Royal Berkshire NHS

NHS Foundation Trust

Operational Plan Document for 2014-16

Royal Berkshire NHS Foundation Trust

Operational Plan Guidance – Annual Plan Review 2014-15

The cover sheet and following pages constitute operational plan submission which forms part of Monitor's 2014/15 Annual Plan Review

The operational plan commentary must cover the two year period for 2014/15 and 2015/16. Guidance and detailed requirements on the completion of this section of the template are outlined in section 4 of the APR guidance.

Annual plan review 2014/15 guidance is available here.

Timescales for the two-stage APR process are set out below. These timescales are aligned to those of NHS England and the NHS Trust Development Authority which will enable strategic and operational plans to be aligned within each unit of planning before they are submitted.

Monitor expects that a good two year operational plan commentary should cover (but not necessarily be limited to) the following areas, in separate sections:

1. Executive summary
2. Operational plan
    a. The short term challenge
    b. Quality plans
    c. Operational requirements and capacity
    d. Productivity, efficiency and CIPs
    e. Financial plan
3. Appendices (including commercial or other confidential matters)

As a guide, we expect plans to be a maximum of thirty pages in length. Please note that this guidance is not prescriptive and foundation trusts should make their own judgement about the content of each section.

The expected delivery timetable is as follows:

Expected that contracts signed by this date	28 February 2014
Submission of operational plans to Monitor	4 April 2014
Monitor review of operational plans	April- May 2014
Operational plan feedback date	May 2014
Submission of strategic plans to Monitor (Years one and two of the five year financial plan will be fixed per the final plan submitted on 4 April 2014)	30 June 2014
Monitor review of strategic plans	July-September 2014
Strategic plan feedback date	October 2014

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

Name *(Chair)*	**Stephen Billingham**
Signature	**[Approved by Stephen Billingham: email, 3.09pm 4 April 2014. Signed copy to follow.]**

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	**Alistair Flowerdew**

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	**Craig Anderson**

Signature

1.2 Executive Summary

Context

The Royal Berkshire NHS Foundation Trust is a large district general hospital trust serving a core population of 500,000 and a wider population of 1 million for specialist and hyper acute services.

In recent years the Trust has seen a significant and sustained growth in activity, most notably in emergency department attendances, non-elective admissions and outpatient attendances. We know that our population is growing and that it is also ageing, with the over 65 population growing the fastest. The prevalence of long term conditions including coronary heart disease, chronic obstructive pulmonary disease, diabetes and dementia is set to increase and presents a challenge. We are therefore planning, both as an organisation and as part of a health economy, for a continued increase in demand for healthcare.

Strategic environment

Together with our local community provider and our CCGs, the Trust is continuously developing its understanding of the needs of the local population over the long term. This is then used to direct the development of how the health economy should be structured. To that end there are ongoing discussions with our commissioners about how we will jointly face the challenge of increasing need and demand in an environment where NHS funding is held flat. A crucial part of this debate is the extent to which services for older people and those with long term conditions are integrated between primary, community and secondary care and also with local authority care. This is being balanced with a more immediate requirement to address the short term internal challenges faced by the Trust including financial viability, continuing to provide safe and effective care and ensuring we have the capacity (both in staffing and in our ageing estate) to cope with demand over the next two years.

Whilst we recognise there is a need to refresh our strategic objectives, the framework of our strategy remains the same and will be developed around three overarching themes:

- A commitment to high quality care that is safe, compassionate, effective and provides a positive experience for patients.
- Meeting the needs of the local population: a) by aligning and influencing commissioner's intentions and local developments; and b) improvement of our capability, capacity and leadership.
- Ensuring financial stability, resilience and sustainability in the longer term, allowing for investment in frontline services that are fit for the future.

Our response

The significant financial challenges faced over the next two years highlights that we must remain committed to ensuring that the quality of services we deliver to patients remains high. Ensuring our services are safe, that our outcomes are excellent and that the patient experience of care exceeds expectations form the core of our strategy. We have recently refreshed our five year Quality Strategy as our core plan for improvement and which sets out the steps we will take to make real and measurable improvements to the quality of services, underpinned by a robust programme of quality impact assessments. Our Quality Strategy will be complemented by the development of a system-wide Organisational Development Strategy and a Workforce Plan which will set out how we will achieve a culture of caring from the Board to the ward.

Our activity plan for 2014/15 reflects the growth in activity we have seen in recent years. We are planning for 2.5% growth overall with 4% growth in emergency care, consistent with CCG growth assumptions. Whilst our elective activity has grown year on year, we have lost market share to the independent sector, primarily driven by our waiting times for elective surgery. We will address this in 2014/15 by installing two

additional orthopaedic theatres which will increase our operating capacity and allow us to reduce waiting times for our patients.

Nonetheless a key challenge for us over the next 5 years is returning to and maintaining financial stability. We are forecasting a deficit of £6.77m for 2013/14. The reasons for this adverse financial position are multifactorial but include the impact of investments made in previous years which have not made returns anticipated and rising costs, particularly pay costs. Our pay bill rose significantly in 2013/14, partly due to investments in quality and safety but also due to inefficiencies in managing vacancies and agency spend. Therefore, ensuring our pay is controlled is a key objective over the next two years as we aim to return to a surplus position by 2015/16.

Delivering a surplus in 2015/16 is also contingent on us achieving extremely challenging levels of CIP savings, some £38.5m over the next two years. We have plans for both incremental and transformational CIP programmes and have worked with external consultants to develop these.

Whilst the plan shows our falling to a COSRR of 1 at the end of June 2014 before rising to a 3 by December 2014 and a 4 by March 2016 we are reviewing the phasing of capital spend and delivery of Q1 2014/15 CIP savings with a view to maintaining our COSRR of 2 at June 2014.

1.3 Operational Plan

***a.*The short term challenge**

The Royal Berkshire NHS Foundation Trust provides healthcare services to a core population of about 500,000 patients in the West of Berkshire and the surrounding areas. We also provide specialist services to a wider population of about a million beyond our core catchment areas.

Together with our commissioners and other stakeholders we are in the process of developing a health economy wide strategy. This overarching strategy will seek to address the issues we face together as a health economy which, in addition to significant financial challenges include acute operational pressures in emergency and non-elective services due to rising demand and patient acuity.

Our strategy is, by necessity, influenced by the overarching health economy strategy. However our strategy also addresses our own internal financial challenges as well as our need to invest to ensure the quality of our services remains high and our facilities fit for purpose.

Our mission statement is "Providing the best healthcare in the UK for our patients in our community". In support of this goal we have set out key strategic themes around which we are developing our strategy for the next five years. These themes are:

- Commitment to high quality care that is safe, compassionate, effective and provides a positive experience for patients.
- Meeting the needs of the local population: a) by aligning and influencing commissioner's intentions and local developments; and b) improvement of our capability, capacity and leadership.
- Ensuring financial stability, resilience and sustainability in the longer term, allowing for investment in frontline service that is fit for the future.

Growth in demand

In recent years we have experienced significant and sustained increases in demand for health care. The population of people aged over 65 in the West of Berkshire is projected to rise faster than other segments of the population, with growth expected to be most significant in the over 85s. This population group places a higher level of demand on healthcare services, being more likely to be admitted to hospital and more likely to have a longer length of stay. Meeting the health needs of the growing elderly population in an affordable and sustainable way is one of the biggest challenges facing the local health economy over the next 2-5 years. We are working collaboratively with our commissioners and our social care partners on our pathways for elderly care and patients with long term conditions as we recognise that the traditional methods of care are not sustainable. It is inevitable that a greater level of integration of primary healthcare, secondary healthcare and social care will be required in future years and we are investigating options with our partners. It is likely that an integrated health and social care system for the frail elderly would, in time, release efficiency savings, however significant upfront investment would be required to drive a transformational change of this magnitude. It is currently unclear how this investment will be met within the current financial envelope of the healthcare economy.

Emergency department

Meeting the 4 hour A&E target is another challenge faced by the Trust and the wider health economy. Over the past three years we have experienced unprecedented levels of demand for emergency and

unscheduled care which is having a significant impact on our ability to meet this target. Our activity outturn for 2013/14 was 100,965 A&E attendances, 10% above our contracted activity plan.

We have responded to this increase in demand a number of ways including:

- increasing staffing levels;
- structural redesign of the emergency department
- clinical pathway redesign in the emergency department and clinical decision unit;
- working with our commissioners on demand management schemes; and
- implementing recommendations from an Emergency Care Intensive Support Team review.

However, despite these actions, achieving the 4 hour target remains a challenge for the Trust and will continue to be a key focus in 2014/15. We and our partners in the health and social sector care across Berkshire West have developed a system wide recovery plan. This was approved by the Trust Executive in February 2014 and will be monitored by the Berkshire West Urgent Care Programme Board. The plan will help all organisations understand why the 4 hour wait target has become such a challenge and take action to deliver immediate and sustained improvement to ensure consistent delivery of the target. The aim is to achieve the 95% target consistently and to build up sufficient data to be able to predict the flows to A&E to help us understand what causes the number of breaches and changing numbers of attendances. The Trust Board has also approved funding to create 10 additional spaces in the emergency department with building works scheduled to start early summer 2014.

Financial challenges

This rise in need and demand described above is set against a backdrop of significant financial challenges facing the whole health sector. We are working closely with our colleagues across the local health economy, in particular our lead commissioner NHS Newbury and District CCG (who commission services on behalf of the three CCGs in West Berkshire) to understand how we can face these challenges together and continue to provide the services our patients require. The healthcare economy has commissioned Ernst and Young to carry out a detailed review of three healthcare pathways, respiratory, hepatobiliary and pain management. These pathways were chosen as they are delivered across different parts of the health economy and have significant volumes of patients. The aim of the review is to find improvements in efficiency, patient experience and outcome.

In addition to the challenges facing the health economy the Trust faces internal financial challenges of its own such as high support costs and pay control. In 2013/14 our pay bill increased significantly, partially due to investments in quality, safety and seven day working. However we do recognise that we need to manage spend on agency staffing more effectively to ensure that our pay bill remains controlled going forward.

The Trust planned for CIP savings of £9.714m in 2013/14 and these were realised in full. It is our intention to ensure that planned CIPs for the next and subsequent years are also realised in full.

Due to the combination of issues raised above we expect our year end position for 2013/14 to be a deficit of £6.77m. The Trust's immediate challenge is to return to a healthy positive balance and return a surplus of about 1% or £3.66m by the end of 2015/16.

Quality of care

Quality of care has always been our priority but recent reports including Francis, Keogh and Berwick have highlighted areas where we need to improve. Learning from events that have happened elsewhere and implementing the recommendations of these reports is a key priority for us to ensure that our patients continue to receive the best care. However it is recognised that in some cases implementing the

recommendations provide a significant financial challenge for providers to meet. For example, following publication of the Francis Report we carried out a detailed review of nursing skill-mix based on the Safer Nursing Care Tool. The objective of the review was to ensure that each care delivery area is appropriately staffed at all times to ensure patient safety. The implications of this review, combined with other quality initiatives led to us increasing our headcount in 2013/14 with further posts directly linked to quality initiatives planned in 2014/15.

We have recently developed our Patient Engagement Strategy which sets out our approach to involving the service users. We encourage patients to give us feedback via a variety of means including NHS choices, patient surveys and the friends and family test. We will aim to drive up the response rate and improve the depth of feedback from both the friends and family test and our patient surveys. We are also investigating new approaches to eliciting patient feedback including web based feedback. We plan to develop our Patient Leadership Programme in 2014/15 in order to provide training and development for patients involved in activities related to improving the patient experience.

Estate

The quality of our estate poses an additional challenge for us both now and in the longer term. We have an ageing estate with significant backlog maintenance issues that need to be addressed. We know that our elective facilities in general compare poorly to the independent sector and that this is one of the factors in patients choosing the independent sector. Maintaining the existing facilities and ensuring they remain fit for purpose will require a major capital investment of around £100m over the next 10 years. The inadequacy of our car parking facilities, in particular, has been a frequent issue raised by our patients and other stakeholders and is a key infrastructure challenge for the Trust in ensuring a positive experience for patients, their carers and families.

Summary of our key challenge

Our key challenges for 2014/15 and 2015/16 can be summarised as the requirement to deliver the necessary savings in response to the immediate affordability challenge, whilst at the same time ensuring that we continue to achieve and maintain the quality of care that our patients and service users deserve. Meeting this challenge cannot be achieved in isolation and we will work with stakeholders and partners to ensure that our services are affordable and that care is delivered in the right place at the right time. We have successfully worked with our commissioners to estimate and predict the volume of activity that we will have to deliver to meet the demand for acute care services over the next two years. We are also working with commissioning and provider partners to ensure that we redesign pathways for those services that are amenable to integrated delivery while we also increase the volume and range of ambulatory care services that we provide at our community sites

b.Quality plans

In the later part of 2013/14 we refreshed our Quality Strategy for the next five years. This underpins our aim to deliver the highest quality healthcare services to our patients and sets out our action plan for making measurable improvements to the quality of our services. Our improvement strategy addresses both our immediate requirement for change, whilst prioritising that improvement to ensure consistency with resource limitations and ensuring that we embed a wider cultural and organisational transformation.

Organisational development and workforce

Our goal is for every member of staff to understand their role in delivering high quality care and be capable to continually strive to improve quality. A trust wide training programme in quality improvement methodologies, tools and techniques is being implemented to ensure that all staff have the necessary skills, support and time to participate in quality improvement projects and ongoing professional development training.

We will undertake a series of engagement initiatives inviting staff and other stakeholder opinion of our vision and values. We will then use this feedback in developing our vision and our value propositions in order to develop a universal framework of behaviours for our staff from board to ward. The detailed implementation of a Board, structures and a workforce that are aligned, competent, well trained and capable of providing high quality care will be delivered through our Organisational Development Strategy that will be put in place by May 2014. This will set out our approach to:

- leadership development;
- strategic development
- continuous improvement;
- bringing values to life;
- aligning structures;
- talent; and
- performance improvement.

Quality Governance

In August 2013 we received a red rating for governance from Monitor due to failure to meet the A&E target and the C.Difficile trajectory. This triggered an investigation into our governance processes by Monitor which was closed in March 2014. During this period we have been implementing a detailed Quality Governance Framework action plan to ensure that we meet and where possible exceed Monitors standards for quality governance.

We will continue to deliver against our quality governance plans during 2014/15 and these will include further progress in embedding:

- Continued delivery of Quality Strategy implementation plans (see below)
- Improvement to performance management and escalation processes from ward to Board.
- Development of an integrated, modular risk management system, supported by systematic joint analysis, learning and local risk escalation, robustly aligned to the BAF/CRR.

- Continued development of Board stability, effectiveness and clarity of responsibilities.
- Development of role of Care Groups in supporting corporate governance and performance management of quality.
- Improvement to clinical and quality governance structures including Board sub-committee and working group interface.

Response to Francis, Berwick and Keogh

In 2013, the Trust conducted a number of briefings and presented to the Board a gap analysis of our response against Francis, Berwick and Keogh reports. We have consequently undertaken a considerable number of quality improvement initiatives over the last eight months. We have made good progress in embedding improvement in our structures and processes, such as: reviewing nursing recruitment and skill mix; medical revalidation; care of the elderly; development of our patient engagement strategy; and understanding mortality.

However, we recognise that there are a number of key areas where we need to improve and these will be forming the focus of our agenda over the next six months:

- better information use and reporting, particularly how we escalate performance
- improving our culture and behaviours through a strategic programme organisational development;
- how we handle complaints and deal with incidents, including being open and transparent.

We have set overarching quality goals over the next five years:

- through our management structure and clinical leaders, ensure that quality and safety dominate thinking at all levels of the organisation;
- continuous improvement in service, outcomes, processes and monitoring;
- to concentrate on the prevention of failure and if failure does occur to ensure learning from it;
- to celebrate success in the delivery of improvements in quality and safety; and
- to commit to the development of learning from benchmarking our performance.

Our plans for these are more immediately articulated in the shorter-term specific goals to focus attention and resource over the next two years. These goals have been categorised into those that will improve patient safety, those that will ensure clinical effectiveness and those that will improve patient experience.

2014/15 Quality priorities

In our 2014/15 Quality Account we have identified 6 quality improvement priorities which reflect our key quality concerns. This is in addition to identifying improvements aligned to the NHS Outcomes Framework. We identified these as key concerns following a series of structured listening exercises across the Trust where staff were able to share their views on the quality of our services. We also sought feedback from the Council of Governors, patients and patient representatives, advocacy group, our CCGs, Healthwatch, Health and Wellbeing Boards and Health Overview and Scrutiny Committees.

Priority	**Why have we chosen this?**	**2013/14 Performance**	**Plans to address performance in**

			2014/15
Reducing the incidence of C.Difficile infections to 30 cases or less.	The disease affects vulnerable people in hospital and elderly patients in particular can become seriously ill. Despite our best efforts in 2013/14 we saw an increase in cases from 29 in 2012/13 to 40 in 2013/14.	Reducing the incidence of C.Difficile was a priority in 2013/14 but unfortunately we saw an increase in the number of cases compared to 2012/13. We anticipate our year end position to be 40 compared to a target of 37. Our 2012/13 position was 29 cases.	We have already taken action to improve hand hygiene, environmental cleaning, isolation and antimicrobial stewardship. An external review is taking place in March 2014 and a detailed response and action plan will be developed.
Reducing new harms (patient safety thermometer.	The NHS Patient Safety Thermometer is an on line tool to assist clinical teams to eliminate harm in patients from pressure ulcers, falls, urinary tract infections in patients with a catheter and new venous thromboembolism (VTE).	We performed well in 2013/14 against pressure ulcers, VTE and falls. However we have more to do to prevent UTI in patients with catheters.	We have set up a group to drive improvements in this area and we are updating our catheter care policy.
Improve weekend mortality rate.	During 2012/13 our weekend hospital standardised mortality rate (HSMR) reported by Dr Foster was statistically significantly higher than expected at certain times of the year. Actions were taken in 2013/14 and whilst our HSMR is now within expected levels our mortality remains high over the weekend, specifically on a Sunday.	We carried out an extensive review of deaths that occurred between April and September 2013 and the month of February 2013. The review indicated that pneumonia was one diagnosis area where HSMR was statistically significantly higher than expected. We have appointed two additional respiratory consultants and have also increased our respiratory bed based which will enhance patient care at the weekends. The relative risk for pneumonia for 2013/14 is 97.86 which is within the expected range. Our overall weekend HSMR for 2013/14 is 108.67 which is within the expected range.	In 2013/14 we will benchmark our position against other Trusts in relation to weekday versus weekend HSMR. We will also identify the key specialities and conditions where the difference seems to arise from the will focus improvements on these areas. Emerging findings from on going mortality reviews include the need to improvement management and identification of sepsis and 72 hour senior medical review.

Improve the availability and quality of medical records.	The availability of medical records is vital to ensuring patients continue to receive safe and effective treatment. Unless records are correctly tracked and stored and the paperwork in the notes is filed correctly there will be a delay in responding to the request for the medical record and the patients' treatment may be delayed.	In January 2014 we conducted a healthcare records audit across all specialities. We found that 96% of notes were available before the time of the appointments. 2% arrived too late and 1.3% were not in the location where they had been tracked. Requests for clinical administration to view or add documents to the record were also reviewed with 76% taking longer than 48 hours. For patients admitted to hospital 44.6%had notes available within 24 hours or less. These levels do not represent a responsive service to clinicians and patients and needs to improve.	An action plan is being developed by the medical records steering group, led by the Medical Director to engage staff and educate them in filing documents in a timely way in accordance with Trust policy. A tracking project in March 2014 will make an in-depth review of issues related to use of the electronic tracking system including accuracy and timelines. We will work with front line staff to develop structured processes and training so everyone is clear on their individual responsibilities.
Improve staff attitudes and behaviours.	In 2013/14 we failed to meet our target to reduce patient complaints relating to staff attitude and behaviour. Our target was 52 complaints and we received 71. We are concerned that we are not providing the most positive experience for patients and so elected to carry this target forward.	In 2013/14 we delivered customer care training to 200 administrative staff who work directly with patients. Additionally 160 staff have taken part in human factors learning and over 150 staff has received coaching on behaviour and communications. Despite this our average number of complaints about behaviour and attitude has remained above our target of 4.3 per month, the average being 6.6 per month.	Our organisational development strategy will be developed by May 2014 and this will set out a framework of values and behaviours that we expect all staff to uphold. Our strategy will also look at our recruitment processes and customer care training. We are implementing 'recruiting for attitude, training for skills' as part of a large scale recruitment project.
Improve outpatient	Patients continue to express frustration and	Although we have improved performance, we have not	We will seek to increase efficiency in cardiology,

booking process and reducing cancellation of appointments.	dissatisfaction with the way appointments are changed by the Trust and we have not done as well as we had hoped in making improvements against this priority in 2013/14.	achieved our target to reduce the average to 9% of outpatient appointments being rescheduled. We also know that we have to improve on some specific service performance on cancellations.	gynaecology and ophthalmology. We will also undertake a speciality review to understand the impact of clinics cancelled at short notice.

In addition to the setting of SMART and specific improvement targets as part of our Quality Account, we have a number of other areas, some related, that we will be focussing on during 2014-16:

Improving patient safety

Key plans include:

- We are continuing our zero tolerance approach for Hospital Acquired Infections (HCAI) and surgical site infections. Specifically we are aiming to reduce the incidence of *C.Difficile* to 30 or less in 2015/16 and by a further 20% a year from 2015/16 to 2018/19. We aim to have zero incidence of MRSA and to reduce our UTI incidence in patients with catheters to below the national median in 2014/5 and to best quartile in 2015/16. We will develop a surgical site care bundle in 2014/15 and will aim for 95% compliance with this care bundle in 2015/16.

- We will continue to measure ourselves against the patient safety thermometer and will aim to improve performance across all areas – falls, pressure ulcers and venous thromboembolism.

- Will continue our efforts to ensure early recognition and timely treatment of sepsis including a zero tolerance approach to avoidable acute kidney injury (AKI). We aim to achieve 95% compliance with the sepsis 6 care bundle in 2014/15 and 100% compliance with the neutropenic sepsis care bundle in 2015/16.

- Key to improving patient safety is maintaining safe staffing levels in all areas of the organisation and we will ensure 95% compliance with statutory and mandatory training targets.

- We will reduce the number of high risk medication errors year on year.

- We will improve our processes for sharing learning from risks and escalation of potential risks from ward to board. We will do this by establishing a fully integrated risk reporting system and the implementation of shared learning forums for staff. These forums will also be used to share learning from never events and serious incidents. We will also increase the rate of incident reporting across the organisation aiming to achieve national median performance by 2014/15 and top quartile performance by 2016/17.

- As a Trust we are committed to improve clinical presence and staffing levels at weekend and nights. As we develop our response to this challenge we will update our quality improvement objectives to ensure that we can demonstrate an appropriate impact on the provision of safe services as part of that programme.

Ensuring clinical effectiveness

Key plans include:

- We want to make improvements to our mortality rate, particularly over the weekends. Our aim is to achieve average mortality across a range of metrics in 2014/15 and then improve to upper quartile performance in lowest risk adjusted mortality by 2015/16. We will achieve this by improving our sepsis management and 72 hour senior medical review. We will also ensure that we are accurately reporting our mortality rate by improving our documentation, data quality and clinical coding.

- We have identified that we need to make significant improvements to our medical records both in terms of availability, accuracy and quality. We are already taking steps towards these improvements by launching a medical records campaign and in 2014/15 we will establish metrics for measuring performance and set improvement targets.

- We will ensure there is a robust 12 month clinical audit programme in place each year to audit clinical outcomes and effectiveness with evidence of learning.

Improving patient experience

Key plans include:

- We want to ensure that our patients can access our services in an appropriate timeframe. We therefore aim to reduce our outpatient waiting lists to 6 weeks. We will also improve our booking processes to ensure that patients do not have their appointments rescheduled apart from when absolutely necessary. Our aim is to reduce both our rescheduled outpatient appointments and cancelled operations by 25% in 2014/15.

- We need to improve the time taken to respond to patient complaints. Our aim is to respond to 95% within 25 days. Learning from complaints needs to be shared across the organisation so that change can be widespread and care improved. With our new process for sharing learning our aim is to see a 5 % year on year reduction in recurring complaint themes. We also want to improve our systems for receiving patient feedback and to encourage feedback from all patients by whichever method suits them best. We aim to improve our NHS choices rating to 4.5 stars and to achieve a 30% response rate on the Friends and Family test with a net promoter score of 70%.

- In 2013/14 at any one time we typically had around 50 patients in an acute bed who were medically fit for discharge or waiting for nursing home places or social care packages. By continuing to work with our partners across the health economy we will aim to reduce this number in 2014/15. This will ensure that patients receive the appropriate care in the appropriate place and that there is appropriate acute capacity for the patients requiring acute care.

- We know from patient feedback that signage around the hospital is not always clear or adequate. We will improve signage enabling patients and carers to find the services they need as easily as possible.

- Enhance the effectiveness of the local patient representative bodies such as Healthwatch, in developing further engagement and feedback forums.

<u>Risks to delivery of plans and contingency</u>

A significant risk to delivery of quality healthcare is affordability. Through our quality strategy we have set out standards of care that we will seek to achieve over the next five years. However, our long term financial planning has identified that the Trust needs to deliver significant savings over that period.

We are convinced that delivering high quality services will contribute to the necessary reduction and sustainability in the long term. It is important that we are able to identify the financial benefits that will

accrue from the work undertaken in each of our quality and safety improvement projects. This will rely on being able to measure the financial impact of the initiatives and compare income and costs of service at the individual project level before and after quality improvement activity.

Our board assurance framework identifies the risks to the achievement of specific quality goals. These include:

- The risk that we will not achieve our planned reduction in the incidence of *C.Difficile.* In 2013/14 we saw a spike in the incidence of *C.Difficile* infection due to community outbreaks. We have an action plan in place which has been externally reviewed and found to be robust. We will continue to carry out our action plan and maintain vigilance but a community outbreak remains a risk to the achievement of our target.

- The risk of failing to recognise or respond to deteriorating patients at night and on the weekend due to increasing activity, acuity and complexity. We have set up a Trust wide weekend and out of hours steering group and developed action plans to address this issue.

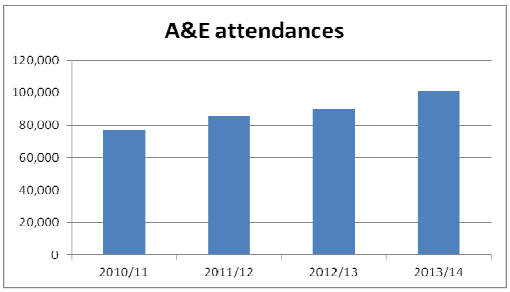
- The risk of poor skill mix due to poor staff retention and increasing reliance on agency staff. We have carried out a skill mix review and additional posts have been agreed. We have also redesigned the appraisal process to incorporate the Trust vision and values and aid retention.

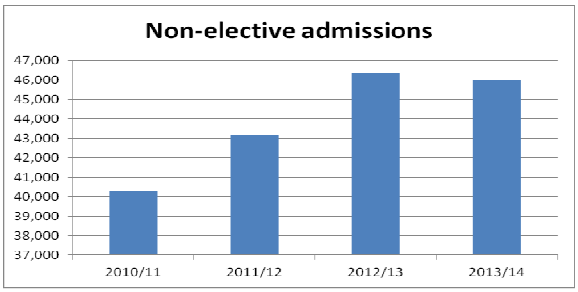
- The risk that we will not achieve our target of 85% compliance with statutory and mandatory training targets. We have reviewed our program and evaluated it with key stakeholders to ensure it is fit for purpose and have made improvements. Our training needs analysis has been reviewed and amended to reflect alignment to the skills for health framework. Additional training and out of hours provision has also been secured.

c.**Operational requirements and capacity**

Growth in demand

In recent years the Trust has experience significant and sustained growth in demand, particularly in A&E attendances and non-elective admissions as demonstrated by the graphs below.





Our analysis, which is in line with an external review by Capita, indicates that demand will continue to grow as a result of population growth and particularly the ageing profile of our population. This is also supported by commissioner growth predictions. There will be an increase in age-related diseases including cancer, diabetes, coronary heart disease, stroke and other cardiovascular disease. The over-65 population is the segment of our population that is growing most rapidly and this cohort places a higher level of demand on healthcare services, being more likely to be admitted to hospital and have a longer length of stay. We are working with our commissioners on our pathways for elderly care and long term conditions as we recognise that the traditional methods of care are not sustainable.

Emergency department

Attendance at our emergency department has grown by 23,000 over a 3 year period. There has been an increase in the number of older patients attending and we are also experiencing a change in case mix with the proportion of major cases increasing from 35% to 65%. This has had a big impact on our resources. Paediatric attendances at A&E have increased by around 8% per annum and to reduce demand we have worked with local GPs to develop pathways for common reasons children attend the emergency department. These protocol based pathways aim to give GPs and parents the confidence to manage these common conditions in the community and explain when it is appropriate to seek secondary care help.

Our A&E department was built to cope with 64,000 attendances and with 100,965 attendances in 2013/14 is significantly under capacity. A major expansion to the current department to provide sufficient capacity to meet current and future demand would cost circa £30m which is currently unaffordable. Therefore in 2014/15 we have made provision within our capital programme to provide 10 additional A&E spaces as an interim solution to ensure the quality of care does not deteriorate

Non-elective admissions

Both the Trust and the commissioners have implemented admission avoidance schemes for non-elective admissions. This includes a scheme run by occupational therapists that assess patients in the emergency department and work with the Red Cross to ensure that patients can be discharged home safely without a hospital admission. We employ Community Geriatricians who work across community hospitals, nursing homes and in patients own homes to ensure that patients can receive the right level of care and the appropriate care packages outside of an acute hospital setting. However our admission avoidance schemes are slowing the growth in non-elective admissions rather than reversing it and demand remains high. We know that over the next two to five years, additional admissions avoidance initiatives are

required if the health economy is to avoid the additional costs of increased acute bed capacity. We will continue to work in an integrated way with our health and social care partners to ensure that there are appropriate and effective demand management schemes in place.

Elective admissions

We are committed to supporting commissioners in the implementation of demand management schemes for elective care, including shifting activities from day cases to outpatient procedures and ensuing reductions in the new to follow-up rate. We have worked collaboratively with commissioners to develop referral pathways for Orthopaedic surgery. These pathways set out the steps that GPs need to take before referring a patient and ensure that surgery is not considered as the first treatment option. However despite demand management schemes we are still experiencing year on year growth in referrals which is leading to a growth in our waiting lists for outpatient appointments and elective surgery.

Over the past three years we have lost market share of high volume elective surgery to the independent sector who have offered shorter waiting lists and superior 'hotel' facilities to patients. Whilst all surgical specialities have lost some degree of market share the effect has been most notable in Orthopaedics. Competition presents a large risk to the Trust's income as independent sector providers tend to target more profitable and simpler elective services leaving the Trust to continue providing the less profitable complex cases. The piece-meal and volatile nature of competition through Choose and Book makes it very difficult for the Trust to take out costs to offset reductions in income.

In 2014/15 we intend to install two additional laminar flow theatres and an additional 8 elective beds. This will be configured with an existing ward to create a dedicated elective orthopaedic centre. This will enable us to reduce our waiting list for elective orthopaedic surgery which will enhance our competitive capability and combined with marketing activities will enable us to regain market share that we have lost to the independent sector in recent years. The centre is to be funded via a lease agreement over 15 years, at the end of which the Trust will own the building. We anticipate that the centre will become functional during Q3 of 2014/15.

Outpatient care

We have recently reviewed our outpatient clinic processes in a number of specialities with a view to increasing the number of appointments available within our existing resources. In each of the specialities reviewed there was scope for efficiency gains of 5-10%. By rolling this learning out Trust wide we believe we will have sufficient outpatient capacity to meet the growing demand.

Contracted activity plan

Our agreed contracted activity plan for 2014/15 and projection for 2015/16 is included in the accompanying financial template. The plan shows an overall growth rate of 2.5% year on year with the highest growth being 4% per year in non-elective admissions and in A&E, reflecting the current pressures we are experiencing. We are also planning for a 2% per year increase in elective activity.

Our commissioners aim to increase the scope and volume of activity that is able to be delivered outside of an acute hospital setting. Their QIPP programme for 2014/15 centres on increasing community based services for the elderly and so reducing avoidable hospital admissions, particularly readmissions. However we anticipate that continued growth in demand in emergency and non-elective care will offset the QIPP reductions and that activity in these areas will continue to increase

Workforce

In the light of the recommendations of the Francis Report, the Berwick report and the Keogh review, the

Trust has undertaken a skill mix review of nursing staff requirement based on safer staffing models. The objective is to ensure that each care delivery area is appropriately staffed at all times to ensure that the safety of patient care is maintained and the expected standards of high quality care and assurance of positive patient experience of care are not compromised by inadequate staffing arrangements.

Each of our Care Groups have reviewed their staffing requirements according to:

- the need to deliver the agreed activity plan
- service developments which have been agreed; and
- the need to have adequate staffing levels to maintain quality of care.

This has the impact of increasing the projected staffing levels for 2014/15 by 115 WTE prior to cost improvement plans (CIP) and the anticipated pay costs by circa £5m.

However, we anticipate that the combined benefits of service remodelling, pathway redesigns and other improvement and efficiency arrangements would lead to reductions in headcount in the following years beginning with a moderate reduction of circa 25 WTE from 2015/16.

In order to deliver the required activity levels and to ensure the delivery of safe and high standards of care, the following level of workforce capacity is planned:

	2013/14	**2014/15**	**2015/16**
Medical and dental	602.96	625.70	625.21
Registered Nursing and midwifery staff	1734.41	1860.78	1869.63
Science, therapeutic and technical staff	611.41	611.09	609.86
Support to clinical staff	686.45	690.25	692.41
Infrastructure staff	1313.61	1317.54	1290.76
QIPP (CIP)	0.00	(108.08)	(210.53)
Total	**4948.84**	**4997.27**	**4877.34**

We plan to deliver a pay CIP of £9.25m in 2014/15. At present CIP is not yet assigned to pay type as plans are in the process of being worked up in detail. The budgeted WTE against the CIP line in the table above is indicative based on average WTE salary.

d.Productivity, Efficiency, and CIPs

Care group and corporate directorates within the Trust, supported by the Trust Programme Management Office, have identified key work streams for delivery of CIPs in 2014/15 and have been developing robust plans for the delivery of the individual projects within these work streams.

We have an agreed target of £13.5m (4%) with a stretch target of a further £5m giving a total target of £18.5m. To date, we have identified circa £21.5m of pure cost saving opportunities, aligned to a number of work streams including:

- Quality (safety outcome and patient experience) - identifying quality and waste initiatives to improve quality, reduce harm and drive 5% per year cost efficiencies in conjunction with the productivity and efficiency work stream.
- Whole system integration/models of care – assessing the patient and financial benefits of whole system integration, either formal or informal.
- Support services – identifying means for 25% step reduction in financial costs through ongoing efficiencies, reduction in assets and shared services.
- Productivity and efficiency – identifying new ways of working to enable us to maximise income and reduce our cost base by 5% in conjunction with the quality work stream.
- Business as usual CIP – continually challenging ourselves to identify initiatives in our day to day work that reduce costs.
- Service line reporting – re-launching and embedding SLR methodologies into care groups to improve speciality operational efficiency and financial contribution by 25%.
- Cost avoidance – managing cost increases such as agency spend.

Our focus will be on driving out cost (particularly pay spend) and whilst we will develop additional income opportunities we will monitor and track these separately. These will not be included within the cost savings target.

Delivery of a further £18.5m over and above the efficiencies already achieved in the past three years is extremely challenging, and therefore to provide further support, the Trust commissioned external consultants to help identify new opportunities and to work with teams to develop their plans. The first draft report identifies between c£10-20m of opportunities and these are reflected in the opportunities listed.

Many of the schemes identified to date are incremental in nature, however we have identified larger transformational projects, including:

- Consolidation of Trust pathology service -The Trust is working in partnership with four other Trusts to consolidate their pathology services into one large service offering. This work is well developed and a final business case is due to be taken to each Trust Board in the next couple of months. Implementation of the new consolidated service is due to take effect on 1 April 2015.
- Berkshire West Clinical Strategy Programme - In partnership with the local health economy, including the Berkshire West CCGs and Berkshire Healthcare NHS FT, we have established the Clinical Strategy Programme for Berkshire West which will improve patient quality of care and outcomes and provide financial stability for both providers and the commissioners. Three clinical work streams have been identified for phase one (respiratory, pain management and hepatobilary) and external support to the programme has been commissioned.

- Corporate Services - A key programme of work is to reduce corporate spend by 25% over the next two years. Work is underway to review opportunities for shared services with Berkshire Health Foundation Trust, and other outsourcing opportunities through organisations such as NHS Shared Business Services.

- Administration - A full review of how the administration function is provided across the organisation is underway. This will include the use of secretaries, PAs and admin roles using technology such as voice activation and transcription services. It will also include initiatives such as self check-in for patients.

- Nursing - A review of all aspects of nursing is another work stream being led by the Trust Nursing Director. This programme of work will include work streams to increase efficiency and reduce costs in areas such as use of agency staff, process and delivery for 1:1 nursing, and the use of rostering systems.

- Consultant Productivity - A full review of the Trust job planning process and policy was undertaken this year. In 2014/15 this will be implemented and embedded across the Trust, with particular regard to achieving improved efficiency and value from our consultant body, whether that be productivity from theatre and clinic sessions, or outputs from non clinical duties. This Programme is being led by the Interim Medical Director in partnership with the three Care Group Directors.

- Inventory and Logistics Management -This year the Trust piloted an electronic inventory management system through Ingenica. Having demonstrated value for money and enhanced benefits to current ways of working, the Trust will now move forward to roll the system out Trust wide. In addition we will be reviewing our whole logistics function to ensure we are operating as effectively as possible. We are currently working with external partners to identify innovative new ways of working in this area.

A breakdown of the CIP projects identified to date for the next two years is shown below:

CIP Programme/Project	**Value in 2014/15**	**Value in 2015/16**
Planned care group projects	£4.231m	
Networked care group projects	£2.241m	
Urgent care group projects	£2.492m	
Corporate services projects	£1.164m	
Corporate cost avoidance scheme	£3m	
Carry forward projects from 2013/14	£1.4m	£2m
Care group administration review	£0.5m	
Bed reconfiguration	£1m	
Nursing efficiency programme	£1m	
Consultant productivity programme	£1m	
Salary sacrifice scheme	£0.5m	
Headcount review		£5m
Speciality review programme		£5m
Order comms. programme		£0.5m
Corporate services programme		£3m
Procurement programme	£3m	£3m

Total	**£21.528m**	**£18.5m**

e.Financial Plan.

The sector faces significant financial challenges such as meeting growth in demand and investment in patient safety and quality, all within an envelope of flat cash for the sector, but reducing income to acute trusts. Additionally the Trust faces some internal challenges such as high support services costs and pay control.

Many of the potential solutions to this challenge require the sector to work together differently and we are working with colleagues from across the health and social care economy.

However, there are also internal actions that the Trust needs to take to ensure it is delivering a safe and efficient service. In 2013/14 the Trust has seen a significant increase in our pay bill resulting from increased activity but also investment in quality, safety and seven day working. The need to secure funding for these investments is a key challenge for 2014/15. The Trust also acknowledges that there has been a degree of management inefficiency in our control of pay, particularly agency spend.

Our financial aim is to return the Trust to financial stability by reducing the underlying deficit (before potential restructuring costs) in 2014/15 and returning to surplus in 2015/16. Whilst we undertake the necessary restructuring we will maintain a strong focus on cash and seek to maintain a cash balance of not less than £8m at the end of any single month.

Key figures:

2014/15 :

- Underlying deficit of £1m pre potential restructuring costs, but with Q3 and Q4 both in surplus.
- Cash of £22.0m at March 2014, versus £21.5m March 2013.
- Income of £348.83m in line with lead Commissioner (BWCCG) and lead Commissioner contract, but excluding BWCCG QIPPs
- Contingency in plan £2.62m, circa 0.75% of income
- NEL marginal rate and readmissions reinvestment of 80% (£6.2m)
- Trust cost QIPP programme of £18.5m (4% sector cost QIPP plus £5m to recover underlying Trust deficit from 2013/14)
- Capital programme capped at £12.5m with some selective use of leasing where needed.

2015/16 :

- Surplus of £3.6m pre potential restructuring costs
- Cash of £26.8m at March 2016
- Income of £354.93m in line with lead Commissioner (BWCCG), but excluding BWCCG QIPPs
- NEL marginal rate and readmissions reinvestment of 80% (£6.3m)
- Contingency in plan £2.7m, circa 0.75% of income
- Trust cost QIPP programme of £20m, (4% sector cost QIPP plus £3m one time reduction in support services costs, particularly EPR operating costs)
- Capital Programme capped at £12.5m with some selective use of leasing where needed.

The table below summarises our two year plan for both SOCI and Cash

		2014/15 Budget £m				
£m	**2013/14 Forecast**	Q1	Q2	Q3	Q4	**FY**
Income	**342.47**	85.62	87.17	88.41	87.63	**348.83**
Pay	**(202.75)**	(52.27)	(51.60)	(49.33)	(49.16)	**(202.35)**
Non Pay	**(123.12)**	(31.39)	(31.33)	(30.56)	(30.42)	**(123.69)**
EBITDA	**16.59**	1.97	4.24	8.52	8.06	**22.79**
Depreciation and other	**(23.37)**	(5.90)	(5.96)	(5.96)	(5.95)	**(23.77)**
Surplus/(Deficit)	**(6.77)**	(3.93)	(1.72)	2.56	2.11	**(0.98)**
Closing Cash	**21.50**	11.97	8.41	13.17	22.03	**22.03**

		2015/16 Budget £m				
£m	**2014/15 Budget**	Q1	Q2	Q3	Q4	**FY**
Income	**348.83**	87.70	88.72	89.97	88.55	**354.93**
Pay	**(202.35)**	(50.54)	(50.07)	(49.67)	(49.39)	**(199.68)**
Non Pay	**(123.69)**	(32.45)	(32.28)	(31.51)	(31.42)	**(127.65)**
EBITDA	**22.79**	4.71	6.36	8.79	7.74	**27.60**
Depreciation and other	**(23.77)**	(5.93)	(6.00)	(6.02)	(5.99)	**(23.94)**
Surplus/(Deficit)	**(0.98)**	(1.22)	0.36	2.77	1.75	**3.66**
Closing Cash	**22.03**	17.29	15.78	18.55	26.99	**26.99**