NNUH Summarised Strategic Plan 2014-2019

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

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Introduction

This strategy has evolved from discussions with patients, staff, local people, and with key stakeholders across the health, social care and voluntary sectors. These are the organisations that we will be working alongside as we implement the strategy over the next five years, adapting our services to meet the evolving needs of the people of Norfolk.

In delivering the strategy, we are mindful that we will be seeking to improve health outcomes and reduce healthcare inequalities at a time of unprecedented financial challenge. It is more important than ever that organisations within the wider health and social care system work together across historic boundaries to identify system-wide cost effective solutions that will prevent episodes of acute illness, help patients to recover more quickly from illness in the appropriate care setting, and provide responsive, effective and affordable healthcare that meets the needs of patients and their families.

Strategic Overview

Our Strategic Aims

- To improve clinical quality and patient safety
- To ensure patients have a positive overall experience of their care
- To identify opportunities to improve operational efficiency and to implement improvements
- To provide accessible services, eliminate unnecessary waiting times for patients and ensure access to emergency care at all times
- To develop and implement clear plans to improve services
- To continue to engage with the local community to enhance our brand

To provide first class quality services and excellent patient experience

To establish a national reputation for excellent teaching, education and research

To enable all staff to realise their potential

- To maintain the Trust in the forefront of teaching across the health professions
- To develop the Trust's research capacity and capability to enable continuous improvement of clinical practice

- To set up systems to obtain regular and reliable staff feedback
- To improve staff health and wellbeing and reduce absence through ill health
- To develop the Trust's capacity and capability across all staff groups
- Values Based Recruitment

Our quality strategy and priorities

Our quality strategy is to **EXCEL**,

to provide **EX**cellent

Care,

prevent **E**rrors and ensure

that **L**earning is

shared with all staff.

We will pursue this strategy across the three quality domains of patient safety, patient experience and clinical effectiveness.

Our patient safety goals

- Continuing reduction of medication errors
- 100% appropriate response to elevated Early Warning Score (EWS) in all areas of the hospital, including paediatrics
- Reducing avoidable pressure ulcers
- Review of all emergency patients by senior clinician within 12 hours of admission

Our patient experience goals

- Improving our score in relation to the Friends and Family Net Promoter Test question
- Improving our discharge process
- Extending in-patient self-administration of medicines

Our clinical effectiveness goals

- Improving infection prevention, focussing on C Diff and surgical site infection
- Identifying the critical path for patients with complex discharge needs
- CT scan within 60 minutes for patients with suspected stroke on arrival in hospital

Market Analysis and Context

Healthcare Needs Assessment

"*Over the next five years patient demand and expectations of quality do not meet the financial resources available, a challenge exacerbated by the workforce and geographical limitations of Central Norfolk*." (Deloitte Central Norfolk Strategic Planning Provider and commissioner workshop pre-read).

Our Geography and catchment population

We provides secondary acute services to a mixed urban and rural catchment population of over 800,000 people from Norfolk and neighbouring counties, with the rural population widely distributed. We also receive tertiary referrals from outside East Anglia.

Norfolk has a relatively poor road network, with lengthy sections of single carriageway. This sub-optimal infrastructure is exacerbated by poor public transport provision, especially in the rural areas. As a result, issues such as the centralisation of acute and emergency services, the integration of care pathways, ambulance response times and the provision of care closer to home generate a great deal of local debate and interest. Fortunately, the position of our main site at the very southern edge of Norwich provides us with good access to the A11 and A47 regional trunk roads. It is also adjacent to the University of East Anglia medical school and the world-renowned Norwich Research Park.

We have a second site at Cromer, where a £15m development led to the complete rebuilding of the Cromer Hospital in 2013. The hospital provides a wide range of consultant and nurse-led day case, ambulatory care and outpatient services to the population of North Norfolk, including renal dialysis, chemotherapy, radiology and a nurse-led Minor Injuries Unit.

Geographic Pros and Cons

Pros

- No major competitive threats from other NHS providers
- Patient choice – most patients want treatment close to home and therefore tend not to choose to have their treatment at another Trust
- We have a strong brand and there is very significant community engagement and loyalty amongst the Norfolk and north Suffolk population
- Currently there is very limited market penetration by the private sector

Cons

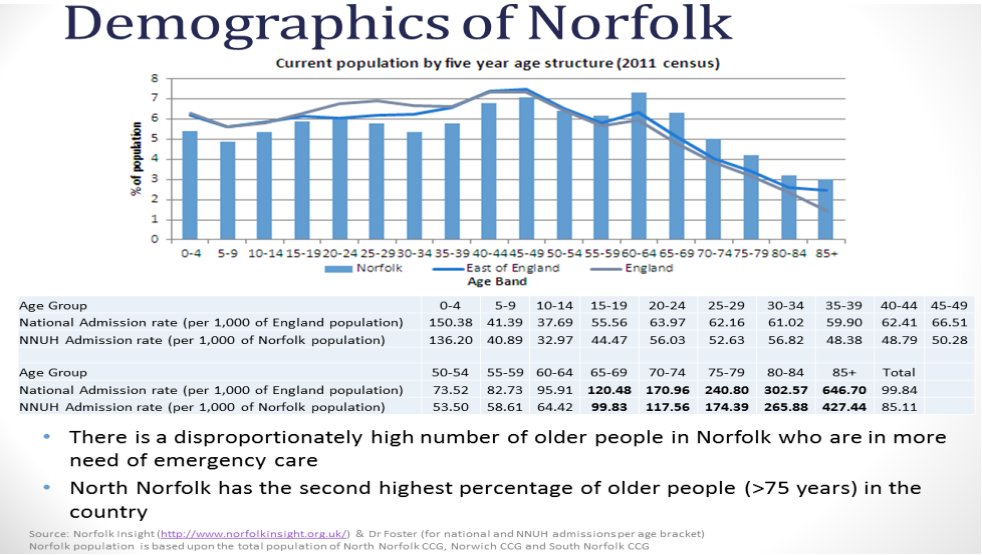
- Inability to divest loss-making services as there are no other providers that could take over the activity
- Our relative geographic isolation means that our scope to attract and retain a high calibre workforce is dependent upon us standing out as a centre of excellence and providing top quality research and development and teaching opportunities
- Scope to attract activity from out-of-area is dependent upon us delivering excellence in quality outcomes

Demographic and Healthcare Trends

As demonstrated by most published indicators, the population we serve enjoys relatively good health compared with the rest of England, and life expectancy is higher than average, reflected in the above average proportion of people aged 65 and over, and a significantly higher proportion of the 'oldest old'. Norfolk is also a popular retirement destination, and the proportion of older people

is forecast to rise over the next 20 years. Projected growth of 21% in those aged 75-84 and 29% in those aged 85+ over the period 2011 to 2021 will place increased pressure on services, especially those associated with older people, such as dementia services.

Figure 2: Demographics of Norfolk



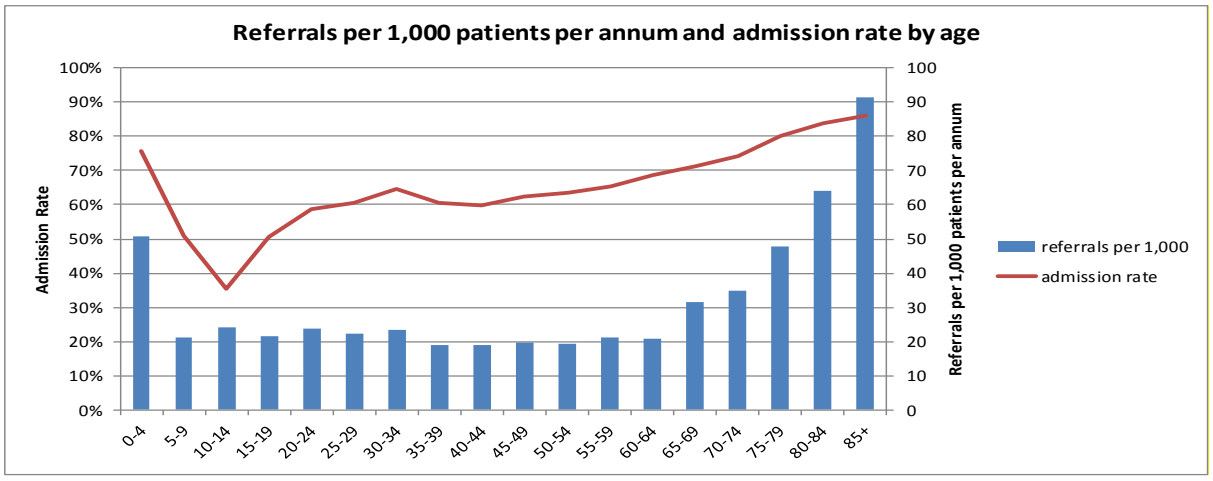
Age Group	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49
National Admission rate (per 1,000 of England population)	150.38	41.39	37.69	55.56	63.97	62.16	61.02	59.90	62.41	66.51
NNUH Admission rate (per 1,000 of Norfolk population)	136.20	40.89	32.97	44.47	56.03	52.63	56.82	48.38	48.79	50.28

Age Group	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+	Total
National Admission rate (per 1,000 of England population)	73.52	82.73	95.91	**120.48**	**170.96**	**240.80**	**302.57**	**646.70**	99.84
NNUH Admission rate (per 1,000 of Norfolk population)	53.50	58.61	64.42	**99.83**	**117.56**	**174.39**	**265.88**	**427.44**	85.11

- There is a disproportionately high number of older people in Norfolk who are in more need of emergency care
- North Norfolk has the second highest percentage of older people (>75 years) in the country

Source: Norfolk Insight (http://www.norfolkinsight.org.uk/) & Dr Foster (for national and NNUH admissions per age bracket)
Norfolk population is based upon the total population of North Norfolk CCG, Norwich CCG and South Norfolk CCG

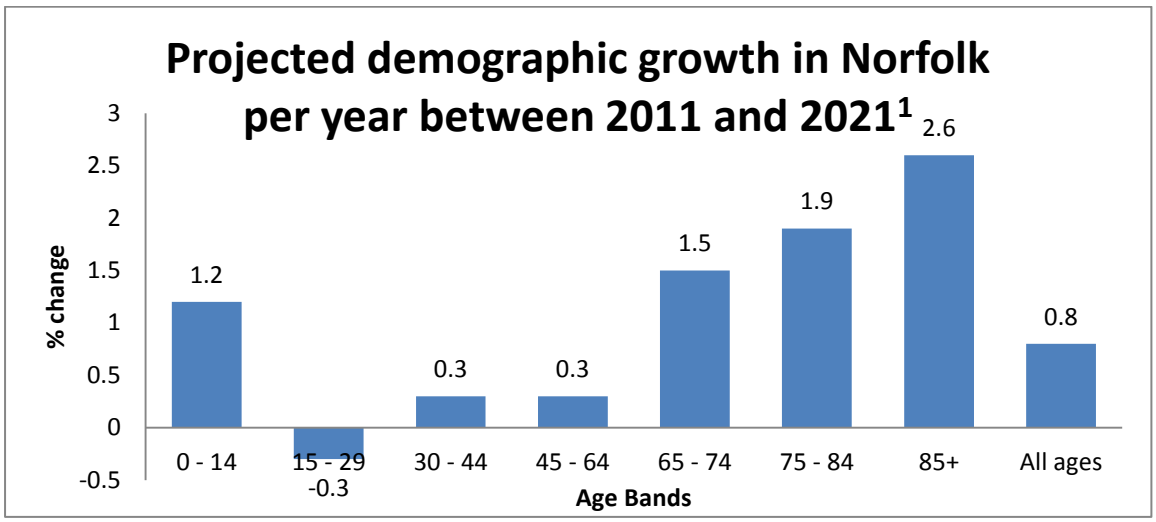
Figure 3: Referrals per 1000 patients and admission rate by age



Source: Internal data showing Norfolk referral and admission rates by five year age group. January to December 2013

Figure 4 overleaf shows growth of 21% and 29% over the period 2011 – 2021 in respect of people aged 75-85 and 85+ respectively, but the projected spike in under-15s means that paediatric capacity and children's services must also be protected and addressed.

Figure 4: Projected demographic growth in Norfolk



1: Source: Norfolk Insight

Given the dominance of older people in central Norfolk, the prevalence of long term conditions and conditions associated with old age are above the national average. The prevalence of asthma and cancer is higher in North Norfolk CCG than in any other CCG in England, and the CCG also has the second highest levels of patients with atrial fibrillation and stroke. Similarly, South Norfolk CCG has above-average prevalence for many long term conditions, and Norwich CCG has above average prevalence for asthma, epilepsy, learning disability and mental health conditions (see figure 5).

Figure 5: Epidemiological Pressures[1]

Disease prevalence [2] (QOF)	N Norfolk CCG	S Norfolk CCG	Norwich CCG
Asthma			
Atrial fibrillation			
Cancer			
Chronic kidney disease (18+)			
CHD			
Dementia			
Epilepsy (18+)			
Heart failure			
Hypertension			
Hypothyroidism			
Learning disabilities (18+)			
Mental health			
Palliative care			
Stroke			

Key	Worst quartile	Middle quartiles	Best quartile
Compared to all CCGs in England			

1: Source of the table: Central Norfolk strategic planning provider and commissioner workshop pre-read, 2nd May 2014 (Deloitte). 2: Source of the data: Commissioning for Value tool.

Dementia Prevalence

In addition to the greater prevalence of long term conditions and complex co-morbidities associated with an aging population, the prevalence of dementia in our catchment population poses us many additional challenges.

Our internal snapshot survey data from 2012 and 2013 shows that currently 1 in 3 of our adult inpatients has either a formal diagnosis of dementia, or a detectable cognitive impairment (e.g. delirium).

The demographic trend and projected incidence of dementia will give rise to workforce challenges and require all of our frontline staff to be aware of the particular care needs of patients with cognitive impairment. Mindful of this, we took a leading role in setting up the Norfolk and Suffolk Dementia Alliance, which is at the forefront nationally of improving the care of patients with dementia. The Alliance has promoted an integrated, ground-breaking approach that engages with patients, their families, carers, commissioners, hospitals, private community healthcare providers, further and higher education providers, voluntary organisations and local media organisations. The Alliance provides education and training to both paid and unpaid carers of people with dementia, and raises awareness in the wider community of the needs of people with dementia.

Deprivation

Deprivation in our main catchment area is lower than the national average but there is wide variation at local level between localities and wards, with some with poor health status largely linked to deprivation, unemployment and the low level of educational attainment.

Capacity analysis

Developing the necessary capacity to deliver our quality goals and our forecast activity levels is a key component of our overall strategy. We will promote an environment which enables us to attract, recruit and retain the highest calibre of staff, and we will optimise the use of our other assets, such as our estate and our beds, to enable us to make the most effective use of our resources. Our plans include the following:

Creating estate capacity

- Expansion of maternity provision
- Expansion of radiotherapy provision
- Centre for food and health
- Expansion of day case theatres
- Emergency care
- ICU expansion

Creating bed capacity

- Conversion of education space into clinical capacity
- Length of stay reductions
- Demand management
- Acute care out of hospital
- Revised care pathways

Creating staffing capacity

- Releasing efficiency gains
- Role transformation and flexible working
- Greater use of apprentices and assistant practitioners
- In-house training
- Leadership and mentoring
- Addressing recruitment and demographically-led workforce challenges

Creating diagnostic capacity

- Extended hours / smarter working
- Repatriating work to other settings
- Strategic partnerships with private providers
- Investment in additional capacity (staff/infrastructure/equipment)

We have developed a number of personal development, mentoring and coaching programs to enable our staff to be more resilient and adaptable, and our Leadership Program identifies and develops the individuals who will be able to take leadership roles in hospital in the future.

We have identified that improvements are required in our management of bank and agency spend, vacancy management and sickness absence; we will focus on delivering the required improvements and will closely monitor our progress in releasing the associated efficiency gains.

We will develop new systems to support more flexible ways of working which will allow for extended days and seven day services. The improved flexibility will be achieved through skill mix reviews and revised team work scheduling. We plan to extend the range of services that offer evening and weekend sessions, and to increase the number of weekend operating sessions. This will provide greater choice to patients and to deliver the 7-day working recommended by the Keogh report. Our support services will also need to work more flexibly to match the new working arrangements.
We have historically found it difficult to recruit some groups of specialist staff, and increasingly we are working with local higher education providers to develop innovative ways of 'growing our own' staff, as well as attracting staff to the UK.

Capital planning and capital expenditure

Our internal strategic service review has identified a number of clear service priorities which will require capital investment over the next five years. **These include**:

The balance of capital investment proposed for the period is made up of capital equipment replacement and smaller individual schemes. The capital investment plan is formally reviewed annually.

The capital programme assumes completion of existing projects, investment in equipment and also capacity and IT development. The final prioritisation of major investments is subject to review by the Board in the first half of 2014/15.

Capital expenditure of £51.8m is included over the course of the plan with £17.4m of this in 2014/15, which includes unspent capital allocations brought forward from the previous year.

Funding analysis

An analysis of income assumed in the five year plan is set out below.

The majority, some 85% of income is for clinical activities and high cost drugs. The remainder is mainly for Education and Training from the Deanery / Health Education bodies and for Research and Development in our capacity as one of the 15 National Clinical Research Networks.

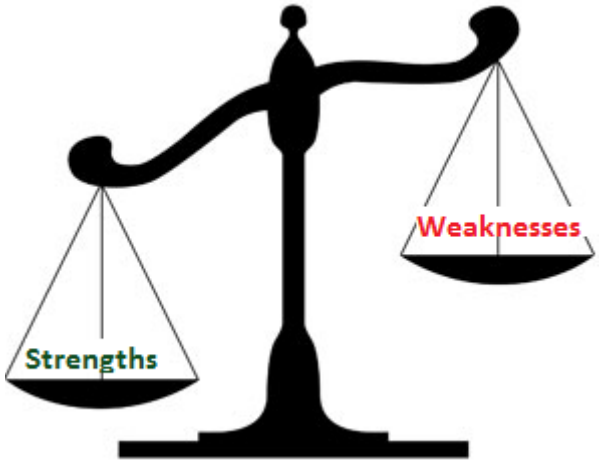
The five year plan assumes a modest increase in activity growth and a 1.5% reduction in tariff year on year. Accordingly the Trust income is expected to remain stable and of the same order as for 2013/14.

What has become clear is that because of the relentless rise in demand for non-elective care and the impact of the marginal rate tariff, the change in income is not sufficient to meet the increase in the cost base driven by inflation, over the next five years. Accordingly it has been assumed that additional funding will be forthcoming either through tariff changes or from commissioners in recognition of the affordability gap created by the demand for non-elective care.

This funding, called 'Support Income' is set out in the table below. It totals £130,150k over the five year period and represents an 6.7% increase on assumed clinical income for the five years, based on current tariff rules and expected deflator of 1.5% each year. This is a small percentage requirement.

	2013/14 Outturn £000	2014/15 Budget £000	2015/16 Forecast £000	2016/17 Forecast £000	2017/18 Forecast £000	2018/19 Forecast £000
Clinical Income	374,943	388,505	386,340	387,700	389,077	386,856
Support Income - New in year	0	0	2,863	30,954	9,806	6,224
Support Income - Brought forward	0	0	0	2,863	33,817	43,623
Support Income - Total	0	0	2,863	33,817	43,623	49,847
Non-Tariff Drugs Income	40,547	41,672	43,964	46,382	48,933	51,624
Other Income	63,782	72,944	72,944	72,944	72,944	72,944
Total Operating Revenue	**479,272**	**503,121**	**506,111**	**540,843**	**554,577**	**561,271**

SWOT analysis



Our strengths

- Our loyal, flexible and committed workforce
- Our brand, good reputation and track record for operational performance
- Our well established links with neighbouring Trusts and key stakeholders
- Our positive feedback from service users – we're engaging them and meeting their expectation, as evidenced by our above-average Friends & Family test scores and national patient survey scores
- Our geographical position which cushions us from competition
- Our world class research facilities (in collaboration with UEA/science park)
- Our track record of meeting our targets (operational, financial, cost saving)
- Our governance structure, which reduces our risk exposure
- The continuity of our strategic vision and direction – meaning that we are building on solid foundations rather than starting from scratch
- Our track record of innovation
- Our flexibility to provide care across a variety of settings and modalities
- Our engagement with the local community.

Our weaknesses

- Our geographical position – which isolates us and perhaps impacts on our ability to recruit staff of the highest calibre (NOTE: in relation to competition, our geography is also a strength)
- Our patient demographic, which means that we face challenges especially in respect of frail elderly patients or those with dementia that other acute trusts don't, and which places significant pressure across the whole local health and social care economy
- Rising emergency demand, which requires cross-organisational solutions
- Ability to access capital/ charitable funds to pay for new equipment
- Lack of capacity in the community to provide alternative models of care. This is also an opportunity for us, and we are exploring upstream and downstream opportunities.

How we will mitigate threats to our revenues and services

Technological advances	• Carry out feasibility appraisals on all new technologies • Provide staff with necessary skills to innovate effectively • Work with patient groups to manage expectations • Model impact of new technologies on revenues
Workforce Pressures	• Build upon our reputation as a great place to work and enhance our brand • Improve communication and staff engagement • Provide leadership and world class education and research • Develop new roles and new types of clinician
Changed care pathways	• Lead the process of re-engineering pathways • Seek opportunities to provide acute care out of hospital • Provide and support care closer to home where possible • Promote preventative and integrated care
Financial Pressures	• Work collaboratively to mitigate risk of the Better Care Fund • Good governance over CIP and QIPP to ensure delivery • Use QIPP to address inability to divest loss making services, by improving the efficiency of loss-making services
Rising Expectations	• Improve communication with stakeholders • As a minimum, meet the expectations for access and quality outcomes of our patients, their families, commissioners, Monitor and external assessors such as CQC.
Increasing Demand	• Work with system partners to bring about the necessary changes in primary and social care that over time will lead to the desired decrease in emergency demand, and reduce pressure on our electives and diagnostic capacity

Our Opportunities

As a consequence of our SWOT/competitor analysis, we have identified many opportunities to expand our services, to safeguard our revenues and to improve the services that we are able to offer to patients. The areas that we are currently exploring include:

- The consolidation of our existing secondary and tertiary services
- The expansion of tertiary services
- Upstream integration into primary care
- Downstream integration into community provision

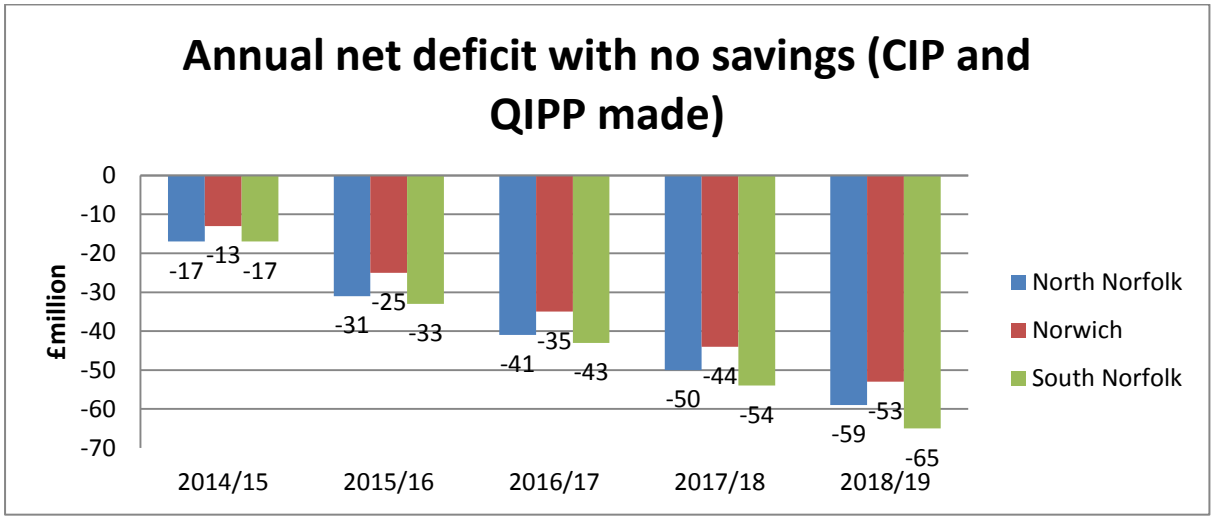
- Closer integration with secondary providers, in particular, JPUH and QEHKL
- Continuing to explore the opportunity to bring high margin NHS work currently being carried out in the private sector back in to the NHS

Scale of potential financial challenge across the Central Norfolk system

Over the next 5 years, in the absence of major transformational change at system level (such as the centralisation of care in specialist centres or the forging of closer links between care providers) we have assumed that the financial and operational pressures that we are currently facing as an acute provider will have increased further, leading to a significant funding gap.

According to the 'Central Norfolk strategic planning provider and commissioner workshop pre-read' document prepared by Deloitte (2nd May 2014), *"although Central Norfolk is forecasting to maintain a surplus over 5 years, remaining in surplus requires substantial year on year efficiency savings on both the commissioner and provider side."* A graph contained within that document is reproduced below, and show the scale of the potential financial challenge across the Central Norfolk system:

Figure 7: Projected Central Norfolk annual net deficit



"Given the gap between forecast demand and forecast allocation, Central Norfolk could be in a combined deficit of over £175m by 2018/19 if savings are not made or allocations do not increase. This assumes that Better Care Fund funding is used for comparable services, if this is not the case the deficit increases by up to £11m per annum from 2015/16." (Deloitte)

Since the 3 CCGs allocate almost 60% of their contract spend on the NNUH, any Central Norfolk deficit will have a material negative impact on our financial standing.

The factors underpinning the projected gap include the rising trend in emergency demand and the associated financial pressure caused by the imposition of the marginal tariff, increased demand for services for older people, including dementia services, and the financial pressures associated with the shift of resource from the acute sector to the care sector under the Better Care funding initiative. These pressures will be exacerbated if system-wide working does not prove effective in sustainably managing demand and delivering admission avoidance solutions.

Demand analysis shows that there has been 25% rise in emergency admissions since 2008/09. We are in the top 15% of providers nationally with the highest growth in non-elective admissions.

Alignment of findings from these analyses with comparable intelligence from LHE partners.

The 3 CCGs that commission the bulk of our services have acknowledged the extent of the financial and operational challenges facing the local health economy over the short to medium term.

In his blog, the CEO of Norwich CCG recently wrote: *"…as problems go, we are having to face up to some big ones. Amongst them…the last six years of budget growth below wage growth and inflation, combined with increasing levels of demand for healthcare. Each year it gets harder for commissioners to balance the overall budget for their system, and providers have to find efficiency savings of 4-5%. They've all done the easy stuff, and now have to find ways of cutting into the wage bill without reducing the quality of care...We cannot pay any of our providers enough to continue with their existing models of care, there is little slack in the system to fund change, and so it becomes increasingly difficult for them to balance the books..."*

In its document 'Health and Wellbeing Strategy 2013-18', published in May 2013, Norwich CCG sets out its plans, which include a whole-system model of integrated health and social care for the city of Norwich, called 'YourNorwich', which aims to improve outcomes, reduce costs, and keep people well, independent, and at home for as long as possible. The scheme, which will be officially launched at the end of June, will focus on older patients and those with long-term conditions, and will involve the creation of an electronic care plan that can be shared across NHS care providers, stating a patient's wishes and support network details. The overall aim of the project is to enable local patients are able to access 24/7 NHS community nursing, therapy and social care as quick as it takes to get a response from calling 999, which in turn should reduce emergency admissions at NNUH.

North Norfolk CCG, in its published document 'NNCCG Strategic Vision, Operational Plan and Financial Plan 2014/15 to 2015/13' acknowledged that the current pattern of service is "*unsustainable over the next 5 years…North Norfolk has the oldest population of any CCG in England. We know that people's use of NHS and social care services increased markedly in later life and this will overwhelm the current system unless we change it…Unless there is a major shift in national economic outlook and investment in public services, the current pattern of services will prove unaffordable very quickly, possibly within 2 years. The historical pattern of making relatively small incremental savings through efficiency will not be enough."*
NNCCG's plans include the establishment of 4 primary care hubs which will provide fully integrated primary, community and care teams that can respond rapidly to the needs of patients in North Norfolk. The teams will focus on people with one or more long term conditions, and primarily support older people who have been identified as being at risk of significant exacerbation of their condition without intervention.

South Norfolk CCG in its document 'Commissioning Strategy 2012/16' stated: "*To make the commissioning strategy viable, it is important for the CCG to "live within its means". It will have to do so in an increasingly challenging financial climate where the NHS, social care and other public*

services will also be responding to the needs of increasing numbers of people with LTCs and an ageing population. Whilst SNCCG has a stable financial position at present there are pressures in the provision of continuing health care and prescribing."

Later in the same document, the CCG states: "*The application of the planning assumptions…leads to a base case ("do nothing") scenario whereby the 2012/13 QIPP target of £5.8m rises to £13.0m by 2015/16...The key elements driving this financial challenge are…continued baseline growth in acute activity, continuing healthcare and prescribing, over and above demographic growth rates. The resulting financial gap…is 3.4% of spend in 2013/14, with an additional 1.3% needed in 2014/15 and a further 0.4% in 2015/16."*

Risk to sustainability and strategic options

We have carried out a full SWOT analysis of all of our key service lines, and in respect of each speciality we have chosen the appropriate strategic response to any current or potential threats to our revenues and our activity. The options that we have chosen to implement include:

- strategic withdrawal (e.g. in respect of metastatic liver cancer surgery)
- consolidation, transformation and strengthening of existing services (e.g. in respect of most of our medical and surgical specialties)
- collaboration / forging closer links with other providers (e.g. in respect of joint posts with JPUH and QEHKL)
- competing for greater market share (e.g. in respect of becoming a Major Emergency Centre and tendering for the provision of Sexual Health services).

As a result of these analyses, and the resultant strategic stance that we have adopted for each service, we are now in a much stronger position to protect our revenues and services from competition, and to achieve our strategic financial and operational goals.

Strategic Plans

Our transformative service delivery plans involve the following themes:

- The consolidation of our existing secondary and tertiary services
- The expansion of tertiary services
- Upstream integration into primary care
- Downstream integration into community provision
- Closer integration with neighbouring secondary providers.
- Continuing to explore the opportunity to bring high margin NHS work currently being carried out in the private sector back in to the NHS

The plans – and our supporting 5 year financial analysis and forecasts - are commercially sensitive, so are included in our main document, which is not for publication.

Overview of Financial Projections

Introduction

The summary financial plan for the five years ending 31 March 2019 is set out below. It is based on activity and demand assumptions having regard to current experience and current costs.

The plan identifies a significant affordability challenge and it assumes that efficiency improvements of between 2% and 3% are delivered by the NNUH each year. However, these savings alone are not sufficient. Accordingly it has been assumed that additional funding will be available to us in recognition of the significant operational pressure with the continuing rise of emergency demand and associated financial consequences from the application of the marginal rate.
For note: in the last 5 years non-elective admissions have risen by 25%, if this continues for the next five years the Trust will no longer have any capacity to deliver any elective work.

Key highlights of the financial plan are as follows:

	2013/14 Outturn £000	2014/15 Budget £000	2015/16 Forecast £000	2016/17 Forecast £000	2017/18 Forecast £000	2018/19 Forecast £000
Total Operating Revenue	479,272	503,121	506,111	540,843	554,577	561,271
Expenditure	433,311	473,941	481,419	492,696	503,197	510,033
EBITDA	45,961	29,180	24,692	48,147	51,380	51,238
Non-operating costs and depreciation	41,340	44,126	45,692	47,147	47,380	47,238
Surplus / (Deficit) (before donated assets)	**4,621**	**(14,946)**	**(21,000)**	**1,000**	**4,000**	**4,000**
Continuity of Service Risk Rating	3	2	1	2	2	2
Savings achieved / target	£21.5m	£12.5m	£13.1m	£13.2m	£14.0m	£14.2m
Capital	£8.1m	£17.4m	£11.6m	£5.6m	£9.2m	£8.0m
Cash at year end	**£66.7m**	**£31.6m**	**£3.7m**	**£4.2m**	**£4.0m**	**£4.7m**

Income and Cost pressure assumptions

The following table shows what has been assumed for income and costs

	2014/15	2015/16	2016/17	2017/18	2018/19
Tariff assumption	-1.20%	-1.50%	-1.50%	-1.50%	-1.50%
Pay Award	0.30%	0.30%	0.30%	0.30%	0.30%
Other Pay Cost Pressures	1.80%	1.80%	1.80%	1.80%	1.80%
Drug Inflation	5.70%	5.50%	5.50%	5.50%	5.50%
Other Non-Pay Inflation	1.50%	1.50%	1.50%	1.50%	1.50%
PFI revenue expenditure	4.20%	3.20%	3.30%	2.50%	2.50%

Taken together with assumed tariff reductions and contingencies for expenditure, and other known cost pressures these create a cost improvement programme (CIP) as follows:

	2014/15	2015/16	2016/17	2017/18	2018/19
Total CIP	£39.8m	£23.0m	£23.2m	£22.3m	£22.1m
MET BY RECURRENT:					
Delivery of CIP at @ 2.6%	£12.5m	£13.1m	£13.2m	£14.0m	£14.2m
Activity contribution	£9.3m	£1.0m	£1.0m	£1.0m	£1.0m
Assumed Support	£0.0m	£2.9m	£31.0m	£10.3m	£6.9m
Change in bottom line	-£18.0m	-£6.0m	+£22.0m	+£3m	£0m

Planned delivery of CIP

The net CIP assumed for 2014/15, is £12.5m. There are a number of schemes in place designed to deliver the required this, which are analysed as below:

Cost / Revenue Type	Gross Cost £m 2014/15	CIP £m 2014/15	CIP % 2014/15	Gross Cost £m 2015/16	CIP £m 2015/16	CIP % 2015/16	CIP £m 2016/17	CIP £m 2017/18	CIP £m 2018/19
Pay	294.7	7.1	2.4%	299.3	8.4	2.8%	8.5	9.1	9.3
Drugs	51.0	1.2	2.4%	53.1	0.7	1.3%	0.7	0.7	0.7
Clinical Supplies	60.3	2.1	3.5%	61.3	2.0	3.3%	2.0	2.1	2.1
Non-Clinical Supplies	58.8	1.4	2.4%	59.4	2.0	3.4%	2.0	2.1	2.1
Misc Other Operating Revenue	29.2	0.7	2.4%	28.5	0.0	0.0%	0.0	0.0	0.0
Total		**12.5**			**13.1**		**13.2**	**14.0**	**14.2**

The CIP % rates for 2016/17 and later are consistent with those for 2015/16.

As the year progresses the amount of savings achieved under each of these headings will inevitably change and a degree of pragmatism will be applied to support overall achievement of the targets Details of the main schemes are set out in this section.