Operational Plan Document for 2014-16

Chesterfield Royal Hospital NHS Foundation Trust

Proud to care for you…

Two year Operational Plan for up to 31 March 2016

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

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Date	**4 April 2014**

The attached Operational Plan is intended to reflect the Trust's business plan over the next two 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 Operational 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 Operational 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 Operational 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 Operational Plan directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	**Richard Gregory**

Signature

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	**Gavin Boyle**

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	**Steve Hackett**

Signature

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Executive Summary

This two year operational plan describes Chesterfield Royal Hospital NHS Foundation Trust's (CRH) vision to be a first class District General Hospital (DGH), and confirms the objectives and supporting strategies in place to enable us to achieve this. Our vision is built on a solid history of delivery and financial stability over our nine years as a foundation Trust and within this document we describe the plans, systems and processes we have in place to achieve this aim. This plan sets out the work we are undertaking to further improve the clinical quality of our services to improve the care and experience for our patients.

The plan describes the work we have in place to deliver £15m in efficiency schemes during 2014-16 and how we will build on our overarching Clinical Services Strategy (CSS) to define at specialty level a strategic plan to ensure medium term clinical, operational and financial sustainability in collaboration with our local health partners. The plan confirms how our transformation programme and associated governance structures have been developed to support the delivery of our forecast requirement of savings and provides detailed confirmation of our financial strategy, in the environment of implementing 7-day services.

The plan also shows how the new Quality Strategy will demand that the Trust make all decisions based on improving the patient experience and delivering sustainable, appropriate, and high performing services.

Section 1 The Short term challenge being faced

1.1 2014-16 Challenges and plan

The Operational Plan for 2014/15 & 2015/16 is structured to respond to a number of key challenges, which are summarised below:

1. **The need to develop sustainable clinical services which deliver improved care in terms of clinical effectiveness, patient safety and patient experience.**
2. **To support the design, development & integration of primary, acute, community based health services and our social services partners.**
3. **Deliver the level of access/clinical activity that meets the expectations of our patients & commissioners.**
4. **To deliver the range of services within agreed financial boundaries, whilst supporting the development of the Better Care Fund.**
5. **To deliver major site infrastructure and IM&T transformational change.**
6. **To consolidate the organisational leadership changes that have recently been introduced and to embed a culture of true staff engagement and involvement in clinical decision making.**
7. **To embed 7-day services into the culture of the organisation and in the service models being developed as part of our Clinical Services Strategy.**

The Trust intends to meet these challenges through the development of a 5 year clinical services strategy (CSS), the implementation of a comprehensive programme of service redesign and through developing a variety of partnerships and networks both within the local health economy (LHE) and also regionally with providers in both South Yorkshire and the East Midlands.

The Trust works in close collaboration with the LHE, in particular both Clinical Commissioning Groups (North Derbyshire and Hardwick) to ensure that both the 2 and 5 years plans are congruent with the commissioning intentions. The Trust CSS is being formulated in close partnership with the Clinical Commissioning Groups (CCGs) to ensure that the Trust is investing in the appropriate services and divesting in services that the CCG and NHS England may want to commission in an alternative way in the future

1.2 Vision, Objectives and Values

Chesterfield Royal Hospital (CRH) has a track record of delivering high performing clinical services for the population of North Derbyshire. This continued success delivered throughout our nine years of Foundation Trust status is due to our dedicated staff, financial stability and investment programme, robust governance processes and joint commitment and assurance by our Board of Directors and Council of Governors to provide high quality services to the people we serve.

Over the last two years working with our governors and external stakeholders we have crystallised the long term vision for the Trust in a simple statement supported by 6 strategic objectives and underpinned by a set of core values which are increasingly at the heart of determining the way in which we approach their delivery.

These values chime with the changing ethos within the wider NHS which reflects the learning from a range of national work but most particularly the public inquiry into the failings at Stafford Hospital led by Sir Robert Francis QC.

We aim to build on this solid foundation to deliver our vision for the sort of hospital we want to be:

A first class district general hospital (DGH) – the model of what a DGH can be in the service of its community – delivering high quality clinical care, offering exceptional experience for our patients; and creating a great place for our staff to work.

To achieve this vision our six strategic objectives are as follows-

For our patients and our community we will:

1. **Provide high-quality, safe and person-centred care;**
2. **Deliver sustainable, appropriate and high performing services; and**
3. **Build on existing partnerships and create new ones to deliver better care.**

For our hospital and staff we will:

4. **Support and develop our staff;**
5. **Manage our money wisely, foster innovation and become more efficient through improving quality of care; and**
6. **Provide an infrastructure to support delivery.**

Each of our aims is supported by a detailed enabling strategy that sets out the specific steps we will take to achieve them, and by when. (See page 6)

Enabling Strategies and key actions to support the delivery of our 6 Strategic Objectives

Strategic Aim		How this links to our Supporting Strategies
1	**Provide high QUALITY, safe and person-centred care**	Launch & implement our **Quality Strategy** (April 2014) providing services that are well-led, caring, safe, effective, and responsive. **Patient Stories.** Improving Safety Thermometer scores. The 6 C's of nursing care. Family & Friends Test. Learning organisation.
2	**Deliver sustainable, appropriate and high performing services**	Completion of a **Clinical Services Strategy** (Sept 2014)**,** in particular reviews of ED, Critical care, & Dementia care. Response to the Francis Enquiry. Implementation of 7-day services.
3	**Build on existing partnerships and create new ones to deliver better care**	Play a leading role in developing a range of partnerships in order to deliver agreed outcomes: • East Midlands Pathology Alliance. • South Yorkshire, Mid Yorkshire, and North Derbyshire 'Working Together' programme. • Derbyshire 21st Century Care Programme- Support the implementation of integrated care investment of the **Better Care Fund** • East Midlands PACS systems procurement.
4	**Support and develop our staff**	Our **Organisational Development Strategy** sets out a systematic approach to improving staff engagement - and explicitly makes the link with a better patient experience. We also carry-out staffing reviews every six-months that are reported to the Board, to make sure that we have sufficient, appropriately skilled staff to deliver a safe and high- quality service. Leadership development training and launch of values based training programme for staff called **Let's talk Care** (March 2014).
5	**Manage our money wisely, foster innovation and become more efficient to improve quality of care; and**	Our **Transformation Programme** supports the delivery of this aim. Each major transformation project is assessed using Monitor's Quality Impact Assessment Tool and a process for monitoring any post implementation impact has been put in place. However, improving quality is the primary principle that underpins this programme, that is – that through improving quality, greater efficiency will follow.
6	**Provide an infrastructure to support delivery**	Implementation of our **IM&T Strategy**. This is specifically intended to deliver clinical benefits and improved ways of working for staff – and include the implementation in 2014/15 of a new Patient Administration System (PAS) and a maternity IT system and embedding E-rostering. Priorities for 2015/16 will be developing a Clinical Portal and PACS replacement. Our **Site Development Plan** also includes a range of capital projects specifically aimed at improving service delivery and the patient environment – for example: Ward upgrades, Theatre Refurbishment, Urgent Care Village, new Cancer Centre etc.

Our Values

At Chesterfield Royal our **Proud to CARE** ethos is at the heart of how we run the hospital – looking after our patients and taking care of our staff:

Compassion

- **Compassionate care delivered with professionalism and a positive, friendly attitude.**
- **Care that preserves dignity and respects the person; putting patients at the heart of all we do.**
- **Respecting the unique and individual contribution that each of our staff members make – fair, positive and inclusive, recognising diversity and using it to enrich our organisation.**

Achievement

- **Excellent care, safe services and a positive experience every time.**
- **Exceeding expectations by delivering first-class performance, bettering national standards through innovation and ingenuity.**

Relationships

- **An open and honest relationship with our patients, staff, partners and our communities**
- **Working in partnership in the interests of our patients.**
- **Acting in a socially responsible way and meeting our commitments to the local community.**

Environment

- **Providing a hospital environment that is modern, clean and safe – conducive to care and recovery; and a good place to work.**

1.3 Collaboration and engagement with the Local Health Economy (LHE)

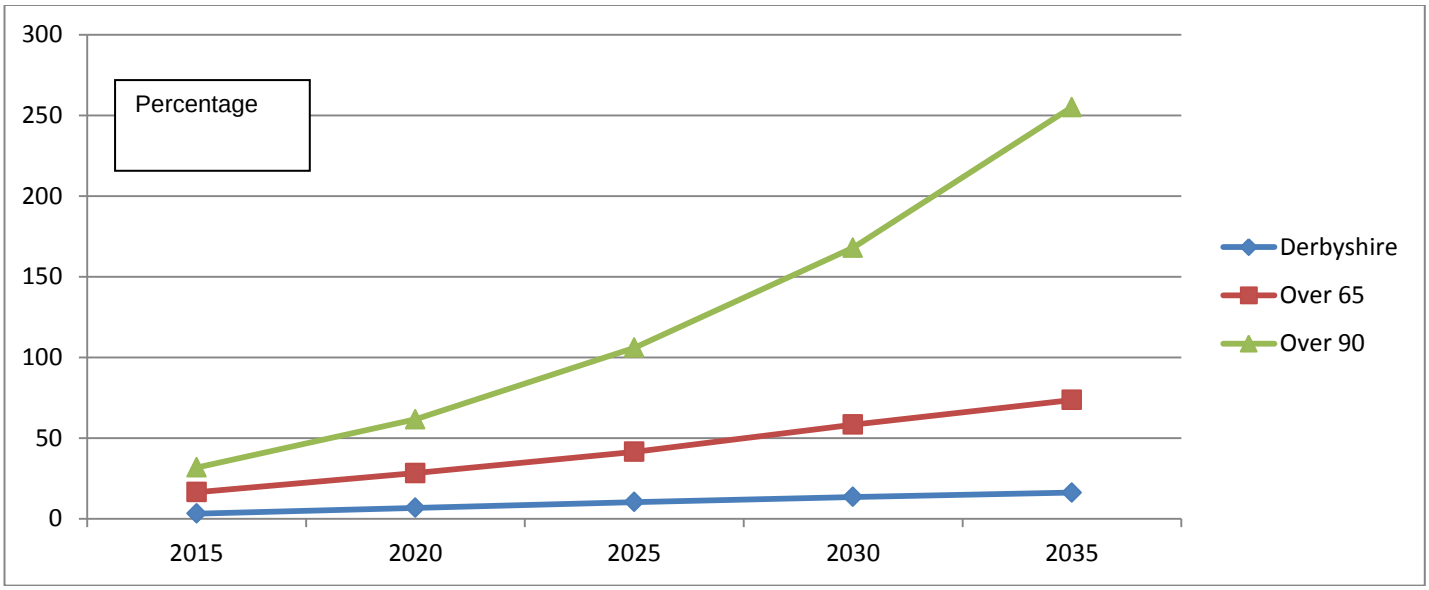
CRH has a strong market presence being the only District General Hospital (DGH) serving the population of North Derbyshire, which consists of approximately 400,000 people. We have a reputation across the health community for delivery of high performing services in terms of clinical standards and waiting times. We have an easily accessible site, have invested significantly in major capital redevelopments over the past 5 years to improve the clinical environment for our patients and have adequate levels of parking available in comparison to similar organisations. All of these factors contribute to ensuring that we remain the hospital of choice for the population of North Derbyshire.

Over the next 2 years we intend to work closely with our clinical commissioners and across our health community to identify and confirm commissioner requested services and location specific services. As part of our commitment to partnership working the Trust is engaging with the LHE in order to develop the Clinical Services Strategy, 7-day Services, and integrated models of care delivered in partnership with health and social care providers, underpinned by the Better Care Fund.

1.4 Planning Process & Local Commissioning intentions

Analysis of population demography and health status conducted in 2013 shows a picture of an ***increasingly aging population*** with ***complex health and social needs*** affecting all areas of the hospital. The Office of National Statistics (ONS) projections for our catchment population suggest a 16.2% population growth across all ages within 20 years. Graph 1 shows further analysis; a significant exponential projected percentage increase for the 65+ and 90+ age range over the next 20 years, patients with higher numbers of co-morbidities creating a challenge for the health economy in Derbyshire.

Graph 1



Trust & LHE Response

The demographic changes present an increased pressure on our health care system. Associated with the aging population we are seeing increased levels of morbidity, an increase in complexity of case mix, prevalence of long term conditions and complex health care requirements. Within our catchment geography are areas with high levels of deprivation, with high levels of incapacity due to chronic ill health, higher than England average levels of hospital admissions for both emergency and elective care and higher levels of cancer and dementia prevalence.

Both local CCGs have indicated their intentions to continue to focus on demand management of elective referrals. Both CCGs have below national average GP referral rates and GP referral growth rates however this is against a backdrop of growth in non-elective admissions year on year over the last 5 years averaging between 2.86% and 5.42%. The development of the Adult Re-enablement Unit in collaboration with the CCGs and other LHE partners will result in fewer non-elective admissions and reduction in Length of Stay for older patients.

The Trust CSS is developing speciality strategies which align with the CCG Commissioning Intentions (see below), 10 NHS Clinical Standards, 7 NHS Outcome Ambitions, and 5 categories in the NHS Outcome framework:

- **Frail & Elderly support-**
  - **Early recognition and management of dementia**
  - **Diabetes**
  - **Respiratory**
  - **Stroke**
- **Integrated Partnership working**
- **Prevention of life-limiting illness**
- **Management of urgent care pathways**
- **Provision of 7-day services**

North Derbyshire Local Health Economy

The development of integrated models of care in this area is being overseen by a steering group comprising of executive level membership of the various health and social care bodies and is known as the 21st Century Steering Group. It is facilitating the implementation of a number of integrated initiatives to provide seamless care across organisational boundaries in North Derbyshire and these are summarised below:

- **implementation of the Virtual Ward led by Hardwick CCG,**
- **the establishment of an Urgent Care Village, bringing together aspects of the LHE concerned with Acute Medicine (AM) and improving the AM pathway,**
- **the establishment of an Adult Re-enablement unit based at CRH supported by a range of partner staff from to shorten Length of Stay (LoS) for patients over 75,**
- **the co-location of the GP Out of Hours service adjacent to the hospital's ED to allow appropriate movement of patients between the two services,**
- **to develop a county wide model for integrated care under the auspices of the Derbyshire Health and Well Being Board, and**
- **to maximise the effectiveness of our collective resources & assets to the benefit of our patients.**

East Midlands

During 2013/14 a good start was made with our partnering arrangements into the East Midlands. These will continue to be operationally embedded and include:

- **East Midlands Trauma Network**
- **Derbyshire county-wide vascular surgical service jointly with Derby Royal Hospital**
- **Integrated Pathology services for the East Midlands**
- **Nottingham University Hospitals for shared procurement of major IM&T systems including the Patient Administration System (PAS) the Picture Archiving and Storage System for digital images (PACS) and a maternity system**

South Yorkshire

In 2013/14 the Trust entered a formal partnership with Trusts in South Yorkshire, Mid Yorkshire and North Derbyshire (SYMYND) 'Working Together'. A PMO was established and a range of projects initiated which will also be operationally embedded and include:

- **Developing sustainable models for smaller specialities e.g. Ear, Nose, & Throat (ENT), Oral & Maxo-Facial Surgery (OMFS), and Opthalmology**
- **Developing consistent acute services across 7-days,**
- **Procurement,**
- **Sharing best practice on service transformation, and**
- **Working in partnership to consolidate back office functions.**

1.5 Demand Profile and Activity Mix Changes

During 2013/14 the Trust delivered the following levels of activity, and expects nil 'overall' growth for 2014/15, but with expected variations at specialty level:

Clinical activity cases	Forecast 2013/14	Planned 2014/15
Elective	31,046	30,566
Non elective	36,193	35,700
Outpatients	238,236	219,822
Emergency Department (ED)	67,666	67,578
Births	2528	2940

As with the national trend the Trust has seen an increase in demand for non-elective activity over the past four years. This reflects the health needs of our increasingly aging population within our catchment population and the increased complexity of both health and social care needs.

The settlement agreed with commissioners for 2014/15 provides a contract value of £184.0m for patient care income. This is a decrease from £186.4m planned in 2013/14 which includes a reduction for tariff pricing efficiency, a reduction for non-elective admissions related to the planned success of Marginal Rate Emergency Tariff schemes, and a reduction in non-recurrent income offset by additional case mix impact and additional quality related investments (see 5.3.1).

In line with commissioner strategies regarding demand management of patient referrals we have seen a reduction in elective and day case activity which was anticipated and planned for. Where appropriate we are supporting the shift of activity from day case to outpatient setting which is reflected in our underlying contracted activity. The contracted activity for 2014/15 assumes waits remain in line with 2013/14 levels.

Within our 2013/14 submission we reported that our underlying assumption for activity within the 2014/15 contract and 2015/16 contract was nil growth. The settlement agreed with commissioners for 2014/15 includes 0.5% activity reduction; predominantly in Non-Electives (1.7%) and Elective/Day Case activity (4.3%). The latter is in line with forecast outturn.

It should be reiterated that there is a risk sharing agreement with the CCG with regards to the reduction on non-elective activity based on the successful implementation of MRET schemes across the LHE. It is subject to effective management in demand. If the planned reduction does not occur then the funding will continue.

Section 2 Quality Plans

2.1 Quality Strategy & Quality Account

In March 2014 the Trust launched its Quality Strategy which describes how the Trust will systematically improve the quality of its services in line with the 5 domains which the CQC uses to assess services which are:

- **That services should be well-led**
- **That they should be safe**
- **That services should be delivered in a caring way**
- **That treatment and care should be effective and**
- **Be responsive to patients and carers needs**

Delivering high quality, safe and person centred care is the most important aim of our hospital. Our Quality Strategy sets out how we intend to do this and make further improvements over the next three years to ensure that we provide the very best care for all of our patients.

The Strategy was subject to wide consultation with the Trust's Leadership Assembly, Council of Governors and Hospital Leadership Team prior to approval by the Board of Directors in March 2014.

On an annual basis the Trust will make information about quality publically available by publishing a report on the quality of our services, focusing on patient experience, clinical effectiveness and patient safety, and describing our quality improvement priorities for the coming year. This report will be linked to the priorities identified in our Quality Strategy.

The Quality accounts provide an assessment of the quality of care provided by the Trust and priorities for improvement. Specifically our Quality Accounts enable:

- The Board to focus on quality improvement as a core function
- The public to hold us to account for the quality of healthcare services that we provide
- Patients and their carers to make better informed choices
- The Board to communicate the priorities and rationale for quality improvement

In line with Commissioning for Quality and Innovation (CQUIN) requirements we have extended the 'Friends and Family Test' (FFT) to include ED and Maternity departments and the FFT for Staff. The FFT score for 2013/14 for In-patients areas was increased by a further 5% (56% to 61%) on 2012/13 and continual work is being carried out with ward matrons to increase further in the next 2 financial years.

2.2 Quality Assurance Process

In July 2013 the Trust commissioned an independent external review of its quality governance arrangements, based on an assessment against Monitor's Quality Governance Assessment Framework (QGAF) for foundation trusts.

The Trust has developed a detailed action plan to ensure the implementation of the required improvements by 2015 with most of the major actions scheduled for completion by August 2014.

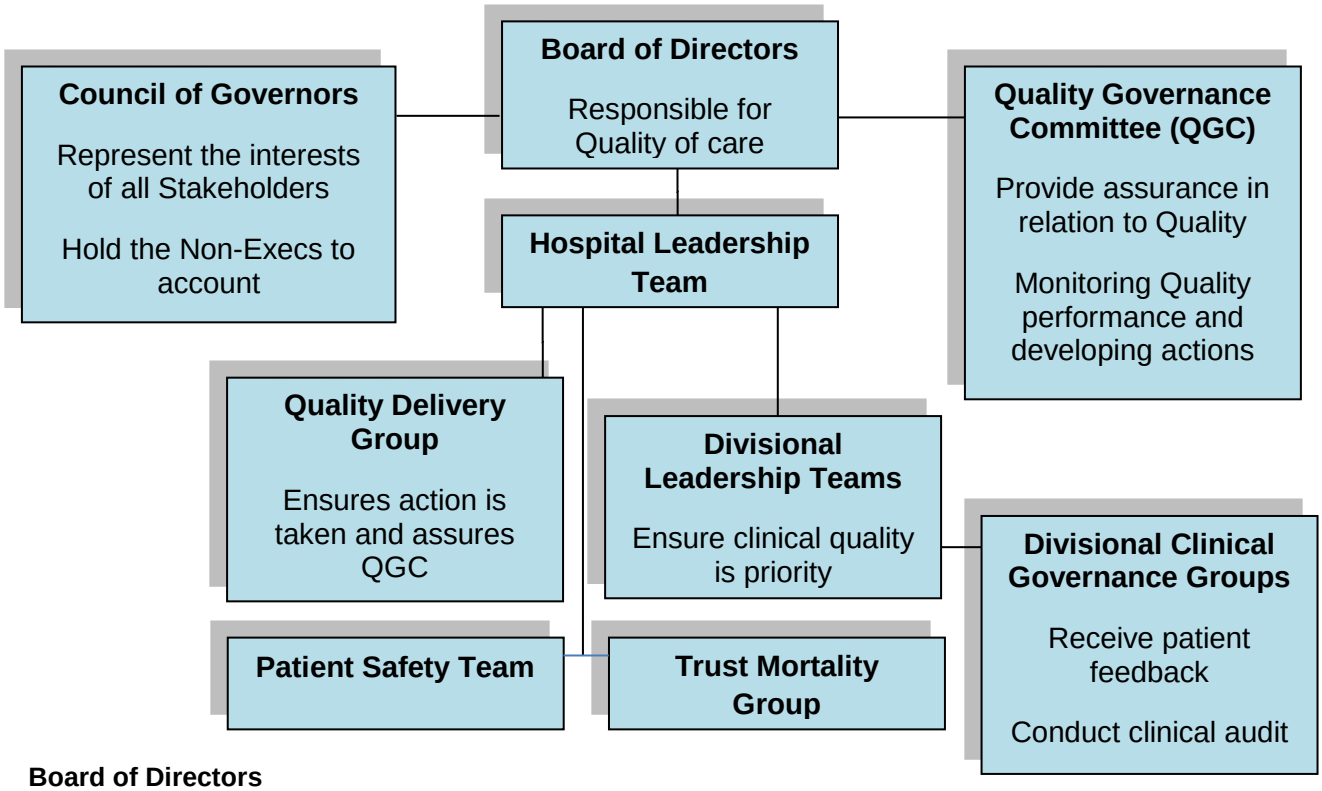
The key actions being taken are designed to create sustainable improvements and to build into the quality delivery and assurance processes monitoring to ensure the improvements are being sustained. A summary of these key actions are provided below :

- **Implementation of an overarching Quality strategy**
- **Streamlined quality performance reporting (linked to the delivery of the Quality strategy), using a smaller number of metrics which are consistent from ward to board,**
- **Implementation of a standard operating procedure for clinical and quality governance, and ward assurance to ensure consistent governance processes across the Trust, including quality measurement and monitoring, and the management of risks to quality,**
- **Integrating the management of quality governance and risk under the leadership of the Chief Nurse/Director of Nursing and Patient Care, with additional capacity to deliver integrated risk management and quality governance.**

The Trust will commission a follow-up review of quality governance in the autumn of 2014 in order to assess the impact of the improvements made, and to be able to measure this in terms of re-assessment against Monitor's quality governance assessment framework.

The Quality Assurance Framework - cascade of responsibilities are shown in figure 1.

Figure 1 Quality Assurance Framework



Board of Directors

- Overall responsibility for the delivery of Quality care to patients.

Council of Governors and PPI sub-committee

- Regular unannounced ward visits to observe first-hand the service quality.
- Lead on quality improvement projects within the hospital resulting in improvements for patients.
- Regular focused review sessions 'holding the board to account'.

Clinical Governance Committee

- Formal assurance committee of the Board of Directors comprising solely of Non-Executive Directors to support the board in discharging its responsibilities by providing objective assurance that we are delivering sustainable, high quality clinical care for patients.

- Responsible for identifying our quality improvement priorities as published in the annual Quality Accounts, reviewing external information such as Care Quality Commission (CQC) Quality Risk profile and clinical internal audit reports, monitoring the clinical risk register and actions arising from the review of serious untoward incidents; and receiving and reviewing data in relation to key clinical performance indicators. An assurance report is provided to each board meeting.

Quality Delivery Group

- Ensure that action is taken, both collectively and individually by Divisions, on matters of clinical management which arise from decisions on clinical policy and clinical governance.

Divisional Governance Groups

- Monitor that processes are in place to ensure patient safety is protected, services are clinically effective and steps are taken to deliver a positive experience for patients.

Patient Safety Team

- Works collaboratively across the Trust to support the identification and management of clinical risk, including the monitoring, investigation and reporting of clinical incidents.

Trust Mortality Group

- Pro-actively reviews mortality data & uses this to identify diagnosis groups for further detailed study, agree action required and monitor delivery of improvements. The group reviews both Hospital Standardised Mortality Ratio (HSMR) data and Summary Hospital Mortality Index (SHMI) data to highlight areas requiring further investigation.

These processes are underpinned by monitoring of key quality metrics including patient survey information, net promoter scores, compliments and concerns reports, safety thermometer data, nursing metrics and performance against compliance and contractual standards.

2.3 Quality Concerns & Risks

Through our risk management and governance processes we have identified the following risks which are captured on our risk register.

Compliance Against CQC Essential Standards – During 2013/14 the Trust has been subject to three visits by the CQC. Of the three outcomes originally inspected, the Trust is now fully compliant with two and the level of concern on the third, Outcome 1 – respecting and involving people who use the service, has been reduced from 'moderate' to 'minor'.

In addition, during the most recent visit in November 2013, the CQC also reviewed Outcome 16 – assessing and monitoring the quality of services. This resulted in a 'moderate' concern which was anticipated by the Trust as we had already commissioned an independent external review by Deloitte of our quality governance system, using Monitors Quality Governance Assurance Framework.

The CQC have recently reduced the Trust's risk rating, in a positive aspect, which is the lowest possible rating of six (6) and is based on the unlikelihood that people may not be receiving safe, effective, high quality care.

Progress on the actions to achieve compliance with the outstanding areas will be monitored weekly by the Hospital Leadership Team (the Executive and Divisional Directors).

The Trust will commission an interim progress review in April 2014 with a further follow-up review of quality governance in the autumn of 2014 in order to assess the impact of the improvements made, and to be able to measure this in terms of re-assessment against Monitor's quality governance assessment framework.

Infection Control – By the end of December 2013 we had reported 28 post 72 hours hospital-acquired C.Difficile infections, which was above our target of 23 for 2013/14. Despite this, the Trust is still likely to continue to show a year on year reduction which has been achieved through a range of interventions put in place to reduce the risk to patients, including:-

- **Improving education and training for staff,**
- **Introduction of the point of care educator,**
- **Daily infection control ward round on all ward areas,**
- **Delivery of targeted projects including the '5 moments hand hygiene' campaign supported by the highly visible and audible hand hygiene stations,**
- **Governors and infection control team providing patient education, and**
- **Infection control link nurses in every ward and department.**

Use of Temporary Staffing – A review in October 2013 showed that following a decision to increase ward establishments across the Trust in the previous 12 months, the Trust has faced a significant challenge in recruiting sufficient numbers of nursing staff to fill the additional posts.

In order to address the staffing issues identified a temporary staffing project board has been set up to deliver the following:

- **Strategic solution – Implementation of a managed service for bank and agency staffing (06/2014),**
- **Overseas recruitment of registered nurses to fill vacant posts within the Trust (05/2014),**
- **Nursing recruitment initiatives for 2013 and beyond to improve the Trust's ability to attract staff. These include:**
  - **Nursing Open Day at the Trust to be advertised in the national press.**
  - **University nursing careers fairs in Nottingham, Derby, Sheffield and Manchester.**
  - **Automatic conditional offers of employment for all Chesterfield Nursing students.**
  - **Collaborative recruitment campaigns with other Derbyshire Trusts.**
- **Nursing establishment review to consider how we proactively aim to recruit to levels above recurrently funded establishments to achieve a significant reduction in vacancy rates e.g. aim for 104% to achieve 100%, rather than aiming for 100% and getting 96% fill.**

In addition to the actions identified above, we will undertake the following actions to continually review nurse staffing levels on our inpatient wards:

- **Undertake a twice yearly review of all in patient ward areas to ensure staffing levels are safe and meet the needs of patients and quality, safe and effective service delivery, which will be provided to the board twice a year (April and October).**
- **We will continue with the 18 month implementation of e–rostering across the organisation to ensure the best use of our existing establishments and ensure that there are no changes to nursing establishments without sign-off by the Divisional Heads of Nursing and the Director of Nursing and Patient Care.**

2.4 Response to Francis[1], Berwick[2], and Keogh[3]

The Francis Report is the final report into the care provided by Mid Staffordshire NHS Foundation Trust. The report's chair, Robert Francis QC, concluded that patients were routinely neglected by a Trust too focused on financial targets, so much so that it lost sight of its responsibility to provide safe care. The report contains 290 recommendations which have implications for all levels of the health service and all who work in the NHS.

Many of the recommendations following the Francis, Berwick, & Keogh reports that define quality care as providing Patient Safety, Patient Experience, and Effectiveness of care, are already in the process of being implemented at CRH. In order to develop an action plan, the report and its recommendations have been shared widely with groups of staff, the Trust Board, and other key stakeholders to gain a wide range of ideas for implementation. These ideas formed an initial action plan which was approved by the Board earlier in the year and is monitored regularly by the Quality Assurance Group.

The Trust is keen to use these reports as a springboard to providing better quality care and a number of themes have stimulated planned action:

- Focus on a culture of caring- There will be an increased focus on nurse training, education and professional development on the practical requirements of delivering compassionate care. In addition to the theory which includes recruitment, training, appraisal. The Trust also plans to re-launch its 'Proud to Care' ethos through the 'Lets Talk Care' programme.

- Improving leadership- Develop a programme for leaders in Band 3-7 designed to enable them to lead departments and enable all nursing staff to complete skills lab training and continue to work to ensure that

matrons spend at least 60% of their time on the ward, and undertake patient safety culture survey (MAPSAF).

- Communication with Patients- Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds, and all staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors.

In addition the Trust is responding to the Cavendish Report[4] by:

- Ensuring that all HCAs recruited undergo the appropriate induction training before they are allowed to work unsupervised.
- Developing a career framework to ensure that individuals are demonstrating the right level of competence before progressing further.
- Revising our recruitment approach to recruit for values.
- Participating in the Pre Degree HCA pilot which is a structured way to provide a career pathway through to nursing.

Section 3 Operational Requirements and Capacity

3.1 Clinical Strategy & Strategic Options

We have developed a programme of work, designed to support our Divisions to undertake a detailed analysis of individual service lines/specialities to test for long term sustainability and where necessary develop plans to address any areas of weakness. We will use the Monitor sustainability tests to ensure the strategies are developed to deliver services which are clinically, operationally and financially sustainable, and which provide a high quality experience for our patients. The underpinning demand and activity projections to support our strategic analysis will be jointly agreed with our commissioners and we will continue to engage with key stakeholders to inform and challenge our analysis and strategic options.

To enable the development of service line strategies and ensure a consistent approach we have classified our portfolio of services against the following areas & identified the following high level strategic options:-

Service Line Strategy	Acute Core Services	Supporting Core Services	Value Added Services
Invest	●	●	●
Divest			●
Redesign	●	●	●
Partner		●	●

The CSS builds on our mission to be a first class district general hospital and specifically supports our corporate objective of *delivering sustainable appropriate and high performing services for our patients and communities;* and alongside our Quality Strategy are the means by which we will drive sustainable quality improvement.

By engaging with our patients, staff, commissioners and local communities our Clinical Services Strategy will provide the framework by which we review each of our clinical services, developing them as necessary, forming partnerships with other providers where this provides the best model of high quality care and occasionally withdrawing from provision of a local service.

The strategy will also identify any areas where we believe we could offer a better service than other providers so will also highlight new areas in which we could provide health care.

It is expected that the Clinical Services Strategy will be summarised by the end of Q1 2014, reviewed and prioritised by the end of Q2 and implementation to follow thereafter.

There are three overarching themes that underpin the CSS and Quality strategy and are congruent with the plans of our commissioners:

3.1.1 Improving the urgent care pathway for our patients

Our aim is to ensure that the quality of care we provide for our patients is of a consistently high standard regardless of the time or day of presentation. We aspire to get it right first time every time for all points on the patient journey from first contact to when the patient is discharged from our care.

To achieve this we are engaging across the whole health community to undertake the planning and development of an Urgent Care Village. This concept is intended to enable a true whole system approach to the clinical management of patients presenting for urgent healthcare.

As part of this model we are reviewing the location of paediatric and adult assessment services, our emergency department and further develop partnership working with co-located urgent primary care providers so a seamless flow of self-presenters can be steered towards the most appropriate service.

We will seek to deploy more senior clinicians at the front end of our processes by locating more of them within the Urgent Care Village and ensuring separation of assessment processes from admitted patients. This will also add to the significant progress in ambulatory medical management of patients we have already achieved. Early senior assessment will aid rapid diagnosis and the initiation of the appropriate care helping to prevent unnecessary admissions or shortening length of stay by starting the right treatment immediately.

We are working with DCHS to improve pathways between our hospital and our local community hospitals with the aim of streamlining discharge and improving patient experience during transfer.

This work will also include the expansion of our diagnostic services to enable 7-day services thus ensuring appropriate access to key information relating to diagnosis and treatment whatever the day. Finally this work will embrace the concept of planning discharge from the moment of admission.

3.1.2 Ensuring our planned care services are of high quality and sustainable

To achieve this we are working with our commissioners to increase interventions in an outpatient setting where clinically appropriate. Our transformation programme will support us in improving our day case rates and further adoption of enhanced recovery techniques will clinically drive reductions in our average lengths of stay. We will build on the success of our theatres admission lounge by investing in redesign of our theatres as part of a two year refurbishment programme.

Where appropriate we will seek to improve the patient experience and gain greater efficiencies from enhancing the 7-day services across services by providing a greater flexibility of planned care provision. The initial aim of extending the working week for planned care will be to give easier access, particularly to outpatient services, for patients with working commitments in normal office hours.

3.1.3 Delivering our commitment to provide robust & accessible cancer care for our local Population

We will work with our cancer network to further develop the oncology services provided for patients locally. We will seek to operationally embed the acute oncology service established in 2012/13, which supports our aim to strengthen urgent care services and provide more ambulatory models of care. We will also work with our partners to enable rapid development of home delivered chemotherapy as new drugs and regimens become available. We will improve non-chemotherapy outpatient treatments for all oncology patients recognising the importance of minimal hospital time to this group of patients.

To achieve this we have developed a comprehensive acute oncology service model and are redesigning our local diagnostic pathways to reduce current waiting times. We have increased capacity to respond to the rise in demand for bowel cancer services and continue to work alongside our local commissioners to project future increases in demand as a result of patient awareness campaigns. We are developing a new cancer unit and are exploring the potential benefits of co–locating haematology and solid tumour chemotherapy services.

The Trust is in the process of working with Macmillan Cancer care to develop a new cancer treatment centre on site by 2016 which will improve the quality of care received by patients in Derbyshire.

3.2 Supporting or enabling strategies- Inputs required

In order for the Trust vision to be achieved it is underpinned by a number of supporting strategies which are outlined in the following paragraphs.

3.2.1 Site Development Plan

The site development plan (details summarised in Section 5.3.2) forms part of the Trusts overall financial plan and also forms the basis of the estate and building elements of the Trusts capital programme. The plan is compatible with the development of the Trusts clinical services strategy.

Aside from the ward refurbishment, the critical building scheme for 2014/15 is the refurbishment of the operating theatres which is due to be completed in June 2014 and the extension to the Medical Records department to assist with the better management of patient notes.

As the programme moves forward into 2015/16 allocations have been ear-marked for work on the Cancer Centre, Endoscopy Upgrade and phase 1 of the Urgent Care Village.

3.2.2 IM&T Strategy

The IT strategy aims to balance many competing priorities on the Trusts IT services in an effective and rational way as the NHS enters a period of intense and rapid change. It is aimed at providing services that are focussed on improving access to patient information and supporting speedier and more effective decision making. After extensive consultation the following are the key priorities for the IT department over the next 2 years.

- **PAS system- May 2014**
- **Clinical portal- 2016**
- **Advanced reporting via the trust's existing data warehouse**
- **Development of a Service Line Reporting Tool via a Patient Level Information and Costing system**
- **East Midlands PACS consortium**
- **Maternity IT system- April - June 2014**
- **Modernise trust IT infrastructure**
- **Further develop the 5-year IM&T replacement system plan**
- **Access to partner IT networks to encourage & enable more partnership and efficient working**

3.2.3 Workforce

The Trust strategic workforce plan is designed to support the achievement of the six objectives for the hospital. It specifically underpins the achievement of delivering sustainable, appropriate and high performing services for our patients and communities, supporting and developing our workforce, and is underpinned by the vision have having a truly engaged workforce.

Staff are more positive about some aspects of working for the Trust and the most recent National Staff Survey (March 2014) has shown encouraging signs of increased engagement, including the opportunity to contribute to improving their working environment, although we recognise we still have more to do to equip leaders with the skills to support and develop their staff effectively. In response to this and to support the overall Trust strategy the workforce strategy can be summarised as follows:

Strengthening our workforce planning processes and initiatives to ensure we have the right numbers and skill mix in the workforce to deliver the strategic objectives.

The following areas have been identified as priorities:

- **Reviewing the use of different workforce models given the challenges in recruiting to traditional roles.**
- **Re-configuring how we source temporary staff to work in the hospital and how we manage movement internally to aid retention.**
- **Developing our learning and education framework to ensure we are able to enhance the skill mix across medical and clinical staff, and**
- **Continuing the development of our programme of apprenticeships and internships to enable us to grow and develop the right skills for the future within the Trust.**

Reviewing our learning and development provision

We will be working to ensure that the training essential to all staff in the NHS is delivered in the most effective and efficient way possible, including through increased provision of e-learning. This will free capacity to deliver more face to face training on patient care, including areas such as dementia and care skills for healthcare assistants.

Reviewing work patterns and remuneration packages across the Trust

As a National pilot Trust for the provision of 7-day services to support patient care we will be reviewing our approach to remuneration and work patterns for 'out of hours' working and also supporting managers with the culture change necessary to enable effective use of resources to deliver services across 7-days.

To put in place an organisation development plan to develop leadership capability and build staff engagement in the Trust

We know that the impact our leaders have on staff engagement is critical and we need to continue to build our leadership capability, particularly amongst our clinical leaders. Evidence from the 2013 staff survey suggests that we are starting to make progress in improving staff engagement and the output from this will further inform the plans in early 2014.

The plan being developed incorporates a number of elements:

- **Further leadership development modules as part of the Skills Lab programme designed to equip all leaders with basic skills building on the modules already delivered in 13/14,**
- **A formal senior leadership development programme,**
- **Launch of our Let's Talk Care programme (March 2014), a series of 250 workshops for all staff to attend to have a conversation about what our Proud to Care values really mean for staff,**
- **A new appraisal process,**
- **A quarterly pulse survey to engage further with staff, and**
- **Incorporating values based recruitment approaches.**

3.2.4 Facilities Services

Setting aside the capital investment programme for the built environment, the role of the facilities team as a whole is to plan its services around both the clinical priorities and the contracts agreed with our commissioners.

The facilities team has the challenge of being more agile in the delivery of their services as clinical requirements change. For example, the move to 7-day services will bring some changes to the facilities function. Although we have a comprehensive 7-day cleaning service on our wards if we are to move toward, for example, more out-patient activity at weekends and during the evenings then we will need to revisit our arrangements for cleaning. Similarly more operating at weekends may change our approach to maintenance within the operating theatres. Changes to theatres scheduling and the level of activity within theatres also brings with it changes to decontamination rotas and the way in which we look to provide our decontamination services. This means revisiting working hours and may mean moving to extended shifts.

The opportunities for taking a more commercial approach to the management of the Trusts estate and its retail functions is a real opportunity for facilities services in future. As part of our transformation programme we are working with commercial advisors to explore opportunities for using our estate as a means to generate additional revenue to support clinical services.

3.3 Impact on Costs

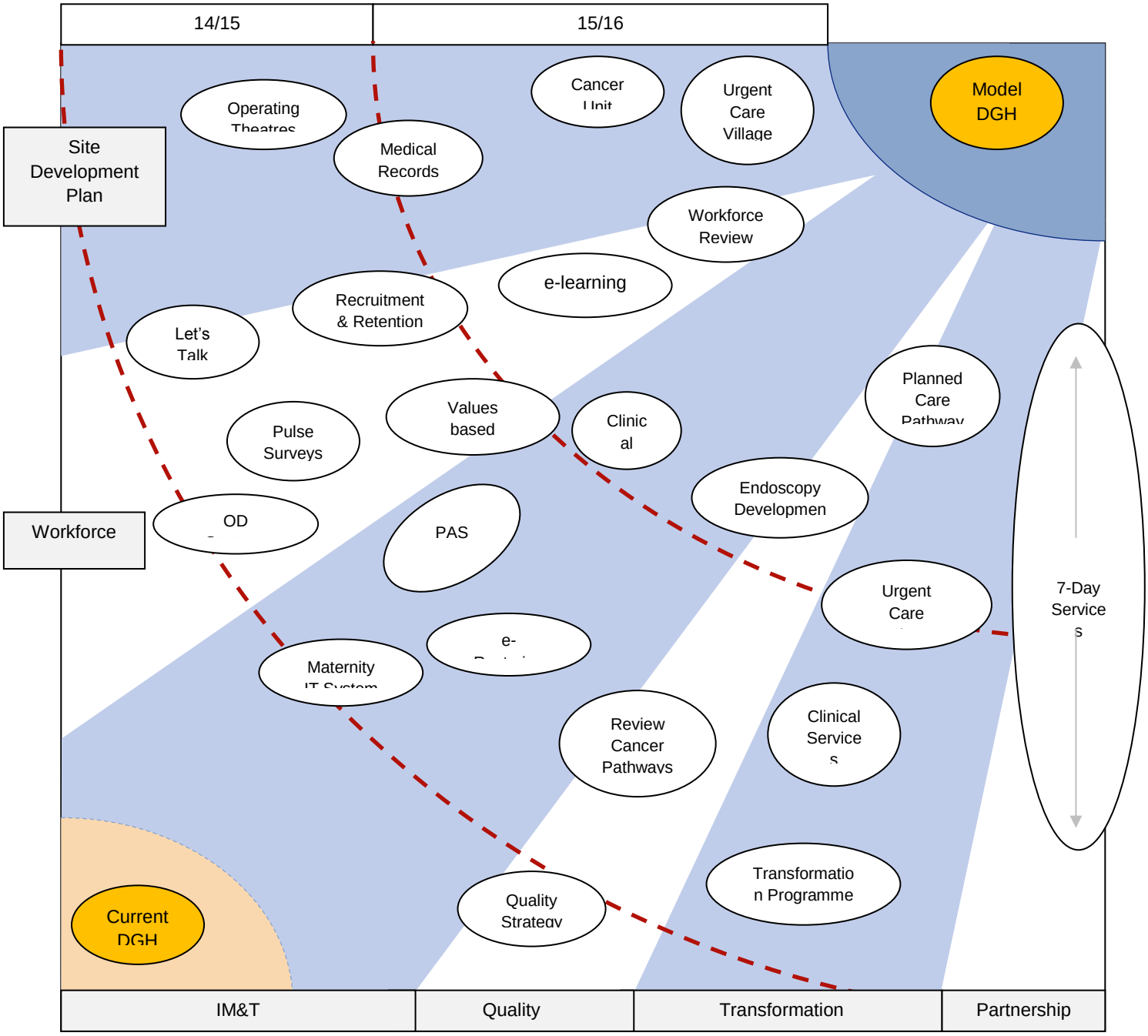
Current headcount in the Trust is 3651 and we anticipate that this will remain relatively stable as our nurse establishment should be fully recruited by end 14/15. Small changes will happen as a result of efficiency initiatives across the Trust to achieve our Cost Improvement Plans (CIP) targets for 2014/15 & 2015/16, including a review of corporate structures following the work done to re-organise clinical services into Divisions.

In addition work will be undertaken reviewing staffing models and flexibility under Agenda for Change terms and conditions to drive improved productivity and reduce pay costs to identify potential contributions to the cost improvement target over the next 5 years. Whilst some investment may be required to support 7 day services this will be required to be off-set by improved efficiency of clinical pathways.

Turnover and sickness absence are both higher than we would want although both have shown a reduction in 13/14. The Organisational Development strategy and the impact of our recruitment plans are hoped to gradually start to improve this as we build staff engagement with our future plans. A further reduction in both is being targeted over the next two years.

Locum and agency spend has been high in some services and action during 13/14 in microbiology and ED has reduced spend on locum doctors in the year. A further reduction is targeted in 14/15. The investment in permanent nursing roles following targeted recruitment activity and a planned move to a managed service for the provision of temporary staff will reduce the agency spend, with a targeted reduction over two years of a third, which equates to £2m. This is supported by the experience of other organisations who have implemented this approach.

Diagram 3 below provides an illustration of the strategies and milestones to be delivered over the next two years.



4.1 Transformation programme

The Trusts Transformation Programme sets out a 5-year plan to deliver a minimum of 4% efficiency improvement (combined internal only and partnership pathway driven) per annum. The Trust engaged KPMG in 2013 to identify potential areas of transformation which could lead to the scale of cost reduction required over the next 5 years. The savings identified in these areas need to be validated as part of the development of the programme.

The transformation programme is designed to support the clinical services strategy and ultimately reduce the costs of delivery whilst continuing to deliver high levels of patient service and experience.

The financial challenge over the next 2 years is to deliver an estimated £15.4m savings which equates to approximately a 4.0% reduction of the operating budget in each financial year.

Delivery of the programme across the Trust is primarily via primary, secondary and tertiary schemes, which can be described as follows,

- ***Primary schemes*** –where Divisions are empowered to progress quickly with simple schemes which affect only their area (e.g. moving to a paperless maternity system as part of improving controls assurance as well as work methods).
- ***Secondary schemes*** - being larger schemes which encompass more than one area working together within the Trust for successful delivery. (e.g. urgent care pathway redesign).
- ***Tertiary schemes*** - again being larger schemes which involve working with partners outside the Trust to deliver services differently across integrated care pathways or across different geographical areas. (e.g. East Midlands Pathology Alliance & South Yorkshire Working Together Programme).

The Transformation programme is overseen by a multi-disciplinary Innovation Board (IB) chaired by the Medical Director. The Transformation Support Team (TST) adopts project management office (PMO) disciplines providing both support and leadership for Transformation/Innovation projects, and an assurance mechanism to track benefits realisation and successful delivery of these projects

The main transformational themes that are expected to deliver the scale of savings is summarised in the table below (note that the savings quoted are an indication of the level of savings and may vary subject to the success of implementation)

Table 1

Schemes	2014/15	2015/16
Primary Divisional Schemes (traditional CIP's)	2.0	1.5
Planned care pathways streamlining (reduced length of stay)	0.6	-
Urgent care pathways streamlining (reduced length of stay)	-	3.4
Theatres efficiency programme	0.6	
Reduced Agency/Locum spend	3.5	0.7
Commercial Arrangements, Procurement & Coding	0.7	1.6
Other	0.6	0.2
Total	**8.0**	**7.4**

4.2 Governance of the Transformation Programme

The Innovation Board is effectively the steering group for the transformation programme. Its prime role is summarised below,

- Co-ordinate the delivery of the Transformation programme
- Ensure that change proposals are assessed in terms of the impact on service quality.
- Promote a culture of innovation in practice across the organisation
- Promote all activities relating to innovation and change, including the Choices project, NHS innovations and work with NHSIQ.
- Review and appraise business cases for quality/service improvement in order to advise the Hospital Leadership Team on those with practicable application.
- Secure effective cross-Division, multidisciplinary working on cross-cutting themes and issues.
- Tracks progress with implementation

The Trust Support Group (led by the Medical Director) effectively holds the Divisions to account in terms of their delivery of transformational change.

Prior to transformation schemes being implemented they are assessed to ensure that they are:

- Financially deliverable
- Have measures in place to ensure that clinical safety is not compromised and the quality impact is understood
- Have evidence of staff engagement or be able to show how wider input will be gathered during more detailed work to shape delivery

For secondary and tertiary schemes, a formal project initiation document (PID) is expected to be created.

The PID includes Monitors quality impact assessment (QIA) and a summary of outcomes required from the change that are deemed as critical to the quality of any revised pathway or process.

The Quality Assurance process is designed to identify prior to CIP implementation the risks from a financial, quality and delivery point of view, and follow-up during implementation to monitor any unintended consequences.

4.3 Training and development of staff

The main focus of the Transformation programme needs to come from and be owned and delivered by front line staff within the Trust. We are therefore continuing with a programme of training and developing staff within the Divisions to deliver transformational change.

The Trust's CHOICES team have devised and delivered a training package for Change Agents, and Service Improvement Leads transformation within Divisions, based on a range of industry best practice methods and including project management techniques.

There are now 70 trained Change Agents within the organisation and all Divisions have dedicated Service Improvement Leads for the Transformation programme. How well these resources are utilised in the transformation programme will be the subject of an audit during 2014 to assess development of learning and put support in on an individual basis if required to ensure they are equipped to deliver the challenge ahead.

The approach taken is one of front line staff being empowered and being given the right tool kit and training to deliver transformational change, whilst also having access to a central support team to help develop ideas and to deliver change programmes.

4.4 2014-2016 commentary on the top 5 schemes

4.4.1 Agency Locum Workforce - £4.2m (2014-2016)

Part of the OD Strategy is focussing on our ability to retain and recruit the appropriate clinical staff to support workforce requirements. For medical locum agency, three areas (ED, Microbiology, and Ophthalmology) have already enabled savings of approximately £0.7m to be achieved in 2013/14, with additional full year effect savings

£0.5m expected to be achieved in 2014/15. Vacant consultant posts in Diabetes and Acute Physicians in our Emergency Management Unit are planned to be filled prior to April enabling further savings of an additional £0.5m on agency cover.

Significant emphasis has also been given to our increasing Nursing agency spend over the last 12 months (as described in section 2.3 – Temporary Staffing). Savings of £2.0 million in reduced nursing agency spend are assumed based on the dual impact of the implementation of a managed nurse bank service and additional recruitment to at least 30 wte's, including recruitment from overseas. Additional £0.7m savings are planned for 2015/16.

In 2014/15 we are planning to reduce agency expenditure on senior administrative roles by £0.5m.

4.4.2 Planned Care Pathway Streamlining - £0.6m (2014/15)

During 2014/15 further work is taking place to improve Length of Stay (LoS) and improve the patient experience for Surgical and Orthopaedic patients. Reductions to LoS on Hips and Knees and Fractured Necks of Femur (NOF) pathway plus the impact of an enhanced discharge pathway will result in significant efficiencies to the Pathway enabling a reduction in associated bed capacity. Savings from the above initiatives will enable £0.6m in savings which equates to half a surgical ward.

4.4.3 Primary Divisional Schemes - £3.5m (2014-2016)

All Clinical Divisions have a minimum 1% efficiency challenge and corporate areas a 2% efficiency challenge, which in total equates to £3.5m.

4.4.4 Urgent Care Pathways - £3.4m 2015/2016

Similarly to the Planned Care pathway work, we are scoping our top 10 opportunities based on diagnosis where the Trust is outside of upper quartile performance for appropriate peers on length of stay. The £3.4m is the anticipated net impact of reducing bed requirements by two wards through reduced length of stay and appropriate discharge.

The Trust has a proven track record of this, implementing a range of schemes through winter 2012/13 which resulted in a length of stay reduction equivalent to a ward. This was subsequently purchased by the commissioners as a transitional ward meaning patients move into a community model ward within the hospital footprint, ensuring they receive the right care, at the right point with reduced handover between organisations and in effect reducing the length of their acute episode of care.

Following a pilot in Q4 2013/14 the local health environment is supportive of continuing the trusts Adult Re-enablement Unit. The Adult Re-enablement Unit will improve patient outcomes and patient flow focusing multi-organisational health and social care expertise immediately on admission to support the return of patient's to their own homes as soon as possible.

4.4.5 Commercial Opportunities and Procurement - £2.3m (2014-2016)

In 2013/14 the trust has been reviewing a number of commercial opportunities to increase cash revenues and/or decrease costs, which directly support improvements to patient care or have no detrimental impacts.

For example the trust will look to make best value of the available site through the Site Development Plan (Section 5.3.2), review opportunity to develop commercial partnerships, support staff with opportunities around salary sacrifice (e.g. Car Schemes) and look to take further advantage of advertising and sponsorship.

The trust will be implementing the above schemes throughout 2014/15 to 2017/18 as opportunities are developed. This is a new direction for the organisation and savings have been set at a conservative £0.3m plan for 2014/15, increasing in 2015/16 by a further £1.4m. Overall savings for future years are continuing to be developed as this work evolves.

Most significant schemes being explored include partnership arrangements for gas extraction from the hospital site and options for land to be used for a care home development as part of discharge arrangements.

The Trust is also targeting procurement savings of £0.6m in three main areas, product standardisation and value for money review of top ten spend clinical and non-clinical consumables, rationalisation of product catalogues and review of contracts.

4.5 Cost Improvement Plans (CIP) enablers

Significant investment has been made into the Transformation programme infrastructure, with the TST Central Team, Service Improvement Leads being supernumerary in nature, and Change Agent element roles. The aim is to ensure that the Transformation programme is sufficiently resourced to avoid being side-lined by the need to 'do the day job'

In addition to the above, external support has been and will be brought in when there is either a need to stimulate thought processes and/or to deliver additional capacity if required. KPMG were appointed during 2012/13 to work with the Trust to provide support to identify and scope efficiency and service transformation opportunities over the next five years.

The benefits that will be realised from this external support are:

The work has identified a number of Project Outline Documents (PODs) covering 85 separate areas for service improvement, which have also been categorised by size of impact and complexity to deliver. Significant savings have been estimated, but further work is required to validate the actual potential.

The report, summarising this work, has been considered by both HLT and with wider staff at a separate Leadership Assembly in April 2013 and was presented to the Trust Board in June 2013. The next stage of the output from this work is to assess the viability of converting the identified project opportunities into transformation projects appropriately phased over the next 5 years, which will complement the CSS.

Section 5 Financial and Investment Strategy

5.1 Trust financial position

The Trust enters the 2014/15 financial year in a strong position. The Trust achieved a Q3 cumulative surplus of £2.2m (plan £2.5m) with a forecast outturn surplus of £2.2m (plan £2.6m) excluding Impairments. This is an EBITDA of 5.8%. In addition the trust has a positive track record of achieving its required efficiency savings year on year.

The Trust also holds contingency reserves of £3.1m to help manage any cost pressures during the course of its financial year.

Cash and liquidity is strong with cash balances at 31st December 2013 of £43.9m (plan £43.6m) with a forecast year end cash balance of £42.6m (plan £41.0m). The Trust had a Finance Risk Rating of 4 throughout Q1 and Q2 2013/14 and a Continuity of Service Risk Rating (COSRR) of 4 for Q3 and also forecast for Q4, the COSRR represents the lowest risk. The Trust's approved working capital facility (WCF) of £11m ended on 30 September 2013 and has not been renewed given the strong cash position of the Trust and also given this is no longer being taken into consideration as part of the COSRR calculations.

5.1.1 Impact of the 'Better Care Fund'

The Better Care Fund (BCF) was launched mid 2013 by NHS England & the Local Government Association setting out opportunities presented to Health & Social care to use public money more wisely in order to provide care to patients closer to home and prevent avoidable hospital admissions, amongst other targets. £3.8bn has been identified and allocated by pooling together the NHS and Local Government resources that are already committed to existing core activities; it is therefore not 'new' money. It calls for a new shared approach to delivering services and presents Councils, CCGs, and providers with an opportunity to shape sustainable health and care. However, it does create challenges for providers, especially acute providers like CRH, as funding will be expected to transfer from acute to community/social care services, rising to c£26m for North Derbyshire & Hardwick CCGs in 2015/16.

There is considerable collaboration already underway within the LHE identifying ways in which this fund can be best utilised to benefit the population of Derbyshire, as mentioned in section 1.3. Integrated models of care are being developed by the 21st Century Steering Group and the Urgent Care Steering Group which is facilitating the implementation of a number of initiatives to provide seamless care across organisational boundaries in North Derbyshire. For example the implementation of the Virtual Ward led by Hardwick CCG, the establishment of an Adult Re-ablement Unit based at CRH but supported by a range of staff from the hospital, community services and adult social care, the co-location of the GP Out of Hours service adjacent to the hospital's ED to allow appropriate movement of patients between the two services and more.

Members of this group and representatives from the South Derbyshire LHE together with partners from Derbyshire County Council have worked collaboratively to develop a county wide model for integrated care, and there has been

very good engagement in the development of the plan, under the auspices of the Derbyshire Health and Well Being Board, which will form the basis for the application of the Better Care Fund (BCF).

5.1.2 Summary Financial Projections

These are summarised in Table 2 below:

	2014/15 £m	2015/16 £m
Turnover	203.8	198.0
Cost Improvement Plan	8.0	7.4
EBITDA	11.4	11.6
Surplus before impairments	1.5	1.5
Impairments	(0.6)	(2.8)
Surplus after impairments	0.9	(1.3)
Cash	37.5	31.8
Financial/Continuity of Service Risk Rating	4	4
Contingency reserve	3.1	3.1

Impairments relate to downward revaluation of assets. The impairments noted above, particularly in 2015/16, relate to capital expenditure on major schemes (see 5.2.2 on theatres, urgent care village, cancer build) being more than the increased value of the asset, resulting in the asset value being impaired on completion down to their new estimated value.

The impairments are therefore a technical accounting adjustment and the surplus before impairments is the true measure of the underlying financial performance of the trust.

5.2 Congruence of Commissioner & Provider activity and revenue assumptions

The trust recognises the need for the local health economy to have congruent operational and strategic financial plans. The trust has worked in partnership with our local commissioners to develop an activity contract plan that is both realistic and sensible in terms of meeting the shifting needs of the local patient population and supporting the financial sustainability of all organisations. The operational and strategic activity and revenue plan for the trust will triangulate to that of our commissioners, including Specialist Services and Local Government commissioned services e.g. School Nursing Contract and Genito-Urinary Medicine (GUM).

Revenue assumptions include agreements for key investments as described in section 5.3.1 below. Those investments from re-investment of Marginal Rate Emergency Tariff have been discussed and agreed via our local Urgent Care Boards as priority investments to support reduced unplanned admissions and/or improve a patient's recovery through earlier discharge.

The trust has planned for a reduction in ward capacity from September 2014 on the basis of the successful implementation of a number of Marginal Rate Emergency Tariff funded schemes across the local health community. This is a based on a mixture of admission avoidance and improvements to patient pathways enabling faster discharge and therefore reduced length of stay. Within the financial plan this equates to £1.7m of capacity reduction to meet the reduced non-elective demand in 2014/15 and £2.8m in 2015/16.

5.3 Key financial priorities and investments

5.3.1 Key investments are summarised in Table 3 below:

	£m	
Overall reduction in activity volumes	(1.0)	
Growth in High Cost Drugs and Devices	2.1	1.8
Counting and Coding Changes	0.7	
Adult Re-Enablement Unit and Community Geriatricians (MRET)	1.1	
Continuation of Senior Clinical Decision makers (MRET)	0.8	
Palliative Care Specialist (MRET)	0.1	
Case Mix Impact	0.5	
CQUIN Movement	(0.1)	
Less net tariff deflator	(2.7)	
Recurrent Commissioner Investments	**1.5**	
Continuation of Step Down Facilities (Elizabeth Ward)	2.1	
Continuation of Increased emergency capacity	0.7	
Children's Community Paediatrics	0.7	
Tariff Structure impact (Maternity Pathway)	0.4	
Transformational Funding Support	1.1	
Ambulatory Care Incentivisation	0.1	
High Cost Drugs Gain Share	0.2	
Less non-recurrent agreements in 2013/14	(8.2)	
Non Recurrent Commissioner Investments 2014/15	**(2.9)**	
Total Commissioner Investments 2014/15	**(1.4)**	

These link into the Trust's overall strategy as follows:

- **The 2014/15 patient care contract shows a £1m reduction in overall activity compared to the 2013/14 contract. This is predominantly a planned reduction in Non-Elective activity (1.7%) on the basis of successful implementation of MRET schemes across the local health economy. Emergency capacity funding of £0.7 million is being continued April to August to ensure that there is sufficient non elective capacity for 2014/15. From September the trusts non elective capacity is planned to reduce by the equivalent of 1 ward, subject to certain conditions being achieved (see section 1.5).**

- **Investment in the Adult Re-enablement Unit is as described in section 4.4.4 and is supplemented with a Community Geriatrician model to support the LHE with an outreach model helping to keep this cohort of patients at home safely.**

- **Additional Emergency Department consultants and Acute Physician consultants in our Emergency Management Unit are in place to provide senior review prior to admission to support quick senior review and decision of patients to enhance patient flow through the hospital and reduce unnecessary admissions. This has proved successful with the trust consistently achieving the quarterly ED 4 hour wait target in 2013/14.**

- **An additional Palliative Care Consultant is being invested to support patients to die in their preferred place of care and with potential to support a 'virtual hospice'.**

- **The £1.4 million investment in step down facilities is being continued to provide on-site capacity for patients who are medically fit for discharge but are awaiting arrangements to be finalised for home, community or social care settings. This service has also been enhanced since autumn 2013 by £0.7m with additional Therapy, Pharmacy and Advanced Nurse Practitioner input taking the total investment to £2.1m.**

- **The specific schemes for Transformational funding support are still to be confirmed with commissioners and other local partners. However it is intended that this supports investment in 7-day Therapies and Diagnostics. This is subsequent to pilots initiated over the last 2 winter periods that have evidenced a reduced length of stay for inpatients and quick review for patients attending ED. This has also been a key enabler with supporting the trust in consistently achieving the quarterly ED 4 hour wait target in 2013/14.**

- **Investment in community paediatrics of £0.7 million is being made to realign contracts where both service volumes and specifications have grown over recent years. This is a continuation of a non-recurrent scheme in 2013/14 whilst a revised service specification is developed across the local health community**

5.3.2 Capital expenditure programme

Capital expenditure investment is forecast as per Table 4 below:

	Reference	2014/15 £'000	2015/16 £'000
Development			
Theatres		3,900	2,600
Urgent Care Village – Initial Phase		100	1,000
Cancer Centre		100	5,000
Endoscopy upgrade		100	1,000
Orthopaedic Fracture clinic		100	900
Medical Records Extension		500	
TOTAL		**4,800**	**10,500**
Maintenance			
Minor Works		230	230
Ward refurbishments		1,000	
TOTAL		**1,230**	**230**
Other Capital Expenditure			
IT equipment & applications		2,525	1,660
Other Equipment		1,841	1,542
TOTAL		**4,336**	**3,202**
Total Capital Expenditure		***10,396***	***13,932***

The investment of between £10.4 and £13.9 million per annum in capital expenditure underpins our corporate objective of providing an infrastructure to support delivery (see 1.1).

5.4 Key financial risks and mitigation

Key financial risks, mitigation, actions and residual concerns are shown in table 5.

Table 5

Category of risk	Description of risk (including timing)	Potential impact	Mitigating actions / contingency plans in place	Residual concerns	How Trust Board will monitor residual concerns
CIP's / Cost base	Ensuring CIP's are delivered and cost pressures managed.	Non achievement of financial requirements leading to impacts on quality.	Investment in Innovation Board (IB) and Transformation Support Team (TST) to support delivery of CIP's (see 4.2). Contingency reserve funding of £3.1 million to act as a buffer.	IB and TST not operating as planned. £3.1 million buffer insufficient.	HLT overseas IB/TST and reports progress to Board. Monthly finance report to Board monitoring progress on achievement of CIP's and use of £3.1million buffer.
Activity	Under performance of activity plans. Inability to increase/decrease capacity sufficiently to match demand. Above contract Non Elective Demand paid at 30% (MRET)	Reduced funding which if not contained will impact on quality. Lack of capacity to match activity impacting on quality. Excess capacity resulting in a cost base in excess of the delivered activity income. Incremental Costs of capacity not supported with sufficient incremental income.	Flexing of capacity to match actual activity (e.g. increased/decreased bed base, theatre lists, and outpatient clinics). Close monitoring of activity versus plan at sub speciality level on monthly basis. Early discussions with commissioners re demand management schemes and balancing of financial risk.	Capacity not flexed sufficiently to deal with significant changes above/below forecast. Demand Management Schemes unable to deliver in the short term.	Monthly reporting of activity to Trust Board and Contract Management Board
Locum / agency	Excessive use of locums / agency staff.	Excess financial cost of locums/agency staff. Impacts on quality of service provided.	Transformation programme work to reduce locum / agency spends. Implementation of a managed nurse bank to manage our temporary non-medical staffing workforce. Clinical services strategy highlighting areas which need to be addressed.	Locum / agency usage not reduced sufficiently.	IB/TST progress reports to HLT and Board. Quarterly monitoring of locum/agency usage by Board.
Quality incentives / penalties	Incentive payments (e.g. CQUIN not being achieved.) Quality targets not being achieved leading to penalties.	Loss of CQUIN income which if uncontained impacts on quality. Penalty payments which if uncontained impacts on quality.	Close monitoring of achievement of CQUIN targets with appropriate action to rectify. Close monitoring of quality targets and contractual limits placed on potential penalties in main risk areas Use of contingency funding of £3.1 million to contain effects of above.	Lost income / penalties that cannot be contained within £3.1 million.	Monthly reporting of performance on CQUIN and quality targets to Board and Commissioners.