Our Vision
To provide every patient with the care we want for those we love the most

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

Norfolk and Norwich University Hospitals NHS Foundation Trust

Operational Plan Guidance – Annual Plan Review 2014-15

The cover sheet and following pages constitute 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	Julie Cave
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Tel. no. for contact	01603 287199
Date	4th April 2014

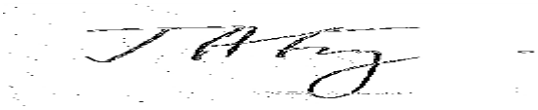
The attached Operational Plan is intended to reflect the Trust's business plan over the next two years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

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)*	John Fry

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Anna Dugdale

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Julie Cave

Signature 

1.2 Executive Summary

Summary of our current position

We are one of the busiest teaching hospitals in England, serving a population of over 750,000. We are located on the southern boundary of Norwich, and our nearest neighbouring acute hospitals are the James Paget University Hospital (JPUH) which is situated 30 miles to the east in Gorleston-on-Sea and the Queen Elizabeth Hospital (QEH), which is situated 40 miles to the north west in Kings Lynn. Both of these are district general hospitals that, unlike NNUH, provide very little specialist care.

We have developed strategic relationships with both of these hospitals over recent years, most recently through partnering together to form the Eastern Pathology Alliance (EPA), with NNUH as the network host laboratory. We have over many years built clinical networks with the majority of clinical specialities at the James Paget Hospital and have a strong strategic relationship with that organisation. There are some clinical service linkages with the Queen Elizabeth Hospital in Kings Lynn although historically that relationship has been less strong. Across both JPUH and NNUH there is a recognition of the need to explore closer collaborative working across clinical networks to ensure that the highest possible quality of care is accessed for local people. A number of projects are already in existence to reduce risk ensure sustainability and improve the quality of services provided by working more closely together to share expertise and optimise the use of expensive capital equipment.

Thus far, competition for our core services from the private sector or from other health and social care providers has been limited due to our relative geographical isolation and the absence of major population centres, which makes inward investment into this region a challenging proposition for many potential market entrants. We categorise competition as an emerging risk, which we monitor closely and mitigate through taking a proactive stance when opportunities for expansion arise. As an example, in recent years, many GP practices have invested significant funds in developing and expanding their premises, our response to this threat has been to outreach into those facilities ourselves, where there is sufficient local patient demand and where the facilities are designed in such a way as to enable the cost-effective provision of services. By doing this we have strengthened our links with primary care, and brought care closer to home for the benefit of our patients.

Key strengths

- We have an engaged and committed workforce that has demonstrated its willingness and ability to learn, to adapt to change, to embrace new methodologies and to work collaboratively for the benefit of our patients and the local community
- We have excellent engagement with the community, and strong relationships with Primary Care and our neighbouring hospitals
- We have a proven track record of developing cross-sector partnerships locally, regionally, nationally and internationally?
- We have consistently delivered strong operational performance, achieving dramatic improvements in infection control, and consistently achieving our statutory performance targets for cancer waits, A&E 4-hour waits and 18 week referral-to-treatment waits despite very significant increases in demand
- We have received the top rating (Band 6) in the latest CQC Intelligence Monitoring Report (published 13th March 2014), which gives assurance that external assessors rate us as a safe, effective, caring, responsive and well led organisation
- We have a very strong governance structure that supports strong clinical and corporate leadership and ensures that there is a clear line of sight from the Trust Board to each individual member of staff. Issues can quickly be escalated 'from Ward to Board' via the sub-Board framework and the structure facilitates a rapid two-way exchange of information and learning between the top and the

bottom of the organisation. The new structure has been built around the 5 CQC domains, with the addition of a 6th workforce domain as recommended by the Keogh review

- We have successfully achieved our QIPP targets for the past 3 years, identifying over £80m in savings and income generation whilst maintaining high quality patient-centred care
- We have developed our own structured leadership programme to promote strong current and future leadership, and to ensure organisational resilience
- We are one of 15 Trusts in England to be appointed to run the local National Institute for Health Research (NIHR) Clinical Research Network, which is testament to our strong ethos of research and innovation. Our partnership with other world-class organisations in the adjacent Norwich Research Park means that we have close links with one of the largest concentrations of bio scientists in Europe, which will enable us to build on our proven track record of academic and service innovation
- We are a listening and learning organisation that actively engages with service users and responds promptly to feedback. This responsiveness is reflected in our improving Friends and Family test scores across inpatient, A&E and maternity services. Which for inpatients has improved from 67 to over 80 t
- Over the last year our Friends and Family score has improved by 3.5% achieving a score higher than the national average, indicating that our staff rate us increasingly highly as a place to receive treatment.
- We have developed a strong reputation for being open and transparent in the sharing of our failures as well as our successes and have a deep corporate consciousness of our responsibility to our community.

Key Challenges

The reports of national reviews of health and social care, such as the Francis Report, the Keogh Report, the Clywd Report and the Berwick Report highlight that the needs of patients should take precedence over an over-emphasis on targets and organisational self-interest. At the same time, the NHS is facing a funding gap of over £20billion, requiring unprecedented efficiency gains at a time of significant cuts in social care funding.

We face significant financial pressures over the next 2 years and uncertainty – especially in an election year - over future health settlements. The impact of the efficiency factor, emergency marginal payment rate, tariff reductions, pay and pension increases, price inflation and other cost pressures mean that we have an annual gross CIP target of approximately £40m in 2014/15 which, after income measures are applied, gives a net cost target of £20.4m in 2014/15 with a CIP target of £21.7m in 2015/16.

At the same time, demand for healthcare is at an unprecedented level. We are one of the busiest hospitals in the country in terms of numbers of patients treated, and emergency admissions account for a particularly high proportion of our overall occupied bed days. This is due in part to our patient demographic; the ageing population in Norfolk is reflected in the size of our geriatric admission numbers, which are significantly higher than the national average. In terms of patient numbers, ours is the busiest single-site geriatric service in the entire country, which brings its own unique set of challenges. It is also notable that we have double the England average number of over 85 year olds in our population. Recent benchmarking shows the NNUH is in the top 10% for emergency admissions; with emergency admissions at the highest ever level since the introduction of the marginal rate tariff rule.

Over the past two years we have worked closely with local commissioners, community providers, EEAST, social services and the voluntary sector to develop initiatives that will reduce emergency demand by enabling greater volumes of patients to be cared for in non-acute settings (Project Domino). Levels of emergency demand, and the corresponding payment of marginal rate monies, continues to be a major

risk.

Against this backdrop of rising demand and political uncertainty, we need to maintain our focus on infection control, and to achieve our other key quality improvement goals, as set out in our 2013/14 Quality Report. These include improving stroke performance, reducing medication errors and pressure ulcers, improving discharge processes and improving compliance with the sepsis bundle and the early warning score.

Our vision over the next two years

Everything that we do will be focused on providing what our patients really need. Our three overarching strategic aims are:

- To provide first class quality services and excellent patient experience
- To establish a national reputation for excellent education, teaching and research
- To enable staff to realise their potential.

We will achieve these objectives through:

- maintaining a relentless focus on high quality, safe, efficient, patient-centred care
- ensuring that we are one of the most efficient and productive Trusts in the NHS, and that we compare favourably with the best hospitals in other parts of the world
- delivering an integrated and well-managed service for our patients and the wider community that encompasses primary, community, acute, domiciliary and social care;
- strengthening our tertiary services, and working collaboratively with neighbouring acute hospitals;
- building on the excellent reputation of the medical school, and implementing the clinical academic research strategy agreed with the University of East Anglia and our partners on the Norwich Research Park
- responding to feedback to improve the patient experience
- maintaining the range and quality of our services, whilst reducing our cost base
- achieving financial sustainability through achieving greater efficiencies within our services and within the wider local health economy
- adapting and modernising our workforce and encouraging each staff member to maximise their potential
- expanding the number of settings across which we deliver healthcare
- fostering a culture of strong clinical and corporate leadership
- promoting governance and performance monitoring frameworks that support high quality and effective care
- delivering more integrated care and more out-of-hospital care, through upstream and downstream integration
- investing in technology and capacity (including infrastructure, workforce and service) that will enable us to deliver increased volumes of activity with greater efficiency and effectiveness
- working collaboratively with stakeholders to redesign care pathways, including the delivery of care closer to home
- providing world-class teaching and research
- challenging traditional ways of working, and working transformatively to deliver high quality, safe and financially sustainable care.

The strategy set out in the body of this plan reflects a balance between the interests of patients, the local community and other key stakeholders.

THE SHORT TERM CHALLENGE

Our challenge over the next two years is to bridge a net funding gap after income measures of around £20m per year, whilst meeting all statutory and contractual performance targets, achieving our quality agenda as set out in our 2013/14 Quality Report, and delivering transformational change in respect of several of our key services, including our emergency admission areas and our prescribing system.

Our strategy, in essence, requires us to do more with less whilst delivering the highest quality of care for our patients. We must modernise our processes and our care pathways to ensure that we deliver our existing activity at a lower cost base, through harnessing productivity gains and embracing smarter working. We need to create a flexible and adaptive workforce, and inspire our teams to challenge old ways of thinking, where the limit of our ambition was to deliver care in a hospital based setting. Instead, we will seek new care settings, new business models and new relationships, which will allow us to expand our horizons and to integrate - or forge closer collaborative links - with primary, community and social care partners.

We will develop specialised services, if it makes good financial and business sense to do so. Namely, when the provision of tertiary services is consistent with our current service provision, need or capability, and where those services break even or make a profit. Exceptionally, we may wish to consider provision of loss-making services, but only when there is significant service interdependency with other core services, making the loss of the unprofitable service more strategically disadvantageous than ongoing subsidisation.

We will explore opportunities for upstream and downstream integration with primary and community care, initially through initiatives such as outreaching into patients' homes through the expansion of our Home Based Therapy service. If opportunities for further integration arise, we will assess each individually to see whether it aligns with our long term strategy, is economically beneficial and helps us to better serve the community and the needs of our patients.

We will collaborate more closely with our neighbouring acute district general hospitals across clinical networks, and integrate or host services where this will help us to improve patient care and clinical governance, achieve scale economies and safeguard the future of services. Our strategy is to support the appropriate provision of care locally consolidating specialist provision where this is supported by evidence that safer higher quality care results.

As much of the detail surrounding our transformative service delivery plans is commercially sensitive and not for publication at this stage, we have included it within the Appendix.

In the remainder of this document, we will outline our transformational, innovative high-impact initiatives, and also outline our traditional, incremental, productivity-driven CIPs. We will also explain how we will gain assurance, via our revised governance framework, that the high quality of our services is being maintained or improved as we rise to meet the affordability challenge.

QUALITY PLANS

In a healthcare environment quality improvement does not inevitably come with a higher price tag. On the contrary, if care is safe, timely, effective, appropriate, and well-planned, it can often be delivered more cheaply than care that is unsafe, delayed, ineffectual, inappropriate and poorly planned. Poor quality care can cost more in the longer term, as it can lead to longer inpatient spells, frequent readmissions, more radical (and costly) treatment than would have been required if the care was provided earlier, higher incidences of infections, falls and pressure ulcers, and so forth.

Our plan, therefore, has quality at its heart. All of the initiatives outlined in the plan – whether transformational or incremental - will benefit patients and ensure that they are treated in the most appropriate care setting, by staff that are highly skilled and passionate about delivering safe, patient-centred care, via care pathways that are streamlined, integrated, effective and well-managed.

Our quality goals

Our quality priorities for 2014/15 and 2015/16 reflect the three quality domains of patient safety, patient experience and clinical effectiveness. In setting our quality goals, we analysed data from a myriad of sources, including responses to the national annual patient and staff surveys, complaints and compliments, analysis of past incidents and real-time feedback gathered from our Trust-wide patient experience initiative.

This wealth of data gave us a clear understanding of our patients' priorities, which included being cared for in a clean, safe and comfortable environment, being treated as an individual, being involved in decisions about their care, receiving the best possible clinical outcomes and being given timely and seamless care that leads to their safe discharge from our services. Our commitment is to address these priorities through our operational and quality plans.

The quality goals that we have set for the forthcoming year with help us to address national and local commissioning priorities, such as reducing infection rates, improving patient flow and improving clinical outcomes. We will focus on the following areas:

- Reducing medication errors
- Achieving a 100% appropriate response to an elevated early warning score
- Reducing avoidable, hospital-acquired pressure ulcers
- Ensuring that all emergency admissions are reviewed by a senior clinician within 12 hours of admission
- Achieving 100% compliance with all elements of the Sepsis 6 bundle
- Improving our score in relation to the Friends and Family test;
- Improving our discharge processes
- Extending patient self-administration of medicine
- Focusing on infection prevention, including C-Difficile and surgical site infection
- Identifying the critical path for patients with complex discharge needs
- Improving the percentage of suspected stroke patients that have a CT scan within 60 minutes of arrival in hospital.

Alongside these corporate quality targets, divisional quality goals have also been developed, which are aligned to those set for the Trust as a whole. The divisional quality goals are publicised in the divisional dashboards, which include specific, measurable quality targets. Progress against the Divisional performance dashboards is monitored on a monthly basis by the Divisional Boards and via the governance Sub-Boards.

Existing quality concerns

We are required to register with the Care Quality Commission and our current registration status is unconditional. The CQC has not taken enforcement action against us during 2013/14, and we have not participated in any special reviews or investigations by the CQC during the reporting period.

The latest CQC Intelligent Monitoring Report (published 13th March 2014) gave us the highest possible

rating (Band 6) There was one area of elevated risk: HSMR at weekends, where we are outside expected range. The confidence limits for this indicator are usually set at 95% by Dr Foster but for this report they were set at 98.9% which is why we are outside expected range. Using the latest available data in the Dr Foster system (Dec 2012 – Nov 2013), our weekend HSMR has fallen to 106.12, and is now within the expected range.

Our latest CQC unannounced inspection has confirmed compliance across four outcomes with minor concerns around the outcome relating to respecting and involving patients and their carers.

The key quality risks inherent in the plan, and how these will be managed

The Trust Board receives monthly Clinical Safety and Clinical Effectiveness reports, prepared by the Medical Director, and a monthly Caring and Patient Experience Report, prepared by the Director of Nursing. These reports contain detailed information on mortality and a wealth of other patient quality, safety and patient experience information. Mortality statistics include analysis of HSMR, SHMI and crude mortality as well as information on outcomes for low-risk groups and patients undergoing surgery. New alerts identified by Dr Foster Intelligence and data from national audits are reported. Additional information relating to quality and safety priorities and CQUINs are also reviewed.

The reports also contain information on other quality metrics, including rates of infection, never events, serious incidents, medication errors, compliance with the Early Warning Score, compliance with clinical documentation standards, Friends and Family scores and feedback, and CQC and internal audit outcomes.

Risks to quality and improvement opportunities are also identified through analysis of complaints, incident reports, patient experience feedback, internal performance monitoring and external benchmarking. The data are analysed to identify underlying trends, and any resultant recommendations are incorporated into quality improvement action plans. Delivery of the action plans is then closely monitored to ensure that the desired outcomes are achieved.

Risks to quality are entered onto our Clinical Risk Register by individual Directorates, working with our Risk Management Department. Risks with a residual risk rating (after mitigation) of 10 or above are reported to the Clinical Safety sub-Board, and the major risks are reported to the Trust Board on a monthly basis as part of the Clinical Safety sub-Board Report.

Each month the Trust Board receives a presentation and has detailed discussion on an element of the quality of services. During the year this has covered all diagnoses for which there is an elevated HSMR and Infection Prevention and Control.

The Trust Board undertakes a self-assessment using the Quality Governance Framework on a quarterly basis to ensure that quality and risk arrangements are robust.

Our Assurance Framework

Given the number of new pieces of guidance and compliance frameworks arising from the Francis Report, the Keogh report, the Clywd report, the Berwick report, the CQC strategy and the new Monitor risk assessment framework, we have undertaken a wholesale review of our governance and committee structure to assess whether it provided the best fit for our assurance processes.

The review concluded that, although our existing framework was adequate, there were gaps and overlaps

in our existing corporate governance structure that would be best addressed by the implementation of a completely revised framework.

Accordingly, we developed a new framework, which built on the 5 'domains' of the new CQC strategy (safe, effective, caring, responsive and well led) and added workforce as a sixth 'domain' (as advised by the Keogh review). Each of these 'domains' is overseen by a subcommittee structure that reports to the Executive Board and the Trust Board.

At the same time as we revised the corporate governance structure, we took the opportunity to implement a wholesale revision of our Board Assurance Framework (BAF). The BAF is a key component of our risk management strategy, and acts as the central repository for our strategic objectives and corporate deliverables for the year, details the assurance process for each, identifies the risks to achievement and how those are being managed and mitigated. Each entry on the BAF is allocated to the most appropriate member of the Executive Board, who takes overall responsibility for ensuring that an action plan is put in place to address the issue, to mitigate any risks, and to provide the necessary assurance through the governance structure that the issue is being dealt with.

We reassigned each individual BAF entry to one of the 6 governance 'domains', which ensured that it would be included within the appropriate sub-Board reporting cycle. We also cross-referenced BAF entries to the CQC's Standard Key Lines of Enquiry (KLOE), which gave us a high level of assurance that each KLOE was covered by our governance framework and that any required actions would be identified and executed swiftly.

This consistency of approach across all our internal performance reporting and monitoring arrangements ensures that there is a clear line of sight from the Trust Board to each individual member of staff. Issues can quickly be escalated 'from Ward to Board' via the sub-Board framework and the structure facilitates a rapid two-way exchange of information and learning between the top and the bottom of the organisation.

We introduced standard Agenda and Minutes templates for use at all Directorate Governance (DG) meetings, which will ensure that items relevant to each of the 6 governance 'domains' are included on the agenda of each DG meeting, and issues arising will be escalated where appropriate to the Divisional Board and thence, if necessary, to the relevant Executive Sub-Board.

To allow us the opportunity to refine the structure the revised structure was implemented on 1/1/2014, and we have tied in all corporate performance management and reporting to this structure, including Board reporting. The new BAF will be fully operational from April 2014.

To provide further assurance, the value of our Quality Assurance Audit programme has been recognised nationally in the prestigious Health Service Journal awards for 2013, where we were one of the finalists in the Acute Sector Innovation category. Although we did not win the overall award, the judges commended our audit programme and described it as 'an energising and engaging initiative'.

The audit programme, which we believe is the only one of its type in the country, ensures that between 1 and 3 inpatient or out-patient areas are audited every weekday; most areas are audited approximately every 4-6 weeks. The audit teams consist of senior nursing staff and volunteer external auditors, who represent a host of organisations, including Norfolk Social Services; Families House; St John's Ambulance; NHS Norfolk; Gender Identity Services; GPs; Learning Difficulties Partnership; UEA; NHS Retirement Fellowship; MND society; The Norwich Older People's Strategic Partnership Forum; Norwich MIND; The Older People's Partnership; LINKs; Age UK; Deaf UK; Crossroads Care; The Alzheimer's Society and Trust Governors. The outcomes are discussed in real time with the ward staff, and are

reported directly to the Trust Board.

Our Audit Committee ensures that, as an organisation, we maintain an effective system of governance and internal control across all of our activities. The Committee also provides assurance that effective arrangements are in place for the purpose of monitoring and continually improving the quality of our care. As part of our formal 2013/14 Internal Audit programme, we participated in 38 national clinical audits and 4 national confidential enquiries. We reviewed the reports of 18 national and 83 local clinical audits, and identified and implemented several key quality improvement recommendations. Compliance with the recommendations will be monitored closely by the Clinical Safety sub-Board and the Caring and Patient Experience sub-Board.

Data assurance for clinical quality data is provided by a programme of internal audit and documentation of processes, which is reported to our monthly Process Assurance Governance Group, chaired by the Data Quality Manager and, in turn, to our Audit Committee.

The Medical Director chairs the monthly meeting of the Clinical Safety Sub-Board, and the Director of Nursing chairs the monthly meeting of the Caring and Patient Experience Sub-Board. Following these meetings, they each produce a report which (alongside the reports of the other sub-Boards) is a standing agenda item at each Trust Board meeting. The reports are also sent to our Governors, are available to every member of staff, and are published monthly on our website. The reports contain key monthly data on the areas covered in our Quality Report, as well as additional indicators of quality and a commentary on the main elements.

What the quality plans mean for our workforce

Internally, we have developed a number of personal development, mentoring and coaching programs for our clinical and non-clinical staff that will make them more resilient and adaptive during what promises to be a period of unprecedented change and scrutiny.

We recognise that our future success and sustainability is dependent on the strength of our staff, who will need to be change champions, receptive to new ways of working and able to inspire and support the challenges that lie ahead. We have developed an innovative leadership program which will identify and develop the individuals who will lead the hospital in the future. This programme was expanded in 2013 to include a clinical leadership programme.

Our workforce strategy ensures that, in addition to promoting resiliency among our staff and supporting them to develop the skills and aptitudes that will enable them to maximise their potential, we will also develop and implement strategies and programmes of work that enable efficiency improvement and cost reduction.

One of the major areas of focus during the next two years will be the development of new systems to support more flexible ways of working, including greater use of extended days and seven day services. We recognise that change of this nature may meet with some resistance, but we will actively engage with staff to convince them of the benefits, not only in terms of enhanced quality of care for our patients, but also in enabling us to meet forecast capacity challenges and the rising demand for unplanned care . This work must be undertaken alongside exploring the potential to increase capacity within normal working hours through reviewing job plans and focusing on team-based job planning, with clear activity targets. As we look to do more activity within existing workforce resources, we must also ensure there is fairness across the organisation and transparency around arrangements for additional activity.

The workforce work stream will also develop plans that will enable us to create a workforce that can operate more flexibly, scaling up to meet peaks in activity or scaling down during periods of lower demand. This flexibility will be an important safeguard against unforeseen and unplanned variations in predicted activity, whether that arises in the form of short term peaks and troughs in demand, or longer term emerging demand trends that do not fully align with the activity plans outlined in this document.

Some of this flexibility will be delivered through a greater use of short term and flexible contracts, through improved use of skill mix and team work schedules, and through ensuring that staff have the skills that will enable them to move between acute and outreach/community settings, and across specialities within the hospital if required.

Our response to Francis, Berwick and Keogh

The Department of Health team responsible for the production of the government response to the Francis inquiry visited on 20th January. We shared the new governance structure, patient experience programme and quality assurance audit work with them and the meeting was attended by three governors and three members of the public involved in auditing our services for us. The feedback from the Francis team was very positive Gavin Larner Director of Quality at the Department of Health wrote following the visit:

'*I was struck by the culture from "board to ward" of openness and searching for improvement, trying to see things from the receiving end, and finding practical ways of addressing them, which is, in a way, the opposite of the old Mid Staffs culture at the time of their troubles. I should also add that two of your matrons, unprompted, said how much they loved their jobs and loved working at the Trust – really great to hear.'*

OPERATIONAL REQUIREMENTS AND CAPACITY

The assumption built into the plan is that our relentless focus on improving patient flow and discharge processes will reduce length of stay and bed occupancy during the period of the plan. Two of our key quality priorities for the forthcoming year – identifying the critical path for patients with complex discharge needs, and improving discharge processes - will focus attention and effort directly on this issue, and we are confident that improvements in this area are deliverable.

The plan assumes that additional activity of £4.41m will be delivered in 2014/of which £1.97m will be inpatient activity. Further detail on our activity assumptions is included within the Appendix.

In order to accommodate the additional activity, a project team will focus on delivering further improvements in patient flow through pathway redesign that will help to minimise delayed discharges and reduce length of stay. Additional capacity will also be created when the undergraduate and post graduate teaching activities relocate from their current premises in the main hospital building to the newly built Medical School building. This move is planned to take place in September 2014. In the longer term – i.e. outside the timeframe of this plan – with capital investment this will enable us to create an additional ward in the main hospital that will enable us to meet our longer term strategic activity plans. In the shorter term, office space will be converted to create bathrooms and a 'discharge' lounge that can accommodate lower risk 'step down' patients early on their day of discharge. This in turn will free up beds on the main inpatient wards earlier in the day and improve patient flow.

Operating theatre capacity will be optimised through continuation of the Theatre Productivity scheme, which will maintain its focus on reducing theatre under-utilisation and making greater use of non-training lists, both of which will create capacity to deliver additional elective work. We will also ensure that as

much work as possible is performed in an outpatient / day case setting.

Workforce Priorities

Our workforce strategy is develop the workforce to support the delivery of our strategic objectives whilst promoting an environment which enables to attract, recruit and retain the highest calibre of staff. This is aligned to the available financial resources and configured to deliver the known activity levels.

The plan assumes an increase in activity and cost savings. These will impact the workforce profile, headcount and working patterns.

The main actions necessary to achieve both the savings and service output are:

- Management of bank and agency / vacancies / sickness and other absence;
- Review of skill mix and clinic, theatre and ward establishments in line with other productivity metrics and variation identified within the patient level costing system;
- Review of working hours and flexibility to support extended days and weekend working – much of this has been facilitated through revisions to contracts of employment and agreements reached with staff groups.
- Significant workforce redesign working closely with Health Education England to learn from best practice internationally and to develop ways of reducing the up-front investment in training and professional silos which can be impediments to progress.

The next steps in the drive to reduce medical locum/agency usage will be to:

- review current job plans;
- improve medical rostering;
- determine whether it makes financial sense to introduce additional posts.

The continued focus on reducing time lost to sickness absence etc. will also allow us to cut expenditure on bank and excess hours' usage.

Our workforce plans are aligned with recruitment, training, retention and development plans in order to ensure that, where possible, any required reductions are achieved through natural wastage. This ensures that key skills are retained, and minimises the requirement for redundancy payments.

The voluntary severance scheme (VSS) has been repeated at the end of 2013/14 and will be repeated in 2014/15. Should the savings schemes take longer to implement than expected, VSS can be used to mitigate the shortfall, again with an emphasis on ensuring that key skills are retained.

The QIPP savings schemes have all been reviewed by the Medical Director and the Director of Nursing to assess the likelihood of any adverse quality and safety impacts, and the final schemes have received approval following their review. The schemes have also been submitted to our main commissioners in line with contractual requirements. No changes to schemes have been required.

KEY RISKS TO THE DELIVERY OF THE PLAN

The delivery of the planned savings target of approximately £20m in each of the two years covered by this plan is the most significant risk to achieving the financial strategy. This equates to 4.2% of 2013/14

outturn expenditure.

Other risks include:

- Maintaining high quality services for as the financial constraints increase
- Failure to deliver the national and local performance targets, in particular infection control targets, cancer targets, 18 weeks and A&E and Ambulance handover times
- Imposition of penalty payments associated with failure to achieve the above national and local performance targets
- Continued rise in non-elective demand, paid at 30% marginal tariff further impacting financial viability
- Failure to achieve the required productivity and clinical service improvements
- Reduced elective demand, arising from the success of commissioner demand management initiatives, which will impact on our income assumptions
- Higher than planned inflation
  Non achievement of CQUIN targets, resulting in loss of income.

Mitigations include:

- Close operational control over expenditure
- Monthly operating and financial reviews to ensure that accountability for performance within budget is maintained and doesn't drift.

We have an excellent track record of delivering against our financial plans and generating surpluses, and we also have well- embedded financial systems which highlight variances and allow prompt corrective action to be taken should the above risks materialise. We have also built contingency into the financial plans.

PRODUCTIVITY, EFFICIENCY AND CIPS

Our QIPP schemes for the period covered by this plan have been developed with significant clinical involvement. Progress on each of the schemes is tracked through a formal project structure and the project teams present regularly to the Executive Board. We have increased the level of clinical leadership, involvement and oversight for all the schemes, as this gives an added degree of assurance that our plans are clinically safe and deliverable. All the schemes are designed to maintain or improve the quality of services, whilst delivering quantifiable productivity gains.

Incremental and efficiency driven CIPs

We have successfully delivered our identified savings requirement each year to date, despite the requirement for the past four years being significant, with amounts ranging from £30.1m to £28.1m for the last financial year. Whilst not every individual scheme has delivered the planned amount in the way initially envisaged, we have been successful overall.

This successful formula for delivering financial savings will continue throughout the period covered by this plan. The savings will be delivered through a combination of income generation and very tight financial control. The additional income will be generated, as in the past, by improving our productivity, which will allow us to deliver the additional activity at very low marginal rates. The tight budgetary control includes the elimination of all non-essential non-pay spend, improved procurement, robust vacancy management and the use of skill mix initiatives to manage pay costs.

Monthly meetings are held with each team responsible for the delivery of the savings programme, which ensures that progress is regularly tracked and the key milestones and quality assurances are regularly reviewed. The meetings are chaired by the Director of Resources and actions are agreed at each meeting. Teams are offered coaching and independent support to validate and challenge their assumptions and to encourage them to think innovatively and creatively about how best to progress their project.

The savings programme is managed as QIPP projects, with quality measures being given equal weight with the financial initiatives. The project teams have wide representation, including clinicians, nurses, finance staff and operational management, which encourages healthy challenge. In addition, each project presents its progress to the Executive Board throughout the year.

The savings schemes are wide ranging and focus predominantly on productivity and service improvement, although they do also include non-operational projects, such as the procurement CIP. The schemes build on those implemented during previous reporting periods, and as such they are incremental and iterative, with challenges and opportunities that are already well understood. This mitigates risk to the overall scheme, and provides a high level of assurance that the individual projects are fully deliverable.

The key 'traditional' schemes are set out in the Appendix.

The delivery of the savings programme has been profiled consistent with the plans provided by each project team. Most schemes are designed to deliver from the beginning of the financial year.

Risk ratings will be updated as the monthly assurance meetings progress. A contingency of £3.5m has been included in the financial plan to mitigate the risk of partial achievement.

Minimal IT or third party type investment is required to support the schemes, and we have identified that the key enabler for all of the projects is operational and clinical engagement. Accordingly, clinical representation is required for each scheme, and engagement is harnessed through the monthly meetings and through the programme of presentations on each scheme to the Executive Board.

Transformational CIPs

Our transformation plans are commercially sensitive, and are therefore outlined in the Appendix.