South Warwickshire NHS
NHS Foundation Trust

Strategic Plan Document for 2013/14

South Warwickshire 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.**

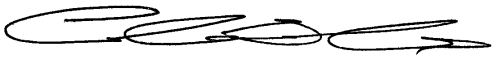
Approved on behalf of the Board of Directors by:

Name *(Chair)*	Graham Murrell Chairman

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Glen Burley Chief Executive

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Nicky Lloyd Director of Finance

Signature 

1. Strategic Context and Direction

1.1 Overview

South Warwickshire Foundation Trust (SWFT) provides a range of local acute services in the south of Warwickshire as well as a full portfolio of community services across Warwickshire. The Trust stands out nationally as one of the top performing trusts on both staff and patient experience indicators and our performance on these indicators continues to improve. The Trust has a relatively strong financial track record having reported a surplus in each of the last six financial years which followed a serious financial failure in 2005/06 when the Trust was placed into turnaround. The debts associated with this were finally repaid at the end of 2012/13 through repayments totalling just over £20m over five years. The early necessity for productivity improvement associated with the Trust's turnaround strategy provides a legacy of productive working solutions which currently leave the Trust as the only acute provider in the vicinity which is operating within national tariff.

The Trust operates within the natural health economy of Arden which covers the whole of Coventry and Warwickshire, a system of diverse communities and the associated challenges of delivering effective healthcare vary considerably. The Arden system currently includes three acute providers, with SWFT being the only Foundation Trust. There is only one other NHS provider in the system, the Coventry and Warwickshire Partnership NHS Trust which provides mental health services across the patch and community services to Coventry. The two other acute providers are currently struggling to achieve Foundation Trust (FT) status for differing reasons. University Hospitals Coventry and Warwickshire (UHCW) is a large teaching trust with tertiary and acute services, their large PFI hospital is generally cited as the reason why FT status has so far eluded them. However there appear to be other underlying efficiency and quality issues which have resulted in SWFT gaining a competitive advantage in a number of key Choice specialties. In the short term it is reasonable to assume that this advantage will continue but it will be important for SWFT to be ready to respond when UHCW inevitably addresses these issues. UHCW will continue to be our tertiary service provider and therefore we will need to help UHCW to strengthen these services so that its viability is driven by tertiary strength rather than through the need to fall back on competing with SWFT for a bigger secondary care market share.

In the north of the Arden patch George Eliot Hospital NHS Trust (GEH) provides a range of local acute services. For over two years the GEH trust has been structuring and subsequently awaiting approval for a market testing exercise to find a suitable partner organisation to deliver a sustainable future. SWFT has registered its intention to respond to this exercise with a proposal to acquire GEH and to create a fully

integrated acute and community provider organisation across the county. In order to strengthen the offer and to de-risk some of the solutions, SWFT has entered into an 'innovation partnership' with private sector outsourcing experts Serco. The Trust has been using this partnership to address existing service challenges and as a consequence a strong partnership is developing which will also help to maintain the sustainability of SWFT moving forwards.

To understand the full potential of opportunities open to the Trust it is important to also consider the immediately adjacent health systems. To the south west of SWFT's catchment area lies the county of Worcestershire. A county-wide service review has questioned the viability of the single acute provider organisation in the county, Worcestershire Acute Services NHS Trust. The most likely scenario is that this will lead to reduced functionality at the Alexandra Hospital in Redditch which is the closest site to South Warwickshire. As a result SWFT has remained as close as possible to the strategic review and will respond to any likely changes to patient flow. It is most likely that this would impact upon obstetrics and urgent care, but we remain watchful regarding elective specialties.

To the south east of Warwickshire lies Oxfordshire, which is dominated by the single acute provider, the John Radcliffe. Various service reviews over the years have examined the functionality of their smaller, Horton Hospital site at Banbury. The development of an elective treatment centre on this site has captured some flow from south Warwickshire, but better access through our local community hospital at Shipston on Stour and the development of our Stratford site could re-balance this.

The demographic projections for South Warwickshire anticipate further population growth, particularly in the towns of Warwick and Stratford-upon-Avon. The likelihood is that we will see increases in young families as well as a continuing increase in older people in what is and will continue to be a relatively affluent area. We have therefore developed a strategy which responds to the needs of our local communities and seeks to maximise the opportunity for the Trust to further perfect its local service offer.

Our main commissioners are South Warwickshire Clinical Commissioning group (SWCCG) who also acted on behalf of our other two main commissioners (the Coventry/Rugby CCG and the North Warwickshire CCG) during this year's contract negotiations. We are familiar with the leadership team of SWCCG and have developed good working relationships with them including effective clinical leadership and pathway redesign. Our local focus, as represented through QIPP priorities has been to work together to reduce unscheduled demand and as a consequence we have agreed a financial risk share for community and emergency services. As part of this we will jointly be investing in community based 'discharge to assess' beds which will speed-up the discharge of frail elderly patients from the hospital setting, reducing their long term need for higher supported care.

Our vision is to develop integrated acute and community services which manage patients effectively in partnership with primary and social care. Better proactive management of older people and people with long term conditions will ensure that the health economy resources are used in as balanced a way as possible, allowing elective specialties to continue to flourish and maintaining a good range of locally accessible and sustainable acute services. Despite our optimism that community services can take more pressure off our inpatient urgent care services, population growth and the need to offer modern accessible facilities have led us to plan to build a new ward block on the Warwick site. The design solution will be flexible so that we could expand emergency or elective capacity or rationalise existing estate if projections vary.

The Trust also provides the specialised Acquired Brain Injury service through the Royal Leamington Spa Rehabilitation Hospital (RLSRH). Last year the RLSRH was successful in achieving national accreditation and through this will access a new national tariff which will make a positive contribution to the Trust's finances.

This is part of a strategy to reduce our dependency on a single NHS commissioner. As a further component of this strategy the Trust has created a Business Development Unit which sifts, and where required, supports business opportunities from ideas generated across the Trust. Some of these ideas will be suitable for implementation through the Trust's arms length company SWFT Clinical Services Ltd which has now appointed a Managing Director and which will contribute to the Trust's overall cost reduction programme.

The Trust operates out of several sites, using community hospitals in south Warwickshire as part of our model of locally accessible services and as bases for our expanding community based workforce. The main pillars of our strategic direction have been clearly set out for the past year covering the domains of Quality, Facilities, Integration, Workforce and Sustainability. Over the coming year the following strategic developments stand out:

- The completion of the expansion plan for the RLSRH;
- Agreement of a business case to expand Stratford Hospital to meet population growth and pressure on the Warwick site;
- The development of additional ward capacity at the Warwick site;
- Further integration of hospital and community services;
- Increasing the productivity and accessibility of community services;
- Investments in technology which improve quality, outcomes and productivity;
- Building discharge to assess capacity to reduce the length of stay and on-going dependency of frail older people;
- Working with Serco to respond to the GEH procurement and to increase the productivity and effectiveness of support services, and
- Maintaining and developing our reputation for excellent patient care and experience.

1.2 Threats and Opportunities

Demographic Growth and Aging Population

Over the past four years, the Trust has experienced growth in demand, driven by local demographic change, which has increased pressure on inpatient capacity and resources, and had a detrimental effect on patient flow. In September 2012, a Capacity Planning Report was presented to the Board of Directors outlining our assumptions about changes to demand and service delivery for the next three years and their impact on capacity requirements. The planning model used GP practice list size growth over the previous four years to inform population growth by age group for future planning assumptions. We calculated growth and capacity requirements using the 2011/12 activity data as a baseline for admission rates and length of stay by admission type and age group to reflect a full year effect of service delivery model changes made during 2010/11, and also a part-year effect of changes made during 2011/12. The report highlighted that the Trust would require circa 40 additional beds by the year 2015/16 if demand continued to grow at projected rates and we maintained our current service delivery models. Operational teams had identified a number of schemes for implementation to reduce this additional capacity requirement and it was agreed that we would measure their capacity implication as part of the on-going development and refinement of the Capacity Plan.

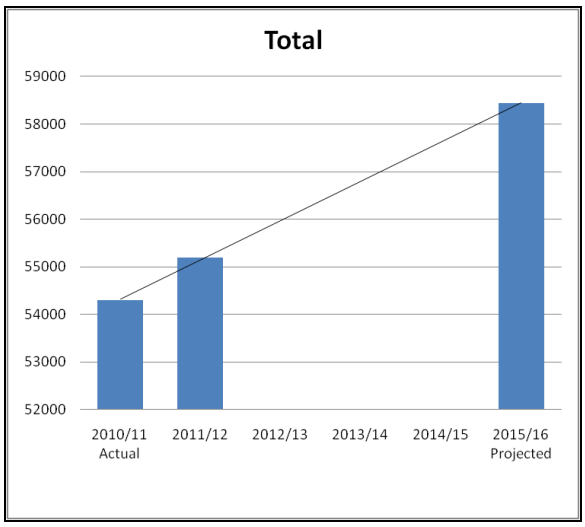


Fig.1 Original Growth Projections

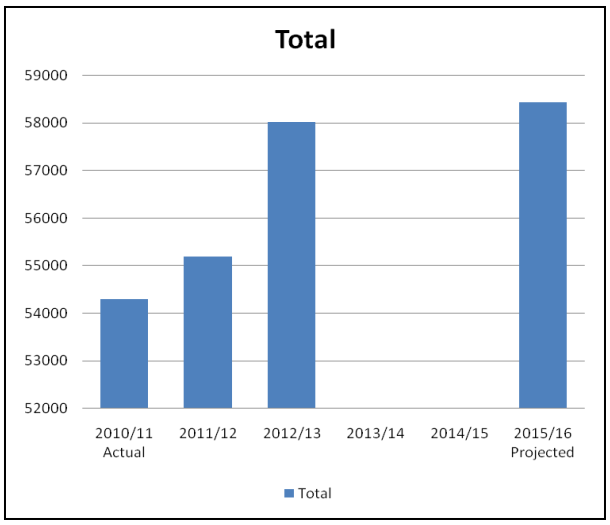


Fig 2. Including up to 2012/13 actual outturn

An updated plan (see fig.2), including actual 2012/13 activity and occupied bed days by admission method, was presented to the Board of Directors in April 2013. This update suggested:

- Outturn admitted activity for 2012/13 was 6% higher than 2011/12 and 4% higher than our original planning assumption. However, during 2012/13 we experienced the full year effect of 2 admission avoidance initiatives, CERT Admission Prevention and the Emergency Ambulatory Clinic. If we assume that we would have had to admit the patients who benefited from these initiatives if they had not been available, we would have seen a 9% growth in activity from 2011/12, 7% more than our original assumption.

- That we have been able to manage the growth in occupied bed days without providing additional beds, by changing capacity previously ring-fenced or designated as 'lower-occupancy' for elective care to general usage.

- If demand for our services continues to grow at the same rate as we saw between 2011/12 and 2012/13 and our admission avoidance schemes continue to meet 60% of the growth as they did in 2012/13, then we will still require an additional 17 emergency beds more per year than our original plan over the next three years. In addition to this, if we wanted to revert to our previous practice of ring-fencing lower occupancy beds to maintain elective activity, we would require a further 16 beds.

- Therefore, assuming no change to current growth rates, by 2015/16 our total bed stock would need to have increased by 100 beds.

Additional analysis has been presented to the Board of Directors for the demographic changes within the Stratford District locality. The Stratford District locality has seen modest growth in population size over recent years compared to other parts of South Warwickshire and the West Midlands, possibly due to the moratorium on residential developments, imposed in 2006, which came to an end in March 2011. Between 2008 and 2012, Stratford District's GP practices' list sizes have increased by 1.7% to about 135,000. Depending upon the District Council's future success at maintaining the recent population growth trend with further residential development restrictions, it is expected that the Stratford District population will grow between 5-10% over the next ten years.

During 2011/12, nearly 37% of the Trust's total admitted activity was attributable to patients registered with Stratford District GPs, occupying 34% of total bed days, equivalent to about 139 beds. Based upon the 10% population growth projection and using the Capacity Plan model to calculate future capacity requirements, this growth in demand is equivalent to an additional 48 beds.

Over the same period of 2008 to 2012, the number of Stratford District's residents aged 80 years and over increased by 13.5%. This cohort of the population are the highest users of healthcare services and Office of National Statistics population projections suggest a further 93% growth in the over 80 years' population between now and 2028, increasing to 15,067 over 80 year olds being resident in the Stratford District. During 2011/12, over 80 year olds registered with Stratford District GPs occupied about 62 beds at any time – the 10% population growth projection would increase this to 94 beds.

Market Share Development

The Trust constantly reviews referral trends and has targeted GP Practices and specialties where there is an identified opportunity to increase market share. This has resulted in increases in market share in a number of areas.

Development of services at Stratford Hospital also provides opportunities to increase market share. There is significant variation in the Stratford District GPs' referral behaviour at individual service level, with some services receiving in excess of 80% of new referrals and others receiving significantly less. The full reasons for this variation are not yet understood but we do know that where competitor providers are delivering outreach clinics in the Stratford locality, we are seeing a reduced market share for these services. Stratford GPs have also confirmed that the reduced waiting times for access at competitor providers is influencing patient choice and resulting in referrals to out-of South Warwickshire Trusts. A key objective for the development of the Stratford site will be to achieve a 90% share of the Stratford District GPs' market for services we offer. This will support us to increase our income through the repatriation of South Warwickshire CCG funding.

Cross Border Service Reconfiguration

From our market analysis, we have confirmed that our main competitors for Stratford GP referred activity are Worcestershire Acute Hospitals NHS Trust and Oxford University Hospitals, both of whom run acute sites within a few miles of South Warwickshire's borders, at Redditch and Banbury respectively. There has been much debate about the future of these acute sites from a clinical sustainability and affordability perspective and it is anticipated that there will be some changes to service provision in the near future. This may result in changes to referral patterns from non-Stratford GPs on our Worcestershire and Oxfordshire borders providing us with an opportunity to further increase our market if we can offer access and capacity to meet demand from these areas.

The Trust has identified that reduction of service provision at Redditch or Banbury Hospitals could present the Trust with additional capacity pressures due to the altered flow of emergency patients. SWFT continues to work closely with both Trusts and the Strategic Review of services to ensure early response to any likely changes to patient flow.

Business Development Opportunities

The Business Development team has been expanded over the previous 12 months. This has included the recruitment of additional expertise in financial planning, commercial development and marketing skills. In addition the Trust has formed a Business Development Forum that considers ideas and opportunities presented from across the organisation.

As part of the Trust's objectives, we have identified the requirement for us to develop our business to increase our income and reduce our dependence upon our main commissioner. Some of the key business developments within this year's plan include

- Further development of Acquired Brain Injury Unit;
- Development of new services at Stratford Hospital;
- Exploration of Increased income from private patient facilities, and
- Expansion of subsidiary company business (SWFT Clinical Services Ltd).

1.3 Trust Strategy and Goals

South Warwickshire NHS
NHS Foundation Trust

Vision

What is our aspiration for the future?

An integrated health care system that is the preferred choice for patients, users and GPs based on our high levels of quality, productivity and clinical outcomes.

Mission

What is our role?

To provide high quality, clinically and cost effective healthcare services that meet the needs of the population that we serve.

Strategy - We will deliver our vision by...

- ***assuring the delivery of best quality services to patients and users***
- ***utilising technology and facilities to deliver modern, accessible healthcare***
- ***integrating hospital, community, primary and social care services***
- ***developing our workforce to be fit for the future***
- ***maintaining financial viability and delivering high levels of productivity***

Goals - By 2015 we will have...

an even more effective system for clinical and corporate governance to deliver safe services.

a single quality dashboard.

reduced the gap from Board to ward/department.

a represented and engaged Membership and Governor base.

delivered better customer service throughout the organisation.

captured timely patient/user feedback to tailor services.

facilitated continuous quality improvement.

continued to develop an open culture where staff can raise any concerns.

reduced backlog maintenance on all owned assets.

implemented electronic mobile working for community staff and be using technology to help patients manage their medical condition at home.

productive and efficient back office functions.

reduced our carbon footprint.

replaced the digital imaging system in Radiology.

increased productivity of elective care through the new theatres.

a nationally accredited Acquired Brain Injury Unit.

developed Stratford Hospital to deliver more care locally.

improved and enhanced our catering and cleaning service.

organised daily operations in a way which promotes home and community based care.

shortened length of stay for patients and reduced inappropriate admissions.

improved mental health liaison arrangements.

re-designed patient care for older people and received national recognition.

integrated teams to reduce overlap and duplication between social and health-care services.

worked in partnership with primary care to enhance the capability of practice based services.

improved communication between our Trust and primary care clinicians.

delivered more productive non-elective services through lean working practices.

developed a stronger medical leadership team and strengthened leadership across the Trust.

joint training packages with primary care.

acted on any issues identified through staff engagement sessions.

reduced sickness absence and spend on agency staff.

a higher proportion of staff rating the Trust as a good employer.

implementated e-rostering across all wards/departments.

ensured that all staff will receive an annual appraisal linked to Trust objectives.

developed a greater understanding of the needs and diversity of the communities we serve.

productive and affordable services delivered in partnership with Clinical Commissioning Groups.

achieved our quality targets and minimised contractual fining.

adopted service line reporting.

continued to operate cost effective and efficient corporate services.

a Business Development unit responding to market opportunities.

improved the data quality that is focused on patient care and outcomes.

implemented new forms of contracting introduced to incentivise effective treatment pathways.

delivered financially rewarding commercial services that do not detract from our core NHS activities.

1.4 Key Objectives for 2013/14

Every year the Trust sets a number of key objectives under each of the domains within the Strategy. These key objectives are based on local and national priorities and they are promoted internally so that all staff are aware of the Trust's focus for the year. Managers are also asked to use these key objectives when setting their team's annual objectives.

The objectives for 2013/14 have been agreed by the Board of Directors and Council of Governors and are summarised below

Provide High Quality Care

- This year in response to the increasing demand for healthcare services from an ageing population we will be focused on making improvements to our processes and in particular our dementia screening.
- We will also be implementing a new patient access system to improve appointment bookings, together with taking steps to improve food quality and complaints handling.
- During 2013, key staff ratios will be reviewed to ensure that we continue to provide safe levels of care in line with our new values which will be embedded throughout the Trust, starting with our recruitment policies to ensure our new staff share our values.

Develop our Services

- Facilities - providing excellent facilities is crucial to our services and this year we have some exciting developments with the completion of our expansion plan at the Rehabilitation Hospital, new ward development at Warwick Hospital and the decision on a new hospital build in Stratford upon Avon which could commence in September 2013.
- Technology - There are also a number of technological projects that will support the delivery of healthcare across Warwickshire including the continued roll out of electronic healthcare records and the installation of new clinical systems in Radiology and Maternity services. To support these developments we will provide more services seven days a week.

Develop our People

- This year we aim to increase our rate of staff appraisals as we believe this is the best way to support our workforce to develop and improve. We will also work with individual managers to help them support the wellbeing of their staff and therefore reduce sickness levels across the Trust.
- We also want to continue to build our workforce and will complete our health visitor recruitment together with increasing the number of apprenticeships. There will also be a focus in line with our proactive recruitment of staff for our organisation.

Integrate our Services

- We continue to work towards our vision of an integrated healthcare system across Warwickshire and are working closely with partners to achieve this. An important focus for this year is on our new models of care; 'Discharge to Assess' and 'Assess before Admission'. These models will be put in place to ensure that patients get treatment in the

right place; ensuring only patients that need acute services are admitted and are then discharged as soon as their medical needs have been met.
- Managing patients with long term conditions remains a challenge for the Trust and this year we will work on improving services so that patients can live more independently.

Provide a Sustainable Future

- Whilst maintaining high quality care throughout the Trust is crucial, it is also important that the organisation recognises the environmental and financial implications which will effect efficiency and pave the way for a sustainable future. The Trust will look for ways to develop income streams outside of our main commissioners to ensure that we can continue to provide high quality services. Developing our sustainable specialities will result in improving productivity, whilst working in line with local and national strategies; we will ensure our carbon reduction targets are achieved.

2. Approach Taken to Quality

2.1 Quality Objectives

The Trust's approach to Quality is reflected in our vision, values and behaviours and the Trust objectives; within these objectives eight quality priorities have been identified. We have sought the views of our staff, members and stakeholders in order to identify the quality priorities, which are categorised as below:

Patient Outcomes
- To improve systems and processes to further reduce mortality rates, and
- To fully implement the frail elderly care pathway to include dementia screening and dementia sensitive services.

Patient Experience
- To implement an improved food service for patients;
- To implement an improved appointment process;
- To put in place a new system for booking and co-ordinating community services, and
- To improve the timeliness of the discharge process for patients.

Patient Safety
- To improve patient safety by achieving 95% harm free care using the Safety Thermometer, and
- To reduce the number of medication errors.

We have sought the views of clinicians and managers about what quality looks like, how it should be measured and how it should be improved. We have held a series of workshops on this subject during a leadership development programme for senior clinicians and managers at the Trust. The resulting outputs from the workshop were developed into a questionnaire and was sent to 3,000 stakeholders of the Trust and were asked to vote on their top three priorities in the three dimensions of quality.

2.2 Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission (CQC) and is registered without conditions. Registration confirms that the Trust meets all regulations and standards stipulated by the CQC. It also confirms that the Trust is authorised to provide all registered services across all locations registered in the Trust's name. The CQC has not taken any enforcement action against the Trust during the period 1 April 2012 to 31 March 2013.

2.3 Quality Risks and their Management

The Executive Directors have identified future risks, which will be managed and mitigated as part of this year's Board Assurance Framework (BAF) process. Measures to assess whether the outcomes have been achieved have been linked to the organisational strategic objectives which have been agreed by the Board.

Areas of quality risk identified to date are predominantly linked to the changing age profile of the population across Warwickshire. The demographic distribution is resulting in an increasingly elderly and frail population who live with long term conditions including dementia. The capacity and skills required to ensure that all patients at the end of their life receive high quality personalised care, tailored to their individual needs and preferences, including preferred place of death is currently insufficient. The quality risks associated with this environment are based on the systems, processes, financial frameworks and the skills of the workforce to meet this increasing demand. Underpinning the identified risks the current IT infrastructure requires further development to support real time data capture to optimise Trust productivity and service developments.

As part of the programme of Internal audits, an annual audit is undertaken to monitor compliance with Monitor's Quality Governance Framework. The findings from the 2012/13 audit demonstrated there were satisfactory levels of assurance within the Trust. This audit will continue as part of the programme for 2013/14.

The Trust has also set up a Programme Management Office (PMO) to manage risks against projects. The PMO will oversee all projects across the Trust including cost improvement plans and projects supporting the delivery of the Trust's key objectives. A monthly meeting, led by the PMO, provides the opportunity to regularly evaluate the projects and in particular any risks to their successful delivery.

Over the previous 12-months the Trust has not performed well against the 4-hour A&E target, resulting in the failure of the target for the year and the resulting risks to the quality of this service. Plans were put in place during the year to mitigate these risks to quality, including the development of an emergency flows project to review and improve the flow of emergency patients within the Trust, led by the Associate Director of Operations for the Emergency Division reporting directly to the Chief Executive. An interim Associate Director was appointed for a 6-month period to oversee the day-to-day running of the division during this period. The Department of Health Intensive Support Team were also commissioned to work with us in this area and to assist with the implementation phase of the project. The immediate action taken at the end of the financial year did lead to the delivery of the A&E target for the month of March 2012.

2.4 Board Reporting

The Board receives a monthly Integrated Quality Dashboard Report on the quality indicators. The report provides details on the indicators displayed using time-trend graphs, with peer comparisons where these are available. Actions to address performance are included in the report. These reports are replicated in content and format through the divisions.

At Board level the report compliments the existing Standards and Targets report produced by the Director of Operations. Where there is an overlap between the two reports, indicators appear in one or other report, to avoid duplication. The two reports together with the finance report are considered together to obtain a full picture about trends in quality, efficiency and effectiveness.

The Board reports include measures for all Monitor targets and selected key measures including, timeliness and access, reducing harm, clinical outcome and patient experience. Reference to the quality objectives are also included on the front sheet of all Board reports.

As part of strengthening quality and visibility of the Board at ward and department level, Board to Ward initiatives are planned for throughout the year. The Executive Team will continue ward visits on a regular basis to improve communication from Board to Ward reinforced by any ad-hoc visits that are not recorded in the formal Board to Ward activity. As part of these walkabouts patient safety, incidents, complaints and issues that impact on the quality of care are discussed. As a result of these discussions, action is sought by either the executive team or by the ward and department managers to ensure the expected quality of care is maintained.

The Board Assurance Framework provides assurance to the Board for delivery of all key objectives including our quality priorities. Each objective has a lead director that is accountable for the delivery of that objective. Our management and governance structure provide a mechanism for reporting progress against the priorities, for implementing change and assurance on risk.

The BAF is updated by the Executive Directors and is reviewed on a quarterly basis by the Risk Management Board and Board of Directors. The Audit Committee is responsible for providing independent assurance on the robustness of governance and risk management in the Trust. The BAF is the key process used by the Board to ensure that all principal risks are controlled, that the effectiveness of those key controls are assured and that there is sufficient evidence to support the Annual Governance Statement.

3. Clinical Strategy

3.1 Service Line Management

The Trust is planning to use service line reporting and patient level costing to enable it to move towards Service Line Management over the coming years. This will enable specialties to be run more as standalone business units, which generate income and use resources. During quarter one of 2013/14, a business case will be developed, for consideration by the Board, to procure suitable software during quarter two and to deploy this during quarter three to deliver service line reports by specialty. It is intended the software will have the functionality for clinical staff to

use the patient level information to understand waste and waiting, and to reduce variation in patient care by using variances in costs to indicate where clinical practice and patient pathways have varied.

The ‘top down’ approach gives overall specialty performance, which indicates which specialties are performing well or otherwise. This smoothing or averaging has little use for understanding *why* a particular specialty is performing well or poorly. The ‘bottom up’ approach of costing individual patients enables a full exploration of outliers and the variation across cohorts of similar patients. The costs for some procedures/diagnoses will be very consistent, however for others; there can be ranges of several thousand pounds per occurrence on contribution level generated.

For the first time there will be a transparent relationship between cost and income at patient level, which will enable peers in the same specialty to review and consider variations in practice. This enables clinicians to engage with the transformation and standardisation of best practice, thereby supporting the culture of continuous improvement and allowing internal benchmarking. For example;

- reviewing the variation in length of stay;
- comparing the time in theatre for patients with the same procedure or diagnosis;
- comparing clinic rules to consider differences in income earning potential per clinic, and
- considering the costs for particular cohorts of patients e.g. age groups, co-morbidities for pathway redesign work.

This can enable evidence based cost improvement targets to be set, and efficiency improvements to be really owned, by teams and individuals working in patient care. It also identifies where low volumes of particular procedures are being carried out, to assist in assessing whether sufficient activity on certain procedures can maintain accreditation by clinicians. It can also identify where high levels of contribution are being generated by particular procedures/diagnoses, with a view to growing market share: conversely, a review of loss making procedures/diagnoses can also assist in informing future strategy. It also allows a validation of coding, so that clinical staff can have confirmation of the coding for each patient, and compare this to what they had understood it to be. Experience at other Trusts has shown that this leads to significant improvements in the quality and depth of information recorded about patients in medical notes, as clinicians then better understand the implication of co-morbidities and complications on tariff.

This will be primarily driven at contribution level (i.e. direct income, less direct costs), to enable clinical staff to focus on costs they can influence, although overall Trust overheads will also be applied to give the fully absorbed profitability level of each specialty. Ongoing, service line reports will be produced quarterly from quarter four, enabling a closer match between income and activity with costs by specialty/point of delivery. The procurement will include the user interface, to enable clinicians to ‘self serve’ by drilling down into the data themselves. Ease of use will be a major influence in the decision as to which product is recommended for procurement.

One of the functions of this deployment is that the data quality of the feeder data systems can be assessed, indicating how much of the costs have been directly matched to the patient and how much has had to be apportioned. For example, theatre time, bed days, prostheses, blood products, radiology, pharmacy. Again, this has been shown to have led to major improvements in data quality at other Trusts, as the link between what happens to patients and what is recorded is better understood.

This is a major information project, and will be closely managed by the Director of Finance and involving clinical, finance and information staff in its deployment.

3.2 Clinical Workforce

The Trust will continue to review skill mix in the development of new and extended roles to support service delivery. This work will primarily focus on the transition from secondary to community care and will include initiatives such as admission prevention and discharge to assess pathways. Different medical models of cover will be designed to meet both service delivery and education, particularly in relation to out of hours and rota cover.

The accreditation to level 1 status for the Trust's Acquired Brain Injury Unit and the associated provision of community neuro rehabilitation services will require skill mix review to deliver this now national service. The Trust will increase maternity provision to increase the midwife to birth ratio in line with national recommendations. The expansion of weekend working to support increased clinical demand will require increased resourcing together with skill mix review. The Trust will build upon existing weekend working models where indicated. It is anticipated there will be an increase in demand for ophthalmology and cancer care provision both from a resourcing and facility perspective, with work underway to address both these issues. The Trust will work to achieve the Health Visiting targets set nationally and by Health Education West Midlands. The target for 2013 has already been met. These workforce initiatives will be funded by the demand this additional work generates.

To meet the sustained increase in emergency care demand, the Trust will be increasing its on site facilities together with appropriately trained staff to support this. This is built into the Trust Capacity Plan and will need to be funded from Trust cost improvement plans (CIPs).

3.3 Clinical Sustainability

Work will be undertaken with other local healthcare providers in the implementation of changes to the stroke pathway. This will impact on how stroke services are currently being delivered and may mean reorganisation of this service within the local health economy. It is planned to increase midwifery provision to meet the birth to midwife ratios in line with national guidance and to review obstetric medical staff resourcing to provide extended working during weekdays and at the weekends in line with Royal College guidance. Work will continue with UHCW to align neurorehabilitation services in Coventry and Warwickshire thus enabling a seamless approach in the provision of this service.

Increased demand for emergency care will require review of the existing medical cover to meet this. There will be a review of skill mix and cover across the medical/nursing and allied health professional workforce to address the new models of care required to meet this demand.

The impact of an ageing population presenting with increasingly complex long term conditions, will require some increase in the resources required to provide care both in the acute and community settings. New models of care will be continually reviewed and refreshed to ensure the best quality of care is being delivered.

4. Productivity and Efficiency

4.1 Overview

Length of Stay

The Trust anticipates a length of stay reduction of 0.5 days for adult emergency admissions based on two change initiatives:

- Discharge to assess – objective 1 – all patients who can be safely cared for at home through early supported discharge to community emergency response team will leave hospital on the day of referral objective 2 -most patients with ongoing care needs who cannot be discharged home to be discharged to a bedded step down facility for assessment of ongoing needs, and
- Full implementation of the emergency process redesign in all wards and departments – objective 1 50% of patients will be discharged before 1pm objective 2 – increase in proportion of patients discharged at weekends.

On this basis a ward is planned to close by quarter 2 releasing £0.75m in CIP.

Bank and Agency Spend

The full implementation of eRostering and the development of the 'Locumpod' initiative along with reducing sickness absence will reduce reliance on temporary labour and is planned to release a CIP of £1m.

Integrated Patient Access, Booking and Patients' Administration

A review of booking processes and outpatient Department clinic utilisation demonstrates that £0.25m improvement is available in year as a CIP.

Further to the review, in partnership with our innovation partner (Serco), a proposal is being developed to integrate all aspects of patient access, booking and patient administration. Initial indications suggest significant savings are possible.

4.2 CIP Governance, Profile, Enablers and Quality Impact

There is a Programme Management Office established at the Trust, with a lead officer who assists the divisions in developing and delivering CIPs. Each scheme has a detailed plan which shows how, where and when the savings will be made, the key dependencies and a quality impact assessment. A governance process is in place, whereby any new scheme requires sign off by not only the budget holder of the area, but the Director of Nursing and Medical Director, if

it affects patient care and safety/quality. Every two weeks, the latest developed schemes are taken to Management Board, the Trust's senior leadership forum, for adoption. Only at this stage are schemes considered as adopted.

The Trust has a CIP of £6.5m for 2013/14, with £1m undelivered brought forward from previous years. The table below shows the overarching themes of the CIPs for delivery in 2013/14.

Theme	Medical Director Lead	Nursing Director Lead	Management Lead	Lower range value £m	Upper range value £m
Closure of Dugdale (capacity ward)	Dr Raj Thanvi	Sue Lee	Malcolm Hunter &	1	1.2
Reduction of use of Agency Medical staff, use of Clinical Fellows	Dr Chris Marguerie	n/a	Ann Pope	0.7	0.9
Consultant Productivity/job planning	Dr Jhothi Nippani	n/a	Jane Ives	0.3	0.5
Reduction use of Agency Nursing staff	n/a	Helen Lancaster	Michael Cox	0.4	0.6
Nursing Roster/Productivity	n/a	Helen Lancaster	Michael Cox	0.2	0.4
Repatriation of Market share from Shipston/Oxford area	Mr Martin Osborne	n/a	Marie Ritson	tbc	tbc
Reduction of Sickness absence levels	Dr Ian Philp	Helen Lancaster	Ann Pope	0.4	0.6
Removal of overtime premium on Bank	n/a	Helen Lancaster	Ann Pope	0.2	0.3
18 Week RTT Flow including OPD & theatres	n/a	n/a	Richard Miller-Holliday	tbc	tbc
Estates Rationalisation	n/a	n/a	Linda Frost		
Replacement PACs			Duncan Robinson	0.3	0.3
Sub total - overarching themes				**3.5**	**4.8**
Sub total other schemes approved by Management Board up to 22/3/13				**2.3**	**2.3**
Income Generation/Best Tariff schemes				0.7	0.7
Other Schemes including cost avoidance being validated (estimated)				1	1.2
Total 2013/14 CIP Schemes (A)				**7.5**	**9**
Target (B)				**6.5**	**6.5**
Potential excess CIP schemes (to mitigate any slippage) **(A)-(B)**				1	2.5

5. Financial and Investment Strategy

5.1 Summary

The Trust's forecast financial position at the end of the three years covered by this plan will be as follows:

	2013/14	2014/15	2015/16
Income	£215.6m	£218.2m	£222.1m
Operating expenditure including depreciation	(£212.6m)	(£212.3m)	(£216.1m)
Non-operating items	£15.6m	(£3.5m)	(£6.7m)
Surplus	£18.6m	£2.4m	(£0.7m)
Surplus counted against financial targets	**£2.2m**	**£2.4m**	**£2.3m**
CIP delivery as % of income	3.5%	4.1%	5.4%
Closing cash balance	£12.9m	£15.8m	£15.1m
Capital expenditure	£15.3m	£21.2m	£4.7m
Overall financial risk rating	**3**	**3**	**4**
Shadow continuity of services risk rating	**4**	**4**	**4**

The significant movements in non-operating items relate to:

- a gain on the transfer of the RLSRH and Ellen Badger Hospital to the Trust on 1 April 2013 (a gain of £19.3m);
- predicted impairments when our extension to the Acquired Brain Injury Unit at RLSRH is brought into use in 2013/14 (a forecast loss in value of £1.5m), and
- when our new ward accommodation is brought into use at the start of 2015/16 (a forecast loss in value of £3.0m).

These movements have no cash impact and do not affect the Trust's financial targets.

5.2 Current Financial Position

The Trust was financially successful in 2012/13, achieving a surplus of £2.3m against a plan of £2.1m and paying off £1m of its Working Capital Loan early, so that all the debts inherited from the years of financial weakness up to 2006/07 have now been cleared. The weakest part of the Trust's financial performance in 2012/13 was identification and delivery of the CIPs. The Trust identified and delivered cost and income CIPs of only £4.6m, and of this £1.7m was found non-recurrently, leaving only £2.9m or 1.3% of the Trust's turnover identified as recurrent savings. This was well below any national average and below Monitor's expectations. However, the Trust's underlying financial strength, the demand for the Trust's services, and the ability of

clinical teams within the Trust to deliver increases in activity levels efficiently, meant that in spite of this the Trust was able to generate a higher than planned level of cash-backed surplus and move into 2013/14 in a stable financial position.
For 2013/14, the Trust plans a surplus of £2.2m, for which CIPs of £7.5m, or 3.5% of turnover, will need to be identified and delivered. Around 70% of the CIPs are supported by delivery plans and of these over 30% have been signed off by the Trust's governance process. The Trust carried out a mid-year financial review in 2012. As a result, expenditure budgets accurately reflect unavoidable cost pressures and the costs of service developments. In addition, the Trust is investing £2.9m above 2012/13 levels of spend to maintain capacity in emergency and integrated care in the face of unprecedented growth in emergency demand, and a further £2.5m in business cases developing capacity and high quality care. It is only possible to do this and remain financially stable because the Trust's efficiency, shown in its low Reference Cost Index (RCI) for acute services, has allowed it to deliver growth in demand and make a contribution to its surplus. However, we need to continue to invest in the fixed costs of capacity longer term to safeguard patient care.

5.3 Financial Priorities and Investments

The Trust's key financial priorities are:

- To invest to allow us to maintain quality and increase market share in profitable specialties, including elective surgery and our Acquired Brain Injury service;
- To invest to improve efficiency in our emergency flow in order to accommodate increases in demand more efficiently;
- To move resources into community services where this improves outcomes for patients;
- To identify and deliver recurrent CIPs based on efficient and high quality service delivery;
- To invest in our estate to enable delivery of these objectives, funded by loans if necessary where a proposal generates the funds to repay the loan, as it is currently possible to borrow from the Foundation Trust Financing Facility at a favourable rate, and
- To maintain acceptable financial risk ratings with Monitor (3 or above under the current system).

Key priority areas identified for investment over the next three years, subject to the approval of business cases, include:

- A unit at Stratford to accommodate growth in cancer services and ophthalmology, to be open by 2015/16 (capital costs of up to £14 million);
- A new ward block on the Warwick site to accommodate the emergency demand indicated by our Capacity Plan and improve quality in existing services, to be open by 2015/16 (capital costs of up to £12 million);
- Expansion of the Acquired Brain Injury unit at Leamington to accommodate 12 more beds in an improved setting, supporting the Level 1b status of the unit and meeting regional demand, to be open in the second half of 2013/14, with additional space in the design to allow for further development (capital spend in 2013/14 of £2.7 million);

- Further increases in capacity, particularly emergency capacity and clinical support services, in the intervening period, to maintain the quality of patient care;
- Maternity, to maintain and improve midwife to birth ratios, and
- Continued development of our technology with a view to increasing efficiency.

5.4 Key Risks and Mitigations

Key risks to our financial strategy include:

- Identification and delivery of CIPs. Our improved governance arrangements around CIPs are set out below. We consider our plans for 2013/14 to be realistic and deliverable, but there is still work to be done to develop and implement them, and plans for identifying savings in future years are relatively high level. One mitigation to these comes through the application of our CIP governance framework, holding divisions to account for delivery and moving from assuring the Board on short-term delivery to developing long term strategic approaches. Another comes through our application of service line reporting to allow us to take a properly informed approach to cost control and efficiency.
- The Trust has faced growth in demand for many years and now bases its financial strategies on this. There are risks to demand, particularly in our highly profitable elective care, where alternative providers may provide competition or commissioners may reduce access to care. The best mitigation to this risk is to maintain the high quality of our elective services, to maintain emergency capacity so that our competitive edge in elective care is protected, and to pursue our intentions regarding out of hours working so that capacity can be more easily flexed up and down.
- Relationships with our biggest commissioners (local CCGs) are in their early stages and will take time to develop. This limits our ability to understand commissioning intentions at present. However, we are working proactively with our commissioners to mitigate this risk as partners in the local health economy. This is evidenced by joint working on schemes such as 'Discharge to Assess' which will be necessary to maintain the financial stability of all parties over the next three years.
- The Trust has short-term options available to mitigate financial risk while recovery plans are put in place, for instance vacancy freezes, use of balance sheet strength, deferring capital expenditure and developments. These options would buy time for the Trust in hard financial circumstances. However, the most effective way for the Trust to mitigate financial risk longer term is to invest in capacity and develop its programmes for identifying efficiencies in service delivery.