West Suffolk NHS

NHS Foundation Trust

Operational Plan Document for 2014-16

West Suffolk 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

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

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

Name	Richard Jones
Job Title	Trust Secretary and Head of Governance
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Tel. no. for contact	01284 713994
Date	4 April 2014

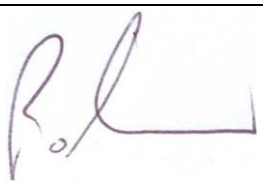
The attached Operational Plan is intended to reflect the Trust's business plan over the next two years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

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)*	Roger Quince

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Stephen Graves

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Craig Black

Signature 

1.2 Executive Summary

Our overall aim is to provide high quality healthcare to the population we serve for the great majority of their needs, both elective and emergency.

The West Suffolk NHS Foundation Trust (WSFT) was named as Trust of the Year 2013 for the Midlands and East of England region as part of the publication of the annual Dr Foster Hospital Guide. WSFT received the award after the hospital recorded lower than expected death rates and in recognition of our performance for weekend working, which shows the Trust delivers the same safe, high quality care at weekends as during the week.

The accolade is a testament to the professionalism and dedication of all our staff, clinical and non-clinical, who strive to provide the best possible services for our patients.

WSFT has also been recognised for "excellence on maternity care" by healthcare intelligence expert CHKS as part of its Top Hospitals awards programme. West Suffolk was shortlisted along with 14 other hospitals following an analysis of nine indicators, including caesarean rates, length of stay, complications, readmissions and injuries. CHKS also took into account three indicators from the Care Quality Commission's 2013 maternity survey when drawing up the shortlist.

The WSFT's financial performance has historically been strong - reporting surpluses and with a good record of cost improvement delivery. During 2013/14, WSFT has seen its financial position deteriorate, stemming predominantly from national tariff reductions and sustained high levels of non-elective activity.

During 2014/15 and 2015/16 these financial challenging will remain and the WSFT is working closing with the Clinical Commissioning Group (CCG), Area Team and Monitor to ensure that the local health economy (LHE) is able to sustainably provide care to the population we serve.

Summary income and expenditure

	2013-14	2014-15	2015-16
SUMMARY INCOME AND EXPENDITURE	Forecast Outturn £m	Plan £m	Plan £m
NHS Contract Income	149.2	147.9	154.0
Non-Recurring Income	1.5	0.0	0.0
Other Income	19.1	19.1	18.6
Total Income	**169.8**	**167.0**	**172.6**
Pay Costs	115.7	115.4	117.4
Non-pay Costs	49.9	49.8	48.3
Winter pressures	1.5	1.5	1.5
Operating Expenditure	**167.1**	**166.8**	**167.3**
Contingency and Reserves	0.0	1.5	1.5
EBITDA	**2.7**	**(1.3)**	**3.8**
EBITDA margin	1.6%	(0.8%)	2.2%
Depreciation & Impairments	4.5	4.5	4.6
Finance costs	2.2	2.2	2.1
SURPLUS/(DEFICIT)	**(4.0)**	**(8.0)**	**(2.9)**

WSFT forecasts a loss of £8m in 2014/15, improving to a loss of £2.9m in 2015/16. The financial position detailed necessitates an injection of cash and an £8m PDC advance is planned for October 2014 along with the sale of land in Sudbury.

The financial position improves in 2015/16 due to a planned increase in elective activity and a reduction in non-elective activity in line with the CCG's plan. The plan also includes the transfer of pathology services from WSFT to the Pathology Partnership (PP), which impacts equally on both income and expenditure.

The population we serve is aging; long term conditions are increasing and costs as well as public expectations continue to rise. The NHS has to change. Acute providers like WSFT, must implement innovative and transformational strategic and operational plans for the delivery of safe, high quality, cost-effective and sustainable services that respond to these challenges.

The WSFT is working in partnership with others to develop better and more effective models of care. This work is focused towards:

1. **Emergency Care Pathway (ECP)**
2. **Planned Care Pathway (PCP)**
3. **Local Savings & Non-recurrent**

Staff across the West Suffolk Hospital (WSH) have been involved in a successful major transformation and service redesign programme focusing on the Emergency Care Pathway (ECP). WSH have seen improvements in the flow of patients and the patient experience and achievement of the 95% A&E target. There is still lots more to do around the ECP to embed the new ways of working, further develop ambulatory care pathways, improve TTOs (To Take Out medicines) and discharge. The aim is to help reduce emergency activity and ensure patients receive the right care in the right place by the most appropriate professional(s).

A similar, clinically led, structured approach is being taken for the Planned Care Pathway (PCP), looking at the 18 week and cancer care pathways, from GP referral through to discharge. To do this will involve rapid, Service Line Reviews, (SLRs) over 7 weeks, up to 5 service areas at a time, which place patients at the centre of all thinking. Each service will have access to a minimum data set plus specific benchmarking, patient outcome, quality and financial information.

Services will produce a 5-year Specialty Clinical Service Strategy, which will look at where they are now, where they aspire to be and what step changes need to be taken to get there. It will include the delivery of an in-year (2014/15) Benefits Realisation Plan.

To underpin the SLRs the WSFT has commissioned an external independent assessment of the WSFT's activity and costs to allow rigorous benchmarking of efficiency,

WSFT are also continuing to work in partnership with the CCG and others to address key national, regional and local drivers of change that will have a direct impact on the future plans and sustainability, including:

- 15% reduction in emergency admissions
- 30% tariff for emergency admissions
- 20% productivity gain in elective (planned) care
- Current economic climate

Through these programmes of work and in collaboration with partners the WSFT believes it can recover its financial position and maintain its excellent record of delivery for quality and performance. The WSFT is currently preparing a five-year strategic plan to be published in June 2014. This will incorporate current work and provide a more in-depth assessment of our challenges and plans for the medium term.

1.3 Operational Plan

1. The Short Term Challenges

The Board of Directors in consultation with staff and Governors, agreed the following revised mission statement:

> **'Excellence in Healthcare – We will provide high quality, safe and caring services; and promote wellbeing'**

The mission statement is underpinned by a set of strategic objectives:

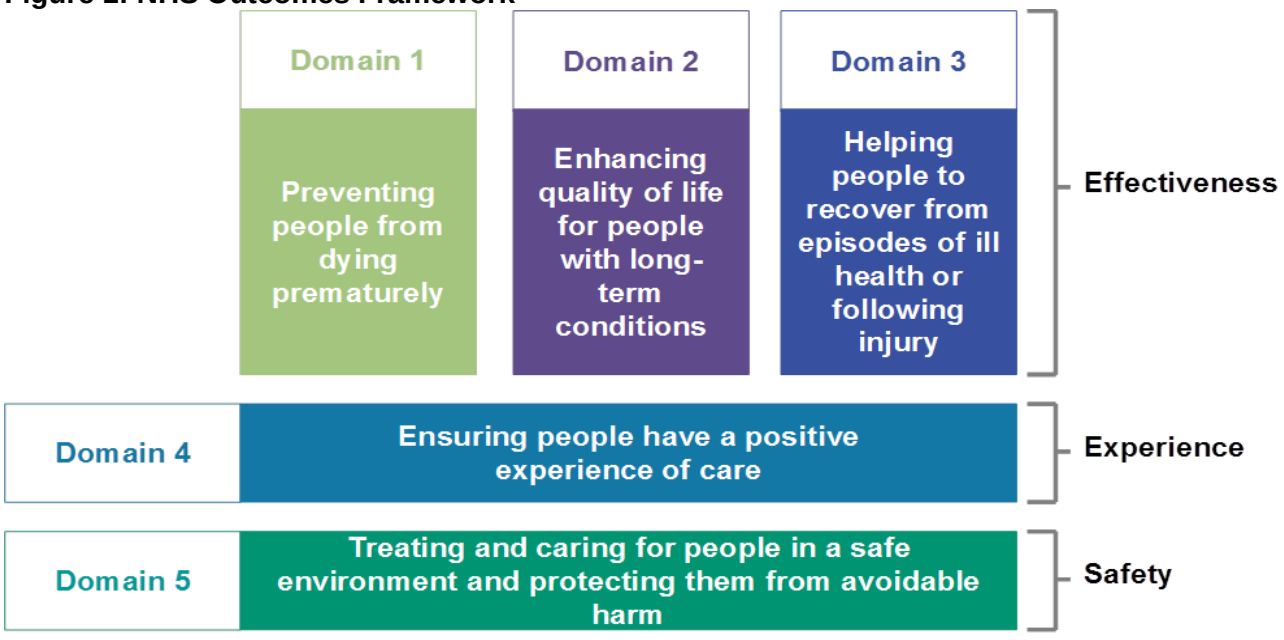
- To be the healthcare provider of first choice by providing excellent quality, safe, effective and caring services
- To work with partners to develop integrated healthcare services to ensure that patients receive the right care, at the right time, and in the right place
- To be the provider of urgent and emergency care services for the local population
- To continuously improve service quality and effectiveness through innovation, productivity and promoting wellbeing in patients and staff
- To continue to secure, motivate, train and develop an engaged workforce which will be able to provide high quality patient focused services
- To deliver and demonstrate rigorous and transparent corporate and quality governance
- To provide value for money for the taxpayer and to maintain a financially sound organisation.

WSFT's strategic and operational plans must take account of the national environment in which the NHS operates and the effect this has on the regional and local picture. The plans are also closely aligned with those of commissioners and local authorities.

1.1 The National Picture

Figure 1 summarises the overarching national framework through which NHS England's vision and ambitions will be delivered, and against which the WSFT will deliver high quality service locally for the people of west Suffolk.

Figure 1: NHS Outcomes Framework



In today's NHS the challenge for all providers is the need to continually find ways to raise the quality of care for our communities to the best international standards, (*responding to recommendations of Francis,*

Keogh and Berwick); while closing a potential funding gap of around £30 billion by 2020/21. This is against a backdrop of increasing demand on services from an ageing population and an increase in the number of people with multiple long-term conditions and those diagnosed with dementia.

NHS England's publication "Everyone Counts: Planning for Patients 2014/15 to 2018/19 outlines the key actions that will need to be taken to meet these challenges:

- significant shift of activity and resources to more integrated out-of-hospital services
- 15% reduction in hospital emergency admissions by 2015
- 20% productivity increase in elective care over the next five years.

1.2 Better Care Fund

The Better Care Fund (formerly the Integration Transformation Fund) was announced by the Government as part of the Comprehensive Spending Review in June 2013 to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) combines £3.8 billion of existing funding into a single pooled budget to support health and social care services to work more closely together and deliver better, person-centred care. The BCF will be implemented in 2015/16.

On 20th December 2013, it was announced that Suffolk would allocate a minimum of £50,099,000 of existing money to the BCF. In order to access the fund, CCGs and Local Authorities must submit a five year delivery plan for approval by Government.

1.3 Suffolk's Better Care Fund Plan

Suffolk's BCF Plan needs to be both ambitious and innovative in driving change and breaking down barriers to integrated care. It is jointly agreed by each of the counties' three Clinical Commissioning Groups (West Suffolk, Ipswich and East Suffolk, and Great Yarmouth and Waveney) its Health and Wellbeing Board and Suffolk County Council.

It involves local health services, care services, district and borough councils, Suffolk County Council, the three CCGs, local GPs and the voluntary sector. Everyone's priority must be to integrate services in a way that improves outcomes and experience for individuals, and reduces overall cost.

Through a shared vision, shared principles and shared priorities the plan shows how the whole system is addressing the need for services that:

- work effectively at weekends
- support patients being discharged from hospital
- make sure people get the help they need early to prevent unnecessary admission to hospital
- help patients to stay as well as possible with a good quality of life.

1.4 The West Suffolk Picture

The population of west Suffolk is around 240,000 people and in comparison with England has a lower proportion of children and young people (up to age 44) and a higher proportion of middle aged and elderly people. This difference is extenuated over the next 20 years. The overall population of west Suffolk is projected to increase by over 7% between 2013 and 2022 (see figure 2), with a 38% increase in people aged over 70 years old. Therefore the population is an ageing one with around 2,000 deaths per year. the leading causes of death are: circulatory disease (35% of all deaths); cancer (29%); and respiratory disease (12%). Cancer is the leading cause for premature death.

By and large, the population of west Suffolk is a healthy one with a higher than average life expectancy (males: 80.2 years; female 84.0 years according to 2007-09 Public Health). However, there are pockets of deprivation and single households which are experiencing significant hardship. Due to the rural nature of the county these are often difficult to identify. Environmental factors such as poor transport and mobile network coverage can affect access to services.

In the last census it was reported that there are approximately 30,000 Family Carers supporting their loved ones across the west of Suffolk, the support to Family Carers is considered to be low in comparison to other local authorities.

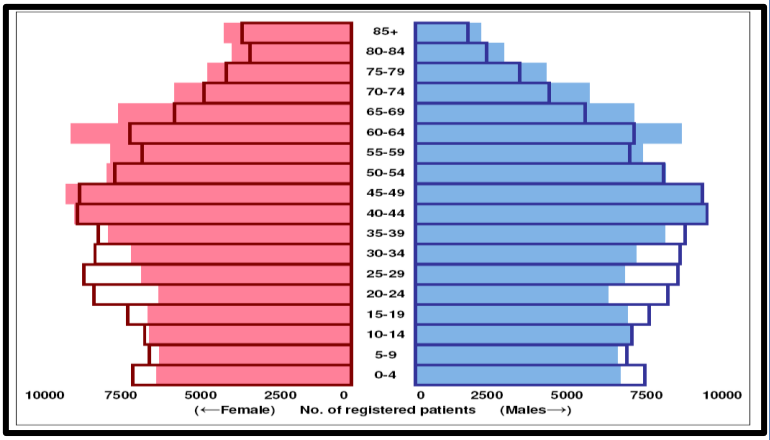


Figure 2: Population profile of west Suffolk CCG

The England average population distribution is overlaid on the chart as an outline box with the shaded areas (pink - female and blue - male) denoting the west Suffolk population

1.5 Major Drivers of Change

A summary of the key national, regional and local drivers of change that will have a direct impact on the future plans and sustainability of WSFT are as follows:

- **15% reduction in emergency admissions**
  Outlined in NHS England's Planning Guidance, this is an extremely challenging target as emergency activity is forecast to increase annually by around 3% under the current model of care.

- **30% tariff for emergency admissions**
  The 30% marginal rate for emergency admissions over the 2008/09 baseline will be retained. Investment plans for the 70% of tariff retained under the marginal rate rule is to be agreed by local urgent care working groups. The aim is to use this money to reduce the number of emergency admissions.

- **Francis, Keogh and Berwick Reviews**
  A number of recommendations have come out of these important reviews requiring a response from WSFT in the following areas:
  - Seven day services
  - New blueprint for emergency and urgent care across England
  - Patient safety
  - Listening to patients
  - Safe staffing
  - Detecting problems quickly
  - Ensuring staff are trained and motivated

- **20% productivity gain in elective (planned) care**
  This challenge is outlined in NHS England's Planning Guidance

- **Current economic climate**
  The tariff assumptions highlighted in the table below will put WSFT and all NHS providers under considerable financial pressure.

Table 1: Tariff assumptions

	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19
Secondary care health cost inflation	2.3%	2.2%	3.0%	3.4%	3.4%
Provider sector efficiency	4.0%	4.0%	4.0%	4.0%	4.0%
Tariff uplift	-1.7%	-1.8%	-1.0%	-0.6%	-0.6%

Tariff deflation will result in a net reduction in clinical income of £2.2M in 2014/15 at 2013/14 activity levels.

1.6 Better care Fund

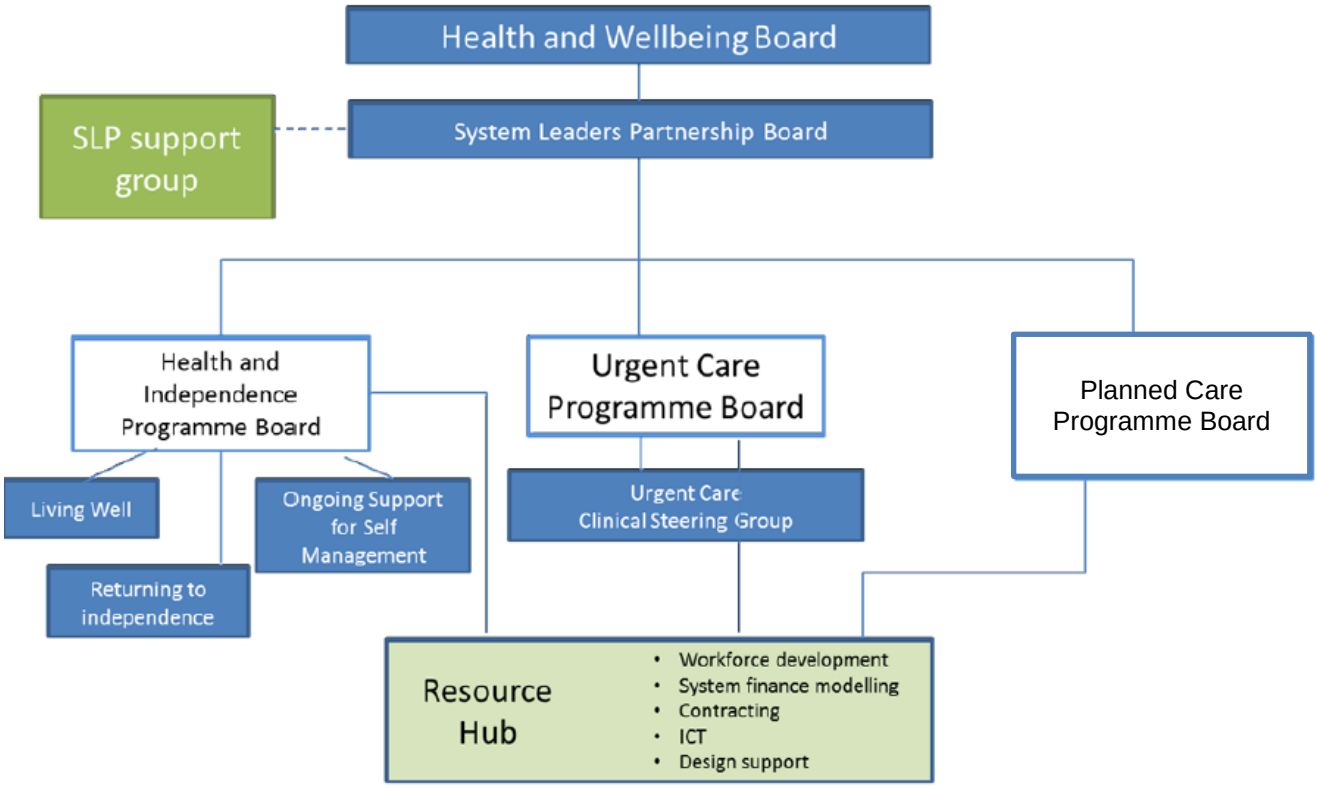
The Better Care Fund plans are being developed as part of the five year strategic planning process through the three system-wide workstreams:

- Health and Independence
- Urgent Care
- Planned Care

The workstreams will specify how the fund will be utilised, planned benefits and how success will be measured. The Resource Hub is modelling potential integration benefits and assuring system-wide sustainability.

The governance framework through which the system transformation will be delivered is shown in Figure 3. The Health & Wellbeing Board retains oversight of delivery.

Figure 3: Governance structure for Health & Care Review



1.7 External Support

Responding to WSFT's challenging financial position the Board has commissioned a review of how efficiently services are being delivered and to look at those services which lose money to fully understand why this is the case. The methodology and terms of reference for the external agency to carry out this work have been discussed with Monitor and approved by the Board.

The scope of the review will include consideration of:

- Efficiency focused benchmarking exercise
- Analysis of market share data
- Provision of community beds and the impact on our ability to discharge patients
- Identification of opportunities to improve our financial position or standing (short and long term)

The review will conclude in May 2014 and, linking with partners within the local health economy, will inform the WSFT's 5-year strategy.

West Suffolk CCG is also currently considering a wider (*more radical*) strategic exercise; identifying essential Commissioner Requested Services (CRS) and options for service/Trust configuration. Partnership working to develop and deliver these changes will be critical to achieving the activity and financial assumptions set out in this Operational Plan.

In February 2014 it was announced that 11 "financially challenged" health economies are going to receive analysis and strategy development support from consultancy companies. Monitor, NHS England, and the NHS Trust Development Authority will fund the companies to help commissioners and providers to "work together to assist the development of their integrated 5-year plans" which deal with the "particular local challenges they face".

The 11 health economies are:

- South West London
- North East London
- Cumbria
- Eastern Cheshire
- Staffordshire
- Mid Essex
- Cambridge and Peterborough
- Leicestershire
- Northamptonshire
- East Sussex
- Devon

Around £800,000 will be made available in each area and overall responsibility for the plans will remain with commissioners and providers. As a result of WSFT's strategic clinical relationship with Cambridge University Hospitals and the flow of activity to Cambridge from the west of Suffolk and from Cambridgeshire to WSH, the WSFT and West Suffolk CCG have been incorporated into the Cambridge and Peterborough work.

Involving West Suffolk CCG in both pieces of work will ensure that WSFT's service plans are aligned with the CCG looking forward over the next five years.

2. Our Quality Plans

WSFT is committed to achieving excellence in all we do and aim to be the hospital our local communities choose first, every time. Our Quality Strategy was updated in September 2013 and set out how we will define, improve and assure the quality of our services. WSFT uses the three domains of quality to structure the focus of our strategy and priorities:

1. **Patient safety** - doing no harm to patients
2. **Clinical effectiveness** - measured using survival rates, complication rates, measures of clinical improvement and patient-reported outcome measures
3. **Patient experience** - care should be characterised by compassion, dignity and respect.

Quality means getting things right for those who use our services, their carers and families. WSFT has developed this strategy through talking, and listening, to our patients and members, and our partners and stakeholders to understand what is important and how they define quality.

2.1 Delivery and monitoring

The Board monitors quality through its performance management arrangements on a monthly basis. The Board also receives assurance regarding quality within the organisation from the Quality & Risk Committee and its three sub-committees which ensure quality is delivered in a coordinated way to support safe, effective and patient-focused healthcare.

The WSFT maintains a self-assessment against the 10 Quality Standards set out in Monitor's Quality Governance Framework through its Quality Memorandum. This provides an outline of the evidence on which the assurance statement is based and is updated on a quarterly basis to reflect current practice.

The Board tracks performance in relation to quality goals and monitors quality through:

- A monthly **Quality and Performance Report to the Board** with a RAG rated dashboard and regular reports on patient and quality issues such as the complaints report, national patient survey reports etc.
- The **Executive Performance Meetings** review performance against the quality indicators from the Trust dashboard; these are reviewed at ward and Directorate levels
- The **Board Assurance Framework** identifies the key risks and assurances to the delivery of the Trust's strategic objectives and is monitored by the Board on a quarterly basis
- The **governance committee structure** is led by the Quality & Risk Committee and supported by its three subgroups, the Clinical Safety & Effectiveness Committee, the Patient Experience Committee and the Corporate Risk Committee
- The **Audit Committee** provides an independent and objective view of the Trust's internal control environment and the systems and processes by which the Trust leads, directs and controls its functions in order to achieve organisational objectives, safety, and quality of services, and in which they relate to the wider community and partner organisations
- The **Risk Register** is monitored by the Corporate Risk Committee of the Board. This considers high risk issues and performance in managing risks. The risk register performance indicators form part of the monthly dashboard to the Board and **risk escalation framework** ensures that "red" risks are received and reviewed by the Board in a timely manner
- A clear process to assess the **quality impact of Cost Improvement Plans (CIPs).** CIP plans are generated at directorate level and, with the support of the Programme Management Office (PMO), presented to the Trust Executive Group (TEG). TEG includes Clinical Directors as well as the WSFT's Executive and Senior Management team. Clinicians and other members of the group use this opportunity to challenge proposals where there is a perceived impact on the quality of services. Proposals are also quality 'scored' by the Executive Medical Director and Executive Chief Nurse prior to approval. During implementation, the quality impact of CIPs is monitored through the Board Quality Report, including the ward level quality dashboard. This complex set of measures picks up very quickly where either there is an impact in a single clinical area or where

there is deterioration in a single metric across a number of clinical areas. The performance of CIPs is reported to the Board each month through the PMO and Finance reports.

Quality improvement is connected from "Board to Ward" - this is achieved through two-way communication between the Board and operational areas (e.g. wards) across WSFT. The monthly Quality and Performance Report to the Board provides both an organisational and ward-level dashboard. This information is underpinned and informed by review by directorates and wards with action planning at these levels. Delivery of improvement at an operational level is managed through directorate Executive Performance Meetings but is also tested through observational visits by Board members and Governors as part of the weekly Quality Walkabouts. A programme of presentations and patient stories relating to the quality priorities and strategic/service developments is also delivered to the Board. The WSFT also actively engages with its members and the public through regular talks and events.

The WSFT has continued to develop its CQC compliance monitoring through structured ward self-assessment and external peer review. The findings and any identified action is reported to the Quality & Risk Committee on a quarterly basis. This CQC assurance framework includes the "15 steps challenge" observational tool which is a guided audit tool measuring the initial responses that visitors experience during the first 15 steps in a clinical area.

In responding to national development, including **Francis, Berwick and Keogh** the WSFT has striven to integrate this learning into what we do every day. This has been targeted through:

Patient Safety

- Developed the range patient safety indictors monitored by the Board and how this information is presented to support a culture that is dedicated to learning and improvement and that continually strives to reduce avoidable harm
- Safety Thermometer Harm Free care used to help inform improvements in key patient safety areas
- Revised the incident investigation process Whistleblowing policy reviewed and strengthened.

Culture of openness and learning

- Implemented Duty of Candour and monitored compliance through Board reporting
- Programme of learning from aggregated analysis of incidents, complaints, claims and PALS complete including sharing of lessons learnt.
- Directorate and corporate audit programmes developed to include this wider range of external drivers in additional to the thematic analysis of internal quality indicators.

Listening to patients

- Good performance against the Friends and Family Test
- Strengthened Board reporting of information on complaints and the lessons learnt
- Self-assessment against Clwyd recommendations for hospital complaints and actions have been implemented or are in the process of being implemented
- Patient First Trust Values embedded in the Organisation.

Safe Staffing

- Active engagement with staff and support their health, well-being and development
- Recruiting staff based on values and behaviours
- Programme of nurse recruitment, including overseas recruitment, completed during 2013 and planned for 2014
- Recommendations of National Quality Board reviewed in line with current Trust practices, including: acuity of patients collected daily; and numbers of staff on shifts displayed outside wards.

Detecting and responding to problems quickly

- Strengthened our CQC self-assessment framework, including external peer review
- Responded effectively to CQC concerns highlighted by CQC which have now been addressed.

2.2 Quality priorities for 2014/15 and beyond

The quality priorities have been reviewed along with other quality indicators reported to the Board and consideration given to quality issues arising nationally and locally. Through the commissioning process the West Suffolk Clinical Commissioning Group has identified performance targets through Commissioning for Quality and Innovation (CQUIN) that have directly influenced the way in which we measure performance against our priorities.

Through these mechanisms and discussions with our service users and public FT members, a quality framework has been developed that describes what success looks like (Table 2). This approach ensures continuity between internal and external (local and national) intelligence regarding quality priorities.

Table 2: Quality framework

High Quality Care for all domains of quality	Patient safety		Patient experience	Clinical effectiveness
Our Patients First priorities	"I feel safe"		"I feel cared for"	"I feel confident"
Our quality goals 2014 - 2016	**To achieve the highest levels of patient safety**		**To continuously improve the experience of patients**	**To achieve optimal outcomes and effectiveness**
Focus	Improved identification and management of risk to patient safety.		Improvements in communication, information and involvement – "No decision about me without me".	Ensuring patients receive specialist management and referral according to their individual needs.
Our priorities	To ensure timely identification and management of patients at risk from infection.	To ensure that all deteriorating patients are identified and managed appropriately.	To ensure patients receive a service that they would recommend to friends and family	To consistently achieve a HSMR and SHMI that is below the expected rate.
	To reduce hospital associated harm on inpatient wards	To consistently implement the Sepsis 6 pathway for patients who require the treatment.	To improve the experience of patients and family carers when the patient they care for is admitted to hospital.	To ensure appropriate specialist care of hospital patients.

Measureable targets are defined for each of these priorities and set out within the WSFT's Quality Report. For example improvements are being targeted towards the care of deteriorating patients and the management of diabetic patients while hospital.

Work to deliver improvements in these areas is being clinically led through focused working groups and will be communicated within the Trust as part of structured briefings and learning events. Through this approach the Trust aims to effect real change in the clinical management of these conditions to improve patient safety, experience and outcome.

2.3 Quality risks to our strategy

In June 2013 the CQC undertook an unannounced routine inspection of the WSFT. The inspection included six of the standards for which the WSFT is registered: Overall the inspection was positive but minor concern was identified due to inconsistent awareness and application of the duties and requirements of the Mental Capacity Act. On the 13 March 2014 the CQC undertook a further unannounced visited to test that the action we had completed was effective in addressing their concern. Feedback from the visit was positive and the draft report indicates that the WSFT is compliant with the requirements of the "Consent to care and treatment" standard.

The CQC use intelligent monitoring of more than 150 indicators to direct their resources. The results of the intelligent monitoring work have grouped the 160 acute NHS trusts into six priority bands for inspection based on the likelihood that people may not be receiving safe, effective, high quality care. Band 1 is the highest priority trusts and band 6 the lowest. The latest CQC report placed the WSFT in band 6, the lowest risk banding.

Risks to our strategic objectives are detailed below and are directly related to the quality of service we provide. These include risks to the organisation's service delivery; workforce; and governance. These risks are captured within the WSFT Board Assurance Framework and monitored by the Board on a quarterly basis. This monitoring considers both the level of risk and the effectiveness of action to mitigate risks is reviewed and challenged. Assurance on the effectiveness of these actions is also reviewed by the Board.

Table 3: Risks to strategy

Description of risk
Reputation damage due to quality/service failure leads to reduced activity
Changes to the provision of services in light of national or regional recommendations
Increasing emergency activity
Implementation of Estates Strategy to provide a building environment suitable for patient care and adequately maintained with regard to backlog maintenance
Failure to identify and deliver the level of CIPs (cost improvement plans) to secure the long term viability of the Trust
Material re-organisation of pathology services across the Midlands and East of England. Proposal to move to Hub and Spoke Model.
Implementation of Electronic Patient Record to replace existing Patient Administration System (PAS)
Ability to meet Workforce Plan linked to the Trust's long term financial model (LTFM)
Staff responsiveness to current economic/environmental challenges
Non-compliance with legislation, regulations and good practice guidelines, including failure to comply with internal policy and procedure
Data quality to support clinical and corporate decision making
Local income level at risk through changes to the tariff; reduced activity levels; and/or West Suffolk CCG application of penalties through contract management and external influences/financial pressure upon NHS.

Within the risk assessment framework delivery of the indicator for C. *difficile* is recognised as a risk by the WSFT. An expert team visited the Trust in October 2013 and we accepted the recommendations from this visit. Our action plan has been updated and the new recommendations implemented or are in the process of being implemented. This included opening a dedicated infection ward with single rooms in February 2014. Performance in the second half of 2013/14 improved, but until this can be demonstrated as sustained improvement the indicator is considered at risk.

3. Operational Requirements and Capacity

3.1 Time for Change - What can WSFT Do?

WSFT's short and longer term plans build on the commitment made by WSCCG in its planning documents, which state that the CCG will be supportive of a full range of acute services delivered in the west of Suffolk, if clinically stable, high quality and affordable.

WSFT is supportive of the CCGs overall vision for west Suffolk's health and social care system which is to ensure that local people:

- *Will not have to navigate around a complex system to find the right information, care or services that meets their needs*
- *Will have their health and care needs identified early before a crisis occurs*
- *Will have access to a range of local services that focus on supporting people to self-care and supporting primary prevention*
- *Will have control and choice over their care*
- *Will have a named co-ordinator when they need help who will ensure that the system works effectively, with a single care record.*

Effective integration of care and services across the primary care, social care and acute sectors will be essential to delivery of the changes required,

3.2 Activity and demand pressures

WSFT are committed to providing patient care in the following core acute and elective services:

Table 4: Core services

Acute	Elective
- *A&E – emergency urgent care* - *General Surgery* - *Urology* - *Gynaecology* - *Maternity* - *T&O* - *Anaesthetics* - *ICU* - *Medicine for the Elderly* - *Short stay and adult medicine* - *Paediatrics*	- *All outpatients* - *General Surgery* - *Orthopaedics* - *Urology* - *Gynaecology* - *ENT* - *Plastics* - *Medical Day Treatments* - *Cancer day treatments* - *Other Day Treatments*

The 2014/15 growth assumptions set out in Table 5 are consistent with the plan agreed with the CCG. 2015/16 growth assumes that more patients that live in west Suffolk or its boarders, but receive their treatment elsewhere, choose to have their elective care at the WSFT.

The WSFT's capacity plan is supported by:

- delivery of the agreed reduction in emergency activity
- maximising efficiency within the planned care pathway, including use of all available theatre capacity and extended working hours

This position would be further improved through the provision of appropriate community capacity, including beds. For example on a daily basis WSH has in excess of 50 patients who could more appropriately be cared for outside the hospital

Growth Assumptions	2014-15	2015-16
PBR		
A&E	3%	3%
OP First	3%	6%
OP Follow Up	1%	4%
OP Procedure	6%	6%
Elective IP	-3%	0%
Elective DC	4%	7%
Non Elective (exc threshold)	2%	-10%
Excluded Drugs	1%	1%
Unbundled Imaging	5%	5%
Audiology	1%	1%
Non PBR		
Echo	20%	5%
OT	20%	5%
Physio	10%	5%
Radiology (Nmkt)	3%	5%

Table 5: Growth assumptions

The WSFT is undertaking a further review to ensure these assumptions will allow future capacity needs to be met. The option of creating additional inpatient capacity within the existing infrastructure is also being assessed as a mitigation.

There is a direct relationship between the elective and non-elective demand and capacity set out in the growth assumptions (Table 5) - the reduction in non-elective capacity creating the capacity required to delivery an increase in elective activity.

Failure to deliver the planned reduction in non-elective activity can be mitigated through the timely discharge of patients who could more appropriately be cared for outside the hospital. The use of this additional 50 bed capacity to meet the requirements for elective activity will adversely impact on other potential schemes, for example creation of a decant facility to support the deep clean programme and additional capacity for private patient activity.

4. Productivity, Efficiency and CIPs

4.1 Introduction

WSFT's future service developments and cost improvement plans will focus on securing the WSFT's clinical and financial stability. To deliver the scale of change needed will require the transformation and redesign of services. Collaboration and integration of services with West Suffolk CCG, GPs, other providers, local authorities and the voluntary sector will be crucial for sustainable care and truly patient centred services. Emphasis will also be on business development opportunities to grow market share and clinical income.

WSFT's transformational programmes will cover three areas:

1. **Emergency Care Pathway (ECP)**
2. **Planned Care Pathway (PCP)**
3. **Local Savings & Non-recurrent**

4.2 Emergency Care

During 2012/13 increases in A&E attendances and the number of GP expected patients coming through A&E challenged WSH's ability to deliver a quality service and the best patient experience. In response WSFT invited the national emergency care intensive support team (ECIST) to review its services. The actions identified by the team were rigorously implemented via the Emergency Care Pathway project.

The project involved the introduction of new ways of working including integrated working across primary and community care, social services and the voluntary sector. The overall aim of ECP is to:

- improve the flow of patients through the hospital
- prevent inappropriate admissions
- support timely discharge
- reduced length of stay
- reduce costs

- meet the 95% A&E target
- most importantly improve the patient experience.

Figure 4 includes all aspects of the ECP project.

The clear and systematic approach taken across the whole emergency care pathway was very successful in delivering beneficial change.

There is still more work to do with ECP particularly around ensuring the following:

- aim for 50% of patients admitted to Acute Medical Unit (AMU) being discharged rather than admitted onto a specialist ward area
- continued collaboration across the local health and care economy
- a consistent approach is taken by all clinicians
- embedding the changes so they are normal practice
- structures are in place to support the new ways of working

Over the next two years the ECP will focus on:

- Emergency Department and Acute Medical Unit (wards F7 and F8)
- Integrated admission avoidance schemes
- Ward-based improvements
- Post-hospital care
- Seven day services.

4.2.1 Emergency Department and Acute Medical Unit (wards F7 and F8)

When people are brought into WSH as an emergency, they want prompt, safe and effective treatment. Our focus will continue to be on the early senior clinical review of patients along all parts of the care pathway.

To reduce unnecessary admissions and deliver care closer to home, the Ambulatory Care Service will be expanded. There are three existing pathways:

- DVT
- PE
- Low risk chest pain

There are also a number of other rapid access pathways in the WSH such as TIA clinics, but the Ambulatory Care development will be focussed on adding new pathways to the service in the Acute Medical Unit on F8, including:

- Headache
- First seizure
- Cellulitis
- Supraventricular tachycardia

Other condition-specific pathways will be developed over the next 2 years supported by a generic process for non-specific presentations. The goal is to develop the emergency medical care pathway so that the default is ambulatory care and same-day discharge. In-patient admission will be only to deliver specific care which cannot be given in the community.

Establishment of urgent clinics will ensure that more patients follow an ambulatory care pathway rather than being admitted to a bed for assessment. Patients will be given an urgent clinic appointment to allow them to leave the hospital returning the next day as an outpatient for a diagnostic tests or specialist review.

4.2.2 Integrated Admission Avoidance Schemes

Early Intervention Team

Work will continue to maximise the use of the short stay unit on F7 where patients stay for up to 72 hours before they are discharged or moved onto a specialist ward. The success of F7 in being able to discharge the majority of its patients, who are frail elderly, depends on input from the integrated Early Intervention Team (EIT).

Work in the hospital has shown that a dedicated multi-disciplinary team providing timely, comprehensive discharge planning, can improve the care of frail older people, reducing length of stay and admissions.
In 2013 the EIT was expanded to cover 7 days with the team working extended hours from 8.30am to 9pm on weekdays and 10am to 5pm at weekends and on bank holidays.
The EIT work within the ED and Short Stay Unit and develop discharge plans which puts the right support in place to allow patients to return home after they have received their treatment and are clinically fit. Age UK Suffolk's 'Welcome Home Service' also expanded its hours of work and is co-located with the EIT. The service works from the hospital to help support more vulnerable patients returning home following discharge.

It is hoped that funding will continue to be available to further develop this important integrated service.

Comprehensive Geriatrician Assessment (CGA) Service

A three month pilot of the CGA service with all Sudbury GP practices, started on 10 February 2014. The intention is to roll out the service to the rest of west Suffolk during 2014/15.

The CGA Service is a fully integrated service involving acute, community and primary care, social services and the voluntary sector. Its focus is on the frail elderly who have complex health and social needs and their family carers. Currently they are accessing services at a time of crisis and coming into hospital rather than being supported to live safely in the community either at home or in a nursing home.

GPs are carrying out a Risk Stratification exercise which involves identifying patients who may tip into crisis within the next year. With this information the CGA can proactively put in place all the services each individual requires to reduce the chances of them coming into WSH. With the right support and intervention a frail elderly patient is able to remain at home where they are more likely to make a better recovery.

In cases where patients are admitted to the WSH the CGA ensures they receive a rapid assessment and integrated management plans are put in place to support an early discharge and reduce the risk of a readmission.

A WSFT Geriatrician, provides clinical leadership for the CGA across primary, community and secondary care. The Interface Geriatrician supports the multidisciplinary teams and care homes in admission prevention, and reducing length of stay in hospital and community beds. The CGA service will significantly improve the quality of care and experience of frail elderly people living in west Suffolk.

CGA supporting digital technology

West Suffolk CCG is supporting the CGA pilot by providing nursing homes in Sudbury with telemedicine equipment. This will provide remote video consultations between the WSH Geriatrician and other healthcare professionals and a patient in the home with the aim of avoiding unnecessary visits and admissions to hospital.

4.2.3 Ward-based improvements

ECP included the introduction of

- electronic whiteboards to support more efficient and effective ward rounds
- nurse-led discharge which uses the skills and expertise of senior nurses to ensure timely discharge for their patients.
- Ward managers becoming supernumerary to allow them to coordinate and drive care.

During 2014/15 the ward initiatives will be driven forward so they are fully developed and operating consistently on all wards. This will be important for supporting delivery of 7-day services and supporting the improved flow of patients through WSH.

Clinical teams led by Consultants will be looking at how WSH can improve our discharge processes particularly around the management of TTOs (to take out medicines) one of the biggest causes of delays in patient discharge. The aim will be to advance the WSH's average discharge time profile as studies by a group of junior doctors (called the Fight Club) demonstrated that advancing the profile by just an hour brings significant benefits, releasing beds earlier in the day and easing the pressure on the ED.

4.2.4 Post –hospital care

Collaborative and integrated working between WSH, Serco (Suffolk Community Healthcare, SCH), the Local Authority, ambulance service and voluntary sector will be developed further to improve the management and discharge pathways of two separate patient cohorts, who occupy a large number of beds in WSH and could be cared for in the community.
They are:

1. **Medically fit patients**
2. **Clinically stable (sub-acute) patients**

Over 40 medically fit patients regularly occupy a hospital bed whilst waiting for discharge, with a length of stay ranging up to 60 days. Beds in Ward G5 are constantly occupied by such patients. Serco provide beds on a range of sites in the community for medically fit patients and other patient needs including rehabilitation, step up admission avoidance and palliative care. However it is unclear if the capacity in west Suffolk is sufficient to meet the needs of the increasingly elderly population.

The care model manages the current dispersed beds as a single bed base to allow seamless case management of patients when they transfer between organisations. This also helps to ensure patients are being cared for in the most appropriate environment, reduce the risk of readmission to hospital and ensures most effective use of the available bed capacity.

Table 6: Post hospital care models

Medically Unfit	Medically Fit
• Clinically unstable patients who are acutely unwell on admission to the acute Trust. • **Clinically stable patients who are being treated in line with a working diagnosis and clinical treatment plan**	• **Patients officially categorized as delays in transfers of care (DTOC)** • **Unofficial delays patients are medically fit and are** undertaking a continued health care (CHC) assessment process for discharge or have had an assessment completed and awaiting equipment/rehousing etc., require rehab before they are transferred,

Clinical treatment plans for clinically stable patients, which are currently taking place in WSH, could be provided in the patient's own home and this was the aim of a new interim model of care. During the winter of 2013/14 staff from both WSH and the Suffolk Community Heathcare (SERCO) worked together to allow

earlier planned discharges into the community.

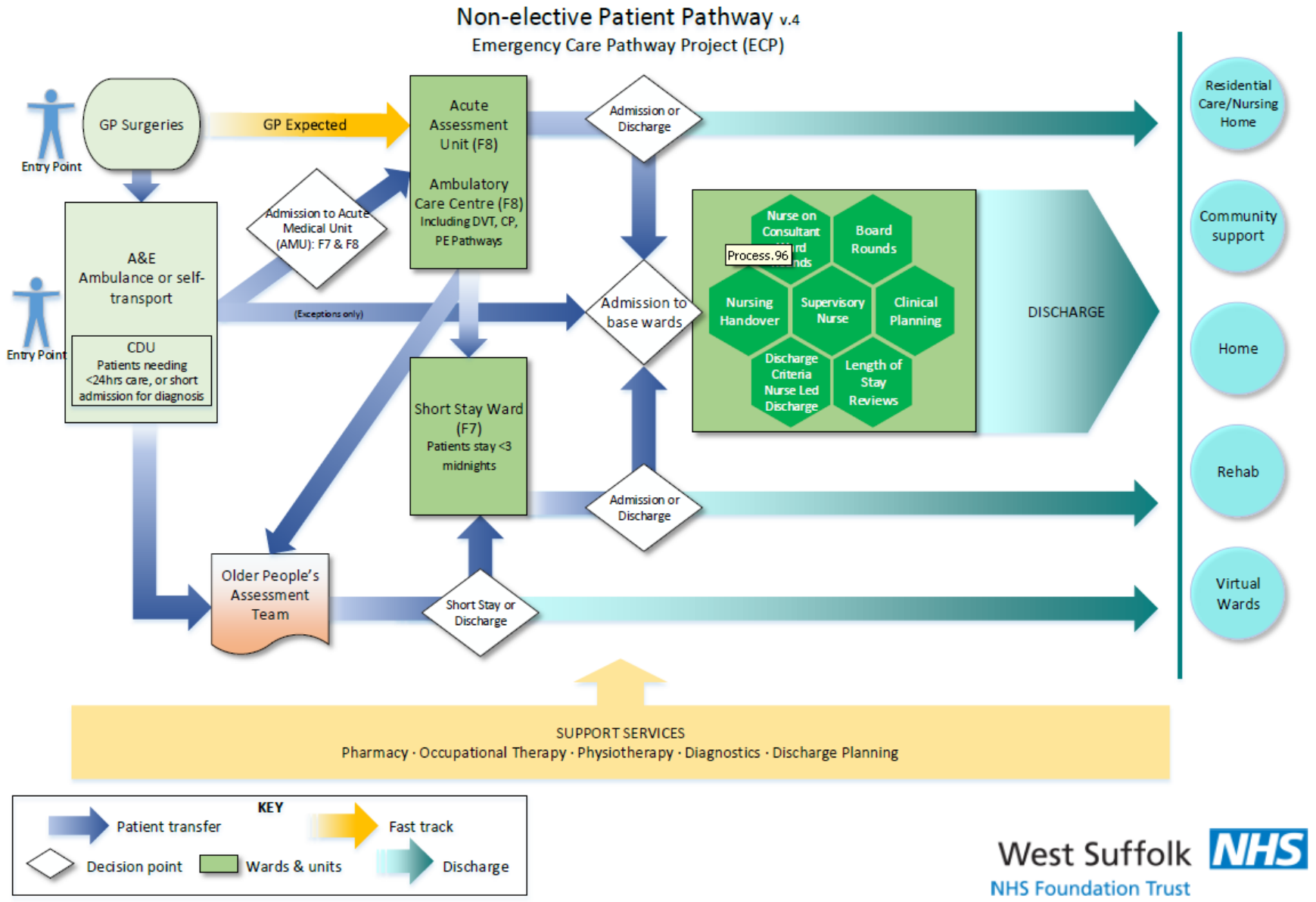
Evaluation of the model will provide valuable information for future commissioning intentions to enable these patients to be managed in the community in the future.

4.2.5 Seven Day Services

Sir Bruce Keogh. NHS England Medical Director, has set out a plan to drive seven day services across the NHS over the next three years, starting with urgent care services and supporting diagnostics. He has identified ten new clinical standards that describe the standard of urgent and emergency care all patients should expect seven days a week, each supported by clinical evidence and developed in partnership with the Academy of Medical Royal Colleges.

For WSFT, baseline reviews and planning will start in 2014 with improvements in service to be introduced over the following 2-3 years. To do this in a way that is clinically and financially sustainable
WSFT and WSCCG will need to explore new ways of working – in networks and collaboratively across the local health and care system.

Figure 4


Non-elective Patient Pathway v.4
Emergency Care Pathway Project (ECP)
Entry Point
GP Surgeries
GP Expected
Acute Assessment Unit (F8)
Ambulatory Care Centre (F8) Including DVT, CP, PE Pathways
Admission or Discharge
Residential Care/Nursing Home
Admission to Acute Medical Unit (AMU): F7 & F8
A&E Ambulance or self-transport
Entry Point
CDU Patients needing <24hrs care, or short admission for diagnosis
(Exceptions only)
Admission to base wards
Nurse on Consultant
Board Rounds
Process.96
Nursing Handover
Supervisory Nurse
Clinical Planning
Discharge Criteria Nurse Led Discharge
Length of Stay Reviews
DISCHARGE
Community support
Home
Short Stay Ward (F7) Patients stay <3 midnights
Admission or Discharge
Rehab
Older People's Assessment Team
Short Stay or Discharge
Virtual Wards
SUPPORT SERVICES
Pharmacy · Occupational Therapy · Physiotherapy · Diagnostics · Discharge Planning
KEY
Patient transfer
Fast track
Decision point
Wards & units
Discharge
West Suffolk NHS
NHS Foundation Trust

4.3 Planned Care

Following successful implementation of the Emergency Care Pathway (ECP) which was based on the recommendations of the national Emergency Care Intensive Support Team, a similar approach will be taken to planned care pathways.

The Planned Care Pathway (PCP) will be a major project for WSFT and will adopt best practice, including recommends from the Elective Care Intensive Support Team and NHS Elect. The programme of work will focus on how sustainable improvements can be made to planned care including seven day services. The emphasis will be on improved efficiency, productivity and income generation, whilst maintaining and wherever possible improving safety, quality and the patient experience.

Lessons learnt from ECP have highlighted the importance of the following to help secure success:

- Strong clinical leadership and clinician engagement
- availability of dedicated resources, including support from the PMO (Programme Management Office),
- protected time for staff to work on the programme
- a clear well structure approach.

The PCP will primarily look at the 18 week and cancer care pathways, from GP referral through to discharge. The programme will cover:

- Service Line Reviews (SLRs)
- 7-step Reviews

4.3.1 Service Line Reviews

SLRs will involve rapid reviews, each over seven weeks, of all WSFT's individual specialties. The first tranche of SLRs, comprising four specialties, will start on 31st March 2014, with all specialty reviews to be completed by the end of March 2015. Each service will have access to a minimum data set plus specific benchmarking, patient outcome, quality and financial information.

The SLR teams will be asked to produce a 5-year Specialty Clinical Service Strategy. This will examine where they are now, where they aspire to be and what step changes need to be taken to get there. In doing this the WSFT should see an improved position in six key areas:

I. Outcomes and patient safety and experience
II. Financial sustainability
III. Clinical sustainability
IV. Operating efficiency
V. Staff – focused on key priorities, motivated and working collaboratively
VI. Networks & partnerships

The structure of the SLR teams is critical and must be driven by and have the full support of the Consultants who are in turn supported by operational and PMO colleagues. The first group of services includes Trauma & Orthopaedics and Paediatrics.

The best dialogue and outcomes will be achieved by involving all staff across the pathway; clinicians, managers and administrators recognising and promoting the valuable and differing contributions they can all make. The PCP has the support of the CCG and the WSFT is engaging local GPs in the pathway work.

4.3.2 7-step Reviews

At the same time as the SLRs there will be reviews of each of the 7 key steps of a patients PCP:

- GP referral and pre-hospital admin (booking services)
- Outpatient department
- Support diagnostics, treatment and procedures
- Pre hospital admin
- Theatres, elective procedures and medical treatments
- Elective inpatient
- Discharge

This work which will be supported by NHS Elect, will deliver a planned care pathway in which the seven steps have been designed with the right staff with the right skills, demonstrate increased efficiency, productivity and standardisation where ever this is appropriate, improved patient flow, patient outcomes, safety and experience.

For example the work in theatres will review theatre efficiency through increased usage by extending the day, greater use of day surgery theatres and investigation of the feasibility of a Day of Surgery Admissions facility.

4.4 Other Areas of Action in Planned Care

4.4.1 Cardiology

The Cardiology Department has been utilising a mobile unit to conduct cardiac angiography procedures and the time is now right to look for a more permanent solution to, improve patient care, reduce length of stay and repatriate work from Papworth Hospital and hence improve income.

Most Suffolk patients needing complex procedures are referred to Papworth Hospital. This can result in patients waiting in a WSH bed for five to 10 days for a transfer to Papworth and they cannot be sent home given their condition.

The short to medium term solution to this is a permanent angiography and pacing suite and a feasibility study is underway to determine a suitable site for the building. The benefits will be reduced length of stay, a safer environment, care closer to home for the patient and income generation as angiography sessions will be more robust and pacing is an additional service. These changes will help retain and attract highly qualified staff as it increases the scope of services delivered.

4.4.2 Partnerships with others

Where an appropriate scale of provision is not possible given the size of the population WSFT serves we will collaborate with other acute providers to operate various forms of joint service. In particular we are strengthening our already close links with Cambridge University Hospitals and Ipswich Hospital.

Each of these partner organisations is around 40 minutes travelling time from WSH and clinical collaboration, for example joint on-call rotas is therefore a practical proposition. This has been the approach taken to support hyper acute stroke services in both WSH and Ipswich Hospital. WSFT and Ipswich Hospital are developing a collaborative bid to provide a county wide service for Early Supported Discharge in stroke.

The WSFT will be pursuing opportunities for networking/collaborating with partner organisations around maternity, paediatric and urology services.

Pathology Services

Six NHS hospital trusts* including WSFT have come together to modernise the way pathology services, such as blood and urine tests, are delivered to these hospitals and GPs. This was part of a competitive process for community pathology across the East of England being driven by NHS Midlands and East.

The partnership, known as the Pathology Partnership (PP), is taking forward the recommendations of the Carter Report and following proven models of delivering pathology services.
Patient quality and safety will be improved through consistency in standards and processes for patient tests ordered by GPs, NHS community staff and in hospitals.

Co-ordinating and centralising large volumes of activity will deliver real value for money for the local health economy. WSH will continue to have an on-site laboratory for urgent tests and non-urgent work will be consolidated through two 'hub' laboratories at Cambridge and Ipswich. The go-live date for PP is the 1st May 2014.

* Pathology Partnership:

1. Cambridge University Hospitals NHS Foundation Trust
2. Colchester Hospital University NHS Foundation Trust
3. East and North Hertfordshire NHS Trust
4. Hinchingbrooke Healthcare NHS Trust
5. Ipswich Hospital NHS Trust
6. West Suffolk NHS Foundation Trust

4.4.3 New Service Development

WSFT will respond to tender opportunities where this is assessed to be beneficial to the organisation's long term clinical and financial stability. The WSFT is currently responding to a tender for the provision of Stroke Early Supported Discharge Services which will support the timely discharge of patients from WSH Stroke Unit.

In its Operational Plan 2014/15 to 2015/16 West Suffolk CCG says that it will also be undertaking the following procurements in 2014/15:

Table 7: Procurement in 2014/15

Ophthalmology triage
High cost drugs: management support
Out of hours, 111 and potentially urgent care integration areas
Musculoskeletal physiotherapy
Stroke early supported discharge
Community services

In addition there may be further market review, including:

- Pain services.
- Learning disability services.
- Dermatology services.
- Community respiratory services, COPD.
- Myalgic Encephalomyelitis and Chronic Fatigue Syndrome

4.5 Local and Non-Recurrent Savings Programme

4.5.1 Procurement review

WSFT is working with Accenture to identify and deliver procurement savings. Payment for this service will be dependent on WSFT making actual savings based on Accenture advice.

4.5.2 Staff management

WSFT will be reviewing the overlap time between nursing shifts, the use of agency and temporary staff and staff to patient ratios. The aim will be to identify potential efficiency savings which will not adversely affect the quality of patient care.

4.6 Increasing our market share

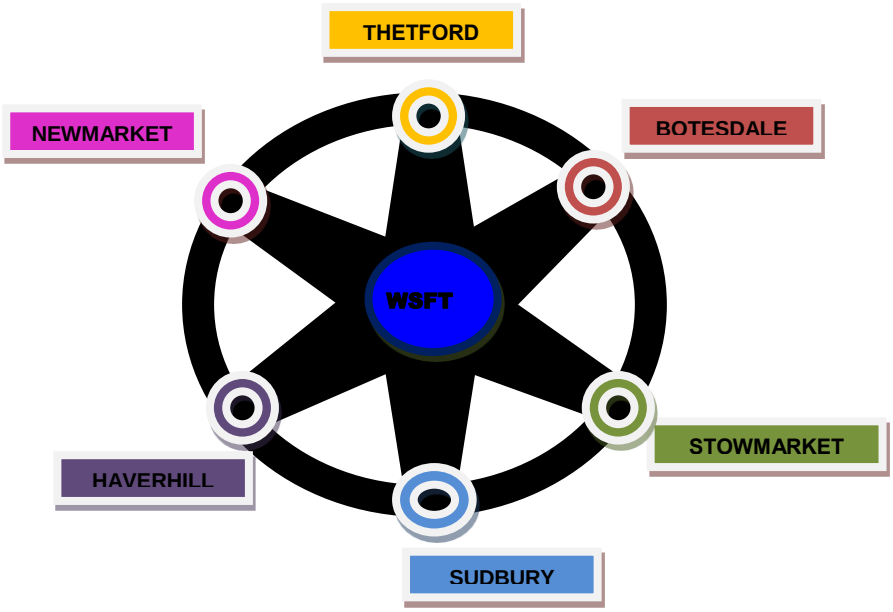
WSFT will continue to serve the population of East of England, through the provision of high quality, safe and caring services; and promoting wellbeing.

Detailed analysis shows that market share is variable across the area served by WSH. Discussions with GPs show that they can be considered in groupings, in particular where they relate to local community hospitals or facilities. These groupings can be identified as a 'Hub and Spoke' with WSFT located centrally (the 'Hub') and six peripheral sites (the 'Spokes').

Figure 5: Hub and spoke model for WSFT

They are as follows:

- Thetford
- Newmarket
- Stowhealth
- Haverhill
- Sudbury
- Botesdale



The current market share in each of these areas differs from a high of over 70% for local GPs, over 60% for those in Thetford and Sudbury to 20% plus in Haverhill. The exception to this is where outpatient clinics are provided in the town when the market share rises to nearly 50%.

4.6.1 Increasing market share by influencing GP referrals

In discussions with GPs they have indicated they would like more WSFT services to be delivered locally, closer to patients' homes to reduce the need to travel to Bury St Edmunds. WSFT is responding by providing more outreach clinics to protect market share in towns such as Thetford and Sudbury whilst in others, for example Haverhill, Newmarket and Stowmarket clinics will be introduced to actively grow our market share. Additionally, WSFT will seek and identify opportunities to provide services in locations outside our core catchment area, i.e. Watton Health Centre.

For a complete and continually growing list of outreach clinics run by WSFT see Table 8.

Cambridge University Hospitals NHS Foundation Trust (CUH) also faces increasing demand based on population growth and rising activity. It too must create a sustainable plan to ensure adequate capacity. WSFT is in discussion with CUH, West Suffolk CCG and GPs in west Suffolk regarding encouraging patients living in west Suffolk to choose to come to the WSH rather than travel out of area to Addenbrookes Hospital for treatments that can be provided by WSH. West Suffolk CCG spends up to £30m with Addenbrookes Hospital in Cambridge to treat patients who could be treated locally at WSH.

4.6.2 Community placement of Optical Coherence Tomography (OCT)

Aiming to provide a first class ophthalmic service to our patients, WSFT recognised the need for essential diagnostic assessment as a fundamental element of the patient pathway in ophthalmic care. OCT equipment is high cost but pivotal in delivering patient assessment for treatment in many clinical pathways in ophthalmology. Recognising the limited capital funding available in the WSFT during a period of financial pressure an appeal was made for grant or donation funding.

The Eye Treatment Centre was successful in an approach, and secured grant funding of £114,000 for the purchase of two OCT machines to enable innovation in providing community services. The machines will be sited at Newmarket and Sudbury.

Table 8: Outreach Services

NEWMARKET	
Audiology	Ophthalmology
Dietetics	Physiotherapy (Paediatric, Respiratory)
ENT	Rheumatology
Geriatric Medicine	Thoracic Medicine
General Medicine	T&O
General Surgery	Ultrasound
Gynaecology	Urology
Midwifery Services	New Open Access echocardiogram
BOTESDALE	
Audiology	T&O
Physiotherapy (Women's)	Ultrasound
Rheumatology	Urology
THETFORD	
Audiology	Neurology
Dermatology	Ophthalmology
Dietetics	Rheumatology
General Medicine	T&O
General Surgery	Urology
Gynaecology	
STOWMARKET	
Audiology	Urology
Neurology	Vascular Surgery
Rheumatology	
HAVERHILL	
Dermatology	Midwifery
Dietetics	Rheumatology
	New Open Access echocardiogram
SUDBURY	
Audiology	Neurology
Dietetics	Ophthalmology
Dermatology	Paediatrics
ENT	Physiotherapy (Paediatric, Respiratory)
General Medicine	Rheumatology

General Surgery	T&O
Geriatric Medicine	Urology
Gynaecology	
WATTON	
Ultrasound	
BURY ST EDMUNDS	
Physiotherapy (MSK)	

4.7 Investing in Our Workforce

"To continue to secure, motivate, skill and develop an engaged workforce which will be able to provide high quality patient focused services" (Trust objective 5)

The NHS needs to make between £30 billion efficiency savings over the next few years, whilst still maintaining a high quality service to its patients and users.

The WSFT needs to deliver 4% efficiency savings year on year. As 70% of our cost is pay, we need to do things differently and reduce our pay bill. This section outlines the approach we will take to improve our staff's ability to continue to deliver high standards and quality of care, whilst also contributing to efficiency and productivity savings.

We know that the people who work with us want to provide consistently excellent care, be productive and deliver good value for the public. We want to create new opportunities for them to have rich careers and opportunities for personal and professional development as we transform our services.

National context

The WSFT is currently responding to a number of national priorities, including the Francis Report, 7 Day services and the need to deal with financial pressures, whilst continuing to improve efficiency and productivity.

The WSFT currently spends over two thirds of its budgets on paying its workforce; consequently workforce priorities will have a significant impact upon our ability to meet our plans.

Local context

WSFT currently employ approximately 3147 (Headcount), plus 912 additional (Bank only headcount) workers who work on an "as and when" needed basis.

Table 9: Staffing

Staff Group	WTE	
Medical and Dental	349	12%
Nursing	1,314	46%
AHP, Professional, Scientific and Technical	384	14%
Admin and Clerical	518	18%
Estates and Ancillary	268	9%
Grand Total	2,833	

WSFT will work closely with our stakeholders and partners to deliver the aspirations of our workforce plans and priorities.

Our workforce challenges can be divided into three main areas;

1. **Recruitment and staffing issues**
2. **Continuing to improve the patient experience and patient safety**
3. **Improving service delivery and increasing productivity**
4. **Leadership and Development.**

The above challenges have been expanded into the following key priorities;

1. **Recruitment and staffing issues**
   - Medical Recruitment plan, including the exploration of recruitment opportunities outside the EU
   - To develop a sustainable Nursing Recruitment plan, which will include further developing our contracted pool, for both registered and non-registered staff, consider the development of a Return to Practice programme and in the longer term, look at the nursing workforce planning processes. WSFT will undertake a recruitment drive in Portugal in July 2014 to recruit up to 40 murses
   - To further support sickness absence management, including reviewing the management of absence policy, by reducing the stages from 4 to 2, and reducing the timescale from one year to six months, where possible. This will be done in negotiation with the trade unions
   - We will invest in a values based recruitment initiative, to further embed our Trust values and patients first standards
   - Continued reduction in bank and locum spend through the use of the contacted pool and fast track recruitment process
   - We will continue to encourage Health and wellbeing activities with our staff to support them.

2. **Continuing to improve the patient experience and patient safety**
   - We will introduce a review of our services in line with “NHS Services, 7 days a week”
   - To undertake a review of the nursing workforce in line with Francis recommendations
   - Introduction of the “Safecare” module in health roster to align staffing levels with acuity
   - We will respond to the outcome of the 2013 national staff survey with a robust action plan to meet those areas identified in the survey
   - Complete full implementation of the medical revalidation system, SARD
   - Further implementation of the Patients First Standards and Trust values into the organisation through the development of a values based recruitment process.

3. **Improving service delivery and increasing productivity**
   - We will continue to improve Theatre productivity, in line with the planned care pathway work
   - Review of the current locum agency provision to ensure best value
   - Further work to extend 7 day services in integrated therapies – orthopaedics and possibly outpatients
   - Introduction of a new electronic patient record (EPR). This will involve new ways of working, increased productivity and a review of staffing levels in back office functions.
   - As a partner Trust, continue to support and facilitate the transfer of pathology services and support new ways of working
   - Further develop opportunities presented by Agenda for Change terms and conditions. We will implement a new performance management approach, which will allow for a more robust management of incremental progression.

4. **Leadership and Development**
   - We will continue to offer leadership development opportunities, such as the national NHS leadership academy offerings (Edward Jenner, Mary Seacole, Elizabeth Garret- Anderson and Nye Bevan), as well as the local liberated leadership programme and skills+ programme, to support managers/ leaders in their development
   - Further implementation of the Patients First Standards and Trust values into the organisation. Through the cascade of the “improving the Patient experience” training programme
   - Continue to work with local stakeholders to ensure a career pathway is open to all staff, from work experience/volunteering to professional qualification and beyond. This will include, apprenticeships, supporting pre-registration students, mentoring, coaching and post registration development.

4.8 Investing in our Information Technology

Historically the NHS has been paper based with paper records and handwritten prescriptions.
Over the last few years, technology has radically changed and with the introduction of innovative systems, this means paper is becoming a thing of the past as we embrace this new technology in becoming a new 21st century hospital.

Currently WSH has over 200 disparate systems in place. Not all these systems communicate with each other and paper-based systems still exist within the WSFT. To enable WSFT to move forward we must replace our core multiple systems with one single, state-of-the-art solution.

From April 2015 WSFT will replace our Patient Administration System (PAS) with a brand new Electronic Patient Record (EPR). Gone are the days of signing-in to multiple systems, the new EPR system, called e-Care throughout the WSFT, will allow staff to access all the key information required from one system.

WSFT's vision for the future is one where computers are part and parcel of every day work for all staff: doctors, nurses, technicians, administrators and the patient. This will make healthcare more efficient, effective, safe, accessible and reliable.

Depending on which supplier is chosen, it is likely that the new EPR system will replace the following systems:

- PAS
- Clinical correspondence and White Boards (EPRO)
- Order Communications (ICE)
- A&E system (Symphony)
- Data Warehouse and Business Intelligence

It will bring the following clinical functionality:

- E-Prescribing and Clinical Decision making
- Clinical Noting, Electronic forms and Nursing Observations
- Electronic Patient Pathways

The intention is to 'go live' with the introduction of the new EPR plus key clinical modules in 2015.

5. Supporting financial information

5.1 Income and Expenditure

Table 9: Summary income and expenditure

SUMMARY INCOME AND EXPENDITURE	2013-14 Forecast Outturn £m	2014-15 Plan £m	2015-16 Plan £m
NHS Contract Income	149.2	147.9	154.0
Non-Recurring Income	1.5	0.0	0.0
Other Income	19.1	19.1	18.6
Total Income	**169.8**	**167.0**	**172.6**
Pay Costs	115.7	115.4	117.4
Non-pay Costs	49.9	49.8	48.3
Winter pressures	1.5	1.5	1.5
Operating Expenditure	**167.1**	**166.8**	**167.3**
Contingency and Reserves	0.0	1.5	1.5
EBITDA	**2.7**	**(1.3)**	**3.8**
EBITDA margin	1.6%	(0.8%)	2.2%
Depreciation & Impairments	4.5	4.5	4.6
Finance costs	2.2	2.2	2.1
SURPLUS/(DEFICIT)	**(4.0)**	**(8.0)**	**(2.9)**

The tables below details the movement between 2013/14 outturn and the plan for the next two financial years.

Table 10a: Financial movement – contracted NHS income

NHS Contract Income	£m
13-14 Outturn	149.2
Deflation	(2.2)
Growth	5.0
Direct Access Pathology (11 months)	(4.1)
14-15	**147.9**
Deflation	(2.2)
10% reduction in Non-elective	(1.4)
Direct Access Pathology (1 month)	(0.4)
Growth	4.1
PCP	6.0
15-16	**154.0**

The income plan over the next 2 years assumes a drop of 10% in non-elective activity by 2015/16, back to around 2008/09 levels

Income increases with the drop in tariff offset by demographic growth along with increase in demand from Newmarket/Haverhill.

Table 10b: Financial movement – non-clinical income

Non-Clinical Income	£m
13-14 Outturn	19.1
14-15	19.1
Profit from PP	0.5
Other Income growth	0.4
PP hosting ceases	(1.4)
15-16	18.6

Table 10c: Financial movement – pay

Pay	£m
13-14 Outturn	115.7
FYE 13-14 CIP	(0.8)
14-15 pay awards and increments	2.3
14-15 CIP	(1.2)
14-15 additional activity	1.8
Nursing Review	0.7
Direct Access Pathology (11 months)	(3.1)
14-15	**115.4**
15-16 pay awards and increments	1.8
15-16 growth	1.8
10% reduction in Non-elective	(2.3)
Direct Access Pathology (1 month)	(0.2)
15-16 CIP	(2.0)
15-16 additional activity (PCP)	2.9
15-16	**117.4**

Pay costs increase in line with pay awards and additional activity offset by pay related CIP.

Table 10d: Financial movement – non-pay

Non-Pay	£m
13-14 Outturn	49.9
Non-pay inflation	0.8
14-15 CIP	(0.5)
14-15 additional activity	0.7
Direct Access Pathology (11 months)	(1.1)
14-15	**49.8**
15-16 growth	0.7
10% reduction in Non-elective	(1.0)
Non-pay inflation	0.7
15-16 CIP	(1.0)
Cease hosting PP	(1.2)
End of non-recurring PP expenditure	(1.0)
15-16 additional activity (PCP)	1.3
15-16	**48.3**

Non pay increases in line with inflation and the growth in activity, offset by savings in procurement and drugs.

The income projections assume growth in activity as follows:

Table 11: Clinical activity growth assumptions

Growth Assumptions	2014-15	2015-16
PBR		
A&E	3%	3%
OP First	3%	6%
OP Follow Up	1%	4%
OP Procedure	6%	6%
Elective IP	-3%	0%
Elective DC	4%	7%
Non Elective (exc threshold)	2%	-10%
Excluded Drugs	1%	1%
Unbundled Imaging	5%	5%
Audiology	1%	1%
Non PBR		
Echo	20%	5%
OT	20%	5%
Physio	10%	5%
Radiology (Nmkt)	3%	5%

These assumptions are in line with local commissioning intentions and reflect their QIPP plans, which have a more significant impact in 2015/16.

The bridge below demonstrates the movement from the planned 2013/14 surplus of £1m, to the forecast outturn of £4m deficit for 2013/14, the planned deficit of £8m in 2014/15 and a possible upside (risk rated red) which could improve the 2014/15 outturn to a deficit of £4.7m

The Trust is undertaking an organisation wide review in partnership with PWC during Q1. It is expected that this review will give rise to a further Cost improvement Programme which will improve on the plan submitted.

The Trust is also carrying out a service by service review designed to both improve efficiency and identify opportunities to increase market share. This should also identify potential for further improvements to the planned position.

Figure 6a: Financial bridge 2014/15

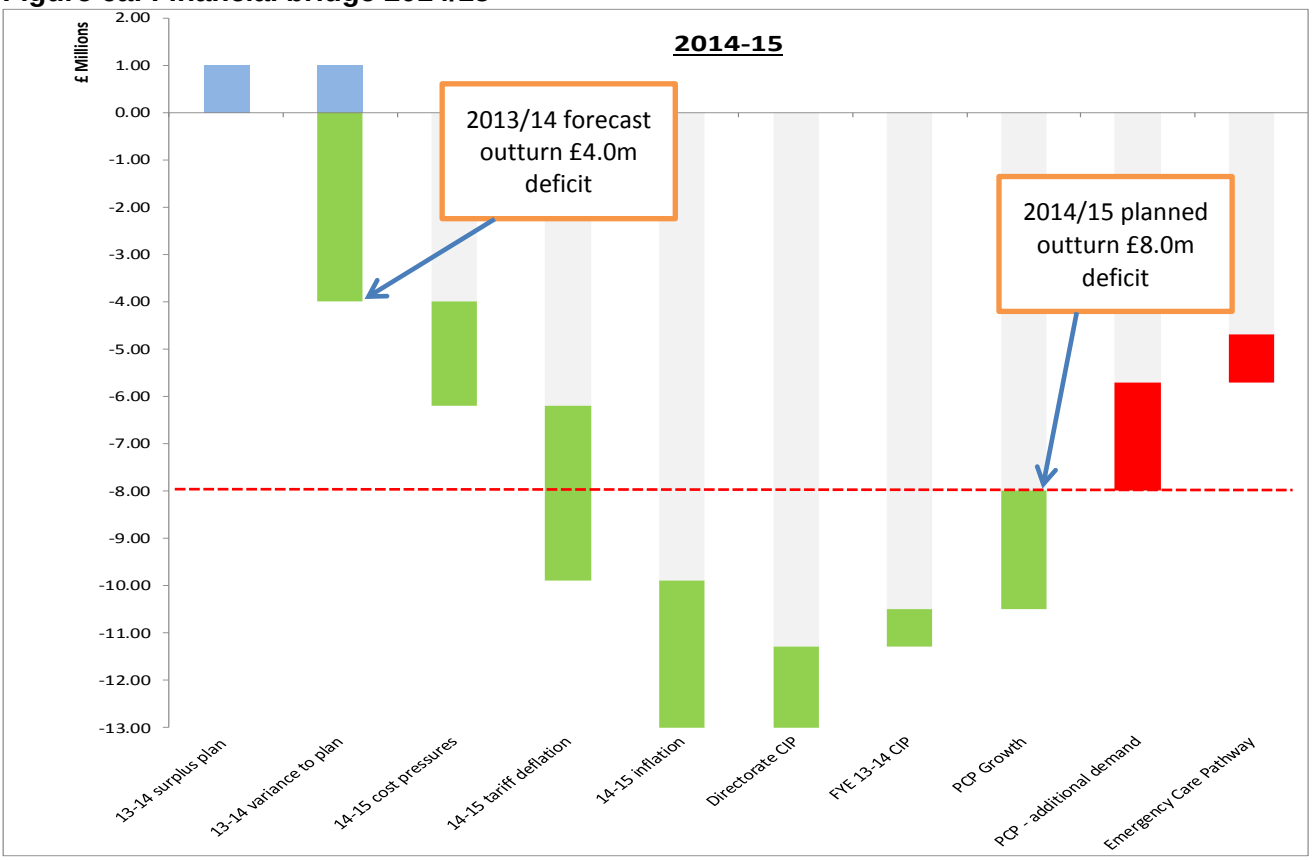


Figure 6b: Financial bridge 2015/16

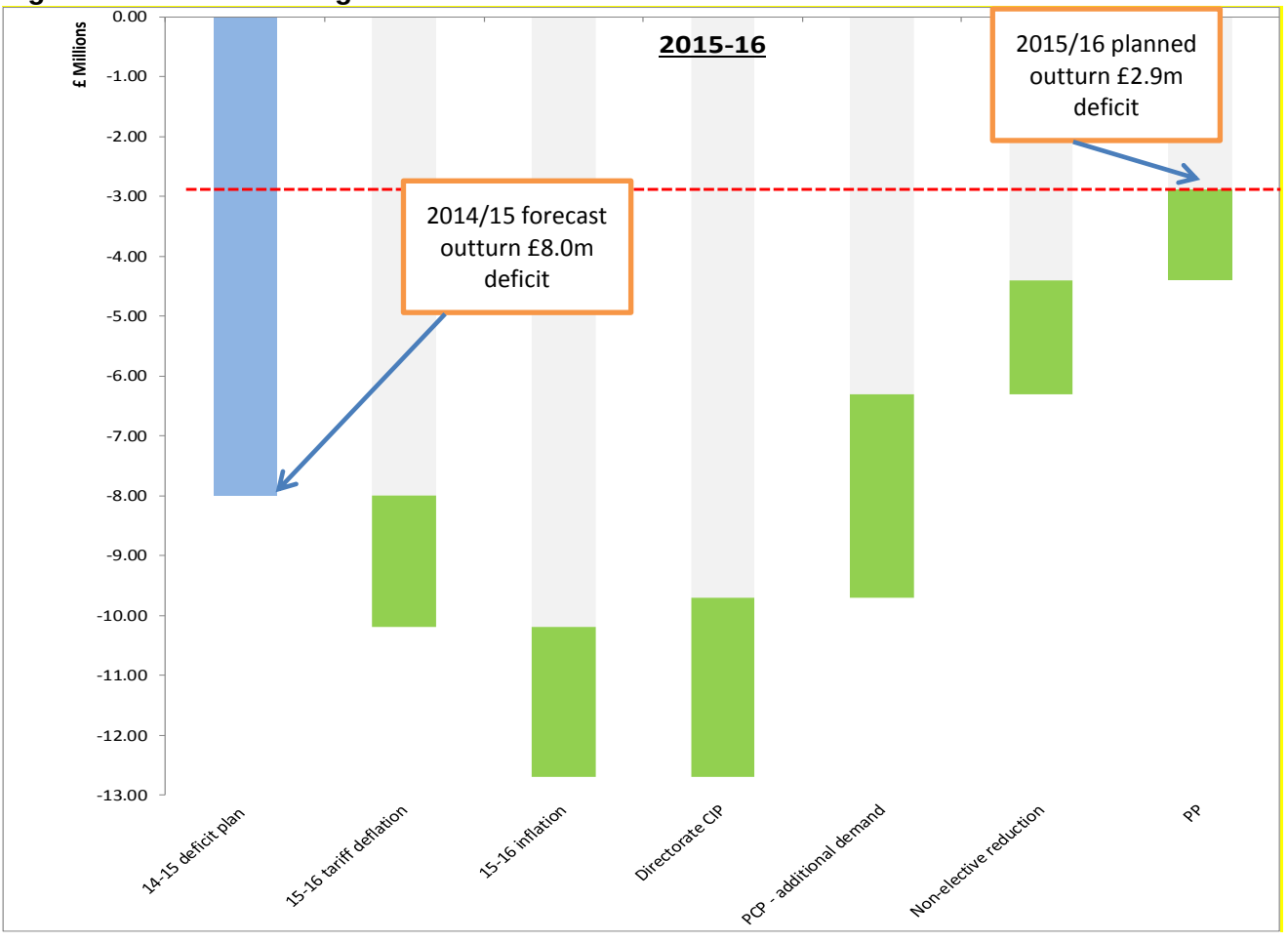
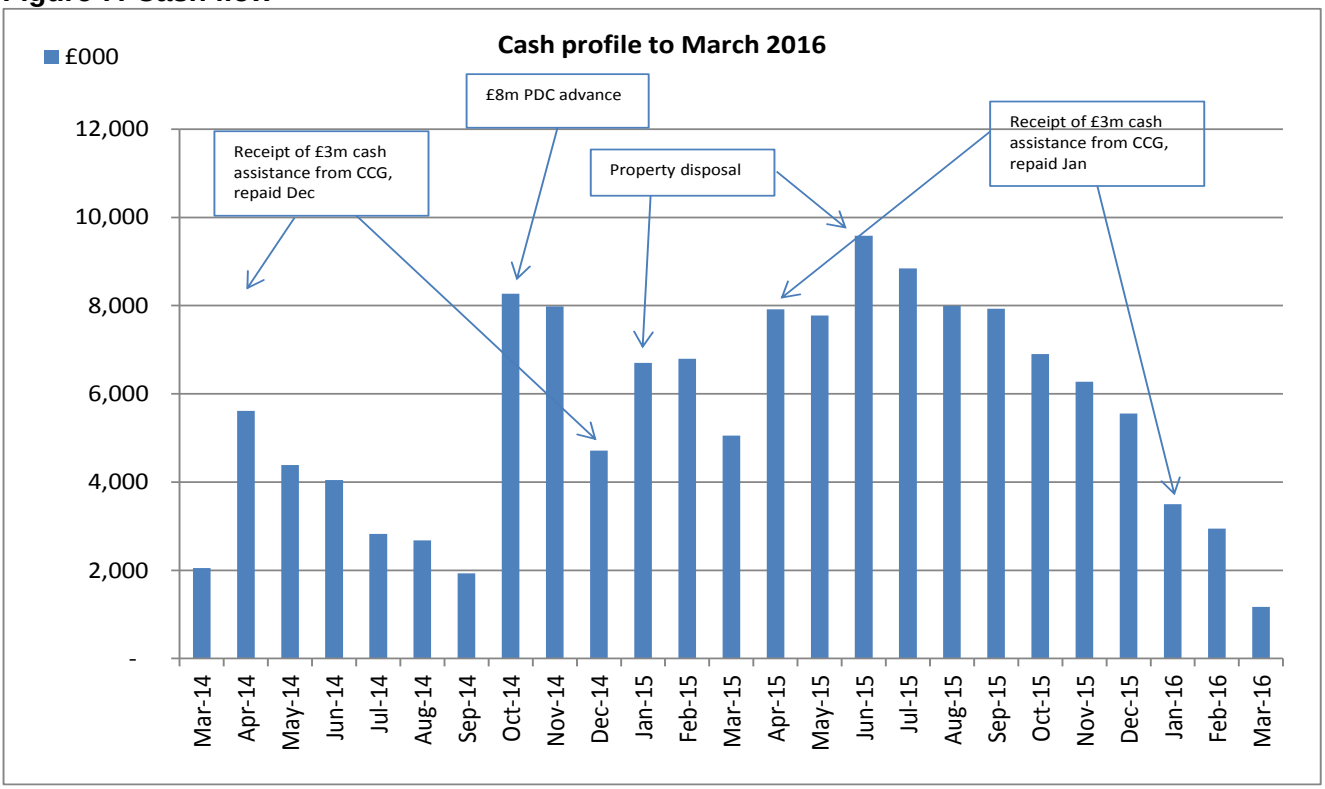


Figure 7: Cash flow



2014/15 cash assumptions

- £0.5m of transition funding to be received in April 2014.
- £3m of transition fund to be received in April and repaid in December 2014.
- PDC support of £8m required in Q3
- Sale of land in Sudbury to be finalised in Q4.
- Capital programme limited to the level of depreciation funding.
- No increase in the level of creditors has been assumed.
- Year end balance allows for slippage on asset sale.

2015/16 cash assumptions

- £3m of transition fund to be received in April and repaid in January 2016
- Sale of Sudbury properties (£1m) in June 2015
- Capital programme increased as a result of the roof refurbishment previously deferred. Capex £2m greater than the depreciation for the year
- No increase in levels of creditors assumed

5.2 Risk Ratings and liquidity

Table 12: Risk Ratings

	2014/15				2015/16			
	YTD Q1	YTD Q2	YTD Q3	YTD Q4	YTD Q1	YTD Q2	YTD Q3	YTD Q4
Debt Service Cover metric	-0.45	-0.45	-0.45	-0.45	1.70	1.70	1.70	1.70
Debt Service Cover rating	**1**	**1**	**1**	**1**	**2**	**2**	**2**	**2**
Liquidity metric	12.20	4.00	4.05	3.33	23.27	9.63	4.58	1.10
Liquidity rating	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**
Overall rating	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**

The debt service cover of 1 in 2014/15 is due to the planned £8m loss, which improves to a 2 in 2015/16 with the planned loss improving to £2.9m.

The liquidity rating of 4 is due to the property sales and PDC advance.

5.3 Capital projects

The capital programme over the period of the forward plan is focussed heavily on addressing issues of backlog maintenance and IT development. The main components of the current capital programme are detailed below.

(i) Backlog maintenance
Plant room maintenance (6 year programme)
Replacement of heating, ventilation, hot and cold water systems, insulation, pipework etc.
Status: Phase 1 - 4 complete
Programme: Phase 5 design in progress
Funding Source: Internally generated capital funds
Value in 2014/15 £300k, 15/16 £760k
Risk to quality: Minimal, work has been seasonally programmed to minimise impact to users.

(ii) Roof Replacement programme (5 year programme)
Replacement of the current flat roofing system to a system of insulation laid to falls, the aim is to reduce water retention, weight and improve insulation properties of the main roof covering.
Status: Phase 1 and 2 complete, phase 3 and 4 due to commence April 2015
Programme: 5 year programme
Funding Source: Internally generated capital funds
Value in 2015/16 £2.462m
Risk to quality: Minimal new solution overlays existing surface - 5 year phased programme localised repairs can be undertaken as a short term measure.

(iii) Compartmentation (2 year programme)
Works to address above and below ceiling compartmentation
Status: Below ceiling completed above ceiling. Strategic review in progress for the above ceiling compartmentation.
Programme: Completion by March 16
Funding Source: Internally generated capital funds
Value in 2014/15 £650k, 2015/16 £400k
Risk to quality: Phased implementation and out of hours working to minimise disruption

(iv) Resilience (5 year programme)
A range of projects identified to ensure capability of current mains services to maintain business continuity and to ensure there is sufficient capacity within the current service infrastructure to meet development schemes.
Status: Not started
Programme: Completion by March 15
Funding Source: Internally generated capital funds
Value in 2014/15: £525k, 2015/16 £550k
Risk to quality: Phased implementation and out of hours working to minimise disruption

(v) Front residences
Essential backlog maintenance and statutory repairs to the front residences (Oak, Pine, Larch, Willow, Cedar and Birch)
Programme: Completion by March 15
Funding Source: Internally generated capital funds
Value in 2014/15: £470k
Risk to quality: Phased implementation to minimise disruption

Other projects funded by other sources:

(vi) Maternity projects
Provision of an additional Birthing Pool within the Midwifery Led Birthing Unit and a Bereavement Suite for women who experience pregnancy loss.
Status: Out to tender
Programme: Completion by Autumn 14
Funding Source: Various
Value in 2014/15: £230k
Risk to quality: Phased implementation to minimise disruption

(vii) Sterile Services Department
Relocation of the Sterile Services Department from Hospital Road site to the rear of the main hospital site at Hardwick Lane.
Status: Not started
Programme: Completion by spring 16
Funding Source: Foundation Trust Financing Facility
Value in 2014/15: £831k, 2015/16 £4.5m
Risk to quality: Access arrangements to the estates service area for the duration of the works

(viii) Cardiac catheterisation laboratory
A feasibility study is in progress to explore 4 locations to provide a cardiac catheterisation laboratory within the main hospital building.
Status: Not started
Programme: Completion 2015
Funding Source: TBC
Value in 2014/15: TBC pending business case approval
Risk to quality: Noise, dust etc., phased implementation to minimise disruption.

Other estates strategy:

Asset disposal - Sudbury Estate
The WSFT has established key principles for the disposal of land and buildings in Sudbury that are surplus to its requirements. Asset value will be maximised though obtaining planning permission for each site to minimise developer risk and eliminate conditional bids.

(ix) Harp Close Meadow
Planning submission determined and approved by Babergh District Council
Marketing - in progress
Disposal forecast for June/July 2014

(x) Walnuttree and St. Leonard's Hospitals
Planning submission March 2014
Marketing - autumn 2014 2014
Disposal forecast for November 2014

(xi) Church Field Road
Investigate the potential for higher value uses through local council consultation of local development framework - autumn 2014
Marketing - spring 2015
Disposal forecast for 2015
Status: In progress

IT capital expenditure

(xii) Document Management System (EDMS)
Complete the process of scanning medical records progressing towards the basis of a digital medical record while providing new electronically designed clinical documents as supported via the NHS Technology fund. The creation of necessary clinical documents as necessary
Status: In progress
Programme: Current plan is to complete early in 2014/15 for digitisation process
Funding Source: Internally generated capital funds and NHS Technology funds
Value in 2014/15: £225k
Risk to quality: Accessing and unavailability of patient records during clinical consultation.

(xiii) Maternity Management Systems
Complete transformation of the current maternity management System to meet new clinical records while supporting a completely new technological change within the department underpinning the need for efficiency
Status: Main work streams completed and last phase in progress
Programme: Completion in 2014/15
Funding Source: Internally generated capital funds and support from Nurse Technology funding
Value in 2014/15: £20k
Risk to quality: Unavailability of current electronic notes during system 'go live '

(xiv) New EPR
The current PAS is due for replacement in 2014/15 and WSFT is currently exploring the option to implement an Electronic Patient Record system. This will enable the WSFT to deploy a complete but integrated clinical system for all Medical, Nursing, Admin and Corporate staff
Status: Full Business Case to go before board in May 2014 and the project to start June 2014 and be completed over next 2 years
Programme: Completion in 2015/16
Funding Source: Bids for national funding and internally generated capital funds
Value in 2014/16: £20M (over 10 year period)
Risk to quality: Considerable disruption and change to working practices associated with a system change of this magnitude. The risks will be fully assessed, mitigated and monitored as part of the implementation programme.