		
• Care home education		
• Admission avoidance/ambulatory care		
Elective Care		730
• Theatre productivity		
• Outpatients		
Divisional CIP targets	5,000	
Commercial income		500
Specialty productivity *		2,000
15/16 provisions potentially not required	2,600	2,600
16/17 provisions (up to £2.8m 16/17, £1.4 full year)	899	460
Total	**11,549**	**11,549**

** Schemes related to items highlighted in the Lord Carter Review*

Agency Nursing Cost

The forecast expenditure related to the use of agencies for the provision of nursing staff (both registered and un-registered nurses) reduced significantly during 2015/16 compared to 2014/15 (£7.6m in 14/15 and forecast to be £3.4m forecast year end at month 11). The premium associated within this cost for the use of agencies is estimated to be circa £2.0m. The main reasons for this expenditure are due to vacancies, increased dependency and acuity of patients requiring one to one care, and the opening of additional beds to manage winter pressures.

Throughout 2015/16 the Nursing Workforce Strategy Group have created and delivered a number of strategies to reduce the reliance on agency staff by increasing the robustness of processes to recruit and retain staff, and increase the usage of the Trust's Bank Staff. The number of vacancies of un-registered nurses has been reduced to a minimal/sustainable level and efforts continue to do the same with vacancies of registered nurses.

Our booking processes automatically place requests with framework agencies who have indicated they are willing to provide at or below the capped rates. Rates for specialist nurses, registered mental health nurses, theatres and critical care nurses are very challenging and we are negotiating with our agency suppliers to reduce their pricing structures. The Trust has been a major contributor to a regional consortium initiative to reduce medical agency spend and continues to maximise these opportunities. We are co-ordinating a collaborative with 13 Trusts in the region to reduce nursing agency spend. Regional working is important to stabilise the temporary workforce and reducing the potential impact on patient safety whilst maximising negotiation with agencies to drive rates down. We are also examining the reasons for agency usage in other staff groups in order to reduce reliance on agencies.

An external organisation continues to be used for the recruitment of overseas nurses to limit the reliance on agencies. For the vast majority of shifts the Trust has complied with the recent guidance on capping rates paid to agencies and ensuring only those agencies on procurement frameworks are used. Any exception to the guidance has been flagged back to Monitor and each shift is signed off by the Director of Nursing/Deputy Chief Executive. Also the Trust has engaged with other local NHS organisations to work collaboratively to share knowledge, processes and where possible bank staff.

The need to use some agency nurses during 2016/17 will remain but every effort to contain this is being taken. A provision of £2.3m has been set aside to cover the cost of the agency premium over the Agenda for Change rate.

A letter has been received by NHS Improvement setting out a ceiling on level of agency expenditure for 2016/17. This ceiling has been set at £7.348m, and compares to a forecast expenditure of £7.8m for 2015/16 (£12.1m in 2014/15). The ceiling will not have taken account of the transfer of Community Services from 1st June 2016, and therefore a request will be made to increase the value of this ceiling. Total Agency costs included in the plan are £10.172m of which £7.322m relate to RD&E 'Business As Usual' position which is within the £7.348m ceiling. The remaining £2.850m relate to the transferred costs identified for TCS expected to be incurred from June 2016.

Reporting against Safer Staffing requirements and agency spend will be included within the Integrated Performance Report to the Board each month.

Procurement

Reductions in non-pay spend are being supported by the procurement team working with clinical and non-clinical teams to identify best value products and services through analysis of data from several sources including the Lord Carter of Coles work, service line reporting and from the Success Regime. Small investments in additional spend analysis tools (Bravo Health Analytics) will allow for further scrutiny of variance both within the Trust and allow benchmarking against our peers. Collaboration in the wider geographic vicinity continues through the Peninsular Purchasing and Supply Alliance and wider alliances. The opportunity to bulk buy at discounted prices direct from suppliers has increased the rate of price reductions particularly on high volume consumable lines. The Trust Medical Director leads the Trust steering group, driving through safe changes to products and services which will achieve better value to the Trust.

2015/16 & 2016/17 Cost of Activity Growth

As described within the section on income, the costs of activity growth are assumed to be 100% of the income received for 2016/17. This results in an expenditure reserve for 2016/17 of £5.4m (including £1.3m relating to growth expected in relation to pass through drugs and devices).

During 2015/16 however the Trust has underperformed on patient income (£3.6m lower then plan at month 11), and therefore the expectation is that this value will be removed from Divisional budgets.

The Divisions are currently going through a process of identifying reductions to both pay and non-pay funding in order to offset the planned reductions in income.

Transfer of Community Services

Current plans reflect that as of the 1st June 2016 the provision of services at Community Hospitals in East Devon will transfer to the RD&E Trust. The plan includes expenditure of £43.9m (£52.7m full year) relating to providing NHS clinical income services, and this value corresponds with the value provided to us by the Northern Devon Healthcare NHS Trust with an adjustment relating to inflation. Income relating to these services has been assumed to be equivalent to 100% of the expenditure. The expenditure has been apportioned between pay and non-pay based on the staffing numbers and levels received valued at average rates with the remainder being allocated to non-pay in line with the Trust's current split of non-pay categories.

Other Operational Expenditure issues

- Winter Pressures (£2.5m). Increased expenditure as a result of opening additional inpatient beds during the winter months during 2016/17 is expected to be incurred. £3.5m was provided for 2015/16.

- Although the new Junior Doctors contract has yet to be issued, the Trust is currently working to identify whether there are any financial implications as a result of the new contract. No provision has been made in the financial plan with the exception of a 1% pay uplift for 2016/17.

- Other reserves / contingency. A recurring revenue reserve / contingency of £3m has been provided for 2016/17. This relates to a £1m reserve for operational or strategic developments, £1m for essential requests that arise during the year and a £1m contingency. Due to the financial position of the Trust, expenditure will not be committed unless it is essential for delivery of the operational or strategic needs of the Trust.

Capital

The Trust's capital programme has been limited to investment in essential capital assets to help support the Trust's cash liquidity. The value of capital expenditure continues to remain lower than the value of depreciation.

A robust capital planning process has been undertaken, capital requests have been risk assessed and checked for consistency, linked to the Trust's strategy, with procurement and lead times being duly considered.

Leasing arrangements will be further considered, for larger schemes, to help support the Trust's cash liquidity.

Capital funding has been focused on replacing existing equipment and IM&T and for re-investment in the Trust's current estate.

Replacement equipment

Replacement equipment requests for 2016/17 have been evaluated and prioritised based upon their risk assessment scores. From the assessments undertaken it was identified that investment of £4m is required in 2016/17.

Estates infrastructure

The level of expenditure for reinvestment in the Trust's estate is provisionally allocated at £1.8m. The purpose of this investment is to continue to reinvest and update the Trust's existing estates infrastructure, so the Trust can continue to maintain its sound operational delivery of services.

New Developments

Due to cash constraints, and limited cash funding support available, the Trust's capital programme has been mainly restricted to investment/replacing existing assets. A £1m development reserve has been allocated to fund the early stages of new developments, subject to further assessments of business need e.g. 4th Linear Accelerator. The plan assumes that the £1m development fund will be sufficient to meet any proposed new development expenditure in 2016/17. External capital funding will be required from 2017/18 to fully fund any approved new developments.

The Trust is focused on establishing a new model of care for the population of Exeter and East Devon. To support this significant change a comprehensive full business case (FBC) was produced outlining the implementation of an EPR system to enable radical transformation of end to end clinical pathways and services to be delivered through the Acute Pathways Transformation Programme. Whilst the FBC focused on transformation activity within an acute setting, the introduction of an EPR would also enable the wider integration agenda outlined as part of the FutureCare Programme spanning the wider health system. Following Trust Board approval of the FBC initial discussions around funding support have taken place, but as loan financing has not been approved the financial effect has not been included within the annual financial plan.

Contingency

A capital contingency fund of £1m is available, similar to previous years, to fund the urgent replacement of equipment that was not planned to be replaced. This funding will only be used when it is essential to replace an asset and unspent funds will be used to support the Trust's cash position.

Capital schemes brought forward from 2015/16

The Annual Plan includes £4.6m of capital schemes that were approved in 2015/16, but have been deferred until 2016/17 to help maintain cash liquidity

Summary of Capital expenditure 2016/17

Category	£m
Replacement equipment	4.0
Estates infrastructure	1.8
New developments	1.0
Contingency	1.0
Schemes brought forward from 2015/16	4.6
Total	**12.4**

Transfer of Community Services

Although there will not be a transfer of buildings from Northern Devon NHS Trust to the RD&E as these will be leased from NHS Property services, there is likely to be a transfer of equipment and current assets (stock). The value of this transfer has yet to be determined until further due diligence work has been carried out, however this will likely require a transfer of PDC capital to the RD&E which is not currently reflected in the plan.

Additionally the Operational Plan does not reflect the purchase of capital assets for 16/17 relating to Community services.

Cash

The cash balance forecast at the end of March 2016 is £13.4m, and the balance is forecast to reduce to £6.7m by the end of March 2017, with the lowest balance reducing to £4.5m during the year. The deterioration is mainly due to the Trust forecasting to incur an operational deficit of £6.596m. The below table summarises the main forecast changes to the Trust's cash position.

The plan has been prepared on the basis that the Trust will not require interim or planned cash support from the Department of Health within 2016/17. The Trust will manage its cash to meet its operating expenditure. This will be dependent upon the Trust meeting its planned financial deficit and other financial targets. A section below includes details of the identified financial risks and mitigations. If some of these risks were realised the Trust may require some financial funding to support its liquidity. Our relationship manager, at NHS Improvement, has been advised that the Trust may require some financial support in 2016/17.

	£m	£m
Opening cash 1 April 2016		**13.4**
Deficit for the year	(6.6)	
Depreciation expenditure non-cash cost included in above deficit	12.3	
		5.7
Capital expenditure as reported above		(12.4)
Movements in working capital		1.3
Repayment of loans		(1.3)
Closing cash 31 March 2017		**6.7**

Financial Sustainability Risk Rating (FSRR)

The impact of the financial assumption as set out above is that the FSRR is rated as a '2' throughout 2016/17. The capital service cover improves from a 1 at the end of 2015/16 to a '2', Liquidity drops from a '3' to a '2' by March 2017 with liquidity days of -7.5. The I&E margin is a '1' throughout the year which results in the overall FSRR being capped at a '2'.

Financial Risks and Mitigation

In setting the budget the Board is aware of a number of potential risks to the financial position which could be offset by a number of sources of mitigation. A summary of the key risks and mitigation is set out below.

Risks	Mitigation to reduce risk
Divisional Overspends impact on CoSRR and cash	• Monthly performance meetings with Divisions to monitor performance and agree corrective action • Monthly escalation process to Executives • Monthly reporting to HOB/Executive Group and Board
CIP fails to deliver minimum levels required	• Monthly meetings in each Division & dedicated to identification and delivery of CIP schemes • Monthly performance meetings with Divisions to monitor performance and agree corrective action • Monthly escalation process to Executives • Fortnightly review of CIP schemes through the Finance Recovery Group (FRG) • Monthly reporting to HOB/Executive Group and Board • Monitoring and exception process through HOB
Access to new capital loans is restricted, compromising the Corporate Strategy	• Detailed work up of likely loan requirement • Early engagement with FTFF • Identification of Business partners (Partnerships and Joint Ventures) and leasing options for alternative funding sources
Health economy pace of delivery of c.£130m of savings in 2016/17 in order to achieve the combined control totals of all the Purchasers/Providers in the system.	• Overseen by Success Regime.

Insufficient management capacity and capability to deliver the operational and strategic plan	• Organisation restructured to facilitate greater clinical and management time – less working down. • Regular workload review and prioritisation • Identification of funding and capacity through short term contracts for specific projects (TCS)
Inability to fund revenue implications of the corporate strategy	• Continued engagement with local and specialised commissioners • Continued partnership working with local health and social care economy (Success regime) – maximise opportunities e.g. Better Care Fund • Profile income generating projects

Sensitivity Analysis

Sensitivity analysis has been undertaken as part of the planning process for 2016/17. The following upsides and downsides factors have been identified, but have not been included within the base plan. If these factors were realised, the Trust's deficit would rise from the planned deficit of £6.6m to an £12.1m deficit. The FSRR would remain as a '2'.

Upsides not included within the base plan	**Value**	**Likelihood**	**Net Value**
	£m	**%**	**£m**
Contingency not required	1.0	50%	0.5
Scoreboard / Development reserve not required	2.0	25%	0.5
Sub-total of upsides – decrease deficit			**1.0**

Downsides not included within the base plan	**Value**	**Likelihood**	**Net Value**
	£m	**%**	**£m**
CIP PBR efficiency not achieved	(5.9)	25%	(1.5)
CIP - additional target to achieve £6.6m deficit not achieved	(3.6)	35%	(1.3)
Sustainability and transformation funding not received due to failure to achieve operational or financial targets	(10.0)	25%	(2.5)
Underperformance on patient income	(5.0)	25%	(1.2)
Sub-total of downsides – increase deficit			**(6.5**)

Net total of upsides and downsides	**(5.5)**

Link to the emerging 'Sustainability and Transformation Plan' (STP)

Overview

The Devon health economy is a first wave Success Regime system[1]. There is Board-level agreement of the system-wide approach across the organisations and joint planning process in place which will then progress to co-ordinated implementation.

Despite significant challenges, the 2015/16 system control total has been delivered when many other systems have breached their control totals. The organisations within the Success Regime are working together well, supported by Carnall Farrar, to identify significant operational and transformational change that (i) can be implemented in 2016/17 in order to deliver each organisation's in year targets, and (ii) delivers a sustainable future for the system over the next two - three years. Without these changes, the system-wide £95m deficit in 2015/16 would rise to £177m deficit in 2016/17 and by 2020/21 the combined health and social care financial challenge would be £442m (14% of funding).

Each organisation's 2016/17 control total is set out below:

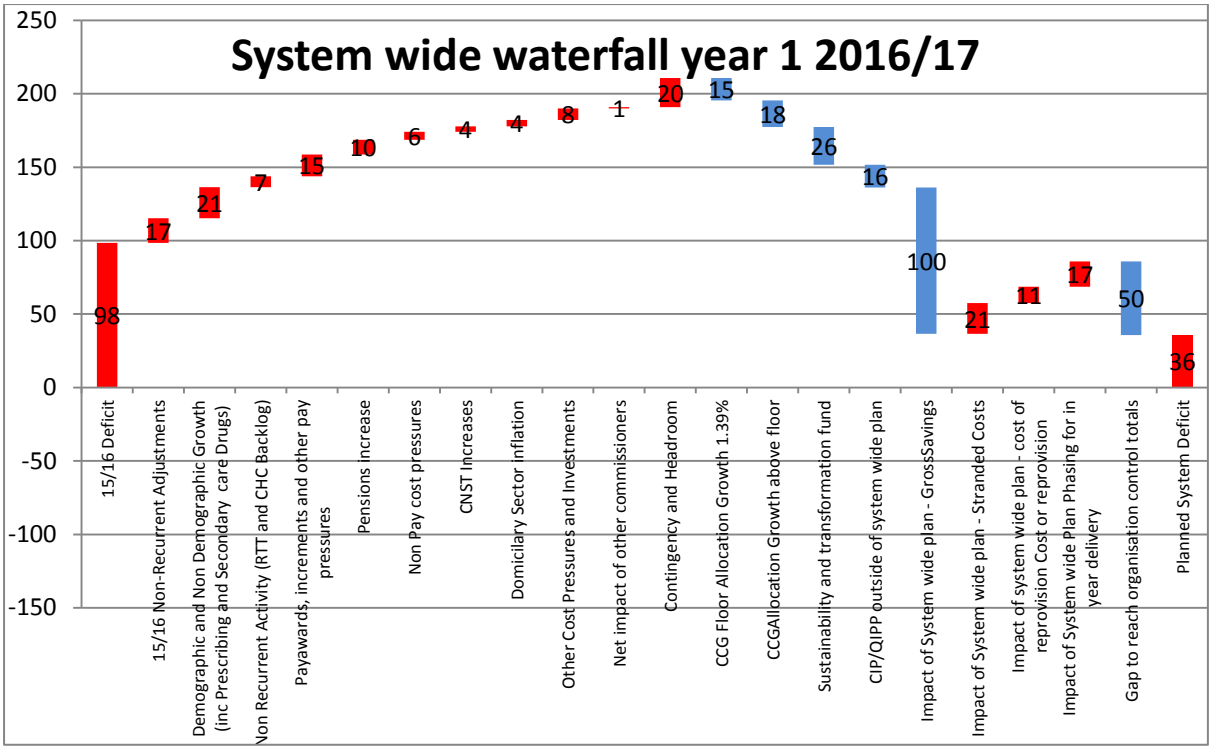
Plymouth Hospital NHS Trust	£11.9m Deficit
Royal Devon and Exeter NHS Foundation Trust	£ 6.6m Deficit
Northern Devon Healthcare NHS Trust	£1.4m Surplus
Devon Partnership NHS Trust	£1.6m Surplus

The CCG does not yet have a confirmed control total with NHS England. The current planned position is as follows however, this does not yet address the requirement to evidence sustainable breakeven at a point in the year.

NEW Devon CCG	£35m Deficit (£22m if 1% headroom is utilised)

The waterfall analysis in the following chart sets out a target cost reduction for the system of £131m to be delivered in the 2016/17 financial year after taking account of the Trust shares of the transformational fund, and the agreed control totals set out above (based on the CCG deficit of £22m).

[1] The STP 'footprint' also includes South Devon & Torbay CCG. While they are not currently part of the Success Regime they will be working closely with the organisations within the Success Regime as part of the STP development.



Approach to Savings identification

The system is working together to produce a fully aligned savings plan for 2016/17. Work to date is bringing together 5 themes produced by the CEOs group, the success regime quick wins and NHS Rightcare. There is duplication between these areas hence the need to integrate them to avoid double counting of savings**.** The differing approach of each perspective provides a good opportunity to challenge the scope and valuation of benefits.

The system has agreed that regardless of where the savings opportunity comes from the delivery schemes will be organised in the way that best enables clinical support and rapid implementation.

It is expected that there will come a point at which the savings opportunities identified will require phasing to ensure that the system can focus its delivery effort and not be spread too thinly. There will also be a point at which providers are unable to release costs at the pace that savings schemes can be implemented. This will mean that there will be a gap between savings implemented and costs released. Due to the nature of referral to treatment processes, there will be a significant amount of work in progress that has not yet materialised in activity which also needs to be taken into account.

At this stage we are focusing our work on maximising the value of savings schemes whilst at the same time taking care to clarify the pace at which provider costs can be removed. As we progress the plan further this will be expressed in terms of the impact on the head-count and bed-stock amongst other indicators, together with the appropriate phasing of costs release.

The table below sets out the current savings plan. This has been developed in the context of the Success Regime and aligned with the diagnostic work carried out in Phase 1. Although still provisional at this stage, the in-year savings expectations are included and all organisations are committed to significant delivery in 2016/17.

Opportunity		Description	Financial impact (£m)
Bed based care	Reduction in length of stay in acute and community hospitals	• Introduce dedicated discharge co-ordinators and reviewing admission/discharge processes at weekends. This will make sure people are not staying in hospital when they could be at home.	8
Elective care	Reduce the differences in the levels of elective (planned) care	• Reduction of levels of referrals combined with new ways of working to deliver follow up appointments. This will make sure that people are not undergoing potentially avoidable operations and appropriate setting for necessary follow ups.	8
Continuing care	Reduce the amount of money being spent on continuing care	• Continue to closely manage the eligibility criteria for those applying for continuing care and working with providers of continuing care to reduce the cost per person. This will make sure people are receiving the most suitable care.	10
Procurement	Joint procurement of back office supplies	• Working across providers to identify areas where services could be quickly re-tendered and where joint procurement would lead to cost savings. This will make sure that there is best value for money for back-office services.	15
Agency spend	Reduction in spending on agency (temporary staff)	• Developing joint processes for recruiting and deploying temporary staff and exploring possibilities for joint appointments. This will make sure that quality and patient experience are not compromised because staff are not permanent.	10

System Estate Opportunities

In addition to the opportunities described above, the system is undertaking a review of its estate and other fixed assets, and has identified significant scope for improving utilisation or release, which could generate system savings of c£20m.

Provider CIP

Provider CIPs are not yet reflected in the above but the system expectation is that each organisation delivers internal budget savings of at least 1% as well as other internal schemes not requiring system support. The system plan expectation totals £15m of CIP across providers and the RD&E's contribution to this is consistent with our financial plans.

Co-ordinated Delivery of Savings

The Success Regime has improved the effectiveness of inter-organisational working and these relationships will continue to be the foundation of sustainable delivery. New models of care will be implemented across the system to deliver equitable services and waiting times. The focus will be upon real cost reduction rather than passing financial problems between organisations. The agreement to work jointly across the system will reduce the staff time devoted to contractual processes and will give additional capacity to deliver transformational change and financial savings.

Summary and Risks

2016/17 represents a significant challenge for all organisations in the Devon health economy, but we are committed to working together to solve the system problem. Once the savings plans are agreed it will be necessary to address any residual 2016/17 shortfall, including use of headroom, and the management of cash. In submitting our plans for 2016/17 it is recognised that the organisational impact of the above is yet to be worked through and therefore presents a number of risks. These are set out below:

- Activity flows may change rapidly causing unpredictable changes and possible unintended consequences.
- Workforce consultation processes may delay change temporarily.

- Formal consultation may be required for some changes
- Providers may take out capacity faster than demand reduces, causing further RTT pressures.

The opportunities outlined above have been included in our plans, e.g. agency expenditure, procurement etc. At this stage the impact of changes to delivery of elective care and bed based care is still being identified and, as such, it is not possible to identify the effect on the Trust's income and expenditure at this stage.

Membership and elections

Governor Elections

In 2015 we had nine vacancies for Governors. Voting took place in the Exeter & South Devon and Staff constituencies, with voting closing on 8 September 2015. We declared the following results on 9 September 2015:

- Exeter & South Devon – Richard May re-elected uncontested for a three year term. The turnout was 31.6%.
- Staff – Stacey Flay elected for a three year term and David Wilkinson elected for a two year term. The turnout was 18.9%.
- In East Devon, Dorset, Somerset and the Rest of England, Richard Bowes (3 year term) and Mervyn Symes (1 year) were elected unopposed. A vacancy for a 1 year term remains.
- In Mid, North, West Devon and Cornwall, Anne Stobart (3 years) and Chris Wilde (1 year) were re-elected unopposed with Michael James (3 years) elected.

We have nine vacancies for Governors in 2016: three in Exeter & South Devon, two in Mid, North, West Devon and Cornwall, three in East Devon, Dorset, Somerset and the Rest of England and one Staff.

For Governor recruitment, we held two prospective Governor meetings in the summer of 2015 with approximately 50 members in attendance in total. Information packs were also circulated to those unable to attend and these were also made available online.

Governor Training

As a Foundation Trust the RD&E has a responsibility to its governors to support them and deliver training that enables them to perform their role effectively and efficiently.

Over the year this support is delivered in a number of ways including, induction, development days, COG sessions, working groups, and buddying and mentoring. The Governors also have access to a secure website and have received specific training when requested.

During 2015 the Trust held four formal development days to support the present cohort and the new governors who were elected the previous Sept. The sessions included the Trust's Strategy and Financial update, Capacity Planning, Cancer Targets and Appraisal Training.

Together with the above an induction programme for new governors was implemented and a buddying system arranged for those new governors who requested it. The new Govern Well Toolkit

which has just been produced will help to develop a systematic approach to New Governor training during 2016.

Membership

The Trust's membership strategy is based on the premise that our membership base is broadly similar in core demographics to the wider population served by the RD&E. Therefore in consulting and engaging with our members on their views, opinions and concerns then we are providing a means of better understanding the sentiment of the wider public. In addition, the Trust has sought to increase its membership base (which it has sought to do in a number of ways) in overall numbers as well as target those segments of society that are currently underrepresented. Efforts have been made in the last year to recruit carers and younger people to become members of the Trust.