

The Dudley Group NHS Foundation Trust
Integrated Business Plan
2 Year Operational Plan 2014 – 2016

Operational 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	3 rd 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 (<i>Chair</i>)	John Edwards
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Signature



Approved on behalf of the Board of Directors by:

Name (<i>Chief Executive</i>)	Paula Clark
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Signature



Approved on behalf of the Board of Directors by:

Name (<i>Finance Director</i>)	Paul Assinder
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Signature



Executive Summary:

- The Dudley Health Economy, like most English health economies, is burdened by the tension that is now being increasingly felt between rising quality standards and decreasing operational budgets to deliver those standards
- Challenges which the Trust faces over the next two years include improvement to the Trust's urgent care performance, planning for the resourcing and recruitment to improved nursing establishments, planning for the admissions avoidance effect of the Better Care Fund (BCF) intentions, planning for the delivery of the 7/7 national standards and recovery of a significantly deteriorating financial position through service improvement
- Central to our operational and financial plan is the creation of significant inpatient capacity to improve our elective activity contract and RTT performance. That plan adopts mitigations for three different scenarios around the anticipated levels of admission avoidance through the BCF developments. Key to those developments is our reconfiguration of locality, multi-agency teams focused on long term conditions and care of the older person
- To underpin both our response to quality and operational challenges, the Trust is adopting a radical new IT strategy and roll out of a new EHR through "Programme Fusion". This programme will be overseen in tandem with our service improvement/financial efficiency plan through a new Board committee
- Our quality strategy will remain applicable throughout the term of this 2 year plan, however this will be revised and re-launched, for inclusion in the Trust's 5 year strategic plan
- The greatest quality risks we face within the duration of this plan are poor patient flow (leading to poor ED 4 hour performance, poor patient experience and potentially higher mortality) and our inpatient nursing establishment, which is not yet optimised in all areas. Mitigations to each are clearly set out in this plan
- The financial plan we have constructed will be a major challenge for the organisation and its staff. We have initiated a financial turnaround programme to ensure that financial balance will be delivered in 2015/16 but are forecast to end 2014/15 with a small operating deficit of £6.7m. The key to moving back into financial surplus by the end of 2015/16 will be Board decisions regarding key loss making services and their disinvestment or radical redesign to enable turnaround to occur
- There are tensions and emerging risks between the CCG's assumptions regarding Trust activity and income levels and our own planning. This is particularly stark with respect to BCF activity assumptions, elective contract activity to return to high performance on RTT and thirdly, the Urgent Care Centre activity and procurement
- The Trust's deteriorating trading position has resulted in a poor liquidity position. In 2015-16 the year ends with liquidity days of -0.2 and a cash balance of £12.0m. This will clearly have a potentially considerable impact on our ability to fund capital enabling schemes from surplus cash from now on. It therefore places even greater emphasis on our financial turnaround planning, in order to improve the Trust's trading position and enable reinvestment in Trust services as a result

Short-term challenge overview of local economy:

The short term challenges faced by the Dudley Health and Social Care economy are no exception to those faced by most, if not all such economies across the English NHS. Those being, the service, quality and financial challenges associated with the national, long term drive to achieve the NHS outcomes framework ambitions, within a reducing real terms resource.

NHS England, in its planning guidance "Everyone Counts – Planning for Patients", has set out a hugely ambitious agenda of improved outcomes across 5 domains. To achieve these outcomes, it has been clear that "transformational change" will be required to service models and pathways of care over the next few years if this is to be achieved set against a backdrop of an ageing population, increasing medical technology, rising public expectation and a national funding shortfall of an estimated £30 billion by 2021. This challenge has been nationally set out in the "Call to Action", which has encouraged local debate and planning to deliver more community based services, reduced reliance on general hospitals and reconfiguration of specialised, regional and sub-regional services.

Dudley, like most health economies, is a microcosm of that challenge. It sits in the Black Country, a largely post-industrial area in the urban West Midlands. The configuration of Black Country hospital services is dominated by small to medium sized district general hospitals. The nearest tertiary centre is in Birmingham, so the specialised services reconfiguration challenge faced here is significant. The

population profile of Dudley is marginally older than the other Black Country economies of Walsall, Wolverhampton and Sandwell. This brings with it its own challenges in terms of both community and hospital care for the older person. The Dudley health economy has also come under significant additional scrutiny of late due to the Keogh quality and safety review process initiated by concerns over historical mortality indicators. Some of the actions required as a result of this review process have put additional pressure on both Trust finances and health economy service response.

The short term challenges over the next two years for The Dudley Group are as follows:

Services:

- The tipping point of clinical and financial sustainability against a backdrop of increasing national and professional standards and tariff deflation has been reached for DGHs. The Dudley Group's services are no exception to this.
- To meet the challenge of different patterns of illness presentation and different expectations, The Dudley Group has made internal process improvements and efficiencies in recent years, most notably in acute medicine and emergency medicine. These changes have not guaranteed safe and effective delivery of urgent care as indicated by our ED 4 hour wait performance. To that end, a significant acceleration of process improvements is required internally, in line with recommendations from the Emergency Care Intensive Support Team (ECIST), to continue to prepare the organisation for this set of challenges.
- Dudley CCG's commissioning intentions signal major pathway change in elective care, urgent care and services for older people. In urgent care, this is manifesting itself in a significant redesign of the urgent care model in Dudley, including the commissioning of an integrated urgent care centre on the Russells Hall Hospital site. In elective care, planning has begun between the CCG and the Trust with respect to a significant shift of routine follow-up activity to primary and community care settings. This is to be complimented by the active patient management approach of assertive pre-investigation, written and telephone advice to reduce hospital based outpatient activity demand. In older people's services, heavy planning and organisation development emphasis is being placed on the development of both integrated health and social care teams and a community-wide rapid response service, with the expressed aim of reducing emergency admissions by 15% by April 2015 (The Better Care Fund challenge).
- There is an explicit national drive to further centralise specialist regional and sub-regional services to achieve better clinical outcomes, provide more resilient out of hours care standards and also potentially release financial efficiencies. DGFT has worked hard in recent years to demonstrate its infrastructure as being capable of safely delivering acute services of a specialist nature and continually improving performance against outcome measures and clinical standards as a result. Given the financial impact of delivering against increasingly exacting national standards for services such as Hyper-acute stroke, Renal Medicine and Vascular Surgery, DGFT now faces a significant imbalance between income and expenditure on these services. The Board of Directors will be considering the future of these services as part of our overall portfolio, within the 5 year strategic plan process.

Finances:

- Moving into 2014/15 DGFT is currently operating in monthly deficit. The financial effect of improving nursing staffing establishments following the Keogh review process, NHSLA premium rises, PFI unitary payment inflation and pay inflation have added significantly to our cost base. In terms of income, tariff deflation, contractual penalties and a relatively smaller percentage of CCG transitional funding compared to our local providers, have added to this imbalance.
- Our reference costs position is already relatively strong (RCI Index 98). There is therefore potentially less latitude for operating efficiencies than in some similar organisations.
- The high level financial gap between contracted revenue and expenditure for 2014/15 has been quantified at £21 million. The total financial gap for the two years of this operational plan is £31 million. These sums have been reduced by the securing of Transitional funds from commissioners and budget paring to £16.9m in 2014/15.
- During 2015/16, in line with national expectations, Dudley CCG's financial settlement reduces significantly also, leaving both commissioner and provider with significant challenges to jointly manage.
- Because of the Trust's deteriorating liquidity position, our capital investment plans are modest and business case scrutiny of return on investment for any significant proposed capital developments will necessarily increase in this planning cycle.

Workforce

- In line with the national reduction in doctors in training and also due to the increasing lack of service exposure for those doctors, DGFT needs to be both cognisant of the effect this will have on its service delivery over the next two years and also of the 5 year investment plan in consultant delivered services this will necessitate. A far broader perspective on new types of clinical roles will also need to be taken, particularly in emergency medicine, for example, where advanced nurse practitioner roles and primary care medical roles will need to be deployed in assessment, triage and non-urgent clinical cases.
- NHS England's medical director, Sir Bruce Keogh, has set out the national challenge to improve health outcomes and reduce mortality by meeting 24/7 demand with 24/7 supply. National tariff will be adjusted to meet this challenge however it is not likely to cover the costs in its entirety. Whilst DGFT has advanced its approach to consultant led services in emergency and acute medicine, for example, a robust gap analysis between the 10 new national standards for 24/7 services and a clear improvement plan, agreed with our commissioners, will be required.
- Following the Francis Report into Mid-Staffordshire FT and following the Keogh Quality review process in our own organisation, the Board of Directors has focused on the issue of nurse to patient ratios on our inpatient wards. Whilst the organisation made a planned incremental investment in nursing establishments between 2011 and 2013 as part of the delivery of our quality strategy, the emerging national guidance about nurse to patient ratios requires a significant further investment of £3.1 million over baseline budgeted establishments should be Board choose to adopt this approach.

A detailed establishment plan has been completed which details nursing for inpatient wards using the RCN ratio of one trained nurse to eight patients as a minimum. This has been costed and equates to £3.1million investment above current nursing establishment. The AUKUH Safer Nursing Care Tool has been repeated 6 months following the initial baseline assessment which looks at historical dependency over a 20 day period excluding weekends. This has been supplemented by the professional judgement peer assessed process based on the RCN's 1:8 ratio.

The overall financial impact as a result of this investment will be a significant expenditure reduction from the current run rate on bank and agency nursing staff in 2013/14.

The associated challenge with this approach will then be recruitment to substantive posts created, to both reduce the clinical and financial risks associated with the employment of supplementary Bank & Agency staff. This will be difficult given the national and regional context of reducing university nursing graduates as a recruitment pool. The recruitment landscape will be competitive. Planned over recruitment will be required in certain parts of the Trust.

- As commissioning intentions change service shape and scope, then any provider Trust should examine what changes need to be made to consultant job plans to meet that new service configuration. Detailed capacity planning has been carried out during this year's planning round to ensure that consultant job plans prospectively meet both elective and non-elective service need.

Quality & Safety

- In light of both the agreement of our clinical strategy, the Keogh review process at DGFT and the CQC inspection in March 2014, we are preparing to review and re-launch our quality strategy. That strategy will be ready for inclusion in the strategic plan submission on 30/6. Our extant quality strategy will continue to guide our approach to both measurement and management of quality and safety improvements in the Trust, including our quality account and discussions with the CCG about CQUIN schemes for the next two years. The major quality and safety challenges in the Trust are as follows:
 - Post Keogh review nurse establishment investment - £3.1 million further investment required in the financial plan and a major recruitment challenge
 - Continuing the improvements to the urgent care pathway and patient flow within the organisation, so as to maintain safe and effective emergency care for all our patients
 - Further develop systems of mortality review and scrutiny and embed these locally in Divisional governance systems
 - An unrelenting focus on practical action to continue to reduce control of infection risk, pressure ulcer risks and risk associated with patient falls
 - The Trust has just agreed its patient experience strategy and now needs to drive this forward
 - Quality governance capacity and systems need further investment and development both at a corporate and divisional level

- Developing our business and clinical case for the establishment of a fully integrated electronic health record

Responding to the National Guidance on 7 Day Working

The “NHS Services, 7 days per week” forum, led by the NHS England Medical Director, has reported on how NHS services can be improved to be more responsive and patient centred. The initial focus of the report and the emergent national guidance is with regard to urgent, emergency and diagnostic services. There are 10 standards to which all health economies must adhere to be 2016/17. The Trust is now engaged in undertaking a gap analysis against these standards and will share our initial stage plans with our commissioners by the end of Q1 in 2014/15.

Our high level self-assessment against these standards is as follows:

- **Standard 1 – patient and carer involvement and shared decision making**

Not being properly informed about their illness and the options for treatment/management is the most common cause of patient dissatisfaction that is why we are developing our patient feedback mechanisms, including complaints so that we can better listen to our patients and understand how they feel we could better communicate with them. Secondly, we maintain and continue to develop tools which support shared decision making. For example, all Trust patient information leaflets are published on the Hub, (intranet), so are available for use seven days a week. The production of patient information leaflets includes patient involvement to ensure that the information presented is understandable. Information is available in alternative formats on request.

All patient feedback is dated so would permit comparison from weekday to weekend.

Future plans

The Trust will be undertaking an audit of its patient information to identify any gaps and improvements.

Feedback comparisons for weekend/weekday are not currently displayed – this will be added to the patient experience action plan.

- **Standard 2 – All emergencies assessed by consultant within 14 hours**

As a result of the significant investment the Trust has made in the last two years into acute medicine, there is now 18/7 consultant cover in our acute medical unit, which is ahead of the position attained by many DGHs of a similar size. In acute surgery, the standard is met the majority of the day and a major service improvement project in the surgery assessment unit has now begun to meet this standard fully within 2014/15. In 2012, a Paediatric Assessment Unit model was established and this will be further developed and extended in 2014/15 to ensure this standard is met for paediatric admissions.

- **Standard 3 – all emergency inpatients must be assessed for complex or on-going needs within 14 hours by multi-professional team**

There is a Social Care Emergency Response team which works 7 days a week, covering 0800 – 2200, based at the front door, and covering non-elective admissions. There is a Therapy Impact team working 0800 – 1800 7 days a week. A Discharge Co-ordinator works 0800 – 1600 across 7 days a week, as does Red Cross support.

We do not currently comply with producing an integrated management plan, with completed medicines reconciliation within 24 hours. The work to develop this will be scoped out in quarter 1 of 2014/15, in line with the SDIP (Service Development and Improvement Plan) agreed with the CCG as part of the contract.

- **Standard 4 – handovers by competent senior decision maker**

The Trust has worked hard to steer a new, hospital-wide handover process through our Hospital 24/7 project. Led by consultants in the post-take phase during the morning and by SpR level doctors at night, continuity of care has improved, together with more clarity on care planning for the acutely unwell patient. The Hospital 24/7 group will now steer the changes required to meet all of the 7/7 standards set out by NHS England

- **Standard 5 – 7 day access to diagnostics**

The development of a non-elective imaging hub at our main acute hospital site together with a 3rd CT scanner and 3rd MRI scanner, are central to our operational plan submission. Through the non-elective imaging hub, we will deliver unfettered access to CT and MRI for the acutely unwell and all in-patients with associated staffing and reporting capability. Elective and direct access patients will be managed separately, to protect the main modalities used for acute and urgent care. We anticipate this development coming to fruition in 2015/16 and 2016/17, having received the business cases for these developments in Q1 2014/15.

We are almost fully compliant in all but 2 key areas already. The 2 areas relate to the MRI & Interventional Radiology, and we are in advanced discussions to have both in place. We have agreed a 7/7 service provision that will put a Radiologist on site and that we will introduce 7 day MRI and Interventional Radiology. At present we deliver a 6 day presence as a matter of course.

We currently already provide the CT to the 1 & 12 hour standards but should be fully compliant with the 24 hour standard specification once the 3rd CT Scanner is in place and resourced.

- **Standard 6 – Hospital in-patients must have timely 24 hour access, 7 days a week to consultant directed interventions that meet the relevant specialty guidelines either on-site or through formally agreed networked arrangements**

Critical Care and Emergency General Surgery Vascular Surgery and Trauma & Orthopaedic, General Acute Medicine and Emergency Department already have 24 hour consultant access.

As described in Standard 5 we have 24 hour access to imaging, there are plans in place to expand on this.

- **Standard 7 – Mental Health Assessments**

The Trust has worked hard with its commissioners and local mental health Trust to develop a comprehensive psychiatric liaison service, including medical cover. Since February 2014 the coverage of this service now extends to 24/7. In addition, our Medical Directorate have been developing a strong older people's mental health/dementia liaison service internally, which we aim to develop further in the time period of this 2 year plan, in a similar vein to the RAID model deployed by the Birmingham acute hospitals.

- **Standard 8 – twice daily ward rounds in critical care and emergency assessment units**

This standard is consistently delivered in our ITU, HDU and acute medical unit areas. A major service improvement project has been launched in the surgery division which will deliver this standard for surgical admissions by 2015/16, whilst also contributing to their length of stay reduction plan, central to the Trust's inpatient capacity plan and drive for elective activity improvement over the next two years.

- **Standard 9 – support and community/primary services available 7 days per week**

Detailed planning is underway with the CCG and the co-terminus local authority with regard to the integration agenda and Better Care Fund arrangements. Central to the plan, which must be deployed early in 2014/15 so the admission avoidance benefits can be felt immediately, is the consolidation of 14 district nursing teams to 5 locality teams, each of which will be integrated with both primary and social care. The resultant care model will therefore be more resilient in service terms and provide the resource latitude to enable the development of a community and social care response, over 7 days. The Rapid Response nursing team, which is being explicitly developed as part of the Better Care Fund arrangements, is the focus of this model of care for the acutely unwell older person, who may have been admitted to hospital in the past. Other key services including:

- CRRT
- Care Home Nurse Practitioners
- Virtual Ward Case Managers
- Care Support Workers
- GP Clinical Leadership, the CCG is doing further work on this we assume that this will be the equivalent of 5 GPSIs

The CCG investment in this new care model will be in excess of £1 million in 2014/15.

For social care, the community re-ablement and residential re-ablement services are 7 days but the other elements of the social care service offer do not provide this resilience. The model will develop during the on-going Better Care Fund discussions and be signed off by Q1 2014/15. The

same principles will be applied to community mental health services.

- **Standard 10 – all those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement**

Mortality Review Process:

The Mortality Tracking System (MTS) was developed by our Information Team and launched in January 2012. Since then the Trust has worked to achieve three primary objectives:

- To ensure that every death within hospital is reviewed by the team responsible for the care of the patient.
- To learn and share experiences with colleagues across the trust to continuously improve the quality of care we provide.
- That the Medical Director, as professional lead, has oversight of the process of reviewing deaths and is therefore able to give assurance to the board, regulators, commissioners and patients.

The MTS records every death, clinical coding and consultant validation of coding.

Every death is audited in a regular multidisciplinary meeting for each speciality. An audit tool within the tracking system is completed during that meeting which may trigger a Mortality Panel Review.

The Mortality Review Panel is a monthly panel chaired by the Deputy Medical Director. Its membership includes consultants, matrons, and the Clinical Coding Manager. GPs are invited from NHS Dudley CCG and attend panels when available. The panel reviews the case notes and will request additional information from the consultant responsible and identify actions when necessary.

National Audit:

The work of the audit department ensures the Trust complies with the Care Quality Commission (CQC) Regulations, outcomes and judgement framework in relation to clinical audit as well as compliance with the participation in the National Clinical Audit and Patient Outcomes Programme (NCAPOP). The Trust also participates in a large number of national audit projects.

The Trust aims to participate in 100% of national clinical audits and 100% of national confidential enquiries of which it is eligible to participate in.

Responding to the Better Care Fund

Our response to the Better Care Fund principles will be on two levels:

1. The delivery of a rapid response nursing team across the borough, which will work closely with primary care to ensure that many of the current admissions of older people to hospital, particularly those who arrive by ambulance following GP referral or direct to the ED, are managed in their initial phase of illness, in the community. Running parallel to this initiative will be the consolidation of our district nursing teams into 5 localities, co-terminus with the CCG's primary care localities and local authority team localities. There will be a great deal of organisational development work done within those teams in 2014/15, to ensure their integration and to deliver the outcome of improved care planning for the older person and for those with long term conditions.
2. The acute general hospital site, Russell's Hall, will reconfigure its bed base significantly to respond to the nationally intended consequent reduction of emergency admissions by 15%. The Trust has already:
 - Undertaken an HRG analysis to understand which specialities would be affected by the admissions reduction
 - Understood the CCG's view that the full year effect financial deduction will be £6 million in 2015/16, which equates to 75 beds (circa 2 inpatient wards)
 - Modelled the effect of this operationally and financially across 3 scenarios (base case, upside and downside)
 - Calculated the full year effect bed reduction as a result of admissions avoidance for the base case scenario to be only 36, as a result of certain patients in the historical analysis by the CCG being unlikely to be managed in community setting (i.e. Multiple pathology, critical care patients etc)

- Begun operational and workforce planning to agree which medical beds will undertake planned closure and how the displaced workforce can be deployed either into vacancies elsewhere, as part of planned nursing establishment improvements or into planned increased elective surgical or orthopaedic bed capacity improvements (please refer to operational capacity section)

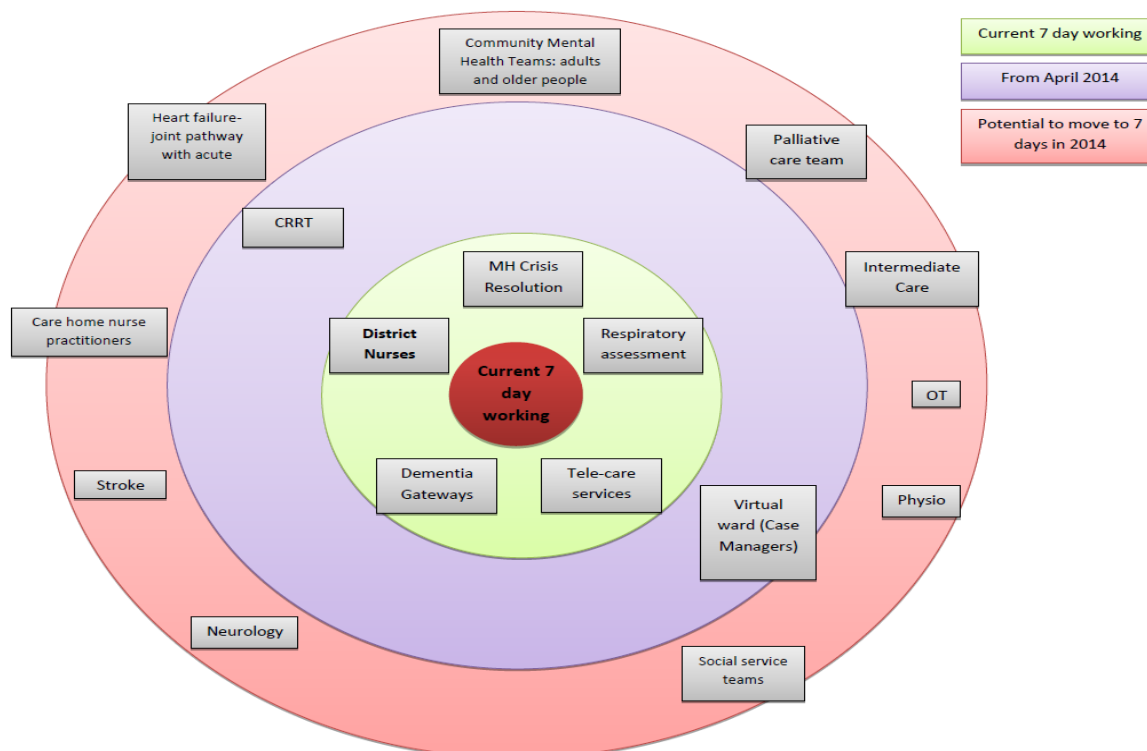
The project structure & proposed timetable for the implementation of BCF:

- Report to Health & Wellbeing Board 28th March 2014
- Better care fund submission 4th April 2014
- 15 DN teams + 1 out of hours team merging with 8 virtual ward teams to provide 5 locality nursing community teams
- Management of change underway to start as soon as possible after 1st April using the existing Single Point Access, (SPA), for referral entry and triage
- LA going through a similar process but will not be ready until September – also using existing SPA for referrals
- Mental Health is on a smaller scale and already have practice based workers

The project plan will include detail on co-location in the long term aligned with the IT to provide mobile solutions.

The BCF has a 2 year implementation but understandably the CCG want to realise significant savings in year one; much of this is pinned on the CRRT which should be 7 standard days in May and 7 extended days in June dependant on successful completion of the recruitment process.

7 day mapping



The three scenarios currently being planned for are as follows:

1. **Base case scenario.** This will assume that 36 medical speciality beds will close as a result of the BCF changes, by 1/4/15. The net reduction in expenditure accounted for in the base case scenario and current Heads of Terms agreed with Dudley CCG significantly exceeds that which we feel can be released through admissions avoidance. Further bed efficiencies will be made as a result of planned service improvement work on length of stay in medical specialities, however the effect of this is likely to be 50% (22 beds) less than those expected in the down side scenario as a result of a necessarily

richer case mix the hospital will be managing net of the admission avoidance effect. The final element of the plan is to create an elective medical unit (EMU), which will deliver a further 10 bed efficiency in medical inpatients beds by eradicating the use of overnight stays for elective medical admissions.

Total bed efficiencies therefore as follows:

BCF admissions avoidance (36) + EMU (10) + Risk adjusted length of stay reductions (22) = 68 beds

The 68 bed efficiency will therefore be deployed for two distinct purposes:

- Winter surge plan physical capacity (48 beds), although the staffing cost for this should it be required would inevitably be at premium rates and is not included in the base case scenario.
- Repatriated and “catch up” elective to guarantee RTT performance in all key specialities, through c20 beds of £5 million gross value with targeted surplus margin of 30% (£1.6 million).

2. Upside scenario. This assumes that a number of the medical beds closed through BCF admissions avoidance and internal length of stay efficiencies, will be utilised as described above, but with an elective increase and repatriation target of £7.5 million generating a net surplus of £2.4 million. Whilst the total demand for elective work has risen significantly in recent years, our market share, particularly in orthopaedics, has reduced significantly from 80% to 60%.

3. Down side scenario. This assumes that the majority or none of the anticipated admission reduction from the BCF changes occurs. The Trust would then be faced with then operational challenge of managing an incremental growth in surgical and medical emergency admissions, together with needing to create capacity for managing elective activity repatriation.

Additionally, a further financial risk is created because the CCG may see the source of finance for continuing to pay for emergency admissions levels which haven't been reduced, being the £4 million transitional support agreed in the 2014/15 Contract. In this scenario, planned capacity gains through the service improvement work stream on length of stay will need to be delivered in medical specialities, inclusive of the EMU development. This efficiency totals 38 beds. In this scenario, 38 beds of released capacity is available to drive through elective catch up and repatriation of £5m revenue. However very little winter surge capacity (only 18 beds approximately) will then be available.

A key mitigation to this has to be created, through the development of transitional care bed capacity (20 additional beds, 40 beds in total) in local nursing homes. This mitigation is currently being discussed with Dudley CCG as part of a potential 2014/15 contract settlement (SDIP).

BCF Downside Impact: Additional ward costs 2014/15. Q3. £0.7m & Q4. £0.7m 2015/16 Ward Costs £2.7m

End of Life Care

The Trust is part of the national initiative to transform the end of life care. It aims to deliver:

- New and improved clinical pathways for long term conditions with regards to end of life care.
- Improved measures to assess quality of care.
- Improved education programme and engagement within the settings.
- Reduce inappropriate admission and length of stay.
- Increase preferred place of care achieved for patients and carers.

The CCG and MacMillan are supporting the project, with £450,000 over 2 years to pump prime the project, including additional consultant in Palliative Care sessions. This will also help to support the objectives of the Better Care Fund.

Programme Fusion

The decision was taken by the Board of Directors that the service improvement/PMO and IT agendas would be overseen together in a single full committee of the Board (Service Improvement Committee) so

that the service improvement and financial efficiency agenda of the Trust will be fully enabled by the IT developments.

The Board of Directors approved the Outline Business Case for Programme Fusion and approval to proceed with the implementation of "Plan B", a read-only clinical repository that will provide a tablet-based (I PAD or similar or smart phone) integrated view of the data imported into the repository.

It is proposed to use the same mobile platform for both Plan B and the Electronic Health Record System (EHR). This will allow a consistent user interface across both applications and facilitate the transition between one system and the other. It will also facilitate early use of devices and smartphones that staff already has.

The Full Business case (FBC) in which the full detail of the benefits, return on investment and affordability will be addressed will be taken to the Board in May 2014. Further detail of the capital implications of Programme Fusion are set out in the capital section of this plan.

Operational Requirements and Capacity

An assessment of the inputs needed e.g. physical capacity, workforce and beds over the next 2 years:

Outpatient and elective capacity

The Trust has utilised a model to link the job plans of both consultants and other healthcare staff (nurses, midwives and allied healthcare professionals) to the available number of sessions that can be run during the year. The model factors in different operational working practises which will influence staff availability for example consultant of the week arrangements to cover emergency activity or to cover particular wards or departments.

For outpatients each clinic has a template specified by clinical staff, this together with the number of working weeks primarily determines the capacity. The outputs from the model for each specialty were shared with directorates and the outputs compared with the proposed contracted activity levels with commissioners. By undertaking this check it was possible to identify specialties that had spare capacity as well as those that would have to run additional sessions in order to meet the contract. That spare capacity is to be handled by either reducing programmed activities in consultant job plans or is central to the Trust's elective activity element of the CIP, by ensuring marginal costs only are incurred to drive through the targeted £5 million of extra elective work.

In certain specialties it may not be possible to attract more patients so this capacity could be exploited in different ways such as reducing waiting times and the need to run waiting list initiative sessions at premium rates; redirecting clinical time to other clinical services within the same specialty e.g. ward rounds, theatres or to reduce discretionary consultant PAs.

The outpatient capacity modelling suggests that the Trust theoretically has a clinic capacity 23% higher than the number of patients seen or didn't attend. If the gap is narrowed and more clinics were run then potentially an additional £3.8m of income could be generated. As an alternative, the details of a reduction in programmed activities for consultants in these specialties will be worked up as part of ongoing CIP deliberations. The breakdown by directorate is:-

Directorate	Spare Capacity	Utilisation Rate	Opportunity
Ambulatory Medicine	10,663	80%	£951k
Specialist Medicine	7,038	87%	£812k
T&O, Plastics	4,536	91%	£323k
Surgery & Anaesthetics	4,009	94%	£310k
Women & Children	16,614	70%	£1,391k
Total	59,757	81%	£3,787k

The same approach was used for theatres using the average number of patients operated on as the estimate of the capacity of the theatre session. This was undertaken at an individual consultant level. The operational practise of specialties to consistently re-utilise sessions when consultants are absent due to annual leave or other operational requirements, (emergency activity), ensures that theatres and theatre staff are not wasted (current elective theatre in session utilisation is measured at 86-89%). The Trust continues to run some waiting list initiative sessions in order to maintain RTT times and/or contract activity levels, some of the specialties have planned as part of their CIP to reduce the use of such lists and make better use of sessions in core time, but the effect of this is marginal compared to the potential we see in the outpatient analysis.

In order to deliver the income assumptions we make in our financial plan (both base case and downside scenarios) the following capacity requirements have been calculated (full year effect):

- Circa 20 additional surgical and orthopaedic beds
- 13 additional theatre sessions per week

The bed base required will be delivered through medical specialities hitting their upper quartile length of stay opportunities. This will be driven through our renewed service improvement programme and PMO approach for our financial plan. The theatre space required is significant and whilst a plan is being developed which would aim for all of this to be delivered through improved theatre utilisation and three session days, there is inherent risk in this. As a result, the development of the capital business case for the Hybrid Theatre, itself a key component of our strategic future as a vascular surgery hub, will be brought forward to be scrutinised by the Trust's Investment Panel, in April 2014.

Workforce

Over the last 2 months each directorate has met and worked with their Human Resource Manager to review and develop a manpower plan by ward and department level. The information used to generate the documents was taken from several areas:

- Statistics from ESR have been reviewed for department FTE, role split by FTE, staff group by FTE, age group by FTE, latest hire date, gender split, full and less than full time.
- The finance team have supplied information from the ledger on budgeted establishment and staff in post.
- Line manager local knowledge from conversation with staff at appraisal.

The teams have then looked at four key areas in detail:

1. Positions and skills
2. Goals and objectives
3. Retention and training
4. Stakeholder influence

Position and skills

With a national shortage of key roles, the Trust has needed to seek alternative ways of filling posts to meet clinically safe staffing levels. This has included overseas recruitment of qualified nurses and emergency medicine doctors. This is proving successful with nurses being recruited from Spain and Portugal, and good levels of emergency medicine doctors being recruited from India. We will continue to pursue this recruitment strategy for the foreseeable future.

Other recruitment strategies have included running novice programmes for Clinical Support Workers, this has proved successful with many member of staff developing a career in nursing, by taking the conversion programme and then training to become a qualified nurse. We have also been running programmes for nurses who have come from nursing homes and need to upgrade their skills to be able to work in an acute hospital.

Physicians Associates and Advanced Nurse Practitioners are also roles that we will be growing in the coming years to help the Trust develop alternative ways of caring for our patients, and still deliver high standards of care within our cost envelope.

The Trust has a growing apprentice programme with 36 now on the programme, and they are a mixture of young apprentices (under 18) and over 18 years old, coming from college and existing members of staff. They are all working in Business Administration; however, we are planning to increase this number by developing a clinical apprentice scheme.

Work is being done in the Trust to modernise our information technology, and when this is completed we will

be entering a management of change programme to reduce the number of administrative staff to meet the new system processes. The numbers involved are being played into the emerging full business case for the electronic health record (EHR). The Board will review this business case in Q1 2014/15.

Goals and Objectives

7 day working will be a major negotiation and implementation plan for the Trust. Whilst we are already a 24/7 organisation, this will require all staff groups to work differently and potentially additional resources will be needed to provide safe care to patients. The scale of this investment will be determined by the Hospital 24/7 Steering Group, during Q1 2014/15, as agreed with the CCG as part of the SDIP.

Integration of the Trusts current management of community services offer into the main Trust management structure and the seamless integration of the patient pathway between the acute setting and care closer to home will require a management of change process to implement the most efficient and cost effective structure. This issue is being managed through the organisational restructuring process, which will be in place by June 2014.

Retention and training

To implement the changes that will be required we will need to ensure that our workforce is engaged and on board with the development plans. As an organisation we have built on the foundations of turnover; sickness absence; training and appraisals to promote well-being within the workforce. All our Quality Assurance visits from the medical schools have been positive and we continue to be a successful teaching hospital. A new Clinical Skills Laboratory is opening in April 2014 which will further enhance our Teaching Academy and multi-disciplinary teaching and way of learning. Clinical skills training is offered to both Doctors and Nurses, by our clinical skills team and this will continue as part of our education programme.

We recognise the need to nurture our leaders to promote change. Leadership training is an area which we have focused on over the last 2 years. We have run an extensive leadership development programme for our senior and developing clinical leaders. This has identified talent for the future which we will be developing over the coming years. We also run an internal leadership course which is open to any member of staff in a leadership role, or who wishes to develop a career in leadership. This will continue to run over the coming years and further work to link this to talent management is about to be launched.

Stakeholder Influence

Two of the most influential groups are the patients and the CCG. Feedback from both these groups has been widely used when thinking about how we take our services forward and the impact this has on our workforce.

We continue to work closely with the Colleges in developing medical roles and the Trust plays a big part in the Local Education and Training Council, working on joint projects to develop our staff and therefore improve patient care. For example, we are exploring the potential for introducing new ways of skilling the current sonographer's workforce.

We work with the voluntary sector to support patient care both in the acute and community settings when people are discharged home. Our volunteers are an integral part of the Trust and we provide training for this group to support them to be able to help people.

Risks to delivery of key plans:

1. Nurse recruitment and establishment improvement

During the Keogh Review concerns were expressed about the ratio of nurses to patients on some of the wards

Risk Mitigation and Action

The Trust carried out an assessment using the UK University Hospitals, (AUKUH), Safer Nursing dependency tool.

Staffing levels have been reviewed in line with the RCN recommendations of 1:8

An international recruitment drive has taken place

Nurse to patient ratios against the RCN recommendations are published on each ward

The use of rostering software, Allocate, which provides an audit trail of staffing rotas.

The Trust's downside modelling assumes that despite recruiting to new substantive posts spending on bank and agency staff continues at £225k per quarter for the 2 years period

Downside case impact: £225k (20 wte) per Quarter for the 2 years plan

2. Inpatient bed capacity plan and the impact of the BCF

The Trust is working through the consequences of the planned 15% reduction in emergency admissions as a consequence of the BCF.

There are concerns that the actions will not reduce the activity presenting at the Trust and that the length of stay gains may also not be met, so as detailed in the section above and in the section on operational capacity, the trust is developing both a base case and downside case response.

There is an additional risk around the theatre capacity required to drive through the elective income plan.

Risk Mitigation and Action

The Trust already commissions 20 transition beds within nursing care homes to support earlier discharge from hospital. The CCG has agreed to continue to pay for these beds for quarter 1 of 2014/15 whilst a review is undertaken on the provision of up to 40 “discharge to assess” beds, to be funded from the BCF. If agreed, this would then provide bed capacity to fully mitigate the downside case of our inpatient capacity plan, thereby enabling both an increase in elective activity and profitability, together with winter surge contingency capacity.

It is also planning on the assumption of improved benchmarking performance, to give a reduction in length of stay in medical specialities.

The Trust plans to increase capacity for elective activity to match planned contract activity, in core capacity, rather than premium initiatives, and then to repatriate Dudley CCG elective activity that is currently being provided elsewhere.

The theatre capacity risk is planned to be addressed through a combination of three session working, additional weekend sessions and the potential of a hybrid theatre, allied to our status as a vascular surgery hub.

3. Urgent Care Centre (UCC) development and care model

The CCG at the end of last year went out to consultation on a proposal for the development of a single point of access and triage function for Dudley, incorporating ED and the Walk-in Centre, which would:

- Reduce primary care demand on the Emergency Department
- Re-design ‘front end’ hospital services; offering a clinically sound, financially efficient emergency service
- Further develop an Ambulatory Emergency Care service as recommended by the ECIST report.

The proposed timetable is for the fully integrated model to be functioning by 1st March 2015.

The CCG are still determining the tender process they intend to pursue and are developing the service specification with us. We are also in discussion with them about the possible novation of the current Dudley Walk In Centre contract to DGFT during Q1 2014/15. Based upon the conclusion of this, there is still a financial risk associated with the development, in particular the planned reduction in ED contract activity as a result.

Risk Mitigation and Action

The financial analysis will be undertaken in detail for both staffing, income and building elements of the planned service and considered by the Board of Directors in a business case associated with the development, which will be reviewed before the end of Q1 2014/15. Income risks intend to be mitigated through discussions with the CCG, so as to continue to provide safe and high quality ED services.

Downside case impact: £0.34m per Quarter from Q4 2014/15

4. Integration model and Community Rapid Response Team

Explicitly linked to the BCF agenda, the Trust is working closely with Dudley Council and with Dudley CCG to develop consolidated integrated health and social care teams in the borough. Currently, there are 14 community nursing teams which will be consolidated to 5 integrated health and social care teams thereby providing more service resilience. In addition, the Trust is responding to the CCG’s investment by recruiting to the Community Rapid Response Nursing Team, (CRRT), model. The combined effect of both these initiatives, together with closer working on older people’s care coordination with general practice, is intended to deliver the 15% reduction in emergency admissions the national planning guidance expects.

There is a risk that the true benefits of integrated working with other agencies are not delivered. There are also risks associated with clinical accountability for the patients that will be managed by the CRRT and may be difficulties in fully recruiting to this team with suitably qualified nursing staff.

Risk mitigation and action

The Trust plays an active role in the Integrated Care Working Group, which jointly manages the BCF implementation. Joint planning of this subtle but complex initiative will continue to be essential to not only ensure joint working protocols and approaches are agreed but also evaluation of the impact of the process is undertaken. Organisation Development work is also being sponsored by the CCG with the nascent teams to ensure joint working ethos is maximised, going forward. With regard to the CRRT development, discussions are underway with the CCG with regard to clarity on clinical accountability in the pathway.

5. Diagnostic demand growth

The Trust currently has 2 MRI scanners but to meet the demand and achieve diagnostic waiting times we routinely use a mobile scanning unit at a cost of £400,000 per annum. There is similar pressure on maintaining access for urgent care and waiting times for CT scanning, which is not showing any signs of reaching a plateau. The growth is in Direct Access, Out Patients and Emergency work, however the impact of the emergency tariff does not provide sufficient income to off-set the expenditure required.

Risk Mitigation and Action

The Trust has approved the progression to a full business case the development of a Community Diagnostic Centre for the 3rd MRI scanner. This looks at options which address not only the current capacity constraints of the existing scanners, but the location of the scanner away from the acute site, to be more accessible for patients within the south of the borough, and to capitalise on the market need for reasonably priced private patient scans.

The business case will be reviewed by the Trust's Investment Panel in May 2014.

The capacity modelling for CT scanning shows that even if the year on year growth is capped and the running times of the existing 2 scanners are extended, there will be the requirement to expand up to 3 scanners, one to be located in the Urgent Care Hub, to support the access and turnaround requirements for non-elective cases. This could be a lease arrangement or the purchase of an additional scanner. The Directorate is to progress to full business case to take back to the Investment Panel by the end of April 2014.

6. Specialist Service developments i.e. Stroke, Renal, Vascular, Paediatrics

As an outcome of the NHS England "Call to Action" it is expected that the provision of specialist services will be reviewed and the Black Country's current configuration of sub-regional specialist services will need to change to allow the new standards expected of these services, to be achieved.

The Trust will complete strategic service reviews within quarter 1 of 2014/15, with a target of agreeing the future strategic shape of the Trust in these key services. The outcome will feed into the 5 year strategic plan which will be submitted to Monitor on 30 June 2014.

Risk Mitigation and Action

Stroke:

Locally the CCGs across the Birmingham & Black Country are already reviewing the way they commission stroke services. The Trust has submitted the required templates and are awaiting the outcome of the assessment. We are also at an early stage of discussions with a neighbouring NHS Trust regarding collaborative working across the two organisations, potentially to develop a joint Hyper-Acute Stroke Unit (HASU).

Renal services:

Have been subject to an external review, do not meet current best practice standards and make a significant SLR loss. The Trust will set out its intended future for this service in its 5 year strategic plan submission to Monitor. As part of this 2 year plan, the development of a business case for the contracting out of renal dialysis services is expected and the resultant cost avoidance part of the Trust's financial plan.

Vascular Services:

The Black Country PCTs put Vascular Services out to tender for a 3 year contract, with a start date of 2012. The Trust was successful in becoming the Vascular Centre for the Black Country. There is lack of clarity about when the service will be re-tendered. The Trust has to assess the further investment required to meet the more stringent contract specification which will be influenced by the Vascular Society new standards. The Trust is currently considering a business case for a Hybrid Theatre which will be key to meeting those new standards. At present, the development would lead the vascular surgery service into a

loss making position financially and as such, the Trust will be clear about the future of its vascular surgery service as part of the 5 year strategic plan submission to Monitor.

Paediatrics:

There have been early discussions within Birmingham and the Black Country about the future provision of in-patient paediatric services. This could result in the reduction in the number of providers commissioned. Clarity about the Trust's strategic intent on this service will be made in the 5 year strategic plan submission.

7. 7/7 working

The impact of the Keogh, "NHS Services, 7 days per week", has been described in the previous section on the short term challenge.

The Medical Director and Director of Operations will be overseeing the implementation via the Hospital 24/7 Steering Group.

8. Financial Efficiency Plan

The Trust recognises the challenge that is faced nationally and locally in achieving a balanced financial position. The mitigating actions that are being taken are described in detail in the section on productivity, efficiency and CIPs. To summarise, the Trust has to find £30m over the next 2 years as a result of carried forward cost pressures, emerging cost pressures and contractual income/tariff changes.

Downside Case Impact: CIP Slippage : £0.1m Q3 & Q4 2014/15 & £2.436m in 2015/16

Rev Gen Schemes Slippage: £1m Q3 & £1m Q4 in 2014/15 and £4.144m In 2015/16.

9. Capital developments

To ensure that form follows function, estate development plans and capital developments must follow once service strategies and plans have been agreed. The Trust has already agreed a high level estate strategy. Central to that strategy was the redesign and reconfiguration of the emergency zone of Russell's Hall Hospital to meet changing service expectations and also to meet the activity demands of an integrated urgent care centre (UCC) on site. Risks to this programme include the potential un-viability of the capital business cases, PFI contract speed of contract variation and design response. Mitigations to these risks will be unique to each scheme and will be set out in each full business case the Board will consider.

National quality plans to meet the short-term challenge

National and local commissioning priorities:

The Department of Health published the NHS Outcomes Framework 2014/15.

It sets out the 5 key themes:

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protecting them from avoidable harm

From this Dudley CCG published Commissioning Intentions with key principles:

1. Every registered CCG member has a high quality experience of healthcare throughout their life
2. Services which support better autonomy, prevention and well-being will be integrated and privileged
3. Diagnosis and treatment is accessible and delivered efficiently, effectively and with compassion
4. Unplanned hospital admissions for people under the care of our services are treated as a system failure
5. Incentivise progressive behaviour, penalise deficit behaviour

The Trust is responding to these by:

- Developing reconfigured and more resilient community nursing teams, co-terminus with local authority and CCG locality boundaries, integrated with primary and social care, whose purpose is the improved management of long term conditions and admission avoidance
- Developing a Community Rapid Response Team (CRRT) to avoid admissions for the frail elderly within a defined range of conditions.

- Continuing to expand our approach to Ambulatory Emergency Care principles (AEC) in Surgery and Medicine, utilising the approach of “diagnose to admit”
- Under the sponsorship of a collaborative leadership team between CCG and Trust, developing redesigned elective care pathways to address the explicit commissioning intention of “active patient management”

Trust quality goals as defined by the quality strategy and quality account:

The Trust has overarching **strategic objectives for quality** of:

- To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.
- To provide the best possible patient experience

Described in the Trust’s Quality Strategy underpinning the strategic objectives there are a number of **principle outcomes**, which are:

- To deliver effective clinical care to all patients.
- To maintain and improve patient safety
- To ensure that the patient receives a good standard of care from his/her perspective through excellent customer service every time to everyone.
- To work in partnership with commissioners and comply with agreed quality standards

There are a number of key aims and initiatives at the Trust to produce the above outcomes. These commitments are:

Patient Surveys/Perspective

The Trust will ensure robust methods for collecting real time patient views, monitoring improvements to services as a result of patient feedback and ensuring overall patient involvement. The Trust will comply with all National Patient surveys and ensure lessons are learnt from results. All directorates and managers will develop and implement action plans and investigate where necessary to improve patient’s experience in their areas. All staff will adhere to Trust policies and guidelines for patient experience and customer care.

Same Sex Accommodation

The Trust will ensure that it complies with national requirements on this issue and will monitor its position through patient surveys. When breaches with the rules do occur, these will be recorded and collated on a monthly basis.

NICE

All NICE guidance will be assessed for its relevance to the organisation, complied with where appropriate and its compliance monitored and audited.

Clinical Guidelines and Nursing Indicators

All specialities will have appropriate explicit, accessible clinical guidelines in place for junior staff and nursing staff will have appropriate, explicit standards (nursing indicators) in place.

Clinical Audit and Monitoring of Standards

All specialties and professional groups will have audit and monitoring systems in place to ensure that both national and local guidelines are being audited and monitored. When results indicate that deficiencies in practice are occurring, plans to rectify the situation are drawn up, implemented and re-audit will occur.

Risk Assessment and Incident/Complaint and Claim Management

The Trust and all specialities has proactive systems in place to assess and manage risk and hold active risk registers in order to reduce incidents (including externally reportable Serious Incidents and ‘Never Events’), complaints and claims occurring. All incidents, patient complaints and claims that do occur will be investigated and lessons learned to try and prevent re-occurrence.

Listening into Action (LiA)

The Trust will continue to deliver the Listening into Action (LiA) programme which is a systematic approach to widespread engagement which empowers staff and leaders around any change or challenge to improve services and patient care.

Assessing and reviewing Mortality

The Trust will have systems in place to locally review all deaths that occur at the Trust and partake in the review using the new nationally agreed indicator - Summary Hospital-level Mortality Indicator (SHMI).

Care Quality Commission (CQC)

The Trust will have clear monitoring and compliance systems in place for the CQC registration standards.

National Health Service Litigation Authority (NHSLA)

The Trust will comply with the NHSLA standards at Level 1.

NHS Outcome Framework

The Trust will consider the above and agree a way forward in terms of the Trust's responsibilities.

External Reviews

The Trust will co-operate with all relevant outside bodies undertaking reviews and put in place any necessary improvement requirements from the variety of external reviews that occur.

Commissioning for Quality and Innovation (CQUIN)

The Trust will monitor and achieve both national and locally agreed CQUIN targets.

Quality elements of contracts with Commissioners

The Trust will monitor and achieve any quality targets as required by commissioners.

Quality Account

The Trust will produce a quality account annually in which there will be clearly defined priority targets for the forthcoming year and the results of the level of achievement of the targets set the previous year.

There is no one way of measuring quality but to achieve the above outcomes the following indicators are being used. For the Quality Account, key quality goals have been agreed. In addition, the Trust has a number of further key quality indicators that come both from national requirements and from discussion and agreement locally.

The indicators can be grouped into a number of sub-sets. These are:

Key Quality Goals

1. Quality Account Key Quality Goals

Commissioning Requirements

2. Commissioning for Quality and Innovation (CQUIN) Targets
3. Operational Standards (Nationally Set)
4. National Quality Requirements
5. Never Events
6. Local Quality Requirements

Internal and National Requirements

1. Nursing indicators
2. CQC Registration
3. NHSLA Standards
4. Other relevant National Guidance impinging on quality

Quality Account Key Quality Goals

Every Trust has to produce a public Quality Account, a report that gives an overview of the quality of its services. The content of this report is stipulated in part and contains some of the indicators listed above, however, each year the Trust needs to agree with its patients and other stakeholders a number of key quality goals. At The Dudley Group, the key quality goals are monitored quarterly at the Clinical Quality, Safety and Patient Experience Committee.

Local Quality Requirements

There are a number of nationally and locally agreed quality requirements that are given the five headings below:

1. Commissioning for Quality and Innovation (CQUIN) Targets
2. Operational Standards (Nationally set)
3. National Quality Requirements
4. Never Events
5. Local Quality Requirements

These are monitored monthly at the Clinical Quality Review Meeting (CQRM) held with Dudley CCG. The

Finance and Performance Committee reviews the Trust position on these indicators on a monthly basis.

For 2014/15 for our quality priorities, six topics have been identified. The exact targets have not been quantified, and will not be finalised until we know the end of year data for 2013/14. The detail will be included in the 5 year strategic plan which will be submitted by 30 June 2014.

The targets will be set on the following priority topics:

- Patient Experience
- Pressure Ulcers
- Infection Control
- Nutrition
- Hydration
- Mortality

These topics were agreed by the Board of Directors on the basis of their importance both from a local perspective, e.g. based on complaints, results of Nursing Indicators and a national perspective, e.g. reports from national bodies e.g. Age Concern, CQC findings etc.

These topics were endorsed by a Listening in Action event on the Quality Account, hosted by the Chief Executive and Director of Nursing, attended by staff, Governors, Foundation Trust members and others from the following organisations: Dudley LINK, Dudley PCT, Dudley MBC, Dudley Stroke Association and Dudley Action for Disabled People and Carers (ADC).

Patient experience is at the core of why the Trust exists, the reduction and maintenance of low infection rates are a key commissioner and patient requirement and there are national campaigns of zero tolerance to pressure ulcers and the need to focus on patients' nutrition and hydration.

This year, it has been decided to continue with the same topics, again because of their importance to both staff and patients. In addition, the recent Keogh review suggested that the Trust should include Mortality as a further priority and this has been agreed by the Governors and Board of Directors.

As well as gaining the Governors views on the priority topics, a questionnaire was devised that has been made available both at a Trust Open Day and on the Trust website. On the website, the questionnaire was made available to all members of the public and local statutory and voluntary bodies were informed that their views were also welcome using this process. The responses received generally endorsed the proposals.

Outline of existing quality concerns, CQC, Keogh etc, and plans to address them:

1. Emergency Pressures:

The Trust is currently failing to meet the 95% four hour target for Q4 and also failed in Q3. We are concerned that failure of this target is a marker for suboptimal patient experience and poses potential risk for quality of care and patient safety. Given our recent performance, Q1 performance is at risk.

Analysis of this significant performance challenge has shown that since October 2013 the Trust has seen an increase in the volume, acuity and age of patients presenting in the ED and into our Emergency Admissions (EAU) and Surgical Admissions Units. In addition to the pressure on admissions we have also seen delayed transfers of care for medically optimised patients with around 70-80 patients in this category. The net result of pressure at both ends of the hospital system has meant that at times bed capacity has been under pressure with patients waiting for prolonged periods in ED and EAU for beds to become available.

Risk Mitigation and Action:

To mitigate this risk the Trust commenced two key developments in November 13 with the opening of both an Emergency Ambulatory Care Unit (AEC) and a Frail Elderly Short Stay Unit (FESSU). Both these Units were developed following recommendations from the national Emergency Care Intensive Support Team (ECIST). The Trust continues to work actively with ECIST to tackle the capacity and flow challenges and has now started working with Monitor to assist further.

Winter Pressures monies have been used for a range of additional service enhancements to help assure patient safety and quality of care including 24/7 Psychiatric Assessment cover for ED, additional transitional care beds, additional Registrar cover to midnight in EAU when escalation trigger measures indicate that the front door will come under pressure and additional community services to facilitate discharges.

The Trust is negotiating the potential novation of the Walk In centre contract and activity to the Trust. This will bring performance benefits and be a pre-cursor to the roll out of the new urgent care centre model on site from April 2015.

2. Nurse Staffing Levels:

During the Keogh Review concerns were expressed about the ratio of nurses to patients on some wards. A recommendation was made to the Trust for the use of a recognised nursing staffing dependency tool such as the one devised by the Association of UK University Hospitals (AUKUH).

Risk Mitigation and Action:

Immediate action took place following the Keogh Report to review nurse staffing levels. The AUKUH Safer Nursing Tool was run and repeated in February 2014.

In parallel staffing levels have been reviewed against the RCN recommendations. Shortfalls against the recommended ratio have been covered by the use of bank and agency staff which has ensured optimal staff ratios but has led to unacceptable levels of expenditure. The national shortage of qualified nurses meant that a recruitment drive for qualified nurses which was run over the summer of 2013 had disappointing results. Therefore international recruitment was undertaken and 30 nurses from Portugal and Spain will join the Trust in April 2014. Further international recruitment is underway. We publish nurse to patient ratios on each ward to the public against the RCN 1:8 standard and achieve this.

3. Compliance with “NHS Services Seven Days Per Week”:

The Trust's progress to all of the 10 standards is indicated in the section above on the response to the short term challenges. Our plans to address any remaining gaps are set out in the SDIP agreed with the CCG as part of the contract for the next two years.

Risk Mitigation and Action:

As described the gap analysis is being completed, and the action plan will be monitored by the Trust's 24/7 Steering Group. There is an agreement within the SDIP of the contract to submit the plans to the CCG by the end of June 2014. An update of the position will be included in the 5-year strategic plan.

4. Infection control – especially C Difficile rates

Whilst the Trust has significantly reduced its numbers of confirmed C Difficile cases from 2012/13 levels, we will nevertheless miss the assigned target of 38 cases in 2013/14.

The Trust's C.Difficile objective for next year is 48 cases. This is 10 higher than the current 2013/14 year. There has been acknowledgement from the Department of Health that whilst NHS organisations have continued to deliver a year on year reduction in C.Difficile cases this has slowed over recent years. Experts have advised that the time has arrived when organisations may be approaching their irreducible minimum level of cases. The objectives have been modified based on each individual organisation's performance over the preceding year but is intended to reflect an achievable target. The Trust is committed to monitoring performance at upper quartile level, and against incidence rates

In order to learn from cases to continue to show improvement each organisation is being encouraged to assess each CDI case to establish whether there is a link with a lapse in the quality of care. This should help identify if cases are considered avoidable. The sanctions imposed on organisations failing to meet their targets can then, with agreement with commissioners, be modified in light of the above methodology. These avoidable/ unavoidable cases will be published on Trust website but are not nationally reported. The intention is to ensure relevant lessons are learned promptly and to provide a basis upon which we can target further improvement to increase patients' safety.

Using local benchmarking data it is clear that many Trusts have struggled with their target this last year and this is reflected in the objectives for 2014/15.

Risk mitigation and action

- Antimicrobial prescribing training and audit process

- New antibiotic prescribing guidelines are being introduced.
- Cleanliness audits and PFI performance management of cleaning via project agreement
- Saving lives audits
- Cohorting and isolation in the event of outbreak or periods of increased incidence
- Adherence to national standards for reporting confirmed cases

5. Keogh Mortality Review findings

The Trust has been in active discussion with Monitor about its action plan following the Keogh review team's findings in June 2013. The key themes identified by the review team included:

- Review of corporate and devolved quality governance arrangements to reduce complexity
- Better understand its mortality ratios and causes of changes to these
- Improve our capacity management and inpatient flow systems and processes
- Develop a coherent patient experience strategy
- Review and improve nurse establishment and skill mix using recognised, evidence based tool
- Improve staff engagement as measured through the national staff survey

Risk mitigation and action

The detailed mitigations and response to these findings and/or risks have been set out in our action plan following the risk summit. Much of these actions have already been carried out and the Trust and Monitor are measuring the effect of these actions through our quality dashboard.

An overview on how the Board derives assurance on the quality of its services and safeguarding patient safety:

The table below illustrates how the Board is using the Board Assurance Framework derives assurance against each of the Strategic Themes. It indicates which committee of the Board of Directors takes the lead for the review.

	Strategic Goals	Key Priorities	Monitor Forward Plan Strategy Ref	CQC	Lead Committee
Board Strategic Themes: Quality, Safety & Service Transformation, Reputation	SG01: To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation	a) Meeting and outperforming targets for HCAIs	Section C: Clinical & Quality Strategy	Outcome 8	F&P
		b) "Getting to zero" – promoting zero tolerance of harm events to patients		Outcome 16	CQSPE
		c) Ensuring we are fully compliant with all 16 CQC standards		ALL	CQSPE
		d) Deliberate focus on preventing premature deaths and improving other safety measures		Outcome 16	CQSPE
		e) Track external reputation using peer, SHA, CCG and patient feedback	Section B: Trust Strategic position in the local health economy	Outcome 6	CQSPE
Theme: Patient Experience	Strategic Goals	Key Priorities	Monitor Forward Plan Strategy	CQC	Lead Committee

	SG02: To provide the best possible patient experience	a) Mobilising the workforce with a passion for getting things right for patients every time	Section C: Clinical and Quality Strategy. Appendix 3E	Outcome 12, 13, 14	Workforce Committee
		b) Creating an environment that provides the facilities expected in 21 st C healthcare and which aids treatment and or/recovery	Appendices 3 C & 3F	Outcome 8 Outcome 10	CQSPE
		c) Providing good clinical outcomes and effective processes so that patients feel involved and informed	Section C: Clinical and Quality Strategy.	Outcome 1,4	CQSPE
Board Strategic Theme: Diversification	Strategic Goals	Key Priorities	Monitor Forward Plan Strategy Ref	CQC	Lead Committee
	SG03: To drive the business forward by taking opportunities to diversify beyond our traditional range of services and strengthen our existing portfolio	a) Adopting a more commercial attitude to developing services and broaden the Trust's income base to reduce reliance on NHS income alone	Section B: The Trusts Strategic position in the Local Health Economy	Outcome 6	F&P
		b) Providing excellent, appropriate and accessible services across community and acute care		Outcome 6	CQSPE
		c) Providing a re-shaped range of financially and clinically viable planned care services	Appendix 3b		Service Improvement
		d) Developing the Trust wide clinical strategy including improved use of Trust resources, quality of care and financial efficiencies	Section C: Clinical and Quality Strategy.		CQSPE
		e) Investing in developments that support the drive for lead provider status in the Black Country	Section B: The Trusts Strategic position in the Local Health Economy	Outcome 6	F&P
Board Strategic Theme: Clinical Partnerships	Strategic Goals	Key Priorities	Monitor Forward Plan Strategy Ref	CQC	Lead Committee
	SG04: To develop and strengthen strategic clinical partnerships to	a) Demonstrate a distributed leadership model with empowered clinical leaders	Section G: Leadership & organisational Development	Outcome 12, 13, 14	Workforce Committee
		b) Promoting risk sharing with CCGs	Appendices 3a & 3d	Outcome 6	F&P

	maintain and protect our key services	c) Developing clinical links with local GPs and healthcare practitioners	Appendix 3d	Outcome 6	CQSPE
		d) Develop new clinical networks that provide resilience through a more distributed service model	Appendices 3a & 3d	Outcome 6	F&P

Board Strategic Theme: Staff Commitment	Strategic Goals	Key Priorities	Monitor Forward Plan Strategy Ref	CQC	Lead Committee
	SG05: To create a high commitment culture from our staff with positive morale and a “can do” attitude	a) Developing a profound sense of mission and direction	Section A: Trust Vision & Strategy	Outcome 12, 13, 14	Board
		b) Embedding staff owned and driven transformation and listening into action as “business as usual”		Outcome 12, 13, 14	Service Improvement
		c) Becoming employer of choice for those wanting to work in healthcare in the Black Country through excellent leadership, staff development and succession planning	Section G: Leadership & Organisational Development	Outcome 12, 13, 14	Workforce Committee
		d) Ensuring staff are able, empowered and responsible for the delivery of effective care		Outcome 12, 13, 14	Workforce Committee
		e) Promoting the Trust’s values and living them everyday		Outcome 12, 13, 14	Board
		f) Embedding diversity and equality	Section G: Leadership and Organisational Development	Outcome 12, 13, 14	Workforce Committee

Enabling objectives	Strategic Goals	Key Priorities	Monitor Forward Plan Strategy Ref	CQC	Lead Committee
	SG06: To deliver an infrastructure that supports delivery	a) Enhancing our reporting and analytic framework to support the delivery of operational objectives	Monitor Compliance with Terms of Authorisation		F&P
		b) Upgrading and investing in the Trust’s IT infrastructure and systems			Service Improvement
		c) Embedding the three year rolling financial plan and CIP to sustain FRR 3 and EBITDA margin levels	Financial Risk Rating		F&P
		d) Ensuring leadership development at all levels		Outcome 12, 13, 14	Workforce Committee
		g) Providing a proactive learning environment – uni, multi and interdisciplinary	Appendix 3a	Outcome 12, 13, 14	Workforce Committee

As part of the ongoing development of its internal Performance Management Framework and in response to the Deloitte governance review, the Trust has developed a balanced scorecard to cover:

- The three pillars of quality; safety, experience, efficacy
- Human resources performance and staff engagement
- Financial performance

- Traditional “performance”, measuring the achievement of patient access targets such as 4 hour emergency access, cancer waiting times, RTT (18 weeks)

The development of our balanced scorecard has intended to show a “helicopter” view of performance against the above 4 quadrants of performance. The intention is that the measurement and management of all 4 areas of Trust performance takes place consistently at a number of levels, to ensure a more balanced approach to assessing performance and managing failure, where appropriate. This approach has already begun in earnest through the Directorate performance review process and, subject to Board approval, will be rolled out further as indicated below:

- Board of Directors – Trust level overview against all 4 quadrants
- Board committees – specific overview and analysis against specific quadrant(s) relating to that committee with exception reports in a specific format as appropriate
- Trust Management Executive – Trust level overview against all 4 quadrants
- Weekly Operations Meeting – analysis of one quadrant per week on short and medium term basis
- Directorate performance review process – Directorate specific analysis against all 4 quadrants
- Director of Operations regular meetings with CDs and GMs – Directorate specific analysis and exception reporting against all 4 quadrants
- Directorate “Board” meetings – Directorate specific overview against all 4 quadrants

What the quality plans mean for the workforce:

The Keogh Review highlighted that both our quality priorities and current operational pressures required an evaluation of current clinical staffing levels and clear workforce plans for the future. Both nursing and medical workforce will need to increase in key areas to better mitigate the risk of failures in quality of care, to manage emergency pressures and to improve the overall quality of service we provide. However both segments of the workforce are subject to national shortages which have had an impact on our ability to achieve even better standards.

The Keogh report recommended that although the Board had received a review of nurse staffing levels which used a methodology of professional judgment and peer review it required that AUKUH (Association of UK University Hospitals). In addition there are a number of recommendations on safe staffing levels which the Trust has taken in to consideration, although there is yet to be a definitive staffing level published by the RCN, NICE. Until that time the Trust continues to employ ‘best practice’ and comply with 1:8 levels using bank and agency to mitigate where levels fall below this. This use of bank and agency is contributing to the Trust overspend and deteriorating financial position.

To mitigate the national shortage in trained nurses we have undertaken an overseas recruitment plan and aim to recruit 75 nurses from Spain, Portugal and Romania.

Although the emphasis nationally is on Registered Nurses, Care Support Workers provide a valuable contribution to both patient care and patient experience. As a Trust we have invested in delivering an innovative programme which was shortlisted for a National Award in 2013. We continue to recruit and train staff entering the NHS with no experience known as the ‘Novice’ programme. These Care Support Workers are all trained to Level 2. We have accreditation within the nursing team to deliver and assess this competency.

Similarly staffing shortages in key areas such as emergency medicine and a national reduction in the allocation of junior medical staff has an impact on the trusts’ ability to maintain our performance against key quality targets such as the 95% four hour target in ED. The Trust has piloted a number of initiatives aimed at solving local issues which have included but are not exclusive to; the use of Physicians Assistants, introducing a junior and senior clinical fellow programme and starting targeted work on recruiting doctors from overseas.

The Trust’s response to Francis, Berwick and Keogh:

The Board of Directors assessed the 18 recommendations of the initial Francis Report when it was published in 2010, allocating the lead for the recommendations to the relevant Directors. The position was updated, with on-going actions on a regular basis until assurance received that all actions were completed. It shared the assessment and progress with the Governors and members.

From the Francis Public Inquiry report, February 2013, the Trust developed an action plan in response to the key themes:

- Emphasis on commitment to common values throughout the system by all within it
- Readily accessible fundamental standards and means of compliance
- No tolerance of non-compliance and the rigorous policing of fundamental standards
- Openness, transparency and candour in all systems business
- Strong leadership in nursing and other professional values
- Strong support for leadership roles
- A level playing field for accountability
- Information accessible and useable by allowing effective comparison of performance by individuals, services and organisations.

Progress against each action within the plan continues to be reported through to the Board of Directors.

The Trust underwent a Keogh Rapid Response Review in June 2013.

The themes under review were:

- Mortality indicators,
- Clinical and operating effectiveness,
- Patient experience,
- Workforce
- Safety

The Risk Summit took place on 6th June, 2013. From the review and summit a report and recommendations were received.

Progress against the action plan has been reviewed by the Board of Directors and Monitor on a regular basis. The main outstanding actions are in the following areas:

- Agreement of balanced scorecard quality and performance dashboard to measure progress of the Keogh action plan against a wider set of indicators – Board has received the 1st draft and the final version will be deployed with effect from May 2014
- Full deployment of the Emergency Care Intensive Support team action plan. The Board continues to actively review this and measure progress through ED performance and a suite of other patient flow related indicators
- Outpatient appointment issues and wider outpatient efficiency. This remains an active element of the Trust's Service Improvement programme and this project is sponsored by the Director of Finance & Information. In addition, the organisational restructure which will be in place by June 2014, includes the creation of a separate patient access management function, which will "own" outpatient services Trust-wide. This function will be accountable directly to the Trust's Director of Operations

Productivity Efficiency and CIPs

Section One - Introduction:

In shaping the financial plan for the next 24 months, the Trust is cognisant of 3 main financial challenges:

- Following the 2 Francis reports and in response to the recommendations of Sir Bruce Keogh's report on Dudley Group, the Trust has incurred significant additional expense on clinical headcount growth, often sourced through expensive agencies. The Trust's current pay run rate is placing significant pressures on P&L.
- In common with much of the acute sector, the Trust is now failing to identify cost saving CIPs consistent with a year on year 4% abatement to tariff, whilst addressing an increase in the acuity of patients presenting from an ageing and more dependent population.
- Again, consistent with the sector generally, the Trust has to meet the exacting challenge of removing £6m of costs over the next 2 years to offset the Better Care Fund funding transfer to local government.

The summation of these challenges is a headline financial gap of £16.9m in 2014-15. The Trust is currently in the process through its Turnaround Programme, of identifying a CIP Plan of £16.9m. To date the Trust has

identified a firm CIP Programme of £10.2m which it is planned will deliver cash releasing benefit next year. Therefore we aim exceptionally to set a deficit budget of £6.7m for the year, with financial balance restored in 2015/16.

In response to these challenges, the Trust has adopted the disciplines and methodologies of formal Financial Turnaround.

The Turnaround Programme formally mobilised on 31 March 2014. The Trust Cost Improvement Programme is a fundamental part of the overall Turnaround Programme.

Efficiency assessments have been completed on workforce and some major sources of acute productivity. An assessment of community productivity commences in month one - 2014/15. Further productivity assessments are due to complete during months one and two of 2014/15.

Figure one - The Turnaround Programme is underpinned by a simple set of imperatives:

Imperatives:

- Our best people are leading this.
- Divisional budget savings – pay and non-pay.
- Rigorous financial control
- Rigorous performance & programme management.
- Consequences of failure and poor performance.
- Clear targets, outcomes and expectations – linked to divisional budget savings.
- Directive, command and control style leadership.
- Stretch targets.
- Clear accountability and responsibility – Divisional clinical and management leaders.

Section Two - Efficiency assessments – benchmarking and upper quartile performance opportunities:

During the last quarter of 2013/14, the Trust engaged Price Waterhouse Coopers to undertake initial assessments of productivity opportunities. This work, along with the Trusts own benchmarking comparisons has identified significant efficiency opportunities. These opportunities have not yet received clinical quality impact analysis (QIA). QIA may challenge the benchmarked assumptions so any figures are very indicative at this stage and are not included in this plan.

Further productivity analysis will take place in month 1 - 2014/15 in diagnostics, pharmacy, theatres, procurement and community care. The results of our initial productivity analysis are shown in figure 2 below.

Figure two – Benchmarking Opportunities - summary

Top Hospital peer group comparison	Financial Opportunity
New to follow-up	£5.9M
Length of Stay	£2.9M
Did not attends	£0.4M
TOTAL	£9.2M

There are also significant opportunities to reduce the current run rate on temporary nurse staffing expenditure of £12m per annum, through implementation of agreed bank and agency controls, which have been implemented immediately.

Section Three – Constructing the CIP Plan.

The Trust has delivered high levels of CIP in previous years, has achieved wide scale service rationalisation through a new hospital project in 2005, has high fixed costs through PFI and has a reference cost index of 98. Therefore further CIP identification is now a challenge.

The recurrent gap initially required for a balanced 2014/15 plan is £16.9m in year 1 of this Plan.

The current status of the resulting gap and identification of CIP opportunities for its recovery in 2014-15 is shown in figure 3.

Figure Three – Status of 2014/15 CIP as of 31 March 2014

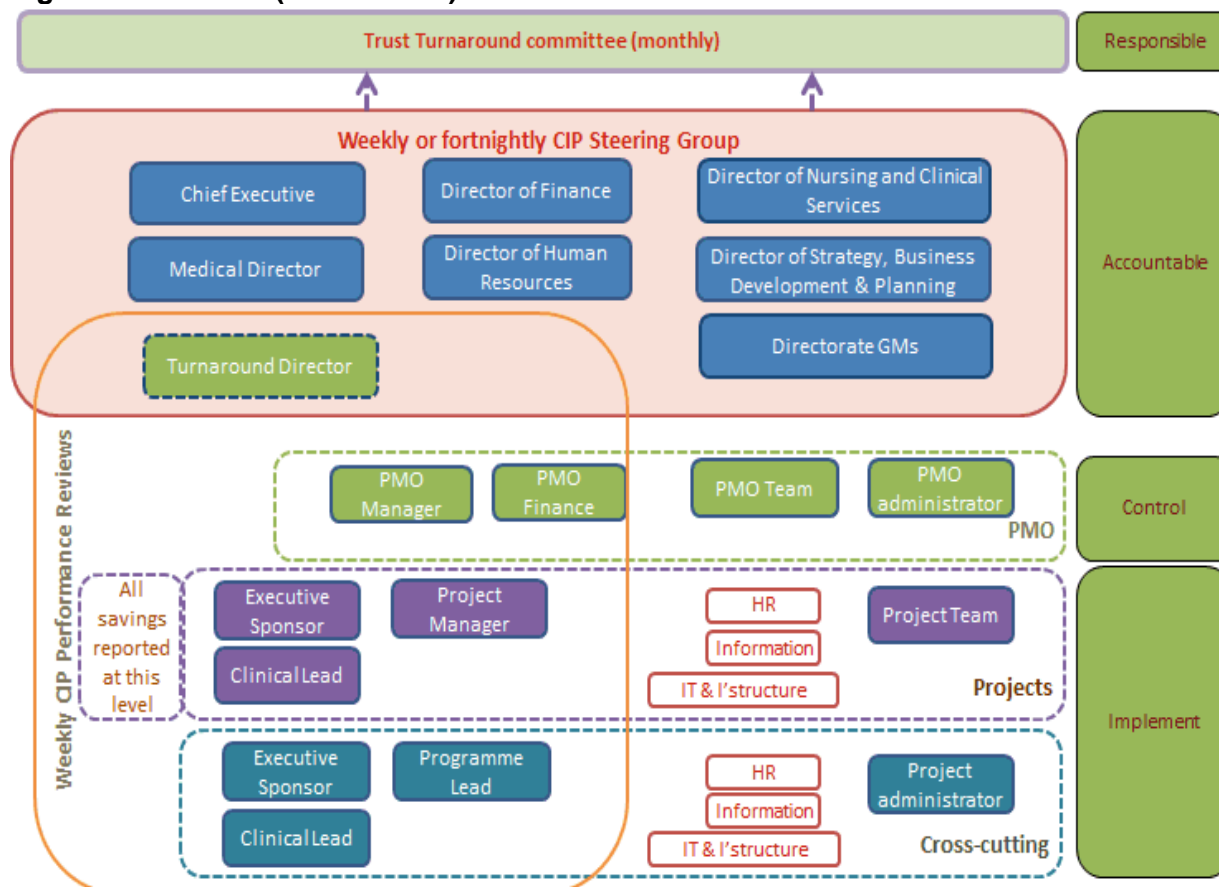
Final CIP Requirement	(£16.9m)
Income schemes identified	£4.9m
Pay schemes identified	£3.1m
Non-pay schemes identified	£1.2m
Work in progress	£1.0m
Total plan (21-3-14)	£10.2m
CIP yet to be identified/Deficit	£6.7m

Work is underway to bridge the £6.7m gap in the CIP programme. This will be complete by the end of Q1 2014/15. However a deficit budget of £6.7m is set for 2014-15.

Section Four – CIP Governance:

The CIP governance is set out in figure four. This governance framework integrates with the Trust governance structure and is governed by an exceptional Board committee, the Service Improvement Committee, which was established in February 2014.

Figure 4 – The CIP (Turnaround) Governance Structure.



Section Five - Clinical leadership of CIP

Separately to the CIP programme, the Trust is adopting a more clinically lead management structure with

effect from June 2014. Clinical Directors are being appointed across all Divisions and will be the most senior authority in each Division. Nursing leadership will be the most senior authority in the ward environment.

These steps will complete in Q1 of 2014/15 and are seen as key enablers to the delivery of 2014/15 CIP – safely and with no compromise to patient quality of service.

Section Six – looking forward to 2015/16.

The Trust expects continued cost pressures in 2015/16.

It is clear that if the Dudley local health economy is going to respond to the challenges posed in 2015/16, it will need a greater degree of transformative schemes that fundamentally alter the methods of delivering care.

The 2015/16 CIP will result from new schemes in the following, key areas and its content will be finalised by June 2014:

- Upper decile performance on key indicators of productivity and efficiency (2014/15 plans are based on upper quartile performance, in large part) driven through a revised service improvement programme
- Board of Directors decisions regarding the medium to long term future or shape of our major loss making services, using latest SLR information (For example, renal medicine, maternity, stroke). Options papers on these will be placed in front of the Board by the beginning of June 2014, for inclusion in both the 5 year strategic plan and the 2015/16 financial plan
- Community services configuration – both integration with acute services and also natural staffing efficiencies resulting from the BCF-driven consolidation of community nursing teams into 5 localities

Financial information

Income and the extent of alignment with commissioners intentions/plans:

The Trust continues to work closely with NHS Dudley and has agreed a contract that factors in significant commissioning intentions, including the impact of the Better Care Fund and the prospective development of a new Urgent Care Centre model.

The Better Care Fund seeks to prevent £6m of emergency admissions by 2015/16 (seeking to deliver £3m in 2014/15) by diverting care for patients over 65 years old and with conditions including respiratory tract infection, urinary tract infection, chronic cardiac failure, cellulitis and some falls. This involved the recruitment of nurse assessor posts within a Community Rapid Response Team that will be employed by the Trust as well as a reconfiguration of Community teams into five localities. Reducing inappropriate emergency admissions is a key jointly held commitment, particularly as current tariff arrangements result in a high degree of unprofitable work for the Trust. However, from a Trust perspective it appears that the modelling undertaken by commissioners potentially overstates the impact and an optimistic viewpoint is that a maximum of one ward's worth of activity (36 beds) could be prevented by the current scope. In addition, closing ward space would result in a degree of operating inefficiency due to the nature of the PFI contract. As a result, there is a necessary divergence from NHS Dudley plans based on the Trust undertaking more elective activity within any space that is freed up. Whilst the repatriation of work should be cost neutral to the health economy, it is likely, at least in the first instance, that a proportion of this elective work will be linked to clearing the RTT backlog in order to place the Trust in a competitive position. This will clearly impact on commissioners and dialogue is ongoing.

A further divergence concerns the new Urgent Care Centre model which is planned to be operational from quarter 4 of 2014/15 following the closure of the primary care managed walk-in centre. There is a commissioner expectation that 30% of A&E activity will be diverted to the new integrated Urgent Care Centre and this has been factored into the contract. However, given the Urgent Care Centre is to be largely integrated with the current A&E department, the Trust has assumed responsibility for this new activity within our plans. This will be different to NHS Dudley plans given the operation of the new model is subject to tender.

Finally, the Trust has a number of revenue generation schemes that, if successful, would give rise to additional income of £6.5m (net benefit of £4.9m after deduction of associated expenditure). Of this figure, nearly 60% relates to transformational opportunities aimed at reducing length of stay and improving outpatient efficiency. The majority of these schemes have been debated with NHS Dudley and form part of the Service Delivery Improvement Plan within the contract. However, clearly there is a risk regarding the level of overall funding

available within the health economy and a significant level of contractual overspend may jeopardise the full receipt of £4m transitional funding.

Costs:

The opening position for budget setting is based on the recurrent budgets as at January 2015 contained within the Trust's five year financial model. Inflationary uplifts have been applied in line with Monitor guidance equating to £5.3m but these have subsequently been abated by £1.8m from a review of each individual inflation uplift. Pay inflation of £2.7m includes a cost for incremental drift of £1.6m. However, based on the latest guidance for pay awards, early indications are that the impact of the pay award itself could be limited to £0.7m giving rise to a further £0.4m saving. The PFI component of the inflation uplift amounts to £1.1m.

The underlying run rate of the Trust is currently in excess of existing budgets and where appropriate, legitimate cost pressures have been factored into the 2014/15 budget package. This includes £1.1m for pay, £2.0m for clinical supplies, £1.2m for CNST, £0.2m for non-clinical supplies, £0.2m for Miscellaneous other and £0.5m for other items (including non-recurrent Turnaround consultancy and PFI costs).

Other major changes include the impact of service developments, in particular a further £2.4m for qualified nursing over and above the £0.7m baseline budget. This will enable ward establishment budgets to be addressed and facilitate the reduction of expensive agency cover that is currently being utilised.

The Downside sensitivity model

The Trust has modelled the impact of downside sensitivities on the following aspects of its 2 years plan:

- Better Care Fund (£1.2m in 2014/15 & £2.4m in 2015/16)
- Temporary nurse spend (£0.9m in 2014/15 & £0.9m in 2015/16)
- Urgent Care Centre Development (£0.3m in 2014/15 & £1.3m in 2015/16)
- CIP Slippage/Loss (£0.2m in 2014/15 & £2.4m in 2015/16)
- Revenue Generation Slippage/Loss (£1.8m in 2014/15 & £3.6m in 2015/16)

The total impact of these changes is to worsen the Trust's position by £4.7m in year 1 and £9.6m in year 2.

The Trust's mitigation strategy for this downside scenario would focus upon the bringing forward into the latter months of 2014/15 CIP opportunities identified for the following year. Principle amongst these would be the cessation of loss making procedures under tariff and the withdrawal of specialty cross subsidisation. If faced with a seriously deteriorating position the Trust would seek to freeze the recruitment of non-front line clinical posts and all discretionary non pay spending. The Trust would rephrase the planned replacement of medical equipment. Over the longer term the Trust would seek to withdraw from one of its satellite sites in the Borough.

These mitigations have been modelled to restore financial surplus in Q3 of 2015/16 and deliver a balanced budget in that year.

Capital Plans:

The Trust has capital plans to spend £16.1m over the two year period 2014-15 to 2015-16. £13.2m of this is funded from surplus cash with the remaining £2.9m funded by the PFI provider. The Trust has no surplus assets for disposal over this period. The estates strategy has driven the capital programme. As the Trust operates out of PFI buildings there is no requirement to fund back log maintenance from our capital resources, this is all the responsibility of the PFI Company. The capital schemes are detailed below.

Development

During 2014-15 the Trust has no plans for capital expenditure for developments. All of our development capital expenditure will take place in 2015-16. The development of clear plans and business cases will take place in 2014-15.

Whilst schemes like the Day Case Unit and non-elective imaging hub are intended, they will be subject to heavy scrutiny via the OBC/FBC process and as such, may not be approved if there is no demonstrable return on investment.

New Out-Patient Pharmacy – The total scheme is £317k of which all will be expended in 2015-16. Funding for the scheme is from surplus cash. The Trust has established a subsidiary company and is currently operating a separate out-patient pharmacy from one of our satellite sites. To maximise the financial benefits of the subsidiary company model the Trust needs to have a separate out-patient pharmacy on the main Russells Hall Site. This project will be developed with our PFI partners and will be subject to external review from the SPV's funders and technical advisors. Any slippage on timetable would result in the Trust not achieving the planned financial contribution. The risk has been mitigated by close working with the PFI Company around a strong project management team.

Pathology Department Enhancement – The total scheme is £500k all of which is planned to be expended in 2015-16. Funding for the scheme is from surplus cash. The Trust is implementing fully managed service contracts for the Pathology Department as well as developing the principles of a Blood Sciences Laboratory. This will require capital expenditure to enhance the current Pathology Department to enable the new service provision to operate effectively. The project will need to be developed with our PFI partners. The development will need to fit in with the timescales of the contract award and start date as any delay would impact on the Trust's ability to deliver savings. This risk will be mitigated by close working with the PFI Company around a strong project management team.

Diagnostic Centre – The total scheme is £1.9m all of which is planned to be expended in 2015-16. Funding for the scheme is from surplus cash. The Trust is developing a business case to establish a community diagnostics centre in the Dudley Borough. This will involve the purchase and refurbishment of suitable premises (£1.2m) and the purchase an MRI Scanner (£0.7m) The associated revenue stream from this development is included in the financial plan for 2015-16. This risk will be mitigated by the establishment of a multidisciplinary project team.

Maintenance or replacement capital expenditure

PFI Lifecycle - Total lifecycle plan of £2.1m over the 2 years. Under IFRS the Trust has to account for the lifecycle applied to the hospital by the PFI Company. This is a technical accounting transaction and the plan is based on information provided by the PFI Company. The Trust is reliant on the PFI Company providing the information to support the application of lifecycle expenditure. The risk is with the PFI Company to maintain the PFI assets to a specific level. It is this element of capital expenditure that carries the biggest risk for the Trust on achieving the capital plan. With expenditure outside the control of the Trust the application of the lifecycle fund by the PFI Company is rarely to plan as evidenced over the past two years.

Other Capital Investment - The Trust is investing £716k over the two years on other small capital schemes. £358k in both 2014-15 and 2015-16. This spend relates to lifecycle of the remaining owned estate and minor works of a capital nature in the PFI buildings. There is also investment in replacement beds. This investment is subject to a rolling lifecycle replacement plan for North Block which is an owned element of the PFI hospital. The minor works are subject to a controlled process which is managed between the Trust and our PFI partners.

Other capital expenditure

Replacement of Imaging Equipment – The Trust is replacing various high cost imaging equipment during the two year period. This entails enabling works of £180k in 2014-15 and equipment purchase values of £816k in 2014-15. All equipment is procured through the Managed Technology Service (MTS) within the operational PFI Scheme. The Trust needs to ensure that it has imaging equipment that incorporates the latest technology. This enables the Trust to operate efficiently and safely and keeps us ahead of our local competition. As part of the MTS in the PFI Scheme imaging equipment is replaced on an equivalent basis. The schemes form part of the Trust's PFI Contract. The enabling works are paid for by the Trust with the equipment funded through the PFI scheme. The risk is around the time taken to agree building works with our PFI Partners especially the external approval required by them to commence with the works. By working closely with them and having a clear project time table this risk is minimised.

IT Programme

The Trust has a substantial IT investment programme for the coming 2 years with investment of £4.6m. £3.8m in 2014-15 and £0.75m in 2015-16. Funding is from surplus cash. The IT capital investment over these two years can be broadly split into two categories:

Termination of the PFI IT Provision

The Trust gave notice in December 2013 to the SPV to terminate the IT provision within the PFI

Contract. A 12 months' notice period is now running which will end in December 2014. The Trust will therefore take over the IT service from Q4 2014-15. At this point the Trust will purchase the IT infrastructure from the SPV at a cost of £2.2m. In 2015-16 lifecycle of £0.75m has been included in the plan to bring the infrastructure up to a required level. By removing the IT service from the PFI contract and providing this in-house the Trust will be able to procure a replacement E.H.R. system and save substantial revenue costs in the longer planning period. The risk is around the termination negotiations with the current provider. Any prolonged negotiations and financial disagreements would lead to a potential increased revenue cost. In addition the Trust is implementing a DRC solution for support during the data migration process from the current provider to the new E.H.R. system. This will incur £1.3m of capital funds in 2014-15.

New Developments & Subsidiary Clinical System Implementations

In 2014-15 there are a number of infrastructure replacement schemes and subsidiary clinical system implementations that need to be addressed. The Trust is investing £355k in these schemes in 2014-15. The Trust is investing in areas such as an E-Chemo system. All of these initiatives act as enablers for increased efficiency throughout the hospital. The efficiencies identified as part of these schemes have been factored into the financial plans. The risk is around the timing of the delivery of these projects and potential delay in the Trust realising the benefits. This has been mitigated by a clear project control process and a defined governance process.

Replacement Medical Equipment

Total 2 year investment of £5.0m. £2.5m in 2014-15 and £2.5m in 2015-16. Funding is from surplus cash. The Trust has a rolling medical equipment replacement programme. The Trust has a clear replacement structure which includes a medical devices group which oversees the purchase of all medical equipment. All key stakeholders are involved in the replacement programme including all wards and departments, our MES provider Siemens and the Trust's Finance Department. The Trust has continued to develop the procurement process for the purchase of Medical Equipment introduced in 2010-11. This reduces the risk of any unnecessary purchases and ensured that resources are available for all required replacement equipment. New equipment has to follow the Trust business case process and is subject to appropriate scrutiny.

Liquidity:

The Trust's liquidity position greatly reduces over the two year planning period.

At the start of 2014-15 the Trust is forecast to have liquidity days of 17.4 and a cash balance of £26.6m. This position deteriorates progressively during 2014-15 to end the year with liquidity days of 5.1 and a cash balance of £16.3m. The cash reduction of £10.3m is as a result of the £6.7m deficit plan that the Trust has set for 2014-15, £6.7m payment of non-service related PFI liabilities offset by £2.2m depreciation above capital expenditure for the year and £900k in working balance movements.

At the start of 2015-16 the Trust is forecast to have liquidity days of 5.1 and a cash balance of £16.3m. Although the liquidity deterioration reduces in 2015-16 the position still experiences a year on year reduction. In 2015-16 the year ends with liquidity days of 0.6 and a cash balance of £12.9m. The cash reduction of £3.4m is as a result of £7.0m payment of non-service related PFI liabilities offset by £3.2m depreciation above capital expenditure for the year. The remainder relates to minor working capital movements in the year.

The Trust maintains a 'Net Current Asset' position over the two years but this is greatly reduced for the reasons explained above.

Risk ratings:

The Trust has the following Continuity of Services Risk Ratings for the two year planning period:

	2014-15		2015-16	
	Metric	Rating	Metric	Rating
Debt Service Cover	0.85x	1	1.20x	1
Liquidity	5.1	4	0.6	4
		3		3

Throughout the two year planning period the Trust maintains a Continuity of Services Rating of 2.5 which is rounded up to 3.

