Peterborough and Stamford Hospitals
NHS Foundation Trust

Operational Plan Document for 2014-16

Peterborough and Stamford Hospitals NHS Foundation Trust

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Operational Plan for y/e 31 March 2015 and 2016

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

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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)	**Rob Hughes**

Signature 

Approved on behalf of the Board of Directors by:

Name (Chief Executive)	**Peter Reading**

Signature 

Approved on behalf of the Board of Directors by:

Name (Finance Director)	**Caroline Walker**

Signature 

Executive Summary

Peterborough and Stamford Hospital NHS Foundation Trust (PASHNFT) is a busy District General Hospital serving the needs of the growing population in Peterborough, South Lincolnshire and neighbouring areas from its sites in Peterborough and Stamford.

Our catchment area is demographically diverse with a relatively young and deprived population in Peterborough, and a much older population with low levels of deprivation in Lincolnshire and Rutland. Our catchment population is forecast to grow faster than the national average, particularly in Peterborough, South Holland and Fenland. The number of people in the over 85 category in Rutland and Fenland is forecast to grow much faster than the national average over the next five years.

This growth in population is reflected in demand for our services. Hospitals lack the capacity to continue absorbing this demand and commissioners cannot continue to meet the associated rise in costs. Commissioners and providers have worked together to develop alternatives to acute care. We play a key role in working together with communuity services to deliver improvements for the people we serve whilst reducing the time they spend avoidably in hospital.

Our local planning unit, comprising health and social care commissioners and providers in Cambridgeshire and Peterborough and South Lincolnshire, has identified areas to reduce hospital admissions. This includes reducing admissions for coronary heart disease, urinary tract infection, lobar pneumonia, gastroenteritis, acute upper respiratory tract infection, cellulitis and acute tonsillitis. They also want to support a higher proportion of older people in living independently at home following discharge from hospital.

The planning unit want to ensure that when people are admitted to hospital, they are discharged in a timely way. They also want to reduce deaths involving venous thromboembolism (VTE), medication errors causing severe harm or death, and harm to children due to inadequate monitoring.

Our Trust is known for providing safe services and good patient experience. More people are choosing to come here, particularly from South Lincolnshire. We will build on our reputation for quality and positive patient experience, supported by excellent facilities. We have a high proportion of single inpatient rooms in one of the most modern hospitals in the NHS. With planned investment in the Stamford hospital site and new radiotherapy equipment in Peterborough, we anticipate more patients will choose our Trust for their care.

Our staff are key to delivering 'Right care; first time; every time.' We have been too reliant on agency and locum staff and will place sustained effort in 2014/15 on reducing the number of vacancies so that we have more of the committed professionals who understand and live our values.

The Trust is also known for facing significant financial challenges, and we will continue to make improvements in efficiency where this benefits patients. We will deliver a challenging Cost Improvement Programme of 5% for each of the coming two years, to help deliver a forecast £45.0m deficit for 2014/15 reducing to £42.3m deficit the following year. The 2014/15 deficit will be higher than previous years due to the costs of the Project Orange market test, and loss of income associated with the closure of the Ministry of Defence Hospital Unit (MDHU) in Summer 2014.

Our significant capacity constraints are in cardiology, neurology, gastroenterology and stroke, as well as some surgical specialties including orthopaedics, ophthalmology, oral and maxillo facial and breast services. We plan to improve capacity both through additional resource and improved efficiency, but are placing significant reliance on commissioners reducing demand for emergency activity to deliver planned activity. Therein lies the significant risk we face.

We have agreed the following seven objectives for 2014/15 to 2015/16.

Trust Objectives	Measure	Due date
1.Be in the top quartile safest district general hospitals in England	DGH mortality rates (HSMR and SHMI) in England in top quartile	Mar 2016
	Top quartile DGH hospital score for patients receiving harm free inpatient care (Patient Safety Thermometer)	Mar 2016
	Achieve 90% CQUIN targets	Mar 2015
	Seven day working:	
	•Baseline assessment and implementation plan	Mar 2015
	•Seven day radiology reporting	Mar 2016
	•Urgent care consultant presence 0900-1700 seven days per week	Mar 2016
2.Be in the top 20% of Trusts for patient care and experience	Trust Friends and Family Test average annual scores in the top 20% of all Trusts for combined ED, inpatient and maternity surveys	Mar 2015
	No final response to a complaint takes more than 30 days without complainant agreement	Apr 2015
	Top 20% scores in national patient surveys for:	
	•Inpatient (six areas)	Mar 2016
	•Outpatient (eight areas)	Mar 2016
	•Maternity (three areas)	Mar 2016
3.Be an effective Trust and meet performance standards	Achieve ED 4 hour standard every quarter for 2014/15	Mar 2015
	Each speciality achieves national 18 week wait standard for admitted and non-admitted patients each month for 2014/15	Mar 2015
	Achieve Monitor national Cancer Waiting Times every quarter in particular:	
	•62 day cancer standards	Mar 2015
	•Cancer patients not treated within 62 days because of non-patient choice diagnostic delay:	
	-Less than 25%	Mar 2015
	-Less than 10%	Mar 2016
	80% of stroke care provided in dedicated stroke facilities for 90% of their care	Mar 2015
4.Have a productive workforce equipped, skilled and motivated to provide the highest quality care	Staff engagement score of 4 in the national staff survey	Dec 2014
	Vacancy rate a maximum of 10% for nursing and 5% non-nursing	Oct 2014
	Reduce locum and agency spend:	
	•25% of 2013/14 outturn	Mar 2015
	•50% of 2013/14 outturn	Mar 2016
	Questions related to Trust values (Caring Creative Community) included in:	
	•80% of all recruitment interviews	Mar 2015
	•100% of all recruitment interviews	Mar 2016
	Staff appraisal rate of 90%	Mar 2015
	Staff 12 month sickness rate of 3%	Mar 2015
	90% staff attend mandatory training in the previous 13 months	Mar 2015
5.Ensure that the Trust is well run and well led	Audit of Board governance and Membership reports substantial assurance	Mar 2015
	'Have your say' internal staff survey, for each question:	
	•Score 80%	Mar 2015
	•Score 85%	Mar 2016
	Agreed complement of senior staff in post	Jun 2014
	Revised integrated performance scorecards from ward to board level	Jun 2014
	Audit of directorate and corporate team governance and performance management:	
	•Baseline audit	Mar 2015
	•Audit report assurance improves by one level for all directorates and teams	Mar 2016
	35 clinical services strategies completed	Mar 2016
6.Deliver our financial targets	Deliver income and expenditure plan	Mar 2015
	Deliver the capital programme	Mar 2015
	Deliver £16m CIP programme	Mar 2015
	Develop improved access and efficiency through IM and T:	
	•Electronic document management	Mar 2015
	•Maternity system replacement	Dec 2014
	•Clinical notes and eForms	Oct 2015
	•PACS reprocurement	Jul 2015
7.Achieve all round 'sustainability' for PCH and Stamford Hospital	Competitive tender process delivered to plan	Jun 2015
	Work with the health and social care economy to develop a joint five year strategic plan	
	Stamford hospital major redevelopment	2015/16
	Business development plan to deliver a £2m recurrent annual contribution:	Mar 2016
	•Radiotherapy	Jun 2015
	•Pathology	Mar 2015
	•Renal dialysis	Mar 2015
	Develop our academic potential in medical and non-medical education, and research and education	Mar 2015

1 The short term challenge

Peterborough and Stamford Hospitals NHS Foundation Trust is an acute services provider with two sites at Peterborough and Stamford and a total of 612 beds. Our vision is 'Delivering excellence in patient centred care in the most efficient way in hospitals where it is great to work.'

Our strategy is in three parts:

- Doing the very best inside the hospitals (quality and clinical performance; organizational development)
- Getting value for money from the hospitals (productivity and efficiency; maximizing the value of the Trust's estate)
- Making the most of the hospitals (relationship management; business development).

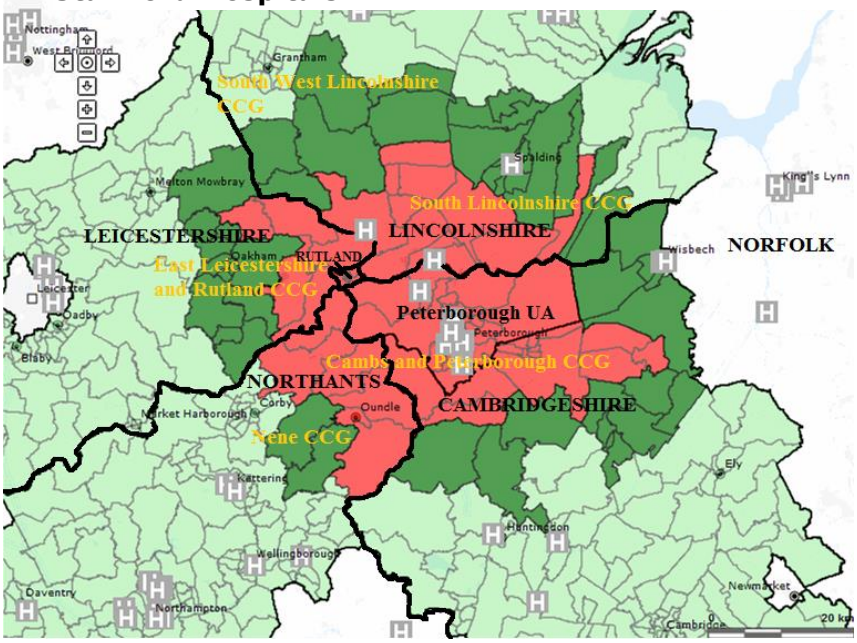
We provide services from the new Peterborough City Hospital which is a Private Finance Initiative (PFI) scheme, and at Stamford Hospital. We have a full range of District General Hospital (DGH) services and some regional specialties for a catchment areas of just over 500,000 people living in Peterborough, North and East Cambridgeshire, South Lincolnshire, and East Leicestershire and Rutland (see Figure 1). The Trust's main clinical commissioning groups (CCG) are Cambridgeshire and Peterborough CCG, South Lincolnshire CCG, and East Leicestershire and Rutland CCG.

Figure 1 – Population and income from core areas served by Peterborough and Stamford Hospitals

2012 populations served by PSH	Cambridgeshire and Peterborough CCG	South Lincolnshire CCG	East Leicestershire and Rutland CCG	Total
Core area	257,713	66,375	13,523	337,611
Wider area	58,562	75,719	25,035	170,064
Income 2012-13/£m	£116	£47	£5.3	

Figure 2 shows the core and wider areas served by the Trust, developed from the percentage of admitted patients in the past three years.

Figure 2 - Core and wider areas served by Peterborough and Stamford Hospitals



Core market – electoral ward of residence where >40% patients admitted to PSH

Wider market – electoral ward of residence where 5-40% patients admitted to PSH

1.1 Demographic profile

The population we serve has a varied demographic profile. Peterborough is predominantly urban with 26% of the population living in the most deprived areas in the country. Parts of South Kesteven have the least deprived areas.

Peterborough

People living in Peterborough are generally in poorer health than the average English population (Figure 3). Deprivation is higher than average and about 9,500 children live in poverty. Life expectancy for men is lower than average. Life expectancy is 9.4 years lower for men and 5.6 years lower for women in the most deprived areas of Peterborough than in the least deprived areas.

Figure 3 - Peterborough health profile

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

England Worst — England Average — England Best; 25th Percentile; 75th Percentile

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	62988	34.1	20.3	83.7		0.0
	2 Proportion of children in poverty	9470	23.5	21.1	45.9		6.2
	3 Statutory homelessness	267	3.7	2.3	9.7		0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths)	1097	49.3	59.0	31.9		81.0
	5 Violent crime	3403	19.6	13.6	32.7		4.2
	6 Long term unemployment	1398	11.6	9.5	31.3		1.2
Children's and young people's health	7 Smoking in pregnancy ‡	476	16.8	13.3	30.0		2.9
	8 Starting breast feeding ‡	2109	74.5	74.8	41.8		96.0
	9 Obese Children (Year 6) ‡	391	19.2	19.2	28.5		10.3
	10 Alcohol-specific hospital stays (under 18)	14	35.5	61.8	154.9		12.5
	11 Teenage pregnancy (under 18) ‡	153	44.5	34.0	58.5		11.7
Adults' health and lifestyle	12 Adults smoking	n/a	23.7	20.0	29.4		8.2
	13 Increasing and higher risk drinking	n/a	21.0	22.3	25.1		15.7
	14 Healthy eating adults	n/a	28.0	28.7	19.3		47.8
	15 Physically active adults	n/a	56.6	56.0	43.8		68.5
	16 Obese adults ‡	n/a	24.9	24.2	30.7		13.9
Disease and poor health	17 Incidence of malignant melanoma	26	16.2	14.5	28.8		3.2
	18 Hospital stays for self-harm	551	297.4	207.9	542.4		51.2
	19 Hospital stays for alcohol related harm ‡	4310	2302	1895	3276		910
	20 Drug misuse	1445	12.0	8.6	26.3		0.8
	21 People diagnosed with diabetes	8413	5.9	5.8	8.4		3.4
	22 New cases of tuberculosis	45	25.9	15.4	137.0		0.0
	23 Acute sexually transmitted infections	1463	793	804	3210		162
	24 Hip fracture in 65s and over	180	538	457	621		327
Life expectancy and causes of death	25 Excess winter deaths ‡	98	22.3	19.1	35.3		-0.4
	26 Life expectancy – male	n/a	77.7	78.9	73.8		83.0
	27 Life expectancy – female	n/a	82.6	82.9	79.3		86.4
	28 Infant deaths	13	4.3	4.3	8.0		1.1
	29 Smoking related deaths	238	208	201	356		122
	30 Early deaths: heart disease and stroke	133	77.7	60.9	113.3		29.2
	31 Early deaths: cancer	179	106.1	108.1	153.2		77.7
	32 Road injuries and deaths	90	49.3	41.9	125.1		13.1

‡ For comparison with PHOF Indicators, please go to the following link: www.healthprofiles.info/PHOF

Over the last 10 years, all-cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen, but is still worse than average.

In school Year 6, 19.2% of children are classified as obese. Levels of teenage pregnancy, GCSE attainment and smoking in pregnancy are worse than average. The estimated level of adult smoking is worse than average as are rates of road injuries and deaths and hospital stays for alcohol related harm.

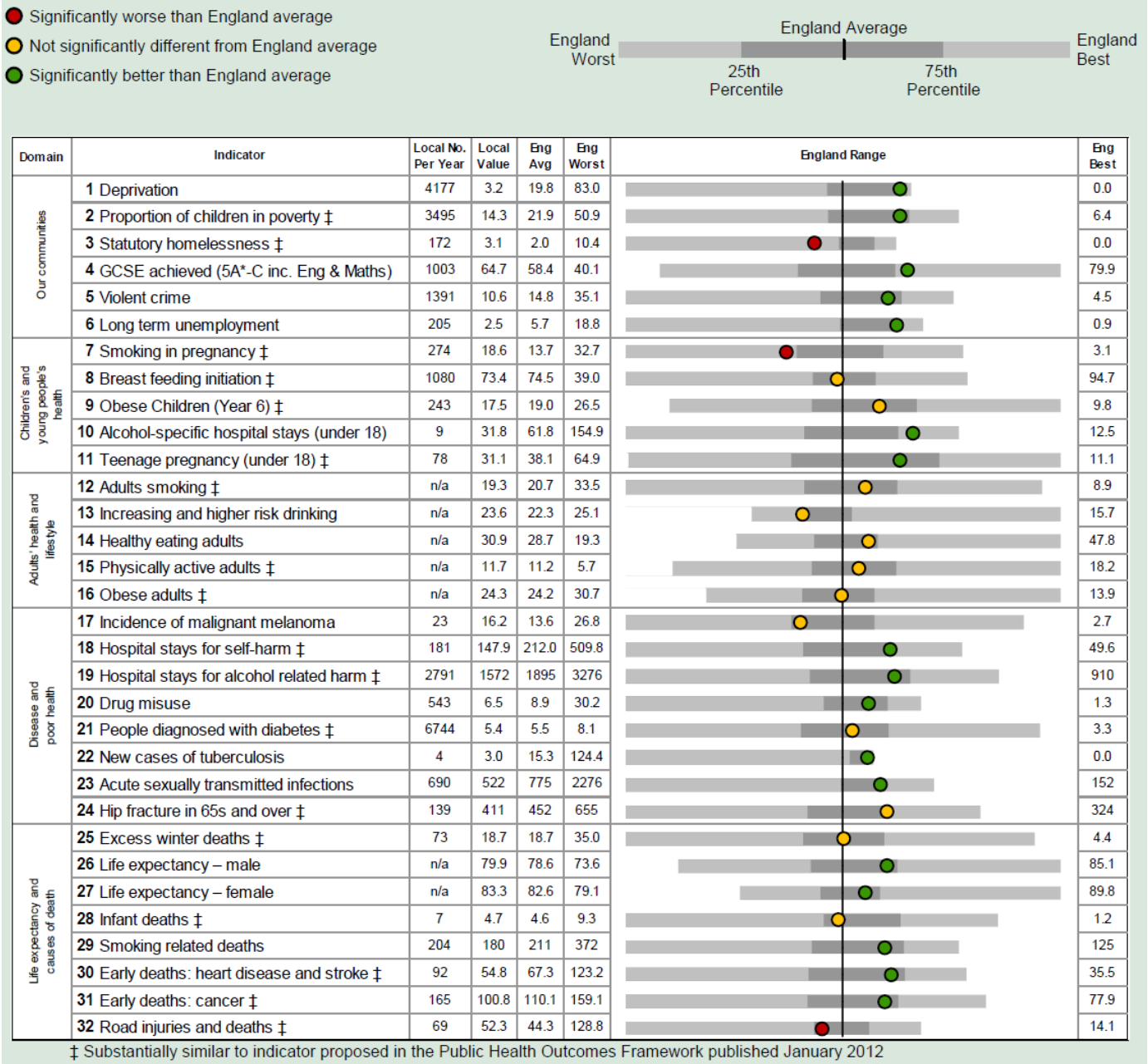
The level of alcohol-specific hospital stays among those under 18 is better than average.

Priorities in Peterborough include reducing premature mortality, reducing inequalities in coronary heart disease and promoting healthy lifestyles.

South Kesteven

The health of people in South Kesteven is generally better than the English average (Figure 4). Deprivation is lower than average, however about 3,500 children live in poverty. Life expectancy for both men and women is higher than average.

Figure 4 - South Kesteven health profile



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	4177	3.2	19.8	83.0		0.0
	2 Proportion of children in poverty ‡	3495	14.3	21.9	50.9		6.4
	3 Statutory homelessness ‡	172	3.1	2.0	10.4		0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths)	1003	64.7	58.4	40.1		79.9
	5 Violent crime	1391	10.6	14.8	35.1		4.5
	6 Long term unemployment	205	2.5	5.7	18.8		0.9
Children's and young people's health	7 Smoking in pregnancy ‡	274	18.6	13.7	32.7		3.1
	8 Breast feeding initiation ‡	1080	73.4	74.5	39.0		94.7
	9 Obese Children (Year 6) ‡	243	17.5	19.0	26.5		9.8
	10 Alcohol-specific hospital stays (under 18)	9	31.8	61.8	154.9		12.5
	11 Teenage pregnancy (under 18) ‡	78	31.1	38.1	64.9		11.1
Adults' health and lifestyle	12 Adults smoking ‡	n/a	19.3	20.7	33.5		8.9
	13 Increasing and higher risk drinking	n/a	23.6	22.3	25.1		15.7
	14 Healthy eating adults	n/a	30.9	28.7	19.3		47.8
	15 Physically active adults ‡	n/a	11.7	11.2	5.7		18.2
	16 Obese adults ‡	n/a	24.3	24.2	30.7		13.9
Disease and poor health	17 Incidence of malignant melanoma	23	16.2	13.6	26.8		2.7
	18 Hospital stays for self-harm ‡	181	147.9	212.0	509.8		49.6
	19 Hospital stays for alcohol related harm ‡	2791	1572	1895	3276		910
	20 Drug misuse	543	6.5	8.9	30.2		1.3
	21 People diagnosed with diabetes ‡	6744	5.4	5.5	8.1		3.3
	22 New cases of tuberculosis	4	3.0	15.3	124.4		0.0
	23 Acute sexually transmitted infections	690	522	775	2276		152
	24 Hip fracture in 65s and over ‡	139	411	452	655		324
Life expectancy and causes of death	25 Excess winter deaths ‡	73	18.7	18.7	35.0		4.4
	26 Life expectancy – male	n/a	79.9	78.6	73.6		85.1
	27 Life expectancy – female	n/a	83.3	82.6	79.1		89.8
	28 Infant deaths ‡	7	4.7	4.6	9.3		1.2
	29 Smoking related deaths	204	180	211	372		125
	30 Early deaths: heart disease and stroke ‡	92	54.8	67.3	123.2		35.5
	31 Early deaths: cancer ‡	165	100.8	110.1	159.1		77.9
	32 Road injuries and deaths ‡	69	52.3	44.3	128.8		14.1

‡ Substantially similar to indicator proposed in the Public Health Outcomes Framework published January 2012

Life expectancy is 8.6 years lower for men and 5.0 years lower for women in the most deprived areas of South Kesteven than in the least deprived areas.

Over the last 10 years, all cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen and is better than average.

About 17.5% of Year 6 children are classified as obese. The level of smoking in pregnancy is worse than average and alcohol-specific hospital stays is better (lower) than average. Levels of teenage

pregnancy, GCSE attainment and alcohol-specific hospital stays among those under 18 are better than average.

An estimated 19.3% of adults smoke and 24.3% are obese. The rate of road injuries and deaths is worse than average. Rates of sexually transmitted infections, smoking related deaths and hospital stays for alcohol related harm are better than average. The rate of statutory homelessness is higher than average.

Priorities in South Kesteven include tackling alcohol and tobacco abuse, and obesity.

1.2 Population

Office for National Statistics data for the Trust catchment population shows that it has grown at a rate higher than the national average and will continue do so for at least the next five years. Total population growth between 2002 and 2012 was 12.5%, increasing from 453k to 510k. This is 6% higher than the rest of England which grew by 7.5%. The populations of Peterborough, South Kesteven and South Holland have grown faster than average due to housebuilding and inward migration.

The population is projected to grow at 5.7% over the next five years (Table 1), 0.6% above the national average of 5.1%; the fastest growth in our catchment area will be in Peterborough (6.9%).

Table 1 - Population projections 2014 to 2019

	Whole population/ '000s			Population forecast over 85/'000s		
Area	2014	2019	% change	2014	2019	% change
England	53,493	56,198	**5.1%**	1,221	1,506	**23.3%**
East of England	6,003	6,295	**4.9%**	161	192	**18.7%**
PSH Trust area	869	919	**5.7%**	22.3	26.7	**19.7%**
-Peterborough	186	199	**6.9%**	3.4	3.9	**14.7%**
-Fenland	100	106	**6.7%**	3.0	3.7	**23.3%**
-Hunts	173	180	**4.0%**	3.9	4.7	**20.5%**
-E Northants	89	93	**5.3%**	2.3	2.7	**17.4%**
-S Holland	93	100	**7.5%**	3.0	3.6	**20.0%**
-S Kesteven	139	147	**5.5%**	4.0	4.7	**17.5%**
-Rutland	38	40	**4.9%**	1.3	1.7	**30.8%**
-Melton	51	53	**3.7%**	1.4	1.7	**21.4%**

Growth in the number of people aged over 85 years, is projected to grow at less than the national average, but at a higher rate than the general population. The Office for National Statistics[1] predicts

[1] Office for National Statistics 2010 based subnational population predictions, quinary age groups, persons (accessed Feb 2014)

that the number of people aged over 85 in our area will grow by 19.7% over the period 2014 to 2019, compared with 18.7% for the East of England, and 23.3% for England. However, growth in this age group will be much higher in two areas in our catchment; forecast growth in Rutland is 30.8%, and Fenland is 23.3%.

This growth and ageing of the population will bring significant pressures on local health services as people require increasing levels of care and support.

1.3 Local health economy

Cambridgeshire and Peterborough CCG (CPCCG), our main local commissioner, has amongst the lowest per capita financial allocation in the country, 4.1% lower than the average or £35m. The provider landscape is complex and financially-challenged, including our Trust which is under a Monitor enforcement notice due to a recurrent £40 million deficit. The wider financial position has resulted in CPCCG being in financial recovery for 2013/14 with a forecast year end outturn of between £4m to £6m deficit.

Resource allocations to CCG's announced in December uplifted the historical allocation by 2.9% in 2014/15 and by 2.45% in 2015/16, against an average of 2.5% for all CCG's. The higher uplift in allocation, the highest in East Anglia, goes part way to address the distance from target.

1.4 Better CareFund (BCF)

The government decision to move a total £3.2bn of health funding to social care in 2015/16 will transfer £74m of funding from our main commissioners to support greater integration of health and social care and reduce demand for health services. Reduction in funding will be allocated proportionately across all providers, but we expect this to impact on our income from 2015/16. Table 2 shows the highest transfer of funding will be from our main commissioner, Cambridgeshire and Peterborough CCG (£47m), although the details of the impact on our Trust have not yet been agreed.

Table 2 - Better Care Fund allocation to transfer from NHS to social care budgets 2015/16

	Cambs and Pet CCG	South Lincs CCG	E Leics & Rut CCG	**Total**
Better Care Fund allocation 2015/16	47,034	9,810	17,232	74,076

This poses a significant challenge and requires the local health economy partners to work together to better serve the local population without defaulting to hospital care. The Trust has worked with partners in the Local Health Economy to develop proposed schemes for the BCF and a wider five year strategy.

1.5 The planning process

Given the scale of the challenge facing the Trust and the wider health economy, it is essential that all health (commissioners and providers) and social care partners work together to develop locally owned and agreed plans. Monitor and NHS England require local health economies to work toegther in planning units across England. The Cambridgeshire and Peterborough planning unit has facilitated mutual working between commissioners and providers, and shared assumptions. The Cambridgeshire and Peterborough CCG agreed the following vision for the delivery of future services:

> "As a health and social care system in Cambridgeshire and Peterborough, we will operate in an integrated way, putting patients' best interests at the heart of all decision-making to achieve the best care outcomes for patients, their carers and the population. By working together in an open and transparent way, we, as commissioners and providers of care, aim to maximise the wellbeing of the population and provide the safest, highest quality care outcomes for patients in our system. We aspire to commission and provide the safest, highest quality care and best patient experience within the resources available. We will seek to maximise the amount of care provided outside hospital as close to the patient's home as possible."
>
> *Cambridgeshire and Peterborough Outline Strategic 5 Year Plan 2014/15 to 2018/19 (Feb 2014)*

Commissioner priorities to address these issues are:

1. Securing additional years of life for our local population with treatable conditions as measured by potential years of life lost (PYLL) from causes amenable to healthcare with a focus on cornonary heart disease and other areas yet to be identified.
2. Improving the health related quality of life of people with one or more long-term condition by measuring patient reported outcomes of treatment using EQ 5D scores in the GP survey, and using the results to identify key areas for improvement.
3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital by reducing admissions for:
    - Urinary tract infection
    - Lobar pneumonia
    - Gastroenteritis
    - Acute upper respiratory tract infection
    - Cellulitis
    - Acute tonsillitis
4. Increasing the proportion of older people living independently at home following discharge from hospital by:
    - Expanding teams to provide 7 day discharge planning and discharge
    - Developing a 'return home' package with voluntary sector to aid speedy discharge and post hospital discharge support
    - Establishing a joint team to oversee integration activity e.g. joint assessments, joined up packages of care
    - Move to 7 day working for The Firm[2] and multi-disciplinary teams and build on existing intermediate care capacity and support
    - Improving psychiatric liaison support and mental health presence in MDTs
    - Developing the potential of telehealth and telecare as well as assistive technologies
    - Enhancing dementia care support for patients and provide better support for carers
5. Increasing the number of people having a positive experience of hospital care through timely discharge.
6. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care. This will be achieved through reducing deaths involving venous thromboembolism (VTE), reducing the incidence of medication errors causing severe harm or death, and reducing the incidence of harm to children due to failure to monitor.

The local planning unit anticipates a 15% reduction in emergency hospital admissions, although it is not clear over what timeframe. Given the experience of recent years, it is far from clear whether schemes are able to deliver, and there is a high level of risk with this ambition.

NHS England and Monitor recently announced additional support for the 11 most challenged health economies, including Cambridgeshire and Peterborough, to develop integrated plans which deal with the particular local challenges we face. This work is due to start shortly with findings presented at the end of July 2014.

1.6 Project Orange

We moved into a new site, Peterborough City Hospital, in December 2010, funded through the Private Finance Initiative (PFI). Since then, we have consistently made losses and reported the highest

[2] The Firm is a 24 hour GP led triage service for elderly patients with complex needs referred by GP's for possible admission to hospital

proportional deficit in the NHS in the financial year ended 31 March 2012. In financial year 2013/14, the Trust incurred an underlying deficit of c£37m - £40m.

The Trust is in breach of its terms of authorisation and was found in 2013 to be clinically and operationally sustainable, but financially unsustainable. Monitor issued an enforcement notice which requires that we deliver a £13m cost improvement each year for 2013/14 and 2014/15, and seek ways of delivering better value from the PFI building through a tendering process. Patients' interests must remain at the heart of the solution and the burden should not be shifted onto other organisations or local populations.

The Monitor Enforcement Undertaking requires a tender process to be undertaken "aimed at securing the maximum value for patients and taxpayers from the utilisation of the Licensee's assets". The Trust Board is clear that the delivery of the above outcome must be in the context of the Trust maintaining and improving the quality of both clinical outcomes and patient experience. In addition, the tender process must result in the Trust's hospitals being run by an organisation, whether the Trust itself or another healthcare provider, that can provide ongoing clinical and financial sustainability. We aim to appoint a successful bidder by July 2015, and seek approval to move to the new arrangement by January 2016. Compliance with the Enforcement Notice is a key element of this annual plan.

2 Trust objectives 2014/15 to 2015/16

The Trust Board has agreed seven objectives summarised in Table 4. They align to the Monitor enforcement notice, and commissioner priorities. There are links to patient safety and experience, long term financial sustainability of the health system as well as support for staff who will deliver the service throughout this short term challenge. Objectives were developed through engagement with senior clinical leaders, the Trust Board and the Council of Governors and are supported by directorate and specialty level plans.

2.1 Be in the top quartile safest district general hospitals in England

We have a track record in delivering safe and effective care as demonstrated by mortality data, and patient safety thermometer data (Table 3).

Table 3 - Patient safety metrics

	PASHN FT	DGH Avg	Upper quartile DGH
Hospital Standardised Mortality Rate[3]	96.23	101.1	96.26
Standardised Hospital Mortality Index[4]	101.36	103.58	99.76
Patient safety thermometer – harm free care	97.11	97.1	-

Over the coming two years we aim to achieve top quartile performance for all District General Hospitals in England. Improvement in hospital mortality will be led by the hospital Mortality and Morbidity Group who will identify particular diagnoses and conditions for deep dive analysis with specific input at Clinical Directorate and specialty level. Directorate clinical governance teams will consider how they manage and record co-morbidities for these conditions.

[3] HSMR (Oct 2013) – Difference between the actual deaths in hospital compared with the expected case mix adjusted. A score of 100 means that the Trust has experienced the expected number of deaths for the complexity and risk factors.

[4] SHMI (Jun 2013) – Difference between the actual deaths within 30 days of patient discharge and the expected, case mix adjusted. As with HSMR, a score of 100 means the deaths are within expected, a lower score indicates that there were less than expected.

Table 4 - Trust objectives 2014/15 to 2015/16

Trust **Objectives**	**Measure**	**Due date**
1. Be in the top quartile safest district general hospitals in England	DGH mortality rates (HSMR and SHMI) in England in top quartile	Mar 2016
	Top quartile DGH hospital score for patients receiving harm free inpatient care (Patient Safety Thermometer)	Mar 2016
	Achieve 90% CQUIN targets	Mar 2015
	Seven day working:	
	•Baseline assessment and implementation plan	Mar 2015
	•Seven day radiology reporting	Mar 2016
	•Urgent care consultant presence 0900-1700 seven days per week	Mar 2016
2. Be in the top 20% of Trusts for patient care and experience	Trust Friends and Family Test average annual scores in the top 20% of all Trusts for combined ED, inpatient and maternity surveys	Mar 2015
	No final response to a complaint takes more than 30 days without complainant agreement	Apr 2015
	Top 20% scores in national patient surveys for:	
	•Inpatient (six areas)	Mar 2016
	•Outpatient (eight areas)	Mar 2016
	•Maternity (three areas)	Mar 2016
3. Be an effective Trust and meet performance standards	Achieve ED 4 hour standard every quarter for 2014/15	Mar 2015
	Each speciality achieves national 18 week wait standard for admitted and non-admitted patients each month for 2014/15	Mar 2015
	Achieve Monitor national Cancer Waiting Times every quarter in particular:	
	•62 day cancer standards	Mar 2015
	•Cancer patients not treated within 62 days because of non-patient choice diagnostic delay:	
	-Less than 25%	Mar 2015
	-Less than 10%	Mar 2016
	80% of stroke care provided in dedicated stroke facilities for 90% of their care	Mar 2015
4. Have a productive workforce equipped, skilled and motivated to provide the highest quality care	Staff engagement score of 4 in the national staff survey	Dec 2014
	Vacancy rate a maximum of 10% for nursing and 5% non-nursing	Oct 2014
	Reduce locum and agency spend:	
	•25% of 2013/14 outturn	Mar 2015
	•50% of 2013/14 outturn	Mar 2016
	Questions related to Trust values (Caring Creative Community) included in:	
	•80% of all recruitment interviews	Mar 2015
	•100% of all recruitment interviews	Mar 2016
	Staff appraisal rate of 90%	Mar 2015
	Staff 12 month sickness rate of 3%	Mar 2015
	90% staff attend mandatory training in the previous 13 months	Mar 2015
5. Ensure that the Trust is well run and well led	Audit of Board governance and Membership reports substantial assurance	Mar 2015
	'Have your say' internal staff survey, for each question:	
	•Score 80%	Mar 2015
	•Score 85%	Mar 2016
	Agreed complement of senior staff in post	Jun 2014
	Revised integrated performance scorecards from ward to board level	Jun 2014
	Audit of directorate and corporate team governance and performance management:	
	•Baseline audit	Mar 2015
	•Audit report assurance improves by one level for all directorates and teams	Mar 2016
	35 clinical services strategies completed	Mar 2016
6.Deliver our financial targets	Deliver income and expenditure plan	Mar 2015
	Deliver the capital programme	Mar 2015
	Deliver £16m CIP programme	Mar 2015
	Develop improved access and efficiency through IM and T:	
	•Electronic document management	Mar 2015
	•Maternity system replacement	Dec 2014
	•Clinical notes and eForms	Oct 2015
	•PACS reprocurement	Jul 2015
7.Achieve all round 'sustainability' for PCH and Stamford Hospital	Competitive tender process delivered to plan	Jun 2015
	Work with the health and social care economy to develop a joint five year strategic plan	
	Stamford hospital major redevelopment	2015/16
	Business development plan to deliver a £2m recurrent annual contribution:	Mar 2016
	•Radiotherapy	Jun 2015
	•Pathology	Mar 2015
	•Renal dialysis	Mar 2015
	Develop our academic potential in medical and non-medical education, and research and education	Mar 2015

Increasing harm free patient care will focus on investigating and learning from mortality data, extending the falls prevention programme, reducing urinary tract infections and C diff, and improving the response to early warning signs that an inpatient's health is deteriorating.

Safety of patients over the weekends is recognised by the NHS nationally and locally as an area for improvement. In 2014/15, the Deputy Medical Director will prepare a seven day service specification in line with the East Midlands Provider Collaborative Seven Day Services project, supported by local specialty and directorate plans. Our baseline assessment of current provision will be used to develop an implementation plan including an outline of the requirements and investment proposals for the required medical cover. By 2015/16, we will increase urgent care consultant presence to 0900 to 1700 hours seven days per week, and increase radiology reporting at weekends.

2.2 Be in the top 20% of Trusts for patient care and experience

Our national Friends and Family Test scores put the Trust just outside the top quartile of all Trusts in the combined inpatient, ED and maternity scores (Table 5).

Table 5 - National Friends and Family Test (FFT) results

	PSH	All NHS Providers	
National FFT (Apr-Nov 2013)		Average (mean)	Top quartile
Combined ED, maternity and inpatient	71	63	73

Each directorate has identified areas for further improvement and developed action plans which should bring the Trust into the top 20% by April 2015.

We will manage our complaints more effectively. When patients and carers need to complain about any aspect of their care, we have a responsibility to investigate concerns in a timely and thorough manner. Whilst parts of the Trust have performed well in responding within agreed timescales, this has not been achieved consistently. By March 2015, no final response to a complaint should take more than 30 days without the agreement of the complainant.

National patient surveys provide a good insight into our patient's experience. The Care Quality Commission (CQC) assess all national surveys and rates Trusts as 'Better than average' when scores are within the top 20%. We perform better than average in a few areas of our national surveys and average in other areas[5]. In the most recent surveys, we have three areas in the top 20% in the inpatient survey, average scores for maternity and one area in the bottom 20% for the Emergency Department survey (receiving test results before leaving the department). We aim to achieve no scores in the bottom 20% and have top 20% scores in more areas by March 2016:

- Inpatient (six areas)
- ED (two areas)
- Maternity (three areas)

2.3 Be an effective Trust and meet performance standards

For 2013/14, we are forecast to meet most of the national standards Monitor requires us to achieve as a condition of our authorisation. Along with an increasing number of Trusts, we are failing to meet the 4 hour standard, have exceeded the number of patients with C difficile, and for the final quarter will not meet the 18 week admitted referral to treat standard.

Our position year to date as of January 2014 is shown in Table 6.

[5] Surveys are conducted over different periods, the most recent being Inpatient 2012 http://www.cqc.org.uk/survey/inpatient/RGN ED 2012 http://www.cqc.org.uk/survey/accidentemergency/RGN and Maternity 2013 http://www.cqc.org.uk/survey/maternity/RGN

We will develop robust plans to improve the flow of patients and ensure that those who need to be admitted are not delayed in the Emergency Department (ED). An urgent care pathway programme board with six work streams will bring together senior clinical leadership and managers with the Service Improvement and Transformation Team. They will develop high level plans, a monitoring framework and progress reports to deliver improvement across the Trust to improve flow through the Trust and ensure that patients who need to be admitted do so consistently throughout the year within four hours. This work programme is key to the delivery of the 4 hour A&E and 18 week standards.

Table 6 - Monitor compliance framework January 2014

Monitor compliance framework standard	Target	YTD
RTT 18 weeks – admitted	90%	90.5%
RTT 18 weeks - non-admitted	95%	97.1%
RTT 18 weeks – incomplete pathways	92%	97.8%
Cancer 2 week wait	93%	97.2%
Cancer 31 day RTT	96%	99.9%
Cancer 62 day RTT	85%	89.1%
Cancer 62 day screening	90%	93.3%
Cancer – subsequent treatment – drugs	98%	100.0%
Cancer – subsequent treatment – surgery	94%	99.2%
Cancer – subsequent treatment – radiotherapy	94%	99.7%
Cancer – subsequent treatment – all	96%	99.8%
Breast symptomatic	93%	97.4%
A&E 4 hours or less	95%	93.6%
C diff rates - inpatient	26	31
MRSA[6] bacteraemia	1	0

With the increasing demand for emergency care leading to less predictable elective capacity, the Trust Management Board identified areas where we need to focus more on each stage of the 18 week referral to treat (RTT) pathway to prevent breaches. We will continue to place increased emphasis on managing each stage of the elective pathway to ensure that patients receive timely care.

We met the standards of care for patients with cancer or who have had a stroke, but have included this as an objective for the coming two years to maintain focus on these important areas. Relevant specialties have prepared plans to deliver sustainable performance.

2.4 Productive motivated workforce

The Trust has identified a number of key performance indicators for 2014/15 and 2015/16. Current performance against these is summarised in Table 7.

We will measure our staff motivation using the National Staff Survey staff engagement score. In the 2013 national NHS staff survey, our score was 3.77 compared with an average of 3.74. We aim to achieve a score of 4.0 in the 2014 survey through the various improvements we are making to staff recruitment and engagement.

We will decrease reliance on locum and agency staff through reducing vacancies across the Trust. A summary of the workforce plan is given at Table 8.

[6] MRSA - meticillin-resistant staphylococcus aureusis

Table 7 - Workforce Key Performance Indicators

Key performance indicator	Current	Target
National Staff survey staff engagement score	3.77	4.0
Nursing vacancies	14.73%	10%
Other vacancies	7.65%	5%
Sickness rate	3.17%	3.0%
Appraisals	81%	90%
Mandatory training	51.7%	90%

The Trust has a high number of vacancies for qualified nurses. The December 2013 vacancy rate was 15.33% for nursing and 6.12% for all other employees. Improvements in this area will not only improve the quality of care by reducing our reliance on bank and agency staffing, but will also reduce the cost of employing temporary workers.

We plan to reduce nurse vacancies to 10% of posts and non-nursing positions to 5% by October 2014. This will result in a reduction of locum and agency costs by almost 50% in 2014/15. Further reductions in agency costs will be achieved through reducing premium pay costs where this is not substantively covering a post, and reviewing the procurement of locum and agency staff to ensure we are getting the best value for money.

Recruitment and retention will be improved through:

- Band 5 nursing campaign which includes international recruitment from March 2014 onwards, supported by a local advertising campaign targeted at nursing staff, and open days for those considering a career in or a return to nursing.
- Medical staff will be offered posts as trust grade doctors where possible.
- We will reduce the time it takes to hire staff by reviewing the recruitment process and introducing real time monitoring of the time it takes to hire individuals.
- Collation and sharing of anonymous exit interview information to better understand why staff leave the Trust.

Table 8 - Workforce plan 2014/15 to 2015/16

Staff group	2013/14 FOT £m	2014/15 Plan £m	Change	2015/16 Plan £m	Change
Consultants (not locums)	25.3	27.1	7.0%	27.1	0
Locum Consultants	7.1	3.3	-52.2%	3.3	0
Junior Medical	14.6	16.2	11.0%	16.2	0
Nurse & Midwives (Total inc Bank)	45.2	50.3	11.1%	50.3	0
Scientific, Tech & Therapies (inc bank)	19.3	18.4	-4.9%	18.4	0
Nurses and Midwives – agency/contr	2.9	0.9	-67.9%	0.9	0
Scien, Tech & Ther -agency, contract	0.6	0.1	-84.8%	0.1	0
Healthcare assistants	11.9	12.7	7.0%	12.7	0
Total clinical	**126.9**	**129.0**	**1.6%**	**128.0**	**-0.8%**
Non-clinical staff	**29.0**	**30.8**	**6.0%**	**30.1**	**0**
Analysis of staff costs					
Permanent Staff	143.9	153.7	6.8%	152.7	-0.7%
Locums, Agency & Contract Staff	12.0	6.1	-49.3%	6.1	0
Total staff costs	**155.9**	**159.7**	**2.5%**	**158.8**	**-0.6%**

Staff appraisal improves productivity by sharing a clear vision and expectation of individuals and providing the opportunity to identify skills gaps. The Trust average 12 months staff appraisal rate as of December 2013 was 80%, and we aim to increase this to 100% of eligible staff by December 2014 through close performance management arrangements from Board to ward.

We will continue the roll out of the 'My Personal Appraisal' (MPA) process across the Trust from March 2014, backed with training which focusses on the skills required to provide high quality appraisal.

We manage sickness absence as well as the private sector and better than the average public sector organisation according to data provided by the Chartered Institute for Personnel Development[7] (Table 9). Actions described previously should make an indirect improvement on sickness levels towards our target of 3% by March 2015. We plan to ensure staff and managers follow the Trust sickness policy, promoting use of the Occupational health and wellbeing services and 'talking therapies', and early referral for musculo-skeletal advice.

Table 9 - Trust sickness rates compared with national sectors 2013

Employer	Avg working time lost per year 5% trimmed mean
Peterborough and Stamford Hospitals*	3.17%
Public sector services:	3.8%
- **Central government**	3.7%
- **Education**	3.6%
- **Health**	4.8%
- **Local government**	3.9%
Private sector services	3.2%

* as of December 2013

Mandatory training attendance remains a concern for the Trust and we aim to improve attendance to at least 90% of all staff (allowing for turnover and long term absence) by March 2015. Directorates have developed local plans to achieve this, and corporately there will be increased use of e-Learning where appropriate to provide staff with more convenient access.

Our values are summarised as 'Caring, Creative, and Community'. We will embed these into the organisation from April 2014 by starting to assess of an individual's values compared with the Trust values. This will be included in our recruitment processes in 2014/15. It is planned that this approach will extend to appraisal at a future date.

2.5 Ensure that the Trust is well run and well led

Monitor has reviewed the governance of the Trust and whilst finding that we were in breach of our duty to be well governed in April 2013, the Contingency Planning Team (CPT) report produced in September 2013 provided assurance that the Trust is clinically and operationally sustainable. The Trust Board has since assessed the improvements we have made including a strengthened finance function, board challenge and review, and further development and scrutiny from the Board's Quality Assurance and Finance and Investment Committees. The Trust has confirmed these improvements with Monitor.

In the next two years we aim to achieve substantial assurance in the internal audits of corporate governance. Our internal staff survey, 'Have your say' has questions relating to how staff perceive leadership of the Trust. We aim to achieve scores of 80% in these sections by March 2015 and 85% by March 2016.

[7] Absence Management Annual Survey Report 2013 http://www.cipd.co.uk the survey was completed by 618 respondents in June–July 2013.

The Trust has already strengthened the governance structures by appointing to key posts and increasing clinical leadership in the clinical directorate structure. We plan to have appointed to the agreed complement of senior roles in all clinical directorates by June 2014.

Leadership development will be provided to all senior and aspiring leaders in the Trust with a focus on Associate Clinical Directors, General Managers, Clinical Directors and Heads of Service through a structured programme. In conjunction with My Personal Appraisal, succession plans will be developed by March 2016 to prepare for any changes in key personnel.

We will use integrated workforce, operations, quality and finance performance data to provide information about key trust indicators at all levels within the organisation. This information will help us to develop a performance focussed culture with improved local accountability. It will also enable individuals at all levels of management to benchmark themselves against other departments in the Trust, and to understand their contribution to overall Trust performance.

Trust level key performance indicators, agreed by executive directors, will be monitored through the existing balanced scorecard reports. These reports will be available electronically with drill down capability from June 2014. Access to the electronic reports will be available at directorate level from quarter 2.

We will audit directorate and corporate team governance and performance management in March 2015, and aim to improve the level of assurance by one level by the following year.

Service line reporting is available at a Trust and directorate level. Further refinements in 2014/15 will see this extended to specialties by June 2014. This early version will be refined through ongoing discussions with clinicians to bring increased accuracy to the cost and income allocations.

Clinical service strategies will be developed for all 35 clinical services. The process will commence in April 2014, with 17 planned for completion by March 2015 and the remainder by March 2016. Once completed, they will inform the future direction of the Trust investment strategy.

2.6 Deliver our financial targets

Given the significant financial challenge that we face, delivery of our financial targets for 2014/15 and 2015/16 is both challenging and necessary. Our key financial priorities over the plan period can be summarised as follows:

- Delivering a sustainable and on-going reduction to the underlying deficit through:
  - Achieving full Cost Improvement Programme (CIP) delivery as planned
  - Delivering Project Orange to deliver a sustainable solution for the Trust and local health system
- Ensuring that the Trust continues to manage its cash flows receiving external funding as required to ensure we can continue to pay our debts as they become due

2.6.1 Underlying Income and Expenditure Surplus/(Deficit)

We are forecasting a net deficit (before impairment costs) of £(36.9)m for the year ending 31st March 2014, £(43.3)m for the year ending 31st March 2015, and £(42.3)m for the year ending 31st March 2016. Material movements between, 2013/14 and 2014/15 include:

- Project Orange costs of £2.2m compared with £0.5m in 2013/14
- £1.0m of additional costs/lost income relating to the Ministry of Defence exit
- £1.3m for the provision of restructuring costs compared with £0.2m in 2013/14
- Pay and benefit cost increase of £5.0m
- PFI, depreciation, and interest costs will be £1.1m higher than 2013/14, £0.4m of which is due to the retail price index (RPI) uplift on the PFI contract.

2.6.2 Income

Contracting principles based on those used last year were agreed with all significant commissioners. Baseline activity was used to inform discussions about any changes. Commissioner Quality, Innovation, Productivity and Prevention (QIPP) schemes for this year are ambitious, but have been provided in more detail than previously, and are now sufficiently detailed to be mapped into the Indicative Activity Plan (IAP). The Trust is planning for 50% of the Commissioners £9.1m QIPP target.

We have a single set of Commissioning for Quality Innovation (CQUIN) schemes across both lead CCGs with the exception of one scheme, which should be finalised shortly.

There will be minor changes to contractual penalties compared with those in 2013/14:

- Penalties will be per breach rather than the current percentage of service line
- Penalties are subject to a nationally agreed cap of 2.5% in a quarter.

Areas where the Trust is at risk of incurring penalties based on current performance include the A&E and 18-week referral to treat (RTT) targets. Under the 2014/15 arrangements penalties will become:

- A&E £200 per breach (beyond the 95% threshold).
- RTT £400 per breach (beyond the 90% Admitted RTT threshold).
- MRSA £10,000 per case over threshold.
- C-Diff £10,000 per case over threshold.

We moved to a new pricing structure for non-PbR activity in 2013/14 and because of the significant change to previous rates, a 3-year phasing was agreed with commissioners in line with the PbR code of conduct. In 2013/14, we received 1/3 of the difference, with 2/3 now reflected in the IAP for 2014/15. In net terms the impact of this increase for 2014/15 offsets the impact of the 1.5% tariff deflator.

2.6.3 Expenditure planning

Detailed activity budgets 2014/15 have been developed with the involvement of Directorates to ensure that resources including staffing, match the planned levels of activity.

Operating costs, excluding depreciation, are budgeted for 2014/15 at £244.5m. This compares with forecast operating costs in 2013/14 of £242.0m and £245.7m in 2015/16.

Material changes between 2014/15 and 2013/14 forecast outturn include:

- Pay
    - Award of pay increments of £2.4m
    - Additional staff to achieve safe staffing levels of £1.6m
    - Inflationary pressure of £1.6m
    - MOD exit staff backfill of £0.8m
- Reduced activity resulting from QIPP schemes being delivered saving pay and related costs of £1.3m
- Clinical Negligence Scheme for Trusts, the Trust's 'insurance' scheme, will incur an additional premium of £1.2m

2.6.4 Private Finance Initiative (PFI)

PFI payments for 2014/15 of £19.3m are budgeted to be £0.4m higher than in 2013/14 in line with the 2% RPI in the contract.

2.6.5 Revenue: Income and Expenditure planning

The income and expenditure referred to above has been analysed and modelled into an Income and Expenditure account, a summary is in Table 10.

Table 10 - Income and Expenditure 2014/15 to 2015/16

		Forecast 2013/14	Budget 2014/15	Plan 2015/16
Income				
	NHS clinical income	213.4	213.3	214.3
	Other income	20.6	20.1	20.1
	Total income	**234.0**	**233.4**	**234.4**
Expenditure				
	Pay	154.9	159.9	161.0
	Consumables	68.2	65.3	64.7
	Private Finance Initiative	18.9	19.3	19.8
	Total expenditure	**242.0**	**244.5**	**245.7**
	EBITDA	**(8.0)**	**(11.1)**	**(11.1)**
	Depreciation	13.4	13.9	14.4
	Interest	12.5	12.7	13.0
	Loss on assets disposed	0.2	0.0	0.0
Deficit from operations		**(34.1)**	**(37.7)**	**(38.5)**
	Restructuring costs	0.2	1.3	1.3
	PMO costs	2.1	2.1	2.1
	Project Orange costs	0.5	2.2	0.4
Deficit before impairment		**(36.9)**	**(43.3)**	**(42.3)**
	Impairment costs	1.0	1.7	0.0
Retained deficit		**(37.9)**	**(45.0)**	**(42.3)**

2.6.6 Capital Planning

Our capital programme is summarised in Table 11 with £13.3m investment in 2014/15 in key projects including medical equipment, radiotherapy, our Stamford site, staff accommodation and IT. These are described in more detail in section 2.7.2 of this plan.

Table 11 - Capital plan

2014/15 Capital Expenditure	Forecast £k
Medical Equipment	1,999
IT strategy	2,879
Stamford Redevelopment	1,000
Radiotherapy expansion	5,450
PCH Residential accommodation	2,000
Total Capital Request	**13,328**
Funded by:	
PDC funding	7,450
Safer Hospitals, Safer Wards Technology Funding (DoH)	878
Total Capital Envelope	5,000

It should be noted that our current IT strategy requires additional funding in excess of the £2.8m in Table 11, and is dependent on successful bids for external funding. We will prioritise expenditure

within the available funding.

2.6.7 Cost improvement programme (CIP)

We agreed with Monitor as part of our enforcement notice that we would deliver a recurrent £13m cost improvement in 2014/15. The Trust has set an internal stretch target of £16m CIP, to mitigate against any potential risks to delivery.

Detailed schemes identified to date total £13m which will absorb some of the inflationary pressure and deliver reductions in the overall deficit. Whilst most of these schemes are for 2014/15, some will extend into 2015/16. The 2014/15 schemes totalling £13m to date are shown in Table 12.

Table 12 - Cost improvement schemes 2014/15

Schemes	Effect 14/15
Pay (balances in pay)	£6.5m
Income	£2.6m
Health care providers	£1.5m
Clinical supplies/services	£1.2m
Other including procurement, insurance etc	£1.2m
Total	**£13m**

2.6.8 Cost improvement schemes

Pay cost improvement of £6.5m will be achieved through reduced medical and dental locum expenditure, supported by recruitment to substantive posts. Medical agency provision will be reviewed to improve value for money. We will review senior management posts in corporate functions and throughout the Trust.

£1.5m health care provider costs will be reduced through repatriation of surgical activity outsourced to private providers due to lack of capacity within the Trust as we increase elective capacity. The Urgent Care Programme Board will be instrumental in delivering greater efficiency for urgent care with the corresponding increase in elective capacity.

Income related CIP schemes of £2.6m include the protection of elective activity, improved efficiency in the pathology service to increase capacity for direct access testing and increased critical care capacity with a resulting increase in income for the Trust.

We will adopt 'lean' methodology across the Trust to deliver improvement in the way we work. Front line staff will be trained in recognised tools and techniques such as structured problem solving to help identify ways of working more efficiently whilst maintaining our focus on patient care. These teams of front line staff will be supported by the Business Transformation Team (BTT) to deliver improvement in their local areas, whilst Trust wide transformation will be facilitated by the BTT who will focus on high value schemes worth £200K or more.

2.6.9 Risks to the financial plan

The significant risks to our financial plan are described in Table 13, the most significant risks are related to failure to reduce the demands posed by emergency care, including the way we resource care for these patients as they move through the hospital, and the need to work with commissioners to deliver more care in the community. This risk also impacts on our ability to deliver elective work in a timely and cost effective way.

At the same time, we face another year of challenging cost reduction to deliver to our financial plan.

Mitigating actions are described for each risk.

Table 13 - Risks to the financial plan

Assumption	Risk	Score (Likelihood x severity)	Mitigation
The Trust 2014/15 QIPP budget target of £4.55m is based on a 50% delivery of the CCG target. Cost reductions have been planned at 60% (i.e. all variable costs), and are phased with a six month lag	Based on current performance (minimal QIPP in 2013/14), delivery of £4.55m is extremely ambitious	4 x 5 = 20	Contract activity monitoring mechanisms where activity varies significantly (>5% for 3 three months for a specialty or 5% for one month for the Trust) from Indicative Activity Plan (IAP)[8]. Provisions in the national contract will be applied where necessary, to recover any additional costs
Activity growth will be in line with the commissioned activity plan,	Growth outstrips capacity in normal working hours and the Trust incurs significant excess costs and realises lower margins through premium payments and activity outsourcing in order to meet performance standards	4 x 4 = 20	Urgent care programme, and the commissioner QIPP schemes
Marginal Rate Emergency Tariff (MRET) reinvestment	The plan assumes MRET reinvestment of £2.5m until 2017/18. If this funding ceases, expenditure will still be incurred which will have an adverse impact on deficit	3 x 4 = 12	Contract management arrangements
The plan is predicated on achieving CIP's of £13m per year, every year	As projects increasingly depend on transformation rather than transactional cost reduction there is an increased risk of non-delivery in year	3 x 4 = 12	CIP programme board

2.7 Achieve all round 'sustainability' for PCH and Stamford Hospital

2.7.1 Project Orange

Project Orange is a key requirement for the all-round sustainability for the Trust and could have a significant positive impact on the local health economy. The project has eight objectives:

1. Maintain or improve quality for patients
2. Maintain or improve clinical and operational sustainability of our hospitals.

[8]Agreed with 2 out of our 3 main commissioners as of 26 March 2014

3. Maximise the use of our hospitals estate.
4. The Trust is able to retain and recruit staff of the necessary calibre to deliver quality services.
5. Contribute to the financial sustainability of our hospitals and minimises DH/NHS England financial support.
6. Deliver value for money such that the contribution to future financial sustainability exceeds what could be delivered by the Trust acting alone and significantly exceeds the costs of the tender exercise.
7. Contribute to the development of health and social care service delivery and the long term financial sustainability of the local health economy.
8. Deliver a solution that has the flexibility to facilitate the future development of health and social care services in the health economy and allow it to respond effectively to future service and financial challenges.

In 2014/15 the tender will be developed and advertised in the Official Journal of the EU (OJEU) and potential bidders taken through the pre-qualification and competitive dialogue stages, with the intention to select the preferred bidder after July 2015. In 2015/16 the Trust will prepare a full business case including assessment of any competition issues and then complete detailed contract negotiations prior to seeking final approvals in the final quarter of 2015/16.

2.7.2 Key financial investments

The Trust is planning investments which are included within the financial plan these are:

Radiotherapy expansion

Expansion of the radiotherapy services provided by the Trust by building a further two bunkers and purchasing a new linear accelerator (LINAC) which will meet the growing demand for cancer treatment.

Accommodation block

The completion of an accommodation block on the PCH site to accommodate medical and nursing students.

Stamford hospital

The project will deliver a smaller Estate which provides hospital services for patients predominantly from the South Lincolnshire area. A final decision on the clinical strategy, finance and programme of works will be agreed by September 2014, with works planned throughout 2015 and 2016.

Investment in Information Management and Technology

The Trust four year IM and T strategy will support the Trust to implement Electronic Patient Records by 2018 and the Trust's overall strategy and expectation for continued productivity and efficiency. This strategy will move our Health Records systems from paper-based to Electronic Patient Records (EPR) and improve the sharing of data.

Projects which will be delivered during the period of this plan include:

- Introduction of Electronic Document Management (EDM) the scanning and electronic viewing of existing paper health records which will provide access to shared records for relevant health care professionals with pay cost savings in the region of £2m in the first two years.
- Development of a patient portal to allow secure communication between patients and clinical or admin staff, and provide online booking
- Maternity IT system replacement will deliver quality improvements with better sharing of information and tracking of cases, assisting delivery of better care and reduce litigation risks. NHS Litigation Authority reductions in contributions are anticipated as a result.

2.7.3 Research and education

The Medical and Non-Medical strategies have been approved by the Board and will be implemented through the the Non-Medical Clinical Tutor and Associate Medical Director (Medical Education). The recently approved Research and Development Strategy will be supported by investment management proposals and overseen by the Quality Governance Operational Committee.

3 Quality plans

3.1 Quality goals

In our Trust, the delivery of patient centred and high quality care is "everyone's business". Delivery is dependent on three quality domains being in place at all times; namely, safety, clinical effectiveness and patient experience. Activities required of all staff to achieve the Quality Strategy objectives are summarised as 'Right care; first time; every time.'

3.2 Quality priorities

Our quality priorities for 2014/15 to 2015/16 are reflected in the first two Trust objectives to be in the top 25% of District General Hospitals in England for mortality rates and harm free care measured on the Patient Safety Thermometer; and to be in the top 20% of Trusts for patient experience as measured by the Friends and Family Test and national patient survey data. The Quality Account for 2014/15 has not yet been prepared, but will reflect these objectives.

Achieving this will be challenging, and as other Trusts make incremental improvement, we will need to improve at a faster than average rate.

We will further reduce the number of avoidable deaths through focus on areas where mortality data suggests a review would be appropriate, and by increasing emergency and radiology medical cover at weekends. In 2014/15 we will conduct a baseline of medical cover provided currently, and make recommendations for change. New working arrangements in emergency teams and radiology will be in place for the following year.

Increasing harm free patient care will focus on:

- Reducing the four harms monitored via the Safety Thermometer i.e. falls, pressure ulcers, venous thrombo-embolism and catheter associated urinary tract infection.
- Reduce the number of avoidable Clostridium difficile infections acquired in hospital
- Reduction in risks associated with medicines particularly prescribing errors
- Full use of the 'Sepsis 6'
- Improve response to Early Warning Signs when the condition of a patient is deteriorating

3.3 Exisiting quality concerns

The Care Quality Commission completed an inspection of the Trust in March this year, as part of their new regime. We will update our plan to reflect any issues identified during the inspection when we receive the report in May 2014.

The Trust has an outstanding CQC compliance action and moderate concerns from their previous visit as previous reports have not yet been lifted. The Trust has taken action to address these issues, and will look to the CQC report in May to see whether these have been lifted.

3.4 Board quality assurance

The Quality Governance Framework sets out the Trust's framework around strategy, risk, capability, culture, structures and processes and measurement. Members of the Board of Directors have recently assessed their knowledge and performance around quality governance using the Monitor toolkit which demonstrated improvement compared with 2012/13.

Assurance for the Board is provided by the Quality Assurance sub-committee whose membership

includes three non-executive directors, four executive directors and key external stakeholders including a public governor, a local GP and the chair of Healthwatch Peterborough.

3.5 Quality and the workforce

We have reviewed the Francis report and the Government's response to it and have a series of action plans in place to address relevant recommendations. This review has included the related reports (e.g. Berwick, Keogh, Cavendish and Clwyd and Hart) and has wide ranging requirements for development including workforce implications particularly relating to the National Quality board paper relating to staffing levels and skill mix. Where appropriate, we have aligned these recommendations to existing work plans, for example, complaints quality improvement plan, action plan to improve the management of deteriorating patients.

3.6 Risks to achieving our quality plans

The significant risks to achieving our quality objectives are described in Table 14:

Table 14 - Risks to the quality plan

Assumption	Risk	Score (Likelihhod x severity)	Mitigation
Patient experience improvement including reduction in cancelled operations	Failure to reduce emergency activity	4 x 4 = 16	Urgent programme board Elective pathway programme QIPP programmes
We will achieve all the Trust CQUIN targets	Failure to achieve improvement in seven day cover and pressure care	4 x 4 = 16	Clear accountability Monitoring group
Achievement of the C Diff target	Achievement of the C diff target remains a risk.	4 x 4 = 16	Build on the recommendations from the external review of our C diff management in February 2014. Revise our interpretation of the national testing protocol Review staffing levels and skill mix in the infection control nursing team Recruit to the vacant Consultant Microbiologist role Complete the benchmarking review for our cleaning specification. Infection prevention programme
Achieve significantly better than average safety and experience for our patients through committed and motivated staff	Inability to recruit substantive staff	3 x 5 = 15	Trust recruitment plans Trust values in the recruitment process

Quality initiatives are adequately funded	Financial challenges pose a significant risk to improving the quality of care our patients have a right to expect	3 x 4 = 12	Clear communication of quality goals Use of quality impact assessments for any proposed change necessitated by financial pressure.
Compliance by every member of staff with agreed quality standards	Staff who lack knowledge or commitment to consistently delivering the right care, first time, every time impacts on our quality of care	2 x 5 = 10	Improved performance management arrangements Increased focus on Trust values in recruitment and appraisal Increased reruitment to staff vacancies

4 Operational requirements and capacity

Our activity plan for 2014/15 is shown in Table 15 below.

Table 15 - Trust activity plan 2014/15

	2013/14 FOT	14/15 Plan	Change	% change
A&E	90,683	86,662	-4,021	-4%
Non-Electives	32,158	34,692	2,534	8%
Electives	7,103	7,674	571	8%
Day Cases	27,572	27,280	-292	-1%
Outpatients	331,596	328,291	-3,305	-1%
Critical Care	13,329	13,417	88	1%
Maternity	20,886	21,167	281	1%
Delivery of Chemotherapy	5,782	5,685	-97	-2%
Radiotherapy	15,777	15,635	-142	-1%
Diagnostics (Payment by Results)	1,773,612	1,712,794	-60,818	-3%
Other clinical income	98,249	113,249	15,000	15%

Overall demand due to population growth has been factored in based on the proportional increase in catchment GP practice lists in the past year, and profiled by age-band.

Attendances to the Emergency Department are forecast to reduce by 4% compared with 2013/14 as a result of various QIPP schemes including the impact of the Emergency Medical Unit (EMU) which will receive some GP medical referrals which would have attended ED previously. These figures do not yet include the reduction due to the new Minor Illnesses and Injury Unit operational since October.

We are planning for an increase of 8% in non-elective activity due to the EMU effect i.e. admitting GP expected patients direct to EMU who would previously have been discharged from A&E.

An additional 8% elective capacity will be made available by the elective care pathway project and the urgent care programme. Some additional 'catch-up' of elective activity to recover RTT performance will also be required as a consequence of the recent volume of elective cancellations.

Day case and outpatient activity will remain relatively flat, although some activity will move from elective inpatient towards day case, and from day case to outpatient minor procedures as part of the elective pathway project.

Critical care capacity will increase by two beds to meet the ongoing demand, and there will be a 1% year on year increase in 2014/15.

Maternity activity will increase by 1% in response to demand and changes in demographic profile.

Lack of capacity for cancer services means that there is limited scope in the Trust for growth until the new radiotherapy linear accelerator is commissioned in 2015/16. There is a slight reduction in the radiotherapy and chemothereapy plan due to the time the baseline was taken to calculate the anticipated demand in 2014/15. We do not anticipate any reduction in activity in 2014/15 compared with the forecast outturn for 2013/14.

The reduction in direct access diagnostics relates to relatively low cost pathology tests. The 15% increase in other clinical income reflects the transfer of activity from non-elective to ambulatory care, and an increase in direct access therapy activity.

4.1 Capacity constraints

There will be capacity constraints in five of our medical specialties, six surgical specialties and two diagnostic services shown in Table 16. Constraints are a combination of beds and workforce capacity.

Commissioner and provider activity and revenue assumptions for 2014/15 and 2015/16 are not yet congruent. Whilst we anticipate having signed agreements with commissioners before the start of the financial year, there will be a gap in the assumptions on which this is based and operationalising the plan may be difficult on QIPP. Taking a risk based approach, the Trust will make its own activity assumptions based on historical demand and track record of QIPP scheme impact.

Table 16 - Capacity constraints and growth opportunities

	Emergency and Medicine	Surgery and MSK	Family and Public Health	Cancer	Diagnostic
Capacity constraints	Cardiology Neurology Gastroenterology /hepatology Stroke	Ophthalmology OMFS/ dermatology ENT Orthopaedics Breast	-	-	MRI Histo pathology
Growth opportunities	Cardiology surgery	-	Maternity	Radiotherapy	-

4.2 Assessment of capacity requirements

We have assessed the inputs needed over next 2 years, based on our understanding of the expected activity levels. We plan to invest in these areas once a capacity assessment is completed.

4.2.1 Theatre Capacity

We have sufficient physical capacity but still have significant theatre nurse and operating department practitioner (ODP) vacancies. This is being addressed as part of our recruitment plan.

4.2.2 Elective and Emergency (including stroke) bed capacity

We increased our day case bed capacity in 2013/14 but have experienced a shortage of inpatient surgical bed capacity due to emergency pressures which has resulted in high cancellation rates, particularly for patients requiring orthopaedics and general surgery/urology procedures.

Protection of all surgical beds is being explored, subject to sufficient emergency bed capacity being identified through a combination of additional capacity, reduced length of stay and investment in community services such as early supported discharge.

4.2.3 Magnetic Resonance Imaging (MRI) capacity

Demand for MRI continues to rise and whilst successful demand management would be the lowest

cost solution, MRI is increasingly seen as best practise for increasing numbers of conditions and disease. A business case for further capacity expansion may be required.

4.2.4 Outpatients

The neurology service consultant provision is fragmented and insufficient to meet the rising demand. A short term solution has been approved by the Trust whilst a longer term solution is identified.

Cardiology outpatient demand is not currently matched by the substantive consultant capacity. One appointment has been made, with one more vacancy still to be recruited to.

Gastroenterology and endoscopy capacity may require further support to reduce diagnostic and cancer pathway waits, but further work to improve processes and productivity may also be necessary.

The Ophthalmology department is not meeting elective and outpatient demand. One consultant appointment has been made and a further appointment with short term support may also be possible alongside further productivity improvements.

Oral and Maxillo Facial Surgery and dermatology capacity constraints mean that we will assess demand and capacity with a case for consideration in 2014/15.

Histopathology is currently experiencing consultant shortages, and we will explore local capacity solutions as part of a wider network.

Breast outpatient and surgery demand has increased significantly in recent years, partly due to the age extension on screening. The Directorate is reviewing options to expand capacity.

4.3 Key capacity and demand risks

The three risks to the capacity plan are described in Table 17:

Table 17 - Risks to the capacity plan

Assumption	Risk	Score	Mitigation
Emergency demand will reduce providing capacity to achieve the 4 hour standard and elective capacity	QIPP plans fail to deliver the proposed reduction in demand for emergency care	4 x 5 = 20	Close review of the impact of QIPP schemes on emergency demand with commissioners
The Trust is adequately staffed to deliver the required care and leadership	The Trust fails to appoint key personnel to provide the required workforce capacity	3 x 5 = 15	Recruitment drive to reduce nursing vacancies Offer Trust contracts to more locum medical staff Agreed complement of leadership staff in post by June 2014
Provide cancer treatment within national performance times	Fail to meet the 31 day wait for radiotherapy due to lack of capacity	3 x 4 = 12	We are increasing capacity from May 2015 with the introduction of the new LINAC on the Peterborough City Hospital site.