



Independent Regulator  
of NHS Foundation Trusts

## Forward Plan Financial Return (IFRS)

**Royal Devon and Exeter NHS Foundation Trust NHS FT**

### Plan for y/e 31 Mar 2011 (and 2012, 2013)

FT forward planning template IFRS version v1.01 customised for use by FT with MARS ID 'RDE'.  
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Approved on behalf of the Board of Directors

Chair: Angela Ballatti

Electronic signature:

## **1. Overview**

NHS foundation trust plans for 2011 – 13 include financial forecasts for three years which will reflect forward looking assumptions, projections or estimations, at least, as to:

- revenues and costs;
- contracts and changes in productivity;
- the likely impact of various external and internal factors;
- key risks, including in relation to the Authorisation, and effective mitigations;
- capital and other investment projects;
- leadership and necessary key skills;
- potential acquisitions and / or disposals; and
- clinical quality objectives and service development.

Each of the above should be underpinned by detailed planning and proposed actions, identification of key responsibilities and clear accountability, and a shared strategic vision led by the Trust's Board and agreed with governors, commissioners and other key stakeholders. To deliver this the Trust's Board must plan, understand, articulate and clearly communicate:

- the Trust's vision;
- the Trust's strategy and how this aligns with its vision;
- key delivery risks to the strategy: internal and external; controllable, semi-controllable and non controllable;
- for each of the main parts of the strategy, the key priorities, actions and resources (both financial and human) needed to deliver them;
- measures of progress and milestones along the way;
- any regulatory risks and mitigations;
- communication and stakeholder engagement.

The strategic part of the annual plan is designed to ensure that:

- NHS foundation trust Boards (both directors and governors) have properly considered and delivered the above requirements for good planning to underpin the delivery of high quality healthcare services;
- the Trust's financial plans demonstrate an integrated and effective approach to, and output from, high quality strategy and realistic planning, and;
- if not, to identify gaps and actions to fill them;

When assessing the effectiveness of the strategic, operational and financial planning undertaken by a Trust as part of the Annual Plan Review, Monitor will consider the clarity with which a Trust Board can describe its overall strategic vision and, for each of the main areas of its business, identify key priorities, assess risk, and design a co-ordinated and credible plan for delivery of its three year plan.

Set out below is guidance for completion of each of the main templates within the plan. Within each template, Boards will be expected to describe succinctly the Trust's key priorities (it is likely that for each template there will be up to a maximum of 10 priorities). For each of the priorities in the templates, the Trust's Board should be able to demonstrate a clear link between its vision for the Trust, strategic objectives, key operational action plans and the assumptions used to drive the plan.

All measures of progress or milestones must be SMART – Specific, Measurable, Achievable, Relevant, Time-bound.

Where more detailed information is already included within the input sheets from which the financial plans are derived, then this information should be referenced (and where appropriate not repeated) within the templates below.

After each template is a box to add further comment by way of additional clarification, although additional comments, if any, should also be limited in length.

Annex A sets out, at a high level, the main stages in the development of the three year plan and the key elements which underpin each.

### ***Template 1: Vision and key priorities***

Guidance: The Board should be able to describe where it believes the Trust is currently placed in terms of progress towards the delivery of its overall vision and strategy, where in this context it aims to get to over the next three years, and the main priorities which will need to be delivered to secure the required progress.

The Trust's vision should describe at the highest level the strategic objective of the Trust and in particular how it wishes to be viewed by its patients and service users, staff, commissioners and other key stakeholders. In most cases this will reflect but not be the same as the Trust's vision statement. The vision should be shared in particular by the Board of Directors and the Board of Governors. Comment as to the likely timescales for the delivery of the vision may be appropriate particularly if this falls outside the three year period of the annual plan.

The Trust Board should be able to articulate the key changes required in order to evolve and develop the Trust from its present position and the key elements of the organisation that need to be in place to achieve the vision. In all parts of the Trust's plan, including the financial forecasts, there must be a clear link between its overall vision and the strategic objectives, operational plans and key assumptions. These main priorities for the next three years are likely to be high level and may, for instance, represent the 'top five' for the Trust. Milestones should similarly be high level but measurable by the Board, to enable an objective assessment as to progress towards their delivery.

The Trust's current position is summarised as:

The Trust has continued to develop and improve the quality and safety of services. In 2009/10 all key service and financial targets were achieved and performance throughout the year was broadly in line with the Annual Plan. As a robust public benefit corporation the journey continues to maximise the benefits of Foundation status. This is built upon the contribution and engagement of our staff, the Council of Governors, supported by the Board of Directors, and developing links with the local community and our members.

During Quarters 1, 2 & 4 a 'green' rating for mandatory services and governance was maintained. In Quarter 3 the governance rating reduced to 'amber' because A&E 4-hour wait performance dipped below target and because a risk of not achieving year-end RTT targets was flagged, due to increased activity and reduced capacity. This risk however did not materialise. The financial risk rating was maintained at 4 in all quarters. In Quarter 4 increased emergency admissions, severe weather and Norovirus all affected the levels of elective surgery, with an impact on costs and income. Whilst overall financial achievement was very close to the planned outturn, expenditure control and recurrent achievement of efficiency savings are areas for further work which have been addressed in 2010/11 planning and budget setting.

The 2010/11 Annual Plan has been prepared in the context of the NHS Operating Framework, Monitor guidance and the expectation of a decline in public spending. Of particular significance are the 0% uplift, 30% emergency tariff and 3.5% efficiency requirement. The Trust has established a strategic redesign programme to lead the identification and delivery of the required efficiency savings, aligned with the Health Community's Transformation Programme and QIPP. For year 2 of the 2009/10 3-year contract, the Trust has currently agreed activity at 2009/10 outturn, but this does not address likely growth. Negotiations continue, incorporating schemes being developed between the Trust, PBC Consortia and NHS Devon to manage demand within NHS Devon's resource envelope to address their underlying deficit.

The Trust has developed the Annual Plan to ensure it remains compliant with its terms of authorisation and meets national and local standards/targets agreed or likely to be agreed with commissioners. The plan also includes progress towards the aspirations in the 'Strategic Directions 2007-2012', developed by the Board in partnership with the Council of Governors. The priorities identified by members (including staff) were: control of infection; clean & tidy hospital; continuing to meet national targets; ensuring patients get the food and nutrition they need; less time waiting (whilst at the hospital).

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

Our vision is for the RD&E to be at the leading edge of healthcare; a modern organisation that is competitive, smart, flexible and distinctive in every way. To do this we will focus our attention and build our services around three key themes: Respond, Deliver & Enable

1) In responding we aim to

- a) Be the provider of choice, delivering care in the most convenient and appropriate location, with no delay
- b) Eliminate all avoidable hospital infections
- c) Deliver services in a comfortable, friendly environment in which staff can care for patients effectively
- d) Recognise our wider responsibility to the environment and local community by using resources wisely

2) We aim to deliver

- a) A high standard of care delivered by experts, which meets the needs and aspirations of patients, staff, carers and the public
- b) A full range of cost-effective accessible local hospital services
- c) A range of excellent specialist services

3) We aim to enable

- a) Staff to do their jobs to the best of their ability, by valuing them, ensuring they have the right skills and giving them the opportunity to focus on meeting the needs of patients, so making the RD&E the employer of choice
- b) Staff to have a good work/life balance, and achieve their full potential
- c) Research and innovation
- d) Future and sustained success through good financial management

During the three years since its publication much progress has been made in delivering the Trust's vision, including the delivery of the 18 week referral to treatment target, significant reductions in the incidence of MRSA and Clostridium Difficile, and high quality care that is valued by patients, against a backdrop of increasing financial challenges and some marked increases in activity. The vision and strategy are currently being reviewed to ensure that they are fit for purpose for the changed future environment, in particular the reduction in that rate of increase of funding for the NHS over the next three years and beyond. This review will be completed by September 2010.

Key priorities for the Trust which must be achieved in the three years of the annual plan to underpin the delivery of the Trust's vision,

Key priority (and timescales)	How this priority underpins the strategic vision	Key milestones (2010/11)	Key milestones (2011/12)	Key milestones (2012/13)
Maintain financial performance by improved efficiency and cost reduction rather than activity and income growth (2010-2013).	This is an enabler for all the strategic priorities and 1d, 2b and 3d in particular.	Deliver in-year CIP targets and develop longer term efficiency improvement programmes. Review supporting information re. theatre and bed optimisation, including reporting of such information to the Board of Directors. Review information, pharmacy and contracting systems to ensure that they capture all income due.	Implement longer term efficiency improvement programmes. Deliver in-year CIP targets. Assess risks in relation to tariff being the maximum price payable and review the profitability and efficiency of services via Service Line Management.	Review delivery of longer term efficiency improvement programmes. Deliver in-year CIP targets. Improve the efficiency of any services acquired under Transforming Community Services.
Further develop the safety and quality culture (2010-2013).	This supports the following elements of the vision in particular: 1a, 1b, 2a, 3a.	Deliver 2010/11 CQUIN schemes. Improve scope of routine safety/quality reporting to the	Embed 2010/11 CQUIN schemes, deliver 2011/12 CQUIN schemes. Incorporate quality scorecards into	Embed 2011/12 CQUIN schemes, deliver 2012/13 CQUIN schemes.

Consolidate the newly-acquired services (community theatres and community midwifery).	This supports the following elements of the vision in particular: 1a, 1c, 2b, 2c, 3a.	Ensure that all key quality, workforce, performance and governance systems are effectively working	Maximise the efficiency of these services and their contribution to the wider maternity and theatre services of	
Further develop job and service redesign	This supports the following elements of the vision in particular: 3a, 3b.	Improve systems for workforce monitoring and management. Develop service line workforce	Deliver more refined workforce plans at service line level and implement role redesign to support	
Further development of the Trust as a membership organisation.	This supports the elements of the vision 1a and 1d. It also underpins the future development of the strategy and the development of the organisation as distinctive.	Involvement of Council of Governors in reviewing and developing the strategy.	Delivery of members' revised priorities in the plans for the year as agreed in revised strategy.	







Key priority (and timescales)	How this priority underpins the strategic vision	Key milestones (2010/11)	Key milestones (2011/12)	Key milestones (2012/13)
Service redesign via Devon-wide Transformation Board and sub-groups.	In controlling demand and optimising pathways this contributes to the following elements of the vision in particular: 1a, 1d, 2b, 3d.	Progress identified local opportunities for gain under QIPP. Deliver quick wins and begin longer term transformation projects, including enhanced recovery and referral management.	Continue longer term projects and mainstream successful pilots, taking into account the position of local services and pathways under Transforming Community Services. Review 2010/11 quick win projects and amend if necessary.	Consolidate and review longer term projects. Review demand and capital plans in the light of benefits of transformation projects. Develop new initiatives to further improve efficiency.
Progress the joint work with the Peninsula College of Medicine and Dentistry and the University of Exeter to develop the plans for the Research, Innovation and Learning Development at Wonford (planning phase in 2010/11).	This supports the following element of the vision in particular: 3c.	Outcome of University bid for capital funding for research (May 2010); agreement of joint	Dependent on outcome of University bid, building work to take place between Q3 2011/12 and	Dependent on outcome of University bid, building work to take place between Q3 2011/12 and

Implement the Carbon Reduction and Sustainability Strategy	This supports the following element of the vision in particular: 1d.	Sustainability Committee leads to identify priorities for each of the Trust's key sustainability areas. Compare	Implement sustainability priorities for each key sustainability area as part of the Trust's sustainable	Implement second stage of carbon reduction energy efficiency programme via renewable energy
Further reduction of Healthcare Associated Infections (including MRSA, Clostridium difficile and Norovirus)	This supports the following elements of the vision in particular: 1b and 1c.	Introduction of new diagnostic testing methodology (with increased sensitivity) for C. difficile.	Assess impact of new diagnostic testing methodology for Clostridium difficile Reduction in	Assess impact of new diagnostic testing methodology for Clostridium difficile Reduction in

## **Template 2: Key external impacts**

*Guidance: The key external impacts template should reflect the significant external impacts on the Trust's plans, and for each of these, a brief description of the related risks and impact on the delivery of the plan, the actions taken and / or planned to be taken to mitigate the impact and residual risks which may then remain, the expected or planned outcome, measures of progress and the person accountable in each case.*

*Key external impacts will vary by Trust and also evolve or develop over time, but may include:*

- *Overall healthcare funding and the wider economic environment (both with regard to the Trust and its commissioners);*
- *Tariff changes;*
- *Quality incentives / penalties;*
- *Other contractual arrangements and challenges;*
- *Service reconfiguration;*
- *Demand management (e.g. practice based commissioning);*
- *Innovation and technology;*
- *Pay – national and local negotiations;*
- *Other changes in national or local policy or law;*
- *Competition, co-operation and patient choice;*
- *Demographic changes.*

Key external impact	Risk to the plan	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
Financial position of NHS Devon in the light of wider financial constraints.	Reduction in growth will reduce funding for the Trust.	Commitment to health-community demand management/system transformation work to reduce activity growth and therefore affordability of current activity levels; robust contract negotiations; focus on CIP delivery. Improved control of temporary staffing costs.	Reduction in commissioner affordability risk; continued contractual protection from commissioner deficit; reduced reliance on income growth.	<p>Delivery of activity and income in line with plan.</p> <p>Jointly agreed Care Redesign Schemes with NHS Devon, with strong clinical engagement</p> <p>Monthly contract monitoring; monthly Director of Finance risk management meetings; Chief Executive Devon-wide Transformation Board meetings re. demand management/system transformation.</p>

<p>Commissioning approach of NHS Devon in the light of wider NHS financial constraints.</p>	<p>Commissioner financial pressures may lead to commissioning minimal margins above national targets, in particular RTT, increasing the risk of target failure.</p>	<p>Robust contract negotiations; analysis and learning from target breaches at patient-level; improved information system support.</p>	<p>Create margin to assure target delivery; reduce risk of breaches without additional activity.</p>	<p>Maintenance of current performance levels for all key targets. Improved chronology and waiting time profiles for all specialties where benchmarks suggest profiles could be improved.</p> <p>Monthly contract monitoring; monthly Director of Finance risk management meetings; Chief Executive Devon-wide Transformation Board meetings re. demand management/system transformation.</p>
<p>Tariffs to be a maximum price from 2011/12.</p>	<p>Commissioner may seek to impose reduced prices to reduce commissioner deficit and increase financial risk to Trust.</p>	<p>Robust contract negotiations; joint work with other local providers re. tariff negotiations; implement new contracting system to improve transparency of activity and income and improve commissioner confidence.</p>	<p>Short term protection from tariff reductions; longer term position difficult to assess until guidance issued.</p>	<p>Maintenance of current financial contribution for all key services.</p> <p>Monthly contract monitoring; monthly Director of Finance risk management meetings; Chief Executive Devon-wide Transformation Board meetings re. demand management/system transformation.</p>

Possible Commissioner attempts to set CQUIN targets and criteria to limit commissioner CQUIN costs.	Failure to earn high % of CQUIN funding.	Plan is not reliant on CQUIN funding; CQUIN schemes designed to minimise cost of delivery of CQUIN targets; robust negotiations.	Additional funding above current plan requirements.	Robust monitoring and management of CQUIN schemes.  Monthly Clinical Quality Review meetings with Medical Director and Director of Nursing.
Commissioner has given notice on 2009/10 Standard Acute Contract, so new Standard Contract to be adopted from 2011/12.	Increased risk of financial penalties.	Internal performance management as if new penalties already apply in preparation for new contract; robust contract negotiations.	No risk in 2010/11; risk for 2011/12 and 2012/13 to be minimised.	Contract negotiations re. Commissioner discretion. Quarterly performance review meetings for each Directorate with Executive Team.



Key external impact	Risk to the plan	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
Future of local community services.	Local service instability; risks of acquisition of unmodernised services; risks of competitor entry into local market.	Board review of strategy; close work with NHS Devon re. options for provision, pathway by pathway.	Avoidance of acquisition on unfavourable terms or with excessive risk.	Ongoing Board discussions.

<p>Commissioner demand management plans (local referral management centre established from Q1 2010/11), and introduction of marginal emergency tariff in 2010/11.</p>	<p>Financial plan already assumes reduction in activity. Risk of failure of new service to contain demand and therefore increase commissioner deficit, and risk of failure of Care Redesign Plans to support restricted growth in emergency activity.</p>	<p>Health community meetings to review effectiveness of service, and impact of Care Redesign Schemes</p>	<p>To deliver the activity predictions in the financial plan; or for additional activity to be funded.</p>	<p>Reduction in rate of growth in demand.  Chief Executive Devon-wide Transformation Board meetings re. demand management/system transformation.</p>
<p>Development of 'new town' within catchment and other increased housing locally.</p>	<p>Increased demand, not affordable to commissioner.</p>	<p>Joint review with NHS Devon of demographic forecasting and impact on NHS.</p>	<p>Gradual increase in demand to be offset by other demand management and system transformation initiatives.</p>	<p>Additional population-driven demand offset by demand management and pathway redesign schemes.  Chief Executive Devon-wide Transformation Board meetings re. demand management/system transformation.</p>

<p>Increased high cost drug expenditure. Commissioner increasing challenges for provider to demonstrate use within guidelines.</p>	<p>Costs not offset by income.</p>	<p>Review of processes in pharmacy to ensure compliance with pharmaceutical industry patient access schemes and compliance with NICE.</p>	<p>Costs to be covered by income.</p>	<p>100% reimbursement under pharmaceutical industry patient access schemes.</p> <p>Quarterly review meetings with NHS Devon re. compliance, with Associate Director of Planning and Performance.</p>
<p>Wider political context, with associated uncertainty as to likely financial settlement for NHS</p>	<p>Uncertainty as to financial settlement for NHS arising from Government elected in May 2010, and associated impact upon both income (through changes to payment by results regime) and expenditure (through changes to national pay arrangements, terms &amp; conditions).</p>	<p>Review of assumptions underpinning financial model in May 2010, with further review scheduled in September 2010</p> <p>Close management of expenditure (including capital expenditure), and delivery of efficiencies, to agreed plan</p> <p>Risk of possible impact of tighter terms and conditions in national pay contracts upon local staff retention</p>	<p>Reflected within financial plan in respect of growth, income and expenditure</p>	<p>Management of financial position in line with (or better than) plan.</p>

### **Template 3: Clinical quality**

*Guidance: A key strategic focus of the Trust's plan is to describe its main clinical quality priorities for the three years of the plan, key actions required to deliver these, the risk of delivery and how the Board will measure progress for each and gain appropriate assurance in a reliable and consistent manner.*

*These clinical quality priorities should be consistent with those disclosed in the quality accounts within the Trust's published report and accounts. It is important that the key clinical quality objectives reflect not only the Trust's own strategic focus but also those of its commissioners, patients and service users*

Clinical quality priorities	Contribution to the overall vision	Key actions and delivery risk	Performance in 2009/10	3 year targets / measures 2010/11 2011/12 2012/13
Malnutrition Universal Screening Tool (MUST)	Objectives 1c, 2a, 3a. Nutritional screening is a very important element in delivering a high standard of care and has been identified by our members as a priority area. Poor nutritional status can result in increased risk of clinical complications, poor wound healing, increased dependency of patients on clinical care, delayed recovery, increased hospital stay and increased risk of mortality. It therefore makes significant contributions to quality and efficiency.	Compliance with MUST scoring is currently monitored via ward reports and via the Nursing Quality Assessment Tool (NQAT) survey. This will be part of the proposed ward level quality monitoring and NQAT is included within CQUIN. There are no identified risks to delivery.	MUST screening compliance is recorded on the ward whiteboard reporting system. For 2009/10 the compliance for initial screening on admission was 64% and 68% for overall compliance with weekly screening. This is based on total patient throughput over this period and number of patients screened.	2010/11 target increase of 5% 2011/12 target increase of 5% 2012/13 target of 80% reached. For a number of patients the completion of MUST may not be appropriate (e.g. those on the Liverpool Care Pathway or with chronic debilitating conditions) and in these cases use of the MUST can be distressing.

Tissue Viability	Objectives 1c, 2a, 3a. As above, pressure sore prevention makes significant contributions to quality and efficiency (staff time and length of stay).	The Tissue Viability incidence data is recorded monthly on the electronic ward reporting system. The results are shared at Divisional level and Board level monthly. In 2010, compliance scores will also be reported at Directorate Quarterly Reviews with an action plan to address poor performance. This will be part of the proposed ward level quality monitoring and has been included within CQUIN. There are no identified risks to delivery.	Inpatient/hospital care: In March 2010, monitoring compliance is below the Trust's internal target threshold of 90% at 86.6%. Incidence of grade 2 and above pressure sores is 0.96% which is above the Trust's own target threshold of 0.8%.	Monitoring compliance: 2010/11 reach the 90% monitoring threshold. 2011/12 reach target of 92% 2012/13 reach target of 95%. Pressure sore incidence: 2010/11 incidence at 0.8%. Targets for 2011/12 and 2012/13 to be set during 2010/11.
Medicines Management Discharge information	Objectives 1c, 1d, 2a. This priority was identified in response to the national CQC inpatient survey. It is part of delivering a high standard of care and being the provider of choice.	A patient drugs card is being introduced that will be issued with discharge medications. This scheme has been included within CQUIN. There are no identified risks to delivery.	National patient experience survey results for 2009/10 show 44% "NO" responses for Question G64.	Question G64 "no" responses will be reduced: 2010/11 target of 42% 2011/12 target of 40% 2012/13 target of 38%  Our aspiration in terms of medications information is more ambitious than these percentages indicate, but as we are using the inpatient survey as the measure, we need to set targets that are realistic in the context of that source of information.

<p>Score for patients who thought that the hospital staff did everything they could to help control their pain.</p>	<p>Objectives 1c, 2a, 3a. This priority was identified in response to the national CQC inpatient survey. It is part of delivering a high standard of care and being the provider of choice.</p>	<p>An internal acute pain survey is being undertaken to identify how pain management could be improved. There are no risks currently identified.</p>	<p>The 2009 survey showed the following results: E47, 66% of patients reported that they had been in pain. Whilst in E48, 77% of patients reported that staff had done all they could to control the pain, 19% felt this was only to some extent. The results suggest a number of patient experienced pain.</p>	<p>Question E47 results improve: 2010/11 64% 2011/12 62% 2012/13 60%</p> <p>Our aspiration in terms of pain control is more ambitious than these percentages indicate, but as we are using the inpatient survey as the measure, we need to set targets that are realistic in the context of that source of information.</p>



<b>Clinical quality priorities</b>	<b>Contribution to the overall vision</b>	<b>Key actions and delivery risk</b>	<b>Performance in 2009/10</b>	<b>3 year targets / measures 2010/11 2011/12 2012/13</b>



#### **Template 4: Service development strategy**

*[Guidance: the main service development priorities in the plan should be described in enough detail so as to provide evidence as to the contribution they are expected to make to the plan, the actions necessary to implement them, key risks, resourcing requirements (financial and human capital), and measures by which the delivery of the service development will be tracked and assessed.*

*Each of these priorities should be categorised under one of three headings: (1) organic or innovation (i.e. delivered internally by the Trust or through co-operation); (2) acquisition, merger, investment, tender etc (i.e. through some form of corporate action or activity external to the Trust); or (3) by transferring out / discontinuing an activity (in agreement with commissioners).*

*Where relevant details are included within the input sheets from which the financial forecasts are derived, then reference to those service development plans should be made in the template above.*

Service development priorities	Contribution to the overall vision	Key actions and delivery risk	Key resource requirements	Measures of progress 2010/11 2011/12 2012/13
<b>Organic / innovation:</b>				
<p>Medical outliers - to remove the need for medical outliers by reducing emergency admissions, increasing use of day case procedures at community hospitals, reducing length of stay and reducing delayed discharges.</p>	<p>Objectives 1a, 1b, 1c, 2a, 2b, 2c, 3a, 3d, and as emphasised by the Trust's Members and Governors. Ensuring that patients are cared for in the most appropriate clinical environment and that their length of stay is optimised.</p>	<p>Key actions:            To set up Trust wide preparation for surgery.            To work with NHS Devon to ensure patients are fit for referral.            To improve the discharge process with NHS Devon and Devon County Council.            To increase day case activity at RDE and community hospitals.            To roll out enhanced recovery.            To set up early supported discharge for patients who have had a stroke.</p> <p>Key risks:            Increase in emergency admissions            Lack of resources within primary and social care to enable patients to be cared for outside of hospital</p>	<p>Focused clinical and managerial leadership.</p>	<p>2010/11 To ensure a significant reduction in medical outliers, increased utilisation of community hospitals to undertake day case procedures, reduced length of stay.</p> <p>2011/12 To ensure no medical outliers.</p>

<p>Strategic Redesign Programme - the Trust has set up a programme to pull together all Trust wide service developments and cash releasing savings schemes, in line with national and local QIPP programmes, to ensure process change delivers high quality care and improved productivity</p>	<p>Objectives 2b, 3c, 3d.</p>	<p>Key actions:          Agree Programme Management Structure.          Set up Programme Office (incorporating a dedicated Programme Director, Project Manager / Administrator, Management Accountant, HR Manager and Information Analyst).          Agree projects.          Identify and implement redesign opportunities.</p> <p>Key risks:          Lack of management time to ensure timely implementation.</p>	<p>Invest to save funding will be made available to services through a structured application process.</p> <p>Staff time to focus on service redesign.</p>	<p>2010/11 - £18.3 million savings realised</p> <p>2011/12 - £22.9 million savings realised.</p>
<b>Acquisition etc:</b>				
<p>Transforming Community Services</p> <p>The Trust will be considering its position in relation to the potential opportunity for integration of some services currently managed by the PCT's provider arm.</p>	<p>Objectives 1a, 1d, 2b, 3a, 3d.</p>	<p>NHS Devon is at the assessment stage currently.</p> <p>Key risks - sufficient capacity to manage a wider range of services over a broad geographical location; potential inefficiency of acquired services.</p>	<p>Board of Directors leadership</p> <p>Management and other resources to support increased scope of services and identification of associated risks.</p>	<p>2010/11 Work with NHS Devon to agree strategy to devolving Devon Provider Services</p>

<p>Community theatre services - NHS Devon transferred all surgical activity carried out in its four community hospital theatres and two endoscopy units, and the theatre and medical staff supporting this work to the RD&amp;E.</p> <p>Community maternity services - NHS Devon had transferred their community midwifery services which enable the RD&amp;E to provide the total pathway of maternity care and we will have a unified approach to governance and workforce development.</p>	<p>Objectives 1a, 1d, 2b, 3a, 3d.</p>	<p>Increase the use of community theatres. The risks to delivering this are a reduction in appropriate day case procedures to be carried out in community settings, and any closure of a community hospital by the PCT who retain ownership of the building.</p> <p>Developing a new model of care for the whole community area, which will improve choice for women. Key risks - governance and workforce; ability to make service changes.</p>	<p>Additional management support has been put in place during 2010/11 to ensure smooth transfer and increase in utilisation.</p> <p>Focused management time.</p>	<p>Increase in utilisation of community theatres and proportion of day cases carried out in the community.</p> <p>Maintain or increase number of birth centre deliveries.</p>
<b><i>Transferred / discontinued activity:</i></b>				
<p>Review Honeylands specialist child development centre and respite facility for children with complex conditions including learning disability, special needs, and challenging behaviour.</p>		<p>Respond to NHS Devon strategic review.</p>	<p>Focused management time. Clinical leadership. Inter-organisational cooperation.</p>	

## **Template 5: Workforce strategy**

*Guidance: the main workforce focused priorities envisaged in the plan should be described, the actions necessary to implement them, key risks to implementation, resourcing requirements (financial and human capital), and measures by which the delivery of the planned changes in workforce size, mix or configuration will be tracked.*

*When considering the main workforce priorities, the following may be included:*

- *Changes in headcount (including benchmark evidence), mix or flexibility (i.e. mix of agency, bank, permanent);*
- *Key recruitment, training, retention and development initiatives;*
- *Redundancy and natural wastage programmes;*
- *Pay, rewards and other key remuneration initiatives or workstreams;*
- *Other workforce issues which may impact the plan.*

*We will publish plans in full except where the Trust indicates that it wishes to exclude specific limited information for publication purposes. For instance, where there are workforce related activities which include commercial or confidential matters which the Trust may not at this stage wish to be published in full, the Trust should indicate this clearly on its plan submission.*

*Where proposed workforce changes may risk impacting service provision or clinical quality, this potential risk should be recognised explicitly in the plan together with the specific actions proposed to mitigate it.*

Key workforce priorities	Contribution to the plan	Key actions and delivery risk	Key resource requirements	Measures of progress 2010/11 2011/12 2012/13
Promote Job and Service Redesign - underpinning systems	Objectives 3a, 3b, 4d. Priorities for key service redesign programmes with workforce implications agreed as part of the Strategic Redesign/CIP programme, in order to match the workforce need to resource availability. Support continued sustainability of Working Time Directive (WTD).	Workforce constraints/opportunities integrated with strategic redesign process and built into the workforce/finance/service strategy and operational plans. Whole systems redesign integrating EWTD projects with admin review. New/extended roles and processes for EWTD sustainability are adequately planned and resources including education and training lead time. Potential risks to plan at Directorate level from national lack of medical staff and implications for service quality. Ensure 48 hrs Aug 2010 for all staff including those under current opt-out clauses.	Systems to accurately track whole system workforce changes due to redesign and TUPE of staff from other organisations as part of service redesign and rationalisation. Staff group mix of medical staff as a proportion of all staff to be reviewed also cost per WTE. Advanced Practitioner development and educational lead time and commissioning appropriate advanced practitioner courses. New roles including Assistant Practitioner development and lead time with educational infrastructure supported by central fund for lead time. New processes and review of Hospital at Night and day.	Current benchmarking shows skill mix by A4C Bands compares favourable with South West Acute trusts. 2010/11: cost effective processes and skill mix in place supported by SLR information. Greater control on the management of medical rotas.

<p>Appraisal Policy development and implementation</p>	<p>Objectives 3a, 3b. Robust appraisal and performance management linked to Knowledge &amp; Skills Framework and recorded by ESR for compliance reports. Productivity improvements through increased engagement, clear objectives and performance management.</p>	<p>Simplify processes to increase appraisal activity and impact on staff involvement. New policy and process agreed and implemented. Reviewed through quarterly review process and supported by quality assurance spot checks.</p>	<p>Continued implementation of PDR on an annual basis. Ongoing training for reviewers. Review mode of delivery.</p>	<p>2010/11 Documentation improved and new handbook issued re streamlined approach using evidence templates. Quarterly PDR review for all Directorates.</p> <p>2011/12 Continue to maintain high standards.</p>
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<p>Staff Involvement, partnership working and good employee relations</p>	<p>Objectives 3a, 3b, 4d. Increase the level and quality of staff involvement to increase innovation and determine priorities for the next three years including Trust wide Strategic Redesign programme.</p>	<p>Implement best practice models of engagement through Trust staff engagement strategy with NHS Constitution staff pledges integrated into all work streams. Ringfence resources/staff time to progress and routinely review key performance indicators through temperature checks, use of action plans and staff conversation programme. Set up Listening into Action and staff survey action plans. Risk to implementation if finance/service pressures restrict time for staff release. Introduction of "staff conversations" as part of engagement programme.</p>	<p>Staff release time for Staff Conversations - Expand staff representatives and engagement champions. Multi-disciplinary matrix team, HR, Communications and Strategic re-design to progress programme and ensure Strategic Redesign/ Fit for Future is integrated as part of programme.</p>	<p>2010/11 Staff Engagement Strategy implemented and programme agreed. Staff involvement policy implemented. Staff suggestions implementation plan. Measurable improvements in all CQC staff satisfaction measures supported by year on year action plans across the trust by June 2010.</p> <p>2011/12 Continued improvements in Staff engagement and satisfaction scores including turnover and sickness. Individual targets for future years for all elements of the workforce strategy will be developed in an integrated process with service and finance. These will need to be set in conjunction with both the Strategic Redesign Programme and the implications resulting from the QIPP / Devon Health Economy Transformation Programme as these are further developed during 2010.</p>
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<p>Championing good people practices</p>	<p>Objectives 3a, 3b. Reinforce the Trust's commitment to demonstrating Equality and promoting Diversity and inclusion. Review employment practices, terms &amp; conditions and a sustainable reward strategy. Improve the working environment for all.</p>	<p>Updated Single Equality Scheme implementation plan agreed and put in place with measurable milestones. Continue to develop robust infrastructure and networks within and external to Trust. HR Benchmark competitive practices, skill mix, cost per wte, sickness and overtime. Review job profiles and bandings in difficult to recruit areas and develop action plans. Develop reward strategy, benchmarking competitive practice with local employers.</p>	<p>Continued specialist resource of E&amp;D Manager to progress agenda. Re-prioritising resources to be required from HR to progress: * Retention initiatives * Redeployment * Workforce data</p>	<p>2010 Single equality scheme reviewed and action implemented. Best practice implemented through position as NHS Employers Equality Partner. High performing organisation supported by the best HR information and performance benchmarks. Benchmark audit of HR costs and performance continues to show Value for Money (CIPFA).  2011/12 Achieve significant progress in E&amp;D measures for staff and patients by March 2012. Achieve measurable improvement in meeting the Trust's ambition to be Employer of Choice through its reputation and focused recruitment, retention and recognition strategy by March 2012.</p>
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<p>Effective training and development</p>	<p>Objectives 3a, 3b. Service led Training Needs Analysis driving training provision.</p>	<p>Learning &amp; development opportunities are fully integrated with service and workforce including skill mix change. LDS VFM Review implemented. Core modules for meeting the internal needs of diploma staff to move to degree and support of newly qualified staff through preceptorship programme. Career pathways identified and implemented to non-registered clinical roles. Implement Essential learning Policy in collaboration with Directorate Governance leads. Core management skill in financial/commercial awareness and SLR principles including service redesign, organisational change &amp; leadership for Managers and Lead Clinicians.</p>	<p>Capacity required to ensure training provision is available to meet Trusts need for maintaining required competencies. The move to an all degree nurse profession will pose risks in the future supply of registered nurse, the development of existing diploma nurses and development of Assistant practitioner roles. E-platform provision required for essential training. Need for effective Trust wide IT strategy/infrastructure. Monitoring that all staff are aware of and have the skill to demonstrate competence in clinical and H&amp;S activities.</p>	<p>2010/11 All staff receive essential training and annual appraisal by Dec 2010. Infrastructure and systems in place to develop required Advanced and Assistant practitioners. LDS Review completed and implemented.</p>
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Key workforce priorities	Contribution to the plan	Key actions and delivery risk	Key resource requirements	Measures of progress 2010/11 2011/12 2012/13
Support and Lead Effective Change Management to increase organisational capability in driving service transformation.	Objectives 3a, 3b. Talent, leadership and succession management strategy continued development. Top Leaders programme, delivery of talent management and succession planning for managers. Workforce development Strategy including workforce plan integrated with Service and Financial Strategy. Plan programme for the development of new ways of working and impact of new roles on service redesign and productivity.	Leadership programme for clinical & non-clinical leaders that equips managers to deliver on key Trust objectives, including SLR awareness/skills. Workforce plan to include demand & supply scenarios linked to Trust capacity plan, financial challenges and changes in services. Ratify and implement development of Advanced Practitioner framework. PWC recommendations on integrated workforce planning implemented and further developed. Respond to HR implications relating to current advanced practitioners e.g. banding, title, education. Respond to staffing implications of service acquisitions and transfers. Potential risks to operational and financial effectiveness programmes if key personnel are lost.	Resources required for internal workforce implications of Trust Strategic Redesign programme and the Devon transformation work streams. Joint modelling (finance/HR) of workforce to develop a balanced consolidated plan. New and extended roles (including Advanced and Assistant Practitioner level) may be at risk if Directorates are not sufficiently focussed on reaching agreed targets aligned to skill mix scenarios.	2010/11 Talent management and succession planning implemented at all clinical and management levels by March 2011. Consolidated workforce plan detailing changes in service provision and likely CIP implications to be achieved by March 2011, 2012, 2013 as a result of changing Healthcare provision, Policy and Finance including Devon Transformation agenda.  2011/12 Continued skill mix shift from 60/40 to 50/50. Minimum move of 100 wte to Assistant practitioner.  2012/13 Continue to review financial position and implications of national policy.

<p>Effective recruitment, good induction and supportive management.</p>	<p>Objectives 3a, 3b. Attract the best candidates and build on reputation as a "Great place to Work". Promotion of positive work / life balance</p>	<p>Develop the RD&amp;E brand image by supporting, developing and valuing our staff. Marketing of generic and unique staff benefits including Apprenticeships, Internships &amp; Preceptorship.          Improve retention through recruitment, selection and induction processes and detailed work on reasons for leaving.          Streamline and automate all systems and processes.          Management training for new processes.          Governance arrangements re fit to practice, CRB, professional registration, pre -employment checks etc.          Introduction of staff conversations as part of wider staff engagement programme.</p>	<p>Action plan recruitment team.          Staff passport.          Staff benefits scheme.          CRB/ISA costs.</p>	<p>2010/11          Improvement in turnover rates, particularly those for staff with less than 12 months service. Individual targets for future years for all elements of the workforce strategy will be developed in an integrated process with service and finance. These will need to be set in conjunction with both the strategic redesign programme and the implications resulting from the QIPP / Devon Health Economy Transformation Programme as these are further developed during 2010.           Management training implemented for key policies and procedures.          ISA regulations implemented.          Compliance rates for CRB maintained at over 90%.          Responses to staff survey</p>
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<p>Promoting staff health and managing sickness absence</p>	<p>Objectives 3a, 3b, 4d. Reduce sickness absence. Promotion of positive work / life balance for staff. Refocus attention on health at work including stress management informed by Health &amp; Safety Committee and Wellbeing group to achieve:  * Efficiency &amp; productivity gains  * Enhance staff involvement &amp; engagement  * Reduce spend on absence  Continue programmes around managing violence and aggression in the workplace e.g. conflict resolution.</p>	<p>Implement best practice in sickness absence management. Monitor position and trends at Directorate and staff group level.  Action plan for Boorman recommendations, implementation monitored through quarterly reviews and sickness management group.  Develop programmes to promote early intervention and self management of personal well being at work.  Support arrangements for corrective action at individual and departmental levels following incidents and risk assessment, reviewing peak times and links to 24/7 security.  Review sickness absence policy.</p>	<p>New Sickness, Bullying and Harassment, and Stress policies implemented.  Sickness management training.  HR Resources to develop and support processes.  Health &amp; Wellbeing action plan.  Occupational health offer and move to prevention.</p>	<p>2010/11  Reduce sickness to 3% by March 2011.  All long term sickness cases being actively managed.  Process in place to manage medium term cases reducing the number moving into long term category.  New process implemented for early rehabilitation of staff back into the workforce.  Implementation of Apprenticeship and internship schemes.   Individual targets for future years for all elements of the workforce strategy will be developed in an integrated process with service and finance. These will need to be set in conjunction with both the Strategic Redesign Programme and the implications resulting from the QIPP / Devon Health Economy Transformation programme as these are further developed during 2010.</p>
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<p>Develop shared service models and effective use of IT</p>	<p>Objectives 3a, 3b. Restructure HR function to maximise effectiveness. Review back office functions. Continue to realise benefits through A4C and consultant contracts. Review internal and Devon transformation progress to date and agree strategy for further development with timescales.</p>	<p>Review HR structure annually to keep it responsive to delivery of key strategic objectives. Integrate Payroll/HR systems- key risk is lack of systems integration at the ESR/Finance interface. Further enhance modern flexible approaches to recruitment, employment and deployment through use of ESR, Rosterpro, identifying efficiencies and CIP opportunities (need for IMT as strategic enabler). Develop ESR module for learning and development function. Further develop routine intelligence, diagnostic trend analysis and Workforce dashboards.</p>	<p>Resources required for HR projects and back office review through Devon transformation Project. Complete rollout of ESR/Rosterpro - possible additional support on training and user query management. Monitoring Doctors hours and sickness. Legal advice review.</p>	<p>2010/11 ESR rollout completed for managers self service. New sickness reporting process onto ESR completed. Essential training recording in ESR embedded. Rosterpro roll out for all nursing staff embedded and KPIs implemented. New process in place to monitor medical staff hours and sickness.</p>
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<p>Managing temporary staffing costs as a major source of efficiency.</p>	<p>Objectives 3a, 3b, 4d. Analysis of medical locum costs in line with WTD and establish monitoring schemes. Ensure efficient processes for recruitment, deployment, development of bank staff. Monitor and investigate agency staff utilisation putting in place best practice in agency usage.</p>	<p>EWTD Steering Group to progress medical staffing changes and alternative roles to reduce locum costs. Agency and bank staff utilisation for all staff groups in place with appropriate procurement processes. Clinical lead support and ownership for change processes.</p>	<p>Use of existing internal resources</p>	<p>2010/11  New processes embedded regarding shift of tasks to payroll with clear process for junior doctors with interface to Deanary in place.  New Occupational health interface implemented.  Bank staff processes reviewed Trust wide with recommendations implemented.  New agency processes implemented Trust wide.</p>
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## **Template 6: Capital programmes (including estates strategy)**

*[Guidance: the main capital expenditure priorities in the plan should be documented, together with amounts, timing and linkages to the delivery of the plan. In addition, key actions and delivery risk underpinning each should be identified. Each of the capital expenditure priorities should be shown under the following main headings:*

- Development – this includes building of new capacity (through whatever funding source) or significant reconfiguration or upgrade of existing facilities.*
- Maintenance or replacement capex – this includes planned or urgent maintenance capital expenditure or expenditure to replace existing facilities.*
- Other capital expenditure – this includes purchases of equipment, technology, intellectual property and significant IT expenditure etc*
- Other estates strategy – this includes net proceeds or expenditure on estates reorganisation or other estates strategy to either use the existing estate more efficiently or to release proceeds from surplus or unused assets.*

*Where delays either in proposed capital investment programmes (including maintenance, equipment, refurbishment or new builds) or in the delivery of an estates strategy may risk impacting service provision or clinical quality, this potential risk should be recognised explicitly in the plan together with the specific actions proposed to mitigate it.*

*Where relevant details are included within the input sheets from which the financial forecasts are derived, then reference to those capital expenditure plans should be made in the template above.]*

Key capital expenditure priorities	Amounts and timing	Contribution to the plan (including service delivery)	Key actions and delivery risk
<b>Development:</b>			
New Pharmacy CIVAS Unit	SOC approved, OBC being finalised for scheme value circa £7.6 million. FBC during summer 2010 for scheme delivery 2010/11 and 2011/12.	Objectives 2b, 2c, 3c.	Finalising the business case, scheme design and detailed costs. Risks to delivery include complexity of design, need to gain pharmacy licensing approvals and planning permission. These are being mitigated by early discussions with licensing authority, appointment of specialist designers (recommended by licensing authority), review of modular building with offsite fabrication of specialised elements.
Extension to Exeter Oncology Centre, Third Linear Accelerator and new CT Simulator suite.	OBC approved, FBC being finalised for scheme value circa £4 million. Scheme delivery 2010/11 and 2011/12.	Objectives 1a, 2a, 2b, 2c, 3c.	Finalising the full business case, scheme design and detailed costs. Risks to delivery include complexity of building services and need for phasing works to enable continuity of oncology services. These are being mitigated by early involvement of construction partners at pre-construction stage.
Conversion of disused ward to Pain Management and Physiotherapy at Heavitree Hospital.	FBC approved circa £2.69 million, ongoing scheme in 2010/11.	Objectives 1a, 2a, 2b, 3c.	Ongoing scheme project management. Risks to delivery around ensuring continuity of service provision from floors above this scheme are mitigated by work stage planning and regular communications.
New Satellite Renal Unit in South Devon	FBC approved circa £1.5 million, ongoing scheme for completion summer 2010.	Objectives 1a, 2a, 2c, 3c.	Commissioning and hand-over of specialised fit-out scheme in 3rd party developer building. Finalisation of lease agreement. Key risk is slippage of programme which is being mitigated by project management.
<b>Maintenance:</b>			

Refurbishment programme of Nucleus templates including reconfigure ward templates to create more single rooms	Rolling programme commencing in 2011/12 and eventually rising to circa £2 million per annum.	Objectives 1c, 2a, 2b, 2c.	Bed capacity planning, preparation of business case. Coordination with strategy for increasing single rooms and other template reconfiguration schemes. Key risk is not being able to obtain vacant possession of wards which will be mitigated by developing estate strategy for decant ward facilities.
Refurbishment programme of accommodation blocks and relocate Occupational Health Service.	Circa £0.5 million per annum commencing in 2011/12.	Objectives 3a, 3b.	Accommodation strategy being produced to inform estate strategy for residential village.
Energy Centre - replace refrigeration plant.	Circa £0.5 million in 2010/11.	Objectives 1d, 3d.	Timing of sequence of works outside the main cooling season.
<b>Other capital expenditure:</b>			
Electronic document management IT system	OBC approved for circa £6.9 million, scheme delivery between 2012/13 and 2013/14 with circa £4.5 million expenditure to 2012/13.	Objectives 3a, 3c, 3d.	OJEU procurement and FBC. Risks associated with organisational changes and HR issues, mitigated by project planning.
Replacement PAS.	OBC approved for circa £1.25 million, scheme delivery in 2012/13.	Objectives 3a, 3c, 3d.	Preparation in 2010/11 for procurement and FBC in 2011/12. Risks to operational continuity mitigated by project planning.
Order comms and e-prescribing IT systems.	OBC approved for scheme delivery in 2010/11, circa £1.15 million.	Objectives 3a, 3c, 3d.	FBC and contract award summer 2010. Risks to operational continuity mitigated by project planning.
<b>Other estates strategy:</b>			

Estate rationalisation - disposal of part of Heavitree Hospital site.	Completion of first sale contract in 2010/11 with circa £5.4 million capital receipt. Completion of second sale contract anticipated in 2012/13 with circa £0.5 million capital receipt.	Objective 3d.	Sale contracts were exchanged in December 2009. Trust enabling works for vacant possession of site one (former maternity unit) are in progress. Relocation of the Occupational Health service required to gain vacant possession of site two. Risks associated with planning as sale contracts are subject to the purchaser obtaining satisfactory planning permission for a retail food store; and if not able to provide vacant possession of site two. Planning decision expected in July 2010. Short term lease back of up to 3 year term negotiated for site two.
Provision of new ward for decant facilities.	Low capital cost solution of circa £0.75 million in 2011/12.	Objectives 1b, 2b, 2c.	Scheme content subject to feasibility study and bed capacity planning. Identification and appraisal of options.
Provision of orthopaedic theatre 6. Phase 2 remodelling of Durbin Ward.	Phase of Durbin ward improvements in 2011/12 circa £0.6 million. Theatre 6 scheme delivery of circa £2.75 million in 2012/13 of £3 million in total.	Objectives 1b, 2b, 2c.	Feasibility study to develop business case for reconfiguration of existing ward for new theatre suite. Remodelling ward required for vacant possession.



Key capital expenditure priorities	Amounts and timing	Contribution to the plan (including service delivery)	Key actions and delivery risk
<b>Development:</b>			
Research, Innovation and Learning Development.	Provisionally in the Capital Plan at SOC stage for scheme delivery in 2011/12 to 2012/13. In partnership with University of Exeter, the Trust's contribution will be £5.6 million.	Objectives 3a, 3b, 3c.	Finalising the business case. Sources of funding for the research element of the proposed development are from the University partner and their capital funding application to the Wellcome Wolfson Trust. The university will know in June if the funding application is successful.
Preparation for surgery.	SOC for scheme value circa £1 million in 2010/11.	Objectives 1a, 1c, 2a, 3a, 3d.	Developing business case for change of use and reconfiguration of part templates K1 and J0. Enabling works involving relocation of existing fracture clinic to JO template adjacent to Fracture Clinic.
Reconfigure and upgrade Bramble paediatric accommodation.	Circa £1 million in 2012/13.	Objectives 1a, 2b, 2c.	Feasibility study to develop business case. Coordination with other template reconfiguration schemes.
<b>Maintenance:</b>			

Refurbishment of Oasis part template.	Circa £1 million with scheme delivery commencing with circa £0.25 million in 2012/13.	Objectives 3a, 3b.	Feasibility study to develop business case. Coordination with programme of refurbishing ward templates. Project plan to mitigate risks of disrupting catering services.
Medical imaging - replacement CT scanners (2 No), MRI's (2No) and x-ray equipment.	Circa £3.2 million in 2012/13.	Objectives 1a, 2a, 2b, 3c.	Business case, OJEU procurement. Risks of services continuity mitigated by project planning.
<b>Other capital expenditure:</b>			
<b>Other estates strategy:</b>			

Relocation of fracture clinic and rationalisation of PEOC and J0 templates for orthopaedic outpatients and associated services including radiology.	Outline plan for circa £5 million with scheme delivery in 2011/12 and 2012/13	Objectives 1b, 2b, 2c.	Feasibility study for SOC and development of OBC in 2010/11. Procurement and FBC for scheme delivery commencing in 2011/12. Risks of coordination with other template reconfiguration schemes, clinical adjacencies and service strategy issues, will be mitigated by early involvement of construction partners.
Estate reorganisation - Honeylands.	Potential for future site rationalisation in 2011/12 subject to outcome of specialist children's services review.	Objective 3d.	Site development control plan and review of site options.
Expansion of satellite dialysis services in North Devon and provision of central water processing plant.	Circa £1 million in 2011/12.	Objectives 1a, 2a, 2c, 3c.	Development of business case subject to service strategy.

### **Template 7: Operational / financial effectiveness**

*Guidance: any other significant productivity / efficiency priorities in the plan should be set out, together with amounts, timing and linkages to the delivery of the plan. In addition, the key actions and potential delivery risks, any resource requirements (capital and human) and key milestones underpinning these should be identified. Clearly, in some instances there will be overlap with other priorities included in other templates (e.g. workforce strategy, capital expenditure and service development strategy) and where this is the case these should be referenced in the template. The key focus of this template will be to bring together any other operational efficiency priorities not already identified elsewhere (e.g. procurement, other non-front line services, development and realisation of specific commercial opportunities, improvements in financing or other costs etc.*

*Where relevant details related to CIPs are included within the input sheets from which the financial forecasts are derived, then reference to those CIPs should be made in the template above.*

Key operating efficiency programmes	Amounts and timing	Contribution to the plan	Key actions and delivery risk	Resource requirements	Milestones 2010/11 2011/12 2012/13
Review of A4C on call arrangements and payments	2010/2011 - £195k  Recurringly - £390k	Objectives 3b, 3d.	Key actions: Review on call arrangements, implement change to obtain consistency and value for money. Creation of Redesign Board (already in place) to oversee all efficiency programmes with invest to save fund of £500k available.  Delivery risk: Complexity of negotiation may delay implementation.	Management and Human Resources support.	Achievement of savings in line with plan.
Administration Services Review	2010/2011 - £344k  Recurringly - £687k	Objectives 3a, 3b, 3d.	Key actions: Review role design, streamline processes, implement technological solutions. Creation of Redesign Board (already in place) to oversee all efficiency programmes with invest to save fund of £500k available.  Delivery risk: Scope of review requires widespread involvement and commitment.	Project manager. Funding for IM&T developments. External consultancy support.	Achievement of savings in line with plan.

Other workforce and human resources projects	2010/2011 - £234k  Recurringly - £318k	Objectives 3a, 3b, 3d.	Key actions: Reduce agency and bank usage, review spend on learning and development. Creation of Redesign Board (already in place) to oversee all efficiency programmes with invest to save fund of £500k available.  Delivery risk: Scope of project requires widespread involvement and commitment.	Significant Human Resources support required for change management of affected staff groups – negotiation/consultation.	Reduced agency usage Reduced bank usage
Medical staff workforce review	2010/2011 - £345k  Recurringly - £420k	Objectives 3b, 3d.	Key actions: Workforce and payment structure review. Creation of Redesign Board (already in place) to oversee all efficiency programmes with invest to save fund of £500k available.  Delivery risk: Complexity of negotiation and need for individual job plan reviews may delay implementation.	Significant Human Resources support required for change management of affected staff groups – negotiation/consultation.	Achievement of savings in line with plan.

<p>Reduce occupied beddays</p>	<p>2010/2011 - £971k Recurringly - £1,166k</p>	<p>Objectives 1a, 1b, 1c, 2a, 3a, 3d.</p>	<p>Key actions: Reduce elective, emergency admissions and length of stay. Creation of Redesign Board (already in place) to oversee all efficiency programmes with invest to save fund of £500k available.</p> <p>Delivery risk: Demand management</p>	<p>Clinical and managerial input.</p>	<p>2010/11 To ensure a significant reduction in medical outliers.</p> <p>2011/12 To ensure no medical outliers.</p>
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Key operating efficiency programmes	Amounts and timing	Contribution to the plan	Key actions and delivery risk	Resource requirements	Milestones 2010/11 2011/12 2012/13
Increase productivity - outpatients, theatres, wards	2010/2011 - £320k  Recurringly - £870k	Objectives 1a, 1b, 1c, 2a, 3a, 3d.	Key actions: Review utilisation data and reporting, reduce DNA's, cancellations, increase utilisation. Creation of Redesign Board (already in place) to oversee all efficiency programmes with invest to save fund of £500k available.  Delivery risk: Scope of change across the Trust requires widespread involvement and commitment.	Strategic Redesign team established to implement this programme. Significant clinical and managerial commitment required across the Trust in parallel with ongoing service delivery, so strategic redesign team will provide resource to maximise benefits and reduce time required from other staff.	Reduction in DNAs. Increased theatre utilisation to 90%. Reduced cancellations by 10%.
Procurement	2010/2011 - £45k  Recurringly - £55k	Objective 3d.	Key actions: Identify areas for saving, purchasing alliance, maintenance contract improvement. Creation of Redesign Board (already in place) to oversee all efficiency programmes with invest to save fund of £500k available.  Delivery risk: Successful engagement regarding change	Significant Procurement Department support required to identify and implement opportunities for procurement savings.	Achievement of savings in line with plan.

Pharmacy expenditure review	2010/2011 - £375k  Recurringly - £1,500k	Objective 3d.	Key actions: Implementation of E-prescribing. Focused review of prescribing. Creation of Redesign Board (already in place) to oversee all efficiency programmes.  Delivery risk: Successful engagement regarding change.	Clinical and managerial input.	2011/12 - E-prescribing rolled out across the Trust.
Order comms - diagnostics	2010/2011 - £625k  Recurringly - £2,500k	Objectives 2a, 3a, 3d.	Key actions: Implement Order Comms. Review diagnostic test requesting. Creation of Redesign Board (already in place) to oversee all efficiency programmes with invest to save fund of £500k available.  Delivery risk: Successful engagement regarding change.	Clinical and managerial input and decision making.	2011/12 - Order Comms rolled out across the Trust.

<p>Other strategic redesign and directorate CIP projects</p>	<p>Identified schemes with agreed implementation plans: 2010/2011 - £6,698k (£7,021k recurrent)</p> <p>Identified schemes with implementation in 2010/11 with full year impact in 2011/12: £4,775k</p> <p>Schemes identified in outline: 2010/2011 - £3,333k</p> <p>Other schemes identified through strategic redesign process: 2011/2012 - £18,130k; 2012/2013 - £19,235k.</p>	<p>Objective 3d.</p>	<p>Key actions: A range of directorate, and trust-wide schemes are planned. Creation of Redesign Board (already in place) to oversee all efficiency programmes with invest to save fund of £500k available.</p> <p>Delivery risk: Ensuring key staff required to deliver change have time to focus on strategic redesign as well as normal operational and clinical activities.</p>	<p>Clinical and managerial input.</p>	<p>Achievement of savings in line with plan.</p>
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## **Template 8: Leadership and governance**

*Guidance: the leadership skills, and supporting governance processes and procedures, necessary to deliver the plan are a key focus and will develop and may fundamentally change as:*

- *Current contracts expire or key personnel leave;*
- *Current gaps are filled;*
- *Service development initiatives (either organic or external) are implemented;*
- *Workforce, efficiency or estates programmes are rolled out;*
- *Acquisitions, investments or mergers are considered and progressed;*
- *Specific and material financial or operational challenges grow or decline;*
- *External impacts change.*

*Planning leadership change, succession and development is core to ensuring that skills are in place to design and then deliver plans to mitigate risk and deliver the overall vision and strategy for the Trust. These should be supported by effective and functioning governance and assurance processes and procedures. Where there are shortfalls, gaps or specific risks then plans need to be in place and described to rectify them. Clear evaluation of current or future skills gaps and requirements going forward, leadership change and governance changes is important.*

*In the context of the current state of Board leadership and effectiveness, and the needs in the future to deliver the three year vision, the Trust Board should set out its priorities for leadership and governance development and evolution, consistent with the plan. This may in many cases entail external advice and periodic re-assessment to assist the Board to agree and then build its own effectiveness.*

Key leadership and governance priorities	Key risks (and gaps)	Actions to rectify / mitigate	Milestones 2010/11 2011/12 2012/13
<p>Board Development:</p> <p>Skills/capacities on scenario planning, specific issues related to the strategic review, and mergers and acquisitions. Common purpose/unitary approach to maintain and enhance Board effectiveness.</p> <p>Information &amp; knowledge – addressing knowledge/information gaps through a programme of seminars and talks</p>	<p>Maintaining strategic overview of a rapidly-changing external context.</p> <p>Maintaining strategic overview of key issues concerning co-operation and competition.</p> <p>Ensuring the Board provides unified leadership through a period of increased pressure due to resource constraint.</p>	<p>Clear programme of Board Development sessions.</p> <p>Timetabled Board workshop sessions to address issues as they arise and allow sufficient time for full discussion, including scenario planning and consideration of the range of possible implications</p>	<p>Scenario planning/cooperation and competition workshop – May 2010.</p> <p>Board effectiveness session – June 2010.</p> <p>Information / knowledge seminars – continual programme linked to Board meetings through 2010/11.</p> <p>Strategy Review - timetable in place with milestones up to publication in September 2010.</p>
<p>Support and Lead Effective Change Management to increase organisational capability in driving service transformation.</p> <p>Talent, leadership and succession management strategy continued development.</p> <p>Top Leaders programme, delivery of talent management and succession planning for managers.</p>	<p>Trust leadership programme for clinical and non-clinical leaders that equips managers to deliver on key Trust objectives, including SLR awareness/skills.</p> <p>Resource requirements for whole organisation roll out.</p>	<p>Retention/development of "High Potentials". Attrition/retirement in key skills/roles and key players.</p> <p>Resources identified for the Devon transformation work streams plus internal workforce implication of Strategic Re-design programme.</p>	<p>2010/11 Talent management and succession planning implemented at all clinical and management levels by March 2011.</p>
<p>Implementation of CIP and long term efficiency programmes.</p>	<p>The Trust's CIP delivery in recent years has been partly supported by increased activity and income. There needs to be a shift in the focus of attention to a more fundamental cost-reduction approach via improved efficiency of beds, theatres and workforce.</p>	<p>Development of a parallel CIP and longer term system/process efficiency improvement programme. This is led by the Strategic Redesign Programme Steering Group, chaired by the Chief Executive and attended by all Executive Directors and a full-time Programme Director.</p>	<p>2010/11 - £18.3 million savings realised</p> <p>2011/12 - £22.9 million savings realised.</p>

Consideration of opportunities for acquisition of services.	The long term future of local providers (in particular the PCT's community services) is uncertain. The Board needs to develop an agreed approach to merger, acquisition and competition/co-operation.	This is part of the Strategy Review and, in addition, the Board have been considering these issues in their own right. This work will continue in line with the timetable for changes to local provider organisations.	2010/11: develop approach to acquisition and competition/co-operation for specific providers and pathways of care. 2010/11-2012/13: respond to opportunities in accordance with the revised strategy and case-specific circumstances.
Review of the Trust strategy.	The programme for the Strategy Review is deliverable. Inevitably there are a number of uncertainties in relation to future health policy, funding and competition.	The Strategy Review process is timetabled to be concluded in September so that the health policy of the new Government can be taken into account.	Publication of revised Strategy September 2010.



Key leadership and governance priorities	Key risks (and gaps)	Actions to rectify / mitigate	Milestones 2010/11 2011/12 2012/13
Review of governance arrangements around patient safety and quality, including reporting framework 'from ward to Board', in the light of the Francis report.	The Board receives regular quality monitoring reports as part of an integrated performance report, but indicators are not all brought together at service line or ward level allowing a ward scorecard to be used as the basis of exception reporting from 'ward to Board'.	The scope of these indicators needs to be reviewed, in particular to consider a 'balanced scorecard' monitoring of quality at service line and/or ward level. Consolidation of ward 'electronic whiteboard' information, internal quality reporting, contractual quality indicators and CQUIN indicators into a quality and safety performance and governance framework.	2010/11: develop framework and process for ward-level quality reports and appropriate exception reporting to formal internal review meetings and the Board. 2011/12: incorporate quality scorecards into service line management programme within the above framework.


## **Template 9: Regulatory**

*[Guidance: the plan should identify current and future regulatory risks, including registration (CQC) and risks to the Authorisation. The plan should also identify key actions to mitigate any material risk and measurement of progress towards rectification. This includes, but is not limited to:*

- *Service performance;*
- *Clinical quality and governance;*
- *Governance processes and procedures;*
- *Financial stability, profitability and liquidity;*
- *Risk to the provision of mandatory services;*
- *Private patient income cap;*
- *Co-operation or completion rules;*
- *NHS constitution;*
- *Ongoing registration with CQC and any conditions.*

*Ensuring ongoing regulatory compliance, with the processes, procedures, assurance and oversight in place to first predict potential breaches with confidence and then take action where necessary, is central to the design and delivery of a high quality plan, and then its implementation.*

*Clear and realistic evaluation of current or future regulatory risks and accountabilities over the three years of the plan is a key requirement.*

Key regulatory risks	Nature of risk	Actions to rectify / mitigate and responsibilities	Measures 2010/11 2011/12 2012/13
Potential Breach of Terms of Authorisation - Condition 2 (General Duty) - The Trust shall exercise its functions effectively, efficiently and economically	Failure to achieve financial plans, including income targets and CIP - Key risk to Financial Stability and Profitability. The Trust needs to focus on cost reduction and improved efficiency rather than relying partly on income growth as has been the case in the past.	<p>Programme Management Structure now in place to identify, plan and realise savings schemes that will impact across the organisation. Management Structure consists of:- Strategic Redesign Programme Steering Group, chaired by the Chief Executive and attended by all Executive Directors and a full-time Programme Director. 5 Work themes have been identified, each with an Executive lead.</p> <p>A Strategic Redesign Working Group has been set up and meets regularly reporting to the Steering Group.</p> <p>A project office is being set up. The Service Development team is refocusing its work to entirely link to the Strategic Redesign programme. In addition to Trust-wide schemes each Directorate has a specific CIP target which will comprise of a number of schemes. Achievement of CIP schemes will be monitored on a monthly basis at both Board and Operational levels, and corrective action put in place as necessary. The Trust has set aside a financial contingency to cover any potential shortfall of CIP or unplanned income or expenditure issues.</p>	<p>2010/11 - £18.3M 2011/12 - £22.9M 2012/13 - £19.2M</p>

<p>Potential Breach of Terms of Authorisation - Condition 2 (General Duty) - The Trust shall exercise its functions effectively, efficiently and economically</p>	<p>Cash Flow insufficient to meet liabilities particularly relating to:</p> <p>PCT Inability to pay above contracted levels. PCT allocations from 2011/12 likely to have minimal or no growth and tariff prices may be a maximum rather than mandatory price from 2011/12. Therefore, additional income to the Trust cannot be assumed.</p> <p>Capital Programme overspend.</p> <p>Under-achievement of CIP.</p> <p>Unplanned operational overspend.</p>	<p>Medium term financial plan delivering surpluses in Years 1-3.</p> <p>High cash balance of £41m as at 31st March 2010, and not planning to drop below £30m during the three years.</p> <p>Access to £18m overdraft facility.</p> <p>Regular monthly reporting to the Board highlighting key variances to plan, and action required to address.</p> <p>PCT inability to pay above contracted levels</p> <p>- Agreement with PCT to actively support the development of a managed referral system, which will aim to ensure that referrals are managed to the level afforded by the 2010/11 contract.</p>	<p>Planned Cash balances:-</p> <p>2010/11: - £43m</p> <p>2011/12: - £37m</p> <p>2012/13: - £31m</p>
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<p>Potential Breach of Terms of Authorisation - Condition 2 (General Duty) - The Trust shall exercise its functions effectively, efficiently and economically</p>	<p>Financial penalties contained within the contract for failure to achieve RTT and Clostridium difficile targets - key risk to Financial Stability and Profitability</p>	<p>Although the value of risk is high to the Trust at c£10m, but the likelihood of occurrence is deemed to be low.</p> <p>We are negotiating a framework within which the commissioner discretion to not impose the Clostridium difficile penalty would be exercised (e.g. if we were above the previous year's level, but still below the target and still performing well compared to benchmarks).</p> <p>All other measures to assure delivery of RTT targets and Clostridium difficile targets will mitigate this risk.</p> <p>As the commissioners are likely to contract at the lower end of the forecasts in our joint demand planning work, the Trust will be ready to issue a Capacity Review request if increased demand threatens RTT delivery. If such a review concluded that the RTT target could not be delivered, the Trust would be exempt from RTT penalties.</p>	<p>2010/11 - measurement of 18 weeks RTT (aggregate performance) admitted (90%), non admitted (95%)</p> <p>2010/11 - delivery of no more than 100 clostridium difficile infections (2009/10 outturn) (contract target of 162),</p>
<p>Clostridium difficile infection targets</p>	<p>Introduction of more sensitive test may increase recorded incidence.</p>	<p>Discussions already taken place with PCT re. new test. Ongoing monitoring of impact of new test.</p>	<p>Monitoring impact of new test on recorded incidence.</p>

<p>Introduction of significant changes to regulatory framework (including NHS Constitution and CQC registration requirements), where ongoing compliance requirements for Providers are not yet fully specified.</p>	<p>Uncertain impact upon Providers of the ongoing compliance requirements associated with the new regulatory approaches introduced by both Care Quality Commission and Department of Health.</p>	<p>Ensuring compliance with existing regulation and registration requirements</p> <p>Contract discussions with NHS Devon where introduction of new waiting times / activity pledges or commitments (as part of NHS Constitution) may have financial implications.</p>	
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Key regulatory risks	Nature of risk	Actions to rectify / mitigate and responsibilities	Measures 2010/11 2011/12 2012/13
Specialty-level RTT targets	<p>In the past aggregate targets have always been achieved. However, specialty-level targets create greater risk of failure.</p> <p>In addition, the PCT has been unwilling to continue to commission waiting times as low as 13 weeks RTT. This will leave less margin to assure delivery of 18 weeks.</p>	<p>Performance in the highest risk specialty (orthopaedics) has been transformed in 2009/10 from historic levels of c50% RTT for admitted patients to c90% by April 2010. This improvement should continue to allow achievement of 90% (and 95% non-admitted) RTT targets.</p> <p>The information systems that support RTT are being reviewed to facilitate earlier flexing of capacity to meet demand (Director of Operations).</p> <p>NHS Devon is introducing a referral management service which is intended to reduce elective demand and therefore risk to elective targets. The effectiveness of this will be monitored via the Health Community Chief Executives meeting.</p>	<p>2010/11: review information system support and implement changes. Co-operate with Referral Management Service implementation and monitor impact.</p> <p>Target higher risk specialties and use the learning from orthopaedics to improve RTT delivery.</p> <p>2011/12: negotiate greater margin below 18 weeks to provide assurance re. 18 week RTT delivery. Implement improved bed and theatre efficiency (part of 2010/11 longer term efficiency programme).</p> <p>Maximise benefits of community theatre capacity acquired in 2010 to increase capacity at minimal additional cost.</p> <p>2012/13: review benefits of other opportunities for acquisition/co-operation to maximise efficiency, throughput and target delivery.</p>

<p>NHS Constitution - 18 weeks guarantee</p>	<p>The Trust may suffer reputational damage and the costs of increased non value adding administrative time to manage patients who want to seek alternative provision if they wait longer than 18 weeks.</p>	<p>The Trust is co-ordinating its plans with NHS Devon to minimise these risks. All the measures designed to meet RTT targets will reduce the 18 week breaches and therefore minimise this risk.</p>	<p>See "Specialty-level RTT Targets", above, plus:  2010/11: briefing to staff on policy guidance, internal arrangements and PCT arrangements.  Review experience of first two months' cases and revise procedures if required.</p>
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Possible change in regulatory approach as a result of outcome of parliamentary election in May 2010	Change in government may result in significant changes to regulatory approach, including balance of regulation between local government and central government, and possible change in function of key health regulators.	Remain abreast of key policy developments. Early assessment of potential impacts upon regulatory approaches.	
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Worksheet "Summary of results"

Financial Summary	2009-10 2010-11 2011-12 2012-13			
	Actuals	Plan	Plan	Plan
Revenue (Total)	335.6	354.0	333.6	325.1
Employee Expenses	(177.0)	(207.3)	(197.7)	(192.7)
Drugs	(26.6)	(27.0)	(27.8)	(29.4)
PFI operating expenses	0.0	0.0	0.0	0.0
Other costs	(102.8)	(94.7)	(80.8)	(74.4)
Clinical supplies	(34.7)	(35.6)	(31.5)	(28.9)
Decrease (increase) in inventories of finished goods & WIP	0.0	0.0	0.0	0.0
Vehicle Fuel costs (ambulance trusts)	0.0	0.0	0.0	0.0
Non-clinical supplies	(4.5)	(5.2)	(5.1)	(5.0)
Cost of Secondary Commissioning of mandatory services	0.0	0.0	0.0	0.0
Research & Development expense	(11.7)	(12.7)	(12.7)	(12.7)
Education and training expense	(19.3)	0.0	0.0	0.0
Misc. other Operating expenses	(32.7)	(41.1)	(31.5)	(27.8)
<b>EBITDA</b>	<b>29.2</b>	<b>25.0</b>	<b>27.2</b>	<b>28.6</b>
Depreciation and amortisation	(13.7)	(12.7)	(13.4)	(14.1)
Net interest	(1.0)	(0.9)	(0.9)	(0.8)
Interest Income	0.1	0.1	0.1	0.1
Interest Expense on Overdrafts and Working Capital Facilities	0.0	0.0	0.0	0.0
Interest Expense on Bridging loans	0.0	0.0	0.0	0.0
Interest Expense on Non-commercial borrowings	(1.1)	(1.1)	(1.0)	(0.9)
Interest Expense on Commercial borrowings	0.0	0.0	0.0	0.0
Interest Expense on Finance leases (non-PFI)	0.0	0.0	0.0	0.0
Interest Expense on PFI leases & liabilities	0.0	0.0	0.0	0.0
Other	(7.7)	(7.7)	(8.0)	(8.7)
Gain (Loss) on Financial Instruments Designated as Cash Flow H.	0.0	0.0	0.0	0.0
Gain (Loss) on Derecognition of Available-for-Sale Financial Asse	0.0	0.0	0.0	0.0
Gain (Loss) on Derecognition of Non-Current Assets Not Held for :	0.0	0.0	0.0	0.0
Gain (Loss) from investments (NOT charitable funds)	0.0	0.0	0.0	0.0
Dividend Income	0.0	0.0	0.0	0.0
Share of profit (loss) from equity accounted Associates, Joint Vent	0.0	0.0	0.0	0.0
Other Non-Operating income, Total	(0.1)	0.0	0.0	0.0
Other Finance Costs	0.0	0.0	0.0	0.0
PDC dividend expense	(7.6)	(7.3)	(8.0)	(8.7)
Impairment Losses (Reversals) net (on non-PFI assets)	0.0	(0.4)	0.0	0.0
Impairment Losses (Reversals) net on PFI assets	0.0	0.0	0.0	0.0
Restructuring Costs	0.0	0.0	0.0	0.0
PFI Contingent Rent	0.0	0.0	0.0	0.0
Expenditure of NHS Charitable Funds	0.0	0.0	0.0	0.0
Other Non-Operating expenses	0.0	0.0	0.0	0.0
Income Tax (expense)/ income	0.0	0.0	0.0	0.0
<b>Net Surplus / (Deficit)</b>	<b>6.8</b>	<b>3.6</b>	<b>5.0</b>	<b>5.0</b>
EBITDA % Income	% 8.7%	7.1%	8.2%	8.8%
<b>Net Surplus / (Deficit)</b>	<b>6.8</b>	<b>3.6</b>	<b>5.0</b>	<b>5.0</b>
Change in working capital	3.7	0.7	(1.4)	(0.4)
(Increase)/decrease in inventories	0.1	(0.3)	0.4	0.1
(Increase)/decrease in tax receivable	0.0	0.0	0.0	0.0
(Increase)/decrease in NHS Trade Receivables	0.6	(0.8)	0.9	0.2
(Increase)/decrease in Non NHS Trade Receivables	0.2	0.3	0.0	(0.0)
(Increase)/decrease in other related party receivables	0.0	0.0	0.0	0.0
(Increase)/decrease in other receivables	(0.0)	0.3	0.0	(0.0)
(Increase)/decrease in accrued income	0.2	(0.0)	0.0	(0.0)
(Increase)/decrease in other financial assets	0.0	0.0	0.0	0.1
(Increase)/decrease in prepayments	(0.2)	0.2	0.2	0.1
(Increase)/decrease in Other assets (non chartable assets)	0.0	0.0	0.0	0.0
(Increase)/decrease in Other assets (charitable assets only)	0.0	0.0	0.0	0.0
Increase/(decrease) in Deferred Income (excl. Donated Assets)	0.6	0.7	0.0	0.0
Increase/(decrease) in Deferred Income (Donated Assets)	0.0	0.0	0.0	0.0
Increase/(decrease) in provisions	0.0	(0.0)	(0.0)	(0.0)
Increase/(decrease) in post-employment benefit obligations	0.0	0.0	0.0	0.0
Increase/(decrease) in tax payable	0.3	0.5	(0.1)	(0.1)
Increase/(decrease) in Trade Creditors	(1.1)	(1.0)	(0.7)	(0.2)
Increase/(decrease) in Other Creditors	0.2	0.5	(0.1)	(0.1)
Increase/(decrease) in accruals	2.8	0.3	(2.1)	(0.3)
Increase/(decrease) in other Financial liabilities	0.0	0.0	0.0	0.0
Increase/(decrease) in Other liabilities (non chartable assets)	0.0	0.0	0.0	0.0
Increase/(decrease) in Other liabilities (chartable assets)	0.0	0.0	0.0	0.0
Non cash I&E items	22.1	21.0	21.8	23.2
<b>Cashflow from operations</b>	<b>32.6</b>	<b>25.4</b>	<b>25.4</b>	<b>27.8</b>
Cashflow from investing activities	(19.6)	(13.9)	(21.9)	(23.0)
<b>Cashflow before financing</b>	<b>13.1</b>	<b>11.5</b>	<b>3.4</b>	<b>4.8</b>
Cashflow from financing activities	(9.9)	(9.6)	(10.1)	(10.8)
<b>Net increase/(decrease) in cash</b>	<b>3.1</b>	<b>1.9</b>	<b>(6.7)</b>	<b>(6.0)</b>
Cash at period end	41.5	43.4	36.7	30.7
Cash and Cash equivalents at PE	41.5	43.4	36.7	30.7

FRR Metrics by quarter			
all on YTD basis	2010-11	2011-12	2012-13
EBITDA margin	7.1%	8.2%	8.8%
EBITDA % of plan	98.1%	98.1%	98.1%
ROA	4.1%	4.4%	4.5%
I&E surplus margin	1.1%	1.5%	1.5%
Liquidity	47.7	45.5	40.3
<b>Financial Risk Rating</b>	<b>3</b>	<b>3</b>	<b>3</b>

Detailed Financial Summary				
£m	2009-10 2010-11 2011-12 2012-13			
	Actuals	Plan	Plan	Plan
Cost & volume contract income	0.0	0.0	0.0	0.0
Block contract income	0.0	0.0	0.0	0.0
Clinical partnership (s31) income	0.0	0.0	0.0	0.0
Secondary commissioning income	0.0	0.0	0.0	0.0
Other clinical MS income	0.0	0.0	0.0	0.0
NHS Elective revenue	45.3	45.8	42.8	41.0
NHS Non-Elective revenue	89.6	87.4	81.2	77.8
NHS Outpatient revenue	44.8	55.7	51.7	49.5
NHS A&E revenue	9.4	9.3	8.7	8.3
NHS other revenue	51.3	49.6	48.1	48.1
Private patient revenue	1.2	1.2	1.2	1.2
Other operating income	94.0	105.1	99.9	99.2
<b>Total operating income</b>	<b>335.6</b>	<b>354.0</b>	<b>333.6</b>	<b>325.1</b>
Employee Expenses	(177.0)	(207.3)	(197.7)	(192.7)
Drugs	(26.6)	(27.0)	(27.8)	(29.4)
Supplies (clinical & non-clinical)	(39.2)	(40.9)	(36.6)	(33.9)
PFI operating expenses	0.0	0.0	0.0	0.0
Other Costs	(63.6)	(53.8)	(44.2)	(40.5)
<b>Total operating expenses</b>	<b>(306.4)</b>	<b>(329.0)</b>	<b>(306.4)</b>	<b>(296.5)</b>
<b>EBITDA</b>	<b>29.2</b>	<b>25.0</b>	<b>27.2</b>	<b>28.6</b>
Depreciation and amortisation	(13.7)	(12.7)	(13.4)	(14.1)
Profit (loss) on asset disposal	(0.1)	0.0	0.0	0.0
Net interest	(1.0)	(0.9)	(0.9)	(0.8)
Taxation	0.0	0.0	0.0	0.0
PDC dividend	(7.6)	(7.3)	(8.0)	(8.7)
Charitable funds I&E included	0.0	0.0	0.0	0.0
Impairments & Restructuring	0.0	(0.4)	0.0	0.0
Other non-operating items	0.0	0.0	0.0	0.0
<b>Net Surplus / (Deficit)</b>	<b>6.8</b>	<b>3.6</b>	<b>5.0</b>	<b>5.0</b>
EBITDA % Income	8.7%	7.1%	8.2%	8.8%
<b>EBITDA</b>	<b>29.2</b>	<b>25.0</b>	<b>27.2</b>	<b>28.6</b>
Change in Current Receivables	0.7	(0.2)	0.9	0.2
Change in Current Payables	(0.6)	0.0	(0.9)	(0.4)
Other changes in WC	3.5	0.9	(1.5)	(0.2)
Other non-cash items	(0.3)	(0.4)	(0.4)	(0.4)
<b>Cashflow from operating activities</b>	<b>32.6</b>	<b>25.4</b>	<b>25.4</b>	<b>27.8</b>
Capital expenditure	(19.7)	(20.0)	(21.9)	(23.5)
Asset sale proceeds	0.1	6.1	0.0	0.5
other Investing cash flows	0.0	0.0	0.0	0.0
<b>Cashflow before financing</b>	<b>13.1</b>	<b>11.5</b>	<b>3.4</b>	<b>4.8</b>
Net interest	(1.1)	(1.1)	(1.0)	(0.9)
PDC dividends (paid)	(7.9)	(7.3)	(8.0)	(8.7)
Movement in loans	(1.3)	(1.3)	(1.3)	(1.3)
PDC received/(repaid)	0.4	0.0	0.0	0.0
other financing cashflows	(0.1)	(0.0)	0.1	0.1
<b>Net cash inflow/outflow</b>	<b>3.1</b>	<b>1.9</b>	<b>(6.7)</b>	<b>(6.0)</b>
Period end cash	41.5	43.4	36.7	30.7
Period end cash and equivalents	41.5	43.4	36.7	30.7