



Strategic Plan Document for 2013-14

Chesterfield Royal Hospital 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	28 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)	Richard Gregory
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Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Gavin Boyle
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Signature



Approved on behalf of the Board of Directors by:

Name (Finance Director)	Paul Briddock
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Signature



Executive Summary

This three year strategic plan describes Chesterfield Royal Hospital NHS FT's vision to be a first class District General Hospital and confirms the objectives and supporting strategies in place to enable us to achieve this. Our vision is built on a solid history of delivery and financial stability over our eight years as a foundation Trust and within this plan we describe the plans, systems and processes we have in place to achieve this aim. This plan describes the work we are undertaking to further improve the clinical quality of our services, including £1.7m investment in additional nursing staff, alongside investment in consultants and middle grade medical staff in our Emergency Department, to improve the care and experience of our patients. It details the interventions we have put in place to reduce the risk of infections for patients and our plans for further actions to support achievement of the stretching C. difficile target.

The plan describes the work we have in place to deliver £6.5m in efficiency schemes during 2013/14 and how we will build on our overarching clinical services strategy to define at specialty level a strategic plan to ensure medium term clinical, operational and financial sustainability. The plan confirms how our transformation programme and associated governance structures have been developed to support the delivery of our forecast requirement of £33.3m savings over the next five years and provides detailed confirmation of our financial strategy.

Section 1 Strategic context and direction

1.1 Vision, Objectives and Values

Chesterfield Royal has a track record of delivering high performing clinical services for the population of north Derbyshire. This continued success delivered throughout our eight years of being a Foundation Trust is due to our dedicated staff, financial stability and investment programme, robust governance processes and joint commitment and assurance by our Board of Directors and Council of Governors to provide high quality services to the people we serve.

We aim to build on that solid foundation to deliver our vision for the sort of hospital we want to be:

A first class district general hospital (DGH) – the model of what a DGH can be in the service of its community – delivering high quality clinical care, offering exceptional experience for our patients; and creating a great place for our staff to work.

To achieve this vision we have six objectives:-

For our patients and our community we will:

1. Provide high quality, safe and person-centred care;
2. Deliver sustainable, appropriate and high-performing services; and
3. Build on existing partnerships and create new ones to deliver better care.

For our hospital and staff we will:

4. Support and develop our staff;
5. Manage our money wisely, foster innovation and become more efficient through better care; and
6. Provide an infrastructure to support delivery.

Delivery of these objectives will be underpinned by our culture and values. At Chesterfield Royal our Proud to CARE ethos is at the heart of how we run the hospital – looking after our patients and taking care of our staff:

Compassion

- Compassionate care delivered with professionalism and a positive, friendly attitude
- Care that preserves dignity and respects the person; putting patients and the heart of all we do
- Respecting the unique and individual contribution that each of our staff members make – fair, positive and inclusive, recognising diversity and treating people equally

Achievement

- Excellent care, safe services and a positive experience every time
- Exceeding expectations by delivering first-class performance, bettering national standards through innovation and ingenuity

Relationships

- An open and honest relationship with our patients, staff, partners and community
- Working in partnership in the interests of our patients
- Acting in a socially responsible way and meeting our commitments to the local community

Environment

- Providing a hospital environment that is modern, clean and safe – conducive to care and recovery; and a good place to work

Through engagement with our staff, Council of Governors and key stakeholders we have developed a number of supporting strategies and associated action plans to enable us to realise this vision.

Strategic Objective	Supporting Strategy	Date approved at Board
Provide high quality safe and person centred care	Care strategy Trust response to the Francis Enquiry	September 2012 June 2013
Deliver sustainable, appropriate and high performing services	Clinical Services Strategy	Working draft reviewed March 2013
Build on existing partnerships and create new ones to deliver better care	Joint working agreements: - Derbyshire 21 century care programme - Pathology Alliance - East Midlands PACS systems procurement - Working together across South Yorkshire programme	June 2012 February 2013 September 2012 January 2013
Support and develop our staff	Workforce and Organisational Development Strategy	June 2012
Manage our money wisely, foster innovation and become more efficient through better care	Finance strategy and transformation plan	April 2013
Provide an infrastructure to support delivery	Site development plan and Information Management and Technology Strategy	May 2012 January 2013

The NHS is changing rapidly and we don't underestimate the size of the challenge ahead of us. Within our strategic annual plan submission for 2012/13 we reported on our assessment of our strengths, weaknesses, opportunities and threats. This strategic plan aims to build on this analysis and on previous year's submissions, reflecting the work we undertook during 2012/13 to clarify and develop our strategy and strengthen our internal governance processes, realigning assurance and accountability functions within our committee structures and establishment of a Programme Management Office (PMO) function to monitor and support service developments and delivery.

1.2 Membership

Our membership is drawn from the areas outlined in our constitution and covers Chesterfield, Bolsover and North East Derbyshire in the entirety, plus a number of council wards in Derbyshire Dales and the North Amber Valley; as well as in the High Peak. The Trust has two membership constituencies – one each for the community and its staff. It does not host a patient constituency. The current membership (assessed at March 31 2013) is shown below, along with estimates for growth during 2013/14.

	2012/13	2013/14 (estimated)
At year start (1 April 2012)	17,110	17,001
New members	289	1000
Members leaving	398	500
Affiliated members *	195	300
At year-end (31 March 2013)	17,001	17,501

Further details including our membership report is provided in appendix C2.

1.3 Market Analysis

1.3.1 Key Competitors and Market Trends

Chesterfield Royal has a strong market presence being the only District General Hospital serving the population of North Derbyshire, which consists of approximately 400,000 people. We have a reputation across the health community for delivery of high performing services in terms of clinical standards and waiting times. We have an easily accessible site, have invested significantly in major capital redevelopments over the past 5 years to improve the clinical environment for our patients and have adequate levels of parking available. All of these factors contribute to ensuring that we remain the hospital of choice for the population of North Derbyshire.

Whilst our population has a long history of loyalty to our services we are not complacent. Our vision to become a *'first class DGH - the model of what a DGH can be in the service of its community'* is based on making sure that we deliver an exceptional experience for our patients ensuring that our services are highly recommended to friends and families. In line with Commissioning for Quality and Innovation (CQUIN) requirements we have achieved a 10% increase in the 'friends and family test' net promoter score for 2012/13 and will seek to build on this over the coming years as we roll out the survey across more service areas.

We are in a healthy market position relative to our local competitors based on a strong performance for both finance and governance as demonstrated Monitor risk rating assessments. Our strategic plans focus on consolidation of current service provision and improving quality, we do not anticipate any geographical expansion of service provision beyond North Derbyshire. However we are conscious of the need to continually monitor the position of our local competitors. This enables us to understand those areas of opportunity where we could expand clinical service provision; determine where it is in the interest of our patients to work in collaboration to further develop robust and sustainable services for our combined population base and also to ensure that our population is not disadvantaged due to the financial position of other local Trusts. Within the next 12 months we will work closely with our clinical commissioners and across our health community to identify and confirm commissioner requested services and location specific services.

The greatest change in terms of competitor landscape across Derbyshire will be the potential emergence of a new community Foundation Trust. Derbyshire Community Health Services NHS Trust (DCHS) provides community domiciliary, inpatient rehabilitation and outpatient services to our population. DCHS has a history of providing consultant led outpatient and simple day case procedures within the community in the south of Derbyshire. The Trust is undertaking significant levels of transformational change to support the progress towards becoming an FT and has not identified any intentions to explore the potential of expanding consultant led services into North Derbyshire.

1.3.2 Future Health Needs of Our Catchment Population

Analysis of population demography and health status shows a picture of increasingly aging population with complex health and social needs. The Office of National Statistics (ONS) projections for our catchment population suggest a 16.2% population growth across all ages within 25 years. Further analysis shows a significant projected increase for the 65+ age range and a 36% increase in 85+ within the next 7 years.

The demographic changes present an increased pressure on our health care system. Associated with the aging population we are seeing increased levels of morbidity, an increase in complexity of case mix, prevalence of long term conditions and complex health care requirements. Within our catchment geography are areas with high levels of deprivation both urban and rural, with high levels of incapacity due to chronic ill health, higher than England average levels of hospital admissions for both emergency and elective care and higher levels of cancer and dementia prevalence.

1.4 Commissioning intentions

We have a history of effective working with our commissioning organisations which have continued with the establishment of clinical commissioning groups and NHS England Nottinghamshire and Derbyshire Area Team. Our health economy is relatively stable and mature with key clinical commissioning organisations operating in shadow form since summer 2011. This has enabled us to form constructive working relationships with our GP colleagues and supported clinically led service redesign work in diabetes, cardiology and ophthalmology services, and a redesign of the post menopausal bleeding pathway to provide a one stop clinic. Our collaborative work to support the delivery of 21 century health and social care within Derbyshire will inform and be informed by our clinical services strategy and has enabled us to work closely on the development of an integrated approach to improving the management of unplanned care through the proposed establishment of an Urgent Care Village (further detail provided in section 3.1.1).

Both North Derbyshire and Hardwick Clinical Commissioning Groups (CCG) have indicated their intentions to continue to focus on demand management of elective referrals. Both CCG's have below national average GP referral rates and GP referral growth rates however this is against a backdrop of growth in non-elective admissions of 3.9% during 2012/13 on top of a 2.15% growth during 2011/12. Management of urgent care pathways features heavily in local QIPP plans through provision of integrated care models and pathways for frail elderly patients, a focus on quality improvement within care homes and additional support for dementia patients.

The Any Qualified Provider (AQP) model was adopted across Derbyshire during 2012/13 to procure Audiology, Community Podiatry and Increasing Access Psychological Therapies services. Chesterfield Royal tendered and was awarded access to provide Audiology services alongside six other providers across Derbyshire. Our commissioners have not indicated an intention during 2013/14 to formally extend patient choice beyond first outpatient consultant led appointments for elective care and those services as covered by AQP outlined above.

We have well established working relationships with our clinical commissioning groups and during the next 12 months we will seek to work in partnership to support the delivery of the collaborative commissioning priorities and action plans as agreed through the Derbyshire Health and Wellbeing Board. Our clinical services strategy reflects the priorities of our local clinical commissioning groups and the requirements of the national commissioning board '5 offers'.

1.5 Plans for collaboration, integration and patient choice

We understand that within the current climate it is vital for us to build and maintain effective partnerships. Our geographical position places us equidistant from two large teaching hospitals within which we have a long history of effective clinical working. We are located within the East Midlands health economy but have clinical links into South Yorkshire and effectively work across clinical networks to ensure our patients receive the highest levels of care. In recent years we have strengthened clinical pathways with Derby Hospitals through vascular services, Nottingham through major trauma and Sheffield for cancer.

We are working in partnership with neighbouring Trusts to develop a pathology alliance from which we have produced a joint bid to deliver the East Midlands Transforming Pathology Services GP pathology service contract. We are undertaking a joint purchasing exercise with partners across East Midlands to procure a Picture Archiving and Communication System (PACS) which will strengthen our ability to develop new ways of working across clinical pathways and are working collaboratively with Nottingham University Hospitals on the procurement of our Patient Administration System (PAS).

Over the last 18 months have been working with our clinical commissioners and partners across Derbyshire to ensure our health and social care services are fit for the 21st Century. This Derbyshire wide programme has initially focused on transforming community services across health and social care to support the development of integrated care teams with a focus on prevention and maintenance of patients within a community setting. We understand the importance of maintaining an effective working partnership with our community service healthcare provider, Derbyshire Community Health Services NHS Trust, both to ensure patient flow through our hospital but also to support patients who have sub-acute health needs to be managed effectively within a community setting. During 2013/14 we will seek to strengthen this working partnership through focusing on improvement of discharge processes and systems as a shared patient experience goal across the health community.

We have a long history of close working with our mental health service provider, Derbyshire Healthcare NHS FT. During the next three years we will work in partnership to explore the potential improvements for patient care in implementing a rapid assessment interface and discharge (RAID) service in line with the Urgent Care Village concept and urgent care pathway developments; and to improve services provided to patients with dementia presenting with acute medical needs as part of our dementia care strategy.

In recent months we have been working with acute Trusts within South and Mid Yorkshire exploring the opportunities to work in a more structured partnership for those particular services for which this approach would be beneficial. This work, alongside our involvement in strategic clinical networks and operational delivery networks, will inform our five year approach to collaborative and partnership arrangements.

1.6 Demand Profile and Activity Mix Changes

During 2012/13 the Trust delivered the following levels of activity:-

Clinical activity cases	Actual 2012/13
Elective	29,575
Non elective	38,898
Outpatients	266,207
Emergency Department (ED)	68,024

As with the national trend the Trust has seen an increase in demand for non-elective activity over the past three years of 2.15% from 10/11 to 11/12 and a further 3.9% in 12/13. This reflects the health needs of our increasingly aging population within our catchment population and the increased complexity of both health and social care needs.

The settlement agreed with commissioners for 2013/14 provides a contract value of £186.4m for patient care income. This is an increase from £174.9m planned in 2012/13 which includes a reduction for tariff pricing efficiency, a reduction for case mix impact experienced in 2012/13 offset by volume growth and additional quality related investments (see 5.2.1).

In line with commissioner strategies regarding demand management of patient referrals we have seen a reduction in outpatient, elective and day case activity which was anticipated and planned for. Where appropriate we are supporting the shift of activity from day case to outpatient setting which is reflected in our underlying contracted activity. The contracted activity for 2013/14 includes non-recurrent activity to support the strategy of reducing waits in some specialties.

Within our 2012/13 submission we reported that our underlying assumption for activity within the 2013/14 contract and 2014/15 contract was nil growth. The settlement agreed with commissioners for 2013/14 includes 1.5% activity growth; predominantly in ED (5%) and Direct Access Imaging (5%).

Section 2 Approach taken to quality

We continuously monitor the quality of healthcare we provide for our patients. We achieve this through our quality governance with systems and processes in place to provide assurance alongside accountability for management and delivery of quality improvements.

2.1 Quality Assurance Processes

We have well established quality assurance processes including:

- **Council of Governors and PPI sub-committee** – Our Council of Governors and PPI sub-committee take an active role in monitoring the quality of services. This is achieved through a programme of regular ward visits to observe first hand the service quality. These visits enable full access to patients, visitors and staff. The council regularly lead on quality improvement projects within the hospital resulting in material improvements for patients. The council also undertakes regular focused review sessions 'holding the board to account'. These sessions focus on the impact on patient care of changes in operational delivery and require members of the board of directors to attend to provide a detailed account regarding plans and actions. Previous sessions have included preparing for winter, IT strategy and systems and cost improvement programmes, with future sessions planned for post project review of ophthalmology pathway changes, further review of the CQC compliance visits and action plans and a review of the proposals regarding potential changes to pathology services.
- **Clinical Governance Committee** - The clinical governance committee is established as a formal assurance committee of the Board of Directors (board) comprising solely of Non-Executive Directors to support the board in discharging its responsibilities by providing objective assurance that we are delivering sustainable, high quality clinical care for patients. The Clinical Governance Committee has specific responsibilities for identifying our quality improvement priorities as published in the annual Quality Accounts, reviewing external information such as Care Quality Commission (CQC) Quality Risk profile and clinical internal audit reports, monitoring the clinical risk register and actions arising from the review of serious untoward incidents; and receiving and reviewing data in relation to key clinical performance indicators. An assurance report is provided by this committee to each board meeting.

Additional assurance is provided by the boards other formal committees, including audit and risk management, who each provide regular assurance report to board. Quality governance is further supported by a number of groups focussed on improving the quality of the services we deliver:

- **Quality Delivery Group** - A sub-committee of our Hospital Leadership team this group has been established to ensure that action is taken, both collectively and individually by directorates, on matters of clinical management which arise from decisions on clinical policy and clinical governance.
- **Directorate Clinical Governance Groups** – Each directorate within our Trust has established a clinical governance group to oversee clinical governance activity throughout the directorate and thereby monitor that processes are in place to ensure patient safety is protected, services are clinically effective and measures are taken to deliver a positive experience for patients.
- **Patient Safety Team** – Our patient safety team works collaboratively across the Trust to support the identification and management of clinical risk, including the monitoring, investigation and reporting of clinical incidents.
- **Trust Mortality Group** – Trust wide forum which meets quarterly to proactively review mortality data, use this to identify diagnosis groups for further detailed study, agree action required and monitor delivery of improvements. The group reviews both Hospital Standardised Mortality Ratio (HSMR) data and Summary Hospital Mortality Index (SHMI) data to highlight areas requiring further investigation.

These processes are underpinned by monitoring of key quality metrics including patient survey information, net promoter scores, compliments and concerns reports, safety thermometer data, nursing metrics and performance against compliance and contractual standards.

Since the publication of the findings of the public enquiry into the care provided by Mid Staffordshire NHS Foundation Trust in February we have held a series of open events across the trust including staff, governors and our board to inform our response. This work is being led by our Medical Director and Chief Nurse and focuses on the key themes of the findings around leadership, care and compassion in nursing and quality assurance processes including the collation and review of complaints data and how feedback from patients can more effectively drive improvements in services. Clinicians across the hospital have been active participants in this process.

2.2 Care Strategy and Key Quality Developments

We have developed our Care Strategy to support the delivery of the Trust's strategic objective of providing high quality patient centred care building on the priority areas as identified in *High Quality Care for All*.

The strategy outlines five key priorities to ensure the quality of essential aspects of care;

1. We will always care for patients professionally and with kindness, compassion dignity and respect.
2. We will always make sure our patients receive the right hydration and nutritional care for their needs.
3. We will always do everything we can to prevent patients falling whilst in our care
4. We will always do everything we can to prevent patients developing pressure ulcers whilst in our care.
5. We will always do everything we can to prevent patients developing an infection whilst in our care.

2.3 Existing Quality Concerns, risks and mitigating actions

Through our risk management and governance processes we have identified the following risks which are captured on our risk register.

Infection Control – In 2012/13 we reported 39 post 72 hours hospital-acquired C. difficile infections, none of which were due to cross infection, against a stretch target of 34. This is the lowest number of cases ever reported by the Trust reflecting a year on year reduction over the last five years, achieved through a range of interventions put in place to reduce the risk to patients, including:-

- Improving education and training for staff through the infection control rolling programme, introduction of the point of care educator, daily infection control ward round on all ward areas, C. difficile antibiotic ward rounds including consultant microbiologist and antibiotic pharmacist.
- Delivery of targeted projects including the '5 moments hand hygiene' campaign supported by the highly visible and audible hand hygiene stations, Governors and infection control team providing patient education regarding the importance of hand hygiene, point of care infection control link nurses in every ward and department and targeted communication campaigns with staff and patients.
- Improving learning and reviewing best practice, including monthly root cause analysis (multi-disciplinary team reviews with the director of infection, prevention and control / chief nurse on an individual case basis to identify individual actions to be taken and highlight potential systematic themes, which is then subject to monitoring and review by the infection control team) and confirmation from the Health Protection Agency that our processes and actions were satisfactory.

Whilst the number of cases reported in 2012/13 exceeded our target by five cases this represented a rate of 0.218 per 1000 bed days which is in line with the national average rate for acute providers during 2011/12 as reported through the Health Protection Agency. To support our aim of further reducing the number of reported cases we have obtained external expert advice from Professor Wilcox of Leeds University, who is the Public Health England national lead for C. difficile. His report indicates that the Trust is taking reasonable steps to reduce the incidence of C difficile, and apart from some suggestions to further improve our current arrangements, he has not identified anything that we have overlooked in our action plans which, if addressed would give us confidence that the new target of 23 cases or less could be achieved. We are also working alongside community colleagues to develop joint actions including education and training for GP practices in relation to antimicrobial prescribing and looking to improve communication across the health community.

In addition to C. difficile the Trust's surveillance programme also includes the antibiotic resistant organisms MRSA (Methicillin-resistant Staphylococcus Aureus), ESBLs (Extended spectrum beta lactamases) and MSSA (Methicillin-sensitive Staphylococcus Aureus). During 2012/13 we were pleased to report only one hospital-acquired MRSA bacteraemia.

Acuity and dependency change of patients – In line with national trends we are seeing an increase in complexity of patients presenting with acute health needs, coupled with an aging population and an increase in patients with long term conditions and multiple co-morbidities. Our quality indicators and feedback from staff via the staff survey in 2011 highlighted that we needed to review our nursing workforce in terms of skill mix and ratio of staff to patients which was carried out using the nationally recognised tool (AUKUH), in line with the Royal College of Nurses recommendations for safe staffing levels predominantly for the older person and benchmarked against neighbouring Trusts. In response to this the Board approved a £1.7m investment in additional 40 whole time equivalent registered nurses.

Our workforce and organisation development strategy identifies how we will support the ongoing training and professional development of staff across the organisation to ensure the delivery of quality, safe and effected care.

Use of Temporary Staffing - Various measures are being taken to reduce the use of temporary staffing, including the additional £1.7 million investment in substantive nurse staffing discussed above, weekly review of staffing and skill mix and investment in consultant and middle grade medical staff across the Emergency

Department. We are also in the process of implementing an e-rostering system to improve the efficiency of our staff deployment. This is a key priority for the trust and is reflected within our workforce and organisational development strategy and efficiency plans.

Quality of patient care in the Emergency Department (ED) – Our internal risk processes, patient feedback and staff concerns have resulted in a full review of the emergency department in terms of the processes and delivery of quality patient care. This resulted in senior managers (executives and nurses) undertaking a 2 week period of observation working with staff, engaging with patients and relatives. These observations have been used alongside analysis of risks, incidents, complaints and feedback, sessions held with ED sisters and staff which have identified a number of pilots to improve both processes and quality of patient care, for example the introduction of 'pit stop' assessment processes. There have been a number of visits by multi-professional teams to other emergency departments to look at processes and to share knowledge and ideas. The trust has also initiated a visit from the National Emergency Care Intensive Support Team to support the whole North Derbyshire system in improving its management of emergency patients.

Compliance Against CQC Essential Standards – Following the Dignity and Nutrition inspection programme visit in August 2012 we were assessed as compliant against staffing and safeguarding, with a minor concern in relation to privacy and dignity and also documentation; and a moderate concern raised regarding nutrition and hydration. Since the review we have taken the following actions to ensure compliance:-

- Privacy and Dignity - Established senior nurse assurance rounds in line with the DoH 15 Step challenge, updated the essential care records to ensure staff re-assess patients essential needs based on a daily assessment, Dignity in Care assessment process initiated within four wards, patient property policy re-issued to all card staff
- Nutrition and Hydration – In additional to the actions outlined above we have appointed a patient services advocate to work in partnership with patients, staff and catering department, undertaken patient food testing with staff and Governors

Over the coming months we will continue to improve our services for patients to ensure that the essential standards are met. We are working with Derby University to agree an education and training package in relation to nursing documentation and care planning, as detailed within our Organisational Development plan during summer 2013 we will roll out a Trust wide engagement process in relation to our values and behaviours, we are undertaking a trust wide review to develop appropriate standards for bedside lockers and management of patient property, we are developing a dementia strategy which will include the development of a dementia friendly standards for all trust future capital projects and we will roll out Dignity in care assessments across all wards.

Staff Survey - Results from the national 2012 staff survey show marginal improvement; but overall the results confirm that improving staff engagement continues to be a priority for the Trust. Worries about nurse staffing levels, reliance on agency nurses, pressure of work and time to care have begun to be answered through the investment described above, however the additional nurses had yet to be deployed at the time of the survey. The Trust has identified a number of specific areas for action based on feedback from our staff including improving the effectiveness of appraisals, better communication, addressing poor behaviour and giving staff greater freedom to improve their services.

The Trust has already invested in workforce and organisational development skills; with an additional director position established on the board; and 'front-line' expertise to set out engaging staff in a planned way. Over the coming year the Workforce and Organisational Development strategy will begin to respond to some of these crucial issues, building on work that includes the creation of a robust leadership development programme; new appraisal processes - and on embedding the hospital's 'journey' across the organisation, including its Proud to Care values. Further details are provided in section 3.3.

Mortality Rates - Our mortality rates have continued to reduce year on year in real terms but as the national figures are also reducing our HSMR and more recently SHMI have remained at steady levels. We proactively review our actual mortality in real time, this work is led by our Mortality Champion who chairs our recently established Mortality Group, identifying any concerns and requiring directorates to complete a full mortality review into any areas that are identified via the Dr Foster HSMR figures as potential outliers. In 2012/13 up until December we had demonstrated a decline in mortality which was predicted to result in our lowest HSMR to date, however in the last three months of the year our actual mortality has increased which will result in our HSMR not reducing by less than anticipated.

Over the past few months the group has reviewed mortality in patients with admission diagnoses of community acquired pneumonia and gastroenteritis in which higher than expected mortality rates were reported. This work led to further actions being planned including redesign and re-launch of a trust-wide fluid balance chart, a plan to raise awareness and promote use of the CURB65 (confusion, urea, respiratory rate, blood pressure and age) assessment tool for community acquired pneumonia and to work with the coders to explore possible closer clinician/coder liaison to further improve coding accuracy. In response to the recent increase in our raw mortality score our work plan for the coming months will focus on a review of urinary tract infection deaths,

congestive cardiac failure related deaths and sepsis related deaths, to lead to specific recommendations for care developments / improvements in these areas.

Harm Free Care – During 2012/13 we have used the national safety thermometer tool to assess the potential harms caused to patients. The tool looks at four key healthcare associated harms: pressure ulcers, falls, catheters and urinary tract infections (UTI) and venous thromboembolism (VTE). Over the past year action has been particularly focused on reducing the number of hospital-acquired pressure ulcers and this has resulted in a significant improvement in performance. We are continuing this focussed approach to support improvements in the following areas:

- A falls group has been established to lead work on improvements in this area, this includes reviewing the risk assessment process and care pathway for patient identified as being at risk.
- The Trust has focussed on ensuring that all patients are VTE risk assessed on admission and from April 2013 will be undertaking a root cause analysis on all patients identified as having developed a healthcare associated VTE.
- The Infection Control team is focusing on the appropriate use and management of catheters to reduce the incidence of catheter-associated urinary tract infections.

In addition to these specific areas, it has been recognised that good, visible leadership at ward level is required to ensure that patients receive the best possible care; to achieve this we are reviewing the roles of our matrons to ensure that they are able to spend at least 60% of their time on their wards. To support this we have also introduced regular senior matron assurance rounds to ensure clear oversight of care delivery.

Section 3 Clinical Strategy

3.1 Clinical strategy and strategic priorities

Our clinical services strategy builds on our mission to be a first class district general hospital and specifically supports our corporate objective of *delivering sustainable appropriate and high performing services for our patients and communities*; and alongside our Care Strategy are the means by which we will drive sustainable quality improvement.

Changing patient demographics, workforce availability and development of novel and alternative forms of treatment requires a robust review of our clinical service portfolio. It remains an overriding imperative that our services must provide safe and effective care to our patients in a timely manner and must do this within an agreed financial envelope. By engaging with our patients, staff, commissioners and local communities our Clinical Services Strategy will provide the framework by which we review each of our clinical services, developing them as necessary, forming partnerships with other providers where this provides the best model of high quality care and occasionally withdrawing from provision of a local service. The strategy will also identify any areas where we believe we could offer a better service than other providers so will also highlight new areas in which we could provide health care.

Our emerging vision for our clinical services can be summarised under the following strategic priorities:-

3.1.1 Improving the urgent care pathway for our patients

Our aim is to ensure that the quality of care we provide for our patients is of a consistently high standard regardless of the time or day of presentation. We aspire to get it right first time every time for all points on the patient journey from first contact to when the patient is discharged from our care.

To achieve this we are engaging across the whole health community to undertake the planning and development of an Urgent Care Village. This concept is intended to enable a true whole system approach to the clinical management of patients presenting for urgent healthcare. We have engaged Health Planners to support the development of the model of service for the Urgent Care Village. This work will begin in the early part of 2013/14. Through this process we will be seeking commissioners support for the new model aiming to commence the necessary capital works before the end of the year as identified in our site development plan.

As part of this model we will seek to co-locate paediatric and adult assessment services, both surgical and medical, alongside our emergency department and further develop partnership working with co-located urgent primary care providers so a seamless flow of self presenters can be steered towards the most appropriate service. We will seek to deploy more senior clinicians at the front end of our processes by locating more of them within the Urgent Care Village and ensuring separation of assessment processes from admitted patients. This will also add to the significant progress in ambulatory medical management of patients we have already achieved. Early senior assessment will aid rapid diagnosis and the initiation of the appropriate care helping to prevent unnecessary admissions or shortening length of stay by starting the right treatment immediately.

We are working with Derbyshire Community Health Services NHS Trust to improve pathways between our hospital and our local community hospitals with the aim of streamlining discharge and improving patient

experience during transfer ensuring comfort and dignity. The rapid access to assessment and diagnostics using the Urgent Care Village model will aid a rapid return to community services for patients whose treatment can be appropriately and safely provided there.

By streaming patients appropriately and improving immediate access to senior decision makers and diagnostics we will also assist in ensuring we meet the target times for ED patients. This work will also include the expansion of our diagnostic services to enable 7 day working thus ensuring appropriate access to key information relating to diagnosis and treatment whatever the day. Finally this work will embrace the concept of planning discharge from the moment of admission. The fact that this major piece of work will involve all providers of health and social care will help to develop this ethos.

3.1.2 Ensuring our planned care services are of high quality and sustainable

Our aim is to ensure that the quality of care offered to patients is of a consistently high standard regardless of which of our services they need.

To achieve this we are working with our commissioners to increase interventions in an outpatient setting where clinically appropriate. Our transformation programme will support us in improving our day case rates and further adoption of enhanced recovery techniques will clinically drive reductions in our average lengths of stay. We will build on the success of our theatres admission lounge by investing in redesign of our theatres as part of a two year refurbishment programme which will commence in the summer 2013.

Where appropriate we will seek to improve the patient experience and gain greater efficiencies from enhancing the 7 day working across services by providing a greater flexibility of planned care provision. The initial aim of extending the working week for planned care will be to give easier access, particularly to outpatient services, for patients with working commitments in normal office hours.

3.1.3 Delivering our commitment to providing robust and accessible cancer care for our local population

We will work with our cancer network to further develop the oncology services provided for patients locally. We will seek to embed the acute oncology service established in 2012/13, which supports our aim to strengthen urgent care services and provide more ambulatory models of care. We will improve the environment within which we provide chemotherapy services for patients and expand the numbers of regimes offered. We will also work with our partners to enable rapid development of home delivered chemotherapy as new drugs and regimens become available. We will improve non-chemotherapy out patient treatments for all oncology patients recognising the importance of minimal hospital time to this group of patients.

To achieve this we have developed a comprehensive acute oncology service model and are redesigning our local diagnostic pathways to reduce current waiting times. We have increased capacity to respond to the rise in demand for bowel cancer services and continue to work alongside our local commissioners to project future increases in demand as a result of patient awareness campaigns. We have commissioned a healthcare planner and architect to undertake a feasibility study regarding the development of a new cancer unit and are exploring the potential benefits of co-locating haematology and solid tumour chemotherapy services.

As detailed above we already have actions in place to deliver improvements towards our strategic priorities, however we acknowledge that further work is required to shape a five year transformational programme supporting the delivery of our clinical services and care strategies.

3.2 Service line strategy over the next three years, process used and clinical sustainability

We have developed a programme of work, which will be delivered during the coming months, supporting our directorates to undertake a detailed analysis of individual service lines to test for long term sustainability and where necessary develop plans to address any areas of weakness. We will use the Monitor sustainability tests to ensure the strategies are developed to deliver services which are clinically, operationally and financially sustainable, which provide a high quality experience for our patients. The underpinning demand and activity projections to support our strategic analysis will be jointly agreed with our commissioners and we will continue to engage with key stakeholders to inform and challenge our analysis and strategic options.

To enable the development of service line strategies we have classified our portfolio of services against the following areas:-

- *Acute Core* – the portfolio of services that are essential for us to provide for acutely unwell patients within our catchment population.
- *Supporting Core* – the portfolio of services which support the delivery of the acute core services and are interdependent
- *Value Added* – the portfolio of services that are not considered to be core DGH services required for our catchment population, but are valued by our community.

We have identified the following high level strategic options that we believe are available to us based on the classification of services:-

Service Line Strategy	Acute Core Services	Supporting Core Services	Value Added Services
Invest	•	•	•
Divest			•
Redesign	•	•	•
Partner		•	•

A framework will be developed to support specialties to review the data from the strategic analysis and determine the strategic options available based on the following principles:-

- The trust will continue to provide a balanced portfolio of services
- All of the services we provide will be of the highest quality compared with national indicators and benchmarking
- We will seek to maximise the financial contributions of the services we provide to ensure the sustainability of our service portfolio
- Our staff will be fully engaged in developing and implementing the clinical services strategy
- We will continue to develop strategic partnerships where this offers opportunities to strengthen the service portfolio we provide
- Our service portfolio will be provided in line with clinical commissioner requirements

3.3 Workforce

Our strategic workforce plan is designed to support the implementation of the clinical services strategy and the achievement of the six strategic objectives for the hospital. It specifically underpins the achievement of *delivering sustainable appropriate and high performing services for our patients and communities and supporting and developing our workforce.*

As discussed within section 2.3 our 2012 staff survey highlighted that staff in the Trust are feeling pressure and don't feel able to give the care they want to patients. Staff are positive about the career opportunities that exist, although it is clear that they don't feel they always get the right level of support from their line managers for their personal development or to be able to perform at the right levels in their roles. In response to this and to support the overall Trust strategy the workforce strategy can be summarised as follows:

Strengthening our workforce planning processes and initiatives to ensure we have the right numbers and skill mix in the workforce to deliver the strategic objectives.

Following the nursing staffing review last year and the decision to invest an additional £1.7m in frontline nursing staff, staffing levels in the majority of hospital directorates are at the required levels. However there are key areas in the hospital where we need to devise plans to manage the workforce to ensure the service is not impacted over the next 3-5 years and that we are proactive in sourcing the right skills for the Trust

- Ongoing middle grade doctor shortages will require creative recruitment approaches and a review of the use of roles such as Physician's Assistants and Advanced Nurse Practitioners to provide services in different ways, in particular in ED and Critical Care;
- The influence on future training numbers across a number of specialisms, e.g. anaesthetists and oncology and ITU nurses
- Reviewing how we use our bank and flexible resource both internally and in partnership with others externally to minimise costs of using locum and agency staff.
- Formalising our education framework to ensure we are able to enhance the skill mix across medical and clinical staff, reviewing the role of NVQs and also training for key groups such as healthcare assistants in the follow up to the Francis report.

Reviewing and developing our learning and development provision to support the clinical services strategy and the changing requirements of patients.

There are a number of changing requirements for patients, e.g. the increase in dementia which require us to review our learning and development focus to up skill our staff to deal with these new and growing challenges. In light of the potential shortages in a number of staff groups we also need to ensure our approach to apprenticeships and internships provides us with a stable platform to both grow and attract the right skills in the future. A review of our rolling programme and specialist skills training will ensure we are well equipped for future needs. We will also engage with partners across the region to optimise use of available resources.

Reviewing work patterns and remuneration packages across the Trust

To support the clinical services strategy certain services will be required across more times in the hospital. To enable the delivery of this service we will need to review working patterns and our approach to 24/7, 7 day and out of hours working to both provide the right care for patients and effective ways of working for staff. We will also be looking at optimizing flexibility under Agenda for Change to ensure that our employment of staff is done in the most cost effective way possible whilst not damaging staff engagement and commitment.

To put in place an organisation development plan to develop leadership capability and build staff engagement in the Trust

Staff engagement at the Trust is not as strong as we would like and a plan is being devised to build leaders' capability to lead teams effectively and also to build a stronger link between each individual member of staff and the overall aims of the Trust. The plan being developed incorporates a number of elements:

- Leadership development modules designed to equip all leaders with basic skills such as undertaking appraisals, having difficult conversations, coaching.
- A formal middle and senior leadership development programme to give more enhanced skills to our most capable leaders, particular in the areas of leading strategy, innovation and change
- Increased communication activity and facilitated sessions with staff to build their understanding and engagement with the Trust strategy and values
- A review of the appraisal process to improve the management of performance in the Trust and the development of performance frameworks for all key staff groups
- Introduction of more formal talent management frameworks to aid the development of potential in the Trust
- Development of HR capability to support the delivery of the plan
- Review of our policies and processes to ensure they are enabling leaders to lead effectively and not constrain them

To lead on the delivery of the workforce strategy we have created and appointed to a new post of Executive Director of Workforce and Development.

3.3.1 Impact on Costs

Current headcount in the Trust is 3651 and it is anticipated that this will increase slightly due to the arrival of the additional nurses recruited during 2012/13, however other than that we expect workforce levels to remain relatively stable. Small changes will happen as a result of efficiency initiatives across the Trust to achieve our Cost Improvement Plans (CIP) targets for 2013/14.

In addition work will be done reviewing staffing models and flexibility under Agenda for Change terms and conditions to drive improved productivity and reduce pay costs to identify potential contributions to the £33m cost improvement targets over the next 5 years.

Turnover and sickness absence are both higher than we would want, the Organisational Development strategy and the impact of the additional nurses are hoped to gradually start to improve this as we build staff engagement with our future plans. A 10% reduction in both is being targeted over the next two years.

Locum and agency spend are at unacceptable levels in some areas and specific plans are underway in microbiology, ED and Ophthalmology to reduce spend on locum doctors. The investment in permanent nursing roles will reduce the agency spend. The review of the bank will also be a way to reduce the spend and we have targeted a reduction of £0.9m in the year (See 4.3.4 for more detail).

Section 4 Productivity and Efficiency

4.1 Potential productivity and efficiency gains

4.1.1 Overall productivity and efficiency challenges

The overall productivity and efficiency gains built into our plans over the next 3 years are as follows:-

	2013/14	2014/15	2015/16
£m	6.5	6.7	6.6
%	4.0	4.0	4.0

4.1.2 Overall approach taken to the efficiency challenges

Given the size of the efficiency challenge for 2013/14 and beyond as shown above, we believe that this cannot be delivered simply through short term incremental changes to the cost base. Instead we have developed a different approach to our efficiency programme from 2013/14 to 2017/18 by establishing a Transformation programme. This is designed to look fundamentally at how we provide services differently so that the clinical

quality of services provided to our patients can be improved during a real terms reduction in funding available to the Trust.

We have used external support via KPMG to help us focus much more on larger projects looking within and outside of the organisation to deliver step change projects. The aim of our Transformation programme is also to focus far more on the medium term in terms of how we change service delivery models to ensure we have a balanced portfolio of sustainable services in terms of clinical, economic and operational sustainability.

We have also set out more formal Programme Management Office (PMO) arrangements via the Trust's Innovation Board and Transformation Support Team to engage staff and provide support to generate ideas for transformation projects and to help them ensure that they achieve full benefit.

We have split our Transformation programme into three areas, being:

- *Primary schemes* - where directorates are empowered to progress quickly with simple schemes which affect only their area (eg orthopaedic hip and knee prosthesis tender).
- *Secondary schemes* - being larger schemes which encompass more than one area working together within the Trust for successful delivery. (e.g. elective pathway redesigns)
- *Tertiary schemes* - again being larger schemes which involve working with partners outside the Trust to deliver services differently across integrated care pathways or across different geographical areas. (e.g. East Midlands Pathology Alliance)

4.1.3 Overview of efficiency schemes 2013/14 and beyond.

For 2013/14 we have already populated our Transformation programme with savings of £6.5 million based largely upon successful pilots in 2012/13 of changes in the way we provide services. These are summarised as follows, with further detail provided in section 4.3 and 4.4 :-

	£m
Primary Directorate Schemes	1.6
Urgent and non urgent care pathways (reduced length of stay)	1.0
Community Services therapies and diagnostics	0.9
Integrated care pathways (reduced length of stay/discharge)	1.4
Reduced Agency/Locum spend	1.1
Other	0.5
	6.5

4.2 Cost Improvement Plans (CIP) governance

We have a long history of delivering Cost Improvement Plans underpinning our solid financial performance over the last eight years as a Foundation Trust. However, we recognise that despite this the approach to identifying and delivering efficiencies needs to change. Time has been spent during 2012/13 in developing a different approach to future efficiencies, moving the mindset from CIP's/efficiencies to one of a Transformational Change programme being implemented over the next 5 years.

The rationale driving this change in approach is a recognition that 'low hanging' CIP's/efficiencies within the Trust have largely already been made as we have delivered annual efficiencies of 3 to 4% per annum over recent years. Our Transformation programme recognises the reality that we cannot keep providing services in the same way given diminishing resources and the need to maintain and improve quality. The programme is therefore designed to fundamentally review the way in which we provide services given the need to improve the quality of services delivered for our patients within fewer resources.

To deliver the Transformation programme we have established an Innovation Board, reporting to the Hospital Leadership Team (HLT), and a Transformation Support Team (TST). The TST is in effect a Programme Management Office (PMO) type approach providing both support and leadership for Transformation/Innovation projects, and an assurance mechanism to track benefits realisation and successful delivery of these projects. The role of both the Innovation Board and TST is to promote a culture of continuous innovation and improvement to the way we provide services and ensure that there is a buy-in to such a culture within the Trust.

The Innovation Board's role and function is crucial and is set up to:

- Promote a culture of innovation in practice across the organisation and provide a clear focus for this, and facilitate the dissemination and adoption of good practice across the hospital.
- Promote all activities relating to innovation and change, including the Choices project, NHS innovations and LEAN working.
- Provide advice to staff and signpost practical support, to enable individuals or teams to develop an innovation idea in service improvement into a practical process.

- Review and appraise business cases for service improvement in order to advise the Hospital Leadership Team on those with practicable application.
- Promote innovation programmes, acting as an agent for service change and continually challenging the status quo.
- Promote the sharing of good practice across the organisation, to enable rapid change and adoption when appropriate.
- Promote and support innovation and service improvement, and a positive, empowering leadership style.
- Secure effective cross-directorate, multidisciplinary working on cross-cutting themes and issues.

In addition to creating the right environment to promote and support ideas for innovation and a culture of change and service improvement, the Innovation Board has another important role in supporting the implementation of innovation projects, to ensure that benefits are fully realised.

Programme Management Officers (PMO's) are being used by many NHS organisations with regards to overseeing the process for delivering CIP's/efficiencies and innovation projects. Having reviewed the operation of PMO's elsewhere, we believe that too rigid a PMO process leads to loss of clinical engagement and ownership of delivering innovation plans, with it becoming seen as a managerial process which is bureaucratic, time consuming and costly.

We therefore believe that whilst it is crucial that a PMO style process is put in place, it must be one that very much supports clinicians to deliver their innovation projects, getting their full engagement in realising the benefits of their projects, without the PMO being seen as a top down managerial process.

The Trust's PMO approach is therefore one of a Core Transformation Support Team (TST) who's role is to:

- Provide support for the formulation of innovation projects and to work with staff to turn good ideas into transformation projects.
- Support the ideas through the Innovation Board and to commence them as projects.
- Support staff in ensuring that the benefits of projects are fully realised and that obstacles to non-fruitition are removed.
- Provide assurance to the Innovation Board via its monthly meetings and weekly TST meetings with directorates that plans are on track to deliver.

The TST is therefore a central support resource for the directorates to utilise. However, the main focus of the Transformation programme needs to come from, be owned by, and be delivered by front line staff within the Trust. We have therefore been embarking over the last two years on a programme of training and developing staff within the directorates to deliver transformational change.

The Trust's Innovation Centre has devised and delivered a training package for Change Agents, Service Improvement Leads and link points for transformation within directorates. There are now 52 trained Change Agents within the organisation and all directorates have dedicated Service Improvement Leads and link points for the Transformation programme. The approach taken is one of front line staff being empowered and being given the right tool kit and training to deliver transformational change, whilst also having access to a central support team to help develop ideas and to deliver change programmes.

4.3 Cost Improvement Plans (CIP) profile

Appendix 2 provides a summary of the Trust's main Cost Improvement Plans (CIP's).

Section 4.4 identifies the work which has been done to create Project Outline Documents which are being used to identify and facilitate transformation projects sequentially for 2014/15 to 2017/18, many of which fall into the Top 5 CIP schemes noted in Appendix 2. The focus of the transformation programme is also medium term in nature focussing on a 5 year programme of service redesign and has identified saving opportunities of between £35.4m and £58.9m against a forecast requirement of £33.3m.

For 2013/14 commentary on the top 5 schemes is as follows:-

4.3.1. Review of Urgent and Non-Urgent Care Pathways - £1.0 million

In line with our strategic objective to improve the urgent care pathway for our patients a series of transformation projects have been successfully piloted within our Medicine directorate to improve patient flow. This work has led to a reduction in the average length of stay for non-elective medical patients of 1 day in 2012/13 compared to previous 5 years. Initiatives have included:

- Appointment of additional supernumerary dedicated discharge co-ordinators across medical wards
- Implementation of a bed based discharge lounge and more focussed use of the discharge lounge earlier in the day
- Routine weekend access to radiology for inpatients
- Access to specialist opinion (eg respiratory and cardiac) on a daily basis within Emergency EMU/CDU

- Routine weekend access to physiotherapists and occupational therapists.

Key performance indicators have been identified for each of the above schemes (eg percentage of weekend radiology scans reported and acted upon on the same day / next week at weekend leading to timelier discharge) to ensure that the benefits of schemes are fully realised.

The reduced average length of stay in medicine of 1.0 day as a result of the above initiatives has meant that acute bed capacity can be reduced by 34 beds (1 ward) for the same activity levels. Gross savings of £1.7 million for 2013/14 onwards for the reduction in the bed base are offset by the recurrent investment in the continued operation of the initiatives at a cost of £0.7 million. Net savings therefore total £1.0 million from the initiatives.

From 2013/14 onwards further work is taking place in the surgical and orthopaedic directorates to pilot similar schemes, focussing on redesigning the non urgent care pathways to reduce length of stay and make other associated savings. These form part of the 37 Project Outline Documents, and will be piloted in 2013/14 and implemented in 2014/15 and beyond.

4.3.2. Review of the Integrated Care Pathway - £1.4 million

In addition to the 1.0 day reduction to the average length of stay for non-elective medical patients, the Urgent Care Pathway transformation projects also meant that a further tranche of patients benefitted from patient flow initiatives and were medically fit for discharge sooner than before. Whilst this is not reflected in further reductions on length of stay (as they were still in acute beds awaiting discharge rather than having been discharged), we successfully piloted use of a 28 bedded step down ward during 2012/13 where patients could be placed whilst discharge to home, community or social care settings was progressed.

From 2013/14 the step down ward will be separately funded by Commissioners, who recognise that improvements need to be made to the integrated care pathway to enable speedier discharge into the right non-acute care setting for the patients, once the acute phase of their treatment has finished.

From April 2013, the patients are being medically discharged onto the step down wards. This will lead to further reductions to the non-elective medical acute length of stay. 28 acute medical beds are therefore being decommissioned and replaced by 28 step down bed on site where patients will have been discharged and are awaiting placement into other non-acute settings. We are working with commissioners and our Health and Social Care partners during 2013/14 to facilitate speedier movement of these patients out of our step down beds. Should this be successful, the need for onsite step down facilities should reduce.

The savings from the above initiative in medicine from 2013/14 onwards is £1.4 million.

In 2013/14 we will also extend the work noted above into surgery and orthopaedics to facilitate reduction in average length of stay to be implemented if successful from 2014/15.

4.3.3. Community Services Therapies and Diagnostics - £0.9 million

During the course of 2012/13, a review took place across community paediatric service care pathways. The review indicated that investment was required to realign contracts as both service volumes and specifications had grown over recent years without being adequately funded due to the contracts being block by nature.

Investment of £1.5 million has been agreed to realign contracts. The work has also highlighted that part of the imbalance between funding and volume specifications was being cross-subsidised by other efficiencies which had been realised with the Women and Children's directorate but which could not be released as efficiencies. These total £0.5 million which are being released into the Trust Transformation programme now that the community paediatric service contract has been rebalanced.

Detailed work on care pathways has identified a further £0.4 million of savings based on revised protocols to demand manage diagnostics more appropriately.

4.3.4 Agency/Locum Workforce - £1.1 million

The Trust's agency locum expenditure has grown significantly in recent years, and part of the Trust's clinical strategy is to look at economic, operational and clinical sustainability by service line. Part of that review is focussing on our ability to retain and recruit the appropriate clinical staff to support workforce requirements. For medical locum agency, three areas have been focussed upon in 2012/13 namely ED, Microbiology and Ophthalmology.

In ED, where there has been a high degree of locum spend over the last two years, we have been actively recruiting into vacant posts and re-designing posts to make them more attractive to potential candidates. This has been successful and all consultant and middle grade medical posts have now been filled leading to significant reduced spend on locums, which will be released from our locum contingency reserve.

Likewise, locum costs for Microbiologists have been high over the last two years due to two vacant microbiologist Consultant posts and the need to cover out of hours through locums. One of the vacant posts has been filled and alternative out of hours cover arrangements are being finalised with a shared on call service with a neighbouring trust. Both of the above will lead to a significant reduction in locum costs currently being funded from contingency.

Ophthalmology is another area where first tier on call arrangements are being reconsidered to significantly reduce locum spend.

Targeted savings from the above three areas where alternative service models have been put in place will lead to savings of £0.9 million in 2013/14. Savings of a further £0.2 million in reduced nursing agency spend following the appointment of 40 additional nursing staff has also been agreed.

4.3.5. Primary Schemes - £1.6 million

Primary schemes for efficiencies within individual directorates have been identified and agreed (for example £0.4 million on the retendering of orthopaedic hips and knees appliances). The schemes have been quality assured (see section 4.5, for more detail on quality assurance process).

4.4 Cost Improvement Plans (CIP) enablers

4.4.1 Clinical leadership and engagement

For the Transformation programme outlined in section 4.2 to be successful there is a need for strong clinical leadership and a high degree of clinical engagement.

There needs to be a strong level of buy in to the transformational change programme within the organisation, top down from the Board and bottom up from front line staff. There is also a fundamental need for a change, from the traditional view that the CIP/efficiency programme is finance driven and that it is the finance department's task to lead on this.

Improvements and changes to the way services are provided need to be owned and driven by our staff. Making sure there is strong clinical engagement is essential and strong clinical leadership is required at Board level and Clinical Director level. Even more crucial is the need for clinicians within the organisation to be empowered to constantly innovate. They need to be given the skills and support required to drive through potentially difficult changes, given the scale of the challenge ahead, and also they need to be supported to achieve the benefits realisation of the changes.

The focus of the Transformation programme is therefore on front line staff being empowered and trained to provide them with capacity, capability and confidence to be working out in directorates on developing and formulating Innovation Projects and executing their successful delivery with full benefits realisation. To facilitate the above the Innovation Board is largely clinically focussed, being chaired by the Medical Director, and consisting of multi-disciplinary representation of Doctors, Nurses, Therapists and other staff from within the hospital. The Innovation Board is also supported by the Transformation Support Team.

The Board, Hospital Leadership Team and the Innovation Board also recognise the need to ensure that a supportive culture exists and is maintained towards innovation and transformational change. Focussing on current clinical practice, how it can be improved, pushing the boundaries in terms of how we can redesign and improve services and not accepting the status quo, will be at times difficult. Staff therefore need to feel assured that they can carry out this difficult element of their role. Without a supportive transformational culture, staff will not feel willing to generate and try new ways of working, some of which may be fundamental changes in practice.

4.4.2 Investment in infrastructure / projects to enable Cost Improvement Plans

The Transformation Support Team (TST) is there to support the Service Improvement Leads, Change Agents and Link Points who are based in directorates leading transformational change at the front line.

A significant investment of over £700,000 has been invested into the Transformation programme infrastructure detailed above, with the TST Central Team, Service Improvement Leads, and Change Agent element roles being supernumerary in nature. The aim is to ensure that the Transformation programme is sufficiently resourced to avoid being sidelined by the need to 'do the day job'

In addition to the above, external support has been and will be brought in when there is either a need to stimulate thought processes and to deliver additional capacity if required. KPMG were appointed during 2012/13 to work with the Trust to provide support to identify and scope efficiency and service transformation opportunities over the next five years.

The approach agreed with KPMG was to:

- Undertake a rapid review of key opportunities across clinical pathways, directorates, Trust wide and externally within the wider health community (CCGs, Local Hospital Trusts and Mental Health Trusts where relevant to the approach).
- Based on the findings from the rapid review recommend 5 year efficiency project schemes at secondary and tertiary level to support our agenda of efficiency requirements over the next 5 years.
- Bring expertise in benchmarking against other Trusts, providing a priority area gap analysis (in all aspects of service delivery).
- Perform a service line sustainability review (accessing existing Trust service line information) to advise on long-term financial stability of clinical pathways and benchmark level of efficiency in comparison to other Trusts of a similar size/nature.
- Provide evidence based best practice opportunities in comparison to other hospitals (both locally and similar size).
- Identify 'outlier' issues in terms of overall CRH efficiency based on experience of other organisations.
- Provide feedback on our Transformation programme governance arrangements.

The above work was completed following a detailed benchmarking exercise and a series of workshops being facilitated with staff. The output of the work was finalised in April 2013 and is focussed on delivering a programme of transformation projects for the period from 2014/15 to 2017/18.

The work has identified 37 Project Outline Documents covering 85 separate areas for service improvement, which have also been categorised by size of impact and complexity to deliver. The base savings opportunities total £35.4 million over a five year period efficiency requirement (against a forecast requirement of £33.3 million), with a potential opportunity at stretch of £58.9 million.

The report has been considered by both Hospital Leadership Team and with wider staff at a separate Leadership Assembly in April 2013 and was presented to the Trust Board in June 2013. The next stage of the output from this work is assess the viability of converting the identified project opportunities into transformation projects appropriately phased over the next 5 years, which we will complete by the autumn of 2013.

To compliment delivery of the 5 year Transformation programme we will also be developing the Clinical Services Strategy at a more granular level by sub speciality/service line to determine clinical, financial and operational sustainability, (see section 3.2 for more detail) which will be linked to the Trusts transformation programme.

4.5 Quality impact of Cost Improvement Plans

Prior to the Trusts CIP programme being implemented, CIP's are assessed by the Trusts Medical Director, Chief Nurse and Director of Finance and contracting to ensure that they are:

- Financially deliverable
- Have measures in place to ensure that clinical quality is not compromised
- Have evidence of staff engagement

Only when the three tests noted above have been passed will CIP's be allowed to progress

The Quality Assurance process is designed to identify prior to CIP implementation the risks from a financial, quality and delivery point of view. Similarly CIP's undergo a commissioner review via a Quality impact assessment / rating as part of the work of the joint commissioner and provider Quality Assurance Groups.

The Trusts Innovation Board regularly tracks CIP's as they are implemented to ensure that clinical quality is not compromised and progress against CIP's is reported to the Board on a monthly basis. Any CIP's which do not deliver from a quality and finance point of view will be reversed with alternative proposals than being sought. Any slippage on CIP's is non-recurrently managed through use of the Trust's contingency reserve. The Trust achieved its 2011/12 CIP requirement of 4%.

5.1 Trust financial position

5.1.1 Opening financial position

The Trust enters the 2013/14 financial year in a strong position. The Trust achieved a surplus of £2.6m (plan £2.7m). This included an impairment of £1.5 million (plan £1.3m) meaning this underlying surplus was £4.1m (plan £4.0m)

The Trust also holds contingency reserves of £3.2m and £4.2m of uncommitted CQUIN funding to help manage any cost pressures during the course of its financial year. Cash and liquidity is strong with cash at 31st March of £44.2m (plan £42.4m) and the Trust had a finance risk rating of 4 throughout 2012/13.

5.1.2 Financial Projections 2013/14

These are summarised as follows:

	2013/14 £m	2014/15 £m	2015/16 £m
Turnover	204.3	202.2	200.1
EBITDA	12.7	13.0	13.3
Surplus before impairments	2.6	2.6	2.6
Impairments	(0.9)	(0.5)	(6.0)
Surplus after impairments	1.7	2.1	(3.4)
Cash	41.0	37.1	35.6
Financial/Continuity of Service Risk Rating	4	4	4
Contingency reserve / CQUIN funding remaining	6.9	6.9	6.9

Impairments relate to downward revaluation of assets. The impairments noted above, particularly in 2015/16, relate to capital expenditure on major schemes (see 5.2.2 on theatres, urgent care village, cancer) being more than the increased value of the asset, resulting in the asset value being impaired on completion down to their new estimated value.

The impairments are therefore a technical accounting adjustment and the surplus before impairments is the true measure of the underlying financial performance of the trust.

5.2 Key financial priorities and investments

5.2.1 Key investments are summarised as follows:

	£m
Planned growth in activity	1.8
Investment in nursing quality	1.7
Increase in ITU capacity	0.8
Community paediatric investment	1.5
Additional step down facilities	1.4
Increased emergency capacity	1.7
Admission avoidance / 7 day working	1.7
Transformation programme infrastructure	0.7
Changes to tariff structure	1.0
Non-recurrent initiatives	1.0
Less net tariff deflator	(1.8)
	11.5

These link into the Trust's overall strategy as follows:

- Planned growth in activity of £1.5 million and emergency capacity of £1.7 million is being made to ensure that there is sufficient non elective capacity for 2013/14 and to ensure Referral to Treatment targets are achieved.
- £1.7 million of investment in additional ward staffing levels is being made to support improvements in the quality of care provided to patients as a response to the 2011 staff survey and a review of ward staffing levels during 2012.

- Investment in ITU capacity of £0.8 million relates to the full year effect investment for the 7th ITU bed which was opened in 2012/13.
- Investment in community paediatrics of £1.5 million is being made to realign contracts where both service volumes and specifications have grown over recent years (see also 4.3.3).
- The £1.4 million investment in step down facilities is being made to provide on site capacity for patients who are medically fit for discharge but are awaiting arrangements to be finalised for home, community or social care settings (see also 4.3.2).
- The £1.7 million investment in admission avoidance/ 7 day working schemes relates to a number of initiatives designed to avoid emergency admissions (eg investment in additional senior clinical decision makers in Emergency Care/Emergency Admissions Unit) or for increased seven day working (eg weekend radiology and therapy support for inpatients). See 4.3.1. for more information.
- The £0.7 million investment in the Transformation Programme infrastructure is being made to support the work of the Transformation Support Team (see also 4.4.2).

5.2.2 Capital expenditure programme

Capital expenditure investment is forecast as follows:

	Reference	2013/14 £'000	2014/15 £'000	2015/16 £'000
<u>Development</u>				
Theatres		3,370	4,054	3,490
Urgent Care Village	3.1.1	100	3,000	1,000
Cancer Centre	3.1.3	113	2,000	500
Endoscopy Upgrade			100	1,000
Second CT Scanner		720		
Discharge Lounge	4.3.1	450		
Medical Record Extension		490		
EMU/CDU Development		60		500
TOTAL		5,303	9,154	6,490
<u>Maintenance</u>				
Clay Cross Clinic refurbishment		150		
Buxton refurbishment		100		
Hartington Wing windows		100	125	125
Minor Works		80	230	230
Ward Refurbishments				800
Trauma Room Improvement		30		
TOTAL		460	355	1,155
<u>Other Capital Expenditure</u>				
IT equipment and applications		2,821	2,500	1,000
Other Equipment		1,374	1,500	1,500
TOTAL		4,195	4,000	2,500
Total Capital Expenditure		9,958	13,509	10,145

The theatre development represents a major investment to refurbish all operating theatres over the next three years. The theatres are now nearly 30 years old and require a major upgrade including replacement of laminar air flow equipment.

The investment of between £9.9 and £13.5 million per annum in capital expenditure underpins our corporate objective of providing an infrastructure to support delivery (see 1.1).

5.3 Key financial risks and mitigation

Re: key financial risks, mitigation, actions and residual concerns are shown below:

Category of risk	Description of risk (including timing)	Potential impact	Mitigating actions / contingency plans in place	Residual concerns	How Trust Board will monitor residual concerns
CIP's / Cost base	Ensuring CIP's are delivered and cost pressures managed.	Non achievement of financial requirements leading to impacts on quality.	Investment in Innovation Board (IB) and Transformation Support Team (TST) to support delivery of CIP's (see 4.2). Contingency reserve/uncommitted CQUIN funding of £6.9 million to act as a buffer.	IB and TST not operating as planned. £6.9 million buffer insufficient.	HLT overseas IB/TST and reports progress to Board. Monthly finance report to Board monitoring progress on achievement of CIP's and use of £6.9 million buffer.
Activity	Under performance of activity plans. Inability to increase capacity sufficiently to match increased capacity.	Reduced funding which if not contained will impact on quality. Lack of capacity to match activity impacting on quality.	Flexing of capacity to match actual activity (eg increased/decreased bed base, theatre lists, outpatient clinics). Close monitoring of activity versus plan at sub speciality level on monthly basis.	Capacity not flexed sufficiently to deal with significant changes above/below forecast.	Monthly reporting of activity to Board.
Locum / agency	Excessive use of locums / agency staff.	Excess financial cost of locums/agency staff. Impacts on quality of service provided.	Transformation programme work to reduce locum / agency spend. Investment in additional nursing and midwifery staff to reduce agency usage. Clinical services strategy highlighting areas which need to be addressed.	Locum / agency usage not reduced sufficiently.	IB/TST progress reports to HLT and Board. Quarterly monitoring of locum/agency usage by Board.
Quality incentives / penalties	Incentive payments (eg CQUIN not being achieved). Quality targets not being achieved leading to penalties.	Loss of CQUIN income which if uncontained impacts on quality. Penalty payments which if uncontained impacts on quality.	Close monitoring of achievement of CQUIN targets with appropriate action to rectify. Close monitoring of quality targets and contractual limits placed on potential penalties in main risk areas (eg C.diff penalty capped at £340k). Use of contingency/un-committed CQUIN funding of £6.9 million to contain effects of above.	Lost income / penalties which cannot be contained within £6.9 million.	Monthly reporting of performance on CQUIN and quality targets to Board.