

Strategic Plan Document for 2013-14

Cambridge University Hospitals 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):

Name	David Smith
Job Title	Director of Finance
e-mail address	davidrsmith@addenbrookes.nhs.uk
Tel. no. for contact	01223 217357
Date	31 May 2013

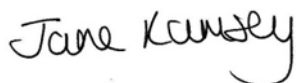
In signing below, the Trust is confirming that:

- The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;
- The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;
- The Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;
- All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission.

Approved on behalf of the Board of Directors by:

Name (Chair)	Jane Ramsey
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Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Dr. Keith McNeil
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Signature



Approved on behalf of the Board of Directors by:

Name (Finance Director)	David Smith
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Signature



Executive Summary

Context

- We provide District General Hospital services for the local population and specialist services for people from the region and beyond. We have a significant focus on research and teaching.
- We are part of a successful Academic Health Science Network and our health outcomes remain amongst the best in the country.
- Performance, quality, patient safety and patient experience remain at the top of the Board's agenda. Our priority remains the care of our patients and we are treating more people than ever before and our health outcomes remain amongst the best in the country.
- The Board of Directors and the Council of Governors are reviewing how the Trust performs in a whole range of areas linked to the recommendations of the Francis Report into care failures at Mid Staffordshire Foundation Trust.
- We have reviewed our strategic goals, objectives and strategic planning arrangements to ensure services are safe and viable for the long term.
- The Quality Committee has reviewed its approach to the Quality Account to create a greater level of staff and patient awareness of patient safety issues.
- The Trust has taken a number of active measures at Board level and operationally to make changes since it was found to be in significant breach of its terms of authorisation in November 2012. A turnaround director is leading a revised Turnaround Programme with fourteen work streams. A new Programme Management Office is in place.
- Meeting national and local performance standards remains a key focus for the Board.
- The population in Cambridgeshire is predicted to continue growing. It is estimated that by 2021 there will be 33,000 more people aged 65 and over in Cambridgeshire (a 33% increase). The Trust is assessing options for increasing facilities on site to meet capacity requirements; and for developing services in community settings.
- The financial position across the health economy and in social care will remain challenging into 2013/14 and beyond.
- The Trust's geographical position within the region means that competition is constrained particularly for District General Hospital (DGH) type services.

Strategy and Direction

- The Trust is keen to promote a systems based approach to tackling the demand for District General Hospital (DGH) services with its partners in the health economy.
- The Trust works with partners across the local health economy and beyond including on the development of a short term programme to develop and integrate health and social care for older people; and is fully engaged with the Contingency Planning Team (CPT) appointed at Peterborough and Stamford Hospitals NHS Foundation Trust to develop a plan which ensures the sustainability of services for patients and minimises the need for further funding from the taxpayer.
- The Trust is participating in the Commissioner-led process for integrating services particularly in the light of changes to services once Cambridgeshire Community Services (CCS) ceases to exist. The Trust recognises the risks inherent in this process and will continue to assess opportunities to mitigate them.
- The eHospital Programme to provide world-class clinical information systems and drive new ways of working is now underway. We expect eHospital to reduce some marginal costs and to provide a platform for the development of integrated care.
- The Transforming Pathology Partnership which will deliver a new service model for acute and community pathology services across 7 Trusts starts in October 2013.

- The strategic partner for The Forum project (education centre, private hospital, hotel and conferencing facilities and associated retail and car parking) has been selected with contracts due to be signed in the summer of 2013.
- Cambridge Biomedical Research Centre (Cambridge University Hospitals and the University of Cambridge) is in the second year of £110 million of government funding (NIHR) to invest in existing and new research themes.

Finance

- The Trust's overall financial objective is to achieve a sustainable financial future. Whilst the Trust has achieved a £4m surplus in 2012/13, this was achieved with the help of various sources of non-recurrent funding and other one-off benefits.
- The underlying financial performance of the organisation may be obscured for potentially 3 years due to the Trust's eHospital project, which carries with it significant up-front costs, but is then expected to facilitate the achievement of significant financial and operational efficiencies for the Trust, whilst at the same time upgrading the Trust's ageing IT infrastructure and providing state of the art clinical systems to the hospital. Although the annual plan has been prepared on the basis of including the costs and benefits of eHospital, the Board is committed to monitoring the Trust's ongoing financial performance both including and excluding the impact of eHospital. This is to ensure that the underlying financial performance of the Trust is not masked by the impact of eHospital.

1. Our patients

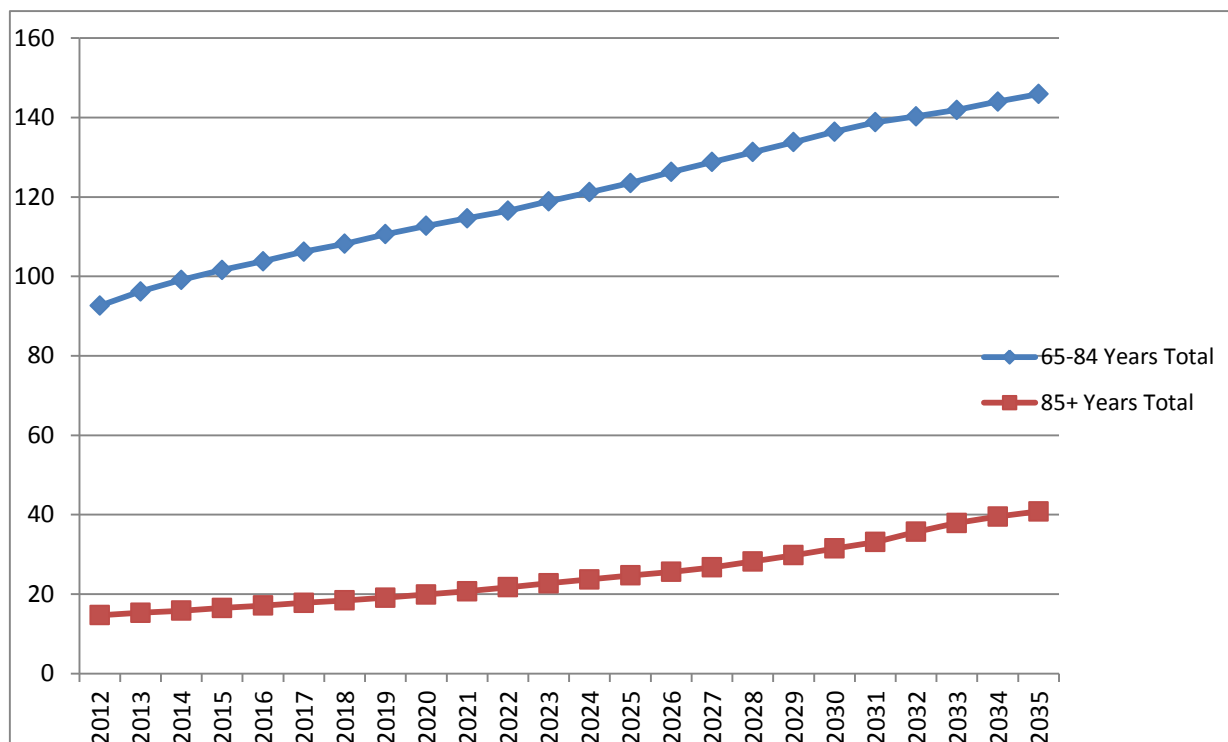
We provide District General Hospital services for the local population and specialist services for people from the region and beyond. Our patients predominantly come from Cambridgeshire, Essex, Suffolk and Hertfordshire.

As well as providing clinical care, we have a significant focus on research and teaching. We are part of a successful Academic Health Science Network.

Performance, quality, patient safety and patient experience remain at the top of the Board's agenda. Our priority remains the care of our patients and we are treating more people than ever before and our health outcomes remain amongst the best in the country. The Trust was named Trust of the Year by Dr Foster in December 2012 on the basis that more patients are surviving following treatment at Cambridge University Hospitals (CUH) than would be expected and that the Trust is performing well on many efficiency measures.

In Cambridgeshire

- It is estimated that there are 605,400 people living in Cambridgeshire, 17.3% are under 15 years of age and 16.3% are over 65+.1 Cambridge City has the highest concentration of the adult working age (16-64 years) age population at 73% of its total population compared to 65.2% on average in Cambridgeshire.
- Life expectancy at birth in 2008-2010 was higher than average for England in all Cambridgeshire districts except for Fenland
- Population forecasts suggest that the population of Cambridgeshire is set to increase by 13% between 2011 and 2021 (78,400 people in total), with the majority of the increase seen in Cambridge City and South Cambridgeshire (2011-2021). This is associated with a forecast increase in the number of new dwellings in the same period, of 44,100. Further population forecasts suggest that the population of Cambridgeshire is set to increase by 21.1% between 2011 and 2031 (128,900 people in total), with the majority of the increases also seen in Cambridge City and South Cambridgeshire. The population of older people is expected to grow significantly. Comorbidity is common in older patients and greatly increases the complexity of managing disease. These factors reinforce the need for a more integrated approach to the care of older people.



Population projections: Older people in Cambridgeshire (000s)

- Cambridgeshire has a predominantly white population. However, Cambridge City has a higher proportion of people from non-white ethnic groups, many of whom are students or professionals. There are also considerable numbers of Travellers and migrant workers within Cambridgeshire.
- Deprivation varies greatly across the county, with Fenland, north-east Cambridge and parts of North Huntingdon having the highest levels of relative deprivation. The same pattern exists for children living in poverty. Income deprivation for older people is more widely dispersed.
- Cambridgeshire is a predominantly rural area; a significant proportion of the population do not have access to a car.
- It is estimated that 35,000 households in Cambridgeshire experience fuel poverty (more than 10% of income required to heat the home). Cold homes during severe winter weather increase the risk of illness and hospital admission for infants and older people, particularly from chest infections, heart attacks and strokes.
- There are on average around 4,800 deaths a year in Cambridgeshire (2008-2010). Circulatory disease and cancer are the main causes of death in the overall population. Cambridgeshire has rates of mortality from all causes significantly lower than for England as a whole. The same is true for mortality from cancer, mortality from circulatory diseases and premature mortality. Conditions originating in the perinatal period and transport accidents are the main causes of death for children.
- Across the county as a whole 15% of residents have a limiting long term illness.

In Essex

- The older population is expected to grow to 28% by 2033, with a 5% reduction in the working age group. Currently 12.4% of the population are from ethnic backgrounds and 30% of travelling families in the county live on unauthorised sites. Essex has some of the most affluent and some of the most deprived areas in the country, with further pockets of disadvantaged communities that are hard to identify.
- Although the trend in life expectancy is upward, there is a 3.5 year gap between males and females across Essex, with more inequalities in disadvantaged communities.
- There is a decreasing trend in cancers and cardiovascular diseases across Essex but with geographical and gender differences. Mortality from chronic obstructive pulmonary disease (COPD) is decreasing.
- The prevalence of diabetes is likely to rise over coming years
- The level of accidental mortality and intended deaths is relatively high in Essex, with the home and roads being the most common sites.
- There is a rising rate of obesity

In Suffolk

- The population is ageing with significant projected growth of those aged 65+
- There are significant social and health inequalities in relation to age, gender, ethnicity, socio-economic groups and disability
- The prevalence for cardiovascular disease and diabetes is higher than the national average for some areas of the county
- The overall incidence of cancer has been increasing
- More than half the local adult population is overweight and obese
- The proportion of the local child population who are overweight or obese is rising

In Hertfordshire

- 1 in every 5 households contains residents who are all aged 65 and over.
- Over 80% of residents say they have either very good or good health.
- 14% of residents say they have a long-term health problem or disability that limits their day to day activities.

Source: County Joint Strategic Needs Assessments

Against this background, the following table shows actual activity in 2012/13 and projections for 2013/14, 2014/15 and 2015/16 by activity type, including Monitors reporting structure. Further details are set out on page 31.

Activity Growth Projections										
	2012-13							Growth %		
	Plan	Actual	Variance	Variance %	Plan 2013-14	Plan 2014-15	Plan 2015-16	2013-14	2014-15	2015-16
Admitted Patient Care:										
Elective										
Day Cases (Excludes Regular Day Attenders)	54,756	58,827	4,071	7.4%	60,651	61,743	62,854	3.1%	1.8%	1.8%
Inpatients	18,861	18,789	(72)	(0.4%)	19,543	20,854	21,211	4.0%	6.7%	1.7%
Total Elective	73,617	77,616	3,999	5.4%	80,194	82,596	84,064	3.3%	3.0%	1.8%
Non-Elective	52,481	52,430	(51)	(0.1%)	53,517	54,275	55,030	2.1%	1.4%	1.4%
Total Admitted Patient Care	126,098	130,046	3,948	3.1%	133,711	136,871	139,095	2.8%	2.4%	1.6%
Outpatients:										
First Attendances ***	130,979	136,756	5,777	4.4%	136,006	140,038	142,206	(0.5%)	3.0%	1.5%
Follow-up Attendances ***	396,190	403,930	7,740	2.0%	408,108	422,101	428,400	1.0%	3.4%	1.5%
Outpatient Procedures ***	80,707	81,284	577	0.7%	105,084	108,846	110,528	29.3%	3.6%	1.5%
Total Outpatients	607,876	621,970	14,094	2.3%	649,197	670,985	681,135	4.4%	3.4%	1.5%
Accident & Emergency										
	100,490	98,720	(1,770)	(1.8%)	99,577	100,632	101,700	0.9%	1.1%	1.1%
Other:										
Chemotherapy Delivery *	14,273	17,300	3,027	21.2%	16,614	16,864	17,120	(4.0%)	1.5%	1.5%
Chemotherapy Procurement *	13,769	16,168	2,399	17.4%	15,314	15,537	15,767	(5.3%)	1.5%	1.5%
Critical Care Bed Days	37,876	35,813	(2,063)	(5.4%)	37,785	37,943	38,027	5.5%	0.4%	0.2%
Diagnostic Tests / Examinations	2,253,082	2,331,491	78,409	3.5%	2,361,511	2,412,335	2,465,500	1.3%	2.2%	2.2%
Radiotherapy	52,826	50,489	(2,337)	(4.4%)	52,317	53,359	54,374	3.6%	2.0%	1.9%
Rehabilitation Bed Days	9,031	9,274	243	2.7%	10,186	10,274	10,365	9.8%	0.9%	0.9%
Renal Dialysis Sessions	70,523	64,894	(5,629)	(8.0%)	65,473	66,823	68,301	0.9%	2.1%	2.2%
Other **	201,115	257,465	56,350	28.0%	512,517	518,155	523,854	99.1%	1.1%	1.1%
Total Other	2,652,495	2,782,894	130,399	4.9%	3,071,717	3,131,289	3,193,309	10.4%	1.9%	2.0%
Grand Total	3,486,959	3,633,630	146,671	4.2%	3,954,202	4,039,777	4,115,238	8.8%	2.2%	1.9%
Monitor Categories:										
Elective Inpatients	18,861	18,789	(72)	(0.4%)	19,543	20,854	21,211	4.0%	6.7%	1.7%
Elective day case patients (Same day)	54,756	58,827	4,071	7.4%	60,651	61,743	62,854	3.1%	1.8%	1.8%
Non-Elective	52,481	52,430	(51)	(0.1%)	53,517	54,275	55,030	2.1%	1.4%	1.4%
Outpatients - first attendance ***	130,979	136,756	5,777	4.4%	136,006	140,038	142,206	(0.5%)	3.0%	1.5%
Outpatients - follow up ***	396,190	403,930	7,740	2.0%	408,108	422,101	428,400	1.0%	3.4%	1.5%
Outpatients - procedures ***	80,707	81,284	577	0.7%	105,084	108,846	110,528	29.3%	3.6%	1.5%
A&E	100,490	98,720	(1,770)	(1.8%)	99,577	100,632	101,700	0.9%	1.1%	1.1%
Other NHS activity * / **	2,652,495	2,782,894	130,399	4.9%	3,071,717	3,131,289	3,193,309	10.4%	1.9%	2.0%
Total	3,486,959	3,633,630	146,671	4.2%	3,954,202	4,039,777	4,115,238	8.8%	2.2%	1.9%
* Subject to major improvements in recording of Chemotherapy activity										
** Introduction of new activity counts from 2013-14 (i.e. Unbundled Diagnostics, Maternity Pathway, PTS etc)										
*** Changes in outpatient billing units due to extension of Outpatient procedure currency usage										

Activity projections for 2013/14 onwards are subject to considerable counting methodology changes, including new contracts currencies (Maternity Pathways, Unbundled Diagnostics etc).

During the year, we have continued to work with the Cambridgeshire Adults Wellbeing and Health Overview and Scrutiny Committee on subjects important to the community's health. The Overview and Scrutiny committee has been particularly concerned about the number of patients whose discharge is delayed awaiting social or health care provision in the community. All health and social care organisations, including primary care, social services, hospitals and community services are working together to consider how they can work better together to ensure that patients can be discharged safely and appropriately without experiencing significant delays. The Trust is aware of the priorities set out in the Joint Strategic Needs Assessment, many of which relate to public health measures. However, it has led a successful and sustained initiative to reduce alcohol related violent crime and is working with partners to review whether a similar approach can have an impact on reducing road injuries and deaths.

We will review opportunities to work with other counties during the year.

2. What our commissioners want

The Trust enjoys positive working relationships with our new commissioners, including clinical commissioning groups (CCGs), NHS England and the local authority.

NHS England commissions specialised, highly specialised, dental, screening, offender health care and military health services based on a national algorithm. Proportionately this is now our biggest contract (£225m). The local authority now commissions sexual health services (excluding HIV which is specialised) from the Trust.

We will work with commissioners and partners to ensure a smooth transition to more integrated community services following Cambridgeshire Community Services withdrawal from the Foundation Trust application process.

We will engage as appropriate with the key priorities of the Health and Wellbeing Strategy for the county.

The Trust works closely with our main CCG, Cambridgeshire and Peterborough, to deliver their commissioning strategy which focusses on 3 main priorities:

- Urgent care for older people
- Strategy for end of life care
- Variation in cardiac care

In addition there are a number of ongoing developments to address improvements in pathways:

Improving pathways for elective care:

- Musculo-skeletal services (MSK)
- Diabetic services
- Ophthalmology services
- Ear nose and throat services (ENT)
- Urology services
- Gastroenterology services
- Gynaecology services

Improving pathways for emergency and unplanned care:

- All patients aged 75 years or over admitted to the Trust, via the emergency pathway, are to be screened for frailty using the clinical frailty scale (CFS) within 72 hours of admission.
- All Frail Elderly patients admitted to the Trust are to be managed under the care of a senior member of the Department of Medicine for the Elderly (DME) Team.

Each clinical division has set out detailed Quality, Innovation, Productivity and Prevention (QIPP) proposals within its business plan. These include proposals to increase evidence based practice and service modernisation; and centralisation to achieve greater cost effectiveness.

Commissioners have invited applications from suitably qualified providers (Any Qualified Provider AQP) for the provision of local, direct access dual energy x-ray absorptiometry (DEXA) diagnostic services. The Trust has responded to the tender opportunity and as we comply with the requirements set out in the service specification, we expect to be approved as a supplier when the new contract is introduced. We were successful in our AQP bid to provide community ultrasound services and are already undertaking scans through the associated contract.

The Trust is developing a consultant led specialist service in the community to provide specialist management for individuals with chronic obstructive pulmonary disease (COPD) across the two

principal local commissioning groups (LCGs -CATCH and CamHealth). This approach will ensure the provision of a high quality and sustainable community COPD service which is multidisciplinary and appropriately targeted. The service will complement existing COPD services in GP practices to ensure an equitable, effective, efficient, responsive and affordable service that contributes to the health and wellbeing of the local COPD population.

The Trust is currently seeking designation as the regional centre for liver metastases surgery; and is the designated vascular surgery centre for the region with operational plans in final stages of completion. The Trust is also preparing a proposal to become the regional burns facility.

3. The health economy

The financial position across the health economy and in social care will remain challenging into 2013/14 and beyond.

The Trust's geographical position within the region means that competition is constrained particularly for District General Hospital (DGH) type services. Patient choice does bring some DGH patients from outside our immediate catchment population but this is limited. There is some competition in a limited number of clinical sub-specialist areas but this is largely dealt with through formal centralisation processes. (e.g. vascular surgery/surgical resection of liver metastases).

Over the life of this plan we currently expect the debate in relation to Peterborough and Hinchingbrooke Hospitals to continue; the Trust is fully engaged with the Contingency Planning Team (CPT) appointed at Peterborough and Stamford Hospitals NHS Foundation Trust to develop a plan which ensures the sustainability of services for patients and minimises the need for further funding from the taxpayer.

Operationally the Trust is committed to seeing a sustainable future for Hinchingbrooke Hospital as part of the local health economy and to this end will continue to develop a mutually beneficial relationship with Circle Health, with CUH providing and/or supporting a number of services either on the Hinchingbrooke site or CUH campus.

We do not expect any significant changes in market share except as a result of planned regional collaboration and repatriation of patients, particularly of children's services, from London hospitals.

4. Our strengths

Service excellence

Cambridge University Hospitals' overall purpose is to deliver innovation and excellence in health and care. We have a clear vision to be one of the best academic healthcare organisations in the world excelling in patient care, education and biomedical research.

We provide District General Hospital services for the local population and specialist services for people from the region and beyond. We have a significant focus on research and teaching.

The Trust offers nationally and internationally renowned services in cancer, neurosciences, metabolic medicine and organ transplantation. We are the regional Major Trauma Centre for the East of England. We host the Operational Delivery Networks for neonatal care, critical care and trauma.

Each clinical division provides a centre of excellence in some specialties, usually linked to their research programmes.

The Trust's campus is home to a number of leading clinical academic institutes and to the new building of the MRC Laboratory of Molecular Biology.

Cambridge University Health Partners (CUHP)

As a member of Cambridge University Health Partners (the local designated Academic Health Science Centre), we are working with our partners to improve patient care, patient outcomes and population health through innovation and the integration of service delivery, health research and clinical education.

Eastern Academic Health Science Network (EAHSN)

Cambridge University Health Partners will be a member of the Eastern Academic Health Science Network (EAHSN) which will bring together universities, hospitals, mental health services, primary care, clinical commissioning groups, public health, social care, the voluntary sector and industry, translating world-class research into improved patient care across the region, thus driving economic growth.

CUHP's particular role will be to bring expertise, particularly in relation to translational research (linked to the NIHR Biomedical Research Centre), the application of genomics, fundamental biomedical discoveries and population health sciences.

Research with Cambridge University

Cambridge NIHR Biomedical Research Centre (Cambridge University Hospitals and the University of Cambridge) is in the second year of £110 million of government funding to invest in existing and new research themes. The money supports projects designed to benefit patients with diseases such as cancer and diabetes, specifically targeting advances in diagnosis, prevention and treatment.

Teaching and training

CUH is a teaching hospital for medical undergraduates and postgraduates, nurses and students in other clinical professions. Patient-centred teaching is one of our core activities and is central to our vision to be one of the best academic healthcare organisations in the world. We are the teaching hospital for the University of Cambridge through the School of Clinical Medicine and the Postgraduate Medical Centre which provide the infrastructure and support to facilitate the education, training and continuing development of postgraduate professionals in hospital medicine, general practice and dentistry.

Much of the clinical teaching occurs within the Trust with the consultants, junior staff, nurses and allied health professionals regularly involved in medical student teaching and assessment. The integration of academic research with full professional clinical training has been the hallmark of the Clinical School since its foundation.

The link between the hospital and the university creates an environment where good clinical practice, teaching and research flourish and can be translated into better care for our patients. This relationship also attracts doctors and academics from around the world to work in the hospital and the university.

5. Our strategies

We have reviewed our strategic goals and over the next year we will prioritise two main goals that will make services safe and viable for the long term:

- A Trust-wide focus on safety, efficiency, productivity, patient experience and service excellence in a way which ensures financial sustainability
- To identify and develop a limited number of clinical service and academic opportunities that support the needs of patients on a local, regional and national basis

In addition, we have reviewed the Trust's objectives and strategic planning arrangements to ensure that we can deliver these goals. We will update our headline clinical strategy concentrating on cancer, neurosciences (to include mental health issues and dementia), immunity, organ transplantation, metabolic disease and cardio-vascular disease. This will inform our discussion about the future balance between specialist and local services.

A turnaround director is leading a revised Turnaround Programme which will also develop successful parts of the previous Transforming Care for the Future programme. External resources have also been brought in to provide support to the Turnaround Programme. A new Programme Management Office arrangement is now in place.

A summary of our clinical strategy, enabling strategies and Turnaround Programme is set out below.

5.1 Clinical Strategy

Each clinical division has a well-developed clinical/operational strategy set out in its business plan. These plans are based on an assessment of opportunities to improve clinical care in the light of forecast demand as well as the need to promote evidence-based care and to meet National Institute for Health and Care Excellence (NICE) recommendations. Divisional business plans are also used to inform budget setting.

A summary of key themes is set out below. In addition the Trust is re-designing its approach to determining major priorities for clinical development. During 2013-14 we will update our headline clinical strategy concentrating on cancer, neurosciences, immunity, metabolic disease and cardiovascular disease.

Quality, patient safety and patient/staff engagement

The Board of Directors and the Council of Governors are reviewing how the Trust performs in a whole range of areas linked to the recommendations of the Francis Report into care failures at Mid Staffordshire Foundation Trust. This will include a significant engagement exercise with patients, staff and partners; and a number of other targeted measures to improve the care and safety of our patients.

The need to promote patient safety and to engage patients in their own care (no decision about me without me) is central to each division's business plan. This is reinforced in the plans for the front line clinical services to move more of their services closer to patients' homes in the community where possible (e.g. in areas of medicine, cancer, investigative sciences, therapies, women's and children's services); and to promote ambulatory care services (e.g. in cancer and perioperative care)

The Trust currently meets all Care Quality Commission quality and safety standards.

The Quality Committee has reviewed its approach to the Quality Account to create a greater level of staff and patient awareness of patient safety and experience issues. This includes an enhanced performance reporting framework and wide-ranging patient safety and patient experience targets. The Trust's Clinical and Quality strategy is being reviewed and aligned to the Darzi definition of quality, as set out below, and also to reflect the 5 domains of the NHS Outcomes framework. It has been set out in a single Quality Report. A revised Quality Strategy will be launched in the summer 2013. The Board's arrangements for ensuring the quality of its services are also being updated in a revised Board Assurance Framework.

Our aim is to achieve quality by delivering person-centred, safe and effective care that is sustained through good leadership, individual and team effectiveness. Supporting our framework for quality we have a rigorous set of standards for monitoring against local and national targets. This helps us to continually assess our performance and tackle issues as they arise.

The standards we measure against are:

National quality indicators – NHS England has mandated that all organisations providing NHS commissioned care review their performance against a common set of measures across the new NHS Outcomes Framework

Quality indicators – form an integral part of a comprehensive range of performance indicators for CUH. These include national targets and regulatory requirements.

CQUINs – (Commissioning for Quality and Innovation) the CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of healthcare providers' income to the achievement of local quality improvement goals

National targets – published in 2011, the NHS Operating Framework sets out the main planning framework, key financial assumptions and national targets for the NHS across all areas of activity

Priorities we identify ourselves

Our quality priorities for 2013/14 have been identified through a process of consultation with our quality committee, the Board of Directors, the Council of Governors and feedback from stakeholder groups. They are:

- improving safety and reducing harm – **harm-free care**
- improving the reliability of care – **delay-free care**
- improving the experience of our patients – **complaint-free care**
- providing **clinically effective care**

The priorities link closely with the definition of quality, set out by, Lord Ara Darzi (in his role as parliamentary under-secretary of state in the Department of Health) (see figure 1) and are also reflective of the five domains of the NHS Outcomes Framework (see figure 2).

FIGURE 1: Definition of quality

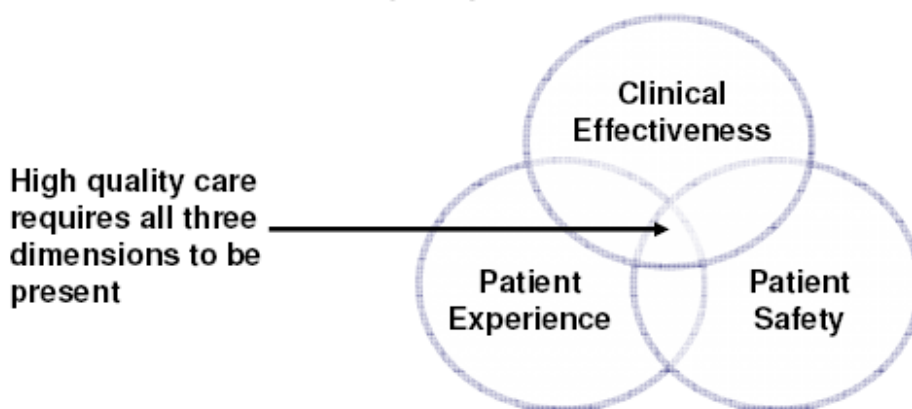


FIGURE 2: The domains of the NHS Outcomes Framework

Domain 1	Preventing people from dying prematurely	Effectiveness
Domain 2	Enhancing quality of life for people with long-term conditions	
Domain 3	Helping people to recover from episodes of ill health or following injury	
Domain 4	Ensuring people have a positive experience of care	Patient experience
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm	Safety

The priorities are all included in the integrated quality report reviewed by the Board of Directors and its quality committee on a monthly basis.

Improving safety and reducing harm – harm-free care

Our goal is that care delivered by the hospital will be safe and harm-free.

This will be measured through:

Safety Thermometer: The Safety Thermometer is a nationally mandated method of assessing the safety of care provided in hospitals. It uses an audit of every inpatient once a month to assess four elements of care to determine how many patients have received 'harm free care.' The four elements are:

- the existence of pressure ulcers
- urine infections in patients with catheters
- falls within the last 72 hours
- a venous thromboembolism.

Our aim is that care, as measured by the monthly audit should be 97% harm-free.

Harm rates: The hospital has in place a well-developed incident reporting process which requires staff to report incidents, irrespective of whether harm occurred. We recognise that the system does rely on identifying that an event which is reportable has taken place, however around 10,000 patient related incidents were reported in 2012. Good reporting is viewed as an indication of a positive safety culture.

We will measure the rate of harm as a percentage of patient contacts each month. Patient contacts are the number of inpatients admitted, outpatient, day case and Emergency Department attendances.

Our aim is that less than 0.2% of patient contacts should result in an incident report where patient harm is recorded.

Minimising infection: We will strive to reduce the number of avoidable infections and the harm they cause and in particular to keep the number of patients who acquire *C difficile* or MRSA in hospital to a minimum. By reducing the numbers of affected patients to a minimum, we will reduce the need for a prolonged length of stay, surgery, admission to an intensive care unit, or causing serious harm.

Our aim is to minimise the number of avoidable hospital acquired infections and to meet our contractual ceilings for these infections during 2013/14. The ceiling for hospital acquired MRSA bacteraemia is zero and for hospital-acquired *Clostridium difficile* cases is 39.

Improving the reliability of care – delay-free care

Our goal is that care delivered by the hospital will be reliable and timely.

This will be measured through:

Outpatient appointments: In excess of 500,000 outpatient attendances occur each year and we believe that patients should expect to be seen at the time agreed, while recognising this is not always possible as some patients will require longer consultations than others.

Our aim is that 80% of patients are seen within 30 minutes of their stated outpatient appointment time.

Emergency department waiting time: In excess of 98,000 patients attended the emergency department at Addenbrooke's in 2012. There is a nationally mandated target to see 95% of patients within four hours.

Our aim is to meet this target each quarter.

Admission within 18 weeks of GP referral: We recognise the importance for patients to be admitted in a timely manner following referral by their GP.

Our aim is that 90% of our patients who require admission will be admitted within an 18-week timeframe.

Cancelled operations: Once a date is set for an operation, we will do our best to ensure that date is kept to, while recognising there will be occasions when emergencies impact on routine operating.

Our aim is that the number of operations cancelled on or after the day of admission is less than 1%.

Delayed transfers of care (DTOC): With Cambridgeshire Commissioning Group and Cambridge County Council we aspire to reach a level of zero delayed transfers of care. However, in 2013/14 if less than 20 (2.5%) of our beds are occupied by DTOC patients the system will have performed well.

Our aim is that more than 95% of patients should have their assessment within the agreed time frame.

Improving the experience of our patients – complaint-free care

Our goal is that care delivered by the Trust will be a positive experience and not result in the need to raise a formal complaint.

This will be measured through:

Inpatient experience: We survey patients each month using a 24-point questionnaire to seek views of the care received. The questions cover topics that include infection control, cleanliness, privacy, safety, nursing and medical care received, being informed and involved in the care provided, and food.

Our aim is that 95% of patients who respond to the surveys answer questions as ‘yes,’ ‘met expectations’ or ‘above expectations’.

Outpatient experience: We survey patients who attend outpatients on a six monthly basis using a 23 point questionnaire to seek views of the care received. The questions cover the quality of experience pre, during and post appointment. Topics include timeliness, information provided, clarity about next steps etc.

Our aim is that 95% of patients who respond to the surveys answer questions as ‘strongly agree’ or ‘agree’.

Friends and family test: This is an NHS wide initiative to gather feedback about patients’ experiences. In simple terms it is seeking to answer the question ‘is the care I received good enough for my friends or family?’ The rating system uses a score out of 100.

Our aim is to improve on our 2012/13 score by 10 points.

Patient complaints: We always welcome complaints as these often help identify areas where we can improve and are a way of measuring the level of quality we are delivering.

We will measure the complaint rate as a percentage of patient contacts each month, patient contacts are the number of inpatients admitted, outpatient, day case and emergency department attendances.

Our aim is that the number of formal complaints received should be less than 0.1% of patient contacts.

Providing clinically effective care

Our goal is that care delivered by the Trust will be effective, in simple terms it delivers what it says it will.

This will be measured through:

Re-admission rate: This measures the number of patients who are readmitted to the hospital within 30 days of being discharged as an inpatient, excluding those being treated for cancer or who are under the care of an obstetrician.

Our aim is to keep avoidable readmissions below 10%.

Hospital standardised mortality ratio (HSMR): This is a nationally calculated ratio prepared by Dr Foster (<http://www.drfoosterhealth.co.uk/>) where a score of 100 would mean actual deaths were in line with what is expected. An HSMR of less than 100 indicates fewer patients than expected died, a figure of greater than 100 indicated more than expected died.

Our aim is have an HSMR that places the hospital in the top 10% of our peer group and have an aggregate hospital HSMR of less than 90.

Patient-related outcome measures (PROMS): These are nationally mandated and provide a patient perspective of the effectiveness of the care they received, in simple terms the improvement gain or loss following the procedure. They cover surgery undertaken in respect of hips and knees, groin hernia and varicose veins. The information is collated nationally and therefore data for 2011/12 is only recently been made available.

Our aim is that for 2014/15 our results show an improvement on those of 2011/12 and are above the national average.

Improving clinical outcomes

All services have identified opportunities to improve clinical outcomes whether through centralisation (e.g. liver metastases centralisation, haematological pathology centralisation, centralisation of vascular services) or new techniques and practice (e.g. peanut desensitisation, new radiotherapy techniques in cancer).

All clinical divisions have extensive research programmes linked to improving clinical outcomes and, as appropriate, key Biomedical Research Centre themes (Brain Injury and Repair, Cancer, Cardiovascular, Immunity, Infection and Inflammation, Mental Health, Metabolism, Endocrinology and Bone, Transplantation and Regenerative Medicine, Women's Health, Dementia).

Integration and partnership

All front line clinical services foresee opportunities to integrate elements of service with primary and/or community healthcare services; and in some instances with social care services. In some services there are opportunities to use technology to localise services, for example in the proposed development of a Teleradiology Service.

A performance driven local and regional service

Growth and further specialisation are proposed in a number of areas (e.g. expansion of brachytherapy for prostate cancer, Regional Interventional Radiology Unit, tertiary haematology work, cardiology, dermatology (Mohs), respiratory medicine)

Capacity remains a concern for all services and the Board is considering overall options for dealing with this. However, reducing length of stay where safe to do so and optimising bed occupancy levels remain essential components of our operational strategy. In some areas (e.g. Paediatric Intensive Care/Long Term Ventilation) a review of capacity has been requested by commissioners. Shortage of rehabilitation facilities regionally continues but new tariffs for rehabilitation should be beneficial for appropriate recognition for the limited service that can be provided on site.

Despite these capacity concerns, all services are committed to meet national and local performance targets.

The need for seven day working is recognised and will be assessed for its overall and corporate implications.

Process improvement

There are opportunities for improving patient flow in some areas (e.g. cancer, some parts of pathology, medicine-stroke, Emergency Assessment Unit). This is key to transforming both inpatient and outpatient services. A systematic review of key patient pathways also underpins the development of the eHospital proposal recently agreed by the Board and set out elsewhere in this plan.

Capital investment

In terms of capital investment a number of services make a case for capital to expand day services/improve outpatient facilities (cancer), improve treatment facilities (vascular services EVAR theatre(endovascular aneurysm repair), reconfiguration and refurbishment of Emergency Department paediatrics, minor injuries and reception/triage areas).There is also a case for a significant increase in investment in medical equipment. These proposals are systematically evaluated by the Trust's Capital Advisory Board which makes recommendations to the Board of Directors on which schemes should be formally adopted into the Trust's capital programme.

Implications for bedpool/physical capacity

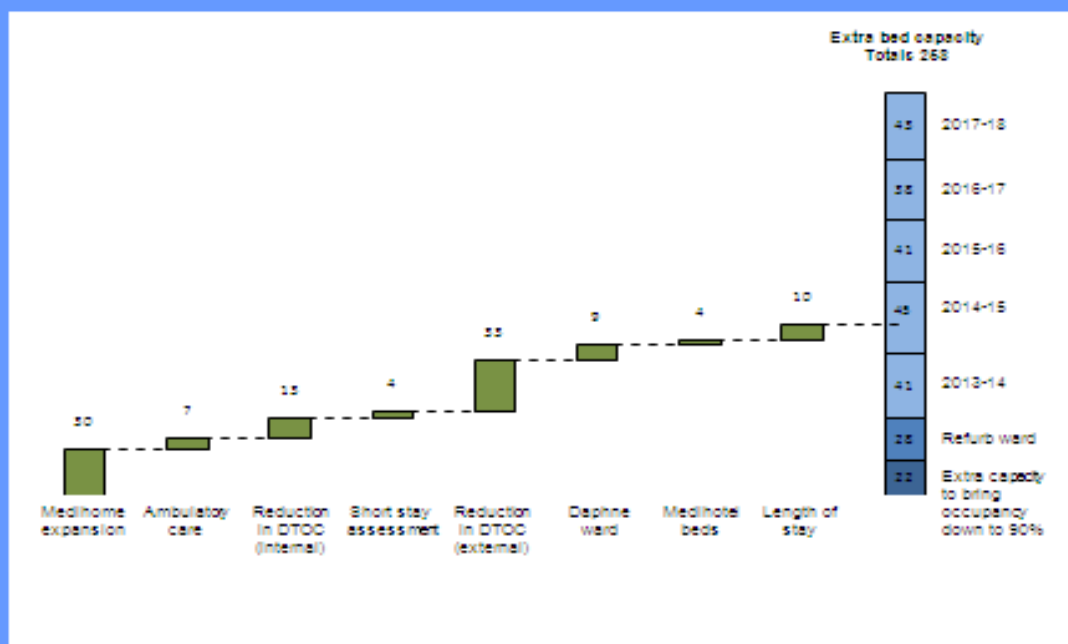
We have identified target bed savings based on upper decile performance from a group of 30 peer hospitals across our 7 Divisions. Target bed savings have been derived using a volume adjusted approach and have been calculated at procedure or diagnosis level for elective and non-elective activity respectively. The overall target bed saving, if the upper decile benchmark is achieved by March 2015 is 171 beds, with a target saving of 85.5 beds for 2013/14.

Forecast changes in activity, taking into account demographic factors such as increased pressure on length of stay due to the ageing population, will require an extra 40 general acute beds to deliver plans for 2013/14, prior to any identified length of stay savings. Additionally activity projections for 2014/15 and 2015/16 would require a further 47 and 42 beds respectively. This would take the total general acute bed requirement for additional activity during the period April 2013 to March 2016 to 129 beds, prior to any identified length of stay savings.

The Trust is also looking to provide additional operational headroom in terms of general bed capacity and is therefore looking to reduce bed occupancy from 92% to 90%. This is equivalent to an additional 22 general acute beds. This would therefore take the overall acute general bed requirement for the period April 2013 to March 2016 to 151 beds, prior to any identified length of stay savings. This still remains within the Trusts target bed saving of 171 beds.

However, there are a number of significant risks to the plan. Firstly, there is the risk that the planned number of patients whose transfer of care is delayed is substantially exceeded. To an extent, overall demographic modelling has sought to ensure appropriate allowances have been made for the ageing population. Clearly however external factors outside the Trust's control could materially affect this planning assumption. Secondly, there is the risk that emergency medical admissions exceed the projections and plans agreed with commissioners, putting significant pressure on general acute beds and target achievements. Finally, the risk exists that the Trust does not achieve its target bed saving of 85.5 beds in 2013/14 and 171 beds by March 2015.

Forecast bed requirements over next 5 years



Clinical Sustainability

Demand for all Trust services remains high. As noted elsewhere in this plan we are aware of the regional debate in relation to Peterborough and Hinchingsbrooke Hospitals and are fully engaged with the Contingency Planning Team (CPT) appointed at Peterborough and Stamford Hospitals NHS Foundation Trust to develop a plan which to secure a strong regional basis for sustainable patient care. In doing so, we are conscious that there are a number of clinical and operational interdependencies with other services that need to be understood to ensure patient service and patient safety. We will need to ensure that any changes offer patients a seamless pathway across different providers and that the impact of commissioning decisions on related services (e.g. clinical interdependencies) safeguards patients' access to care.

We are not aware of any services that lack clinical mass. Every clinical department has 24/7 on call cover and clinical divisions keep these arrangements under review.

Innovation

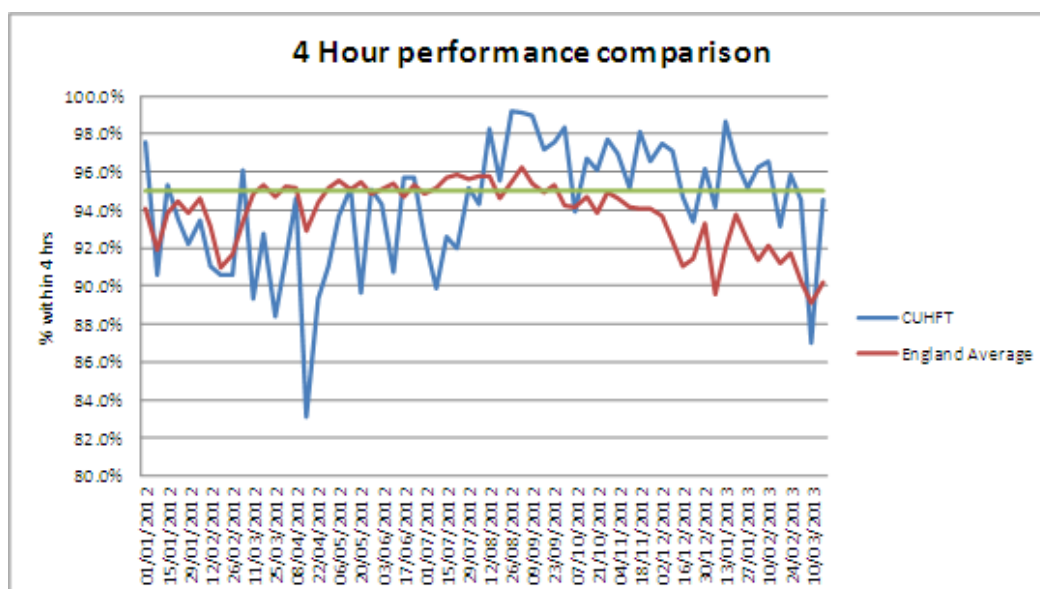
The Trust has a wide range of specific clinical innovations at various stages of development. Examples are set out in Appendix 5. In addition the Variation of Care workstream and the eHospital programme will be reviewing all major pathways of care during its development phase over the next 18 months; this is expected to identify further opportunities for innovation in care delivery.

Operational performance

The Trust was found to be in significant breach of its terms of authorisation in November 2012. This is a serious situation which we are determined to reverse as quickly as possible. We have made a number of new Board level appointments to help us achieve this; and have a task force in place that is making excellent progress.

- **A&E four-hour wait target** achieved every month since August–February the Trust's best ever performance. March has seen some deterioration – we ended the month at 91.3% and the

worst since April 2012. The Trust did not achieve the target for Quarter 4 2012/13. However, this needs to be viewed in the national context:



- **62 day cancer wait target** Met target December 2013 - March 2013; and provisionally for April 2013; one quarter ahead of action plan
- **Zero 'never events'** since August 2012
- Achieved **18 week admitted referral to treatment target** at aggregate level for December-April – backlog lowest since September 2010
- **Health care Acquired Infection (HCAI):** Adverse to both annual ceiling targets. 6 MRSA against ceiling of 2 for the 2012/13 year; 73 C-diff cases against the annual ceiling of 41

6. Changes that will help us implement our strategies

6.1 Transformation

The Trust's Transformation Programme comprises an initial rapid Turnaround Programme to deliver a range of service and cost improvements (CIPs) which will then be embedded as part of normal business. eHospital (see below) is also part of our overall transformation agenda.

Our Turnaround programmes are:

- Medical Productivity: improving doctors' productivity
- Nursing Productivity: improving nurses' productivity
- Workforce Transformation: revised administration and clerical arrangements
- Unplanned Care: ensuring patients receive high quality care in the most beneficial location
- Length of Stay: optimising length of stay
- Outpatients: revised outpatients administration and management
- Theatres: reducing cancellations and increasing productivity to deliver additional activity
- Variation of Care: evidence-based care to deliver consistent outcomes for all patients
- Drugs: prescribing and dispensing cost-effective medicines
- Investigative Sciences (IS): improved emergency and day services; more effective testing

- Portfolio Strategy: identifying and exploiting new income streams
- Estates: efficiencies across energy and sustainability, procurement, workforce, estates IT; development of commercial opportunities,
- Procurement: savings and efficiencies in purchasing and supply chain
- Recording of Care: is critical for clinical quality and making sure we get the right payment by correctly recording the care we deliver

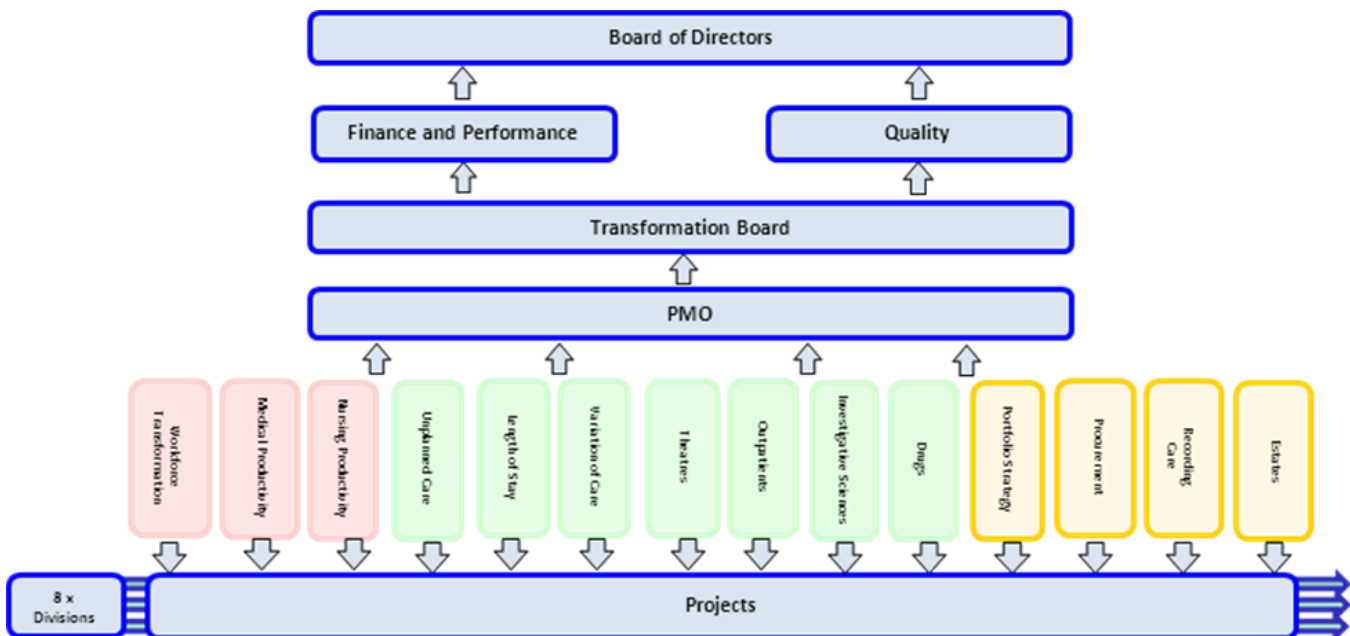
CIP governance

A successful cost improvement programme saves money but also, through long-term plans to transform clinical and non-clinical services, improves patient care, satisfaction and safety. It also helps deliver the standards of operational performance which our patients and clinical commissioners expect.

The Trust's historic performance in delivering CIPs has been assessed by PwC. In order to ensure a sustainable future, the Trust has had to improve the way it goes about both developing and delivering cost improvement projects. We have recognised the need to develop the right capability and capacity required to drive the change programme, underpinned by a new best practice Programme Management Office (PMO) approach to project delivery.

The PMO's approach to developing CIP plans and monitoring and driving implementation is much more proactive and wide ranging than previous years and aims to maximise efficiencies and ensure deliverability. The PMO is responsible for managing the change programme and driving forward the delivery of the identified plans with rigour and pace. At the plan development stage of each project, the PMO will provide the robust check, challenge and reporting processes required to ensure the ambitions of the Trust in successfully delivering its savings and efficiency targets are achieved.

The diagram below outlines the structure adopted within the Trust and shows the channels of reporting and approval.



CIP enablers

Senior clinicians have been involved in developing and delivering CIPs. Investment has been required in the post of Turnaround Director, the creation of a Programme Management Office and external support.

Quality Impact of CIPs

As part of the approach to identifying and implementing its Cost Improvement Programme the Trust assesses the risk of the changes being proposed. This is achieved through formal risk assessment using the Trust's agreed risk assessment methodology by individual divisions and directors, taking into account risks linked to quality, performance, safety, experience, regulatory and compliance.

This approach ensures that risks are identified in advance of any CIP being implemented so that there should be full awareness of the risks arising from the actions being proposed.

The Trust has recognised that any CIP does bring with it some risk and therefore risks identified as low or moderate can be accepted. However CIP's should not be implemented where the risk is identified in advance as high.

Once risk assessments are completed they go through a moderation process, are shared across corporate services and divisions and are ultimately signed off at Executive Director level before any CIP's are implemented. No CIP's are implemented where a moderated risk assessment remains high without mitigation plans.

6.2 eHospital

As part of our Transformation Programme the Trust has started to implement eHospital to provide world-class clinical information systems on a modern, fast, accessible and reliable computer platform fit for the 21st Century.

The Epic IT system which lies at the heart of eHospital is a wholly integrated application which delivers robust, resilient, intelligent context-specific decision support thereby freeing clinical time to make the best, most cost-effective decisions for patients. It is designed to make clinicians more productive by make it easy for users to place orders, request services, prescribe treatments or manage the patient's pathway. The patient record will be wholly integrated across all specialties and disciplines. We will create treatment plans based on standard protocols which will help clinicians make treatment decisions guided by comprehensive decision support using streamlined workflow processes for outpatients, inpatients and day-case treatments. These workflows will cover every aspect of a patient's treatment pathway from referral to discharge. Over time patients will also have access to appropriate information from the system.

Every member of staff, clinician or administrator, will be able to access the service wherever and whenever they need to, with appropriate information governance arrangements in place to ensure patient confidentiality. As part of the eHospital infrastructure there will be over 7,000 access devices including desktops, laptops, computers on wheels (COWS) and other mobile devices. Touch screen access at the bedside will be provided in over a thousand locations.

HP will provide access services for users. This includes a fully managed desktop, including applications hosting, network management, data centre services and remote support services.

As part of our overall transformation agenda eHospital will ensure that any savings already achieved by service improvement and transformation will be sustainable into the future. In addition it will provide us with a modern IT platform which will enable us to drive through many more quality improvements to benefit our patients as well as further significant savings over the lifetime of the investment.

We expect eHospital to provide a robust basis for integrated care across primary, community and secondary healthcare (based on its central use of the electronic patient record) as well as for research and development.

6.3 Transforming pathology

Transforming Pathology Partnership (TPP- a joint venture with seven Trusts in the East of England, one of which is CUH) has been appointed preferred bidder to provide community pathology services across the TPP region, excluding East and North Hertfordshire. The joint venture has been instigated in response to a bid/NHS restructuring process being run across the East of England, which will see unsuccessful bidders lose all their community pathology work

TPP will deliver a new service model for acute and community pathology services across all the trusts. TPP is seeking to transform both community and acute pathology services to deliver improved services and significant savings. Each Trust will be an owner and customer of TPP. Cambridge will be the initial legal host of the Joint Venture and will therefore legally employ the staff and provide the services on behalf of the other Trusts.

It is believed that TPP is the largest clinical transformation currently in progress within the NHS. TPP will be a business with circa £80m per annum in revenues and will have approximately 1,100 staff following transformation. The bidding process requires TPP to set up as a contractual joint venture with the intention that CUH would be the initial host for the joint venture, prior to TPP becoming a corporate entity.

The commissioner's current intention is that the contract for community pathology is signed by the end of May 2013 and for the new service to start on 1st October 2013. This is dependent on resolution of some contractual issues.

Following a comprehensive procurement process CUH has appointed Siemens Diagnostics as our strategic pathology partner, with the contract still awaiting HM Revenue and Customs approval. Siemens will deliver a comprehensive managed equipment service and invest in creating additional capacity as necessary, while working jointly with the Transforming Pathology Partnership

6.4 Site development

Construction on a new 1220 space multi-storey car park and a new Energy Innovation Centre (which will reduce the Trust's carbon emissions by over 40%) is planned to commence in 2013/14.

Outline Business Cases are being prepared as one part of the Trust's capacity action plan to develop new paediatric inpatient facilities and/or elective surgery capacity. The strategic partner for The Forum project (education centre, private hospital, hotel and conferencing facilities and associated retail and car parking) has been selected with contracts due to be signed in the summer of 2013. Construction is planned to start in the spring of 2014 with the facilities due to open in the summer of 2016.

The Medical Research Council (MRC) Laboratory of Molecular Biology's (LMB) staff, equipment and facilities have moved into a new, purpose-built building designed to deliver the right environment in which innovative medical research, translation and collaboration can flourish.

Decisions from the Department of Health and the Treasury regarding the relocation of Papworth Hospital to the Cambridge Biomedical Campus are expected in the spring/summer of 2013.

6.5 Collaboration, Integration and Patient Choice

The Clinical Commissioning Group (CCG) has introduced its approach to securing the future for the services currently provided by Cambridgeshire Community Services (CCS) as CCS will cease to exist after April 2014. The main driver is the CCG's strategic focus on older people's services, but the CCG is also coordinating the process for determining future arrangements for other CCS functions with partner organisations.

The CCG's commissioning intention is to improve care for frail older people, and reduce the amount of time spent in hospital as a result of unplanned admissions. This is consistent with the Health and Well-Being Board's priorities, and is informed by work with the King's Fund to develop innovative approaches to care for older people.

The focus is on improving outcomes, and the CCG's vision is to commission entire patient pathways for older people (acute and community) which will require solutions beyond traditional organisational boundaries and which support the following principles:

- Aligning improved patient outcomes with financial incentives;
- Sharing financial gain and risk across the commissioner – provider system
- Delivering recurrent financial balance in a sustainable way
- Creating the conditions for investment and delivering a return on investment

Future service arrangements will need to ensure that older people are proactively supported to maintain their health, well-being and independence for as long as possible, receiving care in their home and local community wherever possible; and

- For care to be provided in an integrated way with services organised around the patient;
- To ensure that services are designed and implemented locally, building on best practice;
- To provide the right contractual and financial incentives for good care and outcomes
- To work with patients and representative groups to design how we commission services

The process involves a dialogue with providers until December when a full service specification will be available for mobilisation by April 2014. The Trust will participate in this process and review options for partnership with other organisations able to help construct a future service in the best interests of older people.

The CCG is also examining options for children and young people and other specialist services and this may potentially lead to a competitive procurement exercise. The Trust will continue to participate in this process as appropriate.

The Trust recognises the risks inherent in these changes and will continue to assess opportunities to mitigate these during the process.

We think there are benefits in reviewing the development of integrated care from the perspective of systems thinking. This approach recognises that no single organisation can bring about the scale of change that is required to improve the way different parts of the healthcare system work together; and will also help all agencies respond to the significant demographic and financial pressures which confront us.

This approach requires all stakeholders to engage in the process of transforming their service jointly and with an equal voice. This is different from partnership or collaboration in the extent of commitment to coordinate changes across agency boundaries. Some of the elements of a systems thinking approach already exist, for example an agreed map of how health and social care for older people works and a shared vision of what a new system might look like. There is also a shared understanding of how changes to one part of the system have a negative impact on another part. We welcome the opportunity to look at opportunities to develop this approach.

6.6 Clinical Workforce Strategy

The Trust continues to focus on developing its workforce by ensuring that the right people have the right skills and are in the right roles, whilst seeking to reduce overall Trust pay costs in a way that aligns with trust values of kind, safe and excellent.

This will be achieved via a focus on medical workforce efficiencies, nursing workforce productivity and workforce transformation programmes.

In addition we are developing a workforce strategy to take account of Government policy that all aspects of publicly funded health and social care should be more routinely provided to patients and the public 7-days per week.

6.7 Productivity and Efficiency

Length of Stay

Underlying demographic factors will represent a significant challenge to the Trust. In relation to our main Commissioning (Cambridgeshire), ONS population projections predict major increases in the number of over 65s (see below table). This cohort of patients has on average a longer length of stay and is also more likely to become a delayed transfer of care.

The Trusts activity modelling, which takes into account demographic changes, predicts that our average inpatient lengths of stay, prior to any identified length of stay savings, would during the period of the plan, increase by 0.2 days for Elective Inpatients (from a baseline of 3.6 days) and increase by 0.4 days for Non-Elective Inpatients (from a baseline of 5.4 days).

However, after identified bedpool target bed savings on length of stay we anticipate that during the period of the plan, Elective Inpatient length of stay would reduce by 0.5 days to 3.1 days and Non-Elective Inpatient length of stay would reduce also reduce by 0.5 days to 4.9 days.

Bed Occupancy

The Trust is planning to provide additional operational headroom in terms of general bed capacity and is therefore looking to reduce bed occupancy from 92% to 90% during 2013/14. This planned reduction in bed occupancy is equivalent to an additional 22 general acute beds.

Theatre Productivity

The theatre model accommodates redistribution of lists between specialties based upon targeted utilisation and session cancellation rates to maximise efficient use of theatres. For the period April 2013 to March 2016, the Trust would look to increase planned Theatre utilisation from 82.4% (2012/13 actual) to 91.4%. This would mean that combined with limited use of external capacity the Trust could absorb activity projections for the entire period of the plan.

Emergency readmission rates

With regards to Emergency readmission rates within 28 days the Trusts modelling has assumed no change in the underlying rate of 6.2% for the entire period of the plan. Clearly this represents a risk to the organisation given the impact external factors can have on this.

Agency staff

In the budget agency posts have generally been replaced by substantive posts to reduce costs.

6.8 Financial and Investment Strategy

The Trust's overall financial objective is to achieve a sustainable financial future. Whilst the Trust has achieved a £4m surplus in 2012/13, this was achieved with the help of various sources of non-recurrent funding and other one-off benefits.

The underlying financial performance of the organisation may be obscured for potentially 3 years due to the Trust's eHospital project, which carries with it significant up-front costs, but is then expected to facilitate the achievement of significant financial and operational efficiencies for the Trust, whilst at the same time upgrading the Trust's ageing IT infrastructure and providing state of the art clinical systems to the hospital. Although the annual plan has been prepared on the basis of including the costs and benefits of eHospital, the Board is committed to monitoring the Trust's ongoing financial performance both including and excluding the impact of eHospital. This is to ensure that the underlying financial performance of the Trust is not masked by the impact of eHospital.