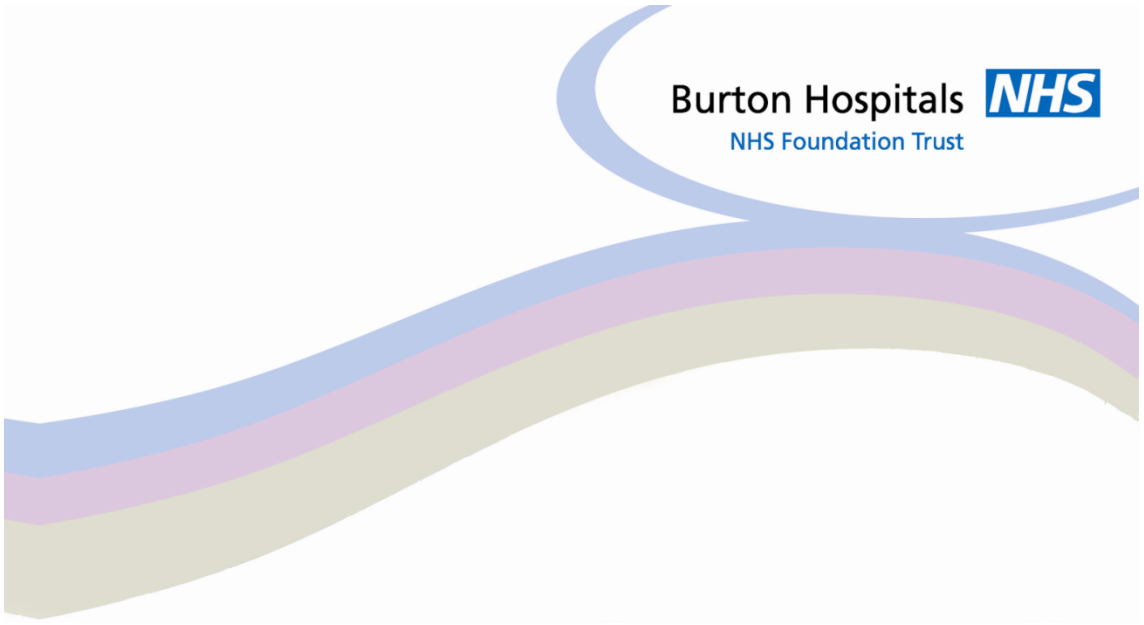


Strategic Plan

2014-19

Burton Hospitals NHS Foundation Trust

APPENDICES

1. East Staffordshire Health Economy – Leadership Ambitions
2. Values
3. Implementation Plan (Gantt Chart)

1 CHAIR'S FOREWORD

The Board of Directors of Burton Hospitals NHS Foundation Trust submits this five year plan for the organisation, against a backdrop of economic challenges at both a local and national level As a consequence this plan though ambitious in its vision and the objectives to be pursued, represents the Trust's view of what is achievable, and what is realistic over the five year period, and seeks to represent a reality, as well as reveal intentions and blueprints for a sustainable future for Burton Hospitals and the patient population it serves.

It is essential that there is no ambiguity around the certainty that this plan, while addressing the financial sustainability for the Trust, is propagated on providing the highest quality of care to patients, whilst proposing new ways in which that care and experience can be delivered.

The Board has looked to be ambitious as well as progressive in its deliberations and decisions, and is in accord with the regulator's view when they state the need for smaller providers to change what care they deliver and how, and that changes in this direction will enable them to, quote, " have an important and sustainable place in the future". However, much of the detail for the more significant change continues to evolve at the present time, and is not dependent on, but will be far better informed and explained, upon completion of the work to support the wider health Staffordshire Health Economy, as part of the challenged health economies work and the maturity of negotiations with our commissioners, our provider partners, primary care and suppliers of services outside of the NHS.

It is this aspect of partnerships and partnering that sits at the heart of this plan enabling the Trust to implement change and deliver patient benefit. The Board is committed to the creation of *strategic partnerships both within and outside of the NHS to deliver its vision. Central to that ambition is a structural and formal relationship with a larger tertiary centre provider. Although early in discussion, the two organisations are agreed that they will work collaboratively to address the current and future challenges, whether it be sharing resources or coproduction of initiatives to improve income and reduce costs to ensure the clinical sustainability of the Trust's portfolio of service. Moving forward the Board is keen to work with partners:

- To secure services to patients and the local community
- To jointly develop the most effective and efficient portfolio of services.

The Trust will find organisations that have services or skills complementary to ours and combine or consolidate to improve and develop our services

Finally, in conclusion the Board of Directors has sought to understand the factors which are driving our challenges, and within an uncertain healthcare landscape, sought to address them in an ambitious and yet practical manner. We believe that this five year plan offers the employees and communities a viable, as well as consistently safe and consistently effective provider of healthcare, with the patient experience at its core.

2 EXECUTIVE SUMMARY

BACKGROUND

Burton Hospitals NHS Foundation Trust (BHFT) is the principal provider of acute hospital services for the residents of Burton upon Trent and surrounding areas. The Trust predominantly provides services from Queen's Hospital in Burton, Sir Robert Peel Community Hospital in Tamworth and Samuel Johnson Community Hospital in Lichfield.

The Trust has faced financial and quality challenges in recent years. Latterly the annual deficit has reduced and following a recent review by external advisors now has a better understanding of the causes of the current underlying financial position.

Following the Keogh review into Trust morality rates there has been considerable investment in improving clinical quality and outcomes.

However our assessment for the next five years is that there will be further challenges to be faced including:

- A health economy which is funded below its fair shares capitation target and facing significant financial pressures
- A trend of increasing demand due to complex factors including rising and aging population, higher births and operational changes in other sectors such as primary and social care
- A commissioner plan which envisages 15% reductions in non-elective admissions, 40% reduction in A&E attendances, reductions in outpatient follow-up activity and a 20% improvement in elective efficiency
- The tendering by commissioners of frail elderly pathways, intermediate care and long-term conditions which will impact on the Trust's existing service provision
- A recognition that BHFT does not have the critical mass to support delivery of some specialist services yet needs to sustain the improvements in quality that have been achieved following the Keogh review
- Immediate and increasing difficulties in identifying CIPs on a long term sustainable basis
- A need to increase our change capacity and capability as we enter a more dynamic and uncertain economic and technological environment.

VISION

In the light of this background The Trust has refined its vision, goals and objectives.

"When the people in our community need healthcare they will look to Burton Hospitals NHS Foundation Trust"

This vision means we will:

- Be a provider that our community ***recommends*** – not just for hospital care, but for ***healthcare*** - because we are offer ***high quality*** and easy ***access*** to specialist capability
- Understand and ***listen*** to our community – this includes the public, our ***patients***, our staff, our ***carers*** and our GPs
- **Evolve** with the changing landscape of healthcare and take a lead on **innovative** approaches to delivering care
- Accept where we cannot sustain a specialist service and ensure our community trusts us to bring it the best alternative provider from our partners

This vision implies we will need to be a very different type of organisation within the timeframe of this strategy. Specifically we will be far more proactive at engagement with the system, operating along more of the patient pathway (in a lead integrator role), enhancing our capability and capacity to deliver change by partnering with others where it makes clinical and/or financial sense,

maximising our market share of the catchment population and reducing our estate footprint for core services only.

GOALS AND OBJECTIVES

The goals and objectives have been designed to ensure we demonstrate our progress with achieving this vision.

Goals	Objectives
1. To completely transform our approach to engaging with and understanding our community 1.1. A wholesale change in our approach from passive, reactive engagement with public, patients and GPs (i.e. waiting for them to need help) to conscious, proactive engagement 1.2. A continuous and 'live' understanding of our markets – a radical change from annual contracting and a reactive culture to a richer and continuous understanding of what our community needs, the issues our commissioners are facing and what our competitors are doing to allow us to adapt our strategy and services far more quickly	• Independent assessments demonstrate a recognised transformation in the way we engage with key stakeholder groups – public, patients and GPs • Implemented and embedded with demonstrable outputs, a new process to continuously update our understanding of our community's healthcare needs and the issues with healthcare provision
2. To deliver an evolved clinical model 2.1. Have the ability to continuously examine the sustainability and clinical viability of our services 2.2. Have a working and commercially effective partnership model for clinical services to deliver clinical viability and support change 2.3. Have an outward looking culture that seeks out best clinical practice, learns from the wider system and understands what its competitors are doing well 2.4. Implement key changes to our clinical services 2.4.1. Renewed 'acute' model of care that emphasises proactive care and rapid access to specialist support – with lowered non-elective admissions and reduced dependence on A&E 2.4.2. A well developed and innovative set of out of hospital services that offer proactive support for the elderly frail and those with long term conditions 2.4.3. A "top decile" elective centre for quality and efficiency	• Top decile performance on PROMs in year 5 • Top decile performance on relevant clinical outcome measures vs our peers • Best in peer group on Family and Friend Testing • Top decile non-elective admission rates & readmission rates (vs. 2012/13 benchmarks), outpatient first to follow up ratios • Top decile performance on key operational and quality measures – 18/52s, 4 hour A&E targets – (vs. 2012/13 benchmarks)
3. Implement a radical new and efficient business model 3.1. A significantly smaller estate footprint to lower running costs and new, fit for purpose, estate where required 3.2. Effective, recurrent delivery of cost improvement schemes, year on year 3.3. Partnerships – including joint ventures and outsourcing arrangements – to deliver all non-core services and functions wherever we can get better value and/or to deliver new revenue streams 3.4. Integrated IT and technology that supports a healthcare provider with services in a hospital, in primary care and in community care	• 5% surplus from clinical services and a positive underlying surplus • Proportionately lowest estate running cost and back office function cost in our peer group • Material performance improvements where partnerships are implemented
4. To create a step change in our delivery capability and organisational effectiveness 4.1. Governance that assures the future as well as the present 4.2. A strategic 'culture' amongst the leadership – for the Board and our Clinical leaders 4.3. An effective programme of staff development and a workforce willing and able to deliver change 4.4. Fully developed, integrated service line reporting and service line management 4.5. Alignment of strategic and operational priorities with performance management	• 100% appraisal rates • 100% of identified clinical and managerial leaders to have been through a new development programme • Top scores on independent governance assessments – e.g. vs. QGF and BGAF

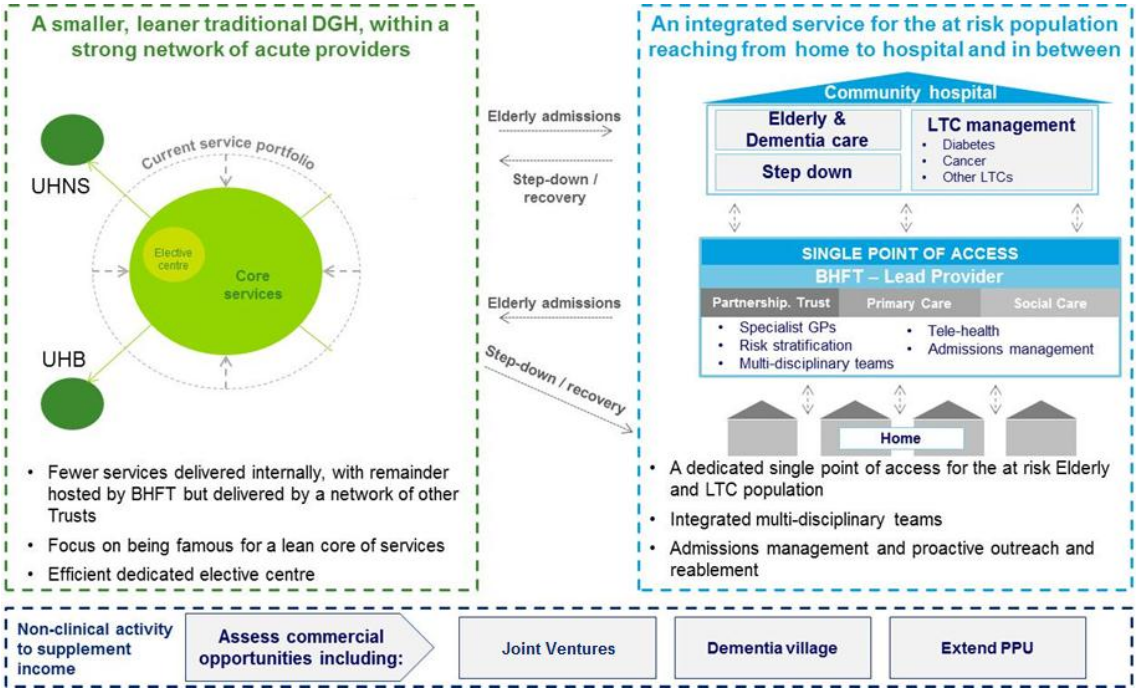
We believe delivery of these goals will enable us to exploit the opportunities we have through:

- Building on our strong local presence with support from the CCGs and residents in our catchment
- Exploiting our key strategic assets such as the elective treatment centre and community hospitals
- Changing our delivery models to meet the increasing demand for healthcare in more innovative ways
- Repatriating patients flowing out of area as our reputation for quality improves as identified by the 'distressed health economy' review
- Engaging our staff in the vision for a vibrant and successful future for the Trust

STRATEGIC OPTIONS

In 2013 the Trust evaluated its strategic options with support from external advisors. In developing this five-year strategy it has revisited that analysis and confirmed it is still relevant in the current context summarised above.

An overview of the selected option is shown in the figure below.



For Acute Services we plan to continue offering a 'very warm site.' This incorporates a full suite of District General Hospital (DGH) services, 24/7 accident and emergency services and some specialist services. However a range of specialist services are acknowledged to be not clinically viable for BHFT to provide and these have been offered to other partners to provide e.g. vascular surgery to University Hospital North Staffordshire NHS Trust (UHNS).

For Community Services the Trust intends to focus on elderly and vulnerable people as this closely matches the future commissioning strategy. The service would consist of a broader range of services than BHFT currently offers and mean working in partnership with other providers – NHS, social care and third sector – to deliver the full range of required care.
One scenario is that BHFT plays the role of lead provider and overall co-ordinator, providing clinical input to the service, whilst other providers take on the day to day delivery of home based nursing care.

For non-clinical services the Trust believes there are opportunities to improve efficiency and effectiveness through a number of initiatives including:

- Developing a joint venture with a commercial partner to operate some support services and the estate

- Making alternative use of the community hospitals – proposals are going to public consultation shortly
- Making better use of spare capacity for income generation such as an enhanced private patients facility

FINANCIAL IMPLICATIONS

Financial projections have been made for the five years of the plan 2014-15 to 2018-19. The first two years are consistent with the two year operating plan submitted to Monitor.
The projections are made for the Baseline, Strategy and Downside scenarios:

1. Baseline - a projection of current activity trends and plans with no transformational changes

2. Strategy – the Trust's forecast activity and services taking account of trends, moderated commissioner plans, potential repatriation and community contracts

3. Downside – less activity due to commissioner success in reducing demand, lower repatriation and loss of community contracts

The projections show the following Income and Expenditure and Continuity of Service Risk Ratings (CoSRR) for each scenario. In undertaking the projections the Trust has assumed it delivers a minimum 4% efficiency gain each year to cover the implications of tariff deflation and cost inflation and pressures.

Forecast	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)
Scenario 1: Baseline					
Income & Expenditure Surplus/(Deficit) £m	(10.6)	(13.1)	(12.5)	(12.0)	(11.3)
CoSRR	1	1	1	1	1
Scenario 2: Strategy					
Income & Expenditure Surplus/(Deficit) £m	(10.6)	(13.1)	(9.9)	(9.4)	(9.2)
CoSRR	1	1	1	1	1
Scenario 3: Downside					
Income & Expenditure Surplus/(Deficit) £m	(10.8)	(13.4)	(10.5)	(10.9)	(11.3)
CoSRR	1	1	1	1	1

The continuing deficit means the Trust will need PDC funding of £7m to £10m per annum to maintain its liquidity requirements.

The Trust recognises that continuing annual deficits and a CoSRR of 1 are not sustainable and has a number of options available to it to mitigate these which are described below. These options have not yet been built into the financial projections because they need more information and analysis before firm figures can be attached to them. However the Trust has developed an implementation plan that schedules this work to be completed shortly.

(a) Partnering with University Hospital of North Staffordshire

The Trust has considered a range of other providers for partnering in the delivery of clinical services and after discussions with all potential candidates is advancing negotiations with UHNS in particular.

Initially the partnership is expected to involve the Trust providing capacity for UHNS to operate some of its more specialist services from on a satellite basis, as well as supporting the Trust in a number of areas where it has medical workforce challenges.

In return UHNS will facilitate the repatriation of some activity from Burton's catchment area. There has been some allowance for this in the activity projections but the potential do more is significant and has not been included because negotiations are at an early stage.

(b) Community Services

Our stated aim is to extend the reach of the Trust along the patient pathway. This will benefit patients through the delivery of joined-up care and commissioners through more efficient and effective provision.

In our Strategy Scenario we assumed we will retain our existing £25m business which relates the commissioner's Prior Information Notice (PIN) about tendering these services and we win the £11m of other work associated with the activity whilst making a 4% margin per annum on that.

However we believe the potential could be far greater as we will be in a much stronger position to rationalise care pathways, control demand for hospital services down the line and make economies of scale.

The detail surrounding this change in commissioning is only now emerging, with a further significant milestone in the development of this approach expected in mid-July

The proposed changes are consistent with the Trust's vision for its role in the delivery of community services and therefore we believe there will be potential to extend our reach into the community for other services. In order to ensure we have the right capability for this we will investigate the possibility of partnering with other organisations with a track record in delivering these services. Potential partners will include public, private and third sector organisations either exclusively or in combination.

(c) Establishing a Joint Venture

The Trust recognises a need to develop its capability and capacity for making a step change in how it operates its business. This includes the introduction a more commercial and efficient approach to operating procedures, more effective ways of enhancing our change culture and more cost effective delivery of services.

The Trust is therefore considering the potential for appointing a joint venture partner to work with it on a transformation programme for its corporate support services and estate management

(d) Engaging External CIP Support

Divisions have a strong history of cost reduction and avoidance, but more limited experience of driving through efficiencies across the patient pathway (as opposed to within individual departments and disciplines). A review of the 2014/15 CIP has revealed significant slippage in the original plan.

As a result the Trust recognises that it does not have the internal capability to generate and deliver CIPs on an ongoing basis. It will therefore be identifying external expertise to support the ongoing identification and delivery of CIPs with early planning for implementation in future years. This will be part of the capability development strategy and involve significant involvement and knowledge transfer to Trust staff.

(e) Rationalising the Estate

The Trust's analysis has demonstrated that it has a large estate relative to the quantum of clinical activity it undertakes. The plan for year 1 includes disposal of the Outwoods site in Burton and redistribution of the vacated services to Queen's Hospital.

In longer term there is potential for further disposals of underutilised land and accommodation at Queen's Hospital.

Also, depending on the outcome of the public consultation and requirements for the integrated frail elderly/long term conditions service there may be further opportunity at the community hospitals.

The Trust has therefore begun a review of its estate requirements with the output being a development control plan for Queen's Hospital which will inform the future decisions about 'right-sizing- the estate the for its medium term requirements. This review will be supported by appropriate professional advisors. The Trust is currently reviewing whether a joint venture partnership for the development of its estate strategy is a best fit solution to its lack of capacity for strategic estates planning.

(f) Internal Systems and Processes

The Trust is believes there is scope for improving its capability and capacity for supporting the delivery of its clinical services in advance of and in harmony with any potential joint venture initiative. It therefore plans a number streams of work which will deliver this including fitness for purpose reviews of key support functions, the development of service line reporting and management and strengthening its strategic planning capability.

IMPLEMENTATION

The Trust recognises that it has considerable further work to undertake on its strategic direction and finding a sustainable future business model. This is largely due to the uncertainties in the local health system which could have a material impact on the plan.

There will be more work undertaken on developing the strategy over the summer months, especially regarding years three to five. The current plans are aligned as far as possible with the output from the Challenged Staffordshire System Review and commissioning plans, however the KPMG report is not due to be finalised until July 11th 2014 and the Trust is aware that the project team are still looking at further options for service change that are not currently finalised.

Giving the ambitious nature of the Trust's objectives, the significant change programme required to underpin the efficiency opportunities, shifts in clinical operating model as well as the requirement to develop long term partnerships it is essential that the Trust puts in place both capacity and capability to deliver the plan. This will be achieved through:

- Anticipated changes to the composition of the Board
- A clearer distinction between delivering day to day operations and future strategy
- Establishment of stronger clinical involvement and capability in leadership
- Development programmes for the Board, Clinical Teams and Business Support
- Learning from our NHS, commercial and third sector partners
- A flexible Programme Management Office

The Trust has identified key milestones for the five years of the plan and aligned these to each of the goals. Progress towards these will be managed through our new governance arrangements which have been improved following several recent external reviews and recommendations.

The emphasis in the short term will on continuing to improve our quality performance, managing cost improvements and developing the plans for partnerships, joint ventures and prime contracting of community services. In this same period there will be greater clarity over the many uncertainties we currently face such as the outcome of the Challenged Health Economy work. These factors combined will help us move towards a more favourable financial position going forward.

3 DECLARATION ON SUSTAINABILITY

Our strategic plan has been developed against a background of challenge, change and uncertainty.

- The Trust is located within one of the 11 areas of the country considered by Monitor, NHS England and the Trust Development Authority as having a 'challenged' health economy. The review of Staffordshire has not yet reported though we have incorporated the emerging findings where known. The Trust plans will therefore need to be reviewed in the light of the final outputs

- We foresee that the first years of the plan will be challenging financially and require an injection of cash through Public Dividend Capital but believe we have a longer term vision that will resolve this through a transformational change in how we deliver our services and are developing plans to achieve this

- The Staffordshire and Stoke on Trent CCGs Five Year Strategic Plan projects growing demand for healthcare due to the increasing and aging population. It envisages that integration of care will be a key theme in meeting the demand challenges alongside prevention and self-care, a stronger primary care sector and refocused urgent care. As a result the CCGs plan envisages large shifts in activity from hospital based locations into the community though the extent and pace of delivery is as yet unproven

- Locally we have received a Prior Information Notice (PIN) relating to long term conditions and frail elderly which will impact on our current non-elective and community services.

However the Trust is emerging from the Keogh review into our patient safety record in a much stronger position with more confidence about the quality of services. The changes in practice and resource allocation that we've implemented give us a better foundation going forward.

The first two years of our strategy are in place by focussing on what we can do best with completed clinical, operational and financial plans developed. This includes:

- Maintaining our improvements in quality

- Increasing efficiency in the delivery of services

- Generating cash and recurrent savings through sale of surplus land

Years three to five of the strategy are less certain and will depend on:

- The outcome of the review of the Staffordshire economy which has not been finalised but will have implications for the Trust and its main commissioners. The early indications are that the review will confirm the Trust has an essential role in providing services within Burton, drawing patients from East Staffordshire, South Derbyshire, North Leicestershire and beyond.

- Our success in becoming a lead provider of integrated care using our community assets as a facilitator.

- The level of repatriation of more profitable work from other areas that can be achieved.

- The success of commissioners in diverting unprofitable non-elective away from the Trust and into other settings.

- The outcome of a consultation on the future of community hospitals.

Our strategy will therefore need to be developed further as clarity emerges on the health economy position, our role within it and our success in capturing the new opportunities that arise.

4 PROCESS FOR DEVELOPING THE PLAN

The Trust has continuously considered its strategic plan and has reviewed the latest strategy in developing this document.

In developing the plan the Trust considered the following external influences:

- Emerging findings of the Staffordshire Challenged Health Economy review
- Draft Staffordshire and Stoke-on-Trent CCGs Five Year Strategic Plan
- The detailed plans being prepared by our main commissioner East Staffordshire CCG

This has ensured the plan takes account of health needs based on demographic and healthcare trend and likely available funding coming from our commissioners.

Whilst we have taken these into account we have made our own assessment of the pace and scale change that can be achieved by the health system. Our plans are therefore presented using three scenarios:

1. Baseline - a projection of current activity trends and plans with no transformational changes
2. Strategy – the Trust's forecast activity and services taking account of trends, moderated commissioner plans, potential repatriation and community contracts
3. Downside – less activity due to commissioner success in reducing demand, lower repatriation and loss of community contracts

The Trust has also considered the range of clinical services that could be provided safely and economically from the main district general hospital (Queen's Hospital) based on critical mass for staffing and specialisation.

The role of the community hospitals was also assessed taking account of the changing commissioner strategies and need for high utilisation to maintain financial viability.

This work informed an assessment of our strengths, weaknesses, opportunities and threats which the Board brought into the development of the strategy and refined vision, goals and objectives.

In undertaking the development of the strategy there has also been extensive engagement with the managers and clinicians operating the services we deliver. There have also been discussions with commissioners to ensure alignment of plans as far it is considered appropriate.

The Trust recognises that it has considerable further work to undertake on its strategic direction and finding a sustainable future business model. This is largely due to the uncertainties in the local health system which could have a material impact on the Trust. There will be more work undertaken on developing the strategy over the summer months, especially regarding years three to five. The current plans are aligned as far as possible with the output from the Challenged Staffordshire System Review and commissioning plans, however the KPMG report is not due to be finalised until July 11 2014 and the Trust is aware that the project team are still look at further options for service change that are not currently finalised. A Gantt chart of the proposed project plan for the Trust's work is included in this plan.

5 BACKGROUND AND CONTEXT

5.1 Overview

Burton Hospitals NHS Foundation Trust is the principal provider of acute hospital services for the residents of Burton upon Trent and surrounding areas including South Staffordshire, South Derbyshire and North West Leicestershire. The Trust serves a population of approximately 360,000 people and is committed to delivering high quality patient care.

The Trust was formed in 1993, going on to obtain Foundation Trust status in 2008, whilst continuing to work in partnership with a multitude of different agencies for the benefit of the local population.

The Trust provides a wide range of services accustomed to a general district hospital and has a number of outreach and community based clinics, all of which are supported by a dedicated team of clinical staff and senior managers. The Trust recognises the importance of working in the community, providing patients with the choice to access services in a setting that may be more amenable or comfortable for them. Since acquiring the Samuel Johnson Community Hospital in Lichfield, the Sir Robert Peel Community Hospital in Tamworth and the Midlands NHS Treatment Centre based on the Queen's Hospital acute site in 2011, the Trust has continued to develop and reconfigure the services provided at these facilities in order to meet the needs of the local population.

The Trust also provides a full complement of Accident and Emergency, outpatient and direct access services. All specialties are supported by a comprehensive range of clinical services in therapies, pharmacy, pathology, and radiology. In addition, we provide facilities to other NHS providers for specialties such as orthopaedics, phlebotomy and obstetrics.

The Trust is committed to delivering sustainable and viable services in order to meet the needs of patients, building on the Trust's vision of being the local healthcare provider of choice, and delivering the best patient experience.

5.2 The Hospital Facilities

The Trust predominantly provides services from Queen's Hospital situated on Belvedere Road in Burton upon Trent, along with the Geoffrey Hodges Wing on the adjacent Outwoods Site.

The Trust also provides maternity services, inpatient and outpatient services, surgery and Minor Injuries Units, from the Community Hospital facilities in Tamworth and Lichfield.

Outreach clinics are also provided in a number of other locations in acute and community settings across a wide range of specialties.

The Trust has a number of operating theatres (on the acute site in its standalone Treatment Centre and at Sir Robert Peel Hospital), two MRI Scanners, two CT Scanners, a dedicated endoscopy suite, a breast care unit, stroke facilities, a stand-alone Day Case surgery facility and a modern maternity unit at both Queen's Hospital in Burton and at Samuel Johnson Community Hospital in Lichfield.

The Trust and South East Staffordshire CCG have commenced a consultation on the future of the Community Hospitals.

There is a proposed vision for the future of Samuel Johnson Hospital in Lichfield which fits in with local population need and also fits with more closely integrating the services with the frailty pathway across BHFT; this is a specialist intermediate care and long term conditions centre where multidisciplinary care (including the voluntary sector) is wrapped around the patient, promoting independence and self-management.

There are a number of potential visions for the future of Sir Robert Peel Hospital, Tamworth, the portfolio being determined in conjunction with CCG following public consultation.

The outcome of the consultation will not be known before publication of this Strategic Plan.

5.3 Quality performance/challenges

On February 6 2013, the Prime Minister announced that he had asked Professor Sir Bruce Keogh, NHS Medical Director for England, to review the quality of care and treatment provided by those NHS trusts and NHS foundation trusts that are persistent outliers on mortality indicators. A total of 14 hospital trusts were investigated as part of this review. After the reviews, 11 of the 14 trusts, including BHFT, were placed into special measures by Monitor and the NHS Trust Development Authority.

The Trust welcomed the review as an opportunity to improve the quality of services that it offers to patients and was accepting of all findings and recommendations that resulted from the review.

The Keogh Review made six urgent recommendations for BHFT in July 2013 which if implemented would improve the quality of our services to patients through the delivery of consistently safe and effective care.

(a) The Board should ensure that there is a systematic approach in place for the collection, reporting and acting upon information on the quality of services. This review should include patient and clinician insights and should ensure that the processes include feedback and engagement of staff in learning and service improvement.

(b) The Trust should review how it communicates with its staff to ensure that it is using the correct methods of communication and is effectively sharing learning from incidents and complaints reporting with its staff. The Trust should also review its handling of patient complaints and ensure that front-line staff are communicating with patients in an effective and compassionate manner.

(c) The Trust should consider carefully the support that Junior Doctors receive as part of their training and ensure that delegation and escalation are appropriate.

(d) The Trust should consider urgently the staffing levels and mix throughout the Trust, particularly at the middle grades, to address concerns about inappropriate delegation, escalation and lack of decision making. In addition, the Trust should undertake a review of the provision of services at its two community hospitals and whether clinical staffing levels are appropriate and provision of care continues to be sustainable at the current level of service use.

(e) The Trust should ensure that the working practices of its staff are safe and sustainable and prevent long shifts or a high number of consecutive working days where possible. It should also review the e-rostering system currently in place and make changes so that it better meets staff and clinical requirements.

(f) The Trust should review all resuscitation trolleys to ensure they are fully stocked, organised and there are no out of date drugs or fluids. Staff should be reminded of the importance of regular resuscitation equipment checking.

Since then the Trust has been working constantly to implement the recommendations and achieve the improvements in outcomes required. In doing so, we have benefitted from the support of our nominated ‘buddy’, University Hospitals Birmingham NHS Foundation Trust, and wish to continue this relationship in the longer term.

The Trust was inspected by the Chief Inspector of Hospitals on 23rd, 24th & 25th April 2014. The Trust expects a final report and outcome from the inspection within the next few weeks. In the meantime the Trust is addressing the matters raised during the visit.

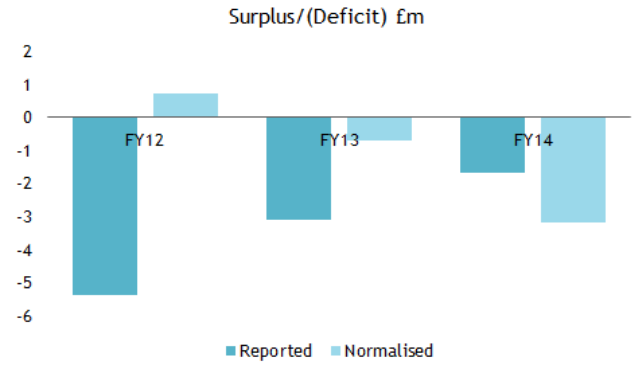
A Quality Summit will be held following which the CQC report will be made public.

5.4 Financial performance challenges

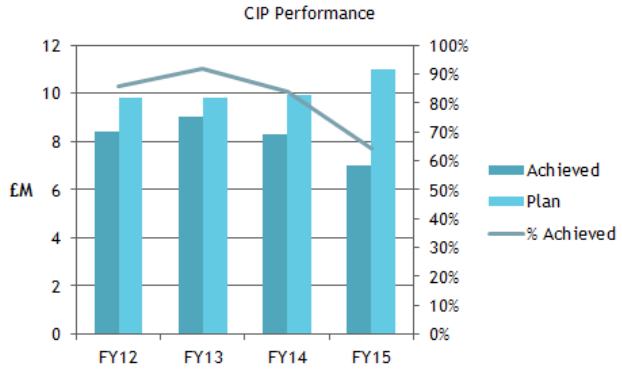
Since last breaking even in 2010-11 the Trust has incurred income and expenditure deficits. Audited Income and Expenditure Accounts show these have reduced year on year to only £1.8m in 2013-14 following a period of turnaround the previous year. However after two month’s performance the Trust’s forecast deficit for 2014-15 is £10.6m compared to a plan of £3.0m at the start of the year.

To get a better understanding of the causes of the continuing financial challenges the Trust commissioned independent financial advisors to review its historic financial performance and identify key drivers of the deficits it is incurring. The advisors concluded that:

- Whilst the Trust's financial position on the face of I&E has been improving since FY12, once the deficit is adjusted for non-recurrent items the financial position reverts to a year on year increasing deficit.



- Although the Trust is achieving high levels of CIP, these have not been sufficient to offset reduced levels of clinical income and increasing cost pressure. In addition CIP programmes are not 100% achieved thus creating further pressure to the financial performance.



- The Trust is experiencing high employee costs pressure due to Keogh review since early FY14 and been having difficulties to recruit permanent staff thus high number of agency is used.

- There may be opportunity for 'big ticket' savings in length of stay for non-elective frail elderly patients, reduced use of agency staff and improvement in day case ratios.

The independent reviewers recommend that financial governance controls be strengthened in the light of these findings and there be more robust activity and workforce forecasting systems put in place.

The Trust recognises that transformational change and much greater capability and capacity is required to maintain the improvements in quality and make a step change in financial performance.

The remainder of this document sets out how we propose to do that.

6 MARKET ANALYSIS

6.1 Healthcare Needs Assessment

Population numbers and structure – age profile, rate of growth, five year projections

BHFT serves a population of around 360,000 in Burton and the surrounding areas of East Staffordshire, South West Derbyshire, Lichfield and Tamworth. East Staffordshire CCG is the major commissioner for BHFT responsible for more than 70% of the Trust's turnover.

The Joint Strategic Needs Assessment (JSNA) is to identify the 'big picture' in relation to health and wellbeing needs and inequalities in the local population.

From April 2013, all upper tier local authorities and CCGs had equal and explicit obligations to produce an eJSNA which is a duty discharged through the Staffordshire Health and Wellbeing Board. eJSNAs must consider current and future health and social care needs and community resilience to match those needs.

East Staffordshire is the fastest growing population in Staffordshire based on Census growth from 2001 to 2011, this growth has continued and is forecasted to growth by 9% by 2020 and 20% by 2035. More telling is the growth in the over 65s increasing by 24% by 2020 rising by 75% in 2035, see the table below:

Population Group	2011	2020	2035
0 - 15	24,910	27,620 (11%)	28,210 (13%)
16 - 64	85,130	88,430 (4%)	91,460 (7%)
65+	22,970	28,530 (24%)	40,130 (75%)
All	133,000	144,580 (9%)	159,800 (20%)

Whilst the population increases will be across all age groups, the biggest rise and the biggest impact will be in people aged 65 and over. Forecasts indicate that there will be a 75% growth in over 65s and 99% growth in over 75s between 2011 and 2035. The over 75s age group is growing faster in East Staffordshire than the average for the rest of the country. There are also local plans to build 7000 new homes in East Staffordshire which would have a significant impact on the ability to meet demand.

Socio-economic indicators

Within East Staffordshire there are four Lower Super Output Areas (LSOAs) that are within the top 10% most deprived LSOAs in England. These four are located within the town of Burton upon Trent, in the wards of Eton Park, Stapenhill, Shobnall and Winshill.

There are 12 Lower Super Output Areas (LSOA), in the most deprived quintile (20%) of the country, this equates to 20% of the total population of East Staffordshire, all12 of these are located within Burton upon Trent; a further 17% live in the second most deprived quintile.

In addition East Staffordshire appears to be more deprived in particular aspects of deprivation such as the Living Environment and Education, Skills and Training, where multiple LSOAs appear within the top 10% most deprived in England, and even within the top 5% most deprived.

Health status

Overall Life Expectancy for men in East Staffordshire is 77.1 years, in England it is 78.3. Male life expectancy is lower than the England average in 13 of the 21 wards and is particularly low in Anglesey, Eton Park, Horninglow, Shobnall, Stapenhill, Town and Winshill.

There is a gap in Male life expectancy or around 10 years between the most advantaged and disadvantaged areas (Needwood is 83.6 years, in Anglesey it is 74 years).

Premature mortality rates are significantly worse in Eton Park, Horninglow, Shobnall and Stapenhill.

BHFT's catchment population has high incidences of heart related condition and strokes which are expected to increase significantly to 2020, mostly due to the aging population. Dementia rates are also expected to increase at or above national levels as illustrated by the analysis (by historic PCT0 shown below.

Region	Population	CVD prevalence (%)	CHD prevalence (%)[1]	Hypertension prevalence (%)	Stroke prevalence (%)	COPD prevalence (%)	Dementia growth CAGR 12-20 (%)	Diabetes prevalence (%)	Cancer incidence
South Staffordshire PCT	622,000	7.0	5.6	33.3	2.6	3.2	1.0	7.6	375.7
Derbyshire County PCT	291,000	7.1	5.7	33.4	2.6	3.2	0.4	7.6	385.9
Leicestershire County and Rutland PCT[1]	687,000	6.4	5.7	30.0	2.5	2.7	0.6	7.3	375.3
England	53.1m	6.8	5.8	30.9	2.5	3.7	0.4	7.6	389.8

Higher than national avg. Lower than national avg. Same as national avg.

Heart related conditions will continue to be strong drivers of demand across BHFTs main commissioning areas. The aging population indicates that hypertension and CVD prevalence rates will continue to be above national average levels through to 2020 and that CHD rates will increase above national levels.

These patterns indicate demand for health services is likely to be enduring and increasing during the period of this strategy and commissioners are seeking new and innovative ways to meet them.

6.2 Commissioning Plans

The Trust's main commissioner is East Staffordshire Clinical Commissioning Group (ESCCG) which falls in the Staffordshire County Council area and is predominately covered by the area governed by East Staffordshire Borough Council with a small part of its population falling under Lichfield District Council.

The CCG serves a population of 134,200 residents and has been formed by the 19 general practices within the East Staffordshire Borough Council Boundary which includes Burton on Trent and Uttoxeter.

The member practices together have had a strong identity, based on historical use of Queen's Hospital in Burton and have a long track record of working effectively together.

Using the national allocations funding formula, ESCCG is lower funded per head of population than other CCGs in the Staffordshire area; this equates to a potential shortfall of £2.1 million per year based on the fair shares toolkit formula.

The six CCGs in Staffordshire and Stoke on Trent have produced their own five year strategic plan. The key themes affecting BHFTs plan are:

(a) There is one key aspiration that we have for Staffordshire and Stoke-on-Trent and that is to integrate care so as to connect people with the care they need, when they need it. This aspiration works across organisational boundaries and is shared by the whole workforce.

(b) To achieve our ambitions for a sustainable health and social economy, we have to bring our citizens on the journey with us so that prevention and self- care become the norm.

(c) The importance of safety, positive experience and quality outcomes are clear. This is especially pertinent to people following the tragedy and harm to patients at Mid-Staffordshire.

(d) The projected financial situation across Staffordshire and Stoke-on-Trent is bleak. This will also be compounded if there is no change to how services are delivered, and if demand is not controlled and decreased.

(e) The Better Care Fund (BCF) agreements will be a key driver for developing integrated commissioning and transformational programmes, which will integrate the whole system of delivery of care and support.

(f) The model of primary care at scale links to and has a coordinating role for integrated care, urgent care, elective access, prevention and maximising self-care capability of citizens. 7 day working, to provide a seamless wrap-around service, is an expectation for delivering sustainability of the health and care system in the next 5 years.

(g) The urgent and emergency care system across our area is at risk of failure if the ever increasing demand is not addressed. This strategy sets out ambitious intentions to reduce A&E attendances by 40% and emergency admissions by 15%.

(h) CCGs and local providers are working together to deliver the national requirement of a 20% productivity improvement in elective care by 2019/20. A step change in the way that planned care services are organised and managed aims to improve access, decision making, recovery times and eliminate errors whilst improving productivity. This will mean using alternative settings of care and stopping some activities.

BHFT supports the direction of travel indicated by the commissioners' plans but locally believes the non-elective and A&E reductions to be ambitious in the timescales indicated given the demographic projections and historic performance in delivering change to the level targeted.

The activity analysis undertaken be the Trust below therefore assumes lower levels of contraction in these services though by taking an active role in the move towards more integrated pathways it will make a significant contribution to managing demand down from trend.

The Trust has recently agreed some high level targets for joint work with its host commissioner. This agreement focuses on a desire for both organisations to work in partnership to change the local service provision for Burton residents by providing top decile performance. This will involve significant changes in the care model particularly for elderly and frail patients. A copy of the areas of agreed partnership principles is included as an appendix .

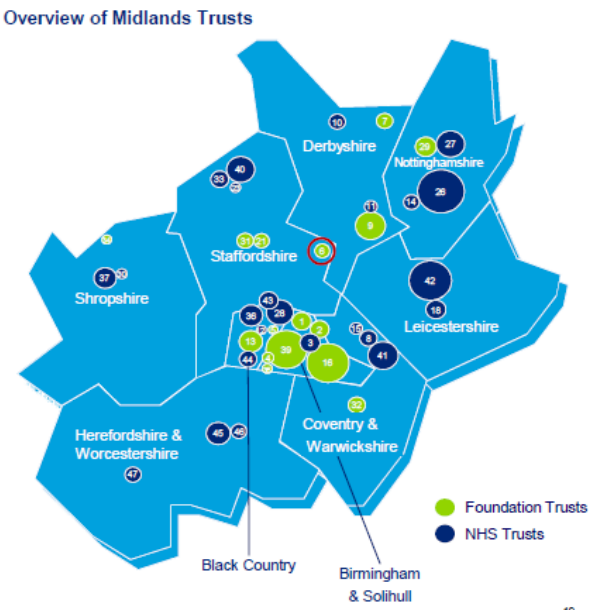
6.3 Competitor Analysis

The Trust operates in a region with a large number of other providers, which creates both competition but also a significant opportunity for networking and partnering.

There are four foundation trusts, six acute trusts and five mental health and community trusts within Burton's catchment area of 30-40 minutes normal drive time.

Some of these are facing significant issues regarding their own financial and clinical agendas. For example the Mid Staffordshire Foundation Trust is being dissolved following the quality issues reported by the Francis report and Derby Hospitals NHSFT and University Hospital of North Staffordshire NHS Trust (UHNS) have financial issues to resolve.

Whilst there is competition with our local providers their own capacity constraints make this a feature at the margins of our activity. We have however reviewed our market share of local GP referrals and will be taking steps to repatriate work from other providers and out of area as identified by the Challenged Health Economy work undertaken by Monitor, the TDA and NHS England.

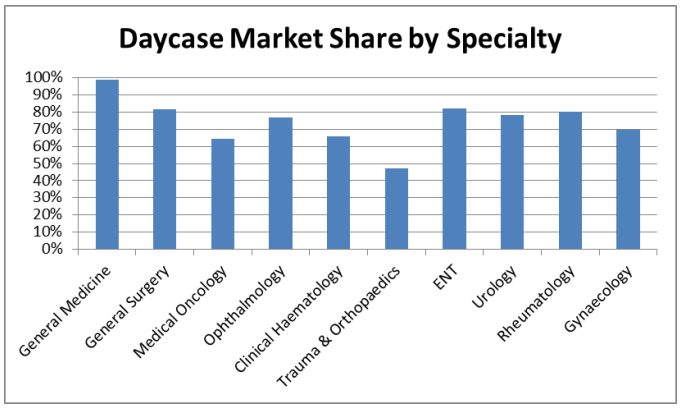


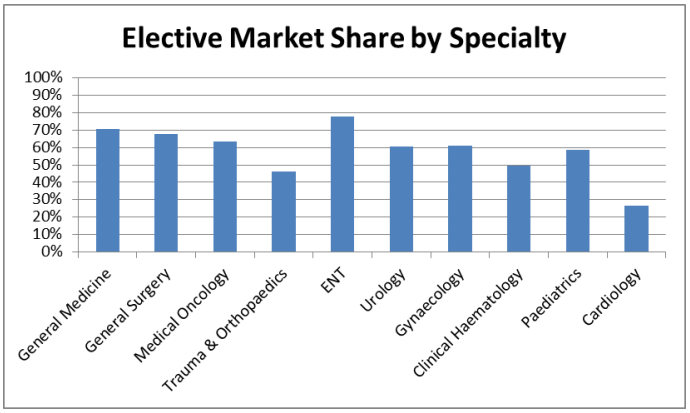
#	County	Type
	Birmingham & Solihull	
1	Birmingham and Solihull Mental Health NHS Foundation Trust	MH
2	Birmingham Children's Hospital NHS Foundation Trust	Ac
3	Birmingham Community Healthcare NHS Trust	Com
4	Birmingham Women's NHS Foundation Trust	Ac
16	Heart of England NHS Foundation Trust	Ac
35	The Royal Orthopaedic Hospital NHS Foundation Trust	Ac
39	University Hospital Birmingham NHS Foundation Trust	Ac
	Black Country	
5	Black Country Partnership NHS Foundation Trust	MH
12	Dudley and Walsall Mental Health Partnership NHS Trust	MH
13	Dudley Group NHS Foundation Trust	Ac
28	Sandwell and West Birmingham Hospitals NHS Trust	Ac
36	The Royal Wolverhampton Hospitals NHS Trust	Ac
43	Walsall Healthcare NHS Trust	Ac
44	West Midlands Ambulance Service NHS Trust	Amb
	Coventry & Warwickshire	
8	Coventry and Warwickshire Partnership NHS Trust	MH
16	George Eliot Hospital NHS Trust	Ac
32	South Warwickshire NHS Foundation Trust	Ac
41	University Hospitals Coventry & Warwickshire NHS Trust	Ac
	Derbyshire	
7	Chesterfield Royal Hospital NHS Foundation Trust	Ac
9	Derby Hospitals NHS Foundation Trust	Ac
10	Derbyshire Community Health Services NHS Trust	Com
11	Derbyshire Mental Health Services NHS Trust	MH
	Leicestershire	
18	Leicestershire Partnership NHS Trust	MH
42	University Hospitals of Leicester NHS Trust	Ac
	Nottinghamshire	
14	East Midlands Ambulance Service NHS Trust	Amb
26	Nottingham University Hospitals NHS Trust	Ac
27	Nottinghamshire Healthcare NHS Trust	MH
29	Sherwood Forest Hospitals NHS Foundation Trust	Ac
	Staffordshire	
6	Burton Hospitals NHS Foundation Trust	Ac
21	Mid Staffordshire NHS Foundation Trust	Ac
23	North Staffordshire Combined Healthcare NHS Trust	MH
31	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	MH
33	Staffordshire and Stoke on Trent Partnership NHS Trust	Com
40	University Hospital of North Staffordshire NHS Trust	Ac
	Herefordshire & Worcestershire	
45	Worcestershire Acute Hospitals NHS Trust	Ac
46	Worcestershire Health and Care NHS Trust	Com
47	Wye Valley NHS Trust	Ac

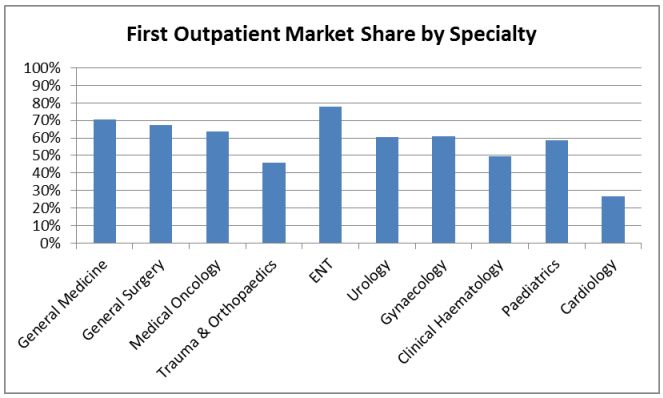
6.4 Market Share

The charts below set out the Trust's market share across the specialties with the highest levels of activity, using a sample of the 20 nearest GP practices, based upon separate work undertaken by CHKS and Dr Foster.

Day case, Elective and First Outpatient Market Share:



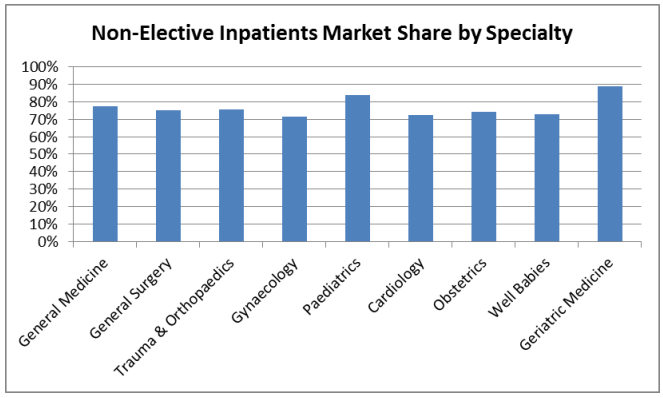




The chart above demonstrates that the Trust attracts 80% of the market from its 20 nearest practices for ENT (across day-case, elective and outpatients), but only 50% of trauma and orthopaedics. Within trauma and orthopaedics, 65% of outpatient market share is achieved, but less than 50% of the market for procedures (either day case or elective). Medical Oncology is also a specialty with low market share (<65% for day case and elective) in comparison to other specialties.

Within General Surgery the Trust attracts over 80% of first outpatients and day cases, but only 68% of elective procedures. This represents an opportunity to the Trust, given this activity is clearly performed by other (most likely, local) Trusts.

Non-elective Market Share:



The above chart demonstrates the variable market share across different specialties. The Trust attracts well in excess of 80% of the market for non-elective Geriatric Medicine and Paediatrics, but only 75% of the activity in Trauma and Orthopaedics, and 74% of Obstetrics and Well Babies. Well Babies is a specialty where the patient is very likely to make informed choices due to networking with other prospective parents and with time to plan their source of care and hence an opportunity for the Trust to influence behaviour based upon the high quality of Burton's service.

Only 71% of non-elective Gynaecology from the 20 nearest practices comes to Burton. The cardiology market share is also low (72%) in comparison with other specialties, but the recently introduced Catheter Laboratory at Burton will aim to target this activity (as well as significant levels of the elective market share).

Looking across both the charts above, it can be seen that elective market share for Trauma and Orthopaedics (<50%) is lower than the non-elective market share (75%). Therefore, patients travel to the Trust for non-elective care, but when they are able to choose a hospital, they go elsewhere. Changing this behaviour is clearly a challenge and an opportunity for the organisation.

Using the data obtained in order to create the charts above, the Trust has also identified a number of outlier GP practices, who are geographically close to the Trust, but who send a disproportionately low level of activity to Burton. This applies mostly to Southern Derbyshire patients who are located closer to Burton than to Derby, but send only a small proportion of their activity to BHFT. An example is Wellbrook Medical Practice, only approximately 5-10% of whose patients travel for day cases at Burton despite being located only 4 miles from Queen's Hospital.

Burton sees 70-80% of patients from practices located a similar distance away but in Staffordshire (although this varies by specialty). The plan to address the above market share opportunities is discussed later in this document.

6.5 Market Opportunities

Based upon the above market analysis, the Trust has identified a number of strategic opportunities which are being taken forward now, but which will impact over the five year period. These are as follows:

1) Working with Commissioners

The CCGs and BHFT have together agreed a set of ambitions for the system of healthcare in the region. This aims to further the process of alignment on respective strategies for the next 5 years and to identify where the organisations are wholly in agreement and where tensions still exist that will need to be addressed further.

- Overall the Staffordshire system wants to shift from a service focused on 'rescue' of the acutely unwell to a service that minimises the need for rescue – i.e. one that prevents and manages illness earlier in the pathway, one that reduces acute episodes and exacerbations, and one that enables patients and the public to manage their own health much more effectively

- In respect of the above – the elderly and frail populations and those with long term conditions would appear to be best placed to benefit from this shift in the care ethos and models of delivery. BHFT have a key role in managing the specialist input required to deliver improvements in these areas outside the hospital environment

- Linked to the above the system needs to reduce non-elective demand and therefore admissions as the growth in this area is unsustainable for the system as a whole. The CCGs and BHFT will work with the system to contribute to a reduction in this demand

- Working in partnership is an essential part of a sustainable future

- The system wants to maintain acute capacity in Burton itself.

As part of this strategy, BHFT have therefore interpreted commissioner intentions and the above principles within underpinning financial and activity plans. This includes reducing non-elective admissions, reducing the first to follow up ratio and further developing the CCG assumptions and benchmarking.

The Trust is also committed to helping the system to move care outside hospitals and will set up a team to manage community expansion. An immediate opportunity which the Trust is pursuing is a recently issued Prior Information Notice (PIN) for a Lead Provider contract relating to Long-term conditions, Intermediate Care and Care of the Elderly. This will be put out to tender from mid-July 2014 and covers approximately £36m of activity (£25m of which is currently delivered by BHFT). The Trust aim to be the Lead Provider, managing all services within the £36m envelope and driving both better outcomes and efficiencies from managing the whole pathway. Should BHFT win the tender, this will result in additional income (and cost), however alternative outcomes include losing the tender to be a Lead Provider but maintaining the £25m currently commissioned from the Trust, and losing the tender and the £25m of services being delivered (to some extent) by a different provider.

The Board consider BHFT to be able to make a strong case to become the Lead Provider and to manage care outside hospital, and through discussions with commissioners have made clear this intention. BHFT consider that given the direction of travel for commissioners in the wider NHS, should this Lead Provider contract prove successful, it is likely that local commissioners will issue similar contracts in the future, supporting additional scope of services for BHFT.

In support of this BHFT's own market analysis also identified opportunities to increase care provided in the community, with care of the elderly activity high in non-elective and relatively low in elective relative to peers. This will be addressed as part of the response to the long-term conditions PIN.

2) Forming Partnerships and Alliances

University Hospital of North Staffordshire (UHNS) has ambition to increase its specialist capacity across the region. BHFT is a key route for UHNS to access a larger catchment in order to achieve this aim. BHFT does not have ambition to increase specialist capacity, but the Trust does wish to offer access to high quality tertiary care through partner Trusts. BHFT does wish to develop a less complex, focussed elective business.

Therefore, a partnership between the two organisations will enable resources to be pooled and activity to be kept within the organisations rather than referred elsewhere, furthering both Trusts' ambitions.

The first phase of this partnership relates to General Surgery procedures and providing UHNS access to Burton's catchment for specialist work. In order to address the capacity issues that this additional work will create, less complex work for patients currently treated at UHNS will be repatriated to BHFT. In the future it is anticipated that this will expand to a wider group of specialties, include co-branding and co-bidding for work and the sharing of clinical resources (addressing medical staffing issues that BHFT foresee).

In addition, it is known that within the period February 2013 to January 2014, for the four most local CCGs, 384 spells were undertaken at UHNS. It is expected that a proportion of this activity, plus other activity for patients more local to UHNS could be repatriated to Burton hospitals with the reciprocal agreement meaning no requirement for additional capacity.

3) Managing Repatriation and Market Share

The Challenged Health Economy work undertaken by KPMG has identified significant activity that could be repatriated to Staffordshire Trusts, including Burton. The precise numbers identified will be shared with the Trust on the 11th July.

The market analysis set out above identifies specialties and services where elective activity can be increased. The Trust is already working with a number of GP practices in order to increase market share in profitable services and this work will be expanded.

The reduction in emergency activity identified as a result of working towards commissioner intentions (including the LTC PIN), allows the Trust the opportunity to accommodate these increases in elective activity within the existing estate.

The former South Staffordshire PCT area is the most significant market for the Trust. Mid Staffordshire NHS Foundation Trust has been the largest provider to date. The Trust Special Administrator has indicated that the impact of the dissolution of that Trust will not impact upon BHFT. The data suggests that the reductions in market share for that organisation over the last 12 years have been largely gained by Burton, Wolverhampton, North Staffordshire and Derby. The Trust has based its planning on the findings of the Trust Special Administrator but this may underestimates the impact on the organisation. The Trust will be monitoring the impact of the overnight closure of A&E services in Stafford from mid-July this year.

6.6 Activity Planning

The Trust has seen an overall increase in Non-Elective admissions over the past 3 years, mainly driven by the General Medicine and Care of the Elderly sub-specialties. July 2011 to March 2012 compared to July 2013 to March 2014 saw an increase of 3% in activity. (Obstetrics admissions have declined by almost 5% over this period).

Elective admissions have reduced significantly over the 3 years (5681 in 2011/12, 4557 in 2013/14). This trend is across all the main surgical specialties, with significant numbers of procedures moving from inpatient to day case.

Until July 2011 the majority of Day Cases were contracted to the independent Treatment Centre. However, a comparison of the last two years (2012/13 and 2013/14) shows a 9% increase in activity on the main site, (although the declining activity in the Community Hospitals reduces this to 4.4% for the Trust as a whole). Again the increase is across most surgical specialties, particularly ENT and Ophthalmology. Urology day case activity has decreased in recent months because Flexible Cystoscopies have moved to an outpatient setting.

The biggest increases in new out-patient attendances are in Medical specialties (Gastroenterology, Neurology, Respiratory, Neurology, Rheumatology) and Paediatrics.

Follow-up attendances rose in line with new during 2011/12 and 2012/13 but have since reduced in 2013/14, representing an improved new to follow up ratio.

Outpatient procedures have risen significantly over the last 3 years (from 23,698 in 2011/12 to 42,108 in 2013/14 on the main site), mainly in Urology, ENT and Ophthalmology. A large part of this increase is due to greater coding of outpatient procedures.

The Trust opened an acute assessment centre (AAC) on 27th August 2013. This has had an impact on A&E attendances in that there has been a reduction in the number of GP referrals to A&E (a reduction of, on average 367 a month) as these patients now go more appropriately to AAC. Over a three year period the number of patients arriving at either A&E or AAC has remained relatively static seeing only a very slight upward trend, however since March 2014 there has been a large increase in the number of A&E attendances, up an average of 458 per month in March, April and May compared with the three previous months.

The baseline plan assumes that activity continues in accordance with current plans and known developments in individual service lines. It is upon this baseline plan that the implications of this strategy are modelled.

The baseline plan defines the following key growth factors:

- 2.8% growth in Non-elective General Medicine and the AAC, compensating for a relatively low growth rate of 1% in A&E attendances (following an underlying historic trend)

- 0% growth in Obstetrics driven by a strong trend of reducing birth rate and reducing impact of immigration

- Growth of 2.5-3% in General Surgery (to reflect the Bowel Scope Screening Programme), ENT, Haematology and Ophthalmology day-cases driven by strong underlying growth

- Growth in Cardiology as the catheter laboratory becomes further established and the range of procedures offered increases

- Continued shift in point of delivery from elective inpatient to day-case, and from day-case to outpatient procedure.

Applying the strategic opportunities identified above to the baseline plan generated the activity for the Trust's strategic plan. Furthermore, a downside scenario assumes that commissioner plans to reduce activity at BHFT are achieved more quickly and more fully than the Trust's strategic scenario. It is important to note that the downside scenario mirrors commissioners' intentions, but does not fully the activity shifts proposed.

Capita were engaged in order to model the capacity requirements resulting from each of the scenarios.

The table below sets out the three scenarios:

	Scenario 1 – Baseline Plan	Scenario 2 - Strategy	Scenario 3 – Downside
Underlying activity trend	The baseline plan (as identified through modelling and division discussions)	The baseline plan (as identified through modelling and division discussions)	The baseline plan (as identified through modelling and division discussions)

	Scenario 1 – Baseline Plan	Scenario 2 - Strategy	Scenario 3 – Downside
Commissioner Plans/Reducing non-elective admissions and follow-ups to create capacity	Non-elective growth/ Follow-up growth at current trends	Mirroring commissioner intentions, with non-elective reduction over years 3, 4, 5 – to 8% in year 5 (vs. 14/15 plan) Follow up ratio reduction – from 1.8 to 1.3	Large reduction in non-electives (12% reduction by year 5 vs. 14/15 plan), which is considerably less than CCGs are suggesting (24%). It has also been assumed, unlike the CCG modelling, that these changes are back, not front, loaded. It is also assumed that A&E attendances reduce by 27% (55% suggested by commissioners)
Community expansion	No expansion assumed	Long term conditions PIN is won resulting in £11m additional income from 16/17 Margin growth on the additional income to 8% by year 2	PIN not won – no community expansion
Repatriation of activity and partnerships with other providers	Nothing assumed	Elective/ Day-case and outpatient procedure growth in years 2, 3, 4 with the same margin assumed, due to repatriation of activity (based upon the triangulation of separate information from CHKS, Dr Foster and KPMG)	Elective/ Day-case and outpatient procedure growth halved from years 2, 3, and 4 with the same margin assumed. This is either because CCGs do not support share gain or the growth is more difficult to achieve than anticipated
Capacity implications	No expanded treatment centre assumed. Sale of building in the short term	No expanded treatment centre assumed. A decision will be made in year 3 of the analysis. Sale of building in the short term	No expanded treatment centre assumed. Sale of building in the short term
Community hospitals	No change – dependent upon outcome of public consultation	No change – dependent upon outcome of public consultation	No change – dependent upon outcome of public consultation

The table below sets out summarised activity levels within each of the scenarios, as expected in the year 2018/19, including community hospital activity:

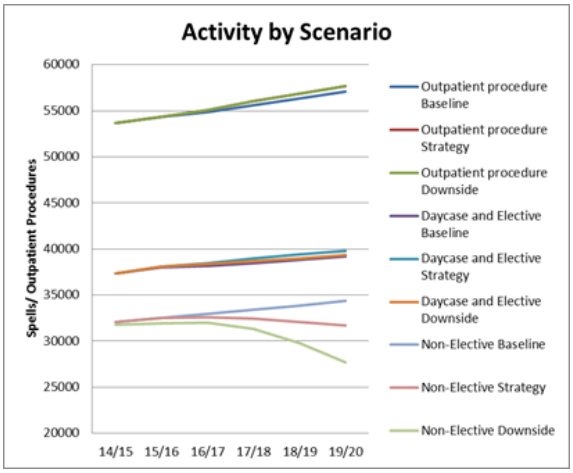
Point of Delivery (PoD)	2014/15 Plan	Activity (2018/19)		
		Scenario 1 – Baseline	Scenario 2 - Strategy	Scenario 3 – Downside
Elective inpatients	4,137	4,157	4,491	4,420
Elective day-cases	27,367	29,561	29,874	29,574
Non-elective inpatients	32,065	33,882	32,075	29,755

Point of Delivery (PoD)	2014/15 Plan	Activity (2018/19)		
		Scenario 1 – Baseline	Scenario 2 - Strategy	Scenario 3 – Downside
Outpatients (first)	80,851	83,539	83,539	82,275
Outpatients (follow-up)	172,820	178,241	156,150	152,358
Outpatient procedures	53,632	56,353	56,879	56,879
A&E attendances	56,689	58,991	58,991	44,222

The table above demonstrates the effect of the Strategy scenario, reducing non-elective admissions and outpatient follow-ups from the baseline through the delivery of the PIN and working to achieve commissioner intentions, with this being replaced by elective and day-case repatriation resulting from the partnerships formed, and from work with GPs to address gaps in market share. This elective work is delivered at a better margin, with no stepped increase in capacity – as space is reused.

The downside scenario (which moves closer towards commissioner plans) reduces non-elective admissions further, as well as significantly reducing A&E attendances. Although growth in elective and day-case work is achieved, this is insufficient to fill the capacity created by the loss of such a significant level of non-elective work.

The trends for each of the scenarios for outpatient procedures, day-case and elective combined and non-elective admissions can be seen in the chart below:



The effect of the downside scenario can be seen most clearly in its impact on non-elective admissions, with the reducing rate assumptions causing a sharp decline from 2016/17. It should be noted that this assumption is based upon commissioner intentions, however it does not reflect the full reduction in non-elective admissions that CCGs have suggested.

Although the Strategy scenario does not facilitate large scale increases in total activity, it does include the creation of a new service – providing out of hospital care as part of a Lead Provider contract. The recent PIN issued by commissioners is likely to create immediate opportunity for the service to be developed, with future growth in these types of services and contracts providing a key element of BHFT's plan for sustainability, and supporting the reduction in non-elective activity seen in the chart above.

The Strategy scenario also enables the Trust to operate on an increasingly planned cost base, with the reduction in non-elective activity and growth in repatriated elective are. This will facilitate the organisation's required improvement in productivity and efficiency, with an increase in planned

work leading to better flow through the hospital and, for example, fewer cancellations, a reduction in waiting list initiatives and less of a reliance of agency staff. This will therefore support the Trust in improving the margin made on activity, thereby facilitating the achievement of CIP targets.

6.7 Capacity

The capacity analysis identifies, that should current length of stay performance be maintained, the baseline activity projections would require an additional 48 beds. The Strategy scenario, despite the growth in more profitable work, would require only an additional 23 beds. Moving to upper decile in length of stay in the Strategy scenario – achieved through the improvements in flow identified above – would in theory allow a reduction in beds from the current establishment (by 14 beds). On this basis, the Trust is not planning on expanding its bed base as part of this strategy but given the complexities of managing medical, surgical, males and females through a day to day operational system tis will be kept under review.

7 VISION AND GOALS

7.1 Vision Statement

Our vision statement, as set out below, takes into account where BHFT is today, the type of healthcare provider we aspire to be for the long term and reflects the nature of change we anticipate over the next 10 years or more for our Trust and within our local health economy.

It is designed to make clear our overarching aspirations and to be meaningful to the leaders in our organisation. It represents a radical change in direction for BHFT – from an inward looking, acute focused, day to day hospital operator to an outward looking, community focused, evolving healthcare provider and will need organisational and culture change to deliver it.

It is born out of our values (see appendix) and was developed by the board in a series of facilitated workshops.

"When the people in our community need healthcare they will look to Burton Hospitals NHS Foundation Trust"

This vision means we will:

- Be a provider that our community ***recommends*** – not just for hospital care, but for ***healthcare*** - because we are offer ***high quality*** and easy ***access*** to specialist capability
- Understand and ***listen*** to our community – this includes the public, our ***patients***, our staff, our ***carers*** and our GPs
- ***Evolve*** with the changing landscape of healthcare and take a ***lead*** on ***innovative*** approaches to delivering ***care***
- Accept where we cannot ***sustain*** a specialist service and ensure our community ***trusts*** us to bring it the best alternative provider from ***our partners***

We will see the physical and virtual 'walls' that disconnect us from our community and our local healthcare colleagues – GPs, Community Nurses, Voluntary Sector providers, Care homes, Social services and more – collapse.

We recognise that our ambition to remain a Foundation Trust is a challenge and will depend in part on a range of issues facing our regional health economy and the outcome of plans to address them; however, it is our belief that our vision to be an embedded and connected part of our community is far more likely to be delivered as a local Foundation Trust – governed locally, with a board whose sole focus is our local community.

This is a 5 year strategic plan, but our ambitions stretch beyond that time frame. To illustrate what we believe this vision implies for the type of organisation we will become we have included some of the more tangible changes our community will see in the future:

- Far more proactive and conscious engagement at all levels
- A material shift the balance of our work from unplanned 'rescue' activity to planned, proactive and preventative care
- BHFT operating along much more of the patient pathway – offering specialist support to our patients much earlier and more proactively than ever before
- BHFT acting as prime contractor for the pathways where our specialist capability means that we can offer our public and our commissioners better outcomes and better value than anyone else
- A 24/7 urgent care service – that includes a broad scope emergency department but extends far more effectively into community and primary care – our population will see BHFT at home, in GP practices, in the high street and in schools
- Our fixed estate will be much smaller with an enhanced, elective centre performing in the top 10%, and an efficient non-elective centre with a fit for the future emergency department also performing in the top 10% compared to peers
- Innovative, commercially sound partnerships with high quality healthcare providers to allow us to deliver better quality non-core clinical services but maintain local access to them for our population
- Sophisticated partnerships to deliver as much of our non-core, non-clinical services and functions as is cost effective, embracing innovate models such as joint venture property companies – all aimed at enhancing the support for our core clinical services

7.2 Goals

In order to deliver this vision we have agreed 4 long term goals – each represented by an ongoing programme of change for our organisation.

These goals have been developed by taking account of where BHFT is today in relation to our vision and what the most important changes will be over the next 5 years to move us towards it. We expect these goals to evolve over time and they may well change if our environment or our community needs them to – we will continuously track our performance against these goals and review them fully in 2017/2018 to ensure that they still reflect the key priorities that keep us moving towards the vision.

We have also set ourselves a number of explicit objectives over the next 5 years – these link our ambitions to the main challenges our system faces. We have spent time working with our main commissioner to understand what the overall system needs to achieve and to consider how BHFT can contribute to those aims. (Our commissioners' aims are set out in more detail in the appendix).

Our four goals are linked directly to our vision and our strategic priorities over the next 5 years. Each goal is represented by a long term work programme.

Table 1: Vision and Goals

Vision	Goals
"When the people in our community need healthcare they look to Burton Hospitals NHS Foundation Trust"	To deliver this vision we need a completely new way of doing business, a radically different model of care and as an organisation we will need to become far more capable at engaging, innovating and changing
• Understand and *listen* to our community – this includes the public, our *patients*, our staff, our *carers* and our GPs • *Evolve* with the changing landscape of healthcare and take a *lead* on *innovative* approaches to delivering *care* • Accept where we cannot *sustain* a specialist service and ensure our community *trusts* us to bring it the best alternative provider from *our partners* • Be a provider that our community *recommends* – not just for hospital care, but for *healthcare* - because we are offer *high quality* and easy *access* to specialist capability	1. To completely transform our approach to engaging with and understanding our community 1.1 A wholesale change in our approach from passive, reactive engagement with public, patients and GPs (i.e. waiting for them to need help) to conscious, proactive engagement **1.2** A continuous and 'live' understanding of our markets – a radical change from annual contracting and a reactive culture to a richer and continuous understanding of what our community needs, the issues our commissioners are facing and what our competitors are doing to allow us to adapt our strategy and services far more quickly **2. To deliver an evolved clinical model** 2.1. Have the ability to continuously examine the sustainability and clinical viability of our services 2.2. Have a working and commercially effective partnership model for clinical services to deliver clinical viability and support change 2.3. Have an outward looking culture that seeks out best clinical practice, learns from the wider system and understands what its competitors are doing well 2.4. Implement key changes to our clinical services 2.4.1. Renewed 'acute' model of care that emphasises proactive care and rapid access to specialist support – with lowered non-elective admissions and reduced dependence on A&E 2.4.2. A well developed and innovative set of out of hospital services that offer proactive support for the elderly frail and those with long term conditions 2.4.3. A "top decile" elective centre for quality and efficiency **3. Implement a radical new and efficient business model** 3.1. A significantly smaller estate footprint to lower running costs and new, fit for purpose, estate where required 3.2. Effective, recurrent delivery of cost improvement schemes, year on year 3.3. Partnerships – including joint ventures and outsourcing arrangements – to deliver all non-core services and functions wherever we can get better value and/or to deliver new revenue streams

Vision	Goals
	3.4. Integrated IT and technology that supports a healthcare provider with services in a hospital, in primary care and in community care
	4. **To create a step change in our delivery capability and organisational effectiveness** 4.1. Governance that assures the future as well as the present 4.2. A strategic 'culture' amongst the leadership – for the Board and our Clinical leaders 4.3. An effective programme of staff development and a workforce willing and able to deliver change 4.4. Fully developed, integrated service line reporting and service line management 4.5. Alignment of strategic and operational priorities with performance management

Each goal has an Executive sponsor who is accountable for the delivery of the supporting programme. The Board as a whole is accountable for the overall strategy and delivering the vision.

7.3 Objectives

As a board we have agreed a set of organisational objectives. Taking both our vision and goals – as set out above – and taking into account the ambitions of our commissioners, we have developed strategic objectives for the next 5 years that reflect the measurable elements of our goals and vision.

Our work with our key commissioners in developing this strategy indicates that the system wide objectives are designed to address specific areas of outlying poor performance (vs peer benchmarks from 2012/13). Commissioner's objectives include:

- Reducing non-elective admission rates (to top decile vs peer benchmarks 2012/13), in particular for ambulatory sensitive conditions, long term conditions, frail elderly and cancer
- Reducing readmission rates (to top decile)
- Increased proportion of patients admitted acutely to be discharged home
- Reduced number of outpatient follow up appointments – where good quality alternative approaches exist
- Reducing the number of 'procedures of limited clinical value' in line with peer top decile
- Reducing the number and impact of falls
- Earlier presentation of cancer sufferers to specialist care and improved outcomes – to improve the quality of care and help reduce high costs.

For our commissioners the need is to deliver the above objectives without any increase in funding.

Our objectives describe a set of key, time bound measures that we will aim for to support the delivery of our four key goals. The Executive sponsors are accountable for the goals and delivery of the objectives.

Goals	5 Year Objectives
1. To completely transform our approach to engaging with and understanding our community	• Independent assessments demonstrate a recognised transformation in the way we engage with key stakeholder groups – public, patients and GPs • Implemented and embedded with demonstrable outputs, a new process to continuously update our understanding of our community's healthcare needs and the issues with healthcare provision
2. To deliver an evolved clinical model	• Top decile performance on PROMs in year 5 • Top decile performance on relevant clinical outcome measures vs our peers • Best in peer group on Family and Friend Testing • Top decile non-elective admission rates & readmission rates (vs. 2012/13 benchmarks), outpatient first to follow up ratios • Top decile performance on key operational and quality measures – 18/52s, 4 hour A&E targets – (vs. 2012/13 benchmarks)

Goals	5 Year Objectives
3. To implement a radical, new and efficient business model	• 5% operating surplus from clinical services and a positive underlying surplus • Proportionately lowest estate running cost and back office function cost in our peer group • Material performance improvements where partnerships are implemented
4. To create a step change in our delivery capability and organisational effectiveness	• 100% appraisal rates • 100% of identified clinical and managerial leaders to have been through a new development programme • Top scores on independent governance assessments – e.g. vs. QGF and BGAF

These objectives indicate how we will measure our progress towards our goals and demonstrate our alignment to system wide objectives.

There are many more measures we continuously use to assess our performance as an organisation.

8 STRATEGIC OPTIONS

8.1 Challenges

The preceding sections have outlined the context within with the Trust is operating. The Trust has considered this and the challenges can be broadly summarised as:

- A health economy which is funded below its fair shares capitation target and facing significant financial pressures
- A trend of increasing demand due to complex factors including rising and aging population, higher births and operational changes in other sectors such as primary and social care
- A commissioner plan which envisages reductions in non-elective, A&E and outpatient follow-up activity as well as a 20% improvement in elective efficiency
- The potential tendering by commissioners of frail elderly pathways, intermediate care and long-term conditions which will impact on the Trust's existing service provision
- A recognition that BHFT does not have the critical mass to support delivery of some specialist services yet needs to sustain the improvements in quality that have been achieved following the Keogh review
- Immediate and increasing difficulties in identifying CIPs on a long term sustainable basis
- A need to increase our change capability as we enter a more dynamic and uncertain economic and technological environment.

8.2 Opportunities

There are a number of opportunities for the Trust that will help us meet these challenges and deliver sustainable services in the longer term. These opportunities include:

- Building on our strong local presence with support from the CCGs and residents in our catchment
- Exploiting our key strategic assets such as the elective centre and community hospitals
- Changing our delivery models to meet the increasing demand for healthcare in more innovative ways
- Repatriating patients flowing out of area as our reputation for quality improves as identified by the 'distressed health economy' review
- Engaging our staff in the vision for a vibrant and successful future for the Trust

8.3 Approach to Strategic Options

In 2013 the Trust evaluated its strategic options with support from external advisors. In developing this five-year strategy it has revisited that analysis and confirmed that it is still relevant in the current context summarised above.

The strategy is structured around three pillars of acute, community and non-clinical activity. Under each of these headings the following questions were addressed.

Acute Strategy	Community Strategy	Non-clinical Strategy
Do we want to be a DGH or a smaller focussed Trust? Which services are core to a clinically viable proposition What configuration represents a financially viable position?	What role should community services play? What should be community services? How should community care be integrated with other services?	Can we improve our current support services? What other services could be provided? Is there a significant opportunity for other services? How could these support the clinical services strategy?

8.4 Acute Options

A long list of options for the acute strategy consisted of six very different configurations ranging from being a hyper acute centre to a community hospital only.

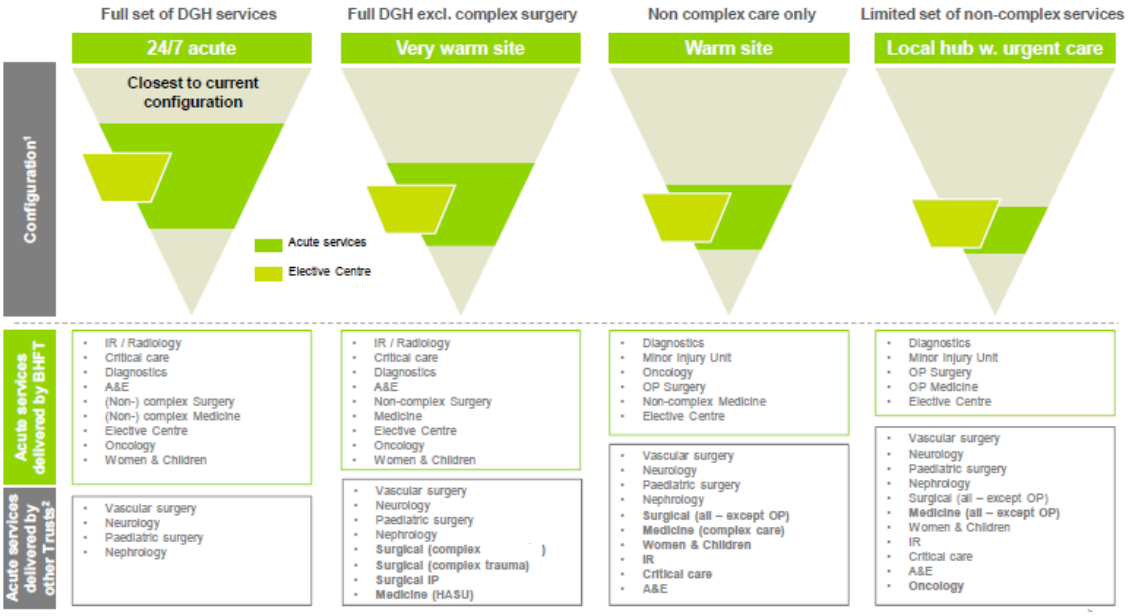
An initial assessment of the long-list options against BHFTs challenges, success criteria, perceived external views and ease of execution resulted in four options being taken forward for further evaluation as shown below.

Strategic option	BHFT challenges addressable by acute care				Additional BHFT success criteria			External stakeholder view (Patients, CCGs, GPs)	Ease of execution	Total
	Critical mass of specialties	Return to profitability	Reduces competition with other Trusts	Helps attract quality staff	Continued good clinical outcomes	Continued existence of an independent Trust	The healthcare provider of choice to the local community			
Hyper-acute, major trauma centre	Unclear whether there is sufficient demand	Unknown at this stage	These services are already offered by other Trusts	✓	Less proven track record	✓	More focus on pulling higher acuity work from farther afield	More limited service scope than before	Requires development of new services	2
24/7 major acute	Not significant enough change	Unknown at this stage	Not significant enough change	Comparable to offer at other Trusts	✓	✓	✓	✓	✓	5
'Very Warm' site	✓	Unknown at this stage	Not significant enough change	Comparable to offer at other Trusts	✓	✓	✓	✓	✓	6
Warm site	✓	Unknown at this stage	✓ (Partnering opportunity)	Likely to be less attractive than other Trusts	✓	✓ (possibly)	✓ (Branding question)	More limited service scope than before	Likely to require a partner	5
Local hub with urgent care	✓	Unknown at this stage	✓ (Partnering opportunity)	Likely to be less attractive than other Trusts	✓	✓ (possibly)	✓ (Branding question)	More limited service scope than before	Likely to require a partner	5
Community only provider	Unclear whether there is sufficient demand	Unknown at this stage	✓	Community staff are readily available	Has not been historic focus	✓	More limited service scope than before	More limited service scope than before	Requires a refocus from acute care	2

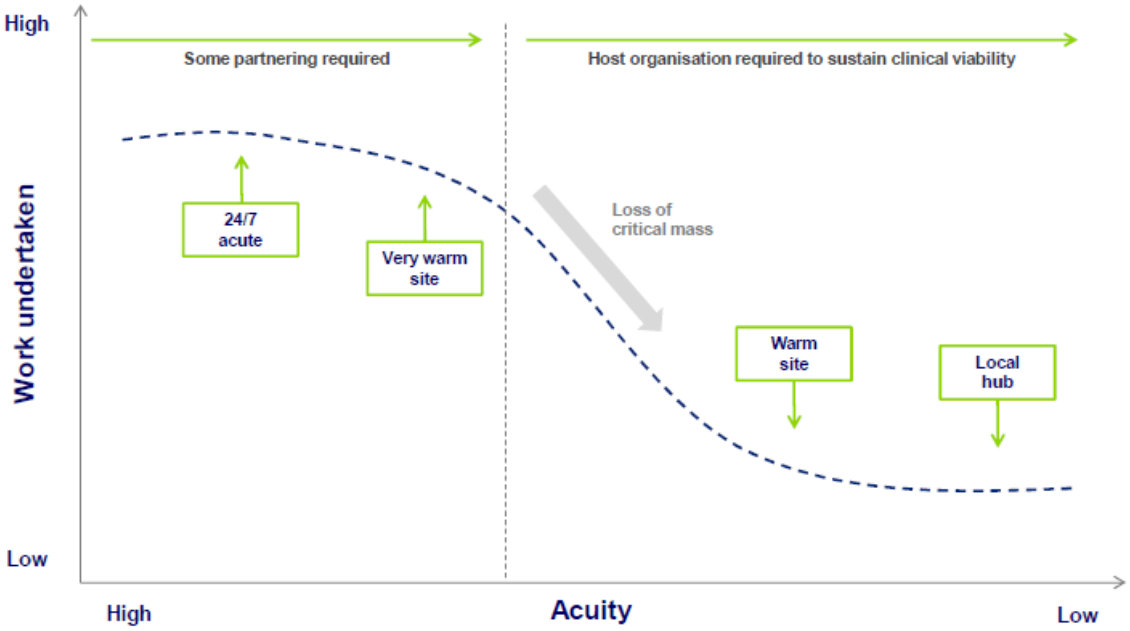
The four options taken forward were therefore:

- 24/7 Major Acute – A full set of DGH services
- Very Warm Site – A full DGH excluding complex surgery and some specialist services. (Some services would be provided/supported by working with partners to maintain them on the Queen's Hospital site)
- Warm Site – non-complex care only
- Local Hub for Urgent Care – a limited set of non-complex services

Further definition of the service content of these options is provided in the figure below. Moving from left to right fewer services are provided by BHFT and more by other Trusts.



However, not all of these configurations were deemed to be clinically viable as a standalone Trust. The Warm Site and Local Hub would require a host organisation to sustain clinical viability and even 24/7 Acute and Very Warm Site require some partnering.



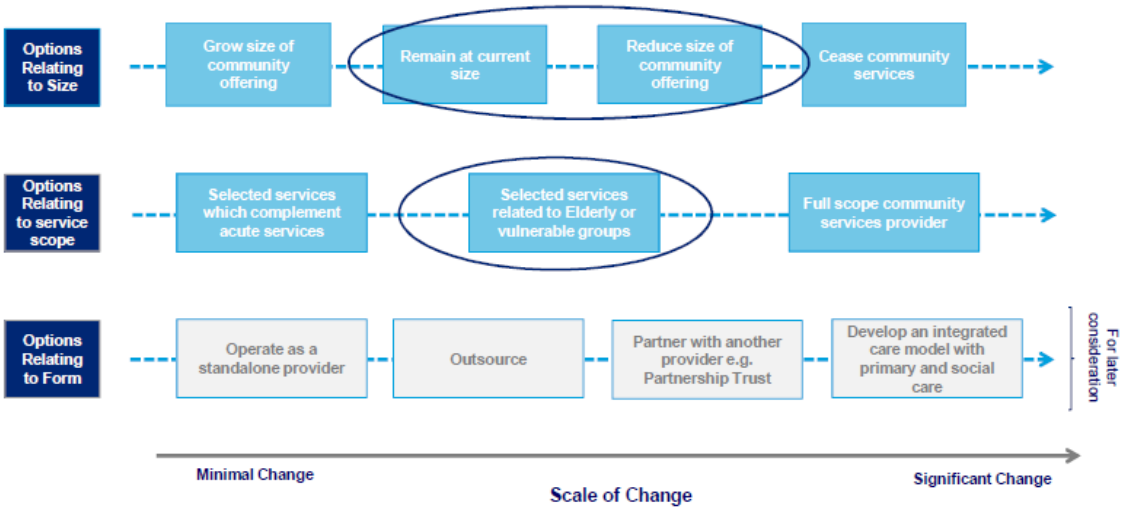
Further detailed assessment of clinical viability, financial opportunity, ease of execution and CCG support confirmed the view that the higher acuity options were most appropriate. However because of the relative importance of clinical viability the Very Warm Site option was selected as the right model for BHFTs acute services as summarised below.

Discussions with the CCGs confirmed that they are keen on the continued presence of a hospital site in Burton but stressed equally that they would encourage more partner working with other Trusts to help deliver more efficiency and ensure good clinical outcomes.

8.5 Community Services options – Integrated care provider

The community strategy was also developed through a high level options assessment. In undertaking a review of this assessment the Trust was mindful of the commissioners' intention to market test long term conditions and frail elderly services as well as the emerging conclusions of the distressed health economy review.

A list of strategic options has been evaluated taking into account size, service scope and form as illustrated below.



This concluded the Trust should be re-focussing community services to target the most vulnerable patient groups.

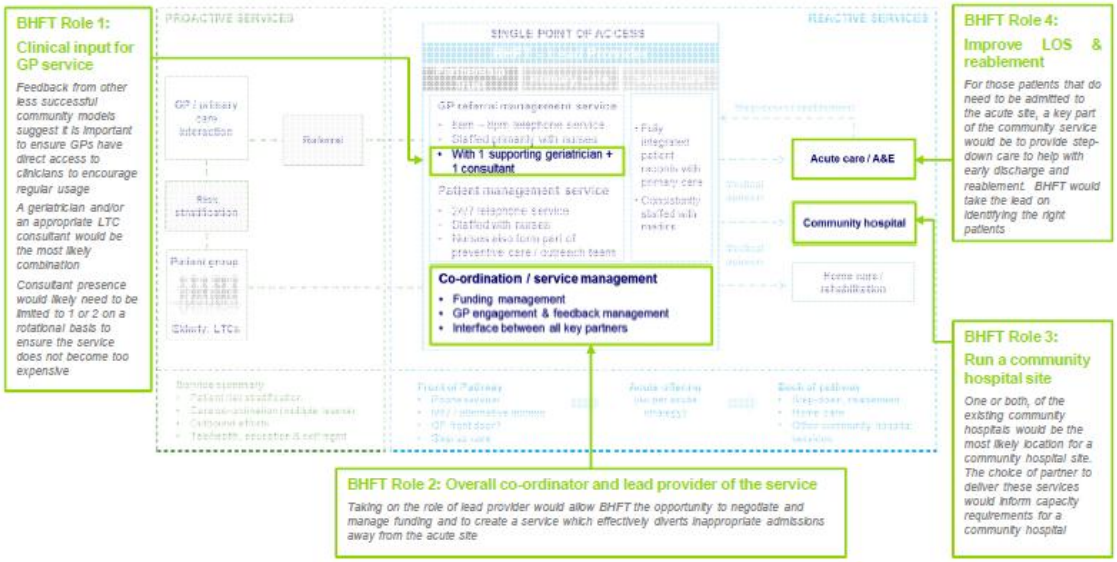
An assessment of all the options against the underlying strategy principles confirmed that this is an option to pursue in more detail.

Strategic option	BHFT challenges addressable by acute care				Additional BHFT success criteria			External stakeholder view (Patients, CCGs, GPs)	Ease of execution	Total
	Critical mass of specialties	Return to profitability	Growing Elderly demand	Offset tariff pressure	Continued good clinical outcomes	Continued existence of an independent Trust	The healthcare provider of choice to the local community			
Continue with current community model offering a selection of services	Insufficient change	Unknown at this stage	Insufficient change	✓	✓	✓	Does not cover all community services	Current community proposition unclear to commissioners	✓	4
Re-focus community offer to serve only the Elderly and/or vulnerable people	✓	Unknown at this stage	✓	✓	✓	✓	Does not cover all community services	✓	✓	7
Grow to become a full service community provider	✓	Unknown at this stage	Does not target this group more than today	✓	No historical track record	✓	✓	Not clear that there is demand for this	Requires new skills	4
Cease all community services delivery	n/a	Unknown at this stage	n/a	No income to offset tariff	n/a	✓	Reduced service offering	Commissioners would like to see more Elderly /LTC care	✓	2

A community offer run by BHFT could divert admissions to the most appropriate settings and provide preventive care to stem some of the anticipated long term increase in demand and support commissioners in reducing unplanned attendances and admissions.

The service would likely consist of a broader range of services than BHFT currently offers and would most likely mean working in partnership with other providers – NHS, social care and third sector – to deliver the full range of required care.

One scenario is that BHFT plays the role of lead provider and overall co-ordinator, providing clinical input to the service, whilst other providers takes on the day to day delivery of home based nursing care. The figure below illustrates how it is envisaged this could operate in practice.

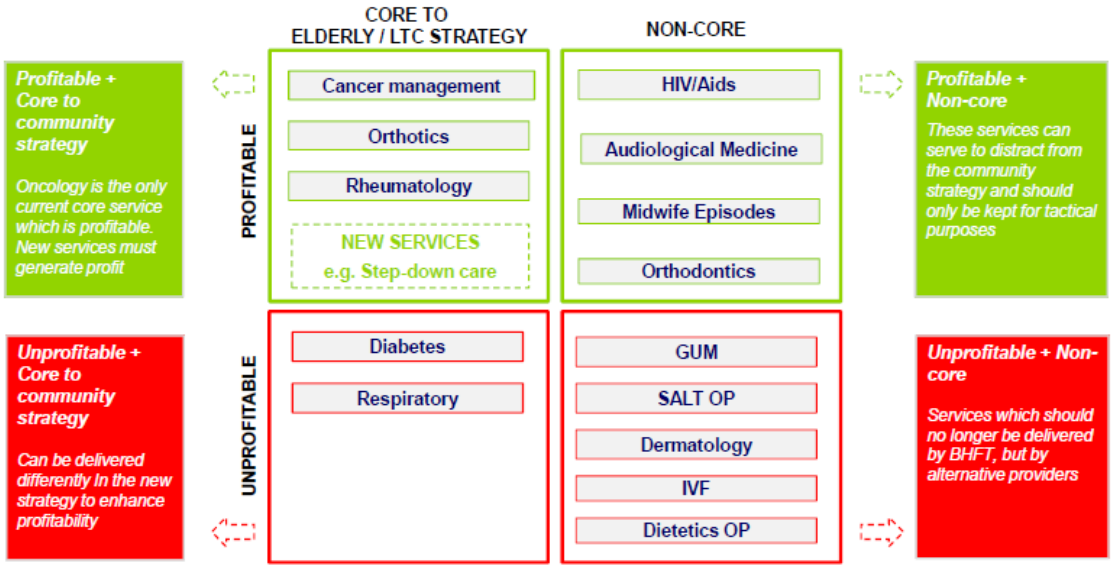


This service will require a number of changes to current ways of working, including launching new services, partnering with other providers to deliver these services and diversifying points of delivery.

Once the scale and scope of the community strategy have been determined and partners identified the Trust will be able to evaluate the best use of its community hospitals.

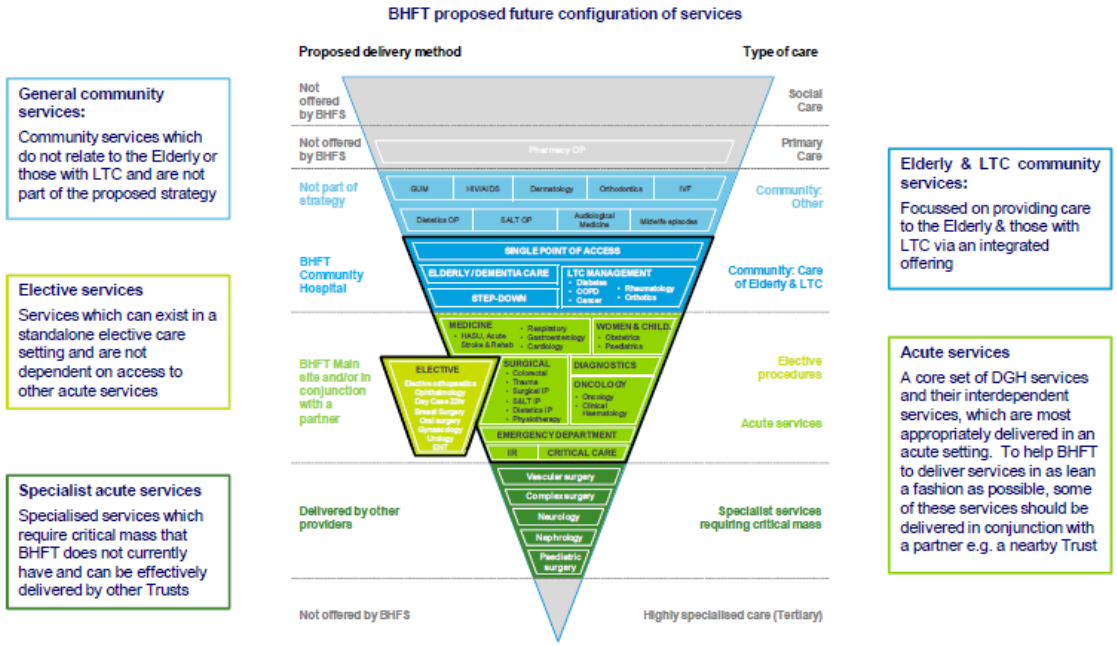
8.6 Other Community Services

Whilst the above analysis for community services covers the anticipated commissioner priorities over the next five years there are other services currently provided on a community basis that the Trust has considered. Not all of these are appropriate for the long term service portfolio or make a profit towards supporting the trust's financial challenge. Therefore these will be considered for transfer to alternative providers where this is feasible and can be agreed with commissioners. This range of services is illustrated below.



8.7 Overall Clinical Strategy

The sustainable clinical model which emerges for the Trust from the above analysis is illustrated below.



The clinical model specifically excludes social care and primary care and relinquishing non-core, non-profitable services on a tactical basis as the opportunity arises.

Community services will be developed via the integrator model through facilitating a single point of access and redesigned care pathways for frail elderly and long term conditions.

BHFT will continue to provide non-complex elective work via the purpose built centre and standard DGH non-elective work, sometimes in partnership with others where this helps with critical mass.

The Trust believes there are a number of benefits of this approach to community services including:

- For patients:
  - A sustainable local general hospital
  - A single point of access for the elderly or those with LTC allowing easier navigation of the social and healthcare system
  - Preventative care improves health outcomes for those in high risk groups
  - Integrated records allows for consistent and uninterrupted patient experience
- For commissioners
  - Fewer admissions and lower costs
  - Healthier population with more stable health status
- For the Trust
  - A clinically viable service offer that maintains its presence in the community
  - Taking charge of the funding thereby increasing flexibility in deployment of resources
  - Reduced admissions for unprofitable non-elective care and non-core services
  - Shorter length of stay as a result of step down and rehabilitation provision

The exact value of the community opportunity will remain unclear until negotiations have commenced with the CCG in line with their procurement process. However there is some evidence from elsewhere of positive return on investment for community and/or integrated models:

Report	Source	Year	Evidence
QIPP National Workstream EOLC Savings Analysis	BEN PCT	2011	• "The average care of inpatient care is double the cost of care in community setting – so potentially 50% savings: this is maximum, minimum level is assumed as 11%"
QIPP Indicator for End of Life Care – proposal of new indicator	NEoLCIN	2011	• "From a financial perspective there may be scope to reduce acute hospital costs for the NHS [...] it is predicted but not guaranteed that costs would be lower for care outside hospital."
Transforming our health care system – Ten priorities for commissioners	Kings fund	2011	• "Some evidence suggests greater co-ordination of care can improve quality without incurring any additional costs. There may be scope to make cost savings, particularly through a reduction of unnecessary admissions into the acute setting, although research on this is limited."
The impact of telehealth on use of hospital care and morality	Nuffield Trust	2012	• Most complex trail of telehealth in the world with over 3,000 patients participating • Statistically significant reduction in emergency admissions and mortality of around 20% and 45% respectively
Understanding patterns of health and social care at the end of life	Nuffield Trust	2012	• Individuals with the highest social care costs had relatively low average hospital costs – this was broadly the case irrespective of age, and suggests that use of social care may prevent the need for hospital care"
Mainstream roll-out of telehealth in the East Riding of Yorkshire	University of Hull	2012	• Evidence suggests telehealth service currently at East Riding provides net savings of £103 per monitoring month (an ROI of 61%) • Running the service at full scale could potentially bring annual net savings of over £158k per annum from reduced non-elective

9 FINANCIAL PROJECTIONS

9.1 Introduction

Financial projections have been made for the five years of the plan 2014-15 to 2018-19. The first two years are consistent with the two year operating plan submitted to Monitor.

The projections are made for the Baseline, Strategy and Downside scenarios.

9.2 Assumptions

In undertaking the projections the following assumptions have been made.

Assumption	14/15	15/16	16/17	17/18	18/19
Cost inflation	Per Plan	2.2%	3%	3.4%	3.6%
Tariff deflator	Per Plan	2.3%	1%	0.6%	0.4%
Efficiency gain	**4.0**	**4.5**	4.0	4.0	4.0
CIPs	£7.0m	£8.4m	£7m	£7m	£7m
Marginal Costs %					
▪ Inpatients/Day Case	50	50	50	50	50
▪ Outpatients	30	30	30	30	30

The marginal cost assumptions stated in the table above apply to both activity reductions and activity increases. This supports the assumption that reductions in non-elective activity create additional space which can be used to accommodate increases in repatriated elective activity. This therefore avoids the requirement for additional beds.

Furthermore, the reduction in follow-up outpatient income assumes only a marginal cost reduction, as all staff will be redeployed in order to deliver the elective and community based activity growth as set out in the strategy. This provides a new income stream for out of hospital services (of the type of the LTC PIN).

9.3 Cost Improvement Programme

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

- Better Care Better Value
- Estates and Facilities Management Information Systems (ERIC)
- Payments by Results Benchmarking Tool
- Albatross patient level costing benchmarking system
- A range of external reports from other areas by agencies such as NHS Benchmarking Club, Dr Fosters, CHKS and CIPFA.

Areas of variation have been identified for further analysis and development. Schemes are developed to Project Plan level using the Trust Programme Management Office workbooks.

The two-year plan of the Trust identified a target saving of £11 million (7.3%) in 2014/15, however the forecasted savings in year is around £7m (4.6%) this is because many of the schemes have a longer lead in time and will deliver a part year effect in-year and will flow into 2015/16.

There are schemes and ideas supporting the assumed CIPs for years 1 and 2 of the plan and years 3 to 5 are bases on an assumed requirement to achieve 4% efficiency.

9.4 Capital Expenditure

The Trust's capital expenditure programme has been developed in detail for 2014-15 and 2015-16. Going beyond that an allowance has been assumed based on expected patterns of replacement and investment required.

Assumption	14/15	15/16	16/17	17/18	18/19
Capital Expenditure £000	7,000	6,300	6,500	6,700	6,800

9.5 Capital Receipts

A net receipt of £3.9m has been assumed in 2015/16 for the sale of Outwoods. Whilst it is expected there is potential for further disposals in future years these will not be factored into the projections until the Trust Estates Strategy is clear allowing for professional valuations to be included based on site proposals and clear knowledge of costs of sales and reprovision of services.

9.6 Overview

The projections show the following Income and Expenditure and Continuity of Service Risk Ratings (CoSRR) for each scenario.

Forecast	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)
Scenario 1: Baseline					
Income & Expenditure Surplus/(Deficit) £m	(10.6)	(13.1)	(12.5)	(12.0)	(11.3)
CoSRR	1	1	1	1	1
Scenario 2: Strategy					
Income & Expenditure Surplus/(Deficit) £m	(10.6)	(13.1)	(9.9)	(9.4)	(9.2)
CoSRR	1	1	1	1	1
Scenario 3: Downside					
Income & Expenditure Surplus/(Deficit) £m	(10.8)	(13.4)	(10.5)	(10.9)	(11.3)
CoSRR	1	1	1	1	1

The Trust recognises that continuing annual deficits and a CoSRR of 1 are not sustainable and has a number of options available to it to mitigate these which are described below.

9.7 Assets and Liabilities

The impact on the balance sheet of the strategy Scenario is shown below.

Balance Sheet	14/15	15/16	16/17	17/18	18/19
	£'000	£'000	£'000	£'000	£'000
Fixed Assets	124,653	118,727	118,699	118,838	119,014
Stock	3,674	3,674	3,674	3,674	3,674
Trade Debtors	5,764	5,764	5,764	5,764	5,764
Cash	(490)	(488)	(491)	(489)	(491)
Trade Creditors	(13,671)	(13,790)	(13,957)	(14,121)	(14,038)
Capital Creditors	(884)	(884)	(1,224)	(1,237)	(1,249)
Other Liabilities (inc Long Term)	(2,085)	(2,211)	(1,683)	(1,155)	(876)
Total Net Assets	**117,941**	**111,786**	**111,764**	**112,252**	**112,750**
Public Dividend Capital (PDC)	62,915	69,886	79,827	89,732	99,475
Reserves	55,026	41,882	31,937	22,520	13,305
Total Funding	**117,941**	**111,768**	**111,764**	**112,252**	**112,780**

The balance sheet shows that the Trust increasingly runs out cash and will require Public Dividend Capital to maintain liquidity, as reflected in the CoSRR above.

9.8 Mitigating Actions

(a) Partnering with University Hospital of North Staffordshire

The Trust has considered a range of other providers for partnering in the delivery of clinical services and after discussions with all potential candidates is advancing negotiations with UHNS.

Initially the partnership is expected to involve the Trust providing capacity for UHNS to operate some of its more specialist services from on a satellite basis. In return UHNS will facilitate the repatriation of some activity from Burton's catchment area. There has been some allowance for this in the activity projections but the potential do more is significant but has not been included because negotiations are at an early stage.

(b) Community Services

Our stated aim is to extend the reach of the Trust along the patient pathway. This will benefit patients through the delivery of joined-up care and commissioners through more efficient and effective provision.

In our Strategy Scenario we assumed we will retain our existing £25m business which relates the commissioner's PIN and win the £11m of other work associated with the activity whilst making a 4% margin per annum on that.

However we believe the potential could be far greater as we will be in a much stronger position to rationalise care pathways, control demand for hospital services down the line and make economies of scale.

More work is needed to firm up these plans and that will be done when we have the Information Memorandum which will provide more details scope involved.

We also believe there will be potential to extend our reach into the community for other services. In order to extend our reach and ensure we have the right capability for this we will investigate the possibility of partnering with other organisations with a track record in delivering these services. These potential partners will include public, private and third sector organisations either exclusively or in combination.

(c) Establishing a Joint Venture

The Trust recognises a need to develop its capability and capacity for making a step change in how it operates its business. This includes the introduction a more commercial and efficient approach to operating procedures, more effective ways of enhancing our change culture and more cost effective delivery of services.

The Trust is therefore considering the potential for appointing a joint venture partner. to work with it on a transformation programme for its corporate support services. The Trust's objectives are to: simplify; streamline and automate internal processes as much as possible; develop a value adding, business focused support service with greater clarity and agreement of expectations; provide an 'enabled service' powered by technology; adopt an organisational model that is more responsive and adaptable to the changing needs of the Trust; be proactive across all spheres of influence.

The Trust wishes to engage a strategic partner who will from the outset deliver a set of, primarily, transactional services including HR, finance, IM&T and property & facilities maintenance.

The strategic partner may also be required to manage the Trust's capital IT investment over a 5 year period.

The Trust is looking for a strategic partner who can deliver opportunities for improvements and benefits from automation and economies of scale in the provision of the Core Requirements.

The Trust is considering structuring the contract so as to provide for the opportunity to increase the scope of services beyond the Core Requirements provided by the strategic partner where the Trust considers that the strategic partner can offer tactical and strategic elements of its corporate function. These areas would include patient administration services; project and programme management; and supporting growth of the Trust's work.

The Trust also anticipates providing the following activities within the scope: insight function; strategy and business planning; communications; contracts and commercialisation; employee health.

The Trust is anticipating to let a 7 year contract with an option (at the discretion of the Trust) to extend for a further 3 years.

(d) Engaging External CIP Support

A review of the 2014/15 CIP has revealed significant slippage in the original plan. As a result the Trust recognises that it does not have the internal capability to generate and deliver CIPs on an ongoing basis. It will therefore be identifying external expertise to support the ongoing identification and delivery of CIPs with early planning for implementation in future years.

(e) Rationalising the Estate

The Trust's analysis has demonstrated that it has a large estate relative to the quantum of clinical activity it undertakes. The operating plan for year 1 includes disposal of the Outwoods site in Burton and redistribution of the vacated services to Queen's Hospital.

In longer term there is potential for further disposals of underutilised land and accommodation at Queen's Hospital.

Also, depending on the outcome of the public consultation and requirements for the integrated frail elderly/long term conditions service there may be further opportunity at the community hospitals.

The Trust has therefore begun a review of its estate requirements with the output being a development control plan which will inform the future decisions about 'right-sizing- the estate the for its medium term requirements. This review will be supported by appropriate professional advisors. The Trust is also currently reviewing whether a Joint Venture partnership for the development of its estate strategy is a best fit solution to its lack of capacity for strategic estates planning.

(f) Internal Systems and Processes

The Trust is believes that there is scope for improving its capability and capacity for supporting the delivery of its clinical services in advance of and in harmony with any potential joint venture initiative. It therefore plans a number streams of work which will deliver this including fitness for purpose reviews of key support functions, the development of service line reporting and management and strengthening the trust's strategic planning capability.

10 ORGANISATIONAL EFFECTIVENESS

10.1 Capability & Capacity

Giving the ambitious nature of the Trust's objectives as well as the significant change programme required to underpin the efficiency opportunities, shifts in clinical operating model as well as the requirement to develop long term partnerships it is essential that the Trust puts both capacity and capability to deliver the plan and increase organisational effectiveness.

Securing the appropriate capability to deliver the plan is essential to ensure its delivery and will be achieved through a number of mechanisms. The Trust's Programme Management Office (PMO) will continue to recruit flexibly to ensure that specialist skills are available to deliver efficiency requirements. The skills requirements will almost certainly shift over the period of the plan and therefore temporary / short term appoints will continue to be used alongside project management skills.

Operationally, there will be a clearer distinction in the capacity to deliver the day to day operations of the Trust and the capacity to deliver the future strategy and operating model. The latter will require further investment below Director level, making permanent, as well as further enhancing, the short term support put in place this year to further the Trusts Community model.

Additionally our increasing work with NHS, commercial and third sector partners will see an injection of new capabilities and expertise previously unavailable to the Trust.

The anticipated changes in the composition of the Board as Non-Executive Directors reach the end of their term of office will allow the Board to refresh its skills and consider the makeup needed for its strategic challenges. As has become characteristic of the Executive Team in the last few years, flexibility will remain to recruit individuals with specialist skills, on a short term basis, to supplement the extensive NHS experience of the team, e.g. Commercial or OD skills.

10.2 Development Programme

During 13/14 Clinical Leadership was enhanced significantly with additional capacity put in place in both the Medical Director's Office and the Divisional Business Units. In line with the Trust's OD Plan during 14/15 onwards the Trust will focus on developing capability. A Clinical Leadership Programme, externally provided, will shift its focus from development of individual clinicians, to a more team based approach more closely aligned to organisational priorities.

A programme is already being developed to support the most senior of the Divisional Team ensuring that they are appropriately resourced to work with in the Trust's plans for devolved management and responsibility. This will align with a shift by the Executive Team away for the day to day management of the Trust towards a greater strategic and external focus required to deliver the plan.

The Trust has designed and will implement an organisational effectiveness programme to help it to deliver its vision and to live by its values. This programme will embed new capabilities into the organisation through the implementation of service line management in its broadest sense. The key goals for this programme are:

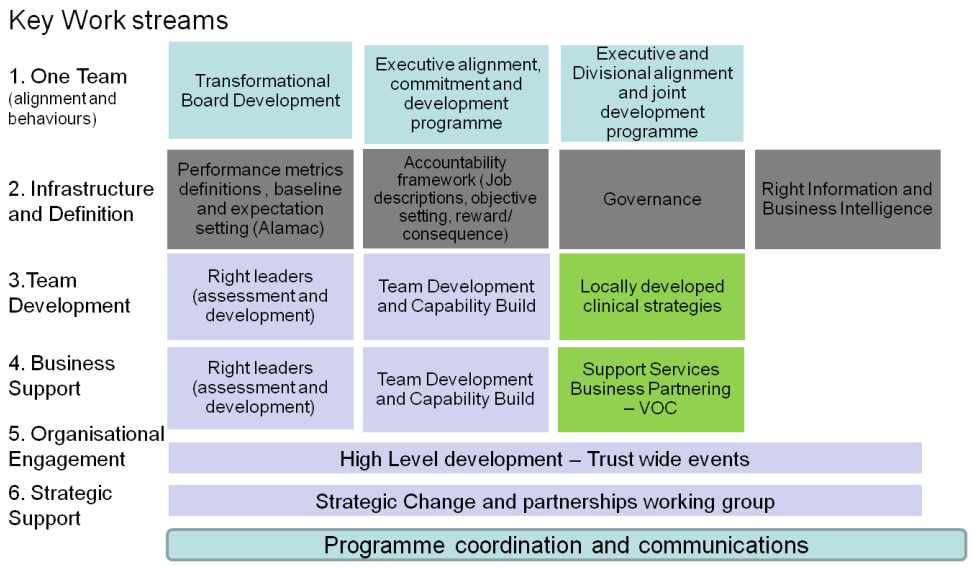
- At Board and Executive level to create more time for strategic thinking and strategic change which will include the development of clinical and non-clinical partnerships
- To strengthen clinical capability, capacity, engagement and involvement in leading change in the planning and delivery of our services
- To create a governance structure that is as much about assuring the future as it is the present
- To better understand performance across the clinical functions by defining 'outstanding', 'good', 'requires improvement' and 'inadequate' against a balanced scorecard of metrics covering quality and safety, satisfaction, access and operations, finance and workforce
- To develop non clinical support teams that are value adding business partners

- To more clearly align strategic intent to objective setting and to the performance management framework

- To make sure the right leaders are in the right places with the right levels of empowerment, capability and support to make change happen deeper in the organisation

- To more deeply engage with the organisation and to create new levels of trust, capability and change energy

The key components of the organisational effectiveness programme are set out below:



The organisational effectiveness programme will be launched alongside the re-launch of the Trust's vision and values as part of the 5 year strategic plan.

11 IMPLEMENTATION PROCESS & TIMETABLE

11.1 Progressing Towards Our Goals

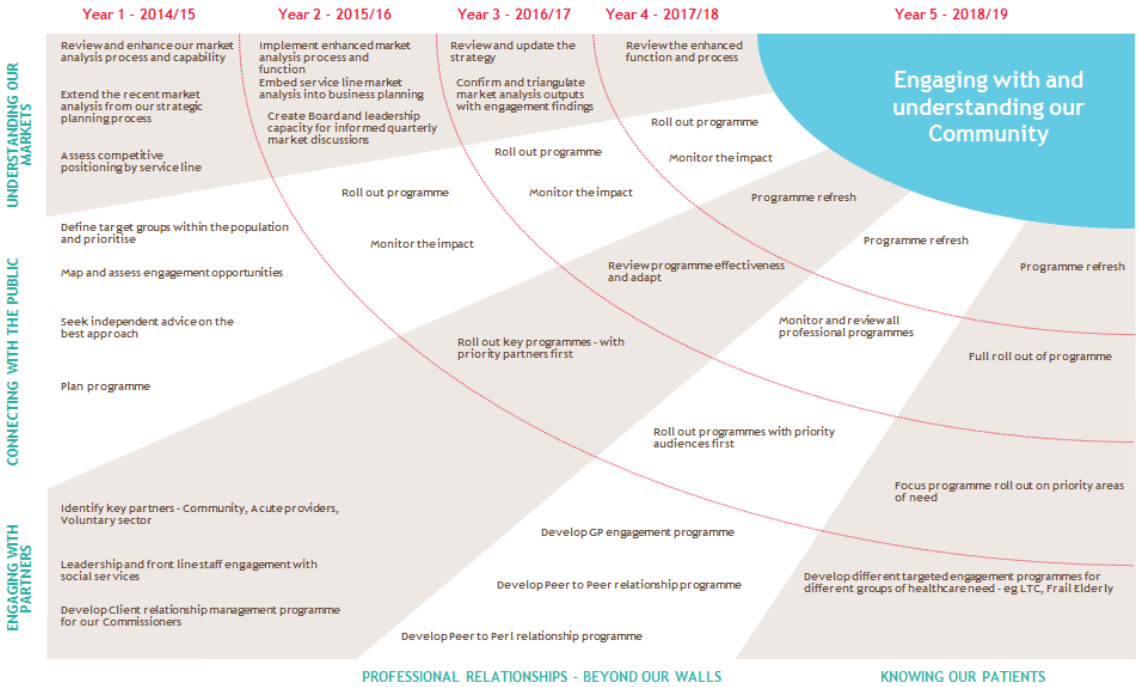
As indicated by our goals we will have four primary change programmes running continuously over the next 5 years.

We have set out the latest view of the key milestones for each programme.

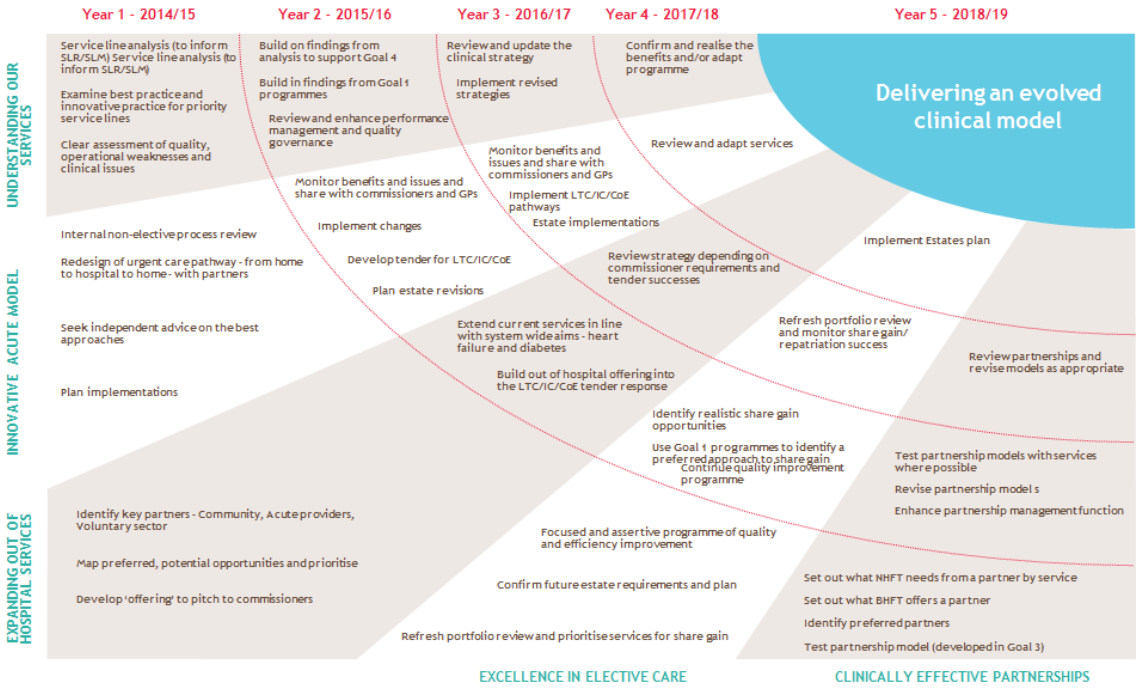
Understanding our Community	Evolved Clinical Model	New Business Model	Organisational Effectiveness
• Understanding our markets • Connecting with the public • Knowing our Patients • Professional relationships – beyond our walls • Engaging with Partners	• Understanding our services • Developing partnerships • Modernised acute care • Develop integrated out of Hospital care models • Excellence in elective care	• Best in class clinical support services • Radical estates strategy • Commercially sound partnerships • Enabling IT • New revenue streams	• Board development • Clinical leader development programme • Enhancing Governance • Embedding accountability and responsibility - SLM • Functional excellence – including SLR

The key milestones on our journey towards sustainability are shown in the diagrams below.

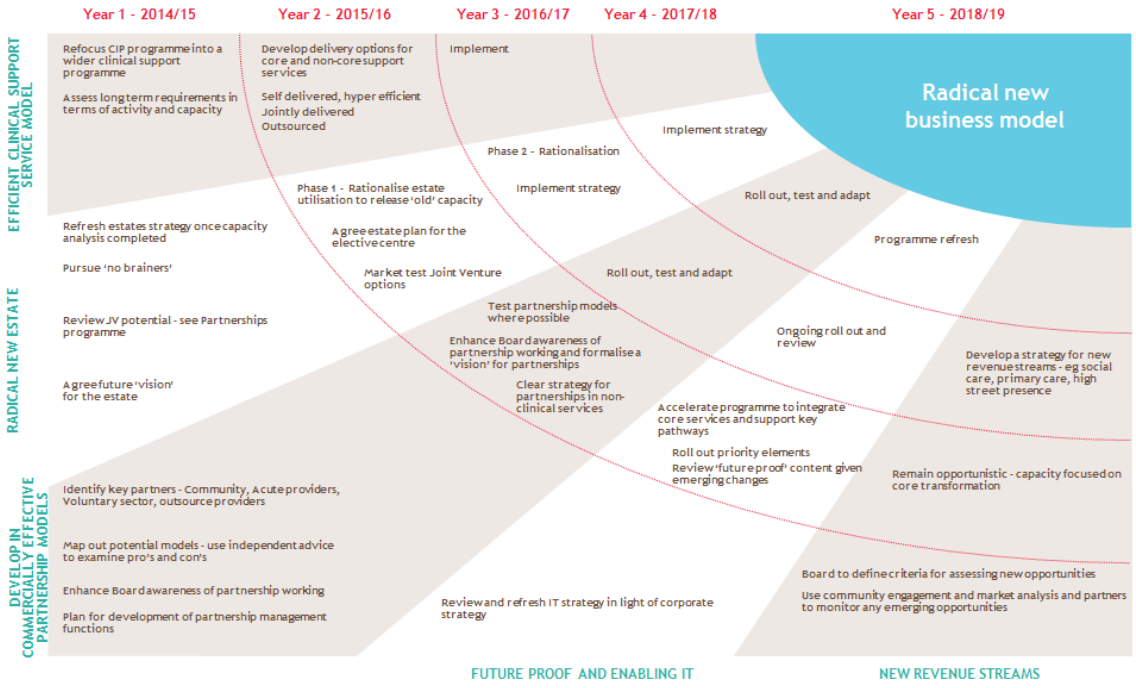
Implementation GOAL 1 – ENGAGING WITH AND UNDERSTANDING OUR COMMUNITY



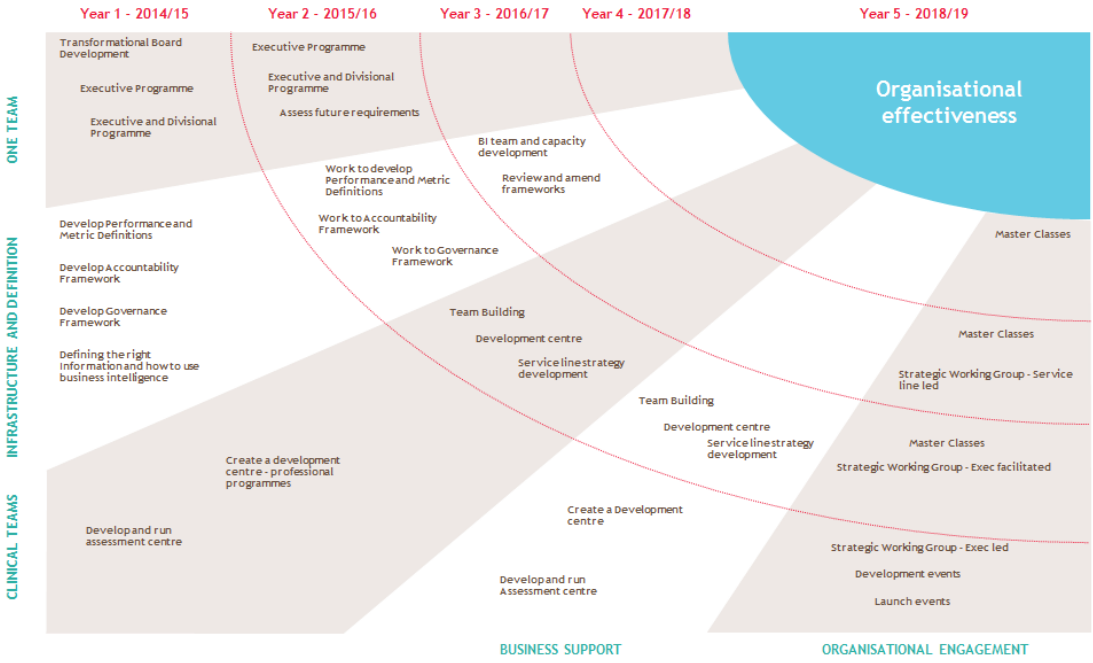
Implementation GOAL 2 – EVOLVING OUR CLINICAL MODEL



Implementation GOAL 3 – RADICAL NEW BUSINESS MODEL



Implementation GOAL 4 – ORGANISATIONAL EFFECTIVENESSS



11.2 Action Planning

As have been set out in this strategy, there are a number of key strategic opportunities which require further work in order to support the Trust's financial and clinical sustainability. The Board has agreed a number of work-streams, supported by a PMO. These are high priority initiatives for the Trust, reporting progress directly to the Board and are agreed by all parties to be fundamental to the success of the organisation.

It should be noted that these are separate and additional to the business as usual processes, such as improving quality, identifying and meeting CIP plans and meeting waiting list targets.

A Gantt chart, setting out the detail behind each of these opportunities, is set out in the Appendices.

1) Working with Commissioners:

- Setting up a team to work with the CCG to understand new models of care. This will include managing the proposed Community expansion and taking the Trust's offer to CCGs for discussion. This will include the impact of the LTC PIN, including assessing the impact of both winning the contract and being unsuccessful in being appointed Lead Provider. The commissioners will put the LTC PIN out to tender in mid-July

- Market analysis also identified opportunities to increase care provided in the community, with care of the elderly activity high in non-elective and relatively low in elective relative to peers. This will be addressed as part of the response to the long-term conditions PIN

- Further development and implementation of CCG assumptions and benchmarking, and agreement regarding top decile performance – helping the system to move care outside hospitals and reducing loss-making non-elective admissions. This will create capacity for the Trust to deliver more sustainable elective work.

2) Organisational Development including Partnerships and Alliances

- Continue negotiations with UHNS including setting out BHFT's approach to the negotiation, signing Heads of Terms and developing targets and a timetable in order to measure and monitor both progress in negotiation, and the shifting of activity

- The approach to partnership needs to be replicable, and opportunities to further partner should be explored as they arise

- Continue discussions with commercial partners relating to a potential joint venture for non-core, non-clinical services – redesigning processes and driving efficiencies for the Trust.

3) Managing the repatriation of activity from other providers

- Incorporate the findings of the CHE work undertaken by KMPG and published on the 11th July

- Plan for and undertake additional activity arising from changes to Mid Staffordshire Hospital

- Actively work with GPs and CCGs in the specialties identified through the CHKS/Dr Foster market analysis work in order to grow market share in services which make a contribution. Build upon strong existing links with some GPs in order to drive this process.

4) Internal Planning

- Developing a Finance Plan which will include:

    - Developing SLR and SLM for the Trust

    - A clear approach to CIP governance, including responsibility for the identification and delivery of CIP, timescales and reporting

    - Diagnosing underlying causes of the deficit and routes to reducing the cost-base

    - Capital planning (including potential developments to the elective care centre and community hospitals).

- Develop an Estates Plan (informed by the community hospital consultation)

    - Set out rationale for future of community hospitals once this has been determined

    - More detailed planning of bed and support services requirements, in light of the activity shifts proposed, plus the detail of the repatriation information and the negotiations with UHNS, plus the shift from Mid Staffordshire

    - This will include a decision relating to whether an elective care centre expansion is required in order to accommodate repatriated work, or whether non-elective activity has been reduced to such an extent this is not necessary.

- Develop an Organisational Development Plan

    - Setting out how the Trust will source the staff, skills, and provide the training to support the above developments

    - Improving Clinical Leadership (through the use of SLM)

    - Develop relationships with the LET-B in order to support workforce and the Deanery relating to the medical workforce specifically

- Develop an IT Plan

    - The Trust is currently reviewing management and governance of its ICT strategy. Currently the Trust receives services from the Staffordshire Shared Services HIS. It has an old network infrastructure that, whilst extremely stable is in need of upgrade and modernisation to provide better and more flexible services to users

    - The Trust has a fully integrated Patient Administration System that includes an integrated financial system including full e-procurement and scheduling systems. This system is due for a major upgrade during 2015/16. This upgrade will provide

the organisation an opportunity to review its operating procedures to apply 'lean' techniques and improve efficiency

- The Trust has very rich data, for example the finance system is linked to patient episode data allowing direct allocation of theatre prosthesis to a patient and cost centre in the general ledger. However, the Trust needs to invest in a modern data warehouse to allow this information to be easily extracted and utilised by the operational management in an intelligent form. This will be addressed by the system upgrade programme and the new performance management framework over the next 6 months

- The Trust Board has agreed for the create of a Chief Information Officer post reporting to the Director of Finance, who will work through the issues outlined above to produce an ICT strategy that support the Trust's clinical and operational models as outlined above.

The steps that the Trust will take in order to deliver upon the strategic opportunities are set out in a Gantt chart in the Appendices.

11.3 Governance

The Trust takes very seriously the criticism of its governance arrangements in response to external scrutiny during 2013, and has introduced a number of changes that focus on improving its Board and quality governance, as well as its performance management and supporting information systems. The Board of Directors has welcomed the findings and challenges posed by these reviews and is committed to building on its achievements thus far to further embed the changes during 2014 and onwards.

The Trust has made a comprehensive response to the findings from external reviews together with its licence undertakings. Such actions have included:

- Employing the Good Governance Institute to facilitate a Board development programme in 2013-14, together with a review of Board effectiveness and that of its sub-committees. This work will lead to further changes in the board assurance structure during 2014 as part of the Director of Governance work programme

- Strengthening the capability and capacity in the Medical Director's management structure by appointing three Associate Medical Directors, as well as strengthening senior medical management in each of the clinical divisions

- Introducing a Mortality Review Group, chaired by the Trust CEO and attended by senior clinicians and representatives from the Trust's commissioners

- Refreshing its Quality Strategy and communicating the changes to all Trust staff primarily through executive director briefings to staff groups as well as badging other patient safety initiatives under the umbrella of the Strategy

- Strengthening both corporate and quality governance leadership, capability and capacity by introducing a Director of Governance role and supporting structure that will be embedded during 2014

- Putting in place a programme of Risk Management improvements at corporate and operational level. This has included the introduction of a new Board Assurance Framework to better link the Board forward plan to sources of assurance related to the achievement of the Trust objectives

- Conducting an internal review of incident reporting and management arrangements and introducing a programme of changes to improve the reporting, investigation and most importantly, learning from incidents and serious incidents

- Introducing a corporate Performance Assurance Framework and supporting management structure to facilitate better performance management across the Trust, covering the three domains of finance, performance and quality

- Revisiting its appraisal process to ensure objectives of individual staff are linked of the organisation's objectives and values

- Providing further investment in the PMO arrangements in place to manage the CIP programme, including the strengthening of quality impact assessment governance.

The Board of Directors is wholly committed to being able to demonstrate good governance. The improvements referred to above have been substantial and have required investment on the Board's behalf to build capability, capacity and leadership in medical management, corporate and quality governance. The changes will continue to mature so that they become 'business as usual' both at Board and operational level across the Trust thus ensuring the strategy is effectively implemented.

APPENDIX 1

East Staffordshire Health Economy – Leadership Ambitions

4 June 2014

Note – Following a meeting between the CCG's and BHFT we agreed to each set out what we believe the ambitions for the system are. This aims to further the process of alignment on our respective strategies for the next 5 years and to identify where we are wholly in agreement and where tensions still exist that will need to be addressed further.

Specifically these are general ambitions for the local system leadership – we have therefore excluded any discussion about numbers and targets for individual providers or commissioners. This aims purely to uncover whether or not we are aligned in principle over the future of the Staffordshire health economy and BHFT.

Context:

Although this document addresses general ambitions, we feel it is worth describing the latest headlines from BHFT's current strategic view for context only.

These aims are currently under review and were developed c.18 months ago, but we do not expect them to change materially – however we understand that this is subject to the outcome of the CCG work and the Challenged Health Economy work.

Our aims:

- To maintain an acute service, long term, that can offer non-elective support to our community. Specifically retaining at its core an A&E and the services that support that – i.e. ITU, a general medical acute take, some emergency surgery.
    - We do expect BHFT's role in urgent care pathways to evolve beyond the core
    - We also expect that some key specialist services will be directed to our partners
    - We do expect maternity services (and therefore Paeds) to remain at Burton
- To use our elective care capacity – particularly using our excellent treatment centre facility – to a) improve elective delivery, b) develop that side of our income to help us sustain the non-elective operations and c) rationalise the range of services to optimise quality and clinical viability
    - We do not necessarily anticipate 'growing' the local market, but do aim to gain market share, repatriate and create a step change in efficiency and quality for chosen, sustainable service lines
- To develop our role in out of hospital services – particularly in areas and on pathways that need specialist leadership, e.g. in many long term conditions
    - This will need to expand our revenue base, enable us to increase the contribution to support loss making non-elective services and to support clinical viability in key service areas
- To work in partnership with local acute, community and primary care partners
    - This will be needed to a) offer access to better specialist care to our population and b) support clinical viability and clinical recruitment
    - Our primary partners will be UHNS and SSOTP – we will work with others are appropriate
- To rationalise and reconfigure our estate in order to a) lower the estate cost and b) get best value from our land so we can reinvest in services

In addition to the above aims, the process of alignment should also take into account BHFT's scale and what that means for the Trust. We are working on understanding this in more detail, but in our interaction

with other system stakeholders we must bear in mind that we are of a size that means that certain services are 'brittle' – i.e. if their scale were to drop at all they would no longer be clinically viable.

This is a particularly important issue where there are strong clinical interdependencies. An easy example is ITU – this is an essential support service for a hospital offering emergency care and some of our elective care – particularly on the surgical side. A reduction in some key service lines could make ITU unviable clinically and financially. The knock on effect would be to undermine a wide range of services to such an extent that BHFT would have to completely revise the vision set out above and consider an alternative future – most likely without A&E, a full medical take, emergency surgery or any medium to high risk elective surgery.

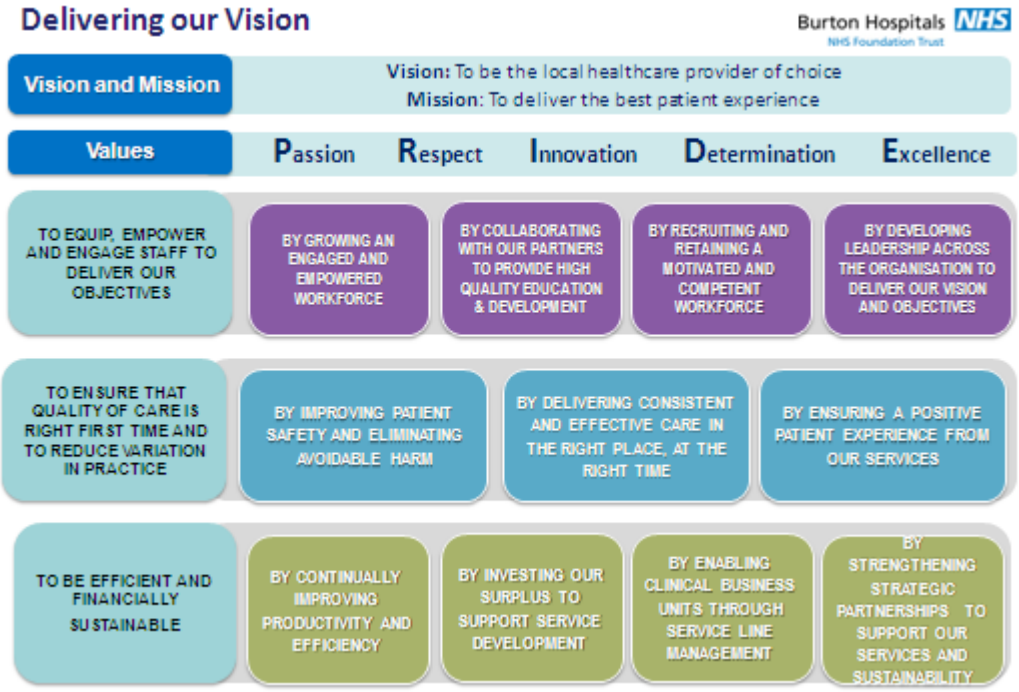
System Ambitions – where we are in agreement:

- Overall the Staffordshire system wants to shift from a service focused on 'rescue' of the acutely unwell to a service that minimises the need for rescue – i.e. one that prevents and manages illness earlier in the pathway, one that reduces acute episodes and exacerbations, and one that enables patients and the public to manage their own health much more effectively
    - We endorse this ambition and believe we have a contribution to make
- In respect of the above – the elderly and frail populations and those with long term conditions would appear to be best placed to benefit from this shift in the care ethos and models of delivery
    - We agree with this ambition and believe we have a role in managing the specialist input required to deliver improvements in these areas outside the hospital environment
- Linked to the above the system needs to reduce non-elective demand and therefore admissions
    - The growth in this area is unsustainable (it has grown month on month already this financial year – in April, May and is trending that way for June) for the system as a whole
    - We will work with the system to contribute to a reduction in this demand
- Working in partnership is an essential part of a sustainable future
- The system wants to maintain some sort of acute capacity in Burton itself – although it is not clear in what form or with what scope of services

Across all the above areas, BHFT is wholly in agreement with the principles behind the ambition and recognises that it can contribute to achieving it with support from the rest of the system.

APPENDIX 2

VALUES



IMPLEMENTATION PLAN (GANTT PLAN)