

Strategic Plan Document for 2013-14

James Paget University 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	29th May 2013

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

In signing below, the Trust is confirming that:

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

Approved on behalf of the Board of Directors by:

Name (Chair)	David Wright
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Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	David Hill
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Signature



Approved on behalf of the Board of Directors by:

Name (Finance Director)	Mark Madden
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Signature



The Strategic Context

In the last year the NHS has undergone the most radical change since its inception in 1948. The introduction of Clinical Commissioning Groups and the removal of Primary Care Trusts and Strategic Health Authorities have had a significant impact on the way services are commissioned and delivered.

As a Trust we face our most challenging times ahead in the history of the hospital. With the projected increase in our population, the growth in the proportion of patients over 65 and 85 and those with dementia, there will be increased demand on our services at a time when resources have to reduce by £20 million from our current income level.

Our fundamental driver will be to protect our core services from the threats posed by gaps in key medical posts and the financial challenge, in order to continue to deliver high quality patient care.

As a Trust, we strive for exceptional high quality, safe and compassionate care for all our patients and their families. We are also passionate about supporting the national direction to provide the right care, in the right place and at the right time. This will require us to work creatively and innovatively with our community and primary care colleagues. We provide local acute services and are committed to providing high quality, safe, reliable, personal and responsive services.

The Trust's first and foremost priority is ensuring our patients remain central to everything we do and they always come first. Our three priority strategic intentions are:

1. Put our patients first – providing exceptional high quality, harm free care
2. Be the best provider caring for our growing elderly population
3. Develop closer working arrangements with our health, social and educational partners.

The Trust is in the fortunate position of having a local Clinical Commissioning Group (CCG), HealthEast that matches our catchment area. We have a good working relationship and this should enable the local healthcare economy to take a long term strategic view on the planning of healthcare services, with complete clarity over the roles to be played by each party. This should greatly assist the transformation that is needed as part of the new NHS. The Trust completely supports local commissioning, will play an active role in the planning and provision of future services and welcomes the openness of the CCG in embracing all stakeholders in the process.

The next three to five years will be extremely challenging for us, the system and the NHS. We will need to radically transform and redesign our existing services and staff will be required to work in different and yet more creative ways using the advancements in information technology available to us. This will ensure we use our resources to meet the demands of our patients, but also deliver them in the most cost effective, high quality and efficient way, eliminating waste and cutting bureaucracy. We must ensure our services represent value for money and they meet all appropriate clinical standards.

To do this, we want to deliver more integrated clinical care with the Norfolk & Norwich University Hospitals NHS Foundation Trust (NNUHFT) and East Coast Community Healthcare (ECCH), the provider of local community services. We want to ensure our patients and their families receive seamless, first class services. This approach will also help to reduce any health or wellbeing inequalities and reduce waste. More importantly, it will help to secure the sustainability of the local health economy for the coming years.

The CCG's new commissioning model is focused on providing care at home whenever it is safe, sensible and affordable to do so. This will require both the Trust and the CCG to develop services and clinical integration. This may lead to a reduction in acute hospital beds as these patients will be cared for in more appropriate settings such as their own home, a care home, care home with nursing or a community hospital.

The Trust's five year strategy

The Trust is nearing the end of the development of a five year strategy to 2018. This identifies our key

areas of focus if we are to remain a viable and thriving organisation. One of the elements underpinning this is the patient activity that is being planned for. The underlying five year assumptions are summarised below:

- A significant increase (11.2%) in emergency admissions due to underlying trends and demographic changes, which could lead to an increase in emergency admissions of 3,136 by 2017/18 and the need for additional 48 beds, if none of the system wide strategies are successful;
- A decrease in elective activity based on underlying referral data; and
- A continuing rise in A&E attendees.

The growth in our elderly population will impact differently on specialties and some of those affected do not have accommodation with sufficient capacity to cope with the increased outpatient workload. In particular, with the growth in demand for care from conditions which require long term treatment, we are outgrowing the capacity or the space we have available. In addition the environment for patient care requires improvements in some areas of the hospital. Other key parts of our strategy include:

- **Education, Training and Research**

The Trust is in the process of developing a comprehensive education, training and research strategy, having set up an Academic Board and having created an academic division by bringing together most of the education and research related work on-going within the organisation.

The aims of the new strategy are:

- Supporting a patient and staff experience culture that ensures safety, expertise, consistency and compassion
- Assuring commitment to service excellence through the delivery of high quality education and training and research allowing JPUH to be recognised as one of the top under and post graduate district teaching hospitals
- Continuously develop leaders and role models
- Hardwiring success through systems of accountability such as the “employee accountability framework” now included in individual appraisals
- Creating and maintaining a culture of innovation and adeptness in responding to changing needs in our provision of education, training and research
- Providing and maintaining “state of the art” infrastructure to support research, education and training delivery and management
- Working collaboratively with educational and practice partners ,supporting multi-agency provision, working relationships and research endeavours
- Creating a culture of research activity across all professional groups and areas with increased “home-grown” research by academics and other professionals

The focus for 2013 -14 will be to:

- Focus on the behaviour changing programme that will support the culture change process overall
- Create high quality and innovative training and research environments
- Strengthen our leadership community development through robust talent mapping and succession planning
- Enhance and strengthen a mentorship framework for all staff groups
- Support evidence based practice and clinical service delivery via education and innovations in multi professional training
- Support the development of our research portfolio

- Improve on mandatory compliance percentages
- In addition, a significant investment is being made to the learning resources of the Trust - specifically to refurbish the Burrage Centre and to relocate the library to this building. Page 24 gives more detail on this.

• **Private Patient Services**

A well-established private patient inpatient service has been run from the Charnwood Suite for many years. At its peak this service generated in excess of £1m per annum but this has reduced in recent years due to improved general access times and worsening economic conditions. There is an opportunity to expand this activity further and with changes to the private patient cap rules there are now fewer restrictions. To support our ambition to grow this activity the Trust has built a new private patient outpatient clinic in the heart of the hospital. This facility has been leased to a company representing clinicians in the Trust. Increased activity through this facility is expected to deliver higher revenue through our inpatients and diagnostic services. The lease price is partly based on this success and will be flexed once increased revenue can be shown.

• **End of Life Care**

The CCG focus is on partnership working between providers of care and providing greater choice and continuity of care. Thanks to the generosity of donors who gave over £1.5m the Trust has built the Louise Hamilton Centre, a palliative and supportive care centre. This centre will uniquely be used by multiple agencies to provide advice and support for those patients and their families and carers who are affected by palliative care issues. It has been designed around the needs of the users and will enhance the patient experience. The charity will continue to fund raise to support running costs alongside commissioner funding.

• **Leadership and Organisational Development**

As a key enabler to delivery of our strategy, there is a requirement to develop our leaders. In March 2012, the Trust agreed an Organisational Development Strategy (ODS), having conducted a comprehensive 'listening and learning' exercise in the context of the CQC's criticisms during 2011/12. The ODS' implementation plan covers eight key themes for improvement. Work on rolling out our behaviours is underway and will continue to ensure this is embedded in all that we do.

Following the KPMG governance review during 2012/13, we are continuing our development of the Board of Directors with an internal assessment. Management structures are under review with the support of KPMG, along with consolidating and confirming the Trust's executive capacity through a number of new Director appointments and the appointment of a new Chief Executive and Director of Nursing, as well as an interim Director of Operations.

These reviews and actions are intended to deliver substantive improvements 'at the bedside' and to embed patient-centred improvements to our governance, leadership and operational management capabilities. This follows on from the 'turnaround' period of intense activity and change during 2012/13.

The Trust's short term objectives

The objectives for the first year of this plan are:

1. As a minimum we will meet CQC standards to ensure we deliver safe and harm free care to all of our

patients.

2. Ensure that every patient experience is a smooth journey through the various stages of the hospital, focusing on timely assessment and treatment in Accident & Emergency (A&E), rapid diagnosis, reducing length of stay and discharge home as soon as possible.
3. Embed our new values and behaviours framework for all our staff in the knowledge that this will lead to improved levels of patient experience.
4. Roll out the new performance framework to ensure all staff have clear objectives, appropriate support and development and are held accountable for their performance.
5. Work with our community, primary care and other partners to develop and implement joined up services for our patients, with an emphasis on moving hospital care to a community setting, enhancing our role in directly providing services and working more closely with our GP colleagues.
6. Implement an improved management structure that is effective, value for money and fit for purpose in line with our strategic challenges.
7. Meet our financial rating agreed with Monitor and deliver sufficient surplus to fund our capital programme.

Challenges within the local health economy

The CCG spends 84% of its acute expenditure with the Trust. 16% is spent with neighbouring NHS and specialist providers. Our nearest competitor is NNUHFT and they received 12% of all referrals from our CCG in 2011/12. We recognise that this is both an opportunity and a risk.

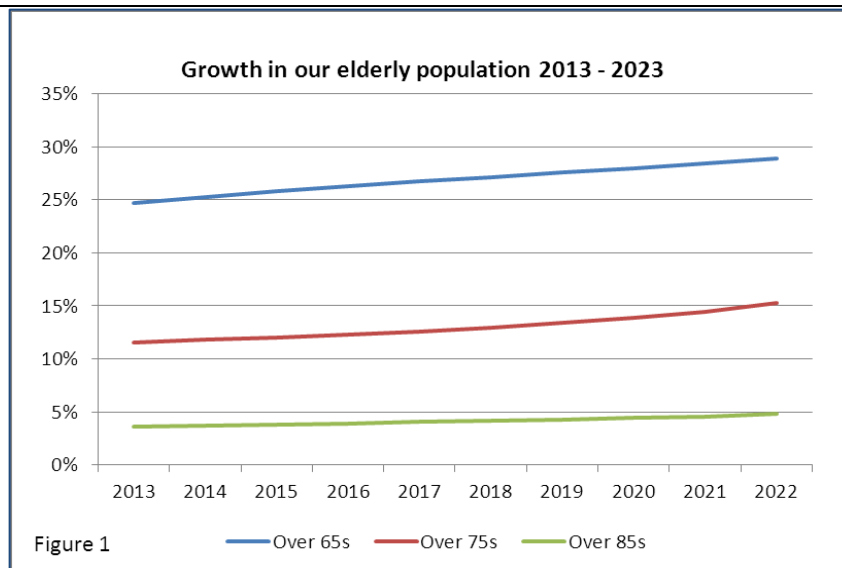
We are continuously assessing our key competitors to ensure we can respond quickly to any reduction in our market share. Currently, we see two key competitors:

1. The NNUHFT is located approximately 29 miles away from the James Paget University Hospital (JPUH) site. Like us, they have a strong reputation for service delivery, high standards and clinical expertise. Although, we see the NNUHFT as one of our key competitors, we want to build upon our already strong clinical and senior management relationships to further increase the level of clinical collaboration over the next three years. This will help us to minimise the risk of competition and will help to secure the health system's long term financial sustainability.
2. The private sector is increasing its presence and resources to compete for both clinical and non-clinical services.

- **Local demographics**

The total number of residents registered with a GP in the Great Yarmouth and Waveney area is 230,000. Over recent years, the local population has continued to grow steadily. Over the next 10 years the biggest increase in our population will be with the over 65 age group which is expected to increase by 20% by 2030. Alongside this we also have one of the highest levels of patients diagnosed with dementia compared to all other CCG areas in the country.

This projected increase in our population and increase in dementia is the single biggest challenge we face as more demand will be placed on our services. We will have to plan and work creatively to change clinical pathways to ensure patients are seen in the most appropriate care setting. The local health needs are also driven up by the high levels of deprivation, largely in the urban areas of Great Yarmouth and Lowestoft.



The 2009/14 strategic plan developed by NHS Great Yarmouth & Waveney, entitled 'Fastest Improving Health in England', details a number of challenges faced as a health and social care economy. Evidence shows that our local population has a particularly high use of acute hospital services including a high proportion of admissions from diseases that could be better managed outside of hospital. This would suggest closer and more integrated working is needed with all partners to make better use of existing services provided in primary care and the community.

The CCG is developing this work through their new out of hospital strategy. Work to reduce health inequalities has been a focus of the local health and social economy for some time and some improvements are already being seen. However, there are still four long-term conditions which account for nearly half of all our local health inequality gaps. These are as follows:

1. **Circulatory diseases**, including coronary heart disease and strokes
2. **Diabetes**, this is an important contributor to high rates of circulatory diseases
3. **Cancers**
4. **Respiratory disease** – mainly chronic obstructive airways disease.

- **Emergency demand**

The CCG has invested significantly in the last few years in community based emergency demand management strategies. The impact to the Trust in the past year has been a small reduction in attendances at the A&E department (-0.5%) but a continuing increase in emergency admissions (3.9%). If this trend continues then it will put further strain on an already stretched system. The review of effectiveness of schemes already in place is being undertaken to ensure that investments have been correctly placed.

- **NHS Reconfiguration**

Our local health economy is fortunate that the CCG mirrors the boundary of the preceding PCT and this boundary is co-terminus with the Trust's effective catchment area. The Trust has therefore not been majorly affected by the split of activity between different commissioners. However a much larger impact has been the split between locally controlled CCG commissioned activity and those budgets now controlled by national bodies. This has reduced the funds under the control of the local system and has reduced flexibility. It will require local services to be delivered through national specifications which may not reflect local need or demographics. The removal of the role of co-ordinating commissioner, as well as the increasing size of the specialist and nationally commissioned services, has made contracting

more complex, more fragmented and introduces some additional risk as the system beds in.

Locally the Trust has worked extremely closely with its commissioner to minimise uncertainty through this change and to provide support in discussions with other commissioners. The uncertainty from the shifts of activity may provide some volatility in funding flows during the first year of the new NHS.

- There is currently no intention to decommission any specific services from the Trust in the next financial year but service restriction through excluded procedures or threshold policies will become increasingly used to control demand for planned services.
- The Norfolk and Waveney procurement for direct access MRI and non-obstetric ultrasound which was awarded in 2012/13 will have the full effect in 2013/14. The impact to the Trust is expected to be limited. No further Any Qualified Provider initiatives have been identified by the CCG at this stage.

Strengths and weaknesses

The assessment of our key strengths and weaknesses is as follows:

Our strengths

- Strong financial track record
- Full Care Quality Commission (CQC) compliance
- University Hospital with a vibrant medical school, education and training facilities
- NHSLA (NHS Litigation Authority) level 2, working towards level 3 in March 2014
- Land, capacity and space to expand into – room for a Health Campus on site
- Strong partnership working with our local CCG, HealthEast, and NNUHFT and developing relationship with the local General Practitioners (GPs)
- Strong and growing research footprint.

Our weaknesses

- Weakened local reputation, due to the critical CQC inspections in 2011
- Difficulties in recruiting senior and junior medical staff
- Size of the organisation
- Lack of system wide transformational change – need to do more with less
- Lack of influence and control in extended patient pathways.
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Threats and opportunities from changes in local commissioning intentions

The key areas identified which may impact on activity are:

- Review of rehabilitation beds in the acute sector – this is part of the CCG's wider Out of Hospital strategy which is likely to recommend care being provided in more appropriate non hospital facilities. This strategy and the impact of consultation in Lowestoft are likely to impact the Trust from 2014/15 onwards
- Self-management of diabetes, stroke, COPD and heart failure to reduce acute attendances
- Primary care clinical services within A&E during out of hours
- Reduce variation/improve quality of GP referrals, through up-skilling, focus on dermatology to reduce referrals by at least 5%
- Adoption of a Non-Routine Treatments and Referral Policy consistent with the current NHS Norfolk

document

- Promoting the shift of cancer services into the community care setting including chemotherapy.

Other areas which will have an impact on the acute services providers are:

- QIPP and demand management.

The current plan from our CCG is to reduce elective and emergency activity but this will be replaced with demographic growth. The CCG's greatest challenge is to reduce emergency demand pressures in an already stretched economy. They have invested heavily in admission avoidance schemes in previous years and these need to produce the desired benefit if growth of emergency admissions is to be curbed.

Collaboration, Integration and Patient Choice

The Trust is developing clinical integration in two ways. Horizontally, it is building stronger clinical networks and relationships with its key partner, NNUHFT. This includes many shared posts to ensure clinical sustainability, individual service and pathway reviews to maximise opportunities and minimise risks. Vertically, the Trust would want to accelerate links with our community care colleagues. The main benefits of this approach are to ensure that all health professionals are working seamlessly, with shared values and purpose, with the obvious benefit for patients.

This is also in line with the national direction to provide the **right care**, in the **right place** at the **right time**. This could include a single point of access, improved information sharing and shared IT systems. To move towards a new service delivery model will require an extension to the current working day, review of patient pathways and processes, and the manner in which resources are managed. Evidence has shown a seven day a week service improves response times, reduces hospital length of stay and enables a rapid response and turnaround of patients who attend A&E. This change in service delivery is essential if we are to achieve a sustained reduction in length of stay of acute patients and support patients in the community, thereby avoiding admissions, and increasing our efficiencies.

Our networking will not restrict patient choice of provider. These are designed to streamline the process, ensure business continuity across systems and provide better quality of service outcomes for the patient.

Our CCG was a pathfinder in the CCG development and wishes to play a pioneer role in the new integration agenda launched by the Department of Health. The Trust is already in discussions on how we can partner our CCG in the development of this initiative to apply for pioneer status in the summer of 2013.

Our Quality Strategy

The quality of care and safety of our patients is at the heart of everything we do. Every single member of our staff has a responsibility for making sure this happens on a day to day basis. Our frontline staff will be central to delivering our vision and the care standards that we expect that every patient will receive. Our key focus is:

- To ensure high quality care at the bedside
- Prevention of harm to any of our patients during their stay with us, and

- An excellent patient experience of the services and treatment that we provide.

‘Our vision for quality care is to ensure ‘safe, patient-centred and effective, high quality, clinical care and treatment is delivered by valued individuals and teams within an environment of continuous improvement learning, accountability and efficiency’.

During 2012 KPMG assessed the Trust against the 10 Quality questions detailed within Monitor’s Quality Governance Framework. Two further in depth self-assessments have been conducted by the Trust with extensive work undertaken to embed quality governance. This was externally validated by the Trust’s external auditors. A further assessment will take place during 2013.

Part of this improvement work included the development of a Quality and Safety Assurance Framework which describes the Trust approach to gaining assurance from ward to board regarding compliance with the CQC outcomes and other external requirements. Performance reporting on quality indicators has significantly improved throughout the year with the development of a Quality and Performance Dashboard, supported by a Quality Situation Report, monthly to the Board of Directors. Furthermore, the Trust’s governance committee structure has been completely reviewed and enhanced so that the three domains of quality, Patient Experience, Patient Safety and Clinical Effectiveness, are given equal and robust attention at the sub-Board level and within operational areas – each domain has its own committee with an Executive Director as Chair.

Patient experience

Board members visit ward and department areas and any themes are considered at their briefing meetings. An informal programme of staff engagement and back to the floor visits has been in place with our interim Chief Executive. A more formal programme will be implemented with our new Chief Executive in addition to her induction. This is supplemented by the triangulation of patient experience information through our newly formed Patient and Carer Experience Committee (PACE) led by our Director of Nursing, Quality and Patient Experience as the responsible Board member. Wide membership facilitates engagement and involvement of patients and carers to make a continued improvement in the quality of service and experience of our patients.

The Friends and Family/Net Promoter (NPS) tool has been in place since April 2012 for adult patients having an acute inpatient stay. It forms part of the monthly Key Performance Indicators (KPI) on the ‘Know How We Are Doing’ boards (KHWD) in our ward areas and lists ward and specialty scores. NPS is also a Commissioning for Quality and Innovation (CQUIN) payment framework item and will continue in 2013/14 with roll out to A&E in April 2013, Maternity services in October 2013 and the expectation to all services (including outpatients) later. Trends on the scores are monitored by the PACE Committee.

Following publication of the Francis Report, the Trust is undertaking a full review of the 290 recommendations and the work required, in readiness for the statutory report due by the end of 2013 on the progress being made.

A range of Department of Health inpatient, outpatient and staff surveys are undertaken by Quality Health & the Care Quality Commission. The Trust monitors its performance against the top 20% of Trusts and the improvement plans developed are monitored through the PACE Committee.

The Trust continues to enhance its quality reporting through the annual quality account. These elements are included within our key quality priorities for the next year:

Patient Safety

- (a) Never Events – to embed systems, processes and other controls into practice across all areas of the Trust to reduce the risk of Never Events occurring

- (b) To reduce patient harm and aim to deliver 'Harm Free Care' as defined by the Safety Thermometer (the absence of preventable pressure ulcers and falls, urinary tract infection in patients with catheters and VTE) in line with CQUIN/contract requirements
- (c) To improve documentation and record keeping compliance, thereby ensuring robust patient assessments and plans of care.

Clinical Outcomes and Effectiveness

- (a) To improve and consistently maintain compliance with the metrics associated with high quality stroke services - to ensure patients, who are diagnosed with a stroke, receive timely treatment in an appropriate care setting and that the Trust improves clinical outcomes for patients with a stroke
- (b) To improve services to better meet the needs of patients living with dementia
- (c) To increase participation in all relevant national clinical audits
- (d) To increase rates of compliance with all relevant NICE guidance.

Care and Staff Experience

- (a) Themes from complaints – to reduce complaints, concerns and patient feedback related to staff attitude and communication
- (b) Mandatory Training – ensure staff receive mandatory training as required
- (c) To achieve improvements in the staff survey for specific areas of concern
- (d) To complete staffing reviews and to approve future steps/ recommendations.

Key risks to quality

The Trust's focus for 2013/14 and beyond is as follows:

1. Maintaining compliance with CQC outcomes. This is managed through a robust internal monitoring process set out in the Quality and Safety Assurance Framework.
2. Capacity and demand within specific specialties, e.g. ophthalmology, managed through Divisional Boards. The performance management framework includes monthly performance management meetings.
3. Staffing issues, particularly related to pathology, and medical staffing in some specialties. For specific issues such as pathology, this is managed through the project structure. For others, through Divisional Boards.
4. Patient safety, in particular patient falls and hospital acquired pressure ulcers. All patient safety risks are identified and monitored via robust risk reporting mechanisms. All incidents are investigated and appropriate action plans developed and actions taken.
5. Emergency demand. The Trust experienced extremely high levels of emergency activity during the 2012/13 winter period, which in turn put pressure on delivering both the national 18 weeks target for admitted patient care and maintaining A&E 4 hour wait targets. The achievement of these key targets and cancer waiting times will continue to be a challenge to the Trust if emergency demand does not abate. This risk is monitored by the Trust information services team and reported through performance reports to departments, divisions, the weekly External Assessment and Performance group and monthly to the Board of Directors.
6. Achievement of the Cost Improvement Programme. This is monitored by the Trust Finance and Transformation teams, with progress being reported monthly to the Board of Directors and fortnightly to the Transformation Board. The enhanced Clinical and Quality Impact Assessments

(CQIA) in place for CIPs is dealt with in detail on page 19.

Our Clinical Strategy

As care pathways continue to be reviewed at national, regional and local level there will be some services we currently provide which may be challenged in the future. We have always enjoyed a number of joint or merged services with the NNUHFT and we are working with them to identify the options and opportunities for providing these services across the two Trusts to secure clinically safe, cost efficient and effective care for patients.

We have demonstrated through our children's and midwifery services that we can deliver an excellent service where we have integrated community and acute care. There are other opportunities to replicate this model including care of the elderly.

We will seek opportunities to directly deliver care in community settings and we will work hard to improve our clinical dialogue and relationships with the local GPs to be a first point of contact for advice, rapid access for diagnosis and the joint delivery of clinical care.

We are committed to continue to providing patient care in the following **core acute services**:

- A&E – emergency urgent care 24/7
- Anaesthetics
- General Surgery
- Maternity
- Medicine
- Paediatrics (acute)
- Pathology (via EPA)
- Radiology
- Trauma and orthopaedics

These services are interdependent. In order to make our services sustainable we will strengthen the pathways for patients through closer working with local GPs, care providers and social services in addition to the partnership working with the NNUHFT.

Emergency and urgent care

Emergency and urgent care is the front door of the hospital for patients whose needs are especially acute. Our services comprise of:

- **The accident and emergency (A&E) department** – this is available 24/7, 365 days per year and treats over 67,000 patients each year brought to the hospital by ambulance, self-referred, referred by GPs or by the out of hours team. We recognise the need to expand the capacity of the existing A&E department to deal with the increased levels of activity. We have a plan to increase the number of resuscitation bays by four. Work will commence on this refurbishment in 2014. We will also increase the level of working with primary care at the front door and some of the future options will include the co-location of the out-of-hours GP unit adjacent to the A&E department, a minor injuries unit and/or an emergency outreach service.
- **Emergency assessment and discharge unit (EADU) and short stay medical unit (SSMU)** – are where we intensively assess and review patients with the aim of enabling them to rapidly return to home or to the place where they are cared for or be admitted to the appropriate ward in the hospital for further care within 72 hours.
- **Medicine and care of the elderly** - is where elderly patients with more complex needs will have

access to care delivered by a multi-disciplinary specialist team of doctors and nurses with rapid access to diagnostics. This will enable early diagnosis and treatment to be introduced to quickly stabilise the condition and enable the patient to leave hospital and be supported in the community. Younger Patients with acute medical conditions will be seen in a timely fashion by the appropriate specialist teams with early diagnosis and treatment initiated. Multidisciplinary teams will plan management chronic medical conditions so that adequate follow treatment is carried out in the community.

- **Critical care** – is a multidisciplinary healthcare specialty providing 24/7, dedicated one to one care for patients with acute, life-threatening illness or injury. Our critical care clinicians also support A&E, theatres, stroke and our hyper-acute stroke units (HASU).

Caring for our ageing population

Caring for this group of people in a planned and responsive way will require our clinical teams to work with GPs and practice nurses to identify and assess their needs quickly. With the support of hospital specialist medical and nursing teams, we will provide direct access to diagnostic tests, with quick turnaround times leading to rapid diagnosis and treatment in the most appropriate setting. This will reduce the number of frequent attendances to hospital and free up the hospital's specialist teams to focus their skills and expertise with patients who have more complex conditions that require acute inpatient care.

There will be a stronger focus on providing excellent care for patients with dementia or with complex co-morbidities. This will require a multidisciplinary team with involvement from our mental health, social services and community colleagues.

We do not currently have a strong and dedicated care of the elderly service with the specialist clinicians required to run such a service. As the need for the service is going to dramatically increase, from evidence elsewhere in this plan, it must be a top priority to establish a well staffed, dedicated care of the elderly department.

Elective care

This refers to those patients whose treatment is provided on a planned basis. The new day case complex will require a complete review of all the processes surrounding inpatient and day case surgery. This will include completely revising all clinical job plans and timetables.

A complete review of the elective service will be undertaken to commence in the first half of 2013/14 and be completed by summer 2014.

Those services that are not core will be subject to ongoing review with recommendations to the Board as to whether the services can meet the clinical standards in a sustainable way within the resources they currently generate. Any review would consider the option of the services continuing to be provided locally but by a different provider.

Clinical Workforce and sustainability

Some specific risks have been identified via incident reporting systems in relation to nursing staff shortages on a short notice basis. This can be due to last minute sickness or the acuity and dependency of patients necessitating the movement of staff from one area to another. Some specialities have been particularly affected due to turnover and national and/or local difficulties in recruiting specialist medical staff, for example, A&E, Radiology and pharmacists. The Trust's key workforce priorities are:

1. **Reviewing ward based clinical establishment/skill mix** in response to changing patient needs, with reference to the Francis Report, recent CQC reports, the patient flow/length of stay project and

the local healthcare system's demand management outcomes.

2. **Reduction in Registered Nurse (RN) agency expenditure** to substantively recruit to all funded RN posts. The Trust successfully used international recruitment during 2012/13 to fill vacancies and will continue with this strategy during 2013/14.
3. **Medical staffing recruitment** working group to identify new recruitment strategies to attract more highly qualified middle and senior medical staff to the Trust.
4. **Review/Restructuring of Management Establishment** to ensure a 'fit for purpose' management structure capable of matching the needs of the Trust and its strategic plan from 2013/14 onwards.
5. **Reduction in staff sickness rates to meet Trust's target of 3.5% based on 2012/13 outturn of 4.2%** to increase overall workforce productivity and savings on cover absences.
6. **Achieve Mandatory Training compliance target** enhancing patient safety through regularly trained and updated staff.

In reviewing its core activities the difficulty in recruiting to key medical posts in certain specialties or service areas has been considered. This is not just a local issue. In certain specialties there is a clear national shortage of suitably qualified senior and middle grade doctors. Strategies are being developed to address these concerns:

- We are striving to recruit to substantive posts by tactically offering enhanced packages such as a golden hello
- Working with our key partner, the NNUHFT, we are enhancing existing clinical networks. We are also reviewing and developing new opportunities for collaboration. Examples of existing successful networks include:

Cellular Pathology	Pathology	Neurology	Rheumatology
Nephrology	Cardiology	Oral surgery	
Oncology (including gynaecological oncology)	Various PAs across a range of surgical specialties	Various surgical on-call / weekend cover	

New networking opportunities include:

Dermatology	Stroke services	Pharmacy
Radiology	A&E	

- Working with the wider provider community in developing new initiatives such as the Eastern Pathology Alliance (EPA) to deliver services in a very different way. Three NHS trusts have totally redesigned hospital based and community pathology services which will protect the clinical service areas and provide efficiencies to the whole system, with JPUH as a partner in this with NNUHFT and Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.
- Developing education and research capability of the Trust in order to attract and retain good quality candidates.

Productivity & Efficiency

The Trust made significant investment in the Transformation team in 2012/13 and the team is now facilitating the drive for productivity and efficiency benefits.

The agreed 2013/14 Big Ticket projects are heavily focused on increasing our productivity and improving efficiencies. A summary of these are detailed overleaf:

Big Ticket project	Summary of project	Savings to be achieved in 2013/14*
Patient flow		
Length of stay	This is one of the key areas of work being conducted by the patient flow project team. Detailed analysis shows the level of challenge and detailed plans on how length of stay will be achieved are currently under development. Benefits: Improved patient flow, patients are discharged home sooner (when medically fit to do so), reduction in the number of medical emergency beds required, which will in turn release cost savings.	£500k
Re-admission rates	Reducing re-admission rates and identifying frequent attenders to A&E is part of the patient flow workstream 3. Benefits: Fewer patients are re-admitted, care is provided closer to home with the support of our community colleagues and our outreach teams.	Financial benefits still to be quantified
Reducing reliance on agency and locum staff		
Nurse, doctor and other non-medical staff	There are already individual workstreams established to identify ways of reducing our reliance on the expensive agency and locum staff. Benefits: Employment of more substantive staff will improve patient continuity, and will ensure services are clinically and financially sustainable in the longer term.	£1.9m
Activity		
Theatre and outpatient productivity	New ways of working and improved productivity is the focus to achieve the activity levels required by the CCG this year. Detailed plans have already been developed detailing how this activity will be delivered. There are also a number of opportunities to move where patients are currently being treated which will include moving patients from inpatient theatres to day case, day case to outpatients etc. Benefits: Waiting times for patients will reduce, staff and theatre utilisation will improve as well as increasing the capacity in outpatients.	£1.2m
Commercialisation of the front entrance		
Increased catering income and commercial rates	A business case is being developed to install a free standing coffee pod to improve the flow of patients and increase the catering income. Discussions are also underway with other commercial suppliers to look at expanding the number and type of shops that are located in the front entrance of the hospital. Benefits: Improve the patient experience and choice in terms of accessing food and retail shops.	£100k
Procurement efficiencies		
Procurement	A number of procurement opportunities are currently being evaluated by the Transformation Board. This work will require heavy reliance on clinical engagement to identify areas of standardisation and rationalisation of both clinical and non-clinical supplies. Benefits: Further rationalisation of existing suppliers, reduced spend on consumables, improved value for money, raised awareness of price, improved utilisation of existing clinical and non-clinical equipment, improved contract management and reduce waste.	£395k
Pharmacy		
Maximising use of generic drugs whether appropriate	The Chief Pharmacist has identified a number of opportunities where the license on branded drugs will end and significantly cheaper generic drugs will be made available. Benefits: Significant cost savings will be achieved through switching to generic drugs, no clinical impact envisaged on patient as drugs are of the same quality as the branded drugs.	£100k

Clinical partnerships		
Clinical partnerships	As set out on page 15, the Trust already has a number of shared consultant appointments with the NNUHFT. Discussions are underway to extend into other clinical areas such as stroke services, dermatology and radiology. Benefits: Services remain clinically and financially sustainable and patients continue to receive services locally.	£100k
Back office partnerships		
Back office partnerships	Opportunities have already been identified to improve the efficiencies of our back office functions. These opportunities include outsourcing, taking on new services from other NHS providers such as the CCG/ECCH. Benefits: Reduce costs through outsourcing, increase income in some areas achieved through winning new work in both the NHS and private sector.	£70k
Management restructure		
Band 7 and above review	KPMG has conducted a review of the Trust's existing management structure. There are currently four options being considered by the Board of Directors. A decision is expected by the end of May, when the full implementation of this project will commence. Benefits: Ensure the new management structure is fit for purpose, is in line with the Trust's five year strategic plan, is as lean as it can be and Francis compliant.	£400k

N.B. the remaining savings for 2013/14 will be delivered through Divisional/Corporate level CIPs.

Cost Improvement Programme (CIP) performance and governance

The Trust's performance on CIP for 2012/13 was not as good as anticipated with utilisation of contingency funds to achieve the Trust's financial targets.

The Board of Directors has led on the need for early planning as it will no longer be possible to continue cutting costs. Significant savings can only be found from transformational change. The Trust has invested in a permanent Programme Management Office (PMO) to drive the CIP / Transformation programme. Clear governance arrangements are now in place including the requirement for quality impact assessments to be completed. There is a clear process between the PMO, finance and the delivery owners to make timely decisions on CIPs from an operational perspective through the tripartite monthly meetings.

There is clear accountability for the 2013/14 programme. Planning began in the autumn, with engagement from senior/clinical leaders to come up with some 'big ticket' items. These have been refined, with each project assigned an Executive/ Divisional lead who is ultimately held accountable for delivery and financial savings. There are also delivery owners identified for each project. Divisional managers/directors are supported by the PMO project managers. There is good use of information with the generation of dashboards for the Divisional Managers to track delivery more effectively.

Progress is monitored through the milestones attributed to each project/scheme. The PMO project managers are responsible for supporting the delivery owners in updating this information on a regular basis. Each of the three Divisions now have very clear reporting structures including Divisional Transformation Boards, monthly performance meetings, regular CIP surgeries and budget challenge meetings.

The Transformation Board, chaired by the Chief Executive and attended by all Directors and Divisional Managers, is the vehicle where key decisions regarding this programme are made, reporting into the Board of Directors.

Transformation strategy

There are a number of initiatives in place to enable the CIP programme to generate new ideas as well

as making change a reality. These include:

‘Making it happen’ meetings, a multi-disciplinary monthly meeting, engaging with corporate and clinical managers, including medical, nursing and therapeutic representation. This group is responsible for identifying new ideas, working up ideas, changing practices to generate further savings and promoting the transformation/service redesign agenda. In addition, at the first ‘making it happen’ meeting, there was a clear consensus that the Trust is not good at identifying or minimising waste.

In order to address this, the following waste campaign will be launched:

- **Eliminating waste** driven forward by members of the ‘Making it happen’ group. Each week there will be a focus on ‘eliminating waste’ within six departments or wards across the Trust. There is a clear plan to involve every ward and department across the next 12 months. This initiative will provide staff, patients and carers the opportunity to highlight any waste or inefficiencies seen in their own area or anywhere else in the Trust. The Transformation Team will support the departments and wards to make changes a reality, realise savings and promote the need for everyone to be involved in eliminating waste.

Walking the floor, a Trust-wide initiative to engage face to face with staff, carers and patients every two months. Ideas or suggestions will be collated, summarised and fed back to the Transformation Board for review.

Blue sky event to generate new ideas and identify different ways of working. This has already been communicated via the monthly Leadership Brief, the Friday Communications email and at the Transformation Board. This event is now oversubscribed, with the exception of medical staffing representation and support staff. Work is in progress to address this through the Clinical Transformation Lead for medical staff, the Head of Support Services and Head of Estates. This event will be externally facilitated to enable all internal participants the opportunity to be fully involved and will be conducted within the next six weeks.

Creative thinking sessions – The Transformation Team has already facilitated a number of clinical and non-clinical workshops to generate additional ideas. Where these ideas are progressed, they will support any slippage within the Big Ticket or Divisional/ Corporate CIP savings.

Escalation of Divisional/Corporate CIP Schemes – Where the gap against the Divisional CIP target is to be covered by the implementation of increasingly radical or controversial schemes, it is likely that support from the Trust’s Transformation Team and/or escalation to the Executive Team for approval will be required. It is expected that such escalation will be via a business case presentation to the Transformation Board.

The requirements for enabling investment in the infrastructure (external support, IT, project delivery resources, etc.) are all identified within the project initiation documentation completed for each of the schemes being carried out this year. These investment requirements are also considered by the Transformation Board as part of the business case for change proposals presented before a scheme is signed off and can progress to having the Clinical Quality Impact Assessment (CQIA) carried out.

Clinical Quality Impact assessment

A new process for assessing the quality impact on services has been implemented. A CQIA tool has been developed which must be completed for each CIP project using a full appraisal, check and challenge to assess the potential impacts on quality for patients, staff or the organisation.

The scoring system is based on the current risk rating matrix already embedded within the

organisation. This scoring system enables us to assess the level of impact and the likelihood of any risks occurring by assigning a score to each quality risk category. All risks assessed between 0 and 7 are considered to be moderate or low risk. All projects with a screening score of below 8 (assessed as moderate or low risk) will be reviewed by one of the following: Head of Business Transformation, Assistant Director of Governance, Safety and Compliance or the Deputy Director of Nursing. This will provide assurance, check and challenge to ensure that the impact scores documented have been completed accurately and risks have been appropriately assessed. Schemes with a screening score of 8 or more will require a full CQIA.

The CQIA panel terms of reference has been developed and were approved by the Transformation Board in April 2013. These clearly define the decision and authority responsibilities of the panel. They have been circulated to all relevant staff. The CQIA panel reports directly into the Transformation Board.

The Medical and Nursing Directors are responsible for recommending sign off for the plans being reviewed, reporting back to the Transformation Board where a collective and corporate decision can be made. Assurances against this will be reported to the Board of Directors and the Safety and Quality Committee (SQG) on a quarterly basis. This will include reporting any changes that have occurred during the year or where new projects have been assessed. SQG will have delegated responsibilities from the Board to ensure that mitigating risks/issues are being dealt with appropriately.

This new process has robust systems and processes developed to flag and monitor the early warning indicators to ensure quality of patient care and safety is not compromised.

Financial & Investment Strategy

Current financial position

The Trust is experiencing similar financial pressures as the NHS in general and acute services in particular. Demand for emergency service continues to increase, paid for at marginal tariff, despite investment being made by commissioners in alternative non hospital services. Overall demand for services is increasing in line with the demographics of the population. Demand increasing, tariff prices reducing and cost pressures including the non-delivery of system wide QIPP, continue to rise making this the most challenging time for the NHS.

Financial Baseline

The current financial position of the Trust remains strong, with an achieved surplus of £2.52m in line with the plan. The EBITDA achievement was 5.0% in line with plan. Income rose from £167.2m in 2011/12 to £173.2m in 2012/13 and expenditure rose similarly by £6.4m to £169.7m. Within the defined expenditure the Trust saw a rise in employee staff costs of 1.3% and direct non pay of 9.2% reflecting the higher levels of activity delivered.

The Trust saw an overall increase in its operating income of £6m, of which £4m related to additional elective income, £1.3m related to additional non-tariff revenue and a one-off charitable fund donation being received related to the new Palliative Care Centre of £1.1m which was completed during the year.

Overall, the Trust maintained its Financial Risk Rating of 4 in line with plan.

Net assets at 31 March are £90.0m, an increase on the previous year of £2.3m which also reflected a revaluation exercise undertaken on 1 March 2013 on a modern equivalent asset basis.

During financial year 2012/13 the Trust achieved £5.8m on its CIP which was behind its £7.9m target. This was offset by contingencies contained within the 2012/13 plan.

The forward plan includes a £0.8m contingency throughout the three year period. In order to deliver a Financial Risk Rating of at least 3 in the next three years, against a background of flat lining income and escalating costs, a clear focus on reducing the recurrent cost base of the Trust is required. To support

this requirement the Trust has established the PMO. This team, along with support from external sources as required, will support the organisation in delivering transformational change to increase productivity, improve quality and reduce costs. The inclusion of clinicians in this process is essential in delivering the challenging targets required of cost improvement and revenue generation valued at £21.2m over the next three years.

Other key priorities include:

- Improving the quality of care to the patients by transforming the way that the Trust carries out its activities
- Delivering the contracted activity with minimal use of premium costs
- Maintaining patient flow for emergency admissions to improve patient experience and clinical outcomes and ensure capacity for the elective programme
- Delivery of the CIP programme; and
- Avoiding contractual underperformance leading to fines being levied.

Financial risks

The major risks and mitigations to delivering this financial agenda include:

Risk	Mitigation
The inability to remove costs as emergency activity levels are maintained or even increased.	This will be mitigated through a service development recognising the impact expected in A&E and is included in the plan.
Timing of activity shifts result in residual cost being retained by the Trust. Significant costs are only able to be released when falls in activity are at a sufficient level to remove stepped costs e.g. ward closure.	Growth is currently mitigating the impact of CCG and system-wide QIPP plans.
Inability to reduce emergency bed demand will not provide sufficient capacity to maintain elective income.	A bed model and capacity plan is now agreed alongside seasonal profile of elective activity.
New financial penalty and fine structure regime within the new NHS model acute contract.	There is an active agreement with the CCG on utilisation of any fines.
Cost improvement plans are not delivered.	This is mitigated through a two pronged approach to cost improvement via 'big ticket' and Divisional schemes. There is now an embedded transformational team with regular monitoring of performance in place through the established Transformation Board. External consultants are used to support the process, for example with the KPMG management review.
Cost base increases are not as predicted due to the use of premium rate costs.	Significant work completed on nursing agency issues in 2012/13 which will continue into 2013/14.
System wide funding constraints will add additional financial risk to the Trust's plan. The commissioner has confirmed that the level of activity currently	There is a contractual agreement on activity levels and a risk share through the contract.

performed by the Trust is not affordable on a recurrent basis.		
Seasonal profiled elective activity not delivered and leads to underperformance against contract.	Successful profiling planned and delivered in 2012/13 is being updated for use in the 2013/14 plan.	