University Hospitals Birmingham NHS
NHS Foundation Trust

# Strategic Plan Document for 2013-14

# University Hospitals Birmingham NHS Foundation Trust

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

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

| | | |
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| **Date** | **31 May 2013** | |

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

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

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

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

| | |
|---|---|
| **Name** *(Chair)* | Albert Bore |

**Signature**

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

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|---|---|
| **Name** *(Chief Executive)* | Julie Moore |

**Signature**

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

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| **Name** *(Finance Director)* | Mike Sexton |

**Signature**

## Contents

## 1. Executive Summary

University Hospitals Birmingham NHS Foundation Trust's strategy for 2013/14 to 2015/16 continues to centre on its vision to deliver the best in care. This is supported by its values of honesty, innovation, respect and responsibility and core purposes of excellent clinical quality, patient experience, workforce, and research and innovation. This serves as the framework for the Trust to deliver its strategy. The context in which the UHB is operating continues to present challenges. The structural reform has had an impact on the way services are commissioned and how these are reflected within contractual agreements. The Francis Inquiry has further driven the focus on quality, safety, and patient experience as well as accountability and assurance at all levels of the NHS. In terms of local context, the Trust has now moved all of its services into the new Queen Elizabeth Hospital Birmingham. There is a continued focus on ensuring improved quality and efficiency across patient pathways and collaboration and integration with partners particularly with rising demand. There is also a greater need to focus on horizontal and vertical integration. The financial challenge also remains and the Trust has again focussed on alternative and more diverse income streams in order to further strengthen its stability.

The Trust continues to have a strong clinical strategy supported by a broad set of objectives within the framework of the four core purposes. There are also cross cutting themes that are considered important to the delivery of the strategy. With regard to specific quality objectives, these will be supported through the delivery of the Quality Improvement Priorities contained within the Quality Report and CQUINS agreed with commissioners.

In terms of workforce, the Trust has a strong set of strategic objectives to ensure the workforce is fit for purpose to deliver safe and high quality services and support new service developments. The Trust has ensured that workforce plans are in place to address the challenges related to increasing patient expectations, increasing activity levels, and the impact of the education tariff.

The Trust's Financial Plan for the next 3 years shows total planned surpluses of £3.9m in 2013/14, £3.1m in 2014/15 and £15.6m in 2015/16 (including a £12.0m asset donation relating to the Institute of Translational Medicine). The detailed assumptions, developments, cost pressures and other factors supporting this plan are set out in detail in Appendix 1 (Financial Commentary) and the other relevant sections in this Strategic Plan.

The Summary of the Key Financial Data is:

| *£ million* | **13/14 plan** | **14/15 plan** | **15/16 plan** |
|---|---|---|---|
| Operating Revenue within EBITDA | 646.1 | 658.3 | 670.8 |
| Operating Expenses within EBITDA | -602.7 | -613.0 | -624.5 |
| **EBITDA** | **43.4** | **45.3** | **46.3** |
| Donations received as Assets | 2.5 | 0.2 | 12.2 |
| Interest Revenue | 0.8 | 0.8 | 0.8 |
| Interest Expense - PFI assets | -18.0 | -17.6 | -17.2 |
| Depreciation and Amortisation | -20.0 | -20.0 | -20.0 |
| Corporation Tax | -0.2 | -0.2 | -0.2 |
| Non operating PFI costs (contingent rental) | -4.6 | -5.4 | -6.3 |
| **Profit (Loss) before impairments** | **3.9** | **3.1** | **15.6** |
| Impairment Losses (Reversals) net | - | - | - |
| **Profit (Loss)** | **3.9** | **3.1** | **15.6** |

Although there are a number of challenges faced by the NHS and the Trust itself, UHB is in a strong position to work to meet these.

## 2. Strategic Context and Direction

### Trust's Strategic Position

UHB is the largest tertiary and teaching provider in Birmingham and the West Midlands. Since the opening of the Queen Elizabeth Hospital Birmingham in 2010 the Trust has seen significant growth in both elective and emergency activity as patients have been attracted from other local providers.

There are two other main tertiary providers in the West Midlands neither of which provides as wide a range of services as UHB. In addition neither has foundation status. For provision of secondary services there are two other providers within Birmingham who offer District General Hospital services and another provider in Worcestershire whose catchment area adjoins the Trust. Over the last year the Trust has seen significant growth in both referrals and in attendances at the Emergency Department which has outstripped its local competitors. In addition it has seen levels of patient satisfaction that exceeded both its local and regional peers, evidenced by its performance in the national Care Quality Commission (CQC) surveys conducted on inpatients and A&E during 2012/13.

Nationally the Trust has gained a reputation for its drive to maintain and improve its quality of care across the organisation. As there is a move nationally to greater candour within the NHS in relation to care quality and failures the Trust aims to be a leader in this area. Key to this will be the launch of the mystay@qehb system during 2013 giving patients who are being admitted to hospital information on the quality of care in the specialty in which they will be treated. Fundamental to this is the Trust's unique electronic systems such as PICS (Prescribing Information and Communication System) and HED (Healthcare Evaluation Data) which give the Trust an unrivalled insight into the quality of care it offers.

Public perception of the unique combination of high quality, innovative services and the environment provided by the Queen Elizabeth Hospital Birmingham is positive. Within the Trust there is both the information, thanks to systems such as HED and the necessary management capacity to be able to assess the Trust's market position and identify and capitalise on the opportunities for growth presented. The Trust has planned developments relating to Cardiac Surgery, Endoscopy, Ophthalmology and the commissioning of the Cyberknife which will lead to growth in the Trust's market share during 2013/14 and beyond. In addition further developments are planned over years 2 and 3 of the Strategic Plan including developments in Liver Surgery and Grown Up Congenital Heart Disease (GUCH) services and the purchase of a Da Vinci Robot which will result in further growth. The Trust is also responding to the requirements set out by commissioners in Worcestershire to develop sustainable plans for the ongoing delivery of services from the Alexandra Hospital, Redditch. In addition the potential for integrating services both vertically (increasing provision of community services) and horizontally in response to regional reconfiguration are being explored.

**Threats and Opportunities from Changes in Local Commissioning Intentions**

Prescribed Services (NHS England)

The local commissioning environment has changed considerably going in to the 2013/14 financial year as a result of the changes to the NHS commissioning structure at a national level. NHS England (NHSE) via the Birmingham and the Black Country Local Area Team (BBCLAT) has become the single biggest contract for the Trust following the incorporation of some Military, all Highly Specialised activity and the revised portfolio of specialised services as defined by the newly introduced national Prescribed Services Identification Rules. The IR rules have resulted in a significant transfer of commissioning responsibilities with approximately £65m moving from West Midlands CCG contracts to NHSE for this Trust alone.

In addition to this change, there has been a protracted national debated about commissioner allocations, both between CCG's and NHSE and also within NHSE itself in terms of the split between commissioners of Prescribed Services based within 10 of the Local Area Teams (LAT's).

Historically, Specialised Service (SS) commissioners were responsible for patients within a geographical area e.g. West Midlands, under the new arrangements each SS LAT team is responsible for all prescribed services for providers within their catchment, regardless of the geography of a patients GP (England only). The unintended consequence of this additional system change is that provider developments which result in changes across market share boundaries will require explicit budget transfer between LAT's in order to facilitate funding for providers and this mechanism is currently unclear, albeit needs clarifying as soon as possible in order to support the patient choice agenda.

NHSE are also responsible for some non specialised public health elements e.g. breast screening and dental work, however, Clinical Commissioning Groups (CCGs) have responsibility for the majority of non specialised services, with the exception of Sexual Health Services which has transferred to Public health departments now based with Local Authorities.

NHSE has introduced a range of national commissioning policies, service specifications and generic policies to support the commissioning of specialised services. These polices, which have attempted to provide national consistency across the NHS, have significant implications for both providers and commissioners, particularly where services are no longer commissioned or where a specification represents a material change to the way a service is currently commissioned or where access criteria have significantly changed. There is limited opportunity for the Trust to influence the development of these specifications and NHSE anticipate that they will be adopted within contracts by October 2013. Within our terms and conditions we have stated that each service specification needs to be formally adopted through a formal contract variation process to allow for a full risk assessment in terms of the cost/benefits and capacity issues for both commissioner and provider.

NHSE have also indicated that they no longer wish to pay CQUIN on total contract bottom line value as in previous years and as stated in guidance; they have stated that it should not be payable on all cost per case drugs and devices. PbR guidance does provide for non payment on "pass through" costs, meaning additional tariff payments or top-ups for new technologies or innovations until such a time as they become embedded in reference costs, however this has become confused with tariff excluded drugs, which are outside the scope of tariff altogether. This is under challenge nationally as it represents a late-notified in year change and hence additional efficiency requirement to Trusts particularly specialist teaching hospitals that have by their nature large drug and device spend.

Clinical Commissioning Groups

The CCG QIPP schemes that have been agreed with the Trust for the coming year are primarily related to Urgent Care. The Trust has agreed to continue to manage non elective activity in an ambulatory care setting through the use of Acute Medical Clinics. This has the aim of reducing non elective admissions to hospital and supporting the achievement of the quality requirements relating to waiting times in A&E. Other QIPP schemes include a reduction in respiratory admissions and a reduction in non-emergency patient transport funding to support revised access criteria and a reduction in journeys.

The Trust has not been advised formally of any upcoming Any Qualified Provider tenders for 2013/14 although there is an expectation that these may be introduced for MSK and Sexual Health Services in future periods. The Trust will continue to monitor these in year and will work closely with commissioners to understand local plans and ensure readiness to respond to any upcoming tenders.

Where appropriate and in conjunction with primary care, the Trust continues to explore opportunities to shift care outside of the hospital setting. Some of the areas of focus to date have included introducing community cardiology clinics, health care at home initiatives and increasing the portfolio of direct access diagnostic services available. In addition the Trust is committed to introducing High Impact Innovations as identified in Innovation, Health and Wealth which specifically look at reducing unnecessary face to face contacts

The impact of local commissioning intentions has been factored into the Trust's strategy through the inclusion of objectives within annual planning documents and assessment of the impact as part of the financial plan. As part of the strategy refresh process these factors are also considered in terms of acting as drivers for change as well as the actual content and direction of the Trust's strategic aims.

Demand Profile and Activity Mix

The Trust has seen significant year on year activity growth both planned and unplanned. Emergency activity has increased significantly in the past two years. Although this is partly in line with growth that has occurred nationally, the Trust has also seen an increase in market share of the overall emergency activity within Birmingham. This has lead to a significant increase in A&E attendances and non elective admissions at the trust leading to capacity pressures. This has been discussed with local CCGs and this issue has been widely recognised within our health economy.

Diversifying Income Streams

The Trust continues to actively seek ways of diversifying its income streams; there are two primary areas of review:

- **NHS Acute Activity Income:** Trust income streams have been updated to reflect changes in commissioning responsibilities e.g. sexual health services are now commissioned by the local authority and military patient activity which is now commissioned by the NHS. The Trust continues to seek opportunities to develop specialist tertiary activity for patients on a regional and national basis with the view that this spreads the annual healthcare across an increasingly wide range of commissioning organisations.

- **Non-Mandatory & Other Operating Income**: The Trust continues to examine income streams from a range of commercial partnerships and developments. Income benefits could be realised through the sale of Trust developed IT systems (PAS, PICS, HED

system etc) along with potential additional income from the various International projects. The Trust continues to bid for further R&D grants as they are announced and is working closely with the University of Birmingham under the Birmingham Health Partners on a number of projects including the new Institute of Translational Medicine (ITM) development. The Trust has extended the range of services offered to private patients recently with the introduction of Tomotherapy and upcoming Cyberknife treatment packages. Also income opportunities through the existing subsidiary company (Pharmacy@QEHB) and new potential subsidiaries continue to be examined.

Collaboration, Integration and Patient Choice

The Trust continues to work with partners to identify and address pathways that require improvement to delivery higher quality and increased efficiency. An example of this is the implementation of the Acute Medical Clinics within the Clinical Decision Unit for emergency attendances that do not require admission but still require treatment. This has been a successful initiative and there are plans to expand the clinics further.

UHB has also worked with the CCG to put in place an on site GP clinic to provide people attending the Emergency Department access to a GP for non urgent attendances and to alleviate pressure at the front door during anticipated busy periods such as bank holidays.

The Trust is currently working with other organisations to address delayed discharges and implement pathways of care post discharge for appropriate patients.

The Trust is also exploring a series of service development and improvement opportunities that have been identified as priorities between UHB and CCGs. These clinically led initiatives look to integrate primary and secondary care to provide improved pathways and patient experience. Specific areas for 2013/14 include Respiratory, Gastroenterology, and non-specialised Liver Services.

The East and West Midlands Transforming Pathology Procurement is a significant project for the region as well as the Trust. Options being explored include a model of partnership working with other providers.

As part of its strategy the Trust will continue to identify opportunities to partner with other organisations in order to improve pathways and patient care.

Impact of Proposals in Relation to Competition Rules and Patient Choice

The Trust is mindful of changes introduced through the Health & Social Care Act 2012 regarding the need for commissioners to protect patient choice and promote good practice potentially through the use of competition and tendering for services. The Trust is also aware of the need to avoid any decisions which could be deemed to encourage anti-competitive behaviour, will continue to actively monitoring the legislation changes affecting competition rules to note the potential opportunities and risks. The Trust is also reviewing recent draft guidance “Licence Conditions: Choice & Competition” issued by Monitor on the 27 March 2013.

## 3. Approach Taken to Quality

Existing Quality Concerns

CQC Outcome 16: Following a recent unannounced CQC inspection, an issue was raised regarding the consistent application of the WHO checklist in theatres. The responsible Divisional team in association with Governance has developed and implemented an action plan to address non compliance which has resulted in standards being maintained and compliance of between 96% – 98% for completion of the checklist. A quality audit is undertaken to corroborate the results and to report contractually to the Clinical Commissioning Group. Any area of continued non compliance is escalated through the Divisional Management Team for discussion and action. The Trust has submitted an updated action plan to the CQC for review and is awaiting a response as to whether the CQC will accept or revisit the Trust to assess compliance.

Mental Health Assessment: The Trust recognises that whilst being an acute provider there has been an increase in the numbers of patients requiring support for their mental health needs. The CQC visited the Trust in March 2013 to assess it application of the Mental Health Act (MHA). The informal feedback was positive and the Trust is waiting for the draft report. The Trust has a partnership with RAID who support staff with the assessment and management of patients. A reconvened Mental Health Group, chaired by the Executive Chief Nurse, has developed a work programme that will address the current issues. Amongst the current developments are a PICS tool for recording the section status of patients and a robust training and education regarding the MHA, all NICE Guidance with reference to mental health has been reviewed and action plans, where appropriate are being developed.

Key Quality Risks

The key quality risks identified by UHB are detailed below:

Increases in demand on both elective and emergency services above and beyond existing capacity due to the Trust's growing reputation, uncertainty in commissioning, inadequate funding of additional activity, failings in community provision and elsewhere in the local health economy, and reconfiguration in the local health economy. Plans to manage include increasing capacity by use of retained estate and improving delayed discharge by contracting with a third party for the provision of healthcare at home and supporting neighbouring providers.

Failure to maintain registration with the Care Quality Commission as a result of not achieving agreed objectives for MRSA bacteraemia and Clostridium difficile infection (CDI). Controls in place include;

- Infection Prevention and Control Action Plan.
- Monthly review of risks and controls at IPCC.
- Monthly review of compliance to mandatory training for IP&C.
- RCA review of all cases MRSA and CDI.
- Local review of CDI RCA and Executive Review of Trust Apportioned cases of MRSA bacteraemia and CDI deaths.
- Robust process for review of policy and procedures.Improvement of pathway for patients between primary and secondary care and
- Increased vigilance and management of IP&C.

Changes within the Care Quality Commission and its approach to regulation and compliance in light of the appointment of a Chief Inspector of Hospitals. This is an unknown and therefore the risks are difficult to quantify. The Trust has a robust governance and compliance framework that will take any changes into account and assess the risks when they are known. The Trust has a robust framework in place for assessing compliance and providing assurance to the Board of Directors. The underpinning processes are being reviewed by the Clinical Compliance Unit to

ensure that the Trust has continued assurance on the delivery of high quality services to the patients.

NICE Quality Standards have been introduced over 2012/13 with increased significance post Francis review. The application of the standards is difficult to achieve, even though the Trust has advanced informatics systems making data capture easier. A fixed term post for 6-months has been agreed to allow the Trust to review its position against the NICE Quality Standards which now form part of the 2013/14 NHS Contract. 3-months after the post holder commences there will be a review of the work carried out so far and the revised Trust position.

National Audit Consultant level data. From 30 June 2013 Consultant outcomes against national audit data will be published against those consultants within a royal Society. Trusts will have to publish data against those Consultants who are not a member. There is no formal plan against this as HQIP have not published metrics for the data. The key risk concerns reputational damage for poor results.

Board Assurance on Quality of Services and Safeguarding of Patient Safety

The Board of Directors has set out how it derives assurance on the quality of its services and safeguards patient safety in its Clinical Quality Strategy. In summary, the fundamental principles underpinning the Trust's approach to Clinical Quality are:

- Definition of standards and measurement of outcomes and performance;
- Clear responsibility and accountability of all staff for patient safety and clinical quality;
- Identification and management of clinical risks;
- An appropriately skilled workforce;
- Patients should be at the centre of safety and quality processes;
- An emphasis on the need to seek continual improvement of performance in patient safety, quality and effectiveness, identifying, sharing and ensuring delivery of good practice;
- A just and open approach for managing adverse events; and
- Transparency and accountability to patients.

The Executive Medical Director oversees the Trust's systems for the monitoring of the quality of treatment, clinical effectiveness and safety of each service, reviewing key indicators and, wherever possible, benchmarking the effectiveness and safety of each service against appropriate comparators and taking action where appropriate. Significant exceptions against agreed indicators are reported to the Board of Directors, either directly or via the Clinical Quality Committee.

The Medical Director reports regularly to the Board of Directors, either directly or via the Clinical Quality Committee, bringing to their notice all Serious Incidents Requiring Investigation, any other relevant investigations and matters regarding clinical quality which are identified, through monitoring of quality data or otherwise.

The Chief Nurse oversees the Trust's system for the monitoring of the quality of the care and the patient experience provided by each service, reviewing key indicators and, wherever possible, bench marking against appropriate comparators and taking action where appropriate. Significant exceptions against agreed indicators are reported to the Board of Directors, either directly or via the Clinical Quality Committee.

The Chief Nurse reports regularly to the Board of Directors, either directly or via the Clinical Quality Committee, bringing to their notice all serious complaints and any other matters regarding care quality which are identified, through monitoring of quality data or otherwise.

The Trust is focused on using information to improve quality, developing information technology and improving the data capture and reporting processes that contribute towards safety of patients and staff, continuity of care, collaborative decision making and measuring and monitoring outcomes.

The Trust has set up a number of groups and processes to support this strategy, key ones of which are as follows:

- The Board of Directors has established a Clinical Quality Committee to support, and provide continuity for the Board of Directors in relation to the Board's responsibility for ensuring that the care provided by the Trust meets or exceeds the requirements of its strategy.
- The Clinical Quality Monitoring Group receives reports from Risk Management, Health Informatics, Medical Director's Services, Strategy and Performance, and Divisional Clinical Quality Groups, and reviews the key indicators for Clinical Quality and report on any significant exceptions.
- The Care Quality Group develops care quality measures and facilitates their measurement and actions to improve them; creates key indicators related to patient care; and evaluates patient experience and monitors actions that are put in place to improve this across the Trust. It regularly assesses the compliance of the Trust with relevant CQC Essential Standards of Quality and Safety.
- A programme of Executive-led governance ward or departmental visits. These consist of a walk-around and are unannounced to ensure the ward/department visited is seen in its normal operation. The locations for the visits are identified using information sources including risk management reports, clinical incident data, complaint information, results of Executive-led Root Cause Analysis and operational information. The visits include discussions with staff and family/carers, checks of paper and electronic documentation, reviews of policy adherence and assessment of the environment to allow both areas of excellent practice as well as areas that require improvement in practice to be identified.The Clinical Risk & Compliance Unit supports; the administration of Divisional Clinical Quality Groups and the review of any significant exceptions that are raised by the Clinical Quality Monitoring Group or the Care Quality Group; national and Trust clinical audit programmes; follow up of action points from clinical audit and incident investigation recommendations; and compliance against NICE and National Confidential recommendations.
- The Trust has created a dedicated unit, the Quality and Outcomes Research Unit, whose role is to link a wide variety of information systems together to enable all important elements of service delivery to be analysed and monitored in a sophisticated way in order to improve patient care, experience and outcomes.
- Each Divisional Clinical Quality Group reviews the clinical quality issues that support and underpin the Trust's Quality Key Performance Indicators and the Trust Quality Account Report for the Division; based on Risk Management, clinical audit programmes, PALS/ Complaints, legal claims and infection control reports. Additional review may be required from significant exceptions as identified by Clinical Quality Monitoring Group, reporting when the review is complete.

The Trust has assessed its arrangements for deriving assurance on the quality of its services and safeguarding patient safety against Monitor's Quality Governance framework and considers that the requirements of the framework are met, although the potential for further improvement has been identified against some elements. The assessment is reviewed on a quarterly basis.

## 4. Clinical Strategy

### Service Line Management Strategy

The Trust has continued to build upon its work to deliver its vision, values, and core purposes during the financial year. This has been achieved through the development and delivery of the Trust Strategy and associated Annual Plans. The main objective of the strategy and plan continues to be the Trust's vision to deliver the best in care. The Trust values provide the framework within which these purposes are delivered (honest, innovation, respect, and responsibility).

The structure of the Strategy has been developed to ensure cohesiveness, consistency, and provide assurance that it contributes to the overall delivery of the Trust vision. Therefore, each core purpose is supported by a Strategic Aim, and four Strategic Enablers. These are refreshed every 12 months as part of the annual planning cycle. The Trust's 3 year strategy within the framework of the 4 core purposes is as follows:

| **Core Purpose 1:** | **Clinical Quality** |
|---|---|
| Strategic Aim: | To deliver and be recognised for the highest levels of quality of care through the use of technology, information, and benchmarking |
| Strategic Enabler 1: | To strengthen the organisational systems and arrangements for the collection, access, use, and reporting of quality outcomes to key stakeholders |
| Strategic Enabler 2: | To deliver and communicate the best in quality outcomes |
| Strategic Enabler 3: | To improve quality and efficiency along the patient pathway working with local health economy partners |
| Strategic Enabler 4: | To ensure care is delivered using the best available treatment and technology that produces the best clinical outcomes |

| **Core Purpose 2:** | **Patient Experience** |
|---|---|
| Strategic Aim: | To ensure shared decision making and enhanced engagement with patients |
| Strategic Enabler 1: | To deliver improvements in the fundamental aspects of care and priority areas identified by patients |
| Strategic Enabler 2: | To provide patients with high quality information and support to allow informed choice and shared decision making |
| Strategic Enabler 3: | To develop the Trust culture and staff behaviour to focus on the patient experience and ensure improved engagement with marginalised groups |
| Strategic Enabler 4: | To strengthen cross-organisation partnerships with the new Clinical Commissioning Groups and other organisations within and outside the NHS |

| **Core Purpose 3:** | **Workforce** |
|---|---|
| Strategic Aim: | To create a fit-for-purpose workforce for today and tomorrow |
| Strategic Enabler 1: | To strengthen the Trust's capacity and capability for developing and managing the workforce |
| Strategic Enabler 2: | To ensure effective management of the workforce |
| Strategic Enabler 3: | To deliver learning and development programmes and career opportunities to meet the needs of patients, staff, and the organisation |
| Strategic Enabler 4: | To strengthen the Trust's status as a leader in workforce development and management |

| **Core Purpose 4:** | **Research and Innovation** |
|---|---|
| Strategic Aim: | To ensure UHB is recognised as a leader of research and innovation |
| Strategic Enabler 1: | To strengthen and consolidate the Trust's capacity and capability to deliver research |
| Strategic Enabler 2: | To strengthen the Trust's capacity and capability for innovation |
| Strategic Enabler 3: | To maximise the opportunities for the commercialisation of Trust services |
| Strategic Enabler 4: | To undertake and be recognised for high quality research and innovation |

In addition to the overarching Strategic Aims and Enablers, the Trust has developed its Quality Improvement Priorities (within the Quality Account) and CQUINS for 2013/14 and reflect the Trust's key quality aims for the financial year.

Quality Improvement Priorities (2013/14)
Priority 1: Improving VTE prevention
Priority 2: Improve patient experience and satisfaction
Priority 3: Electronic observation chart – completeness of observation sets (to produce an early warning score)
Priority 4: Reducing medication errors (missed doses)
Priority 5: Infection prevention and control
Priority 6: Improving patient safety through bar-coded wristbands

2013/14 CQUIN Indicators agreed with UHB's host commissioner Birmingham Cross City Clinical Commissioning Group

- Friends and Family – Patient and staff experience monitoring using friends and family test.
- NHS Safety Thermometer – Improve collection of data in relation to pressure ulcers, falls, and urinary tract infection in those with a catheter and maintain performance for new pressure ulcers.
- Dementia – Find, assess, investigate and refer; clinical leadership; and supporting carers of people with dementia.
- VTE Risk Assessment – percentage of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool and relevant cases undergo a root cause analysis.
- Falls management and prevention – Improve communication to GPs around inpatients at risk of fall, improve falls risk assessment in the Emergency Department (ED), improve system to notify GP practice of patients who have attended ED due to a fall, and patients who attend ED who have fallen more than three times.
- Pressure ulcer management – Deliver a reduction in grade 2 hospital acquired avoidable ulcers.
- Formulary adherence – The proportion of prescribed and recommended items that meet the local formulary criteria.
- Discharge planning – Reduce to take out (TTO) drugs turnaround time and increase the proportion of patients discharged before 1pm.

2013/14 CQUIN Indicators agreed with NHS England (Specialised Services)

- Friends and Family – Patient and staff experience monitoring using friends and family test.
- NHS Safety Thermometer – Improve collection of data in relation to pressure ulcers, falls, and urinary tract infection in those with a catheter and maintain performance for new pressure ulcers.
- Dementia – Find, assess, investigate and refer; clinical leadership; and supporting carers of people with dementia.
- VTE Risk Assessment – Percentage of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool and relevant cases undergo a root cause analysis.
- Haemophilia – Joint scores in severe and moderate haemophilia A and B patients and an increase in the number of these patients for whom clotting factor usage data are provided via the Haemtrack electronic monitoring system.
- Human Immunodeficiency Virus (HIV) – Registration and communication with GPs about the care of HIV patients where consent has been provided.
- Bone Marrow Transplant (BMT) – Donor acquisition measures
- Specialised Cancer – Access to and impact of clinical nurse specialist (CNS) support on patient experience.

- Neurosurgery – Ensure patients receive optimal outcomes from neurosurgical shunt surgery.
- Quality dashboards – Embed and demonstrate routine use of the specialised services clinical quality dashboards.

Each of the above goals has underpinning work programmes in place to ensure delivery and performance improvement. The Quality Improvement Priorities and CQUINS are reviewed and agreed on an annual basis so are subject to change. Selected goals will cover a period longer than 12 months so will be included in subsequent Annual Plans. Also, some goals will be retained as a priority and will also feature in subsequent plans on this basis also.

Cross Cutting Enablers

There are a number of cross cutting enablers that support delivery of the Core Purposes, Strategic Aims, and Strategic Enablers and the priorities within the Trust's strategic plans.

- Financial health

  The country continues to experience weak economic growth and rising unemployment and is it is unlikely that this position will change in the short term. This is having an impact on all sectors and the NHS is under pressure to contribute by delivering savings of £20 billion. This is against a backdrop of rising inflation, the requirement for national pay settlements and tariff changes. Across the region, there is a need to ensure financial balance or a saving which is planned to be achieved via the Quality, Innovation, Productivity, and Prevention (QIPP) work programme in collaboration with commissioners. Cost improvement programmes (CIP) have become even more challenging and there is a greater focus on delivering planned activity growth. Far tighter control will be required on managing cost pressures going forward. The New Hospital unitary payment provides further pressure to maintain financial probity.

  It is vital that UHB maintains financial performance and delivers growth during this period of downturn. In order that stability is maintained across the local health economy the Trust will continue to focus on sustaining effective relationships with commissioners and work jointly through the uncertainty while the reform settles.

- NHS Commissioning Context

  The structural changes that have taken place over the last year have had a fundamental effect on the relationship between providers of healthcare services such as UHB and their commissioners. The Operating Framework for 2012/13 set out the priority areas for the NHS to improve performance over the year. As the former structure of Primary Care Trusts (PCTs) was replaced by first PCT clusters and then Clinical Commissioning Groups, commissioners have found themselves under increasing pressure from the Local Area Teams (initially part of the cluster Strategic Health Authorities which is now NHS England) to apply the contractual levers available to them in the Acute Contract.

  This forms part of a trend for greater accountability for quality that results from both the NHS reforms and the outcome of the Francis Inquiry into the Mid Staffordshire NHS Foundation Trust. The Trust has therefore found that it is under greater scrutiny than ever before from Monitor, the Care Quality Commission and commissioners to ensure that standards of quality and performance are maintained and improved.

  The Trust will continue to build upon its strong relationship with commissioners to further improve the quality of care through the redesign of pathways.

- Collaboration and integration
  The Trust has continued to work in partnership with other local providers including primary and social care. Strong links with the Trust's commissioners and local GPs are maintained through the Joint Clinical Commissioning Group. Work continues to redesign pathways and over the last year work on avoiding emergency admissions has continued with the expansion of Acute Medical Clinics in the Clinical Decision Unit and their development to also include surgical patients.

- Reputation
  The Trust has been undertaking work to obtain local, national, and international recognition. It has cemented its local reputation and this has been reflected in the increasing levels of both elective and emergency activity over the last year. At a national level, the Trust is recognised for its work with the military, quality outcomes, and research and development. Internationally, UHB's reputation has grown further, particularly in research with its increased participation in international and European research studies. Its reputation has also grown in the area of education and training with overseas medical staff receiving specialist education in partnership with the Trust. The Trust will continue to focus on enhancing its reputation in a targeted way.

The Trust Strategy (and supporting Annual Plans) is the vehicle for delivering the organisational vision and aims. The Trust regularly reviews and refreshes its Vision, Values, Core Purposes, Strategic Aims, and Strategic Enablers where required to ensure they remain fit for purpose. This forms part of the process of development of the internal Trust Annual Plan and annual/strategic plans developed for Monitor. In addition to this, the Trust refreshes its longer term Strategy on a regular basis. This is a very thorough and detailed process and involves engagement with all clinical and corporate services. A number of factors are considered as part of the Strategy refresh process including:

- Historic performance
- Service risks
- Opportunities and threats
- Market share
- Trends and growth in activity including projected activity
- Regional reconfiguration of services
- National and local priorities
- Changes in technology and practice

The Trust uses existing data systems and intelligence gathered at a macro and micro level to determine the process, focus, and content of the Strategy. This will include internal and external benchmarking where data is available.

**Clinical Workforce Strategy**

Overview
The Trust has a strategic workforce plan which is updated annually. This identifies workforce demand requirements for the next 5 years. The plan is developed with the Clinical Commissioning Groups and Health Education West Midlands and supports the NHS education commissioning process. Key to the strategic plan is the expansion of a wide range of services as we open new capacity created by community demand, patient choice and commissioning priorities. Major areas for expansion include general nursing and therapy staff to support the expansion of medical and surgical capacity, neurosurgery and vascular services. Out of hours, imaging services will also expand to areas such as outpatients, MRI, CT and ultrasonic scanning.

We also continue to scrutinise our workforce across a wide range of areas. This will include:

- Extension of Endoscopy Service working day and week to include Saturdays.
- This is in response to national bowel screening programme.
- Creation of a single Catheterisation Lab/Coronary Care Workforce to provide enhanced service provision and on call rota.
- Development of skill mix and requirements of health care assistants.
- Review of sexual health services.
- Detailed analysis of the workforce regarding the next phase of the Major Trauma Centre and a review of emergency department skill mix.
- Review of service delivery in laboratory services.

Associated risks may include the potential difficulty in recruiting specialist staff although to date, with the exception of emergency medicine and critical care nursing this has not been a problem for the Trust. In general, recruitment activity is high in volume (due to capacity expansion) and high in quality.

Whilst recruitment activity is high it is also essential to maintain a high standard of employment checking to ensure that we have an appropriate workforce to deliver high quality patient care. It is, therefore, important to note that the Trust was awarded an A rating by the UK Border Agency in July 2012 for our employment checking processes.

Work also continues to be undertaken in support of improving staff attendance and health improvement strategies.

With regard to terms and conditions of service, the Trust is in the process of implementing the changes to the agenda for change agreement.

The Trust has no significant redundancy programme for 2013/14 as service developments are fully resourced.

In summary the Trust is expecting to see a small net increase in the size of the workforce in order to deliver increased clinical activity.

Key Workforce Pressures

The Trust has established a Workforce Strategy Group to oversee workforce planning and development across all areas of the workforce with a specific focus on key areas where there are service delivery changes that will impact on the workforce, areas of national priority and areas of the workforce where there are felt to be perceived immediate and future risks. In addition the Trust works in close collaboration with the newly established Health Education West Midlands to ensure its future workforce demand directly impacts on the commissioning of the future health care professional workforce. Equally through this collaboration, the Trust is able to work with other providers of health care and health education to ensure the development needs of the existing workforce can be met.

The current areas identified for action are as follows:

Emergency Medicine

In line with the national picture, UHB is experiencing an unusually high volume of emergency medicine activity and which has been compounded by the impact of the Trust becoming a Major Training Centre. The increase in activity has led to some workforce pressures across the medical and non medical workforce for which we have been able to establish short term measures to resolve and which include increasing our nursing workforce in key areas. We are

concerned that longer term, in spite of the rapid expansion of the specialty recruitment, into training is still restricted by limited training capacity and a shortage of Emergency Medicine (EM) doctors at all grades. To enable us to meet this immediate and longer term workforce pressure we have initiated the following plan:

- Expansion of our current Junior Specialist Doctor (JSD) training programme offering a bespoke training programme that will take the trainees up to Certificate of Eligibility for Specialist Registration (CESR).
- Working with current Trauma and Orthopaedic CCT holders to work directly in EM for a fixed period of time before being employed within the speciality
- Expansion of the very successful Physician Assistant role within Emergency Medicine and our Clinical Decision Unit (CDU)
- Commissioning of a bespoke Advanced Nurse Practice programme to support the continued development and advancement of nursing roles within both EM and CDU

Intensive Care Nursing

The continued expansion of critical care provision across the Trust has required a significant expansion across the nursing workforce and which has led to challenges in the recruitment of this specialist workforce. A number of measures have been established to support resolution of this issue both in the short and medium term and which include:

- A bespoke recruitment campaign which includes recruitment of specialist intensive care nurses from key European countries which yield very high quality trained nurses.
- Expansion of the role of the innovative jointly developed Physician Assistant in Anaesthesia (PAAs) to support both an increase in the overall numbers of PAAs and their role within Critical Care.
- Commencement of a skill mix review across the specialist ITU services.

Imaging

The continued demand for imaging as a central part of most disease pathways results in a need to regularly review the workforce numbers and skill mix across the service. Although seven day working in relation to emergency Imaging has been in place for some time, this will expand into areas currently considered "routine" diagnostics i.e. outpatient scanning – MRI, CT and Ultrasound.

A workforce plan is in place to meet the required expansion. Additionally the role of Imaging Department Assistants, more than ever, is one which has demonstrated its potential around supporting service development and as such forms part of the services workforce strategy.

Retirement Profile

There is an increasing need to focus on the retirement profile of experienced staff particularly within Therapy Services and Medical Engineering over the next five years. The recruitment of newly qualified Therapists remains buoyant and which is very positive the emphasis is now on talent management, leadership development and succession planning to support the development of staff into key senior roles.

Impact of the Workforce Strategy on Costs

The identified small net increase in the size of the workforce will be met through both the additional income associated with the increase in commissioned activity and through the Trust strategy to continue to drive down the usage of agency staff. This strategy is further supported by the long term introduction of the Trusts unique role of 'Junior Specialist Doctor' (JSD) which has enabled the Trust to ensure provision of a consistent level of the right junior doctor hours through direct employment of high quality trainees rather than costly agency use.

The loss of SIFT income will result in a short term cost pressure to the Trust for which the Trust has a strategy in place to address. The strategy includes a re-basing of the costs associated with the provision of education to increase both its efficiency and its capacity to expand its student base and associated income.

Benchmarking and Assessments

The Trust is planning to undertake a Trust review of their current nursing establishment following a period of steady state after the move into the New Hospital and Major Trauma Centre status. This will be timed to coincide with the expected launch of the AUKUH Dependency & Acuity Tool in 2013 which the Trust has been an active participator in developing via the Shelford Group and which will calculate nurse staffing requirements based on the acuity and dependency of the patients linked to nurse sensitive outcome indicators. The Executive Chief Nurse will consider the implementation of the revised tool once validation is complete as part of a nursing establishment review.

All Specialist wards units which are accredited use nationally recognised validated tools to determine the nurse per hour per patient bed ratio i.e. critical care, Burns units etc.

Outpatient workforce NHPPD (Nursing hours per patient day) is based upon clinics and duration/size and volume with Dialysis and day case units based upon activity, length of day and local historical outcome data.

The Trust has previously worked with management consultants to undertake reviews of selected specialties and undertaken assessments such as consultant productivity. The learning from this work has been incorporated into plans.

The Trust will continue to work with other organisations and networks such as the Shelford Group to undertake benchmarking assessments in order that the Trust can identify further opportunities for performance improvement.

Clinical Sustainability, Critical Mass, and Consultant Cover

The Trust has reviewed its services and has not identified any issues of significant concern relating to clinical sustainability or critical mass. The Trust's Workforce Strategy Group will review this going forward as part of its remit.

In relation to consultant cover however there are two main areas that the Trust is actively addressing.

The Trust's Emergency Department (ED) currently has fewer consultants than set out in the Major Trauma Centre specification. To achieve a 24/7 consultant delivered service the Trust would require 16 WTE consultants in ED. From a baseline of 5.85 WTE the Trust has conducted a phased recruitment of consultants and currently has 12 WTE in post. In August 2013 this will increase to 13 WTE. Currently therefore the service is not consultant delivered between midnight and 7.30am. Analysis has shown the risk associated with this to be tolerable as this is the time of lowest major trauma activity. In August this will decrease to between 2am and 7.30am. The Trust is continuing its phased recruitment programme in the context of a national shortage of A&E consultants and is currently exploring other solutions to increasing consultant cover including increasing the use of military consultants.

The Trust currently has two fewer Cardiac Transplant consultants than the standards set out by NHS England. One additional consultant has already been appointed and will be in post in June

2013 and the Trust will be advertising in June for the final post which will return the service to full staffing.

**Quality and Safety**

Nursing

In response to an identified concern over new nursing starters taking up to 3 months to become competent administering drugs using the Trust electronic patient system (PICS) and which was further compounded by the increased recruitment of nurses in line with Trust service strategy. The Trust has developed and mandated a Healthcare Practitioners Induction Programme (HPIP) for all registered and non registered new starters. New nursing starters of any band will attend HPIP in their first week of employment. HPIP covers the following critical areas of competence:

- All mandatory training
- A clinical skills check and monitoring of areas requiring training / development.
- Comprehensive PICS training.
- Enrolment onto the Trust preceptorship programme which includes clinical development, support and assessment of competence in line with role requirements and is underpinned by a clear remediation process.
- Each experienced nurse who will be administering drugs is provided with a drug administration workbook.
- All nurses meet with and are provided with the Clinical Education Teams details to access external support if required.
- Additionally the Trust introduced numeracy and literacy testing in April 2012 for all newly registered nursing staff. The testing is undertaken in partnership with an external education provider and the required standard expected to achieve an interview is Level 2 in both numeracy and literacy.

Medical Revalidation

Implementation plan is in place to ensure the recommendations for medical revalidation are fully met. A Responsible Officer has been appointed and has been revalidated with 11 consultant staff members already positively recommended to the GMC for revalidation with a roll out plan for remaining 514 consultant medical staff established over the next 3 years with the aim of further front loading this.

Response to Francis recommendations

The Trust will implement its action plan to address the workforce related recommendations following the Francis Report. Actions will include:

- The further refinement of the current education programme for Auxiliary Nurses to fully address the recent implementation of competency based job description
- Work with Health Education West Midlands to look at a fully accredited education programme for Nursing Auxiliaries
- Launch of a Leadership and Talent Management Strategy for the Trust and which will have an emphasis on the development of clinical leaders and will commence with a refreshed and bespoke programme for the Trust Clinical Service Lead Clinicians
- Leading a collaborative review of the Undergraduate Nursing provision at a local education provider to support both value based recruitment and an enhanced clinical teaching model
- Review of current communication skills education and development provision in line with staff and patient experience / feedback

Cost pressures related to the implementation of education tariff

The implementation of the Service Increment for Teaching (SIFT) (acute) has been confirmed from 1st April 2013 with the tariff associated with Medical and Dental Education Levy (MADEL) to follow in the financial year (2014/15). The model on which tariff has been based, and the proposed national transition plan pose a significant risk to the Trust in terms of the financial losses associated with the Trust future education income. The main losses are incurred over the next 3 years and will result in a total loss of SIFT income over a 12 year period of circa £8.26m per annum with a further loss of circa £1.5m associated with the implementation of MADEL tariff.

The Trust made an investment of approximately 9.6% of the floor plan in the very high quality education infrastructure in the Queen Elizabeth Hospital Birmingham resulting in a cost pressure of around £4 million per annum over the life of the PFI and which was approved and undertaken based on commitments made in good faith by both commissioners and providers. Additionally placement funding does not take into account the real economic costs around teaching students within a high cost low volume speciality e.g. the Medical School the Trust are associated with wish to have all of their students placed at some point in years 3-5 at UHB to have access to specialist tertiary services such as Liver Transplantation.

The Trust has submitted their risk assessment to Health Education West Midlands and has made repeated communications both regionally and nationally around the impact of tariff on Teaching Trusts. We remain concerned that the proposed transition model gives UHB an enormous cost pressure to manage which will adversely impact on our plans to drive forward continued developments for students and trainees on placement within our Trust.

## 5. Membership Commentary

**Overview**
The Trust has three membership constituencies as follows:

- Public constituency
- Patient constituency
- Staff constituency

Public Constituency
The public constituencies correspond to the Parliamentary constituencies of Birmingham. Public members are drawn from those individuals who are aged 16 or over and:

- Who live in the area of the Trust; and
- Who are not eligible to become members of the staff constituency

Patient Constituency
Patient members are individuals who are:

- Patients or Carers who are aged 16 or over; and
- Not eligible to become members of the staff constituency and are not members of any other constituency

N.B. A patient who lives in a public constituency area of the Trust will normally be registered as a member of the Public Constituency but this does not affect his/her ability to be a patient member by making an application for that membership.

Staff Constituency
The Staff Constituency is divided into four classes:

- Medical Staff;
- Nursing Staff;
- Clinical Professions Allied to Healthcare Staff; and
- Corporate and Support Services Staff.

Membership Overview by Constituency

| **Constituency** | **Total at 31/03/13** | **%** |
|---|---|---|
| Public | 11,532 | 48 |
| Patient | 4,251 | 18 |
| Staff | 8,158 | 34 |
| **Total Membership** | **23,941** | **100** |

*Numbers correct up to 31 March 2013

The Public constituency saw an overall increase in members of 479 (4.3%). Some of this increase can be attributed to a recruitment campaign week which was held in January 2013 - this attracted 150 new members. The Patient constituency fell by 196 (4.4%) however 416 individuals who had registered an interest in becoming a member became Public (Rest of England) members on 01/04/13 and this constituency is likely to increase in size over the next year.

The population figures for the total membership, age, ethnicity, socio-economic group and gender are taken from separate data sets from the Office for National Statistics when they are released; and are based on the results of the most recent census figures available; because of this it is common for them not to add up to the same total in each category.

Public Constituency - Analysis by Age:

| Age | No. of Members | Eligible population | Variance from last year |
|---|---|---|---|
| 0-16 | 5 | 14,106 | + 400% |
| 17-21 | 113 | 77,240 | + 24.2% |
| 22 + | 10,983 | 657,362 | + 3.3% |
| Unknown | 431 | - | + 31% |

The small number of members under 16 are patients who have been admitted through A&E as a matter of emergency. We are not licensed to treat patients under 16 in normal circumstances. A slight increase in our younger members (17-21) could be accounted for by the work we do with the military and our specialist cancer centre.

Public Constituency - Analysis by Ethnicity:

| Ethnicity | No. of Members | Eligible population | Variance from last year |
|---|---|---|---|
| White | 7,020 | 687,504 | + 6.6% |
| Mixed | 108 | 27,970 | + 6.9% |
| Asian | 1,332 | 190,695 | + 8.6% |
| Black | 378 | 59,794 | + 13.9% |
| Other | 8 | 11,322 | + 700% |
| Unknown | 2,686 | - | - 4.3% |

No real change can be seen here – the 700% increase in the "Other" grouping is down to 7 people joining but not providing their ethnicity details.

Public Constituency - Analysis by Socio-Economic Groupings:

| Socio Economic Group | No. of Members | Eligible population | Variance from last year |
|---|---|---|---|
| ABC1 | 7,579 | 317,580 | + 7% |
| C2 | 877 | 107,234 | + 9.1% |
| D | 1,401 | 157,955 | + 9.6% |
| E | 1,363 | 149,251 | + 7.8% |
| Unknown | 312 | N/A | - 50% |

The above figures correlate with the socio-economic area we serve and the figures have increased in proportion to the amount of new members joining. The 50% decrease in the "Unknown" figure can be attributed to database cleansing and allocating correct groupings to members who supply their postcode.

Public Constituency - Analysis by Gender:

| Gender | No. of Members | Eligible population | Variance from last year |
|---|---|---|---|
| Male | 4,979 | 473,435 | + 0.9% |
| Female | 6,372 | 503,738 | + 4.5% |
| Unknown | 181 | N/A | + 687% |

Any changes here reflect our overall recruitment campaign which in the main has been aimed at patients and visitors inside the hospital. The increase in "Unknown" arises from a report that was uploaded without all the gender data on Voluntary Services. This is being amended shortly.

Patient Constituency - Analysis by Age:

| Age | No. of Members | Variance from last year |
|---|---|---|
| 0-16 | 0 | 0 |
| 16-22 | 20 | - 20% |
| 22 + | 4154 | - 4.4% |
| Unknown | 77 | + 2.7% |

The increase in "unknown" ages is due to the fact that not every member wishes to provide their dates of birth.

Staff Members: 8,158 – increase of 6.9%
The increase here could be attributed to our requirement for more staff to cover the A&E and related departments.

Membership Objectives 2012/13
The Board of Directors agreed in April 2012 to replace the annual churn and maintain existing membership numbers to no less than 23,000. Emphasis was placed on the retention of existing members and further engagement, and achieved through:

- The quarterly publication Trust in the Future
- Further development of the Ambassador Programme, ensuring that Ambassadors are involved in appropriate activities and contributing to the recruitment of new members
- Further developing membership content published via social media and the Trust website
- The inclusion of members on appropriate patient groups
- Raising the profile and role of Foundation Members, Ambassadors and Governors within the Trust
- Working with QEHB Charity to increase membership opportunities amongst fundraisers

Forward Plan/Objectives 2013/14
In order to ensure that the membership is representative of the constituencies it serves, an additional constituency was created from 1 April 2013 – the Rest of England constituency – which allows individuals who live outside the Public constituency but are not Patient or Staff members to become members of the Public constituency. There are currently 416 members of the Rest of England constituency, but it is estimated that during 2013/14 this constituency will see much growth as individuals living outside the Public constituency will be automatically assigned to this constituency unless they opt out to join the Patient constituency.

There are no plans to launch a major recruitment campaign during 2013/14. Such a campaign would cost between £11,000 and £14,000 to yield around 3,000 new members. The objectives for 2013/14 are:

- To replace the annual churn and maintain existing membership numbers to no less than 23,000. With a membership of 23,000, UHB would be in the top 10 of foundation trusts with the highest number of members, based on 2011/12 figures which are the most recent available; and
- To ensure the membership is representative.

Engagement/Retention

In order to maintain membership and develop engagement further over the next 12 months, the Trust will continue to use the tried and trusted methods listed below:

- Trust publications
- Internal leaflets
- Trust website
- Social media tools
- GP surgeries
- Existing members
- Community groups
- Governors
- Ambassadors
- Health talks
- Drop-in sessions
- Membership Week

Governor Elections

Elections were held in July 2012 for Patient and Public Governors –the Trust used Opt2vote in Belfast as the returning officer who can confirm that all rules were adhered to. Elections for Staff and Rest of England constituencies are currently under way and will be completed in June 2013.

Data Explanation

The population figures for the total membership, age, ethnicity, socio-economic group and gender are taken from separate data sets from the Office for National Statistics when they are released; and are based on the results of the most recent census figures available; because of this it is common for them not to add up to the same total in each category. To provide an example, the total figure for the socio-economic groupings is this case is 245,344 less than the total of 977,364. A socio-economic grouping (NRS) is allocated to an individual based on the employment status they provide in the census. Therefore, it is entirely understood that this figure will be less if you take into account members of the population who would not be given an NRS grading (i.e. if someone is unemployed). All NHS Foundation Trusts will experience this difference in their population figures and Capita Membership Services can only upload the population figures provided by the ONS.

## 6. Productivity and Efficiency

### Overview

The Trust has a strong record of increasing its efficiency to both improve services for patients and deliver financial savings. As part of its Cost Improvement Programme for 2013/14 the Trust has 115 Internal Service Reviews planned which include schemes to increase theatre utilisation, outpatient clinic throughput and individual consultant productivity and reduce length of stay. These schemes will be based on benchmarking within specialties and against peers. These should produce improvements including increased efficiency, reduced cancellations of operations, reductions in waiting list initiatives and the use of private sector capacity and bed day savings. The Trust also aims to reduce its utilisation of agency staff. External nursing agency usage will be reduced through over-recruitment of nursing staff and likewise reduction in medical locums through overseas staff recruitment. The Trust's usage of external agency is reviewed on a monthly basis by the Nursing Operations Group. The Trust's Performance Framework for 2013/14 includes key performance indicators of theatre capacity, outpatient capacity and bed utilisation, emergency readmissions and agency and bank usage with exceptions reported to the Board of Directors. The financial impact associated with these efficiency schemes is set out in Appendix 2.

### CIP Governance

The Trust's Strategic Plan includes CIP targets (expenditure reduction and revenue generation) of £16.7m (2013/14), £18.0m (2014/15) and £19.2m (2015/16) in the period covered by plan. The planned CIP targets, whilst challenging for the organisation, are broadly consistent with the actual savings delivered in recent years and are below the FT sector average due to the emphasis placed on cost control and managing the overall bottom line finances (rather than just CIP delivery). This suggests that the Trust does not face a 'step change' in CIP delivery in the near term which provides a buffer against quality risks. The Trust has a strong track record of delivering against planned CIP targets and this is shown in the table below:

| Financial Year | CIP Target £m | Delivered % | Delivered £m |
|---|---|---|---|
| 2008/09 | 11.5m | 98.8% | 11.4m |
| 2009/10 | 12.1m | 93.6% | 11.3m |
| 2010/11 | 15.9m | 94.5% | 15.2m |
| 2011/12 | 18.8m | 90.5% | 17.0m |
| 2012/13 | 18.3m | 96.4% | 17.6m |

This shows delivery against the original programme for each year. In practice any in year slippage is covered by contingencies including additional non-recurrent savings or early commencement of future year schemes.

The Trust gains assurance that its Cost Improvement Programme (CIP) targets will be achieved through the planning, monitoring and control systems that exist within the organisation as well as the proven track record of delivery. The overall responsibility for financial planning and setting the CIP target for the organisation rests with the Chief Financial Officer. However, the responsibility for identification and delivery of schemes rests with each executive director for their share of the target. In practice this means that the Chief Operating Officer is responsible for delivering around 85% of the annual target, although the majority of this is devolved to Divisions with responsibility delegated to divisional management teams led by the Divisional Director (lead clinician) and Divisional Director of Operations.

The Trust does not have a formal Project Management Office (PMO) or equivalent. Instead the Trust's philosophy is to embed the CIP delivery into all managers' roles and responsibilities and make the monitoring and reporting a key component of the monthly financial reporting. This is a more sustainable way to ensure a strong culture of efficiency across the Trust and reduces potential risks to quality as individual specialties are far less likely to put forward schemes that have a detrimental impact on the quality of their own services than others might if a centralised top down approach was adopted. Project management support is available from the Trust's project team to assist with the management and delivery of larger schemes and any strategic or transformational projects. Robust monitoring and control arrangements are in place which includes:

- CIP reporting at monthly finance meetings attended by Finance Managers, Directors of Operations, Associate Directors of Nursing, the Director of Finance, the Director of Operational Finance and the Chief Operating Officer.
- Specific bi-monthly CIP delivery meetings between the Chief Operating Officer, the Director of Operational Finance and divisional management teams which review the progress of schemes, identify problems and allow other divisions to challenge assumptions on a peer review basis. Alternate meetings are also attended by the Executive Director of Delivery, the Chief Financial Officer and the Director of Finance.
- Fortnightly strategic CIP planning meetings which include the Chief Financial Officer, Chief Operating Officer, Chief Nurse, Director of Delivery and New Hospital Project Director. These meetings review progress of current projects and the pipeline of future projects to ensure CIP delivery.

Performance updates are provided to the Board of Directors through the monthly finance and activity report and assessment of the Trust's savings plans and monitoring arrangements are also part of the Internal Audit programme with the findings reported to the Audit Committee.

A consolidated register of all CIP schemes is held centrally within Finance. This contains details of each individual scheme and is updated each month for actual performance. This enables CIPs to be reviewed by service, division, by project and to monitor delivery in terms of % CIP achieved, % CIP slippage against plan and what % slippage may be due to phasing / timing issues. All targets are posted to the ledger in equal twelfths unless specific approval is granted for exceptions to this. This ensures that a worst case position is reported in the first half of the year and that there are no surprises in Q3 and Q4.

**CIP profile**

The Trust's CIP programme generally involves two different types of scheme:

- Incremental schemes – these schemes are generated at a departmental, specialty or divisional level and involve discrete changes, for example doing things more efficiently, stopping doing things that don't add value or revenue generation schemes. Examples include procurement savings, skill-mix reviews, revised clinical protocols (drug / product rationalisation) and a review of SLA charges to other Trusts. They are typically identified by budget holders, clinicians, operational managers and finance staff as part of the ongoing budget management and financial planning process.
- Strategic schemes – these are larger schemes which are more transformational in nature and often affect multiple services or divisions. They are often identified centrally, for example from specific initiatives, clinical redesign, learning gained elsewhere or benchmarking and are usually implemented via a project group (task and finish group) led by an executive director. Recent examples include the Outpatient Pharmacy Subsidiary, the Logistics Review, the EPR project and New Hospital Single Site Savings.

In recent years a significant proportion of the savings have been generated from the larger strategic transformational projects. This follows the successful transfer into the new hospital which necessitated and enabled significant clinical redesign, a reduction of service duplication and increased automation in certain services. The Trust has also benefited financially during this period from some significant service developments including the transfer of specialised activity from other providers and the addition of some Community Services.

For 2013/14 it is the smaller incremental schemes that make up the majority of the expected savings. The Trust's Cost Improvement Programme for 2013/14 involves over 500 individual schemes with an average value of £33,500. These have been grouped into the following main themes as set out in Appendix 2:

1. Procurement Schemes - £3.2m
2. Internal Service Reviews (Productivity and Efficiency) - £4.1m
3. Pharmacy Schemes - £3.1m
4. Workforce Efficiency CIPs - £2.5m
5. Other expenditure reduction Schemes - £2.1m
6. Revenue generation schemes - £1.7m

Each individual scheme has been risk assessed both for delivery and potential impact to quality. Due to the high number of schemes and low average value of each there is a low value of significant slippage occurring.

Transformational CIP schemes are limited in 2013/14 however the Trust continues to work on service redesign initiatives in conjunction with GP commissioners, for example the roll out of Acute Medical Clinics to reduce emergency admissions. Whilst these schemes undoubtedly improve efficiency they will not necessarily result in cash releasing efficiency savings for the Trust. Although detailed CIP proposals are not yet finalised for years 2 and 3 of the plan it is recognised that more transformational savings may be required to deliver the necessary savings over the longer term. Current work-streams include the redesign of dialysis services, estate rationalisation (Selly Oak), the GP pathology tender and further automation / IT developments.

**CIP enablers**

As set out above, the vast majority of CIPs are identified and delivered by individual specialties, wards and departments on a bottom up basis. This ensures that clinical staff engaged early in the process and take ownership and responsibility for the planning and delivery of savings. Once individual schemes have been identified they are reviewed by divisional management teams and added to the Division's overall cost improvement programme. This is then signed off at the Divisional Board meeting by the Divisional Director (Lead Clinician) and the Associate Director of Nursing.

Where Divisions are planning larger schemes a centrally funded project team is available to support delivery if required. Divisions have access to expertise from support functions such as Pharmacy, IT, Informatics, Finance, Commercial Development, HR and Procurement to help plan and manage savings. They can also bid for additional dedicated resource on a non-recurrent basis if necessary, for example Division A has received funding for a full time HR Project Manager to lead a number of workforce redesign schemes in 2013/14. Most of the enabling infrastructure is in place within the Trust and therefore any requirement for additional investment is usually limited.

In addition to Divisional Schemes the Trust undertakes some Strategic Schemes. These are larger schemes which are more transformational in nature and often affect multiple services or divisions. Strategic Schemes are often identified centrally, for example from specific initiatives, clinical redesign, learning gained elsewhere or benchmarking and are usually implemented via a project group (task and finish group) led by an executive director. Recent examples include the Outpatient Pharmacy Subsidiary, the Logistics Review, the EPR project and New Hospital Single Site Savings, although the 2013/14 Cost Improvement Programme is predominantly based on Divisional Schemes.

**Quality Impact of CIPs**

As detailed above the vast majority of CIPs are identified and delivered by individual specialties, wards and departments on a bottom up basis. This generally ensures that schemes which have a high potential risk to quality are not brought forward, however all proposals are quality impact assessed by divisional management teams and signed off at a Divisional Board meeting by the Divisional Director (Lead Clinician) and the Associate Director of Nursing. Following this process the Divisional programmes are collated along with corporate schemes and the Trust's overall programme is reviewed by executive directors including the Medical Director and Chief Nurse prior to formal sign off by the Board of Directors.

CIPs are just one of many input factors to the level of resources available and more widely the quality of care provided. Therefore organisational focus is placed primarily on the monitoring of output measures of quality and safety, such as healthcare acquired infections, falls, complaints, incidents, etc., using the clinical dashboard and other advanced IT systems, rather than trying to measure the input factors (CIPs, etc.). Any deterioration in performance against the quality indicators is fully investigated and a Root Cause Analysis is undertaken to determine any causal factors including the level of resources available. Action plans are then developed which could involve additional investment.

## 7. Financial and Investment Strategy

Despite the difficult financial climate the Trust has ended 2012/13 in a strong financial position. An un-audited surplus of £3.7m has been reported (excluding impairments), comfortably ahead of the £0.6m planned surplus. Turnover has increased by 9.1% to £640.0m in 2012/13 from £586.7m in 2011/12, driven by a record increase in the numbers of patients treated. This is partially attributable to the impact of the new hospital and the growth has ensured that the Unitary Payment for the PFI scheme now accounts for less than 8% of total turnover. Cash balances have increased from £67.7m at the end of 2011/12 to £76.2m at the end of 2012/13 despite capital investment of over £10.2m in addition to the PFI costs.

Strong financial performance is a critical part of the Trust's strategic vision as good financial health is accepted to be an underpinning enabler for all four of the core purposes. Robust finances enable appropriate investment to be made in clinical quality, patient experience, the workforce, and research and innovation, and more importantly give the organisation the breathing space to develop these areas rather than focussing excessively on financial performance. The Trust's financial priorities over the next three years can be summarised as follows:

- To enable the delivery of the Trust's strategic, clinical and quality plans.
- To maintain a minimum Financial Risk Rating of 3 under Monitor's Compliance Framework (or an equivalent rating under the new Risk Assessment Framework).
- To continue to reduce the reliance on non-recurrent PFI transition support funding in line with or ahead of the planned trajectory. The Trust's 2012/13 financial plan included £10.9m of PFI transition funding and this is planned to reduce to £9.0m in 2013/14, £7.1m in 2014/15 and £5.1m in 2015/16. The full value of transition support was received by the Trust prior to the new hospital opening and is held on the balance sheet as deferred income, therefore there is no risk of non-payment. However, the organisation is purposely reducing it's reliance on this funding on a phased basis in order to avoid a sharp decrease when the funding is exhausted. The average level of non recurrent PFI income over the life of the plan is only around 1% of total revenue and therefore it is of less significance than in previous years,
- To continue to increase operating revenues, primarily through further growth in market share for tertiary services.
- To maintain effective cost control and sound financial planning to ensure that the cost improvements required by the organisation are at an achievable level in order to reduce the potential risks to quality.
- To continue to deliver recurrent efficiency savings at the level required to achieve the financial plan.
- To enable key investments in the Trust's asset base including:
    - The development of an Institute for Translational Medicine through Birmingham Health Partners, in conjunction with the University of Birmingham and supported by a grant from the Department of Business Innovation and Skills. This will enhance the Trust's research capability in line with the strategic vision by bringing together academic staff, commercial organisations and NHS clinical research, to increase translational research leading to direct improvements in patient outcomes.
    - Further investment in the medical technology including Cyber-knife Stereo-tactic Radio-surgery, replacement Linear Accelerators, MRI and CT scanners to the latest standards and the potential purchase of a Da Vinci Robotic Surgery System, subject to business case approval.
    - Continued investment in the development of the QEH site including redevelopment of the old hospital to provide additional accommodation for clinical services research and education. Early projects include the relocation of breast services and additional short stay surgical capacity.

- Long term accommodation solutions for the support staff remaining at the Selly Oak site ahead of the potential future disposal.

During 2013/14, the key risks to the financial strategy include:

- Delivery of the activity and income targets associated with service developments. This is managed through monthly activity monitoring and is reported at board level.
- Delivery of planned Cost Improvement Programmes. This is monitored at a range of forums which include executive directors and performance is reported regularly to the board.
- Achievement of CQUIN goals. CQUIN payments are worth up to 2.5% of contracted healthcare income (circa £12.5m) and therefore there is a risk of significant revenue losses if targets are not achieved. This is managed through regular reporting including the real time information available via the clinical dashboard.
- Contract penalties. The new standard contract includes a range of significant financial penalties for failure to achieve performance targets. As above this is subject to regular monitoring and reporting to executives and operational groups.
- Operational cost control. Good cost discipline is equally important to the delivery of cost improvements. This is managed through the monthly reporting process and divisional performance reviews.

The Trust has a strong track record of managing these risks and they can largely be mitigated through effective planning and a strong control framework, including robust monitoring to ensure that remedial actions can be taken at an early stage should the need arise. In addition the Trust has the ability to offset any unplanned in year losses via greater utilisation of the non-recurrent PFI transition support. This would create the headroom required to develop and implement a recovery plan but would also reduce the funding available in later years and therefore should be seen as a measure of last resort.

In the longer term there are further risks around changes to the national tariff and business rules, the impact of commissioning changes and the cost of new technologies which will determine the level of efficiency savings required by the Trust. These risks are evaluated as information emerges and mitigating strategies are developed accordingly. The next refresh of the Trust's long term financial plan, which includes downside sensitivity analysis and mitigating options, will be presented to the Audit Committee later in the year.