Royal Devon and Exeter NHS
NHS Foundation Trust

Forward Plan Strategy Document for

Plan for y/e 31 March 2012 (and 2013, 2014)

This document completed by (and Monitor queries to be directed to):

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Section 1: Strategy

The Trust's current position and vision are summarised as:

The Trust's "Strategic Directions 2007-2012" were developed and agreed between the Board and Council of Governors to reflect the aspirations of our members and the general public for the development of services at the Royal Devon and Exeter Foundation Trust (RD&E). 2010/11 proved to be another successful year for the Trust; all year end key financial, performance and quality targets have been achieved with many demonstrating better performance than the stretching targets that had been set.

In line with our strategic intent the Trust has increased its delivery of care closer to home particularly in relation to community outpatient, day case surgical activities and community midwifery. Clinical partnerships with neighbouring Trusts have continued to develop and expand, enabling more patients to benefit from the expertise of RD&E specialists in their local hospital settings. The partnership with the Peninsula Medical School and the University of Exeter has also been strengthened via joint work to develop a new research, innovation and learning centre. Our programme of implementing Service Line Reporting has been successful and is beginning to support our clinical service redesign programme.

It is important for all organisations to review internal systems to ensure they continue to reflect best practice and learning from national reports such as the Francis Inquiry and the report of the Health Service Ombudsman on ten investigations into the NHS care of older people. An internal governance review has been completed and the outcome will further strengthen the Trust's internal assurance systems and structures and support our programme of ongoing improvement in the safety and quality of our services.

The Trust's strategy over the next three years is to:

In the light of the changed financial and policy environment the Board, in partnership with the Council of Governors, has reviewed the Trust's strategy and the agreed vision is as follows:

Our Vision

The Trust's long term vision is to provide "Safe, high quality, seamless services delivered with courtesy and respect".

Our Strategic Direction

In order to progress this vision during the five year timespan of this strategy, the strategic direction for the development of services will be the integration of care pathways from community through to acute care within the Trust's acute services catchment area. This will be done in partnership with other service providers of care as well as by increasing the Trust's own provision of whole pathways. In addition, the Trust will further develop its acute services across a wider area by building upon the clinical networks and partnerships that are already in place.

Our Strategic Objectives

The strategic objectives that will support this strategic direction have been grouped under three themes, **R**espond, **D**eliver & **E**nable:

1. We will Respond by:

a) Eliminating avoidable hospital infections.
b) Delivering services in a comfortable, caring environment.
c) Recognising our responsibility to the community and the environment.
d) Listening and responding to the views of our patients and community.

2. We will Deliver:

a) National and local performance targets.
b) Highest possible standards of care.
c) Cost effective, accessible services.
d) Excellent, up-to-date general and specialist services.
e) High quality teaching, research and innovation.

3. We will Enable:

a) Prompt delivery of care in the most convenient, appropriate location.
b) RD&E to be an employer of choice, with our staff being valued.
c) Staff to achieve their potential by developing and supporting them.
d) Sustained future success by sound financial management.

Our Values

Our work to progress these strategic objectives will be underpinned by the following values:

- Honesty, openness and integrity
- Fairness
- Inclusion and collaboration
- Respect and dignity.

The strategic objectives are cross-referenced throughout this Forward Plan Strategy Document, using the numbering on the previous page. In addition, we have run a number of events during 2010/11 to identify the priorities of our membership to inform the vision and strategy and these are also referenced throughout this document as follows:

1. A hospital where I am seen as soon as possible
2. A hospital that has access to the latest technologies and drugs
3. A well maintained environment that is clean, safe and modern
4. A seamless NHS service from GP through to the hospital and beyond

Key priorities for the Trust which must be achieved in the three years of the annual plan to underpin the delivery of the Trust's strategy, with milestones of delivery of each over the period of the plan:

While the priorities in the table below should not be exhaustive, they should represent the key initiatives n the trust's strategy and be consistent with the following sections, where we expect an appropriate level of detail to rest.

Key Priorities & Timescales	How this Priority underpins the strategy	Key milestones (2011-12)	Key milestones (2012-13)	Key milestones (2013-14)
Maintain financial performance by improved efficiency and cost reduction rather than activity and income growth.	This supports strategic objectives 2c, 3d.	Implement longer term efficiency improvement programmes (see CIPs table for detail). Deliver in-year CIP targets. Review the profitability and efficiency of services via Service Line Management. Develop additional project management support for the Programme Management Office if required.	Review delivery of longer term efficiency improvement programmes. Deliver in-year CIP targets. Use Service Line Information to develop new set of service-specific efficiency initiatives.	Delivery of service line efficiency initiatives. Development and delivery of further trust-wide efficiency programmes.
Further develop the safety and quality culture.	This supports strategic objectives 1a, 1b, 1d, 2b and members' priorities 2, 3.	Embed the Governance Review action plan. New committee structure in place by end Q1. Policy revision process completed by year end. Embed 2010/11 CQUIN schemes; deliver 2011/12 CQUIN schemes. Incorporate quality scorecards into Service Line Management programme within the above framework. Continue work with Quest to benchmark performance, identify UK and international "first in class" organisation, and learn	Implement findings of internal audit review of revised governance arrangements. Post-implementation review of governance review. Embed 2011/12 CQUIN schemes; deliver 2012/13 CQUIN schemes. Review Outcomes Framework and NICE Quality Standards across all service lines.	

		from examples of good practice. Further develop 'ward to Board' reporting e.g. develop more comprehensive range of 'theatre to Board' quality indicators and reports.		
Progress the joint work with the Peninsula College of Medicine and Dentistry and the University of Exeter to develop the plans for the Research, Innovation and Learning Development (RILD) at Wonford (planning phase in 2011/12).	This supports strategic objectives 2d, 2e, 3b, 3c.	Following the successful University of Exeter bid to Wellcome-Wolfson, the planning phase is well underway and will be concluded by the end of 2011/12.	Commence building works (April 2012).	Completion of building works and handover for operational commissioning (November 2013).
Consolidate the newly-acquired services (community theatres and community midwifery).	This supports strategic objectives 1d, 2c, 2d, 3a and members' priorities 1, 4.	Maximise the efficiency of these services and their contribution to the wider maternity and theatre services of the Trust. Transfer 3,000 daycases from the acute hospital to community sites by April 2012. Continue work with community midwifery and community theatres staff to ensure that trust HR and governance processes are embedded and to strengthen the teams within services across	Review opportunities for further expansion of community day case activities. Review acute and community maternity services in the light of proposed tariff changes.	Prepare for potential opportunity in 2014/15 to bid for additional community services.

		sites.		
Further develop workforce and service redesign and underpinning systems as part of Strategic Redesign Programme (SRP).	This supports strategic objectives 3b, 3c.	Trust wide Workforce Plan to be put in place for SRP and risks/redeployment plan to be put in place. Workforce constraints/opportunities integrated with strategic redesign process and built into the workforce/finance/service strategy, operational plans and SRP. Whole systems redesign for workforce ensuring co-dependencies identified and managed.	Second year of workforce plan implemented. Cost effective processes and continuing competitive skill mix in place.	Third year of workforce plan implemented and further three year strategy to be put in place aligned to Trust service strategy.
Further development of the Trust as a membership organisation.	This supports strategic objective 1d.	Implementation of new approach to membership recruitment and engagement in line with the Trust's new engagement strategy including targeted recruitment; recasting membership offer; focus on improving staff governor engagement; running three membership engagement events; and focus groups.	Continued implementation of strategy in line with the direction set out by the Experience & Engagement Committee. Milestones include three member engagement events; exploration of the concept of social value and membership; continued targeted recruitment so that membership closely mirrors the wider community.	Ongoing implementation of membership strategy using data from members as a proxy for the wider community which will then be triangulated against patient engagement work on strategic issues and on service redesign.
Implement the Carbon Reduction and Sustainability Strategy	This supports strategic objective 1c.	Implement sustainability priorities for each key sustainability area as part of the Trust's sustainable development management plan.	Implement second stage of carbon reduction energy efficiency programme via renewable energy schemes. Achieve target levels against 'good	Review implementation of energy efficiency programmes. Make progress towards 2015 target levels against 'good corporate citizenship assessment model'.

		Review sustainability and carbon reduction potential in recently-acquired community services (maternity and theatres). Implement first stages of carbon reduction energy efficiency programme for already proven technologies. Produce sustainable procurement strategy.	corporate citizenship assessment model'. Implement sustainable procurement strategy.	
Further reduction of Healthcare Associated Infections (including MRSA, Clostridium difficile and Norovirus)	This supports strategic objectives 1a, 1d, 2a, 2b and members' priority 3.	Assess impact of new diagnostic testing methodology for Clostridium difficile. Reduction in incidence of Clostridium difficile & MRSA in line with (or better than) contractual targets (taking into account increased Clostridium difficile test sensitivity). The reduction of medical outliers as part of bed utilisation work should also help to reduce Norovirus. Continue formal exception reporting process regarding audits of handwashing compliance, and rigorous implementation of other measures to prevent & contain Norovirus outbreaks.	Implement SRP workstream programme and Right Patient, Right Care, Right Place work. Improved handwashing performance across all clinical areas and all staff groups demonstrated at each formal directorate quarterly review.	
Further develop relationships with GP Commissioners	This supports strategic objectives 1d, 2a, 3d and members'	Focus on building effective relationship with new PCT Cluster Board in preparation for handover to GP Consortia. Develop further direct	Clinician to Clinician (C2C) groups functioning effectively for all QIPP workstreams and demonstrating benefit in terms of clinical improvement and	Implement formal committee/working arrangements with GP commissioning organisations.

	priority 4.	relationships with GP consortia chairs and locality director and involve them in more routine meetings (e.g. contract meetings). Take advantage of opportunities to jointly develop care pathway solutions and care closer to home in line with the Trust strategy.	reduced referrals to secondary care. Participation in the Tiverton “One Place One System” Test of Change. Plan committee/working arrangements with GP commissioning organisations and implement in shadow form.	

Section 2: External environment

The table below should reflect the significant external impacts on the Trust's plans.

Key External Impact	Risk to/impact on the strategy	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
Financial position of NHS Devon in the light of wider financial constraints.	Reduction in growth will reduce funding for the Trust.	Commitment to health-community demand management/system transformation work to reduce activity growth and therefore affordability of current activity levels; robust contract negotiations and supporting financial plan.	Reduction in commissioner affordability risk; continued contractual protection from commissioner deficit; reduced reliance on income growth via CIP delivery.	Delivery of activity and income in line with plan. Jointly agreed care redesign schemes with NHS Devon, with strong clinical engagement on both sides. Monthly contract monitoring; monthly Director of Finance risk management meetings.
Commissioning approach of NHS Devon in the light of wider NHS financial constraints.	Commissioner financial pressures may lead to commissioning minimal margins above national targets, in particular RTT, increasing the risk of target failure.	Robust contract negotiations; analysis and learning from target breaches at patient-level; improved information system support.	Create margin to assure target delivery; reduce risk of breaches without additional activity.	Maintenance of current performance levels for all key targets. Improved chronology and waiting time profiles for all specialties where benchmarks suggest profiles could be improved. Monthly contract monitoring; monthly Director of Finance risk management meetings.
Commissioning function in transition to cluster arrangements and then GP-led commissioning.	Commissioner attention diverted from demand management; loss of continuity in commissioning leading to delayed decision-making; GPs may have a more assertive	Robust contract negotiations; development of more direct relationships with GP commissioners at a service level (via clinician to clinician interface groups that exist for most key specialties)	Maintenance of health community QIPP programme; development of longer term commissioning plans via clinician to clinician groups rather than GPs attempting to secure short term	Health community QIPP plans on track, monitored via contract meetings and Health Community Transformation Board.

	approach to commissioning.	and at a corporate level.	coding/contractual gains.	
Social care in transition	Risks to social care system as a result of financial pressures and adverse impact on acute care (e.g. delayed discharges).	Joint social care, PCT and provider meetings to agree use of reablement funding to benefit whole system.	Minimise impact of social care financial pressures on acute services.	Progress monitored via local Urgent Care Group and Health Community Transformation Board.
Financial framework changes (tariff reductions, contract penalties, no payment for readmissions, emergency marginal rate)	Risks of income reductions.	Reductions already reflected in financial plans. There should be no residual risk not already covered.	Achievement of financial plans.	Routine monthly contract monitoring and financial reporting processes. Monthly Integrated Performance Report to Board of Directors.
Commissioner demand management plans and GP Commissioner measures to reduce demand.	Financial plan already assumes reduction in activity. Risk of failure of new referral management service to contain demand and therefore increase commissioner deficit, and risk of failure of care redesign plans to support restricted growth in emergency activity.	Health community meetings to review effectiveness of referral management service, and impact of care redesign plans.	To deliver the activity predictions in the financial plan; or for additional activity to be funded.	Reduction in rate of growth in demand. Monthly contract monitoring; monthly Director of Finance risk management meetings; health community Transformation Board meetings.
Readmissions and proposals for post discharge responsibility in 2012/13	No payment for elective-emergency readmissions and cap on number of emergency-emergency readmissions that	2011/12: £2.2m income loss already assumed in the financial plans for elective-emergency readmissions, so this is already covered, but if no	Minimise loss of income via technical/contractual work. Reduce readmission rates following clinical audit and	Internal plan to be developed following audit which will be monitored at the Performance Management Group (led by Chief Operating Officer)

	generate income.	action is taken, this could increase to £2.6m (if recent years' growth rates continue). Collaborative work with neighbouring providers to ensure correct coding of transfers. Scrutiny of readmissions data to avoid transfers being coded as readmissions. Audit of readmissions to identify additional data issues or clinical issues that need to be addressed. Extension of Early Supported Discharge scheme for stroke to other care pathways to improve rehabilitation and reduce readmissions. Collaborative work with PCT and Social Services on investment in reablement. There should be no residual risk not already covered in the financial plans.	implementation of follow-up actions. Improvement in post-discharge support in the community.	and impact monitored by the Board of Directors via the Integrated Performance Report. Cross-community work to report to Health Community Transformation Board.

Section 3: Trust plans

Financial plans: income

The majority of contractual income for patient services comes from NHS Devon, with five smaller associate commissioners and the Specialist Commissioning Group as an additional commissioner acting on behalf of the other six PCTs in the commissioning of specialised services.

Contract signing for 2011/12 was delayed due to NHS Devon being unable to afford the anticipated activity levels and their QIPP plans being insufficient to reduce growth by c£4m. The 2010/11 contract was formally extended until the end of May 2011 to allow time for the new contract to be signed. This extension included agreement that CQUIN schemes will be payable for the full-year if CQUIN milestones and targets are achieved. The contract was signed at the end of May 2011.

All PbR and contractual rules are being followed apart from Stroke Best Practice Tariff which is not being claimed for Q1 as the PCT has directly funded the Early Supported Discharge Scheme (which has an equivalent estimated value).

The commissioner track record of care redesign and demand management has been of the order of £2.0m per year. The plans for 2011/12 that are agreed total £4.7m with a further £1.0m currently being jointly developed. The further plans required are being developed by the PCT and the total of £9.9m is reflected in the financial plans. The income assumptions (after QIPP) that support the Trust's financial plans for 2011/12 are prudent and would allow the Trust to accommodate further reductions in demand as GPs take a more active role.

Key income risk	Amounts and timing 2011/12 2012/13 2013/14	Mitigating actions and delivery risk
Failure to achieve Best Practice Tariffs	2011/12: £500k assumed in the financial plans for Best Practice Tariffs, up to £800k may be achievable.	Information on data capture has been issued to all relevant departments. Data will be reviewed after Month 1 and improvements implemented where necessary (whether in terms of data or clinical practice).
No payment for readmissions	2011/12: £2.2m income loss assumed in the financial plans. If growth continues as in previous years, this could increase to £2.6m.	2011/12: £2.2m income loss already assumed in the financial plans for elective-emergency readmissions, so this is already covered, but if no action is taken, this could increase to £2.6m (if recent years' growth rates continue). Collaborative work with neighbouring providers to ensure correct coding of transfers. Scrutiny of readmissions data to avoid transfers being coded as readmissions. Audit of readmissions to identify additional data issues or clinical issues that need to be addressed. Extension of Early Supported Discharge scheme for stroke to other care

		pathways to improve rehabilitation and reduce readmissions. Collaborative work with PCT and Social Services on investment in reablement. There should be no residual risk not already covered in the financial plans.
Contract penalties	The new contract penalties are unlikely to create significant income risk.	RTT delivery is secure as are almost all cancer targets. The contract includes a local agreement to waive the Clostridium difficile penalty in the light of the implementation of testing with increased sensitivity. Capital works and changed ward arrangements put in place in 2010/11 should minimise the risk of Eliminating Mixed Sex Accommodation (EMSA) breaches.

Financial plans: Service developments

Service development priorities	Contribution to the strategy	Key actions and delivery risk	Key resource requirements	Measures of progress 2011/12 2012/13 2013/14
Organic / innovation:				
Bed utilisation – internal group as part of Service Redesign Programme. Objective: to make the most effective and efficient use of beds by ensuring patients receive the right care in the right place at the right time, by: avoiding inappropriate admissions, improving efficiency and effectiveness for patients that are admitted, preventing delayed discharges.	This supports strategic objectives 1b, 2b, 3a and 3d and members' priorties 1 and 4.	Key actions: To set up Trust wide preparation for surgery. To work with NHS Devon to ensure patients are fit for referral. To improve the discharge process with NHS Devon and Devon County Council. To increase day case activity within RD&E and in local community hospitals. To roll out enhanced recovery. Key risks: Increase in emergency admissions; lack of resources within primary and social care to enable patients to be cared for outside of hospital.	Focused clinical and managerial leadership.	2011/12 To ensure a significant reduction in medical outliers; increase of 3,000 (FYE) day case procedures in community hospitals; reduced length of stay. 2012/13 Use discharge work to inform commissioning of post-discharge services in the community. Continue roll-out of enhanced recovery and development of fit for surgery work with primary care.
Reablement – Early Supported Discharge (ESD)	This supports strategic objectives 2b, 2c and 3a and members' priorities 1 and 4.	Confirm arrangements for stroke ESD pilot to be continued. Apply model to other care pathways.	Funding required to support stroke ESD either via direct commissioning of this service or via stroke best practice tariff.	2011/12: Agree funding mechanism for stroke ESD with PCT. Develop plans for similar models for other conditions. 2012/13: implement additional ESD services.

Electronic prescribing and medicines administration	This supports strategic objectives 1d, 2b and 2c and members' priorities 2, 3 and 4.	Implement electronic prescribing. This will reduce the risk of medication errors and is key to the development of a sustainable electronic system for the production of discharge summaries.	£2.2m capital cost	2011/12: from Q3 rollout component by component, starting with TTO drugs.
Electronic requesting and results viewing of diagnostics	This supports strategic objectives 2b, 2c, 3a and 3d and members' priority 2.	Implement diagnostic order communications. This will increase the speed of diagnostic testing and results, thereby facilitating more rapid diagnosis and treatment and reduced length of stay. It will also facilitate demand management of diagnostics via protocols built into the system (e.g. minimum repeat testing intervals).	Included as part of the £2.2m electronic prescribing scheme (above)	Early adopters already in place March 2010 2011/12: Rollout Trust-wide from August 2011
Acquisition, etc.:				
Transferred / discontinued activity:				

Financial plans: activity and costs

Table A (Items included in the CIPs worksheet in the financial template:

Key operating efficiency programmes	Amounts and timing	Contribution to the overall strategy	Key actions and delivery risk	Key resource requirements	Milestones 2011/12 2012/13 2013/14
Bed Utilisation	£1.5 million (2011/12) £2.1 million (recurring savings)	This supports strategic objectives 1b, 1d, 2b, 2c, 3a and 3d and members' priorities 1 and 3.	Reduction in emergency admissions through the development of ambulatory emergency care pathways. Transfer of day case procedures from inpatient beds to dedicated community day case units. Reduction in length of stay through the role out of Right Patient, Right Care, Right Place, early supported discharge and enhanced recovery. Main delivery risk – higher than planned emergency admissions	For all projects: A dedicated Programme Management Office has been established. The Service Development Team has aligned its work programme to the CIP plan. The CIP plan is embedded within the Trust's 'Fit for the Future' branded Strategic Redesign Programme. The Trust has joined others through NHS Quest, and this work will also be embedded within the Strategic Redesign Programme	2011/12: Reduced length of stay. Reduced number of medical outliers. Reduced same day cancellation of elective surgery 2012/13 & 2013/14: Further reduction in admissions and length of stay leading to potential further reduction in bed stock
Theatre Productivity	£0.7 million (2011/12) £0.9 million (recurring savings)	This supports strategic objectives 2c, 3a and 3d.	Development of 'Formula 1 theatres', using Productive Operating Theatre methodology. Reduction in number of operating	See above	2011/12: Reduced cancellations of surgery due to theatre factors. Reduced number of day cases performed on RD&E site.

			theatre sessions required due to increased utilisation and transfer of day cases to dedicated community day case units. Main delivery risk – higher than planned elective or emergency surgical activity.		Reduced number of theatre sessions 2012/13 & 2013/14: Reduced theatre sessions due to transfer of day cases to outpatient settings.
Outpatient Productivity	£0.3 million (2011/12) £1.1 million (recurring savings)	This supports strategic objectives 2c, 2d, 3a and 3d and members' priority 1.	Outpatient nursing skill mix review. Reduction in number of outpatient clinics required due to reduced clinic cancellations and DNAs and increased utilisation Main delivery risk – higher than planned referrals.	See above	2011/12: Reduced clinic and patient cancellations. Reduced DNAs.
Workforce	£1.6 million (2011/12) £1.8 million (recurring savings)	This supports strategic objectives 2c, 3b and 3d.	Review of all administrative services to increase efficiency and reduce costs. On-call review to ensure standardisation of payments and reduction in requirement. Further reduction in staff sickness through robust	See above	2011/12: Reduced pay costs. Reduced overtime costs, Reduced sickness rates (to 3.0%).

			management. Main delivery risk – ability to negotiate changes in required timescales.		
Medical Staffing	£1.0 million (2011/12) £2.2 million (recurring savings)	This supports strategic objectives 2b, 2c and 3d and members' priority 3.	Implementation of Hospital at Night, leading to reduced spend on agency locum doctors. Reduction in additional payments. Reduction in medical sessions required as a result of increased clinic and theatre productivity. Main delivery risk – increased complexity of patients' care requirements, leading to need for more highly skilled medical workforce.	See above	2011/12: Reduced cardiac arrest and early warning score calls. Reduced spend on agency locums. Reduced waiting list spend. 2012/13 & 2013/14: Increased usage of nurse practitioners and allied health professionals.
Nursing and Allied Health Professionals	£1.1 million (2011/12) £1.6 million (recurring savings)	This supports strategic objectives 1a, 2b, 2c, 3a, 3c and 3d and members' priority 3.	Implementation of High Impact Actions. Ward team and shift standardisation. Review of housekeeping service and implementation of Modern Housekeeper role. Main delivery risk – increased complexity of	See above	2011/12: Increase in number of wards with nurse-led discharge. Increase in number of wards which have implemented standardised ward teams and housekeeping

			patients' care requirements, leading to need for more highly skilled nursing and AHP workforce.		roles.
Procurement	£1.1 million (2011/12) £1.9 million (recurring savings)	This supports strategic objectives 1b, 1d, 2b, 2c, 3a and 3d and members' priorities 1 and 3.	Systematic review of high volume, high cost non-pay items. Increase in number of items procured through a contract. Main delivery risk – inflation.	See above	2011/12: Increase in non-pay expenditure through contracts. Increase in items coded on electronic ordering system. 2012/13 & 2013/14: Reduced use of consumables.
Diagnostics	£0.6 million (2011/12) £1.2 million (recurring savings)	This supports strategic objectives 2b, 2c, 3a and 3d and members' priorities 1, 2 and 3.	Reduction in demand for tests. Repatriation of send away tests. Increased laboratory and imaging efficiency leading to reduced cost per test. Main delivery risk – higher than planned demand.	See above. External consultancy commissioned to assist implementation of plans.	2011/12: Reduction in number of tests requested. Reduction in number and cost of send away tests. 12/13 & 13/14 – Increased provision/use of shared diagnostic services.
Pharmacy	£0.5 million (2011/12) £0.7 million (recurring savings)	This supports strategic objectives 2b, 2c and 3d and members' priority 2.	Increased use of generic drugs. Procurement savings. Reduction in use of FP10s. Reduction in medicines wastage.	See above External consultancy commissioned to assist development of plans.	2011/12: Reduction in FP10 spend. Reduction in medicines waste.

			Consideration of outsourcing outpatient pharmacy dispensing service. Main delivery risk – increases in drug costs.		
Back Office Productivity	£0.6 million (2011/12) £0.6 million (recurring savings)	This supports strategic objectives 2c and 3d.	Reduction in transactional costs. Cessation of non-essential functions. Exploration of increased opportunities to share services. Main delivery risk – services already on or below average in running cost; therefore may be limited opportunities for savings.	See above External consultancy commissioned to assist development of plans.	2011/12: Reduction in transaction costs. 2012/13 & 2013/14: Increased provision/use of shared services.
Other Schemes	£8.075 million (2011/12)	This supports strategic objectives 2c and 3d.	The 2011/12 £17.1m plan has been focused on each of the 10 projects. The 2011/12 £9.0m value identified in the financial plan reflects the current plans identified. The projects have a recurrent impact of £14.2m and the		

			Trust is identifying plans to deliver the remaining £2.9m. Of this, it is expected that there will be a significant element delivered in 2011/12. The non-recurring shortfall in 2011/12 (£5.2m) will be covered by holding vacancies and by non-pay expenditure controls, where this does not impact on the quality of services provided or key developments. Detailed plans for 2012/13 and 2013/14 will be developed by each of the 10 projects. This will be supported by the strengthened Programme Management Office, with a remit to scope opportunities from outside the organisation (both public and private sector).		

Table B (Other savings/efficiencies – not included in the CIPs worksheet in the financial template):

Other savings/ efficiencies	Amounts and timing	Contribution to the overall strategy	Key actions and delivery risk	Key resource requirements	Milestones 2011/12 2012/13 2013/14
QIPP Savings (see section 3) Shown in the financial templates as an income, expenditure and activity reduction	2011/12 £5.9m 2012/13 £7.0m 2013/14 £5.6m	Achievement of identified QIPP schemes will help to maintain financial performance of the RD&E by enabling planned transformation with the PCT. This supports strategic objectives 2c and 3d and members' priority 4.	Commitment to health community demand management and system transformation work to reduce activity and therefore affordability of current activity levels Areas of joint work include: limited value procedures; fitness for surgery and enhanced recovery; referral pathways; End of Life care; ambulatory care pathways; reduction in follow up outpatient appointments.	Existing clinical and management capacity	2011/12: £5.9m 2012/13: £7.0m 2013/14: £5.6m

Financial plans: Workforce

Key workforce priorities	Contribution to the overall strategy	Key actions and delivery risk	Key resource requirements	Milestones 2011/12 2012/13 2013/14
Reduce pay costs while safeguarding employment for substantive contracts and minimising risk of redundancy.	This supports strategic objectives 2c, 3b and 3d.	Deliver pay savings equivalent to c250 (wte) per annum (maybe cost rather than post reduction e.g. sickness reduction). Continue benchmarking to ensure size and shape of workforce remains in the lower quartile cost of NHS organisations. Vacancy Scrutiny Panel continues to risk assess vacancy non-replacement on safety/quality measures. MARS review Agree phase-out of Recruitment & Retention premia for all current staff. Review Agenda for Change terms and conditions, informed by national guidance and local agreements. Key Risk: removal of default retirement age may affect turnover.	External benchmarking; • NHS Benchmark • NHS Quest • PWC/CIPFA Panel established linked to patient safety agenda to avoid unanticipated impact on safety/quality. HR and Finance support in place for future MARS scheme. Consultation with trade unions and affected staff.	2011/12: Agree 3 year Workforce plan as part of Strategic Redesign Programme including risk management strategy. Pay cost reduction whilst patient safety maintained. Scenario and risk mitigation plan in place in the case of reduced turnover. Return on Investment and business case for MARS finalised. Wider remuneration strategy agreed. 2012/13: review all workforce efficiency initiatives and progress outstanding actions.
Managing flexible staffing costs as a major source of efficiency.	This supports strategic objectives 2c, 3b and 3d.	Monitor overtime/on-call and agency staff utilisation putting in place best practice. Expanding the range of current Fixed term Contracts (FTCs) to enable flexing of	Covered within Strategic Redesign Programme.	2011/12: New agency and bank worker processes implemented Trust wide by March 2012. 2012/13: Review new processes and

		workforce in response to service change. Ensure efficient processes for deployment, and development of bank staff. Progress medical staffing changes and alternative roles as part of Strategic Redesign Programme to reduce locum costs. Overtime/Agency and bank staff utilisation for all staff groups in place with appropriate procurement processes.		refine if required. Implement medical staff changes.
Support and lead effective change management	This supports strategic objectives 3c and 3d.	Continue leadership programme for clinical & non-clinical leaders, equipping managers to deliver on key Trust objectives, including Strategic Redesign, Service Line Management and organisational change. Respond to staffing implications of service change, redeployment, acquisitions, and transfers. Potential risks to operational and financial effectiveness programmes if key personnel are not retained.	Capacity already in place to deliver programme. Joint modelling (Finance/HR) of workforce to develop a consolidated plan.	2011/12: Leadership Development Plan implemented at senior clinical and management levels. Consolidated workforce plan detailing changes in service provision and likely CIP implications to be produced for each year by March the preceding year. 2012/13: Continue to review financial position and implications of national policy. Implement workforce plan to address service and financial change.
Staff engagement and satisfaction	This supports strategic objectives 2b, 3b and 3c.	Continue to develop the Trust Staff Engagement Strategy recognising the relationship between Quality Staff and Quality Care.	Multi-disciplinary matrix team, HR, communications and strategic re-design Expand staff representatives and	2011/12: Implement staff engagement recommendations. Staff suggestions implemented through Strategic Redesign

		Culture and values programme. Embed best practice models of engagement through the Trust. Staff survey action plans in all areas. Risk to implementation if finance/service pressures restrict time for staff release.	engagement champions.	Programme. 2012/13 Achieve improvements against NHS Quest benchmark for Patient Experience & Staff Engagement and Satisfaction.
Reinforce the Trust's commitment to demonstrating equality and promoting diversity and inclusion.	This supports strategic objectives 3b and 3c.	Review employment practices, terms & conditions and ensure a sustainable reward strategy. Create a 'Great Place To Work', a productive working environment for all which supports NHS Constitution Staff Pledges. Implement the Equality Delivery System and align with patient equality and experience.	HR staff released to support initiatives.	2011/12: Achieve measurable improvement in Equality & Diversity indicators.
Effective training and development	This supports strategic objectives 3b and 3c.	Learning & development delivery fully integrated with service and workforce change. Rebalancing skill mix by developing Assistant Practitioner roles. Implement Essential Learning Policy in line with Trust governance requirements. Ensure Trust priorities are embedded in all staff objectives.	Cost effective e-platform required for essential training as part of IT strategy.	2011/12: Advanced and Assistant Practitioners developed. PDR performance and process review for all Directorates. Increase percentage of staff receiving essential training (100% not achievable due to staff on maternity leave and other long term absences). 2012/13 Review implementation and improve coverage of e-learning.

Effective recruitment, good induction and supportive management.	This supports strategic objectives 3b.	Reinforce reputation of RD&E as local NHS employer of choice by marketing of generic and unique staff benefits. Develop apprenticeships. Review governance processes around pre-employment checks and probationary period for new recruits.	Action plan for recruitment team, including staff passport and staff benefits scheme. Change management and managerial skills development programme.	2011/12: Management training implemented for key policies and procedures in selection and recruitment. 2012/13: Provide a strategic sustainable employment offer matched by best practice in employment, engagement and recognition.
Promoting staff health and managing sickness absence	This supports strategic objectives 3b and 3d.	Additional focus on health at work including stress management to achieve reduced absence and therefore productivity benefits. To support this the Health & Wellbeing action plan will be further developed as an integral part of wider workforce strategy. Continue programme to manage violence and aggression in the workplace (e.g. conflict resolution training). Continue programmes to promote early intervention, prevention and self management of personal well-being at work. Support arrangements for corrective action at individual and departmental levels following incidents and risk assessment.	Occupational Health support to focus further on intervention and prevention.	2011/12: Continue reductions in sickness to achieve 3% by March 2012.
Further develop HR functions and systems to support workforce priorities.	This supports strategic objectives 2c and 3d.	Restructure HR function to maximise effectiveness. Further develop routine intelligence, diagnostic trend analysis and	Additional staff training on ESR and Rosterpro. Additional IT support.	2011/12: Rosterpro to be extended from covering all nursing staff to be rolled out to Facilities Directorate by March 2012.

		workforce dashboards. Integrate Payroll/HR systems. Key risk is lack of systems integration at the ESR/Finance interface. Further enhance modern flexible approaches to recruitment, employment and deployment through use of ESR, Rosterpro, identifying efficiencies and CIP opportunities.		2012/13: Updated ESR to include all mandatory/essential training by March 2013.
Develop a strengthened medical appraisal policy in line with forthcoming introduction of medical revalidation	Strengthened medical appraisal to ensure fitness of medical workforce to practice at standards required by the GMC from 2012/13. This supports strategic objectives 2b.	Complete Organisational Readiness Self-Assessment tool (ORSA). Determine information requirements of strengthened medical appraisal.	Core group of appraisers trained to new requirements. IT support to streamline data acquisition.	2011/12: Complete self assessment, appoint appraisers, Responsible Officer to complete training. 2012/13: Ensure all non-training medical staff have annual strengthened appraisal and commence revalidation. 2013/14: Embed process to ensure all medical staff have annual appraisal and are revalidated every 5 years.

Financial plans: Capital programmes (including estates strategy)

Key capital expenditure priorities	Amounts and timing (including financing schedules)	Contribution to the strategy (incl. service delivery)	Key actions and delivery risk (inc. finance risks)
Financing Capital Programme: The capital programme is being finance by the Trust's future surpluses, depreciation charge less loan repayments. Development:			
Total Development	**Total 2011/12-2013/14: £12.4m**		
Increasing radiotherapy capacity – building (equipment included in other capital expenditure – see below)	Total 2011/12-2013/14: £1.8m 2011/12: £1.8m	This supports strategic objectives 1b, 2a, 2b and 2c and members' priorities 1, 2 and 3.	Construction phase is on programme for building completion by end January 2012. Main risk to scheme delivery is the CT machine which is scheduled for delivery to site in November 2011. Clinical commissioning for live use in February 2012.
Research, Innovation and Learning Development (RILD) building	Total 2011/12-2013/14: £3.5m 2011/12: £0.4m 2012/13: £1.8m 2013/14: £1.3m	This is a key part of partnership working with the Peninsula Medical School and University of Exeter. It will offered improved facilities for clinical and non-clinical staff training and should increase attractiveness as an employer for clinicians with a keen interest in research and innovation. This supports strategic objectives 2d, 2e, 3b and 3c and members' priority 2.	Signing of a Development Agreement with the University in May 2011. Joint Trust and University SOC confirmation June 2011. Finalisation of Trust's brief June 2011. Outline Business Case (OBC) July 2011. Full Business Case (FBC) February 2012. Building works commence in April 2012. Completion and hand-over in November 2013 for operational commissioning. Key risks to delivery include planning, as gaining Planning Consent in November 2011 is critical path. The risk is being mitigated by early involvement of the planning authority. The existing Post Graduate Education Centre building is to be replaced and must therefore be vacated by December 2011 for its demolition and site clearance to enable commencement of the new RILD building in April 2012. A decant group is responsible for the relocation of services and people in the interim.

Aseptic Unit Pharmacy development	Total 2011/12-2013/14: £7.0m 2011/12: £2.2m 2012/13: £3.3m 2013/14: £1.5m	This supports strategic objectives 1b, 2b and 3d and members' priority 2.	Initial Outline Business Case (OBC) approved in November 2010. Updated OBC June 2011. Planning consent expected July 2011. Full Business Case (FBC) September 2011. Start on site October 2011. Building hand-over end September 2012 for operational commissioning ready for use in April 2013. Main risks to delivery are planning permission and compliance with MHRA licensing requirements. These risks are being mitigated by early involvement of the Planners and ongoing consultations with the MHRA.
Balance	£0.1m		
Maintenance:			
Estates Infrastructure	Total 2011/12-2013/14: £5.8m 2011/12: £3.0m 2011/12: £1.5m 2013/14: £1.3m	This supports strategic objectives 1b, 1d, 2b, 2c and 3d and members' priority 3.	Business cases and detailed costs to be developed for schemes from a risk ranked and prioritised estates infrastructure programme. Also refurbishment programme of wards and templates. Key risks to delivery are bed capacity requirements, not being able to obtain vacant possession of areas and timing the sequence of works to avoid cooling/heating seasons. These risks will be mitigated by bed capacity planning and interim decant facilities.
Other capital expenditure:			
Replacing and upgrading equipment – includes IT redesign	Total 2011/12-2013/14: £30.5m 2011/12: £9.2m 2011/12: £9.4m 2013/14: £11.9m	This supports strategic objectives 2b, 2c, 3a, 3b and 3d and members' priorities 2 and 4.	Electronic prescribing and medicines administration. Rollout component by component, starting in 2011/12 with TTO drugs. Electronic requesting and results viewing of diagnostics: Early adopters are already in place. Trust-wide roll out will be commenced in August 2011.
Other estates strategy			

Clinical plans

Quality issues and measures	Contribution to the strategy	Key actions and delivery risk	Performance in 2010/11	3 year targets / measures for 2011/12 2012/13 2013/14
Malnutrition Universal Screening Tool (MUST)	Good nutrition and hydration is of critical importance in hospital. If patients are adequately hydrated and nourished they will recover more quickly and have better outcomes. Significant improvements have already been made. Further improvements will be supported by assessment via the nationally recognised Malnutrition Universal Scoring Tool (MUST). This is also a CQUIN scheme. This supports strategic objectives 2a, 2b and 2d.	Risk assessment for malnutrition to be completed on 90% of adult inpatients within 24 hours of admission by April 2012. Risks: None identified.	Achieved plan that compliance with monitoring be increased by 5%. Compliance with initial screening increased: April 2010:28.5% March 2011: 46.3% Compliance with weekly screening increased: April 2010: 45.4% March 2011: 73.7%	2011/12: Achieve compliance of 90% with initial and weekly screening. 2012/13: Achieve 95% compliance with initial and weekly screening.
Tissue Viability	Pressure sore prevention makes a significant contribution to quality and efficiency This supports strategic objectives 2a and 2b.	Actions: 95% compliance with completion of the Waterlow score (or similar nationally recognised tool) within 24 hours of admission to a hospital ward. Tissue viability incidence is monitored monthly and reported though the quality to dashboard to the Board. Implementation of the Skin Bundle of evidence based best practice. Risks: None	Achieved monitoring target of 90% assessment. Exceeded target, and reduced incidence to 0.69 (grade 2 or above) sores developed subsequent to admission per 1000 bed days.	2011/12: Reach 95% compliance with completion of Waterlow risk assessment. Implementation of the Skin Bundle. 2012/13: Evaluation of the Skin Bundle.

		identified		
Customer experience	The Council of Governors proposed this indicator for progression through 2011/12. Attitude and behaviour of staff are critically important in determining the experience of our patients and visitors. We want to work with our patients and public to develop a strategy that fosters a partnership approach based on mutual courtesy and respect. This supports strategic objectives 1d, 2b and 3c.	Actions: Development of priorities and principles of the strategy. Production of the strategy. Stakeholder involvement in evaluation of effectiveness and usefulness, Risk: Identification of service user representative and establishing shared principles.	Not a measured priority in 2010/11.	2011/12: Stakeholder engagement in development of Customer Care Strategy and launch strategy. Pilot and evaluate. 2012/13: Trust-wide embedding of strategy 2013/14: Involve stakeholders in the evaluation and review of the effectiveness.
Easy read documentation	The availability of 'Easy Read' information identified through the recent Learning Disability and Dementia peer reviews. This is the second indicator chosen by the Council of Governors. Throughout 2010/11 we focused on improving the information provided to patients and their families on discharge. This improvement is reflected in the 2010 National In-patient Survey. The next stage is to look at how we can improve information across the patient pathway. This supports strategic objectives 1d and 2b.	Actions: Development of the document format. Identify priority documents to be produced. Production of priority documents. Stakeholder involvement in evaluation of effectiveness and usefulness, Risk: Identification of Learning Disability and Dementia user and carer representatives through the life of the project.	Not a measured priority in 2010/11	2011/12: Scope existing resources and evaluate sustainability for acute care use with stakeholders. 2012/13: Consider readers panel to help stakeholders prioritise and validate easy read information. 2013/14 Stakeholder evaluation and establish sustainable process for managing and further developing a library of easy read titles.

Dementia “this is me” passport	Improving dementia care is a key national and regional priority, supported by local feedback identifying the need for consistent, effective and compassionate care for this group of our most vulnerable adult patients. The ‘This is Me’ passport for people with dementia is a document that accompanies any patient with a confirmed diagnosis of dementia outlining their individual needs and preferences, providing staff with essential information on how best to communicate and keep patients safe. We will work in partnership with the local Mental Health Trust to progress this initiative, drawing on their expertise in this field of care. This supports strategic objectives 1d, 2a and 2b and members’ priority 4.	Action: Establish stakeholder working group. Develop pilot document and pilot. Evaluation and review. Possible wider dissemination across the healthcare community. Risks: Identification of Dementia user and carer representatives through the life of the project. Dissemination across the wider healthcare community to be decided by Commissioners in years 2/3.	Not a measured priority in 2010/11	2011/12: Scope existing resources. Through collaboration with stakeholders including Devon Partnership Trust, develop the patient held ‘This is me Passport’. Pilot the passport in an acute and community setting. 2012/13: Undertake a qualitative study to evaluate the effect on patient and staff perceptions of care and refine as necessary. Consider roll out to wider healthcare community.
Ward team redesign	The importance of the Matron role is well recognised within the nursing profession and by patients, their families and carers. Matrons have a high clinical presence and are crucial to the delivery of the RD&E response to the challenging national healthcare agenda. This supports strategic objectives 1d, 2b, 2c, 3c and 3d and members’ priority	Action: This initiative is a component part of the Trust’s Fit for the Future service redesign and CIP programme and is managed as part of this. Risk: None identified	Not a measured priority in 2010/11	2011/12: Pilot and test models. Collect baseline data and pilot evaluation data. Analyse findings and test robustly a ward team reconfiguration with new roles and responsibilities. Develop an implementation plan. Evaluate the impact of the new model on quality, safety and productivity. 2012/13: As part of a

	3.			phased implementation plan, roll out standardised ward team model across the Trust. Re-evaluate the impact of the new model on quality, safety and productivity.
Enhanced Recovery	The Enhanced Recovery programme is now well established in gynae-oncology, major urology and colorectal surgery. There has been a reduction in the length of hospital stay across these specialities and patients have fed back that they feel in control of their care. The innovative' Ticket To Go' approach to discharge of these patients involves key information needed for patients to make the appropriate arrangements for leaving hospital and the support provided afterwards in their home. This supports strategic objectives 2a, 2b, 2c and 3d and members' priorities 2 and 4.	Actions: Implement the Enhanced Recovery methodology to the orthopaedic patient pathway. Risks: None identified	Achieved plan to implement in urology, gynaecology and colorectal services.	2011/12: Roll out of the current enhanced recovery programme to include orthopaedics in particular primary joint replacements. 2012/13: Evaluation of the expanded Enhanced Recovery programme.

As part of its duty to involve and consult members, patients and the local community, the Trust held three Members' Say engagement events in May and November 2010 and March 2011. Approximately 500 members attended these events. The opinions and information gathered from the feedback at these events were used to inform a survey for Trust members and staff. Approximately 850 survey responses were received in time to contribute to the discussion of priorities; a further 800 have been received. These results will be used by the Trust to improve its ongoing and more in-depth understanding of members' views and to ensure these are properly considered in Trust decision-making.

In addition, a range of other information sources has been used to identify the key priorities for this year. These include: benchmarked national survey, local surveys/audits, including the Nursing Quality Assessment Tool, patient comment cards, national and regional priorities, National Ombudsman, Patient Association, CQC reports and the Trust's performance scorecard and quality dashboard. Thematic analysis of this information also contributed to the development of the Trust Member and Staff surveys.

1. Clear focus on quality with ambitious SMART goals reflecting national and local priorities. Board development days. Quality embedded in monitoring and reporting structures. Roles and accountabilities clearly defined. Processes for managing quality clearly defined. Ward to Board quality dashboard scrutinised and data challenged.

2. Incidents and response reported thorough Governance Committee and Board. Risk registers reviewed.

3. Progress clinical quality indicators monitored though the Ward to Board clinical quality dashboard. Data quality reviewed through establishment of a 3 year data assurance audit cycle.

4. In relation to the Monitor Quality Governance Framework, the Board commissioned a comprehensive review of the Trust's governance arrangements. The revised structure will be implemented in Quarters 1 and 2. The result of this implementation will be a strengthened governance framework with streamlined governance structures facilitating critical analysis of data by the Governance Committee.

Other priorities

If trusts have any other strategic priorities not covered in the sections above, they should place them here, along with the attendant strategic rationale, resources required, risks involved and delivery milestones:

Priority	Contribution to the overall strategy	Key actions and delivery risk	Key resource requirements	Milestones 2011/12 2012/13 2013/14
Add rows as necessary				

Section 4: Regulatory requirements

Key regulatory risks	Nature of risk	Actions to rectify / mitigate and responsibilities	Measures 2011/12 2012/13 2013/14
Potential Breach of Terms of Authorisation - Condition 2 (General Duty) - The Trust shall exercise its functions effectively, efficiently and economically	Failure to achieve financial plans, including income targets and CIP - Key risk to Financial Stability and Profitability. The Trust needs to focus on cost reduction and improved efficiency rather than relying partly on income growth as has been the case in the past.	Programme Management Structure and Programme Management Office in place to identify, plan and realise savings schemes that will impact across the organisation and health system. Management Structure consists of: Strategic Redesign Programme Steering Group, chaired by the Chief Executive; 10 Work streams, each with an Executive lead. Achievement of CIP schemes are monitored on a monthly basis at both Board and Operational levels, and corrective action put in place as necessary. The Trust has set aside a financial contingency to cover any potential shortfall of CIP or unplanned income or expenditure issues.	£17.1m (2011/12), £19.2m (2012/13), £17.8m (2013/14)
Potential Breach of Terms of Authorisation - Condition 2 (General Duty) - The Trust shall exercise its functions effectively, efficiently and economically	Cash Flow insufficient to meet liabilities - particularly relating to: PCT Inability to pay above contracted levels. PCT allocations from 2011/12 likely to have minimal or no growth and tariff prices likely to be deflated. Therefore, additional income to the Trust cannot be	Medium term financial plan delivering surpluses in Years 1-3. Regular monthly reporting to the Board highlighting key variances to plan, and action required to address. Agreement with PCT to actively support the further development of a managed referral system, which will aim to ensure that referrals are managed to the level afforded by the 2011/12 contract. C2C primary/secondary care	Planned Cash balances: £47.6m (2011/12), £44.9m (2012/13), £44.1m (2013/14).

	assumed. Capital Programme overspend. Under-achievement of CIP or unplanned operational overspend.	working group in place for urgent care to redesign pathways and reduce non elective admissions. Similar groups in place for most key specialties. Regular monitoring via Strategic Capital Group and reporting to Board. See items in row above.	
Potential Breach of Terms of Authorisation - Condition 2 (General Duty) - The Trust shall exercise its functions effectively, efficiently and economically	Financial penalties contained within the contract.	Although the value of risk is high to the Trust at c£10m, the likelihood of occurrence is deemed to be low. All targets subject to contractual penalties to be monitored as part of internal performance management. Contractual mechanisms to reduce risks of penalties to be fully employed. A contract clause within which it has been agreed that the commissioner will not impose the Clostridium difficile penalty if failure relates to the increased test sensitivity. Ward reconfigurations to achieve EMSA compliance in place.	
Potential breach of CQC registration requirements	Large number of registration requirements to be maintained across a number of locations.	Unconditional registration in place. Assurance and governance systems in place.	Senior matron rounds. Clinical Quality Assessment Tool satisfactory outcome measures. Ward to Board Reporting indicators confirm ongoing compliance.

Introduction of significant changes to regulatory framework, where ongoing compliance requirements for Providers are not yet fully specified.	Uncertain impact upon Providers of the ongoing requirements.	Ensuring compliance with existing regulation and registration requirements Contract discussions with NHS Devon where introduction of new targets or commitments may have financial implications.	
Potential breach of Compliance Framework Requirements: **Revised A&E Target Total time in A&E (within 4 hours)**	The revised target no longer allows the RD&E to include minor injury unit activity in measurement of the 95% performance. This, combined with 2010/11 Q4 increases in attendances, makes target achievement more challenging.	Joint work with the PCT, GPs and ambulance Trust via the Urgent Care Group to understand recently-increased levels of attendance at the Emergency Department and to agree interventions to address this. Set or formalise internal standards for response times within the hospital for main specialties interfacing with Emergency Department. Formalise and monitor response standards within the department itself.	July 2011 First draft June 2011, implement September 2011
Potential breach of Compliance Framework Requirements: **62 day cancer urgent GP referral to treatment target.**	Target not achieved in Q1 and Q4 2010/11, but achieved for the year as a whole. Complex pathways can make this target more difficult to deliver than others. Increased numbers of patients being referred for endoscopy as a result of bowel cancer screening campaign will result in additional referrals for surgery and oncology. Potential impact of the lung awareness campaign on referrals; lessons learnt from the bowel cancer screening would indicate an increase in fast-track referrals with the consequent diagnostic and treatment pathways.	Review of capacity and demand in endoscopy, surgery and oncology reviewed and additional capacity to be identified. Liaison with Peninsula Cancer Network regarding commencement of lung awareness campaign. Sub-specialty completing initial draft response plans. Weekly Cancer Waiting Times (CWT) predictors will continue to be sent out to Directorates in addition to standard weekly breach reports. Additional two week wait, outpatient and surgical capacity scheduled to replace lost activity due to bank holidays in	May 2011 June 2011 Ongoing May 2011

		April/May. Additional MDT meetings rescheduled to avoid delays in case presentation and clinical decision making. Review of clinical pathways of high volume 62 day cancer sub-specialties (including lung) with the support of the Service Development Team. The Trust is working closely with the Peninsula Cancer Network (PCN) to review patient pathways from neighbouring Trusts, to understand specialty specific issues around tertiary referrals and address any concerns.	Complete June 2011 Ongoing
Potential breach of Compliance Framework Requirements: **Clostridium difficile target.**	Clostridium difficile target has been met every year, but a new, more sensitive test was introduced in October 2010 (in line with Department of Health recommendations) which will identify greater volumes. The targets were still hit for Q3 and Q4 2010/11, but the new test makes the 2011/12 target more challenging even if the Trust delivers a further reduction in underlying numbers. The target risk relates solely to the number of cases identified by the new test when compared to a target developed in relation to the previous, less sensitive test. The new test identifies approximately 2.5 cases for every 1 case identified by the old test.	The contract includes a clause that waives contract penalties if target levels are not achieved due to increased test sensitivity. Measures are in place to keep numbers as low as possible and have proved to be effective in delivering reductions year-on year. C.diff numbers will be monitored for both the old and new test to pick up any underlying increase in cases.	Complete Ongoing Ongoing

Uncertainty about progress and implementation of the Health and Social Care Bill including the impact of cooperation and competition rules.	There is significant uncertainty around the Bill and any possible changes arising from the “Listening Exercise”.	Regular review and dialogue with partners to ensure any modifications are built into a revised plan if necessary.	Ongoing

Section 5: Leadership and governance

Key leadership and governance priorities	Key risks (and gaps)	Actions to rectify / mitigate	Milestones 2011/12 2012/13 2013/14
Board Development: Ensuring the appropriate skills/capacities are in place to drive and deliver the revised Strategic Direction for 2011-2016	Risk: The Board may not have the right information or capacity to ensure that its strategic direction can translate into clear delivery plans and the Trust misses strategic opportunities or is subject to threats.	Clear programme of Board Development sessions. Timetabled Board workshop sessions to address issues as they arise and allow sufficient time for full discussion, including scenario planning and consideration of possible implications. Routinely consider the opportunity to revise the skill composition of the Board when vacancies arise.	Board development sessions: June 2011, September 2011, November 2011, February 2012. Focused work on organisational form May-December 2011. Chairman retirement 2012 NED contract reviews 2012-2013.
Focus on maintaining a strategic overview of the changes to the external context and the implications for the Trust	Risk: The Board does not respond appropriately or in a timely way to external changes resulting in risks to its core business.	Focus on building professional skills of all the Board to ensure that they are equipped appropriately to handle a period of change.	Board improvement programme revised 2011/12.
Continued focus on Board improvement and effectiveness.	Risk: Board continues in a 'business as usual' mode and does not focus on continuous and ongoing improvement leading to deteriorating corporate governance.	Board focuses on ensuring that what it does and how it does it is fit for purpose in the changing external context. The Board will complete the Quality Governance Framework.	Revised Quality Governance Framework in place by end of Q1 2011/12.

Working in partnership with new health and social care partners requires good relationships.	Risk: changes in commissioning arrangements lead to delayed decision making and more difficult joint working as new relationships have to be built.	Focus on building effective relationship with new PCT Cluster Board in preparation for handover to GP Consortia. Develop further direct relationships with GP consortia chairs and Locality Director.	Board to Board meeting held with cluster 2011/12 Meetings held between the Board and Devon County Council Overview and Scrutiny Committee/Health and Wellbeing Board Inclusion of Lead GP in contract meetings from May 2011. Revised stakeholder engagement strategy in place by September 2011
Corporate Governance: Ensuring that the Trust's new governance structures continue to be fit for purpose and delivering enhanced levels of assurance.	Risk: Governance development plan not implemented in full and governance arrangements do not keep pace with external/internal demands. Risk: Board does not receive the right overview or granularity of information and analysis to make effective decisions.	Implementing the outcomes of the governance review in full. Further develop 'ward to Board' reporting (e.g. develop more comprehensive range of 'theatre to Board' quality indicators and reports). Service line reporting and patient level costing in place.	Q3 2011/12 internal audit post-implementation review of governance review implementation. 2011/12: incorporate quality scorecards into service line management programme.
Ensuring the Board takes into account changing roles within the governance structure as a result of the new Health & Social Care Bill	Risk: The Board does not take due account of the changes set out in the Bill particularly in regards their own liabilities, the role of the Governors, and the changes to Monitor's	The Board enhances its ongoing partnership and engagement with the Council of Governors. The Board reviews whether any changes in corporate governance	Board considers its ongoing engagement of the Council of Governors (CoG) as part of its emerging engagement strategy. A review of corporate governance arrangements

	role.	arrangements are required in response to the Act and puts these in place. This is likely to entail a stronger role for Governors in providing enhanced local governance oversight.	is established in the second half of 2011.
Leadership: The current chairman's term of office ends in April 2012	Risk: Recruitment is not well planned or managed.	A process to consider the requirements of the post, the selection and recruitment process and the induction of a new Chairman to be established.	Recruitment process agreed by end of June 2011. Recruitment process to take place between October 2011 and March 2012 with the new Chairman to take up the position in May 2012.
Quality: Safety and quality are guiding principles that influence all Trust business. As such, the Trust's Strategic Redesign Programme aligns quality and safety initiatives and indicators with the productivity and savings programme.	Risk: Quality deteriorates due to unanticipated impacts arising from savings schemes. Risk: Safety & Quality initiatives are given less priority than financial or productivity initiatives.	Balanced scorecards approach operated from Board to service lines. Governance Review and revised governance structures provide clarity of reporting and risk escalation; financial, safety, quality and business risks. Scrutiny from Board to Ward through Integrated Performance Report, including Ward to Board Framework. - Analysis of individual ward performance, identification of emergent themes requiring improvement and remedial action taken. The governance review, the emphasis on safety and quality in the strategy and the focus on safety and quality in Board reporting all help to ensure the continued	Governance Review implementation in Q1 and Q2 2011/12. Organisational evaluation of Governance Review implementation in 2012/13. Governance review – see above; Board reporting – ongoing.

		priority of safety and quality. Building on the South West Safety Programme, membership of NHS Quest provides continued motivation and focus on driving formal safety and quality initiatives.	Participation in NHS Quest programme and analysis of comparator data by Safety & Risk Committee.

In preparing the trust's "forward plan", the board of directors must have regard to the views of the board of governors. In that respect, please set out below how the board of governors have been engaged (including any material feedback received) in relation to the production and finalisation of this plan.

The Governors have been involved in preparing the Trust's forward plan by:

1. *Working with the Trust to better understand the views and opinions of its members through surveys and focus groups.*
2. *Contributing to the development of the Trust's strategy.*
3. *Commenting on the Board's declaration in regards compliance with the Code of governance at a Council of Governors (CoG) meeting in April 2011.*
4. *Membership group considering the plans for membership engagement and recruitment.*
5. *Discussing the outline annual plan at a development day in May 2011.*
6. *Considering the future development of the Trust and its strategic plans at its annual joint development day.*

Detailed Financial Summary £m		2010-11 Actuals	2011-12 Plan	2012-13 Plan	2013-14 Plan
Total operating income		350.7	340.5	329.8	324.7
Employee Expenses		(203.4)	(198.6)	(188.2)	(183.1)
Drugs expense		(27.8)	(29.1)	(28.5)	(28.0)
Supplies (clinical & non-clinical)		(44.7)	(43.2)	(41.7)	(40.2)
PFI expenses		0.0	0.0	0.0	0.0
Other Costs		(49.5)	(45.9)	(46.8)	(47.9)
Total operating expenses		**(325.4)**	**(316.8)**	**(305.3)**	**(299.2)**
EBITDA		**25.3**	**23.7**	**24.5**	**25.4**
Net Surplus / (Deficit)		**4.1**	**3.5**	**3.5**	**3.5**
EBITDA % Income	%	7.2%	7.0%	7.4%	7.8%
CIP% of Op.Exp. less PFI Exp.	%	5.2%	5.1%	5.9%	5.6%
Capital expenditure		(12.6)	(16.6)	(16.0)	(16.0)
Net cash inflow/outflow		**12.1**	**(5.9)**	**(2.7)**	**(0.9)**
Cash and cash equivalents		**53.6**	**47.6**	**44.9**	**44.1**
Liquidity days		**57.7**	**58.4**	**58.8**	**59.4**
Net current assets/(liabilities)		**38.8**	**38.0**	**36.3**	**35.7**
Planned borrowings		**21.5**	**20.2**	**18.9**	**17.7**

Cost Improvement Plans (CIPs) Totals Totals	Actual for Year ending 31-Mar-11	Plan for Year ending 31-Mar-2012 Value £m	Plan for Year ending 31-Mar-2013 Value £m	Plan for Year ending 31-Mar-2014 Value £m
Analysis of Revenue Generation and Expense CIPS				
Recurring CIPs + revenue generation schemes	15.955	11.895	19.192	17.777
Non-recurring CIPs + revenue generation schemes	2.042	5.166	0.000	(0.000)
Total (agrees to above)	**17.997**	**17.061**	**19.192**	**17.777**
1 **Short Name or Description**				
Bed Utilisation				
Total revenue generation scheme effect		**1.485**	**0.596**	**0.000**
2 **Short Name or Description**				
Theatre Productivity				
Total revenue generation scheme effect		**0.702**	**0.243**	**0.000**
3 **Short Name or Description**				
Outpatient Productivity		**0.325**	**0.749**	**0.000**
4 **Short Name or Description**				
Workforce		**1.633**	**0.166**	**0.000**
5 **Short Name or Description**				
Medical Staffing		**1.021**	**1.157**	**0.000**
6 **Short Name or Description**				
Nursing & Allied Health Professionals		**1.057**	**0.573**	**0.000**
7 **Short Name or Description**				
Procurement		**1.052**	**0.892**	**0.000**
8 **Short Name or Description**				
Diagnostics		**0.633**	**0.548**	**0.000**
9 **Short Name or Description**				
Pharmacy		**0.505**	**0.170**	**0.000**
10 **Short Name or Description**				
Back Office Productivity		**0.573**	**0.073**	**0.000**
11 **Short Name or Description**				
Other Schemes		**8.075**	**14.025**	**17.777**
12 **Short Name or Description**				
		0.000	**0.000**	**0.000**

Service Developments Totals Totals	Plan for Year ending 31-Mar-2012 Value £m	Plan for Year ending 31-Mar-2013 Value £m	Plan for Year ending 31-Mar-2014 Value £m
Revenue from Service Development	**0.000**	**0.000**	**0.000**
Expense of Service Development	**0.000**	**0.000**	**0.000**
1 **Short Name or Description**			
Total effect of this service development	**0.000**	**0.000**	**0.000**
2 **Short Name or Description**			
Total effect of this service development	**0.000**	**0.000**	**0.000**
3 **Short Name or Description**			
Total effect of this service development	**0.000**	**0.000**	**0.000**
4 **Short Name or Description**			
Total effect of this service development	**0.000**	**0.000**	**0.000**
5 **Short Name or Description**			
Total effect of this service development	**0.000**	**0.000**	**0.000**
6 **Short Name or Description**			
Total effect of this service development	**0.000**	**0.000**	**0.000**
7 **Short Name or Description**			
Total effect of this service development	**0.000**	**0.000**	**0.000**

Membership size and movements

Public constituency			2010/11	2011/12 (estimated)
	At year start (April 1)	+ve	13,385	12,916
	New members	+ve	211	500
	Members leaving	+ve	680	500
	At year end (31 March)		12,916	12,916

Staff constituency			2010/11	2011/12 (estimated)
	At year start (April 1)	+ve	5,459	5,325
	New members	+ve	414	100
	Members leaving	+ve	548	100
	At year end (31 March)		5,325	5,325

Patient constituency			2010/11	2011/12 (estimated)
	At year start (April 1)	+ve		0
	New members	+ve		
	Members leaving	+ve		
	At year end (31 March)		0	0

Analysis of membership at 31 March 2011

Public constituency		31 Mar 2011 Actual members	31 Mar 2011 Eligible membership
	Age (years):		
	0-16	23	614,308
	17-21	95	210,832
	22+	9538	2,534,743
	Unknown	3,260	
			3,359,883
	Ethnicity		
	White	9,694	3,077,863
	Mixed	37	17894
	Asian or Asian British	30	9,397
	Black or Black British	18	5271
	Other	45	11813
	Unknown	3,092	237,645
	Socio-economic groupings*:		
	ABC1	7,537	1,009,077
	C2	2,419	397,515
	D	2264	373,721
	E	696	95,012
	Unknown	0	1,484,558
	Gender:		
	Male	5,819	1,642,790
	Female	7,036	1,717,093
	Unknown	61	0

Patient Constituency		31 Mar 2011 members	Eligible membership
	Age (years):		
	0-16		
	17-21		
	22+	0	

Staff Constituency		31 Mar 2011 members	Eligible membership
	Members	5,325	5325

rectors *(at 31 May 2011 or date of submission, whichever is earlier)*

Role	Job Title	Name of Director	Tenure			Date appointed
Finance Director	*Director of Finance and Information*	*Ms Jane Doe*	*Acting*			*01/05/2010*
Chair	Chairman	Ms Angela Ballatti	Permanent			01/04/2006
Chief Executive	Chief Executive	Mrs Angela Pedder	Permanent			01/09/1996
Finance Director	Director of Finance & Business Development	Mrs Suzanne Tracey	Permanent			01/08/2008
Medical Director	Joint Medical Director	Mr Martin Cooper	Permanent			01/04/2009
Medical Director	Joint Medical Director	Dr Vaughan Lewis	Permanent			01/04/2011
Nursing Director	Director of Nursing & Patient Care	Mrs Em Wilkinson-Brice	Permanent			01/07/2010
Other Board Director	Director of Human Resources	Mrs Lynn Lane	Permanent			01/07/2006
Other Board Director	Chief Operating Officer	Miss Elaine Hobson	Permanent			01/12/2000
NED	Non Executive Director & Vice Chair	Mr Brian Aird	Permanent			01/04/2008
NED	Senior Independent Director	Mr David Wright	Permanent			01/04/2008
NED	Non Executive Director	Mr Andrew Willis	Permanent			01/02/2011
NED	Non-Executive Director	Mr David Robertson	Permanent			01/11/2010
NED	Non-Executive Director	Mr John Rackstraw	Permanent			01/08/2006
NED	Non-Executive Director	Mr James Gaisford	Permanent			01/05/2010

overnors *(at 31 May 2011 or date of submission, whichever is earlier)*

Constituency Type	Full Name of Constituency	Name of Governor	Origin			Date appointed/e
Public	*North west ourtown*	*Mr John Jones*	*Elected*			*01/05/2010*
Public	East Devon, Dorset & Somerset	Mr Christopher D'Oyly	Elected (Contested)			16/06/2008
Public	East Devon, Dorset & Somerset	Mrs Jill Gladstone	Elected (Contested)			16/06/2008
Public	East Devon, Dorset & Somerset	Mr Peter Hull	Elected (Contested)			23/06/2010
Public	East Devon, Dorset & Somerset	Mr Andrew Kyle	Elected (Contested)			23/06/2010
Public	East Devon, Dorset & Somerset	Mr Nicholas Morse	Elected (Contested)			23/06/2010
Public	East Devon, Dorset & Somerset	Mrs Linda Vijeh	Elected (Contested)			17/06/2009
Public	Exeter & South Devon	Mr Keith Broderick	Elected (Contested)			16/06/2008
Public	Exeter & South Devon	Miss Janice Cackett	Elected (Contested)			23/06/2010
Public	Exeter & South Devon	Ms Kate Caldwell	Elected (Contested)			23/06/2010
Public	Exeter & South Devon	Mr Richard May	Elected (Contested)			17/06/2009
Public	Exeter & South Devon	Mr Edward Pitman	Elected (Contested)			23/06/2010
Public	Mid, North, West Devon & Cornwall	Dr David Giles	Elected (Contested)			23/06/2010
Public	Mid, North, West Devon & Cornwall	Mr Martin Perry	Elected (Uncontested)			12/05/2009
Public	Mid, North, West Devon & Cornwall	Mrs Dianah Pritchett-Farrell	Elected (Contested)			23/06/2010
Public	Mid, North, West Devon & Cornwall	Mrs Cynthia Thornton	Elected (Contested)			16/06/2008
Staff	Allied Health Professionals	Mr Tony Cox	Elected (Uncontested)			13/05/2008
Staff	Admin, Clerical & Managers	Mrs Loveday Varian	Elected (Uncontested)			12/05/2009
Staff	Medical & Dental	Dr Mike Jeffreys	Elected (Uncontested)			12/05/2009
Staff	Nurses & Midwives	Mrs Monica Overy	Elected (Uncontested)			18/05/2010
Stakeholder	NHS Devon	Mrs Rebecca Harriott	Appointed			01/08/2010
Stakeholder	Peninsula School of Medicine & Dentistry	Professor Mark Overton	Appointed			01/02/2008
Stakeholder	Devon County Council	Cllr Stuart Barker	Appointed			01/10/2010
Stakeholder	Exeter City Council	Cllr Normal Shiel	Appointed			01/08/2008
Stakeholder	East Devon District Council	Cllr Peter Halse	Appointed	Yes		01/12/2009
Stakeholder	North Devon, Torridge & Teignbridge District Council	Cllr John Gill	Appointed	Yes		01/01/2010

ections Held *(between 1 April 2010 and 31 March 2011)*

Constituency Type	Full Name of Constituency	No. of candidates	No. of Votes cast	Turnout	No. of Eligible voters	Date of election
Public	*North west ourtown*	*4*	*1,345*	*16.3%*	*8,230*	*01/05/2010*
Public	East Devon, Dorset & Somerset	5	2,152	45.1%	4,775	23/06/2010
Public	Exeter & South Devon	6	2,165	41.5%	5,216	23/06/2010
Public	Mid, North, West Devon & Cornwall	6	1,388	41.2%	3,366	23/06/2010
Staff	Nurses & Midwives	1	0	0.0%	2,500	18/05/2010