Royal Devon and Exeter NHS
NHS Foundation Trust

# Strategic Plan Document for 2013-14

# Royal Devon & Exeter NHS Foundation Trust

# Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

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

| | |
|---|---|
| **Name** | Warwick Heale |
| **Job Title** | Associate Director of Planning and Performance |
| **e-mail address** | w.heale@nhs.net |
| **Tel. no. for contact** | 01392 402356 |
| **Date** | 31 May 2013 |

**The attached Strategic Plan is intended to reflect the Trust's business plan over the next three years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.**

**In signing below, the Trust is confirming that:**

- **The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;**
- **The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;**
- **All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission.**

**Approved on behalf of the Board of Directors by:**

| | |
|---|---|
| **Name** *(Chair)* | James Brent |

**Signature**

**Approved on behalf of the Board of Directors by:**

| | |
|---|---|
| **Name** *(Chief Executive)* | Angela Pedder |

**Signature**

**Approved on behalf of the Board of Directors by:**

| | |
|---|---|
| **Name**<br>*(Finance Director)* | Suzanne Tracey |

**Signature**

# Strategy Guidance - Annual Plan Review 2013-14

**Principles underlying the Annual Plan Review (APR) process**

1. This document sets out the requirements for the principal published forward plan ("Strategic Plan") for Foundation Trusts. The Strategic Plan should set out how the Trust's Board intends to deliver appropriate, high quality and cost-effective services for its patients on a sustainable basis. It should, therefore, lay out the Trust's assessment of the challenges it faces (both within the organisation and more broadly within its local health economy), its strategy to address those challenges and its implementation plans over the 3 years from 13/14 to 15/16.

2. The Strategic Plan should be consistent with the information submitted in the finance template (being issued on 29th March), and provide context for key figures included in the finance template.

3. It is crucial to recognise that the Annual Plan is not meant to be a simple budgetary exercise, but rather a key governance document which explains how high quality services will be delivered into the future. This will involve analysis of a broad range of issues, which may, for example, include: demographics and health trends; clinical sustainability and the implications of 24/7 consultant rotas; opportunities and threats from reconfiguration; cultural factors and their impact on delivering services which are safe, clinically effective and result in high patient satisfaction; cost benchmarking and the opportunity for transformational CIPs. Clearly, this is not meant to be an exhaustive list and different Trusts will have differing starting positions and face somewhat differing challenges.

4. Monitor has for many years emphasised the importance of robust planning over a multi-year time horizon in maintaining a healthy and sustainable FT sector. Our experience in prior Annual Plan Reviews has shown, however, that FTs on the whole tend to focus on a one-year planning cycle and look less at addressing longer-term strategic issues. The context to the 2013/14 Annual Plan is particularly challenging, with FTs facing rising demand and the need to deliver increased quality and efficiency and an improved experience of healthcare services for patients. Against this background, a short-term planning outlook, particularly one which does not take due consideration of the local health economy or the sustainability of service delivery models, would be inadequate.

5. There is no prescribed format for the published section of the Strategic Plan. However as a guide we would expect plans to be between 10 and 20 pages in length. To support APR analysis there is some specific information, not for publication, that we require from all Trusts and we have therefore included space for these in Appendices 1-4. Where there are commercially sensitive or confidential matters that Trusts do not want to include in the main published section and which cannot be accommodated within Appendices 1-4, these may be included in Appendix 5[1].

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

7. Monitor expects that Strategic Plans would include an Executive Summary outlining key elements of the Strategic Plan, including a summary of key financial data.

8. The main section of the Strategic Plan should normally address the areas set out in the following table, and any other relevant areas.

[1] Although Monitor does not intend to publish these Appendices, all information provided to Monitor is potentially subject to disclosure under the Freedom of Information Act 2000 (subject to the normal exemptions).

**Executive Summary (DRAFT)**

The following key themes run throughout the Annual Plan for the Royal Devon & Exeter NHS Foundation Trust for the period 2013/14-2015/16:

1. Strategic objectives

- Maintaining sound operational delivery of existing clinical, research and teaching services
- The integration of core pathways from the community coming through to acute care within its acute services catchment area and out again into the community
- The further development of the Trust's acute services across a wider area by building upon the clinical networks and partnerships already in place

2. The Trust responded well to emergency pressures in 2012/13, partly due to the development of two new wards. However, the impact of the aging population on the volume and acuity of emergency admissions remains a risk for the Trust, particularly given the 30% tariff arrangements. In response, there is a significant programme of work in place to develop improved services for frail and older people.

3. A focus on patient safety and quality, in particular ensuring that the Trust's ambitious Transformation Programme has considerations of quality embedded within its processes to ensure that financial pressures and service changes do not have an adverse impact on patient safety.

4. Developing the workforce to meet the above objectives.

5. Sound financial management, recurrent CIP delivery and maintaining a Financial Risk Rating of 3. The delivery of recurrent CIP is the key financial risk for the Trust, but delivery of this will have to be balanced against any risks to quality.

The accompanying 'Targets and Indicators' sheet highlights [number] targets that the Trust is declaring at risk during 2013/14:

- Referral to treatment time, 18 weeks in aggregate, admitted patients
- Cancer 62 Day Waits for first treatment (from urgent GP referral)
- Cancer 31 Day Waits for first treatment (from diagnosis)
- Clostridium Difficile -meeting the C.Diff objective

Plans are in place to improve performance and provide assurance about target delivery in 2013/14. In summary, these are:

- Referral to treatment time, 18 weeks in aggregate, admitted patients
  Following work with the Intensive Support Team, the Trust has focused on reducing waiting list sizes to ensure sustainable delivery of RTT targets in all specialties. The primary focus has been on orthopaedics. In addition, the Trust has reviewed is operational process and performance management arrangements to support delivery of this target. This plan has been shared with Monitor.

- Cancer 62 Day Waits for first treatment (from urgent GP referral) and Cancer 31 Day Waits for first treatment (from diagnosis)

The Trust has developed an action plan to address all cancer targets. Actions to address 62-day and 31-day wait pressures are prioritised within this and will be managed via a newly-established Cancer Action Group. This plan has been shared with Monitor.

- Clostridium Difficile -meeting the C.Diff objective
  The reduction in the Trust's target from 2012/13 to 2013/14 will be challenging to achieve. The Trusts C.diff incidence has reduced every year in recent years and is anticipated to reduce further in 2013/14. However, the reduction in the target means that this will remain a risk.

## 1. Strategic Context and Direction

### 1.1 Trust's strategic position within LHE including:

- An overview of the Trust's key competitors and an assessment of the Trust's key areas of strength/weakness relative to the key competitors;
- Forecast health, demographic, and demand changes; and
- Impact assessment of market share trends over the life of the plan.

Summary of Local Health Economy:

- The Trust provides specialist tertiary acute services to a wide population in East, North and South Devon and parts of Somerset and Dorset and acute secondary care services and some community services to the population in the eastern part of Devon. The catchment population for the Trust is circa 429,000 The majority of the Trust's services are delivered at the Wonford and Heavitree Hospital sites in Exeter, with additional services delivered at other locations in Exeter, Mid Devon and East Devon and some specialist services delivered more widely across Devon, Cornwall and parts of Somerset.
- The majority of the community services in the Trust's catchment area are provided by Northern Devon Healthcare Trust (NDHT). These services will be re-tendered during the three years of this plan.
- The recent Health & Social care reforms have led to a lack of clarity within the healthcare system, particularly as new organisations are established over the period of this plan. These changes will inevitably impact on the Trusts deployment of its strategy. Furthermore it is recognised that there is an increasing tension between the delivery of quality services to an expanding and aging population against the need to make significant financial savings. Savings at the levels forecast within this plan can only be achieved by the radical transformation of service delivery across the wide health economy, not solely within the four walls of the hospital.
- Reduction in local authority budgets is likely to impact on social care provision and to cause an increased burden on community and acute health services.

Neighbouring hospitals summary

- Competition for specialised services is primarily from tertiary providers in Plymouth & Bristol, plus potentially from Taunton & Somerset NHSFT for vascular surgery and some cancer services. However, with the exception of those services noted in Section 1.2, there are no known plans for changes in provision that would affect the Trust within the next 3 years. For the majority of specialised services the Trust is a well-established provider and should not be vulnerable to changes being driven by local competitors as the specialised service commissioning arrangements will limit the scope for provider-initiated changes in the market.

- Competition for general acute services is primarily from NDHT and South Devon Healthcare Foundation Trust (SDHT). However, geographical distances and travel times mean that any competitive risks from these providers are unlikely to be material.
- There has been limited emergence of private sector competitors locally (e.g. Virgincare for integrated children's services from April 2013).
- A potential shortfall in the local market has been identified for services for frail and older people including domiciliary social care. The Trust is considering how to respond to this, alongside consideration of the Trust's position in relation to local community services.

Demographic summary

- Devon has an older population profile than the country as a whole, with a particular peak in those aged 85 years and over. From 2011 to 2031, the number of people aged 85 and older is projected to rise by 77.6%. Devon is 20 years ahead of the rest of England in this respect. The number of people with life-limiting long-term conditions and those with dementia are predicted to increase rapidly. Furthermore, the catchment population for the Trust is more elderly than the population profile for Devon as a whole. The Trust is therefore likely to be ahead of the national curve in having to shape services to meet the needs of a more elderly population.
- In response to the present and predicted demographic profile across Devon, the health, social care and third sector system is working collaboratively to redesign services which maximise people's ability to remain in their own home, with 'no bed like your own bed' as a defining principle. The Trust is working with partners in the health and social care system to review and redesign pathways of care and associated services for older people.
- There is likely to be significant urban expansion within the Trust's catchment, with a local new urban development, Cranbrook, due to reach 30,000 population by 2020. During the three years of this plan this may increase overall catchment population, but less significantly in the older age groups that use more acute healthcare services.
- The Trust aims to increase its catchment influence to 800,000 population in next 5 years in collaboration with other providers to further improve economies of scale and service sustainability.

The Trust's strategic direction over the next three years is based on three strategic objectives:

- Maintaining sound operational delivery of existing clinical, research and teaching services
- The integration of core pathways from the community coming through to acute care within its acute services catchment area and out again into the community
- The further development of the Trust's acute services across a wider area by building upon the clinical networks and partnerships already in place

During 2013/14 the Board of Directors will be finalising the supporting strategies i.e. clinical, workforce, estates, IM&T etc to deliver these strategic objectives. However elements of these supporting strategies are already developed and are included within this plan.

### 1.2 Threats and opportunities from changes in local commissioning intentions

- An overview of the key changes to local commissioning strategy and intentions and their anticipated impact on the Trust, including:
  - QIPP & demand management;
  - Decommissioning;
  - Potential "Any Qualified Provider" Tenders;
  - Shifting care delivery outside of hospitals; and
  - Reconfiguration plans.
- An explanation of how the Trust has factored these considerations into its strategy;

- Analysis of how the Trust's demand profile and activity mix has evolved over recent years and what changes are forecast; and
  Details of how the Trust is diversifying its income streams (e.g. research, private patients, exploiting intellectual property).

Following changes in commissioning organisations, 68% of the Trust's contracted income relates to the North, East and West (NEW) Devon CCG, with 19% the responsibility of NHS England (specialised services and Cancer Drugs Fund). The remainder is distributed across 4 other CCGs. Therefore, the Trust has only one major commissioning organisation to work with on non-specialised QIPP and demand management.

The key commissioning intentions are to provide care closer to home, to reduce demand for acute services and to deliver the vision of, 'Healthy people, living health lives in healthy communities'. Given the significant and rapid changes in the demographics in Devon, there is a risk that the demand for frail and older people services maybe underestimated and in addition of delivery the commissioner's vision maybe further constrained given the pressures on social care funding and services. Furthermore, given historical financial pressures for local commissioners, the Trust believes there is a risk that 70% emergency tariff is not appropriately deployed to meet the needs within community and for patients awaiting discharge from acute care

The Trust's strategic direction as outlined in section 1.1 is aligned with commissioners' intentions.

The Trust currently provides a number of services in the community:

- Surgical outpatients and day case treatments
- Satellite renal dialysis
- Community midwifery
- Early Supported Discharge (ESD) for stroke patients
- Community paediatrics
- Integrated Acute and Community Speech & Language Therapy (from 01/04/2013) and Community dietetics

The Trust intends to maintain and expand these services where possible to become a more significant provider of community services in the local area. In particular the Trust intends to expand integrated services for frail and older people.

The Trust has worked closely with NEW Devon CCG in the development of QIPP and demand management schemes to ensure that these are robust. The plans have been informed by the well-established 'Clinician to Clinician' specialty-specific review and redesign groups. The financial plan assumes £1.3m of QIPP related to 'pass through' PbR-excluded drugs and devices – the delivery of this plan is jointly led by the Trust's Chief Pharmacist and a lead pharmacist for the CCG. There is a further £1.8m of QIPP that relates to other clinical activities, primarily avoiding emergency admissions and 'rapid access to consultant review' to offer advice and guidance, non face-to-face outpatient appointments and GP education.

The QIPP programme is subject to joint governance arrangements across the Trust and CCG and, where QIPP aligns with CIP or CQUIN, there is a single plan for implementation to ensure that the Trust's internal objectives are delivered alongside the health community demand management requirements. A Programme Manager is being jointly appointed to coordinate this work.

Demand management plans for specialised services are less well-developed and instead there is a focus on ensuring compliance with service specifications and commissioning policies that should ensure that

access criteria are met and that services are provided to the required standards. Given the stage of development of NHS England in commissioning specialised services, the only significant changes that can be foreseen to affect the Trust in the short term are:

- CF services: the Trust is likely to be the 'hub' of a local network of providers with all the income flowing via the Trust before distribution to the other providers in the network. We have developed close working relationships with these providers and this change is unlikely to create financial risks based on 2013/14 tariffs.
- Vascular Surgery services: the Trust is working in partnership with another local FT to provide a local vascular surgery network.
- NICU services: there may be a change in the level of care provided by the Trust over time, with babies at earlier gestation being cared for in the Level 3 centre at a neighbouring Trust. However, given capacity constraints at that provider, there is unlikely to be a sudden change in activity at RD&E.

No decommissioning intentions that might affect the Trust have been declared.

NEW Devon CCG is pursuing AQP for primary care requested non-obstetric ultrasound and MRI. However, this has not developed as quickly as expected and is not expected to be 'live' until Q2 2013/14. The current assessment is that this is likely to lead to an increase in diagnostic requests which will at least offset the risks of loss of activity due to competition.

The only known reconfiguration plan that will affect the Trust is the recommissioning of the Walk-in-centre on the Trust's main Wonford site which is currently provided by another provider. This may give the Trust to opportunity to develop an integrated 'emergency front door' service.

There may be additional opportunities arising from other commissioners e.g. the Trust is currently bidding for the provision of renal dialysis services in Somerset in response to a re-procurement by the Specialised Services commissioners.

The Trust acquired a surgical robot in 2012/13 and 2013/14 will be the first full year of operation for this service. This will have a short to medium term impact on 62-day referral to surgical treatment cancer target performance, but will make the Trust's delivery of optimal quality care to patients and performance more robust in the longer term.

The above developments are consistent with the Trust's Strategy and have been reflected in the strategic and financial plans as noted in the above text, with no assumption of financial gains unless these are certain.

The joint provider-commissioner activity plan was based on a 3-year activity trend, adjusted for movements in waiting lists and the adjusted for further specialty-specific anticipated changes. There are no material changes in case-mix assumed in the plan.

While the Trust continues to reduce waiting lists in 2013/14 to address RTT and other targets, there will be excess elective activity above the underlying demand growth. £1.7m additional non-recurrent activity has been agreed with commissioners in the activity/financial plan. There has been an increased elderly case-mix in emergency care in particular which has led to increased acuity for emergency medical inpatients. This has been accommodated by the creation of an additional rehabilitation and medical ward in 2012/13.

In order to mitigate potential reductions in NHS funding the Trust is considering creating a private patient ward in space freed-up by the reduced length of stay that will be delivered by the Transformation programme. There is a potential threat that an increase in emergency demand above anticipated levels would result in the Trust not being able to free up spare capacity created through length of stay reductions. Therefore, there is a need to caveat the private ward plans in this respect.

Due to the successful introduction of the rehabilitation and reablement ward in 2012/13, linked to the robust work undertaken to respond to changes in emergency demand, case mix and ensure compliance with RTT performance targets,further work will be undertaken during 2013/14 to assess whether this model of care should be expanded. This is in line with CCG commissioning intentions.

### 1.3 Collaboration, Integration and Patient Choice

- Plans to integrate services to provide better care and/or increase efficiency;
- Development of partnerships and collaborations with other providers; and
- Consideration of impact of proposals in relation to competition rules (CCP etc.) and patient choice, where applicable.

The Trust has recently engaged in strategic joint working with Taunton & Somerset NHSFT, which initially is likely to have an impact in relation to 'back office' functions. The Trust will also maintain existing collaborative working arrangements in a range of clinical services with NDHT and SDHT to ensure we continue to offer safe patient services across the locality balanced with enabling patient choice. This reflects pressure on the medical workforce in particular services at these smaller providers. There are some possibilities of some joint working with more distant Trusts on selected services e.g. Pathology.

In developing its stakeholder engagement strategy, the Trust is undertaking a programme of stakeholder engagement as a means to build collaborative relationships across the system. In particular the need has been identified to further develop relationships with the local authority in relation to areas of mutual interest (e.g. adult social care, children's services, major housing and new town developments within the Trust's catchment).

There is the potential for business diversification into services for Frail and Older People that have traditionally been the preserve of social care providers (such as domiciliary care). The provision of these services is in response to the increase in admissions from this population, to reduce the adverse impact of 30% emergency tariff and to increase efficiency given delays in onward care. This is being considered in terms of specific care pathways as well as in general terms in relation to an aging population.

The local Academic Health Sciences Network is in its first year of establishment. The Trust is a key partner in the AHSN and is working actively with other partner organisations.

In line with our strategic objectives, the Board of Directors regularly considers emerging opportunities for collaboration and acquisition/merger that will support the improvement of patient care and sustainability of services to maximise the availability of choice for patients and the public..

## 2. Approach taken to quality (including patient safety, clinical effectiveness and patient experience)

- An outline of existing quality concerns (CQC or other parties) and plans to address them;
- The key quality risks inherent in the plan and how these will be managed; and
- An overview of how the Board derives assurance on the quality of its services and safeguards patient safety. (Trusts may find Monitor's Quality Governance framework helpful in appraising quality arrangements).

### Response to Care Quality Commission (CQC) findings

The Trust was inspected by the CQC in November 2012, as a scheduled, routine planned review. Eight standards were inspected and the CQC found that the RD&E met five of the standards fully and action was required for three of the standards. An action plan approved by the Board of Directors was developed to enhance documentation processes within theatres and also on the wards. All actions were completed within the agreed timeframe of 31st March 2013. Spot checks of the changes implemented have been undertaken in April 2013, the results of which show significant improvements. The Trust will continue to monitor these areas to ensure improvement is sustained.

Over the next twelve months the Trust will continues to monitor the areas to ensure improvement is sustained, in addition to the work that is ongoing to further enhance the completion of documentation. Whilst it is reassuring that the CQC have continued to provide feedback that there is good evidence that a high standard of care is being delivered to patients, the challenge going forward is ensuring that documentation of care is robust. Electronic solutions to support the reduction in time taken for clinical staff to complete documentation are being developed (fully integrated electronic patient record).

**Francis II**

Following the release of the report of the Public Inquiry into the failings at Mid Staffordshire NHS Foundation Trust, the RD&E has reviewed the 290 recommendations and is working through the 76 actions which relate specifically to Acute Trusts. This work commenced with a full appraisal of Sir Robert Francis' report to both the Board of Directors and the Governance Committee and a clear and strong communication from the Chief Nurse/Executive Director of Service Delivery to all members of RD&E staff urging staff to act on and report poor quality care.

Further work will be undertaken throughout the year which will include a detailed review of the actions specifically relating to the direct delivery of patient care; the Deputy Chief Nurse is leading on these actions together with the Lead Nurses. The Trust is also engaged in a Peninsula-wide review of the recommendations to identify gaps and share best practice.

The Transformation Programme (see section 4.2) has, at its heart, an intention to provide a culture which supports and nurtures staff so that they can provide safe, compassionate care.

**Safety and Quality**

The Trust will continue to develop safety and quality priorities identified by the Board following engagement with the Governors and members of the Foundation Trust and respond to the increased national emphasis on safety and quality by driving improvements in quality and developing ever more robust governance arrangements. In addition, the Trust will focus on ensuring patient safety is not compromised by the constrained financial environment and the corresponding increased activity and cost reductions. The aim of the RD&E is to be in the top 3 Trusts in the South of England within the next 5 years as measured by the Safety Thermometer. Two key overarching pieces of work that reflect our safety and quality priorities (as noted in the Quality Account) are:

<u>The Nursing Midwifery and Allied Health Professions Vision – Year 2</u>

A number of high profile cases of unacceptably poor care in other organisations have been reported in the national media during the last year. These have caused real public concern. The most significant of these is detailed in the Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry, published in February 2013. We have reviewed the recommendations in this report, alongside the earlier outcomes from the first report into this failing Trust. The Trust has identified the following areas for further work.

1. Ensuring we further develop a culture of openness which means that anyone who has a concern about care feels able to report it.

2. As part of that culture of openness we will continue to inform patients (and the family or carers where appropriate) if ever we either cause harm or suspect that we have caused harm to patients.
3. We will explicitly ensure that we recruit staff who share the Trust's corporate values.

This work will form part of year two of the work plan of our three year vision of the Nursing, Midwifery and Allied Health Professionals Vision.

Focus on Cancer Services

Providing the best care to our patients is the central aim of all we do. For our cancer patients, it is vital that we pay particular attention to timely access to services and the ease with which they move along the cancer pathway. We want to make sure everyone has the right information and support at each point on their journey.

The National Cancer Strategy seeks to improve outcomes for people with cancer as well as improving their experience of care. Here, at the RD&E we echo that intention. Over the past 12 months we have experienced challenges in meeting some of the national cancer performance targets. Our biggest challenge has been achieving the target to commence treatment within 62 days of referral. We want to reduce waiting times so that our cancer patients receive timely, effective and safe treatments. To help clarify and reinforce where to focus our efforts, we enlisted the help of the Department of Health's Intensive Support Team [IST]; a resource we can draw on to provide an objective review and critique of our services and systems. The IST provided us with a report outlining their findings and our Trust-wide Cancer Plan will take account of their recommendations.

Throughout 2013/14 we will hold a series of Cancer Summits. These events will pull together Clinical, Support and Management staff involved in cancer care. Our aim is to place our cancer patients 'centre stage' and to review and improve our treatment pathways so that we reduce our waiting times, whilst retaining a personal and compassionate service for patients and their families.

The outcomes of this work will be monitored through the operational performance management framework and the action plan for improvement will be monitored through the Trust's Senior Operations Group.

The Trust has agreed a number of CQUIN schemes cover the following areas:

- Friends and Family Test
- NHS Safety Thermometer
- Dementia
- VTE
- Discharge Summaries and Clinic Letters
- Frail Elderly
- Medicines Management
- Stroke
- Planned Care
- Sustainability
- Improved Communication

The Trust is working closely with commissioners to ensure that these schemes are delivered and that quality benefits across the health system are maximised.

CQUIN schemes for specialised services are in the final stages of agreement. There is no risk to Q1 CQUIN income from this delay.

Key quality risks inherent in the plan and how these will be managed

A key challenge will continue to be maintaining quality and safety whilst reducing costs. This will be managed through the Transformation and CIP Programmes, and close monitoring of quality and safety standards through our benefits realisation process and the Governance Performance System reporting and providing assurance to the Board of Directors. An identified risk is that of maintaining safe and quality services when emergency admissions are higher than planned levels and measures are in place within the Trust and across the health community to mitigate any such risks. The Trust's Performance Framework provides a balanced scorecard approach ensuring that quality and cost of delivery are kept in balance. Board decisions on business cases will be based on both safety and financial implications. The Board have discussed risks to safety and quality as a result of financial, target or emergency pressures and have unambiguously stated that the Trust will not compromise on safety.

Risk re recruitment of staff ref section 3.2

<u>An overview of how the Board derives assurance on the quality of its services and safeguards patient safety</u>

The Board has a robust system of Governance and Performance Management in place; the effectiveness of and compliance with the Governance System has been reviewed as the Internal Audit Programme. Board assurance is achieved through a number of performance and quality reports including, Ward to Board, Safety Thermometer, Governance processes including Governance Committee report to the Board (safety and quality issues reported by exception, which includes sight of the Corporate Risk Register, External audits/inspections), Audit Committee report to the Board (summary of internal audit assurance), Board Assurance Framework Board review of integrated performance report to ensure balance on quality, cost and delivery.

The Board have received and are planning to work through the "Quality Governance: How does a board know that its organisation is working effectively to improve patient care?" which was published in April 2013 and has been developed to support the Quality Governance Framework.

The Board has used the Quality Governance Framework, July 2010, to support the completion of the Corporate Governance Statement, ready for submission in line with this Annual Plan at the end of May 2013. This has been underpinned by the 'green' assurance rating from Internal Audit in May 2013 for the Monitor Compliance Framework and the Code of Governance Review. An Internal Audit review of the revised Governance Performance System (the system which monitors and operationalises Governance throughout the organisation and provides the bases of assurance to the checklist within the Quality Governance Framework to the Board,) is due to be completed by the end of May 2013. The interim Internal Audit findings reported early 2012 were very positive.

## 3. Clinical Strategy (Consistent with information contained within the Trust's published Quality Account).

### 3.1 Service Line Management Strategy:

- The Trust's overall clinical strategy over the next three years;
- The Trust's service line strategy over the next three years; and
- The inputs the Trust used to develop this strategy (e.g. SLM, benchmarking etc).

The Clinical Services Strategy is currently work in progress and will be completed during 2013/14. In developing the Clinical Services Strategy the Trust will make use of the Academic Health Sciences Network to ensure adoption of best practice.

The focus over the next 12-18 months will be:

- To implement service plans for frail and older people (recognising that such service encompass health and social care, not just healthcare). Key projects include the establishment of a multi-disciplinary assessment for frail and older people in A&E to reduce admissions to hospital and to provide better care planning for those who are admitted (with the aim of reducing LOS). This scheme will either be implemented as part of Trust's bid to reconfigure the front door urgent pathway or as a separate scheme. In addition the Trust will seek to develop Hospital at Home facilities in two sub-localities in the East Devon area. Longer term, opportunities will be explored (in partnership with commissioners and other providers) to reduce the Local Health Economy shortfall in EMI facilities which currently delays discharges.
- The development of improved integrated services around urgent care, via the recommissioning of services currently provided by the Walk-in-Centre on the Trust's Wonford site (currently provided by another provider).

The Trust has implemented plans to redesign end-to-end pathways both within the walls of the hospital and across the wider health economy. The Trust is exploring new models of integrated care across acute and community settings e.g. reablement post-discharge for stroke and other frail elderly patients.

Work will continue in collaboration with Taunton & Somerset NHSFT to explore the patient benefit in coordinating clinical services across Devon and Somerset. Current clinical networked arrangements with other providers (primarily NDHT and SDHT) will continue.

Service Line reporting is well-developed in the Trust and is supported by a patient level costing system. Service Line Management is a central thread of the new management system as described in section 4.2.

### 3.2 Clinical Workforce Strategy

- An overview of the clinical workforce strategy (covering doctors, nurses and other key clinical groups);
- Key workforce pressures and plans to address them;
- The impact of the Workforce Strategy on costs (short-term and long-term); and
- Findings of benchmarking or other assessment (e.g. using the DH Workforce Health Tool).

During 2013/14 we will complete the implementation of our new Senior Management structure to ensure we improve delivery of today's services and that we are able to meet future challenges effectively. A core principle our new structure is to strengthen all types of clinical leadership, for example we are investing in moving matrons supervisory to shift increasing their time to lead effectively the Wards they are responsible for and have allocated increased time for medical leadership within our Associate Medical Director and Clinical Lead roles.

As part of the work to develop the Trust's Workforce Strategy we have identified the risk of attracting clinical staff of the calibre and capacity required to meet our plans to Exeter due to the high cost of living in the south west region, and will be implementing a number of actions to mitigate this risk (see below). We are underway with the following work to ensure our clinical workforce is in line with service requirements (current and future):

**Medical Workforce:**

- An extensive review to baseline current consultant working patterns and to align consultant contracts to current and future service demands will be completed.

- In anticipation of a reduced number of junior doctor placements during the period of the plan a mitigation plan will be developed. . This will include introducing advanced practitioner roles, surgical practitioners, realignment of clinical tasks through upskilling of nurses and Allied Health Professionals to support a move towards more 24/7 models of care.

- In line with national requirements our medical revalidation plan will be delivered.

**Nursing, Midwifery and AHP workforce:**

- A ward nursing establishment review which commenced in 2012/13 is nearing completion. It has assessed the workforce needs against case mix demands taking into account both acuity and dependency. The methodology used is threefold:
    - Professional judgement
    - National benchmarking
    - Bespoke dependency tool developed by the author of the AUKUH 'Safe Staffing Tool')

- Linked to the outcomes of the establishment review ward and team staffing changes will be implemented over the period of the plan to ensure that we maximise the potential and maximise the efficient deployment of all our nursing and AHP professionals.

- Recruitment of Band 5 nurses in the South-West has been identified as a problem area and the deployment of the national/international recruitment strategy developed in 20-13/14 will continue

- An increase our temporary resourcing through bank workers will be pursued to enable a reduction in agency staff costs.

- The successful programme of "clinical apprentices" will continue to be developed.

**Key workforce pressures and plans to address them**

Key workforce pressures include:

- Junior doctor placement numbers (see above)
- Recruitment of Band 5 nurses (see above)
- Use of agency staff (see above)

**The impact of the Workforce Strategy on costs (short-term and long-term)**

For 2013/14 workforce numbers are expected to increase as a result of additional activity and the ward management review. However in 2014/15 and 2015/16 the anticipated workforce costs will fall. However we are anticipating a potential change in the mix of our workforce and will continuously monitor this, and provide assurance to the Trust Board.

**Findings of benchmarking or other assessment (e.g. using the DH Workforce Health Tool)**

The Trust used the RCN's, 'Guidance on Safe Nursing Levels in the UK' as part of a triangulated methodology to inform the ward nursing establishment review.

### 3.3 Clinical Sustainability

- Identification of which of the Trust's services could potentially lack critical mass (defined by Royal Colleges etc.);
- Identification of which services have consultant cover below those recommended by Royal Colleges etc. (link to financial template); and

- Innovations in care delivery developed at the Trust or in conjunction with partner organisations.

With the exception of Thoracic Surgery, where discussions on service change have commenced, there are currently no services that have been identified as lacking critical mass or which have inadequate consultant cover. Whilst the Thoracic Surgery service currently has good outcomes the cohort of patients is small and therefore an independent service is not sustainable at RDE. The Trust is working with commissioners and another provider to ensure that there is a sustainable longer term future for this service.

Our strategic partnering with other organisations is described in section 1.3.

## 4. Productivity & Efficiency

### 4.1 Overview

An overview of potential productivity and efficiency gains built into plans, including financial impact of projected gains, in areas such as:

- Length of stay;
- Bank and agency spend;
- Bed occupancy
- Theatre productivity; and
- Emergency readmission rates.

There is an acknowledgement that the Trust needs to take a different approach to CIP to ensure that we can continue to provide safe services in the long term, in the face of ongoing pressures on NHS budgets. The Trust is working with commissioners to align plans for QIPP, CIP and CQUIN so that there is a single combined delivery plan where there are interdependencies across the health economy; and is jointly appointing a Programme Manager to coordinate this work. The Trust's productivity and efficiency plans are driven externally by QIPP and internally to delivery CIP requirements as follows:

**Externally-driven QIPP plans**

- 'Pass through' PbR-excluded drugs and devices (£1.3m)
- Activity reductions and redesign (£1.8m):
  - A&E attendance avoidance
  - Emergency admission avoidance
  - Primary care pathology testing: improved information and guidelines adherence
  - 'Rapid access to consultant review' to offer advice and guidance, non face-to-face outpatient appointments and GP education
  - Follow-ups: alternatives to face-to-face follow-ups, condition-specific follow-up guidelines

**Internally-driven CIP Programme**

Transformation Programme:

- Total Ward Management project – benefits of reduced length of stay and corresponding impact on bed occupancy.
- Management system review
- Adult admissions avoidance and onward care coordination service for older people is being commissioned by NEW Devon CCG and will reduce emergency admissions to the RDE

- An external review of theatre productivity is being commissioned, to identify if there are any further gains that can be made in terms of utilisation and throughput.
- End to end clinical pathway redesign.

Business As Usual

- Internally-driven efficiencies in 'Business as Usual'

Business Development:

Other initiatives

The Trust is undertaking a bed capacity review using discrete event simulation. This links closely to the Ward Management project and the aim is to reduce existing bed requirements to deliver capacity to develop a private patient facility and to reassign some beds as a rehabilitation and reablement facility.

The Trust is involved in ongoing benchmarking and reviews of other organisations' systems, processes and outcomes e.g. QUEST.

### 4.2 CIP governance

- An assessment of historic performance, including main drivers, and necessary further action to ensure future delivery; and
- An overview of PMO, leadership and assurance arrangements for the life of the Strategic Plan.

The Trust has a strong track record of delivering on CIP plans and has met overall targets in recent years. However the on-going recurrent need for savings does pose a significant challenge to the Trust going forward. There has been a small level of underperformance on the recurrent CIP plans in 2012/13 of £1.8m and this has been incorporated into the CIP requirement for 2013/14. Even in advance of this, the Trust embarked upon a more fundamental Trust-wide approach to CIP via the Transformation Programme. This recognises that long term financial success will be dependent upon work across the wider health economy as well as within the walls of the acute hospital. In addition, we are increasing our focus business development activity to grow our income contributing delivery of our CIP target.

The following actions are being taken this year to ensure CIP delivery:

- The CIP programme has been restructured for 2013/14 in order to provide a clear structure and accountability based around three core themes:
  - Business as usual
  - Transformation
  - Business Development opportunities
- A Senior Management Review is being undertaken to ensure strong leadership is in place on a range of operational and management issues including CIP. Divisional Director roles have been created and will be the Senior Accountable Officer for Divisional performance.
- We have commenced the implementation of a new way of managing performance that will improve the rigour and assurance around delivery of 'business as usual' (day to day delivery of patient care and services) and 'step change' (scalable projects) activity. This will strengthen the Trust's ability to deliver on the CIP challenge.
- Induction and on-going training of operational managers is planned to build organisational capacity and capability to address the CIP challenge.
- Following external review by an independent management consultancy, the PMO and Service Development team have been expanded and permanently funded in order to support Trust-wide and directorate based CIP schemes.

- Recent work to use SLR information to identify areas for service improvement and efficiency gain will be continued through collaborative working across the operational divisions with assistance from the support functions.
- The Transformation Programme is enabling the organisation to take a radical and whole system approach to service redesign and cost reduction both within the organisation and the wider health economy.

The Cost Improvement Programme reports to the Executive Team and thereafter the Board of Directors on a monthly basis. A Benefits Realisation Group has been established, chaired by the Director of Finance and Business Development, to provide timely assurance.

The Transformation PMO comprises a number of project managers and project support officers who are providing robust project management support to the range of patient pathway improvement projects and management system project within the Transformation Programme. They are also providing support to the Divisions with BAU and business development CIP plans where required. The projects report to their Steering groups and then the Transformation Programme Board on a monthly basis.

The Trust internal auditors review the CIP planning and reporting process annually. The objective of this review is to provide assurance to the Audit Committee that the Trust has implemented a sound system of internal control surrounding financial efficiency planning to enable the achievement of the savings target.

### 4.3 CIP profile

- Key CIP schemes including risk ratings for individual schemes (see Appendix 2); and
- An outline of transformational /service redesign CIP schemes which represent step changes in processes rather than incremental changes and a brief explanation of how this change will be achieved.

**Transformation Programme**

We will continue implementation of our trust-wide Transformation Programme which commenced in September 2012. The overall purpose of the Programme is:

*"To create a way of working at Royal Devon & Exeter NHS Foundation Trust which engages staff in continuously improving and sustaining the delivery of safe, high quality and financially sustainable efficient services to Patients"*

The programme of work during 2013/14 is comprised of a set of integrated projects, including the following key CIP schemes (for individual schemes see Appendix 2);

- **Length of stay initiatives** – The intention is to reduce length of stay by 0.5 days per medical patient. There is, however, a risk that any increase in emergency admissions at only 30% tariff may negate any savings.

- **Ward Management Project** – this project is being implemented on all wards in the Trust and is minimising delays and eliminating non-value adding activities. It is being achieved via increased empowerment of ward teams using visual management, problem solving and work place audit.

- **Procurement Savings** - Reduction in cost of supplies leading to direct savings for the Trust. Active management of contracts and tendering in order to reduce non-pay expenditure

- **Pharmacy Savings** - Reduction in drug-related expenditure across the Trust. Savings achieved through locally agreed contracts, products moving off patent, recycling of medicines and SCEP (Supply Chain Excellence Program) implementation.

- **Diagnostic savings** - Review of staffing levels and non-pay expenses. Replacement of higher-banded staff with lower bands in Clinical Chemistry as well as supply chain and methodology changes to realise further cost reductions.

The following transformational/service redesign CIP schemes are being worked up and may deliver significant savings in 2013/14 or 2014/15:

- **Adult admissions avoidance and onward care co-ordination service for frail older people** – this service is being tendered for by NEW Devon CCG. It is expected to enable patients who might ordinarily have been admitted to return to their own home or normal place of residence as soon as it is safe to do so.

- **Pharmacy redesign** – preparatory work is being undertaken to consider the provision of outsourced outpatient pharmacy dispensing and the provision of a pharmaceutical robot. This would yield savings in 2014/15.

A set of KPI's for the Transformation Programme has been agreed, and will be used through the Governance Structure outlined above to assess the success of the Programme, including:

- **Patient Safety:** reduction in no. of avoidable harm incidents, compliance to safety standards
- **Patient Experience:** improved patient satisfaction, reduced no. of complaints
- **Financial:** cash releasing savings, maximising income, cost avoidance savings
- **Operational:** improved patient flow, 85% bed occupancy, reduced length of stay
- **People:** improved staff satisfaction, reduced absenteeism, increased skills/capability

### 4.4 CIP enablers

The extent of clinical leadership and engagement in identifying and delivering CIPs;

- The requirement for enabling investment in infrastructure (external support, IT, project delivery resources, etc.)

The Trust has an active set of service-line focused 'Clinician to Clinician' groups that meet regularly to identify efficiency and quality challenges for the clinical specialty and to agree solutions that benefit patients and the wider health economy. Via these groups, the Trust and commissioners have designed QIPP plans collaboratively and these are reflected in the Trust's finance and activity plans.

Clinicians participate in service line team meetings and assist in the scrutiny of SLR financial and performance information to identify potential CIP opportunities. Clinical engagement has been a feature of deep dive work to scrutinise loss making service areas to identify potential savings and this work will continue.

The Trust has invested in both systems and people to increase its capability to identify and deliver on CIP plans. Refining and improving patient level costing systems and techniques is allowing the production and use of SLR financial information to bring a focus to poor financial performance and enable investigation and improvement. Performance management systems are being developed to to ensure the right tools are in place to allow robust performance management in the drive towards service improvement and financial efficiency.

A review was undertaken of all projects relating to patient pathway redesign and Clinical Directors and Lead Nurses were pivotal in weighting projects in terms of regulatory compliance, financial impact, patient safety and experience. This informed the revision of project structure and priorities.
The Patient Pathway Improvement Programme has a Clinical Director as Project Sponsor. Each of the 6 projects within the programme have a clinical lead.

Investment has been made in 2012/13 and 2013/14 into significant support from an external management consultancy. They are assisting with the implementing of the Transformation Programme, including projects such as the Ward Management Project and Management System Project.

The Trust has also committed significant resource within its Capital Programme to invest in IM&T projects, particularly the implementation of phase II of an Electronic Patient Record, however there is a risk that there is insufficient investment to fully support productivity plans.

### 4.5 Quality Impact of CIPs

- The mechanism by which the Trust ensures that its CIP plans won't adversely affect quality of services;
- The measures of quality which will be used to inform this assurance and how the Trust monitors quality impact of CIPs on an on-going basis.

CIP plans within the Divisions are formally submitted via the annual Operational Planning process and, as part of this process, Divisional Managers are asked to provide assurance that patient safety is maintained. The Chief Nurse/Director of Service Delivery and Medical Director will review all assurance statements. In addition, it is planned to develop a quality impact assessment in line with the National Quality Board's document, "Quality Impact Assessments for Cost Improvement Programmes". All pathway work will integrate Patient Safety aspects to ensure that the quality of services is maintained/improved.

For 'step change' CIP plans a gateway process is in place, in which the approval process requires that an assessment is made of whether the change will adversely affect the quality of services. All pathway work will integrate Patient Safety aspects to ensure that the quality of services is maintained or improved.

For CIP plans that initially have not been identified as having an adverse effect on quality of services, close scrutiny of incidents, complaints and claims will be made and where possible appropriate measures put in place.

The creation of a benefits realisation group will monitor the achievement of all stated outcomes across domains of quality, cost and delivery. In addition the Board of Directors have recently commissioned a review of its Integrated Performance Report to strengthen the balanced scorecard approach.

The Performance Assurance system that is being implemented will ensure that a range of key measures are monitored on a systematic basis across all services. This will enable early identification of any adverse impact of CIP plans. This will sit within the wider Management System that will increase the rigour of staff at all levels monitoring and identifying early warning signals. The Senior Management review will create a strengthened clinical leadership in the organisation with clear accountability for quality of services.

## 5. Financial & Investment Strategy

### 5.1 An assessment of the Trust's current financial position

2012/13 was a challenging year which saw the RD&E recording a surplus of £1.3m prior to an impairment of £22.8m. This was below the £3.5m target but still produced a Financial Risk Rating of 3, in line with the planned FRR. The Trust has now generated a surplus in eight out of the nine years since becoming a first

wave Foundation Trust in 2004/05 which has been essential to enabling the Trust to reinvest to improve infrastructure and patient care. The Trust had a significant cash balance of £41.2m (24.6 days liquidity) against the plan of £41.7m as at 31st March 2013 which puts the Trust in a healthy position during this challenging financial period for the NHS. The Trust achieved recurrent CIP savings of £15.1m, against the £16.9m target.

The Board has approved a small surplus position of £100k for 2013/14 and 2014/15 returning to a surplus of £3.5m by 2015/16. This approach should enable the Trust to finance sufficient capital development over the planning period, whilst also setting a challenging but realistic CIP target and providing a reasonable contingency level for the risks identified (see below).

**5.2 Key financial priorities and investments and how these link to the Trust's overall strategy**.

The Trust has a key priority of maintaining financial stability over the long term. In line with strategic and operational plans, the following revenue and capital investments are planned:

- Nursing establishment review to ensure staffing levels continue to delivery safe care
- £1m further investment in reablement ward in 2013/14, building on the investment made in 2012/2013 to address issues around increased emergency admissions
- Enhanced Clinical leadership delivered through the senior management review
- Research & Development, learning and Development, jointly funded with the University of Exeter to reinforce compassionate care by staff
- Electronic Patient Record phase II – to enable productivity and safe care

**5.3 Key risks to achieving the financial strategy and mitigations.**

The key risks identified in achieving the Trust's financial strategy are:

- Increase in demand for services that result in an affordability problem for commissioners. Also in particular an increase in emergency activity that is only paid at 30% tariff
- Non delivery of CIP
- Budget overspending

Commissioner affordability

For 13/14, the Trust and New Devon CCG have jointly agreed a demand plan for the year offset by a realistic assessment of QIPP (at £3.1m compared to previously required levels of circa £10m that were not delivered through Commissioner plans). Even with this joint plan in place, there remains a risk that activity levels will exceed planned levels and in particular that the increase will be for emergency admissions (linked to the frail elderly population). This could lead to affordability issues for both the Commissioners and Trust. To mitigate this a risk management agreement has been developed with NEW Devon CCG to trigger and escalate to management action issues around QIPP non-delivery and unanticipated demand growth; and of QIPP delivery above expectations and associated activity and income reductions. The key purpose of the risk management agreement is to focus management effort to work together to plan and implement QIPP savings in a structured and co-ordinated way in order to deliver recurrent benefits to the local heath economy.

**Cost Improvement Plans (CIP)**

The total internal CIP target for the next three years (excluding QIPP) is expected to be £51.9m with £16.9m to be delivered in 2013/14. The main components of this target are:

- PbR efficiency built into the local and national tariff (£39.3m). This represents an efficiency reduction of 4.0% in Year 1, rising to 4.5% in Years 2 and 3.

- An additional internal savings requirement of £6m to support potential essential safety/quality developments that may be required has been included.
- In addition, the internal CIP target set by the Trust also reflects the need to save around 40% of the value of the income reduction related QIPP plans in the short-term (£6.1m). This represents the overheads that cannot immediately be saved as a result of activity reductions (such as depreciation, PDC dividends and other overheads). Some of this saving is likely to be generated by providing activity growth at a lower rate than the tariff provides and by improved productivity.

The achievement of this level of cost-improvement is potentially a significant risk to the organisation. The Trust has, however, demonstrated its ability to achieve a similar level of CIP in previous years. Risks will be managed by the monitoring of plans via the Transformation Board, Quarterly review, Board of Directors and the weekly PMO and project managers' meetings to track progress.

The Trust has currently identified CIP plans for 2013/14 with a recurrent impact of £9.6m (£16.7m plan) and a part-year effect in 2013/14 of £5.1m. The Trust has also identified a financial contingency for the non-recurrent impact of CIP profiling for 2013/14, which will ensure the focus of the organisation remains on delivery of recurrent savings rather than resorting to potentially damaging short term measures.

**Overspending on expenditure budgets**

The 30% tariff for emergency care above the 2008/2009 threshold creates a major challenge for the Trust and has the potential to impact negatively on the quality of care and over expenditure on operational budgets.

There is a risk that expenditure budgets will incur levels of expenditure above levels of additional income due to lack of budgetary control ; the impact of treating patients with higher acuity that are funded at 30% tariff; or the impact of social care finding reductions delaying onward care and tying up acute beds due to delayed discharges. To mitigate this risk the following action is being undertaken:

- Senior management review will provide an opportunity to redefine budgetary responsibility linked to enhanced clinical leadership. This will also link to further development of SLM
- Nursing establishment review has been undertaken to seek to address acuity issues. Ward Matrons will become supervisory to shift to enable greater budget management at ward level
- Risk management agreement with CCG includes escalation to address increased emergencies and delayed discharges

**Appendix 1: Financial commentary (NOT FOR PUBLICATION)**

NHS FT plans for 2013/14 should include financial forecasts for the three-year period 2013/14 to 2015/16 and reflect forward looking assumptions, projections or estimations as to revenues and costs, changes in productivity, and strategic capital and other investment projects. Where more detailed information is already included within the financial template, then this information should be referenced (and where appropriate not repeated) within the relevant sections.

**Guidance:** A good summary would normally include but not be limited to the factors listed below:

## 6. Income

- The principal drivers of income in the Strategic Plan (reflecting tariff deflation), making reference to the proportion of income under contract and where contracts have been signed; and non-NHS income;
- A summary of the principal income generation schemes (revenue generation CIPs) and other service developments;
- The risks to planned income (e.g. commissioning intentions, threats from other providers, marginal income thresholds, CQUINs and contractual penalties) with any accompanying mitigating actions;
- Where Trust income in 2012/13 has materially diverged from the Strategic Plan submitted in 2012, the extent of that divergence and what actions have been taken to ensure this is not repeated;
- An assessment of any non-recurrent funding received in 2012/13; and
- Underlying I&E surplus/deficit for each year of the Strategic Plan.

A single multi-commissioner contract has been agreed and Heads of Terms have been signed with NEW Devon CCG as co-ordinating commissioner on behalf of other CCGs and NHS England. All contract terms have been agreed, but the commissioning organisations need to resolve some inter-commissioner financial allocation issues before the contract can be formally signed. The values in the Heads of Terms and the agreed draft contract are consistent with the figures in the Financial Plan. The contract value for the NEW Devon CCG, which represents 68% of patient income, has been set at a higher level than the outturn for 2012/13. Despite the tariff deflator of 1.1% and the pressure on commissioners to reduce acute activity, this represents an agreed, realistic assessment by the Trust's commissioners of activity and income for 2013/14. The contract will run according to PbR rules, but includes additional management arrangements to minimise risk and incentivise all parties to focus on QIPP delivery and improved patient flow.

Risks to planned income as the result of commissioning intentions have been covered in Section 1.2.

The Trust is the majority provider for its local catchment area which includes both the city of Exeter, a number of coastal and market towns and a dispersed rural population. There is little competition for the Trust's acute services in this area, with neighbouring acute providers being located at some distance and with only small private providers within the Trust's catchment. No assumptions have been made about changes in market share. There are no anticipated changes in the local competitive environment apart from in relation to Any Qualified Provider which is covered elsewhere in this document.

CQUIN income is assumed in the plan at 85% which has been assessed as a reasonable expectation. A provision for contractual performance penalties has been included within the financial plan.

Principal drivers of income:

- Activity Growth – Activity growth of £8.2m has been allowed in the 2013/14 contract in addition to £2.9m of PbR-excluded 'Drugs and Devices' growth. In Years 2 and 3, 1.5% activity growth has been incorporated in the financial plan along with non-PbR growth of £1.5m in line with previous

years. This assumes 1% for population growth and a 0.5% estimate for an ageing population and technological changes.

- QIPP - in line with the agreed position with Commissioners, QIPP is assumed to offset growth in Years 2 and 3. Combined with a tariff deflator, this means that patient income shows a decrease from Year 1 to Year 3. QIPP for Year 1 is minimal at £3.2m and is lower than growth.
- CQUIN – Assumed level of CQUIN at 85% for each of the three years of the plan.
- RTT Target - In 2013/14 it is planned that in order to achieve the RTT target, additional non-recurring income (£1.7m) and expenditure (£1.7m) is required.
- Penalties of £370k have been included in the plan for 2013/14. These relate to ambulance handovers and orthopaedic RTT targets. These elements have been included in the plan based on the likelihood of these penalties being incurred. There is a risk of further penalties, particularly around Clostridium difficile which will need to be dealt with as part of the Trust's financial mitigation plans
- 98% of patient income (excluding private patients and RTA income) relates to contracted activity under the Standard National Acute Services Contract.

Income-generating schemes amount to c.£1.7m in 2013/14 (£2.6m full year) and includes an increase to private patients income.

Patient income for 2012/13 was £299.9m versus the planned £289.6m. This included £6.9m of additional income for PbR-excluded Drugs and Devices above the planned level along with activity over-performance. The final contract position for 2013/14 reflects this over-performance in activity and drugs and devices where these are deemed to be recurrent.

## 7. Strategic developments

- The contribution they are expected to make to the Strategic Plan;
- Financial impact (income, costs);
- The actions necessary to implement them;
- Key risks;
- Any regulatory requirements;
- Resourcing requirements (financial, staff and site);
- Measures by which the delivery of the service development will be tracked and assessed; and
- An assessment of how previous developments have subsequently performed and lessons learnt.

### Service Developments

There are no significant developments between 2013/14-2015/16 other than those detailed elsewhere in these Forward Plans.

## 8. Transactions

- Details of any planned UK health care investments or other transactions worth more than 10% of the Trust's assets, revenue or capital; or details of any planned changes in capital structure representing a change of more than 10% in the licence holder's capital employed over a 12-month period, and the contribution they are expected to make to the Strategic Plan;
- Financial impact (income, costs);
- The actions necessary to implement them;
- Key risks;
- Any regulatory requirements;
- Resourcing requirements (financial, staff and site);
- Measures by which the delivery of the transaction will be tracked and assessed; and

- An assessment of how previous transactions have subsequently performed and lessons learnt.

There are no planned investments or transactions worth more than 10% of the Trust's assets, revenue on capital currently included within this plan.

## 9. Activity

- Activity assumptions including detail on demographics, market share and demand management, with timing and linkages to the delivery of the Strategic Plan;
- Key actions/initiatives and potential delivery risks;
- Changes in resource requirements (staff and site); and
- Key milestones underpinning delivery.

Clearly, in some instances there will be overlap with other priorities included in other sections (e.g. income, workforce strategy, capital expenditure and service development strategy) and where this is the case these should be referenced in this section.

The following should be noted:

- Activity Growth – Activity growth of £8.2m has been allowed in the 2013/14 contract in addition to £2.9m of PbR-excluded 'Drugs and Devices' growth. In Years 2 and 3 non-PbR growth of £1.5m has been assumed in line with previous years, along with 1.5% for activity growth. This assumes 1% for population growth and a 0.5% estimate for an ageing population and technological changes.
- QIPP/Demand Management – QIPP is assumed to offset growth in Years 2 and 3. Combined with a tariff deflator, this means that patient income shows a decrease from Year 1 to Year 3. QIPP for Year 1 is minimal at £3.1m and is lower than growth.
- RTT Target - in 2013/14 in order to reduce waiting lists to provide additional assurance of target delivery, additional non-recurring income (£1.7m) is required and has been agreed with commissioners.

## 10. Workforce priorities

- The actions necessary to implement them;
- The key risks to implementation;
- The resourcing requirements (financial, staff and site);
- The measures by which delivery of the planned changes in workforce size, mix or configuration will be tracked; and
- How the Trust Board is assured that workforce changes will not impact quality e.g. benchmarking, skill- mix reviews.

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

Workforce priorities should be consistent with activity assumptions and CIPs. When considering the main workforce priorities, the following may be included:

- Changes in headcount (including benchmark evidence), skill 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 work streams; and
- Other workforce issues which may impact the Strategic Plan.

The overall aim of our Workforce Strategy is to ensure we are:

- Creating flexible workforce capacity
- Supporting staff to build skills and capability
- Establishing policies and processes which reinforce our values and that enables delivery of our corporate strategy

**Priority 1: Resource planning:**

For 2013/14 workforce numbers are expected to increase as a result of additional activity and the ward management review. However in 2014/15 and 2015/16 the anticipated workforce costs will fall. However we are anticipating a potential change in the mix of our workforce and will continuously monitor this, and provide assurance to the Trust Board. Changes to our workforce will be managed via a combination of fixed term contracts, bank workers, apprenticeships, secondments, assessing all vacancies, retention plans and managing turnover and absence. Where services are redesigned the strategy is to redeploy staff where possible, including retraining, to minimise the risk of compulsory redundancies.

We will continue to follow national pay agreements wherever possible and have completed steps to implement the recent Agenda for Change agreements. In addition, we will review the optimisers within the existing Agenda for Change Framework. We will actively encourage and support the national negotiations, agreed within the 2013/14 Agenda for Change, to identify further changes to the framework to ensure it remains affordable and fit for purpose. The Board will review progress and should the national negotiations not deliver the required progress will consider reinstating the South West Consortium approach.

To mitigate staff reaction to any changes we have improved our staff engagement and communication approach including the introduction of a new recognition scheme called ‘Extraordinary People’ will enable us to recognise our staff on a quarterly basis.

We will continue our national benchmarking to ensure size and shape remains in the lower quartile, and through this year will implement plans to sustain retention of key resource, maintain turnover at 10% or below and attain a sickness absence rate of 3%.

Any proposed service redesign changes will be risk assessed for the impact on the workforce, clinical services and patient care. Assurance to the Board of Directors will be provided through the Clinical Governance reporting structure.

**Organisational Capability:**

We will complete implementation of our new senior management structure reducing down to three operational divisions, an operational support team and central support functions. The design principles for the new structure are:

- Strengthen clinical leadership
- Seek to devolve decision making to the frontline
- Drive end to end pathway working
- Increase capacity and capability to deliver business as usual and future strategy performance
- Drive consistent application of a clearly defined management system

- Clarify roles and responsibilities

To support this change we will implement a comprehensive training and development programme enabling individuals to build their capability to fulfil their new role in the organisation.

**HR Processes & Systems**

We will review our HR policies and processes to ensure they are fit for purpose, and are aligned to our corporate strategy, the key focus is to:

- Reduce the number of policies and processes
- Simplify policies and processes ensuring they are clear to follow
- Embed our organisational values within policy and process design
- Clarify responsibility and accountability
- Monitor KPI's and maintain effective reporting enabling visibility of HR process performance

Developments with information technology will continue embedding the new CRMS medical staffing system to strengthen the job planning process for doctors, supported by further use of ESR and Rosterpro.

**Workforce Strategy - Resourcing:**

To drive and support implementation of the Workforce Strategy we have formed a Transformation & OD Team which integrates our PMO (Programme Management Office), Service Development, Communication & Engagement, and HR teams. This strategy will be the primary step change project undertaken the HR team, with support provided by the clinical and non-clinical staff.

**Recruitment**

The recruitment of Band 5 nurses in the region has been identified as a problem area and the deployment of the national/international recruitment strategy will continue. Formal links have been established with Job Centre Plus to work with the Trust on recruitment drives and work experience opportunities.

**Workforce Strategy - Governance & Risk:**

The core risks to the Workforce Strategy are:

| **Risk Identified** | **Mitigating Actions** |
|---|---|
| **Risk 1: Effective workforce planning is not aligned to service development, business development and/or financial plan** | • Establish mechanism which aligns all related activity<br>• Agree and train Leaders in workforce planning process, and evaluate consistent application |
| **Risk 2: Proposed changes to pay, terms and conditions, and cost of living affects attracting new talent and/or retaining existing capability** | • Implement a set of changes which reduces the impact staff feel of pay, terms and conditions changes – for example:<br>- engagement in pathway improvement work<br>- recognition via Extraordinary People<br>- investment in training and development<br>- involvement in designing new management system<br>- encourage staff to participate in staff |

| | |
|---|---|
| | benefits such as salary exchange schemes<br><br>• Maintain a collaborative working relationship with Staffside/Union Stakeholders<br>• Communication and engagement plan |

## 11. Capital Expenditure

- An overview of the estates strategy, including estates reorganisation and disposal of surplus assets;
- Capital Expenditure plans including an assessment of backlog maintenance levels, and general quality and sustainability of the estate;
- The purpose and description of each of the material schemes, amounts, timing and linkages to the delivery of the Strategic Plan;
- The key actions and delivery risk underpinning each material scheme;
- How each scheme is being financed; and
- The risk to quality from each scheme if slippage occurs.

The Board agreed that the priorities for capital investment should be to:

- Ensure that there is a proper programme of equipment replacement (safety, efficiency).
- Maintain the building infrastructure at an adequate standard (safety, patient experience).
- Fund existing commitments and future developments that contribute to the future strategic direction of the Trust and delivery of improved efficiency (safety, patient experience, efficiency).

The Board strategy is to maintain liquidity at around 25 days of operational expenditure, and therefore capital expenditure is broadly expected to be funded by depreciation, operational surplus, specific contributions and any slippage of capital from previous years.

The three year capital plan shows an overall source of funding of £44.3m, and a capital expenditure plan of £51.2m.

The Trust's Strategic Capital Group (SCG) acts as a steering group/capital projects programme board to maintain overall control and provide strategic direction for the delivery of the Capital Plan and the development of the Estate Strategy. In prioritising capital expenditure, the SCG has considered an Estates condition survey and has taken a view on an appropriate rolling programme to ensure buildings remain in a satisfactory condition. Furthermore finding replacement equipment is based on a percentage allocation based on fully depreciated items on the Trust's asset register. Funding for existing commitments and future developments includes the Research, Innovation, Learning and Development facility (jointly funded with the University) and investment in IM&T schemes.

The table below summarises the source and application of capital funds.

| | 2013/14<br>£'m | 2014/15<br>£'m | 2015/16<br>£'m |
|---|---|---|---|
| Surplus | 0.1 | 0.1 | 3.5 |
| Depreciation | 11.7 | 12.0 | 12.2 |
| Loan repayments | -1.3 | -1.3 | -1.3 |
| RILD funding from Exeter University | 8.6 | - | - |

| | | | |
|---|---|---|---|
| Funding available | 19.1 | 10.8 | 14.4 |
| Capital expenditure | -24.4 | -11.4 | -15.4 |
| Cash reduction | -5.3 | -0.6 | -1.0 |

## 12. Costs

- Marginal cost assumptions for additional activity;
- Workforce-related changes;
- The impact of inflation (e.g. pay; non-pay; drugs) and other cost pressures; and
- Identification of material non-recurrent revenue expenditure.

### Inflationary pressures

The table below sets out the inflationary pressures over the three year planning period that are assumed within the financial templates. The assumptions are based on a mixture of evidence-based items, estimates and historical evidence. Income and expenditure are assumed to increase by the same value as a result of inflationary pressure, and therefore there is no inherent benefit or loss incorporated into the model as a result of inflation.

| | 2013/14 | | | 2014/15 | | | 2015/16 | |
|---|---|---|---|---|---|---|---|---|
| | £ | Weighted % | | £ | Weighted % | | £ | Weighted % |
| Pay | 2.1 | 0.7% | | 2.2 | 0.7% | | 2.2 | 0.7% |
| Employers NI | -0.1 | 0.0% | | 0.0 | 0.0% | | 0.0 | 0.0% |
| Consultant CEA awards / Incremental | 0.6 | 0.2% | | 0.6 | 0.2% | | 0.6 | 0.2% |
| Non pay inflation | 1.4 | 0.5% | | 1.7 | 0.6% | | 1.6 | 0.6% |
| Commercial income inflation | -0.5 | -0.2% | | -0.8 | -0.3% | | -0.8 | -0.3% |
| Secondary care drugs | 0.8 | 0.3% | | 0.9 | 0.3% | | 0.9 | 0.3% |
| CNST | 0.6 | 0.2% | | 0.7 | 0.2% | | 0.7 | 0.2% |
| Capital Charges | -0.3 | 0.0% | | 0.4 | 0.1% | | 0.5 | 0.2% |
| Other | 4.0 | 1.2% | | 2.0 | 0.7% | | 1.9 | 0.6% |
| | 8.6 | 2.9% | | 7.7 | 2.5% | | 7.6 | 2.5% |

### Additional / Reduced costs of Activity growth / QIPP

The cost of activity and 'drugs and devices' growth has been included in the financial model, equivalent to the associated income growth. This makes the assumption that any impact on income of the emergency marginal tariff, non-payment for readmissions etc. can be offset by lower costs, but also that no contribution is being made by having costs lower than income for elective services. It is felt that this is a prudent assumption, particularly as experience has shown that an efficiency gain has been realised in recent years due to the cost of activity growth increasing at a lower rate than income.

It is anticipated that 60% of the income loss relating to QIPP reductions can be saved in reduced pay or non-pay costs. It is assumed that the remaining 40% of costs relating to overheads including buildings costs cannot be readily saved, and therefore the CIP target has been increased to allow for this.

**CQUIN**

Although for planning purposes it is assumed that the costs of achieving the CQUIN targets equal income, it is anticipated that the actual costs will be minimal and the financial surplus relating to CQUIN will be used as part of the Trust's mitigation plans to offset risks in year.

**Non-Recurring cost of achieving the RTT target**

In 2013/14 it is planned that in order to reduce waiting lists and provide additional assurance about waiting time target delivery, additional non-recurring income (£1.7m) and expenditure (£1.7m) is required.

**Other Provisions**

A cost provision of £2.0m is assumed for each of the three years 2013/14-2015/16 to allow for the revenue cost of developments (capital or revenue) in addition to any unavoidable cost increases. This provision is funded by an increased CIP. The expectation is that 60% of these costs will be pay related.

## 13. Risks and mitigation

- Financial downside analysis;
- Contingency built into the plan.

An explanation of the key checks will be e-mailed separately to the Monitor relationship team on submission of the Annual Plan.

The Board considered the potential risks and mitigation of its forward financial plan as part of the provisional budget set for 2013/14 in the March Board meeting. The key risks identified are set out below:

- Activity growth might be higher than jointly predicted by the Trust and commissioners and could therefore be unaffordable to the PCT, leading to difficulties for the Trust in recovering income.
- Potential non-achievement of the 2013/14 CIP target.
- Risk of overspending on pay or non-pay budgets.
- QIPP – risk of not being able to reduce the cost base in line with the planned income reductions.
- Risk of contract penalties relating to underachievement of targets for RTT, cancer, Clostridium difficile, mixed sex accommodation, A&E 4-hour wait, diagnostic 6 week waits.

These risks will be monitored at Board level through the year as part of the monthly Integrated Performance Report, and action plans developed where necessary. In addition the contract risks will be monitored and discussed with the NHS Devon contracting team on a monthly basis with the development of actions plans as necessary.

Delivery of CIP remains the key financial risk to the Trust for 2013/14 and beyond. Delivery of schemes will continue to be monitored on a monthly basis by the Executive Team which has a membership of all the Executive Directors and reports directly to the Trust Board of Directors via the Integrated Performance Report.

A financial contingency of £2.3m in 2013/14 and £2.0m in each of the subsequent years is available within the financial plan. This will be monitored throughout the year and the position against the contingency will be updated along with any changes in financial risks.

**Appendix 2: Cost Improvement Plans (CIPs) - Top 5 CIP Schemes (NOT FOR PUBLICATION)**

Note: this schedule is to provide additional information regarding CIPs. Please refer to CIPs guidance on page 5.

| Ref | Scheme | Scheme description including how scheme will reduce costs | Under-pinning IT / information or management systems | Total savings £m | Phasing over three-year period (£) | | | WTE Reduction | Has the scheme been subject to a quality impact assessment (Y/N) | Who is responsible for signing off on the quality impact assessment | Key measure of quality for plan | Scheme Lead |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Yr. 1 | Yr. 2 | Yr. 3 | | | | | |
| 1 | **Length of Stay initiatives** | **Reduction in patient length of stay. Reduced costs of care and increased patient throughput. Aim is to reduce inpatient stay by 0.5 days per patient.** | | **1.9** | **0.9** | **1.9** | **1.9** | **0.0** | **Will be carried out at point of decision to proceed with scheme** | **Scheme Lead** | **Readmission rates**<br><br>**Reduction in delayed discharges** | **E Wilkinson-Brice** |
| *2* | **Ward Management project** | **Improvements in patient flow, primarily by minimising delays and eliminating non-value adding activities. Achieved via** | | **1.5** | **0.8** | **1.5** | **1.5** | **0.0** | **Will be carried out at point of decision to proceed with scheme** | **Scheme Lead** | **Readmission rates**<br><br>**Reduction in delayed discharges**<br><br>**Reduced Diagnostic delays** | **T Cottam** |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **increased empowerment of ward teams and use of visual management tools and techniques.** | | | | | | | | | | |
| *3* | **Procurement Savings** | **Reduction in cost of supplies leading to direct savings for the Trust. Active management of contracts and tendering in order to reduce non-pay expenditure.** | | **0.7** | **0.7** | **0.7** | **0.7** | **0.0** | **Will be carried out at point of decision to proceed with scheme** | **Scheme Lead** | **?Procurement process ensures quality of purchases** | **S Tracey** |
| *4* | **Pharmacy savings** | **Reduction in drug-related expenditure across the Trust. Savings achieved through locally agreed contracts, products moving off patent, recycling of medicines and SCEP** | | **0.4** | **0.3** | **0.4** | **0.4** | **0.0** | **Will be carried out at point of decision to proceed with scheme** | **Scheme Lead** | **?** | **E Wilkinson-Brice** |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **(Supply Chain Excellence Program) implementation** | | | | | | | | | | |
| *5* | **Diagnostics savings** | **Review of staffing levels and non-pay expenses. Replacement of higher-banded staff with lower bands in Clinical Chemistry as well as supply chain and methodology changes to realise further cost reductions.** | | **0.3** | **0.3** | **0.3** | **0.3** | **3.1** | **Will be carried out at point of decision to proceed with scheme** | **Scheme Lead** | **Reduction in duplicated / unnecessary tests and treatment delays.** | **E Wilkinson-Brice** |

**Appendix 3: PFIs costs and utilisation (NOT FOR PUBLICATION)**

If during the Strategic Plan period a Trust has or will have a PFI scheme, please detail:

- Where a PFI already exists, please summarise the assumptions underpinning the business case for the PFI at the time of entering into the PFI and the assumptions underpinning the business case for the PFI now, explaining the reason for and financial impact of any changes;
- Where a new PFI scheme is planned, please summarise the assumptions underpinning the business case for the PFI or investment; and an assessment of the financial sustainability of the investment;
- PFI Unitary payment as % of income and any plans to reduce the proportion; and
- Utilisation of PFI resources and any plans to maximise use.

**This commentary should be consistent with the Trust's associated financial template.**

*Not applicable*

**Appendix 4: Use of external assurance (including internal audit) (NOT FOR PUBLICATION)**

Third party reports are a valuable tool for Trust Boards to gain assurance and to highlight areas of weakness within the Trust. Please indicate below the material assurance projects which the Trust has commissioned within the last 12 months, particularly in respect of the delivery of this plan and/or diagnosis of the issues it is trying to address, and any material issues or recommendations which were raised and proposed action plans to address them.

Over the last 12 months the Trust has engaged external input to help address issues linked to the delivery of this plan as follows:

- Unipart Expert Practices – Organisation and pathway diagnostics. The outputs of this work are linked into the Trust's plan for implementation of the Senior Management Review, the Transformation Programme and pathway redesign linked to this
- IMAS – Cancer and RTT delivery. Recommendations are being taken forward in respect of approach, systems and procedures which will help to ensure the Trust has sustainability for delivery against these targets
- PWC – collaboration with Taunton & Somerset NHS FT/market assessment regarding Frail and Older People. Both of these reports support key strands of the Trust's forward plans
- LINK – report a discharge process, this links to the Trust's work on improving services for frail and older people
- Board Intelligence – Board effectiveness, review and recommendations to ensure that Board is working effectively in its role, in particular around the delivery of strategy

**Appendix 5: Commercial or other confidential matters (NOT FOR PUBLICATION)**

None that have not been separately identified within this plan.