

**Strategic Plan Document for 2013-14**

**Lancashire Teaching Hospitals NHS Foundation Trust**

# Annual Plan 2013-14

## Summary

This annual plan is designed to ensure that we continue to focus on the delivery of high quality care to our patients as encapsulated in our vision: excellent care with compassion.

As reported in previous annual plans, Lancashire Teaching Hospitals NHS Foundation Trust (the Trust) has three stated strategic priorities, namely:

- the provision of clinical services as district general hospitals
- the provision of specialised / tertiary services for people in Lancashire & South Cumbria
- developing as teaching hospitals to support clinical education and research

These priorities are supported by four strategic objectives which are to enhance quality, improve productivity, reform service delivery and build partnership. Together they provide the focus on clinical quality and financial improvements whilst informing local service planning and development priorities.

Over the past two years, as part of our on-going drive to improve patient care along with an enhanced patient experience, we have reflected on the purpose and values of Lancashire Teaching Hospitals NHS Foundation Trust (LTH). This work has resulted in the following values:

- working in partnership to provide safe and effective care that patients expect and deserve
- enabling confident and competent staff to provide the highest standards of care and services.
- leading improvements in healthcare through innovation, research and education.

We have shared these priorities and objectives with the newly founded Clinical Commissioning Groups (CCGs) as well as our Council of Governors and can confirm that there is broad agreement with what we are seeking to achieve.

## Our strategic context

Lancashire Teaching Hospitals NHS Foundation Trust (LTH) is situated within the Lancashire and South Cumbria region. There are a total of four NHS hospital trusts in Lancashire and South Cumbria, covering a population of 1.6m people.

The commissioning landscape continues to develop with a Lancashire Area Team of NHS England which, along with the Area Team for Cumbria, covers the majority of our catchment population. There are eight clinical commissioning groups in Lancashire with Greater Preston and Chorley and South Ribble CCGs being our major commissioners.

The Trust has actively engaged with the two local CCGs, and a range of channels are in place to build relationships and discuss service priorities – most notably a Clinical Senate that LTH is an active member of. Many of the CCGs' clinical leaders have worked with LTH in the past which provides a foundation to further develop the partnership.

Specialised services commissioning continues to develop with a changing range of services included within the definition set. This brings a new set of opportunities and challenges as the commissioners develop their skill sets.

There are a number of private hospitals in the area providing a range of services. The Trust monitors closely its market share of elective activity levels in key specialties, and the figures remain stable and are as projected. Indeed, through proactive management, the Trust has seen a return of elective activities from the private sector in some areas.

At the moment, there is little competition amongst NHS hospitals in Lancashire and South Cumbria for district general hospital services. However, as more service reconfigurations are taking place in the region, this might change and there could be challenges to existing clinical services at LTH. This situation will be assessed on a case by case basis, and managed accordingly.

The position of the Trust remains strong in terms of size, clinical capabilities and performance. Notwithstanding this, there are a number of challenges that have been discussed internally and have featured in the contract discussions with the CCGs and specialised services team.

The continuing development of the choice agenda and the opening up of the market through policies such as the 'Any Qualified Provider' model, could offer further opportunities to the Trust in the coming years. For 2013-14, there are a number of developments that can be grouped under the following broad categories:

- key initiatives agreed as part of the contract with the central Lancashire CCGS including market share and demand management / admission avoidance schemes.
- planned service developments.
- changes due to notification of a code of conduct.

Some of the above have a positive impact on the Trust's activity and income, while others will have an adverse effect.

There is a strong focus on delivering more services closer to home and managing demands for acute care. They include:

- reductions in follow up rate in selected specialties.
- extended range of direct access tests.
- introduction of referral management tools.

The activity changes identified above have been included in the contract activity schedules and in overall terms represent a fairly steady state for the immediate future.

The Clinical Senate that has representatives from Clinical Commissioning Groups, Lancashire Teaching Hospitals NHS Foundation Trust, Lancashire Care NHS Foundation Trust (mental health and community services provider) and Lancashire Social Services acts as one of the vehicles to support collaborative working, and allows the strategic partners to address whole system issues collectively and identify joint solutions, including prevention of unnecessary admissions and re-admissions.

There are a number of planned major service developments including radiotherapy expansion and vascular services as well as the consolidation of the major trauma service. These improvements aim to enhance the service quality and bring opportunities to the Trust to strengthen its position as a regional centre.

Due to the significant organisational changes that have occurred over the 12 months, there has been a limited response to the Quality Innovation Productivity and Prevention (QIPP) challenge across Lancashire and South Cumbria. Over time, it is likely that more services will be consolidated. The absence of a strategic view for Lancashire is beginning to be addressed by commissioners and providers, both separately and collectively, and is being led by the Lancashire Area Team. This is further driven by

other external drivers such as medical training, recruitment issues and higher service standards. These developments offer both opportunities and threats to the Trust.

LTH is the tertiary centre for a number of specialised services, and the clinical capabilities and infrastructure provide a strong foundation to respond to future challenges. Further expansion of specialised services along with proactive development of research at LTH will strengthen the Trust's position as a regional centre for Lancashire and South Cumbria. This will enhance the Trust's income position and more importantly will enhance patient experience and outcomes. These developments will have impacts on the workforce, capacity and finance and will be managed carefully to ensure success.

At a local level, strategic service changes are organised under the following four priorities:

- improving rehabilitation, ambulatory care and day case surgery.
- delivering high quality acute medical care, particularly for acute admissions.
- streamlining urgent and emergency care.
- providing a 7 day service.

Information management and technology are recognised as key enablers to service and quality improvement and the key developments are being led by a newly-formed IM&T Clinical Strategy Board.

The Trust has also begun a review of its clinical services to ensure they support the delivery of these priorities. The coming year will see the formulation of more long term plans for the Trust in order to ensure it meets the challenges of a modern health service including workforce changes, new technologies and the impact of maturing commissioners.

## **Our approach to quality**

The key safety and quality goals are:

- a reduction in inpatient mortality.
- a reduction in harm
- year-on-year improvement in the patient experience.

The Trust will build on progress to date. Quality continues to underpin improvements in productivity and the reforms in service delivery. These goals will be reviewed in 2013 in the context of the learning from the Mid-Staffordshire NHS Foundation Trust Public Inquiry. The process will involve members, governors and staff and our Safety & Quality Strategy will be updated and published in the autumn.

Our goals will be achieved within a framework of safety and quality programmes facilitating service improvements that are explicitly linked to improved care processes and outcomes. Achievement of these improvements will be supported by a development programme that engages clinicians and harnesses their knowledge and expertise to promote high quality care.

The features of the Trust's safety and quality programmes will continue to include:

- prioritising the areas for improvement.
- measuring, monitoring and reporting progress.
- identifying clinical leaders as champions for change.
- supporting clinical leaders to deliver change.
- improving information and sharing results and outcomes.
- developing the skills and knowledge of all staff.

## *Mortality*

The hospital standardised mortality rate has continued to improve year on year, whilst the summary hospital mortality indicator (SHMI) indicates performance within the expected range. The cumulative strategic goal of reducing mortality by 15% was exceeded and an 18.2% improvement against the 2008-09 baseline figure was achieved. Future reduction in mortality rates will be achieved through the Trust's quality programmes, specifically in relation to enhanced recovery, prevention and management of pressure ulcers, prevention of venous thrombo-embolism and early intervention for deteriorating patient conditions.

## *Safe Care*

The reduction in the numbers of MRSA bacteraemia were not sustained in 2012-13, however the reductions in *C. difficile* infections, medication administration and harm associated with falls were significant. Whilst the number of inpatient falls increased during 2012/13, (due in some part to changing case mix, particularly in respect of the age and acuity of patients that we have seen), improvement actions have contributed to a 37% reduction in harm events associated with falls. During 2012-13, the Trust also achieved its objective to reduce harm associated with medicine administration errors by 5%, with 18 recorded harm events against a trajectory of 24. The revised strategy will continue to focus on the reduction of harm to patients through ongoing delivery of the Trust's quality improvement programmes, benefitting from effective clinical leadership, clear goals and effective monitoring and response systems.

## *Experience of Care*

The use of patient feedback devices provides a wider range of information and more detail about the patient experience. During 2012-13, 10,306 patients have provided responses to questions providing feedback on the quality of services that were over 86% positive. This intelligence, along with national survey and complaints data, informs the Trust's quality programmes and improvement plans, with a specific focus on communication, information and involvement. Patient feedback results are available to wards and departments on a near real-time basis, supporting the development of local, specific action plans.

Safety and quality initiatives are dynamic and constantly evolving in response to learning, innovation and listening to patients. They are at the heart of the Trust's service development strategy and, in a rapidly changing NHS, remain the top priority for patients, public and staff. In the wake of the Francis report, these initiatives and their focus on quality have never been more important in building public confidence in the NHS. The success of these initiatives is grounded in research, supported by a positive culture and driven and sustained through effective leadership (particularly at ward level) team effectiveness, and staff satisfaction. Everyone within Lancashire Teaching Hospitals NHS Foundation Trust has a role to play in improving safety and quality and there are already many excellent examples of services and care provided by highly committed teams and individuals. The evidence on the importance of engagement in the delivery of high quality care is compelling. In revising the Trust's safety and quality strategy, clinical and quality priorities and milestones over the next three years will be developed in consultation with directors, governors, members and staff and will build on the many achievements to date by providing focus, drive and commitment to achieve measurable and sustained improvement. These priorities and milestones will be described within the revised safety and quality strategy and will continue to focus on the delivery of safe, reliable and compassionate care. As a minimum these priorities will be included:

Goals	Key actions	Key milestones	Delivery risks	How risk will be managed
<b>Tissue viability:</b>  Reduction in avoidable pressure ulcers	Root cause analysis (RCA) of causes of all grade 2/3/4 pressure ulcers to identify cases that may be avoided.  Creation and completion of local action plans in response to all RCAs.  Monthly Board report.	2013-14 and 2015-16 milestones will be established as part of the review of the strategy during 2013	Timeliness of clinical assessment and response.	A clinical lead has been identified and is in place. Improvement programmes have been identified and will be subject to ongoing monitoring throughout the year, with rapid response to any deviations from the plan.
<b>Mortality:</b>  Year on year reduction in mortality	Implementation of the Safety and Quality Strategy.  Monthly Board report.	2013-14 and 2015-16 milestones will be established as part of the review of the strategy during 2012-13	Significant changes to case-mix. Rebasing of mortality data.	A clinical lead has been identified and is in place. Improvement programmes have been identified and will be subject to ongoing monitoring throughout the year, with rapid response to any deviations from the plan.
<b>Nutrition:</b>  Assessing and meeting the nutritional needs of all inpatients	Ensure sustained implementation of uninterrupted meal-times initiative. Continue monitoring of compliance with the MUST tool assessment and action plans.  Maintain compliance with CQC outcome 5 'Meeting Nutritional Needs'.  Continue close multi professional working to support delivery of target.  Monthly Board reports.  Monitoring of dietetic referrals of high-risk patients via patient electronic patient referrals.	2013-14 and 2015-16 milestones will be established as part of the review of the strategy during 2013	Significant changes in number of highly dependent patients requiring nutritional support.  Changes in the number of staff able to provide nutritional support.	A clinical lead has been identified and is in place. Improvement programmes have been identified and will be subject to ongoing monitoring throughout the year, with rapid response to any deviations from the plan.

Goals	Key actions	Key milestones	Delivery risks	How risk will be managed
<p><b>Infection prevention:</b></p> <p>Delivery of mandatory targets for the reduction of MRSA bacteraemia and <i>C. Difficile</i> infections</p>	<p>Rationalise the use of urinary catheters, expedite removal and improve documentation of care and management.</p> <p>To refine and expand access to the Outpatient Parental Antibiotic Therapy service in conjunction with the Medicine Directorate.</p> <p>To introduce the administration of a probiotic for all patients on therapeutic antibiotics</p> <p>To provide joint gastroenterology, microbiology, infection prevention and specialist reviews of all patients with <i>C. difficile</i></p> <p>Executive director involvement in RCA meetings with specialist teams Escalation pathway to ensure prompt review of all <i>C. difficile</i> patients</p>	<p><b>MRSA bacteraemia:</b></p> <p>zero tolerance to all trust attributable bacteraemia</p> <p><b>C. difficile:</b></p> <p>41 <i>C. difficile</i> cases for the year</p>	<p>Adverse patient experience.</p> <p>Public confidence.</p> <p>Financial penalties.</p> <p>Failure to comply with the Monitor Governance Framework.</p>	<p>A clinical lead (Director of Infection Prevention and Control) will coordinate improvement programmes that will be subject to ongoing monitoring throughout the year, with rapid response to any deviations from the plan.</p>
<p><b>Falls prevention:</b></p> <p>Year-on-year reduction in incidents of harm due to inpatient falls</p>	<p>Consistent compliance with risk assessment processes</p> <p>Action plan and reporting mechanisms where risk/incidence identified.</p> <p>Embedding of intentional rounding</p> <p>Monthly Essentials of Care Audit Programme (ECAP) audits Monthly Board report.</p>	<p>2013-14 and 2015-16 milestones will be established as part of the review of the strategy during 2013</p>	<p>Ongoing promotion of incident reporting may lead to an increase in the numbers of falls reported that could be interpreted negatively</p> <p>Changes in case mix.</p> <p>Inadequate levels of supervision (workforce)</p> <p>Reliability of incident reporting may vary</p>	<p>A clinical lead has been identified and is in place. Improvement programmes have been identified and will be subject to ongoing monitoring throughout the year, with rapid response to any deviations from the plan.</p>

Goals	Key actions	Key milestones	Delivery risks	How risk will be managed
<p><b>Safe administration of medicines:</b></p> <p>Year-on-year reduction in incidents of harm due to medication error</p>	<p>Monthly review of compliance with National Patient Safety Agency (NPSA) targets.</p> <p>Planned audit cycle including: a) clinical incident reports, b) practice of controlled drugs and prescription intervention, c) prescription chart audit and compliance, d) safe storage of medication.</p> <p>Monthly Essential Care Audit Programme (ECAP) audits. National Reporting &amp; Learning Service (NRLS) reports to identify comparative difference to peers.</p> <p>Use of local remedial action plans. All medication incidents are subject to root cause analysis.</p> <p>Use of the Incident Decision Tree is encouraged to support a fair blame culture.</p>	<p>2014-15 and 2015-16 milestones will be established as part of the review of the strategy during 2013</p>	<p>Reliability of incident reporting may vary.</p> <p>Lack of engagement in Root Cause Analysis.</p> <p>The inaccurate perception of a blame culture may lead to underreporting.</p>	<p>A clinical lead has been identified and is in place. Improvement programmes have been identified and will be subject to ongoing monitoring throughout the year, with rapid response to any deviations from the plan.</p>
<p><b>Privacy and Dignity:</b></p> <p>Year-on-year improvement in patient confidence in respect of promotion and preservation of privacy and dignity</p>	<p>Maintain a suitable environment where patient's privacy and dignity is protected at all times.</p> <p>Promoting effective communication, reflected in positive staff behaviours and attitudes.</p> <p>Ensure that patients who are dying have access to the highest standards of care within an environment that protects their privacy and dignity.</p> <p>Maintain and enhance same sex accommodation arrangements.</p> <p>Annual patient survey underpinned by monthly patient feedback data</p>	<p>2014-15 and 2015-16 milestones will be established as part of the review of the strategy during 2013</p>	<p>Activity levels.</p> <p>Delayed transfer of care / discharge.</p>	<p>A clinical lead has been identified and is in place. Improvement programmes have been identified and will be subject to ongoing monitoring throughout the year, with rapid response to any deviations from the plan.</p>



Goals	Key actions	Key milestones	Delivery risks	How risk will be managed
<p><b>Involvement in Care:</b></p> <p>Year-on-year improvement in patient confidence in the extent to which they are involved in decisions about their care</p>	<p>Promotion of positive staff behaviours and attitudes.</p> <p>Increased patient engagement and involvement in clinical and care decision-making.</p> <p>Increase access to information to support decision-making.</p> <p>Embedding of bedside handovers, integrated care pathway documents and ward round standards</p>	<p>2014-15 and 2015-16 milestones will be established as part of the review of the strategy during 2013</p>	<p>Capacity of staff to support timely information sharing.</p> <p>Failure to assess patients' desired levels of involvement</p> <p>Accessibility of key clinical staff.</p>	<p>A clinical lead has been identified and is in place. Improvement programmes have been identified and will be subject to ongoing monitoring throughout the year, with rapid response to any deviations from the plan.</p>
<p><b>Patient Information:</b></p> <p>Year-on-year improvement in patient confidence in the quality of information communicated and received</p>	<p>Maintain accreditation for published patient information (Information standard).</p> <p>Continue to develop / strengthen the communication skills of the front line staff.</p> <p>Explore and develop wider platforms to support delivery.</p>	<p>2014-15 and 2015-16 milestones will be established as part of the review of the strategy during 2013</p>	<p>Limited access to information resources capacity to support timely information sharing.</p>	<p>A clinical lead has been identified and is in place. Improvement programmes have been identified and will be subject to ongoing monitoring throughout the year, with rapid response to any deviations from the plan.</p>

## **Clinical strategy**

Throughout 2012-13 the Trust has undergone a programme of work entitled “Better for Patients” which has entailed a review of elective and non-elective pathways.

This work stream was led by Right Place Consulting, an organisation that specialises in working with existing clinical teams utilising a structured project management approach. This has helped deliver significant pathway changes that have improved both patient care and efficiency.

Included within this programme was a specific specialty viability work stream. This review utilised our existing service line/patient-level costing intelligence along with our current and future workforce data as well as a forecast of anticipated service changes that will be driven by the Francis report and other quality drivers.

This review confirmed that we need to plan for a number of economic and service consequences of workforce and quality changes. We are therefore engaged in recruiting a new director responsible for driving these strategic changes, including engaging with all commissioners and other internal and external stakeholders. It is unlikely that this will change the overall strategic priorities but will lead to a change in the way our assets are currently used.

This work will be supported by a comprehensive review of the impact of technological advances, in particular in areas such as imaging where developments are moving at pace. This review will inform our capital programme and our approach to funding long term investments.

## **Workforce strategy**

The Trust continues to implement its human resources strategy which was agreed in early 2012. The strategy, which is modelled on an organisational development approach, is concerned with creating sustainable improvements in business results by:

- achieving successful outcomes at every step.
- getting everything and everyone working together.
- expanding the knowledge base and developing problem solving techniques.
- realising collective and individual potential.
- integrating purpose, vision, mission and values.

This strategy is supported by a leadership development strategy and a talent management process, both of which are aimed at ensuring that staff at all levels are given the opportunity to develop their potential and that there is a ‘pipeline’ of organisational talent. In 2012-13 there was a focus on the development of clinical leadership skills aimed at ensuring key clinical leaders are involved in making decisions that impact on patients. This has been particularly successful and has seen greater clinical engagement in strategic decisions than ever before. There will be a continued focus on the development of senior nursing and consultant medical staff in the year ahead.

In respect of the board, we now have a full complement of non-executive directors, having held a successful recruitment round in March 2013. The skills and composition of the Board was reviewed prior to commencing recruitment and in the coming year there will be further focus on board development. The Trust has already participated on the *Boards on Board* programme with the NHS North West Leadership academy and is keen to build on this work.

Board effectiveness continues to be evaluated in a number of ways. These include:

- annual appraisal for all NEDs which assesses their competence against a skills, knowledge and behavioural framework with the outcomes of each individual assessment being collectively considered to determine the strengths and areas of development for the group as a whole (internal).
- annual appraisal for all executive directors (internal).
- Chairman's appraisal which is a 360° feedback process involving NEDs, executive directors and governors (internal).

Organisational effectiveness is further enhanced through a governor effectiveness survey which provides governors with the opportunity not only to reflect on their own performance as individuals and a group but to evaluate the effectiveness of the council as a whole.

With the changing role of the governors, there will be a further focus on governor development in 2013-14 as the Trust supports governors to be effective in their current role and prepare for the changes ahead.

The focus on the integration of the Trust's values will continue in 2013-14. Key work streams include:

- embedding values assessment in recruitment processes
- ensuring job descriptions are explicitly linked to values
- assessing staff's performance in respect of the values through annual appraisal
- publicising the values across the organisation through new and innovative communication techniques

Leadership in the divisions and directorates is critical to enabling change in a manner which supports the values to which we aspire. Having filled a number of gaps in the management structure in 2012-13, this year will bring a focus on ensuring the teams are developed and supported to deliver excellent care with compassion.

A number of service changes and workforce reviews (for example therapies and pharmacy) have taken place in 2012-13 and these will continue into the next year as the Trust continues to drive its three major reform programmes. We will continue to emphasise the importance of lean and the use of service improvement methodologies as a way of streamlining processes, releasing efficiencies and improving effectiveness.

## **Productivity and efficiency**

For 2013-14 the Trust has a £22m efficiency programme consisting of large cross-cutting, corporate schemes and specialty specific plans. The Trust had a recurrent shortfall in 2012-13 of £2m of the £21m programme.

During 2012-13 a virtual Programme Management Office (PMO) was in place and supported the development and delivery of the programme. The recruitment of a new Transformation Director in May 2013 has introduced enhancements to the programme including the central management of the PMO which aims to introduce economies of scale, consistent approaches and shared knowledge and resource across the strategic programmes. A review of the PMO structure and fitness for purpose against the evolving programme is also taking place.

The existing monitoring and control process of the programme will continue. The Trust has already enhanced the qualitative review and risk assessment part of the process and escalation through the Efficiency Programme Board.

CIP targets are allocated at divisional level. Divisions undergo efficiency planning sessions within their operational teams to identify areas for potential efficiencies. Divisions also participate in a number of national benchmarking initiatives that help identify areas of efficiency.

Schemes are worked up at divisional level and recorded on an efficiency template for circulation to the relevant authorising officers within the division. The template requires the division to identify clinical and delivery risks associated with the scheme prior to sign off by the authorising officers who include lead clinician, nurse and accountant.

Schemes are then circulated to members of the Programme and Delivery Boards which include all executive directors and the senior management team. Schemes are not approved until any risks identified during a voting process have been resolved to the satisfaction of the individual who raises the risk. The Chief Executive, Medical Director, Nursing Director and the Finance Director also have the option to veto any scheme if they believe that the scheme may have a negative impact on the operation of the Trust.

The Trust monitors achievement of targets through a monthly Programme Board which considers:

- annual divisional targets
- review of major schemes
- barriers to current progress and cross Division issues
- support/resources for individual schemes
- high risk schemes
- benefits review

Divisions are held accountable through a monthly Delivery Board and fortnightly individual divisional review.

The monthly finance report to the Board of Directors identifies any shortfall against target, its effect on the overall financial plan and the Trust's strategy to ensure the financial plan risk rating is achieved. The Trust's financial plan includes a contingency for non-achievement and a surplus of 1%. The Trust may approve investment but does not implement future investment until efficiencies are identified. The Trust has a good track record of ensuring the planned risk rating has been achieved despite in year slippage on efficiency schemes.

## **CIP Profile**

The main elements of the Efficiency Programme for 2013-14 are:

1. Review of patient flow, particularly the emergency pathway throughout the organisation.
2. A review of services on both hospital sites will reconfigure services and re-provide the same services to the population.
3. Outpatient Services will be redesigned to provide a centralised & uniform service across the organisation. Central booking and management of clinics will ensure duplication and waste is eliminated.
4. Theatres & Endoscopy utilisation is a programme that is close to full delivery. The programme is almost at the end of a 2 year development and is seeing many clinical and operational benefits which will culminate in the planned financial saving.

5. Medical workforce planning & strategic administrative review. An external review has been commissioned to provide an analysis and potential efficiency plan for both medical & administrative workforces. Efficiencies in these areas have previously been managed by individual specialties.
6. Procurement of both medicines and general supplies & services has seen major changes in approach over the last 12 months. The main Procurement department managerially transferred to be located within the Finance Directorate and this has introduced efficiencies in practices with integration with the accounting teams. The Procurement team has a detailed programme of work with each directorate and also across strategic programmes for process reduction and catalogue rationalisation.

## **CIP enablers**

The Trust has seen a significant change over the last two years in the clinical engagement within the organisation. Clinicians are involved at every level of discussion from the divisional workshops and directorate meetings to the management team discussions and individual programme development meetings. Clinicians are actively involved in activity and capacity discussions and have become part of the management process for changes and improvements.

The investment in the PMO has also supported the programme delivery and includes investment in back office functions including finance, IT, information and human resources. The impact of the efficiency programme on these functions is significant and without this investment the programme would be hindered.

## **Quality impact of CIPs**

The Trust ensures the quality impact of CIPs is considered at an early stage by ensuring directorate clinical and nursing staff are satisfied for the scheme to progress. The scheme is then distributed to a wider audience including other divisional nursing staff. Finally, the Executive nurse and medical posts have a right of veto on any individual scheme, regardless of divisional approval.

The on-going review of CIPs will be driven by nature of the individual programme. With regard to the large cross cutting schemes we have agreed that the CCGs will have the opportunity to the schemes both prior to and following implementation.

## **Financial Strategy**

The Trust's financial strategy is to maintain a financially viable organisation capable of delivering the needs of the future through:

- understanding the healthcare environment
- maximising income from meeting population needs
- reducing cost by attention to detail and innovation
- a workforce committed to achieving effectiveness and efficiency

Over the last few years, the Trust has seen increases in activity however in 2012-13 this changed. In addition, the commissioning landscape has significantly changed with a number of new relationships being developed. The focus of attention in 2012-13 was therefore the improvement to patient pathways and reduction to costs and this continues in the plan to March 2016.

A summary of the financial plan is shown overleaf:

	<b><u>2012/13</u></b> <b><u>Plan</u></b> <b><u>£m</u></b>	<b><u>2012/13</u></b> <b><u>Actual</u></b> <b><u>£m</u></b>	<b><u>2013/14</u></b> <b><u>Plan</u></b> <b><u>£m</u></b>	<b><u>2014/15</u></b> <b><u>Plan</u></b> <b><u>£m</u></b>	<b><u>2015/16</u></b> <b><u>Plan</u></b> <b><u>£m</u></b>
Income	390.0	402.2	396.6	392.0	391.3
Expenditure	364.9	379.9	371.4	365.6	364.9
EBITDA	25.1	22.2	24.8	26.1	26.1
Net Surplus/(Deficit) before exceptional items	3.8	1.9	3.8	3.8	3.9

Future years' plans are predicated on the following assumptions:

- activity to follow outturn unless there are specific CCG plans in place that will change the service
- in the early years of the plan tariff deflation is significant however this is expected to even out over the later years of the plan
- future changes from Payment by Results are unknown and not included in the plan
- pay inflation to remain low given the national financial position
- non-pay inflation to remain at 2.5% over the period of the plan

The assumptions above result in a plan that requires efficiency savings per annum of 6% in 2013-14, 4.5% in 2014-15 and 2.5% in 2015-16. The efficiency requirement is beyond the Trust's original QIPP modelling which expected large efficiencies up to 2013-14 and returning to previous levels from 2014-15 onwards. The main aim of the financial strategy is therefore to enable the Trust to achieve significant efficiency savings to March 2015.

The Trust's financial strategy recognises that growth from patient activity will not be significant in the period of the plan. However, there are a number of service developments that the Trust is currently working on – development of specialist rehabilitation services to complement designation as the Lancashire Trauma Centre, extension to renal dialysis services, the national cancer reform strategy and centralisation of vascular services. These are not reflected in the plan at this stage, and are likely to have a positive impact overall in terms of contribution to overheads.

Until the effect of these service changes are known, the main part of the Trust's financial strategy is therefore the need to achieve significant efficiency savings through reduced expenditure. This has necessitated an increased investment programme partly funded externally via loans and PDC. In addition to 'invest to save' schemes, the Trust has been developing patient pathways to improve the patient experience and use pay resources more efficiently; the Trust currently spends over 8% of its pay expenditure on flexible working i.e. locum, bank, agency and overtime. The Trust is also placing a significant emphasis on its procurement strategy having invested in resources and technology to support this programme.

The Trust is part-way through implementing a case note digitisation system which will significantly reduce the resources associated with managing patient records. The scheme will offer significant savings in future years however during implementation will have a number of additional costs some of which have been classified as restructuring costs in agreement with the Trust's auditors.

The plan reflects an estimate of the impact of good housekeeping annual fixed asset impairments and an estimate of the 5-year estate revaluation.

The Trust is planning on a risk rating of 3.