THE COUNCIL OF GOVERNORS MEETING
Monday 2 March 2020 at 10.30

The Mews Room
Exeter Golf and Country Club
Topsham Road
Exeter
EX2 7AE

PUBLIC AGENDA
Please note the estimated time of the public meeting - 10.30-12.40

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<tr>
<th>Item</th>
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<th>Presented by</th>
<th>Item for approval, information, noting, action or debate</th>
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<td>1.</td>
<td>Apologies</td>
<td>James Brent, Chairman</td>
<td>Information</td>
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<td>2.</td>
<td>Declaration of Governor Interests</td>
<td>Melanie Holley, Head of Governance</td>
<td>Noting</td>
<td>10.31</td>
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<td>Secretary's Notes</td>
<td>Melanie Holley, Head of Governance</td>
<td>Noting</td>
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<td>Chairman's Remarks</td>
<td>James Brent, Chairman</td>
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<td>5.</td>
<td>Minutes of the last meeting held on 22 November 2019</td>
<td>James Brent, Chairman</td>
<td>Approval</td>
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6. Accountability & Engagement

6.1 Chief Executive’s Public Report
Suzanne Tracey, Chief Executive
Information
10.44

6.2 Open Question & Answer
Suzanne Tracey, Chief Executive
Discussion
10.54

6.3 Confirmation of the local quality indicator for the Quality Report 2019/20
Melanie Holley, Head of Governance
Approval
11.04

7. CoG Business

7.1 CoG Coordinating Committee and Working Groups progress reports
Peta Foxall, Lead Governor Tony Ducker, CoG Effectiveness Faye Doris, Patient Safety & Quality Kay Foster, Public & Member Engagement
Information
11.09
### 7.2 Approval of the Non-Executive Director Remuneration Committee Terms of Reference
Peta Foxall, Lead Governor

| Approval | 11.19 5 |

### 8. Performance & Assurance

| 8.1 Q3 2019/20 Performance Report | Dave Thomas, Interim Chief nurse | Information | 11.24 45 |
| 8.2 Non-Executive Director Update | Peter Dillon, Vice Chair and Chair of Audit Committee Alastair Matthews, Non-Executive Director | Information | 12.09 30 |

### 9. Stakeholder Engagement

### 10. Information
The next meeting of the Council of Governors will be held on 1 June 2020, at the Exeter Golf and Country Club, Topsham Road, Exeter.

Meeting closes at 12.40
MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS OF THE ROYAL DEVON & EXETER NHS FOUNDATION TRUST

Held on 22 November 2019 in Seminar Rooms 3&4, RILD, Royal Devon & Exeter NHS Foundation Trust Barrack Road, Exeter EX2 5DW

Present
James Brent, Chairman

Public Governors
East Devon, Dorset, Somerset & Rest of England:
Kay Foster
Peta Foxall
Bob Maskell
Rachel Noar
Barbara Sweeney
Tony Wilkinson

Exeter & South Devon:
Faye Doris
Tony Ducker
Olwen Goodall
Desmond Kumar
John Murphy

Mid, N. W. Devon & Cornwall:
James Bradley
Peter Flatters
Monika Herpoldt-Bright
Marcus Pipe

Staff Governors:
Rob Biggar
Hazel Hedicker
Anum Shuja

Appointed Governors:
Angela Shore (University of Exeter)

Apologies
Andrew Beresford (East Devon, Dorset, Somerset & RoE)
Catherine Geddes (Staff)
Dominic Hazell (Staff)
Christopher Green (Exeter & South Devon)
Michael James (Mid, N. W. Devon & Cornwall)
Phil Twiss (Devon County Council)

In Attendance:
Chris Bones, Non-Executive Director
Bernadette Coates, Governance Coordinator (minute taker)
Jeff Chinnock, Stakeholder Engagement & Inclusion Director
Melanie Holley, Head of Governance
Paul Honey, Head of Facilities Management (for item 53.19 only)
Janice Kay, Senior Independent Director
Hisham Khalil, Non-Executive Director
Chris Tidman, Chief Financial Officer/Deputy Chief Executive

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<td>APOLOGIES AND QUORUM CHECK</td>
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Apologies were noted as above. The meeting was confirmed as quorate. Mr Brent welcomed everyone to the meeting, including the newly elected Governors and newly appointed Non-Executive Directors. Mr Brent said Mr Tidman was attending on behalf of Mrs Tracey, Chief Executive, who had sent her apologies.

Mr Brent commented on the recent death of public Governor, Rosemary...
Shepherd, recording condolences and best wishes to her husband and family. This was echoed by the Council.

2. **48.19 ANNUAL REVIEW OF THE REGISTER OF GOVERNOR INTERESTS**

Mrs Holley presented the updated Register of Governor interests following its annual review. Miss Doris clarified that she was a member of University of Exeter Nursing Academy PPI Advisory Group. Mrs Shuja declared she was a member of Unison, with Mrs Hedicker stating she was no longer a member of Unison. Mrs Noar said she was a member of Living Options Devon.

She reminded Governors to flag any interests should they arise during the course of the meeting.

The Council of Governors noted the updated Register of Governor Interests.

3. **49.19 SECRETARY’S NOTES**

Mrs Holley said the 2020 Council of Governors meeting dates had been circulated to all Governors. The next meeting was a Development Day on Monday 20 January 2020, with the next formal CoG meeting on Monday 2 March 2020. The venues for both is currently Exeter Golf and Country Club.

Mrs Holley said that Professor Shore had recently been re-appointed by the University of Exeter as its Governor for a further three-year term.

The Council of Governors noted the Secretary’s Notes.

4. **50.19 CHAIRMAN’S REMARKS**

Mr Brent said there was currently a period of purdah ahead of the General Election in December 2019. This meant the Trust could carry on its business but the meeting was not able to raise any issues considered politically sensitive.

Mr Brent referred to behaviours of the Council. He said it was a privilege for him to chair the Council of Governors and that everyone gave a significant amount of time and effort for the benefit of the community. He said the work of the Council was about that collective effort and not about individuals and that it was important the Council maintained its focus on the Trust’s patients and communities.

The Council of Governors noted the Chairman’s remarks.

5. **51.19 MINUTES OF LAST MEETING, MATTERS ARISING & ACTION SUMMARY CHECK**

The minutes of the meeting held on 23 August 2019 were agreed as an accurate record.

**Action Summary Check**

The action was completed as per the action summary.

**Matters Arising**
It was agreed to recirculate the election statements from the 2019 election.

**ACTION:** The election statements from the 2019 election to be circulated to all Governors.

### ACCOUNTABILITY AND ENGAGEMENT

#### 6.1 52.19 CHIEF EXECUTIVE’S PUBLIC REPORT

Mr Tidman said the Trust was currently challenged operationally, adding that the MY CARE Programme was moving at pace and was now in the testing phase. The Trust was also making good progress in nurse recruitment and would be in a better nurse staffing position going into the winter period. He said the recruitment team were to be congratulated on the improvements made.

Mr Tidman said that from 350 nominations, the RD&E’s Neonatal Unit was selected for the National Bliss Excellence Award due to its outstanding commitment to its work for delivering excellent family-centred care.

Mr Tidman said that earlier in the month, the Trust’s Cancer Lead Nurse, Tina Grose, had been awarded NHS England/NHS Improvement (NHSE/I) Chief Nursing Officer Silver Award. Mr Tidman gave his congratulations to Mrs Grose, saying the Award was designed to recognise the lifetime achievements for nurses and midwives.

Mr Tidman said that at the last public Board meeting, the Board made a pledge to reduce the amount of single-use plastics at the Trust. By April 2020, the Trust would no longer purchase single-use plastic stirrers and straws, except where a person had a specific need. By April 2021, the Trust would no longer purchase single-use plastic cutlery, plates or single use plastic/polystyrene cups. Mr Tidman said he chaired the Trust’s Sustainability Group and this would work to continue to reduce the amount of single-use plastic and plastic packaging.

Mr Tidman said work was well under way to construct the new Mireille Gillings Neuroimaging Centre on the Wonford site. This was a cutting-edge new imaging centre expected to rapidly accelerate dementia research and improve healthcare. It would form part of the University of Exeter Medical School’s clinical research infrastructure and would transform research and diagnosis of dementia and other neurological diseases. It was funded by part of a £10million donation from the Dennis and Mireille Gillings Foundation, the largest ever single donation to the University of Exeter. Mr Tidman said the Centre was due to open in Spring 2020.

#### 6.2 53.19 QUESTION ON NOTICE: CAR PARKING & IMPACT ON PATIENTS

Mr Tidman said that concerns had been raised by Governors regarding car parking and patient access to appointments. This had arisen following updates to the Patient Experience Committee on 7 November 2019 regarding the reported impact of the current parking situation on some patients attending the hospital. Mr Tidman said two questions on notice had been put forward by Governors; 1) what were the current arrangements for patients in need and 2) are there any areas where patients in need were not given guaranteed priority parking.
Mr Tidman outlined the current parking situation at the Wonford site, where demand was exceeding supply. There are 561 pay and display parking spaces and 502 on-site staff parking spaces. Mr Tidman said there was an immediate need to provide more parking but long-term sustainable alternatives were also required and the Board had agreed a strategy to invest in these. The Trust had temporarily lost some parking spaces on the Wonford site due to essential building work to improve clinical care. Mr Tidman said it had not been operationally possible to delay these schemes. There had been an impact of having contractors parking on site and a contractors’ parking compound was now established and being enforced.

Mr Tidman said the Trust had temporarily lost some parking spaces on the Wonford site due to essential building work to improve clinical care. Mr Tidman said it had not been operationally possible to delay these schemes. There had been an impact of having contractors parking on site and a contractors’ parking compound was now established and being enforced.

Mr Tidman provided an overview of the steps taken by the Board. 1750 bus passes providing a 33% subsidy on Stagecoach buses had been issued to staff. The Digby Park and Ride was now exclusively for staff use, with its opening hours extended. Mr Tidman said the 200 staff waiting list for the Digby site had now been eliminated. The Sowton and Digby Park and Ride routes had been connected and the Trust had seen an increase in the use of the Sowton route. The Trust had been reviewing what other trusts were doing and it was clear that offering alternatives to driving to the hospital needed to be the default position and so the Trust needed to push Park and Ride as the first choice for visitors.

Mr Tidman said the Trust had entered into discussions with Exeter City Council over a further Park and Ride facility and increased frequency of buses for staff. The Board had agreed to explore the feasibility of a barrier pay on exit system to protect patient/visitor spaces and to remove the stress of having to pay up front.

In terms of next steps, Mr Tidman said the construction compound at Oncology was due to be removed by 13 December 2019 with the work on Mireille Gillings Neuroimaging Centre due to be completed by the end of January 2020. Feedback from patients on the Sowton Park and Ride was that it was reliable and less stressful than parking on site and so the Trust would promote Sowton as the default, not secondary, option. The Trust was looking at how it could utilise the 50-60 spare spaces at Digby and at the Exeter Mobility Centre on Wonford Road. Mr Tidman said that 10% of all outpatient visits were for Ophthalmology and the Trust was actively working on setting up an Ophthalmology service in Axminster for East Devon so that patients did not have to travel into Exeter. Mr Tidman said the Board was regularly reviewing progress with travel and parking improvements.

Mr Tidman addressed the specific questions put by the Council. In regards to the current arrangements for patients in need, Mr Tidman said there were dedicated parking spaces for Oncology, Haematology, Renal and Diabetes. Some patients were also exempt from parking charges when receiving treatment including cancer, renal dialysis, patients admitted directly from the Emergency Department and neonatal unit parents. The second question asked about any areas where patients in need are not given guaranteed priority parking. Mr Tidman said the Trust had 56 spaces for disabled/blue badge holders at Wonford and 8 at Heavitree; however this did not guarantee parking.

Mr Tidman said there was an action from the August 2019 meeting to update the Council on the trial of the Co-Car scheme at Newcourt House. The trial resulted in a very low uptake and staff had fed back that the App was not useful for parking.
easy to use. To widen the potential for use, the Co-Wheels car was relocated to Wonford and offered to a range of users of private vehicles for business use. Again the uptake was lower than anticipated, in the main due to the format of the current policy and process for users. Mr Honey added that the Trust was working with Devon County Council and the University of Exeter on a joint tender for a car hire company to see if the offer can be improved.

Mr Tidman invited questions.

Mrs Sweeney said her concern was the anxiety caused by a lack of parking; however she appreciated that car parking was a societal issue and there needed to be a reduction of cars on the road. She said she would welcome a more proactive approach to communication regarding parking and the encouragement to use Park and Ride. Mr Tidman said the Trust recognised that proactive communications were important.

Dr Foxall said she would like to reinforce Mrs Sweeney’s view regarding communications and said this was an action the Trust could take immediately through its website and social media channels. She said if patients were made aware of building and mobile units on site in order to reduce diagnostic waits they would understand why there was a temporary reduction in parking spaces. Dr Foxall added that staff had informed her that it was often the people accompanying patients who were the most anxious or frustrated by parking. Mrs Hedicker referred to MY CARE and how new patient appointment letters were currently being developed. She said she would check to see if they included messaging regarding car parking [Post-meeting note: Mrs Hedicker confirmed in the Confidential meeting that information about Park & Ride was being built into patient letters from June 2020 when MY CARE goes live].

Dr Ducker commented on the Trust establishing an Ophthalmology service in Axminster and asked if other services were also being considered for such a move. Mr Tidman said the Axminster Ophthalmology pilot service would be evaluated to see if it could be applied to other services.

Miss Foster said she was disappointed that it had taken so long for the issue to be taken seriously but said it was important to focus on the future and to make it easier for patients and staff. She said she was concerned that the Trust did not lose staff due to parking issues.

Mrs Noar asked if the 56 disabled parking spaces at Wonford were identified on the parking map. Mr Tidman said this would be reviewed to see if the site maps can be improved.

**ACTION:** Site maps to be reviewed in relation to identification of location disabled parking spaces.

Miss Doris asked about the possibility for a Park and Ride facility on the Crediton side of the city. Mr Honey replied that land was very limited but the Trust was working with the University of Exeter and Exeter City Council to review options.

Professor Shore asked for details of the methodology for identifying which members of staff are able to park on site. She said being able to park at work was crucial for those staff with family and caring responsibilities. Mr Tidman replied that there were two tiers for staff parking permits; the first
being priority parking, for senior clinicians for example, and the second, a points-based system for non-priority staff. This took into account personal circumstances for example. Mr Honey added that staff whose children attend the on-site Nursery were issued with a permit and he assured the meeting that personal issues are taken into account.

Mr Bradley asked if the Trust provided sufficient cycle parking spaces for staff. He added that it was his view that the Trust should consider subsidising 100% of staff cycle costs out of the income raised from car parking. Mr Tidman replied that the Trust was considering all options and incentives regarding cycling. Some of the car parking income had been invested in a shuttle bus for staff from Newcourt House to Wonford and Heavitree, in the Park and Ride services and in cycle shelters. The Trust was also talking to Devon County Council regarding the provision of cycle paths. Mr Brent added that the Devon healthcare system was running at a significant deficit and it was not possible to move all of the £1.7m income per annum from car parking into alternative solutions as the Trust also had direct patient care that needed to be funded. Mr Bradley acknowledged the responses but encouraged the Trust to provide the CoG with more details, in its confidential meetings if necessary, in order to assure the CoG and reduce the need for it to ask so many questions. This was noted.

Miss Foster said that the signage for Digby Park and Ride did not inform people that it was for staff parking only and so patients and visitors were attempting to park there and were being turned away. Mr Honey said that Devon Highways were responsible for the signs and the large majority had now been changed with the remaining signs due to be completed soon.

There being no further questions, the Council noted the response to the question on notice.

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<th>OPEN QUESTION AND ANSWER</th>
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<td>There were no further questions raised.</td>
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<th>6.4</th>
<th>55.19</th>
<th>NON-EXECUTIVE DIRECTOR UPDATE</th>
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<td>Mr Brent said that Ms Ashman was unfortunately not able to attend the meeting due to illness. He said the presentation she had prepared on the Patient Experience Committee (PEC), which she chaired, would be circulated.</td>
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**ACTION:** The Patient Experience Committee slide presentation to be circulated to the Council of Governors.

Mr Brent said Ms Ashman had also planned to show a Patient Story which had been presented to the October 2019 public Board meeting and said this would still be presented. Mrs Sweeney provided some background to the development of patient stories, which had been done through a working group also involving the University of Exeter. She said the first film, with the story presented by a patient call Bill, presented a collective view of the group.
Following the showing of the film, Mr Brent invited comments. Dr Foxall gave her thanks to Bill and the working group for the film, commenting on how it showed compassion between patients. Mrs Goodall asked if the film was being used as part of staff training and it was confirmed that it was. Mr Brent gave his thanks to everyone who was working on Patient Stories. He said it worked well at Northern Devon Healthcare Trust and it was making good progress at the RD&E.

The Council of Governors noted the update.

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<th>PERFORMANCE &amp; ASSURANCE</th>
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<td><strong>7.1  56.19 Q2 2019/20 PERFORMANCE REPORT</strong></td>
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Mr Tidman presented the report. He said the Trust’s performance during the quarter was pressured and similar to the nationwide picture. He highlighted the Operational Pressure Escalation Level (OPEL) for the quarter. Mr Tidman said there had been a dip in performance of the A&E four hour target. This was as a result of operational pressures and also significant staff shortages, particularly middle grade doctors. Mr Tidman said nationally waiting list numbers were increasing; however the Trust was making progress and the number of patients waiting was starting to fall. Diagnostic performance was disappointing but again, there were early signs of sustained improvement.

Mr Tidman said the focus of the Board at its October 2019 meeting was the Trust’s Winter Plan and as part of that the Trust had invested in additional in and out of hospital capacity. The Board was closely monitoring the quality indicators, which were positive. The staffing position had improved; although there remained an on-going issue with sickness absence.

Mr Tidman said the operational issues also linked to the financial position, adding that acute trusts were all largely in deficit, with the NHS continuing to see demand outstripping investment. Mr Tidman said the agreed 2019/20 plan for the Devon system was a £70m deficit. The RD&E Board was concerned about this at the time it was agreed and the most recent forecast was for a £146m deficit. Mr Tidman said the system was unsustainable and it required more financial investment and investment in the workforce. He added that the Trust was currently able to achieve its financial plan for the year; however this would be dependent upon receiving Global Digital Exemplars (GDE) revenue funding by year end and also to favourable accounting treatment of a property transaction. He invited questions from the Council.

Dr Foxall said it was useful to have the list of acronyms at the front of the report. She said the Governors had themed their questions and they were all focussed on best intent and how the Board could assure the CoG.

Miss Foster noted the pressure in the system, including for partners such as Devon Doctors. She asked if it too had staff shortages. Mr Tidman said Devon Doctors had experienced staff shortages which resulted in it having to occasionally stand down its streaming service and this added pressure to A&E.

Mr Murphy commented on the positive news with regards to increased nurse recruitment, noting that vacancies were down to 64 in total. He noted the
number of staff who had left the Trust and asked what was being done to try and reduce the turnover, which was at 11%. Mr Brent said this was an area of concern for the Board and it was aware of the impact operational pressures was having on staff; for example, in the Staff Survey, staff were very supportive in terms of recommending the hospital to family and friends but also say they are not satisfied with the quality of care they are providing. Mr Tidman outlined some of the health and wellbeing initiatives being put in place for staff. This included consideration about how physical space could be made available for staff to take breaks. Mr Kumar asked how Brexit might affect staffing and Mr Brent replied, that due to purdah, he would answer the question in the confidential meeting.

Mrs Sweeney referred to the data on sickness absence and said that if she was a NED, she would want to challenge the large percentage of sickness absences where the reason for the absence was unknown. Mr Brent confirmed that this had been discussed as part of public Board.

Dr Ducker commented that activity was less than planned but that the Trust was often at OPEL 3. Mr Tidman said the Trust had triangulated this information and emergency work was less than planned as the Trust was undertaking more assessments at the front door, and, for example, providing ambulatory care. These interventions were currently not reflected in the metrics and this was under review. Mr Tidman said those patients who were admitted were often more complex, more frail with increased acuity and as a result were staying longer. Mr Brent said that the increase in the number of patients on the 'Green to Go' list was a concern to the Board but it was not all in the control of the Trust, for example the availability of beds in residential homes. Dr Ducker said it was unusual for the Trust to have issues with middle grade staffing in A&E. Mr Tidman said that typically the Trust had no issues with attracting Consultants and nurses to A&E; however middle grade doctors were in high demand, with availability decreasing, and as a result, the Trust was putting together different packages, such as special interest training, in order to attract staff.

Mr Bradley said that the CoG had previously been told that deep dives into sickness absence had taken place and that learning would be taken and yet the position was getting worse. He commented on the Trust recruiting staff from overseas and said it was his view that is was morally wrong to remove nurses from emerging nations. He added that beds were being lost in the community, for example in Okehampton, due to a lack of staff. Mr Brent said that, due to purdah, he would talk more about the Trust’s workforce strategy in the Confidential meeting; however the focus on staff wellbeing had encouraged staff to speak up when under pressure. Mr Bradley asked how many staff had the time and opportunity to take the health and wellbeing initiatives. Mr Brent said he was not sure of numbers but the feedback from staff was positive and the initiatives were well received. Mr Bradley replied it would be useful to know numbers as it would help to measure improvement. Mr Brent said it was complex as, as more staff are encouraged to speak up about stresses and pressures, the number of absences may increase. He added that the Board was due to receive a further update at its meeting on 27 November 2019.

Mrs Goodall said she had recently spoken to a Healthcare Assistant who was undertaking a nursing apprenticeship but was struggling to progress due to nurse colleagues being required to focus on overseeing Bank staff and
international nursing staff. Mr Tidman replied that the Board was mindful of not overloading staff but also that it was important for staff to have career progression. He said that internationally recruited staff do require support and this can increase pressure on substantive staff. Mr Brent added that the Trust tries to manage the integration of new staff by not having an influx into one ward or area. He said it was recognised that some staff could progress quicker than they currently are. Mrs Holley said that the Trust had invested in a Practice Education Team, whose role it was to support and induct new staff, particularly those from overseas. She added that she would pass Mrs Goodall’s comments on to Dave Thomas, Interim Chief Nurse, as he had responsibility for the Practice Education Team.

**ACTION:** Mrs Goodall’s comment regarding nursing apprentice progression to be passed to Dave Thomas, Interim Chief Nurse.

*Professor Bones left the meeting.*

Dr Foxall said the Council noted the change in *Clostridium Difficile* and Malnutrition Universal Screening Tool performance. Mr Kumar asked for the reasons behind the long waiting times for patients. Mr Tidman said the waiting list was comprised outpatient appointments, diagnostics and treatment and all these areas were under pressure, with some specialties performing better than others. In cancer, for example, an increase in demand combined with staffing issues had impacted on diagnostics. Referrals were above plan and recruitment of additional staff takes time, so there is a time lag before additional clinics can be put in place. Mr Brent added that the 52 week waiting list was unacceptable but it was important that the Trust continued to see patients according to clinical need. He said that Cardiology was incredibly challenged and this had had a significant amount of Board focus, with the Board aware of the anxiety caused to patients. Staffing issues, including a shortage of Cardiologists, plus high demand meant the department and its staff were very pressed. Mr Kumar noted the responses and asked how the Board challenged the Trust’s response to the long waiting times and the anxiety caused to patients. Mr Brent said the Board received detailed reports and presentations, including details of action plans and the progress against these. He said there was lots of complexity and there were no easy solutions, citing the example of increasing diagnostic capacity on site leading to temporary issues with car parking. Mr Pipe said there was an expectation that the next government would increase funding to the NHS. He asked how the Trust was managing these expectations and how quickly improvements would be seen. Mr Brent said candour was important and the Trust cannot set expectations it cannot meet and he did not expect to see transformation in services in the short-term. Mr Tidman added that in quarter 4 of 2019/20 the Devon Sustainability & Transformation Partnership (STP) was expected to produce its plan for 2020/21 and this would require a workforce solution. He said it was important to manage expectations within the system.

Dr Foxall said it was noted there was no data in the report regarding maternity. Given recent failings in maternity services at other Trusts, could the Council be assured that maternity data was received by the Board. Mr Tidman replied that the Board received a maternity dashboard and performance was positive. [post-meeting note: this forms part of the quarterly Home, Community and Hospital Report, which is presented to the public]
Board meeting

Professor Shore asked what the focus was for the Non-Executive Directors (NEDs). Professor Kay said a lot of the issues had been discussed at the meeting and so the Council had a similar focus to the NEDs. This including the hospital’s performance, the workforce issues and the MY CARE programme being delivered on time and the financial benefits and transformational opportunities it could provide. Professor Kay said in addition, there was a focus on the environment and sustainability as already mentioned by Mr Tidman. Professor Khalil said that as a clinician and a newly appointed NED, his focus was integrated care systems, the pace of change, ensuring the organisation takes its staff along with it and improves the patient experience improves. Professor Kay concurred with Professor Khalil and said this was a key point for the RD&E. Professor Shore said it was reassuring that the NEDs and the Governors were focussed on the same issues.

There were no further questions.

The Council of Governors noted the report.

Mr Tidman left the meeting.

CoG BUSINESS

8.1 57.19 CoG COORDINATING COMMITTEE AND WORKING GROUPS PROGRESS REPORTS

Dr Foxall said the reports would be taken as read and invited questions.

Mr Bradley noted the update from the CoG Effectiveness Working Group and the progress made with document reviews. He said the Governors’ Expenses Policy had been updated in 2018 but the previous version was still on the Trust website. It was agreed to update the website with the up to date version.

ACTION: Governor Expenses Policy to be updated on the Trust’s public website.

Professor Shore commented on the output from the 2019 CoG Effectiveness Review and asked about the plans to improve interaction between the Governors and the NEDs. Dr Ducker replied that the Joint Development Days in 2019 had used small working groups of NEDs and Governors and the agendas had protected lunch times to ensure interaction. This format would continue to be used.

There were no further comments or questions.

The Council of Governors noted the report.

8.2 58.19 ELECTIONS TO THE COUNCIL OF GOVERNORS 2019

Mrs Holley presented the report. She highlighted the recommendation to defer the by-election for the vacancy in Exeter & South Devon, caused by Mrs Shepherd’s death in post, until the routine round of elections in 2020. This was approved by the Council of Governors. She invited questions on the election report.
Mr Bradley asked what the Trust would do to try and improve voter turnout. Mrs Holley said encouraging members to vote was a challenge and there had been significant work by the Communications and Engagement Team to better engage members in the process. She said the Trust would welcome suggestions from the Council; however the Trust had a finite resource which needed to be effectively used. Mrs Sweeney said it was worth noting that, with a fall in turnout, the RD&E was not an exception to the national trend in Foundation Trust elections.

Dr Ducker asked at what point the Trust would call a by-election if there were to be more vacancies amongst public Governors during the year. Mrs Holley said there would be a discussion with the CoG Coordinating Committee but the tipping point may be five vacancies amongst the public Governors. She added that lessons learnt from the 2018/19 Governor year was that by-elections perhaps should have been called. The significant number of vacancies impacted upon the Council and resulted in a significant intake of new Governors in September 2019.

There were no further comments or questions.

The Council of Governors noted the report and approved the recommendation to defer the by-election for the vacancy in Exeter & South Devon until the routine elections in 2020.

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<th>COG COMMITTEES AND WORKING GROUP MEMBERSHIP UPDATE</th>
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<td>Mrs Holley presented the report and invited questions.</td>
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<td>Mr Bradley asked if information on the term of office of Working Group Chairs could be added to the membership information. This was agreed, with Dr Ducker adding that Chairs are elected at the second meeting in the Governor year and are in post for three years.</td>
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<td><strong>ACTION:</strong> Term of office for Working Group Chairs to be added to the membership summary.</td>
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<td>The Council of Governors noted the report.</td>
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### STAKEHOLDER ENGAGEMENT

### INFORMATION

<table>
<thead>
<tr>
<th>60.19</th>
<th>ANY OTHER BUSINESS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There being no further business, the meeting was closed.</td>
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</table>

<table>
<thead>
<tr>
<th>61.19</th>
<th>DATE OF NEXT MEETING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monday 2 March 2020, Exeter Golf &amp; Country Club, Topsham Road, Exeter</td>
</tr>
</tbody>
</table>
MEETING OF THE COUNCIL OF GOVERNORS  
22 November 2019  
ACTIONS SUMMARY

This checklist provides a summary of actions agreed at the CoG meeting, and will be updated and attached to the minutes each quarter.

<table>
<thead>
<tr>
<th>Minute No.</th>
<th>Month raised</th>
<th>Description</th>
<th>By</th>
<th>Target date</th>
<th>Remarks</th>
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<tbody>
<tr>
<td>51.19</td>
<td>November 2019</td>
<td>The election statements from the 2019 election to be circulated to all Governors.</td>
<td>MH</td>
<td>March 2020</td>
<td>These were circulated by email on 25/11/2019. Action completed.</td>
</tr>
<tr>
<td>53.19</td>
<td>November 2019</td>
<td>Site maps to be reviewed in relation to identification of disabled parking spaces.</td>
<td>CT</td>
<td>March 2020</td>
<td>The car parking maps on the Trust website identify where the disabled parking spaces are located. Action completed.</td>
</tr>
<tr>
<td>55.19</td>
<td>November 2019</td>
<td>The Patient Experience Committee slide presentation to be circulated to the Council of Governors.</td>
<td>MH</td>
<td>March 2020</td>
<td>The slide presentation was circulated by email on 25/11/2019.</td>
</tr>
<tr>
<td>56.19</td>
<td>November 2019</td>
<td>Mrs Goodall's comment regarding nursing apprentice progression to be passed to Dave Thomas, Interim Chief Nurse</td>
<td>MH</td>
<td>March 2020</td>
<td>MH shared the information with DT. Action completed.</td>
</tr>
<tr>
<td>57.19</td>
<td>November 2019</td>
<td>Governor Expenses Policy to be updated on the Trust's public website</td>
<td>MH</td>
<td>March 2020</td>
<td>This was completed in December 2019.</td>
</tr>
<tr>
<td>59.19</td>
<td>November 2019</td>
<td>Term of office for Working Group Chairs to be added to the membership summary</td>
<td>MH</td>
<td>March 2020</td>
<td>This has been added to the summary. Action completed.</td>
</tr>
</tbody>
</table>

Signed:

Name: James Brent  
Position: Chairman
COUNCIL OF GOVERNORS PAPER

Meeting date: 2 March 2020
Agenda item: 7.1, Public meeting

Title: COG COORDINATING COMMITTEE AND WORKING GROUP PROGRESS REPORT

Purpose: To update the Council of Governors on the work of, and the progress being made, by the three working groups and the CoG Coordinating Committee.

Background: The three working groups are: CoG Effectiveness, Public and Member Engagement and Patient Safety and Quality. Each Group is led by a Governor with membership of each Group open to all Governors. Each Group reports quarterly to the CoG Coordinating Committee, with the Chair of each Group a member of the CoG Coordinating Committee.

CoG Coordinating Committee (update from Peta Foxall, Lead Governor)

This report provides an update on the discussions and actions from the meeting of the CoG Coordinating Committee held on 13 January 2020.

Apologies were received from Hazel Hedicker. Melanie Holley and Jeff Chinnock gave apologies for the second part of the meeting.

The action notes of the last meeting held on 7 October 2019 were confirmed as accurate. Progress against the action tracker was noted, including confirmation that all current Governors bar one had signed the media consent form for use of their photos in any promotional material. The Governor who did not sign would not have their photo used.

The first part of the agenda was confidential. Issues discussed were in relation to the Trust’s Code of Conduct, the related Standard Operating Process and communications with external agencies.

The Committee moved on to the standard agenda items and received updates and recommendations from the working groups. The proposal to delay the CoG effectiveness review until Spring 2020 to allow more time for new Governors to provide feedback was agreed. The Committee received an update on Governors' suggestions for this year’s Quality Priorities and noted that they would be presented at the CoG Development Day on 20 January 2020. The Committee supported the ongoing work of the Public and Member Engagement Group to enhance its purpose and focus and involvement in specific projects. Similarly, it was noted that Staff Governors had met with Hannah Foster, Director of People, to discuss a piece of work related to staff experiences of working for the RD&E. The draft agenda for the CoG meeting in public and private on 2 March 2020 was received and agreed. Agenda planning for the CoG Development Day on 16 March 2020 was considered,
including a session on finance and an item to confirm the Quality Priorities. Governor attendance at meetings, including the observation rota for the Board of Directors meetings in public was noted. It was agreed to revise the current NED assessment form, to circulate to all Governors and encourage its use by those who attend meetings where a NED is present.

The date of the next meeting of the CoG Coordinating Committee is 20 April 2020.

Public and Member Engagement working group (PMEG, update from Kay Foster)

**Purpose of the working group:** To ensure that the Council of Governors is meeting its duty to represent the interests of members of the Trust and the interests of the public and contribute a Governor perspective to the development of the Trust’s engagement work.

The key emphasis of this meeting was a way to revise and drive forward other ways of conducting the outcomes of this working group. The purpose remains the same.

What’s new:

1. The Committee will look at using social media (Twitter and Facebook) to communicate with the public and members.
2. The PMEG committee has started engaging with RD&E Twitter feed.
3. The Comms team has started running training for Governors on Social Media tools.
4. A private Facebook group will be set up for Governors, with social media etiquette pinned at the top of the page.
5. The above will be discussed at the next COG or Development day to include all Governors.
6. It was suggested that Medicine for Members’ seminars/talks could be run from Community site and not only the main Wonford site.
7. There was discussion for Governors who have links with Community activities could promote the Royal Devon and Exeter Hospital Charity.
8. There was discussion that the PMEG committee could work closely with the Patient Safety & Quality Working Group and the annual quality priorities for 2020/21. In parallel a Community survey could be conducted to get patients’ stories about their experiences - TBC. Governors to report back to the Board on these findings.

The Comms and Engagement team had drafted a suggested outcomes driven focus for PMEG (see one pager attached) which was reviewed at the meeting, the social media element was added as a new focus – which may merge/replace the ‘Community Voice’ outcome.
Patient Safety and Quality Working Group (update from Faye Doris)

**Purpose of the working group:** To contribute a lay/governor perspective to the Trust’s Patient Experience Committee (PEC) and to the development of the Trust’s Quality Account submissions and future priorities on quality.

Since the last CoG meeting, the Group has met twice, on 5 December 2019 and 20 February 2020. Its focus across the two meetings has been on the Governor Quality Priorities, in particular the selection of the two priorities for 2020/21. A request was made in December 2019 for Governors to submit quality priority suggestions and these were discussed at the CoG Development Day on 20 January 2020. Following this, all Governors were asked to rank the suggestions in order of preference. The outcome from the ranking exercise was discussed at the 20 February 2020 working group meeting. An update will be provided to CoG at its meeting on 2 March 2020, with the agreement of the details of the priorities to take place at the CoG Development Day on 16 March 2020.

A meeting of the Patient Experience Committee took place on 20 February 2020 and an update will be provided to CoG at its meeting on 2 March 2020.

CoG Effectiveness working group (EWG) (update from Tony Ducker)

**Purpose:** To enhance the effectiveness of the CoG by ensuring that its knowledge base, processes and operations are fit for the purpose defined in the Health and Social Care Act 2012.


At the December meeting there were only two members of the group present and four observers, two of which have since joined the group. At this meeting Barbara Sweeney announced her intention of leaving the group as she was very heavily committed to other groups and committees and the February meeting was her last attendance.

The Group agreed the best way of sharing information with Governors from the Board, Audit Committee and PEC was for them to be reported on in the informal Agenda at each CoG this had been discussed at the coordinating committee. CoG Performance Report – there was a discussion about ensuring the CoG’s report contained information that was supplied to the Board on a quarterly basis.

The Document Review Group had not meet. There were four documents to be reviewed as a group: Governor’s code of conduct, Governors Behaviour charter, Standard operating procedure for an alleged breach of the code of conduct, Standard operating procedure for the removal of a Chair. It was also felt that the CoG/Board relationship document be reviewed in particular with regards to the Governor’s role of representing their constituents. The review of Constitution was on hold till the relationship between RD&E and Northern Devon Healthcare Trust (NDHT) was clarified.

The Document Review Group includes not only members of the effectiveness
group but other Governors and it would be important to have representatives from the staff Governors on this group

The next effectiveness review was delayed to start in March 2020 giving the new Governors time to contribute more. The proforma will be circulated to all Governors in early March 2020, with the aim to present the final report to the 1 June 2020 CoG meeting.

The election for a new Chair and vice Chair was undertaken, in view that there were only Four group members present, one of whom was leaving the group and one of whom was already a Chair of another group. Tony Ducker agreed to stay on as Chair until the end of his term as a Governor in September 2020. Marcus Pipe agreed to become Vice Chair till September and then take over as Chair.

**Recommendation:** That the Council of Governors notes the report

**Presented by:**
- Peta Foxall, Lead Governor
- Faye Doris, Chair of Patient Safety & Quality
- Kay Foster, Public & Member Engagement
- Tony Ducker, CoG Effectiveness
A proposal: PMEG - our purpose

To represent the voice of our members & communities to the Trust and Board

How will we do this?.. ... with an outcome driven agenda for 2020!

**Outcome 1: Governor Quality Priorities**

**Input**
- Identify member/public sentiment analysis with support from the engagement team
  - Eg. Facilitate member focus groups/survey
- Gather patient stories by engaging with members & community groups
- Link with Patient Safety and Quality Group & PEC for consistent messaging

**Outcome**
- Collect qualitative & quantitative data from members and public to feed into the quality report and Board

**Outcome 2: Community Voice**

**Input**
- Develop links with community groups & voluntary sector orgs. Eg. Community conversations, League of Friends, Health & Wellbeing Boards, Wellmore, PPGs, Wellbeing Exeter, Health Watch, patient charities
- Identify key events or meetings to attend
- Focus on obtaining feedback on views and patient experiences for Governor Quality Priorities report

**Outcome**
- Help improve two-way communication and gain a greater voice for our local community by becoming an RD&E ambassador

**Outcome 3: Membership and recruitment**

**Input**
- Engage with members/public at Trust events including AMM & M4M
  - At community group events and networks, take the opportunity to promote membership
- Governor recruitment: continue to support the engagement team to recruit sufficient, and diverse candidates

**Outcome**
- On-going recruitment of new members and Governors

**Outcome 4: RD&E Charity support**

**Input**
- Support the building of new relationships with community groups eg. local Rotary clubs
- Get involved with the Star Fish appeal linking with Charity Team (tbc)
- Capitalise on opportunity to promote further involvement with Trust Eg. via membership/volunteering

**Outcome**
- Help develop awareness of the Charity using your social/community networks

**EVALUATION**

- End of year progress report to the Board

PMEG Group meets twice a year (when?) + task and finish groups linked to deliver each objective
COUNCIL OF GOVERNORS PAPER

Meeting date: 2 March 2020               Agenda item: 7.2, Public meeting

Title: Non-Executive Director Remuneration Committee update

Purpose: To request approval of the Terms of Reference.

Background: The NEDRC is appointed and authorised by the Council of Governors to recommend appropriate remuneration and terms and conditions of service for the Chairman and NEDs.

The Committee membership comprises: Peta Foxall, Lead Governor; Phil Twiss, Appointed Governor; Hazel Hedicker, Staff Governor; Barbara Sweeney, East Devon, Dorset, Somerset and the Rest of England; John Murphy, Exeter & South Devon; Marcus Pipe, Mid, North, West Devon & Cornwall.

Key Issues:
The Committee met on 16 January 2020. The Committee undertook a routine review of its Terms of Reference. These are attached at Appendix 1, with tracked changes, and are presented for approval.

Due to issues of confidentiality, an update on the discussions regarding levels of NED remuneration and terms and conditions will be provided in the Confidential meeting.

Recommendation:
1. That the Council of Governors approves the Terms of Reference

Presented by: Peta Foxall, Lead Governor
### APPROVED DOCUMENT COVER SHEET

#### NON-EXECUTIVE DIRECTOR REMUNERATION COMMITTEE

#### TERMS OF REFERENCE

<table>
<thead>
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<td>Version:</td>
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<tr>
<td>Sponsor:</td>
<td>Executive Director of Transformation &amp; Organisational Development Update</td>
</tr>
<tr>
<td>Approval authority</td>
<td>NEDRC Council of Governors</td>
</tr>
<tr>
<td>Date of first approval:</td>
<td>20 February 2007</td>
</tr>
<tr>
<td>Date of first issue:</td>
<td>20 February 2007</td>
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<tr>
<td>Review date:</td>
<td>February 2020</td>
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<tr>
<td>Review commenced:</td>
<td>February 2018 January 2020</td>
</tr>
<tr>
<td>Date of approval by NEDRC:</td>
<td>15 February 2018 16 January 2020</td>
</tr>
<tr>
<td>Date of approval by COG:</td>
<td>15 March 2018 1 March 2020</td>
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<tr>
<td>Next review due by:</td>
<td>February 2023</td>
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NON-EXECUTIVE DIRECTOR REMUNERATION COMMITTEE

Terms of Reference

Reference to “the Committee” and “NEDRC” shall mean the Non-Executive Director Remuneration Committee.

1. Accountability

1.1 The Committee shall report to the Council of Governors on its proceedings after each meeting on all matters within its duties and responsibilities. This will be conducted in private session. The Chair will propose that, under the provisions of section 1(2) of the Admission to Public Meetings Act 1960, the public and press should be excluded from the meeting on the grounds of the confidential nature of the business to be discussed. The Lead Governor shall chair any discussion at a Council of Governors meeting regarding the remuneration of the Trust Chair in the Chair’s absence.

1.2 The Committee shall make whatever recommendations to the Council of Governors it deems appropriate on any area within its remit where action or improvement is needed.

1.3 The Committee shall make a statement in the annual report about its composition, attendance, activities, the process used to make decisions, and an explanation as to whether external advice has been utilised.

2. Purpose

2.1 The main functions of the Committee are to:

- Receive advice as necessary on overall remuneration and terms of service for Non-Executive Directors (including the Chair of the Trust)
- Recommend fair levels of remuneration and terms of service for Non-Executive Directors (including the Chair of the Trust).

2.2 The Committee may also be called upon to provide advice to the Council of Governors on remuneration, which includes all aspects of salary (including any allowances) and other contractual terms for the Chair and Non-Executive Directors.

3. Membership

3.1 Core membership of the Committee shall be comprised as follows:

- Lead Governor
- Five Governors, as follows:
  - 1 from each public constituency (total 3)
  - 1 staff governor to represent the staff Governors (total 1)
  - 1 appointed governor to represent the appointed Governors (total 1)
3.2 The Committee Chair will be the Lead Governor. In an unexpected short-notice absence of the Lead Governor, the Committee will nominate one of the Public Governors to act as Chair.

3.3 With the exception of the Lead Governor, appointments to the Committee shall be for a period of up to three years, which may be extended. Extensions of office shall be by ballot of the CoG. Governors will be elected by the CoG by means of a ballot organised by the Foundation Trust Secretary in accordance with a process agreed by the CoG.

3.4 Due to the confidential nature of the Committee, only members of the Committee shall have the right to attend Committee meetings. However, other individuals such as external advisers may be invited to attend for all or part of any meeting, as and when appropriate. The Head of Governance and Human Resource Directorate support will always be in attendance.

3.5 The Committee is authorised to seek any information it requires from any employee of the Trust in order to perform its duties.

3.6 The Committee is authorised to obtain, at the Trust’s expense, outside legal or other professional advice on any matters within its terms of reference.

4. Quorum

4.1 The quorum necessary for the routine transaction of business shall be four members, who must as a minimum consist of the Committee Chair and three Governors of which two must be from public constituencies.

4.2 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

5. Procedures

5.1 The Foundation Trust Secretary or approved substitute shall act as Secretary to the Committee.

5.2 Meetings of the Committee shall be arranged by the Secretary of the Committee at the request of the Chair of the Committee.

5.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date shall be forwarded to each member of the Committee, and any other person required to attend, no later than 7 working days before the date of the meeting. An agenda of items to be discussed and supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

5.4 The Secretary shall minute the proceedings and resolutions of all Committee meetings, including the names of those present and in attendance.

5.5 Minutes of Committee meetings save for items of individual confidentiality, shall be circulated promptly to all members of the Committee. Minutes are to be held securely by all members.

5.6 The Foundation Trust Secretary will maintain the official Non-Executive Director Remuneration Committee file, which may be accessed by Auditors on request.

6. Frequency of Meetings

6.1 The Committee shall meet as required to fulfil its duties, as the Chair of the Committee shall decide. One meeting per year will ordinarily be scheduled, linked to the annual review of remunerations.
7. Duties and Responsibilities

7.1 The Non-Executive Director Remuneration Committee is appointed and authorised by the Council of Governors to recommend appropriate remuneration and terms of service for the Chair and Non-Executives Directors, and is guided by best practice.

7.2 Recommendations made by the Committee shall be submitted to the next scheduled meeting of the Council of Governors.

7.3 The Committee may also be called upon to provide advice to the Council of Governors on remuneration, which includes all aspects of remuneration (including any allowances) and other contractual terms for Non-Executive Directors.

8 Review

8.1 The Committee shall periodically review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the COG for approval.

8.2 These Terms of Reference will be informally reviewed by the Non-Executive Director Remuneration Committee annually, and approved by the Council of Governors at intervals not exceeding three years.
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<thead>
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<th>Agenda item:</th>
<th>8.1, Public Council of Governors meeting</th>
<th>Date: 2 March 2020</th>
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<tbody>
<tr>
<td>Title:</td>
<td>Q3 2019/20 Performance Report</td>
<td></td>
</tr>
<tr>
<td>Presented by:</td>
<td>Dave Thomas, Interim Chief Nurse</td>
<td></td>
</tr>
</tbody>
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**Summary:**

To provide the Council of Governors with an overview of performance in Quarter 3 2019/20 (October to December 2019).

It was agreed at the 30 May 2019 Development Day that the Council would be provided with the most recent Integrated Performance Report (IPR) to Board with the addition of the Executive Summaries presented to Board from the preceding two months in the quarter. This report is therefore the IPR presented to Board at its 29 January 2020 meeting, providing performance information for December 2019, with the Executive Summaries for November and October.

Information reported to the Board on a quarterly or bi-monthly basis during Q3 2019/20 has also been included in this report.

Governors are reminded that the purpose of the report is to allow the Council to focus on what the Board has done to provide assurance on operational challenges and not on operational delivery and to provide an overview of the key issues to note.

Governors are further reminded that the Integrated Performance Reports can be found on the Trust’s public website as part of the Board’s public meeting papers: [https://www.rdehospital.nhs.uk/trust/board/boardpapers.html](https://www.rdehospital.nhs.uk/trust/board/boardpapers.html)

The Council is requested to consider the content of this report.
# Performance Report – Q3 2019-20

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<td>Quality &amp; Safety</td>
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<td>32 - 35</td>
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<tr>
<td>Finance</td>
<td>36 - 47</td>
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## Acronyms – frequently used acronyms

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<td>2WW</td>
<td>Two Week Wait</td>
<td>ENT</td>
<td>Ear Nose &amp; Throat</td>
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<td>#NOF</td>
<td>Fractured Neck of Femur</td>
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Q3 2019/20 Performance Report
2 March 2020

Author: Phil Luke
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<th>Description</th>
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<td>RD&amp;E</td>
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<td>Summary Hospital-level Mortality Indicator</td>
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<td>Venous Thromboembloism</td>
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<td>Walk in Centre</td>
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<td>WTE</td>
<td>Whole Time Equivalent</td>
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Overview

December 2019 was a mixed month for the Trust, with operational pressures continuing to put pressure on a number of key areas such as staffing, urgent care performance and finance but with encouraging improvements in some elective care measures.

As expected, there was a high number of discharges in the week leading up to Christmas, with 120 empty beds on Christmas day itself, followed by a period of increased medical admissions and lower discharges due to reduced domiciliary care capacity over the holiday period. In order to optimise patient flow, the Trust continued to utilise a number of escalation beds during December, which increased the pressure on staffing levels and care fill rates fell slightly from the November level. The operational pressure, as well as ongoing shortfalls in junior medical staffing, resulted in significant challenges for the Emergency Department, with performance against the 4-hour target for December of 84.7%.

Safety and quality metrics continued to show high quality, safe care delivered to our patients, with safety thermometer indicators showing an improving picture, both in terms of absence of new harm and harm free care. Indicators for pressure ulcer and stroke care, as well as time to surgery following hip fracture, were all at or above targeted levels. Infection rates continued to be within expected levels, with no cases of hospital acquired MRSA since July 2018.

The increased pressure on staffing may be evident in some of the quality indicators, although the impact was marginal. The number of reported slips trips and falls was higher than expected, however, only one was graded as moderate impact, and none were recorded with a major or catastrophic grading. Nutritional screening fell slightly below the 90% threshold to 89%. December data also shows a slight reduction in the proportion of reported patients undergoing a risk assessment for venous thromboembolism, however, the proportion of patients receiving appropriate VTE thromboprophylaxis increased to 96.2% against the 90% threshold.

Performance against the elective care standards was generally positive, given the reduced number of operational days in December. Performance against the 62-day cancer standard improved from the November position, with four of the other seven cancer targets being met, although workforce challenges in the Breast Care team have impacted in performance for December. The number of patients waiting longer than 6 weeks for a diagnostic test remained broadly stable. With regards to performance against the RTT standards, the total number of incomplete pathways reduced by over 500 to 34,251, and the number of patients waiting over 52 weeks fell from 143 in November to 92 at the end of December.

Workforce metrics for turnover and staff sickness were stable and the number of registered nurse vacancies decreased to 73.8 WTE, a reduction of 28 from the end of the previous quarter. A number of nurses from the Philippines (21), Australia (9) and India (36) have been recruited and will be joining the Trust between February and June 2020. Good progress in consultant job planning has been made, with rates increasing to 63.3% at the end of December.

Finances continue to be challenging, with increasing divisional overspends being seen on clinical pay and consumable budgets, coupled with the costs of outsourcing to reduce long waiters. Confirmation has now been received from NHS Digital that the £5m Global Digital Exemplar (GDE) funding assumed within the MyCare FBC will not be received during 19/20. Furthermore, final confirmation has been received from NHSE that the decision to exclude profit on asset disposal from control totals will remain. As a result, it has been agreed with NHSE that the Trust will formally amend its financial forecast to move away from control total by £11m. A financial mitigation plan is now in place to cease all but the most critical spend between now and the year end to ensure that the gap to control total remains at £11m, in line with original risk assumptions. This would leave the Trust with a forecast deficit of £7.7m after receipt of MRET and Q1/ Q2 PSF- this may be mitigated further in the event of any year end distribution of residual national PSF funding. To support the Divisions in reducing their current expenditure run rates and maximising their income, confirm and challenge sessions led by the CFO and COO have been initiated and will continue until year end.
Executive Summary for December 2019

Activity and Flow:

- The operational pressures seen throughout 2019 continued into December. As expected, there was a high number of discharges in the week leading up to Christmas, with 120 empty beds on Christmas day itself, followed by a period of increased medical admissions and lower discharges due to reduced domiciliary care capacity over the holiday period.

- The number of Delayed Transfers of Care (DTOCs) increased slightly in December as a result of the reduced level of domiciliary care described above.

- Emergency and elective activity was broadly at planned levels during December.

- Good progress was made in the implementation of the winter plan during December, with almost all of the 45 winter schemes having been implemented. There are three significant issues to note as follows:
  - Early indications are that the implementation of same day emergency care is working well, with significant numbers of patients being triaged from AMU for transfer to the ambulatory care unit to support increased admissions avoidance.
  - Due to ongoing shortfalls in nurse staffing, it has only been possible to open 5 of the 22 additional community beds proposed as part of the plan.
  - The 400 additional hours of domiciliary care capacity planned for December will not be available until 27th January due to recruitment issues by the independent sector provider.

Operational Performance:

- Including all local WICs and MIUs, performance against the 4-hour target for December was 84.7%. The key issues continued to be medical staffing levels and reduced patient flow from the ED due to operational pressure across the Trust.

- Performance against the 6-week diagnostic standard decreased by 1.58% in December to 76.62%, however the number of patients waiting longer than 6 weeks for a diagnostic test remained broadly stable from the November position. The reduced performance is due to the overall waiting list size reducing.

- For December, current performance against the 62-day standard is 77.8%, against the national standard of 85%. The final, post validation, performance is expected to be 74% against a Trust trajectory of 81.2%. Urology and Lower GI continue to be the key challenged specialties.

- For December, the Trust will achieve four of the other seven cancer targets, with particular challenges being experienced in the delivery of the 2-week waiting times targets.

- The number of incomplete pathways reduced in December to 34,252 from 34,749 in November, meaning that the Trust is on track to achieve the target of maintaining the waiting list at below 34,300 by the end of March 2020.

- Following good progress being made in Cardiology and General Surgery, the number of patients waiting longer than 52 weeks reduced to 92 in December from the November position of 143.
Patient Experience, Safety & Quality:

- Our performance for Safety Thermometer continues to track above the national average of 94% for Harm Free Care and 97% for absence of new harm for by approximately 1%.

- Trust wide compliance with Falls risk assessment was at 90.6%, against a threshold of 95%. Operational Pressures in December 2019 appear to be the main contributory factor.

- Previous success in bringing the Trust’s mortality indices towards the national average has not been sustained. A number of data quality issues are contributing to the deterioration in the Trust’s position. Themes identified from clinical review of cases through the Structured Judgement Review (SJR) process do not identify significant deterioration in the quality of care over the timescales suggested by the mortality index position.

- Antimicrobial prescribing position shows a dip in both the indication specified on the drug chart and empirical therapy as per guidelines. A review undertaken by the Clinical Lead for antimicrobial stewardship has identified a number of reasons contributing to the reduced compliance, which in many cases were deemed as clinically appropriate.

Our People:

- The Trust-wide turnover rate has recorded a small increase over the last month from 10.9% to 11.0%.

- The consultant job planning compliance rate has increased to 63.3% in December.

- The exit interview compliance rate has worsened this month to 14.1% although the rate for the last 12 months is 25%.

- In December the monthly sickness absence rate matched the 4.8% reported in November. The 12 month rolling rate stands at 4.7%.

- Total PDR compliance remains below the target 80%, though December saw a small increase from November’s 73.5% to 74.1%.

- With a reported rate of 85.2% at the end of December, overall statutory and mandatory training compliance has remained stable – matching the rate at the end of Q2.

Finance:

- A deficit of £13.0m excluding PSF / MRET has been incurred to month 9, £8.0m adverse to budget and £4.6m adverse to plan.

- Year to date clinical income is £463k adverse to budget, mainly due to an under performance on the Devon CCG contract (£610k). However the expectation is that the Devon CCG contract will be break even by year end. Along with other Acute providers, the Trust has also underwritten a 30% share of STP demand management risk up to a cap of £1.0m.

- As agreed at December board, the financial forecast has been revised to a deficit of £13.8m before PSF/MRET, a deterioration of £11.0m. This is due primarily to confirmation that the £5m GDE funding assumed within the MyCare FBC will not be received in 19/20, along with final confirmation that a £5m profit on sale of assets cannot be counted towards control total.

- Clinical income is forecast to be £1.1m over performed at year end mainly related to the Specialist Commissioner contract.

- Pay budgets are overspent by £1.5m year to date, largely related to medical agency costs associated with filling junior and middle grade rota gaps.

- Non Pay budgets are overspent by £4.3m mostly due to the costs of outsourced clinical activity to treat the longest waiting patients (mainly Cardiology) and overspends on clinical supplies.

- The Trust has achieved £12.0m towards its savings target of £22.0m, albeit only £5.2m on a recurrent basis. A combination of unidentified savings slippage in the delivery of the recurrent ‘One Plan’ benefits and the inability to include profit on disposals will leave a £7.3m shortfall to the 2019/2020 CIP plan.

- A mitigation plan is in place to address the operational position and to ensure the revised plan is delivered.
Please note that as there was not a public meeting of the Board in December 2019, a full IPR was not produced and therefore there is not a detailed Executive Summary for the month of November 2019.
Executive Summary for October 2019

Activity and Flow:

- October continued to be challenging operationally, with 29 days at OPEL 3 and 2 days at OPEL 2.
- Combined elective activity across the first seven months of the financial year was 3.9% higher than the equivalent period for 2018/19 albeit still below planned levels.
- Non-elective activity is stable compared to 2018/19, with only 0.1% growth compared to a plan of 2.6% growth. This is likely to be the result of the continued focus on ambulatory care thorough the Ambulatory Care Unit, Surgical Assessment Unit and the Medical Triage Unit.
- The Acute Delayed Transfers of Care (DTOC) position has shifted slightly from 42 to 44 during October, which remains significantly higher than trajectory and peer comparators.

Implementation of the winter plan:

- The Trust has made good progress in the implementation of all schemes in the winter plan. A small number of initiatives, such as the “flying squad” were launched in October, with the majority commencing in November, December or the beginning of January. Progress continues to be monitored by the Operational Capacity Steering Group, with any unresolved issues being escalated to the Strategic Delivery Group.
- Planning to staff the 22 community beds is highlighting that there may be challenges in staffing additional beds on three different sites. This work is still ongoing, however, it appears likely that a reduced number of beds will be opened.

Operational Performance:

- Including all local MIUs and WICs, performance against the 4-hour target for October was 84.51% meaning that the PSF trajectory of 91.7% was not met. This represents a slight deterioration in performance from September when performance was 85.70%.
- Performance against the diagnostic standard has increased from 75.65% in September to 77.22% in October following the continued provision of additional capacity in a number of modalities
- For October, current performance against the 62-day standard is 81.2%, against the national standard of 85% and a Trust trajectory of 77.9%. The position will change as pathology results are reviewed and the final performance is expected to be adjusted downward post validation.
- For October 2019, the Trust is expecting to meet three of the remaining seven cancer targets.
- The total number of incomplete RTT pathways continued to decrease from 35,923 in September to 34,749 at the end of October. A total of 7,107 pathways remain open beyond 18 weeks, equating to performance of 79.55% which is a 1.25% increase on the 78.3% position at the end of September.
- At the end of October 159 patients had waited more than 52 weeks and increase from 147 patients in September. However, more encouragingly patients waiting over 40 weeks has reduced from 804 to 723.
Patient Experience, Safety & Quality:

- The number of complaints responded to within 45 days has declined during Q2. Work is underway via the Divisional patient experience leads to provide assurance that regular contact is being maintained with people who have raised a complaint or concern which is taking longer than 45 days to complete.
- The Safety Thermometer in October demonstrated an improvement, with 97.6% of patients experiencing no new harms.
- Throughout October 2019 there were no falls which resulted in moderate or greater harm to patients.
- Mortality Indices - whilst SHMI has returned to be just within the ‘as expected’ range the overall trend in relation to both SHMI and HSMR indices demonstrate a worsening position although initial analyses indicates this is due to changes in activity classification and coding practices.
- There were a total of eight cases of E-Coli identified in October and following reviewing, a theme around provision of antibiotics for catheterised patients has been identified and actions taken as required.
- The Flu vaccination of healthcare workers Self Assessment has been appended to the Healthcare Associated Infection section within the IPR

Our People:

- The Trust has successfully recruited 4 radiographers from a recent trip to Italy and is working towards a start date of January 2020.
- The consultant job planning compliance rate continues to improve with the current rate of 59.4% recording an increase on last month’s rate of 53.5%.
- The exit interview compliance rate has improved this month from 22.9% to 24.2%.
- At 5th November 40% of frontline staff had received the flu vaccine, which is ahead of the same time last year.

Finance:

- Month 7 has seen a deterioration in the expenditure run rate, with an deficit in month of £2.4m, largely due to a worsening in the pay overspend, increases in clinical consumables and an under delivery of CIP against the higher monthly target.
- A deficit of £8.1m (ex PSF & MRET) has been incurred to month 7, £4.2m adverse to budget and £1.6m adverse to plan. As a result, additional controls are being put in place to ensure all new or discretionary spending is related solely to critical spending commitments such as elimination of over 52 week waits.
- Year to date clinical income is £675k adverse to plan, mainly due to an under performance on elective activity through the Devon CCG contract. Under the risk share arrangement this will clawed back by the CCG, however the expectation is that this activity underperformance will recover by year end. Along with other Acute providers, the Trust has also underwritten a 30% share of STP demand management risk up to a cap of £1.0m.
- Clinical income is forecast to be £1.8m over performed at year end mainly related to the Specialist Commissioner contract. However, due to delays in the bidding process, It should be noted that there remains a material risk of £5m for the GDE digital funding bid.
- Pay budgets are now overspent by £1.2m, largely related to medical agency costs associated with filling junior and middle grade rota gaps. Nursing agency pay costs remains high despite improved recruitment, although new staffing arrangements put in place by the Interim Chief Nurse has seen a reduction in agency usage during November.
- Non Pay budgets are overspent by £2.6m mostly due to overspends on outsourced clinical activity to meet 52 week waits (mainly Cardiology), clinical supplies and miscellaneous expenses. Cardiac device expenditure has seen an increase in October of £435k following a review of controls and stock processes.
- The Trust has achieved £10.9m towards its savings target of £22.0m, albeit only £2.5m on a recurrent basis which remains a concern. Whilst full savings achievement is currently forecast there is a significant risk to this position, due to a combination of unidentified savings and slippage in the delivery of ‘One Plan’ benefits. It is likely that delivery of the in year savings target will only be possible with the support of various commercial transactions and non recurrent savings.
- It has been reported to the STP that the Trust has a cumulative net risk to control total of £15.0m (£2.0m operational, £1.0m external funding pressures, £1.0m STP, £5.0m GDE income, £6.0m savings target). After further mitigation it is planned to reduce this risk back to the original £11m, which could still by closed off through receipt of the GDE funding in Q4 coupled with a relaxation of national rules around allowing profit on asset disposals to count against control total. However, in the event that this £11m risk materialises, the Trust would end the year with a final deficit of £8m.
- On the basis of the original planning assumptions, the Trust is still forecasting a deficit of £2.8m by year end (excluding PSF/MRET) in line with plan. After assumed PSF/MRET, donated asset income and expenses, the Trust would then deliver a surplus of £8.6m.
Referrals: As referenced in the previous month’s IPR, the Business Intelligence team has undertaken a review of the completeness and consistency of referral data. For November it was reported that referrals were 3.6% higher than prior year (YTD) but 0.2% below plan. The review has identified that the inclusion of Appointment Slot Issues (ASIs, where the service does not have a vacant slot to book a patient into within an agreed timescale) in the referral data was likely to include an element of duplication of referrals, over-accentuating growth. Consequently ASIs have been excluded from referral reporting. Following application of this adjustment, the year to date position to the end of December is referral growth of 2.0% on prior year, but 2.1% below plan.

Elective activity: Combined (Inpatient and Daycase) elective activity was 1.1% higher than plan in the month of December, but 5.0% below plan YTD. Inpatient activity has now been above plan for two consecutive months, but still currently 4% below plan YTD. The Daycase position is below plan at 5.3% YTD. The main specialties reporting under plan are Orthopaedics (inpatient and daycase), Urology (Inpatient), and Dermatology (Daycase).

Emergency /Non-elective inpatient: Activity was in line with plan for the month of December but 2.6% below plan YTD, which is in line with previous reporting.

**NB. Emergency/Non-Elective Inpatient chart:** Maternity, ante and post-natal activity excluded from April 2019 as per national guidance.
Overall performance:
- Including all local WICs and MIUs, performance against the 4-hour target for December was 84.7%.
- National performance for December was 68.6% for type 1 performance and 79.8% for all patient types.
- The breakdown of ED performance for different categories of patients is shown in the table below.

<table>
<thead>
<tr>
<th>Type of Activity</th>
<th>Denominator</th>
<th>Patients &gt; 4 Hours</th>
<th>% Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Only</td>
<td>7658</td>
<td>2150</td>
<td>71.92%</td>
</tr>
<tr>
<td>All RD&amp;E Delivered Activity (including Honiton MIU and the WICs)</td>
<td>11366</td>
<td>2172</td>
<td>80.89%</td>
</tr>
<tr>
<td>Total System Performance (including MIUs)</td>
<td>14433</td>
<td>2209</td>
<td>84.69%</td>
</tr>
</tbody>
</table>

- Twelve patients waited longer than 12 hours from decision to admit to transfer to an inpatient bed, including two patients on each of 21 and 29 December, and three on 06 December. Unusually, five of these 12 patients were awaiting a bed on AMU, with the other seven patients awaiting a mental health bed in another provider. The long waits for an AMU bed occurred at the weekends during times of high operational pressure. The circumstances have been reviewed by the Medicine divisional team and the key learning points will be shared with the Operational Capacity Steering Group.

Key challenges and improvement actions:
The key reasons for the low level of performance remain as they were in recent months.
- The shortage of junior doctors and middle grades continues to present significant pressure, with 9.65 WTE vacancies, resulting in regular gaps across rotas. The department continues working on a number of approaches to improve this position. Unfortunately, however, early indications for the next junior medical staff rotation in February show that further deterioration in the medical staff position is likely.
- In order to address the staffing difficulties, a number of actions have been put in place, including 1 additional registered nurse every night and the development of a proposal to increase the consultant establishment. The ED team continues to utilise all available routes to increase junior medical staffing in the short term, including overtime and the use of locum and agency shifts where possible.
- Challenged flow through the hospital has also resulted in exit block in ED, impacting on the ability to see patients in a timely way. Winter plans have been implemented across the Trust, which aim to improve patient flow. The plan is monitored fortnightly through the Operational Capacity Steering Group.
- The ED continues to work closely with colleagues in Devon Partnership Trust to improve the pathways for patients presenting with mental health needs.

Ambulance Handover Delays
- An average of 98 ambulances arrived per day in December, a slight increase from November, when there were 96 arrivals per day.
- There were no handover delays greater than 60 minutes and 43 handover delays greater than 30. The primary reason for these delays was exit block in ED, which impacts on the ability to offload crews in a timely manner.
- The Trust has been allocated a Hospital Ambulance Liaison Officer (HALO) as part of SWASTs winter plan, which will further support timely ambulance handovers.
Performance against the diagnostic standard decreased by 1.58% in November to 76.62% in December.

The number of patients waiting longer than 6 weeks remained broadly stable at 1220 compared to 1204 at the end of November. The total number of patients on the diagnostic waiting list, however, decreased by approximately 300 since November and has reduced from 6894 at the end of September 2019 to 5218 at the end of December. This is positive in terms of reducing the overall list size, although there is an adverse impact in reducing the denominator used to calculate percentage performance, which is why performance has deteriorated slightly in December.

A description of the actions in place to regain compliance for each diagnostic modality is incorporated overleaf.
Echocardiography
The Echocardiography position improved during December, despite continued physiologist vacancies, with 400 patients waiting in excess of 6 weeks at the end of December, compared to 467 at the end of October. The Trust has worked with the CCG to identify capacity from a 3rd party provider, which will commence from January 2020. This will enable 450 direct access (diagnostics ordered directly by GPs) to be undertaken by the Independent Sector, which aims to allow the Cardiology Department to clear the backlog for echocardiography by the end of Q4.

Non-obstetric Ultrasound
The number of patients waiting longer than 6 weeks for non-obstetric ultrasound reduced over December to 248 compared to 321 at the end of October. The department continues to work with third party suppliers and use overtime and agency sonographic staff to deliver additional capacity. The department aims to have significantly reduced or cleared the backlog of patients waiting for ultrasound by the end of March 2020.

Endoscopy
The number of patients waiting in excess of 6 weeks for an endoscopic procedure reduced in December, from 182 patients to 163 patients. A programme with three key elements to reduce endoscopy waiting times is being progressed by the Trust. The first element is the implementation of additional weekend working which, aims to treat approximately 400 additional patients during December and Q4. This is progressing well and has helped reduce the backlog during December. The second element is a proposed plan to utilise local Independent Sector capacity to treat around 150 patients during February and March 2020. Both of these initiatives are funded externally following successful bids to the Cancer Alliance. The third strand of the work programme relates to the implementation of NICE guidance, which recommends a reduced frequency of surveillance (follow-up) endoscopies for some patients. The clinical team is currently reviewing the notes of patients due in February and March to assess their requirement for a repeat endoscopy, which will release capacity to treat other patients. Assuming the three elements of the plan deliver to estimated levels, the Endoscopy Department is aiming significantly reduce backlog of patients waiting longer than 6 weeks for a routine endoscopy by the end of Q4.

Cardiac MRI/CT
The position for Cardiac imaging has been maintained between November and December, with 147 breaches in Cardiac MRI at end December compared to 146 at the end of November, and Cardiac CT moving from 184 to 188 across the same period. As of December, additional recurrent capacity has been arranged for both modalities which will help to meet recurrent demand. Further work is ongoing to identify opportunities to create ad hoc capacity to clear the current patients waiting in excess of 6 weeks.

Non Cardiac MRI & CT
The number of non-cardiac MRI patients waiting longer than 6 weeks has risen slightly during December, reporting 53 breaches for non-cardiac MRI (up from 14 in November). This small rise is due to lost capacity during the December bank holidays (approx. 150 appointment slots) and essential maintenance on the scanners (25 appointments.) There is a number of patients waiting longer than 6 weeks for non-cardiac CT at the end of December, relating to a specific one-stop clinical service for a service provided by DPT. Options to address this group of patients are being explored.

In the longer term, more sustainable capacity is required to recover the MR position fully and sustain performance. Proposals for a 4th MRI scanner are being prepared for presentation to the Board during Q4.

DXA
At the end of December no patients were waiting longer than 6 weeks for a DEXA scan, which has reduced from a position of 123 in October 2019.

Summary
Work to improve the diagnostics position continues, with good progress in developing and implementing plans being made in a number of areas. The encouraging reductions to the overall diagnostics waiting list should continue to improve the position during Q4. Robust plans to provide sustainable capacity to meet ongoing demand for diagnostics are being developed as part of the 20/21 budget setting process.
Cancer 62 Day – Proportion of patients treated within 62 days following referral by a GP for suspected cancer

For December, current performance against the 62-day standard is 77.8%, against the national standard of 85% and the Trust trajectory of 81.2%.

Urology
There continues to be a significant amount of work undertaken to support improvements in urology performance.
- The service appointed a locum in December to support the overall number of patients being treated; benefits are already being seen with an increase in planned activity.
- Waiting times for Transperineal Prostate (TP) biopsy (7-8 weeks) and robotic surgery (4-5 weeks) are the key factors in pathway delays. Further training for the locum to support the reduction in TP waits and the relocation of benign ‘stone’ work to Heavitree to release capacity in Main Theatres are both planned to commence in Quarter 1. In the meantime, the Urology team is increasing capacity for TP biopsy using ad hoc sessions wherever possible.
- In February Urology will see the introduction of an outpatient cystoscopy service to meet the capacity requirements for haematuria referrals.

Colorectal
- Waiting times for endoscopy are still having a significant impact on the 62-day position for Colorectal with seven of the ten breaching patients experiencing delays.
- Colonoscopy and oesophago-gastro-duodenoscopy (OGD) waiting times have remained stable compared to previous months at 2–3 weeks. The actions described in the diagnostics section of the IPR will support a reduction in waiting times for patients referred under the 2 week cancer process and the backlog is expected to be cleared by the end of Q4.

Haematology
Delays in diagnosis and the inherently complex nature of these pathways is the root cause of the Haematology Service missing the 62-day standard in December. Three of the five Haematology diagnoses started in other sites, due to the symptoms these cancers often initially present with.

Sarcoma
4 of the 4.5 sarcoma patients booked over 62-days are not expected to have cancer, however, until confirmed by pathology, patients are recorded as breaches of the 62-day standard.
For December 2019, the Trust is expecting to meet four of the seven targets above.

Two-week-wait:
- The Trust’s two-week-wait position was 71.7% in December. Additional patient choice breaches were apparent during the Christmas period.
- Whilst still accounting for 40% of the Trust 2WW breaches, colonoscopy and oesophago-gastro-duodenoscopy (OGD) waiting times are remaining stable on previous months, averaging 19 days and 14 days respectively. The plan described in the diagnostics section relating to endoscopy will improve performance against the 2ww standard.
- Within the Breast Care Team, decreased activity due to staff retirement in November, led to a significant number of breaches in December, however, patients were still being booked at an average of 17 days. Additional capacity has been provided where possible to improve this position leading into January and waiting times have improved. A proposed increase to the core capacity of the Breast Care team is currently being considered as part of the budget setting process.

31 Day First
- 31 day compliance remains reliant on the recovery of Urological performance, with surgeon and theatre capacity being the predominant theme. A tenth consultant was appointed in December on a locum basis to increase Urology capacity and an additional theatre list is planned by April 2020 to coincide with the relocation of ‘stones’ work to Heavitree.

104 Day Waits
- As at the 13th January there were 47 patients on an open pathway who had waited more than 104 days for treatment. Of these patients, 23 were on a urological pathway, 7 were sarcoma patients and 5 were lower gastrointestinal patients. The remaining 12 were spread across upper gastrointestinal (4), lung (4), Head and Neck (2) and Brain/Central Nervous System (2).
An update on key actions at specialty level is set out below:

**Cardiology**
- Actions are being undertaken to increase Trust outpatient and diagnostic activity including the outsourcing of GP direct access echo which commenced on 13th January and multi professional additional clinics with capacity for 40 outpatient attendances being introduced in February.
- A locum has been appointed who will fill the remaining gap on the consultants’ rota from December 2019 and has provide further additional outpatient capacity
- In conjunction with the CCG, Cardiology will be the next Trust specialty to roll out the NHSE “Choice at 26 Weeks” initiative. This is proposed to be in place from the beginning of February.

**Orthopaedics**
- Orthopaedics had 1979 patients waiting over 18 weeks at the end of December, the majority of which were on admitted pathways. This has increased due to the reduction in elective operating days in December and the operational bed pressures experienced in recent months.
- Additional ISP capacity has been identified and is being utilised to reduce the number of long waiting patients for hip and knee surgery.
- In conjunction with the CCG patients awaiting longer than 26 weeks for a foot or ankle procedure have been contacted as part of the NHSE “Choice at 26 Weeks” initiative in order to reduce the numbers waiting with individual providers.
- Additional weekend capacity has been identified in during Q4.

**General Surgery**
- At the end of December 673 patients were on open pathways longer than 18 weeks in General Surgery, which is a reduction of 98 patients since the end of October.
- Additional ISP and Trust theatre capacity has been identified and is being utilised to reduce the number of long waiting patients.
- Additional outpatient / clinical review capacity is being provided by the Trust team to further reduce the number of open pathways.
At the end of December, 92 patients waited more than 52 weeks to start their treatment against the revised forecast of 82. Although above the forecast, this is a significant reduction against the November position of 143. Of the 92 patients, 14 were not available or had chosen to delay their treatment.

In December the Trust hosted a visit for the National Lead for 52 weeks recovery and presented a 100 day recovery plan to reduce the Trust position to 38 plus 15 patient choice breaches at the end of March 2020.

**Cardiology:**
- At the end of December, 28 patients had waited longer than 52 weeks for treatment, a reduction from 57 last reported at the end of October 2019. The reduction is due to good utilisation of the Capacity provided by the local Independent Sector and the hard work of the clinical and managerial teams working to reduce waiting times.
- Although the number of long waiting patients is reducing the most challenging pathway continues to be the waiting times for cardiac ablation procedures. Between January and March a further 60 slots have been made available at a local ISP and opportunities to access capacity at ISPs out of region are being finalised.
- Capacity at another tertiary cardiac centre has been identified with an aim to commence transfers of patients in February 2020.

**Orthopaedics:**
- At the end of December, 22 patients had waited longer than 52 weeks for treatment, a reduction from 33 last reported at the end of October 2019.
- Additional capacity has been utilised at a local ISP and with the support of the CCG long waiting patients are being sign-posted to and supported to be treated by other ISPs.
- Further additional Trust weekend lists are being planned through January to March for the most significantly challenged sub specialities within Orthopaedics.
- At the end of December, 30 patients had waited longer than 52 weeks for treatment, a reduction from 41 last reported at the end of October.
- Additional Trusts capacity is being provided to address the capacity deficit to treat the longest waiting patients; including outpatient clinics, treatment clinics, further clinic reviews and theatre lists.
- Further ISP capacity has been identified for the general surgery patients. The Trust is working with the CCG to utilise this capacity during Q4.

**Others:**
- 12 further patients in Urology (6), ENT (1), Oral Surgery (1), Plastic Surgery (3) and Dermatology (1) also waited longer than 52 weeks for treatment at the end of December.
- All of these 12 patients have since been treated or have a date for treatment.

**Patients Waiting Longer than 40 Weeks**

The overall number of patients waiting over 40 weeks has increased over last 2 months from 702 at the end of October to 766 at the end of December. This has been due to the reduced number of elective operating days and the planned transfer of a number of elective orthopaedic operating lists to trauma lists in order to manage expected high demand for trauma surgery over the Christmas period. Consequently, the orthopaedic waiting list saw an increase from 243 at the end of October to 311 at the end of December. However, other key areas continue to see a decrease in patients waiting over 40 weeks. Cardiology reduced from 188 in October to 162 December, whilst General Surgery reduced from 116 in October to 108 in December.
DToc shows a steadily increasing trend since August (Average of 5.4% per month). Referrals to Urgent Community response increased by 3.1% year on year. Reflected within the increase is admission avoidance work which has increased 10.4% year on year.

**Actions to improve DTOC performance and reduce the “Green to Go” list are:**
- Seven nursing home beds have been procured from a local nursing home to expedite the pathway for palliative care patients.
- An additional 400 hours of domiciliary care agency staffing have been procured to help manage personal care commencing 27-1-20.
- The Trust has increased the number of “Trusted Assessors” (Key link between Acute & Care homes which expedites the discharge process) from 2.6wte to 5.0wte (Commencing Jan 2020).
- As part of the winter planning, daily GP input has been arranged to support cluster-level multi-disciplinary team meetings, which will provide additional clinical support for admission avoidance and hospital discharge work.
- On-going collaborative work is being carried out between CCG & DCC partners to improve access to care homes beds.
- The Trust has supported the recruitment of an additional support workers to respond to increased urgent community response demand due to shortfalls in the domiciliary care market.
- A senior manager has been allocated to work with partner organisations to review system-wide demand and capacity, processes and opportunities for working differently across the health and social care system. Feedback on their findings and recommendations will be presented during Q4.
Demonstrating Difference

• A patient, who was receiving care on Mere Ward disclosed to a specialist nurse that they wanted to get married but believed that it was too late. She was receiving end stage cancer treatment at this point.

The team worked together to arrange a Registrar to conduct the service. A clinical room within the ward was transformed into a suitable venue and a member of the ward team made a cake which was iced and decorated with flowers. Celebratory drinks were also arranged. The Wedding took place on 8 August 2019 and the team went the extra mile to make this a special day for the Bride and Groom.

• The Urology and Colorectal Cancer team ran a pilot of an After Cancer Treatment (ACT) for four months.

Patients and their supportive person were invited to attend a group session for 8 people 12 weeks after their surgery/treatment. Content included a formal presentation covering psychological and emotional effects and healthy lifestyle benefits around diet and exercise.

Following the presentation each patient was given the opportunity to have 1:1 support and advice from the presenting team which is based on personal goal setting to support changes in diet and exercise. A holistic needs assessment is offered which includes signposting to services available within the community.

Benefits included:

• Personalised care planning
• Improved patient experience
• Prepares patient for remote monitoring and open access to acute services when needed.
• Promotes partnership working and an environment of trust between HCP and service users
• Reduces need for OPD appointments
• Gets the right people in the room to deliver care
• Helps to develop future services to patient needs
• Patients being signposted to services such as FORCE, weight loss classes, group gym sessions, 1:1 Sessions and our new front room to fundraiser: 5k your way.

The plan is to run 4 clinics per month for urology and colorectal cancer patients for the next year with 8-10 patients per session. This will give provision to invite all prostate cancer patients 3 months after their Robotic-Assisted Laparoscopic Prostatectomy (RALP) and all colorectal patients who have had treatment with a curative intent at 3 months post treatment.
The Safety Thermometer presents point of prevalence data, which is collected within the Trust on alternative months. New harms are those which occur whilst a patient is in our care, whilst the Harm free care included harms which occurred in the 72 hours prior to the census, even if the patient was not in our care.

- Our performance for both these target areas continues to track above the national average of 94% for Harm Free Care and 97% for absence of new harm by approximately 1%.

- The Trust is exploring the introduction of the Maternity Safety Thermometer and the Children and Young Peoples Safety Thermometer, as the harms measured by the Classic Tool are not clinically significant for these areas.
Previous success in bringing the Trust’s mortality indices towards the national average has not been sustained.

A number of data quality issues are contributing to the deterioration in the Trust’s position.

Themes identified from clinical review of cases through the Structured Judgement Review (SJR) process do not identify significant deterioration in the quality of care over the timescales suggested by the mortality index position. Quality of end-of-life care and response to deterioration/sepsis remain consistent themes amongst reviews citing poor care. Further detail regarding the SJR outcomes can be seen in the Quarterly Learning from Deaths Report which is being presented to the January Board of Directors.
Prevalence rates for pressure ulcers continue to demonstrate an overall downward trend. Trust-wide compliance with pressure ulcer risk assessment is at 95.2%, with the highest performance reported in our Community Hospitals, at 98%.

Pressure ulcers which are graded at stage 3 or 4 undergo validation by the tissue viability team, and a moderate investigation is undertaken. These report into the Incident Review Group for learning to be identified.
Trust wide compliance with Falls risk assessment was at 90.6%, against a threshold of 95%. Operational Pressures in December 2019 appear to be the main contributory factor. The Trust reported a daytime fill rate of 92.9% for registered staff and 91.9% for care staff during this month. Escalation beds were open throughout December, and there was an increased requirement for temporary staff due to this.

Review of all falls by ward demonstrates that each ward has remained within its normal variation, and the number of patients who experienced multiple falls was lower throughout December 2019.
The Malnutrition Universal Screening Tool (MUST) forms an integral part of the patients holistic assessment on admission to the hospital.

The December position in relation to MUST initial assessment has deteriorated to just below the target position at 89%. Areas of specific challenge seen in December were within the Medical Wards and particularly on the Acute Medical Unit, which is reflective of the OPEL level seen throughout December 2019. The weekly review position remains stable at 93.1%.

Matrons continue to work with their teams to ensure these assessments are completed in a timely way to ensure appropriate measures are put in place for individual patients.
The December position shows a dip in both the indication specified on the drug chart and empirical therapy as per guidelines. A review undertaken by the Clinical Lead for antimicrobial stewardship has identified a number of reasons contributing to the reduced compliance. In relation to empirical therapy as per guideline, a number of complex patients, concomitant with an increase in the number of Flu Admissions necessitated appropriate deviation from existing guidelines. In addition, staffing challenges within the department has adversely impacted the position; however successful recruitment to posts has taken place and it is anticipated that this will improve the position.

- Individualised prescriber feedback continues on a monthly basis within the Medical and Surgical Division.
- An incentive scheme which rewards areas that excel in antimicrobial prescribing and helps to raise awareness of the importance of antimicrobial stewardship was introduced in September and will be on-going.
- The Antimicrobial Stewardship team have been working with the MyCare team to ensure duration, indication and 72 hour review are mandatory within the new system for antimicrobial prescribing. The ARK trial criteria have also been incorporated into the new MyCare system.
C. difficile: As previously explained, definitions for cases of C. difficile apportioned to the Trust changed from April 2019. Data is now split to show the cases that were identified on or after day 3 of admission defined as ‘hospital onset/healthcare associated (HOHA)’ and those that are defined as ‘community onset/healthcare associated (COHA)’. The community onset/healthcare associated have occurred in the community or on day 1-2 of admission when the patient has been an in-patient in our Trust in the previous 4 weeks.

The three HOHA cases were investigated and not associated with any contributory lapses in care and were therefore deemed unavoidable. The COHA case was investigated and did not identify any lapses of care during the previous Trust admission and therefore this case was also unavoidable. All four cases received appropriate antibiotic therapy as per Trust guidelines with prompt isolation and specimens obtained.

Methicillin Sensitive Staphylococcus aureus (MSSA): One of the two MSSA bacteraemias was associated with a peripheral venous cannula infection and phlebitis. Learning has been identified and fed back through the relevant divisional governance structure.

Escherichia coli (E.coli): One was associated with obstetric sepsis and an investigation is ongoing. The remaining two were associated with urosepsis and an upper gastrointestinal tract infection with no contributory lapses in care identified.
VTE Risk assessment on admission remains just below the target position largely driven by MTU East and West and Abbey Ward. The % of patients receiving appropriate VTE Thromboprophylaxis continuing to exceed the target position.

In December there was a total of 57 patients treated for a hip fracture, 52 patients were deemed medically fit and ready for surgery from the outset, with 46/52 patients receiving their surgery within 36 hours (88.5%).

The six patients who breached were due to a lack of theatre time. During December, 23 trauma patients had their surgery within PEOC elective theatres.

Two medically fit patients waited over 48 hours for surgery (1 waited 63 hours and 1 waited 51 hours). Neither of these patients came to any harm as a result of their delay to theatres. On a daily basis all trauma patients, including those with a Fractured NoF are reviewed and clinically prioritised in relation to the urgency of their operation. Therefore patients with a fractured NoF may be appropriately superseded by other trauma patients with a greater clinical need.

An NOF Action Plan was taken to CEC at the beginning of November. This has now been approved at T&O Governance and Surgical Services Governance and will be taken back to CEC for approval.
There has been a general decline in the rate of admissions to the Acute Stroke Unit on Clyst within 4 hours of hospital arrival, together with its implications for the Best Practice Tariff.

Delayed access to the stroke unit feeds forward into a reduction in the headline metric of ‘90% of the patient’s stay being spent on the Stroke Unit’, particularly for short-stay patients.

The falling rate is linked to the current pressures on hospital beds, as the site team are often required to allocate the required 2 ‘trolley’ (acute admission) beds available on Clyst, when the average number of daily admissions to the stroke unit has risen to 6.

Our Nurse Practitioners continue to work with the ED, AMU and the Patient Flow team to expedite admissions through their monthly Breach Reports.

The importance of the 2 trolley beds being kept available, even at times of peak bed pressure, is key as patients admitted directly to the Stroke Unit have a shorter length of stay than those admitted elsewhere.
The work to embed safe care within the twice daily staffing meetings by the Assistant Directors of Nursing (ADNs) for Medicine and Surgery has continued to reduce our reliance upon off-framework agencies. Patient safety metrics and quality indicators from the Ward 2 Board data have remained within normal variation.

There has been a third consecutive increase in nursing bank and agency staff being required due to escalation beds being opened, which has increased by 5% over the last quarter. This now accounts for 16% of our temporary staffing requests.

The nursing band 5 vacancy prediction is shown appended to this IPR – whilst this shows a deteriorating position in relation to vacancies, it should be noted that the full escalation bed requirement has not been realised due to being unable to recruit to the posts in full in the community. Only 4 beds have been opened in the community hospitals as a result.

The recruitment pipeline remains positive and will improve the position against vacancy from April onwards.

Medical staff expenditure is overspent year to date, mostly relating to vacancies and sickness absence requiring high cost agency cover, or additional hours worked to reduce the waiting list or cover escalation areas.
During December the nursing fill rate for days was 92.9% for Registered Nurses and 91.8% for unregistered. For nights it was 97% for registered nurses and 101.7% for unregistered staff.

There are a number of factors which have impacted upon nursing fill rates, the main contributor being open escalation beds. There have been an average of 26 escalation beds open daily across the hospital, which have required redeployment of staff or diversion of bank staff to support their safe running.

There has been an increase in our Band 2 care staff vacancies, which is reflected in our day fill rates.

There remain a number of transitional registered nurses who are still reported as Band 4 Care Staff, but contribute to the registered nursing skill mix.

The higher fill rates at night demonstrate that nursing staff are being deployed when the risks are higher. Additional nursing support is available during the day from senior nurses and matrons, although this will not always be reflected in our registered fill rates.
Establishment, Turnover & Vacancy – Established workforce vs plan, turnover rate, & vacancy position

- The Trust-wide turnover rate has recorded a small increase over the last month from 10.9% to 11.0%. The annual turnover rate for registered nurses has also increased over the last month from 10.4% to 10.6%. Turnover for registered nurses employed in the community continues to be high with a December rate recorded of 14.8%. Although this rate is a reduction on the 15%+ rates of the previous 12 months it is still significantly higher than the 11.0% reported December 2018. Of the community nurses leaving in the last year 36% have moved to another NHS organisation, 9% to general practice and 7% to private healthcare.

- The number of registered nurse vacancies at the end of December was 73.8 WTE – a decrease of 28 WTE from the end of the previous quarter. Registered Nurse vacancies actively being recruited to stands at 195 WTE a reduction of 27 WTE from the previous month. 67 have a confirmed start date with a further 87 having been made a conditional offer of employment.

- A number of nurses from the Philippines (21), Australia (9) and India (36) have been recruited and will be joining the trust between February and June 2020. Until funding has been agreed no further international recruitment campaigns are planned.

- The consultant job planning compliance rate has increased to 63.3% in December. A further 14.5% have been agreed, signed off or submitted. These are being actively chased by the HRBPs. The consultant job planning process is currently under review with a plan to introduce a new electronic system by year end. The number of consultants with no job plan recorded has decreased to 39.

- The exit interview compliance rate has worsened this month to 14.1% although the rate for the last 12 months is 25%. Of the 171 staff retiring from the trust since December 2018 only 20 (11.7%) completed an exit interview. The highest response rate of 37% (35 leavers) was for the 95 staff who moved from the trust for a better reward package or promotion. Although a small number none of the 8 leavers who cited ‘Lack of Opportunities’ or ‘Incompatible Working Relationships’ completed a survey. The HR Helpdesk processes the forms and has confirmed that ESR is updated in a timely manner. A number of initiatives are being considered including redesigning the exit interview and introducing retention interviews rather than or alongside exit interviews.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Establishment FTE</th>
<th>Contracted FTE</th>
<th>Vacancies being recruited</th>
<th>Vacancies as % of staff group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Prof &amp; Technical</td>
<td>215.9</td>
<td>207.4</td>
<td>19.2</td>
<td>9.2%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>1548.5</td>
<td>1467.6</td>
<td>124.8</td>
<td>8.5%</td>
</tr>
<tr>
<td>Admin &amp; Clerical</td>
<td>1869.5</td>
<td>1742.8</td>
<td>138.7</td>
<td>8.0%</td>
</tr>
<tr>
<td>Allied Health Professional</td>
<td>612.9</td>
<td>547.0</td>
<td>39.7</td>
<td>7.3%</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>636.4</td>
<td>609.8</td>
<td>43.4</td>
<td>7.1%</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>218.4</td>
<td>211.4</td>
<td>11.6</td>
<td>5.5%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>797.6</td>
<td>840.3</td>
<td>14.7</td>
<td>1.7%</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>2050.6</td>
<td>2003.6</td>
<td>195.2</td>
<td>9.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7949.8</strong></td>
<td><strong>7629.9</strong></td>
<td><strong>587.3</strong></td>
<td><strong>7.7%</strong></td>
</tr>
</tbody>
</table>
• In December the monthly sickness absence rate matched the 4.8% reported in November. The 12 month rolling rate stands at 4.7%.

• The percentage of days lost to Anxiety / stress / depression / other mental illnesses increased slightly from 26.7% in November to 27.5% in December. In Q2 the monthly average for this reason was 33%. However a factor in this drop is likely the seasonal increase in absence due to Colds/Coughs/Flu averaging 11% a month since October (<4% in the previous quarter). The sickness rate attributable to short term cases (less than 28 days) has also increased to an average of 2.2% where it had been previously 1.7% per month.

• There is an extensive list of conditions available on ESR, however they are not always straightforward for employees or administrators to navigate. The percentage of sickness episodes recorded with an unknown or unclassified reason remains high and for the December absences these reasons were used for almost 15% of days lost (1,694 days out of the December total of 11,320 days absent sick). We are undertaking work to seek to improve this number particularly with those who enter ‘return to work’ data. At the moment this unknown / unclassified data is likely to have an effect on the top 5 reasons for sickness.

• An additional physiotherapist has joined the Occupational Health team and will support staff in preventing and managing musculoskeletal problems.

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**Health & Wellbeing – Staff sickness absence rate including breakdown of reason for absence**

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**Sickness Absence by Top 5 (inc. Other)**

- Other
- Cold, Cough, Flu - Influenza
- Musculoskeletal problems

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- Apr 2018
- May 2018
- Jun 2018
- Jul 2018
- Aug 2018
- Sep 2018
- Oct 2018
- Nov 2018
- Dec 2018
- Jan 2019
- Feb 2019
- Mar 2019
- Apr 2019
- May 2019
- Jun 2019
- Jul 2019
- Aug 2019
- Sep 2019
- Oct 2019
- Nov 2019
- Dec 2019
- Jan 2020
- Feb 2020
- Mar 2020

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- Other
- Injury, fracture
- Gastrointestinal problems
- Stress (and related illness)
- Trust Position

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### Sickness Absence by Top 5 (inc. Other)

- 2018/19
- 2019/20

---

0.00% 1.00% 2.00% 3.00% 4.00% 5.00% 6.00%

- Apr
- May
- Jun
- Jul
- Aug
- Sep
- Oct
- Nov
- Dec
- Jan
- Feb
- Mar

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**Q3 2019/20 Performance Report**

2 March 2020

Executive Lead: Hannah Foster
Total PDR compliance remains below the target 80%, though December saw a small increase from November’s 73.5% to 74.1%.

With a reported rate of 85.2% at the end of December, overall statutory and mandatory training compliance has remained stable – matching the rate at the end of Q2.

Occurrences of staff showing as status “never trained” for the statutory & mandatory competences continue to be flagged to ESR Supervisors requesting that staff complete training. Never trained levels are also monitored by the HR Business Partners as part of the PAF set of metrics.

Compliance for the core safeguarding competences remain below the 90% mark, however there has been an improvement over Q3 with the rate increasing to 89.8% by the end of December - in September the rate was 86%. CP Level 3 compliance has continued to decrease. A review of CP training took place in the Autumn to bring the training mapped to each role in line with the Trust Safeguarding Team’s guidance. Monitoring of compliance and training for these subjects is overseen by the Integrated Safeguarding Committee.

- Child Protection Level 2: 89.4% end-December from 87.5% end-September
- Child Protection Level 3: 69.5% from 75.6%
- Safeguarding Adults: 88.8% from 86.7%
A Special Board Development Day workshop was held in the Autumn to define the direction of travel for the inclusion agenda.

The Board is aware that a the Diversity and Inclusion Steering Group is currently putting together a draft emerging strategy to shape and take our future inclusion agenda forward.
**Clinical Income - Year to date**

- Overall clinical income, including private patients, is £464k adverse to budget. The Devon CCG contract is underperforming by £610k at Month 9, due mainly to elective underperformance. Outpatient and A&E activity continues to be higher than plan, although the Trust's emergency bed pressures are linked to an increase in 'Green to Go' patients rather than higher admissions, with SDEC being successful in streaming urgent care. Under the risk share agreement, the CCG can recover any underperformance which has been reflected in the year to date position. However, it is anticipated that contract income will catch up by year end and therefore no risk has been built into the forecast year end position.

- Specialised Commissioning is over recovered at month 9 by £2.6m, mostly related to high cost drugs and devices. This is before a credit note which has been raised relating to a 2018/19 underperformance of £1.0m and included within the position.

- Clinical income is forecast to over recover the budget at year end by £1.2m related to non Devon CCG activity (mainly Specialist Commissioner). This includes a net transfer of £575k relating to a movement of Services from Devon CCG to Specialist Commissioner (known as Identification Rules).

- Pay budgets are overspent by £1.5m year to date, largely related to medical agency costs associated with filling junior and middle grade rota gaps.

- Clinical Income Forecast

- Pay budgets are overspent by £1.5m year to date, largely related to medical agency costs associated with filling junior and middle grade rota gaps.

- Non Pay budgets are overspent by £4.3m mostly due to the costs of outsourced clinical activity to treat the longest waiting patients (mainly Cardiology) and overspends on clinical supplies.

- The Trust has achieved £12.0m towards its savings target of £22.0m, albeit only £5.2m on a recurrent basis. A combination of unidentified savings slippage in the delivery of the recurrent 'One Plan' benefits and the inability to include profit on disposals will leave a £7.3m shortfall to the 2019/2020 CIP plan.

- A mitigation plan is in place to address the operational position and to ensure the revised plan is delivered.
Pay was overspent by £171k in December - resulting in a year to date overspend of £1.5m (0.57%). Year to date overspends of £1.5m on medical staff, £686k on Nursing and “Other” staff (£310k) are offset with an underspend on admin & managers (£690k). Pay is forecast to overspend by £2.3m (0.71%) by year end, a deterioration in the month of £180k.

- The main cost pressure is Medical staff which is overspent by £1.5m (a deterioration of £256k in December) and forecast to be overspent by £2.1m at year end (a deterioration of £256k in the month). The year to date position mostly relates to issues within the Surgery Division (£1.3m) which are due to cover for vacancy and sickness including additional Waiting List Initiatives and Agency/Locum usage.

- Nursing has overspent by £84k in December to an overspend of £686k year to date and is forecast to overspend by £967k (an improvement of £95k in December). The year to date overspend mostly relates to the Medicine Division (£659k) to cover vacancies and 1:1 specialing requirements, some of which is due to violence and aggression experienced on the wards.

- ‘Other’ staff is overspent by £299k year to date and forecast to be £367k overspent by year end. The year to date overspend mostly relates to Radiology (£447k - agency premium) and Domestic Services (£144k - sickness related). Admin and Managers are underspent by £1.0m year to date and forecast to be underspent by £1.1m as vacancies are predicted to be filled.

Agency staffing

Year to date agency expenditure has amounted to £8.0m (£673k in December), which is under the NHS Improvement (NHSI) ceiling of £7.6m for the month (£8.7m for the year). The Trust is currently forecasting agency expenditure of £10.7m for the year, which would be an improvement for the first time this year from the £11.6m out turn for 18/19.
The CIP target for 2019/20 is £22.0m which consists of the 2019/20 target of £12.2m in addition to CIP schemes that were achieved on a non-recurrent basis in 2018/19 of £9.8m brought forward. In signing up to the challenging control total, the Board recognised that it had a £5m gap to close. It was hoped that this risk could be mitigated by flexibility in the treatment of profit on disposal of assets, which is now being excluded from control total achievement. This flexibility had been used in previous years to achieve control total.

Current Year
£12.0m of the current year target of £22.0m has been achieved with £660k has been achieved in December. There is a forecast gap of £7.3m due to challenges in releasing capacity as a result of the operational pressures. To achieve the forecast CIP of £14.7m a further £2.7m of savings schemes need to be delivered in the remaining 3 months. (£1.4m through Divisional Savings). Given the operational pressure within the Trust there is a risk that this will not be achieved.

Recurrently
Schemes totalling £5.2m have been achieved on a recurrent basis against a target of £22.0m. Plans are in place for £4.4m through Trust wide schemes with a remaining balance of £12.2m currently unidentified.

A deterioration of £1.5m in December mainly relates to:
- Drugs (£561k). This is mostly due to rechargeable drugs that are unable to be passed on to Devon CCG due to a cap on the contract (£272k) and an increase in the purchases of drugs in December (£289k).
- Misc. Operating Expenses (£448k). This relates to an increase in energy costs (£115k), Maintenance Contractors (£38k), IT Hardware and Software costs (£53k), Doctors Overseas Work permits (£28k), Training costs for Emergency Department Doctors (£28k) and other smaller variances across the Trust.
- Services Received (£354k) relates to further cardiology outsourcing (£101k), Cytogenetics outsourcing (£131k) and additional NHS PS costs invoiced (£137k).

The forecast overspend has therefore deteriorated by £1.3m.

An email to all budget holders from the Chief Finance Officer, Medical Director, Director of Operations and the Chief Nurse has been sent requesting that all non-essential/business critical expenditure is deferred until the new financial year.
Cash & Capital Expenditure

Year to Date
Cash is £11.5m higher than budget at M9. The table provides details of variances, with the key variances relating to the value of payables being £9.8m higher than the value profiled within the budget; and capital expenditure net of budgeted disposals being £13.6m lower than budget; partly offsetting these increases in cash is a deterioration in cash inflows from operating activities of £9.7m.

Forecast
Cash balances deteriorate over the remainder of the year as capital expenditure increases and, with the adverse movement in the financial forecast of £13.8m, the cash balance is forecast to reduce to £55.2m by the year end.

### Cash compared to budget

<table>
<thead>
<tr>
<th>Year to date - Month 9</th>
<th>Cash</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget</td>
</tr>
<tr>
<td></td>
<td>£m</td>
</tr>
<tr>
<td>Opening cash balance</td>
<td>82.4</td>
</tr>
<tr>
<td>Cash inflow / (outflow) from operating activities</td>
<td>6.9</td>
</tr>
<tr>
<td>Depreciation charge - non cash expense</td>
<td>9.0</td>
</tr>
<tr>
<td>Working capital movements - inventories</td>
<td>(0.7)</td>
</tr>
<tr>
<td>Working capital movements - receivables</td>
<td>10.6</td>
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<tr>
<td>Working capital movements - payables</td>
<td>(4.3)</td>
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<tr>
<td>Capital expenditure</td>
<td>(45.0)</td>
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<tr>
<td>Net interest</td>
<td>(2.7)</td>
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<tr>
<td>Loan repayments</td>
<td>(0.6)</td>
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<tr>
<td>Loan drawn down</td>
<td>8.7</td>
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<tr>
<td>PDC drawn down</td>
<td>0.0</td>
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<tr>
<td>Closing cash balance</td>
<td>64.4</td>
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### Capital expenditure

<table>
<thead>
<tr>
<th>Outturn</th>
<th>Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year to date - Month 9</td>
<td>Capital</td>
</tr>
<tr>
<td></td>
<td>Budget</td>
</tr>
<tr>
<td></td>
<td>£m</td>
</tr>
<tr>
<td>Capital expenditure</td>
<td>45.7</td>
</tr>
<tr>
<td></td>
<td>59.2</td>
</tr>
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</table>

### Year to Date
Actual capital expenditure is £14.3m lower than the budget mainly due to slippage of £7.3m on My Care, Estates schemes of £2.7m, £1.6m Laundry Dryers, £538k 4th Linear Accelerator equipment, Replacement of CT3 £750k, Energy Performance £1.0m and various small schemes making up the remaining balance. These are all forecast to be on track by year end.

Forecast
The planned capital programme for 2019/20 was £59.2m. It was acknowledged that delivering such a large capital programme would be a challenge. A review of the capital programme has been undertaken. Although project managers are generally confident that they will deliver their programmes, it is likely that there will be some slippage to the programme. The capital forecast has been lowered to £57.0m to take into account the likelihood that programme may slip by circa £2.2m.

The planned property disposal of Honeylands has been delayed, and is expected to take place late in 2019/20. Other property disposals are currently under review and are now planned for 2020/21.
The Trust has achieved a Finance and Use of Resources rating of 3 for December compared to the planned risk rating of 2. The forecast position expects a Use of Resources score of 3 compared to a plan of 1 as set out in the table on the left.

Overall rating descriptions:
1 - Providers with maximum autonomy
2 - Providers offered targeted support
3 - Providers receiving mandated support for significant concerns
4 - Special measures

- The Trust was planning to receive £10.1m of PSF and MRET income, however, is now expecting to receive £6.0m, as set out in the table below.

- Funding for PSF in 2019/20 will be received quarterly in arrears for delivering the planned year-to-date financial performance. The Trust has secured £2.2m for the first half of the year however will not receive any further funding due to the Trust financial position.

- Funding for MRET is guaranteed upon acceptance of the control total, there are no performance criteria to be met. The Trust has secured £2.9m of MRET Funding for the first nine months of the year and will receive £3.8m in full at year end, in line with plan set out below:

- The Trust has received an additional £560k PSF income which relates to a final bonus redistribution nationally of 2018/19 PSF. It cannot be used towards the 2019/20 control total.

- Divisional positions are analysed in detail on the next page.

- Divisional financial performance is reviewed at monthly performance meetings (PAF’s) and where necessary action plans are developed where overspends are being incurred.
### Surgical Services Summary

<table>
<thead>
<tr>
<th>Category</th>
<th>Year to Date Variance</th>
<th>Forecast Variance</th>
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</thead>
<tbody>
<tr>
<td>Medical</td>
<td>(Under budget)</td>
<td>(Over budget)</td>
</tr>
<tr>
<td>Surgical</td>
<td>(Over budget)</td>
<td>(Under budget)</td>
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</tbody>
</table>

### Medicine Summary

<table>
<thead>
<tr>
<th>Category</th>
<th>Year to Date Variance</th>
<th>Forecast Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>(Under budget)</td>
<td>(Over budget)</td>
</tr>
<tr>
<td>Surgical</td>
<td>(Over budget)</td>
<td>(Under budget)</td>
</tr>
</tbody>
</table>

### Surgical Services Commentary

**Overall** - Year to date the Division is £1.8m under budget and forecast to be £2.8m under budget. Confirm and challenge sessions between now and the year end have been re-initiated to ensure the necessary controls and mitigations are in place to reduce the run rate.

**Clinical Income** - Year to date income is underperforming by £30k, reducing to £30k with the inclusion of the NHS Devon capped contract adjustment. Trauma (£40k) and Plastic Surgery (£30k) are the main drivers of the adverse position. The forecast position broadly assumes that activity and income levels will continue with some exceptions where capacity is expected to increase by the end of the year for example in Ophthalmology and Urology.

**Commercial Income** - There are small favourable balances on commercial income due to non- recurrent benefits which are not expected to continue.

**Pay** - Pay is £1.3m adverse to plan at month 9 with the forecast at £1.4m. On going cost pressures relating to sickness cover, additional capacity, and cover for junior Dr vacancies continue. Overseas recruitment will improve the nursing position when their training is complete.

**Non-pay** - Non-pay is overspent by £463k which mostly relates to outsourced activity (Glance £370k).

**Reserves** - The reserves position includes CIP - this has moved adversely in month 9 by £420k as the division are no longer forecasting full CIP achievement.

### Medicine Commentary

**Overall** - Year to date the Division is £3.8m over budget and forecast to be £4.9m over budget. Confirm and challenge sessions between now and the year end have been re-initiated to ensure the necessary controls and mitigations are in place to reduce the run rate.

**Clinical Income** - Clinical income has under-performed by £2.0m year to date, which is reduced to £700k underperformance relating to the NHS Devon CCG capped contract (£2.2m). This is mostly due to ongoing underperformance in Gastroenterology (£675k due to reduced emergency activity), Dermatology (£550k due to clinician sickness and absence) and General Medicine (£365k due to pathway changes and the success of ambulatory care). It is forecast that clinical income will be £1.1m favourable by year end, driven mainly by continued over-performances in A&E and Thoracic Medicine.

**Pay** - Pay is overspent by £562k year to date which mostly relates to Medical staffing (£541k overspent) as a result of emergency bed pressures. Middle Grade pressures in the ED rota have resulted in the use of short term agency doctors, as well as the ongoing use of agency locums to cover the Neurophysiology service. Nursing is overspent by £472k due to high costs of maternity cover and pressures funding vacancies, as well as supernumerary working during the training of overseas nurses.

**Non-pay** - Non-pay is overspent by £1.7m year to date mostly due to Cardiology activity being carried out at the Nuffield (£0.5m). High levels of emergency activity are also creating overspends in Cardiology device spend within the cath labs. Non pay is forecast to end the year £2.4m overspent.

**Reserves** - CP is currently forecast to be delivered in full, both divisionally and in One Plan; although this is not without risk.
Financial Tables

Specialist Services: Year to Date and Forecast Variances to Budget

Specialist Services Commentary

Overall - year to date the Division is £2.2m under budget and forecast to be £1.6m under budget.

Clinical Income
Year to date income is £2.5m up against budget (after a NHS Devon capped contract adjustment of £221k adverse), mainly driven by Cancer Services due to activity over contract in Radiotherapy Treatments (£610k), Stem Cells (£236k), Haematology (£382k) and Interventional Radiology (£321k).

Commercial Income
Commercial income has overachieved by £271k mainly attributable to Genetics for the NHS provider-to-provider test income, which is now expected to continue at the same level.

Pay
Pay is £382k favourable due to vacancies in the first part of the year. The forecast position indicates this will deteriorate mostly due to vacancies now being filled, agency medical staffing and middle grade role issues.

Non Pay
Non pay is £1.5m adverse year to date which is forecast to continue for the remainder of the year, (£2.1m adverse).

The year to date overspend relates to Drugs (£492k - due to rechargeable drugs that are unable to be passed on to the Commissioner (£372k) and an overspend in the purchases of drugs (£120k)), services received (£463k - further Cytogenetics outsourcing), chemical & reagents (£285k) and lab equipment (£221k).

Reserves
Full CP delivery is forecast.

Community Divisional Summary

Community: Year to Date and Forecast Variances to Budget

Community Commentary

Overall - year to date the Division is £108k under budget and forecast to be £197k over budget. This reflects the delivery of CP in advance of plan. Current year savings (£654k) have been fully achieved.

Income
Clinical income is broadly on plan both year to date and forecast. The under recovery relates to out of area activity which is less than budgeted.

Pay
Pay is £365k adverse year to date and forecast to be £365k adverse at year end. Overspends on nursing are being off set by vacancies in physiotherapists. Non-business critical vacancies are being held in order to manage the financial position.

Non Pay
Non pay is £68k overspent year to date and forecast to be £68k adverse at year end. This relates mostly to telephone charges, training costs, and furniture spend which are being reviewed.

Reserves
CP has been fully achieved.
### Financial Tables

#### Royal Devon & Exeter NHS Foundation Trust

<table>
<thead>
<tr>
<th>Income Statement</th>
<th>Period ending 31/12/2019</th>
<th>December 2019</th>
<th>Year to Date</th>
<th>Outturn</th>
<th>Prior Yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>Budget</td>
<td>Varience to Budget</td>
<td>Actual</td>
<td>Budget</td>
<td>Varience to Budget</td>
</tr>
<tr>
<td>£000</td>
<td>£000</td>
<td>Fav./Adv.</td>
<td>£000</td>
<td>£000</td>
<td>Fav./Adv.</td>
</tr>
</tbody>
</table>

#### Income

- **NHS Clinical Income - NHS DEVON CCG**: £25,979 (£25,987) (8)
- **NHS Clinical Income - Other**: £9,514 (£9,676) (162)
- **Private Patient Income**: £103 (£110) (7)
- **Research and Development**: £1,512 (£1,513) (1)
- **Education and Training**: £1,135 (£1,135) (0)
- **Other Income**: £5,156 (£5,126) (30)

#### Total Income

- **43,399 (£43,547) (148)**

#### Expense

- **Employee Benefits Expenses (Pay)**: £28,965 (£28,794) (171)
- **Drug Costs**: £5,728 (£5,167) (561)
- **Clinical Supplies**: £3,991 (£3,927) (64)
- **Non Clinical Supplies**: £571 (£496) (73)
- **Research & Development Expenses**: £1,628 (£1,628) (0)
- **Misc. Other Operating Expenses**: £4,133 (£3,686) (448)
- **Services Received**: £1,137 (£783) (354)

#### Cost Improvement Programme

- **0 (813) (813)**

#### Specialist Commissioner - Quality Innovation Productivity and Prevention (QIPP)

- **0 (0) (0)**

#### Reserves / Mitigation

- **0 (0) (0)**

#### Total Costs

- **(46,153) (£46,669) (2,484)**

#### Net (Surplus|deficit) before Donated Asset & PSF/MRET Income

- **(2,325) (£2,945) (5,720)**

#### 2019/20 PSF and MRET Funding

- **(951) (951) (1,902)**

#### Net Surplus(deficit) after Donated Asset & PSF/MRET Income

- **(2,928) (£2,945) (5,720)**

#### KEY MOVEMENTS

1. Over recovery of clinical income for Haematology, Accident and Emergency, Radiology, Thoracic and Intensive Therapy Unit is offset with under recovery in the specialties of General Medicine, Nephrology, Gastroenterology, Dermatology, and Trauma.
2. Pay - overspends on Medical Staff (£1.5m), Nursing (£686k) and 'Other' staff (£310k) are offset with underruns on Admin and Managers (£1.0m).
3. Services Received is overspent due to additional costs committed to reduce the number of patients over 52 weeks waiting for treatment.
4. A 2018/19 PSF bonus (£560k) and depreciation related to donated assets are shown separately as these items are unable to be counted towards the 2019/20 financial control total target.
### Royal Devon & Exeter NHS Foundation Trust

#### Statement of Financial Position

<table>
<thead>
<tr>
<th>Period ending</th>
<th>31/12/2019</th>
<th>Month</th>
<th>09</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Assets, Non-Current</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Property, Plant and Equipment, Net (including intangibles)</td>
<td>252,924</td>
<td>266,581</td>
<td>(13,657)</td>
</tr>
<tr>
<td>Investment in joint venture</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non NHS Trade Receivables, Non-Current</td>
<td>1,282</td>
<td>1,117</td>
<td>165</td>
</tr>
</tbody>
</table>

**Total** | 254,211 | 267,703 | (13,492) |

<table>
<thead>
<tr>
<th>Assets, Current</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inventories</td>
<td>8,461</td>
<td>8,500</td>
<td>(39)</td>
</tr>
<tr>
<td>Trade and Other Receivables, Net, Current</td>
<td>32,614</td>
<td>30,738</td>
<td>1,876</td>
</tr>
<tr>
<td>Non Current Assets held for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cash</td>
<td>75,918</td>
<td>64,387</td>
<td>11,531</td>
</tr>
<tr>
<td>Other Assets - Current Assets Held by Charitable Funds</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Total** | 116,993 | 103,625 | 13,368 |

#### Year to Date

<table>
<thead>
<tr>
<th>Liabilities, Current</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Loans, non-commercial, Current (DH, FTFF, NLF, etc)</td>
<td>(2,365)</td>
<td>(1,935)</td>
<td>(430)</td>
</tr>
<tr>
<td>Finance leases - Current</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Trade and Other Payables, Current</td>
<td>(22,061)</td>
<td>(13,910)</td>
<td>(8,151)</td>
</tr>
<tr>
<td>Deferred Income, Current</td>
<td>(3,885)</td>
<td>(3,241)</td>
<td>(644)</td>
</tr>
<tr>
<td>Provisions, Current</td>
<td>(257)</td>
<td>(257)</td>
<td>0</td>
</tr>
<tr>
<td>Current Tax Payables</td>
<td>(6,857)</td>
<td>(6,700)</td>
<td>(157)</td>
</tr>
<tr>
<td>Other Financial Liabilities, Current</td>
<td>(23,775)</td>
<td>(23,097)</td>
<td>(679)</td>
</tr>
</tbody>
</table>

**Total** | (59,200) | (49,140) | (10,061) |

#### Liabilities, Non-Current

<table>
<thead>
<tr>
<th>Liabilities, Non-Current</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Loans, Non-Current, non-commercial (DH, FTFF, NLF, etc)</td>
<td>(59,621)</td>
<td>(60,615)</td>
<td>994</td>
</tr>
<tr>
<td>Deferred income - Non-current</td>
<td>(2,139)</td>
<td>(2,139)</td>
<td>0</td>
</tr>
<tr>
<td>Other Creditors, Non-Current</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Provisions, Non-Current</td>
<td>(325)</td>
<td>(344)</td>
<td>19</td>
</tr>
</tbody>
</table>

**Total** | 249,919 | 259,090 | (9,172) |

#### Assets Employed

| Assets Employed | 259,090 | (9,172) |

#### Tax Payers' Equity

<table>
<thead>
<tr>
<th>Tax Payers' Equity</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Public dividend capital</td>
<td>157,531</td>
<td>157,531</td>
<td>0</td>
</tr>
<tr>
<td>Retained Earnings (Accumulated Losses)</td>
<td>44,921</td>
<td>53,574</td>
<td>(8,653)</td>
</tr>
<tr>
<td>Charitable Funds</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Revaluation Reserve</td>
<td>47,467</td>
<td>47,985</td>
<td>(518)</td>
</tr>
<tr>
<td>Donated Asset Reserve</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Total** | 249,919 | 259,090 | (9,172) |

#### Prior Yr

**## Financial Tables**

#### TAX PAYERS' EQUITY

| Tax Payers' Equity | 259,090 | (9,172) |

#### Prior Yr

**## Financial Tables**

**3. Trade and other payables are £1.5m higher than budget.** The cash flow statement provides greater analysis of the key variances.

**4. Trade and other payables are £2.0m higher than budget.** Cash is £11.5m higher than budget. The cash flow statement provides greater analysis of the key variances.

**5. Trade and other payables are £1.9m higher than budget.** NHS Trade Receivables are £0.7m lower than budget, mostly relating to an improvement in the recovery of NHS receivables, offset by the inclusion of income due from SDFT in respect of the Children and Young Peoples Alliance. Accrued income is £1.8m higher than budget, including £1.5m relating to University of Exeter Income refurbishment costs not yet invoiced, and £0.8m relating to BCF / iBCF income not yet invoiced.

**6. Prepayments are £1m higher than budget, due to the phasing of the budget.**
### Royal Devon & Exeter NHS Foundation Trust

#### Financial Tables

<table>
<thead>
<tr>
<th>Monthly Period Ending 31/12/2019</th>
<th>Year to Date</th>
<th>Outturn</th>
<th>Mar-19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Actual</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td></td>
<td>Variance</td>
<td></td>
<td>Variance</td>
</tr>
<tr>
<td></td>
<td>to Budget</td>
<td></td>
<td>to Plan</td>
</tr>
<tr>
<td></td>
<td>Fav./Adv.</td>
<td></td>
<td>Fav./Adv.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CASH FLOW STATEMENT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NET CASH INFLOW (OUTFLOW) FROM OPERATING ACTIVITIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surplus/(deficit) after tax</td>
<td>(6,648)</td>
<td>2,531</td>
<td>(5,903)</td>
</tr>
<tr>
<td>Non-cash flows in operating surplus/(deficit)</td>
<td>0</td>
<td>(30,695)</td>
<td>0</td>
</tr>
<tr>
<td>Finance (income)/charges</td>
<td>(129)</td>
<td>92</td>
<td>141</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>9,104</td>
<td>9,024</td>
<td>12,131</td>
</tr>
<tr>
<td>Impairment</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PDC dividend expense</td>
<td>4,007</td>
<td>4,367</td>
<td>5,342</td>
</tr>
<tr>
<td>Other increases/(decreases) to reconcile to profit/(loss) from operations</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other recognised gains/losses straight to reserves</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-cash flows in operating surplus/(deficit), Total</td>
<td>12,862</td>
<td>13,412</td>
<td>17,333</td>
</tr>
<tr>
<td><strong>Increase/(Decrease) in working capital</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Increase)/decrease in inventories</td>
<td>(689)</td>
<td>(725)</td>
<td>(672)</td>
</tr>
<tr>
<td>(Increase)/decrease in NHSD Trade Receivables</td>
<td>13,550</td>
<td>12,840</td>
<td>12,880</td>
</tr>
<tr>
<td>(Increase)/decrease in Non NHSD Trade Receivables</td>
<td>402</td>
<td>72</td>
<td>72</td>
</tr>
<tr>
<td>(Increase)/decrease in other receivables</td>
<td>422</td>
<td>613</td>
<td>845</td>
</tr>
<tr>
<td>(Increase)/decrease in accrued income</td>
<td>(2,169)</td>
<td>(4,11)</td>
<td>(1,757)</td>
</tr>
<tr>
<td>(Increase)/decrease in trade payables</td>
<td>(3,489)</td>
<td>(2,519)</td>
<td>(2,159)</td>
</tr>
<tr>
<td>(Increase)/decrease in dividends received</td>
<td>1,555</td>
<td>588</td>
<td>544</td>
</tr>
<tr>
<td>(Increase)/decrease in working capital, Total</td>
<td>12,865</td>
<td>6,867</td>
<td>6,976</td>
</tr>
<tr>
<td><strong>Net cash inflow/outflow from investing activities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property - new land, buildings or dwellings</td>
<td>(31,377)</td>
<td>(45,725)</td>
<td>(45,725)</td>
</tr>
<tr>
<td>Property - maintenance expenditure</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Plant and equipment - Information Technology</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Plant and equipment - Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Proceeds on disposal of property, plant and equipment</td>
<td>0</td>
<td>774</td>
<td>777</td>
</tr>
<tr>
<td>Increase in Capital Creditors</td>
<td>682</td>
<td>(1,319)</td>
<td>1,981</td>
</tr>
<tr>
<td>Other cash flows from financing activities</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net cash inflow/outflow from investing activities, Total</td>
<td>(30,695)</td>
<td>(46,270)</td>
<td>(46,270)</td>
</tr>
<tr>
<td><strong>Net cash inflow/outflow from financing activities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PDC Dividends paid</td>
<td>(2,639)</td>
<td>(2,656)</td>
<td>(2,650)</td>
</tr>
<tr>
<td>PDC Dividend Received</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Interest (paid) on non-commercial loans</td>
<td>(274)</td>
<td>(397)</td>
<td>(124)</td>
</tr>
<tr>
<td>Interest received on cash and cash equivalents</td>
<td>526</td>
<td>315</td>
<td>211</td>
</tr>
<tr>
<td>Repayment of non-commercial loans</td>
<td>(636)</td>
<td>(636)</td>
<td>(635)</td>
</tr>
<tr>
<td>Receipt of finance leases and loans</td>
<td>8,133</td>
<td>8,739</td>
<td>8,739</td>
</tr>
<tr>
<td>(Increase)/decrease in non-current receivables</td>
<td>129</td>
<td>36</td>
<td>36</td>
</tr>
<tr>
<td>Increase in non-current payables</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net cash inflow/outflow from financing activities, Total</td>
<td>4,381</td>
<td>5,406</td>
<td>5,349</td>
</tr>
<tr>
<td><strong>Net increase/(decrease) in cash and cash equivalents</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net increase/(decrease) in cash and cash equivalents</td>
<td>(6,525)</td>
<td>(18,054)</td>
<td>(11,529)</td>
</tr>
<tr>
<td>Opening cash and cash equivalents</td>
<td>82,440</td>
<td>82,440</td>
<td>82,440</td>
</tr>
<tr>
<td>Closing cash and cash equivalents</td>
<td>75,915</td>
<td>64,386</td>
<td>60,994</td>
</tr>
</tbody>
</table>

*Actuals are as at 31/12/2019*
## Capital Expenditure

Period ending: 30/12/2019

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Approval level</th>
<th>YTD actual expenditure</th>
<th>YTD planned expenditure per annual plan</th>
<th>YTD variance (expenditure / (over/underspend))</th>
<th>Full year expenditure per annual plan</th>
<th>19/20 forecast expenditure per annual plan</th>
<th>Forecast total capital expenditure for the year</th>
<th>Forecast total capital expenditure for the year (B + F)</th>
<th>YTD variance (slippage / (overspend))</th>
<th>Forecast future capital expenditure for the year</th>
<th>Expected completion date</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Care</td>
<td>FBC</td>
<td>£12,161</td>
<td>£19,453</td>
<td>£7,292</td>
<td>£14,239</td>
<td>£26,400</td>
<td>£23,918</td>
<td>( £2,482)</td>
<td>£51,570</td>
<td>£56,029</td>
<td>( £4,459)</td>
</tr>
<tr>
<td>Energy Improvements</td>
<td>OBC</td>
<td>£2,287</td>
<td>£3,314</td>
<td>£1,028</td>
<td>£1,799</td>
<td>£4,086</td>
<td>£4,032</td>
<td>(54)</td>
<td>£6,927</td>
<td>7,751</td>
<td>(824)</td>
</tr>
<tr>
<td>Estates Infrastructure 19/20</td>
<td>CRIC</td>
<td>£1,883</td>
<td>£2,027</td>
<td>£144</td>
<td>£2,465</td>
<td>£4,348</td>
<td>£4,110</td>
<td>(238)</td>
<td>£4,500</td>
<td>4,500</td>
<td>0</td>
</tr>
<tr>
<td>Deck Car Park</td>
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Summary by Planning Status

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<td>Predicted Health &amp; Social Care direct recruitment to start (based on previous 18 month average)</td>
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<td>Predicted internal conversion from HCAs via IELTS and OSCES (33 identified to date)</td>
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<td>Predicted sponsorships/ internal conversion from band 4 to 5 (7 in Sept 2018 plus 12 in Sept 2019)</td>
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<td>Opening Balance - from previous month actual vacancies</td>
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<td>PLANNED GENERIC RECRUITMENT DAYS</td>
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**Please note - not all vacancies identified as a shortfall in establishment will be recruited to**

### Band 6 Nursing Bank/Agency Usage

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<td>Registered Nursing Bank/Agency Usage</td>
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**Predicted position**

**Actuals**

**Impact of increased recruitment being approved**