Royal Devon and Exeter NHS
NHS Foundation Trust

Operational Plan Document for 2015/16

Royal Devon & Exeter NHS Foundation Trust

Establishing Strategic Context and Progress against Delivery of the Strategy

The Trust's Corporate Strategy for 2014/15 to 2018/19 includes three strategic objectives:

- Maintaining sound operational delivery of existing clinical and research services
- Integration of care pathways from community through to acute care and back out again into the community. This will be done in partnership with other service providers of care as well as by increasing the Trust's own provision of whole pathways
- Further development of the Trust's acute services across a wider area by building on clinical networks and partnerships already in place.

The Operational Plan 2015/16 summarises how the Trust will progress these objectives in the context of a challenging national and local environment in terms of both finance and performance. The requirements for Operational Plan emphasise the immediate resilience challenge of 'maintaining sound operational delivery of existing services', but this is balanced with a longer term strategic focus on sustainability and transformational change.

Response to the 'Five Year Forward View'

The Trust has reviewed the 'Five Year Forward View' as part of the annual refresh of the Corporate Strategy and has confirmed that our strategic objectives and the schemes on our Trust Roadmap are aligned to achieving the vision of the Five Year Forward View. In particular, we are redefining our model of care to place more emphasis on health and wellbeing, with people gaining more control over their own care. We have a focus on integration with the transfer of community services adults with complex needs for the Eastern Devon locality as part of our plan for 2015/16. Our aspiration is ultimately to become an Accountable Care Organisation and our plans accord with the Primary and Acute Care Systems model outlined in the Five Year Forward View and we are working with local primary care in a pilot known as ICE (Integrated Care Exeter) to develop our plans in this respect. We applied to be a Vanguard Site for the PACS model but were unfortunately unsuccessful in the final stage of the process. We will nevertheless seek to deliver the plan outlined in our bid document.

Local Health Economy Financial Position

Planning for 2015/16 has been particularly difficult given the financial position of NEW Devon CCG and the uncertainty caused by insufficient commissioner resources to meet likely patient demand.

The Devon Health Economy, with North, East and West (NEW) Devon CCG as the commissioner, was identified in 2014/15 as a 'challenged health community'. Despite investment in turnaround capacity and external reviews, the position remains extremely challenging with a 2014/15 deficit of £27m and a cumulative deficit of £41m. The CCG received the lowest possible level of growth in its 2015/16 allocation.

This financial position led to NEW Devon CCG proposing a series of 'Urgent and Necessary Measures' in 2014/15 which involved restrictions on access to some treatments and challenges to contractual payments to acute providers. Many of these measures were subsequently withdrawn to allow more time for consultation and revised plans are due to be developed and implemented in 2015/16. The

Trust is working closely with the CCG to address the longer term financial sustainability of the Local Health Economy via a challenged health community recovery programme known as 'NHS Futures'.

The CCG is relying upon c.£7.5m of QIPP schemes in order to make its contract with the Trust affordable within the CCG's financial plans. At present, it has not been possible to assess how realistic these plans are. Some of these plans may be welcomed if they reduce the demand on acute services as this would help the Trust to deliver A&E, RTT and cancer targets, reduce backlogs and reduce excess pay costs (e.g. agency nursing). However, the CCG's plans will include a focus on reducing payments to the Trust via data challenges and other contractual enforcement measures. While experience shows that the Trust's contract data is robust, defending the Trust against such challenges is resource-intensive and there may be some as yet unidentified income risk.

Trust's Financial Position

The Trust's financial position for 2014/15 has been extremely challenging. The Trust finished the year with an £11.2m deficit compared to a planned deficit of £8.9m. A significant increase (8.5%) in emergency patients above 2013/14 levels was experienced for much of the year. This was particularly acute from December-March and led to the cancellation of surgical patients and subsequent loss of elective income during the last quarter of the year.

A significant proportion of CIP was achieved on a recurrent basis in 2014/15 (£15.7m compared to the £16.6m plan), however the majority (£11.4m) was achieved by using central reserves and by assuming CQUIN income is recurrent. The in-year CIP achievement was £12.6m, representing 3.8% of patient income.

During planning for 2014/15 the expectation was that registered nurse vacancies would be significantly reduced by October 2014. Despite a significant focus on recruitment, a combination of staff turnover, high patient acuity and operational pressures caused by excess emergency demand resulting in the need for extra capacity have led to continued high levels of agency expenditure. Total expenditure on agency nursing for 2014/15 was £7.6m out of a total nursing spend of £67.3m (11.3%) compared to £3.6m in 2013/14. With a premium of approximately 60% for agency nursing staff compared to Agenda for Change rates this equates to an excess cost of around £4.6m.

Slippage on planned developments has offset the majority of the financial shortfall.

Productivity, Efficiency and CIP

In order to break-even in 2015/16 the Trust would need to achieve CIP savings of around £27m which equates to 9.4% of Patient Income. The strategic initiatives noted elsewhere in this plan (e.g. integration, APT/EPR, bed and theatre capacity modelling) are expected to go some way to improving efficiency within the Trust in the future but it is unlikely that the Trust will see significant benefits in 2015/16. For 2015/16 the Trust is focusing on delivering savings via procurement, control of agency staffing expenditure, a number of Service Line and Trust wide savings and central mitigation. However as set out within last years' strategic plan, without a significant system change the Trust is unlikely to be able to deliver savings in excess of 2% going forward.

Having reviewed the scope for CIP schemes, the Board is expecting to achieve savings of around £6m (excluding carry-forward of 2014/15 CIP schemes) which represents just under 2% of forecast patient income in 2014/15. The plan for 2015/16 was predicated on delivering productivity efficiencies of £3m for 2015/16, however given the levels of expenditure on nursing cost at premium rates, and the capacity issues highlighted earlier in this plan, this is unlikely to be deliverable.

The Trust will continue to identify and develop schemes with the aim of achieving CIP in excess of the planned target. However a number of internal and external reviews have indicated that there are limited opportunities to make further cost savings.

Capital Programme

The proposed capital programme for the Trust for 2015/16 is £15.9m. The programme has been identified to support both the Trust's strategic plans and to ensure that there is a clear plan of replacement to support business as usual. Last year the Board of Directors took the decision to set the capital programme at a level which maintains the level of replacement equipment and estates infrastructure at an acceptable level, but also helped to support the Trust's liquidity. The Board recognised that in the longer term it was not sustainable to set the level of expenditure below the value of depreciation. However the Board also recognised the need to maintain a reasonable level of liquidity and therefore has adopted this approach over the short term only. This is supported by a process for identifying and risk assessing bids for replacement capital equipment through the divisional teams and for estates infrastructure based on a condition survey and infrastructure improvement plan.

During 2015/16 the Trust will spend £5.2m on replacement equipment and £2.6m on estates infrastructure. In addition there are plans to spend £3.0m on essential developments, and the expenditure mainly relates to providing additional theatres and ED resuscitation facilities to meet expected demand and growth.

The case for an EPR system to enable the Acute Pathways Transformation programme is described in more detail below. This scheme will have a capital requirement of £35.5m over a 15 year period of which £6.4m is required in 2015/16 (this is estimated to increase by a further £1.7m if the proposed community services transfer goes ahead in this year). Loan financing will be required to support this scheme. As the loan financing has not been approved, the financial effect has not been included within the annual financial plan.

Capacity and Demand

Over recent years the Trust has experienced emergency inpatient admissions growth of over 5% per annum in addition to an average growth in referrals per annum of around 9%. The Trust has accommodated this growth by productivity improvements (reduced LOS, improved theatre utilisation) and by some investment in increased bed numbers. However the Trust is reaching the point whereby projected growth cannot be contained in existing facilities.

This pressure on capacity has been exacerbated during 2014/15 due to the high number of emergency admissions (approximately 8.5% higher than 2013/14). Despite extensive actions by the Trust to create additional capacity (above that already planned during the winter period) there have been a significant number of cancellations of elective patients.

Target Performance

The Trust's performance across RTT, Cancer, Diagnostic and A&E targets was challenged in 2014/15 to a much greater extent than in previous years.

The cancellation of elective patients noted above, combined with increased referrals in some specialities, meant that elective surgery waiting list numbers rose by 12.5% during 2014/15, increasing the backlog to be addressed and presenting a risk to the achievement of RTT targets during 2015/16.

Referral rates were high in Q4 2013/14 and Q1 2014/15 which translated into conversions onto the admitted waiting list. During September the Trust experienced a four week period of Norovirus infection that led to bed closures and elective cancellations.

Emergency winter pressures began to manifest in late November with a slight respite prior to the Christmas period. The unprecedented demand for medical emergency and urgent care that followed in late December and January once again resulted in the cancellation of routine operations. This was compounded by further Norovirus problems with the consequent elective cancellations. The increase in the elective waiting list is shown in the graph below.

Achievement of cancer targets has been challenging in 2014/15 (2 week wait; 31 day diagnosis to first treatment; 31 day subsequent surgery; 62 day referral to treatment). In addition, the A&E 4-hour target was failed in Q4. The emergency demand and bed pressures outlined above were the major contributory factor. Cancer target delivery is likely to continue to be challenging in 2015/16.

Contract penalties are likely to be significant in 2015/16, in particular those for incomplete RTT pathways for which a) penalty rates have increased and b) performance will deteriorate further as a result of the recent emergency pressures and cancellations.

Actions to Improve Performance

In order to deliver key targets and provide increased assurance of delivery in the context of increased demand and reduced commissioner affordability, the Trust will,

- Create sufficient capacity within available financial resources to deliver 2015/16 anticipated demand with flexibility to respond to changes in emergency and elective demand, in order to provide short term resilience.
- Work closely with commissioners to manage demand to help the Local Health Economy achieve longer term financial sustainability.
- Where demand cannot be reduced, drive productivity as far as possible to accommodate additional demand within existing capacity.
- Create sufficient capacity in theatres and endoscopy.
- Plan and deliver sufficient staff.

These actions will create capacity for long term sustainability of RTT and cancer target delivery. However, as a consequence of the emergency pressures in 2015/16 and the knock-on effects on waiting list size and profile, there are immediate risks in relation to RTT and cancer target delivery in 2015/16.

Performance management of the action plans to restore target delivery will be done on a monthly basis via the Divisional Performance Meetings. These are structured meetings, supported by performance dashboards, numerical analyses and action plan monitoring across the domains of Finance, Performance, Operational Efficiency, Safety & Quality and Workforce. In addition, via the monthly Integrated Performance Report to the Board of Directors, the Trust Board will monitor performance and delivery of the action plans.

Quality

As at Q3 2014/15, the Trust had continued for a third quarter to maintain the maximum (lowest risk) Band 6, with 'no evidence of risk' against all indicators. Although it is too soon to say, the Trust is anticipating that this will also be the case in Q4. Quality and Safety indicators within the Board's monthly Integrated Performance Report have also shown impressive performance, with consistent Green ratings for the majority of indicators within the domains of 'Quality' and 'Clinical Effectiveness'.

Quality priorities for 2014/15 included:

- Hydration
- Outpatient Experience
- Integrated Care Exeter (ICE)
- #hello my name is….
- Nursing, Midwifery and Allied Health Professions Vision
- Patient Safety Programme

These initiatives have all delivered benefits in line with or exceeding expectations, with additional benefits not anticipated at the outset. Full details will be within the 2014/15 Quality Account. Further highlights relating to safety and quality in 2014/15 included:

- Devon Garden and Memory Walk
- Genomes Project
- End of Life Gold Standard Framework
- Living Beyond Cancer Project
- Integration Programme
- A&E Survey Results and National Cancer Survey Results

These will also be detailed within the 2014/15 Quality Account.

How the Trust will achieve its Strategic Objectives

During 2015/16, the Trust will commence the Future Care Programme which has been devised and developed to enable the RD&E to provide a sustainable, effective, efficient and personalised care system for the population of eastern Devon and the surrounding areas. The Programme will enable work to deliver a new model of care that focuses as much on wellness and prevention as ill health; that drives the need to see patients as people first and that empowers them to be in control of their own health care. The delivery of the new model of care, in a financially sustainable way, aligns to the direction of travel outlined in the NHS Five Year Forward View, which also promotes the use of modern technologies.

The key elements of the Programme are Integrated Care and Acute Pathway Transformation, with both enabled by a comprehensive Electronic Patient Record (EPR). These will not only support the transformation of services, but will also support the ongoing delivery of 'business as usual' (e.g. Hospital at Home is part of the integration programme, but also helps to reduce the demand on acute beds). These programmes are currently subject to a funding approval process.

a) Acute Pathway Transformation (APT) Programme, enabled by EPR

The APT Programme will redesign acute pathways and processes across the Trust in order to reduce variation, improve the safety and quality of care delivered and to increase the accessibility and reliability of information for the population of Devon, the provider partners and our commissioner stakeholders. These changes will be enabled by a comprehensive EPR and IT infrastructure as well as the appropriate organisational structure which will align workforce requirements to the future model of care requirements. Through addressing inefficiencies, the Trust will establish standardised ways of working that improves patient care outcomes and experience. In summary it will enable the following outcomes to be achieved:

- **Outcome 1:** Improved quality and safety of care – improved access to accurate and timely information speeding up diagnosis and treatment.
- **Outcome 2:** Standardisation of working practices.
- **Outcome 3:** New models of care – enabling integration of care across multiple settings and supporting care to be delivered in the right place (e.g. remote from an acute setting).
- **Outcome 4:** Single integrated patient record – aiding faster decision making and higher quality outcomes through instant access to real-time information for stakeholders across the health and, in the future, social care system.

- **Outcome 5:** A paperless environment – enabling achievement of national requirements relating to digital care records.
- **Outcome 6:** Improved efficient working – to drive removal of waste, duplication of effort, productivity improvement to create more capacity across all staff groups for higher value adding activity.
- **Outcome 7:** Future proofing the IT capability and capacity - that is required to support the new model of care thereby replacing legacy software, systems and infrastructure.

The APT Programme will enable a platform to be established through which the Trust's integration agenda can be progressed. The key milestones for 2015/16 include:

- Business Case approved by Board of Directors in April 2015.
- Acute pathway transformation programme to maximise efficiency benefits of EPR.
- Implementation team selected and trained by October 2015.

The financial plan does not currently incorporate the impact of the APT Programme as the EPR financing is going through an approvals process. If approved, the estimated impact on the I&E position would be to increase the deficit for 2015/16 by £15.0m to reflect set-up costs, with a loan requirement of £23.7m being the likely amount drawn down in Year 1 of the total £67.4m loan requirement. The FBC has recently been approved by the Board and will be the subject of a review by Monitor before an application is made to the ITFF. In order for the APT Programme to be implemented ahead of the winter in 2017/18, the Board has agreed to commence the Programme at risk requiring up to £1m of investment whilst a decision is awaited from Monitor/ITFF.

b) Integration

The community services within the Trust's natural catchment area are due to be transferred to the Trust during 2015 (anticipated date 1st January 2016). While the North East and West (NEW) Devon CCG's process for determining this arrangement has been challenged and is being considered by Monitor, the Trust is continuing to plan for that transfer.

The Trust intends to transform these community services by developing new models of integrated care, with a particular focus on,

- Single pathways of care between the acute hospital and community services for adults with complex care needs.
- Frailty - improving the co-ordination of services wrapped around frail older people, providing a rapid and integrated response to crisis supported by intensive reablement aimed at minimising the hospital length of stay and maximising rehabilitation potential.
- Long term condition management of "mostly well" and "pre-frail" people. This includes a fundamental review of how, why and where we deliver outpatient services for people with multiple long-term conditions that work to meet the holistic needs of the people (not just their disease management) and pulls on a wider range of service providers, in particular the voluntary sector and local community groups.
- Increased delivery of outpatient services closer to the people they serve, making better use of existing community and social facilities and resources.
- Work with the established social care and mental health teams to develop care co-ordination, system navigation and collaboration of multidisciplinary teams.

- Work with Eastern Devon GPs to identify groups with multiple health conditions and partnering with them to redesign services whilst promoting self-management and control for people e.g. through patients holding their own health and care budgets.

The financial plan does not currently incorporate the impact of the transfer of community services. Delays in the provision of information from the transferring Trust mean that there is limited information for the RDE to base assumptions on at this stage. If the transfer does take place, it is assumed that income and expenditure would both be uplifted by £12.5m for 2015/16 (£50m full year). There would also be additional costs in respect of due diligence and implementation costs of £1.9m, along with additional costs relating to the integration of the new EPR system within the community with a revenue cost of £2.2m and loan requirement of £3.9m to be drawn down in Year 1. The plan currently does not assume any capital or cash impact of the recurring running costs of the transfer of community services.

c) Specialised acute services

The Trust is working closely with neighbouring providers and commissioners to ensure that tertiary and specialised services are sustainable and meet commissioning requirements, recognising the particular access issues for the population of the South West. A number of services are likely to require particular focus in 2015/16, including Thoracic Surgery, Vascular Surgery, Specialised Respiratory Medicine, Cardiac Ablation and some cancer services.

The ETO 70% gain share/risk share rule for specialised services adds a further challenge to the development of these services. While the gain share/risk share is only currently in place for 2015/16 it is likely to have adverse consequences for the development of specialised services:

- Services that could be repatriated from out of area providers will, by definition, be above the 2014/15 Stated Base Value and so may only be funded at 70%. This will prevent more local services being developed.
- Service reconfigurations and rationalisation within the South West Peninsula are also likely to proceed more slowly until the longer term position on the 70% rule is known.

In the meantime, the Trust is continuing to plan for changes in specialised service provision in support of the Trust's longer term strategic aims and in support of local access to high quality services for our population. However, implementation of these plans is likely to be slower than previously intended.

Recommitment to the Strategy

The Trust Board has reconsidered its Corporate Strategy for 2014/15 to 2018/19 in the light of the above challenges. The Trust Board has concluded that this Strategy still offers the right direction for the Trust and gives the Trust the best path for longer term success and stability to meet the needs of the population that we serve. The Trust Board therefore recommits to the Strategy, despite these challenges. The Strategy offers potential solutions to some of the challenges (e.g. integration with community services to reduce pressure on acute beds and support RTT target delivery).

Plan for short-term resilience

a) Quality priorities

The Council of Governors discussed a list of quality priorities during their Development Day on 20th March 2015 and identified their key priorities as 'discharge processes' and 'patients with multiple health needs', as follows:

Discharge

Review of complaints under the category of Discharge? Identify themes, learning/changes as a result:

- Focus on those patients who do not require an acute hospital bed – how can we support earlier discharge? With a link to Mental Health – how many patients are delayed awaiting mental health onward care?
- How does the Trust ascertain if there is anyone at home to look after the patient on discharge?
- Information provision "care after discharge" – can this be enhanced?

Patients with multiple health needs

How can we improve the experience for patients? – Look at data to identify numbers affected, what specialties and does this include diagnostics?

- How can we join up appointments to reduce multiple attendances?
- Improvement of information flows to support the above?
- What can be done to ensure health records are available for multiple appointments on the same day, on different sites, i.e. RD&E Wonford and Heavitree?

These have been included amongst the Trust's quality priorities for 2015/16. Other priorities are:

Review of the Nursing, Midwifery and Allied Health Professionals Vision

We will develop a further three year Nursing Midwifery and Allied Health Professionals Vision. Within which we will feature the new "Code" which details the professional standards that registered nurses and midwives must uphold. We will use the four areas to develop our work, which are:

- Prioritise people
- Practice effectively
- Preserve safety
- Promote professionalism and trust

We will support our teams to provide evidence for revalidation, enabling our staff to provide evidence of fitness to practise and enable patients, carers and families to feedback as part of this process. We will also work together to deliver our future Model of Care. This will require us to continue to recruit and retain our staff but also develop new roles and continue to build the skills of our staff. We will continue to focus on safe staffing and implement new guidance as it is published over the forthcoming year. We will extend the Clinical School to incorporate our unregistered staff recognising the contribution that that they make to our patients, carers and their families.

Further development of the Integration Programme

(see, "Establishing strategic context")

Acute Pathway Transformation

(see, “Establishing strategic context”)

Patient Safety Programme

Key highlights for this year will be:

- Delivering a structured day and night for patient care to reduce falls – by having a greater focus on some of the fundamentals of care and providing care in a systematic way we anticipate that we will further reduce patient falls.
- Human Factors (continuing work of last year with additional focus on ward based human factors) – we plan to further implement our human factors training to encompass all ward areas. We hope to further improve outcomes for patients and reduce incidents.
- SKIN Matters (awaiting trajectory)- as a Trust we have made a significant impact on reducing the numbers and severity of pressure ulcers. We plan to continue this work over the next year to make further improvements.
- Acute Kidney Injury – a sudden reduction in Kidney function is both harmful and preventable. The goal of this work is to follow up and monitor those who have the condition and prevent further issues.
- Sepsis including ward areas – the aim of this work will be to ensure that through our direct admission areas including the Emergency Department, Medical and Surgical Assessment Units that we rapidly assess and treat patients with suspected sepsis.

Plan for short-term resilience

b) Operational requirements

Expected Activity Levels

The modelling of demand has been done jointly between the Trust and NEW Devon CCG. The joint provider-commissioner activity plan has been completed based on a three year activity trend, adjusted for movements in waiting lists. Following review by Divisional and Specialty management and clinical teams, the plan has been adjusted to reflect specific anticipated changes in clinical practice or anticipated demand that may result in volume changes. This process is jointly-managed with the CCG to ensure LHC alignment and to ensure that the best available data is used to inform demand forecasts.

This activity forecast has then been reviewed by Divisional and Specialty teams to ensure that the expected contracted activity levels can be delivered operationally. Based on the demand plan, growth has been included in the financial model as set out in the table below.

Patient Type	2014/15 outturn	2015/16 contract	% change
Elective inpatients	13,255	13,955	5.3%
Elective day case patients (Same day)	85,375	87,887	2.9%
Non-Elective*	53,243	54,028	1.47%
Outpatients - first attendance	122,408	143,204	17.0%
Outpatients - follow up	214,980	240,655	11.9%
Outpatients - procedures	97,796	86,304	-11.8%
A&E	94,742	92,879	-2.0%

* 2014/15 volume adjusted for Paediatric Assessment Unit activity for comparability with 2015/16

The demand planning process that is undertaken on an annual basis assists the Trust in identifying whether it has sufficient capacity to cover anticipated demands for elective and urgent care activities. The central focus has been on assessing bed and theatre capacity with an intended move to providing a unified approach to establishing on-going workforce requirements.

Bed Capacity Modelling

The Trust has completed comprehensive planning of bed capacity requirements and hospital occupancy which enables a planned response to any predicted growth in activity. The improved approach developed in previous years has allowed the Trust to predict with greater accuracy the bed requirements for the organisation and has led to improved outcomes of operational service delivery.

A Discrete Event Simulation (DES) model estimates the number of occupied beds in each of the four bed pools (Medical, Surgical, Gynaecology and Orthopaedic) for a number of scenarios. The scenarios used are:

- No change in admissions and no change in length of stay.
- Contracted growth in admissions and no change in length of stay.
- Contracted growth with admission avoidance scheme assumptions and length of stay with pathway redesign assumptions.

The model provides forecast information on percentage occupancy levels across the four defined bed pools to aid operational and financial decision making. The bed modelling output is also used to support proactive joint CCG, health and social care system resilience planning and required surge action plans.

A review of forecast bed capacity outputs takes place in year and is adjusted if any deviation from the forecast bed requirement is seen, which enables a system wide response to be considered.

Bed Capacity modelling outputs and key assumptions

Based upon the forecast joint Provider-Commissioner 2015/16 demand and capacity activity plan, adjusted for movements in waiting lists, the following bed capacity assumptions have been made:

- There will continue to be Medical Outliers at times of peak demand.
- It is acknowledged that infection control outbreaks may affect the provision of the proposed levels of activity.
- It is assumed that that there are no changes to onward care and community services provision.
- The forecast 2015/16 elective and non-elective surgical demand plan activity can be accommodated within the existing bed pools for Gynaecology, Surgical and Orthopaedics whilst maintaining agreed levels of occupancy, although it is recognised that some sub-specialty bed re - allocation may be required.
- Surgical bed occupancy will increase with the forecast growth which will increase risks to RTT delivery with the implementation of the winter swing ward to respond to medical non elective pressures during this period.
- Maintaining the Trust Board's stated ambition of 90% bed occupancy for 2015/16 within the Medical bed pool, would result in a deficit of between 61 and 92 beds. Even accepting a higher interim target of 92% (at which level quality of care could be maintained), the Trust would still require significant additional bed capacity..
- Forecast future growth will increase again in 2016/17 and beyond particularly within the Medical bed pool without significant investment or service change.

For 2015/16 both increased bed capacity and non-bed based solutions (clinical pathway redesign) are being considered to mitigate the forecast shortfall in bed capacity across all bed pools.

Theatres Capacity Modelling

The 'Formula 1 Theatres' project continues to drive efficiency within the Trust's operating theatres where utilisation levels are consistently high. Sustained improvements to increasing robust data quality within the theatre scheduling system is helping to further reduce late starts and early finishes

and identifying other potential inefficiencies, which enables more patients to be treated within the same resources.

Current work streams are also focusing upon increasing efficiencies, with further work looking to improve the productivity of hip and knee replacement and cataract lists due to their high value, and maximising the utilisation of lists in the Trust's Heavitree Hospital and the community hospitals' Day-Case Units. In addition to the work to refine theatre processes themselves, significant work continues to take place to reduce cancellations due to bed capacity, which has proved to be a significant barrier to theatre efficiency over the last quarter of 2014/15.

Optimising theatre efficiency, and balancing this within the overarching requirement to deliver services safely, is the core work of the Theatres Steering Group (TSG). The group meets monthly and is supported by the "Formula 1 Theatres" team who ensure that the decisions taken are supported by the best information available. Over the past two years the TSG has steadily improved theatre efficiency to its current high levels, however, there is unanimous agreement that the potential gains that might be made through increasing productivity are now relatively small.

The Trust is applying an elective surgical growth assumption of 3% which equates to a deficit of 47 theatre sessions across the next five years as outlined in the table below. This takes into account information provided on future demographic changes, the rate of technological and pharmacological change and the clinical view from the forward look at theatre requirements (carried out in 2014). Demand will be carefully monitored to identify any deviation from the forecast growth level. Based on the working growth model the demand for additional theatres is therefore forecast as follows:

Year	2015/16	2016/17	2017/18	2018/19	2019/20
Rate at which additional theatres could be implemented	0.8 (already agreed)	2.0	1.0	1.0	
Forecast theatre requirements	1.5	2.3	3.1	3.9	4.7

For 2015/16 an additional 8 theatre sessions have already been agreed following a business case to fully utilise the operating theatres on the Heavitree Hospital site. The remaining shortfall for 2015/16 and future predicted requirements for 2016/17 and onwards are currently being considered as part of the Long Term Financial Model (LTFM).

Contracted elective surgical activity has been restricted for 2015/16 as a result of the identified shortfall in theatre capacity. Contractual penalties and RTT performance implications are currently being considered.

Workforce

It is also likely that agency staff will need to be employed due to recruitment shortfalls, thereby increasing costs on a non-recurrent basis. An improved approach to workforce planning has been implemented which will quantify any different and/or increased requirement that may be driven by the Trust's strategic intention to establish a new model of care spanning both the acute and community settings. This new model of care may see the Trust diversifying into new markets

particularly for frail and older people, broadening existing portfolio of services and/or delivering care in the community. The combination of these will require the Trust to complete work to define changes to roles, increased flexibility requirements and changes to delivery of education and training. There are also likely to be line management challenges as the numbers of staff working remotely increases.

Potential investment may be required to support recruitment of increased staff and additional educational and learning activity to ensure new or changing service needs and any redesign of system-wide care pathways can be delivered safely and efficiently. The Trust's workforce profile will be monitored via the Workforce Strategy Group which will ensure that any anticipated change in the mix of the workforce is delivered effectively and that we take a broad range of approaches to establish staffing as required, including a combination of fixed term contracts, bank workers, apprenticeships, secondments; assessment of all vacancies; effective retention planning; and management of turnover and absence. Where services are redesigned, the strategy is to redeploy staff where possible, including retraining, to minimise the risk of compulsory redundancies.

Working in collaboration and maximising workforce opportunities with potential partnership arrangements is likely to mean the Trust will employ staff on different terms and conditions of service or have service level agreements in place to utilise the resource available across organisational boundaries. The Trust will explore the freedoms available to a Foundation Trust within existing national pay agreements, wherever possible, to ensure that our Terms and Conditions remain affordable and fit for purpose. The requirements to deliver 7/7 services will necessitate the review of all contractual arrangements and working practices to ensure that workforce plans are integrated with service plans.

To ensure our workforce is competent to deliver a world class service to the population it serves, we will continue to implement a structured suite of programmes to support senior leadership and middle/junior management capability development and will improve organisational performance through effective talent management, with a focus on retention and succession planning as a key component within the Trust's workforce development plan. In addition, the Trust will seek to influence the LETB to ensure adequate numbers of student places are commissioned.

To support the Workforce Strategy, the Trust has created an infrastructure of five Workforce subgroups covering all staff groups across the hospital. Each group will understand and use changes driven from the Trust Clinical Service Strategy and from the wider health and social care system to develop their workforce plans.

<u>Accommodating Fluctuations in Demand</u>

In addition to the longer term plans to increase available capacity, as outlined above, the Trust is also developing plans to flex short term capacity. This work includes outpatient capacity where increased cancer 2 week wait referrals in some specialties caused short-term capacity pressures in 2014/15.

The most important element of these plans is the identification of risks and development of plans well in advance of additional capacity being needed. As part of the demand/capacity modelling work, the Trust is identifying specialties that are particularly vulnerable to fluctuations in demand.

These will then provide the focus for joint QIPP work with the commissioners. In addition, the Trust's transformation projects, focused on beds, theatres and outpatients are intended to release capacity and will also identify additional ways to support the flexing of capacity to respond to fluctuations in demand. Specialties with excess capacity will also be identified to allow capacity to be switched if required.

The Trust's risk management approach to the 2015/16 contract with the CCG will also include a joint commitment to address fluctuations in demand by the CCG commissioning additional capacity or managing demand for services, following the breaching of agreed thresholds for action. The CCG has established an Elective Control Centre and an Emergency Control Centre to Co-ordinate commissioner and primary care responses to increases in demand or delays in onward care.

To further mitigate the 2015/16 forecast growth which cannot be accommodated without service continuity risks, joint operational planning through the Systems Resilience Group is underway, involving commissioners and partner agencies to plan alternative models of care to accommodate the forecast levels of growth. These plans are fundamental to the CCG strategy to deliver more care closer to home and reduce the reliance on bed based services, particularly in acute services. The alignment of the strategic intentions across all parts of the Local Health Economy should guarantee the leadership commitment to deliver these service changes.

Plan for short-term resilience

c) Financial forecasts

Financial Context

Prior to 2013/14, since becoming a Foundation Trust in 2004/05 the Trust has achieved a financial surplus (prior to impairments) in all but one of the financial years. This enabled the Trust to build a healthy balance sheet, increasing cash from less than £1m in 2004/05 to £38.4 at the end of 2013/14. Since 2013/14 the Trust has experienced an increasing deficit position rising from £3.1m (before impairments) to £11.2m in 2014/15 as a result of an increasing difficulty in achieving the efficiency requirement built into the annual tariff. Although the efficiency target assumes a level of "tariff drift", due to the challenged Local Health Economy (LHE) position in Devon, the Trust has seen little benefit of this.

For 2015/16 the Trust is planning for an operational income and expenditure deficit of £20.2m, The key reason for the further increase in the operational deficit in 2015/16 is that CIP has been included at a level the Board expect can be achieved, along with operational pressures in particular relating to the premium cost of agency nurses, the introduction of marginal tariffs for specialist services and the continued negative impact (circa £17m) of the application of the market forces factor deflator.

In consultation with Monitor, this plan has been prepared on the basis that the Trust continues to deliver its current patient services and activity ('business as usual'). The strategic developments relating to Integration and the implementation of an Electronic Patient Record system have not been included within the Trust's annual financial plan. Instead they have been included within the financial commentary to provide information on the future significant strategies that have been identified by the Trust's Board of Directors.

The impact of the increased deficit for 2015/16 is that cash reduces from £27.4m at the end of 2014/15 to £5.2m by the end of 2015/16. Although the draft plan submitted to Monitor in April declared a requirement for £10m working capital by the end of the year, clarification of the procedure for drawdown received from Monitor on 20th April 2015, indicates that the Trust cannot access the facility until Trust cash is below two operating days (approximately £2m). The lowest cash balance predicted during 2015/16 is £3.3m, and therefore the plan assumes no working capital is required, however the downside scenario included within the plan shows a requirement for £2.4m of working capital facility. The Board of Directors has based its self-certification on the availability of resources based on the baseline plan.

Due to the reduced level of liquidity days by the end of 2015/16 the Trust Continuity of Service Risk Rating (CoSRR) reduces to a '2' during Q3. The Board is therefore unable to confirm that the Trust will continue to maintain a Continuity of Service Risk Rating of at least 3 over the next 12 months.

The table on the following page highlights the key financial indicators.

	2014/15 outturn £m	2015/16 plan £m
Patient Income	330.9	336.2
Commercial Income	68.3	68.1
Total Income	399.1	404.3
Expenditure	-410.3	-424.5
Deficit	**-11.2**	**--20.2**
Cash	27.4	5.2
Capital	9.0	15.9
Loan Requirement	0.0	2.1
EBITDA	**1.8%**	**0.0%**
CoSSR	**3**	**2**

The key movements from the previous planned £13.5m deficit for 2015/16, submitted as part of the Operational Plan in March 2014, and the revised £20.2m operational deficit relates to an improvement on patient income assumptions of £5.0m offset by a reduced CIP target of £4.9m, increased winter pressures, e-notes and inflation costs of £4.7m and increased operational costs relating to agency nursing of £2.1m.

Patient Activity

Over-performance against the annual plan submitted in April 2014 was £1.8m. It is expected that this will be consolidated into the contract for 2015/16 along with forecast growth expected during 2015/16 of £8.6m. Of the total £10.4m, £2.5m relates to growth in excluded drugs and devices for which the costs are passed directly to the commissioners at 100% of cost, (but with growth for Specialised services only reimbursed at 70% of cost).

The joint provider-commissioner activity plan was completed based on a three year activity trend, adjusted for movements in waiting lists and for anticipated changes in clinical practice or demand.

Clinical Divisions are in the process of developing detailed operational capacity plans to ensure that they have sufficient staffing resource to meet the changes in demand. These plans will be finalised alongside the final agreement of the financial schedules which support the patient contract.

Patient Income

The Trust has accepted the ETO tariff. Contract schedules with NEW Devon CCG (as Co-ordinating Commissioner for CCGs) and NHS England are in the process of being finalised and therefore the figures above may be subject to change. Delays in the national tariff and contract guidance and CCG affordability constraints have delayed the agreement of contracts, but the position with all commissioners is that contracts are close to agreement and there is no need for mediation or arbitration. At the time of writing this plan the CQUIN schemes have not yet been agreed, but negotiations are ongoing and schemes should be agreed ahead of the national backstop date of 31st May 2015.

Contract penalties of £1.5m have been assumed in the financial plan, based on the new 2015/16 Standard Contract penalty rates and an estimate of performance against key targets in 2015/16.

QIPP

The CCG is assuming c.£7.5m of QIPP schemes in order to make its contract with the Trust affordable within the CCG's financial plans. These schemes are still in development and the Trust is working

with the CCG to assess the likely impact. If the schemes are effective in reducing demand this will help to mitigate risks to key targets (RTT, cancer, A&E, diagnostic waits). Effective demand management schemes will also improve commissioner affordability, enable the Trust to reduce costs (e.g. agency nursing) and provide a more sustainable financial position for the Local Health Economy. There are a number of schemes focused on reducing PbR-excluded drug expenditure that should give financial benefits for commissioners without any financial effect on the Trust.

Cost Assumptions

The key assumptions which impact on cost are inflation, efficiency (CIP), activity growth and strategic expenditure issues, the detailed assumptions for which are set out below:

Inflation

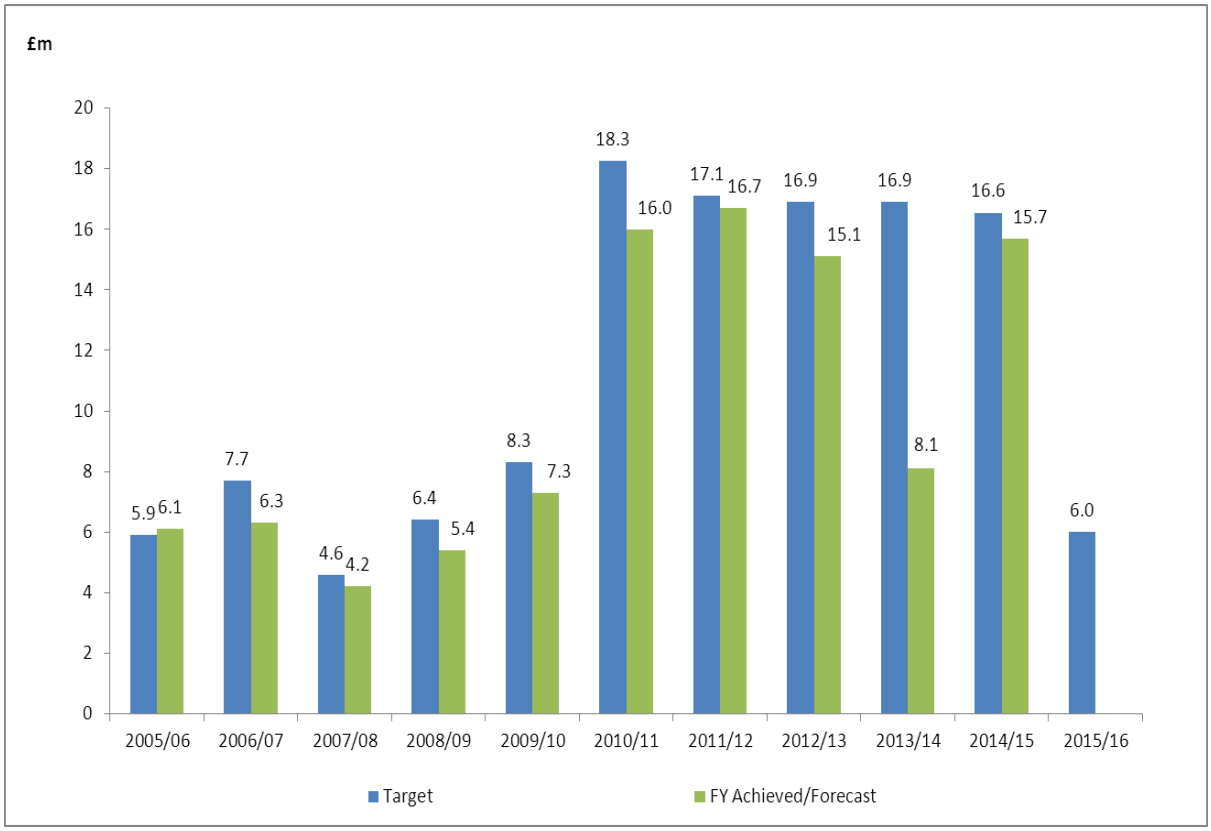
An uplift in cost for 2015/16 has been assumed at £9.8. This reflects known changes such as CNST, pay and non-pay inflation, pensions and capital charges with the balance relating to reserves which have been set aside for the year (based on the information in the table below) until cost increases are known.

Description	2015/16	£m	Basis of calculation
Pay Inflation/Incremental Uplift (up to point 42)	0.66%	1.9	In line with agreed AFC pay settlement
Pension increase	0.17%	0.5	Revised employers pension contributions in 2015/16 in line with national guidance.
CEA awards / incremental	0.21%	0.6	For 2015/16 Clinical Excellence Awards, derived based on the national calculation for CEAs.
Non pay	0.53%	1.5	1.5% of 2014/15 non-pay budget
Drugs	0.22%	0.6	7% of 2014/15 drugs budget excluding pass through drugs recharged to the commissioner
Capital Charges	0.46%	1.3	Forecast capital charge increase expected for 2015/16
CNST	1.32%	3.8	Increase as per NHSLA notification
Utilities	0.17%	0.5	7.5% increase forecast for 2015/16 for electricity, gas, water and sewerage.
Commercial income	-0.32%	-0.9	1% applied to expected income from other NHS bodies and 2.5% on other commercial income.
	3.41%	9.8	

CIP

Nationally the NHS is facing an uncertain financial position over the next 4-5 years, with an expected funding gap of £30 billion by 2020/21. This is likely to result in a lower level of resources being available to acute trusts as a result of efficiency targets, with an expectation of changes in patient flow with better integration of care across primary, secondary and social care.

The following graph shows the target and achievement of CIP from 2005/06 through to 2015/16.

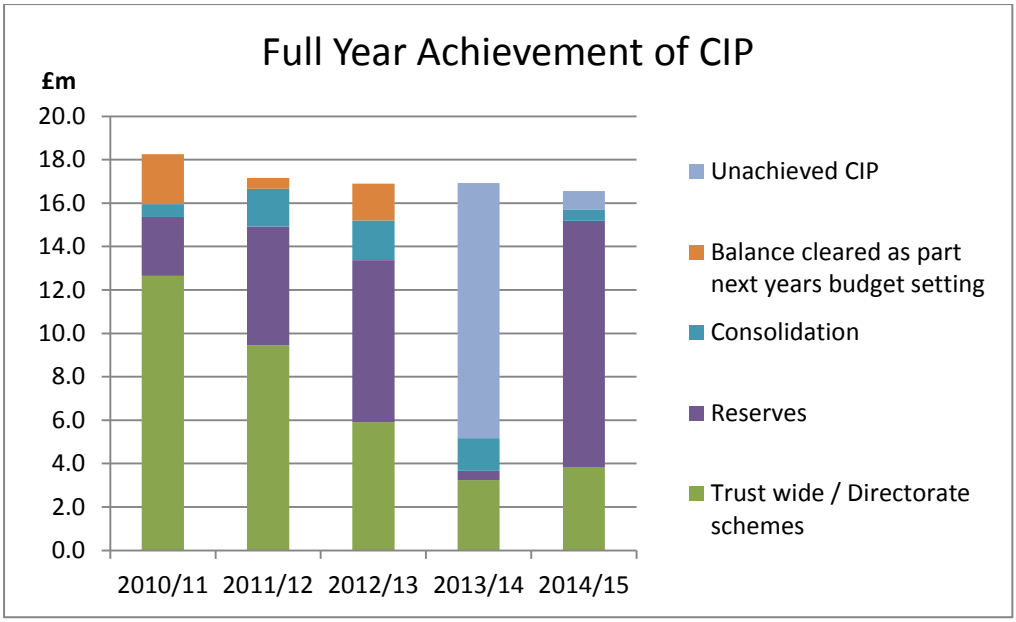


Note - £11.9m of CIP achieved in 14/15 related to use of reserves and CQUIN income.

Since 2010/11 a tariff efficiency requirement of 4% of income has been applied. This has led to the Trust achieving £71.6m of recurring savings between 2010/11-2014/15.

In addition to the efficiency requirement reflected in the tariff, other tariff rules designed to encourage Local Health Economies (LHEs) to reduce hospital admissions have also led to a significant reduction in income received by the Trust. For 2015/16 these include the emergency rule (£3.0m) emergency readmissions (£2.7m), and a 70% marginal rate on specialist commissioning from 2015/16 (£0.6m).

Savings for 2014/15 have been difficult to achieve and although recurrently £15.7m was achieved, £6.9m of this came from reserves along with £5m being achieved by treating CQUIN income as recurring income. CIP has increasingly been achieved by using reserves which have now been utilised. Delivery of CIP through traditional CIP schemes has fallen over the last five years from £12.7m in 2010/11 to £3.8m in 2014/15, this can be seen in the graph below.



Although nationally it is recognised that the NHS has delivered around 0.4% - 1.4% of productivity savings per annum, Monitor believe that there is an opportunity for acute providers to deliver 2.0% per annum over the next four years. The tariff efficiency however has been set at a level of 3.5% per annum due to the fact that commissioners are assumed to have paid additional income to providers in the past in addition to activity changes. These payments have been described as 'tariff leakage'. It is unlikely however that the Trust will see any benefit from tariff leakage given that the largest commissioner of services from the Trust (NEW Devon CCG representing £216m of £330m patient income in 2014/15) is currently in financial distress.

The Trust has averaged CIP delivery of 5.2% per annum over the last five years and demonstrated with numerous benchmarking exercises that it is efficient. The most widely used indicator, which provides an overview of efficiency across £308m of the Trust's £318m cost base, is reference costs. One of the outputs of the exercise is an efficiency factor, which for the Trust gives a figure of 91 (96 adjusted for Market Forces Factor). An indicator below 100 indicates a trusts are more efficient than would be expected, and this therefore makes it more difficult for the Trust to realise efficiency savings in the future, although there is further work that can be carried out to give assurance that the Trust is doing all it can to achieve the savings including:

- Benchmarking of service line cost / consultant productivity
- Review of reference cost services in excess of 100
- Continued benchmarking of other services through membership of NHS Benchmarking – older people, theatres and corporate services all reviewed in last year.
- Comparison of other Trusts plans (e.g. AUKUH, membership of South West CIP Network)
- Comparison of operational performance with upper quartiles nationally (e.g. length of stay, DNAs etc)
- Seek and develop opportunities to increase commercial income (e.g. Pharmacy, EMI facilities)
- Market testing of services – e.g. Pathology, Facilities

In recent years the Trust has been reviewed by external organisations to identify additional CIP opportunities. Most recently Unipart Expert Practices were engaged on a number of projects and during this time undertook an extensive review of CIP possibilities. At that time very little was identified and the opportunities that were identified have now been acted upon.

The CIP target for 2015/16, based upon Monitor's 2015/16 efficiency target would be £10.1m, (excluding drugs and devices income). Due to the current deficit position, the Trust would need to achieve savings of £27.1m in 2015/16 in order to achieve a break-even position (around 9.4% of patient income).

Following Board discussions in February 2015, and recognising the level of achievement of CIP (excluding central budgets) in the previous two years, the Board has set a realistic but challenging minimum target of £6m.

The table below shows the CIP plans for 2015/16. In addition to the 2015/16 planned CIP of £6m a further £0.9m CIP requirement has been brought forward from 2014/15.

CIP Category	**CY £m**	**FY £m**
Procurement	0.5	1.3
Pharmacy Drugs	0.1	0.1
Private Patients	0.0	0.7
Medical LoS	0.2	0.6
Specialist Commissioning of Complex Patients	0.2	0.4
Nursing Agency	0.1	0.3
Other	1.1	2.0
Unidentified	3.9	0.7
Total 2015/16 Plan	**6.0**	**6.0**

The CIP schemes have built on the work of the Trust's Transformation Programme and can be categorised as follows:

- Procurement (£1.3m 0.95% of non-pay spend) – The Trust has commissioned a piece of work on the procurement strategy which will include how we can better engage with clinical teams, as well as consideration of the mix of local / regional and national procurement models going forward. In conjunction with this, working with the PPSA, the Trust will seek to further standardise products and negotiate lower prices, particularly within cardiology and gastroenterology.
- Pharmacy drugs (£0.1m 0.04% of non-pay spend).
- Private patients – The building of a 12 bedded private patient unit for inpatients and outpatients to improve patient experience and increase income. This is currently under review given the level of capital requirement for strategic and 'business as usual' projects.
- Medical Length of stay - There are a number of projects within Medical Services that are expected to have a positive effect in either reducing admissions or length to stay. These include the expansion of the Hospital at Home Service and early supported discharge for stroke service. The development of home delivered IV antibiotics and day case facilities are being explored.
- Specialist commissioning for complex patients - The tariff arrangements and provision of services for certain spinal procedures and support for intestinal failure will be reviewed with Specialist Commissioning.
- Nursing Agency – Following successful awarding of the tender for Medical Agency services across a consortium of Trusts in the South West, a similar approach is being set up for Nursing Agency series. This could have significant impact, along with increased use of bank nurses and recruitment (including overseas), in reducing the use and spend on agency nurses.

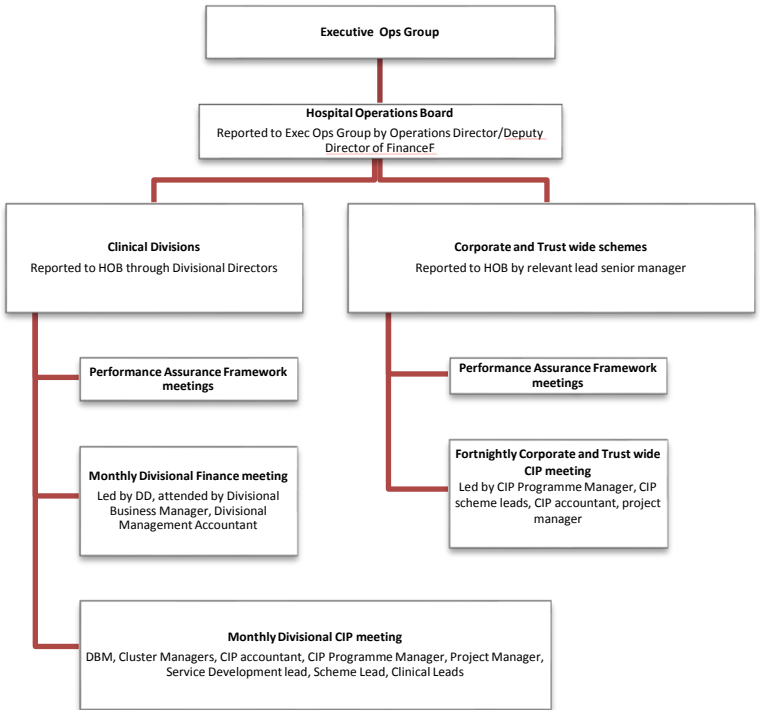
In order to reduce the level of unidentified CIP for 2015/16, the following work will be undertaken:

- Benchmarking data packs being produced for each Clinical Division –
    - to include 13/14 ref costs data, theatre operating times, PbR national benchmark data, NHS Better Care Better Values data, NHS benchmarking network reports, Monitor FTC data.
    - to be reviewed by central CIP team to identify opportunities.
    - to be discussed with Divisions within May to agree additional CIP plans.
- Healthcare Evaluation Data System – currently being purchased to be used to provide further benchmarking data to Divisions in June 2015.
- Procurement strategy development and proposals sought for further standardisation of products
- Exploring benefits of creating productivity model for clinical services
- Further work on agency premium
- Scope 17 schemes currently with no target attached to identify CIP benefit

Risk rating for 2015/16 CIP Schemes:

Risk Category	**CY £m**	**FY £m**
High	4.4	3.2
Medium	1.1	1.8
Low	0.5	1.0
Total 2015/16 Plan	**6.0**	**6.0**

In order to mitigate this risk a robust governance process and dedicated corporate resource is in place. The governance process for CIP schemes is as shown below:



Each CIP scheme is led by a senior manager who is accountable for delivery. The Hospital Operations Board is responsible for monitoring and performance managing the delivery of the annual CIP programme.

The Transformation Project Management Office and Service Development team provide dedicated support to the Clinical Divisions on CIP schemes. Project management methodology is implemented where appropriate for CIP schemes. Quality Impact Assessments are carried out for all CIP schemes. High risk schemes are then reviewed by the Chief Nurse/Chief Operating Officer and Medical Director who make a decision about whether they can proceed.

2014/15 & 2015/16 Cost of Activity Growth

As described within the section on income, the costs of activity growth are assumed to be 100% of the income received for 2015/16. This results in an expenditure reserve for 2015/16 of £10.4m (£2.5m relating to pass through drugs and devices).

Expenditure plans have been submitted by both clinical and non-clinical Divisions over and above the funding allocated for activity growth. This is in part due to expenditure issues arising in 2014/15 of which the key areas of expenditure are:-

- Agency premiums for staff (particularly nursing) above Agenda for Change rates (see below).
- Expenditure on waiting list initiatives due to increased activity, physical capacity shortfalls and difficulty in recruiting to some specialties.
- A reduction in funding by the Deanery during 2014/15 and into 2015/16 for training grade medical staff which has either been reduced or withdrawn for posts that are still required by the Trust in order to fulfil rota's.

Following agreement of the CCG activity plans at the end of April, the Divisions will present their plans to a panel consisting of the Deputy Directors. Once finalised a summary of the plans will be presented to the Director of Finance and Business Development and the Chief Nurse / Chief Operating Officer.

The planning process as described above is expected to be completed during May.

Due to the cost pressures highlighted above, an additional £3.0m has been set aside to fund any agreed increased level of expenditure.

Agency Nursing Cost

During 2014/15 the use of agencies for the provision of nursing staff (both registered and un-registered nurses) was the highest experienced by the Trust at a cost of £7.6m. The premium associated within this cost for the use of agencies is estimated to be circa £4.6m. The main reason for this expenditure is due to vacancies, increased dependency and acuity of patients requiring one to one care, and the opening of additional beds to manage winter pressures. At the end of 2014/15 the Trust had 94 whole time equivalent (wte) registered nurse vacancies and 14 wte un-registered nursing vacancies.

The Nursing Workforce Strategy Group over the past year have created a number of strategies to reduce the reliance on agency staff by increasing the robustness of processes to recruit and retain staff, and increase the usage of the Trust's Bank Staff. The strategies that have been implemented recently or are currently being developed are:

- Recruitment of Practice Educators across the Trust to work with new staff, particularly those from overseas to help develop essential competency; this has been well received and beginning to make an impact on staff turnover. It is proposed that these arrangements are developed further to support the teams in the year ahead.

- Increased direct (local) and overseas recruitment from Italy, Ireland, Spain, Portugal, Greece, Poland and Romania. The Trust is currently considering going further afield e.g. to the Philippines.
- Work with Exeter University to set up a number of training posts within the Trust, increasing the number of student nurses.
- Addressing how non-registered staff can be supported in becoming registered and increasing the number of student placements.
- Increased recruitment of apprentices to fill the un-registered vacancies.
- Incentives for staff to remain on the Trust's Nurse Bank.
- Changes to the way Nurse Bank operates, for example offering a weekly payroll service.

Posts have been established within Divisions to undertake interviews for staff that submit resignations to help establish reasons and to try and persuade staff to continue to work for the Trust.

Other Operational Expenditure issues

- E-Notes (£0.5m). The Trust is in the process of scanning all the medical records for patients so they can be accessed quickly and efficiently by clinicians. It will also remove the need to provide storage facilities and staff to maintain the records. This is an on-going scheme for which additional resources are required.

- Winter Pressures (£1.6m). £1.1m of additional expenditure is expected to be incurred during April - June 2015, with £0.5m available for the winter of 2015/16.

- Other reserves / contingency. A recurring revenue reserve / contingency of £3m has been provided for 2015/16. This relates to a £1m reserve for operational or strategic developments, £1m for essential requests that arise during the year and a £1m contingency. Due to the financial position of the Trust, expenditure will not be committed unless it is essential for delivery of the operational or strategic needs of the Trust.

Capital

A capital planning cycle has been undertaken to identify the Trust's capital requirements for 2015/16 and future years. Clinical Divisions and Support Directorates have submitted capital requests to replace existing equipment, maintain the Trust's existing estate infrastructure and to invest in new development initiatives.

Replacement equipment

Last year the Board of Directors took the decision to set the capital programme at a level which maintains the level of replacement equipment and estates infrastructure at an acceptable level, but also helped to support the Trust's liquidity. The Board recognised that in the longer term it was not sustainable to set the level of expenditure below the value of depreciation, however also recognised the need to maintain a reasonable level of liquidity. Replacement equipment requests for 2015/16 were evaluated and prioritised based upon their risk assessment scores. From the assessments undertaken it was identified that an additional investment was required in 2015/16 to replace existing equipment. The original funding planned was £3m and this value has now been increased to £5.2m. Further work

will be undertaken within 2015/16 to assess the level of funding that is required to replace equipment in future years.

Estates infrastructure

The planned level of expenditure is £2.6m and is in line with last year's planned expenditure. The purpose of this investment is to continue to reinvest and update the Trust's existing estates infrastructure, so the Trust can continue to maintain its sound operational delivery of services. The allocation is based upon an estate's condition survey previously undertaken by an external company. Essential development requests

As part of the capital planning cycle, Divisions and Support Directorates have identified future capital development schemes. These schemes have been prioritised based upon their risk and funding assessments and have also been aligned with the Trust's strategy. The planned level of expenditure for 2015/16 is £3.0m and mainly relates to providing additional theatres and ED resuscitation facilities to meet expected demand and growth.

The plan assumes that the Trust will enter into and receive loans to fund £2.1m of these capital developments.

Contingency

A capital contingency fund of £1m is available, similar to previous years, to fund the urgent replacement of equipment that was not planned to be replaced.

Capital schemes brought forward from 2014/15

The Annual Plan also includes £4.1m for other capital schemes that were approved in 2014/15, but their delivery was delayed until 2015/16.

Summary Capital expenditure 2015/16

Category	£m
Replacement equipment	5.2
Estates infrastructure	2.6
New developments	3.0
Contingency	1.0
Schemes brought forward from 2014/15	4.1
Total	**15.9**

Cash

The cash balance at the end of March 2015 was £27.4m, and the balance is forecast to reduce to £5.2m by the end of March 2016, with lowest balance reducing to £3.3m during the year. The deterioration is mainly due to the Trust forecasting to an operational deficit of £20.2m. As previously stated the plan assumes that the Trust will require external loans to fund the capital developments reported above. The table below summarises the main forecast changes to the Trust's cash position.

Item	£m	£m
Opening cash 1 April 2015		**27.4**
Deficit for the year	-20.2	
Depreciation expenditure non-cash cost included in above deficit	12.6	
		-7.6
Capital expenditure as reported above		-15.9
Movements in working capital		0.5
Repayment of loans		-1.3
New ITFF loans drawn down		2.1
Closing cash 31 March 2016		**5.2**

The plan has been prepared on the basis that the Trust is unlikely to require interim or planned cash support from the Department of Health. Some sensitivity analysis has been carried out considering various financial risks and potential mitigations. If these risks were realised the Trust may require some financial funding to support its liquidity. See the 'Sensitivity Analysis' section below for further details.

Continuity of Services Risk Rating (CoSRR)

The impact of the financial assumptions as set out above is that the CoSRR reduces from a '3' at the end of 2014/15 to a '2' during 2015/16.

Due to the increased deficit during the planning period the liquidity ratio reduces from a '4' at the end of 2014/15 to a '3' by October 2015. During Q4 (Feb16) the liquidity ratio drops to a '2', with -9.4 liquidity days by the year end.

The Capital Servicing Capacity was a '1' at the end of 2014/15, and this continues throughout 2015/16.

Financial Risks and Mitigation

In setting the budget the Board is aware of a number of potential risks to the financial position which could be offset by a number of sources of mitigation. A summary of the key risks and mitigation is set out below.

Risks	Mitigation to reduce risk
Divisional Overspends impact on CoSRR and cash	• Monthly performance meetings with Divisions to monitor performance and agree corrective action • Monthly escalation process to Executives • Monthly reporting to HOB/Executive Group and Board
CIP fails to deliver minimum levels required	• Monthly meetings in each Division & Corporate departments dedicated to identification and delivery of CIP schemes • Monthly performance meetings with Divisions to monitor performance and agree corrective action • Monthly escalation process to Executives • Monthly reporting to HOB/Executive Group and Board

	• Monitoring and exception process through HOB • New programmes of work developed through transformation programme
Access to new capital loans is restricted, compromising the Corporate Strategy	• Detailed work up of likely loan requirement • Early engagement with FTFF • Identification of Business partners (Partnerships and Joint Ventures) for alternative funding sources
CCG inability to pay for activity overperformance and delays in receiving payment for services provided	• Agreement with CCG over likely activity increases • Work with CCG to identify and deliver QIPP / transformation schemes • Local NHS Futures groups led by Chief Executives of Devon Commissioning and Provider organisations • CCG Financial support from NHSE / LAT • Agreement with the CCG to receive prompt payment
Insufficient management capacity and capability to deliver the operational and strategic plan	• Organisation restructured to facilitate greater clinical and management time – less working down. • Leadership and management development programme • Regular workload review and prioritisation • Consider short term contracts for specific projects
Inability to fund revenue implications of the corporate strategy	• Continued engagement with local and specialised commissioners • Continued partnership working with local health and social care economy – maximise opportunities eg. Better Care Fund • Profile income generating projects

Sensitivity Analysis

A sensitivity analysis has been carried out as part of the planning process for 2015/16. The sensitivity analysis consists of the following:

- An in-year increase in emergencies of 5% more than planned, which results in delays in treating elective inpatients due to cancellations and increased lengths of stay. The delay in treatment of elective inpatients results in additional RTT penalties (£-2.2m).
- Non-achievement of unidentified CIP (£-4m)
- Increase in agency nursing costs of 50% from £5.6m to £8.4m (2014/15 £7.6m) due to increase in emergencies, acuity and specialling (£-2.8m).

The mitigations consist of three factors:-

- Reduction in capital expenditure of £1m relating to holding back capital contingency in order to offset impact of loss of cash.
- Reduction in expenditure relating to the £1m revenue reserve and £1m contingency reserve.
- Negotiation with the CCG to waive the RTT penalty of £0.5m where it could be demonstrated that the penalty was as a direct result of the increase in emergency activity.

The value of mitigations is not sufficient to offset the risks, and would therefore result in an increase to the deficit and a further reduction in cash of £5.5m. The reduction in cash would lead to the potential requirement of £2.4m working capital facility for 2015/16.

Conclusion

2015/16 is set to be an extremely challenging for the Trust. The operational context of increasing demand, largely attributed to our increasingly aging and complex population against physical capacity constraints in both theatres and beds in our acute facilities is a significant issue. The pressure on physical capacity is impacting on achievement of operational targets including cancer targets and likely failure of RTT targets during 2015/16. To address this, the Trust could opt to simply increase acute beds and theatres, but this is not in line with the Trust's strategic objective to develop integration of care pathways from community through to acute care and back into the community. In addition this option is not financially sustainable. Our aim therefore is to deliver our 'business as usual' whilst progressing our corporate strategy to deliver longer term transformational change. The focus in 2015/16 to achieve this will be to implement an Acute Pathways Transformation Programme enabled by EPR and to conclude the transfer of community services for adults with complex needs from Northern Devon NHS Trust in line with NEW Devon CCG's strategy. However this level of transformational change will require resources beyond the level currently available internally to the Trust and therefore it awaits the outcome of approval for external financing in order to progress these schemes. Our financial templates therefore exclude these strategic plans at this stage.

Without radical transformation the Trust will have no option but to continue to respond to increasing demand in traditional ways through increasing the capacity of acute facilities. However it is clear that this is not in line with future models of care as outlined in the 5YFV plan for the NHS neither is it best for our patients nor financially sustainable for the Local Health Economy. Our deficit in a 'business as usual' scenario is set to rise from £11.2m in 2014/15 to £20.2m in 2015/16 and our longer term financial model predicts this will rise significantly over future years. A key driver of this deficit is the requirement for the Trust to meet efficiency factor requirements (3.5% in 2015/16). Over recent years the Trust has been required to make an efficiency saving of around 5% per annum against turnover. This is as a result of the tariff paid to the Trust for patients treated being lowered each year plus some internal investment in service development. Over the period 2010/11 to 2014/15 recurrent CIP reductions of £71.6m have been achieved via service efficiency, service transformation and the application of recurrent reserves. However this is becoming increasingly difficult to achieve year on year, particularly as the Trust is already a relatively efficient Trust as indicated by the national reference cost index. Against the national reference cost index, where the average Trust is expected to score 100, the RD&E underlying score is 91, 9 points below the average; when the Market Forces Factor is applied the figure is artificially increased to 96 but remains well below the average.

In recognition of the above financial issues, the Trust's Board of Directors has set a realistic financial plan that will increase the Trust's deficit further to £20.2m. The Trust has sufficient cash reserves to support this deficit plan for 2015/16 based on its baseline plan. However should the Trust downside scenario materialise there will be a requirement for working facility in the final quarter of the year to maintain 2 days' operating expenditure. Whilst under the base case the Trust can maintain the availability of cash resources, it is recognised that this position cannot be maintained over the medium to long term and there is a need for the Trust to work with other partners in the Local Health Economy in order to transform the way services are delivered to ensure financial sustainability. However the Trust can only progress these plans and start to move back into a sustainable position if external investment is supported. Without this transformational support, over future years the Trust is likely to become a distressed provider and will therefore require financial support for day to day operations in any event.