Sherwood Forest Hospitals NHS
NHS Foundation Trust

Strategic Plan 2013-14

Sherwood Forest Hospitals NHS Foundation Trust

Strategic Plan for y/e 31 March 2014

This document completed by:

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The Sherwood Forest Hospitals NHS Foundation Trusts Strategic Plan will be submitted in two parts. The 2013/14 Plan (this Plan) sets out the business plan over the next year. It includes additional information over a 5 year period utilising the existing planning assumptions and business model, reporting on the underlying deficit and the impact on the PFI. The implications of the commissioner led Mid Nottinghamshire Review may be significant, so the full Strategic Plan will be submitted one month after the Review has concluded or by 31st October 2013. The information included here accurately reflects the current strategic and operational plans agreed by the Trust Board.

In signing below, the Trust confirms that:

- The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors, but subject to the impact of the Mid Nottinghamshire Review;
- The Strategic Plan has been subject to Trust Board scrutiny;
- The Strategic 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;
- All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission.

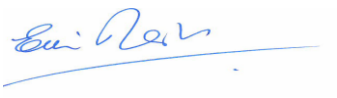
Approved on behalf of the Board of Directors by:

Name	Chris Mellor, Chair

Signature 

Approved on behalf of the Board of Directors by:

Name	Eric Morton, Interim Chief Executive

Signature 

Approved on behalf of the Board of Directors by:

Name	Fran Steele, Director of Finance and Performance

Signature 

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Executive Summary

This one year Plan for 2013/14 will set out how the Trust will deliver appropriate, high quality and cost-effective services for its patients on a sustainable basis, with a plan to come out of serious breach conditions with Monitor over three years. Additional information over 5 years reporting on the underlying deficit and the impact on the PFI is included. This Plan focuses on 2013/14 and it has been agreed with Monitor that a three year Plan will be submitted one month after the Mid Nottinghamshire Review has concluded or by 31st October 2013.

The Board has spent a significant amount of time learning from previous mistakes that led to the serious breach conditions. These included failures in financial and capital planning, non-delivery of plans – e.g. failure to tackle the underlying deficit including failure to deliver workforce reductions and cost improvement programmes, quality and patient safety problems and failures in governance. This learning has been used directly in developing the new Strategic Plan for the Trust.

This Plan forms Phase One, encompassing stabilisation and progress towards recovery. Alongside this, the Board has focused on stabilisation and rebuilding good corporate and clinical governance, improving financial control, (including external assurance), performance management, exercising the FTs functions effectively, efficiently and economically, and analysing the impact on the PFI on future financial plans.

2012/13 was a very difficult year for the Trust. Since Monitor's intervention in October 2012, the Trust has focused on addressing the underlying governance, financial and performance management, patient safety and quality issues. The Trust is reporting a year-end deficit of £15.5m, with an underlying deficit of £22.2m for 2012/13. Most of this deficit has been funded by cash resources from within the Trust and some non-recurrent resources made available by commissioners.

At the time of Monitor's intervention it was forecast cash would have been exhausted during Q1 2013/14, however, constructive negotiations with commissioners have resulted in months 11 and 12 of 2013/14 contract income being paid in month 1. As a result, the requirement for PDC cash support is delayed until late in 2013/14. This is not a solution in itself, indeed the Trust's cash deficit rises very rapidly in months 11 and 12 due to the early payment, but gives time for the Trust and key stakeholders, including Monitor, to plan and agree the scope and direction of the longer term sustainable plan during 2013/14. The Mid Nottinghamshire Review is an important aspect of this and will further develop over the next 18 months. There is a misalignment between these dates. This will mean that the level and robustness of analysis possible to inform the planning assumptions in the October plan will not be as detailed as needed.

Latterly there have been some significant positive developments. The actions to secure stability have mainly been achieved, including the delivery of the Q4 CIP plan, strong progress on governance action plans, contract concluded for 2013/14, including effective and active clinical participation, quality improvements, the Trust ended 2012/13 with mainly positive service delivery and the first part of new organisational structure and cultural change has begun.

Phase Two (2013/14) will focus on transformation and transition. Improvements in quality and patient safety will continue with a focus on 3 key priorities:

- patient safety and mortality- including c. diff reduction
- improvements in clinical pathways – with a priority on redesign of the emergency pathways to deliver sustainable A&E performance within the context of rising demand and increasingly complex needs of an aging population
- the elimination of pressure ulcers.

Ensuring that we have the right workforce with the right skills, training in a learning organisation within a reduced cost base will support the pathway redesign work. These will be underpinned by investment in organisational development, using innovation and research and development as major enablers to a transformed Trust.

The Trust Board has agreed that we should develop an integrated care organisation philosophy and offer care as close to home as possible and put in place plans that encourage more local people to use the Trust's services, including repatriating activity that flows elsewhere. The Trust will reposition itself in the marketplace by resolving the issues described above and build a stronger reputation as an excellent provider of local services by focusing the branding on the names of the Hospitals sites rather than the name of the Trust. Newark Hospital, Mansfield Community Hospital and Kings Mill Hospital are known to local people and this will form the basis of the rebranding.

This Plan includes a robust one year financial plan, based on an agreed 2013/14 contract with our principal commissioners, existing planning assumptions and includes scenarios over 5 years and agreed following extensive debate at the Board. It includes a plan to deliver CIP of £13.3m, based on strong programme management discipline and improved ownership and accountability throughout the Trust. The Plan also includes a thorough analysis of the level of PFI premium support required going forward and a realistic level of capital investment to start to address the problems of the equipment, IT and estate backlog. These planning assumptions together with the underlying deficit and investment in transformation explain the lack of deficit reduction planned for 2013/14.

A new Board is coming in place during May and June 2013, with appointments to the Chair, Chief Executive and Non Executive Directors having been made and this will signal an important step forward. A new clinically led and delivered organisational structure is in place and forms the basis for delivery going forward, together with clear accountability and supporting performance management and programme management mechanisms. A major theme of the transformation and transition programme is to begin the processes to engage and communicate more effectively with staff, governors, volunteers and partners and embed new organisational culture and behaviours. Having medical, nursing and AHP clinicians in senior positions will ensure that the clinical business is delivered, supported by an effective organisational development plan and an inclusive communication plan.

Phase 3 covers 2014/15 onwards and this will focus on delivery and sustainability. This will follow the conclusions of some important pieces of work over the summer that will shape the October Plan. The commissioner led Mid Nottinghamshire Review has focused on clinical and pathway redesign and may alter the current service mix and activity flows across the social and healthcare system. The Trust is developing a plan to increase its market share with commissioners that will follow the Mid Nottinghamshire Review, but is moving forward cautiously as the East Midlands and South Yorkshire market has a large number of other providers all seeking to move in the same direction. The review considers the configuration of the estate within the patch that may impact on the Trust. The Trust has started to develop its own clinical and estates strategies to formulate a business case to resolve the problems with the retained estate and eliminate maintenance costs. Work to secure PFI premium support will be the third major strand of work going forward. These key significant factors will be worked through and will form the basis of the October Plan.

There are a number of risks that could impact on the delivery of the 2013/14 Plan:

- reliance on external support
- achievement of the cost improvement targets
- Mid Nottinghamshire Transformation Plans

That said the Board consider that the 2013/14 Plan is robust and will continue the improvements started and provide the new Trust Board with a strong platform on which to move forward.

1. Introduction

The 2013/14 Strategic Plan for Sherwood Forest Hospitals NHS Foundation Trust (the Trust) sets out how the Trust Board intends to deliver appropriate, high quality and cost-effective services for its patients on a sustainable basis. The underlying philosophy is that by getting the quality of care right, financial sustainability will follow. This will happen as a result of our ability to maintain the support of our local populations, commissioner support, repatriate activity and attract and retain first class employees committed to a culture of continuous improvement.

The Plan lays out the Board's assessment of the challenges, our strategy to address those challenges and implementation plans over 2013/14. Additionally, the Plan recognises the significant importance of the need for PFI support and responding to the Mid Nottinghamshire Review. As the conclusions are not available prior to the submission, the Trust Board will submit the full three year Plan by the 31st October at the latest. This will include the early conclusions from the Review, but it should be recognised that the level and robustness of analysis possible to inform the planning assumptions in the October plan will not be as detailed as needed.

The Trust has structured the approach to recovery with a plan come out of breach in three phases:

- Stabilisation (2012/13 into 2013/14)
- Transformation and transition (2013/14)
- Delivery and sustainability (2014 onwards)

2. Strategic Context and Direction

Vision: Dedicated to providing quality care locally

The Trust's vision is to be the local healthcare provider of choice for our communities by delivering safe, high quality care. We will do this by valuing our staff and underpinning everything we do with our constant pursuit of excellence and efficiency.

Strategic Objectives:

1. **Achieve the best patient experience**

   Director of Nursing and Quality

2. **Improve patient safety and provide high quality care**

   Medical Director and Director of Operations

3. **Attract, develop and motivate effective teams**

   Director of Human Resources

4. **Achieve financial sustainability**

   Director of Finance and Performance

5. **Build successful relationships and partnerships with external organisations and regulators**

   Director of Strategic Planning and Commercial Development

Strategic Position

The Trust provides services in a market of geographically close competitors and in which there is excess elective capacity. There are 8 other NHS acute / community providers and 2 independent sector providers within a 25 mile radius of our 2 main hospital bases. This competitive environment together with the impact of the PFI costs, financial challenges, the year on year rise in emergency activity, an ageing population and a further reduction in local authority spending results in a challenging local context.

The Trust's demand profile has increased in non-elective by 2% and reduced in elective by -5% over the last 2 years. The Trust has also seen a change to case mix and complexity demonstrated by the increase in income over the past two years for non-elective that has increased by 5.5%. The trend for non-elective activity is forecast to continue whilst the forecast for elective activity is to reduce.

The Mid Nottinghamshire Review has established a mechanism to respond to these challenges within the limited geographical scope of the two local CCGs. The Board is keen to work with commissioners on delivering a strategy to provide care closer to home and consider the benefits of integrated services, both vertical (primary, community and secondary) and horizontal (social care).

We believe that integrated care systems present opportunities for an improved patient experience, service development, skill sharing and skill development throughout the workforce, but acute Trusts will increasingly need to work within clinical networks and in partnership with other health and social care providers to ensure local retention of an appropriately skilled workforce and viable organisations.

Local commissioning intentions: Threats

The Trust attracts 67% of the secondary care admissions from the host CCGs. This is 19.2% of our market share from our core market, representing a potential additional annual revenue of £22.6m which was delivered by our closest competitors (Nottingham University Hospitals and by the Nottingham Independent Treatment Centre). We recognise that we operate in a market with diminishing income, falling tariff prices, and strong local competition from providers who have a lower cost base and arguably, at present, a better brand. Whilst there remain further opportunities to increase our market share for elective activity, continuing to grow revenue and margin from elective services will be extremely challenging, particularly where it is dependent upon taking market share from competitors who have identical ambitions. During 2013/14, local commissioners are moving towards providing more services in community settings (e.g. musculoskeletal services, dermatology, cardiology, gastroenterology, ENT, gynaecology, pain management) with the possibility of different providers partnering with the Trust.

The future landscape in terms of growth for traditional hospital services whilst providing some opportunities is pessimistic over the longer term, and it no longer presents a sustainable future strategy for the Trust. The increasing centralisation of services such as major trauma, vascular surgery, hyper acute stroke and cardiology also presents major additional clinical and financial threats.

Whilst the Trust is working with local commissioners and other providers on the Mid Nottinghamshire Review there are also threats from AQP processes, significant QIPP schemes seeking to move activity away from the Trust and possible reconfiguration.

Local commissioning intentions: Opportunities

Whilst the competitive environment is strong, there are service specific opportunities available. For example, we currently attract 19% of orthopaedic inpatient work from Derbyshire and are targeting a further 19% over the course of the next three years whereas in Newark & Sherwood, we are aiming to attract 80% of elective work (compared to our current 58%). These opportunities exist in other specialties and strategies developed over the summer.

The market for community / home based services is strong, vertically integrated with acute and primary care and horizontally linked with social care, is strong. It matches Government policy and commissioner's long term plans around wellness, early intervention and better management of long term conditions and the transformation of public services. Locally, there is a significant market centred in community services that is likely to be opened to growing opportunities as a result of choice, personalisation of budgets and the opportunity to market test community (TCS) contracts in 2014/15 (c.£85m pa). Looking at providing valued specialist and diagnostic support to GP practices aligns with the Trust' plans

Local commissioners are supportive of repatriation and for example have supported the Trust in moving some gastroenterology activity back to the Trust during 2013 (c£0.9m). How much further this is possible depends on the development work over the summer and the outcome of the Mid Nottinghamshire Review.

Whilst there are a number of threats from current and possible commissioning decisions, the relationship with commissioners has improved significantly and there are a number of opportunities going forward to further improve this.

There are some areas of threat in specific service areas which may impact on the Trust during 2013 / 14. Our pathology service is currently subject to market testing within a networked procured process as part of a commitment with five other Trusts. The procurement process is well advanced and the Trust is reviewing the risk assessment.

Partnerships and integration

The Trust will work better than in the past with commissioners and partners to ensure a sustainable future. The current business model is not fit for purpose and moving towards an integrated care organisation will demand the need for the consideration of alternative business models. The detail will depend on the clinical strategy and will be set out in more detail in the October Plan. Models of service delivery with joint arrangements with local primary care providers will form part of these integration plans and these are currently being tested in musculoskeletal services. A dual role for the Trust and a named primary care provider are responding to a new commissioner specification, as a test of different partnership arrangements.

Strategic Direction Framework

Strategy	**Outcome**	**Enablers**
Quality	One of the safest organisations in the NHS	Clinical & Quality Improvement Strategy
Efficiency	Above sector performance	Strong clinical businesses (Flotillas), owning continuous improvement
Integration	Streamlined and efficient patient pathways	Skill in developing partnerships
Care close to home	Repatriate activity and above sector average GP referral Increase market share Expand / develop specialist services	Organisational Development Communications and Marketing Skill in developing partnerships
Maximise estate and land utilisation	Industry standard space utilisation Resolution to retained estate	Clinical and Estates strategy Business case
Export our services / franchise	Development of profitable activity	Communications and Marketing Skill in developing partnerships
Branding	Excellent reputation, attract profitable activity and excellent staff	Communications and Marketing Organisational Development

Table 1

The Trust will complete a number of Plans to inform the Strategic Plan submission in October 2013:

- Quality Improvement Strategy and Plan
- Organisational Development Strategy and Plan
- Communication and Marketing Strategy and Plan
- IM&T Strategy and Plan
- Workforce Strategy and Plan
- Clinical Strategy and Implementation Plan
- Estates Strategy and Plan

3. Quality and Patient Safety

Our goal is to pursue a culture of continuous improvement and promote a safety culture which embeds the Hippocratic Oath "*first do no harm"* at all levels.

Our Key Aims

Our overarching aim is 'through continuous quality improvement to be one of the safest organisations in the NHS, providing safe, clean and dignified care to every patient, every time'. We see this as an essential precursor to financial sustainability.

We are mindful of the challenging and changing NHS landscape, which requires greater efficiency, increased activity, greater consistency and innovation to meet the needs of the ageing population. It is our ambition to meet these challenges whilst ensuring we continue to provide the high quality healthcare that local people expect. This is at the forefront of our minds following the publication of the *Francis Report* in February 2013. We are already considering how we respond to the recommendations, learning lessons that lead to improvements in care across the healthcare community. This will inform our clinical and quality strategy over the coming years.

To be a safe organisation, the Trust requires effective governance from ward to board. This requires an infrastructure which ensures risks to quality and financial stability are well managed and that actions taken to improve performance and safety are implemented quickly and in a sustainable manner.

The Monitor *Quality Governance Framework* tests whether a combination of structures and processes are in place, to enable a trust board to assure the quality of care it provides. The Board's aim is to meet the ten areas within the framework. As of December 2012, an independent assessment identified the Trust did not meet all the quality governance standards that are expected. We also have a moderate concern against CQC outcome 16; clinical governance. The Trust recognises that it needs to improve. During 2013/14 we will continue to implement underpinning governance structures and processes that will place us within the highest standards for quality governance. We aim to demonstrate a score of less than four against the Quality Governance Framework, with the overriding rule that none of the four categories of the quality governance framework (strategy, capabilities and culture, structures and processes and measurement) may be amber / red rated.

During 2013/14 the Trust will develop a quality improvement strategy. Within our key aim we have identified three principal objectives for 2013/14.

- To reduce mortality Hospital Standardised Mortality Rate (HSMR) and Summary Hospital Mortality Indicator (SHMI) by 10% (HSMR is currently 116 and SHMI 107)
- To reduce all harmful event, with a specific aim to completely eliminate all avoidable Grade 3 & 4 pressure ulcers
- To reduce average length of stay to less than 6 days and readmissions to less than 8% by improving patient flows (i.e. reducing the number of bed movements during the inpatient stays)

Mortality will be measured by both HSMR and SHMI in 2013/14. The mortality programme of work instigated in 2012/13 will continue. This reduction programme has five key areas: clinical care, clinical processes, end of life care, governance & leadership and coding. The appointment of an Associate Medical Director for Patient Safety was an important appointment and he will lead the delivery of programmes of work relating to a reduction in mortality rates. The Trust is one of the 14 sites being visited as part of the Sir Bruce Keogh programme. The mortality programme of work will be updated after the visit, to reflect any recommendations from this visit.

During 2012, the Trust identified problems in the breast screening service with oestrogen receptor testing. Significant progress has been made together with the implementation of a thorough action plan and

external support from a number of agencies. In April 2013, the CQC / Royal College of Pathologists report was published. In the opinion of the authors:

- The standard of reporting by SFH laboratory was adequate
- The conclusion by the East Midlands Breast Screening Network that SFH systematically under-reported ER status was flawed. In their opinion, our laboratory was not an outlier in respect of the National External Quality Assessment Service (NEQAS)
- Nevertheless, they recommend that SFH does not recommence testing due to inadequate staffing levels, even though they did not find that the service under-performed.

The report has been accepted by the Trust. The ladies and families have been informed of the publication of the report. As a consequence of the report findings, patients will be reviewed by the multi-disciplinary team.

In 2013/14 there will be on-going measurement of harms.

These include:

- Hospital acquired infections
- Cardiac arrests
- Safety Thermometer measures (pressure ulcers, falls, catheter associated infections and venous thromboembolism
- Medication errors
- Surgical site infections
- Sepsis

The Trust has made significant improvements in reducing harms to patients over the last 2 years. This is demonstrated in:

- Over 3 years without hospital acquired MRSA bacteraemia
- A substantial reduction in C difficile rates
- A 50% reduction in avoidable cardiac arrests
- Introduction of the *Safety Thermometer* showing 94% of our inpatients receive harm free care
- Introduction of the *Global Trigger Tool*. This tool requires us to randomly select 20 clinical records per month and review them for harmful events

We have an excellent track record for meeting our infection control targets, and will make a further reduction in C diff rates during 2013/14. In 2012/13 the Trust reported 29 cases of C*. difficile* against a trajectory of 36, which is a fantastic achievement.

The trajectory set for 2013/14 is 25 cases or less of hospital acquired *C. difficile* cases; the trajectory is 2 cases or less per month. This is an extremely challenging target. We have a clear infection prevention work programme to deliver this, monitored at the Infection Control Committee.

For 2013/14 we have chosen to focus upon reducing and eliminating avoidable pressure ulcers. We need to improve the management of pressure ulcers and have set ourselves the following targets:

- To have zero avoidable Grade 4 pressure ulcers
- To reduce avoidable Grade 3 ulcers so that we have nil by March 2014
- To reduce avoidable Grade 2 ulcers by 30%
- To work with community services to support improvements across the whole patient pathway

The experience of patients continues to be our priority and as a Trust, we have to ensure we make the healthcare experience for our patients, the best it can possibly be. Our third principal objective ‘to reduce

length of stay and readmissions by improving patient flows' was identified in response to patient and staff feedback. As well as aiming to improve the patient experience it will also contribute to achieving our patient safety and clinical effectiveness improvement goals. The focus for 2013/14 will be to redesign across the whole non-elective pathway to ensure patients are admitted to the correct specialty ward within 24 hours of admission.

There are 3 work streams to achieve undertaking this key work;

- devise a new medical model
- review and implement changes to manage capacity and patient flow
- review the workforce requirements including on-call arrangements.

A major drive behind this work is a focus on the frail elderly and improving discharge processes. The aim is to reduce average length of stay to less than 6 days and readmissions to less than 8%

The 4 hour target will be challenging for most organisations in 2013/14. Work is on-going nationally to devise ways to support acute trusts with rising non-elective admissions and significant increases in delayed transfers of care. An urgent care board consisting of all stakeholders is already in place in Nottinghamshire and discussions are taking place to establish systems that have worked well during the winter of 2012/13 and further recommendations for investment to support the pathway. Commissioners are supporting the development of an early seasonal plan to ensure that all relevant services are in place. The Trust has also received an assurance visit from the Emergency Care Intensive Support Team in May 2013 and has incorporated recommendations from the Team into the programme of work.

4. Clinical Strategy

The Trust's clinical strategy is to be the best provider of high quality, integrated and secondary care for more local people - *care closer to home*. This will include providing more community based services and caring for local people who currently choose to go elsewhere for community, general and specialist care. We will focus on driving the key changes needed to transform the Trust, changing our current acute and secondary care model – ensuring that our clinical services, patient pathways and delivery models better fit the future healthcare landscape.

A detailed clinical strategy will be developed over the summer, working with the early conclusions of the Mid Nottinghamshire Review and the new clinical management units and clinical teams within the Trust. The aim is to develop a sustainable and integrated health and social care model; a model, which delivers services flexibly in partnership to meet the needs of our community and deliver the highest care quality.

Supporting the achievement of this overarching vision and strategy are the 5 stated core objectives. The successful delivery of these objectives will ensure that the Trust has a sustainable, credible, clinical strategy which is firmly supported by our clinicians and staff by gaining a reputation for quality excellence by ensuring that we deliver the right care, effectively, first time every time and in the right place for our patients and customers.

A significant part of this work is driving towards improved clinical productivity and efficiency as we know that the Trust can, in comparison with our peer group, improve significantly in areas like theatre productivity (as evidenced by Newton Europe), Average Length Of Stay (as evidenced by Better Care Better Value Indicators) and Pre-Procedure Non Elective Beds Days(BCBVI).

The use of technology to support clinical teams and improve the efficiency of services is part of our clinical strategy going forward. The Trust has increased capital investment to demonstrate this priority and a major aspect will be to implement the Integrated Care Record (ICR) and a replacement PAS this year. The Trust will also develop a new IM&T strategy to reflect the developing clinical strategy.

Research and Innovation remain an important aspect of the work of the Trust with a great deal of success – e.g. we plan a year-on-year increase in recruitment to clinical trials. The Trust is also expanding its programme of patient and public involvement (PPI) in research, and is working to improve the visibility of the department to both patients and staff. Research and innovation will form an important aspect of the clinical strategy going forward as well as a valuable aspect of creating a learning environment and attractive place in which to work.

The Trust has commenced a large scale, though rapid piece of work to develop, with the new Clinical Divisions a clinical strategy fit for the next 3 - 5 years. The conclusions to this work will be informed by the outcomes of the Mid Nottinghamshire Review and the commissioning plans that follow. The construct of the review was around four clinical work streams (below) with a number of enablers for example estates.

There are four high level outcomes from the work to date:

- Maintaining personal independence and increasing community care
- An integrated urgent care service
- “Right people, right place” elective care
- Re-abling people to go home

The outcomes of the Mid Nottinghamshire Review will inform the October Plan, but the degree to which commissioners have made final decisions and the level of detailed analysis available will drive the planning assumptions within the Plan. An estates strategy and plan will follow the Trust’s own work, with the aim of resolving the problems with the retained estate and for the Board of Directors to consider options.

Clinical Workforce Strategy

The workforce plan for the transitional and transfer year has been difficult to establish due to the many changing factors described elsewhere in the Plan. The work over the summer months will enable the Trust to build more confidence and assurance in the workforce plan and associated staff requests. The aim for 2013/14 is to reduce the workforce cost and the workforce numbers within the organisation. Plans for 2013/14 include significant workforce reductions within the CIP programme (CIP of £9.646m equal to 146.5 wte) and conversions from variable pay to permanent posts where assessed as vital to maintain high quality care.

There are increases in the workforce elsewhere due to expanded capacity to meet the increase in non-elective demand and service developments. In addition, the Trust has decided to invest in additional short term capacity to ensure that the transition is managed effectively and additional project management supports further development and delivery of the CIP.

The workforce plan for 2013/14 recognises the significant investment in workforce aligned to the budget setting process. The provision of workforce resources that reflect out-turn pay expenditure provide the opportunity for clinical services and departments to not only staff with the appropriate staff mix to required levels to deliver high quality care but to put plans and processes in place to allow for true transformation, thus providing the platform for the required cost efficiencies during 2014/15 and beyond. The Trust spent significantly more than its planned pay expenditure during 2012/13 (£161.4 m actual versus £146.3 m). This was due in part to additional workforce costs associated with servicing £11m additional unplanned income coupled with non-delivery of workforce related CIPs and interim management costs. Budgets and establishments have been set more robustly for 2013/14 to allow for more effective longer term planning and in year delivery of agreed plans. The Trust recognises the financial impact of pay awards and incremental progression each year (£3.4m) for 2013/14. Whilst it is recognised that national changes to Agenda for Change terms and conditions and the negotiations that have commenced in relation to medical staff will assist the Trust in managing staff costs to budget, the Trust will take the opportunity of reviewing the benefits of local pay.

The Trust has struggled to recruit medical staff within specialities that are recognised areas of national shortage; these include consultants in emergency medicine, neurology, interventional radiologists and acute physicians and specialty doctors in geriatrics. Service leads are reviewing their workforce plans in these areas to determine alternative models of provision. Possible solutions, for example, include up-skilling of associate specialist roles, working with partner organisations, appointment of overseas doctors with supported training along with extended nursing roles particularly to support the skills shortage in emergency medicine. The Trust has successfully acquired the required nursing numbers during 2012/13 but recognise this will become increasingly difficult as Trusts increase numbers in light of Francis and other reviews.

The Trust relied heavily on temporary agency staff and locums across the medical and nursing specialties during 2012/13. This was due to a number of factors including the failure to contract for out-turn activity

which impeded long term workforce planning and recruitment, coupled with increased unplanned activity requiring the need for additional capacity. The Board recognise that this is neither acceptable nor sustainable going forward both from a quality and financial perspective. Initiatives to reduce the reliance and cost of agency include enhancement of the in-house nursing and administrative and clerical bank and the staff flow arrangement for medical staff will be implemented to support the Trust. These will support the Trust in achieving its strategic priorities both in relation to the provision of high quality care and financial viability.

The Trust recognises the effective management of its staff is one of the key elements of an organisation that is fit for purpose and can respond quickly to a rapidly changing environment. Workforce priorities include effective management of variable pay, improvement in the management of sickness absence and improvement in completion of staff appraisal rates. The Trust sickness absence target remains at 3.5%. The outturn rate for 2012/13 of 4.73% was 0.42% more than in the previous year. The initial focus for 2013/14 will be the effective management of short term absence which showed the most significant increase – additional central resources have been put in place, together with further training to assist managers in more effectively managing sickness absence. Managers have been set clear objectives in relation to the completion of staff appraisals; only 47% of Agenda for Change staff received an appraisal during 2012/13 which in unacceptable at a time of significant change when it is even more essential that staff are clear about their priorities and receive support for their developmental needs. Central resources and a review of appraisal documentation will again assist managers the achievement of the objective that 79% of staff will receive an appraisal. Medical and dental staff achieve the required 100% appraisal rate.

The workforce plan will be reviewed later in the year in light of the Mid Nottinghamshire Transformation review which will further define future service provision and associated workforce requirements.

The Trust has continued its journey towards clinical leadership and the required shift from corporate management control to patient focused clinical decision making. New operational structures that have been introduced place Clinical Directors at the head of the three clinical operational divisions thus providing the opportunity for clinical specialties to incentivise high standards of performance, delivery and achievement of sustained efficiency gains and adapt to the local changing health environment.

Leadership and management development programmes have made a positive impact in embedding the values and behaviours required and more is planned through a new OD strategy. New programmes being introduced include a new nursing leadership programme, which is accredited by the Royal College of Nursing. This programme is aimed at a strategic level to equip ward leaders with the higher level skills required to operate in an ever changing NHS landscape as well as being patient focused. A bespoke medical leadership programme has been developed, designed to equip medical service directors with the essential skills necessary to manage clinical services effectively and safely, lead and manage change and the delivery of high quality patient care through high performing professional teams. It is through these programmes that the culture of continual improvement will continue to flourish.

The Council of Governors Nominations Committee has continued to assess the capacity and capability of board members. The turnover of many board level posts during 2012/13 led to a number of new non-executive director appointments – five Non-Executive Directors commenced on 1 May 2013 and bring with them extensive financial, governance and experience from both across the NHS and outside. A new Chair was appointed in May, thus concluding the appointment to all board posts.

In addition, the Board of Directors Remuneration and Nominations Committee reviewed the capacity and capability of the Board, executive team and direct reports required to deliver the strategic objectives. An extensive review of executive director portfolios has been completed to ensure clarity of responsibility and accountability. All Executive directors now have clear portfolios and clarity regarding their objectives and priority areas for delivery.

5. Productivity & Efficiency

An overview of the productivity and efficiency gains built into our plans, are set out below. The main themes for the delivery of the CIP programme which have well developed and robust project plans underpinning them, including risk ratings for individual schemes, are described at Appendix 2.

2013/14 CIP Programme Overview

Clinical	Workforce	Non Clinical
•Reduce length of stay •Improve theatre utilisation •Improve outpatient productivity •Service redesign •Review clinical pathways to eliminate waste and improve quality •Repatriation of services •Benchmarking services with peer group to identify other opportunities	•Align workforce with capacity and demand •Improve attendance management •Reduce bank and agency spend •Improve recruitment process reducing time to fill	•Robust pricing of hosted services •Progress work on estates strategy aligned to clinical strategy •Procurement efficiencies •Benchmarking with peer group to identify other opportunities

Table 2

CIP governance

A diagnostic of the 2012/13 CIP programme revealed poorly functioning structures and processes together with a lack of accountability and delivery. Key risks against the programme were not identified and actively managed, and benefits reporting were disconnected from progress reporting. Benefits realisation for the 12/13 CIP was an in-year effect of £7.72m against £14m target with a recurring, full year effect of some £5.3m against £22m target. This was mainly achieved in quarter 4 - £3.24m (42%)

The findings of the diagnostic and recommendations have led to a complete overhaul of the Programme Management Office (PMO), leadership and assurance arrangements for the life of the Strategic Plan. The Programme Board, comprising the executive directors and specialist senior managers, has been refreshed and best practice programme and project management governance and process. A permanent and robust PMO has been established. The PMO is co-located with the trust executives with the Programme Board meeting monthly and, in addition, the weekly 'executive team' meeting dedicates the first hour to a programme update with the PMO. There is a clear framework and accountability in place that will be maintained. The primary assurance tool is the programme 'dashboard' which is updated on a daily basis and discussed weekly with executives; the ratings on the dashboard are the aggregate of the project workbooks hosted on a dedicated 'intranet' site.

CIP Profile

The Trust has implemented a significant service redesign process, including:

Outpatients*;* In 2012/13 there was 46% overall utilisation and this level of efficiency is a trend over a number of years. Significant efficiencies can be achieved.

Theatre productivity*;* Diagnostic work identified inefficiencies in many aspects of theatre productivity, e.g. a loss of 100 sessions in 18 months (2.3 theatres). Significant efficiencies can be achieved.

Endoscopy; A comprehensive review of the service, including; management structure, improved productivity and repatriation of activity from across the region.

Stroke; Creation of an integrated stroke unit. Review of on call arrangements. Review of utilisation, patient profiles and development of new services.

Cardiology; A comprehensive review of the service, including catheter lab utilisation, productivity and workforce model. Service development to increase market share.

Improving Acute Care; Creating a CDU and implementation of ambulatory care models leading to improvement in emergency department flow

Surgical Procedures; focus on improved patient pathways by optimising day case activity, leading to reductions in length of stay and the alignment of demand and capacity resulting in a review of skill mix.

CIP enablers

The extent of clinical leadership and engagement in identifying and delivering CIPs has been encouraging and is growing as project planning, including engagement strategies, becomes more robust. Each CIP project has accountability appropriately divided amongst an: executive sponsor (this may be the director of nursing or medical director where appropriate), clinical lead from the specialist area under consideration; divisional/corporate lead as well as the project manager. All of these positions are communicated with, and held accountable on behalf of the programme Board, by the PMO. There is weekly communication regarding all CIP projects.

The requirement for enabling investment in infrastructure has been 'needs led' in terms of CIP governance and programme delivery. The PMO together with programme governance and a delivery framework were put in place in December 2012 and the PMO team is now substantive with recruitment completed by March 2013. This has been supplemented with four specialist project managers, one to each clinical division with a fourth to focus on improving emergency pathways and flow. Moreover, the Trust's internal service development team has been re-deployed to facilitate the changes inherent in CIP delivery. Furthermore, the Trust has engaged *Newton Europe* to support the design and delivery of outpatients and theatre productivity projects.

Quality Impact of CIPs

The mechanism by which the Trust ensures that its CIP plans won't adversely affect quality of services is as follows. A Quality Impact Assessment (QIA) is completed for all projects which have potential to significantly impact on quality, in line with the National Quality Board document 'How to: Quality Assess Provider Cost Improvement Plans; July 2012 – 31 March 2013. QIA's are focussed on three domains – patient safety, patient experience and clinical effectiveness.

The Programme Board, which includes the Medical Director and Director of Nursing and Quality, consider at the point of 'initiation' whether a project requires a QIA. Whatever the decision at this point in the programme quality gate regime, each project reserves the right – at any time – to raise a QIA should the potential impact on quality become significant. All QIA are approved by the Divisional Clinical Directors and Divisional General Managers before being approved by the Medical Director and Director of Nursing and Quality.

6. Financial & Investment Strategy

An assessment of the Trust's current financial position

As a result of Monitor's intervention, the Trust has focused on addressing the underlying problems but this has been at significant financial cost and the Trust is reporting a year-end deficit of £15.5m for 2012/13. Appendix 1 provides a bridge from the 2012/13 planned deficit (c£12.6m) to the actual deficit (£15.5m) and then to the normalised deficit (c£22.5m). Most of this deficit has been funded by cash resources from within the Trust. The continued deficit means cash would have been exhausted during Q1 of 2013/14 however negotiations with commissioners have resulted in months 11 and 12 of 2013/14 contract income being paid up front with month 1 income. This has provided some cash headroom and thus the requirement for PDC support is delayed until early 2014. Whilst this is welcome it is not a solution in itself, it does enable the Trust to work with stakeholders, including Monitor, to plan and agree the scope and direction of the longer term sustainable plan with 2013/14 being the first year.

The financial bridge in appendix 1 sets out the principal additional costs that have contributed to the deficit in 2012/13 of £15.5m. If the non-recurrent items are stripped out then the real underlying position is a c£22.5m normalised deficit. The significant contributing factors being:

- Undelivered recurring pay CIPs of £5.2m which partly manifests in the variable pay overspend of c£12.8m (directly related to non CIP delivery, high sickness and absences and capacity issues)

- One-off redundancy costs.

The Trust delivered CIPs of £7.7m in 2012/13 equivalent to 3.2% of outturn operating expenditure for the year (£242.8m). However, the Trust is planning for the run rate of CIPs to accelerate throughout 2013/14 to deliver a run rate reduction of £13.3m (5.2%) of net operating expenditure (£253.8m).

Note - Throughout this section of the plan we refer to operating expenditure in 3 different ways so we include the table below to clarify the different definitions using the 13/14 year as the example.

Definitions of Opex	**13/14** **£m**
Gross operating expenditure (before CIP)	265.7
Expenditure CIP (£11.9m out of £13.3m total)	11.9
Net operating expenditure (after CIP)	253.8
Gross operating expenditure less the 2 PFI impacts (see Table 6 , Appendix 1). (£265.7m-£1.6m-£0.4m)	263.7

Table 3

Within a slightly reducing overall cost base, the proportion of CIPs related to employee costs has remained in the region of 67%. Temporary staff expenditure is a significant and continuing problem for the Trust; for example, in 2012/13 agency and contract staff costs were budgeted to be £3m, whilst the actual cost was £11.6m. Compared with its peers, the Trust has consistently underperformed in controlling its levels of usage of temporary staff and such staff mix comes at a premium.

The Trust's PFI scheme is constructed in such a manner that the interest and debt payment attracts an annual RPI uplift. Under IFRS, the resultant uplift is added to the service charge and flows through as operating expenditure thus impacting the EBITDA calculation. A secondary financial impact occurs due to differences between RPI and NHS funding for inflation with the RPI impacts being much higher. For 2013/14 these two factors have an in year impact of just over £2m.

The table below demonstrates the results of these PFI impacts. A more detailed analysis is provided at Table 6 in Appendix 1.

	2012/13 %	2013/14 %	2014/15 %	2015/16 %	2016/17 %	2017/18 %
EBITDA – PFI adjusted	5.3	2.5	3.1	4.2	5.2	6.1
EBITDA	4.9	1.7	2.0	2.7	3.3	3.8

Table 4

The table shows that the 2012/13 EBITDA adjusted for PFI impacts (5.3%) is much nearer to the average performance of the FT community (5.8%). Going forward the plans project this performance to initially fall and then to return to acceptable levels in 2016/17 onwards. The impact of the PFI is the key barrier to a sustainable future.

Extensive analysis, assessment and modelling have been undertaken to understand better the reasons for the Trust being in deficit. The analysis of the future financial position is based on the Trust's normalised position. In the course of this analysis, three key drivers for the annual deficits have emerged:

- *Assets* – The Trust owns a significant amount of land and buildings (licensed to PFI until 2043) and some of these assets could be more efficiently used. In addition, the Trust's PFI assets are significantly more expensive than the average cost of NHS estate. Current payment arrangements mean the Trust is not being adequately recompensed for the costs of the PFI-funded buildings. The Trust also needs to invest significantly in the retained estate not renewed under the PFI. The scale of this investment will only be properly understood once the clinical strategy is finalised.
- *Operational efficiency* – When compared with their peers, the Trust is less efficient in a range of areas; particularly staffing
- *Leadership* – The Trust has undergone a series of reviews and turnaround programmes over the last two years, which have not resulted in the intended action. In addition, a lack of clinical and managerial leadership capacity and an insufficiently developed organisational culture have meant lasting improvements have not been delivered.

Key Financial Priorities

The aim is to embed transformation into *business as usual* so that it becomes standard practice to routinely undertake service line and budget reviews, keep up to speed with best practice and to take an innovative approach in the provision of services. The Trust aims to have the principles of on-going transformation embedded across the organisation during 2013.

The Trust has set out a programme of work which is about forward planning and focuses on sustained, long-term benefits. The Trust is also considering how clinical rotas can best be managed in collaboration with other local providers and within network solutions as well as reviewing the optimum levels of staff and facilities to deliver the commissioned services.

The Trust has a three year cumulative savings target of c£40m with a mix of transformation projects and traditional CIPs delivered through the divisions. The transformation projects broadly fall into four categories:

- Efficiency measures – undertaking our business with less cost per unit of output
- Protecting and growing income e.g. avoidance of fines, repatriation
- Service quality – improving patient experience; improvements in booking and scheduling (assertive flow management) of services e.g. theatres and outpatients; reduction in complaints from patients and GPs and
- Planning for changes to the external environment e.g. activity reductions, service reconfigurations and speciality level changes in provision and productivity

CIP programmes will be targeted at previously poor performing areas and will be subject to rigour of reporting and performance management.

The Trust has embarked on a series of actions to improve its financial & performance management environment including finance and performance reporting to the Board and introduction of a focused performance review framework that cascades down to the front line. The emphasis is on turning the performance curve with increased scrutiny through the Finance and Performance Committee.

Capital expenditure is planned to be boosted recognising that the Trust has failed to adequately invest in replacing old equipment and up-dating technologies. An estates strategy is emerging and this is likely to need additional capital over and above that assumed in the table above.

Key Risks and Mitigation

The Trust, like most NHS organisations, faces a challenging financial future. Coupled with other drivers for change, major strategic renewal is essential to maintain clinical services within a financially sustainable organisation. The Trust is actively working with commissioners to ensure the turnaround plan is aligned with their proposals for service changes. Support from CCGs both in the development of a jointly-owned strategy, and in transitional financial support in 2013/14, 2014/15 and beyond, is vital. The Trust is working hard to build robust working relationships with CCGs and individual GP Practices which is seen not only as good business sense but as one of our main mitigating actions.

The payment arrangements in the NHS mean the Trust is not being adequately recompensed for the costs of the PFI-funded buildings. Accordingly, if financial sustainability is to become a reality, then a permanent solution to the PFI premium needs to be brokered with the DH which could be a combination of renegotiation with the provider and/or some form of PFI premium funding. This issue affects several NHS Trusts and therefore a national solution is required to a national problem.

Other key risks and mitigation actions are as follows:

Risk Description	**Mitigation Action(s)**
Non-delivery of CIP plans	• PMO and governance environment is now robust with plans scrutinised and implementation monitored • Clinical engagement in the process has been strengthened • Development of CIPs led by divisions thus ownership is not an issue • Additional project management capacity added to divisions

Clinical income levels not secured	• Working relationship and engagement with CCGs is improving • Clinicians are proactively managing relationships with GPs • Market share analysis undertaken and targeting individual GP practices • Outturn activity has been commissioned • Discussions around non-elective thresholds are progressing
Commissioners become over reliant on procurement process to stimulate Any Qualified Provider (AQP)	• Proactive stakeholder management • Actively putting "own house" in order e.g. discharge letters and choose and book
Cash flow	• Agreement with commissioners to pay months 11 and 12 in month 1 • PDC support paper developed

Table 5