Quality *for all*

Sherwood Forest Hospitals NHS
NHS Foundation Trust

# Sherwood Forest Hospitals NHS Foundation Trust

## Annual Plan

2016/17

**Communicating** and **working together**
**Aspiring** and **improving**
**Respectful** and **caring**
**Efficient** and **safe**

## Contents

Strategic context ..... 2
Strategic Plan ..... 2
Quality for All ..... 2
Our values ..... 2
Quality Standards ..... 3
Quality Improvement Plan ..... 5
Operational Performance ..... 5
Emergency Department performance Referral to Treatment (RTT) performance ..... 6
Financial Performance ..... 6
Restating our strategic intent ..... 7
Delivering the strategy in 16/17 and beyond ..... 7
Response to the 5 Year Forward View ..... 7
Overarching objectives for 16/17 ..... 8
Initiatives to deliver objectives and improve performance ..... 8
Emergency Flow ..... 8
Elective care ..... 9
7 day services ..... 9
Better Together initiatives ..... 9
Summary of CIP schemes ..... 11
Operational requirements ..... 13
Activity modelling ..... 13
Workforce ..... 14
Leadership Development ..... 15
Physical capacity and estates development ..... 15
Performance risks ..... 16
Financial Planning ..... 16
Approach to financial planning ..... 16
Income and expenditure position ..... 17
Carter ..... 18
Agency rules ..... 18
Procurement ..... 19
Capital planning ..... 19
Cash ..... 20
Financial Risks ..... 20

## Strategic context

### Strategic Plan

1. Sherwood Forest Hospitals NHS Foundation Trust (SFH) strives to provide safe, efficient, personalised and consistent care for the people who use its services. Our plan is to continue on the journey set out in our five year strategic plan developing partnership working with the wider health and social care community through the Better Together Alliance to deliver the best care, service and wellbeing outcomes for the communities we serve.

2. The Trust is facing unique challenges following the recent Care Quality Commission (CQC) inspection which rated the Trust as 'Inadequate' overall whilst recognising the caring nature of its services. The inspection outcome, combined with a worse than expected financial position, led the CQC and sector regulator Monitor to conclude that the Trust should remain in 'special measures' whilst seeking a long term partnership with another acute Trust. Nottingham University Hospitals has been identified as the partner organisation and this will lead to the creation of a new organisation that will be responsible for the delivery of safe and sustainable clinical services for Mid-Nottinghamshire and the other communities currently served by Sherwood Forest Hospitals.

3. The Better Together Alliance is fundamental to the vision set out in the Five Year Forward View (5YFV). The selection of Mid-Nottinghamshire as one of nine vanguard sites for Integrated Primary and Acute Care Systems (IPACS) in the '5YFV into action' initiative recognises the ambition, the progress that has been made to date and the support required to accelerate progress into the future. The Trust remains a core member of the alliance, and committed to service transformation to secure a sustainable future for health and social care.

### Quality for All

**Our values**

4. The Trust continues to prioritise the values and behaviours expressed in its 'Quality for All' initiative. These values now form the basis of a values-based recruitment programme, our induction programme and our appraisal process for all staff.

5. Despite its difficulties, the Trust's services continue to be highly valued by the communities it serves, and positive feedback predominates. We endeavour to learn lessons when things do not go as well as we would wish. Following the 'Freedom to Speak Up' recommendations the

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Trust also benefits from staff feedback and incident reporting. Our governance structures have been fundamentally overhauled to improve the learning and dissemination of good practice across the Trust and improve the quality and safety of our services.

## Quality Standards

6. Specific quality standards were identified in the 2014/15 strategic plan. These standards of care are derived from a combination of national and local focus on patient care. Our Quality Account reaffirmed those areas of greatest focus in improving quality and safety.
Our Focus:

***Hospital Standardised Mortality Ratio (HSMR):***

- To reduce mortality as measured by HSMR to within the expected range;
- To implement a robust mortality reporting system that is visible from service to board;
- To eliminate the variation between weekend and weekday HSMR.

The Trust has seen a sustained reduction in its HSMR; it was below 100 in June, July and September 2015 and just above in August.
This is due to the improvements that have been made both in the clinical care pathways and in record keeping and coding.

***Sepsis*:**

- To implement a recognised local protocol / screening tool within emergency department / other units that directly admit emergency patients;
- To administer intravenous antibiotics to patients presenting with severe sepsis within one hour of presentation to hospital.

The CQUIN target for quarter 3 (October to December 2015) was to achieve 90% compliance with sepsis screening within our admission areas.
We have exceeded this target with compliance of 99.3%

***Falls:***

- Reduce the number of inpatients falling in hospital with harm from Q2 onwards;
- Reduce the number of inpatients reporting severe or catastrophic harm as a result of a fall in hospital‟ from Q2 onwards;



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- Delivery of safety improvement programme which has been developed through learning from the best and linking with local and national organisations, notable for their innovation/best practice.
  Our performance data demonstrates a return to the quarter 3 position 2014 in the number of patients falling sustaining harm. We reported a total of 73 harms in quarter 2 and 66 harms in quarter 3 of 2015/16.

***Infection Prevention and Control:***

- Zero tolerance Hospital Acquired MRSA;
- Minimise rates of *Clostridium difficile* – No more than 48 cases in the year;
- No more than 5 Urinary Catheter Related bacteraemia.

MRSA bacteraemia: Quarter 1; Zero: Quarter 2; One; Quarter 3; Zero.
Clostridium difficile: Quarter 1; 16: Quarter 2; 11: Quarter 3; 3. At the end of December 2015, the Trust had 30 cases and is below the threshold for cases of *clostridium difficile* infection. The RCAs have been performed and lapses of care due to delays in sampling and treatment were identified in 2 cases during Q3.

***Improving Patient Flow & Discharge Processes:***

- Trust Target - To reduce Length of Stay (LoS) (excluding 0-1 day LOS) to 7 days

The organisation continues to steadily reduce its average length of stay towards the 7 day target.
The continued reduction in LoS has enabled the organisation to close 48 beds on the King's Mill Hospital site and temporarily close 11 beds at Newark Hospital.
However in terms of quarterly performance and given the caveat described above the current LoS for each of the first three quarters for 2015/2016 are:

Q1 = 7.73 days
Q2 = 7.51 days
Q3 = 7.15 days
The average LoS is reported, in this format, monthly and presented to the Emergency Flow Steering Group and the Emergency Flow Operational Group. The CIP programme for 15/16 and 16/17 is based on a continued reduction in LoS which in turn reduces occupied bed days. This is because national and international best practice evidence is that patients, once medically optimised, should be returned to their usual place of residence in a safe and



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timely manner to prevent a loss of functionality and independence particularly for our older, frail patients.

## Quality Improvement Plan

7. We were hugely disappointed by the findings of the Care Quality Commission (CQC) from their inspection in June 2015 and are determined to make the changes necessary to deal with the underlying quality issues identified. In conjunction with our Improvement Director we have developed a comprehensive Quality Improvement Plan (QIP) based around ten workstreams. Thus incorporating our response to all of the issues raised in the CQC reports (2014 and 2015) (including the must do's and should do's) and issues raised within the Section 29a and 31 enforcement actions. The QIP describes our response to immediate concerns and longer term systemic issues such as leadership, governance and culture.

8. We have developed enhanced governance arrangements which include – executive leads for each of the ten workstreams, monthly confirm and challenge by the Improvement Director and Programme Director – Quality Improvement, the establishment of a Quality Improvement Board chaired by the Chief Executive, external scrutiny via the Oversight Group chaired by the CCG Chief Officer and effective use of board sub committees for assurance. The formal governance arrangements are supplemented by assurance visits, ensuring actions are truly embedded into our day to day practices.

9. Work is progressing at pace to deliver the 285 actions outlined within our QIP and we are utilising external support from other NHS providers and specialist experts to enable us to quickly implement best practice and learn from others. We believe the enhanced scrutiny and governance arrangements in place and our continued focus on improving the care we provide to our patients will enable us to continue on our quality improvement journey to build better, safer, higher quality services for the future.

## Operational Performance

10. In quarters 1 and 2 of 2015/16 the Trust achieved the ED 4 hour wait standard. This dipped to 94.77% for quarter three which is a significant improvement on performance in the same quarter in 2014/15. This improvement represents significant progress in improving flow through the Trust, enabled by effective discharge procedures and partnership working with other organisations. The Transfer to Assess Programme with the Clinical Commissioning Groups, deployment of a highly effective Short Stay Unit and two hourly flow meetings have led to improved performance but sustained achievement of the 95% target is yet to be achieved.



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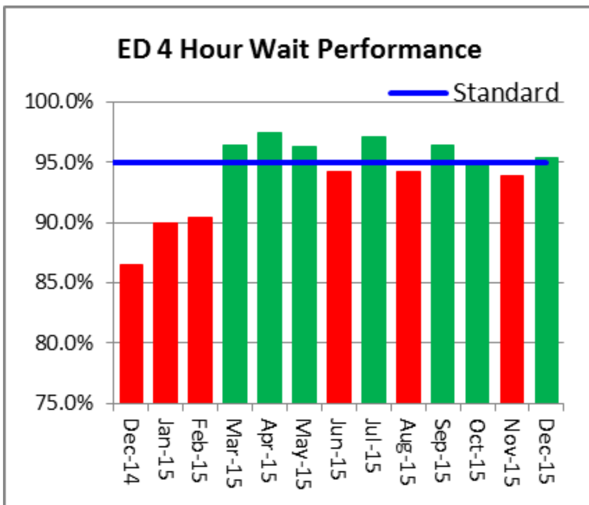
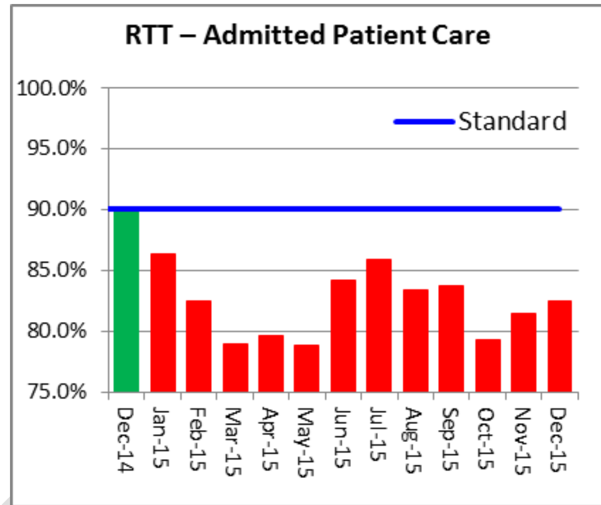
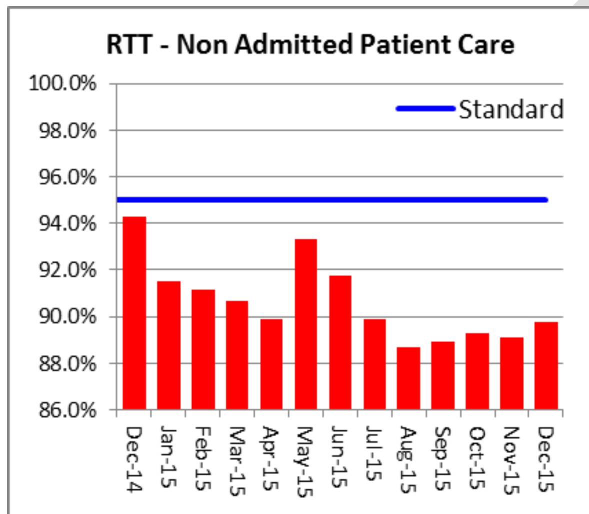
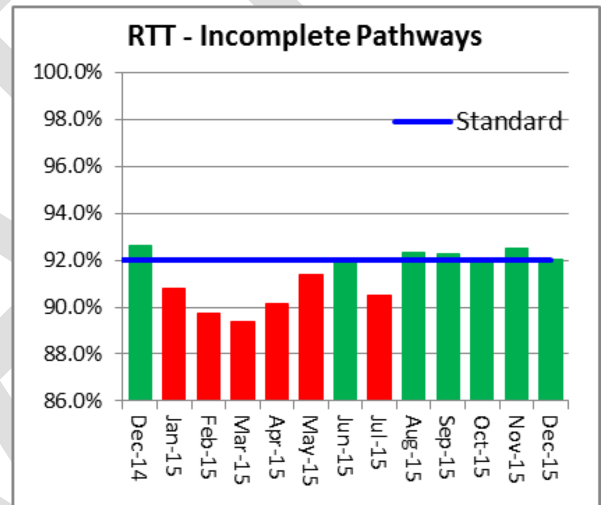
**Emergency Department performance**




**Referral to Treatment (RTT) performance**




## Financial Performance

11. The Trust is forecasting to be £53.3m in deficit at the end of 2015/16. This represents a deterioration of £8.8m compared to the planned deficit of £44.5m. Ongoing work has highlighted that forecast deficit is more in line with the underlying financial positions. The deterioration in the financial position is due to the ongoing recruitment challenges in both medical and nursing staffing and the corresponding need for premium rate pay. In addition investment has been needed in some areas to improve quality in year.

12. Work has been ongoing throughout the year to deliver improvements in quality and financial control. This has been supported by Monitor and PWC. A Programme Management Office is in place designed to deliver both improvements in quality and to support the CIP programme. As a result CIP delivery will be in line with plan in year at £6.5m.

### Restating our strategic intent

13. The Trust remains committed to the ideals of the Better Together Alliance, to address the financial challenges and improve care in mid-Nottinghamshire. We therefore remain committed to the strategy set out in our five year plan and to working with our commissioners to support the priorities outlined in their annual commissioning plan.

## Delivering the strategy in 16/17 and beyond

### Response to the 5 Year Forward View

14. Building on our progress in 2015/16 and looking ahead to 2016/17 and beyond, we can confirm our commitment to participation in delivering the vision set out in the 5YFV. The publication of the 5YFV has come at a significant time as our local health economy continues its transition through the Better Together Programme and the development of a Commissioner/Provider Alliance. As a vanguard for the Integrated Primary and Acute Care System (IPACS) approach, we are participating in the New Models of Care Programme and sharing our learning with others.

15. Better Together Alliance priorities remain; to prevent avoidable admissions, facilitate self-care and deliver care closer to patients' homes, delivered through closer integration between Alliance partners across health and social care. The Alliance will share and rationalise key assets including clinical expertise, managerial functions and estates and in removing traditional organisational boundaries deliver improved access and outcomes for citizens. During 2016/17, the Better Together Alliance will develop the future model for a capitated outcome based contract and as the lead Vanguard site for the development of the future payment mechanism will have the benefit of building on shared learning. Part of the development of the future payment model will see the introduction of some agreed outcomes and a "live" outcome based payment mechanism to enable the Alliance members to test the principles and behaviours of the new Alliance Agreement and to start delivering improved patient outcomes as soon as possible. The Alliance represents mid-Nottinghamshire CCGs and local providers (including SFH), social care and the third sector. We have a collective commitment to work together and demonstrate our ability to improve outcomes, reduce costs and provide care in appropriate settings. The Alliance partners are currently finalising the Alliance Agreement that will set out the aims and objectives for 2016 onwards with all partners committed to entering the Agreement in March 2016.

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## Overarching objectives for 16/17

16. The aims and ambitions of Better Together Alliance remain integral to our strategic priorities and objectives. Continuing the work that started in 2015/16, service line plans are increasingly aligned with these priorities and designed to address the challenges that we face as an organisation and within the wider health and social care economy.

17. The Trust has identified the following key priorities for 2016/17:
    - Ensuring the highest standards of safe care are consistently delivered for patients by, and for, individuals, teams and departments;
    - Providing timely access to diagnosis, treatment and care when people need it and safely reducing the time patients spend in hospital;
    - Raising the level of staff engagement through strong leadership, communication, feedback and recognition;
    - Reducing the scale of our financial deficit by reducing reliance on expensive agency staff, improving the utilisation and productivity of our resources, and achieving best value for money for every pound spent;
    - Working in partnership to keep people well in the community, and enable them to return as soon as they are ready to leave hospital;
    - Working with our NUH colleagues and our regulators to create a new organisation that will ensure the long term safety and sustainability of health services in Nottinghamshire.

## Initiatives to deliver objectives and improve performance

**Emergency Flow**

18. We will build upon previous work to improve flow through the organisation through:
    - **Engagement and communication** – ensuring medical, nursing, social service and therapist staff awareness and involvement;
    - **Understanding demand and modelling capacity** – improving activity forecasting through the year and developing KPIs to measure success;
    - **Reviewing ED working arrangements** – directing more patients to primary care services co-located with ED through the single front door development
    - **Reviewing EAU working arrangements** – developing the assessment unit, short stay and ambulatory services. Significantly improving short stay and admission avoidance
    - **Reviewing assessment areas** – increasing use of the Clinical Decisions Unit to avoid unnecessary admissions

DRAFT

- **Implementing the SAFER care bundle across all wards** – developing our morning board rounds and planning an expected date of discharge for every patient arriving on a ward from assessment areas
- **Increasing use of the Discharge Lounge –** aiding discharge earlier in the day
- **Comprehensively reviewing all patients with Length of Stay (LoS) of over 14 nights** – working with social services and Clinical Commissioning Groups to assess patients out of hospital and developing a programme to review 7-14 day length of stay
- **Reviewing capacity management and escalation arrangements** – supporting modelling in emergency and elective care through predicter tools and use of the NHS Intensive Support Team
- **Developing Internal Professional Standards** – in emergency, acute and general medicine

**Elective care**

19. The Elective care transformation work is focused on improving patient care whilst maximising productivity. This has seen improved utilisation in outpatient productivity and the commencement of a theatre improvement group to lead productivity and efficiency gains during 2016/17 in elective theatres. The group will also look to maximise the elective services offered locally to Newark patients.

**7 day services**

20. As described above, our service line plans include new approaches to improving service access and consistency across the 7 day week. This is particularly in relation to emergency, acute and general medicine. There is an enhanced Consultant presence augmented by nurses, therapist and others to give access and quality of service at a weekend and improve flow through the organisation across the week.

**Better Together initiatives**

21. In addition to the core strands of our transformation programme, we have worked with our partners in the local health community to deliver a number of important initiatives as part of the Better Together programme in 2015/16. For example, we have created a 'single front door' at King's Mill Hospital (KMH) and are in the process of reconfiguring the model at Newark Hospital, using finances secured as part of the Prime Minister's Challenge Fund. At KMH this has involved creating a single, jointly run service across ED and the Primary Care 24 service, for triaging patients who present requiring care. The service saw the introduction of a single reception/triage service where patients are streamed to the most appropriate point of care with direct access to GPs for primary care conditions or into ED for cases requiring emergency

DRAFT

care. The changes at Newark will see GP service co-located with the Minor Injuries Unit (MIU), to facilitate better integration.

22. We will continue to play our part in the 'Transfer to Assess' initiative, supporting patients to be discharged to their own homes (where possible) or to a community setting. A small team of dedicated nurses and therapists work with social care colleagues at King's Mill and Newark hospitals to:
    - Assess patients within ED who do not require an acute admission and facilitate transfer to a suitable alternative community setting;
    - Facilitate discharge from EAU and ambulatory clinics;
    - Assess patients on specific named wards who are medically fit for discharge, and support their transfer into appropriate community settings.

23. In November 2015 the Call for Care service was introduced following the development of the model as a collaboration between SFH, EMAS, NHCT and CNCS. The service provides a telephone service to clinicians where following a simple call streaming service, clinicians have direct access to:
    - clinically trained assessors providing access to physical and mental health support, and who have the ability to deploy assessors to the patient's home where needed or:
    - a comprehensive directory of services that can provide support or care packages enabling patients to remain at home.

    The aim of the service is reduce admission to ED for patients not requiring emergency care but with the right care package at the right time are enabled to be treated closer to or at home. Initially the service was only accessible to EMAS but a full roll out to all GP practices is currently being undertaken. 14 practices accessed the services during December 15, and the rest will be on line in the early part of 2016.

24. We will continue to support and be actively involved in the PRISM service, working collaboratively with partners across health and social care to deliver an integrated hospital, community, primary and social care model, that will:
    - Improve outcomes for patients with Long Term Conditions and the frail elderly.
    - Deliver better access to more integrated care outside hospital
    - Reduce unnecessary hospital admissions.
    - Facilitate more effective cross boundary working – including Social Care, Mental Health and the Third Sector.
    - Support to increase citizen's independence & involvement in their own care

DRAFT

25. Additional community based services such as Specialist Intermediate Care Teams will come on stream in 2016/17. The combination of these services will lead to reductions in demand for acute hospital-based care, as more people are supported in other settings. This will enable the Trust to focus on those people who really need to be in hospital.

## Summary of CIP schemes

26. The Trust has set an efficiency savings target of £12.6m. This includes £1.7m of revenue generation and £10.9m of cost reduction and is a total of 4% of the cost base. This target will deliver the 2% requirement within tariff as well as support delivery of the control total deficit of (£41.2m) and improve the underlying deficit.

27. The Trust has workstreams as detailed in table 1 below. Each of these workstreams has a target based on scoped opportunity and identified schemes. Detailed development of plans and implementation is underway, ensuring delivery as soon as possible to support maximum delivery in year and FYE.

*Table 1 – CIP workstreams*

| Tier | | Workstream | Accountable Sponsor |
|---|---|---|---|
| 1 | 1. | Length of Stay (urgent and planned care) | Jon Scott |
| | 2. | Theatres | Jon Scott |
| | 3. | Outpatients | Jon Scott |
| | 4. | Medical Task Force | Andy Haynes |
| | 5. | Nursing Task Force | Suzanne Banks |
| 2 | 6. | Diagnostics | Andy Haynes |
| | 7. | Procurement | Peter Wozencroft |
| | 8. | Pharmacy & Meds Management | Andrew Haynes |
| | 9. | Clinical Coding & Income | Ross Dunworth |
| | 10. | Corporate | Ross Dunworth |
| | 11. | Estates & Facilities | Peter Wozencroft |
| Divisions | 12. | Emergency and Urgent Care | Amanda Robson |
| | 13. | Medicine | Jayne Slater |



DRAFT

| | | | |
|---|---|---|---|
| | 14. | Planned Care | Dale Travis |
| | 15. | Women and Children's | Simon Hallion |
| | 16. | Diagnostics and Outpatients | Elaine Torr |

28. The workstreams are based on improvement opportunities identified through internal and external benchmarking and these correlate to the Carter review findings for the Trust. The structure is based on the FY 15-16 model with the addition of the specific divisional schemes.

29. The trust has an established assurance process in place. Each workstream has a 'workstream plan' that identifies the improvement opportunities, rationale and describes how schemes will be delivered. Following Turnaround Director approval of the workstream plan, PID's are developed with approved financial savings, workplans, KPI's and a quality impact assessment. This process is managed by the CIP Director, the lead for the overall delivery of the target.

30. Each workstream has committed project management office support, along with an accountable lead, operational lead, clinical lead and a programme manager with dedicated finance support.

31. Workstream accountable leads are held to account on a regular basis through the CIP Board, chaired by the Turnaround Director.

32. The PMO will provide assurance of delivery through reporting, tracking of milestones and the assembling of evidence that the performance benefits are realised. The Trust Board will receive assurance via the Finance committee and external assurance and challenge will be provided by the Turnaround Director.

## Patient Experience and Involvement Strategy

33. The Patient Experience & Involvement Strategy was developed and subsequently implemented during 2014 following the launch of the Quality For All campaign, In Your Shoes and Our Shoes events and review of a number of complaints and patient surveys.

34. The strategy is clear in its intention, mirroring national guidance to primarily create a culture that actively seeks out and listens to our patients and visitors regarding their experiences whilst in our care and secondly from an organisational perspective demonstrates robust and effective learning.

DRAFT

35. The Patient Experience & Involvement Strategy is underpinned by seven key commitments borne out of the above that will be successfully implemented and embedded into the organisation over the next three years. The intention being that this will make a measureable difference to our staff, patients, carers and visitors alike.

36. The strategy continues to drive the patient experience and engagement agenda, in addition to the aims for year 2, it is clear from patient feedback involvement and engagement with patient and carers is essential, therefore the following initiatives will be implemented during year 3 led by the Patient Experience Team:

    a) Experience Based design – ask patients about their feelings and experiences at agreed 'touch points' within a patient journey

    b) Patient stories – capturing patient stories on film and providing versions to Board or as training resources for Divisional staff

    c) Patient forums – establish and support patient forums based within Divisions and specialities

    d) Further Listening events – supporting events focused on specific areas for improvement shaped by the intelligence from complaints, concerns and Friends and Family Test

    This feedback will be shared with staff to help highlight and improve services and systems, and shape the strategy for involvement and engagement from 2017-2020.

## Operational requirements

### Activity modelling

37. The Trust has continued its bottom up approach to activity and capacity planning through our divisions, using the IST capacity and demand tool, whilst working closely with its commissioners. Using the same model previously, we have made adjustments for known changes, growth, QIPP and capacity and as such the activity plan agreed within the contract reflects on the one hand a context of rising demand and on the other, a local transformation programme that includes interventions designed to reduce pressure on secondary care. As the following data show, we have experienced year on year increases in ED attendances and emergency admissions:



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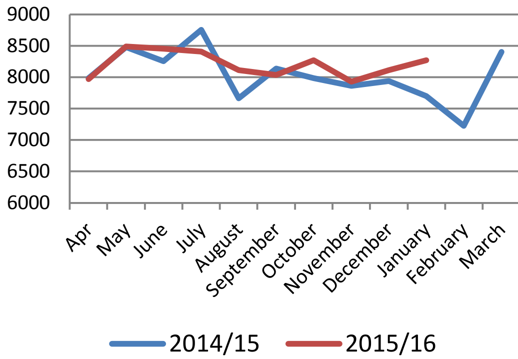


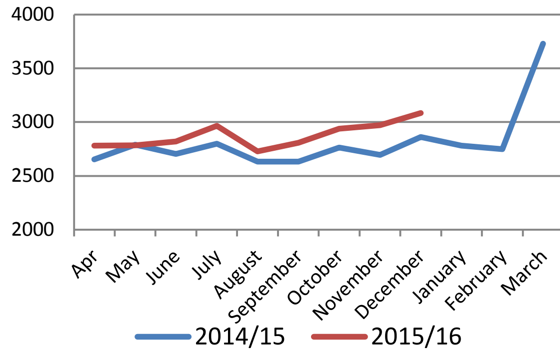


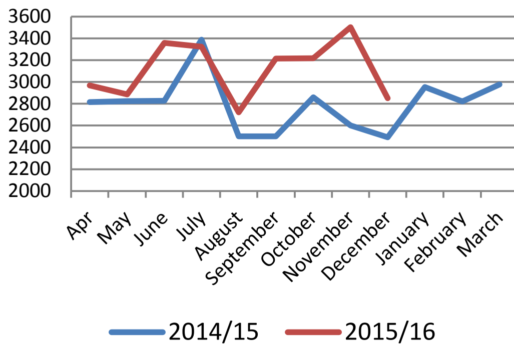


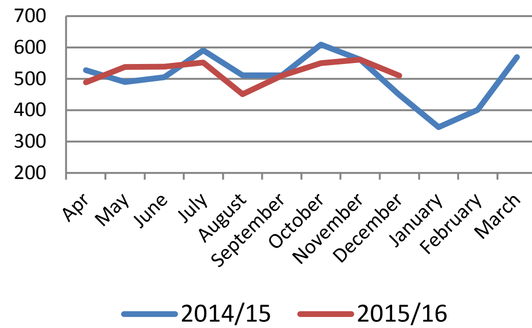


38. The graphs show the fluctuations across the Last two years, reflecting the increase in elective day case activity, whilst elective in-patient activity follows similar activity levels as the previous year.

## Workforce

39. In response to the challenges associated with sourcing the right workforce, we will continue with innovative recruitment approaches. The Trust needs to recruit to 140 registered nursing vacancies and 68 medical posts. Our recruitment plan includes the development of a UK and local recruitment campaign, as well as the recruitment of staff internationally, both from the EU and beyond. Medical recruitment remains a considerable challenge, but we are working with specialised agencies to help recruit the staff we need and also looking at alternative recruitment options.

40. HR is a principle component to the Quality Improvement Programme. HR Business Partners are working closely with divisional teams to achieve 98% compliance in the appraisal process, 100% completion of mandatory training and less that 3.5% sickness absence across the



DRAFT

Trust. Plans have been developed within each division detailing trajectories for completion of the above.

41. To support effective Human Resource Management, the Trust has invested in the Allocate software system to support the job planning and electronic health roster for medical and nursing staff. This system is currently in the implementation phase but is expected to deliver efficiencies in the management of the capacity within the organisation.

### Leadership Development

42. Leadership development continues to play a central part in equipping our leaders and managers with the knowledge, skills and behaviours to deliver services to support the delivery of high quality patient care. Our nursing and medical leadership programmes in particular will also play key role in supporting succession planning across the organisation.

43. During 2016/17, we will continue to offer a suite of leadership development programmes to equip leaders at different stages with the knowledge and skills to support and lead others. A key focus for 2016/2017 will include training leaders in employee engagement and performance management.

44. We will continue to work closely with Health Education East Midlands (HEEM) and the Local Education and Training Council (LETC) during 2016/17 to develop our wider workforce, influence national and local workforce and training strategies, enable systems leadership and to develop new flexible roles for the health and social care system.

### Physical capacity and estates development

45. Our approach to maximising the high quality PFI estate across King's Mill and Newark Hospitals is consistent with the community-wide Better Together Alliance estates strategy. These two sites account for circa 80% of the annual estates running costs in mid-Nottinghamshire and contribute substantially to the estimated £70m financial gap that our health and social care community is facing over the next 4-5 years. We therefore recognise the importance of effective estate utilisation as an enabler to the wider Better Together Alliance transformation agenda.

46. In line with the DH Estates Strategy guidance and the DH Section 42 deficit support conditions, the Trust developed its own Estates Strategy to address known estate priorities. The strategy, aligned to the Better Together Alliance Estates strategy, progresses the programme to exit



DRAFT

deteriorating, engineering intense retained estate and consolidate acute services and improve the estates offer to the whole health community.

47. Any developments across the Trust will be made in line with the Trust's refreshed Sustainable Development Management Plan (SDMP) to promote the Trust's green credentials.

## Performance risks

48. In light of the performance issues experienced during 2015/16 in relation to RTT, the ED 4 hour standard and Cancer 62 day waits for first treatment (from urgent GP referral), we are highlighting these areas as risks for 2016/17. Recent improvements mean that the Incomplete RTT achievement has been sustained but the diagnostic RTT remains a risk in Q1 due to issues with sleep studies. The 95% emergency access standard is yet to be sustained for the winter quarters and despite the introduction of a weekend discharge team and increased flow meeting frequency there is a compliance risk. The Cancer 62 day wait is a risk for Q1, following a trajectory for recovery from failure to achieve the standard during Q3 and Q4 of 2015/16. The trajectory is planned to meet the 85% standard during Q1 2016/17 and be sustained thereafter.

## Financial Planning

49. The Trust has been set a control total of (£41.2m) deficit, inclusive of £10.3m of Sustainability and Transformation funding. In summary the financial plan has the following implications:-

- Planned I&E deficit in line with control total of (£41.2m);
- CIP of £12.6m which includes £1.7m of revenue generation and £10.9m of cost reduction;
- Capital spend of £9.5m;
- Cash requirement of £47.2m to support the revenue and capital position.

## Approach to financial planning

50. The Trust is adopting a rigorous planning approach to financial planning for 2016/17. Each Division and Corporate Directorate has produced draft budgets that will be reviewed and challenged by the executive to ensure only necessary costs are incurred. Divisional budgets are based on bottom up costing of establishment requirements to deliver effective, safe, quality services. Non pay costs are based on forecast outturn. Each divisional first cut has been reviewed with further challenge scheduled for February and March.

51. Key to delivery of the plan is enhanced budgeting and budget understanding. Each budget holder has been involved in the development of the plan and construction of their budget within defined terms. Executive challenge will lead to explicit agreement on what costs are funded

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and which are not. This will form the basis of strong financial control and accountability in 2016/17.

52. This approach, along with the assumptions the plan is currently based on were approved by Trust Board in January. Planning updates will be discussed at the Executive Team, Finance Committee and Trust Board in February prior to full agreement of the final plan before 31st March.

## Income and expenditure position

53. The forecast outturn for 2015/16 for the Trust is a (£53.3m) deficit. Once adjusted for non recurrent items there is an underlying recurrent deficit of (£54.8m). Chart 1 below details the bridge between 2015/16 outturn and 2016/17 plan. Key elements include pay and non pay inflation of (£7.1m) and cost pressures of (£4.9m) predominately associated with the recruitment challenges faced by the Trust. The Trust has included no discretionary revenue items above £0.25m.

54. Each of these assumptions is being reviewed, adapted and verified. Each additional increased cost is being challenged by the executive team with a view to minimising as far as possible and to ensure full ownership of the financial plan by all budget holders.

*Chart 1 – Income and Expenditure bridge*

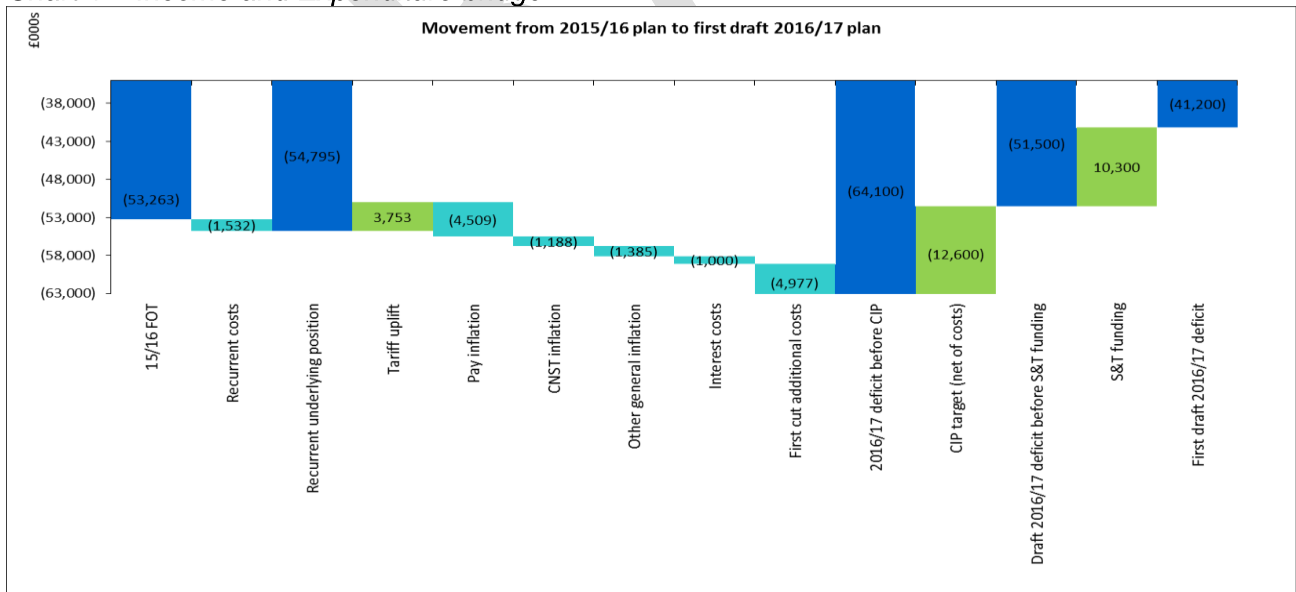

*Table 2 – Draft income and expenditure plan*

| | Forecast Outturn 15/16 £000 | Annual Plan 16/17 £000 |
|---|---|---|
| **Operating Income** | | |
| NHS Clinical Income | 222,909 | 240,563 |
| Non NHS Clinical Income | 1,178 | 1,146 |
| Non Clinical Income | 35,985 | 34,142 |
| **Total Operating income** | **260,072** | **275,851** |
| **Operating expenses** | | |
| Pay | (183,847) | (187,492) |
| Non Pay | (83,406) | (80,660) |
| PFI | (18,714) | (20,584) |
| **Total operating expenses** | **(285,967)** | **(288,736)** |
| **EBITDA** | **(25,895)** | **(12,885)** |
| Donations and Grants | 300 | 300 |
| Depreciation and Amortisation | (9,515) | (9,750) |
| Non Operating income | 265 | 258 |
| Interest Expense | (18,418) | (19,123) |
| **Total non operating income and expense** | **(27,368)** | **(28,315)** |
| | | 0 |
| **Surplus / (deficit)** | **(53,263)** | **(41,200)** |

## Carter

55. The Carter review identified the Trust has an Adjusted Treatment Cost of £1.04. The workstreams identified with the CIP programme are activity addressing the areas identified by the Carter Review and seek to reduce costs, for example ALOS and outpatient costs. This will include review of pay costs in particular the nursing and medical workforce workstreams. These workstreams will identify opportunities by speciality; in addition, specific areas for review will be addressed through the divisional 1% target.

## Agency rules

56. Since the application of price caps for staff, the Trust has seen an improvement compliance with nursing, with the number of shifts out of cap reducing from 224 to 36 for week ending 24th January. Performance against the qualified nurse agency ceiling target of 9% has remained at 9.3% since implementation of the ceiling as a result of continuing difficulties with recruitment. The Trust has a number of overseas nurses planned to commence early in 2016/17 and continues to work on other recruitment and retention initiatives.
57. Adherence to the caps is a more significant challenge with medical staff. In mid January the Trust had 88 medical staffing gaps, of which 75% were being filled on a weekly basis with

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agency. Key to improvement of the Trust financial position and delivery of the CIP target is a reduction in vacancies.

58. The Trust has set a target of £1m for each of the medical and nursing workstreams. Key to delivery of these targets will be working towards adherence to price caps and ceilings and ensuring control over processes used for booking agency staffing.

## Procurement

59. The Trust has active workstreams in place with regards to Procurement. Procurement will support in areas identified by Carter as well as aspects around agency caps and framework arrangements. Key areas of work include the following:-

- Management of ward consumable stock to ensure that we only order Band 2 quantities, to ensure we get the greatest discount
- Use of Bravo analytics to enable more detailed understanding of purchasing and benchmarking.
- Implementation of all NHSSC Core List items
- Submission of benchmarking data to Carter team at BSA in late January
- Delivery of training to Departmental staff on application of SFIs and SoD
- No PO, No Pay project
- Monthly spend analysis to identify trends and potential problem areas
- Interaction with clinical leads to consolidate down to a single supplier and then negotiate volume discounts

## Capital planning

60. In common with the process that was adopted for 2015/16, all capital spending leads (for ICT, Equipment and Estate/environment) were asked to prepare their proposed capital plans in September/October 2015. On completion of the draft five year forecasts a planning workshop was held with all functional leads and Divisions.

61. As part of the compilation and review process, all proposals were given a risk rating. This has been used to refine the forecasts from version 1 to version 3 with the 2016/17 plan reducing from £18.32m to £9.53m. The current plan for 2016/17 does not include any planned expenditure unless the item/issue to be addressed is risk rated 16 or above. The risk ratings have been subject to peer confirm and challenge.
The five year capital plan is as per table 3.

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*Table 3 – 5 year capital plan*

| | 5 year plan £m | | | | |
|---|---|---|---|---|---|
| **Plan 2015/16** | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2020/21** |
| 9.11 | 9.53 | 17.40 | 13.00 | 33.70 | 31.98 |

## Cash

62. The Trust will require cash loans to support the revenue and capital position planned for in 2016/17. Cash requirement for 2016/17 is therefore a total of £47.2m. The following assumptions have been used in developing the cash flow:-

- Sustainability and transformation funding will be received quarterly in arrears the month after quarter end. A final payment for Q4 will be received in March.
- There will be no change in creditor payment terms
- The resulting cash requirement is based on working capital facility at 3.5% for 6 months when this borrowing will be reverted to Interim loan support at 1.5%.

Table 4 below shows the draft net cash flow each month and the draft required borrowing

## Financial Risks

63. Delivery of a (£41.2m) deficit is a challenging target which the Trust is stretching itself to deliver, most significantly through a £12.6m CIP target. There are a number of risks associated with delivery table 6 below.

*Table 4 – Risks and Mitigation*

| Risk | Mitigation |
|---|---|
| Unidentified and unmet CIP target | The plan assumes full delivery of the CIP target. The process in place for development of CIP must be adhered to and strong governance of the CIP programme is needed. |
| Unforeseen and unplanned for costs worsen the financial plan and impact on delivery | The development of the financial plan includes Executive review and challenge of all Divisional and Corporate plans. This will ensure costs are captured and planned for.<br>Any costs that are identified in year will be a risk to delivery and new income or cost reduction will be required to offset these as there is no contingency within the plan. |
| At this stage full tariff guidance is unknown meaning the NHS clinical income figure is based on draft prices | Guidance from NHS Improvement is expected in March 2016. |
| Cost implication of any partnership arrangements are assumed to offset with income | Currently assumed to come with additional income and clarification will be sought through the planning process. |
| Clinical Income assumptions to be negotiated, full contract terms and conditions as yet unknown | Contract negotiations have begun to agree activity baselines. Once full tariff and contract guidance is known implications will be managed. Income will be negotiated to support delivery of the control totals |
| Costs of delivery of any increased activity are in excess of the income | Currently it is assumed that any increased activity can be delivered within income received. Further work is ongoing through Divisional planning ensure that activity and capacity are planned and funded appropriately. |



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