Sherwood Forest Hospitals NHS
NHS Foundation Trust

Agenda Item:

Board of Directors Meeting Report

Subject: **Sherwood Forest Hospitals' Operational Plan submission to Monitor**
Date: **24th April 2014**
Author: **Peter Wozencroft**
Lead Director: **Peter Wozencroft/Fran Steele**

Executive Summary

This document and associated appendices represents the submission made to Monitor on 4th April 2014. This is the Sherwood Forest Hospitals Operational Plan submission covering the two year period from April 2014 to March 2016.

Following the PRM meeting between Monitor and the Trust on 11th April, the Trust has been asked to re-submit these documents having removed any assumptions about receiving income support for the excess costs associated with our Private Finance Initiative. (PFI) Cash/liquidity support will still be provided.

For the purposes of the Board of Directors' meeting, the relevant sections of the narrative have been amended using tracked changes/comments, whilst the financial templates have been fully amended (having been submitted to Monitor on 17th April). In order to show the relevant changes the format of the document has been impacted. This will be addressed once final content has been approved

Recommendation

The Board of Directors is asked to:

- Note and endorse the narrative plan and its appendices as being properly reflective of the short-term challenges and the Trust's response to them in the two year timeframe.
- Discuss the implications of the revised approach to the PFI premium, and approve the revised narrative plan for re-submission to Monitor with any modifications resolved by the Board.

Relevant Strategic Objectives (please mark in bold)	
Achieve the best patient experience	**Achieve financial sustainability**
Improve patient safety and provide high quality care	**Build successful relationships with external organisations and regulators**
Attract, develop and motivate effective teams	

Links to the BAF and Corporate Risk Register	There is a fundamental link to these documents in the articulation of the Trust's Operational Plan.
Details of additional risks associated with this paper *(may include CQC Essential Standards, NHSLA, NHS Constitution)*	N/A

Links to NHS Constitution	Fundamental
Financial Implications/Impact	Fundamental
Legal Implications/Impact	This has a bearing upon the Trust's constitution and its license to operate.
Partnership working & Public Engagement Implications/Impact	Fundamental.
Committees/groups where this item has been presented before	Nil in this form.
Monitoring and Review	BoD at appropriate intervals.
Is a QIA required/been completed? If yes provide brief details	N/A

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

Sherwood Forest Hospitals NHS Foundation Trust

Operational Plan Guidance – Annual Plan Review 2014-15

The cover sheet and following pages constitute operational plan submission which forms part of Monitor's 2014/15 Annual Plan Review

The operational plan commentary must cover the two year period for 2014/15 and 2015/16. Guidance and detailed requirements on the completion of this section of the template are outlined in section 4 of the APR guidance.

Annual plan review 2014/15 guidance is available here.

Timescales for the two-stage APR process are set out below. These timescales are aligned to those of NHS England and the NHS Trust Development Authority which will enable strategic and operational plans to be aligned within each unit of planning before they are submitted.

Monitor expects that a good two year operational plan commentary should cover (but not necessarily be limited to) the following areas, in separate sections:

1. Executive summary
2. Operational plan
    a. The short term challenge
    b. Quality plans
    c. Operational requirements and capacity
    d. Productivity, efficiency and CIPs
    e. Financial plan
3. Appendices (including commercial or other confidential matters)

As a guide, we expect plans to be a maximum of thirty pages in length. Please note that this guidance is not prescriptive and foundation trusts should make their own judgement about the content of each section.

The expected delivery timetable is as follows:

Expected that contracts signed by this date	28 February 2014
Submission of operational plans to Monitor	4 April 2014
Monitor review of operational plans	April- May 2014
Operational plan feedback date	May 2014
Submission of strategic plans to Monitor (Years one and two of the five year financial plan will be fixed per the final plan submitted on 4 April 2014)	30 June 2014
Monitor review of strategic plans	July-September 2014
Strategic plan feedback date	October 2014

1.1 Operational Plan for y/e 31 March 2015 and 2016

This document completed by (and Monitor queries to be directed to):

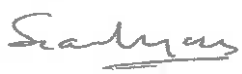
Name	Peter Wozencroft
Job Title	**Director of Strategic Planning and Commercial Development**
e-mail address	**peter.wozencroft@sfh-tr.nhs.uk**
Tel. no. for contact	**01623 622515 x 3135/07580773817**
Date	**4th April 2014**

In signing below, the Trust is confirming that:

- **The Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;**
- **The Operational Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Operational Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans; and**
- **All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	Sean Lyons

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Paul O'Connor

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Fran Steele

Signature 

1.2 Executive Summary

In essence, the plan for Sherwood Forest Hospitals NHS Foundation Trust (SFH) over the next two years is to continue with its rapid trajectory of improvement in the quality and efficiency of the services it delivers to the communities of Mid-Nottinghamshire.

The Trust went through a very difficult period during 2012/13 and the first half of 2013/14, when doubts were cast upon the quality and safety of the services it delivered, and the reality of the Private Finance Initiative (PFI) deal that was signed in 2005 and its consequent impact upon the financial viability of the organisation became clear. In response to these challenges, the second half of 2013/14 was characterised by strong and rapid improvement in the quality and safety of the care delivered, and whilst the financial situation remained very challenging, the Trust adhered to its plan – delivering a marginally better than expected position at the year end.

In the wider health and social care economy, we have continued to engage fully and positively with our commissioners and fellow providers in Better Together – the area-wide transformation programme previously known as the Mid-Nottinghamshire Integrated Care Transformation Programme. The blueprint for the way in which services will be provided in the future is now moving into its implementation phase, and the period 2014-2016 will see substantial changes to service provision – most crucially the building up of community-based resources to provide support to people at risk of experiencing a medical crisis, and to return as many people as possible to independent living after a hospital stay. The implication of these changes for SFH, in conjunction with our own work to optimise the efficiency of care delivery in our hospitals, will be to reduce demand for beds, theatres and associated infrastructure.

We have aligned our financial assumptions with those of our commissioners, and in doing so have acknowledged a worsening of our future financial position from that reported in the October 2013 improvement plan – primarily due to the loss of income that this entails. The fact that the PFI is a fixed point in the health economy, and an increasing financial commitment as time passes, has been acknowledged in Better Together, with the aim that every possible alternative use will be considered for vacated space in order to support the on-going payment of the Unitary Charge without detracting from service delivery elsewhere. As we move into 2014/15, anticipating a full Care Quality Commission (CQC) inspection at the end of April 2014, there is a great sense of optimism about consolidating improvement and emerging strongly from Special Measures during the year. We have agreed a contract with our main commissioners, which facilitates the early implementation priorities of Better Together, along with the SFH service transformation goals for the year. Within this context, we are developing a mature approach to benefit realisation and risk management. This is woven into strengthened governance arrangements for Better Together, and will enable us to develop robust contingency plans if elements of the programme do not deliver changes and realise benefits at the anticipated rate. This acknowledges that in the execution of a system-wide transformation programme, there needs to be a collective approach to risk and mitigation that incentivises the parties to drive through the required changes for the benefits of the health and wellbeing of the local communities.

Within SFH our focus remains upon delivering the highest standards of care we can possibly achieve, fulfilling the rights and expectations of our communities that they should have safe and effective health services available locally and should be able to access these services in a timely manner when they need them. To achieve this, we are embarking upon a transformation journey, which will change what we do and, more fundamentally, how we do it.

"Quality for All" is the expression of a set of values and behaviours developed in conjunction with a large number of patients, carers, staff members and members of the public through an extensive range of engagement events. It articulates what good care looks like from a patient perspective, and combines this with how we want our working lives as teams of healthcare professionals to be.

Our Service Improvement Strategy will build upon Quality for All by disseminating new sets of skills and tools to bring about service improvement and change. We anticipate that this will harness the potential of a wide range of staff of all disciplines – ideally everyone in the organisation – to contribute to delivering

excellent care, and re-designing the way in which services are delivered.

Recruitment and retention of a high-calibre workforce to deliver this bright future remains one of our key challenges, but we believe the good progress we are making will repair the reputational damage that resulted from the difficulties experienced in 2012/13 and we can and will become an employer of choice for the best talent in the NHS.

We acknowledge that there is further work to do on the utilisation of our estate and infrastructure. Having described the financial impact of the PFI, we must also recognise that it gives us a 'state of the art' facility from which to deliver healthcare. This gives us a great backdrop for the service change and improvement work described above. Nonetheless, there is significantly more work to do to complete the re-location of services at King's Mill Hospital into first-rate accommodation. Our main theatres, critical care facilities, and much of our diagnostic imaging capacity remains in the retained estate. Whilst there is no immediate threat to quality or continuity of service, we must develop plans to re-provide these facilities at an appropriate scale in the PFI core within a five year time horizon, and our financial plan contains a contingency sum for a liquidity requirement in line with this assumption.

Partnerships will be at the centre of everything we do in the future. We will continue to work closely with our PFI consortium partners to maintain the best possible environment from which to deliver healthcare. Many of our key partnerships are encompassed by Better Together, into which we are making an enormous investment. In addition, we will be seeking new partnerships to further our core objectives and do so in a way that will be financially sustainable into the future.

In conclusion, the next two years will be characterised by continuing to improve within a challenging environment, whilst laying the ground work for a radical re-shaping of the way in which health and social care is delivered in Mid-Nottinghamshire. The Trust will remain at the heart of the healthcare provision, with its core acute service continuing to serve the needs of its local communities to the highest possible standards. The ethos that underpins Quality for All, and the dynamism of our Service Improvement Strategy will enable us to meet the many challenges ahead with positivity and pride.

1.3 Operational Plan

1.3.1 The short term challenge

This plan builds upon and updates the Improvement Plan submitted to Monitor at the end of October 2013. The short term challenge for the Trust remains formidable, in respect to both finance and quality governance. We acknowledge the emphasis in the planning guidance on 2015/16 as the year in which the system-wide challenges facing the NHS and social care will come into sharpest focus. Nevertheless, we are moving forward with pace and confidence to address challenges facing the organisation and are making rapid progress.

In October, we framed our short term objectives under four headings. The following section represents a brief update on each of them:

Achieve compliance status against conditions that make up the Trust's license

The fact that the Trust is in Special Measures inevitably divides the focus between service quality and financial sustainability.

Sir Bruce Keogh, NHS Medical Director undertook a review of the quality of the care and treatment being provided by those hospital trusts in England which had been persistent outliers on mortality statistics. This Trust, along with 13 others, fell into the scope of the review.

The initial Rapid Response Review (RRR) took place on 17th and 18th June 2013, and resulted in a report and risk summit which identified 13 urgent actions and 10 high and medium priority actions.

An assurance review was undertaken by the Keogh panel on 4th December 2013. Following desktop reviews of evidence and scheduled visits, the panel made their assessment of whether they were 'assured', 'partly assured' or not assured' that the Trust had implemented the actions agreed following the initial RRR.

The review assessed the Trust's 23 actions and recorded 6 as 'assured' and 17 as 'partly assured', predominantly because a more significant period of time was required to demonstrate that improvements had been fully embedded. There were no areas recorded as 'not assured'.

The Executive Director leads for each of the actions have provided a report on progress and recommended their revised assessment of the position at March 2014. The table below summarises the position and outlines the target trajectory for full assurance against all assessed criteria:

Keogh Actions - Trajectory for full assurance

	Action	Executive Lead	Formal Assesment 4th Dec 2013	Forecast month of full assurance Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14
1	Complaints	Director of Nursing	Partly Assured							Assured		
2	Nursing and medical staffing levels and nurse skill mix	Director of Nursing	Partly Assured				Assured					
3	Fluid Management	Director of Nursing	Partly Assured					Assured				
4	Strategic Direction	CEO	Partly Assured					Assured				
5	Newark Hospital strategy, facilities and governance	Director of Operations	Assured	Assured								
6	Board Development and development of a quality focus at Board level	Director of Corporate Services	Partly Assured									
7	Ward performance information and Organisational learning	Director of Nursing	Partly Assured				Assured					
8	Patient locations and patient moves	Director of Nursing	Partly Assured					Assured				
9	Handovers	Director of Nursing	Partly Assured				Assured					
10	Patient Experience	Director of Nursing	Partly Assured				Assured					
11	NEWS roll out	Director of Nursing	Partly Assured				Assured					
12	Whistleblowing Policy	Director of HR	Assured	Assured								
13	Supporting structures and services:	Director of Operations	Partly Assured									
	Radiology						Assured					
	Clinical Typing						Assured					
	Junior doctors							Assured				
14	Anaesthetists	Medical Director	Partly Assured									
15	Staff Development	Director of HR	Assured	Assured								
16	Communication with Patients	Director of Nursing	Partly Assured	Assured								
17	Ability to Rescue	Medical Director	Partly Assured					Assured				
18	Maintaining the pace of change	CEO	Partly Assured				Assured					
19	Governors	Director of Corporate Services	Assured	Assured								
20	Organisational Learning	Medical Director	Partly Assured									
21	A & E	Medical Director	Assured	Assured								
22	Medicines Management	Medical Director	Partly Assured								Assured	
23	Infection Control	Medical Director	Assured	Assured								

Under the requirements of Monitor's Section 105 notice and its discretionary requirements, the Trust was required to obtain external validation on the delivery of its improvements in respect of board and quality governance.

In order to achieve this, the Trust engaged PwC to undertake an independent review of the Trust's delivery of improvements to Board and Quality Governance in November 2013; the final report was received in January 2014 and provided external validation of the Trust's Board and Quality Governance reporting a score of 4 in January 2014.

This review followed on from an initial appraisal of the Trust's governance arrangements at both Board and clinical service level carried out by PwC in November 2012 and reported on in January 2013 which detailed a score of 13 against the Quality Governance Framework (QGF).

In March the Trust Board reviewed the improvements made in respect of the QGF and reported an improvement in the score to 3.5. A trajectory of further targets for improvement

is to be reported to the Trust Board of Directors in May 2014.

Looking forward into 2014/15, the Trust has identified two areas in which it believes there is an enhanced risk of non-compliance:

C Difficile

For 2013/14 the Trust experienced 36 cases of C. *difficile* against a trajectory of 25. The achievement of the Clostridium Difficile target represents a risk for the organisation in 2014/1 The Trust has made a significant improvement in the identification and management of *C. dif* infection over the past five years, with the Trust currently being one of the best performing Tr within the East Midlands for testing and C.difficile rates per 100,000 bed days. Profession Duerden was commissioned by the Trust to provide an external view of the functioning and effectiveness of the infection prevention and control arrangement within the Trust, with partic reference to the recent occurrence of MRSA bacteraemia. Although Professor Duerden did r have any specific recommendations to make about the leadership, management, governance assurance arrangements, he made some recommendations about clarity of policies and reinforcement of messages. The Trust has implemented the recommendations, and therefor believes it is doing everything in its powers to minimise infection rates. However, this may nc sufficient to meet the 2014/15 trajectory of 37 cases in light of the acuity of the patient popula and the prevalence of complex co-morbidities.

Care Quality Commission (CQC)

On 5th October 2012, Monitor placed the Trust in significant Breach of its Terms of Authorisation (Licence) for failure on Governance and Finance. In 2013, as part of the review into the quality of care and treatment provided by 14 hospital trusts (Keogh) a CQC inspection was undertaken. This inspection resulted in five compliance judgements, of which one indicated a 'warning notice' in respect of Outcome 16, *assessing and monitoring of the quality of service provision.* The judgements were issued to the Trust in September 2013 in the CQC formal report, with a separate issue of a 'warning notice'. The enforcement action was issued as the Trust had on two occasions, not met the required standard. The Trust was revisited on 4th December 2013 to assess the Trusts position against the warning notice. The formal report was published on the CQC website on 8th January 2014. Like the Keogh follow up visit, the CQC saw evidence of demonstrable improvements, but acknowledged that in some areas more time was required to embed or audit against compliance. The Trust has received notice of a CQC visit week commencing 21st April 2014, in which the Trust will be assessed against the five new CQC domains. The Trust anticipates the CQC to observe continued improvement and receive a formal lifting of the warning notice (removal from special measures), but the very fact of the current state of non-compliance and the approaching CQC inspection mean that there is a theoretical risk of continued non-compliance.

Secure central support for PFI premium and cash

The required liquidity support has been forthcoming from the Integrated Trust Finance Facility (ITFF), but any resolution of the PFI premium impact on our trading position remains as yet unresolved. We have acknowledged, in conjunction with our commissioners, that any support secured does not represent a long-term solution and closing the gap is part of the sustainability challenge facing us. As an organisation we therefore need to continue to work with our regulators to seek a more substantive solution to this issue.

Securing support from our commissioners

There has been substantial progress in aligning our views with those of our commissioners regarding the pre-eminence of the Better Together programme, and the early implementation priorities that will accelerate our transformation journey. There is still some difference of perspective regarding the pace and impact of Better Together, particularly as it

relates to the overall levels of demand for hospital-based urgent and emergency care. The planning implications of this for the Trust go directly to our assumptions about the scale and timing of bed capacity reductions, and consequent cost base reductions. The focus of our on-going discussions is upon aligning these assumptions whilst building in the necessary contingency and transition arrangements to ensure risk is appropriately allocated and mitigated across the local health economy. We have recently agreed to adopt a combined Programme Management Office (PMO) approach that will assure the alignment of commissioner-led QIPP schemes, provider (SFH and County Health Partnerships) internal cost reduction and service improvement programmes and the commonly agreed priorities of Better Together.

Delivering the Trust's plans; resolving the deficit, achieving the CIP in order to achieve financial and clinical sustainability

Removing the impact of external factors, the Trust is building upon a solid platform of performance in 2013/14, during which it delivered its financial plan in all aspects including the cost reduction element. The financial challenges facing the Trust and the local health economy are well known to Monitor, and have not altered in global terms since the submission of the October 2013 Improvement Plan. The Trust's cost reduction target for 2014/15 is £8.7m, which represents 4.4% of the controllable spend. This compares with the 2013/14 sector average plan of 3.9% with delivery at Q3 being 0.7% below plan. Since October, as the work has progressed on the detailed implementation plan for Better Together, it has become clear that even successful delivery of all its component transformation schemes does not address the totality of the sustainability gap facing the local health and social care economy. At best, it bridges half of the gap (£35m of £70m) within the four year time horizon ending in 2017/18. Nonetheless, we are confident that the trajectory set by Better Together, collaborative working with our health and social care partners and other aspects of service re-design involving front-line clinical services, clinical and non-clinical support services will lead to a sustainable Foundation Trust within a sustainable health and social care community within a six or seven year time horizon.

The biggest rate-limiting factor on this journey to sustainability relates to various aspects of the workforce. First and foremost, the recruitment and retention of a clinical workforce that has the necessary attributes to deliver safe and sustainable clinical services of a consistently high quality in hospital and community settings is crucial. The reputational damage the Trust has suffered in recent years, and the comparative fragility of some of its clinical services, has made this recruitment and retention challenge particularly difficult. This is in the context of a difficult recruitment picture for the East Midlands as a whole comparative to the rest of England – for example, there are 44 consultant radiologist vacancies across the region. We need to build upon the rapid recent progress in improving the quality and safety of our services, and apply innovative workforce planning and development tools to tackle this issue.

Secondly, the ability of every single member of staff in our organisation to make a contribution to transforming the services we provide, with the skills and attitudes that will make that change sustainable, is a substantial challenge. We are currently considering how to build a framework within which service improvement capacity can be developed and harnessed. This approach to service transformation is discussed in greater detail in section 1.3.4 below.

In summary, the short term challenge for Sherwood Forest Hospitals NHS Foundation Trust is to begin to re-shape its services in preparation for a very different future – one in which a far greater range of diagnostic and treatment services will be provided in community settings, and there will be a consequent reduction in demand for hospital based care and treatment. Much of the focus for the re-design work will be very local, involving GPs/primary care teams, County Health Partnerships as the prime provider of community health services, and local authority commissioned social care provision. However, we also envisage and are actively planning for collaborations with other providers of NHS services

in public and private sectors, and specifically including Nottingham University Hospitals NHS Trust, Derby Hospitals NHS Foundation Trust and Chesterfield Royal Hospital NHS Foundation Trust. These collaborations will encompass a range of clinical services and support services, and aside from the specific challenges faced in Mid-Nottinghamshire, they will be driven by :-

- the requirement to deliver a safe, high quality and consistent service over all seven days of each week and all twenty-four hours of each day;
- the increasing consolidation of specialised services, including those related to major and multiple trauma, in tertiary centres;
- a combination of increasing clinical sub-specialisation, and constraints upon workforce supply in certain clinical and diagnostic specialties, such as those which are being most keenly felt in radiology services at present.

1.3.2 Quality Plans

Our framework for service quality is modelled around the three domains of quality identified by Lord Darzi in 2008 and adopted across the NHS. It says that care provided by the NHS will be of a high quality if it is:-

- **Safe**;
- **Effective**;
- with positive **Patient Experience**.

All our efforts shall be directed towards ensuring that improvement is measured and achieved within the 5 domains of the NHS outcomes framework:

1. Preventing people from dying prematurely;
2. Enhancing quality of life for people with long term conditions;
3. Ensuring that people have a positive experience of care;
4. Helping people to recover from episodes of ill health or following injury;
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

Domains 1-3 include outcomes that relate to the effectiveness of care, domain 4 includes outcomes that relate to the quality of the healthcare experience from the patient's point of view, and domain 5 relates specifically to patient safety. The framework also aligns well with the overall Sherwood Forest Hospitals' objectives.

Within this overall framework and context, we have engaged with patients, community representatives and staff to develop a set of local guiding principles that reflect our particular circumstances.

Our guiding principles in relation to quality and patient safety are:

1. We will build on our strengths and previous successes on quality initiatives already in place, and on our clinical governance infrastructure.
2. We will aim to eliminate all avoidable patient deaths and avoidable harm events.
3. We recognise the benefits of community integration, and will ensure our safety and experience systems follow the patient's journey.
4. We will ensure every member of staff is aware of their individual role and contribution in achieving our quality objectives, aligning to our 'Quality for All' values and behaviours.
5. We will implement a proactive safety and learning culture, integrating risk management activity into our day to day practice.
6. We will listen and involve patients to ensure the care we provide reflects our vision for patient experience "I want to go there because I know it's the best place to be cared for" because:
    - ✓ It delivers the best possible outcomes;
    - ✓ It provides safe, efficient, timely care – in a caring, respectful way;
    - ✓ Its care is delivered as close to home as possible;
    - ✓ The staff listen and involve patients, carers and colleagues as part of the team;
    - ✓ The people there anticipate and understand patient and carer needs and tailor services to best meet them;
    - ✓ Involving patients in continuous improvement and innovation is woven into what they do.

During 2013/14, we have achieved some very significant successes in relation to the quality of our services. These include:

- ✓ A reduction in mortality rates from 120 (above average) to 102 (within range)
- ✓ Zero Grade 4 pressure ulcers for 12 months across the trust
- ✓ 25% reduction in Grade 3 avoidable pressure ulcers across the trust
- ✓ 30% reduction in Grade 2 avoidable pressure ulcers across the trust
- ✓ 95% of our patients are screened for Venous Thromboembolism (VTE)
- ✓ Zero trust acquired MRSA bacteraemias for 6 months
- ✓ A 15 % reduction in cardiac arrest calls
- ✓ Consistently good scores in our friends and family test (upper quartile)
- ✓ Improvements in dementia care, which includes 95% of emergency admission patients aged 75 and over screened, assessed and referred onto specialist services within 72 hours

Looking forward to the period encompassed by this operational plan and the beginning of the strategic planning time frame, our key priorities to drive continuous improvement are shown in the table below:

	2014/15	2015/16
PATIENT SAFETY		
	Mortality Reduction Plan as measured by HSMR	Mortality Reduction Plan as measured by HSMR
	Harm Free Care Pressure Ulcers Falls Medication Surgical Site Infections VTE Catheter Associated UTI Sepsis	Harm Free Care Pressure Ulcers Falls Medication
CLINICAL EFFECTIVENESS		
	Myocardial Infarction Heart failure, Stroke Care and Comfort Rounding	Structured ward Rounds Care and Comfort Rounding
IMPROVED PATIENT EXPERIENCE OF CARE		
(through workforce development)	Workforce Strategy	Workforce Strategy
	Organisational Development Strategy,	Organisational Development Strategy

	including- Medical Leadership Programme	
	Nursing Strategy	Nursing Strategy
	Patient Experience and Involvement Strategy	Patient Experience and Involvement Strategy
	Nursing Leadership Programme	Nursing Leadership Programme
QUALITY GOVERNANCE		
	Risk Management Training	
	Robust Risk Management Systems and Processes	
	Data Quality Review and Accreditation	Data Quality Review and Accreditation
	Development Programme for Clinical Directors and Clinical Leaders	Development Programme for Clinical Directors and Clinical Leaders
	Realignment of Clinical Audit Plan Patient Safety & Quality Priorities	Realignment of Clinical Audit Plan to Patient Safety & Quality Priorities
	Revised risk management strategy	
	Communications Plan and Engagement Strategy	
	Implement Corporate Risk Register	
	Board Assurance Framework development	

We have recognised that we must improve our governance processes, strengthen our leadership and make the Trust one of the safest organisations in the NHS. Our staff acknowledge that we must also drive those priorities that we failed to achieve in 2013/14, whilst also striving to achieve excellence in all areas of care. To be a safe organisation, the Trust requires effective governance at all levels within the Trust. This requires an infrastructure, which ensures that risks to both quality and financial sustainability are identified and well managed. This will ensure that timely actions are taken to improve performance and safety in a sustainable manner. Continued actions are currently being taken at the Trust to strengthen the governance structure and embed the new systems and processes across the organisation, from ward to Board. The detailed plans for improving quality governance are contained within our 2014-17 Patient Safety and Quality Strategy but from this strategy we have developed a list of specific outcomes for 2014/15. For

2015/16 we will drive some of these outcomes further (e.g. HSMR and falls reduction) but will also identify other specific priorities which will be decided as the year progresses.

The targets / outputs for 2014/15 are:

	2014 / 15	Target / Output
IMPROVING THE SAFETY OF OUR PATIENTS	**1. Reduce mortality as measured by HSMR**	Headline & specific **HSMR withi the expected range** and **below** To have an embedded mortality reporting system visible from ser to board
	2. Reduce harm from falls	Total falls **< 7 per 1000 occupie bed days** by quarter 4 (quarter c quarter reduction) Falls resulting in harm **<2 per 10 occupied bed days** by quarter 4 (quarter on quarter reduction) Reducing the number of patients who fall more than twice in hosp (baseline Q1 14/15) Reduce the number of fractures falls to **<25** for 2014/15
	3. Reducing the number of patients with avoidable pressure ulcers	To **eliminate** Grade 3 and 4 hos acquired pressure ulcers by Oct 2014. By October 2014 reduce hospital acquired Grade 2 press ulcers by **50%** and achieve zero March 2015.
	4. Reducing the number of patients with a catheter associated urinary tract infection	To have **< 5** Trust acquired cath associated urinary tract infection during 2014/15
	4. Ensuring adult inpatients are risk assessed for VTE	**95%** inpatients risk assessed
	5. Improve medication safety	**Zero** medication-related 'Never Events'. To increase the number of repor medication-related incidents by 2 (compared to 2013/14 data). To reduce the number of medica related incidents resulting in moderate / severe harm by **25%** (compared to 2013/14 data),

		particularly for high-risk medicines such as opioids, insulin, anticoagulation etc.
	6. Improving compliance with surgical site infection bundle	**95%** compliance with the surgical site care bundle by March 2015
IMPROVING THE EFFECTIVENESS OF CLINICAL CARE	7. Patient flow	To reduce LOS (excluding 0-1 day LOS) to **8 days**
	8. Implement care bundles (stroke, myocardial infarction, heart failure & COPD)	Care bundles in place for all pathways by March 2015
	9. Compliance with sepsis bundle	**95%** compliance with the sepsis bundle by March 2015
	7 day working across the hospital linking with Better Together initiative	**Eliminate** the difference in weekend and weekday HSMR
	Underpinning these objectives will be the continued implementation of care and comfort rounds across the Trust and the introduction of VitalPAC (patient observations)	
IMPROVING PATIENT & STAFF EXPERIENCE	10. Improve response rates and scores in the patient and staff friends and family test	Increase our F&F response rate to **50%** by October 2014 To improve the score to **80%** by March 2015
	11. Improve the experience of care for dementia patients and their carers	**95%** inpatients over 75 years of age screened for dementia. **80%** of our carers *whom we survey through our monthly carers survey* to report that **'they felt supported during their relatives stay'**
	Underpinning this objective will be the delivery of the 2014/15 work plan for both the Patient Experience and Involvement Strategy & the Organisational Development Strategy. This includes improving the way we communicate with patients via a number of initiatives, improving discharge planning, helping patients and relatives to understand who's who and improving pain relief.	

Quality for All

Our commitment to providing the highest quality of care is absolutely unshakeable and we recognise that this will only become a reality all the members of the Trust staff act in accordance with a set of values and behaviours that underpin this.

In conjunction with large numbers of staff, patients, carers and other stakeholders, we have developed four Trust values that will shape our organisation's culture and underpin everything we do in the future. Our Quality for All aspirations are that everything we do and every encounter we have in giving and receiving care will be characterised by:

•Communicating and working together.

•Aspiring and improving.

•being Respectful and caring.

•being Efficient and safe.

There is an extensive programme of work that has been developed around these principles – they are the key points of convergence for our Quality, Organisational Development and Workforce strategies, which were adopted by the Board of Directors in January 2014.

1.3.2 Operational requirements and capacity

SFH provides clinical services to wide demographic areas across a number of geographic locations including Mansfield, Ashfield and Newark. We provide these services from three main sites - King's Mill Hospital, Newark Hospital and Mansfield Community Hospital.

The health and social care system in the Mansfield, Ashfield, Newark and Sherwood Forest area has recognised that it faces some very significant challenges in order to be able to deliver care to the quality and outcomes required with the resources likely to be available in the medium term.

The current models of care are not delivering best health outcomes and are not affordable if scaled up to address growth in population demand. The partner organisations have estimated that, given the projected changes in the population and a simultaneous reduction in social care funding, the health and social care economy would face a gap of at least £70m and possibly more than £100m by 2018 if services continue to be delivered in the same way as currently.

As an organisation, we have focused on developing a future clinical services plan which aims to address these significant challenges. This has been driven by:

- A desire to deliver better health and social outcomes for the population and an improved experience of the services people receive
- Delivery of care in the most appropriate location
- A recognition that the way care is currently delivered is not sustainable for the expanding and ageing population
- Ensuring the best use of 'state of the art' health care facilities

The plan articulates our vision of providing high quality cost effective care for our patients, developing our workforce to its best potential and working with our partners, particularly in health, social care and local services to improve health and well-being of the local population.

We have been focused on a programme of change, aimed at:

- Improving patient flow, urgent and elective care
- Improving equity of service delivery 24/7
- Delivering services 24/7 as appropriate
- Promoting ourselves
- Extending service offer to include evenings and weekends as appropriate
- Increasing market share
- Marketing and communications for our service portfolio
- Pathway redesign opportunities linked to integrated care transformation programme (better together)

Capacity planning

Providing care to patients in a timely manner, in accordance with all the national standards and targets is a key priority for the clinical divisions. Capacity plans have been developed utilising the NHS Intensive Support Team (IST) tool to ensure delivery of the contracted baseline activity. QIPP schemes have been worked up by commissioners and taken into consideration, along with efficiencies identified by the intensive review of outpatient services and theatre scheduling undertaken by the Trust with external support.

Any identified adjustments for new to follow-up ratios have also been considered, along with plans to deliver reductions. Examples include the implementation of more one-stop clinics, early clinician review of diagnostic test results to discharge patients if there is no requirement for them to be followed up and the use of telephone follow ups. Detailed modelling to reflect seasonal demand has been undertaken, and is being used to increase service flexibility and responsiveness.

In light of our plans to increase market share across our range of services, enabling local people to access services locally, we have planned our capacity to achieve a 5 week wait for outpatient services, and ensure we reduce our Appointment Slot Issues (ASIs) to less than 1%.

Streamlining our services across our sites has been a key priority, ensuring optimum utilisation of capacity and staffing resources. Key to this flexible working is the standardisation of systems and processes across the locations from which we deliver services. By the end of 2015/16, we will have eradicated unwarranted variation across the sites.

Agreeing a sustainable bed/infrastructure model for future years is dependent upon working with partner organisations in the context of Better Together to ensure appropriate services are developed in community settings to avoid acute medical crises wherever possible and to enable patients to be securely and safely discharged from hospital. The Trust is fully committed to the programme and engaged in its delivery.

Improving patient flow

Urgent care

Much work has been undertaken to implement alternative models of care such as outpatient delivery of service that had historically been delivered as an in-patient service, introduction of a Clinical Decisions Unit within the Emergency Department and Emergency Assessment Unit. Over the next year more opportunities for improving flow will be worked through.

We have worked closely with CCGs to develop new pathways, identify barriers and issues to ensure more streamlined delivery of services. For example, we are the provider of acute stroke and rehabilitation services, and have fully integrated stroke services, streamlining pathways between acute care and rehabilitation across the site. We plan to extend our service offer, convert appropriate procedures to day case and ensure our outpatient services are efficient and effective.

Dedicated dementia care services will be delivered, supported by a programme of fundraising to ensure facilities within in-patient areas are fit for purpose and appropriate for patients with Dementia.

Our comprehensive improvement programme for re-designing the emergency care pathway and improving flow incorporates priorities identified in 'Better Together', and by the Urgent Care Network, Emergency Care Intensive Support Team (ECIST) and Trust clinical teams. A senior programme lead and lead clinicians will drive the further design and the delivery of the programme, working alongside CCG and partner organisation colleagues.

The improvements planned will improve the quality of patient care and facilitate cost reductions, through length of stay and discharge delay reductions.

Elective care

We will sustainably embed the improvements currently being made to outpatient, pre-operative assessment and theatre scheduling. The early benefits of this work, including productivity and efficiency savings, have been accounted for in our rolling CIP programme.

To support delivery of high quality, efficient patient care, a review has been undertaken of patient administration. A new model has been implemented supported by up to date technology in digital dictation, which has enabled timely communications to patients, other clinicians and GPs in ensuring no delays in patient care. This model is currently being evaluated and will be subject to continuous improvement.

ICT will be strengthened, and to facilitate this a new Patient Administration System (PAS) for the Trust will be implemented by October 2014 offering more functionality and reducing administration processes. In addition we will develop ICT links with local providers to improve sharing of appropriate information to support shared care of patients across providers

Improving equity of service delivery 24/7

Many areas of the organisation already deliver 24/7 care. However, any gaps in provision will be identified and planning undertaken to deliver 24/7 care. We will explore efficiencies in service delivery through procurement routes.

We are taking part in a region-wide baseline assessment and gap analysis of our services against the ten clinical standards for 7 day services. The results will inform our 7 day services improvement plan, which will be driven by a senior programme lead, a lead clinician and supporting programme management staff, all agreed as part of our service improvement strategy.

Promoting ourselves

It has been widely acknowledged that our market share across the health community is lower than expected. There are opportunities within our local health economy to improve information to referrers, give more timely access to existing services, and expand the range of services and procedures offered.

Communications and marketing of our services will be improved, through closer working with CCGs, individual practices, other stakeholders utilising innovative routes to access all areas of the community. Working with CCGs and the Better Together programme, our aim is to provide more community clinics. Telephone and email advice systems have been adopted across specialties to ensure accessibility of our clinicians for advice and guidance relating to patient care. Local GPs find this service extremely valuable and we therefore plan to strengthen and expand this.

In the future months, capacity and capability will be strengthened to ensure we are best placed in responding to tendering opportunities to attract and secure more service provision where it is beneficial to do so.

Through pathway redesign, standardised data sets will be developed and implemented, a key driver in working with referral management to ensure patients can access care close to home. We are focused on the marketing of our services with local primary care colleagues and the public to ensure that Sherwood Forest Hospitals is the provider of choice.

Pathway redesign

Through the Better Together programme, urgent and proactive care and elective services review, we will work towards delivery of more community clinics, more one stop service provision, working with clinical colleagues and CCGs to agree protocols for offering direct access services.

Planning with our partners is critical to the success of this, to ensure effective use of our premises to support the co-location of integrated teams, improving patient handover, care and communications will be integral to redesigning how we deliver our services.

Our people

The recently refreshed Workforce and OD Strategies were developed through extensive consultation with our staff ("in our shoes" events). This emphasised that the same values and behaviours that underpin our interactions with patients and carers, must also apply to our relationships with one another as colleagues, and we will deliver higher quality care now and in the future by acting in accordance with these values. These are prominent in our recently launched Quality for All programme. This will sit, alongside the service improvement strategy, as a key tool for culture change and empowerment in the organisation so that we can all play our part in securing the future of the Trust.

A comprehensive review, at service level, of contract capacity requirements against available workforce will ensure that we have sufficient staff to sustain high quality care. The Trust recognises that it has, in recent years, had a heavy reliance on high-cost agency staff and is looking to create new and innovative roles in order to successfully attract and retain individuals for hard to fill roles across a range of clinical specialties. This includes consultant radiologists and some of the medical, nursing and AHP staff who have the heaviest input into the urgent care pathways. We recognise that some of these workforce issues are, and will remain, key determinants of the safety and sustainability of our clinical services. Stroke and vascular services are current examples of our acceptance that we will not be able to provide the full range of services required by our local communities by standing alone. We will continue to pursue partnerships and construct clinical networks to ensure that the greatest possible range of safe and sustainable clinical services is provided from our hospitals.

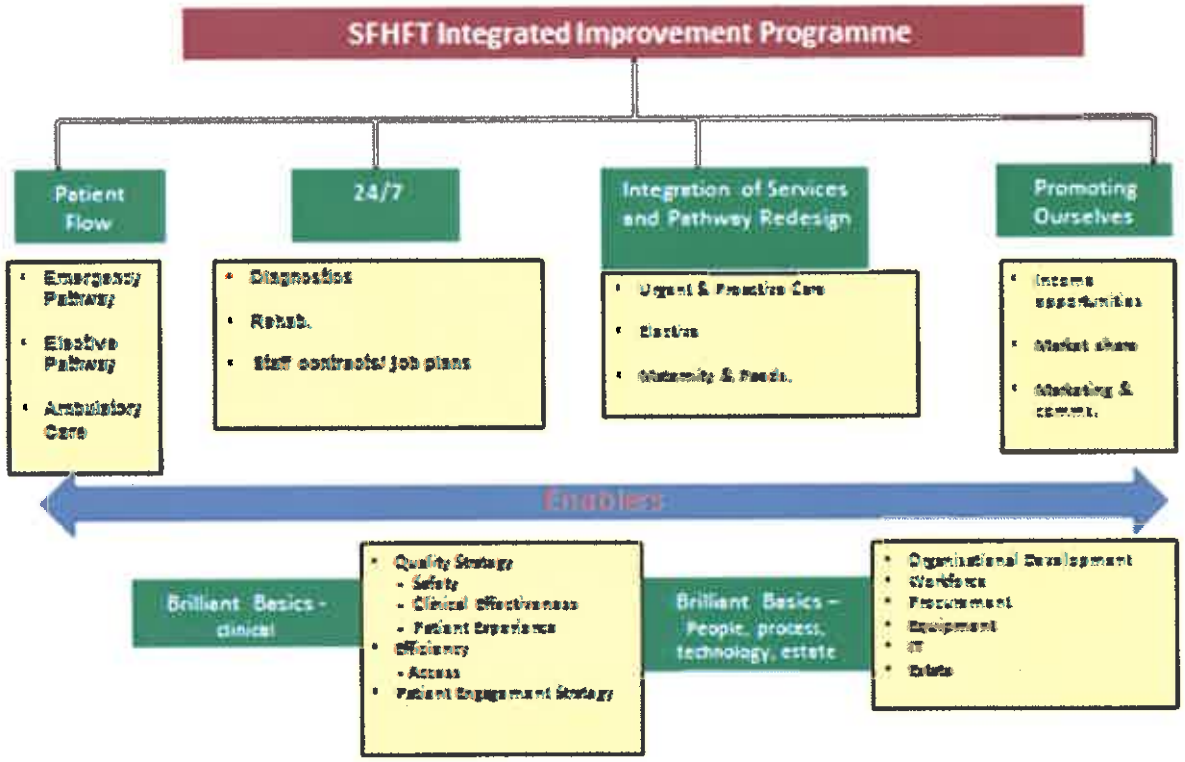
As part of its response to the Keogh review, the Trust has recently agreed a significant investment in registered nurses in order to secure improved nurse to patient ratios. The Trust is currently utilising international recruitment as well as a range of local recruitment campaigns in order to secure the required number of high-calibre nurses in a challenging labour market. Work is also progressing to create a more efficient flexible staffing function in order to support the Trust in meeting fluctuating demand by the provision of in-house bank staff.

In respect of clinical and non-clinical support services, the Trust is taking steps to utilise apprentices widely across the organisation. This acknowledges the significant part we play in the local economy as its largest employer, and that "growing our own" future generations of staff who have a strong affinity with, and commitment to, the organisation is one of the keys to future success. We have excellent links with local schools and colleges to support this goal.

The Trust's Service Improvement Strategy and the Integrated Improvement Programme will support long term sustainability and will equip staff with service improvement skills, thus supporting the long term transformation agenda. Key initial areas of focus include the assessment of the impact of 7 day services, as part of the base-lining exercise referred to above and being undertaken across the East Midlands. We have had an early success with the recent successful implementation of 24/7 working within our pathology laboratories.

1.3.3 Productivity, efficiency and CIPs

The Trust developed its Integrated Improvement Programme (IIP) during Q3 2013/14 to agree and structure business change priorities in support of Trust and health economy wide objectives.

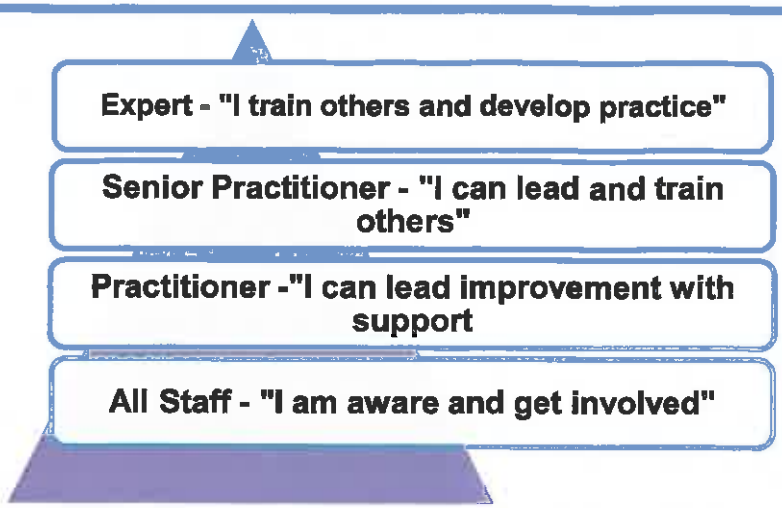


Service Improvement Strategy

A new service improvement strategy has been developed and agreed by the Board of Directors (March 2014) in recognition of the scale of the change management challenge faced by the Trust.

The programmes will use the NHS Change Model, Lean and Large Scale Change tools.

Staff will receive a level of training with clear competencies.



Projects will follow a 5 step process:

Training will be delivered to clinical teams before projects begin.

Set Up will identify stakeholders, use Kano Workshops to gain staff engagement, present current state process maps where they exist or develop them, use Ideas Walls and identify quick wins.

Discovery will establish baseline data, use benefits realisation to identify key performance indicators to track benefits from trials, consider links to PAS, ICR and PLICS implementation, Better Together transformation projects and workforce development with extended scope practitioners. IT enablers may be identified at this stage.

Trials will have a signed off, planned structure with key measurements aligned with KPI's. Staff will need to be free to engage whilst maintaining "business as usual". Service changes need to be tested at a variety of times and activity levels. Where a series of trials are required to focus a change, clear analysis of each trial will be used to inform the design of the next trial.

Implementation will need to be agreed once a new future state has been identified. This may simply involve continuing the new process from a final trial or may require planning if staffing changes are necessary.

Embedding a service change will require a clear handover of metrics, reports and function to the relevant service line management team with a clear transfer of ownership. Storyboards should be used to visualise and report the change.

Each programme will identify a space to use as a "hub" which will act as a focus for meetings, sharing of ideas and presentation of projects. Any staff member will be able to

drop in to a hub for an update, as indeed could Governors and Board members. The Trust Management Board will reach out to the hubs and receive programme updates on a quarterly basis. A public facing hub will be placed in the main concourse accessible to service users and visitors. Hubs are actively managed and dynamic with project updates and storyboards displayed to provide a "status at a glance" or "knowing how we are doing" view of the programme.

Structure

The programme will have three main workstreams: Elective, Flow and 24/7.

The ambitious aim of the programme is to give training at the appropriate level to all staff in the organisation and target that to relevant teams in advance of projects rolling out. The programme will provide a major vehicle for cultural change within the organisation. Engagement will break down professional silos, reinforce positive values and behaviours, empower staff to question the status quo, facilitate staff development and open a review of core processes. The programme is the bridge to deliver a new way of working within Sherwood Forest Hospitals Trust.

Staff will be involved in identifying problems in current processes and developing new ones. This will require intensive support from teams to allow training and engagement whilst delivering business as usual. In turn this requires clear understanding and communication of the programme.

The internal opportunities presented by the Medway PAS implementation, Integrated Care Record and Patient Level Information and Costing Systems will be worked in to all of the projects within the programme when redesigning ways of working. The Better Together transformation programme within the local health and social care community will be integrated with this programme to enable joined up healthcare across the community. The need for the Trust to respond to the workforce changes required to meet the changing agenda for the NHS must be a core component of all projects to identify, train and use extended scope practitioners.

The programme will support the Trust in building its pipeline of cost improvement schemes.

Cost Improvement Programme (CIP)

The CIP scheme themes are identified below:

Ref	Scheme	Scheme Description	Total Savings 2014/15 (FYE) £m	Key measure of quality for the plan	Scheme Lead
1	Service Redesign	Significant redesign of a number of services, including: • Theatres • Outpatients • Ophthalmology • Cardio-Respiratory	£5.884	Reduction in Length of Stay Reduction in short stay admissions	Medical Director

		• Radiology • Pathology Optimising utilisation of capacity, aligning workforce with redesigned clinical models leading to improved productivity and increased efficiencies together with improved patient pathways		Improvements in day case procedure rates Reduction in Readmissions	
2	Workforce Redesign and Reduction	Review of skill mix within and across divisions to improve productivity and identify efficiencies	£0.186	WTE actual staff in post	Director of Human Resources
3	Procurement	Review procurement process across a number of product lines to identify savings from re negotiation of contracts and prices	£1.032	Non pay expenditure run rate	Director of Strategic Planning and Commercial Development
4	Income Generation	Repatriation of services from external providers Optimisation of income through achievement of Best Practice Tariff criteria	£1.034	Income and Activity run rate	Chief Financial Officer
5	Reduction in Variable Pay	Recruitment of substantive staff to reduce reliance on Locum and Agency requirements Reduction of sickness absence across the Trust to target levels through robust sickness management process	£0.564	Staff sickness levels WTE Actual staff in post Variable pay expenditure	Director of Operations
		TOTAL	**£8.700**		

These main themes for the delivery of the CIP programme are underpinned by well-developed project plans, including risk ratings and Quality Impact Assessments.

The Programme Management Office (PMO) provides the governance for all CIP schemes, the programme board meets monthly and the main tool of assurance is the programme

dashboard. This is updated weekly and reported monthly and details the ratings of the aggregate of the project workbooks by RAG rating specific criteria against each workbook, for examples milestone up to date, QIA completed. The dashboard is then discussed by the programme board and actions identified to address any areas which are under performing.

Each CIP project has accountability appropriately divided amongst an: executive sponsor, clinical lead, division/corporate lead as well as the project manager. There is weekly communication between the project managers and the PMO regarding all CIP schemes. Any slippage on delivery is reported via the dashboard to the Programme Board.

A Quality Impact Assessment (QIA) is completed for all projects which have potential to significantly impact on quality. The Programme Board consider at the point of 'initiation' if a QIA is required, this is agreed between the Medical Director and Executive Director of Nursing who are members of the Programme Board. The project manager can still raise a QIA as the project develops if it becomes clear one is required as the risks have increased.

All QIA's are approved by the divisional triumvirate of Clinical Director, Divisional Matron and Divisional manager. The Medical Director and Executive Director of Nursing then approve the QIA to ensure a whole Trust approach and finally the QIA's are signed off by the CCG, to ensure stakeholder approval of the plans.

1.3.4 Financial Plan

Context

SFH was authorised in 2007 and since becoming an FT has dealt with an increasingly challenging financial landscape. Financial year 2011/12 was the first year the PFI became fully operational which was the same point in which transitional relief ceased and the increasing financial difficulties became more apparent.

As the extent of the financial challenge became clearer the Trust has undertaken many reviews, some of which have involved external expertise. Common findings cover 4 key factors:

- There is an underlying deficit the extent of which has previously been masked by one-off gains
- The costs of the PFI are disproportionate to what can be earned under the tariff payment arrangements
- There are efficiency gains still to be had when benchmarked against our peers
- The liquidity of the Trust will continue to be a challenge and require ongoing support.

Financial year 2013/14

There has been a significant focus on finance throughout 13/14 as a result of discretionary requirements being placed on the Trust by Monitor as part of the issue of its licence in April 2013. These included:

- A need to report monthly additional information which identifies the Trusts trading position before and after perceived PFI premium support
- Delivery of the Financial Governance Action Plan submitted to Monitor in February 2013; and
- Submission of an interim improvement plan in October 2013 to reflect the longer term commissioner intentions articulated in the Better Together strategy.

The Trust has delivered against all these actions.

During this period the Trust has also undertaken a finance transformation which has taken longer than was originally envisaged and introduced additional pressures during critical times. Whilst the change has also caused frustration across the wider organisation the journey remains the right one with an ambition to ensure the finance service is fit for the future in an ever changing financial, economic and performance driven climate.

Despite the intensely pressurised year the Trust has delivered against its key financial targets whilst having to also absorb some additional 'cost shocks'. In particular these relate to the review of the Keogh team and the subsequent 13 point action plan. The recommendations from the review in respect of nurse staffing are being addressed by the Trust and together with other workforce pressures create additional financial challenges. Not unexpectedly these additional pressures make the articulation of a sustainable future for the Trust ever more difficult.

Financially the Trust reported a deficit outturn of c£21.7m for 2013/14 which was ahead of

plan.. Attachment 1 provides a bridge from the 2013/14 planned deficit (£23.3m) to the forecast deficit (c. £21.5m) and then to the normalised deficit (£23.8m)

A key contributing factor to the improved out turn position has been delivery of over c£14m of in year CIP's. Some of this over performance is however non recurrent as a result of some deep dives undertaken by the transformed finance team creating a more transparent financial platform going forward.

Our 2 year financial plan – 2014/15 and 2015/16

Over the next 2 years the Trust has identified some key actions which directly impact on the supporting financial plan:

- To transform the way clinical services are delivered in line with the Better Together ambitions and translated through joint QIPP plans
- To implement the Integrated Improvement Programme which encompasses 24/7 working and implementation of the Integrated Care Record Programme/replacement Patient Administration System (PAS)
- An intense recruitment focus so we can continue to actively reduce our reliance on temporary staffing solutions
- Seek to reduce bed capacity as a result of non-elective demand management schemes
- To actively pursue benchmark efficiencies as part of our re-energised focus on service line management
- Consider options for the use of the wider Trust estate given the considerable fixed costs associated with our premises
-

Despite our plans to deliver a transformation agenda during this 2 year time frame the Trust will continue to face an on-going financial deficit and a requirement for liquidity support. The summary position is included in the following table:

	13/14 Outturn (£m)	**13/14 normalised outturn**	**14/15 £m**	**15/16 £m**
I&E deficit	(21.7)	(23.8)	(26.4)	(29.7)
Liquidity and capex requirements	26.9		31.2	35.2

Key assumptions

There are a number of key financial assumptions which underpin our 2 year plan these are

outlined below and summarised in the table overleaf:

- We have agreed a payment by results (pbr) based contract for 14/15 but are already in discussions with our commissioners about how we might consider new ways of contracting in future years. For the purposes of this 2 year plan we have however also assumed a pbr approach for 15/16 including a tariff deflator, QIPP and growth impacts;
- There is a cost associated with delivering change and the significant requirements of our Integrated Improvement Programme of which Better Together forms a key part. There is also an acknowledgement from our Commissioners that as we remove capacity from the Trust there will be a need for some transitional support towards our fixed costs whilst more substantive solutions are identified;
- We need to continue to invest in our nursing workforce with a particular focus on achieving the ideal nurse skill mix on our wards in response to the Keogh review;
- We continue to have pressures from medical vacancies in difficult to recruit areas. There is particular pressure resulting from middle grade doctor shortages in ED;
- Trust is planning for CIPs of 4.4% (£8.7m) of influenceable spend in 2014/15 and c5% (£9.9m) in 15/16. These higher targets reflect our benchmark ambitions which show that when compared with our peers we are less efficient in a range of areas, particularly staffing
- PFI uplift - The Trust's PFI scheme is constructed in such a manner that the interest and debt payment, which is a below the line/balance sheet item, attracts an annual RPI uplift. Under IFRS the resultant uplift is added to the service charge, included above the line and impacting on reported EBITDA. A secondary distortion occurs due to differential between RPI and NHS funding for inflation. These impacts have been discussed at length with Monitor as part of on-going discussions regarding cash and PFI support. The impact of the PFI is a key barrier to a sustainable future;
- PFI premium. The Trust has undertaken a lot of work to assess the distorted impact the PFI has on its trading position. A significant piece of work was undertaken during the year that confirms the Trust is one of a handful of organisations for which the impact of the PFI has a particularly onerous impact upon the trading position. we will continue to work with Monitor on how this issue might be addressed.Capital expenditure is planned to be increased recognising that the Trust has failed to adequately invest in replacing old equipment and up-dating technologies
- An estates strategy is emerging and it is currently envisaged that additional PDC funded capital will be required. At present £30m has been assumed overall with the first elements being included in year 2 of this submission.

Key financial assumptions	**(£m) Impact 14/15**	**(£m) Additional 15/16**
pbr approach and impact of tariff deflator, QIPP and growth	Contract agreed	(3.5)
Cost of delivering change • IIP • Transitional support from CCG	 (2.8) n/a	 1.4 (1.6)

Additional Keogh nurse investment	(2.2)	(0.8)
Middle grade doctors in ED	(0.9)	
CIP - 100% delivery in year but 25% will be non-recurrent	8.7	9.9
PFI uplift	(1.3)	(1.3)
Capital investment – • rolling capital programme • estates strategy	(6.0) 0.0	1.0 (3.1)

Downside case and Mitigations

The Trust, like most NHS organisations, faces a challenging financial future. Within the context of this plan we have considered some of the key risks that create instability in some of our plan assumptions. The key ones are included in the following table alongside the mitigations that as an organisation we will continue to pursue. The first 3 relate to income challenges.

	2 year cumaltive potential impact £m	Likelihood % and £m	Mitigations
Replacing acute bed capacity with a rehab income stream does not materialise (net impact more significant in outer years)	(0.2)	50% (0.1)	Clear strategy to pursue other income streams
Re-admissions/other sanctions continue to apply	(2.4)	25% (0.6)	Explore other contracting approaches with CCG
Non elective demand management does not have sufficient impact on MRET	(4.0)	50% (2.0)	Dedicated QIPP programme support aligned with B+T
CIP efficiencies relating to reduced capacity not achieved	(5.0)	75% (3.75)	Executive sponsorship and alignment with QIPP CIP forward pipeline enhanced
Total potential impact	**11.6**	**6.45**	

THIS NEXT TABLE IS TO BE DELETED

Attachment 1 – Income and Expenditure Bridge

THIS NEXT SLIDE WILL BE DELETED REPLACEMENT ON NEXT PAGE

Attachment 1 – Income and Expenditure Bridge