



Strategic Plan Document for 2013-14

The Queen Elizabeth Hospital, Kings Lynn NHS Foundation Trust

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

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

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Date	31 May 2013

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)	Kate Gordon
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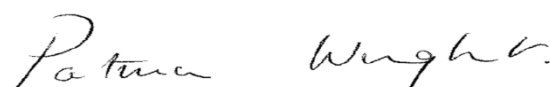
Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Patricia Wright
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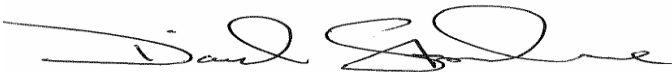
Signature



Approved on behalf of the Board of Directors by:

Name <i>(Finance Director)</i>	David Stonehouse
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Signature

A handwritten signature in black ink, appearing to read 'David Stonehouse', written in a cursive style.

1 Executive Summary

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH) provides healthcare services at The Queen Elizabeth Hospital, a 472 bed acute hospital with an annual income of £168m which opened in 1980 and is located 2 miles outside King's Lynn town centre. The Trust is a community focused District General Hospital, providing high quality acute, elective and specialist care for the rural communities it serves across West and North Norfolk, part of Breckland, North Cambridgeshire, and South Lincolnshire. This comprises a population of circa 240,000 with a relatively elderly age profile.

As part of its work on reviewing and agreeing the future strategy for QEH the Board of Directors (BOD) has agreed two absolute priorities that will guide all our decision making, and that we care about above all else:-

- **Ensuring High Quality Care, and**

Improving the Accessibility of our Care

To deliver this the organisation plans to focus on three areas of development

- Acute Medicine on QEH
- Integrated Services, and
- Reviews of Future Models of Care

However, analysis of the financial and clinical sustainability of the trust in its current configuration in the context of the national economic environment and the stated aims of local Commissioners suggests that the Trust will not be financially sustainable in the timescale of this plan and a rapid system-wide review of health and social care provision will be required within 13/14.

2 Strategic Content and Direction

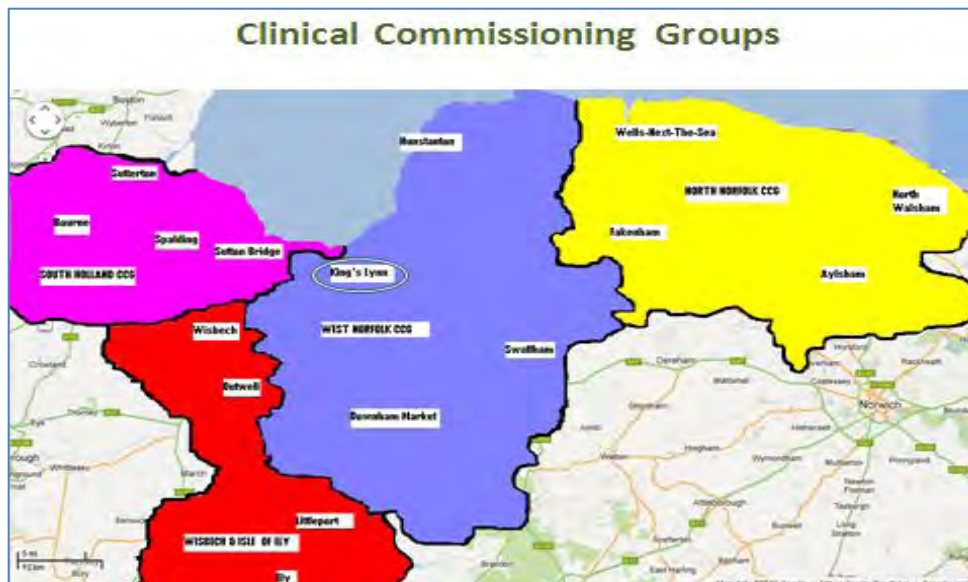
2.1 Introduction to the Trust

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH) provides healthcare services at The Queen Elizabeth Hospital, a 472 bed acute hospital with an annual income of £168m which opened in 1980 and is located 2 miles outside King's Lynn town centre. The Trust is a community focused District General Hospital, providing high quality acute, elective and specialist care for the rural communities it serves across West and North Norfolk, part of Breckland, North Cambridgeshire, and South Lincolnshire. This comprises a population of circa 240,000 with a relatively elderly age profile. With many of the people working at the QEH also living locally, there is a pride in and local ownership of the hospital and its future, and our staff commitment is second to none.

With strong local support, QEH provides a wider range of services and treatments than many District General Hospitals of our size. This is in response to the relative rural isolation of local residents, and limited public sector transport. We are committed to enabling access to specialist acute care locally for our communities, and to this end have developed shared specialist services with tertiary centres in Norwich and Cambridge.

Emphasis by the Trust in recent years has been on increasing the availability of our elective services to a population that may live many miles from the hospital. Accordingly we have developed successful outreach services for many procedures that formerly could only have been carried out in the main hospital. Working from centres such as the custom-built operating theatre suite at St George's Medical Centre in Littleport, or clinics at local GP practices, we are able to take our services to where patients require. We currently run outreach services in Littleport, Wisbech, Swaffham and Fakenham, and in 13/14 will be exploring options for South Lincolnshire.

We work closely with 43 GP practices across a catchment area of approximately 750 square miles and especially closely with West Norfolk Clinical Commissioning Group (CCG), whose GPs are responsible for commissioning the majority of our services.



Our traditional catchment area covers the towns of King's Lynn, Wisbech, Hunstanton, Downham Market and Swaffham. Our population profile includes a high proportion of older residents, since this is a popular coastal retirement area. However, new housing developments in recent years have seen large population growth in towns such as Downham Market, principally of families with children.

The hospital Trust employs 2,659 staff which includes 366 Bank Staff and we are strategically important to the Borough Council of King's Lynn & West Norfolk as a major local employer.

There is at least one hour's travelling time between us and the nearest acute Trusts: Pilgrim Hospital, Boston (part of The United Lincolnshire Hospitals NHS Trust), Peterborough and Stamford NHS Foundation Trust, The Norfolk & Norwich University Hospital NHS Foundation Trust and Cambridge University Hospital NHS Foundation Trust, the latter two Trusts being our Tertiary referral centres.

In 2012/13 we treated 425,000 patients at our Trust. 55,500 attended the accident and emergency department, 37,500 attended for inpatient or day case treatment, 32,000 attended as non-elective admissions and there were 300,000 outpatient appointments including 5,000 telephone consultation outpatient appointments.

The Trust provides a comprehensive range of specialist, acute, obstetrics and community-based services. While a strength lies in the Trusts' geographical location, this can bring difficulties in hard to recruit specialties. As a result such services have been developed through clinical networks with our tertiary centres to provide care locally.

We provide a broad range of secondary care services in line with other general hospitals but we also provide some specialist services such as chemotherapy and Level 2 Neonatal Intensive Care.

Treatment of cancer patients is amongst the best in the country - our new Macmillan Centre provides palliative care for patients with cancer and other chronic illnesses - and we have a 'Charter Mark' award-winning Day Surgery Centre and a nationally recognised Radiology Department that is one of only five units nationally to have achieved the Imaging Standards Accreditation Scheme status.

3 Overarching Strategy and Vision of the Trust

3.1 Our Two Priorities

As part of its work on reviewing and agreeing the future strategy for QEH the Board of Directors (BOD) has agreed two absolute priorities that will guide all our decision making, and that we care about above all else:-

- **Ensuring High Quality Care, and**
Improving the Accessibility of our Care

Everything we do should be to provide our patients with a high quality service. The definition of Quality that we will use is that of the National Quality Board:-

- Care that is effective
- Care that is safe
- Provides as positive an experience as possible.

“An organisation focused on quality should always place the interest of patients, before an individual or organisation ambition.”

National Quality Board

And secondly, to provide highly accessible and increasingly accessible healthcare, that is easy for the public to use, and responsive to their needs. This will require the Trust to invest in improving our booking processes, look to use technology and telehealth in a new way, review the times when we run services, seek to provide outreach services using community/GP locations, and many other approaches. This second priority is supported by a 2012 Ipsos-Mori survey that identified that the majority of the public choose their healthcare provider because of the convenience of the location and the appointment time. Through delivery of these first two priorities of a high quality service, and radically improved accessibility, the QEH must ensure it delivers sustainable, high value healthcare for the long term. At a time of clinical innovation, and reductions in public sector funding, this means we will need to work differently in many areas. The refreshed Clinical Strategy can be summarised as:



High Quality Care

To deliver high quality care, three key themes will be progressed:-

- Acute Medical on Site – a new clinical approach to providing emergency care, fronted by immediate Senior Review, and a single triage approach regardless of referral method, i.e. GP, ambulance, self referral, Ambulatory care referral etc. Within this, the Trust will specifically develop a new Ambulatory Care service as an alternative to A&E/GP admissions, seek to develop 'Hospital @ Home' Services via contracting with an alternate provider, and undertake a review of the potential for a full 7/7 service.
- **Integrated Services** – Additionally, explicit networks will be developed to underpin strong local care, in particular over Cancer Services, Integrated Paediatrics, and GP-Acute pathways. Through this range of approaches, the Trust seeks to regain control of the wider patient pathway, and support patients better at both admission and discharge.
- Review of Future Models of Care – Recognising changes in policy and provision, the Trust will start to review future models for Cancer care, Lead Provider status, and End of Life, in order to improve a patient and family's experience.

Radically Improved Accessibility

To deliver improved access the Trust will strategically develop a range of approaches:

- Location and outreach – to continue our development of outreach elective services to nearby towns, making access to appointments more convenient.
- Extending hours for ease of access through evening or Saturday clinics and daycase procedures.
- To pilot telehealth approaches to improve options for patients to access care, and for the Trust to provide additional triage services, eg visual outpatients using home technologies, text and home monitoring.
- To invest in improving the environment and experience on site at the QEH through modernising the 'front door', continuing to improve parking options, and redesigning the electronic access to the hospital of Choose and Book.

Delivering Sustainability

To support longer term sustainability, the following services will be supported to develop:-

- Develop commercially strong additional outreach services, to increase the ease for patients to choose the QEH.
- To invest and develop diagnostic and imaging services, including options for mobile services, and significant enhancement of the new Treatment and Investigations Unit, to ensure prompt access to tests and procedures.
- To invest and specialise in 23hr Surgery and Day Surgery, building on the regional anaesthesia skill set that the Trust has developed, and the proven best practice in day case rates.

Corporate Objectives

For 2013/14, the BOD has agreed the following Corporate Objectives:-

- i. Develop new ways to provide access to services which are safe, personalised, timely and cost effective.
- ii. Consistently provide and promote to users, an excellent patient experience.
- iii. Continually review the Trust's portfolio to ensure it remains relevant to local communities and where appropriate develop complimentary partnerships, new delivery models or service growth.

- iv. To develop a culture that supports the individual with professional development, and so secure an expert workforce that can shape services, and have passion for great care.
- v. To manage resources effectively and improve our financial strength in order to reinvest in service improvements and facilities.
- vi. Ensure systems are in place to meet national and local regulatory and compliance standards.
- vii. Further develop the Trust's corporate social responsibility for West Norfolk and beyond.

5 Our Values, Which Underpin Everything We Do

Through the joint work of the Values Council (comprising both Governors and Staff members), a series of staff workshops, and debate within the Board, the Trust has now agreed the Values that will underpin how we care for patients and each other to secure and support the delivery of a high quality, personalised, and principled healthcare experience. The values we have agreed are:-

- We are dedicated to providing safe, quality and individualised care.
- We treat all people with respect, kindness and compassion.
- We display courage in our actions.
- We innovate, and embrace new technologies.
- We value all staff equally and see teamwork as the basis of high quality care.
- We are open and honest in our relationships with patients, families and colleagues.
- We listen to learn.

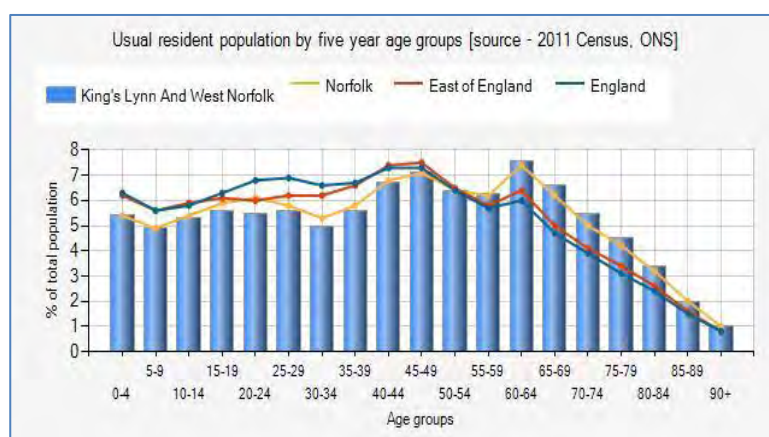
6 The Competitive Market and Changing Commissioner Landscape

As part of the review of its Clinical Strategy the Trust has undertaken a comprehensive market assessment of the Trust in relation to current market share and future market opportunity, understands its needs to build upon its policy of outreaching acute services in peripheral locations to maximise market opportunity and has a line of sight in terms of the key commissioner changes happening both within West Norfolk, North Cambridgeshire (and the whole of Cambridge) as well as national commissioning policy. This section analyses the underlying demographic and market share position of the Trust. This has been used to inform the Trust's strategic direction and APR submission.

6.1 Demographics and Population Size

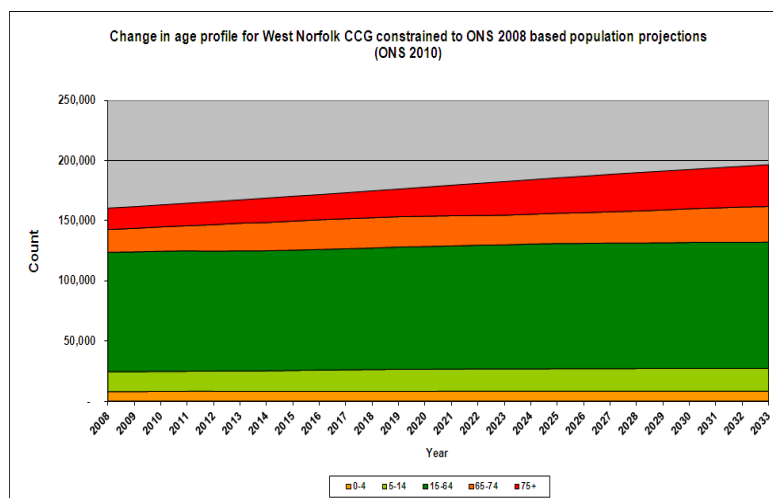
One of the challenges for the Trust and its commissioners in West Norfolk face is the higher than average age profile versus the England position which is even more differentiated at county level as West Norfolk has a higher elderly population than the rest of the county

Population Age Groups – Norfolk, East of England and England



The chart below shows how the size of the population aged over 65, and 75+ will continue to grow. This level of need is potentially exacerbated through people retiring to West Norfolk, and living locally without extended family support. The longer term impact of an aging population is well documented, but the visual demonstration below, drives the case for the wider health economy coming together to develop the right models of care for the locality.

Changing Age Profile for West Norfolk

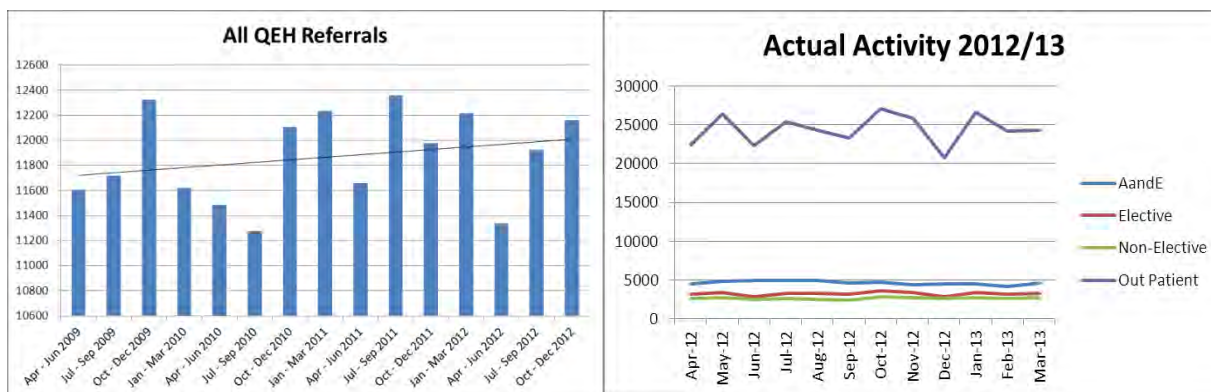


Source: West Norfolk CCG – developing an understanding of health and wellbeing needs
Public Health NHS Norfolk and Waveney Cluster and Norfolk County Council

7 Demand for Trust Services

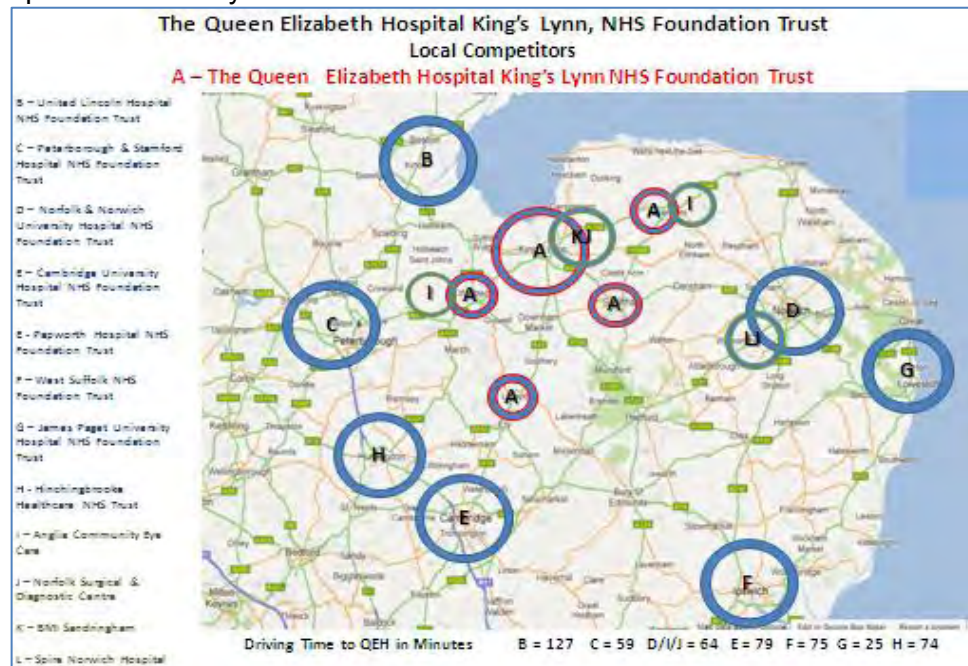
Whilst the tables below demonstrate that demand for acute services at the Trust, particularly in terms of OP referrals, has not seen a dramatic shift in activity away from the Trust, in some specialties (particularly orthopaedics and ophthalmology) the introduction of local competition has seen a drop in referrals.

Whilst the Trust is confident in its aim of recovering this loss of market share in 2013/14, this is the first year where West Norfolk commissioning intentions explicitly stated their intention to manage down referrals to outturn levels and they have set their activity plans accordingly. This has not been replicated with the Trust's other 2 main commissioners (27% of Trust activity) where the Trust and commissioner have a joint agreement on activity levels. The Trust has undertaken a comprehensive activity planning exercise which indicates that on known trends, current referral and conversation rates, it believes West Norfolk Clinical Commissioning Groups intentions are highly ambitious and, as a result, we have positioned our activity plan above that indicated by West Norfolk CCG.



8 Key Competitors and/or Partners

Whilst the Trust is relatively isolated from other acute provider organisations (at least an hour's drive from King's Lynn) and there is no current evidence of market drift to these providers, it does have a number of small local competitors and has previously taken the decision to provide outreach services at major local towns. In addition to a long term presence in Wisbech, the Trust now has outreach services at Littleport, Fakenham, and to a lesser degree, Swaffham. The map below geographically represents the location of our potential competitors for easy review.



8.1 Non NHS Key Competitors

The Trust operates in an increasingly competitive environment, and there are many pressures affecting patient activity and choice.

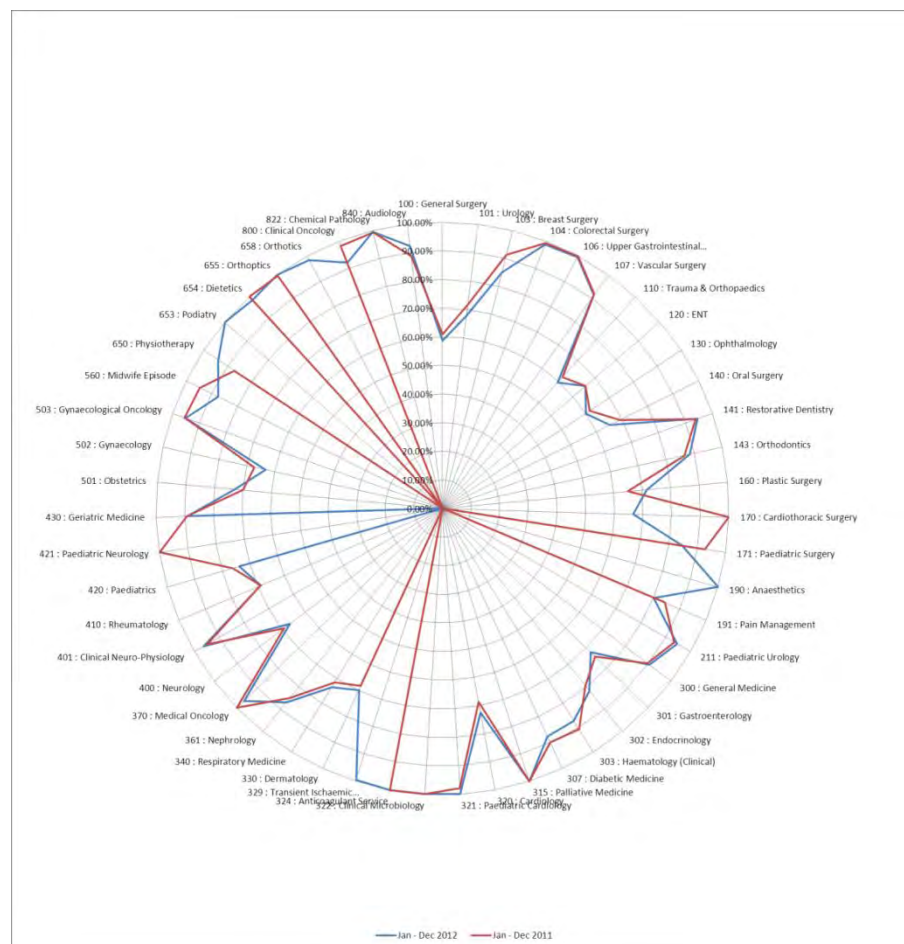
- **Anglia Community Eye Services (ACES)**
A local provider that is operating in both Cambridgeshire and Norfolk providing general eye surgery in community settings.
- **Norfolk Surgical & Diagnostic Centres (NSDC)**

A partnership that has been formed between four GP partnerships; three located in King's Lynn:- St James Medical Centre, Southgates Medical Centre, Vida Healthcare (Gayton Road Health Centre and Carole Brown Health Centre) and one in Norwich, St Stephens. NSDC provides various procedures within the locality. The main areas in direct competition with QEHL are General Surgery, Urology, Ophthalmology and Trauma & Orthopaedics. Data from CHKS shows that referrals from these four practices have shown a slight decline over the last 4 years.

- **BMI Sandringham Hospital**

The BMI Group currently runs a facility on The Queen Elizabeth site – The Sandringham Hospital. The facility provides a range of private elective services as well as additional capacity for the NHS. At present, the hospital operates under capacity within its private base and is known to seek further NHS work. Many of the QEHL consultants work in a private capacity at The Sandringham. The Sandringham has a strong interface with the QEHL, and is dependent on the Trust for many of its support facilities, for example, critical care and diagnostics.

Competitor analysis has also been undertaken for each specialty, to understand trends in demand, changes in referral patterns, and to predict future demand if no specific actions were taken, eg improvement in patient experience, improvement in access, promotion of clinical outcomes or new sub specialties on offer, new Consultant colleagues working at the Trust etc. The chart below indicates our current Market Share (Jan-Dec 2012) by specialty against practices that refer to the Queen Elizabeth Hospital. This indicates the areas where we can focus on improving the service, to increase our market share. In particular, General Surgery, Ophthalmology, ENT, Urology, Dermatology, Gastro and Orthopaedics stand out.



Current Market Share (Jan-Dec 2012 vs Jan-Dec 2011)
(New OP Referrals Data from CHKS)

9 Local Commissioning

The Trust has a lead Commissioner in West Norfolk Clinical Commissioning Group but this is made more complicated with 2 further commissioners from Cambridgeshire and South Lincolnshire identifying different priorities and the resultant impact on care pathways this can have. For example in 2012 commissioners in Norfolk undertook a county wide tender for Termination of Pregnancy Services which the Trust was not successful in securing with its partner organisation,.However, Cambridgeshire and South Lincolnshire CCGs both wish us to continue with the service.

In addition, Cambridgeshire CCG is currently undertaking a large scale Older Persons tender for all services from the community through to acute care. With a countywide budget of £1bn, this will result in specific care pathways for the Wisbech & Ely populations. Such commercial approaches will also test our corporate capacity to manage multiple service tenders and redesign projects.

It is difficult with commissioners being encouraged to market test a number of services to gain a clear line of sight of potential risk to the Trust which in turn makes it difficult to plan for longer than an 18 month horizon span.

Consequently, agreeing contracts with our local West Norfolk Clinical Commission Group was a challenging process. Activity levels have been set at 12/13 outturn levels with an expectation that in order to manage back to this level commissioners will have to quickly implement QIPP schemes to manage elective demand. Activity levels have been set at forecast outturn levels with an expectation that in order to manage back to this level commissioners will have to quickly implement QIPP schemes to manage elective demand. *We have set above out-turn*

The BOD has had a Board to Board meeting with West Norfolk Clinical Commissioning Group colleagues to discuss both organisation's Vision for the future. The Trust recognises it needs to build upon this discussion and agree how to approach a system wide review of health and social care provision with partners.

9.1 Competition, Tenders and Any Qualified Provider

Countywide tenders were commissioned by Norfolk PCT for a range of services during 2012/13, and others are expected via local Clinical Commissioning Groups in 2013/14. In order to successfully compete, partnerships of varying guises (from renting clinical space to formal Joint Ventures) will be required with NHS, private or voluntary organisations to enable the Trust to meet specifications.

Any Qualified Provider (AQP) is now an established mechanism by which policy makers can increase the range of providers of NHS funded care. With the basic proviso that all approved providers are clinically competent, patients can then choose from a range of providers for NHS care. Areas for AQP to date include Musculoskeletal, Audiology, Radiology, Therapies, Dietetics and Health Screening programmes. Whilst there is potential for market growth and the QEH extending its services into new community programmes, there is also a real risk that where the QEH has historically been the only provider market share loss may result in non-viable services to support local acute care, in particular, diagnostic services.

A key requirement for successful provision under AQP is location. Many CCGs have tendered AQPs in order to increase 'care closer to home', and to encourage the provision of care in additional locations. Therefore, the Trust must carefully choose to provide some services off-site, and in other healthcare locations, in order to retain or gain new patients. In doing so, there is a risk that the existing estate is utilised less efficiently and new uses for parts of the estate will need to be considered going forward.

We continue to work with Specialised Commissioners, whilst the portfolio of such work at the Trust is small we must continue to ensure we understand the potential risk of any further expansion.

9.2 Decommissioning

During 2013/14 the Trust will see the 'loss' of the Termination of Pregnancy Service for patients with a gestation of less than 18 weeks. The Trust bid with a private provider for the patch wide service but was unsuccessful. Whilst other commissioners wish us to continue to provide this service the Trust is currently evaluating if this is commercially and operationally the right thing to do. Whatever the outcome of this work the Trust as an acute provider must work with the new provider to link clinical pathways for the emergency occasions when they will be unable to provide urgent acute interventions. The Trust, therefore, needs to retain some level of clinical service irrespective of the commissioning decision.

This year sees the roll-out of the East of England Pathology procurement. The Eastern Pathology Alliance (of which the Trust is a partner) will undertake GP 'cold pathology' testing at the NNUH site, with the work West Norfolk GP work historically done at QEH transferring by the end of the calendar year. All hospital microbiology work will also be undertaken at the NNUH site. A transfer of North Cambridgeshire cold pathology work from the Trust to Peterborough will happen in June.

Previously mentioned in this Plan is the intention of Cambridgeshire commissioners to tender the full extent of older peoples services. Work in year at the Trust will be undertaken as the timescales intended are met this would be effective from 1 April 2014 and the Trust must have in place any transitional arrangements.

10 Strategic Sustainability Challenge

The Trust is not alone in having the challenge of remaining a financially sustainable organisation, but additionally as many 'small' DGH do, we have a greater challenge in terms of maintaining this whilst also ensuring the clinical strategy of the Trust meets the need for providing services 7/7 and retaining critical mass in terms of population and clinical staff. The financial assumptions within the APR whilst allowing for some catchment growth and repatriation of orthopaedic work from the private sector but these are not sufficient in scale to solely deliver sufficient EBITDA contribution to drive significant improvement to the current underlying financial position of the Trust.

10.1 Small DGH Challenge

The Challenge for the QEH is perhaps best summed up through the Dr Foster Annual Report for 2012. In this independent annual report, The QEH is identified as being an organisation where the Health Regulator Monitor has concerns about our financial situation, whilst also being identified by Dr Foster as being one of the most efficient Trusts in the country.

This situation is in part the result of small DGH's losing specialist, elective clinical work to tertiary centres, whilst also having challenges over medical emergencies, and commissioner intentions to provide low level acute care that was core business, in primary and community settings, eg tendering for diagnostics.

Nationally smaller DGHs serving populations below 350,000 are finding it harder to provide the full range of clinical services, and experiencing conflict in operational demand between elective and emergency services.

The urgency to address this issue for the QEH and the wider West Norfolk health system has been escalated following the inability of the Trust to deliver a balanced financial position in 2013/14 on the basis of current commissioner intentions.

10.2 Clinical Pathway Opportunities and Threats

Despite the differences in contractual approaches, there is a national and local push to develop clear pathways of care to better manage a patient's care across all providers. Often focused on long term conditions, this approach seeks to better manage a patient's condition in the community, by an improved interface with the acute specialists supporting GPs and colleagues, and additional investment in sub-acute care. Overall, the expectation is a reduction in traditional acute care.

Opportunities exist to co-develop such pathways with GPs such as the Headache MRI pathway, or with NCH&C over Older Persons Care, developing step-down intermediate care beds, or working across a range of organisations to reduce admissions/readmissions for patients with COPD..

Commissioners are just starting to consider purchasing care through a Lead Provider, who would be capitated resourced for all care episodes, to then coordinate investment and expenditure across the system to drive improved care coordination, and value. As a DGH, the QEH needs to be clear in its clinical strategy about how it responds to such developments. The drive is to reduce acute/emergency admissions, and taking a lead role moves the Trust toward integrated provision outside the hospital. Eg; countywide musculoskeletal services are being tendered in other health economies.

10.3 Clinical Sustainability and Critical Mass

As with all small organisations, the challenge of the loss of low cost work to other providers, either via choice or commissioner market testing, whilst being required to maintain acute rota's for general surgery and general/acute medicine is increasingly difficult. This is especially problematic in general surgery with increasing sub-specialisation.

Single handed consultant-led specialties are increasingly difficult to sustain without networked clinical support. The majority of the Trust's services are networked although some specialties are in the early stages of this pathway working.

The Trust has a 24/7, 7 days a week consultant led A&E service, but this does not include a consultant presence on site at all times. Whilst recruiting to consultant medical staff posts has been difficult the Trust is approaching this challenge by recruiting a consultant nurse as part of its strategy to develop, strong, multi-professional teams.

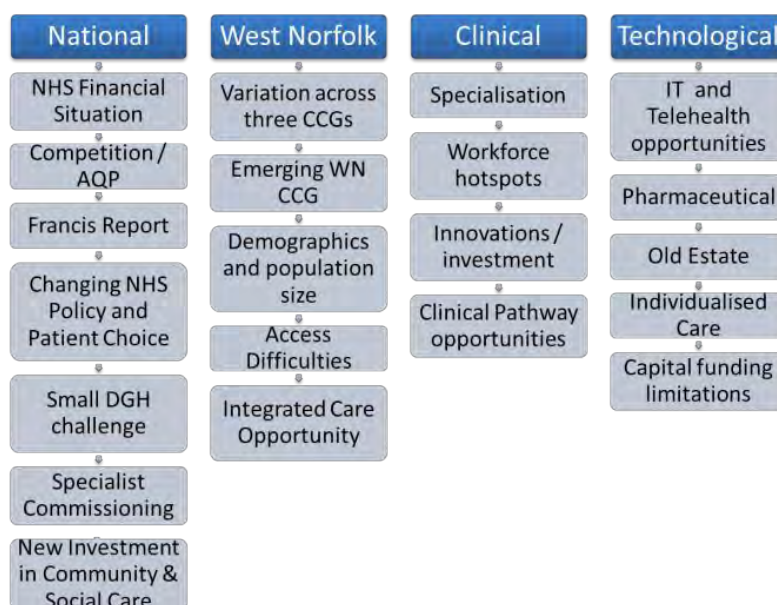
Areas of particular risk are:-

- Acute Stroke – we currently provide a hyper-acute service which is 24/7 via telemedicine which our lead clinician participates in and which has clinical outcome measures which are excellent and is fully supported by our local commissioners. This service is being reviewed by the Stroke Network pan East of England.
- Cancer services and the increasing move to centralisation.

Other areas of clinical sustainability and, therefore, areas of future planning being addressed are those in relation to non-medical areas. The Trust continues to struggle to maintain a full pharmacy complement and, as has been referenced in the CIP section, a review of this service has been undertaken and a new Head of Pharmacy recruited.

11 How The Trust Will Respond To These Challenges

The diagram below concisely identifies the challenges facing the Trust and this APR has been produced to address the challenges these pose. A summary of the key approaches are highlighted in this section. However, the Trust acknowledges that even if it achieves success in all of these ventures it might still not enable the Trust to be financially sustainable in the medium/longer term without radical system-based change in health and social care provision across West Norfolk and the local environs.



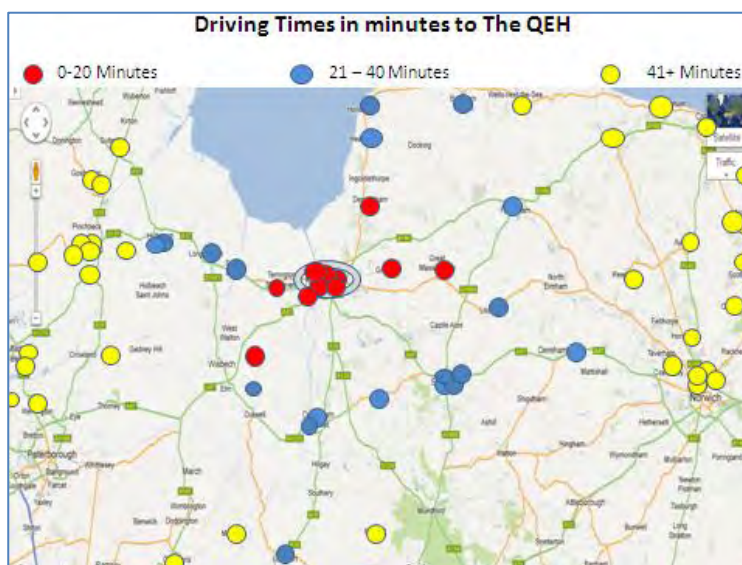
11.1 Collaboration, Integration and Patient Choice

11.1.1 Patient Choice

In response to the wider trend towards a consumerism and the right to choose, 'Choice' in elective care is now firmly established as an individual's right to choose their healthcare provider. With private organisations now holding NHS contracts, along with other NHS 'competitors', there are now more options for patients and families to choose the provider that most suits them. Our clinical strategy must respond to this, recognising the need for some treatment options to be 'more conveniently located away from the QEH site, and outside standard office hours. To support this, the Trust has reviewed all of its Choose and Book templates with the aim of ensuring in terms of order of 'choice' the Trust's offering is at the top of the wider list offering.

11.1.2 Location and Outreach

The Trust must ensure robust delivery of outreach services, in areas such as Wisbech and Littleport, with consideration of other towns where population size and levels of demand makes outreach clinics viable. The map below indicates the travel time for patients who have to travel to the main site. Without outreach, the Trust is not the closest provider for many services.



Extending the geographical area and population served by many surgical departments, is central to sustaining elective and emergency surgical services into the future. The need to secure sufficient surgical work to support a 24/7 emergency 'take' is central to the Trust's long term sustainability. With the transfer of specialist surgery to tertiary centres, the Trust needs to increase its population base for routine surgery. If outpatients are local, it is more likely that a patient will travel once for the procedure. This approach may also apply to specific medical departments such as gastroenterology and rheumatology where there may be a need to a post outpatient intervention such as endoscopy.

This approach is clearly linked to the wider assessment of competitors, with South Lincolnshire being identified as a key area where commissioners wish to see new entrants to the market.

Finally, the development of extended service hours to meet patient requirements is critical, particularly for those services that are elective, and where our competitors have been much more proactive in identifying customer need and tailoring their services to meet these needs by running services at more convenient times.

11.1.3 Partnership Working – Community Outreach Services

The following examples demonstrate the Trust's aim to deliver care in areas other than the Kings Lynn site.

a) Wisbech

The North Cambridgeshire Hospital (NCH) is approximately 13 miles West of King's Lynn and was part of the Trust until 2004 when the site transferred to the PCT. The Trust still provides extensive outreach services at NCH and has agreed to develop further services with local GPs. The services currently provided at this site are:

- Paediatrics
- Gastroenterology
- Urology
- Ophthalmology
- Dermatology
- Orthopaedics
- General Surgery
- Colorectal
- Gynaecology
- Palliative Care
- ENT
- Cardiology
- Oral Surgery
- Oncology
- Haematology
- Respiratory
- Endocrinology
- Obstetrics
- Rheumatology
- Neurology
- Dietetics
- Hearing Therapy

We are working closely with Wisbech and Ely Local Commissioning Group to review and extend our offering from this site.

Newer, smaller, but equally ambitious, ways in which the Trust has moved into providing acute elective intervention outside the Trust can be seen in the following 2 examples. The services are Consultant-led and supported by a full team of specialist nurses and day surgery staff.

b) Littleport

In 2008 the Trust entered into a partnership with St Georges Medical Centre in Littleport to develop a day surgery theatre for local procedures with recovery and clinical areas. We now provide outpatient clinics for Ophthalmology, General Surgery, Fertility, Urology, Gynaecology and Gastroenterology. We have further developed these services to also include local anaesthetic procedures for Ophthalmology, General Surgery and Urology.

Future plans for this service development include the addition of Orthopaedic services and the development of existing services into one-stop facilities including procedures for Gynaecology.

c) Fakenham

In 2012 the Trust entered into partnership with the Fakenham Medical Practice to provide acute care interventions in an integrated treatment centre. The services that we currently provide at this site are:

- i. Ophthalmology General Surgery
- ii. Rheumatology Orthopaedics
- iii. Gastroenterology Orthoptists
- iv. Low Visual Aids Midwifery
- v. Audiology

11.1.4 Continuing Health Care, Community Services and Integrated Care Models

Despite the financial challenges highlighted above, commissioners are seeking to refocus investments to secure better value care; this often includes investment 'upstream' in the care pathway through public health programmes, and through resourcing alternatives to acute care. The Trust as part of its CIP programme is currently working with KPMG to develop an options appraisal to determine the potential opportunity for the Trust in the Continuing Health Care Market.

The dissolution of Cambridge Community Services and Cambridge commissioners' intention to tender under a lead provider Older Peoples services in 2013/14 gives the Trust the opportunity to assess the potential market opportunity in these services areas.

11.1.5 Hospital @ Home

The Trust aims to extend its ability to provide care for patients who have a requirement for ongoing medical or social care but have no need to be in an acute bed – we call this Acute Outreach. Working with a commercial partner the Trust has invested in establishing the feasibility of and opportunity for providing a 'Hospital at Home' 24 hour service. The evidence base for this has been established following a recent independent audit of QEH patients to establish the baseline need.

11.1.6 Clinical Specialisation and Specialist Commissioning

New strategic clinical networks hosted and funded by the NHS Commissioning Board will cover conditions where improvements can be made through an integrated, whole system approach. The first patient groups chosen to be a strategic clinical network are:

- Cancer
- Cardiovascular disease (including cardiac, stroke, diabetes and renal disease)
- Maternity and children's services
- Mental health, dementia and neurological conditions

The impact on QEH and the wider NHS is still to be understood. The risk is that these approaches tie in with the Royal Colleges trend to clinical sub-specialisation based on improved health outcomes, and drive

a greater range of care towards larger, tertiary centres. In response the Queen Elizabeth Hospital has actively developed clinical networks with tertiary centres in Norwich and Cambridge, with many jointly appointed consultants that work across both sites. This approach will need enhancing in the future.

12 Approach Taken to Quality

The Trust has in place quality, safety and risk management arrangements to ensure the organisation meets the challenge of ensuring that the clinical services it delivers meet the expectations of its patients, regulators and commissioners.

The Trust is currently reviewing its quality strategy in light of the 'Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013 - The Francis Report' recommendations. and more recent feedback from a Care Quality Commission visit to the Trust which will necessitate a swift Trust response.

During 2012/13 the Trust:-

- Strengthened the governance arrangements within the organisation through the creation of two sub-committees of the Board, the Quality and Risk committee and the Performance and Standards committee; each in turn able to undertake detailed scrutiny of quality measures, risks to patient safety, performance and adherence to standards.
- Focussed investment and development in those areas that most effectively support improvements in the quality of care.
- Set measurable objectives by which quality can be measured and improvements in care demonstrated.
- Set out a refreshed Quality Strategy Implementation Plan which included all the quality improvement work streams for that year and the performance indicators by which improvement was judged.
- Devolved responsibility for meeting quality objectives to the clinical divisions and ensuring that any failure to meet milestones and metrics is quickly identified and addressed.
- Ensured the Trust undertakes a self-assessment against external measures of quality and in particular, constantly reviews compliance with the CQC's essential standards of quality and safety.
- Put in place key quality committees to drive improvement in the organisation and to provide leadership and innovation to each aspect of quality improvement. This includes a patient safety committee, a patient experience committee and a clinical outcomes group.
- Agreed an annual quality improvement programme with our commissioners that is delivered through the CQUINS programme.

Areas under consideration for strengthening are:-

- Placing a greater focus the interest of patients as central before all other considerations.
- Making a commitment to transparency and openness – fully implementing the Duty of Candour.
- Recognising that quality improvements will only be made if we can first deliver high quality, fundamental care to all our patients.
- Recognising the importance of ensuring that the culture of care in the organisation is compassionate and values the dignity and worth of all individuals.
- Listening to patients and the public so that their voice is heard and both provides feedback on patient experience but also informs service developments.
- Ensuring that services are accessible, sustainable and meet the needs of the local population.
- Embracing opportunities for development, innovation and change.
- Valuing and investing in staff – listening to staff, providing training and educational opportunities, valuing individual's contributions.
- Meeting external measurable standards of regulatory and quality compliance.
- Recognising that the quality outcomes for patients will only improve if all health and social care providers work together to support improvements – improved partnership working, development of clinical networks & valuing patient choice.

13 Service Line Management

During 2012/13 the Director of Clinical Services/Deputy Chief Executive reviewed the operational management arrangements of the clinical teams. This new structure consists of nine clinical groups (8 service groups) appropriately aligned with revised leadership roles to ensure optimum service delivery. With each group headed by a Clinical Director working alongside the general management teams, we aim to ensure full clinical engagement in service development, service delivery, workforce planning and financial planning activities. Through this structure we aim to ensure that workforce priorities remain consistent with activity assumptions and Cost Improvement Plans (CIPs). Group workforce plans, including plans for staffing reviews, organisational change proposals, etc are then aligned to produce the overall Trust Workforce Plan. All areas, both clinical and non-clinical, are required to engage in a comprehensive budget setting exercise and ongoing monitoring to ensure that business plans are fully aligned including workforce, activity and financial assumptions across the organisation.

This redesign was in line with the Trust's wish to develop a clinically-led organisation with clinicians and managers work in a more accountable and transparent way to deliver high quality, efficient and effective clinical services. This has resulted in increasing the number of Clinical Directors at the Trust to 8 from 4, to align with the new structure of 8 Service Groups. All Clinical Directors are members of the Trusts Executive Committee. The Clinical Director roles were open to both medical, nursing and other clinical professionals and the Trust was very pleased to announce its first Clinical Director with a nursing background.

Management support is provided by 2 general management groups led by the Deputy Directors of Clinical Services, supported by service managers and business partners for Finance, HR and Information.

The Trust intends to review the success of this work in May/June 2013 and will make changes to the structure as required to ensure that it has appropriate capacity and capability to drive its clinical strategy.

13.1 Performance Against Governance Targets

In general the Trust has demonstrated good compliance with standards of performance and an ability to respond quickly to deterioration in performance. Over the last 6 months the Trust has failed to achieve sustainable delivery of the 4 Hour Emergency Access standard. System wide discussions led by NHS England's Area Team for Norfolk, Suffolk and Cambridge are currently underway and the Trust has a recovery trajectory agreed Monitor.

Pressure on this target is a direct result of pressure on emergency bed capacity in the Trust. There remains a risk if this continues that this could compromise performance on 18 weeks and/or healthcare acquired infection ceilings. On that basis we have highlighted this risk in our governance statements accompanying this document.

14 Clinical Workforce Strategy

The Trust recognises that the provision of high quality and accessible care requires a highly committed and highly performing progressive workforce, effective and dynamic leadership and a commitment to modernising the service infrastructure. The organisation continues to seek to ensure we have the "right people, in the right place, with the right skills at the right time and at the right cost". Through the effective deployment, development and commitment of staff we seek to ensure a modern and progressive working environment enabled to deliver the quality and accessible service that our patients seek.

A number of initiatives, including the publication of a revised Clinical Services Strategy, the roll out of the newly established Trust 'Values and Behaviors' and the findings of the Denison Corporate Culture Survey will all inform the Trust Organisational Development Strategy and, thus, help to shape the Trust workforce requirements for the future.

The primary risk is one of retaining sufficient, suitably experienced, and qualified staff to deliver the significant change agenda whilst also achieving the CIP savings target. It is becoming increasingly challenging to attract, retain and motivate both clinical and non-clinical staff in the current climate requiring the achievement of 'more' for 'less'. However, alongside the requirement for efficiency and increased performance, the Trust remains cognisant of the need to ensure high quality patient care. As such all POD-related initiatives are regularly assessed as to the potential 'risk' to the quality of our services by the Medical Director and Director of Patient Experience, Lead for Nursing and Non Medical Professionals.

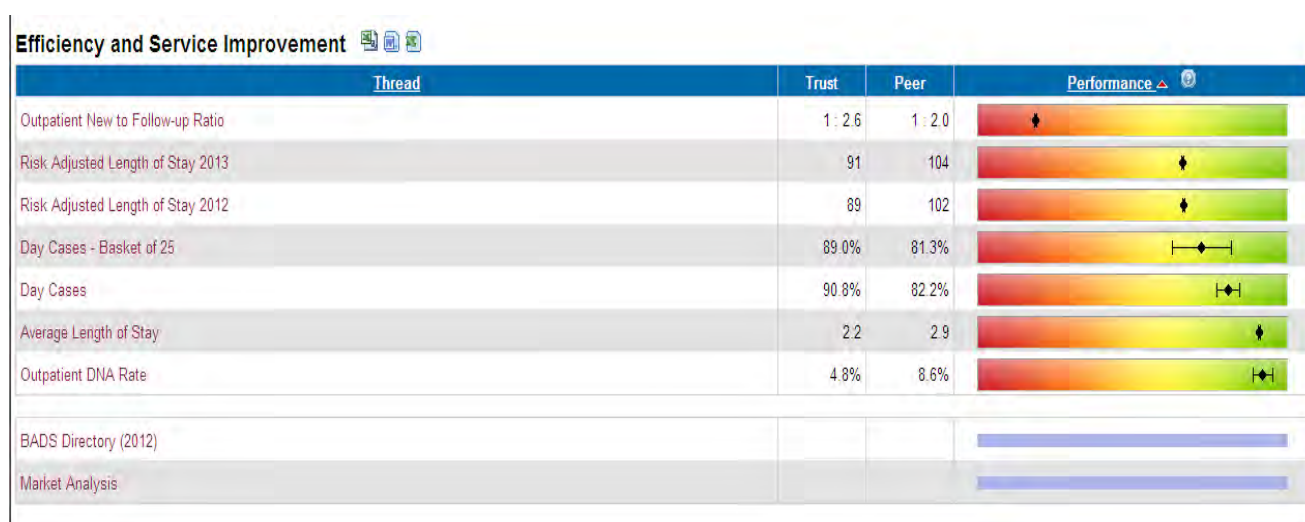
As in 2012/13, it remains likely that realising the Trust Business Sustainability Plan (BSP) in 2013/14 will test the Trust employee relations climate and culture to its full extent. This will be mitigated by the continued commitment to work in partnership with Staff Side representatives and the sound working relationships established between the senior HR team, Executive Directors and Staff Side representatives. This is evidenced by the extended recognition time afforded to the JSCC Chair in order to permit representation at the large number of consultation and organisational change discussions anticipated throughout the year.

It continues to be acknowledged that compulsory redundancy settlements are unlikely to yield the target 'in period' savings and that in applying MARS and voluntary redundancy, it is the most capable of 'key' staff that tend to express an interest under such circumstances. Therefore, Trust workforce plans look to optimise vacancies, redeploy staff to best effect and fully explore a range of options when re-aligning the workforce to make the required savings before considering redundancies. Details of the workforce priorities for the Trust are given later in this document.

15 Our Business Sustainability (BSP/CIP) and Transformation Programme

The Trust was described in the Dr Foster Good Hospitals Guide as an organisation which is very efficient. Whilst this is good news in terms of reassuring the Board of Director's and wider stakeholders of the Trust's ability to deliver hospital services cost effectively it means that in terms of on-going efficiency improvements a more whole system approach needs to be adopted. The work of the Trust's Business Sustainability and Transformation Programme is the workstream which will lead this approach.

15.1 Productivity and Efficiency



The Trust routinely monitors operational productivity at Board, service group and individual specialty level. This informs discussions on potential opportunities, or re-affirms why the Trust or service might be at variance from benchmarked performance. For example, whilst the Trust's new to review ratio at

aggregate level in the table below is higher than the peer, the Trust understands the reasons for this and they in themselves relate to the Trust delivering care at the forefront of the modernisation curve for some areas. Gynaecology for examples has 7 agreed disease pathways agreed with commissioners which encourage the use of an outpatient attendance to undertake procedures which previously, or in other organisations, are done in a day surgery environment. This is complemented by the routine analysis of clinical productivity information and workforce analysis, currently derived from the DH Workforce Health Tool.

Such detailed knowledge of these issues is helpful in terms of understanding the productive opportunities the Trust still has. The Trust plans to commission some further external analysis of efficiency early in 2013-4 to ensure that no stone is left unturned and to demonstrate there is no 'low hanging fruit'.

15.2 Business Sustainability Programme Content and Governance Arrangements

In February 2012 a suite of high level benchmarking information was provided to the Trust by KPMG which looked at a series of performance measures, including:

- Length of stay
- Readmission rates
- Pre-operative bed days
- Day of surgery admission rates
- Day case rates
- Outpatient Did Not Attend (DNA) rates
- Outpatient first to follow up ratios

The Trust recognised at an early stage that a more transformational approach to its efficiency programme would be required, and engaged KPMG to provide additional support in the development of a 3 year efficiency programme in February 2012. From this work, and in collaboration with KPMG, a Business Sustainability Plan was compiled which focussed on strategic change and potential opportunities. To reflect the ambition of the Trust in terms of scale of the overall programme, it was agreed that this would be a longer term programme with short term in-year benefits but also longer term more challenging opportunities.

A Programme Management Office (PMO) approach was adopted in 2012 and current responsibility for its operation lies with the Director of Planning and Performance.

The PMO team works closely with the Finance Department to forecast and risk assesses the delivery of the Trusts Business Sustainability Programme (BSP) and offers practical support and advice where appropriate to the wider clinical teams delivering the changes.

There is an escalation process for schemes where there are concerns over deliverability which remains in place until such time as assurance is gained that performance is back to plan or that grip on delivery is regained. This is done through regular or extraordinary meetings with the Director of Planning and Performance to ensure that project leads have the support necessary to meet key milestones and deliverables resulting in full benefits realisation.

A comprehensive suite of documentation for each scheme has been created as a Project Overview Document (POD). This is kept up to date by project leads, and is reviewed on a weekly basis. It includes the following information:

- An overview of the scheme; what it aims to achieve and how, including what is in scope and anything that is specifically excluded from the scope of the project. This will include the names of the project group including Project Lead, Finance Business Partner, HR Business Partner, Clinical Lead and Executive Director responsible.
- Tasks, milestones and deliverables, with dates and those responsible attached to each.

- Profiled financial plans split by pay, non-pay and income, recurrent/non recurrent, and also including any wte impact of the scheme identified by staff group.
- KPIs phased across the year.
- A risk log using the Trusts risk scoring matrix for RAG rating all risks.
- A Clinical & Quality Impact assessment identifying the likely impact on quality, patient safety, patient experience, clinical effectiveness and outcomes.

For 2013/14, the BSP has been condensed into 10 programmes – each with its own Programme Board. These are:

15.2.1 CIP

Each division has a cost improvement savings target of 1.5% for 2013/14.

15.2.2 Clinical Staffing Review

As well as capturing some elements of consultant job planning, this programme will review work undertaken by clinical specialists. The long term aim is the provision of 75% of all work time as face to face contact with patients. The possibility of increasing revenue activity to meet target savings will also be explored. The Trust is actively reviewing external support options where further HRG level benchmarking with specialty peers will be triangulated with areas of weaker EBITDA contribution identified through our Service Line Reporting data e.g. Orthopaedics

15.2.3 Income

This programme encompasses all income opportunities, including reviewing Best Practice Tariffs and ensuring that the Trust is maximising the income it could achieve.

15.2.4 Inpatient Flow & Efficiency (i-Flow)

I-Flow is looking to redesign and reconfigure emergency pathways in all Service Lines. The aim is to reduce length of stay through improved care delivery and improve patient experience e.g. not having outliers. Key projects within this programme are the Treatment and Investigation Unit (TIU), Emergency Ambulatory Care, 23 hour ward and discharge.

15.2.5 Non-Clinical Staffing Review

The administration and clerical support function is an important and essential part of the Trust. This programme is to evaluate that function and ensure that it provides the maximum support possible for the resources that are available. It includes a review of structures and roles to ensure we have the correct structure in place to deliver our clinical services in the future.

15.2.6 Outpatient Transformation

The aim is to provide streamlined, efficient and effective pathways throughout the Outpatient department. This will be achieved by matching capacity with demand and improving internal processes, as well as reviewing and standardising clinics where possible, improving our offering on Choose & Book, implementing partial booking and reviewing the outpatient nursing skill mix. Marketing of our services is also a key component to increase market share.

15.2.7 Pharmacy

This programme has taken into account the outcomes of an external benchmarking report on the service and is shaped around implementing the changes recommended over a phased period and include issues which are related to cost savings and procurement of drugs.

15.2.8 Procurement

The Trust has successfully achieved financial benefit in terms of pricing reductions of items procured. This will obviously continue but the programme itself has been widened out to relook at the Trust's procurement strategy and where there are opportunities to join local consortia and other local providers on various opportunities (outside of the usual procurement hub benefits).

15.2.9 Service Development & Outreach

There are 4 key components to this programme:

- Performance management of existing new service development schemes including maximising further opportunity
- Maintaining the pace on the delivery of proposed service developments and ensuring the final approval to proceed is achieved in the most effective way.
- Assist and support other projects that have challenges and blockages and who may need specialist support from corporate specialists to progress an opportunity/benefit; and
- Maintain an overview of potential market opportunity or risk to the Trust's income basis and put in place mitigating actions.

15.2.10 Theatre Efficiency

The aim of this programme is to maximise use of theatres and increase productivity, as well as creating cost savings. To do this they will try to increase patient flow through the department and to work in a smarter way

New monthly meetings have been timetabled in 2013/14 with the Director of Patient Experience, Nursing and Non Medical Professionals and Medical Director to review quality indicators at Programme and Project level in detail and ensure that issues can be escalated in a timely way and that any risks identified are being managed in line with Trust policy.

Weekly BSPG meetings will continue to be chaired by the Director of Planning and Performance. However, the format will change slightly to provide more focus on key issues as they arise. Monthly reporting will be structured over a 4 week period to enable 2 weeks to focus on operational reviews, one week on delivery and dependencies and one week on governance in terms of quality, risk and patient safety.

The 2013/14 Plan has been signed off from a clinical and quality impact perspective by the Medical Director and the Director of Patient Experience, Nursing and Non-Medical Professionals. In line with new national recommendation the Trust has also shared its programme with West Norfolk CCG.

The graphic below demonstrates, at programme level, the way in which the Trust can, at a glance, establish where and what is happening in terms of delivery for each of the 10 Programmes. These dashboards are used at Trust level BSPG meetings but the more granular information of the full project plan is discussed at the individual Programme Boards. Each Programme Board is chaired by a Clinical Director, supported by a senior operational manager and has Executive Board representation as appropriate.

Service Development & Outreach

Project Description	Project Lead	Milestones	KPIs	Risk Log	Clinical/Quality
PTNS Income Recovery	Sarah Jones	G	G	G	G
Spalding Outreach	Louise Proctor	G	R	G	G
Continuing Care	Louise Proctor	R	R	A	G
Other Service Developments	Sarah Jones	G	R	G	G

Key/Red Rated Issues

Milestones

Immediate plan identified for most projects, more work to be done for Continuing Care.

Risk Log

Risk Log complete.

Clinical & Quality Impact Assessment

Clinical & Quality Impact Assessment complete.

KPIs

KPIs identified, baseline and target data to be agreed as and when outreach specialties agreed.

Cumulative progress against plan		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
PTNS Income Recovery	Plan	1.3	2.5	3.8	5.0	6.3	7.5	8.8	10.1	11.3	12.6	13.8	15.1
	Actual & F'cst	0.0	1.3	2.5	3.8	5.0	6.3	7.5	8.8	10.1	11.3	12.6	13.8
Spalding Outreach	Plan	0.0	0.0	0.0	11.0	22.0	33.0	44.0	55.0	66.0	77.0	88.0	99.0
	Actual & F'cst	0.0	0.0	0.0	11.0	22.0	33.0	44.0	55.0	66.0	77.0	88.0	99.0
Continuing Care	Plan	0.0	0.0	0.0	0.0	0.0	10.0	50.0	90.0	130.0	170.0	210.0	250.0
	Actual & F'cst	0.0	0.0	0.0	0.0	0.0	10.0	50.0	90.0	130.0	170.0	210.0	250.0
Other Service Developments	Plan	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Actual & F'cst	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	Plan	1.3	2.5	3.8	16.0	28.3	50.5	102.8	155.1	207.3	259.6	311.8	364.1
	Actual & F'cst	0.0	1.3	2.5	14.8	27.0	49.3	101.5	153.8	206.1	258.3	310.6	362.8

Comments

Programme board meeting 9.5.13 to agree priorities.

Development areas include:

PTNS expansion

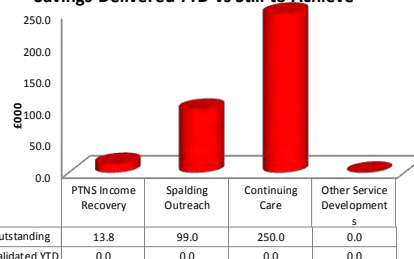
Spalding outreach (potential developments include Ophthalmology, General Surgery, Rheumatology, Orthopaedics)

Littleport extension of services

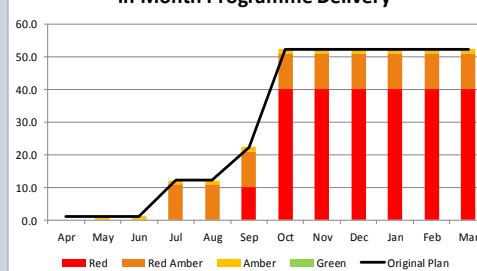
Fakenham review

Optometrist partnership working opportunity

Savings Delivered YTD vs Still to Achieve



In Month Programme Delivery



15.3 Transformation Programme

During 2012/13 the Trust identified key service transformation programmes that will support the modernisation of existing services to achieve high quality, sustainable and commercially viable services. 13/14 is the year for completing the existing transformation programmes and driving implementation.

The Transformation Team is being enhanced to better support the key priorities of the Trust, with a mix of internal and external Lean and Service Improvement methodologies and project management skills.

In addition, the Trust is planning to commence a new three year review cycle of improvement for all departments, with the aim of embedding a culture of continuous improvement. Supported by the Transformation Team, each department in turn will be supported to consciously review its performance against peer organisations, Royal College recommendations, patient and staff feedback and experiences, as well as its EBITDA contribution. Using a lean methodology, each department will review and redesign their service to ensure it is best placed to thrive in a high quality, high choice environment. Current departments being supported include Respiratory and Ophthalmology.

The Board of Directors also commissioned work from the NHS Leadership Academy with support from KPMG in 2012/13 to develop the Board's skill in assessing investment decisions against a Trust Commercial Framework. The framework has been produced on the premise of a 'Gateway' model of decision making where at each stage of an investment or potential investment decision those presented with the decision to take have the relevant information and knowledge to do so. The wider cultural transformation journey of the Trust is supported through the refresh of the Organisational Development Strategy and implementation plan for 2013/14.

16 Financial and Investment Strategy

This is included at Appendix 1 of this Report.

