Frimley Park Hospital NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

Frimley Park Hospital NHS Foundation Trust

1.1 Operational Plan for y/e 31 March 2015 and 2016

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

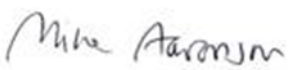
Name	**Martin Sykes**
Job Title	**Finance Director and Deputy Chief Executive**
e-mail address	**martin.sykes@fph-tr.nhs.uk**
Tel. no. for contact	**01276 604006**
Date	**4 April 2014**

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 of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;**
- **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; and**
- **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:

Signature *(Chair)*: **Name:**	 Sir Michael Aaronson

Approved on behalf of the Board of Directors by:

Signature *(Chief Executive)*: **Name:**	 Andrew Morris

Approved on behalf of the Board of Directors by:

Signature *(Finance Director)*:	

Name:	 Martin Sykes

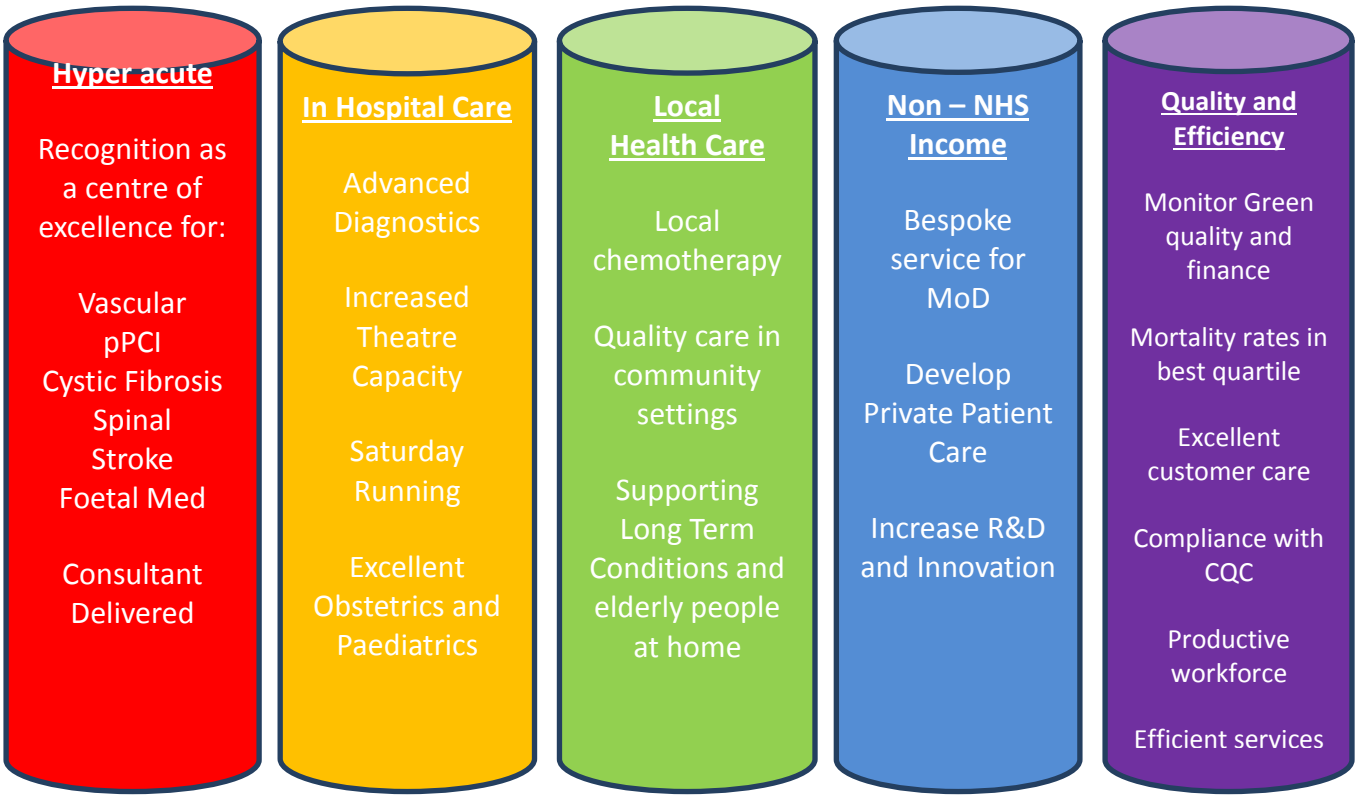
1.2 Executive Summary

Frimley Park Hospital (FPH) is one of the country's leading foundation trusts. Its recent CQC inspection (in November 2013) stated that there were no actions the Trust must take to improve patient services. It was named "Trust of the Year 2013" in the South of England by Dr Foster Intelligence. However, it still faces the challenges and a strong desire to continue to improve services for patients while also dealing with the on-going financial pressures on the NHS (including required annual efficiency savings of at least 4%).

The conclusions from recent NHS staff surveys indicate that the Foundation Trust has a committed workforce and well embedded organisational values. The Trust values overarch our key strategic themes as illustrated in the diagram below.

OUR VALUES

By being committed to excellence and by working together, we will face the future with a focus on efficiency and improvement to ensure our continued success as a leading healthcare provider



A number of the Trust recent key objectives have related to the delivery of the Hyper-Acute clinical aspirations, and these will continue in 2014/15 and beyond. The Trust has been accredited as a centre for Vascular Surgery, providing a key hub between Oxford in the North and Southampton in the South and wishes to build on this accreditation and upon the excellent reputation of its other high-end services. Key to successful delivery of these highly specialised and low volume services is the requirement to serve large enough patient volumes.

Over recent years the Trust has significantly grown market share, particularly from Berkshire with the demise of Heatherwood and Wexham Park NHS Foundation Trust (HWP). The Trust is currently examining whether the formal acquisition of HWP, would provide a rapid and permanent way of meeting this part of the Trust strategy.

It is currently anticipated that the Full Business Case for the acquisition of HWP will be completed in May 2014. Should the case prove compelling and financially viable, then the formal acquisition may take place in the summer of 2014. Clearly, the operational and financial plans detailed here relate to a 'standalone' Frimley Park NHS Foundation Trust, but should the acquisition proceed, will still need to be delivered to maintain the operational and financial viability of the Frimley Site.

The Trust financial models have been predicated upon relatively flat activity levels, reversing the trends of the recent years of significant growth. The uncertainties within the first year of the plan are largely related to activity, given that the tariffs have been published by Monitor. Monitor however, has signalled that there may be significant change in NHS pricing and reimbursement mechanisms is 2015/16 and clearly the Trust is unsighted on the impact of these. The year two figures have been estimated using the current reimbursement methods and will clearly be inaccurate to the extent that Monitor changes these tariffs in 2015.

The current two-year financial plan projections can be summarised as follows:

Summary Projections £m	2014/15	2015/16
Gross Surplus	**4,372**	**3,615**
Impairment	**- 1,086**	**- 835**
Net Surplus	**3,286**	**2,780**
CIP (cost reduction)	**9,000**	**12,500**
Capital Programme	**13,000**	**14,000**
Closing Cash	**49,095**	**48,973**

The Trust anticipates a reducing surplus over the coming two years, with the transformation plans and CIPs not entirely covering the national savings targets and local investment pressures.

The Trust anticipates a small increase in NHS income when moving from 2013/14 to 2014/15. This is after the impact of the 1.5% reduction in the national tariff, which is partly offset through 'capped' 2013/14 contracts resulted in c£2m of activity not being reimbursed in that year. Moving from 2014/15 to 2015/16, the Trust anticipates NHS income to decline. Both of these represent a significant reduction in the growth seen in recent years, where the Trust has seen activity and income growth totalling c£10m per annum. The Trust is working closely with commissioners to help to mitigate the historic growth trends and together we hope to limit growth to the relatively flat levels indicated in the Trust plans.

Summary Financial Projections £m	**2013/14**	**2014/15**	**2015/16**
NHS Income	254,195	254,287	252,878
Other Income	35,993	36,140	37,108
Total Income	**290,189**	**290,427**	**289,986**
Operating Expenditure	-269,881	-271,658	-271,192
All Other Expenditure	-15,043	-15,479	-16,014
Total costs	**-284,923**	**-287,137**	**-287,206**

The Trust capital programme has been set at a level that, all other things being equal, should maintain the Trust current cash holding.

The Trust anticipates that it will register as a '4' in both of the Monitor financial risk metrics in both years of the plan.

Local 'Better Care Fund' schemes are embryonic, and that these are being consolidated into 'whole of Hampshire' and 'whole of Surrey' plans, means that the Trust is very much on the border of both. There is however a good level of engagement and the Trust and CCGs will be working together over the coming months to progress these plans for the benefit of patients.

In summary, the Trust continues to work closely with local CCGs and the wider health economy, both to meet its own strategic objectives and to support those of commissioners. Whilst the Trust currently strong financial position is expected to weaken slightly, it should remain in the upper quartile of Foundation Trusts.

1.3 Operational Plan

This section details how the Trust plans to continue to deliver high-quality and safe services over the coming two years, in light of the Trust key strategic objectives and the local and national context for the delivery of NHS services.

The Trust has worked closely with local commissioners, including hosting a joint strategic forum in January 2014. Trust Governors have been involved in the Trust annual planning processes through a series of public council of governors meetings and private Board / Council of Governors workshops. The most recent of these were the workshops held on 21st January 2014 and the 18th of March 2014.

As part of planning for the potential acquisition of HWP, the local Health economy has also convened a group led by the Thames Valley Area Team of NHS England, with representation from all local CCGs, Specialised Commissioners and the two Trusts. This group has commissioned detailed modelling, to extract activity and financial assumptions from the Trust plans and from CCGs plans, and to aggregate these to demonstrate the future 'gap' between these positions. This modelling aims to incorporate the current and future Better Care Fund financial changes, as well as all other known CCG strategic initiatives, and to clearly demonstrate the impact upon system-wide affordability. The group then aims to collectively address this gap, targeting service change as appropriate. The outputs from these models will be approved and discussed in April and May 2014, feeding into the CCG and FT five-year plans that are to be completed in June.

a) The short-term challenge

The Trust has worked closely with local health economy partners to define the extent of the anticipated short term challenges. These are summarised in the section below.

Frimley has been a very successful NHS provider in recent years (e.g. Dr Foster runner-up Trust of the year 2012 and 'Best Hospital in the South 2013) and patients have increasingly chosen to use the services that it offers. The associated increase in scale and catchment have enabled the Trust to develop high-end services closer to the tertiary end of the spectrum of service provision (for example interventional cardiology, vascular surgery, cystic fibrosis), than the more typical 'district general hospital' services.

Increasingly, these highly specialised services require larger patient populations to maintain their viability; this is increasingly evident in the national specifications for specialised services. As such, Frimley needs to continue to grow its population base, and is currently investigating the acquisition of Heatherwood and Wexham Park NHS FT to further this requirement.

Commissioners of NHS services in the locality (previously PCTs now CCGs and ATs) have experienced financial problems for the majority of the past two decades. The current NHS funding constraints compounded by the 'Better Care Better Value' transfer out of NHS funding, means that these issues are

likely to continue for the foreseeable future and may worsen. This means that income growth is likely to slow, and may even reverse.

The impact of the Better Care fund and other National initiatives to reduce Hospital care will be felt through reduced patient volumes and associated income. Should these reductions exceed underlying growth (i.e. present a net reduction in activity for the Trust) then there will be a net reduction in income. There will however also be a reduction in associated cost, thus mitigating the financial impact of the change. The key task for the Trust will be firstly to continue to grow catchment to minimise any net reduction in income, and secondly to drive out as much associated cost as possible should there be a net reduction in activity. In contrast, the annual national tariff deflator (efficiency target) is a straight reduction in income for the same activity (and associated cost) and is potentially therefore a more significant issue. Monitor planning guidance indicates that that the efficiency requirement for the coming two years will be 4.0% and 4.5%, with Monitor's own research indicating that only approximately half of this is likely to be deliverable through more efficient ways of working. Monitor expects that the difference will be achieved through 'tariff leakage' (getting paid more for the same activity), which will be increasingly difficult to achieve in light of the pressure that the Better Care Fund reductions will bring to bear on CCG baselines.

Regardless of these constraints, we wish to build on our ambitions to develop pioneering, specialist services. We have delivered the largest primary cardiac angioplasty service in Surrey and wish to extend its scope to a larger catchment service. This is partnered with our delivery of a hyper-acute service for patients with acute stroke and our emergency vascular service. We believe these are model integrated services that allow us provide this expertise to a wider catchment population. As part of this vision, we have launched the Surrey Heart, Stroke and Vascular Centre to co-ordinate this service. It will be the next logical step that we help deliver the Keogh ambition to form a 'Super A and E' service for this area.

The Board monitors a number of national KPIs relating to the quality and performance of the vascular, stroke and angiography services and aims to stay within the upper quartile in England as assessed by these measures.

b) Quality plans

National and local commissioning priorities

In line with national requirements, and the continued Commissioning for Quality (CQUIN) scheme under the acute services contract, we will continue to focus on improving the percentage of patients who have a Venous Thromboembolism (VTE) risk assessment completed and we will also continue to complete the NHS Safety Thermometer (NHS-ST) tool that measures harm from falls, pressure ulcers, VTE and catheter associated urine tract infections.

Trust quality goals as defined by quality strategy and quality account

To further improve the quality of our services we have set ourselves stretching targets for the year ahead. Performance against these indicators will be included in the Trust-wide Performance and Quality Report, which is reviewed by relevant committees on a regular basis and ultimately by the Board of Directors (the Board) and the Council of Governors (the Governors).

Keeping patients safe is a fundamental and long standing commitment for the Trust and it is, as in previous years, the key rationale for the identified range of quality improvement indicators for 2014-2015.

In consultation with a wider public of stakeholders, we have identified that we will specifically, but not solely, focus on three trust wide indicators:

- *Sepsis (continued from 2012-2013)*
- *Catheter Associated Urinary Tract Infection (continued from 2012-2013)*
- *Acute Kidney Injury (new 2013-2014)*

As in previous years, we will also remain focussed on reducing the number of preventable harms from pressure ulcers, falls, and medication errors, as well as aiming to maintain the significant reductions in hospital acquired infections such as methicillin resistant staphylococcus aureus (MRSA) and clostridium difficile (C.Diff).

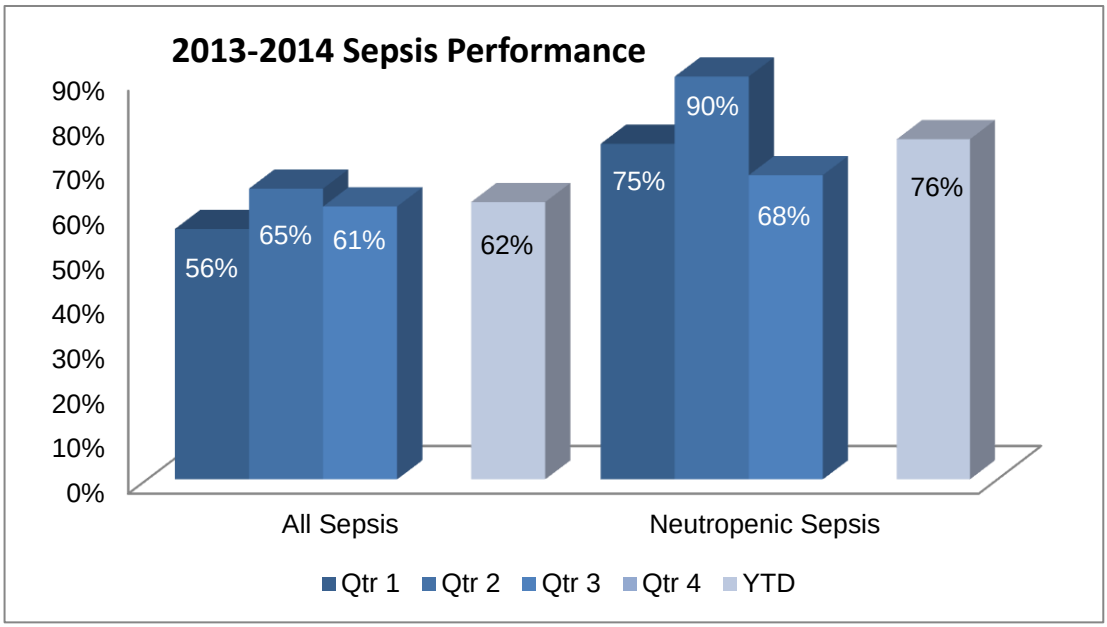
Sepsis

Sepsis is a life-threatening illness caused by the body overreacting to an infection. The body's immune system goes into overdrive setting off a series of reactions that can lead to widespread inflammation (swelling) and blood clotting in the body. In the Trust 241 patients were diagnosed with sepsis, 42 of whom were neutropenic during 2013 2014.

In 2012-2013 we started collecting data to establish a baseline for all patients with sepsis who receive antibiotics within one hour. The 2012-2013 data showed that we achieved an average compliance

percentage for all septic patients receiving antibiotics within one hour of 33%.

For 2013-2014 the Trust Sepsis Steering Group and safety committee set a target of 50% for all sepsis patients and a progressive neutropenic septic patient target of; 50% in quarter one; 75% in quarter two; and 100% during quarters three and four. 2013-2014 performance set out below.

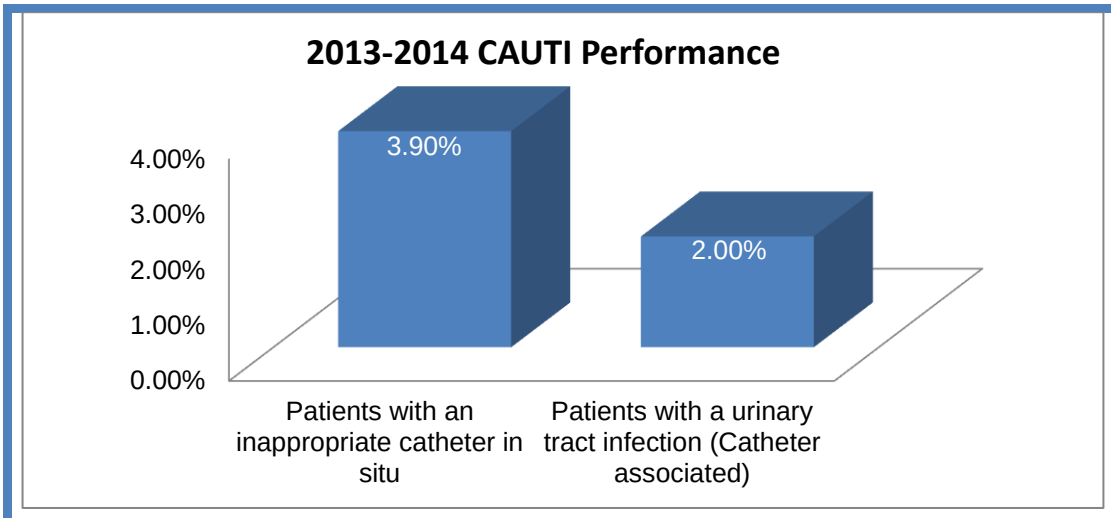


The rationale for continuing the focus on sepsis is linked to the performance data presented above. From this data it is evident that we have substantially improved our practice from the baseline of 33% for all sepsis; however there is still room for improvement in order to reach the targets described above. The Sepsis Steering Group will drive the work to embed the pathway and oversee the training programme to rapidly identify patients that develop a sepsis whilst in hospital.

Performance against these indicators will be included in the Trust-wide Performance and Quality Report which is reviewed by relevant committees on a regular basis and ultimately by the Board and the Governors.

Catheter Associated Urinary Tract Infection

A catheter-associated urinary tract infection (CAUTI) is an infection that occurs in someone who has a tube (called a catheter) in place to drain urine from the body. There is no national definition available.



The rationale for remaining focused on catheter infections is to reduce harm and the number of patients with a catheter associated urinary tract infection linked to inappropriate insertion. We intend to continue data collection against the following indicators:

- The number of patients with a urinary catheter.
- The number of patients who have the catheter inserted appropriately.
- The number of patients who have a catheter associated urinary tract infection (pathology confirmed).

Performance against these indicators will be included in the Trust wide Performance and Quality Report which is reviewed by relevant committees on a regular basis and ultimately by the Board and the Governors.

Acute Kidney Injury (AKI)

AKI is the rapid loss of kidney function.

In last year's quality report we reported that extensive internal medical record audits had been undertaken for patients who passed away in our care or within 28 days of discharge. This audit highlighted improvement could be made in the management of patients with acute kidney disease. During 2013-2014 we collected data by using the national best practice tool and established three specific work streams.

The rationale for identifying AKI as a key priority for improvement is that there is further work to do to fully embed the pathway and improve compliance. We also intend to develop an alert for the Pathology results system to improve AKI recognition and diagnosis. Key themes will include:

Further embedding of the recently developed AKI pathway.

A pathway has been developed from the London AKI network pathway. This includes a care bundle checklist to enable the early recognition and treatment of AKI. The bundle also includes the complications of AKI and the appropriate medical interventions and management options for this.

Development of medical staff training.

A training program for the junior doctors is in progress, facilitated by one of the lead patient safety clinicians. An AKI scenario has been incorporated into simulation training for junior doctors. It is a top 20 teaching subject (twice yearly) and has been the subject of the bi-monthly Medical Directors briefing to trainees on two occasions. ID badge identification reminder/prompt cards have been developed for junior doctors and poster reminders about the AKI management checklists are displayed on every ward.

Development of nursing staff training on the recognition of AKI and appropriate monitoring.

The AKI pathway was launched at the nursing skills blitz day in November 2013. The management and treatment of the AKI patient has been included in patient safety training for all registered nurses, developed around a patient scenario. AKI training has also been incorporated into ALERT (in full) training. The Preceptorship Program for nurses includes a session on AKI and the student nurses also undertake an AKI training session. Training for unregistered staff has been delivered via the care assistant induction program and the BEACHES (in full) training.

Progress will be monitored by use of the Global Trigger Tool (GTT) and an AKI audit twice yearly. Progress will be reported to the AKI Steering Group, chaired by the lead consultant for morbidity and mortality.

Other patient safety indicators

Alongside the three key areas for improvement described above, we will also aim to further reduce preventable harm in the following areas:

	2010/11	2011/12	2012/13	2013/14	Target 2014/15
HA* pressure ulcer grade 2	243	247	144	87	10% reduction
HA* pressure ulcer grade 3	16	13	15	7	10% reduction
HA* pressure ulcer grade 4	4	2	0	0	10% reduction
% falls resulting in significant injury	0.10%	0.08%	0.03%	0.02%	10% reduction
VTE % risk assessment	83%	91%	93%	97%	95%
NHS-ST %harm free	NA	NA	93%	95%	95%

c) Outline of quality concerns and risks and our plans to address them

Following the Frances report, the quality of care provided by the NHS came under the national spotlight again during 2013. In February, the Prime Minister announced that he had asked Professor Sir Bruce Keogh to review the quality of care and treatment provided by those NHS trusts and NHS foundation trusts that were persistent outliers on mortality indicators. Frimley Park Hospital NHS Foundation Trust has a very low mortality rate and was therefore not one of the trusts selected for investigation. It was however selected as one of the very low risk Trusts, to pilot the 'new style' of CQC inspection that was developed out of the earlier mortality reviews and was inspected in November 2013.

In addition to mortality indicators, the Keogh investigation looked more broadly at the quality of care and treatment provided across six key areas:

- mortality,
- patient experience,
- safety,
- workforce,
- clinical and operational effectiveness,
- Leadership and governance.

The report following this CQC visit was published in January 2014 and showed no areas of concern. Nevertheless, the Trust has developed an action plan to address areas that were highlighted either having some potential to improve, or to pose potential risk to quality and patient experience. These include the following headings that have been consolidated into an action plan monitored by the Trust Quality Committee. We are targeting a number of areas which we wish to become part of the fabric of the care we deliver:

1. Patients with dementia

The proportion of patients with dementia is increasing. We have highlighted the special requirements of these patients in the past with the use of the "Butterfly scheme". We now wish to embed the care and needs of these patients throughout the organisation, regardless of whether their need is primarily related to dementia or is present as an associated co-morbidity. To further this ambition we will invest to develop a bespoke area of the hospital for the care for these inpatients, developing an environment and dedicated to facilitate their care. We aim to have all appropriate members of our trust trained to recognise and serve the specific needs of these patients.

2. The management of the dying patient and palliative care

We appreciate that hospitals are often the place where patients spend their final days. We aim to improve how we look after patients at this important time, minimising any distress, and improving the support we give to families. Our aim is to listen to what patient's want and work with our partners in the palliative care community to provide the best possible support, seven days a week. For instance, we understand that some patients do not wish to spend this time in hospital and we will strive to respect these wishes.

3. The development of a consultant delivered 7 day a week service

We understand that patients deserve to receive a high quality consultant delivered service regardless of the day of the week they attend our hospital. For instance, we currently have daily cardiology, respiratory and stroke physicians on site but we will extend this service for all major specialities in medicine and surgery. We believe this will ensure that patients will see the most appropriate consultant at the earliest opportunity and provide the highest level of supervision for our trainee doctors.

4. The management of emergency admission pressures

The increase in daily consultant presence is part of our wider strategy to improve our response to rising emergency activity. We are adding a number of in-patient beds to accommodate this activity. Importantly, half of these will be dedicated high dependency beds to provide more specialist care provision for our sickest patients.

5. Morbidity and Mortality review

Although we strive to provide excellent care, we understand that the care of patients can always be improved and that occasionally things go wrong. We are determined that we continually monitor how we treat our patients, acknowledge to them if we could have done things better, and use these experiences to learn how to improve. We have established a hospital-wide review group to ensure that all patients who die in our care have had appropriate treatment. This group also looks at all untoward incidents that may have affected our patients and how we can learn from these incidents and prevent further episodes.

d) Quality Assurance

In August 2013, the National Advisory Group on the Safety of Patients in England, chaired by Don Berwick published the Berwick report '*Improving the safety of patients in England'*, which proposed the following principles:

- *Place the quality of patient care, especially patient safety, above all other aims.*
- *Engage, empower, and hear patients and carers at all times.*
- *Foster whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work.*
- *Embrace transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.*

The Trust has endorsed the principles defined in the Berwick report. We take pride and joy in the professionalism, skill, care, compassion and empathy that our staff exhibit every day and will work to ensure that our staff have the confidence to challenge poor practice and know that they will be supported and encouraged to do so.

The Trust has taken the following actions to strengthen and assure quality throughout the organisation, listed here against the ambitions highlighted within the Berwick report:

Ambition 1: We [the NHS] will have made demonstrable progress towards reducing avoidable deaths in our hospitals, rather than debating what mortality statistics can and can't tell us about the quality of care hospitals are providing. We recognise that we should maintain our desire to be within the best quartile for mortality regardless which statistic metric that is used.

Actions: A monthly trust wide Morbidity and Mortality (M&M) Group in place to oversee Directorate M&M groups and provide assurance to the Board that all unexpected deaths are reviewed and specialty mortality trends examined on a rolling basis.

The Medical Emergency Team (MET) scoring criteria and escalation process for the deteriorating patient has been fully embedded into practice.

The Trust has one of the highest proportions of Consultant delivered care nationally out of hours and at weekends, in line with the latest Keogh recommendations.

Ambition 2: The boards and leadership of provider and commissioning organisations will be confidently and competently using data and other intelligence for the forensic pursuit of quality improvement. They, along with patients and the public, will have rapid access to accurate, insightful and easy to use data

about quality at service line level.

Actions: The Trust uses a monthly Performance and Quality Board report to monitor national and local priority patient safety, clinical effectiveness and patient experience indicators.

We plan to introduce new specialty-level Quality Dashboards to monitor performance against stretch targets in 2014-2015.

Quality impact assessments are being conducted on our innovation and transformation programmes to ensure that the quality of services is not adversely impacted.

Ambition 3: Patients, carers and members of the public will increasingly feel like they are being treated as vital and equal partners in the design and assessment of their local NHS. They should also be confident that their feedback is being listened to and see how this is impacting on their own care and the care of others.

Actions: The Trust holds constituency meetings once a month (with the exception of August and December) in different locations throughout the Trust catchment area. The constituency meetings are very well received with an average attendance of 105 people. Twice a year extended constituency 'plus' meetings are held which are even more popular and have an average of 250 people attending. All meetings are advertised in our newsletter which reaches over 11,000 public foundation trust members, on our website, and on our patient information touch screens in the main entrance foyer to the hospital.

We have successfully implemented the national Friends and Family Test programme. Outcomes and actions are reported to, and monitored by, the Patient Experience Forum and ultimately the Board and Governors.

Ambition 4: Patients and clinicians will have confidence in the quality assessments made by the Care Quality Commission not least because they will have been active participants in inspections.

Actions: The Trust was selected as a low risk hospital to participate in the new style CQC inspection regime. Our inspection took place in November 2013 and the Trust received an excellent report.

Ambition 5: No hospital, however big, small or remote, will be an island unto itself. Professional, academic and managerial isolation will be a thing of the past.

Actions: The Trust continues to benchmark its services locally, nationally and indeed internationally.

A number of consultants have worked with National Institute for Care Excellence (NICE) to develop Clinical Guidelines ensuring patients benefit from their expertise nationally.

In February 2014 the Board was named as national Governing Body of the Year by the NHS Leadership Academy.

Ambition 6: Nurse staffing levels and skill mix will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by trust boards.

Actions: The Director of Nursing has undertaken a patient to nursing ratio and skill mix review on a shift-by-shift basis. As a result, the numbers of nursing staff have increased. Particularly trained nurses on night shifts.

Ambition 7: Junior doctors in specialist training will not just be seen as the clinical leaders of tomorrow, but clinical leaders of today. The NHS will join the best organisations in the world by harnessing the energy and creativity of its 50,000 young doctors.

Actions: The Trust was positioned as the top hospital for junior doctors in 2013 by Health Education Kent, Surrey and Sussex.

Junior doctors regularly participate in Mortality and Morbidity review meetings, clinical audits and are core members of our Clinical Governance committee. The Medical Director meets with Junior Doctors each quarter to receive feedback.

The Trust has identified the need to train future clinical leaders and has appointed a consultant to develop junior doctors in this role.

Ambition 8: All NHS organisations will understand the positive impact that happy and engaged staff have on patient outcomes, including mortality rates, and will be making this a key part of their quality improvement strategy.

Actions: The Trust Quality Strategy 2013-2016 has been shared with all staff.

Staff representatives sit on the Trust Council of Governors.

Specific comments were received from the CQC in their recent inspection report highlighting our '*overwhelmingly happy*' staff and described them as '*a workforce of dedicated staff caring for people*.' The staff survey for 2013 placed the Trust in the top decile Nationally.

The quality strategy will address a number of additional themes including:

- Emergency pressures: providing extra beds via the new ward, using winter pressures funding for more doctors in the Emergency Department (ED); running our own patient transport service; and reducing delays in discharging patients.
- Medical staffing out of hours: more juniors in the ED, medicine and orthopaedics; boosting consultant cover out of hours in medicine aiming for four consultant physicians (gastro, chest, cardiology and care of the elderly) providing leadership at the weekends, and trying to extend it still

further in the ED.

- Clinical handover: ensuring a robust handover process and having clear consultant ownership of patients.
- Ward staffing: an extra £2m has been invested in boosting staffing levels, aiming for a staffing ratio of 1:8 (days) and 1:10-13 (nights), and moving towards 12 hour shifts.
- Improving communications systems, including replacing bleeps with digital telephones.
- Medicine errors: reviewing options for safer medicines culminating in ePrescribing.
- Falls - progress work in this area to reduce number of falls further (analysis shows most occur during daytime on Mondays).
- The Trust has a well-developed strategy to improve the care of patients with Dementia; working in partnership with the Alzheimer Society that trust is aiming to be a Dementia friendly organization.

- It is recognised that people with dementia do not respond well to changes in environment and their routine. The Trust intends to develop ward F14, in partnership with patients, families and careers to provide a centre of excellence for patients living with dementia.
- The Francis Report emphasised the need for strong ward leadership therefore the Trust has undertaken Ward Leadership programme, jointly with the military - 22 senior sisters embarked on a clinical leadership programme over 9 months, finishing in the summer of 2014. The key focus of the programme was to support the ward sisters to develop the skills necessary to take ownership of their clinical area with the aim of improving safety, experience, performance and outcomes for patients.
- In April 2013, the NHS commenced reporting on the first phase of the national Friends and Family Test (FFT) for inpatients and those attending the Accident and Emergency department. We are proud to say that due to the enthusiasm with which the test is being received by our patients, our response rate is one of the highest in the country.

e) Operational requirements and capacity

The Trust has modelled a number of scenarios, taking into account potential changes in both patient lengths of stay and activity numbers, to assess its operational capacity requirements for the next two years and in particular for the coming twelve months.

Average length of stay in Medicine was 5.42 in December 2013 and the Trust plans to reduce this to 5.0 during 2014/15 (national average 5.8, national upper quartile 5.1).

Average emergency length of stay in Surgery was 5.01 in December 2013 – the Trust plans to reduce this to 4.8 in 2014/15 (national average 5.1, national upper quartile 4.6).

Average elective length of stay in Surgery was 2.7 in December 2013 (national average 3.0 national upper quartile 2.7); the Trust aims to maintain surgical elective length of stay at this level.

Taken together, these length of stay reductions will enable the Trust to accommodate a 4% increase in emergency admissions and a 2% increase in elective admissions, and would provide headroom of seven beds when operating all other beds at 95% occupancy.

The risks of non-achievement have also been modelled. Should there be no reduction in length of stay the Trust would have a shortfall of 34 beds if operating at 95% capacity and after accommodating the increases in activity as above.

The current capacity plans leave one 14-bedded ward permanently closed, but to reopen this ward will be the first risk mitigation should extra capacity be required. The Trust has access to an additional 20 beds of emergency escalation capacity through converting day surgery beds into 24/7 beds, but this does provide operational difficulties and is only contemplated in extremis (short term winter surges).

The Trust financial modelling has assumed no increase in emergency and a 1% elective activity. Taken together we anticipate that the Trust should have sufficient operational headroom and that the risks of non-reduction of length of stay can be mitigated.

As part of working towards full seven-day working the Trust is planning a number of service improvements in the coming year. As well as those listed below, each Directorate has been tasked with developing medium term plans to enhance weekend working. The immediate plans include:

- Appoint two further consultant gastroenterologists to enable seven-day ward rounds and timely referrals from other specialties. This will add to the existing 1-in-6 rota for chest medicine, 1-in-6 rota for cardiology and 1-in-7 rota for endocrine and care of the elderly thus giving all key emergency specialties a daily specialist review.

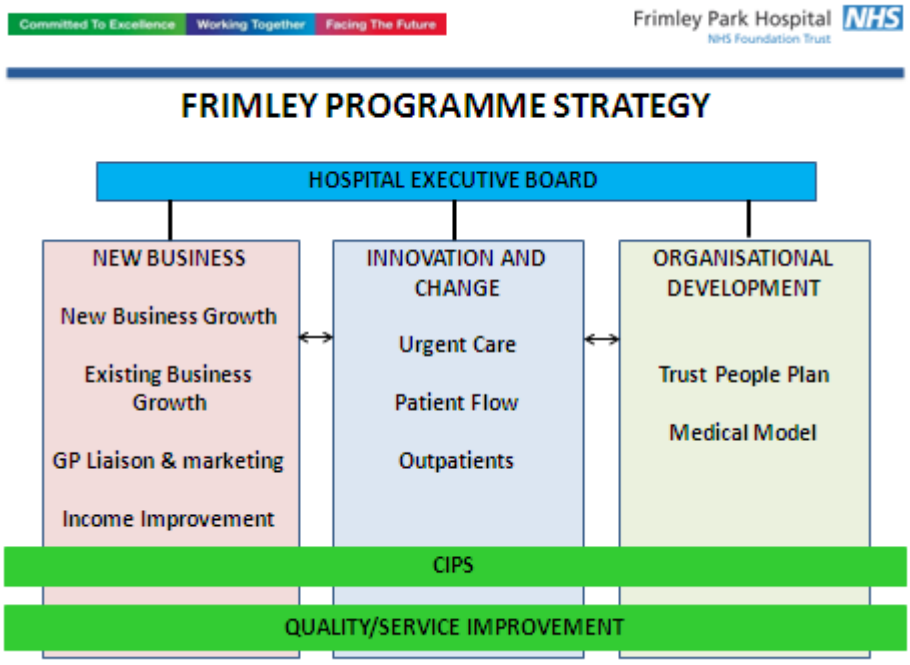
- Appoint one further MAU consultant to move towards seven-day cover and more closely match the existing A&E consultant cover that is in place from 8am to midnight seven days of the week.
- Use existing resources to ensure that all patients in critical care areas are seen twice daily by a consultant.

f) Productivity and Efficiency

The Trust has for some years operated a Transformation Plan approach that aims to modernise services across directorates thus reducing the need for individual cost improvement programmes. The Trust savings programme is formed from a number of these cross-cutting initiatives and a number of more traditional CIPs.

The cost reduction impact of the Trust CIP/Transformation Programme has been included as £9.0m in 2014/15 and £12.5m in 2015/16. The 2014/15 figure is based upon schemes that have been developed and validated. The programme for year two is less well developed and the increased requirement provides a degree of financial risk.

Each of the CIP and transformation plans has been assessed for any adverse impact upon quality. Each of the Trust transformation programmes has a set of indicators that are monitored to help to indicate whether any adverse impact may become apparent (for example the length of stay project monitors readmission rates). The Trust transformation projects are monitored in detail on behalf of the Board by the Commercial Development and Investment Committee (CDIC), which is a formal subcommittee of the Board. Transformation plan progress and the full range of Trust quality indicators are also routinely reported to the full Board. The programme strategy is illustrated below:

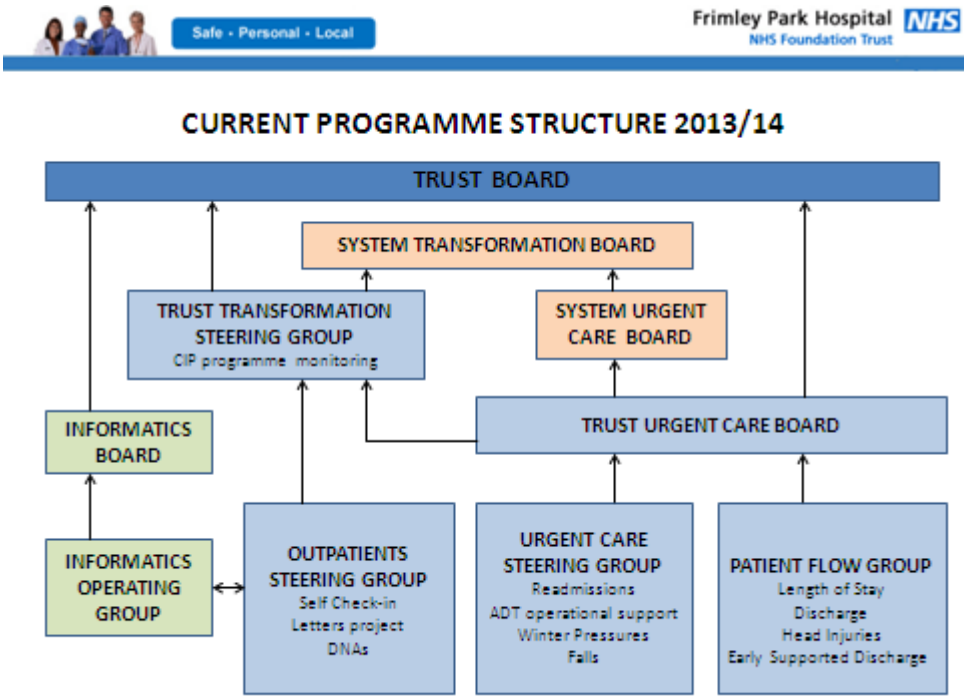


INNOVATION AND CHANGE

The Innovation and Change team report into the Director of Operations. The new team comprises an Associate Director, two Project Managers and an Analyst with admin support.

The Innovation and Change team support the three main work streams: Urgent Care, Patient Flow and Outpatient Utilisation. They have also developed a new CIP monitoring process, working with the finance department to ensure regular operational updates and reviews. The team also provide project support to other trust projects and work streams as required.

The Governance Structure for the Innovation & Change teams work streams is outlined below, together with a brief description of the work programmes being conducted by each work stream.



Urgent Care Programme

Readmissions

The trusts readmission rates have been reviewed and analysis undertaken to better understand areas of pressure. Audits have been completed in Cardiology and Orthopaedics which has shown two key issues. The first being that information patients receive on discharge could be improved to help them manage and understand what is normal and expected. In addition there are gaps in some of the services available in the community to support patients following discharge. Discussions have been held with commissioners and GPs relating to this, and the trusts new FORT team are also looking at how their service could support these patients to prevent readmission. Following analysis of historic data, General Surgery has started a daily review of readmissions. There is an action plan in place for ensuring readmissions are

managed and monitored. At this stage there is no evidence of poor practice leading to this readmission rate.

Length of Stay (LoS)

There are LoS groups in place for a number of key Directorates examining LoS by consultant and diagnosis. These groups have made changes to ward rounds which is hoped will further reduce the rate, with an emphasis on a consultant delivered service. We are also working closely with the therapies teams to ensure a full MDT approach to reviewing patients on a daily basis. The medical directorate for instance review their LoS at their fortnightly transformation meeting.

Length of stay is a key CIP programme for 14/15, with progress being reported up to the Transformation steering group on a monthly basis. Terms of reference for this programme have been developed, supported by a comprehensive action plan.

Escalation and winter pressures

The trusts escalation policy has been updated, and this has in turn supported the CCGs escalation policy and winter plan. In order to further strengthen the trust policy, action cards are being developed to ensure every job role has clearly defined actions that they take when required. To date the RAG rating of pressure has been well utilised and is being recognised and supported by other organisations to provide assistance when requested.

Patient Flow Programme

Discharge from hospital

There are a range of work streams supporting improved discharge from hospital, driven through the discharge team, and supported by the Innovation and Change team. Not least improved communication and discussion with Social Care teams to facilitate discharges speed up assessments and understand the reasons why patients are delayed in being discharged. The Patient flow group have secured agreement from both Hampshire and Surrey social services to have dedicated community nursing beds, to facilitate early discharge for medically fit patients awaiting assessment or placements. Initially this is being funded through winter pressure monies, and will be reviewed for the three month period. The trust has been attending the Surrey Rapid Improvement Events (RIE) to work with other trusts in Surrey in order to standardize documentation and improve information provided to patients and their carers.

A full day event was organised for partner organisations to visit the trust, reviewing processes and blockages from ED through to discharge. The feedback regarding the trust itself was very positive, but the day did highlight the issues we were aware of relating to delays with responsiveness of some partner

organisations. Since the walkthrough that took place in October, there have been on-going discussion and greater transparency regarding these issues with commissioners as well as providers, which has proved helpful in facilitating discharges.

Outpatients Programme

Self Check-in

Self Service Check in has been implemented in both main outpatients and Ophthalmology. In Ophthalmology, usage in the first week averaged 60-70%, reaching 91% usage in one day. Feedback from staff and patients has been very positive.

Performance reporting

A revised action log and dashboard has been produced to support all outpatient project areas. This supports the board performance reporting structure and strengthens integrated working between different teams from across the trust.

Other areas of support

CIPs

In previous years CIP development and monitoring have been led by the finance team. The transformation team have recently introduced an improved process. This provides greater structure to the monitoring of CIPs, which will be taken through the Transformation steering group. Operational teams will be supported by the Innovation and Change team to ensure milestones, risks and issues are captured for all areas.

Medical Model and Payroll

A number of actions have been taken and are underway including:

- On call rotas being reviewed
- SPAs being standardised to 1.5
- Retire and Return Scheme
- Bank overtime rates changed

Procurement

Procurement has successfully delivered significant CIP savings over a number of years. The CIP target for procurement in 14/15 is £1.5m. This is as a key programme due to the scale of this financial target. The transformation steering group will ensure all operational areas are linked to the procurement programme in order to identify any additional opportunities.

Bank and Agency

Innovation and Change will provide support as required. Bank and Agency spend is a key CIP for the medical and surgical directorates. A monthly meeting will monitor and deliver the bank and agency savings The objectives of the bank and agency meeting are:

- To reduce the demand for Bank and Agency staff across the trust
- To replace agency use with Bank use
- To support operational teams to track Bank and Agency use and spend
- To ensure there are robust systems in place for booking temporary staff.

These actions will result in a £1m reduction in agency costs.

Other Transformation Programmes

In addition to the programmes of work outlines above the Innovation and Change team are also involved in supporting a range of other work programmes across the trust. These include improving consultant allocation, Energy saving programme, improving patient information, Patient Transport booking process and performance, Patient information folders and Informatics strategy.

g) Financial Plan

The Trust has used the following growth and inflation assumptions within its financial models:

2014/15 Activity Assumptions	Growth	Net QIPP	Total
Outpatients	**3.0%**	**-2.0%**	**1.0%**
Elective	**3.0%**	**-2.0%**	**1.0%**
Daycase	**3.0%**	**-2.0%**	**1.0%**
A&E	**1.0%**	**-1.0%**	**0.0%**
Non-Elective	**3.0%**	**-3.0%**	**0.0%**
Non-NHS	**5.0%**	**0.0%**	**5.0%**
Other NHS	**3.0%**	**-1.0%**	**2.0%**

2015/16 Activity Assumptions	Growth	Net QIPP	Total
Outpatients	**3.0%**	**-2.0%**	**1.0%**
Elective	**3.0%**	**-1.0%**	**2.0%**
Daycase	**3.0%**	**-1.0%**	**2.0%**
A&E	**1.0%**	**-1.0%**	**0.0%**
Non-Elective	**2.0%**	**-2.0%**	**0.0%**
Non-NHS	**5.0%**	**0.0%**	**5.0%**
Other NHS	**3.0%**	**-1.0%**	**2.0%**

Income Inflation	2014/15	2015/16
Tariff Gross	2.5%	2.9%
Efficiency	-4.0%	-4.5%
Tariff Net	**-1.5%**	**-1.6%**

Cost Inflation	2014/15	2015/16
Pay	1.5%	1.5%
Non-Pay	2.1%	2.5%
Other in-tariff (non-pay)	0.4%	0.0%
Other within tariff (pay)	0.4%	0.7%
Drugs	7.2%	7.2%

These assumptions broadly mirror those within the Monitor financial planning guidance, with the tariff deflator and cost inflation assumptions giving an implied efficiency requirement very close to 4% and 4.5% respectively.

The Trust capital programme has been set at a level that is close to depreciation plus surplus cash generated, meaning that the Trust cash holding is projected to remain close to current levels.

Annual Plan Capital Programme	**Prior Year(s)**	**Budget 2014/15**	**Budget 2015/16**
	£'000	**£'000**	**£'000**
Infrastructure Schemes			
A&E Minor/Paediatrics area improvements			520
New MRI Scanning Centre with two MRI scanners			3,000
New 24-bedded Ward Block	1,600	2,409	
Interventional radiology/Fluoroscopy suite	1,750	1,316	
Breast Care Outpatients			
Day Unit Urology/Pain beds	20		540
Midwife Led Unit	75	1,235	
Central Delivery Suite Upgrades	395	500	
Office block to replace residences offices			3,000
Total of Strategic Schemes - (Property - new land etc)	**3,840**	**5,460**	**7,060**
Maintenance Projects /Other			
Parkside Refurbishment		425	
Essential Maintenance (Property maintenance)		750	750
General Ward Upgrade (Property maintenance)		1,200	1,200
Roof/Structural Works (Property maintenance)		850	850
Dementia Area Refurbishment		250	
Medical Equipment / General Plant (Plant and equipmt)		750	750
IT Hardware, Software and Infrastructure (Info Technology)		3,000	3,000
Endoscopy Improvements (JAG)		250	
General Contingency / future schemes provision		65	390
Total of Infrastructure Projects	**-**	**7,540**	**6,940**
Grand Total	**3,840**	**13,000**	**14,000**

Taken together, the Trust models project the following key outputs:

Summary Projections £m	2014/15	2015/16
Gross Surplus	**4,372**	**3,615**
Impairment	**-1,086**	**-835**
Net Surplus	**3,286**	**2,780**
CIP (cost reduction)	**9,000**	**12,500**
Capital Programme	**13,000**	**14,000**
Closing Cash	**49,095**	**48,973**

The Trust surplus is anticipated to decline over the period of the plan, with the transformation/cost improvement programmes not entirely covering the national efficiency requirement plus local cost pressures.

NHS income is anticipated to remain relatively flat over the period as follows:

Summary Financial Projections £m	2013/14	2014/15	2015/16
NHS Income	254,195	254,287	252,878
Other Income	35,993	36,140	37,108
Total Income	**290,189**	**290,427**	**289,986**
Operating Expenditure	-269,881	-271,658	-271,192
All Other Expenditure	-15,043	-15,479	-16,014
Total costs	**-284,923**	**-287,137**	**-287,206**

There is a small increase in NHS income moving from 2013/14 to 2014/15 despite the national tariff deflator. This mainly results from the unwinding of 'capped' income contracts in 2013/14, whereby c£2m of NHS income was not paid across.

The Trust models have a very moderate level of activity growth. These therefore assume a significant reduction in the growth seen in recent years, where the Trust has seen activity and income growth totalling c£10m per annum. The Trust is working closely with commissioners to help to mitigate the historic growth trends and together we hope to limit growth to the relatively flat levels indicated in the Trust plans.

The main new cost pressures that have been included in the 2014/15 plan are summarised below:

Main Cost Pressures	Pay	Non Pay
New Ward Staffing costs (NET)	250	
FYE 2013/14 new posts	902	
IT Strategy	250	500
2 new Gstroenterology consultants	260	
1 new MAU consultant	130	
1 new Cardiac Technician	50	
1 new Respiratory Technician	50	
Extend Paed Consultant at weekends	130	
0.5 colposcopy/uro gynae nurse	25	
1 new radiology consultant	130	
Other cost pressures	250	250
Total	**2,427**	**750**
Non-Recurring Items	**Pay**	**Non Pay**
Slippage on new posts above	-500	
Total	**1,927**	**750**

The new posts recruited in 2013/14 (shown as full-year effect above) reflect the Trust investment in trained nursing capacity in light of the Berwick and Frances reports.

The Trust anticipates achieving a financial risk rating of '4' in both of the Monitor risk metrics, in both years of the plan.

The Trust has modelled a downside scenario whereby CIP delivery falls to 75% of that planned in each of the two years. This would reduce the bottom-line surplus levels from £3.2m in 2014/15 and £2.7m in 2015/16, to £1.1m in 2014/15 and a deficit of £2.5m in 2015/16. To mitigate this risk (should it crystallise), the Trust would have the option of not investing in the 'quality' staffing improvements that are planned in each year of the plan. Reversing these investments would move the above figures upwards to a surplus of £2.5m in 2014/15 and a deficit of £0.2m in 2015/16. Under each of these scenarios the Trust would retain an overall Monitor financial risk rating of '4'.

Local ‘Better Care Fund’ schemes are embryonic, and that these are being consolidated into ‘whole of Hampshire’ and ‘whole of Surrey’ plans, means that the Trust is very much on the border of both. There is however a good level of engagement and the Trust and CCGs will be working together over the coming months to progress these plans for the benefit of patients.