Sherwood Forest Hospitals NHS
NHS Foundation Trust

Board of Directors Meeting

Subject: **Service Improvement Strategy**
Date: **Thursday 27 March 2014**
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Executive Summary
This report provides an update on progress with the development of the Service Improvement Strategy detailing what success will look like , why it will be different and the principles of the change.
Recommendation
The Board are asked to note the content of this paper

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	
Details of additional risks associated with this paper *(may include CQC Essential Standards, NHSLA, NHS Constitution)*	
Links to NHS Constitution	
Financial Implications/Impact	
Legal Implications/Impact	
Partnership working & Public Engagement Implications/Impact	
Committees/groups where this item has been presented before	
Monitoring and Review	
Is a QIA required/been completed? If yes provide brief details	

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SERVICE IMPROVEMENT STRATEGY

(QUALITY FOR YOU)

Vision: Consistent, excellent, innovative care for our local population

LOCAL, FIRST CHOICE, FIRST CLASS

What will success look like:

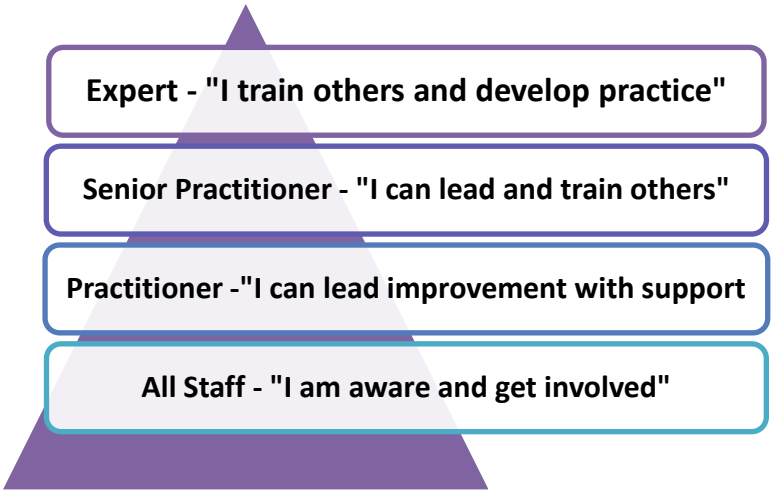
- All staff empowered to continuously review and improve service delivery
- All staff share a common service improvement language in a cultural network; all voices are valid
- Continuous identification and delivery of “quick wins”
- Service teams are capable to innovate, test and implement new ways of working to deliver small scale change
- Divisional teams retain “superuser” capability to problem solve; an “in house” consultancy to deliver step change
- Projects facilitate talent identification to sustain clinical champions, develop staff and grow future leaders
- Staff are proud to share achievements both internally and externally
- The voice of the patient will be present in service redesign

Why will this be different: staff will identify the need for and deliver change rather than have this done to or for them.

Principles

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

All 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 need to 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 should be able to drop in to a hub for an update as indeed could Executive Directors, Governors and Board members. The Trust Management Board should outreach to visit hubs or receive Programme Updates on a quarterly basis. A public facing hub should 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 support structure is outlined in Appendix 1.

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 values and behaviours, empower staff to question the status quo, facilitate staff development and open a review of core processes. In short the programme is a bridge to deliver Sherwood Forest Hospitals Trust a new way of doing business.

Staff will be involved in identifying problems in current processes and developing new ones. This will require massive 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, ICR and PLICS will need to be worked in to all of the projects within the programme when redesigning ways of working. The external Better Together transformation programme within the local CCG's must be integrated with the Quality For You 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 involvement of patients and Governors within the projects should be encouraged. This could be on a formal or informal basis.

Resource

The calculations are based on utilising the existing service improvement team and hence an assumption about their capability within the new programme.

Associate Service Improvement Director	Salary to attract key individual
Programme Leads x 3	£231k
Clinical Leads	£ 70k
Service Improvement Leads x 7	£ 55k (6 in post)
Service Improvement Facilitators x 4	All in post
Project Management Support x 6	£132k (3 in post)
Analysts x 3	£80k (1 in post)
Business Intelligence x 1	In post
Training Lead Band 7 x 1	£45k
Training Delivery Band 5 x 5	£155k
PMO Support Band 7 x 2	£71k
	£839k plus SID salary

The trust is short of capable analysts and I would envisage the three posts within this programme forming part of the wider team of analytical capability. The programme is likely to run for 5 years. There are no costs included for computers or office equipment. Space will need to be found to accommodate some individuals but hot desking from hubs should be used. Hubs will require some set up costs.

The programme will be carefully evaluated for benefits. Some quick wins will be developed but the benefits are longer term and in reality, the programme will facilitate and support major CIP's within Divisions hence clear attribution to the Service Improvement Programme may be difficult.

Recommendations

The Board is asked to consider and debate the Service Improvement Programme outlined in this paper with regard to scope, suitability, resourcing and deliverability.

APPENDIX 1