



Our Vision

To provide every patient
with the care we want
for those we love the most

Norfolk and Norwich University Hospitals 
NHS Foundation Trust

Strategic Plan Document for 2013/14

Norfolk and Norwich University Hospitals NHS Foundation Trust

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

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Strategic Context and Direction

A. The Trust's vision is summarised as:

At the highest level our vision is ' **to provide every patient with the care we want for those we love the most**'. The clear articulation of this very simple vision over the last three years has enabled us to connect with our own staff and patients, members, support groups and the voluntary sector and ensure that we have a clear consistency of purpose.

The vision is underpinned by the need to develop our quality metrics and report openly and honestly about the things we do well as well as those we don't. Our clinical teams understand that the delivery of the vision is underpinned by financial stability and this in turn will enable us to recruit train and retain excellent staff to deliver high quality care.

The aspirational vision statement is underpinned by three strategic aims under which our strategic activities are grouped. These are:

1. To provide first class quality services and excellent patient experience

We will continue to set ourselves stretching and aspirational targets to improve performance. Our focus will be on reducing infection, reducing mortality and improving the experience of our patients.

Improving quality

A number of key performance metrics have been developed internally to measure our progress in this area. All the work we have done is underpinned by the fundamental principle that we will be open and transparent with our staff, patients and public about the things that go badly as well as those that go well. We publish our full quality and safety board report on the Internet every month and circulate it to every individual member of staff and all our governors. All are invited to raise comments and questions.

We have continued to develop our unique ' improving patient safety ' development program in which multidisciplinary teams learn and receive coaching and development about improvement methodology, whilst working on projects to improve the safety and quality of patient care. We have developed and run this program largely in house and, now in our fourth year; we have trained over 300 clinicians and support staff in statistical process control and project methodology. The projects are selected by the clinical teams who go through an application process culminating in approval by the Executive Board to ensure that they are focused and consistent with the overall strategy.

Following our success in significantly reducing the incidence of Clostridium Difficile in our hospital we have radically changed our approach to the management of the risk of MRSA bacteraemia. This has involved the engagement of our medical and nursing staff in the importance of the reduction of the current level of bacteraemia, the complete overhaul of our policies and procedures in relation to screening and isolation and the taking of blood cultures, standardisation of our antiseptic non-touch technique and the development of an electronic whiteboard which supports us in the identification and management of every colonised patient in our hospital. This approach proved successful in 2012/13 with 1 MRSA bacteraemia.

We have agreed an objective to eliminate avoidable grade 2, 3 and 4 pressure sores. This is a very ambitious target and will be driven by increasing awareness and education amongst staff, carers and vulnerable patients. We will ensure that risk assessments are completed promptly and accurately. Individual patient care plans will be developed in line with these risk assessments and adapted as the overriding medical condition of the patient changes.

We will continue to look for opportunities to integrate services with other providers and agencies, and thus improve the quality and continuity of patient care, whether this is by collaborative working, acquisition or joint venture arrangements.

We are exploring a number of opportunities for networking acute services with other DGH providers to secure the provision and development of tertiary services. This builds on the work we have done over the last two years with the James Paget University Hospitals, Queen Elizabeth Hospital Kings Lynn and Ipswich Hospital.

Improving experience

Following involvement of patients and engagement with the private sector (including advice from the John Lewis partnership and SERCo), we have developed a detailed patient experience survey methodology based on the net promoter index. The results are now being used both at ward and outpatient level and corporately to drive changes aimed at improving patient experience.

Our CQC inspection methodology has continued throughout the year and is now embedded as standard practice. We have invited governors, members, members of local voluntary, third sector and patient representative groups and CCG members to accompany our internal audit teams (composed of senior clinical staff) to audit compliance against CQC outcomes. We now have over 50 independent people regularly auditing the quality of care delivery with us and reporting on the standards achieved against the CQC outcomes. The process brings complete independence and the subjective view of patients and carers or potential patients and carers to our audit process and has led to a number of changes being made to services as a result. We have held 6 monthly briefing sessions with our independent auditors to continue to ensure that they are engaged in our quality priorities and are exchanging views and ideas on potential improvements. We will continue to develop the audit process moving it to additional areas and inviting additional external bodies to participate in these audits.

2. To establish a national reputation for excellent education, teaching and research.

Education and teaching

We work closely with our main higher education partner the University of East Anglia and in particular the school of health which encompasses training and education across all main professional groups. Our unusual geography provides an excellent opportunity to ensure that the training received at undergraduate level is tailored to local need as we retain a significant proportion of graduates post qualification. We have recognised the opportunity presented by the reforms to true funding and commissioning of training and education and are instrumental in the development of the East of England Local Education and Training Board (LETB) and the local education and training strategic partnership group. Our Chief Executive is currently the Chair of the East of England LETB and shares the role of provider Chief Executive representative on the Board with the Chief executive of the Norfolk and Suffolk NHS Foundation Trust. There are significant opportunities to change the type of workforce being trained for the future and ensure it is clinically and financially fit for purpose. The development of a national tariff for undergraduate training will also be a significant advantage for us as we are currently a very low outlier in terms of SIFT funding per capita for undergraduate medical students. Influence through the LETB on the transition period to the new tariff will be strategically very important in rectifying the very significant historical imbalance within the East of England.

We have developed a number of internal development programs for our own clinical and non-clinical staff and will build on the development programs, mentoring and coaching schemes we have established. The organisation's future success is dependent on the strength of its leaders, who will need to innovate and motivate our staff through a period of change. We have recognized this need

through the development of a leadership program which will identify and develop the individuals who will lead the hospital in the future. This programme will be expanded to include a clinical leadership programme during the course of 2013.

Research

We have devoted significant energy and effort in the development of our research program over the last two years and will continue to drive this development over the next three years and beyond. Two years ago we set out through our clinical academic investment strategy to recruit a small number of world class researchers with established reputations in key fields in which there exists already strong and complementary basic science research in Norwich (within other research park institutes or at the UEA). This strategy has been successful and we have been able to recruit excellent researchers across the areas of microbiology, bone metabolic disease, sarcopaenia and cachexia and gastroenterology. In the last year we have also recruited an experienced Director of R and D jointly with UEA who is supporting the execution of the overall R and D strategy.

Working with other partners on the Norwich Research Park we have secured the interest and involvement of local landowners adjacent to the hospital in the development of the research park. The UEA has committed to the development of a new clinical research building adjacent to the hospital and the move of the whole of the medical school teaching space to a site adjacent to the hospital within the next 10 years. The juxtaposition of facilities and expertise on the Norwich Research Park gives Norfolk a unique global advantage and we have begun to exploit this in discussion with major international commercial and philanthropic research funders.

We have been instrumental in setting up a joint governance structure for the 6 institutes on the Norwich Research Park and are working with partners to ensure that the potential for translational research across the park is realised over the next 5 to 10 years.

3. To enable staff to realise their potential

Our involvement in the LETB will support this objective as will the series of tailor made internal development courses, mentoring and coaching arrangements we have developed.

We have significantly expanded our staff health and well-being activities to include a series of sporting and cultural activities throughout the year. These have been well received by staff and our local community and have supported staff engagement and team building.

It is essential to ensure that the above activities continue to be underpinned by financial stability. Whilst we have an excellent financial track record we recognise that maintaining financial stability without compromising clinical quality will be increasingly challenging. Our QIPP schemes for 2013/14 have been developed with significant clinical involvement. Progress on each of the schemes is tracked through a formal project structure and the project teams present to the Executive Board. We are strengthening our cadre of Associate Medical Directors recognising the benefit of increasing clinical involvement in leadership and the added degree of assurance we will achieve through close senior clinical involvement in the definition and leadership of these projects.

We are one of the busiest hospitals in the country in terms of numbers of patients treated with a particularly high proportion of overall bed days occupied by emergency admissions. This is against the backcloth of a low standardised admission ratio when compared to the demographically adjusted population. The ageing population in Norfolk is reflected in the size of the geriatric admission numbers; we are the busiest single-site geriatric service in terms of patient numbers in the country.

The NNUH is located on the southern boundary of Norwich with the nearest acute hospitals being the James Paget Hospital (JPH) 45 minutes east in Great Yarmouth and the Queen Elizabeth Hospital (QEH) 1 hour west in Kings Lynn. Both of the aforementioned hospitals are district general hospitals with little provision of more specialist care. Strategically our relationship with the JPH is very strong with a number of existing networked clinical services. The relationship has been strengthened recently with board-to-board meetings which agreed to align services where this is beneficial to patients, and to consider other back office services which may be provided jointly. A number of clinical services are under discussion with a view to forming a network provided by the NNUH, including Dermatology, Rheumatology and Radiology. Shared management of clinical support services are also in progress eg Pharmacy. This will have a major advantage for both Trusts in sharing the formulary where NNUH clinicians operate across both sites.

The QEH looks to both Addenbrookes and NNUH for tertiary services, and is expected to continue to do so, given its geography. Further south is Ipswich Hospital with which we have developed some networked clinical services and are looking at further opportunities to work closely with Ipswich.

Our joint bid (alongside the JPH and QEH) to provide pathology services to primary care in Norfolk and North Suffolk was accepted by the Strategic Health Authority and Commissioners in 2012/13. This service will go-live in 2014.

As part of the local health system we work alongside the newly formed Clinical Commissioning Groups, Community Trust, Social Services, Ambulance Service and Mental Health Trust to ensure capacity is in place to meet the rising demand for emergency care. The collaborative working has proved successful in meeting recent demand. These working relationships will continue through 2013.

As yet competition in Norfolk has been limited due to the relative geographical isolation and the absence of major population centres which make significant capital investment unattractive to new market entrants. The Commissioners have tendered for the termination of pregnancy service and awarded the service to Marie Stopes. Whilst the NNUH made a bid for the service, this was not considered to be a service that we would invest in or develop beyond the existing level. As such this was not considered a strategic opportunity. Other Any Qualified Provider contracts that have been tendered are Audiology and MRI direct access services, both of which were awarded to the NNUH.

We have a very significant strategic relationship with SERCo and will continue to work in partnership with them to improve services for our patients. Where this presents wider opportunities for both parties then we will consider the appropriate vehicle to take this forward.

The new Cromer and District Hospital has now been open since April 2012. This has been a popular place of care for the local population and for GPs. Significant funds have been invested in the development of GP surgeries around Norfolk and potentially this represents a threat in that there are premises that could be used by new market entrants. Our approach to this threat has been to work with GPs to take space in these facilities where there is sufficient local patient demand and where the facilities are designed in such a way as to enable the provision of services.

The newly formed Clinical Commissioning Groups have shown a willingness to understand the pressures and challenges faced by the providers within Norfolk, and have engaged with the health system in delivering change and improvement to emergency care. Strong relationships have been formed with the lead CCG and regular contact and communications are established at both operational and strategic levels.

The other key areas for commissioners include reviewing end of life and palliative care provision, and the reconfiguration and redesign of stroke services. We feel we are in a strong position to contribute

to the strategies for the delivery of these services in the future, given our position as a tertiary provider within Norfolk.

Approach Taken to Quality

We are committed to providing the highest quality clinical care to our patients, by placing clinical outcomes and safety at the top of our clinical agenda. Through gathering real-time feedback, reviewing complaints and surveys, and analysing past incidents, we have gained an understanding of our patients' priorities, and our commitment is to address the aspects of care that are most important to them. These include providing a clean, safe and comfortable environment, treating our patients as individuals, involving them in decisions about their care, delivering optimal clinical outcomes and providing timely and seamless care that leads to their safe discharge from our services.

Our strategic quality priorities fall under the three domains of patient safety, clinical effectiveness and patient experience. Underpinning the strategy are a number of specific priorities and work streams:

- Reducing medication errors;
- 100% appropriate response to elevated Early Warning Score (EWS);
- Reducing pressure ulcers;
- Improving our score in relation to the Friends and Family Net Promoter Test question;
- Improving ambulance hand overs;
- Improving discharge processes;
- Primary Percutaneous Coronary Intervention (PPCI) within a set time;
- Reducing cardiac arrests outside critical and coronary care areas;
- Improving infection prevention, focussing on C Diff and surgical site sepsis.

Executive, implementation and delivery leads have been appointed for each of these work streams, and detailed action plans have been established in order to ensure that we achieve the desired outcomes. Performance against the action plans will continue to be systematically and routinely monitored at Trust, division and clinical level and reported to the Trust Board through the mechanism of the Clinical Governance Committee. The overall plan for achieving these key corporate quality priorities is set out in our 2012/13 Quality Report.

Alongside these corporate quality targets, Divisional quality goals are developed, which are aligned to those set for the Trust as a whole. The Divisional quality goals are publicised in the Divisional Operating Plans, which include specific, measurable quality targets. Progress against the Divisional Operating plans and Performance Dashboards is monitored on a monthly basis by the Divisional Boards and by the Director of Resources.

Existing quality concerns and plans to address them

We are required to register with the Care Quality Commission (CQC) and our current registration status is unconditional. The CQC has not taken enforcement action against us during 2012/13, and we have not been required to participate in any special reviews or investigations by the CQC during the reporting period. The latest published CQC report (dated 4th April 2013) shows that our compliance ratings in respect of the 16 Essential Standards range from high green to high yellow. We continue to have no overall amber or red compliance ratings.

We have established a robust internal auditing programme in relation to CQC standards. The audits are undertaken by matrons and representatives from a wide range of external organisations including

the Norwich Older Peoples Strategic Partnership Forum, Norwich MIND, Age UK, LINKs and Trust Governors and the outcomes are reported directly to the Trust Board.

How the Board derives assurance on the quality of its services and safeguards patient safety

The Trust Board monitors the achievement of its objectives, and the management of associated risks, through the annual cycle of Board reporting. This includes:

- Monthly clinical quality and safety reports;
- The Board Assurance Framework;
- The quarterly presentation of the corporate risk register, which highlights major risks;
- Performance reports, supporting quarterly self-certifications for Monitor.

Risks to quality which do not meet the criteria for escalation to the corporate risk register are managed at Divisional level and are monitored by the Clinical Governance Committee.

The metrics contained within the Performance Dashboards, which are reported via the mechanism of the monthly Performance Report, are selected to promote the achievement of key strategic goals under the three quality domains of patient safety, patient experience and clinical effectiveness. The performance report also monitors performance against CQUIN targets and Monitor's compliance framework.

The Audit Committee ensures that, as an organisation, we maintain an effective system of governance, risk management and internal control across all of our activities. The Committee also provides assurance that effective arrangements are in place for the purpose of monitoring and continually improving the quality of our care.

The Clinical Governance Committee - chaired by the Medical Director - ensures that robust and appropriate governance structures, processes and controls are in place, in all areas, to promote safety and excellence in patient care. The Committee is also responsible for identifying, prioritising and managing risk, ensuring the effective and efficient use of resources through evidence-based practice, and protecting the health and safety of employees and all others to whom we owe a duty of care.

We gain external assurance on our governance arrangements and our quality standards from Internal Audit, the Care Quality Commission (CQC), Monitor and the NHS Litigation Authority (NHS LA). We are also very proud of our comprehensive and far-reaching internal Quality Assurance Audit programme, which we believe is the only one of its type in the country. The programme ensures that between 1 and 3 inpatient or out-patient areas are audited every weekday; most areas are audited approximately every 4-6 weeks.

The audit teams consist of senior nursing staff and volunteer external auditors, who represent a host of organisations, including Norfolk Social Services; Families House; St John's Ambulance; NHS Norfolk; Gender Identity Services; GPs; Learning Difficulties Partnership; UEA; NHS Retirement Fellowship; MND society; The Norwich Older People's Strategic Partnership Forum; Norwich MIND; The Older People's Partnership; LINKs; Age UK; Deaf UK; Crossroads Care; The Alzheimer's Society and Trust Governors. The audit outcomes are reported directly to the Trust Board, and feedback is provided to the wards. Action plans to address any shortcomings are established and monitored by the Director of Nursing and her team.

As part of our formal Internal Audit programme, we participated in 40 national clinical audits and 6 national confidential enquires during 2012/13. We reviewed the reports of 25 national clinical audits

and 53 local clinical audits, and identified and implemented several key quality improvement recommendations. Compliance with the recommendations will be monitored closely by the Audit Committee.

Data assurance for clinical quality data is provided by a programme of internal audit and documentation of processes, which is reported to our monthly Process Assurance Governance Group, chaired by the Director of Resources and, in turn, to our Audit Committee.

How the Trust mitigates risks to quality

The Trust Board receives a monthly Clinical Quality and Safety report, prepared by the Medical Director and the Director of Nursing, which contains detailed information on mortality and patient safety statistics and patient experience. Mortality statistics include analysis of HSMR, SHMI and crude mortality as well as information on outcomes for low-risk groups and patients undergoing surgery. New alerts identified by Dr Foster Intelligence and data from national audits are reported. Additional information relating to quality and safety priorities and CQUINs are also reviewed.

In addition the Board receives a monthly report from the Trust Clinical Governance Committee, which in turn reviews mortality statistics and patient safety information.

Risks to quality and improvement opportunities are identified through complaints, incident reports, patient experience feedback, internal performance monitoring and external benchmarking. The data are analysed to identify underlying trends, and any resultant recommendations are incorporated into quality improvement action plans. Delivery of the action plans is then closely monitored to ensure that the desired outcomes are achieved.

Risks to quality are entered onto the Trust Clinical Risk Register by individual Directorates, working with our Risk Management Department. Items with a residual risk rating (after mitigation) of 10 or above are reported to the Clinical Governance Committee, and the major risks are reported to the Trust Board on a monthly basis.

The Trust Board undertakes a self-assessment using the Quality Governance Framework on a quarterly basis to ensure that quality and risk arrangements are robust.

Clinical Strategy

We are committed to providing the highest quality clinical care to our patients by placing clinical outcomes and safety at the top of our clinical agenda. We believe that our patients should expect the best possible expert care in a safe, clean and comfortable environment. All our patients should expect the attention and respect we all wish for. Our clinical vision is that within the next three years the Trust will become the safest hospital in the UK exemplified by there being no preventable patient deaths and no preventable harm to patients.

Our priorities for our clinical strategy are as follows:

1. To improve the quality of care to our patients
2. To ensure the safety of our patients
3. To improve the patient experience

These 3 strategic priorities have been established in line with our vision to provide every patient with the care we want for those we love the most. The specific quality indicators (see page 7) have been established in line with our commitment to place clinical quality at the top of our agenda.

As well as the quality indicators we wish to improve those areas where most adverse events are known to occur, namely:

- medication errors
- failure to intervene
- falls
- pressure sores
- hospital acquired infections

In addition we will continue to monitor and target a progressive reduction in HSMT/SHMI and clinical outcomes specific to each specialty. Each consultant will be expected to take part in an improvement project (required for revalidation) related to one of the areas above.

In 2013/14 our work on patient level costing has developed with detailed plans for each specialty. The plans focus on consultant variation and have been led by the clinical director in each specialty. This work will be a main focus for our savings programme and will develop throughout the next three years.

Clinical Workforce Strategy

The Trust clinical workforce strategy will ensure that we:

- Develop enhanced management and leadership capabilities to ensure clinical staff are appropriately trained and developed
- Increase the flexibility of the organisation to adapt to change
- Develop and implement strategies and programmes of work that enable efficiency improvement and cost reduction

One of the major areas of focus for 2013/14 will be the consideration / development of new systems and ways of working to support extended days and six/seven day working. The Medical Director is taking the lead and, working alongside specialty leads, will begin to implement change at a local level, but as change spreads across the organisation, further consultation will be required to ensure that existing and new staff are engaged in this potential development and a possible future working model. The driver for this is improving the quality of care to our patients as well as meeting capacity challenges and management of the increase in demand for unplanned care in particular.

Consideration is being given to potential barriers to changes in working model including contractual terms, which need to be addressed across the organisation. This work must be undertaken alongside further consideration of the potential to increase capacity within normal working hours through reviewing job plans and focusing on team based job planning with clear activity targets. As we look to do more activity within existing workforce resources, we must also ensure there is fairness across the organisation and greater transparency around arrangements for additional activity.

Work is being undertaken to ensure we have the right skills in the right place at the right time. Skill mix reviews are being led locally in a number of directorates to ensure that high quality, safe services are delivered in the most efficient and effective manner. Bank and agency staff usage is currently under review to maximise cost efficiency and achieve workforce flexibility, and work is also being undertaken to ensure growing flexibility within nursing to enable staff to move between acute and outreach / community settings more effectively.

This work will consider the use of benchmarking tools to facilitate change.

The plan does not assume any direct savings resulting from this strategy however productivity and service improvement QIPPs are in place which relate to this plan.

Productivity and Efficiency

An overview of potential productivity and efficiency gains built into plans, including financial impact of projected gains.

The savings programme, excluding additional clinical activity, amounts to £23.4m for 2013/14 and the key schemes are described in Appendix 2. The productivity benefits accruing from the schemes and reflected in the plans are mainly regarding activity, length of stay, theatre productivity and Bank and Agency spend. The assumed savings and how they will be delivered are outlined below.

Length of stay and Bed occupancy and Theatre Productivity

The plan assumes that length of stay and bed occupancy will shorten during the period of the plan. The plan assumes that additional activity of £4m will be delivered in 2013/14, of which £2m will be inpatient activity. In addition the plan assumes that a ward will close for three months to facilitate the planned refurbishment programme in conjunction with our PFI partner. In order to accommodate both the additional activity and the refurbishment programme the equivalent of between 15 and 20 beds will need to be created. The plans in place to deliver this capacity include the Theatre Productivity scheme, which will focus on utilisation of known periods of relative under-utilisation and the introduction of non-training lists, both of which will create capacity to deliver additional elective work. In addition, the Patient Level Costing scheme which has a focus on variation and efficiency, will ensure that as much work as possible is performed in an outpatient / day case setting, thus creating bed capacity.

Bank and Agency spend

The plan assumes that £3m will be saved as a result of improving controls over bank and agency spend. The underlying schemes to deliver this saving include recruitment to established vacant posts which will be more cost effective and also improve both safety and quality through displacing more expensive locum and agency rates of spend. In addition the controls over procuring bank / locum spend have been revised and require a higher level of authority and explanation, and finally the Trust is reviewing its procurement methods for this type of resource to ensure that best prices are secured.

CIP/Savings Programme Governance

The Trust has successfully delivered its identified savings requirement each year. The requirement for the past three years has been significant with amounts ranging from £30.1m to £35.2m for the last financial year. Whilst not each of the specific schemes has delivered the planned amount in the way envisaged, the Trust has been successful overall without recourse to non-recurrent methods. Savings have come from both additional income from activity which has been delivered at very low marginal rates as productivity has improved and a real tight focus and control over expenditure. This includes vacancy management and skill mix initiatives to manage pay costs – which is the biggest expenditure component of the Trust (or any acute hospital) cost base.

Transformation initiatives have been successful in the diagnostic areas in particular. Looking ahead and to ensure future delivery of savings requirements the Trust needs to do more of the same but also develop further the use of the patient level costing information it has to both identify and drive out variation in costs of delivery. This is a key area of the CIP plans for 2013/14, having been largely introduced in detail in 2012/13.

Leadership and Assurance arrangements

Monthly meetings are held with each team responsible for the delivery of the savings programme. The meetings are chaired by the Director of Resources and actions are agreed at each meeting. The teams are offered coaching and independent support to validate and challenge their thinking. This ensures that the progress is regularly tracked and the key milestones and quality assurances are regularly reviewed. The savings programme is managed as QIPP projects with quality measures being seen equally as important as the financial initiatives. The project teams have wide representation, including clinicians, nurses, finance and operational management. This facilitates healthy challenge. In addition each project presents its progress to the Executive Board throughout the year.

Savings Programme profile

The savings schemes are wide ranging with a main focus on productivity and service improvement. However they also embrace non-operational areas through the procurement CIP and review of procurement arrangements. The schemes build on those implemented during 2012/13 as such they are incremental and more controllable and thus less risky.

The 5 main schemes are set out in Appendix 2.

The delivery of the savings programme has been profiled consistent with the plans provided by each project team. The majority of which are designed to deliver from the beginning of the financial year, however others will contribute from Q2.

Risk ratings will be updated as the monthly assurance meetings progress. A contingency of £3.5m has been included in the annual plan each year to mitigate risk.

Savings Programme enablers

The key enabler required to drive the delivery of the savings schemes is operational engagement, in particular for the productivity related schemes, clinical engagement. There is little in the way of IT or third party type investment required to support the schemes.

Clinical representation is required for each scheme and engagement is harnessed through the monthly meetings, and in particular a programme of presentations on each scheme to the Executive Board.

Quality impact of the savings programme

Each scheme has been subject to a quality assessment via the multi-disciplinary team approach to the QIPP team structure and quality is also discussed and challenged at the monthly assurance meetings. The schemes have also been approved by the Medical and Nursing directors to provide a further level of assurance over quality and associated risks arising from service change.

Quality is measured on an on-going basis via the monthly progress meetings and the quality impact overall will dovetail with the Trust's quality strategy and associated performance management processes.

Financial and Investment Strategy

The Trust's financial strategy is designed to achieve sufficient surpluses each year to support the Trust's capital programme which will improve the built environment and embrace technology and innovation to improve patient care and experience. It is important for the Trust to maintain its position of strength relative to the sector and also its reference cost index which is reflective of better than average efficiency.

The Trust's financial targets for the next three years are driven in the main by anticipated national efficiency requirements for acute services, commissioner QIPP requirements and unavoidable cost increases. Against that backdrop the Trust's income and expenditure plan which underpins the strategy is based on contracts in place with its main Clinical Commissioning Groups (CCGs) and the expenditure plans of clinical and non-clinical directorates.

The overall financial objectives for the three year period are:

- (i) To achieve a sustainable surplus, which allows for future healthcare investment and supports the delivery of high quality patient care
- (ii) To achieve the requirement of the foundation trust financial region
- (iii) To deliver the savings target required to meet the above
- (iv) To ensure the quality of care is maintained whilst operating within the financial sum available to us.

The Trust is planning to deliver a surplus of £4.6m - £4.7m per annum over the three year period covered by the plan, excluding any donations received during this period.

Current financial position

The Trust has met its financial targets and been in full compliance with the financial terms of authorisation since its inception as a Foundation Trust in 2008. The Trust achieved a surplus of £6,257k in 2012/13, which after adjusting for the inclusion of donated assets is a surplus of £4,441k which represents an over achievement on plan of 6%.

The Trust's balance sheet is strong; it shows net assets of £108.6m, represented by net non-current assets of £91.3m and net current assets of £17.3m. The working capital balances are highly liquid and include £70.1m of cash.

The Trust has a working capital facility of £19.5m which has not been required to be used and there is no plan to draw on it.

Overall, the Trust is in a strong financial position.

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

The key financial investments are designed to enable the Trust to better meet demand and access targets in order to provide high quality care to patients with improved cost effectiveness.

The priority investments for 2013/14 and through to 2015/16 include:

1. £5m - for improving the quality of emergency care – particularly within A&E and the assessment areas.
2. £4m – for transforming the medical school ‘ward’ into a hospital ward and providing capacity for increases in demand / assurance over elective programme and to maximise opportunities for repatriation of Orthopaedic work from other providers.

The capital programme assumes completion of existing projects, investment in equipment and also capacity and IT development. The final prioritisation of major investments is subject to review by the board in the first half of 2013/14.

Operationally the Trust is reviewing nursing ratios and skill mix mainly through benchmarking with colleague Trusts, with a view to ensuring that the right staffing establishment is in place to ensure that the right people are doing the right thing at the right time. This should be mostly self-financing.

The Trust is also working to ensure that the benefits from the newly established pathology ‘hub and spoke’ service are realised – these are real transformational benefits. The Trust has become the hub for the pathology work for itself and two neighbouring acute hospitals – the spokes. This is a major change in working and has required £6m of investment, half of which is from the Trust.

Each specialty has held clinical service strategy meetings with the Trust executives where people, process and technology was addressed with a view to understanding better how demand and treatment will change in the short to medium term and how the Trust should shape its capacity and resources in line with expectation. These strategy meetings are on-going and the plan reflects any likely changes of significance over the three year period to 2015/16.

Key risks to achieving the financial strategy and mitigations.

The delivery of the planned savings target of £28m is the most significant risk to achieving the financial strategy. This equates to 6% of 2012/13 outturn expenditure.

Other risks include:

1. Delivery of national performance targets, in particular re 18 weeks and A&E and Ambulance handover times.
2. Achievement of productivity and clinical service improvements
3. Commissioners are successful in reducing demand for services, in particular elective demand.
4. Inflation is higher than planned
5. Non achievement of CQUIN target resulting in loss of income

Mitigations include:

1. Close operational control over expenditure
2. Cash management, establishing good relationships with CCG senior finance officers
3. Monthly operating and financial reviews to ensure accountability for performance is maintained and doesn't drift

The Trust has a history of delivering financial plans and surpluses and has well embedded financial systems which highlight variances and allow prompt corrective action to be taken should the above risks arise.