University Hospital Southampton NHS
NHS Foundation Trust

Strategic Plan Document for 2013-14

University Hospital Southampton 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.

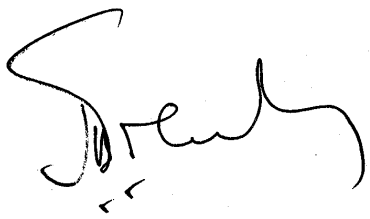
In signing below, the Trust is confirming that:

- **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)*	**John Trewby**

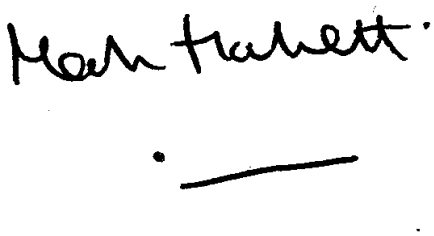
Signature



Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	**Mark Hackett**

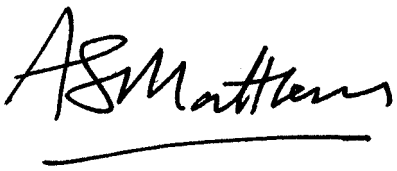
Signature



Approved on behalf of the Board of Directors by:

Name *(Finance Director/ Deputy CEO)*	**Alastair Matthews**

Signature



EXECUTIVE SUMMARY

The Trust remains committed to the 2020Vision and delivery of quality services to both the local population and via wider tertiary services; at regional and national levels. This commitment is underpinned by delivery of the Trust's patient experience and safety strategies which will continue to provide high quality and safe care in a highly complex system, together with high levels of patient and staff satisfaction based on a culture of the Trust values.

The 2020Vision enables the Trust to attract and retain high calibre staff to deliver NHS services safely and sustainably, together with world class research through the strong partnership that the Trust has developed with the University of Southampton. The Trust will build on this research base to become an Academic Health Science Centre, which will enable it to exploit opportunities in research, education and enterprise, whilst also significantly contributing to these fields. The Trust is now recognised as a major teaching hospital and is committed to delivering excellent education and training to both students and staff.

The current economic climate has led to the development of QIPP plans that will manage growing demand for services, coupled with capacity plans that will enable the Trust to meet key performance targets. The pressures on emergency departments across the country are now widely reported in the media due to demand and capacity issues. The Trust became a major trauma centre for both adults and paediatrics from April 2012 and is now treating an increasingly complex case mix, with patients

often requiring long-term care and rehabilitation.

Following demand growth in the local health system, the priority over the first year of the plan will be to consolidate. The Trust plans to invest £8.1m in capacity to meet rising demand which will enable it to continue to deliver quality, reduce operational pressures and deliver key performance targets. The ED four hour wait and referral to treatment targets (across all specialties) have recently been compromised due to growing demand, but plans are now in place to fully meet these targets by quarter three 2013/14. However, the Trust is still reliant on, and will continue to work with, partners and agencies to improve patient pathways and flow in the local health system. Whilst this will manage demand and improve quality a further challenge will result from an ageing population which will also increase demand for management of long-term conditions putting further pressure on the health system.

Achieving the balance of work undertaken at the Trust will be vital to securing long-term financial stability. With growth in emergency work, it is essential that the elective programme is deliverable and the Trust will be dependent upon the health system and partners to ensure patient pathways, flow and capacity are aligned. This will promote closer collaborative working and the reduction of organisational boundaries, as the patient pathway will be the focus to achieve better patient experience, outcomes and efficiencies. It will continue to be a priority to develop the Trust's services in a planned way with commissioners and partners fully engaged.

This plan recognises that the market has changed with the NHS commissioning restructuring leading to NHS England now being the greatest commissioner of Trust activity, followed by local clinical commissioning groups. The specialist specification consultation that commenced in January 2013 has started the process of bringing services to a common national standard of care, together with potential centralisation in some cases, which will be both an opportunity and a threat to the Trust. The Trust has recently seen Winchester and Basingstoke NHS Hospitals merge into Hampshire Hospitals NHS FT, followed by a strong strategic intent expressed by that Trust to expand traditional boundaries and services provided. Bournemouth and Poole NHS Foundation Trusts are also seeking to merge. These mergers, together with increasing 'any qualified provider' and private sector entrants, mean that the market will be constantly changing. The ISTC tender due in November 2015 will also be a key strategic priority depending on whether there is an opportunity for the Trust or not and how this may impact the organisation in future. The ISTC now undertakes much of the non-complex work the Trust previously provided which was important for managing patient flow and training of staff.

In order to retain a balanced portfolio of services, and ensure the Trust's financial stability is not solely reliant on NHS clinical income, commercial and charity partnerships and services will be expanded. Initiatives to grow income will include the development of education, research, private patient services, parent accommodation and a front entrance development schemes. The development of the Trust Children's Hospital will also be a key critical success factor of the 2020Vision and will enable the Trust to become the major provider for paediatric patients on the south coast; supported by a dedicated charity campaign. The Trust has also had an excellent track record of low reference costs and sustained delivery of cost improvement programmes historically which it will continue, to ensure the Trust utilises finite resources and capacity effectively and efficiently.

Over the next three years the Trust aims to deliver a pre-impairment surplus of at least one percent each year. This reflects a recognition that the Trust must continue to prioritise investment in service quality, invest in key areas and service its debt to maintain liquidity. The financial template indicates an FRR of 2 for the first two quarters of 2013/14 before returning to an FRR of 3. This is driven by a one off exceptional transaction which the Trust has advised Monitor about. The Trust expects this transaction will be normalised after which the Trust expects to deliver an FRR of 3 throughout the year. The Trust anticipates that under the proposed new continuity of service risk a rating of 3 will be

delivered across the three year period.

1. STRATEGIC CONTEXT

1.1 Vision Statement

"Our goal is to be the country's leading centre of clinical and academic achievement and establish a world-class reputation by 2020. We will constantly improve patient care and foster innovation in an organisation that exceeds the expectations of patients and meets the needs of its purchasers and providers. At the same time we will offer a more attractive place to work, learn and research than any of our competitors and be rated by our customers as consistently excellent in everything we do.

Achieving this ambition will challenge us to grow our income and reduce our costs so that we can re-invest 5-7 per cent of our turnover in the organisation each year. We will need to be less centred on traditional district general hospital services and more externally focused throughout the organisation, in order to grow our regional and supra-regional services significantly. We will work more closely with the University of Southampton and other academic institutions and provide the service that our customers want instead of simply delivering the product that we have traditionally provided.

As an organisation we will be more flexible, less bureaucratic and faster at delivering excellence to our patients, purchasers and providers. We will become a hospital that we would choose for the care of our own families.

We believe that by working together and embracing change we can achieve our stated goals and the trust will truly deliver its duties to the public."

To support delivery of the 2020Vision, the Trust has set itself three patient centred strategic objectives:

- SO1: Trusted on quality: trusted by staff, patients and the public to provide high quality services
- SO2: Delivering for taxpayers: delivering the services commissioners want and taxpayers can understand and afford
- SO3: Excellence in healthcare: developing better treatment for patients and developing future healthcare professionals

1.2 Market Assessment

The Trust operates within a health economy that serves a local population of circa 1.9 million and covers Southampton City and West Hampshire (New Forest, Eastleigh and Test Valley). The Trust also serves a wider health economy of circa 3.6 million people, and for paediatric cardiac services a population of 5.6 million, stretching from West Sussex in the East, to Devon in the West. Whilst the Trust provides a full range of services to the local health economy, the service provision to the wider region focuses on specialist tertiary activity.

The market in which the Trust operates is complex and rapidly changing. In response to this the Trust has developed a clear understanding of the marketplace in order to maintain its market share and develop specialist and defining services to support the region. The new commissioning

changes will mean an increase in the volume of services that are recognised and commissioned as specialist services resulting in circa 50 percent of the Trust clinical work being specialist in 2013/14.

Pressure on finance in the local health economy means an increased need to work in partnership with commissioners and other providers and social care to deliver both a high quality and affordable health system.

The Trust's major elective care programme includes ophthalmology, orthopaedics and gynaecology together with other surgical and medical specialties; these predominantly serve the local population and wider Wessex region. Chronic disease care includes long-term conditions such as COPD, heart failure, stroke and diabetes. These pathways cross the organisational boundaries of the Trust with for example GPs, community and social care sectors that require partner collaboration to deliver effective and efficient care with excellent patient experience. The Trust now has an increased portfolio of specialist services following the transfer of activity to NHS England.

Despite strengths in these areas, it is also important that the Trust recognises any potential opportunities and threats within the evolving local economy, such as the merger between Basingstoke and Winchester (Hampshire Hospitals NHS FT), and the proposed merger between Poole and Bournemouth. The independent sector treatment centre (ISTC) contract in Southampton is due to expire in 2015, thereby presenting a potential opportunity and/or threat. Delays and difficulties for Portsmouth Hospitals and Solent NHS Trusts in achieving Foundation Trust status will also continue to cloud potential opportunities/threats in local provision.

The proximity of the Spire hospital to the UHS site means that the Trust will continue to work collaboratively, but with a developing private patient strategy; there may be increasing areas of competition in the future. The Trust does not expect to see new market entrants in the short term, although the ISTC contract tender could open an opportunity for new competitors.

Further afield, the landscape is determined by the provision of tertiary services, with the main competitors being in London, Bristol, Oxford and Brighton; while Bournemouth and Portsmouth also compete for some services. In July 2012 the joint committee of primary care trusts (JCPCT) undertaking the Safe and Sustainable review of children's congenital heart services decided that the best configuration of providers included UHS NHS FT. The Trust awaits the views of the independent reconfiguration panel on the process that was followed by the review.

The new specialist commissioning specifications circulated for consultation earlier this year will also potentially see specialist activity transfer to the Trust; including ophthalmology, genetics, gastroenterology, respiratory, vascular, paediatrics, neurosurgery and orthopaedics (hip revisions). The Trust will respond to this challenge within its operational development as plans are confirmed. The Trust is working with commissioners to build on its excellent clinical outcomes in vascular surgery to improve outcomes across the wider region.

Historically, the Trust had two main commissioners; NHS Southampton and NHS Hampshire, representing 77- 80 percent of the local PCT clinical income. Within the new clinical commissioning groups (CCGs) framework this relationship will remain but will also include specialist commissioning as a key contractor of Trust services. This has resulted in a shift of activity to the specialist commissioning contract (estimated at circa £200 million) which in turn will change the Trust's contracts with NHS Southampton and NHS West Hampshire from circa £120 million income each to circa £100 million each in 2013/14.

Strengths:

- Large catchment population of 1.9 million for local services and 3.6 million (Adult) / 5.6 million (Paediatrics) tertiary services
- Strong portfolio of specialist (defining) services
- Established strategic partnerships with the University of Southampton, other Southampton universities (Solent) and local councils
- Proven track record of delivery, particularly on financial management, low reference costs
- High quality, patient centred care (Dr Foster)
- Strong academic portfolio including a biomedical research centre (BRC), biomedical research unit (BRU), MRC, experimental cancer research unit AHSN host
- Commercial opportunities with research, education and support functions expertise
- Balance of commissioners following maximum take shift to specialist commissioning

Weaknesses:

- Capacity to meet continued increasing demand, particularly in emergency
- Limited ability to influence demand management
- Some parts of estates are not functionally suitable to enhance patient experience in terms of environment
- Patient access issues linked to transport/parking
- National policy of marginal payment for emergency over performance
- Competitors taking low volume, high profit work leaving the current PbR tariff structure inadequate to fully cover high complex work provided by acute Trusts
- Relatively low levels of liquidity

Opportunities:

- Service redesign and system reform in SW Hants including pathway integration, improving emergency flow/system, drug procurement
- National policy direction on centralising of specialist and emergency services (e.g. heart attack centres, major trauma and stroke, specialist cancers, neurosurgery)
- Defining services : new services, expand catchment, extend pathways to community
- New processes for research & development and education & training funding
- Partnerships with NHS, independent providers and commercial sector to address income/cost issues (including clinical networks)
- Estate development potential
- Cap on private patient income removed to increase volume of work
- Outsourcing clinical activity, for example diabetic nurses into homes, older peoples outreach and support team (OPOST)

Threats:

- Commissioner affordability
- NHS £20bn savings via QIPP/activity management targets
- Continued cost improvement programme deliverability
- Impact of ISTC and options when contract ends November 2015
- National policy changes – financial impact of readmissions
- Pressures from ageing population – complex health needs, potential discharge issues
- Impact of locally retained tariffs
- Hampshire Hospitals strategic direction, Bournemouth and Poole merger

- National centralisation of services, including paediatric cardiac and paediatric neuro Safe and Sustainable consultations
- Growth of local emergency workloads and social care budget reductions

1.3 Demographics

The Trust is a member of the NHS Southampton joint strategic needs assessment forum that reviews need for the population of Southampton. It also produces an annual report through the healthcare planning forum on key trends and national benchmarking.

Between 2001 and 2011 the population grew by 0.9 percent and 0.7 percent for Southampton city and Hampshire PCTs respectively. The future pressures on UHS will manifest not only in terms of volume, but also composition, as there will be a significant increase in the over 65 age group. It is estimated that the impact of these trends could potentially have a c.3-5 percent increase on UHS admissions which the Trust is including in its forward planning. The full impact of new welfare reforms introduced from April 2013 is currently unknown but will be assessed as details emerge.

The Trust five year integrated business plan (2011 to 2016) assumed overall activity growth (including population change) of 2 percent per annum in 2013/14 and 2014/15.

The Trust is therefore reliant on the delivery of the QIPP Programme, including the emergency care intensive support team (ECIST) system action plan, with local system collaboration to maintain planned growth levels. Failure to achieve this target will leave the Trust at risk of demand being above planned and contracted levels, which risks impacting quality of service.

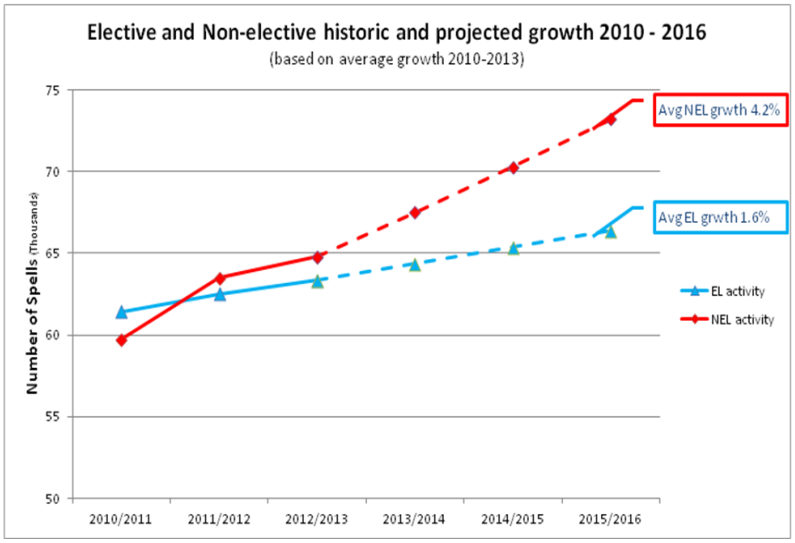
1.4 Market share trend assessment

The Trust exists in a competitive local market with other NHS providers and private providers serving the population. The Trust is well placed to continue being the local provider of choice and deliver services in: unplanned/emergency care, screening services, more complex planned surgery (ophthalmology, gynaecology, orthopaedics) and more specialist 'defining' services (cardiovascular, neurosciences, respiratory, cancer, gastro-intestinal, women and children).

The national increase in the elderly population is expected to continue and be reflected locally resulting in growth in related diseases such as dementia, diabetes, heart failure and other long-term conditions. Alcohol related diseases and obesity are also expected to continue to be growth areas.

With the current consultation over specialist services nationally, over the next three years, the designation of centres for specific conditions could impact the Trust both favourably and negatively.

1.5 The evolving demand profile and activity mix



Source: SLAM (contracted demand)

Nationally, inpatient growth (elective and non-elective) has had a 10 year compound annualised growth rate (CAGR) of 3.5 percent and the Trust is consistent with this trend (4.2 percent emergency growth and 1.6 percent growth in elective activity). The Trust's demand profile has evolved over time. When the ISTC was introduced, local Trust activity reduced; with the transfer of simple elective work to this provider (2008/09 to 2009/10). However, whilst demographic growth and the increase in tertiary specialist work, in line with the Trust 2020Vision, has seen demand backfill this change, it has also led to increased acuity making patient and capacity management more complex.

The Trust continues to experience higher growth in emergency demand which can put the elective programme at risk of delivery. It is also critical to the financial stability of the organisation for a balance of this demand to be achieved, in view of payment of marginal rates for emergency over performance. At this time, QIPP has yet to deliver any significant change in emergency demand, therefore, local system reform plans need to alter this demand; particularly as in some areas growth is predicted to significantly increase for example an ageing population, dementia, LTC and obesity.

1.6 Changes in local commissioning intentions

A major influence over the plan period will be the changing nature of commissioning strategies. An overview of the key changes to local commissioning strategies and intentions and their anticipated impact on the Trust includes:

- **QIPP demand management**
- £10.1m overall target for 2013/14:

Southampton CCG	£3.1m
Hampshire CCG	£3.7m
Specialist	£2.5m
Other	£0.8m

2014/15 and 2015/16 targets will be agreed via the annual planning round. The Trust Integrated Business Plan assumptions agreed with Commissioners in 2011/12 were:

	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m
Hampshire	9.2	4.1	3.3	3.5
Southampton	10.7	9	3	4
Total	**19.9**	**13.1**	**6.3**	**7.5**

- **Decommissioning**: The Trust is considering the feasibility of disinvesting in the outpatient chronic pain service following the shift of that work to a local community setting, the current inpatient service will however remain.
- **Potential "Any Qualified Provider" Tenders:** The Trust applied for, and was successful in, the audiology AQP process at the end of last year. However the reconfiguration of commissioners has delayed the signing of a contract in relation to this service and any change will not now realistically be in place before Q2 2013/14
- **Shifting care delivery outside of hospitals:** The main focus over the next one to two years is improving the discharge of medicine for older patients into community and other settings; the Trust is working with partners and CCGs to implement a project in 2013/14.
- **Reconfiguration plans:** Paediatric cardiac and paediatric neurosciences are key services currently under Safe and Sustainable reviews. The national specialist services specification review may also inform further future reconfigurations.

The Trust has factored the above issues into its strategy and is collaborating with local CCGs and NHS England on agreed targets and frameworks of delivery. Strategically, for other service changes or new services, the Trust is planning on a prudent basis. This approach is governed by the need to ratify decisions and approval for any step change; an appropriate business case is presented to enable the impact of change to be assessed, considered and agreed. This reflects the degree of uncertainty in the environment in which the Trust is now operating and the need to ensure that service changes are planned and implemented in a way that delivers patient benefits in a financially sustainable way.

1.7 Collaboration, Integration and Patient Choice

1.7.1 Plans to integrate services to provide better care and/or increase efficiency: The main focus over the plan period is on improving patient flow internally within the Trust and also at the point of discharge with partners. This is particularly true for older people so that patients are in the 'right healthcare setting at the right time' in their pathways. A local system project will be launched this year to improve the efficiency and patient experience of this pathway. This is a significant growth area due to the ageing population, where patients have a high usage of Trust beds. Patients are often fit for discharge (approximately 80 patients per day, rising during winter pressure) but remain in beds due to delays getting them into wider system capacity or the provision of support to go home.

The Trust will also host a pathology consortium, collaborating with partners to deliver efficiencies for the health system.

1.7.2 Development of partnerships and collaborations with other providers: There is

discussion with Hampshire CCG and Southern Health NHS Foundation Trust on the potential future of the Lymington Community Hospital; its use for a broader elective surgical service as well as the provision of care for the local population.

1.7.3 Consideration of impact of proposals in relation to competition rules (CCP etc) and patient choice, where applicable: There is a proposed merger between Bournemouth and Poole hospitals currently. The proposed merger is not expected to change activity at UHS unless, as a new entity, the new Trust developed a competitive market share growth strategy. Patient choice however is largely influenced by GPs and the reputation of Trust services.

1.7.4 Governors: The Trust engages and communicates with members through the council of governors, and its strategy sub-group, in order to share and seek feedback on key plans, performance and developments**.**

2. STRATEGIC APPROACH TO QUALITY

2.1 Existing quality concerns

In October 2012 the CQC undertook an inspection of the Southampton General Hospital (SGH) site and reported that patients and relatives were overwhelmingly positive about the staff and the care they had received, with staff acknowledged as incredibly hard working. Many of the wards the CQC inspectors visited were compliant against standards but in a small number, specific issues were observed that did not reflect Trust quality standards or clinical policies and practices. This then contributed negatively to the final assessment. Monitor revisited the Trust in April 2013 and had no concerns; the Trust is now waiting for the final report.

In December 2012 the CQC also undertook their first inspection of the Princess Anne Hospital (PAH) and reported that mothers and partners were very positive about the care they received, their consultation and their involvement in decision making. The PAH inspection found that the two outcomes reviewed were fully compliant with the essential standards of quality and safety.

The cellular pathology service within UHS was inspected by the clinical pathology accreditation (CPA) (UK) Ltd in June 2012. The critical and non-critical non-conformities identified during the inspection resulted in the loss of CPA accreditation. Urgent actions to address the issues, particularly staffing, were undertaken and a significant number of the critical and non-critical non-conformities were addressed. Actions are continuing to address the remaining non-conformities to enable the Trust to reapply for accreditation when it is satisfied that it meets the CPA standards.

UHS failed to deliver against the ED four hour standard in three quarters in 2012/13. The Trust has shared with Monitor its remedial action plan and trajectories for improvement. The top five actions currently being taken, as part of delivery of the recommendations of the internal and external ECIST Remedial Action Plans, in 2013/14 are:

- Establish new beds to support increased demand and reduce occupancy to improve patient flow and experience, including a new isolation ward to manage winter pressures. The Trust is investing £8.1m capital to deliver approximately 80 beds during 2013/14

- Patient flow and capacity transformation activity to maximise productivity and minimise

inefficiencies in patient flow internal and external of the hospital.

- Develop integrated services outside the hospital with partners
- Continue to invest in the seven day emergency hospital
- Continuing to work with external partners including ECIST to develop and deliver action plans to improve the local health system

Improvements in line with the trajectory will see the delivery of the standard, on a weekly basis, towards the latter part of quarter one however, this will not be sufficient to recover the quarter one performance. The Trust has set up a series of management groups to implement the remedial action plan, headed by a high level assurance group led by the CEO and a non executive director.

Based on current trajectories, the Trust is highlighting a risk of failure in 2013/14 quarter one, although delivery of the target will be achieved in quarter two and quarter three. A risk still remains in quarter four 2013/14 and this has been indicated within the corporate governance statement.

The Trust was unable to deliver the incomplete RTT standard in 2012/13 quarter four. This was as a direct result of cancellations of elective surgery that were needed to safely manage emergency flow and capacity shortfalls in outpatients. Recovery of this performance will be directly linked to the ED recovery and detailed capacity plans which are being developed. The Trust maintains its commitment to shorten waits for elective surgery and in order to deliver this, the Trust will need to fail the non admitted standard in quarter one and quarter two and the admitted standard in quarter two. The increase in the number of patients waiting over 18 weeks will result in the failure of the incomplete standard in Q1 until these plans take effect.

2.2 Key quality risks inherent in the plan

The Trust has strong risk management processes which have received high assurance feedback from the internal auditors. Risks are reviewed regularly and all have robust, well monitored action plans in place which should mitigate them in a timely manner.

Top risks to quality at year end which will remain an issue in 2013/14 are likely to be:

2.2.1 Monitor Compliance Framework Achievement. The referral to treatment (RTT) waiting target, four hour waits and CQC full compliance are all risks. Monitor red rated the Trust performance for 2012/13 quarter four. The Trust has remedial action plans in place to deliver compliance in 2013/14.

2.2.2 Inpatient capacity. An investment of £8.1m in the Trust bed capacity plan will enable the Trust to continue to provide quality services and reduced occupancy rates which will create greater flex of the inpatient flow. This will enable the Trust to deliver performance targets and meet planned demand, including reduced cancelled operations and outlying of beds. Capacity will then be fully optimised to pull patients through from ED and admissions to discharge. The Trust will continue to be reliant on system partners to pull patients from discharge and actions have been agreed through the ECIST action plan to support this.

2.2.3 Maternity. The birthing staffing 1:1 care ratio recommendation is being managed by:

- The service have reviewed escalation and plans are in place

- A 1:30 midwife ratio being maintained against a national standard of 1:28

Maternity theatre capacity plans are now in place with consultant job plans being reviewed to deliver an additional obstetric list per week. A contingency plan is also in place to provide emergency cover during high pressure peaks.

2.2.4 Increased delayed discharges during winter pressures will be managed through system resilience planning coupled with a Trust investment to open a new isolation ward which can manage higher volumes of CDifficile patients in a dedicated facility.

2.2.5 Insufficient physical emergency department capacity plans are in place to relocate Paediatrics to a new facility by the end of 2014/15. This will release space in main ED and will include the build of a shell for further adult resuscitation expansion.

2.2.6 Staffing risks include nursing, midwifery and medical cover out of hours – overseas recruitment plans have been successful for reducing nurse vacancies and medical posts will also be recruited in view of the national shortage of these staffing groups. There will be an ongoing risk if labour market factors continue.

2.3 Assurance on quality and safeguarding patient safety

The Trust Board reviews and monitors risks to quality and patient safety through a variety of assurance processes, these include:

- **The role of governors** is twofold. Firstly to hold the board of directors to account for the performance of the Trust. Secondly to represent the interests of the Trust's members and public and relay information about the Trust, its vision and performance to them.

- **The audit and assurance committee** which oversees the work of internal and external audit, regularly reviews the board assurance framework/corporate risk register and scrutinises the delivery of the CQC essential standards of quality and safety. The committee has a rolling programme of such reviews, which includes the management of the risk registers and their effectiveness.

- **The Trust executive committee (TEC)** acts as the overarching committee with responsibility for risk management and the quarterly review of the board assurance framework /corporate risk register. This process follows review by the executive risk scrutiny group (ERSG) and is prior to its approval by the audit & assurance committee and Trust board. As well as the executive risk scrutiny group, TEC is supported by the quality governance steering group; both groups provide oversight and leadership on all aspects of integrated governance and risk management. They also horizon scan for emerging risks

- **The quality governance steering group (QGSG)** ensures that there is an annual comprehensive programme of quality improvement for the care of patients, reporting on a regular basis to the Trust board and Trust executive committee on the full range of its activities. The Committee also ensures that clear lines of governance accountability exist within the Trust for the overall quality of clinical care.

- **The Trust's patient improvement framework (PIF)**, which is updated and reviewed annually to reflect ongoing or new priorities, forms the basis of the quality governance framework. The PIF focuses on patient safety, patient experience and clinical outcomes as

well as regulatory assurance and performance targets. The PIF priorities align to both external and internal drivers where possible. These include local and national CQUIN priorities, DH national targets, the operating plan and outcomes framework (appendix D), and the Monitor compliance framework. Key leads propose rationale detail for the improvement framework and priorities on an annual basis.

The PIF is also mirrored in the Trust's committee structures and high level reporting practices. This integrated approach ensures that staff understanding of the quality governance framework, operationalised through the PIF, is embedded throughout the organisation and reflected in the Trust's dashboards and key performance indicators.

- **Monitoring** of quality metrics is undertaken through quarterly patient safety, patient experience, clinical outcomes and effectiveness and regulatory assurance reports as well as ward accreditation, clinical dashboards and other performance indicators.

- **The 'quality pyramid'** which is reported to the board acts as an early alerts tool, which integrates financial and quality performance to ensure that effective management of financial resources does not have a negative impact on the delivery of a high quality service.

- **Divisional performance reviews** are held on a quarterly basis coupled with regular visits to divisions to review and ensure the delivery of the quality agenda.

3. CLINICAL STRATEGY

3.1 The Trust's clinical strategy over the next three years:

Deciding the priorities for improvement is a collaborative process involving staff, the council of governors, primary care trust colleagues, community partners, local patient groups and other key stakeholders.

The Trust patient improvement framework (PIF) forms the basis of quality governance assurance. The PIF is updated and reviewed annually. It is designed to reflect a broad approach to quality, in addition to patient and staff feedback. This then informs the priorities for patient quality of care and ensures the proposed PIF priorities align to both external and internal drivers where possible. These drivers include local and national CQUIN priorities, DH national targets, operating plans and frameworks and the Monitor compliance framework.

The PIF is also linked to the local community quality priorities, the Trust risk register and the assurance framework.

3.2 Clinical Priorities

The clinical priorities for the Trust over the plan period will be to:

- **Consolidate** by addressing Trust demand pressures through reducing bed occupancy, (including rebasing analysis to mid-day occupancy rather than mid-night to reflect peak flows more) and improving flexibility of inpatient flow, from ED and from admission to discharge. This is a key priority for 2013/14 for the Trust to continue to deliver quality services, meet key performance targets and improve winter resilience planning.

Historic	Planned

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Trust Midnight Occupancy	90.8%	90.4%	90.9%	91.9%	91.0%	90.0%	90.0%

- **Increase funded bed capacity** in adult surgery and medicine by circa eighty extra beds, which will include the development of improved clinical infection facilities, more medical beds alongside a partnership with community providers to develop more integrated elderly care models. This will reduce bed occupancy and deliver more certain elective care. £8.1 million has been allocated within the Trust capital plan in 2013/14.

- **Developing seven day and out of hours consultant services** in medicine, surgery and elderly care. This will improve resilience and the safety of services in inpatient wards, whilst increasing staffing at consultant level in the emergency department and the admissions medical unit/admissions surgical unit to meet demand, targets and the ECIST action plan.

- **Ensuring high standards of care** through maintaining low infection rates; active intervention of deteriorating patients and improved nurse staffing for patient acuity.

- **Achieve national specialist service specifications** for UHS services

- **Continue to grow defining services** in line with the 2020Vision. Expansion of key defining services will be linked to market share growth, partnerships and internal expansion in cardiac surgery, neurosciences, paediatrics, cancer, vascular, gastroenterology and respiratory. This will ensure the Trust continues to use the clinical expertise and knowledge available to develop centres of clinical excellence and support the delivery of research and development.

- **Implement the children's hospital strategy** to provide modern, fit for purpose facilities and excellent services to children in the south coast.

- **Expand endoscopy services** to meet complex therapeutic needs and the new flexi sigmoidoscopy bowel cancer screening programme. Capital investment will increase capacity, NHS and private patient income.

- **Expand the capacity and capability of imaging services** to support service needs and research, over seven days, along with pharmacy and therapy services. The imaging infrastructure support service (IISS) programme will replace ageing equipment over a phased plan.

- **Deliver six day working** to consolidate the development of elective operating in key specialties such as orthopaedics, ENT, neurology and neurosurgery.

- **Increase services in key areas** such as muscular degeneration, paediatric orthopaedics, neurosciences, urology services, imaging services and general medicine/care of elderly.

- **Increase private patient** activity of privately funded and self-pay patients.

- **Develop a LifeLab centre** doctors and scientists at UHS are set to develop a state-of-the-art laboratory, as a joint initiative with the University of Southampton, dedicated to improving

health and lifestyle education among school pupils and students in the city. The LifeLab centre will give youngsters the chance to understand more about the relationship between diet, lifestyle and disease.

- **Develop an Outpatient Dispensing Service** as an independent entity.

3.3 The Trust's service line strategy

The strategy is to continue to embed service line reporting in the Trust, to inform strategic planning and other priorities. This strategy is founded on an ability to optimise and evaluate key inputs upon which it is built. The Trust undertakes an annual strategic review including executive, divisional management teams and clinical engagement, to appraise current and future strategic direction. Benchmarking, market share analysis, service line reporting and clinical and quality information support this process. The end result of the review is the delivery of the Trust annual plan.

3.4 Clinical workforce strategy

The Trust will continue to recruit, train and educate staff to meet the need to deliver excellent, quality services and the 2020Vision. The Trust strategy will reduce it's reliance on doctors in training due to the reduction in the national training programme. The Trust needs a sustainable workforce to support the consultants, registered nurses and therapists across all wards and departments.

3.4.1 Key workforce pressures

The Trust assessed its own compliance against CQC Standard 13 (safe staffing) as moderate during 2012/13. Plans are being executed to recruit to nurse vacancies and there have been successful campaigns to attract overseas staff to the Trust, in view of the current national shortage in the labour market. Initial feedback from the last CQC visit was they found no area for concern.

The workforce will continue to grow in 2013/14 with recruitment plans for additional consultants and nurses aligned to increasing capacity initiatives. Recruitment will support:

- increases in capacity in cardiac theatre, ITU and beds
- reducing bed occupancy (with resultant increase in medical bed capacity)
- investment in ward staffing levels and hospital at night teams
- potential growth from other tertiary work
- changes to patient pathways
- further increases in consultant delivered care in the emergency department and "out-of hours" clinical cover to in patient ward areas
- reducing agency dependency

In addition, plans to centralise regional pathology services into a consortium run by one provider organisation, will result in a large scale TUPE transfer of approximately 400 WTE "in scope staff" to

UHS (this is not included in the financial plans pending contract signature).

The Trust plans for consultant delivered care in appropriate specialties and will review staffing models as it continues to reduce reliance on doctors in training. In particular the Trust is expanding the number of advanced practitioners with appropriate assistant practitioners to support them.

3.4.2 The impact of the workforce strategy on costs

The Trust pay bill is expected to continue to rise in 14/15 beyond the growth planned in 13/14 as service demand rises together with developments in the clinical, commercial, education and research sectors. The pay bill is then predicted to fall marginally in 15/16 as a consequence of CIPs exceeding the modest growth in planned activity.

3.4.3 Clinical Sustainability

This will be achieved through investment in key clinical capacity with associated support to meet service demand, together with excellent training and education. With the national reduction in doctors in training, as well as shortages in key staff groups such as nursing, the Trust will continue to plan to deliver excellent staff and be innovative to ensure clinical sustainability.

3.4.4 Services that could lack critical mass

Chronic outpatient pain service and potentially some specialist services subject to the standards outlined in the new specifications however the Trust will have time to respond to this to determine future service provision.

3.4.5 Services with consultant cover below recommended levels

No concerns have currently been reported other than:

- Cancer care does not meet the acute oncology standards for consultant oncologists cover and review royal college practitioner guidelines (RCP) however, the Trust have plans to incrementally invest in the medical workforce.
- Obstetric labour ward consultant cover is below royal college of obstetrics and gynaecology recommendations. Local commissioners are aware of this and have discussed it regularly with acknowledgement that few if any Trusts with similar birth numbers are currently meeting the recommendations. The Trust has been making progress by increasing cover via incremental investment.

3.5 Innovations in care delivery developed at the Trust or with partner organisations

The medicine for older people project is a key pathway being developed in collaboration with local partners and agencies. With an increasing ageing population the demand for beds is high for this patient group and effective discharge and management across the health system is essential to manage the demand effectively.

4. PRODUCTIVITY AND EFFICIENCY

Potential productivity and efficiency gains incorporated into the Trust plans are presented.

4.1 CIP governance

4.1.1 Historic performance

UHS has a strong track record of CIP identification and delivery. In 2012/13 UHS delivered 103 percent [£24.1m] of the Trust's £23.2m CIP plan. Whilst a degree of this CIP was non-recurrent this was significantly mitigated by the full year effect of schemes implemented part way through 2012/13 Sustained strong performance has been delivered by integrating cost improvement into strategic, financial and performance planning and delivery mechanisms on an on-going basis.

The CIP programme is extensive and wide ranging covering all aspects of hospital spend including: non-pay; drugs; skill mix reviews; and care pathways. The devolved nature of the programme produces around 600 CIP schemes each year. Whilst the Trust does not typically run large corporate CIP programmes it does have common themes which run through the CIP plans. Over time there is a shift in CIP to more 'transformational' themes, for example where clinical care pathways are changed to deliver the same or a higher quality of care at less cost to the organisation. An example would be enhanced recovery in surgery reducing length of stay.

CIP forward planning is built around the overall organisational strategy; an example is further integration of care for elderly people. Going forward the Trust is developing the following new areas for cost improvement:

- **Integrated care** working in partnership with community providers to deliver a proportion of the elderly care pathway in the community
- **Cross divisional targets** moving a proportion of support services CIP targets into a cross divisional 'pot' to incentivise more schemes which cut across different teams and departments
- **New areas** opening up a new tranche of CIP schemes in outpatient services based on improved clinic flow and productivity.

4.1.2 Clinical leadership and engagement

A high degree of clinical and managerial engagement in the CIP process has delivered a consistently high number of sustainable CIP projects over the past five years. This engagement is led by the Chief Executive and reinforced by executive led CIP reviews with executive and divisional management teams on a monthly basis. Divisional management teams which include strong clinical and nursing leaders are accountable for all schemes. Clinical leadership to redesign patient care is an integral part of delivering the overall programme. This balance of devolved responsibility, clinical and managerial engagement and tight central controls has produced consistently good performance.

4.1.3 The requirement for enabling investment in infrastructure

UHS have a cost improvement and transformation team which support CIP, led by a head of cost improvement and transformation. Service improvement managers (6wte) support divisions to deliver corporate transformation schemes, a proportion of which have an efficiency benefit. An example would be the improving customer services project which centralised outpatient booking staff and introduced lean processes.

UHS use limited external advisory support on cost improvement and transformation. The Trust recently bought in four weeks of consulting support to scope opportunities for efficiency improvement in outpatients. Following this scoping work the Trust is pursuing an internal delivery programme using in-house project managers.

The strategic IT investment underpins many wide ranging CIP schemes as well as some specific schemes. Examples include software to improve efficiency of portering and electronic notes in outpatient clinics.

4.1.4 Protecting quality of services

All schemes are reviewed by the divisional management teams to ensure there are no quality risks. For schemes that relate to pay savings over £100k or greater than five whole time equivalents a quality assurance form (QuAF) needs to be completed. This process ensures that any clinical risks have been assessed and mitigated prior to delivery of a CIP. Once divisional management teams have signed off the QuAF, this is passed to the director of nursing and the medical director to assess the risk to the Trust. If they agree that there are no risks or that suitable mitigation is in place then the scheme can be moved forward.

4.1.5 Monitoring the quality impact of CIPs on an on-going basis

All CIP schemes are assessed for quality impact at the outset by divisional management teams, and executive directors where required. When a CIP scheme is delivered it becomes normal practice and is governed within the trust's standard quality governance frameworks. Safeguards such as minimum clinical staffing levels on wards are absolute and override the requirement to find CIP. When staff raise concerns on the impact of CIP changes, the Trust conducts a retrospective review and makes adjustments where required. A recent example of this was when concerns were raised about patient access to administrative staff following the 'improving customer services project'. A review was conducted and an action plan implemented to address the concerns that were raised. An "early warning" pyramid of indicators is also included in the monitoring KPI report to Trust board.

4.1.6 The PMO and leadership and assurance arrangements

The cost improvement programme is managed by the programme management office (PMO) whose function is to:

- Ensure structure, rigour and governance of the monitoring and delivery of the savings programme
- Performance manage work streams and divisions in the delivery of the savings schemes
- Provide the executive team with the information it needs to focus its attention on the areas that would most benefit from its intervention
- Support the divisions and trust headquarters to identify and release savings
- Document governance processes at divisional and individual scheme level to ensure quality and safety are maintained
- Disseminate into the organisation good practice project management and programme delivery skills
- Offer an objective and independent view of the CIP schemes

The PMO team is led by the head of cost improvement and transformation, who reports directly to

the chief operating officer.

The CIP schedules are owned by the divisional management teams (DMT) and relevant executive directors for THQ and they are held accountable for all schemes on the schedules and achievement against their targets.

4.2 CIP profile

To deliver CIP key step changes are made in processes through workforce redesign, integrating patient pathways internally and with partners, non-pay savings for example by procurement and drug saving opportunities, innovation schemes including new IT schemes.

4.3 CIP enablers

Divisional management teams are accountable for all schemes and clinical leadership to define and deliver opportunities and redesign patient care as an integral part of delivering the programme as well as success to date.

If additional enabling investment is required a case would be made to the CEO for approval.

5 FINANCIAL AND INVESTMENT STRATEGY

This 3 year plan focuses on stabilising operational performance through incremental increases in capacity and quality whilst maintaining delivery of CIPs. Investment in capacity is significant in 2013/14 and will deliver a full year effect in 2014/15 with minor increases thereafter. The trust continues to plan to invest additional sums recurrently in quality initiatives including ward based nursing and in the hospital at night initiative whilst at the same time providing for the annual pay and non pay cost pressures within the financial plans.

Key challenges for the Trust over the next 3 years will be to continue to deliver high levels of CIP to enable ongoing improvements in quality whilst remaining financially sustainable and to maintain adequate liquidity. The Trust is in the process of securing a £15m loan to finance part of the capital investment planned which will mitigate the liquidity risk. The Trust has a good track record of CIPs and is currently at 80% identification of the 2013/14 target.

The Trust's main commissioners have supported a move to full PbR contracts so that the risk of non payment is small. The 18 week and A&E targets present a significant risk although sizeable investment in additional capacity in the 2013/14 plan to compensate for the levels of demand will help address this but there remain risks of contractual fines with estimates provided for in the financial plans.

Over the next three years the Trust aims to deliver a pre-impairment surplus of at least 1% each year. This reflects a recognition that the Trust must continue to prioritise investment in service quality, invest in key areas and service its debt to maintain liquidity. The Trust expects to maintain a financial risk rating (FRR) of two for the first two quarters of 2013/14 rising to three for the remainder of the year. This is driven by a one off exceptional transaction which the Trust has advised Monitor about. The Trust expects this transaction will be normalised. After normalisation the Trust expects to deliver an FRR of 3 throughout the year.

5.1 Income

2012/13 saw activity levels continue to increase. Activity management plans developed with PCTs failed to have a significant impact on overall activity levels and the Trust received income at marginal rates well in excess of plan. Premium costs were incurred to deliver this extra activity and non elective activity pressures had a significant impact on elective income and service performance.

In 2013/14 the Trust has secured recognition of outturn activity and agreed additional funding from its main commissioners to virtually eliminate underlying discounts within its contracts. This is a key step and returns the Trust to a full payment by results (PbR) basis which, whilst imperative to the financial strategy, exposes the Trust to the full risk of fines and penalties.

Income reduction relating to QIPP activity management schemes totalling £5 million has been assumed in 2013/14, although should these schemes not prove successful the Trust will secure payment according to PbR for any over performance. Given the track record of delivery in previous years and the current status of the QIPP plans, the Trust is anticipating that half of the overall QIPP plan of £10m will be delivered. For the £5 million that it is anticipated will be delivered it is assumed that costs at 50 percent of this sum will be removed from the cost base. Costs will only be removed after demonstrable reductions in activity are in evidence, to avoid any risk that clinical quality could be compromised. It is assumed that similar levels of reduction will be required in 2014-2016.

The Plan is largely based on agreed contract values for 2013/14 and contained in signed heads of terms. The main exceptions to this being where CCGs have not commissioned the full year effect of capacity increases made in the latter part of 2012/13 or they do not have clear plans to remove activity which will lead to income in excess of contracted levels.

For 2014/15 and 2015/16 a tariff deflator of 1.1 percent has been used although experience shows that as a tertiary centre the Trust has tended not to suffer the full extent of the headline tariff pressure when applying PbR rules against the Trust's activity profile. A modest amount of growth (1 percent) has been offset by £5m of anticipated activity management/QIPP savings each year.

The 2013/14 income from research and development (R&D) is planned to be £18 million which compared to the 2012/13 outturn (£30 million) appears to indicate a material reduction. This reflects a change in how the Trust will report R&D income it receives as host on behalf of a third party. From 2013/14 this income will directly offset the expenditure incurred and not be reported as gross. On a like for like basis R&D income in 2012/13 was £18 million.

Education income is anticipated to fall in all three years primarily as a result of the transition arrangements relating to the introduction of tariffs for education placements, instead of the block-based system used up until 2012/13.

Other income is expected to reduce in 2013/14 due to the cessation of a hosting arrangement, with the resulting reduction in expenditure, and will then a stay broadly level in the following 2 year period although the Trust will review opportunities for increasing commercial activity and partnerships throughout the period.

5.1.1 Diversifying income streams

The Trust acknowledges the current economic challenge, as well as the opportunities provided through its in-house intellect, expertise and support functions to diversify income. The Trust will continue to provide excellent healthcare, aiming to become an Academic Health Science Centre and exploit research and education opportunities.

The Trust will also develop stronger relationships with the commercial and private sectors to secure

and diversify income streams for the benefit of patients and the Trust. This is important to help support the future financial stability of the Trust to enable it to invest in key strategic priorities which include:

- Commercial research
- Education
- Commercial and charity partnerships for example Ronald MacDonald parent accommodation, front entrance and car parking schemes
- Private Patient Strategy to attract both privately funded and self-pay patients both nationally and internationally

5.2 Expenditure

Expenditure in 2013/14 is based on agreed budgets for the year as approved by the Board. These take account of a realistic view of capacity, activity levels and cost pressures. Investments have been set aside in the budget to improve quality, specifically in areas such as ward staffing and capacity where risks have been highlighted on the corporate risk register. CIP targets for the year are £28.5 million with a further £2.5 million cost reduction anticipated as a result of QIPP activity management. Overall planned CIP levels are expected to be around £23 million in 2014-16.

Pay is budgeted to increase by £18 million in 2013/14, and then flatten in 2014/15 to then reduce slightly in 2015/16 as a result of CIPs and activity management schemes. The growth in 2013/14 relates to activity growth, full year effects of 2012/13 developments plus investment in capacity to enable improved target delivery and deliver occupancy reductions.

Drug expenditure is budgeted to increase by c. £4 million in 2013/14, in line with previous years. Other costs will fall as a result of the change of accounting in respect of R&D hosting (mentioned above) where expenditure will net off the income received as host. Non-operating costs reflect the full year effect of the Trust's long-term Radiology contract which commenced in October 2012.

For 2014/15 and 2015/16 cost inflation has been assumed (1 percent pay, 3 percent non-pay) along with pressures relating to the consultant contract and investments in ward based staffing and hospital at night.

5.3 Key challenges

Over the next three years the Trust will continue to deliver high levels of CIP to enable ongoing improvements in quality whilst remaining financially sustainable and maintaining adequate liquidity. In order to meet demand, a new capital loan will be sought in quarter one of 13/14 of £15 million to fund new ward capacity, endoscopy rooms and theatre facilities. The Plan shows that the Trust achieves a risk rating of "2" during the first two quarters of 2013/14 and then will return to "3" for the rest of the year and over the following two, subject to normalisation of an exceptional transaction which Monitor have been advised of, after which the FRR would be 3 for all 4 quarters of 2013/14. Also, under the proposed new continuity of service risks a rating of 3 would be delivered.

Other key risks to the delivery of the financial strategy relate to the affordability of the Trust's income and activity plans. The Trust's main commissioners have supported a move to full PbR contracts. Whilst the 18-week and ED targets present a significant risk, sizeable investment in capacity in the 2013/14 plan will compensate for growing demand and will help the Trust to mitigate

this.