Colchester Hospital University NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

Colchester Hospital University 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):

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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)*	

Signature

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	

Signature

1.2 Executive Summary

The Trust recognises that the next two years are fundamental to it emerging from being placed in special measures and recovering to a position where it is able to assure the provision of high quality health services within a financially sustainable health economy and able to live within its own means.

It expects to achieve this through focusing in a number of areas, specifically

- *Establishing a clinically led organisation*
- *Developing and implementing an overarching quality strategy for the organisation*
- *Working closely with stakeholders and providing assurance on progress with a number of qualitative agendas*
- *Ensuring the Board of Directors and the Council of Governors are assured as to the delivery of the detailed plans and the delivery of quality health services and that the Board is able to assure partner organisations of progress and the quality of services delivered*
- *Being paid appropriately and fairly for the work we undertake, seeking clarity where needed from commissioners as to the services they expect to commission.*

Performance metrics

The Trust expects to deliver against all of its qualitative performance metrics in 2014/15. There remains some risk that the methodologies currently used to monitor and record these metrics are flawed and these are being reviewed both internally to the Trust and using independent bodies.

Where errors are found the Trust will meet its duty of candour by declaring any such shortcomings and resolving them quickly.

Key changes in service delivery

Over the course of the next two years there are some fundamental changes that are being made to the manner in which services are being provided by the Trust. Including:

Transferring services from Essex County Hospital to the main Colchester General Hospital site and agreeing the future for the Essex County site.

Transferring pathology services to a private sector provider with whom the Trust has an equity stake.

Changing the Trusts Patient Administration System and some other associated clinical systems as well as developing "order comms" to allow the electronic ordering and tracking of diagnostic tests.

The delivery of a 10% efficiency programme over the next two years will require different ways of working. With change comes risk and the Trust will manage the changes with a focus on quality.

Living within our means

The Trust has not set a balanced financial plan in 2014/15; however it expects to be back in financial balance by the end of 2015/16.

The Trust recognises that delivering a £8.1 million deficit in the first year of the turnaround is not ideal; however its delivery of real cost improvement plans in recent years has been in the region of 1%. The Trust expects to maintain its Continuity of Service Risk Ratio (CoSRR) above a rating of 3 throughout its turnaround. The Trust has set itself an expectation that during 2014/15 its distance from financial balance will not deteriorate and that productivity and cost improvements in excess of 4% will be delivered.

The £8.1 million deficit includes non-recurrent turnaround and development costs in the region of £3.1 million with the remainder £5 million part of the recurrent position. The Trust is aiming to resolve the

underlying position through the delivery of a FYE 6% cost and productivity improvement programme in 2014/15. All things being equal, delivering the programme in this way will deliver a break-even position in 2015/16. Financial summary

The Trust is committed to delivering its change agenda and re-establishing financial balance and a sustainable financial position over the next two years. It expects to achieve this despite planning for the £8.1 million deficit in 2014/15. The identification of the Cost Improvement Programme for 2014/15 is also behind plan with key areas of focus only just identified.

Although the analysis shows that during 2014/15 a positive continuity of service risk rating of "3" can be maintained, by the end of the financial year, the Trust is only £0.6 million inside the required metric albeit with a cash position around £5 million ahead of this expectation. Further mitigation around reducing the level of stock held is planned as well as finding alternative financing methods for replacing medical equipment.

FY	2011/12 Actual £m	2012/13 Actual £m	2013/14 Forecast £m	2014/15 Plan £m	2015/16 Plan £m
Operating Income	244.1	257.5	266.8	265.9	264.4
EBITDA / %	23.2	21.5	12.0	6.1	15.9
	9.50%	8.35%	4.50%	2.29%	6.01%
Surplus / %	12.3	9.1	(0.5)	(8.1)	0.0
	5.04%	3.53%	(0.19%)	(3.05%)	0.00%
Capex	23.6	8.0	27.4	12.7	9.0
Cash for Liquidity purposes	27.6	35.4	13.2	0.6	0.6
CIPs	14.5	4.4	7.0	11.0	12.8
Revenue Generation	n/a	2.2	2.7	2.1	-

The chart below shows a pictorial analysis of the movement from the forecast £0.5 million deficit (before impairments) and the derived plan for 2014/15

The key element of delivery is the cost improvement programme of £11 million. Areas of focus are being identified with an expectation that schemes in excess of the £11 million are put in place. The final position will be completed by the end of June.

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1.3 Operational Plan

Context

2013/14 has been a difficult year with significant adverse criticism from regulators and commissioners.

The Keogh Review in February 2013, reported in July 2013, was followed by the CQC investigation into the management of cancer pathways which resulted in a report in November 2013. As a result, the Trust was placed in special measures by Monitor in November 2013. External scrutiny of the Trust continued and the subsequent NHS England immediate review of all cancer services that reported in December 2013, found some shortcomings in cancer pathways.

The system and governance failure highlighted by the series of external reviews is now encompassed by a turnaround programme that not only looks to resolve the qualitative issues but also seeks to resolve a financial deficit arising predominantly from:

The need to fix the qualitative issues Emerging downsides of business cases The 4% real terms reduction in tariff in 2014/15 and beyond

In the latter half of the financial year the Board of Directors was reconstituted to include a number of interim directors, including the Chief Executive, Finance Director and Chief Operating Officer, together with a new HR Director, new Nursing Director, an interim Turnaround Director and four newly appointed Divisional Clinical Directors.

In addition to placing the Trust in special measures, Monitor as the regulator require the Trust to resolve and address some discretionary requirements

(i) Governance breaches relating to the cancer pathway

(ii) Governance breaches relating to Board effectiveness

(iii) Implement programme management and governance arrangements to enable the delivery of the requirements

The Short Term Challenge

Response to context

The Trust has a key short to medium term objective to emerge from special measures as well as to deliver long term financial and service sustainability.

Notwithstanding the specific requirements of Monitor as the Trusts regulator, the Board has agreed that in order to achieve its vision of "becoming the Trust that patients, carers and staff would recommend 100% of the time to family and friends" to focus in a number of areas:

Providing the best NHS care for our patients Realising the potential of our workforce and being a great and safe place to work Exceeding all local and national targets for service delivery Achieving the best in NHS care at best value Becoming an exemplar hospital which supports and advises other healthcare providers both locally and nationally Achieving innovative and academic excellence by expanding the boundaries of healthcare

This plan in addition to describing how these requirements will be delivered, will focus on the actions

arising from

(i) an emerging organisational development strategy

(ii) overarching clinical and quality strategies including the management of complaints and serious incidents

(iii) the implementation of the two year financial plan

(iv) development of risk management systems

(v) reviewing and improving Board assurance

Commissioner expectations

North East Essex CCG

The North East Essex Clinical Commissioning Group has identified the following major priority areas, building on their 2013-18 strategy:

Urgent and emergency care Integrated care End of life care

The CCG contributes significantly to the Essex wide financial surplus. Comparative data suggests an underinvestment in acute services in favour of care closer to home. The CCG is currently over target against its "fair share" allocation.

Urgent and emergency care

The focus for the CCG is in creating a better aligned model of emergency care, recognising the CGH Emergency Department (ED) as being at the core of the Emergency and Urgent care system and developing a wider infrastructure with multiple providers. The CCG stated intention is to explore "the feasibility of urgent care centre for 2015. This would be an integrated Urgent Care Centre at the front of A&E in partnership with existing providers. The CCG have identified a need to develop an urgent care centre that is integrated with A&E and its staff. CHUFT as the local DGH provider of A&E services have been identified as a key partner to develop an UCC integrated with A&E and community services."

The Trust's response is to work with the CCG led Urgent Care Strategy Board to develop and implement the plan to achieve this intention. In vacating the old Pharmacy area the Trust has now identified an important location for future infrastructure adjacent to the ED to develop the elements of the urgent and emergency care service. A joint capital investment plan to develop the appropriate facilities will be agreed with the CCG and other partners.

Better Care Fund / Care Closer to Home / Integrated care

The CCG is committed to a strategy of competitive procurement for a range of services that are considered to be most appropriately delivered in a community setting. This includes services provided by the Trust, as well as community services provided by others including Anglia Community Enterprise (ACE) and North Essex Partnership Foundation Trust. (NEPFT)

Within the expected procurement there are a number of potential service „bundles", including community beds; community gateway services/virtual wards; community based adult and elderly mental health; re-ablement services; and planned care. The Trust is a major provider of services included in the planned care bundle, which is likely to include aspects of musculoskeletal services, ophthalmology, audiology, dermatology, cardiology and neurology.

The current CCG expectation is that the new contractual arrangements for these service bundles will

commence in October 2015.

The Trust believes it is a natural provider of these services and will revisit its plans in order to develop potential mitigating opportunities and improvement plans against any downside

Scenario.

In recognition of the re-ablement work to be undertaken, a marginal activity increase of around 1% has been built into the Trusts assumptions for the year that maintains the Trusts turnover at or around 2013/14levels

End of life care

The health economy made considerable progress in 2013/14 in improving provision and access to end of life care. A single point of access to end of life care has been established.

The Trust is working with North East Essex CCG in developing additional plans for services on this pathway and working with them in delivering care closer to home

Specialised Commissioning strategic development

Commissioning of the Trust"s „specialised services" is coordinated on behalf of the NHSE Essex area team by the NHSE East Anglia area team.

In developing its five-year strategy for specialist services NHSE has made explicit its intention to oversee the concentration of specialised services into fewer compliant specialist sites, and in doing so to eliminate the many hundreds of derogations from the core service specifications of the current configuration. The desired outcome is that in concentrating services into larger centres of excellence, world class outcomes can be achieved.

At present the Trust derives £25.7m (10.5%) of its income from specialised services. The major clinical services provided are: Renal Services, Neonatology, Radiotherapy, Chemotherapy, Cardiology Implants, Vascular Surgery, National Screening Services (Breast, Bowel, Vascular and Cervical), HIV services.

In the 2013/14 commissioning round the Trust had two areas of derogation approved relating to HIV services (Out of hours cover) and chemotherapy (electronic prescribing). These derogations are being addressed.

The approach by NHSE to the rationalisation and concentration of services is, as yet, unclear and as such, the impact on the Trust is difficult to assess.

The Trust aspires to maintain its involvement with specialised services and will be working with NHSE to ensure that the services we provide meet the specification standards and deliver excellent care to the residents of the Essex and Ipswich & East Suffolk CCGs.

A particular area of focus for the Trust following the expansion and development of the radiotherapy centre on the Colchester General site is to establish itself as a centre of excellence for cancer care with surrounding commissioners. The achievement of this ambition has been compromised to some extent by the events in 2013/14 and hence the need to re-engage with stakeholders and to renew the Trust"s reputation amongst its patients is a key area of focus.

The Trust is working with the specialist commissioners and Ipswich Hospitals NHS Trust to resolve residual issues following the centralization of major vascular surgery on the Colchester site.

Essex review of acute providers network

The Chief Executives of the five Essex acute provider FTs and Trusts have convened a working group to look at how services can be planned between sites to ensure good access to specialised services for Essex residents, and sustainable local acute services.

The Trust expects to be a good corporate citizen in this regard and is actively engaging in this review. The Trust believes that the services it provides should be of high quality and sustainable especially in light of the workforce and financial challenges.

Where the Trust has too small a population of patients or insufficient workforce to provide a safe, high quality service, it will look to partner with neighbouring organisations. The Trust has aspirations to provide Stroke, Urology Cancer and specialised Rectal cancer surgery services, amongst others to a wider population.

A Focus on Quality

Recognising the identified performance issues over the last year, a focus on quality and the development of a clinically lead organisation is a fundamental item for delivery during 2014/15.

Quality goals as defined by quality strategy and quality account

Trust Quality Strategy priorities for 2014/15 and 2015/16

The recently reviewed Quality Strategy focusses on how the Trust will deliver against the three pillars of Quality – patient safety, patient experience and clinical effectiveness.

Following the Keogh review, the Trust identified specific priorities:

Priority 1 – Deliver safe high quality patient care

To improve learning from incidents

To improve the recognition of and response to deteriorating patients

Action plans are in place for the Trust to be able to deliver and assure these priorities.

Priority 2 – Improve patient experience

We understand that the experience of healthcare for service users is dependent on the relationships they foster with health professionals. Part of providing a high quality service ensures that service users have trust and confidence in us and that they experience kind, compassionate and competent care and treatment. We aim to improve the experience of service users:

We will:

- *Improve the way we communicate and ensure that respect, dignity and compassion are at the heart of our relationships with service users;*
- *Improve the ways in which we communicate with each other, from service to board, from an individual to a whole systems level and provide safe handover of care;*
- *Provide appropriate, kind and effective care for those with learning and communication disabilities;*
- *Ensure that we are responsive to inpatients" personal needs;*
- *Listen to concerns and complaints, ensuring that we respond, act upon and learn from them;*
- *Improve people"s experience of outpatient care;*
- *Reduce the number of appointments that are cancelled;*
- *Reduce waiting times for Emergency Department care;*
- *Improve women"s and families" experience of maternity care;*

- *Provide better care for people at the end of their lives;*
- *Improve the experience of care for people with mental illness;*
- *Ensure all members of staff have received appropriate training in equality and diversity issues and customer care;*
- *Ensure that the transfer of our patients" care from the hospital to primary care is done as safely as possible, with no disruption of the patients continuing care*

<u>Priority 3 – Listen, support and engage our workforce</u>

We will:

Implement change programmes in line with those recommended by Deloites and Keogh to improve the organisational capability through engaged staff; and

Enhance the Trust's reputation.

Through Refreshing and expanding the reach of the existing "At Our Best" programme; (planning underway for implementation to commence May/June 2014); Building engagement and learning into our culture through practical and developmental support for the turnaround programme (underway); Effectively managing reputational risk during the coming months where a number of reports, visits and inspections are due (media strategy developed March 2014);

Proactive media plan; (including social media) – target one positive news story placed every week; Developing and equipping internal audiences (including volunteers, Friends, Governors) to act as advocates and ambassadors;

<u>Priority 4 – Improve our service delivery performance</u>

In concert with commissioners we will expand the use of Care Bundles in the emergency pathway to ensure consistent delivery of care

<u>Priority 5 – Improve our information technology and facilities</u>

The Trusts capital programme is focused largely on the delivery of improved facilities on the Colchester General Site, with services being centralised from Essex County Hospital during 2014/15. A review of residual services provided at Essex County will be undertaken and the future for the site will be agreed with local stakeholders.

The Trust is also planning to go live with a new clinical portal during the second quarter of the year including the development of order comms and a new Patient Administration System.

The improvement of data quality is another key area of focus. The implementation of the clinical portal, while a risk in terms of on-going reporting, also presents an opportunity for the Trust to improve.

<u>Priority 6 – Working with partner organisations</u>

We will ensure we are appropriately positioned for local decisions when complementary services currently provided by alternative providers are let. We will also place ourselves to demonstrate a competitive advantage in order to retain critical services that we currently provide.

Collaborate on a pan-Essex review on the sensibility of specialised and sub-specialised services e.g. urology, vascular, radiotherapy and those services currently provided by a single-handed practitioner.

Ensure adequate local provision is in place for services that we can no longer sustainably provide, such as

spinal and orthodontics.

Build on our collaboration with patient representatives such as Healthwatch ensuring that the patient's voice is heard loudly and clearly at each stage of the decision-making process.

Notwithstanding the above actions, the Trust is committed to being paid fairly for the services it provides for the residents of North East Essex as its core population and for the patients it treats as part of its contribution towards specialised service provision. This not only will contribute towards the Trusts overall financial sustainability it will also ensure that the sector does not "overtrade".

Priority 7 – To achieve sustainable financial balance

More detailed arrangements as to how the financial pressure will be managed over the next two financial years are set out in more detail in the Cost Improvement and Finance sections of this plan.

In summary, the financial pressure arising predominantly from the qualitative improvements required means that a two year programme is being developed to return the Trust to a position of some financial stability. Assuming delivery of a challenging cost improvement and productivity plan, the two year plan described expects a deficit of £8.1 million in 2014/15 followed by a break even position in 2015/16.

QUALITY ACCOUNT

Quality CQUINs

The Trust is negotiating the Commissioning for Quality and Innovation (CQUIN) arrangements with the CCG and specialised commissioners. The total value of the CQUINs in 2014/15 is expected to be circa £5.5m (2.2% of the Trust's clinical income).

The mandated CQUINs account for 0.5% of Trust income.

The Trust's financial income model, driven by historical delivery assumes that 85% of potential CQUIN income is recovered.

Quality concerns and associated actions

Keogh – and action plan

In February 2013, as part of the government response to the Francis reports into Mid Staffordshire Hospitals, the prime minister announced that Colchester was one of fourteen acute Trusts with higher than expected SHMI or HSMR that Sir Bruce Keogh, the NHS Medical Director, was to scrutinise.

The Keogh report published on 16 July 2013 identified a number of areas for urgent action and improvement. As part of the publication of the report a risk summit required the Trust to produce and agree with the parties to the summit an action plan to address the deficiencies and concerns identified.

The priority areas identified as requiring attention were:

1. Quality Focus - the Trust needs further development and an underpinning strategy.

2. Clinical Leadership - The Trust needs to empower clinical leadership through an improved governance and organisational structure, and leadership development.

3. Deteriorating Patient - Processes to recognise and escalate deteriorating patients are not operating effectively as they could

4. Radiology Escorts - The Trust's policy on radiology escorts is not being consistently applied.

5. Communication & Engagement with Staff - The Trust needs to continue to listen to staff.

6. Staffing and Skill Mix - Nursing staffing levels and skill mix review needs to be regularised

7. Complaints - Complaints management processes need urgent improvement

8. End of Life Care - Health community review of End of Life Care provision has started but needs early resolution.

A „Keogh Action Plan" to address these issues was developed and agreed with regulators, NHS England, and the local CCG in July 2013.

A revisit in February 2014 recognised the `green shoots" of progress against our agreed action plan. 33 areas were assessed with the majority being partially assured and where further embedding needed to take place. 6 areas were not assured, including continued development of a quality focus, absence of clear prioritisation and pace of change and patient follow and management between A&E and EAU.

The Trust will continue to embed and assure the good practice changes that have been instituted in response to Keogh.

<u>CQC Cancer Review and action plan</u>

In August 2013, as a consequence of actions by some members of staff acting as whistleblowers, the CQC commenced an investigation into the management of cancer waiting times within the Trust.

The CQC investigation reported in November 2013 and concluded that there had been inappropriate adjustments to a sample of patient pathways which may have jeopardised the outcome for individual patients.

Specific actions were required by the CQC and are being taken by the Trust in relation to the patients who had formed part of the group identified by the CQC as being at risk of sub-optimal care.

As a consequence of the CQC investigation, a number of other enquiries and investigations were established, specifically, NHS England commissioned an immediate review of all fourteen cancer pathways used in the management of patient care at Colchester. Each cancer pathway was examined by an external team made up of senior clinicians including a cancer specialist, GP, senior nurse, cancer managers and other support staff. The teams looked at the clinical quality of services, waiting time information, treatment outcomes and the overall organisation of each cancer specialty. The report of this review was published by NHS England (NHSE) on 19 December 2013. Concurrently with the NHSE review, the Trust invited the NHS Intensive Support Team in to review the Trust's cancer pathways. The IST looked at whether any aspects of the current processes for the cancer pathways at the Trust placed patients at risk and formulated an action plan for improving these processes. The review team also published its final report on 16 December. As a result of the CQC report, the NHSE pathway review and the NHS IST review, the Trust has agreed a consolidated action plan which encompasses all the actions and areas for attention identified. The action plan is being implemented and progress co-ordinated through the Trust"s Cancer Group. The Trust has appointed a very experienced cancer manager to act as Project Director overseeing the action plan and guiding and supporting managers, clinicians and staff in implementing sustainable improvements. The action plan is internally assured through the Board"s assurance processes and is shared with the CCG and Monitor as part of their oversight of the Trust.

Separately to the two externally-led reviews, the Trust Chair asked the Board"s Senior Independent Non-Executive Director, to commission an independent investigation into how the Trust responded to concerns about cancer waiting times. This has been jointly led by Professor Pat Troop, former NHS Deputy Chief

Medical Officer, and Carole Taylor-Brown, a former PCT Chief Executive. The review specifically seeks to:

establish whether or not there may be a case to answer under the Trust's Disciplinary & Performance Management Policy & Procedure by any Trust employee concerned in either the handling of, or the response to, any of the concerns that were raised by any route consider the effectiveness of the Trust's whistleblowing policy and its implementation, and any wider issues around bullying and harassment that are relevant to this matter consider if the Board's approach to assuring itself was adequate and how the Board's assurance processes could be strengthened to ensure it is alerted to such serious staff concerns more promptly consider what lessons can be learnt from the handling of the concerns raised, and what could be done differently in the future

The report from this investigation was released to the Trust Board and Monitor in early March 2014.

Chief Inspector of Hospitals Review – May 2014

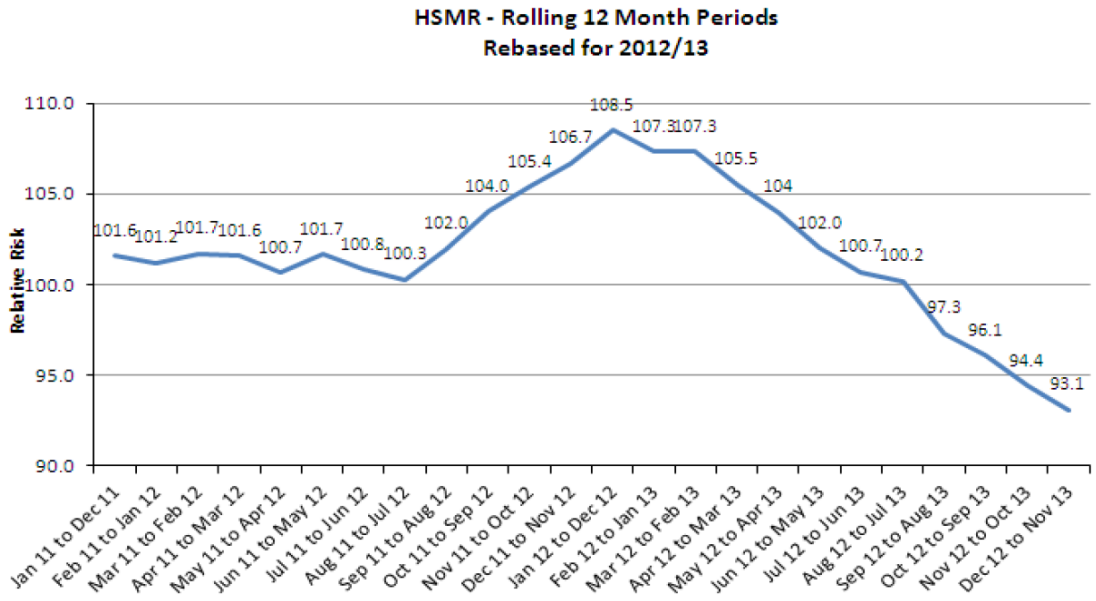
The Trust has been notified that the programme of reviews established under the aegis of the Chief Inspector of Hospitals will include an inspection visit to Colchester Hospital in May 2014.

Managing Quality

Mortality

HSMR

The following chart shows the 12-month rolling HSMR position, including data to November 2013.



SHMI

The SHMI for NHS Northeast Essex has been an outlier since the inception of this metric. The Trust and PCT (now CCG) together with the local hospice and social care partners have worked together to improve a shared understanding of the drivers behind the outlier position.

This underlying consistently high SHMI was the trigger for the Keogh scrutiny in 2013.

The Trust has worked closely with CCG commissioners and Dr. Foster Intelligence (the company the produces HSMR and SHMI aggregated performance data) to try to understand the extreme discrepancy between HSMR and SHMI performance. Although some is explained by palliative care coding a significant

proportion still needs attention.

Mortality performance is routinely reported by the Medical Director and Chief Executive to the Board; the Board actively debates mortality issues. The Board's Quality & Patient Safety Committee receives and reviews detailed analysis of mortality data.

The Trust has a well-established clinically-led Mortality Review Group which meets weekly to consider and implement learning from patient deaths. At each meeting 10% of deaths in the preceding week are randomly selected and the responsible consultant and matron are invited to present the case to a group of clinical peers, GPs, executives and clinical safety managers.

The Trust has well-established support and data interrogation functions to investigate mortality data and work with clinical teams where performance suggests areas for further work. The Trust operates a monthly alerts review process using the Dr. Foster Intelligence tool to identify diagnosis or procedure groups where the relative risk is higher than expected or where there is an emerging risk.

Cancer Access Times / Pathways (NHSE review and action plan)

In response to the CQC and NHSE reviews of cancer services and cancer pathways, the Trust has implemented a significant number of measures to ensure cancer pathway compliance.

The Trust has reviewed all documented cancer pathways which have been externally reviewed and certified as acceptable. As part of its new role, the Trust Cancer Board is now regularly „calling in" pathways for scrutiny and compliance assessment.

The Trust has invested in clinical and non-clinical posts to increase the capacity where necessary and to support pathway management.

Data Quality Assurance

During 2014/15 the Trust will fully implement electronic patient pathway tracking using the Somerset Cancer data system. This will ensure that reliance on paper based systems in tracking patient waits is eradicated, and that all changes and transactions on patient pathways are logged and auditable. The Somerset system is entirely compatible with the National Cancer Waiting Times database, and will help ensure the integrity of performance data reported by the Trust to commissioners and the public.

18-weeks Referral to Treatment (RTT)

During 2014/15 the Trust will review and assure all of the administrative and clinical processes that operate in ensuring that patients' experience of access to elective care is delivered within the 18 weeks from GP referral to treatment, in line with the NHS Constitution rights.

The Trust has commissioned support from the DH Elective Intensive Support Team to review all stages of the patient pathway management, and will be rolling out a Trust-wide training programme to reflect the Trust Access Policy.

The Trust failed to achieve the overall admitted standard since November 2013 and is at risk of not achieving the admitted standard for Quarter 4. This is the first time in over 4 years that the Trust has not met the standard. The specialities that did not meet the admitted standard were Dermatology, Trauma and Orthopaedics and Urology.

An RTT Steering Board is overseeing the implementation of a detailed action plan to turnaround performance.

Managing Emergency Care Targets

Emergency Department Capacity

The Emergency Department (ED) was built over 20 years ago to accommodate 40,000 patients a year; the number of patients treated last year was in the region of 75,000. Work commenced in August 2013 to enlarge the Emergency Department, and as a result the capacity will increase as follows:

	Previous capacity	Capacity from April 2014
Resus	3	6
ADULT		
Majors	13	20
Minors	5	8
Triage	3	5
Early assessment	-	1
CHILDREN		
Treatment	3	4
Triage	-	1
Observation chairs	In waiting area	4

The layout of the department will also have changed to improve patient pathways, enhance experience and improve supporting facilities. The increased capacity will enable a much improved oversight of the department, with patients being assessed and treated in the most appropriate facility.

ED resourcing

During 2014 it is planned to recruit 10 additional nurses for the Emergency Department, and a further 10 paediatric nurses to support the Paediatric Emergency Department and Children 's Assessment Unit.

ED performance

For the first time in over 3 years, the Trust under-achieved the 4 hour standard for Q3 in 2013, achieving 92.6% against the 95% national standard. Performance deteriorated further in January 2014, but improved in February 2014 to 95.2%.

Despite the dip in 4 hour performance, the Trust has maintained its performance against the key Clinical Quality Indicators (CQI) for both its 15 minute triage assessment and 60 minute treatment by a doctor. These are important patient safety indicators, which demonstrates that the clinical evaluation of patients, has been undertaken responsively when the patient arrives in the Department, in order to prioritise clinical urgency and commence treatment.

EAU process changes

Alongside the additional capacity in the ED, the EAU has been reconfigured to improve patient flows and to improve the cohorting of patients, through initial assessment and diagnosis to either discharge or admission to an acute bed.

Early in 2014/15 the Trust will establish a Surgical Assessment Unit on one of the emergency surgery wards. This will ensure that patients identified in A&E as requiring surgical intervention are directly admitted to the most appropriate bed rather than through the EAU. This will both ensure swifter surgical assessment and consequent intervention. It will also relieve some of the day-to-day pressures on the

EAU, by taking a cohort of patients out of EAU.

Discharge and on-going care

Since December 2013, the Trust has been actively working with partner organisations to improve interface working and patient assessment in order to improve discharge planning for patients requiring on-going care with Anglia Community Services, Mental Health and Social Services.

Emergency and Urgent care model

During 2014/15 the Trust will work with the CCG and partners in the urgent and emergency care services in North East Essex to develop plans for an integrated service model. The CCG are proposing that the service hub for the urgent and emergency care system should be based on the Trust ED, with a single point of access „front end" assessment provided adjacent to the ED to support patient streaming to the most appropriate service to meet their needs.

24/7 staffing

Nursing dependency review (AUKUH, etc.)

In 2013/14 the Director of Nursing and Patient Experience conducted a comprehensive review of nurse staffing and patient dependency levels in all nursing areas. As a consequence new model target nurse staffing establishments have been identified for all clinical areas.

The impact of the review has been to establish a significant number of additional nursing posts across the Trust in 2014/15 and to plan for an increase of further posts in 2015/16. The Director of Nursing and Patient Experience has confirmed that risks associated with this phased implementation will be appropriately managed.

Consultant delivered emergency care

The Trust aspires to have early Consultant Assessment of all new patients attending the Emergency Department and within 12 hours of admission to an inpatient bed.

During 2014/15 we will focus on how to extend the hours of consultant delivered emergency care sustainably 7 days a week.

Charitable giving

In line with the Trust's ambition to develop its position within cancer services in the local area, the Trust Charity is developing a plan to attract £4.5 million of donations in order to increase the footprint on the Colchester General site.

The plan comprises three distinct phases:

Planning Phase : February to August 2013 Leadership Phase & Asking Phase : September 2013 to February 2015. Completion Phase : March and April 2015

The Campaign Executive Committee, chaired by Sir John Ashworth, has been enlisted and CEC members information events are being rolled out. Applications to Charitable Trusts are being made and it is anticipated that a lead gift of £0.5m will come from a major Trust. The Community Fundraising phase targeted to raise £700,000 over 2 years and will begin in 2014.

Board assurance (ref. Monitor's quality governance framework)

The Colchester Hospital University NHS Foundation Trust (CHUFT) believes that the role of the governing

body is pivotal to the success of the Trust. We believe that an effective governing body is vital not only to provide legal accountability, but to make sure our organisation keeps working within the framework that it is licensed to provide.

The governance arrangements will lead CHUFT and ensure that it documents the mechanisms by which the Board will ensure that the staff employed within the Trust are appropriately trained and supported to operate effectively and deliver the organisational objectives. Governance will also ensure that the systems and policies that are in place are reviewed for fitness for purpose in minimising any gaps in assurance, through the Assurance Framework.

The Assurance Framework describes the organisational key priorities, identifies potential risks to their achievement and gaps in assurance on which the Board relies. It will be considered in conjunction with the Trust's Risk Register which provides detail on operational risks and action plans to address these. This framework provides the structure against which the Board can fulfil its responsibilities and will be reviewed regularly.

Monitor, the Independent Regulator, requires Chief Executives of NHS Foundation Trusts, as Accounting Officers, to sign an assurance statement, the Annual Governance Statement on behalf of the Board to assure stakeholders on the robustness of internal financial controls. Stakeholders include patients, relatives and carers, the public and partner NHS organisations. This duty expands beyond financial assurance to the production of an Annual Governance Statement covering wider organisational controls, including risk management.

The 1999 Health Act and subsequent Acts (2006 and 2012) placed a statutory duty of quality upon NHS Trusts. Integrated governance is the framework by which the Trust fulfils this duty.

The Trust has developed integrated governance further to ensure that decision making is informed by intelligent information covering the full range of corporate, financial, clinical and information governance. Integrated governance enables the Board of Directors to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

The CHUFT Governance Strategy and Assurance Framework aim to achieve convergence of the elements of governance.

<u>Board Assurance Framework</u>

The assurance framework is a simple but comprehensive method for managing the principal risks to meeting the Trust's objectives.

The Trust's Board Assurance Framework will:

- *cover all of the Trust's main activities;*
- *identify the objectives and targets the Trust is striving to achieve;*
- *identify the risks to the achievement of these objectives and targets;*
- *identify and examine the system of internal control in place to manage the risks;*
- *identify and examine the review and assurance mechanisms which relate to the effectiveness of the system of internal control;*
- *record the actions taken by the Board to address control and assurance gaps.*

The Trust's Assurance Framework makes it possible for the Chief Executive and the Board of Directors to demonstrate that the Board has been properly informed about the totality of risk and is able to make appropriate declarations and self/certifications.

The Board Assurance Framework is based on six key elements:

i) Clearly defined principal objectives together with clear lines of responsibility and accountability;

ii) Clearly defined principal risks together with an assessment of their potential impact and likelihood;

iii) Key controls by which these risks can be managed;

iv) Management and independent assurances that the risks are being managed;

v) Reports to the Board that enable members to agree as to the level of assurance on the controls in place;

vi) Board action plans which ensure the delivery of objectives, the comprehensive control of risk and reduction of gaps in assurance.

Programme Management Office

In December 2013 the Trust established a Programme Management Office (PMO), initially under the direction of the Turnaround Director, to support the Board in controlling the many projects of work that both support the turnaround in areas where the Trust had difficulties, and to give structure to how the Trust manages assurance on performance in the future.

The PMO has two key strands one focusing on the qualitative improvements identified already and the second focusing on assuring the financial turnaround and the delivery of plans to achieve the Cost Improvement Programme.

Board Committee Structure

In October 2013 the Board of Directors approved a number of changes to the Board and Executive committee structures, including changes to the responsibilities of some assurance committees, and the establishment of a new People and Organisational Development Committee. The new Board assurance structure now comprises:

- *Audit & Risk Committee*
- *Quality & Patient Safety Committee*
- *Finance Committee*
- *People & Organisation Development Committee*

Each committee is chaired by a designated non-executive director and meets monthly (other than the Audit Committee which meets quarterly

The role of the Quality & Patient Safety Committee

The Quality & Patient Safety Committee scrutinises and interrogates the Trust's performance in relation to the quality of services provided, specifically focusing on testing and being able to give assurance to the Board that the three domains of quality – patient safety, patient experience, and clinical effectiveness – are being delivered.

Clinical Leadership

In 2013/14 the Trust made significant changes to the leadership arrangements within the divisional structure placing four Divisional Directors in explicit leadership roles for their divisions with a (non-voting) seat at the Board of Directors. In addition to the Medical Director and Director of Nursing and Patient

Experience, the Board therefore now has four more senior clinicians present at its meetings. These Divisional Directors have time set aside each week to deliver their clinical leadership roles, with their clinical duties being backfilled and supported accordingly.

Operational requirements and capacity assessment

Cancer centralisation to CGH

During the first half of 2014/15 all oncology services will be re-provided from Essex County Hospital onto the Colchester General Hospital site. The new radiotherapy centre opens in May 2014 with radiotherapy services completely transferring to the main Colchester General site by the end of July 2014.

Inpatient capacity will transfer by the end of August 2014 following a major refurbishment; with outpatients along with their clinical administrative functions transferring in the same timeframe.

The move of the inpatient facilities will allow for improved patient environment and for the integration of oncology and haematology inpatient beds.

Essex County Hospital

With the oncology move the Trust's long held plans to vacate the ECH site move forward. In the first quarter of 2014/15 plans will be developed for the transfer of other services currently provided at ECH to alternative locations, this includes transferring some services to CGH, and some into alternative community settings.

This move is integrated with the Trust's ambition to support the CCG objective of delivering more aspects of secondary care in facilities closer to home.

The subsequent future for Essex County will be discussed with stakeholders.

Better Care fund /Care closer to home /Integrated Care Model

One of the key CCG strategic objectives is to focus on whole pathways of care and as far as practicable for those pathways to be delivered in community based settings.

In the period 2014/15 to 2015/16 the CCG has described its intention to subject a number of services, traditionally provided by a range of providers including the Trust, to a competitive procurement. These services include a range of clinical specialties and service that operate largely under an elective ambulatory care model. For the Trust this includes Musculoskeletal services, including aspects of orthopaedics, rheumatology, neurology and pain management; ophthalmic services; ENT/Audiology services; Dermatology; continence; urology and falls.

The CCG intend to refine the detail of the bundled pathways in Q1 2014/15, with a procurement process in the remainder of 2014/15, leading to an award in Q1 2015/16 and service start in Q3 2015/16.

It should be noted that a number of the services affected by the CCG care closer to home procurement are currently delivered from the ECH site. Aligning these initiatives will form an important part of the continuity of patient services in these specialties.

The Trust will develop an appropriate response to prepare its services for the competitive procurement and to develop strategic clinical alliances with providers of other aspects of the clinical pathways to ensure a strong position in the competitive process.

Transforming Pathology Partnership

The Trust is embarking on a change programme with regard to the provision of pathology service across

North Essex, North Hertfordshire, Suffolk and Cambridgeshire. The long term financial benefits associated with this change are significant since as an equity stakeholder in the joint venture, the Trust will receive the benefits of both economies of scale and also the benefits of subsequent profits as and when new customers come on stream.

In order to protect services, the Trust has been insistent that appropriate governance and veto processes exist to protect its longer term interests, particularly around its desire to be a major cancer centre.

Workforce

It is explicitly acknowledged in the Trust"s workforce strategy that achieving an appropriate skilled and engaged workforce is achieved by reviewing how work is undertaken, the role of technology, innovation, process improvement, skill improvement and individual performance and motivation to deliver the highest level of performance and effectiveness.

The priorities of the Trust and workforce are:

To implement the recommendations of the external reviews and regulators (Keogh, CQC, and Monitor) that improves the planning and retention of a substantive workforce. To reduce by 50% in the first instance the reliance on temporary resourcing and thereby reduce the risk to patient safety and reduce cost To identify and plan for the appropriate clinical staffing levels to provide safe care at all times To identify strategies to attract sufficient developing talent into the Trust, in conjunction with external partners To provide mechanisms that support a productive and efficient workforce

Ward and Departmental Nursing

As identified in the quality section of this plan, the Director of Nursing and Patient Experience has conducted a comprehensive review of nurse staffing and patient dependency levels in all nursing areas.

As a consequence new model target nurse staffing establishments have been identified for all clinical areas.

This increase in the establishment will present significant recruitment challenges. The Trust will approach this in the short term through

Creating and implementing divisional workforce plans which identify future changing needs of the workforce and internal demographics so we can be better prepared Improving recruitment capability in HR and streamlining all resourcing process starting with the medical recruitment process Target recruitment hotspots and agree focus and approach of campaigns for difficult to fill roles

Review innovations in ways of working and skill mix i.e. more nurse led services which demonstrate career paths for attraction and in the longer term

Build partnerships with overseas learning organisations to develop a rolling programme of middle grade placements (areas of national shortage) Promote the Trust within local schools/colleges, continue to ensure our proven success for trainee placements across all Divisions and support our junior Doctors as ambassadors of the Trust Work with wider economy to share resources across the Trust

24/7 emergency medical staff support

In 2012/13 and 2013/14 the Trust has made substantial progress in increasing the presence of senior medical decision makers in the emergency pathway, including consultant present working in the department:

In order to ensure consistently high quality of clinical decision making and appropriate supervision of the

clinical team, the Trust is investing in:

7-day from 5-day services and extended working day

In 2013/14 the Trust has introduced greater 7-day working in therapies, pharmacy and aspects of radiology focusing on the needs of patients primarily on emergency care pathways. The benefits of seven-day working for patients are qualitative with research suggesting that outcomes are worse for patients admitted over a weekend and that length of stay increases as a result. Research by the HFMA suggests a 2% cost impact associated with the move to seven day working.

Some of the benefits, particularly those in relation to expediting discharge, are dependent on others in the patient pathway being able to provide seven-day cover so that patients can be discharged safely seven days a week. In 2014/15 the Trust will be working with commissioners and partner provider organisations to agree changes across the pathway of care that will extend seven-day working to all key linked services.

The Trust needs to ensure that in developing seven-day models that this is not simply a dilution of the clinical input previously available over five days but is a genuine increase in clinical capacity that will improve the quality of patient care interventions and will expedite recovery and return to patients " normal life.

Research suggests that some patients would prefer hospital appointments to be outside of their normal working days. In response the Trust will be expanding the availability of a range of elective services, including outpatient appointments, some diagnostic testing and elective operations over an extended working day with the introduction of more evening clinics and surgical lists, and potentially over a six or seven-day working week. This will increase the utilisation of space and will also support the potential transfer of services from Essex County Hospital to the Colchester General Hospital and other outpatient clinic sites.

As part of the development of these services the Trust will be validating with the CCG their expectations with regard to 7 day working and confirming their commitment (or otherwise) to this model of care. The potential excess costs of these services will be transparent.

Temporary staffing spend

Reducing our reliance on temporary staffing is a key component of the Trust "s overall strategy both to deliver the undoubted qualitative benefits associated with the employment of its own staff and also the significant financial benefits that will be derived through the reduction in this spend

Strategies to reduce this spend include:

Urgent and specific recruitment into areas of key risk Targeting long term locums and interim staff Moving to Bank as opposed to agency staff Establishing recruitment targets / strategy Establishing long term thresholds for individual temporary staff Reviewing roles of CNS in service delivery Developing assurance reporting

Risks, Mitigations, Downsides and Upsides

Risks

Inadequate Capacity Planning Model in the medium term

The Trust is commissioning a new capacity and demand planning model to forecast capacity needs principally expressed in beds, outpatient clinics and theatre lists. The model will be sensitive to seasonality and variability in demand and productivity.

The data model has been run for 2014/15 based on the commissioning intentions of the CCG and specialist commissioners together with the Trust's assessment of productivity variables. Capacity in 2014/15 is not expected to be a major issue particularly recognising the need to improve productivity around theatre, out-patient and bed utilisation

In the absence of such a model the Trust is focusing its attention on ensuring that current capacity is well utilised and this will form an important element of the emerging cost improvement and productivity programme.

Contingency emergency pressures capacity

The Trust will maintain one ward (34 beds) as a first line contingency capacity that is managed as part of the Emergency Admissions Unit, and would expect this to be routinely opened during Q3 and Q4. The Trust will have capacity for a further 24 extreme pressure beds which will be opened in extreme pressure periods.

History shows that the Trust has adequate theatre capacity with flexibility to, for example, open additional emergency lists at short notice to cope with untoward pressures. For elective work, the Trust has progressively moved to longer operating hours, full day lists and some evening operating. We anticipate further movement in this direction.

Delivering the required cost improvement programme

The Cost Improvement section of this document sets out how the risks associated with non-delivery will be managed.

Turnover in Director and Associate Director posts leads to instability

The Trust is committed to bringing stability to the senior leadership team and has a clearly timetabled resourcing plan that staggers the engagement of the permanent hires and exit of current interim Directors. This focus is similarly adopted for the resourcing of the Associate Director roles.

A senior development and coaching programme is being designed to work in compliment to the formal leadership programmes already commissioned.

Divisional Directors will be given support to tailor and cascade development activity into their Divisions.

The Trust has already instigated a fresh approach to the identification and support of talent management, which will be taken forward and extended.

Local and National Staffing skills shortages

The Trusts is undertaking Local and National HR planning engagement as well as investigating opportunities for overseas recruitment. Turnover is not currently a major issue, however a great deal of focus is underway to ensure control systems such as appraisal are in place.

The Trust has a significant issue in the number of temporary staff it employs and resolving this issue from a qualitative viewpoint forms a material part of the Trusts turnaround.

On-going reputational risks associated with managing clinical and safeguarding issues

In mitigating these risks the Trust expects to meet its mandatory training requirements deliver operational plans to deliver mandatory quality targets. actively manage data quality. deliver its obligations against the recommendations associated with external reviews. comply with CQUIN targets reduce in Temporary staffing levels respond promptly and learn from complaints from patients and staff

Downside Risks and Upside opportunities

Downsides

Information Commissioner fine (up to £0.5 Million)

Cost of Turnaround exceeds the 2.5 million non-recurrent provision in 2014/15

Other unexpected qualitative issues arise

Costs in Divisions and Corporate teams exceeds expectations

Upsides

Successful negotiation of income associated with stroke rehabilitation (£1.7 Million)

Existing plan allows for a 1% contingency for unplanned events

Demographic and activity growth exceeds the level in the plan > 1%

The Trust has applied for revenue and loan capital support from the NHS Surplus Land Growth Efficiency Fund as the site of ECH is eminently suitable for housing development. Such funding will assist the Trust in expediting an early exit from the site.

Lower levels of CIP attrition than planned through OD plans

Bringing forward CIP from 2015/16 to mitigate any 2014/15 shortfall

Cost Improvement Programme

With the qualitative issues identified in 2013/14 and the changes in the executive team in the latter half of 2014/15, the Trust has come late to the development of its cost improvement programme for both 2014/15 and 2015/16.

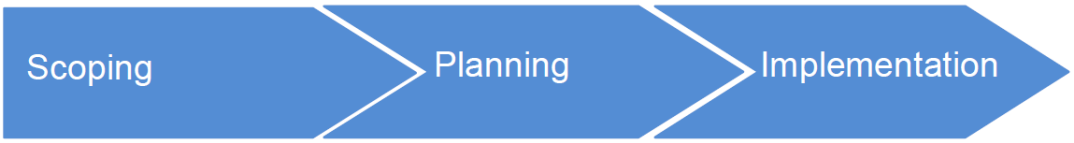
Additional resource has been secured with PWC to support the Clinical and Corporate teams in the identification and development of the plans for CIP delivery.

A key risk for the Trust to manage during 2014/15 is the non-delivery of the cost improvement programme particularly recognizing the relatively low level of cost improvement delivered over the last two financial years. The baseline review undertaken by PWC recognised around 1% delivery. This risk has been mitigated by allocating a Project Steering Group structure led by an Executive Sponsor to each of the 15 proposed CIP work streams.

Notwithstanding this lack of delivery the Trust is planning to deliver a 4% improvement in 2014/15 (with a 6% FYE) along with a further 4% in 2015/16. (10% overall)

Process

The Trust has recognised the linear process associated with the identification and implementation of cost improvements, and has set itself a timeline within which it will deliver against the plan.



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	…	Mar
Scoping											
Planning											
Implementation											

The Trust through the development of its PMO has established a gateway process against which individual divisions will be monitored and held to account for their delivery of the plan.

Recognising the likelihood for attrition, a 5% improvement will be targeted in each of the next two years and the progress against each element of the gateway process will be reduced against standard risk assessments.

The scoping of the size of the opportunity against a number of key areas has been assessed.

The identification process will continue in parallel, as some of the originally identified schemes will be discarded and/or fail to deliver the expected improvement The ongoing identification process will feed into the 15/16 CIPs programme.

It is important to recognise that the trust will not prejudice the improvements in the quality of services being provided as a consequence of the need to identify and deliver cost improvements.

Indeed it expects that in large part qualitative improvement will be derived through the improvements that are identified in a number of areas

Patient experience though initiatives such as the changing of pathways (best practice tariffs) and improving the number of people readmitted Resource deployment brought about by the way we manage our teams and deploy resource across North Essex Improving access to services

Financial Analysis

Context

Despite having delivered significant surpluses in both 2012/13 (£12.3 Million) and 2013/14 (£9.1 Million) this position had been delivered without significant levels of CIP delivery with income and cost control being the largest sources of the in-year solutions

Financial Baseline

As is described in the financial assessment there are a number of pressures facing the Trust in 2014/15 arising from a number of sources. Original estimates validated as part of a PWC baseline review total £28.1 million with the outcome of the review determining that the likely outcome for the Trust in 2014/15 was a deficit (pre-cip) between £16.0 million and £24.4 million.

In setting the financial plan for 2014/15 the Trust established an investment group chaired by the Chief Executive or nominee and taking appropriate clinical advice to ensure sufficient resource has been delegated to the divisions in order to ensure ownership and understanding about the level of resource available to the division in 2014/15 and beyond.

	Best Case	Worst Case	Planning Case
Identified Cost Pressures	(28.1)	(28.1)	(31.0)
Investment Group Challenge	12.1	3.7	14.4
	(16.0)	(24.4)	(16.6)
CIP	5.2	2.5	11.0
Additional Costs of Turnaround	(1.0)	(2.0)	(2.5)
	(11.8)	(23.9)	(8.1)

The size of the management challenge to deliver at least a balanced position in 2014/15 is not underestimated arising from both securing the qualitative gain required of the Trust as well as the historic level of underachievement against cost improvement plans.

Although the Trust has a history of delivering against its financial duties, the Trust does not have a history of delivering against its planned cost improvement programme. This will need to change for the Trust to deliver the expectations described. Appropriate processes have been designed to achieve the expectation.

The Cost Improvement section of this strategy sets out the monitoring and performance management processes that are being designed to support the cultural change needed to deliver an improvement in the region of 10% over the period of this plan.

Contract Negotiations

We hold major contracts with NHS England and North East Essex CCG. Within these contracts there are partner organisations from who we receive income.

The delivery of an appropriate contract value for 2014/15 is fundamental to our success. The Trust's Board approved negotiating stance is to ensure that it is paid fairly for all of the work it undertakes and to work with the CCG in controlling demand.

The Trust takes the view that it is responsible for the price it charges for its services and the CCG as the commissioner is responsible for the demand placed on those services. It is important that in order to ensure resources are available for the provision of quality patient care, the predicted demand for those services is closely aligned with the capacity the Trust is planning to provide. This will ensure that resources are properly planned and best value is obtained for the North Essex Health £.

Where services are not appropriately commissioned the Trust will seek clarity from the CCG as to how the patient pathway will be maintained in order to ensure that patient safety and the quality of care for our patients is maintained.

The Trust will actively engage with commissioners to ensure best value is obtained for our population and will seek to establish focus groups that look outside of the hospital and to other partner health organisations (NEPT and ACE in particular). This engagement will also seek to ensure compliance with qualitative standards such as the A&E 4 hour target and the 18 week referral to treatment standard.

Budgetary Control

The setting of financial plans for 2014/15 is predicated on establishing real expenditure plans in line with the 2013/14 outturn position and then overlaying the changes expected in 2014/15 over the top of these assumptions.

Each Division, whether they be patient facing or Corporate will be expected to manage their financial affairs and deliver the appropriate qualitative care or service within this overall cash envelope.

This process has in effect resulted in budgets being rebased based on the 2013/14 outturn position.

A memorandum of understanding will be developed with each division in order to understand and gain acceptance of the deliverables expected for the cash spent.

In the event that Divisions are not able to live within the delegated expenditure envelope then they must in the first instance and before the extra costs are incurred make a submission to the investment group citing:

The expected qualitative gain The expected delivery and timing of recruitment

The clear expectation is that in setting financial plans in this way we expect to improve accountability and gain increased ownership of the Trust's financial position.

Cost Improvement Programme (CIP)

We know as described earlier that 4% productivity is required of the Trust in 2014/15 and that this is likely to continue for the foreseeable future. This productivity gain will be achieved through a variety of means including:

Real terms improvement in productivity (more activity for less cost in line with CCG contract expectations) Reductions in staff numbers Reductions in temporary staff usage and saving the commission Reductions in temporary staff and losing the post Procurement and rationalisation Maintaining activity while reducing capacity

In the main our CIP ambitions should play out through reduced costs and not through increased income. Where increased income is due to the Trust but for which it has historically been unable to secure agreement with commissioners then this will support the overall position and will be used to offset any shortfall in the cost improvement programme or be used as a source of funds to support further as yet unidentified qualitative pressure.

Where in year costs are able to be avoided that are not funded then this will only exceptionally be recognized as part of the cost improvement programme.

The detailed cost improvement programme will cover at least two years and will include a number of individual detailed schemes as well as well as schemes that are strategic in nature. The expectation is that in each of the next five years then a 4% financial/productivity improvement will be required as a minimum if we are able to retain our position as a good local health citizen.

Process

The Trust has established a Programme Management Office supported by PWC for which it is actively recruiting substantive personnel.

Performance targets are being set by individual divisions that seek to recover a 4% improvement in 2014/15 and that yield a 6% Full Year Effect efficiency in 2015/16.

The Trust has established a gateway process that seeks to identify and track areas of concern. Each

target set by Division will be reported in this way describing Divisional performance across 5 gateways

Gateway	Descriptor	% £ of scheme recognised
Gateway 0	No ideas generated	0%
Gateway 1	Idea generated and embryonic plan and value	25%
Gateway 2	Idea Generated and local plan and Quality Impact Assessment completed	50%
Gateway 3	Quality Impact Assessment agreed and signed off by Medical Director and Director of Nursing. Detailed plan signed off by the accountable director and the finance team	67%
Gateway 4	All tasks on the implementation plan completed	90%
Gateway 5	Financial Validation	100%

Ownership of individual plans will be obtained from the relevant Director whose responsibility for delivery will be explicit

Establishing the individual plans for 2014/15 will be concluded by the end of June 2014. The delivery of the plans will be picked up as the individual initiatives progress through the gateways described above. Implementation will be delivered by existing teams and appropriate acceptance and sign off of the proposals will be achieved.

Capital Programme

In order to secure the cash required to assure the provision of services, the Trust has collated an abridged capital programme for the two years 2014/16.

Much of the plan is predicated on the movement of services from Essex County hospital following the expected opening of the radiotherapy centre in May 2014.

Capital Programme	2014/15	2015/16
	Year 1	Year 2
Medical Equipment	1,303	1,200
Estates & Facilities	1,565	1,400
ICT	512	500
Clinical Portal	1,100	-
Relocation of Cancer Wards from ECH	1,400	-
Relocation of Services from ECH	400	-
Laparoscopic Theatre Upgrade (OR1s)	860	-
CT Scanner Replacement	950	500
Cardiac Catheter Lab	-	1,200
A&E redesign	-	1,500
MRI Unit	-	1,000
Pathology Blood Sciences lab	-	850
Other Capital expenditure	370	850
In year programme	**8,460**	**9,000**
E-prescribing	650	-
Refurbishment of Central Delivery Suite	1,000	-
A&E Development	765	-
Radiotherapy Centre	800	-
Other 13/14 Capital slippage	1,020	-
13/14 Slippage	**4,235**	**-**
Total Capital expenditure	**12,695**	**9,000**

Cash

As identified, although a Continuity of Service Risk Rating of 3 is expected to be maintained all year, towards the end of the year the rating is marginal and there remains a risk that this may not be maintained subject to delivery of both the cost improvement plan, variation in commissioned activity and the Trusts ability to reduce its current level of stock holding.

Notwithstanding the above the Trust has sufficient cash below the CoSRR 3 threshold in the region of £5 Million. Active monitoring of the cash and CoSRR threshold will be carried on throughout 2014/15 and beyond using a 13 week forecasting model.

The quarterly model is shown below:

Continuity of Service Risk Ratings

Debt Service Cover	Quarter to 30th June 2014	Quarter to 30th September 2014	Quarter to 31st December 2014	Quarter to 3st March 2015	Quarter to 30th June 2015	Quarter to 30th September 2015	Quarter to 31st December 2015	Quarter to 3st March 2016
PDC dividend expense	(1,210)	(2,419)	(3,629)	(4,838)	(1,291)	(2,583)	(3,874)	(5,165)
Other Finance Costs	(146)	(292)	(439)	(583)	(146)	(292)	(439)	(583)
Repayment of non-commercial loans	-	-	-	(594)	(594)	(594)	(594)	(594)
Capital element of finance lease rental payments - Other	(75)	(150)	(258)	(333)	(75)	(150)	(258)	(333)
Revenue available for Capital Service	(332)	766	1,918	6,157	2,208	5,710	9,352	15,968
Debt Service	(1,430)	(2,861)	(4,326)	(6,348)	(1,512)	(3,619)	(5,165)	(7,269)
Debt Service Cover metric	-0.23x	0.27x	0.44x	0.97x	1.46x	1.58x	1.81x	2.20x
Debt Service Cover rating	**1**	**1**	**1**	**1**	**2**	**2**	**3**	**3**
Liquidity								
Cash for CoS liquidity purposes	5,918	2,918	1,455	592	-375	-892	-192	2,219
Operating Expenses within EBITDA, Total	-65,691	-130,043	-195,374	-259,850	-62,780	-124,350	-186,806	-248,509
Liquidity metric	8.1	2.0	0.7	0.2	-0.5	-0.6	-0.1	0.8
Liquidity rating	**4**	**4**	**4**	**4**	**3**	**3**	**3**	**4**
Continuity of Service Risk Rating	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**4**

1.4 Appendices: commercial or other confidential matters