

Strategic
Plan 13-
14

2013/14

Milton Keynes Hospital NHS Foundation Trust

SUBMISSION VERSION
31.5.13

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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The attached Strategic Plan is intended to reflect the Trust's business plan over the next three years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;
- The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;
- The Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;
- All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission.

Approved on behalf of the Board of Directors by:

Name (Chair)	David Wakefield
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Signature

Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Joe Harrison
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Signature

Approved on behalf of the Board of Directors by:

Name (Finance Director)	Robert D Toole
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Signature

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Milton Keynes NHS Foundation Trust

Annual Plan Review 2013-14

Executive summary

This document set out how the Trust's Board intends to deliver appropriate, high quality and cost-effective services for its patients on a sustainable basis, lays out the Trust's assessment of the challenges it faces (both within the organisation and more broadly within its local health economy), its strategy to address those challenges and its implementation plans over the 3 years from 13/14 to 15/16.

The Hospital currently enjoys the benefit of working primarily with one unitary authority and one community provider. The boundaries and catchment areas of these organisations are co-terminus and good joint working arrangements are well established.

The Trust wants to ensure that its patients receive the best possible experience of care, and that the quality and safety of care is continuously reviewed and improved.

Over time the Trust intends to consolidate its place as the secondary care provider of choice for the Milton Keynes citizens, and to win and build market share and critical mass through either acquisition/merger or competition/choice. The Trust believes that this offers the best deal to patients and provides for a strong and sustainable healthcare organisation.

The current population of Milton Keynes Unitary Authority is estimated to be 251,900 (by July 2013) and is one of the fastest growing areas in the country. Current forecasts predict that the population will reach 266,600 by 2016, and 297,300 by 2026, equating to a 21% growth over the next 14 years. There is significant growth in the over 60 age group, with current numbers increasing placing additional pressure on resources. Between 2013 and 2014 alone the population aged between 65 to 75 years is forecast to grow by 5.4%, and the population is expected to change such that almost 25% of the population will be aged 60 plus by 2026. This compares to around 14% in 2001. In addition, the proportion of the population aged 75+ will have risen from under 5% in 2001 to almost 9% in 2026.

The Trust is clear that more needs to be done to gain market share and this will be achieved through continuously building on the Trust's reputation and relationships with local stakeholders of whom GPs are a key partner. The Trust's Medical Director is leading work across MKHFT's Clinical Network to develop clinician to clinician relationships and the Trust is seeking to appoint a GP liaison manager for the first time to proactively enhance these relationships, promoting the Trust and its services.

Currently, only 66% of elective activity (60% by value) is referred to MKHFT, (based on Q1-Q3 FY13) demonstrating a clear opportunity for the Trust to better compete for market share and to capture higher-value activity by offering more specialist activity.

The main elements of the Trust's three year financial strategy FY14-FY16 can be summarised as follows:

1. The Trust must continue with its drive to reduce costs and seek to optimise opportunities for a financially sustainable future. This three year plan recognises the need for a level of financial support in terms of additional Public Dividend Capital ("PDC") in order to achieve this. Improving to a Financial Risk Rating of '3', without substantial organisational development, will be challenging to achieve over this plan period. This inhibits the Trust's ability to secure a working capital facility hence the requirement for further PDC support.
 - i. The risk rating metrics are forecast in the prescribed model as follows

Metric		FY14	FY15	FY16
i)	<u>Underlying performance</u>			
	EBITDA margin	0.1%	0.1%	1.3%
	EBITDA margin rating	1	1	2
ii)	<u>Achievement of plan</u>			
	EBITDA % of plan achieved	24%	24%	24%
	EBITDA % of plan achieved rating*	1	1	1
iii)	<u>Financial Efficiency</u>			
	Net return after financing	(8.1%)	(8.5%)	(7.3%)
	IS surplus margin	(6.7%)	(7.2%)	(6.1%)
	Financial Efficiency rating	1	1	1
iv)	<u>Liquidity</u>			
	Liquidity days	(26.5)	(27.5)	(27.8)
	Liquidity days rating	1	1	1

* The Monitor APR model assumes achievement is in line with the previous year, making this metric a '1'. Given that the Trust has reviewed and updated the plan, then full achievement is expected and this metric would change to '5'. The overall financial risk rating of the Trust would remain at '1'.

2. Prudential Borrowing Code compliance; MKHFT is in its current form likely to be unable to maintain Minimum Dividend Cover through the life of the plan.
3. The annual budget agreed by Board of Directors will provide for a centrally held and managed contingency reserve. Throughout the 3 years, this contingency reserve is planned to be the equivalent to 0.6% of total annual income. This contingency reserve is currently planned to cover cost pressures within the organisation, subject to a formal business case process.

To support our financial recovery a significant efficiency savings programme is still required. The Trust delivered £10.0m efficiency savings in 2011/12 and £5.5m in 2012/13. The Trust is experiencing significant operational and financial challenge, and had a net deficit of £(8.8)m (5.5% of total forecast income) for 2012/13. The Trust's We Care Transformation programme is set to deliver £8.0m over 8 Months (FYE £12M) of efficiency savings in FY14 and c.£8.2m & c.£7.6m respectively in Years 2 & 3. The work-streams include expanding existing schemes as well as developing new opportunities.

Activity assumptions for FY14 are based on an analysis of actual activity for the twelve months April 2012 to March 2013, and have been adjusted based on published population projections and GP referral trends. The impact of business cases to reduce waiting times and increase market share through repatriation of out of area healthcare activity have also been included.

MK CCG has put forward commissioning plans for FY14 which contain c.£4m of QIPP driven activity reductions. The Trust activity assumptions at time of submission do not fully reflect the QIPP ambitions although the Trust is in on-going dialogue as part of its support to whole-system working as well as agreeing a realistic contract activity and financial baseline.

The Trust has limited capital expenditure over the past year in order to support its liquidity / cash requirements. With a clearer understanding of its financial plan requirements and in order to maintain and improve quality and sustainability across the Trust the capital programme has been reviewed and increased for FY14. As such a proposed spend of £8.4m is planned for FY14 which balances off the key clinical and operational priorities within the resources deemed available.

1.0 Strategic Context and Direction

1.1 Trust's strategic position within the Local Health Economy

Our vision is to create with our partners a local health system that:

- provides an excellent range of high quality local services ;
- is shaped around individuals and
- is future-proofed to meet the challenges ahead by building critical clinical mass in cooperation with partner acute trusts including Bedford Hospital.

The Hospital currently enjoys the benefit of working primarily with one unitary authority and one community provider. The boundaries and catchment areas of these organisations are co-terminus and good joint working arrangements are well established.

Over time the Trust intends to consolidate its place as the secondary care provider of choice for the Milton Keynes citizens, and to win and build market share and critical mass through either acquisition/merger and/or competition/choice. The Trust believes that this offers the best deal to patients and provides for a basis of a strong and sustainable healthcare organisation.

Within Milton Keynes there are two other providers offering elective care. The Blakeland NHS Treatment Centre (Ramsay Healthcare) providing ambulatory care services and outpatient services, and BMI Saxon Clinic, a conventional independent hospital offering inpatient and ambulatory care located directly next to the hospital campus. The provider of community services is Central and North West London NHS Foundation Trust (CNWLFT). While the current overlap in services is modest, Milton Keynes CCG's stated ambition of moving services out of hospital means that providers of community services are simultaneously a threat and a potential partner. It is also notable that there are several independent providers of outpatient services and diagnostic tests in the city: a provider of imaging, a provider of a range of outpatient musculo-skeletal services and other independent sector services are emerging. These all produce competition in varying degrees and whilst they could be seen as a threat to the Trust's range of services it also serves to ensure that the Trust continues to review and enhance its service offering and maintain effective relationships with key stakeholders.

Several other NHS Trusts are easily accessible to the local population, historically affecting the Trust's market share and flow of patients-

- Bedford Hospital NHS Trust; provides the full range of general hospital specialities to the catchment population covering north and mid Bedfordshire. Some specialities are operated in partnership with other hospitals: Luton & Dunstable Hospital for oral-maxillo facial surgery, ENT surgery, ophthalmology and East & North Hertfordshire NHS Trust for plastic surgery. MKHFT is increasingly collaborating with Bedford Hospitals NHS Trust (e.g. in vascular, cardiology and haematology).
- Buckinghamshire Healthcare NHS Trust; provides a full range of general hospital services and serves Buckinghamshire, Thame (Oxfordshire), Tring (Hertfordshire) and Leighton Buzzard (Bedfordshire) – it has a catchment population of c.500,000, but serves a much larger population of c.1.5m for burns and plastic services and c.14m for spinal injuries. There are three hospitals in the group – Amersham Hospital, Stoke Mandeville Hospital, and High Wycombe Hospital.
- Luton and Dunstable Hospital NHS Foundation Trust (L&D NHSFT); provides a comprehensive range of general medical and surgical services for c.300,000 people in Luton, South Bedfordshire and parts of northwest Hertfordshire and Buckinghamshire. The Trust has developed some specialist services including cancer, bariatrics and oral maxilla-facial surgery and treats the most premature babies across Bedfordshire and Hertfordshire.
- Northampton General Hospital NHS Trust (NGHT); provides general acute hospital services for the geographical area of south Northamptonshire, serving a population of c.400,000. The Trust acts as a local centre of expertise in oncology and stroke.
- Oxford University Hospitals NHS Trust (OUH) is a large tertiary centre and teaching trust, providing a wide range of general and specialist clinical services and is a base for medical education, training and

research. It serves the local population for their general secondary care needs, and offers more specialist services for patients from a wide geographic area. OUH provides the majority of tertiary care for residents of Milton Keynes.

The MKHFT, whilst providing general acute services has identified a lack of its development as a specialist provider in any area as a current significant weakness in relation to long term financial stability and its position relative to neighbouring hospitals. There are two key historical reasons for this position:

- The original catchment area was not large enough on its own to support the economic provision of many 24/7 services. Over the years the city has grown rapidly to around 250,000;
- The Hospital's funding has tended to lag behind population growth and that brought with it a reluctance to invest in specialist services that had begun to develop at other local centres.

On the positive side, the Trust is well placed to attract new patients from both within and beyond the city, with excellent access to the site, extensive car parking and accessibility by public transport. The site has significant potential for growth and has the opportunity to develop into a first-class health campus with the proposed development of a new medical school, research facilities and additional services including linear accelerators to support the provision of local radiotherapy. These developments are within the purview of the three years of this plan.

Culturally, local people have a strong allegiance to the city and to the hospital that was established in 1984 following a fervent local campaign for the new city to have its own hospital. This loyalty to the hospital has not been fully exploited to date but we are increasing the resources being directed at building and maintaining reputation both through the use of the FT members and stakeholders such as local GPs.

Population Trends

The current population of Milton Keynes Unitary Authority is estimated to be 251,900 (by July 2013) and is one of the fastest growing areas in the country. Current forecasts predict that the population will reach 266,600 by 2016, and 297,300 by 2026, equating to a 21% growth over the next 14 years. Just over 25% of the population is currently aged under-19 and the Milton Keynes Joint Strategic Needs Assessment (JSNA) identified a need for services to be targeted and more representative of the borough's comparatively young population. The total natural catchment area of the Trust is considered to be circa 15% wider than Milton Keynes Unitary Authority boundary consisting of patients from the market towns of Buckingham and Leighton Buzzard and the surrounding villages.

Equally significant is growth in the over 60 age group, with current numbers increasing even faster and therefore placing additional pressure on resources. Between 2013 and 2014 alone the population aged between 65 to 75 years is forecast to grow by 5.4% or 1,080. This will occur independently of the growth in migrants, who have a younger age profile and help to offset the impact of the native population aging. However, even with migration, the population is expected to change such that almost 25% of the population will be aged 60 plus by 2026. This compares to around 14% in 2001. In addition, the proportion of the population aged 75+ will have risen from under 5% in 2001 to almost 9% in 2026. This change to the population profile is likely to drive both an increase in the demand for health services whilst also changing the range and scope of the services required.

Milton Keynes has significant pockets of deprivation and poverty; parts of Eaton Manor and Woughton wards (where the hospital is located) are in the 10.0% most deprived in England in relation to various measures of deprivation, including income, employment and education. There are also inequalities in the outcomes for children and young people across Milton Keynes. As a result of the impact of social and economic inequalities on health, increased levels of respiratory disease, cancer, type 2 diabetes, poor mental health and substance misuse are prevalent.

Market share

The Trust is clear that more needs to be done to preserve and gain market share through building the Trust's reputation and relationships with local stakeholders including GPs. The Trust's Medical Director is leading work across MKHFT's Clinical Network to develop clinician to clinician relationships and the Trust is seeking to appoint a GP liaison manager for the first time to proactively enhance these relationships, promoting the Trust and its services.

Currently, only 66% of elective activity (60% by value) is referred to MKHFT, (based on Q1-Q3 FY13) demonstrating the clear opportunity for the Trust to better compete for market share from the two local independent sector providers, and to capture higher-value activity by offering more specialist activity. (Table 1 below)

Organisation	Elective	Non Elective	Out patient
Milton Keynes Hospital NHS Foundation Trust	66%	89%	72%
Oxford University Hospitals NHS Trust	9%	4%	9%
Northampton General Hospital NHS Trust	7%	1%	5%
Ramsay Healthcare UK Operations Limited	5%		2%
Buckinghamshire Healthcare NHS Trust	2%	1%	2%
BMI Healthcare	2%		1%
Bedford Hospital NHS Trust	1%	1%	1%
Luton and Dunstable Hospital NHS Foundation Trust	1%	1%	1%
Total	94%	96%	94%

Table 1: Percentage of MK PCT Commissioned activity at each local provider

There are six specialties where there is significant activity in the independent sector, which currently equates to approximately 10% of the market; these include trauma and orthopaedics, gastroenterology and general surgery. Whilst independent sector providers within Milton Keynes have gained significant footholds in some areas the majority of activity not being managed by the Trust has been to other NHS providers in specialties such as cardiology, oncology, respiratory medicine and maxillo-facial surgery.

MKHFT is now looking to address these shortfalls and is expecting to make gains in cardiology, oncology (including radiotherapy) and respiratory services over the life of this plan. The development of oncology services within Milton Keynes is in part reliant on significant capital investment for linear accelerators through partnership with OUH or NGHT. Whilst the model of care will be 'hub and spoke' this will result in many more patients being treated locally and the repatriation of associated work and more local chemotherapy to the Trust.

The Trust's Transformation Programme, kick-started by a leading third party firm, will improve efficiency and release additional capacity that will allow for both significant savings as well as reduced access times that again should begin to encourage market share.

The Trust has successfully engaged through the local 'Any Qualified Provider' framework and has been accredited as a provider of imaging for both local and neighbouring populations. There is active horizon-scanning for potential opportunities, with responses from the relevant Clinical Service Unit supported by the Commercial Development team.

1.2 Threats and opportunities from changes in local commissioning intentions

Milton Keynes Clinical Commissioning Group (MKCCG) is the lead commissioner for the Trust. The CCG's set out in their Commissioning Intentions document their key principles, these are to:

- Commission services which are value for money,
- Involve clinical leadership to make a real difference,
- Improve quality and safety to positively impact on clinical outcomes and patient experience,
- Develop effective engagement with stakeholders.

The document stresses the need for structural change and states that "the local acute provider is a self-acknowledged struggling hospital that does not see itself as being financially viable. The status quo for acute service provision cannot be maintained."

In order to meet its overall QIPP requirement of £13m in FY14 MKCCG plans to deliver significant reductions in national tariff activity. The CCG's proposed QIPP adjustments to the Trust's plan include:

- 5% reduction in first outpatient attendances;
- 13% reduction in outpatient follow-ups;
- 9% reduction in emergencies;

- 7% in reduction in A&E by volume and value.

Much of the QIPP saving is planned to be delivered through the CCG Programme Boards. Whilst many individual schemes represent continuation of existing or previously planned initiatives, there are also several which reflect a desire to reduce prices paid /payments rather than reduce hospital activity or cost.

The Trust has for some time been working with GPs and commissioners to develop strategies to plan for a shift in activity between hospital and primary care. However a significant proportion of CCG proposals are not currently developed to a level that allows complete confidence in delivery and therefore enabling the Trust to plan with assurance for a disinvestment in capacity. Over the next three years reducing the cost of unplanned care is critical to MKCCG's achievement of its QIPP target saving of £50.0m. A central element of this is providing a coherent health service response to patient demand through a single point of access. The Trust's Common Front Door project is at the heart of this strategy.

To deliver this level of QIPP specific schemes have been devised which include:

- Referral Management Service (or Gateway) which will monitor all referrals, help patients choose providers with short waiting times and ensure prior approval is given before referral. This will concentrate on three specialties initially.
- Development of a community ophthalmology service.
- Development and improvement of the musculoskeletal pathway in Milton Keynes. However, the intended service provider has withdrawn and the CCG has restarted the procurement process.
- Commission Primary Care to implement a Minor Injuries Local Enhanced Service ("LES") (i.e. additional service from linked to payment to GPs) to achieve a 20% reduction in lower tariff A&E HRGs.
- Work with primary care and clinical navigation service to 'guarantee' all urgent primary care patients attending ED instead of GP practice in core hours are offered an appointment or contact with a GP on the same day.
- Commission MKHFT to undertake utilisation management on all emergency admissions.
- Commission the use of a Clinical Navigator to 'eye-ball' all walk-in patients and stream to the most appropriate service. This services needs to work alongside the process of See and Treat within the ED
- Commission Milton Keynes Urgent Care Service(MKUCS) and South Central Ambulance Service (SCAS) to develop further clinical pathways suitable for ambulance conveyance
- Commissioners support to the Trust's 'Common Front Door' project
- Out of hospital services - There will be a focus on identifying those areas where care can be delivered closer to home across an integrated pathway of care, thus reducing avoidable admissions.

The Trust recognises that improvements are necessary and is committed to improving the non-elective care pathway. In 2012 the Trust commissioned a report on its delivery of unplanned care from Emergency Care Intensive Support Team (ECIST). The report highlighted areas for improvement and the Trust is committed to delivering on its recommendations to improve the flow of emergency patients through the hospital.

The CCG has not formally identified its intention to decommission specific services. However, it has indicated its wish to develop a community cardiology service which would substantially replace the hospital based Rapid Access Chest Pain clinic. In 2012, plans to develop integrated community musculo-skeletal services were published, which would reduce orthopaedic out-patient activity, as well as pain management and rheumatology. In addition the Trust is working with the Specialised Commissioners and MK CCG to redefine the HIV outpatient service in conjunction with other providers.

A further significant risk from commissioning intentions relates to the limited detail currently available for years 2 and 3 of the plan. The Trust has actively engaged with Commissioners to work up plans for FY14. The Trust's activity plans and revenue budgets have been developed with the operational teams who have reflected not only the commissioning intentions but also historic performance, existing demand and current waiting list position.

In order to mitigate risk emerging from an inability to robustly model activity past year 1, the Trust is looking to work collaboratively with its Commissioners to address any financial gap in years 2 and 3 together, as opposed to both organisations attempting to bridge its own gap in isolation.

A key opportunity for the Trust in years 2 and 3 will be to demonstrate a tangible saving from closer collaborative working with other organisations such as CNWLFT and other acute providers including Bedford Hospital.

Commissioning for Quality and Innovation (CQUIN)

CQUINs continue to have a potential maximum value of 2.5% of contract income (c.£3.5 million). The four existing national CQUINs are continuing with a total maximum value of 0.5% of contract income (c.£0.7 million). The Trust has evidenced its compliance with the pre-qualification stage relating to High Impact Innovations. The CCG had proposed that 1.5% (c£2.1 million) be set aside for a whole system unplanned care CQUIN. This did not get further developed in the time allotted and the Trust has provided and is working with Commissioners on a revised CQUIN arrangement. The balance of 0.5% (£0.7 million) is for continuation of an existing CQUIN related to antibiotics management.

Growth

The Trust has internally planned upon a level of activity in line with organic growth, repatriation through Patient Choice and its assessment of the risk attached to the Commissioner plans and is working with commissioners to keep this under constant review. The Trust will monitor levels of activity closely throughout the year, and develop plans to reduce costs to align to lower levels of activity as they occur.

Since the Hospital became a Foundation Trust part way through FY10 it has seen an increase in the activity delivered in the hospital. Table 2 below shows how the activity has grown year on year. FY13 was the first year when this has slowed significantly. The Trust's activity plans for FY14-16 reflect not only the known commissioning intentions but also an assessment of the likely demand management initiatives proposed by the CCG and experience which may indicate that GPs may be starting to more effectively impact demand.

Activity type	FY11	FY12	FY13	FY14	FY15	FY16
Elective spells	21,494	23,061	24,080	25,678	26,012	26,350
Non Elective spells	31,273	34,814	32,618	31,687	32,099	32,516
OP First Attendances *	88,267	83,197	88,060	80,227	81,270	82,326
OP FU Attendances *	143,644	143,406	148,957	169,850	172,058	174,240
A&E Attendances	72,402	66,860	72,556	72,912	73,860	74,820

Table 2 Historic and projected activity

Notes: * *

OP First attendances are not necessarily comparable from year to year. For example with FY14 movements the key issue is that Maternity services are now counted on a pathway basis rather than on an attendance basis.

OP Follow Ups now includes Diabetic Retinopathy screening activity where previously this was under a block contract arrangement.

Private patients

The lifting of the Private patient cap has allowed the Trust to put in place specific proposals for increasing both the amount and type of activity offered. The Trust has opened a new private outpatient facility on the hospital site and plans to develop this organically over the lifetime of the plan. In FY13 the Trust employed a Private Patient manager to develop this service.

Research & Development

The Trust is essentially a local service based institution and therefore it has a very low historic research base. The Trust recognises the importance of developing this area both in regards to income but also its ability to recruit and retain high quality staff. It has therefore included it in its core objectives for the FY14 the exciting

prospect of a partnership with Buckingham University for the development of the UK's first private medical school is also a step closer with signed SLA and outline agreement from the GMC.

1.3 Collaboration, Integration and Patient Choice

MKHFT has good partnering relationships with its main tertiary providers, such as OUH and it works closely currently with NGHT for the provision of cancer services. With the improved transport infrastructure running from the West to the East of the region including the A1-M1 link road, the Board is now focusing on developing clinical relationships with other acute hospitals including Bedford Hospital. Bedford is MKHFT's closest neighbouring hospital and faces similar clinical and financial challenges. MKHFT has already started collaborating on mutually beneficial clinical projects including the provision of vascular services and are now working actively to develop mutually beneficial specialist cardiology services with its neighbours such as PCI, device implantation, urology and advanced imaging.

This work is starting to deliver both clinical quality and effectiveness as well as efficiency savings. In the short term these collaborations include the creation of effective clinical networks, shared consultant on-call arrangements and in the longer term it is the creation of sufficient critical mass to effectively deliver a broader range of clinical services that will bring very significant care and financial benefits to both organisations. The Trust is fully committed to these collaboration arrangements with other care providers.

The development of radiotherapy on the hospital site will be in collaboration with another NHS provider and the process for agreeing this model is currently underway. The Trust is mindful of the need to ensure that Patient Choice is maintained and all developments are taking place with appropriate commissioner approval.

2.0 Approach taken to quality

The Trust's quality priorities for FY14 are set within the context of wide ranging schemes of development and improvements that have been put in place over preceding years and are specifically focussed to ensure the Trust improves the patient experience so that the Trust are recommended as the hospital of choice for MK residents.

As the major provider of healthcare for the people of Milton Keynes and the surrounding area, MKHFT want to be the first choice for local residents and GPs. The Trust wants to ensure that its patients receive the best possible experience of care, and that the quality and safety of care is continuously improved to the level of the best in the country. The Trust has chosen three quality priorities for the year to be included within Part 2 of the Trust's 2012/13 Quality Accounts. The rationale for choosing these priorities was:

- Determined following a review of the quality of service provision,
- Reflective of both national and local indicators,
- Aligned with the 3 domains of quality: patient safety, clinical effectiveness and patient experience.

The Trust's priorities are:

- The elimination of Grade 3 and 4 avoidable pressure ulcers;
- 100% Compliance with WHO checklist audit;
- A 5% reduction in hospital based falls.

In addition the Trust will continue to monitor the national mandatory indicators and the quality priorities identified by the commissioners.

The Trust has a number of areas for improvement (see CQC web-site report 20/04/2013) and no outstanding enforcement notices following removal of sanctions on the Trust in January and April 2012 regarding standards associated with infection prevention & control and paediatric services. The Trust was declared compliant with CQC Essential Standards for Health and Social Care in April 2012. To ensure that the Trust maintains compliance with CQC and other regulators standards, the Trust manages risks to quality in a pro-active manner. Using the CQC essential standards list for all specialties, the Board receive early warning of deviation from the required standards. The Board gains visibility of this information through the Essential Standards Dashboard which is reviewed regularly by the Quality committee. This in combination with operational review at the Clinical Service Unit level ensures that risks to quality are identified and managed before significant concerns arise.

The Trust has responded to the Dignity and Nutrition Inspection (DANI) carried out by the Care Quality Commission (CQC) last summer. The inspection took place in August 2012 and the Trust's results were published in December. Since the inspection the Trust has:

- Introduced intentional nurse rounding of all in patients so that every 2 hours nurses ensure patients personal care needs are attended to and that patients are treated with dignity and respect;
- Improved nutrition and hydration with a streamlined process for protected meal times ;
- Introduced a 'Your Stay in Hospital' leaflet so that every in patient has all the essential information they need;
- Introduced a new nursing assessment documentation that makes it easy for nurses to record key care needs of patients;
- Improved safeguarding process and staff education (appointment of dementia lead nurse imminent)
- Appointed a falls prevention co-ordinator to reduce the number of inpatient falls.

The key risks the Trust has identified to achieving the quality priorities during the lifetime of this plan are:

- Risk of decrease provision of quality clinical care underpinned by sound risk management and patient safety practices;
- Risk of non-compliance with regulatory requirements e.g. CQC and HSE
- Inability to recruit to certain roles;
- Risks associated with ED e.g. inappropriate physical size of the department for the number of patients, length of stay of patients in ED and patient management throughput to Medicine/Surgery. Also additional patients requiring access to ED services than planned;
- Risk of financial intervention through inability to deliver Trust financial plan;
- Lack of patient information systems that are fit for purpose. Inability to meet the need to replace our IT Requirements by October 2015;
- Risk of disagreement with Commissioners regarding settlement of invoices;
- Risk of having an inappropriate equipment replacement scheme in place e.g. defibrillators.

The Trust uses the Board Assurance Framework (BAF) as the standard process for formal and informal review of risks added to the Board; to effectively drive the delivery of the organisational objectives set out within the Trust's Business Plan and provides assurance about the effectiveness of the overall system.

Improving the quality of patient care is very important to the Trust and this is always the first section of every Board meeting. Board Directors want to continue to increase their own visibility across the organisation further so that directors can see the organisation at work for themselves, and listen to the experiences of staff and patients first-hand. The Board uses a variety of mechanisms to test the delivery of improvements in quality and to ensure that quality standards are maintained. Examples include:

- Patient safety walk-arounds are conducted by Directors;
- Director attendance at a sample of clinical improvement groups;
- Clinical risk assessments and clinical gateways for the Transformation Programme;
- Patient surveys;
- Audits, including participation in national audit programmes;
- Board scorecard and CSU scorecards reporting against key quality metrics including CQUINs;
- Patient panels and other work led by the Council of Governors;
- Quarterly matrons' reports to the Board;
- Real-time patient feedback to matrons on their weekly walk rounds;
- Inviting external peer reviews as appropriate.

Oversight of the Trust's quality indicators is provided by the Quality Committee who scrutinise the range of quality dashboards and reports to ensure achievement of quality standards set by external regulators (such as the Care Quality Commission (CQC)) and those areas identified by CSUs as areas of quality improvement. Over the coming years this range of metrics will expand with the addition of the Net Promoter Score amongst other feedback mechanisms to provide insight into the quality based choices of the Trust's patients.

The Trust committee structure has increased the focus on quality governance with better clarity of communication throughout the Trust on quality issues. The following changes have been instrumental in achieving this:

- The range of meetings was streamlined with a reduction in Care Standards & Compliance Committees and increased clarity of reporting to Management Board and Quality Committee;
- The membership of committees was reviewed to minimise numbers with the expectation that members will attend and participate actively. Members will ensure information is cascaded to front line staff from each meeting;
- All nominated Trust committees will have either the Medical Director or Director of Nursing as part of their core membership.

The Trust has re-focused its approach to reporting on quality matters from a quarterly Governance Report to a Monthly Quality Performance and Safety Report. A key element of the report is the Trust's performance in four areas, morbidity, Quality Schedule and CQUIN, CQC and Maternity. This combined report provides multiple dashboards and associated KPIs covering the areas of clinical quality and safety, patient experience, efficiency, finance and access and targets. Within this metrics from Monitor's compliance framework are included, for example:

- Infection control;
- A&E - 4 hour;
- Referral to treatment waiting times;
- 62 day cancer standard.

The CQC dashboard has been in use in the Trust since January 2012. Alongside the Trust's internal intelligence such as information from complaints, incidents and patient feedback MKHFT also utilises the CQC Quality and Risk Profile (QRP). The QRP outlines the CQC's view of the evidence available to it on the Trust's performance against each Outcome. Exception reports are completed when a key metric scores red in month or where the metric scores two consecutive amber ratings over two months. These reports are presented separately on the Board of Directors meeting agenda.

3.0 Clinical Strategy

3.1 Service Line Management Strategy:

The Trust is committed to providing high quality and cost effective services, across the range of local acute services both on its own and with a range of partners including other acute trusts and community providers. The Trust will develop and invest in new services where it is right to do so, as well as pulling out of services where the quality of care cannot be guaranteed and other alternative arrangements can be put in place.

This vision is demonstrated through the Trust's objectives which are to:

1. Improve Patient Safety;
2. Improve Patient Experience;
3. Improve Clinical Effectiveness;
4. Deliver Key Targets;
5. Developing a Sustainable Future;
6. Develop Robust and Innovative Teaching and Research;
7. Become Well-Governed and Financially Viable;
8. Improve Workforce Effectiveness;
9. Make Best Use of the Estate;
10. Develop as a good Corporate Citizen.

The Trust is committed to continue the path towards greater clinical control and accountability. To facilitate this each CSU and Division has available to it a suite of reports that identify how well the area is performing against quality and financial metrics. The development of Service Line Management has had increasing prominence in the Trust for the last 18 months and now is well placed to facilitate informed decision making as

to the viability of individual service lines. As part of the We Care Transformation Programme the Trust has developed an approach to benchmarking which consistently applies peer group analysis across a wide of metrics. The Trust now has a dedicated member of staff to develop this capability further and will look to use an extended range of tools to ensure that the greatest benefit can be gained.

3.2 Clinical Workforce Strategy

The Trust continues to develop its workforce plan to further align and be in conjunction with the Financial and Operational Plan, and necessarily to reflect the assumptions contained within the Trust's forward view over the next 3 years. The Trust Board is setting up a separate Workforce and Remuneration committee to improve governance and assurance in respect of workforce planning.

Each Division is targeted to be consulted annually on likely changes in workforce needs for the coming year and beyond for up to three years. This includes consideration of numbers, skill mix, skills, training needs and potential risk areas across all staffing groups.

There is co-ordinated consideration of workforce issues through the Recruitment Forum that develops and implements a range of recruitment and retention policies. The Trust's weekly vacancy control forum ensures that all recruitment requests are in line with Divisional and CSU workforce plans.

The Trust's workforce planning seeks to actively consider national, regional and local analyses of workforce availability and the Trust work closely with commissioning groups, local area teams and Thames Valley Local Education and Training Board (LETB) in workforce and education planning matters.

An example of longer term strategy formation is the current model of staffing of A&E services, with reliance on middle grade doctors which the Trust recognises is not sustainable, certainly in DGHs. The Trust is working on longer term models that fully explore the potential to expand the use of Emergency Nurse Practitioners and create attractive, integrated roles for consultants. Operationally, the Trust has also had to ensure safe and increased staffing within year resulting from increased acute workloads. The Trust has achieved this through a combination of targeted recruitment campaigns and increased flexible staffing through e-rostering, as well as the use of bank, agency and locum staff.

The requirement for staff is driven by the clinical services the Trust are contracted to provide by its commissioners and by developing care pathways, together with statutory and regulatory considerations, and changes in technology and productivity. We learn from events and incidents that may indicate specific training or development needs and we regularly review staffing levels in key clinical areas.

The Trust's approach to workforce planning considers not only the qualified workforce, but also staff in supporting and non-clinical roles. This is so that the Trust can address the needs of changing services and new ways of working in a holistic way, challenging some of the existing boundaries between staff groups and increasing the potential for multi skilling.

The Trust has supported many apprenticeships, including being the first in the region to have apprentices within the Pathology department. The Trust has also sponsored several staff to undertake foundation degree courses to support the development of assistant practitioner roles.

In developing the workforce plan underlying staffing assumptions regarding numbers and skill mix accurately reflect the opening underlying position prior to application of operational and savings efficiency plans. A nursing skill mix review has been completed and approved by the Trust Board. The full year effect of service developments in A&E, midwifery and paediatrics were incorporated as were any full year impact of FY13 savings plans.

The main factors that will impact on FY14 are;

- Service developments - the impact of agreed investment has been included in the plan;
- An investment in nursing establishment has been approved by the Board to further improve clinical care as well as seek to address and minimise any potential CQC or the second Francis report (FR2) issues (detailed below).

Quality assessments have been undertaken as part of the FY14 planning process, with schemes implemented to ensure establishments are adequate in terms of both numbers and skill mix.

The recent review of nursing staff levels has led to an agreement that to maintain quality of care an additional 40 WTE registered and unregistered nurses are required across the Trust. In addition the mix of nurses will also require to be realigned to meet the current needs of the organisation. The Trust has also identified that there is likely to be significant changes in the Consultant workforce over the next three years. The Trust therefore requires a more flexible workforce. Whilst the Trust will look to gain from point of scale deflation on recruitment of new staff, it has previously proved difficult to secure significant reductions in the cost base. The Trust also recognises that there are still a significant number of hard to recruit to posts such as medicine middle grades etc. The Trust is looking to the opportunity of more joint appointments and placements to help provide an attractive environment for staff and thus encourage people to regard the Trust as a desirable place to work.

The developing workforce strategy seeks to contain costs through working across organisations and continually reviewing the skill mix and clinical requirements for each area.

3.3 Clinical Sustainability

The Trust continues to work to develop services in line with Royal College guidelines in both a planned and opportunistic way. The Trust is working with local providers and tertiary centres to develop joint appointments and flexible working to ensure staff numbers are appropriate.

The Trust has recently recruited additional consultants in Urology and elderly care, the latter to assist in delivering a new model of care for older people within the Trust. Oral surgery medical staff are currently contracted through Luton and Dunstable NHS Foundation Trust and this is being reviewed to ensure that staff levels and working patterns provide the necessary cover and flexibility needed to deliver the service. The Trust has already begun joint working with other trusts such as Bedford Hospital to address critical mass issues in services such as vascular surgery.

4.0 Productivity & Efficiency

4.1 Overview of potential productivity and efficiency gains within the plan

The Trust's We Care Transformation programme is set to deliver £8.0m over 8 months (FYE £12m) of efficiency savings in FY14 and c.£8.2m in and £7.6M in Years 2 & 3. The work-streams include expanding existing schemes as well as developing new opportunities. They range from conventional CIPs through to greater collaborative working arrangements with other Providers/Trusts to provide different models of care across organisations.

4.2 CIP Governance

The Trust delivered £10.0m CIPs in 2011/12 and £5.5m in 2012/13. Despite this the Trust is experiencing significant operational and financial challenge, and had a deficit of £(8.8)m (5.5% of total forecast income) for 2012/13. The Trust recognises that its existing Transformation Programme, which has been in place since 2010, continues to face challenges in successfully delivering schemes and measuring their impact. Therefore it has been decided to re-organise and re-launch the Transformation Programme, to more effectively support the delivery of an urgent and rapid programme of turnaround and transformation, ensuring deliver of the Trust's efficiency targets for 2013/14 and beyond, in addition to the existing plans.

The re-organisation will significantly strengthen the programme's governance, controls and approach to communications and engagement. The new ways of working have been designed to ensure that:

- There is operational and clinical engagement and acceptance of the proposed improvements;
- The quality of services delivered is at the heart of the programme and will be maintained or enhanced through proposed improvements;
- The desired changes and benefits are fully embedded in the organisation and will be sustained.

The re-launch of the We Care Transformation Programme positions the programme firmly at the centre of the Trusts decision making process, central to the success of the organisation.

The programme governance arrangements have been strengthened to ensure clear lines of accountability, a focus on clinical engagement, vigorous management of clinical and non-clinical risks and a unifying ethos and change methodology. The detailed arrangements from the programme level through to 'theme' and work-stream levels and the role of the Programme Transformation Team in delivering the quality and cost improvement opportunities are described in more detail below.

- Accountability for delivery of the Plan will be with the SRO – the Trust's Chief Executive;
- The Programme is broken down into 4 themes (Clinical service redesign, Workforce productivity, Collaboration and Conventional CIPs) together with enabling projects, which are led and owned by an Executive Director (the Executive lead). The Executive lead is responsible for the successful delivery of their theme;
- Each theme is divided into work-streams which will have a clinical lead, responsible for ensuring appropriate clinical governance and risk management, and a skilled operational lead, responsible for delivery to the Executive Lead;
- The Programme structure provides controls which operate at 'programme', 'theme', and 'work-stream' level;
- In addition, Divisional/CSU delivery will be scrutinised through the Trust's Performance Management framework;
- Every work-stream undertakes a robust clinical risk assessment prior to proceeding to implementation. The Quality Committee has oversight of clinical risk assessment processes;
- The Programme Transformation Team provides coordination of the application of all programme controls. The Programme Transformation Team maintains an overview of all cross cutting issues and interdependencies. This includes oversight of risk management, benefits management and stakeholder management;
- The operational and clinical work-stream leads are responsible for providing the Executive with timely and accurate information to enable high quality decision-making. The Programme Transformation Team supports the operational and clinical work-stream leads to maintain up-to-date the suite of standard templates to be used by the projects.

The Programme Board, Quality and Finance Committees and the Management Board are critical to the successful delivery of the Plan. Whilst the Programme Board is responsible for the oversight of the Plan, the finance and quality committees have a responsibility in providing assurance to the Trust Board regarding the impact of the Plan on the overall performance of the Trust. The Management Board has overall operational responsibility to performance manage delivery of the programme within the Divisions and Clinical Support Units.

4.3 Efficiency Savings / CIP profile

The Transformation Programme structure consists of five core elements with a number of supporting work-streams as set out below:

- Theme 1: Clinical pathway redesign;
- Theme 2: Workforce productivity;
- Theme 3 : Collaboration;
- Theme 4 : Conventional CIPs;
- Enablers.

The work-streams and enabling projects are planned to deliver a minimum of £8.0m (over 8 months FYE £12m). The five key schemes are detailed in Appendix 2. These have been selected on the basis of financial value and organisational impact.

The development of collaborative schemes with other providers offers the opportunity to make the largest step changes not only to the mode of provision but also to its cost effectiveness.

4.4 Efficiency Savings / CIP enablers

In order for the Trust to develop and deliver a robust transformation programme, designed to deliver the target Efficiency / CIP savings whilst maintaining or improving performance and quality, External support has been engaged to provide support for an initial six month period, with an option to extend that support after six months to provide on-going advice as a critical friend or to continue with an increased level of support, dependent upon an assessment of the Trust's needs at that time.

4.5 Quality Impact of Efficiency Savings / CIPs

Before work-streams can be implemented they are scrutinised via a quality impact assessment process to ensure that quality risks associated with the programme are identified and managed effectively. This control is completed by the work-stream's clinical leads and reviewed and signed off by the Programme Clinical Risk Group, which is chaired by the Medical Director and the Chief Nurse and meets weekly.

5.0 Financial & Investment Strategy

5.1 An assessment of the Trust's current financial position.

The main elements of the Trust's three year financial strategy FY14-FY16 can be summarised as follows:

- i. The Trust must continue with its drive to reduce costs and seek to optimise opportunities for a financially sustainable future. This three year plan recognises the need for a level of financial support in terms of additional Public Dividend Capital ("PDC") in order to achieve this. Improving to a Financial Risk Rating of '3', without substantial organisational development, will be challenging to achieve over this plan period. This inhibits the Trust's ability to secure a working capital facility hence the requirement for further PDC support. The Trust is therefore working on two fronts, firstly to capitalise on the internal opportunities and secondly to work with partners to collaborate at a local level to maximise quality and deliver financial savings.
- ii. The risk rating metrics are forecast in the prescribed model as follows

Metric		FY14	FY15	FY16
i)	<u>Underlying performance</u>			
	EBITDA margin	0.1%	0.1%	1.3%
	EBITDA margin rating	1	1	2
ii)	<u>Achievement of plan</u>			
	EBITDA % of plan achieved	24%	24%	24%
	EBITDA % of plan achieved rating*	1	1	1
iii)	<u>Financial Efficiency</u>			
	Net return after financing	(8.1%)	(8.5%)	(7.3%)
	IS surplus margin	(6.7%)	(7.2%)	(6.1%)
	Financial Efficiency rating	1	1	1
iv)	<u>Liquidity</u>			
	Liquidity days	(26.5)	(27.5)	(27.8)
	Liquidity days rating	1	1	1

* The Monitor APR model assumes achievement is in line with the previous year, making this metric a '1'. Given that the Trust has reviewed and updated the plan, then full achievement is expected and this metric would change to '5'. The overall financial risk rating of the Trust would remain at '1'.

- iii. Prudential Borrowing Code compliance; MKHFT is likely to be unable to maintain Minimum Dividend Cover through the life of the plan.
- iv. The annual budget agreed by Board of Directors includes a cost pressure reserve, centrally held and managed, described as a contingency reserve. Throughout the 3 years, this contingency reserve will be equivalent to 0.6% of total annual income. This reserve is currently planned to cover cost pressures within the organisation, subject to a formal business case process. Those elements of the reserve committed non-recurrently during FY14 will be made available recurrently as a reserve into future years.
- v. A clear scheme of delegation within the Trust, so that responsibility for financial management and control is clear and unambiguous, building on the Service Line Management established in 2012;
- vi. A clear understanding of the contributions:
 - ii) that are made by individual service lines to the overall financial performance of the organisation;
 - iii) to the Trust from the research and development, teaching, charitable and League of Friends funding;
 - iv) that self-financing and income generation activities, both academic and non-academic, make to the Trust;
- vii. Whilst the Board seeks to approve a long-term Estate Strategy driven by a clear strategic direction, the Trust has put in place a short-term Capital Investment Framework, that ensures that the Trust continues to improve the quality of its environment for patients and staff, allows for a full risk assessed equipment replacement programme, delivery of the Trust's IT strategy, while meeting all statutory compliance requirements and reducing backlog maintenance.

Key financial priorities and investments and how these link to the Trust's overall strategy.

The key financial priorities for the Trust are to:

1. Drive out costs in the long term through a focus on improving and investing in quality. Manage cash to limit the extent of support required, forecast at £11.9m PDC and £4m Revenue support, a total of £15.9m to March 2014, without mitigation based on an I&E position of £(13.1)m deficit in FY14, with corresponding I&E positions respectively of £(11.5)m FY15 and £(9.8)m FY16. Outer year benefits from collaboration with other acute providers are included but no benefits from M&A activity taken in base case;
2. Manage demand and demographic growth along with commissioning intentions impact assessed at a total of c.£4m p.a. for FY15 and FY16, c.2.5% of income base.
3. Full compliance with the Prudential Borrowing Code; MKHFT is likely to be unable to maintain Minimum Dividend Cover through the life of the plan.
4. Maintain a contingency reserve as above in each of the three years for generic cost pressures.
5. Commit to fully investing our capital programme of internally generated cash c.£20.4m over three years.

The priorities reflect the Trusts overall aim to continue to provide a full range of services on the hospital site but to look to do this more and more in partnership with other organisations. The Transformation programme will continue to develop and will become an integral part of the Trust's processes combining traditional CIPs with wider transformational and service improvement projects

Key risks to achieving the financial strategy and mitigations.

The main financial risks to delivery are as follows (more detail on financial risks is provided in appendix 1):

Delivery of the We Care Transformation Programme financial benefits: High levels of savings required to meet the planned position, in each of the three years. For FY14, the Trust is developing benefit plans valued at £12m, requiring a minimum of £8.0m (FYE £12M) to be delivered over 8 months in year.

The risk is planned to be mitigated through external support to develop the programme and provide robust performance management through a dedicated PMO, with regular Transformation Programme Board and Team meetings, a clear overall governance framework, continued investment in capacity and skills and obtaining an independent assessment of the Programme to clarify the risks of sub-programmes. Nevertheless, the overall level of saving requirement, the capacity of Trust staff to support the programme and the fact that a proportion of the savings remain unidentified, means that a significant risk remains in delivery. Further non-recurrent contingency options such as vacancy freezes and controls on agency are being considered.

Restructuring Costs are expected to be Revenue funded through sources external to the Trust

The Trust will seek to mitigate any additional cash risk, beyond that identified in this plan, through a combination of either 1) delaying any restructuring commitments into FY15 (which would increase the recurrent savings requirement in the next financial year), and/or 2) reductions to the Capital Programme.

Given the high level of savings planned to be delivered in each year of the plan, the opportunity to deliver additional savings appear limited which represents a significant risk and requires collaboration and income growth.

SLA agreement with MKCCG: There is currently a gap between the Trust view of expected contract activity value from MKCCG and that being proposed by the commissioner. This largely relates to reality of QIPP plans being deliverable in the period suggested.

CCG QIPP plans are largely targeted into second half of FY14, so the risk sits largely in this most difficult autumn/winter period. To note April 2013 activity income was in line with Trust plans. Should CCG plans deliver then the Trust would look to reduce capacity where possible in a clinically safe fashion although it is expected that the timing of this would be post activity reductions to ensure activity reduction is sustainable are not simply seasonal fluctuations. As such mitigation would largely be required through a planned reduction in Capacity supported by Transformation funding.

Trust lose market share: Whilst the market share of the Trust is already at a level which indicates an opportunity to repatriate work to MK, it is nonetheless a possibility that activity could be lost to other local providers, both primary and secondary, in certain key specialties such as orthopaedics where AQP is being implemented. A full evaluation of this has yet to be completed but the risk in FY14 is expected to be no more than £1m. This is not embedded in the Trust plan. Current referral patterns do not suggest this as an immediate risk but this is likely to be seen more over winter months if the Trust sees significant pressure on elective bed capacity as in FY13. Mitigation would be through reducing or standing down elective capacity as appropriate. Again the expectation is that the capital programme would be a potential source of offset as a last resort.

