Quality for all

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Sherwood Forest Hospitals NHS Foundation Trust

Annual Plan

2015/16

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

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Strategic context and 14/15 review

Strategic Plan

1. The plan for Sherwood Forest Hospitals NHS Foundation Trust (SFH) is to continue on the journey set out in our five year strategic plan[1], building on the significant progress made in 2014/15. To achieve clinical and financial sustainability and to be a Trust that consistently delivers the best care and outcomes for the communities we serve, we must maintain our focus on the priorities described in our strategy. Our continued participation in the Mid-Nottinghamshire Better Together programme[2] is fundamental to this strategy and consistent with the compelling vision set out in the Five Year Forward View (5YFV). The selection of Mid-Nottinghamshire as one of nine vanguard sites for Primary and Acute Care Systems (PACS) 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.

2. 2014/15 has seen substantial progress on a number of priorities, with significant strides being made to improve the quality of our services. Nevertheless, residual quality concerns remain, which combined with performance issues and a worse than expected financial position, presents particular challenges for 2015/16. Our plans for the coming year include initiatives to address these three areas of concern, but we recognise that 2015/16 will be another challenging year as a result of pressures across the wider health and social care system, as well as those specific to our locality.

Our priorities

3. The priorities set out in our strategic plan have shaped our work in 2014/15 and are reaffirmed in our plans for 2015/16 (see Appendix 1 for a diagrammatic summary of our strategic plan). Our priorities continue to be to:
    - consistently deliver safe, effective and high quality care, achieving positive staff and patient experiences;
    - eliminate the variability of access to and outcomes from our services;
    - reduce demand on hospital services and deliver care closer to home;
    - develop extended clinical networks that benefit the patients we serve; and
    - provide efficient and cost-effective services and deliver better value healthcare.

Quality for All

Our values

4. Underpinning these priorities are the values and behaviours expressed in our 'Quality for All' initiative, which recognises that cultural change is fundamental to service improvement. These values describe the ethos of the Trust and its approach to working with patients, the public, staff, and partner organisations. We have continued to embed these values across

[1] Available here
[2] The Better Together programme has developed as a coordinated response to the sustainability challenges facing mid-Nottinghamshire. It is a partnership of the health and social care organisations in the area, working together to deliver whole system change in a 3 – 5 year timeframe.

the organisation during 2014/15, through a programme of staff engagement sessions, changes to our induction programme and values-based recruitment and appraisal of our staff. In addition, we have reviewed our Raising Concerns Policy in line with the Quality for All values, and will be conducting a further review in light of the 'Freedom to Speak Up' recommendations.

Quality Standards

5. In our strategic plan, we set out specific quality ambitions for 14/15. Our achievement of these standards is mixed, as the following examples demonstrate (further details will be available in our Quality Account):

Falls:

We have not met the target for reducing falls resulting in harm to <1.7 per 1000 occupied bed days by Q4. However, we have reduced the number of patients falling more than twice during their inpatient stay – in Q4, there were 10 patients against a target of <16.

Pressure ulcers:

We have had no Grade 4 hospital acquired pressure ulcers (PUs) in 14/15 but the target of zero Grade 3 PUs from Q3 onwards has not been achieved, with 4 developing in Q4. We also exceeded the annual target of 53 Grade 2 PUs for the year by 11.

Hospital Standardised Mortality Ratio (HSMR):

HSMR deteriorated through the summer and autumn months, but generally mirrored crude mortality. In December HSMR reduced despite a significant rise in crude mortality, indicating that these were expected deaths – this is supported by case-note reviews. The gap between weekend and weekday mortality has reduced, as a result of improvements made in 7 day working.

Friends and Family Test (FFT):

Although we have consistently not achieved our internal response rate target of 50% for both inpatients and Emergency Department patients, in March 2015 our response rate for inpatients exceeded the target (reaching 53.2%). Our FFT results show that 90% of inpatient respondents would recommend King's Mill and Newark hospitals, whilst 90% of patients would recommend our ED.

Infection control:

We have met the zero tolerance MRSA target, but the annual target of <37 cases of attributable Clostridium Difficile infections has been exceeded by 30.

Quality Improvement Plan

6. In addition to progress against the range of quality measures above, we have made significant headway in addressing the quality concerns highlighted in the 'Keogh review' and subsequent CQC inspections. The Trust has developed a Quality Improvement Plan, which incorporates and coordinates the resulting action plans from each. In November 2014, SFH's Board confirmed to Monitor that it was fully assured that all 23 actions required in response to the 'Keogh review' had been completed. This and the progress made against the Quality Improvement Plan engender confidence that following the CQC's visit in 2015/16,

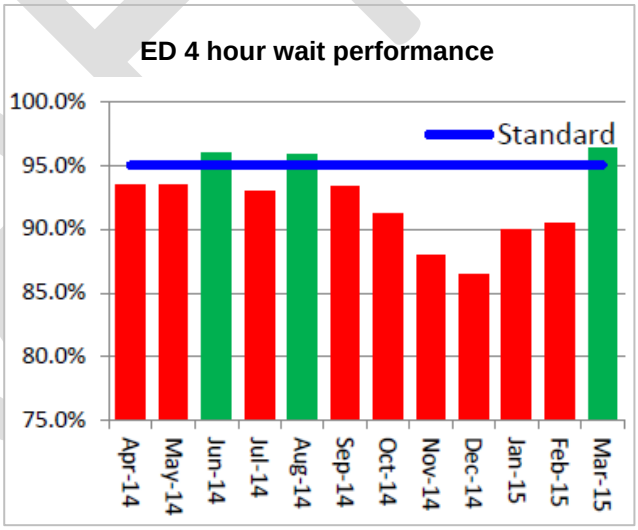
the Trust will exit special measures. In the meantime, we will continue to seek internal assurances about the quality of care we provide. Moving out of special measures will not mark the end of our quality improvement, but instead will provide a platform on which to build better, safer, higher quality services during 15/16 and beyond.

Operational Performance

7. Operational performance across 2014/15 represents a mixed picture, but is in a context of rising demand and pressures across the health and social care system, and an especially difficult winter. Of particular note is the increase in activity in the following areas, when comparing 2014/15 to 2013/14 totals:
    - Emergency Department (ED):
        - attendances have increased by 3.8%
        - majors at KMH have increased by 7.1% (whilst minors have decreased by 2.1%)
    - Emergency admissions have increased by 4.5%
    - Elective day-cases have increased by 3.7%
    - Outpatient attendances have increased by 8.3%

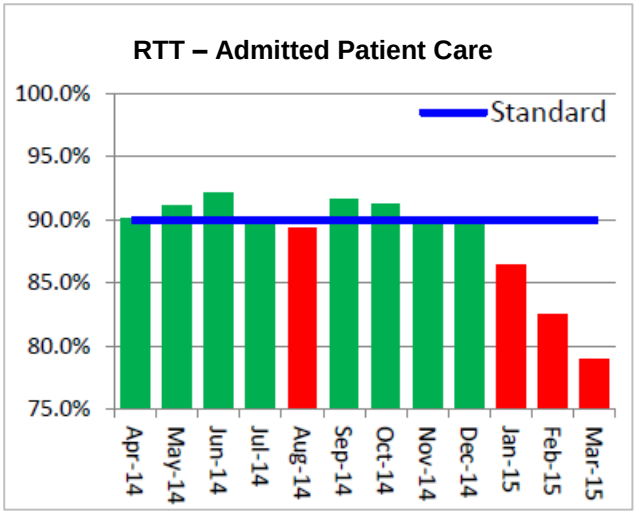
Emergency Department performance

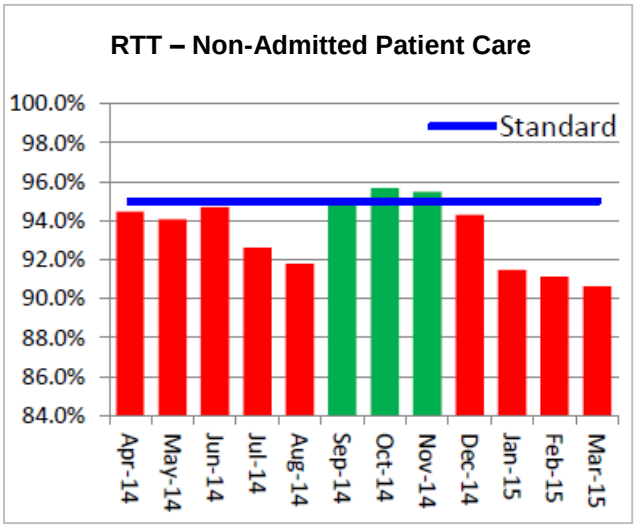
8. In each quarter of 2014/15, we missed the ED 4 hour wait standard. However, at the end of 2014/15 (and into the beginning of 2015/16), performance improved significantly. In March 2015, the Trust achieved the 4 hour ED target for the first month since August 2014. This improvement represents significant progress in improving flow through the Trust, enabled by effective discharge procedures and partnership working with other services.

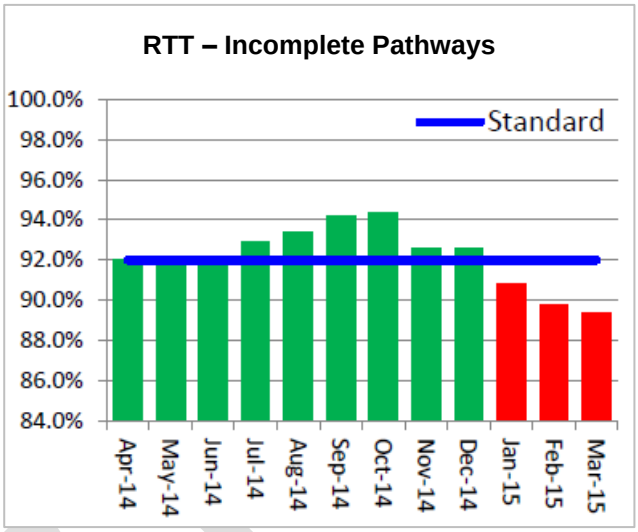


Referral to Treatment (RTT) performance

9. An exception to the pattern of increased activity described above, is a decrease in elective inpatient activity of 4.6% over 2014/15. This reflects a period of cancelled appointments early in 2015, in response to intense winter pressures and associated performance challenges. These cancellations are a major contributory factor to the deterioration of RTT performance in Q4. In response we have initiated an RTT recovery plan, which has been agreed with our commissioners.







Cancer Waiting Times

10. All cancer waiting targets were met in each quarter of 2014/15, with the exception of the 2 week wait (All Cancers) in Q1 and the 62 day wait for urgent referral to treatment in Q4.

Financial Performance

11. The need for the whole system transformation that is central to the Better Together programme is only emphasised by our Forecast Outturn for 2014/15. Our end of year deficit was £32.6m, before a revaluation gain of £18.7m which reduced the reported deficit to £13.9m. The £32.6m deficit (before revaluation gain) represents a deterioration of £6.2m from the trajectory set out in our strategic plan. The substantial deviation from our plan is primarily due to non-delivery of recurrent Cost Improvement Programmes (CIPs). Against an £8.7m CIP target, we achieved £2.7m (£1.5m of which are recurrent), giving a £6.0m CIP shortfall. In addition to the considerable financial impact of the PFI, we are facing significant workforce challenges, adding further financial pressure.

12. In 2014/15, we recruited substantively to 85 more whole time equivalent posts, compared to the end of 2013/14, which has been achieved through local and international recruitment campaigns and improved relationships with colleges and schools. However, we ended 2014/15 with 210 vacancies remaining. This has driven greater agency and locum expenditure, which has been compounded by the planned ward closure not being achieved and all capacity being open at peak times. The result is that in 2014/15 we have spent circa. £25m on premium rate and variable pay.

13. A further driver of financial performance in 2014/15 has been pressure on emergency care, particularly during the winter. As described above, this has led to the cancellation of elective work, not only affecting patient care and experience, but also reducing our income.

Restating our strategic intent

14. Our financial performance in 2014/15 means that it is necessary to adjust the financial trajectory set out in our five year plan (see 'Financial Forecasts' section for details). The strategic plan, based on the objectives of the Better Together programme, remains the best way to address our financial challenges and improve care in mid-Nottinghamshire. We therefore remain committed to the strategy set out in our five year plan, aligned to Better Together and committed to working with our commissioners to support the priorities outlined in their annual commissioning plan.

Delivering the strategy in 15/16 and beyond

Response to the 5 Year Forward View and Dalton Review

15. Building on our progress in 2014/15 and looking ahead to 2015/16 and beyond, we can also confirm our commitment to playing our part in delivering a local expression of the vision set out in the 5YFV. The publication of the 5YFV has come at a significant time in our local health economy, as the Better Together programme across mid-Nottinghamshire gains increased momentum. The alignment between the Better Together programme, the 5YFV and the recommendations in the Dalton review, demonstrates that we are on the right track. Indeed, having been selected as a vanguard for the PACS approach, we look forward to participating in the New Models of Care Programme and sharing our learning with others.

16. Many initiatives designed to improve integration across organisational boundaries, prevent avoidable admissions, facilitate self-care and deliver care closer to patients' homes are already in train as part of the Better Together programme. Nevertheless, far greater transformation is required and we are therefore committed to working in partnership with commissioners and other local providers to respond to a recently launched re-commissioning process.

17. From 2016/17, the local commissioners will be moving away from activity based contracting, towards outcomes based commissioning, utilising a capitated budget. The transition will be towards an adapted PACS model. In the spirit of collaboration, the mid-Nottinghamshire CCGs have asked seven local providers (including SFH) to work together and demonstrate our collective ability to improve outcomes, reduce costs and provide care in appropriate settings. Our capability to do this will be assessed against a series of metrics during 2015.

18. An important component will be determining the organisational form and commercial model between the providers. Commissioners have asked the seven providers to design and decide this between us, with the requirement that there is a single contractual counterparty i.e. an Accountable Provider Alliance. This leaves us with a number of possible options, as outlined within the Dalton review, and we will be working with our provider partners to determine the most suitable approach in the early part of 2015/16. In the transitional period, prior to full implementation of the new model of care, we will work with our partners within the framework of a Memorandum of Understanding (MoU), a draft of which has already been agreed in principle.

19. We recognise the opportunity that the re-commissioning process presents to align incentives across the local health economy and a major focus throughout 2015/16 will therefore be to ensure we build a strong platform for the significant changes in 2016/17. Indeed, the Better Together programme will only be successful if the re-commissioning process and the new contractual model drive and facilitate integrated care and better outcomes for patients. For this reason, we are committed to continuing to play our part in 2015/16 in the delivery of service changes that benefit patients.

Overarching objectives for 15/16

20. The aims and ambitions of the Better Together programme are integral to all of our strategic priorities and objectives (see Appendix 1 for further details). Service line plans are aligned with these priorities and designed to address the performance challenges that we face as an organisation and wider health economy. The initiatives in the following table demonstrate this with concrete examples:

Strategic priority	Service line plans for 2015/16
1. To consistently deliver **safe**, **effective**, high **quality** care, achieving positive **staff** and **patient experiences**	Plans are in place to develop the use of Musculoskeletal Ultrasound scanning in Rheumatology services, reducing follow ups and improving patient experience and quality of care
	A redesign of our Emergency Assessment Unit (EAU) is planned, which it is anticipated will improve flow, reduce beds in EAU on a sustained basis and reduce costs
	During 2015, the transformation of Ward 52 into a Medical Mental Health ward will be completed, using charitable funding. This will improve safety, quality of care and patient & staff experience
2. To eliminate the variability of **access** to and **outcomes** from our **acute** and **community** services	Across a range of services, we are planning significant workforce changes to meet 24/7 clinical standards, which will improve capacity and access to services
	Plans are in place to extend the osteoporosis screening service to Newark, which will reduce waiting times, improve access (at multiple locations) and generate income for the Trust
	Gynaecology and Antenatal ambulatory clinics will be established on a 7 day basis, providing better access to services and potentially reducing emergency admissions
3. To **reduce demand** on hospital services and deliver care **closer to home**	In Respiratory, the pathway for sleep studies is being redesigned to deliver more diagnostics in the community, leading to a reduction in inpatient studies, lower costs and better patient experience
	In Gastroenterology, the introduction of a telephone follow up service for Inflammatory Bowel Disease is planned, to reduce follow up appointments and increase access / support for patients
	As part of the Better Together programme, therapy services will support the Transfer to Assess initiative, to improve discharge processes and enable patients to be assessed in other settings

Strategic priority	Service line plans for 2015/16
4. To develop extended **clinical networks** that benefit the patients we serve	In Gastroenterology, partnership working with another Trust to develop a Viral Hepatitis nurse service is planned
	Plans are in place to build upon the MoU between SFH and two other Trusts and jointly provide pathology services for the local populations, leading to greater efficiencies and reduced costs
	Partnership working with NUH will contribute to increased workforce capacity and skill mix within Radiology and Stroke services, and delivery of 24/7 services for specialist HIV care
5. To provide **efficient** and **cost-effective** services and deliver better **value** healthcare	Improved reminder services (e.g. text message reminders) are being planned and implemented across a number of services, to reduce the occurrence of patients not attending appointments
	In Haematology, we aim to further develop nurse-led clinics and specialist nurse roles, to improve flow through our services, thereby increasing our productivity and effectiveness
	For our Community Paediatrics service, we will be seeking agreement for ADHD drugs to be prescribed by GPs under the shared care protocol, to reflect clinical appropriateness and reduce cost

Initiatives to deliver objectives and improve performance

21. In addition to these service line initiatives, which all contribute to our strategic plan, we have an established transformation programme, designed to radically change and improve our own ways of working. The programme is aligned to the ambitions of Better Together and is focused on the following areas: Emergency Flow, Elective care and Seven Day services.

Emergency Flow

22. We developed a comprehensive Emergency Flow Action Plan to address some of the performance issues the Trust was facing in Q4 2014/15, by focusing on all aspects of patient flow between ED, assessment and wards. The plan is built around 10 key areas and a programme management approach has been adopted until the end of June 2015, to drive and embed the new ways of working. Benefits of this approach are already being yielded, as indicated by the improved ED performance that the Trust has delivered at the turn of the financial year. The 10 areas of focus are:
    - **Engagement and communication** – ensuring 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 or specialist assessment areas;
    - **Reviewing EAU working arrangements** – developing the assessment unit, short stay and ambulatory services. Supporting admission avoidance and early discharge;
    - **Reviewing assessment areas** – increasing timely flow from ED for patients requiring assessment in surgery, gynaecology and orthopaedics;

- **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 to ensure robust discharge arrangements are in place and blockages addressed promptly'
- **Reviewing capacity management and escalation arrangements** – supporting improved flow by understanding activity and capacity levels throughout the day;
- **Developing Internal Professional Standards** – assisting all diagnostic and support services to develop agreed response times

Elective care

23. The Elective care transformation work is focused on improving patient care whilst maximising productivity. This requires pathway redesign and close working with the wider health community, to ensure improvements in referral patterns, information flows and decision making. This is a key work-stream within the Better Together programme, which we as a Trust will continue to fully participate in during 2015/16.

7 day services

24. As described above, our service line plans include new approaches to improving service access and consistency across the 7 day week. We have successfully moved to an enhanced 7 day service model in pathology and will continue to implement these new ways of working during 2015/16. In addition, we will continue to work with our partners across the East Midlands to identify solutions to enable a wider provision of 7 day services, in line with national priorities. Having participated in a region wide assessment exercise, we are aware of our strengths and weaknesses against the 10 clinical standards, providing a strong platform to develop our services in the coming year. However, we recognise that our financial position will affect our ability to drive implementation in this area.

Better Together initiatives

25. In addition to the core strands of our transformation programme, we are working 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 are introducing a 'single front door' at King's Mill Hospital (KMH) and at Newark Hospital, using finances secured as part of the Prime Minister's Challenge Fund. At KMH this will involve creating a single, jointly run service across ED and the Primary Care 24 service, for triaging patients who present requiring care. The changes at Newark will see GP service co-located with the Minor Injuries Unit (MIU), to facilitate better integration.

26. Of particular importance to successful implementation of the 'single front doors' is the training and change in working practices required by the staff. Plans continue to develop in support of this, including agreeing a single triage process to be used consistently. The initiatives at both sites will improve and streamline access to services, ensure patients are treated in the most appropriate way and potentially reduce pressure on our services.

27. In 2015/16 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;

Summary of CIP schemes

[DN – to be updated with financials once finalised]

28. Our CIP schemes for 2015/16 are consistent with the ambitions of the Better Together programme and designed to generate £12.9 of cash releasing savings. A particular focus will be on reducing LoS for inpatients of 14 days or more. This is an ambitious programme, which recognises the progress made through Better Together, the associated developments in alternative services in the community and the improvements we therefore expect to see in our ability to discharge patients. By focusing our attention on those who have been inpatients for 14 days or more, we expect to see the biggest gain in reduced length of stay, enabling 3 wards to be closed during the year.

29. The closure of wards is fundamental to our plans to address our workforce challenges because it will reduce our overall staffing requirements, enabling us to maximise our substantive workforce, reduce our dependency on agency staff and reduce our variable pay. Complementing this CIP is the introduction of a new rostering system, which will improve workforce management, provide real-time visibility of staffing across the Trust and therefore enable staff movement to meet demand. Furthermore, following development of our bank staffing function, admin and clerical bank staff will be managed centrally from April 2015, with the result being an expected reduction in the use of agency staff. For the agency and locum staff that we do require in 2015/16, we expect to achieve more competitive rates as a result of the planned implementation of a master vendor arrangement.

30. In addition, we have plans within our Planned Care and Surgery Divisions (PC&S) to improve productivity of theatres and clinics, identifying areas for improvement through greater analysis and use of benchmarking data. The expected benefits of our CIP schemes for 2015/16 are detailed in the Financial Forecasts section.

Capital programme overview

31. Our capital programme for 2015/16 (totalling £8.3m) underpins our strategic objectives by supporting investment in important enablers across our estates, informatics and medical equipment. Plans for 2015/16 include:
    - The introduction of a new medical workforce management and e-rostering system, which will improve our job planning, absence management, in-house staff utilisation

and monitoring. As well as saving money, these improvements will support safe staffing levels;

- Reconfiguring the radiology department and purchasing a new Gamma Camera to enable the provision of a more effective and efficient radiology service;
- Improving our endoscopy service through the purchase of a C-Arm to support the delivery of Endoscopic Retrograde Cholangiopancreatography (ERCP). Purchasing the C-Arm will allow the ERCP procedure currently delivered from the X-Ray department, to be provided in the endoscopy department, releasing X-Ray capacity and increasing productivity and capacity of the service.

Allocation of resources to meet needs

32. The plans and ambitions for 2015/16 described in the preceding sections are bold, and necessary if we are to continue to make progress in the implementation of our strategy. Our CIPs for 2015/16 will only be achieved by significant service and pathway changes both within the Trust and across the health community, requiring a renewed focus and increased level of support across our divisions and service lines. For this reason, we are strengthening our divisional teams, whilst integrating our Transformation team with our Programme Management Office within a single leadership structure. This is to ensure we are taking a coordinated approach to substantial service changes and cost reduction.

33. The integrated team will focus on supporting seven key areas of the Trust's business, with an emphasis on improving our use of Business Intelligence (BI) and financial information, and a focus on operational performance management. The seven areas, which will form a single programme, are as follows:
    - Workforce strategy
    - Timely emergency care and discharge planning, enabling smooth patient flow through our hospitals
    - Outpatient productivity
    - Theatre productivity
    - 7 day services
    - Our Quality Improvement Plan

34. Each of these areas will be treated as projects, with their own project manager from the new, integrated team. Furthermore, we have recruited a senior team to oversee the work (along with other responsibilities), including a Recovery Director, Programme Office Director and Deputy Director of Finance. A structure for this delivery team is available at Appendix 2.

Plan for short term resilience

Quality priorities

35. We are entering the second year of our Patient Safety and Quality Strategy and continue to focus on the quality priorities that it describes. Having made the progress outlined in our earlier review of 14/15, we recognise that a number of areas requiring significant improvement remain. In determining our quality priorities for 2015/16, we have gathered feedback and information from a number of sources, including:

- stakeholder and regulator feedback;
- commissioners observations and CQUIN priorities;
- inpatient and outpatient surveys;
- Council of Governors' forums;
- patient complaints and PALs information;
- internal performance metrics e.g. falls data
- our staff and in particular the outputs from our 'Quality for all' initiative and a staff survey designed to inform our quality priorities

36. Building on this information and a number of existing strategies (our Patient Safety and Quality Strategy, our Patient Experience and Involvement Strategy and our Organisational Development Strategy), we have identified a long list of specific priorities for 2015/16, from which we have identified the following 3 key priorities:

Priority area for 15/16		Description	Standard / Target
1	**Reduce mortality (HSMR)**	Mortality ratio as measured by Hospital Standardised Mortality Ration (HSMR)	Within expected range on weekends and weekdays
2	**Reduce mortality from sepsis**	A protocol and clinical tool are established to screen for sepsis patients in ED and units that admit emergencies	XX% eligible patients screened
		Patients with severe sepsis receive intravenous antibiotics within 1 hour of presentation	XX% relevant patients
3	**Reduce harm from falls** (Local CQUIN)	Reduce the number of inpatients falling in hospital	Reduction against 14/15 baseline
		Reduce the no. of inpatients sustaining a fracture as a result of a fall in hospital	
		Deliver a safety improvement programme for the prevention of falls	

37. Whilst these are our top three priorities, we have identified a number of other important quality objectives requiring particular focus in 2015/16:

Priority area for 15/16		Description	Standard / Target
1	**C. difficile**	Minimise the rates of C. difficile	<48 annually
2	**Length of stay**	Reduce hospital length of stays in excess of 15 days	Reduced from 15% to 10%
3	**Medication safety**	Medication-related 'never-events'	Zero annually

Priority area for 15/16		Description	Standard / Target

		• To increase the number of:
		  ○ medication-related incidents and near-misses reported
		  ○ patients whose medicines are reconciled by pharmacy staff within 24 hours of admission to hospital
		• To reduce the number of:
		  ○ patients with omitted doses of critical medicines
		  ○ medication-related incidents resulting in 'harm'
		• Ensure all patients have a documented allergy status on prescriptions
		• Improve learning from medication related incidents graded '3' and above	

4	**Acute Kidney Injury (AKI)** (National CQUIN)	To improve the discharge information for AKI diagnosis and treatment in hospital to include: • stage of AKI • evidence of medication review having been undertaken • type & frequency of blood tests required on discharge for monitoring	
5	**End of life care** (Local CQUIN)	End of life champion in place by Q1	
		Increase in no. of in-patients who die in their place of preference (baseline to be set in Q1 and targets to follow)	
		Ensure patients are discharged safely & effectively with required support (3 audits to be undertaken)	
		Train staff in end of life care (training programme, baseline figures and targets for future quarters to be set in Q1	
6	**Dementia care** (National CQUIN)	Improve the experience of care for dementia patients and their carers. To: • find, assess, refer and inform (FAIR) all patients over 75 admitted to hospital for unplanned care; • provide a dementia training programme; • undertake a supporting carers survey	
7	**Complaints**	Ensure that our complaints system and processes are robust, responsive and support organisational learning by: • ensuring complaint responses are in line with national timescales; • evidencing a reduction in unresolved cases being referred to the Parliamentary and Health Service Ombudsman (PHSO); • undertaking internal and external peer reviews of formal complaint processes; • demonstrating organisational learning from patient feedback	
8	**Safeguarding**	Continue to assess and report to CCG's against the Local Safeguarding Adults and Children Boards' (LSAB & LSCB) self-assessment and accountability frameworks;	
		Ensure that safeguarding training targets are achieved	
		Ensure that Mental Capacity Act (MCA) and Best Interest systems and processes are embedded within clinical practice	
		Embed the recently implemented safeguarding champion model	

Key quality risks

38. The priorities described above have been selected to support focused attention on the potential quality risks that they represent. In addition, we will focus on reducing the incidence of Clostridium Difficile (C. diff) infections, which we recognise as a significant risk and continue to address through scrutinising our procedures and environmental cleaning, whilst working with colleagues in the community to identify improvements.

39. Our governance structures and processes support active management of quality risks, underpinned by our recently refreshed Risk Management Policy. Progress on our three key priority areas will be reported on a monthly basis to the Trust Board, whilst a quarterly report will provide details of our progress against the broader set of quality objectives. This is supported by the assurance provided by the Clinical Governance and Quality Committee and the Trust Management Board.

40. Our Quality Improvement Plan will continue to support our approach to addressing the quality risks and concerns that have been raised by previous regulatory inspections, by enabling us to identify, carry out and track the actions required. Further information about our quality objectives and our approach to improving quality in 2015/16 will be available in the Trust Quality Account.

Patient Experience and Involvement Strategy

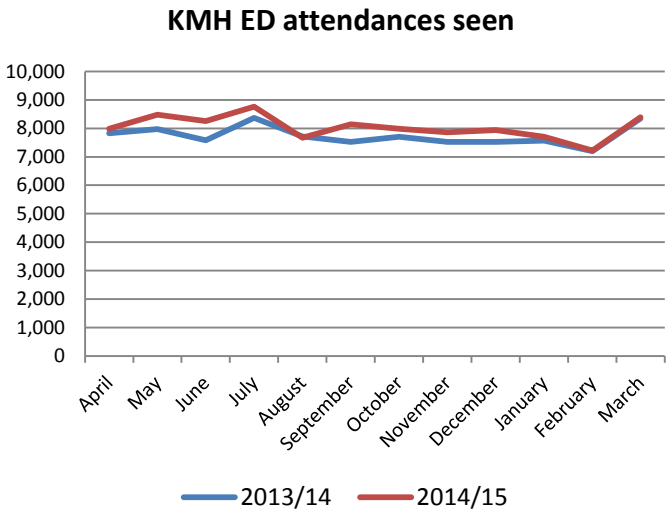
41. This year is the second in our 3 year 'Patient Experience and Involvement Strategy'. Building on progress in 2014/15, we will continue to deliver qualitative improvements in relation to the following objectives:
    - Involving patients and carers;
    - Providing clear information;
    - Reducing waiting times and delays;
    - Helping patients to feel cared for;
    - Welcoming patients and putting them at ease;
    - Treating patients as individuals
    - Organising systems and processes to improve patient experience.

42. Specific examples of improvements planned for 2015/16 include:
    - All staff to be issued with a 'Hello my name is….' badge as part of the national campaign to improve compassionate care;
    - Improved handovers when transferring patients between KMH and Newark, supported by a dedicated discharge nurse;
    - Better communication with patients, through improved information on wards and improved accuracy, efficiency and consistency of appointment letters.

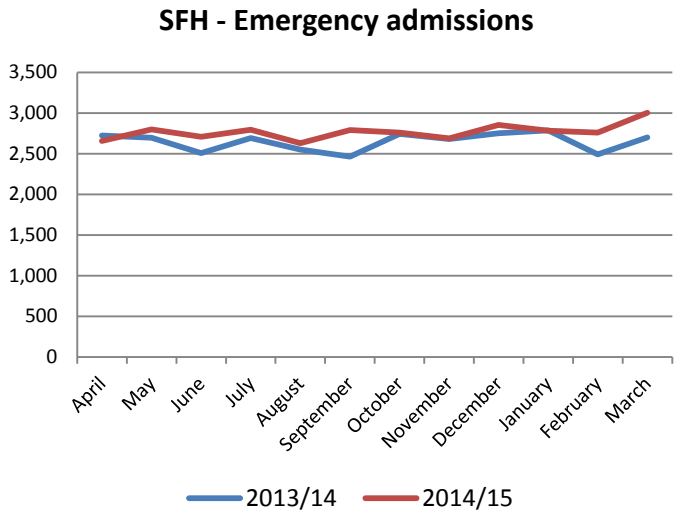
Operational requirements

Activity modelling

43. For the coming year, we have taken a bottom up approach to activity and capacity planning through our divisions, using the IST capacity and demand tool, whilst working closely with our commissioners. 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 services. As the following data show, we have experienced year on year increases in emergency department attendances and emergency admissions:

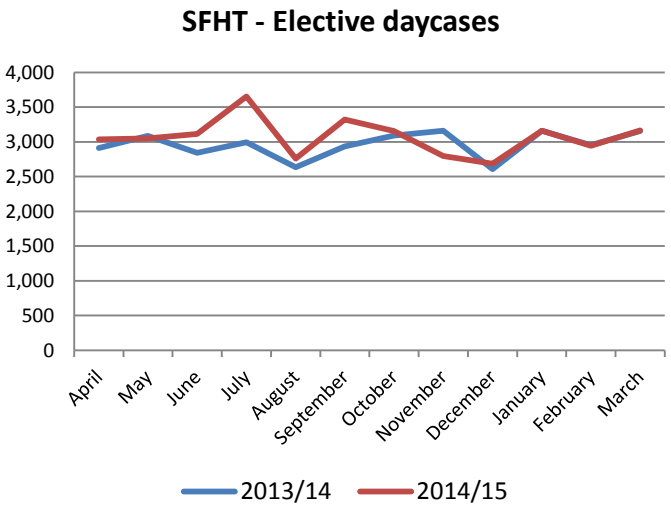


Graph 1 – Total ED attendances at King's Mill Hospital (2013/14 compared with 2014/15)

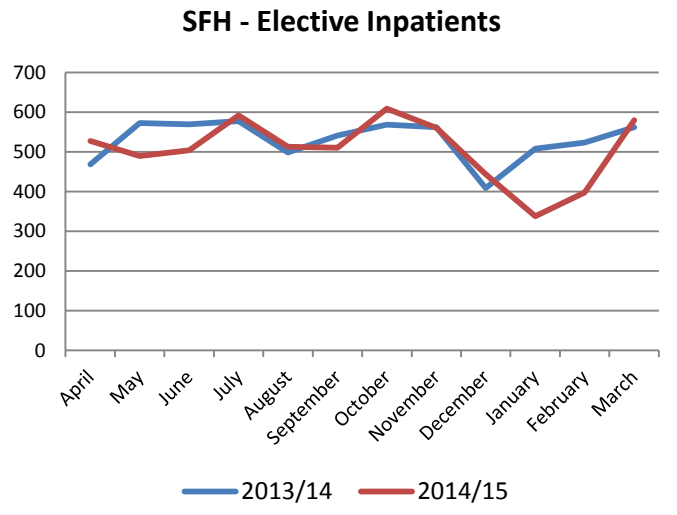


Graph 2 – Emergency admissions at SFH (2013/14 compared with 2014/15)

44. Elective activity has been on a different trajectory, as set out in our earlier review of 2014/15. The following graphs show the fluctuations across the last two years, reflecting the reduction in elective activity in January and February particularly, in response to winter pressures:



Graph 3 – Total Elective day-cases at SFH (2013/14 compared with 2014/15)



Graph 4 – Total Elective inpatients at SFH (2013/14 compared with 2014/15)

45. Based on the trends that this data demonstrates and our expectations about the impact of the Better Together programme, our activity plans are summarised as follows:

Summary PoD	14/15 Planned Activity	14/15 Actual Activity (1st cut)	15/16 Planned Activity	Change Activity (no.)	Change Activity (%)
A&E	113,005	114,078	115,962	1,884	1.65%
Elective Admissions	32,897	32,700	34,743	2,043	6.25%
Excess Bed-days	19,589	24,226	17,575	-6,651	-27.45%
Non-Elective Admissions	40,581	42,147	40,742	-1,405	-3.33%
Other	1,358,358	1,397,636	1,399,065	1,429	0.10%
Outpatient All Other	261,320	260,790	253,866	-6,924	-2.65%
Outpatients First	105,893	101,175	99,942	-1,233	-1.22%

46. This planned activity will generate the following income (see 'Financial forecasts' for further details):

Summary PoD	14/15 Planned Income	14/15 Actual Income (£) (14/15 prices)	15/16 Planned Income (£) (15/16 prices)	Change Income (£)	Change Income (%)
A&E	11,516	11,866	13,002	1,136	9.57%
Elective Admissions	35,003	33,981	34,822	841	2.47%
Excess Beddays	4,440	5,446	3,776	-1,670	-30.66%
Non-Elective Admissions	61,609	64,976	60,956	-4,019	-6.19%
Other	31,694	32,671	32,382	-288	-0.88%
Outpatient All Other	22,507	22,105	22,932	827	3.74%
Outpatients First	15,621	14,674	14,655	-19	-0.13%
Sub Total Activity Driven Income	**182,390**	**185,719**	**182,526**	**-3,193**	**-1.72%**
Block	34,421	34,189	36,534	2,346	6.86%
Grand Total	**216,811**	**219,907**	**219,060**	**-847**	**-0.39%**

47. The planned activity described above are based on the following assumptions and expectations:
    - there will be no material unplanned changes in demand;
    - there will be no material workforce issues other than those that we are already aware of (see 'Workforce' section below);
    - we will deliver our plans to reduce Length of Stay;
    - the Better Together programme and local QIPP schemes will deliver the changes in activity that we and our commissioners have anticipated

48. Our activity plan and the assumptions on which it is based carry a number of risks. Firstly, all modelling is a theoretical guide that is subject to unforeseen variation in demand. The Better Together programme (that we are actively participating in) is a system-wide approach to mitigating this risk, as well as improving outcomes for patients. Our expectation is that in 2015/16, the Better Together schemes already initiated and active (such as the Transfer to Assess approach described above) will result in reduced non-elective admissions, excess bed days and outpatient activity, whilst slowing the trend of year on year increases in ED attendances.

49. A further risk to our ability to deliver the activity plan relates to our workforce capacity. Recruitment of staff across a range of specialties and staff groups continues to be challenging nationally and locally. Our response to this risk is set out in the following section.

Workforce

50. Consistent with our activity modelling, we are undertaking a bottom up approach to workforce planning, to ensure our workforce has the capacity and capability to deliver activity to the required standards. In recognition of the challenges associated with sourcing the right workforce, we will continue with innovative recruitment approaches into 2015/16, including:
    - a recently developed an 'Introduce a Friend' campaign and incentive, which encourages our existing staff to introduce registered nurses to the Trust;
    - to support recruitment of Newly Qualified Nurses, the Trust will pay the first year's Nursing and Midwifery Council (NMC) registration for new recruits;
    - recruitment and retention premiums, which have been agreed for hard to recruit medical specialties.

51. In 2015/16, the Trust will need to recruit 140 registered nurses, taking account of expected nurse turnover and planned investment in registered nursing. Our recruitment plan includes the development of a UK and local recruitment campaign, as well as the recruitment of 80 members of staff internationally, both from the EU and beyond. Medical recruitment remains challenging, but building upon progress made in 2014/15, we will work with specialised agencies to recruit the staff we need.

52. To further minimise our reliance on agency staff and improve our staffing flexibility at peak times, we are developing a temporary staffing function, with a view to improving recruitment of registered nurses to the bank. This will be complimented by ongoing work to develop improved flexibility in contracts of employment.

53. Understanding and supporting our workforce are key elements of our 'Quality for All' ethos. The Trust has an average turnover rate of 1.13% per month (including junior doctors) and the Trust will be undertaking to better understand the reasons that staff leave, to inform improved retention strategies. All our key findings from the NHS staff survey for 2014 are consistent with the previous year, with the exception of job satisfaction, which has shown a marginal reduction (from 3.62 out of 5 in 2013, to 3.49 in 2014). However, our position relative to other acute Trusts has deteriorated and as a result of the findings we are developing an action plan, to improve staff experience of working for SFH. Our ambition for 2015/16 is to see improvements in three areas, relating to the following staff survey questions / statements:
    - How satisfied are you with the extent to which the organisation values your work?
    - I am able to deliver the patient care I aspire to.
    - I would recommend my organisation as a place to work.

Leadership Development

54. We recognise the important part that leaders play in sustaining high quality, compassionate and continually improving care. We are being supported by the King's Fund to develop 'collective leadership' within the organisation, with an initial 'cultural assessment' planned for the first part of 2015/16. This will provide an overview of the Trust's culture across a range of dimensions and allow a collective leadership strategy to be designed and implemented.

55. During 2015/16, 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. In particular, we will continue to run our successful medical leadership development programme in the coming year. This programme is designed to equip existing and aspiring service directors with the essential skills and behaviours required to manage clinical services effectively and safely, lead and manage change and deliver quality patient care through high performing professional teams.

56. We will continue to work closely with Health Education East Midlands (HEEM) and the Local Education and Training Council (LETC) during 2015/16 to develop our wider workforce, influence national and local workforce and training strategies and develop new flexible roles for the health and social care system.

Physical capacity and estates development

57. Our approach to maximising the high quality PFI estate across King's Mill and Newark Hospitals is consistent with the community-wide Better Together 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 transformation agenda.

58. In line with the Better Together programme, and having assessed the impact of our CIP schemes for 2015/16, we anticipate being able to reduce our overall bed capacity by closing 3 wards. Primarily this will be as a result of decreasing length of stay, particularly for inpatients typically staying for more than 14 days. Not only will this improve patient

experience and reduce our dependency on agency staff, but it will release physical capacity, enabling us to reconfigure our use of estates and reduce our dependency on the lower quality retained estate (which incurs additional maintenance costs). Furthermore, it will allow us to improve our infection control, by providing appropriate space for cleaning in a more systematic way.

59. In addition, we are planning to develop a new area at King's Mill to operate as a discharge lounge, building on the increased use of our current discharge lounge. This initiative will support flow through the hospital, freeing up vital bed capacity as early as possible.

60. In 2015/16, we will also complete the transition of administrative staff from temporary accommodation into the PFI estate, creating space for additional car parking, reducing maintenance costs and maximising our efficient use of the PFI facilities.

Information Technology and Systems Development

61. Our Information Technology (IT) plans for 2015/16 include the second phase of our Patient Administration System (PAS) implementation. Having introduced the Medway PAS in 2014, we will be implementing further developments in 15/16 to support the integration of clinical systems and enable the secure sharing of digitally held patient information across providers.

62. Our plans for 2015/16 include the implementation of a Patient Level Information and Costing System (PLICS). This will support our renewed emphasis on Service Line Management (SLM), which we see as vital to understanding, managing and improving our services. In particular, understanding the costs, efficiency and productivity of our services is vital in our continued efforts to drive financial sustainability. Moreover, as we move towards a new provider model in 2016/17, with the majority of our income derived from a capitated, outcomes based payment system, it has never been more important to understand our financial strengths and weaknesses. PLICS will therefore contribute to a greater focus on performance management across a range of domains in 2015/16.

Financial forecasts

Overarching projections for 2015/16

63. In our strategic plan, we set out a £10.9m CIP target for 2015/16, with the expectation that the end of year deficit would be £24.8m. A number of factors, including our deteriorating position in 2014/15, mean that the required CIP for 2015/16 would be significantly greater, if we are to achieve alignment with our financial plan by the end of the year. The following tables provide more detail:

[DN – details to be added once final financial plan agreed]

[DN – I&E, balance sheet and cash flow details to be inserted here prior to submission]

64. As a Board and in discussion with Monitor, we have recognised that it will not be possible to deliver a CIP of the magnitude required to reach an end of year deficit for 2015/16 of £24.8m. Rather we have planned a CIP of £XXm (full year effect), with an estimated £12.9m of associated cash releasing savings (as detailed above in the CIP section). Achieving this will leave the Trust with a deficit of £35.8m at the end of 2015/16.

65. The planned CIPs (described earlier) have the following expected financial benefits:
[DN Final CIP details totalling at least £12.9m will be added here]

Drivers of financial performance

66. A number of factors will influence our financial performance in 2015/16, many of which generate a challenging picture.

[DN – further information is to be added here as progress is made in finalising financial plans for 15/16. Key information to be included here is outlined by the following bullet points]

- *Activity and trends*
  - *Better Together impact*
  - *Our assumptions*
- *Local financial pressures*
  - *PFI*
  - *Premium cost variable pay*
- *Other changes e.g. non-recurrent income or expenditure / local investment in quality*
- *Strategic initiatives described earlier in plan*
  - *Delivery engine*
  - *PLICS*
- *Assumptions*
  - *Impact of contract*
  - *ETO tariff*

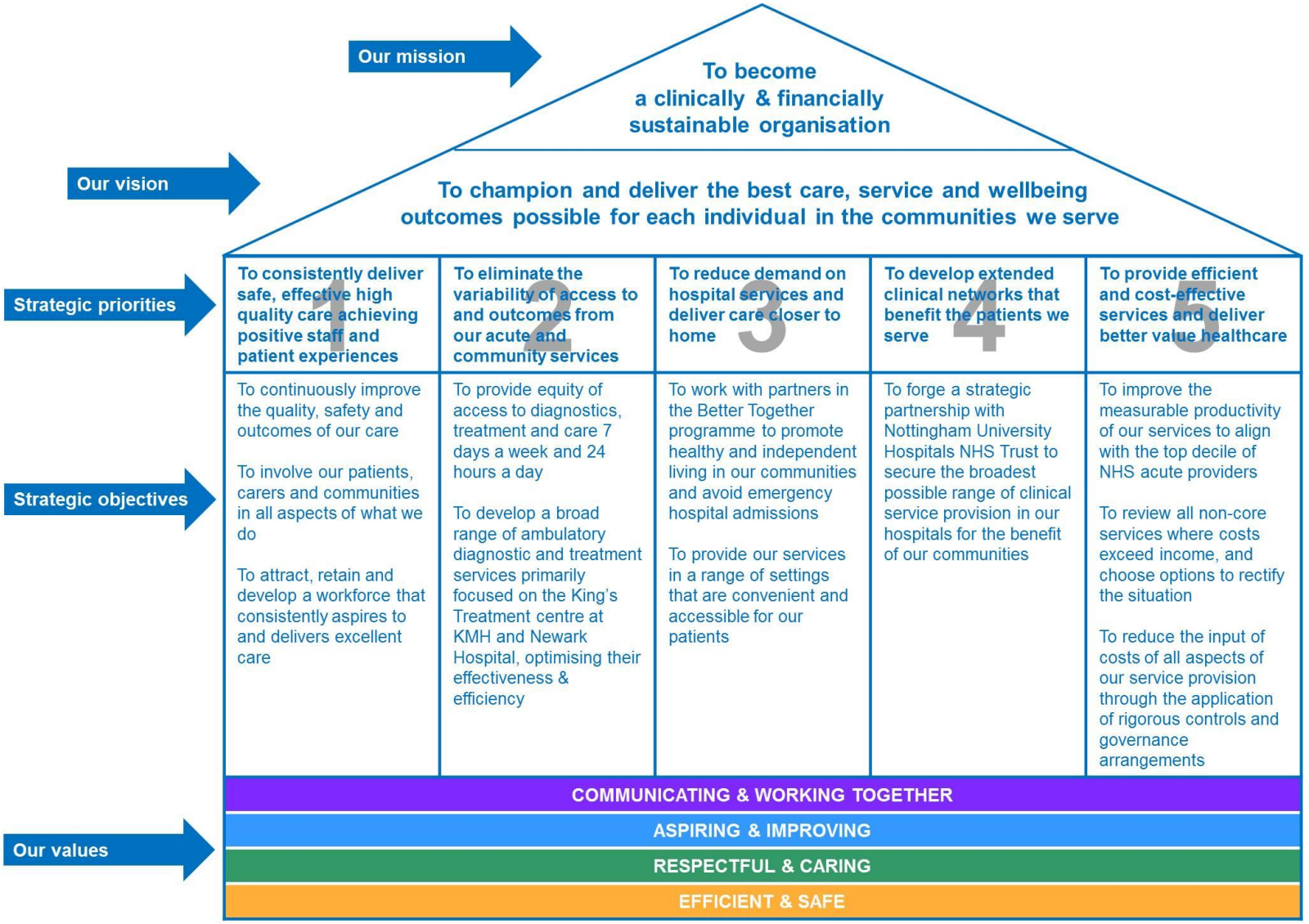
Sensitivity analysis

[DN – this section will include possible scenarios in both directions (i.e. better and worse than plan) and their impact on our overall financial position. In particular the impact of not achieving CIPs or timing being affected, as well as contract sanctions]

Revised long term trajectory

[DN – a statement on the impact on our five year plan financials will need to be included here]

Appendix 1 – Summary of Strategic Plan



Appendix 2 – Integrated delivery structure