



**Strategic Plan Document for 2013-14**

**Mid Cheshire Hospitals 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):

Name	Mark Oldham
Job Title	Director of Finance & Strategic Planning
e-mail address	<a href="mailto:Mark.oldham@mcht.nhs.uk">Mark.oldham@mcht.nhs.uk</a>
Tel. no. for contact	01270 621453
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.**

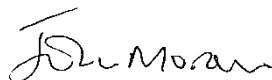
In signing below, the Trust is confirming that:

- 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 Directors by:

Name (Chair)	John Moran
-----------------	------------

Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Tracy Bullock
---------------------------	---------------

Signature



Approved on behalf of the Board of Directors by:

Name (Finance Director)	Mark Oldham
----------------------------	-------------

Signature



# Strategy Guidance - Annual Plan Review 2013-14

## Principles underlying the Annual Plan Review (APR) process

1. This document sets out the requirements for the principal published forward plan ("Strategic Plan") for Foundation Trusts. The Strategic Plan should set out how the Trust's Board intends to deliver appropriate, high quality and cost-effective services for its patients on a sustainable basis. It should, therefore, lay out the Trust's assessment of the challenges it faces (both within the organisation and more broadly within its local health economy), its strategy to address those challenges and its implementation plans over the 3 years from 13/14 to 15/16.
2. The Strategic Plan should be consistent with the information submitted in the finance template (being issued on 29<sup>th</sup> March), and provide context for key figures included in the finance template.
3. It is crucial to recognise that the Annual Plan is not meant to be a simple budgetary exercise, but rather a key governance document which explains how high quality services will be delivered into the future. This will involve analysis of a broad range of issues, which may, for example, include: demographics and health trends; clinical sustainability and the implications of 24/7 consultant rotas; opportunities and threats from reconfiguration; cultural factors and their impact on delivering services which are safe, clinically effective and result in high patient satisfaction; cost benchmarking and the opportunity for transformational CIPs. Clearly, this is not meant to be an exhaustive list and different Trusts will have differing starting positions and face somewhat differing challenges.
4. Monitor has for many years emphasised the importance of robust planning over a multi-year time horizon in maintaining a healthy and sustainable FT sector. Our experience in prior Annual Plan Reviews has shown, however, that FTs on the whole tend to focus on a one-year planning cycle and look less at addressing longer-term strategic issues. The context to the 2013/14 Annual Plan is particularly challenging, with FTs facing rising demand and the need to deliver increased quality and efficiency and an improved experience of healthcare services for patients. Against this background, a short-term planning outlook, particularly one which does not take due consideration of the local health economy or the sustainability of service delivery models, would be inadequate.
5. There is no prescribed format for the published section of the Strategic Plan. However as a guide we would expect plans to be between 10 and 20 pages in length. To support APR analysis there is some specific information, not for publication, that we require from all Trusts and we have therefore included space for these in Appendices 1-4. Where there are commercially sensitive or confidential matters that Trusts do not want to include in the main published section and which cannot be accommodated within Appendices 1-4, these may be included in Appendix 5<sup>1</sup>.
6. Annex A sets out, at a high level, the main stages in the development of the three-year Strategic Plan and the key elements which underpin each.
7. Monitor expects that Strategic Plans would include an Executive Summary outlining key elements of the Strategic Plan, including a summary of key financial data.
8. The main section of the Strategic Plan should normally address the areas set out in the following table, and any other relevant areas.

---

<sup>1</sup> Although Monitor does not intend to publish these Appendices, all information provided to Monitor is potentially subject to disclosure under the Freedom of Information Act 2000 (subject to the normal exemptions).

<b>Strategic Context and Direction</b>	<p>Trust's strategic position within LHE including:</p> <ul style="list-style-type: none"> <li>• An overview of the Trust's key competitors and an assessment of the Trust's key areas of strength/weakness relative to the key competitors;</li> <li>• Forecast health, demographic, and demand changes; and</li> <li>• Impact assessment of market share trends over the life of the plan.</li> </ul> <p>Threats and opportunities from changes in local commissioning intentions</p> <ul style="list-style-type: none"> <li>• An overview of the key changes to local commissioning strategy and intentions and their anticipated impact on the Trust, including: <ul style="list-style-type: none"> <li>○ QIPP &amp; demand management;</li> <li>○ Decommissioning;</li> <li>○ Potential "Any Qualified Provider" Tenders;</li> <li>○ Shifting care delivery outside of hospitals; and</li> <li>○ Reconfiguration plans.</li> </ul> </li> <li>• An explanation of how the Trust has factored these considerations into its strategy;</li> <li>• Analysis of how the Trust's demand profile and activity mix has evolved over recent years and what changes are forecast; and</li> <li>• Details of how the Trust is diversifying its income streams (e.g. research, private patients, exploiting intellectual property).</li> </ul> <p>Collaboration, Integration and Patient Choice</p> <ul style="list-style-type: none"> <li>• Plans to integrate services to provide better care and/or increase efficiency;</li> <li>• Development of partnerships and collaborations with other providers; and</li> <li>• Consideration of impact of proposals in relation to competition rules (CCP etc.) and patient choice, where applicable.</li> </ul>
<b>Approach taken to quality</b> (including patient safety, clinical effectiveness and patient experience)	<ul style="list-style-type: none"> <li>• An outline of existing quality concerns (CQC or other parties) and plans to address them;</li> <li>• The key quality risks inherent in the plan and how these will be managed; and</li> <li>• An overview of how the Board derives assurance on the quality of its services and safeguards patient safety. (Trusts may find Monitor's Quality Governance framework helpful in appraising quality arrangements).</li> </ul>
<b>Clinical Strategy</b>  (Consistent with information contained within the Trust's published Quality Account).	<p>Service Line Management Strategy:</p> <ul style="list-style-type: none"> <li>• The Trust's overall clinical strategy over the next three years;</li> <li>• The Trust's service line strategy over the next three years; and</li> <li>• The inputs the Trust used to develop this strategy (e.g. SLM, benchmarking etc).</li> </ul> <p>Clinical Workforce Strategy</p> <ul style="list-style-type: none"> <li>• An overview of the clinical workforce strategy (covering doctors, nurses and other key clinical groups);</li> <li>• Key workforce pressures and plans to address them;</li> <li>• The impact of the Workforce Strategy on costs (short-term and long-term); and</li> <li>• Findings of benchmarking or other assessment (eg using the DH Workforce Health Tool).</li> </ul>

	<ul style="list-style-type: none"> <li>• Clinical Sustainability</li> <li>• Identification of which of the Trust's services could potentially lack critical mass (defined by Royal Colleges etc.);</li> <li>• Identification of which services have consultant cover below those recommended by Royal Colleges etc. (link to financial template); and</li> <li>• Innovations in care delivery developed at the Trust or in conjunction with partner organisations.</li> </ul>
<b>Productivity &amp; Efficiency</b>	<p>An overview of potential productivity and efficiency gains built into plans, including financial impact of projected gains, in areas such as:</p> <ul style="list-style-type: none"> <li>○ Length of stay;</li> <li>○ Bank and agency spend;</li> <li>○ Bed occupancy</li> <li>○ Theatre productivity; and</li> <li>○ Emergency readmission rates.</li> </ul>
	<p>CIP governance</p> <ul style="list-style-type: none"> <li>• An assessment of historic performance, including main drivers, and necessary further action to ensure future delivery; and</li> <li>• An overview of PMO, leadership and assurance arrangements for the life of the Strategic Plan.</li> </ul>
	<p>CIP profile</p> <ul style="list-style-type: none"> <li>• Key CIP schemes including risk ratings for individual schemes (see Appendix 2); and</li> <li>• An outline of transformational /service redesign CIP schemes which represent step changes in processes rather than incremental changes and a brief explanation of how this change will be achieved.</li> </ul>
	<p>CIP enablers</p> <ul style="list-style-type: none"> <li>• The extent of clinical leadership and engagement in identifying and delivering CIPs;</li> <li>• The requirement for enabling investment in infrastructure (external support, IT, project delivery resources, etc.)</li> </ul>
	<p>Quality Impact of CIPs</p> <ul style="list-style-type: none"> <li>• The mechanism by which the Trust ensures that its CIP plans won't adversely affect quality of services;</li> <li>• The measures of quality which will be used to inform this assurance and how the Trust monitors quality impact of CIPs on an on-going basis.</li> </ul>
<b>Financial &amp; Investment Strategy</b>	An assessment of the Trust's current financial position.
	Key financial priorities and investments and how these link to the Trust's overall strategy.
	Key risks to achieving the financial strategy and mitigations.

## **Strategic Context and Direction**

The Trust remains strategically well placed within the Local Health Economy to maintain its status as provider of choice for a range of elective and non elective services, a view which is shared by local commissioners.

The Trust continues to be well integrated into its community through its Members and Governors who have continued to be involved in the development of the Trust's strategy and the formulation of this Plan.

The Trust is geographically located in a semi rural location with no other acute provider within 20 miles of the main site (Leighton). Blue light travel time to the nearest neighbour, University Hospital North Staffordshire (UHNS) is 25-30 minutes. As a result Leighton Hospital has been accredited and designated as a Major Trauma Unit aligned with UHNS, who are a designated Trauma Centre. This ensures the populations of Cheshire and Staffordshire receive a full range of trauma services.

The Trust has maintained relatively high levels of market share with over 90% from the core areas of the population served. Some drift is seen from the border locations ie South Cheshire (Alsager) and Northwich / Holmes Chapel, where realistic alternative travel times are available. Similarly the Trust receives referrals from Stoke-on-Trent where capacity and waiting times are more favourable than neighbouring hospitals.

The Trust has performed consistently since receiving Foundation Trust status in 2008, delivering against national targets and standards at the same time as delivering its financial strategy. This has put the Trust in a strong position relative to its closest neighbours who continue to be challenged both financially and in terms of operational delivery.

To deliver the efficiency requirements going forward greater vertical integration between acute, community and social care will be required. Currently community services across the area are managed by another acute provider and this limits the opportunity to actively redesign pathways for the Trust's catchment population.

The Health and Social Care Act heralds a new era in competition in health care which has the potential to attract new providers into the market. New entrants also take the shape of GP Federations and Limited Liability Partnerships formed by Consultants employed within the Trust. The Trust is working with these potential new entrants to establish mutually beneficial opportunities to enhance service provision for specific pathways.

In respect of demographic and demand changes the Trust has seen sustained growth in demand in recent years. This has been accepted by commissioners as consistent with expected population and demographic health need changes. A consistent underlying demographic impact of 2% is recognised by the Trust and commissioners and is the starting point for assessing future demand. Elective activity has been growing at a slower rate in part due to the transfer of activity to a daycase setting where appropriate.

Daycase activity has seen significant growth in recent years, specifically around endoscopy activity as a result of increased cancer surveillance activity. This is expected to continue in 2013/14 but then steady out over the next two years. Outpatient activity has also been impacted by the increase in endoscopy as a result of these patients requiring a post procedure review.

Non-elective activity has seen significant growth in recent years and although this activity has not reduced, it has subsequently stabilised and is now growing at a level consistent with demographic changes. This level of growth is based on the assumption that continued joint work with primary care on admission avoidance and managing patients in non-acute settings will continue.

### **Local commissioning intentions**

The Trust has been working closely with its CCG Commissioners to understand and respond to their commissioning intentions over the life of the plan. At this stage these plans are not fully developed, but represent a list of priorities. Key areas which potentially impact on the Trust are:

- Develop and implement proposals for 24/7 Urgent Care services. The Trust currently runs an Urgent Care Centre, adjacent to A&E, whilst the Out of Hours service is run by another provider. Bringing these together as a co-ordinated single seamless service represents a significant opportunity;
- The CCG have highlighted a number of priorities aimed at improving services provided in the community through integrated neighbourhood teams. This will be a proactive approach to managing patients to avoid escalation to the point that an emergency admission is required. This service will not be in place until 2014/15 at the earliest. The Trust has, as a result, taken a conservative approach to forecasting non elective demand, with forecasts in 2013/14 of 3.0%, 2014/15 2% and 2015/16 2%, compared with the current profile of 8% increase in 2012/13.

The CCGs have given no indication at this stage of any intention to decommission any services and the Trust will be working with the CCGs through 2013/14 to fully understand the services to be designated as Commissioner Requested.

The CCGs have undertaken two Any Qualified Provider (AQP) tenders during 2012/13 which have been minor in financial value. The Trust has been successful in securing both tenders. There have been no further AQP's issued and no indication at this stage of any future services to be put out to competitive tender.

Local Authorities who now commission Sexual Health and Family Planning Services have expressed an intention to tender these services in the future, although no detailed guidance has been received.

In 2012/13 the Trust saw a reduction in births from 2876 in 2012/13 to 2828. This was partly due to disruption caused as a result of a significant capital development of the maternity facilities and partly due to a reduction in birth rates. This work is now complete and it is expected that 2013/14 and beyond will see market share return and early indication would support this assumption based on current bookings.

In respect of elective care the Trust plans to utilise improved productivity in Orthopaedics to repatriate 100 additional joint replacements during 2013/14. In 2014/15 and beyond the Trust is expecting to increase its elective workload, through utilising the efficiencies enabled by the new theatre build. This will also be supported through working collaboratively with other local providers to support wider system reconfiguration along with the special administration of Mid Staffordshire.

The Trust will take advantage of opportunities that will arise during 2013/14. These include:

- Extension of the national bowel screening service to offer testing to people over 55 years of age. The Trust is a regional centre for this service and the expansion offers financial and quality opportunities to the Trust-;
- Enhanced ophthalmology service to increase market share from the border areas where capacity is limited;
- Provision of Sexual Health Services across the local Health Economy. This is due to be tendered by Local Authorities, although no formal process has begun and provides an opportunity to bring units together. However, if the Trust is unsuccessful this also represents a threat to MCHFT as an existing service provider.

The Trust continues to explore opportunities to diversify income flows into the Trust. This diversification will look to:

1. Give the Trust a greater influence in private patient activity;
2. Widen the Trust's footprint into the community setting;
3. Develop wider horizontal integration through collaboratives with UHNS;
4. Improve commercial income streams from trading activities, such as laundry, where 60% of the Trust's activity is for other providers.

### **Collaborations, Integration and Patient Choice**

In 2013 the Trust reviewed and updated its Trust strategy which will be ratified by the Board of Directors in July 2013. The key principles of the strategy remain;

- clinical and financial sustainability;
- vertical and horizontal integration to increase economies of scale;
- remain the provider of choice for the local population.

To achieve the Trust's ambition for remaining the provider of choice, the Trust's priority work programme during 2013/14 and for the next two years includes a continuous programme of partnership reviews and collaborations.

### **Reviews Undertaken in 2012/13**

Clinical Haematology, Diabetes and Pathology Services. During Quarter one and Quarter two of 2013/14, improvement plans for each of these services will be implemented in line with business case approvals. The most significant change from these reviews will be the wider integration of Histopathology and Microbiology onto single site provision across MCHFT and East Cheshire Trust (ECT). This will be followed by a further review of the remaining pathology services, delivering increased efficiencies for 2014/15 and 2015/16 as the benefits take effect.

### **Reviews Planned**

Further reviews will be completed with ECT during the first 6 months of 2013/14 to include Ophthalmology and ENT services. These are currently provided in part to ECT by MCHFT. Scoping of these reviews has identified that both services require significant redesign and offer opportunity for greater efficiency and financial contribution to both Trusts

### **Develop New Collaborations**

A joint paper is being developed between UHNS and MCHFT outlining the principles, values and contractual frameworks for expanding collaborations with UHNS. This paper will be presented to respective Board of Directors of both Trusts in July 2013.

Service redesign projects are already underway with UHNS, including audiology services. A schedule of joint service reviews and clinical senates will then be agreed and undertaken, the first of which will be General Surgery and is planned for June 2013.

### **Integration**

In collaboration with CCGs and other local health economy providers, a joint programme of work to review non elective demand is underway. To ensure momentum the appointment of a Programme Director will take place led by the Partnership Board. The Programme Director will continue work already started to review existing services against population needs.

### **Approach taken to Quality**

The Trust performs well in respect of quality and safety with largely positive reviews from both the Friends and Family Test and NHS Choices. However, where issues do arise, the Trust responds swiftly and appropriately. To date, the Trust has one area that the CQC raised as a minor concern following an unannounced visit in December 2012. The CQC found that the service did not fully protect people against the risks associated with the unsafe use and management of medicines because staff did not consistently adhere to the Trust's procedures for medicines handling and recording. As such the CQC judged that this has a minor impact on people who use the service, and have instructed the Trust to take action. An action plan has been submitted to the CQC, and is being monitored via the Safe Medicines Practice Committee. The action plan will be completed by end of June 2013.

The Trust has received a Mortality Outlier Alert from Imperial College London in relation to peripheral and visceral atherosclerosis. Senior clinicians within the Trust have undertaken a case note review of all patients in the alert and no significant clinical concerns have been identified.

### **Risk Management**

#### **The key quality risk**

Objective Risks	Mitigation
-----------------	------------



Objective Risks	Mitigation
Reduced Numbers of Junior Doctors, particularly in the Emergency Care Division	<ul style="list-style-type: none"> <li>○ Use of Locum medical staff</li> <li>○ Forward planning of on-call rotas</li> <li>○ Divisional Board monthly monitoring of length of stay and discharge performance</li> <li>○ Recruitment processes</li> <li>○ Clinical workforce model is being developed to address workforce issues</li> <li>○ Use of alternative roles (e.g. Advanced Practitioners)</li> </ul>
Provision of Ophthalmology Services including Backlog of Follow-Up Appointments	<ul style="list-style-type: none"> <li>○ All referrals are graded by Consultants</li> <li>○ Dedicated glaucoma eye clinics</li> <li>○ Dedicated waiting lists for glaucoma and diabetes</li> <li>○ Use of external support to review follow up routine appointments</li> <li>○ Ophthalmic triage service</li> <li>○ Locum Consultants and SAS Doctors appointed to work on backlog activity</li> <li>○ Partnership working with the local Clinical Commissioning Groups to redesign clinical pathways</li> <li>○ Non-recurrent funding from Clinical Commissioning Group</li> </ul>
The resources and infrastructure to deliver high quality clinical care 24/7	<ul style="list-style-type: none"> <li>○ 24 hour senior medical staff cover</li> <li>○ Increased Consultant on site presence at weekend</li> <li>○ 24 hour senior nursing staff cover including Night Nurse Practitioner Team</li> <li>○ Critical Care Outreach Service 24/7</li> <li>○ Early warning scores in place to enable staff to detect and manage the deteriorating patient</li> <li>○ Escalation plan for the detection and management of the deteriorating patient</li> <li>○ Increase in Consultant posts in Emergency Department, Anaesthetics, General Surgery, Care of the Elderly, Cardiology and Gastroenterology</li> </ul>
Poor State of Repair of the Patient Case Notes	<ul style="list-style-type: none"> <li>○ Medical records rebind case notes as necessary</li> <li>○ Health Records Management Policy in place with clear actions for staff</li> <li>○ Updated Trust IT Strategy centred around the implementation of an electronic patient record, for which funding has been identified.</li> </ul>

The Board of Directors derives assurance on the quality of its services and safeguards patient safety through three key committees, namely the Quality, Effectiveness and Safety (QuEST) Committee, the Strategic Integrated Governance Committee and Patient Experience Committee.

The QuEST Committee meets bi-monthly and is chaired by the Chief Executive.

The Committee's responsibilities include:

- Ensuring delivery of the Quality and Safety Improvement Strategy, including the "10 out of Ten" Programme
- Ensuring delivery of CQUINS
- Reviewing, and challenging, patient safety data
- Reviewing, and challenging, patient experience data
- Overseeing the Quality Account (developed through widespread stakeholder engagement)

The Strategic Integrated Governance Committee meets monthly and is chaired by the Medical Director / Deputy Chief Executive.

The Committee's responsibilities include:

- Monitoring, and responding as required, to incident reporting and trending
- Ensuring that the actions and learning from Serious Untoward Incidents (SUI) are delivered
- Reviewing gap analyses against national documents to ensure that the appropriate lessons are learned and that the Trust benchmarks favourably against other organisations
- Reviewing the Board Assurance Framework and Strategic Risk Register
- Ensuring the Trust remains compliant with all CQC requirements
- Ensuring compliance with NICE guidance

The Patient Experience Committee meets bi-monthly and is chaired by a Non-Executive Director.

The Committee's responsibilities include:

- Approve and monitor progress against the PPI strategy
- Review evaluations from local and national patient surveys
- Monitor compliance against the Patient Experience CQUIN
- Receive reports and action escalated issues from Complaints Review Panel and Patient Information Committee
- To monitor and evaluate public access to, and the effectiveness of, PALS and Complaints

Through a robust integrated governance committee structure, the Board of Directors has commissioned the development of strategies and objectives that specifically focus on improving quality of care, patient safety and patient experience. The effectiveness of these are monitored through the three committees described above. When a specific area of underperformance or delivery risk is identified, this is addressed through a specific work stream or task and finish group. For example the Pressure Ulcer Operational Group has been established by the QuEST Committee to review each pressure ulcer and ensure that all the required actions to eliminate avoidable pressure ulcers have been delivered.

### **Clinical Service Strategy**

The Trust has completed 2 years of a 5 year clinical service strategy. The programme of work for years one and two was undertaken in each Division through Elective and Non Elective work strands. This included reviewing each service line at subspecialty level, developing and implementing revised workforce models and establishing the capacity requirements to meet existing workload and future projected activity demand. For years 3 – 5 the two work strands will be further developed across Divisions and will include three priority areas of work:

### **Theatre Efficiency**

In line with the new theatre and critical care build, a programme of work will continue to improve the efficiency and effectiveness of these facilities. This will include the implementation of a new theatre computer system, as well as an advanced stock management system to support better scheduling and utilisation of theatre sessions and patient level tracking of non pay items. A review of workforce models and skill mix is also underway to continue the programme of improvement and to further maximise productivity and efficiency opportunities.

### **Length of Stay**

The Trust has reduced length of stay by 1.5 days during the past 2 years. However, although progress continues the pace has slowed. A re-focus on actions to further reduce length of stay is now being undertaken to include:

- Delayed Discharges – work with social services and intermediate care to review the current pathways and processes, agree service level KPI's, assess utilisation of community beds and to develop an integrated service across providers. Shared KPI's will be developed and a trajectory for improvement will be monitored through an Executive level task and finish group.
- Event Led Discharge – a programme of work is being undertaken to improve and extend event led discharge across the Trust. This will be supported by clinical leads and matrons to further develop and empower ward nurses to facilitate discharge in a more timely and proactive manner
- Increase medical interventions provided on a day case basis. The Trust has identified a number of patient pathways that can be delivered through different models of care in day case facilities, for example, patients receiving long term antibiotics and heart failure regimes that would normally require admission into an acute hospital bed. The review includes clinical specialty leads assessing current pathways of care and to introduce benchmarked and nationally recognised alternatives.

### **Outpatient Services**

A key marketing strategy for the Trust is to deliver outpatient services in a timely manner (first routine appointment within 5 weeks) and at an appropriate place of provision (utilisation of community facilities). A project group has been established to review the current provision of outpatient services across all Divisions and to agree an improvement programme which involves:

- Improved productivity through better Out Patient utilisation;
- Reduced levels of cancellations and rebooking;
- Extended use of Northwich Infirmary capacity and other health facilities to relocate activity as appropriate;
- Review and implement other methods of service delivery including tele-medicine and provision of other non face-to-face clinical advice, both to patients and GP's where clinically appropriate

### **Service Line Management Strategy**

The Trust has embarked on a programme of specialty reviews in 2012/13 commencing with Accident and Emergency; Elderly Care; General Surgery Emergency Admissions and Obstetrics. The reviews considered sustainability in terms of clinical quality, financial delivery, application of accepted national guidance / Royal College advice and the immediate and long term workforce. The results of these reviews will inform future discussions with CCGs concerning options available. The Trust will continue with a rolling programme of reviews during the life of the plan.

### **Clinical Workforce Strategy**

The Trust Workforce Strategy focus contributes to the Trust Strategy and Objectives, specifically:

- Maintaining and further improving quality;
- Enhancing financial and service sustainability;
- Continuing to deliver on the Trust rolling programme of investment.

The Trust has a well-developed approach to its service and infrastructure development, using a business case approach, which includes workforce review and investment where this is required. This approach is being enhanced by effective utilisation of the Service Line Reviews to support prioritisation of a rolling programme business cases.

Areas where known staffing issues exist include A&E services, Care of the Elderly service and respiratory care. Planned investments are already established in each of these areas and recruitment plans are well underway in A&E and Care of the Elderly. These investments are included in the forward plan.

Additionally, a specific review of Junior Doctor staffing will be undertaken to include alternative models of delivery to address any shortfalls. These will include greater use of Enhanced and Advanced Nurse Practitioners.

### **Workforce Planning**

Trust workforce planning uses a bottom-up approach guided through clinical and service divisions who have a greater understanding of service needs. This is aligned to a Trust-wide overview which is completed using the standard NHS Workforce Planning Template.

As noted above, service specific issues will be addressed through the prioritised rolling programme of business case investment and where appropriate, with the involvement and support of CCGs. Specifically for 2013/14:

- Benchmarking of costs has been reviewed as part of other exercises (SLM Reviews and a national benchmarking group to which the Trust subscribes) and the Trust consistently compares very favourably. A key strategy for the Trust going forward is to maximise use of Extended and Advanced nurse practitioners. This will allow the Trust to address known workforce issues, some of which are national;
- During 2012/13 the Trust undertook several very successful overseas recruitment exercises from which over 30 vacancies were filled, significantly reducing average carried vacancies;
- For 2013/14 several initiatives are already underway:
  - Enhancement of the current Medical Leadership to support the Medical Director and further develop clinical engagement in service transformation and CIP delivery;
  - Ophthalmology service expansion to meet referral needs;
  - Endoscopy service expansion to meet service demand including bowel screening;
  - Pathology collaborative to achieve service efficiencies and thereafter to ensure an appropriate workforce model to meet collaborative service requirements;
- The Trust also completes an annual review of its clinical strategy to ensure this remains fit for purpose, and addresses upcoming staffing issues over the forthcoming years

### **Innovative Service Delivery**

Meeting service delivery needs in different and innovative environments is an important driver for service improvement. To date, the Trust has:

- Provided 'Out of Hospital' services in support of GP's through, for example, provision of diagnostics in GP practices which has been received favourably;
- Provided clinical services to meet communities needs in non medical community settings, for example, Trust Sexual Health Services are provided direct to service users in community settings in Northwich;
- Developed and established joint posts and care-pathways with other providers, for example, the UHNS for Cardiology and vascular services.

During 2013/14, the Trust will look to increase 'Out of Hospital' services such as those provided for Outpatients, using primary care accommodation to increase service accessibility and flexibility.

### **Productivity and Efficiency**

The Trust has consistently delivered improvements in productivity and efficiency and benchmarks positively against peer for daycase rates, outpatient Did Not Attend rates and outpatient first to follow up ratios. Furthermore, there is little opportunity when peer comparisons are made in increasing bed occupancy or reducing emergency readmissions.

<b>Better Care, Better Value Indicators (Q3 12/13)</b>	<b>Indicator Value</b>	<b>PROVIDER RANKING (out of 153)</b>
Daycase Rate %	85	18
Pre-procedure bed day rate	0.11	28
Emergency re-admissions (%)	5.0	47
Outpatient DNA %	7.7	75
First follow up ratio	2.1	77

The Trusts key opportunities for increased productivity and efficiency are identified as reducing length of stay for emergency admissions and improving theatre and Out Patient utilisation.

The Trust has been working on reducing length of stay with key programmes of work since the beginning of 2010/11 and has delivered a reduction of 1.5 days over the 2 year period. However, the Trust still benchmarks adversely against peer with a rate of 8.7 against 7.0 for medical emergency length of stay. It has been identified that a further 2 days may be achieved to rank within the top percentile performers and a programme of work is underway to achieve this as outlined earlier.

In addition, the Trust has achieved an increase in the percentage of patients that are discharged within '0' day which also facilitates a reduction in capacity required but which will not show within the length of stay trend. This has been achieved by the introduction of dedicated assessment areas, Acute Physicians and rapid access to diagnostics. This work is continuing and is expected to provide further gains.

The Trust has a programme of work over the next 3 years which focuses on redesigning clinical pathways, reducing delayed discharges and improving discharge arrangements at weekends that will enable further improvement in length of stay to be achieved together with the ongoing work on rapid assessment to discharge patients within '0' day. This will facilitate a reduction in the capacity required and allow the Trust to close beds and realise financial savings that support the CIP programme. The financial value associated with the work plan is £445k in 2013/14, £1,337k in 2014/15 and £1,080k in 2015/16.

Although, there is no recognised national benchmark data with regard to theatre efficiency, the Trust has identified from its own internal review and reporting that there are opportunities to improve theatre efficiency in the areas of theatre utilisation and scheduling. There is an established project group responsible for delivering these improvements. The Trust continues to work with the Foundation Trust Network to complete a detailed benchmarking exercise to validate the extent of the opportunity.

Improved efficiency will facilitate an increased number of cases being delivered within the existing capacity and therefore grow contribution by undertaking more work from within our local population, attracting work from the surrounding areas and supporting partners with capacity constraints. The financial value associated with contribution from revenue generation schemes facilitated by theatre efficiency is £641k in 2013/14, £800k in 2014/15 and £800k in 2015/16.

The Trust has recently further identified that there is an opportunity to improve the productivity of outpatient clinics through reductions in cancelled clinics and scheduling and this will also support a growing contribution from revenue generation schemes. The financial value associated with contribution from revenue generation schemes facilitated by outpatient efficiency is £90k in 2013/14, £500k in 2014/15 and £450k in 2015/16.

Bank and agency spend in Nursing has been identified as an opportunity to improve both quality and financial efficiency. The Trust will focus particularly on agency spend as there is a high premium locally for agency staff whereas bank staff rates are comparable to substantive staff. The Trust spent £1.4M on agency nursing in 2012/13 which had increased from £0.5M in 2011/12 and there is a plan to reduce agency spend by improving vacancy rates, sickness absence and investment in additional substantive

nursing posts to support acuity shortfalls. The financial contribution from this programme of work is expected to be £170k in 2013/14, £250k in 2014/15 and £250k in 2015/16.

### **Historic Cost Improvement Programme Performance**

An assessment of historic performance, including main drivers, and necessary further action to ensure future delivery is outlined below:

Historic CIP performance has been strong, in 2012/13 the Trust delivered £5.4M against a target of £6.7M. The key areas not delivered are shown below:

- Improvements in rostering reducing bank and agency spend (£252k)
- Pathology configuration (£217k)
- Procurement savings (£405k)

The reductions in bank and agency spend underachieved against its targets due to higher than anticipated non elective admissions resulting in additional beds being utilised at short notice. Financially those additional costs were offset in year by increased income; however, to deliver the improvements in costs in 2013/14 in a sustainable manner, the Trust will need to continue with its programme of work to:

- i. Reduce Length of Stay
- ii. Reduce readmissions
- iii. Reduce delayed discharges
- iv. Reducing Non Elective demand in conjunction with our health economy partners

The improvements in programme management and increased clinical management time will be a key contributor to this scheme going forward.

The Pathology reconfiguration has been paused in terms of the wider collaborative with University Hospitals North Staffs, Mid Staffordshire Hospitals NHS Foundation Trust, Burton Hospitals NHS Foundation Trust and East Cheshire Hospitals Trust due to West Midlands tendering of GP Direct Access activity. Whilst this configuration remains the long term strategic direction, to ensure improvements in sustainability and efficiency an interim rationalisation of services across the existing Mid Cheshire and East Cheshire collaborative will progress in the first 6 months of 2013/14.

Shortfall on the procurement savings is partly due to tightening of rules in respect of VAT recovery which has been reflected in the plan going forward and delays in securing procurement gains on major consumable spend, these have now been completed and will deliver for the future years of the annual plan.

Overview of Programme Management Office (PMO), leadership and assurance arrangements for the life of the Strategic Plan:

A new approach to the management of CIPs and significant transformation projects was initiated at the end of 2012/13 with the introduction of a programme management approach. Roll-out of this will continue through the first quarter of 2013/14, particularly for CIPs, which will see 'Gateway Milestone' decision approach to key project phases, coupled with robust reporting to help ensure projects are appropriately scoped and controlled, stay on track, or there is sufficiently early notice for refinement and corrective action if they leave trajectory

The initial focus of the PMO is:

- CIPs delivery and identification;
- Service transformation priorities:
  - Length of stay to enable a ward closure in July 2013;
  - Increased theatre productivity to maximise theatre infrastructure development due for completion at the end of 2013/14;
  - Increased Outpatient productivity and service flexibility to respond to market needs.

### **Cost Improvement Programme Profile**

The Cost Improvement programme for the life of the plan is a balance of cost reduction schemes and productivity schemes which give additional revenue delivered at marginal costs. The cost improvement profile is shown below:

	2013/14 £000s	2014/15 £000s	2015/16 £000s
Cost Reduction Schemes	4,851	4,508	4,170
Income Enhancement Schemes	1,200	3,350	2,630
<b>TOTAL</b>	<b>6,051</b>	<b>7,858</b>	<b>6,800</b>

The top five cost reduction schemes and their associated risk ratings are detailed below:

Scheme	RAG	2013/14 £000s	2014/15 £000s	2015/16 £000s
Ward productivity	G	445	1338	1080
Bank and Agency staff	A	171	250	250
Drug & Procurement savings	A	800	750	750
Information Management Strategy	A	-	500	1000
Pathology reconfiguration	G	100	500	250

Whilst there remains a focus on traditional incremental change, the cost improvement schemes moving forward require a much more transformational approach to service redesign. The significant redesign programmes have been detailed on page 8 linked to the Trust's Clinical Service Strategy, in particular, theatre efficiency, length of stay reductions and outpatient review.

In addition to the length of stay reduction programme focusing on internal process, work will also continue to further enable pathway developments into community settings.

### Cost Improvement Programme Enablers

The CIP plans have been developed through a bottom up process, designed and signed off by individual divisional leadership teams including clinical directors, in addition to a number of corporate schemes which cut across divisions.

The programme management office will monitor the delivery of the CIP schemes, supported by the new clinical management structure where additional investment has been made to increase the amount of clinical management time available. The new structure has created a Deputy Medical Director role, part of whose remit is specifically to work with the Director of Service Transformation and Workforce in delivering service transformation.

Within the financial plan there are a number of capital and revenue investments which enable the delivery of the CIP schemes, these are detailed below:

### Capital Investments

Investments	Investment Value £000s	CIP / Efficiency scheme supported
Theatres and Critical Care	18,391	Theatre efficiency and productivity gain
Restaurant and Main Entrance	650	Restaurant income generation
Endoscopy Developments	330	Delivers growth in endoscopy screening programme
Ophthalmology Equipment	120	Enables services to run out of Northwich to improve access and market share

Investments	Investment Value £000s	CIP / Efficiency scheme supported
Stock Management System	200	Improved stock management gives non pay efficiencies
Site Rationalisation	750	Rationalisation of Trust premises enabling longer term residential strategy which will provide cost efficiencies
IM&T investments	4,230	Move to electronic patient records system, reducing administration costs, increasing productivity and improving quality through better access to more comprehensive patient records

### Revenue Investments

Investments	Investment Value £000s	CIP / Efficiency scheme supported
Medical Leadership structure	154	Support in delivering all CIP and service transformation schemes
Programme Management Office	29	Support in delivering all CIP and efficiency schemes (to supplement other resources)
Acute Oncology service	130	Supporting reduced length of stay and admission avoidance
Primary Assessment Area	696	Recurrent investment to maintain flow in order to deliver 4 hour target, reduce length of stay and improve quality, safety and outcomes
Surgical Assessment Area	147	Recurrent investment to maintain flow in order to deliver 4 hour target, reduce length of stay and improve quality, safety and outcomes

### Quality Impact of CIPs

A robust process has been developed by the Medical Director and the Director of Nursing & Quality to assess, in conjunction with the Divisional Senior Teams, all CIPs against the following quality domains:

- Duty of Quality
- Patient Experience
- Patient Safety
- Clinical Effectiveness
- Prevention
- Productivity and Innovation

Any CIP scheme identified by this process as being “high risk” in terms of its potential impact on quality undergoes a full risk assessment to establish whether the CIP scheme can go ahead. The quality impact assessment process also identifies the key clinical impact assessment measures that require monitoring, so that any adverse impact of the CIP scheme on quality can be quickly identified. Examples of the clinical impact assessment measures that are routinely monitored include:



- Complaints
- Clinical incident forms
- Infection rates
- Length of stay
- Cancelled operations
- Mortality rates
- Number of outliers

### Trust's Financial and Investment Strategy

The Trust financial position to 31 March 2013 remains positive with a financial surplus delivered of £1,420k after adjusting for exceptional impairments. In year the Trust received additional non recurring resources of £2.3M to support additional activity, improve the waiting list profile, and to provide additional capacity to improve patient flows and support the delivery of the 4 hour target.

Whilst CIP delivery has been at 80% of target, the Trust has strengthened governance arrangements through increasing clinical leadership and the introduction of a formal programme management office;

The Trust secured Public Dividend Capital of £25.2M to principally build its replacement Critical Care and Theatres. To the end of March 2013, £8.1M has been drawn down in line with actual spend. The draw down of the balance has been agreed with the Department of Health and will be complete by 2014. This has enabled the Trust to deliver its capital programme of £11.5M in 2012/13 whilst maintaining a cash balance of £10.3M at the end of the financial year, an improvement of £1.4M of 2011/12.

This performance gives the Trust a strong base to start 2013/14 in terms of underlying surplus and ability to meet its estates strategy required in 2013/14 and beyond.

A summary of the forward plan is shown below:

<b>2012/13 Actual £000s</b>		<b>Plan 2013/14 £000s</b>	<b>Plan 2014/15 £000s</b>	<b>Plan 2015/16 £000s</b>
154,817	NHS Clinical Income	155,799	159,667	162,208
22,379	Other income	20,290	20,655	21,202
<b>177,196</b>	<b>TOTAL INCOME</b>	<b>176,089</b>	<b>180,322</b>	<b>183,410</b>
(121,153)	Pay Costs	(122,375)	(124,078)	(126,042)
(47,542)	Non-Pay Costs	(46,002)	(46,803)	(47,555)
<b>8,501</b>	<b>EBITDA</b>	<b>7,712</b>	<b>9,441</b>	<b>9,813</b>
(4,785)	Depreciation owned and leased assets	(4,629)	(6,048)	(6,167)
75	Interest receivable	44	44	44
(201)	Interest payable (Finance Leases)	(144)	(148)	(205)
(2,170)	PDC Dividend / Other	(2,368)	(2,550)	(2,650)
<b>1,420</b>	<b>NET SURPLUS / (DEFICIT) before exceptional items</b>	<b>614</b>	<b>739</b>	<b>835</b>
0	Donated Asset Income	1,800	0	0
(8,001)	Impairments	(7,216)	(681)	0
<b>(6,581)</b>	<b>NET SURPLUS / (DEFICIT)</b>	<b>(4,798)</b>	<b>58</b>	<b>835</b>

### Key financial priorities and investments

The table below shows the Trusts capital programme and investment priorities over the next three years:

<b>Scheme</b>	<b>2013/14 £000s</b>	<b>2014/15 £000s</b>	<b>2015/16 £000s</b>
<b>Estates Development Schemes</b>			

Theatre and Critical Care project	17,061	1,330	0
Asbestos / Fire compartmentation	1,059	250	250
Restaurant Scheme	650	0	0
Ward refurbishment Maternity ward	750	1,300	1,300
Neonatal Intensive Care	1,800	0	0
Endoscopy Capacity	330	0	0
Site rationalisation priming	250	250	250
<b>Backlog Maintenance Schemes</b>	1,640	1,975	1,975
<b>IM&amp;T Schemes</b>	3,364	866	0
<b>Equipment</b>	120	0	0
<b>Total Indicative Programme</b>	<b>27,024</b>	<b>5,971</b>	<b>3,775</b>

## **The key contributions to the Trust's strategy are shown below:**

1. Completion of the replacement Critical Care and Theatres Project. This will facilitate improved efficiencies in elective surgery through eight purpose built theatres of which two are fully integrated operating theatres and one "barn" type theatre providing two operating facilities.

Furthermore, this investment will address outstanding actions required under the Cheshire Fire and Rescue improvement notices and ensure these key facilities are fit for the future needs of the population.

2. Implementation of the IM&T Strategy is focused on the migration to Electronic Patient Records (EPR), this will allow the Trust to improve quality through better access to patients health records in both primary and secondary care. EPR will also improve recording in patient notes at the same time as facilitating the streamlining of administrative functions that will reduce costs and improve productivity in clinics.
3. Investments have been approved for Endoscopy services to build additional capacity both in terms of facilities and operator time. The Trust is currently the regional centre for bowel screening and 2013/14 will see increased activity relating to the national Age Extension Programme. Beyond this, 2014/15 will see the Trust undertaking the extended screening of the over 55 year old flexible sigmoidoscopy national programme, which is expected to significantly increase activity through the endoscopy service.
4. The restaurant scheme will provide a new "grab and go" and sit down facility for visitors and staff prominently placed at the Trusts main entrance. This will both improve the image of the main portal into the Trust and generate additional revenue to support the delivery of care.
5. Site rationalisation funding will enable the Trust to reduce its footprint by consolidating accommodation on the main hospital site. Releasing savings from improved space utilisation will enable the strategic development of the Trusts residential accommodation.

In addition to these capital investments the Trust will be making investments in revenue funding to support the Trusts quality agenda. The key elements are shown below:

6. Nursing Acuity – over the life of the plan the Trust will invest an additional £460k to increase qualified nursing ratios. These ratios will be increased through a combination of reducing the Trust's bed base through improved efficiency and the redeployment of nurses into existing wards.
7. Accident and Emergency – the Trust will increase the A&E consultant numbers by a further 3 over the next 3 years, facilitating increased senior presence during evening and weekends.
8. Care of the Elderly – the Trust's demographics show, in line with the national picture, an aging population which brings more complex needs. To respond to these needs the Trust will invest in new models of delivery for Elderly care, increasing access to therapy services.
9. To supplement our two existing Respiratory Physicians a third Respiratory Physician will be recruited. This post holder will ensure the respiratory service is able to provide appropriate cross cover arrangements for the Respiratory Department activity

During the 3 years of the plan, taking into account the capital investments and the income and expenditure plans, the Trust will maintain a positive cash balance. The cash profile is shown below:

	<b>31.3.14</b> <b>£000s</b>	<b>31.3.15</b> <b>£000s</b>	<b>31.3.16</b> <b>£000s</b>
Cash Balance	7,189	5,172	7,409

## **Key risks to achieving the financial strategy and mitigations**

There are a number of risks which have the potential to impact on the Trust's financial delivery. These are summarised in the table below:

<b>Risk</b>	<b>Impact 2013/14 £000s</b>
Delivery against all CQUIN targets	230
Delivery of 18 week target	300
C Difficile penalties	310
Failure to delivery CIP programme (20%)	1,210

All these risks have mitigation strategies in place to reduce the likelihood of these challenges materialising. The mitigations include:

- Strong governance arrangements through the project management office to ensure potential slippage and failure on CIP schemes are identified early enough to put in place corrective action;
- Robust Performance monitoring arrangements in place;
- Detailed capacity and demand plans to ensure sufficient capacity available to deliver all national targets;
- Robust processes in place with the CCGs to ensure that local CQUIN targets are realistic and achievable;
- Monthly performance meetings with Divisional Management teams to ensure future CIP schemes are sufficiently developed to replace approved schemes where necessary;
- The Trust has a full PbR contract in place which allows for additional activity to be paid to offset the impact on cost reduction targets.

Where residual risks materialise the Trust will initiate “pressure valve” mechanisms which will quickly allow tighter establishment control to manage any non-recurrent financial impact.

### **Key Governance Risks**

There are two compliance targets where the Trust Board has declared a risk of failure, these are :

1. 18 week referral to treatment (admitted pathway) – in declaring this risk the Trust Board has taken into account additional non recurrent activity required in Quarter 1 mainly in respect of increased listings for cataract surgery. This activity has been commissioned by the CCGs to deal with the backlog waiting over 18 weeks.

The action plan agreed is delivering increased activity in Quarter 1 through internal additional capacity and also through an external partner arrangement. As these patients are treated, the breach will be allocated to the treatment period of the admitted pathway causing both the specialty and aggregate level to fail.

Furthermore, the Trust has also identified a capacity gap in colorectal general surgery. A business case for a further consultant is in development for the July Board of Directors. As an interim, additional lists have been approved and locum consultant appointed to take up post in July 2013. Whilst this specialty is currently failing in Quarter 1 we do not expect this to continue into Quarter 2 when the additional capacity is in place.

The Trust fully expects to continue to meet the 18 week admitted standard from Quarter 2 and going forward for the remainder of the year.

2. C Difficile target – historically the Trust has performed very well in meeting this target. In 2011/12 the Trust had 30 cases against a target of 70 and in 2012/13 the Trust had 23 cases against a target of 54.

For 2013/14 the target is 15 this represents a further 21% reduction. This was calculated nationally using baseline data October 2011 - September 2012 actual which was 19 cases. The step change reduction delivered and sustained in the two previous years makes it an extremely challenging position to deliver further improvement. The baseline rate per 100,000 bed days is 10.5, this places the Trust amongst the best performers nationally and in the top 5 Trusts in the North of England.

Review of performance, process and practice suggest there is little scope to make further improvements, suggesting the delivery of the target to be at risk. The Trust is not complacent about the position and is actively reviewing each case to understand any actions however small that can be taken which may further improve the performance.

In addition general actions include:

1. Focus on timeliness and appropriateness of samples - Ensuring all appropriate patients are sampled on admission, or as soon as possible following admission. In relation to inpatients, a sample must be taken as soon as CDI is clinically suspected when diarrhoea cannot be attributed to any other cause
2. Prompt Treatment - If patient result has been reported positive and diarrhoea/clinical signs continue, treatment of the patient should be initiated (as required) as per the treatment algorithm
3. Isolation- Continued focus on prompt and strict isolation of all patients with diarrhoea symptoms

In conclusion, the Trust is well placed to deal with the clinical, financial and operational challenges that lie ahead. The Trust recognises the importance of greater collaboration and integration with both Local Acute Providers and Secondary Care Providers. Through the well established, positive relationships with our CCGs and through greater clinical engagement, a collective health economy strategy will be delivered to ensure sustainability of services going forward. This plan builds on the key principles enshrined in the Trust's strategic direction to "deliver excellence in healthcare through collaboration and innovation".