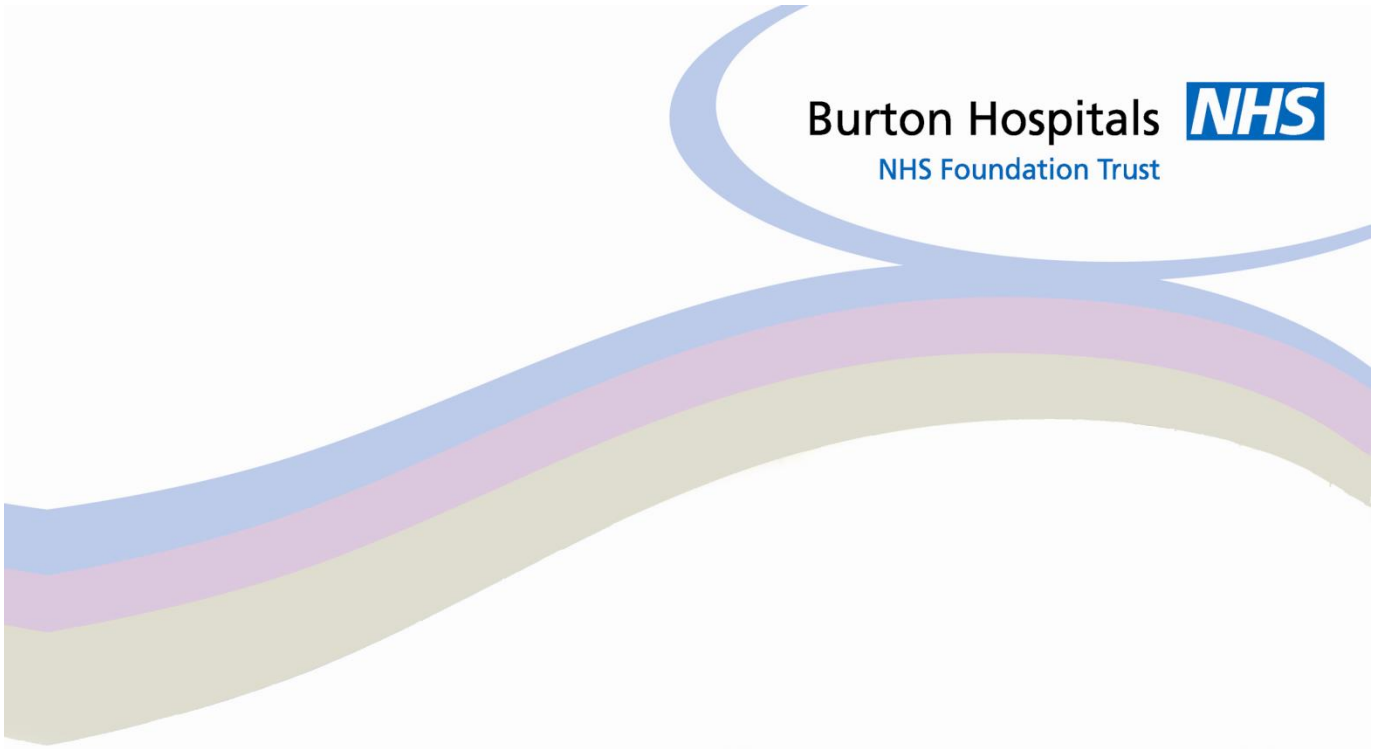


Operational Plan

2014-16

Burton Hospitals NHS Foundation Trust

Operational Plan Guidance – Annual Plan Review 2014-15

The cover sheet and following pages constitute the operational plan submission which forms part of Monitor's 2014/15 Annual Plan Review.

The operational plan commentary must cover the two year period for 2014/15 and 2015/16. Guidance and detailed requirements on the completion of this section of the template are outlined in section 4 of the APR guidance.

Annual plan review 2014/15 guidance is available here.

Timescales for the two-stage APR process are set out below. These timescales are aligned to those of NHS England and the NHS Trust Development Authority which will enable strategic and operational plans to be aligned within each unit of planning before they are submitted.

Monitor expects that a good two year operational plan commentary should cover (but not necessarily be limited to) the following areas, in separate sections:

1. Executive summary
2. Operational plan
    a. The short term challenge
    b. Quality plans
    c. Operational requirements and capacity
    d. Productivity, efficiency and CIPs
    e. Financial plan
3. Appendices (including commercial or other confidential matters)

As a guide, we expect plans to be a maximum of thirty pages in length. Please note that this guidance is not prescriptive and foundation trusts should make their own judgement about the content of each section.

The expected delivery timetable is as follows:

Expected that contracts signed by this date	28 February 2014
Submission of operational plans to Monitor	4 April 2014
Monitor review of operational plans	April- May 2014
Operational plan feedback date	May 2014
Submission of strategic plans to Monitor (Years one and two of the five year financial plan will be fixed per the final plan submitted on 4 April 2014)	30 June 2014
Monitor review of strategic plans	July-September 2014
Strategic plan feedback date	October 2014

1.1 Operational Plan for y/e 31 March 2015 and 2016

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

Name	**Helen Ashley**
Job Title	**Chief Executive Officer**
e-mail address	**helen.ashley@burtonft.nhs.uk**
Tel. no. for contact	**01283 566333 ext 4151**
Date	**4 April 2014**

The attached Operational Plan is intended to reflect the Trust's business plan over the next two 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 Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;**
- **The Operational 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 Operational 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; and**
- **All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.**

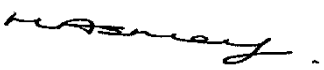
Approved on behalf of the Board of Directors by:

Name *(Chair)*	**Chris Wood**

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	**Helen Ashley**

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	**Lynne Mansfield**

Signature 

1.2 Executive Summary

Our strategic objectives for 2014/16 reflect the following three key areas:

- To equip, empower and engage staff to deliver our objectives
- To ensure that quality of care is right first time to reduce variation in practice
- To be efficient and financially sustainable

The Trust is operating in a constrained financial environment with a lead commissioner who is one of the five CCG's furthest from fair share allocation. The Trust has reported deficits for the last three years. The affordability gap identified by the Trust for 2014/15 is £14 million and in 2015/16 this rises to £15 million.

The local demographics show a growing population and an older population with a below average economic position and above average level of adverse health factors. Analysis by commissioners and the Trust suggest that the impact of the aging population with a growing number of co-morbidities and longer term conditions is impacting on hospital costs.

Analysis by the commissioner and Trust does identify opportunities to change care pathways to reduce this cost impact, but this will require focussed and multi-agency changes to pathways that are likely to take a number of years to implement on a sustainable basis and are likely to require enabling funding to ensure that alternative provision is in place before hospital provision is fundamentally changed.

The Trust is currently in special measures. The Chief Inspector of Hospitals will be visiting the Trust in April 2014 to assess the progress made against the recommendations of the 2013 Keogh Report and to assess the Trust against the minimum standards of the Care Quality Commission. The outcome of this visit is critical to a key 2014/15 objective of the Trust to restore the confidence of patients and stakeholders in the service provided by this organisation.

The Trust has reported that the costs of addressing issues raised in the Keogh review have been £2.685 million in 2013/14 with a recurrent impact moving forward of £2.205 million. These costs have not been met through tariff and the Trust has received £0.2 million of earmarked funding from commissioners to assist with these costs in 2013/14.

The short term challenge for the Trust is to continue to drive forward our quality strategy and to simultaneously generate sufficient efficiencies to meet the national efficiency challenge.

The aim of the Trust, therefore, is to secure provider efficiencies in 2014/15 to achieve at least national efficiency targets and to aim to exceed these by at least 2%. In 2015/16 the Trust plans to develop more radical plans based on collaboration, networks and strategic partnering while still delivering provider efficiency of at least 2.5%. This will still result in a reported deficit in 2015/16 although the Trust will continue to correct the underlying position with a consistent over performance against national requirements.

The challenge for the Trust is therefore delivery of sustainability in cash terms through this two year period. The Trust has exhausted historic retained surpluses at the end of 2013/14 and so must realise cash to support the deficits of 2014/15 and 2015/16. The Trust plans to do this through the sale of surplus assets. The Trust has identified surplus estate and has also identified that its average income per square metre of occupied space is some 20% lower than the average for similar sized acute hospitals. The sale of assets will facilitate changes to the estate to enable significant service change and will support cash balances to ensure a Continuity of Service Risk Rating of 2 rising to 3 during this two year period.

The Trust's strategic plan acknowledges that significant transformational change will be required from 2016/17 onwards to ensure sustainability. The Trust is within one of the 11 challenged health economies identified by the NHS regulators. These health economies will receive targeted assistance with capacity and demand planning and the development of a strategic plan by June 2014.

1.3 Operational Plan

The short term challenge

Demographic and local health economy characteristics impacting upon the two year challenge

East Staffordshire is the fastest growing population in Staffordshire based on Census growth from 2001 to 2011 and growth in Burton over this period has been 65.5%. The median age of the population is 40 which is higher than the national average. 23% of the population are over 60 years old and there has been a 27% increase in the number of residents over 90 years old in the 10 year census period noted. Population growth over the next ten years suggests growth in excess of 10% by 2021 with further recent known housing growth not factored into this estimate. In excess of 1,000 units of housing are planned or being built within 3 miles of the hospital within the next 2-3 years. English is not the main language in 3.7% of households compared to a national average of 1.4%. Manufacturing remains the largest industrial sector of employment although this sector is in decline while the service sector is growing. The median gross annual earnings of the population are below the national average. 17.7% of the population reported that health issues limited day-to-day activities and over 10% of the population reported that they provided some sort of unpaid care. There are four wards within the East Staffordshire Borough Council boundaries falling within the 10% most deprived areas in England.

Deprivation in East Staffordshire is lower than the average for England; about 3,700 children live in poverty. Life expectancy for men is lower than the national average being up to 9.9 years lower in the most deprived areas.

An estimated 20% of the population aged over 18 smoke and 25.7% of adults aged 16 and over are classified as increasing and high risk drinkers. 18.8% of children aged 10-11 are classified as obese and 9.7% of children aged 4-5 are similarly classified. It is estimated that 25.7% of adults are obese compared to the national average of 24.2%.

Priorities for East Staffordshire include action to tackle health inequalities especially focussed on preventable causes of ill health including cardiovascular disease and male life expectancy, rising hospital admissions for alcohol, and population increases in particular the impact of an ageing population.

In the other key catchment areas such as Tamworth and Lichfield priorities include a focus on improving healthy lifestyles by addressing obesity and alcohol consumption, and a similar focus on supporting an ageing population and particularly the number of falls in those areas.

Hospital demographics and how this reflects population demographics

The Trust has 404 beds across its three sites. In the first nine months of 2013/14 28% of available bed days were occupied by patients aged 85 or above, 54% of bed days were occupied by patients aged 75 and above, and over 70% of bed days were occupied by patients aged 65 or above.

In the same period the equivalent of 66 beds were occupied by patients receiving end of life care, while 48 beds were occupied by patients with delirium associated with infections, 38 beds were occupied by patients with functional and organic mental health issues and 24 beds were occupied by patients with drug and alcohol related health complaints.

Of the 109,234 bed days available in that period 52,508 were attributable to patients whose stay exceeded 11 days and the Trust received an average income per bed day for that cohort of patients of £147.82.

The combination of population growth, an above average age population, areas of significant deprivation and lifestyle issues is likely to increase the pressures on hospital occupancy noted above.

East Staffordshire Clinical Commissioning Group two year operational plan

East Staffordshire Clinical Commissioning Group (ESCCG) is the lead commissioner of services for the Trust. The East Staffordshire Delivery of Change Plan sets out the CCG five year strategy. The commissioning for value data packs utilised by the CCG show that outcomes for ESCCG residents benchmark as better than average or in the upper decile of national indicators in almost every service area. The two year operational plan sets an aspiration to work towards upper decile performance in every measurable outcome but notes that achievement of this aspiration will still leave a significant financial gap in commissioning plans. The two year operational plan identifies the need for further innovation, integration and utilisation of technologies to close this gap.

ESCCG is £12 million below fair share allocation in 2014/15. BHFT reported a deficit of £5.4 million in 2011/12, £3.1 million in 2012/13 and is forecasting a deficit of £1.7 million in 2013/14.

The ESCCG operational and strategic plan includes a focus on Long Term Condition management and Intermediate care and care of the frail elderly. The CCG intends to see a movement in patient flows and settings across the range of services delivered closer to home in the community. The vision and underpinning principles are outlined in the Long Term Conditions and Intermediate Care and Frail Elderly Prior Information Notices (PINs). By 2015 ESCCG intends to introduce a new model of intermediate care and reablement which will empower patients, carers and families to maximise independent living and actively support individuals to attain optimal levels of functioning. This will require significant development of a range of community-based options to provide alternatives to, and reduce the demand for, bed-based care.

The intention is to develop a whole-system model of service delivery that fundamentally rebalances in-hospital and out-of-hospital care and focuses on the needs of individual patients and carers within community settings. The CCG's intention is that people will be better and appropriately supported to remain at home during periods of crisis.

The Right Care "Commissioning for Value" data sets are highlighting that ESCCG could potentially save on both elective and non-elective admissions for identified cohorts of patients, as benchmarked against comparable CCGs across the country.

ESCCG's 2012 baseline rate is 2260.2 for admissions for ambulatory care sensitive conditions which is in excess of the national average (2098.8); and is an area that ESCCG believes improvements can be achieved, based on the aspirations of achieving upper quartile performance.

ESCCG are further investigating why they are outliers on spend for the following cohorts of patients and thus highlight that they may change the way in which they commission these services:

- Respiratory
- Urology
- Cancer

The ESCCG two year operational pan highlights the following key workplans:

- Reduction of Non Elective admissions to National Average for Ambulatory Care Sensitive Conditions and acute admissions which currently benchmark below National Average in 14/15.

For 15/16 it is anticipated that this rate will be maintained

- Dramatically reduce the number of Procedures of Limited Clinical Value in line with national benchmarking to best decile
- Reduce the first to follow up ratio to better than average in year 15/16
- Reduce Musculoskeletal spend
- Reduce spend on medicines.

The ESCCG two year operational includes an operational plan on a page that includes anticipated savings against the aspirations noted above and these will constitute the QIPP plan of the commissioner, they are:

ESCCG Outline QIPP Plans

Operational Plan	Outcome	Anticipated Value
Improving outcomes for specific Long Term Conditions, including Respiratory, Diabetes and Heart Failure	Reductions in Non-elective admissions	£153,000
Reducing Emergency Admissions	Reductions in Non-elective admissions - gain share proposed with BHFT	£200,000
Reduction in new to follow up ratio from current 1:2.27 to 1:1.97	Reduction equating to £600,00 with gain share proposed with BHFT	£300,000
Reduction in procedures of limited clinical value	Reduction in Joint Injections, Hysterectomy arthroscopy, Adenoidectomy cataracts, Cholecystectomy	£376,676
Musculoskeletal	Reduction in Elective and Day case spend	£250,000
		£1,279,676

The Trust is working closely with the commissioner. The outline QIPP plans above have been recognised in our downside model although our base case reflects our own assessment of the opportunities noted above based upon more recent data than the 2012 benchmarks utilised by the commissioners. These assumptions are noted in full under the Trust plan section “Productivity, Efficiency and CIPs”.

Staffordshire Health and Wellbeing Board (SHWB)

SHWB consists of senior officers from Clinical Commissioning Groups, Councils and one patient stakeholder group (Engaging Communities Staffordshire).

The SHWB signed off the better Care Fund draft submission on 13 February 2014. The Trust was not directly consulted on the document although the document does reflect a number of the priorities identified in local commissioning intentions.

The work programme of SHWB includes:

- Frailty/complex needs/long term physical and organic mental health problems
- Learning Disability
- Mental Health
- Carers
- End of Life/Cancer
- Community Equipment

- Major Housing Adaptations (Disabled Facilities Grant).

The work programme above drives the basis of the Better Care Fund application. The assumption is that significant disinvestment in acute care will fund developments in primary and community care to ensure patients are supported in the community or home environment. By 2015/16 there is an aspiration to reduce non-elective admissions in South Staffordshire by 2,000 cases. In 2012/13 the number of cases at this Trust rose by 3,136 from 2011/12 and a further rise is anticipated to 2013/14 meaning that a step change in provision is required in a two year period. The minutes of SHWB identify a need to move approximately £200 million of resource from the acute hospital sector and residential care sector which equates to 400 beds to community service provision.

There are specific initiatives within each programme header, for example under frailty/complex needs/long term physical and organic mental health problems there is:

- A revised approach to intermediate care, reablement and rehabilitation
- Development of user led service specification for long term conditions
- Primary Care Led Integrated Locality Teams
- Falls prevention
- Medications management
- Personal Health Budgets
- Support to nursing homes
- Community geriatrician support
- Wellbeing hubs.

The SHWB notes the development of a pan Staffordshire financial strategy, IT and data management and risk stratification plans and also notes the aspiration to move to seven day working.

While the plan acknowledges that there has been little significant engagement with the acute sector to date in South Staffordshire there is an assertion that savings of £15 million per annum will be realised from 2015/16 onwards and this is presented under the section entitled “implications for the acute sector”.

The Trust Operational Plan and Operating Model

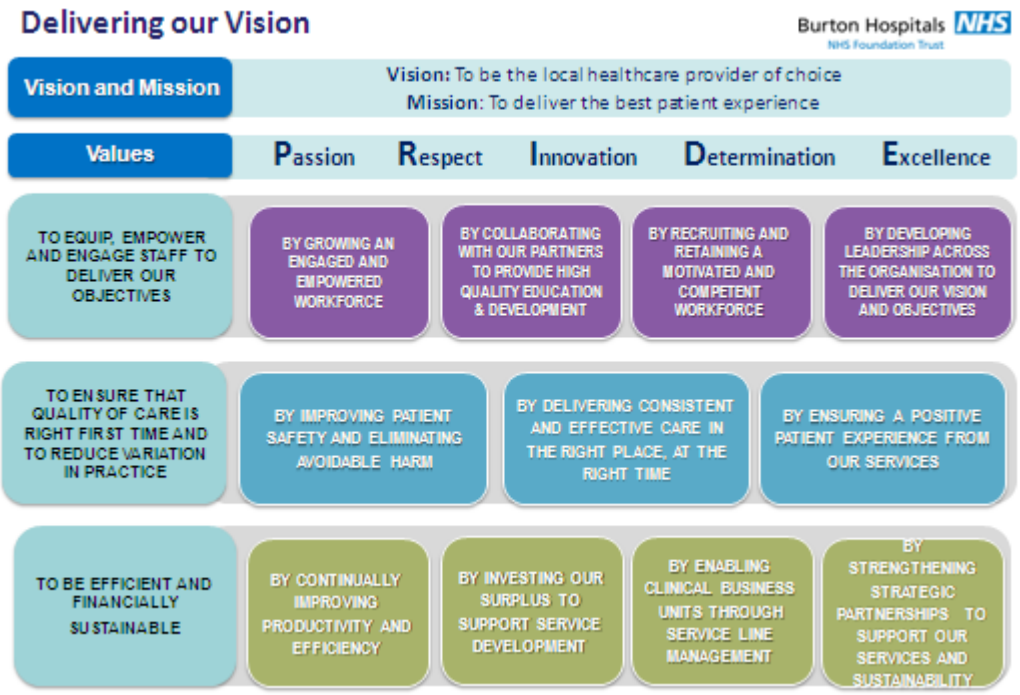
The Trust captures its Vision, Mission and Values on the “Plan on Page”. This articulates our forward objectives in three key areas:

- People
- Quality
- Finances

Our strategic objectives reflect the three key areas:

- To equip, empower and engage staff to deliver our objectives
- To ensure that quality of care is right first time to reduce variation in practice
- To be efficient and financially sustainable

The three key areas are then further subdivided and outcomes and measures attributed to each area. It is the Trust’s intention to ensure that all staff can clearly articulate this plan and can clearly see their role in delivering elements of that plan.

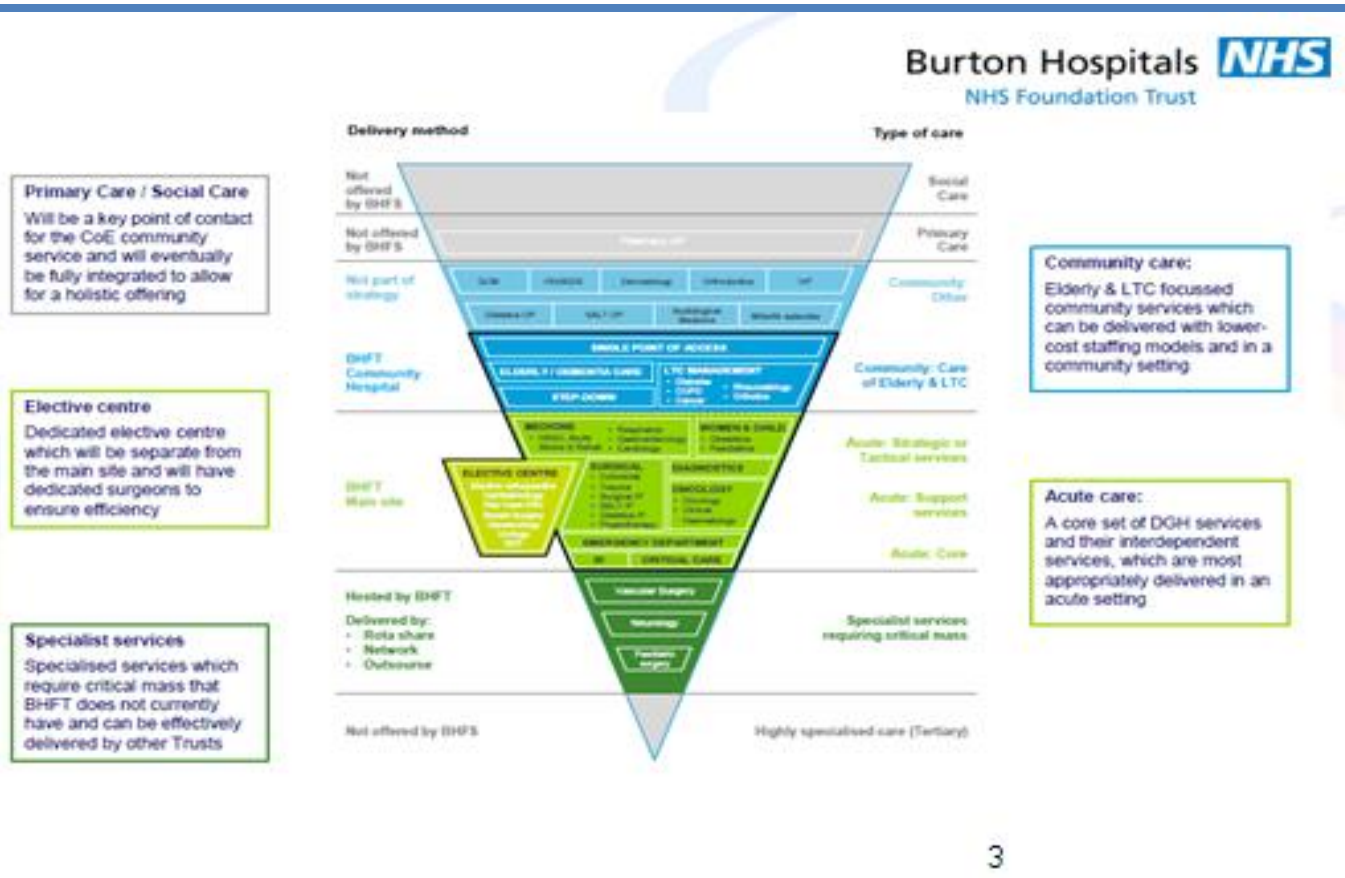


This plan is underpinned by the operating model of the Trust where the three key business units of the Trust are defined. These business units are now reflected in the Divisional structure of the organisation and the organisation is aligning leadership structures to further strengthen this structure. Each Division is led by a Medical Director, Associate Director of Operations and Head of Nursing. Support services such as Finance, Human Resources, Information and Procurement are now aligning senior staff to the Divisional structure to support the units as service lines.

The Trust reviewed its Divisional structure in 2013/14 and three Divisions were formed that reflect the Trust Operating model below. Medical leadership structures have been reviewed and changed to reflect this structural change and the Trust now proposes to build development programmes around its Medical leadership to maximise the benefits of senior clinical engagement in the planning, operational and strategic management of the Trust.

The Operational model of Planned Care, Acute Care and Community Services correlates strongly to the Divisional structure of Surgery, Medicine and Community and Clinical Support services.

The Operating model is shown below:



This model and the outputs are described in greater detail within our Strategic Plan which informs this Operating Plan.

The three operating units of the Trust are:

- Planned Care
- Acute Care
- Community Services

Divisional Structure and Plans

Each Clinical Division has written a Plan for the Operational period 2014/16 in order to inform this Trust Plan. The Divisional planning cycle commenced in January 2014 with guidance issued to Divisions. Divisions presented Draft Divisional Business Plans at the end of January. Further guidance was shared with Divisions to outline the Strategic priorities noted in this document and Divisions updated their plans and presented again at the beginning of March 2014.

Baseline Budgets were agreed with each Division by the start of March. The development of Cost Improvement Plans is described later in this document.

Divisions will finalise their Divisional Business Plans through Divisional Boards at the end of March at the same time as this Operating Plan is approved by the Trust Board. Divisional Boards consist of the Medical Director of the Division, the Head of Nursing and the Associate Director of Operations as a minimum with Clinical Directors of Service Lines attending. The Divisions will publish their Operational plans on the Trust Intranet. The objectives within the Divisional Plans will be basis upon which the Trust Performance Management Framework will assess performance from May 2014.

Service Line Reporting

The Trust Service Line Reporting and management reporting reflects that planned care continues to be profitable while acute care is a significant loss making service line and Community Services is contributing a small loss. The Operating Plan therefore focuses on growing planned care, growing the margin of Community Care and critically reviewing acute care to determine whether losses can be abated, mitigated or transferred.

Service Line Reporting indicates that the Trust continues to lose money in Obstetrics, General Surgery and Adult Critical Care. The Trust continues to lose money on Obstetric procedures related to caesarean section in Obstetrics. In Adult Critical Care the Trust loses the majority of income where patients are supported for 4 organs or more.

The Trust is also losing money in Orthopaedics. Further analysis points to a cohort of patients within the non-admitted face-to-face contacts and it is clear from further analysis that a group of patients are being seen by Orthopaedic Consultants but admitted through medicine and are subsequently in hospital beds for an extended period of time. This group fall within the frail elderly cohort and complex discharge patient group that the Trust and commissioner plan to focus on. The data also suggests issues with the cost of hip procedures for the Trust.

The Trust is a member of the Albatross patient costing benchmark club and the comparison with a cohort of 60+ other Trusts indicates that the Trust is an outlier in the services noted above and General Medicine where the income generated by the Trust is lower than anticipated for the volume of activity attributable to the service.

Market Analysis

The Trust utilises the Dr Foster Market Analysis tool to assess market share and competitor analysis and focuses particularly on integrating this assessment at Service Line level for use by the Divisions and services in annual planning.

The Market share data is available to the Trust for the last 12 years. Data is available from January 2002 and shows the Trust has slightly increased market share in volume for all admitted care (having accounted for the transfer of the activity from Nations) although market share by tariff has remained stable suggesting that the Trust is gaining share in the less profitable acute operating unit and is potentially losing share in higher income/margin services. The former South Staffordshire PCT area is the most significant market for the Trust. Mid Staffordshire NHS Foundation Trust has been the largest provider to date. The Trust Special Administrator has indicated that the impact of the dissolution of that Trust will not impact upon BHFT. The data suggests that the reductions in market share for that organisation over the last 12 years have been largely gained by Burton, Wolverhampton, North Staffordshire and Derby. The Trust has based its planning on the findings of the Trust Special Administrator but is concerned that this underestimates the impact on the organisation.

For the same period the Outpatient market share has shown a similar trend although the Trust has maintained stronger shares on a tariff basis.

2013/14 has, however, provided some market share indicators that are of concern. The Trust market share of admitted patient activity is relatively stable although there has been a clear shift in activity in Leicestershire, predominantly in Obstetrics.

Market share of Outpatient activity is beginning to show signs of erosion in key service lines like Trauma and Orthopaedics and while this has not translated to erosion in admitted care market share it is likely that there will be an impact if this trend continues. The loss of share in Obstetrics is helpful in the context

of the service line reporting information that shows this speciality to be significant loss making area for the Trust. Trauma and Orthopaedics is a significant element of the work of the Trust and the aim is to remedy the current margin issues in this service line and preserve market share so this trend is of concern.

The Trust share of GP practice activity shows some inconsistency in terms of share compared to the distance of the practice from the Hospital. The Trust will set a target market share for each practice for the ensuing year.

Engaging with our staff

Listening into Action

In support of the Trusts objective to engage and empower its staff, there are two significant workstreams that will underpin the Trusts 2 year operational plan. The first is in respect of internal communications, having established a plan to improve communications across the Trust and its 3 sites. Through its "Keogh Action Plan" the Trust has taken a number of actions to improve visibility and communication at both Board and Executive level. The focus going forward will be to empower both senior and middle managers to achieve a greater consistency and flow of communication.

The second workstream specifically relates to Listening into Action and the Trust's ambition to fundamentally shift the way that we work and to put staff at the centre of its change programme.

During March and April the Trust the Executive Team will undertake a number of staff conversations from which a programme of work will be established that will support, either directly or indirectly, the delivery of the Trusts objectives.

Quality plans

SAFE | EFFECTIVE | POSITIVE

The Review of Quality of Care and Treatment by Sir Bruce Keogh in May 2013 represented a sobering call to action and we have already put in place all of the work highlighted by the review as needing immediate attention. Much of this focussed on workforce planning, improving training for ward nurses and healthcare assistants, reducing the need for agency and bank staff and improving the experience of junior doctors and student nurses. However, we are committed to going far beyond the remit of these specific recommendations. As part of this programme the Trust refreshed and re-launched the Quality Strategy of the Trust.

The key strategic objectives of the Quality Strategy 2013/15 are:

Consistently Safe – ensuring that essential patient care is safe, effective, positively experienced and delivered to a consistently high standard

Consistently Effective – ensuring high quality of care for all people using the service and reducing the variation in clinical practice

Perceived in a positive way by patients – continued development of the patient experience, with particular focus on the patient journey, and ensuring effective communication between staff and all patients and carers.

Our approach is built on:

- Developing real time patient feedback in all wards and departments and acting on it locally (including a rating of whether the patient would recommend the hospital)
- Developing the range and quality of public and patient information in consultation with patients and carers
- Defining the values and behaviours that we expect from our staff and embedding these through recruitment, induction, development and appraisal
- Using all forms of feedback to influence how are services are developed, delivered and evaluated
- Embedding our patient promises in the way we work with patients, families and carers.

Consistently Safe

While acknowledging that healthcare environments inevitably carry risk of harm to patients, we have clearly asserted that any incident of preventable harm is unacceptable. We have put in place appropriate measures to minimise the risk of harm, set up robust systems to ensure that any incidents are identified, reported, escalated and monitored, and established processes to ensure that learning from incidents is embedded and shared to support the reduction in variation in practice. We are also committed to being transparent with our patients when harm has occurred in a manner that is timely and open.

In order to achieve this we intend to minimise the risk of harm to patients by reducing or eliminating:

- Pressure ulcers
- VTE
- Healthcare acquired infections
- Avoidable Incidents

And by enhancing:

- Management of Acute Kidney Injury
- Management of the Acutely Ill /Septic Patient

Consistently Effective

The Trust is focussing on three particular elements of patient care to reflect and facilitate the changes needed to address the short term and longer term challenges identified in our plan, these are:

- Mortality – monitoring trends and performance, and demonstrating lessons learnt
- Learning from Serious Incidents and incidents
- Building on ward assurance – through the introduction of the ward toolkit.

Positive Patient Experience

The Trust is consistently delivering performance in excess of 70% for the Friends and Family Test. In 2013/14 the Trust was one of the highest achievers in the region for operational performance in the Emergency Department while maintaining amongst the highest patient experience scores in that Department. In keeping with our strategic intention to move well beyond the minimum standards expected we have set ourselves challenging stretch goals in this area, including:

- Consistent and positive patient discharge procedures
- Reduction in formal complaints
- Wider engagement with patient groups
- Focus on delivering compassionate care, embracing the 6Cs at all levels and introducing the touch point methodology
- Engagement with minority groups within our community.

Patient Promises:

- We will always be approachable and acknowledge that you are there
- We will treat you in the way you would expect to be treated – with consideration and respect
- We will be polite, professional and courteous
- We will listen to what you tell us – your opinions are our opportunity to improve
- We will admit our mistakes and do all we can to put them right
- We will talk to each other so that we can care for you better
- We will be caring and kind.

"Hard Truths" – the Francis Report

The Board of Directors has considered both the findings of the Francis Inquiry and the government response. The Trust's three pillars of our Quality Strategy capture our response to the Francis Inquiry, and include our Patient Promises. It re-states our openness and transparency as an organisation, and our contract of quality with our patients. Our commitment to a consistently safe, effective and positive patient experience will be delivered through:

- Displaying our performance data on quality, staffing and patient feedback in public
- Holding Board meetings that are open to the public. We welcome feedback from the public in these meetings on the openness and effectiveness of the Board
- Directors and Non-Executive Directors engage in Board to Ward assurance visits, engaging with staff and patients in discussions about their experience in the hospitals and how this can be improved
- Complaint handling in real-time to bring about immediate resolution and learning
- PALS relocation to main hospital site for ease of access and visibility
- Directors and the Chair independently operate employee forums to enable quality to be openly discussed and concerns or issues to be raised.

Commissioning for Quality and Innovation (CQUIN)

Commissioning for Quality and Innovation (CQUIN): 2014/15 Guidance issued in December 2013 notes that CQUIN monies should be used to incentivise providers to deliver quality and innovation improvements over and above the baseline requirements set out in the NHS Standard contract, whether this be incremental improvement or radical service redesign. It is recommended that there is a maximum of 10 local CQUIN goals per contract.

CQUIN is set at 2.5% value for all healthcare services commissioned through the NHS standard contract,

excluding high cost drugs, devices and listed procedures. As a minimum one fifth of this value (0.5% of the overall contract value) is to be linked to national CQUIN goals.

Variations are acceptable if three principles are followed – the best interest of patients, promoting transparency, and constructive engagement of Providers and Commissioners.

National CQUINs

Goal Number	Indicator Number	Indicator Name	Indicator Weighting (% of CQUIN scheme available)	Expected Financial Value of Indicator
1	1a	Friends and Family Test – implementation of staff FFT	1.50%	£47,866
1	1b	Friends and Family Test – early implementation	0.75%	£23,933
1	1c	Friends and Family Test – increased or maintained response rate	0.75%	£23,933
1	1d	Friends and Family Test – increased response rate in acute inpatient services	2.00%	£63,822
2	2	NHS Safety Thermometer improvement	5.00%	£159,554
3	3a	Dementia – Find, Assess, Investigate and Refer	1.67%	£53,291
3	3b	Dementia – clinical leadership	1.67%	£53,291
3	3c	Dementia – supporting carers of people with dementia	1.66%	£52,972
4	4a	Safe and effective management of non-elective patient's	56.00%	£1,787,006
4	4b	Supporting effective discharges within a hospital setting	9.00%	£287,197
4	4c	Improved communication	10.00%	£319,108
5	5	Medication safety thermometer	5.00%	£159,554
6	6	Sepsis care pathway	5.00%	£159,554
		TOTAL	**100.00%**	**£3,191,083**

Local CQUINs

At least 2% of the total contract outturn is attributable to local CQUINs. There is a national pick list of validated indicators to assist Commissioners in deriving an agreed CQUIN. CQUINs must be agreed and validated before contracts can be signed. Templates for any new local CQUIN must be published to the NHS England site.

The Commissioners have identified 3 local CQUINs

Local CQUIN negotiations continue and the Trust has rejected the safe and effective care proposal from the CCG which does not appear to fulfil the quality aspirations of CQUIN.

The Trust would favour local CQUINs directed to the priorities noted in this Annual Plan, namely

Mortality, Patient Safety, Frail Elderly Care and End of Life care. It is noted that the NHS England pick list contains a number of CQUINs of this description.

Board Assurance

The Trust received a Board Quality Governance Assurance Framework assessment from Deloitte in 2012. The Trust is addressing the action plan that arose from that report. It is the intention of the Trust to commission a follow up scored assessment in the summer of 2014 to confirm that the actions taken have addressed the issues raised and that the Board of Directors is able to take assurance that the Quality Governance framework of the Trust is operating effectively.

The Trust has been working with the Good Governance Institute to review Governance and Risk Management structures and has appointed an interim Director of Governance with a view to seeking a permanent appointment in this role in 2014/15.

Risks to Quality and Mitigation

The Trust maintains a comprehensive Risk register and key risks to the achievement of Trust objectives are recorded and monitored through the Board Assurance Framework.

The following Risks have been identified for the purposes of this 2 year operational plan.

Risks

- Failure to provide patients with a positive patient experience from our services.
    - The risk is mitigated by ensuring that mechanisms are in place to both capture and act on patients feedback, and that standards of privacy, dignity and respect for all service users are at the forefront of all operational planning.
    - The Trusts Governance, Risk and Assurance Committee retains oversight of this risk on behalf of the Board.
- Failure to improve patient safety and eliminate avoidable harm.
    - The risk is mitigated by have the appropriate staffing levels across all departments, the ongoing focus on reducing healthcare acquired infections, and the utilisation of recognised pathways, protocols and guidelines.
    - The Trusts Governance Risk and Assurance Committee retains oversight of this risk on behalf of the Board.

Operational requirements and capacity

The analysis undertaken by the Trust has informed the overall service strategy that in turn informs the Divisional Plans. Workforce Plans and Capacity Plans have identified services where clinical sustainability is challenged by scale, recruitment, and capacity. This is then correlated with the Market Trends and our analysis of Service Line Margins that identifies a number of service lines where the Trust would economically wish to pursue partnerships and collaboration in order to scale services and reduce the impact of low or negative margins.

The Trust has refreshed its bed model and is now operating the model internally to forecast bed usage based on the assumptions within the contract and Divisional activity plans.

Overview of Services

The Trust Divisional plans identify clinical constraints in terms of workforce or rota management and sustainability. The demographics of the catchment area we serve have been outlined above and will be considered in more detail in the Trust Strategic Plan. These factors are triangulated to identify service lines where the Trust needs to consider strategies for growth, partnering or divestment.

Frail Elderly Care Pathway and Intermediate Care services - Growth

The Trust Length of Stay project includes implementation of a new frailty team, joint redesign of the complex discharge pathway with our partners in the Staffordshire and Stoke on Trent Partnership Trust (SSOTP), closure of Ward 44, and a review of alternative models of care closer to the patient's home.

The closure of Ward 44 to new admissions is planned for the summer of 2014. The phased closure of the Ward over the summer requires action from partners to put in place services to maintain the cohort of patients on the ward in Community or home settings. In addition, it is likely that some 50% of the current cohort of patients will need to be absorbed within the main site bed stock. The Trust has commissioned an audit of the patients to identify the clear pathways required. The plan will require some estate reconfiguration to accommodate the acute rehabilitation beds noted. The decision will also impact upon the income received by the Trust for rehabilitation. The plan will be developed for submission to the Better Care Fund as a key project for the frail elderly priority. Funding will be sought to bridge the transition of the service to a final frail elderly care pathway which we believe should be supported by a locally modified pathway tariff. It is anticipated that the transition will take at least two years to complete.

In 2012 the Board of Directors agreed a strategy to refocus Community Service provision on the most vulnerable group of patients. Commissioners have signalled an intention to tender services for both intermediate care and long term conditions.

The frail elderly care pathway programme is intrinsically linked with the Trust vision for Community Services.

The Trust has undertaken a significant engagement exercise drawing on the views of staff, service users, non-statutory sector partners, commissioners, Borough Councils and other NHS providers through engagement events.

The Trust is seeking, in the short to medium term to utilise space in the Community Hospital in Tamworth by leasing ward space to the Mental Health provider for South Staffordshire and Shropshire, leasing theatre space to Cross City CCG for their new assessment model, and to reconfigure the remaining bed space to meet the anticipated needs identified for intermediate care.

The Trust is seeking to reconfigure the space in the Community Hospital in Lichfield to meet the anticipated requirements of the Intermediate Care and Long Term Conditions tender.

The Trust is currently building a strategic shortlist in order to develop more detailed proposals. The intention is to build the volume and value of Community services closer to the patient home, sustain the use of the Community Hospital assets, increase the margins in service lines within this Operating Unit and consolidate service lines where margins are weak and unlikely to recover given the scale of the services offered.

This project is led by a senior project lead and the Board of Directors will consider first options in April 2014 with a view to full Business Cases being developed by July 2014. Implementation is likely to be

2015/16.

Long Term Conditions – Growth and Partnering

Commissioners have undertaken a market research exercise to establish the willingness of providers to deliver a horizontally and vertically integrated and multi-agency Long Term Conditions service. Services are currently provided by a combination of primary, community and scheduled and unscheduled secondary care providers. There is some involvement of third sector providers. Commissioners for East Staffordshire, Stafford and Surrounds, and Cannock Chase have combined for this exercise. The model envisaged is a lead/prime provider model to ensure effective integration across the statutory and non-statutory sector.

The Commissioners wish to move to an outcome based commissioning agreement for these services, informed by the NHS Public Health and Adult Social Care outcomes framework, particularly outcome 2: enhancing quality of life for people with long term conditions. The model envisaged by Commissioners relies increasingly on assistive technology and the use of direct payments and personal health budgets.

The prime provider model is seen as a means of increasing the critical mass of the Trust, however, the Trust will need to assess whether the service represents integration or diversification and whether there are true economies of scale from the possible tender. The Trust does, however, plan to explore the resultant contract tender and is currently working with Commissioners to support changes to the Long Term Conditions services provision in our catchment area.

Hyper Acute Stroke Service – Partnering and divestment

The Local Health Economy plans to create a Hyper Acute Stroke service at Derby Hospitals NHS Foundation Trust supported by stroke services at BHFT and Stroke Rehabilitation services at Staffordshire and Stoke on Trent Partnership NHS Trust have been significantly delayed.

The Trust plan assumes continuation of the current service model in 2014/15 and 2015/16 although it is anticipated that the longer term service plan will identify this area as one of particular focus.

Endoscopy - Growth

Derbyshire Screening Centre (covering both Derbyshire and East Staffordshire) was in the first wave of the Faecal Occult Blood tests (FOBt) screening programme for bowel cancer. A new screening programme utilising a one-off flexible sigmoidoscopy (FS) is currently being rolled out across the country. This is initially being targeted at centres with successful age extension of the FOBt programme and proven resilience. Derbyshire Screening Centre has recently been approved for the programme by the national office following a Quality Assurance visit in January 2013.

The second wave of the programme roll out commences in April 2014. It is anticipated that this will result in increased demand of between 6000 to 8000 examinations per 1 million population. The catchment area of Derbyshire and East Stafford is approximately 1.13 million. 5% of examinations are expected to result in the need for colonoscopy.

The activity increase for colonoscopy has been built into the Trust baseline assumptions in partnership with our neighbouring acute providers.

Radiology Services – Partnering

The Trust has undertaken a number of reviews of its radiology services both in terms of efficiency and sustainability and has concluded that a strategic partnership for the future provision of radiology services

is the preferred option for the delivery of this service. The Trust will therefore develop a series of options, for formal evaluation, for moving the service by the end of 2014/15. The enquiry of the market will be framed to move the Trust towards the longer term objective of ensuring optimum care no matter the hour or day of delivery ("24/7").

Implementation of Electronic Medical Record

The Trust operates the Meditech system, an integrated clinical and corporate IT system. The Trust plans to upgrade the system to Version 6 during this year. The upgrade is so significant that the plan is constructed as a new system implementation. The upgrade opens up a range of benefits and opportunities including:

- Community Integration – Community Hospitals access
- Mobile access – access for Community Staff/ patients
- The "Clinical Assistant" – Track and Trigger systems
- "Order sets" – understanding care pathways and implementing care bundles and prompting orders
- Clinical Letters – information tagged for inclusion and letters created for emailing
- "Clinical Panels" – one view of a series of interventions and trends plotting the success of those interventions
- Bar Coding – enabled for patient ID for patients and tests and medication
- "Header section" – one stop for alerts
- "Scheduling" – how our most expensive and profitable resources are applied
- Bedside Nursing Assessment – increased direct patient contact time
- Bedside Prescribing – reduction in near misses and prescribing errors
- Enhanced Formulary Service – patient safety alerts
- Paperless Internal Referral Services – administrative burden and patient pathway
- Enhanced Cancer Pathways
- Improved Clinical Audit environment
- Text Message Reminders – DNA reduction in Outpatients
- Improved Web Technology Integration – patient engagement
- Coding – systematise coding improvement and depth.

The Trust will invest £1.5 million of capital funding in the development and implementation of the system in 2014/15. Financial benefits realisation has been prudently estimated in the CIP programme for 2014/15 and 2015/16.

Transfer of Fertility Services

The Burton Clinic for Reproductive Medicine is a small IVF service with a mixed market of NHS and private fertility work and primary care testing. The Board of Directors has considered a business case for the transfer of this service to a private supplier. The Business Case notes that future growth of the service requires considerable capital investment in laboratory assets and the regulatory framework which can only be supported through increased scale. The case concluded that transfer to a private supplier would preserve the local service and mitigate the capital and future sustainability risks of the service. The private provider has guaranteed the contribution to Trust overheads for a two year period and will continue to purchase services from the Trust while the service is located at Queen's Hospital. The Service with an annual turnover of £0.6 million will transfer in April 2014.

Pathology Services - Partnering

The Trust has undertaken a tendering exercise and shortlisted to two possible suppliers of pathology services. Both suppliers are NHS organisations. The Trust anticipates final selection and contract

mobilisation in 2014/15.

Theatres – Growth and Partnering

The Trust has significant physical capacity in terms of available Theatres. We have identified that current activity could be consolidated into a reduced number of Theatres.

The realisation of this efficiency, through improved scheduling, opens up immediate opportunities to either close capacity or to apply this capacity to activity not currently undertaken. Initial discussions with partner organisations are exploring the concept of an elective partnership model similar to the South West London Elective Orthopaedic Centre model or the Avon Orthopaedic Centre where a number of organisations utilise a cold elective site to repatriate activity from the private sector or from premium sessions within their own organisations.

A senior Programme Manager is attached to the Surgery Division to implement the plans. Those plans identify efficiencies in 2014/15. Further development of partnership models will follow when it is clear that the Trust can vacate the capacity required to support a partnership model. Plans for 2014/15 recognise the efficiency target noted but do not include the partnership model which will require a Business Case by September 2014 to implement in 2015/16.

Productivity, efficiency and CIPs

How the Cost Improvement Programme is managed

Planning

The Board of Directors approves the Strategic and Annual Plans of the Trust. The Trust has developed detailed two-year operational plans and a three to five year strategic plan. The Staffordshire health economy has been identified as a challenged economy and tripartite support from the three Regulators of the Health system will be provided in 2014/15 to develop an economy wide view of the three to five year strategic plan.

Accountability for delivery of the Cost Improvement Plan is through the Executive Management Board of the Trust and directly through the Chief Executive to the Trust Board. Each Cost Improvement Plan has a project sponsor and a lead project manager. The project sponsor is accountable to the Chief Executive for the overall delivery of the plan and holds the project manager to account for day-to-day delivery. The Chief Executive has established a fortnightly Cost Improvement Plan management Board attended by all project sponsors.

The Trust has a Programme Management Office that supports the Chief Executive oversight of the programme with regular monitoring and exception reports. Project managers update programme workbooks on a fortnightly basis with support from the programme management office that administer the full suite of workbooks. These workbooks are based upon the suite provided by PwC.

Identification

The Trust has identified opportunities and projects through central analysis of data, the input of external support, the input of the Programme Management Office senior lead and project plans within the library of schemes collected over the last 3-4 years. The Trust has also used benchmarking from sources such as:

- Better Care Better Value
- Estates and Facilities Management Information Systems (ERIC)

- Payments by Results Benchmarking Tool
- Albatross patient level costing benchmarking system
- A range of external reports from other areas by agencies such as NHS Benchmarking Club, Dr Fosters, CHKS and CIPFA.

Areas of variation have been identified for further analysis and development. Schemes are then developed to Project Plan level using the Trust Programme Management Office workbooks or if the scheme is significant the Trust develops Business Cases following the Risk Evaluation Investment Decision (REID) planning principles, and these cases are considered at the appropriate Governance forum based on delegated authority limits in the Trust Standing Orders.

The central schemes are supported by additional programme management resource that is either protected within existing Trust resources or is purchased through interim or consultancy support. This additional resource is placed as close to the operational service delivering the scheme as possible.

In this way, the Trust is maintaining a small but senior administrative support service through the Programme Management Office and placing resource as close to service lines as possible.

Cost improvements are tested with Divisions and service lines and when the savings opportunity has been tested and accepted the budgets are removed from Divisional budgets. Divisions are then held to account for benefits realization through the existing performance management arrangements of the Trust.

Divisions have been asked to identify a basic efficiency saving of 1.5% in 2014/15 to reflect the net efficiency requirement of the tariff deflator as a basic business as usual target. The Trust is planning to introduce a “bright ideas” scheme through the Programme Management Office to elicit savings ideas from the whole Trust workforce and to assist in building a wider understanding of the cost improvement plans.

The Programme Management Office ensures that double counting does not occur within plans.

Delivery

Each scheme is managed through a workbook that sets out project goals and objectives, milestones, key performance indicators, phased financial savings, Risk Assessments and mitigation plans and a detailed Quality Impact Assessment.

The Cost Improvement Plan management Board is responsible for signing in and closing schemes. The group also provides peer challenge to schemes to assist the Chief Executive to hold the organisation to account.

Monitoring

The Programme Management Office meets on a weekly basis with project managers to assist those managers to self assess progress (RAG rate) and to provide the Chief Executive with an independent view on progress (process and financial). The Cost Improvement Plan management Board meets fortnightly and reports exceptions (Red schemes) for escalation. The fortnightly meeting reports progress against milestones and the key performance indicators identified in the project plan.

Escalation for Red rated schemes is initially through the Director of Finance and Chief Operating Officer and ultimately to the Chief Executive. Divisions are required to identify mitigating savings for schemes that have been accepted but where benefits are not being realised as planned.

The detailed reports from the Cost Improvement Plan management Board are summarised and reported through the monthly Finance Report. The Executive Management Board and the Finance and Investment Committee, a sub-committee of the Trust Board, consider this report. A summarised version of this

monthly report is taken to the public Board meeting on a monthly basis.

Evaluation

The Trust has developed a post project evaluation model that is applied to all material projects and to any schemes where the respective governance bodies wish to seek assurance. The Trust Internal Audit Plan contains dedicated resource to assess effectiveness of the Cost Improvement Plan.

The two year cost improvement plan

The Trust has identified a series of opportunities. In 2014/15 the Trust will focus on provider driven efficiencies or traditional savings plans. In 2015/16 the Trust will expand its ambitions to include system wide efficiencies driven through collaboration, sharing and networking. From 2016/17 onwards the Trust is clear that its five to ten year plans will need to be based upon transformational change in terms of whole pathway, system and organisation structure redesign. The notification that Staffordshire has been identified as a challenged health economy requiring tripartite support from Regulators is welcome and the Trust hopes to frame the 2016/17 plans on the work that will flow from that Local Health Economy Review and support.

As noted above the Trust has used a series of external and internal benchmarks to identify opportunities that have informed the Cost Improvement Plan for the next two years. The NHS Better Care, Better Value efficiency indicators for Quarter 2 of 2013/14 identifies theoretical opportunities if the Trust performs at levels commensurate with the top 25% or 10% of Trusts. The measures do not account for scale or diseconomies of scale.

Better Care Better Value Indicators 2013/14 Quarter 2

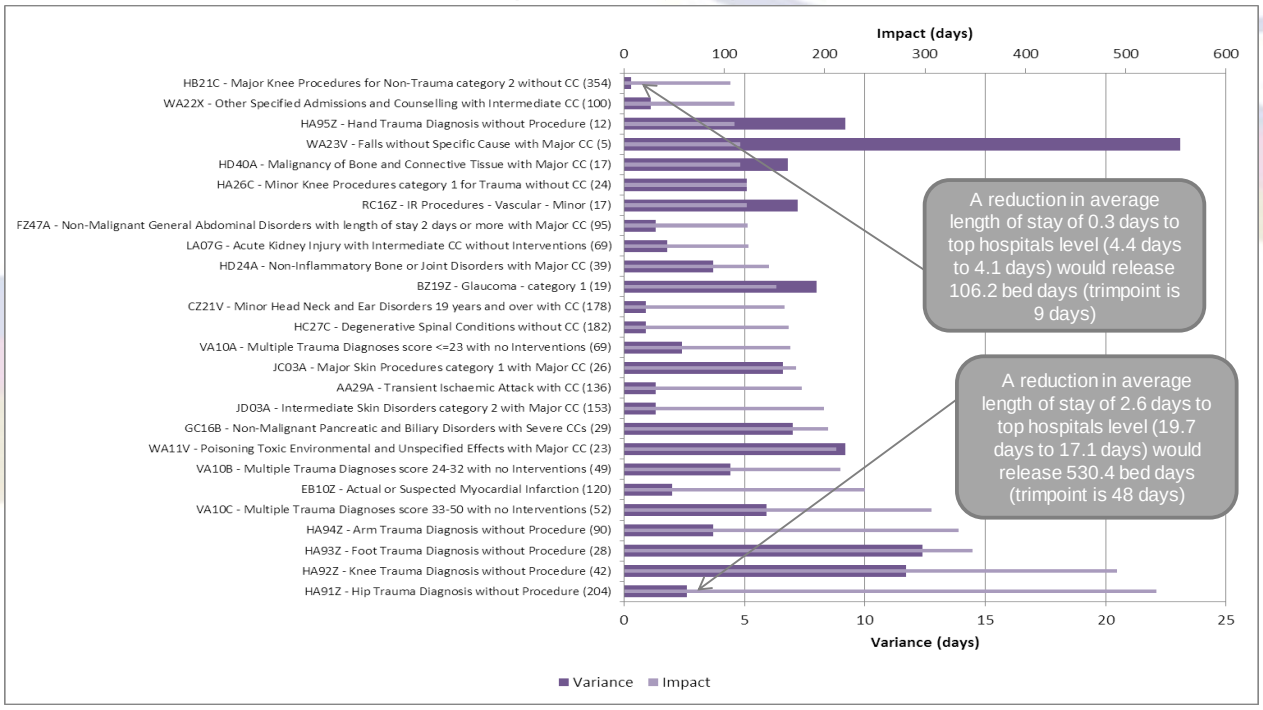
	Relative Performance	
	Opportunity at 25% £	Opportunity at 10% £
Reducing Length of Stay	988,418	
Managing First to follow up	585,019	1,300,000
Emergency Readmission (14 Days)	535,371	886,615
Outpatient Appointment (DNA)	477,717	698,651
Increase Day Surgery Rates	61,175	97,112
Pre-procedure Non-Elective bed days	5,244	36,746
Pre-procedure Elective bed days	3,706	7,691

The Trust has identified a scheme for Length of Stay with a target saving of nearly £1.0 million. This is well in excess of the top 25% of Trusts. The work undertaken by the Trust has identified genuine diseconomies of scale for a small District General Hospital where reduction in length of stay resulting in an ability to close beds is curtailed when ward areas are established at a minimum base level. For example the Trust has one male surgical ward area where further reductions in bed numbers are unlikely to save significant fixed costs.

Burton Hospitals NHS
NHS Foundation Trust

Comparison with CHKS top Hospitals

Top HRGs by Impact



Numbers in brackets are spells at Burton

The Trust has identified some scope within Outpatient services but it is noted that a significant proportion of the identified opportunity is in areas where there is currently no community provision, such as Respiratory services and Diabetes. The Trust has however, identified a scheme in 2015/16.

The Trust has invested in the EPS Engage system to enable services to review Emergency Readmissions within five days of the data submission in order to reduce the number of readmissions. This will reduce the penalties imposed by the Commissioner. Unfortunately, the Local Health Economy has not reinvested this funding in 2013/14 and this is unlikely to improve whole economy savings.

The Trust has also reviewed the Capital Payments by Results benchmark toolkit. It is acknowledged that this data is based upon historic reference cost submissions and data but the use of the information, triangulated with other data such as the NHS Better Care Better Value indicators can point to areas of opportunity. The Trust considered the most significant specialties to identify whether the average price per spell indicated inefficiencies within the Trust. The key specialities of the Trust all show an average price per spell that is significantly lower than the expected price per the toolkit.

Mean Price of a spell per National PbR benchmarking tool

Specialty	Burton	Expected Average Price per spell per Toolkit	Variation from average Over(Under)	Burton spells
General medicine	£1,625	£1,718	-£93	11,166
General Surgery	£1,283	£1,575	-£292	8,314
Obstetrics	£1,110	£1,283	-£173	7,803
Trauma and Orthopaedics	£2,891	£3,076	-£185	4,335
Paediatrics	£716	£803	-£87	4,150
Urology	£784	£898	-£114	3,429
Ophthalmology	£696	£771	-£75	2,486

The Trust has used the Hospital Estates and Facilities Statistics Return (ERIC) to identify potential opportunities.

Hospital Estates and Facilities statistics (ERIC) 2012/13

	Burton Hospitals	Average Small Acute Trust
Total Energy Cost per heated volume	£10.65	£9.24
Average fee charged per hour for patient/visitor parking	£0.67	£1.07
Average fee charged per hour for staff parking	£0.06	£0.17
Total Parking spaces available	1,789	1,368
Cost of feeding one inpatient per day	£8.96	£9.40
Waste Food	6.35%	5.40%
% of Hard FM and Soft FM services contracted out	6.00%	30.55%
Value of Hard FM and Soft FM services contracted out	£717,000	£5,076,600
Income per square metre of occupied space	£2,408	£2,993

On the basis of this analysis the Trust has included a programme of outsource market testing for the two years of this plan and would anticipate an on going process for the full five year plan. The Trust has also identified the need to reduce the Estate footprint. This will realise cash to support the financial position of the Trust but will also result in recurrent savings against running costs. In this way the Trust is aiming to increase income per occupied square metre of space to well above the current £2,993 average for the small acute Trust peer group.

The Cost Improvement Plan includes schemes on Energy management and patient feeding (wastage).

The Trust has also utilised internal benchmarking to assess efficiency in areas like Theatre scheduling. The Trust has identified an opportunity within this work to rationalise activity to a smaller number of theatres in order to either close or reallocate theatres. This is reflected in the key priorities noted above.

The two-year plan of the Trust identifies a target saving of £13 million (8.6%) in 2014/15, although the projected outturn in the Trust plan is based upon achievement of £11 million (7.3%) savings. In 2015/16 the Trust has set a target of £15 million of savings but the outturn is based upon achievement of £13

million (81% of target).

The risks associated with workforce relate to on-going recruitment challenges and the sustainability of workforce numbers required by the safer nursing care tool. The Trust has limited the planned saving in this area to approximately 1% of gross employee costs in order to mitigate this tension.

The risks associated with the length of stay project reflect the issues of scale faced by the Trust. While the Trust metrics identify a length of stay opportunity for the Trust if performance can be raised to the top decile, analysis shows that the opportunity is spread over a number of wards. A number of the wards are single specialty or function wards and the removal of bed days will have no significant impact on the cost base due to the cost base floor required to operate those units. The Trust has, however, identified a possible opportunity that requires significant cross system collaboration. The opportunity will also result in a loss of income for the Trust that the Trust would wish to see managed non-recurrently through the Better Care Fund to enable fixed costs to be removed over time.

Financial plan

The Operational plan describes the Trust's route to achieving income and expenditure balance and a reduced and sustainable cost base by the end of 2015/16.

2014/15 is a transition year in which a significant Cost Improvement Programme will be delivered in conjunction with asset sales that will generate cash, facilitate estate rationalisation and reduce the Trust's cost base in the longer term.

The Trust Operational plan will result in a deficit of £3m and a CoSRR of 3 during 2014/15, whilst preparing itself for longer term financial sustainability and a break even position in 2015/16. The Trust Operational plan includes a local stretch target for CIP but prudently assumes a level of delivery consistent with national evidence at 80% of the target saving.

The Trust takes forward into 2014/15 a recurrent deficit of £4.3m having delivered a deficit of £1.7m in 2013/14 with non-recurrent funding sources of £2.6m. The impact of national efficiency requirements, developments and cost pressures is to increase this deficit to £14m. To achieve a break even position, the Trust would be required to reduce its costs by 7.4% from April 2014. Cost Improvement Programmes have been identified which are planned to deliver £17.5m in a full year, with £11m of costs being released in 2014/15. These savings will reduce the Trust's deficit to £3m in 2014/15, and achieve an underlying surplus of £3.5m to be carried forward into 2015/16. Further CIP of £4.6m in 2015/16 will enable the Trust to achieve the national efficiency requirement and deliver a break even position.

The Table below shows the Income and Expenditure Position and the CIP for 2014/15 and 2015/16.

	2013/14 Forecast £m	2014/15 Pre CIP £m	2014/15 CIP pye £m	2014/15 Plan £m	2015/16 Pre CIP £m	2014/15 CIP pye £m	2014/15 CIP bal to fye £m	2015/16 CIP £m	2015/16 Plan £m £m
Patient Income	153.2	152.8	1.5	154.3	149.4	1.5	0.7	0.0	151.6
Other Income	25.7	22.2	0.5	22.7	22.2	0.5	0.6	0.0	23.3
Pay	-116.8	-120.7	5.8	-114.9	-123.1	5.8	3.2	3.6	-110.5
Non Pay	-54.2	-57.2	3.0	-54.2	-58.9	3.0	2.0	1.1	-52.8
Capital Charges	-9.6	-11.0	0.2	-10.8	-11.6	0.2	0.0	0.0	-11.5
	-1.7	**-14.0**	**11.0**	**-3.0**	**-22.1**	**11.0**	**6.5**	**4.6**	**0.0**

The Table below shows Cost Improvement Plans for 2014/15 and 2015/16 which reduce the Trust's cost base by £22.1m. Divisions are required to deliver productivity savings of £4.5m being equivalent to the national requirement of 1.5%. The balance of savings is found over a range of schemes, with the maximum value for an individual scheme being £3.3m.

Within the organisation, the value of the CIP targets for 2014/5 has been set at £13m on the assumption that slippage of £2m can be accommodated within the plan.

For 2014/15, 22% of the required savings are delivered in Q1 and Q2 with the remaining 78% being delivered in Q3 and Q4.

Cost Improvement Programme

	Grouping from APR Model	2014/15 q1 £000's	2014/15 q2 £000's	2014/15 q3 £000's	2014/15 q4 £000's	2014/15 total £000's	2014/15 bal to fye £000's	2015/16 pye £000's	2015/16 Total £000's	2 year CIP Total £000's
Divisional Target	1.5% Efficency Savings	0.5	0.5	0.5	0.5	2.1	0.0	2.4	2.4	4.5
Procurement	Corporate Schemes	0.2	0.4	0.5	0.6	1.6	0.8	0.9	1.7	3.3
Income	Corporate Schemes	0.2	0.2	0.2	0.2	0.8	0.0	0.0	0.0	0.8
Pay Inflation	Corporate Schemes	0.0	0.0	0.0	0.0	0.2	0.0	0.2	0.2	0.3
Non-Recurrent Stock	Corporate Schemes	0.0	0.0	0.0	0.2	0.2	-0.2	0.0	-0.2	0.0
Finance Issues (CNST/Drift)	Corporate Schemes	0.0	0.1	0.1	0.1	0.3	0.1	0.0	0.1	0.4
Pharmacy Costs	Clinical Efficiencies	0.0	0.0	0.1	0.2	0.3	0.4	0.0	0.4	0.6
Length of Stay	Clinical Efficiencies	0.0	0.0	0.4	0.4	0.8	0.8	0.4	1.2	2.0
Theatre	Clinical Efficiencies	0.0	0.1	0.1	0.1	0.4	0.1	0.0	0.1	0.5
Agency volume/Bank optimisation	Workforce	0.0	0.1	0.2	0.1	0.4	0.0	0.4	0.4	0.8
Waiting List and premium payment reduction	Workforce	0.0	0.0	0.2	0.3	0.5	0.0	0.0	0.0	0.5
Workforce	Workforce	0.0	0.0	0.5	0.6	1.1	1.3	0.0	1.3	2.4
Outsourcing	Commercial	0.0	0.0	0.3	0.3	0.5	0.5	0.3	0.8	1.3
Private Sector utilisation	Commercial	0.0	0.0	0.0	0.2	0.2	0.6	0.0	0.6	0.8
Market Share/Collaborative Working	Commercial	0.0	0.0	0.1	0.2	0.3	0.4	0.0	0.4	0.6
Maintenance Contract Management	Commercial	0.0	0.0	0.0	0.1	0.1	0.3	0.0	0.3	0.4
Meditech and IT/HIS benefits realisation	Commercial	0.0	0.0	0.0	0.1	0.1	0.3	0.0	0.3	0.4
Estates Rationalisation	Commercial	0.0	0.0	0.0	0.3	0.3	0.0	0.0	0.0	0.3
Elective Surgery Collaboration	Commercial	0.0	0.0	0.0	0.1	0.1	0.3	0.0	0.3	0.4
Margin improvement Community - Intermediate and LTC	Commercial	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Partnering and Collaboration efficiency	Commercial	0.0	0.0	0.0	0.1	0.1	0.3	0.0	0.3	0.4
Radiology	Commercial	0.0	0.0	0.1	0.1	0.2	0.3	0.0	0.3	0.5
20% Mitigation and Headroom - not yet identified	Commercial	0.0	0.0	0.2	0.2	0.3	0.3	0.0	0.3	0.6
PMU and Pharmacy External review	Commercial	0.0	0.0	0.1	0.2	0.3	0.0	0.0	0.0	0.3
		1.0	**1.4**	**3.5**	**5.1**	**11.0**	**6.6**	**4.6**	**11.1**	**22.1**

The Trusts CIP Programme is overseen by a strong governance structure and Programme Management Office, resourced with a combination of substantive staff and interim specialist staff. All schemes have been RAG rated, with £6.8 million of schemes having detailed plans.

The timing of the savings programme, in conjunction with lower activity levels during Q1 and Q2 result in a planned deficit of £5.1m for the first half of the year, but a surplus of £2.1m for the second six months when activity increases and savings are released. The Table below shows the planned phasing of the income and expenditure position for 2014/15 and 2015/16:

Income and Expenditure

	2013/14 Forecast £m	2014/15 Q1 £m	2014/15 Q2 £m	2014/15 Q3 £m	2014/15 Q4 £m	2014/15 Plan £m	2015/16 Q1 £m	2015/16 Q2 £m	2015/16 Q3 £m	2015/16 Q4 £m	2015/16 Plan £m
NHS Clinical Income	153.2	38.0	38.4	38.9	39.0	154.3	37.3	37.8	38.2	38.4	151.6
Private Patients	1.2	0.3	0.3	0.3	0.3	1.3	0.3	0.3	0.3	0.3	1.3
Other Patient income	1.0	0.2	0.2	0.2	0.2	1.0	0.2	0.2	0.2	0.2	1.0
Donated Income	0.3	0.0	0.0	0.0	0.1	0.2	0.0	0.0	0.0	0.1	0.2
Other (non-patient) income	23.3	4.9	4.9	5.0	5.3	20.2	5.2	5.2	5.2	5.2	20.8
Total Income	**178.9**	**43.5**	**44.0**	**44.5**	**44.9**	**176.9**	**43.1**	**43.6**	**44.0**	**44.2**	**174.9**
Less Expenditure											
Pay costs	(116.8)	(29.6)	(29.5)	(28.0)	(27.7)	(114.9)	(27.5)	(27.7)	(27.7)	(27.7)	(110.5)
Non-Pay costs	(54.2)	(14.0)	(14.0)	(13.5)	(12.7)	(54.2)	(13.1)	(13.3)	(13.3)	(13.2)	(52.8)
Total Expenditure	**(171.0)**	**(43.7)**	**(43.5)**	**(41.5)**	**(40.4)**	**(169.1)**	**(40.6)**	**(40.9)**	**(40.9)**	**(40.9)**	**(163.3)**
EBITDA	**7.9**	**(0.1)**	**0.4**	**3.0**	**4.5**	**7.8**	**2.5**	**2.6**	**3.1**	**3.3**	**11.5**
Profit/(Loss) on fixed asset disposals	(0.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Finance and Interest Charges	(0.1)	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Depreciation and Amortisation	(6.8)	(1.7)	(1.7)	(1.7)	(1.8)	(7.0)	(1.8)	(1.8)	(1.8)	(1.8)	(7.2)
Total Interest Receivable	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC Dividend Paid	(2.7)	(1.0)	(1.0)	(1.0)	(0.8)	(3.8)	(1.0)	(1.0)	(1.0)	(1.0)	(4.2)
Annual Surplus (Deficit)	**(1.7)**	**(2.8)**	**(2.3)**	**0.3**	**1.8**	**(3.0)**	**(0.4)**	**(0.3)**	**0.2**	**0.4**	**(0.0)**

Activity projections have been developed in the Divisions with the engagement of both clinicians and managers. Following a day of consultation with Commissioners, the plans have been accepted and reflected in the contract requirements. With the exception of movements between categories, for example from day cases to outpatient procedures, the plan represents a relatively stable activity position. The plans do not reflect the Commissioners' QIPP programme as the value of these plans were shared with the Trust at the end of March and the operational details have not, as yet, been discussed. The total value of QIPP schemes across all commissioners is £2.2m with £1.5m in East Staffordshire CCG. This is reflected in the Trust downside plans.

Activity assumptions (Excluding Transformation)	2013/14 Forecast Total	2014/15 Plan Q1	2014/15 Plan Q2	2014/15 Plan Q3	2014/15 Plan Q4	2014/15 Plan Total	2015/16 Plan Total
	Spells	Spells	Spells	Spells	Spells	Spells	Spells
Main Site and TC (Exc part year Angio development)							
Elective inpatients	4,595	1,159	1,179	1,157	1,294	4,789	4,789
Elective day cases	24,302	5,699	5,812	5,933	5,875	23,319	23,319
Non-elective inpatients	31,189	7,548	7,480	7,864	7,743	30,635	30,635
Total Spells	**60,086**	**14,406**	**14,471**	**14,954**	**14,912**	**58,743**	**58,743**
Annual percentage movement						-2.24%	0.00%
Outpatient Activity assumptions	**Attends**	**Attends**	**Attends**	**Attends**	**Attends**	**Attends**	**Attends**
Total outpatient contacts	**251,760**	**64,582**	**64,765**	**65,417**	**65,456**	**260,220**	**260,220**
Annual percentage movement						3.36%	0.00%
A & E attendances	59863	14,458	14,227	14,119	13,885	56,689	56,689
Community Hospitals	**Spells**	**Spells**	**Spells**	**Spells**	**Spells**	**Spells**	**Spells**
Elective day cases	2,770	835	735	805	835	3,210	3,210
Annual percentage movement						15.88%	0.00%
Stay remunerated by Beddays	23,220	6,310	6,102	5,767	6,499	24,678	24,678
MIU attendances	67,203	18,351	18,837	16,342	15,721	69,251	69,251
Outpatient Activity assumptions	**Attends**	**Attends**	**Attends**	**Attends**	**Attends**	**Attends**	**Attends**
Total outpatient contacts	**55,197**	**13,958**	**13,775**	**14,005**	**14,292**	**56,030**	**56,030**
Annual percentage movement						1.51%	0.00%

Capital Expenditure Plans have been developed in two parts. Cash generated internally through depreciation will be invested in replacement and maintenance of equipment and the estate. Strategic Capital of £4.72m in 2014/15 and £5.5m in 2015/16 is being invested to facilitate the estate rationalisation process. The Trust will be approaching the FTFF for a bridging loan of £8m pending the sale of the land and properties on its “Outwoods site” as well as some office accommodation. Asset sales are anticipated to generate income of £12.6m over a four year period based on current net book values. Strategic investments of £12.6m have been planned with the loan providing bridging finance to enable the sales. £3m of sale proceeds released in 2014/15 will be retained in order to maintain the Trust’s liquidity rating pending the sale of the remaining assets.

Capital Programme

	Grouping from APR Model	2013/14 Forecast £m	2014/15 Q1 £m	2014/15 Q2 £m	2014/15 Q3 £m	2014/15 Q4 £m	2014/15 Programme £m	2015/16 Programme £m
Estates & Facilities replacement/maintenance	Estates & Facilities replacement/maintenance	3.27	0.69	0.82	1.32	1.37	4.20	2.78
Medical equipment replacement	Medical Equipment including Imaging & PACS	0.97	0.57	0.39	0.05	0.04	1.05	1.15
IM&T replacement	IM&T	0.73	0.09	0.16	0.15	0.12	0.51	0.60
IM&T strategic projects	IM&T	0.46	0.37	0.53	0.32	0.36	1.58	0.00
Contingency	Contingency & provision for site refurbishment & redesign	0.13	0.07	0.00	0.15	1.01	1.23	1.78
Site refurbishment & redesign	Contingency & provision for site refurbishment & redesign	0.00	0.00	0.00	0.05	0.95	1.00	3.50
Relocation of Endoscopy decontamination	Relocation of Endoscopy decontamination	0.00	0.00	0.16	0.84	0.00	1.00	0.00
Imaging / PACS	Medical Equipment including Imaging & PACS	0.71	0.14	0.30	0.00	0.05	0.48	1.20
Telephone system	IM&T	0.05	0.00	0.10	0.20	0.20	0.50	0.50
Total		**6.30**	**1.93**	**2.45**	**3.08**	**4.10**	**11.55**	**11.50**
Total comprises								
Replacement/maintenance capital		6.30	1.56	1.36	1.67	2.25	6.83	6.00
Strategic capital		0.00	0.37	1.09	1.41	1.85	4.72	5.50
Total		**6.30**	**1.93**	**2.45**	**3.08**	**4.10**	**11.55**	**11.50**

The balance sheet and a summary of cash movements are shown in the Table below. It is assumed that a loan of £2.5m is secured in Q2 along with £5.2m in cash from sale proceeds.

Balance Sheet and Cash Management

Summary Balance Sheet	2013/14 Forecast £m	2014/15 Plan Q1 £m	2014/15 Plan Q2 £m	2014/15 Plan Q3 £m	2014/15 Plan Q4 £m	2015/16 Plan Q1 £m	2015/16 Plan Q2 £m	2015/16 Plan Q3 £m	2015/16 Plan Q4 £m
Capital Assets	126.9	127.7	123.2	124.6	127.0	127.4	127.7	129.4	132.2
Stock	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1
Trade Debtors	9.5	6.5	6.5	6.5	6.5	6.5	6.5	6.5	6.5
Cash	3.7	8.4	12.2	10.7	3.0	13.4	11.5	11.3	4.2
Trade Creditors	-10.6	-16.7	-15.6	-15.5	-8.2	-13.9	-12.3	-13.2	-8.2
Capital Creditors	-1.9	-0.6	-1.0	-0.8	-1.0	-0.4	-0.8	-1.2	-1.5
Other Liabilities (inc Long Term)	-8.1	-8.1	-10.4	-10.3	-10.2	-16.3	-16.2	-16.2	-16.1
Total Net Assets	**122.6**	**120.3**	**118.0**	**118.3**	**120.2**	**119.8**	**119.5**	**119.7**	**120.2**
Public Dividend Capital (PDC)	54.6	54.6	54.6	54.6	54.6	54.6	54.6	54.6	54.6
Reserves	68.0	65.7	63.4	63.7	65.6	65.2	64.9	65.1	65.6
Total Funding	**122.6**	**120.3**	**118.0**	**118.3**	**120.2**	**119.8**	**119.5**	**119.7**	**120.2**
Cash Management									
EBITDA (cash from trading operations)		-0.1	0.4	3.0	4.5	2.5	2.6	3.1	3.3
Balance Sheet movements		8.0	-0.3	-1.2	-5.9	4.9	-0.4	-0.2	-4.0
Loan(s)		0.0	2.5	0.0	0.0	5.0	0.0	0.0	0.0
Capital payments for fixed assets		-1.8	-2.4	-3.0	-4.4	-1.4	-2.1	-3.4	-4.5
Capital Creditors		-1.3	0.4	-0.2	0.2	-0.4	0.2	0.4	0.3
Impact of finance leases		-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
Dividend paid		0.0	-1.9	0.0	-1.9	0.0	-2.1	0.0	-2.1
Income from asset sales		0.0	5.2	0.0	0.0	0.0	0.0	0.0	0.0
Interest received		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Cash movement in-year		**4.7**	**3.8**	**-1.5**	**-7.7**	**10.4**	**-1.9**	**-0.2**	**-7.1**
Closing Cash Balance		**8.3**	**12.2**	**10.7**	**3.0**	**13.4**	**11.5**	**11.3**	**4.2**

The Trust is planning to deliver a CoSRR of 3 by the end of 2014/15 and thereafter. The timing of the CIP, activity, loan and sale proceeds, result in a CoSRR of 1 in Q1, 2 in Q2 and Q3 and 3 thereafter as shown in the Table below:-

Continuity of Service Shadow Risk Ratings

Metric	Weight	Risk Ratings Table Good << Score >> Bad 4	3	2	1
Debt Service Cover metric	50.00%	2.5	1.75	1.25	<1.25
Liquidity metric	50.00%	0	-7	-14	<-14
Continuity of Service Risk Rating	**100%**				

Risk rating based on 2014/15 plan submitted in April 2014

	Weight	2013/14 Forecast		2014/15 Plan		2015/16 Plan		Q1 2014/15	Q2 2014/15	Q3 2014/15	Q4 2014/15
Debt Service Cover metric	50.00%	2.5	4	1.8	3	2.4	3	1	1	1	3
Liquidity metric	50.00%	-8.8	2	-11.5	2	-10.6	2	1	2	2	2
Calculated rating	**100%**		3.0		2.5		2.5	1.0	1.5	1.5	2.5
Actual Rating			**3**		**3**		**3**	**1**	**2**	**2**	**3**

Downside scenarios considered

The sensitivity of each element of the plan was considered in formulating a downside scenario. The impact of the Cost Improvement Programme on the financial plans has been modelled at 80% of the target for delivery and as such represents a downside planning assumption. 65% of the Trust's costs are pay costs and subject to national pay award settlements that have been published and are reflected in the plans. The inflationary costs of pay are therefore not considered to be a material risk to the Trust. In terms of non pay inflation, 74% of the Trust's drugs costs are pass through and there are no significant NICE issues that are anticipated to impact on the remainder of the costs.

Downside scenarios included in the plan

The Trust is anticipating a loan of £2.5m in 2014/15 and £5.5m 2015/16 in order to facilitate its strategic capital programme and generate £3m to support the Trust's liquidity programme. If the Trust was not able to secure a loan, the capital programme of £23m of which £11.2m is for strategic developments would be slipped and consideration given to extending creditor days if necessary.

The plans do not reflect QIPP schemes reflected in the contracts given that only the values and not the details of the schemes have been received by the Trust. The total value of QIPP schemes is £2.2m and the downside scenario reflects the impact of 50% being successful.

The categories of the QIPP schemes are given in the Table below:-

Scheme	Value	50% risk
Elective	£472,430	£236,215
Non Elective	£844,810	£422,405
Outpatients	£632,146	£316,073
A & E / MIU	£294,541	£147,271
Total	**£2,243,927**	**£1,121,964**

If 50% of the QIPP schemes are successful the Trust would look to take the following mitigating action in order to maintain the planned deficit at £3m:-

1.) Replace elective work in specialties where the 18 week target is challenging to achieve (£250,000)

2.) Reduce costs associated with the activity that has been reduced, targeting areas that incur costs at premium rates (£500,000)

3.) Further reduction in corporate costs and overheads (£350,000).

Enabling investment through the Better Care Fund

As noted above the Better Care Fund for Staffordshire contains a minimum sum of £7.48 million of identified funding from East Staffordshire CCG but identifies a much larger pooled budget based on current spending. The Trust plans to submit proposals to the SHWB for enabling funding to support the following key priorities:

- Transformation of the acute rehabilitation pathways as part of the frail elderly pathway development – c.£1 million per annum for 2014/15 and 2015/16
- Transitional support to the movement of non-acute rehabilitation patients to community or home care through funding for Nursing Home or Care at Home services managed by the Trust for 4 weeks prior to hand over to Local Authority – c.£1 million per annum for 2014/15
- Transitional support for the provision of Long Term Conditions support, respiratory and diabetes – c.£0.5 million for 2014/15 while final service commissioned
- Complex Discharge Team, Audit resource for frail elderly pathway and project leadership for admissions avoidance - £0.2 million for 2014/15