Medway NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

Medway NHS Foundation Trust

v1.0

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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The operational plan attached is an interim view only following the recent appointment of a new interim Chairman and CEO, as a result of the substantial quality, financial, and governance issues identified by Monitor. The plans have been reviewed by the Board, but in their current form are not adequate to ensure the long term sustainability of the Trust. Further work will be completed in co-operation with Monitor and others over the next few months to develop a more comprehensive strategic plan.

Approved on behalf of the Board of Directors by:

Name *(Chair)*	Christopher Langley

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Nigel Beverley

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	David Meikle

Signature 

Executive Summary

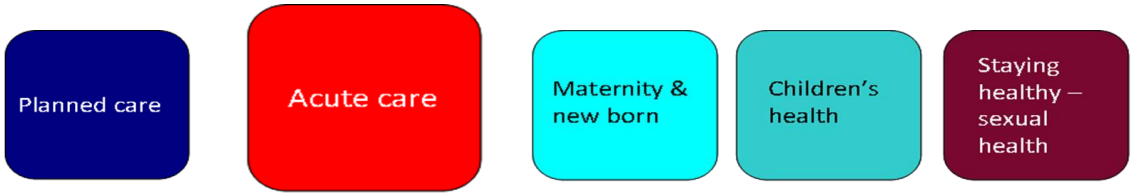
This plan sets out how we intend to deliver high quality and cost effective services for our patients over the next two years (2014/15 to 2015/16). We are one of four acute trusts in Kent, primarily providing acute secondary care to a population of over 400,000 in Medway and Swale, with a budget of c. £245m in 2014/15.

The short term challenge

In assessing our short term challenge, we have taken into account:

- local health economy challenges;
- national challenges;
- national and local commissioning priorities; and
- short term challenges specific to the Trust.

Our main service lines are:



Our key focus over the next two years is to work with our partners and stakeholders across the local health economy to improve the quality of services we provide to the local population we serve, and specifically the acute emergency care pathway.

Quality goals

We have five strategic objectives, each underpinned by three sub-objectives, led by executive directors and overseen by Board committees, with quality at the heart of everything we do. At an operational level, our transformation programme, **Transforming Medway**, sets out how we will improve over the next two years:

- leading the way on emergency acute care;
- excellent system relationships;
- an organisation that desires to improve even more;
- well managed patient flow;
- positive staff engagement and culture;
- top performing patient experience; and
- top performing clinical outcomes.

Existing quality concerns

We are addressing all quality concerns, with robust plans underway to address them:

- Professor Sir Bruce Keogh's review into the quality of care and treatment at 14 hospital trusts – we have a Quality Improvement Plan in place due to be completed by June 2014, with 90% of actions currently on track or delivered;
- Care Quality Commission inspections of maternity services and emergency department in 2013 – warning notices were issued following these reviews and action plans have been implemented;

- ongoing difficulty in sustainably achieving the 95% access quality standard – with renewed operational focus on achieving and maintaining this national target from March 2014 onwards;
- Francis report – an action plan has been in place since March 2013 to implement the relevant recommendations and progress is reviewed by the Board;
- we have attempted to address issues in relation to higher than expected mortality rates through a multiagency Mortality Working Group. This will continue, with a focus on whole health economy issues, but a more internally-focused group led by the Medical Director will oversee the internal improvement projects that are underway, as well as those which are part of Transforming Medway; and
- an external review of our quality governance systems highlighted a number of ways in which we could improve our quality systems and processes. We have detailed plans in place to address these in 2014/15.

Moving forward with a single plan: Transforming Medway

We realise that to fully achieve the transformation required, we need to bring together all our actions in train across our services in order to become a top performing hospital, and acknowledge that our journey will be challenging. Our transformation programme, Transforming Medway, unifies and builds on the plans already underway and progress made. It is the implementation of this programme that is our focus for the next two years.

An assessment of the key issues affecting quality has led to the identification and agreement of seven priority tasks for improvement and change:

- improve the emergency pathway (primary focus);
- ensure we have sufficient well trained staff at all times;
- further improve management of the deteriorating patient;
- deliver fit for the future information systems;
- provide an excellent patient experience (primary focus);
- standardise key treatment pathways to improve outcomes; and
- improve communication and enable leadership throughout Medway NHS Foundation Trust.

These have been developed into workstreams to be implemented across 2014-16, with our primary focus being on improving the emergency pathway and providing an excellent patient experience.

Key risks

Key risks have been identified in the implementation of Transforming Medway, all with mitigating actions, and are closely monitored by an Executive Steering Group.

Quality assurance

In 2013/14, an external quality governance assurance framework review and both internal and external corporate governance reviews were undertaken and recommendations will be implemented in 2014/15, to ensure that our governance systems are fit for purpose. We also have governance, audit and patient safety leads in each division, and in Quarter 1 2014/15, our Director of Transformation will be establishing a new programme management office to support the delivery of our change programmes.

Operational requirements and capacity

Our hospital's physical capacity and layout are both sub-optimal. A number of projects are proposed over the next two years to improve our physical capacity and hospital layout, most notably the centralisation and development of emergency facilities ('The Medway Emergency Village', a key part of Transforming Medway), which will result in facilities that support our staff to deliver excellent care, improving patient flow and productivity.

We propose to significantly increase our emergency assessment bed base, but over time it is expected that, with new ways of working through Transforming Medway, seven day services and improved community and primary care, less inpatient beds will be necessary within the hospital. However, we do not plan to reduce our substantive bed capacity until these new ways of working in the hospital and across the local health economy are fully embedded. In longer term developments, the clinical model for the 'Urgent Care Front Door' is being discussed with partners across the local health economy.

Integral to our planning has been the ongoing development of short and long term workforce plans and we are one of thirteen early adopters of seven day services. A long term workforce transformation plan is being developed.

Productivity, efficiency and cost improvement programmes (CIPs)

We have a number of both traditional and transformational schemes in place to realise productivity, efficiency and cost improvements. Key traditional schemes include procurement and reduction in agency spend, including through improvements in e-rostering. Our transformation plans include the development of the proposed 'Medway Emergency Village' which will see us develop a 'hot' hub of emergency services, ensuring day surgery is the norm for planned elective surgery and the standardisation of pathways, as a key output of Transforming Medway. For 2014-15 the planned CIPs of £6m will be predominantly traditional in nature whilst investment is undertaken in relation to the Transforming Medway programme, whereas in 2015-16, the £14.4m (including full year effect of 2014/15 schemes) CIP programme delivery will focus on more transformational projects, as the investment and changes in models of care and practice are embedded within the organisation.

Financial plan for 2014/15 – 2015/16

We are forecasting a deficit of £29.5m for 2014/15 and a deficit of £29.4m is forecast for 2015/16. The continuity of services risk rating (COSRR) for 2014/15 is projected to be a 2.

The opening cash balance for 2014/15 is expected to be £6.3m. Our cash position throughout the financial year will need to be monitored closely due to the planned deficit in 2014/15. We will need to produce a further cash business case for 2014/15 following the submission of this two year operational plan.

We have a proposed capital programme for 2014/15 amounting to £33.7m and for 2015/16 it will be £16.4m. This will be paid for through internally generated funds and proposed external public dividend capital. The key capital project is the proposed development of the Medway Emergency Village, which includes the refurbishment of our emergency department and development of a co-located Acute Assessment Unit.

Specific provision has been made in our planned expenditure for Transforming Medway, our transformation programme, and specific divisional service developments.

Contents

Note: Appendices are held within a separate, confidential document.

1. Medway NHS Foundation Trust: Overview

Medway NHS Foundation Trust is one of four hospital trusts in Kent and we are predominantly based on one site at Medway Maritime Hospital, in Gillingham, Medway. We primarily serve the populations of the Medway towns (within Medway Unitary Authority) and Swale (within the county of Kent), illustrated in **Figure 1** below.

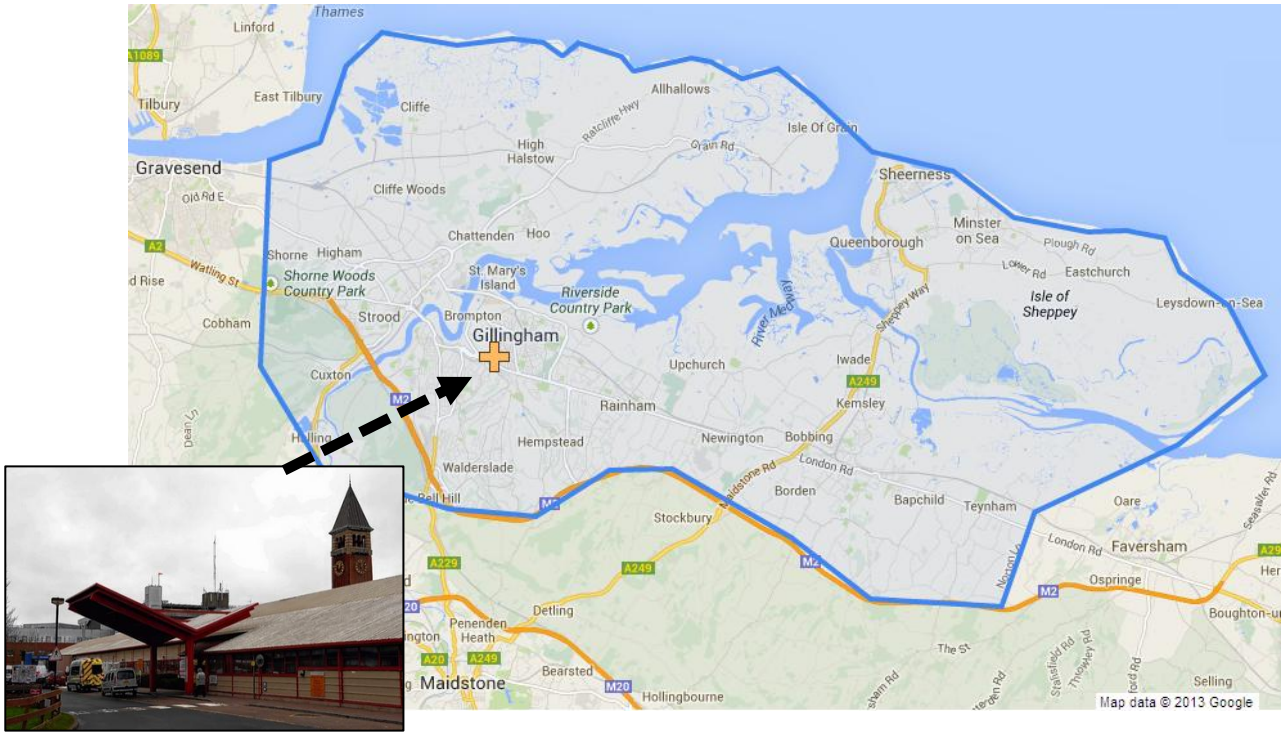


Figure 1: Medway NHS Foundation Trust and our local population

Our service lines encompass five main areas of care, illustrated in **Figure 2**.

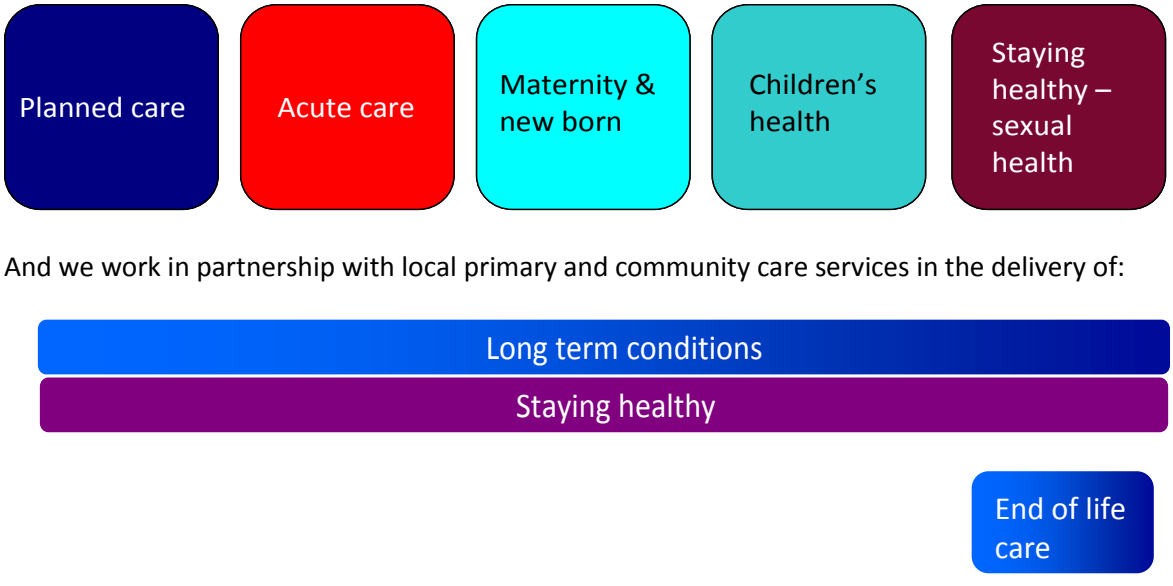


Figure 2: Medway NHS Foundation Trust's main clinical service areas – in line with 'High Quality Care for All' [1]

[1] High Quality Care for All: NHS Next Stage Review Final Report, Darzi (2008)

Table 1 summarises our key statistics for 2012/13:

Key Facts and Figures (2013/14)	
Turnover	£251m
Substantive staff	c. 3,700 wte[2]
Births	4,900 est.[3]
Emergency department attendances	Over 90,000[4]
Outpatient attendances	Over 300,000
Elective activity	Over 30,000
Emergency activity	c. 40,000

Table 1: Key statistics 2013/14

Departments and Services
Accident & Emergency, Breast Surgery, Cardiology, Clinical Haematology, Colorectal Surgery , Dermatology, Diabetic Medicine, Diagnostic Imaging, Ear, Nose and Throat (ENT), Endocrinology, Gastroenterology, General Medicine, General Surgery, Geriatric Medicine, Gynaecology, Interventional Radiology, Medical Oncology, Midwife Episode, Neonatology, Nephrology, Neurology, Nuclear Medicine, Obstetrics, Paediatric Surgery, Paediatrics, Pain Management, Rheumatology, Thoracic Medicine, Trauma & Orthopaedics, Urology, Vascular Surgery, Well Babies

Source: NHS Choices

Specialised Services
Cancer chemotherapy for adults, children, teenagers and young adults, Cardiology: Inherited Cardiac Conditions (All ages), Implantable aids for Microtia, Bone Anchored Hearing Aids and Middle Ear Implants (All Ages), Neonatal Critical Care, Neonatal Critical Care Retrieval (Transport), Complex Gynaecology: Severe endometriosis, Complex Gynaecology: Recurrent prolapse and urinary incontinence, Complex Gynaecology: Urinary fistulae, Specialised Vascular services (Adult), Fetal medicine

The tables below show our activity broken down into top inpatient and outpatient areas (including split between planned and unscheduled care for the top 10 inpatient main specialties):

Top 10 Inpatient Main Specialties as a % of Total Inpatient Activity	TOTAL	Planned	Unscheduled
General Medicine	14%	0.4%	13.3%
General Surgery	13%	7.3%	5.4%
Paediatrics	10%	0.4%	9.5%
Trauma & Orthopaedics	9%	5.8%	3.0%
Urology	9%	6.8%	2.0%
Obstetrics	8%	0.0%	8.2%
ENT	5%	3.4%	1.7%
Gastroenterology	5%	4.1%	0.7%
Gynaecology	5%	3.1%	1.4%
Clinical Haematology	4%	4.1%	0.3%

Table 2: Top inpatient main specialties as % of total inpatient activity, also showing planned and unscheduled split (Jan 2013 – Dec 2013)

Top 10 Outpatient Main Specialties as a % of Total Outpatient Activity	
Dermatology	13%
Trauma & Orthopaedics	12%
ENT	10%
Gynaecology	6%
General Surgery	6%
Rheumatology	6%
Urology	5%
Anaesthetics	5%
General Medicine	5%
Neurology	4%

Table 3: Top 10 outpatient main specialties as a % of total outpatient activity (Jan 2013 – Dec 2013)

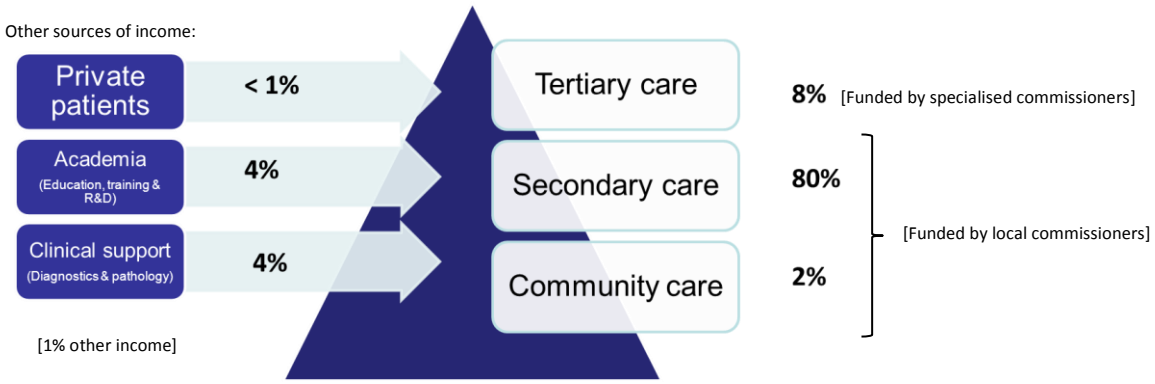
These, together with **Figure 3**, highlight that we are principally a provider of secondary care, with a relatively small portfolio of complimentary tertiary services, focused on sub specialty areas of relative strength.

As part of the national programme of Transforming Community Services in 2011 our local community services were established as a social enterprise Community Interest Company (CIC), which has resulted in our community services portfolio being limited.

We do not have a diversified portfolio of non-clinical income, as shown in **Figure 3** which outlines our main sources of income.

[2] Substantive whole time equivalent
[3] Activity figures are projected end of year figures, extrapolating from existing data
[4] Including c.17,350 attendances at the same day treatment centre on the hospital site, which is run by Medway Community Healthcare

Figure 3: Main sources of income (2012/13)



In terms of balancing our clinical and business models, we face a key underlying challenge - our ability to manage the expected levels of both acute care and planned care over the last three years has been subject to extreme difficulties, which is highlighted by our bed occupancy levels and, over the last year, our sub optimal accident and emergency waiting time performance. Our bed base is heavily dictated by demand for acute care, with a resultant adverse impact on our ability to effectively manage planned care. This has resulted in sub optimal urgent care, with medical patients not placed in those areas of the hospital best designed to provide the care they require, and patients who are to be admitted for planned care too often subject to cancellation. With this there has also been an associated financial implication, as hospitals are relatively better reimbursed for secondary planned care, than secondary acute care.

We started the 2013/2014 financial year in the context that our strategy to develop a balanced clinical and business model was to establish a new North Kent hospitals trust through integration with Dartford and Gravesham NHS Trust, which would have ensured sustainability of services across both main hospital sites and provided an opportunity to grow specialised services in Kent.

In May 2013, we were one of the fourteen trusts visited as part of the NHS England Medical Director, Professor Sir Bruce Keogh, review into the quality of care and treatment provided, based on having been a persistent outlier on the hospital standardised mortality ratio (HSMR). In 2011, our HSMR was 115, while in 2012 our HSMR was 112. In both years we were above the expected range, where a score of 100 means that there had been exactly the same number of observed deaths as expected.[5]

Following the Keogh Review and our imperative to ensure we addressed the issues identified, in tandem with Dartford and Gravesham NHS Trust's new strategic focus towards South London, both parties agreed in September 2013 that the integration should not proceed at this time.

Our two year journey

Our main focus over the next two years is to be an excellent local hospital, providing the highest levels of safety, effectiveness and experience, with particular emphasis on the continuous improvement in the way we provide acute care.

As a NHS foundation trust regulated by both Monitor and the Care Quality Commission (CQC), we aim to reach a position whereby we have a provider licence with no conditions, and a CQC rating which highlights that our services are safe, effective, caring, well led and responsive to people's

[5] Keogh Review Data Pack, 2013 (slides 13 and 14), http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx

needs. Details of the current conditions on our provider licence and CQC notices can be found at **Appendix A**.

Our longer term journey
Supporting our two year journey, we will be working with partners and stakeholders to ensure we have developed integrated plans, which will result in clinically and financially sustainable services for our local populations.

Our future strategic options will be set out in more detail within our five year strategic plan, due to be published later in the year.

2. The short term challenge for Medway and Swale

2.1 National commissioning priorities

National commissioning priorities are brought together in NHS England's vision: high quality care for all, now and for future generations, as illustrated in **Figure 4**.

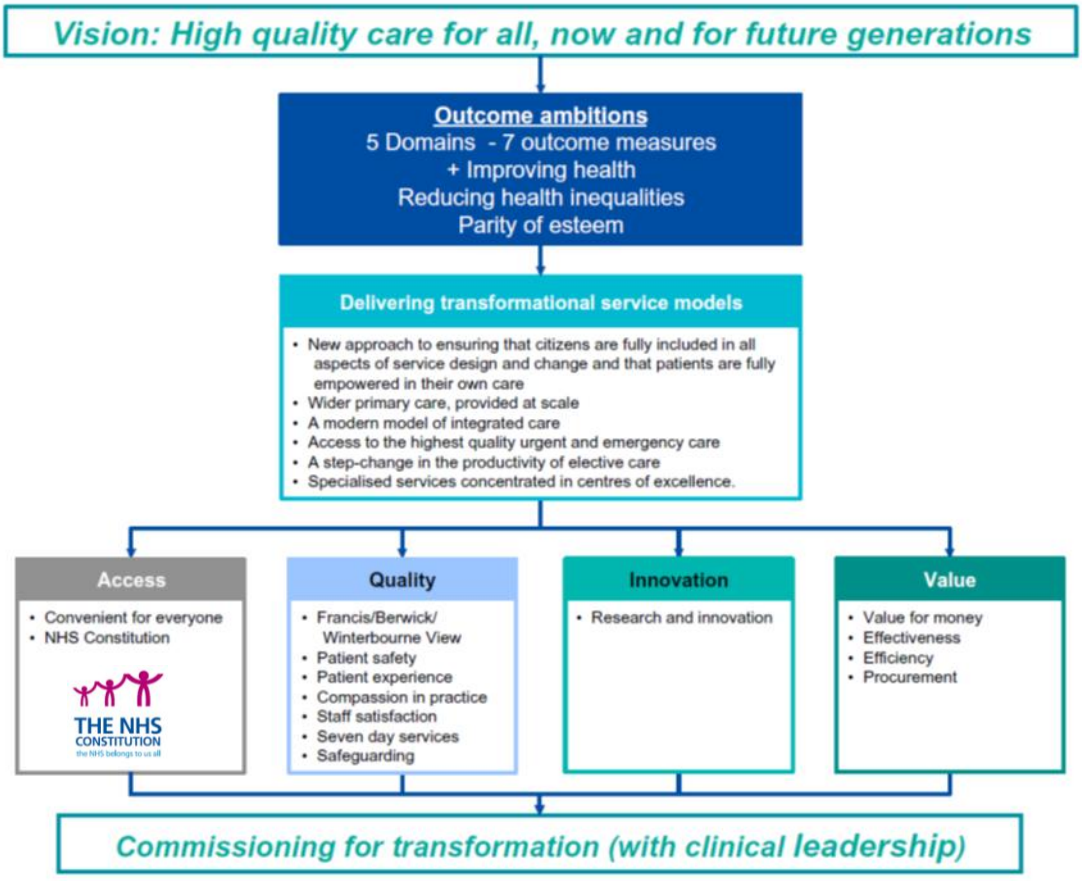


Figure 4: NHS England vision[6]

We need to ensure that the local populations we serve are provided with local hospital services with the highest levels of safety, effectiveness, and experience across all stages of their care.

[6] Everyone Counts: Planning for patients 2014/15 – 2015/16, NHS England, December 2013 (page 5)

2.2 Our local populations

We predominantly serve two distinct populations – those of the Medway towns and Swale. There are a number of common themes when we consider the current situation and projections for both populations:[7]

- growing populations with significant increases in the over 65s;
- significant variation in mortality rates and life expectancy across wards, linked to deprivation;
- unemployment is a significant issue across both Medway and Swale, which is seen as a key factor in driving health and wellbeing and is likely to play a key role in health inequalities seen across the populations;
- significant increase in long term conditions among the over 65s is expected, particularly around dementia, diabetes and heart disease;
- the leading cause of death across Medway and Swale is cancer, with particularly high rates of lung cancer and colorectal cancer; and
- circulatory diseases, such as heart attacks, strokes and heart failure, along with respiratory diseases, such as Chronic Obstructive Pulmonary Disease (COPD), predominantly caused by chronic tobacco smoking, are the next two primary causes of premature death in Medway and Swale.

2.3 Local health economy challenges

These themes indicate key challenges for the local health economy over the next few years:

- chronic conditions, particularly in relation to the increasing elderly population, are likely to result in an increase in intensive health and social care users;
- management of long term conditions, such as diabetes, dementia, respiratory diseases and heart disease, to reduce unnecessary hospital admissions and ensure that when these patients are admitted, they receive appropriate, high quality care, as well as prevention of premature death;
- management and treatment of cancers, as the number one cause of death across Medway and Swale; and
- a focus on prevention, to reduce the incidence of diseases such as lung cancer resulting from smoking, diabetes due to obesity and avoidable emergency department attendances and admissions.

Local Clinical Commissioning Groups have led a piece of work across the local health economy, informed by work undertaken by The King's Fund[8] and Oak Group[9], to review the demand for acute services and how provision could be improved.[10] The findings highlighted that in a 'do nothing' scenario:

- only 16-18% of patients across Kent and Medway are consuming 70% of non-elective bed days in local trusts;
- all populations across North Kent and Medway will see substantial increases in the old and very old groups, meaning that activity and bed use is likely to increase very significantly;
- Accident and Emergency (A&E) demand increases by 9% over the next ten years if it tracks population growth and age structure change; and

[7] Medway's JSNA (July 2013). Public Health Directorate, Medway Council, Chatham, Kent ME4 4TR; and Health and Social Care Map – Swale, Overview, Kent and Medway Public Health Observatory (http://www.kmpho.nhs.uk/health-and-social-care-maps/swale)

[8] The King's Fund is an independent charity working to improve health and health care in England – www.kingsfund.org.uk

[9] Oak Group is an organisation that specialises in comprehensive review and improvement based on emerging healthcare needs - www.theoakgroup.co.uk

[10] Local Health Economy (Medway & Dartford, Gravesham, Swanley and Swale) King's Fund workshops, with input from the Oak Group, were held in December 2013 and January/February 2014 - the findings are taken from the slides used and report that followed the December workshops (owned by Medway and Swale CCGs)

- if performance stayed the same and population changes are taken into account, half a small hospital worth of beds would be needed to cope with the change in demand for hospital stays.

On the basis on these findings, it is clear that the local health economy needs to work together in the development of integrated care. This will be reviewed in more detail in the development of our five year strategic plan.

2.4 Local commissioning priorities

In response to national commissioning priorities, local population and demographic profiles and emerging challenges outlined above, our two primary Clinical Commissioning Groups (CCGs), Medway CCG and Swale CCG, have identified their priorities.

Medway CCG's focus is on preventing illness and re-organising the health (and care) services and pathways locally so that current illnesses can be better managed and better outcomes can be delivered, through high quality services. Medway CCG's objectives are:

- prevention - to prevent people becoming ill and to support people to live healthy and well through a systematic approach in primary care that identifies patients at risk and to achieve this by working closely with the Medway Public Health team and community providers;
- early diagnosis - when people do get ill, to ensure that their condition is diagnosed early to secure better outcomes. This includes helping people to self-diagnose but to also take responsibility to see their GP at the earliest opportunity;
- better care - promoting patient responsibility to choose well; accessing the right services at the right time and in the most appropriate place and empowering patients to be better able to self-manage their own conditions;
- better integration – to secure a seamless transition between providers where patients need the support or intervention of community care, secondary care, social services or the voluntary sector; and
- better end of life care - support people to die in a place of their choice with the support they need to allow that to happen.

These objectives are supported by four additional objectives on quality and safety, value for money, engagement and accountability and transparency. These objectives are delivered through five clinical strategies that focus on the transformations required within the system.

Swale CCG's priorities for 2014/15 also clearly respond to the challenges:

- reduce health inequalities through tackling cancer, cardiovascular and respiratory disease;
- improve the quality of life of people living with long term and complex health conditions and their carers by improving the quality, range and choice of services and giving them information to better manage their own health;
- improve care through integration of services especially for the frail elderly;
- promote wellbeing and mental health;
- transform the life chances for disadvantaged children; and
- improve access, quality, value for money and choice of services in appropriate settings, and where possible closer to home.

These priorities and plans from our key commissioners all highlight the need for greater partnership working across the local health economy, with every organisation playing their part to ensure that the right care is provided in the right place at the right time by the right person. It has been acknowledged that the biggest whole system priority is the urgent care model, which the whole local health economy is working on together, informed by The King's Fund and the Oak Group.

2.5 National key challenges translated locally

In addition to these locally identified challenges, there are challenges that the local health economy must face that apply to all areas across the NHS. These include:

- **The Better Care Fund**

Medway

- Medway's vision for health and social care to 2018/19 reflects Medway's Joint Health and Wellbeing Strategy (2012-17) and is: 'We will foster a healthy and flourishing Medway through an integrated health and social care service that provides the right care, in the right place and at the right time.'
- There are 11 overarching themes (including 3 key themes) to Medway's Better Care Fund Plan:
  - infrastructure development and control;
  - combatting social isolation;
  - reablement, rehabilitation and intermediate services (key theme);
  - community equipment and assertive technology;
  - carers' support;
  - universal information, advice and advocacy;
  - community services redesign (key theme);
  - integrated rapid response;
  - care co-ordination and lead professional (key theme);
  - integrated dementia services; and
  - falls prevention.
- Medway CCG's contribution to the Better Care Fund (£16m) will significantly affect funding of acute services, which includes the proposed impact of a 15% reduction in our non-elective attendances, and highlights how important it is to achieve the optimum urgent care pathway and system interfaces. This includes: the local health economy's work on emergency care, linking to the discussions underway regarding the future clinical model for the 'Urgent Care Front Door', and interfaces between primary, secondary and community care in patient pathways.

Swale

- Swale intends to use their Better Care Fund to integrate health and social care professional teams, enhance neighbourhood care teams supporting GP practices, form a joint accommodation strategy and implementation plan for vulnerable adults needing accommodation and care input (with the project including health and social care centres running within community hospitals), make electronic health and social care records available to patients and relevant services, and implement an enhanced multidisciplinary rehabilitation pathway to enable patients to receive the support they need to manage their conditions and social issues.
- It is anticipated that these areas of focus should result in a decreased need for intense health support at acute level, manifesting in acute hospitals seeing proportionally fewer frail and elderly patients within the hospital setting, fewer unplanned admissions and a reduction in length of stay. Swale CCG's contribution to the Better Care Fund amounts to £6.5m.

Further details of the projected financial impact of the Better Care Fund on us are set out within the financial commentary in **section 10**.

- **IT challenges**
  - As part of the drive to become more efficient, there is the expectation that trusts will be, at least, paper light and preferably paperless by 2018.[11] Therefore, we and neighbouring providers need to be making significant progress towards this in the next two years. E-prescribing is an area of focus for the local health economy in the near future, alongside exploring technology opportunities to support remote working, improvement in patient communications, improving working relationships with GPs and other clinicians (such as order-communications) and supporting more flexible learning and development programmes.

- **Specialised commissioning**
  - Following on from the publication of draft specialised service specifications in 2013, and review of services against these, providers across Kent and Medway are putting derogation action plans into effect. For some services, this includes a review of arrangements across the area, such as vascular services, to ensure sustainable arrangements for high quality care. NHS England is developing a five year specialised commissioning strategy, and some of the key themes are already clear, such as significantly reducing the number of centres providing NHS specialised services, requiring standards of care to be applied consistently and maximising synergy from research and learning.[12] Providers across Kent, Surrey and Sussex are involved in informing the strategy.[13]
    - It has also been noted by local specialised commissioners that no new market entrants for specialised services will be accepted in 2014/15 unless there are clinical safety issues.
    - A summary of the specialised services offered by us can be seen in **section 1**, and their position with regards to the new service specifications can be seen at **Appendix B**.

- **Balancing financial sustainability with public expectation**
  - Balancing financial sustainability and quality of care is a key challenge for all local health economies, and for Medway and Swale in particular, considering:
    - ongoing cost improvement requirements;
    - increasing costs to provide services
    - reduced local health economy funding per capita;
    - flat rate funding combined with increasing populations;
    - populations that are increasingly elderly, suffering complex and chronic illnesses; and
    - ever increasing public expectation.
  - Opportunities for traditional cost improvement programmes to realise benefits are now limited across local health economies, and so the focus needs to move towards transformational programmes - changing ways of working, models of care and patient pathways across organisational boundaries. This will involve more cross-organisational working than ever before.

- **Quality challenges**
  - There have been a number of recent publications and reviews outlining the key quality challenges being faced by local health economies, including the Keogh review and the Francis and Berwick reports. The Keogh review is particularly relevant for the Medway

[11] Everyone Counts: Planning for Patients 2013/14 sets out the expectation of trusts being paperless by 2018, but it has been widely acknowledged that 'paper light' may be more realistic in this timescale.
[12] Everyone counts: Planning for patients 2014/15 to 2018/19
[13] Specialised services five year strategy event – 11 February 2014

and Swale local health economies, with us having been one of fourteen NHS trusts involved (see **section 4** for further detail).

- **7 day services**
  - In 2012, the national NHS agenda highlighted the long standing necessity for NHS services to be provided over seven days.[14] We were very pleased that our application to be one of thirteen early adopter trusts for seven day services was successful, and during 2014/15 and 2015/16, we will be developing plans to deliver seven day services.

2.6 Short term challenges specific to Medway NHS Foundation Trust

Our key focus over the next two years is to work with our partners and stakeholders across the local health economy to improve the quality of services we provide to the local population we serve, and specifically the acute emergency care pathway. This is particularly important given the projections for our local populations' change and growth over the coming years (increasingly elderly and more patients with long term conditions), and this must be supported by Better Care Fund projects.

In addition to the challenges facing both ourselves and partners, we have identified our key service delivery challenges for each of our main areas of service provision, which are summarised in **Table 4.**

In addressing these key internal challenges we need to ensure that we have excellent leadership across all levels of the organisation, robust supporting strategies, systems and infrastructure, and a 'can do' attitude in making sure our local population is served by a first class local hospital.

Our transformation programme, Transforming Medway, has been developed to address these issues.

Table 4: Key clinical service delivery challenges

Acute care	We need to improve our whole emergency pathway and ensure that: ○ we reduce our levels of mortality; ○ we improve our emergency department performance, address the concerns raised by the Care Quality Commission (CQC) and can sustainably achieve the 95% 4 hour access quality standard; ○ our medical and surgical assessment units supporting our emergency department have the appropriate capacity and capability and are co-located next to the emergency department; ○ we introduce new working practices, embracing new ways of working; ○ we improve our capacity management, reduce our bed occupancy resulting in inpatients being placed in the right bed first time, every time; ○ we have the right numbers of the right professionals in the right place, with the right skills and training, at the right time, particularly addressing the balance of registered to non-registered nurses, ensuring essential training compliance and working with Health Education England (Kent, Surrey & Sussex) to ensure continued placement of junior doctors with us; ○ we provide harm-free care, reducing medication delays and errors, preventing falls, implementing effective infection prevention and control, and recognising and responding to deteriorating patients; ○ we improve our patient record keeping; and ○ those patients who no longer require hospital acute care are discharged in a timely manner to services who can better serve their care needs.

[14] Everyone counts: Planning for patients 2013/14

Planned care	We need to: ○ improve our outpatient model so as to ensure we have the right balance between doctors undertaking new and follow up outpatient appointments and having appropriate time for caring for inpatients; ○ ensure, for patients requiring planned surgery, that 'day surgery is the norm', and increase our day surgery to working three sessions a day, initially 5 days a week, moving to 7 days a week once established; ○ improve our working practices and capacity management so that cancellations for elective surgery are significantly reduced; and ○ improve our car parking management to ensure that there is sufficient car parking available on our busiest days.
Maternity & new born	We need to ensure: ○ continued compliance and improvement in the areas identified by the recent CQC inspection of maternity services, including: ratio of midwives to births (1:29), midwifery appraisals and mandatory training, and effective monitoring and assessment of the quality of services; and ○ our fetal medicine service meets the required standards through the specialised commissioning derogation process.
Children's health	We need to ensure we can continue to provide safe, high quality children's services, by: ○ refurbishing and expanding our neonatal intensive care unit; ○ developing improved facilities for paediatric surgery; and ○ ensuring that children can be seen and treated in a dedicated Children's A&E.
Staying healthy – sexual health	We need to review our operational model informed by emerging commissioner intentions, and ensure that our services are located in the most appropriate setting.

Across all these areas, we also have the challenge of infection prevention and control, particularly with the new 'de minimis' target for C. Difficile (14 cases in 2014/15). Our year-end performance for 2013/14 was 13 cases against a target of 25 and this was our best ever performance. Root cause analyses of this year's cases have identified areas for improvement, including the timeliness of specimen taking, and the proactive approach by the Infection Prevention and Control Team will continue on the wards, to monitor and maintain best practice. However, we recognise that delivering such a low target will be a significant challenge, with the low numbers reducing our ability to predict cases. We are ranked 8th in the non-teaching acute trusts category for this measure, with an objective of a rate of 7.7 cases per 100,000 bed days, with the highest objective in this category being a rate of 33 cases per 100,000 bed days.

Our risk register can be seen at **Appendix C.**

3. Our quality goals

3.1 Our strategic objectives: quality is at the heart of what we do

At a strategic level, our vision is to provide Better Care Together, and our number one strategic objective is: **we will provide safe, high quality care and an excellent patient experience**.

Figure 5: Our strategic objectives 2013/14 – 2015/16

Table 5 outlines our strategic sub-objectives, executive leads and their overseeing committees.

Over the next few months, we will be considering our longer term strategic direction and also moving to become a more clinically led organisation. In the context of our developing longer term strategy, our objectives will need to be fully reviewed during the coming months, to ensure alignment with our strategic direction and executive portfolios.

Table 5: Strategic sub-objectives 2014/15 to 2015/16

1. We will provide safe, high quality care and an excellent patient experience **Executive Leads:** Medical Director and Chief Nurse **Overseeing committee:** Quality Committee
1.1 Through Transforming Medway ensure consistently safe services – get care right first time every time **1.2** Through Transforming Medway ensure evidence based care for every patient, including both expanding and promoting research and development **1.3** Through Transforming Medway ensure patient centred delivery: use patient experience insight to improve service delivery and patient satisfaction
2. We will attract and develop a first class workforce **Executive Lead:** Director of Organisational Development and Communications **Overseeing committee:** Workforce Committee
2.1 Capacity Plan: Right professional, right grade, right place, maximising new roles and ways of working seven days/week and in the evenings **2.2** Capability plan: Competent and capable individuals and teams with the right values and behaviours **2.3** Culture and people experience plan: Clear roles and responsibilities for best in class leadership, people and change management; health and wellbeing policies and practice
3. We will run an efficient acute hospital **Executive Lead:** Interim Director of Operations **Overseeing committees:** Performance & Investment Committee
3.1 Deliver the performance improvements in the Transforming Medway Programme **3.2** Achieve top quartile performance on theatre utilisation and day case procedures, new to follow up ratios and length of stay **3.3** Deliver all mandated national targets and CQUINs to improve patient care
4. We will manage our finances prudently **Executive Lead:** Director of Finance **Overseeing committee:** Performance & Investment Committee
4.1 Achieve our finance plan, including delivery of the cost improvement plan **4.2** Invest in our services with a particular focus on improvements in quality and new technology **4.3** Ensure the highest standards of financial governance and improve contract management
5. In partnership, we will develop great healthcare **Executive Lead:** Director of Strategy & Infrastructure **Overseeing committee:** Performance & Investment Committee
5.1 Improve our regulatory status **5.2** Work jointly with partners to develop integrated care **5.3** Work with partners to ensure the medium to long term clinical and financial sustainability of local hospital services

3.2 Operational quality goals for 2014-2016

For 2014-16, our key focus in ensuring we deliver the highest levels of quality is the implementation of our transformation programme, **'Transforming Medway'** – the next step on our improvement journey, following on from the Keogh review and our Quality Improvement Plan. The programme details are attached as **Appendix D**.

Figure 6: Transforming Medway – Our Vision, shows where we are now and what we want to become over the next two years, using the CQC's five key areas of focus. We have a clear primary focus on getting the emergency care pathway right, from both an operational and estates perspective, as the first step.

We have engaged with our members and governors on our priorities for the coming years. Our governors have formally endorsed that they believe Transforming Medway addresses their key priority areas for the coming years, at the Council of Governors meeting in January 2014.

3.3 Quality Account Priorities

Our governors agreed that "first contact, first impressions" should be the guiding principle for identifying the specific patient experience, patient safety and clinical effectiveness priorities, building on the Listening into Action methodology we have successfully adopted in recent years.

Our quality account priorities for 2014/15 are shown in **Table 6**, below.

Table 6: Quality Account Priorities 2014/15

Category	Priority	What we will monitor
Patient Safety	Reduce Mortality	Improve the management of patients who suddenly become unwell
		Implement standardised care bundles and pathways for a five medical and five surgical pathways
		Reduce the number of adult inpatients who experience a fall resulting in a fracture
Patient experience	Improve Appointments	Number of cancelled and changed appointments
		Number of formal complaints relating to the Outpatient Experience to be reduced
	Improve physical hospital environment	Work to improve the bathrooms and toilets across the Trust through delivering the Patient Led Assessment of the Care Environment (PLACE) actions
		Improve both the response rate and the overall score to the Family and Friends test in the emergency department, adult inpatient areas and maternity
Clinical effectiveness	Open new Acute Assessment Unit	Improved patient flow through the emergency pathway, highlighted by consistently delivering the four hour access quality standard

These priorities have been developed from Transforming Medway's goals, as set out in **Figure 6**.

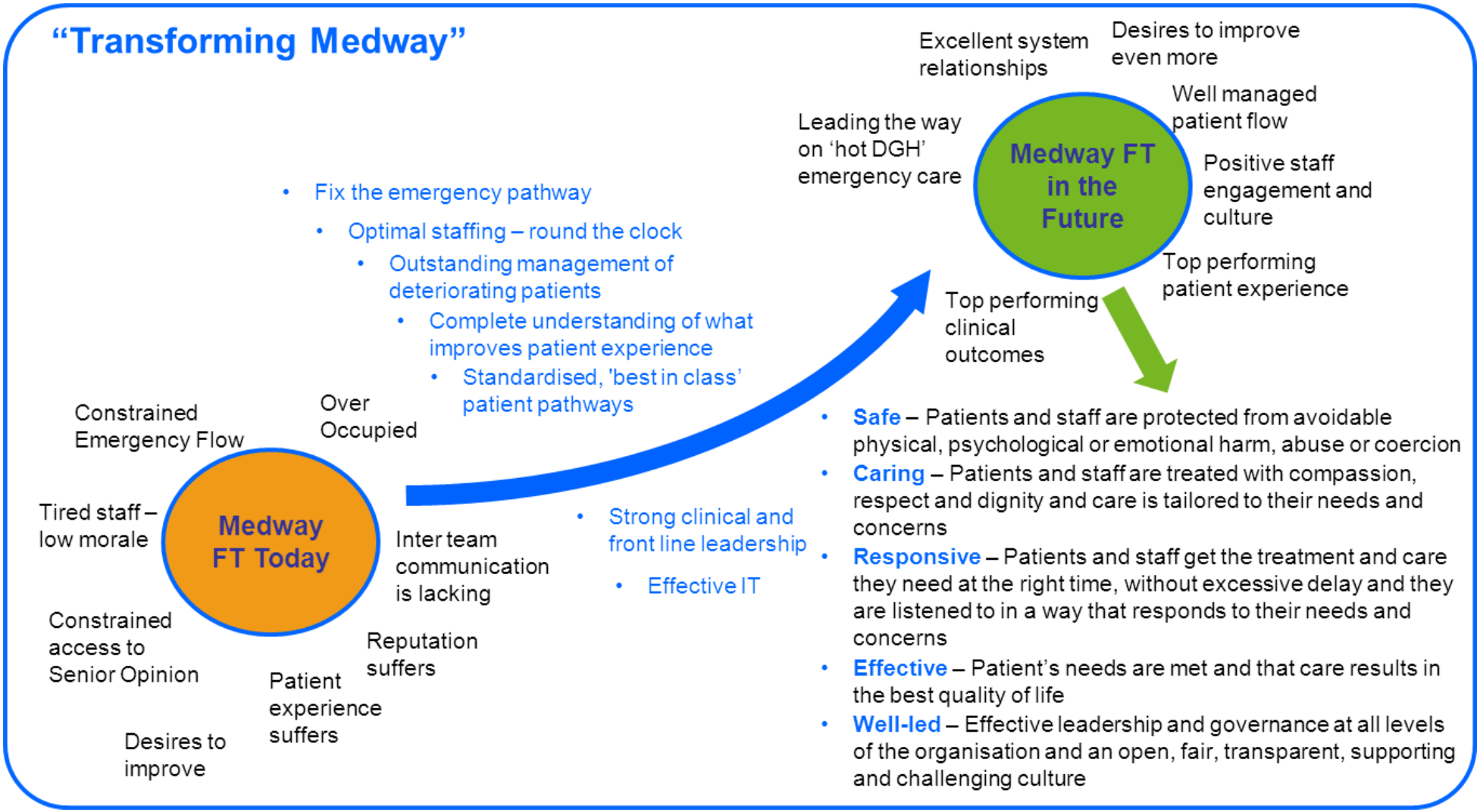


Figure 6: Transforming Medway – Our Vision

4. Existing quality concerns and plans in place to address them

4.1 Our response to the Francis Report and recommendations

We have had an action plan in place in response to the Francis report since March 2013, which is updated regularly and reviewed by our Trust Board, in line with the national requirements to publish our response by 31st December 2013. Our plan can be seen at **Appendix E**.

Furthermore, we have been involved with a whole system North Kent workshop to consider actions taken in response to Francis, Berwick and Keogh reports, and what additional work could be undertaken to further improve.

4.2 Professor Sir Bruce Keogh's Review into the Quality of Care and Treatment at 14 hospital trusts

In spring 2013, we were one of fourteen trusts reviewed as part of Keogh's Review into the Quality of Care and Treatment, due to our high hospital standardised mortality ratio (HSMR). We had already identified our mortality rate as a concern and had founded a Mortality Working Party in November 2012 with local health economy partners to monitor, review and address concerns, but welcomed the NHS England review's scrutiny and recommendations.

The Keogh review identified six areas of focus and improvement:

1. greater pace and clarity of focus at Board level to improve the overall safety and experience of patients;
2. a review of staffing and skill mix to ensure safe care and improve the patient experience;
3. the redesign of unscheduled care and critical care pathways and facilities;
4. improved senior clinical assessment and timely investigations;
5. to galvanise the good work that is already going on in wards and adopt and spread good practice; and
6. the need to improve public reputation.

We have worked with partners to develop a 50 point Quality Improvement Plan to address these areas, which is due to be completed by June 2014. Good progress is being made against this plan, with 90% of actions green or completed (see **Appendix F**).

Since the review:

- we have strengthened our leadership, with a new Chair and Chief Executive in place;
- overhauled our complaints process and cleared our backlog of complaints;
- partnered with East Kent Hospitals University NHS Foundation Trust to improve our informatics; and
- gained more than 100 additional nurses and nursing support staff.

There are 10% of actions which are rated amber, all with mitigating actions in place or requiring stakeholder support:

- extension of the Clinical Training Programme to enable multi-disciplinary teams to learn together – this is being further developed within Transforming Medway and recruitment is underway for a Deputy Director of Multi-Professional Training and Education;
- urgent review of the design and layout of the emergency department, admission and critical care areas to be incorporated in an estate strategy – Transforming Medway is developing this further, enabling works for the proposed development of the 'Medway Emergency

Village' has begun with user groups for each phase established and a timeline in place, and local health economy wide work continues through the Medway and Swale Executive Programme Board; and

- key themes and actions from weekly multi-disciplinary mortality reviews to be reported to the Board monthly – this report is due to start from March 2014, to both the Board and Mortality Working Party, as we move towards current best practice.

This Quality Improvement Plan was the first major step in our improvement journey and the next step is our transformation programme, 'Transforming Medway'. As such, Transforming Medway will take forward and build on the actions and areas of focus within the Quality Improvement Plan (and our Urgent Care Plan, which has been a condition on our licence as noted in **Appendix A**).

4.3 Care Quality Commission

The Care Quality Commission (CQC) introduced a new intelligent monitoring system and inspection regime in 2013. As a 'Keogh trust', we are within Band 1, consisting of those considered to be the highest risk trusts, and expect a full hospital inspection at the end of April 2014. In our March 2013 intelligent monitoring report, we had 6 risks and 5 elevated risks indicated (see **Appendix G**). Our elevated risks referred to mortality and whistleblowing. All our plans incorporate the aim of reducing our mortality rates, and we are involved in the Speak Out Safely Campaign, while our Joint Staff Committee approved a revised whistleblowing policy in March 2014.

In 2013, the CQC carried out unannounced visits to our maternity services and emergency department on separate occasions. Both visits highlighted areas for improvement, and comprehensive action has been taken in both services to address these areas.

4.3.1 Maternity Services

Shortly after the Keogh review took place, the CQC carried out an unannounced inspection of our maternity services. They found three specific areas for urgent improvement, in line with findings from the Keogh review (see **Appendix A** for details). We have taken comprehensive actions to address these areas:

- the ratio of midwives to patients – we have been successful in increasing the ratio of midwives from one to 34 mothers per annum to one to 29 mothers per annum;
- midwifery appraisals and mandatory training - all midwifery staff are professionally registered and competent to discharge their roles, and a programme has been put in place to improve the rate of appraisal and mandatory training completion for our midwives; and
- effective monitoring and assessment of the quality of services - the maternity services team is ensuring that staff understand and are actively involved in the processes and systems for effectively monitoring and assessing the quality of services to continuously improve the safety, outcomes and experience of women's services.

4.3.2 Emergency Department

The CQC carried out an unannounced inspection of our Emergency Department on 31st December 2013. The inspection found two key areas for improvement (see **Appendix A** for details), and we have implemented actions necessary to address these areas:

- care and welfare of people who use the services; and
- cleanliness and infection control.

We have introduced a daily Executive Director led review of the department, implemented a new Executive and Deputy Director rota providing an on site presence seven days a week

and during bank holidays, and patient safety rounds are carried out by the Matron and Consultant three times a day focusing on nutrition, hydration, pain relief, good documentation, talking to patients and a clean, safe environment. We have also recruited more clinical and non-clinical staff, and the Infection Prevention and Control team carry out weekly unannounced visits.

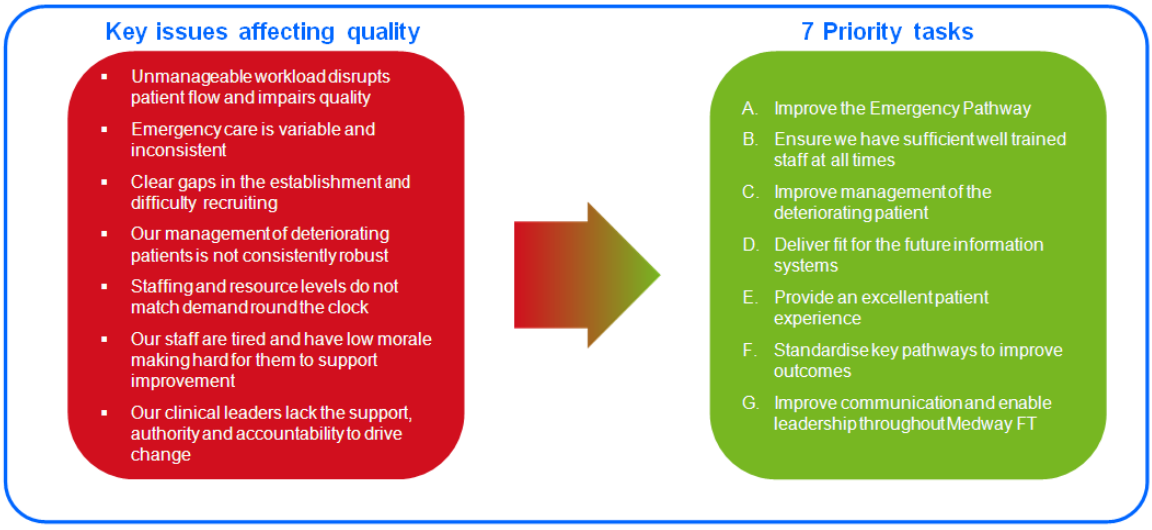
5. Moving forward with a single plan: Transforming Medway

5.1 What is Transforming Medway?

We realise that to fully achieve the transformation required, we need to bring together all our actions in train across our services, in order to become a top performing hospital, and we acknowledge that our journey will be challenging. Our transformation programme, 'Transforming Medway' (as introduced in **section 3**), unifies and builds on the plans already underway and progress made. The implementation of this programme is our focus for the next two years.

In the development of our transformation programme, the key issues affecting quality were identified, leading to the agreement of seven priority tasks, shown in **Figure 7**.

Figure 7: Transforming Medway – key issues leading to 7 priority tasks



These seven priority tasks are being taken forward in the next two years, with our primary focus being:

- A – improve the emergency pathway; and
- E – provide an excellent patient experience.

However, a number of projects under the other areas will be progressing over the next two years.

The sun-beam diagram, **Figure 8,** shows a summary of the programme and its key milestones to 2016. More detailed plans for these workstreams have been developed and can be found within the Transforming Medway document at **Appendix D**.

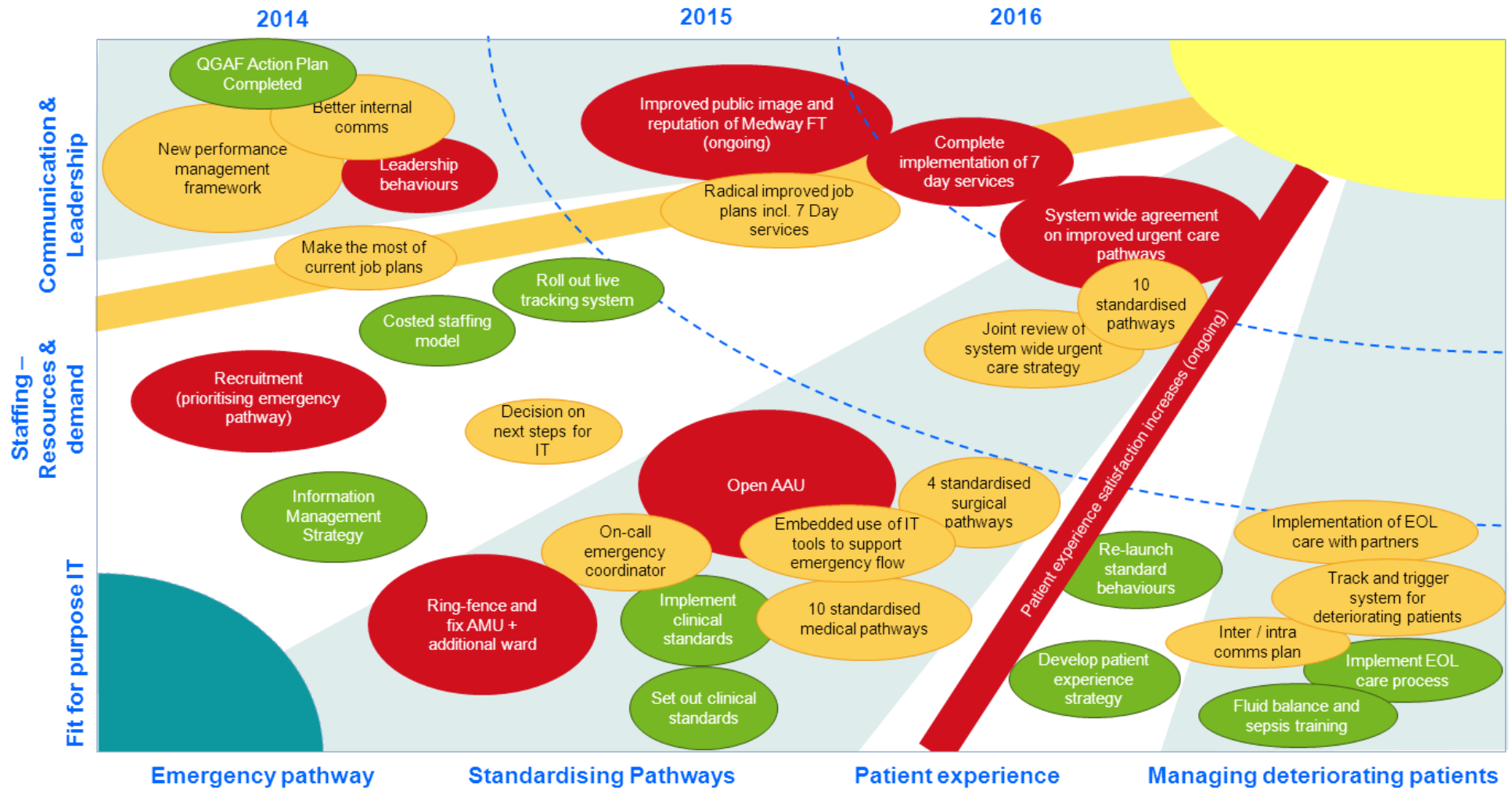


Figure 8: Transforming Medway – Programme Plan to 2016

5.2 Division level plans supporting the delivery of our strategic objectives

The direction of Transforming Medway flows through the organisation, with four new clinical divisions becoming operational as of Quarter 1 2014/15, all with plans in place to support the delivery of Transforming Medway.

Our new operating model and organisational map have been designed to reflect natural patient pathways, resulting in four operating divisions as follows:

- Acute, Emergency Medicine (including critical care)
- Clinical Support (including diagnostics, pharmacy and cancer)
- Surgery, Theatres and Anaesthesia
- Women's and Children's

The divisional management teams will be clinically led structures, with devolved divisions grouped around the key patient pathways, as outlined above. It is at this level that the divisional management arrangements are being strengthened, with a triumvirate structure comprising Divisional Directors, Associate Directors of Operations and Heads of Professions. This Team will also be supported by defined finance, HR, information and clinical governance business partners, and will represent the central unit of operational management. However, ultimate responsibility, accountability and line management will sit with the Divisional Director, who will report directly to the Chief Executive.

These divisional management teams will be expected to develop their plans with the full engagement of their teams and lead delivery, implementation and improvement. They will manage the day to day work of the division and its inter-relationships as well as shaping their culture and strategy within the context of the overall vision, values and strategic objectives of the organisation.

For 2014/15 to 2015/16, our divisions have developed business plans and presented them both to each other and Executives at a Business Planning Challenge Day that we held in January 2014. Their key plans include:

5.2.1 Acute, Emergency Medicine Division

The immediate short term priority is to ensure the sustainable delivery of the four hour access quality standard. New operational processes have been put in place by the Interim Director of Operations, alongside new monitoring and information communication processes established by the division, to achieve this.

Over the next two years, the Division (supported by Estates) is focusing on the delivery of the emergency care pathway through a refurbishment of the Emergency Department and redesign of the hospital's estate to create the proposed 'Medway Emergency Village'. This will realise a larger combined medical and surgical assessment unit (an Acute Assessment Unit) and ensure as many aspects of the emergency care pathway can be co-located as possible. **Figures 9 and 10** shows where emergency care is currently provided (shown by the red crosses), as well as where the proposed acute assessment unit will be located, next to the emergency department, and the new zoning of services.

This will result in improved safety, improved effectiveness in the way we provide care, and a considerably better patient experience. To this purpose, the Division is also continuing its focus on caring appropriately for patients with long term conditions, dementia and the frail elderly, with a dementia unit opened in 2013/14.

Looking forward even further, the clinical model for the 'Urgent Care Front Door' is being discussed with partners across the local health economy, to ensure that patients are seen by the right professional at the right time. We are also in the process of developing a Clinical Estates Strategy to determine the best use of our estate and whether some services would better serve patients and be more cost-effective provided in alternative facilities. This all builds on the work carried out to date with the support of the Emergency Care Intensive Support Team.

Figure 9: Current urgent and emergency care layout at Medway Maritime Hospital

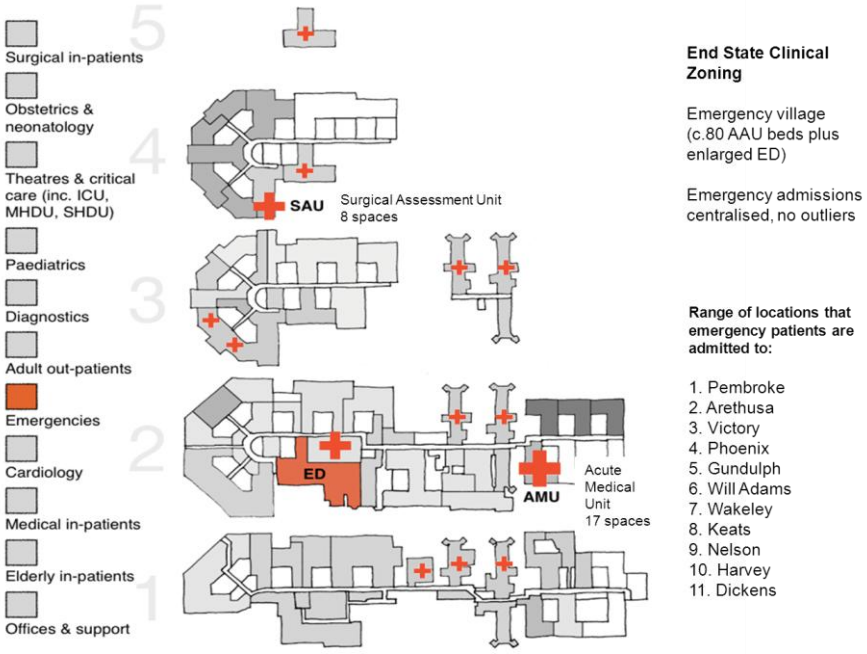
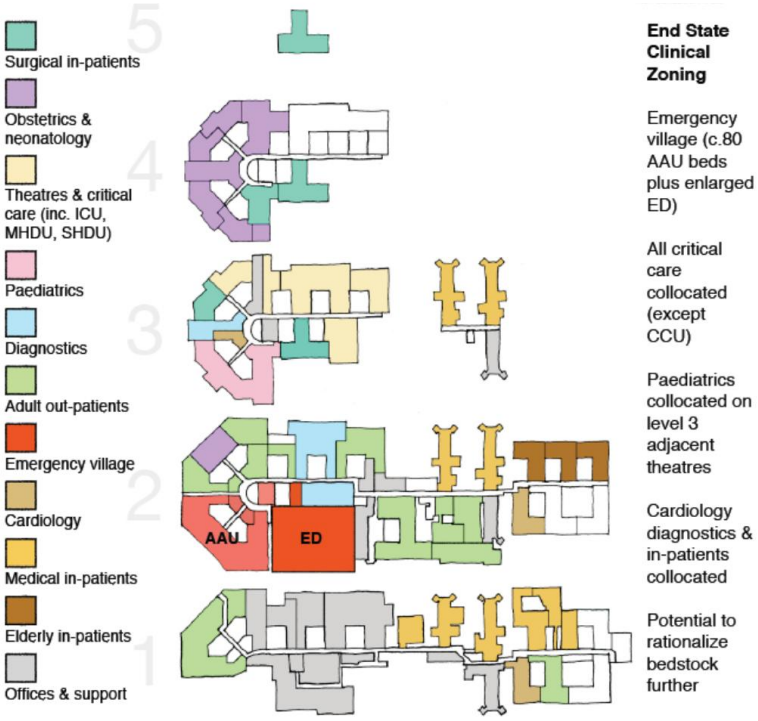


Figure 10: Proposed layout of the Medway Emergency Village and resulting zoning across the Medway Maritime Hospital site



5.2.2 Women's and Children's Division

Women's Health are focusing on embedding the actions from their CQC action plan to ensure safe, high quality care for their patients, improving their emergency gynaecology pathway, to support overall emergency pathway improvement, and are considering the potential to develop some of their gynaecology services to tertiary/centre status level. They are also working with specialised commissioners to ensure that the fetal medicine service meets the new specialised service specification through the derogation process.

Children's Services are working alongside the Emergency Department to facilitate the development of a designated paediatric emergency area, with Estates on the remodelling of the neonatal high dependency unit to ensure that it continues to be fit for purpose, which will result in two additional cots, and also with Surgery, Theatres & Anaesthesia to improve facilities for paediatric surgery, which they are looking to develop further in coming years. They are also hoping to work with local health economy partners on a new community nursing model and as part of the acute assessment unit development estate moves, look forward to being involved in the redesign of the newly located paediatric ward and outpatient area.

5.2.3 Surgery, Theatres and Anaesthesia Division

This Division will be moving to three session days in the Sunderland Day Unit (5 days a week moving to 7 days a week once established), working to improve their emergency care pathways and working with Children's services to improve facilities for paediatric surgery. The Division's aim is to reduce elective cancellations to the required national target of 0.8% by the end of 2014/15. This will be achieved through a number of initiatives:

- revised theatre cancellation policy;
- re-education of theatre staff and clinicians to avoid patient cancellations; and
- all cancelled operations to be approved by the Assistant Director of Operations, Head of Nursing, or Director of Operations.

They are also involved in a Kent and Medway-wide review of vascular services, are recruiting an orthogeriatrician to support the increasing number of elderly patients, and are exploring the potential for a dedicated pain management area, which is a growing and efficient service. With regards to the organisation of physical space, the division will be developing specialty based wards, to enable the delivery of the best clinical care in the right place first time.

5.2.4 Clinical Support Services Division

The teams that make up this Division are working closely with the other divisions to ensure appropriate diagnostic, clinical and pharmacy support for the new emergency pathways and proposed Medway Emergency Village. In addition to this, looking forwards, Diagnostics have carefully considered their growing activity and are in the process of developing a business case for two replacement CT scanners, following on from the replacement MRI scanner recently purchased, which should be operational by Quarter 1 2014/15. Future capital plans include the need to replace the chest x-ray rooms with digital radiography technology and to address the capacity shortfall in accommodation for recovery in imaging.

Cancer services also form part of this division. The team will be recruiting two nurses and an additional consultant for their acute oncology service in 2014/15 and are looking at increasing social work hours and nursing time further. This is to improve their service, in response to the recent review of acute oncology through the National Cancer Peer Review

Programme and the local challenge, with cancer being the number one cause of premature death across Medway and Swale.

In addition to our divisional plans, our corporate teams have plans in place to support the delivery of Transforming Medway and our strategic objectives, including:

5.2.5 Our Finance and Information Teams will be focusing on improving the services provided to divisions and the Trust. Finance will be working on improving its systems and governance, and delivering effective service line reporting, while we have 'buddied' up with East Kent Hospitals University NHS Foundation Trust to improve our informatics. This partnership will include the development of an information management strategy.

5.2.6 Information Management and Technology

A new Patient Administration System (PAS) will go live in Quarter 1 2014/15, and provides a number of opportunities to move away from paper-based systems, and towards paper light or paperless systems. Theatres will be the first area to benefit from moving towards a paperless system, and there will be the opportunity to reduce the use of paper through order communications / results reporting later down the line. The PAS will also enable improved bed management to support reducing length of stay. A real-time bed management system, working in conjunction with electronic whiteboards on wards, and other potential opportunities arising from the new PAS, will be explored throughout 2014/15.

In addition to delivering the new PAS and making the most of the opportunities it presents, the IM&T team will be supporting Transforming Medway by leading the delivery of the track and trigger system for deteriorating patients. The team also continues to work to improve our IT infrastructure, which will include the deployment of a wireless network across the hospital site.

5.2.7 Organisational development, leadership and learning and development

A new multi-professional education and training team will be established in 2014/15. The focus for this team, and the Head of Organisational Development, for the next two years includes:

- creation of a single learning and education development plan and prospectus for the whole organisation;
- launch of new leadership development initiatives at all levels and staff groups, with nursing and medical leadership linking in to design these;
- ensuring all staff access timely mandatory training, professional and management development appropriate to their role;
- embedding the new appraisal process so improvements are seen in the frequency and quality of appraisal, with attention to staff personal objectives being aligned with our strategic objectives; and
- starting a new programme to embed Medway's values and Commitment Framework throughout the employee pathway, and continuing the on-going engagement of staff in cultural and transformational change.

These teams will work closely with the communications and human resources teams to develop a number of projects within the Communications and Leadership workstream of Transforming Medway, including:

- internal communications;
- leadership development;
- performance management; and

- external stakeholder engagement.

5.2.8 Communications and engagement

The communications team are developing a communications plan to support the delivery of Transforming Medway, which is due to include a stakeholder engagement and communications calendar and the launch of a refreshed website and intranet. The team is also focusing on best ways to identify and share positive news, to galvanise best practice, and is considering how our improvements can best be demonstrated.

5.2.9 Human resources (HR)

The HR team impact on all of our strategic objectives, with particular focus on the development and attraction of a first class workforce. This is predominantly achieved through the 'Capacity Plan' element of the Organisational Development and Communications strategy objectives. The HR team are therefore focusing on improving the recruitment processes and timescales, so that staff can be recruited more quickly, using innovative methods of sourcing and attracting staff. This will include the extension of the Rapid Recruitment Programme, as part of the Transforming Medway priorities, which will include the development of new roles and ways of working. The impact of such initiatives are monitored on a monthly basis and reported to the Board and Workforce Committee.

The HR business partners will be members of the new divisional management teams and lead workforce transformation and improvements.

5.2.10 Infection prevention and control

We have an excellent record of mandatory infection prevention and control indicators. The team aims to sustain their annual work plans and are looking to focus learning from mandatory infections to a wider agenda, to improve patient safety. A part of the team's role is assisting in the redevelopment of the site and improving the patient environment.

5.2.11 Patient experience, Patient Advice and Liaison Service (PALS) and complaints

These services will be co-located during 2014/15, with a single point of access. This single point of access will be operated by staff with excellent customer service skills and will have improved opening hours, moving to seven days a week in time. There will be improved triangulation between PALS, complaints and serious incidents, to better understand trends and ensure robust improvement plans and follow up meetings are in place. A key message is to learn from our feedback and complete actions. The teams are also looking to provide more support to divisions to encourage patients to complete the Friends and Family test and other surveys to collect patient feedback, and are considering how technology could help with this.

5.2.12 Research and development

A refreshed research and development strategy is currently being developed, and will include the following ambitions:

- increase staff awareness of research and make research a 'core' event;
- increase patient and public involvement in research;
- increase number of clinical studies and recruitment, and commercial studies;
- widen our research activity;
- increase collaborations with academic partners;
- maximise research grants from external sources; and
- engaging nursing and midwifery in research.

5.2.13 Membership and corporate affairs

Ongoing improvement continues to be made to membership engagement, and the upcoming governor elections will be used as an opportunity to communicate with not only our members, but also patients and the wider public.

A corporate governance review is underway and recommendations will be implemented as appropriate in 2014/15. This review includes consideration of Board committees and their terms of reference as well as a review of good governance with regards to agendas, papers and minutes. A full assessment of our risk management (including the Board Assurance Framework and the Corporate Risk Register) is being carried out.

5.2.14 Clinical audit

A new Trust lead for clinical audit was appointed in 2013/14 and a new clinical audit strategy will be developed during 2014/15. There will be increased focus on quality improvement, including a new database for quality improvement projects signposted to our priorities and outcome measures, in line with Transforming Medway. The team are also exploring options for closer working with Kings College, London.

5.2.15 Risk, governance and legal services

In 2014/15, there will be a re-structure of governance and risk functions, with additional resources allocated, to align governance arrangements. There is also work underway to support divisions in developing their governance structures and leads.

5.3 Partnership working

Transforming Medway was developed with input from key local health economy stakeholders and our own clinicians, and involves some explicit partnership working, such as with East Kent Hospitals University NHS Foundation Trust on Informatics. Aside from the plan itself, we are working in partnership across the local health economy in a number of areas, which we hope to grow over the coming years, including:

The 'Urgent Care Front Door'

It is broadly acknowledged across the local health economy that a significant number of patients arrive at our emergency department who could have been more appropriately cared for in a different setting, despite those options being available to the local communities we serve. In recognition of this issue, discussions are ongoing across the local health economy on the clinical model for the 'Urgent Care Front Door', which could be established in front of our emergency department and staffed by professionals from primary care, community care, mental health services and acute care, so that patients can be appropriate directed and cared for. This concept is currently at discussion stage, with clinical and social models being considered, and we hope to progress to planning in 2014/15.

Integrated Discharge Team

The new Integrated Discharge team (IDT) based on site encompasses staff who have previously worked in separate teams for the hospital, Medway Council, Kent County Council, Medway Community Healthcare and Kent Community Health NHS Trust. The team is led by Medway Community Healthcare.

The IDT assists with discharging patients who require intermediate care or community hospital placement and patients who have complex discharge needs requiring care packages or long term care placement. The team's role is to provide direct liaison with the wards regarding Expected Dates of Discharge (EDD's) to ensure that the relevant discharge process is in place. This includes the

oversight of systems supporting discharge, such as transport and provision of equipment and medications.

From January 2014, the IDT has implemented cluster working - individual team members are now allocated specific wards, as a dedicated point of contact regarding any discharge issues. Clinical triage rounds of the assessment areas, emergency department and the observation ward are also conducted daily.

South East Coast Adult Critical Care and Neonatal Operational Delivery Network
We were selected as the first host of the South East Coast Adult Critical Care and Neonatal Operational Delivery Network in September 2013, and look forward to learning from other trusts in the network, and sharing best practice and innovation.

Kent, Surrey and Sussex Academic Health Science Network (KSS AHSN)
We look forward to working closely, as a full and active member, with our local AHSN. We have active and successful enhancing quality and recovery programmes, which are now hosted by KSS AHSN, and look forward to exploring further opportunities with the network.

5.4 Workforce implications

Workforce reviews are incorporated into the Transforming Medway programme, to ensure that we have the right number of staff with the right training in the right place at the right time for our new models of working. Therefore, we expect to see workforce changes as result of these reviews, but many of the exact changes will not be clear until the reviews are complete. However, our divisions have already identified the potential need for a number of different roles as part of their business planning, which will now proceed to full business case for review, including:

- substantive and increased numbers of acute physicians, with appropriate specialised skills in care of the elderly, to support the development of our proposed 'Emergency Village', and ensure that patients are only admitted to an inpatient bed when clinically necessary;
- two endoscopy nurses to support the move to three session days for endoscopy;
- consultant nurse for elderly care – in recognition of the expected increase in elderly patients;
- review of the paediatric high dependency unit nursing establishment; and
- an additional vascular consultant – to ensure we meet the specialised commissioner's specification for vascular services, supporting our vision to provide excellent emergency care.

In addition, following on from the workforce review undertaken in June 2013, a further nursing and midwifery review was undertaken in February 2014 and our Chief Nurse is currently developing plans to move towards 1:8 nurse to adult inpatient ratio, 24 hours a day, 7 days a week.

6. Transforming Medway: Key risks and mitigations

The Transforming Medway programme's risks and associated mitigations have been identified and reviewed by the Trust Board. These risks and mitigations, with likelihood and impact scorings, can be seen within **Appendix D**, and are monitored by an Executive Steering Group. There is limited financial contingency built into the plan.

We recognise that our priority over the next two years is delivering Transforming Medway, with the redevelopment of the emergency care pathway being a major estates and operational project. In response to this focus, approval to pursue service developments has been limited and the majority of service developments over the next two years have been required to be directly linked to the delivery of Transforming Medway.

7. Quality assurance and safeguarding patient safety

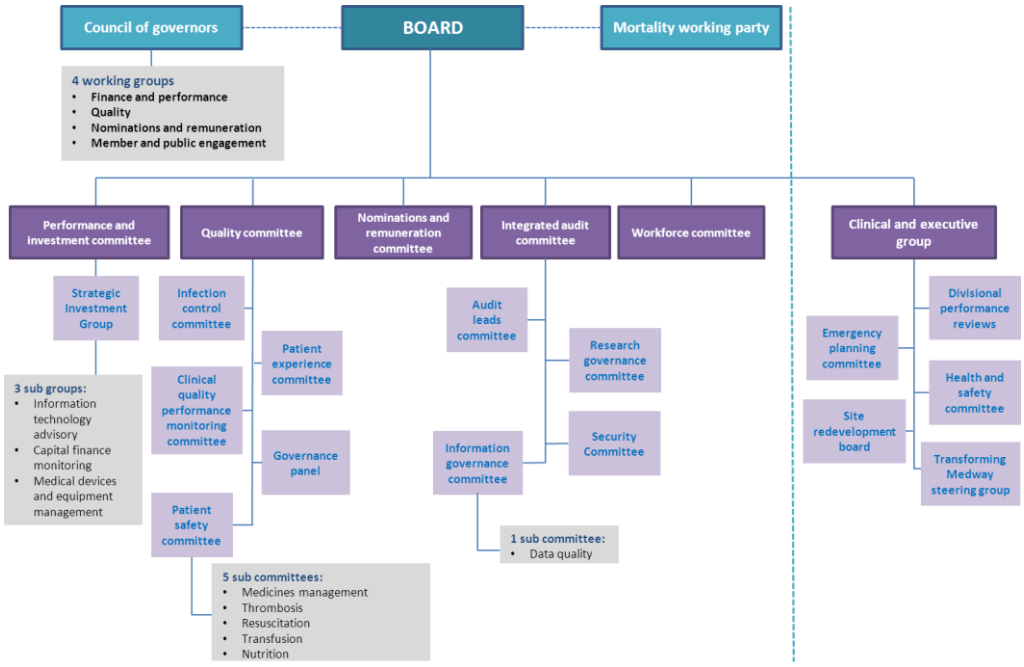
7.1 Quality Governance Assurance Framework Review

In the autumn of 2013, we commissioned an external review of our quality governance arrangements, using Monitor's Quality Governance Assurance Framework. This review was undertaken by KPMG, and resulted in 25 recommendations and an associated action plan, approved by the Trust Board in January 2014. These actions are underway and KPMG will be returning to the Trust within 12 months to confirm completion of these actions. The action plan, including the recommendations, is attached as **Appendix H.**

7.2 Quality governance arrangements - process

Our current Board committee structure can be seen in **Figure 11**.

Figure 11: Trust Board Committee Structure



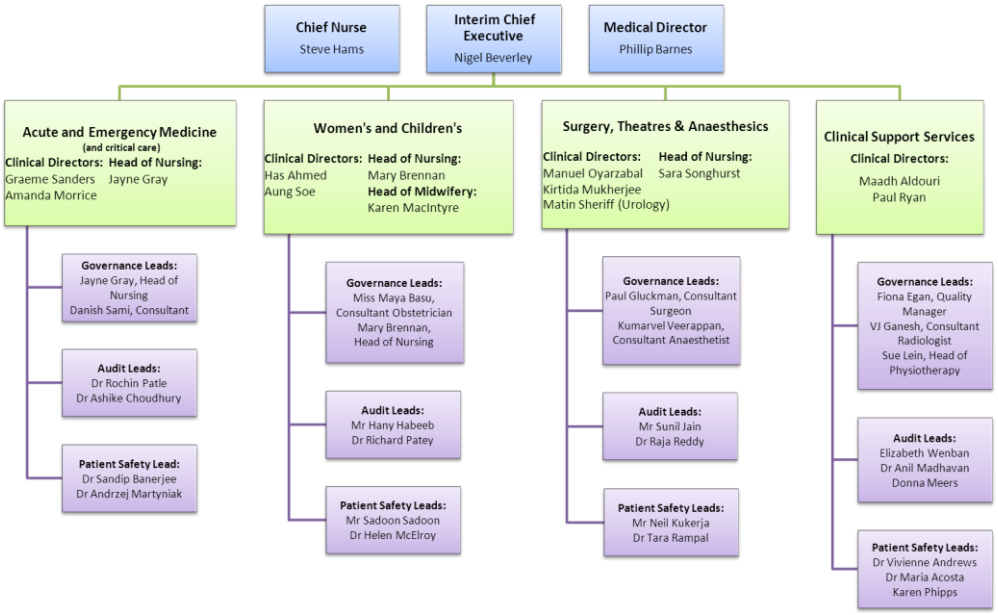
This structure is subject to change, as an external corporate governance review is currently underway to ensure appropriate scrutiny and governance arrangements are in place. Recommendations from the review will be received by the Board in early 2014/15 and will be implemented as appropriate.

7.3 Quality governance arrangements – people

We have dedicated corporate and divisional teams driving our quality agenda, supporting our team of clinical and executive directors. Each of our clinical divisions has patient safety, governance and audit leads, which are either a consultant or head of nursing and current arrangements are highlighted in **Figure 12**.

This structure is being reviewed with the appointment of divisional directors, and also to ensure that governance arrangements appropriately support the new divisions going forwards, as part of the governance workstream within Transforming Medway, therefore is subject to change in the near future.

Figure 12: Divisional governance, audit and patient safety leads



We have appointed a Director of Transformation who will be establishing a new Programme Management Office (PMO) in Quarter 1 2014/15. This PMO will support delivery of all our change programmes, with a primary focus on our vision, values and five strategic objectives. This will ensure clear executive leadership of all programmes and centralisation of project management arrangements for governance purposes. This will be crucial in the delivery of Transforming Medway and the realisation of cost improvement initiatives.

8. Operational requirements and capacity

8.1 Physical capacity

As Transforming Medway acknowledges, the physical capacity and layout at Medway Maritime Hospital is sub optimal and hinders the delivery of safe, efficient and effective patient pathways, and those relating to emergency care in particular.

In response to this, we are:

- developing an acute assessment unit, which combines medical and surgical assessment, resulting in a significantly expanded assessment unit model (as noted in **section 5.2** and shown in **Figure 10**);
- carrying out refurbishment and redevelopment of the emergency department over the next two years to provide increased capacity, a better environment and improved patient flow;
- redeveloping the neonatal high dependency unit, resulting in two extra cots;
- developing paediatric surgery facilities, including recovery, to ensure they meet national guidance, firstly in the Sunderland Day Unit and planning for main theatres;
- developing specialty based wards to enable the delivery of the best clinical care in the right place first time;
- addressing the balance between patient and staff car parking onsite, by exploring the opportunity to procure additional staff car parking offsite so that additional patient car parking can be provided onsite;
- planned refurbishment of hot pathology facilities, in line with the wider reconfiguration of pathology services;
- reviewing the use of our estate by non-acute clinical services and reviewing more appropriate settings of care with commissioners;
- assessing outpatient clinic and administrative space needs in 2014/15 and considering where there are opportunities to move these off the main hospital site, to allow greater space for acute clinical activity, as well as a review of existing off-site facilities; and
- longer term, we are in discussion with partners across the local health economy about developing the 'Urgent Care Front Door', involving primary care, community services, mental health services, secondary care and local councils.

8.2 Workforce

Clinical divisions have developed business plans, a key element of which is the workforce plans for the future, triangulating activity, quality standards, finance and workforce. Part of these plans review the current workforce profile, including key performance indicators (KPIs): turnover, sickness absence, vacancy rates and temporary staffing usage. The workforce plans also include summary qualitative workforce related developments, to support achieving our objectives. Finally, the plans address actions to support the capability of the workforce, assessing current appraisal and mandatory training compliance, with a learning and development plan.

Work is also being progressed to develop a long term (5 year) workforce plan together with a planning tool which will take account of assumed future activity, the move to 7 day services, national minimum clinical standards, integration of pathology services and cost efficiencies. The long term workforce plan will be a key enabler to achieving the service improvements outlined in Transforming Medway.

The overall short term workforce plan has been reviewed by the Workforce Committee and Trust Board, in March 2014, as will the long term workforce plan once fully developed.

In addition to the detailed service specific developments, as noted above in **section 5.4**, Transforming Medway incorporates workforce reviews (starting with a detailed demand, capacity, productivity and skills analysis). Therefore, although it is clear that some workforce changes will be needed to deliver the programme, the exact nature of those changes will not be clear until the reviews are completed. Similarly, seven day services will clearly have a workforce impact, with the relevant model development and requirement reviews built into Transforming Medway.

A summary of the current planned whole time equivalent numbers for the next two years is detailed in our financial return to Monitor. Key headlines from our workforce plan are summarised below:

- our whole time equivalent staff will grow over the next year from 4071.4 (March 2014) to 4091.20 (March 2015), with a reduction in administrative and clerical staff, but an increase in consultants and nursing staff;
- there will be a focus on reducing agency spend with actions being taken both at divisional level and centrally - the Procurement Team aims to reduce agency spend through improved procurement of agencies ultimately by 20-30% and plans to reduce the spend on locum doctors in a similar manner;
- there are a number of Trust Initiated Developments underway to advance the skills of individuals and ensure that current vacant spaces can be filled, including the Leadership Skills Programme, new Consultant Development Programme, Clinical Triumvirate (part of the Clinical Leadership Strategy) and Organising for Quality and Value (delivered with NHSIQ); and
- further development of the workforce plan for the next five years is underway, considering the impact of seven day services and Transforming Medway.

This is supported by a full recruitment plan, and identifies business critical posts.

Operationally, we monitor progress against the plan, by reporting key performance indicators monthly via the Board, Workforce Committee and Clinical Divisional Performance Review Meetings. Supplementary pieces of work include 6 weekly reviews of consultants' workplans and cover on site.

8.3 Beds

In 2014/15, we expect our substantive assessment bed base to increase, through the proposed development of the Medway Emergency Village, which will support new ways of working. In turn, we expect to significantly reduce the use of escalation beds in our hospital, building on the operational changes currently underway to begin this reduction.

It is expected that, over time, the developments identified in Transforming Medway, the implementation of seven day services and the impact of improved community and primary care services for those with chronic conditions and the elderly, will reduce the number of substantive inpatient beds necessary on the hospital's main site and eliminate escalation beds. We see this being achieved particularly through:

- the proposed acute assessment unit (totalling approximately 80 beds in 2015/16, more than doubling our current acute assessment capacity of 17 medical and 8 surgical, which will result in reduced length of stay, and reduced inpatient beds through the establishment of a

new integrated model of acute care within the hospital and across partner agencies) and emergency department refurbishment;
- agreed standardised pathways; and
- improved discharge planning, with the establishment of a highly efficient and effective integrated discharge team supporting complex discharges.

However, we are not planning to reduce our bed capacity until we have embedded new ways of working across the hospital and the local health economy.

A summary of our bed forecasting for the next two years is detailed in our financial return to Monitor.

9. Productivity, efficiency and CIPs

The national efficiency requirement is set at 4%, which, for us, would mean an effective saving of £9.65m. Of this, £6m has been included for delivery in the financial plan for 2014/15, with our focus being on working up and implementing Transforming Medway, which will in time yield productivity, efficiency and cost improvement gains. For 2015/16 a CIP programme of £14.4m (2015/16 programme of £9.65m plus the full year effect of 2014/15 schemes amounting to £4.75m) has been included with a greater focus on transformational programmes resulting from the investment and changes in practices made as part of the Quality Improvement Plan (resulting from the Keogh Review) and during the first year of the Transforming Medway programme in 2014/15.

This is a significant challenge, particularly in ensuring that changes made improve the quality of care, efficiency and effectiveness, and patient experience. We have procured external support to support the identification and implementation planning of cost improvement schemes, and an interim Director of Transformation joined us in March 2014.

9.1 'Traditional' Cost Improvement Programme Schemes

The majority of the programme for 2014/15 is made up of 'traditional' schemes and covers areas such as procurement, medicines management and the NHS Litigation Authority premium. Additionally, we are reviewing not only how we can make our clinical services as efficient as possible, but we are also applying the same expectation to our corporate services.

9.2 Transformational Schemes

Although an element of the 2014/15 programme is more transformational (such as the 3 session days in day surgery), this is more reflective of the approach to savings schemes for 2015/16 as the benefits from Transforming Medway and other system wide changes are realised. Examples of these projects are:

- the proposed development of the 'Medway Emergency Village', which will see a 'hot' end of the hospital developed, with key aspects of the emergency pathway co-located and the formation of a larger, combined medical and surgical assessment unit, to support the 48 hour assessment model and improvement of patient flow. This will ensure that patients are only admitted when necessary, have a smoother patient journey with reduced length of stay and also prevent 'hot' activity impacting on the our ability to continue with planned elective activity. Plans are in place for this development (as noted in **section 5.2**) and the estates aspect is planned to be largely complete by December 2014. New ways of working will be

needed to make the most of the re-developed estate and all divisions will be reviewing their emergency care pathways in 2014/15;

- the introduction of 3 session days in day surgery as the norm, 5 days a week moving to 7 days a week once the model is established. This needs to be implemented with discipline, and relies on the success of the improved emergency pathway to ensure that day surgery is not bedded overnight, which is what currently prevents implementation of this model;
- emergency department refurbishment is due to start in early 2014/15 and will ensure a better working environment for the Emergency Department Team, providing an opportunity for more efficient ways of working;
- standardised pathways, which will improve length of stay, patient flow and patient experience;
- development of specialty based wards for surgical patients to ensure delivery of the best clinical care in the right place first time;
- skill mix and rota reviews across a number of services and divisions and efficient job planning in line with new models of care;
- review of the Children's Services outpatient model, including non-attendance rates, telephone triage and nurse led clinics; and
- new approach to outpatients, including a review and implementation of a standardised approach to outpatient clinics – templates will be reviewed and adjusted to appropriate new to follow up ratios across specialties, with a retrospective review of fulfilment and clinic slot utilisation. These templates will subsequently be reviewed alongside job plans to ensure that the cost is removed or throughput increased.

Further detail can be found within our financial submission to Monitor, outlining values by theme.

10. Financial Plan

10.1 2013/14 Financial outturn

We are forecasting a year end deficit of £9.0m before impairments compared to a planned deficit of £1.2m, therefore adverse to plan by £7.8m. The forecast capital spend for 2013/14 is £15m. The closing cash balance for 2013/14 is £6.3m, which includes Public Dividend Capital (PDC) funding of £7.9m.

10.2 Financial overview

The proposed budget for 2014/15 is a planned deficit of £29.5m, excluding impairments. This equates to a proposed EBITDA of -£13.9m (-6%). We are not currently planning impairments in the next financial year due to the anticipated increase in general property prices. The continuity of services risk rating (COSRR) for 2014/15 and 2015/16 is shown in **Table 7**.

Table 7: Continuity of Services Risk Rating for 2014/15 and 2015/16

	2014/15				2015/16
	Q1	Q2	Q3	Q4	
Liquidity Ratio	1	1	2	3	3
Capital Servicing Capacity	1	1	1	1	1
Weighted COSRR	**1**	**1**	**2**	**2**	**2**

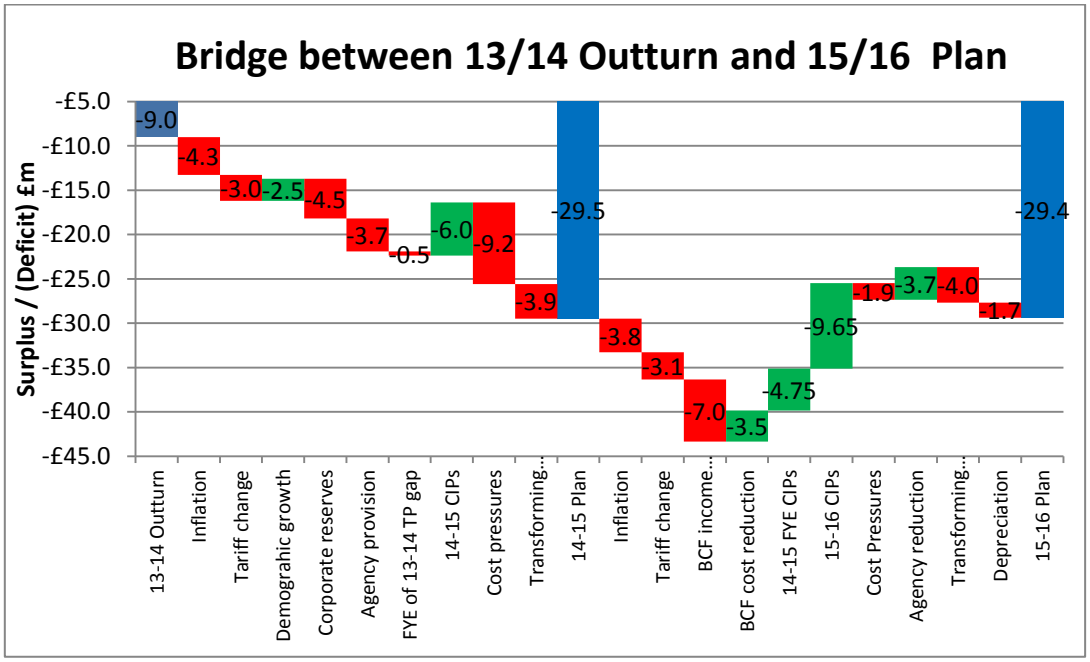
The current Statement of Comprehensive Income (SoCI) for 2014/15 and 2015/16 is as per **Table 8**. A detailed SoCI is included in **Appendix I**.

Table 8: Financial overview

Statement of Comprehensive Income (SoCI)	2013/14 Plan (£m)	2013/14 Forecast (£m)	2014/15 Plan (£m)	2015/16 Plan (£m)
Income				
Clinical Income (Inc Drugs)	217.6	220.1	220.5	210.6
Other	24.2	31.1	24.5	24.7
	241.8	**251.3**	**245.0**	**235.3**
Expenditure				
Pay	-155.3	-165.4	-178.4	-170.5
Drugs	-15.7	-18.5	-18.1	-17.9
Other Non-Pay	-58.3	-63.0	-62.3	-58.7
	-229.4	**-247.0**	**-258.8**	**-247.1**
EBITDA: Surplus / (Deficit)	**12.3**	**4.3**	**-13.8**	**-11.8**
EBITDA %	*5%*	*2%*	*-6%*	*-5%*
Depreciation & other	-8.6	-8.4	-10.3	-12.2
Restructuring Costs	0.0	0.0	-0.3	-0.3
Net Interest	-0.1	-0.1	-0.2	-0.1
PDC Dividend	-4.9	-4.8	-5.0	-5.0
	-13.5	**-13.3**	**-15.7**	**-17.6**
Net Surplus / (Deficit)	**-1.2**	**-9.0**	**-29.5**	**-29.4**

Figure 13 shows a high level bridge analysis showing the movement from the 2013/14 outturn of £9.0m deficit to the current proposed deficit of £29.4m for 2015/16.

Figure 13: Bridge analysis for 2013/14 outturn to 2015/16



The opening cash balance for 2014/15 is expected to be £6.3m, assuming the full draw down of the £7.9m PDC funding requested from the Independent Trust Financing Facility (ITFF). Our cash position

throughout the financial year will need to be monitored closely due to the planned deficit in 2014/15. We will need to produce a further business case for 2014/15 following this two year operational plan submission.

The proposed capital programme for 2014/15 is expected to be £33.7m. It is proposed that this requirement is funded both through internally generated funds of £8.1m and proposed external funding support of £25.6m. The external source of funding is proposed to be in the form of additional PDC.

10.3 Income

As shown in the summary SoCI, the current income plan for 2014/15 is c.£245m. The key components of this are:

- clinical income equating to c.£220.5m - this includes emergency department attendance, outpatients, inpatients, non-payment by results, block payments, commissioning for quality and innovation payments (CQUINs) and high cost drugs income from specialised commissioning; and
- other income equating to c.£24.5m - this includes education and training, research and development, services to other providers and other non-clinical income.

Included within the 2015/16 income plan is an assumption of the commissioning actions resulting from the Better Care Fund (BCF). Nationally NHS England is informing commissioners and trusts that 15% of non-elective activity should be moved from the acute setting to the community from April 2015. The impact on us is a reduction in income of £14m (£10m from Medway CCG and £4m from Swale CCG). Based on discussions with commissioners, we have assumed £7m (NHS Medway £5m and NHS Swale £2m) of our current non-elective activity will be moved to the community from April 2015. We have also assumed that when this activity is transferred, it will affect our cost base, but not to the same financial impact. Therefore we have assumed that 50% of the costs relating to this income will be removed. This equates to £3.5m, generating a net negative impact on our deficit of £3.5m.

Other Trust income has adversely moved from the 2013/14 outturn value of £31.1m to a planned value of £24.5m in 2014/15. A total of £6.6m non-recurrent income has been removed from 2014/15, in line with changes to non-recurrent funding.

10.4 Expenditure

As shown in the summary SoCI in **section 10.2**, our current expenditure plan for 2014/15 is £258.8m.

The key components of this are:

- Pay £178.4m
- Clinical supplies £27.5m
- Drugs £18.1m
- Other £34.9m

Table 9 shows the expenditure forecast for the 2013/14 and the 2014/15 & 2015/16 plans.

The 2014/15 plan includes a total of £14m cost pressures identified by the divisions as part of their business plans and a provision for anticipated agency pressures. This consists of the £9.2m cost pressures highlighted in the bridge (**Figure 13**) and the full year impact of existing cost pressures, including quality and agency overspends in 2013/14 outturn. Provision has been made within the plan for a contingency, escalation areas to cope with winter pressures and external consultancy to

support Transforming Medway. An allowance has also been made for additional agency, for the budgeted increased in staff establishment in recognition of a short term increase in temporary pay as we move to a largely substantive workforce through 2015-16. The change in substantive staffing expenses between 2014/15 and 2015/16 is due to transformational new ways of working and system wide re-organisation relating to the Better Care Fund. Increased spend in 2015/16 above the level budgeted in 2014/15 has been included in relation to the second year of Transforming Medway, and this is being further refined.

Expenditure plans have been reduced by £6m and £14.4m respectively in 2014/15 and 2015/16 in relation to CIPs, with an offset of £0.85m in 2014/15 and a further £0.5m in 2015/16 in relation to service developments.

Table 9: Expenditure forecast 2013/14, and 2014/15 – 2015/16 plans

	2013/14 Forecast Outturn £m	2014/15 Plan £m	2015/16 Plan £m
Substantive Staffing Expenses	-142.4	-161.3	-156.0
Temporary Staffing Expenses	-22.2	-17.1	-14.5
Total Pay Expenses	**-164.7**	**-178.4**	**-170.5**
Clinical Supplies & Services	-28.5	-27.5	-25.3
Drugs	-17.7	-18.1	-17.9
Other	-34.3	-34.8	-33.4
Total Non-Pay Expenses	**-80.5**	**-80.4**	**-76.6**
Total Operating Expenses	**-245.1**	**-258.8**	**-247.1**

The expenditure plan includes £3.9m of revenue costs relating to Transforming Medway for 2014/15 and a further £4m for 2015/16. These are division-based estimates. A high level cost assessment has been completed based on the plan submitted to Monitor in early January 2014. KPMG have been commissioned to support us in developing detailed level costing for Transforming Medway.

10.5 Capital Investment Programme

The proposed capital programme for 2014/15 equates to £33.7m. Our proposed capital programme is extensive for the next financial year and has been designed to support Transforming Medway, which includes the redesign work of the emergency pathway. The Strategic Investment Group, together with the relevant directors, programme managers and general managers/associate directors have assessed our relevant investment priorities and risks for the coming two financial years.

Table 10 shows an overview of the proposed capital programme.

Table 10: Proposed capital investment summary

Proposed Capital Investment Summary	2014/15 £000's	2015/16 £000's
Recurrent Estates and Site Infrastructure projects	3,300	4,400
Medical & Surgical Equipment Programme	1,600	1,520
IM&T Specific Projects and Infrastructure Programmes	3,642	4,294
Medway Emergency Village	19,000	-
Specific business cases, business planning and development proposals	5,702	5,670
Capital Programme Contingency	500	500
Total	**33,744**	**16,384**

Business cases are required for equipment replacement schemes. Medical equipment replacements will be approved via the correct approval routes. Divisions are responsible for completing the required paperwork aligned with our standing financial instructions (SFI's).

There is currently a degree of uncertainty relating to some of the capital schemes included in the programme for 2014/15 in respect of the total cost. This is due to plans being in the early stages of formation for the proposed 'Medway Emergency Village'. Plans are in the process of being developed and more a more detailed view of costs will be available as part of a detailed outline business case to be completed in Quarter 1 2014/15.

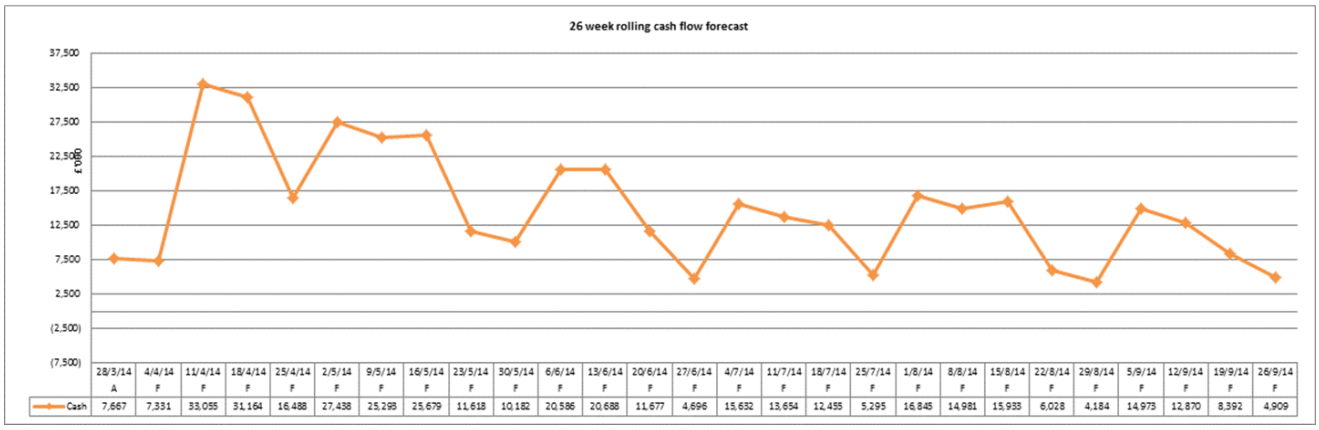
It is planned that the proposed capital programme will be financed by two principal sources. Firstly by funds that have been generated internally during the year and retained as a provision for depreciation. The full provision will amount to £10.3m, although £2.2m will be used to repay existing capital debt, leaving the balance of £8.1m to be applied to the capital programme. The remaining requirement of £25.6m is proposed to be financed by an external source as increased Public Dividend Capital (PDC). Discussions have already commenced with Monitor regarding the initial assessment of the external financing requirement. This will be finalised with a formal submission in May 2014.

10.6 Cash Management

The opening cash balance for 2014/15 is expected to be £6.3m, assuming the full draw down of the £7.9m PDC funding requested from the ITFF. Our cash position throughout the financial year will need to be monitored closely due to the planned deficit in 2014/15. We will need to produce a further business case for 2014/15 following the submission of this two year operational plan.

Figure 14 shows the cash flow for 2014/15, and further detail can be seen at **Appendix J**.

Figure 14: 2014/15 Cash flow



The 2014/15 cash plan assumes a cash advance. Please note that it is our view of the contract baseline and is equal to 2/12th from our three main commissioners in April 2014. After the contract negotiations are finalised this will be spread evenly during the financial year on a monthly basis as per the agreed contract baseline.

Our cash position throughout the financial year will remain critical due to the 2014/15 forecast deficit and the proposed level of capital investment. The significant cash pressures will be the payment of the dividend in September 2014 and March 2015, coupled with the timings of the revenue deficits and capital programme. It is forecast that cash will be at its lowest in February 2015 and towards the payment of salaries in March 2015 as the unwinding of the cash advances nears fruition and the full effects of the revenue and capital positions are experienced.

10.7 Risk assessment

There are a number of key risks to our financial plan, which have been identified as follows:

10.7.1 Contract negotiations not complete before the start of the financial year

We are in the process of finalising negotiations with commissioners on the contract for 2014/15. Agreement is expected to be reached during Quarter 1 2014/15.

10.7.2 Activity Risk

Detailed quality, innovation, productivity and prevention plans have not yet been received from commissioners, therefore at this point we have assumed a zero impact. A further risk relating to activity is in respect of the non-delivery of the planned demographic growth included. This equates to approximately £2.5m.

10.7.3 Commissioning for Quality and Innovation Payment (CQUIN) Risk

We are assuming 80% achievement of the 2.5% CQUIN target during 2014/15. We have had several meetings with the CCGs to discuss the local CQUIN requirements for 2014/15. The CCGs would like the CQUIN relating to Outpatients to continue into 2014/15. New objectives/milestones will be set for this CQUIN. Our plan assumes income at the current 2013/14 block level for Outpatients. Any change to this will be an upside to the plan.

10.7.4 Inflation Risk

Should inflation rise above the projected levels, this would impact upon our financial position. However it should be noted that the inflation assumptions have been made in line with the national indicators.

10.7.5 Baseline Budgets (2013/14 CIP delivery)

2013/14 budgets have been used as the baseline for 2014/15 with known adjustments for full year developments (including the nursing establishment review and maternity CQC action plan). This has meant that any unidentified CIP targets from 2013/14 are included within the budget. Due to the realism of delivering significant CIP programmes, there was not an expectation that the divisions will deliver these targets in 2014/15 in addition to their 2014/15 CIP targets. The divisions have put this forward as a cost pressure for 2014/15 and this has been included in the baseline. We are in the process of strengthening strict non-pay controls, which will be established in April 2014.

10.7.6 Baseline Budgets (Agency Spend)

There is an assumption that the divisions will reduce their agency spend in line with budgets, which is significantly below the current agency spend levels seen during 2013/14. Cost pressures have been included for some aspects of agency, but if current vacancy rates continue and temporary staff are maintained at 2013/14 levels, this will place pressure on the 2014/15 plan. A further £3.7m has been phased into the baseline plan to mitigate this risk over the first eight months of the financial year. In addition to the non-pay controls, we are also strengthening controls on agency spend in 2014/15.

10.7.7 CIP Risk

The 4% national efficiency target, which equates to £9.65m, represents an extremely challenging target. The local challenges Medway will face during 2014/15 & 2015/16 relating to the emergency pathway and Transforming Medway could adversely affect the delivery of this, therefore in collating this plan we have assumed delivery of £6m CIPs for 2014/15. The significant amount of change we are about to undertake could mean the divisions fall behind with their CIP plans. In addition a further risk is that the cost of the changes is higher than currently estimated.

10.7.8 Capacity Risk

A large proportion of our proposed capital programme relates to building and structural changes. This presents a risk to capacity whilst these changes are taking place. Therefore, activity could be lower than planned during periods of building work.

10.7.9 Capital Risk

We have a significant proposed capital programme for 2014/15. There are two main risks relating to this. The first risk is the financing requirement to enable the proposed capital programme to be delivered within the financial envelope. The second risk is that delays against the planned schemes occur and this results in an activity or governance risk. In addition to this, there could be significant unplanned capital expenditure, which would result in an overspend against the plan.

10.7.10 Cash Risk

We have sought additional cash support in March 2014 of £7.9m and had our case for 2014/15 deferred to after the submission to Monitor of this two year operational plan. There is a risk that the case for the cash funding will not be approved. We have assumed in our cash plan that our main commissioners (Medway, Swale and Dartford Gravesham & Swanley CCGs) will continue with a cash advance in April 2014 that is unwound during the rest of the financial year. The additional risk remains around timing of cash flows for clinical activity service level agreements (SLAs) where the actual activity undertaken varies from 1/12th of the baseline contract. In addition, our working capital facility (WCF) with Lloyds

Bank comes to an end in May 2014. Flexibility is required for us to manage cash effectively, therefore we will renegotiate a WCF with commercial providers.

10.7.11 Information Risk

The implementation of the new Patient Administration System (PAS) may compromise our ability to report performance both internally and externally to commissioners, resulting in lost income.

10.7.12 Performance Risk

Failure to deliver the national access targets could result in financial penalties being incurred. We have identified that meeting the 95% 4 hour access quality standard (A&E) and the C.Difficile objective are our key risks.

10.8 Sensitivity analysis

We have completed a sensitivity analysis of the 2014/15 and 2015/16 plan, which can be seen at **Appendix K**.

Version	Comments
v0.1	First draft: 30th January 2014
v0.1 – v0.30	Updates and further iterations informed by Trust executive, non-executives, divisional planning away day, clinical directors, Trust management team, CCG presentations and negotiations, council presentations and feedback, governor and member presentations and feedback.
v0.30	Performance & Investment Committee, March 2014
v0.31	Clinical Executive Group, March 2014
v0.32	Trust Board, March 2014
v1.0	Updated final version, further to updates from Finance – submitted to Monitor, 4 April 2014