South Devon Healthcare NHS
NHS Foundation Trust

Strategic Plan Document for 2013-14

South Devon Healthcare NHS Foundation Trust

Strategic Context and Direction	Strategic Statement and Objectives South Devon Healthcare NHS Foundation Trust's (SDHFT, the Trust) strategic statement remains: "To be the best provider of healthcare, delivering excellence in all that we do" This statement is under-pinned by a more detailed set of Corporate Objectives approved by the Board for this planning period: Quality: 1. Safest care: To ensure that safety and safeguarding is embedded as the Trust's foremost priority, achieving further improvements in safety and effectiveness, and ensuring regulatory compliance. 2. No delays: To minimise the time people wait to receive care from the Trust, through service improvement and re-design of pathways. 3. Best experience: To achieve the best possible service experience, learn and take action from concerns raised through the Governors, Members surveys, complaints and other feedback mechanisms. 4. Personal, Fair and Diverse: Use the Equality Delivery System to ensure that all people receive care of the highest standards and to ensure that services are accessible to all groups within our Community. 5. Delivering improved value: To support care services by achieving excellent levels of financial performance, as measured by the requirements of Monitor, and to deliver best value for taxpayers' funds. The Trust will work with its partners to deliver the challenges of QIPP (Quality, Innovation, Productivity and Prevention). Board Direction: 6. Leadership: To improve continuously the effectiveness and contribution of the Board, providing leadership and strategic direction to the Trust and the wider Health and Care Community. To build leadership capacity, capability and skills suited to a combined health and social care provider, through effective role modelling and providing tools and techniques to operational teams. To further the reputation of the Trust and strengthen relations with the clinical leadership, Local Authorities and the Council of Governors. 7. Strategy: To create an integrated provider of health and social care for the South Devon community, working with partners to define a suitable business model and to achieve Governor and Regulator support for the associated transaction. To develop an integration and organisational development plan that ensures a smooth transition to the new organisation and, in partnership with Commissioners and the Joined-Up Cabinet delivers the transformational change required to achieve success. The delivery of these objectives will be supported through a range of 'enablers' that will develop the organisation and its capacity to deliver change and improvement: 8. Workforce development: To deliver an organisational development programme that builds inclusive, accountable clinical leadership and a flexible working culture that

motivates, supports and develops our staff in meeting the challenges of organisational change, demanding performance targets and budgetary restraint whilst retaining a strong focus on service quality.

9. Innovation: To promote leading-edge development, applying this knowledge to facilitate service redesign, to drive improvements in patient care, experience and value for money. To build the Trust's reputation and presence as a provider of high quality Research and Development and Commercial Trial activities, delivering an increased portfolio and financial contribution during the year.

10. Education: To develop improved links with providers of education and the developing Academic Health Science Networks, enhancing the Trust's reputation as a provider of education.

11. Transforming and developing our estate: To invest in the estate, ensuring that we develop a safe, effective and resilient environment that promotes the most positive of experiences. To prepare a medium term strategy and integrated estates plan linking service and estates developments across the wider Health Community, supporting the service objectives of all organisations.

12. Good Citizenship & Sustainability: To recognise the Trust's position in and responsibilities to the local community. To promote the Trust's role as a key contributor to the development and sustainability of the local community; building links with the community and local schools, supporting their development, promoting inclusion and delivering the objectives outlined in the Trust's sustainability strategy.

13. Information and Information Technology: To implement the Information Technology Strategy, ensuring that the board, clinical leaders and managers receive reliable and timely business intelligence, and to focus information technology developments on improving business intelligence, clinical effectiveness, patient safety and experience.

14. Commercial Development: To maximise the contribution of commercial activities in support of the Trust's wider objectives.

<u>Strategic Position Within the Local Health Community</u>

South Devon Healthcare NHS Trust was established in 1991 and became an NHS Foundation Trust in 2007. As a medium sized District General Hospital (DGH) it provides patients in the South Devon area with a full range of secondary care services. The Trust serves a resident population of approaching 300,000 people, but this increases by as many as 100,000 visitors at any one time during the summer holiday season.

The local health system is managed by South Devon and Torbay Clinical Commissioning Group (CCG), who now represent more than 80% of Trust business. The two Local Authorities (Devon County Council and Torbay Council) have taken responsibility for public health commissioning from the 1st April 2013. The Local Authorities (LA) are therefore now commissioning sexual health and a range of related services from the Trust. This, discrete nature of the local health community makes it critical for the Trust to work in partnership with what are, effectively single commissioners. The Trust is actively supporting the local CCG and the LAs, engaging with its leadership through our 'Joined Up Cabinet', pursuing a collective ambition for an integrated model of care across the community. The local health community enters this new organisational model in a position of comparative financial strength, benefitting from the historically sound performance of NHS Torbay (previously Torbay Care Trust). However, in common with LAs across the country the challenging

budget position of Local Government partners is recognised.

North, East and West Devon Clinical Commissioning Group have a relatively small contract with the Trust, the majority of the former NHS Devon's commissioning activity having moved to South Devon and Torbay CCG in the establishment of the CCG from April 2013. NHS England, through its specialist commissioning function, its dental commissioning and Public Health England are also new commissioners for the Trust, and we are actively seeking to build strong working relationships with these commissioners. Taken together the contracts with these minor commissioners amount to £34m or 17% of total turnover.

Competition is comparatively limited in the local health community. The key features are:

- There is a small private sector provider of routine elective care in Torquay receiving a reasonably stable flow of around 25% of Orthopaedic referrals. It is at capacity with limited opportunity to expand.
- Some patients towards the North of the Teignbridge locality find it equally convenient to access either SDHFT or the Royal Devon and Exeter Foundation Trust in Exeter. There has been very little movement in the numbers of patients choosing to move between providers over the years and this is not expected to change.
- The same principle is true to the South of the patch with patients in the South Hams having the choice of Plymouth Hospitals Trust or SDHFT. There is some private sector competition in the Plymouth area although this is has historically been to a challenge to Plymouth Hospital Trust rather than SDHFT with the population, by and large being reluctant to travel.
- There is a limited exposure to the agenda driving centralisation of specialist services. During the lifetime of this plan, the only known risk is around open arterial vascular surgery – value circa £300k – which is likely to transfer to Exeter.
- The impact of any qualified provider (AQP) has been allowed for in this planning cycle. The implementation of AQP has been a challenge for commissioners and providers alike. The estimated impact of existing AQP activity is not significant at a Trust total.
- Our patient survey and staff survey results are both very positive in respect of the question asking if the respondent would recommend SDHFT as a place to receive treatment.
- In the 2012 staff survey SDHFT was ranked in the top 20% of trusts in the country on the question of recommendation as a place to work or receive treatment.

The Trust's share of the local healthcare market is not expected to change significantly during this Annual Plan period. The prevailing stable market positions have made it possible to enter into risk management agreements with commissioners, further under-pinning market share into the future. This is not expected to change over the life of this plan.

<u>Collaboration, Integration and Patient Choice</u>

Against this backdrop, much of the Trust's success and comparatively secure competitive position stems from the integrated care model developed within the local health and social care community. The most significant aspect of the Trust's strategy for this planning period is to further develop these benefits through its decision to pursue an acquisition of Torbay and South Devon Health and Care NHS Trust (TSDHCT). A business case will be presented to the NHS Trust Development Agency (TDA) on 31 May 2013, supporting our proposal to create a single, integrated health and social care provider organisation to serve our local community.

The Trust, like all providers, faces a severe demographic challenge. Demand for care is

	expected to increase by 2 to 3% per annum, and is compounded by the complexity of caring for an increasingly elderly population, often presenting with multiple diagnoses and living for many years with often numerous long term conditions. Our proposal therefore recognises the importance of health promotion as a means of reducing the incidence and toll of long-term conditions. It will aim to maximise the independence of individuals for both health and social care. When care is required, we will ensure that it is person and carer-centred. Where appropriate we will endeavour to deliver care close to home. The Trust will prioritise the joining up of community teams with the primary care teams by working with the locality groups and zones to consider the best models of care. This is to ensure a patient centred whole population approach to health and care. Local care providers in the domiciliary, nursing and care home sector are an integral part of the local infrastructure. The Trust will recognise this and build on existing arrangements with nursing homes to provide and receive support from these care providers within an agreed network arrangement. The aim will be to support a vibrant and resilient community of providers. We will ensure that, as far as possible, the information we use to help deliver care is owned by individuals and shared appropriately by care professionals to deliver world-class care. When higher levels of dependency and care are required, we will endeavour to deliver this in a planned and co-ordinated manner, aiming to reduce the amount of unscheduled care that is delivered. We recognise that certain levels of specialist care cannot be provided to the requisite standard in a local setting and will ensure that our population has access to the highest standards of specialist care when necessary. This may be provided within the District General Hospital (DGH), at regional or national centres. In the future, the DGH is likely to be smaller but looking after patients who have higher levels of acute dependency. When individuals are reaching the end of life, we will endeavour to ensure that their wishes are supported and that care is delivered appropriately. We recognise that there are communities with exceptional needs, be that due to age, disability, or deprivation. We will endeavour to ensure that our care system identifies and responds appropriately to minimise the inequalities that arise from these circumstances. In the new organisation we will see: • Joined-up professional practice with the further integration of health and social care teams; staff working flexibly to deliver care in the most appropriate setting, seven days a week, where appropriate • A networked approach with primary care, mental health and the independent and voluntary sector; enabling increased value through shared expertise to encourage people to stay well • Health and social care records that are linked to ensure that information is not duplicated and that when people access the health and care system, information is accessible from any parts of the organisation, at the point of need. We will also make this information available to the users of our services • An estate that is designed to enable the delivery of high quality health and care services now and in the future and where there is increasing synergy between health, care,

	housing and strategic planning across South Devon and Torbay • A flexible financial framework that allows services to be delivered around the needs of our users • New organisational structures and governance work-streams to support the delivery and provide assurance of high-quality care • Care focused on the individual The Trust's business case describes a model of care that is cost effective into the future and, importantly accommodates the increasing demographic demand within a financial environment characterised by flat or negative real terms financial growth across the wider care system. The new organisation, with a turnover in excess of £350m, is of sufficient size to operate effectively into the future. Whilst clearly seeking improvements in the wider care system as a primary objective, this 'critical mass' is also a major factor in the Trust's decision to pursue the acquisition. Going forward, it creates the best environment in which the maximum range of secondary care services can be maintained locally. The Trust recognises the need, now to engage more formally with the Co-operation and Competition Directorate of Monitor and, subsequently the Office of Fair Trading, to secure agreement to the proposed transaction. The Trust believes that the 'vertical' nature of the integration limits the most immediate effects on competition in the local market and is confident that, by demonstrating significant benefits to patients, any perceived competition impact will be offset. Given that the Business Case is yet to be considered by the TDA, the remainder of this Annual Plan submission and its detailed appendices necessarily focuses on the business on the existing Trust. That said, the acquisition of TSDHCT is the most significant aspect of the Trust's strategic plan in this period.
	<u>Threats and Opportunities from Changes in Local Commissioning Intentions</u> Activity plans for the period of this plan have been created jointly with, and with output agreed by, CCG colleagues, using well established, empirically proven models. The demand profile within these models is based on historic experience and updated by clinical teams to reflect known changes in service patterns, allowing particularly for the introduction of new therapies and technologies. For elective care, additional activity has been built into models to enable consistent delivery of the referral to treatment time (RTT) standards at specialty level, as required under the terms of the standard NHS Acute Services Contract. A total of 400, predominantly Orthopaedics cases in excess of the recurring run rate are built into plans in 2013/14. The Trust experienced a significant (6%) increase in demand for urgent and non-elective care in 2012/13. However, demand in 2011/12 was unusually low and, when examined over a five year period, growth has been reasonably consistent at around 2% per annum. In global terms, this level of growth has, therefore been for the duration of this plan, although detailed specialty level modelling shows growth of up to 9% in some areas. The model output varies at specialty level, with maximum of 7% growth on 2012/13 in some areas, and is broadly consistent with demand profiles seen in previous years. The only significant service change included in the plan period is the repatriation of some neurology activity, specifically neurophysiology and multiple sclerosis (MS) services, from

	other local NHS providers. The local CCG's resultant commissioning intentions have been accommodated with the financial plans for 2013/14. No demand management plans have, therefore developed under the Quality, Innovation, Productivity and Prevention (QIPP) agenda. Rather than attempting to secure change through contractual routes, the CCG prefer, in conjunction with the Trust, aim to this challenge in the longer term through the cost effective delivery of integrated care The CCG has extended Any Qualified Provider (AQP) contracts to a number of additional providers to deliver audiology, MRI and Non Obstetric Ultrasound. The impact assessment of these new providers is not expected to be significant at Trust level. However there are many issues in operationalising the pathways as defined under the AQP tendering process. The Trust will continue to support the pathway work with commissioners in each of these areas to secure the most sensible outcome possible for patients. The Trust is exploring, with three other Trusts in Devon and Cornwall, the creation of a joint pathology service, seeing this as critical to ensure not only cost effective delivery of in-house services, but to ensure retention of GP Direct Access contracts, which represent some 60% of all pathology activity. The CQUIN agreement with commissioners provides for incentives across a number of innovative areas which will assist in developing the Trusts services. This includes rolling out enhanced recovery techniques for medical patients, productive discharge and developments in heart failure services. The Specialist Commissioning Team have issued a large number of draft service specifications which are still going through review processes as a result of consultation. At this stage the Trust has been informed not to expect many amendments to the draft specifications. The Trust has begun a detailed clinical assessment of each specification and will conclude an impact assessment when the final specifications are all confirmed. The operational and clinical teams are working closely through the inter provider clinical networks and with the local team of NHS England to ensure we can confirm compliance with the specifications or seek derogation. The timescale for assessment against the service specification has understandably been extended to the October 2013 and the Trust is confident internal assessment of compliance will be complete within this timescale. The Trust plans a significant expansion for the Pharmacy Manufacturing Unit (PMU). Work has begun on the new facility which will be handed over for fit out in November 2013. Following its fit out, the new unit is expected to be operating from the Autumn of 2014. As well as providing a secure supply of pharmaceutical products to the NHS the PMU will provide a growing revenue stream to the Trust, supporting capital investment plans into the future. The Trust is developing its capacity to secure benefit from its Research and Development (R&D) and Innovation activities. The Trust has a range of projects in the pipeline from which it expects to deliver value from Intellectual Property (IP) over the lifetime of this plan; the most significant being 'Hiblio', an on-line library of training, patient information and public health service. The Trust will also actively engage with the newly formed Academic Health Science Network for the South West, using its expertise to leverage greater opportunities. The Trust also believes that there is a significant opportunity to market an integrated health provider, especially one serving a population with an age profile 20 years ahead of the UK average, as being particularly suitable for clinical trials of therapies to treat age related

	conditions such as dementia.
Approach taken to quality (including patient safety, clinical effectiveness and patient experience)	Delivering high quality services is critical to the future sustainability of the organisation. As such ensuring quality is an integral part of the Trust's strategy and vision. The Trust has no conditions on registration with the Care Quality Commission. Under the Clinical Negligence Scheme for Trusts (CNST), the Trust's maternity services have recently been assessed at level 3 under the Maternity Clinical Risk Management Standards. The Trust's core services have, during 2012/13 been assessed at level 1. The Trust is preparing for assessment under level 2 for core services, most likely in early 2014/15, and will continue to review and monitor itself against the CNST standards and CQC compliance framework throughout. The Trust has agreed framework for CQUINN, under which progressive targets are sets against a range of enduring priorities including dementia, carers, heart failure, discharge, pressure ulcer reduction, enhanced recovery in medicine, timeliness of information to GPs and alcohol. The Trust will focus quality improvement activities in support of the delivery three key target areas. Recognising the pressures being experienced in the urgent care system, both locally and nationally, the Trust will develop 7 day working / services, shared decision making and operational measures to improve patient flow. This will not only underpin delivery of the 95% A&E standard but also ensure that standards of care and patient experience are maintained and delivered consistently throughout the week. The Trust has not declared a risk of non-delivery against the A&E standard in its Annual Plan governance template, but recognises the demand pressures and the fact that the forthcoming implementation of the 111 service could compound this pressure. The Trust has reviewed operational and escalation processes in taking this decision, has considered the impact of demand peak on historic performance and determined that it is unlikely to result in failing against the 95% standard across a full quarter. In support of elective waiting time standards, and to support the specialty level delivery both expected by patients and required under the terms of the Acute Services Contract, the Trust is engaged in a programme to deliver a step improvement in theatre efficiency. Despite extremely low levels of hospital acquired infection – 4 cases - in the six months preceding this submission, the Trust recognises the challenge presented by the high incidence of C-Diff infection existing in the Community. The Trust will continue the actions that have resulted in this reduction in hospital acquired infection, investing in further Bioquell machines to enhance deep clean capacity. The Trust will actively engage with Community Teams, providing all support possible to reduce the rates of infection in the wider community. These areas of quality improvement and service redesign are managed through the Continuous Improvement Programme (CIP) Board and through the Trust's Clinical Management Group. The Medical Director and Director of Nursing & Patient Experience lead on quality. The Board derives assurance regarding the quality of its services through a number of mechanisms including: • Performance dashboards and data books which include quality indicators. These are shared within the organisation and at Board Level. Action plans support areas of

quality improvement or non-compliance against these indicators.

- Five governance Workstreams (below) which report to the Trust Board. Each Workstream includes in its membership senior clinicians, nurse leads, Trust executives and is chaired by a Non-Executive Director. Governors attend as observers and the local commissioners attend both the Safety and Experience Committees. Each is tasked with reviewing sources of assurance in their specific area of responsibility.

- Each Directorate/Department produces an individual Quality Account which is presented to Workstream 1 with subsequent reporting to the Board.

Work stream1	Work stream 2	Work stream 3	Work stream 4	Work stream 5
Patient safety *(incorporating clinical effectiveness)*	Patient experience & community partnerships	Finance Committee	Workforce & educational governance	Infrastructure & environment

- Annual Quality Account and progress against annual quality improvement priorities reported to the Board and to clinical teams.

- Executive sponsorship and clinical leadership for quality improvement / service redesign programmes.

- The Trust uses Monitor's Quality Governance Framework in setting up systems and structures to monitor quality. The Trust undertakes a regular review of its governance systems, processes and controls.

- Information is also shared with commissioners with performance reviewed against a range of quality measures.

- The Trust is also part of the South of England Quality Improvement Programme.

Clinical Strategy

(Consistent with information contained within the Trust's published Quality Account).

<u>Service Line Management Strategy</u>

The Trust has a strong model of medical management, with all clinical services having an identified Clinical Lead. Clinical Leads are actively involved in most aspects of business management, from planning to performance and financial management.

The Trust has used Service Line Reporting (SLR) data to support clinical and management teams to identify services where there are opportunities to improve quality and efficiency. SLR data is also used to inform the allocation of cost improvement targets.

Service Line Management (SLM) has been introduced in a number of services giving clinical teams greater freedoms to manage their service lines and drive efficiency and quality. A clear accountability framework has been produced to describe the responsibilities and accountabilities of Service Line Directors, the criteria that must be met for Service Lines to be established and the process through which the levels of autonomy of the service lines are

	managed. Key lessons to date have been to promote the ownership of auditable data by the clinical teams and to ensure its effective presentation. Using patient level information at consultant level has helped to develop that ownership. The Trust has also been part of the 'Albatross' patient level bench marking group which has been used by Monitor to set its initial view on Patient Level Costing.
	<u>Clinical Workforce Strategy</u> The Trust's Care Strategy includes the need to build on and improve integrated services across the whole health and social care sector and to develop 7 day a week services where this would support service delivery and provide our patients and clients with more and appropriate choice. Within this context and taking account of increases in demand the following are the key features of the Clinical Workforce Strategy: • Developing the medical workforce to ensure assessment and diagnosis at the "front door" and directing patients to the most appropriate services. At the same time it will be critical to manage the reduction in Junior Doctors training placements across all specialties. A review is currently being undertaken which includes delivering and planning increased medical input in Emergency Services and the Community, developing appropriate and sustainable Career Grades, the use of extended Nurse roles and the use of Physicians Assistants. • On-going activity to fill vacant nursing posts and reduce agency and bank usage, including recruitment drives, changes to bank terms and conditions, targeting newly qualified staff, the on-going education and development of Assistant Practitioners. • Flexing our workforce across our wider community to manage CIP and direct resources to the front line. The above and changes in specific specialties are reflected in workforce plans which predict, within a net overall reduction in staff numbers, an investment in front line services. It is anticipated, therefore that the changes required can be made whilst making the necessary cost reductions as demonstrated in the analysis of workforce numbers and pay costs.
	<u>Clinical Sustainability</u> The principal area where the Trust services could potentially lack critical mass is vascular surgery. Plans have been agreed with Commissioners to develop a vascular service linked with the Royal Devon and Exeter Hospital, where our two vascular surgeons will join the four surgeons there to perform a six man unit, providing in-patient surgical treatment for arterial conditions. Out-patient and venous services would remain on site. Recruitment plans are in place for the majority of services that have consultant cover below those recommended by the Royal College, particularly Rheumatology and Dermatology. The Trust agreed a development plan for Acute Paediatrics with Commissioners during the course of 2012/13. The recruitment aspect of this plan is largely complete following the appointment of three Consultant posts, who will come into post in 2013/14. This will underpin acute paediatric on call rotas and enable the development of a short stay assessment service. Pilots have been carried out in extending the working week for specialist physicians covering in-patients units in a move toward delivering 7 day care; negotiations to make this a

	permanent change will be progressed in 2013/14. In support of this, it is further planned to increase the number of acute physicians to provide 12 hour cover for the Emergency Admissions Unit, with three ward rounds per day. This will also further enable a step towards 7 day working for the medical specialities.
Productivity & Efficiency	The Trusts benchmarked position on a range of efficiency measures demonstrates good performance. SDHFT has very low length of stay and a 2011/12 reference cost index of 89; 96 adjusted for market forces. The ability to deliver further efficiencies in the health and care system through integration will be evidenced in the acquisition business case. Medical admissions over the past 18 months have been rising in line with nationally reported trends, at around 3% per annum. This has required additional staffing and opening of escalation beds in order to secure a level of capacity to manage safely. In order to respond quickly increased use of bank and agency staffing has pushed up costs. It has been estimated that these additional costs exceeded the additional income relating to increased admissions by approximately £1.2m. In part this was due to the 2008/09 baseline being exceeded at the beginning of the year and the additional activity attracting only 30% of tariff. The escalation capacity is now being staffed substantively and this will enable us to deliver more sustainably both from a service and a financial perspective. Plans are in place to further develop the in house nurse bank and eradicate agency spend, running at £3.6m in 2012/13, by September 2013. There are three key areas of Trust wide productivity being pursued during 2013/14; ○ Theatre Productivity – Plans are in place to develop in-house capacity sufficient to enable the repatriation of £3m of activity scheduled to be provided in the independent sector. A net contribution of at least £1.5m is expected. ○ Patient Flow – A range of actions are scheduled across all aspect of 'flow' for urgent care, with a target saving of £600k ○ Rostering – The Trust has introduced a standard 12 hour shift pattern in 2012/13 providing more continuity of care and, through fewer handovers, reducing clinical risk. This programme will roll forward into this Annual Plan, with focus on ensuring effective rostering and compliance with establishment levels. More detail on each of these and other efficiency plans is described in the Continuous Improvement Section (CIP) of this plan.
	<u>CIP Governance</u> The Trust has a consistent record of CIP delivery, backed up a robust system of CIP Programme Management. For the three financial years, between 1st April 2010 and 31st March 2013, the Trust has over-delivered against its CIP Target. This has enabled the Trust has meet its planned Surplus and retain its high Financial Risk Rating.

The following table illustrates delivery over the last 3 financial years':

	12/13 £'m	11/12 £'m	10/11 £'m
Target	9.3	8.9	11.3
Actual	10.1	9.5	11.3
Variance	-0.9	-0.6	-0.0
	Surplus	Surplus	Surplus

Delivery broken down by Recurrent / N/R split :

	12/13 £'m	11/12 £'m	10/11 £'m
Target	9.3	8.9	11.3
Delivery:			
Recurrent	5.0	7.7	4.5
Non Recurrent	5.1	1.8	6.8
Total Delivery	**10.1**	**9.5**	**11.3**
Variance	-0.9	-0.6	-0.0
	Surplus	Surplus	Surplus

The Trust has ambitious plans to implement systems to constantly improve quality, remove waste, innovate and therefore improve efficiency.

The Trust is using SLR data to help identify the Clinical Specialties where there are opportunities to improve quality and efficiency.

*Lean** based Continuous Improvement training has been introduced across the organisation to provide Clinicians with tools to undertake these Specialty based service reviews. The reviews will focus on the principle of care being right, first time on time for every patient and should not be expected to have any detrimental impact on service quality.

*Lean methodologies are extensively and successfully used in world class manufacturing and service provider organisations, such as Toyota and Unipart and have also successfully adapted within healthcare organisations, such as *Jonkoping Health Care*.

	The programme is prioritised to allow the roll out of training to best fit with Clinical workload and make best use of scarce Clinical and Managerial time. Although project reviews have started, benefits will materialise during the life of this plan. The project will be rolled out across the whole organisation and become part of "business as usual" and will be a significant enabler to deliver future CIP targets. All Specialties will be trained and implement this methodology and all staff will play a part in continuously improving the quality of healthcare. This will become the main route through which CIP is delivered in the future. During 2013/14 the Trust has plans to introduce a formal Improvement and Innovation Strategy which will describe how to better harness the work that the Innovation, Training, Transformation and IT team undertake to deliver further efficiencies. <u>Project Management Office (PMO)</u> The Trust has, for a number of years had a robust Programme Management function in place, overseen by a CIP Programme Board, with Board and senior clinical membership. CIP proposals are collected as part of the business planning process. Details of the schemes are captured and schemes delivering values in excess of £50k (net) are recorded on CIP Mandates (PIDs). Projects are submitted to a 'CIP Scrutiny Board' to assess viability. Membership includes Medical Director, Director of Nursing and Quality, Finance Director and CIP Programme Director. A Quality Impact Assessment is undertaken to ensure no adverse risks to patients exist. Projects with risks are only deemed suitable to proceed if mitigating circumstances exist to remove that risk. The projects are then approved by the Board before being shared with the Commissioners, who also undertake their own Quality Impact Assessment. Once schemes are approved they are formally programme managed. They are recorded on a database which is linked to the general ledger to identify scheme and delivery progress. Progress is reported to the CIP Programme Board where progress is monitored, delays challenged and advice provided to the managers responsible for delivery. Both Internal and External Audit devote considerable time allocation within the work programme to inspect the leadership and assurance framework for the Trust's CIP schemes. The 2012/13 report was complimentary of the programme management arrangements and recommendations for improvements in other areas have either been implemented or are being worked on.
	<u>CIP Profile</u> The CIP schemes for 2013/14, the most significant of which are listed in Appendix 2, are as follows: • Procurement savings: The Trust allocates this out to each Division, assigning a qualified procurement professional to support the programme. The Trust is also a member of the Peninsula Procurement Alliance, through which contracts are consolidated across organisations and volume and commitment discounts are sought. Operational managers and clinical staff are required to cooperate on these contracts across the membership. This partnership has been successfully delivering verified savings for nearly ten years.

	• Theatre productivity and scheduling savings: The Trust has outsourced operations to the private sector to a value of £1.5m in 2012/13, a figure which has been increased by £3m in 2013/14 as commissioners commit to reducing waiting list backlogs in support of RTT delivery. Analysis of theatre data suggests there is potential to improve utilisation and the flow of patients, maximising the productive time delivered by each theatre. This has the potential to provide on-going capacity to eliminate work being outsourced and to deliver future growth. • Nurse rostering savings: The Trust has introduced an electronic rostering system to drive improved staff utilisation, allocating staff according to clinical need and reducing the need for bank and agency resources to maintain safe staffing levels. The Chief Executive and the Director of Nursing and Quality are driving this project with the senior nurses. • Patient flow across acute and community savings: There are good working relationships across the community. There are a number of joint operational groups beneath a 'Joined up' Clinical Cabinet working to put people at the centre of what we all do. The purpose of these groups is to make the journey the right one, at the right time and this is expected to continue to facilitate improvements in the system and will enable appropriate non-elective patients to be kept out of the acute hospital, as well as increase volumes of elective activity, reduce length of stay, and reduce the need for escalation beds. • Pharmacy Manufacturing Unit (PMU) savings: Savings will be made through increased productivity achieved by using Lean techniques and increased sales from the introduction of a new marketing manager. • Estates savings (and revenue improvement): Numerous estates savings schemes include energy consumption savings to be achieved through new boilers and planned savings on clinical waste contracts. In addition, there are plans to increase revenue from catering sales. • Clinical Division savings: Various schemes are in place to achieve savings, including the introduction of the Outpatient Pharmacy, skill mix changes and elective implant rationalisation. • IT developments savings: Savings will be achieved by way of automated outpatient registration, new A&E system with automated coding and paperless solutions. The schemes will be enhanced in subsequent years with a range of programmes, including: • Information technology investments joining up systems across the wider health community will deliver efficiencies to contribute to managing the increase in activity, assisting the movement of activity between settings of care and contribute to CIP. These initiatives include e-prescribing, order communications and single community care record. • Further back-office savings will continue to be sought into the medium term. As systems become integrated across our local community, more benefits will be identified and delivered. The Trust is also pursuing 'shared service' solutions for a range of services, partnering with other Provider Trusts in Devon and Cornwall. • Estates reviews and the effective application of modern equivalent asset valuations. • Extending medical and nurse staffing models into the community, partnering colleagues

in primary care to better manage demand for services at source.

- The levels of therapies and the ability to address the length of stay.

- A formal review of all services which, on the basis of SLR data, appear to be loss making, addressing contractual and productivity issues as necessary.

- Formalising systems of 7 day working, utilising the asset base more effectively and delivering productivity, particularly from out-patient, diagnostic and theatre facilities. Equally, working with partners to develop flow across the urgent care system including 24/7 service across health and social care should reduce the overall capacity needed to deal with increased throughput.

- Community diagnostic hubs to reduce the need to secondary care interventions, increased support for primary care management of long term conditions.

CIP Enablers

As part of the Trust's business planning and management processes, service managers and clinical staff lead the identification of opportunities for service improvement and cost reduction. In common with most organisations Continuous Improvement Programme (CIP) schemes are a combination of:

- Ideas from operational staff, looking to improve patient safety, remove barriers to better pathways of care, such as delayed discharge; or remove waste and duplicated effort from day to day tasks.
- Suggestions from Senior Management, Finance & Performance team etc., based on best practices at other Trusts or outputs received from the NHS Benchmarking Club (to which the Trust is a member).
- Requirements from Commissioners related to changes in service delivery/QIPP schemes.

Clinical leadership and engagement is underpinned by an approach to 'cost improvement' through a 'continuous improvement' methodology that focuses on improving quality and safety; the operating principle being that right care, first time, on time for each patient is, ultimately more efficient. From this approach, and best practise information available, we have concluded that "the path to improved safety and quality is the same path to reduced costs".

The resultant CIP programme is a combination of 'traditional' savings schemes, including procurement, shared support services and maximising non-commissioned income, coupled with a series of transformational programmes, developing changed clinical practices, ultimately requiring fewer beds, theatres and out-patient session, with the consequent reduction in cost. The key enabler to the Programme is operational and project management resource to implement service change, the levels of which are kept under constant review. We have plans in future, by agreement with our local CCG, to combine commissioning and operational resource, to create a wider pool of change management resource.

Some elements of the Trust's capital programme underpin savings plans during the planning period. Most notable are IT investments in Order Communications, E-Prescribing and a new Emergency Department system, all of which further progression towards a paperless environment. This is supplemented by the development of a clinical portal, bring these and

	all other major clinical systems together through a single 'front end', supported by extensive wireless and portable device roll out. Through this, clinician's efficiency at the bedside will be greatly enhanced, enabling not only better throughput and reduced lengths of stay, but ensuring that key clinical information is shared with appropriate clinicians on a timely basis. Some estates based investments are also scheduled in support of CIP savings throughout the lifetime of this plan. These investments are required to reconfigure the estate to facilitate pathway improvements. An example would be the creation of an out-patient hub for long term conditions with facilities that for one-stop treatment services; a investment derived from service improvement plans developed by the Rheumatology and Dermatology teams. During the course of this planning period, the Trust will finalise the expansion of its Pharmacy Manufacturing Unit, the future revenues of which will make a significant contribution to Trust surplus going forward.
	<u>Quality Impact of CIPs</u> All CIP schemes are Quality Impact Assessed by the Clinical Executives to ensure no adverse patient safety or quality risks exist in any CIP scheme. Where risks exist, the scheme will only be allowed to proceed if sufficient mitigating circumstances have been put in place. All new CIP Schemes are referred to the CIP Scrutiny Committee whose membership consists of the Medical Director, Director of Nursing and Quality, Finance Director and CIP Programme Director. Schemes are presented to the Committee who consider whether there is likely to be any patient safety, clinical effectiveness or patient experience risks. Larger projects are risk rated using a scoring methodology; total scores indicate whether the project is low, medium or high risk. A total of 67 Divisional and Trust-wide CIP Schemes have been reviewed to date in the 2013/14 cycle. A total of 65 schemes were deemed to have no adverse patient safety, clinical effectiveness and patient experience risks. Many schemes enhanced the patient experience. The remaining two schemes were felt to have a medium risk but the committee felt the mitigating circumstances were acceptable. The outcome of this exercise has been submitted to the Board for ratification and then passed to the Commissioner in order that they can undertake their own Quality Impact Assessment. Quality Improvement projects are also monitored through our current CIP governance arrangements. The qualitative indicators are collected on the CIP Mandate and monitored at regular project meetings. Larger projects are managed via the CIP board. For example one of the largest projects of 2012/13 was implementing 12 hour shifts for Nursing staff. This had the benefit of releasing time saved from shift overlap and standardisation of practices to improve the quality of patient care. Quality measures were undertaken before and after implementation, as follows: • Impact of Staff: Staff well-being questionnaires • Impact on Patients: Patient questionnaires, number of falls, length of stay, infection rates, use of temporary staff, etc.

Financial & Investment Strategy

The Trust has a strong financial track record which continued in 2012/13. Subject to Monitor's final assessment, the Trust achieved a Financial Risk Rating of 4.

The Trust has seen non-elective pressure in 2012/13 which has resulted in the opening of escalation capacity to cope with demand. The Trust has maintained the national A&E standard throughout despite significant pressure seen both locally and nationally. This unplanned activity has contributed to the challenges in delivering the capital programme in 2012/13. The Trust has managed its finances through this period to deliver the planned surplus, though additional CIP has been required as the income derived from increased admissions has not covered the cost of delivery.

With main Commissioners, the Trust has contracted for the outturn levels of activity, uplifted for forecast growth in 2013/14 and is substantiating the former escalation capacity to reduce the reliance on agency staffing and better cope with the demand.

The Trust has delivered £0.9m of savings in excess of its CIP programme in 2012/13, although the non-recurrent element was higher than expected. The CIP programme for 2013/14, at £11.4m represents a savings target of a little under 5% (based on income). The programme developed to deliver this target has undergone a formal Quality Impact Assessment by the Clinical Executives, Board and the CCG. Whilst challenging, the Trust has commitment from commissioners to fund the delivery of £3m of extra activity to reduce waiting times. Historically the Trust has outsourced around £1.5m per annum to other providers. This creates a significant opportunity to increase in-house capacity, improve standards of care and realise substantial cost reduction.

The table below sets out the headline financial plan for the Trust over the period of this Annual Plan submission:

	2012-13 Actual (£m)	**2013-14 Plan (£m)**	**2014-15 Plan (£m)**	**2015-16 Plan (£m)**
Total Income	231.3	233.4	233.3	234.9
Total Operating Expenses	-217.5	-218.2	-215.6	-215.9
EBITDA	13.8	15.2	17.7	19.0
I&E* Surplus (normalised)	**2.6**	**2.4**	**3.0**	**2.6**
Cash	**16.6**	**16.8**	**17.1**	**17.4**
Capital Expenditure	**16.8**	**28.7**	**31.6**	**15.3**
CIP	**10.1**	**11.4**	**11.4**	**9.0**

*Income and expenditure

	For 2013-14 and beyond, the Trust will continue to develop its Pharmacy Manufacturing business which, through increased productivity from Lean techniques and sales growth, is expected to deliver a further £500k contribution to the Trust's position. Further information has been provided in Appendix 1 – Financial commentary.
	<u>Key Revenue Investments</u> The Trust will invest in a significant increase in elective capacity 2013/14 to deliver the waiting list reduction commissioned by the South Devon and Torbay CCG. The Trust will be making targeted investments to improve productivity in theatres, delivering as much of this capacity as possible within core resources. Further investment in extended days, seven day working and a contingency for independent sector provision will bring costs to a budgeted £1.5m. A budget of £1.0m has been set for the acquisition of Torbay and Southern Devon Health and Care NHS Trust. The formal establishment of former escalation beds has been effected through budgets for 2013/14 following the CCG agreement to commission outturn levels of non-elective activity plus 1% growth. This cost is already in the run rate as the Trust has had its escalation beds open most of the year and was in the process of recruiting permanent nursing staff towards the end of 2012/13. <u>Key capital Investments</u> The Trust continues to address the backlog maintenance risk identified in previous years. Due to the potential acquisition of Torbay and Southern Devon Health and Care NHS Trust the Trust is not planning to apply for new loan in 2013/14 but will drawdown existing loan agreed to concentrate on completing the schemes approved to date. The FT has prepared a plan for future years to address the highest risk estate and medical equipment issues and key strategic Information Technology requirements. This has been kept within existing old prudential borrowing limits in order to maintain appropriate financial discipline in a period which is expected to be more finically challenging to all providers. The capital programme for 2014/15 and beyond will be reviewed, and could change significantly, if the acquisition of Torbay and Southern Devon Health and Care NHS Trust proceeds.
	<u>Key risks to achieving the financial strategy and mitigations</u> The delivery of the CIP programme represents the most significant challenge, not just to this Trust but to all provider organisations. The Trust has a number of key schemes that will be subject to rigorous programme management. The Trust has a limited reserve and will manage investments and is expecting to agree over performance on the 2012/13 contract which it will used to mitigate the risk in this area. Secondly, the Trust saw significant growth above the historic trend, in non-elective activity in 2012/13 which had not been planned. This resulted in capacity being opened at premium rates, and this activity being delivered at a cost substantially in excess of tariff. The risk of this continuing is being addressed through the 'Joined-Up Cabinet' through which local system leaders - commissioners, hospital services, community services and Local

	Authorities - work together to manage the issue. Alongside this, the Trust is staffing increased bed capacity with permanent nursing staff to keep the costs to a minimum. The acquisition process of the Community and adult social care organisation will help the management of these issues in the longer term. The outline Business case has been submitted to the Trust Development Agency.