



Strategic Plan Document for 2013-14
The Dudley Group 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 | 23 rd May 2013 |

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:

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| Name (Chair) | Mr John Edwards |
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Signature



Approved on behalf of the Board of Directors by:

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| Name (Chief Executive) | Ms Paula Clark |
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Signature



Approved on behalf of the Board of Directors by:

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| Name (Finance Director) | Mr Paul Assinder |
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Signature



Strategic Plan Contents

Forward Plan

- A. Strategic context and direction**
 - i. Introduction**
 - ii. Vision & Values**
 - iii. Our Strategic Goals**
 - iv. National & local Commissioning Environment**
 - v. The Local Provider Landscape & Competitive Environment**
- B. Quality Of Services**
 - i. Quality Strategy**
 - ii. Clinical Strategy**
 - iii. Other Quality & Safety Issues**
- C. Productivity and Efficiency - Cost Improvement Programme (CIP)**
 - i. CIP Governance**
 - ii. Profile of CIP schemes**
 - iii. CIP Enablers**
 - iv. Managing the Quality Impact of CIPs**
- D. Financial & Investment Strategy**

A. Strategic context and direction

i. Introduction:

The NHS is facing the most challenging era in its existence. Dudley Group, with its flexible and committed workforce, embedded commitment to transformational change, sound finances and ambitious investment plans is well placed to address such challenges and cement its position amongst the best performing foundation trusts in the Country. The Trust recognises that the scale of the financial squeeze now faced by the NHS, coupled with the challenge to further improve patients' safety and quality, has rendered traditional approaches to cost reduction outdated. The Trust is now committed to driving improved productivity through transformational changes to clinical practice and is now embarking upon an ambitious programme of whole systems change with NHS Dudley.

In last year's Annual Plan, we described how we had renewed our vision, values and strategic goals in response to the changing demands of the health and social care landscape, following the Royal Assent of the Health & Social Care Act and the significant challenge of financial austerity and major commissioner reconfiguration.

This Plan will demonstrate how we are now actively employing these vision, values and strategic goals, to underpin the development of ambitious commercial plans and transformational change with our main commissioner. These strategic goals, together with the objectives set out in our recently agreed *Clinical Strategy* also provide a framework within which during 2013-14, we will refresh our 5 Years *Integrated Business Plan*. The final version of that renewed IBP will reflect a realistic yet ambitious and comprehensive plan of action for the next 5 years, a period which promises to be the most challenging ever for the NHS. Supporting strategies, such as IT, Estates, Finance, Quality and Workforce will form key components of that Plan.

In the interim, this Annual Plan represents an important milestone on this journey and sets out the Trust's commitment to maintain our excellent record of business achievement, through a period of prolonged financial austerity and to further strengthen the quality of services we provide to the citizens of Dudley and our surrounding populations.

The development of this Annual Plan, together with the process for the refreshing of our IBP, has been shared extensively with our Council of Governors. Specific elements of our Plan, particularly that relating to the care of the older person, have been developed with the Council's Strategy Sub-committee.

ii. Vision and values

In last year's Annual Plan, we described the extensive process of internal and external stakeholder engagement used to drive a new organisational vision for our staff, together with a refreshed set of values for our staff to live by. Our agreed strategic goals, our Clinical Strategy, our planning work for 2013/14 described in this document and our planned refresh of our IBP, are all aimed at delivering that organisational vision:

"To be a highly regarded healthcare provider for the Black Country and the West Midlands, offering a range of closely integrated acute and community based services driven by the philosophy that people matter"

Our values also have been agreed with our staff to underpin that philosophy – '*that people matter*':

- **Care**
- **Respect**
- **Responsibility**

iii. Our strategic goals

Having agreed our vision and values during 2011/12, the Board of Directors engaged the Organisation in the development of a set of key strategic goals, to guide the development of our individual clinical directorate plans and the overall Trust Annual Plan. In addition, those strategic goals, together with the objectives in our *Clinical Strategy* will provide the framework for the development of a 5 year strategy for our clinical services as part of the planned refresh of the IBP in 2013/14. Our strategic goals, highlighted in last year's Annual Plan, are reaffirmed:

a. To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.

We will achieve this by achieving the following strategic goals:

- Meeting and outperforming targets for HCAs
- "Getting to zero" – promoting zero tolerance of harm events to patients
- Ensuring we are fully compliant with all 16 CQC standards
- Deliberate focus on preventing premature deaths and improving other safety measures
- Track external reputation using peer, SHA, CCG and patient feedback

b. To provide the best possible patient experience

We will achieve this by achieving the following strategic goals:

- Mobilising the workforce with a passion for getting things right for patients every time
- Creating an environment that provides the facilities expected in 21st Century healthcare and which aids treatment and or/recovery
- Providing good clinical outcomes and effective processes so that patients feel involved, valued and informed

c. To drive the business forward by taking opportunities to diversify beyond our traditional range of services and strengthen our existing portfolio

We will achieve this by achieving the following strategic goals:

- Adopting a more commercial attitude to developing services and broaden the Trust's income base to reduce reliance on NHS income alone
- Providing excellent, appropriate and accessible services across community and acute care
- Providing a re-shaped range of financially and clinically viable planned care services
- Developing the Trust wide clinical strategy including improved use of Trust resources, quality of care and financial efficiencies
- Investing in developments that support the drive for lead provider status in the Black Country

d. To develop and strengthen strategic clinical partnerships to maintain and protect our key services

We will achieve this by achieving the following strategic goals:

- Demonstrate a distributed leadership model with empowered clinical leaders
- Promoting risk sharing with CCGs
- Developing clinical links with local GPs and healthcare practitioners
- Develop new clinical networks that provide resilience through a more distributed service model
- Improving partnerships with third sector organisations and community groups

e. To create a high commitment culture from our staff with positive morale and a "can do" attitude

We will achieve this by achieving the following strategic goals:

- Developing a profound sense of mission and direction
- Embedding staff owned and driven transformation and listening into action as "business as usual"
- Becoming employer of choice for those wanting to work in healthcare in the Black Country through excellent leadership, staff development and succession planning
- Ensuring staff are able, empowered and responsible for the delivery of effective care
- Promoting the Trust's values and living them everyday
- Embedding diversity and equality

- Providing a proactive learning environment – uni, multi and interdisciplinary

f. Enabling Objectives: To deliver an infrastructure that supports delivery

We will achieve this by achieving the following strategic goals:

- Enhancing our reporting and analytic framework to support the delivery of operational objectives and Trust performance and governance/compliance requirements
- Upgrading and investing in the Trust's IT infrastructure and systems
- Embedding the three year rolling financial plan and CIP to sustain FRR 3 and EBITDA margin
- Ensuring leadership development at all levels
- Continue to maintain a strong membership base representative of local communities.

iv. The national and local commissioning environment

The Health and Social Care Act 2012 has now become law. The structures and philosophies set out in that act are now taking shape. The NHS Commissioning Board, now NHS England, is central to the management of the commissioning priorities nationally and will drive the priorities to which CCGs and ultimately, provider organisations must respond. A new operating framework, "Planning for Patients" has been published and has been central to the development of our local CCG's commissioning strategy and intentions this year. That operating framework has:

- A renewed emphasis on quality, safety and transparency
- An 11 point, outcomes based scorecard, through which commissioning success can be judged.

That outcomes framework developed by NHS England, was already pre-empted by us as a Trust, given that our strategic goals and transformation programme objectives focus very much on patient and staff experience and financial health for the long term.

Despite these nationally set, outcome based priorities, the spirit of the Health & Social Care Act remains, as NHS England's Business Plan for 2013/14, maintains QIPP and local innovation plans as a key theme. However, we as a Trust are aware that NHS England has already signalled its intention to accelerate clinical service reconfiguration on a large scale, to meet the increasing challenge of having a framework of clinically and financially viable, healthcare providers. We can expect service reconfigurations that we have already successfully responded to, such as Vascular Surgery, to be extended to other specialities and/or services. For example, we are already well into the tendering process for the delivering of GP Pathology Services in the Midlands & East. Hyper-acute Stroke Service changes are also on the horizon.

Much of our future function and form will however, be decided through working with our local CCGs, to deliver their strategic intentions. We have worked hard in developing a new approach to engaging the Dudley CCG's new Board, recognising their unique status as a membership organisation. The product of that engagement is starting to bear fruit, as the strategic/transformation priorities of both organisations are increasingly converging.

The CCG's strap line is "*Thinking Differently*", encompassing the strategic challenge and differing approach to the challenges, which all health economies now face. Their Strategic Commissioning Plan, agreed in November 2012, sets out the following strategic priorities:

- Urgent Care redesign and new urgent care model
- Older people's service resilience and improvement
- New overarching model of care, based on stepped care model
- Improved access to Cardiology services
- Redesigned models of care for long term conditions (i.e. Diabetes, Heart Failure)
- Stroke service improvement

Other significant QIPP plan schemes, each a subset of the above priorities, are set out by Dudley CCG thus:

- Redesigned front end to ED, incorporating Walk In Centre Activity

- Further reductions in activity on procedures of limited clinical value
- Outpatient modernisation – referral triage, reduction in follow-ups and tertiary referrals
- Readmissions reduction

Our response to the above CCG strategic and QIPP efficiency priorities will be as follows:

- **Urgent Care**

The Trust and the CCG have established a jointly funded project, under the umbrella of the Trust's Transformation Programme. DGFT have struggled with managing urgent care demand this year as admissions rise and ED attendance profiles change. The project's objectives are threefold. Firstly, to agree and implement a "stepped care" approach to urgent care demand, particularly within primary care, thereby reducing demand on the ED at the hospital. Secondly, to redesign the ED "front end" of the hospital to incorporate the activity of the local CCG Walk In Centre and current ED activity. Thirdly, to embrace the recommendations of the ECIST review of the Trust and the principles of the Ambulatory Emergency Care Network by introducing new emergency care pathways within the Trust, thereby delivering a more efficient service as a result and reducing the burden of subsequent admissions. There is real consensus on the way forward between both organisations and progress is being made in planning the changes.

- **Older people's services**

We have engaged the former national clinical director for older people's services, Dr David Oliver, to help us implement both significant changes to our Elderly Care clinical service and also to introduce best practice principles of the frail elderly pathway, to our ED and medical assessment unit. The changes to the service are intended to deliver a more primary/community based focus for the work of our Consultant Geriatricians, focusing on both falls prevention and community based rehabilitation, reducing length of stay. The introduction of frail elderly pathway changes will drive earlier intervention of specialist skills in acute medical assessment, thereby improving clinical outcomes and reducing length of stay. Dementia assessment initiatives under a local CQUIN scheme, together with the proposed introduction of an inpatient mental health advisory service, complete the picture. There is potentially a significant impact on our bed base and service structures as a result of these changes, which are being quantified through our financial planning process both this year and next.

- **New primary, community and secondary model of care**

The CCG wish to develop a clear and overarching model of care for the Borough, driven by the central principles of single point of access, multi-disciplinary teams and risk stratification. Through the long term conditions project of our Transformation programme, and the planned consolidation of our community nursing teams to fewer, locality based teams, we aim to support the roll out of these principles, as they get agreed. There is a potentially significant finance and activity impact on the Trust if this model is delivered as the CCG intends it to be. We will work closely with the CCG to model and mitigate that impact, as well as continuing to seek alternative sources of income to replace any lost through service consolidation, locally.

- **Outpatient modernisation**

The CCG's QIPP priority with the largest potential financial and activity impact, is outpatient modernisation. The CCG wishes to see the introduction of referral triage to a greater level, thereby reducing outpatient activity generated through pre-diagnostic phase attendance, for example. Similarly, the CCG continues to assertively manage a reduction in the number of follow-ups in certain specialities deemed to be over the best practice benchmark level. Significant progress has already been made by the Trust during 2012/13 on their third outpatient QIPP priority, the reduction in consultant to consultant, or "tertiary" referrals. We are establishing a series of clinically-led meetings with CCG GP board members, to explore how to safely and appropriately roll out their referral triage principles. The finance and activity risk associated with this is to be mitigated by accelerating the Outpatient project within our

Transformation programme. This project aims to take a speciality by speciality look at matching demand and capacity, reducing DNA's and improving efficiency of outpatient services overall by replacing unnecessary follow-up appointments with new patients. Waiting time performance will also benefit as a result. Whilst we anticipate some continued out patients activity reductions in year 1 of this plan, we do anticipate that this impact will be partly reversed in year's 2 and 3 of the Plan, as the Trust's transformation activities create scope for increased new attendances to respond to continued demographic driven growth and the exploitation of new clinical service areas (e.g. vascular services) and recovery of market share.

- **Readmissions reduction**

We have invested heavily in our Acute Medicine (AMU) service in the Trust, ensuring senior medical, nursing, social care and therapy support are present for extended periods of the day and at weekends. As a result of this, and the introduction of regionally recognised ambulatory emergency care services such as community IV antibiotic therapy, we have already reduced our readmission rate to amongst the lowest in the West Midlands. Further roll out of the AMU investments will play a large part in mitigating the financial risk associated with readmissions penalties.

- **Procedures of limited clinical value**

To mitigate the continuing financial risk associated with the roll out of this, other QIPP activity reduction schemes from 2012/13 and to mitigate the impact on our RTT performance as a result of emergency admissions pressure, the Trust is already in the process of procuring nursing home beds via a separate contract with two nursing home companies. This procurement will release 20 medical beds at the hospital which will be immediately re-designated to Surgery and Urology, increasing activity in these profitable service lines.

v. The local provider landscape and competitive environment

Dudley Group continues to be the only acute foundation trust in the Black Country region (*the area of c1.2m people spanning the metropolitan boroughs of Dudley, Wolverhampton, Sandwell and Walsall*). The acquisition of the former Dudley PCT provided Adult Community Services, in April 2011, has added a new dimension to the Trust's service offering.

As the only acute foundation trust and as a relatively strong performer in quality, financial and performance terms, with access to some of the best estate in the NHS, we retain a strong position in the local market. Other planned service reconfigurations and/or strategic review processes locally also place us in a position to take advantage in business terms and for us to achieve our vision of being a significant healthcare provider in the West Midlands.

For example:

- **The Royal Wolverhampton NHS Trust (RWT).** This organisation's FT application has been deferred and its emergency and maternity services are under increasing pressure as a result of activity shifts resulting from service attrition at Mid Staffordshire NHS FT. Detailed planning work with Mid Staffordshire FT administrators is underway and as a result, the focus of this organisation's attention, together with any growth in activity for this Trust, will be to and from their northern boundaries. Local boundaries that we share with RWT, such as the Seisdon Peninsular and Sedgley, will be increasingly targeted by DGFT from a marketing and referral capture perspective. For example referrals to DGFT Orthopaedics from these areas are already increasing significantly.
- **Worcestershire Acute Hospitals NHS Trust (WAHT).** This organisation is in significant financial and clinical viability difficulty and a strategic review process, driven by local commissioners and the TDA, has been underway for some time. Local CCG commissioners in Wyre Forest (North Worcestershire) have previously expressed a desire to shift more activity to the Dudley Group and even to potentially afford DGFT the opportunity of acquiring Kidderminster Hospital (part of WAHT) as part of any agreed strategic service review solution in Worcestershire. We will continue to keep these opportunities under review as

one of the key elements of our strategic goal to diversify and increase our income base.

- **Sandwell & West Birmingham Hospitals NHS Trust (SWBH).** This organisation has been planning its service configuration future in detail for some time, driven by competition within Birmingham and also their need to develop a new, single site hospital within Greater Birmingham, to reduce their reliance on outmoded and poorly planned, estate. The strategic opportunities for DGFT as a result of this were already signalled by our needing to respond to significant shifts in maternity activity from Sandwell to Dudley following the planned closure of maternity services in Sandwell during 2010. DGFT is working in partnership with SWBH and a commercial partner as part of a tender bid for the regional Pathology service reconfiguration, which may lead to a full integration of both Trusts' Pathology services. Further strategic partnership opportunities are being explored with the Trust, including both Vascular Surgery and Stroke Services, both of which are likely to form part of wider health system strategic review by NHS England.

B. Quality of services

As stated in last year's Plan, the reason for our existence as an organisation is to provide the highest quality care to our patients and carers.

Our long term approach to quality and safety of our services has been set out in our *Quality Strategy* and our *Clinical Strategy*, both of which were approved by the Board of Directors in 2012/13.

i. Quality Strategy

Due to both the increasing complexity of healthcare and differing expectations of what quality entails, this means that ensuring a quality service is not undertaken or measured in one single way. The Quality Strategy outlines a framework of structures and processes to achieve the quality strategic objectives of the Trust outlined above.

The Quality Strategy, which also represents the Clinical Governance Strategy of the Trust, is based on national and local NHS requirements, Monitor's Quality Governance Framework as well as on listening to a wide range of staff and patients. The latter was comprised of a variety of mechanisms including Director Patient Safety Walk rounds and Listening into Action (LiA) events with staff, patients and governors.

There are a number of key aims and initiatives at the Trust to produce the above outcomes. These are:

- **Patient Surveys/Perspective.** The Trust will ensure robust methods for collecting real time patient views, monitoring improvements to services as a result of patient feedback and ensuring overall patient involvement. The Trust will comply with all National Patient surveys and ensure lessons are learnt from results. All directorates and managers will develop and implement action plans and investigate where necessary to improve patient's experience in their areas. All staff will adhere to Trust policies and guidelines for patient experience and customer care.
- **Same Sex Accommodation.** The Trust will ensure that it complies with national requirements on this issue and will monitor its position through patient surveys. When breaches with the rules do occur, these will be recorded and collated on a monthly basis.
- **NICE.** All NICE guidance will be assessed for its relevance to the organisation, complied with where appropriate and its compliance monitored and audited.
- **Clinical Guidelines and Nursing Indicators.** All specialties will have appropriate explicit, accessible clinical guidelines in place for junior staff and nursing staff will have appropriate, explicit standards (nursing indicators) in place.
- **Clinical Audit and Monitoring of Standards.** All specialties and professional groups will have audit and monitoring systems in place to ensure that both national and local guidelines are being audited and monitored. When results indicate that deficiencies in practice are occurring plans to rectify the situation

are drawn up, implemented and re-audit will occur.

- **Risk Assessment and Incident/Complaint and Claim Management.** The Trust and all specialities will have proactive systems in place to assess and manage risk and hold active risk registers in order to reduce incidents (including externally reportable Serious Incidents and 'Never Events'), complaints and claims occurring. All incidents, patient complaints and claims that do occur will be investigated and lessons learned to try and prevent re-occurrence.
- **Listening into Action (LiA).** The Trust will partake in the Listening into Action (LiA) programme which is a systematic approach to widespread engagement which empowers staff and leaders around any change or challenge to improve services and patient care.
- **Assessing and reviewing Mortality.** The Trust will have systems in place to locally review all deaths that occur at the Trust and partake in the review using the new nationally agreed indicator - Summary Hospital-level Mortality Indicator (SHMI).
- **Care Quality Commission (CQC).** The Trust will have clear monitoring and compliance systems in place for the CQC registration standards.
- **National Health Service Litigation Authority (NHSLA).** The Trust will comply with the NHSLA standards at Level 1.
- **NHS Outcome Framework.** The Trust will consider the above and agree a way forward in terms of the Trust's responsibilities.
- **External Reviews.** The Trust will co-operate with all relevant outside bodies undertaking reviews and put in place any necessary improvement requirements from the variety of external reviews that occur.
- **Commissioning for Quality and Innovation (CQUIN).** The Trust will monitor and achieve both national and locally agreed CQUIN targets.
- **Quality elements of contracts with Commissioners.** The Trust will monitor and achieve any quality targets as required by commissioners.
- **Quality Account.** The Trust will produce a quality account annually in which there will be clearly defined priority targets for the forthcoming year and the results of the level of achievement of the targets set the previous year.

The Board of Directors gains its assurance on all matters relating to quality and safety, via a dedicated sub-committee of the Board, the Clinical Quality, Safety and Patient Experience Committee (CQSPE).

The CQSPE Committee ensures that the Trust has appropriate and effective systems in place that cover all aspects of Quality and Clinical Effectiveness, Patient Safety and Patient Experience. It provides assurance to the Board on Clinical Quality and Safety, (including Clinical Effectiveness, Patient Safety and Patient Experience) utilising best practice metrics that provide robust clinical governance processes to deliver safe, high quality and patient centred care.

ii. Clinical Strategy

Our recently agreed Clinical Strategy amalgamates the strategic objectives of the Trust, with our Quality Strategy, to provide a broad planning framework for our clinical services, going forward. It will form the base from which the development of a services strategy will emerge in 2013/14, itself part of the planned refresh of our IBP.

To deliver our vision to become a highly regarded healthcare provider for the Black Country and West Midlands we established our organisation strategic goals in six key areas (described in section A, entitled "Strategic Context and Direction". Four of those relate to:

- Being well known for the safety, quality and transformation of our services
- Providing the best possible patient experience
- Strengthening and diversifying our service portfolio and income base
- Strengthening and developing clinical partnerships to maintain and protect our key services

The remaining two recognise that none of this is achievable without committed and engaged staff and a sound infrastructure from which to operate.

Our strategic goals therefore provide the platform for the necessary actions to deliver the clinical strategy.

a) Providing the highest quality local hospital care in the most effective and efficient way

The Trust has an established Quality Strategy which outlines in detail our structures and processes in place to achieve both the above and other standards related to the quality of care that we provide. We will:

- “Get to zero” – promote zero tolerance of harm events to patients through the delivery of the Quality Strategy in areas including nursing care indicators, audit and monitoring of standards, Safety Thermometer;
- Ensure we are fully compliant with all CQC standards using mock assessments, risk assessments on real time compliance against outcomes
- Deliver the IT strategy and systems to drive transformation and efficiency
- Use our enhanced reporting and analytic framework to support the delivery of services in the most efficient and effective manner
- Make transformation business as usual amongst staff driven by objectives and monitored by appraisal
- Create and maintain a highly engaged and committed workforce by the staff engagement strategy, training and development opportunities, positive communications with feedback loops and Listening into Action to enable staff owned and driven problem solving and service improvement
- Invest in developments that support the drive for lead provider status in the Black Country

b) Excellent integrated services enabling people to stay at home and be treated as close to home as possible

Treating patients as close to home as possible is both desirable to the patient themselves but also often makes sense financially for the health system. As an integrated Trust providing both hospital and community services we are very well placed to make sure that we work with commissioners and social care to increase the community resources we need to look after more people at or near home instead of in hospital. We Will:

- Work with commissioners to put forward sound business cases for increasing the scope and capacity of the community services we provide and wish to provide in the future
- Build on the existing successful community respiratory service model as the model of choice for other long term condition services and in developing new patient pathway models consistent with the proposed new model of care for Dudley

c) Providing a series of specialist services across the Black Country

Although the Trust is always seeking to innovate and develop best practice we are not planning to become a specialist hospital. However, we are already a successful tertiary level provider for key areas of our services and provide the Black Country hub for the vascular surgery network. Therefore we will continue to provide these services and where there are clinical developments in these services we will expand. Opportunities may also present themselves via specialised services commissioner changes to commissioning intentions and through the appointment of new Consultants who bring with them areas of special interest or expertise. In both circumstances we would consider each proposal on a case by case basis if it strengthened the Trust's position and was financially advantageous.

iii. Other quality or safety issues

On 19th and 27th February 2013, the Trust received an unannounced inspection by the Care Quality Commission (CQC). No significant or moderate concerns were raised and all 5 key CQC standards were deemed to have been met.

On 7th and 8th May 2013, a “Quality Review Team”, led by the Regional Chief Nurse, managed under the umbrella of the Sir Bruce Keogh mortality indicators review process, undertook a significant review of the hospital and community team's care standards, processes and Board approach to the management of governance and risk. The review was triggered, for ourselves and a further 13 NHS Trusts in England, by virtue of our mortality

indicators (HSMR and SHMI) being deemed higher than expected at any time in the previous two years.

At the time of writing this Annual Plan, the results of this review are unknown. However following a series of planned and unplanned visits by the Team no significant matters have been raised for intervention and the Trust awaits participation in a Risk Summit on 6th June 2013. Notwithstanding this process, the Trust will continue to give due care and attention to matters such as mortality reporting, staff feedback and patient experience.

C. Productivity & Efficiency

i. Overview of Productivity Gains Built into the Financial Plan

The Trust has drafted these plans on the assumption of continued national austerity budgets throughout the 3 years planning cycle. It is anticipated that during each year of the Plan the Trust will need to address significant cash releasing savings sufficient to offset a 4% per annum recurrent abatement of PbR tariff (to reflect assumed provider efficiency) and to meet the costs of internal cost pressures and development opportunities.

The Trust is conscious that traditional sources of CIP will provide limited scope for identifying savings going forward and redesign of clinical pathways through more holistic systems wide change is the only real opportunity to drive change on such a scale. Fortunately, the Trust has a good pedigree of demonstrating incremental service improvement and has had a lean based "Transformation" Team in situ for some years. Similarly we see the significant investment in IT services as providing scope for increased automation and the release of scarce staff time as a source of improved productivity. A move from service improvement, to larger scale, transformational change is now planned.

The main 5 CIP initiatives are as follows:

a) Implementation of the Trust's IT Strategy

Contribution Yr. 1 £0.6m Yr. 2 £3.3m Yr. 3 £1.1m

The Trust is in the advanced stages of negotiating termination from its existing outsourced PFI contract for IT and has acquired a local Data Centre facility from the PCT. Detailed costing analyses and negotiations with external providers suggest that the Trust will realise a reduction in cost of £1m per annum from bringing the service in-house.

The Trust plans to drive improved efficiency through a combination of external trading opportunities and an escalation of the programmes to develop an electronic patient's record and automated clinical processes. CIP includes the assumed revenue streams of providing IT capability to neighbouring NHS organisations and potentially private customers, together with the well-established benefits of electronic patients record technology (estimated to save 50% of health records staff costs) and electronic drugs prescribing (contributing to reduced drugs errors, reduced drugs costs and reduced length of stay).

b) Transformation Programme (Length of Stay and Out Patients)

Contribution Yr. 1 £1.3m Yr. 2 £2.1m Yr. 3 £0.4m

A main focus of the Transformation Team's efforts over the next few months involves the delivery of length of stay reductions to accommodate the impact of activity pressures, predominantly in non-elective admissions in both Surgery and Medicine. In addition, phase 2 expansion of the Black Country Vascular Surgery Hub requires accommodating and length of stay reductions will allow us to work at lower bed occupancy to deliver this safely.

In addition, Transformation work to improve throughput rates in Out-Patients is planned to yield significant financial benefits in years 1 & 2 of the Plan. This will accommodate additional market share and demographic increases in activity.

c) Transformation Programme (Medical Capacity reduction)

Contribution Yr. 1 £1.4m Yr. 2 £1.0m Yr. 3 £0

Further initiatives, delivered by the Medical Directorate focusing on delayed transfer process improvement, but also further aided by Transformation Programme initiatives, is focused upon the improvement of length of stay in acute medical specialties at RHH. This will enable supplementary bed capacity currently built into the Trust's capacity model and base budgets, to be closed and further Acute Ward bays capacity to be closed. It is anticipated that 58 WTE of staff can be released through this targeted improvement.

d) Reduced Bank and Agency spend

Contribution Yr. 1 £1.6m Yr. 2 £0 Yr. 3 £0

In spite of significant improvements in reliance upon bank and agency staff in recent years, the Trust has a residual high continued spend in this area, with consequent cost and quality implications. The Trust has embarked upon two specific initiatives to reduce this reliance:

Firstly, we have launched a programme of new training grade doctor recruitment to replace expensive middle grade locum staff.

Secondly, we have commissioned a new nurse rostering system which will be administered centrally to give assurance on nurse staffing levels across wards and departments and which will reduce dependency on agency staff.

e) Service rationalisation/PFI changes

Contribution Yr. 1 £1.2m Yr. 2 £0.4m Yr. 3 £0

The Board has established a Board to Board joint forum with our PFI partners to drive a programme of cost reduction initiatives in support services. The Trust and partners are currently revising service specifications for catering, portering, domestics, laundry, EBME etc. and a 4% saving is planned.

ii. CIP Governance - Background

In 2011/12 the Trust achieved over 98% of its £12.9 million CIP target, followed by 95% of a £10.7 million CIP target in 2012/13. In both years the financial plan targets were exceeded.

The Trust's recent history of CIP achievement is relatively strong, but underlying CIP performance indicates an increasing reliance on one-off or non-recurrent savings. In 2012/13, 40% of CIP achieved was from non-recurrent sources. Whilst non-recurrent savings help to achieve year end targets, the downside is that they create an additional amount of a savings to be achieved in future years.

The Trust's traditional approach to delivering CIP has been to set directorates and departments individual CIP targets, the aggregate of which is insufficient to achieve the Trust's financial objectives. The individual CIP targets are based on a combination of factors including service line reporting performance and deliverability.

The Trust has recognised for some time that directorates and departments cannot continue year after year working individually in delivering the majority of the Trust's CIP target. The increasing reliance on non-recurrent CIP to achieve financial targets is symptomatic that directorates/departments may start to struggle to achieve 4-5% CIP on their own in the long term.

To mitigate this risk, the Trust is developing a dual approach to find alternative financial efficiency measures and/or income diversification. The Trust has for three years taken an incremental, service based approach to facilitated service improvement and smaller scale, financial efficiency. This year, we have developed an active and larger scale, Transformation programme. A new Transformation governance framework has recently been introduced and the Trust is openly engaging with Commissioners and stakeholders to identify deliverable opportunities that will achieve substantial efficiencies into the long term. The Transformation programme is expanded on in more detail in the section below.

The second element of our mitigation to the traditional CIP approach is to develop a more assertive management of Trust-wide, corporately sponsored schemes. These take the form of both centrally coordinated projects aimed

at staffing/financial efficiency (i.e. Ward off-duty/e-rostering) and commercial development schemes aimed at diversifying our income base, such as subsidiary company development in outpatient medicines and nursing home acquisition.

Similarly, in 2012/13 the Trust invested in its IT staffing structure, recognising that IT solutions will realise sustainable financial efficiencies in the long term. The Trust is also reviewing the role of its current IT partner in the PFI agreement; this too should result in significant savings and service improvements.

The CIP 2013/14 plan includes an increased proportion of CIP to be delivered centrally from Transformation and IT, as detailed above. The 2013/14 finance plan also includes other organisation wide schemes such as savings that may arise from more efficient estate utilisation.

iii. CIP Profile and an Outline of Transformation CIP schemes

Dudley Group has a successful tradition of delivering efficiency gains to sustain cost effective care. It is recognised looking forward that traditional CIP approaches will no longer provide improved productivity at the levels and pace now required and the Trust has moved into a new phase of transformational change and will in future move into a third phase of whole systems transformation. The Transformation programme was originally established in May 2010 to drive a culture of continuous service improvement to achieve quality, financial and patient experience enhancements.

So far Transformation Team initiatives have helped to achieve service improvements and contributed to realising benefits of some £4.8million in the Trust.

The programme has also delivered significant quality and patient experience gains made through a variety of initiatives from specialty level to Trust wide implementation of improvements. To implement and sustain the change, a robust project management office (PMO) governance framework, utilising lean tools and techniques, has been implemented. The CCG is now adopting this approach, in jointly sponsored projects this year, such as that on Urgent Care.

As discussed earlier, the Trust has identified that its historic model for identifying and delivering financial efficiencies may struggle to deliver the financial efficiencies that will be required in the long term. To meet this challenge the Trust is looking for significant savings to be delivered from organisation wide schemes, including savings arising from investment in IT as well as Transformational projects.

Whilst the Trust's Transformation programme has been relatively successful in realising benefits, it was recognised that the structure and governance of the programme needed to be rethought and enhanced if it is to meet the long term financing challenges and help to achieve the Trust's strategic objectives. In short, the Transformation programme needed to be more 'transformational rather than transactional' and to engender a focus on more aspirational goals.

Five key Transformation objectives have been developed that form the foundation of the Transformation programme of work for the next 3-5 years. Individual projects and work streams are being developed from them to deliver cost improvements.

- **Outpatients** – to achieve upper quartile performance in efficiency and patient experience
- **Length of stay** – to be a benchmark setter in both elective and non-elective length of stay, including improvements to our multi-agency approach on delayed transfers of care
- **Responsive service** – to meet the demands on the service over the whole week and to have a

flexible workforce.

- **Long Term Condition Management** – driving a culture of self-management and/or management from home where appropriate and developing pathways to support this approach across the health economy.
- **Urgent Care** – deliver an integrated and efficient urgent care solution to provide optimal patient flow and care pathways

Some £1.3 million of savings is expected to be delivered in 2013/14 directly from the 5 transformational schemes outlined above. In addition, Transformation projects are expected to assist the delivery of financial savings for a number of directorate CIP schemes, particularly those on length of stay reduction. Whilst the delivery of 2013/14 Transformation savings is extremely challenging, the Trust is confident that its new approach is the only way that efficiencies can be achieved in the long term.

The new approach to Transformation in the Trust is underpinned by a new governance framework. A Transformation Programme Board has been established, which is led by the Trust's Chair. Each of the 5 key Transformation projects has its own working group that reports directly to the programme Board; each working group is led by a different executive director, assisted by a senior clinician and an external stakeholder, usually from the CCG. In addition there are steering groups for both 'performance enablers' as well as information management and technology. The performance enablers steering group will shortly become the advisory group which will develop the methodology and approach to conducting a speciality specific analysis of each of our main services, the collective product of which will form our service strategy and IBP refresh in 2013/14.

iv. CIP Enablers

The section above has outlined how senior clinicians are involved in the governance of Transformation driven CIP. Other than Transformation, the principle sources of 2013/14 CIP are from organisation-wide schemes. Clinical directorates are still expected to deliver the majority of the Trust's 2013/14 financial efficiencies however; clinicians have a leading role in identifying and assessing all sources of CIP.

Clinical Directors are specifically responsible for producing annual directorate business plans, which includes the identification of CIP schemes; this process is discussed in more detail below. In the case of organisation wide CIP, these schemes are typically approved by the Trust Management Executive which includes all Trust executive directors, as well as all clinical directors and general managers.

Each clinical directorate produces a 3 year business plan, refreshed annually, that details its strategy for each specialty and sets out its key directorate priorities for the forthcoming year, linking them to the Trust's strategic objectives.

The Trust followed a predetermined process for the production of the latest 2013/14 business plans, which included a number of reviews and critical assessments. The business plans were only approved after the Board of Directors scrutinised each plan and agreed these with each clinical director.

v. Managing the Quality Impact of CIPs

The Trust continues to refine and improve its process for ensuring that CIP schemes will not impact on quality. All CIP schemes are jointly reviewed by both the Medical Director and the Director of Nursing. This process continues through the financial year with individual CIP schemes being assessed as plans continue to be developed.

In the majority of cases full quality impact assessments are completed for each individual CIP scheme. In a minority of instances, where CIP schemes have a very small financial benefit (and associated risk) and available information clearly indicates that there is no risk, then the Medical and Nursing Directors have instead decided to

opt for a less detailed 'statement of assurance' from the relevant general manager and clinical director.

The quality impact assessment process covers the following areas:

- The possible impact of implementing the CIP schemes on clinical services, quality of service, access to services, patient safety etc.
- Current controls in place
- Gaps in control
- Sources of assurance
- Gaps in assurance
- Mitigating actions
- A numerical risk assessment scoring

Each individual CIP scheme is quality impact rated as follows:

- **green** - saving schemes proceed as normal
- **Amber** –further details/assurances requested. In most cases amber CIP schemes can be progressed, but the Directors of Nursing and Medicine decide on additional controls that need to be introduced
- **Red** – either the scheme is stopped immediately, or alternatively further information is requested with a specific deadline. A scheme cannot continue to be red rated – it is either reassessed as green or amber, alternatively it is stopped

For 2013/14 the quality impact assessment process has been enhanced in a number of ways

- extended to cover CIP schemes arising in non-clinical areas, in order to fully ascertain if there could be any indirect impact on the delivery of clinical services
- the distinction between CIP quality impact assessments and the Trust's risk management process has been defined more clearly ; this ensures that the Directors of Medicine and Nursing get the key information that they require
- there is much more focus on ensuring that the Trust is reviewing the potential impact on quality well in advance of any CIP initiative going live. This process has been tested recently by the Keogh Quality Review Team.

The Trust's internal audit provider was used to review the previous year CIP quality impact assessment process and results. This gave the Board the assurance required that a quality impact process is in place and that it is working. An internal audit review of CIP and the quality impact will be repeated in 2013/14.

The measures of quality which will be used to inform this assurance

In excess of 500 key performance indicators and other measures are currently used to measure all aspects of the Trust's performance. These include indicators that are defined in the NHS Operating Framework ("Planning for Patients") or other originators including Monitor and the CCG local quality or CQUIN requirements. .

The whole performance management framework in the Trust is being reviewed and amended during 2013/14 and will be fully implemented by the end of this period. The intention of this review is to create a more "three dimensional" framework of quality and efficiency indicators and to ensure executive scrutiny of clinical service performance against them is more systematic.

Quality indicators and specific CIP related issues are monitored through the Trust's existing management and governance frameworks. A directorate performance review programme includes a regular review of CIP schemes, and this will also cover CIP quality issues, particularly those relating to amber and red rated schemes.

In the 2012/13 the Trust has put into place a performance management exception reporting approach. This specifies a process that gives the Board and executive Directors assurance that underperformance is being

appropriately managed in areas where failure has a significant and immediate adverse impact for the Trust. The approach ensures that:

- Key Trust staff are alerted as soon as possible
- There is a clear understanding of the reasons why the failure/breach occurred
- Clarity on the implications of the breach/failure
- An achievable plan and trajectory are to redress performance

The high impact quality indicators currently included in this process include A&E 4 hour waits; cancer target; infection control; referral time to treatment; diagnostic waits. As part of the performance framework review process described above, it will be expanded to cover exception reporting against other indicators such as CQUINs, workforce and OD indicators, etc.

D. Financial & Investment Strategy

In common with the rest of the English NHS, the Trust has prepared plans for the current planning cycle (2013-14 to 2015-16) against a background of national austerity and a focus upon delivering unprecedented levels of productivity improvement. At the same time, we are cognisant, in the Post-Francis era, of the need to sustain and improve patient safety and to deal with the organisational turbulence in the English NHS, caused by the recent structural changes to NHS commissioning.

The Trust has calculated that it needs to realise some £45m of cash releasing savings over the next 5 years strategic period. For 2013-14 reduced real terms funding for the NHS has translated into an efficiency deflator in PbR tariff of 4% and a similar scenario is assumed for years 2 & 3 of this Plan. In the past two years the Trust delivered cash releasing efficiency savings of £11m and £10m respectively (plus net benefit in revenue generation schemes in each of these years) and this represents by far the largest productivity gain ever achieved in Dudley. This benefit was driven by a combination of traditional cost reduction strategies (reduced agency spending, procurement opportunities etc.) but was also the result of a longer term lean-based clinical transformation programme. In future planning cycles the Trust will seek to drive the benefit of transformational change to clinical processes to deliver more service quality and volume for less cost and will seek to drive benefit from clinical collaboration and the automation of clinical and support functions through investments in information technology.

Looking forward, the Trust has set itself the objective of delivering improved productivity of c4% per annum throughout the planning period. Although we do not anticipate a major reduction to the cash value of Clinical Commissioning Group (CCG) income streams during this period (with CCG QIPP Commissioning activity reduction plans broadly being offset by equal and opposite demographic and market share increases) cash releasing savings of this magnitude will need to be realised to meet forecast cost pressures and to sustain essential service development. In addition the Trust will seek to pursue some of the commercial trading opportunities presented by the raising of the private patients cap and by the development of an in-house IT capability.

1. Financial Objectives

In 2012-13 the Board approved the following Key Strategic Financial Objectives, which remain valid:

- Develop and maintain a portfolio of clinically and financially viable services
- Maintain a Financial Risk Rating of 3 or above in each of these years
- Exceed national efficiency requirements

We committed to achieve these by:

- Expanding our portfolio of clinical services to develop increased specialisms in vascular surgery and screening
- Increase market share in surrounding catchment areas of Sandwell, South Staffordshire and North Worcestershire
- Undertake increased private patients and other commercial activities
- Maximise income through concentration on high margin services
- Reduce costs through lean led transformation of services resulting in reduced lengths of stay and improved theatre and clinic utilisation
- Reduce fixed and variable costs through traditional and transformational CIP processes
- Reduce costs through collaboration with competitors in the delivery of clinical and support services

These objectives remain equally valid (and good progress has already been achieved in most areas in 2012-13) and these will form the main financial strategy in the period of this plan.

The Trust's financial plans for the period are summarised below:

Table 1. Key financial information 2013-14 to 2015-16

| | 2013-14 | 2014-15 | 2015-16 |
|------------------------------|---------------|-----------------|---------------|
| | £000's | £000's | £000's |
| Income | 303,542 | 309,487 | 321,946 |
| Expenditure | (280,194) | (285,131) | (297,482) |
| EBITDA | 23,348 | 24,356 | 24,464 |
| Net Surplus | 500 | (1,282)* | 994 |
| | | | |
| Cash Holding | 28,523 | 22,518 | 22,190 |
| | | | |
| EBITDA Margin | 7.7% | 7.9% | 7.6% |
| EBITDA % Plan Achieved | 100% | 100% | 100% |
| Net Return After Financing | 0.2% | 0.4% | 0.4% |
| IS Surplus Margin | 0.2% | (0.4%) | 0.3% |
| Liquidity Days | 31.9 | 23.4 | 22.4 |
| Financial Risk Rating | 3 | 3 | 3 |

Note*: the Trust makes a deficit in 2014-15 due to the non-operating IT termination payment to our PFI provider. Our 'true' position represents a normalised surplus of £1.1m.

In preparing the detail of the 2013-16 Plan, the Trust has based its modelling on various key assumptions. These are set out below.

Key planning Financial assumptions are as follows:

1. Activity & Income Overview

The Trust maintains excellent relations with its key commissioner Dudley CCG and has once again prepared detailed activity and income models in association with our major customers. We see continuing and growing pressure on emergency activity during the planning cycle as financial pressures in the economy generally translate into greater demand on the NHS and financial pressures in local government further reduce support infrastructure outside the hospital environment.

The Trust has entered into a programme of joint working with Dudley CCG to ensure planning alignment

between Commissioners QIPP plans and Trust Transformation plans. This relationship will facilitate clinical change whilst maintaining income levels and removing the perverse incentives of PbR.

However continued pernicious reductions to the acute tariff will reduce the value of unit income to acute providers and will result in an increasing number of service lines becoming unprofitable during the next three years, with increased cross subsidisation. Given the relatively high fixed costs associated with the PFI in Dudley a more creative response to growing profitable lines will be a key focus of the Board.

2. Activity volume

We assume that in overall terms activity volume will increase over the planning cycle, with CCG decommissioning plans and other negative factors being more than offset by demographic pressures, transformational improvements, the impact of successful tenders for vascular surgery for the Black Country, AAA Screening and Worcester Immunology, plus continued growth in market share on the borders of our catchment area. In addition specific increases linked to the move to co-locate the current walk-in centre provision on the “front-end” of the Emergency Department and an assumption regarding the potential outcome of the region-wide Pathology tendering process have been factored into the plans.

3. Cash impact of Tariff

We see net tariff funding being impacted by significant 4% efficiency assumptions throughout the period but offset in years 2 & 3 by increased recognition of pay cost pressures and inflation. Key net changes to tariff are assumed to be:

2013-14 -1.3%

2014-15 -0.5%

2015-16 -0.5 %

4. Pay Inflation

2013-14 sees the end of a two year pay freeze in the NHS. A 1% pay award has been made to all grades and in addition the Trust has honoured the impact of incremental increases to pay. The Trust envisages some modest across the board award in each of years 2 and 3. Modelled assumptions are as follows:

2013-14 +1.7%

2014-15 +1.5%

2015-16 +1.5%

5. Non Pay

The Trust has a PFI contract linked to RPI and we have modelled a 3.5% impact in 2013-14 and 3% and 2.5% for subsequent years. We have estimated other non-pay inflationary pressures at 2% and drugs inflation at 3%, for each of the years of the plan. For CNST, an increase of £1.9m has been incorporated into the figures for 2013-14 (30% based on the NHSLA premium) and a figure of 6% per annum has been factored in thereafter.

6. Major Cost Pressures

Our major areas of cost pressure over the planning cycle will be:

a. Nursing numbers and skill mix

In 2012-13 we planned to increase nursing numbers by £2.1m over a 3 years period, to enrich nurse to bed ratios and drive improved patient experience. Budgets for 2013-14 include a £0.7m investment in qualified nursing grades, £0.6m for additional qualified midwives and £0.1m for theatre staff. A further £0.8m and £0.4m has been incorporated into 2014-15 and 2015-16 respectively.

b. Information Technology

The Trust has a major programme of IT developments and plans to invest £3m over the period.

c. Capacity

The Trust recognises the need to increase capacity in recognition of volume and related clinical pressures and to improve patient flow. This includes investment in the Acute Medical Unit and

other Winter Pressure initiatives totalling £2.6m in 2013-14,

Negotiated levels of clinical income from CCGs and Specialised Services in 2013-14, have a marginally higher value than the previous year's contracts. The Dudley CCG (main service) contract was rebased to more appropriately reflect current activity trends and includes demographic growth of £1.9m and activity levels reflect local commissioning intentions on restrictions to access for procedures deemed to be of 'limited clinical value', reductions to follow up out patients in several specialties and targets to reduce emergency admissions.

Other notable movements to the contract linked to changes to NHS tariff architecture and the application of the operating framework for 2013-14 are set out below. These will represent a significant challenge to financial stability:

1. A significant proliferation of commissioning organisations with the change from PCTs to the NHS Commissioning Board (NHS England), Local Authorities and 19 local CCGs has caused much additional workload on the Trust's Finance Team and introduces greater financial instability than previously.
2. Application of the emergency readmissions PbR rules, estimated to cost the Trust £2.3m in 2012-13. Deductions that should have been levied in previously have effectively been blocked back by commissioners and this agreement has been reached for 2013-14. However, this funding has been reinvested on the Acute Medical Unit and other Winter Pressure schemes.
3. Agreement to charge a local price for "admissions" to both EAU and CDU that is subsequently discharged home. The initial net reduction of £1.4m from these local pricing arrangements has been reduced by the £0.5m in 2013-14 by agreement of a higher local tariff. This has been fully factored into our income plans. The other benefit of this change to the Trust is that activity no longer breaches the emergency threshold.
4. Embedded efficiency of 4% and the application of a 1.3% deflator to the majority of non PbR services. This has been factored into our plans.
5. Continuation of CQUIN at 2.5%, (2.4% for Specialised Services) of contract value has been factored into our income targets allowing the Trust the possibility of earning an additional £6m income. Commissioners no longer pay CQUIN on pass through drugs and devices but the impact of this has been more than mitigated by the agreement of an overhead charge.

On the expenditure side of the P&L Account the Trust is conscious of a range of budgetary issues that have had to be addressed in the 2013-14 budget setting round and in subsequent years of the Plan. Principal development and unavoidable cost pressures include:

- Increases in the overall pay bill in 2013-14 of 2.64% (inflationary impact as outlined above plus service developments –see below- less CIP)
- Drugs expenditure is planned to increase by 3.9% in 2013-14 with other non-pay budget heads reducing marginally.
- The Trust has invested heavily in the establishment of an Acute Medical Unit at Russells Hall Hospital. Together with other initiatives originally funded on a non-recurrent basis under the 'winter pressures' heading last year, this will add £2.6m to spending in 2013-14.
- Nursing pay will increase in total by £1.4m next year. Of this sum, £0.7m will result from the second tranche of the Board's nurse investment plan and the balance relating to increased investment in midwives and vascular surgery/theatre nurses.
- Other key service developments in expenditure budgets for 2013-14 are £0.3m additional junior medical staff; £0.2m additional medical and nursing staff for stroke care; £0.4m cancer pharmacy staff; and £0.3m for consultant training.

In summary, in common with other NHS providers, the Trust faces a challenging productivity challenge over the planning cycle of this plan and delivery of CIP schemes, without jeopardising patient safety, will be paramount to its future sustainability. In 2013-14 this task will be compounded by the heightened business risk and uncertainty caused by major structural change to the commissioning landscape. However, Dudley is well placed to achieve its strategic financial objectives due to its excellent working relationships and aligned objectives with local

commissioners, its well embedded transformation processes and its significant commitment to investment in IT and automation.