

Strategic Plan Document for 2013-14

Ashford and St Peter's Hospitals NHS Foundation Trust

Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

This document completed by (and Monitor queries to be directed to):

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Date	31 st 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.

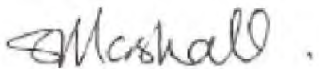
Approved on behalf of the Board of Directors by:

Name (Chair)	Aileen McLeish
Signature	

Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Andrew Liles
Signature	

Approved on behalf of the Board of Directors by:

Name (Finance Director)	Simon Marshall
Signature	

1. Introduction and Overview

- 1.1 Our vision is to be one of the best healthcare Trusts in the country. We are now entering our third year as a Foundation Trust, having made good progress in 2011/12 and 2012/13 in delivering our strategy. [This document summarises our business plan for 2013/14 – 2015/16.](#)

The context for our plan

- 1.2 The context within which we work continues to evolve. As a result of a restructuring of the NHS, from April 2013 the Trust's services will be commissioned by two new bodies:

NW Surrey Clinical Commissioning Group (CCG) who will commission the majority of our services and will be the source of c65% of our income. Our plan describes the action we will take in 2013/14 to further improve the services we provide for local people, in line with the NW Surrey health system strategy for integrated care.

The National Commissioning Board (NCB), who will commission the specialist and dental services we provide, with an expected contract value of c£29m (c13% of our income). Our business plan sets out our plans to strengthen and develop our vascular, cardiology and stroke services, and to develop a business case for renal services at St Peter's Hospital.

In the previous financial year, South East Coast SHA, undertook an accreditation process for new AQP services. This has resulted in a potential new threat to our outpatient income from our Woking catchment. Whilst we expect a decline in outpatient referrals from this area we are working with the AQP competitors locally and in new catchments to retain elective market share and gain new referrals.

North West Surrey CCG has developed a QIPP programme of £10.8m, £8.4m and £8.3m for the next three years beginning in 2013/14. Of the £10.8m around £4m applies to services provided by ASPH. The Trust is supporting the delivery of this QIPP programme as it should reduce primary admissions, readmissions to near the 2008/09 cap level and provide innovative ideas to deliver services in a more cost effective way to our local GPs.

- Our GP referrals for outpatients increased by 2% during 2012/13 and the Trust is expecting this growth to stabilise over the next three years from our core catchment as GP commissioners increase referral thresholds. This has resulted in a growth in day case and elective activity. Demand for A&E services has increased by 2% since 2010/11, even with demand management schemes initiated by commissioners and the Trust to redesign clinical pathways. Emergency admissions have as a consequence increased over the period, though new models of ambulatory care are being implemented to contain this increase.

Within Surrey there are 4 Acute Providers, three of which, including ourselves, are strong performing Foundation Trusts offering a comprehensive portfolio of District General Hospital services.

In November 2012/13 we agreed a Principal Partnership with Royal Surrey County Hospital NHS FT to consider the opportunities to develop joint clinical and support services.

1.3 We operate in an environment with two key challenges:

Rising demand for acute healthcare, from an ageing population. In Surrey the number of people aged 85 and over is projected to double in size over the next 16 years. Elderly people are more likely to experience disability and long term conditions and have the greatest need for the hospital services we provide.

Reduced levels of funding. Whilst the costs of delivering acute care continue to rise, the tariff paid for the services delivered by the Trust is falling. Our plan for 2013/14 includes action to reduce our costs by £11.8m; we also face the long term prospect of year on year efficiency requirements of around 5% per annum.

1.4 The diagram below illustrates the architecture of our plan. The organisational values we developed with our staff in 2011 continue to guide *how* we behave to release our vision; our four strategic objectives describe *what* we will do to become one of the best.



Twin focus of our plan

1.5 Our 2013/14 business plan sets out the action we will take in relation to each of the four strategic objectives. Two objectives will have a new focus during 2013/14:

We are clear that achieving the highest possible quality standards (our first strategic objective) and putting patients first (our first value), are the most important. We have achieved year on year improvements to patient surveys but our ambition is to make much more progress. In 2013/14 we will introduce the Friends and Family Test and act on what we learn, and we will make significant further steps in terms of our openness and candour. Following the *Francis Report* we are fostering a learning organisation where patients, staff and relatives feel safe to share their experience and where poor care will not be tolerated.

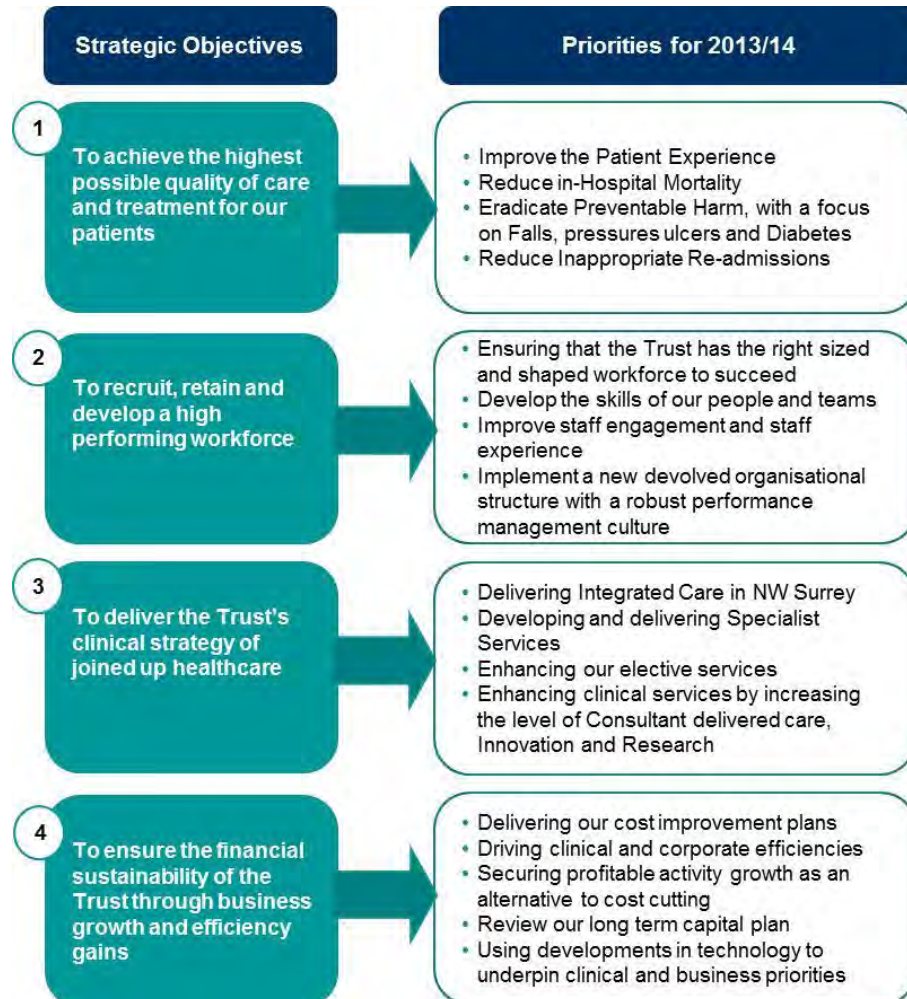
- We are committed to making substantial improvements following the 2012 staff survey. We will develop the organisation so that staff are much more engaged in decision making and change; and help front line managers to support this change in culture. We will develop our organisation to be more clinically led with a focus developing our 26 speciality teams. We will introduce a quarterly Pulse Survey (internal survey tool) to provide regular feedback on how staff are feeling. We are serious about developing the culture of ASPH to improve the experience of working here – and through this, being cared for here.

How we deliver our plan

- 1.6 Internally we have restructured our clinical services into four clinical divisions, led by a triumvirate formed of a Divisional Director, Associate Director of Operations, and an Associate Director of Nursing. This structure, supported by the leadership development programmes described within objective 2 (page 10-11), and by the Programme Management Office (PMO), will enable a stronger focus on quality and efficiency in each division. A key priority within our plan for 2013/14 is effective devolution to these divisions.
- 1.7 Our performance management regime now focusses on 26 clinical specialties, each with a clinical leader, and with whom monthly Chief Executive led performance meetings are held.
- 1.8 Externally, we work in partnership to deliver excellent healthcare. During 2012 we established a „Principal Partnership“ with Royal Surrey County Hospital NHS FT, which is designed to foster collaboration both on the delivery of clinical services and on the provision of support functions. The vision of both Trusts is to establish a „Surrey University Hospitals Partnership“, working in close collaboration with academic partners, which will;
 - Deliver a joint and complementary Clinical Strategy for Surrey for specialist and core services – improving the clinical outcomes and patient experience for our population.
 - Create a Centre of Excellence for Academic and Clinical Research and Training.
 - Be an exemplar for the partnership delivery of support and clinical support services that are cost effective, high quality and resilient
- 1.9 We look forward to our first year working with our new commissioner the NWS Clinical Commissioning Group. We will collaborate with them on the production of a new 3-5 year Strategic Commissioning Plan that will give added direction and plans for our local health system. We welcome the opportunity to build a system with much more clinical engagement and a better balance of care and support outside of the acute hospital setting.
- 1.10 During 2013/14 we will also work closely with the Surrey & Sussex Area Team of the NCB to develop our specialist services, and we will assess how we work most effectively with Virgin Care, who, in 2012, took responsibility for the delivery of community services in NW Surrey.
- 1.11 With the increase in AQP providers ASPH is developing joint services with these organisations by providing consultant services either as a mitigation strategy or as a growth strategy in new catchment areas.

2 Our Priorities for 2013/14 and beyond

2.1 The figure below summarises our priorities for 2013/14 related to each of our four strategic objectives. The rationale supporting each priority and the 3 year road map for each objective is set out on the following pages.



2.2 The annual priorities and actions for each Strategic Objective will be delivered through the Programme Management Office (PMO), Divisional business plans and staff personal objectives. Progress is reviewed by the Strategic Delivery Committee and monthly and half yearly business plan reviews.

Our Objectives – 3 Year road Map

		2013-14				2014/15				2015/16			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
STRATEGIC OBJECTIVE 1: To achieve the highest possible quality of care and treatment for our patients	Improving the patient experience	Releasing time to care											
		Friends & Family: Inpatients/Maternity				Friends & Family: Outpatients							
		In-hospital Mortality Project											
	Reducing In-Hospital Mortality	Quality & Safety Half Days				Quality Improvement Discussions							
		Secure pathways to Hospice beds				Admiral Nursing Project							
	Eradicating Preventable Harm	Falls & Pressure Ulcers				Catheter Acquired UTIs				VTE			
		Think Glucose Project											
		Frailty Pathway											
	Reducing Inappropriate Re-admissions	Risk Predictor for high volume pathways											
		Nurse Led Discharge / Transition Care co-ordination											
STRATEGIC OBJECTIVE 2: To recruit, retain and develop a high performing workforce	Ensuring the Trust has the right sized and shaped workforce to succeed	Recruitment, Retention and Talent Management strategies				Consultant Delivered Services / 7 Day Working							
		Temporary Staffing Programme											
	Developing the skills of our people and teams					Learning & Education Plan							
		Leadership development & Driving a High Performance Coaching Culture											
	Improving staff engagement and staff experience	Improving Staff Experience				Employee Promise							
						Organisational Development							
		Health & Wellbeing											
	Implementing a new devolved organisational structure with a robust performance management culture	Workforce Utilisation (rostering) / Job Planning				Maximising Clinical Efficiencies							
		Pay and Reward Strategy				Performance Management							
		Transactional HR & Payroll shared service review											

		2013-14				2014/15				2015/16				
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
STRATEGIC OBJECTIVE 3: To deliver the Trust's clinical strategy of joined up healthcare	Delivering Integrated Care in NW Surrey		Community Re-enablement / Rehabilitation											
			Care of the Older Person				Lead Provider Model							
	Developing and delivering Specialist Services		Critical Care											
			Service development of Cardiology, Vascular, Stroke and Renal											
	Enhancing our elective services						Ashford Orthopaedic Centre							
			Increasing Inpatient Surgery at Ashford Hospital											
	Enhancing clinical services by increasing the level of Consultant delivered care, Innovation and Research		Increasing Consultant Presence in A&E, Obstetrics and Paediatrics											
			R&D, Innovation and Education Strategy											
STRATEGIC OBJECTIVE 4: To ensure the financial sustainability of the Trust through business growth and efficiency gains	Delivering our cost improvement plans		£11.8m				£11.62m				£11.6m			
			Length of Stay Reduction				Length of Stay Upper Quartile							
	Driving clinical and corporate efficiencies		Theatre Utilisation											
							Staffing Efficiencies							
			Theatre Procurement				Other Procurement							
			Clinical Office				Corporate Shared Services							
	Securing profitable activity growth as an alternative to cost cutting		Vascular Surgery				Ashford Orthopaedic Centre				Renal			
			Urology				Community Services							
							Managed Equipment Service							
	Review our long term capital plan		Catheter Lab Redevelopment				A&E							
			Ashford Outpatient Dept											
	Using developments in technology to underpin clinical and business priorities		Midwife Led Unit											
			RealTime				Document Management				Electronic Records			
			GP Communications				E-prescribing				PAS			
			Clinical Automation											
		PACs												

Objective 1: To achieve the highest possible quality of care and treatment for our patients

Context

Overall 2012/13 has seen many positive highlights for the Trust and assurance that we continue to offer high quality and safe care to our patients. Following visits by the Care Quality Commission to both Ashford and St Peter's hospitals we have no outstanding concerns and are fully compliant in all their standards. We have continued to score well against the majority of our quality and performance standards, and this year's national inpatient survey shows good improvements for our hospitals for the third year running. Like many hospitals nationally, we have experienced a busy winter and at time have struggled to maintain the four hour waiting target. That said, our performance compared to last year has improved, and we continue to make improvements in the way we manage our emergency patients. As the national debate around A&E continues, we continue to work proactively with our partners in the local health economy to help keep people out of hospital and care for in the most appropriate place.

The Mandate from the Government to the NHS Commissioning Board was published on 13 November 2012, and signalled a further move to a more liberated and innovative NHS that can be more responsive to patients. The Mandate has five objectives which correspond with the five parts of the NHS Outcomes Framework:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

The National Commissioning Board planning guidance for 2013/14 „*Everyone Counts*“ sets out 5 NHS „offers“ to direct the delivery of better local health outcomes: support for routine NHS care seven days a week, greater transparency on outcomes, mechanisms to enhance patient feedback, better data collection to drive evidence-based medicine and high professional standards.

The publication of the Francis report – a „*watershed moment for the NHS*“ - has challenged the NHS to reconsider how it can foster a common culture which genuinely puts the service of patients at the forefront of all that it does, and has provided a wealth of recommendations in how the delivery, regulation of and culture of healthcare within the NHS can be improved. We are formulating our full local response to the Francis report; action in response to the key themes of the report is embedded in each of our strategic objectives.

It is in this context that the Trust's Quality improvement priorities have been developed, reflecting national and local priorities, as well as the themes and issues patients tell us matter to them. We will continue to focus on creating a culture of real openness characterised by compassion and candour, by always putting patients first and widening staffing engagement, improving the experience of patients and their families (and particularly noting the needs of our local demographic of an ageing population), reducing in hospital mortality and preventable harm, and working across the health and social care system to reduce readmissions for those individuals with complex needs, and for those undergoing procedures in our hospitals.

Objective 2: Recruit, retain and develop a high performing workforce

Context

Our priorities in relation to the development of our workforce have been identified in response to external and internal factors which will impact on the ability to recruit, retain and develop high performing individuals and teams who will in turn, deliver the overall vision, values and strategic objectives at Ashford & St Peter's NHS Foundation Trust.

In Equality for all: Delivering safe care - seven days a week there is an overwhelming evidence base upon which the Trust can draw to shape current service and workforce models in response to demand and deliver the highest standards of treatment and care. The Francis enquiry reminds all organisations of their responsibility to ensure that the culture and climate is conducive to the highest standards of patient safety, outcomes and experience. Fundamentally, this places high quality leadership, people management and development processes / systems at the heart of effective corporate and clinical governance.

The NHS Staff Council reached agreement to introduce changes to Agenda for Change (national terms and conditions including pay) with effect from 31 March 2013. These reforms will be integral to developing and nurturing leaders at all levels to bring out the best in people through effective appraisal, performance management, development, reward and recognition.

The NHS Commissioning Board have signalled the importance of the Friends and Family Test and as such the plan has been developed to ensure that staff feel confident in recommending Ashford and St Peter's Hospitals NHS Foundation Trust as a place to work and be treated. This will be achieved through robust processes and systems to regularly engage staff in shaping and improving services and the staff experience. A regular testing and monitoring system will be introduced to ensure that the entire team can listen to, and respond to staff feedback.

Ashford & St Peter's NHS Foundation Trust is one of the few Trusts nationally to have been SEQOHS accredited and is recognised for spearheading creative approaches to health and well-being. This plan reaffirms the commitment to invest in health and well-being programmes in accordance with the Boorman Report as well as maximising opportunities to celebrate and recognise award winning individuals and teams. The plan will achieve sustainable excellence through health and is based on an evidence base which shows that organisations which focus on performance and health simultaneously are twice as successful as those that focus on health alone and three times as successful as those that focus on performance alone.

The workforce is a key element to enable the Trust to successfully achieve its strategic objectives. The Workforce Plan for the Trust reflects supply and demand across staff groups and within divisional service plans and is consistent with the long term financial model (LTFM). The plan seeks to determine the mix of permanent, temporary and contingent workforce required to deliver services effectively and efficiently as well as addressing shortages in the labour market.

The changes in predicted headcount reflect the development of consultant delivered services, seven days a week where appropriate, through redesigned clinical roles (medical, nursing, support and therapy) and new ways of working. Seven day working, as a project, will look at the needs of the patients across various pathways and how the workforce will need to reflect the ongoing drive for improvements in our services.

Reducing Agency Spend (medical and nursing) is a key strand of our recruitment and retention strategy which is being developed into action plans at local levels to ensure the specific needs are addressed at both a corporate and local level.

A plan has been agreed with the Board in response to the Staff Survey results. The purpose of this plan is to set a refreshed „cultural tone“ for the Trust where staff and in turn patients experience a positive and respectful culture. The plan is intended to provide an overarching approach for further culture shift and at the same time includes some specific actions that relate directly to areas of concern identified within the Staff Survey such as the quality of appraisal conversations.

The reforms to the Agenda for Change (national terms and conditions including pay) will be embraced with a newly devised pay and reward strategy that will be developed to support the effective recruitment and retention of staff.

The Workforce and Organisational Development Committee (which is a sub committee of the Board) will act as an assurance committee to ensure that workforce changes will not adversely impact on quality.

Objective 3: Deliver the Trust’s clinical strategy of joined up healthcare

Context

National and local Commissioning Policy emphasises: the need to improve core services through improving Consultant delivered care seven days a week; the need to optimise and maximise care outside hospital; the strong rationale for providing ring-fenced elective care, and the need to centralise specialist care over large population areas in order to deliver high quality outcomes and financially efficient services. In response to this, ASPH’s Clinical Strategy continues to be to improve its internal core DGH services for its local population and to further develop, in conjunction with partners, its specialist hyper-acute services to serve a wider population within Surrey. In order to do this:

For our core services: A&E, Obstetrics, and Paediatrics, we have firm plans to increase Consultant presence over the coming year (up to 16 hours per day in AE, 96 hrs per week labour ward coverage, 12 hours per day in paediatrics)

In addition to this, building on our work over the last 12 months that has transformed our model of care for emergency medical admissions through our medical assessment unit, we are now going to focus on the geriatric pathway, looking at how we can improve our Older People’s outreach service and develop a differentiated assessment model of care for elderly patients. We will redesign the pathways for rehabilitation following Stroke and fractured Neck of Femur to ensure patients can leave hospital as soon as is possible to continue their rehabilitation at home or in alternative care settings. Our three-year aim is to deliver upper quartile performance (quality and operational performance metrics) for all non-elective patients. Our new local commissions, NW Surrey CCG, have indicated that they will undertake a strategic review of their Commissioning Strategy. We will actively collaborate in this process to ensure that we support the CCG to articulate a fully aligned long-term plan for delivering healthcare both in and out of hospital within available commissioning resources. With the primary aim of reducing emergency admissions and facilitating timely discharge.

For our elective services, we are undertaking more work to review the extent to which we can move more of our in-patient surgery to Ashford, away from the pressures of our „hot“ site at St Peter’s. In parallel to this, we will seek to develop an orthopaedic centre of excellence at Ashford, growing our market share and driving up our internal efficiencies there.

- For our Specialist Services, our three-year aim is to be a leading provider of hyper-acute services within Surrey, serving a population of at least 800,000. ASPH has entered a Principal Partnership with the Royal Surrey County Hospital to further develop our clinical services together. This builds on the complementary nature of our respective specialist services (RSCH – Cancer, ASPH – hyper acute services) and over the coming year will seek to fully develop and commence implementation of a joint clinical strategy, as well as seeking to deliver joint efficiencies through back office synergies in the HR and Finance functions. Specifically, this joint clinical model will examine how to expand the market share and improve our joint pathways for cancer services, how we can deliver jointly a Surrey based renal service, and how to enhance the networks for hyper acute services. In addition, it will look at how other sub-specialities, particularly in elective surgery, can be enhanced by being delivered in closer partnership

Objective 4: To ensure financial sustainability of the Trust through business growth and efficiency gains

Context

The resources the Trust receives from its commissioners comprise two key elements:

A CCG allocation to cover the local services they will commission on behalf of their local populations which will increase by 2.3% over 2012/13 levels

A specialist commissioning allocation for the regionally commissioned, specialist, or rarer conditions which will increase by 2.6% over 2012/13 levels.

Although, after inflation these represent a small real terms increase of c0.3%, they also imply the achievement of a substantial commissioner efficiency programme to contain activity and historic expenditure growth trends. The national tariff annual deflator and various contractual levers, including those over emergency thresholds after which only marginal tariffs are paid, and the non-payment for a proportion of readmissions, also reinforce the requirement on providers to deliver substantial efficiencies to both contain costs and provide resources for investment in improved service quality and better health outcomes.

The Trust starts from a strong underlying surplus position but in order to respond to these financial drivers and to ensure we remain financially sustainable in the medium term we need to: deliver a substantial efficiency programme of at least 5% per annum; to work across the health economy to reduce our emergency activity to 2008/09 levels; and achieve upper quartile readmissions levels. As an alternative to cost cutting, we also need to look to repatriate specialist activity which could be undertaken more locally on our sites in order to replace activity which will be lost to community based settings and pathways in the future.

In order to deliver an efficiency agenda of this scale it is important we consider schemes which are more transformational in nature and which will drive fundamental productivity improvements in our clinical and corporate services. This also implies working in partnership with other organisations to delivery schemes beyond the Trust's traditional boundaries and the adoption of new more efficient technologies to support streamlined pathways and care in less costly settings. We also plan to review our capital investments programmes in the light of our evolving clinical priorities and strategies. The key risks to achieving our financial strategy over the medium term include the continued delivery of sufficient cost releasing savings, our ability to deliver the quality expectations within our current contract, our ability to secure sufficient specialist work / catchment populations and the potential impact of losses driven by continued rising emergency activity paid for at marginal tariffs. To mitigate these we have put a range of measures in place however these will need to be delivered on a timely basis and in partnership with the local health economy.

3 Delivery and Performance Management of the Plan

Embedding our new divisional structure

- 3.1 We have a clear view that long-term operational success relies on a devolved organisational structure underpinned by strong performance management at the clinical speciality level. From April 2013 our current 7 Clinical Divisions will be restructured into four Divisions, grouped around patient pathways. The diagram below sets out the new clinically led structure, with each Division led by a triumvirate formed of a Divisional Director, Associate Director of Operations, and Associate Director of Nursing.



- 3.2 This new structure will enable a stronger focus on both quality and efficiency within the Divisions, and create increased accountability. Team working will be key to the success of the new Divisions; a comprehensive programme of development and coaching will be in place, with input and support from the NHS Leadership Academy.

Specialty Review Meetings

- 3.3 During the last Quarter of 2012/13 a new performance management regime was introduced which uses a service level focus to generate engagement between the Executive Team and front line clinicians. We will continue to embed this during the early part of 2013/14. Performance meetings with individual Specialty Teams to review their performance and agree priority actions now take place monthly, and are chaired by the Chief Executive with all of the Executive Directors in attendance. During the performance meetings the lead clinician for each of the 26 Specialties uses a range of bespoke scorecards to present their performance across the 4 domains of clinical quality, workforce, operational performance, and finance & efficiency (and this includes benchmarked peer performance).

Programme Management Office

- 3.4 The Programme Management Office (PMO) has proven to be an effective vehicle for delivery during 2012/13, successfully managing the achievement of the CIP target and providing project and performance management to the CQUINS programme. In 2013/14 and beyond, as in previous years, all projects will be driven by the strategic objectives and linked directly to the business plan. To support the new devolved structure, the PMO will focus on a series of strategic projects, with particular attention on those with complex, cross-Divisional deliverables, such as reducing mortality, reducing admissions, and enhancing the planned care pathways. The emphasis will be on supporting and enabling the Strategic Business Units to develop and manage their own programmes of change (through training or project start up advice and support), and in complex projects on bringing together cross Divisional teams to work together with the support of the executive Team.

3.5 The initial list of projects to be reported to the Strategic Delivery Committee via the PMO from April 2013 onwards is listed below:

Strategic Objective One: High Quality of Care - <i>The projects below link directly to the priorities in corporate business plan under objective one</i>	Executive Sponsor
Releasing Time to Care	Chief Nurse
Preventing Readmissions	Medical Director
Reducing in-Hospital Mortality	Chief Nurse
Strategic Objective Two: High Performing Workforce - <i>The projects below are proposed and will be confirmed prior to April 2013</i>	Executive Sponsor
7 day services	Director of Workforce Transformation
Reducing Agency Spend (medical and nursing)	Director of Workforce Transformation
Improving Staff Experience	Director of Workforce Transformation
Strategic Objective Three: Clinical Strategy - <i>The projects below link directly to the priorities in corporate business plan under objective three and the PMO will work with the Medical Director to support delivery of the wider clinical strategy</i>	Executive Sponsor
Integrating Critical Care	Medical Director
Delivering the Stroke Service Strategy	Medical Director
Care of Older Person Model	Deputy CEO
Strategic Objective Four: Financial Sustainability - <i>The projects below link to the specific priorities of "Driving Clinical Efficiencies" and "Using developments in technology to underpin clinical and business priorities" in corporate business plan under objective four</i>	Executive Sponsor
RealTime	Deputy CEO
E-Prescribing	Deputy CEO
Capacity Allocation Programme	Deputy CEO
Improving Patient-Facing Communications	Deputy CEO
„Ready to Go“ – No Delays	Deputy CEO
Supporting Clinical Divisions in delivery of their business plans - <i>A number of the projects continuing into 2013/2014 will be transitioned into the divisional business-as-usual. In these cases the projects will be transitioned to the divisions in early 2013/2014 but will continue to be supported by the PMO</i>	Executive Sponsor
Ambulatory Emergency Care Pathways	Deputy CEO
Planned Care	Deputy CEO
Improving the Emergency Surgery Pathway	Deputy CEO
Improving the Emergency Paediatrics Pathway	Deputy CEO

4. Quality and Transformation Efficiency

- 4.1 Cost Improvement or Efficiency Plans are integral to all Trusts' financial planning and they require strong and sustained focus in order to be delivered. The robustness of our efficiency programme planning process was demonstrated through the full delivery of our 2012/13 programme. The consistent message from higher performing organisations such as ourselves is the need for significant transformational change in order to deliver efficiency without reducing service quality and patient safety. This has again been our focus in planning for 2013/14 and beyond.
- 4.2 During 2012, significant developmental work has been undertaken to support a shift in mindset to a Quality and Transformation Planning approach. Our approach to identifying Quality and Transformation has:

- Recognised the need for significant transformational change in order to deliver the planned efficiencies without reducing service quality and patient safety
- Used benchmarking performance data to help identify saving opportunities and to engage clinicians.
- Facilitated workshops to support engagement with staff (both clinical and non-clinical), specialties and divisions in order to produce new ideas for service change that were transformational and genuinely produces realistic, sustainable cost savings
- A rigorous appraisal of both the efficiency plans' achievability and impacts on quality.
- A cross checking with the overall clinical strategic direction of the organisation and the plans of partners.

4.3 The Trust has set its budget based on Quality and Transformation efficiency delivery of £11.8m and has detailed divisional level plans in support of these. This is an improvement on the 2012/13 Programme which was at £10.4m against a £12m target at this stage last year.

4.4 Our plans for 2013/14 are robust and will be monitored monthly to ensure delivery. All of our projects / schemes have been through a quality impact assessment process and key potential quality impacts will be monitored monthly by our Strategic Delivery Committee to identify and resolve any adverse impacts, particularly on safety, the patient experience and staff feedback. Work continues on the identification and development of new schemes in order to both de-risk the 2013/14 CIP target, and further develop our plans for 2014/15 and 2015/16. Our main cross-cutting transformational schemes focus on:

- Moving towards 7 day working and the continued review of all aspects of staffing headcount, productivity, skill-mix, recruitment and the usage/cost of our temporary workforce.
- A 5% reduction in Length of Stay for 2013/14 with the delivery of across the board upper quartile performance in 2014/15, with particular focus on improved assessment unit processes and improved flow from the hospital into community services.
- Improvements to our planned care pathways with the delivery of upper quartile theatre utilisation, reduced on the day cancellations and conversion of day cases to outpatient procedures.
- Better matching of outpatient and diagnostic capacity / utilisation with demand, delivery of upper quartile new to follow up ratios and review of our internally generated referrals.

4.5 Our efficiency plans are supported by a range of enabling investments. Key facility investments include projects across our theatres, cath labs, reconfiguring our acute bed base and Ashford outpatients. Key equipment investments include our new imaging 10 year Managed Equipment Service, and endoscopy / urology scopes. IT investments include the completion of the roll out of discharge planning software across the Trust, a new A&E IT system, improved transcription and communication technologies and the adoption of other clerical automation technologies. These are on top of our normal rolling replacement programmes.

Delivering Quality and Transformation

4.6 The Trust continues to develop both its leaders and structures to ensure that Divisions and specialties are capable of driving sustained change.

The Programme Management Office (PMO) is tasked with ensuring that the organisation keeps its Quality and Transformation programme on track and supports the divisions and Specialties. This PMO has again been strengthened with additional resource deployed in 2013/14 to further enhance our delivery capability.

- By running our performance meetings at the specialty level the Trust ensures that its organisational culture promotes the interests of patients as well as finance and performance targets. We have also recently commissioned additional external training to further develop our existing clinical leadership team and to widen our clinical leadership skills base.

Divisions and specialties are fully engaged in both identifying and delivering efficiencies with further investments being made in 2013/14 around our information systems to improve decision making and increase the availability of benchmarking information.

Future Quality and Transformational Planning

4.7 Our intentions for our future Quality and Transformation plans include:

Expanding our long term Quality and Transformation plans to 5 years

Fully investigating the clinical and corporate shared efficiency opportunities with the Royal Surrey County Hospital.

Increasingly positioning ourselves as the lead provider for local community services so that the right care, is provided by the right professional, at the right time, and in the right setting.

- Migrating our workforce to 7 day working.
- Ensuring that all proposals result in improvements to patient care, satisfaction, safety and yield a related efficiency saving.

Balanced Scorecard - Our balanced scorecard for 2013/14 is below.

Trust Balanced Scorecard - PROPOSED LAYOUT FOR 2013/14

1. To achieve the highest possible quality of care and treatment for our patients

	Patient Safety & Quality		Annual Target 13/14	Annual Forecast 13/14	Month Actual	Performance			YTD 13/14
						M-2	M-1	M	
1-01	Summary Hospital-level Mortality Indicator (SHMI)	N	<72						
NEW	Actual deaths	L	<945						
1-05	MRSA (Hospital only)	N	0						
1-06	C.Diff (Hospital only)	N	<13						
1-07	VTE (hospital acquired with PE or DVT)	L	<24						
1-09	Serious Incidents Requiring Investigation (SIRI)	L	<75						
1-13	Average Bed Occupancy (inc escalation)	L	<92%						
1-14	Patient Moves (ward changes >=3)	L	<7.5%						
1-15	Formal complaints (Total Number)	L	<450						
NEW	Friends and family test	L	70						
1-10	Falls (Total Number)	L	<700						
1-11	Falls - resulting in significant injury (grade 3)	L	<15						
NEW	Pressure ulcers grade 2 and above	L	<139						
NEW	Catheter acquired UTI*	L	<1.28%						

*Achieved by 6 months then maintained

3. To deliver the Trust's clinical strategy of joined up healthcare

	Clinical Strategy		Annual Target 13/14	Annual Forecast 13/14	Month Actual	Performance			YTD 13/14
						M-2	M-1	M	
NEW	Emergency activity level above 2009/10 outturn	L							
3-03	Trust 4Hr Target	N	>95%						
3-04	Emergency Conversion Rate	C	<23.8%						
3-05	Ambulatory Care Pathways	N	>30%						
NEW	95% of all LOS < 27 days	L	>95%						
3-06	Readmissions within 30 days - elective & emergency	N	<6.3%						
3-10	Overall Elective Market Share	L	>66%						
3-12	Overall Elective Market Share (Vascular)	L	>50%						
1-12	Stroke Patients (90% of stay on Stroke Unit)	N	>85%						
NEW	% Elective inpatient activity taking place at Ashford	L							
NEW	Discharge rate to normal place of residence	L							
3-13	R&D - Observations & Interventions	L	>444						
3-14	Elective Activity (Spells)	L	>34,417						
3-15	Emergency Activity (Spells)	L	<37,644						
3-16	Outpatient Activity (New Attendances)	L	>110,242						

2. To recruit, retain and develop a high performing workforce

	Workforce		Annual Target 13/14	Annual Forecast 13/14	Month Actual	Performance			YTD 13/14
						M-2	M-1	M	
2-01	Establishment (WTE)	L							
			£142m (1% inc)						
2-02	Establishment (£Pay)	L							
NEW	Vacancy Rate (%)	L							
2-05	Establishment Reduction - CIPs (WTE)	L							
NEW	Growth (New/Redesigned Roles)	L							
2-07	Agency Staff use (WTE)	L	<45WTE						
2-08	Agency Staff (£Pay)	L	% of pay bill						
2-09	Bank Staff use (WTE)	L	<280 WTE						
2-10	Bank Staff (£Pay)	L	% of pay bill						
2-12	Staff turnover rate	L	<13%						
2-13	Stability	L	>85%						
2-14	Sickness absence	L	<3%						
2-15	Staff Appraisals	L	98%						
2-16	Statutory and Mandatory Staff Training	L	99%						
NEW	Staff engagement	L							

4. To ensure the financial sustainability of the Trust through business growth and efficiency gains

	Finance & Efficiency		Annual Target 13/14	Annual Forecast 13/14	Month Actual	Performance			YTD 13/14
						M-2	M-1	M	
4-01	Monitor Financial Risk Rating	N	3						
4-02	Total income excluding interest (£000)	L	£232,399						
NEW	Total expenditure (£000)	L	£215,045						
4-04	R&E net operational surplus (£000)	L	£3,000						
4-05	CIP Savings achieved (£000)	L	£11,839						
4-06	CQUINs achievement %	L	tbv						
4-07	Month end cash balance (£000)	L	£12,900						
4-08	Capital Expenditure Purchased (£000)	L	£16,058						
NEW	Emergency threshold/readmissions penalties	L	<£2.3m						
4-12	Average LoS Elective	L	3.32						
4-13	Average LoS Non-Elective	L	6.99						
4-14	Outpatients first to follow-up ratio	L	1:1.5						
4-15	Daycase Rate (whole Trust)	L	>84%						
4-16	Theatre Utilisation	L	>=80%						

Delivering or exceeding Target		Improvement on previous Month	▲
Underachieving Target		No change to previous month	◀▶
Failing Target		Deterioration on previous month	▼

6 Innovation and Research & Development

- 6.1 Research and Innovation are recognised as essential to the future because:
- They can improve the quality of care provided
 - They connect and drive quality and productivity
 - They will support financial investment
- 6.2 The demand, nationally and internationally, to do more health care with less resource means that „business as usual“ is no longer an option. We all want to do the best for our patients and their needs and expectations change over time; this ambition combined with the financial challenges the NHS is facing, makes a very strong case for taking an innovative and forward thinking approach.
- 6.3 In responding to these, the key priorities of our Research & Innovation Strategy are to;
- offer patients opportunities to participate in research and increase the number of patients participating in studies
 - increase the quality and value of research and innovation within the Trust
 - develop research capacity and capability by directing support for high quality research and innovation
 - translate research findings and service innovations into benefits for patients and the Trust make the Trust the NHS research and innovation partner of choice for academia and industry
- 6.4 Our Research & Development programme for the forthcoming year will continue to be a varied portfolio, with highlights including:
- **Stroke:** *BMET* study into Cognitive Screening Post Stroke;
 - **Obstetrics & Gynaecology:** *Femme study* A randomised controlled trial of treating fibroids with embolisation or myomectomy to measure the effect on quality of life;
 - **Cardiology:** *GLORIA – AF* To investigate the patient characteristics influencing the choice of antithrombotic treatment for the prevention of stroke in non-valvular AF patients;
 - **Respiratory:** *AUSTRI (GSK SAS115359)* Safety and efficacy of inhaled FP/Salm combination vs inhaled FP in adolescents and adult subjects with asthma
 - **Oncology:** *CRcST* A study into stenting versus emergency surgical treatment for colorectal cancer patients;
 - **NICU:** *ePRIME* Evaluation of MRI imaging use in preterm infants;
 - **Paediatrics:** BCRD Biologics for children with Rheumatic disease;
 - **Rheumatology:** *RAFT* Reducing Arthritis Fatigue – clinical Teams using cognitive-behavioural approaches;
 - **Parkinsons:** *MUSTARDD PD* A multi-centre UK study of Acetylcholinesterase Inhibitor Donepezil in early dementia associated with Parkinson's disease
- 6.5 2013/14 will be the first year of the Kent, Surrey and Sussex Academic Health Science Network (AHSN) which will provide us, as a member organisation, with clear opportunities for wider and better engagement with NHS peers, industry and academia. The aim of the AHSN is to combine all of our local strengths within the NHS, industry and academia to achieve demonstrable benefits in service improvement, research and people development. The programme of work will include a focus on:
- implementing the High Impact Innovations and reducing unwarranted clinical variation through the uptake of NICE guidance;
 - delivering a step change improvement in the initiation and delivery of clinical research on time and on target;
 - ensuring consistent delivery of healthcare services across Kent, Surrey and Sussex.

6.6 During 2012/13 our Innovation Fund supported the development of 13 projects within the Trust through an investment of £258,000. This success will continue in 2013/14 within a similar level of funding allocated to the Fund. To date the following projects have reached completion:

- a pilot to extend the Acute Stroke Therapy Service to a 6 day model;
- a Goal Directed Therapy trial to enable the advanced monitoring of a patient's heart function through high risk surgical procedures;
- a bespoke Picker Institute Patient Survey for the Blanche Heriot Sexual Health Unit;
- a trial of Cardiopulmonary Exercise Testing as a new way of assessing patients before their operation;
- a pilot of Voice Recognition Software in the Ultrasound Department.

7. Communications and engagement

7.1 A robust communications and engagement strategy will help to support the Trust's vision by ensuring our key audiences – staff, volunteers, patients, public, wider stakeholders – are well engaged and motivated in the aims of the Trust. To be most effective, we need to encourage and facilitate a robust two-way dialogue based on conversation, feedback and subsequent action to ensure we remain a credible and trustworthy organisation.

7.2 It is also clear that a more strategic approach to marketing our services is required, ensuring that people who want or need healthcare services see Ashford and St Peter's Hospitals NHS Foundation Trust as the provider of first choice. Reputation management and brand expansion are key areas for development as part of this wider marketing strategy. To do this we will need to have a better understanding of the Ashford and St Peter's brand so we can develop a compelling narrative around it that is consistent across all our communication and engagement platforms.

7.3 With this in mind the Trust must also review and refresh existing communication and engagement techniques and embrace modern technologies that offer new ways of reaching our different audiences.

7.4 Over the next year, our specific objectives will be to:

- Develop a digital communications and engagement strategy (internal and external) to encompass new social media platforms and improved use of web technologies;
Conduct an external website audit to inform a refreshed website (content and home page) and further development of specialty micro-sites (e.g. maternity, paediatrics, stroke, trauma and orthopaedics, colorectal services, public membership);
Take a more structured approach to promoting staff success onto the national platform by developing a formal plan for nominations to national awards;
- Develop a regular and more targeted supply of high quality good news stories to local media, aiming for a minimum of two proactive stories a week and a monthly column in the Surrey Herald, linked to our marketing objectives;
- Expand use of local media to include a series of targeted articles for local borough magazines;
- Develop a robust forward planning diary to ensure we are fully prepared for national reports/data publication, surveys and audits;
Develop a more structured stakeholder engagement programme including regular presentations to local borough councils, MP briefings, and public events (in close collaboration with the Membership Office);
Support high profile Trust developments with robust communications and engagement plans including formal openings, in particular the Ashford Outpatients and the Midwifery Led Unit at St Peter's;

- Working with the new Divisions to establish communication champions to facilitate improved communication and engagement within divisions;
- Refresh Chief Executive staff briefing sessions, moving to a divisional/departmental format;
- Continue production and ongoing development of all regular staff and corporate publications including Aspire, the Ebulletin, Innovations, Members Matters, Annual Report and Review and others as appropriate.

Complete the first year and evaluate the new CEO sounding board of 40 staff from across the organisation

Work with the Council of Governors to find new and better ways of engaging with our membership (e.g. using social media tools), ensuring we represent their views and that of the wider public. From April 2013 6 monthly meetings will take place between the council of Governors and Non-Executive Directors to enhance the assurance process. Elections will take place prior to 1st December 2013 for 3 Staff Governor and 11 Public Governor posts.

8 Risks and Mitigating Action

- 8.1 The Trust has robust and effective processes in place to identify and manage risks to the organisation, to enable us to deliver our strategy objectives and continue to improve the way we provide our services and engage with our patients, our staff and the public.
- 8.2 Our organisational risks are identified and managed in the context of our Quality, Safety and Risk Management Strategy which identifies the roles and responsibilities of Directors, Managers and Staff in relation to the identification and management of risks. The Trust's key risks can be considered in terms of four elements; Quality, Workforce, Clinical Strategy and Productivity and Efficiency.
- 8.3 Through the **Integrated Governance Assurance Committee (IGAC)**, which is chaired by a Non-Executive Director, and attended by the Chief Executive together with the Chair of the Audit Committee, Head of Internal Audit, Executive Directors and senior managers, the Trust seeks to learn and share good practice through rigorous assessment of the Trust's risk registers (both Trust-wide and division-specific) and the Board Assurance Framework, and to cascade this information both to and from relevant Divisional teams through constructive challenge, training and support. The frequency of IGAC has been moved from quarterly to monthly following feedback from the quality governance review commissioned by Monitor and undertaken by PwC.
- 8.4 The **Clinical Governance Committee** has responsibility for overseeing progress and assurance for clinical quality standards. Divisions report to the CGC annually with a full report on clinical governance activities. The Committee reviews Divisions' risk registers at every bi-monthly meeting to provide input into action plans and progress and to ensure risks are appropriately mitigated. Where further actions are required, the committee requests an update on those actions at the next meeting or earlier if required. The CGC has responsibility for overseeing the Committees or Groups shown under the CGC arm of the Integrated Governance and Risk Management structure.
- 8.5 The Board Assurance Framework describes the key risks which could threaten the achievement of the Trust's Strategic Objectives, and outlines the controls and assurances together with any further actions needed to manage these risks. The key risks encapsulated within the Board Assurance Framework are detailed below alongside the high level controls in place to mitigate these.

Objective 1:

To achieve the highest possible quality of care and treatment for our patients, in terms of outcome, safety and experience.

Lead	Risk	High level controls
CN	1.1 If there is a national publication at an organisational and/or clinician level of outcome data that is unknown, or unverified, to the Trust and is indicative of poor quality of care.	1. Clinical outcome steering group. 2. Health Informatics Group. 3. Clinical Coding team with national coding structures.
CN	1.2 If the Trust provides poor quality care leading to a regulatory response by the CQC and/or Monitor.	1. Policies, procedures and training programmes. 2. Compliance in Practice review audits undertaken by matrons. 3. Best Care dashboard.
CN	1.3 If the quality governance and impact assessment processes fail during the design of CIPs this could lead to poor quality of care.	1. New Template and tools available for completion on CIP schemes. 2. Quality and Safety Impact Assessment Form available.
CN	1.4 If divergent and multiple organisational priorities compete with and undermine staff engagement leading to a distraction from the focus on high quality care.	1. Clear Strategic Objectives with quality as first priority with strong quality monitoring. 2. PMO approach helps prioritise competing priorities.
CN	1.5 If the Trust fails to secure a Friends and Family score that is within an acceptable and reassuring range when benchmarked with peers.	1. Monthly reporting - monitor FFT score by Division 2. Roll out Valuing Frontline Feedback project, using the FFT score and feedback as a key metric for improvement.
DCE	1.6 If there is poor capacity and flow in the emergency pathway this could result in a poor patient experience and outcome and potential failure of the Monitor Compliance Framework.	1. Unscheduled Care Programme Board. 2. Weekly NWS Capacity meeting with Partners. 3. Escalation Policy ratified and shared with Partners. 4. Divisional Recovery Plan.

Objective 2:

To recruit, retain and develop a high performing workforce to deliver high quality care and the wider strategy of the Trust.

DWT	2.1 If the Trust workforce was not appropriately aligned to demand and acuity: particularly to meet reductions in WTE, agency usage and pay costs, resulting in overspends against agreed budgets.	1. Annual Workforce Plan. 2. Monthly Vacancy Control panel. 3. Centralised change programmes led by an Executive Director. 4. NHSP bank, internal bank and Framework Agencies.
DWT	2.2 If the Trust was unable to retain high calibre staff through developing leadership potential.	1. All employment policies, including appraisal, structured in accordance with the 4Ps. 2. Leadership and management commitment framework.
DWT	2.3 If individuals and teams do not feel valued or motivated resulting in poor patient care and staff experience and ineffective team working.	1. Participation targets and implementation for Living our Values set in 2012/13. 2. Individual and team diagnostics conducted. 3. Launch of Team ASPH: Beyond Good to Great in 2012/13.
DWT	2.4 If levels of sickness increased, adversely affecting patient and team working, and organisational performance.	1. Sickness absence policy and absence targets. 2. Occupational Health and Staff Physiotherapy Service (in-house). 3. Employee Assistance Programme (independent).
DWT	2.5 If roles and responsibilities for leadership and workforce development were unclear, thereby impeding individual, team and corporate performance.	1. Employment policies clarify leadership and workforce roles and responsibilities. 2. Leadership and management commitment framework. 3. Key Workforce Performance Indicators set for 2013/14.

Objective 3:

To deliver the Trust's clinical strategy of joined up healthcare

DCE	3.1 If the Trust does not fix the emergency pathway this will limit the Trust's ability to safely care for emergency patients, grow elective work and will damage the Trust's reputation and potentially impact on the Trust's strategic ambitions.	1. Escalation Policy and procedures in place. 2. New medical model for emergency care pathways implemented in October 2012. 3. Stage 1 of bed reprofiling is complete. 4. Daily capacity meetings. 5. Partial implementation of RealTime.
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MD	3.2	If the Trust is unable to secure sufficient alignment and support from other key partners, it will not be possible to fully develop integrated out of hospital care in NW Surrey.	<ol style="list-style-type: none"> 1. Clinical Strategy Programme Board supported by PMO. 2. Participation in NWS Transformation Board. 3. Clinical Strategy Programme Manager.
MD	3.3	If the Trust is unable to secure sufficient support from Acute Partners and Commissioners, it will not be able to develop the required scale for its specialist services.	<ol style="list-style-type: none"> 1. Principle partnership in place with RSCH. 2. Director of Strategic Development in post to support partnership working. 3. Formal partnership agreement and Partnership Board in place with Virgin/SCH.

Objective 4:

To improve the productivity and efficiency of the Trust in a financially sustainable manner within an effective governance framework

DCE	4.1	If the Trust's clinical workforce is not aligned around the Trust's efficiency improvement programme.	<ol style="list-style-type: none"> 1. KPIs on LOS, admissions, discharges. 2. Clear demand and capacity plan. 3. Weekly length of stay meetings in place. 4. Weekly Trust wide urgent care dashboard.
CN/ MD	4.2	If ASPH fails to deliver the clinical quality incentives (CQUINS), fails to deliver the performance standards, or fails to respond to the admission thresholds/readmission caps/ambulance turnaround penalties within the 2013/14 contract and under recovers income.	<ol style="list-style-type: none"> 1. Service planning processes in place with clear targets. 2. Clear internal Performance Review Framework. 3. Clear articulation of internal programme of work via PMO. 4. Monthly contract KPI monitoring. 5. CQUIN project managed through PMO with Executive Director leads.
DoF	3	If ASPH fails to deliver 2013/14 CIPs to the level required and/or allows pay and non-pay expenditure to exceed budget without a compensating increase in income.	<ol style="list-style-type: none"> 1. Monthly Directorate and Divisional performance reviews look at workforce, activity, finance and quality. 2. Major Productive schemes identify patients experience objectives as well as productivity objectives and monitor any adverse impacts during implementation.
DoF	4	If the contribution from individual divisions and service lines is less than required to deliver the EBITDA margin for ASPH as a whole. If ASPH cross-subsidises uneconomic service lines with the financial contribution of unrelated service lines.	<ol style="list-style-type: none"> 1. SLR information reported bi-monthly. 2. Financial accountant to support development of financial benchmarking. 3. Programme management in place with Project lead.
DoF	5	If financial or service pressures on third party providers of health and social care or commissioners cause operational difficulties or leads to enforcement of contract levers more aggressively than expected.	<ol style="list-style-type: none"> 1. Focus on NW Surrey Locality relationships. 2. Signed contract in place with monitoring arrangements. 3. Activity profiled across year. 4. Demand management scheme monitoring.

8.6 The Trust has declared a risk against the target for A&E Clinical Quality- Total Time in A&E under 4 hours.

The Trust failed the target in Q4 2012/13 following achievement in Quarter 1, 2 and 3. In terms of the failure of Q4 2012/13 this was due to a number of factors which are summarised below:

There was not a significant increase in the number of A&E attendances in Q4 2012/13, but there was a shift in case mix from December 2012 with a statistically significant increase in the number of patients that attended A&E and were treated through the "majors" stream. This change in acuity had a significant impact on capacity and flow throughout the hospital;

As a consequence of increasing patient acuity and a lack of capacity downstream in the hospital, the Medical Assessment Unit (MAU) was "blocked" with patients waiting for inpatient beds. This compromised the functioning of the new medical pathway of care because there was insufficient space to accommodate patients requiring assessment and

created additional pressure in A&E because patients that could not get to MAU were seen there instead. A lack of physical space in A&E caused very long waits for treatment and delays with ambulance handover; and

Complex discharges have been particularly problematic. On any given day in December there was an average of 55 patients with complex needs that were fit for discharge from hospital. This increased to an average of more than 80 cases per day in January and February.

In terms of performance in Q1 2013/14 the increase in the number of patients that attended A&E and were treated through the "majors" stream in December 2012 has been sustained in April and May 2013. This has been exacerbated by a peak in operational pressure for two weeks during early April 2013, which coincided with the soft launch of NHS111. Progress has been made with reducing the number of complex discharges, and as such flow through St. Peter's hospital has improved, reducing blocking of the MAU and A&E. In May 2013, performance has improved yet flow through the hospital remains a challenge especially for those patients who need community support.

Since failure of the target in Q3 and Q4 2011/12 the trust have put in place a number of actions; including:

The implementation of the ECIST model of emergency care in October 2012 which was signed off as all actions having been completed in December 2012;

To support the on-going development of the new medical model for emergency care implemented in October 2012, arrangements were put in place during March 2013 to formally monitor compliance with the internal professional standards agreed for MAU and the Medical Short Stay;

The Trust has made substantive appointments to the posts of Associate Director of Operations for Medicine & Emergency Services and Head of A&E; and

The Trust has participated in the newly established, multi-agency, discharge "task force";

There is a robust mitigation plan involving regular internal briefings alongside improvements to pathways, patient flow monitoring tools and practices amongst medical, and nursing and allied health professional staff;

There is work well in train aimed at improving integrated pathways and standardising pathways and treatment approaches where appropriate.

As a result of some of the actions above the Trust saw a 4.5% improvement in performance in Q3 and a 0.4% improvement in performance in Q4 against the previous year.

The Trust have further actions which are due to be implemented in 2013/14 which are forecasted to improve performance; these include:

- Development of a frail elderly pathway (to include frailty assessment, comprehensive geriatric assessment and a frailty assessment unit) as recommended by ECIST and the British Society of Geriatricians.
- Implementation of a new Surgical Emergency pathway, including significant improvements to the Surgical Assessment Unit.
- Recruitment of additional A&E consultants, including the Trust's first dedicated paediatric A&E consultant.
- Development of our partnership with Virgincare through Swift at Home, facilitating the care of older people closer to home.

- Collaboration with NW Surrey CCG to reinvest reablement funding into more community services.
- A further reallocation of our inpatient beds to better match demand and capacity.

Despite the actions already taken, the actions due to be implemented in 2013/14 and the improvement in performance year on year there remains a risk to the Trust achieving the A&E waiting time target following failure of the target in Q4 2012/13 and continuing pressure to meet the target in Q1 2013/14. A number of these pressures are not within the control of the hospital and therefore a risk of non-compliance has been declared.

9. Membership Report 2013/14 Annual Plan

BACKGROUND

The membership was established in May 2009 as part of the application to become a Foundation Trust, to ensure that the local population had a say in its local health service and also to increase the organisation's accountability to the people we provide services to.

There are nine public constituencies which correspond with electoral wards. These reflect the area the Trust views as its natural catchment (c 410k population) but extended to include other adjacent wards which reflect the Trust's position on the Surrey/London border.

ANALYSIS OF PUBLIC MEMBERSHIP

The following sections should be read in conjunction with the Membership template worksheet.

Membership Recruitment Analysis

The public membership figure stands at 6,497, as of 31st March 2013. This shows an overall increase in public membership, as planned.

The main day to day avenues of recruitment include the on-line joining form on the Trust website and sending joining letters to all new outpatients.

Holding membership stands in the outpatient and main reception areas at both hospital sites continues to be successful in recruiting new members. These stalls are timed to coincide with the publication of our quarterly newsletter, "Members Matters" and have been run by the Membership Manager and a number of Governors. This has resulted in many new members and also given patients and visitors the opportunity to speak to the Governors and express their views on services.

Community Events were also attended to recruit new members during 2012/13 and included:

- Laleham Methodist Church
- Ashford Jubilee Fun Day
- Englefield Green Village Fair
- Hounslow Cardiovascular Alliance
- Spelthorne Assembly
- Bariatric Support Group at Ashford Hospital
- Wolsey Shopping Centre, Woking

Membership Changes

The Membership database is regularly reviewed. During the year we lost 283 members. These were primarily members who had passed away or had moved out of the catchment area. We had 803 new joiners and encouragingly, the trend is for there to be more joiners than leavers.

Constituency Breakdown Analysis

Figure 1. Public Constituency Breakdown

Trust Membership by Constituency 1 April 2012 – 31 March 2013

	PUBLIC MEMBERS 1 APR 2012	PUBLIC MEMBERS 31 MAR 2013	Increase/decrease	Increase or decrease
Elmbridge	381	437	+56	
Guildford	89	89	0	↔
Hounslow	777	895	+118	
Richmond Upon Thames	139	134	-5	↓
Runnymede	673	799	+126	
Spelthorne	1,473	1,662	+189	
Surrey Heath	270	275	+5	
Windsor and Maidenhead	233	217	-16	↓
Woking	1,999	1,989	-10	↓
TOTAL:	6,034	6,497	+463	

As a result of a number of recruitment initiatives 463 members have been recruited during the period 1 April 2012 to March 2013 confirming a positive growth trend.

Figure 2. Constituency Representation

	ELIGIBLE POPULATION	PUBLIC MEMBERS 31 MAR 2013	% REPRESENTATION in MAR 2013
Elmbridge	9,1891	437	0.47
Guildford	6,636	89	1.34
Hounslow	144,105	895	0.62
Richmond Upon Thames	21,109	134	0.63
Runnymede	87,554	799	0.91
Spelthorne	94,597	1,662	1.76
Surrey Heath	17,206	275	1.60
Windsor and Maidenhead	10,927	217	1.99
Woking	94,725	1,989	2.10
TOTAL:	568,750	6,497	1.14

Figure 2 highlights the numbers of members per constituency, to ensure that they are representative of the communities that we serve, in terms of the local population figures.

There are lower percentage representations in Elmbridge, Hounslow and Richmond Upon Thames. Although some constituencies show a decrease in membership, these decreases are relatively small numbers and are due to deceased members and members moving out of the area.

Diversity Report

The Trust was very marginally under-represented in the Socio Demographic Categories „C2“, „D“ and „E“, during 2011/12 but this has improved tremendously in 2012/12 and is no longer the case. In fact we now have a healthy representation in these categories. The data suggests that the Trust is marginally under-represented in the 14-16 and the 17-21 age categories. Plans to address this are set out below.

STAFF MEMBERSHIP

Staff membership is on an „opt out“ basis and to date only one current member of staff has opted out.

ELECTIONS

Five elections were held in 2012. This was due to the positions coming up for re-election after the two year terms had ended. Three of the five elections were uncontested. Nine candidates stood for two remaining elections (five vacancies) and the turn out rate for the two elections averaged 33.6%. The elections were carried out in accordance with the model rules. Electoral Reform Services were contracted as Returning Officer to ensure professional management.

MEMBERSHIP PLAN

The Council of Governors refreshed its Membership Strategy in 2013 and this includes a clear action plan with SMART objectives. These are monitored regularly by the Membership and Community Engagement Group.

The net target to increase the membership in 2013/2014 is 325 members allowing for natural wastage.

The Membership plan is to:-

- Maintain current recruitment systems e.g. outpatient letters / online applications.
- Continue with a programme of Health Events. These are very popular with the members and are also a good means of recruiting friends of existing members and new members. During 2012/13 events on Diabetes, Vascular Surgery, Osteoporosis, Cancer, Infection Prevention and Control, End of Life Care, Dementia and Organ Donation took place.
Undertaking targeted recruitment in underrepresented areas including Elmbridge and Hounslow through community and social groups.
To increase membership in the 14-16 age group

Plans to Increase Foundation Trust Membership in the 14 – 16 Age Category

The Membership Manager will attend the Trust's Work Experience Event to publicise membership to students attending and hold a stall throughout the event. Membership application forms are also included in all information packs sent to students wanting to participate in work experience at the Trust.

Plans are underway to organise a Members' Health Event on "A Career in the NHS" and this is due to take place on 22nd October 2013. Invites will be sent to local schools and presentations from various members of staff will be included.