

Basildon and Thurrock University Hospitals 
NHS Foundation Trust

Strategic Plan Document for 2013-14

Basildon and Thurrock 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):

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Date	20 May 2013

The attached Strategic Plan is intended to reflect the Trust's business plan over the next three years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

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)	Ian Luder
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Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Clare Panniker
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Signature



Approved on behalf of the Board of Directors by:

Name (Finance Director)	Andy Ray
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Signature

A. W. King -

Strategic Context and Direction

The Trust's vision is to be an excellent hospital providing high quality, safe care for our community. There are six values and five aims associated with this vision, as shown in the following diagram:



The Trust provides secondary care services to the 405,800 population of south west Essex (from 2011 census), and provides tertiary cardiothoracic services to a wider geographic area. The south west Essex population has grown by 28,100 (7.4%) in 10 years from the 2001 census. As at December 2012, the Trust performed 76.3% of elective inpatient procedures for NHS South West Essex (by volume, increased 1.5% from 75.1% in December 2011), and 79.1% of outpatient activity (by volume, increased 3.4% from 76.4% in December 2011). In summary, the Trust's local population is growing and the Trust is obtaining a larger share of this market, despite recent reputation impacting events.

As Basildon was a new town developed in the 1960s, it is now contributing to a rapidly aging population in south west Essex. For example, there were 2,700 residents aged 90 and over in 2011 compared with 1,800 in 2001, an increase of 50% which is nearly double the increase for England and Wales overall. This growth is placing an increasing strain on health and social care services across south west Essex.

Local Authority income is reducing by 30% until 2017 whilst the NHS is required to meet an efficiency challenge of 4% a year. To tackle growing demand and public expectations against constrained resources, Essex was selected by central Government as one of four areas in England to pilot Whole Place Community Budgets. The aim of the programme is to integrate services across a broad range of partners in order to reduce complexity, deliver savings through improved efficiency and improve outcomes for the people of Essex. This work is ongoing in 2013/14.

In April 2004, the Trust became one of the first 10 foundation trusts. In November 2009, Monitor, the Independent Regulator of Foundation Trusts, found the Trust to be in significant breach of its Terms of Authorisation following concerns raised by the Care Quality Commission (CQC). These concerns were due to a high Hospital Standardised Mortality Ratio (HSMR), the care and treatment of four people with learning disabilities and a poor Hygiene Code assessment in the Accident and Emergency Department following an unannounced CQC inspection in October 2009.

The Trust commissioned McKinsey & Company at the end of 2012 to undertake both an Organisational Health Index (OHI) survey and values survey to assess the Trust's current health and both current and desired values. The findings resulted in a plan to focus on the following areas:

- Increased transparency and follow up on concerns/ issues
- A trusting culture with a shared vision
- Leaders capable of being inclusive/ consultative as well as authoritative
- Recognising good performance and enforcing consequences for poor performance

The Trust had a £0.2m surplus, with a Financial Risk Rating of 3 and has met all financial targets for 2012/13. The Trust finished 2012/13 with an EBITDA of 5.9% and a strong liquidity position with £34.4m cash.

The Trust has a 12 month SHMI of 1.14 for October 2011 to September 2012 (the latest information available), above the upper confidence limit of 1.12. The Trust was recently identified as one of 14 Trusts with a persistently high mortality index and was subject to a Rapid Response Review in May 2013, with the outcome expected in June 2013. This has again focussed attention on the Trust's mortality rate and this will be a key feature of patient safety work in 2013/14.

As part of granting a license to the Trust, Monitor decided to accept enforcement undertakings from the Trust. This required the Trust to submit a Turnaround Plan to oversee the effective delivery of the Urgent Care Plan, the Mortality Plan, the Paediatric Plan, the Governance Plan and other transformational changes defined by the Trust. In addition, the Trust undertook to implement sufficient programme management and governance arrangements to enable delivery of the Urgent Care Plan, the Mortality Plan, the Paediatric Plan, the Governance Plan and the Turnaround Plan.

Such programme management and governance arrangements will enable the Board to:

- Obtain a clear oversight over the progress in delivering the plans;
- Obtain an understanding of any risks to the successful achievement of the plans; and
- Hold individuals to account for the delivery of the actions in the plans.

The Turnaround Plan is one strand of the Trust's Quality and Safety Transformation Programme, which seeks to make transformational changes beyond those set out in the enforcement undertakings relating to the Urgent Care Plan, Mortality Plan, Paediatric Plan, and Governance Plan.

A contract for 2013/14 is in place with CCGs that for the two south west Essex CCGs has a value of £176.4m, and with NHS England, for activity designated as specialist, with a value of £47.8m. This CCG contract includes other CCGs as associate commissioners, with values as follows:

Commissioner	2013/14
Basildon and Brentwood CCG	£103.4m
Thurrock CCG	£73.0m
Castle Point CCG	£8.3m
Southend CCG	£3.1m
Mid Essex CCG	£3.7m
North Essex CCG	£2.2m
West Essex CCG	£1.7m
Barking and Dagenham CCG	£0.5m
Newham CCG	£0.3m
Redbridge CCG	£0.2m
Havering CCG	£2.5m
Waltham Forest CCG	£0.2m
NHS England	£47.8m
NHS England (Public Health)	£3.3m
Total	£250.2m

A contract for 2013/14 is in place with the Trust's second largest commissioner, NHS England.

A number of the Trust's services are currently under threat from commissioner led service reconfiguration plans. In particular, commissioners have recently designated a consortium of providers in Bedfordshire and Hertfordshire as preferred bidder for GP direct access pathology services. The contract for GP direct access pathology services has not yet been signed, but has a provisional service commencement date of April 2014. Approximately £5.5m of income is at risk, and plans are being developed to mitigate this risk by merging pathology services with a neighbouring Foundation Trust, probably with the input of a private sector partner, to reduce the costs of the residual pathology services. This will also provide a lower operating cost pathology model with which to compete for GP direct access pathology contracts.

Other services under threat in their current model include stroke and vascular services.

The Trust hosts a strategic planning event for its governors each year, and the outcomes from the event are used to inform the priorities and service developments for the following year's annual plan. Relationships have remained strong with the governors through the period of regulatory pressures.

Priorities from governors for 2013/14 were as follows;

Rank	Issue	Total Score
1	A Mary Portas Review	31
2	Culture and Morale	22
3	Residential Care Homes – Link to our Hospital	20
4	Continuing and Sustaining	15
5	Hit the Road	14
6	Grand Design	14
7	Access	7
8	Services (Right Place Right Time)	9
9	Investing in success	2

The Mary Portas Review related to the standard of the environment and the need to make improvements, particularly in outpatient and main entrance areas. 'Hit the Road' was about taking our services into the community and publicising what the Trust is good at. The other priorities are self-explanatory.

After considering the Governors' priorities and the Trust's vision, values and aims, the Board has set the following objectives in the 2013/14 to 2015/16 Annual Plan.

Objective 1. We will do no harm to our patients.

Measure 2013/14. To reduce the crude mortality rate to under 2% by March 2014.

Measure 2014/15. To maintain the crude mortality rate at under 2% in every quarter.

Measure 2015/16. To maintain the crude mortality rate at under 2% in every quarter.

Objective 2. We will develop a skilled and motivated workforce

Measure: Training reports and improvements in a quarterly mini survey of staff opinion.

Description	Score
Mandatory training	>80%
Local Education and Training Board (LETB) training take up for healthcare professions	>80%
Nursing skill mix (qualified:unqualified)	65:35 ratio by June 2014
From survey, "I am enthusiastic about my job"	>68% (median for acute Trusts) (BTUH baseline 64% in 2012)

Objective 3. We will improve patient and staff satisfaction.

Measures: Improvements in the patient net promoter score (friends and family test) and the quarterly mini survey of staff opinion.

Period	Patient Experience	Staff Satisfaction	
	Net Promoter Score	Recommend for treatment	Recommend as a place to work
2012 (Baseline)	57%	51%	50%
April 2013	69% (CQUIN Target)	>60% (median for acute trusts)	>55% (median for acute trusts)
April 2014	73%	Above median	Above median
April 2015	78%	Above median	Above median

Objective 4. We will reduce the length of stay (LoS) for admitted patients by working with our partners to ensure care is integrated.

Measure: Length of Stay – source: NHS Comparators

Period	Elective LOS (days)*		Emergency LOS (days)*	
	Value	Details	Value	Details
2012/13	3.6		7.0	
2013/14	3.1	14% reduction by M12 to achieve median	5.6	(20% reduction by M12 to achieve LQ**)
2014/15	2.8	23%reduction by month 12 to achieve UQ	5.1	(27% reduction by M12 to achieve median)
2015/16	2.8	To be attained all year	4.6	(34% reduction by M12 to achieve UQ***)

* Or equivalent occupied bed days (OBDs) reduction.

** Lower Quartile

*** Upper Quartile

Objective 5. We will ensure our services are sustainable, by delivering strong financial performance.

Measures:

EBITDA minimum 5% in all 3 years.

Cash minimum £15.0m in all 3 years, with a minimum liquidity risk rating of 4 (under proposed new risk rating system).

Capital programme expenditure of greater than 75% in all 3 years (72% is FT sector average)

Reduction in outpatient 'did not attend' (DNA) rates from baseline 10.1% (poor) to within expected range by March 2014, to national average (currently 8.6%) by March 2015 (Source: Dr Foster Intelligence; My Hospital Guide).

Temporary staffing shifts <180 per day (NHS Professionals judgement of the threshold for delivering a safe service).

Objective 6. We will achieve full CQC compliance by Quarter 3, 2013/14.

Measure: Monitor risk rating for governance.

Approach taken to quality

The Trust Quality Strategy has been in place since the beginning of 2011. It provides the foundations on which to continuously build improvements into clinical services and will be reviewed during Q1.

The Quality Strategy identifies:

- To provide safe, effective and reliable care to patients
- To ensure standardisation and consistency of practice
- To ensure the provision of high quality, compassionate care with evidence of assurance
- To implement mechanisms to ensure sustainability of the delivery of care
- To identify poor and best practice and set standards and challenge practice
- To identify issues that have an impact on the Trust and devise necessary actions
- To ensure efficient and effective systems and processes are in place in to improve patient experience
- Demonstrate real improvements across the system in clinical outcomes, patient safety and patient experience
- To be the leaders in developing innovative practice
- To initiate, support and develop Research & Audit
- To initiate, ensure delivery and evaluate the patient experience and identify examples of excellence

A significant amount of work is being undertaken by the Trust to improve the quality of services provided to the public. There are a large number of quality improvement initiatives in the strategy and this does not reflect all of the quality improvement related activity within the Trust. Progress is being made and the delivery of aims within the strategy should send a message to stakeholders that quality is taken seriously and is a central feature of the activity within the Trust driving out complacency and leading change and improvement.

The Trust has chosen to use the Quality Account as an annual review of clinical quality within the organisation. This is a transparent and open critique of performance and includes an appraisal of performance that meets the required standard and where it does not.

The Trust has been visited by the CQC and they have identified areas where they believe the Trust could perform better when measured against the CQC Essential Standards for Quality and Safety.

The following table identifies the standards reviewed at the most recent CQC visit in January 2013.

Outcome	Regulation	Compliance
1	Respecting and involving people who use services	Met this standard
4	Care and welfare of people who use services	Action needed
5	Meeting nutritional needs	Met this standard
7	Safeguarding people who use services from abuse	Met this standard
8	Cleanliness and infection control	Improvement required
9	Management of medicines	Met this standard
13	Staffing	Met this standard
14	Supporting workers	Met this standard
16	Assessing and monitoring the quality of service provision	Enforcement action taken
17	Complaints	Met this standard

Detailed action plans in response to the CQC's findings are in place. The Trust is confident that all appropriate steps are being undertaken to improve lapses in meeting Essential Standards.

The Care Quality Commission has taken enforcement action to achieve compliance with outcome 16. There are plans which are in place to address the appropriate concerns which are reviewed as to progress at Board or sub committees of the Board both to achieve compliance and sustainability.

Risk Management in the Trust is currently under review and has undergone a 'Rapid Review' by the Good Governance Institute (GGI), with Board development sessions planned throughout the year.

The organisational structure has been reviewed to lead and manage risk and quality in an effective way with the appointment of designated leads for governance and risk both at a corporate and divisional level.

A significant focus is being placed on patient experience with the appointment of a Patient Experience Lead and the introduction of 'real time' feedback from patients. Relationships are being established with Healthwatch and other key stakeholders as well as other modes of engagement with patients and their relatives and carers.

Key quality metrics have been identified and reported monthly to the Board and are being further refined both at a corporate, divisional and ward level.

In order to improve and sustain quality improvements across the Trust a Quality and Safety Transformational programme has been established with an Executive Lead. A number of surveys have been undertaken to support this work including the OHI.

A Quality Governance review is planned for Q2.

Clinical Strategy

An overarching clinical strategy for the Trust will be developed by the end of Q3, 2013/14. The first component (Women and Children) and the second component (integrated health economy elderly care) is almost complete. The next components are the Cardiothoracic Centre first stage review (June), emergency care, elective care, then pulling it together incorporating support services, research and education. At Q3 we will consolidate with bottom up Service Line strategies that will be informed by the overall strategy and feed into annual planning for 2014/15. This work will mainly be supported by external consultants, but with the full participation of our internal and external stakeholders.

The focus of the Trust's strategy for its clinical workforce in 2012/13 has been to provide a consistent level of senior presence seven days a week and for an extended working day. This continues to be the priority for 2013/14 onwards. The objective is to ensure that patients, particularly non-elective admissions, are seen when they attend by a senior decision maker, in line with Royal College recommendations, irrespective of the day of the week or time of the day. Rotas for consultants have been revised and implemented to provide seven day extended working day presence on site in the main acute specialties, i.e.;

-A&E

-acute and general medicine

-general surgery

-paediatrics

-Obstetrics and Gynaecology

In 2013/14 this is expected to be extended to include anaesthetics, in line with the refurbishment and expansion of ITU.

There are long-term issues in recruiting substantive A&E consultants and acute physicians and both specialties are below recommended Royal College of Physicians (RCP) consultant levels. This is not unique to Basildon. A hybrid model has been adopted to manage the adult urgent care pathway which has mitigated some of these gaps. A seven day week model was implemented in 2012/13 but requires further refinement to be sustainable. Work will be done in 2013/14 to understand the gaps in medical cover at all levels to ensure safe levels of care throughout the 24 hour period. This is likely to result in the development of a hospital at night model and enhanced critical care outreach.

It is considered that there a number of surgical specialities lacking critical mass of activity: urology, head and neck and vascular. Changes in commissioning arrangements will resolve the issues in vascular and other service model options will be explored with neighbouring providers where there is no commissioning drive.

Similarly the diagnostic and clinical support services of pathology, pharmacy and diagnostic imaging have implemented extended on site rotas to replace the previous on-call rotas and to provide a more consistent level of cover across the working week. These are expected to be further revised from 2013/14 onwards.

The level of vacancies in the Trust is low, at 6.3% at 1 April 2013, having fallen steadily month on month since July 2012. The figure for 1 April 2012, by comparison was 9%. Vacancies for clinical staff are 5.8% and for non-clinical staff are 7.6%. This position would provide resilience in the workforce.

Care delivery models are being adapted for the adult urgent care pathway with front-end use of GPs in A&E in partnership with the local CCG and further enhancement of the community geriatrician model to provide better services to the frail elderly, in partnership with North East London Foundation Trust.

There are residual recruitment difficulties with some parts of the workforce. A&E and acute medicine and non-consultant career grades across most specialties are hard to recruit substantively. These are recognised as NHS-wide problems. The Trust has engaged recruitment specialists and is exploring options for sustainable recruitment from overseas.

In the non-medical workforce there are periodic recruitment hotspots, particularly in small professional groups. These are not expected to constrain service provision. The Trust is working with the Local Education and Training Board to improve the supply of the future workforce.

Productivity & Efficiency

The Trust submitted a turnaround plan to Monitor in May 2013 to oversee the effective delivery of an Urgent Care Plan, Mortality Plan, Paediatric Plan, Governance Plan and other transformational changes defined by the Trust. In addition, the Trust undertook to implement sufficient programme management and governance arrangements to enable delivery of the Urgent Care Plan, the Mortality Plan, the Paediatric Plan, the Governance Plan and the Turnaround Plan.

As part of the annual plan development and to support the Urgent Care Plan, detailed bed modelling has taken place to identify bed requirements for 2013/14. A worst case activity scenario has been used, based on a small reduction in demand from QIPP schemes and a small reduction in length of stay, but with continued growth of the activity baseline. This gives the following bed requirement:

	Current Bed base	Activity Plan Worst case scenario	Impact LOS reduction	Reduction for Partial QIPP schemes	Required Bed Base	Additional beds required
BEDS	Mar-13	Average	Average	Average	Average	Average
Cardiology and CTC	83	83	0	0	83	0
T&O Elective	22	22	0	0	22	0
T&O Non Elective	55	57	-5	0	51	-4
Medical & Elderly Medicine Specs.	346	426	-31	-18	376	30
Surgical Specs.	70	88	-2	-3	82	12
0 LOS beds	0	7	0	0	7	7
Total	576	683	-39	-22	622	46

Notes:

Partial QIPP schemes applied

- 9% reduction in Elderly Medicine admissions from extension of community geriatrician scheme. Phased implementation July 13 to March 14. Represents in total 50% of level assumed by CCGs.

- Reduction in surgical emergency admissions in line with that seen in Q4 2012/13.

- Reduction in general medicine emergency admissions of 3 %. Represents 25% of level assumed by CCGs.

Assumptions:

- Excludes Paediatric, Maternity, Critical Care and Daycase activity and beds

- Ring fenced James Mackenzie, CTC beds & Horndon ward for elective T&O

- Zero day LOS bed requirement based on throughput of 2 per day

- Bayman ward excluded from current Bed base

- Hordon ward as at March 13 used for T&O and Short Stay Ward as Medical Ward

- Target occupancy based on 92% except T&O at 85% and CTC at current occupancy rate

- Realistic LOS trajectory (Achieving Median or at least a 10% reduction by March 14, to a maximum reduction of 20%)

Average length of stay analysis using a number of different benchmarking sources has identified that reductions in average length of stay should be possible, and these are factored into the above model. Using the realistic length of stay reduction scenario and a 92% target bed occupancy, the requirement is for an average of 46 extra beds, although the requirement is considerably more in the first half of 2013/14 until QIPP impact and length of stay reductions impact. Historically, the bed shortfall has been met through the use of escalation beds in elective day facilities and in 2012/13, through beds at Brentwood Community Hospital and virtual beds from a hospital at home scheme. This annual plan aims to meet the bed shortfall without resorting to the use of elective daycase or inpatient beds, which impacts upon referral to treatment waiting times. The actual length of stay reduction requirements by specialty to achieve this are shown below. Actions to reduce the average length of stay are part of the Right Place Right Time project within the Trust's Transformation Programme. Further information on the length of stay improvement opportunity is provided in Appendix 1, not for publication.

ELECTIVE SPELL LOS BENCHMARKING FROM NHE COMPARATORS

Based on 2011/12

		NHS Comparators Published Mean and Standardised			Crude rate calculated based on EOE Peer Group			Basildon variance from		Target LOS Reduction by March 2014	
Code	Specialty	Trust	SHA	National	Basildon	Median	UQ	Mean	UQ	Realistic	Aspirational
100	General Surgery	3.5	3.2	3.4	3.6	3.3	2.9	-8%	-19%	-10%	-19%
101	Urology	2.2	2.1	2.3	2.2	2.0	1.9	-9%	-14%	-10%	-14%
110	T&O	4.1	3.4	3.5	4.2	3.6	3.3	-14%	-21%	-14%	-21%
120	ENT	1.3	1.2	1.3	1.1	1.1	0.9	0%	-18%	-10%	-18%
170	Cardiothoracic Surgery	5.7		5.6	5.7	5.4	4.8	-5%	-16%	-10%	-16%
300	General Medicine	10.3	9.3	9.6	9.8	5.2	4.4	-47%	-55%	-20%	-25%
301	Gastroenterology	4.2	3.5	3.3	4.2	3.6	2.5	-14%	-40%	-14%	-25%
320	Cardiology	1.9	1.8	1.8	1.9	2.4	1.6	26%	-16%	-10%	-16%
340	Thoracic Medicine	5.5	2.7	2.4	7.1	4.5	3.0	-37%	-58%	-20%	-25%
502	Gynaecology	2.2	2.1	2.2	2.2	1.9	1.7	-14%	-23%	-14%	-25%
Other Specialties		Benchmarking information not available								-10%	-20%

EMERGENCY SPELL LOS BENCHMARKING FROM NHE COMPARATORS

Based on 2011/12

		NHS Comparators Published Mean and Standardised			Crude rate calculated based on EOE Peer Group			Basildon variance from		Target LOS Reduction by March 2014	
Code	Specialty	Trust	SHA	National	Basildon	Median	UQ	Mean	UQ	Realistic	Aspirational
100	General Surgery	4.1	4.3	4.6	3.8	4.4	3.8	16%	0%	0%	-5%
101	Urology	3.6	3.7	4.0	3.4	4.0	3.1	18%	-9%	-9%	-10%
110	T&O	8.9	7.5	8.2	9.0	7.8	7.4	-13%	-18%	-13%	-18%
170	Cardiothoracic Surgery	13.3		10.8	13.5	10.4	8.5	-23%	-37%	-20%	-25%
300	General Medicine	7.3	6.3	6.3	7.5	6.5	5.9	-13%	-21%	-13%	-21%
301	Gastroenterology	14.9	11.5	10.2	15.7	12.3	10.6	-22%	-32%	-20%	-25%
315	Palliative Care	14.8	12.9	12.6	15.0	11.2	8.0	-25%	-47%	-20%	-25%
320	Cardiology	7.7	6.6	6.2	7.7	7.7	6.0	0%	-22%	-10%	-22%
340	Thoracic Medicine	10.5	9.0	7.9	10.8	9.2	6.8	-15%	-37%	-15%	-25%
430	Medicine for Elderly	7.3	6.3	6.3	7.5	6.5	5.9	-13%	-21%	-13%	-21%
502	Gynaecology	2.6	1.5	1.2	2.7	1.7	1.4	-37%	-48%	-20%	-25%
Other Specialties		Benchmarking information not available								-10%	-20%

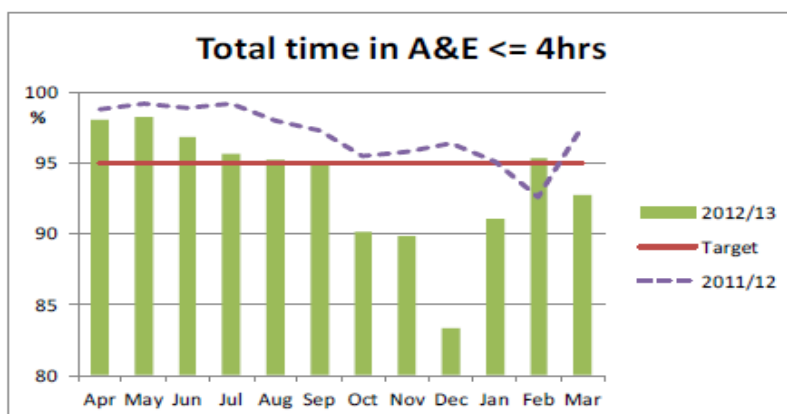
NHS Comparatives Mean - Methodology

- Covers only PbR spells =93%>
- General Medicine includes Endocrinology and Geriatric Medicine
- LOS in excess of 90 days is trimmed at 90 days
- Standardised rate accounting for age and gender
- Cardiothoracic Surgery based on national benchmarking
- Benchmarking information is not available for other specialties such as Nephrology but suggest reduction is based on Trust overall opportunity for reduction

Target LOS Reduction

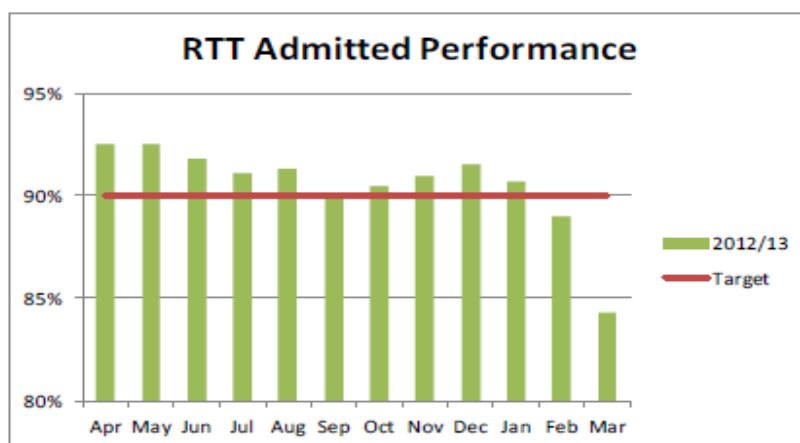
- Realistic based on achieving at least 10% unless UQ achieved, then achieving median to a maximum reduction of 20%
- Aspirational based on achieving UQ to a maximum reduction of 25%

The Urgent Care Plan was produced as the Trust breached the 4 hour standard in Q3 and Q4 of 2012/13. Within that period the Trust achieved only one month (February 2013) of compliant performance, as shown below.

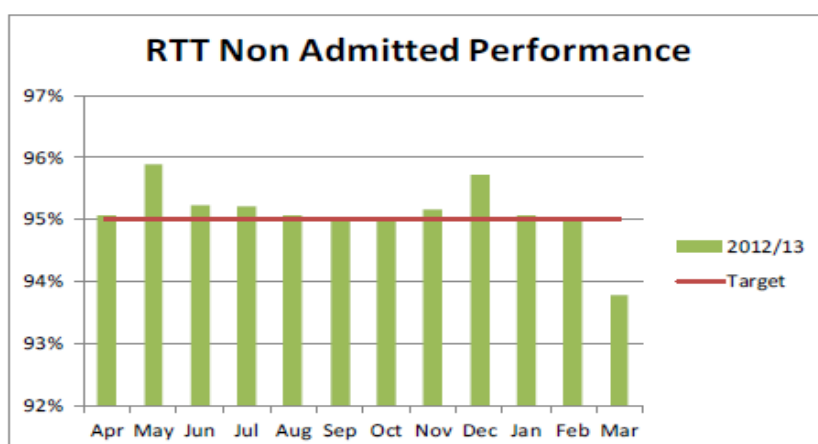


Also during this period the Trust breached the 12 hour trolley wait standard on seven occasions on 1st January 2013. Lack of bed capacity was the major cause of poor A&E performance.

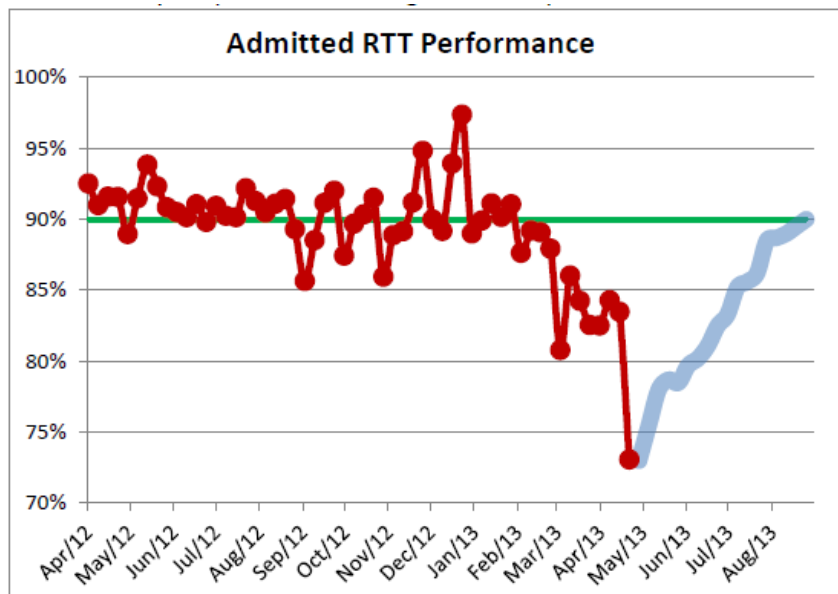
The Urgent Care Plan also includes recovery of 18 week referral to treatment performance, as lack of bed capacity has led to failure against this target. During January to March 2013 the Trust performed minimal elective inpatient operating due to lack of bed capacity, and this has resulted in breaches of the 18 week standard. This is shown in the following graph.



The non-admitted 18 week performance has also suffered, due to the focus on the emergency pathway, as shown below.



The Urgent Care Plan includes a recovery trajectory, as follows.



Recovery is based on a full return to elective operating and outsourcing suitable patients to private providers. The activity plan for 2013/14 includes additional elective activity on a non-recurrent basis to return to 18 week compliance. Any shortfall in elective operating will be compensated for by increased outsourcing.

For non-admitted 18 week performance, the Trust is forecasting that it will not meet the 95% target for non-admitted patients in April and May 2013. It is anticipated that performance will recover in June 2013.

The Trust has established a Quality and Safety Transformation Programme with an associated corporate structure including executive leadership (Deputy Chief Executive), programme management capacity and improvement skills. The delivery of productivity, efficiency and cost improvements is essential to implement further quality and safety improvements. A number of schemes have specific targets in these areas including a project to apply Lean principles within pharmacy, a productive outpatients project and Right Place, Right Time which focusses on improving the emergency patient pathway in the hospital to drive the length of stay improvements in the above tables.

As the programme is further developed it will identify additional transformational productivity and efficiency opportunities both within the Trust and working with local health partners.

The programme is targeting an additional 2.5% cost improvement above the 5% included within the operational budget for year one of the plan, which will then be available for additional investment in quality and safety. Cost improvement plan performance will receive oversight by the governance structures in place for the transformation programme as well as through operational management arrangements reporting to the Board.

As part of an IT Strategy, the Trust is investing heavily in IT developments that will further improve efficiency and improve the safety of care. In particular, the Electronic Medical Records programme described in previous annual plans will complete in April 2014, at which point all medical records will be available electronically. In addition to this, The Trust signed a contract in February 2013 for an Electronic Patient Records system, which will be deployed incrementally starting with a new Patient Administration System (PAS) and an order communications and results reporting system in 2013/14. This will require circa £7.0m of capital expenditure on IT in 2013/14 from a total capital programme of £15.0m. A business case will be developed by December 2013 to agree the timescale and order of deployment for the remaining EPR modules covered by the contract in subsequent years e.g. electronic prescribing, clinical observations and noting etc.

During 2012/13 the use of temporary staff, bank, agency and interim increased significantly in response to organisational change and capacity demands. Bank and agency use averaged around 13,000 hours per week by the end of 2012/13. Sustained successful recruitment will contribute to significantly reducing that figure.

CIP Governance

In 2010 the Trust commissioned Tribal Consulting to assess the approach to cost improvements and to critically review the financial planning process. The review suggested the Trust develop the theme of identifying cost improvement programmes in three categories: Operational, Tactical and Strategic. These are explained in further in the Finance and Investment Strategy. This has been completed for the last three years and will continue. The schemes to date have predominately been operational, but over time these schemes reduce in number, so the Trust board will need as an approach to find more tactical and strategic schemes to deliver the size of savings required. This is now happening with initial dialogue with other local acute trusts on collaborating for larger joint savings eg pathology services. Further, the Trust has invested in a 'transformation programme' led by the Deputy Chief Executive.

The Trust has had considerable success with cost improvement delivery in recent years. This resulted in the largest surplus the Trust ever achieved in 2011/12 with fairly flat income. The financial year completed in 2012/13 was more challenging with a considerable increase in unplanned care which resulted in a substantial increase in cost to meet this activity demand. This increase in demand coupled with increased external scrutiny in the quality of care resulted in an increase in operational costs. Even with these demands the Trust delivered a financial surplus in line with the Annual Plan, but the efficiency programme was income led rather than cost led, whereas in the previous years was cost led.

The Trust increased its EBITDA margin in 2011/12, against a falling EBITDA within the FT sector through cost management, though the EBITDA for 2012/13 reduced to 5.9% with a small surplus.

The Trust has not adopted the Project Management Office (PMO) approach, but uses the same principles of monitoring through detailed workbooks and milestones. The milestone performance of each scheme is measured each Monday and shortfalls highlighted for immediate action plans. Each programme is RAG rated for delivery as well as impact on quality.

The cost improvements are locally owned and generated from the divisions, and these are nearly all operational. The cost improvement process is on-going all year, but will be reviewed in detail during January to March to take into account new commissioning intentions and changes to The Operating Framework and national tariffs.

CIP Profile

Over the three year Annual Plan the efficiency target will be 4% per annum, totalling 12%. The Trust has assessed that 5.5% of this will be achieved via productivity and 6.5% through reduced cost. The CIP total over the three years of the Annual Plan is circa £35.9m, of which £18.1m (50%) is expected to be pay related, £13.2m (37%) is expected to be pay related and the £4.6m (13%).

The Trust is running a large number of CIP schemes for 2013/14, but the schemes for the following years are higher level, including the 'Right Place Right Time' and Electronic Medical Record (EMR) projects which will deliver significant benefits in future years.

The cost improvement target for 2013/14 is circa £13.8m, of which £9.2m is cost reductions and £4.6m income related. The income is not included in the analysis.

The 176 schemes for 2013/14 are primarily operational schemes. The breakdown by category is 159 operational, 13 tactical and 4 strategic. Though there are a large number of operational schemes, the tactical and strategic schemes account for £5.2m (38%). This value of the tactical and strategic schemes for years two and three of the Annual Plan increase significantly, as that is the only way to achieve the cost improvements required.

The cost improvement schemes have been RAG risk rated for delivery, and at the start of the financial year 11 schemes are **red** rated, 79 schemes are **amber** rated, 85 schemes are **green** rated and 1 is **blue** (already delivered). This is an improvement from the previous year at the corresponding time. This information indicates that additional schemes will need to be found. It is important to note that a number of central schemes are to be added to the matrix (for example, the benchmarking and external saving analysis on drugs).

The savings are currently weighted towards pay and labour costs, with £5.5m of the total being in the category. There are 61 schemes of which 6 are red rated for delivery. The two significant cost savings initiatives are Right Place Right Time bed reductions, and reducing the amount of expenditure on temporary staffing related to agency. These schemes are rated **amber** for delivery at the moment.

It is important to note that only recurring schemes are included in the internal CIP reporting, and non-recurring schemes are not included. These are considered a bonus within year, but are financially significant.

The Trust has had some success in reducing the number of suppliers for many products and rationalising products. The Trust is also more aggressive in negotiating discounts. The procurement team are involved in over 30 cost improvement schemes, which are **amber** or better. The Trust is a member of a procurement hub and is also involved in joint working projects with other trusts to increase the economies of scale benefits.

The Trust has successfully reduced the cost of support functions over the last two years, but is looking to do more. The savings to date have been operational in nature. The Trust has 41 corporate schemes covering estates, facilities, finance and personnel for 2013/14. These schemes are RAG rated for delivery and have milestones.

The financial template and Annual Plan includes no financial impact of the commissioner led Transforming Pathology Services programme. The Trust will work in partnership with Southend Hospital to create a joint service to mitigate any financial impact in 2014/15 onwards.

The Trust produces weekly metrics to review financial income and expenditure, activity, CIP milestones, operational targets and KPIs metrics. This includes a detailed review of weekly hours worked. This is an award winning process, with the Trust receiving the HFMA Efficiency Award for 2010.

Previous information provided by the National Benchmarking club would indicate that the non-elective admissions to the hospital is the lowest in the East of England and one of the lowest in the country, which would suggest that further reducing non-elective admissions will be a significant challenge to the commissioners. The benchmarking also shows that the length of stay of admitted patients is longer than the typical trust, also confirmed by external reviews. This is a focus of the Right Place Right Time programme described above, and is a focus of cost improvement the Trust can control and influence.

The Trust will continue with its Invest to Save programme, in particular regarding the 'green' agenda and becoming more energy efficient. The Trust has invested significantly in this agenda, including photovoltaic panels, LED lighting and recycling for profit. The Trust was shortlisted for the HSJ Efficiency awards in 2012.

A management re-structure was implemented in April 2013 with the clinical divisions being led by a clinical director, with the support of a general manager and head of nursing. At the heart of this is enhanced clinical leadership with additional protected time identified for the five newly appointed Clinical Directors and the clinical service unit leads. The re-structure provides visible leadership, clear accountability and manageable spans of control. Cost effective quality improvement is explicit within this re-structuring and facilitated through the Service Line Management (SLM) roll-out.

The Trust has restructured into six new divisions, with locally owned cost improvements. The divisions will be provided with SLM information to support devolving targets. Having completed the first stage of implementation of a new structure we now have an 18 month - 2 year implementation plan for SLM which will be overseen by the transformation programme. The SLM strategy has been informed by the Monitor / McKinsey SLM programme that the Trust has participated in, and built upon by the Trust led quality and patient safety turnaround work and the OHI. This means that the SLM strategy has been informed just as much by the cultural / behavioural and safety change priorities identified by our own staff, as the need to deliver effectively at service line level. The key is that the significant change for us is the move we have made to have a model of management that has a single line of clinical accountability. The evidence suggests that the safest and most successful healthcare organisations are clinically led. Though the Trust is devolving much responsibility as part of its SLM strategy, some central controls will remain. This is primarily the Vacancy Control Group that reviews all posts prior to advert. A number of controls will remain on non-essential purchases to ensure best value is obtained.

If the demand management reductions from the CCGs in future are successful, then the Trust will have to review the use of its estate. The Return on Assets (RoA) is not a strong metric, and so if income is reduced then the RoA will decrease.

The underlying theme for the Trust reflected in the divisions is that quality costs less, and doing the right thing at the right time is efficient and saves resource. The process of only counting recurrent savings will continue.

The top 5 cost improvement schemes listed in the table are schemes that are unaffected by activity, and these are schemes within the Trust's own control and remit. If the commissioners successfully reduce demand then additional cost reductions will be found to meet the income lost.

Quality Impact of CIPs

It is imperative that the impact of cost savings and efficiencies do not adversely impact on quality, and this was key to the approach for the Trust prior to the Francis Report, and is even more apparent and transparent in our planning now. The Trust must look at delivering value in all services.

All CIP schemes are locally owned within divisions and directorates, but they are centrally monitored. There are a number of central schemes, which cover the potential slippage within the divisions. Each division cost improvement process involves clinicians.

The Trust's approach is to have many schemes, both large and small. The large schemes have the big financial impact, but the small schemes improve the culture and mentality to cost control and cost behaviour. All schemes have milestones and are RAG rated for risk of delivery.

All schemes are quality assessed within the clinical divisions and directorates. These are reviewed and approved by the Clinical Directors. The schemes are then presented by the Clinical Directors for peer review to the Executive Directors. The majority of the schemes improve either patient quality or experience or both. If any scheme has the potential to impact quality or experience then mitigation has to be shown. Over the last three years a number of schemes have been rejected due to adverse effect on patient quality or experience. The reporting structure is via the Senior Management Group, Finance and Resources Committee and Board of Directors.

Financial & Investment Strategy

The NHS, and the public sector in general, are facing a continued period of reduced funding, exacerbated locally by the challenged financial position of the local CCGs. Therefore, to achieve financial targets and to continue to invest in capital resources, the underlying cost base must be reduced, requiring further productivity improvements. The financial strategy will need to meet the national efficiencies required within the national tariff, and to ensure costs are removed equal to any reduction in income from commissioners. The reduced cost base must include reducing corporate overheads and back-office functions. The Trust's financial strategy includes invest-to-save schemes, particularly in IT and for reducing the organisation's carbon footprint. The organisation is aware that reducing cost cannot be at the expense of patient quality or safety.

As in the previous Annual Plan, the Trust's financial strategy is as follows:

- To maintain a minimum Financial Risk Rating (FRR) of 3;
- To maintain a liquidity FRR of 4, with a planned minimum cash balance of £15 million to safeguard the Trust during a sustained economic downturn, and a minimum liquidity financial risk rating of 4 (based on proposed new risk rating);
- To avoid any new borrowing unless there is a business case to deliver either:
 - i) Three year payback;
 - ii) Essential replacement equipment to maintain current activities;
- To manage investments with financial institutions that have the strongest ratings; and
- To deliver a net surplus over any three year period.

The Trust cost improvement strategy will require the savings requirement to be cost focussed and not income focussed. The financial strategy includes assessing cost efficiencies into three measures:

- **Operational** – 'Doing things that we do now, better' by significantly improving the productivity of the current business and clinical model
- **Tactical** – 'Changing the way that we do things' by flexing the business and clinical model to improve the underlying economics
- **Strategic** – 'Changing what we do' by redesigning the business and clinical model to adopt a new model of care for the system as a whole

To date the Trust has focussed on operational savings, but the strategy is based on moving through these three levels.

The Trust has met all its financial targets and obligations for 2012/13 with a £0.2m surplus which was above plan. The Trust has a strong liquidity position and finished the year with a £34.4m cash balance. The Trust had an EBITDA of 5.9% and achieved 98.2% of its plan.

Capital Investment

Due to the tightening of government fiscal policy and the increase in national efficiency savings requirements, to maintain the Trust's cash position the capital programme processes and governance have been strengthened over the last two years. The experience from the private sector recession, and in previous economic fiscal tightening within the public sector, strong cash balances become of increasing importance. Many NHS organisations are experiencing cash balance reductions and problems.

The Trust's current cash balance strategy requires a year-end cash balance of circa £15.0m, which equates to circa 3 weeks working capital. This figure is required to ensure liquidity FRR is at 4, which will be required to achieve an overall FRR of 3. The £15.0m allows for risks due to the financial uncertainty and potential income and expenditure slippage and uncertainty of our main purchaser's financial position. The value of the required cash balance to achieve the financial metrics can be tested quarterly; this may require increasing or decreasing the capital programme within year or revising borrowing plans.

For high priority projects that cannot be afforded within the resources available, there is the option of further borrowing within the constraints of the Prudential Borrowing Limit (PBL), and revenue impacts. The terms of any borrowing, including interest and repayment, cannot be determined with any certainty at present. It is likely that the Foundation Trust Financing Facility will be reduced in the future and if banks are used then repayment periods are likely to be shorter and interest rates significantly higher.

The Capital Programme requires tighter monitoring in both the short and long-term, and the Capital Investment Group (CIG) reviews the capital programme at least quarterly. The CIG will review the current capital position and revise the programmes accordingly, applying the updated knowledge of the wider economic climate. The revised programme will be presented quarterly to the Finance and Resources Committee for scrutiny, review and approval.