



## **Strategic Plan Document for 2013-14**

**Aintree University Hospital NHS Foundation Trust**

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

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

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Date 

31 <sup>st</sup> May 2013
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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:

<b>Name</b> (Chair)	Mr Christopher Baker
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Signature 

Approved on behalf of the Board of Directors by:

<b>Name</b> (Chief Executive)	Mrs Catherine Beardshaw
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Signature 

Approved on behalf of the Board of Directors by:

<b>Name</b> (Finance Director)	Mr Steve Warburton
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Signature 

# Strategy Guidance - Annual Plan Review 2013-14

## Principles underlying the Annual Plan Review (APR) process

1. This document sets out the requirements for the principal published forward plan ("Strategic Plan") for Foundation Trusts. The Strategic Plan should set out how the Trust's Board intends to deliver appropriate, high quality and cost-effective services for its patients on a sustainable basis. It should, therefore, lay out the Trust's assessment of the challenges it faces (both within the organisation and more broadly within its local health economy), its strategy to address those challenges and its implementation plans over the 3 years from 13/14 to 15/16.
2. The Strategic Plan should be consistent with the information submitted in the finance template (being issued on 29<sup>th</sup> March), and provide context for key figures included in the finance template.
3. It is crucial to recognise that the Annual Plan is not meant to be a simple budgetary exercise, but rather a key governance document which explains how high quality services will be delivered into the future. This will involve analysis of a broad range of issues, which may, for example, include: demographics and health trends; clinical sustainability and the implications of 24/7 consultant rotas; opportunities and threats from reconfiguration; cultural factors and their impact on delivering services which are safe, clinically effective and result in high patient satisfaction; cost benchmarking and the opportunity for transformational CIPs. Clearly, this is not meant to be an exhaustive list and different Trusts will have differing starting positions and face somewhat differing challenges.
4. Monitor has for many years emphasised the importance of robust planning over a multi-year time horizon in maintaining a healthy and sustainable FT sector. Our experience in prior Annual Plan Reviews has shown, however, that FTs on the whole tend to focus on a one-year planning cycle and look less at addressing longer-term strategic issues. The context to the 2013/14 Annual Plan is particularly challenging, with FTs facing rising demand and the need to deliver increased quality and efficiency and an improved experience of healthcare services for patients. Against this background, a short-term planning outlook, particularly one which does not take due consideration of the local health economy or the sustainability of service delivery models, would be inadequate.
5. There is no prescribed format for the published section of the Strategic Plan. However as a guide we would expect plans to be between 10 and 20 pages in length. To support APR analysis there is some specific information, not for publication, that we require from all Trusts and we have therefore included space for these in Appendices 1-4. Where there are commercially sensitive or confidential matters that Trusts do not want to include in the main published section and which cannot be accommodated within Appendices 1-4, these may be included in Appendix 5<sup>1</sup>.
6. Annex A sets out, at a high level, the main stages in the development of the three-year Strategic Plan and the key elements which underpin each.
7. Monitor expects that Strategic Plans would include an Executive Summary outlining key elements of the Strategic Plan, including a summary of key financial data.
8. The main section of the Strategic Plan should normally address the areas set out in the following table, and any other relevant areas.

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<sup>1</sup> Although Monitor does not intend to publish these Appendices, all information provided to Monitor is potentially subject to disclosure under the Freedom of Information Act 2000 (subject to the normal exemptions).

<p><b>Strategic Context and Direction</b></p>	<p><b><u>Aintree's Strategic Vision</u></b></p> <p>The context to the 2013/14 Strategic Plan is particularly challenging and therefore the Trust Board of Directors has taken this opportunity to refresh the <i>Trust's vision, purpose and aspirational values</i>.</p> <p>In agreeing its vision the Trust Board of Directors has taken account of changing circumstances within the local health economy; including:</p> <ul style="list-style-type: none"> <li>• An acknowledgement that we are facing a time of significant NHS reform and associated uncertainty, which is likely to continue for some considerable time yet as pressures of economic austerity, and an ageing society, with increasing poor health, weighs on the system;</li> <li>• A recognition that the focus for service delivery is on the quality of care, patient experience and responsiveness to patient needs as expressed by the various commissioners plans, the operating frameworks, and the NHS Constitution. This priority is further strengthened by recent events at Mid Staffs, and Winterbourne View</li> <li>• An acceptance that we are facing a time of severe financial constraint and the ability to redesign and reconfigure services within a fixed financial envelope will be central to the Trust's future success seeking efficiency alone will not deliver the changes required.</li> <li>• An acceptance that as providers, we must engage and work with the wider system to help shape the new models of delivery. Collaboration, partnership, and change, must be embraced.</li> </ul> <p>The Trust's vision going forward from 2013/14 is to be a <i>'provider of outstanding health care in the heart of our community'</i>.</p> <p>The Trust Board of Directors consider that this statement accurately reflects the sustainable healthcare provider role that Aintree University Hospital will hold in the future: This role will be to operate as a provider of high quality elective and emergency care services meeting the day to day needs of its local community. The Trust will also continue to be a provider of high quality specialist services such as:</p> <ul style="list-style-type: none"> <li>• Major trauma services</li> <li>• Hyper-acute stroke services</li> <li>• Complex obesity services including bariatric surgery</li> <li>• Regional maxillo-facial surgery services</li> <li>• Regional specialist respiratory services</li> <li>• Complex rheumatology services</li> </ul> <p>Underpinning the overarching vision statement is the Trust's day to day purpose which is <i>'to get it right for patients every day'</i>. This statement expresses the desire of the entire Trust workforce to provide high quality care for all patients. This statement is underpinned by the following aspirational value statements:</p> <p>To always:</p> <ul style="list-style-type: none"> <li>• Deliver safe, compassionate care</li> <li>• Continually improve through learning and innovation</li> <li>• Communicate honestly and effectively</li> <li>• Work as a TEAM</li> </ul>
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- Use resources wisely, and
- Value each other.

The Trust's corporate objectives will continue to be the means by which the Trust will measure its progress against delivering its Strategic Plan. These corporate objectives are:

- To deliver high quality safe patient care
- To deliver on our service commitments
- To develop our people to be caring, flexible and skilled
- To improve our external relationships by developing key partnerships.

The Trust's Strategic Plan has been developed as an integral part of the 2013/14 business planning process and will be updated as the Trust completes the refresh of its Clinical Service Development Strategy. An overview of the Trust's Strategic Plan on a single page is provided in Appendix 5. This provides an overview of the quality improvement priorities, service transformation priorities and workforce priorities mapped against the four overarching corporate objectives. This 'plan on a page' also shows identifies those priorities which will support the Trust in responding appropriately to the recommendations of the Francis Report.

### Aintree Hospital Profile

Aintree University Hospital has 720 inpatient beds. At the end of 2012/13 the Trust had fixed assets of just over £169 million and an annual income in excess of £278 million. During 2012/13 the Trust handled 73,459 spells of inpatient and day case care, 319,613 outpatient attendances and 85,965 attendances to the Accident and Emergency Department.

The Trust provides general acute health care to a population of 330,000 people in North Merseyside and surrounding areas, and also works with a range of partners to provide services in the community

The Trust also operates as a tertiary centre providing some specialist services to a much wider population of around 1.5 million in Merseyside, Cheshire, South Lancashire and North Wales. These include:

- Major trauma services
- Hyper-acute stroke services
- Complex obesity services including bariatric surgery
- Regional maxillo-facial surgery services
- Regional specialist respiratory services
- Complex rheumatology services

### Population Health Need

The population served by Aintree includes some of the most socially deprived communities in the country, with high levels of illness creating a high demand for hospital-based care. The population is ageing rapidly with projected growth of around 45% expected in the over 75s in the constituent CCGs. Merseyside has some of the worst rates for heart disease and cancer in the UK. A long history of underfunding in primary care and over provision of secondary care services has also been associated with a culture among patients of low empowerment over their health status and a reliance on the availability of hospital care.

### Priorities for the NHS

Nationally the burden of disease is growing and medical advances offer increasing opportunities to treat disease, but at a cost. This pressure, if nothing else changes, will result in unmet need and threats to the quality of care.

The ageing population and increased prevalence of chronic diseases, mean commissioners are starting to orientate away from the current emphasis on acute and episodic care towards prevention, self care, improving primary care, and care which is co-ordinated and integrated. Additionally, commissioners nationally and locally will be working to address the wider determinants of health and ensure that every contact helps make positive changes to lifestyles individuals.

### Strategic Service Changes

The Trust acknowledges its duty to work in partnership with the local health economy, whilst operating in a national context, to ensure that limited NHS resources are spent as efficiently and effectively as possible. This approach will minimise the potentially negative impact of increased competition in the market place and the risk of market share moving from Aintree over the life of the plan. The strategic service changes which influence the Trust's relative position within the local health economy include:

- The delivery of major trauma services in partnership with The Walton Centre Foundation Trust and The Royal Liverpool and Broadgreen University Hospital
- The delivery of Liverpool Vascular Services as a joint venture between Aintree, Southport & Ormskirk NHS Trust and The Royal Liverpool and Broadgreen University Hospital
- The development of a hub and spoke model for delivering pathology services as a joint venture between Aintree and The Royal Liverpool and Broadgreen University Hospital
- An increased involvement of private sector providers in health service delivery in partnership with Aintree e.g. the delivery of bariatric surgery services in partnership with Phoenix Health Ltd.
- An increase range of private sector providers across the health economy as a result of the Department of Health Any Qualified Provider initiative e.g. audiology services, ophthalmology services, musculoskeletal services
- An increased range of services provided in community settings e.g. alcohol services, weight management services, diabetes services and anticoagulation services
- Agreement on a single site across Cheshire and Merseyside for upper GI cancer services
- Treasury approval for the new Royal Liverpool and Broadgreen Hospital PFI initiative which will see a new state of the art hospital opening in the centre of Liverpool in 2017

Taking into account increasing population health need, the priorities for the NHS and the increasing importance of strategic partnerships the Trust Board of Directors has recognised the importance of redesigning and reconfiguring our services within a fixed financial envelope. Achieving this goal will be central to the Trust's future success as we strive to deliver more services within an overall reducing financial envelope.

### Environmental Context

The environmental context that providers within the NHS are operating includes:

- An acknowledgement that we are facing a time of significant NHS reform and associated uncertainty, which is likely to continue for some considerable time yet as pressures of economic austerity, and an ageing society, with increasing poor health, weighs on the

system;

- A recognition that the focus for service delivery is on the quality of care, patient experience and responsiveness to patient needs as expressed by the various commissioners plans, the operating frameworks, and the NHS Constitution. This priority is further strengthened by recent events at Mid Staffs, and Winterbourne View
- An acceptance that we are facing a time of severe financial constraint and the ability to redesign and reconfigure services within a fixed financial envelope will be central to the Trust's future success seeking efficiency alone will not deliver the changes required.
- An acceptance that as providers, we must engage and work with the wider system to help shape the new models of delivery. Collaboration, partnership, and change, must be embraced.

### **CCG Commissioning Intentions**

Taking account of these factors the key priorities that our local Clinical Commissioning Groups are aiming to address include:

#### ***Quality Innovation Productivity and Prevention:***

Reducing admissions, length of stay and care closer to home are themes for all Mersey CCGs. The focus being improved quality, effectiveness and cost saving.

#### ***Health Promotion and Ill Health Prevention:***

Investment on the lifestyle factors that contribute to the main causes of death. These lifestyle factors include: smoking, cardiovascular disease and stroke, alcohol misuse, obesity and mental ill-health. It is estimated that by 2020, 37 per cent of men and 34 per cent of women (aged 16+) will be obese. Despite this rise, death rates from CVD have reduced by up to 50% leading Clinical Commissioning Groups to believe that investment in these areas will deliver the greatest impact on health improvement and the greatest improvement in life expectancy.

#### ***Planned Care Services:***

Joint working between primary and secondary care clinicians to redesign care pathways to improve local access and the quality of primary and secondary intervention. Specific care pathway priorities include:

- Respiratory
- Diabetes
- Cardiology
- Urology
- Dermatology

#### ***Non-elective and Emergency Care Services:***

Joint working between primary and secondary care clinicians to put in place admission avoidance and other community based support initiatives with the aim of reducing the annual rate of hospital admissions, reducing emergency bed days and reducing delayed transfers of care. In particular, Clinical Commissioning Groups have prioritised action on the development of alternatives to admission to hospital for people with Chronic Obstructive Pulmonary Disease and also for alcohol related A&E episodes.

The Trust's detailed proposals for collaboration, integration and Patient Choice are detailed within the overarching section on Clinical Strategy.

<p><b>Approach taken to quality</b> (including patient safety, clinical effectiveness and patient experience)</p>	<p><b><u>Approach to Quality</u></b></p> <p>Aintree University Hospital NHS Foundation Trust is absolutely committed to the delivery of high quality, safe patient care. This strategic objective has driven the work we have done in recent years and continues to drive forward progress against the achievement of our overarching quality improvement goals, which are: (i) improving clinical effectiveness, (ii) improving patient safety and (iii) improving patient experience.</p> <p>During the year, we embarked on the Listening into Action (LiA) engagement programme. This programme is designed to involve and empower staff in identifying what could be done to improve services. Initial feedback from this is very positive with some really good examples of improvements in patient care and this approach will continue to be used to improve patient care in the future.</p> <p><b><u>Quality – The Challenges and Risks</u></b></p> <p>The challenges that face the Trust in 2013/14, are similar to the those experienced by many Foundation Trusts, and include:</p> <ul style="list-style-type: none"> <li>• Higher numbers of patients with complex illness, particularly frail older people with multiple co-morbidities, attending Accident &amp; Emergency (A&amp;E) department</li> <li>• High non-elective emergency admissions, including patients with poly trauma.</li> <li>• Difficulty in achieving the A&amp;E target for 95% patients to be seen within 4 hours, due in part to difficulties in discharging patients from the main hospital wards (patient flow). This is influenced by limited access to intermediate care beds, complex social service assessment processes, patient and relative choice and nursing / residential home placement issues.</li> <li>• The increase in overall length of stay in some areas, particularly those areas caring for older people with multiple health and social care needs.</li> <li>• Achievement of the 18 week admitted patient target as a result of increased demand for specialist services, late referrals from other providers, patient choice and complex patient pathways.</li> <li>• Minimising the risk of hospital acquired infection.</li> </ul> <p>Plans are in place to mitigate the risks identified above, which often require a ‘whole system’ approach to problem resolution. The Trust is working closely with the commissioners and other local health and social care providers to reach high quality, sustainable solutions.</p> <p><b><u>Care Quality Commission Inspection</u></b></p> <p>During 2012/13 The Trust participated in one unannounced inspection by the Care Quality Commission relating to the following areas:</p> <ul style="list-style-type: none"> <li>• Outcome 4 (Care and Welfare of people who use services) for reassessment</li> <li>• Outcome 5 (Meeting Nutritional Needs) for reassessment</li> <li>• Outcome 7 (Safeguarding) for a new planned review</li> <li>• Outcome 9 (Management of Medicines) for reassessment</li> <li>• Outcome 14 (Supporting Workers) for reassessment</li> <li>• Outcome 16 (Quality of Service) for a new planned review</li> <li>• Outcome 17 (Complaints) for reassessment</li> <li>• Outcome 21 (Record Keeping) for additional review</li> </ul>
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The report from the Care Quality Commission (CQC) identified two areas of non compliance of minor impact and improvement action required against Outcome 9 (Management of Medicines) and Outcome 21 (Record Keeping). The Trust has discussed and shared an action plan focussed on addressing these shortfalls with the CQC. The actions have been incorporated into our Strategic Plan and also into the Quality, Safety and Patient Experience Improvement Programme.

### **Quality Priorities for Delivery**

Taking account of the environmental context and the challenges ahead it is clear that, if we are to continue to deliver high quality safe patient care and meet the significant financial challenges facing all NHS organisations, we will have to look at the way we run our services and work with others to do things differently. Our top three quality improvement goals related to patient safety, clinical effectiveness and patient experience remain consistent and will be used to drive forward quality improvement activities.

**Goal 1: Positive Clinical Outcomes (Clinical Effectiveness)** - The Trust will improve its mortality ratings. This is measured through the monthly monitoring of Hospital Standardised Mortality Ratio, Summary Hospital-Level Mortality Indicator (SHMI) using national systems and crude death numbers.

**Goal 2: Patient Safety** – To reduce avoidable harm in the areas of; Venous Thromboembolism (VTE), preventing malnutrition, falls and pressure ulcers. Progress is monitored using recorded incidents via the Trust incident reporting system (Datix) and the recording of risk assessments on Sigma.

**Goal 3: Patient Experience** – To improve patient experience measured by results from the Trust's In-house Patient Experience Questionnaire (PEQ), the National In-Patient Survey and from the new Friends & Family Test.

These overarching improvement goals have been agreed in consultation with local PCTs, LINKs and the Governors.

To achieve these goals specific service improvement priorities and initiatives have been identified. These initiatives and priorities have been derived from a number of sources including: peer review, external inspections and CQC visits, the Trust's performance over the past year against its quality and safety indicators; national and regional priorities and finally from trend and risk analysis undertaken on patient and public feedback.

Specific clinical quality and transformation service improvement projects are detailed in the table below. Failure to deliver against any of these projects will mean that key performance indicators, operational targets and corporate objectives will not be successfully achieved.

	OBJECTIVE	OUTCOMES	PROJECTS	KPIs
	<b>TARGETS: Deliver our service commitments</b>	<b>Operational Targets</b>	Improve and maintain cancer operational targets	2 week waits from referral to appointment 31 days from referral to diagnosis 62 days from referral to treatment
		<b>Operational Targets</b>	Improve and maintain RTT and diagnostic waiting time operational targets	90% of admitted patients seen within 18 weeks of referral 95% of non admitted patients seen within 18 weeks of referral % 18 Weeks Incomplete pathways Maximum wait of 6 weeks for diagnostic tests
		<b>Operational Targets</b>	Improve and maintain IPC targets	Number of MRSA bacteraemia infections (Positive samples) Number of C. difficile (CDI's)
		<b>Operational Targets</b>	Improve and maintain delivery of A&E clinical indicators through emergency medicine service review	Maximum wait of 4 hours from arrival to transfer, discharge or admission A&E unplanned re- attendance rate % patients left the department without being seen Time to initial assessment Time to treatment
		<b>Operational Targets</b>	Improve and maintain delivery of stroke clinical and operational targets	90% Hospital Stay on a Stroke Unit % TIA cases seen and treated within 24 hours % stroke patients eligible for thrombolysis scanned within 1hour and in receipt of thrombolysis % patients referred to ESD team
		<b>Operational Targets</b>	National, regional and local CQUIN initiatives	Full delivery of CQUIN performance standards

	<b>SERVICES: Deliver high quality safe patient care</b>	<b>Patient experience</b>	Implementation of NICE Quality Standard 15 - Patient Experience in adult NHS Services and full implementation of the national Friends and Family Test Question	Improve PEQ scores Better capture and utilisation of patient & staff stories Visible Executive and Senior Team leadership ward level walk-rounds Reduce number of complaints
			increase and improve collection of patient experience data	Reduce incidents causing harm to pts
			Delivery of service standards as outlined within the acute service contract Quality Schedule	Full delivery of Quality Schedule service standards
			Work with Governors/Healthwatch – to get greater involvement of patients, quality accounts management and service developments/changes	Improve PEQ scores Develop and deliver Approve Foundation Trust engagement strategy
		<b>Workforce capacity</b>	Ensure safe nurse clinical staffing levels through (i) Nursing Establishment Benchmarking (ii) Acuity (Patient Dependency) Study (iii) Use of e-Roster	Improve PEQ scores Improve staff survey score Achievement of CQUIN and operational targets
			Ensure safe Medical staffing levels through (i) Medical Staffing Review (ii) Junior Doctor Rotas (iii) Consultant Workforce Planning	Improve PEQ scores Improve staff survey score Achievement of CQUIN and operational targets
		<b>Service transformation</b>	Improving care of the frail elderly	Ward based Ortho Physician' 'Aintree at Home' / Transitional care Beds Acute Frailty Unit Delivery of the Dementia CQUIN

			Introduce greater 7 day working as appropriate	Undertake gap analysis against London standards Discuss with Commissioners opportunities for funding the quality improvement
		<b>Standards of care</b>	Achieving the appropriate care standards for all emergency care patients	Delivery of AQ standards for stroke, pneumonia, heart failure, AMI patients, for pneumonia patients
			Improving the service model and care pathway for patients admitted to the hospital as an emergency including the 'acute take'	Maximum wait of 4 hours from arrival to transfer, discharge or admission Reduced delayed discharges Improved PEQ scores
			Reviewing and developing our safety culture & safety thermometer through the delivery of 'Harm free Care' Project (, Pressure Ulcer Prevention, Falls Reduction, E4E)	Reduction in falls, pressure ulcers, catheter induced UTIs Improved nutritional care
			Development and implementation of staff values and minimum standards of behaviour and clinical care	Development of the Aintree Essential Standards Ward Accreditation Tool (AAA)
		<b>Learning from Mistakes</b>	Review of Serious Untoward Incident risk areas	Better triangulation of the data and reduce incidents causing harm to pts
			Review of Complaints processes and revise current approach inc. approach to large scale complaints/trends	Reduction in complaints More timely response
			Adopting a multi-disciplinary approach in reviewing hospital mortality	Better triangulation of the data and reduce incidents causing harm to pts
			Implement revised governance processes to create greater transparency	Implementing the recommendations arising from the External board Review Public Board meetings Agree 'Just Culture' approach to learning from mistakes

	<p><b>Assurance:</b> All quality improvement initiatives are subject to the relevant accountability and assurance structure governed under Safety &amp; Risk, Clinical Effectiveness, Patient Experience and Workforce which includes:</p> <ul style="list-style-type: none"> <li>• Weekly/Monthly Operational Working Groups</li> <li>• Monthly/Bi-monthly Sub Committee Meetings</li> <li>• Monthly progress updates to the Trust Assurance Committee</li> <li>• Quarterly report to the Audit Committee</li> </ul> <p>In addition, to ensure the Trust maintains this positive progress the Trust Executive has agreed to commence internal reporting on the Department of Health core set of indicators, to the Board via the relevant Sub-Committee from April 2012 and to include performance against these indicators in the 12/13 Quality Account.</p>
<p><b>Clinical Strategy</b> (Consistent with information contained within the Trust's published Quality Account).</p>	<p><b><u>Aintree's Clinical Service Development Strategy</u></b></p> <p>Several drivers for change have been used to frame our thinking as we refresh our Clinical Service Development Strategy so that the focus is on service transformation rather than additonality: These include:</p> <p><b><i>The "Right Thing" for the population:</i></b> The changes in commissioning will reward those who deliver improved outcomes for the population based on their current needs as assessed by Health and Wellbeing Boards, Joint Strategic Needs Assessment and the National Commissioning Board. Therefore the Trust must seek to align values, processes and activity to a sustainable outcomes-based approach.</p> <p><b><i>A Clinically Led Vision:</i></b> National policy has shifted towards a clinically led commissioning environment. Therefore, the development of Clinical Heads of Division and other clinical leaders will allow the Trust to operate a clinically-led provider model. This approach will help Aintree develop partnerships across the economy:</p> <p><b><i>A Compelling Story:</i></b> Political and economic imperatives mean that the way we have always done things is no longer sustainable. The Clinical Service Strategy will serve as the framework for sustainable change to be built and owned by all members of the organisation.</p> <p><b><i>Delivers System Awareness:</i></b> Nationally and locally, the current configuration of Health Service Providers is not sustainable on clinical, financial and quality grounds. Staff tend to be aware of their position within individual teams, they may have some awareness of their contribution to the corporate agenda, but if asked to place themselves within the healthcare system many would struggle. The strategy must enable directorates and departments to understand their interrelationships, strategic importance and fundamental interconnectedness as part of the overall system of healthcare.</p> <p><b><i>Transformational Change:</i></b> Financial challenge will require health service providers to deliver the most effective services possible whilst seeking a reduction in cost or increase in overall productivity. Sustainable services will be those that seek transformation in terms of higher productivity, reduction in waste or responsiveness to the changing health landscape.</p>

## Developing the Strategy

In refreshing our Clinical Service Development Strategy for 2014 – 2017, the Trust has engaged consultancy support from Finnamore Ltd. (July 2012) and Ernst and Young (March 2013) to independently review and validate the scale of service transformation that could potentially be delivered.

Their work confirmed that the Acute healthcare provision for the catchment of the Trust (Sefton, Knowsley and Liverpool) is typically 'more intense' than the regional average, the national average, and in a comparator Trust. Therefore, the conclusion was that the potential for shape change in the Trusts core catchment is substantial. Opportunities for change that have been identified include:

- Potential productivity and efficiency improvements through aligning workforce capacity to demand, by improving theatre productivity
- Potential improvements in the productivity and efficiency of theatres through increasing the % utilisation of theatre sessions
- Improving the efficiency of outpatient clinics by reducing DNAs and clinic cancellations
- An increase in the provision of outpatient services outside of the acute hospital setting in the largest 8 specialties by volume: respiratory medicine, ophthalmology, trauma & orthopaedics, rheumatology, gastroenterology cardiology and oral surgery
- A reduction in non-elective admissions through early / rapid assessment in AED and the MAU in the following specialties: general surgery, respiratory medicine, general medicine and elderly medicine, as well admissions under emergency medicine. Together, the impact of shape change in those specialties could account for over 60% of the total potential reduction in admissions (4,900 out of 7,700).
- Changes in elective inpatient admissions within respiratory medicine and urology through shifts to daycase activity and reduced length of stay
- Potential bed day savings through the timely discharge of patients from the acute care setting, mostly in trauma and orthopaedics and respiratory medicine.

In summary this work concluded that the overall potential of shape change for the Trust:

- Day cases reduced by 20%
- Elective inpatients reduced by 8% - 7 beds
- Non elective admissions reduced by 22% - 207 beds
- A&E Attendances reduced by 25%
- And more opportunity through efficiency
- More than 40% of the LOS reduction is accounted for by admitting patients on the day of their procedure

The Trust's Director of Strategy and Innovation and Clinical Heads of Divisions have validated the review undertaken by Finnamore Ltd and their assumptions are outlined in the table below:

- 18% of current activity would not be 'clinically' missed if it were lost as it is not 'core' to an acute provider (conversely, any reduction in activity would undermine the financial viability of the Trust)
- Over 6% of current activity was at risk from a commissioner purchasing from another Acute
- Over 27.5% of current activity was at risk from a commissioner purchasing from Primary Care

- Over 11% of current activity was at risk from a commissioner purchasing from a Community Trust
- Around 34% of current activity was at risk from a competitor
- Only 9.5% of current activity was not at risk

The conclusion of this work has been that the Trust would gain maximum benefit by developing for three distinct Transformational Clinical Strategies:

***Quality Specialist Acute Care – Vision:***

To provide Acute Specialist care to meet the needs of the population. These services should be responsive to acute need, be delivered by appropriate staff at the times required in the most appropriate location.

***Quality Specialist Long Term Condition Care – Vision:***

To provide specialist long term condition care. Work will focus on the use of technology and working with patients to help them self-manage their condition, providing quick access when expert advice is required.

***Quality Diagnostic and Support Services – Vision:***

Access to diagnostic apparatus has been a major driver for co-location of acute and long term conditions services. However, access to diagnostics from a community perspective offers the potential to reduce reliance on activity based services. Therefore the Trust will focus on flexible provision of quality diagnostic and support services which will offer a potential growth opportunity as investigations move closer to the patient, but also as transformational support for Acute and Long Term Conditions care.

The Trust recognises that working in partnership with other health and social care providers is essential in order to deliver this Clinical Service Development Strategy. Consequently, the Trust will continue to actively contribute to any regional service improvement reviews; to work jointly with other primary and acute care providers through the North Mersey QIPP programme; and to actively seek out other opportunities to take forward work that will deliver the objectives for Better Care and Better Value. During the summer of 2013/14 the Trust will work in with its clinicians and stakeholder partners to agree improvement goals for each of the Transformational Clinical Strategies. These improvement goals align with the Quality Strategy and include:

- Improving access/activity
- Improving patient experience
- Improving safety
- Improving partnerships.

These goals will be used to frame annual implementation plans which will drive the delivery of the Clinical Service Development Strategy and service transformation. In order to assess the likely success of identified improvement goals any service development or change will be tested against seven Strategic Principle Tests:

- Is there a public health benefit arising from the delivery of the service?
- Is it a service the commissioners want to buy?
- Does the service have sufficient volume of activity to be clinically safe?
- If the service requires emergency cover, can this be consistently provided to maximise patient safety (24 x 7)?
- Is there sufficient capacity to match demand to ensure all performance standards are

met?

- Is the service essential to maintain key linkages/support for other services?
- Is the service financially viable in the context of tariff income?

### Transformational Clinical Strategies – 2013/15 Priorities

As part of the 2013/14 business planning round the operational Divisions and clinical teams have identified the following priorities for service transformation which will be included in the transformational clinical strategies:

OBJECTIVE	OUTCOMES	PROJECTS	KPIs
<b>OBJECTIVE: To deliver our service commitments</b>	<b>Productivity and efficiency</b>	Improving theatre productivity	(i) Improved scheduling, (ii) Reduction in non-clinical cancellations (iii) Increase average no's of cases per list (iv) Optimise Daycase % in ECC
		Managing demand for diagnostic tests	Reduced demand for inappropriate diagnostic tests
		Improving outpatient productivity	(i) Resource: optimal facility utilisation ('Right Person, Right Place, Right Time') (ii) Informatics : OPD Booking System (iii) Delays , late running, cancellation rates (iv) DNA – text messaging service
		Data Quality; improvements and income optimisation	
		Aligning available service capacity to meet demand eg non-invasive ventilation services and endoscopy services	Achievement of RTT targets
		Delivering savings through better and standardised procurement	
		Improving cancer services	Patients with suspected cancer have their first outpatient appointment within 7 days
		Procurement and implementation of IT systems e.g. e-prescribing for Chemotherapy and theatre management	



	<b>OBJECTIVE: To develop effective partnerships</b>	<b>Partnership working</b>	Increase the range of services available in community settings	Urology community collaborative Knowsley community diabetes services Comprehensive weight management services for Cumbria and Lancashire patients Cardiac rehabilitation services Kirkby LIFT diagnostic assessment and treatment services
			Increased delivery of specialist services in partnership	Phase 2 of Bariatric surgery service implementation Upper GI cancer services Major trauma services
			Continued delivery of DGH services in partnership	Liverpool Clinical Laboratories Service Formation of Liverpool Clinical Laboratories Service

### Clinical Workforce Strategy

The key determinant of high quality, safe patient care is the attitude and behaviour of our staff. Consequently, the Trust will focus on developing a workforce who put patients, their families and carers at the heart of what they do. Our approach to Human Resources and Organisational Development will strengthen the link between patient experience and staff development and performance management by developing feedback loops and developing an organisation with clear Standards and Values at the heart of its day to day business.

The key strengths of the Aintree workforce include:

- Stable workforce which is committed to the delivery of high quality, safe patient care.
- Level of staff engagement equal to national Trust average. (Source: Staff Survey)
- Established clinical leadership structure in place i.e. CHOD/CHBU/Clinical Leads
- Acceptable turnover rate of 8-9%
- Sickness Absence rates improving - now at around 4%

However the following factors may hinder our flexibility to respond quickly to changing circumstances:

- Inflexible pay and reward systems
- Recruitment and retention issues in certain areas e.g. Consultant Anaesthesia recruitment, MAU, Clinical Management post, Pharmacy
- Lack of experience of working in community settings
- Potential redundancies if insufficient redeployment opportunities exist contributing to skills drain from Trust
- Large-scale contractual change
- Reduction in education funding

- Reduced number of medical training posts having an impact on cover
- Impact of change on current cohorts of trainees. Short-term destabilisation of training rotas and clinical placements may jeopardise young careers and compromise future service delivery.
- Impact of graduate-only qualified nursing
- Impact of Francis Report

The Trust intends to address these issues by developing and delivering the Aintree People Strategy 2013-2016 and which will have at its core the overarching aim of: ***Creating an organisation in which our people understand what is expected of them, feel able to do it and, critically, choose to do so.***

The following priorities, identified as part of the 2013/14 business planning process, will be included as integral elements within this strategy:

OBJECTIVE	OUTCOMES	PROJECTS	KPIs
<b>STAFF: Develop our staffs potential</b>	<b>Developing the right culture</b>	To develop a clear vision and strategy for the future	All staff aware of the revised Trust vision and mission statement Common shared values from owned from Board to Ward Transformational Clinical Strategy approved by the Board
		To create a flexible, responsive and affordable organisation	Positive feedback from trainees Full implementation of COMPASS appraisal
		To create a workplace where our people feel safe and well, valued as individuals and able to give of their best	Reduced sickness Reduced turnover Delivery of contract service commitments Improved staff survey scores
		To provide effective HR policies, processes systems and information.	Enhanced Recruitment & Selection processes Extend pre-employment screening for attitude Review Healthcare Assistants Programme (fit for purpose)
		Improving our internal communication	Communications Strategy agreed Communications support for divisional teams Team briefing process updated
	<b>Workforce capability</b>	Development and implementation of staff values and minimum standards of behaviour and clinical care	Clinical and behavioural standards agreed and measured through appraisal

			Developing a skilled, knowledgeable and innovative workforce and capable and confident leaders and managers through the organisation	Improved Bands 1-4 Skills development programme Improved Band 6/7 development programme Improved role clarity
			Develop an effective integrated leadership by establishing the Aintree Staff Leadership College programme	
<b>Productivity &amp; Efficiency</b>	<p>The CIP plan for 2013/14 and beyond takes forward the principles adopted in 2012/13, with delivery aligned against specific themes which principally revolve around:</p> <ul style="list-style-type: none"> <li>• length of stay;</li> <li>• theatre efficiency/productivity;</li> <li>• outpatient productivity;</li> <li>• medical workforce;</li> <li>• clinical support functions (labs, therapies etc)</li> <li>• admin and clerical review (incl. back office);</li> <li>• procurement and drugs; and</li> <li>• non-clinical income generation schemes</li> </ul> <p>In all areas, the principles underpinning the programme are to ensure changes do not:</p> <ul style="list-style-type: none"> <li>• negatively impact on the quality of service provision;</li> <li>• conflict with the strategic priorities;</li> <li>• impact on the service development plans of the Trust.</li> </ul> <p>Each strand has been allocated either for Divisional/Departmental specific delivery (e.g. length of stay), or has been allocated as a Trust led review, either due to the complexity, resources needed to deliver (manpower/expertise), or the need to ensure a consistent approach across the Trust (e.g. medical Workforce job planning).</p> <p>To monitor key metrics in delivery of CIP (e.g. average length of stay etc), the Trust will utilise its Business Intelligence System (aBI), contract monitoring system (SLAM) and other divisional/departmental specific systems.</p> <p><b><u>CIP governance</u></b></p> <p>The Trust has a well-established approach to CIP identification and delivery, adopting a holistic approach incorporated into the business planning cycle. This business planning process comprises of 3 distinct, yet inter-related processes/functions:</p> <ul style="list-style-type: none"> <li>• The <b>Annual Planning Cycle</b> which will facilitate (i) the Trust in determining an agreed set of corporate objectives with clear delivery milestones, (ii) the production of Divisional and Directorate operational business plans, (iii) monitoring and reporting of progress to</li> </ul>			

the Board against agreed corporate objectives and (iv) the production of the Annual Plan submission to Monitor.

- The establishment of a **Portfolio Management Office** which will facilitate the delivery of the business change projects which have been included within operational business plans.
- **COMPASS II Appraisal Programme** which will ensure staff have (i) agreed work based objectives to support the delivery operational business plans (ii) individual personal development plans that drive behavioural and cultural development.

The Annual Planning Cycle comprise of 4 phases:

- **(Oct – Jan) - Horizon Scanning and Confirming the Strategic Direction** - to ensure that our corporate objectives match with national priorities and future commissioning intentions and also that they support the Trust in addressing key risks
- **(Jan – Mar) - Agreeing Divisional Operational Business Plans** – Clinical Heads of Divisions and their clinical teams were provided with a business planning guidance (based on the NHS Operating Framework and local commissioning intentions) and a business planning template for completion. Proposals were categorised as: organisational development / workforce, business developments, quality developments or service and financial improvement proposals
- **(April – March) - Supporting Delivery** - the portfolio management office and the Trust appraisal process (COMPASS II) will be used to ensure delivery of specific schemes.
- **(Ongoing) - Monitoring Progress** - the Executive Team will use quarterly business planning review meetings to monitor the progress of Divisions in delivering their operational business plans and the delivery of Trust Corporate Objectives

CIP schemes once developed are subject to review and voting by multi-disciplinary representatives across divisions/departments before implementation. This 'voting' process ensures clear visibility of each scheme, delivers challenge from outside the divisional boundaries and provides a robust quality impact assessment.

Historic performance of CIP delivery has, hitherto 2012/13, been extremely positive, with £20.8M of cost savings being delivered in the previous two years. 2012/13 however has proved difficult in delivering the transformational change and productivity gains necessary. As such the Trust moves into 2013/14 with a recurrent legacy CIP deficit of £6.6M, which when added to the c4% efficiency requirement for the current year, gives an overall CIP target in 2013/14 of £17.0M.

Aintree operates in a low socio-economic area and has a disproportionate level of high acuity patients than the norm. In light of this, commissioners have agreed to provide £5.0M of financial support to underpin the continued delivery of high quality non-elective services for the local economy. This additional income reduces the CIP target for 2013/14 from £17.0M to £12.0M.

The CIP target of £12.0M is still challenging and in light of this, the Trust has appointed a Director of Transformation, who will be responsible for leading the change programme in conjunction with the clinical service leads and in partnership with CCG's.

This post will form part of a strengthening of the PMO processes adopted in the Trust, with the PMO evolving into a Portfolio, Programme and Project Management Model (P3M). This model is a Business Change process based on a virtual office construct which will align key organisational skills, resources and competencies to prioritise support for the development and delivery of the Transforming Care Business Change Programme.

The (P3M) Model will have an Executive Director Lead (Director of Finance and Business Services) who will oversee delivery of the Trust Transforming Care Programme. The Executive Director will be supported by a Programme Director (Director of Transformation) who will be responsible for the scoping, implementation, monitoring and reporting of the Transforming Care Programme through the action of the (P3M) Office. The (P3M) Office will be managed by a Programme Manager with support from a Benefits Realisation Manager who will form the core (P3M) Office Management function and the (P3M) Team.

The P3M management focuses on an organisation's investment in transformational change and will ensure that:

- Programmes and projects are prioritised in terms of their contribution to the organisation's strategic objectives/risk;
- Programmes and projects are managed consistently to ensure efficient and effective delivery of outcomes; and
- Benefits realisation is maximised to achieve the greatest return from the investment made.

### CIP profile

The main CIP schemes for the Trust are outlined in Appendix 2.

The transformational service redesign schemes are embedded in the ability of the Trust to derive savings in length of stay which will enable the Trust to reduce capacity and fulfil the capacity needs to deliver increases in demand for NHS services going forward, as envisaged in the modelling of the NHS gap. Delivery will be managed and realised through the P3M approach outlined above.

Such schemes involve, but are not limited to, review of the urgent care pathway, GP direct access, the concept of virtual wards, 24/7 hospital, caring for the frail elderly, the productive ward and theatre programmes, partnership working, integrated care pathways, strategic market modelling mapping into local service demand, active medicines management and effective procurement.

### CIP enablers

Clinical leaders are pivotal to the Trust's strategy of delivering sustainable CIP's without negatively impacting on the quality of services. The CIP programme, developed through the annual business planning cycle, is based on a bottom up approach through Clinical Specialties to Clinical Business Units and Clinical Divisions.

Each Division is led by a Clinical Head of Division (CHoD) and each Business Unit, by a Clinical Head of Business Unit (CHBU). These Clinical leads carry the overall responsibility for identifying and delivering CIPs and all schemes that proceed for voting (see section on quality below) have initially been signed off by the respective CHBU and CHoD.

The Trust operates a PMO approach to CIP enablement, which encompasses subject matter experts from IT, HR, Service Improvement, Finance and other corporate areas. Each scheme is assessed for the input requirement from these internal sources.

In addition, external support to the programme will be engaged where appropriate and the costs of such support will be factored into the overall financial plan of the scheme.

	<p><b><u>Quality impact of CIPs: The mechanism</u></b></p> <p>The Trust has a well-established PMO approach to CIP delivery and monitoring, providing a systematic approach to quality assurance of scheme design and identification of risk areas in scheme delivery.</p> <p>Where appropriate the Trust will use metrics to ascertain the deliverability of schemes, for example reductions in bed numbers will use metrics such as average length of stay, and theatre savings through theatre efficiency measures such as slot utilisation.</p> <p>The process for CIP management is as follows:</p> <ul style="list-style-type: none"> <li>• Ideas submitted to the PMO for inclusion in CIP register, (Trust wide, Divisional or Departmental);</li> <li>• Project Initiation Document (PID) developed for individual schemes;</li> <li>• PID identifies rationale for the scheme, expected savings, risks and constraints on delivery and key milestones for implementation;</li> <li>• PID signed off by Divisional/Departmental Team and submitted to PMO;</li> <li>• PID submitted for voting to senior level, cross divisional, multi-disciplinary team. This includes all executive board members of the Trust Voting members are required to assess that the CIP can be achieved without adversely affecting patient care and to consider if there is any 'knock-on' impact on other service areas.</li> <li>• More than 50% of votes must agree to scheme and reasons for any dissensions to be investigated and resolved. If dissention not resolved, scheme will not proceed to implementation. In all cases both the Medical Director and Nurse Director must approve the scheme before it can proceed to implementation.</li> <li>• Key risks and constraints to delivery identified in the PID are reviewed and actions taken to mitigate impact on scheme implementation as necessary;</li> <li>• Fortnightly meeting on SFIP delivery held between the PMO and Divisional teams, together with the Executive Director sponsor for each Division;</li> <li>• Each scheme is monitored for delivery through the milestone plan;</li> <li>• Remedial action plans required should schemes fall behind plan;</li> <li>• CIP progress reported to the Board of Directors as part of the monthly Corporate Report and to the Exec team prior to the Board;</li> <li>• Ad-hoc extraordinary meetings with Divisions/Departments if required.</li> </ul> <p>In addition to the above, the Trust has an operational vacancy review panel to monitor all vacancies within the Trust and ensure there is no undue delay in replacing staff that may impact on the quality of service delivery. This vacancy review panel comprises the Medical Director, Director of Finance and Business Services and the Director of Human Resources.</p>
<p><b>Financial &amp; Investment Strategy</b></p>	<p><b><u>Current financial position.</u></b></p> <p>The Trust met its financial objectives for 2012/13, returning a surplus of £1.27M, an improvement of £0.27M on the original plan. Liquidity remained strong throughout the year and an FRR of 3 was reported.</p> <p>Activity performance through 2012/13 was positive, with elective work, non-elective throughput, outpatient demand and AED footfall all increasing. In 2012/13 this equated to around £4.6M in additional income, although this did not manifest itself in the accounts due to the fixed price contract arrangement in place during the year.</p>

Operational costs remained under control considering the additional throughput, however as outlined above, whilst the CIP target was met in-year, delivery against the recurrent efficiency target stalled, with the consequence that a legacy deficit of £6.6M is being taken into 2013/14.

Our contracts for 2013/14 are agreed. Contract negotiations were favourable, with all the additional activity delivered in 2012/13 built into the baseline position. This helped offset the headline reduction of -1.3% built into tariff prices.

The nature of the contract for 2013/14 is a full PbR contract, excepting non-elective activity, where the Trust has agreed to a fixed price arrangement in return for a 1% increase on the baseline. Whilst this contains some risk should non-elective activity and/or acuity increase, the Trust considers this to be relatively low risk. Furthermore the blocking of non-elective income, negates the impact of the readmission policy to what was agreed in the contract for 2012/13 and gives some surety on income flows against an area which is an area of focus by commissioners for the coming year.

Expenditure budgets for the forthcoming year are robust and reflect 2012/13 outturn delivery. National pay and price inflation have been assessed, as has the impact of any new NICE initiatives prevalent for the year. Funding to deliver our key strategic initiatives has been set aside and are included in the financial planning assumptions.

The 'efficiency gap' for 2013/14 is estimated at £10.4M, which represents c4% of turnover. Taken with the legacy issue from 2012/13, gives an overall target of £17.0M, abated to £12.0M by the additional £5.0M support for non-elective services referred to above.

The continued squeeze of public finances and the impact on the NHS, particularly the secondary care sector, cannot be under estimated. This coupled with rising patient expectations of levels of service and care will mean we can no longer continue in 'the same old way' and we will need to develop new ways of working to meet this future 'efficiency gap'. The Trust is confident that it can meet this challenge, but it represents the main risk moving forward.

Primary care initiatives around demand management as well as our commitment to a joint approach with CCG colleague to ensure that patients receives the right care, in the right place at the right time, means we have considered the impact on future activity flows, however this has to be taken against a backdrop of an increasingly frail, elderly population and increasing consumer demand for utilising NHS services.

The projected financial gap for the NHS includes the need to meet this growing demand, but within limited, but not decreasing financial resources. As such the Trust expects income to remain relatively static throughout the planning period, with tariff reductions being offset by growth in demand. The challenge for the Trust will be to deliver these increases whilst keeping cost increase to a minimum. This forms a major strand in the transformational and productivity agenda over the coming years.

The wider local health economy is in a strong financial position with the local CCG commissioners and Area teams in financial balance, before the 2.3% allocation growth for 2013/14.

We are committed to working with our commissioning partners to ensure health services are delivered in the most effective way and in the most appropriate settings. We remain confident of Aintree's ability to work in partnership to help shape the future provision of health services in our community and that this will lead to a financially sustainable position for the Trust.

A summary of the operating position over the three years of the planning cycle is shown below

	2012-13 Actual £M	2013-14 Model £M	2014-15 Model £M	2015-16 Model £M
Income	280.612	282.166	276.104	275.128
Expenditure (excluding exceptional items)				
Drugs	(21.391)	(21.725)	(21.314)	(20.947)
Clinical Supplies	(32.327)	(31.990)	(31.651)	(32.212)
Non-clinical supplies	(32.935)	(29.282)	(28.928)	(29.853)
Employee expenses	(176.444)	(181.258)	(174.977)	(172.131)
Consultancy expense	(1.028)	(0.720)	(0.700)	(0.700)
Miscellaneous	(2.817)	(2.891)	(2.780)	(2.708)
EBITDA	13.670 4.9%	14.300 5.1%	15.754 5.7%	16.576 6.0%
Depreciation	(7.570)	(7.991)	(9.021)	(9.503)
Interest receivable	0.200	0.050	0.050	0.050
Interest payable	(1.231)	(1.488)	(1.419)	(1.357)
PDC dividend	(3.798)	(3.868)	(4.285)	(4.467)
Underlying Surplus/(Deficit)	1.271	1.003	1.079	1.299
I&E margin	0.5%	0.36%	0.39%	0.47%
Impairments	0.000	0.000	0.000	0.000
Surplus/(Deficit)	1.271	1.003	1.079	1.299
CIP		(12.000)	(15.500)	(10.500)
CIP income generation			(0.948)	(0.948)
CIP total			(16.448)	(11.448)
CIP as a percentage of turnover	0.0%	4.3%	6.0% ✓	4.2%

The trust goes into 2013/14 with a strong liquidity position. Whilst cash resources reduce over the planning cycle as the trust develops its capital estate, liquidity remains healthy and coupled with the forecast revenue position, will deliver an FRR of 3 in each year.

### Key financial priorities

Aintree was accredited trauma centre status alongside local partner organisations. Phasing of patient flows between trauma units and centres has occurred, however the final strategic aim to make Aintree the single receiving site has yet to be initiated. A move to a single site strategy for trauma remains a key priority for the future.

Linked to, but not exclusively due to trauma centre status, is the c£20M urgent care capital development, This incorporates a new accident and emergency department and critical care department and will provide a much improved experience and environment for patients and staff.



The Trust's planning assumptions for 2013/14 include a limited number of investments, c£0.5M, focused on improving the quality of care and hospital experience for our patients. These include the appointment of an Orthopaedic Geriatrician; increased 24/7 consultant cover in critical care; targeted nursing input to improve and ensure delivery of advancing quality programmes; and support to further develop and strengthen the 'governance structures' at divisional level.

### Key financial risks

#### Income

Income delivery of the baseline position and in improving flows through better productivity is a key component of the Trust's strategy and therefore represents a key risk area for 2013/14 and beyond. The main components being:

- Failure to meet activity targets/goals, thus reducing income receipts;
- Tariff reductions being greater than the 1.3% built into the financial planning assumptions, each 1% cut in tariff and/or activity represents c£2.1M;
- Possible under recovery of income from CQUINs, CQUIN represents c£5.7M in 2013/14;
- Penalties fines for non-delivery of national and local targets (e.g. infection control, RTT);
- Trauma centre income flows do not cover costs of service delivery;

To mitigate against these risks:

- The Trust is working with commissioners to agree a benefit sharing programme that will allow service changes to be managed without undermining financial stability;
- CQUIN schemes require little investment to deliver; all targets assigned a lead; a risk reserve of 10% of CQUIN income has been built into the plan;
- Robust monitoring arrangements put in place to track performance against areas of risk for fines/penalties, Operations Group tasked with identifying remedial action plans should performance move off target;
- Trauma element of Specialised Commissioning contract likely to be covered by a fixed price arrangement in 2013/14 which will cover all costs of delivery.

#### Expenditure

Control of operational expenditure budgets is another key component in delivering the financial strategy. The main risks to delivering this requirement are:

- Pay and price inflation increases are in excess of those included in the financial modelling. For 2013/14 the Trust has built the 1% pay award into its plans and therefore there is minimal risk for that year. Going forward pay has been uplifted by a further 1% p.a. Every 1% in excess of this would cost a further c£1.8M p.a. Each additional 1% increase in non-pay inflation increases costs by £0.8M.
- Divisions fail to manage within their operational budgets;

To mitigate against these risks:

- Inflation assumptions included in the plan are prudent across major expense headings (see financial commentary)
- Expenditure budgets reflect 2012/13 outturn;
- Monthly performance reviews which would require over spending areas to identify and implement remedial action plans;

- |  |  |
|--|--|
|  | <ul style="list-style-type: none"><li>• Each main expenditure heading has a contingency reserve, which combined is equivalent to around 1% of total expenditure</li><li>• Further review of efficiency savings targets</li></ul> |
|--|--|

**CIP**

The delivery of the on-going cost improvement programme represents the main financial risk area for the trust in 2013/14 and beyond. The target of £17.0M is extremely challenging, (c6% of income), particularly in light of the c£30M in savings delivered over the previous 4 years. Whilst the Trust will clearly continue to look for further efficiencies wherever possible, it has to be recognised that the on-going delivery of CIPs of this scale, without impacting upon the quality care, will ultimately become unsustainable without greater collaboration in the local health economy.

To mitigate against these risks the trust has appointed a Director of Transformation and an Interim Chief Operating Officer at Board level to develop a 2 year programme and is strengthening its approach to programme management through the P3M approach as outlined above. In addition the Trust is discussing its approach to transformation with local CCGs in order to find a sustainable solution for the Trust going forward.