Royal Devon and Exeter NHS
NHS Foundation Trust

Summary Strategic Plan for 2014-19

Royal Devon & Exeter NHS Foundation Trust

Introduction

Welcome to the Royal Devon & Exeter's summary strategic plan 2014-19.

The summary provides an over view of the Trust's strategic plan and covers our corporate strategy, the context and market analysis for the Trust, our plans and supporting initiatives and a summary of our financial projections.

The Trust continues to provide good quality healthcare to the communities it serves achieving the highest ratings from Monitor and the CQC. The Trust has met its regulatory targets, it has reduced cancellations for elected patients and delivers high quality, safe and sustained care despite the demographic and financial constraints it faces.

Going forward, the scale of the financial and demographic challenges, and the need to substantially change the way in which healthcare is delivered, means that what the Trust does and how it does it will look significantly different at the end of this period in comparison to today. However, I am confident that, in working closely with our partners, having a strong sense of what matters and who matters, a robust governance system and a corporate model that ensures that the voice of our key stakeholders are listened to and acted on as a public benefit corporation, we can continue to provide high quality care to the people of Devon and beyond.

James Brent

Chairman

Corporate Strategy

The Trust has developed a Corporate Strategy for 2014/15 to 2018/19, which forms the context for our Strategic Plan. The Corporate Strategy sets out our vision, values and strategic objectives.

Vision

The Trust's long term vision is to provide 'safe, high quality, seamless services delivered with courtesy and respect'

Values

In striving to achieve this vision, the Trust has set out a number of values that encapsulate what is important to us in the way we work. They are:

- Honesty, openness and integrity
- Fairness
- Inclusion and collaboration
- Respect and dignity

Strategic Objectives

The Trust has three strategic objectives for the period of this strategy:

- Maintaining sound operational delivery of existing clinical and research services
- Integrating care pathways from community to acute care and back out again. This will be done in partnership with other service providers of care as well as by increasing our provision of whole pathways
- Further developing acute services across a wider geographical area by building on clinical networks and partnerships already in place.

To give future shape to what achieving our strategic objectives will mean for the Royal Devon and Exeter NHSFT, our patients, staff, governors and other partners, the Board of Directors have developed a set of statements which describe what we will have achieved over the next five years.

These are to:

- Serve a population of minimum 800,000 mainly across Devon and Somerset
- Be ranked among the top three 'safest' hospitals in the South West
- Ensure patients feel cared for
- Provide a comprehensive range of core hospital services, including:
    - high quality emergency care
    - scheduled elective treatments across all existing specialties
    - diversification into new markets, particularly to an improved service for frail and older people
    - establishing a regional treatment centre pelvic cancer services
    - continue to provide specialised services where they can be done so safely and at class leading quality
- Work in partnership with primary care, mental health and social services to ensure patients have smooth access to hospital when required, are maintained in the community wherever possible, and return to the community as soon as possible after a hospital admission
- have a reputation for the efficient delivery of high quality, safe care using innovative service models
- have gained international recognition for research, doubled the level of income from research and, in collaboration with the AHSN, further developed its relationship with the University of Exeter in support of research and innovation
- maintain 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.

- become a recognised brand for patient care excellence, regionally and across the UK, and be known/admired for our entrepreneurial approach to business
- be the employer of choice for highly skilled health professionals of all disciplines and levels
- be in the top 10% of trusts nationally which staff would recommend for their family and friends
- be respected and valued as a partner organisation
- ensure the values of the organisation are always evident in our relationship with staff and partners.

Supporting Strategies

In order to deliver the strategic objectives, the following supporting strategies are being developed:

- Clinical Services Strategy
- Workforce strategy
- IM&T strategy
- Estates strategy
- Transformation strategy
- Stakeholder engagement strategy
- Business Development strategy
- Financial strategy

This work has been primarily defined by the development of Clinical Services Strategy (CSS). The CSS outlines the key areas of service change that the Trust will expect to implement over the next five years in order to achieve its strategic objectives. The other supporting strategies have built on the CSS and other clinical service priorities.

Market analysis and context

Trust Profile

The RD&E provides acute hospital and specialised services to a core population of around 460,000 people living in and visiting Exeter, East and Mid Devon. Some of our patients come from further afield because we are recognised nationally and internationally for excellence in specialist fields including orthopaedics, molecular genetics, neuro-rehabilitation, diabetes, neonatology and cancer services. The Trust is the largest provider of acute and specialist care for the population of Devon.

The RD&E is an undergraduate teaching hospital, partnered by the University of Exeter Medical School, and is the leading research centre for the South West Peninsula with a national and international reputation for research.

Our main hospital sites are at Wonford and Heavitree in Exeter; but increasingly we are providing patient care closer to home, including outpatient and day case surgery in the local community hospitals, community midwifery services and renal dialysis units.

Each year, we manage over 100,000 emergency department attendances, 300,000 outpatient attendances and over 115,000 elective or emergency admissions.

The Trust has performed well in its clinical care, operational delivery, achieving targets and research and innovation. However, the financial environment in which we operate has been increasingly difficult and the Trust reported an operating deficit of £3.1m in 2013/14 for the first time in many years. Despite continuing to drive out savings, we plan to deliver a deficit for the next two years and recognise that significant change to the delivery of services is required to enable the Trust to return to a sustainable financial position.

Local Health Economy

There are a number of factors across the local health economy that will drive changes to the delivery of health and social care services, particularly the aging population of Devon, which is significantly higher than the population profile of the rest of England.

The local health economy is recognised nationally as one of 11 that are financially challenged and other local providers have experienced problems in delivering national targets and financial performance. This, combined with budget cuts in social services, provides significant impetus to redesign the way health and social services are delivered. The strategies of other stakeholders indicate that personalisation and integration of services is a key tenet of any future approach and NEW Devon CCG's document 'Community Services in the 21st Century' is currently out to public consultation. Nationally there are a number of factors that set the context for the Trust's strategy. There is recognition that services need to be redesigned and reconfigured, delivered by primary and community care wherever possible, and that the number of acute hospitals delivering emergency care and specialised services may be reduced. Recent high-profile failures in the quality of services for patients such as events in Mid Staffordshire, have led to the recognition that substantial improvements are needed to deliver safe and consistent services across the NHS. However, this need is set against a backdrop of significant shortfalls in resources over the next 5-6 years, estimated to reach £30bn by 2020/21. The 'Challenged Health Communities' work, sponsored by Monitor, TDA and NHS England, has identified a £430 million funding gap between 2014/15 and 2019/20.

Services Provided

The Trust provides a full range of general hospital services, along with a wide range of specialised services, reflecting its position as an undergraduate teaching hospital and a centre of research and innovation. The main commissioners for RD&E's services are:

- NEW Devon CCG (67% of the Trust's income)
- NHS England (specialised services) (21% of the Trust's income)
- South Devon and Torbay CCG (5% of the Trust's income)

Delivery of Performance Targets and Quality of Services

Performance against national and local targets by the RD&E and across the Local Health Economy is good, with the Trust consistently delivering A&E performance throughout 2013/14 and recovering its position from previous challenges to RTT performance; although some cancer targets remain very close to threshold levels.

The Trust is registered with the Care Quality Commission in full without conditions. The most recent (March 2014) findings of the Care Quality Commission's 'Intelligent Monitoring Report' recorded a risk score of 6 (the maximum, lowest risk score awarded).

We perform strongly against the 17 safety and quality indicators that are reported monthly to the Board of Directors. The Trust is the best in the South West measured against key safety and quality indicators, and benchmarks well against other NHS QUEST hospitals.

We have introduced more robust management of performance. Staff survey results have also improved, with 19 out of 28 Key Findings showing higher scores in 2013 compared to 2012.

The Trust has a strong emphasis on research and putting this into clinical practice and has a close partnership with the University of Exeter in support of this agenda. The Trust also has a strong track record of continuous improvement, innovation and redesign, with a clear focus on safety and quality.

Catchment Population

The RD&E has a natural catchment area across Exeter, Mid and East Devon, and Teignbridge with a population of around 460,000. We also provide specialist services for the population of North Devon (c.170, 000). The population is predicted to grow by 0.7% each year up to 2021. Our natural catchment area sits within a wider Devon population of around 1.2m, which includes Torbay, Plymouth, West Devon and North Devon. The Devon population is mostly concentrated around three major centres (Exeter, Plymouth, Torbay) and then a large number of smaller coastal and market towns. The graph below illustrates this, but excludes tourists, who are significant to the local economy and have an impact on the local health system (particularly during the summer holiday season).

Demographics

Devon has a significantly older population profile than nationally, particularly among people aged 55 and above, and those aged 85 years and over. The proportions of those aged 20-39 and those under 10 years are below the national average, particularly in those aged 25-39. This overall pattern is even more marked in areas of East Devon and South Hams. The population in Exeter is similar to the national average, but with an increased young adult population due to the university.

Looking forward to 2021, the overall population is forecast to grow by around 0.7% per annum. However while there is relatively little change in the under-60 age groups, the major change occurs in the population over 60 years, both in numbers and as a proportion of the whole. The population of over 75s in the Trust's catchment is just under 50,000 and their growth rate is forecast to be around 2.4% per annum, whilst for over 90s this rises to 3.9% per annum. Of the 23,000 net increase in population, almost 40% will be in the over 75 age group. This will mean that by 2021 the proportion of over 75s in our catchment population will have increased from 1 patient in 9 to 1 patient in 8.

In terms of acute hospital service use, Devon has a high proportion of inpatient episodes relating to patients with long term conditions. The primary cause of death in Devon is cardiovascular disease and within this disease grouping stroke is more significant than in other parts of the country due to the more elderly population. The increasing elderly population represents a major challenge for the Trust and has been a significant influence on our strategy.

Ethnicity

The Devon population consists of almost 95% White British, compared to almost 80% nationally. Although still less diverse than nationally, Exeter has a greater variation in ethnic origin than the rest of Devon (Exeter: 88.3% of people identifying as White British; Devon total: 94.9%). Ethnic diversity therefore has less of an influence on the Local Health Economy than in other areas of the country.

Deprivation and rurality

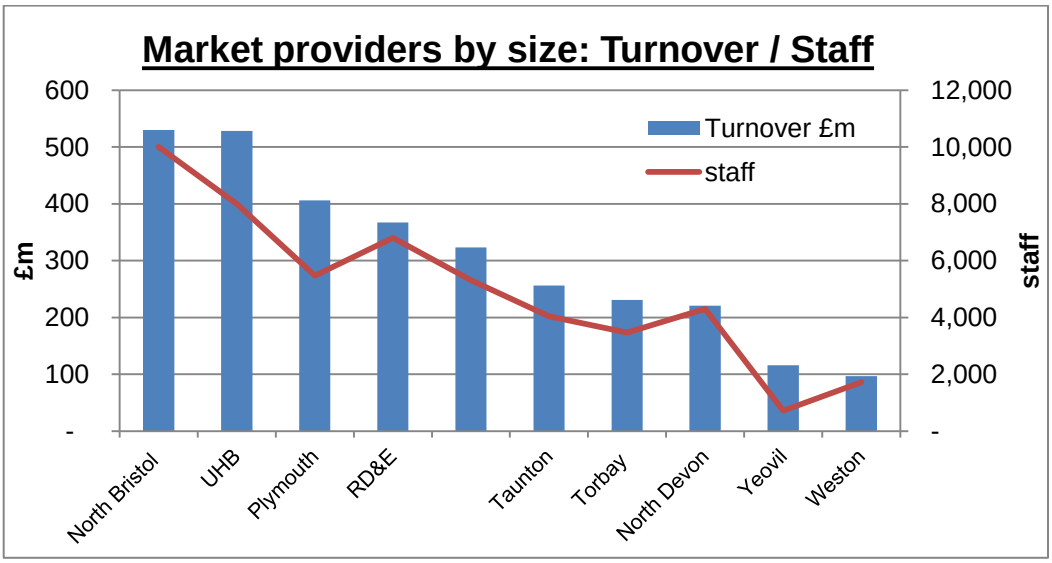
Just below 5% of the Devon population live in the most deprived national population quintile, which includes parts of Exeter, Ilfracombe, Barnstaple, Bideford, Dawlish, Dartmouth, Teignmouth, Newton Abbot and Tiverton. Just over 10% of the Devon population live in the least deprived quintile. While overall levels of deprivation across Devon are lower than the national average, there are some local patterns of deprivation. Rural areas are generally more deprived than rural areas elsewhere in England, whilst urban areas are generally less deprived than urban areas nationally.

Devon is the third largest county in the country and is one of the most sparsely populated. The rural nature of the area makes planning and delivery of services to meet population needs a complex issue. The distance that people have to travel to access services has a profound effect on whether people will choose to access those services. This 'distance decay' effect has an impact on people accessing health services from rural areas in comparison with urban areas. This is a particular problem for people who rely on public transport, but also affects wider groups.

The national policy direction towards care closer to home is therefore more important in Devon than in other areas and is reflected in the Trust's strategy and the LHE priorities.

Local Acute Providers/Competitors

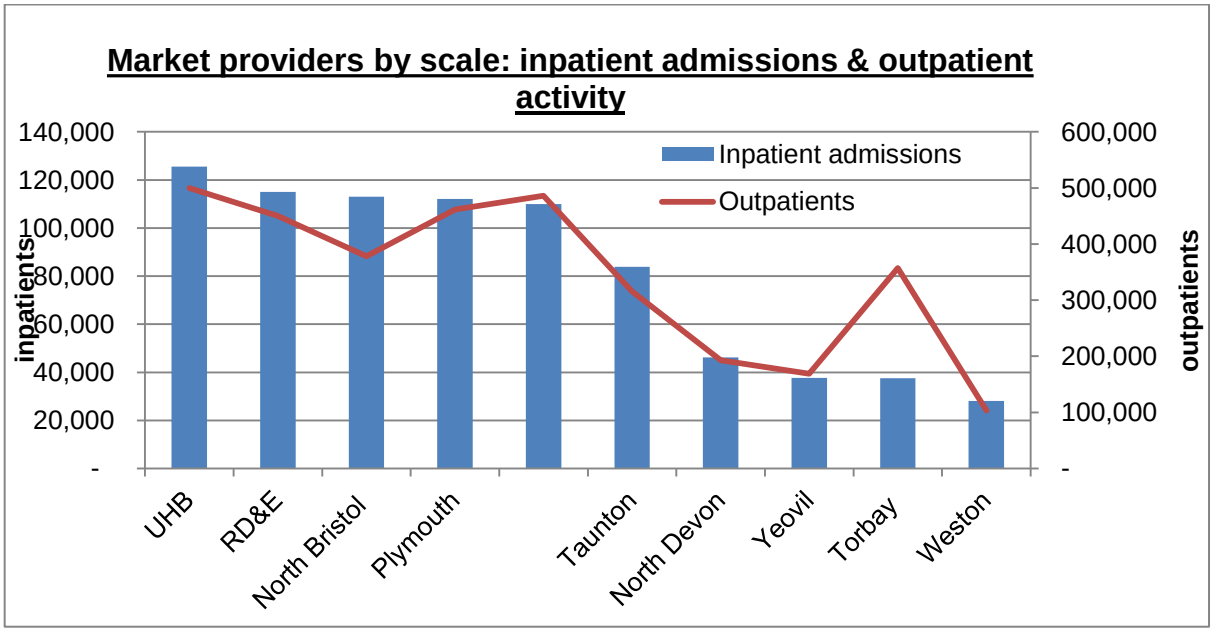
There are currently 10 main acute providers in the South West, covering the area from Bristol down through Somerset and Devon to Cornwall and the Isles of Scilly. The graph below shows the provider picture for the South West based on size (by revenue and staff) with providers ranging from c.£100m-£530m and c.700-10,000 staff.



(Northern Devon Healthcare Trust provides significant community as well as acute services, both are included in this chart.)

The four largest acute hospital Trusts in the South West are the North Bristol (NBT), University Hospitals Bristol (UHB), Plymouth (PHT) and the RD&E. However, in relation to inpatient admissions, RD&E is the second largest provider in the South West, after UHB.

The largest six trusts (out of 10) provide more than 80% of inpatient admissions and more than 75% of outpatient activity for the South West as a whole. The average volume of inpatient admissions of the largest 6 is nearly 3 times that of the average of the smallest 4 trusts (Weston, Yeovil, North Devon and Torbay). Given the scale of services being delivered at these smaller hospitals, there may be challenges around their clinical and financial sustainability in the future.



(Northern Devon Healthcare Trust provides significant community as well as acute services, both are included in this chart.)

There are two other acute providers located in the NEW Devon CCG area, Plymouth Hospitals NHS Trust and Northern Devon Healthcare NHS Trust, with one, South Devon Healthcare NHS Foundation Trust, in the neighbouring South Devon & Torbay CCG area.

Choice and competition

The RD&E competes against local acute providers in the following ways:

- Local Devon catchment - where the commissioning group is the same e.g. NEW Devon CCG for NDHT, RD&E and PHT; or
- Wider South West Peninsula catchment - where there are a number of neighbouring CCGs e.g. South Devon & Torbay CCG for SDHCT, Somerset CCG for Taunton & Somerset NHS Foundation Trust, Kernow CCG for Royal Cornwall Hospitals NHS Trust; or
- Wider South West region catchment - where a specialised commissioner issues contracts for services across the wider South of England Specialised Commissioning Group.

The competitive landscape for the RD&E is shaped by:

- Services where there is currently competition 'in the market' so that patients may choose, usually in discussion with their GP, their preferred consultant and hospital provider for an outpatient appointment; or
- Services where there is competition 'for the market' where commissioners will offer a contract for a fixed-term and the service is provided by the service provider as a monopoly or quasi-monopoly e.g. satellite renal haemodialysis services; or
- Mixed market – where services are provided by a restricted number of providers, selected by the CCGs, and competition takes place as a combination of 'for' and 'in' the market.

The local competitive environment is described in more detail in relation to specific services in the 'Risk to sustainability and strategic options' and 'Strategic plans' sections of this document.

Commissioners and other stakeholders

North, East and West (NEW) Devon Clinical Commissioning Group

NEW Devon CCG is the largest clinical commissioning group in England covering a population of 890,000 with an allocation of £1.1bn. It covers most of Devon, excluding South Devon & Torbay.

The CCG's priorities emphasise consistent quality of service across its providers; meeting the NHS Constitution standards for access; and better management of care pathways and the interfaces between the various health and social care providers as well as other agencies. The CCG's strategies seek to direct a greater share of resources towards prevention, self-care, better management of long term conditions and urgent care. Clinical outcomes across the CCG area are good, but the cost of provision is higher in a number of areas. Benchmarking indicates that access to elective services is higher than the rest of England but that emergency activity is lower. The CCG has historically experienced financial overspends and whilst this has improved more recently, the forecast position for 2013/14 is a deficit of £14.7m. There is an acknowledgement that the underlying financial issues across the county will not be addressed by short term fixes, but rather that long term transformation change and service reconfiguration is required. As one of 11 'Challenged Health Communities' it is likely that the CCG's strategy will be refocused over the coming year to better meet these financial challenges.

NEW Devon CCG has identified 5 key strategic priorities:

- Partnerships to deliver improved health
- Personalisation and integration
- GP practice as organising unit of care
- Regulated system of elective care that delivers efficient and effective care for patients
- A safe and efficient urgent care system.

In addition, the CCG's 'Commissioning Framework 2014-16' identifies a number of key commissioning principles:

- NEW Devon CCG will work with its partners to commission services that contribute to the delivery of the Joint Health and Well Being Strategy
- A focus on integration, including the development and adoption of a shared set of commissioning principles with local authority partners and embracing the opportunities presented by the Better Care Fund
- Transforming Community Services
- To create a clear view of the future provision of health and social care and sustainability
- To work with the Area Team to ensure specialised commissioning and primary care meet the needs of the population

The CCG is currently consulting on its strategy for community services and the proposals include RD&E being the provider for community services within its catchment area. This will enable the Trust to drive forward one of its key strategic objectives and will give significant opportunity for benefit for the local population and the Local Health Economy.

NHS England (Specialised Services Commissioning)

NHS England is responsible for the commissioning of specialised services. For the South West, the specialised commissioning team is hosted by the Bristol, North Somerset, Somerset and South Gloucestershire Area Team. There are a number of challenges faced by NHS England nationally in relation to specialised services and a turnaround team is working with them to improve their financial position. The Trust regards the turnaround work as low risk in relation to its own income.

In addition, NHS England is reviewing the current provision of specialised services across the NHS. This work is likely to lead to some service reconfigurations, with fewer providers commissioned to provide particular specialised services. The Trust has plans in place to ensure that the Trusts specialised services are protected.

Devon County Council Social Services

Devon County Council (DCC) serves a population of 750,000 and has a budget of £1.4bn. The council's strategic plan places an emphasis on health and wellbeing. Its vision is that by 2020 every resident will enjoy good health and wellbeing with fewer health inequalities across the county. DCC supports approximately 19,000 adults to live at home and 3,500 adults in residential and nursing care.

There is a focus on personalised care and promoting independence and choice across all health, social care and educational services and priorities include delivering a wider range of community options for people with dementia.

Devon spends above average on social care per head of population at £438 per head, compared to England average of £411. The People Department of DCC needs to make savings of approximately £37m against a net service budget of £314.8m (12%), over the period 2014/15 to 2017/18.

DCC commissions a significant proportion of independent sector care and is a substantial provider of residential beds. There is sufficient capacity of residential care homes, with oversupply in some market towns, but the pattern of demand is changing and the needs of older people with dementia within care homes is increasing. The existing provision needs to be reshaped and DCC are currently consulting on plans that will:

- Manage anticipated demand and investments in Extra Care Housing, Carers Support and Reablement (900-1000 units) with an expectation that 30% will be for people who would have otherwise been admitted to residential care.
- Withdraw DCC from residential care provision to focus solely on commissioning.
- Support providers to maximise capacity to meet needs of people with dementia and people with more complex and intensive needs.

Demand Planning

Demand modelling has been done jointly between the Trust and NEW Devon CCG for 2013/14 and 2014/15. This plan is based on a three year activity trend, adjusted for movements in waiting lists and anticipated specific changes in clinical practice or demand that may result in volume changes.

The two year activity forecast has then been reviewed by the RD&E's 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.

Predicted Activity Growth	2014/15		2015/16		2016/17		2017/18		2018/19	
	%	£m	%	£m	%	£m	%	£m	%	£m
Outpatients	5.2%	£2.6	5.0 %	£2.6	5.0 %	£2.7	5.0%	£2.9	5.0%	£3.0
Elective Inpatients	4.9%	£3.0	1.7%	£0.7	-0.1%	£0.0	-0.1%	£0.0	-0.1%	£0.0
Day-cases	4.1%	£1.9	3.8%	£1.6	3.0%	£1.3	3.0%	£1.3	3.0%	£1.4
Emergency Inpatients*	-0.4%	-£1.4	4.7%	£3.0	3.1%	£2.1	3.0%	£2.1	2.9%	£2.0
Drugs & Devices	13.8%	£4.6	11.7%	£4.4	11.7%	£4.9	11.7%	£5.5	11.7%	£6.1
Other		£2.5	0	£1.9	0	£1.3		£1.3		£1.4
Total		£13.2		£14.2		£12.3		£13.1		£13.9

** The reduction in predicted 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.*

Estates

The Trust has two main sites (Wonford and Heavitree), provides services from 13 satellite locations (such as Community Hospitals) and accommodates offices and other support services in six additional buildings. The Trust has invested nearly £60m in improving and extending the estate. By 2014, significant additional projects (c. £30m) will complete to enhance core services, training and research.

Workforce Profile

The RD&E employs 6,195 people (5,421 FTE), accounting for 63% (£222m) of the Trust's total budget. The Trust currently has c.700 temporary staff with the majority in registered and unregistered clinical roles. There are challenges in recruiting registered nursing staff particularly in theatres, specialist non-clinical roles such as IT specialists and consultant staff in some specialties. Turnover in recent years has been relatively stable at 10-11%.

Operational requirements and capacity

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 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 model is based on contracted growth and makes assumptions about admissions avoidance and pathway redesign. It forecasts information on percentage occupancy levels across the three defined bed pools to aid operational and financial decision-making. The bed modelling is also used to support proactive joint CCG, health and social care winter planning and surge action plans.

Bed Capacity modelling outputs and key assumptions.

The following bed capacity assumptions have been made:

- The forecast 2014/15 contract demand plan activity can be accommodated within the existing bed pools, but not for 2015/16 and beyond 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, increasing risks to RTT delivery
- There will continue to be medical outliers at times of peak demand
- infection control outbreaks may affect the provision of the proposed levels of activity
- there are no changes to onward care and community services provision.

To accommodate the 2015/16 forecast growth, joint operational planning is underway with commissioners and partner agencies to plan alternative models of care. These plans are fundamental to the CCG strategy of delivering more care closer to home and reducing reliance on bed-based services, particularly in acute services.

Theatres Capacity Modelling

The 'Formula 1 Theatres' project has continued to drive efficiency within operating theatres 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 one, three and five years. The key conclusions are:

- Current utilisation is high. However, it might be possible to increase utilisation by a further 0.7% (the equivalent to 1.5 additional theatres) to reach maximum achievable utilisation.

- In the next five years, it is estimated that up to 8 additional operating theatres will be required, with the largest growth rate being within orthopaedic theatres.

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, potentially there may be a further impact on staffing numbers in 2015/16, but these are not yet quantified. An improved approach to workforce planning has been implemented, which will quantify any increase that may be needed by diversifying into new markets, broadening our existing portfolio of services and/or delivering care in the community.

Investment may be required to recruit increased staff and additional education/learning to ensure new or changing service needs and any redesign of system-wide care pathways can be delivered safely and efficiently. Where services are redesigned, the strategy is to redeploy staff where possible, including retraining, to minimise the risk of compulsory redundancies.

Demand and Capacity Risks and Mitigations

Key risks that have been identified 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 in a number of joint work programmes with the NEW Devon CCG and partner agencies including:

1. Demand management for elective referrals (cancer and non-cancer) and admissions to support planned care sustainability, 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
3. Delays in onward care
4. A new five-year Clinical Service Strategy.

Forecast activity and revenue in a 'do-nothing' scenario and resulting financial gap across the LHE

In February 2014, Devon was identified as one of 11 financially challenged health economies, and Monitor, NHS England and the NHS Trust Development Authority appointed PricewaterhouseCoopers to assist the providers and commissioners to work together to achieve three objectives:

- to submit strategic plans that are robust, deliverable and clearly set out how the anticipated challenges will be met
- to develop full implementation plans for the change required to prevent risk of failure
- Provide the partners with confidence that the capacity is in place to deliver the plans.

After analysis of the financial plans of providers and commissioners, it has been estimated that the financial gap in a 'do nothing' scenario is £430m across the Devon health economy (£459m assuming that organisations achieve the required 1% surplus). This compares to an allocation for NEW Devon CCG of £1,100m (excludes specialised commissioning).

Work is now progressing to validate the potential savings in three categories:

- Organisational planning
- Activity
- Future models of care.

This work will need to continue well past the end of June and a draft plan is currently being reviewed containing the vision and methodology required to help the Devon Health Economy to be operationally and financially sustainable.

The activity, income and expenditure assumptions that are contained within this plan have been used to form the basis of LHE work that has identified the £430m gap assumed in the 'do nothing' model.

Risk to sustainability and strategic options

Strategic Objectives

The national financial outlook requires the Trust, over the short to medium term, to generate cost improvements of between 4.5% and 5% of turnover each year. The Trust had been achieving this over the last three years. During the last financial year, (2013/14) we failed to meet cost improvement target recurrently. There is acknowledgement that the Trust cannot accommodate the levels of growth in patient numbers and treat sicker and more complex patients, whilst continuing such ambitious efficiency targets year on year. The Board of Directors is very clear that these operational and financial pressures will not compromise the safety of our patients, but, inevitably, there is likely to be an impact on the quality of care that can be delivered unless we think differently.

In order to respond to this, the Trust has set the three strategic objectives already noted earlier.

Hierarchy of Priorities and Future Care Design Principles

Given the challenging environment and competing demands on our resources and capacity, the Board of Directors has explored the need for a hierarchy of priorities to help inform strategic decision-making. This hierarchy will give the Board a blueprint of 'what' and 'who' is important to us. It will also help us to communicate this more effectively with diverse stakeholders.

‘What is important’ to us is defined as follows:

- Safety and Quality (Darzi definition): a place or situation where harm, damage or loss is unlikely
- Outcome: a satisfactory result that realises the expected outcome
- Risk: the likelihood and consequence of something going wrong
  Financial viability: the ability to fund the operations it determines to undertake for aperiod of 3-5 years.
- Enhanced Quality - the standard or grade collectively defined beyond the Darzi definition.

These factors are set against ‘who is important’ to us as follows:

Priority	What is important	Priority	Who is important
1	Safety & quality	1	patient
1	Outcome	1	community
1	Risk	3	staff
4	Financial viability	4	regulators
5	Enhanced quality	5	wider non-local NHS

When making both investment and disinvestment decisions that may affect the delivery of care to patients to support the delivery of this corporate strategy, the Board of Directors will seek to ensure that as many as possible of the top priorities in the above table are addressed.

Clinical Service Strategy (CSS)

The Clinical Services Strategy has been developed in collaboration with internal and external stakeholders and takes account of national policy direction. Patient and public feedback has formed a critical component of the process. The following future care design principles have been developed in conjunction with staff, governors and commissioners:

- Outstanding customer service will be at the heart of all we do
- ‘no bed like your own bed’
- We will understand the needs of our local communities and serve them well, making the best use of technology
- We will be a recognised centre of excellence for staff development
- Patient and carers will be involved in and helped to manage their care
- Patients will see the most appropriate practitioner, at the right time
- All care must be compassionate, safe within clear, measurable quality standards
- We will listen to patients and consider the need to challenge traditional hours of working and where care is delivered
- Research and innovation will underpin redesign of services and pathways
- Integration potential will be explored for service and pathway redesign activity.

These future care redesign principles will shape the way in which we approach service change over the period of this strategy. In order to deliver our aspirations over the next five years, services will need to change radically, either with the RD&E as lead provider or in collaboration with other providers.

The clinical service strategy comprises 12 key elements built around 3 themes and the Trust's 3 strategic objectives as summarised below:

Continuous Improvement	Integrated Care	Specific Service Expansion
Emergency Pathway Redesign	**Lead Provider for Stroke**	**Pelvic Cancer Centre of Excellence**
Elective Pathway Redesign	**Patch Geriatrician Model**	**Orthopaedic Centre of Excellence**
7/7 Working	**Expansion of Hospital at Home**	**Development of Private Patient Services**
Outpatients Redesign	**Exeter City – Integrated Care Project**	
	Care Home Provision	
Corporate Objective Maintain sound operational delivery of existing clinical and research services	Corporate Objective Integration of care pathways from community through to acute care and back out to community again	Corporate Objective Further development of Trust's acute services across a wider geographical area, building on existing networks and partnerships

The following sections describe each of these elements and highlight key enablers from the other supporting strategies that will be required to deliver these service changes.

Delivery of Strategic Objective 1:
Maintain sound operational delivery of existing clinical and research services

The Trust has a strong track record of continuous improvement, innovation and redesign, with core focus on safety and quality. In order to deliver this objective, the following priorities will be delivered:

- Emergency pathway redesign, which will comprise a comprehensive review of emergency pathways across the Trust and with partners to improve clinical outcomes and efficiency
- Elective pathway redesign with an initial focus on high volume specialties, such as Urology, Dermatology and Ophthalmology
- Outpatients redesign, which will consider whether alternatives to outpatient attendances, such as providing advice and guidance to GPs, could be offered as a more appropriate way of meeting patients' needs
- 7/7 working, which aims to deliver NHS services at the same level over the weekend as during the traditional working week.

Impact on other supporting strategies to deliver clinical service strategy elements

In order to deliver the four priorities noted above, there will need to be enabling activity across a number of the other supporting strategies, particularly the transformation and workforce strategies.

Delivery of Strategic Objective 2:
Integration of care pathways from community through to acute care and back out to community

The CCG is currently consulting on its strategy for community services and the proposals include RD&E being the provider for community services within its catchment area. This offers the opportunity for the Trust to make a significant step forward in delivering this strategic objective.

However, a change to the provider of community services will not, in itself, deliver the change that is required. There will also need to be a new model of integrated care incorporating local acute services, community and social care. The move to community and out of hospital care alongside the integration agenda should result in fewer patients being treated in a traditional acute care model and stimulate the emergence of new models of care.

The development of services for frail older people is a key priority. Enabling older people to live independently and integrating care into the community are key tenets of our Clinical Services Strategy. The projects under this objective rely on continued collaboration with health, social care and third sector partners to engage in the design, testing and full implementation of a new way of working. We have has

identified the following five priority projects for implementation over the next five years to deliver our 'integration' objective:

- Lead provider for stroke: our aim would be to ensure that patients spend more of their hospital stay on a specialist stroke unit. This would be delivered by a reconfiguration of services across acute and community facilities. The intention would be for the Trust to become the provider of an integrated stroke service
- Patch geriatrician: the focus would be to move secondary care expertise from hospital into the community resulting in consultant geriatricians being aligned with geographical areas to provide additional outpatient care. 'Patch Geriatricians' would provide leadership, education, training and support to the care, particularly for complex patients, in order to prevent inappropriate admissions to hospital
- Expansion of Hospital at Home: the Hospital at Home provides people with active care and treatment by social and health care professionals at home rather than community hospital in-patient care or residential rehabilitation care. We will build on a successful pilot scheme in the WEB (Woodbury, Exmouth and Budleigh Salterton) locality which has demonstrated that an enhanced community service can safely support people with more complex needs in their own homes.
- Exeter city – integrated care project: this ambitious project aims to change the way the local population access services across health, social care, housing and other public and third sector services by simplifying pathways and giving easier access to appropriate services at the earliest opportunity. The project will require close collaboration with other partners, and the initial focus of the project will be frail and elderly people
- Care home provision: this scheme is in response to the over provision of residential homes but shortfall in care homes for patients with nursing and dementia needs. The Trust would like to provide a dementia assessment facility, which cannot be done appropriately in an acute hospital, with the intention of ensuring patients are provided with support on return to their usual place of residence.

Delivery of Strategic Objective 2 – Impact on Other Supporting Strategies

The CSS elements described above will have impact on the other supporting strategies, particularly workforce and IM&T. The Workforce Strategy will address the need to recruit additional staff, in particular additional geriatricians to support the Patch Geriatrician Model. .

There is an important role for the IM&T strategy as technology will be needed to deliver integrated care, and provide access to an integrated care record across the community. The Transformation Strategy will deliver the support for the cross-economy patient pathway work required to deliver the Hospital at Home, Patch Geriatrician and Exeter City Integrated Care Projects.

The development of a care home facility will potentially have implications for our Estates Strategy.

Delivery of Strategic Objective 3:
Further development of the Trust's acute services across a wider area

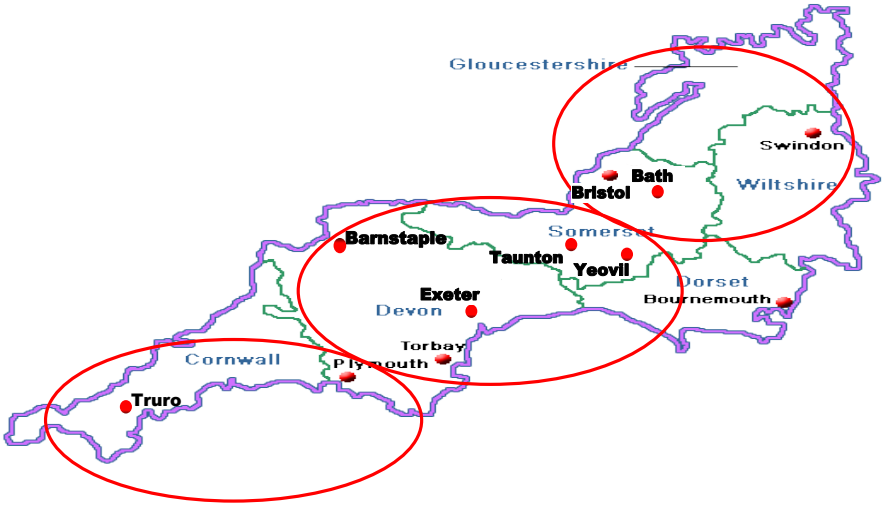
The RD&E is the fourth largest provider of specialised services in the South West. National policy on specialised care continues to be formulated: the policy drivers outlined in NHS England's 'Everyone Counts' regarding emergency care and specialised services suggests larger population solutions to provide improved economies of scale and sustainable comprehensive 7/7 specialised provision. Whilst the Trust currently serves a population base in excess of 500,000 for some of its specialised services and plans to increase this to a minimum of 800,000 over the next five years.

The dispersed population within the South West creates a number of challenges and opportunities for acute and specialised provision: dispersed populations need to be able to access specialised care within reasonable travelling times but specialised centres need a minimum population base to sustain quality provision. To meet both requirements the existing network of specialised provision across the South West region needs to be reviewed and further developed. The Trust would like to see the creation of three specialised networks each supporting a population of approximately 1 million people. Establishing this model would require a formal alignment of service provision for population groupings serving:

Bristol, Bath and Swindon; Devon and Somerset; and Plymouth and Cornwall. Together the three centres will be more capable of supporting delivery of specialised care to support redefined local acute care to smaller population centres like Yeovil, Weston, Barnstaple and Torbay. It is expected for more highly specialised services like Cardiac Surgery and Major Trauma Care there will continue to be a two centre model within the South West based in Bristol and Plymouth.

This distribution of service described in the diagram below will maximise the offer of quality specialised care within reasonable travel times to the whole population of the South West in a clinical and financially sustainable manner. The proposal has been informally tested with the Area Team responsible for specialised commissioning and the CCGs for Devon and Somerset and the Trust is already exploring with Taunton and Somerset NHS Foundation Trust options for developing this work.

The Trust has carefully considered the means of achieving these intentions, with options of collaboration, chain, merger or acquisition as potential mechanisms to deliver this. At this stage it is not clear which of these approaches would best suit the needs of our population and clinical and financial sustainability and this will need further analysis and consideration as our strategy develops. The Trust has, however, formed a view around its target catchment area and the impact of this on the potential configuration of acute providers across the South West as described below.



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 the 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.

In order to expand the specialised services catchment, the Trust will expand the services it provides in a number of key areas:

- Pelvic Cancer Centre of Excellence: the Trust has a reputation for providing a highly comprehensive service for patients with abdomino-pelvic conditions. There is a significant opportunity to extend the provision of these high quality pelvic services to the wider region if the internal capacity, strategic planning and the associated human resources are put in place

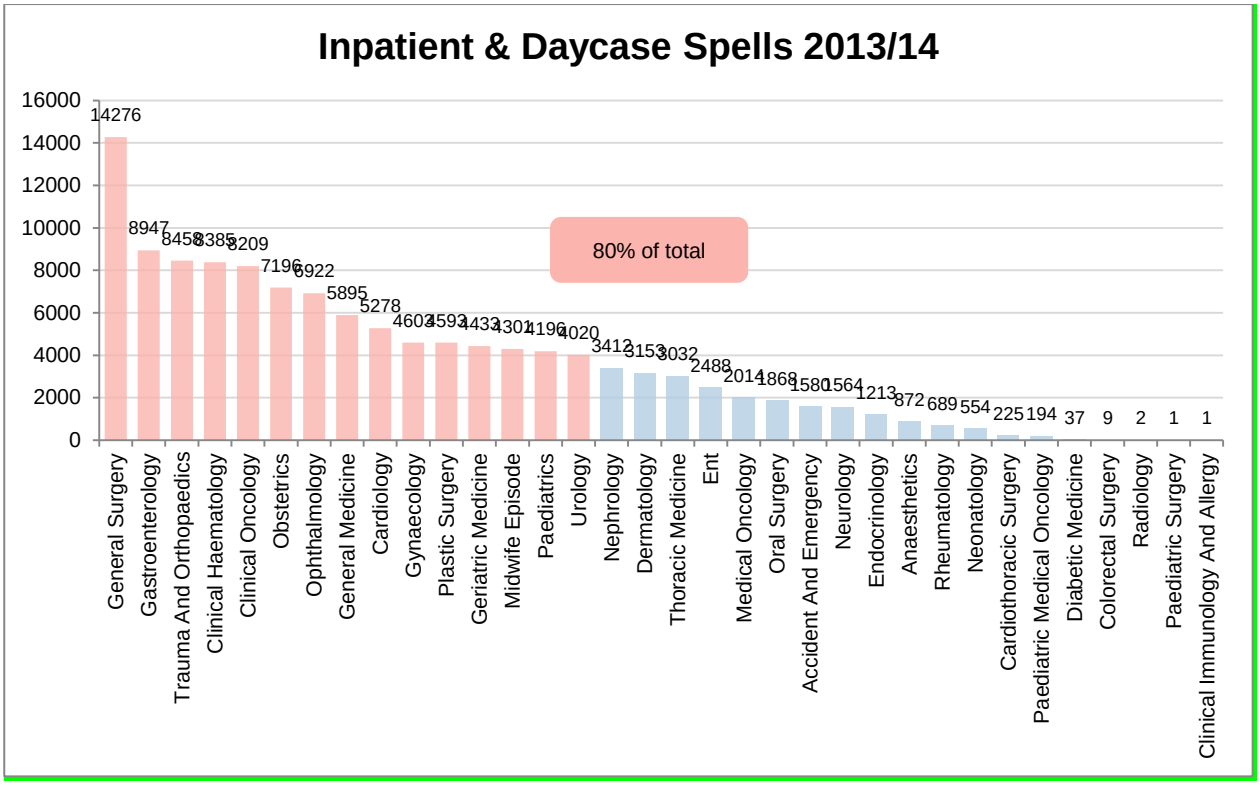
- Orthopaedic Centre of Excellence: this scheme would involve the Trust building on its national and international reputation to expand its catchment area outside of Devon to other areas of England that are experiencing capacity shortfalls and to abroad, particularly for private patients
- Development of Private Patient Services: we currently generate around £1m in private patient income each year. A scheme to expand private patient provision could secure a new income stream for the Trust to help finance investment in other patient services.

Delivery of Strategic Objective 3 – Impact on Other Supporting Strategies

The expansion of specialised and private patient services will potentially have an impact on a number of our supporting strategies. In particular, these are key elements of the Trust's Business Development Strategy and we will have to ensure that our Stakeholder Engagement Strategy recognises stakeholders beyond our normal catchment population and is responsive to their needs.

Service Line Analysis and Strategic Options

The Trust's inpatient volume of admitted patient activity (spells) in 2013/14 is shown by Service Line in the graph below. This covers both elective and non-elective activity. The first 15 services (out of 34) cover over 80% of the Trust's volume of inpatient work.



In developing the Clinical Service Strategy, each Service Line team considered the position of their specialty in relation to current and future challenges and opportunities, via a SWOT-type analysis. These analyses were discussed with the Divisional management teams in order to develop a prioritised list for inclusion in the CSS.

The strategies for the key clinical services within the CSS have been outlined in the previous section, 'Risk to sustainability and strategic options'. The key elements are:

- Emergency pathway redesign
- Elective pathway redesign
- 7/7 working
- Outpatient redesign
- Lead provider for stroke
- Patch geriatrician model
- Expansion of Hospital at Home
- Exeter City integrated care project

- Care home provision
- Pelvic cancer centre of excellence
- Orthopaedic centre of excellence
- Development of private patient services

Some of these elements are focused on a single Service Line (e.g. 'Lead provider for stroke'), some bring together a small number of Service Lines (e.g. 'Pelvic cancer centre of excellence') and others bring together themes that were identified by a large number of Service Lines and have been grouped under a Trust-wide heading. The Service Line is therefore the fundamental building block of all the elements of the CSS.

In order to ensure that development is maintained in services that were not prioritised for the Trust-wide CSS; a further exercise is underway to ensure that opportunities in other Service Lines are also progressed and to keep the Service Line strategies up-to-date in the face of the changing policy, technological and competitive environment.

The following three stage approach is being used to refine the additional strategies by Service Line.

- SWOT analysis by Service Line, with reference to other providers across the South West Region.
- An assessment of competitive advantage, using a McKinsey model, which seeks to identify whether these drive a demand premium based on quality of service or offer a cost/efficiency advantage.
- An assessment of market share and profitability by Service Line.

By understanding both competitive advantage, through incorporating quality; market share; capacity constraints and opportunities; patient experience including access times; relationships with commissioners; and financial performance, the RD&E looks to match the further development of key Service Lines across the various strategic options (growth; transform; cooperate; divest). While this work is underway, the elements already identified via the CSS are being progressed.

Strategic plans

Communication Plan

The plan for communicating our Strategy, Clinical Services Strategy and key Service Line initiatives is encompassed in the Trust's wider 'Stakeholder Engagement Strategy 2014-2019' and communications about service changes will be managed in accordance with this strategy.

The Stakeholder Engagement Strategy has been developed in consultation with staff and stakeholder groups. The strategy describes a number of key themes and how it will support corporate services. It also clearly sets out how the key initiatives within the CSS will be supported by:

- Identifying key stakeholders
- Undertaking analysis to understand the current positioning and interests of these stakeholder groups
- Providing assistance to understand where we want those stakeholders to be
- Helping deliver formal consultations and engagement with the Oversight and Scrutiny Committee as necessary
- Identification of best practice to deliver messages or change behaviours
- Co-developing plans on how key stakeholders might be influenced or moved along a spectrum
- Identifying key risks and mitigation plans
- Assisting in the implementation of agreed plans
- Monitoring stakeholder perceptions and adjusting plans as necessary/post-evaluation

Monitoring of Strategic Plan

Over the last year the Trust has made significant progress in establishing a new way of managing performance called 'Connecting Care'. The system enables a parallel focus on managing the delivery of

'business as usual' and 'step change' performance, and engages all staff in continuously improving how that performance is delivered.

As an integral part of Connecting Care we have introduced Strategy Deployment as our way of managing the translation and delivery of the corporate strategy into a 12-18 month programme driving step change.

Strategy Deployment is essentially a plan on a page developed by the team responsible for the successful delivery of the plan. Against each of the strategic objectives the team will identify the Quality, Cost and Delivery results to be achieved by year end with overall owners agreed for each result area. The team will then identify the step change projects and key milestones that will need to be delivered in order to achieve the results, with an accountable owner agreed for each project. Monitoring the delivery of the Strategy Deployment projects is supported through our central Programme Management Office.

Future changes to Strategic Plans to respond to unexpected future challenges

There will be quarterly Board reports on progress on strategy implementation in addition to regular Board Strategy Workshops, during which actual or potential changes in the external environment are discussed and the strategic approach is refined as required in response. These workshops include regular updates on potential changes in political direction, national policy or national and local commissioning intentions. The annual process of engaging the Board in the refresh of the Annual Plan will also provide the opportunity for an additional stock take of progress in delivering the strategic objectives and the need for any changes to the strategy.

Financial Background

The Trust has had a stable financial position over a number of years and has been generating modest surpluses of around 1% against a turnover of approximately £385m. These surpluses have been used to invest in capital expenditure to ensure good quality buildings and investment in equipment. The Trust's capital programme per annum has been around £16m. In addition the Trust has built up a reasonable level of cash reserves to ensure it has sufficient cash flow to pay its staff and suppliers.

However, 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 2012/13 recurrent CIP reductions of £47.8m 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 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.

The inability to continue to generate cost improvements year on year whilst delivering increasing levels of patient services has meant that the Trust did not meet its financial plan in 2013/14 and incurred a deficit of £3.1m.

In addition, there are a number of other factors that adversely affect the Trust's finances compared to other parts of the country. The current payment system has a threshold for the number of emergency patients based on the level of activity delivered in 2008/09. Above this level the Trust is paid at 30% of tariff for all new emergency patients and this income does not cover the costs of treating these patients, meaning the Trust makes a loss of approx. £140 on each emergency patient above 2008/9 levels. Overall this 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. Finally 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. If the Trust was to be reimbursed at the same MFF as (say) Bristol University Hospital, this would result in an additional £16.9m per annum.

In recognition of the above financial issues, the Trust's Board of Directors has set a financial plan that will incur a deficit in each of the financial years of the planning period. The Trust has sufficient cash reserves to support these deficit plans and will continue to maintain a regulatory rating with Monitor of 3 over the first two years of this plan. However 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. As highlighted above there is currently a projected financial shortfall of around £430m across the local health economy.

In summary, the Board has assessed that it is unrealistic to plan for and achieve the currently assumed levels of efficiency requirement each year for the next 5 years and as a result the Trust has planned for a deficit to be incurred for each of the next five years. In the absence of changes to national assumptions around PbR tariff as outlined, this would lead to a cash shortfall for which it is assumed in the plan that financial support in the form of a working capital loan from the FTFF of £70m would be required whilst a longer term financial strategy is developed. The impact of this is that cash reduces significantly from £29.6m at the end of 2013/14 to £1.9m by the end of 2018/19, and the Trusts Continuity of Service Risk Rating (CoSRR) will reduce from a '3' for 14/15 and 15/16 to a 2 from 2016/17.

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Patient Income	315.6	330.2	341.9	354.7	364.7	375.5
Commercial Income (includes R&D & Education)	65.6	67.3	68.3	69.7	71.2	72.7
Total Income	381.2	397.5	410.2	424.4	435.9	448.2
Expenditure	-384.4	-406.4	-423.7	-445.9	-465.6	-486.1
Surplus / (Deficit)	-3.2	-8.9	-13.5	-21.5	-29.7	-37.9
Cash (at year end)	29.6	21.8	14.2	0.3	3.3	1.9
Capital Spend	21.9	14.1	7.6	7.6	11.1	9.2
EBITDA	4.05%	2.70%	1.70%	-0.18%	-1.91%	-3.55%
CoSSR	4	3	3	2	2	2
Capital Servicing rating	2	1	1	1	1	1
Liquidity Ratio	4	4	4	2	2	2