Royal Devon and Exeter NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

Royal Devon & Exeter NHS Foundation Trust

Operational Plan Guidance – Annual Plan Review 2014-15

The cover sheet and following pages constitute operational plan submission which forms part of Monitor's 2014/15 Annual Plan Review

The operational plan commentary must cover the two year period for 2014/15 and 2015/16. Guidance and detailed requirements on the completion of this section of the template are outlined in section 4 of the APR guidance.

Annual plan review 2014/15 guidance is available here.

Timescales for the two-stage APR process are set out below. These timescales are aligned to those of NHS England and the NHS Trust Development Authority which will enable strategic and operational plans to be aligned within each unit of planning before they are submitted.

Monitor expects that a good two year operational plan commentary should cover (but not necessarily be limited to) the following areas, in separate sections:

1. Executive summary
2. Operational plan
    a. The short term challenge
    b. Quality plans
    c. Operational requirements and capacity
    d. Productivity, efficiency and CIPs
    e. Financial plan
3. Appendices (including commercial or other confidential matters)

As a guide, we expect plans to be a maximum of thirty pages in length. Please note that this guidance is not prescriptive and foundation trusts should make their own judgement about the content of each section.

The expected delivery timetable is as follows:

Expected that contracts signed by this date	28 February 2014
Submission of operational plans to Monitor	4 April 2014
Monitor review of operational plans	April- May 2014
Operational plan feedback date	May 2014
Submission of strategic plans to Monitor (Years one and two of the five year financial plan will be fixed per the final plan submitted on 4 April 2014)	30 June 2014
Monitor review of strategic plans	July-September 2014
Strategic plan feedback date	October 2014

1.1 Operational Plan for y/e 31 March 2015 and 2016

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

Name	Warwick Heale
Job Title	**Associate Director of Planning & Performance**
e-mail address	**w.heale@nhs.net**
Tel. no. for contact	**01392 404668**
Date	**04/04/2014**

The attached Operational Plan is intended to reflect the Trust's business plan over the next two 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 Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;**
- **The Operational 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 Operational 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; and**
- **All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directors by:

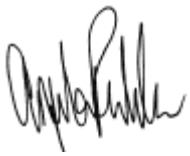
Name *(Chair)*	James Brent

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 *(Finance Director)*	Suzanne Tracey

Signature

1.2 Executive Summary

The Royal Devon & Exeter NHS Foundation Trust (RD&E) has a successful track record of delivering safe and effective care to people in Devon and its surrounding environs, in a cost effective and sustainable manner. Continuation of this sustained excellent service to our population is at the heart of work of the Board supported by our Council of Governors. The wider social, economic and political environment within which we operate and the significant reduction in the funding available for acute and specialist care makes this task increasingly difficult.

Our mission which is at the heart of this Annual Plan submission is 'To provide safe, high quality care, delivered with courtesy and respect. This is underpinned by three key strategic objectives:

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

A series of statements, developed in partnership with our staff, members and Governors articulating what successful delivery of these objectives will look like is attached as Appendix 1, '*In 5 Years RD&E will…*'

The Trust's strategy refresh process commenced in 2013/14 aligned to the previous (end of May) timetable for Annual Plan submission. This programme of work will be sufficiently complete to inform the second stage of the Annual Plan submission in June 2014.

The Annual Plan for 2014/15 reflects the very challenging environment all acute providers face, amplified by the local circumstances within North, East & West (NEW) Devon. This has been recognised by Monitor, NHS England and the Trust Development Authority, via the jointly-commissioned support programme for financially-challenged health systems.

The 2014/15 tariff efficiency requirements are accepted by Monitor as being above the level that has been historically achieved within the acute sector and the Trust has no access to commissioner 'tariff leakage' to allow this gap to be bridged. In addition, the 2008/09 emergency admission threshold has not been rebased and the 'emergency marginal rate' creates income loss of £4.3m. While this is a challenge faced by all acute providers, it puts particular financial pressure on the RD&E because our catchment population has a significantly aged profile which results in increased demand for high-acuity emergency care amongst the 80+ age group. The Trust is also negatively impacted by of the continuation of the non-payment for 'avoidable' emergency readmissions (loss of £2.8m) even when these are due to acts or omissions in the social care, primary care or community services sectors.

The planning efficiency assumptions issued by Monitor continue to profile a level of efficiency and cash releasing savings that remain significantly above the levels that have been historically achieved within the acute healthcare sector or indeed wider industry. If these assumptions hold they have the potential to undermine the financial and service sustainability of the Trust. Development of the operational plan has identified a £13.8m recurrent CIP requirement for 2014/15 and £15.5m for 2015/16 i.e. an additional £28.8m to address the additional efficiency requirement set by Monitor. The £10m 2013/14 non-achieved recurrent CIP increases the total requirement to £38.8m.

Between 2010/11 and 2012/13 recurrent CIP reductions of £47.8m have been achieved via service efficiency, service transformation and the application of recurrent reserves. In the 2013/14 Annual Plan a further £16.9m CIP requirement was identified to address the impact of: the 4% tariff deflator; incremental impact of the 30% emergency marginal rate; readmission non-payment; and essential investment to

maintain safe care in response to the increased demand, acuity and dependency for care of the frail elderly. In addition the Trust is further disadvantaged by a Market Forces Factor (MFF) of 1.02 which does not appropriately recognise the difference in cost base between acute providers.

Clinical and operational performance has been good throughout 2013/14 with significant reductions in the number of Clostridium difficile infections and compliance with the majority of national standards and targets, including much improved RTT performance. Performance on cancer targets was also generally good, with just single quarter failures in cancer 62-day and symptomatic breast targets. The necessary investment to maintain safety, particularly in nurse staffing, has been made but the Trust has not delivered planned CIP in-year and recurrently. As a consequence, financial outturn against plan is expected to be a deficit of £3.2m, with a Continuity of Service Risk Rating (CoSRR) of 4. As noted above, recurrent CIP has underachieved by £10m which will add to the challenge for future financial sustainability.

The impact of the 30% tariff, MFF, non-payment for 'avoidable' emergency admissions, the effect of delayed transfers of care and the increasing acuity and dependency of our aged population will be further compounded in year with an associated increased risk to the quality and safety of care that can be delivered within the reducing resource envelope. The Trust recognises this risk and will address this as outlined later in this plan. The Trust has benchmarked the cost and effectiveness of its services to identify areas where it can achieve additional cost reductions. Against the national reference cost index, where the average Trust is expected to score 100, the RD&E underlying score is 89, 11 points below the average, when the Market Forces Factor is applied the figure is artificially increased to 94 but remains well below the average. An independent review of all cost improvement programmes completed, against a menu of good practice actions and service improvements to drive efficiency, has confirmed RD&E performance against peers was very strong and only £1.5m potential additional savings was identified.

The Board is very mindful of its responsibilities for maintaining the sustainability of safe, effective care and finance. As our work on refreshing our corporate strategy has progressed and in the light of Monitor's planning guidance for the next five years it has become increasingly clear that achieving these responsibilities within the current projected financial envelope will not be possible. The Board has therefore developed a hierarchy of priorities to aid strategic decision making.

Reconfiguration of specialist services across Devon and Somerset and for local acute and community health and social care services within Devon will be necessary to provide a sound platform upon which to build a new model of care which is increasingly locally based. Difficult decisions will need to be made that have the potential to impact negatively on the sustainability of safe care or finance. It is not possible to assess currently if major reconfiguration will totally address the significant challenges facing the local system, but what is clear is that without it current health and social care services are unsustainable.

The policy drivers outlined in NHS England's Everyone Counts regarding emergency care and specialist services will require a larger population solution to provide improved economies of scale. Only through increased scale will further investments to meet higher standards be affordable. During 2013/14 the Trust has been working with the Taunton & Somerset NHS Foundation Trust (T&SFT) to explore ways of improving the financial and clinical sustainability of a range of clinical services through closer integrated models. New ways of working across a range of service opportunities are being tested to reduce costs across the two catchments or provide critical mass to sustain services against higher commissioner standards. Opportunities for shared services for supporting functions, e.g. IM&T, finance, HR and procurement are also being explored.

At this stage many of the clinical changes have been small scale to resolve specific sub-specialty issues such as the spinal service on call rota across the two counties. There is a growing acceptance that, in light of the challenges facing both organisations in the future, the scale and pace of these changes will need to

increase. The Trust has agreed to explore further with T&SFT the potential for more substantial changes which may only be facilitated though a different organisational form. The potential options for reconfiguring services will be tested as part of the Acute Services Review being commissioned by Somerset CCG jointly with provider trusts in Somerset; and a similar exercise that is to be undertaken in Devon to look at how organisations may look at achieving sustainability through new integrated models.

This plan continues to focus on ensuring the service the Trust provides is safe and delivered with courtesy and respect; this is dependent on continuing to develop our workforce to deliver care today and to build the capability to work with the new models of care that will emerge in future. The new models of care for that will be right for the wider health and social care system in Devon are in the early stages of development, supported by the production of community service strategies by North, East and West (NEW) Devon CCG and Devon County Council. It is anticipated that whilst pilot testing of this initiative should commence during 2014/15 the major redesign and transformation of services will not occur until mid 2015/16.

In the face of an extremely challenging environment, in addition to developing new models of care, the Trust will seek to ensure that the quality of its services are maintained and wherever possible improved. The Trust's quality plans reflect national, local and internal priorities and processes to provide assurance about safety and quality are well-established. Quality priorities include:

- Focus on improving documentation
- Implementation of "Hello, my name is…" campaign
- Focus on Safety & Quality, ensuring that the Connecting Care programme pulls through key markers of safety & quality from the Trust's Patient Safety Programme
- Year three of implementation of the Vision for Nurses, Midwives and AHPs
- Human Factors training
- Strengthening the Trust's Mortality Review Process

The Trust, in conjunction with commissioners, has assessed the likely levels of patient activity over the next two years. The only material difference in assumptions between the Trust and its commissioners is that the commissioners anticipate QIPP demand-management schemes to deliver greater levels of activity reduction than have been achieved in previous years. Based on a comprehensive bed modelling exercise together with planning of theatre capacity, the Board has received assurance that there are sufficient facilities available to deliver the planned level of activity in year 1 of our plan but there are potentially some shortfalls in year 2. The Trust's workforce plans support the delivery of the anticipated activity levels.

The Trust financial performance in the past, and prudent approach to building cash reserves, means the Board is able to submit a plan for the next 2 years that achieves a CoSRR of 3 and a Green Governance (service safety) Rating. In 2014/15 and 2015/16 we are planning for financial deficits of £8.9m and £13.5m respectively. This is possible due to the cash reserve that has been built over a number of years. However, it is a short term measure that can be applied whilst the wider system work that has started and will be supported by the Challenged Communities work develops a plan which delivers sustainability for all elements of Devon's Health and Social Care services. It should be noted that the level of cost reduction required over the 5 year strategic period commencing in 2014/15, based on Monitor's current guidance, is £80m for the RD&E alone. The size of the community wide challenge is immense.

The Trust is declaring risk to three targets for 2014/15. The reasons for this are as follows:

- Clostridium difficile. The Trust has been very successful in recent years in reducing Clostridium difficile infections. For the first 11 months of 2013/14 there were 24 cases against a full-year objective of 39. The objective for 2014/15 for the Trust is 30 which is so low that it must be

regarded as a risk, even if just due to normal variation. Furthermore, the Risk Assessment Framework measure includes cases not attributable to any lapse in care (in contrast to the NHS England guidance on contract penalties that excludes such cases).

- Cancer 62 day waits for first treatment, from GP referral. This target has proved difficult to achieve sustainably, partly due to the low number of cases involved – so that a single breach due to unusual circumstances can lead to target failure. The Trust's performance against this target has generally improved during 2013/14 and the Cancer Action Plan, which was produced with the support of IMAS and has been shared with Monitor, is being kept as a live document, with additional improvements implemented as they are identified.
- Cancer 2 week wait (breast symptoms). This target has only been failed for one quarter in the last two years, but was failed for 3 individual months during 2013/14. The risk to the target is largely due to patient choice cases being included in the reportable breaches. The Trust's performance against this target has generally improved during 2013/14 and the Cancer Action Plan which has been shared with Monitor is being kept as a live document, with additional improvements implemented as they are identified.

This Operational Plan is consistent with the Strategic Intentions of the NEW Devon CCG and with the CCG's plans for 2014/15-2015/16 except where noted in the text (e.g. in relation to the value of QIPP demand-management schemes).

The short term challenge

Devon is 20 years ahead of the rest of England with its older population profile, with a particular peak in those aged 85 years and over. Two local market towns, Seaton and Sidmouth, have today a population with the age profile that the rest of the country could expect to see in 2075. From 2011 to 2031, the number of people aged 85 and older is projected to rise by 77.6%. 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.

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 and a number of other significant housing developments underway or planned. During the two years of this plan this may increase overall catchment population, but less significantly in the older age groups that use more acute healthcare services, more likely in maternity and paediatric services

The Trust has plans in place to deliver the operational capacity required to meet the anticipated demand resulting from these population changes, although there are significant affordability pressures in being able to support this capacity within the financial framework of the 30% emergency tariff, efficiency requirements (which assume tariff leakage) and non-payment for readmissions. To mitigate against the future outlook based on population and financial pressures, the Trust is working closely with its local NHS commissioners and local authority to identify and implement plans to integrate services. It will be a challenge to ensure the pace of change is timely enough to respond to the changing environment.

The Trust's local health economy (NEW Devon CCG) has been identified as one of eleven financially-challenged health economies. The CCG faces significant financial challenges across its commissioning portfolio with two other acute providers in its catchment in addition to the RD&E. The CCG is forecasting a deficit in 2013/14. NEW Devon CCG is planning on the basis of 2% growth in its allocation in 2014/15 and 2015/16 and an assumed medium term reduction of 2% (due to changes in the allocation formula and the Better Care Fund). The requirement to address the 2013/14 deficit and deliver 1% surplus and 2% headroom will be a challenge for the CCG. While it has a devolved structure, with separate locality management arrangements around the catchment of each of its acute providers, the Eastern Locality (centred on the RD&E catchment) will have to share the financial pressures of the wider CCG. This is likely to make commissioner affordability a key risk for the Trust over the next two years.

The CCG's QIPP plans have not been delivered to planned levels in recent years. While the Trust is closely engaged in the delivery of QIPP and is driving some of the Health Community QIPP schemes, it is unlikely that this will be sufficient to materially bridge the commissioner affordability gap. This has led the CCG to attempt to employ local pricing mechanisms and contract limiters to address its financial risks, but with the likely effect of transferring risk to providers – as set out in its published Commissioning Framework documents. While the Trust will engage with the underlying efficiency and redesign challenges that such intentions represent (e.g. follow-up rates, outpatient procedure rates), it will be unable to accept a reduction in payment for clinical activities where these are not supported by real demand management or redesign. The Trust is confident that the positive relationships within the local health economy will be maintained, but recognises the pressure that commissioner affordability and attempted contract payment limiters could bring to these relationships.

There are similar financial pressures across local social care budgets, with Devon County Council having a savings requirement (across all services) of £27.8m in 2014/15 and a further £49m in 2015/16.

Target performance within the Trust and across the health economy is good, with the Trust having delivered consistent A&E performance throughout 2013/14 and having recovered its position from

previous challenges to RTT performance. Similarly, the local health economy has high performing primary care and a significant community services infrastructure. However, there are local challenges in relation to delayed transfers of care and difficulties with the local patient transport service that adversely affects patient flow.

In Year 2 of this plan, NEW Devon CCG is likely to recommission the community services within the Trust's acute catchment area. These services are currently provided by Northern Devon Healthcare NHS Trust. This may offer an opportunity for the Trust to progress its strategy of providing services along whole acute-community pathways.

The possible future rationalisation of specialised service providers by NHS England is a potential risk for all acute providers. The Trust's specialised services generally comply with the National Service Specifications. Those that do not comply have detailed derogation plans or the service specifications are accepted by commissioners as requiring further review. Currently, there is no threat to the Trust's services, but the Trust will continue to work closely with commissioners and other providers to ensure that future risks and opportunities are identified and addressed.

Quality plans

The Trust has a sound track record of delivering safe and effective care. As resource constraints tighten the Board recognises the need for increased scrutiny to ensure short term actions to address financial pressures do not negatively impact on the quality and safety of care we deliver to our patients. The most significant risk to maintaining the safety and quality of care operationally is the impact of increased emergency admissions and delayed transfer of care, particularly amongst the frail older population we serve. This is compounded further by the national approach to tariff setting particularly the 4% tariff efficiency factor and 30% marginal emergency tariff and together they present the biggest risk to safety and quality the Trust faces. As described in the operational capacity section of this plan the Trust has a robust process in place to mitigate this risk wherever possible but these actions do not address the underlying problem; the solutions to which are not within the control of the Trust Board. In acknowledgement of the risk to safety and quality these challenges create, the Board has developed a Hierarchy of Priorities to help shape its thinking; the approach it will take when making disinvestment and investment decisions that may affect the delivery of care to patients. This hierarchy of priorities is based on 'what is important' and 'who is important'.

Our CIP review process includes a quality/safety impact assessment overseen by the Chief Nurse/Chief Operating Officer and Medical Director.

Key quality priorities for 2014/15 are:

- Focus on improving documentation
- Implementation of "Hello, my name is…" campaign
- Focus on Safety & Quality, ensuring that the Connecting Care programme pulls through key markers of safety & quality from the Trust's Patient Safety Programme
- Year three of implementation of the Vision for Nurses, Midwives and AHPs
- Human Factors training
- Strengthening the Trust's Mortality Review Process

To gain safety and quality assurance and manage risk the Board has a robust Ward to Board governance system in place to monitor and triangulate quality, cost and delivery performance. This facilitates the early identification of concerns and the action being taken to address them, thereby providing assurance that

effective systems are in place and confidence that our services are safe and effective. The Board oversees this work via its governance structure and the sources of assurance it considers include:

- Governance performance system.
- Performance management and assurance framework.
- Internal audit and external audit reports
- Reports to the Board of Directors from the Audit Committee and Governance Committee.
- Board Integrated Performance Report
- Ward to Board and Safety Thermometer reporting.
- Never Events reporting
- Care Quality Assessment Tool (CQAT) outcome report
- Engagement and Experience (complaints) report.
- Regulatory inspection reports

The quality, governance and assurance processes were externally reviewed by KPMG during 2013/14 and were found to be comprehensive and robust.

Our quality plan is developed in partnership with our Governors and members as reflected in the Trust's Quality Account and Plan. Good progress has been achieved in implementing the 2013/14 plan and work is ongoing for the further development of this programme of work which will be fully presented in the 2013/14 Quality Account due to be published in July 2014. The quality plan also reflects commissioned national priorities established in the NHS mandate, NHS Constitution and 'Everyone Counts – Planning for Patients'. These are supplemented by local CCG priorities. The local priorities centre on the redesign of care pathways to ensure the most effective care is delivered in a timely, cost effective manner which ensures we maximize the use of increasingly scarce resources. The CCG has indicated a desire to link QIPP and quality improvement schemes and the key areas identified are:

- Right care – targeting resources to best effect (treatments of limited clinical value; use of patient decision aids).
- Targeted follow up care – targeting resources to best effect.
- Focusing on conservative management and evidence based practice within orthopaedic care.
- Transforming urgent care system with emphasis on services for frail older people.
- Ensuring care in the best settings to improve outcomes and longer term goals, particularly relevant to the RD&E in respect of avoiding inappropriate CAMHs and MH admissions which is a highlighted risk associated with the limitations in the current services commissioned from other providers.
- Standardising the diagnostic approach to diagnosis and management planning.

NHS England 2014/15 commissioning priorities for specialised services have not been published in sufficient detail for inclusion in this plan, although compliance with published service specifications should ensure that key quality priorities are met.

The Trust adopts an integrated approach to safety and quality and a part of its transformation programme is seeking to reduce variation through improved standardisation to deliver improved safety, quality and performance outcomes. Connecting Care, our programme to deliver this, is in place in 50% of our wards and some clinical departments and will be rolled out to the remaining wards and departments in 2014/15.

Key markers of safety, quality, operational and financial performance are monitored holistically to ensure robust scrutiny, and if necessary mitigating action, via the Quality Cost and Delivery Group. An ambitious Patient Safety Programme is in place, which is monitored by the Safety and Risk Committee, a sub-group of the Board Governance Committee. Key features of the 2014/15 and 2015/16 work programme include

the introduction of a strengthened Mortality Review process and expanding the Human Factors Training programme to cover all clinical staff.

Implementation of the vision for Nursing and AHPs continues to be a key feature of our quality work programme. In its third year, the values-based priorities that will progressed during 2014/15 will include:

- Developing new roles to support our patients linked to our workforce strategy
- Increasing the provision of development opportunities
- Completing the roll out of our leadership programme for matrons and senior nurses to maximize the quality gain we can achieve from the decision to release 60% of our Matrons' time to focus on clinical leadership at ward level to ensure the delivery of safe, effective and compassionate care

These priorities will build further on the excellent performance achieved to date against the National Safety Thermometer indicators of harm, compassion agenda and the continuing programme of work to provide dementia training for all staff.

The Board has completed a self-assessment exercise to map compliance with the recommendation from the Francis, Keogh, Berwick and Clwyd Reports. Overall there is a good level of compliance with the recommendations. Where there is identified partial or non-compliance, action plans are in place for delivery during 2014/15. This work programme is being led by the Chief Nurse/Chief Operating Officer and monitored on behalf of the Board by the Governance Committee.

There are no known CQC or Monitor quality concerns. The Trust has received two planned CQC inspections during March 2014, no concerns have been raised but the inspection reports are not yet available. In the CQC intelligent Monitoring Report published in March 2014 ranked the Trust at level 6, the highest possible ranking.

Operational requirements and capacity

Demand Planning

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 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.

	2014/15		2015/16	
	% Increase	£m	% Increase	£m
Outpatients	5.20%	£2.6m	5.00%	£2.6m
Elective Inpatients	4.90%	£3.0m	1.70%	£0.7m
Daycases	4.10%	£1.9m	3.80%	£1.6m
Emergency Inpatients*	-0.40%	-£1.4m	4.70%	£3.0m
Drugs & Devices	13.80%	£4.6m	11.70%	£4.4m
Other		£2.5m		£1.9m
Total		£13.2m		£14.2m

** The reduction in planned emergency admissions in 2014/15 is due to the introduction of a clinical 'Front Door Service' team designed to improve clinical quality whilst also reducing emergency admissions and length of stay of admitted patients*

This demand plan has been used to assess whether the Trust has sufficient capacity. Capacity planning currently focuses on beds and theatre capacity. However, the Trust intends to strengthen this process further during the coming months, to directly link the effects into workforce planning.

Bed Capacity Modelling

Comprehensive bed capacity modelling has been completed based on the three major bed pools of Medicine, Surgery (including Gynaecology) and Orthopaedics.

The inputs for the model are the arrival rate (admissions per day) and service rate (the reciprocal of the length of stay) for the elective and non-elective inpatient admissions for each of the bed pools. A Discrete Event Simulation (DES) model is used to estimate the number of occupied beds in each of the bed pools 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 final scenario has been used to plan future bed capacity requirements across the organisation and

plan for changes in demand throughout the year including winter planning. The model provides forecast information on percentage occupancy levels across the three 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 winter planning and required surge action plans.

Bed Capacity modelling outputs and key assumptions.

Based upon the forecast joint provider-commissioner 2014/15 demand and capacity activity plan, adjusted for movements in waiting lists, the following bed capacity assumptions have been made:

- The forecast 2014/15 contract demand plan activity can be accommodated within the existing bed pools however forecast growth is not sustainable for 2015/16 without significant investment or service change.
- Provision of this level of activity assumes that the recently-introduced changes to medical acute assessment and 7/7 Consultant review models of care will fully deliver the expected length of stay changes.
- 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.
- 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.

To mitigate the 2015/16 forecast growth, which cannot be accommodated without service continuity risks, joint operational planning is underway, involving commissioners and partner agencies to plan alternative models of care to accommodate the forecast levels of growth.

Theatres Capacity Modelling

The 'Formula 1' Theatres project has continued to drive efficiency within operating theatres with current utilisation levels high and improvements to data quality and accessibility being used to further reduce late starts and early finishes, enabling more patients to be treated within the same resources.

Following a comprehensive review led by senior clinicians from critical care, a report has been produced outlining forecast requirements for theatres in 1, 3 and 5 years. The key findings are:

- Current utilisation is high. However, it might be possible to increase utilisation by a further c.7% (the equivalent to 1.5 additional theatres) to reach maximum achievable utilisation.
- In the next 5 years, it is estimated that up to 8 additional operating theatres will be required, with the largest growth rate being within orthopaedic theatres. The impact of 7/7 working will be reflected into these plans as they develop.

This work is overseen by the theatres steering group and includes optimisation of the use of Heavitree Hospital and community operating facilities, alignment of theatres with specialty teams and continuation of the successful Formula 1 Theatres project approach which will continue to move the care setting from inpatient to day case to outpatient procedure.

Workforce

The Trust is forecasting that current staffing numbers will support predicted demand for patient services during 2014/15. As the Trust makes progress to deliver its strategy there may be a further impact on staffing numbers potentially in 2015/16, but these are not yet quantified. An improved approach to workforce planning has been implemented which will quantify any increased requirement that may be

driven by 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>Demand and Capacity Risks and Mitigations</u>

Key risks that have been identified as a result of the demand & capacity modelling are:

- Increased non elective admissions particularly in frail older people
- Growth in outpatient referrals in some sub specialties
- Growth in cancer referrals in some tumour sites.

To mitigate these risks the Trust is working collaboratively in a number of joint work programmes with the NEW Devon CCG and partner agencies including:

1. Demand management for elective referrals and admissions to support planned care sustainability, this work includes primary care and secondary care referral review, advice and guidance from consultant to GP and alternatives to routine outpatient new and follow up appointments. This will

help to address outpatient referral growth and also release capacity to accommodate growth in 2 week wait cancer referrals.

2. A comprehensive joint review of the frail older people pathway has been completed with a strategic action plan being formulated. The Trust is in discussion with the CCG and Local Authority regarding a pilot for Exeter City on joint end-to-end pathway delivery for this population. This will be supported by discussions and planning on the utilisation and application of the Better Care Fund proposals which will be taken via the Health and Wellbeing Boards.

3. Delays in onward care remain a concern which is subject to detailed discussions with partner agencies and the CCG regarding reducing delays and alternatives to current models of delivery including the expansion of early supported discharge for stroke patients and increased provision of Hospital at Home services.

4. The Trust has also reviewed and completed a new 5 year Clinical Service Strategy. This has been produced following detailed work within each of the service line specialties considering service demand and capacity pressures, patient pathway changes and transformation and financial challenges and opportunities. To support the delivery of the Trust's strategy a detailed work programme of change has been developed.

In addition, the Trust has its own strategic plans that should have a beneficial effect on capacity:

Development of Surgical Emergency Pathways

Building upon the successful approach taken within the Medical Division, a project team led by the Associate Medical Director for Surgical Services and the Assistant Director of Nursing is considering options for transforming the care of emergency patients.

Options being evaluated include the formation of a Surgical Assessment Unit (SAU), rapid access clinics, a reorganisation of emergency operating provision and changes to emergency surgical medical cover to increase the seniority of decision making earlier in patient pathways. The SAU is expected to open during 2014/15.

Outpatients

In addition to the joint work with the CCG as outlined above, the Trust plans to undertake a 'root and branch' review of outpatient services. This review will look at when attendances are required and how and where they are delivered. This review will help to mitigate the increased demand being experienced in some specialties such as Dermatology and Urology.

Medical Acute assessment Services

The Medical services Division will continue to develop the new arrangements for assessing patients presenting as potential medical emergency admissions. From April 2014 the new service should be fully staffed, including staffing from partner organisations, such as Devon Partnership Trust and Age UK. The team will be monitoring the patient experience provided by the new system as well as looking closely at a set of quality parameters, and ensuring it links into the growing network of care available outside of hospital to prevent admissions and care for people in their own homes, such as the Hospital at Home scheme and similar initiatives.

Ability to Flex Capacity

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 2013/14.

The most important part 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 at particular risk. 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 will also continue its focus on keeping waiting lists down to the levels that have been agreed internally as allowing sustainable delivery of RTT targets – this will allow short term fluctuations in elective demand to be accommodated without compromising target delivery.

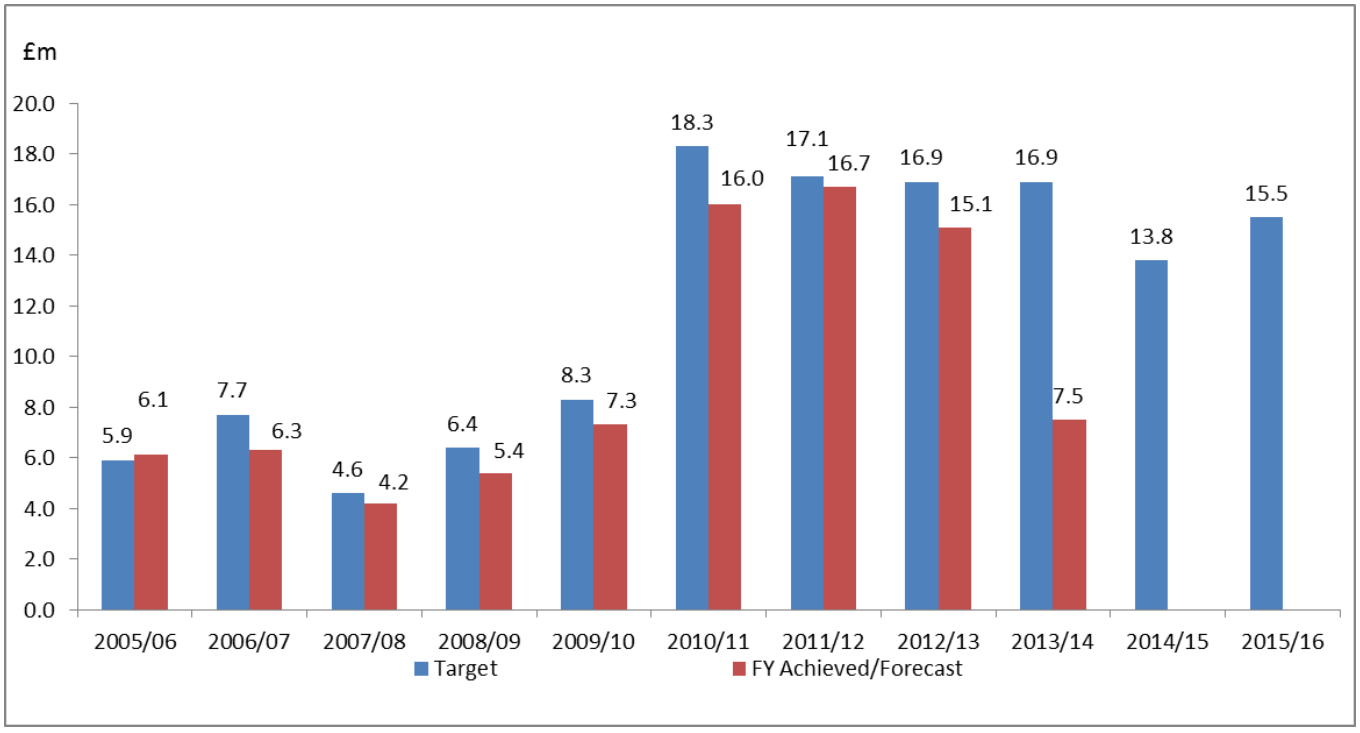
The Trust's risk management approach to the 2014/15 contract with the CCG will also include a joint commitment to address fluctuations in demand by the CCG commissioning additional capacity or managing demand for services, following the breaching of agreed thresholds for action.

<u>Productivity, efficiency and CIPs</u>

CIP

Nationally the NHS is facing an uncertain financial position over the next 5-6 years, with an expected funding gap of £30 billion by 2020. This is likely to result in less resource to individual acute trusts, with an expectation of changes in patient flow with better integration of care across primary, secondary and social care.

The table below shows the target and achievement of CIP from 2005/6 through to 2015/16.



Since 2010/11 a tariff efficiency requirement of 4% of income has been applied. This has led to the RD&E having achieved £47.8m of savings between 2010/11-2012/13.

In addition to the efficiency requirement reflected in 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 RD&E. These include the emergency rule (approximately £4.3m), and emergency readmissions (£2.8m). These rules have been the subject of much debate nationally as to whether they should continue, and they will be reviewed as part of the national tariff which Monitor are now responsible for.

CIP has increasingly been achieved by using reserves which have now been utilised except for a contingency of £3m. Savings for 2013/14 have been increasingly difficult to achieve which has led to a significant under-achievement in the region of £10m which will have to be found in future years. Although the RD&E currently has a healthy cash balance (£29.6m) compared to many acute Trusts, this equates to only 21 days liquidity and would be quickly eroded with the cumulative impact of CIP under-performance if significant additional savings are not found.

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% per annum over the next five years. The tariff efficiency however has been set at a level of 4% 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 RD&E will see any benefit from tariff leakage given that the largest commissioner of services from the RD&E (NEW Devon CCG representing £211m of £316m patient income) is currently in financial distress with a projected deficit for 2013/14 of £15m.

The RD&E has demonstrated over a number of years and with numerous benchmarking exercises that it is an efficient Trust. The most widely used indicator, which provides an overview of efficiency across £287m of the Trust's £299m cost base, is reference costs. One of the outputs of the exercise is an efficiency factor, which for the RD&E gives a figure of 89 (94 adjusted for Market Forces Factor). An indicator below 100 indicates a Trust which is more efficient than would be expected, and this therefore makes it more difficult for the RD&E to realise efficiency savings in the future, although there is further work that is being done 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 (e.g. Emergency Department)
- Continued benchmarking of other (corporate) services
- Independent reviews (e.g. Unipart)
- Comparison of other Trust plans (e.g. AUKUH)
- 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. R&D / Pharmacy)

The table below shows the CIP target and schemes planned / required for 2014/15 and 2015/16.

Target CIP	2014/15 £m	2015/16 £m	**Total £m**
PbR Efficiency	11.4	13.1	24.5
Essential Funding / development provision	2.0	2.0	4.0
QIPP	0.4	0.4	0.8
B/Fwd CIP	10.0		10.0
Target CIP	**23.8**	**15.5**	**39.3**
CIP Delivery			
Service Line & corporate targets	3.4	4.4	7.8
Identified Schemes (Pharmacy outsourcing/nursery)	0.6	0.5	1.1
Planned traditional CIP Schemes	**4.0**	**4.9**	**8.9**
Central Mitigation	9.3	0.0	9.3
Transformational CIP*	1.5	6.0	7.5
Total CIP Achievement required	**14.8**	**10.9**	**25.7**
% achievement of CIP (compared to patient income)	4.50%	3.65%	3.90%
Shortfall / -overachievement	**9.0**	**4.6**	**13.6**

**Additional schemes required to achieve sustainability (CoSRR 3)*

As can be seen the majority of the target (£24.5m) relates to the 4.0% and 4.5% efficiency target assumed for 2014/15 and 2015/16, the balance consisting of a likely £10m recurring carry forward from 2013/14 and a small amount for essential funding / developments and impact of QIPP.

The minimum CIP requirement to be achieved across 2014/15 and 2015/16 is £25.7m. This is a value that the Board believes to be achievable based on the level of CIP previously achieved, and the level of plans that have been developed for 2014/15. This will ensure that the Trust maintains a reasonable level of cash and liquidity to maintain operations and also maintain a CoSRR of 3. The Trust's financial plan is based on £25.7m as the value that the Trust realistically estimates can be achieved. Wherever possible, the Trust will seek to stretch this target but this cannot give assurance that any greater than £25.7m can be achieved over the two year period.

The planned achievement ensures that the Trust delivers savings significantly in excess of the 2% that Monitor expects providers to deliver.

The £25.7m planned to be delivered for 2014/15 and 2015/16 consists of traditional CIP of £8.9m, Central CIP mitigation of £9.3m and a transformational CIP requirement of £7.5m as set out below.

A Quality Impact Assessment (QIA) is required to be completed for each cost saving scheme. This QIA is then reviewed and signed off by the Medical Director and Chief Nurse / Chief Operating Officer if appropriate.

Traditional CIPs (£8.9m over 2 years)

This consists of a % target to be achieved by Divisions and Departments as set out below:-

- Service line target for Divisions to develop and deliver plans – 1% of service line income plus b/fwd under-achieved from 2013/14 (£4.9m)
- Procurement target – 1.5% of non-pay spend (£1.4m)
- Pharmacy drugs – 1.5% of PbR drug spend (£0.8m)
- Corporate departments – 1% of budget (£0.8m)
- Other identified projects (£1.1m) – this includes specific projects such as Pharmacy outsourcing and an income-generating scheme relating to the Trust nursery.

Of the £4.0m of CIP target relating to 2014/15, £3.6m (£4.9m FY) of schemes have currently been identified, of which £1.1m have firm plans in place, £2.5m (£3.7m FY) have plans which are being scoped and £0.4m of schemes are unidentified.

Central Mitigation (£9.3m) – The key components of this are:-

- CQUIN £5.0m – This assumes that the majority of CQUIN income gained during each financial year can be achieved without significant cost. This assumes achievement of 82.5% of income is achieved and £800k of provision made available for the cost of delivering those schemes.
- Development provision (£1m) – Although the CIP target assumes that a £1m recurring development reserve is to be required in each financial year, for 2014/15 this reserve would not be available. Any developments would therefore have to be funded within the essential funding reserve, consolidation / growth funding or existing resources
- QIPP (£0.4m) – This assumes that any impact of QIPP can be offset against consolidation and growth
- Existing reserves (£2.9m) - Use of existing reserves

The Trust will endeavour to identify further CIP plans that negate the need for central mitigation outlined above, but if this is not possible, these items will ensure the Trust can achieve and overall plan of £14.8m in 2014/15

Transformational CIP (£7.5m over 2 years)

The Trust has had a transformational CIP programme in place for 4 years and has developed a well-established approach. The Trust continues to support Service Line Management by allocating a CIP target to each service line, as well as developing Trust wide CIP plans.

There are currently 7 Trust-wide projects, within the Quality, Cost and Delivery Programme and supported by the Project Management Office and Service Development Team, that are planning to deliver transformational CIP, some of which are detailed below:

• Outpatients – the Trust is focusing on redesigning the outpatient service provision to ensure that efficiencies are realised, driven by improving the quality of services offered to patients. Clinicians are working with GPs and NEW Devon CCG to review patient pathways across primary and secondary care to ensure best practice is implemented and patients have the optimal experience. The development of rapid referral review by consultants within 48 hours of referral will reduce inappropriate referrals and support the provision of advice and guidance to GP, thereby reducing demand to support QIPP plans, and enabling outpatient capacity to be matched to demand, reducing unnecessary costs.

- Hospital at home – the Trust is working with NEW Devon CCG to make a step change in the roll-out of the Hospital at Home service across Eastern Devon to provide a multi-disciplinary system wide enhanced community service to safely support people with more complex needs in their own homes. A test of change has been successfully carried out. Further provision of the service will facilitate further admission avoidance or earlier discharge – reducing avoidable emergency admissions and extended lengths of stay. These community pathways improve the patient experience and their rehabilitation pathway, and they can be substantially cheaper than alternative pathways involving the acute provider.

- Bed capacity – detailed planning is underway to ensure that productivity gains on length of stay, such as through 7/7 working, are translated into an appropriate bed model over the next 2 years, taking into account anticipated growth. Opportunities to provide on-site care for groups of patients who have had an acute stroke or a fractured neck of femur over the totality of their hospital stay, rather than transferring them onto a community hospital are being explored with the NEW Devon CCG. If these services are funded it is expected that there will be a CIP benefit as well as a benefit to the CCG in terms of cost.

- Business development – opportunities to increase income are being taken forward, with a focus on private patients and outsourcing of pharmacy outpatient dispensing in the coming year. This recognises the limited growth in NHS funded services.

Transformation Programme

The Trust has reconfigured its Transformation Programme, 'to create a way of working at RD&E which engages staff in continuously improving and sustaining the delivery of safe, high quality and financially sustainable efficient services to patients'.

We are pursuing three key programmes that will, when delivered, bring about a cultural shift in the way we provide services, as well as how we manage both day-to-day business activities and our longer term, step-change agenda. These will generate benefits across a range of quality, cost and delivery indicators, from patient safety and experience metrics to length of stay, RTT and financial performance.

- Connecting Care – in January 2014 we introduced a new way of working called Connecting Care. This is a systematic way of teams working together, using a set of tools and techniques that will be rolled out across the Trust during 2014 and 2015. This approach provides a foundation for innovation and the creation of a culture of continuous organisational improvement, which will generate benefits in terms of quality, cost and delivery.

- Patient Pathway Redesign – the Trust will work with partners across the health and social care system to create models of care that more effectively and efficiently meet the needs of our communities. The focus will be on the end-to-end patient pathway from the point at which a GP has first contact through to treatment, ongoing management of a long term condition or palliation.

- Support Function Redesign – the Trust will systematically review the key processes operated by support functions to ensure they are fit for purpose. The initial focus is on HR and ensuring that all activities linked to the employee lifecycle (from recruitment to exit) are robust.

Financial Commentary

Financial Background

Since becoming a Foundation Trust in 2004/5 the RD&E has achieved a financial surplus (prior to impairments) in each financial year with the exception of 2004/5. This has enabled the Trust to build a healthy balance sheet, increasing cash from less than £1m in 2004/5 to an estimated £29.6m at the end of 2013/14.

As mentioned under the CIP section, the RD&E has demonstrated over a number of years and with numerous benchmarking exercises that it is an efficient Trust, the most recent reference cost data showing the RD&E with an index of 89 (pre MFF adjustment).

Although operational performance has been good in 2013/14, the financial position has been challenging, leading to a forecast deficit position of £3.2m (forecast at Month 11). The primary reason for the deficit is due to a predicted shortfall on CIP of £3.1m with an achievement of £13.8m compared to a target of £16.9m. Much of this CIP has been achieved on a non-recurrent basis, and plans for 2014/15 have assumed that £10m of recurring CIP target will need to be carried forward into 2014/15. Part of the reason that the Trust failed to meet its recurrent plan in 2013/14 can be attributed to a decision taken not to close beds as planned because of the impact across the health economy, particularly during winter.

Given the scale of the CIP challenge from 2014/15, the Board have decided to set a budget which reflects the CIP that is likely to be achievable for the next two years based on realistic plans, rather than a budget that assumes that the full CIP target will be achieved regardless of the absence of such plans. This assumes a CIP achievement of significantly more than 2% in each of the two years which is in line with Monitors expectation of what is achievable by Providers. In view of the recognised 'financially challenged local health economy', the Trust is not assuming any benefit from tariff leakage.

The Board have therefore set a budget which reflects a deficit in each of the two years of the operational plan of £8.9m in 2014/15 and £13.5m in 2015/16. The impact of this is that cash reduces significantly from £29.6m at the end of 2013/14 to £14.2m by the end of 2015/16, although the Trust is still able to maintain a Continuity of Service Risk Rating (CoSRR) of '3' during this two year period.

A summary of the financial position is shown in the table below, and the following sections describe the key issues in more detail.

		Current Plan	
	2013/14	2014/15	2015/16
Patient Income	315.6	330.2	341.9
Commercial Income (includes R&D & Education)	65.6	67.3	68.3
Total Income	381.2	397.5	410.1
Expenditure	-384.4	-406.4	-423.6
Surplus / (Deficit)	**-3.2**	**-8.9**	**-13.5**
Cash (at year end)	29.6	21.8	14.2
Capital Spend	21.9	14.1	7.6
EBITDA	4.05%	2.70%	1.70%
CoSSR	4	3	3
Capital Servicing rating	2	1	1
Liquidity Ratio	4	4	4

Patient Income

The financial plans for 2014/15 are based on activity assumptions that have broadly been agreed with the CCG, but there is currently a significant financial gap between the income assumed within the RD&E financial plan, and the affordability envelope for the CCG. The income assumptions reflect the Trust's assessment of a realistic position for 2014/15 and 2015/16, based on the jointly agreed demand plan, but these will not be the same as the commissioners' aspirations based on their affordability levels.

At the time of writing, it looks unlikely that the CCG will be able to afford a realistic contract value for the Trust in its 2014/15 plans, with adequate recognition of the funding required for likely activity levels. Without significant, realistic QIPP plans in place, the Trust can only assume that the recent growth trends in activity will continue. This puts the Trust in the position where it will have to operationally plan to deliver the likely level of activity, with an agreement with commissioners to reduce capacity in-year as demand management/QIPP plans are developed in more detail and implemented to bring the contract closer to commissioner affordability levels.

The key components of the patient income position are:

Activity

Income growth in 2013/14 was around £8m higher than shown in the annual plan submitted in May 2013 and the expectation is that the full year effect of this growth (£13.6m) will be consolidated into the contract for 2014/15. Of this £13.6m, a significant amount (£6.5m) relates to growth in excluded drugs and devices for which the costs are passed directly to the commissioners at 100% of cost.

As noted under, 'Operational requirements and capacity', based on the demand plan, growth has been included in the financial model as set out in the table below.

	2014/15		2015/16	
	% Increase	£m	% Increase	£m
Outpatients	5.20%	£2.6m	5.00%	£2.6m
Elective Inpatients	4.90%	£3.0m	1.70%	£0.7m
Daycases	4.10%	£1.9m	3.80%	£1.6m
Emergency Inpatients*	-0.40%	-£1.4m	4.70%	£3.0m
Drugs & Devices	13.80%	£4.6m	11.70%	£4.4m
Other		£2.5m		£1.9m
Total		£13.2m		£14.2m

** The reduction in planned emergency admissions in 2014/15 is due to the introduction of a clinical 'Front Door Service' team designed to improve clinical quality whilst also reducing emergency admissions and length of stay of admitted patients.*

Clinical Divisions are also 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 are expected to be finalised and agreed during April alongside the final agreement of the financial schedules which support the patient contract. Whilst plans are being developed for planning purposes it is assumed that the cost of developments is 100% of income. It is anticipated however that up to 40% will be used to cover either known cost pressures or to contribute to the CIP programme.

QIPP

In previous years planning the expectation of the NHS Devon PCT was to assume that any growth in demand was to be offset by QIPP, and the Trust reflected this expectation in its own planning. The reality however is that a relatively low value of QIPP schemes have been realised, and therefore for planning purposes a value of £1m has been included in each of the planning years for 2014/15 and 2015/16, based on the current position of QIPP planning. This does conflict with the commissioning intentions of NEW Devon CCG which assume a value of £5.9m, The Trust is working closely with the CCG to develop the commissioning intentions into realistic, deliverable plans that can be confidently reflected in the contract schedules with the CCG. Given the level of growth as set out above and the fact that costs are provided at 100% of income, this is unlikely to impact on the Trust's overall financial plan for 2014/15.

Tariff deflator

The section on inflation below sets out the key components of tariff inflation alongside the anticipated efficiency expectation. For 2014/15 the national tariff deflator of -1.2% has been applied through national and local prices and has resulted in a reduction in income of £3.4m. In 2015/16 the expectation is a tariff deflator of -1.1% which results in a further reduction in income of £3.2m.

Cost Assumptions

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

Inflation

An uplift in cost for 2014/15 has been assumed at £8m. This reflects known changes such as CNST, however the majority relate to provisions which have been set aside for the year (based on the information in the table below) until cost increases are known.

The forecast uplift for 2015/16 is 3.4%. The majority of this relates to the employers pension increase which is expected to cost the Trust £2.0m.

Efficiency

An efficiency expectation has been assumed in line with PbR tariff (for 2014/15) and as per guidance for

2015/16. This results in an anticipated net reduction in tariff for 2015/16 of 1.1% and reflects a cost increase of £9.9m offset by an efficiency requirement of £13.1m. See section on CIP for more details.

Inflation provision	2014/15	2015/16	Rationale
Pay	1.00%	1.20%	1% for National pay award + provision for incremental
Pension increase	-	0.70%	Per Monitor planning guidance
CEA awards / incremental	0.20%	0.20%	
Non pay	0.60%	0.70%	Assumes 2% inflation per government target for CPI
Drugs	0.10%	0.20%	assumes 7% uplift of PbR drugs
Capital Charges	0.30%	0.30%	14/15 per actual cost, 15/16 assumes 5% increase
CNST	0.20%	0.20%	Increase for 14/15 = £500k, same assumed in 15/16
Service Development	0.40%	-	Provision per tariff
Other	0.20%	0.20%	
Commercial income	-0.20%	-0.30%	
	2.80%	3.40%	
PBR efficiency rate	-4.00%	-4.50%	Per tariff / guidance
Tariff inflation	**-1.20%**	**-1.10%**	

Activity Growth

As described within the section on income, the costs of activity growth have assumed to be 100% of the income received for both 2014/15 and 2015/16. This results in a expenditure reserve for 2014/15 of £26.7m (£11m relating to pass through drugs and devices), and £9.8m for 2015/16 (£4.4m relating to drugs and devices)

Contingency

A recurring contingency of £3m is available on a recurring basis for 2014/15 and 2015/16. This contingency forms part of the mitigation in the downside scenario.

Capital

As a result of the material deficits forecast to be incurred in 2014/15 and 2015/16, the Board has taken 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 helps to support the Trusts liquidity.

The Board recognises that in the longer term it is not sustainable to set the level of expenditure below the value of depreciation, however also recognises the need to maintain a reasonable level of liquidity.

An exercise has been carried out on both replacement equipment and estates infrastructure to ensure that the funding available is reasonable to maintain the asset base at a safe and sufficient level. A low level of contingency and development funding has also been included within the capital programme.

No further expenditure has been assumed to fund any implications of the Clinical Service Strategy. Any

funding required will need to be sourced from increased CIP achievement, existing funding or new loans, and the development will need to demonstrate a net contribution to support I&E and ensure that liquidity is not further diluted.

The Trust's Strategic Capital Group and Capital Programme Board have prioritised the capital requests after considering their associated risks and benefits. The table below sets out the key sources and applications of capital over the planning period. The capital additions are based upon the capital forecast as at month 10, the value of additions may increase as further capital slippage may be identified within months 11 and 12.

	2014/15 £m	2015/16 £m
Sources of Funding		
Depreciation	12.3	12.9
New Loans	0.0	0.0
Repayment of loans	-1.3	-1.3
Total Source	11.0	11.6
Less Additions		
Schemes planned / Bfwd – See below table	6.9	0.0
Replacement equipment	3.7	3.0
Estates infrastructure	2.1	2.6
Contingency	1.0	1.0
Developments	0.4	1.0
Total Additions	14.1	7.6
Cash increase to be used towards the I&E deficit	**-3.1**	**4.0**

Cash

As can be seen from the table below, cash decreases over the operational planning period from £29.6m to £14.2m. The key reason for this movement is due to the planned deficits on I&E over the next two years. The cash impact of this deficit is partly offset by the contribution from capital as set out above.

	2014/15 £m	2015/16 £m
Opening cash	29.6	21.8
I&E position	-8.9	-13.5
Capital	-3.1	4.0
Working capital	4.2	1.9
Closing cash	21.8	14.2

Continuity of Services Risk Rating (CoSRR)

The impact of the financial assumptions as set out above is that the CoSRR reduces from a '4' at the end of 2013/14 to a '3' for the duration of 2014/15 and 2015/16.

Despite the reduction of cash during the planning period the liquidity ratio remains at a '4' throughout the two years of the operational plan with a minimum liquidity days of 0 days during Quarter 4 in 2015/16.

The Capital Servicing Capacity however reduces from a '3' forecast at the end of 2013/14 to a '1' during Q1 14/15 as a result of reduced revenue available to service the annual debt.

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 SOG/Board
CIP fails to deliver minimum levels required	• Monthly performance meetings with Divisions to monitor performance and agree corrective action • Monthly escalation process to Executives • Monthly reporting to SOG/Board • Monitoring and exception process through QCD • New programmes of work developed through transformation programme
Access to new capital loans is restricted, compromising the Clinical Service Strategy	• Detailed work up of likely loan requirement • Early engagement with FTFF • Identification of Business partners (Partnerships and Joint Ventures) for alternative funding sources • Identify potential to generate additional CIP
CCG inability to pay for activity overperformance	• Agreement with CCG over likely activity increases • Work with CCG to identify and deliver QIPP / transformation schemes • LHE Financial distress consultancy • CCG Financial support from NHSE / LAT
Insufficient management capacity and capability	• 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 strategy implementation	• 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

Downside Risk and Mitigation

The downside scenario consists of three factors:-

- Assumes non-achievement of CIP where currently no plans exist (£7.5m).
- An in-year increase in emergencies of 5% more than planned in the winter months, which results in delays in treating elective inpatients. The effect of this is to delay treatment of elective patients by two quarters, causing RTT penalties and increasing the cost of treatment by having to pay premium rates on evenings and weekends.
- Additional expenditure on nurse specialling and nurse agency costs as a result of increased activity, acuity of medical patients, and difficulty in recruiting trained nurses. In addition, there may be some impact as a result of the recent Safe Staffing Guidance issued by the National Quality Board.

The mitigation again consists of three factors:-

- Further reduction in capital expenditure of £3.8m relating to estates infrastructure and replacement equipment in order to offset impact of loss of cash.
- Reduction in discretionary expenditure (computers / low value equipment replacement) and use of the Trust contingency (£3m).
- Negotiation with CCG to waive the RTT penalty where it could be demonstrated that the penalty was as a direct result of the increase in emergency activity, and to readjust the emergency rule baseline to allow 100% income on the additional patient admissions.

The table below summarises the position.

Downside	**2014/15**	**2015/16**	**Total**
CIP shortfall relating to unplanned CIP not being achieved			
- Transformational CIP 14/15	1.5	1.5	3.0
- Transformational CIP 15/16	0.0	6.0	6.0
5% increase in emergency medical patients (@ 30% tariff)	-0.3	-0.3	-0.6
Reduced elective admissions as a result of medical outliers	2.5	0.0	2.5
RTT Penalties on delayed elective patients	0.4	0.4	0.8
Additional cost of additional theatre lists	0.0	0.6	0.6
Expense Overrun			
- Nurse Specialling - 50% higher cost than 13/14	0.5	0.5	0.9
- Nurse Agency 50% higher than 13/14	1.7	1.7	3.4
Total Downside	**6.3**	**10.3**	**16.6**
Mitigation			
Slip Capital expenditure			
- Replacement equipment (assume 50%)	0.0	1.5	1.5
- Estates Infrastructure (assume 50% Yr2)	0.0	1.3	1.3
- Developments 50%	0.0	0.5	0.5
- contingency 50%	0.0	0.5	0.5
Reduction in discretionary expenditure			
- 50% £5k-£15k asset provision	0.5	0.5	1.0
- reduce computer replacement programme by 50%	0.4	0.4	0.8
- Utilise contingency	3.0	3.0	6.0
- Assume no spending of the Essential Funding Provision	1.0	2.0	3.0
Mitigate RTT penalties by agreement with the CCG	0.4	0.4	0.8
Negotiate 30% emergency rule on additional patients with CCG	0.7	0.7	1.4
Total Mitigation	**6.0**	**10.8**	**16.8**
Surplus / (shortfall)	**-0.3**	**0.5**	**0.1**

Appendices: commercial or other confidential matters

Appendix 1

"In 5 years' time, the RD&E will…"

- Serve a population of minimum 800,000 mainly across Devon and Somerset (it is not envisaged the Trust will serve a national population within this timescale)
- Be the 'safest' hospital in the South West (be in top 3 ranked trusts in South region on Safety thermometer and ranked in top three for Quest network)
- Ensure patients treated by the Trust feel cared for (ranked in top 5 on Net Promoter score)
- Provide a comprehensive range of core hospital services. This will include the provision of high quality emergency care for patients presenting via primary care, the emergency department and emergency transfers from neighbouring hospitals. The Trust will also provide scheduled elective treatments across all existing specialties. Furthermore the Trust is likely to have diversified into new markets particularly to have improved the service provided to frail and older people in recognition of the increasing demographic and service needs of these patients.. The Trust will exploit the strength of its co-located pelvic cancer services by establishing itself as a regional treatment centre and will continue to provide specialist services where the patient volumes are such that these can be provided safely and sustainably at class leading quality.. The Trust has no plans to diversify into organ transplantation, cardiothoracic surgery or neurosurgery and has no plans to establish itself as a major trauma centre.
- Work in partnership with Primary Care, Mental Health and Social services to ensure patients have smooth access to hospital only when required (maintaining patients in the community wherever possible particularly our aging population by providing outreach services) and ensuring patients return to the community as soon as possible after a hospital admission. To achieve this the Trust will have assessed whether it needs to 'own' the pathway and is likely to deliver integrated community solutions
- Will have a reputation for the efficient delivery of high quality, safe care using innovative service models that address the challenge of both horizontal and vertical care integration
- Have a strong reputation for research internationally with the level of research income having doubled over the 5 year period. Working in collaboration with the AHSN the Trust will have further developed its relationship with the University of Exeter in support of the research and innovation agenda.
- Maintain the equivalent of a Monitor financial risk rating of 3 (in particular aiming to achieve a surplus of 1% and ensuring availability of operating cash for 28 days cover)
- Maintain and improve the current governance systems to ensure they remain fit for purpose. The Trust will take calculated risks to deliver its strategy but only if it can be demonstrated that it can return to regulatory compliance within an appropriate timescale.
- Have achieved demonstrable brand and reputation growth which includes being a recognised brand, regionally and across the UK for patient care excellence; being known/admired for our entrepreneurial approach to business development which deeply understands the market and what customers want
- Be an employer of choice for highly skilled health professionals of all disciplines and levels.as measured by National staff survey Staff engagement score (top 10% of trusts nationally)
- Be in the top 10% of trusts nationally, as measured by National staff survey, where staff would recommend the trust to care for their family and friends
- Be respected and valued as a partner organisation both inside and outside the health economy
- Ensure the values of the organisation are always evident in the relationship with staff and with partners.