West Suffolk NHS
NHS Foundation Trust

Strategic Plan Document for 2013-14

West Suffolk 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)*	Roger Quince

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Stephen Graves

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Craig Black

Signature 

1. Strategic Context and Direction

1.1 Executive summary

Our strategy for the medium term can be summarized as follows:

Our overall aim is to provide high quality healthcare to the population we serve for the great majority of their needs, both elective and emergency:

- We will ensure that we can maintain quality by operating at an appropriate clinical scale, closely monitoring outcomes and periodically reviewing services

- Where an appropriate scale of provision is not possible given the size of the population we serve we will collaborate with other acute providers to operate various forms of joint service. In particular we are strengthening our already close links with Cambridge University Hospitals and Ipswich Hospital and are developing a relationship with Colchester Hospital. Each of these partner organisations is around 40 minutes travelling time from West Suffolk Hospital and clinical collaboration, for example joint on-call rotas is therefore a practical proposition

- There may be some services for which we cannot, even in partnership, provide the necessary quality of care. We do not feel that this is the case with any service at present but this issue will be kept under close review.

There are areas where we can develop new services in line with our CCGs wish to provide care closer to home by repatriating services currently contracted outside the area. This has already happened with plastic surgery and there are other areas that offer opportunities, for example cardiology where previously complex procedures have become much more straightforward and commonplace.

The Trust has been successful in achieving high levels of cost improvement in the recent past but we are clear that the scope for similar types of cost saving initiative in the future are limited and that future efficiency gains will be achieved only by transformational change. We are clear that such change can also improve the quality of care. We have established the necessary organisational infrastructure to achieve transformational change and are actively pursuing a number of projects, many of them facilitated by IT changes that are in train.

Within our immediate local authority's development plan we have secured a site which is earmarked for a healthcare campus. In effect no other development can occur on this site for about the next 20 years. While our long-term ambition is to develop a new facility on this site we recognise that for some time the prospects for funding are likely to be hugely problematic. The Board has therefore committed to continuing to improve the facilities on our current site to ensure that we are able to offer the highest quality of care.

1.2 Strategic position

Monitor, the independent regulator of NHS Foundation Trusts, authorised West Suffolk NHS Foundation Trust on 1 December 2011. On authorisation, and in line with the requirements set out by Monitor, the Trust reviewed its mission statement and strategic objectives as part of a comprehensive strategic review.

The Board of Directors in consultation with staff and Governors, agreed the following revised mission statement:

> **'Excellence in Healthcare – We will provide high quality, safe and caring services; and promote wellbeing'**

The mission statement is underpinned by a set of strategic objectives:

- To be the healthcare provider of first choice by providing excellent quality, safe, effective and caring services
- To work with partners to develop integrated healthcare services to ensure that patients receive the right care, at the right time, and in the right place
- To be the provider of urgent and emergency care services for the local population
- To continuously improve service quality and effectiveness through innovation, productivity and promoting wellbeing in patients and staff
- To continue to secure, motivate, train and develop an engaged workforce which will be able to provide high quality patient focused services
- To deliver and demonstrate rigorous and transparent corporate and quality governance
- To provide value for money for the taxpayer and to maintain a financially sound organisation.

WSFT's strategic objectives reflect our focus on strong governance arrangements. This is recognised as critical to delivery of our substantial transformation programme to take the WSFT successfully through challenging economic times.

A range of strategic options have been considered that will help to ensure that WSFT remains a sustainable provider of safe, high quality patient care. Working closely with the Council of Governors, Senior Managers and Clinical Directors, the Board of Directors has agreed that WSFT should remain an independent, standalone Foundation Trust and that further work, including financial modelling, is required on the following options:

- **Standalone FT underpinned by sharing of back office functions:** Consider sharing information, IT, finance, estates and HR with one or more NHS organisations
- **Standalone FT underpinned by integration of some clinical services:** Where clinical or productivity benefits are evident, clinical services may be shared with another NHS organisation. This may range from sharing cover arrangements for smaller specialties to operating a specialised service in collaboration with a regional provider
- **Standalone FT underpinned by critical appraisal and maximising of capital assets:** Consider developing WSFT assets in commercial partnerships. For instance with a housing association to replace the current staff accommodation which is in poor repair and generates little income
- **Standalone FT underpinned by charitable funds:** Building on the excellent support WSFT receives from local communities a more professional approach to charitable donation and legacies will be considered and the money used to help improve the environment for patients.

The four options above are all possible within WSFT's existing structure and are not mutually exclusive and we are progressing all of them.

Following Monitor's review of the Trust's Annual Plan the Trust was chosen for a second stage review (APR2) along with five other small to medium sized District General Hospitals (DGHs). This requirement, by the regulator, is consistent with their concerns about the viability of small to medium sized DGHs and the need for these organisations to consider their strategy and service plans to remain viable. The APR2 was undertaken by McKinsey and reported to the Trust in the autumn of 2012.

The Trust Board also worked with other organisations to consider clinical options and what core services the Trust should continue to provide and areas where it could collaborate with other organisations. The Trust Board and Governors have considered these options to provide greater clarity on what the Trust should do and what services could be provided in partnership with other organisations.

The Trust's work is progressing both internally and externally regarding these options. This plan provides greater insight into how the local population demographics are changing, the emerging plans of the West Suffolk Clinical Commissioning Group (CCG) and how the Trust is progressing its own plans.

WSFT manages West Suffolk Hospital, a District General Hospital which provides a range of acute core services with associated inpatient and outpatient facilities to a catchment population of around 280,000. There is a purpose-built Macmillan Unit for the care of people with cancer, a dedicated Eye Treatment Centre and a Day Surgery Unit. West Suffolk Hospital has around 450 beds and 14 theatres, including three in day surgery and two in the Eye Treatment Centre.

Indicators	2012/13	2011/12	2010/11	2009/10	2008/09
Inpatient Planned	**4,002**	4,794	4,770	5,038	5,195
Inpatient Non Planned	**25,443**	25,142	26,749	27,051	25,241
Day Cases	**21,997**	19,848	19,442	20,486	19,021
Outpatient Attendances (inc. Ward Attenders)	**158,167**	162,990	157,592	156,574	187,371
Outpatient Procedures	**67,481**	60,404	57,735	46,884	14,120
A&E Attendances	**59,303**	55,627	51,936	48,115	47,638

Procedures which were traditionally carried out as a day case or inpatient procedure are now being undertaken in an outpatient setting, which is more efficient for WSFT and more convenient for patients.

The time patients stay in hospital (length of stay) has reduced across directorates and specialties. The WSFT continues to improve length of stay with the redesign of patient care pathways as part of its transformation programme. In achieving this reduction in length of stay, we continuously monitor the number of patients readmitted to hospital following discharge.

WSFT achieved a surplus of £1,512k for the year 2012/13. Total income was £167.0m which was an increase of 4.7% over that for 2011/12.

	2012/13 £000	2011/12 £000	2010/11 £000
Operating income	**166,988**	159,501	155,432
Operating costs	**(158,627)**	(152,015)	(148,669)
EBITDA* surplus	**8,361**	7,486	6,763
Depreciation, dividend and other costs	**(6,827)**	(6,816)	(6,728)
Fixed asset impairments**	**(22)**	(51)	(63)
Retained earnings	**1,512**	619	(28)

* EBITDA – measurement of Earnings Before Interest, Taxes, Depreciation and Amortisation
** Fixed asset impairments – these occur when the value of individual fixed assets reduces as a result of damage or obsolescence

1.3 Opportunities and threats

The historic activity summarised above can be viewed against contracted activity for 2013/14 and actual performance for April 2013 which are summarised below.

Indicators	2013/14 April*	2012/13 April*	2013/14 Contract	2012/13 Actual
Inpatient Planned	**299**	301	**4,115**	4,002
Inpatient Non Planned	**2,071**	1,950	**24,709**	25,443
Day Cases	**1,976**	1,654	**22,609**	21,997
Outpatient Attendances (inc. Ward Attenders)	**14,844**	11,595	**161,746**	158,167
Outpatient Procedures	**5,654**	4,845	**66,854**	67,481
A&E Attendances	**5,000**	4,713	**54,565**	59,303

Activity continues to increase, particularly for emergencies and outpatients. The Trust continues to work with West Suffolk CCG and primary care practitioners to manage this activity through a locally agreed

QIPP plan (Quality, Innovation, Productivity and Prevention). Action is also being undertaken to modernise emergency care services during 2013/14 to help accommodate this additional demand.

The map below sets out areas of service development the Trust has worked with local GP practices and the local community. This is in addition to existing services provided within Newmarket and Sudbury and has focussed on:

- Ultrasound and Audiology – Thetford
- Rheumatology – Botesdale
- Urology – Stowmarket
- Paediatrics and Rheumatology – Haverhill

Map of Local Heath Economy including Trust Catchment Area

We are also working with GPs and the CCG to develop more community based services for: Orthopaedics; Rheumatology; Audiology; ENT; Ophthalmology; Plastics; Endoscopy; and Ultrasound.

In the medium term future the Trust intends to provide broadly the same range of services as currently i.e. a range of secondary healthcare services that meet the main needs of the population it serves, however this will be in greater partnership with other providers than today. For example, it is planned that pathology services across seven trusts will be provided by an NHS organisation owned by the seven partners. This will provide sustainable services of high quality and in a more cost effective way.

From the map it can be seen that there are a number of acute providers local to West Suffolk, although none are closer than 30 miles and 45 minutes travel time.

Trust	Type	FT
Cambridge University Hospitals	Teaching Hospital £600m plus	√
Colchester University Hospital	DGH - £200 - £250m	√
James Paget Hospital	DGH - £150-£175m	√
Ipswich Hospital	DGH - £200 - £250m	X
Norfolk and Norwich Hospital	Teaching Hospital c£450m	√
Queen Elizabeth, Kings Lynn Hospital	DGH - £150-£175	√
West Suffolk Hospital	DGH - £150-£175m	√

All the local DGHs provide very similar core services with some elements being provided by neighbouring Trusts, for example Cambridge University Hospitals provide vascular services to WSFT and Colchester does so for Ipswich. Cambridge University Hospitals has a world famous reputation for the teaching and research it undertakes in association with Cambridge University. None of these are focussed on increasing their market share at the expense of WSFT; rather they are also facing the challenge of capacity constraints. Of more relevance are the new entrants into the market, for example the community and elective care hospital in Braintree which may pose a threat to WSFT for Sudbury patients and local private hospitals which are now actively competing for choose and book activity. WSFT is monitoring this situation carefully as these organisations tend to have short waiting times, are not challenged by emergency activity and often utilise the local consultant workforce. To date there has been little impact on activity or income.

The integrated Suffolk QIPP plan forecasts that patient activity will not change over the next few years, taking into account population growth and an ageing demographic, balanced with investment in alternatives to hospital based care. This though will require a different model of service outside the hospital as at present hospital based activity continues to rise.

The West Suffolk CCG has developed this thinking further as part of its CCG authorisation process and it has developed a plan with the following focus:

Planned Care	• Focus on Trauma and Orthopaedics (develop pathways for Hips, Knees, Shoulder and Carpal Tunnel) • Development and implementation of new service model for Pain & Dermatology • Review and develop Diabetes service model in West Suffolk • New elective pathways and supporting services (IBS, Headache, Community Gynaecology Service etc.) • Deliver Consultant led community health plans for GP's • Review appropriateness of variation, coding and demand of acute activity.
Integrated Care	• Establish an Urgent and Emergency Care network to deliver: whole system wide urgent care pathway review to focus on 7 day working, demand and capacity modeling, integrated crises response, pull based discharge, ACSC and AEC pathway development, and an alcohol pathway review • Implement Integrated neighbourhood team and community development supported by Risk Stratification and Comprehensive Geriatric Assessment • Implement self-management strategy including use of assistive technology and workforce development • Review and development of system wide dementia strategy • Implementation of integrated falls and bone health pathway • Development and implementation of Family Carers strategy • Implementation of findings of stroke review and development of Hyper acute stroke care and early supported discharge.
Mental Health/ Learning Disabilities	• Develop a dedicated Psychiatric Liaison Service with West Suffolk hospital and NSFT • Define and develop Service Specifications in support of Mental Health payment by results (PbR) • Development of an Age Inclusive Autism Service (county-wide) • Develop system wide Dementia services (see also Integrated Care) • Review of CAMHS Services and development of new model of care • Procurement of new Learning Disabilities services.
Cancer/End of Life	• Reduce cancer emergency admissions and follow-up appointments into acute hospitals • Implement alternative cancer follow up pathways, starting with prostate cancer • Implement Electronic Palliative Care Coordination System across primary care • Provision of out of hours crisis at home service • Implement EoL training strategy and develop EoL education.
CYP & Maternity	• Improve LTC Management to avoid unnecessary emergency admissions (Asthma, Diabetes, Epilepsy • Improve early diagnosis and management of Eating Disorders and reduce Tier 4 referrals • Roll out PbR for Maternity services • Review Paediatric Urgent Care Pathways (Asthma, D&V, Minor Infection etc) • Develop Integration of Children's Services across providers and wider health economy

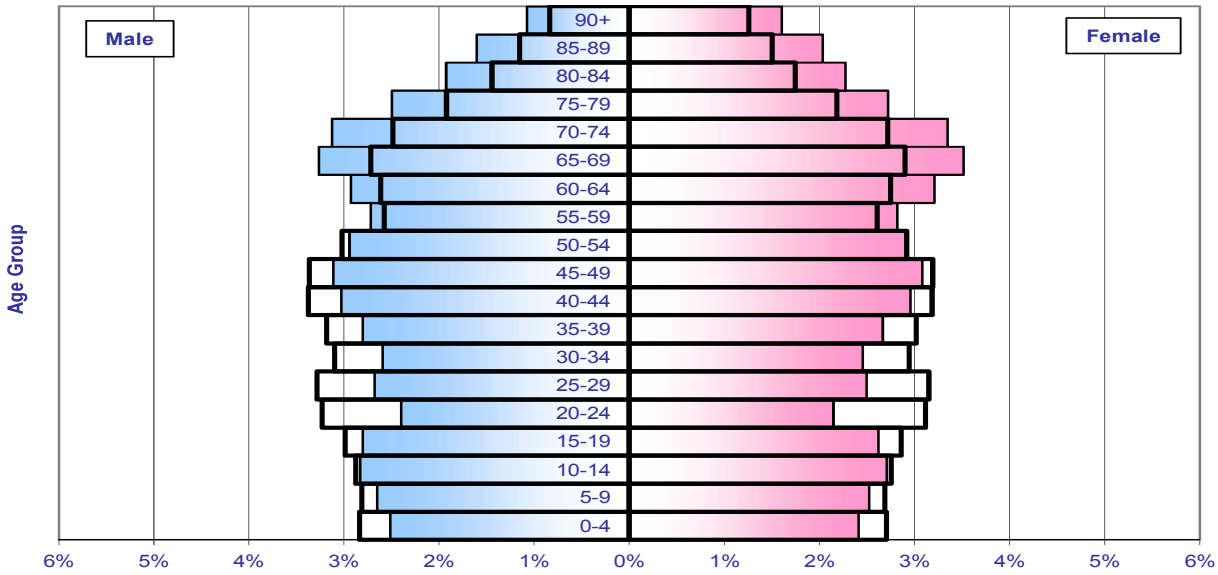
GP prescribing	• Implementation of prescribing recommendations, as recommended by West Suffolk CCG Medicines Management Team; • Review of prescribing of DROP-List items, i.e. drugs of low priority, poor value for money or where there are safer alternatives available • Medication reviews and optimisation for patients on complex regimes • Review of dietetic prescribing: oral nutritional supplements, gluten free foods and infant formulae.

Clinicians and managers at the hospital are involved fully with West Suffolk CCG in taking forward the relevant pieces of work. In particular the WSFT is focussed on the Integrated Care workstream to ensure that there is a clear and agreed plan for winter 2013/14 and beyond.

This is particularly relevant as Suffolk has one of the fastest growing elderly populations in the country and is forecast to be the county with the second oldest population after Norfolk.

- The total population is forecast to grow by 20% from 2010 to 2035
- The population between 35-49 will only grow by 2%
- The 85-89 age group is forecast to grow by 142%.

The diagram below shows how the male and female population compares to the England average, black rectangles. It shows clearly that for both the male and female population there is a lower than England average in the younger age group and higher in the elderly.



Despite the work that is set out above it is not forecast that there will be a reduction in activity, however the plans and programmes will dampen the historic growth in demand. Indeed the current joint working may already be achieving this as East Anglia has this year seen one of the lower increases in emergency activity across the Midlands and East Region, 2.7% against an average of 6.9% (December 2012 position). This is though 4.5% above plan which assumed an actual reduction in activity. In addition the hospital has seen a 6.9% increase in A&E attendances compared to last year and at the end of April there has seen a further 6% increase on the same month last year.

In planning for 2013/14 WSFT has worked closely with the Suffolk PCT and West Suffolk CCG to agree the contract, activity schedules and financial plan. The difference between WSFT's activity plan and CCG plan is about 1% of the financial contract and this relates to the level of QIPP delivery. WSFT has not assumed an increase in activity over last year, despite the experience of recent years and the first six weeks of this year.

The Midlands and East SHA has undertaken a review of stoke services, facilitated by an expert advisory panel. The review has considered the whole service but in particular focussed on the location of Hyper Acute Stroke Units (HASUs) across the Region. The SHA Board meeting in March 2013 received the report which suggests a reduction in the number of HASUs across the Region, including at WSFT. This is counter to the proposal put forward by NHS Suffolk, supported by the two CCGs and the two acute

Trusts. WSFT has considered the implications of this development in its plans and is clear that the majority of the activity would transfer to Cambridge and the plan would be that patients would then be transferred back to West Suffolk after the initial assessment and hyper-acute intervention. The local CCGs have confirmed their support for a HASU at West Suffolk and hence the Trust is investing in further consultant presence and specialist nurse cover.

1.4 Collaboration, integration and patient choice

WSFT has reviewed the services it provides and in consultation with McKinsey and other consultants and Trusts, considered what it will definitely provide into the future and those services that it will consider providing in partnership with others. We have confirmed with the West Suffolk CCG that they still wish to commission DGH services from WSFT.

In reviewing the clinical sustainability of services we have and continue to take into account national discussions being led by Royal Colleges on, for example, some 24/7 surgical services and the training of physicians. In addition, as a consequence of the pathology procurement, some Trusts are looking to explore greater collaborative working.

Through the commissioners the WSFT is working with local NHS trusts to develop collaborative models of service delivery. This supports the delivery of high quality care 24/7 across the health economy while maintaining access to services locally. During 2012/13 a service model for stroke has been developed in partnership with Ipswich Hospital and will continue to evolve during 2013/14. This model of collaboration for commissioner-led services reconfiguration will provide local clinically sustainable services.

To support patients' choice the Trust continues to develop and delivery district general hospital services which meet the needs of the local population. In collaboration with primary care the Trust continuously reviews how these services are delivered, and where appropriate services are provided in the community "closer" to our patients.

2. Approach taken to quality

At WSFT we are committed to achieving excellence in all we do. We are passionate about providing the highest quality care and aim to be the hospital our local communities choose first, every time. Our Quality Strategy was updated in September 2012 and set out how we will define, improve and assure the quality of our services.

Quality means getting things right for those who use our services, their carers and families. We have developed this strategy through talking, and listening, to our patients and members, and our partners and stakeholders to understand what is important and how they define quality.

The WSFT has an unconditional registration with the Care Quality Commission (CQC). In August 2012 the CQC made an unannounced visit to the WSFT to carry out a review of services provided. The focus of the visit was dignity and nutrition and they reviewed five of the outcomes for which the Trust is registered:

The inspection team included four CQC inspectors joined by a practising professional who was an experienced nurse manager. The team visited six wards; three medical wards with a high proportion of older people and three surgical wards. The CQC found the Trust to be meeting all the standards reviewed and made a large number of positive comments along with some suggestions for improvement.

In 2012/13 the WSFT received three requests from the CQC to investigate concerns raised with them. Each concern has been fully investigated and feedback provided to the local CQC Compliance inspector including any actions undertaken. The CQC have accepted the Trust response on each occasion as fully addressing all the concerns raised and have not made any amendments to registration status or enforcement action.

The Health and Safety Executive (HSE) visited WSFT in October 2012 following a patient fall from an unrestricted window. As a result of this incident the Trust undertook immediate action to fit window restrictors to all windows in the WSH. The Trust also commissioned a detailed investigation of the incident, the recommendations of which have resulted in changes in its systems in order to prevent future, similar incidents. The Trust cooperated fully with the HSE in its investigation and pleaded guilty at the earliest opportunity in respect of the subsequent prosecution which resulted in a £10,000 fine. Ensuring that users of the WSH are safe is the Trust's highest priority and the Trust remains committed to fulfilling all of its obligations in respect of patient, staff and visitor safety.

Awards and accolades

- WSFT was presented with a national safety award in recognition of excellent performance in preventing deep vein thrombosis (blood clots) among at risk patients. The hospital received the Lifeblood VTE (venous thromboembolism) 2013 award in the category of best performing trust for its Commissioning for Quality and Innovation (CQUIN) results for 2011/12, and was described as providing "exemplary leadership in VTE prevention"
- The Macmillan Unit at WSH was awarded the Macmillan Quality Environment Mark (MQEM). The award is given to units which are welcoming and accessible, respect privacy and dignity, support patients' comfort and wellbeing, provide choice and give patients, families and carers the chance to feed back their views for ways to further improve care
- Patient Environment Action Team (PEAT) assessors rated the food at WSH as "excellent" and its standards of cleanliness and patient privacy and dignity as "good" for the second year running
- Following a successful Year Two assessment the radiology department team maintained accreditation for ISAS, (Imaging Services Accreditation Scheme). The assessing team were very complementary about the service, including the level of organisation and the way in which all staff, including first year students, discharge their duties reliably, courteously, and in line with the written protocols. The hospital was one of the first in the country to achieve this accreditation.

Quality risks to our strategy

Risks to our strategic objectives are detailed below and are directly related to the quality of service we provide. These include risks to the organisations service delivery; workforce; and governance. These risks are captured within the WSFT Board Assurance Framework and monitored by the Board on a quarterly basis. This monitoring considers both the level of risk and the effectiveness of action being taken to control risk.

Description of risk
Reputation damage due to quality/service failure leads to reduced activity
Changes to the provision of services in light of national or regional recommendations, including: paediatrics, stroke and smaller service specialties (cardiology, urology, and dermatology).
Increasing emergency activity.
Implementation of Estates Strategy to provide a building environment suitable for patient care and adequately maintained with regard to backlog maintenance.
Failure to identify and deliver the level of CIPs (cost improvement plans) to secure the long term viability of the Trust.
Material re-organisation of pathology services across the Midlands and East of England. Proposal to move to Hub and Spoke Model.
Ability to meet Workforce Plan linked to the Trust's long term financial model (LTFM).
Staff responsiveness to current economic/environmental challenges.
Non-compliance with legislation, regulations and good practice guidelines, including failure to comply with internal policy and procedure.
Local income level at risk through changes to the tariff and/or reduced activity levels. West Suffolk CCG application of penalties through contract management and external influences/financial pressure upon NHS.

The Trust maintains a self-assessment against the 10 Quality Standards set out in Monitor's Quality Governance Framework through its Quality Memorandum. This provides an outline of the evidence on

which the assurance statement is based and is updated on a quarterly basis to reflect current practice.

The Board tracks performance in relation to quality goals and monitors quality through:

- A monthly **Quality and Performance Report to the Board** with a RAG rated dashboard and regular reports on patient and quality issues such as the complaints report, national patient survey reports etc.
- The **Directorate Quality and Performance Meetings** with issues being reported to the Trust Executive Groups. Performance against the quality indicators from the Trust dashboard is examined at ward and Directorate level. These performance management arrangements ensure targeted improvement against the quality goals.
- The **Board Assurance Framework** which identifies the key risks and assurances to the delivery of the Trust's strategic objectives and is monitored by the Board on a quarterly basis
- **The Governance Committee structure** with the Quality & Risk Committee being chaired by the Trust Chairman and membership which includes Executive and Non-Executive Directors. This is supported by three subgroups, the Clinical Safety & Effectiveness Committee, the Patient Experience Committee and the Corporate Risk Committee.
- **The Risk Register** is monitored by the Corporate Risk Committee of the Board. This considers high risk issues and performance in managing risks. The risk register performance indicators form part of the monthly dashboard to the Board

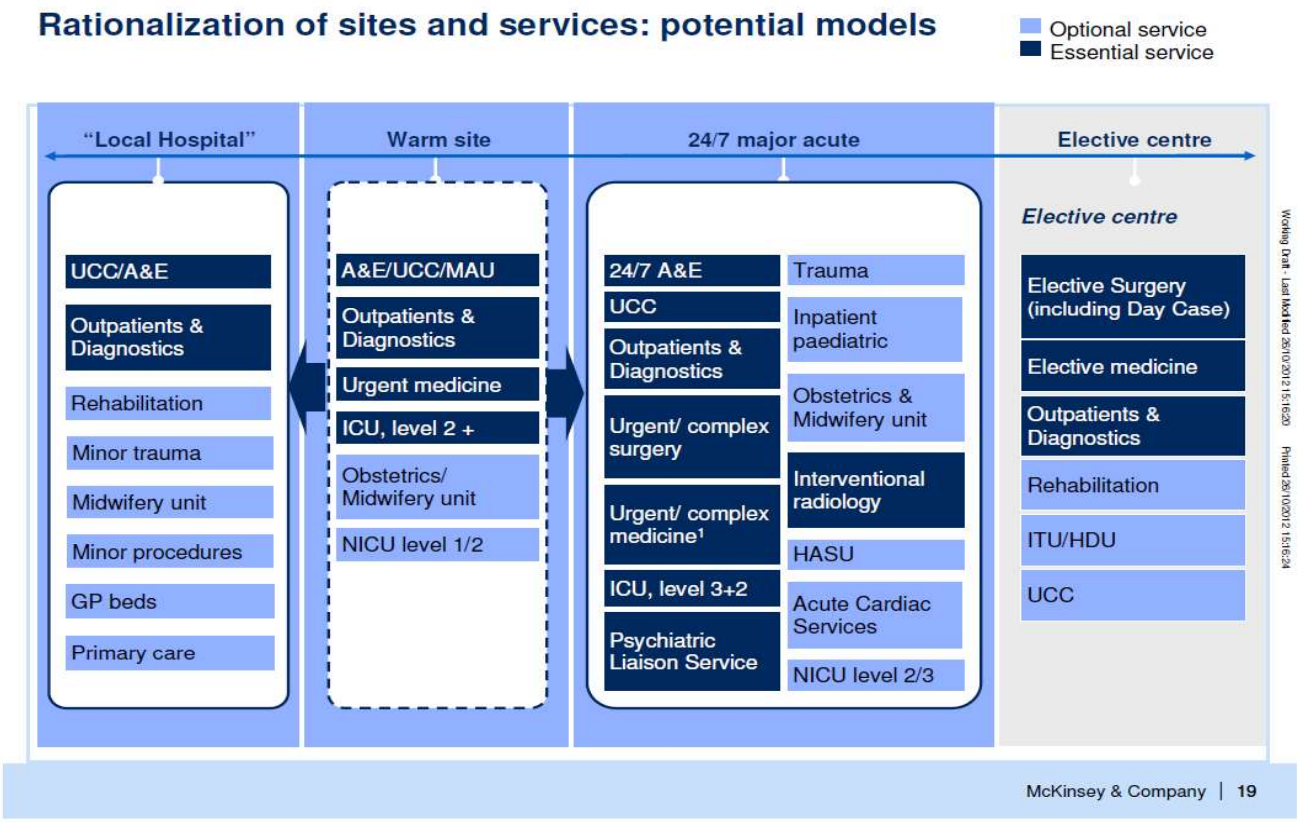
Quality improvement is connected from "Board to Ward" - this is achieved through two-way communication between the Board and operational areas (e.g. wards) across WSFT. The monthly Quality and Performance Report to the Board provides both an organisational and ward-level dashboard. This information is underpinned and informed by review by directorates and wards with action planning at these levels. Delivery of improvement at an operational level is managed through directorate Quality & Performance Meetings but is also tested through observational visits by Board members and Governors as part of the weekly Quality Walkabouts. A programme of presentations relating to the quality priorities and quality developments has also been delivered to the Board.

In 2012/13 the WSFT has strengthened and formalised an assurance framework to provide a method of monitoring CQC compliance through structured ward self-assessment and external peer review. The findings and any identified action is reported to the Quality & Risk Committee on a quarterly basis. This CQC assurance framework has been expanded to include the "15 steps challenge" observational tool which is a guided audit tool measuring the initial responses that visitors experience during the first 15 steps in a clinical area.

3. Clinical strategy

3.1 Service line management strategy

On achieving Foundation Trust status, Monitor asked WSFT to review it strategy and the Trust was also asked to undertake a second stage Annual Plan review in the summer of 2012/13. This work was undertaken by McKinsey on behalf of Monitor. Further work by McKinsey provided a framework which the Trust has used to review its services. The framework below was used and our strategy is based on the 24/7 acute scenario.



In addition WSFT has discussed with West Suffolk CCG its strategy for acute services, has considered the strategic review of Stroke led by the SHA and the reviews and views of the Royal Colleges.

WSFT has therefore focussed on the following areas

- Paediatrics
- Obstetrics
- Emergency and Urgent Care
- Stroke
- Cardiology
- Pathology
- Planned Care

Paediatrics and Obstetrics

Two areas the Monitor/McKinsey work identified were Obstetrics and Paediatric services. The Trust has therefore reviewed its services in line with the work by the two Royal Colleges (Back to Facing the Future RCPCH April 2013 and Report on Patterns of Maternity Care in English NHS Hospitals April 2013.

Both reviews identified that, at present, WSFT meets all their key criteria based on activity and staffing levels and performance standards. Whilst we are not complacent and individual parts of the service and partnerships with other hospitals will need to continue to develop, these services should remain core to the services we provide to the local population. In partnership with other hospitals this work will continue in 2013/14, identifying any areas for further review. This work will be linked to the emerging role of the Clinical Senate and clinical networks.

Emergency and Urgent Care

The McKinsey work also highlighted that small DGHs needed to regularly review if they had enough activity to sustain the service in small 24/7 emergency surgical services. This position is supported by the Royal College of Surgeons in its paper 'Reshaping Surgical Services' January 2013. There are ongoing discussions with the consultant teams and if and where relevant we will over the course of this year develop these conversations with our CCG and other Trusts. This does not mean that elective services or much of the emergency services would not remain local. Rather we would consider how hospitals cover a 24/7 rota with a team of 3/4 consultants and whether a partnership arrangement with another hospital would improve the service as we already do in some areas.

The Royal College of Physicians is undertaking a commission on the 'Future Hospital' and NHS England is undertaking a review of Emergency and Urgent Care as part of its consideration of the extreme pressures hospital A&E departments experienced over the winter and continue to experience. Our discussions with the Royal College, albeit in the early stages of its work, has identified the recruitment challenge for emergency and acute medicine, now and into the future.

As a consequence of these convergent forces WSFT has engaged with the national Emergency Care Intensive Support Team who have helped us, in partnership with our CCG and community colleagues develop a detailed and comprehensive plan. The key hospital elements are set out below.

- Emergency Department
- Assessment and Short Stay
- Inpatient Medical Wards and Discharge
- Frail Elderly
- Complex Discharge

We have already started to make investment decisions, for example, increasing capacity in the A&E Department by building a Clinical Decision Unit (CDU), increasing the senior doctor levels in the Department and increasing the capacity of our Emergency Admission Unit. The CDU development has been planned so that it complements a further increase in capacity in the A&E department, which could include a major build.

We have also reviewed overall capacity within the Trust and its environment. Over the next few months we will decide whether to undertake a major refurbishment of two unused wards which could be available in 2014/15.

For frail elderly services the WSFT is recruiting two additional consultants for the hospital and two Interface Geriatricians to support the community.

In addition the ECIST team are supporting us, the CCG and the community service to review out of hospital care and the interface between the hospital and the community. WSFT has also engaged in discussions with the major nursing home provider to establish whether joint work would benefit their residents and help reduce emergency admissions to hospital. WSFT is also planning to commission services so that patients who do not need the facilities of an acute hospital but do need regular nursing inputs, for example to provide their antibiotics, can be cared for at home.

This work on emergency and acute care has full support across the clinical body of the Trust and the Trust Board and will be a major focus over the next year. The whole system review is led by the Urgent care Network Board which is Chaired by the CCG.

Stroke

The Midlands and East Strategic Health Authority led a review of Stroke services across its area. At the point of writing this plan the outcome of this review is not public. The local CCG has confirmed its wants Hyper acute stroke services to remain at the Trust. WSFT is therefore recruiting a third Stroke consultant and is improving access times to the ward and diagnostics. It is also working with partners to

further develop arrangements for consultant cover at weekends, and to develop an Early Supported Discharge Service. The CCG is chairing the Stroke Board and clinical groups are responsible for delivery of the detailed service changes.

Cardiology

WSFT commissioned an external review of Cardiology services so that we could consider how best to develop the service. This was undertaken by Papworth Hospital. The service was also reviewed by the Deanery who had concerns about the oversight of trainees and hence removed the training posts. Due to excellent work by the local team, the Deanery has agreed to reinstate the training posts, the service continues to be developed and extra consultants are being recruited. This will result in more patients being treated locally which is supported by clinicians and commissioners.

Pathology

In the future clinical support services are likely to be further integrated across providers. The SHA led process to market test GP pathology services has led to a major planned change to the organisation of pathology services. The consortium that WSFT is a member of has gone further and taken the opportunity to review hospital requested services alongside GP pathology. A contractual joint venture is being created to provide pathology services across seven different providers with a turnover of more than £80m. The approach will deliver substantial savings to the trusts while ensuring that the service is sustainable.

Planned Care

The CCG plan shows a number of areas that it wants to review and change the service model. WSFT is supporting the CCG in all relevant services. For example, the Pain services review will provide clarity for the service users, providers and commissioners on the type of service that is available.

Dermatology service reviews are featuring across a number of CCGs, the goal is for more elements of this service to be provided outside hospital by nurses and trained GPs. Dermatology has historically been a hard to recruit to service in some Trusts, although not the WSFT. Therefore we could see a service model being developed by CCGs that leads to the service being provided closer to home and across a larger population.

Our review of theatre performance and the efficiency of our systems has led to increased usage of main theatres by extending the day and plans for a greater use of our day theatre capacity are in development. These changes have supported the delivery of increased activity in the first six weeks of 2013/14. The Board has also supported the development of a new Sterile Services Department which, for the first time, will be on-site.

Clinical Information Technology

A key support to improving the quality of care we provide to patients and ensuring their safety is the clinical information system available to our clinical and support staff. The hospital system is based on a 20 year old Patient Administration System (PAS). A variety of clinical systems have been developed and purchased to enhance this. The Trust has reviewed its future options and has concluded that it should procure an integrated Electronic Patient record system and this procurement will start in this financial year with implementation in 2014/15.

Collaborative arrangements

Through the commissioners the WSFT is working with local NHS trusts to develop collaborative models of service delivery. This supports the delivery of sustainable high quality care across the health economy while providing appropriate local access to services.

3.2 Clinical workforce strategy

To meet the challenges the WSFT faces our workforce will need to be increasingly focussed on our patient needs and their experience, whilst continuing to demonstrate better quality outcomes to meet the trust's quality strategy and QIPP outcomes.

Our strategy focuses on ensuring that we "continue to secure, motivate, skill and develop an engaged workforce (all staff) which will be able to provide high quality patient focussed services".

With regard to recruitment the Trust continues to attract a strong field of candidates for appointments. There are however a number of nationally hard to recruit medical specialties which remain challenging: emergency medicine, EAU, Stroke and care of the elderly, and the national shortage of qualified nursing staff. We are implementing a number of actions to meet these shortfalls and have been successful in appointing a further A&E consultant and a care of the elderly consultant. Interviews for further care of the elderly and stroke consultants are currently being arranged. The Board of Directors receives regular updates with regard to vacancy levels and plans to fill them. We have also put in place a single preferred provider for the supply of locum doctors at a competitive rate and are recruiting overseas for qualified nurses.

During 2012/13 the Trust reviewed its capacity and nursing recruitment plans which led us to look abroad to recruit nurses and resulted in a very successful recruitment process in Portugal. The nursing and operational team have reviewed the current staffing, the likely turnover rate and the number of local trained nurses that will become available. As a result we will need to recruit further nurses, a picture which is being mirrored by those organisations around us. Therefore we will encourage newly qualified and return to work candidates to start at the hospital but will also recruit both in this country and abroad. To ensure that we have the nurse available for the busiest period, the winter, we will pursue this over the next few months. We have also led the region in the development of Trainee Assistant Practitioner (TAP) posts, with one cohort in post, and another due to complete in 2014/15.

Where recruitment is not possible the WSFT has committed to training staff with the skills and competence to provide specialist role. An example of this is the enhanced scope of practice (ESOP) nursing roles for the care of stroke patients. Three staff are currently being trained in these roles which will be completed for winter 2013.

Cross boundary working is also being developed so that staff are trained and competent across more than one field of expertise. An example in Pathology is staff being trained to be competent in both biochemistry and haematology activities.

Overall staff motivation is currently high as measured against the national staff survey engagement score, the Trust has as score of 3.83, against a national average of 3.69, putting us in the top 20% for acute trusts. Our staff survey action plan has measures in place to ensure that the trust is able to improve again next year. The Trust also has in place mechanisms to report staff motivation by department/directorate; this is reported to the patient experience committee.

We continue to be committed to the development of all staff with skills programmes available to all staff groups. The multi professional education centre will be expanded in 2013 with the expansion of a larger clinical skills suite, which will include a clinical skills simulator. We will also continue to actively support the continued delivery of the Liberated Leadership programme for Band 7 staff, with particular emphasis on developing clinical ward managers.

3.3 Conclusion

The WSFT has taken up the challenge set by the APR stage 2 review. It has considered the key areas that McKinsey highlighted and is clear where it sits against current college and commissioner guidelines and requirements.

It has engaged fully with the SHA led reviews and procurements and has agreed service models in these areas.

It has sought expert advice in service areas where we are concerned about our current model and is actively engaged in changing how we deliver these services.

It is also looking at areas of planned care where greater integration with other providers will enable the service to develop in line with commissioner requirements, best practice and utilise staff most effectively.

The detailed plans provide clarity and purpose. WSFT is also aware of the emerging clarity of the role of the regulators with regard to choice and competition and hence is ensuring that it involves the CCG in any of its thinking and is encouraging the CCG to take the lead wherever possible.

4. Productivity & Efficiency

4.1 Overview

The Trust's CIP plan focuses on productivity and efficiency gains across a range of areas and activities and is predicated on deliver of additional activity within existing financial resources. The table below details our planned cost improvement programme for 2013/14, with schemes totalling £9m. The schemes have been developed with reference to both previous performance and a range of benchmark indicators.

Scheme	Target £'000
Medical staffing expenditure	1,000
AHP's and Scientific & Prof	1,220
Non-ward based nursing	1,120
Community Midwifery	240
Paediatric Nursing	135
Admin Review	500
Agency usage	250
Income review	339
Elective growth	489
Non-elective growth	44
Outpatient growth	176
Other clinical activity growth	289
Further productivity	2,054
Car park income	250
Agency pricing	250
Procurement savings	144
Strategic Partnerships	500
Total	**9,000**

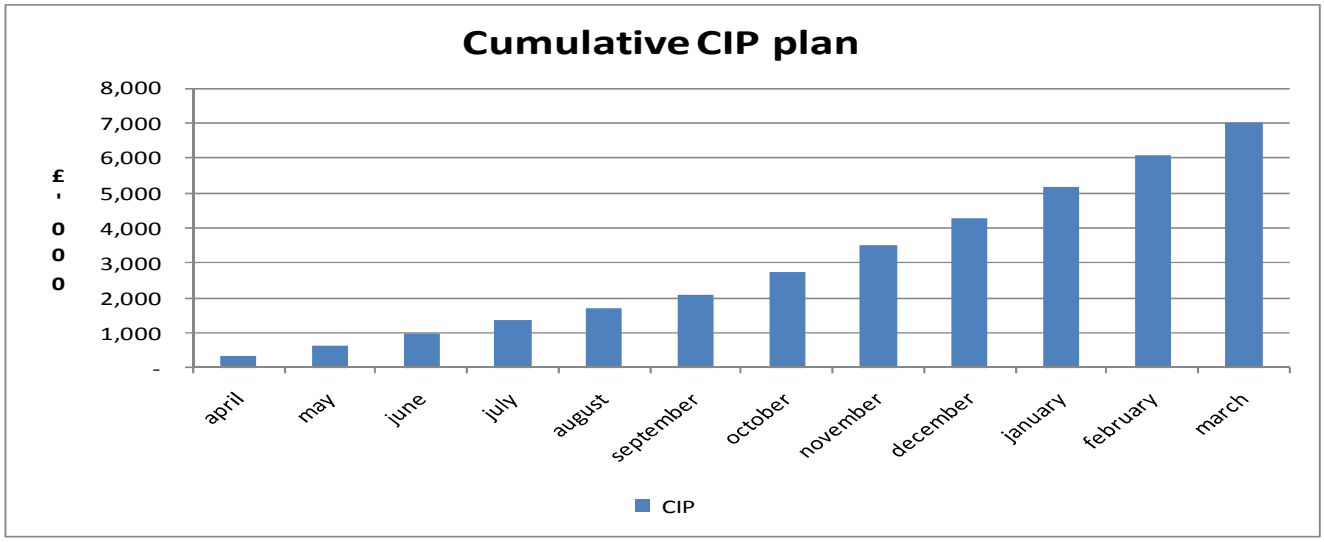
Improved staffing efficiency is a combination of replacing agency with employed staff;

Individual schemes have been risk assessed to score their financial deliverability.

Risk assess deliverability	2013/14 full plan £'000	2013/14 risk assessed plan £'000
Red	4,715	943
Green	4,285	4,285
Grand total	9,000	5,228

The Trust continues to work to identify and implement replacement schemes to remove the remaining red schemes.

In order for the Trust to achieve the planned surplus of £1m the Cost Improvement Plan for 2013/14 is £7m of which over 70% has been identified and risk assessed as deliverable. This recognises that there may be slippage or savings may not be fully achieved against all the identified schemes. It is planned to achieve these savings over the year as per the phasing below.



4.2 CIP governance, enablers and quality impact

WSFT's Project Management Office (PMO) which was set up in June 2011 is now referred to and known as the Trust's *Programme* Management Office, which aligns to industry best practice. The PMO has three key functions:

- **Planning:** including likelihood of programmes to succeed (via advice to decision-making groups on business cases, risks, project performance and Return on Investment (ROI))
- **Delivery:** ensuring programmes are delivered collaboratively and successfully with staff who have the right operational, business and programme management skills
- **Centre of expertise:** offering a range of services such as consultancy, advisory and governance and ensuring programmes conform to agreed standards and best practice.

The PMO is led by a dedicated and experienced PMO manager. There will be up to four full time dedicated posts covering programme management, analysis, facilitation and expert methodology.

Clinical and managerial engagement is critical to success of the PMO and the Trust's programmes of service changes. To achieve and maintain the highest levels of engagement, a clinical 'senate' oversees and advises on programme delivery. The senate is drawn from clinicians at all levels from across the organisation. Additionally, but proportionally, each project has a Project Board which includes the sponsoring clinician and Executive Director, lead manager, patient representation (as appropriate) and a dedicated project manager.

The Board recognises that without appropriate control, the delivery of cost improvement can present a potential risk to quality, including patient safety. Appropriate managers are responsible for CIP delivery; however clinicians are involved in assessing any impact on quality. The General Manager and the relevant clinicians discuss the new CIP and award a RAG rating. Where new technology is being used or medical consumables substituted an evaluation trial is carried out to assess the risk. Metrics such as mortality rate and length of stay are used to assess the risk impact of the CIP. Project Overview Documents (PODs) provide an effective summary of the CIPs, including ownership and responsibility.

The performance of CIPs is reported at the Trust Executive Group (TEG), where financial and quality concerns can be raised. Performance is also monitored at Directorate Quality & Performance meetings. Through this process the Board can be confident that CIPs are assessed for quality and that initiatives are accepted and understood by clinicians. The Trust's quality indicators and performance management framework monitor post implementation impact on quality. Clinical engagement in this framework provides further assurance to the Board that negative impacts on quality would be identified and appropriately escalated.

A clear governance framework is therefore in place to assess the quality impact of CIP plans pre, peri and post implementation. Pre-implementation CIP plans are generated at directorate level and, with the support of the Trust's PMO, presented to the TEG. TEG includes Clinical Directors as well as the Trust's Executive and Senior Management team. Clinicians and other members of the group use this opportunity to challenge proposals where there is a perceived impact on the quality of services. Proposals are also quality assessed by the Trust's Executive Medical Director and Executive Chief Nurse. During implementation, the quality impact of CIPs is monitored through the Trust's ward level Quality dashboard. This complex set of measures picks up very quickly where either there is an impact in a single clinical area or where there is deterioration in a single metric across a number of clinical areas.

A key support to delivery of CIPs and continuing to improve the quality of care we provide to patients are the clinical information systems available to our clinical and support staff. The hospital system is based on a 20 year old Patient Administration System (PAS). A variety of clinical systems have been developed and purchased to enhance this. The Trust has reviewed its future options and has concluded that it should procure an integrated Electronic Patient Record (EPR) system and this procurement will start in this financial year with implementation in 2014/15. The project will be clinical led as a change management initiative rather than an IT project.

These internal arrangements are also support and strengthen through external challenge and leadership. Examples of this include the restructuring of pathology services through the Transforming Pathology Partnership (TPP) and emergency and urgent care review. These developments have drawn on external experts to challenge and inform local decision making, for example through the national Emergency Care Intensive Support Team (ECIST).

Staff are actively engaged in developing CIPs through:

- Staff Conversations. Staff generated ideas with the facilitation of staff governors following the Chief Executive's Annual Plan presentations.
- The 'Bright Ideas' scheme on its intranet site. Ideas presented by staff are reviewed by the PMO and feedback given to the proposer.

A clear process is in place to sign of budgets including the CIP requirement and Board members are fully engaged and updated on CIP planning and performance.

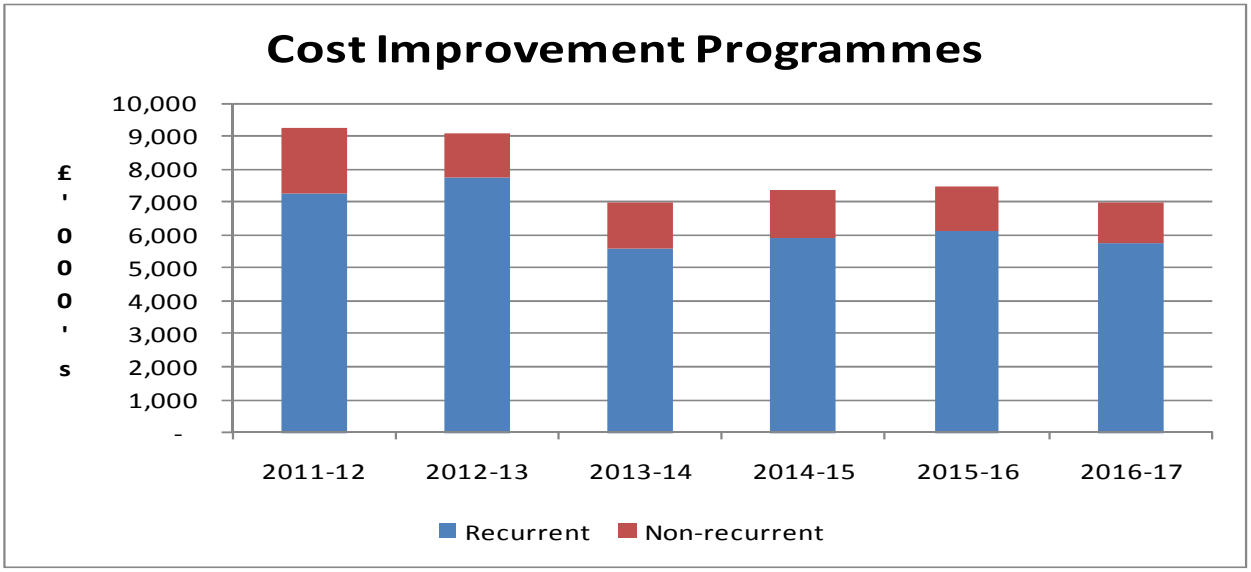
4.3 CIP profile

The Trust has a detailed Cost Improvement Plan (CIP) for the period of the forward plan. The Programme Management Office (PMO) is responsible for managing the risk assessment of CIPs, including quality and finance. Regular reports are presented on CIP progress to the Board.

The Board of Directors recognises that the implementation of these plans will be challenging and in some cases will be required the Trust to provide services in a way that is significantly different from today. However, this will be true of all NHS Trust's regardless of FT status and size.

Key to making these changes will be engaging with partner organisations, staff and the public. West Suffolk has a good track record of doing this. For example, recently the Trust has been actively engaged with external partners to explore shared on call rotas between providers. This will be in the best interests of patients because it will sustain the delivery of high quality care.

	2011-12 £'000	2012-13 £'000	2013-14 £'000	2014-15 £'000	2015-16 £'000	2016-17 £'000
Recurrent	7,250	7,743	5,600	5,890	6,143	5,766
Non-recurrent	1,983	1,355	1,400	1,473	1,307	1,241
Total CIPs	9,233	9,098	7,000	7,363	7,450	7,007
Achieved	8,852	8,587				
Recurrent	79%	85%	80%	80%	80%	80%
Non-Recurrent	21%	15%	20%	20%	20%	20%
CIP as % of cost base	5.9%	6.0%	4.4%	4.6%	4.7%	4.9%
EBITDA	5.0%	5.3%	4.9%	3.6%	2.3%	6.6%



5. Financial & Investment Strategy

The following table summarises the financial plan over the three year planning period. The main features of the plan are small increases in activity with income levels suffering from a fall in tariff, and a cost improvement plan designed to counteract the impact of inflation.

SUMMARY INCOME AND EXPENDITURE	2013-14 Plan £m	2014-15 Plan £m	2015-16 Plan £m
NHS Contract Income	145.6	147.7	149.8
Contract contingency	(1.0)	(1.0)	(1.0)
Other Income	15.7	15.9	16.1
Total Income	**160.3**	**162.6**	**164.9**
Pay Costs	108.9	109.4	111.6
Non-pay Costs	36.9	37.7	38.4
Operating Expenditure	**145.8**	**147.1**	**150.0**
Contingency and Reserves	6.6	7.5	6.7
EBITDA	**7.9**	**8.0**	**8.2**
EBITDA margin	4.9%	4.9%	5.0%
Depreciation & Impairments	4.5	4.7	4.8
Finance costs	2.4	2.4	2.4
SURPLUS/(DEFICIT)	**1.0**	**1.0**	**1.0**

Service development, for example in emergency and urgent care, is critical to improving the quality of services we provide and achieving the efficiency gains required in the plan. The integration of service quality and efficiency gains is central to the WSFT's strategy and is being driven through the clinically engaged workforce.

Key risks

Category of risk	Description of risk	Potential impacts
Quality	Reputation damage due to quality/service failure leads to reduced activity	Loss of public and GP confidence that leads to reduced referrals as a consequence of public choice. Reduction in income. Restricted authorisation / licensing by regulators. Reduced income and contractual penalties
Urgent care	Changes to the provision of services in light of national or regional recommendations, including paediatrics, stroke and smaller service specialties (cardiology, urology, and dermatology).	Potential loss of inpatient services regarding required standards for surgery and anaesthesia. Breakdown of on call arrangements due to (small) size of rota, eg cardiology, ophthalmology and urology. Potential change to cardiology service provision. Potential loss of stroke (hyper acute) services.
	Increasing emergency activity.	Potential patient safety risk due to demand and capacity. Cumulative impact of contract penalties: A&E targets, stroke targets and ambulance turnaround.
Environment & effectiveness	Implementation of Estates Strategy to provide a building environment suitable for patient care and adequately maintained with regard to backlog maintenance.	Unknown financial impact of reputational consequences. Risk of improvement notices if the Trust fails to effectively maintain building(s). Potential reputation risk of disposal strategy.

	Failure to identify and deliver the level of CIPs (cost improvement plans) to secure the long term viability of the Trust.	Capital plan would need to be reduced to reflect the reduced level of surplus. Financial Risk Rating would be adversely affected with associated impact upon service quality and potential enforcement action. Could lead to short term initiatives to reduce expenditure with potential impact upon service quality and reputational damage. Working with other organisations if local plans are insufficient to secure long term sustainability of Trust.
	Material re-organisation of pathology services across the Midlands and East of England. Proposal to move to Hub and Spoke Model.	Potential impact of GP pathology testing being removed from Trust and Trust's ability to remove fixed cost. Efficiency of remaining activity once GP pathology testing commissioned elsewhere. Staff implications, possible redundancies, lack of clarity on transitional costs and impact on WSFT's financial position. The transition phase may impact upon the Trust's ability to continue to provide a pathology service. Different IT systems across the seven partners within the TPP consortium may cause inefficiency and reduce information available to clinicians.
Workforce	Ability to meet Workforce Plan linked to the Trust's long term financial model (LTFM).	Reduction of staff costs and whole time equivalents as part of existing CIP plans. Quality and safety and impact on reputation. Adverse employee relations and staff motivation.
	Staff responsiveness to current economic/environmental challenges.	Impact of changes upon staff morale and responsiveness including resistance may lead to impact upon current discretionary efforts of staff.
Governance	Non-compliance with legislation, regulations and good practice guidelines, including failure to comply with internal policy and procedure.	Poor care and treatment of patients (impact also links to choice for local patients and GPs). Qualified registration with Regulators. Fines and civil awards. Loss of confidence. Insufficient capacity to deal with regulatory reviews (including Monitor). Potential fines and legal costs.
	Local income level at risk through changes to the tariff and/or reduced activity levels. West Suffolk CCG application of penalties through contract management and external influences/financial pressure upon NHS.	Loss of activity/income due to changes in commissioning decisions, which include: referral practices; patients' choice; and new entrants to market. Local management of relationships through contract management. Changes to local provision of services (increased use of private sector). Application of penalties risk, including *C. difficile* performance penalty (£0.75M).