Northern Devon Healthcare NHS Trust

Incorporating community services in Exeter, East and Mid Devon

Northern Devon Healthcare NHS Trust operational plan 2016/17

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The purpose of this document is to set out the Trust's operational plan for the financial year 2016/17 including its approach to activity, quality, workforce and financial planning as well as to its emerging plans as part of the wider Success Regime and Sustainability and Transformation Plan.

VERSION HISTORY

Version	Date Issued	Brief Summary of Change	Owner's Name
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NORTHERN DEVON HEALTHCARE NHS TRUST OPERATIONAL PLAN 2016/17

This One Year Operational Plan sets out the Northern Devon Healthcare Trust's plan for the financial year 2016/17 including its approach to activity, quality, workforce and financial planning as well as to its emerging plans as part of the wider Success Regime and Sustainability and Transformation Plan. The latter system-wide challenges identified during the engagement and planning processes have informed this 2016/17 Operational Plan for Northern Devon Healthcare NHS Trust (NDHT).

1. Context

1.1. NEW Devon Success Regime

In 2015, the Success Regime was established in North, East and West Devon to provide external support to help the health and social care organisations in Devon work together to tackle the significant clinical and financial threats to sustainability. All of the local NHS organisations, and local authorities are committed to working as a system to deliver system-wide improvements.

Following a thorough analysis of all of the clinical and financial information across Devon, we published a 'Case for Change' in February 2016(1). This identified that if no action is taken, Devon's health and social care system will be in £440million of debt by 2020 and patients will not be able to access the high-quality services they deserve.

The organisations within the Devon Success Regime are working well together, demonstrating the requirements set out by the STP guidance in developing system-wide plans through iterative engagement. This work is supported by Carnall Farrar and has identified significant operational and transformational change that can (i) be implemented in 2016/17 in order to deliver each organisation's in-year targets, and (ii) deliver a sustainable future for the system over the next two to three years.

1.2. Success Regime priorities for 2016/17

The Case for Change presents twenty transformation opportunities for NEW Devon which will be incorporated into the Sustainability and Transformation Plan (STP) and see the transformation of care in Devon by 2020.

There is system-wide agreement that whilst these longer term transformational workstreams are being developed, there are five areas of priority which each organisation in Devon will focus on in 2016/17:

- **Priority 1:** Bed based care – reduction in length of stay in acute and community hospitals and a subsequent reduction in bed based capacity
- **Priority 2:** Elective care – reduce the differences in the levels of elective (planned care) through a review of referral and conversion rates

- **Priority 3:** Continuing care – optimise the amount of money being spent on continuing care through close management of eligibility criteria
- **Priority 4:** Procurement – Joint procurement of clinical and non-clinical supplies through collaborative working across providers
- **Priority 5:** Agency spend: reduction in spending on agency staff through developing better processes for recruitment and deployment of staff

The 2016/17 operational plan for NDHT supports these priorities.

1.3. Sustainability and Transformation Plan (STP)

Sustainability and Transformation Plans (STPs) are place-based, multi-year plans built around the needs of local populations. They will help ensure that the investment secured in the Spending Review is used to drive a genuine and sustainable transformation in patient experience and health outcomes over the longer-term rather than a short-term measure to mask structural unsustainabilities.

The constitution of the NEW Devon Success Regime is helping Devon's organisations deliver an STP plan which sees organisations and leaders working together and leaving organisational interests and boundaries to one side. Success depends on having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards.

As a truly place-based plan, the STPs must cover all areas of CCG and NHS England commissioned activity including: (i) specialised services, where the planning will be led from the 10 collaborative commissioning hubs; and (ii) primary medical care, and do so from a local CCG perspective, irrespective of delegation arrangements. The STP must also cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.

STPs will be delivered by local health and care systems or 'footprints': organisations working together to deliver transformation and sustainability. The local STP footprint includes NEW Devon and South Devon and Torbay. The strategic priorities for Devon's STP are:

- Health improvement through reducing health inequalities and differences in life expectancy between the least deprived and most deprived communities
- Delivering services that are designed around people and communities, not patients and organisations
- Significantly improving service delivery and productivity through reducing reliance on bed-based care, reducing LOS where bed-based care is necessary and providing much more integrated placed-based care
- Improving the effectiveness of care and outcomes for people with mental illness
- Improving services for the elderly and those with multiple long-term conditions
- Developing a safe, accessible, sustainable and affordable service delivery model for the people of Devon

NDHT representatives are playing a full part in delivering the work of the Success Regime and the development of the Devon-wide STP in accordance with the principles detailed above. The content of the one-year operational plan is consistent with the workstreams identified through the Success Regime which will ultimately form the content of the STP.

1.4. PLACE-based approaches to care

The approach that the Success Regime has adopted is essentially a place-based system of care (as set out by the King's Fund in November 2015). NDHT had already recognised that making progress in our challenging environment depends on changing the way commissioners, providers and communities work together as a local health and wellbeing economy to govern the common resources available for meeting their population's health needs.

NDHT has been supporting the piloting of a place-based system of care with One Ilfracombe which went live in April 2013. As has been demonstrated by the One Ilfracombe pilot, the strength comes from a partnership between all those involved a person's wellbeing including the wider determinants of health such as housing, employment and education and involving people in the health of their communities. It has demonstrated the value of a unified proposition led from the bottom up, but we have learnt that this also requires a supporting structure that organisations have agreed strategically. Therefore in 2016/17 we will be working together with our partners to develop "One Northern Devon".

This will allow the benefits that have been seen in Ilfracombe to be expanded into the other communities in Northern Devon who are considering using the principles to develop their own 'One' teams.

2. Trust's vision and strategic objectives

NDHT has revised its Vision and Strategic Objectives to align with NEW Devon emergent thinking of the Success Regime.

Our vision:

Delivering high quality and sustainable services that support your health and wellbeing.

Our strategic objectives:

We will deliver **high quality** care measured by effectiveness, safety and the person's experience of care.

We will ensure access to a **sustainable** range of services that are delivered locally through partnerships and networks.

People will tell their story only once. We will deliver **integrated health and social care**, seamlessly to meet the needs of individuals.

We will recruit and develop a flexible, fulfilled and multi-skilled **workforce** fully engaged in turning our vision into a reality.

We will **efficiently and effectively** run our services to benefit our local communities.

We will work in partnership with stakeholders to **promote independence and well-being**.

We will support **individuals and communities to have more influence** over how services are delivered and encourage others to do likewise.

In line with the Success Regime's approach, our mission statement is to focus on improving:

- Population health
- People's experience of care
- The cost per person

3. Our strategies

Having articulated the origin of the 2016/17 priorities, section three will articulate the service reconfiguration that will take place, the benefits to patients, the impact on our capacity and activity and how these strategies translate through to workforce, constitutional performance and finance.

All of our activity supports our over-arching strategies of:

- Improved integration and co-ordination both within our services, and with other agencies
- Taking a place-based approach to the commissioning and delivery of services
- Shifting resource from acute care to out-of-hospital care
- Operational efficiency and effective resource utilisation

Our approach has been to take the five identified system-wide priority areas for 2016/17 (Bed based care, Elective care, Continuing care, Procurement and Agency spend) and develop a response for NDHT which helps us meets our NHS constitutional and contractual requirements (waiting times, A&E type 1 performance, cancer targets and so on).

The sections below identify and summarise the transformation projects that NDHT will develop in response to these five priorities.

3.1. Delivery strategies

Priority 1: Bed-based care

We will continue to build on our excellent progress in embedding the "Breaking the Cycle" initiative, which is based on ECIP's Perfect Week methodology, but which has grown into something very unique. The Trust has developed and enhanced the methodology to suit our challenges and the initiative has now become fully embedded within the organisation. We believe that efficiencies gained through this process will result in the Trust requiring fewer acute and community beds. Specific activities in this area include:

- Establish an Emergency Assessment Unit function at NDDH to include frailty, ambulatory care and older person's rapid access to diagnostics
- Participate in a review of stroke services across Devon with an initial aim of repatriating the Stroke Rehabilitation Unit to NDDH to support co-location with acute stroke services
- Increase in community management and assessment of patients

Impact on 2106/17 Plans

- Reduction in admitted activity and length of stay
- Reduction in the number of beds on the acute site and in community hospitals
- Associated reduction in headcount and need for workforce transformation to support Out of Hospital care
- Shift acute-based therapy workforce to out of hospital settings
- Optimised stroke pathway

Priority 2: Elective care

We currently have 3,000 patients on the overdue follow-up pending list and are already taking steps to address this. A steering group has been set up with GPs to discuss creative ways to address this issue. Some specialties are already seeing reduced referral activity. The Trust will:

- Support the development of risk stratification of follow-up appointments
- Implementation of advice and guidance for primary care
- Increase in non-face to face appointments
- Implementation of the Electronic Health Record to optimise process & pathways improvements
- Apply Right Care methodology & implementation (see below for more information)

Impact on 2106/17 Plans

- Reduction in consultant sessions
- Shift activity from consultant to CNS
- Shift to primary care for management of patients with LTCs
- Reduction in administrative workforce
- Optimised clinical pathways

Priority 3: Continuing care

Our focus in this area will be ensuring that patients are assessed in their home, not in hospital when they are often at their weakest and disorientated. Our focus in this area is to:

- Develop discharge to assess methodology
- Enhance enablement in out in and out of hospital settings to reduce institutional placement and high cost PoCs
- Explore how domiciliary care can support CHC objectives (see information on link with Devon Cares)

Impact on 2106/17 Plans

- Reduction in length of stay and subsequent number of beds
- Reduction in institutional placements and complex packages of care
- Workforce transformation to support out of hospital care

Priority 4: Procurement

The Trust is a member on the South West PPSA procurement collaborative and is achieving procurement savings. The Bravo system has been purchased to secure further opportunities and benefits to drive down price and reduce unwarranted variation through both clinical engagement and collaboration.

- Establishment of a clinical opportunities forum
- Identify a medical and surgical clinical lead to support procurement opportunities
- Work collaboratively across the SR footprint to implement best practice and realise best value
- Report and share data on prices paid for the top 100 most common non-pay items to only pay the best price available for the NHS as required.

Impact on 2106/17 Plans

- Reductions in waste & variation

Priority 5: Agency spend

Considerable progress has been made in the reduction of agency spend since action was taken to address agency spend in 2015/16. This will continue in 2016/17:

- Review of existing staff rotas in line with national guidance
- Roll out e-rostering to community-based services
- Review of SLA arrangements
- Peninsula-wide standardisation

Impact on 2106/17 Plans

- Reduction in agency prevalence
- Requirement to work collaboratively with other providers to develop new models of care

Implementation of these schemes and the anticipated impact will support the delivery of the key constitutional standards (4-hour flow target, RTT and cancer) in 2016/17 through a

reduction in the demand for inpatient placement, reduction in length of stay, reduced number of delayed transfers of care and lower level of referrals for elective care.

There are a number of additional strategies which are linked to or partially within the five priority areas. The following narrative describes how these additional plans will impact on NDHT's activity, capacity and demand. They are as follows:

Improved integration: domiciliary care service development

NDHT has been awarded a contract by Devon County Council to undertake the Prime Contractor role for the provision of regulated domiciliary care services across Northern and Mid Devon (Zones 1, 2 and 3). NDHT is one of the first NHS Trusts to enter the domiciliary care market and the planned launch date is July 2016.

The turnover of the contract across the county is in the region of £36mover 3 years with a total additional contribution to Trust overheads of £0.3m per annum reflected in the plan.

NDHT's role will be to lead the brokerage, monitoring, invoicing and payment, performance management and strategic development of the service. It will not directly provide care and has formed an alliance with existing providers in the awarded zones to offer a package that will:

- Provide a sustainable solution which supports the local domiciliary care market – both in terms of cost and workforce
- Improve the timeliness of response to the delivery of new packages of care
- Improve substantially the current 'fill-rate' of packages
- Offer a career route for care staff through NDHT's Care Academy
- Offer Emergency Cover Teams to ensure 100% fill-rate of packages of care
- Provide a platform for deeper integration between health and social care
- Co-ordinate and promote continuous quality improvement between NHS and domiciliary care
- NHS-delivered specialist training to domiciliary care providers
- Improve the overall quality of care provided in the home

The service will be managed through a Locality Management Board on which NDHT, lead care providers and representatives from the acute and community services provider will sit, leading the development and quality assurance of the service.

The service will offer significant benefits to the Northern system through the reduction in numbers of patients staying in hospital because they are waiting for packages of care. In addition, with over 14,000 hours of face-to-face contact delivered to in excess of 1,318 people per week, there is the very real opportunity to develop the role of individual carers – providing early warning of possible deterioration enabling enhanced care to be delivered in the home, thus preventing admissions through proactive intervention.

In Zone 3, where the acute interface is with the RD&E, the Trust will seek to develop an enhanced offer to the RD&E that would improve on the existing standards for the timeliness of package delivery.

Transfer of Eastern community services and assets (TCS)

A material transaction will take place in 2016/17 involving the transfer of direct service provision and costs to the Royal Devon & Exeter NHSFT.

In addition a significant element of estate will transfer to either NHS Property Services or Royal Devon & Exeter NHS Foundation Trust relating to these services.

Lord Carter's provider productivity work programme

The Trust has engaged with the process and has a project plan that has been presented to the Board that will be monitored on an on-going basis through the Trust's PMO and other internal assurance routes to demonstrate achievement against these opportunities against national milestones.

The key focus is on:

- Reducing agency expenditure;
- Achieving procurement savings through procurement; and
- Optimising estate utilisation opportunities.

4 Financial Planning

NDHT's financial model to support our One Year Operational Plan sees resources moving from acute and community hospital-based care to out-of-hospital care. This model is consistent with the established national policies and direction of travel and continues to deliver year on year efficiency and productivity gains.

We are confident this strategy will deliver sustainable and high quality services from our recent experience of transforming community services in the northern and eastern locality which successfully delivered:

- Reduced overheads to protect front-line services
- Transformed community inpatient services – in line with CCG commissioning specifications - to incorporate safer staffing (nurse to patient ratios) and eradicate lone-working RGNs to create more resilient inpatient units
- Reduced 25 community and 12 acute beds in the northern locality whilst maintaining our patient flow at NDDH and enhancing the capacity and capability of our out of hospital services delivered in/near the patients' home

We will continue to progress opportunities that focus on prevention and admissions avoidance by enhancing our out of hospital models. These result in more efficient service delivery, reduce the cost of delivery and achieve more effective health outcomes.

4.1. Achieving a retained surplus in 2016/17

The Trust's forecast for 2015/16 was a deficit of £4.7m, which occurred for a number of reasons. Control measures were implemented to mitigate income risk from the commissioner's approach to contract compliance, and to reduce expenditure, particularly on agency staff.

4.2. Financial objectives

The Trust's financial plan for 2016/17 is a surplus control total of £1.4m that is consistent with the regulators' expectation and assumes the recurrent receipt of £3.7m from the System Transformation Fund by achieving all operational standards and a £0.5m planning contingency.

The full bridge analysis is set out below:

2016/17 Source and Application of Funds Review Summary	Total				Total	
	Income £000s	Expenditure Pay £000s	Expenditure Non Pay £000s	Total £000s	Recurrent £000s	Non Recurrent £000s
Adjusted Surplus/(Deficit) 15/16	**233,103**	**(159,548)**	**(78,202)**	**(4,647)**	**853**	**(5,500)**
Add back non recurring:						
Non recurrent B/fwd impact of non delivery of recurring prior year efficiencies		(1,187)	(1,050)	(2,237)	0	(2,237)
Financial sanctions including penalties	200			200	0	200
Full year effect of prior year service changes	0	8,579	1,050	9,629	0	9,629
Other non recurrent income / expenditure effects	(2,092)	0	0	(2,092)	0	(2,092)
Non-recurring adjustment to underlying	**(1,892)**	**7,392**	**0**	**5,500**	**0**	**5,500**
Underlying 15/16	**231,211**	**(152,156)**	**(78,202)**	**853**	**853**	**0**
Show full year effect:						
FYE of prior year efficiencies	0	856	1,381	2,237	2,237	0
Full year effect of prior year service changes	476	(4,883)	0	(4,407)	(4,407)	0
FYE adjustment to underlying	**476**	**(4,027)**	**1,381**	**(2,170)**	**(2,170)**	**0**
Adjusted Underlying 15/16	**231,687**	**(156,183)**	**(76,821)**	**(1,317)**	**(1,317)**	**0**
Efficiency movements 16/17:						
Efficiency programme	60	8,119	2,938	11,117	11,117	0
Efficiency in tariff	(3,043)			(3,043)	(3,043)	0
Gross Commissioner efficiency (QIPP reductions in excess of tariff deflator)	(3,087)			(3,087)	(3,087)	0
Efficiency movements 16/17:	**(6,070)**	**8,119**	**2,938**	**4,987**	**4,987**	**0**
Other Changes for 2016/17:						
Inflationary Uplift	5,548			5,548	5,548	0
Pay inflation costs		(4,917)		(4,917)	(4,917)	0
Non Pay inflation costs	0		(2,414)	(2,414)	(2,414)	0
Volume changes (relating to prescribed specialised services volume changes excluding the price effect of any gain and loss sharing)	49	0	0	49	49	0
Volume changes (relating to other continuing services) - Row 3	1,965	(696)	(300)	969	969	0
Marginal Rate emergency tariff deduction	(37)			(37)	(37)	0
Emergency Re-Admissions	(35)			(35)	(35)	0
Change in exp CQUIN income / investment to deliver CQUIN	(860)	0	0	(860)	(860)	0
Service Changes - Row 1	(42,865)	33,845	5,367	(3,653)	(3,653)	0
Pass throughs - drugs and devices excluded from the tariff	1,819		0	1,819	1,819	0
Education & Training	(913)	0	0	(913)	(913)	0
Contingency		0	(1,723)	(1,723)	0	(1,723)
Change to Non EBITDA spend		0	4,141	4,141	4,141	0
Sustainability and Transformation Fund	3,700			3,700	0	3,700
Other Changes	(3,944)	0	0	(3,944)	(3,944)	0
Other Changes for 16/17:	**(35,573)**	**28,232**	**5,071**	**(2,270)**	**(4,247)**	**1,977**
Closing Adjusted Surplus/(Deficit) 16/17	**190,044**	**(119,832)**	**(68,812)**	**1,400**	**(577)**	**1,977**
Remove non recurring income/expenditure	**(3,700)**	**0**	**1,723**	**(1,977)**	**0**	**(1,977)**
Closing Underlying Surplus/(Deficit) 16/17	**186,344**	**(119,832)**	**(67,089)**	**(577)**	**(577)**	**0**

4.3. Transfer of Eastern community services and assets (TCS)

A material transaction will take place in 2016/17 involving the transfer of c.£52m full year effect (£43.3m part year) of direct service provision and costs to the Royal Devon & Exeter NHSFT.

In addition it is likely that a significant element of estate (c.£66m) will transfer to either NHS Property Services or Royal Devon & Exeter NHS Foundation Trust relating to these services. This has reduced impairments by £1m and depreciation and PDC by c.£3.6m.

The final plan includes the best assessment of the operational and workforce position on the Trust.

4.4. Efficiency savings for 2016/17

The financial plan sets an efficiency requirement of £11.1m (5.9% of total income) against the national efficiency indicator of 2%.

As set out in the plan, the development and delivery of the 2016/17 efficiency savings programmes has focused on cost reduction rather than income growth, whilst recognising transparent tariff premia attributable to specific commissioner-requested services such as A&E and maternity services that are underpinned by joint adherence to Monitor's 'Guidance on Locally Determined Prices'.

The planned efficiency savings deliverable in 2016/17 is a combination of:

- Full-year effect of 2015/16 cost-saving schemes (including the recurrent reduction of community hospital inpatient beds)
- Previously identified internal cost reduction opportunities e.g. Energy Performance Contract, EHR
- Productivity opportunities by streamlining patient pathways
- Productivity opportunities by reducing duplication and hand-off and increasing enhanced care co-ordination in community-based services
- Procuring a Managed Equipment Service for Pathology facilitating recurrent cost reductions and modernising the future staffing of blood sciences
- Completion of the Electronic Healthcare Record (capital programme) and the realisation of business case benefits
- Workforce and establishment reviews that maintain agency rules whilst reducing agency expenditure
- Opportunities afforded by Lord Carter's provider productivity work programme
- Local opportunities from 'Success Regime' cost reduction themes set out above:
    - Elective Care
    - Urgent Care
    - Continuing Care
    - Agency expenditure
    - Procurement

The financial plan is within the requirements of the Trust's notified agency cap.

4.5. Capital planning

Due to a material transaction taking place in 2016/17 that will involve the transfer of 12 community hospitals to another provider, the Trust is re-prioritising its capital programme with a focus on:

- Developments that enable delivery of the Trust's savings programme
- The on-going investment in the Electronic Healthcare Record project
- Continuing with the Energy Performance Contract – a £3.4 million project which will save £750K each year
- The refurbishment of the physiotherapy department
- There is also the on-going need to invest in replacing old equipment as well as urgent maintenance to buildings (replacing lifts, generators, repairs to roof etc.)

The full impact of the TCS asset transfer is reflected in this draft plan.

4.6. Estate utilisation

The Success Regime is undertaking a review of its estate and other fixed assets, and has identified significant scope for improving utilisation or release, which could generate system savings of c£20m.

Within NDHT, the facilities team continually reviews the utilisation of the Trust's estate. An annual assessment is carried out and this is fed into the Estates Strategy. The current Estates Strategy is due for ratification by the Trust Board in April 2016 and the key part of our action plan is to ensure effective utilisation across all sites.

Future estates strategies will be influenced by the transformation workstreams in elective – the impact of reducing outpatients and follow-up activity as well as theatre capacity as well as length of stay – by reducing the number of beds required across the system.

Opportunities will also be reviewed regarding site disposals as part of this strategy to fund the future capital programme.

4.7. Risk

It has been identified that there is a surplus that would be attributable to the total Eastern services. The Trust's plan assumes the transfer of TCS services at cost as detailed in 5.6 above. Should a different view be taken by NEW Devon CCG there is a potential risk for income to reduce by £8m.

5 How NDHT is going to achieve its objectives:

6 Approach to Activity Planning

NDHT's operational teams focus on the following performance measurements:

- Referral to treatment standard (RTT
- Cancer standards
- 4 hours A&E standard
- Diagnostic standard

6.1. Activity planning methodology

NDHT has worked closely and openly with its main commissioner, NEW Devon CCG, on all aspects of activity planning. Trust planning is led by operational teams with support from the finance and performance teams, undertaking an iterative process to agree baselines, quantify growth and service changes and validate the final results. As operational teams plan on a "Trust total" basis, this approach has been agreed with NEW Devon and then checked with smaller commissioners (NHSE, Kernow CCG and Somerset CCG). The exception has been where significant service areas are commissioned by NHSE, in which case the agreement has been with them.

Whilst commissioners and providers use different activity planning models, they all follow the same methodology. Apparent differences in results between organisations are discussed and iterated, which aids mutual understanding and eventual alignment of the final plan. Financial implications are explicitly excluded at this stage in order to focus on developing accurate plans based on the current status quo. This allows for an honest joint-assessment of the activity challenge, to which financial consequences can be applied. This forms the basis of the on-going work being undertaken under the direction of the Success Regime mentioned above.

Community services

Initial plans for community services use the same methodology as acute services. It is widely recognised, as part of the Success Regime work, that investment will be required in non-acute settings (hospital and out of hospital settings), in order to deliver the scale of change required to deliver a sustainable model of care for Devon. As yet, the level of investment and service specifications required is still work in progress, but the planning process covers the full system, rather than having separate discussions around community and acute, to ensure consistency and interaction between different care settings.

Timeline

Whatever the outcome of the Success Regime work, it is incumbent on trusts to make efficient and effective use of their resources. Therefore, following a delay in obtaining data due to information resource issues, NDHT has begun the capacity and demand review process using the IMAS suite of tools as recommended by NHS Improvement. The first data sets are being put together in April 2016 for the first ten specialties identified as priority for review, starting with ophthalmology.

This review programme will inform updating of consultant job plans during 2016/17 and will ensure that NDHT configures services and plans its whole workforce in a way that responds to the Carter challenge and meets the system capacity requirements that will be set by the whole system work. The review will also enable early work as part of the wider planning process to develop the 17/18 Indicative Activity Plan.

Growth rates

The Trust uses growth rates provided by the DCC public health team to begin discussions with operational teams. These are provided alongside two years of historic local growth data for comparison. For outpatient and elective activity, growth is based on referrals/demand, while non-elective and emergency activity (including A&E) is based on historic activity trends and demographic growth. The Trust view is then compared to commissioner growth rates, and discussions held to align the organisational perspectives and eventually confirm the agreed growth figure to be used.

Independent sector

As the Trust believes it has the capacity to deliver the commissioner's requirements, there are currently no plans to utilise independent sector capacity. In any event, the past uptake of any independent sector treatment provision amongst the NDHT catchment area has been very small, and while the Trust would always consider becoming involved in any future exercises should it become necessary, in practice, patients are reluctant to travel longer distances for treatment away from Northern Devon.

6.2. Referral to treatment (RTT) standard

NDHT has a record of consistently meeting RTT standards at a provider level and for the majority of specialties. Activity required to deliver the RTT incomplete target is closely monitored through weekly operational meetings with key divisional staff. Areas that are currently not meeting, or at risk of not meeting this standard are required to demonstrate how they will recover back to the 92% target as part of the discussions and agreement of 2016/17 plans. Discussions with commissioners have also taken place to ensure transparency and demonstrate the appropriate level of activity reflected in the agreed IAP.

RTT key risks

- Impact of junior doctors' industrial action
- Theatre capacity in certain specialties
- Specialties with lower volumes

- Impact of fluctuations in demand in the cancer specialties particularly as a consequence of national campaigns
- Urgent care and emergency activity pressures
- Increasing numbers of long term condition patients requiring ongoing follow-up and care in accordance with NICE Guidance

RTT mitigating actions

- Weekly operational meetings with divisional teams
- Detailed demand and capacity planning linked to consultant job plans and workforce planning
- Theatre utilisation
- Success Regime elective workstream 2016/17 and "Right Care"
- Robust divisional management of patient level pathways
- Transfer of work from consultant to clinical nurse specialist
- Development of new non-medical pathways of care management

During 2016/17 NDHT will begin implementing its EHR Project with the first wave of TrakCare going live in July 2016. This may impact on RTT reporting.

6.3. Cancer Standards

NDHT has in place a Cancer Action Plan and, under the 2015/16 NHS Standard Contract, a Remedial Action Plan (RAP) agreed with its CCG Commissioners. The RAP actions are almost complete.

Cancer standards are monitored weekly through meetings with key divisional staff, and performance has improved to deliver all major targets as at December 2015. The Cancer Team works closely with service teams to plan for known predicted increases in demand (e.g. through national awareness campaigns), which are built into the Demand and Capacity Plan.

Cancer standards key risks

- Specialties with low patient numbers
- Patient choice
- Shared pathways
- Dependency on shared services delivered by other providers on NDHT site
- Peninsula-wide difficulties with Breast Cancer Services, particularly recruitment and retention of breast consultants and breast radiologists.

Cancer standards mitigating actions

- Ongoing delivery of Cancer Action Plan and completing actions of RAP
- Robust management of internal pathways to reduce time to onward referral
- Improved patient-level tracking at cancer site level

- Haematology and Oncology service improvement plans
- Focused work with GP practices identified as having high numbers of patient choice breaches
- Breast cancer services health system-wide solutions to address manpower issue
- Review of clinical nurse specialist numbers and roles

6.4. 4-hour A&E standard

The A&E 4 hour standard remains challenging for Type 1 and the transfer of some MIUs out of NDHT will also affect the Trust's "all types" performance. Modelling has taken place to demonstrate the impact of the loss of the Eastern MIUs. The Trust has invested a significant amount of management time into improving performance against a number of flow indicators (i.e. morning discharge, extended length of stay patients and delayed transfers of care) which should improve performance against the 4-hour flow standard.

This has been done through adoption of the ECIST/ECIP 'Breaking the Cycle: Perfect Week' methodology and applying this across the acute hospital, Northern community hospitals and Northern locality community teams. The January 'Perfect Week' was extended for the whole month, and learning from this, and others run during July and October, has been used to develop a detailed patient flow plan and shared more widely across the Northern and Eastern locality SRG. Discussions continue regarding significant service changes which will support improvement in performance e.g. development of proposals for a remodelled emergency assessment function to include an enhanced frailty assessment pathway.

The Trust also plays a significant role in the Health Community SRG and continues to work with other system partners in developing solutions to mitigate the impact of winter pressures on its urgent and emergency care system.

A&E standard key risks

- Increasing activity overall for Type 1
- Later time of day presentation by patients to ED
- Fluctuations in demand by day/time of day
- Demographic challenge of ageing population
- Impact of seasonal demand
- Transfer of eastern community MIUs
- Uncertain future of the remaining Type 3 services impacting on recruitment and retention, and the subsequent ability to maintain services
- Ability to recruit substantively into key urgent care specialities
- Impact of potential changes to junior doctor numbers
- Impact of DTOC and longer LOS patients

A&E standard mitigating actions

- Continuation of patient flow workstream including "Breaking the Cycle" methodology

- Success Regime workstream actions (see link to Section 6 Link to the Emerging STP below)
- Review and redesign of front end assessment for urgent care and older people
- Continued robust operational and nursing management of patient flow
- Rolling recruitment of medical, nursing and AHP staff
- Developing non-medical models of patient care in key hard to recruit areas, i.e. frailty
- Detailed plan for ambulance handover delays developed collaboratively with South Western Ambulance NHS Foundation Trust
- Robust review of length of stay +10 patients and DTOCs

There is a joint approach to patient flow across the acute and community services (Rapid Response, Rapid Intervention Centre (RIC) in Eastern and Northern communities, spot purchase of care home beds, with community capacity ensuring on-going care after initial crisis responses). Intention is always "home first" in response, unless not clinically appropriate.

6.5. Diagnostic standard

The diagnostics standard is currently being achieved and those services not included in the Acute Indicative Activity Plan are undergoing a separate demand and capacity planning exercise, using the same principles, to prepare a Diagnostics Indicative Activity Plan.

For acute activity, early warnings of changes in demand in elective care are provided through weekly review of referral trends. Where a significant unplanned change is identified, service teams are then supported by corporate functions such as finance and performance to develop plans to address any increase or decrease in demand, and commissioners are also informed. Non-elective changes in demand are managed through the Trust's programme of daily bed meetings and the actions mandated in the Patient Flow Policy.

7 Approach to Quality Planning

Objective 1: we will deliver high-quality care, measured by effectiveness, safety and the person's experience of care.
Quality standards for patient services are clearly set out in the NHS Constitution and in the fundamental standards of quality and safety published by the Care Quality Commission. Northern Devon Healthcare NHS Trust supports these matrices of quality standards through a range of comprehensive and well-established processes and procedures.

Approach to Quality Improvement

7.1. Organisation-wide process

The Trust's approach to quality is informed by listening to patient experience and understanding safety alongside delivering and maintaining services. This approach has been formally identified through Trust values and strategic objectives with executive leadership and Board ownership. Committee structures at sub-Board level include a Quality Assurance Committee (QAC) and a Clinical Services Executive Committee (CSEC) The Trust Chair attends the Quality Assurance Committee which is chaired by a non-executive director to ensure that "ward to the board" quality feedback is a reality.

Organisational structure enables a quality-driven approach through divisional triumvirates (General Manager, Clinical Director and Senior Nurse). This has recently been reviewed to enhance clinical engagement and leadership across the Trust with a particular focus upon quality and governance within the division. Use of QI methodologies such as root cause analysis, continuous improvement processes and run charts explore improvements or concerns in quality and safety. Through Listening into Action projects, the Trust encourages local PDSA cycles and tests of change which inform wider organisational learning and take up of innovative approaches. Business planning templates encourage staff to promote ideas with feasibility studies or sharing.

There is a robust overview from the Corporate Governance Department of serious incident investigation, risk management and incident collection. There is a strong culture of reporting incidents which is encouraged and embedded across all staff groups. The organisation is consistently in the top percentile of trusts for the number of incidents reported, which is a good indicator of a safety-aware culture and the Trust is developing ways of cascading this further to ensure wider learning.

7.2. Named Executive lead

The Executive leads for Quality are the Director of Nursing and the Director of Medicine supported by a robust committee structure.

7.3. Quality priorities for 2016/2017

- **Making the most of the informal networks of care.** We have a vision to embrace the carer's role and the inputs of volunteers to enhance the experience of people in our care. This includes the embedding of John's Campaign and the recruitment of volunteers to support people in hospital with the intention to publish to a Carers Strategy by end 2016.
- **Keeping hydrated**. We recognise that our robust approach to nutrition needs to extend to meeting people's hydration needs when in our care. Clinical project leads and plans will be implemented during 2016 with objectives likely to include: senior nurse leadership, utilisation of allied health and housekeeping workforce, the new Carers Strategy and audit measurements for progress monitoring.
- **Mortality rate review**. Our Mortality Review Committee will continue to focus on understanding the detail behind unexpected/unexplained deaths to identify learning, and ensure that clinical coding is properly reflective of each patient's episode of care. This organisation will provide positive confirmation that we will participate in the publication of avoidable deaths.

7.4. Top three risks to prevent delivery and plans to mitigate the risk

- **National and local workforce limitations**. We will explore creative solutions, including active recruitment, robust job planning and engagement with education providers.
- **New Devon Success Regime**. NDHT is encouraged by the collaborative approach to creating solutions for care provision across Devon. By being an active and engaged partner within this fast-paced process NDHT is able to reduce some elements of the risk and uncertainty.
- **Temporary Divisional structures**. The current teams are enthusiastic to adopt fresh approaches to governance within their divisions. To enable the implementation of more robust and meaningful clinical governance, a stable structure of senior leaders is required. The current test of change will be evaluated during 2016 when a permanent structure will be announced.

7.5. A focus on the well-led elements

- Our people and our values: by recruiting to values which include striving for excellence and working compassionately, the Trust ensures that all staff understand the importance of delivering quality.
- The Trust's education strategy focuses on human factors in order to embed learning from incidents, complaints and patient feedback. Examples of implementation are the Essential Patient Safety Review (EPSR) workshops and the new simulation training suite.
- The Patient Safety Improvement Plan identifies the requirement to increase staff formally trained in QI methodology. The Trust has nominated six clinicians to attend the forthcoming programme scheduled by IHI later this year.
- Formal mortality reviews of inpatient deaths are being piloted and will be rolled-out to ensure a formal review of every inpatient death is carried out. In the last year the Trust has understood the causes of our elevated HSMR and resolved these issues resulting in our HSMR significantly improving. In addition, we will be extending the learning from our mortality improvement through the introduction of structured senior peer review with senior nursing and senior medical staff reviews of every death to include Hogan score and NCEPOD.
- The Trust is developing links with South West Academic Health Science network to work collaboratively towards driving positive change in health care delivery. Current projects include mortality review and reducing patient harm from falls.
- The Trust has also recently appointed deputy medical directors for clinical effectiveness and patient safety who will work closely with the clinical audit team and Head of Quality and Safety to ensure that in future the QI activities undertaken annually are aligned to identified risks and priorities.

7.6. Sign up to safety priorities 2016/2017

The Trust joined the "Sign up to Safety" campaign network in August 2015 and adopted the five core pledges (putting safety first, continually learning, being honest, collaborating and

being supportive). The Trust has set measures of success to support the national and local safety improvement programmes over the next three years with the aim to:

- Reduce overall patient falls rate and to reduce harmful falls occurring in our care by 50%
- Reduce the incidences of pressure ulcers, aim to reduce grade 2 pressure ulcers by 50% and to eliminate grade three and grade four pressure ulcers
- Ensure our clinical teams are using the very highest standards of communication: aid early recognition of patient deterioration; ensure safe and robust handovers; safe discharges and transfers from our care
- Improve the identification and sharing of learning when things go wrong
- Increase capacity and capability in quality improvement skills
- Work in partnership with patients and families to prevent harm whilst in our care

7.7. Association of Medical Royal Colleges Guidance

The clinical teams have processes aligned to the guidance on the Responsible Consultant outlined by the Association of Medical Royal Colleges; patients have a named consultant for their stay and there is an established process of transfer to another named consultant. The nursing teams identify the named nurse on each shift at each bed space.
The medical teams already:

- Provide scheduled ward rounds,
- Participate in daily ward board rounds with the multi-disciplinary team
- Offer continuity of care for outlier patients
- Some consultants have an overview of community hospital care

NDHT continues to develop ways to deliver and comply with the suggestions within this document. We plan to provide more comprehensive welcome packs for our hospital patients to include their named clinician and job plans are being reviewed to optimise the clinical time of our consultants.

7.8. Progress against CQC Quality Improvement Plan

The Trust underwent a Chief Inspector of Hospitals Inspection in July 2014 and then an unannounced inspection in August 2015 and on both occasions was found to require improvement across three specific areas: maternity, end of life and emergency services. Since the last CQC visit, the action plans have been further scrutinised and strengthened to ensure there are robust actions to address the inspectors concerns. There have already been substantial achievements to date with plans that have included the following;

- **End of life**: appointment of an End of Life Lead, instigation of End of Life Steering group, Treatment Escalation Plan (TEP) audit completion, bereavement audit for families.
- **Maternity**: enhanced training programmes for midwifes, obstetricians and gynaecologists, facilitated team building.
- **Emergency services**: facility for medical gas storage and training provision for staff.

7.9. Seven Day Services

NDHT is working with the wider system through the Success Regime to act on the need to improve access to the out of hours component of health and social care. This work is being managed through the Success Regime Length of Stay workstream which has an aim of delivering rapid change early in 2016/2017. This work includes the Trust's delivery of domiciliary care as part of its pathway, looking at the development of hubs and the provision of radiology and other diagnostic services out of hours.

NDHT is currently developing a proposal for a different emergency admission assessment model with the aim of increasing the availability of senior decision makers to prevent emergency admissions to hospital where possible and ensure a regular and timely review for all admitted patients. This is consistent with the strategic aims identified within the New Devon Success regime work programme.

The Medical Director is working with the directorate leads to ensure work plans include the required weekend cover working within the constraints of the existing workforce. Our associate medical directors are working through all consultant job plans to identify opportunities for enhancing medical cover over the weekend, particularly in relation to ongoing review of inpatients.

During 2015/2016 financial year, NDHT has improved its internal patient flow processes through the adoption and enhancement of ECIST's "Breaking the Cycle" methodology. Part of NDHT response has involved trialling enhanced weekend services i.e. ultrasound, therapy, pharmacy and weekend discharge ward rounds to try and understand the clinical benefits for patients and flow through the hospital. The learning from this process has been used to inform the priority areas for enhanced 7 day services in the hospital.

Progress has been made around developing sustainable business cases for the implementation of 7 day services specifically in relation to diagnostic and therapeutic teams.

7.10. Quality impact assessment QIA process

There is an agreed process for ensuring Quality Impact Assessments are completed and routinely reviewed which is outlined within the Trust policy document 'Management of Quality Impact Assessments Procedure'. Implementation of this policy will ensure that quality impact assessments are completed for cost improvement programme schemes and other key projects, major risks have been identified and mitigation has been scoped. This is the process by which The Director of Nursing and Medical Director, become aware of internal activity that will need their QIA oversight and approval. The guidance also ensures Quality Impact Assessments are monitored and reviewed through corporate planning and contracts teams within the organisation.

All business cases will include a quality impact assessment whilst maintaining consideration for efficiency, effectiveness and economy. This will describe benefits and risks to patient outcomes and/or experience and any safety issues. All CIP plans will include QIA for the

same purpose. In addition to the impact upon patient safety, patient experience and patient outcomes the assessment will include staff experience.

Triumvirate arrangements will govern and oversee the initiation of business cases within divisions. In addition, they will be looking at other improvement programmes and assessing those in relation to quality impact.

CIP and business cases will all come through the Finance Committee and CSEC. The terms of reference for those committees will include the need for the QIA process. The QIA process and any outcomes will be an agenda item and report to the Quality Assurance Committee (a sub-committee of the Trust Board). The Director of Nursing and Medical Director are required to agree, monitor and oversee each QIA and report.

7.11. Triangulation of Indicators

The Trust's approach to triangulation of quality, workforce and financial indicators is seen primarily in action at CSEC. This committee has an overview of all these data streams, and is attended by the executive team and chaired by the Chief Executive with membership including senior clinical leaders, operational managers and other key stakeholders.

The key indicators include thresholds and benchmarks agreed from local and national guidance and are well established in our processes. These include:

- Patient harm indicators (falls, pressure ulcers, hospital acquired infections, medicine errors)
- Workforce compliance (hand hygiene, bare below the elbows)
- Workforce data (appraisals, overtime, sickness, use of temporary staffing)
- Patient flow and activity data (length of stay, readmission, Emergency Department breaches, and ambulance delays)
- Audit

Results are considered and reviewed by divisional teams, operational teams, and the Trust performance team as well as at CSEC with some triangulation of metrics provided through informal and intuitive methodologies. Regular trend analysis is undertaken by the Interim Head of Quality and Safety and clinical speciality teams for dissemination to further committees including the Quality Assurance Committee, Mortality Review Committee, Drug and Therapeutics Committee and others as appropriate with additional scrutiny by the Director of Nursing and Medical Director. The recently adopted tripartite divisional structure will aim to strengthen the robustness and planned scrutiny of indicators with the intention of increased sharing and transparency of results across the organisation to improve quality care delivery.

Our Corporate Governance department enables a comprehensive overview of the organisational risks, incident reporting and other areas of concern to quality. This system for identifying, recording and managing risks supports the on-going development of a robust patient and staff safety culture across the organisation. We wish to strengthen links between governance and clinical teams by building on and further improving the divisional governance forums where events are scrutinised and shared for learning and transparency.

The Board uses information to monitor the quality and safety of care and enhance productivity by considering trends and any emerging risks, to understand where best practice is having a positive impact and to ensure this is shared. At Trust Board briefing sessions a retrospective look and a forward planning approach is used to ensure quality improvement is being delivered and the organisation is working within the Trust values to strive for excellence.

8 Approach to Workforce Planning

8.1. Delivering the forward view 16/17 – 20/21 workforce plans

The Trust's aspirations for service transformation have been challenged due to hard to recruit specialities or competencies. Though well-documented as national shortages, these are exacerbated by our geographical location and ageing workforce. It is essential that these be addressed to deliver plans that are sustainable and meet the Trust's aspirations.

Our corporate risk register includes our reducing vacancies, increasing service resilience, increased quality indicators and a radically-reduced reliance on variable pay including agency, bank and locum spending.

The Trust's workforce plans and recruitment strategies have been supplemented by overseas recruitment over the last three years. However we acknowledge that reliance on this transient workforce will reduce in our future planning.

8.2. Workforce aims

We ensure our workforce plans meet four dominant aims in order to ensure they are robust:

1. Support transformation through an agile, skilled workforce across all professions and grades
2. Maintain high quality efficient services
3. Enhance patient care and flow and support place-based care
4. Improve Health and Wellbeing outcomes

These plans will deliver a sustainable workforce of the right size, with the right skills and competences, responsive to health and social care demand. They will also ensures an effective and person centred service is delivered across a broad range of services and locations.

8.3. Links with clinical strategies and service innovation

Our processes ensure all plans link forward at least three years but ideally five years or beyond, depending upon lead-in times for staff or workforce development. The plans are linked to clinical strategies which lead to service innovation and new ways of working including:

- Efficiencies and new ways of working the support strategies

- Workforce is one key workstream of the Success Regime
- Plans that focus on patient flow, admission avoidance and care closer to home
- Staff development is shifting from traditional bed based models of care to more robust health and wellbeing approaches,
- Plans clearly articulate new roles that will be supportive of revised care pathways
- Skills will transfer from bed-focused to home-based or community-focused
- There is strong foundation of enhancing existing roles or develop new roles to drive efficiency and reduce pay bill
- Workforce transformation considers ways in which seven day working can be delivered without increasing the overall financial burden of the pay bill

Workforce Transformation is a key element of plans, looking at how delivery can be supported by the existing workforce but also how the roles and workforce will transition to deliver programmes including seven day working, care closer to home, efficiencies in elective care, CHC transformation, elimination of agency usage and integration.

A number of workforce initiatives which have been agreed locally or as part of a clear system-wide approach are integrated into Trust plans and will deliver transformation and efficiency. These include:

- Reduction to 1% use of agency
- Reduction in hospital beds
- Reductions in elective care
- Potential to enhance involvement in domiciliary care
- Enhance the health and wellbeing of the workforce through established health and wellbeing strategy
- Establish 7 day working
- Reductions in ED attendance
- Support opportunities for new integrated models through Vanguard
- Review of back office functions

8.4. Workforce planning processes

Enhancements in our workforce planning processes are now in place, aligned and led through operational services. Our processes are underpinned by the CFWI model. The steps include horizon scanning such as information gathering; we utilise qualitative and quantitative data triangulated with clinical feedback through listening events. This has resulted in our development and implementation of new roles including Assistant Practitioners and Physician's Associates (our first year with 5 students 2016).

We also use Issues and Drivers analysis, utilising local workforce data and national information to understand the future workforce challenges. We review service models to build skills and competencies for the future such as the Health and Social care innovation career pathway.

Scenario Generation and Scenario Workshops are clinically led and based on a Listening into Action (LIA) model to inform our plans based upon CIP targets and future models of care. These workshops also expand beyond the NHS workforce and look at wider systems. The Delphi Method used groups of clinicians to provide responses to a series of questions.

Members of the group then received feedback on the group's responses building from LIA events. The process is repeated to refine plans with the goal being clinical and operational consensus.

We use Quantified Scenarios in the technical testing phase to ensure plans have minimal or no impact on other elements of the system. We also ensure that we analyse policy impact on supply and demand – plans are modelled against business as usual but also against risks such as service transformation or shifting settings of care to ensure final plans are robust. We ensure robust workforce plans by considering multiple scenarios, each proposal based on the operational plan can be tested against a range of potential futures and measured against probabilities with actions be taken to mitigate risks. The 'gap' between demand and supply is measured. Estimates are made of workforce cost over the lifetime of the projection. Our Workforce Modelling includes:

- **Demand and supply**: this element is supported by HEE and utilises recognised modelling software to test assumptions.
- **Policy levers**: this focusses on such issues such as student supply and identifies which issues can be within our gift such as outputs of workforce from the local care academy.
- **Data assumptions:** this builds on clear data foundations within ESR to analyse current training and workforce numbers. The assumptions we make include age, gender, attrition and part-time working which are all modelled.

8.5. Clinical engagement and service ownership

It is important to note that within the trust workforce planning activities there is always service ownership of plans that articulate challenges, plans and transformation. We recognise how important it is that plans are taken beyond numbers and that action plans are reviewed. The clinical engagement in the co-design of plans as detailed above, ensures staff engagement to deliver achievable plans.

Quality impact assessments are signed off by clinical teams and reviewed by a Board sub group. Cross-service challenge as well as learning and listening events test and enhance the planning and ensure engagement. These include triangulation with activity, efficiency and finance along with delivering quality. A Trust workforce planner is employed to support managers with data and articulate their workforce plans and facilitate a review of the actions identified.

8.6. Impact on staff groups

Admin and clerical: there are no recruitment issues, although development plans focus on enhancing skills and greater use of technology which will see an overall reduction in WTE as technology is embedded.

Scientist: greater use of technology is helping support recruitment challenges, with service transition and new models of diagnostics working in partnership with primary care. These are driving efficiencies within existing establishments and mitigating hard to recruit positions.

Nursing: a review of safer staffing and bed reductions is mitigating recruitment challenges and reducing substantive posts. This ultimately is helping to address a reliance on agency workers and is supported by new roles and migration into community services.

Medical: recruitment challenges remain and there have been some service changes and enhancement of roles, including the development of physician associates.

Therapy: there is a likely to be an increase in therapy roles to support care closer to home and admission avoidance. There are some recruitment challenges in this area but introduction of consultant roles and advanced support practitioners will aid in mitigating these risks.

8.7. Rostering

The Trust has a long record of using effective rostering and utilises a full suite of rostering tools, supported by monitoring, that delivers safe, effective workforce. All clinical services are utilising health roster systems which has real time reporting enabling efficiency metrics to be monitored. We have roster policies which are regularly reviewed to ensure rule and violations deliver an effective workforce. We have introduced Clinical Activity rostering which enables more effective rostering of non-bed based areas, such as theatres and brings all elements of the workforce into one roster. The roster system now links to job planning and enables delivery of the most effective medical workforce. The system also feeds into safer staffing elements which ensure quality, resilience and actions to address immediate acuity pressures.

8.8. Agency use

There has historically been an over-reliance on agency activity within the Trust and previous attempts to reduce this have been challenging, which has subsequently impacted on financial performance. The work we have taken in this area has achieved significant reductions in agency activity. Appropriate staffing levels have been achieved through daily workforce monitoring, twice-daily acuity censuses, use of technology to monitor the workforce as well as implementation of contact time monitoring.

We review the skill mix against the acuity on a prescribed frequency and have enhanced the skills and workforce beyond the registered nursing workforce. The actions we have taken includes a review of the bank and temporary workforce including pool solutions to address short term challenges; a review of establishments; development of escalation rules and assurances; implementation of cap; removal of off framework activity; a system wide target of 1% of pay bill and development of the qualified non registered workforce. This has resulted in a reduction in the hourly rate and we are continuing negotiations to reduce rates. We are also actively working with other trusts to deliver the most efficient workforce.

All activity above the cap and framework requires executive sign off. The executive team have weekly reports on cap and ceiling activity and this is raised at alternate month Board meetings, there are also alternate week meetings that are chaired by the executive team to review agency and bank activity. The divisions report their weekly performance through CSEC. These processes cover all staff groups.

8.9. Developing the local young workforce

The Trust is active in working with the regional LETB and the workforce planning teams to signify demand. This will be further enhanced by the local initiatives we've instigated or are working on and that are supported by HEE such as the Care Academy which is a model of work experience for students and enables growing skills local from apprentice to graduate.

Funding was provided in 2015-16 to support progression of our Talent for Care work in developing local education links. We are now investigating and progressing opportunities that can be delivered locally as a result of changes to undergraduate bursary, such as the development and implementation of a clinical school and development of graduate non-registered practitioners.

We have commissioned and are working to embed the new role of assistant practitioners and physician assistants, (15 qualified, 15 on training and 20 new placements planned for September 2016) and invested in the development of these roles as well as working closely with our local college to design the foundation degree to meet our future service needs.

We continue to build our local school links with career visits and raising awareness of and maximising opportunities for apprentices' routes into the Trust. We support the primary care practice development community and support nursing and residential homes' staff development. We are developing our links with our local authority to enhance social care skills

8.10. Governance

Governance processes are underpinned by Board assurance of the plans, ensuring board visibility of plans and risks. This process includes monitoring of progress with plan outputs and intentions set out in the 2014/15 Workforce Plan.

- The Workforce Plans are published on the intranet after Workforce committee (WODC) approval chaired by a non-executive director and reported to the Board.
- Monitoring reports on the implementation of the Workforce Plan are presented to WODC and progress is discussed at a planning sub-committee every other month throughout the year
- At local level, the initiation and implementation of plans and workforce implications are also closely monitored and progress reported to local management and partnership groups such as CSEC
- Effective workforce planning ensures that services and organisations have the necessary information, capability, capacity and skills to plan for current and future workforce requirements.
- Plans are signed off and owned by operational Triumvirates who use narrative plans to inform the quantitative data, giving the planning committee assurance of plans.
- Clinical executive signoff is achieved once planning committee is assured of the plan and there is clinical sign off of quality impact assessments.
- The process is regularly audited through internal audit. The Trust uses a template to support assurance which includes sections for quality, impact, capacity, innovation, robustness and identifies risks.

8.11. Monitoring and measurement

Our dashboards and workforce metrics are compared with performance and quality indicators to ensure effects are positive or identify risks early. We produce integrated performance reports and triangulation of quality indicators with workforce indicators to CSEC to monitor and assure the Board of activity. The daily tactical meetings are used to raise and address immediate risks and quality impact assessments are used to assess medium to long-term impact.

All workforce plans and CIP plans have a quality impact assessment with clear risk escalations and this process includes the clinical executive sign off with escalation to relevant committees of the board for workforce and additions where necessary to the corporate risk register. Quality and monitoring is undertaken through CSEC. And early warning is supported through workforce planning and monitoring processes.

9 Summary and risks

2016/17 represents a significant challenge for all organisations in the Devon health economy, but we are committed to working together to solve the system problem.

This plan has been constructed on the basis of the system working together to drive down delivery costs so that the NEW Devon health economy has a financially sustainable future into the long term. Due to the size of the financial challenge, this is unlikely to be achieved within one year, but the system latest iteration, which includes considerable stretch and non-recurrent measures, is that it can return to a sustainable surplus by 2018/19.

In order to achieve this, it would be necessary for each organisation in the health economy to take a share of the additional shortfall against currently advised control totals. This is not reflected in the above plan.

In submitting our plans for 16/17 it is recognised that the organisational impact of the above is yet to be worked through and therefore presents a number of risks. These are set out below:

- Activity flows may change rapidly causing unpredictable changes and possible unintended consequences
- Workforce consultation processes may delay change temporarily
- Formal consultation may be required for some changes – strong engagement will be required to manage political messages.
- Providers may take out capacity faster than demand reduces, causing further RTT pressures

In order to manage risk explicitly, rather than agreeing a mechanism for sharing the consequences of not managing it, system leaders are working on a business continuity plan, that will set out a range of actions to be taken in priority order, to ensure continued delivery in the event that there is a material lapse in any element of the plan.

In the event that the rules don't support achievement of this system plan, it is very likely that the outcome in terms of financial sustainability and performance stability and improvement would deteriorate as behaviours regress to adversarial contractual disputes.

9.1. Organisation specific caveats

In addition to the system risks identified above, the following risks specific to NDHT will also need close attention:

- Transfer elements of TCS services to an alternative provider subject to CCG procurement processes
- Transfer of TCS assets to NHS Property Services if this goes ahead
- Current system plan is quantifying the option of a purely rules based approach. As mentioned above, this may precipitate a worse outcome for the system and individual organisations, which would require further access to cash and other non-recurrent support.

10 Monitoring and measurement

The plans and priorities for quality, workforce and activity have been robustly developed and accurately reflected in the financial forecasts contained in this draft operational plan. Assurance has been overseen by designated Executive leads.

In addition this plan is consistent with the Success Regime and the direction of the common Sustainability and Transformation Plan (STP). This ensures the financial forecast is based on robust local modelling and reasonable planning assumptions that are aligned with both national expectations and local circumstances.

In each of the sections above, mechanisms for measurement have been identified and outlined. KPIs are monitored at Board level and during weekly senior management and Executive-level meetings. Action will be taken where any deviation from plan is identified. This forms a key part of the Board Assurance Framework and performance monitoring processes.

In particular, patient experience data is scrutinised to monitor the impact on patients, and staff feedback is fed back into the organisation through the Trust's new staff engagement platform.