ANNUAL PLAN
2009/10

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SECTION ONE:
PAST YEAR PERFORMANCE
2008/09

1.1 Chief Executive's Summary of the Year 2008/09

The Royal Devon and Exeter NHS Foundation Trust has completed its fifth successful year as an NHS Foundation Trust. Since it was authorised as one of the first group of ten NHS foundation trusts in April 2004, the Foundation Trust sector within the NHS has grown considerably with 120 NHS provider organisations having achieved the required standards.

The RD&E has performed well in comparison with other Foundation Trusts. During Quarter 1, 2 and 4 the Trust maintained a "green" rating under Monitor's compliance regime for mandatory services and governance. This is the highest level of performance against the regulators key performance indicators. In Quarter 3 the governance rating reduced to amber because the Trust flagged a possible risk of not achieving year end Referral to Treatment targets due to increased activity and reduced capacity. This risk however did not materialise.

Monitor's scale for financial risk rating is 1-5, 1 representing high risk of failure and 5 indicating low risk of failure. The Trust's financial risk rating has been maintained at 5 throughout the year and reduced to 4 in accordance with plan at year end.

The RD&E's journey toward becoming a robust public benefit corporation capable of exploiting the mutual and financial benefits and freedoms associated with NHS foundation Trust status continues. Systems and processes that have been introduced over the last five years have bedded down and we have become increasingly confident in our role in engaging with the community we serve, ensuring our service development strategies reflect their needs and aspirations. This has been made possible by the contribution and engagement of the Council of Governors, supported by the Board of Directors, our staff, and developing links with local people and our membership community.

The 2008/09 Annual Plan was prepared in the context of a clear NHS Operating Framework. This set out the service and financial expectations NHS organisations were required to deliver. These national expectations were translated into Devon PCT commissioning and local delivery plans, that were formalised into contracted service quality and activity agreements between the RD&E and its commissioners. Within this framework of agreement the Trust developed its annual plan to ensure it remained compliant with its terms of authorisation and met the required national and local standards and targets it had agreed with commissioners. The plan also included making progress towards achieving our strategic aspirations, identified by members and governors, and set out in the Board's approved 'Trust Strategic Directions 2007 – 2012'.

The five key priorities identified by our public and staff membership as priorities for the improvement of services provided by the Trust are:

- Control of infection
- Clean and tidy hospital
- Continuing to meet national targets
- Ensuring patients get the food and nutrition they need
- Less time waiting (whilst at the hospital).

Significant progress has been made in addressing all elements of the plan. 2008/09 has proved to be a more demanding and challenging year for the RD&E and Devon PCT, than had been anticipated in the Annual Plan. Unprecedented increases in both emergency and non emergency referrals created service pressures for the Trust. These pressures were exacerbated by reductions in capacity due to norovirus and associated ward closures to maintain high standards of infection control.

Unfortunately, the increased demand for acute care was replicated across Devon PCT and together with greater than planned costs for continuing health care, created significant financial pressures for the Trust's main commissioner. By the end of March 2009 the RD&E had undertaken 10% more elective admissions, 5% more emergency admissions and 4% more daycases than planned. Priority is always given to meeting the needs of our emergency and clinically urgent patients, but national and contractual performance targets remained unchanged creating additional challenges for our clinical and operational staff.

The size and nature of financial difficulties faced by Devon PCT has caused a significant challenge for the wider health community in Devon with all provider organisations working collaboratively to reduce the impact of the PCTs financial difficulties on the provision of services for patients.

A key measure of success is the Trust's ability to manage these risks whilst also continuing to deliver excellent performance and patient care. With the exception of the percentage of patients who had their operations cancelled all, key service and financial targets as set out in the 2008/09 plan have been achieved or exceeded.

Table One demonstrates this achievement, underlining the excellent overall performance that has been achieved. Achievement of the 18 week RTT has proved to be the major challenge particularly in the light of the increase in both elective and non elective referrals. However, the significant programme of service redesign and identification of new ways to improve the patients' pathway throughout the healthcare system, allied with the hard work and commitment of our staff has resulted in an excellent all round performance.

The key highlights of our progress in 2008/09 are:

- Working in partnership with Devon PCT, opening the Honiton renal satellite unit providing specialist care closer to home for a group of patients who previously would have needed to travel to Exeter for treatment up three times per week.
- Achieving a double excellent rating in the 2007/08 Healthcare Commission annual health check placing the RD&E in the top 10% of acute and specialist trusts over a three year period.
- Achieving the maximum 18 week treatment target with over 90% of admitted patients and more than 96% of non-admitted patients receiving treatment within 18 weeks of GP referral.
- Exceeding national targets with 88% of admitted patients and 95% non-admitted patients receiving treatment within 15 weeks of GP referral.

- Reducing waiting times for access to all modalities in medical imaging with 95% of patients waiting a maximum waiting time of less than 4 weeks for a routine appointment.
- A 17%, in year reduction in MRSA Bacteraemia.
- A 32%, in year, reduction in *Clostridium Difficile* cases.
- Increasing the range and scope of services provided with an additional 500 patients being able to access treatment by RD&E specialist staff in local community settings.
- Through sound financial planning and management investing £5 million of the surplus we have generated in new equipment and facilities to improve patient experience and to help our staff provide the quality of care they aspire to deliver for all patients. Schemes commissioned include:
  - A remodelling of the main entrance to the hospital to provide better access and facilities whilst making it more welcoming for patients.
  - Equipping a dedicated minimally invasive theatre suite to enable to continued development of our clinical staff pioneering work in minimally invasive techniques.
  - Purchasing a vehicle to provide a mobile glaucoma outpatient clinic to deliver care closer to home for patients and meet the increasing demand for glaucoma care.
  - Refurbishment at Mardon House specialist rehabilitation unit.

  Work on these schemes is ongoing and will be completed during 2009/10
- As part of our strategy to reduce our reliance on temporary staff and to improve the quality and continuity of care we offer to patients; increasing the number of permanent staff by 300, including over 150 additional nursing staff.
- Achieving a financial surplus of £7.7 million, £1.2 million more than plan.

Operationally, the competitive environment within which the Trust operates remains largely unchanged. Devon PCT's proposal to tender the use of community hospital theatres during 2008/09 did not progress. The Trust has been successful in negotiating a five year arrangement for the continued use of the theatre sessions currently provided by RD&E staff, with the potential to increase further the amount of day case surgery offered locally.

The 2008/09 annual plan confirmed the Trust's intention to protect patient services for the medium to long term by steadily building a surplus and using some of that surplus on a non-recurring basis to invest in service improvement. This strategy was designed to ensure the underlying financial position was strong enough to weather unforeseen changes in the NHS service and financial environment or health care market changes in future years. The plan therefore concentrated on the need for the Trust to build on previously good financial performance and to establish robust underpinning strategies to ensure the Trust is able to effectively respond to potential future changes and prepare for a time when NHS growth may decline. This strategy, which predated the reduction in investment and an increased requirement to achieve efficiencies announced in the Chancellor's 2009 budget, has proved to be robust and positions the Trust well as it moves on to consider its strategy for the next three years.

Table 1: Review of Achievement of 2008/09 Targets

Monitor Compliance Framework Targets for 2008/09

ID	Target	Threshold	Position	Achievement
MON01	Clostridium difficile year on year reduction (to fit the trajectory for the year as agreed with PCT – assumed a 15% reduction if no level agreed in a contract)	230	145	✓
MON02	MRSA maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 level (to fit the trajectory for the year –assumed target is 50% of 2003/04 level if no contract agreed)	18	15	✓
MON03	Maximum waiting time of 31 days from decision to treat to start of treatment extended to cover all cancer treatments	To be confirmed	94.3% (Jan-09 to Mar-09)	✓
MON04	Maximum waiting time of 62 days from all referrals to treatment for all cancers	To be confirmed	86.0% (Jan-09 to Mar-09)	✓
MON05	18-week maximum wait by 2008 Admitted patients: • This will incorporate the data completeness measures outlined by the Department of Health as a minimum requirement • Maximum time of 18 weeks from point of referral to treatment	90%	91.9% (Jan-09) 90.6% (Feb-09) 91.7% (Mar-09)	✓
MON06	18-week maximum wait by 2008 Non-admitted patients: • This will incorporate the data completeness measures outlined by the Department of Health as a minimum requirement • Maximum time of 18 weeks from point of referral to treatment	95%	95.3% (Jan-09) 96.6% (Feb-09) 96.1% (Mar-09)	✓
MON07	Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	98%	98.8%	✓
MON08	Maximum waiting time of 31 days from diagnosis to treatment for all cancers	98%	99.0% (Apr-08 to Dec-08)	✓
MON09	Maximum waiting time of 62 days from urgent referral to treatment for all cancers	95%	95.2% (Apr-08 to Dec-08)	✓
MON10	People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	Not applicable to this Trust		
MON11	Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	98%	99.3%	✓

Locally Agreed Contractual Targets for 2008/09

ID	Target	Threshold	Position	Achievement
LOC01	15-week maximum wait by 2008 Admitted patients: • This will incorporate the data completeness measures outlined by the Department of Health as a minimum requirement • Maximum time of 15 weeks from point of referral to treatment	85%	87.4% (Jan-09) 86.2% (Feb-09) 87.9% (Mar-09)	✓
LOC02	15-week maximum wait by 2008 Non-admitted patients: • This will incorporate the data completeness measures outlined by the Department of Health as a minimum requirement • Maximum time of 15 weeks from point of referral to treatment	90%	95.4% (Jan-09) 95.2% (Feb-09) 95.0% (Mar-09)	✓
LOC03	11-week maximum outpatient stage of treatment wait	100%	100.0%	✓
LOC04	6-week maximum diagnostic stage of treatment wait	100%	99.3%	✓
LOC05	20-week maximum inpatient stage of treatment wait	100%	100.0%	✓

Healthcare Commission Annual Health Check Existing Commitments Targets for 2008/09

ID	Target	Threshold	Position	Achievement
HCC01	Access to genito-urinary medicine (GUM) clinics	Not applicable to this Trust		
HCC02	Data quality on ethnic group	85%	85.30%	✓
HCC03.I	Time to reperfusion for patients who have had a heart attack – Position	Not applicable to this Trust		
HCC03.II	Time to reperfusion for patients who have had a heart attack – Data Quality	80% in each field	Over 80% in each field	✓
HCC04	Delayed transfers of care	To be confirmed	2.70%	✓*
HCC05	Total time in A&E	98%	98.8%	✓
HCC06	Inpatients waiting longer than the 26 week standard	0.03%	0%	✓
HCC07	Outpatients waiting longer than the 13 week standard	0.03%	0%	✓
HCC08	Patients waiting longer than three months (13 weeks) for revascularisation	To be confirmed	0%	✓*
HCC09	Waiting times for Rapid Access Chest Pain Clinic	To be confirmed	0%	✓*
HCC10.I	Cancelled operations	0.8%	1.21%	×
HCC10.II	Cancelled operation not admitted within 28 days	5%	0%	✓

Indicator achievement marked with an asterisk signifies that the target and/or indicator construction are unknown and the position is estimated

Healthcare Commission Annual Health Check National Priorities Targets for 2008/09

ID	Target	Threshold	Position	Achievement
HCC11.I	Infant health and inequalities: smoking during pregnancy	Change between 2007/08 and 2008/09 <= 0%	-0.7%	✓
HCC11.II	Infant health and inequalities: breastfeeding initiation	Change between 2007/08 and 2008/09 >= -5%	1.8%	✓
HCC12	Experience of patients – health & wellbeing domain(s)	To be confirmed	Trust position predicted to be OK	✓*
HCC13.I	Participation in heart disease audits – ACS Audit	To be confirmed	Not applicable as the service not provided	n/a
HCC13.II	Participation in heart disease audits – BCIS Audit	To be confirmed	✓	✓*
HCC13.III	Participation in heart disease audits – CRM Audit	To be confirmed	✓	✓*
HCC13.IV	Participation in heart disease audits – CHD Audit	To be confirmed	Not applicable as the service not provided	n/a
HCC13.V	Participation in heart disease audits – MINAP Audit	To be confirmed	✓	✓*
HCC14	Engagement in clinical audits	Question 1 and 4 out of 5 other questions answered Yes	✓	✓
HCC15	Stroke care	To be confirmed	✓	✓*
HCC16	Experience of patients – clinical quality domain(s)	To be confirmed	Trust position predicted to be OK	✓*
HCC17	Maternity Hospital Episode Statistics: data quality indicator	To be confirmed	Trust position predicted to be OK	✓*
HCC18	Incidence of MRSA Bacteraemia	18	15	✓
HCC19	Experience of patients – safety domain(s)	To be confirmed	Trust position predicted to be OK	✓*
HCC20	Incidence of Clostridium difficile	230	145	✓
HCC21.I	18 week referral to treatment times – Admitted Data Completeness	Between 90% and 110%	107.6% (Jan-09) 107.6% (Feb-09) 105.6% (Mar-09)	✓
HCC21.II	18 week referral to treatment times – Non-Admitted Data Completeness	Between 90% and 110%	101.2% (Jan-09) 100.0% (Feb-09) 90.1% (Mar-09)	✓
HCC21.III	18 week referral to treatment times – Admitted RTT Position	To be confirmed	91.9% (Jan-09) 90.6% (Feb-09) 91.7% (Mar-09)	✓*
HCC21.IV	18 week referral to treatment times – Non-Admitted RTT Position	To be confirmed	95.3% (Jan-09) 96.6% (Feb-09) 96.1% (Mar-09)	✓*
HCC21.V	18 week referral to treatment times – Diagnostic Waiting Times	To be confirmed and possibly removed		
HCC22	All cancers: two week wait	To be confirmed	99.3%	✓*
HCC23	All cancers: one month diagnosis to treatment (including new cancer strategy commitment)	To be confirmed	99.0% (Q1 - Q3) 94.3% (Q4)	✓*
HCC24	All cancers: two month GP urgent referral to treatment (including new cancer strategy commitment)	To be confirmed	95.2% (Q1 - Q3) 86.0% (Q4)	✓*
HCC25	Experience of patients – patient focus & access domain(s)	To be confirmed	Trust position predicted to be OK	✓*
HCC26	NHS staff satisfaction	To be confirmed	Trust position predicted to be OK	✓*

Indicator achievement marked with an asterisk signifies that the target and/or indicator construction are unknown and the position is estimated

1.2 Summary of Financial Performance

1.2.1 During 2008/09 the Trust exceeded the financial targets as set in its annual plan submitted to Monitor. The Trust generated a surplus of £7.7m, with an EBITDA margin of 9.7% and improved its liquidity position, to a closing position of 62.5 days against a plan of 46 days.

1.2.2 The following table details the Trust's performance against plan for income and expenditure:

Table 2: Planned and Actual Income and Expenditure 2008/09

	Plan £m	Actual £m	Variance £m
Elective Income	68.39	70.80	2.41
Non Elective Income	63.62	85.09	21.47
Outpatients	34.71	44.53	9.82
A&E	7.35	8.03	0.68
Other	70.38	45.24	-25.14
Total NHS Clinical Income	244.45	253.69	9.24
Non NHS Clinical Income	1.37	1.30	-0.07
Other Income	49.93	57.84	7.91
Total Income	**295.75**	**312.83**	**17.08**
Pay Costs	-171.92	-177.93	-6.01
Drug Costs	-23.54	-23.33	0.21
Clinical Supplies	-32.96	-35.69	-2.73
Other Costs	-39.49	-45.61	-6.12
Total Costs	**-267.91**	**-282.56**	**-14.65**
EBITDA	27.84	30.27	2.43
Exceptional Items	0.00	-0.86	-0.86
Profit / Loss on Asset Disposals	0.00	-0.10	-0.10
Total Depreciation	-13.49	-13.54	-0.05
Interest Receivable	2.13	1.87	-0.26
Interest Payable	-1.18	-1.19	-0.01
PDC Dividend	-8.80	-8.80	0.00
Net Surplus/ Deficit	**6.50**	**7.65**	**1.15**

The Trust generated £17.08m more income than planned during 2008/09. Approximately £9.3m relates to NHS clinical income and reflects increases across all major patient types including elective activity, outpatients, emergency

activity and drugs and devices. Patient activity was up across all categories compared to 2007/08 with a 14% increase in GP referrals and 9% increase in elective activity, particularly in Urology, Gastroenterology, Dermatology and Orthopaedics specialities. Emergency admissions rose by 4.4%. The apparent reduction in other income is largely due to the plan being set too high due to reclassification of Critical care, Short stay and outpatient procedure income. The table below reflects the necessary changes to the plan to show the corrected variance for each of the clinical income headings. Other income over performed by approximately £8m, mainly due to increased R&D income.

Table 3: Planned and Actual Clinical Income 2008/09

	Plan Restated £m	Actual £m	Variance £m
Elective Income	67.71	70.8	3.09
Non Elective Income	82.77	85.09	2.32
Outpatients	41.02	44.53	3.51
A&E	7.35	8.03	0.68
Other	45.60	45.24	-0.36
Total NHS Clinical Income	244.45	253.69	9.24

1.2.3 Expenditure rose as a result of additional activity with pay costs rising by approximately £6m due to increased medical and nursing costs. The unplanned increase in activity resulted in additional work being undertaken outside of normal working hours at enhanced rates. Other costs exceeded plan due to increased costs of R&D which offsets increased income as above, patient appliances and prosthetics due to increased activity, and small increases over a number of expense headings.

1.2.4 During the year the Trust commenced marketing of excess land on the Heavitree site. The revaluating of this asset to reflect its open market value resulted in an impairment of £0.86m which was not planned at the beginning of the year. Furthermore due to reduction in interest rates, interest receivable underachieved against plan, although the reduction was offset partly by increased cash balances. The higher levels of activity for 2008/09 have been reflected in the baseline contract negotiated with the PCT for 2009/10. Wherever possible the Trust will plan to deliver increased activity in normal hours. However it is likely that some out of hours working will still be required, particularly in Orthopaedics during 2009/10.

1.2.5 Whilst the position on the Trust's revenue was exceeded, performance on capital expenditure during the year was underachieved. The Trust set a capital programme of £22.9m for 2008/09, this included a number of significant schemes for which planning and procurement needed to be undertaken. In some cases the planning stage exceeded initial timescales which led to slippage on these schemes including, the replacement of nursery facilities, pharmacy robot and stock system and renal dialysis at Heavitree. Patient care has not been compromised due to these extended timescales and the schemes will progress during 2009/10. The Trust has however strengthened the monitoring and management of capital schemes to minimise capital slippage in future years.

1.2.6 At 31 March 2009, the Trust had significantly more cash than planned (£36.26m, £13.25m above plan). The majority of this increase in cash is due to slippage on capital expenditure.

1.3 Other Major Issues & Board Appointments

- Mr Brian Aird and Mr David Wright were appointed as Non-Executive Directors of the Trust, to serve for 3 years from 1 April 2008.
- Mr Mike Stevens, Director of Finance, left the Trust on 30 June 2008.
- Mrs Suzanne Tracey joined the Trust as Director of Finance & Business Development on 4 August 2008.
- At a meeting on 14 January 2009, the governors approved the re-appointment of Ms Angela Ballatti as Chairman of the Trust, to serve for a further 3 years from 1 May 2009.
- Dr Iain Wilson resigned as Joint Medical Director with effect from 31 March 2009. Mr Martin Cooper was appointed as Joint Medical Director from 1 April 2009.
- At a meeting on 8 April 2009, the governors approved the re-appointment of Mr John Rackstraw and Mr Gerald Sturtridge as Non-Executive Directors of the Trust, to serve until 31 August 2012 and 31 October 2010 respectively.

The Trust considers that there are no other major issues.

SECTION TWO:
FUTURE BUSINESS PLANS

2.1 Overall Vision

2.1.1 Vision Statement & Formation

The RD&E has a long and proud history of delivering quality care to the population it serves. Its success in part rests on its ability to adapt and respond positively to change. The desire to continue our excellent tradition lies at the heart of our aspiration, vision and values.

The process to develop the 'Trust's Strategic Direction 2007 -2012' was led by the Board, working in partnership with the Council of Governors. Members and staff involved in the process were asked to identify their top five priorities for improvement. The priorities identified were:

- Control of infection
- Clean and tidy hospital
- Continuing to meet national targets
- Ensuring patients get the food and nutrition they need
- Less time waiting (whilst at the hospital).

Our vision is for the RD&E to be at the leading edge of healthcare; a modern organisation that is competitive, smart, flexible and distinctive in every way. To do this we will focus our attention and build our services around three key themes:

Respond, **D**eliver **& E**nable

In **responding** we aim to

- Be the provider of choice, delivering care in the most convenient and appropriate location, with no delay
- Eliminate all avoidable hospital infections
- Deliver services in a comfortable, friendly environment in which staff can care for patients effectively
- Recognise our wider responsibility to the environment and local community by using resources wisely

We aim to **deliver**

- A high standard of care delivered by experts, which meets the needs and aspirations of patients, staff, carers and the public
- A full range of cost-effective accessible local hospital services
- A range of excellent specialist services

We aim to **enable**

- Staff to do their jobs to the best of their ability, by valuing them, ensuring they have the right skills and giving them the opportunity to focus on meeting the needs of patients, so making the RD&E the employer of choice
- Staff to have a good work/life balance, and achieve their full potential
- Research and innovation
- Future and sustained success through good financial management

In addition to achieving all Operating Framework national targets and standards and Devon PCT contracted quality and service standards in 2009/10 the Trust will continue to progress its strategic aims and objectives. Key milestones for 2009/10 include:

- Eliminating avoidable hospital acquired infections
- Ensuring privacy and dignity by ensuring patients are accommodated in single sex accommodation and increasing the availability of single rooms
- Increasing the amount of care (day cases and outpatients) that are delivered closer to patients homes in community settings

Further details of planned service developments are provided in Section 2.2.4 of this plan.

2.2 Strategic Overview

2.2.1 National and Local Challenges

In formulating the annual plan for 2009/10 the Trust has regard to the national and local context for its operations. The Trust identifies the following as the significant challenges facing the organisation during 2009/10 and beyond:

- Reduced investment and an increased requirement to achieve efficiencies as announced in the Chancellor's 2009 budget. PCT's annual allocations for 2009/10 and 2010/11 will continue to rise in line with 5.5% growth announced in December 2008. It is likely that there will be significant reductions in growth in 2011/12, even possibly resulting in a real term reduction in investment over this period. It is important for the Trust to use the relatively stable period over the next two years to prepare for the tough environment it will face from 2011.
- Increased requirement for efficiencies. Current assumptions on national tariff efficiency are based on 3% per annum. However recent budget announcements indicate that the Department of Health will be contributing £2.3bn of additional public sector savings in 2010/11. This increase is on top of a total of £30bn in this Comprehensive Spending Review period. As a result the assumption of cash releasing efficiencies inherent in the national tariff increases from 3% to 3.5% for 2010/11.
- Devon PCT's continued financial pressures. The PCT starts 2009/10 with an underlying deficit of £17m (approximately 1.5% of turnover) however plans to deliver financial balance during the year. Given the PCT's financial position, the outcome of 2009/10 contract negotiations is a sensible baseline for the year with reasonable levels of growth. The Trust recognises that to reach this settlement the PCT has stretched available finances and therefore has little contingency for the year. This leaves an increased risk of non payment for any over activity that occurs during 2009/10.
- Increased levels of demand – although reasonable levels of growth have been purchased by our commissioners during 2008/09 the Trust experienced significant levels of growth that impacted on delivery of services, particularly Orthopaedics. There remains a risk that growth levels will be higher than those planned. In the longer term it is possible that increased unemployment will place additional demand on healthcare services. At present this is not a significant issue for Devon residents as a

significant proportion are public sector employees, however this may change over coming year.

- Impact of changes to the prices the Trust are paid for patient activity under payments by results – the introduction of HRG version 4 in 2009/10 and 'best practice tariffs' in 2010/11 will create some level of uncertainty around the Trust's income .
- Introduction of the national standard contract between the Trust and its commissioners in 2009/10. The contract includes penalties should a provider not achieve targets for Clostridium Difficile or 18 week referral to treatment. In response the difficult financial situation of the Trust's main commissioner it has been agreed not to incorporate CQUIN payments into the 2009/10 contract. The Trust has identified stretch quality targets it will seek to meet but there are no contractual commitments linked to these targets.
- Development of commissioning capability through 'World Class Commissioning' and primary care led commissioning may reduce future levels of demand for services at the Trust in future years.
- Impact of European Working Time Directive (EWTD). There is a requirement for all NHS organisations to achieve EWTD 48 hours compliance by 1 August 2009. This will require the Trust to review its rotas for junior doctors across all specialties to ensure that no member of staff works more than 48 hours per week averaged over a 26 week period, by 1 August. The 2009/10 tariff includes funding for this change and the Trust has already reviewed the potential impact of implementation. There are a few areas which may prove difficult to achieve compliance including paediatrics. Having established compliant rotas, there is a further risk that inability to recruit to rotas may impact on EWTD compliance.
- Impact of increased contributions to the NHS Litigation Authority (NHSLA). Net costs of the fund have increased from £2.167m in 2008/09 to £4.356m, an increase of £2.189m even after allowing for an additional 10% risk management discount on the maternity element in 2009/10 (£254k). This compares to funding through PbR tariff of £1.665m, a shortfall of £534k. In future years, there are a number of pressures that are likely to increase the costs including a maturing casebook and the withdrawal of legal aid.

2.2.2 Quality

The Trust has an established commitment to continuous quality improvement evidenced by our selection in 2002 as one of only four pilot sites in the early quality initiative *Pursuing Perfection*, to our enrolment in the Leading Improvement in Patient Safety programme in 2007/08. From April 2009 the Trust has achieved unqualified registration with the Care Quality Commission (CQC), this follows an external inspection which confirmed full compliance with the Hygiene Code.

In September 2008, the Board made a further investment in the Trust's quality strategy by signing up to participate in the national Patient Safety First campaign. The campaign aims to create a strong culture where the safety of patients is the highest priority and where there is **no avoidable death and no avoidable harm.** We will continue to build our safety culture and improve our organisational capabilities to ensure that patient safety and quality are firmly embedded at the heart of everything we do. The increased resources

committed to support the development of this work will continue in 2009/10 to further enhance our patient safety capability.

In the Annual Health Check for 2007/08, the Trust attained the top rating of Excellent for quality of services and managing resources, as well as a Green rating for Governance and Mandatory Services,. We have also achieved compliance with all 44 of the Department of Health's core healthcare standards. These results place the RD&E amongst the very best performing trusts in the country, we will continue to work very hard to maintain this top rating.

A Patient Safety Steering Group has been established, reporting directly to a sub committee of the Board, the Governance Committee. It meets every six weeks to oversee a variety of work streams that seek to improve practice in the following specific areas:

- **Leadership for safety**
  Building a leadership culture to provide an environment which promotes quality, patient safety and continuous improvement in harm reduction throughout the hospital
- **Care of deteriorating patients**
  Reducing in-hospital cardiac arrest and mortality rates through earlier recognition and treatment of the deteriorating patient
- **Perioperative care**
  Prevention of surgical site infection and improving care for patients undergoing surgery by using the WHO Safe Surgery Checklist
- **Prevention of in-hospital patient falls**
  Reducing the number of in-hospital falls by identifying high risk patients and establishing the use of a proactive Checklist to enhance nursing care

The Trust has maintained a consistently low Hospital Standardised Mortality Ratio (HMSR) for a number of years. HSMR calculation for NHS organisations is complex. It is based on routinely collected data adjusted to take account a variety of indicators such as age, sex, socio-economic factors and whether the patient is being treated within the specialty of palliative care, etc. The figure "100" is representative of the number of "expected" in-hospital deaths. Any number below 100 indicates a better than expected performance, and any number above is a worse than expected performance. The Trust's current HSMR is 92.3 indicating a better than the "expected" performance.

The aim is to improve on this position and reduce this rate still further by reviewing variation by specialty to identify where improvement can be made. A number of quality improvement initiatives introduced during 2008/09 will be maintained. These include:

- Improving the safety culture by implementing director-led Patient Safety Walkrounds and addressing the issues identified.
- Identification of unintentional harm events using the Global Trigger Tool (GTT) to identify the real level of adverse events in the hospital
- Reducing in-hospital cardiac arrest and mortality rates by establishing regular reporting of Early Warning Scores (EWS). These ward level observations based on level of consciousness, blood pressure, heart and respiratory rates and body temperature allows staff to spot deterioration in a

patient at an early stage. These patients are then able to access intensive or high dependency care earlier.

- Reducing inpatient falls by using a Checklist on an hourly basis on patients with a high risk of falling to proactively reduce the number of triggers that cause falls
- Continued reductions in MRSA and c.difficile infections

The Board has identified three top quality and safety priorities for 2009/10 which will have a significant impact on patient safety and patient experience. These are:

Patient Safety
To further reduce hospital acquired infections:

- MRSA – no more than18 infections.
- C. Difficile – no more than 183 infections.

Clinical Effectiveness

- To ensure 85% of patients spend 90% of their hospital stay on a dedicated specialist unit.

Patient Experience

- To increase the percentage of patients who would recommend the RD&E to their relatives and friends, through initiatives to increase patients' privacy and dignity.

A detailed work programme has been developed for 2009/10 and will include:

- Reduction in unintentional harm events.
- Preventing Central Line Infections.
- Reducing Harm from Mechanical Ventilation.
- Reduction of harm from high risk medications, e.g. anti-coagulation and risk of venous thromboembolism (VTE).
- Implementing the "Nursing Quality Assessment Tool" (NQAT) to provide wards with real-time patient feedback and overall standard of care.

2.2.3 Key Actions

The healthcare market around Exeter has remained relatively stable over recent years. Royal Devon and Exeter NHS Foundation Trust remains the main provider for Exeter residents (which comprises 44% of Devon PCT's population). Other key providers include South Devon Healthcare NHS Foundation Trust based in Torbay and Plymouth Hospitals NHS Trust, providing 26% and 18% of acute care for Devon residents respectively. Devon PCT is currently working through the implications of world class commissioning, however has not sought to introduce any significant other providers to the local health economy. The PCT is currently focussing on divesting its provider arm from the provision of daycase/outpatient services through negotiations with other existing providers including RD&E (Note: as these negotiations are currently underway and not concluded, the impact is not yet reflected in the financial and activity plans for the Trust). The terms of engagement for this transfer allow for other providers to tender for up to 25%

of any additional community theatre capacity created. This is not expected to impact on the existing workload of RD&E. Devon PCT has introduced an alternative provider for Dermatology (Exeter Medical) based on the outskirts of Exeter, however referral rates to RD&E have remained static. ISTC centres are based in Shepton Mallet 66 miles away providing General Surgery, Orthopaedics and Ophthalmology and Plymouth at 47 miles away providing orthopaedic services. Both ISTCs have had little impact on the level of referrals to RD&E.

Due to increasing referral levels year on year, the Trust has not formally marketed its services, however it continues to work proactively with its commissioners, both the PCT team and with individual GP practices.

During 2008/09, Devon PCT has experienced financial difficulties and the health community has worked jointly to address this issue both in 2008/09 and into 2009/10. Devon Health and Social Care Community Chief Executives forum has been established and the Trust's Chief Executive is an active participant. In addition a forum has been established to ensure better engagement between the Trust's clinicians and local GPs. "C2C" meetings are helping to shape the agenda around care redesign which is a prominent feature of the PCT and Trust's joint plans to tackle referral increases during 2009/10.

The ongoing development of the Trust's strategy and the Board's capacity to deliver it will continue during 2009/10. In 2008/09, the Board held several Board Development days including a joint one with Governors to review revised governance effectiveness frameworks. During 2009/10, the Board of Directors will undertake a review of its existing Strategic Direction, with a particular focus on the impact of the economic downturn. This is likely to have a significant impact on the financial forecasts currently within Year 3 of this current plan.

A significant element of the Trust's strategy continues to be focussed around delivering patient centred healthcare services, undergraduate and postgraduate medical education and allied healthcare education in a research active culture. This is in line with Darzi's suggestion that a defining criteria for leading NHS organisations will be the quality of engagement and partnership with higher education institutes. Recognising integration of knowledge as a key long term goal of the partnership with Peninsula College of Medicine and Dentistry and the University of Exeter, the Trust is currently working with its partners to develop a plan to extend current medical school facilities to provide additional space for integrated learning and research facilities.

The Trust hosts the Peninsula Comprehensive, Diabetes and Stroke Local Research Networks and therefore plays a major role in promoting clinical trials in the Peninsula. The RD&E plans to increase recruitment into research network clinical trials by 20% in the next 12 months to support the national ambition of doubling the number of patients in trials within the next five years (Operating Framework for the NHS in England for 2009/10).

As an active member of Peninsula Collaboration for Leadership in Applied Health Research and Care (PenCLAHRC) the Trust will work with academic colleagues to identify problems or questions that would benefit from new primary research or evidence synthesis and also challenges for the implementation of changes for which evidence is already known.

As host to the Peninsula Clinical Research Facility, the Trust will undertake cutting edge research into increased understanding of mechanisms of disease and translate discoveries in the laboratory into clinical care. The clinical research facility will also recruit large patient cohorts to enable excellent genetic research to flourish.

2.2.4 Service Development Plans

For 2009/10, the Trust has worked in conjunction with Devon PCT to develop contract baselines through an agreed demand planning model. The jointly agreed assumptions have been reflected in the signed contract for 2009/10 and are summarised as follows:

Table 4: Planned Activity Levels 2009/10

	2008/09 Outturn	2009/10 Plan	% Movement
Daycase (spells)	44,608	45,854	2.79
Elective Inpatient (spells)	19,244	20,355	5.77
Emergency Inpatients* (spells)	38,303	38,458	0.40
Outpatient Attendances	414,435	419,661	1.26

*Note: percentage increase for emergency inpatients was originally based on 2.5% on 2008/09 Month 7 forecast, however activity increases in latter part of year and the impact of planned care redesign schemes have reduced this level of growth against outturn.

The above activity levels have been calculated to achieve target referral to waiting times of 13 weeks for all specialities with the exception of Orthopaedics which will achieve 18 weeks. Growth figures have been assessed looking at cumulative growth rates in referrals over the last 3 years with other speciality specific factors brought in as relevant.

The ambitious target to limit growth in emergency inpatient activity is predicated on care redesign schemes across the health and social care community. Redesign of urgent care flows across the hospital is being undertaken, to complement the work in the wider community. An incentive scheme to reduce delays for patients waiting to transfer from RD&E to the community is being developed.

Contained within the overall figures shown above, the key 5 movements from 2008/09 in mandatory goods and services is summarised as follows:

Table 5: Key Changes in Mandatory Goods and Services

Service	2008/09 Schedule 2	2009/10 Schedule 2	% Increase
Emergency Spells	34820	36828	5.8%
Elective Inpatient Spells	19423	20180	3.9%
Daycases	38717	45420	17.3%
A&E	63168	76340	20.8%

During 2009/10, the Trust has not planned the development of any significant new service. Devon PCT is seeking to transfer surgical outpatient and day case activity in East Devon community hospitals to the management of RD&E and this will enable RD&E to transfer more day case and outpatient activity into a community setting in

line with the Trust's strategic direction and as highlighted in section 2.2.3. Furthermore, Devon PCT is also seeking to transfer community maternity services for East Devon to RD&E. If approved by both parties this is likely to occur in 2009/10. Children's services at the Trust currently provided at Honeylands could be transferred from the Trust to the PCT during the forthcoming period. As these changes are still under negotiation, they are not reflected in the enclosed financial or activity plans, however they do not constitute significant transactions and the Trust will take account of best practice advice when considering their approval.

Finally, a review of the provision of Upper GI Cancer Services within the Southwest Peninsula has recently been concluded and as a result, this service will be transferred to Plymouth Hospitals NHS Trust during 2010. The impact of this transfer is low (estimated at 40 patients per annum). Contracts have not yet been adjusted for the outcome of this review.

Although there are no significant service changes planned for 2009/10, the Trust will continue to improve the quality and range of services for patients including:

- the introduction of a low risk birthing unit
- implementation of a bowel cancer screening service
- development of capsule endoscopy service
- implementation of endobronchial ultrasound service
- mobile glaucoma outpatient service
- the introduction of a medical triage service supported by experienced acute care GPs, the first major step towards establishing the Trusts strategic intent to remodel the provision of its emergency care.

The Trust continues to provide private patient facilities, however recognising that the demand for private patient activity is reducing, the annual plan for 2009/10 assumes income of £1.2m. This plan constitutes 0.4% of planned patient income and is well within the Trust's private patient cap of 1.2%.

2.3 Summary of Financial Forecasts

2.3.1 How the Plan was Built

Activity projections were produced jointly in conjunction with Devon PCT from the demand planner. The outcome of this exercise then formed the basis for the patient contract with Devon PCT and associated commissioners, and the RD&E directorate operational plans. These plans include revenue and capital resources required to achieve planned activity levels, along with plans to enable the Trust to meet its strategic objectives.

This information forms the basis of the detailed financial plans for 2009/10, which is supplemented with planned activity growth for 2010/11 and 2011/12, and forecast key assumptions to complete years 2 and 3 of the Monitor three-year plan.

2.3.2 The impact of IFRS

The accounts for the year ending 31 March 2009 were prepared in accordance with UK Generally Accepted Accounting Principles (UKGAAP). Accounting policies have

been updated to reflect the new IFRS reporting requirements and the Trust's opening balance sheet as at 1 April 2008 has been restated in accordance with the new accounting standards. The Trust's external auditors have reviewed the restated balance sheet. The Trust's accounts for the year ended 31 March 2010 will be prepared in accordance with International Financial Reporting Standards (IFRS).

The only change to the Trust's reserves as a result of the move to IFRS is the requirement to accrue for untaken holiday leave. The value of the accrual as at 31 March 2009 is estimated at £1.614 million. The accrual is expected to increase to £1.679 million as at 31 March 2010.

Some reclassification changes will be required within the Income Statement, Balance Sheet, and Cashflow Statement. These are only presentational changes and have no further impact on the Trust's reserves.

2.3.3 Key Financial Assumptions

In developing the financial model for 2009/10, the figures reflect agreements made both with PCTs for contracted patient income and Directorates for commercial income, pay and non-pay budgets. These agreements take account of the national patient income uplift of 1.7%, savings requirement of 3.0%, and national pay award of 2.5%.

The challenging economic outlook has been reflected in 2010/11 and 2011/12 by assuming a PBR uplift on patient income of 1.0% in 2010/11 reducing to 0.5% in 2011/12, and a cash releasing savings requirement of 3.5% in 2010/11, going up to 4.0% in 2011/12. The final year of the three year pay agreement has been built into the plan at 2.5% for 2010/11 and an assumed 2.3% applied for 2011/12.

Growth assumptions for 2009/10 are based around a demand planner produced by the RDE and agreed with Devon PCT. For elective activity, the assumption is for an RTT target of 13 weeks for all specialties with the exception of Orthopaedics (18 weeks). Elective growth in 2010/11 has been assumed to achieve an RTT of 8 weeks, and thereafter only annual growth of referrals is assumed. Emergency growth of around 3% is planned for each year; however activity has been abated in 2009/10 due to planned PCT care redesign schemes.

A detailed analysis of non-mandatory growth has been carried out for 2009/10, however for years 2 and 3, an assumption has been made for £2m of growth which is offset by costs of the same value.

As plans for the transfer of activity carried out in community hospitals, and community midwifery are at an early stage, activity and I&E assumptions have not been included within the plan.

Growth in Clinical staff for 2009/10-2011/12 has been based on demand plan growth. Non-clinical staff have the same uplift applied, however are also planned to reduce in line with anticipated savings in pay.

A general provision of £2m has been assumed in each of the three years.

Table 6: Key Financial Assumptions

	Units	Actual for 01 Apr 08 to 31 Mar 09		Plans for 01 Apr 09 to 31 Mar 10	Plans for 01 Apr 10 to 31 Mar 11	Plans for 01-Apr 11 to 31 Mar 12
Income Related Assumptions						
NHS Acute Activity Income Attendance						
PbR Tariff Inflation	%	2.3%		1.7%	1.0%	0.5%
Non PbR clinical income inflation	%	2.3%		1.7%	1.0%	0.5%
Clinical Income Private Patients						
Private Patients Income Inflation	%	2.3%		1.7%	1.0%	0.5%
Research & Development (where applicable)						
R&D inflation	%	2.9%		1.7%	1.0%	0.5%
Education & Training (where applicable)						
Education & Training Inflation	%	2.9%		1.7%	1.0%	0.5%
Other Income						
Other Income Inflation	%	2.9%		1.7%	1.0%	0.5%
PFI Related Income Inflation	%	0.0%		0.0%	0.0%	0.0%
Cost Improvement Programme (CIP)						
Income Generation CIP Income	£m	1.323		0.268	0.336	0.423
Cost Related Assumptions						
Pay Awards						
Salary Inflation	%	2.6%		3.2%	2.8%	2.5%
Staff Numbers						
Clinical Staff Numbers	WTEs	2301		2381	2455	2490
Of which Nursing Staff Numbers	WTEs	1760		1821	1885	1951
Non Clinical Staff Numbers	WTEs	2491		2497	2507	2434
Agency Costs	£m	2.850		1.207	1.237	1.265
Pay Cost Pressures						
Consultant Contract Cost Increase	£m	0.422		0.624	0.538	0.500
Consultant Staff Costs	£m	32.120		34.702	36.107	37.438
Consultant Staff Contract as a % of Consultant Costs	%	1.3%		1.8%	1.5%	1.4%
Agenda for Change Cost Increase	£m					
Staff Costs Excluding Medical and Agency	£m	122.840		123.573	128.258	130.844
Agenda for Change as a % of total pay including medical and agency	%	0.0%		0.0%	0.0%	0.0%
EWTD cost increase	£m			0.507		
Jnr Medical Staff	£m	20.090		20.062	20.553	20.603

	Units	Actual for 01 Apr 08 to 31 Mar 09		Plans for 01 Apr 09 to 31 Mar 10	Plans for 01 Apr 10 to 31 Mar 11	Plans for 01-Apr 11 to 31 Mar 12
Costs						
EWTD as a % of Junior Medical Costs	%	0.0%		0.0%	0.0%	0.0%
Other Costs Pressures: CNST Increase	£m	(0.275)		2.847	0.500	0.500
CNST Cost	£m	2.442		2.167	5.014	5.514
CNST Increase as a % of CNST Cost	%	(10.1%)		(418.7)%	11.1%	10.0%
Pay Costs – Cost Improvement Programme (CIP)						
Pay Costs Saving CIP	£m	1.235		3.806	4.769	5.997
Drug Costs						
Drug Price Inflation	%	0.0%		0.0%	0.0%	0.0%
NICE Guidance	%	8.9%		8.5%	7.5%	6.8%
Other Drug Developments	£m	0.0%		0.0%	0.0%	0.0%
Drug Cost Improvement Programme (CIP)						
Drug Costs Saving CIP	£m	0.050		0.105	0.131	0.165
Other Costs						
Other Cost Inflation	%	2.9%		1.4%	1.5%	1.5%
PFI Operating Cost Inflation	%	0.0%		0.0%	0.0%	0.0%
Other Costs – Cost Improvement Programme (CIP)						
Other Costs Saving CIP	£m	2.753		4.094	5.130	6.451

2.3.4 Phasing

The following specific assumptions have been made for the profiling of the income statement and working capital:-

- Patient Income – Elective activity is based on the number of operational days in the month, and emergency activity is based on activity from the previous financial year. Adjustments are then made at individual specialty level for known changes.
- Pay and non-pay – Equal monthly profile, with the exception of capacity increases, contingencies, and specific non-pay headings
- Capacity Increases – based on planned profile by scheme
- Contingencies – based on previous years spending pattern
- Non-pay – Clinical supplies and patient related headings based on the monthly income profile

Working Capital balances have generally been uplifted by growth of income and expense where applicable. The exceptions to this rule are:-

- Trade Creditors, whereby a reduction is planned in order to improve the percentage of invoices paid within the Public Sector Payment Policy

- Non-NHS debtors based on an improved collection in the second part of the year
- NHS Debtors based on a consistent number of debtor days

2.3.5 Investment and Disposal Plans

The Trust's capital programme for the 3 year period beginning 2009/10 has been compiled in conjunction with the operational planning process to ensure that any capital investment underpins the key service priorities for the Trust. Capital investment for 2009/10 is £23.5m which is funded through internally generated funds of £19.2m and funding carried forward from 2008/09 of £4.3m. There is no requirement for any additional external borrowing to finance the 2009/10 programme.

During 2009/10 the programme focuses on the following priorities:

- Expansion of capacity in key areas of growth:
  - Daycare facilities on the Heavitree site
  - Development of additional kidney dialysis units in South Devon and in Exeter at Heavitree site
  - Third Linear Accelerator to support radiotherapy treatments

- Ongoing replacement of medical equipment including:
  - Specialist x-ray equipment
  - CT Scanner
  - Fluoroscopy equipment

- New technology to improve quality and efficiency of treatments including:
  - E Prescribing
  - Order communications
  - Wireless LAN rollout

- Improving hospital facilities for the benefit of staff and patients:
  - Upgrade and improvement of main concourse
  - Reprovision of nursery facilities

During 2008/09 the Trust marketed part of the Heavitree site vacated by the transfer of maternity services into a new unit on the Wonford site. A contract for the sale of the site is likely to be signed during 2009/10, however final disposal will be conditional on planning permission being granted to the developer and therefore sale proceeds are not expected until 2010/11. The Trust has followed Monitor's guidance 'Protection of Assets' during the disposal process.

During 2009/10 the Trust will complete the next stage of its Estate Strategy. This exercise will finalise in more detail plans to increase the number of single rooms, together with a longer term view of the Heavitree site. In addition the Trust have commenced planning in conjunction with its partners in outline for the further development of the Peninsula Medical School building to provide integrated education and research facilities. This further development of the Estate may impact on future years capital programme but is not anticipated to affect planned capital expenditure for 2009/10.

2.3.6 Loans and Working Capital

The Trust's current cash and working capital position remains strong with liquidity days of 43.2 planned for the end of 2009/10. The Trust's committed facility with its bank remains at £18m and is due to expire in September 2009. There are no changes to the covenants of this facility. There has, to date, been no requirement to utilise this facility and the Trust's plans for 2009/10 do not require any drawdown. As part of its work to review the impact of the changed economic position during the early part of 2009/10, the Trust will take a view in year about whether it needs to continue with this facility.

The Trust currently has long term loans of £24m outstanding at the beginning of April 2009. The capital development plan for 2009/10 will be funded through internally generated funds and therefore no further long term loans will be entered into during the year.

The following table shows the Trust's compliance with Prudential Borrowing Code limits:

Table 7: Compliance with Prudential Borrowing Code

PBC Ratios		**Tier 1 Thresholds**	08/09 Actual	09/10 Plan
Minimum Dividend Cover	Revenue available for Debt Service - Annual Interest / Annual Dividend Payable on PDC	**>1x**	3.5x	3.5x
Minimum Interest Cover	Revenue available for Debt Service / Maximum Annual Interest	**>3x**	27.0x	26.6x
Minimum Debt Service Cover	Revenue available for Debt Service / Maximum Annual Debt Service	**>2x**	13.1x	12.5x
Maximum Debt Service to Revenue	Maximum Annual Debt Service / Revenue	**<2.5%**	0.8%	0.7%

2.3.7 Cost Improvement Plans (CIPs)

The Trust's total cost improvement plan for 2009/10 is £8.3m, representing 3% of operating costs. Schemes have been identified across individual directorates on a recurrent basis. Due to growth in activity levels during 2009/10, divisions have been able to demonstrate some plans to deliver additional activity within the same facilities, however this has been restricted and income generation schemes will only contribute approximately £1.32m of the total CIP plan. Each scheme is assigned a responsible project lead and will be closely monitored during the course of 2009/10 to ensure full achievement against target.

As service line management (SLM) tools and processes are developed and rolled out to service lines over the next two years, it is anticipated that ownership for generating savings will ultimately be passed onto those clinical leaders who are best placed to identify and secure those savings. This will be particularly important given the level of expected savings will increase to 3.5%, and potentially higher in future years.

Table 8: Cost Improvement Plans

	Plan 2008/09 £m		**Actual 2008/09 £m**		**2009/10 £m**	**Current Plan 2010/11 £m**	**Current Plan 2011/12 £m**
Income	0		1.32		0.27	0.34	0.42
Pay	3.51		1.24		3.81	4.77	6.00
Non Pay	2.34		2.79		4.19	5.26	6.61
Total CIPs	5.85		5.36		8.27	10.37	13.03

SECTION THREE:
RISK ANALYSIS

3.1 Governance Risks

3.1.1 Governance Commentary

The Board of Directors have assessed compliance with the seven elements of governance requirements defined in the Compliance Framework in a number of different ways as follows:

- Legality of constitution: there have been no changes to the constitution therefore previous assessments undertaken by the Board remain unchanged
- Growing a representative membership: as outlined in the membership report contained in Section 5
- Appropriate board roles and structures between Council of Governors and Board of Directors: During 2008/09 the Board and Council of Governors have undertaken a joint exercise to revise governance effectiveness frameworks
- Service Performance: Assessment made at each Board of Directors meeting through review of performance reports
- Clinical Quality: The Governance Committee meets nine times a year, and, chaired by a non executive director, considers quality issues across both the clinical and corporate landscape. The Board of Directors considers a suite of quality information to enable it to sign off the annual health check declaration, including the results of an annual audit by Internal Audit of the evidence collated against all of the core standards. In 2009/10 the quality report and dashboard will be presented to the Board of Directors on a monthly basis
- Effective risk and performance management: The Board of Directors reviews the Trust's risk register and assurance framework on a quarterly basis. In addition internal audit have undertaken an audit of the assurance framework development during 2008/09
- Duty to cooperate with NHS bodies and local authorities: The Board is regularly appraised of significant issues arising in our partnerships with NHS organisations and local authorities.

3.1.2 Significant Risks

The Trust has assessed that there are no significant risks.

3.1.3 HCAI Targets

Table 9: Details of 2009/10 MRSA and C.difficile targets

Target		Q1	Q2	Q3	Q4
MRSA	2008/09 Target	6	2	2	8
	2008/09 actual	4	4	2	5
	2009/10 target	3	3	5	7
C. difficile[1]	2008/09 Target	50	59	53	68
	2008/09 actual	38	48	34	25
	2009/10 target	41	46	42	54

[1] In respect of clostridium difficile, 2009/10 target data relates to the revised definition for the attribution of cases to acute trusts, as contained within Letter from Chief Nursing Officer & Director General (Finance, Operations & Performance), 28 November 2008.

3.2 Mandatory Services Risk

3.2.1 Mandatory Services

The six most significant mandatory services risks have been highlighted below. The Trust is confident it has appropriate plans in place to mitigate these risks where there is a clear threshold stated and, where guidance is still awaited, the planning assumption seeks to meet worse case scenario.

- **Healthcare Acquired Infection**

a. Clostridium difficile

The 2008/09 target was a maximum of 230 *Clostridium Difficile* infections where the specimen was taken at least two days post admission which the Trust achieved with a total of 145. The measurement of this target for 2009/10 has now changed to where the specimen was taken at least three days post admission and consequently the threshold has also changed to a maximum of 183 infections. Close attention to the management of prescribing and the treatment for vulnerable patients continues and it is anticipated that this target will be achieved.

b. MRSA

Only 15 MRSA bacteraemias were reported in 2008/09 against a target of 18 cases. This represents a 17% reduction on the previous year and a reduction of 60% over the last two years. The locally agreed target with Devon PCT is to maintain current levels to a maximum of 18, and it is anticipated that this target is achievable. Screening of all elective patients prior to admission to hospital has been introduced, and the Trust is working with Devon PCT to link this development to delivering care in a primary care setting.

- **Cancer Waiting Times**

The target for monitoring the delivery of timely care for patients with cancer was significantly expanded in 2008/09. The enhanced targets recognise the need for all patients to be managed equitably irrespective of their referral route. The emphasis moves from solely primary care targets to include secondary care referral pathways:

- The 62 day wait includes: Consultant upgrades of suspected cancers and all referrals from breast, cervical and bowel screening programmes;
- The 31 day wait includes: DTT for every treatment episode within the patients treatment journey for newly diagnosed cancers and for all recurrent cancer diagnoses from where the treatment is surgery or a drug; and (Dec 2010) from where the treatment is radiotherapy.
- 2 week wait monitoring includes all referrals to Breast Care Service

Information systems within the Trust have been significantly improved and work to reduce waiting times for all patients to ensure that we can achieve the new targets. Performance for the last quarter against the new 31 day target was 94.3% and for the new 62 day target it was 86.0%. The new cancer targets have an additional complexity as the threshold level against which compliance will be measured has yet to be released. The measurement mechanism for the new cancer targets within Monitor's Compliance Framework means that failure in one area has a cumulative effect on performance in the other targets, thereby increasing the risk assessment for these targets. As soon as the thresholds are identified any remedial action will be taken to ensure compliance.

- **Maximum Waiting Time in A&E**

The Trust maintained performance against this community wide target throughout 2008/09 despite a challenging winter. Continuing to achieve this target remains a challenge and especially so in the last quarter of each financial year. This is due to increases in A&E attendances, emergency admissions and bed shortages across the community. Action plans are in place to achieve this key target and maintain positive outcomes for patients.

- **Referral to Treatment Targets**

The Trust will be assessed by Monitor against an aggregate Trust position for admitted and non-admitted patients against an 18 week maximum wait. There are however locally agreed targets (90% admitted patients and 95% non-admitted patients) for all specialties apart from Orthopaedics to be achieving a 13 week wait by the end of March 2010 and an 18 week wait for Orthopaedics. Monitor requires the Trust to inform them of any specialty that does not currently achieve the 18 week wait but they will only adjust the risk rating should the Trust move from the planned trajectory. Current performance against a 13 week target excluding Orthopaedics stands at 92.9% and 95.7% for admitted and non-admitted pathways respectively, and Orthopaedic performance against an 18 week target stands at 59.7% and 81.9%. Achieving wait time targets in orthopaedics is the significant challenge and the Trust is working with Devon PCT in order to manage demand and increase capacity.

- **European Working Time Directive**

Currently 93% of the rotas for doctors in training are compliant to EWTD 2009. 52% of our rotas require the doctors in training to work between 45 and 48 hours per week, and 41% of rotas are below 45 hours. Work is still underway to ensure the remaining non-compliant rotas meet the regulations required by this piece of legislation in time for 1 August 2009.

Areas of risk include vacancies for both training and service posts. The reduction of working hours impacts on training opportunities whilst a requirement to release staff for dedicated training sessions reduces ability to carry out service roles. Future risk may also include a decision by the UK Government to fully withdraw from the 48 hour opt-out clause which other Member States in the EU have already enforced.

In anticipation of this decision compromising the Trust's ability to fulfil service needs alternative established workforce models are being spread more widely and new roles being developed to reduce the dependency on doctors in training to provide services for patients where other health care professionals could meet their needs.

- **Skilled Workforce Supply**

The future workforce supply for skilled staff has been identified as a risk due to a combination of factors including the increase in demand for service, age profile of experienced skilled staff with resultant retirement risk and potential difficulties in skilled labour market supply.

However, a workforce strategy has been developed addressing these areas and action plans are progressing including alternative resourcing models, covering new roles particularly in relation to advanced and assistant

practitioner and ensuring any non-clinical activities are undertaken by other staff. These will enable any reduction in medical staff time through EWTD or changes to medical training to be addressed.

The implementation of the Single Equality Scheme for Equality and Diversity will ensure the widest possible access to employment and support recruitment to the Trust and development of the full potential of its staff.

There is a clear link between patient satisfaction and staff satisfaction. A clear plan is in place to continually improve the current high level of staff satisfaction in the Trust ensuring its position as "Employer of Choice". Evidence of links between high staff satisfaction and productivity will support the Trust in addressing any challenges in service delivery.

3.2.2 Significant Risks

The Trust considers that there are no other significant risks to the Trust's ability to comply with its Terms of Authorisation.

3.3 Financial Risk

3.3.1 Commentary on Financial Risk Rating

The planned Financial Risk Rating (FRR) for 2009/10 is 3.9 rounded to 4. This remains constant at 4 for 2010/11 and 2011/12. The actual FRR for 2008/09 was 4.4 rounded to a 4.

The individual indicators of the FRR for 2009/10 show a rating of 4 for return on assets (ROA), I&E surplus margin and Liquidity ratio. % EBITDA achieved currently indicates a rating of 3 with 8.99% planned compared to a 4 of 9.0%. % EBITDA achieved shows 5, although the actual will depend on real performance in-year against the plan.

In order for the Trust to drop to an overall FRR of 3 for 2009/10, the I&E surplus would need to reduce by £2.0m to £5m. This would result in a rating of 3 for financial efficiency (average of ROA and I&E surplus) along with a 3 for % EBITDA achievement of plan.

3.3.2 Significant Risks

The Trust has identified a number of risks which could impact on financial performance during 2009/10:

- Devon PCT's ability to pay for in year overperformance: As outlined in section 2.2.1 of this plan, Devon PCT has limited ability to fund any growth above agreed baselines during 2009/10. This risk is considered to be of medium impact and likelihood due to the joint agreement of expected growth rates being reflected in the 2009/10 contract agreed with the PCT. Mitigation of the risk includes monthly contract meetings with PCT to identify any potential overperformance and agreed rectification. The PCT and Trust have agreed care redesign schemes aimed at controlling activity to contract levels and progress is monitored by Devon Health & Social Care Chief Executive's Group and internally by the Trust.

- Ability to achieve cost improvement plans: Historically the Trust has not fully achieved its plans for cost improvement. The likelihood of this risk occurring is rated high, with a low impact as historic underperformance has been between £1-2m. To mitigate this risk, the Trust has improved its structures to monitor and manage CRES achievement. In addition work will commence early in 2009/10 to identify schemes for 2010/11 and beyond, some of which could be pulled forward to 2009/10 if required. Furthermore the Trust could forgo planned developments in 2009/10 to offset any underachievement if required.

- Impact of operating under HRG version 4: The Trust has assessed the likely impact of HRG4 as a loss of approximately £2m and this is already built into current financial plans however there is a risk that there could be further impact in year once activity is priced at the new tariff. This risk is assessed as medium likelihood with low impact. To mitigate against this risk, the Trust will ensure regular monitoring to assess variation of HRG4 compared to version 3.5 with action taken with relevant directorates for any identified variances.

- Financial penalties contained within standard contract for failure to achieve RTT and C Diff targets: The introduction of the standard contract in 2009/10 contains financial penalties for non achievement of targets for referral to treatment and C Diff. The potential impact of these are £9.3m and the likelihood of occurrence is deemed low, with the exception of achievement of 18 weeks referral to treatment in orthopaedics which is considered to be of medium risk. To militate against this risk, the Trust has identified an operational plan to manage programmed work for Orthopaedics, including the expansion of capacity through out of core hours provision and alternative facilities. Should referral levels increase above planned levels the Trust will work with Devon PCT to manage demand.

- Increase in emergency admissions to the extent that elective work is compromised: The Trust has assessed this risk as medium likelihood with low to medium impact. To militate against this risk, the Trust has a plan to increase capacity on the Wonford site by September through the creation of additional daycase facilities on the Heavitree site.

Beyond 2009/10, the Trust's most significant risk is the potential for reduced or negative growth, particularly in 2011/12. During the early part of 2009/10 the Trust will be expanding it's modelling of this scenario and generating plans to militate the risk.

Table 10: Significant Financial Risks and Potential Financial Impact Sensitivity Analysis

Assumptions	Impact £'000	Maximum Cash outflow £'000	Opening cash £'000	Minimum Cash balance 09/10 £'000	Minimum Headroom* 09/10 £'000	09/10 Surplus £'000	09/10 Risk Rating
Base Model		6.,404	38,359	31,955	49,955	7,000	4
£2M underperformance in income for 09/10 (no corresponding reduction in expense)	-2,000	8.418	38,359	29,941	47,941	5,000	3
£2M CRES not achieved in 09/10	-2,000	8,418	38,359	29,941	47,941	5,000	3
50% CRES achieved in 09/10	-4,136	10,487	38,359	27,872	45,872	2,864	3
Capital Overspend in 09/10	-4,000	10,474	38,359	27,885	45,885	6,930	4
Capital Underspend in 09/10	4000	2,474	38,359	35,885	53,885	7,070	4
RTT/CDIFF Risk	-9,000	15,287	38,359	23,072	41,072	-2,000	2

*Note Minimum headroom includes £18m relating to the working capital facility

3.4 Risk of Any Other Non Compliance with Terms of Authorisation

The Trust considers that there are no other significant risks to the Trust's ability to comply with its Terms of Authorisation.

SECTION FOUR: DECLARATIONS & SELF-CERTIFICATION

4.1 Self Certification & Board Statements

The Board of Directors can confirm the following statements, regarding compliance with the Trust's Terms of Authorisation:

Clinical Quality

- The Board is satisfied that, to the best of its knowledge and using its own processes (supported by any relevant Care Quality Commission metrics and including any further metrics it chooses to adopt), its NHS foundation Trust has and will keep in place effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.
- The Board will self certify annually that, to the best of its knowledge and using its own processes, it is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

Service Performance

- The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) and national core standards and with all known targets going forwards;

Risk Management

- Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner;
- All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned;
- The necessary planning, performance management and risk management processes are in place to deliver the annual plan;
- A Statement of Internal Control ("SIC") is in place, and the NHS foundation Trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to the most up to date guidance from HM Treasury (see http://www.hm-treasury.gov.uk); and
- the Trust has achieved a minimum of Level 2 performance against the requirements of their Information Governance Statement of Compliance (IGSoC) in the Department of Health's Information Governance Toolkit; and
- All key risks to compliance with its Authorisation have been identified and addressed.

Compliance with the Terms of Authorisation

- The Board will ensure that the NHS foundation Trust remains compliant with its Authorisation and relevant legislation at all times;
- The Board has considered all likely future risks to compliance with its Authorisation, the level of severity and likelihood of a breach occurring and the plans for mitigation of these risks; and

- The Board has considered appropriate evidence to review these risks and has put in place action plans to address them where required to ensure continued compliance with its Authorisation.

Board Roles, Structures and Capacity

- The Board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the board;
- The Board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability;
- The selection process and training programmes in place ensure that the nonexecutive directors have appropriate experience and skills;
- The management team has the capability and experience necessary to deliver the annual plan; and
- The management structure in place is adequate to deliver the annual plan objectives for the next three years.

SECTION FIVE: MEMBERSHIP

5.1 Membership Report

Analysis of the membership of the Trust indicates the following changes during 2008/09, alongside forecast changes in membership during 2009/10. Additional demographic data with regards to current Trust membership are as detailed below.

Table 11: Membership Size and Movements

Public Constituency	2008-09	Next Year (estimate) 2009-10
At year start (April 1)	13,900	14,202
New Members	1,164	1,400
Members Leaving	862	850
At year end (March 31)	14,202	14,752
Staff Constituency		
At year start (April 1)	5,259	5,613
New Members	1,283	1,000
Members Leaving	929	950
At year end (March 31)	5,613	5,663

In line with the Trust's Terms of Authorisation there is no patient constituency.

Table 12: Analysis of Current membership (Age)

Age (years)	Actual Members*	Eligible Membership
0-16	61	468,896
17-21	76	176,925
22+	9,474	2,207,963

Source data on eligible membership taken from 2001 Census data found on the websites of Dorset, Somerset & Cornwall County Councils. Devon data taken from Family Health Services Authority (FHSA) data for 2005 and taken from Devon County Council's website.

* Actual membership analysis based on 9611 RD&E members who supplied their date of birth; the remainder (4591) chose to withhold this information.

Table 13: Analysis of Current Membership (Ethnicity)

Ethnicity	Actual Members*	Eligible Membership
White	9,455	2,810,088
Mixed	48	16,683
Asian or Asian British	39	9,992
Black or Black British	19	5,843
Other	145	11,178

Source data taken from 2001 Census data found on the websites of Devon, Dorset, Somerset & Cornwall County Council

* Actual membership analysis based on 9706 RD&E members who supplied their ethnicity; the remainder (4496) chose to withhold this information.

Table 14: Analysis of Current Membership (Gender)

Gender	Number of Members*	Eligible Membership
Male	4,590	1,381,791
Female	5,356	1,471993

Source data taken from 2001 Census data found on the websites of Devon, Dorset, Somerset & Cornwall County Council

* Actual membership analysis based on 9946 RD&E members who supplied their gender; the remainder (4256) chose to withhold this information.

Table 15: Analysis of Current Membership (Socio-economic groupings)

Socio-economic groupings	Number of members	Eligible Membership
ABC1	6,135	1,230,802
C2	1,023	219,421
D	2,968	577,534
E	4,076	826,027

Source: Office for National Statistics (2001 Census).

Minimum numbers of members required under Schedule 1

The minimum number of members for each of the three public constituencies, and the staff constituency, is six.

Table 16: Analysis of Election Turnout

Date of election	Constituencies involved	Number of members in constituency	Number of seats contested	Number of contestants	Election turnout %
June 2008	Exeter & South Devon	5446	3	5	44.4%
June 2008	East Devon, Dorset & Somerset	5114	3	5	49.6%
June 2008	Mid, North, West Devon & Cornwall	3432	2	3	45.1%
June 2008	Staff - Allied Health Professionals	849	1	1	n/a
June 2008	Staff – Hotel Services & Estates	880	1	0	n/a
June 2008	Staff – Admin, Clerical & Managers	1262	1	0	n/a

5.2 Membership Commentary

Public Membership
The RD&E provides tertiary, specialist and local acute hospital services, within a teaching and research environment, to a population of approximately 350,000 people within the local authority administrative boundaries of Exeter City Council, East Devon District Council and Mid Devon District Council. This is considered to be our core population.

The RD&E also provides specialist secondary and tertiary services to the wider population in the rest of Devon, increasing the population served to over 500,000, and to a lesser extent to the populations of Dorset, Somerset and Cornwall.

The public constituencies have been defined on this basis.

Membership is open to everyone aged twelve years and over, with no exclusions.

Public constituencies:

- Exeter and South Devon
- East Devon Dorset and Somerset
- Mid North West Devon and Cornwall

The community described above, and in particular the North and East Devon healthcare community from which most of our public members are drawn, has some specific features that shape our response to meeting national objectives. These include:

- A dispersed population;
- Market town settlements;
- Mixed rural/urban communities;
- Social and economic deprivation in some parts of North Devon, East Devon and Exeter.

Although the population is located around the main towns, the area is principally rural in character. There are almost 490,000 people in North and East Devon, with a higher proportion of people over the age of 75 than the national average, and a lower than average population from among BME groups.

In order to develop a membership that is representative and reflective of the local population, an analysis of the membership takes place on an annual basis to identify areas or groups that are under-represented. The analysis presented at the Annual Members Meeting in September 2008 (and subsequently to the Board of Directors) indicated that membership numbers are, broadly speaking, evenly spread throughout the three constituency areas. A more detailed breakdown accurately reflects referral patterns from outlying areas, with significant numbers of members from parts of Devon other than the three closest local authority areas (Exeter, Mid Devon and East Devon), and very small membership numbers from Dorset, Somerset and Cornwall.

Membership continues to broadly mirror the demographics described, though with a higher proportion in the older age group. Membership continues to be

reflective of the patient population to a noticeable degree and is consistent with the fact that membership recruitment is most effectively achieved from among that group.

There have been no changes in electoral ward boundaries that have affected membership numbers.

Staff Membership
All employees of the RD&E are eligible to become staff members of the RD&E NHSFT, including any member of staff who is employed by the RD&E on a permanent contract, and anyone who has a short-term contract of twelve months or more. Staff who are employed by the Trust but who work within other NHS organisations locally, for example Shared Services, are also included. Staff members may not be public members. As the RD&E has no contracted out services there has been no need to consider potential staff membership of additional groups. Staff who work for the Trust on a voluntary basis are not included in staff membership and may therefore become public members.

Staff constituencies:

- Medical Staff and Dentists
- Nurses/Midwives (including auxiliary nurses)
- Allied Healthcare Professionals (including scientific and technical staff)
- Hotel Services and Estates
- Admin & Clerical/Managers

Staff constituencies remain unchanged.

Engagement with Members & Future Membership
A review of the Membership Development Strategy was carried out in 2008, to ensure alignment of membership and patient and public involvement initiatives within the RD&E. Since becoming a foundation Trust, the RD&E has had two parallel approaches to the involvement of users via the patient and public involvement (PPI) and membership agendas.

The review resulted in a single overarching approach to involvement, whilst still retaining the distinctiveness of membership, and ownership of the membership strategy by the Council of Governors. Two Governors from the Membership Development Group (which reports to the Council of Governors) are also members of the Involving People steering group, ensuring a joined up approach to engagement activities whenever possible. Both the Council of Governors and the Board of Directors will continue to receive regular reports on membership.

The Membership Development Group meets regularly to discuss membership engagement, and is responsible for overseeing delivery of the strategy and the workplan for membership recruitment and activity each year.

The group has carried out a review of public meetings, revised and updated the Trust membership form and covering letter, reviewed progress against the 2008/09 workplan and revised this to ensure it is mapped to the key priorities identified in the membership development strategy.

Seven membership development priorities were identified for the next three years, which reflect the shared commitment to involving members and staff to enhance services for patients.

During the past year, membership has been encouraged within the Trust and via mailing to a variety of voluntary sector and other local organisations, and to GP surgeries and libraries. Membership is also actively promoted at a range of local meetings, and is widely publicised at the Trust's open day. It remains the case that the most effective method of recruitment is via direct mailing to recent patients. In the past year approximately 20,000 membership forms were mailed to this group, resulting in 957 people being registered as new members during 2008/09. The RD&E continues to take the view that a slow and steady increase in membership numbers is optimum.

Close monitoring of membership takes place via the database used to capture information supplied by members on the application form. Regular analysis and review of this enables the Trust to undertake detailed demographic analysis of the membership, and identify where gaps exist. Public membership continues to be largely representative of the local population in terms of ethnicity and gender.

Members receive a quarterly newsletter providing them with information about the Trust and ways to become more involved, including regular Medicine for Members events, public meetings, and a variety of surveys. All of these activities will continue during 2009/10. Turnout in elections to public constituency posts remains consistently high at around 46%, with a similar response to significant surveys, indicating that members feel sufficiently well engaged.

The Membership Development Group has highlighted a need to reflect on engagement with staff members and as a result have included this in their workplan for 2009/10.

Elections to the Council of Governors
The following governors were elected at the annual elections in June 2008:

Table 17: Public Governors

Constituency	Outcome
Exeter and South Devon	Keith Broderick and Richard May elected; Andrew Webber was re-elected (turnout 44%)
East Devon, Dorset and Somerset	Jill Gladstone elected; Christopher D'Oyly and Linda Fryer re-elected (turnout 50%)
Mid, North, West Devon & Cornwall	Dianah Pritchett-Farrell and Cynthia Thornton elected (turnout 45%)

Table 18: Staff Governors

Constituency	Outcome
Allied Health Professionals	Tony Cox, elected unopposed

The Board confirms that all elections to the Council of Governors are held in accordance with the election rules, as stated in the Constitution.

SECTION SIX:
FINANCIAL PROJECTIONS

SECTION SEVEN:
SUPPORTING SCHEDULES