Royal Devon and Exeter NHS
NHS Foundation Trust

THERE WILL BE A MEETING OF THE BOARD OF DIRECTORS

At 9.30am on Wednesday 26 September 2018 in the Boardroom, Noy Scott House, Royal Devon & Exeter Hospital.

AGENDA

Item	Title	Presented by	Item for approval, information, noting, action or discussion	Time Est.
1.	**Chairman's Opening Remarks**	James Brent, Chairman	Information	2
2.	**Apologies**	Melanie Holley, Head of Governance	Information	1
3.	**Declaration of Interests**	Melanie Holley, Head of Governance	Information	2
4.	**Matters to be discussed in the confidential Board**	James Brent, Chairman	Noting	2
5.	**Minutes of the Meeting of the Board held on 25 July 2018**	James Brent, Chairman	Approval	5
6.	**Matters Arising and Board Actions Summary Check**	James Brent, Chairman	Information	15
7.	**Chief Executive's Report**	Suzanne Tracey, Chief Executive	Information	5
8.	**Policy and Strategy**			
9.	**Performance**			
9.1	**Integrated Performance Report**	Chris Tidman, Chief Financial Officer	Information	30
10.	**Assurance**			
10.1	**Audit Committee Report and Terms of Reference for approval**	Peter Dillon, Non-Executive Director and Chair of Audit Committee	Information	10
10.2	**Referral to Treatment and Diagnostics Deep Dive**	Peter Adey, Chief Operating Officer & Phil Luke Deputy Chief Operating Officer	Information	45
10.3	**Learning from deaths quarterly report**	Adrian Harris, Medical Director	Information	30
10.4	**Revalidation Report**	Adrian Harris, Medical Director	Approval	5
11.	**Information**			
12.	**Any Other Business**			
13.	At the conclusion of the formal part of the agenda, there will be an opportunity for members of the public gallery to ask questions on the meeting's agenda. Where possible, questions should be notified to members of the Corporate Affairs team before the meeting. Every effort will be			

	made to give a full verbal answer to the question but where this cannot be done, the Chairman will ask a director to make a written response as soon as possible.
14.	**Date of Next Meeting:** The next meeting of the Board of Directors will be held at 9.30am on **Wednesday 31 October 2018** at the Royal Devon and Exeter Hospital.
15.	The Chairman 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.

NHS
Royal Devon and Exeter
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS OF THE ROYAL DEVON AND EXETER NHS FOUNDATION TRUST

25 July 2018
Held at Boardroom, Noy Scott House, RD&E Hospital

MINUTES

PRESENT:	Mr J Brent	Chairman
	Mrs J Ashman	Non-Executive Director
	Mrs T Cottam	Executive Director of Transformation & Organisational Development
	Mr P Dillon	Non-Executive Director
	Professor A Harris	Executive Medical Director
	Professor J Kay	Non-Executive Director
	Ms M Romaine	Non-Executive Director
	Mr C Tidman	Chief Financial Officer
	Mrs S Tracey	Chief Executive
	Professor E Wilkinson-Brice	Deputy Chief Executive/Chief Nurse
APOLOGIES:	Mr P Adey	Chief Operating Officer
	Mr S Kirby	Non-Executive Director
	Dr S Knowles	Non-Executive Director
IN ATTENDANCE:	Mr J Chinnock	Head of Stakeholder Communications & Engagement
	Dr A Colville	Joint Director of Infection Control
	Mrs M Holley	Head of Governance
	Mr P Luke	Deputy Chief Operating Officer
	Mrs J Potter	Joint Director of Infection Control
	Ms H Quinn	Chief Operating Officer, NIHR, Clinical Research Network, South West Peninsula
	Miss L Vine	Executive Support Officer
FOR AGENDA ITEM 10.5, PRESENTATION ONLY:	Mr R Bethune	Consultant Colorectal Surgeon
	Miss P Budden	Cluster Support Manager
	Dr N Dyar	Quality Improvement Fellow 2017/18
	Dr G Hirst	Foundation Year 2 Doctor
	Mrs C Holmes	Transformation Programme Director
	Dr S Lawday	Quality Improvement Fellow 2018/19
	Miss E White	Medical Student

		ACTION
89.18	**CHAIRMAN'S OPENING REMARKS**	

	Mr Brent welcomed Governors and members of the public to the meeting, and Mr Luke who was deputising for Mr Adey. He reminded the Board that the meeting was a meeting in public, but was not a public meeting. Questions would be welcome from members of the public at the end of the meeting and he reminded the public that the questions should relate to the meeting agenda. Mr Brent reminded the Board that it would be Ms Romaine's last Board meeting. On behalf of the Board, he thanked Ms Romaine for her tremendous commitment and dedication to the Trust. In particular, he noted the achievements of Ms Romaine as Chair of the Governance Committee. He expressed his sincere thanks which was echoed by the Board.	
90.18	**APOLOGIES**	
	Apologies had been received from Mr Adey, Mr Kirby and Dr Knowles.	
91.18	**DECLARATION OF INTERESTS**	
	Mrs Holley said there were no new declarations. Mr Brent reminded Board members to flag any interests if they arose during the course of the meeting.	
92.18	**MATTERS TO BE DISCUSSED IN THE CONFIDENTIAL MEETING AND TO BE DISCUSSED IN THE BOARD SESSION**	
	Mr Brent informed the meeting that the Board would be discussing in its confidential meeting the post-transaction report regarding Castle Place Practice Tiverton, a Strategic Outline Case for the Breast Care Unit, an Outline Business Case relating to the Energy Performance Contract, an update on the Linear Accelerator replacement and additional bunker, a Travel Improvement update, an update on the Children and Young People Services tender, the Q1 2018/19 financial return to NHS Improvement, a presentation from the South Western Ambulance Service NHS Foundation Trust, and a key strategic issues update which was a standing item.	
93.18	**MINUTES OF THE LAST MEETING HELD ON 27 JUNE 2018**	
	The minutes of the meeting held on 27 June 2018 were agreed as a correct record subject to the following amendments: Minute 83.18, page 6, third paragraph, first sentence to read: '…Trust was both optimistic but realistic.' Minute 83.18, page 6, third paragraph, second sentence to read: '…Trust was working with Devon County Council who were looking to block book …' Minute 83.18, page 7, fifth paragraph, first sentence to read: '…note the reduction in staff turnover…' Minute 84.18, page 8, second paragraph, second sentence to read: '…concern remained in Orthopaedics…' Minute 85.18, page 9, third paragraph, last sentence to read: '…and stillbirth rates…'	

	Mr Dillon suggested that, for the avoidance of doubt, all references to 'Dr Kay' in minute 85.18 should read 'Dr Tracey Kay'.	
94.18	**MATTERS ARISING AND BOARD ACTION SUMMARY CHECK**	
	Action check The actions were as per the tracker with the following additions: 122.17 Professor Harris and Professor Wilkinson-Brice to review the ward staffing structures and provide an update to the Board at the meeting in April 2018. Professor Wilkinson-Brice informed the Board that this work was on-going and suggested that the nursing establishment review be reported back to the Board in September 2018 but that the comprehensive clinical workforce review should be postponed to January 2019 so that a more thorough review could be undertaken. The Board agreed this extension. 67.18 (1) Mr Adey to review the current medical bed occupancy and produce a forecast trajectory for improvement. The Board agreed an extension to September 2018.	
95.18	**CHIEF EXECUTIVE'S REPORT**	
	Mrs Tracey raised the following: 1) Mrs Tracey informed the Board that the Trust had received urgent guidance from NHS Improvement (NHSI) on 10 July 2018 regarding a high vigilance restriction period in relation to vaginal tapes. Trusts were requested to postpone all cases if clinically safe to do so. Mrs Tracey confirmed that an urgent and same day review had been carried out by Professor Harris with the Clinical Leads for Urology and Gynaecology. Professor Harris said that the Trust had identified 20 patients who were waiting for the procedure and all of these cases had been paused. All of the patients were contacted with an explanation provided as to the reason why their surgery had been postponed. Professor Harris added that the patients were also offered the opportunity to discuss this with their Consultant should they wish to. Professor Harris reported that further guidance was received from Professor Keith Willett (Medical Director for Acute Care and Emergency Preparedness – NHS England) and Dr Kathy McLean (Executive Medical Director and Chief Operating Officer – NHSI) on 20 July 2018. This guidance explained that a Clinical Advisory Group, comprising a number of subject matter experts, had met and agreed a set of recommendations. Professor Harris said that these recommendations detailed that the procedure would still be permitted but only following an extremely rigorous Multi-Disciplinary Team (MDT) review, which Medical Directors were accountable for ensuring took place, to determine the necessity and appropriateness. He said that Medical Directors would also be responsible for ensuring that all procedures were logged, certifying appropriate information and consenting processes were in place, along with the competence of any surgeon performing the procedure. Professor Harris confirmed that a team had been identified within the Trust to establish a clearly defined process. Mr Brent expressed concern that national guidelines would result in fewer options being available to patients experiencing acute issues. Professor	

	Harris acknowledged this and said that he anticipated patients would continue to opt for this treatment, despite the risks, due to the lack of other successful options available to them. He added that the Trust had always carried out an MDT review before performing this procedure. Professor Wilkinson-Brice asked if the high vigilance restriction period and associated guidelines applied to private practice. She expressed concern that patients may then seek this procedure privately and that if there were complications with the treatment, this could have an impact on the Trust in trying to rectify these complications. Professor Harris said that it applied to both NHS and private practice. He added that the log, which he as Medical Director was responsible for, of each time this surgery was performed would be reported to the Governance Committee. 2) Mrs Tracey reported that the events surrounding the 70th birthday of the NHS were a great success both within the Trust and nationally. She said she had been privileged to accompany two members of staff to a special service at Westminster Abbey and that a number of celebratory events had taken place on the day at the Trust. There were no questions from the Board. **The Board noted the Report from the Chief Executive.**	
96.18	**INTEGRATED PERFORMANCE REPORT**	
	Mr Tidman highlighted to the Board that despite best endeavours, the Integrated Performance Report (IPR) reflected a system under significant financial pressure. He said the main challenge was identifying how the Cost Improvement Programme (CIP) gap could be closed under this pressure and that, whilst technology could assist in achieving this, it needed to be balanced against the performance issues the Trust continued to experience. Mr Tidman said he was confident the Trust could close this gap and added that a series of 'check and challenge' sessions had been scheduled in the coming weeks and months. He said that the Board should be mindful of the operational delivery but said that the teams were doing everything possible to mitigate the financial pressure. Mr Brent asked if the Board should be concerned in relation to the Sustainability and Transformation Fund (STF) funding. Mr Tidman said there were no in year concerns and that he was highlighting the difficulties being experienced in reducing the potential recurrent gap which had not been forecast. He added that there had been a great level of positive engagement with the teams to date. Mrs Cottam said she would take the report as read, inviting questions from the Board. Ms Ashman referred to the activity levels and asked for clarification in relation to the lower than expected elective levels and the non-elective which was at planned levels. Mr Luke said that this was partly due to workforce levels with general surgery and particularly endoscopy. He added that the Trust had experienced lower demand for emergency cancer, particularly within haematology day case, which was categorised as elective. Ms Ashman enquired as to the cause of the breach in agency usage during June 2018. Professor Wilkinson-Brice said that this was in part due to the additional staff required for a CAMHS patient on Bramble Ward. She added that the Trust had also reached a 'tipping point' for nursing vacancies which the staff bank was not able to cover. Professor Wilkinson-Brice said that there were	

	rigorous processes in place for agency usage, which was a last resort, but said that the Trust was reaching this last resort more frequently. Mr Tidman added that an exacerbating factor was the increase in support the Trust was providing across the system; including providing a Histopathology locum to Torbay and the provision of IT Service Desk support to an additional organisation. Mr Tidman said that the Trust needed to backfill currently but this would begin to dissipate. Mr Brent noted that there appeared to be a heightened pressure within the Medical Services and suggested that a deep dive would be welcome. Professor Wilkinson-Brice acknowledged this and agreed to incorporate this within the Ward to Board report at the October 2018 Board meeting. **ACTION: Professor Wilkinson-Brice to include a deep dive into nursing vacancies, within the Medical Services Division, in the Ward to Board report at the October 2018 Board meeting** Professor Kay asked if the overspent medical workforce position was caused by the mutual aid which the Trust was providing. Mr Tidman acknowledged that this was inferred in the wording of the report but clarified that this was not a new issue and was due to the difficulties experienced in recruiting to some specialities. He added that the Trust was recovering the costs for providing mutual aid to other organisations. Ms Ashman asked what was meant by the 'system wide reset' and what this involved. Mr Luke said that both the Royal Cornwall Hospitals NHS Trust (RCH) and University Hospitals Plymouth NHS Trust (UHP) had come together to adopt an approach called a 'hard reset' to support capacity challenges through honest and open challenge with partners to unlock problems and delays. He said this had proved a significant benefit and so the Trust would be running a similar but reduced process for two weeks, beginning the following week. Mr Luke said that one particular focus would be domiciliary care. Mr Dillon expressed concern as to whether there were a high number of people living alone and not receiving care due to the limited resource available. He asked whether Devon County Council (DCC) were aware of the issues in this area. Professor Wilkinson-Brice said she did not believe there to be people with unmet need in their homes but that it was more likely people were being held in community hospitals as the outward flow could not be met. She said that backfilling through the Urgent Community Response service was underway. Mrs Tracey added that DCC was acutely aware and that this was a priority for them. Ms Romaine commented that over the last few months the Trust had repeatedly reported a decline in performance within Urology and Upper GI, which was having an impact on cancer performance, and asked if it would be worthwhile to carry out a deep dive. Mr Luke said that a deep dive relating to Referral To Treatment performance would be presented to the September 2018 Board and suggested that a cancer deep dive could then be presented to the Board in October 2018. The Board agreed with this proposal. **ACTION: Mr Adey to carry out a deep dive into cancer performance and report back to the Board in October 2018** Professor Kay commented on the potential risk that the My Care recruitment could lead to a short term increase in backfill agency costs and said it was imperative that the Trust continued to monitor this. Mrs Cottam confirmed the impact on not just the Trust but also the wider Sustainability and Transformation Plan (STP) was being closely monitored on a daily basis. She added that the programme team held fortnightly discussions regarding any issues and impacts on Business As Usual with Mr Adey, Mr Luke and the Divisional Directors and problems were resolved as they emerged. Mrs Cottam assured the Board that	**EWB** **PA**

	there were no specific issues at present. Referring to the decline in response rate of exit interviews, Professor Kay suggested that staff should be contacted a few months after they have left to get a more rounded view. Mrs Cottam said that this was being explored. Mr Dillon commented on the Trust's mortality rate and asked for clarification on the reference to both Aintree and Sheffield Hospitals. Professor Harris said that Aintree had experienced a similar issue as the Trust relating to their Summary Hospital-level Mortality Indicator (SHMI) and so good relationships had been built between the teams in each organisation to enable learning in relation to coding, counting and clinical changes made. He added that Sheffield was regarded as a national exemplar in terms of the Learning from Deaths framework so the Trust was keen to gain learning from them. Professor Harris said that the Medical Examiner from Sheffield would be visiting the Trust in early September in order to gain an understanding of how the Learning from Deaths process is managed. Mr Dillon said he would be keen to attend this meeting as the Non-Executive Director representative. Professor Harris welcomed this and acknowledged that the Trust continued to have concerns in terms of the quality of the data in relation to coding issues but confirmed that the teams were working hard to address this. He said that the process was becoming increasingly rigorous and whilst the Trust currently reviewed 20% of cases, he anticipated that in time all cases would be subject to a Structured Judgement Review (SJR). **ACTION: Mr Dillon to be invited to attend the visit of the Sheffield Medical Examiner in September 2018** In relation to the Trust's performance against the fractured Neck of Femur target, Mr Brent said that the action plan appeared very functional. He also expressed concern regarding the diagnostic performance and asked for assurance with regard to the speed of recovery. Mr Luke confirmed that an action plan was in place within endoscopy, including additional staffing and capacity, but said it would take time to clear the backlog. Referring to MRI, Mr Luke said that the Trust had allocated significant resource to enable the use of the mobile facility until the scanner purchased by the University of Exeter (UoE) came online. Mr Luke said that a more in depth view would be provided in the IPR for the September 2018 Board meeting. Mrs Tracey said that the Programme Delivery Executive Group (PDEG) had highlighted this as an issue across the system; recommendations to increase capacity were due to be presented to the September 2018 PDEG meeting. Mr Brent congratulated the teams on the exemplary Emergency Department performance. **The Board noted the report.**	**AH**
97.18	**NIHR CLINICAL RESEARCH NETWORK: SOUTH WEST PENINSULA ANNUAL REPORT 2017-18 AND ANNUAL PLAN AND FINANCE PLANS 2018-19**	
	Professor Kay declared an interest in this item. Mr Brent welcomed Ms Quinn to the meeting. Ms Quinn reported that the national annual review had taken place the previous week at which the network was congratulated on their overall success. She said that the communications and public engagement had continuously improved throughout the year and notable achievements had been made	

	outside of the national requirements. Ms Quinn said that a large number of patients had taken part and had been happy to share their stories. She invited questions from the Board. Professor Kay commented on the lack of reference to Universities within the report which was surprising given the engagement with them. She congratulated the team on the fantastic achievement of High Level Objective (HLO) 3 relating to recruitment to commercial studies for which the South West Peninsula achieved the top IQVIA Prime Site position globally. Ms Quinn acknowledged this and said it had been highlighted to the national centre as they were very proud of this and believed it helped encourage more patients to come forward to share their stories. Mr Brent noted the decline in recruitment at primary and community sites in the Kernow and Somerset CCG areas and asked what was being done to address this. Ms Quinn said that conversations were taking place locally with the Commissioners as this decline in recruitment was linked to Excess Treatment Cost (ETC) not being paid by CCGs. She added that a consultation, carried out by NHS England (NHSE), had concluded in January 2018 and that from October 2018 the ETC budget would be held nationally and Local Clinical Research Network (LCRN) hosts were being asked to be in receipt of these funds to pass on to local providers. **The Board approved the Annual Report 2017-18, the Annual Plan 2018-19 and the Annual Finance Plans 2018-19.**	
98.18	**Q1 2018/19 HOME, COMMUNITY AND HOSPITAL REPORT**	
	Professor Wilkinson-Brice reminded the Board that this report was previously known as the Ward to Board report and she said she welcomed feedback on both the format and content. Professor Wilkinson-Brice reported that the demand on the Single Point of Access (SPOA) service included patients in both acute and community hospitals needing care to support them home, in addition to admission avoidance referrals. Referring to the Medical Services Division, Professor Wilkinson-Brice said that the biggest challenge was the number of nursing staff vacancies which also correlated with staff sickness levels. She said that, despite using agency staffing, the Division continued to see a high level of vacancies. Professor Wilkinson-Brice added that the 'red line' continued to be maintained however, which was a minimum of two registered nurses overnight on a ward. She said that Dave Thomas, Deputy Chief Nurse, was underway with a piece of work to maintain rosters and ensure good cover throughout the upcoming holiday period. Mr Brent asked how this worked in practice and gave the example that a ward with only two registered nurses then had one call in sick before their shift. Professor Wilkinson-Brice said that the usual establishment was three or four registered nurses so this was unlikely, but should it occur, she said staff would be moved between wards or a ward would be de-escalated to ensure they were adequately staffed. Professor Wilkinson-Brice highlighted the continued increase in Datix reports relating to violence and aggression and assured the Board that David Stevenson (Assistant Director of Nursing – Medical Services) had commissioned a deep dive to identify what was driving this. She added that the findings of this would be presented to the September 2018 Board meeting. Mr Dillon enquired as to whether the movement of staff, to ensure adequate cover,	

	had diluted the training in this area. Professor Wilkinson-Brice confirmed that the reliance on agency had partially diluted this.	
	ACTION: Professor Wilkinson-Brice to present the findings of the deep dive into reports of violence and aggression to the September 2018 Board meeting	**EWB**
	Ms Romaine asked how specialling was being managed whilst there were such high levels of nursing vacancies. Professor Wilkinson-Brice said this was largely achieved by cohorting of like-needed patients.	
	Mr Dillon referred to the number of Venous Thromboembolism (VTE) risk assessments which, although performed, were not entered onto the whiteboard and asked if this caused a risk to the patient. Professor Wilkinson-Brice confirmed that it did not.	
	Mr Brent commented on the pressure experienced by staff which was likely to be exacerbated by the nursing vacancies and asked if there was anything further the Trust could do to support these staff. Professor Wilkinson-Brice reminded the Board that the Trust Health and Wellbeing (HWB) plan was now in place and she confirmed that the Trust HWB Improvement Practitioner, Amy Colwill, was working particularly closely with the Medical Services Division. She added that the practice coaching was due to commence in September 2018 and the Trust could take some level of assurance that turnover had not increased.	
	Professor Wilkinson-Brice reported that both the Surgical and Specialist Services Divisions were in a much stronger position in terms of performance.	
	Referring to the Community Services Division, Professor Wilkinson-Brice said that an increase in vacancies was beginning to be seen but she said that recruitment was likely to be very successful and a proposal had been put forward, as part of the establishment review, to increase the number of Healthcare Assistants (HCAs). She added that IT had also been a real enabler within the Division.	
	Professor Wilkinson-Brice said that the Board were well apprised of the position and performance within Maternity as they received a detailed presentation at the June 2018 Board meeting. Ms Ashman queried how the Red/Amber/Green rating on adequate staffing should be interpreted. Professor Wilkinson-Brice said she would circulate this information to Board members.	
	ACTION: Professor Wilkinson-Brice to circulate an explanation of ratings for adequate staffing on the Maternity dashboard to Board members	**EWB**
	Professor Wilkinson-Brice referred to an audit commenced in April 2018 with the community nursing teams to help understand whether patients who were receiving end of life care were able to die in their preferred place of care. She was pleased to report that 90% of patients had been supported to die in their preferred place; at home. Professor Wilkinson-Brice said that work would take place to better understand the reasons why 10% of patients had not. Ms Romaine asked how the audit was carried out and whether it was evidenced through advanced care plans. Professor Wilkinson-Brice said she believed this was the case and said the plan would be incorporated within the report as an appendix the next time it is reported on.	
	Referring to chronic wound assessments, Professor Wilkinson-Brice was pleased to inform the Board that the Community Services Division had achieved 61% performance, exceeding the initial 50% target. She added that this had been stretched again to 75% to drive continuous improvement.	
	The Board noted the report.	

99.18	**JOINT DIRECTORS OF INFECTION PREVENTION AND CONTROL – ANNUAL REPORT 2017/18**	
	Dr Colville announced that this would be his last report to the Board as Joint Director of Infection Prevention and Control as he would be taking retirement later in the year. He said that the role was independent from the Board to ensure no potential conflict of interest. Dr Colville said that although the 2017/18 performance was not quite that of 2016/17, the Trust had still performed well. He highlighted that there had been two cases of MRSA bloodstream infections in 2017/18, one of which was believed to have been 'avoidable', and that learning had been taken from these incidents. Dr Colville said that increasing concern with antimicrobial resistant gram negative organisms had resulted in a new objective to achieve a 50% reduction in healthcare associated Escherichia Coli (E.coli) bacteraemias by 2020-21. He commented that this was a particularly challenging target. In summary, Dr Colville said that the annual report should be commended, particularly in the context of a decrease in the number of side rooms, and given the point of care funding for influenza had not been available this year as it was last year. He invited questions from the Board. Ms Romaine praised the team for identifying the deterioration of the "O" ring in trial heads in HSDU. Ms Ashman noted the disappointing response from NHS Property Services in relation to the community premises identified as falling short of the management levels and asked if anything further could be done to resolve these issues. Mrs Tracey said that much work was underway to follow this up but that the premises in question were still not at the standard expected and the Trust would continue to pursue this. Professor Kay congratulated both Dr Colville and Mrs Potter on the report and asked if there were any issues relating to mycological infections. Dr Colville said that these were usually seen in elderly populations and patients receiving high dosage chemotherapy but that the Trust had not experienced any problems in this area. Mr Dillon enquired as to the presence of an Infection Control (IC) team within primary care. Mrs Potter clarified that IC teams had always been present within Community Services; provided by the Trust via Service Level Agreements (SLAs), however this did not include primary care. In the absence of a team for primary care, Mrs Potter said that the Trust IC team was investigating all E.coli bacteraemias which was a significant burden as the majority of cases originated from primary care (from people living in their own homes and are not receiving any healthcare input). Mrs Potter said that NEW Devon CCG were developing plans for an IC team, funded by the CCG, whose focus would be GP and care homes. In relation to the rate of Clostridium difficile (C.Diff), Mr Brent asked if any further assurance could be gained by extending the sample size. Mrs Potter said that all cases were investigated and confirmed to be within normal variation. On behalf of the Board, Mr Brent expressed his gratitude to Dr Colville and Mrs Potter for their great leadership. **The Board approved the report.**	

100.18	**INFECTION CONTROL ANNUAL PROGRAMME 2018/19**	
	Dr Colville presented the annual programme of infection prevention and control activities for 2018-19 which he said was largely the same as the previous year and based upon national guidance. He invited questions from the Board. Mrs Tracey referred to the 'catheter passport' referred to within the programme and asked what this was. Mrs Potter said that, although this was not generally seen at the Trust, urinary catheters often increased the occurrence of E.coli via urinary tract infections. She added that the 'catheter passport' would provide a record for each patient detailing why a catheter was necessary and the duration that it was in place. Mrs Potter said that the passports were not expected to have a vast impact, due to the low numbers experienced within the Trust, but that it was important that the Trust supported them. Mr Dillon expressed concern in relation to the reduction in the number of single rooms and asked if allowance had been made within the plan to give the teams the required support. Mrs Potter confirmed that the team continued to work closely with Mr Luke, risk assessing that those available are used by the patients with the greatest need. She added that the Trust continued to cohort patients wherever possible to reduce the need for single rooms. **The Board approved the report.**	
101.18	**F1 QUALITY IMPROVEMENT ACADEMY PRESENTATION**	
	Mr Brent welcomed the team to the meeting. Mr Bethune informed the Board that the Quality Improvement Academy (QIA) programme had begun in 2004, primarily focussing on junior doctors and pharmacists. He said the programme encouraged junior doctors to keep their eyes open, particularly so in the first year, to then formally present back their project at the end of the year. Mr Bethune said this provided the junior doctors with autonomy and was an opportunity to engage them with developing systems and use statistical process control to improve care for patients. Dr Lawday outlined his project which had looked at ways to improve the phlebotomy service within the Trust. The aim was to have the results of all blood tests ordered by 6am available by 3pm, within a six month timeframe. Dr Lawday explained that initially he had explored ways to improve communication between phlebotomists and junior doctors, including raising awareness of existing protocols which the junior doctors were otherwise unaware of. When he examined the pre-intervention success rate, Dr Lawday said he discovered that this was better than he had anticipated and the interventions had led to no significant change in this. Another project looked at increasing the number of wards with an anaphylaxis kit and standardising both the location this was stored within the ward, and the contents of the kit. Miss White described how her intervention had a huge clinical impact and how the programme empowered junior doctors to impact on their working environments. Mr Bethune added that inspiration for this project had come from a junior doctor who had previously worked at Torbay and South Devon NHS Foundation Trust and seen the impact the standardised kits had. Mr Bethune reported that junior doctors spent on average 20% of their time completing discharge summaries. He gave details of a project which	

	implemented the use of Dictaphones by junior doctors to dictate discharge summaries; these were then transcribed by medical secretaries. Mr Bethune said that this process had spread rapidly and beyond the wards included in the initial trial. He confirmed that the project was successful in significantly reducing the time taken to complete a discharge summary. Ms Ashman asked if the timeliness or accuracy of the discharge summaries had been affected by the change in process. Dr Lawday said that the junior doctors remained responsible for checking the typed discharge summary, and the time taken for this additional check was included in the total time taken to produce it. Dr Dyar presented her project which explored two different approaches to prescribing gentamicin, their impact in terms of clinical outcomes and medication errors, and their feasibility in terms of healthcare professional's experiences of the process. Dr Dyar reported that she found the more complicated the protocol was, the less accurate the prescribing and vice versa. She added that there was good awareness of the protocols but some uncertainty remained. Dr Hirst outlined her project which had focussed on reducing the impact of the Trust on the environment by saving energy. She said that by identifying how many PCs were used during the day, overnight and at weekends, and comparing this with the calculations of how many were required, they had been able to establish that the Trust could save approximately £30,000 each year by forcing unused PCs to switch off. Dr Hirst said that work was on-going with the IT department to implement a programme which would run and automatically switch PCs off when they were not being used. Mr Bethune said that the Trust currently had only two Fellows with specific time in their job plans to focus on QI but he said this was increasing to four. He added that they were working closely with the Clinical Audit department to reduce the number of audits carried out so that the remaining audits were both useful and of a higher quality. Mr Bethune said that additional administrative and IT support would assist the QIA in achieving its next steps. Mrs Cottam noted a theme throughout the projects relating to variability versus standardisation and commented that My Care would remove the option for variability. She asked if moving to standardised approaches would further improve the care provided. Dr Lawday said that this would depend on whether the appropriate frontline staff were involved and added that the adaptability of processes would also have an impact. It was acknowledged that having one QI strategy approach, to incorporate the various strands, would be the most appropriate way forward for the Trust. Mr Brent thanked the team for their excellent presentation. **The Board noted the report.**	
102.18	**GOVERNANCE COMMITTEE REPORT**	
	Ms Romaine reminded the Board that they had already received an update relating to vaginal mesh in the CEO report. She invited questions from the Board. Professor Wilkinson-Brice sought approval for the proposal of Non-Executive Directors involvement in the Care Quality Assessment Tool (CQAT). Ms Romaine said this required further discussion amongst all NEDs but that there was approval in principle.	

	The Board noted the report.	
103.18	**OPEN VISITING FEEDBACK**	
	Professor Wilkinson-Brice reported that a detailed presentation had been provided at the Patient Engagement Committee (PEC) on 5 July 2018 in relation to the open visiting feedback. She said that there had been debate both for and against at the Care Matters meeting and engagement with medical staff at all levels. Professor Wilkinson-Brice said the Trust had carried out a poll on Twitter and open drop in sessions had been held for people to attend and have their say. Professor Wilkinson-Brice said that comments from staff were fairly evenly distributed between positive and negative. Some of the negative feedback related to a perception of a lack of dignity, minor cleaning issues, a perception of poor eating and disruption to medication rounds. Professor Wilkinson-Brice said that a solution to this was being looked into. The more positive feedback included that patients appeared more settled, there were fewer visitors at any one particular time, there was an improvement in the onsite parking availability, patients had more time to talk to visitors, the perception of a reduction to the risk of falls, and visitors provided additional assistance at meal times. Overall, Professor Wilkinson-Brice said the consensus from the PEC was that the open visiting should continue. The teams would look to use and reinforce the visitors' charter to lessen the disruption to ward rounds and a suggestion for tabards to be worn making it clear that medication rounds were in progress and patients/staff should not be disturbed at this time. Professor Wilkinson-Brice said that the notion of rest time, particularly on surgical wards, would also be explored. It was agreed that the Board would receive a further update at the January 2019 Board meeting. **ACTION: Professor Wilkinson-Brice to provide a further update on visiting times at the January 2019 Board meeting** **The Board noted the report.**	**EWB**
104.18	**ANY OTHER BUSINESS**	
	No other business was reported.	
105.18	**PUBLIC QUESTIONS**	
	Mrs Freeland, Staff-side Chair, referred to the staffing challenges and asked as to the progress of the portering review. Mrs Cottam said she would provide a detailed update outside of the meeting. **ACTION: Mrs Cottam to provide Mrs Freeland with a detailed update in relation to the portering review** Dr Foxall, on behalf of the Council of Governors, thanked Ms Romaine for her years of commitment, specifically around raising awareness of the Governors. She said it was evident that the NEDs played a crucial role and the Trust would sorely miss Ms Romaine. There being no further questions from the public, the meeting was closed.	**TAC**

106.18	**DATE OF NEXT MEETING**	
	The date of the next meeting was announced as taking place at 9.30am on Wednesday 26 September 2018 at the Royal Devon and Exeter Hospital.	

PUBLIC MEETING OF THE BOARD OF DIRECTORS
Held on 25 July 2018
ACTIONS SUMMARY

This checklist provides a status of those actions placed on Board members in the Board minutes, and will be updated and attached to the minutes each month.

PUBLIC AGENDA					
Minute No.	**Month raised**	**Description**	**By**	**Target date**	**Remarks**
122.17	October 2017	Professor Harris and Professor Wilkinson-Brice to review the ward staffing structures and provide an update to the Board at the meeting in April 2018	AH/EWB	~~April 2018~~ ~~September 2018~~ January 2019	April 2018 update: A clinical skills pathway mapping process has been undertaken within Healthcare for Older People (HfOP) and ENT identifying competencies required to deliver ward based care across a range of professions/alternative roles. The outputs of this are being presented initially to the Medical Workforce Strategy Group on 27th April 2018. A further update will be provided to the Board meeting in September 2018. **July 2018 Update:** The Board agreed an extension to January 2019 for the comprehensive clinical workforce review to be presented. Action on-going
06.18 (2)	January 2018	Patient story to be trialled at the beginning of each meeting to be trialled at the Patient Experience Committee meeting for three months.	EWB/JA	November 2018	
36.18	March 2018	The PEC to compare the staff survey results with that of the national inpatient survey in relation to the use of feedback from patients and service users to inform decisions within departments and Divisions	JA	October 2018	**July 2018 Update:** The patient survey results were presented to PEC on 5th July 2018. These will now be compared with the Inpatient Survey results and will report back to PEC in September 2018 and to the Board of Directors in October 2018. Action on-going

PUBLIC AGENDA					
Minute No.	**Month raised**	**Description**	**By**	**Target date**	**Remarks**
67.18 (1)	May 2018	Mr Adey to review the current medical bed occupancy and produce a forecast trajectory for improvement	PA	~~July 2018~~ September 2018	**July 2018 Update:** Due to unexpected absence in the information team it has not been possible to provide this information in July 2018. Information will be provided for the September 2018 Board. Action on-going **September Update:** The current average medical bed occupancy is 94.1%, or 337 occupied beds. The Hospital Improvement plans are forecast to provide the equivalent of 30 medical beds, which would reduce medical bed occupancy by 8.3% if demand remains stable. Action complete.
67.18 (4)	May 2018	Mr Adey to provide an update in relation to the trajectories and performance for RTT at the end of Q1	PA	September 2018	**September 2018 Update:** This is scheduled on the afternoon of the September 2018 Board meeting. Action complete.
87.18	June 2018	Mr Adey to provide the Outpatient Project Overview presentation to the CoG meeting in August 2018	PA	September 2018	**September 2018 Update:** The Outpatient Project Overview slides were made available to the CoG meeting in August 2018. Action complete.
96.18 (1)	July 2018	Professor Wilkinson-Brice to include a deep dive into nursing vacancies, within the Medical Services Division, in the Ward to Board report at the October 2018 Board meeting	EWB	October 2018	
96.18 (2)	July 2018	Mr Adey to carry out a deep dive into cancer performance and report back to the Board in October 2018	PA	October 2018	
96.18 (3)	July 2018	Mr Dillon to be invited to attend the visit of the Sheffield Medical Examiner in September 2018	AH	September 2018	**August 2018 Update:** Mr Dillon has confirmed his attendance at the visit on 24 September 2018. Action complete
98.18 (1)	July 2018	Professor Wilkinson-Brice to present the findings of the deep dive into reports of violence and aggression to the September 2018 Board meeting	EWB	September 2018	**September 2018 Update:** This is scheduled on the September 2018 Board agenda. Action complete
98.18 (2)	July 2018	Professor Wilkinson-Brice to circulate an explanation of ratings for adequate staffing on the Maternity dashboard to Board members	EWB	September 2018	**September 2018 Update:** A verbal update will be provided at the September 2018 Board meeting. Action on-going.

PUBLIC AGENDA					
Minute No.	**Month raised**	**Description**	**By**	**Target date**	**Remarks**
103.18	July 2018	Professor Wilkinson-Brice to provide a further update on visiting times at the January 2019 Board meeting	EWB	January 2019	
105.18	July 2018	Mrs Cottam to provide Mrs Freeland with a detailed update in relation to the portering review	TAC	September 2018	**September 2018 Update:** Mrs Cottam met with Mrs Freeland on 7 August 2018 and provided an update. Action complete.

Signed:

James Brent
Chairman

Agenda item:	9.2, Public Board meeting	Date: 26 September 2018
Title:	Integrated Performance Report	
Prepared by:	Pete Adey, Chief Operating Officer Tracey Cottam, Director of Transformation & Organisational Development Adrian Harris, Medical Director Chris Tidman, Chief Financial Officer Em Wilkinson-Brice, Deputy Chief Executive / Chief Nurse	
Presented by:	Chris Tidman, Chief Financial Officer	
Responsible Executive:	Pete Adey, Chief Operating Officer Tracey Cottam, Director of Transformation & Organisational Development Adrian Harris, Medical Director Chris Tidman, Chief Financial Officer Em Wilkinson-Brice, Deputy Chief Executive / Chief Nurse	
Summary:	To advise the Board of the Trust's performance against key performance standards and targets; and progress on the implementation of the Trust Strategy and key supporting projects.	
Actions required:	The Board is asked to receive the Performance Report and note the current risks and the proposed action plans to mitigate the risks against performance delivery.	

Status (*):	Decision	Approval	Discussion	Information
		Yes		

History:	This is a standing agenda item at each meeting of the Board of Directors.
Link to strategy/ Assurance framework:	This paper details the Trust's performance in respect of key performance standards and targets. Achievement of these performance standards and targets is a key objective within the Trust's Strategy.

Monitoring Information		Please specify CQC standard numbers and tick ✓other boxes as appropriate	
Care Quality Commission Standards	Outcomes		
Monitor	✓	Finance	✓
Service Development Strategy		Performance Management	✓
Local Delivery Plan		Business Planning	
Assurance Framework		Complaints	
Equality, diversity, human rights implications assessed			
Other (please specify)			

Contents

Overview

The Trust has seen continued high demand for planned and emergency care in August, but staff are performing superbly under the circumstances to deliver good outcomes and patient experience. Our ED performance continues to be strong despite high numbers of emergency attendances, which is testament to efforts of all of our teams involved throughout the patient pathway. Increased referrals for planned care continues to put pressure on RTT, diagnostics and cancer performance.
On the emergency pathway, flow was better than in July, particularly earlier in the month when the Trust was able to close a number of bays on wards to ease staffing pressures, contrasting with a more difficult period in which escalation beds had to opened and staffed with bank/agency staff. Better flow supported ED system performance of 94.2% against the PSF target of 91.5% which is a superb performance given the added complexity of the rotation of junior medical staff, which has historically added pressure to the ED team. The hot weather in August is likely to have been a factor in driving up ED attendances through tourism and medical admissions through elderly frail people struggling to maintain good levels of hydration. During August there were 22 days where the Met Office issued a level 2 heatwave and 5 days where level 3, which is the highest level, was declared.

During the early part of the month the Trust worked with several local partner organisations in undertaking a “system reset” aimed at identifying and challenging cross system barriers to patient flow. Following this process a working group has been established to take forward the key areas and develop long term sustainable solutions. During this period Devon County Council (DCC) have agreed a new contractual framework for providers of domiciliary care from October which will guarantee hours for business and domiciliary care workers themselves and is expected to increase capacity.

The main driver of pressure across planned care is the sustained increases in demand across a number of key areas, which is being seen both locally and across the wider Devon area. A secondary but important challenge has been issues relating to consultant medical cover, which has led to capacity shortfalls in specialties such as General Surgery and Cardiology. A broad range of actions, underpinned by significant investment, is in place to improve performance against all indicators over the remainder of the year. A more detailed update on RTT and diagnostics is provided separately on the Board agenda.

The quality and safety metrics continued to show sound delivery of patient care, with the harm-free care safety thermometer, nutritional needs assessment and infection control measures all remaining at high levels of compliance. Levels of healthcare acquired infection in August were low and performance against the stroke indicators continue to be excellent. There were some challenges relating to medical prescribing, which is likely to be a consequence of the change over of junior doctors which took place in August.

Some encouraging patient-centred changes were reported in August, including further centralisation and streamlining of the pre-assessment process, improvements to the environment for patients undergoing radiotherapy and the introduction of a support group for patients with inherited breast cancer genes.

Workforce indicators have generally improved during August, with turnover remaining stable and sickness reducing to 4.03% (the lowest level since September 2017). However, the levels of sickness related to stress and anxiety, coupled with the reduction in time released for statutory and mandatory training are possible signs of a system that is working with little headroom. Overseas recruits are beginning to join from the Philippines which will provide a much needed boost for our medical wards over the coming months, to address the vacancy position.

The increased workload is now putting the Trust under financial pressure, particularly given the block contract agreed with our main CCGs. Year-to date a deficit of £4.5m has been incurred, which is £1.6m adverse to budget, albeit still within the planned levels to attract the Q2 PSF payment. The main drivers are higher agency and consumable costs. The Trust is still forecasting a year end £5.7m deficit in line plan which will maximise PSF, although there is a residual £3m gap that will need to be addressed through reducing demand and spend and/or increasing income. A mitigation plan will be confirmed at the October Board.

Executive Summary

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
OPEL Status	2	1	1	1	1	1	1	1	1	1	1	1	2	2	2	2	2	2	2	2	1	2	2	2	2	2	2	2	1	2	1
Unplanned Escalation Beds	0	6	0	0	0	0	0	0	0	0	0	0	3	0	3	0	0	4	0	6	9	14	11	7	0	0	0	16	10	10	5
Delayed Transfer of Care (DTOC)	45	33	32	37	45	53	45	37	31	36	32	35	39	36	32	29	27	33	39	44	39	39	35	34	38	42	45	42	43	41	31

Activity and Flow :

- Medical discharges were higher in the first fortnight of August than the remainder of the month, leading to a better position regarding patient flow, as shown in the OPEL status table above.
- Overall flow was an improvement on previous months, with 14 days at OPEL 1, 17 at OPEL 2 and no days at OPEL 3.
- The more challenged flow position towards the second half of the month required the use of a number of escalation beds, which placed some pressure on clinical staffing levels. As anticipated, ward staffing remained challenged throughout August due to the school summer holidays, which almost certainly impacted upon the level of ward discharges across the month.
- The Delayed Transfers of Care (DTOC) position remained stable during August, although significant capacity issues relating the shortfalls in domiciliary care capacity over the school holidays was a challenge throughout the month. Devon County Council (DCC) have a greed a revised contract with domiciliary care providers which will guarantee hours for business and domiciliary care workers themselves.
- The Trust collaborated with colleagues from commissioner and provider organisations to undertake the Eastern Devon “System Reset,” which commenced on 31st July and finished on the 22nd August. The exercise proved useful as a system diagnostic, and in gaining cross organisational alignment on tackling the key issues relating to patient flow.

Operational Performance:

- Overall performance has been challenging during August due to continued increasing demand in a number of areas, which was has been seen across the Sustainability & Transformation Partnership (STP) area.
- The more favourable patient flow position supported better Emergency Department (ED) performance and enabled delivery of 92.8% for Trust managed services alone and 94.2% for the Eastern Devon system against the 91.5% Provider Sustainability Fund (PSF) trajectory.
- Of the 2753 ambulance arrivals in August, there were no handover delays greater than 60 minutes and 35 delays greater than 30 minutes.
- Performance against the diagnostics standard deteriorated in August to 87.01% due to continued high levels of demand, which was challenging to manage due to a reduced capacity to deliver additional flexible sessions over the holiday period.
- At the time of writing this report, performance against the 62-day cancer standard is 74.6% against the PSF trajectory of 83.1% and the national standard of 85%.
- The number of incomplete pathways increased in the last month by 731 to 33961 at the end of August and the number of long waiting patients increased to 90, caused predominantly by increases within Cardiology and patient choice within Orthopaedics. A more detailed update will be provided elsewhere on the board agenda.

Patient Experience, Safety & Quality :

- Demonstrating Difference continues to evidence the sustained focus on improving the experience of people using our services.
- There were 262 complaints and concerns received across the Trust during Quarter 1 (2018/19) which is similar to Quarter 4 (2017/18) (260).
- Safety Thermometer - Harm Free care has remained above 95% for the past 2 audits, currently at 96.04%.
- July and August have been particularly challenging months with regards to ensuring clinical shifts are adequately filled. Once again it is important to note that ward teams have worked tirelessly to ensure the safety of our patients.
- Hospital Standardised Mortality Ratio (HSMR) figures have now been released up to June 2018. Whilst the rolling 12 month position has started to reduce, it currently remains in the above expected level; it is however expected to continue to reduce over the coming months as the 12 month rolling position catches up with underlying reductions in the monthly HSMR position which have been seen between January 2018 and June 2018.
- August has been a challenging month in relation to antimicrobial prescribing compliance, which is largely impacted by the new intake of junior doctors.
- VTE performance remains stable with both 'Risk assessment on admission' and 'Thromboprophylaxis' metrics exceeding the target position.

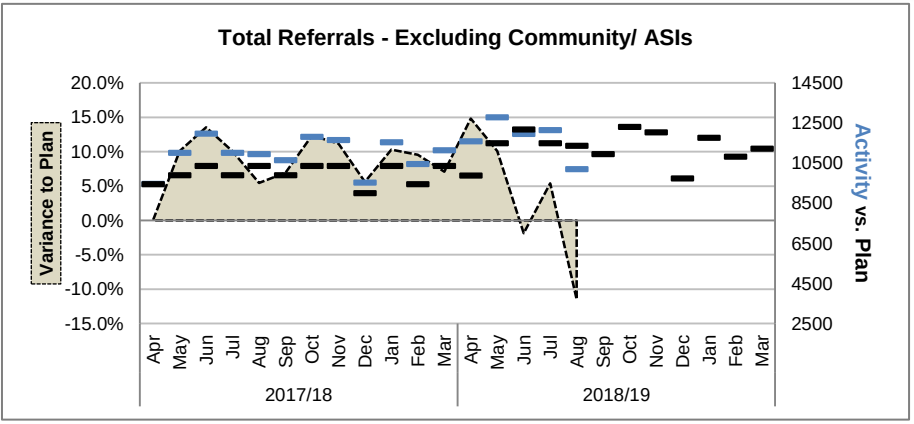
Our People:

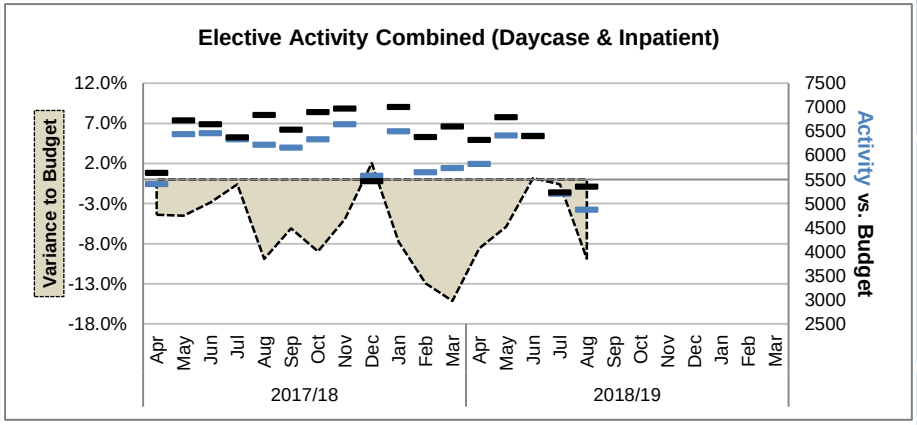
- The completion rate for exit interviews is currently 42.6% based on leavers during August. This is a significant increase on the 26% reported last month and the highest rate since reporting started.
- There has been a significant increase in the number of roles being actively recruited against this month as a result of the backfill requirements arising from internal appointments to the My Care programme.
- Overall staff turnover rates remain stable at 11.3%
- Turnover rate for registered nurses continues to reduce with 9.7% recorded in August.
- The monthly rate of sickness for August was 4.03%. This is the lowest recorded since September 2017.
- Anxiety, stress, depression and other psychiatric illnesses continue to be the highest reported cause of sickness accounting for 25.02% of all sickness absence (down from 27.40% last month).

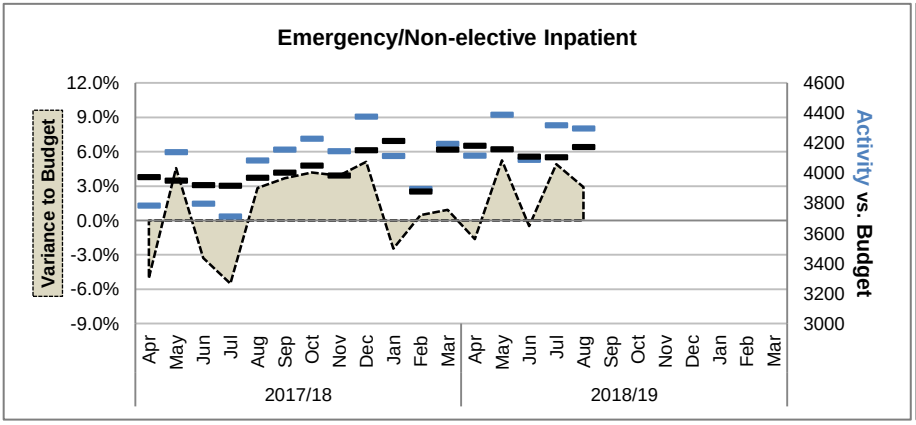
Finance:

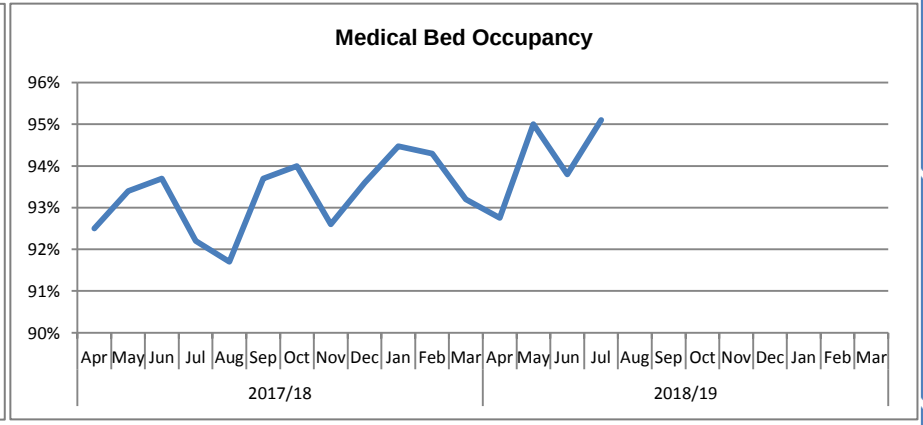
- A deficit of £4.5m has been incurred as at end of August, which is £1.6m adverse to budget (£0.75m favourable to plan).
- Year to date overspends on pay (£1m), non pay (£1m) are partially offset by a PDC benefit and an overachieved CIP position (£0.4m).
- Post mitigation, the Trust is still forecasting a deficit of £5.7m, in line with budget and annual plan. After assumed PSF income of £12.2m, the Trust will outturn a surplus of £6.5m in line with plan.
- The forecast position assumes mitigation will offset the CIP shortfall of £6.0m. However, at month 5 there remains a residual risk of £3.0m to manage.
- The £3.0m risk is primarily due to increased spending of £2.2m on agency and consumables as a result of increased patient demand above contract. There is also a net £0.8 shortfall forecast on Specialist commissioning income, albeit it is still possible that this could recover .
- The Trust has achieved £11.1m of the £23.3m CIP target. A check and challenge process led jointly by COO and CFO continues, and this has confirmed that the Divisions will under deliver in year by £5.9m. Whilst the Trust is delivering more activity than planned, this cannot be counted until the block contract is rebased. A mitigation plan shared with the Board as part of budget setting will be enacted to bridge the CIP gap
- If the £3m risk is not addressed, then the Trust could miss its control total and as a result will fail to secure the Q4 PSF payment of £4.3m. The Executive team will be reviewing all options to close down this risk and will report back with an action plan to the October Board.
- The Trust has achieved a score of 2 in the NHS Improvement Finance and Use of Resources year to date, in line with plan.

Activity vs. Plan – *comparison of in-month demand & activity in relation to the 2018/19 operational plan*









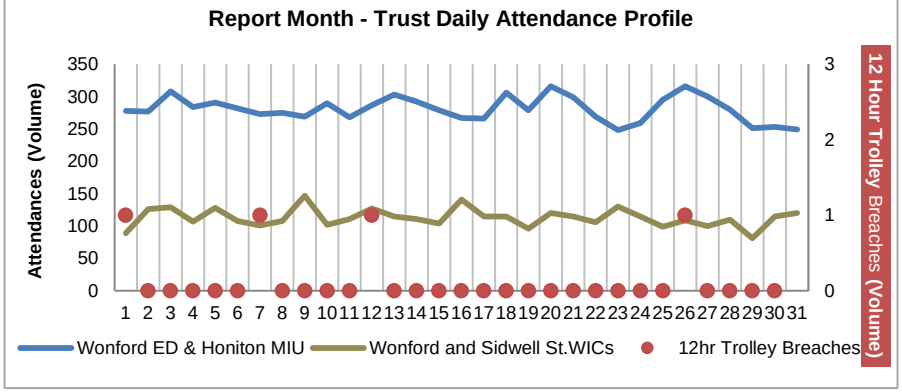
***How to Read Chart**: Left hand values indicate the variance of the actual activity to plan whilst the right hand provides an indication of total volume of activity and plan. The colour in the axis titles acts as the legend.*

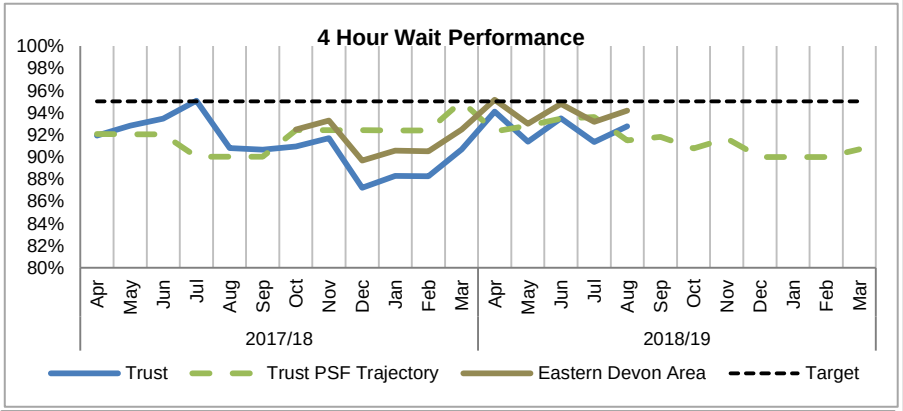
- Elective activity during August was lower than anticipated for both day case and inpatient activity, with a combined year to date underperformance of 5.4%. Whilst some specialties are above plan (Urology, Ophthalmology and Oral Surgery) other key specialties are below plan such as General Surgery, Gastroenterology and ENT, where medical workforce shortfalls are the key driver. Cardiology is also below plan, where continued high levels of emergency demand has necessitated the conversion of some elective capacity into emergency operating lists.

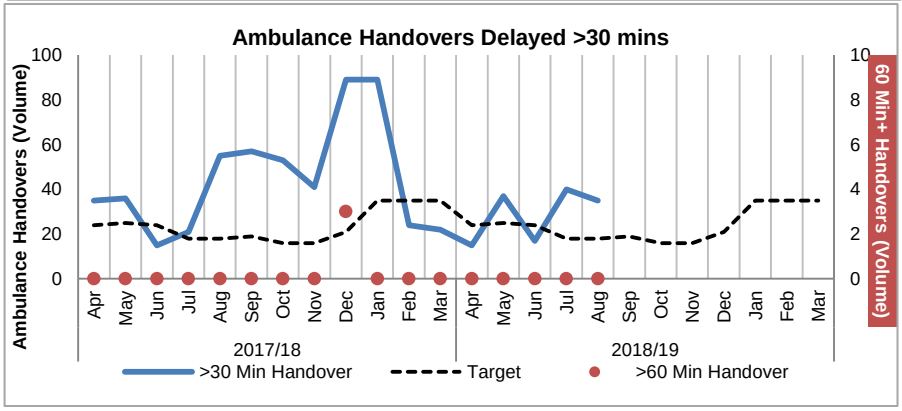
- Overall emergency and non-elective activity was 2.9% above plan for August and 1.7% above plan for the year. In terms of year on year growth, emergency admissions are 5.7% up the April-August 2017 period.

- The comparison of referrals against plan excludes ASIs which are now a material number. Once this is taken into consideration referrals were 1% above plan in August. The cumulative position for GP/Dental referrals (once the impact of ASIs is included) is 8.2% growth (~2900 more referrals) in 2018/19 compared to the same period in 2017/18. Key specialties experiencing growth are Urology (33%), Oral surgery (14%), Gastro (20%), Cardiology (23%), Dermatology(11%)

Emergency Department – *key metrics relating to activity & performance in urgent & emergency care services*







Overall performance

- Including local MIUs, performance against the 4 hour target was 94.2% for August, meaning the PSF trajectory target of 91.5% was met. The details of the different elements of the Trust and system performance is shown in the table below:

Type of activity	Denominator	Patients > 4 hours	% Performance
ED only	7532	914	87.9%
All RD&E Delivered Activity (including Honiton MIU and the WICs)	12649	914	92.8%
Total System Performance (including MIUs)	15843	925	94.2%

- There were 4 patients who waited longer than 12 hours from decision to admit to transfer to an inpatient bed, all of whom were awaiting a mental health bed in another provider.
- Year to date ED attendances for ED and Honiton MIU are 2278 higher than the same period last year, which represents 4.8% growth in demand.

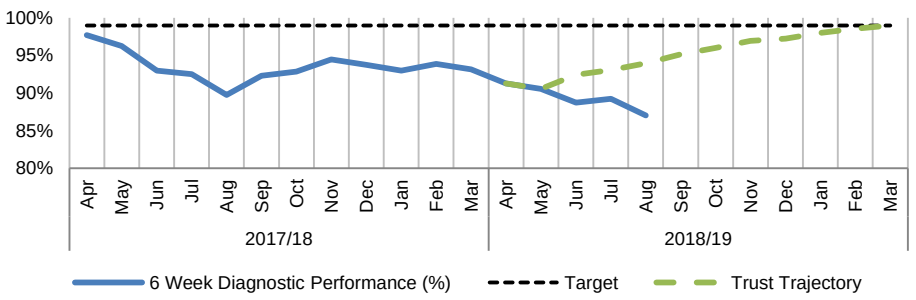
Key challenges and improvement actions:

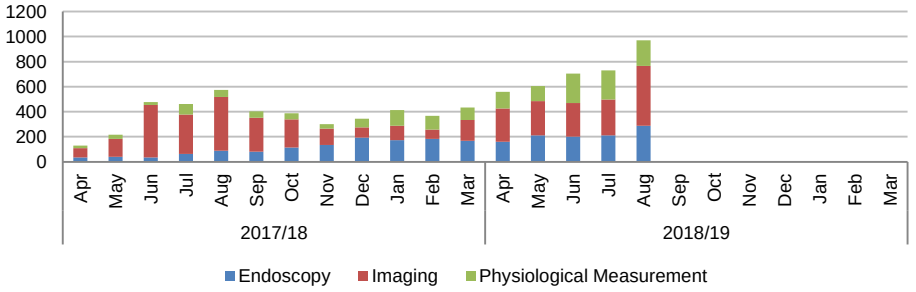
- The ED continued to see increased demand over the evening period, with additional shifts being deployed wherever possible in order to meet this demand.
- Additional clinical staffing has been allocated to tackle the increasing demand overnight, including changes to the Middle Grade and Nurse Practitioner rotas.
- Work to streamline the admissions process for spinal patients, as well as to triage urgent orthopaedic referrals from GPs to direct less urgent patients to fracture clinic is progressing well and should be complete by October 2018.
- Further system wide meetings to progress solutions for psychiatric patients requiring inpatient beds are being established by the A&E Delivery Board

Ambulance Handover Delays

- Of the 2753 ambulance arrivals in August, there were no handover delays greater than 60 minutes and 35 delays greater than 30 minutes, equating to 98.73% of handovers being under 30 minutes in duration.
- Improvement work relating to data capture and further streamlining the process for rapid assessment and triage continues to progress through partnership working between the ED and SWAST teams.

Diagnostics - *volumes of patients waiting longer than 6 weeks for one of fifteen key diagnostics tests*





Overall position - Performance against the diagnostics standard deteriorated in August to 87.01% due to continued high levels of demand, which was challenging to manage due to a reduced capacity to deliver additional flexible sessions over the holiday period. With the exception of Cardiac MRI (where additional solutions are currently being scoped) , plans in place for all modalities are expected to regain compliance against this standard by the end of Quarter 4.

MRI - There were 99 non cardiac MRI breaches in August due to continued increases in demand. A further increase in the utilisation of the mobile unit has been secured from October and breaches are expected to reduce from October onwards. There were 138 cardiac MRI breaches in August, due to continued high demand within Cardiology in general. Additional capacity from the local independent sector is being scoped to clear this backlog.

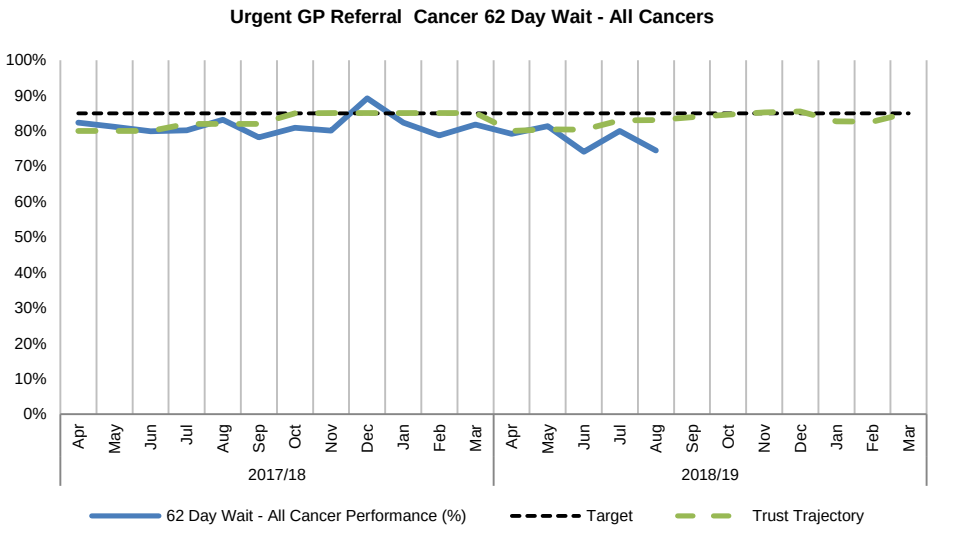
CT - There were 98 CT breaches in August. This was as a result reduced capacity to deliver flexible sessions over the holiday period. Additional sessions have been provided in September, which has cleared this backlog.

Endoscopy - The planned recruitment to cover historic workforce shortfalls is complete with the last vacancy scheduled to be filled in October. Additional non-medical endoscopist capacity and in-sourced weekend capacity has been set in place for mid-October. This is initially planned for 8 consecutive weekends to address the backlog and will see a significant reduction in the longest waiting patients on both the cancer and routine diagnostic pathways by the end of Quarter 3.

Echocardiography - Continued high inpatient echo demand and equipment failure in July has caused the backlog to increase from 108 in June to 138 in August. Two additional echo machines are on order and recruitment is underway for additional echo technicians, as part of the Cardiology Recovery Plan. The additional capacity (of over 2000 slots per year) is expected to be in place from October 2018.

Area	Diagnostics By Specialty	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Endoscopy	Colonoscopy	82.2%	72.0%	74.0%	65.8%	67.8%	64.2%	67.6%	78.8%	69.8%	69.6%	70.9%	69.9%
	Cystoscopy	100.0%	94.4%	100.0%	73.3%	92.9%	72.2%	66.7%	83.3%	72.2%	68.8%	72.7%	52.2%
	Flexi Sigmoidoscopy	90.6%	79.5%	81.0%	69.7%	74.2%	81.8%	74.3%	80.9%	83.2%	86.3%	85.9%	69.5%
	Gastroscopy	86.3%	71.3%	84.1%	79.9%	76.5%	78.8%	82.3%	80.1%	71.0%	71.5%	71.8%	66.8%
Imaging	Barium Enema	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Computed Tomography	82.4%	87.0%	97.5%	99.7%	100.0%	100.0%	99.9%	93.5%	100.0%	99.6%	97.8%	91.7%
	DEXA Scan	100.0%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Magnetic Resonance Imaging	95.1%	80.0%	92.8%	94.7%	93.2%	95.8%	90.4%	88.2%	83.8%	83.3%	85.2%	84.6%
	Non-obstetric Ultrasound	99.9%	91.7%	100.0%	99.9%	100.0%	99.8%	100.0%	100.0%	100.0%	99.7%	100.0%	97.7%
Physiological Measurement	Cardiology - Echocardiography	89.6%	79.9%	92.4%	85.8%	78.9%	76.9%	75.6%	70.7%	76.1%	69.0%	64.4%	69.4%
	Cardiology - Electrophysiology	-	0.0%	-	-	-	-	100.0%	100.0%	-	50.0%	-	100.0%
	Neurophysiology - peripheral neurophysiology	92.9%	100.0%	100.0%	33.3%	80.0%	100.0%	98.1%	78.6%	62.1%	35.8%	32.7%	50.5%
	Respiratory physiology - sleep studies	88.8%	72.6%	91.6%	93.6%	63.4%	73.2%	66.0%	100.0%	100.0%	97.3%	91.2%	100.0%
	Urodynamics - pressures & flows	100.0%	93.1%	94.4%	95.9%	95.1%	97.5%	96.7%	94.6%	95.6%	-	88.9%	88.8%
Total		92.3%	92.8%	94.5%	93.8%	93.0%	93.9%	93.2%	91.3%	90.5%	88.7%	89.3%	87.0%

Cancer 62 Day – *Proportion of patients treated within 62 days following referral by a GP for suspected cancer*



62 Day Wait by Tumour Site	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Total	Breaches
Brain & CNS	100.0%	-	-	100.0%	100.0%	-	-	100.0%	-	100%	0.5	0.0
Breast	97.4%	97.9%	100.0%	95.2%	93.3%	94.7%	100.0%	95.6%	93.6%	87.5%	16.0	2.0
Gynaecological	100.0%	100.0%	84.6%	81.8%	87.5%	71.4%	84.0%	92.1%	100.0%	91.7%	18.0	1.5
Haematological	50.0%	81.8%	40.0%	54.2%	70.6%	42.9%	70.0%	55.6%	89.5%	62.5%	8.0	3.0
Head & Neck	72.7%	80.0%	21.1%	66.7%	46.2%	72.2%	76.9%	70.8%	70.0%	75.0%	10.0	2.5
Lower Gastrointestinal	74.1%	77.3%	77.8%	57.1%	76.2%	66.7%	56.3%	17.4%	30.3%	31.3%	16.0	11.0
Lung	69.2%	91.7%	73.3%	46.2%	76.5%	54.6%	79.3%	75.0%	81.8%	79.0%	9.5	2.0
Sarcoma	78.6%	40.0%	40.0%	0.0%	83.3%	100.0%	81.8%	100.0%	79.0%	56%	12.5	5.5
Skin	96.5%	97.7%	100.0%	97.9%	98.6%	98.4%	99.0%	98.9%	98.8%	98.3%	171.5	3.0
Testicular	-	-	-	-	-	-	-	-	-	-	0.0	0.0
Thyroid/Endocrine	33.3%	100.0%	-	-	-	-	0.0%	0.0%	50.0%	-	0.0	0.0
Unknown Primary	100.0%	0.0%	50.0%	100.0%	100.0%	66.7%	100.0%	100.0%	-	-	0.0	0.0
Upper Gastrointestinal	95.0%	74.2%	100.0%	92.3%	83.3%	0.0%	82.4%	33.3%	65.0%	62.1%	14.5	5.5
Urology	44.2%	83.9%	65.8%	65.8%	71.8%	62.5%	65.0%	62.5%	55.9%	44.4%	57.5	32.0
Total	80.1%	89.2%	82.4%	78.8%	81.8%	79.2%	81.4%	74.1%	80.0%	74.5%	334.0	68.0

Overall performance

- At the time of writing this report, performance against the 62-day standard is 74.5% against the Trust's Performance Improvement Trajectory of 83.1% and the national standard of 85%.
- The main areas of challenge are Urology, Lower GI, Upper GI and Sarcoma.
- Continued high levels of demand, particularly within Urology, and the on-going challenges within Endoscopy remain the two key drivers of the current position.

A review of the key drivers and actions in place to improve performance will be presented to the Board of Directors in October 2018.

Lower GI:

- Capacity constraints within Endoscopy continue to significantly impact upon the Colorectal pathway, with a slightly reduced average wait of five weeks for this stage of the pathway. The actions described on page 8 of this report will clear the backlog of endoscopy patients by the end of Q3.
- Workforce issues previously highlighted have improved and will continue to improve from October 2018. This will provide additional capacity and flexibility in both outpatients and theatre.

Urology:

- Referrals into the service have started to plateau, however, this is at a 35% increase in demand, approximately 40 additional referrals per month. This position is reflected across the STP area, with all trusts noting similar increases in demand. A strategic, Devon-wide solution to this level of increasing demand may be required and is being considered by system leaders.
- Within the Urology service work continues to maximise capacity, effectively prioritise activity and optimise pathways.

Sarcoma:

- The number of Sarcoma breaches is higher than average in August although a case notes validation of each patient is expected to reduce this number of breaches.

Upper GI:

- At the time of writing, it is forecast that there will be 4 breaches for 62 Day target. These are due to surgical capacity (1), clinical factors (2) and late referral from another provider (1).

Cancer 14, 31 & 62 Day Waits – *Cancer Access Targets*

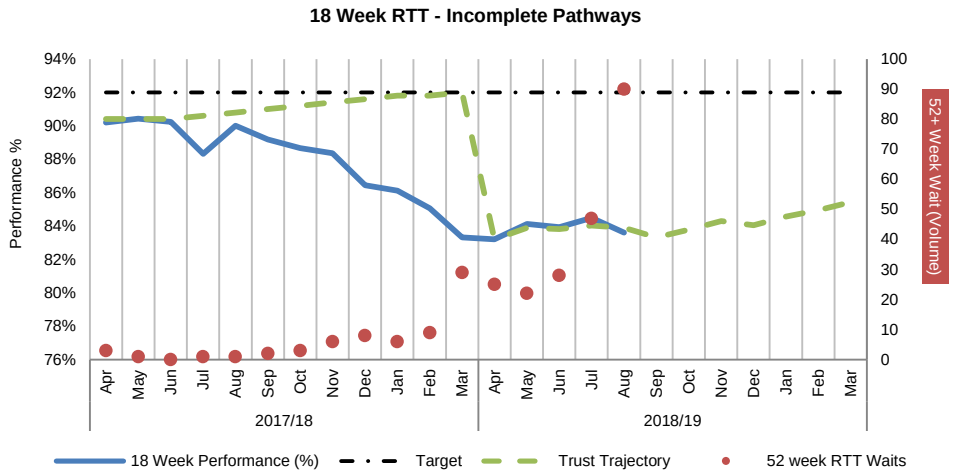
Cancer - 14, 31 & 62 Day Wait

	Performance(%) and Number of Breaches	TARGET	2017/18 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
14 Day	All Urgent (%)	93%	95.1%	95.8%	94.2%	96.0%	94.7%	93.5%	96.3%	96.1%	94.6%	94.3%	91.9%	82.0%	86.5%	82.9%	82.3%	85.3%	84.1%							
	All Urgent		75	69	108	72	98	105	69	66	88	91	121	322	240	339	342	304	304							
	Symptomatic Breast (%)	93%	91.7%	100.0%	97.1%	96.7%	94.1%	97.4%	96.7%	92.5%	95.2%	98.0%	98.5%	98.1%	96.1%	84.2%	92.9%	92.9%	97.1%							
	Symptomatic Breast		5	0	2	2	4	1	2	5	3	1	1	1	3	12	6	4	2							
31 Day	All Decision To Treat (%)	96%	97.2%	98.5%	98.6%	99.0%	98.6%	97.0%	98.5%	97.7%	98.6%	97.1%	97.9%	97.0%	99.6%	98.1%	95.8%	96.0%	95.0%							
	All Decision To Treat		7	4	4	3	4	9	5	7	4	10	6	11	1	6	13	14	23							
	Subsequent - Surgery (%)	94%	98.6%	100.0%	98.6%	97.7%	98.7%	97.7%	98.0%	98.9%	97.4%	95.9%	93.8%	98.7%	98.7%	98.9%	96.6%	97.7%	92.0%							
	Subsequent - Surgery		1	0	1	2	1	2	2	1	2	3	4	1	1	1	3	2	7							
	Subsequent - Radiotherapy (%)	94%	97.7%	100.0%	99.2%	100.0%	97.0%	100.0%	99.3%	100.0%	100.0%	99.4%	95.8%	96.6%	100.0%	97.9%	99.0%	98.4%	97.7%							
	Subsequent - Radiotherapy		3	0	1	0	4	0	1	0	0	1	6	5	0	3	1	2	3							
	Subsequent - Anti-Cancer Drug (%)	98%	100.0%	98.9%	100.0%	100.0%	98.9%	97.9%	99.1%	100.0%	98.8%	96.9%	98.8%	97.8%	99.1%	99.2%	98.2%	100.0%	98.8%							
	Subsequent - Anti-Cancer Drug		0	1	0	0	1	2	1	0	1	4	1	2	1	1	2	0	1							
62 Day	All Screening Service (%)	90%	95.0%	94.1%	96.0%	84.6%	100.0%	85.7%	96.6%	100.0%	100.0%	100.0%	83.3%	91.4%	87.5%	17.0%	88.1%	95.5%	80.6%							
	All Screening Service		0.5	1	1	2	0	2	1	0	0	0	3	4	2	2	3.5	1	3							

Cancer Performance:

- Good progress in the delivery of cancer targets had been made earlier in the year, however, the following issues are now materially impacting upon cancer performance in a number of areas:
  - Recent significant increases in demand for cancer services
  - Continued medical workforce pressures in Urology and General Surgery
  - Significant increases in demand for cancer diagnostics, which have increased by as much as 60% in some areas.
- At the time of writing this report 3 of the 7 (above) cancer performance targets were met in August 2018.
- A review of the key drivers and actions in place to improve performance will be presented to the Board of Directors in October 2018.
- Within the Trust, key actions currently underway to recover performance against these targets are:
  - The delivery of the Endoscopy action plan described on the previous page, which is expected to clear the backlog by the end of Q3.
  - Additional diagnostics capacity for MRI and CT described in the diagnostics section.
  - The recruitment of an additional locum consultant in General Surgery to provide additional capacity for 2 week wait urgent cancer clinics.
  - The surgical divisional teams have developed robust processes for tracking and prioritisation of cancer patients to ensure theatre capacity is allocated appropriately.
- Due to the impact and significance of these factors, solutions are being explored at a STP-wide level and progressed by the System Performance and Delivery Group.

Referral to Treatment – *Proportion of patients waiting longer than 18 weeks or 52 weeks for elective treatment*



RTT By Specialty	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Total	18+ weeks
General Surgery	84.8%	83.0%	79.5%	77.4%	74.1%	71.6%	76.6%	73.6%	72.3%	69.2%	3,056	931
Urology	92.9%	92.2%	92.8%	90.3%	91.0%	87.8%	90.9%	89.0%	88.3%	87.6%	1,428	159
Trauma & Orthop.	74.9%	72.4%	71.1%	69.0%	66.7%	64.1%	64.4%	65.5%	67.5%	68.7%	5,243	1,646
Ear, Nose & Throat	89.5%	84.7%	85.2%	84.4%	82.9%	84.0%	85.2%	86.4%	87.0%	84.2%	2,556	395
Ophthalmology	98.7%	97.5%	97.8%	97.7%	97.9%	96.9%	98.2%	97.8%	98.6%	96.5%	2,841	97
Oral Surgery	90.8%	90.2%	90.6%	89.4%	88.7%	85.9%	87.1%	87.2%	87.1%	89.7%	1,672	174
Plastic Surgery	91.2%	88.5%	89.5%	88.0%	83.2%	87.8%	82.0%	79.9%	78.9%	77.1%	838	187
Cardiothor. Surgery	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%	6	0
General Medicine	96.4%	97.4%	98.1%	98.1%	95.1%	96.5%	98.2%	98.0%	99.5%	99.5%	216	1
Gastroenterology	96.9%	96.8%	96.5%	95.6%	96.4%	95.4%	93.9%	92.9%	92.1%	87.9%	1,622	183
Cardiology	75.3%	75.3%	75.4%	73.5%	70.6%	70.6%	70.4%	68.7%	69.3%	67.6%	2,955	952
Dermatology	95.3%	92.5%	91.6%	91.3%	90.1%	88.8%	90.4%	90.4%	90.3%	89.6%	1,937	202
Thoracic Medicine	90.8%	84.5%	90.5%	91.2%	83.5%	80.3%	79.3%	76.5%	73.7%	72.0%	743	208
Neurology	95.6%	96.0%	96.4%	96.0%	96.0%	94.1%	93.8%	93.2%	92.1%	85.3%	389	56
Rheumatology	95.2%	96.4%	97.3%	96.4%	93.6%	94.7%	95.7%	94.6%	96.6%	95.2%	300	16
Geriatric Medicine	98.9%	98.9%	99.4%	98.5%	99.0%	99.0%	96.3%	96.8%	99.5%	98.8%	245	3
Gynaecology	95.3%	91.9%	92.6%	92.3%	92.4%	93.2%	92.5%	94.0%	93.9%	93.7%	1,414	91
Other	94.0%	92.6%	94.3%	93.3%	93.1%	93.1%	93.9%	94.6%	94.7%	94.0%	3,264	193
Total	88.4%	86.4%	86.1%	85.1%	83.3%	83.2%	84.1%	83.9%	84.5%	83.6%	33,961	5,948

Overall Performance

The number of incomplete pathways increased in the last month by 731 to 33961 at the end of August. Performance for August is currently at 83.6% compared to the Trust's Performance Improvement trajectory of 83.9%.

This growth in the waiting list is primarily driven by increased demand. After Including the impact of ASIs, the cumulative position is a 8.2% growth in referrals– equivalent to ~2900 more referrals year to date compared to the same period in 2017/18.

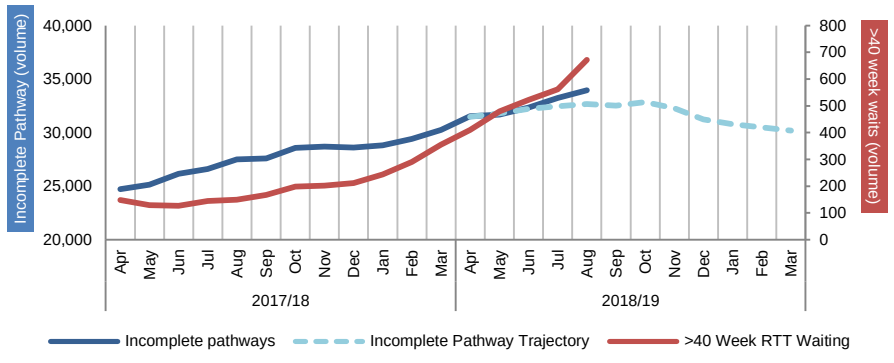
The second significant driver is workforce pressures, which have reduced capacity, particularly in Cardiology and General Surgery.

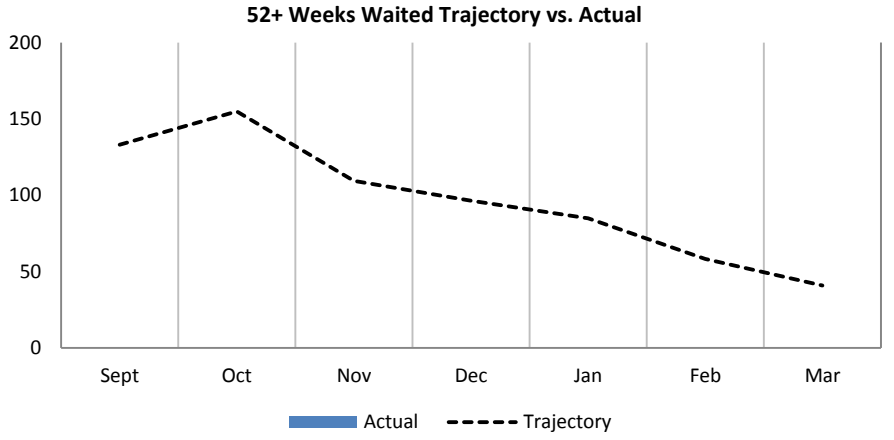
A detailed presentation on RTT will be given to the Board of Directors at the September meeting.

Continuing actions in place to improve performance

- Recruitment to additional medical, nursing and therapy workforce has continued at pace during the first half of 2018/19, with several posts having now commenced and others commencing throughout Q3 and Q4.
- Once all posts are in place the additional capacity for outpatient procedures is anticipated to deliver capacity for over 10000 outpatient appointments per year.
- There is expected to be some slippage in ENT and Ophthalmology, where the first round of consultant recruitment was not successful.
- The Trust continues to support all available initiatives for demand management being developed and implemented by the CCG. This will include the use of GPSIs where available.
- Actions to improve theatre productivity are being developed using two external expert resources to support delivery.
- The Trust is working closely with the CCG to identify opportunities within the independent sector and aims to begin transferring patients within the next few weeks.
- **Long waiting patients – Please see overleaf.**

Referral to Treatment – Long Waiting Patients

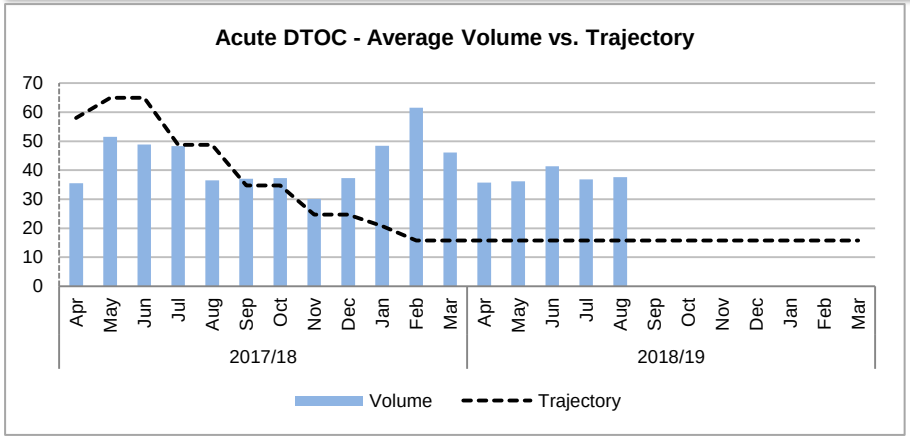


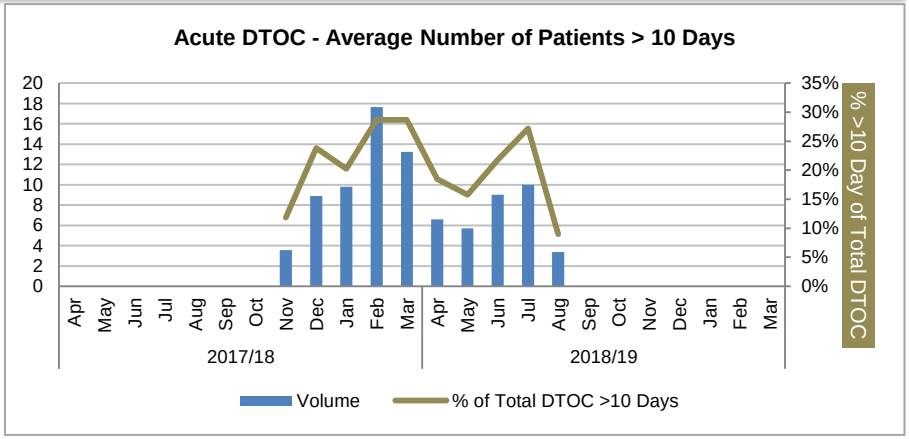


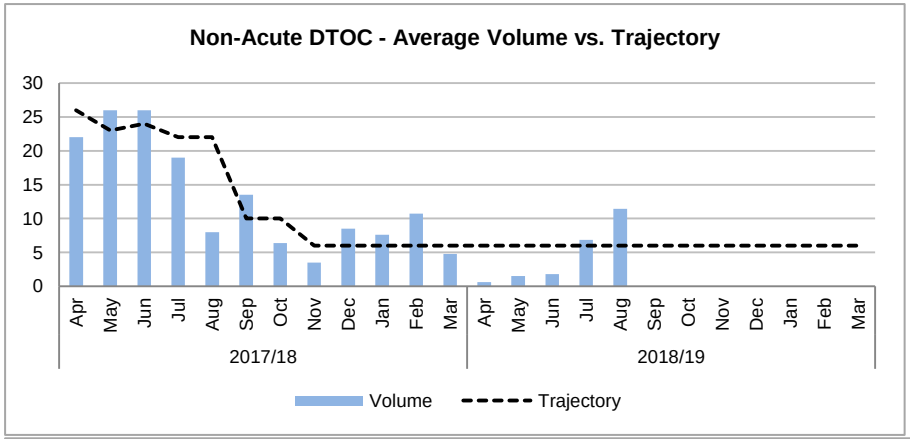
Specialty		2018/19				
		Apr	May	Jun	Jul	Aug
40+ weeks	Orthopaedics	193	209	233	250	272
	Cardiology	120	144	182	185	223
	General surgery	51	47	59	77	89
	Other	50	76	46	55	84
52+ weeks	Orthopaedics	8	9	9	12	24
	Cardiology	13	8	9	21	52
	General surgery	4	3	5	6	6
	Other	6	3	6	8	8

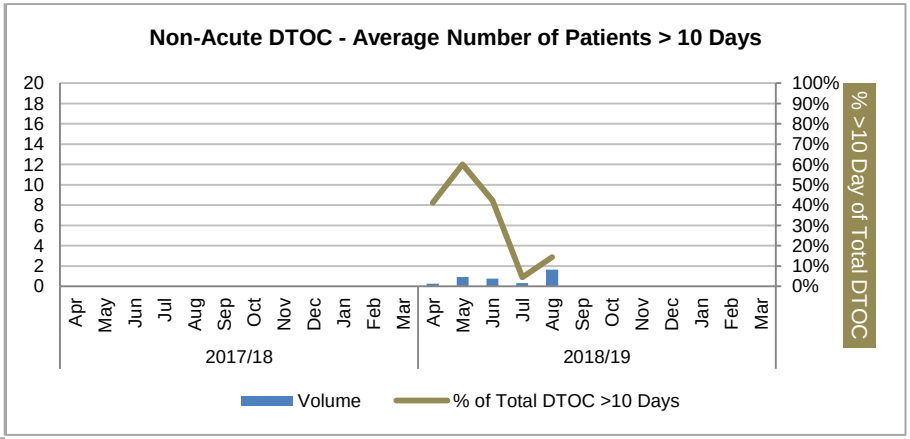
- **Due to the increase in waiting times and in particular the number of long waiting patients, more detailed information has been provided below.**
- Due to the deterioration in the number of long waiting patients nationally, trusts have been asked to submit a revised trajectory for patients waiting over 52 weeks. The Trust's submission is shown in the graph on the middle left.
- The table (bottom left) shows the number of patients waiting over 40 and 52 weeks at specialty level. The rise in long waiting patients is a significant concern for the senior teams across all divisions and is the subject of considerable management scrutiny and action.
- One issue resulting in 52 week breaches is patient choice, where patients are choosing to significantly delay their surgery due to the long post operative recovery times but who are now required to remain as open pathways on the waiting list. This applies to 16 of the 24 patients waiting longer than 52 weeks within Orthopaedics.
- Key actions to improve performance include:
  - **Delivery of the Cardiology Recovery Plan** – this plan supported by over £2m recurring investment is currently on track, with reductions in the number of long waiting patients expected to show from October 2018 onwards as numerous new appointments commence.
  - **Progression at pace with the recruitment and logistics** agreed as part of the 2018/19 budget setting in order to inject clinical capacity into specialties struggling with RTT performance.
  - **Insourcing of surgical and endoscopic activity** targeting long waiting patients using RD&E theatres and a combination of trust and external clinical staff.
  - **Use of the Independent Sector (IS)** for Orthopaedics, General Surgery and Cardiology.
  - **A senior RTT team** combining all three divisions and representation from the CCG has been established to drive implementation of specialty level plans, support demand management and maximise use of the IS to the limit of available funding.

Delayed Transfers of Care – *Volumes of patients identified as clinically ready for discharge*









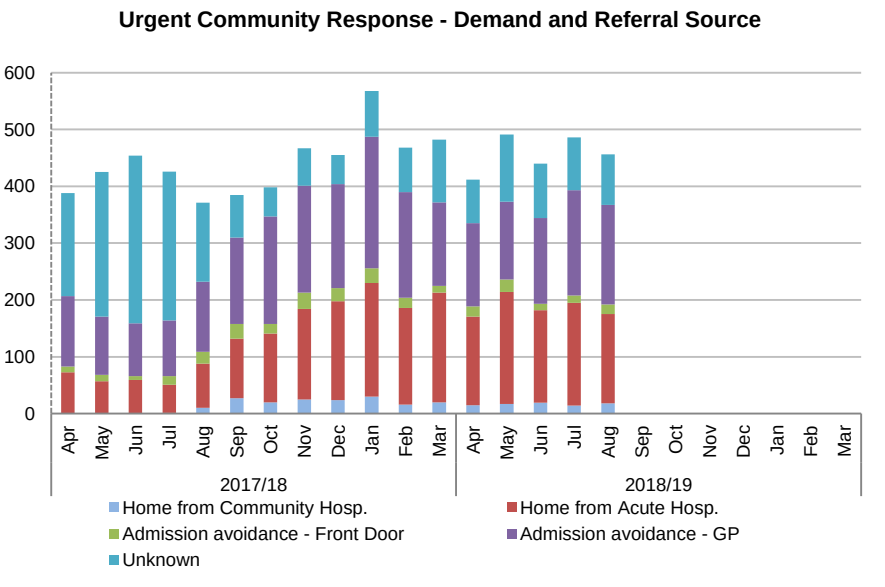
Overall performance

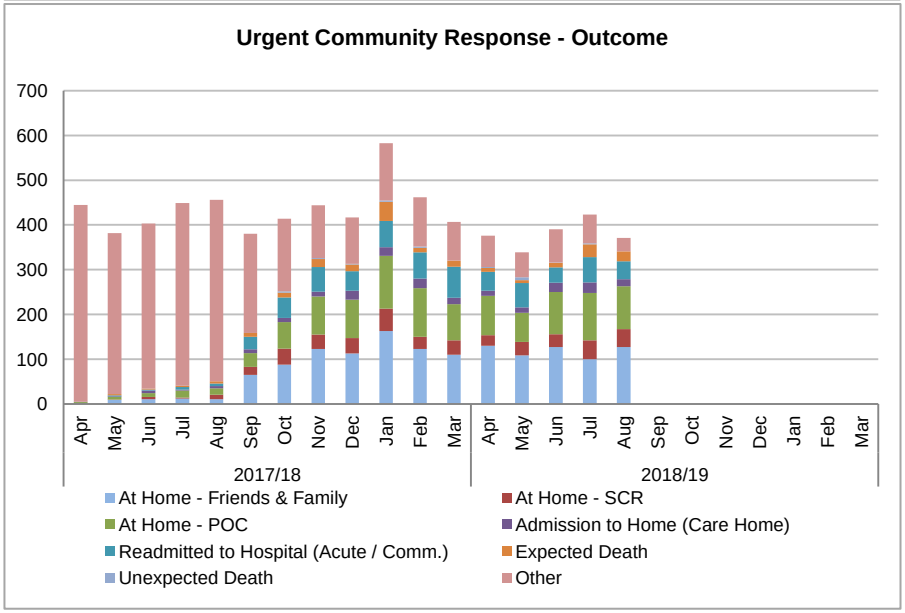
- The Delayed Transfers of Care (DTOC) position remained at a daily average of 37 patients for August.
- The Non Acute DTOC position has increased with an average of 11 patients delayed, a reflection of the increased complexity of their caseload and issues relating to staffing of the community hospital beds during August.
- The most significant challenge is the volume of cases that are being covered as "backfill" due to a significant shortage of domiciliary care for those patients who require long term care following their period of reablement.

Action in place to improve performance

- Through continued focus on recruitment, the vacancy position for support workers has improved from 30wte vacancies to 8.4wte.
- From October, Devon County Council (DCC) is aiming to improve domiciliary care capacity through a revised commissioning model Importantly, this change in the commissioning process will guarantee hours for domiciliary care for both providers and their workforce, which aims to drive up capacity through providing increasing financial security to staff, thereby reducing staff turnover and increasing staffing levels.

Urgent Community Response *- access to & effectiveness of urgent community response services*





Background
Urgent Community Response (UCR) is a function of the community teams which includes Support Workers providing short term packages of care and nurse/therapy assessment within 2 hours if required, to support people at home or to return home.

Outcome following Urgent Community Response
At the point of the patient no longer needing UCR input (for which the average length of input is currently 9 days), 36% of patients were independent at home, and 20% of people needed long term care package at home, and 3.4% needed a care home setting.

Key issues contributing to Urgent Community Response performance and supporting actions
Due to the increasing pressures in the market for domiciliary care provision, the UCR team is on average providing care for 38 patients who should be cared for by private providers commissioned by Devon County Council (DCC). This significantly impacts upon capacity available to support people to avoid admissions or return home from hospital quickly – this is a particular issue within Exeter and HOSM/SAS clusters.

DCC are currently refining the block contract arrangements with providers to enable them to increase capacity with reduced financial risk.

The Division is monitoring the recruitment progress on a weekly basis to ensure that the workforce position continues to improve.

An audit programme of work continues to understand at cluster level what number and percentage of readmitted patients were appropriate, and which were avoidable. From October all clusters will have regular readmission reviews with MDT including medical staff in order to ensure that any lessons learnt are fed into the improvement programme of the community division.

Demonstrating Difference - *examples of service improvements or change arising from patient feedback*

Demonstrating Difference

Medical Services

Renal Department

The Renal dietetic staff identified the lack of a weight management service for renal patients and a questionnaire was compiled which identified a patient's preference with regards to how a weight management service would be delivered. Following the results of this an eight month nutrition and exercise weight loss service was developed and commenced on 9th May offering 1:1 diet and exercise advice in a 90 minute appointment. An evaluation will be conducted at the end of the 8 sessions (December 2018).

Surgical Services

Pre-Assessment Unit; Acute Surgery Admin Teams;
Specialist Surgery Admin Teams ; Knapp Ward

Patient feedback was received with regard to problems with pre-assessment appointments. The Preparation for Surgery team reviewed their booking process for pre-assessment to identify if there was a way that patients could be seen on the same day they were listed for Surgery and also, if they could prevent patients attending for surgery without being offered a pre-assessment. This led to two changes in their processes:-

1) The clinics were restructured to create "one-stop" clinics on a number of the lists and where patients are listed for surgery they now have the pre-assessment on the same day. This has been positively received by the patients and is currently in practice for four specialities with the view of rolling this out across the remaining areas. The main focus is cancer patients and those who have travelled out of area.

2) Pre-Assessments booking has been centralised within the actual team rather than each speciality leading to maximising the utilisation of their capacity, resulting in more patients being seen together with the introduction of a reminder service. There has been an increase in the number of patients now attending with a pre-assessment and a reduction in cancellations due to unknown co-morbidities.

Specialist Services

Yeo Ward – Radioactive Iodine Room

Patients often feel very isolated as they have minimal contact with nursing staff during their stay due to the radiation levels. Artwork has been provided for the walls and staff have provided a DAB radio, TV, games, puzzles, DVD's, books for entertainment and a laptop so patients can keep in touch with family and friends. There are tea and coffee making facilities also provided.

Peninsula Clinical Genetics – Truro

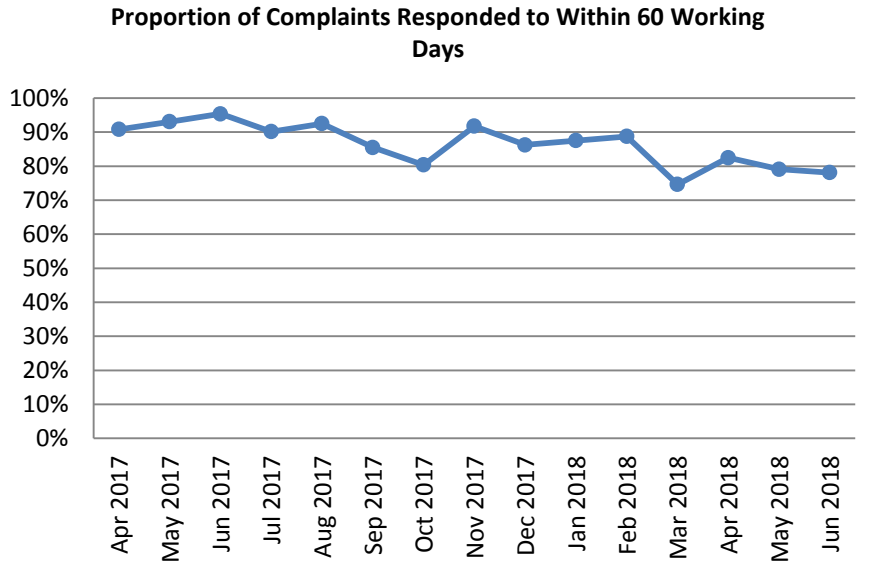
A support group has been set up for women who have inherited breast/ovarian cancer genes (BRCA 1 and BRCA2). The first support group was set up at The Cove, Macmillan Support Centre, RCHT. Thirteen ladies attended and were able to discuss their experiences. Positive feedback has been received as these patients often felt that they were alone and had limited support. It is hoped this can be replicated across the network.

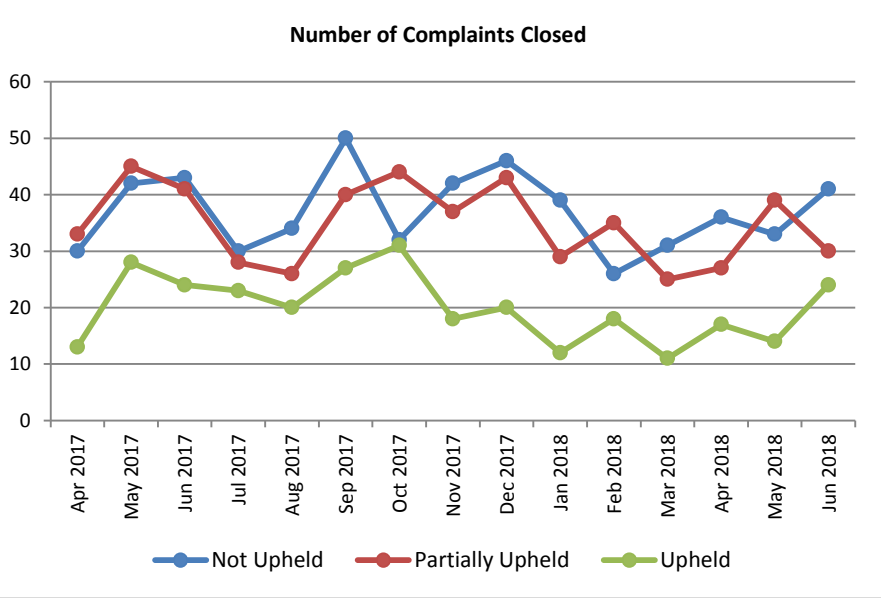
Community Services

Exmouth Community Nursing

A complaint was received from a patient's family regarding funding arrangements and care home availability. Following a meeting with the staff involved one of the actions was to create a "family meeting agenda"- ensuring everyone is heard, gives a record of what was said and if any actions are required and by whom, allowing the family to be involved.

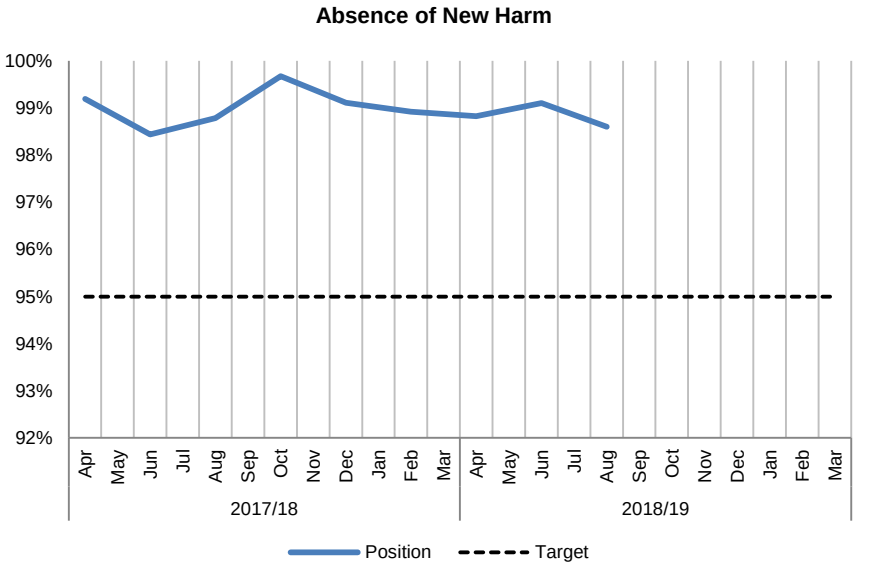
Complaints – *Quarterly analysis of patterns in complaints*

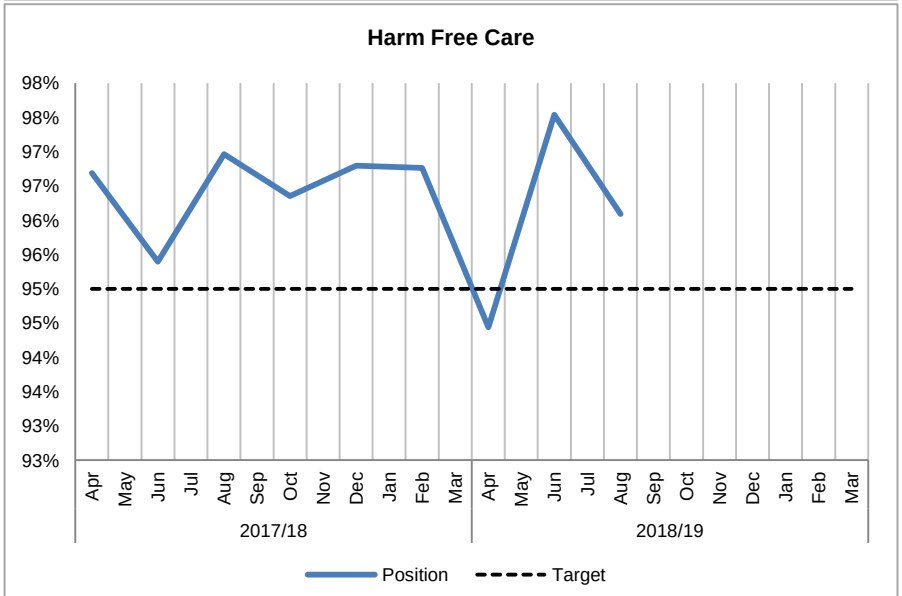




- It is noticeable that the Trust compliance with its own internal target of 45 days to close complaints is challenged, however when noted against the national target of 60 days we are in a significantly better position (80%). Attention to closing complaints within 45 days continues.
- There have been 262 complaints and concerns received across the Trust during Quarter 1 (2018/19) which is similar to Quarter 4 (2017/18) (260). The main themes Trust-wide this quarter are in relation to communication issues, initial treatment being incorrect and the length of wait for review/treatment. Further scrutiny of this was undertaken at the Patient Experience Committee (PEC), particularly in relation to initial treatment being incorrect. In part the number of cases deemed to be not upheld relates to a number of these complaints.
- A revised Cardiology recovery plan was signed off in early May 2018 and implementation is on track, with increases in capacity planned from August 2018. This is unlikely to fully reduce waiting times back to target levels until Autumn 2019 with the current waiting times for Cardiology having increased to 12-15 weeks. We are informing patients of the potential wait within their post appointment letter, also confirming the escalation pathway for patients who feel their disease process is deteriorating. GP Communication is to coincide with the changes to the letters.
- There has been an overall decline in the length of time taken to respond to complaints across the Trust. This is primarily due to operational and staffing pressures; each division has a plan in place to try and reduce this. The Clinical Divisions are still tasked with ensuring regular contact is made with patients throughout the complaints process. In future quarters detail of agreed timescales with the patient, in relation to their complaint, will be reported.
- There have been 2 new cases received from the PHSO. We have also received 2 final reports with one of these being partially upheld and the other not upheld. The PEC scrutinises the detail of all PHSO cases and outcomes.

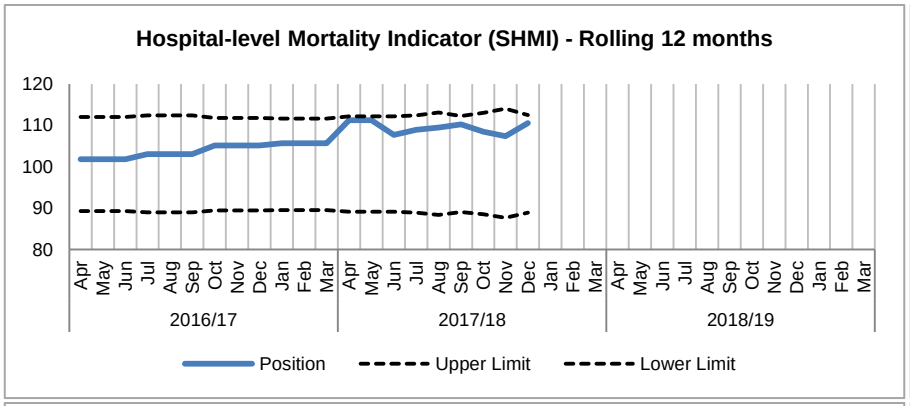
Safety Thermometer - *Patients who have experienced harm free care (no pressure ulcers, falls, VTEs or UTIs)*

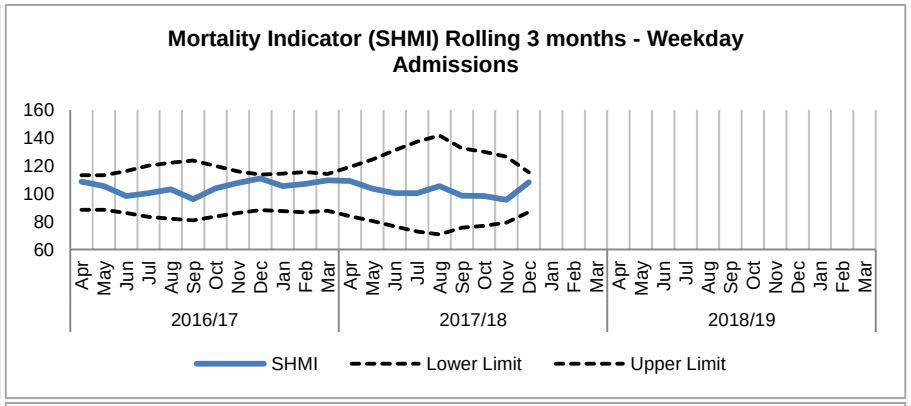


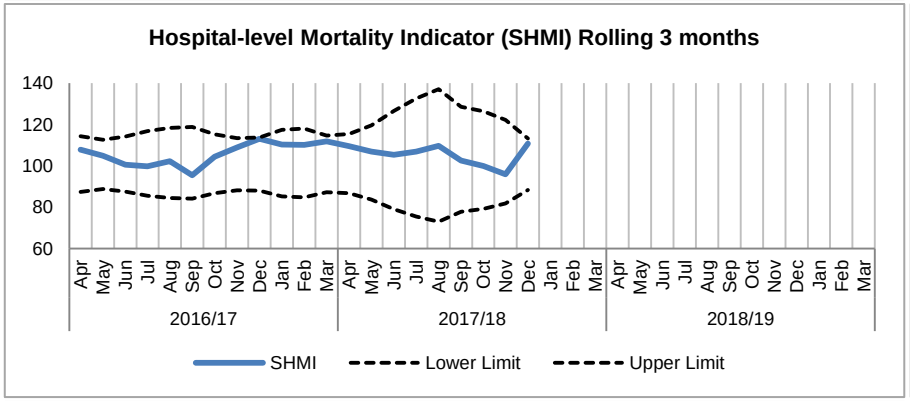


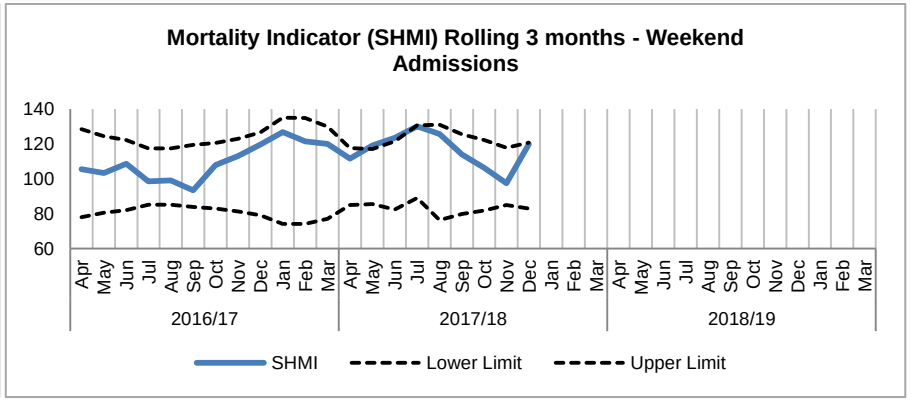
- The Safety Thermometer is completed on alternate months and provides a snapshot audit on one day.
- It is completed by the Ward Matrons or a deputy and the Acting Lead Nurse for Safety and Patient Experience provided support to the teams on the day in order to validate the data.
- The absence of 'new harm' remains stable at 98.6%.
- Harm Free care has remained above 95% for the past 2 audits, currently at 96.04%.
- The presence of 'old harm' in relation to old pressure sores was reviewed. There were 33 patients identified as meeting this criteria. The Acting Lead Nurse for Safety and Patient Experience reviewed 21 of the 'old harms' and only two of these patients were known to a community nursing caseload. This will be repeated to provide further assurance.
- It is important to note that despite the current nursing vacancy position staff are continuing to deliver a high level of care with an absence of new harm.

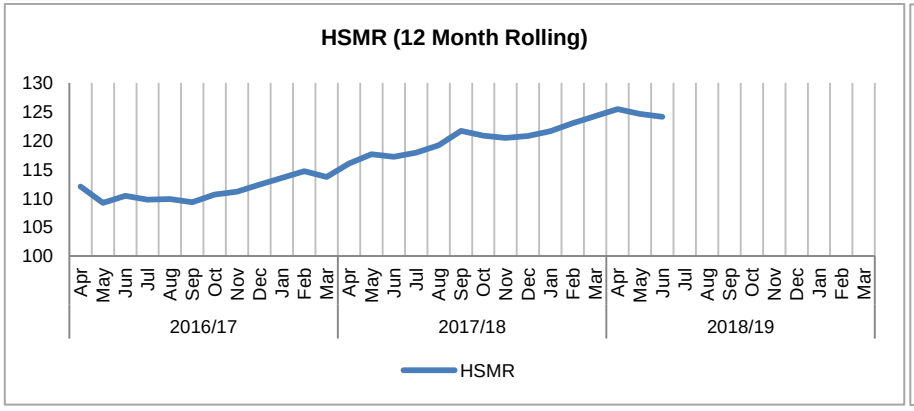
Mortality Rates – SHMI & HSMR – *Rate of mortality adjusted for case mix and patient demographics*





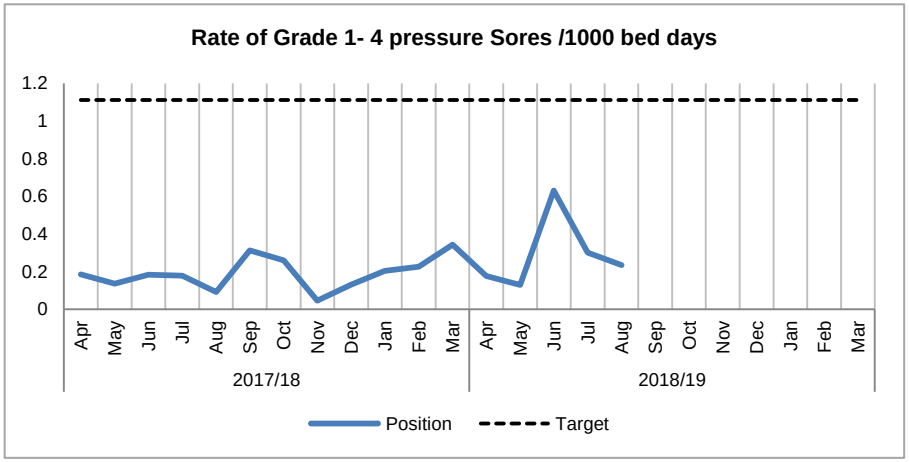


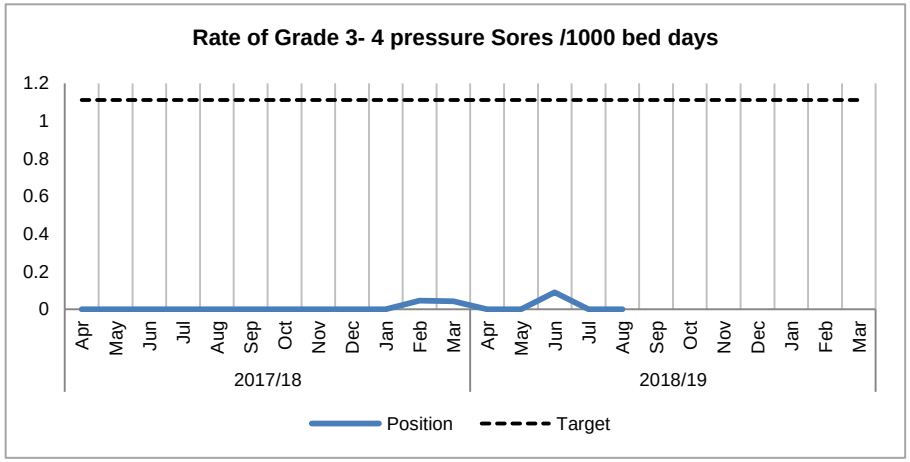


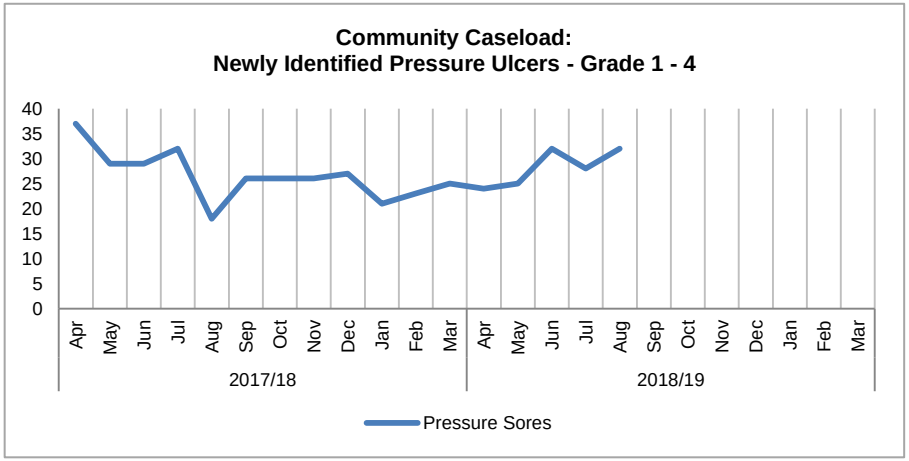


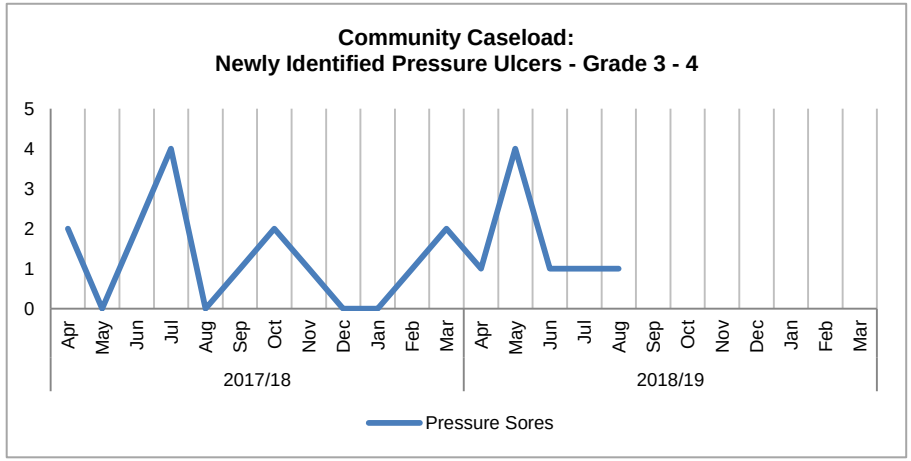
- Calculation of updated positions in respect of both the Standardised Hospital Mortality Indicator (SHMI) for the Trust are awaited nationally as a result of ongoing issues with NHS Digital's external data supplier. These will be reported as soon as they become available.
- Hospital Standardised Mortality Ratio (HSMR) figures have now been released up to June 2018. Whilst the rolling 12 month position has started to reduce, it currently remains in the above expected level; however it is expected to continue to reduce over the coming months as the 12 month rolling position catches up with underlying reductions in the monthly HSMR position which have been seen between January 2018 and June 2018.
- Improvements in HSMR are multifactorial but are mainly due to the progressing comprehensive mortality work programme reporting through the Patient Safety and Mortality Group to the Safety and Risk Committee.

Pressure Ulcers – *Rate of pressure ulceration experienced whilst in Trust care*



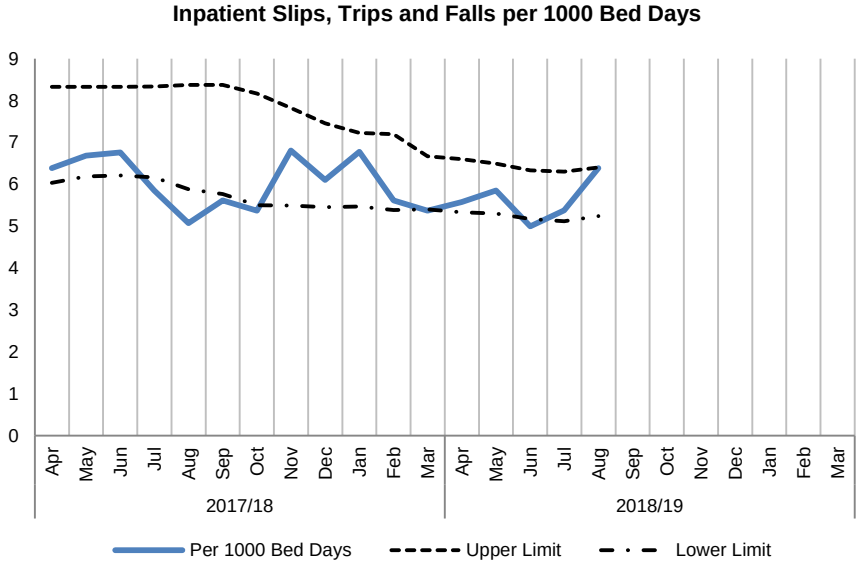


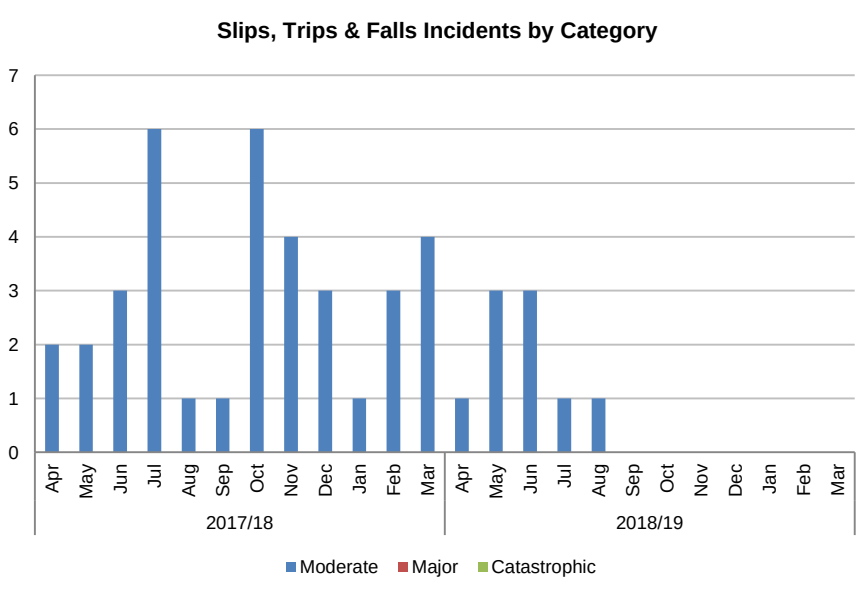




- Pressure ulcer assessment rates continue to remain above the Trust threshold of 95% at 96.2% for August. Considering the current nursing workforce challenges it is commendable that this has remained above 95% since March 2018.
- The Tissue Viability Steering Group has its first meeting planned for early October and progress from the group will report back through the Patient Safety & Mortality Review Group.

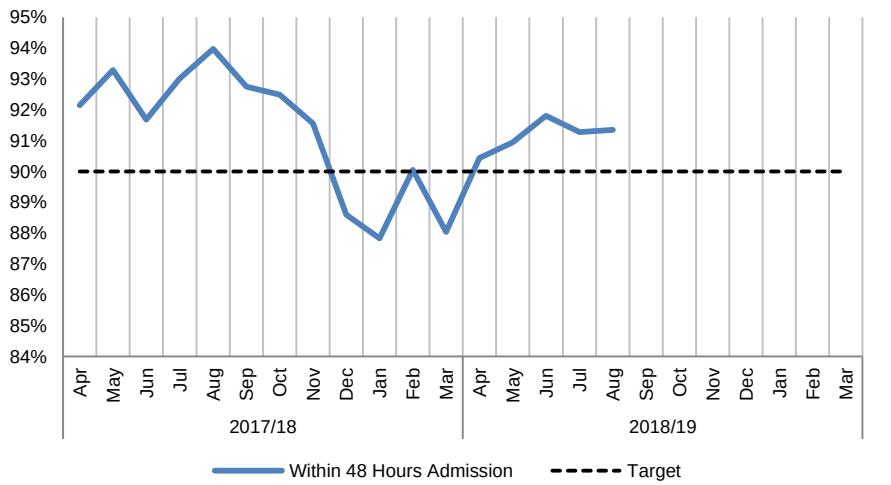
Slip, Trips & Falls – *Rate of incidence of slips, trips & falls amongst inpatients and categorisation of patient impact*

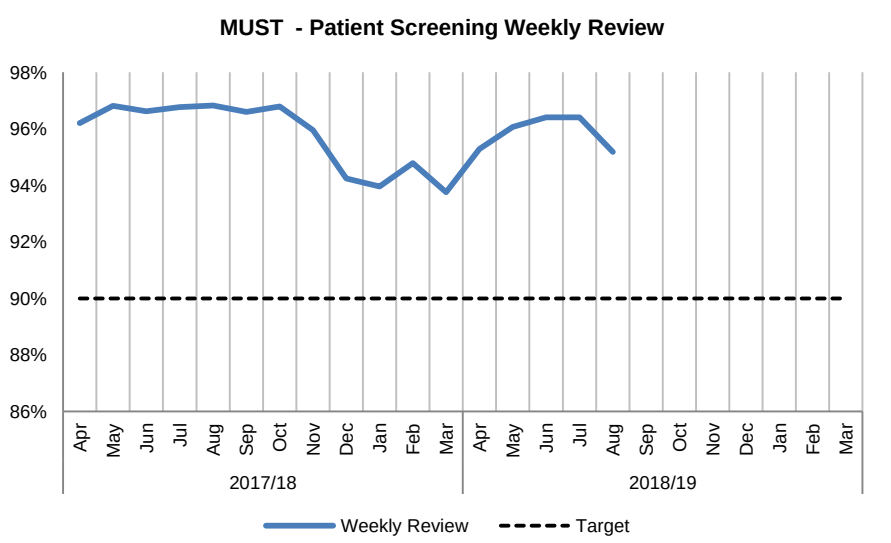




- The total number of fallers remains within normal variation, although the falls per 1000 bed days has increased.
- The falls risk assessment compliance for August has reduced slightly for the 4th consecutive month from 92.9% to 91.9% which remains below the 95% target. It is important to note that although there has been a slight decrease month on month there has not been an increase in the number of falls or those sustaining harm as a result of falls which is positive given the continued pressure on nursing vacancies.
- There were two falls initially graded as moderate (as per national definitions) during August, one of these has subsequently been downgraded to minor harm. The second incident, the patient sustained a fractured hip and a full investigation is underway. Early information indicates that this incident was likely to be unavoidable.
- There were no investigations brought forward relating to falls requiring discussion at IRG during August.

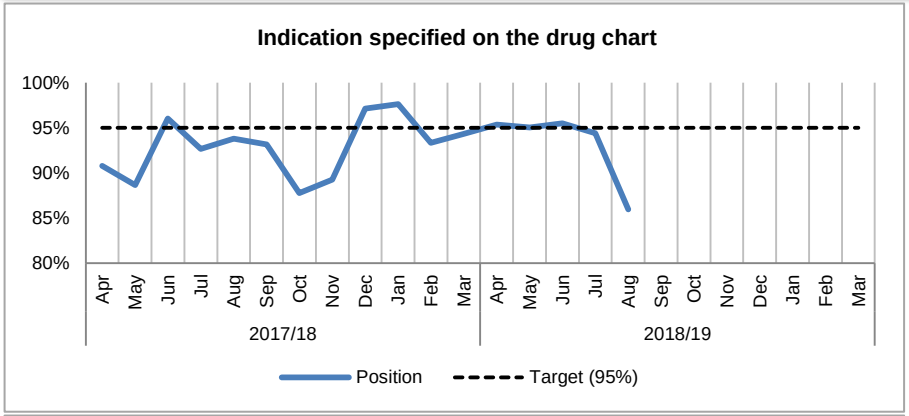
Nutrition Screening *Proportion of adult inpatients assessed for their nutritional needs on admission & each week*

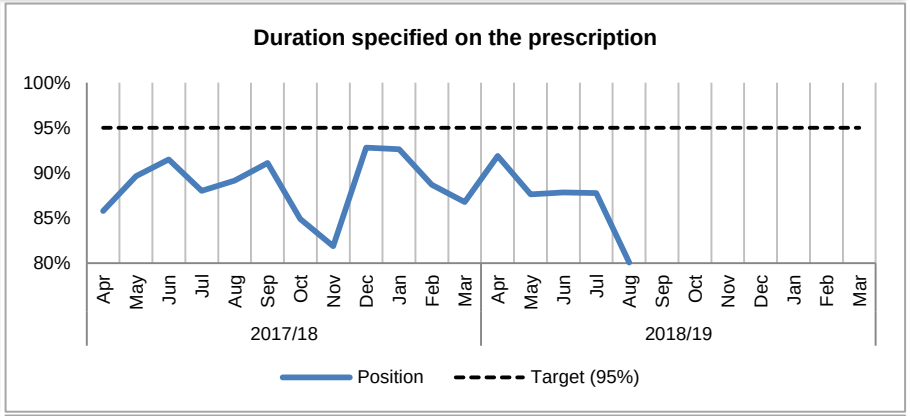


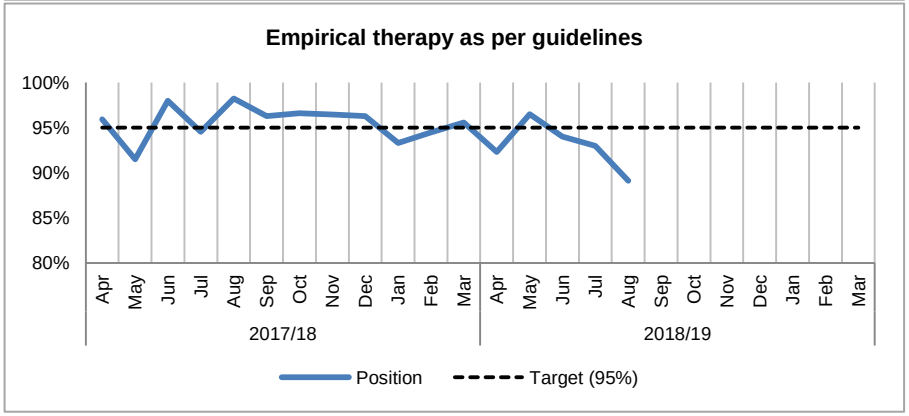


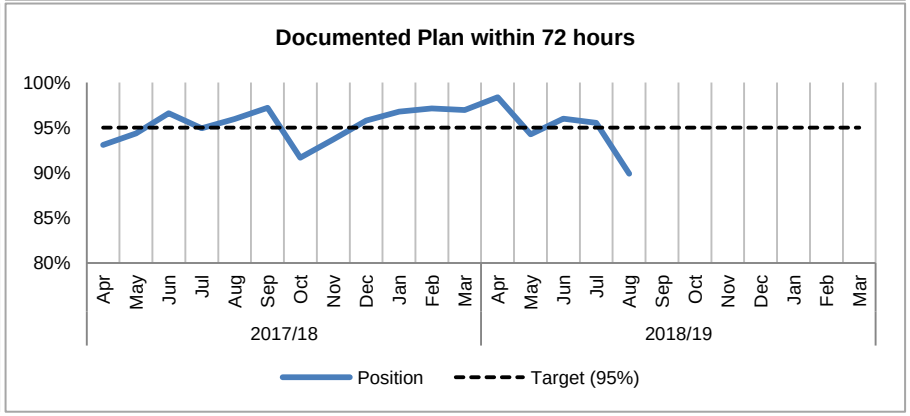
- The Malnutrition Universal Screening Tool (MUST) forms an integral part of the patients holistic assessment on admission to the hospital.
- August position remains stable for both the initial screening of patients and the patient screening weekly review, with performance of 91.3% (initial assessment) and 95.2% (weekly review) respectively. For both elements this is above the Trust threshold of 90%.
- 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.

Antimicrobial Prescribing – *Proportion of patients with an antibiotic prescription containing key information*



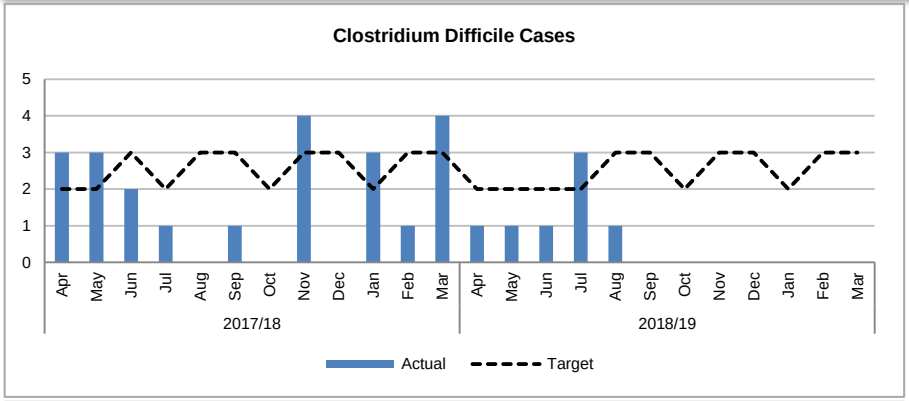


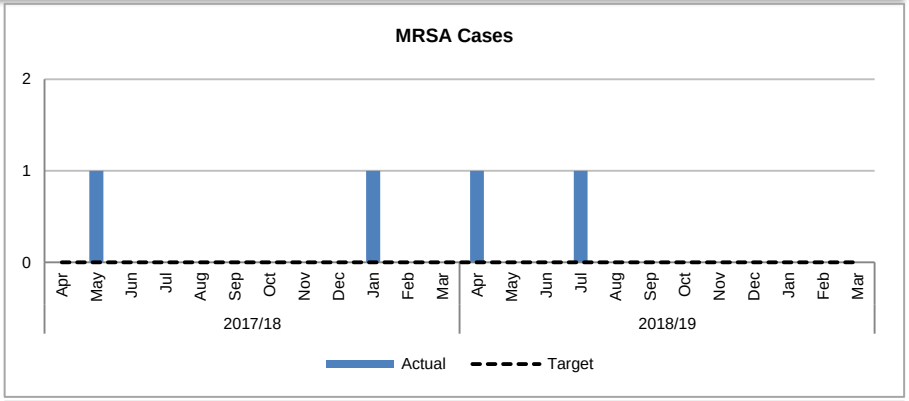


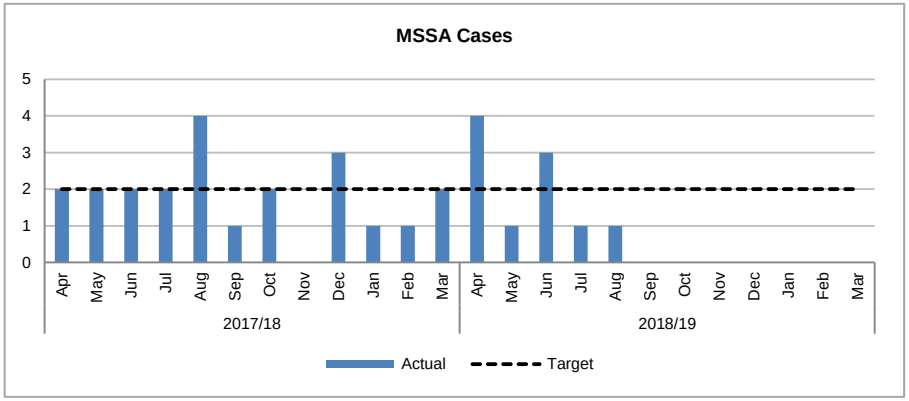


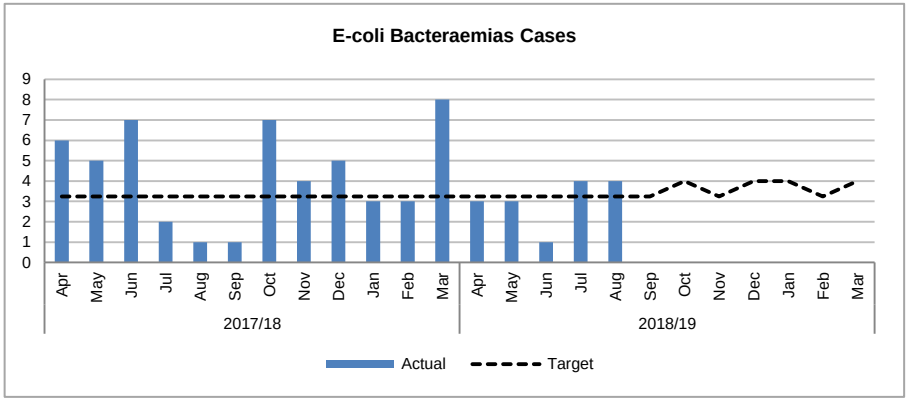
- Compliance with almost all indicators (with the exception of guideline compliance) has fallen this month – this may in part be explained by the large intake of new medical staff in August. However, the impact on practice in August 2017 was not so profound.
- The Antimicrobial Pharmacist has met with the new AMD for Medicine and agreed actions to improve performance including individual prescriber feedback where possible (following each audit cycle). However, to date, a clear action plan has not yet been agreed for the Surgical Division. Therefore a meeting with the Deputy Medical Director – Operations and Strategy has been arranged to develop a targeted improvement plan.
- An incentive scheme will be introduced in November to reward wards from across the Trust that excel and to raise awareness of the importance of antimicrobial stewardship. The scheme will be run in conjunction with activities to promote World Antibiotic Awareness Week and European Antimicrobial Awareness Day (18th November).

Healthcare Associated Infection *–Volume of patients with Trust apportioned laboratory confirmed infection*







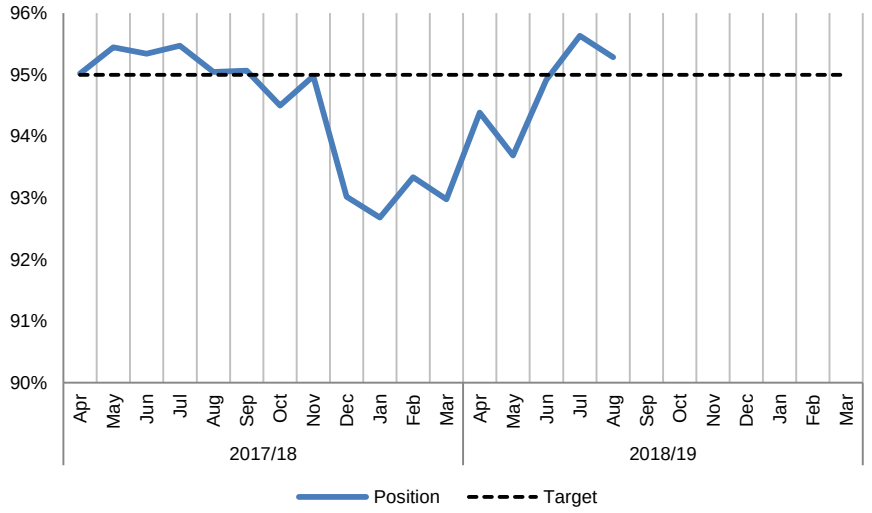


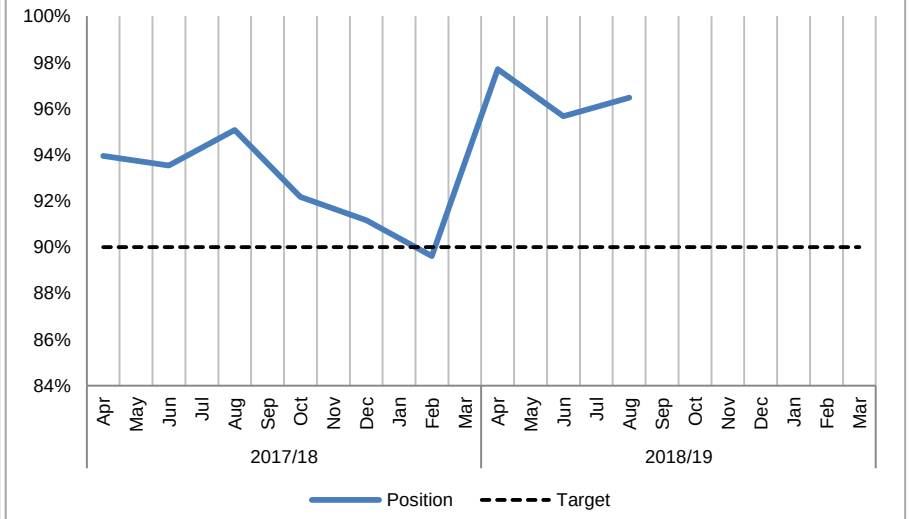
MRSA bacteraemia - There have been no new cases of MRSA blood stream infection identified in August. However, the investigation highlighted in last month's report into the case on Yarty Ward in July and two other cases also associated with Yarty Ward over the last 15 months has been completed. The investigation included screening of all staff working on Yarty Ward to determine whether there was a common source for all three patients who had the same strain of MRSA but had at no time had contact with each other. Screening is now complete and has identified a member of staff who is carrying the same strain as the patients and is very likely to have been an unwitting source. This does not in any way suggest poor practice on the part of the member of staff. As reported previously, the investigations into all three cases have identified good clinical practice and no contributory lapses in care. The employee has been excluded from clinical duties currently whilst treatment is provided to eradicate MRSA carriage. A final investigation meeting will be held shortly to conclude the investigation and consider and propose any actions to support reducing future risk.

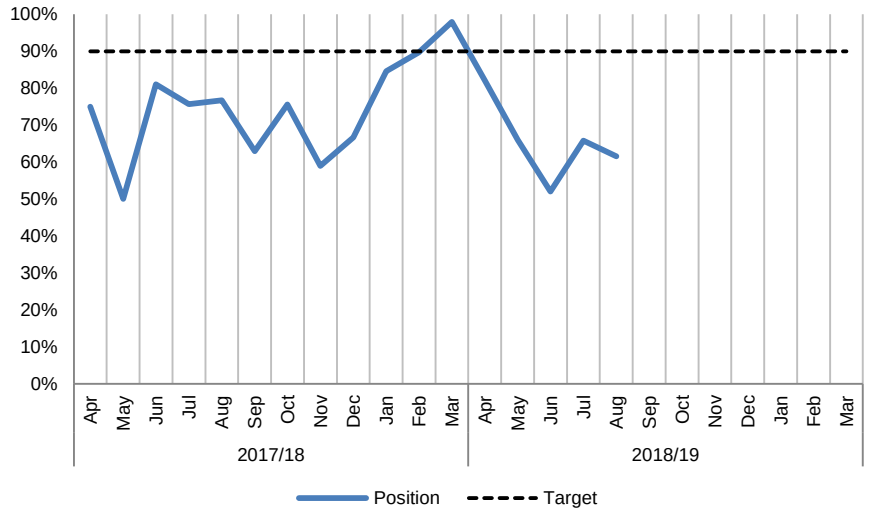
C.difficile - The single case in August is likely to be concluded as being unavoidable; however typing results are currently awaited to exclude the possibility of cross infection.

E.coli bacteraemia – All investigations are complete and no Trust learning was identified for three of the four cases. The fourth case identified issues with poor documentation of multiple unsuccessful attempts to insert a urinary catheter on the day of admission and timeliness of urine / blood culture sampling to inform antimicrobial prescribing. This has been fed back to the clinical areas concerned.

Efficiency of Care – *Patients risk assessed for VTE, given prophylaxis, & operated in 36 hours for a fractured hip*

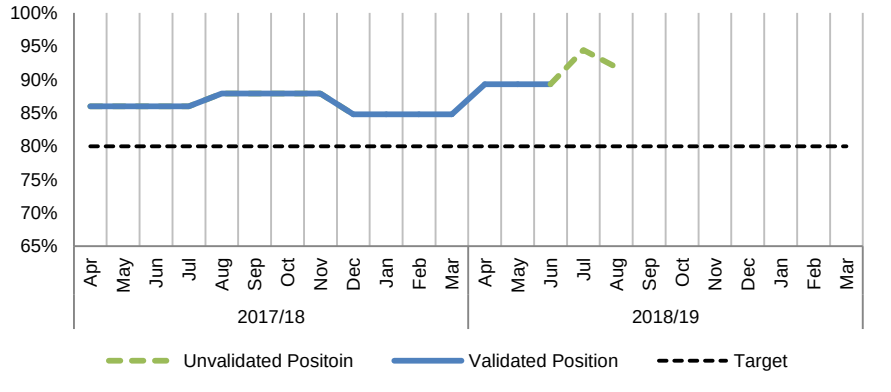


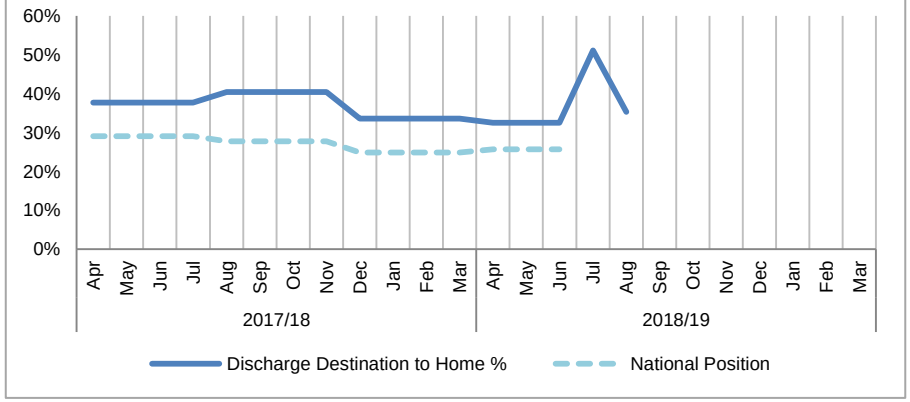


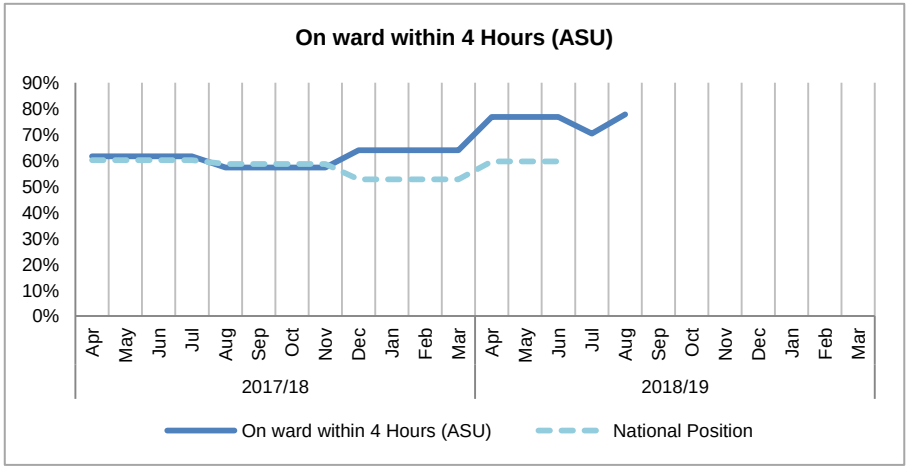


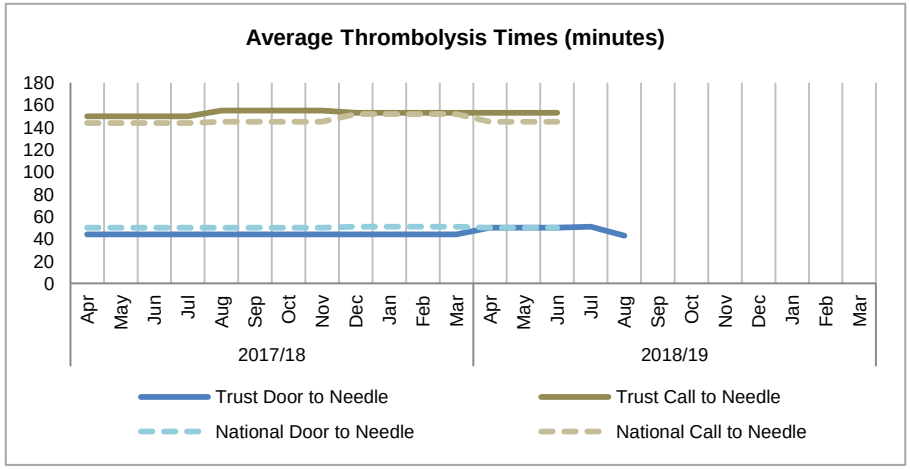
- VTE risk assessment on admission performance remains above the target level of 95% with 95.3% achieved in August and 95.6% in July 2018.
- VTE Thromboprophylaxis performance continues to exceed the target position.
- In August 2018, 61.5% of Fractured Neck of Femur (FNOF) patients received surgery within 36 hours. Of the 15 who had to wait for longer than 36 hrs, 11 had surgery within 48 hrs and 4 had surgery over 48 hrs (49, 63, 70, 71). Six of the patients that breached the 36 hour target were admitted over the long bank holiday weekend, when there was limited trauma capacity (one list per day in theatre 8). During the month of August there were 39 Trauma patients who had their procedure undertaken within PEOC Theatres.
- From September, there will be a weekly NOF List allocated every Friday within PEOC theatres, with the aim of reducing the number of breaches that occur over the weekend due to the variation in trauma presentation, recognising there is no elective capacity to utilise at the weekends.

Stroke Performance – *Quality of care metrics for patients admitted following a stroke*





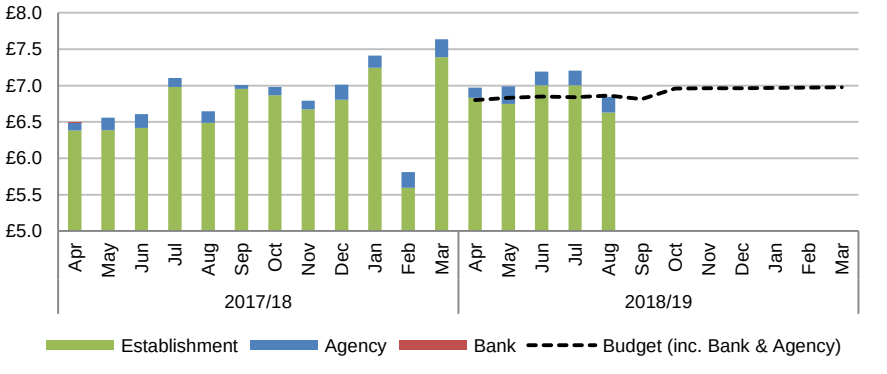


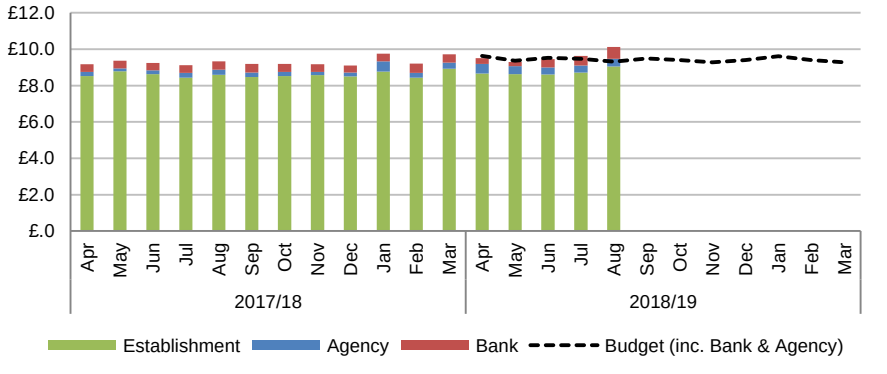


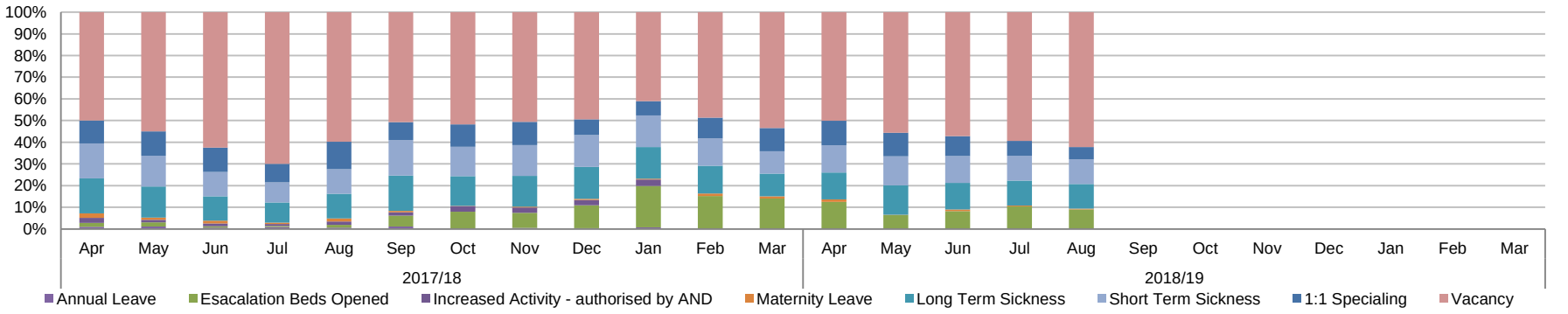
- NB the figures for July to August are based on actuals and the final quarterly position will change due to the completion of patient episodes and use of the yearly rolling average.

- Following some focussed work regarding the flow of patients to the Acute Stroke Unit (predominantly from the ED) improvements have been seen in both the arrival times on the unit after hospital admission, and subsequently spending the majority of in-patient time on the unit (90% stay indicator). This has been achieved despite a 30% increase in acute stroke admissions over the last 5 years, to nearly 800/year in 2017/18. This has been achieved mainly through reductions in length of stay on the Acute stroke unit and more latterly on the Stroke Rehab Unit on Yealm.
- The stroke team also continue to perform well against the SSNAP indicators, demonstrating the importance of a resilient consultant led 7 day service.

Safe Clinical Staffing - *Cost of Medical & Nursing Staffing by month against plan, & reasons for temporary staff*

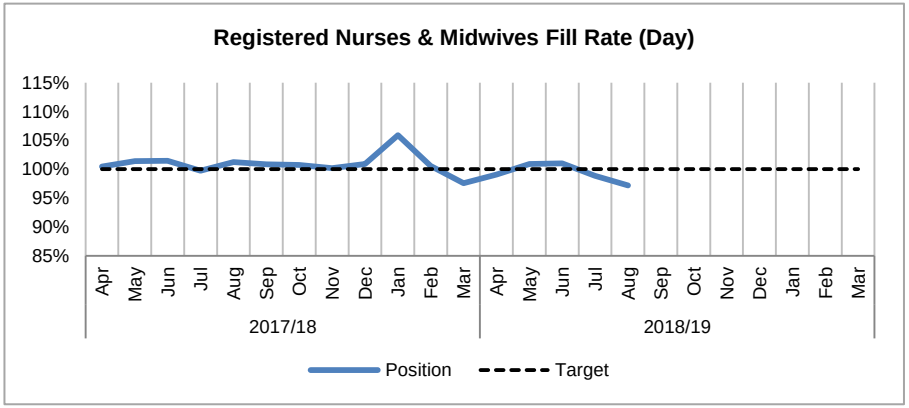


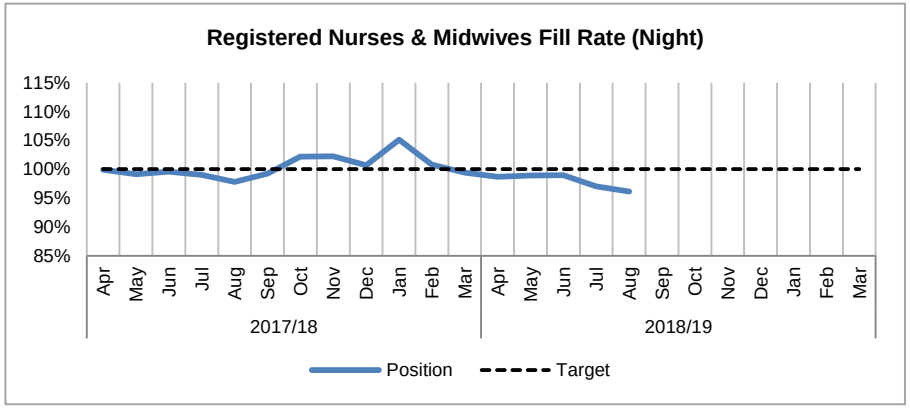


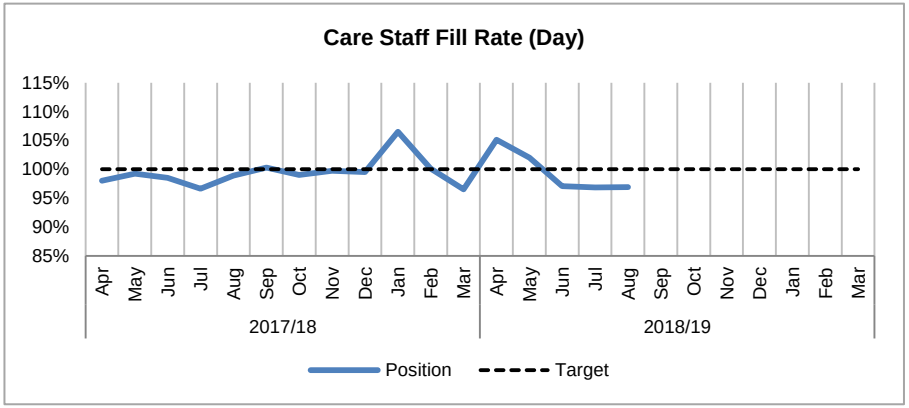


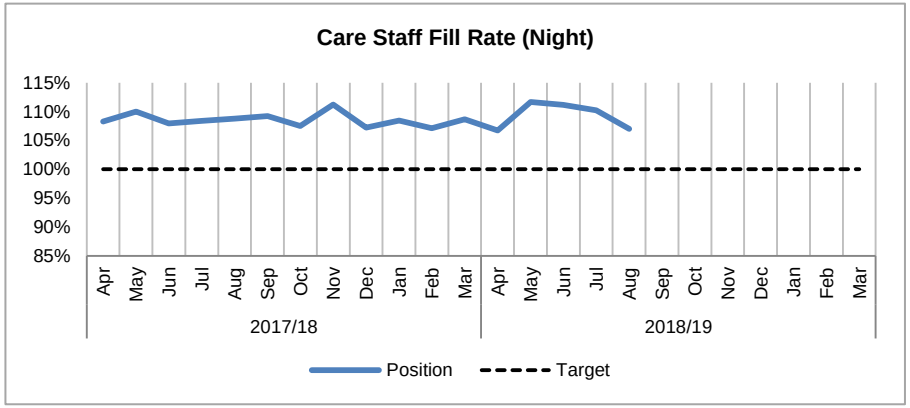
- The Trust is currently developing a more targeted overseas recruitment strategy for the medical workforce and will be participating in an overseas recruitment round in November 2018. Plans are being developed to convert a number of unfilled Trust Grade posts to Internal Medicine Training posts which will provide improved opportunities for recruitment , retention and increased resilience. Interviews for Physicians Associate training posts are scheduled for early October 2018.
- The current Registered Nurse vacancy rate for acute and community facing front line posts is showing as 152.15wte vacancies. There had always been an awareness that August would be the most challenging month against vacancy. Predicted new starters including newly qualified nurses, return to practice and normal recruitment routes are showing 41.7wte band 5 nurses expected to begin working with the Trust throughout September. Ongoing overseas recruitment, primarily from the Philippines at present, is providing a steady arrival of between 6-9 new starters per month, with the resource plan showing steady state. In real terms there has been an increase in the number of Filipino colleagues passing the necessary tests in the Philippines to be ready for visa processing and an ability to travel to Exeter to begin their OSCE support. There is an expectation that the number of new arrivals will exceed our plan of 6 per month.
- Further focus on improving Registered Nurse retention is ongoing, linking closely to the Professional Development Plan. In particular reviewing the workforce model through the establishment review and enhancing the delivery of education and support through the Collaborative Learning in Practice model (CLiP). Alongside this we are ensuring our Registered Nurse workforce has a clear understanding of routes for advancement. To aid recruitment and retention the nurse ambassador and the BME leader are advising the nurse leadership teams.

Safe Clinical Staffing – Fill Rate – *Proportion of rostered nursing and care staff hours worked, against plan*



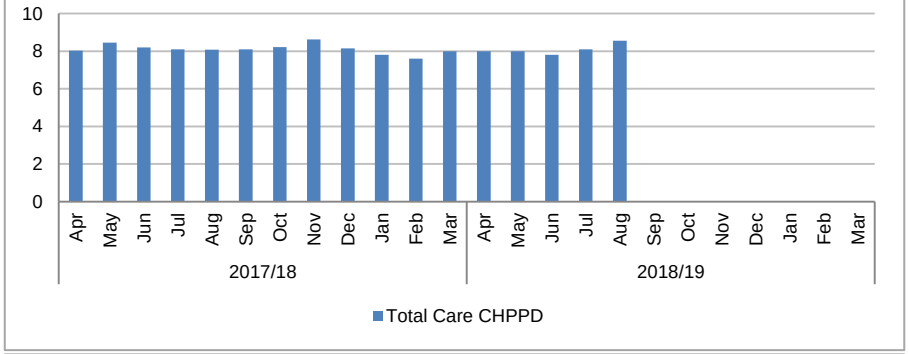


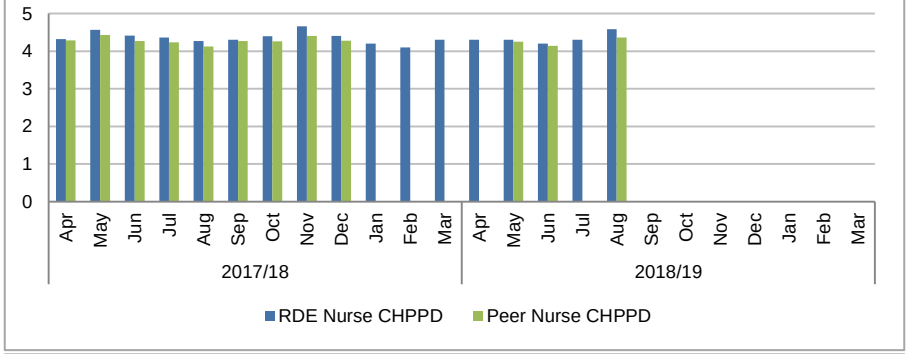


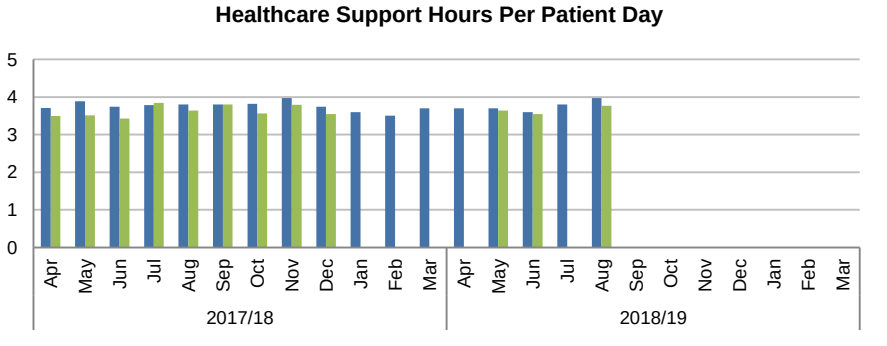


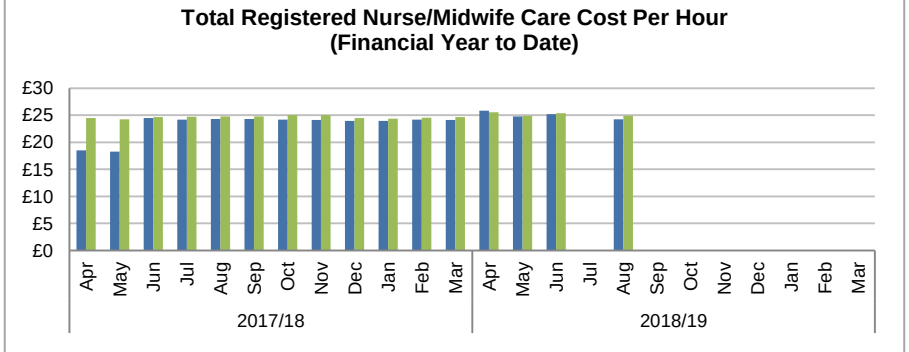
- The data continues to correlate with the registered nursing vacancies.
- The overnight position for registered nurses at 96.12%, it is important to remember that while this appears only slightly under 100% this is having a significant impact on the allocation of staff on a day to day basis. In order to help manage this The Assistant Directors of Nursing continue to monitor staffing on a twice daily basis. Each division is represented at these meetings to ensure that each area is safely staffed.
- July and August have been particularly challenging months with regards to ensuring clinical shifts are adequately filled. Once again it is important to note that ward teams have worked tirelessly to ensure the safety of patients.

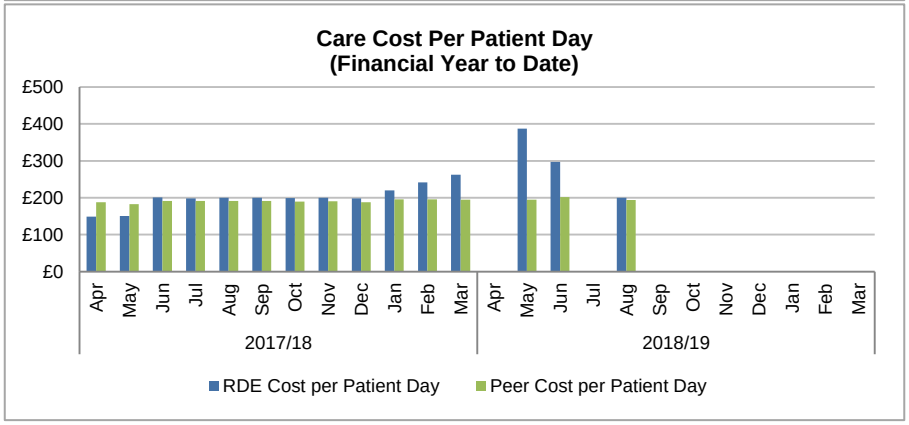
Care Hours – *Volume of care hours provided per inpatient per day, and cost per day*





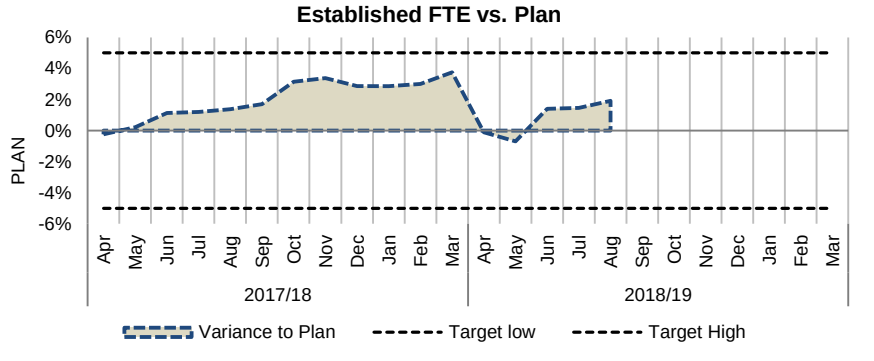


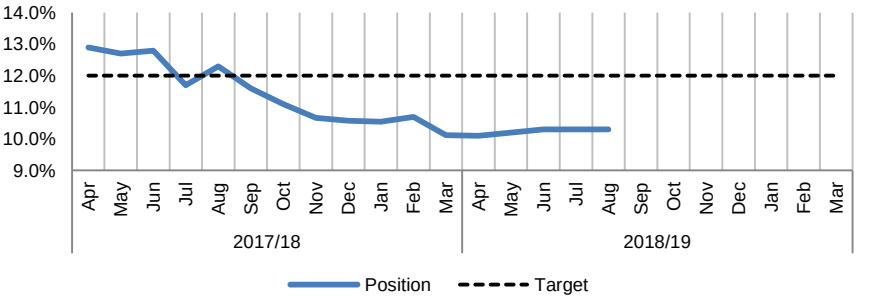




- The link between our Registered care hours per patient per day and our Healthcare support hours per patient per day is indicative of the acuity faced in the Trust during the summer and a requirement to have increased registered nurses for a number of individual patients in the organisation.
- The higher proportion of healthcare hours also outlines the difficulties encountered covering base line Registered vacant shifts during the summer months and as such used unregistered staff to ensure care delivery.

Establishment, Turnover & Vacancy – *Established workforce vs plan, turnover rate, & vacancy position*

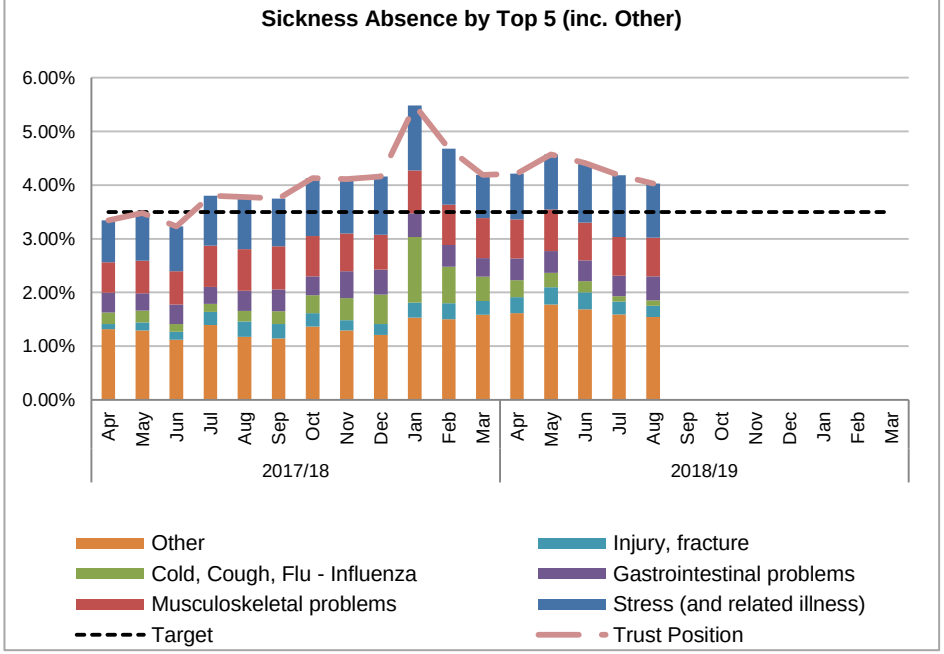




- The completion rate for exit interviews is currently 42.6% based on leaver during August. This is a significant increase on the 26% reported last month and the highest rate since reporting started. Measures to increase completion have included renewed information on comm cells, posters to remind staff and feedback on compliance.
- Overall turnover rates remain stable at around 11.3% with the rate for registered nurses continuing to reduce with 9.7% recorded this month. This is almost 5% lower than the rate reported 12 months ago
- The first stage in the implementation of HealthRoster has been completed with all areas previously using RosterPro now live. A 12 month project plan has been developed for the next phase of the project which includes the introduction of the SafeCare module which matches dependency and acuity of patients in inpatient areas to staffing requirements.
- There has been a significant increase in vacancies being recruited against this month. This is almost exclusively as a consequence of the number of roles being backfilled as selection of internal staff for the My Care programme progresses. A comprehensive recruitment stocktake will be completed by the end of September which will inform future action plans.
- Recruitment in the Philippines continues with 13 registered nurses starting this year including 4 in September. We have another 56 in different stages (12 already sponsored and 8 out of these awaiting for visa)

Staff Group	Establishment FTE	Contracted FTE	Vacancies being recruited against	Vacancies Filled (August)	Vacancies as % of staff group
Additional Prof & Technical	209.8	199.9	24	4	12.01%
Additional Clinical Services	324.7	350.1	75	6	21.42%
Admin & Clerical	1648.0	1572.9	164	48	10.43%
Allied Health Professional	515.1	492.3	85	10	17.27%
Estates and Ancillary	700.4	603.9	40	7	6.62%
Healthcare Scientists	226.2	206.9	16	3	7.73%
Medical and Dental	719.5	792.1	49	24	6.06%
Registered Nurses	1983.4	1845.3	248	40	13.44%
Unregistered Nurses	1113.8	1062.0	111	12	10.45%
Total	7441.0	7125.4	811	154	11.38%

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



- Although the rolling 12 month sickness absence rate has remained stable at 4.46% the monthly rate of 4.03% is the lowest recorded since September 2017. Monthly rates have gone down over the last 4 months.

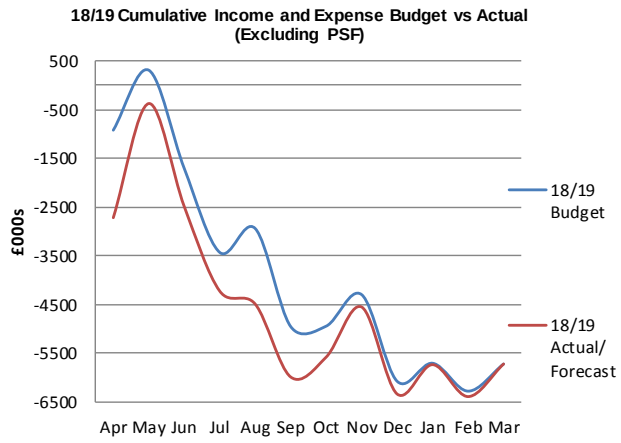
- Anxiety, stress, depression and other psychiatric illnesses continue to be the highest reported cause of sickness accounting for 25.02% of all sickness absence (down from 27.40% last month. Research by MIND in 2016 found that 92% of emergency workers have experienced stress, low mood and poor mental health in their role and the Health and Safety Executive report that work-related stress alone accounted for 45% of all working days lost to ill health in 2015/16. Although the Trust performs well against the reported figure, this continues to be a focus of attention across the Trust. We can report that our Health and Wellbeing Improvement Practitioner has successfully completed the 'Train the Trainer' course and is now able to deliver accredited Mental Health First Aid Training to staff across the Trust. Whilst there is an inevitable lead time as the training is rolled out we are confident that overt support for staff with mental health issues will not only improve the level of mental health related sickness (MHFA estimate the average reduction in days lost to be in the order of 30%) but will also impact on general health, wellbeing and motivation of staff over time.

Talent Management – *Quarterly update on the training & development of our people, including PDRs & essential training*

- PDR compliance rates remain unchanged at 77.3% this month but still falls short of the 80% target.
- At 87.5% the completion rate for statutory and mandatory training is the lowest for 10 months but still remain above Trust targets. This is primarily driven by the pressures across the clinical areas that are making it more difficult to release staff for training and the reduced management time for clinical leaders to organise and manage the training due to their increased clinical activity has compounded this.
- The rate for the 3 safeguarding competencies, Child Protection Levels 2 and 3 and Safeguarding Adults is currently at 87.9% . Despite being above the Trust target this is a reduction on the 90% reported last month.
- Although there has been a small increase in completed consultant job plans this month to 41.4% this still falls short of the target rate. This is being explored by the Medical Staffing Sub-Group.

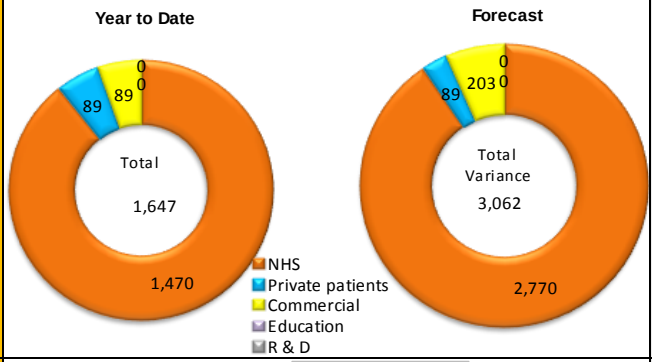
Income & Expenditure

I & E Surplus/(Deficit)



- A deficit of £4.5m has been incurred as at end of August, which is £1.6m adverse to budget (£0.75m favourable to plan).
- Year to date overspends on pay (£1m), non pay (£1m) are partially offset by a PDC benefit and an overachieved CIP position (£0.4m).
- Post mitigation, the Trust is still forecasting a deficit of £5.7m, in line with budget and annual plan. After assumed PSF income of £12.2m, the Trust will outturn a surplus of £6.5m in line with plan.
- The forecast position assumes mitigation will offset the CIP shortfall of £6.0m. However, at month 5 there remains a residual risk of £3.0m to manage.
- The £3.0m risk is primarily due to increased spending of £2.2m on agency and consumables as a result of increased patient demand above contract. There is also a net £0.8 shortfall forecast on Specialist commissioning income, albeit it is still possible that this could recover .
- The Trust has achieved £11.1m of the £23.3m CIP target. A check and challenge process led jointly by COO and CFO continues, and this has confirmed that the Divisions will under deliver in year by £5.9m. Whilst the Trust is delivering more activity than planned, this cannot be counted until the block contract is rebased. A mitigation plan shared with the Board as part of budget setting will be enacted to bridge the CIP gap
- If the £3m risk is not addressed, then the Trust could miss its control total and as a result will fail to secure the Q4 PSF payment of £4.3m. The Executive team will be reviewing all options to close down this risk and will report back with an action plan to the October Board.
- The Trust has achieved a score of 2 in the NHS Improvement Finance and Use of Resources year to date, in line with plan.

Income Variance to Budget Fav/(-Adv) (£'000)



Clinical Income - Year to date

- Clinical income is £1.6m over budget, an improvement of £591k in month mostly related to an improvement in the specialist commissioner contract. However, this still remains below expectation.
- The Trust is currently on a block contract with NEW Devon and South Devon CCG. If the contract was on a variable basis, year to date income would be £2.6m higher , extrapolated to £6.0m for the year.
- The main over performance is in General Medicine (£2.5m), due to a 5% growth in emergency admissions. Other specialties over plan are Plastic Surgery (£357k), Trauma (£284k), Ophthalmology (£236k) offset with underperformances in General Surgery (£708k), Obstetrics(£348k), Haematology(£408k).
- Uncoded activity has reduced to £1.7m (from £3.6m in the previous month) and an assessment of commissioner activity has been made. This will be re-assessed in month 6 and an action plan continues to reduce the level of uncoded activity.

Clinical Income - Forecast

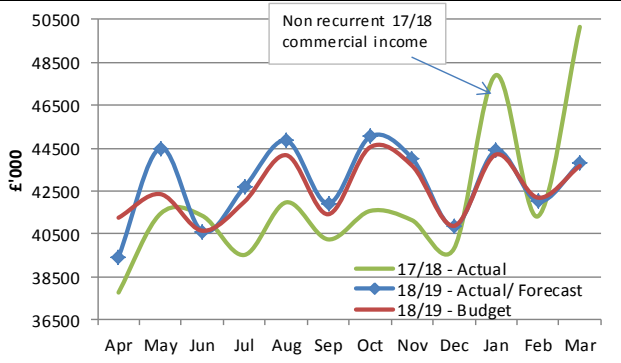
- Clinical income is forecast to be £2.9m over budget by year end, mostly related to over recovery for specialist commissioning, however the contract includes a QIPP reduction of £4.4m (offset in central reserves). Without this QIPP adjustment income would be underperforming by £0.8m. No specific QIPP schemes have been identified and therefore the contract reduction has not been applied to individual specialities or in divisional expenditure budgets. As it is still early in the year, it is still possible that the contract returns in line with expectation.

- Block contracts agreed with NEW Devon CCG and South Devon CCG provide stability to the year end clinical income position , however the level of over-performance on patient activity and 4% growth in referrals is putting significant pressure on expenditure.

Other income

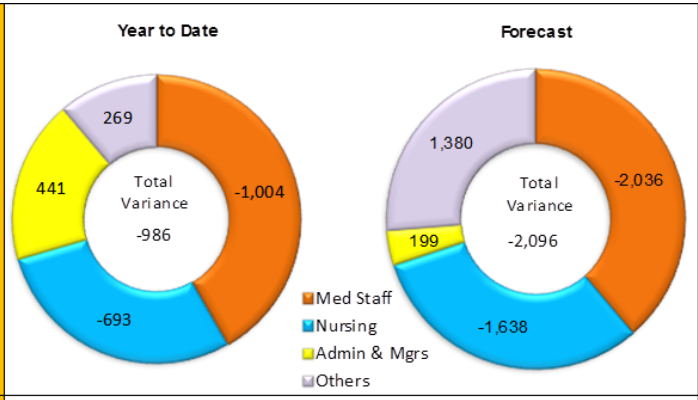
- Private patient income is ahead of plan by £89k year to date.
- Commercial income has improved by £95k in the month to £89k over recovered year to date and is expected to over recover by £203k for the year.

Income Actual v Budget Profile £'000



Income & Expenditure Continued

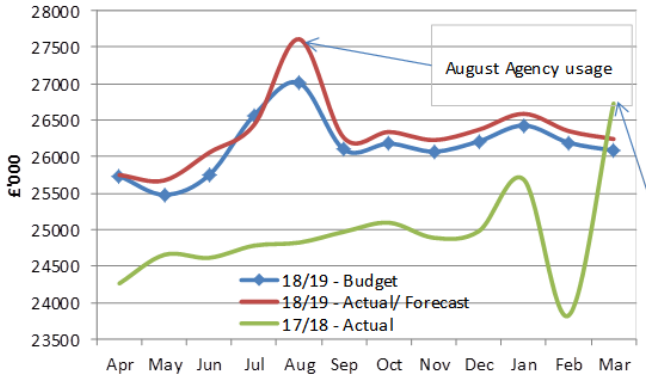
Pay Fav/(-Adv) (£'000)



Pay has overspent by £598k in August, resulting in a year to date overspend of £986k (0.8% of budget). Overspends on medical staff (£1.0m) and nursing (£693k) are offset by underspends on other staff (£710k).

- In August, medical staff expenditure overspent by £142k and is £1.0m overspent year to date, mostly relating to vacancies and sickness requiring high cost agency cover. Medical staff is forecast to overspend by £2.0m at year end, a similar position to last month.
- Nursing staff has overspent by £598k in the month to a year to date overspend of £693k. This is largely due to the higher number of agency hours booked from the more expensive non framework agencies over August. During August, it becomes more challenging to source bank and framework agencies. Whilst agency spend is expected to fll back from September, nursing is now forecast to overspend by £1.6m by year end. The main drivers of increased agency spend continue to be the vacancy position within Medicine, higher levels of sickness, escalation beds and the cost of specialling. A plan is in place to reduce the vacancy position through overseas recruitment, however this will take a number of months before it begins to deliver. In the meantime, a number of tactical actions will be taken including a review of enhanced pay for bank shifts and the forward booking of framework agencies.

Pay Actual v Budget Profile £'000

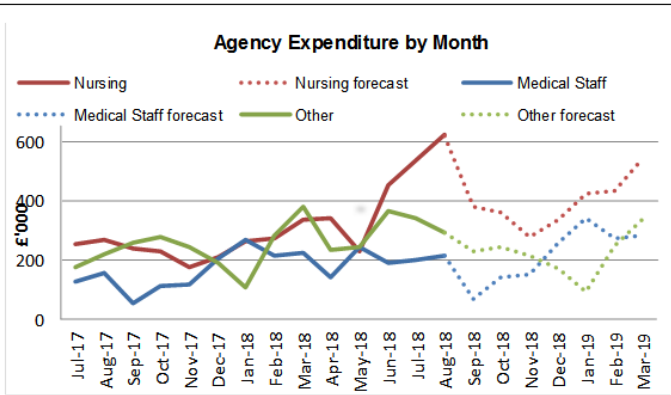


High number of operational days in March 2017 - pay linked to additional activity

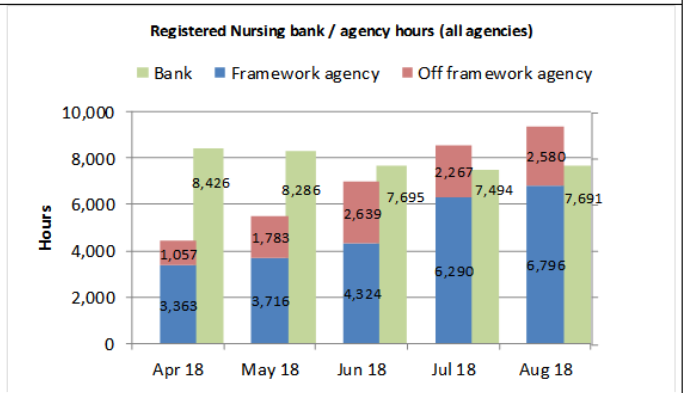
Agency staffing

- The Medical staff pay award has been included in the forecast position as requested by NHSI at a rate of 1.5%. The Trust awaits the detail of the actual award.
- Year to date agency expenditure has amounted to £4.6m with expenditure of £1.2m in August. This increase in expenditure has breached the NHS Improvement (NHSI) ceiling of £726k per month for the third month in a row.
- As well as the drivers above, the Trust continues to incur agency costs as part of offering mutual aid.
- The Trust is now forecasting agency expenditure of £10.5m, breaching the NHSI celling of £8.7m for the year.
- Usage of agency staffing are continually being monitored and a review of the agency plan is currently being actioned by Workforce.

Agency Staffing £000

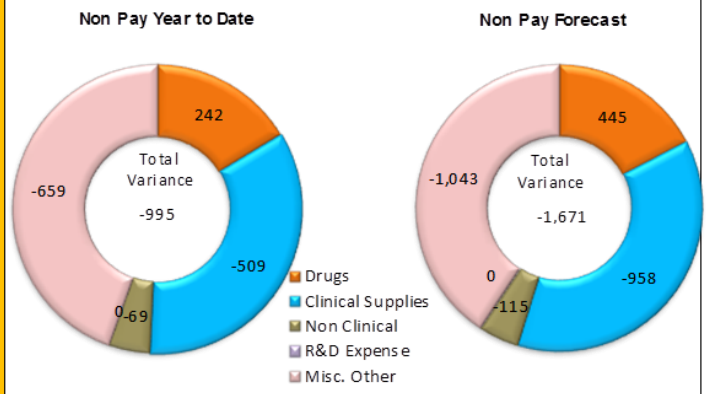


- Off framework agency usage has increased significantly from June.
- Bank usage has reduced since May.



Non Pay & CIP

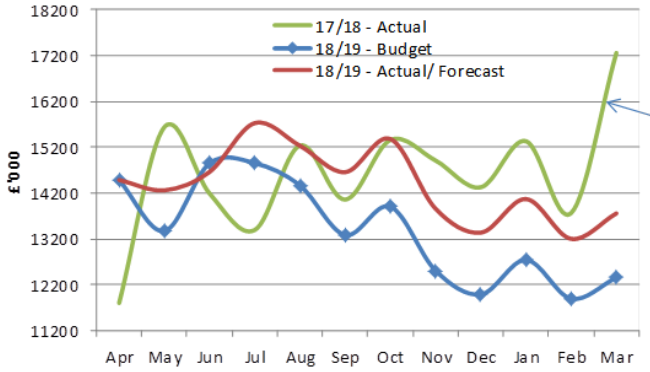
Non Pay and Reserves Fav/(-Adv) (£'000)



Non-pay expenditure at the end of June is £995k overspent (1.4%) and is forecast to be £1.7m (1.0%) overspent by year end.

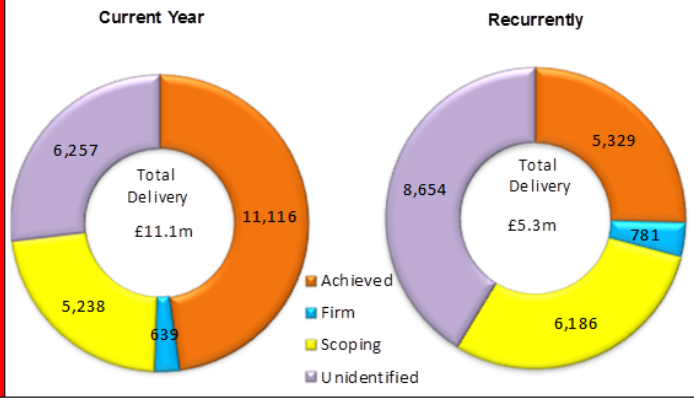
- Overall non pay expenditure has deteriorated by £609k in the month, partly related to Clinical Supplies (£302k - as a result of additional activity e.g. additional patient appliances due to increased cardiology emergencies in the month £184k) and Misc. Other Operating Expenses (£350k - mostly relating to a retrospective rates review on commercial property £246k).
- The forecast for non pay has deteriorated by £706k in the month to an overspend of £1.7m.
- A QIPP line on the income statement highlights the planned contract reduction for Specialist Commissioning of £4.4m in 2018/19 (£1.8m year to date). It has not been possible to allocate this to individual specialty budgets due to the lack of detail.
- Reserves - this highlights the mitigation required through reserves and accounting adjustments required to offset the £5.9m shortfall on CIP and current overspending. There remains a £3m residual risk

Non - Pay Actual v Budget Profile £'000



High number of operational days in March 2017 - non pay linked to additional activity

Cost Improvement Plan (£'000)



The CIP total target for 2018/19 is £23.3m which consists of the 2018/19 target of £18.2m in addition to CIP schemes that were achieved on a non-recurrent basis in 2017/18 of £5.1m brought forward. The full year target is £21.0m.

Current Year

£11.1m of the current year target has been achieved . There is currently a £5.9m shortfall as discussed above.

Recurrently

Schemes totalling £5.3m have been achieved on a recurrent basis . Plans are in place for a further £7.0m through Divisional and Trust wide schemes with a remaining balance currently unidentified of £8.7m . £12.6m of schemes are currently classified as high risk including the unidentified schemes.

Check and challenge meetings with each Division led by the Chief Finance Officer and Chief Operating Officer continue to progress current schemes and help with identifying new schemes. This remains the most significant risk to the financial plan. Divisions are sourcing additional resource where necessary to facilitate delivery. Plans are being developed to mitigate the risk. The Chief Nurse, Medical Director and Chief Operating Officer will review schemes that are identified as potentially having a high quality impact on services with the divisions to ensure that patient safety is protected.

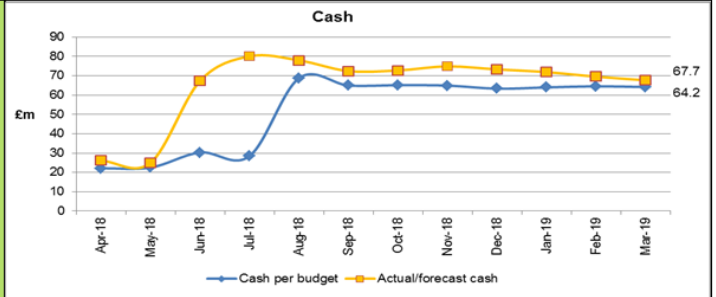
Cash & Capital Expenditure

Cash compared to budget

Cash	Year to date - Month 5 Budget £m	Actual £m	Variance £m	
Opening cash balance	**23.5**	**23.5**	**0.0**	⇨
Cash inflow / (outflow) from operating activities	2.9	1.1	(1.8)	⇩
Depreciation charge - non cash expense	5.0	5.1	0.0	⇧
Working capital movements - inventories	(0.4)	(0.1)	0.3	⇧
Working capital movements - receivables	10.0	11.0	0.9	⇧
Working capital movements - payables	(2.2)	(0.6)	1.6	⇧
Capital expenditure	(9.9)	(4.1)	5.8	⇧
Net interest	0.0	0.1	0.0	⇧
Loan repayments	0.0	0.0	0.0	⇨
Loan drawn down	42.0	42.0	0.0	⇨
PDC drawn down	0.0	0.0	0.0	⇨
Closing cash balance	**71.0**	**78.0**	**7.0**	⇧

Year to Date
Cash is £7.0m higher than budget at month 5. The main increase in cash is due to the reduction in capital expenditure of £5.8m.

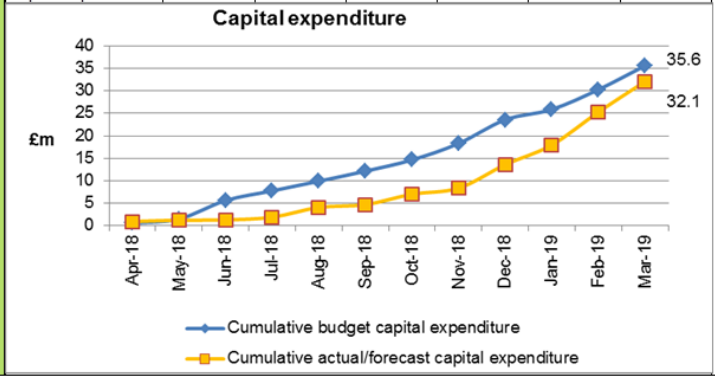
Cash graph



Forecast
Cash is forecast to be £67.7m by the end of 2018/19 compared to the planned value of £64.2m, which is due to a forecast £3.5m slippage in the Capital Programme.

Capital expenditure

Capital	Year to date - Month 5 Budget £m	Actual £m	Variance £m	Outturn Budget £m	Forecast £m	Variance £m
Capital expenditure	9.9	4.1	5.8	35.6	32.1	3.5



Year to Date
Actual capital expenditure is £5.8m lower than the budget and the variance is mostly due to slippage of £1.6m on Private Patients' Unit, £0.8m on the 4th Linear Accelerator scheme, £0.7m for the 2018/19 Estates Infrastructure programme and £0.2m for EPR.

Forecast
Capital expenditure of £32.1m is forecast, a reduction of £3.5m compared to £35.6m per the annual plan.
The value includes a number of new capital developments including £13.5m for the EPR scheme, £0.5m for the reconfiguration of the Emergency Development and £6.1m for the 4th Linear Accelerator. There is still some uncertainty relating to the timing of the 4th Linear Accelerator.

Use of Resources & Provider Sustainability Fund

Finance and Use of Resource Ratings

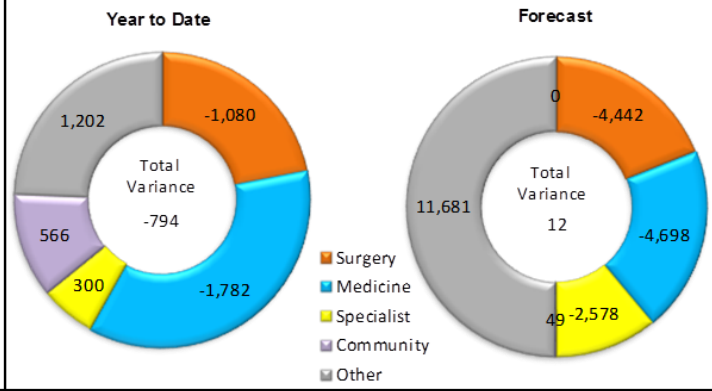
Finance and Use of Resources Rating	Year to date - Month 5 Plan £m	Year to date - Month 5 Actual £m	Outturn Plan £m	Outturn Actual £m
Capital service cover rating	2	1	1	1
Liquidity rating	1	1	1	1
I&E margin rating	3	3	1	1
Variance from the control total rating	1	1	1	1
Agency rating	1	2	1	2
Overall rating unrounded	1.6	1.6	1	1.2
Risk Ratings rounded before overrides	2	2	1	1
Trigger / No trigger	No trigger	No trigger	No trigger	No trigger
Risk rating rounded after overrides	**2**	**2**	**1**	**1**

The Trust has achieved a Finance and Use of Resources rating of 2 as at Month 5, which is comparable to the planned risk rating of 2.
The Trust is forecasting a planned risk rating of 1 as at the end of 2018/19, which is in line with the planned rating.

As at month 5, due to increased agency expenditure the agency rating has worsened to a 2 (year to date and forecast). Forecast expenditure on agency would need to worsen by £2.5m (full year forecast >£13.0m) to achieve an agency rating of a 4. With a rating of 4, the best overall rating that can be achieved is a 3.

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

Divisional Position Fav/(-Adv) (£'000)



Surgery
- Year to date income would be broadly on budget if the block arrangement was not in place. Small overspends on pay and non pay year to date are forecast to worsen by year end mostly due to additional medical staff expenditure (vacancies and sickness) and additional expenditure on clinical supplies. CIP is currently underachieved by £270k and forecast to be £2.4m underachieved by year end.

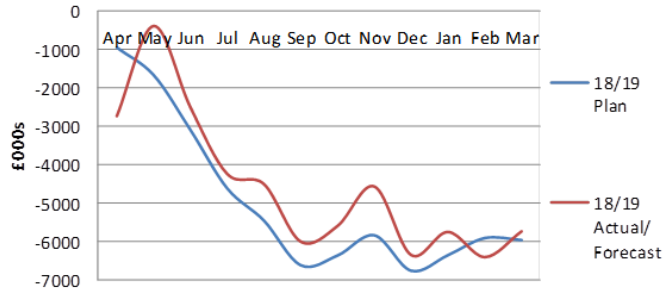
Medicine
- Medicine income would be significantly over recovered if not on block. Pay has overspent by £1.2m year to date and forecast to be £2.4m by year end due to Medical Staff (additional activity/vacancies) and Nursing (vacancies requiring significant agency staff cover). Small overspends on non pay mostly relate to additional activity. CIP is forecast to be under recovered by £1.6m.

Specialist
- Year to date clinical income is on budget, however is expected to deteriorate by year end due to winter pressures.. Pay and non pay is broadly in line with budget both year to date and forecast. CIP is forecast to underachieve by £1.8m.

Community
- Overall the Division has a favourable position mostly related to year to date CIP overachievement (£532k). CIP is forecast to be fully achieved and the Division is expected to be marginally underspent at year end.

Other
- The most significant variances relate to Trust reserves and central income adjustments (most significantly QIPP, NEW Devon/South Devon CCG block income adjustment, Better Care Fund, RTT.

Provider Sustainability Funding (PSF)



- The Trust is expecting to receive £2.6m of Provider Sustainability Funding for the first 5 months of the year and is expecting to achieve £12.2m in full at year end, in line with plan set out below:

18/19 PSF Funding		Quarter 1 £000	Quarter 2 £000	Quarter 3 £000	Quarter 4 £000		Total £000
Finance	Plan	1,283	1,712	2,566	2,995		8,555
	Forecast	1,283	1,712	2,566	2,995		8,555
A&E	Plan	550	734	1,100	1,283		3,667
	Forecast	550	734	1,100	1,283		3,667
Overall Plan		1,833	2,445	3,666	4,278		12,222
Forecast Achievement		1,833	2,445	3,666	4,278		12,222

Whilst ED performance during Q2 has been above trajectory, early September has been challenging so there remains a risk of not achieving the plan for quarter 2 resulting in a loss of PSF of £734.

Financial Tables

Royal Devon & Exeter NHS Foundation Trust Income Statement Period ending 31/08/2018 Month 05	Current Month			Year to Date				Outturn				Prior Yr
	Actual	Budget	Actual Variance to Budget Fav./(Adv.)	Actual	Budget	Actual Variance to Budget Fav./(Adv.)		Actual	Budget	Actual Variance to Budget Fav./(Adv.)	Annual Plan	Mar-18 Actual
	£000	£000	£000	£000	£000	£000		£000	£000	£000	Fav./(Adv.) £000	£000
Income												
NHS Clinical Income	37,573	36,966	607	175,972	174,503	1,470	1	427,289	424,519	2,770	420,317	404,994
Private patient Income	107	123	(16)	695	606	89		1,539	1,450	89	2,258	1,801
Research and Development	1,550	1,550	0	7,706	7,706	0		17,541	17,541	0	18,137	18,137
Education and Training	1,182	1,182	0	5,953	5,953	0		13,722	13,722	0	13,618	13,993
Other Income	3,624	3,530	95	18,260	18,171	89		41,694	41,491	203	39,252	48,430
Total income	**44,036**	**43,350**	**686**	**208,586**	**206,939**	**1,647**		**501,786**	**498,723**	**3,062**	**493,582**	**487,355**
Expense												
Employee Benefits Expenses (Pay)	(27,611)	(27,013)	(598)	(131,536)	(130,551)	(986)	2	(315,918)	(313,822)	(2,096)	(307,788)	(299,333)
Drug Costs	(4,658)	(4,723)	65	(23,556)	(23,798)	242		(55,152)	(55,597)	445	(58,651)	(55,829)
Clinical Supplies	(4,134)	(3,832)	(302)	(20,348)	(19,839)	(509)	3	(48,036)	(47,078)	(958)	(42,210)	(47,118)
Non Clinical Supplies	(486)	(463)	(23)	(2,381)	(2,312)	(69)		(5,167)	(5,052)	(115)	(5,229)	(5,610)
Research & Development Expenses	(1,551)	(1,551)	0	(7,123)	(7,123)	0		(15,746)	(15,746)	(0)	(17,282)	(17,284)
Misc. Other Operating Expenses	(4,404)	(4,054)	(350)	(20,968)	(20,309)	(659)		(48,560)	(47,517)	(1,043)	(49,459)	(49,462)
Cost Improvement Programme	0	(112)	112	0	(389)	389		0	5,944	(5,944)	0	0
Specialist Commissioner - Quality Innovation Productvity and Prevention (QIPP)	0	366	(366)	0	1,836	(1,836)		0	4,407	(4,407)	0	0
Reserves	(1)	2	(3)	(1)	(1)	0		(1,508)	(12,238)	10,730	0	0
Total Costs	**(42,845)**	**(41,381)**	**(1,464)**	**(205,913)**	**(202,485)**	**(3,428)**		**(490,086)**	**(486,697)**	**(3,388)**	**(480,619)**	**(474,636)**
EBITDA	**1,191**	**1,969**	**(778)**	**2,673**	**4,454**	**(1,781)**		**11,700**	**12,026**	**(326)**	**12,963**	**12,719**
Profit / loss on asset disposals	0	0	0	0	0	0		0	0	0	0	0
Exceptional Income / Costs	0	0	0	0	0	0		0	0	0	0	0
Total Depreciation and Impairments	(990)	(986)	(4)	(4,933)	(4,931)	(2)		(11,834)	(11,834)	0	(11,834)	(11,900)
Total operating surplus (deficit)	**201**	**984**	**(782)**	**(2,260)**	**(477)**	**(1,783)**		**(134)**	**192**	**(326)**	**1,129**	**819**
Total interest receivable/ (payable) - inc committed WC facilities	33	8	25	94	43	51		250	104	146	104	96
Total interest payable on Loans and leases	(51)	(51)	0	(257)	(257)	0		(617)	(617)	0	(1,783)	(645)
PDC Dividend	(450)	(450)	0	(2,070)	(2,250)	180		(5,220)	(5,400)	180	(5,400)	(5,420)
Net Surplus/(deficit) before donated asset & PSF Income	**(267)**	**491**	**(757)**	**(4,493)**	**(2,941)**	**(1,552)**		**(5,721)**	**(5,721)**	**(0)**	**(5,950)**	**(5,150)**
2018/19 Provider Sustainability Funding Income (PSF)	815	815	0	3,463	3,463	0		12,222	12,222	0	12,222	16,775
Net Surplus/(deficit) after 2018/19 PSF	**548**	**1,306**	**(757)**	**(1,030)**	**522**	**(1,552)**		**6,501**	**6,501**	**(0)**	**6,272**	**12,519**
Donated asset income & depreciation	(22)	(19)	(3)	(104)	(96)	(8)	4	(229)	(229)	0	0	486
Net Surplus/(deficit) after donated asset & PSF Income	**526**	**1,286**	**(760)**	**(1,134)**	**426**	**(1,560)**		**6,272**	**6,272**	**(0)**	**6,272**	**13,005**

KEY MOVEMENTS

1 Over recovery of clinical income for General Medicine, Plastics, Trauma and Ophthalmology are offset with an under recovery in the specialties of General Surgery, Obstetrics, Haematology and Cardiology.
2 Pay - overspends on Medical Staff (£1.0m) and Nursing (£693k) are offset with underspends on other staff (£710k).
3 Clinical supplies expenditure is overspent mainly due to laboratory equipment and consumables and patient appliances.
4 Depreciation and income related to donated assets are shown separately as these items are unable to be counted towards the financial control total target.

Financial Tables

Royal Devon & Exeter NHS Foundation Trust Statement of Financial Position Period ending 31/08/2018 Month 05	Year to Date						Outturn						Prior Yr
	Actual	Budget	Actual Variance to Budget Fav./(Adv.)		Annual Plan	Actual Variance to Plan Fav./(Adv.)	Actual	Budget	Actual Variance to Budget Fav./(Adv.)		Annual Plan	Actual Variance to Plan Fav./(Adv.)		Mar-18
	£000	£000	£000		£000	£000	£000	£000	£000		£000	£000		£000
Assets, Non-Current														
Property, Plant and Equipment, Net (including intangibles)	198,976	204,832	(5,856)	1	204,792	(5,816)	236,285	239,799	(3,514)		239,799	(3,514)		199,955
Investment in joint venture	5	5	0		5	0	5	5	0		5	0		5
Non NHS Trade Receivables, Non-Current	1,093	1,200	(107)		1,200	(107)	1,200	1,200	0		1,200	0		866
Assets, Non-Current, Total	**200,074**	**206,037**	**(5,963)**		**205,997**	**(5,923)**	**237,490**	**241,004**	**(3,514)**		**241,004**	**(3,514)**		**200,826**
Assets, Current														
Inventories	8,705	9,000	(295)		9,000	(295)	9,000	9,000	0		9,000	0		8,649
Trade and Other Receivables, Net, Current	27,122	27,944	(822)	2	27,944	(822)	26,567	26,567	0		26,567	0	1	38,316
Non Current Assets held for sale	0	0	0		0	0	0	0	0		0	0		0
Cash	77,979	70,957	7,022	3	68,784	9,195	67,681	64,167	3,514		64,167	3,514	2	23,529
Other Assets - Current Assets Held by Charitable Funds	0	0	0		0	0	0	0	0		0	0		0
Assets, Current, Total	**113,806**	**107,901**	**5,905**		**105,728**	**8,078**	**103,248**	**99,734**	**3,514**		**99,734**	**3,514**		**70,494**
Liabilities, Current														
Loans, non-commercial, Current (DH, FTFF, NLF, etc)	(1,270)	(1,270)	0		(1,270)	0	(1,393)	(1,393)	0		(1,393)	0		(1,270)
Finance leases - Current	0	0	0		0	0	0	0	0			0		0
Trade and Other Payables, Current	(13,625)	(11,843)	(1,782)	4	(11,843)	(1,782)	(12,615)	(12,615)	0		(12,615)	0		(13,059)
Deferred Income, Current	(2,689)	(2,700)	11		(2,700)	11	(3,000)	(3,000)	0		(3,000)	0		(3,102)
Provisions, Current	(233)	(233)	0		(233)	0	(233)	(233)	0		(233)	0		(233)
Current Tax Payables	(6,701)	(6,200)	(501)		(6,200)	(501)	(6,200)	(6,200)	0		(6,200)	0		(6,095)
Other Financial Liabilities, Current	(21,566)	(22,416)	850		(22,416)	850	(20,632)	(20,632)	0		(20,632)	0		(20,631)
Liabilities, Current, Total	**(46,084)**	**(44,662)**	**(1,422)**		**(44,662)**	**(1,422)**	**(44,073)**	**(44,073)**	**0**		**(44,073)**	**0**		**(44,390)**
NET CURRENT ASSETS (LIABILITIES)	**67,722**	**63,239**	**4,483**		**61,066**	**6,656**	**59,175**	**55,661**	**3,514**		**55,661**	**3,514**		**26,104**
TOTAL ASSETS LESS CURRENT LIABILITIES	**267,796**	**269,276**	**(1,480)**		**267,063**	**733**	**296,665**	**296,665**	**(0)**		**296,665**	**(0)**		**226,930**
Liabilities, Non-Current														
Loans, Non-Current, non-commercial (DH, FTFF, NLF, etc)	(53,320)	(53,320)	0		(53,320)	0	(56,131)	(56,131)	0		(56,131)	0		(11,320)
Finance leases - Non-current	0	0	0		0	0	0	0	0			0		0
Other Creditors, Non-Current	0	0	0		0	0	0	0	0			0		0
Provisions, Non-Current	(376)	(300)	(76)		(300)	(76)	(300)	(300)	0		(300)	0		(380)
TOTAL ASSETS EMPLOYED	**214,100**	**215,656**	**(1,556)**		**213,443**	**657**	**240,234**	**240,234**	**(0)**		**240,234**	**(0)**		**215,230**
TAX PAYERS' EQUITY														
Public dividend capital	153,883	153,883	0		153,883	0	155,584	155,584	0		155,584	0		153,883
Retained Earnings (Accumulated Losses)	27,143	28,699	(1,556)		26,486	657	35,595	35,595	(0)		35,595	(0)		27,923
Charitable Funds	0	0	0		0	0	0	0	0		0	0		0
Revaluation Reserve	33,074	33,074	0		33,074	0	49,056	49,056	0		49,056	0		33,424
Donated Asset Reserve	0	0	0		0	0	0	0	0		0	0		0
TOTAL TAX PAYERS' EQUITY	**214,100**	**215,656**	**(1,556)**		**213,443**	**657**	**240,235**	**240,235**	**(0)**		**240,235**	**(0)**		**215,230**

KEY MOVEMENTS

1 The value of property plant and equipment is £5.9m lower than the forecast and budget due to the reduction in capital expenditure.
2 Trade and other receivables are £0.8m lower than the budget, this is largely due to phasing of the budget.
3 Cash is £7.0m higher than budget. The main increase in cash is due to the reduction in capital expenditure noted above of £5.9m. The cash flow statement provides a greater analysis of the key variances.
4 Trade and other payables are £1.8m higher than budget, this largely relates to NHS trade payables, including amounts due to NHS Property Company and Northern Devon in respect of Community property charges.

Financial Tables

Royal Devon & Exeter NHS Foundation Trust	Year to Date					Outturn					Prior Yr
Cash Flow Statement Period ending 31/08/2018 Month 05	Actual	Budget	Actual Variance to Budget Fav./(Adv.)	Annual Plan	Actual Variance to Plan Fav./(Adv.)	Actual	Budget	Actual Variance to Budget Fav./(Adv.)	Annual Plan	Actual Variance to Plan Fav./(Adv.)	Mar-18
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES											
Surplus/(deficit) after tax	(1,134)	425	(1,559)	(1,787)	653	6,272	6,268	4	6,272	(0)	8,195
Non-cash flows in operating surplus/(deficit)											
Finance (income)/charges	163	214	(51)	353	(190)	367	513	(146)	1,679	(1,312)	549
Depreciation and amortisation	5,050	5,043	7	5,079	(29)	12,100	12,100	0	12,100	0	12,188
Impairment	0	0	0	0	0	0	0	0	0	0	0
PDC dividend expense	2,070	2,250	(180)	2,250	(180)	5,220	5,400	(180)	5,400	(180)	5,420
Other increases/(decreases) to reconcile to profit/(loss) from operations	0	0	0	0	0	0	0	0	0	0	0
Other recognised gains/losses straight to reserves		0	0	0	0		0	0	0	0	
Non-cash flows in operating surplus/(deficit), Total	7,283	7,507	(224)	7,682	(399)	17,687	18,013	(326)	19,179	(1,492)	18,157
Increase/(Decrease) in working capital											
(Increase)/decrease in inventories	(56)	(351)	295	(351)	295	(351)	(351)	0	(351)	0	412
(Increase)/decrease in NHS Trade Receivables	831	458	373	458	372	(357)	(357)	0	(357)	(0)	(423)
(Increase)/decrease in Non NHS Trade Receivables	1,737	1,130	607	1,129	608	529	529	0	529	(0)	(1,781)
(Increase)/decrease in other receivables	845	306	539	1,307	(462)	306	306	0	306	(0)	(210)
(Increase)/decrease in accrued income	10,901	10,533	368	10,533	368	11,091	11,091	0	11,091	0	(5,612)
(Increase)/decrease in prepayments	(3,120)	(2,055)	(1,065)	(2,055)	(1,065)	0	0	0	0	0	(553)
Increase/(decrease) in Deferred Income (excl. Donated Assets)	(413)	(402)	(11)	0	(413)	(102)	(102)	0	(102)	0	630
Increase/(decrease) in provisions	(4)	(80)	76	(80)	76	(80)	(80)	0	(80)	0	15
Increase/(decrease) in Trade Creditors	1,488	(72)	1,560	(402)	1,890	(300)	(300)	0	(300)	0	(1,969)
Increase/(decrease) in tax payable	606	105	501	105	501	105	105	0	105	0	362
Increase/(decrease) in Other Creditors	382	(38)	420	(1,846)	2,228	(38)	(38)	0	(38)	(0)	398
Increase/(decrease) in accruals	(1,392)	(716)	(676)	0	(1,392)	1	1	0	-	1	2,411
Increase/(Decrease) in working capital, Total	11,805	8,818	2,987	8,799	3,006	10,804	10,804	0	10,804	(0)	(6,320)
Net cash inflow/(outflow) from investing activities											
Property - new land, buildings or dwellings	(4,071)	(9,916)	5,845	(9,916)	5,845	(32,099)	(35,613)	3,514	(35,613)	3,514	(8,876)
Property - maintenance expenditure	0	0	0	0	0	0	0	0	0	0	0
Plant and equipment - Information Technology	0	0	0	0	0	0	0	0	0	0	0
Plant and equipment - Other	0	0	0	0	0	0	0	0	0	0	0
Proceeds on disposal of property, plant and equipment	0	0	0	0	0	700	700	0	700	0	2
Increase/(decrease) in Capital Creditors	(1,304)	(1,106)	(198)	(1,106)	(198)	(106)	(106)	0	(106)	0	844
Other cash flows from financing activities	0	0	0	0	0	0	0	0	0	0	0
Net cash inflow/(outflow() from investing activities, Total	(5,375)	(11,022)	5,647	(11,022)	5,647	(31,505)	(35,019)	3,514	(35,019)	3,514	(8,030)
Net cash inflow/(outflow) from financing activities											
PDC Dividends paid	0	0	0	0	0	(5,040)	(5,220)	180	(5,220)	180	(5,102)
PDC Dividend Received	0	0	0	0	0	1,701	1,701	0	1,701	0	818
Interest (paid) on non-commercial loans	0	(6)	6	(126)	126	(617)	(617)	0	(1,783)	1,166	(645)
Interest received on cash and cash equivalents	94	43	51	43	51	250	104	146	104	146	96
Repayment of non-commercial loans	0	0	0	0	0	(1,270)	(1,270)	0	(1,270)	0	(1,268)
Receipt of finance leases and loans	42,000	42,000	0	42,000	0	46,204	46,204	0	46,204	0	(3)
(Increase)/decrease in non-current receivables	(227)	(334)	107	(334)	107	(334)	(334)	0	(334)	0	97
Increase/(decrease) in non-current payables	0	0	0	0	0	0	0	0	0	0	0
Net cash inflow/(outflow) from financing activities, Total	41,867	41,703	164	41,583	284	40,894	40,568	326	39,402	1,492	(6,007)
Net increase/(decrease) in cash and cash equivalents	54,446	47,431	7,015	45,256	9,191	44,151	40,634	3,518	40,638	3,513	5,996
Opening cash and cash equivalents	23,529	23,529	0	23,529	0	23,529	23,529	0	23,529	0	17,533
Closing cash and cash equivalents	77,975	70,960	7,015	68,785	9,191	67,680	64,163	3,518	64,167	3,514	23,529

Financial Tables

Royal Devon and Exeter NHS Foundation Trust

Capital Expenditure

Period ending 31/8/2018
Month 5

Scheme	Approval level	Actual expenditure to date compared to budget on annual plan			Total expenditure forecast for the year compared to the budget on the annual plan				Total expected expenditure compared to the value approved by the Exec Group / Board of Directors — Schemes over £500k in progress or planned				Expected completion date
		Column B	*Column C*	*Column D*	*Column E*	*Column F*	*Column G*	*Column H*					
		YTD actual expenditure £'000	YTD planned expenditure per annual plan £'000	YTD variance slippage / (overspend) (C - B) £'000	Forecast future capital expenditure for the year £'000	Forecast total capital expenditure for the year *(B + E)* £'000	Full year expenditure per annual plan £'000	18/19 forecast slippage / (overspend) *(G - F)* £'000	Expenditure approved by the Exec Group £'000	Total expenditure forecast for the scheme £'000	Scheme variance under spend / (overspend) £'000	Note	
EPR	FBC	1,829	2,007	178	11,661	13,490	8,752	(4,738)	52,000	52,000	0		TBC
ED - Reconfiguration	OBC	205	270	65	295	500	500	0	17,200	17,200	0		TBC
Estates Infrastructure 2018/19	CRIC	218	900	682	3,729	3,947	4,000	53	4,000	3,947	53		Mar-19
Linear Accelerator 4th Bunker	OBC	12	788	776	3,315	3,327	3,327	(0)	3,398	3,398	(0)		Mar-19
Estates Infrastructure 17/18	CRIC	24	0	(24)	0	24	0	(24)	3,240	3,075	165		Jun-18
Linear Accelerator Equipment	OBC	0	0	0	2,809	2,809	2,809	0	2,809	2,809	0		Mar-19
Cath Lab Replacement - Lab1	CRIC	118	200	82	0	118	362	244	2,509	1,555	954	1	Sep-18
Private Patient Unit	OBC	93	1,700	1,607	100	193	2,050	1,857	1,948	1,948	(0)		TBC
Deck Car Park	Unapproved	0	80	80	200	200	1,500	1,300	5,000	5,000	0		TBC
GE Infinia Gamma Camera	CRIC	0	0	0	1,000	1,000	1,000	0	1,000	1,000	0		Mar-19
Estates Rationalisation	Unapproved	0	0	0	500	500	1,000	500	1,000	1,000	0		TBC
GE VCT CT Scanner Acquisition Console	CRIC	0	0	0	750	750	750	0	750	750	0		Nov-18
Other schemes < £500k and contingency	CRIC / Unapproved	1,571	3,970	2,399	3,669	5,240	9,563	4,323					
Total 2018/19 Capital Schemes		**4,070**	**9,915**	**5,845**	**28,028**	**32,098**	**35,613**	**3,515**					

Financial Tables

Royal Devon & Exeter NHS Foundation Trust Cost Improvement Programme Period ending 31/08/2018 Month 05	Year to Date - Achieved			Current Year - Achieved			Current Year - Forecast		Full Year (recurring) - Achieved				CY Target	FY Target
	Actual	Target	Variance to Budget Fav./(Adv.)	Actual	Target	Variance to Budget Fav./(Adv.)	Forecast	CY Forecast Variance Fav / (Adv)	Actual	Target	Variance to Budget Fav./(Adv.)	Forecast FY	Forecast Rating	Forecast Rating
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	R/A/G	R/A/G
Business As Usual														
Medical Services	196	433	(237)	211	3,178	(2,967)	1,566	(1,612)	21	3,324	(3,303)	1,807	R	R
Specialist Services	564	298	267	693	3,349	(2,656)	1,432	(1,917)	203	3,504	(3,316)	1,624	R	R
Surgical Services	287	558	(271)	362	3,617	(3,255)	1,192	(2,425)	83	3,783	(3,723)	1,557	R	R
Operations Support Unit	263	34	229	399	984	(585)	984	0	234	913	(679)	405	R	R
Corporate	483	431	52	887	1,297	(410)	1,307	10	691	1,201	(655)	1,067	R	R
Community	532	0	532	550	801	(251)	801	0	31	1,201	(1,170)	311	R	R
	2,326	1,753	572	3,101	13,226	(10,125)	7,282	(5,944)	1,264	13,926	(12,846)	6,772		
Trustwide Projects														
Productivity / Inflation	2,744	3,135	(391)	6,515	7,524	(1,009)	7,524	0	4,065	4,274	(209)	4,274	G	G
Estates Rationalisation	0	0		0	0	0	0	0	0	1,250	(1,250)	1,250	R	R
STP	625	0	625	1,500	1,500	0	1,500	0	0	0	0	0	G	G
Trustwide - mitigation	0	0	0	0	0	0	0	0	0	0	0	0	R	R
Commerical Income	0	417	(417)	0	1,000	(1,000)	1,000	0	0	0	0	0	R	R
	3,369	3,552	(183)	8,015	10,024	(2,009)	10,024	0	4,065	5,524	(1,459)	5,524		
Central Unidentified (excl BAU and Trustwide Projects)										1,500	(1,500)			
Total CIP	5,694	5,305	389	11,116	23,250	(12,134)	17,306	(5,944)	5,329	20,950	(15,805)	12,296		

Summary by Planning Status			
Achieved		11,116	5,329
Firm Plans	High Risk	35	10
	Medium Risk	24	24
	Low Risk	580	747
Plans being Scoped	High Risk	1,904	3,895
	Medium Risk	3,168	2,176
	Low Risk	166	115
Unidentified	High Risk	6,257	0
Total Forecast Plans		23,250	12,296

Royal Devon and Exeter NHS Foundation Trust

Agenda item:	10.1, Public Board meeting		**Date:** 26th September 2018	
Title:	Audit Committee Report			
Prepared by:	Andy Clark, Head of Financial Management			
Presented by:	Peter Dillon, Chair of Audit Committee			
Responsible Executive:	Chris Tidman, Chief Financial Officer			
Summary:	A report from the Audit Committee on the key issues arising from the Audit Committee meeting on 20th July 2018.			
Actions required:	It is proposed that the Board of Directors notes the report from the Audit Committee.			
Status (*):	**Decision**	**Approval**	**Discussion**	**Information**
				x
History:	The previous update was given to the Board meeting on 28th March 2018, following the Audit Committee on 23rd February. A verbal update has also been provided to the Board meeting in May and June 2018			
Link to strategy/ Assurance framework:	The primary role of the Audit Committee is to conclude upon the adequacy and effective operation of the organisation's overall internal control system. In setting the Internal Audit plan for the year, the Audit Committee would seek to ensure that a programme of work has been put in place to review the risks of the Trust on a regular basis.			

Monitoring Information		Please *specify* CQC standard numbers and tick ✓other boxes as appropriate	
Care Quality Commission Standards			
Monitor		Finance	
Service Development Strategy		Performance Management	
Local Delivery Plan		Business Planning	
Assurance Framework	X	Complaints	
Equality, diversity, human rights implications assessed			
Other *(please specify)*			

1. Purpose of Paper

1.1 To provide, as requested by the Board of Directors (Board), a report on the key issues arising from the Audit Committee following the meeting held on 20th July 2018.

2. Background

2.1 The primary role of the Audit Committee is to conclude upon the adequacy and effective operation of the organisation's overall internal control system. It is responsible for providing assurance to the Board in relation to the financial systems and controls of the Trust. The Annual Governance Statement which is included in the Annual Report reviews the effectiveness of the system of internal control. By concurring with this statement and recommending its adoption to the Board, the Audit Committee also gives its assurance on the effectiveness of the overarching systems of integrated governance, risk management and internal control.

2.2 The Audit Committee's Chair, on behalf of the Audit Committee, is responsible for reporting back to the Board, highlighting the key issues arising from each meeting.

2.3 A copy of the approved Audit Committee minutes is available for inspection.

3. Analysis

3.1 For escalation

There were no items identified for escalation to the Board.

3.2 For information

The Audit Committee identified the following items for sharing with the Board:

3.3 Audit Committee Effectiveness Review 2018

We received the results of the Audit Committee's (AC) effectiveness survey. This showed high levels of satisfaction that AC is meeting its requirements and that behaviours are as to be expected. It remains a target to maximise AC's "Prioritisation and focus on key issues". The AC reviewed the comments received as part of the survey, noting that overall the survey result was positive.

3.4 Internal Audit Annual Report 2017/18

The Director of Audit South West presented the Internal Audit Annual Report which summarised the work Internal Audit delivered to the Trust during 2017/18. You will recall that our overall Head of Internal Audit's opinion is a Significant rating that the Trust maintains a system of internal control. During the year 662 days were delivered compared to the planned 637. This over delivery was due to days from the previous financial year being brought forward. The AC thanked Internal Audit for their work during 2017/18 and noted the report.

3.5 Re-Tendering Process for External Audit

The Head of Financial Management (HoFM) reported that the current contract with External Audit was in place until 31st October 2019. The process for re-tendering the contract needs to commence shortly to ensure a service is in place in time.

The HoFM set out that the Trust's Council of Governors (CoG) is responsible for appointing the new External Auditors. CoG was informed in August of this requirement and to nominate the necessary representatives to join the Project Panel. The term of the new contract is expected to be for a five year period.

The key dates for the re-tendering exercise are:

- September 2018 – 1st meeting of the Project Team.
- January 2019 – Deadline for receiving expressions of interest and completed key participation requirements.
- March 2019 – Invitation to tender document sent to shortlisted suppliers.
- May 2019 – Tender submission dealine.
- July 2019 – Presentations by suppliers to the Project Panel.
- September 2019 – CoG to approve the recommended supplier.
- 1st November 2019 – Commencement of the new contract.

3.6 **Internal Audit Progress report**

Internal Audit (IA) reported that the Audit programme was behind plan mainly owing to staff sickness. This has now been resolved and additional staff have also recently been appointed to assist in addressing the backlog. IA have delivered 64.5 days of the planned 90 days expected. A total of 663 days is to be delivered by year end.

Ten reports had been issued as final since the last committee along with two management reviews. One further report have been issued in draft form and was expected to be signed off shortly, and seven audits are work in progress. There were no outstanding audit recommendations.

3.7 **External Audit Reports**

KPMG updated the AC on their progress report and technical update. The progress report confirmed the completion of the external audit of 2017/18 Annual Report and Accounts and issuing of the independent auditor's statement to the Board.

In relation to the Technical Update they referenced that the Prime Minister has set a 5 year funding plan for the NHS and the Department of Health has issued the Group Accounting Manual for 2018/19.

3.8 **Other reports**

The Head of Financial Management gave an update on the position regarding overseas patients receiving care at the Trust. During the first quarter of the financial year the Trust has written off £171k, with £125k related to one patient. Due to this exceeding the delegated £50k limit this needs to be reported to the Board and the AC requested the Board discuss if the limit is set at an appropriate level.

3.9 **Representation to the Board**

The Audit Committee confirms to the Board that it is compliant with its Terms of Reference and that it continues to review the adequacy and effective operation of the Trust's overall internal control system. This report highlights to the Board the key issues from the most recent Audit Committee meeting on 20th July 2018.

4. Resource/legal/financial/reputation implications

4.1 No resource/legal/financial or reputation implications were identified in this report.

5. Link to BAF/Key risks

5.1 None identified

6. Proposals

6.1 It is proposed that the Board of Directors notes the report from the Audit Committee.

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AUDIT COMMITTEE

Terms of Reference

These Terms of Reference are used as evidence for:	
Care Quality Commission Regulation:	Regulation 17 Good Governance
Other (*please specify)*:	

1. Accountability

1.1 The Audit Committee is a non-executive committee accountable to the Board of Directors (Board) and has no executive powers other than those specifically delegated in these terms of reference. It is, however, authorised by the Board to investigate any activity within the Trust and all employees are directed to co-operate with any and all requests it makes.

1.2 The Audit Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2. Purpose

2.1 The primary role of the Audit Committee is to conclude upon the adequacy and effective operation of the organisation's overall internal control system. Without prejudice to the generality of the foregoing, the Audit Committee is responsible for providing assurance to the Board in relation to the financial systems and controls of the Trust.

3. Membership

3.1 The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of four members, at least one of whom shall have substantial financial expertise. The members will serve for three years and be eligible for re-appointment for a further three years. In exceptional circumstances a member may be re-appointed beyond the usual six years maximum for up to a further year.

3.2 One of the members will be appointed Chairman of the Audit Committee by the Board. In the absence of the Chairman, the members attending shall appoint one of their number to Chair the meeting. This shall not be the Chair of the Governance Committee.

3.3 The Chairman of the Trust shall not be a member of the Committee.

3.4 Members of the Audit Committee will normally be required to attend at least one half of the meetings held each year; any member failing that requirement will continue to be a member only at the discretion of the Chairman of the Audit Committee.

3.5 The Audit Committee meetings will also be attended by:

- The Director of Operational Finance or in their absence the Chief Financial Officer
- External Audit
- Internal Audit
- Local Counter Fraud Specialists
- The Head of Governance
- The Chief Operating Officer

4. A Quorum

4.1 A quorum shall be two members.

5. Procedures

5.1 The Director of Operational Finance (or deputy) and appropriate internal and external audit representatives shall normally attend meetings. Additionally, at least once a year the Audit Committee will meet privately with the external and internal auditors to learn whether they have encountered any resistance to the proper discharge of their duties or become aware of any conduct capable of bringing the Trust into disrepute. Such meetings will be minuted and will be the subject, at least initially, of an oral report to the Chief Executive and Chairman of the Trust.

5.2 The Chairman of the Trust will be invited to attend for discussion of the Annual Report and published financial statements and may attend at other committee meetings as appropriate to discharge the duties of a Trust Chairman.

5.3 The Chief Executive and other Executive Directors may attend when the Audit Committee is discussing areas of risk or operation that are the responsibility of that Director. The Chief Executive will be invited to attend discussions involving the Trust's Annual Governance Statement.

5.4 The Audit Committee shall appoint a secretary to convene meetings, prepare agendas, attend to take minutes, advise the Audit Committee on pertinent areas and, generally, provide support to the Chairman and Committee members as required for the proper discharge of their obligations.

5.5 Any member of staff may raise an issue with the Chairman of the Audit Committee, normally by written submission. The Chairman will decide whether or not the issue shall be included in the Committee's business and whether the individual raising the matter will be invited to attend.

6. Frequency of Meetings

6.1 Meetings shall be held not less than four times a year. Further meetings may be requested by the Chairman of the Audit Committee, the Trust Chairman, any other Director, the external auditor and the Head of Internal Audit.

7. Duties and Responsibilities

Governance, risk management and internal control

7.1 The Audit Committee shall review the establishment and maintenance of an effective system of integrated governance across the whole of the Trust's activities (both financial and non-financial), that supports the achievement of the Trust's objectives.

7.2 In particular, the Audit Committee will review:

- all risk and control related disclosure statements together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the board

- the assurance processes that underpin the achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

- the policies and procedures for all work related to fraud and corruption as set out in NHS England Standard Contract and as required by NHS Counter Fraud Authority.

- The Annual ISA260 report and Letter of Representation produced by External Audit in relation to the Annual Report, Quality Report and Accounts.

7.3 In carrying out this work the Audit Committee will primarily utilise the work of internal audit, local counter fraud specialists, external audit and other assurance functions, but will not be limited to these functions. It will also seek reports and assurances from the Governance Committee, Directors and Managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

Internal Audit

7.4 The Audit Committee shall ensure that there is an effective internal audit function, including the Counter Fraud function, established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
- review and approval of the annual internal audit plan, ensuring that this is consistent with the audit needs of the Trust as identified in the assurance framework

- consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise audit resources
- consideration of the annual Head of Internal Audit's Opinion
- follow up by the Governance Committee, or one of its sub-committees, where internal audit's work is an area covered by that committee, as set out in internal audit's plan
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the Trust, and
- an annual review of the effectiveness of internal audit.

External Audit

7.5 The Audit Committee shall:

- review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements
- keep under review the level of non-audit services provided by the external auditor, taking into account relevant guidance
- make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the external auditor and
- approve the remuneration and terms of engagement of the external auditor.

7.6 Further, the Audit Committee shall review the work and findings of the external auditor and consider the implications of and management's responses to their work. This will be achieved by:

- discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in their annual plan
- discussion with the external auditors of their evaluation of audit risks and associated impact on the audit fee, and
- reviewing all external audit reports, including their report on the Quality Report and agreement of the annual audit letter, before submission to the board, together with the appropriateness of management responses.

Other Functions

7.7 The Audit Committee will consider the work of other committees within the Trust, the work of which can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Governance Committee because of its management of the Trust's Corporate Risk Register and the Clinical Audit function.

7.8 The Audit Committee will also:

- review material changes to standing orders and standing financial instructions and schemes of delegation and
- receive a report from management on the review of data quality included in the Quality Report.

Financial Reporting

7.9 The Audit Committee shall review and, if thought appropriate, recommend to the Board approval of the annual report and financial statements, focusing particularly on:

- specific enquiry into the question of whether the Trust keeps proper books of account
- the integrity of the financial statements
- the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- changes in, and compliance with, accounting policies and practices
- unadjusted mis-statements in the financial statements
- major judgemental areas, and
- significant adjustments resulting from the audit
- The Annual ISA260 report and Letter of Representation produced by External Audit in relation to the Annual Report, Quality Report and Accounts.

7.10 The Audit Committee shall review and provide assurance on behalf of the Board to the Department of Health around the costing process and methodology as required by the Reference cost guidance.

Board of Directors Reporting Arrangements

7.11 The Chair of Audit Committee will provide a report highlighting the key issues arising from the Audit Committee to the meeting of the Board that directly follows the Audit Committee. The minutes of the Audit Committee will also be available to the Board.

7.12 The Annual Governance Statement, which is included in the Annual Report, reviews in considerable detail the effectiveness of the system of internal control. By concurring with this statement and recommending its adoption to the Board, the Audit Committee also gives the Board its assurance on the effectiveness of the overarching systems of integrated governance, risk management and internal control.

8. Review

8.1 Annually, the Audit Committee will assess the processes it has put in place to discharge its duties as outlined in these terms of reference and will implement changes if required.

8.2 The Audit Committee, supported by the Internal Auditors, will undertake an annual review of its performance against its work plan in order to evaluate the achievement of its duties.

8.3 The Board will review the Terms of Reference of the Audit Committee every three years to ensure that it remains fit for purpose and is best facilitated to discharge its duties.

Royal Devon and Exeter
NHS Foundation Trust

Board Performance Update
RTT & Diagnostics

Pete Adey – Chief Operating Officer

Phil Luke – Deputy Chief Operating Officer

This Presentation

- Previous Board updates
  - Where were we?
  - What did we say we would do?

- Analysis of performance
  - Where are we now?
  - What's happened with demand?
  - Did we do what we said we would?

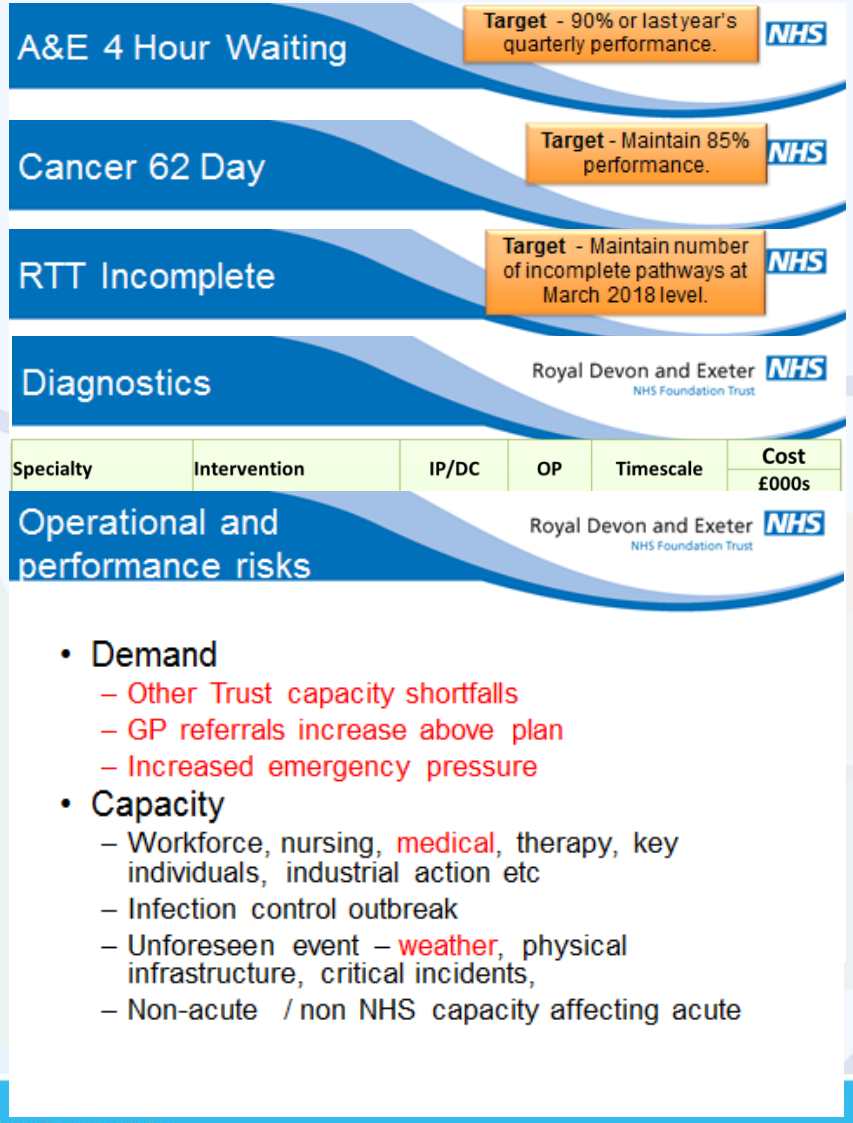
- Plan to improve performance
  - What are we doing?
  - What could we do?
  - Revised trajectories & risks

February RTT Board update
- 18/19 RTT strategic planning intentions

1. **Clear the backlog within Cardiology** and provide resilient capacity to meet future demand.
2. **Meet the recurrent demand for Orthopaedics** to prevent increase of the waiting list.
3. Reduce the orthopaedic waiting list size utilising **additional national funding as it is released**.
4. **Work with local commissioners** to optimise pathways to manage demand.
5. **Work with other providers** to optimise use of resources across the STP.

April Board Update

- ED trajectory
- Cancer trajectory
- RTT
- Diagnostics
- Investment in RTT
- Risks – Demand, workforce, weather



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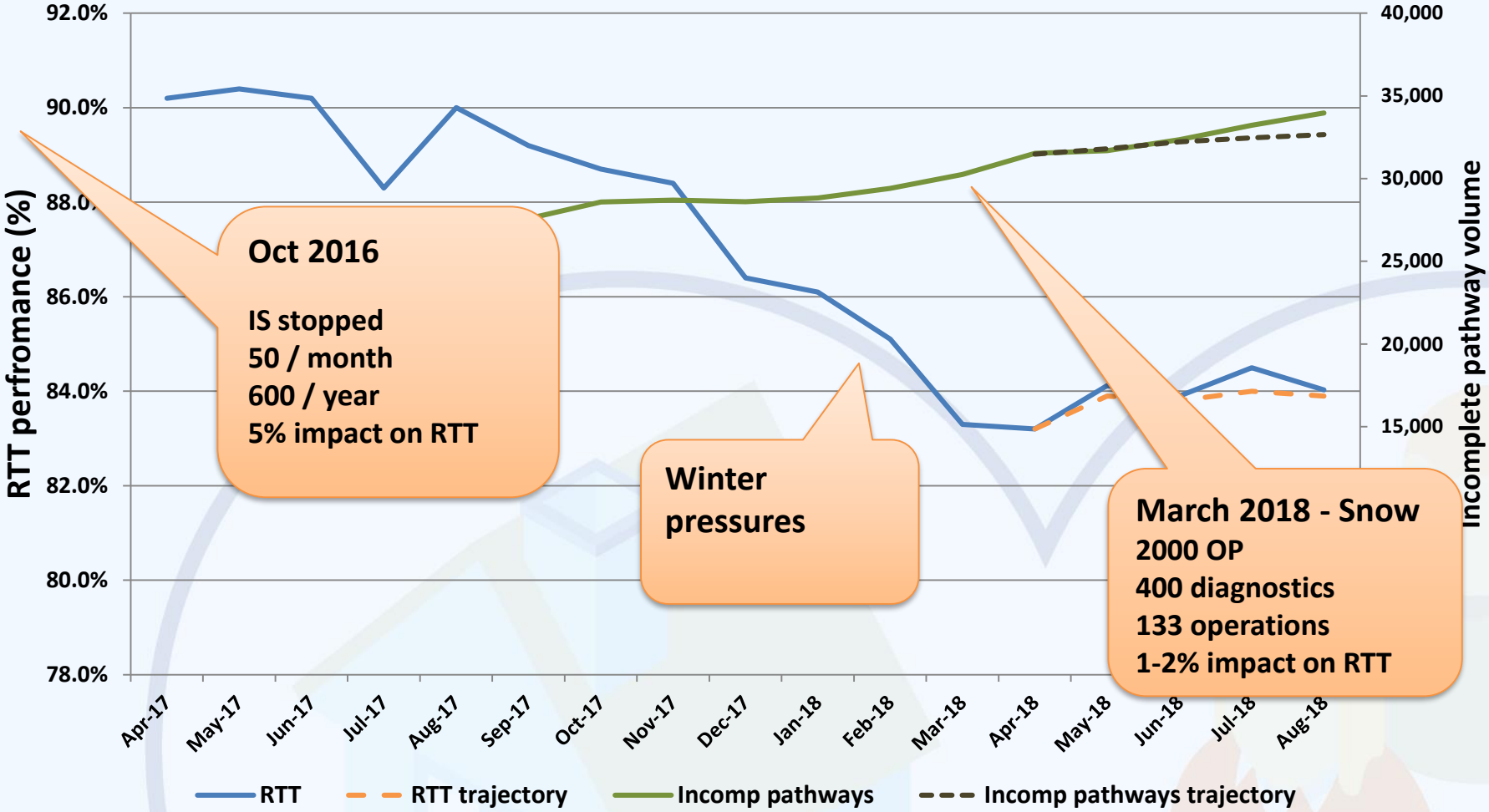
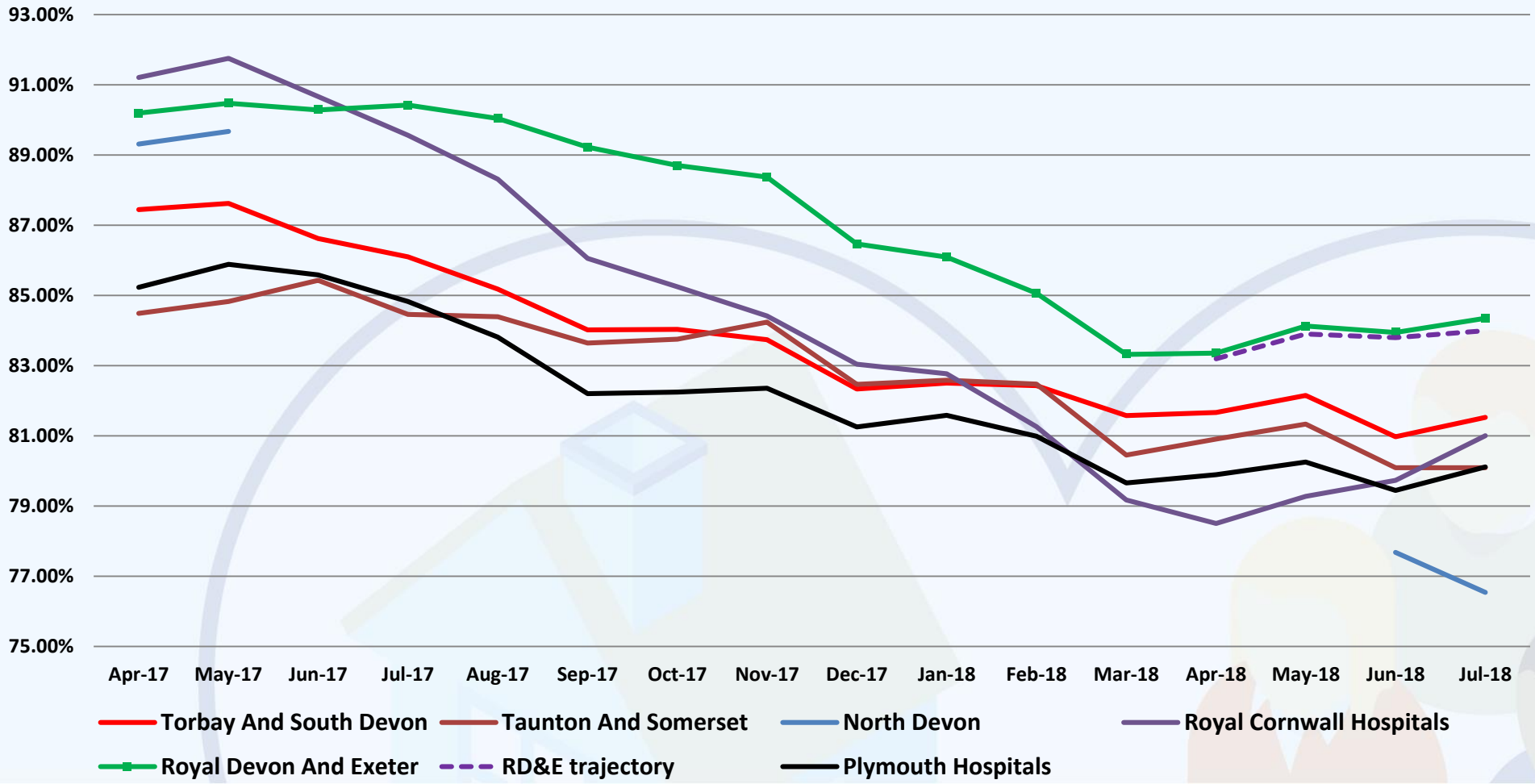
Performance analysis

Current RTT and Incomplete pathway performance: Apr 2017 - Aug 2018

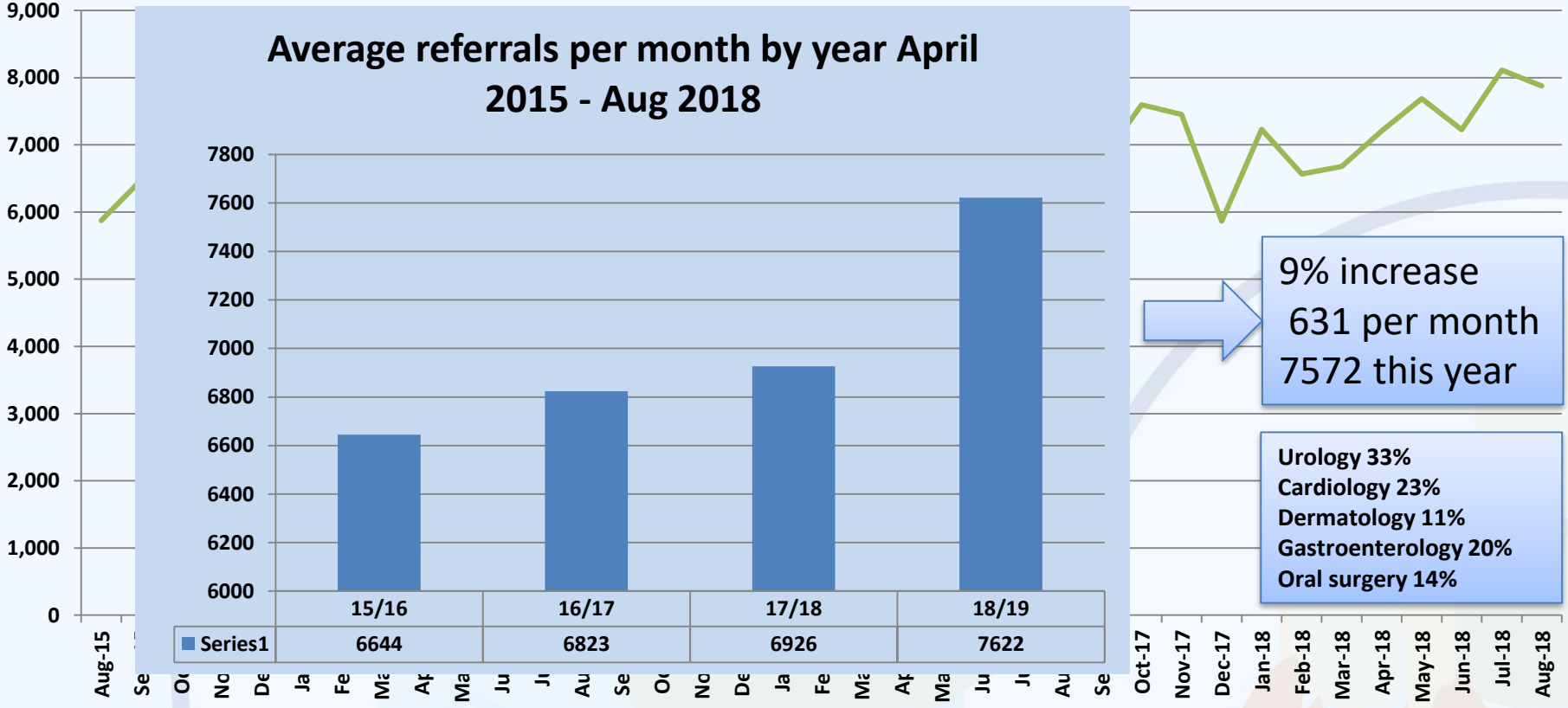


Current RTT Performance –SW Peninsular
April 2017 – Aug 2018

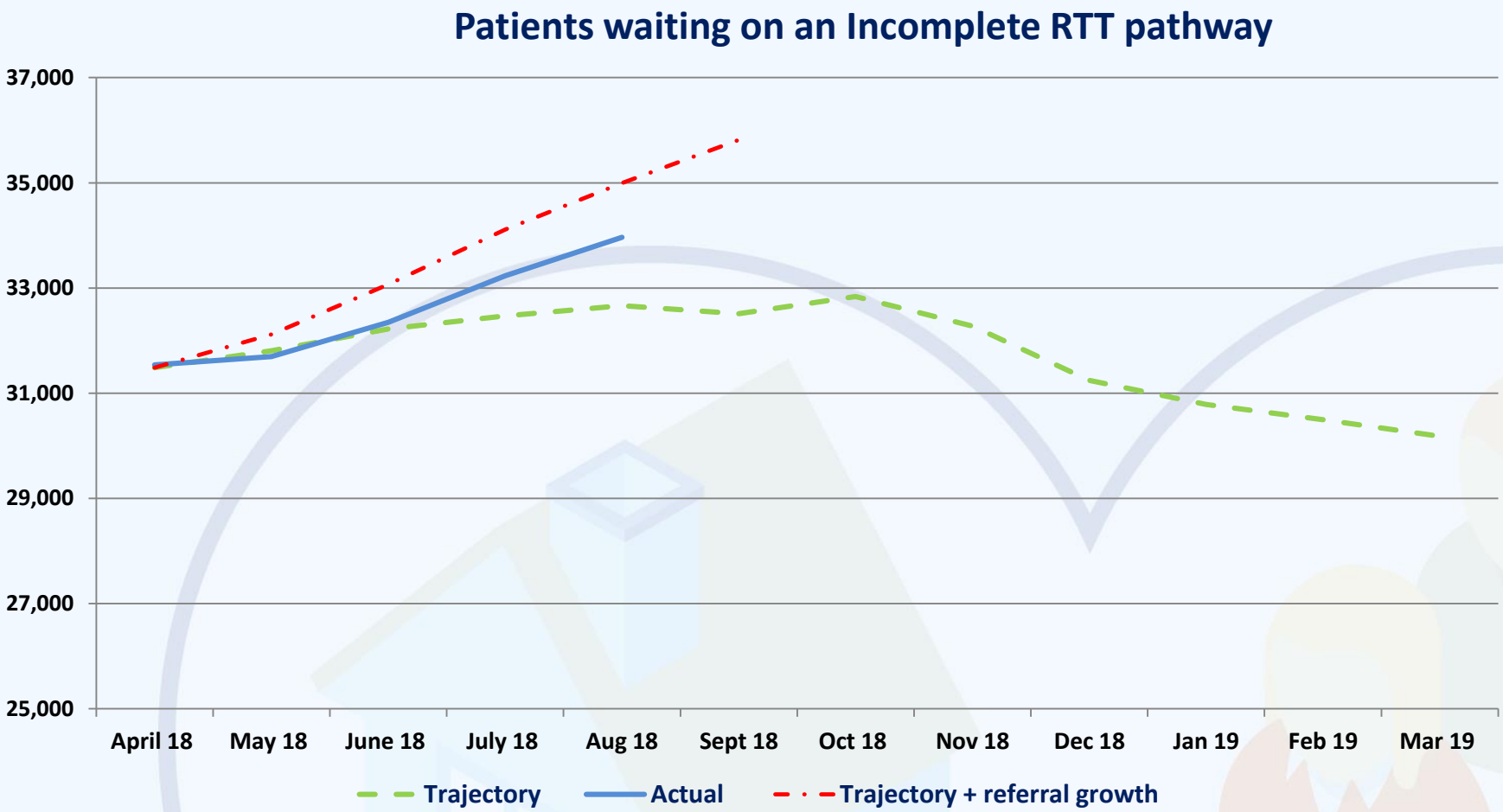


Referrals

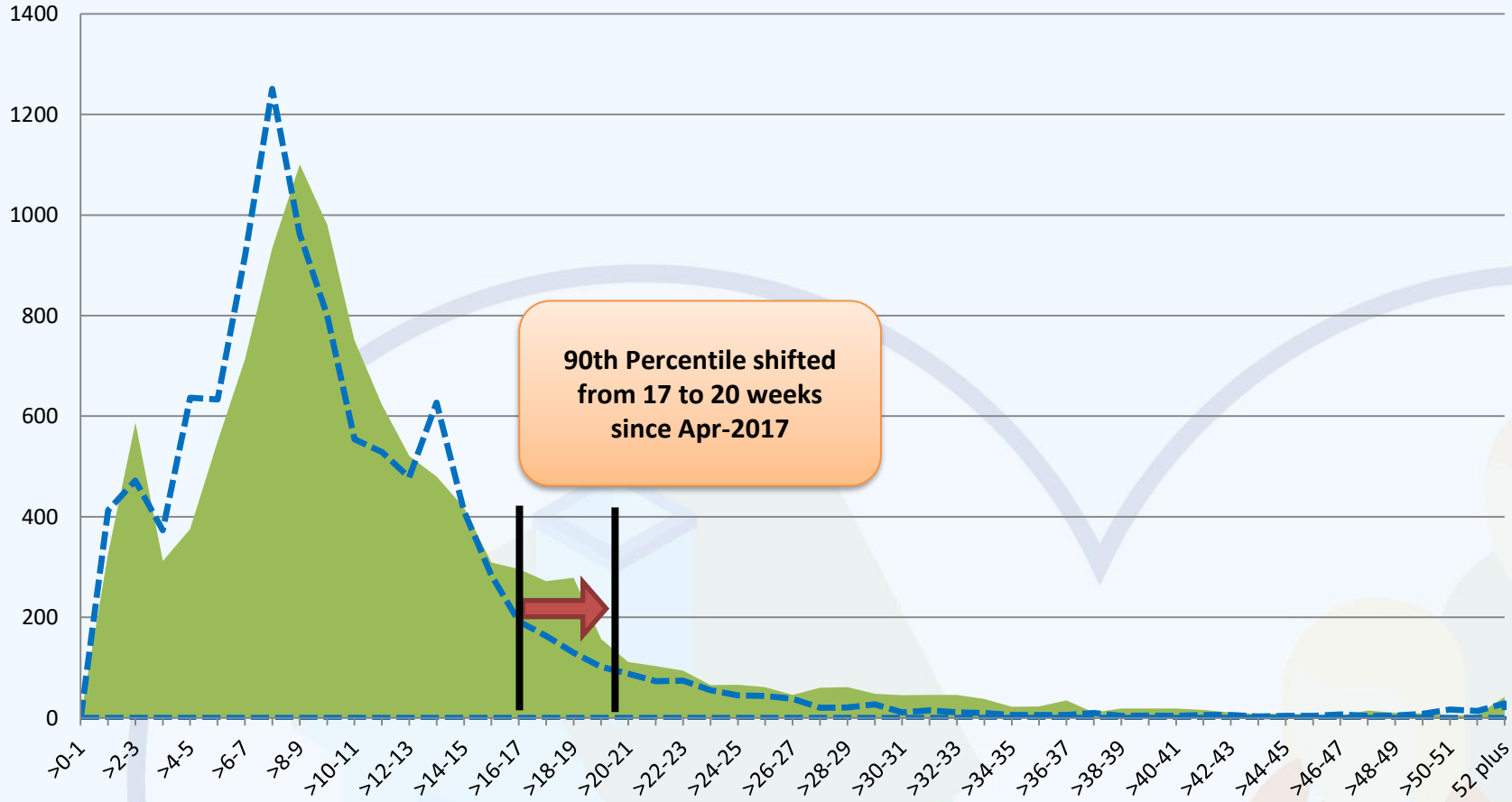
Trust GP & dental referrals
Aug 2015 – Aug 2018



Incomplete pathways



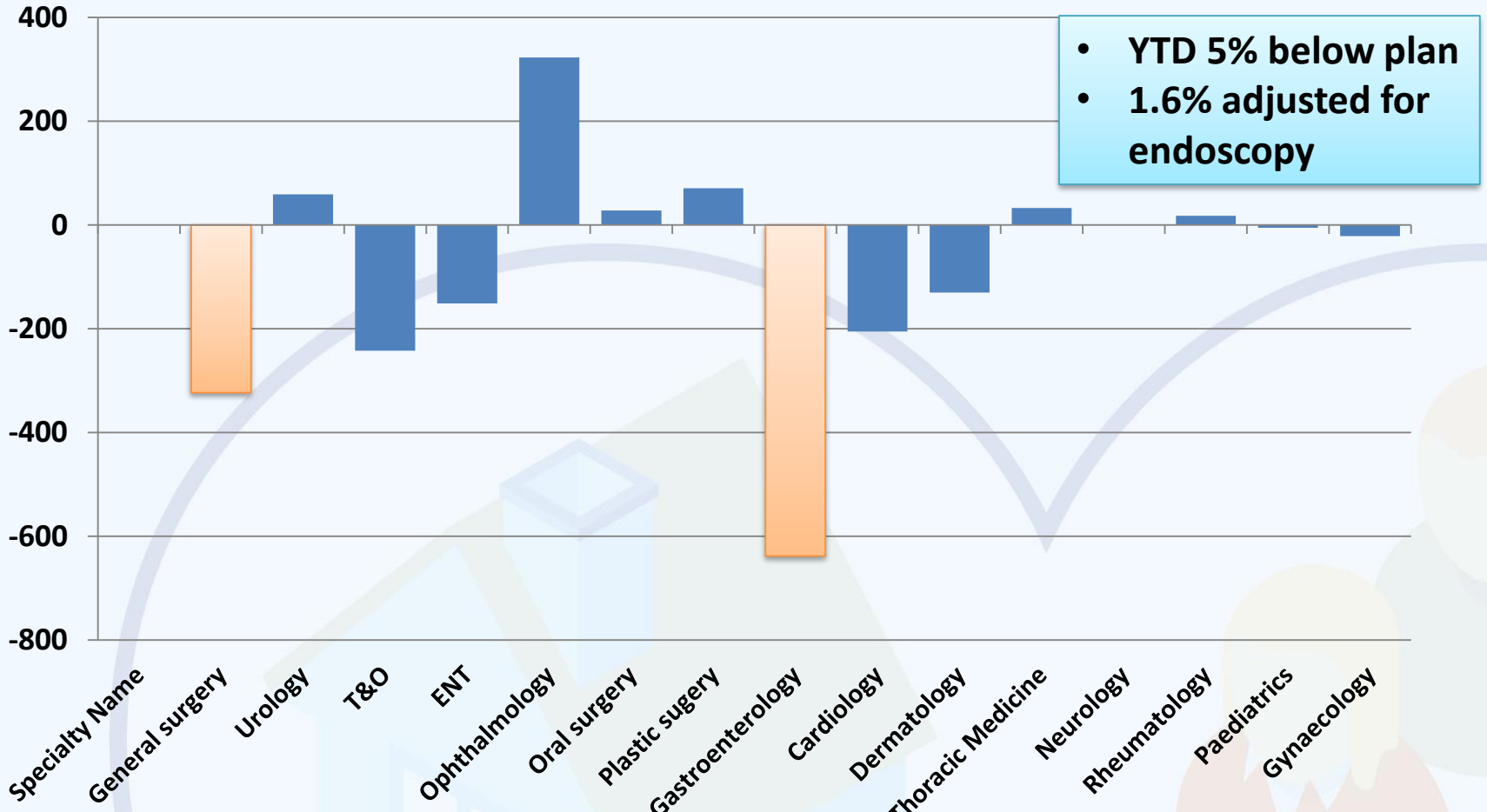
Outpatient waits Apr-2017 to Aug 2018



Delivery update

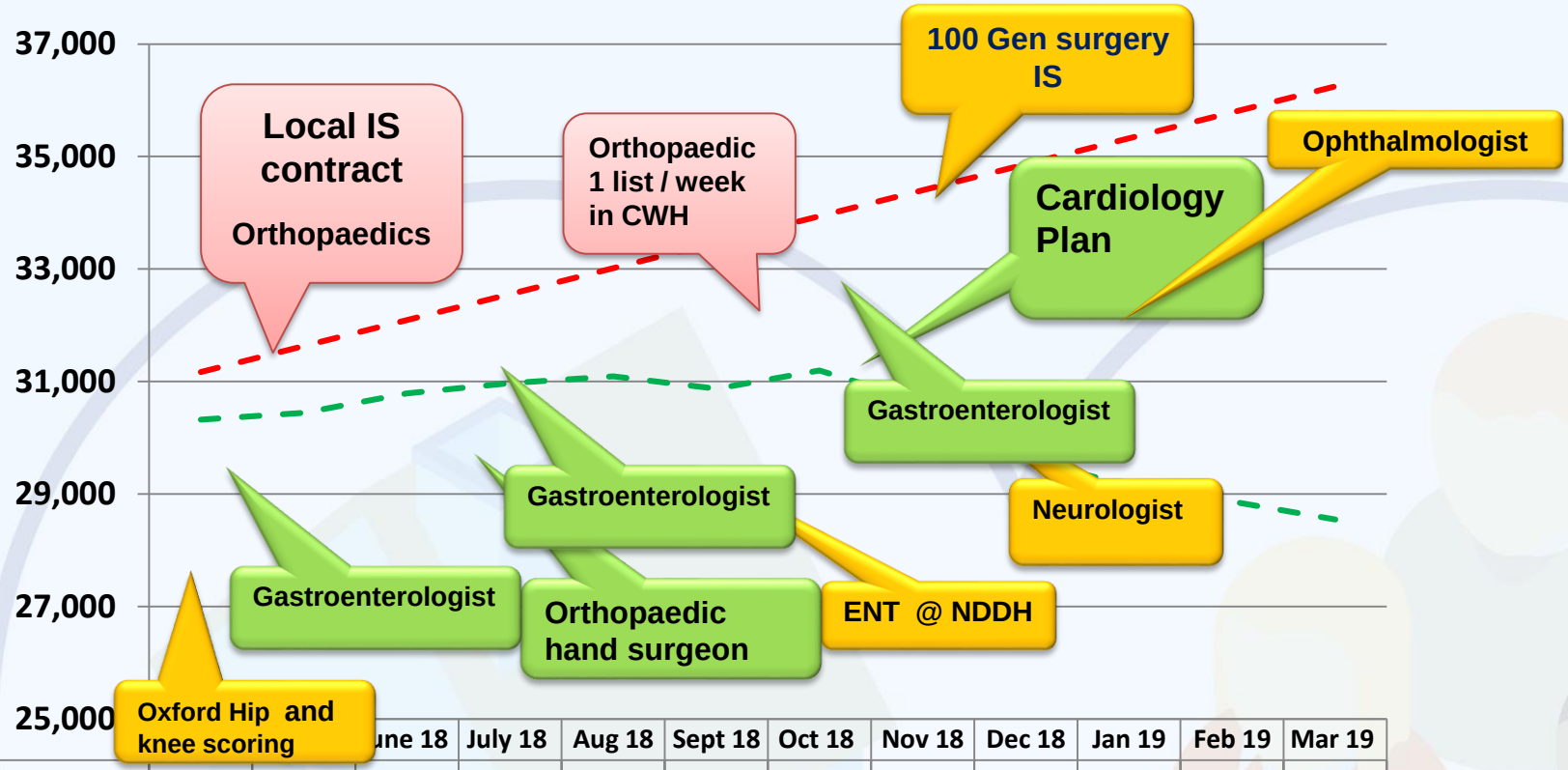
- Are we delivering our contracted activity?
- Are we delivering the Improvement plan?
- Other actions to improve performance?
- Where are we with diagnostics?
- Recovery plans
- Recovery trajectories

Activity v plan



Delivery of improvement actions

Patients waiting on an Incomplete RTT pathway

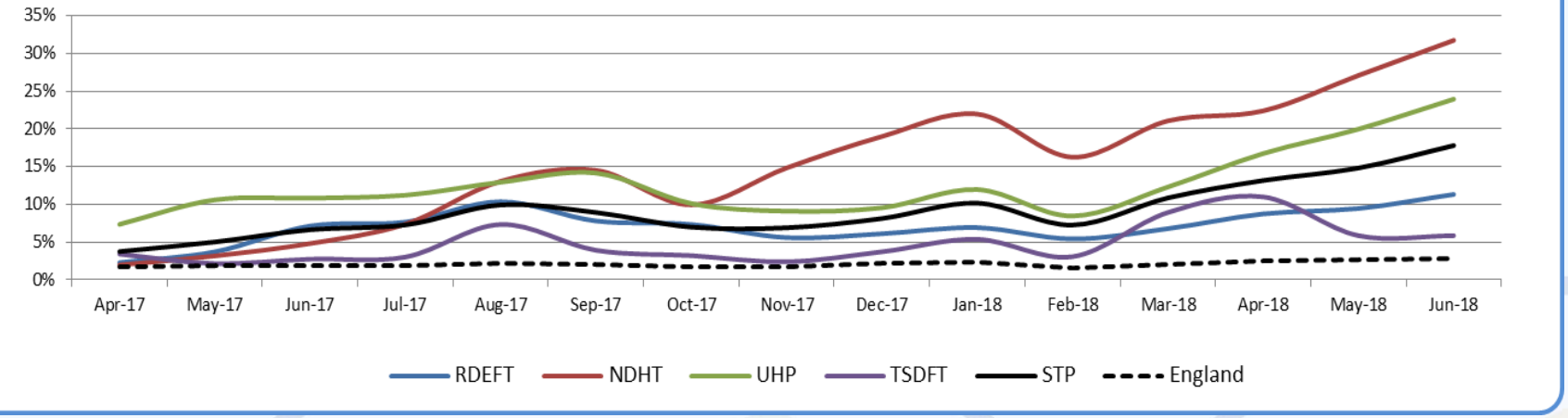


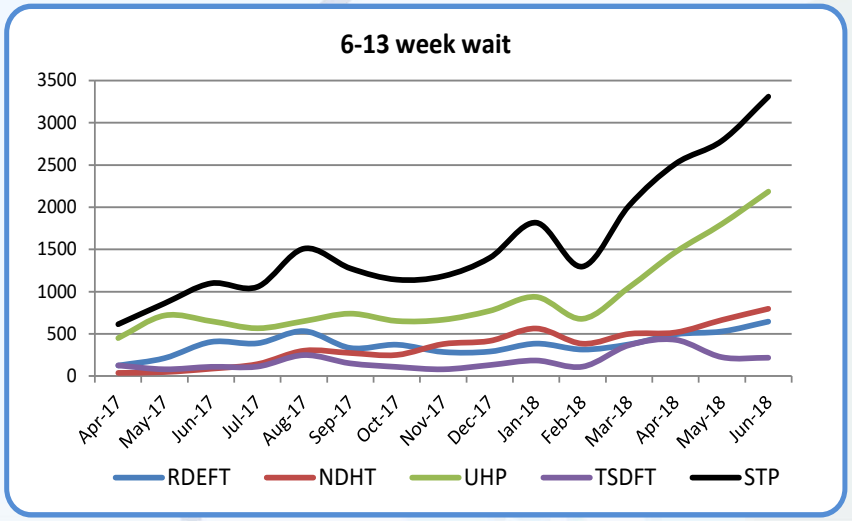
	June 18	July 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Current trajectory	31167	31629	32091	32553	33015	33476	33938	34400	34862	35324	35785	36247
Adjusted for plans	30319	30444	30787	30968	31089	30869	31198	30636	29604	29148	28863	28548

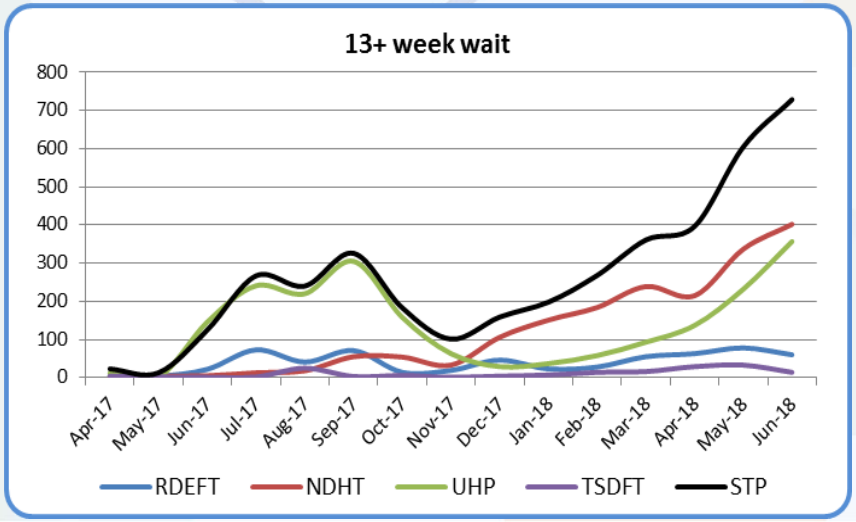
Other improvement actions

- Commissioner meetings – demand management & IS utilisation
- COO commissioned external review
- Redirected RTT funding to achievable actions
  - £300K MRI
  - £300K Endoscopy
  - £200K OP activity once consultants start
  - £50K admin backlogs
- Information Manager full time diagnostics 4 months
- Weekly and daily meetings in key specialties
- Additional management support in Cardiology

Diagnostics

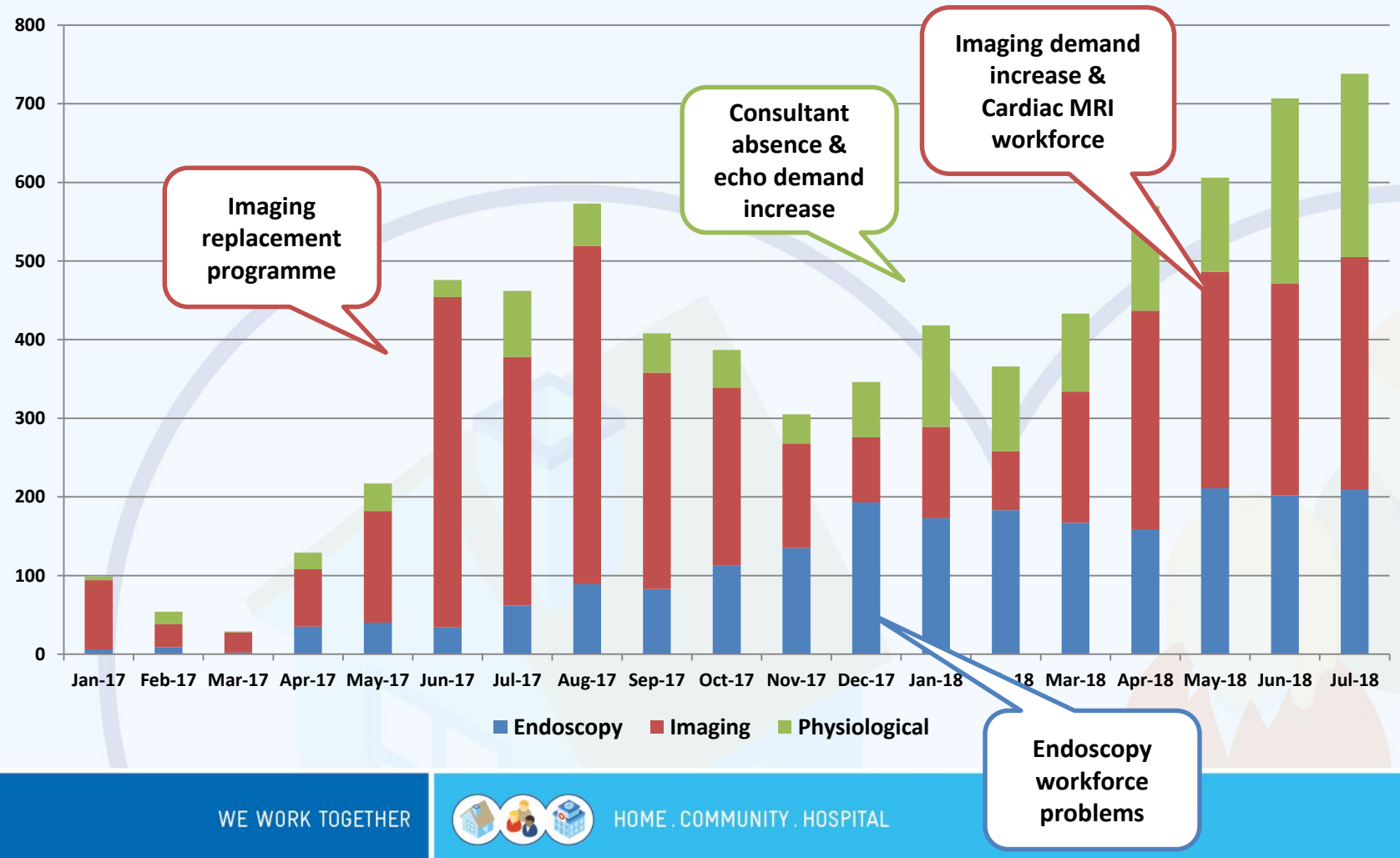






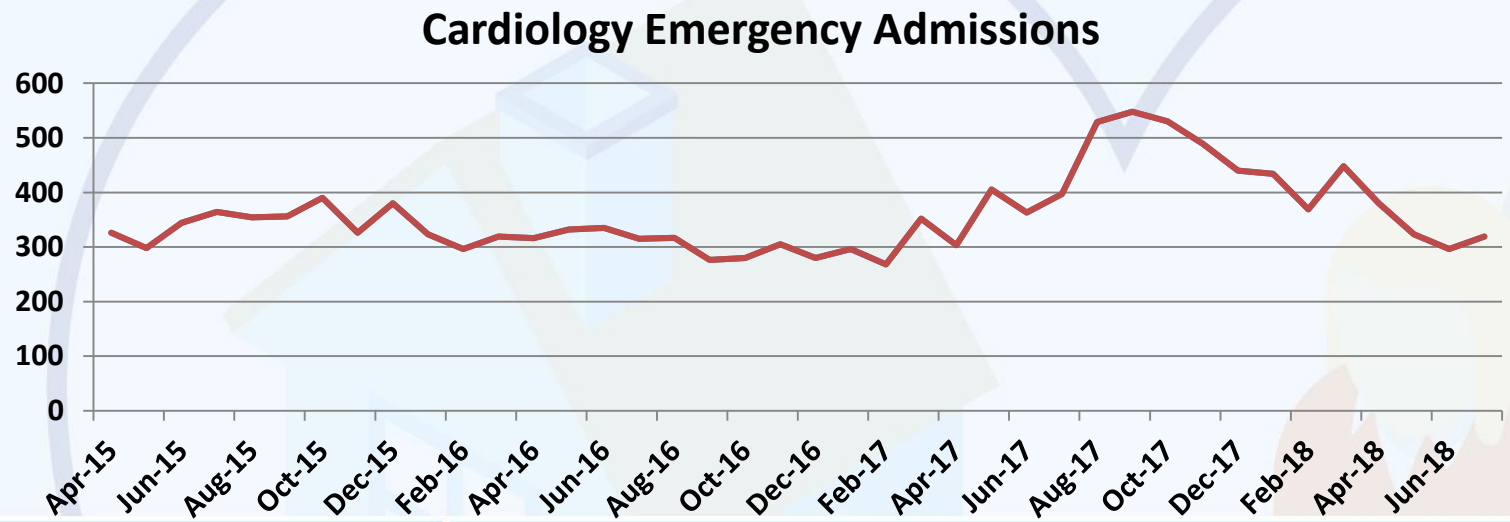
RD&E Diagnostics

Diagnostic Volume of 6+ Week Waits



Other factors affecting RTT performance

- IS Capacity
- Emergency demand
- Diagnostics reporting times
- PAS & data connectivity
- Admin & training



Elective care recovery governance

Trust Board

SDG

Operations Board

RTT & Diagnostics Recovery Programme Board

Monthly Performance Assurance Framework

Weekly specialty PTLs & Comms cells

Demand Management

- Ortho triage
- Urology triage
- Stopping procedures
- OOA work
- Pre OP choice
- GP information

Outpatients

- Workforce
- Facilities
- Booking rules
- Job plans
- Productivity

Diagnostics

- Workforce
- Facilities
- Demand management
- Reporting
- IS capacity

Elective activity

- Workforce
- Facilities
- IS capacity
- Productivity
- Job plans

Data, Admin Training

- My Care prep -Deconstruction
- Core data & metrics
- Validation
- Training of team
- National codes

RTT Recovery – Trust-wide actions

Plans being implemented

- Theatre productivity programme – (4-Eyes)
- OP productivity programme
- Pre My Care data deconstruction & validation

The Trust could also do

- Additional independent sector activity
- Additional theatres (approx. 1000 cases / year per theatre)
- Orthopaedic treatment centre

RTT Recovery - Surgery

Plans being implemented

- Consultant workforce, Gen surg, Rheumatology, Orthopaedics, ENT, Ophthalmology
- Orthopaedic theatre productivity
- Insourced surgical activity

The Trust could also do

- Greater use of IS
- Over-recruit to Urology & Gen surgery consultants
- Urology STP diagnostic & treatment centre

Areas of concern

- National workforce shortages
- Urology – scale of growth
- Orthopaedics – theatre capacity

RTT Recovery - Medicine

Plans being implemented

- Cardiology plan (£2m recurrent investment)
- Dermatology expansion (£700K recurrent investment)
- Additional consultants, Neurology, Respiratory, Gastroenterology,

The Trust could also do

- STP / SEND - Service delivery networks, (Neurology, Neurophysiology, Respiratory, Dermatology)

Areas of concern

- Dermatology – growth & national workforce shortage

RTT Recovery - Diagnostics

The Trust is doing

- Endoscopy workforce & insourcing
- Mobile MRI capacity
- 2 echo machines & technicians
- Additional ultrasound capacity
- Investigate reporting radiographers

The Trust could also

- Purchase mobile unit with STP
- Additional MRI scanner
- Consider AI reporting
- Expand Endoscopy (future proofing)

Areas of concern

- RD&E facilities high utilisation with continued growth
- Histopathology & radiology national shortage

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Improvement Trajectories

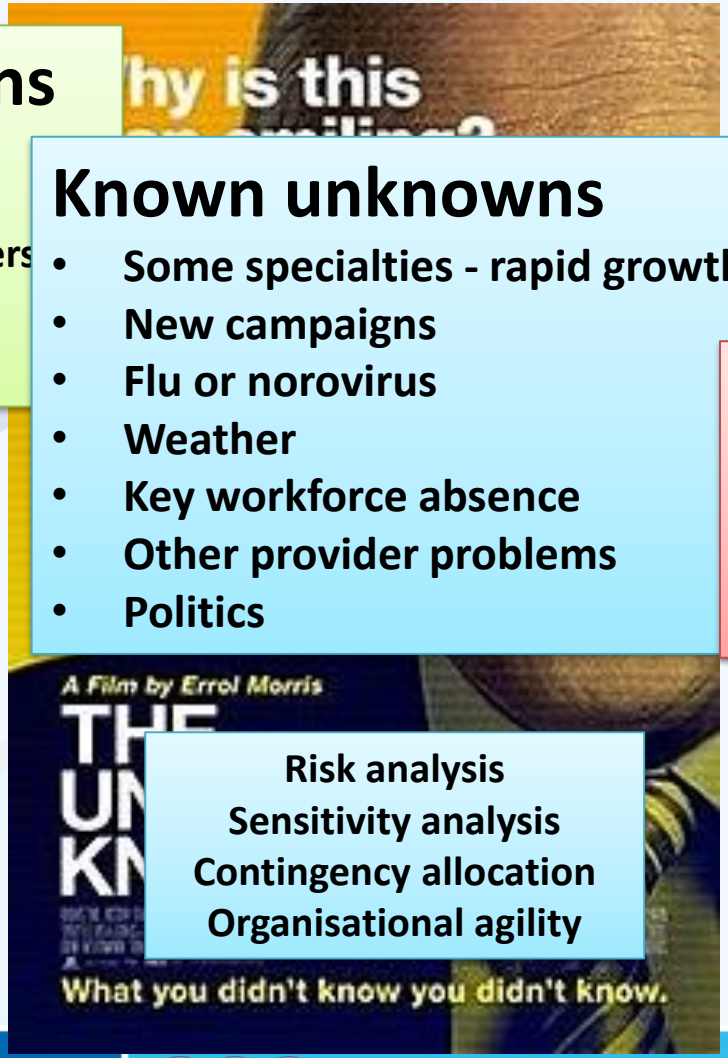
Shooting at a moving target

Known knowns, known unknowns, unknown unknowns

Known knowns

- Past referrals
- Past activity
- Impact of past winters
- Future agreed upon initiatives

Good planning
Good data
Good engagement



Known unknowns

- Some specialties - rapid growth
- New campaigns
- Flu or norovirus
- Weather
- Key workforce absence
- Other provider problems
- Politics

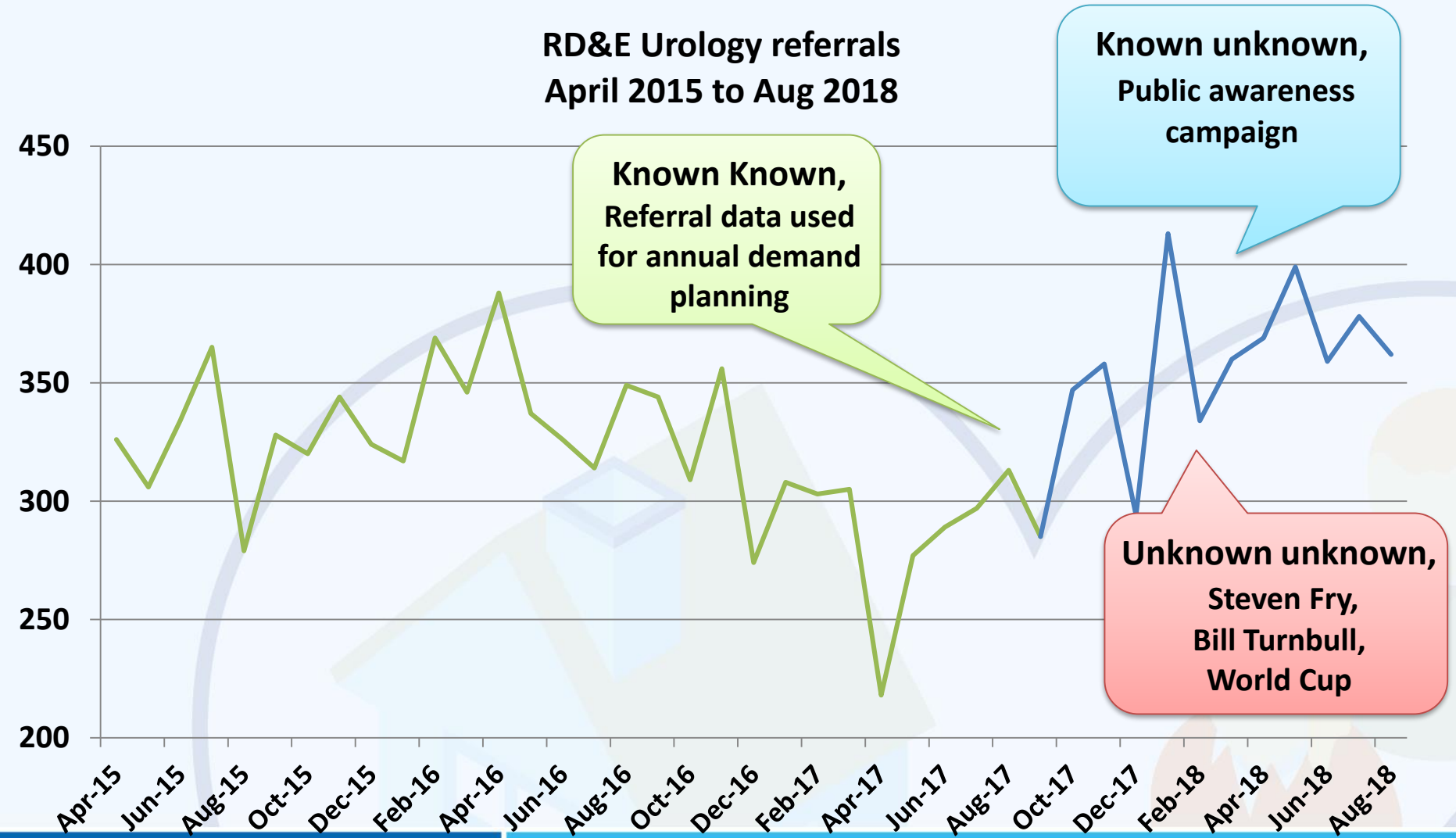
Risk analysis
Sensitivity analysis
Contingency allocation
Organisational agility

Unknown unknowns

Angelina Jolie effect
Technological changes

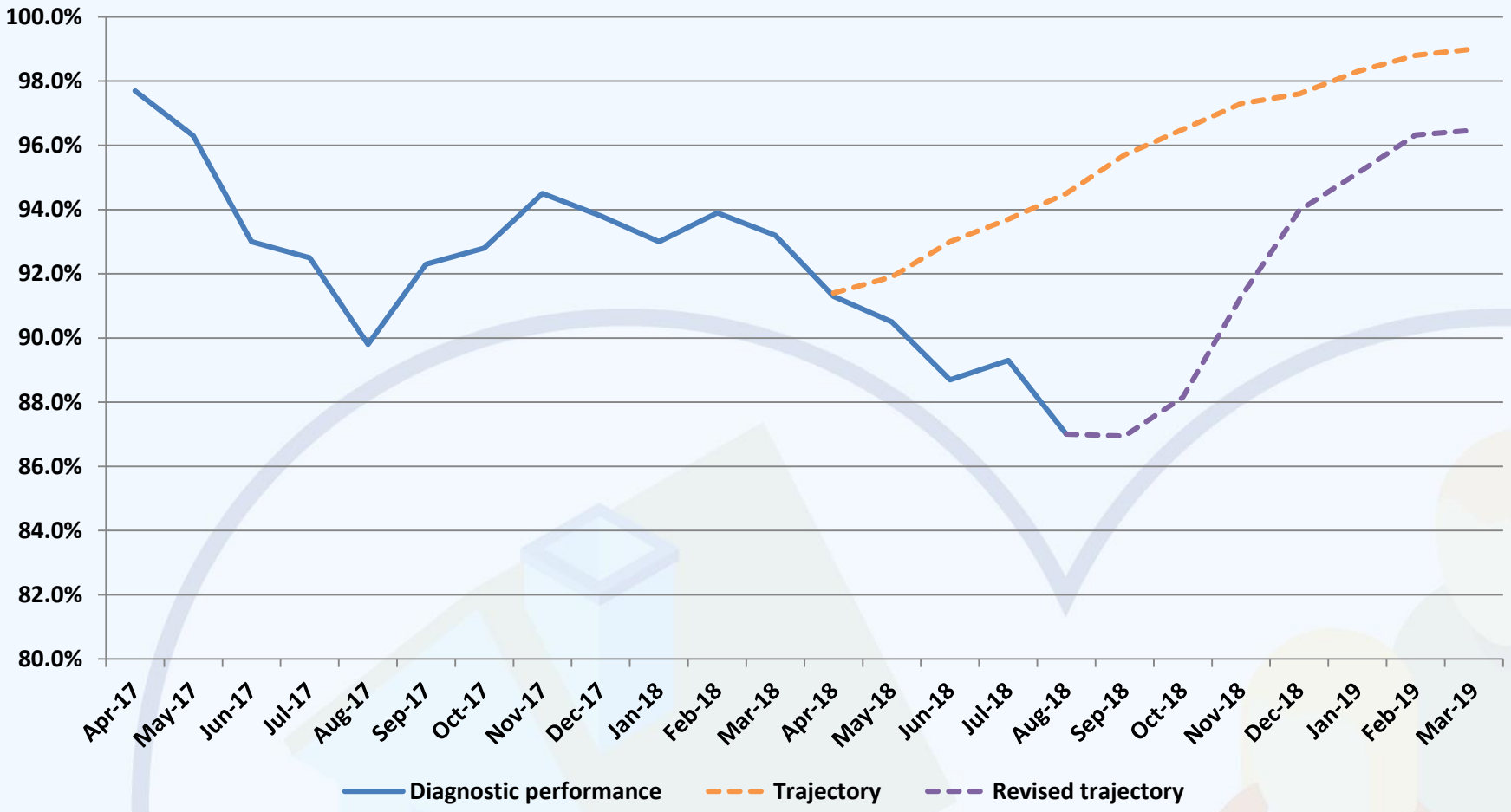
Horizon scanning
Organisation agility
Leadership

Urology example

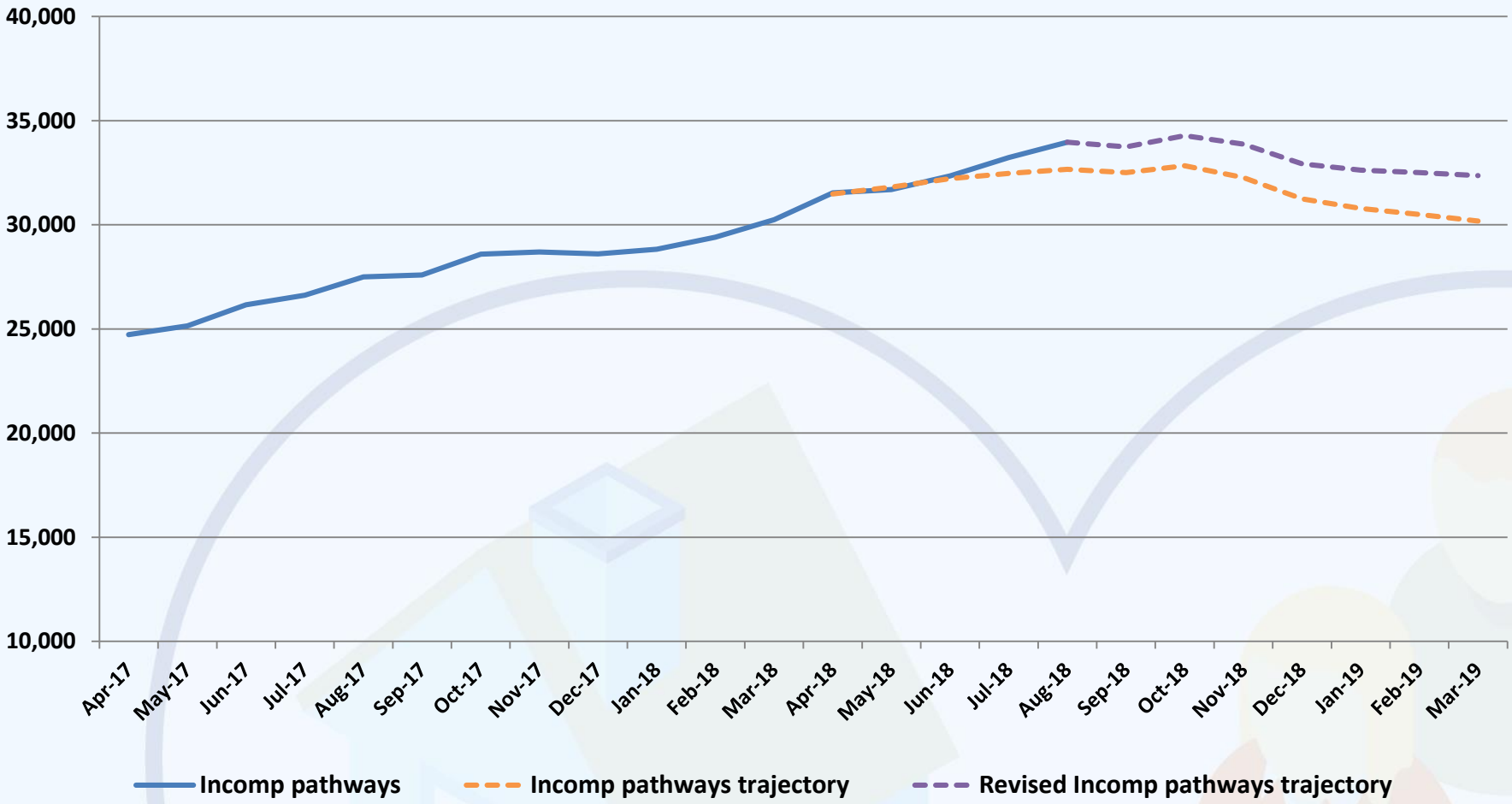


So … based on what we know

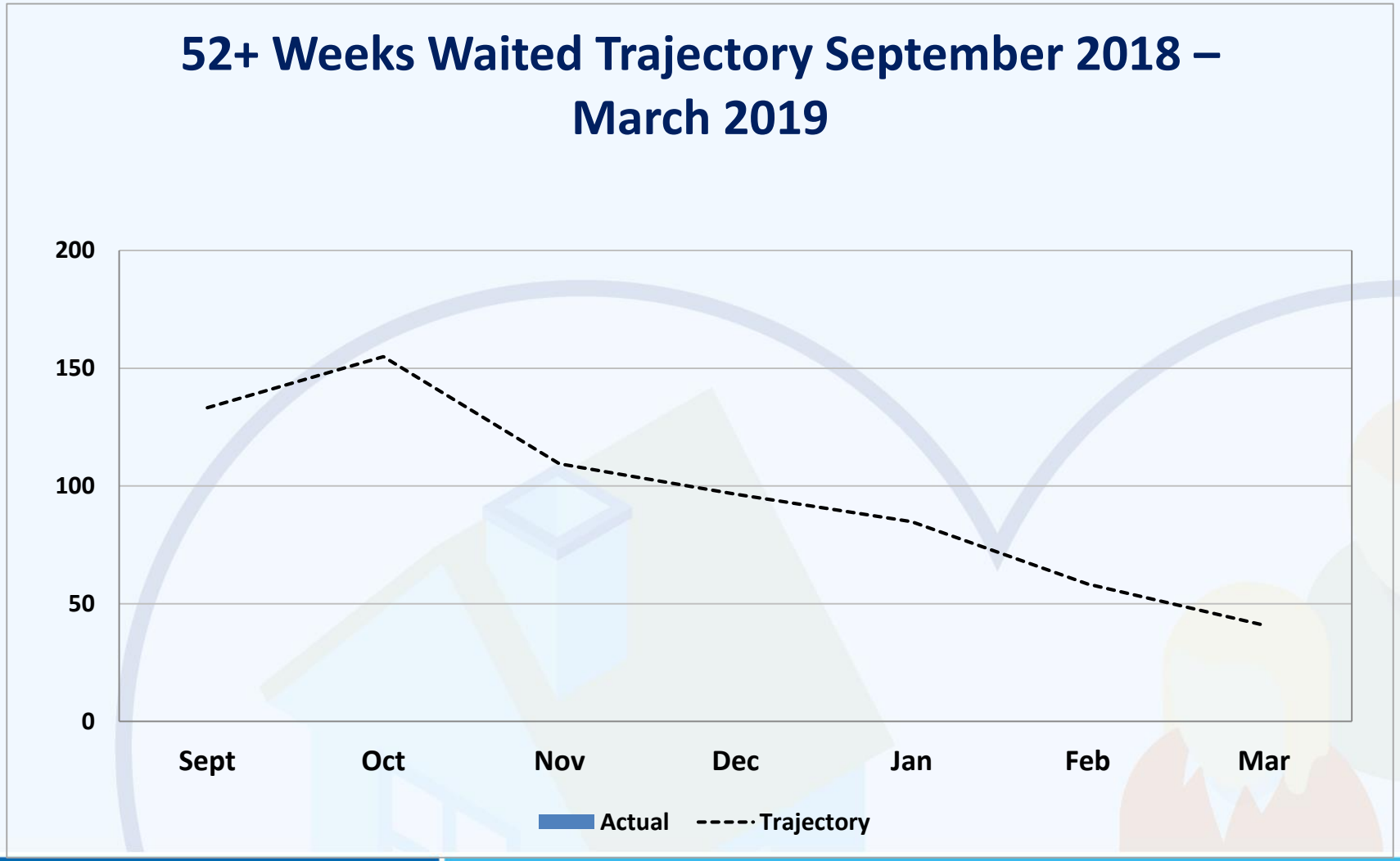
Diagnostics performance vs trajectory



RTT incomplete pathways vs trajectory



Long waiting patients



In Summary

- Delivery is challenging across the STP
- Significant demand rises
- £6m investment in operational delivery
- PAS limitations - pre My Care data deconstruction
- Revised trajectories based what we know
- Not able to provide assurance for all specialties due to external factors
- Robust approach & governance
- Opportunities for faster / more resilient recovery with long term investment & partnership working

Thank you for listening

Any questions?

NHS
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Agenda item:	10.3, Public Board Meeting		**Date:** 26th September 2018	
Title:	Responding to and Learning from Deaths, Quarterly Report 2018/19 – Q1 and general synopsis of the relationships between programmes of work underway by NHS England and the Department of Health to scrutinise and learn from deaths of patients.			
Prepared by:	Lisa Richards – Trust Risk Manager Tom Martin – Trust Mortality Lead and Consultant Anaesthetist James Hobbs – Executive Support Manager Mark Rogers, Safety and Risk Systems Manager			
Presented by:	Professor Adrian Harris, Executive Medical Director			
Responsible Executive:	Professor Adrian Harris, Executive Medical Director			
Summary:	In March 2017 the National Quality Board (NQB) published National Guidance on Learning from Deaths. This includes specific guidance for the responsibility of Trust Boards and the requirement to collect and publish on quarterly basis specified information on deaths and learning points, which is undertaken through a paper and an agenda item to the public Board meeting.			
Actions required:	It is proposed that the Trust Board of Directors note the Responding to and Learning from Deaths, Quarterly Report 2018/19 – Q1.			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
				X
History:	The Board of Directors received their initial Responding to and Learning from Deaths Quarterly Report in January 2018. This included ratification, by the Board of Directors, of the Responding to and Learning from Deaths Policy and approval of the Responding to and Learning from Deaths Draft Dashboard. A second report followed in May 2018 detailing Q4 and an annual review of 2017/18 of Responding and Learning from Deaths.			
Link to strategy/ Assurance framework:	The issues discussed are key to the Trust achieving its strategic objectives including meeting the requirements of the NQB guidance – Learning from Deaths (March 2017).			

Monitoring Information

Please *specify* CQC standard numbers and tick ✓other boxes as appropriate

Care Quality Commission Standards	Outcomes		
NHS Improvement		Finance	
Service Development Strategy		Performance Management	
Local Delivery Plan		Business Planning	
Assurance Framework		Complaints	
Equality, diversity, human rights implications assessed			
Other *(please specify)*			

1. Purpose of paper

To provide the Board of Directors with;

- A broad overview of the relationships between the "Coroners and Justice Act 2009" which requires the implementation of the Medical Examiner role by April 2019, the requirements set out in the National Quality Board (NQB) guidance, Learning from Deaths, published in March 2017 and the on-going monitoring of the Trust's key mortality indicators, the national Hospital Standardised Mortality Rate (HSMR) and the Trust Summary Hospital-level Mortality Indicator (SHMI).
- An overview of progress in relation to the implementation of the Trust's Responding to and Learning from Deaths agenda.
- The quarter one (Q1) volume of deaths and the number of deaths subjected to either case record review using the Structured Judgement Review methodology or Serious Incident investigation for this timeframe.
- A summary of the outcomes of those deaths subjected to review and what the key learning points have been.

While the volume of deaths is specifically reporting on Q1, as cases are reviewed in accordance with the NQB criteria much of the SJR activity will focus on cases across a broader timescale. Therefore there will be further reviews being undertaken currently and in future which relate to deaths that occurred in Q1.

Mortality is reported to the Board of Directors through both the Integrated Performance Report and through escalation as required via the Governance Committee structure. Therefore, although clearly linked, this paper focusses on the Learning from Deaths agenda.

2. Background

The Responding to and Learning from Deaths agenda is closely aligned to the Coroner Reforms and the implementation of the role of Medical Examiner, both borne out of the need for greater scrutiny of deaths. Initially highlighted by Harold Shipman's conviction in 2000, the Department of Health accepted the conclusion of the subsequent Shipman inquiry third report, published in June 2003 recommendations for change in how death is scrutinised . In addition since 2000 there has been over a 25% increase nationally in inquests to 32,542 in 2012. This trend has only continued, as the importance of healthcare scrutiny of deaths has become further emphasised by the inquiries into deaths and practices at Mid Staffordshire and Southern Health NHS Foundation Trusts which showed that improved reporting and investigations could have prevented many unnecessary deaths.

The Coroner Reforms embodied in law with the "Coroners and Justice Act 2009" set out a new system that cross references with the NQB Responding to and Learning from Deaths. Together they introduce independent safeguards and checks to highlight patterns, both through a review of relevant medical records and by making sure that the family has the chance to raise any concerns. This independent review makes identifying issues with care easier providing opportunities for the Trust to learn and address system failures earlier. It also enhances triangulation with other key indicators such as the HSMR and SHMI and other components already embedded in safety programmes such as Sepsis and Acute Kidney Injury (AKI).

This paper is a requirement of the National Quality Board (NQB) National Guidance on Learning from Deaths. This includes specific guidance for the responsibility of Trust Boards, as stated in previous reports specifically:

- Ensuring the Trust has robust and transparent systems for recognising, reporting and reviewing or investigating deaths where appropriate
- Ensuring the Trust learns from problems in healthcare identified by reviews or investigations as part of a wider process that links different sources of information to provide a comprehensive picture of their care

The Trust is required to collect and publish on quarterly basis specified information on deaths and key learning points, which is undertaken through a paper and an agenda item to a public Board meeting. This information should include the total number of the Trust's in-patient deaths and those deaths that the Trust has subjected to case record review. Of the deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

Learning in the context of this report is defined as: knowledge or skill gained through education, a relatively permanent or permanent change in, or acquisition of, knowledge, understanding, or behaviour.

3. Assessment

Volumes of deaths and those subjected to case record review or investigation.
Deaths that occurred in Q1 are detailed in Appendix 1 within the Learning from Deaths Dashboard; as described previously as much of the SJR activity is initiated by the NQB criteria this means that there is a time lag between a death occurring and that death being reviewed, therefore within Appendix 1 a rolling, two quarterly and 12 month position is provided for comparison.

The Datix Mortality module is in the process of being implemented; once the transfer of existing information is complete SJR activity undertaken per quarter, will be much more visible.

Deaths of patients with a learning disability and those subjected to case record review / LeDeR review.
The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. It aims to guide improvements in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities faced by people with learning disabilities. A key part of the LeDeR Programme is to support local areas to review the deaths of people with learning disabilities. The programme is developing and rolling out a review process for the deaths of people with learning disabilities, helping to promote and implement the new review process, and providing support to local areas to take forward the lessons learned in the reviews in order to make improvements to service provision.

The Trust are currently in the early stages of working with the LeDeR programme and will provide further information regarding this in future Quarterly reports to the Board of Directors.

Outcomes of case record reviews
Each review addresses a possible total five phases of care as required;

- Admission / initial assessment
- On-going care
- During a procedure

- Perioperative
- End of Life
- *Overall Care*

Against each of these phases the reviewer makes explicit judgement comments on the phase/overall care reviewed which allows the reviewer to concisely describe and assess the safety and quality of care provided. Judgement comments are made on anything the reviewer thinks is pertinent to a particular case, including technical aspects of care such as management plans, whether care meets good practice and the interventions undertaken. More holistic aspects of care such as end-of-life decision making and involvement of families are also reviewed. Each phase of care is graded with a care rating/score of Excellent, Good, Adequate, Poor or Very Poor. Subsequently, the reviewer concludes with an overall rating of care as Excellent, Good, Adequate, Poor or Very Poor. Any cases identified with an overall rating of, Poor or Very Poor are subjected to a second SJR undertaken by a separate reviewer.

Overall care ratings for Q1 April 2018-June 2018 and for the rolling 12 month period July 2017 – June 2018 are also included in Appendix 1.

This shows that despite the large majority of the case reviews being undertaken in response to alerts and /or potential concerns with care, it is positive that there is a larger proportion of excellent and good overall care identified, as summarised in Table 1.

Table 1: Overall Care Rating

Overall Care Rating	Q1 April 2018-June 2018 (% / Volume)	Rolling 12 Month July 2017 – June 2018 (% / Volume)
Excellent Care	18% (9)	19.9% (31)
Good Care	44% (22)	44.2% (69)
Adequate Care	24% (12)	21.7% (34)
Poor Care	12% (6)	12.8% (20)
Very Poor Care	2% (1)	1.28% (2)

In Q1 there were a total of nine cases (18%) where care was deemed to be overall excellent a common feature apparent in these cases was in relation to the timeliness of a senior medical review and the delivery of a treatment management plan.

Problems identified with care

Whilst the explicit judgement comments and care scoring are the main two elements of the SJR, reviewers are subsequently asked to make an assessment of problems identified with care. The reviewer records whether one or more specific types of problems were found and, if so, identify if it is deemed this led to harm. These prescriptive problem types are as follows;

- Problem in assessment, investigation or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls).
- Problem with medication / IV fluids/ electrolytes/ oxygen (other than anaesthetic).
- Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE).
- Problem with infection management.
- Problem related to operative/ invasive procedure (other than infection control).
- Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes).

- Problem in resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR).
- Problem of any other type not fitting the categories above including communication and organisational issues.

In Q1 there were six cases (12% of those reviewed) where problems with care were identified, these are reflected in Table 2 by problem type and phase of care. As you can see, within these six cases there were multiple problems with care identified 15 in total.

While there is no overt pattern emerging with these cases, they initially centre around two phases of care, on-going care and end of life care. Work continues to establish if there are any emergent trends or themes across a wider timeframe of reviews and this is kept under continual review as the volume of SJRs undertaken increases.

In addition to second SJR review being triggered by overall care graded as poor or very poor, where harm is deemed to have occurred as a result of a problem in care a second review is also triggered. If the second review reaches the same conclusions as the first review, a formal investigation is commissioned. As yet this scenario has not materialised to trigger a formal investigation.

Table 2: Problems identified in care

Problem	**Phase of Care**					
	Admission / initial assessment	On-going care	During a Procedure	Perioperative	End of life	**Total**
Assessment	0	2	0	0	0	2
Medication / IV fluids / electrolytes / oxygen (other than anaesthetic)	0	2	0	0	2	4
Related to treatment / management plan	0	3	0	0	1	4
Infection Management	0	1	0	0	0	1
Related to Operation	0	1	0	0	0	1
Clinical Monitoring	0	2	0	0	0	2
Resuscitation	0	0	0	0	0	0
Any type not fitting	0	0	0	0	1	1
Total	0	11	0	0	4	15

The SJR Process

The now established SJR team continue to develop a peer support model required to facilitate open discussion/debate for the case record reviews, this will also further strengthen the formal and informal contacts between senior and junior medical staff and between specialty teams.

Looking forward

The systems and processes that surround mortality review continue to be rapidly evolving as part of a dynamic work programme within the Trust. As the review team

continue to work through case record reviews using the SJR methodology advocated by the NQB, the supporting local/specialty governance arrangements continue to emerge as a clinician led consensus which will therefore produce a more sustainable and robust system for Learning from Deaths.

Along with changes to the process of case selection for mortality review and coronial referral the implementation of the role of Medical Examiner is anticipated to compliment the openness and transparency of responding to and learning from deaths within the Trust with their work focussing on the relationship between bereaved families and the Trust.

Links to Mortality Indices

Whilst the Trust's current position against both the Standardised Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) remains in or near the above expected level, a significant level of assurance and reassurance is taken from the SJR and Learning from Deaths process in relation to the safety and quality of care being delivered, supporting the notion that the Trust mortality rates are being driven by a number of other factors and are not solely in relation to issues with excess deaths or care delivery issues. Both the outputs of the SJR process and trends and shifts in mortality indices are regularly monitored by the Patient Safety and Mortality group and are used to continually inform the ongoing work regarding both the Trust-wide Patient Safety Programme and the Mortality and Learning from Deaths work programme.

4. Resource/legal/financial/reputation implications

Compliance with the NQB recommendations regarding learning from deaths forms part of the Trust's regulatory requirements and as such, is monitored by NHS Improvement, and the Care Quality Commission.

5. Link to BAF/Key risks

N/A

6. Proposals

It is proposed that the Trust Board of Directors note the Responding to and Learning from Deaths, Quarterly Report 2018/19 – Q1.

Appendix 1

Appendix 1 - Responding to and Learning from Deaths - Dashboard

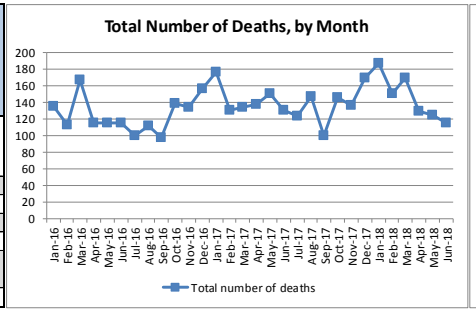
Royal Devon and Exeter NHS Foundation Trust

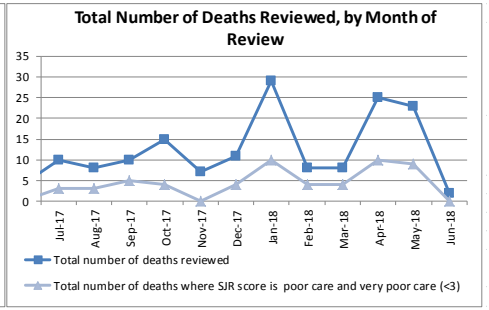
Description:
The dashboard is a tool to aid the systematic review of deaths and learning from care provided by NHS Trusts as required by the NQB "responding and learning from deaths".

Summary of total number of deaths and total number of cases reviewed under the Structured Judgment Review Methodology

Total Volume of Deaths and Total Volume of Deaths Reviewed (does not include patients with identified learning disabilities)

Total Number of Deaths occurring in Scope		Total Numbers Deaths Reviewed in Scope by Date of Death		Total numbers of deaths reviewed via SI investigation		Total number of deaths where SJR score is poor care and very poor care (<3)	
Jun-18	May-18	Jun-18	May-18	Jun-18	May-18	Jun-18	May-18
115	125	2	23	0	0	0	3~~9~~
April - June 18	Jan - Mar 18	April - June 18	Jan - Mar 18	April - June 18	Jan - Mar 18	April - June 18	Jan - Mar 18
369	507	50	45	0	0	7	8
Rolling 12 Months Jul 17 -Jun 18	Rolling 12 Months Jul 16 -Jun 17	Rolling 12 Months Jul 17 -Jun 18	Rolling 12 Months Jul 16 -Jun 17	Rolling 12 Months Jul 17 -Jun 18	Rolling 12 Months Jul 16 -Jun 17	Rolling 12 Months Jul 17 -Jun 18	Rolling 12 Months Jul 16 -Jun 17
1699	1602	156	38	6	1	22	NA





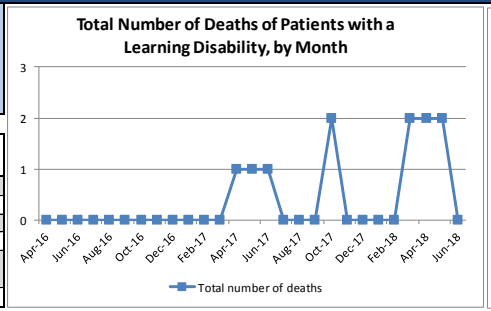
Deaths Reviewed by SJR Methodology Score

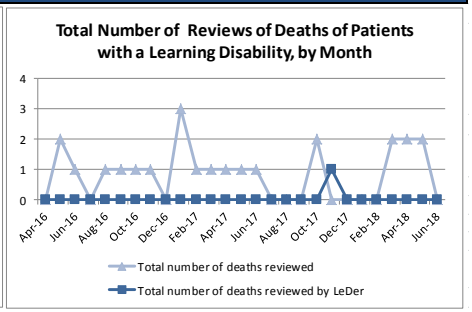
1 = Very Poor Care			2 = Poor Care			3 = Adequate Care			4 = Good Care			5 = Excellent Care		
April - June 18	1	2.00%	April - June 18	6	12.00%	April - June 18	12	24.00%	April - June 18	22	44.00%	April - June 18	9	18.00%
Rolling 12 Months Jul 17 -Jun 18	2	1.28%	Rolling 12 Months Jul 17 -Jun 18	20	12.82%	Rolling 12 Months Jul 17 -Jun 18	34	21.79%	Rolling 12 Months Jul 17 -Jun 18	69	44.23%	Rolling 12 Months Jul 17 -Jun 18	31	19.87%

Summary of total number of deaths of patients with a learning disability and total number of deaths reviewed under the LeDeR methodology

Total Volume of Deaths and Total Volume of Deaths Reviewed for patients with identified learning disabilities

Total number of deaths in scope		Total deaths reviewed by LD team		Total deaths referred to LeDeR for review		Total deaths reviewed through LeDeR methodology	
Jun-18	May-18	Jun-18	May-18	Jun-18	May-18	Jun-18	May-18
2	0	2	0	2	0	0	1
April - June 18	Jan - Mar 18	April - June 18	Jan - Mar 18	April - June 18	Jan - Mar 18	April - June 18	Jan - Mar 18
2	0	2	0	2	2	2	1
Rolling 12 Months Jul 17 -Jun 18	Rolling 12 Months Jul 16 -Jun 17	Rolling 12 Months Jul 17 -Jun 18	Rolling 12 Months Jul 16 -Jun 17	Rolling 12 Months Jul 17 -Jun 18	Rolling 12 Months Jul 16 -Jun 17	Rolling 12 Months Jul 17 -Jun 18	Rolling 12 Months Jul 16 -Jun 17
9	12	9	12	5	0	3	0





The above correction was reported to the Board before the paper was presented at the September 2018 meeting

NHS
Royal Devon and Exeter
NHS Foundation Trust

Agenda item:	10.4, Public Board meeting	**Date:** 26th September 2018
Title:	Medical Appraisal and Revalidation – Framework of Quality Assurance (FQA) Annual Report – FQA Annex D Statement of Compliance – FQA Annex E	
Prepared by:	James Hobbs, Executive Support Manager	
Presented by:	Professor Adrian Harris, Executive Medical Director and Trust Responsible Officer	
Responsible Executive:	Professor Adrian Harris, Executive Medical Director and Trust Responsible Officer	
Summary:	Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. It defines a number of legal entities – The Royal Devon and Exeter NHS Foundation Trust (RD&E) is the 'Designated Body' for 471 doctors with a 'Prescribed Connection', and the Medical Director, as 'Responsible Officer', is required to make recommendations to the GMC about their continuing fitness to practice. As part of the NHS England (NHSE) Framework of Quality Assurance, the attached paper (Annexe D) follows the format defined by NHSE to inform the Trust Board of Directors of the Trust's compliance with the Responsible Officer Regulations and current revalidation and appraisal arrangements. The Trust Board of Directors is subsequently required by NHS England to complete an annual 'Statement of Compliance' Annexe E for submission to the Trust's Higher level Responsible Officer. The RD&E has performed well across a range of aspects within the appraisal and revalidation process and has attained an overall appraisal rate of 90.9% (428/471) against a national position of 88.3%. The Trust has made continual progress in 2017/18 against the quality improvement plan identified as part of the 2016/17 annual report. The Trust remains compliant across the range of Responsible Officer Regulations, with some identified areas for further improvement included in the 2018/19 quality improvement plan.	
Actions required:	The Board of Directors are asked to • Accept the report • To note the actions planned and underway • Approve the 'statement of compliance' confirming that the organisation, as a Designated Body, remains in compliance with the regulations and has a robust quality improvement plan in place. • To note that the report will be shared with the Higher Level	

	Responsible Officer at NHS England			
Status (x):	**Decision**	**Approval**	**Discussion**	**Information**
		x		
History:	In previous years the Trust Governance Committee, within its scope of delegated authority from the Board of Directors, reviewed and approved the Annual Report and the Statement of Compliance.			
Link to strategy/ Assurance framework:	The issues discussed are key to the Trust achieving its strategic objectives			

Monitoring Information

Please *specify* CQC standard numbers and tick ✓other boxes as appropriate

Care Quality Commission Standards	Outcomes		
NHS Improvement		Finance	
Service Development Strategy	**x**	Performance Management	**x**
Local Delivery Plan		Business Planning	
Assurance Framework	**x**	Complaints	
Equality, diversity, human rights implications assessed			
Other *(please specify)*			

1. Purpose of paper

The medical revalidation legislation came in to law in December 2012. It defines a number of legal entities – The Royal Devon and Exeter NHS Foundation Trust (RD&E) is the 'Designated Body' for 471 doctors with a 'Prescribed Connection', and the Medical Director, as 'Responsible Officer', is required to make recommendations to the GMC about their continuing fitness to practice.

The Responsible Officer's recommendations are based on the outputs of the medical appraisal system, which has been strengthened under this legislation. The attached paper follows the format defined by NHS England to inform the Trust Board of Directors of the Trust's compliance with the Responsible Officer Regulations and current revalidation and appraisal arrangements. The Trust Board of Directors is required by NHS England to complete an annual 'Statement of Compliance' **Annexe E** for submission to the Trust's Higher level Responsible Officer, by 28th September 2018.

2. Background

This paper covers the reporting period of 1st April 2017 – 31st March 2018. The figures included in the attached paper are accurate for that time period, however at the time of writing this report (August 2018) the numbers will have been subject to change due to turnover of staff and appraisals being received outside of that time period which were completed within that time period.

The Royal Devon and Exeter NHS Foundation Trust (RD&E) is the Designated Body for 471 medical staff with a Prescribed Connection. This paper informs the Trust Board of Directors of the appraisal and revalidation arrangements for these doctors.

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that provider boards (or delegated committees) will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work they will perform.

3. Analysis

The RD&E has performed well across a range of aspects within the appraisal and revalidation process and has attained an overall appraisal rate of 90.9% (428/471) against a national position of 88.3%. There were 43 missed or late appraisals in total, these were for a variety of reasons; 16 of these were approved in advance by the Responsible Officer.

The Trust has made continual progress in 2017/18 against the quality improvement plan identified as part of the 2016/17 annual report. In particular;

- There are now much improved training opportunities, increased capacity for the Trust Clinical Appraisal Lead Role
- There is a more robust quality assurance (QA) process, which includes individual

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

review by the Trust Clinical Appraisal Lead, a peer review of appraisal portfolios with Devon Partnership Appraisal Lead and further QA review by the Revalidation Recommendation Review Group, which has also been formalised and strengthened in 2017/18.

- A review of the appraisal process for Trust Grade/short term doctors has seen an increase in the appraisal rate achieved from 52% in 2016/17 to 66% in 2017/18 and whilst this remains below the national average position further planned changes should see this to continue to improve.
- Whilst there remain some further opportunities to improve the appraisal process and the quality of medical appraisals, the standard of completed appraisals has continued to improve in 2017/18 particularly in relation to the fullness of appraisal summaries.
- Intranet (HUB) pages have been developed for medical Appraisal and revalidation which provides a single repository of information, guidance and documentation, which has been accessed just under 1000 times in the last eight months.
- Although lay representation hasn't been brought into the Trusts internal process regarding appraisal and revalidation of medical staff, this annual report is being taken through the Public Section of the Board of Directors. A review of lay representation forms part of the 2018/19 quality improvement plan.
- As yet the Trust has not moved to an electronic system for Medical Appraisal and Revalidation and this is being revisited as part of the 2018/19 quality improvement plan.

In January 2016 the Trust was subject to its five yearly 'Independent Verification Visit', conducted by NHS England, which forms a further part of the Framework of Quality Assurance. The process consisted of the Trust submitting a comprehensive self-assessment of compliance against the 92 standards of the Responsible Officer Regulations, followed by a verification visit by a review panel. The review panel included members of the regional revalidation team, a patient representative, a responsible officer from elsewhere and an NHS England area team representative. The visit concluded that the Trust is compliant across the range of Responsible Officer Regulations, with some identified areas for improvement against national best practice which have been implemented over the last two years.

The Trust has developed a quality improvement plan for 2018/19 which can be seen at section 6 Proposals or in the main body of the paper at section 11 Corrective Actions, Improvement Plan and Next Steps.

4. Resource/legal/financial/reputation implications

The Board of Directors must be apprised of the findings and content of the Medical Appraisal and Revalidation Annual Report and the 'statement of compliance', in order to provide assurance to NHS Engalnd that the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and that plans are in place to address any potential areas of weakness.

5. Link to BAF/Key risks

N/A

6. Proposals

The following actions have been identified and agreed to enable continuous quality improvement across the range of Responsible Officer Regulations and are not required as a result of any areas of non-compliance. Further detail can be found at Section 11 Corrective Actions, Improvement Plan and Next Steps;

- Appointment of new Responsible Officer (Deputy Medical Director – Professional Governance)
- Associate Medical Directors attendance at Case Manager Training
- Increase Case Investigator numbers and hold local Case Investigator Training
- Formalise the process for remunerating Case Investigators for undertaking investigations
- Implementation of Case Investigation Peer Review group.
- Educational Supervisors take on Trust Grade Doctor Appraisals
- Improve visibility of appraisal compliance to Divisional Teams through quarterly report to the Associate Medical Directors meetings
- Continue to recruit and train Medical Appraisers aiming to achieve 1:8 ratio of appraisees
- Formalise inclusion of individualised activity / outcome data to be included in appraisal portfolios
- Explore the use of an electronic system for Medical Appraisal and Revalidation to support administrative, reporting and monitoring requirements
- To review the potential of Lay representation within the Trusts internal processes regarding medical appraisal and revalidation.

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D - Annual Board Report Template

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**03551**
Document Purpose	Guidance
Document Name	A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D - Annual Board Report Template
Author	Gary Cooper, Project Manager Quality and Assurance, Professional Standards Team
Publication Date	16 June 2015
Target Audience	All Responsible Officers in England
Additional Circulation List	Foundation Trust CEs , NHS Trust Board Chairs, Medical Appraisal Leads, CEs of Designated Bodies in England, NHS England Regional Directors, NHS England Directors of Commissioning Operations, All NHS England Employees, Directors of HR, NHS Trust CEs
Description	A template board report for use by designated bodies to monitor their organisation's progress in implementing the Responsible Officer Regulations.
Cross Reference	The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012
Superseded Docs (if applicable)	A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D - Annual Board Report Template, version 4 April 2014.
Action Required	Designated Bodies to receive annual board reports on the implementation of revalidation and submit an annual statement of compliance to their higher level responsible officers.
Timing / Deadlines (if applicable)	**From June 2015**
Contact Details for further information	england.revalidation-pmo@nhs.net http://www.england.nhs.uk/revalidation/

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet. **NB:** The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Annual Board Report Template

Version number: 2.0

First published: 4 April 2014

Updated: 16 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Contents

1. Executive summary

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The Royal Devon and Exeter NHS Foundation Trust (RD&E) is the Designated Body for 471 medical staff with a Prescribed Connection. This paper informs the Trust Board of Directors of the appraisal and revalidation arrangements for these doctors.

The RD&E has performed well across a range of aspects within the appraisal and revalidation process and has attained an overall appraisal rate of 90.9% (428/471) against a national position of 88.3%. There were 43 missed or late appraisals in total, these were for a variety of reasons; 16 of these were approved in advance by the Responsible Officer.

The Trust has made continual progress in 2017/18 against the quality improvement plan identified as part of the 2016/17 annual report. In particular;

- There are now much improved training opportunities, increased capacity for the Trust Clinical Appraisal Lead Role
- There is a more robust quality assurance (QA) process, which includes individual review by the Trust Clinical Appraisal Lead, a peer review of appraisal portfolios with Devon Partnership Appraisal Lead and further QA review by the Revalidation Recommendation Review Group, which has also been formalised and strengthened in 2017/18.
- A review of the appraisal process for Trust Grade/short term doctors has seen an increase in the appraisal rate achieved from 52% in 2016/17 to 66% in 2017/18 and whilst this remains below the national average position further planned changes should see this to continue to improve.
- Whilst there remain some further opportunities to improve the appraisal process and the quality of medical appraisals, the standard of completed appraisals has continued to improve in 2017/18 particularly in relation to the fullness of appraisal summaries.
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In January 2016 the Trust was subject to its five yearly 'Independent Verification Visit', conducted by NHS England, which forms a further part of the Framework of Quality Assurance. The process consisted of the Trust submitting a comprehensive self-assessment of compliance against the 92 standards of the Responsible Officer Regulations, followed by a verification visit by a review panel. The review panel

included members of the regional revalidation team, a patient representative, a responsible officer from elsewhere and an NHS England area team representative. The visit concluded that the Trust is compliant across the range of Responsible Officer Regulations, with some identified areas for improvement against national best practice which have been implemented over the last two years.

The following actions have been identified and agreed to enable continuous quality improvement across the range of Responsible Officer Regulations and are not required as a result of any areas of non-compliance. Further detail can be found at Section 11 Corrective Actions, Improvement Plan and Next Steps;

- Appointment of new Responsible Officer (Deputy Medical Director – Professional Governance)
- Associate Medical Directors attendance at Case Manager Training
- Increase Case Investigator numbers and hold local Case Investigator Training
- Formalise the process for remunerating Case Investigators for undertaking investigations
- Implementation of Case Investigation Peer Review group.
- Educational Supervisors take on short term Trust Grade Doctor Appraisals
- Improve visibility of appraisal compliance to Divisional Teams through quarterly report to the Associate Medical Directors meetings.
- Continue to recruit and train Medical Appraisers aiming to achieve 1:8 ratio of appraisees
- Formalise inclusion of individualised activity / outcome data to be included in appraisal portfolios for discussion and reflection at appraisal.
- Explore the use of an electronic system for Medical Appraisal and Revalidation to support administrative, reporting and monitoring requirements
- To review the potential of lay representation within the Trusts internal processes regarding medical appraisal and revalidation.

2. Purpose of the Paper

Medical revalidation legislation came in to law in December 2012. It defines a number of legal entities – The Royal Devon and Exeter NHS Foundation Trust (RD&E) is the ‘Designated Body’ for 471 doctors, and the Responsible Officer is required to make recommendations to the GMC about their continuing fitness to practice.

The Responsible Officer’s recommendations are based on the outputs of the medical appraisal system, which has been strengthened under this legislation. This paper follows the format defined by NHS England to inform the Trust Board of Directors of the current revalidation and appraisal arrangements within the Trust. The Trust Board of Directors is required by NHS England to complete an annual ‘Statement of Compliance’ **Annex E** for submission to the Trust’s Higher Level Responsible Officer at NHS England.

3. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that provider boards (or delegated committees) will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work they will perform.

4. Governance Arrangements

Mr Adrian Harris, Executive Medical Director, is the Trust's Responsible Officer (RO). He is accountable to the Higher Level Responsible Officer, Nigel Acheson, and his Prescribed Connection is to the Regional NHS England South Designated Body. Mr John Renninson, Associate Medical Director, is the Trust's Deputy Responsible Officer. It is acknowledged that the RO cannot delegate their statutory responsibilities to another individual and therefore the deputy RO role merely supports the RO in discharging their duties.

The Trust has now appointed two Deputy Medical Directors and the role of RO will be formally transferred to the Deputy Medical Director – Professional Governance, Prof David Mabin, once he has attended his formal RO training on 19th / 20th September 2018. It is anticipated that the role will formally transfer in September 2018.

All doctors with a Prescribed Connection to the RD&E Designated Body are accountable to the Responsible Officer, which includes all senior medical staff and junior doctors holding local contracts. For Junior Doctors with training contracts, their designated body is Health Education England (South West) and their RO is Professor Martin Beaman.

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

The RO is supported by his Executive Support Manager, James Hobbs, Trust Clinical Appraisal Lead, Dr Mike Jeffreys and the Human Resources (HR) Transactional Team. The HR Transactional Team monitor and track the appraisal process for all staff with a prescribed connection, including but not limited to:

- advising on appraisal due dates
- allocating appraisees to appraisers
- receiving and storing completed appraisals
- maintaining an accurate database of appraisal information
- updating systems of any new starters or leavers on a monthly basis
- managing the list of doctors with a prescribed connection via the GMC Connect portal
- sharing and receiving information with/from other Ros / Designated Bodies

The HR Transactional Team produces quarterly reports, and supports the completion of the detailed Annual Organisational Audit on behalf of the RO, which is submitted to the Higher Level Responsible Officer, as part of the Framework of Quality Assurance.

Calibration and Networking
The RO, Deputy RO or Clinical Appraisal Lead attends quarterly 'RO and Appraisal Lead Network' meetings.

The GMC Connect website is the portal from which revalidation recommendations are made to the GMC. This site is routinely reviewed to ensure an accurate list of medical staff with a Prescribed Connection to our Designated Body is maintained.

The Trust has a well-established Revalidation Recommendation Review Group (RRRG) which meets on a monthly basis and comprises, the RO, Deputy RO, Clinical Appraisal lead, Executive Support Manager and HR Transactional Team members. The group reviews the status of individual's progress towards revalidation, via a locally developed dashboard and will agree the recommendation to be made by the RO to the GMC. Recommendations to the GMC are in the main made between 2-3 months in advance of an individual's revalidation due date. Additionally at this meeting the RO will also spot audit appraisal portfolios for quality assurance purposes and to validate the view of the RRRG sub-group.

The RRRG sub-group also meets on a monthly basis, comprising the Clinical Appraisal Lead, Executive Support Manager and the HR Transactional Team. At this meeting a more detailed review of the status of each individual's progress towards revalidation is undertaken and any actions required of individuals to support their revalidation are identified, agreed and communicated out. The Clinical Appraisal Lead quality assures every individual's appraisal portfolio and provides feedback on these at the meeting. Where required, feedback is also provided by the Clinical Appraisal Lead to individual appraisers following the quality assurance check, which is agreed at the meeting. The group subsequently make a recommendation to the RRRG as to whether an individual should be recommended for revalidation or deferred. If a deferral is recommended, the outstanding actions required are described and a deferral timeframe is suggested.

The Trust's Medical Workforce Strategy Group, chaired by the Medical Director and RO also provides high level oversight of the appraisal and revalidation process and monitors compliance / appraisal rates across the relevant medical workforce. This group also oversees the recruitment process of all medical and dental staff.

a) Policy and Guidance

There have been revisions to the following policies which have been ratified through both the Local Negotiating Committee (LNC) and the Workforce Governance Committee and are now live;

- Medical and Dental Staff Study Leave Policy
- Medical and Dental Staff Appraisal and Revalidation Policy

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

Appraisal and Revalidation Performance Data

The following summary table gives a breakdown of the number of completed or missed or late appraisals.

Staff Group	*Number of Prescribed Connections*	*Number of Completed Appraisals*	*Number of Approved Missed or Late Appraisals*	*Number of unapproved Missed or Late Appraisals*	*RD&E % Appraisal Rate*	*National Acute Sector % Appraisal Rate*
Medical Consultants	*344*	*332*	*4*	*8*	*96.5%*	*92%*
SAS Doctors	*49*	*44*	*3*	*2*	*89.8%*	*88.4%*
Temporary or Short Term Contract Holders	*78*	*52*	*9*	*17*	*66.6%*	*77.2%*
Total	*471*	*427*	*16*	*27*	*90.9%*	*88.3%*

- Over the time period there three members of staff who undertook a formal remediation programme. One following a local case investigation process, under the Maintaining High Professional Standards Policy and the others as a result of concerns being raised regarding personal dynamics and relationship challenges and a request for NCAS supported mediation.

Details of exceptions i.e. missed appraisals and reasons, incomplete appraisals etc. (See **Annual Report Template Appendix A;** Audit of all missed or incomplete appraisals audit)

b. Appraisers

To date, the Trust has 50 Trust Approved Appraisers, each undertaking around ten appraisals annually, or a ratio of 1:9.6. This ratio is within the range specified within the Responsible Officer Regulations – 'a ratio of not less than 1:5 and not more than 1:20'.

In 2017/18 the Trust appointed eight new Trust Approved Appraisers although this was off-set with eight existing Trust Approved Appraisers standing down or leaving the Trust. The ambition is to recruit a sufficient number of appraisers to enable a ratio of 1:8 appraisees, which is more commensurate with their PA allocation to undertake the appraiser role. To support this, the Trust has agreed that short term Trust Grade doctors' educational supervisors would be better suited to undertake their appraisals. Educational Supervisors already undertake a quarterly review of performance with these doctors; however these are not deemed a formal Trust Appraisal. This should also be borne in mind when reviewing the current appraisal rates of this cohort of doctors. The educational supervisors are in the process of completing appraisal training and should be concluded within the coming months.

Formal Appraiser Training has been provided to all new and was open to existing appraisers which has been well attended and well received. These have been scheduled in conjunction with Devon Partnership Trust. Further training sessions are planned and will be provided locally with a view to providing further update training supported by NHS England.

c. Quality Assurance

For the appraisal portfolio:

- A review of the appraisal portfolio is undertaken prior to the appraisal meeting, to ensure that the appraisal inputs: the pre-appraisal declarations and required supporting information is available and appropriate. This is completed by each individual appraiser prior to the appraisal meeting. The information is sent by the appraisee to the appraiser for review one week prior to the appraisal meeting.
- Following submission of the Appraisal portfolio
    - The HR Transactional team review the summary of appraisal outputs to ensure all declarations have been completed and the appraisal document has been signed off by the appraisee and the appraiser.
    - Where this has not been completed the HR Transactional Team will chase up both the appraisee and appraiser to ensure that this is completed prior to the 28 day deadline from the appraisal meeting.

For the appraiser:

- The Appraisal Lead undertakes a snapshot audit of a completed appraisal portfolio. The results of the audit are fed back to the individual appraiser, by the appraisal lead.

    - The Clinical Appraisal Lead undertakes QA of appraisals. This is also undertaken in partnership with the Clinical Appraisal Lead from the Local Mental Health Trust, to ensure sufficient peer challenge and enable calibration and comparison of appraisal standards.
    - Further quality assurance is provided by the Revalidation Recommendation Review Group as part of the revalidation process and feedback is provided to the individual appraiser where required.
- There is a process in place for the appraisee to provide feedback on the appraisal, to the appraiser and a standard template is available. Identifiable details of the appraisee are removed before being distributed to the individual appraiser.
- In addition, an electronic survey has been developed and sent out to all Trust appraisees asking for feedback on the appraisal process and their individual appraiser. Respondents to this survey have been extremely useful and insightful. The individual appraiser results are shared with the appraiser to include within their own appraisal portfolio. Any key themes identified are being used to provide targeted training to individual appraisers and the appraisers as a whole for further update training and have informed this year's quality improvement plan.

In 2017/18, 98 individual appraisal portfolios have been audited, which represents a sample size of just fewer than 23% of all appraisals conducted in that year. This has been undertaken either as part of the revalidation recommendation process, or through the snapshot audit of individual appraisers performance undertaken by the Clinical Appraisal Lead. Feedback has been provided where appropriate and any themes have been fed into the Appraiser Training Programme.

Also see **"Annual Report Template, Appendix B;** Quality assurance audit of appraisal inputs and outputs" *as an example of what could be carried out*

d. Access, Security and Confidentiality

When appraisals are completed, the portfolios are sent via e-mail to the HR Transactional Team and copied to the Medical Director. The appraisal portfolios are saved on a secure shared drive to which the HR transactional team and Medical Directors office have access.

Appraisal Portfolios are reviewed as appropriate by the RO, Deputy RO, Clinical Appraisal Lead, Executive Support Manager and HR Transactional Team as part of the Revalidation Recommendation Review Group's remit and as part of the ongoing quality assurance process.

The Appraisal Policy states that patient identifiable data must be excluded from appraisal portfolios and the HR Transactional Team are not aware of any information management breaches in this regard.

Individual appraisers may save copies of appraisal forms on Trust computers, and their responsibility for information security is set out in the Appraisal Policy and Information Governance Policy, as well as being an important part of their appraisal training.

e. Clinical governance

There are robust and well established governance processes in place within the Trust which enables formal escalation of any issues regarding clinical governance / practice. There are also informal channels which enable the RO to be made aware of and act upon any issues regarding any fitness to practice concerns.

There is a self-certification process in place as part of the appraisal process whereby statements regarding involvement in incidents and or being named in complaints is provided by the appraisee. To support this process, as outlined in a previous year's quality improvement plan, changes have been implemented within our Datix System (complaints and incidents) such that the Trust is able to report on a named clinician basis. A cross check of the inclusion of this data within the appraisal portfolio is undertaken as part of the QA process.

For doctors in training there is a monthly meeting with HR representation, Heads of year, the Director of Medical Education (DME) and the deanery whereby progress is reviewed and any doctors in difficulty are discussed and flagged. The DME has regular 1:1 meetings with the RO.

At a specialty and divisional level there are specialty level Mortality and Morbidity Meetings and Specialty Governance meetings which report through to the Divisional Governance Groups. The Divisional Governance Groups are chaired by the Associate Medical Directors (AMDs). The RO has weekly meetings with the AMDs.

The Trust's Incident Review Group triangulates any trends in claims, complaints and incidents and monitors the completion of resulting action plans. This group reports to the Trust's Safety and Risk Committee. The Patient Safety and Mortality Group monitor the delivery of the Patient Safety Programme and oversee the Trust's Mortality Review Process, which includes Learning from Deaths, this group also reports to the Safety and Risk Committee. The RO attends the Safety and Risk Committee and the Patient Safety and Mortality Group and has regular meetings with the Trust Mortality Lead and the Trust's Risk Manager. The Lead Nurse for Safety and Patient Experience, the RO and Chief Nurse also meet regularly at their weekly 'Safety Huddle Meeting'.

The RO attends the Trust's Clinical Effectiveness Committee, which oversees, amongst other aspects of clinical effectiveness, the Clinical Audit Programme and regularly receives the results of national clinical audits through which outlying clinical outcomes can be identified and acted upon.

Outside of these more formal processes, any identified issues are immediately escalated to the RO as appropriate and in line with the Maintaining High Professional Standards Policy.

As part of this year's quality improvement plan, individual clinician's activity and clinical outcome data will be requested for inclusion in their appraisal portfolio. This will be an iterative process as the Trust works through potential challenges around availability of individualised, robust data. In many cases this data is already included in appraisals, for example through national audit data; however this requirement will be formalised.

Also see **"Annual Report Template Appendix C;** Audit of concerns about a doctor's practice" *as an example of what could be carried out*.

6. Revalidation Recommendations

- Number of recommendations between April – March 2017/18 – Total 31
- Recommendations completed on time 29; not on time 2
- Positive recommendations 25
- Deferrals requests 6
- Non-engagement notifications 0
- Reasons for all missed or late recommendations – Awaiting information from the individual doctor to avoid the need to defer.

Also include reference to reasons recorded for missed or late recommendations. See **"Annual Report Template Appendix D;** Audit of revalidation recommendations"

7. Recruitment and engagement background checks

The attached Appendix (E) includes data on the pre and post-employment checks carried out on all medical staff employed by the Trust. The HR Transactional Team follow the guidance set out by NHS Employers for the recruitment of doctors.

Also see "**Annual Report Template Appendix E.** Audit of recruitment and engagement background" *as an example of an audit that can be carried out in this area.*

8. Monitoring Performance

The appraisal system is the process used for monitoring the performance of all medical staff within the RD&E. This applies to all grades of doctor with local contracts. For doctors in training the process for monitoring performance is undertaken in partnership with the Deanery, using Consultant level 'Educational Supervisors' provided by the Trust, adhering to the nationally mandated Deanery processes. The RO also regularly meets with the Director of Medical Education.

As described in a previous quality improvement plan the Trust has developed the 'Job Plan Review' process which runs in parallel to the Medical Appraisal process. This looks across a broader range of factors and metrics relating to the doctor's specific contribution to the performance of their individual department and the wider Trust as a whole. This process continues to be further developed and implemented on an iterative basis and will be supported by formalising the inclusion of individualised activity and outcome data through the medical appraisal process.

9. Responding to Concerns and Remediation

The Trust has the 'Maintaining High Professional Standards Policy' (MHPS) in place for managing and responding to concerns. This is based on the national Maintaining High Professional Standards in the Modern NHS Policy developed in 2003 by the Department of Health.

The Trust has 23 Trained Case Investigators, 13 of which are senior medical staff and 10 are HR representatives. All Case Investigators have undergone training provided by the National Clinical Assessment Service (NCAS). A further round of Case Investigator Training is planned for January 2019 jointly with Devon Partnership Trust (DPT). As part of this year's quality improvement plan it has been agreed that the options for remunerating Case Investigators for undertaking investigations should be formalised. Additionally, a semi regular meeting will be put in place to enable Case Investigators to review completed investigations and to receive feedback on investigations they have undertaken. This will support calibration, shared learning and quality improvement, although there will be some information governance and confidentiality issues to work through.

In addition to the Medical Director, the Trust has three trained Case Managers, both Deputy Medical Directors and the Deputy RO. The three Associate Medical Directors have been requested to undertake Case Manager Training and are in the process of identifying and booking on to this.

The Trust has a number of strategies in place for managing and supporting medical staff requiring remediation. These include focussed Continuing Professional Development (CPD), mentoring, occupational health support, team mediation, and psychological interventions, where required.

The RO has access to a range of external support for advice and guidance or more formal interventions. The RO regularly meets with his Employer Liaison Advisor from the GMC, access support from NCAS and has also commissioned previous external reviews from the Royal College of Physicians. The RO also seeks external expert clinical opinion where required in order to investigate any concerns regarding clinical practice of individual practitioners.

Following the Independent Verification Visit from NHS England, the Trust has developed an internal 'Revalidation Recommendation Review Group', this group meets on a monthly basis and reviews all doctors due for revalidation three months in advance of their revalidation due date.

10. Risks and Issues

There are no specific risks or issues to highlight to the Trust Board of Directors.
Areas for improvement and development are included within Section 11.

11. Corrective Actions, Improvement Plan and Next Steps

The following actions are identified to enable continuous quality improvement across the range of Responsible Officer Regulations and not required as a result of any areas of non- compliance.

Action	**Owner**	**Timescale for completion**
Appointment of new Responsible Officer (Deputy Medical Director – Professional Governance)	RO	September 2018
Associate Medical Directors attendance at Case Manager Training	RO	December 2018
Increase Case Investigator numbers and hold local Case Investigator Training	RO	January 2019
Formalise process for remunerating Case Investigators for undertaking investigations	RO	October 2018
Implementation of Case Investigation Peer Review group.	RO	January 2019
Educational Supervisors take on Trust Grade Doctor Appraisals	RO / Appraisal Lead	December 2018
Improve visibility of appraisal compliance to Divisional Teams through quarterly report to the Associate Medical Directors meetings	RO / Appraisal Lead	December 2018
Continue to recruit and train Medical Appraisers aiming to achieve 1:8 ratio of appraisees	RO / Appraisal Lead	On-going process
Formalise inclusion of individualised activity / outcome data to be included in appraisal portfolios	RO	March 2018
Explore the use of an electronic system for Medical Appraisal and Revalidation to support administrative, reporting and monitoring requirements	RO / Appraisal Lead	December 2018
To review the potential of lay representation within the Trusts internal processes regarding medical appraisal and revalidation.	RO / Appraisal Lead	March 2018

12. Recommendations

The Trust Board of Directors are asked to accept the report, to note the actions planned and underway, and note that the report will be shared with the Higher Level Responsible Officer at NHS England.

The Trust Board of Directors are asked to approve the ‘Statement of Compliance’ confirming that the organisation, as a Designated Body, is in compliance with the regulations and has a robust quality improvement plan in place.

13. Annual Report Template Appendix A – Audit of all missed or incomplete appraisals

Doctor factors (total)	**Number**
Maternity leave during the majority of the 'appraisal due window'	1
Sickness absence during the majority of the 'appraisal due window'	3
Prolonged leave during the majority of the 'appraisal due window'	0
Suspension during the majority of the 'appraisal due window'	1
New starter within 3 month of appraisal due date	8
New starter more than 3 months from appraisal due date	17
Postponed due to incomplete portfolio/insufficient supporting information	0
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	5
Lack of engagement of doctor	8
Other doctor factors	0
(describe)	0
Appraiser factors	**Number**
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	0
Other appraiser factors (describe)	0
(describe)	0
Organisational factors	**Number**
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

14. Annual Report Template Appendix B – Quality assurance of appraisal inputs and outputs

Total number of appraisals completed		428
98 appraisals quality assured out of 428 completed appraisals. **23%** sample of appraisals quality assured	Number of appraisal portfolios sampled (to demonstrate adequate sample size)	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs		
Scope of work: Has a full scope of practice been described?	98	96
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	98	97
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	98	97
Patient feedback exercise: Has a patient feedback exercise been completed?	98	95 (3 Not required Histopathology and ICU only)
Colleague feedback exercise: Has a colleague feedback exercise been completed?	98	98
Review of complaints: Have all complaints been included?	98	96
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	98	98
Is there sufficient supporting information from all the doctor's roles and places of work?	98	96
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed by year 5? • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? • Have all types of supporting information been included?	98	88
Appraisal Outputs		
Appraisal Summary	98	98
Appraiser Statements	98	97
Personal Development Plan (PDP)	98	97

15. Annual Report Template Appendix C – Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level[2]	Medium level[2]	Low level[2]	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern				
Capability concerns (as the primary category) in the last 12 months			3	3
Conduct concerns (as the primary category) in the last 12 months			7	7
Health concerns (as the primary category) in the last 12 months		1		1
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2017 who have undergone formal remediation between 1 April 2017 and 31 March 2018. Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice A doctor should be included here if they were undergoing remediation at any point during the year				3
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				3
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				
General practitioner (for NHS England only; doctors on a medical performers list, Armed Forces)				
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-				

[2] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

term employment contracts, etc) All Designated Bodies	
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies	
TOTALS	
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	2
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	 1 1
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	2
GMC Actions: Number of doctors who:	
Were referred by the designated body to the GMC between 1 April and 31 March	0
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	3
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	1
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	
Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment	7
Number of NCAS assessments performed	0

16. Annual Report Template Appendix D – Audit of revalidation recommendations

Revalidation recommendations between 1 April 2017 to 31 March 2018	
Recommendations completed on time (within the GMC recommendation window)	29
Late recommendations (completed, but after the GMC recommendation window closed)	2
Missed recommendations (not completed)	0
TOTAL	31
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	2
Describe other	Awaiting information from individual doctor, to avoid the need to make a deferral recommendation
TOTAL [sum of (late) + (missed)]	2

17. Annual Report Template Appendix E – Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	19
Temporary employed doctors	254
Locums brought in to the designated body through a locum agency	0
Locums brought in to the designated body through 'Staff Bank' arrangements	58
Doctors on Performers Lists	8 (already included in above figures)
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc.	160 honorary contract holders
TOTAL	491

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)

	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS investigations	Disclosure and Barring Service (DBS)	2 recent references	Name of last responsible officer	Reference from last responsible officer	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance concerns
Permanent employed doctors	19	19	19	19	19	19	***	*	*	N	19	**	*	*	*	*
Temporary employed doctors	254	254	254	254	254	254	***	*	*	N	254	**	*	*	*	*

Locums brought in to the designated body through a locum agency																
Locums brought in to the designated body through 'Staff Bank' arrangements	58	58	58	58	58	58	***	*	*	N	58	**	*	*	*	*
Doctors on Performers Lists																
Other (independent contractors, practising privileges, members, registrants, etc.)																
Total	491	491	491	491	491	491	***	*	*	N	491	**	*	*	*	*

***This is asked at Recruitment Stage.**

* Not routinely at recruitment but is picked up by the Medical HR Team following appointment, when inputting key data onto Medical Appraisal Tracking Spread sheet or is collected as part of the appraisal process. For specific issues/information requests a process is in place for contacting the previous RO or sharing information with a new RO.

** GMC registration and specialist registration is checked for every doctor. The GMC check all qualifications as a requirement of registration, and Trusts are not required to check them again.

*** 2 recent references are collected for all however occasionally 1 reference will be accepted if covering a period of >=3 years of previous employment

Annex E

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

Statement of Compliance

Version number: 2.0

First published: 4 April 2014

Updated: 22 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Publications Gateway Reference: 03432

NB: The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Designated Body Statement of Compliance

The Governance Committee of the Royal Devon and Exeter NHS Foundation Trust can confirm that

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments: GMC Connect is regularly monitored and updated using monthly "starters and leavers" data to ensure accuracy.

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: The Trust has enough Medical Appraisers to undertake 10 appraisals per year, which covers the number of appraisals requiring completion and is well within the guideline ratio of appraisers to appraisees.

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent);

   Comments: Formal appraisal training has been provided to all new and existing appraisers. There are quality assurance processes in place with feedback mechanisms to individual appraisers regarding their performance. There is a peer review process in place as part of the QA process

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: All completed appraisals are in keeping with GMC requirements using the MAG documentation. There were a total of 43 missed or late appraisals in 17/18 and reasons have been provided and action taken where appropriate.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

that information about these matters is provided for doctors to include at their appraisal;

Comments: This requirement is met through the completion of the MAG appraisal portfolio. Information to support this is provided by the Trust and will be further strengthened in 2018/19. Feedback from patients and colleagues is provided through a 3rd party company, as required, within the revalidation cycle.

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Comments: The Maintaining High Professional Standard Policy is invoked and followed as required and appropriate.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[3]

Comments: The Recruitment and Transactional HR teams follow NHS Employers guidance on medical recruitment. Compliance with guidance is regularly audited. Information is shared with other Designated Bodies as requested. Information is sought from other designated bodies as required.

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed;

Comments: As point 8 above

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

Comments: A development plan is in place to ensure continuous quality improvement of the appraisal and revalidation process.

Signed on behalf of the designated body

Chief executive

Official name of designated body: Royal Devon and Exeter NHS Foundation Trust

Name: Suzanne Tracey Signed:

Role: Chief Executive

Date: 26th September 2018

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents