NHS
Royal Devon and Exeter
NHS Foundation Trust

Operational Plan Document for 2017/18 to 2018/19
Royal Devon & Exeter NHS Foundation Trust

Foreword

The Operational Plan for 2018/19 for the Royal Devon & Exeter NHS Foundation Trust (RD&E) is set out in the following document.

Our plan has been established in the context of the wider plan established for the whole Devon population, driven originally by the Devon Success Regime and more recently the Devon Sustainability and Transformation Plan (STP). The STP for Devon seeks to respond to some of the key challenges facing the county, primarily the ability to continue to deliver financially and clinically sustainable services in the face of increasing demand from a growing and ageing population. Our STP aims to address the financial challenge whilst improving health outcomes for people in an equitable way through shifting our model of care to provide more effective joined up services in, or closer to, people's homes and thereby reducing reliance on bed-based care.

The RD&E is a full partner, along with other health and social care organisations across Devon, responsible for working within our local communities in order to deliver this vision. Whilst the vision and outlined plan is starting to take shape, there is still a great deal of work to be undertaken to reflect detailed plans for delivery. Good progress is being made and following submission of this plan, further work will continue to ensure the RD&E can meet the needs of today whilst transitioning towards the model of care for tomorrow.

In forming this plan for submission, the RD&E has had to take a careful view of what it has been asked to achieve, across the spectrum of indicators covering financial, access and quality. The Board of Directors is clear that whilst there will be no compromise on patient safety, it will be increasingly difficult to maintain delivery across all aspects of regulatory indicators. To achieve the control totals that have been indicated by NHS Improvement (NHSI), the RD&E will need to balance the ability to deliver increased activity and this has the potential to impact on patients' constitutional rights to be treated within 18 weeks. This impact has been discussed across the STP footprint and is consistent across health partners in Devon. The RD&E is currently in discussion with partners to assess an acceptable approach for 2018/19.

In reaching a conclusion as to whether the RD&E can achieve the control totals set for 2018/19, the Board of Directors has assessed the actions that can be taken independently by the RD&E and whilst it is acknowledged this approach will form a significant contribution to the required solutions, that it will not be sufficient to balance the required financial targets. It is our expectation that we will combine the actions that can be delivered by the RD&E together with what is possible across the STP footprint in order to meet our financial targets and we look forward to working collaboratively with our partners over the coming months to ensure we can successfully deliver for the benefit of our local population.

Devon STP Context

In 2016/17 organisations within the health and care system in Devon came together to develop a five year Sustainability and Transformation Plan. Set against a backdrop of longstanding financial challenges with the expenditure on healthcare exceeding allocations, at the time the projected financial gap for Devon system was £557 million by 20/21.

By taking positive action as a system, strong advances have been made, and whilst challenges remain, the Devon system is now working towards financial balance in 2019/20. Last year system savings plans were aligned and managed jointly across the STP footprint and a signed memorandum of understanding confirmed the shared commitment to working together to achieve a clinically, socially and financially sustainable health and care system.

In addition to this improving financial position and system wide working, there have been advances in community based care models accompanied by reductions in the overall bed base. Ground-breaking collaboration has brought about mutual support arrangements for clinical care and new clinical networks. There are many other examples[1].

The original STP strategy has now been refreshed to reflect the systems' learning so far, to take into account current national strategy and policy direction. Whilst the Devon Case for Change published in 2016 still holds true we now have a more in depth and up to date understanding of local health needs, and care models through the work of the STP programmes.

The system remains committed to the triple aim of improving: population health, experience of care and cost effectiveness per head of population. In this context, the refreshed strategy sets out strategic priorities and associated outcome indicators for the next three years with a specific focus on:

- Enabling more people to be and stay healthy
- Enhancing self-care and community resilience
- Integrating and improving out of hospital care
- Delivering modern, safe and sustainable clinical services

With regard to 2018/19, whilst there is a continuing need for individual organisations to deliver their respective annual operating planning accountabilities including their contribution to the national 2018/19 deliverables, a single shared system plan has also been developed. With a specific focus on actions that will bring 'in year' benefit, as well as those which will set strong foundations for future years, the emphasis of the system plan is:

[1] http://www.devonstp.org.uk/

- **Productivity:** Delivering the existing care model more effectively and efficiently. This includes plans to utilise the Model Hospital digital information services to identify and realise productivity opportunities; addressing unwarranted variations by implementing the Getting it Right First time programme; and opportunities to share key corporate services.

- **Transformation:** Continuing the shift towards a new model of care including using new data on frailty to identify people most at risk and intervene accordingly. There will be a renewed system wide and local focus on the most effective approaches to moderate demand using tried and tested approaches, benchmarked tools, and new initiatives where these are assessed to be of value.

- **Integration:** Building on the progress of partnership working across the system and the policy direction for integrated care, the foundations are already in place to establish an Integrated Care System in shadow form from April 2018 with an integrated strategic commissioner for Devon, and local integration through four place based Local Care Partnerships and a Mental Health Care Partnership.

Financial principles have been signed up to, and the content of the system plan for 2018/19 has been developed and endorsed by all constituent commissioner and provider organisations in the Devon health and care system working through the governance of a Collaborative Board and supporting system infrastructure. The system plan is therefore a central aspect of the RD&E operating plan

Approach to activity planning

The health community has a well-established activity planning process. This year's process consolidates and builds upon the existing partnership working to balance a realistic view of demand and capacity with the need to deliver key performance targets and financial balance. This can be summarised as follows:

1. 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 coded by Health Resource Group (HRG)
2. 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
3. Modelling of primary care referral trends, at specialty level coded by HRG, adjusted for demographic growth and Quality Innovation Productivity Prevention
4. 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. Whilst growth in activity is indicated by the modelling work undertaken to date, increased workload at acute hospitals is contra to the direction set out by the STP model of care for Devon. The RD&E will work with its STP partners and activity figures will change as the discussions across the health economy continue, particularly in relation to the quantification of the impact of QIPP and Devon STP programmes of work. Also noted below are the guideline growth rates at national level set out in the "Refreshing NHS Plans for 2018/19" guidance, with a brief explanation of any key differences.

	2017/18 Plan (from 16/17)	**2018/19 Plan (from 17/18)**	**National guidance**	**Comments**
A&E	6.0%	8.4%	1.1%	• In line with local growth trends over the past three years.
Elective Daycase	3.4%	5.0%	3.6%	• In line with local & national growth trends.
Elective Inpatient	1.0%	7.30%	3.6%	• Figure includes some counting changes (approximately 300 cases.) • Includes some RTT backlog clearance.
Non-elective Inpatient	2.9%	-0.2%	2.3%	• 2017/18 actual growth was 0.74% • This reflects that admissions avoidance strategies such as community services developments, front door OT and ambulatory care are helping reduce admissions.
Outpatient attendance (consultant lead)	2.7%	-0.5%	4%	• In line with local trend. • Some activity has shifted from consultant led to non-consultant led.

One key area where the local growth planned for 18/19 is less than the national planning assumption is non-elective inpatients. Historically growth in non-elective admissions has been higher, averaging at around 4% year on year. In October 2016, the Trust acquired the provision of local community services, which included community hospital beds as well as services such as district nursing, urgent community response, and rehabilitation services. This has facilitated a much greater degree of integration of services and the establishment of a single point of access for all discharge and admissions avoidance activity. In addition an Ambulatory Care Unit aimed at reducing length of stay and avoiding unnecessary admissions has been opened and this has enabled the Trust to reduce growth in admissions, with the 17/18 admissions levels being only 0.74% above those in 16/17. Further development of these services is planned in 18/19, which is reflected in the anticipated growth being lower than the national average.

The work under the Devon STP 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 delivery of national performance targets. Where capacity constraints require alternative provision, including independent sector capacity, this is agreed between CCG and provider.

As part of the demand and capacity planning process, Divisional teams assess the potential impact of all known national publicity campaigns, particularly those relating to cancer, and ensure that changes in cancer 2-week wait referral patterns have been taken into account in planning for the following year.

Activity plans are developed such that they are sufficient to improve and achieve the majority of key national requirements for cancer, diagnostics and the A&E 4-hour waiting times target, however delivery of the incomplete pathway 92 % 18 weeks RTT standard will remain challenged. Where additional activity is required either to meet a recurrent increase in demand or to clear a non-recurrent backlog, this is discussed with the CCG to agree an approach consistent with the 18/19 planning guidance and local commissioning intentions. In 2018/19, there are a number of specialties including Orthopaedics, Urology and Cardiology where backlogs of patients will exist, which at the point of writing this document are the subject of local discussions.

Performance Trajectories

Trajectories for the key national standards have been developed in line with the principles outlined in the 2018/19 Planning Technical Guidance.

Referral to Treatment Times/Incomplete Waiting List change

Following a number of years of successful delivery of the RTT standard, RTT performance has deteriorated significantly over the course of 2017/18. Clinical and

managerial staff across the Trust, as well as the Trust Board are mindful of the impact that increased waiting times can have on patients and are focused on delivering and, where possible, exceeding the performance trajectory below. The trajectory is based on the 2018/19 guidance, which states that the size of the RTT waiting list should be sustained at or lower than the level at March 2018.

The trajectory for the RTT incomplete waiting list size and associated performance is shown below:

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Referral to treatment Incompletes - Total patients	29,000	29,400	29,800	30,200	30,600	31,000	30,600	30,200	30,000	30,000	29,400	29,000
Referral to treatment Incompletes - %	83.5%	84.0%	85.0%	85.0%	85.0%	85.0%	85.2%	85.5%	85.8%	85.5%	85.7%	86.0%

Due to the effect of the historical cancellations, capacity shortfalls caused by workforce issues, and cessation of Independent Sector transfers, an initial increase in the baseline waiting position is expected. A comprehensive sub-speciality delivery plan has been developed to recover this position from Q3 onwards. A static position is forecast over December and January due to Winter pressures and a planned elective activity reduction. There is a risk that this may extend into February and March 2019.

The following services have received additional funding during the budget setting process to support delivery of plans to mitigate against an increase in incomplete pathways, with some improved performance during 2018/19:

- Orthopaedics
- ENT
- Ophthalmology
- Rheumatology
- Dermatology
- Cardiology
- Respiratory
- Gastroenterology
- Neurology
- General surgery

As with all access targets, the delivery of RTT performance is monitored and managed through a comprehensive framework, which reviews performance at an individual patient, specialty, divisional and Trust aggregate level. Improvement plans will continue to be closely monitored so that any additional support or interventions required to deliver the trajectories can be identified and implemented quickly.

Cancer

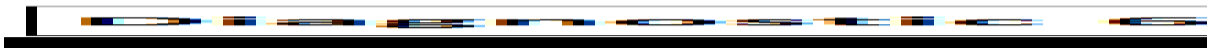
In line with the Single Oversight Framework, a single cancer performance metric will be reported nationally: 62 Day GP urgent referral to treatment. The 2018/19

guidance requires performance to be sustained at or above 85%. An operational delivery plan has been developed to improve performance across currently challenged tumour sites with a large emphasis on the diagnostic phase of patient pathways. It is forecast that achievement of the 85% standard will return in quarter 3; however, the unavoidable impact of patient choice over the December period is expected to result in a deterioration in performance in January and February, with recovery in March 2018.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Cancer 62-days	82.7%	83.4%	80.3%	83.0%	85.2%	83.9%	85.1%	85.1%	85.5%	82.7%	82.6%	85.2%

6 week diagnostic test waiting times

The trajectory has been based on the 2018/19 guidance, which mandates performance of less than 1% of patients breaching 6 weeks. Plans have been developed across a number of diagnostic modalities, which forecast a small improvement during Q1 as Magnetic Resonance Imaging (MRI) and Computerised Tomography (CT) issues are resolved, followed by further improvements from Q3 as plans are implemented within Endoscopy and Cardiology. With the current plans, it is forecast that performance will return to compliance in Q4.



4 Hour A&E waiting times performance

The 2018/19 planning guidance requires trusts to achieve above 90% in September 2018, and sets an expectation that the majority of providers will achieve the 95% standard for the month of March 2019. Sustainability & Transformation Fund trajectories require trusts to achieve the better of 90%, or the performance for the same quarter in the previous year.

The Trust 2018/19 trajectory for the 4-hour target is set out below and is based on 2017/18 performance for the ED department and Honiton MIU.

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Month	91.9%	92.8%	93.5%	95.1%	90.8%	90.7%	90.9%	91.7%	87.2%	88.3%	88.3%	90.7%
Quarter		92.7%			92.2%			90.0%			89.1%	

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Month	92.3%	92.8%	93.5%	93.6%	91.5%	91.8%	90.8%	91.7%	90.0%	90.0%	90.0%	90.7%
Quarter		92.9%			92.3%			90.8%			90.2%	

Co-ordinated by the local A&E Delivery Board, system partners from across the Eastern Devon Health and Social Care community have worked together over 2017/18 to build resilience into all aspects of the urgent care system, which will support the delivery of the 4-hour target. This work is set to be further enhanced during 2018/19 and every effort will made to deliver performance that exceeds the above trajectory throughout the year.

Risks to delivery of key targets

Whilst the demand and capacity planning process is undertaken with the intention of delivering on all key national standards, there remain significant risks to the delivery originating from other areas. These include but are not limited to:

- Changes in the urgent care landscape, such as the provision of 111 services, MIUs, WICs, access to primary care and support for patients with urgent mental health issues
- Changes to service provision at local acute trusts
- Unanticipated increases in General Practitioner or other referrals, particularly in cancer specialties requiring urgent 2 week outpatient appointments and subsequent diagnostics
- Severe adverse weather affecting capacity
- Major infection control outbreaks, such as the high levels of flu experienced in 17/18
- Workforce shortages – particularly for trained nursing staff and junior doctors
- Unplanned workforce availability such as the junior doctors' industrial action during 14/15 and 15/16
- Unplanned events such as the "cyber-attacks" or other disruption events seen in 17/18

In the event of events such as those listed above, further discussions with commissioners, providers and regulators will take place to minimise the risk to performance.

The Trust has systems in place to closely monitor capacity and demand. Any unanticipated excess capacity and demand 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 Improvement

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 maintaining a good/outstanding CQC rating, including governance processes

The Trust is currently registered without condition with the Care Quality Commission (CQC). 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 being double the national average, the absence of cases of MRSA for almost 5 years and good or outstanding outcomes for patients.

Governance System

The Trust adopts a balanced scorecard approach, represented through the Board Integrated Performance Report (IPR) and has a robust governance system, commended by the CQC.

- Governance 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
- In terms of quality, the Trust has a Ward/Department accreditation process called Clinical Quality Assessment Tool (CQAT). This covers all inpatient and outpatients areas. In 2016/17 this was 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
- Performance is managed through the Performance Assurance 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 Director of Operations, 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

- "Connecting Care", the Trust's infrastructure and methodology for monitoring and supporting team performance is now embedded in every day practice. In 2018/19, the focus will be on completing the roll out of the principles of Connecting Care to community services, following the transfer of clinical services from Northern Devon Healthcare NHS Trust in October 2016 and the transfer of Castle Place GP Practice in January 2018.

Quality Improvement Capacity & Capability

- The established Junior Doctor Quality Improvement Academy; a unique way of enabling F1 and F2 doctors to develop their quality improvement capability is expanding to other professional groups
- Connecting Care; a systematic way of working with a strong emphasis on shared learning, creative problem solving at team level, ideas generation through Comms Cells (commended by CQC)
- Research & Development is a strong thread running through the RD&E. To augment this and encourage wider participation in research activity, the Clinical School, a partnership between RDE and Plymouth University is supporting nurses, midwives and AHPs to engage in research and quality improvement work
- The Trust has developed a Memorandum of Understanding with the University of Exeter, with both partners committing to improve the amount and quality of research undertaken. This is borne out in the development of academic departments, with 9 being created in the first tranche
- Generated by a clinician, the idea of creating an Innovation Hub is being worked through such that staff at all levels of the organisation can be supported to innovate, with a focus on developing best practice locally which can then be shared and spread across the wider system

Summary of the quality improvement plan

- The annual Quality Account details the full detail of the clinical audits undertaken and how the Trust has responded to the national quality improvement agenda
- 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), chaired by the Head of Safety, Risk and Patient Experience. Our patient safety programme ensures that we address both national and local priorities, including sepsis, AKI, reducing incidents of pressure ulcers and falls and End of Life care. We will be particularly focusing on community services for the forthcoming year
- NHS Safety Thermometer is firmly embedded within the Trust and performance is consistently in the upper quartile nationally
- The maternity service has benchmarked well against Better Births. Further improvements are planned by increasing the cover of the integrated midwifery model and introducing a triage service. The maternity service is also developing a bespoke safety package which incorporates the elements of Saving Babies' Lives
- Patient experience is an integral part of our quality process. It is incorporated from Ward to Board (W2B), through our CQAT and examples are presented to the Board of where we have "Demonstrated Difference"
- The Trust has been working with the national Carter team and the cohort of 32 Trusts to develop the Model Hospital. We are reporting Care Hours per

Patient Day (CHPPD) on a monthly basis and this is part of our regular board report. We will publish our CHPPD and Cost Per Patient Care Per Day alongside other safety and quality outcomes to enable peer benchmarking for improvement

- The Trust is aligning its quality improvement effort to the local STP aims and priorities:

- **To improve population health and wellbeing** – an active partner within the Devon STP, the Trust's own plans mirror the STP and indeed predated the 5YFV and STPs. The RDE Future Care Programme recognised that the way in which care services were delivered needed to adapt, change and become more person centric, moving from 'patients' to 'people' and that working as a collaborative, across multiple agencies and partners was a critical factor in improving the health and wellbeing outcomes for the people of Devon. ICE [Integrated Care Exeter] a strategic alliance of 17 organisations working for the past 2 years across the city of Exeter, has provided a demonstrator site where population risk stratification, targeted intervention for both immediate need and focusing on prevention through community building and connecting has developed. Developing trusted relationships and a shared understanding and purpose has been critical; valuable learning as we move towards creating Place Based Care across Devon. The development of an STP-wide Integrated Care Blueprint provides the basis upon which to benchmark the 'current' whilst identifying areas for improvement. The Eastern Locality Forum [the system-wide group made up of multiple stakeholders] will oversee the local system plan for delivery against the Blueprint.

- **To introduce a fully integrated model of care, promoting independence and reducing the reliance on hospital beds.** Successful implementation in 2017 of the Your Future Care proposals to reduce the community hospital bed base by 72 beds, alongside augmentation of the community-based service offer, has provided a foundation upon which to build in terms of implementing the new model of care. A series of Community Conversations are underway resulting in local place based plans emerging where community leaders are, in collaboration with local people and organisations identifying local need and how best to respond to that need with a central focus of promoting citizen independence. During 2017, the RDE acquired its first primary care practice: Castle Place in Tiverton. Throughout 2018/19, a fully integrated health and social care model will be developed and tested in Tiverton.

  Within the acute side of the organisation, Your Road to Wellbeing, the Trust's re-ablement campaign will continue to elicit changes in focus and practice such that patients receive care in the lowest possible intensity setting and remain in a bed that is not their own, for only as long a period as adds value to them. Development of the Advice & Guidance offer for community clinicians, together with development of more ambulatory care pathways and hot clinics, aims to reduce admission, offering an alternative which is both reliable and timely.

- **To ensure cost-effectiveness per head of the population.** Using a variety of tools and methodologies, such as GIRFT, Model Hospital and Risk Stratification the Trust and its partners will make considered decisions based

on productivity and securing the best possible outcomes for the people we collectively serve. A programme, under the STP seeks to explore the need and viability of securing acute networked services under which clinical and financial sustainability can be secured. The Trust is actively engaged in this work.

Summary of quality impact assessment process

The Trust operates within a Quality Impact Assessment (QIA) framework, based on the National Quality Board guidance – largely orientated to Cost Improvement Plan (CIP) schemes. In order to ensure that there are no adverse consequences on the three core quality domains (patient safety, clinical effectiveness, patient and staff experience) and equality for both patients and staff, a Quality Impact Assessment (QIA) is carried out for all CIP schemes. When a scheme is identified, the relevant clinical staff inform the development of the QIA, which is then reviewed and signed off by the Divisional Director, Associate Medical Director and Assistant Director of Nursing. The framework insists, in line with the stated Board risk threshold, that any scheme with a risk score higher than the risk threshold is then referred to the Medical Director and Deputy Chief Executive/Chief Nurse who together make a decision about whether the scheme can proceed.

The Operations Board has oversight of the QIA process in order to ensure compliance. QIAs include identification of key performance metrics to identify potential impact on patient care and these are monitored through the appropriate governance route. The overall Performance Assurance Framework would identify any impact of CIP schemes including the cumulative impact of several schemes, at divisional level and then at Trust wide level via the integrated performance report reviewed by the Board on a monthly basis.

Summary of triangulation of indicators

The Trust's Performance Assurance Framework ensures that performance monitoring and performance are aligned from service line and ward level to Board. The monthly Board Integrated Performance Report (IPR) 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 aggregate performance could mask individual areas of concern.

Each Clinical Division meets monthly with the corporate team (Finance, Performance, Workforce, and 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 prepared for the meeting provide the opportunity for the Clinical Division to undertake its own triangulation 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 2017/18 and 2018/19.

Seven Day Services

The Trust has maintained and improved their position in relation to compliance with the four priority standards for seven day services. This includes the achievement of the standards within the relevant priority specialised services, Vascular, Stroke and Cardiology (STEMI heart attack provision).

The Trust participates in the twice-annual Seven Day Services audit and data collected through this process in 2017/18 demonstrates the following:

- Clinical Standard 2 – Time to first consultant review <14 hours of admission 90%:
    - Trust weekday position 86%
    - Trust weekend position 83%
    - Trust combined position 85%
    - Although the Trust is narrowly missing the 90% standard, the Trust is benchmarked nationally as an upper quartile performer. There remain two key areas of focus to ensure the consistent delivery of the 90% standard and work is underway to address this in General Surgery and Paediatrics.
- Clinical Standard 4 – Access to diagnostics for patients with an Urgent or Critical need
    - Trust assessed as compliant with this standard; however, as is consistent with the local and national position, Cardiac ECHO remains an area of focus.
- Clinical Standard 5 – Access to key interventions
    - The Trust is fully compliant with this standard
- Clinical Standard 8 – On-going review
    - 98% of patients requiring twice daily review received these reviews.
    - 94% of patients requiring once daily review received their review.

Through 2018/19, the Trust will continue to make progress to support the consistent achievement of the clinical standards, with a principal focus on paediatrics and general surgery as remaining areas not consistently achieving clinical standard two. The Trust will continue to engage fully in both local and national seven day services events with NHSE and NHSI regarding delivery and the Trust is actively working with

other trusts nationally to identify best practice and innovative service models to support or sustain achievement of the standards.

In addition, the trust is implementing a number of supporting interventions as part of the 2018/19 'In Hospital Programme' which will further strengthen compliance with the standards, such as the implementation of SAFER bundles, Red to Green days, enhancing ambulatory care and enhancing the provision of advice and guidance and access to hot clinics.

Furthermore, work across the Devon STP, as part of the review of acute services, continues to consider the delivery of Seven Day Services standards within reviews of service configurations across a wider footprint or on a networked basis, where required for relevant services.

Approach to workforce planning

During 2017/18, the Trust has continued to operate the annual workforce planning process that is aligned to the Trust's operational plans (derived from commissioning discussions) and/or to meet the needs of the corporate strategy. The workforce planning process is consistently adopted across the whole Trust (acute and community settings) and is service line driven, completed by the service line cluster teams led by a Clinical Lead, Senior Nurse and Operational Manager. Each Cluster team submits a workforce plan, which is then collated into a divisional workforce plan for first level approval by the Divisional Leadership Team. Once approved, the divisional workforce plans then comprise the overall Trust workforce plan, which receives second level approval by the Operations Board and is ratified by the Executive Team prior to submission to Health Education South West.

From a governance perspective, the Trust operates robust processes to ensure successful delivery against the strategic and operational plans (including the workforce plan). This process has a range of daily, weekly, monthly workforce reviews involving staff from frontline teams to the Trust Board of Directors (BOD) and/or Governance Committee. The mechanisms used include daily Communication Cell Briefings at team level, a monthly Performance Assurance Framework (PAF) process involving clinical and non-clinical leaders, monthly reporting to the BOD – all of these are monitoring performance against a range of workforce metrics to ensure services are efficient, safe and sustainable from a clinical and financial perspective. Below are some examples of the key workforce achievements during 17/18:

- **Community Transfer:** the transfer of community services was completed smoothly from a workforce perspective, with the focus during 17/18 on integration to become one organisation
- **Staff Engagement:** further incremental improvement in our staff engagement results of 3.9 placing the Trust in the top 20% nationally
- **Staff Health & Wellbeing:** further work completed to broaden the range of support and services available to staff resulting in reduced sickness absence, and improve staff morale
- **Inclusion:** the Board has reset its future ambition with the aim of becoming recognised nationally as an employer of choice and an exemplar organisation which values diversity and is truly inclusive

- **Staff Retention:** a significant amount of work has been undertaken to listen, and respond, to the reasons for staff leaving which has resulted in a reduction in turnover to the lower end of our target range of 10%-12% (10.6% as at Jan 18)
- **Vacancies:** the competitive recruitment market has made sustainment of a positive vacancy position extremely challenging. However, as at Jan 18, our aggregate vacancy rate was 6.8%. For our registered nursing staff group, a proactive recruitment strategy (UK, Europe and Overseas) is enabling us to manage our challenging vacancy position
- **Agency Spend – all staff groups:** the Trust has continued to manage agency spend across all staff groups, with spend below the agreed NHSI ceiling
- **Workforce planning –** work has continued to ensure operational, financial and workforce alignment from a planning perspective which has enabled the Trust to effectively manage increased demand, greater patient complexity and flue/winter related pressures
- **e-Rostering –** consistent achievement of published rosters 6 weeks in advance
- **PDR, Statutory and Mandatory training –** consistently above 80% completion

The Trust has completed the refresh of its Corporate Strategy. This work has included the definition of the future care model that will be delivered through a 2 Year Operational Delivery Plan enabling clinical and financial sustainability. The workforce and cultural related implications of this transformational change programme have been identified, with a future People Strategy developed, that will see work completed over the next c.2 years through the following supporting plans:

- **Attraction & Resourcing:** engaging with STP Partners to build a strong Devon brand – 'Proud to Care' in order to attract new staff and aid retention of existing staff
- **Environment & Staff Support:** creating the conditions and ways of working which celebrate difference and which recognise the needs of individuals and teams, ensuring support is in place for them
- **Continuous Learning & Development:** working collaboratively with STP Partners to establish a continuous learning and development approach that nurtures talent now and in the future
- **Staff Engagement in Quality Improvement:** developing and embedding a comprehensive quality improvement approach which engages our community (public, patients, carers and staff) in delivering our future care model
- **Medical Education:** maintaining high quality postgraduate medical training programmes which will continue to attract and retain doctors
- **Professional Development:** establishing and developing our clinical workforce that is fit for purpose now and in the future

In parallel with the above medium to longer strategic plans, the Trust will prioritise work in the shorter-term (e.g. the next 6 – 9 months) to address the following immediate workforce related challenges, including:

- **Retention of existing staff** – sustaining a reduced turnover level of between 10%-12%
- **Recruitment of new staff** – sustaining a reduced vacancy rate of c.5%-7%
- **Making Devon, and the RD&E, an attractive and easy place to work** – including consideration of more flexible work patterns

- **Continuing the review of skill mix** – challenging historical practice and professional boundaries
- **Creating career paths to attract additional resources** – for clinical and non-clinical staff groups and across all ethnic groups
- **Considering alternative resource options for hard to fill roles, particularly those where we are unable to compete under Agenda for Change terms and conditions** – apprenticeships, volunteers, etc.
- **Exploring opportunities to influence the political landscape with reference to EEA workers and overseas worker visas** – address issues with current process which is negatively impacting ability to fill key clinical vacancies

In the context of the Wider Devon Sustainability and Transformation Partnership (STP), work is underway to produce the future STP Workforce & Organisational Development (OD) Strategy that will support delivery of the STP programme of work across its seven priority areas. The RD&E is represented on the STP Workforce Strategy Group and leads the STP OD Strategy Group with the priorities for both defined as:

Workforce Priorities	Organisational Development Priorities
Priority 1: Nursing and Medical Agency Spend **Priority 2:** Short term workforce supply **Priority 3:** Longer term workforce supply **Priority 4:** HEE and Education Provider Commissioning **Priority 5:** Workforce Strategy development	**Priority 1:** System leadership capability **Priority 2:** Collaborative working and behaviours **Priority 3:** Translating the STP vision into practical action **Priority 4:** System ways of working **Priority 5:** Effective and efficient organisational systems and processes **Priority 6:** OD Support for STP work streams

Through delivery of the above priorities, the STP will be enabled to deliver its programme of transformational change to establish a new model of care that will see care being delivered closer to home and which enables greater independence by the population to manage their health.

The STP Workforce Strategy Group will lead on the development of the new workforce model aligned to the new care model, and will monitor delivery of this change to provide assurance around sustainability from an efficiency, financial and safety perspective. The STP OD Strategy Group will support the Devon System to build a new way of working, which sees collaboration and partnership working as well as effective system leadership as fundamental enablers to success.

Approach to financial planning

Financial forecasts and modelling

Context

2017/18 has seen a continued improvement in the underlying financial position of the Trust, which has also been supplemented by a one-off income benefit generating additional STF. The Trust achieved a surplus of £13.0m (including the STF incentive and bonus) compared to a planned deficit of £0.5m.

During 2017/18, the Trust has maintained a tight control on all expenditure including agency expenditure, which remains well within the limit set by NHS Improvement.

The Trust continues to work closely with other organisations within the Devon STP across a number of work programmes to develop sustainable services over the STP footprint. The seven priority work programmes include:-

- Prevention
- Integrated Care Model
- Mental Health
- Children & Young People
- Acute Services Review
- Productivity (including Elective Care & Corporate Support Services)
- Enablers (including estates & IM&T)

As at month 12 £114m of recurrent savings are forecast to be achieved within the Devon STP which (with non-recurrent flexibility) will enable a deficit of £52m to be achieved against the planned £61m deficit.

The Trust achieved £21.9m compared to the planned £21.6m CIP requirement in 2017/18; however on a full year basis £16.6m has been achieved which will leave £5.0m to be carried forward to 18/19. Whilst planning for 2017/18 – 2018/19, the Trust elected to take up the offer from NHSI of a lower control in 2018/19 (originally a £1m surplus compared to a £4.3m surplus) on the basis that there were non-recurring CIP schemes planned in 2017/18 leading to a likely rollover CIP requirement.

For 2018/19, the Trust is planning for an operational income and expenditure surplus of £6.3m in line with the revised control total now identified by NHS Improvement.

In order to achieve the control total the Trust will need to achieve a CIP of £23.3m for 2018/19 (5.5% of patient income, excluding STF).

This CIP target assumes block income from both of the Devon CCGs on a flat cash basis i.e. there has been no uplift from 2017/18 for growth or inflation in line with the agreed STP financial principles, to return the CCG to financial balance over the next 2 years.

As can be seen from the following narrative relating to cost improvements the Trust is currently only able to identify around £18.0m of the expected target, and therefore other options will need to be explored in order to help to close the financial gap.

The Trust's CIP target of £23.3m is part of an overall £149m requirement for the Devon STP, significantly higher than the £112m forecast to be delivered in 2017/18, and therefore there is a significant risk of the plans not delivering the full savings meaning that the system will lose an element of the CSF/PSF available.

Having been approved by the NHSI Resources Committee, the plan for 18/19 includes the Clinical Pathway Transformation (CPT) programme enabled by EPR. The cost of the programme in the first ten years totals £133m (2 years of implementation), with cash releasing benefits of £117m expected over the same period. The programme is expected to be funded by a commercial loan of £42m in addition to the future benefits.

The expected capital cost of CPT for 18/19 is £14.0m with additional revenue spend of £1.3m, which is included within the Trusts CIP target.

Also included within the capital programme for 18/19 is expenditure relating to an extension of the Emergency Department, and an additional Linear Accelerator and bunker. The Independent Trust Financing Facility (ITFF) has approved the loan for the ED scheme and to part fund the Linear Accelerator bunker, although this is still awaiting release of funds from DH. The funding of the Linear Accelerator is expected to be mostly funded through additional PDC, although this has yet to be confirmed.

The table below highlights the key financial indicators.

	2017/18 outturn	**2018/19 Plan**
	£m	**£m**
Patient Income	407.7	422.6
PSF Income	16.8	12.2
Commercial Income	80.6	71.3
Total Income	505.1	506.1
Expenditure	-492.1	-499.8
Surplus	**13.0**	**6.3**
Cash	23.5	64.2
Capital	8.9	35.7
Loan Requirement	-	46.2
PDC		1.7
EBITDA	**6.0%**	**5.0%**
UOR	**1**	**1**
Agency spend	**7.6**	**7.4**

* Capital expenditure includes expenditure funded by loan or PDC funding.

The key movements from the forecast position for 2017/18 to the 2018/19 plan are:

- Additional income and cost for, Full Year Effect (FYE) of the transfer of Castle Place GP Practice £1.4m.
- The transfer of the Walk-in centres (WIC) from 1st April 2018 of £1.1m
- Growth excluding service changes of £6.5m (inc drugs and devices growth)
- STP return of £1.5m due to a contract reduction in 17/18.
- Additional private patient income and expenditure of £0.8m in 18/19 relating to the new Private Patient Unit.
- Removal of non-recurrent commercial income of £5.5m in 17/18.
- Additional iBCF income and costs of £3.5m in 18/19.
- Inflation costs of £8.8m less £0.9m reduction in CNST costs.
- Change in the Trusts control total of £5.3m.
- CIP savings of £23.3m for 18/19.

Income / Activity

Activity planning is covered on pages 5 and 6 of this document. The Trust is working closely with the CCG and other providers in the STP 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.

Clinical income expected for 2018/19 includes Provider Sustainability Funding (PSF) of £12.2m this is an increase of £3.5m from 2017/18 planned levels and will still be split by 70% meeting the financial control totals and 30% for achieving the A&E trajectories. This change has also meant the Trust's control total has been increased by this value. It also includes the impact relating to the change in CNST.

Due to NEW Devon and South Devon being treated as a flat cash contract, this has added additional CIP to the value of £5.1m. This is offsetting the Devon Growth of £2.2m and inflationary/pricing changes of £2.9m.

Control Total

The original control total for 18/19 was a £1.0m surplus and has now changed to £6.3m surplus, the table below shows the adjustments that have affected the control total.

	£m
Original 2018/19 Control Total	1.0
Net impact of CNST income and spend changes	2.9
Risk Reserve (available for deployment)	- 1.1
Additional STF (now PSF) allocation	3.5
2018/19 Control total (after donated depreciation)	**6.3**

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 2018/19 has been assumed at £8.0m. This reflects known changes such as CNST, pay and non-pay inflation, and capital charges. The uplift is allocated to reserves (based on the information in the table below) until cost increases are known.

Description	2018/19		Basis of calculation
	%	£m	
Pay inflation/incremental uplift	2.1%	5.8	In line with STP return, also covers incremental uplift and apprenticeship levy increases.
CEA awards and Threshold increases	0.2%	0.8	For Clinical Excellence Awards, derived based on the national calculation for CEAs. Increments are based on expected increases.
Non pay	2.1%	1.8	% of 2017/18 non-pay budget using STP inflation rates.
Drugs	1.5%	0.9	Recharged to the commissioner except Devon area, 2018/19 rate based on 3.6% for non-pass-through and Devon pass through.
Commercial income	-0.4%	- 0.3	1% applied to income from all NHS bodies and 2.5% on non-NHS bodies.
	1.7%	8.9	

CNST	-6.7%	- 0.9	Decrease as per NHSLA notification.

In line with NHSI guidance, the proposed pay award has not been reflected in the 2018/19 annual plan. Although the expectation is that additional funding will be provided for the cost of the award above 1%, there is a risk of a shortfall between the cost of the award and the funding received.

Agency Usage

Expenditure on agencies for the provision of non-NHS staff for 17/18 has been £7.6m, and for 18/19 we are expecting the total spend to be £7.4m. This is compared to the expenditure limit applied by NHS Improvement for 2017/18 of £9.2m. This level has been reduced by NHSI in 18/19 to £8.7m.

The use of agencies is continually questioned and work to reduce the reliance on agencies is being undertaken by the Workforce Strategy Group, as set out in the workforce section of this plan.

2018/19 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 the year. This results in an expenditure increase for 2018/19 of £6.5m (including £3.9m relating to activity growth and £2.6m relating to pass through drugs and devices).

Transfer of Services
Included in the plan is the full year effect of the transfer of Castle Place GP Practice, increasing the Trust's income and expenditure by a further £1.4m to that incurred in 2017/18. A transfer of the local Walk-in centres to the Trust from 1st April 2018 with additional income and expenditure of £1.1m is also expected.

Other Operational Expenditure issues

- Other reserves / contingency. A recurring revenue reserve / contingency of £2.5m and a non-recurrent reserve of £1.0m has been included. This relates to a £0.5m reserve for operational or strategic developments, £0.5m for essential requests that arise during the year, £0.5m strategy and CIP investment and a recurrent £1.0m contingency. The non-recurrent £1.0m is to cover the in-year cost of overseas nurse recruitment initiatives. 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. The £1m contingency is assumed to contribute to the CIP target on a non-recurring basis in 2018/19.

- Additional costs have also been added for risk reserve relating to the CNST rebate of £1.1m and STP return of funding of £1.5m. These are not required in 2018/19 and will be used towards the achievement of our CIP.

Sensitivity Analysis

The table below highlights the potential risks and mitigations that have been identified within three scenarios of best case, worst case and a most likely financial outturn for 2018/19.

Financial Risks & Mitigation	**Best case**	**Most likely**	**worst case**
	£m	**£m**	**£m**
Income & Expenditure plan	**6.3**	**6.3**	**6.3**
Potential Risks			
Shortfall on CIP - Unidentified	0.0	-2.0	-5.2
Shortfall on CIP - High Risk schemes	0.0	-2.2	-5.6
Patient demand exceeds plan	0.0	0.0	-2.0
Overspend on I&E	2.0	-1.0	-2.0
sub-total	**2.0**	**-5.2**	**-14.8**
Potential Mitigation			
CIP gap closing (inc. technical/STP)	0.0	5.2	4.0

Operational I&E position	8.3	6.3	-4.5
Impact on Provider Sustainability Fund (PSF)			
Loss of Q4 PSF	0.0	0.0	-3.0
Loss of all ED PSF	0.0	0.0	-3.7
Potential incentive gain*	2.0	0.0	0.0
Net PSF Gain / (loss)	**2.0**	**0.0**	**-6.7**
Net I&E position	10.3	6.3	-11.2

* Assumes 1:1 matching of improvement from NHSI

Efficiency savings for 2018/19

The CIP target has been set taking into account the 2% efficiency requirement, provision for in-year additional cost pressures/developments, the impact of the NEW Devon STP Financial Principles agreement to bring the STP back into financial balance over a 2 year period, and the change in the Trust's control total. An under-performance of recurrent CIP from 2017/18 has occurred (£5.0m). This underperformance is an improvement on the 16/17 position (£7.6m).

The BOD has set out an intention to deliver a surplus £6.3m control total for 2018/19 which will require a £23.3m CIP target which is higher than was expected at the beginning the two year planning period (£9.9m CIP target).

The BOD recognises that although achievement of the 2% efficiency saving is likely to be challenging; at this point it is thought to be achievable. The risk of delivering the additional CIP requirement in order to achieve the control total is however thought to be higher as the challenge of delivering system wide change intensifies.

CIP schemes of £18.0m have been identified to date for 2018/19. Although work will continue to identify and develop further schemes, other options need to be explored to close the gap.

For 2018/19 the BOD have approved a CIP approach that combines divisional productivity targets and trust wide schemes The trust approach to identifying schemes is to work with key stakeholders using benchmarking information where it is available. Once schemes have been identified, a Quality Impact Assessment is carried out to determine whether it is appropriate to proceed with the scheme, to ensure patient safety is maintained. The delivery of schemes is monitored through the monthly Performance Assurance Framework meetings and Operations Board. Where additional support is required, targeted meetings are held with specific areas.

The high level CIP targets allocated to date are:

CIP schemes	18/19 Current Year CIP £m	18/19 Full Year CIP £m
Divisional Target	12.9	13.2
Productivity	5.6	3.1
Bed reductions re: DTOC – delayed transfers of care	0.0	1.5
CNST	1.1	1.1
Site Reduction	0.0	1.2
STP Additional income	1.5	0.0
Community service redesign - reduction of bed capacity	0.4	0.8
Other (Additional required to meet EPR expenditure)	1.8	0.0
Total	**23.3**	**20.9**

CIP schemes identified are £18.0m with a further £5.3m needing to be identified.

CIP plans for 2019/20 are being developed, and the following areas are being scoped:

- Private Patients
- STP Acute Service redesign
- Site Reduction

Where CIP plans have been developed an assessment on the impact on staffing numbers has been made and reflected in the workforce return. Where the plans are unidentified, an apportionment impact on pay and non-pay has been applied to the workforce return.

Operational productivity work programme

The Trust has identified the actions required to deliver the recommendations within Operational productivity and performance in English NHS acute hospitals: Unwarranted variations (Lord Carter of Coles 2016). It is implementing the 10 Point Efficiency Plan. Opportunities for productivity improvement identified through the Model Hospital Portal with clinical service teams, functional and workforce leads are incorporated into the trust's CIP plan. In addition, the trust is working with Devon providers and the STP to identify system wide opportunities indicated by the Model Hospital, associated programmes and *Getting It Right First Time.*

Procurement
The Procurement team have benchmarked against the Productivity and Efficiency Teams Procurement Transformation Plan (PTP) with green ratings in 3 of the 10 metrics, amber in 6 and red in only 1 which is ensuring 90% of spend is on contract. The Procurement team continue to strive to meet this metric and work collaboratively across Devon in the STP to share knowledge and best practice.

Recently a new initiative for the Trust has been implemented where a warehouse has been utilised to increase the opportunity to bulk buy at discounted prices direct from suppliers. This has increased the rate of price reductions particularly on high volume consumable lines. The Trust Associate Medical Director leads the Trust's medical products steering group, driving through safe changes to products and services which will achieve better value to the Trust.

The Trust has participated and is fully supportive of the Future Operating Model and has led engagement of South West Trusts with NHSI and with the BSA. The PBIB benchmarking tool is used daily for price checking against peers and challenge of suppliers. GIRFT presentations at the Trust have included Procurement to ensure the best value, not just lowest costs are achieved.

Capital Planning
A robust capital planning process was undertaken, capital requests were risk assessed and checked for consistency and linked to the Trust's and clinical service strategies, with procurement and lead times being duly considered. Leasing arrangements will be further considered, for larger schemes, to help support the Trust's liquidity.

Capital projects that are above £2m in value are subject to a further robust business case process, comprising the production of strategic outline case, outline business case and full business case documents that require the approval of the Trust's Board of Directors.

Equipment
The process to identify, evaluate and prioritise replacement equipment has been thoroughly implemented with the level of risk to the Trust being the fundamental basis upon which schemes have been selected for approval.

The process involved the Capital Programme Group (CPG), which includes representation from all the Trust's Divisions and Support Directorates, and was supported by MEM. All members helped to scrutinise requests, by evaluating the business need and their compliance with the Trust's strategy. All schemes were risk assessed and independently scrutinised by the Trust's Head of Governance to help ensure risk assessments were scored consistently, with procurement lead times and contingency plans being considered.

£5.2m of funding has been allocated towards replacing existing equipment. A further £2.8m of expenditure has been included for a fourth linear accelerator machine. It has been assumed that this machine will be part funded via Public Dividend Capital (PDC) funding of £1.7m, however confirmation has not been received from NHSE.

Estates infrastructure
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. £4.8m of expenditure for reinvestment in the Trust's estate has been allocated, and this includes £0.8m relating to three strategic capital schemes. This level of required investment has been identified from a commissioned estate's infrastructure survey.

New Developments
The Trust continues to focus 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 Electronic Patient Record (EPR) system to enable radical transformation of end-to-end clinical pathways and services to be delivered through the Clinical Pathways Transformation Programme.

The business case has been approved by NHSI and the investment will be funded through future revenue savings and from external loans.

The plan includes other capital developments and the plan assumes that the following schemes will be part or fully funded by loans from the Independent Trust Financing Facility (ITFF).

- 4th Linear Accelerator Bunker
- Reconfiguration of the ED

The plan also includes the capital development of a new Private Patients Unit, a Decked car park to increase spaces, and funding to enable rationalisation of the Trust's estate. These schemes will be funded by a combination of the Trust's forecast surplus in 2018/19 and its opening cash reserves.

The value for each of the above capital developments are included in the below table.

Contingency
A capital contingency fund of £1.5m is available in 2018/19 to fund the urgent replacement of equipment that is 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 2017/18
The plan includes £3.9m of capital expenditure deferred from the 2017/18 capital programme.

Summary of capital expenditure and sources of capital funding 2018/19

	2018/19 £m	Total capital cost of scheme £m	Sources of funding
Replacement equipment	5.2		Depreciation charge & surplus
Estates Infrastructure and Strategic schemes	4.8		Depreciation charge & surplus
New Developments:			
- EPR	8.8	52.0	External loans and revenue savings
- 4th Linear Accelerator bunker and equipment	6.2	6.2	ITFF loan, PDC Capital funding and cash reserves
- ED Department	0.5	17.2	ITFF loan
- Private Patients Unit	2.1	2.1	Opening cash and surplus
- Decked car park to increase spaces	1.5	5.0	Opening cash and surplus
- Estates rationalisation	1.0	1.0	Opening cash and surplus
- Car park to enable University MRI	0.2	0.2	Opening cash and surplus
Contingency	1.5		Depreciation charge & surplus
Schemes deferred from 2017/18	3.9		Opening cash reserves
Total	**35.7**		

Capital Disposals

It is planned that the land and buildings at Honeylands will be disposed of within 2018/19.

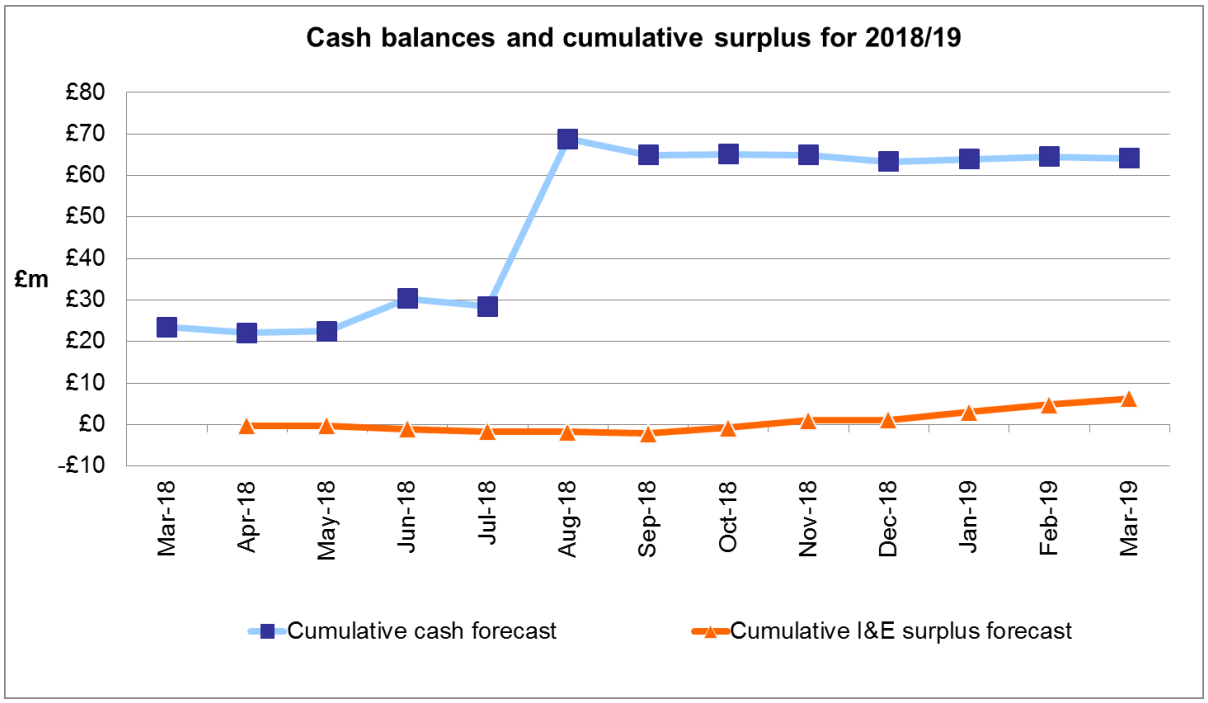
Effective use of the Trust's Estate

The Trust is an active member of the Devon STP process, which includes an Estates Group that is reviewing the extent and usage of the estate across the county. This, together with the introduction of new models of service delivery will lead to rationalisation of the Trust's estate. Where sites are identified as surplus these will be disposed of, with the Honeylands site soon to be sold. It has been identified from current data that the Trust meets the Carter targets in terms of unoccupied or underused space and percentage of non-clinical space, but we are also in the process of implementing software that will facilitate a more pro-active approach to actively manage clinical and non-clinical space with the aim of further improving the efficiency of the Trust's property portfolio.

Cash

The cash balance as at the end of March 2018 was £23.5m, and the balance is forecast to rise to £64.2m by the end of March 2019. The cash forecast assumes that £42m of the EPR loan will be drawn down in one tranche within August 2018. However, the drawdown of loan funding may change to match the expenditure as it is incurred.

The below chart provides a summary of the cash balance modelled for 2018/19:



The below table summarises the key estimated changes in cash balances during 2018/19.

	2018/19 £m
Brought forward cash	**23.5**
Surplus for the year	6.3
Depreciation expenditure – non-cash cost	12.1
Capital expenditure as reported in the above table	(35.7)
PDC capital funding drawn down – 4th Linear Accelerator	1.7
New ITFF loans drawn down to fund capital developments	3.1
New EPR loans drawn down	43.1
Movements in working capital balances (mostly due to receivables being lower as at March 2019, as the 17/18 STF Bonus will have been received)	10.7
Repayment of existing and new ITFF loans	(1.3)
Proceeds from the sale of Honeylands	0.7
Closing cash	**64.2**

The sensitivity analysis section includes details of the identified financial risks and mitigations.

Finance and Use of Resources Score (UOR)
The Trust has achieved a UOR of 1 at the end of 17/18. The impact of the financial assumption, as set out above, is that for 18/19 the UOR is rated as a 1 at the end of 2018/19 and fluctuates between either a 1 or a 2 during the year.

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

Devon STP Position Statement

The Devon STP footprint are working to a common memorandum of understanding (MoU) that binds all constituent organisations, including regulators to work together to achieve a clinically, socially and financially sustainable health and care system that will improve the health and wellbeing of the population and address inequalities. This MoU was approved by the system Program Delivery Executive Group on 16th December 2016, and forms the basis of contractual agreements between the parties.

Partners within the Devon STP have successfully delivered our agreed plans for 15/16, 16/17 and 17/18. Planning for 18/19 has been an on-going process during the year and has been subject to a "peer review" process of scrutiny supported by NHSE and NHSI. The basis of contracts between commissioners and providers within the Devon system is block contracts, and we are confident of full alignment between commissioner and provider positions.

The current plan demonstrates significant stretch in all organisational positions and CIP requirements for some organisations well above the 6% considered the maximum achievable by the STP as set out in our local planning principles. This leaves limited scope for any further negotiation within the system.

Whilst we continue to work on our plans, the position for the Trust is that we have identified £18.0m of our £23.3m savings requirement leaving a current gap to control total of £5.3m. We continue to develop recurrent schemes to reduce the gap and the Trust Board are assured that there is a non-recurrent mitigation plan in place in case of slippage. Consequently, whilst accepting there is a level of risk, the Board will agree to the control total.

Other Considerations

Mental Health

The 21st October STP submission was clear that it did not yet address some material mental health commissioning issues that are subject to clarifying the commissioning strategy across the system. This work was completed early in 2017, with agreement to invest additional funding in Mental Health as part of the system wide commitment to the Parity of Esteem principles.

Inequitable Resource Consumption

Further work has been completed, with some final elements due for review in social care and specialised commissioning. Once this work is finalised, Devon is committed to reduce health inequalities across Devon as part of a wider change programme.

Membership and elections

Governor Elections

In 2017 the Trust had a total of 12 vacancies. Voting took place in the public constituencies of East Devon, Dorset, Somerset & Rest of England and Mid, North, West Devon & Cornwall and in the Staff constituency. Voting in the public constituencies closed on 6 September 2017 with the results declared on 7 September 2017. Voting in the Staff constituency closed on 13 September 2017 with results declared on 14 September 2017. All results are below.

East Devon, Dorset & Somerset and the Rest of England

Barbara Sweeney elected, Kay Foster and Alan Murdoch re-elected, all for terms of three years. The turnout was 26.9%.

Mid, North, West Devon & Cornwall

James Bradley was re-elected for a term of one year, with Linda Hall elected for a three year term. The turnout was 24.5%.

The total turnout for the public constituencies was 25.7%.

Exeter & South Devon

Tony Ducker and Rosemary Shepherd were elected uncontested. Two vacancies remained and the Council of Governor decided at its August 2017 meeting that the vacancies would be carried to the next routine round of elections in 2018.

Staff

Michele Baxendale-Nichols was re-elected, with Susie Costelloe and Chris Gardner elected, all for terms of three years. The turnout was 14.6%.

For Governor recruitment, two prospective Governor meetings were held in the July 2017 with approximately 25 members in attendance in total. Information was also available on the Trust website and was circulated to those members who expressed an interest in the meetings but who were unable to attend.

At the time of writing, the Trust will have eight vacancies for Governors in 2018: six for public Governors and two for staff Governors.

Governor Training

As a Foundation Trust, the RD&E has a responsibility to its governors to deliver training that enables them to perform their role effectively and efficiently and to encourage members to become Governors. As in previous years, this support was delivered in a number of ways including:

- Intensive Induction Programme for new Governors including existing Governors mentoring new Governors; and a formal review led by the Chairman after 6 months to ensure that new Governors understand and are able to perform their role effectively
- Regular development days that allow Governors to explore common interests and find out more about key strategic and operational matters. The Governors

and the BOD have also agreed that there should be a greater number of formal and informal sessions between the two bodies to allow for greater mutual understanding and ensures the BOD are made aware of the views of the public as interpreted by Governors

- Three Governor working groups that enable Governors to focus on specific work areas undertaken by the Council as a whole. Through undertaking this focused work, Governors build expertise and insight into important aspects of their role. In addition, new Governors are encouraged to attend these working groups as a means of assisting their learning
- The RD&E has a Governor Representative on the NHSI Governor Policy Board and this provides a means of promoting best practice and learning for the Trust's Governors. In addition, some Governors regularly attend regional or national workshops and training on the role of the governor.
- The CoG has discussed its own priorities for meeting its training needs over the coming year including effective questioning, appraisal skills, social media/, listening techniques and this will form the basis of the training plan for the financial year.

The Trust focused its major effort to engage with members on its successful Members' Day event at which around 150 members spent the day at the Trust hearing about key developments and also taking part in surveys, focus groups and interactive activities. In 2017 the public was invited to these sessions and not just members. Governors had a stand at the event and used a survey of members and the public as a focus for interaction. The Trust has also established a successful member's website, which has replaced the magazine that was sent to members. This has enhanced our ability to use digital communications to regular update and interact with members.

Membership Strategy

The Trust is working with Governors to develop a new approach to membership and ensuring that the Governors are representing the public voice. Place-based systems of care involve organisations working together, managing common resources, to improve health and care for a geographically defined population. However, achieving this alone will not bring about the level of change needed to address the complex issues facing the NHS. By releasing the 'renewable energy of communities' through developing a health and care social movement - these actions and others like them will help shift power to patients and citizens, strengthen communities, improve health and wellbeing, and – as a by-product – help moderate rising demands on the NHS.

Unfortunately, there is no miracle formula we can readily apply to 'place' or harnessing social action but instead will be using common approaches and principles to drive forward this strategy. As we develop place and support local initiatives there is an opportunity for Governors - who represent the interests of members and the public in constituencies - to help their constituents have a voice and act as an intermediary to communities or community groups. With this principle in mind, our plan is for Governors to be instrumental in helping the Trust to:

- Identify whether 'need' vs. 'want is understood in place
- Understand the key partnerships, and partners, in place and are we involved
- Reinforce the message that the Trust is a partner, leading from behind

- Advocate and support community building from bottom up.

Governors are positioned as a group of lay people who are legitimately elected to represent members and the public rather than as representatives of the Trust. Therefore, the overarching message is the encouragement or “licence” to get more involved locally in supporting communities to lead. As a representative of the community and being well informed or connected with what is going on, Governors are ideally placed to take on the role of a local community activist.