

Strategic Plan Document for 2013-14

**Heatherwood & Wexham Park 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):

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Date	31 May 2013

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)	Mike O' Donovan
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Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Philippa Slinger
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Signature



Approved on behalf of the Board of Directors by:

Name (Finance Director)	Colin Gentile
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Signature



Annual Plan 2013-14

Strategic Context and Direction	<p>Within the Trust's 2012/13 Annual Plan, it was recognised that, given the internal structural financial issues that need to be addressed and the fact that the Trust operates within a financially challenged and highly competitive commissioning environment, the Trust as a stand-alone organisation faced severe short-term (cash-flow) and long-term financial viability risks.</p> <p>Throughout 2012/13, the Trust has worked with NHS Berkshire, its main commissioner, on a strategic programme called "Shaping the Future" (StF) that looks to model long term service configuration options for the area served by the Trust. That programme has led to some small but significant service changes and examined the opportunities for the Trust to merge or be acquired by another Trust to provide benefits to patients through increased economies of scale and the ability to develop further services and specialisms.</p> <p>Acknowledging the ongoing risk to its clinical and financial viability, the Trust pro-actively engaged with other neighbouring acute providers to assess the feasibility of a major service reconfiguration (involving merger or acquisition) taking place by the commencement of 2014/15.</p> <p>In this regard, the Trust is currently in discussion with Frimley Park NHS Foundation Trust (FPH) with regard to their potential acquisition of the Trust. At the time of writing, these discussions are at a preliminary stage; although the Trust's key stakeholders (Monitor, Department of Health, Council of Governors, Clinical Commissioning Groups and staff) are largely supportive of the proposal.</p> <p>Given this position and recognising that 2013/14 effectively represents the 'second year' of the Trust's three-year plan submitted to Monitor in 2012/13, the Trust's overriding vision and corporate objectives for 2013/14 remains unchanged, with the exception of the key performance measures which underpin these. The Trust continues to aim:</p> <ul style="list-style-type: none"> • To provide safe, effective, high quality acute secondary care; • To ensure that patients remain at the centre of all we do and have a positive experience of all we offer; • That the communities we serve will feel confident in our care and know they can trust us; • To make our staff feel confident in us as an employer and know they will be supported to do their very best; • To allow our partners to see us as simple to work with and feel confident that we will deliver what
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we say.

In order to deliver this vision, the following corporate objectives have been agreed:

- To maintain high quality, safe, clinically effective care that ensures a positive patient experience;
- To deliver efficient services within the activity and resource levels agreed with our commissioners; improving our clinical effectiveness and productivity;
- To be a good employer, improve staff morale and develop a highly skilled and engaged workforce;
- To work in collaboration and partnership with all parties to ensure maximum benefit to the population served;
- To deliver significant cost improvements and to develop programmes that will achieve recurrent cost improvements of appropriate scale in later years to ensure the overall clinical and financial viability of the Trust.

The delivery of these corporate objectives will be measured through the following measurables:

Corporate Objective	Strategic Aim	Measurable
1) To maintain high quality, safe, clinically effective care that ensures a positive patient experience.	Improve and maintain mortality and infection control performance	Improved/ sustained C.diff / MRSA rates of infection
		Improved/ sustained mortality data
	Improve separation of capacity for elective and unplanned admissions - reducing risk of cancellations, maintaining access to stroke beds and meeting the 18wk target	Reduction in cancellations
		Achieve access to stroke bed within 4 hrs and 90% of stay on a stroke unit for stroke patients standards
		Sustain RTT performance
	Development of an agreed capacity plan based upon commissioning intentions and including plan for dealing with increased winter pressures.	Capacity Plan 2013/14 signed off by Executive Board and understood by all operational staff.
	Deliver 4-hour Emergency Access Standard for full year	Deliver 4-hour Emergency Access Standard for full year

			Establishment of A&E Development Group led by Deputy CEO, overseeing capital developments and A&E process improvements	
		Improve outpatient appointment booking - reducing risk of cancellations, maximising efficiency and improving pt experience	Reduction in cancelled clinics	
			Achieve 2ww cancer standards for full year	
			Improved patient experience	
		Develop functional 24/7 services by increasing access to Consultants and all clinical support services	Implementation of 7 day access to therapy services	
			70% of wards to have daily consultant ward rounds	
			Implementation of 7 day discharge team	
		Improve access to clinical information via improved information systems	Full Trust-wide Implementation of RealTime	
		Operate at optimum bed occupancy levels by improving discharge planning and integrated working with primary/ community/ social care services	Operate at 95% bed occupancy for surgical specialties	
			Operate at 90% bed occupancy for acute medical specialties	
		Collaborative working/ networking to provide access to specialist care and ensure optimum levels of consultant cover	Quantitative measure of consultant cover against recognised national benchmarks for specialist services.	
		Implementation of partnership re: Pathology services	Partnership agreement in place by the end of 2013/14.	
		Provide CSSD to other organisations	CSSD provision agreement in place by end of 2013/14.	

		Work with GPs to support primary care and develop clinical pathways - ensuring referrals are only when indicated	Development and implementation of joint clinical pathways	
			Reduction in referrals that are not clinically indicated	
		Quality Accounts Priorities (to also be linked with CQUINs)	Reduce the number of non clinical moves	
			20% decrease in patient who have a urinary catheter and develop a urinary tract infection in hospital	
			To reduce the number of cardiac arrest calls on general areas	
			Increase the percentage of Neonates receiving Total Parenteral Nutrition by day 2 of life	
			Sepsis pathway – baseline audit Q1 with trajectory set for Q4	
			Increase timely discharge of patients prior to 12 noon	
			Reduce number of operations cancelled on the day to 0.8% by the end of Q4	
			Reduce the number of complaints concerning communication and professional conduct by 15%	
		Timely completion of incident investigations and regular circulation of 'lessons learnt' through Newsletter.	Elimination of Datix incident backlog within the divisions.	
		Timely completion of complaint responses	Responding to 90% of complaints within the agreed timescale by the end of 2013/14	
	2) To deliver efficient services within the activity and resource levels agreed with out commissioners; improving our			
		Reduce premium staffing costs to 5% of staff costs	As stated in objective.	

	clinical effectiveness and productivity	Reduce workforce spend as a percentage of income to 65%	As stated in objective.	
		Deliver efficiencies in outpatient booking, theatres and bed utilisation	Deliver £1.5m annually	
		Streamline how A&E works with AMU to improve 'front door' access and work with CCGs and others in developing pathways that ensure patients are treated in the correct venue - reducing length of stay and leading to savings	Reduce length of stay by 10% leading to £0.6m saving	
		Modernise Heatherwood Hospital with a partner to provide a highly efficient surgical hospital unit	Success will be dependent on funding and long term strategy for the entire health economy	
		Develop clinical networks and collaborations with other acute providers to sustain improvements in quality and efficiency	Implementation of 'Shaping the Future' strategy - provision of services within E. Berks	
		Maximise efficiency in clinical and 'back office' support services	Share services with others to deliver £3m annually	
		Development of a comprehensive Clinical Audit plan for 2013/14, that incorporates all national mandatory audits in addition to local audits, prioritised according to levels of risk.	End of year Clinical Audit review paper; assessing implementation of plan.	
	3) To be a good employer, improve staff morale and develop a highly skilled and engaged workforce	Capacity to Deliver Plan: Improve the fabric of the Trust's sites and hotel services.	Redevelopment / Merger projects to be run by the Chief Executive	

		Provide range of options for leadership development with the aim of enhancing patient care in the community, using a mix of learning opportunities	Measure of number of individuals taking part in leadership development programmes
		Managerial/ Clinical Leadership Development: Systems Quality Improvement Programme - using a GP facilitator to lead on a quality improvement approach	Robust succession planning in place - with an internal pool of potential clinical/operational leaders
		Managerial/ Clinical Leadership Development: Development centre for potential clinical leaders - building on work to revise consultant appointment processes and working with Real World consulting	Improvements in the Medical Engagement Scale
		Improve staff morale through: Internal communication processes - increasing opportunities for staff to have a voice - increasing involvement in and ownership of organisational change	Aiming for the top 20% in terms off staff engagement
		Appraisal rate of more than 80% plus an increase in the staff survey score for 'well structured appraisals'.	As stated in objective.
		Improve staff morale through: Develop a health and wellbeing strategy - to increase the sense of value	Reduction in sickness absence levels; improvement to scores on health, safety and well being in the National Staff Survey
		Improve staff morale through: Continued active recruitment campaigns - to reduce reliance of temporary staff and to reduce stress/pressure on the workforce	Reduction in vacancy rates and increase in clinical: non clinical ratios
	4) To work in collaboration and partnership with all parties to ensure maximum benefit to the population served	Contribute to and participate in "whole system" groups to ensure seamless transition from hospital to community care/support.	Improved A&E performance; Improved length of stay.

		Redesigned care pathways that optimise the delivery of service in primary care with use of secondary care only when necessary	Delivery of CCG QIPP plans.
		Successful transition from MIU service to Urgent Care at Bracknell	Successful bid for service.
		Improved integrated working to ensure people are only in hospital when needed	Reduced medically fit for discharge patients in hospital.
		Work with partners to deliver innovative clinical solutions to tendered services	Successful bid for rehabilitation and physiotherapy services.
	5) To deliver significant cost improvements in 2013/14 and to develop Programmes that will achieve recurrent cost improvements	Measurables of CO5 contained within COs 1-3	

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

The Trust provides inpatient and outpatient district general hospital services to a large and diverse population of more than 450,000 in the Ascot, Bracknell, Maidenhead, Slough, Windsor and south Buckinghamshire areas.

Local NHS service commissioners provide nearly 90% of the Trust's planned income for 2013/14: 70% from east Berkshire Clinical Commissioning Groups (CCG), 17% from Buckinghamshire CCGs and 2% from west Berkshire CCGs. In addition, a small proportion of income, approximately 4%, is derived from specialist commissioners.

One of the major strengths of the Trust is that, as a result of the closure of High Wycombe Hospital, A&E Department in October 2012, Wexham Park Hospital is the closest regional Level 2 trauma

centre for patients in South Buckinghamshire, as well as for its local catchments in Slough, Windsor and Bracknell.

The Trust operates in a very competitive environment in close proximity to other major acute NHS services providers. The southern part of east Berkshire, mainly the Bracknell area, is the most contested area with FPH and Royal Berkshire Hospital NHS Foundation Trust (RBH) being the main competitors for elective inpatient, outpatient and diagnostic services. Other competitors are Hillingdon Hospitals NHS Foundation Trust to the east, and Ashford & St Peter's NHS Foundation Trust to the east / south east.

On 26 March 2013, the Board of NHS Berkshire approved the service reconfigurations forming the '*Shaping the Future of Healthcare in East Berkshire*' consultation on proposals for healthcare services in Bracknell and Ascot which will impact strongly on services at Heatherwood Hospital; resulting in the loss from that site of minor injuries service, the closure of a rehabilitation ward and the permanent closure of a midwife-led birthing services. Nevertheless, plans to redevelop Heatherwood Hospital into a new surgical hospital with modern facilities for planned surgical inpatient and day case activity will strengthen and establish the Trust's position as a major elective inpatient service provider in this locality.

Forecast health, demographic and demand changes

The population of east Berkshire is diverse with significant pockets of deprivation and wealth. In general, the health of people in Slough is mixed and overall worse than the populations in the Bracknell Forest, Windsor and Maidenhead localities. Early death from heart disease and stroke has fallen in all localities in recent years but remain some of the leading causes of death, particularly for black and minority ethnic (BME) populations. High levels of diabetes, obesity, smoking related diseases, infectious diseases, sexually transmitted infections, problematic drug users and hospital stays for alcohol admission all feature to varying degrees across the Trust's catchment areas.

The population is growing fast, particularly amongst children and elderly people, those most likely to use health services. Slough already has the highest number of births in east Berkshire and the birth rate is predicted to rise further over the next decade. Increased immigration of BME populations has led to significant increases in births, high risk births and paediatric pathology, which is consequently driving demand for maternity, neonatology and paediatric services. Asthma and allergies in children are also high. The growing elderly population is increasing the demand for dementia and stroke services which in turn is increasing the need to develop community, rehabilitation and early discharge services to reduce pressures on acute sector services.

Threats and opportunities from changes in local commissioning intentions

The Trust envisages that the following commissioning intentions will have the greatest impact and drive the demand for services during 2013/14 and beyond:

Procedures of limited clinical value (PLCV):

The Commissioner has signalled the intention to restate adherence to National Institute for Health and Clinical Excellence (NICE) and priorities guidance for planned care to limit PLCVs to Best Practice procedures. This is likely to reduce demand for certain elective procedures of limited clinical value, allied with appropriate safeguards to ensure best clinical care is provided. The projected financial impact of this is built into the financial plan.

30 day re-admission threshold:

It has been agreed that the same planning assumption as 2012/13 of 25% retention of funding for admission avoidance schemes by the PCT will be assumed until the Commissioner undertakes a clinical audit in line with PbR guidance to set the threshold for 2013/14. The Trust has requested evidence of PCT admission avoidance projects funded in 2012/13 from retained funding that will have an impact on reducing readmissions in 2013/14.

Shift from consultant to nurse-led clinics:

The Trust is working with the Commissioner to develop all areas on non-PbR pricing. There is a risk to the Trust that the Commissioner will be unable to afford the activity delivered on the basis of activity / price, leading to non-payment or part payment for activity performed.

Day case (DC) to outpatient procedure (OPPROC):

The Trust has agreed to work with the Commissioner to transfer an appropriate quantum of procedures from a DC to OPPROC setting. This includes but is not limited to the Best Practice Tariffs. This may pose a financial risk to the Trust, or conversely the Commissioner, depending upon the value of procedures when delivered as an outpatient procedure.

Move of minor injuries unit from Heatherwood Hospital to Bracknell:

The Commissioner has indicated that it will move the nurse-led Minor Injury Unit at Heatherwood Hospital to an alternate location in Bracknell. The Trust is keen to bid for and win the contract to deliver the new service. If unsuccessful this presents a risk to the Trust's income.

Extension to 7-day working:

The Trust already provides a number of services on a 24/7 basis but has agreed to work with the Commissioner to identify appropriate areas where other services could be commissioned on a 7-day working basis.

New-to-follow up outpatient ratios:

The Trust and the Commissioner are working together to develop a proposal which removes a quantum of patients from outpatients and ensures appropriate care for them in primary care. This will reduce the Trust income however is preferable to the 'business rule' which applied in previous years which resulted in non-payment beyond a certain threshold.

Service re-commissioning:

The Trust qualified in January 2013 under Any Qualified Provider (AQP) for non-obstetric ultrasound services. This diagnostic modality represents a significant income for the Trust and increased competition for services from other NHS providers and private providers, coupled with uncertainty of future volumes and income to cover costs, risks destabilising the Trust's activity base. The arrangement is subject to contract and the commissioners have confirmed that the Trust will continue to provide the service within the current block payment until agreement is reached on how this is broken down.

The Commissioner has signalled their intention to put the existing direct access musculoskeletal (MSK) physiotherapy service out to competitive tender to procure a new community service capable of improving current waiting times and supporting the development of new pathways across all CCGs in east Berkshire. This aspect of rehabilitation services represents a significant income and presents a risk in 2014/15 if the Trust is not successful at securing a contract.

QIPP & Demand Management:

The Commissioner's QIPP programme if delivered will pose a significant financial challenge as it impacts on all areas of acute services: reduced hospital admissions, reduced outpatient attendances, reduced length of stay, and the shift of services from hospital to community.

The Trust has been finding it challenging to achieve the A&E 4-hour waiting time targets, given the high volume of resource intensive activity following an increase in A&E attendances as well as a 25% increase in admissions as a result of closure of the High Wycombe Hospital A&E Department in October 2012. Two modular wards providing 28 additional beds for surgical and medical admissions have been erected on the Wexham Park Hospital site to improve capacity in response to the increased demand for beds. Enhanced service provision within the Unscheduled Care Centre at Wexham Park Hospital to divert less complex work from A&E has been put in place. The Trust is working with the CCGs and other partners to review the resources available within the community and the Trust in effort to ensure that performance can be back to plan.

Decommissioning:

The outcome of the '*Shaping the Future of Healthcare in East Berkshire*' consultation indicates that the following services will be decommissioned from Heatherwood Hospital:

- Closure of the Minor Injuries Unit and the incorporation of these services into a new Urgent Care Centre located in Bracknell;
- Closure of Ward 8 as a result of changes to general rehabilitation and stroke rehabilitation services and the development of community-based packages of care; and
- Permanent closure of the Ascot Birth Centre; and the development of consultant-led and midwife-led services based at Wexham Park Hospital and at FPH, and a range of other local options for midwife-led deliveries

The Trust has been served notice on the Direct Access Musculoskeletal Outpatient Service with an end date of 31st March 2014. Organisations have been invited to tender for the work and application submissions are due on by the 31st August. The final award of contract will be on the 31st October 2013. The Trust is currently scoping this work with a view to submitting an application.

Shifting care delivery outside of hospitals

The development of community-based rehabilitation and early discharge services should help to relieve pressure on acute inpatient beds but risks losing income to community services. The Early Supported Discharge (ESD) service for stroke patients' should allow the transfer of patients to the

community, reducing length of inpatient stay and pressure on acute inpatient beds. Also it should allow the closure of beds at Heatherwood Hospital and the transfer of resources to Wexham Park Hospital. It would, however, also result in the loss of the outpatient rehabilitation PbR tariff to community services.

There is a further risk of losing outpatient activity and income from Heatherwood Hospital as a result of Bracknell and Ascot CCG commissioning services at Bracknell Health Space e.g.: stroke, rehabilitation, direct access physiotherapy for MSK, direct access non-obstetric ultrasound.

Windsor, Ascot and Maidenhead CCG's intentions to commission a range of local, integrated outpatient, one-stop clinics and diagnostic services for their area, potentially based at St Mark's Hospital, could have a similar impact.

A community-based ENT clinic is being piloted in Slough with potential to reduce acute referrals into the Trust and thereby improve acute inpatient capacity.

There is potential to develop new patient pathways within primary care, e.g.: a pilot is in progress within Slough CCG with regard to a new protocol for the management of acute renal colic in primary care to provide more appropriate and faster diagnosis whilst reducing A&E attendances.

There is the opportunity to deliver care closer to the patient's home and in community settings, e.g.: a community MDT pain management programme pilot is in progress based at Windsor Leisure Centre

Reconfiguration and development plans

FPH is in discussion with the Trust regarding a potential acquisition arrangement which, if it proceeds, should realise financial and service benefits by 2016/17.

The redevelopment of Heatherwood Hospital provides an opportunity to provide a modern, fit for purpose hospital and strengthen the Trust's service infrastructure on both sites and improve the Trust's position competitively

A planned £61.25m in capital investment over 3 year years (£17.25m in 2013/14, £21.75m in 2014/15 and £22.25m in 2015/16) will enable improvements in efficiency through improved technology, ensure medical equipment is in good order and allow modest improvements to the fabric of the building (enhanced A&E, establishment of an escalation ward, enhanced maternity unit).

Discussions are in progress to centralise all Pathology Services across Berkshire, together with an option to centralise Cervical Cytology Services across Berkshire.

Changes in funding arrangements

Historically, the main commissioner's financial envelope has been insufficient to cover costs of delivering expected activity levels which has imposed financial constraints on developing services and infrastructure, and reducing the Trust's deficit. From 2013/14, the Trust's main commissioners comprise four Clinical Commissioning Groups which risks fragmentation of funding and exacerbating this position, and also the potential for multiple contracts which hinder effective contract management and standardisation of service delivery.

The 2013/14 financial year sees a significant shift in the national tariff which impacts across a wide range of services provided by the Trust. We have agreed with the East Berkshire CCGs a price neutrality mechanism for 2013/14. This will allow all parties to monitor the impact of price shifts within the new tariff without being exposed to additional risk. The Trust will however still gain or lose income against the planned levels in the contracts should there be over or under performance in year.

The Trust will be (jointly with commissioners) reviewing non-PbR prices in 2013/14. Again, this will not impact in the current financial year but will put future years on a better footing.

The Trust provides some services now designated 'specialist' and risks losing or non-payment for these services should designated specialist centres or the NHS Commissioning Board decide not to re-commission from 2013/14.

The Trust is seeking to reach agreement with commissioners to move services currently included in block pricing agreements to a cost per case basis or to cease providing these services. This includes the remaining radiology services following the move to AQP commissioning for non-obstetric ultrasound services.

Analysis of how the Trust's demand profile and activity mix has evolved over recent years and what changes are forecast

Geographically, in recent years the Trust has focussed and consolidated its clinical services for the northern part of its catchment to ensure it can offer clinically safe and sustainable services. This has involved the closure of the Medical Admissions Unit, the closure of the Paediatric Unit and the withdrawal of high dependency level inpatient services at Heatherwood Hospital. Any residual demand in this area has been absorbed by local competitor acute service providers.

In addition, the Trust has relinquished certain service lines, such as vascular surgery and hyper-acute stroke, which has enabled it to focus on basic and core district general hospital service lines.

Over the past few years, The Trust has made changes in the point of delivery of services moving from elective inpatient to DC, DC to OPPROC, and pathways of new and follow up appointments to one-stop clinics. This has reduced the time required for the delivery of treatment thereby enabling clinical resources to be released and focused on other demands.

Overall the number of cases has increased year on year across most age groups, for elective and non-elective activity, with a general shift in the focus and balance of care from elective to non-elective. There has also been a general rise in the acuity of cases, which has impacted on operational demand but not always been matched by increases in resources and income.

These trends are expected to continue in the future.

Details of how the Trust is diversifying its income streams (e.g. research, private patients, exploiting intellectual property)

The majority of the Trust's income is derived from NHS commissioners, with a small proportion, approximately 8%, of planned income for 2013/14 coming from other activities, the main areas being education, training and research (2.5%), private patients (1.4%) and the sale of goods and services (1.1%).

Proposals to develop private patient services and income have been restricted by the need to use of private patient facilities as escalation beds to meet inpatient demand. The opening of an additional 28 beds should help to alleviate this situation during early 2013/14. The Trust is exploring other income opportunities, for example plans are being developed to exploit the potential of the Da Vinci robot for both NHS and private patients by extending the usage to specialities other than Urology, commencing with Gynaecology.

<p>Approach taken to quality (including patient safety, clinical effectiveness and patient experience)</p>	<p>CQC and Other Quality Regulator Concerns</p> <p><u>CQC</u></p> <p>At the beginning of May 2013, the Trust continues to operate with a 'clean', unconditional Care Quality Commission (CQC) license. However, at the time of writing, the Trust is awaiting the CQC's findings in respect of two unannounced inspections that were undertaken during the w/c 7 May and on 22 May 2013. The informal feedback on these inspections is detailed below.</p> <p>The Trust was visited by the CQC in April 2012 in response to some concerns which had been raised to them about the Trust. This visit was looking specifically at Outcome 1 (people should be treated with respect, involved in their discussions about their care and treatment and able to influence how the service is run) Outcome 4 (people should get safe and appropriate care that meets their needs and supports their rights, Outcome 14 (staff should be properly trained and supervised, and have the chance to develop and improve their skills) and Outcome 16 (the service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care). The CQC found the Trust to be fully compliant and meeting all essential standards.</p> <p>The Trust had a further visit by the CQC in June 2012 in response to some concerns which had been raised to them about the Trust. This visit was looking specifically at Outcome 1 and 4, Outcome 5 (meeting nutritional needs), Outcome 6 (safe and coordinated care between different services), Outcome 11 (people should be safe from harm from unsafe or unsuitable equipment) and Outcome 16. The CQC found the Trust to be fully compliant and meeting all essential standards. However, the inspectors did note that in some areas meal times appeared to be rushed. The Trust has therefore taken a number of steps to improve the patient meal time experience through a review of protected meal times which has led to a 'staggered' approach within the Trust, with some wards starting at 12 midday and some at 12.30, this allows clinical staff visiting wards to continue necessary work, whilst not disturbing the patients meal time. This improvement has received positive feedback from patients who have observed that not only does the food taste better and look better that it is served more quickly. It is expected that with this success it will be launched Trust wide later this year.</p> <p>In meetings held with the CQC from December 2012 – March 2013, it became clear that the Trust's discharge processes represented another potential concern due to the high level of operational pressure experienced by the Trust over the 2012/13 winter period. In response, the Trust has provided the CQC with the plans going forward to work collaboratively across health and social care to better plan the pathways of patients being discharged from the Trust. In March 2013, the terms of</p>

reference of a newly formed 'Multi-Agency Safe Discharge Task and Finish Group' has been shared with the CQC and the Local Authorities Safeguarding Adults Board. It has also been agreed that improving patient discharge will be a priority in the Quality Accounts for the Trust for 2013 / 2014.

As indicated above, the most recent CQC inspections of the Trust's services took place in mid May 2013. Whilst the feedback reports from these inspections is not currently available, the Trust has received informal feedback from the regulator which raised concerns in the following areas:

- **A&E**- As is consistent with the operational capacity pressures that the Trust has experienced in the latter half of 2012/13, there was a concern that the volume of emergency demand outweighing capacity and it was noted that this had an impact upon ambulance queues, clinical handover and most importantly, on the patient experience.
- **Escalation areas** – There was a view that the escalation areas which the Trust had temporarily opened in order to address the capacity pressures provided a poor patient experience. The staffing of these areas was also noted as a concern, relying on the movement of substantive staff from other areas and interim staff.
- **Infection control / environmental concerns** – The inspection team reported general untidiness and clutter due to a lack of space and storage facilities. In addition, other aspects of the physical environment appeared 'tired'. Cleaning schedules were not readily available.
- **Fire doors** - These were found to be propped open in a few areas.
- **Privacy & Dignity** – The inspectors found several examples of patient bed curtains not being closed when it was appropriate to do so.
- **Record keeping** – It was found that some patient care plans were either not completed or were not always representative of the care; specifically for the non-elective patients.
- **Poor communication** – The inspection team found evidence of poor communication between staff and with patients.
- **Call Bells** – It was noted that, on occasion, some patients had their call bells out of reach.
- **Medicines storage** – The inspectors witnessed a ward where drug / lotion cupboards were unlocked.

The Trust has instigated a series of immediate actions to address these interim, informal findings. However, given the feedback to date, the Trust recognises the potential risk in 2013/14 with regard to its assessed compliance with the CQC *Essential Standards*.

NHSLA

On 17 January, the Trust underwent a CNST maternity assessment at Level 1. The Trust succeeded in 'passing' 50/50 of the relevant criteria with no concerns relating to compliance being raised.

Key Quality Risks in the Plan

The Trust's Risk Assurance Framework document captures the key risks to organisational service quality. The table below details these risks, providing an explanation as to the nature of the risk, risk assessment, existing controls and how the risk will be managed/mitigated:

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
CQC Compliance	As detailed above, the Trust was subject to two separate periods of CQC inspection during mid May 2013. There is a risk that the shortfalls identified by the inspecting team will result in conditions being applied to the Trust's licence with the CQC.	Damage to reputation; adverse impact upon Governance Risk Rating.	1. Robust action plan in place to address all problematic areas- this will be adapted once the CQC inspection report is received.	That some of the concerns raised by the CQC can be linked to the extreme operational capacity pressures faced by the Trust towards the end of 2012/13 /beginning of 2013/14 and that these pressures will continue throughout the year.	The action plan to address the CQC concerns will be monitored on a monthly basis by the Healthcare Governance Committee on behalf of the Board.

	Patient Safety	The Trust recognises that delivering its Annual Plan will be challenging due to the nature of the operational and transformational changes required for sustainability. The Trust will need to ensure its strong record in patient safety is maintained during this period, recognising the ongoing risk of clinical incidents and risks to patient safety.	Harm to patients, non-compliance with CQC requirements	Patient safety metrics such as mortality, infection control, falls and pressure tissue damage prevention are monitored rigorously. Each service has mechanisms to collect and review evidence of compliance with CQC requirements. Specific areas of concern, such as Maternity, are subject to CEO and Medical Director review and scrutiny with specific plans in place to address issues.	That the scale and pace of change required within the plan has the potential to compromise clinical safety.	The Board receives the patient safety dashboard at every meeting. The Healthcare Governance Committee reviews all aspects of clinical safety in detail. There is a Governor-led Joint Clinical Assurance Working Group that also reviews safety. Board members undertake regular CQC walkabouts. Single issues, such as maternity are discussed in detail at Board meetings.
	Patient Experience	Within the context of the Trust's financial position, the Trust now needs to continue driving forward the patient experience agenda whilst continuing to maintain its strong performance on patient safety.	If this is not addressed, the Trust will be not deliver to patient expectations and this will have a negative impact on patient outcomes.	In 2013/14, the Trust will roll out a comprehensive Quality Strategy across the Trust that will look to specifically target ways to improve the patient experience. This is described in detail within the Quality Strategy section of this Plan/	The Trust recognises that key elements of the remedial measures required to improve the patient experience require long-term commitment and focus and staff engagement.	The Healthcare Governance Committee directly scrutinises a number of patient outcome measures on behalf of the Board. The Board directly receive feedback from patients on the quality of their care through Board walkabouts.

	Information	There is a risk that service planning and operational management will be less effective due to the degradation of data quality and unavailability of clinical systems because of inadequate systems infrastructure.	Inefficiency of service provision, sub-standard quality of care and non delivery of structural cost changes.	The Trust has implemented systems to improve patient flow in 2012/13, including 'Realtime software' to allow for the 'e-tracking' of patients and is currently working with Newton to improve systems and processes within Theatres, Diagnostics and Outpatients. The capital requirement of the plan includes significant IT investment over the 3 years.	The Trust's ability to invest capital expenditure into IT systems is restricted and will need to be prioritised.	The implementation of the IM&T Strategy and review of capital expenditure in this area is to be monitored by the Finance & Business Development Committee on behalf of the Board.
	Workforce: Morale & Recruitment	<p>The 2012/13 National Staff Survey; whilst showing areas of improvement, continued to indicate a relatively low level of staff engagement.</p> <p>The Trust has suffered from difficulties with recruitment that have historically led to high numbers of temporary staff and interim senior leadership.</p>	High levels of temporary and interim staff affects high quality, safe care, as does a lack of leadership. The environment is not conducive to good staff engagement and a culture of courteous debate and challenge.	<p>Active recruitment in place for all vacancies with weekly director level monitoring; review of attraction methods with actions including use of social media, revision of NHS jobs/ internet text, overseas recruitment; use of R&R premia.</p> <p>Further actions to improve ongoing retention of staff including review of reasons for leaving, active</p>	<p>Staff in post numbers have continued to increase and use of agency has fallen as a result.</p> <p>However, engagement of staff is problematic given organisational changes and ongoing work pressures</p>	Workforce indicators are reviewed on a monthly basis by the Board and at divisional/ departmental level.

				management of stress through Stress Working Group; active internal communications to improve engagement.		
	Operational Capacity Pressures	<p>The plan requires significant degree of change to the way the Trust's hospitals operate to be undertaken whilst delivering all required quality and performance targets. Capacity to deliver change on this scale whilst delivering good operational performance is a risk.</p> <p>Emergency Access 4hr standard is at risk due to high levels of demand putting pressure on capacity and patient flow.. Additional escalation areas opened to support the demand which adversely impacts upon patient safety, quality of care and patient experience.</p> <p>Performance against the 18 weeks admitted pathway and incomplete pathway standards is at risk during the year due to the high number of patients waiting over 18 weeks which has developed over the</p>	Poor patient experience, regulatory risk. Non-achievement of 4 hour standard, 18 weeks incomplete and non-admitted pathways.	<p>The Trust monitors operational performance through regular Divisional performance reviews. Problem areas, such as 18 weeks and Maternity have specific programme Boards joined by commissioners. QIPP programmes have specific project management arrangements. Capacity and flow managed proactively by site management team.</p> <p>Capacity plan to be completed in June to inform correct number of beds required to support activity levels.</p> <p>Additional capacity available through two additional modular wards.</p> <p>System-wide 4 hour Recovery Plan</p>	<p>A&E performance will continue to be under pressure while the actions are implemented and embedded within the Trust.</p> <p>Availability of additional capacity with other providers to support 18 weeks Recovery Plan may be difficult to secure.</p>	All operational KPIs (A&E, 18-weeks, backlog etc.) are reviewed by the Board on a monthly basis. They are also reviewed monthly by the Executive Board, and in detail at monthly Divisional Bilateral meetings. A&E is reviewed daily and 18 weeks, weekly.

		winter period due to pressure on bed capacity caused by non-elective admissions.		in development for short, medium and long-term achievement and sustainability. 18 weeks Recovery Plan in development.		
	Longstanding Clinical Issues	The Trust has commissioned two substantial programmes in 2012/13 (continuing into 2013/14) that acknowledge historical behavioural/relationship issues within the Trust's maternity and general surgery departments.	The risk is that poor team-working/communication within teams will adversely affect patient safety/patient experience.	<p>General Surgery: The Trust has commissioned InPractice to undertake a historical review of all clinical concerns raised amongst the clinicians over a 20-year period. This aims to bring finality to various allegations and investigations raised in the past. The trust has also asked Dr. Foster to develop a safety dashboard for surgery that will allow the trust to monitor the patient outcomes of all surgeons' work. Lastly, Fiona Reed Associates have been contracted to support and develop the team through an engagement programme.</p> <p>Maternity: The approach to the issues in maternity has been</p>	For both areas, that not all clinicians will 'buy in' to the new ways of working / change or that positive developments will not be sustained. This may require the Trust to take further action, as appropriate.	The Board will receive direct reports from the CEO on both work programmes.

				<p>also been systemic in endeavour to resolve issues for the long term. The issue of senior clinical leadership has been addressed through the appointment of a new Clinical Lead. That has had a very positive impact and a number of the clinical indicators are improving. The department has also been supported by a very experienced ex NHS FT CEO who has provided management supervision and mentoring to ensure that governance and managerial processes are in place and working effectively.</p> <p>Professor Draycott undertook his third visit to the Trust's maternity unit in mid-March 2013. Initial feedback notes some improvements and is clear that the unit is clinically safe, however there</p>		
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			remain challenges in Consultant behaviour.		
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An overview of how the Board derives assurance on the quality of its services and safeguards patient safety

The Trust Board agreed to a new internal CQC assurance process in March 2013 which will significantly enhance the Trust's pre-existing clinical quality control systems, ensuring 'ward-to-board', evidence-based assessment against the CQC's *Essential Standards of Care and Quality*. The new process involves four stages:

Firstly, Ward/ Departmental CQC evidence templates will be produced, updated and signed off by the relevant ward/ department lead. This will also be discussed at any ward/ department clinical governance meetings

Secondly, each ward/ department evidence template will be reviewed, approved and signed off at divisional level. This will then lead to the development, review and update of divisional CQC scorecards. These scorecards will be discussed at Divisional Clinical Governance Meetings.

Thirdly, each divisional scorecard will be validated by an objective CQC Operational Lead (an expert on the particular standard).

Lastly, the validated divisional dashboards will be used to populate the Trust-wide CQC dashboard. Here, the Divisional findings will be used alongside:

- i) Monthly CQC risk-based assessments undertaken by the relevant Operational lead;
- ii) The CQC-produced Quality & Risk Profile (QRP);
- iii) 'CQC Walkabout' outcomes; and
- iv) Any other intelligence source affecting compliance.

The combination of these 'inputs' will allow the Trust to gain both a 'macro' and 'micro' level understanding of its level of compliance. The completed CQC dashboard will be presented on a monthly basis to the Trust Board.

The Board also reviews Trust compliance against the Monitor *Quality Governance Framework* (QGF) on a quarterly basis. In 2012/13, the Trust developed a QGF self-assessment tool. The tool is

	<p>arranged to show the percentage compliance against each of the four key quality areas under the QGF, broken into ten key questions.</p>
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	<p>Each of these questions has a number of good practice prompts against which evidence of compliance (both quantitative and qualitative is demonstrated). The Trust's tool was further enhanced at the end of 2012/13 as a result of a PWC-led audit with regard to the Trust's quality governance arrangements.</p>
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<p>Clinical Strategy</p> <p>(Consistent with information contained within the Trust's published Quality Account).</p>	<p>The Trust's overall clinical strategy over the next three years:</p> <p>The Trust will place improvement across all the three dimensions of quality i.e. Clinical Effectiveness, Patient Experience and Safety, at the core of everything the Trust does - both as ends in themselves, but also because delivering the best quality of care will ultimately yield the best value from the whole system.</p> <p><i>'our aim is to deliver excellent and accessible hospital care to our patients, be the first choice for local people for hospital treatment and the employer of choice for staff'</i></p> <p>Our vision is one where all clinical care provided is appropriately measured for its safety, effectiveness and patient experience, where we can increasingly demonstrate improved outcomes of care, and where information on quality is acted upon rapidly and effectively to ensure continuous improvement.</p> <p>Quality is everyone's responsibility and an effective early warning system for quality must begin within the organisation providing care.</p> <p>As a Trust we must:</p>

- Reaffirm our commitment to the primacy of quality in the new system;
- Emphasise the critical importance of values and behaviours in creating a service that is truly focused on quality and always places the interests of patients ahead of individual or organisational ambition;
- Set out the central role that patients and service users must play in the oversight and scrutiny, design and measurement of high quality services;
- Present a new approach for supporting collaboration across the system and facilitating the sharing of information and intelligence on quality;
- Ensure that there is a clear and agreed approach to taking swift and coordinated system-wide action in the event of a serious quality failure being identified, in order to rapidly protect patients and service users;
- Foster a culture of openness, transparency and candour throughout the organisation.

The way in which we act has a significant impact on the quality of care that we deliver to people and how this care is perceived. We need to create environments where we model the right behaviours and demonstrate them to those who use our services. This will be critical to achieve the common aim of high quality, compassionate care and excellent health and well-being outcomes for people. All staff have a role in setting standards and leading multi-disciplinary teams to deliver high quality care and outcomes, whether they are in a formal leadership role or not. The values and behaviours described in the 6C's, Care, Compassion, Competence, Communication, Courage and Commitment, have evolved around discussions and consultations with nurses, midwives and other care-givers nationally and encapsulate what those in the caring professions do in ways that are clear and recognisable.

The NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority in everything we do.... from caring, compassionate and committed staff..... in a system which recognises and applies the values of transparency, honesty and candour (Francis 2013).

In order to provide care to patients that embodies all the behaviours described above it is imperative that our workforce behaviours and values reflect this going forward. The Quality Strategy will be aligned with the Workforce strategy and include the following dimensions:

- Systems in place to ensure sufficient numbers of skilled staff to ensure care is safe and

effective.

- Increased focus in all training days on the practical requirements of delivering compassionate care.
- Selection of recruits to include aptitude test for compassion and caring and values of commitment.
- Standards for appraisal / revalidation and support to include a focus on the 6C's and evidence to support staff members' compliance with this.
- Leadership at all levels from ward to Board committed to and taught the skills to be capable of involving all staff with those values and behaviours described.

The Trust has identified priorities within the three dimensions of safety, effectiveness and patient experience. The priorities are as follows:

SAFETY

Priority 1: *100% incidents concerning falls categorised as major or extreme will have followed the appropriate post fall pathway. Q4 frequent fallers included in trajectory*

- Checks by nursing staff for signs or symptoms of fracture or potential for spinal injury before the patient is moved;
- Safe manual handling methods for patients with signs or symptoms of fracture or potential for spinal injury;
- Frequency and duration of neurological observations for all patients where head injury has occurred or cannot be excluded (e.g. unwitnessed falls) based on National Institute for Health and Clinical Excellence (NICE) Clinical Guideline 56: Head Injury;
- Timescales for medical examination following a fall (including fast track assessment for patients with signs of serious injury, or high vulnerability to injury, or who have been immobilised).

Rationale: When a serious injury occurs as a result of an inpatient fall, safe manual handling and prompt assessment and treatment is critical to the patient's chances of making a full recovery.

How it will be measured: All cases of falls that are categorised as major or extreme will be monitored. Quarterly figures will be presented to the Trust Board and in Q4 frequent fallers will also be included.

Priority 2: *Reduce the number of non clinical moves – Zero tolerance*

Rationale: Moving patients from area to area has a detrimental effect on their experience, can increase the length of stay and increase the risk of hospital acquired infection.

How it will be measured: Monthly ward reports to be included in board paper

Priority 3: *20% decrease in patient who have a urinary catheter and develop a urinary tract infection in hospital*

Rationale: From data sources the Trust is aware that at times we have a higher than expected rate of patients with catheters and urinary tract infections. A work programme has been launched and new documentation is to be introduced.

How it will be measured: An audit will be undertaken.

EFFECTIVENESS

Priority 4: *To reduce the number of cardiac arrest calls on general areas*

Rationale: If staff monitor and respond appropriately to patients whose condition is deteriorating then they should not reach the point of cardiac arrest.

How it will be measured: Cardiac arrest call data will be monitored and cases will be reviewed by a specialist group.

Priority 5: *Increase the percentage of Neonates receiving Total Parenteral Nutrition by day 2 of life*

Rationale: Neonates receiving TPN by day 2 of life is a best practice measure. Optimal nutritional support to infants below 30 weeks gestation, or below 1500g.

How it will be measured: Data is submitted monthly on all admissions. This will be monitored and reported monthly

Priority 6: *Sepsis pathway – baseline audit Q1 with trajectory set for Q4*

- Sepsis recognised
- Blood cultures obtained prior to administration of antibiotics

- Administration of a broad spectrum antibiotic within 3 hours of sepsis being suspected

Rationale: Sepsis claims over 37,000 lives in the United Kingdom annually. Research shows that early recognition and intervention saves lives.

How it will be measured: An audit will be carried out in Q1 and a trajectory and work programme commenced. A repeat audit will be carried out in Q4

EXPERIENCE

Priority 7: *Increase timely discharge of patients prior to 12 noon (after 8am)*

Rationale: Data shows that the majority of patients at present in the Trust are discharged after noon.

How it will be measured: From the computer system used in the Trust a report will be collated monthly and reported to board

Priority 8: *Reduce number of operations cancelled on the day to 0.8% by the end of Q4*

Rationale: Cancelling a patient's operation on the day contributes to a poor experience and impression of the Trust. This is a priority that is continuing from last year as there is further work that needs to be completed this year.

How it will be measured: Monthly data will continue to be collected and reported to the Trust board.

Priority 9: *90% of complaints received in 2013/14 will be responded to on time*

Rationale: The Trust's complaints process is a key learning tool which the Trust uses to learn from patient feedback. Additionally, there is evidence to suggest that the timely and effective management of patient complaints has a positive result on the patient experience, reassuring complainants that particular matters of concern are fully investigated and addressed.

How it will be measured: All complaints are on a tracker and the time taken respond is monitored. This will be reported to the Trust board on a monthly basis.

Priority 10: *Reduce the number of complaints concerning communication and professional conduct by 15%*

Rationale: Feedback shows that the Trust has a higher number of complaints regarding communication and professional conduct than is acceptable.

How it will be measured: The subject of all complaints is monitored and this will be reported to the Trust board on a monthly basis.

Other Quality Campaigns/Initiatives

There have been a number of improvements and high impact campaigns in 2012 / 2013 that have enhanced the quality of care for patients and this work will continue and, where possible, expanded as part of our forward planning of the clinical strategy.

Registered Mental Health Nurses

The Trust has employed a team of three Mental Health Nurses whose role is:

- To support ward staff in the early identification of patients with a diagnosis of dementia or undiagnosed cognitive problems.
- To review patients with undiagnosed/early onset cognitive problems and refer to the appropriate community services i.e. GP, Memory services.
- To support the implementation of care plans for patients with cognitive problems covering areas such as communication, nutrition and carer support.
- To support staff with the management of patients whose presentation is difficult to manage as a result of their cognitive problems i.e. dementia, acute delirium.
- To support the quality team with the implementation, daily screening and validation of the dementia CQUIN.
- To contribute to various quality groups such as the Dementia CQUIN Group, Improving Patients Outcomes Group, Dementia Strategy Meetings, Safeguarding Meetings, Liaison meetings with Berkshire Healthcare trust (mental health trust).
- To support staff with patients who have been detained under the Mental Health Act

Since the introduction of the Dementia CQUIN in August 2012, the Mental Health Team have seen on average 25 patients a month who have reported early signs of memory problems. These patients have been given advice and reassurance regarding memory and age related memory problems as well as a more comprehensive cognitive assessment. All these patients are then referred either to their GP for review or are referred directly to memory services.

The Mental Health Team will see between 2 and 10 patients a day where ward staff are finding their behaviour difficult to manage. This can be patients who are acutely confused and/or aggressive due to dementia, acute delirium i.e. urinary tract infection, alcohol withdrawal and patients with psychiatric problems such as acute anxiety or psychosis.

The Team will often meet with the carers of patients with dementia and provide education, support and sometimes referrals to carer support organisations.

Practice Development

The preceptorship framework is now well established and staff attend within their first month of employment, this week establishes clear standards and expectations regarding patient safety and quality of care using a holistic learning approach that immerses the learner into the patient experience. Six months later they attend the foundation programme which uses the same approach and is centred on recognition of the deteriorating patient. During the first six months, the team work alongside the preceptees in their clinical areas giving support and guidance.

Learning methods used within all the Practice Development programmes include:-

- *The human patient simulator* – this life size ‘dummy’ can be programmed with various clinical conditions. The facilitators interact with the learners via the simulator and by playing the parts of the ‘patient’s’ visitors, allowing learners to see the immediate effect of their actions, inactions, communication styles and general attitude. Feedback after the scenarios concentrates on the clinical skills, communication, situational awareness and compassion. A pregnant simulator and baby simulator have also been purchased in 2012 to further enhance the training for our maternity staff groups.
- *The empathy suit* – this is worn by the learner and reduces limb movement, centre of balance, hearing and visual capacity. The learner is invited to take a walk with a facilitator and their feelings and thoughts are noted. Learners have identified feelings of vulnerability, fear, frustration and general consideration of the limits of the environment. Learners are asked to reflect on their feelings and discuss how they will adapt their nursing care to meet the needs of patients with impairments. The kit also includes tremor gloves that simulate hand tremors similar to those experienced by patients with Parkinson’s disease, alcohol and drug dependencies and these are used in the same way.

These innovative approaches aim to ensure that staff feel well supported and cared for to enable them to give their best to their patients and further enhance the quality of care provided to patients.

Macmillan Information Centre

Improving the patient experience is a key theme in the Cancer Reform Strategy and evidence of this can be seen in the projects undertaken this year to improve holistically the lives of people affected by cancer. The goals of cancer care are to improve services with the patient at its heart and the staff at the Trust in collaboration with Macmillan have collaborated on a number of projects during

the past 18 months which see us move closer to this goal. The cancer Information and support centre was one venture that demonstrates the Trust working collaboratively with external agencies. Macmillan funded the refurbishment of the disused flower shop at the entrance of the hospital converting into a tranquil information and support centre operated by trained staff and volunteers. The centre also provides CAB financial advice and a wealth of publications including non cancer literature of local groups, such as the local age concern.

Venous Thrombo-Embolism VTE Award

The Trust has sustained the dramatic improvement it made in increasing the number of Venous Thrombo-Embolism (VTE) assessments for inpatients in 2011/2012 which is an important step in reducing the risk of hospital acquired VTE. This has been achieved through extensive training programmes, patient, public and staff health awareness campaigns and careful performance monitoring.

In recognition of the hard work and improvements made the Trust was delighted to be given a coveted national award from the VTE prevention charity 'Lifeblood' for the most improved Trust 2011/12.

The expert panel of judges felt the Trust's submission demonstrated an exceptional level of leadership and innovation, and the strategies wider adoption throughout the NHS could lead to significant improvements in VTE prevention nationwide.

Work on reducing hospital acquired VTE continues, with the roll out of new pathways for extended VTE prophylaxis for certain high risk surgical and orthopaedic patients.

Going forward VTE prevention remains in the spotlight through our high impact action campaigns and audit programme, together with ward based activities led by our VTE link Nurses to promote awareness and prevention and local press articles to raise awareness of VTE prevention in the local community.

Dementia

The Trust has continued to develop good working relationships with the local carers associations and members from the association have participated in training for staff on the role of carers. The Trust also participated in a Slough Carers event in November 2012 to reach out to the local community.

The Trust cares for many patients who, once recovered from the acute phase of their illness, are unable to be discharged immediately back to their own homes. In 2012 a room was designed especially for patients with dementia, called the Sunflower Lounge, this room offers a homely environment in order to support these patients further and to improve the experience of those who

have to remain in hospital as they continue to need treatment. We know that when patients are given the opportunity to reminisce it can provide stimulation which may enhance mental well-being and result in an improved health outcome.

Over the past 12 months, 267 members of staff have attended the full day dementia training day. The day covers the different types of dementia, symptoms and interventions, delirium, communication, end of life care, nutrition, pain management and mental capacity. We also have a session when a carer comes in to share her experiences of caring for someone with dementia.

Going forward we are in the process of introducing the 'Sunflower Scheme'. The idea is that a patient with 'cognitive impairment' will have a sunflower symbol on their bed, on the outside of their notes, on realtime and on the menu board in the kitchen. This will alert all staff that there may be some communication issues that they need to be aware of and they need to speak with staff or check the patients care plans before they interact with the patient. Dementia Champions across the trust are being introduced. Every area, clinical and non clinical will have a nominated member of staff to 'champion' good dementia care in their area of work. The Dementia Champions will receive specialist training over a 6 month period and have protected time to attend meetings and liaise with other organisations and support carers.

Maternity

The maternity department have had a focus on staff development over the last year. Two consultant midwives enhance the focus on normal birthing and there has also been the introduction of Consultant Obstetrician hot week which ensures better pathways for women and improves safety as identified good practice by the Royal College of Gynaecology and obs. Midwife recruitment has been at a high rate over the year and hence vacancies are low. The focus is now on staff retention. There are daily Multi Disciplinary Team review meetings on the labour ward of all Emergency caesarean sections reviewing practice against guidance.

Other Key Quality Measures (Measured as of February 2013)

Mortality – The Trust's mortality index has remained below the previous 12 months average and has been below the peer group average since September 2012

Falls – the number of patients with a fall in a care setting
National position 2.30%
Trust position 1.81%

Pressure Tissue Damage – The proportion / number of patients with a new pressure ulcer (developed after 72 hours of a hospital admission)

National position 1.34%
Trust position 1.45%

VTE Assessment – The proportion of patients with a documented VTE risk assessment
National position 62.61%
Trust position 92.74%

VTE Prophylaxis – The proportion of ‘at risk’ patients receiving appropriate prophylaxis
National position 66.44%
Trust position 92.81%

Caesarean section rates – continued to decrease throughout the year following a number of actions described above - rate in February 23.5%.

Complaint Response Rates – In February 86.7% of complaints that were closed were responded to within the agreed timescale.

Service line strategy

During 2012/13, the Trust has been progressing to an advanced level the procurement of a system to generate service line reporting (SLR). The preferred option, involves creating a system of internal pricing and using standard costs which enables a system of internal trading to be developed. In this way variances for usage are attributable to specialty service lines and so variances for efficiency will remain with the service responsible for managing costs. This system known as integrated SLR (iSLR) developed by Guys and St Thomas’ allows the Trust to develop trading accounts for all service lines. A significant criterion for selecting this system was that it is relatively quick to implement when compared to a full patient level costing approach (PLCs). The strategy for three years would be to implement in 2013/14 to generate output that could be used to inform investment decisions, support QIPP and form the basis of reporting at a service line by the beginning of 2014/15 and then to develop this into a full PLCs over years two and three.

However, in March 2012, the proposal to enter into discussions with FPH stalled the procurement of the system. Discussions with colleagues at FPH indicated that if an acquisition were to proceed FPH would favour a PLCs based system and not iSLR. The Steering Group took the decision to defer procurement rather than invest in a system that may have to be shelved and for which a short term payback could not be guaranteed.

	<p>Should the discussions with FPH not lead to an acquisition the Trust is in a position to implement iSLR very quickly. Otherwise the Trust will need to work in partnership with FPH to integrate using a common system platform. In the meantime the current local in house method of generating contribution level reports will be developed alongside new proposals for tracking activity and finance during 2013/14.</p>

Clinical Workforce Strategy

The short to medium strategy for the Trust is to reduce staffing costs to that comparable to peer group average and in the longer term to be below peer group average. This will be achieved by substitution of agency staff with lower cost permanent recruitment. As the table above demonstrates this is achieved by in an increase in recruitment of permanent clinical wte and a reduction in temporary staff wte. The level of staffing has been informed by capacity planning exercises undertaken in 2012/13 that established a level of beds, activity and staffing that reflects operational and financial plans. The net result is a reduction in staff costs as a proportion of total income to 65% and agency costs down to 5% of total staff costs by the end of 2013/14. Further reductions in these key indicators are expected as the Trust moves towards its optimum operational level.

See Appendix 1e for further detail.

Key Workforce Pressures/ Plans to Address

A enabling workforce transformation programme has been developed as part of the 13/14 QIPP programme to address a range of key workforce pressures. The programme board is executive led and meets monthly to ensure each element of the workstream is on track. The three key elements of the programme are:

- Pay costs
- Culture
- Working patterns -24/7 working arrangements

Pay costs

Pay costs have fallen to 67% of income during 12/13 in line with plans and as a result of action taken during 12/13, but still remain higher than similar acute FTs. The Trust will continue to aim to reduce costs to 63% over the next two years in line with previous plans, through a continued strategy of replacing temporary staff with permanent recruits and ensure that working arrangements support productivity and value.

The main challenges in recruitment of specific staff groups have been consistent with local and national trends around skills gaps and quality of supply and have impacted particularly on emergency medicine, theatre nursing and neonatal nursing. The Trust will continue to work with education commissioners including Thames Valley LETB to try to find collaborative solutions. Other problems for the Trust have been associated with proximity to London and reputation, although during 2012/13 there has been much success in recruiting to consultant roles. Overall, actions over the past 18 months have led to an increase in substantive staff with an additional 206 over a two year period. 87% of these staff have been clinical.

Two key areas of pay costs which will continue to be addressed relate to premium rate medical staff costs – use of agency and high cost additional sessions for substantive staff - and administrative and clerical costs/ staff numbers.

During 13/14, the Trust will continue to address medical premium pay costs through a robust recruitment programme to reduce further the need for gaps to be filled by agency staff. Savings are targeted to come into effect from Q2 onwards, and actions to monitor this are reviewed at least weekly through Director of HR and Chief Operating Officer leading joint meetings with senior staff. Additional metrics will also be included as part of performance scorecards. Work will also continue with agency suppliers to reduce pricing, as part of local consortia arrangements.

Pay rates for sessions undertaken by existing medical staff have been reduced in the last quarter of 12/13 following a review. Work led through the Newton project is leading to improved use of theatre capacity and planning of outpatient clinics reducing clinical costs as a result; and a newly implemented rota planning tool in anaesthetics has already led to a reduction in staff costs and additional time required.

Regarding A&C numbers, workforce benchmarking undertaken by PWC and internally in 2012 identified that in comparison with similar acute trusts, the Trust has proportionately more staff at bands 7 and above. Work to reduce this down to comparable levels is in place as part of the QIPP programme through corporate service reviews and active vacancy management at Executive team level, supporting preparation work for potential acquisition.

In summary, actions to support ongoing paybill reductions include:

- Recruitment/ retention - Medical and nursing staff campaigns based on workforce plans;
- Sickness absence management - continued focus on management of sickness absence (the Trust's sickness rates currently lowest in NHS South Central);
- Workforce information and management - extension of e-rostering, rota management, ESR self service;
- Revision of AfC: implementation of changes agreed nationally;
- Medical Staff: - restructuring HR support to improve medical recruitment, and to optimise efficient management of locum doctors and rotas; continuing to implement best practice in job planning- focus on speciality doctors.

Culture

While the 2012 staff survey showed improvements overall compared with the previous year, the Trust remained below average for staff engagement. Other areas of concern included staff experiencing harassment or bullying, numbers feeling able to contribute towards improvements at work and recommendation of the trust as a place to work or receive treatment.

The Trust therefore recognises the need to improve its workforce culture, creating a culture of compassionate care as described in the quality section of this Plan. This will be supported by:

- A communications plan with key aims of managing the Trust's reputation including active engagement from public, members, CCG's; improving platforms for staff achievement and recognition to improve staff morale; and encouraging two-way communication by providing more accessible and speedy routes for feedback;
- Encouraging openness - reporting of adverse events, near misses, concerns; improving feedback of outcomes; revising policies and processes for whistleblowing;
- Maximising existing leadership programmes and opportunities, e.g. Building Confidence programmes for O&G and General Surgery; new consultant action learning set; working with Thames Valley & Wessex Leadership Academy; and
- Staff recognition – additional staff awards programmes linked to compassionate care culture.

Seven day working

A number of changes were put in place during 12/13 to improve Consultant availability out of hours and this will extend further during 13/14. Each specialty will undertake a review of access to key services across the full seven days, including radiology, rehabilitation services and pharmacy to improve response times, efficient discharge planning and support an improved patient experience. The Trust has agreed to work with the Commissioner to identify appropriate areas where other services could be commissioned on a 7-day working basis.

Clinical Sustainability & Identification of which of the Trust's services could potentially lack critical mass (defined by Royal Colleges etc.)

The robustness of clinical arrangements for the Trust is most at risk in emergency and acute medicine, where front end pressures combined with long term difficulties in filling posts included middle grade create a number of pressures. A significant amount of work is in place to address both aspects of this issue. The Trust has had some success in recruiting to vacancies in these specialities in the last 12 months, and is offering posts in a very flexible way in order to be open to the widest possible field. The impact of potential acquisition will help to promote attractive career opportunities

for clinicians within the Trust and will provide greater resilience to a number of clinical services. This will be aided by improved scope for innovation, research and development, and educational opportunities beyond those which are available currently.

Identification of which services have consultant cover below those recommended by Royal Colleges etc. (link to financial template)

Additional consultants have been recruited to address areas where consultant cover has caused concern linked to Royal College recommendations. In Radiology for example, four new posts have been recruited to, and three additional consultants have been recruited to obstetrics and gynaecology, due to start in the early part of 13/14.

Innovations in care delivery developed at the Trust or in conjunction with partner organisations.

There are a number of good examples of innovations in the delivery of care. The Urology department continues to build its robotic practice which is a centre of excellence for prostate; the service is growing to include gynaecology. In ENT, one of the Trust's consultants is being training for the use of robotic surgery in head and neck and another is leading on the webcast of live operations. The Trust's Enhance Recovery Programme has been extremely well received for Orthopaedics (for hip and knee surgery), Gynaecology (for hysterectomy patients) and Colorectal Surgery.

Productivity & Efficiency	<p>An overview of potential productivity and efficiency gains built into plans, including financial impact of projected gains</p> <p>An ongoing drive to deliver substantial productivity and efficiency gains is essential to delivery of the Trust's long term financial model and organisational development goals. The key areas of focus for driving out these efficiencies are highlighted below.</p> <p>Recruitment</p> <p>During 2013/14, focus on recruitment is vital to the success of the Trust and therefore a robust recruitment plan has been devised across all Divisions to support substantive appointments across all staff groups. This is essential to support patient safety and quality of care, staff satisfaction and optimising use of resources by reducing reliance on ad-hoc premium staffing provision. The aim is to ensure that continuity of nursing care is improved, and that recruitment in clinical support service areas incorporates forward planning and facilitates delivering diagnostic demand and provision of appropriate levels of support across the clinical services. Vacancy levels will be addressed through a rolling programme for nurses and a whole system review of working patterns for junior doctors is underway, with an international recruitment drive in hard-to-recruit medical specialties.</p> <p>Key Objectives:</p> <ul style="list-style-type: none"> • Reduce agency usage and associated reduction in reliance on temporary staffing • Reduction in ad hoc sessional activity at premium rates • Further reduction in vacancy rates

- Improved cover with substantive staff for maternity leave in support service areas
- New junior doctor rota in Medicine
- Improved staff morale

Enhanced Recovery Programme

The Trust is continuing its focus on Enhanced Recovery ensuring the principles are adopted across all surgical specialities to enhance patient care and improve efficiency through the associated reductions in length of stay.

Theatre Project

The Trust is engaged in a programme of work supporting efficiencies in Theatres.

The key objectives are to:

- Enhance the patient and staff experience
- Increase utilisation of time theatres are operational
- Reduce requirements for additional lists by managing a higher percentage of demand within existing resources

Fully sustainable change will be underpinned by standardisation and improvements in booking processes, reduction in delays and minimising cancellations to maximise the utilisation of theatres and optimise patient flow, whilst maintaining the highest patient care. The process will be supported by improved performance reporting through accurate and comprehensive data capture in real time.

Pathology Project

One of the key Trust developments is to implement a secure, modernised, and scale effective pathology service in collaboration with another provider during 2013/14. This will enable an increase in utilisation and maximise efficiencies across organisations.

Outpatient Project

The Trust is engaged in a programme of work supporting efficiencies in Outpatients.

The key objectives are to:

- Enhance the patient and staff experience
- Increase clinic utilisation and maximise clinic efficiency
- Improve the clinic booking process to ensure visibility of capacity and to maximise bookings
- Reduce requirements for additional clinics by managing a higher percentage of demand within existing resources
- Reduce the numbers of clinics overall by improving the clinic templates and maximising

- the booking potential
- To reduce the DNA rate to the Trust target of 7.5%
- Improved utilisation of Choose and Book

The changes will ensure standardisation across all booking processes and areas, to ensure patients are booked within required time frames, cancellations and DNAs are reduced and bookings to clinics are maximised to ensure optimum clinic utilisation. The process is supported by improved performance reporting through accurate and comprehensive data capture.

Radiology Project

Radiology services are engaged in a programme of work supporting efficiencies in primary care, outpatients and inpatients.

The key objectives are to:

- Enhance the patient and staff experience
- 100% of requests to be made electronically
- Improve the vetting and booking process
- Increase session utilisation and maximise efficiency
- Reduce length of stay for inpatients
- Reduce the diagnostic waiting time for primary care, inpatients and outpatients

No direct cost savings have been planned for within this project, although substantial efficiency gains through improved turnaround times are anticipated.

Ambulatory care – Same day emergency care

Ambulatory care principles support improvement in the management of ambulatory sensitive conditions, through improved patient self-management, disease management, case management or life style interventions.

Implementing ambulatory care will require examination of new ways of working across the emergency pathway. Avoiding overnight stays will improve the quality of care and patient experience, together with alleviating some of the capacity pressures.

The key objectives are:

- Integrated working practices between emergency department consultants and acute care physicians
- Patients identified for ambulatory care are diagnosed and treated on the same day with

- appropriate clinical follow-up
- Development of a dedicated ambulatory care unit
- Development of governance framework

The quality improvements associated to this work are enhanced quality of life for people with long-term conditions; avoiding emergency admission for patients; preventing readmission following discharge; ensuring people have a positive experience of care and a reduction in the incidence of avoidable harm.

Emergency Pathway – long conditions; seven day working; integrated care plans

The emergency care pathway can often be complex and success in managing in efficient ways will require new ways of working. Although there are many constraints on staffing levels, the five day working week philosophy needs to move towards seven days to improve the efficient management of activity.

The key objectives are to:

- Integrate a targeted discharge standard into daily one-stop board rounds
- Identification of long-stay patients at an early stage
- Development of integrated care plans from community to acute care for long-term conditions

Improvement programme designed to address bottlenecks in the system internally and externally.

	CIP governance Historical CIP achievement and plan is set out below:

£m	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Plan	n/a	12.7	17.3	15.1	11.6	8.1
Reset	12.4	8.0	-	-	-	-
B/fwd	n/a	n/a	4.4	1.4	1.4	1.4
In year	12.8	7.9	11.4	13.7	10.2	6.7
Achieved/Planned	12.8	7.9	15.8	15.1	11.6	11.6

In early years, the plan was reset during the year and CIPs to the end of the year were tracked against the revised plan. No reset was required in 2012/13 and achievement has been good against a very challenging target. The target for in year delivery for 2013/14 is every bit as challenging.

CIPs: Looking Forward

The QIPP program is organised around a matrix structure consisting of five delivery programmes:

	SRO	Clinical Lead	Operational Lead	Programme Lead
Planned Care	COO	Div A Clinical Lead	Div A Operations Director	Transformation Director
Emergency Care	COO	Div B Clinical Lead	Div C Operations Director	Transformation Director
Support Services	Deputy CEO	Div C Clinical Lead	Div B Operations Director	Director of Strategic Projects
Back Office	Interim CFO	N/A	N/A	Director of Strategic Projects
Estates	Director of Estates	N/A	Estates Programme Manager	Director of Strategic Projects

These delivery programmes will be supported by four enabling work streams:

	SRO	Operational Lead	Programme Lead
Workforce Transformation	Director of HR	Associate Director of HR	Transformation Director
IM&T	CIO	Assistant Director IT Strategy & Governance	Transformation Director
Procurement	Director of Estates	Interim Head of Procurement	Director of Strategic Projects
SLR	CFO	Interim Deputy CFO	Programme Accountant

Accountability rests with Executive Directors and the operational leads. In addition, all QIPP programmes have the support of a Programme Director and Programme Manager. All individual projects have identified leads and appropriate project management support. Each of the programmes reports into the QIPP Board which in turn reports into the Finance and Business Development Committee, a formal Committee of the Trust Board.

An external review by Price Waterhouse Coopers in August 2012 highlighted some good practice but certain areas for improvement both in terms of structure and process were also identified which would enable the PMO to be better prepared to support the delivery of the CIP plan. The QIPP PMO structure has been redesigned to deliver on the key outcome requirements whilst at the same time contribute to Back Office savings.

The core PMO has 6 wte comprising of a Programme Director, Admin Support, 2 Programme Managers and 3 Project Managers. In addition there is a dedicated Programme Manager for Estates & Capital projects under the direction of the Director of Estates and a Director of Strategic Projects providing additional support to a number of the key projects.

A CIP database linked to the Trust's financial ledger system is maintained and monthly finance and project highlight reports are produced each month for the QIPP Board. These include delivery milestones and metrics.

Risk to CIP delivery is identified as part of project management of individual schemes and are

reported along with mitigation plans to Programme Boards and collated onto a QIPP Risk Assurance Framework. The QIPP Risk Assurance Framework is managed through the QIPP Board and feeds through to the overall Trust-wide Risk Assurance Framework which is reported to the Trust Board.

Each programme will also ensure there are effective contingency plans to ensure delivery of overall CIP target and to develop further schemes to build a pipeline of schemes to close the small residual CIP gap (£311k) and for future years' CIP requirement.

The formal budget setting process has included specific confirmation from budget holders as to the delivery of CIPs.

CIP profile

As part of the Trust's high level vision, Corporate Objective 5 states the Trust will deliver a second year of significant cost improvement in 2013/14 set at a target of £15.1m and to develop programmes that will achieve recurrent cost improvements of appropriate scale to ensure the future clinical and financial viability of the Trust. Plans have been developed to balance the need to maintain or improve service delivery and quality whilst achieving the necessary reduction in our cost base.

Programme	Example Schemes	SRO / Programme Lead	Green	Yellow	Amber	Red	Total £m
Planned Care	Rota transformation, Outpatient and Theatre productivity, admin review, AfC changes	Chief Operating Officer	1.8	0.6			2.4
Emergency Care	Premium staffing, pathway change, AfC changes	Deputy Chief Executive	3.0	0.8			3.8
Clinical Support Services	Pharmacy review, premium staffing, review of staffing, AfC changes	Chief Operating Officer	1.4	0.2			1.6
Back Office	Review of corporate areas and staffing, Review of expenses, AfC changes	Chief Finance Officer	2.3	0.8	0.8	0.7	4.6
Estates / Procurement	Procurement, review of staffing, CSSD	Director of Estates	1.0	1.2		0.5	2.7
		Grand Total	9.5	3.6	0.8	1.2	15.1

An assessment of the deliverability of the schemes is made each month. A project is rated as "red" where the current assessment of financial benefit is below 75% of that estimated in the plan. It is amber when between 75% and 90%, yellow when above 90% but not 100% and is only green when 100% of the originally estimated benefit is still projected to be delivered.

The split by expense category is as follows:

Pay	£9.14m	60.5%
Non Pay	£3.82m	25.2%
Income	£2.17m	14.3%

Within the above total of £15.1m certain schemes are monitored at an operational level through established budgetary control and governance processes. These are: £1.8m relating to corporate, back office and agenda for change savings already removed from budgets; £0.6m income related schemes confirmed in commissioner contracts; £2.0m of non-recurrent savings under divisional control and £1.8m of 2012/13 schemes carried forward. This leaves a balance of £8.9m which is subject to central control and monitoring through a QIPP Programme Board. The following sections describe the design, process and management of the £8.9m.

CIP programmes and individual schemes were designed 'bottom-up' to ensure alignment with divisional financial/service delivery strategies and clinical engagement. The overall context was given by the need to ensure congruence with the medium-term financial strategy.

The CIP plans have been designed to address a number of issues which include the following:

- Move closer to peer benchmarks for staffing costs (twin problem of higher average substantive costs and higher temporary staff costs);
- Ensure optimal level of capacity utilisation in planned care;
- Reviewing provision of support services, in particular pharmacy, pathology and CSSD;
- Benchmarking indicators that prima facie suggest the Trust's proportion of back office spend is higher than its peer group; and
- Reviews of patient pathways to ensure optimal patient flow from front end to discharge
- Maximise savings potential through procurement and product rationalisation.

The individual schemes will be delivered through 5 programmes that capture these themes and address the issues above. Main schemes are summarised below:

Planned Care

Premium Staffing	Reduction in pay costs through optimisation of substantive staffing, efficient service aligned
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		rotas and optimising productivity whilst minimising the use of staff costs in excess of NHS substantive pay rates to deliver demand based activity
	Newton Outpatients & Theatres	Improved utilisation and productivity of funded capacity and a reduction in additional sessions
	Nurse Recruitment Phasing	Aim to Reduce overall vacancy rate within nursing. Plan demonstrates an increase in nurses of 1.2 each month with a corresponding reduction in reliance on bank and agency staff
	Admin Review	Review of admin roles to identify opportunities for team centralisation and reduction through not backfilling vacancies
	Drugs Expenditure	Improved use of FP10s, reduced wastage and reduction in drug expenditure through strategic purchasing
	Procurement	Reduction in non-pay expenditure through price negotiation, strategic purchasing & rationalisation of clinical products
	Emergency Care	
	Bed Based Remodelling	Net gain from South Buckinghamshire patient flow changes
	Premium Staffing	Reduction in pay costs through optimisation of substantive staffing and a 1:1 replacement at

		NHS pay rates
	Nurse Recruitment Phasing	Aim to Reduce overall vacancy rate within nursing. Plan demonstrates an increase in nurses of 1.2 each month with a corresponding reduction in reliance on bank and agency staff
	Drugs Expenditure	Improved use of FP10s, reduced wastage and reduction in drug expenditure through strategic purchasing
	Procurement	Reduction in non-pay expenditure through price negotiation, strategic purchasing & rationalisation of clinical products
	Clinical Support Services	
	Pay Schemes	Various schemes including reviews of pharmacy, outpatient nursing, histopathology, radiology and speech and language therapy to achieve reductions in pay spend and Q4 benefit from the Pathology Strategic Change Project.
	Premium Staffing	Reduction in pay costs through optimisation of substantive staffing, efficient service aligned rotas and optimising productivity whilst minimising the use of staff costs in excess of NHS substantive pay rates to deliver demand based activity
	Non-pay Schemes	Savings through the introduction of the

		pharmacy robot, procurement savings from teleradiology and outpatient nursing consumables and savings from the repatriation of serology tests and provision of blood products	
	Back Office		
	Pay Schemes	Various schemes including removal of recruitment & retention premia, removal of individual posts across a number of directorates, reduction in use of interims/consultancies, revised medical staffing support arrangements, PMO restructure and corporate office review.	
	Non-pay Schemes	Various Schemes including RTA income, review of IM&T maintenance contracts and review of legal services	
	Corporate Review	Strategic review of all corporate functions with a focus on reduction of Band 7-9 staffing levels	
	Estates		
	Pay Schemes	Various schemes including skill mix & shift pattern reviews, Health & Safety, CSSD operational arrangements for Heatherwood, appropriate capitalisation of posts	

Non-pay Schemes	Various schemes including medical illustrations, review of contracts & franchises, vending subsidies and car parking
CSSD	Outsourcing or provision to other providers
Private Patients	Better utilisation of facilities

The successful delivery of the CIP is underpinned by a number of transformational projects or enabling programmes:

- Workforce Transformation
- Newton Theatres & Out-patient Projects
- Emergency Care Programme
- IM&T

Workforce Transformation

This is a key enabler to the vast majority of QIPP schemes and will:

- align our workforce with our service and financial planning
- enable and support the workforce through creating a culture of compassionate care - 6cs (care, compassion, competence, communication, courage & commitment)
- reduce our pay bill and improve productivity
- build roles and responsibilities which bring out the best in people
- develop the current and future workforce to deliver services to the highest standard and to drive innovation and competency development
- reduce waste including errors and over processing, in order to add value to the patients experience
- improve staff engagement

A number of the schemes rely on our ability to recruit to key clinical posts and the following steps are being taken to ensure this happens:

- Detailed recruitment plan for each division
- Recruitment activity tracker for each division
- Realignment of HR resource to support recruitment priorities

- PMO support and assurance

Newton Theatres & Outpatients Project

2 Phase project to improve productivity within Theatres and Outpatient services with support to identify improvements in Clinical Coding and scope opportunities in Diagnostics. The process improvements will be supported by new information tools. Savings will be achieved by eliminating need for sub-contracting activity; reducing extra sessions and reducing some core Programmed Activities (PAs).

1st Phase to scope benefits completed December 2012, 2nd Phase implementation underway and currently on track.

- **Theatres** work includes improving start & finish times, flow, booking efficiency, scheduling and pre-operative assessment
- **Outpatients** start & finish times, effective clinic templates, first to follow-up slots. 1st 3 months aligned capacity/demand/contractual position

Supports savings achievement by eliminating need for sub-contracting activity, reducing extra sessions and reducing some core PAs.

Emergency Care Programme

An overarching programme, involving community providers and CCGs, bringing together all the initiatives and projects focussed on ensuring sustainable Emergency and Unscheduled Care services under 3 main workstreams:

- **Patient Flow** addressing internal and external delays, improving discharge processes, implementing the agreed new medical model across the whole health pathway and embedding the operational use of Realtime
- **Space/Estates** ensuring emergency care facilities are fit for the medium term, support operational efficiency and improve patient experience
- **Staffing** ensure staff levels and skills are appropriate for the delivery of safe and effective patient care

IM&T

The Trust has a comprehensive programme of work to implement its IM&T strategy including:

- **Core Clinical Systems** implementation of Newton, Realtime and theatre system improvements

- **Diagnostic/Clinical Support** PACs/RIS, endoscopy and pharmacy systems
- **Route to EPR** electronic document management and case note tracking
- **Corporate Systems** workforce information including e-expenses, rostering & job planning
- **Data warehouse** review of 'insource' pilot and maternity dataset
- **Infrastructure** including disaster recovery improvements and roll-out of wireless capability

Other Transformational Programmes

There will also be an overarching combined programme for Planned Care & Clinical Support Services.

CIP enablers and QIPP Development (including Clinical leadership and engagement)

The QIPP programme commenced in November 2012. Meetings were held with all relevant senior managers and clinicians at a divisional level to explore all potential CIP opportunities.

Over a period of the next two months initial plans were developed in which were subject to extensive Executive scrutiny and by January 2013 first cut emerging CIP plans were shared with the Trust Board.

Date	Actions	Responsible
Nov 2012	Meetings with all line managers and where relevant clinicians to ensure that March 2013 I&E exit rate supports both the 12/13 actual and 13/14 plan and that CIP proposals for 2013/14 were being developed	QIPP/Transformation Director with attendance from all functional directors and heads of dept
Dec 2012	Follow up sessions with all functions to ensure progress and first cut of emerging CIP plan reviewed by Executive	Chief Executive/Transformation Director
Jan 2013	First detailed review of CIP proposals with face to face presentation by Operations Directors to Exec board. Less than 50% approved. Board updated	Chief Executive/Transformation Director
Feb 2013	Follow up review to identify deliverability and barriers - revised plan content approved by Executive. Board updated and additional session of Finance & Business Development Committee held to provide additional assurance. Plan presented to PEC and received initial support.	Chief Executive/Transformation Director

	Mar 2013	Final CIP approved by Executive. Further board update. QIPP Programme and Project delivery boards established. Further Finance & Business Development Committee review. Plan and Quality Impact Assessment presented to PEC and endorsed subject to additional QIA detail (subsequently provided)	Chief Executive/Transformation Director
	Apr 2013	Further presentation to PEC and final endorsement confirmed	Chief Executive/Transformation Director
<p>Every CIP project has a project scoping document which outlines key benefits, costs, quality service impact, risks and mitigations. Larger projects (and all programme boards) are supported by project initiation documents. Key milestones and financial/quality metrics are reported within the monthly financial tracker and highlight reports.</p> <p>CIP plans are internally resourced and supported by a formal PMO structure (see previous section). Any implementation costs including external resource and capex have been identified in project scoping documentation and accounted for in deriving a net financial benefit.</p> <p>Programme Boards have appropriate clinical representation and QIPP Programme Board output is shared with the Professional Executive Committee (Executive and clinical directors) every month.</p>			
<p>Quality Impact of CIPs</p> <p>Each scheme has undergone a Quality Impact Assessment which has been reviewed and signed off by the appropriate clinical lead, the Director of Nursing, the Medical Director and the PEC. These will also be reviewed by our CCGs.</p> <p>Each programme has established an initial set of quality metrics which they will monitor and develop further. Key milestones and quality metrics are reported monthly to the QIPP Board.</p>			

Financial & Investment Strategy	<p>The Trust's financial strategic goals directly relate to Corporate Objective 2 of the Trust's high-level vision; to deliver efficient services within the activity and resource levels agreed with our commissioners; improving our clinical effectiveness and productivity.</p> <p>The summary of the financial plan over the next three years is as follows:</p>

Income and expenditure account				
£m	2012/13	2013/14	2014/15	2015/16
Income	232.3	232.6	227.1	224.3
Pay	(155.1)	(156.2)	(150.9)	(146.3)
Non-pay	(73.4)	(68.6)	(67.1)	(66.1)
Total expenditure	(228.5)	(224.8)	(218.0)	(212.3)
EBITDA	3.8	7.8	9.1	12.0
Restructuring costs	(0.6)	(1.0)	0.0	0.0
Financing costs	(10.1)	(11.7)	(13.4)	(14.9)
Net surplus / (deficit)	(6.9)	(4.8)	(4.2)	(2.9)
Revaluation impairment	(8.4)	0.0	0.0	0.0
Net surplus / (deficit) after impairment	(15.3)	(4.8)	(4.2)	(2.9)

To achieve its financial strategy, the Trust intends to:

- Reduce its premium staffing costs from 7% of revenue in 2012/13 to 5% in 2013/14;
- Generate efficiency savings of a further £15.1m or 6.5% of cost base (6.1% of revenue)
- Improve its operations to deliver efficiencies in outpatient booking, theatres and bed utilisation to deliver around £1.3m annually from 2013/14 onwards;
- Streamline the way A&E works with the Acute Medical Unit to improve the “front door” access and work with CCGs and others to develop pathways that ensure patients are treated in the right place of care to reduce length of stay by 10%, by end of quarter 2, leading to overall full year savings of £1.0m;
- Continue to integrate into business as usual the additional emergency activity from south Bucks during 2013/14 – the income and related costs of this are £4.1m and £3.7m respectively;
- Release surplus land in 2014/15 to an estimated value of £25m to provide incremental capital investment estimated at £15m. The first priority for any spend will be to develop the Heatherwood site including building 4 new Theatres.

- A £17 million capital expenditure programme in 2013-14 has been developed to deliver improved patient care, manage essential backlog issues and support cost improvement delivery and transformation including A&E.
- Develop clinical networks and collaborations with other acute providers to improve quality and efficiency beyond the life of the plan; and
- Embark on a long term strategic solution with a partner organisation; at present discussions are in progress for a potential acquisition by FPH.

The plan assumes:

- £17m of further temporary PDC to support the capital position and forecast deficit plan
- £2m of one off SHA support for restructuring costs
- A contingency of £3m for unexpected and unavoidable costs

Income

The Trust and Berkshire CCGs have signed a contract for 2013/14 which reflects more closely a PbR type arrangement. Contracted activity is below outturn but provision exists in the contract for fair payment for both elective and non-elective activity above plan. Future years are predicated on a similar degree of alignment. Delivery of the income element of the plan is dependent on continuation of this strong relationship with commissioners.

Income is, broadly, governed by four factors:

- PCT QIPP (demand management);
- Tariff changes;
- Activity; and
- Additional Support.

As noted above, the Trust is in discussions with FPH for a potential partnership arrangement. The consequences of this and the impacts that this will have on income and market share have not been

determined as yet and so have not been included within the three year plan.

Expenditure

In general, expenditure has been forecast on the basis of activity, consistent with the history over the past two years. This has then been adjusted for relevant elements of the contract agreed with CCGs and known service developments i.e. South Bucks commissioning changes. As such, general cost movements are primarily the net effect of inflationary increases and savings from efficiency projects. Indeed, operating costs will be reduced by £3.7m in 2013/14, £6.8m in 2014/15 and £5.6m in 2015/16 despite the effect of inflation and other cost pressures which are forecast to increase costs over the three year period by £38m.

The Trust has made significant progress in reducing its pay costs as a proportion of income to 66.8% which is close to the peer average. The plan assumes that this will be reduced further to a level of 65.2% of income by the end of 2015/16 delivering a recurrent saving of nearly £25m (see workforce section for more detail). The Trust has in the past relied heavily on agency staff and the reduction in pay costs will be delivered in large part through CIP plans designed to improve recruitment to substantive posts in order to reduce this dependency.

The plan for 2013/14 reflects the actual level of cost pressures and inflation that the Trust is aware of and this totals £16.6m. A contingency is being held of £3m for unexpected and unavoidable cost pressures that may arise during the year. In later years, an average inflation rate of 1.5% is included and a provision of £0.75m is set aside each year for as yet unidentified cost pressures in addition to that.

Delivery of the expenditure element is dependent on the Trust implementing efficiency measures to bring the cost base in line with its peers. Successful delivery of the above factors will however not solve the Trust's cash needs in the near term. Sustainability remains dependent on a long term strategy for the entire health economy.

While the Board is confident that such a solution will be forthcoming, as it has not yet been agreed, the plan as presented still reflects a significant funding gap of £17m which has been notified to Monitor and the Department of Health.

Risks

At a summary level, the principal risks to delivery of the financial strategy are as follows:

- | | |
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| | <ul style="list-style-type: none">• Failure to secure short and long term sustainability - Long term modelling has shown that even with an aggressive QIPP plan, available funding of the local healthcare economy, coupled with the Trust's geographical location relative to other providers does not allow the Trust to remain sustainable on an independent basis. This is being addressed both in the context of the local health economy and from the perspective of the Trust as a stand alone provider. Within the Shaping the Future Programme, the Trust is actively collaborating with other providers, commissioners and stakeholders to develop a strategy to ensure sustainable provision of healthcare for the local population. The Trust is also in discussion to be the subject of an acquisition by FPH that will seek to take advantage of both operational, capacity and demographic synergies to develop a vision for a financially viable Trust.• Failure to deliver the Trust QIPP plans - Delivery of the QIPP programmes will continue to be supported by robust governance processes embedded during 2012/13 and which have been developed for 2013/14 to provide an integrated delivery framework. Further detail on this is included within the CIPs section of this Plan.• Failure to respond flexibly to activity changes – The form of contract that has been agreed with CCGs will require robust arrangements for monitoring and reviewing to ensure that i) early warnings of demand reductions are flagged so that variable costs can be shifted downwards and/or ii) early engagement with CCGs for demand increases so that fair payments can be programmed to match budgets during the year. Current SLA monitoring systems are considered sufficient to track activity variances against plan and new tracking and reporting processes have been designed for implementation in 2013/14 to better understand the relationships between financial and activity data.• Failure of PCT demand management / increases in demand – any general increase in demand will put pressure on quality targets within given capacity constraints. |
|--|---|