Hampshire Hospitals NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

Hampshire 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):

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Date	**4 April 2014**

The attached Operational Plan is intended to reflect the Trust's business plan over the next two years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

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:

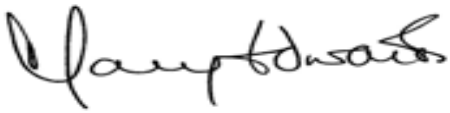
Name *(Chair)*	Elizabeth Padmore

Signature

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Mary Edwards

Signature



Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	David French

Signature

1.2 Executive Summary

A) Summary of year 13/14

- In 13/14, the FT has made significant progress in addressing RTT and A&E target issues. All RTT targets have been achieved each month since July. A&E 4 hour performance has been compliant since August and has remained above 95% each month over the winter period.
- The Clostridium Difficile (C.diff) target for 13/14 was unfortunately not achieved. The FT commissioned a review by Public Health England and is implementing an action plan based on their recommendations and work by the Director of Infection Prevention and Control. The target for 14/15 has been confirmed as 37 cases which the Board believes is challenging but achievable.
- Activity levels over the year were higher than expected, with commissioner intentions of reduced activity through QUIPP schemes not materialising. The impact of clinical fines, particularly for C.diff, meant that the contract over-performance did not fully translate into additional income. Negotiations with CCGs on the final 13/14 out-turn position have not yet concluded.
- CQC inspections took place on both the Basingstoke and Winchester sites during the year. For Basingstoke, five standards were reviewed, of which four were compliant and there was a minor concern on the fifth, 'Medicines Management'. An action plan is in place to address this concern. There was also a CQC visit to the Winchester site as part of a national review of dementia care. We await formal feedback on this visit.
- Final clinical contract values for 13/14 are not yet finalised, but the surplus in 13/14 is expected to be in the range £0m-1m, compared to the plan of £3.5m. Profitability has been below expectations due primarily to clinical penalties, increased staffing levels, particularly nursing staff in response to the Francis Report, and below-Plan CIP performance as organisational efforts were focused on targets achievement and quality improvements.
- CoSRR is forecast to be '3' at year-end and for the remainder of this 2 year planning period.
- The FT is completing a number of major capital investment schemes, notably a new radiotherapy unit and private patient facilities. These schemes, consistent with the Board's objective of increased income diversification, will benefit the financial position in 14/15 and beyond.

B) Summary and Key Messages: 2014/15 and 2015/16

- Clinically led integration of services across the Basingstoke and Winchester sites continues as a priority. The clinical model for HHFT included plans to reconfigure the existing DGH sites and the construction of a new critical treatment hospital. This will deliver clinical and financial sustainability. Work is continuing with commissioners to initiate the public consultation process.
- Affordability issues in the local health economy, particularly in North Hampshire, are a cause for concern. Whilst the *rate* of activity growth has declined, activity levels are not in

line with commissioner intentions who have signalled financial concerns for 14/15. The FT is working closely with commissioners on demand management and pathway redesign projects but is concerned that these schemes may not reduce activity in line with commissioners' plans and budgets. The FT cannot reduce capacity until activity rates reduce and there is risk that activity will be performed for which the CCGs is unable to pay.

- Contracts with major commissioners have not yet been agreed and negotiations are proving to be challenging. The FT's income plan for 14/15 is approximately £8m higher than current contractual offers from CCGs. Given this environment, the FT will be demanding full PbR contracts and an increase in the threshold for non-elective work above which 30% marginal tariff is paid; it is important that the FT is paid appropriately for the activity performed. The FT will adopt a robust approach to contract management through the year.
- For 15/16, CCGs have indicated that contract values will reduce in cash terms and budgets will be transferred from acute providers in line with the Better Care strategy. We have incorporated income reductions in our financial forecast but remain concerned that future activity levels do not reduce in line with commissioner intentions.
- Whilst significant patient benefits and efficiency savings will arise from the implementation of the new clinical model, the importance of improvements in the meantime is acknowledged. A new strategic objective of 'Operational Excellence' has been agreed by the Board, and the FT aims to improve both efficiency and patient experience through the redesign of operational processes such as outpatient appointment booking and telephone call handling etc. These projects are anticipated to contribute strongly to CIP performance, particularly towards the end of 14/15 and throughout 15/16. A senior transformation director has been recruited to lead this programme.
- Capital investment from internally generated funds is planned to be lower than in recent years. This is in response to reducing cash availability and recognition that clinical reprovision will mean that certain facilities currently provided at the two DGH sites will in future be provided elsewhere and hence capital expenditure on those facilities should be minimised. External PDC funding for IT upgrades has been secured and will be utilised appropriately.
- In common with the mid-sized DGH sector, we anticipate financial pressure and risk will intensify further in 14/15 and 15/16. The FT has £5m contingency to mitigate downside risk in 14/15. In 15/16, a small surplus has been forecast but with no contingency included. As year 14/15 progresses, we will monitor trends and their implications for future years which may necessitate some challenging decisions about the services provided.
- Our work on clinical reprovision indicates that the proposed clinical model is the best solution for future clinical, financial and workforce sustainability. We are committed to working with our local partners to deliver this vision for the benefit of our patients and staff.

1.3 Operational Plan

1 Introduction

Hampshire Hospitals NHS Foundation Trust (HHFT) serves a population of approximately 600,000 across Hampshire and parts of west Berkshire. This includes Andover, Basingstoke, Eastleigh and Winchester as well as the surrounding towns and villages.

HHFT has a turnover of £333 million a year and employs more than 5,000 staff. There are 18,000 public and staff members. HHFT is managed by the Board of Directors which consists of the chairman, five other non-executive directors and four executive directors, including the chief executive. Clinical services are organised into three divisions. Each division has a medical director who is supported by an operations director: Surgical Services, Medical Services and Family and Clinical Support Services.

Basingstoke and North Hampshire Hospital (BNHH) and Royal Hampshire County Hospital (RHCH) both provide a full range of planned and emergency services including accident and emergency, general and specialist surgery, general medicine, intensive care, rehabilitation, chemotherapy, diagnostic services, maternity, neonatal, gynaecology, paediatric care and out-patient clinics. Andover War Memorial Hospital (AWMH) provides community and hospital services including a minor injuries unit, outpatient clinics, diagnostic imaging, day surgery, rehabilitation and maternity services.

In addition we provide some specialist services such as intraoperative radiotherapy for breast cancer surgery, treatment for liver cancer, colorectal cancer, a national surgical service for pseudomyxoma peritionei and a regional haemophilia service.

This plan sets out how HHFT plans to deliver high quality services over the next two years. The vision set out by the Board of Directors is:

“We wish to be the focus for healthcare in Hampshire with an excellent reputation for patient care. To achieve this we recognise the need to be an organisation that is innovative and collaborative, working tirelessly to provide outstanding care and treatment to all of our patients.”

The strategic objectives which underpin this vision are:

- Sustaining excellence: provide high quality, readily accessible services delivered by the best quality staff.
- Strategic improvement: provide flexible, modern facilities for our patients and staff.
- Strategic improvement: improve financial performance in order to fund better facilities and services.
- Strategic improvement: exploit technology in order to transform our services and make us more efficient.
- Strategic improvement: improve patient experience through ‘operational excellence’ in administrative processes.

2 Short Term Challenges

HHFT faces a number of key short term challenges which this plan seeks to address or mitigate but many of these challenges are shared across the local health economy. Relationships with our commissioner partners are good but it has nonetheless been difficult to fully determine, define and agree the extent and effect of all of these challenges.

Tariff Deflators, Commissioner Intentions and Affordability

The FT faces continued pressure from tariff deflation (4% gross, 1.5% net) which contributes to a CIP challenge in 14/15 and 15/16. This is exacerbated by the financial challenges faced by our principal commissioners. North Hampshire CCG inherited legacy financial issues from the predecessor PCT and this has not been improved in their recent financial settlement. The CCGs are also preparing for large budget reductions for acute providers in 15/16 as part of the Better Care initiative. Commissioning intentions for the coming 24 months are not consistent with current and historical activity growth levels, with CCGs assuming significant activity reductions being delivered through QUIPP schemes, in line with their view of financial affordability. Historically, these QUIPP schemes have not delivered. HHFT's income assumptions are based on internal forecasts of activity levels and this, in turn, has led to a gap between current CCG contract offers and HHFT's income forecasts.

The volume of activity being performed above the non-elective threshold at a marginal rate of 30% continues to increase and is now unsustainable from both a financial and capacity perspective. The Non-reimbursement of activity over-performance on commissioner contracts has historically been absorbed by the FT, but increasing financial pressure means this cannot be sustained. Clinical engagement in demand management schemes is helping to ensure activity levels more closely match reimbursement.

Risk to Business Security

Commissioners (both health and social care) are increasingly using open-market tender exercises to drive efficiencies and introduce innovative ways of working. As an FT this brings opportunities to develop our commercial expertise and HHFT is confident that we will minimise any downside impact

In the last year HHFT took part in several tender exercises for NHS and non-NHS business, two of which were from local CCGs. HHFT secured the contract to provide geriatric rapid response services to West Hampshire but the extent of reduced income for potential tender losses is likely to leave stranded costs. The pattern of stranded costs is a risk with any loss of work through competitive tender.

Loss or Reduction of Other Income Sources

As an FT, HHFT continues to maintain profitable relationships with other clients such as local private hospital providers and the local community NHS provider for such services such as pathology and EFM services. These other sources of income are subject to pricing pressure and loss of work for long-standing clients who in turn are under pressure to terminate local contracts in favour of nationally negotiated agreements. In response to this, HHFT has strengthened its commercial function to protect existing contracts and seek new opportunities.

Workforce sustainability

In common with all acute hospital organisations, HHFT faces a number of challenges in the changing nature of its medical workforce:

- Reduction in availability and available service commitment in all training grades
- Increasing specialisation of the consultant workforce

- Need for 24/7 cover of clinical specialities
- Increasing consultant delivered care

The clinical strategy aims to reduce service dependency on doctors in training and to centralise the provision of rotas that require 24/7 specialist consultant availability.

3 Quality plans

HHFT's goal is to continuously improve the quality and safety of our patient-centred care. HHFT takes an integrated approach to governance that includes clinical quality, performance and finance. This is widely visible across the organisation and is a fundamental aspect of the organisational structure. The CEO holds the Divisional Medical Directors (senior consultants) accountable for all three elements within our governance framework. They are supported by the Divisional Operations Directors.

Clinical quality is not reported separately from the other aspects of performance but is reviewed alongside them; as such, quality governance is inherent in the day to day running of the organisation. This approach ensures that all aspects of governance are given the same weight and are discussed, reviewed and improved on a daily basis.

The FT has a corporate support function, led by the Chief Medical Officer (CMO) that supports the divisions in all aspects of governance. This expert Governance Team operate across divisions on trust-wide themes such as safety or patient experience and use clear mechanisms of accountability and engagement to ensure specific trust-wide actions are implemented as appropriate. This corporate Governance Team is led by senior clinical staff with full-time managerial support. The Chief Medical Officer is executive lead for this function and for trust wide clinical quality. The Executive Committee consists of the executive directors plus the divisional medical and operations directors. It oversees all governance aspects of the organisations and is, in turn, accountable through the CEO to the Board of Directors. There are specific trust wide groups reporting directly to the Executive Committee which include Patient Safety, Clinical Effectiveness, Patient Experience, and an integrated approach to risk management. There is a Clinical Quality and Safety Committee, chaired by the CMO, where trust-wide quality and clinical governance initiatives are reviewed, monitored and analysed in detail to provide additional assurance. The membership of this group includes executive and non-executive directors.

HHFT is located on three main sites (Basingstoke, Winchester and Andover). This geographical distribution adds the potential for additional risks to occur in areas that might be affected by the move of staff and patients between sites. In response to this challenge, links have been established with the clinical divisions through their Governance Leads and the Associate Medical Directors for Governance each attend a Divisional Governance Board.

The three separate sites also present challenges in interpreting data, as the organisation must be assured that good performance at one site is not masking less good performance at another with the overall numbers for the organisation equalling out. Data reviewed at the Board therefore includes data by site, as well as trust-wide.

The monthly review of governance performed by the Board of Directors includes detailed analysis of SIRIs, patient complaints and thank-you letters, scores and feedback from NHS Choices and Friends & Family. As with clinical metrics, analysis is presented by clinical division and by hospital site.

Quality goals, as defined by our quality strategy and quality account

HHFT has identified a number of quality priorities for 2014/15. The development of these priorities has been an active process with clinical engagement at all levels. The quality priorities for 2014/15 are presented here under the five headings the CQC use and incorporate quality priorities for patient safety, patient experience and clinical effectiveness.

Caring (Patient Safety and Patient Experience)

Priority outcome	Reason for choice	Measurement and monitoring	Reporting
We will ensure call bells are answered in a timely way (patient safety)	The results of national inpatient surveys indicate that patients are concerned about this and that it has an impact on how safe they feel	Development standard and audit against this. This will be monitored by the divisions through Matrons with the expectation that 95% of call bells will be answered within the standard Complaints in relation to call bells will be monitored quarterly	Divisional Governance Boards, Clinical Quality and Safety Committee, Executive Committee and Board of Directors
We will improve patient experience through the delivery of bespoke customer care training for staff and will achieve a reduction in complaints related to staff attitude	The Board of Directors identified this as a key quality priority	Monthly measurement of complaints by category and sub category with areas/departments that have received bespoke customer care training Monitored by divisional governance boards	Divisional Governance Boards, Clinical Quality and Safety Committee, Executive Committee and Board of Directors

Safe (Patient Safety)

Priority outcome	Reason for choice	Measurement and monitoring	Reporting
We will help patients understand their medicines and the side effects associated with them	Patients have told us that they would like more information about medicines at discharge	Feedback will be available through the national inpatient survey with the expectation that 75% of patients will answer yes to the question: did a member of staff explain the purpose of the medicines you were to take home, in a way that you could understand? AuditR will be used to capture feedback in real time Pharmacy will report	Divisional Governance Boards, Clinical Quality and Safety Committee, Executive Committee and Board of Directors

		on the number of calls to the help line as part of the divisional scorecard and KPIs	
We will reduce the time patients spend in unnecessary isolation through the introduction of rapid molecular screening for infectious agents	Rapid screening will prevent patients from being unnecessarily isolated in side rooms	The implementation and impact of this intervention will be monitored and reported on by the Family and Clinical Support Services Division	Infection Control Committee, Family and Clinical Support Services Governance Board, Executive Committee and Board of Directors

Responsive to People's needs (Patient Experience)

Priority outcome	Reason for choice	Measurement and monitoring	Reporting
Patients and their families and carers will receive consistent advice post operatively on discharge from hospital	Staff identified this a quality priority and while patients have told us we provide the right amount of information pre-operatively we have identified that we could improve post-operative information	Develop a consistent, evidence based, procedure specific, post-operative advice for identified procedures Utilise a single discharge advice checklist for use by medical and para-medical staff Quarterly audit at divisional level	Divisional Governance Boards, Clinical Quality and Safety Committee, Executive Committee and Board of Directors
"Patient Listening " sessions will be established for patients to share their experience of our service with us face to face	We receive feedback and information from patients in a number of ways. We intend to use "active listening" in this way because it is extremely powerful in helping front line staff improve patient experience	Patient Listening sessions will be established in Surgery initially, there will be a one session per quarter The impact will be measured through the complaints monitoring process	Divisional Governance Boards, Clinical Quality and Safety Committee, Executive Committee and Board of Directors

Effective (Clinical Effectiveness)

Priority outcome	Reason for choice	Measurement and monitoring	Reporting
We will introduce the requirement for all clinical staff to participate in at least one audit or quality improvement initiative in 2014/15	This will support the culture of continued quality improvement throughout the Trust	This will be monitored through individual annual appraisal and reported on at divisional level The resultant audit activity will be captured on divisional audit plans	Divisional Performance review meetings, Clinical Effectiveness Group, Divisional Governance Boards, Clinical Quality and Safety Committee, Executive Committee and Board of Directors
In theatres they will carry out a	This will support learning from near	This project will be implemented by the	Divisional Governance Boards, Clinical Quality

multidisciplinary "simulation session" once a month to support shared learning and improvement	misses and incidents and this quality priority provides an opportunity for this and involves the multidisciplinary team	Surgical division and progress will be reported at divisional level	and Safety Committee, Executive Committee and Board of Directors

Well Led (Clinical Effectiveness)

Priority outcome	Rationale	Measurement and monitoring	Reporting
We will develop individual consultant dashboards in each of the clinical divisions	This quality priority will support quality and data improvement across the Trust	Clinical areas within each division will be identified to start this work and by the end of the year there will be an individual dashboard in each business unit in each division	Divisional Governance Boards, Clinical Quality and Safety Committee, Executive Committee and Board of Directors

Existing quality concerns (CQC or other parties) and plans to address them

In November 2013 the CQC made an unannounced visit to the Basingstoke site over a period of 3 days. This was a routine or scheduled, unannounced visit and they reviewed compliance against the outcomes below and the inspectors were accompanied by a Mental Health Act commissioner.

Outcome 2 – Consent to care and treatment
Outcome 4 – Care and welfare of people who use services
Outcome 6 – Cooperating with other providers
Outcome 9 – Management of medicines
Outcome 13 – Staffing

The CQC found the hospital was compliant with four of the five essential standards reviewed. The inspectors identified minor concerns in relation to the management of medicines (outcome 9). In response to the findings the Trust submitted an action plan (below) to the CQC which sets out the Trust response.

The inspection included speaking to patients and staff in a range of wards, the emergency department and operating theatres, as well as a review of documentation. In their report, inspectors highlighted good team working, relationships between hospital staff and other agencies, ward leadership and the warm, friendly atmosphere that staff worked to create.

These actions identified here are monitored through the divisional structure and reported on through the governance structure, through to the executive committee and clinical quality and safety committee.

Findings	Action required (specific)	How success will be measured (measurable/achievable)	Named lead	How will this be reported on (realistic/achievable)	Deadline for completion (timeliness)
Management of Medicines					
Medicines were not always being provided in a timely manner for discharge	Improve the timeliness of provision of medications at discharge. Provide additional information for ward staff illustrating what medications are in patients lockers	Support provided leads to improved discharge times and prevents delays Pharmacy tracker implemented both sites National Inpatient Survey (repeated 2014)	Divisional Pharmacists Pharmacy leads - Jo Blain ,Julia Marsh, Jane Hawley, Nichola Jones Governance Team coordinate national survey	Audit and report turn round times to pharmacy board and the divisional governance board Patient satisfaction with discharge process	Audit April 2014 Results Feb 2014 (for 2013)
In ED 3 medicine cupboards and the refrigerator were not locked and were located in a treatment room with an open door	Working with ED staff review and improve the security of medicines in the ED whilst minimising the impact on service delivery	Complete the trust wide audit of storage and develop and action plan with ED staff	Jo Blain	Identify actions and presented to division with an audit report	March 2014
There were gaps in the monitoring of stored medicines and the Trust could not assure itself that medicines were always fit for use	Review the extent of issues that exist regarding medicines storage and determine what actions are required and how these will be managed and monitored	Complete audit on storage and action plan from it	Ruth Whale	Present findings to divisions	March 2014

Auditing of controlled drugs registers by pharmacy staff was not evident since Jan 2013	Urgently complete audit of controlled drugs registers. Establish process to ensure regular repeat audits	Divisional pharmacists review the audit programme Audit of Controlled drugs to be completed for each area every 6 months	Jo Blain, Julia Marsh, Jane Hawley, Nichola Jones	KPI for CD audits are included on the F&SS dashboard and these will be green in March 2014	end Feb 2014 March 2014
Medicines were not always managed safely – only 50% of patients were receiving a medicines reconciliation service by the pharmacy team (note: this is also included in the quality element of the contract)	Determine further actions required to ensure that medicine reconciliation is carried out to manage medicines safely Develop a programme and actions to achieve incremental increase Review skill mix and pharmacist and technician contact time on the wards	Staff skill mix review to focus on this area. Medication reconciliation to be completed for 65% patients within 24 hours by April 2014	Jo Blain, Julia Marsh, Jane Hawley, Nichola Jones, Ruth whale	Data to appear in the data warehouse monthly to highlight areas of service and areas of further action Medicines reconciliation rate to be reported monthly on FCSS dashboard Pharmacy to continue to provide quarterly reporting at the CQRM with Commissioners	April 2014 On-going
Medicines were not always managed safely - the maternity theatre drug book had three signatures missing	Review the practice in maternity theatres with the theatre staff. Identify good practice and determine the appropriate actions	Divisional pharmacist to review storage of medication in theatres Spot checks in addition to the 6 monthly audit will show correct documentation	Nichola Jones	KPI for CD audits are included on the F&SS dashboard and these will be green in March 2014	March 2014

Patients are not always advised of the risks associated with medication	Ensure that patients are advised of the risks associated with their medications and include this as a quality improvement priority for 2014/15	Prepare an in-patient information sheet giving advice about asking for further information and ensure the help-line leaflet distributed Promote the medication help-line to provide additional information Develop / procure drug information sheets for top 20 drugs commenced in hospital	George Byrne and Claire Williams	Quarterly reporting to Board regarding performance against this measure Gather and report on patient feedback in local audits with PEG/PVF Review progress in Board report	Start July 2014 Start July 2014 September 2014

Key quality and performance risks and how these will be managed

C. difficile

HHFT did not achieve its C.diff target of 21 in 13/14. Next year's target will be 37 which appears challenging but achievable. In December 2013, Public Health England (PHE) undertook a support visit at HHFT's invitation to provide further advice and guidance and support improved performance. PHE submitted their report in February 2014 and highlighted many areas of good practice including:

- Coherent, consistent, transparent and well-managed application of national guidance in relation to case ascertainment and reporting
- Infection Prevention and Control is a high priority with Board level engagement
- Good emphasis on cleanliness with a trained rapid response team
- Specialist antibiotic pharmacists providing a valuable resource including audits and antibiotic ward round
- A full-time surveillance co-ordinator in place
- Clear pathways for identification, isolation and management
- Strong refurbishment programme with an emphasis on hand washing facilities

For future planning and improved performance the report also set out several recommendations which HHFT will use as part of its operational plans to improve performance. The Board of Directors has reviewed and approved the following action plan in response to the recommendations.

Action required	Named lead	Deadline for completion
Update the CDI policy to include the adoption of ribotype subtyping when cross contamination is possible. (It should be noted that this is a research tool and not real time monitoring)	DIPC	30 Apr 14
Investigate the epidemiology of community disease in conjunction with PHE / CCDC	DIPC / Infection Control Surveillance Officer	31 Aug 14
Review antibiotic pharmacist provision	Interim Chief Pharmacist	31 Dec 14

Develop an IT work programme for Infection Prevention and Control, including the implementation of flag reminders for antibiotic stop dates and IV/oral switch	DIPC / Consultant microbiologist (antibiotic lead) / Antibiotic Pharmacist / Chief Information Officer	31 Aug 14
Establish a programme for regular promotion of the Trust antibiotic guidelines	Consultant microbiologist (antibiotic lead) / Antibiotic Pharmacist	Ongoing
Implement antibiotic prescribing application for smart phones	Consultant microbiologist (antibiotic lead) / Antibiotic Pharmacist	31 Oct 14
Undertake a failure to isolate audit and implement an action plan as required	Lead Nurse, Infection Prevention and Control	30 Apr 14
Embed full screening tests for all cases of diarrhoea to allow prompt exclusion of infection (allowing management of isolation capacity)	Lead Nurse, Infection Prevention and Control / Laboratory Manager	31 Mar 14

RTT

RTT achievement has been, and continues to be, a challenge. However, robust plans implemented in 13/14 have resulted in full achievement each month since Q2 and a clearer mechanism for early warning of RTT issues through more granular, detailed forecasting. This allows time for proactive action to take place to avoid performance problems. This revised process of RTT management provides increased assurance that RTT performance will be maintained throughout 2014/15.

Overview of how the board derives assurance on the quality of its services and safeguards patient safety

Quality governance is delivered across the organisation through an integrated approach and the arrangements for the Foundation Trust were developed using the Monitor Quality Governance Framework.

The central governance function is led operationally by the Director of Governance who is a senior clinician. The clinical divisions have a monthly divisional governance meeting and clinical governance is reviewed corporately at the Clinical Quality and Safety Committee which reports to the Executive Committee and includes Executive and Non-Executive Directors in its membership. Clinical governance and data quality are also a key part of the monthly divisional performance reviews.

The Directors receive a monthly governance report which includes a quality scorecard and reviews of key elements – patient safety, clinical effectiveness and patient experience. The governance report also includes a monthly internal assessment of compliance with the CQC registration requirements. This is developed from meetings with outcome leads and feedback from the unannounced Governors' visits undertaken with members of the Governance team.

The Monitor Quality Governance Framework is used to assess overall quality governance within the Foundation Trust. This framework is reviewed at the Trust Clinical Safety and Quality Committee.

There is a senior clinical lead for patient safety, a senior clinician who is also part of the governance team

and leads the patient safety work streams within the Trust. Incidents, near misses and SIRIs in relation patient safety are reviewed at the Trust Serious Event Review Group (SERG). They are also reported to the Board of Directors and the Executive Committee in the Governance paper.

Quality plans and the foundation trust's workforce

The development of the quality priorities for 2014/15 has been an active process. Clinical staff have been engaged in the process at all levels, making suggestions from the things that they experience and witness. In addition we have used information from a variety of external sources including feedback from national surveys. We then developed a 'long list', which was also used to inform the 2014/15 contract quality discussions and some of the priorities from the long list have been incorporated in local CQUINs or the quality indicators in the contract with commissioners.

The foundation trust's response to Francis, Berwick and Keogh

HHFT has carefully considered the Francis Report, the findings of the inquiry and the recommendations and identified those recommendations that are relevant to the Trust.

In our review of the Francis Report recommendations we have sought to take a fresh approach to ensure that we capture the good practice that exists and that the ideas for further actions come from across the whole Trust and that these actions are then embedded and make a demonstrable difference. We identified 10 themes which incorporated the recommendations from the Francis Report and we mapped the 8 Keogh ambitions to these and considered Berwick in each of these. Each theme has an executive lead, a champion and a cross Trust working group. This work is not yet completed and will be developed further. Below is a working example of how we are developing responses to the identified themes.

Francis Theme	Actions at Jan 2014
Theme 1 Patient Experience - Putting the patient first	Patient listening event has been held in Cardiology Further event planned for outpatients in Winchester Listening events being planned in surgical division
Theme 3 Effective incorporation of external standards	Care Boards have been developed in some areas of the Family and Clinical Support Services division Mechanism identified for sharing learning points for a wider forum i.e. template to be shared and shared learning points to be collated by the central governance team for displaying on the Governance Intranet pages and a link to be included regularly in Midweek Message
Theme 4 Working together	Senior clinicians are engaged in confirmation of what HHFT can provide in terms of quantity and quality of outcome at contractual discussions Confirm organisational change policy is updated to prompt managers to understand wider impact of change on patient population/health system.
Theme 7 Training and education	Exploratory conversations via a number of reference groups to determine priority and nature of response to this theme

Theme 8 Frontline carers	Established acuity and dependency monitoring at ward level Arrange and carry out CNO ward reviews for Adult Wards Report to Board on the above the actions taken Plan inclusion for other departments and professional groups Q1 2014/15
Theme 9 Ageing population	Focus group to be set up with relatives to understand best ways to communicate Look through a random sample of medical notes to review how patients were communicated Look at implementing an emailing or phone in system (dedicated time) for carers and relatives to speak to a Consultant

4 Operational Improvements, Capacity and Transformation Planning

Short term plans
The Clinical Reprovision Programme (see below) will bring major change in the local health economy as well as for HHFT and provides the focus for transformational activity. However, in the shorter term the FT has undertaken work, and will do further work over the next two years, to address capacity requirements. Many of these schemes align to major capital projects as summarised in section 6. These requirements have been developed in response to growth assumptions and the need to find new ways of working.

Front Door Project
In response to rising numbers of Emergency Department (ED) attendances and the increasing use of the ED service, a new operating model has been introduced in the Basingstoke ED. In partnership with the North Hampshire CCG and the out-of-hours primary care provider, a GP is now present within the ED 24/7 as an extension of the existing out-of-hours process for walk-in / minor patients. Nurse Triage has been replaced with first assessment by an Emergency Nurse Practitioner (ENP) and the patient is treated at first contact by the ENP, then referred to either the ED pathway or to a GP. The results have been positive with up to 20% of walk-in attendances now seeing a GP instead of using the ED pathway.

Building on the momentum and success of the project, 14/15 will see the expansion of the front door programme to include an on-site multi-disciplinary assessment team including social care, and plans to merge the ED and Acute Assessment Units into a more efficient model of streaming patients directly to the appropriate services.

Increased Capacity
There are several programmes underway or planned that will increase capacity in response to demands and opportunities.

As one of two national centres for the treatment of pseudomyxoma, HHFT have responded to a national request to expand its capacity to treat more patients and to begin to treat peritoneal carcinomatosis, a

secondary spread of colorectal cancer. This will require an expansion of ITU capacity for which a business case has been approved.

Likewise, the need for more endoscopy capacity means that in 14/15 additional scoping and specialist decontamination facilities will be completed.

Operational Improvement Schemes

In addition to those schemes outlined above, each clinical division has plans for operational improvement schemes in 14/15 in response to challenges and the quality agenda:

Family and Clinical Support Services Division

- The early pregnancy unit at BNHH now offers an alternative to surgery for some groups of women experiencing a pregnancy loss. This has been evaluated positively and will be introduced at RHCH in 2014.
- Roll out of the ICE IT system to outpatient areas, with a subsequent reduction in paper reports.
- Centralisation of direct access pathology work onto one site.
- Pharmacy plan to improve medication reconciliation and to increase ward-based pharmacy staff.
- Providing more of our services locally.
- Developing seven day working across all our services.
- The phlebotomy service will continue to be extended with services developed in GP practices and other community based settings.

Medical Services Division

- Provide an extended GP integrated service operating within the Emergency Department at RHCH to provide access to primary care during the daytime.
- Develop seven day working with increased access to diagnostics, therapists and pharmacy, working alongside social services and Southern Health.
- Refurbish the Emergency Department at RHCH to provide improved facilities for patients and additional capacity.
- Continue to develop more telehealth initiatives for patients with conditions such as diabetes, COPD and cardiac problems.
- Provide high care respiratory services.
- Develop rapid access clinics for elderly care patients.
- Work with primary care to provide integrated geriatrician services.

Surgical Services Division

- Investment in decontamination and sterilisation services at RHCH.
- Phase 1 of the cancer centre opening in April 2014, to provide radiotherapy treatment.
- Refurbishment programme for the hospice facility on the Andover site
- Expansion of aural nurse-led clinics

The Clinical Reprovision Programme

The establishment of HHFT in 2012 created an organisation serving 587,000 people with a greater economy of scale to enable better financial sustainability and the development of a sustainable workforce.

As the Keogh review into urgent and emergency care identifies there are a number of drivers for change that impact on the majority of hospital providers in England. The specific drivers for the organisations

within Hampshire include:

- To ensure consultant-delivered care 24/7 for the sickest and highest risk patients
- To ensure we can treat more people
- To ensure financial sustainability for the health economy

To deal with these drivers our clinical strategy plans to centralise and co-locate the elements of hospital services that are required for the sickest and most at risk hospital patients (approximately 15%). This will include, for example, services for heart attacks, acute strokes, trauma, emergency surgery, critical care, obstetrics and very sick children. There is a strong relationship between these services in that they all have the same potential need for life-saving support services including critical care (ITU) and specialist interventional radiology. The strong evidence base for this assumption shows that these services should be delivered by fully-trained specialist consultants 24 hours a day, 7 days per week. Our plan proposes that we build a new, state of the art Critical Treatment Hospital between Basingstoke and Winchester to treat this 15% sickest of our patients. The new build would be designed around the emergency pathway to ensure very rapid access to specialist treatment.

The majority of patients (the remaining 85%) do not require the life-saving interventions and support outlined above. The remaining patients require urgent access to walk-in front of house services (eg with a broken arm), rapid assessment service (eg following GP referral), outpatient consultation, diagnostic services (x-ray scanning and pathology), planned medical and surgical interventions (eg endoscopy, surgery), rehabilitation or maternity services (including birthing centres for delivery). These patients can be much better cared for in the appropriate environment of a community-facing general hospital where relevant partner organisations work together to deliver appropriate services. This model is what we will develop in the existing hospitals in Basingstoke and Winchester.

The plans that have been supported by local commissioners and clinicians in and out of hospital have a number of benefits including:

- Guaranteeing consultant-delivered care for the sickest and most at risk patients 24 hours a day, 7 days a week. This will lead to safer care and better outcomes for all.
- Delivering care in the most appropriate facility and facilitating integration with community and social care services.
- Providing local services for communities outside Winchester and Basingstoke such as Eastleigh, Andover, and Alton. This will reduce travelling distances and provide a better experience for patients.

The plans also provide a solution to future financial sustainability. The current projections for secondary care income suggest increasing downward pressure year-on-year. Controlling costs and improving efficiencies continue to be required in all areas of the FT's operations but running the two district general hospital estates in their current states will likely become unaffordable. Consolidating services where appropriate allows economies of scale and more significant service redesign opportunities to improve efficiencies.

The organisation will continue to need to achieve efficiencies over the coming years, but the future clinical model provides efficiency opportunities over-and-above those available in the current clinical

model. These include:

- increased theatre productivity through cohorting and single emergency/overnight theatre provision;
- single rotas for 24/7 activities co-located on central site;
- improved length of stay due to rapid consultant-led assessment, diagnosis and treatment of sickest patients;
- controlled bed capacity against rising activity pressures due to cohorted patient management models;
- reduced duplication in centralised services;
- energy efficiency benefits of new site and estate management efficiencies by optimised use of assets on existing sites.

Our assessment is that the additional costs incurred from the CTH such as loan interest, increased transport costs etc are more than offset by the efficiency savings described above.

During 2014/15 we will complete our public engagement and consultation programme as well as the detailed design work required prior to planning application. We will also submit our proposal to access a loan from the ITFF to cover the build costs for the CTH. Our expectation is that planning will commence in 2014/15 and that the build phase would commence during 2015/16 with a build timeline of 2-2.5 years.

The FT will engage with Monitor further over the coming months as the business case is finalised.

5 Productivity, efficiency and CIPs

HHFT has defined a programme of schemes which will improve quality whilst driving increased productivity. These include CIPs delivering both efficiency savings aswell as transforming the way we work.

Whilst significant patient benefits and efficiency savings will arise from the implementation of the new clinical model, the importance of efficiency improvement in the meantime is fully acknowledged. A new strategic objective of 'Operational Excellence' has been agreed by the Board, and the FT aims to improve both operational efficiency and patient experience through the redesign of administrative processes such as outpatient appointment booking and telephone call handling etc. These projects are anticipated to contribute strongly to CIP performance, particularly towards the end of 14/15 and throughout 15/16. A senior transformation director has been recruited to lead this programme.

The overall Cost Improvement Plan for 14/15 is £10.2m of which 88% is recurrent. Of the £10.2m, £3.5m relates to pay reductions, £1.6m drugs and the remaining £5.1m from non-pay savings. The pay reductions include schemes focused on reducing non-contractual staffing costs (bank, premium rates, extra session payments and overtime), sickness rates, and flexing capacity during the summer period.

Drugs savings are focused on reducing price, prescribing patterns and waste. One of the key deliverable will be the implementation of a new outpatient pharmacy service which is expected to significantly reduce overall drug costs and improve the quality of the pharmacy service provided.

Non-Pay savings include both price reductions and retendering of some existing contracts as well as targeted procurement schemes to reduce spend in areas such as patient transport, prosthesis, mobile

telephony and printing.

In addition, the decommissioning of the Cerner patient information system on the Winchester site and the associated switch to a single HHFT system to capture all aspects of patient information provides significant opportunity for streamlining processes and reducing duplication and inefficiency. Plans are in place to retire the Cerner system by Q1 of calendar year 2015.

The identification and development of CIPs in the divisions has been a combination of central guidance and locally defined initiatives. Where organisation-wide cost saving opportunities exist, for example procurement, they have been identified by the relevant functional area, scoped in conjunction with the clinical divisions and captured in the relevant expenditure budget.

Clinical divisions and corporate support functions were each given a budget target for 14/15 expenditure based on out-turn expenditure for the prior year. This out-turn expenditure was normalised to capture part-year effects and exclude non-recurrent events. CIP schemes were prepared by each division and function to achieve this budget target and these plans were then reviewed by both the Board and senior leadership team including the Medical Directors of each clinical division.

An improved assessment and milestone template for each major scheme will be introduced in 2014/15. As well as taking a more rigorous approach to phasing, the template includes a review and rating of deliverability and clinical and quality impacts. Divisional budget targets were set to ensure that the accepted CIP schemes were equitable and realistic, with accountability for delivery owned at a divisional level. Where the CIP programme is not without risk, the individual assessment of each scheme including mitigation plans means that our overall assessment is that no CIP schemes included in this submission are detrimental to patient safety or clinical quality.

The Trust has expanded the Trust's procurement team which is under new leadership recruited from the retail sector. These appointments provide greater capacity and expertise to deliver non-pay cost reduction. The team has also been restructured to a category management model in line with best practice from the private sector.

6 Financial Plan

The financial outlook remains challenging with another 2 years of continuing tariff deflation and cost inflation. Identification and delivery of CIPs is becoming increasingly difficult and it is recognised that wider transformational changes will be required. The financial pressure from commissioners and threats to income all contribute financial risk to the coming years. If activity reduces, beyond the marginal cost savings, there will be a requirement to take out costs and capacity and this will likely result in stranded costs which will require management to eliminate as quickly as possible.

Income and Costs

HHFT assumptions on clinical income for 14/15 are not wholly aligned with CCGs but dialogue is on-going. Clinical contract negotiations with CCGs for 14/15 are still ongoing and are challenging.

The Foundation Trust's income forecast is based on current year outturn, assumptions around future growth and factors in HHFT's assessment of CCGs' ability to deliver QIPP. In total, the FT's income forecast for 2014/15 is £8m higher than current contractual offers.

The plan assumes that HHFT will fully capture CQUIN payments and negotiations have been led by the quality team with a specific remit to ensure the agreed schemes are realistic and achievable. In year, the FT will robustly performance manage CQUIN delivery.

Contractual penalties are assumed to be minimal over the period; the higher C. diff target in 2014/15 reduces financial exposure to potential fines, as does the lower penalty for each case. Improvements achieved in 14/15 on ED and RTT performance further reduces potential liability to fines. The FT is closely managing performance at a specialty level against all these penalties.

There is an assumed £1.4m additional income arising from the provision of radiotherapy services. This is activity previously delivered by other acute providers which will be repatriated to the new cancer centre on the Basingstoke site which will treat its first patient in April 2014.

Transitional funding support from the SHA relating to the acquisition of Winchester and Eastleigh Healthcare NHS Trust in January 2012 has been received in both 2012/13 (£6.8m) and 2013/14 (£5.4m). No funding is available in 2014/15 and hence the loss of £5.4m compared to 2013/14 represents a financial pressure moving forward.

There has been significant investment in private patient facilities to create a significant expansion of suitable capacity. Completed in January 2014, The Candover Clinic is a stand-alone, purpose-built out-patient unit which includes 12 consulting rooms, two large treatment rooms, a comfortable patient waiting area and dedicated private patient parking. The clinic building incorporates a range of diagnostic suites including MRI, CT, X-Ray and ultrasound. In addition, a new, dedicated private patient ward offers comfortable, friendly and expert care in a high quality environment. The Suite incorporates a 22-bed ward and operating theatres within the same building. The plan includes private patient income of £4.6m in 14/15 and £5.2m in 15/16

The Trust will see an increase in its education funding over the next 2 years as it benefits from the switch to education tariffs and the reallocation of education funding from established centres. The plan assumes an increase of £0.5m in each of the next 2 years in line with the transition path agreed with Health Education Wessex.

The plan assumes the following inflation assumptions:

	Pay	Non-Pay	Drugs
2014/15	1.30%	3.00%	5.00%
2015/16	1.80%	3.00%	5.00%

Staff costs are expected to rise in line with the recently announced pay award guidance of '1% or increment'. The forecast pay assumptions incorporate an assessment of the proportion of staff eligible for increment increases or the 1% increase. For 2015/16, it is assumed that employer pension contributions will rise from 14% to 14.3% and that other pay increases will be 0.2% over and above increases forecast for 14/15. Staff number increases are driven by the expansion of private patient facilities, new radiotherapy services and investment required to meet the anticipated increase in carcinomatosis cases.

A contingency of £4.8m is included in the 14/15 plan to mitigate downside risks such as unpaid over-performance on commissioner contracts and CIP slippage. The 15/16 plan includes no contingency.

There are some potential financial upsides which have *not* been included in the Plan and provide financial protection against unforeseen events should the contingencies included be insufficient. These upsides include the potential sale of land and buildings on the Winchester and Basingstoke sites, and cashflow benefits from the Trust's wholly owned subsidiary company, which has been established to provide a commercial vehicle for the provision of managed clinical facilities to both HHFT and external clients.

In the 'Sensitivity Input' area of the submission template, the FT has tested the impact in 14/15 of i) commissioner income being £8m lower than planned and ii) CIP delivery being only 50% of planned levels. These assumptions assume two significant, simultaneous downsides which, in the view of the FT, do not have a high probability of occurring, but nevertheless have been used to test the FT's resilience to extreme financial pressure. The commissioner income downside would crystallise if CCGs' QIPP and demand management schemes are delivered fully in line with their expectations; these aspirations have not been achieved in previous years. The CIP downside arises if delivery continues at the level seen in 13/14; this is not considered likely following the changes made to the construction and management of the CIP programme.

The FT's response to these downsides includes the release of contingency (£4.8m) and marginal cost savings arising from reduced activity. In addition, bed capacity would be reduced in line with this lower level of activity. For 15/16 and beyond, clinical reprovision and the construction of the Critical Treatment Hospital is a crucial development in addressing longer term sustainability challenges and 14/15 will see further assessments of financial performance. Dependent on the outcomes from these on-going reviews, HHFT has developed options which include step changes which it would implement ahead of construction of the Critical Treatment Hospital. These include the consolidation of ICU, consultant led paediatric services and overnight emergency surgery to a single site rather than the existing two. It is acknowledged that implementing these changes ahead of the building of the Critical Treatment Hospital will be politically contentious for both the FT and local CCG partners.

Capital Plans

The capital plan for the coming 24 months and beyond is, for our existing sites, much reduced from previous years. The resulting positive cash impact is instead being turned towards schemes to facilitate the Clinical Reprovision Programme and the construction of the proposed Critical Treatment Hospital. Despite their relative smaller scale compared with developments in recent years, all schemes are focused on the FT's strategic aims to develop new income streams, drive improvements in patient care, and increase efficiency.

Monitoring of all capital schemes is undertaken by the Executive Committee chaired by the CEO. Excluding the expenditure on the Critical Treatment Hospital (£1.5m), the Trust has planned an internally funded capital programme of £8.8m in 14/15 and £6.8m in 15/16. In addition, external monies have been secured to fund IT investment of £1.5m and an upgrade of the hospice facility on the Andover site.

The key schemes over the next two years include:

- £1.6m investment in a 3rd endoscopy room on the Basingstoke site to deliver additional capacity as well as an additional £0.5m investment in endoscopy decontamination at the Winchester site in order to improve productivity.

- £1.1m investment in a replacement interventional radiology suite.

- £3.1m IT investment of which £1.5m is externally funded from the '*Safer Hospitals Safer Wards*' fund in 14/15, with an additional £1.2m of capital expenditure in 15/16 to further develop the IT infrastructure and clinical systems.

- £1.5m backlog maintenance in each year totalling £3m addressing all high priority concerns.

- Other costs include continued investment in, and replacement of, equipment totalling approximately £2.7m.

Critical Treatment Hospital

The 14/15 capital plan assumes £1.5m in costs, primarily professional fees, which will be incurred in Q1 and Q2 14/15 to develop design plans to support the submission to local authority for planning permission. Upon planning approval, a further £6.2m spend in 14/15 will include the purchase of land, more detailed architect plans fees and the commencement of construction. In 15/16, capital expenditure of £49.8m is assumed for the build costs. Funding is assumed to be secured from ITFF for the entire project. Clearly this plan is subject to public consultation, commissioner support, ITFF funding approval and Monitor review but has been included in this APR submission following discussion with Monitor. Monitor should note that the final business case submission may differ from the figures quoted in this APR submission as plans are finalised over the coming months.

Liquidity and Risk Ratings

The FT has reduced its cash reserves over the past 2 years following significant investment in its estate and facilities.

The FT forecasts that it will exit 13/14 with cash on hand of £19.6m and that in 14/15 the cash balance will reduce by £5.5m to £13.1m. Whilst capital expenditure is within planned levels of depreciation, the plan reflects a cash outflow due to the payment of trade / capital creditors associated with the 13/14 capital programme in Q1 14/15. The 14/15 plan assumes receipt of £1.5m of PDC funding from the '*Safer Hospitals Safer Wards*' fund and £7.7m of external funding (ITFF) for the Critical Treatment Hospital. Loan interest and a capital repayment schedule has been included.

In 15/16 the overall cash position is planned to improve due primarily to reduced capital investment.

The FT forecasts that it will maintain a Continuity of Service Rating of '3' throughout 14/15 and 15/16 with sufficient surplus to fund debt and the maintenance of sufficient net assets to manage liquidity.