



**Strategic Plan Document for 2013-14**

**Barnsley Hospital NHS Foundation Trust**

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

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

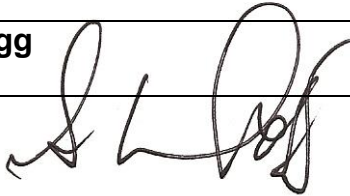
Name	Elizabeth Libiszewski
Job Title	Director of Quality & Performance
e-mail address	<u>e.libiszewski@nhs.net</u>
Tel. no. for contact	01226 435000
Date	30 <sup>th</sup> May 2013

**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.**

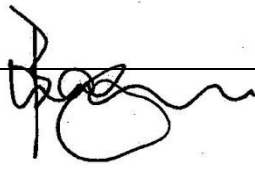
In signing below, the Trust is confirming that:

- 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.

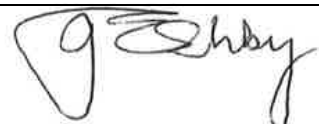
Approved on behalf of the Board of Directors by:

Name (Chair)	Stephen Wragg
Signature	

Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Paul O'Connor
Signature	

Approved on behalf of the Board of Directors by:

Name (Finance Director)	Janet Ashby
Signature	

## 1. EXECUTIVE SUMMARY

- 1.1. The Trust has in place three key strands of work which support the delivery of sustainable health care for the population the Trust serves. These are: - maximising the Trust efficiency and effectiveness in quality performance and finance; Working collaboratively with health and social care providers to deliver care locally for the people of Barnsley; and thirdly working across wider networks to deliver changed pathways of care to ensure safe sustainable services.
- 1.2. The Trust has in place seven transformation programmes, developed in 2012/13 as the basis of its work programme. This approach has used a programme management methodology embedding quality and risk reporting alongside the other delivery metrics. Each programme has an executive lead reporting to a Programme Board chaired by the Chief Executive, reporting monthly to the Board of Directors. This has formed the foundation for delivery in 2012/13 with a high degree of success in delivering the CIP. This approach will continue in 2013/14.

The programmes are:-

- Urgent Care
  - Elective Care
  - Outpatients
  - Consistency in Care
  - Strategic Service Review
  - Workforce
  - Information MT/Estates/Non-clinical
- 1.3. However the Trust recognises that as a small district general hospital the need to work increasingly in partnership to improve pathways of care for patients. This collaborative approach is both within the Borough of Barnsley working with the CCG and other health and social care partners to deliver care closer to home. The key priorities of the Health and Wellbeing Strategy and the priority areas of action for the CCG align to the Trust Transformation Programmes and a collaborative approach has been agreed as to how best to take the work forward, meeting the individual needs of each organisation whilst reducing duplication of effort and maximising benefits for the Local Health Economy (LHE).
  - 1.4. The Trust is full committed and actively participating in the Working Together Programme, which is collaboration with seven other acute providers in South Yorkshire, Mid Yorkshire and North Derbyshire. This work is also supported by the relevant commissioner and the Area Team.

The aims of the Working Together programme include:-

- Sharing information, skills and experience – there is an opportunity to share experience and learning and implement best practice across the region
- Clinical Services – working together will give each organisation the opportunity to improve the quality, safety, productivity and sustainability of clinical services.
- Workforce – changes to clinical models cannot be made without changes to workforce. Areas where the Trusts will benefit include 7 day and 24/7 working, locum and agency use, on-call rotas

- Back office services – priority areas for collaboration include procurement, HR and Training and Development
  - Better use of technology – three main areas have been highlighted for consideration; trusts that are planning to purchase the same system or have found ways to use their system much more effectively; trusts strategically thinking through the requirements of systems to enable better communication between organisations; trusts looking at how technology will enable better ways of working, for both staff and patients.
- 1.5. The Trust recognises the opportunities to support improved pathways of care with the use of technology. The Trust has committed to invest in a new Electronic Patient Record which will enable significant change in 2014/15 (yr. 2 of this plan) the Trust is also using other technologies to support changes to care delivery exemplified in the Urgent Care transformation programme.
  - 1.6. The Trust has worked closely with the commissioner to agree the demand profile and activity mix which continues the move to care being delivered in a less acute setting which is reflected by the reduction in elective procedures in years 2 and 3. Impact of Transformation Programme will see a smaller increase in both elective admissions and outpatient attendances in year 2 than in previous years with a reduction in both areas in year 3.
  - 1.7. The Trust has a key Transformation Programme improving the approach to provide consistency in care, moving to seven day care across a number of patient pathways. This will have an impact not only on the efficiency of the Trust, provide opportunities to deliver care to suit the needs of patients but also improve the quality of care.
  - 1.8. The transformation programme will lead to reductions in workforce numbers. An overall reduction of approximately 124 WTE of the workforce is anticipated throughout the three-year plan. This will impact on all categories of staff. The reductions will be achieved in the main by a 1% reduction of pay budgets, the closure of two wards and a redesign of outpatient processes. These initiatives will be supported further by a voluntary severance scheme and robust vacancy control.
  - 1.9. The Trust has carried out workforce reviews for Medical, Nursing and AHP staff groups as part of its workforce Transformation Programme. The reviews map out the respective workforce, and uses benchmark data, and professional guidance to identify where the workforce does not reflect the current and future needs of the Trust.
  - 1.10. The Trust is committed to continuously driving the quality and safety of care throughout the organisation and in support of this introduced the Service Leadership Management Model (SLM) to promote effective clinical leadership in 2012/13. The SLM comprises fourteen Clinical Service Units (CSUs) each led by a Clinical Director who has overall accountability and responsibility for the delivery of clinically sustainable and financially viable services. The Clinical Directors now have an integral senior role and contribute to decision-making within the organisation and as such have participated in an internal leadership development programme.
  - 1.11. Within the framework of the seven transformational programmes CIP plans for 2013/14 were presented and accepted by the Board in April 2013. Detailed schemes have been clinically and financially risk assessed as appropriate. Quality impact assessments were undertaken by the Medical Director and Chief Nurse. On this basis a number of proposed cost improvements were rejected or deferred pending more work. The target for 2013/14 is £6.2 million in order to deliver a 1% surplus.

- 1.12. The fundamental aim of the financial strategy over the period is to maintain and build on the stable base that has been achieved. The Trust ended 2012/13 with a financial risk rating of 3 and a 1% surplus margin, but which was in excess of its target, despite an extremely challenging year operationally. The financial strategy going forward is to maintain a minimum financial risk rating of 3 or the equivalent in any future proposed metrics. The requirement to achieve surpluses is a key component of the capital investment plans. It is recognised that support in the form of external loans will not be required to deliver the future capital programme.
- 1.13. The cost improvement target for 2013/14 (£6.2 million) represents 4.1% of the planned cost base (3.9% of planned turnover), to achieve a 1.0 % surplus margin. The 1.0% surplus margin is expected for the three year period ending 2015/16. The processes and approach around the design, process and management of these targets are described in further detail in this document. Cognisant of the historic delivery on efficiency targets the approach adopted includes stretch and a more sustainable programme of delivery over the medium term.
- 1.14. The Commissioners have indicated that they do not anticipate activity growth over the next two years. In addition, tariffs will not increase for providers as they are used as levers to generate efficiency. For the purpose of planning assumptions a 1.0% reduction in tariff is assumed for the next two years. CQUIN income is prudently capped at 2%.

## **2. STRATEGIC CONTEXT AND DIRECTION**

### **2.1. Trust's strategic position within LHE**

- 2.1.1. In line with the national trend there are an increasing number of patients attending the hospital over the age of 65 with an increasing proportion being over the age of 85. This presents a number of challenges in designing service models that accommodate this complex cohort of the population ensuring that they receive high quality care in the right setting by staff with the right skills and knowledge to meet their needs.
- 2.1.2. In addition the Trust has seen an increase in the number of unplanned attendances and to support this there has been significant investment in specific areas of the Trust – for example the re-design of the Emergency Department and the expansion of the Acute Medical Unit to facilitate the flow of patients, particularly through the Urgent Care pathway.
- 2.1.3. For those planned pathways when interrogating national comparator data, the Trust generally performs favourably and this has been demonstrated through some of the benchmarking exercises undertaken as part of the Transformation Programme.
- 2.1.4. The Trust has a relatively traditional medical model of service delivery that will have future workforce sustainability issues as local deaneries reduce the number of medical training posts available and specific specialties such as Emergency Medicine, Acute Medicine and some specialised Radiology posts become increasingly difficult to recruit to.
- 2.1.5. The Transformation Programme is now well established within the organisation with a robust governance structure that monitors progress and reports directly to the Board of Directors. Two of the original programmes

have amalgamated resulting in seven internal Transformation Programmes as set out below:

- Urgent Care
  - Elective Care
  - Outpatients
  - Consistency in Care
  - Strategic Service Review
  - Workforce
  - Information MT/Estates/Non-clinical
- 2.1.6. An eighth programme will incorporate the Working Together Programme – details are outlined further in this report.
- 2.1.7. Year one of the programme was focussed on the planning of the work streams, identifying the resource requirements and agreeing achievable and measurable measures of success.
- 2.1.8. Year two of the Transformation Programme will focus on delivery and benefits realisation with the absolute requirement to ensure that each transformation work stream is owned by the appropriate Clinical Service Unit (CSU) and that there is clarity around accountability for achievement of key quality indicators and financial milestones.
- 2.1.9. The Transformation Board will hold to account and encourage clinical teams to be more ambitious in their aspiration of where they wish to be placed in comparison to surrounding providers and robustly challenge traditional ways of working and staffing models to be much more creative in where services are delivered and by whom in the future.

#### Competition

- 2.1.10. Currently the majority of acute services for Barnsley patients are commissioned from Barnsley Hospital NHS Foundation Trust (BHNFT). However there is clear evidence of choice for acute provision for residents of Barnsley. Geographically there are a significant number of acute sites (ten NHS and six private) within easy access defined as 20 miles or approximately 30 minutes driving time, of Barnsley offering choice of provision. Ideally placed within a mile and a half of the M1 and halfway between Sheffield and Leeds, BHNFT provides a real and viable alternative choice for residents from a range of different locations. There is clear evidence that commissioning groups from outside of Barnsley are spending on care from BHNFT in response to their population exercising choice. Each of these trusts has strengths and weaknesses in differing areas allowing for patients to choose their provider based on their own priorities.
- 2.1.11. BHNFT has a number of key strengths. The Trust is perceived to be a source of stability within a changing health and social care landscape. The Trust has good external accreditation ending 2012/13 with a financial risk rating of 3 and a modest surplus as well as a governance rating of amber/green. The Trust is closely linked with the local authority and the Clinical Commissioning Group as all three are coterminous, serving the same population, to support this aligned approach the Trust sits on the Health and Well Being Board. The Trust has clear clinical leadership having introduced a new medically-led

organisational structure called the service leadership model increasing the number of clinical directors.

- 2.1.12. In terms of weaknesses there are many challenges the Trust is facing including an increase in unplanned demand impacting on the delivery of the 4 hour target. To combat this there has been an external review and a subsequent action plan developed with a performance framework in place to support delivery. Relative to other Local Health Economies, South Yorkshire provides a larger share of care in more expensive settings e.g. South Yorkshire has the highest number of acute beds per weighted population, 47% above their peer group and low community provision relative to acute spend, at 36% below national average, the Trust is working through these issues with commissioners and other local providers including the community services provider South West Yorkshire Partnership FT through the urgent care Transformation Programme. In the past the Trust, like many other smaller acute foundation trusts, has been perceived to be too inward looking. This issue is being tackled in 2 key ways. First through the Strategic Review of Services Transformation Programme where all Clinical Service Unit's are undergoing external review and challenge around their services ensuring they are high quality, cost effective and sustainable. The second is through the Working Together Programme linking up to other acute trusts in South Yorkshire, West Yorkshire and North Derbyshire.
- 2.1.13. The Working Together Programme's stated aims are: to establish a clear and agreed framework, mechanism, and process to enable acute providers to work together in a structured, systematic and collaborate way to enable them to achieve benefits that they would not achieve by working on their own; to support the delivery of high quality and sustainable services to people in the most appropriate care setting(s) as local and as close to their home(s) as possible; to support the achievement of financial viability and sustainability for each participating organisation; to ensure that strong acute providers are working collaboratively with strong commissioners to meet commissioners' intentions, improve the health and wellbeing of the people we serve, and do so in the most economic, efficient and effective way.

#### Forecast health, demographic, and demand changes

- 2.1.14. The Office for National Statistics estimates the current population of Barnsley at 231,900. The median age of the population of Barnsley in mid-2011 was 41 years. In 2011, there were 2,991 live births in Barnsley and 2,274 deaths. The total population of Barnsley is projected to rise by 7.2% by 2021 (2.9% from 2011 to 2015). The largest projected increase is likely to be those aged over 65, by 20.9% (9.7% from 2011 to 2015). 20% of the total population will be aged over 65 in 2021. The demographic trend of an ageing population means that demands on health and social care services will continue to grow. It is important that residents are supported to maintain healthy and independent living for as long as possible, to not only improve the quality of life in elder years but also to reduce the burden on health and social care services.
- 2.1.15. Barnsley is ranked as the 47th most deprived borough of the 326 English boroughs, with 32% of the population living in the 20% most deprived areas in the country. The deprivation is concentrated in the east of the borough. Life expectancy at birth in Barnsley is increasing from 76.4 years in 2007-09 to 76.8 years in 2008-10 for men and from 80.1 years in 2007-09 to 80.4 years for women. This is 1.75 years less for men and 2.17 years less for

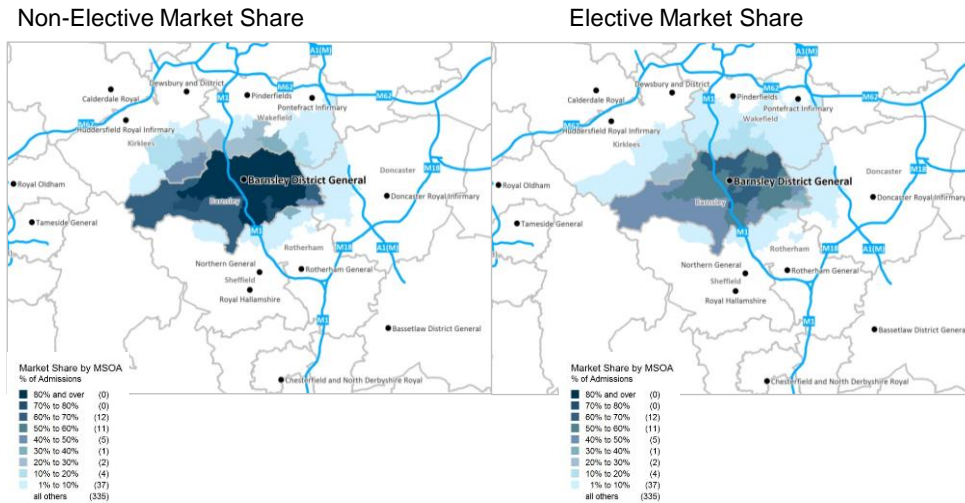
women compared to England's average. Unfortunately, the rate of improvement is not as fast as the national average, with the gap in life expectancy widening both within the borough and between Barnsley and the national average, particularly for men.

- 2.1.16. Improvement in the arrangements for meeting the health needs of children in care is a key action for health and social care resulting from the inspection of Safeguarding and Looked After Children. All local organisations are working together to improve their collective performance in this area and tackling the issues that have been raised.
- 2.1.17. Cancer is the leading cause of premature death in Barnsley, and the second leading cause of death overall. Although premature mortality from cancer is falling, the rate of this fall is not as fast as that seen across the rest of the country and therefore the gap in cancer mortality between Barnsley and England is widening. For the period 2008-10, the cancer premature mortality rate was 140.5 per 100,000 population compared to 143.21 per 100,000 population in 2007-09. The number of premature cancer deaths for the same period was 1118.
- 2.1.18. Cardiovascular disease (CVD) is the leading cause of death in Barnsley, and the second leading cause of death in those aged less than 75 years. For the period 2008-10, the CVD premature mortality rate was 84.7 per 100,000 population compared to 86.66 per 100,000 population in 2007-09. The majority of these deaths were from coronary heart disease and stroke. Whilst improvements are being made locally, Barnsley has a significantly higher premature CVD mortality rate compared to the national average.
- 2.1.19. Respiratory disease is the third most common cause of death in Barnsley, accounting for 1155 deaths per year (2008-10). The largest number of deaths from respiratory disease is from pneumonia, with Barnsley having the highest mortality rate for women and the second highest for men from pneumonia in the Yorkshire and Humber region. Pneumonia also accounts for a large proportion of hospital admissions. There are also a large number of deaths from Chronic Obstructive Pulmonary Disease (COPD), with a mortality rate of 34 per 100,000 between 2008-10; COPD is responsible for a substantial burden of disease locally. The predominant risk factor for COPD is smoking.
- 2.1.20. Demand changes are listed in section 2.

Impact assessment of market share trends

- 2.1.21. The Trust is clear that the Business Plan does not reflect a desire to increase growth in activity beyond contracted levels. It recognises and understands where it is positioned with regard to market share for both planned and unplanned activity.
- 2.1.22. As is expected for a smaller District General Hospital and outlined below the market share based on the acute provider activity for the Barnsley population is less for planned episodes of care than for unplanned episodes due to patient choice options, the requirement to access some services in specialist or tertiary centres and the proximity of other acute providers around the boundary edges of the borough.





Source: Finnamore

Page 3

Copyright © 1992-2013 Finnamore Ltd

www.finnamore.co.uk



2.1.23. The Clinical Service Units have access to specialty-specific data that indicates the year on year trend of either an increase or decrease in market share and this is used to inform discussions around future activity and CSU plans for service development and improvement.

2.1.24. Understanding the future direction of the aspirant foundation trust (FT), Mid Yorkshire Hospitals Trust (MYHT), within the locality will be significant to future plans. The Trust will continue to work with MYHT on service partnership development whilst it works through the FT pipeline process. The most notable service changes to date have been around increased unscheduled care and obstetric referrals to BHNFT. Mid Yorkshire Hospitals Trust is also part of the Working Together programme.

## 2.2. Threats and opportunities from changes in local commissioning intentions

### Key changes

2.2.1. NHS Barnsley Clinical Commissioning Group (CCG) is the new NHS commissioning organisation serving the borough of Barnsley, authorised as of 1<sup>st</sup> April 2013. The CCG stated aim is: - “will commission effective and efficient high quality and sustainable NHS services for patients, with prioritised use of resources, improved patient outcomes and greater financial stability.” The CCG has identified 7 priority areas it intends to focus on during the period 2013-14 and beyond. These priority areas are aligned to the key priorities included in the Joint Health and Wellbeing Strategy. Underpinning each of the priority areas are key programmes of work / actions that are planned for 2013/14 these include: cancer, cardiovascular disease, long term conditions, mental health, unplanned care, planned care, and maternity/children.

2.2.2. The CCG states in its 2013-16 commissioning plan that it places the greatest emphasis on quality and patient outcomes from the services it commissions, and expects all providers including primary care to play their part in ensuring that wherever patients receive care it is of the highest quality possible, and that it delivers the best outcomes. “By encouraging the people of Barnsley to demand the best and our local providers of health care to deliver safe, high

quality services we will reduce unacceptable variation in performance and ensure the right care is delivered to meet the needs of patients. In our determination to maintain financial stability we will promote clinical leadership and stronger partnerships within our local community; we will also champion innovation and prevention strategies that deliver improved outcomes for the people of Barnsley. There is nothing of any significance that we can achieve in isolation. We must work closely with our local partners, in particular Barnsley Metropolitan Borough Council, the local Children's Trust, Barnsley Hospital NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust and Primary Care providers on issues across Barnsley and with other CCGs on matters that cross CCG boundaries. Joint work with other clinical commissioners will be particularly important when considering the future shape of acute services."

- 2.2.3. The Trust has developed a collaborative approach on Quality Innovation Prevention and Productivity (QIPP) and demand management, taking the opportunity to involve CCG and local partners in Transformation Programmes. This ensures that shared issues are addressed and organisations can develop integrated whole system solutions.
- 2.2.4. The Trust is working with numerous commissioning bodies beyond the CCG including associate commissioners, Public Health England, NHS England and the Specialised Commissioning Group to ensure existing and any new services are accounted for and delivered to the best standard. The delivery of national and local Commissioning for Quality and Innovation priorities (CQUINs) are challenging but the Trust is committed to improving quality delivery. A prudent financial assumption of 2% has been planned based on historical performance. The current approach to commissioning has involved commissioners with smaller values being associated to the main contract; there is the potential in future that others will hold contracts in their own right. This will apply to specialist commissioners but may apply to other contract holders.
- 2.2.5. The Trust has no decommissioning plans to date. Any future reconfiguration will feature as part of the Working Together programme. The 5 relevant CCGs and the Area Team are integrated into the Working Together steering group.
- 2.2.6. Any Qualified Provider (AQP) initiatives potentially present the biggest opportunity and risk in terms of competition, so the Trust has undertaken preparation work in impacted areas to ensure it is best placed to deliver these services. In 2012/13 opportunities for Barnsley included: Community cardiology diagnostics, flexi sigmoidoscopy and community musculo-skeletal and carpal tunnel. In collaboration with commissioners an evaluation was conducted of our existing services which have been proven to provide both quality and value for money so to date these services are being provided as commissioned, subject to regular re-evaluation. Future opportunities are being reviewed in conjunction with relevant CSUs as part of the Strategic Review of Services Transformation Programme risks
- 2.2.7. The Trust will work with all local organisations in terms of shifting care delivery outside of hospitals. This includes working with CCG and the SCG on agreeing local service development plan and how this impacts on our services and patients. The Trust recognises that the contract for community services in Barnsley is due to be reviewed at the end of this financial year

and will be working with partners to ensure this opportunity to review care delivery is maximised. This and delivery of the 4 hour target remain a key focus of the urgent care programme. Examples of services where the Trust has focused include COPD, Diabetes and virtual ward programme to support patients on discharge from hospital.

#### Consideration of factors

2.2.8 The Trust recognises that it needs to deliver service change and improvement as part of a system wide, partnership approach. The overall changes in the policy direction as set out in the new Health & Social Care Act 2012 provide opportunity and challenge, responding to the integrated collaborative agenda at the same time as increasing choice and competition through such initiatives as Any Qualified Provider. The Trust recognises that how it responds to this will be critical to its longer term financial sustainability.

#### Demand profile and activity mix

2.2.9 Demand profile and activity mix details included in the table below.

2.2.10 Continuing the move to less acute setting is reflected by the reduction in elective procedures in years 2 and 3. Impact of Transformation Programme will see a smaller increase in both elective admissions and outpatient attendances in year 2 than in previous years.

POD	2011/12	12/13 Outturn	13/14 Plan	Y2	Y3	Y2	Y3
ELECTIVE INPATIENTS	4,708	4,371	4,555	4,436	4,270	-2.6%	-3.7%
DAY CASES	21,790	22,925	24,012	24,189	24,278	0.7%	0.4%
NON ELECTIVE INPATIENTS	34,695	35,676	35,776	35,862	35,776	0.2%	-0.2%
OUTPATIENTS	268,025	275,787	283,270	285,853	285,853	0.9%	0.0%
A&E	78,217	79,953	81,963	81,963	81,636	0.0%	-0.4%
OTHER NON PBR*	2,605,315	2,717,608	2,787,272	2,768,145	2,744,235	-0.7%	-0.9%

\* Other Non-PBR – The majority of other non PBR activity relates to Pathology conducting high volume low value activity.

#### Diversification of income streams

2.2.11 The Trust is maximising other income streams. This work includes: the formation of Barnsley Hospital Support Services Limited (BHSS) which currently provides a pharmacy service for outpatients, with other services including Sterile Services and Information Technology currently being considered; work with Medipex (the Yorkshire Innovation hub) to develop innovative ideas for commercialisation in line with the high impact innovation CQUIN; the Trust has partnered with a private sector optometrist to provide our patients, staff and visitors the option of purchasing spectacles on site; potential opportunities from the “hospital street” and other retail opportunities are being explored; commercial research brings in some income to the Research and Development department; and further out of area tenders are being worked on for sterile services.

## **2.3. Collaboration, Integration and Patient Choice**

- 2.3.1 As a small-medium sized Acute District General Hospital the Trust recognises the continued need to build on strong clinical partnerships in order to ensure clinically sustainable and financially viable services.
- 2.3.2 The Trust has a good record of working collaboratively with partner provider and commissioner organisations and has been an active participant of the well established South Yorkshire joint commissioning network group.
- 2.3.3 The Trust is also well represented on regional clinical network groups that have supported the development of clinical alliances where necessary and there are good examples of effective partnership working between the Trust and surrounding partners. These include a number of integrated pathways between the Trust and South West Yorkshire Partnership Foundation Trust (SWYPFT) and Barnsley Metropolitan Borough Council (BMBC), a Service Level Agreement with Doncaster and Bassetlaw NHS Foundation Trust (DBH) for the provision of breast radiology to support the breast screening and symptomatic services, The Pathology Partnership with Rotherham NHS Foundation Trust (RFT) and support to the vascular, urology and oral maxillofacial services from Sheffield Teaching Hospital NHS Foundation Trust (STHFT).
- 2.3.4 BHNFT is represented, as a provider, on the Barnsley Health and Wellbeing Board (HWB) and as such supports the strategic direction of travel as outlined within the Health and Wellbeing Strategy 2013/16. This strategy is a statement of the HWB vision to identify the health and wellbeing needs and assets of the residents of Barnsley. It is set within the wider landscape of the One Barnsley Community Strategy 2012/15 that translates into the overall vision for the borough and should inform the strategic intentions of all the local stakeholders.
- 2.3.5 The Trust has worked closely with the Barnsley Clinical Commissioning Group (CCG) through the development phase of their formal authorisation to develop a collaborative approach in understanding and meeting the needs of the local population. The CCG Commissioning Plan 2013/14 clearly sets out their intention to work closely with the Trust. The plan builds on the collaborative approach undertaken with all partners across health and social care to encourage the introduction of new and innovative ways of working to improve the overall health of the local population; reduce the health inequalities that exist across Barnsley and improve productivity and efficiency of the services delivered.
- 2.3.6 The key priorities of the Health and Wellbeing Strategy and the priority areas of action for the CCG align to the Trust Transformation Programmes and a collaborative approach has been agreed as to how best to take the work forward, meeting the individual needs of each organisation whilst reducing duplication of effort and maximising benefits for the Local Health Economy (LHE).
- 2.3.7 The seven acute providers within South Yorkshire, Mid Yorkshire and North Derbyshire have agreed in principle to work together to help meet the challenges faced by each organisation to improve the quality of care they deliver. The principles of the Working Together Programme were discussed by the Board of Directors at each Trust Board in March 2013.

2.3.8 This collaborative approach to Working Together is driven by the collective need to improve the quality of care, safety and the patient experience. The stated aims of this programme are:-. It will strengthen the ability of each organisation to:

- Deliver high quality and sustainable services to people, keeping them as local as possible.
- Maintain clinical sustainability and financial viability
- Influence and meet commissioner intentions to improve health and wellbeing in the most efficient and effective way

Five areas of initial collaboration have been identified:

- Sharing information, skills and experience – there is an opportunity to share experience and learning and implement best practice across the region
- Clinical Services – working together will give each organisation the opportunity to improve the quality, safety, productivity and sustainability of clinical services.
- Workforce – changes to clinical models cannot be made without changes to workforce. Areas where the Trusts will benefit include 7 day and 24/7 working, locum and agency use, on-call rotas
- Back office services – priority areas for collaboration include procurement, HR and Training and Development
- Better use of technology – three main areas have been highlighted for consideration; trusts that are planning to purchase the same system or have found ways to use their system much more effectively; trusts strategically thinking through the requirements of systems to enable better communication between organisations; trusts looking at how technology will enable better ways of working, for both staff and patients.

2.3.9 Working collaboratively with partners across South Yorkshire to strengthen local services, ensure consistency in the quality of services offered and equality of timely access to services will ensure the Trust remains competitive.

2.3.10 The Trust however, remains committed to the principles of patient choice as set out in the 2013/14 Choice Framework and although currently promotes 95% of services through Choose and Book a focus going forward will be to continue to work with Primary Care to maximise the choice offered to patients for both new referrals and on-going treatment options.

### **3 Approach taken to quality**

#### **3.1 External Quality Concerns**

3.1.1 The Trust was subject to 3 inspections by the CQC during 2012/13 and has no concerns outstanding following these inspections.

3.1.2 Similar to a number of Trusts across the NHS, the Trust failed to achieve the A&E 4 hour target in quarter 3 and 4 of 2012/13 and is currently failing to achieve the A&E 4 hour target consistently. The Trust engaged the Dept. of Health Emergency Care Intensive Support Team (ECIST) following this review the Trust has developed a comprehensive internal action plan which addresses urgent care flow throughout the Hospital. The action plan has

been submitted to the CCG and Monitor. The Board of Directors review progress at each Board meeting. The Trust has also met with partner agencies to look at what further actions need to be taken to support patient care across the system.

- 3.1.3 The Hospital Standardised Mortality Ratio (HSMR) remains above 100. The Trust has in place an action plan which is monitored at the Board of Directors on a regular basis. The Trust commissioned an external review of mortality in 2012/13 which enabled a further set of actions to be developed. The Trust has in place a rigorous approach to mortality review and all actions identified are reviewed at the Mortality Steering Group led by the Medical Director.
- 3.1.4 The Chief Executive is leaving the Trust at the end of May 2013; interim arrangements have been put in place these include an interim Chief Executive and the Chairman working full time for the Trust. Recruitment to a substantive Chief Executive is in progress.

## **3.2 Key quality risks**

- 3.2.1 The Trust has used a Programme Management Office (PMO) to ensure the delivery of Transformation. This has been in place for all of 2012/13. This approach has used a risk assessment and risk register, which have been aligned to the Trust governance structure. Key quality measures are included in each of the programmes and reported at Board using the transformation dashboard.
- 3.2.2 The plan for 2013/14 is predicated on this existing work and therefore the risks within the plan have been identified using this approach.
- 3.2.3 The key quality risks inherent within the plan are: -

- 3.2.3.1 Workforce reduction

Each of the workforce schemes is clinically led and uses a quality impact assessment approach. Full engagement and discussions take place with stakeholders including staff representatives. Risks are reviewed at each of the Workforce Boards and reported to the Board via the Transformation Board. A proportion of the planned reductions are based on a reduction in bed base, but will use turnover, and current levels of discretionary spend (overtime, agency) to reduce the headcount. Where alternative roles are being developed or changed a full competency framework and governance arrangements will be developed to ensure safe practice.

- 3.2.3.2 Urgent care demand

The Trust has a full programme of transformation along the urgent care patient pathway including the reduction of beds. This work is clinically led and is developed with CCG engagement. However the Trust, along with many others nationally, is currently not achieving the 4-hour Emergency target of 95%. Actions taken include a review by the Dept. of Health Emergency Care Intensive Support Team (ECIST) who has identified a number of additional actions, many of which relate to operational performance but some which link into the Transformation Plan. Streaming of demand and ensuring support for the plan by commissioners is the subject of regular Board-to-Board discussions. Support from other providers is

essential to the plan, the trust is working closely with social care partners both operationally and strategically to ensure increased integration of care delivery.

#### 3.2.3.3 12/7 recruitment

A specific Transformation Programme is reviewing the delivery of care 7 days a week, which will contribute to improving efficiency and delivery of patient pathways. A key risk is recruitment to these specialities and reviewing existing job plans to meet the needs of the service. The Trust has put in place a clinically led management structure to take forward these changes and is engaging with staff representatives. The medical director leads this work-stream.

#### 3.2.3.4 Cultural change and engagement

The Trust has a low turnover workforce and has an improving staff survey response, however stress and engagement remains a factor. The Trust has put in place an organisational development framework to support leaders across the Trust to enhance transformation skills. The Trust has also focused on appraisal rates and has reached 86% against a target of 90%. The Trust has a track record of working collaboratively with staff side representatives. Following the Francis report into Stafford Hospital the trust has implemented an engagement strategy called the “Big Conversation” to discuss the findings of Francis and learning for BHNFT. Our response to the Francis report will be encompassed within our overall quality plan.

#### 3.2.3.5 Working Together

The Trust has developed a transformation work stream identifying service redesign and greater collaboration with other providers both within the borough of Barnsley but also across the acute providers of Mid Yorkshire, South Yorkshire and North Derbyshire - Working Together. All provider boards in the relevant organisations have now agreed in principle to the approach. A programme management approach will be adopted and BHNFT is committed to this approach. A full programme of clinical engagement has been in place over the last year to review services and develop clinical challenge on the sustainability and viability of each service. The Trust has supported this approach with the use of Finnamores consultancy to ensure that a rigorous approach is adopted and that alternative models of care are explored. Finnamores are also providing consultancy to deliver the Working Together programme. The Trust sees this as an advantage to improve alignment of the Trust and Working Together Strategy. The Trust recognises the potential of destabilisation of services and understanding the impact on changes to other services and has factored this into the Transformation Board risk register approach. The Trust recognises the opportunities of Working Together and will ensure the Trust is fully engaged in the process, but also acknowledges the risks that commitment of other Trusts is essential to the delivery of the programme. The structured approach being taken by Working Together will reduce this risk.

#### 3.2.3.6 Scale of Change

The scale of transformation required is significant. To mitigate this, the Trust has invested in programme management support to each Transformation Programme with skilled change agents. Each programme is led by a director and the Transformation Board regularly reviews capacity to deliver. The Board of Directors has considered the impact of the Working Together programme and will review the impact on a regular basis. Previous developments in relation to the Transformation Programme performed well. The final outturn for 2012/13 against a target of £7.269m was £7.007m.

#### 3.2.3.7 Overview of Board Governance

- The Trust regularly assesses its governance and quality arrangements using the Monitor Quality Governance Framework as a self-assessment tool. The Board has recently commissioned an external review of quality and safety and used the “Quality in the NHS” and Francis report to review its reporting structures and approach to governance.
- The Trust in the last year has reviewed its committee reporting with a review of membership of those committees and aligning the agendas of these committees to directly correlate with the Board Assurance Framework, in order to ensure the relevance of assurance information received and reviewed at each of these Committees (which in turn enhances the upward assurance provided to the Board of Directors).
- The Board of Directors has sought assurance through quarterly scrutiny of the full Board Assurance Framework and a monthly review of a Board Assurance Framework exception report. The Board also receives reports from the four Board/Assurance Committees, following each committee meeting. The assurance committees, and in particular the Clinical Governance and Non Clinical Governance & Risk Committees, receive exception reports from a number of sub committees that closely monitor areas of risk including: the Quality and Safety Improvement and Effectiveness Board, Infection Prevention and Control Committee, Safeguarding Adults and Children’s Committees, and the Health & Safety and Information Governance Committees. All these groups have a role to provide regular monitoring for best practice as well as to identify themes and trends for learning and sustained improvements.
- Sharing the learning throughout the organisation from risk related issues, incidents, complaints, claims and significant events is key to maintaining the risk management culture within Barnsley Hospital NHS Foundation Trust. Learning is acquired from a variety of sources, including:
  - Analysis of incidents, complaints and claims and acting on root cause analysis
  - External inspections
  - Health and safety issues
  - National Patient Safety Agency data



- Assurance from Internal and External audit reports
  - Clinical Audit
  - Clinical Service Unit and departmental governance meetings
  - Corporate governance committees
- The risk management function, risk registers and the Board Assurance Framework have all been continually developed throughout 2012/13 by managers within the Quality and Performance Directorate, led by the Director of Quality & Performance and the Board committees. These enhanced practices have all been robustly reviewed in year by the Trust's Internal Audit team, the results of which have demonstrated significant improvements in the Trust's controls assurance processes.
  - The Board is well informed and assured that the right systems and processes are in place. The Trust does this through its five committees; The Audit Committee's purpose specifically is to provide the Board of Directors with assurance on the effectiveness of processes around corporate objectives. This assurance is validated through the Annual Governance Statement. The Committee also provides the Board with an independent commentary of the fitness for purpose of the Board Assurance Framework and the effectiveness of the governance, risk management and internal control mechanisms. It focuses on the work of the Internal Audit Annual Plan and liaises with external audit in relation to the findings.
  - The Board reports regularly to the Council of Governors who can also ask for additional reporting.
  - The Trust has continued to participate in national and local audit programmes to ensure it reviewed patient outcomes and reviewed services in line with benchmarked practice. The Trust's participation in clinical research demonstrates Barnsley Hospital's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Clinical research supports our clinical staff to stay abreast of the latest possible treatment and active participation in research leads to successful patient outcomes.
  - The Trust is committed to learning and improving through listening to our patients and users. The Trust uses a range of different patient experience information to ensure trends are identified and improvements made. These include undertaking patient surveys on a monthly basis; through face-to-face interactions using hand held devices and collating information from stand alone terminals. Additionally the Trust has developed its links to social media and network sites, running targeted events to encourage feedback from patients and Trust members.

## **4 CLINICAL STRATEGY**

### **4.1 Service Line Management Strategy**

- 4.1.1 The Trust is committed to continuously driving the quality and safety of care throughout the organisation and in support of this introduced the Service Leadership Management Model (SLM) to promote effective clinical leadership in 2012/13. The SLM comprises fourteen Clinical Service Units (CSUs) each led by a Clinical Director who has overall accountability and responsibility for the delivery of clinically sustainable and financially viable services. The Clinical Directors now have an integral senior role and contribute to decision-making within the organisation and as such have participated in an internal leadership development programme that will be further enhanced by a programme to be delivered in partnership with Sheffield Hallam University during 2013/14. A thorough review of SLM is being undertaken commencing in May 2013 to evaluate the continued effectiveness of the model; the impact of clinical leadership on the delivery of the business and to determine the most appropriate configuration of clinical leadership for the future.
- 4.1.2 A key responsibility of the Clinical Director has been to agree, develop and lead the strategic direction of travel of the clinical areas, taking account of the internal and external drivers for change.
- 4.1.3 During 2012/13 phase one of the development of the Clinical Strategy was a thorough review of each clinical service. This provided the baseline of where each individual clinical service was placed internally with regards to performance against their quality and financial indicators and workforce implications. In addition national and local benchmarking information was used to further inform service provision and understand strengths and those areas that required focus and further development.
- 4.1.4 Phase two of the programme was supported by the external consultancy Finnamore Ltd who were commissioned by the Trust to work alongside each CSU providing a challenge to their current vision and to help the CSU clinical team develop alternative ways of working and challenge traditional practices, strive for and adopt best practice, and understand where future service models are appropriate and should be applied.
- 4.1.5 Phase three of the Strategic Service Review will be implemented in 2013/14 and will determine the future configuration of clinical services identifying key strategic issues and proposing solutions and transformational plans to ensure a planned and responsive transition securing the viability of local services. This will link closely with the strategic direction of travel for the local health economy and will compliment the strategic plans of all local providers of health and social care and local commissioners.
- 4.1.6 From the work completed to date the Trust is proposing a model whereby each service is positioned under one of three key headings:
- Core Services – those that are required to support a fully functioning level one Emergency Department
  - Central Services – those that due either to the volume of demand or requirement to support a core service are deemed essential to the business of a District General Hospital
  - Discretionary Services – those that are currently provided but could be delivered elsewhere or in a very different way

- 4.1.7 A combination of transactional and transformational approaches will be required for all services regardless of grouping, however for many services the transformational and strategic options will need to include greater collaboration with other District General Hospitals and Tertiary Centres, potentially leading to the disinvestment of specific services, developing and running more services in a community setting and radically changing the workforce – namely exploring options around a collaborative medical model and the further development of extended practitioners.
- 4.1.8 Each CSU is working through and further refining a Clinical Strategy that highlights their current position, identifies where each CSU needs to be and describes the actions that will be required in order to achieve their desired outcome.
- 4.1.9 These actions will form the Workplan of each CSU for 2013/14. The actions identified from each Clinical Strategy will be monitored and measured either through the Trust performance management framework of the Trust Transformation Programme as appropriate with a clearly identified lead with full accountability for achievement and delivery.
- 4.1.10 The final strategy will be shared with partner provider organisations from both health and social care, the local commissioners and will inform the work to be taken through the Working Together programme.

## **Clinical Workforce Strategy**

### **4.2 Overview of the clinical workforce strategy**

- 4.2.1 The Trust has carried out workforce reviews for Medical, Nursing and AHP staff groups as part of its workforce Transformation Programme. The reviews map out the respective workforce, and uses benchmark data, and professional guidance to identify where the workforce does not reflect the current and future needs of the Trust.
- 4.2.2 Each Transformation Programme will have an impact on the future workforce requirements. These are currently being mapped out so that the combined implications of the programmes can be captured, and the workforce strategy can be refined in light of the emerging information.
- 4.2.3 Key workforce pressures
  - 4.2.3.1 Hard to recruit posts– Dermatology, Acute medicine, A&E, Radiology and Radiography. These are being addressed through use of locum Doctors in the short term. A Medical Training Initiative scheme is being used to assist with the recruitment of Doctors. In-reach arrangements are being explored as a method of addressing the Acute Medical Assessment Unit gaps, and the Trust has an on-going recruitment campaign in place to address the increased requirements for Radiographers – in particular Sonographers. Increased use of Specialty Doctor posts, and recruitment via agency on an introductory fee will be used as additional methods to fill these posts as appropriate.
  - 4.2.3.2 Reducing numbers of medical trainees which are most likely to affect the Trust are: Anaesthetics, Trauma and Orthopaedics and General Surgery. Failure to provide allocated trainees in Obstetrics and Gynaecology is an additional pressure. The Trust is looking to increase the number of advanced practitioners in a number of areas,

to help address the pressure on medical rotas, to align the skills of the workforce to needs, and to provide improved career progression. Electronic job planning is currently being implemented, and will assist with better match of medical resource to Trust needs.

4.2.3.3 Anaesthetics – The split between critical care and general anaesthesia requires additional investment. The Trust currently has one additional post funded to assist with this.

4.2.3.4 Consistency in Care – The requirement to provide extended cover will place pressure (both financial and resourcing) on all elements of the clinical workforce. The Trust has identified the need to invest additional resource in this work stream, using some of the methods described above, and exploring opportunities to re-align workforce released by other Transformation Programmes such as Outpatients where possible.

4.2.3.5 Escalation wards – Place increased pressure in particular on the nursing workforce. This requirement is met by the Trusts Nurse Bank wherever possible, to minimise the premium agency rates. Sustained requirement for escalation facilities potentially places particular pressure on quality and safety of care. Our Urgent Care Transformation Programme is targeted to minimise the need for escalation wards by 2014.

#### 4.2.4 Impact on costs

Addressing the key workforce pressures requires additional investment. The additional investment will be completely offset by the transformation programme. The transformation programme will lead to reductions in workforce numbers. An overall reduction of approximately 124 WTE of the workforce is anticipated throughout the three-year plan. This will impact on all categories of staff. The reductions will be achieved in the main by a 1% reduction of pay budgets, the closure of two wards and a redesign of outpatient processes. These initiatives will be supported further by a voluntary severance scheme and robust vacancy control.

#### 4.2.5 Findings of benchmarking and other assessments and clinical sustainability

4.2.5.1 The workforce reviews carried out during 2012/13 have used a number of benchmarking and professional workforce modelling tools to assess the current and future workforce needs. Although the reviews have identified areas for further investigation, the initial findings are:

4.2.5.2 Medical – comparison of doctor numbers across local, similar Trusts – overall the Trusts medical workforce in Barnsley is marginally larger. By specialty, the ability to match best practice college guidance is mixed. In particular, specialist services such as Oral Maxillo Facial Service (OMFS), Rheumatology and Urology are currently under review in terms of viability of service. Whilst other specialties have particular challenges in terms of recruitment, loss of trainees and in some cases (Women's services) age profile of the workforce – which presents challenges in meeting best practice guidance, but are able to maintain safe and sustainable services.

- 4.2.5.3 Nursing and Midwifery – The Trust has made significant investment in its nursing and midwifery workforce in recent years and as a result, is in a strong position to meet professional standards set. The review of nursing workforce undertaken in 2012/13 shows that this Trust compare well with other similar Trusts in the region. The overall qualified to unqualified skill mix is 77:23, and the Midwife to Women funded establishment is 1:28. Nursing staff in post is marginally higher than the establishment – set in 2010. The recent review has used a number of benchmarking tools – including the Safer Nursing Care tool, and professional guidelines alongside professional judgement. The results of this review indicate that there is a potential re-profiling of the current bandings whilst maintaining the skill-mix ratios. The baseline funded establishment on care of the elderly wards will need to be realigned. In light of the second Francis Inquiry, work is being undertaken to further explore the implications of supervisory band 7 lead nurses and the role and competency requirements of health care support workers.
- 4.2.5.4 Therapies – a review of therapy services has been undertaken during 2012/13. Benchmarking against similar Trusts in the region indicates that this Trust is low in comparison to others in terms of therapy headcount. Requirements for extended working and improved service support are included in the report.

#### 4.2.6 Innovations in care delivery

- 4.2.6.1 The Trust has a number of Advanced Practitioners in post, and is looking to increase that number to improve career opportunity, and to increase flexibility and stability in the workforce.
- 4.2.6.2 The Trust has a number of collaborative service arrangements in place such as Head & Neck – weekend cover, Ophthalmology, Virtual Ward, OMFS. The Regions Working Together programme is key to identifying opportunities for shared service delivery.

## 5. PRODUCTIVITY AND EFFICIENCY

### 5.1 Potential productivity and efficiency gains

- 5.1.1 Length of stay. The Trust has a relatively good average length of stay (ALOS) for Elective Care and benchmarks as average for Urgent Care Pathways. For the longer term the Trust is working to improve this as part of the Transformation Programme.
- 5.1.2 Bank and Agency Spend. The Trust has a high level of bank and agency spend i.e. £6m for 2012-13. This equates to 5.7% of the overall budget. To combat this the following arrangements have been put in place: master vendor introduced to manage locum doctors, internal doctors bank, internal administration bank, also links to wider workforce Transformation Programme ensuring we have the right skill mix and effective job planning.
- 5.1.3 Bed Occupancy. The Current Bed Occupancy level is approximately 85%; detailed analysis is limited due to how data is currently recorded on the PAS system. In 2012/13 the Trust had 10,296 excess bed days (under plan) with the majority being in General Medicine. (Any hospital stay above the nationally expected length of stay is called an excess bed day and is paid on a per day basis).

- 5.1.4 Theatre Productivity. Theatre Utilisation within the Trust is 91.7%. As there is no national benchmarking data readily available the Trust is giving consideration to joining the FTN benchmarking programme.
- 5.1.5 Emergency Readmission rates. The elective readmission rate (30 days) is less than the SHA average (3.9% compared to 4.1%); the urgent care readmission rate (30 days) is more than the national average (11.4% compared to 10.3%). There is significant variance at a speciality level with some pathways demonstrating a top 10% performance nationally; others are lowest quartile. This is a key element of the urgent care programme for 2013/14.
- 5.1.6 Further efficiency schemes include a review of outpatient efficiency metrics, where the Trust recognises it is an outlier for new to review ratios; delivery of the Trust sustainability plan including a major space utilisation review designed to ensure best use of Trust space and commissioning of a combined heat and power generator, a demand and capacity review, an absence management strategy and plan are in place, as well as schemes to ensure better value/quality procurement and medicines management.

## **5.2 CIP Governance**

- 5.2.1 Historically the Trust has taken an incremental approach to development of CIPs, as part of the business planning cycle. Responsibility for devising schemes has been very much led at individual operational, clinical team or departmental level. The interdependency between wider corporate and strategic objectives has not always been clear which has led to issues with deliverability in some instances. However in developing business plans for 2012-15 the Board of Directors and Trust Executive team have deliberately developed a new approach, which does not detract from a “bottom up” method for identification of individual schemes but has created a more structured, sustainable strategic framework.
- 5.2.1 Within the framework of the seven transformational programmes CIP plans for 2013/14 were presented and accepted by the Board in April 2013. Detailed schemes have been clinically and financially risk assessed as appropriate. Quality impact assessments were undertaken by the Medical Director and Chief Nurse. On this basis a number of proposed cost improvements were rejected or deferred pending more work. The target for 2013/14 is £6.2 million in order to deliver a 1% surplus margin.
- 5.2.2 In addition to the full year effect of current schemes the Trust is scoping outline plans to match the assessment of the size and scale of the on-going forecast challenge. These are based on the themes and priorities set out in this document. The Trust recognises that whilst it needs to remain internally focused on increasing efficiency and productivity, going forward some of its major efficiencies will be reliant on external working with partner organisations.
- 5.2.3 Each programme is reviewed on a monthly basis by the Trust executive with each programme having a risk log, which is cross-referenced to the Trust risk register. The Trust has extended the role of the existing Project Management Office (PMO) to support in the delivery of the Transformation Programmes and link to progress on the financial tracker to ensure delivery of the CIPs. The trust has developed a Quality Impact Assessment (QIA) process for all CIPs. Each programme has a signed off programme definition document that includes objectives, targets, deliverables and risks. Updates are presented at a fortnightly Transformation Board meeting via the presentation of a status report by the executive lead; this

report includes a risk log in the accepted Trust format including details on plans for risk mitigation. At a corporate level financial mitigation and utilisation of contingency reserves to manage, slippage is in place. In addition to the transformation board a fortnightly transformation delivery group has been established chaired by the Chief Operating Officer with clinical and operational representation from the CSUs and support functions in order to address issues raised at the transformation board at a more granular level.

5.2.4 To further support this work and enhance SLM working relationships a revised Trust CIP process has been put in place to capture in year schemes for 2013. The CIP process has 3 stages: first is idea generation by the CSU team, second idea validation overseen by the Director of Finance and the Director of Quality & Performance and the final stage is implementation sign off and planning which will be signed off by the Trust Transformation Delivery Group. The Quality impact Assessment process is integrated into this approach.

5.2.5 Management of delivery of CIP is intrinsic to the delivery of the business plan and accountabilities are clear. Each CIP is allocated to a Clinical Service Unit (CSU) or department budget but will also be cross-referenced against the Transformation Programmes through a financial tracker that will be transparent to all. Each CSU has a clinical director who is accountable and each programme has an executive chair who is accountable for delivery. The overarching accountability sits with the Transformation Board chaired by the Chief Executive with a monthly report going to the Trust Board. To ensure further clarity and develop the SLM model a revised performance framework will in place for 2013-14.

### **5.3 CIP profile**

Seven trust transformational programmes have been identified, which clearly align to one or more of the five Trust strategic aims and are thematically based to cover every aspect of the Trust's business. The programmes correlate to the wider strategic priorities for the local community and the national/local QIPP agenda. The main commissioner of our services is supportive of this transformational approach and the Trust continues to actively engage commissioners and other local stakeholders as appropriate to roll out specific elements of work within each of the programmes. The Board recognises that this wider collaborative approach to transformation is key. Further detail on the top 5 CIP's is included in Appendix 2.

### **5.4 CIP enablers**

5.4.1 There has been a multi-stranded approach to budgeting and CIP identification this year. All CSUs and departments were involved in a performed a realignment of budgets process- as opposed to the traditional "roll forward" of existing budgets. And simultaneously all Transformation Programmes were assessed to understand current and future productivity and financial efficiencies. In many cases the two are intertwined for example the urgent care programme and the emergency medicine CSU. Throughout the process clinicians have been engaged and this culminated with a cost workshop delivered on the 26th April. At this workshop the Executive team talked through the financial targets for 2013/14 and how they linked to Transformation. Further to this a workshop was conducted by an external facilitator relating to cost and where the biggest opportunities are, outputs of the workshop include clarity for CSU teams on the financial context and an agreed set of priorities for the teams to focus on.

5.4.2 Benchmarking best practice and identifying changes to care and delivery models has been integral to the Trust approach. This enables assurance that the

transformational programmes address the key priorities for the Trust in terms of quality of service.

- 5.4.3 The CSUs and programme leads have developed the required capital/revenue investment in transformation schemes, with an assessment process in place. The Trust continues to invest in PMO and programme leads as well as external support e.g. Finnamore. The major Trust IT investment over the next 5 years will be in the delivery of an Electronic Patient Record system for the Trust. Programme leads are working hard to ensure that the extra functionality offered by such a system supports transformation and that the two programmes remain closely linked.

## **5.5 Quality Impact of CIPs**

- 5.5.1 The Quality Impact Assessment tool is escalated to the overarching Transformation Programme Board through each of the Transformation Programmes. The Programmes encompass all of the CIPs; any risks not mitigated will form the basis of the Transformation Programme reporting to the Trust Board and entry on the Trust's risk register for upward scrutiny by the Trust's recognised monitoring and assurance processes.
- 5.5.2 This way of working has been adopted as supporting the achievement of tough financial targets without compromising frontline services and patient care, and supports the realisation of sustainable savings over the longer term.
- 5.5.3 The Trust has adopted the approach developed and implemented in the West Midlands. The layered approach includes clinical risk assessments at three stages of scheme development: inception (ideas), implementation and post implementation. Scheme assessment is based on risk and level of complexity, with the most complex schemes being subject to a confirm and challenge session, with the relevant Clinical Directors and teams, Medical Director and Chief Nurse participating in a structured review. Quality Indicators are developed through this process to ensure continuous monitoring of the impact of any scheme on the quality of patient care.
- 5.5.4 All impact assessments are logged and coordinated via the risk team to ensure links into the Trust risk and governance processes. The Transformation Risk Register is updated based on the clinical risks identified through this process in addition to the current process.
- 5.5.5 Lower level risks are submitted and review conducted by members of the quality review team. This team comprises: the Director of Quality and Performance, the Head of Corporate Governance, the Deputy Chief Nurse and the Assistant Medical Director (patient safety). This review reports to the Strategic Risk Group with the Medical Director and Chief Nurse, who will then report into the Transformation Board for addition to the Transformation Risk Register.
- 5.5.6 Each Transformation Programme has a set of quality metrics which are reviewed at the Transformation Programme boards and at the Transformation Board. These are reported to the Board of Directors monthly.



## **6 FINANCIAL AND INVESTMENT STRATEGY**

### **6.1 An assessment of the Trust's current financial position**

- 6.1.1 The fundamental aim of the financial strategy over the period is to maintain and build on the stable base that has been achieved. The Trust ended 2012/13 with a financial risk rating of 3 and a 1% surplus margin, but which was in excess of its target, despite an extremely challenging year operationally. The financial strategy going forward is to maintain a minimum financial risk rating of 3 or the equivalent in any future proposed metrics. The requirement to achieve surpluses is a key component of the capital investment plans. It is recognised that support in the form of external loans will not be required to deliver the future capital programme.
- 6.1.2 For 2012/13, the Trust had a favourable year end income position, with a positive variance of £8.513m. The aggregate over trade on clinical income included non-recurrent funding in support of escalation and transformation pressures.
- 6.1.3 The income plans for 2013/14 are based on fully agreed contracts with commissioners including realistic activity targets.
- 6.1.4 The Commissioners have indicated that they do not anticipate activity growth over the next two years. In addition, tariffs will not increase for providers as they are used as levers to generate efficiency. For the purpose of planning assumptions a 1.0% reduction in tariff is assumed for the next two years. CQUIN income is prudently capped at 2%.
- 6.1.5 The key area of risk, which we are working on closely with the commissioner, follows on from the enabling work during 2012/13 and will again look further to reduce the level of unscheduled care and the targets for reducing emergency readmissions. It is critical that we continue to work with the local health community to effectively manage demand. The Urgent Care Transformational Programme is the key enabler to success.
- 6.1.6 The expenditure budgets for 2013/14 have been derived recognising areas of cost pressure which have been funded. This is the first year the Trust has performed a realignment of budgets.
- 6.1.7 The expenditure plan also includes significant reserves for planned new investments which will support the achievement of the business plan objectives. The majority of this is recurrent but there is an element of non recurrent included. A significant contingency reserve (£1.6 million) has been set aside for in year risk issues, in addition to a substantial non pay inflation reserve of £0.5m, which is unlikely to be fully utilised if prices and costs are controlled as anticipated in the plan. There is a restructuring provision of £350,000 set aside to facilitate potential severance costs. The 2013/14 efficiency savings targets in relation to overall reductions in the pay bill continue to be driven through the transformational programmes. The Trust will build on the significant achievements secured through 2012/13 where we made savings of £2.16m from the Workforce Transformation Programme, which accounted for 31% of the total savings of £7.007m . The target for 2013/14 equates to £1m and will again largely be achieved through further improvements in workforce efficiency.

### **6.2 Key financial priorities and investments and how these link to the Trust's overall strategy.**

- 6.2.1 The cost improvement target for 2013/14 (£6.2 million) represents 4.1% of the planned cost base (3.9% of planned turnover), to achieve a 1.0 % surplus margin. The 1.0% surplus margin is expected for the three year period ending

2015/16. The processes and approach around the design, process and management of these targets are described in further detail in this document. Cognisant of the historic delivery on efficiency targets the approach adopted includes stretch and a more sustainable programme of delivery over the medium term.

6.2.2 The cost improvement targets and forward plans are key enablers in achieving two of the Trusts key strategic aims:

- **Make the best use of our resources.** We will do this by increasing efficiency and productivity across the Trust, effective and efficient use of technology, sustainable resources and physical assets.
- **Maintain financial viability and sustainability.** We will do this by improving **relationships**, maximising current services, achieving best practice tariffs, continually reviewing costs.

6.2.3 Plans for the forward two years are based on an assessment of a range of factors. The key drivers are assumptions in relation to activity changes, which are assumed to be modest and inflationary pressures/price inflation. The table below provides an overview of the assumptions included in the financial plan for years two and three:

Key Assumptions - Annual Plan	14/15	15/16
Clinical Income tariff deflation	-1.00%	-1.00%
Activity movements	-0.50%	-0.75%
CQUIN uplift	2.00%	2.00%
Non clinical Income Uplift	0.00%	0.00%
Efficiency requirement - % of Turnover	4.00%	4.00%
Pay award inflation	1.00%	1.00%
Incremental Drift	1.00%	1.00%
Non Pay Inflation	3.00%	3.00%
Net I & E Surplus margin	1.00%	1.00%

### 6.3 Key risks to achieving the financial strategy and mitigations.

6.3.1 The key risks to delivering the financial plans over the forward plan period link specifically to;

- Slippage on Transformation Programmes resulting in under achievement of efficiency targets
- The scale of capital programme impacting on cash and liquidity.
- The Trust will be subject to the marginal rate threshold of 30% for non-elective activity over and above 08/09 income valued at 13/14 rules and tariff.
- CQUIN – The Trust achieved 2% of the 2.5% available for 2012/13 and as such the same assumption has been made in this years plan.
- Readmissions – if the Trust exceeds the agreed threshold, the commissioner will not pay for the episode of care.
- Demand Management – if above the new to follow-up ratio, the commissioner will not pay for the follow-up.
- Failure to achieve best practice tariffs.
- Any Qualified Provider (AQP) – This initiative increases the level of competition the Trust faces.

6.3.2 Mitigation in relation to these factors will be managed as part of the overarching approach to managing risk and ensuring delivery of business plan objectives. Financial management processes provide clear indicators of potential forward risk materialising. Contingencies are in place and sensitivity analysis is applied to the financial position so the Board is fully aware of the degree of tolerance and the actions required.

6.3.3 Processes supporting delivery of the Transformation Programme are robust. There is a high degree of performance management of each programme allied with significant engagement from senior clinicians. The Trust is working effectively with the now embedded Clinical Service Units to develop these as an aid to informing key decisions on resource utilisation in the context of service requirements.

## **7 MEMBERSHIP / GOVERNORS**

### **7.1 Membership**

7.1.1 Membership levels remained broadly unchanged throughout 2012/13 despite good recruitment from targeted campaigning on the hospital site and at a high profile regional event (the latter to be repeated in 2013/14). It is anticipated that this is primarily due to losses following deaths offsetting recruitment numbers, reflecting the age and socio-economic health profile of the community.

7.1.2 The Trust and Council of Governors values the support of the membership and members of the public. Engagement has been maintained through feedback from and liaison with governors, representation at local meetings and events, publication of regular newsletters and growing use of social media, and this will continue to be developed year on year.

7.1.3 Capacity to support membership has been limited to date and it has been agreed to boost this with the appointment of a membership manager in 2013/14, initially on a 12 months trial basis to assess benefits/return on investment.

### **7.2 Governors**

7.2.1 The Trust can confirm that its annual plan was developed having had regard to the views of the governors – via presentations and feedback at Council of Governors' General and sub-group meetings; the Governors' annual strategy development session and direct discussions between Governors with individual directors and the Chairman.