



Strategic Plan Document for 2013-14

Mid Staffordshire NHS Foundation Trust

Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

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

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Date	30 May 2013

The attached Strategic Plan is intended to reflect the Trust's business plan over the next three 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 Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;
- The Strategic 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 Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;
- All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission.

Approved on behalf of the Board of Directorsby:

Name (Chair)	Mr A Bloom, Trust Special Administrator
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Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Mrs M Oldham
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Signature



Approved on behalf of the Board of Directors by:

Name	Mr A Cummins
<i>(Finance Director)</i>	

Signature

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Strategy Guidance - Annual Plan Review 2013-14

Mid Staffordshire NHS Foundation Trust's (MSFT's) vision is summarised as:

Our vision

Our vision is to deliver *'To be recognised as the safest and most caring Trust in the NHS'*

The Vision Statement will be achieved through the delivery of the Trust's 5 Corporate Objectives, which have been updated and are based on the previous 5 strategic themes. These corporate objectives continue to be the focus for our effort and measurement for improvement.

- Deliver the highest quality care through a culture of caring
- Zero harm is always our target to keep patients safe
- Improve patient experience by listening, responding and acting on what our patients and community are telling us
- Support staff to become excellent: giving responsibility but holding to account as well
- Achieve financial stability and satisfy our regulators

In preparing our plan, MSFT has looked at what is happening both locally and nationally in the NHS and further afield, to confirm that our strategic direction and business objectives are as up to date and inclusive as possible. In 2011/12, the white paper, *Equity and excellence: Liberating the NHS*, (now the Health and Social Care Act 2012) was freshly published and the NHS was developing new structures, systems and processes in response. This year, the Strategic context remains challenging as public finances remain under intense scrutiny in response to the global recession.

The NHS landscape is however becoming clearer. For MSFT it comprises:

- Commencement of local clinically led commissioning groups¹ on 1 April whose focus will be on quality and safety with more contractual quality targets than ever before.
- Increasing competition for provision of new and existing services.
- Reducing hospital based activities, with more care provided in the community.
- Low or flat income growth set against increasing costs.

Regardless of what goes on around us the Trust's core commitment remains unchanged.

Our goals are to ensure Quality whilst maintaining Resilience. This will be fundamental, throughout the changes we experience, locally and nationally.

They are consistent with the priorities of our commissioners and have full support of the Trust's Council of Governors.

Within our aim to provide Quality whilst maintaining Resilience we have developed a clear view of what we will achieve. Quality comprises safe, evidence base care, experienced positively by patients whilst care, resilience comprises fitness for purpose at the appropriate cost.

Our financial vision

Our financial vision is to build a strong financial base, maintain financial control, deliver agreed financial targets, contribute to our overall service strategy Long Term Financial Model and identify and mitigate future financial risks.

¹ Stafford and Surrounds Commissioning Group and Cannock Chase Commissioning Groups

The Trust will manage its resources efficiently, economically and effectively within the agreed financial plan submitted to Monitor and subject to the risks noted within the plan.

This will be achieved by a focus on:

- Maintaining market share within a 15 minute travel time and increasing to 30 minutes
- Cost control
- Upper quartile clinical efficiency
- Payment for quality, including achievement of CQUIN
- Reduction in overhead costs
- Best value in procurement
- Minimising costs and maximising benefits of major investments in the Electronic Patient Record (EPR)
- Share clinical support services
- Estate rationalisation
- Service rationalisation within the Trust's main facilities

STRATEGIC PRIORITIES

In response to the recent Health Act, which brings changes in NHS commissioning and the arrival of the Trust Special Administrator (TSA), the Trust is taking further time to review its strategic plans this year.

Although we are entering into a transition period, our strategic priorities remain firm.

We are dedicated to the provision of safe, sustainable services, through achieving a balance of Quality and Resilience.

The Trust has four Values and a supporting Behaviour Framework, which sets out our aspirations for behaviours and values for all staff; these are fundamental to the delivery of our Vision.

Our Values:

- Care for people.
- Listen and improve.
- Work together.
- Do the right thing.

There are five corporate objectives, which have been agreed by the Board, which are:

- Deliver the highest quality care through a culture of caring
- Zero harm is always our target to keep patients safe
- Improve patient experience by listening, responding and acting on what our patients and community are telling us
- Support our staff to become excellent: giving responsibility but holding to account as well
- Achieve financial stability and satisfy our regulators

The Clinical Services Implementation Plan was developed over the spring and summer of 2011. This was a health economy plan to change the delivery of services to meet the changing needs of the local population. The Plan had 4 main areas of focus, Women and Children, Planned Care, Emergency Care and Long Term Conditions. It was decided in early 2012 that the care provided to Women and Children would continue as it was currently being delivered. However it was agreed that further work would be undertaken to direct appropriate children to the community paediatric services.

Planned Care

- Vascular surgery has been centralised at UHNS.
- The move of Urology service is planned to be completed in September 2013.
- Any network or move of General Surgery was delayed until the completion of the CPT review.

Emergency Care

- Work was undertaken to create a new specification to create an Emergency and Urgent Care Centre on the Stafford hospital site, however in November 2012 this was delayed by the Primary Care Trust (PCT) to await the TSA review.
- In collaboration with Staffordshire and Stoke on Trent Partnership Trust we are looking at several areas to improve emergency care, which will see improvements in Ambulatory Care, further integrated working within the Accident and Emergency department, and extended out of hour's pathways.

Long-term conditions

- Pathways for Diabetes, Chronic Obstructive Pulmonary Disease, and Heart Failure are in the process of being developed across the health economy to provide more seamless care for patients.
- We are also working to merge the delivery of neurology services with University Hospitals North Staffordshire.

The threat of losing services through new contracts, tender processes and new providers in the market – all seeking to offer best value and high quality - sets the trust a number of challenges. It requires the trust to look at service provision in a different way – developing partnerships, creating clinical pathways, which seamlessly span organisational boundaries and initiating new ways of working that benefit, the trust, its commissioners and the local community it serves.

To meet its strategic aims the Trust has reviewed and assessed its market position; and the strengths, weaknesses, opportunities and threats (SWOT) it presently faces; or has as an available advantage. In being aware of its market position, within a wider, precarious economic climate, the trust can look to take advantage of openings to secure its future – and to thrive in the new NHS.

Strengths	Weaknesses
<ul style="list-style-type: none">•Market share and presence•Commercially focused board & executive•Clinical leaders becoming increasingly involved in decision-making and leading change•Improving local community support which is having a positive effect on public reputation•Able to adapt to and to deliver change•Loyal, committed workforce•Ability to develop managers through the partnership with a provider of leadership and management development	<ul style="list-style-type: none">•Limited promotion of the Stafford brand outside traditional catchment areas•Some poor information technology and information systems•Number of services which are reliant on staff from neighbouring / competing trusts•Trust's drive to 'exceed expectations' is often seen as a negative by staff•Some reported poor patient experience in A&E•Some off-site services require extensive asset replacement programmes•Lack of mature relationship with new commissioners as CCGs evolve•Some complacency that patients will continue to choose Stafford rather than travelling further afield and/or using competitors•Workforce can be introspective•Difficulty recruiting to some consultant posts•Further development required to assist middle management to deliver Trust aims and objectives•Structural deficit of circa £15m to £20m
Opportunities	Threats
<ul style="list-style-type: none">•Repatriate services by improving relationships with neighbouring trusts, PCTs and GP practices	<ul style="list-style-type: none">•Active competition from other providers who may promote their brand to potential new markets

<ul style="list-style-type: none"> •Potential to exploit a range of markets outside the normal catchment areas, principally on the borders •Opportunities for partnership and collaboration across the NHS, wider public sector and private sector including opportunity to develop more integrated services to improve care pathways •Opportunity to more aggressively market the trust utilising its Unique Selling Points (USPs) •Potential to build capacity through improved efficiency and service redesign •The shift away from acute to community services provides an opportunity for vertical integration e.g.inclusion of a rehabilitation facility on site •The reduction in NHS funding may result in Merger & Acquisition (M&A) opportunities as other hospitals fail to remain viable 	<p>traditionally in the trust catchment</p> <ul style="list-style-type: none"> •Commissioner plans to market tests services. In the event the trust fails to retain these services, or specifications are reduced i.e. the type and/or number of services procured by the commissioner reduces, the trust will need to rapidly reduce costs and acknowledge that it is not able to provide the current wide range of services •Increasing competition from the NHS and independent sector could dilute profitable work •Pressure to erode tariffs resulting in a potential marginal loss should referrals exceed planned levels •External network alliances and flows could hinder growth of specialist work and cause smaller specialties to become unsustainable •Failure to manage relationships effectively could result in the failure to maintain current market share and develop strategic alliances with other providers •The Trust fails to keep up with new Information Technology (IT) which allows better transfer of patients between District General Hospitals (DGH) and community and therefore reduces potential referrals •Perceptions that trusts of this size will no longer be viable and therefore subject to threat of takeover
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How we wish to be viewed

We wish to be viewed by patients and GPs as the first choice of referral for our catchment population. Our branding to do so will build on the loyalty we have developed over many years, our clinical expertise, the range of our specialties and innovative clinical achievements offered at Mid Staffordshire Hospitals. In parallel we wish to be viewed as understanding and meeting patient and GP expectations and will achieve this through:

- Reducing our outpatient waiting times that are reflected on Choose and Book to provide quick access to a consultant opinion
- Providing a desirable healthcare environment and as required care at, or near to home
- Being responsive to the needs of GPs requiring direct access support
- Working in collaboration with GPs to deliver services that are clinically integrated

Overall we wish our patients and GPs to see themselves as being treated as valued customers. We wish to be viewed by our staff as being an employer that creates an environment, which is the best place to work, train and learn. The strategies and plans within this forward plan are based largely on the input from the new care groups. We wish to be viewed by our current commissioners the NHS England, and Clinical Commissioning Groups (CCGs) who will follow them, as responsive and responsible providers who are delivering the best healthcare outcomes, the best patient experience and the best value for money. In short, we want to be seen as being the provider of choice for safe, high quality care that is affordable to our customers and meets the needs of the populations we serve.

Our position within the local health economy

The Trust's core business is providing major acute medical and surgical services to patients in Stafford and Cannock. However, changes in healthcare policy effectively giving patients living outside this catchment a greater choice of provider and provide us with the opportunity to penetrate a wider patient catchment for a broader range of services.

To do so our marketing strategies will focus on:

- Becoming the provider of choice for a wider 30 minute drive time catchment focusing on improving the patient experience and maintaining our strong relationship with local GPs and Clinical
- Commissioning Groups – working closely with them to respond to their needs and those of their patients
- Pursuing Any Qualified Providers (AQPs) bids which enable a wider market penetration.
- Focusing on market intelligence and pro-actively redesigning services that are likely to be delivered under AQP contracts over the next three years, including pathology.
- Regaining, and as feasible, increasing market share
- Collaborative working with NHS, private sector and 3rd sector providers to enable a greater degree of one stop healthcare and faster more effective pathways for the benefit of patients.

We have no plans for further market diversification. However we are likely to pursue collaboration agreements. Key to the success of the marketing strategy will be ensuring that we provide the range of services that GPs and patients as our customers wish to see, short waiting times, good car parking, and an excellent patient experience.

Impact of competition

The economic environment in which we operate is changing significantly and we have already felt the impact of increased competition on our activity, particularly first outpatient appointments. We further anticipate in roads being made into our in-patient planned care, particularly Orthopaedics, from other acute NHS Trusts and private providers. The risk of losing market share to our competitors is a significant risk within the forward plan.

Private providers Spire, Ramsey and BMI all have strong presence in the area; this will have significant day case capacity and will, be able to offer shorter waiting times. We believe this poses a very significant threat to our activity.

In addition the introduction of AQPs is going to have a marked impact on us. Following the introduction of AQPs we will almost certainly see a reduction in market share and income. Increased competition also brings opportunities, which we will harness. AQP gives us the opportunity to expand our services into other geographical areas.

Changes in commissioning intentions

There are a number of changes in commissioning intentions and service delivery models, which will have an impact on our services. These include our commissioners overall message of 3% growth and 2% top slicing.

MSFT has had regard to the views of the Trust Special Administrators and the Trust Governors by:

Following the appointment of the TSA on 16 April 2013, the TSA as Accounting Officer has reviewed and contributed to this Plan and approved it at TSA Board on 30 May 2013. Additionally, prior to the appointment of the TSA the Council of Governors has made a vital contribution to the development of the Trust's strategy and annual plans. The Council of Governors had a strategy committee, chaired by a Governor, with which Trust Board members worked to ensure that the views of the Governors informed the annual plan and strategy. The Governors were engaged and actively involved throughout the process for producing our forward plan and in addition to the ongoing interaction with the Governors strategy committee, a formal meeting of that Committee was held to specifically discuss and agree the annual plan and strategy. The views of the Governors were therefore fully reflected in this Plan.

The monitoring and assurance of delivery of the Strategic Plan will be administered through a new Corporate Governance Structure developed between the TSA, the Chief Executive and Executive Directors and approved at TSA Board on 30 May 2013, effective from 1 June 2013. This includes the Chief Executive and Executive Directors reporting to the TSA at both TSA Board and Senior Management Team on a monthly basis.

Clinical Strategy

Approach taken to quality (including patient safety, clinical effectiveness and patient experience)

An outline of existing quality concerns (CQC or other parties) and plans to address them.

1. Care Quality Commission (CQC)

The Trust underwent three unannounced Care Quality Commission inspections during 2012/13, in March 2013, February 2013 and June 2012. The Care Quality Commission judged that the Trust was fully compliant with all standards assessed. The inspectors did not request the Trust to take any actions in respect of outcomes reviewed during these inspections.

2. Clinical Commissioning Group (CCG)

MSFT has been working with the CCG around key quality concerns to be addressed in 2013-2014, these include:

Hospital Acquired Pressure Ulcer reduction.

Avoidable pressure ulcers are a key indicator of quality of nursing care. The Trust was actively engaged in the SHA's Change Champion Programme in 2012 but failed to eliminate all avoidable hospital acquired pressure ulcers despite achieving a reduction in 2012-2013. A 20% reduction target has been set for 2013-2014.

Falls

In 2012-2013 there were 745 patient falls; this was higher than in 2011 when the Trust had 647 falls. Reported rates of falls in acute hospitals range from 0 to 10 falls per 1,000 bed days. In 2012 the ratio of falls to bed days was 6.37 per 1,000 bed days compared to 5.5 per 1,000 bed days in 2011. The NPSA (2009) ratio is 5.6 per 1,000 bed days.

Infection Control

We were set a target of no more than 24 cases for Clostridium Difficile. 25 cases were identified which means we were over our target by one patient, although this was still a reduction of 1 case from the previous year. Mid Staffs has seen a year on year reduction in cases of C.diff but there has not been a significant reduction in cases over the last 2 years. The target for 2013-2014 is very challenging, as it would see the Trust achieving a reduction of 50% on the 2012-2013 target.

3. Quality Governance

The Trust is required to be compliant with the Quality Governance. The Trust's internal auditors completed a review in April 2012. This concluded that the Trust's self-assessment previously undertaken was supported by sufficient evidence to confirm the overall score of 2.5 against a maximum Monitor target of 4.0. The report identified that the Trust still had some further work to do and that this was represented with 5 areas remaining at an amber/green status (each attracting a score of 0.5) with the other 5 areas being compliant and therefore green and a score of 0.0.

During 2012/13 at the request of the Trust a further review was undertaken by Price Waterhouse Cooper in to two specific areas of “is appropriate quality information being analysed and challenged?” and “is quality information being used effectively?” In their report of October 2012 it was acknowledged that the Trust had continued to make improvements in these areas and had plans to continue to refine and embed these improvements and the status at that point in time was amber/green.

The main issue arising from the audits referred to above was one of the Trust needing to embed governance structures and processes consistently throughout Divisions, Directorates and down to clinical departments.

The key quality risks inherent in the plan and how these will be managed

Pressure Ulcers

Trust wide training programme continues to be implemented, Trust wide and local action plans (for areas with high numbers) being developed and implemented 2013-2014

Falls

A Falls Strategy and Trust wide action plan has been developed and will be implemented across the Trust in 2013-2014. This will be monitored through the Trust's Governance Structure outlined in the subsequent section.

Infection Control

The Infection Control Team have developed a C.diff Recovery Plan which outlines actions to be taken in 2013-2014 to reduce the number of C.diff cases with the aim of achieving the very challenging target set of no more than 12 cases in 2013-2014.

Quality Governance

Through working with Clinical Directors and General Managers the Trust believes that good progress has been made in improving governance processes within the Divisions. Further improvements will be made during 2013/14 by further supporting the Governance structures within the Divisions. In order to achieve this, the Chief Executive and Director of Nursing have set up a project to review the Quality & Safety Strategy 2011-2015 and the Governance arrangements within the Trust with the aim of strengthening the Divisional Governance structures in 2013-2014.

Ward Clinical Quality Dashboards have been developed for all clinical areas alongside Ward Patient Experience Dashboards. These will be used by the Ward Sisters and Matrons at Ward level to address Quality, Safety and Patient Experience; these will also be used to inform the Divisional Governance meetings by triangulating this data at an individual clinical area level and will complement the Trust Quality and Safety Dashboards.

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

The monitoring and assurance of delivery of the Strategic Plan will be administered through a new Corporate Governance Structure developed between the TSA, the Chief Executive and Executive Directors and approved at TSA Board on 30 May 2013, effective from 1 June 2013. This includes the Chief Executive and Executive Directors reporting to the TSA at both TSA Board and Senior Management Team on a monthly basis.

The new structure includes:

Divisional Governance Meeting:

Each of the 4 Clinical Divisions holding a monthly Governance meeting chaired by the Divisional Clinical Director who has responsibility for ensuring the delivery and performance management of the Quality and safety agenda within their respective areas of responsibility.

Quality Committee:

This Committee meeting is held monthly and will be chaired by an Independent Member to support the Executive Directors in scrutiny and challenge of all matters relating to quality and through its' sub committees will provide communication channels with the Clinical Divisions. Reports will be provided from this Committee to management Board to help provide assurance for onward communication to TSA.

Productivity & Efficiency

CIP governance

- The Trust has delivered its CIP plan for the past two financial years (11/12 and 12/13)
- The Trust has a PMO structure in place that supports the organisation in delivery of CIP

The organisation structures its CIP through workstreams identified as part of a Trust wide McKinsey review of efficiency opportunities that took place. These workstreams are sponsored by an Executive Director and consist of Project teams from across the Trust.

CIP profile

The CIP programme has the following Key Schemes

- Procurement – A continual review of our procurement opportunities and non pay expenditure
- Estates and Facilities – Review of all Support Services – reviewing how services work, can be delivered differently. This reviews all areas of Estates and Facilities expenditure
- Non-Clinical – This work stream continually reviews Non Clinical Roles and expenditure with a primary focus on corporate areas.
- Nursing – Nursing reviews all elements of Nursing Spend including substantive Nursing and Bank and Agency Spend – the scope of the work stream covers both Ward Based and Non Based Nursing models
- Demand and Capacity – This work stream has a wide scope and looks at all specialties Capacity and utilisation of that Capacity – this work stream is broken down into several sub projects including
 - Theatres Efficiency
 - Outpatient Efficiency
 - Waiting List Initiatives
 - Contractual (Including Job Planning)
 - Specialty Reviews of current Demand versus Capacity
- ST&T- reviews all Scientific, Therapeutic and Technical Staff primarily across our Diagnostic, Imaging and Therapy department – this work stream would also include any savings anticipated from the Pathology Alliance.
- Medicine Management reviews all elements of Pharmaceutical Expenditure and develops plans to improve expenditure on drugs and promote clinical engagement in reviewing opportunities to change prescribing patterns.

CIP enablers

- All of the work streams as part of the McKinsey review process were signed off by an Executive Lead – and have continued to have an executive sponsor.

- Where appropriate the work streamsteams consist of clinical staff or are overseen by Clinical Directors. Nursing, ST&T and Average Length of Stay all have clinical membership on the project groups. In addition for Demand and Capacity due its size, complexity and link to Specialties – this work stream is overseen by an Assurance Committee that includes all of the Clinical Directors

Information support for some work streams has been key. The PMO has developed a benchmarking capability to give Work streams information on where they outlier against other Trusts. In addition for the modelling of Demand and Capacity the input of the information team has been key to specialties being able to deliver these plans.

Quality Impact of CIPs

- The Trust has implemented a robust process Quality Impact Assessment process led by the Medical and Nursing Director. These take place at the conclusion of the planning process prior to implementation to ensure that the plans laid out are safe and have no impact on quality.
- During the year the CIP projects will submit a Quality Impact Assessment on a bi weekly or monthly basis which is reviewed by the PMO
- During the year a formal QIA review is carried out quarterly by the Medical and Nursing Director of each work stream to ensure that during implementation there are no changes / impact on quality and safety.
- In 13/14 there will be a development in the process which will not only ensure that Quality and Safety are not impacted by CIP plans but also Patient Experience – it is possible CIPs will not impact on the Clinical Quality and Safety of services but reduce Patient Experience.

Financial & Investment Strategy

The Trust has set a financial plan for 2013/14, which results in a planned Income and Expenditure (I&E) deficit of £22.21m. This is an increase in the outturn deficit of £14.74m in 2012/13 due mainly to the loss of £4.5m non/recurrent funding received from the PCT, along with increases in depreciation and shortfalls in savings and income.

Within the outturn deficit for 2012/13 the Trust achieved cost improvement programme (CIP) savings of £10.4m. The national efficiency target for NHS trusts in 2013/14 is 4% - equating to approximately £6.5m in required savings for MSFT. The 2013/14 financial plans includes circa £5.5m of new savings schemes in addition to the £1.7m impact of schemes that commenced in 2012/13 – an efficiency programme totaling £7.2m or 4.54%

The Trust will be spending £16.03m on capital in 2013/14, which includes the continuation of some major schemes such as the introduction of a new Electronic Patient Record system and the development of a new Endoscopy Suite. There is also expenditure on Medical and Surgical Equipment, the Estate and the IT infrastructure.

As a result of the I&E deficit and the high level of capital investment the Trust will require cash support from the Department of Health of £30.7m in 2013/14.

The Trust has built its 2013/14 financial plan on a 'steady state' basis with no impact of major organisational change. However, as a result of the increasing uncertainty around the future of the Trust there is a potential risk to the financial stability should we be unable to retain key staff and services. The Trust will be working with the administrators to minimise the impact of this.

Workforce Priorities

Overview

The removal of the long-term financial model (LTFM) reporting submission and its replacement with an annual financial plan until 31 March 2014 sets the theme for the clinical workforce strategy.

In essence, the strategy is to maintain existing clinical services and fill vacancies to maintain those services until the revised TSA model is known then proceed to safely transfer services as necessary once this is the case. The Trust is at the point where it is developing an operational forecast to cover the 2013/14 financial year.

For workforce planning purposes, agreement has been reached with the CCG lead that the Trust will “flat line” its workforce position after 31 March 2014 to allow established numbers to remain within the health economy.

