City Hospitals Sunderland NHS

NHS Foundation Trust

Operational Plan Document for 2014-16

City Hospitals Sunderland NHS Foundation Trust

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

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

Name	**Mr Peter Sutton**
Job Title	**Executive Director Strategy and Business Development**
e-mail address	**peter.sutton@chsft.nhs.uk**
Tel. no. for contact	**(0191) 569 2851**
Date	**01 April 2014**

In signing below, the Trust is confirming that:

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

Approved on behalf of the Board of Directors by:

Name	**Mr John Anderson** *(Chair)*

Signature 

Approved on behalf of the Board of Directors by:

Name	**Mr Ken Bremner** *(Chief Executive)*

Signature 

Approved on behalf of the Board of Directors by:

Name	**Mrs Julia Pattison** *(Finance Director)*

Signature 

1.2 Executive Summary

VISION

Although this is the operational plan it is important to outline the Trust's vision and strategy in order to provide the context for the operational priorities.

The Trust's vision is 'Excellence in Health, Putting People First'. We will deliver this by:

- Ensuring our care is high quality, safe and personal
- Enabling our staff to use their skills to treat patients in clean, comfortable surroundings to the highest quality, offering choice as widely as possible
- Encouraging our patients to come here for their care because we aim for excellence in everything we do – our first priority is our patients; and
- Setting high standards of behaviour and professionalism for all our staff

The Trust has five values as follows:

- Best Quality
- Highest Safety
- Highest Morale
- Shortest Lead Time
- Cost Leadership

To deliver this vision the Trust has a robust planning framework in place which describes the **Objectives** of the Trust, the specific **Goals** that need to be achieved, the **Strategies** that will be adopted and the **Measurements** that will be in place to track progress. The **OGSM** framework is used across the Trust to ensure all plans are aligned to deliver the Trusts key objectives.

STRATEGIC DIRECTION

The Trust's strategic aim in relation to service provision is captured in the concept of 'the 3rd Centre' and it is important to define this further to avoid confusion and provide clarity on exactly what this means. The Trust has no plans to develop a range of tertiary services similar to that provided by The Newcastle upon Tyne Hospitals or South Tees Hospitals, the two main tertiary centres in the North East. However, the Trust has always provided a range of sub regional services over and above a standard DGH, including Urology, Nephrology, Ophthalmology, Head and Neck and other service lines.

The Trust will focus on becoming the 3rd Centre in the north east region which means we will plan to develop more complex/specialised sub-regional services for a larger population with appropriate alignment of investment in the workforce, technology, equipment and capital plans as required.

This direction of travel is aligned with national strategies which include having fewer centres of excellence and the development of 40-70 major emergency centres across England. The Trust currently provides a range of services for heart attacks, stroke, vascular, and critically ill children as outlined in the Keogh report and this national description is exactly aligned to the Trust's vision of the '3rd centre'. The Trust has full support from local commissioners and for a number of years, through the 'Accelerating Bigger Picture' programme, the Trust has worked closely with other local providers and commissioners and has started service transformation in a number of areas.

The Trust's investment strategy, covering areas such as a state of the art endovascular theatre, 2nd catheter lab and a new Emergency Department demonstrates its commitment to delivery of its vision. The Accelerated Bigger Picture, in collaboration with 2 local NHS Foundation Trusts, demonstrates a cooperative health economy that is willing to concentrate services at key locations in order to achieve a high quality, safe service for the population, whilst delivering financial and clinical stability and sustainability for the NHS Foundation Trusts. As part of this process Pathology, Medical Physics and Acute Paediatrics have already been implemented as hub and spoke models across the Trusts.

CENTRE OF EXCELLENCE

The Trust already has a number of 3rd Centre services such as Bariatric surgery, ENT, OMFS, Urology, Ophthalmology and Nephrology which operate on a regional/sub regional basis and where part of the services are commissioned by the North of England Specialised Commissioning Group and part by the local CCGs. The Trust's direction of travel to be the 3rd Centre supports commissioners to demonstrate that they are delivering a key element of their plan to have specialised services concentrated in centres of excellence relevant to the locality.

It is also important to note that such services operate on a hub and spoke model, which ensures local provision of services where possible (outpatients and daycases) and the advantage of Sunderland Royal Hospital as the hub is that, with the exception of Ophthalmology, all the key services are delivered on one site, therefore ensuring that patients have the benefit of immediate input from specialist teams 24/7.

ALIGNMENT OF THE TRUST PLANS WITH THE LOCAL HEALTH ECONOMY

The Trust's plans are fully supported by local commissioners and other key stakeholders, including other local FTs. The Trust has highlighted our strategic plans to local commissioners through various forums, including executive to executive sessions and they fully support the Trust's direction to travel.

The Trust is fully engaged in the wider health economy strategies in relation to integrated care, the use of the Better Care Fund and the requirement for appropriate patients to be managed outside of hospital. The Trust will contribute to the work being led by Sunderland CCG through the 'Person Centred Coordinated Care Partnership'. This is focussed on developing multi agency teams, which are based around GP localities and the Trust will offer appropriate clinical and nursing input into these local teams to help manage patients, where appropriate, in their local area.

Co-operation within the local health economy is further evidenced by the Trust being represented and fully engaged in key planning forums such as the local Health and Well Being Boards and local CCG's main planning groups in relation to unscheduled care, planned care and integrated care.

Co-operation within the local health economy is further evidenced by our joint bid for the procurement of Urgent Care Centres in Sunderland which is supported by South Tyneside NHS Foundation Trust, Primecare (out of hours GP providers) and the local GP Federation. This tender provides the opportunity to deliver truly integrated emergency and urgent care services across the community and demonstrates alignment between our plans and those of our commissioners. Contracts are to be awarded during 2014.

This development provides the local CCGs with the opportunity to deliver a modern model of integrated care along with access to the highest quality urgent and emergency care. For the future, and in conjunction with the GP Federation, the service may also provide the opportunity to provide wider primary care at scale which is both a local and a national priority.

NHS England, through the 'Everyone Counts' document highlights the national direction of travel, which includes the move toward centres of excellence with specialised services being delivered by limited number of providers. The Trust's ambition to be the 3rd centre and a 'Major Emergency Centre' is aligned to national strategies developed by NHS England.

OPERATIONAL PRESSURES

The Trust faces a continual increase in demand for its services with A&E being a prime example and this brings with it the problem of continuing to deliver a quality patient experience with excellent outcomes from a department that was built to cope with smaller volumes and now has problems with "flow" and ambulance handovers from the sheer numbers of patients arriving.

At periods of peak demand bed pressures can cause problems with the flow of patients through the hospital and the delivery of the A&E targets becomes challenging, therefore the Trust has chosen to invest in a significant Emergency Department rebuild as well as two strategic trust wide projects, Safe and Sustainable Emergency Care and 7 Day Services. These projects will reduce admissions by moving patients to ambulatory care pathways and reduce the length of stay/number of beds required in order for the Trust to be able to more easily flex its capacity to meet demand.

Our Endoscopy Department is facing increasing pressure and the current endoscopy facilities will not be able to deliver the anticipated future demand. The Trust is therefore investing in a new endoscopy unit which should future proof capacity for between 7 to 10 years (operational by summer 2015).

With the ever-increasing demand for elective procedures, the Trust's theatre capacity is coming under increasing pressure and this is compounded by the development of more complex procedures which, whilst delivering better outcomes, often require more theatre time. The Trust has chosen to invest its resources in corporate projects such as Scheduling and the Surgical and Theatre Efficiency Programme to improve the efficiency and quality of existing assets rather than building additional physical capacity in the first instance.

COMISSIONING PRESSURES

Sunderland CCG commissions 77% of its acute healthcare from the Trust spending circa £180 million. The CCG is potentially overfunded vs. the allocation formula by approximately 11%. The CCG's intention is to invest significant non-recurrent funds until 2015-16 to facilitate service redesign to improve efficiencies prior to an expected reduction in allocation funding.

The Trust also provides care across its full range of services to the North Easington locality of Durham CCG. Whose £50m spend is significant for the Trust and the potential reduction in funding is less severe than for Sunderland CCG. North Easington has similar health needs and levels of deprivation as Sunderland therefore Durham follow the commissioning lead of Sunderland, in terms of direction and commissioning intent.

A key focus for Sunderland CCG is urgent and emergency care including the Urgent Care Centre (UCC) procurement and integration of A&E and UCCs. Further development of ambulatory care pathways across the Trust's services will also contribute to an expected reduction in avoidable non-elective and A&E attendances. The cooperative manner of these developments allows CCGs to reduce their spend whilst the Trust is able to improve efficiency and free up capacity to deliver more complex or specialised pathways of care currently delivered at other Foundation Trusts.

In addition, utilisation of the Better Care Fund will help to improve integration across local health economy services.

The commissioning responsibility for a number of services is unclear and whilst there is a defined need for a service, current budgetary pressures are driving this to be a competitive process between the potential commissioners. This means that the Trust can be caught up in arguments between commissioners, examples of which can be seen with the tier 3 weight loss service which is required to provide patients for bariatric surgery but there is a dispute between the local CCG and the local authority over who will pay. Similarly for the more specialised dental activity there is a discussion of whether this will be commissioned directly by NHS England or by the local area specialised commissioning teams.

In addition to the above, the Trust experienced significant delays receiving contract intentions for 2014/15 from a number of CCGs. The on-going delay in information flow from these commissioners has had a detrimental impact on the Trust's ability to finalise activity and financial plans from 1st April 2014 and therefore financial assumptions are in some cases predicated on the best available information.

For the future, the proposed changes to the funding formula for CCGs/GP funding will place an increasing financial pressure on local CCGs, a portion of which will be transferred to the Trust to deliver in terms of improved efficiencies.

QUALITY PRESSURES

Whilst the Trust is suffering some transitory pressures in areas such as Urology and Breast it is expected that these will be quickly resolved and the remaining long term quality pressures/priorities will be:

- Enhancing the quality of life of patients with long term conditions: Improve the in-hospital management of patients with Dementia
- Ensuring that we give compassionate care and people have a positive hospital experience
- Treating and caring for patients in a safe environment and promote 'harm free' care

In addition to this, the implementation of the recommendations from the Francis, Berwick and Keogh reports will be on-going priorities for the Trust.

FINANCIAL PRESSURES AND SUMMARY

The Trust will face significant pressures in delivering a balanced financial position for the upcoming periods with expected increases in expenditure and patient demand outstripping income growth. Overall financial balance will be delivered through a number of challenging, and long term sustainable cost efficiencies.

The Trust has in place a number of corporate CIP programmes aimed at transformational changes in service delivery, in addition we have a number of local specialty efficiency schemes focusing on financial balance across all areas of the organisation.

It is recognised that significant long term efficiencies need to have the involvement of the wider health economy, and there is close alignment with Sunderland CCG around the Trust's Safe and Sustainable Emergency care programme which will improve patient experience and deliver a more cost effective service for the local health economy.

The forecasted financial position for Trust in 2013/14 is £874k deficit, this is behind our planned surplus of £2m predominantly due to a number of one-off challenges linked to the introduction of a new patient information system. The cash position is ahead of plan predominantly linked to the delayed capital expenditure in year. The Trust expects to end the year with a continuity of service risk rating score of 3.

Over the next two years it is expected that greater levels of system transformation will be required to ensure that the Trust and its partners are able to meet the quality improvements envisaged nationally and locally whilst maintaining financial balance. Local commissioners across health and social care have identified 'in hospital' and 'out of hospital' work programmes that are expected to consolidate best practice, remove duplication of services and deliver patient and financial benefits. The impact of these plans will be delivered through the Better Care Fund, however at this early stage the impact of this on the Trust is not worked through and therefore these plans are not as yet incorporated.

The planned financial surplus for each of the periods 2014/15 and 2015/16 is £500k.

1.3 Operational Plan

Annual Plan – 2014+

THE SHORT TERM CHALLENGE (2014-6)

The affordability challenge has been reiterated in numerous national documents including the Annual Planning guidance and is detailed in the table below.

	2014/15	2015/16	2016/17	2017/18	2018/19
Affordability challenge for the NHS	3.1%	6.6%	5.5%	4.7%	4.6%
Inflation assumptions	2.6%	2.9%	4.4%	3.4%	3.3%
Net affordability gap	0.5%	3.7%	1.1%	1.3%	1.3%

It is assumed that between 2% and 2.5% of this challenge will be met by improved provider efficiency with a further 1-2% from system wide efficiencies. However, there remains a financial challenge after the impact of these.

The traditional means of meeting this financial pressure is for health communities including Foundation Trusts to deliver cost improvement plans. The planning guidance makes reference to the 'real' efficiency saving historically delivered on a recurrent basis often being significantly lower than the headline efficiency requirement included in the tariff. This is quoted as being due to system wide management to mitigate financial risks. Given the scale of the financial challenge going forward the risks are that this system wide management approach is unlikely to be sustainable.

Locally the Trust has a good history of delivering challenging cost improvement targets, but on occasions they are non-recurrent in nature and in year financial pressures are often mitigated by system management in the form of local or national one-off funding for pressures such as winter. National retention of resources to mitigate risk is logical but it can create an environment whereby the underlying pressures are not addressed as all parties in the system know there will be additional funding in year.

The Trust recognises the importance of underlying financial balance and the need to take a longer term approach to managing the cost drivers for the benefit of patients and has for the last few years embarked on an ambitious programme of service redesign and reform with local Trusts and Commissioners. To date the intent has not necessarily materialised in significant financial benefits for either the Trust or its partners, but the direction of travel puts us in a good position to capitalise on the financial opportunities.

Local financial pressures:

- Francis requirements, the Trust invested £1.3 million in 2013/14 in increased nurse staffing ahead of any national direction and will invest further into 2014/15
- Planning for the delivery of 7 Day Services (due to increased staffing or working pattern changes)
- Impacts of the Safe & Sustainable Emergency Care programme – medium term cost implications (pump priming) ahead of being able to realise any longer term financial and quality benefits
- NHSLA cost pressures
- Technology developments including an Endovascular Theatre and Urology Robot which have capital and revenue consequences
- The impact of an ambitious capital programme to ensure facilities and equipment are fit for the 21st century.
- Underlying financial pressures in a number of departments linked to the profitability of those services

Measures to address these pressures include:

- A refocus of our corporate programmes, some new and others from previous years, to concentrate primarily on 'doing things differently' and delivering transformational CIPs rather than the more traditional CIPs. Further detail is provided elsewhere in this document.
- Joint working with commissioners around:
    - 7 Day Services including the appointment of a joint project lead across all sectors and organisations
    - Urgent care provision, specifically looking at the location of provision and the types of services provided in and out of hospital

- A focus on risk management processes to understand the clinical and non-clinical risks and embed learning into the organisation to prevent reoccurrence. This is more likely to be a longer term benefit given the timescales around NHSLA settlements, but there are expected to be significant quality benefits in the shorter term.
- Obtaining the full benefits from using the new Meditech EMR. Much of the focus of 2013/14 was implementing the system successfully which has now been predominantly achieved. However, the operational benefits that the new system will enable the Trust to deliver are yet to be realised and over the next two years a greater focus will be applied using Lean techniques to maximise benefits realisation.
- The completion of a new Multi-Storey Car Park, an improvement for patients but also expected to have a short payback period

ACTIVITY & CONTRACTUAL ASSUMPTIONS

DEMAND AND ADMISSION TRENDS

Chart 1

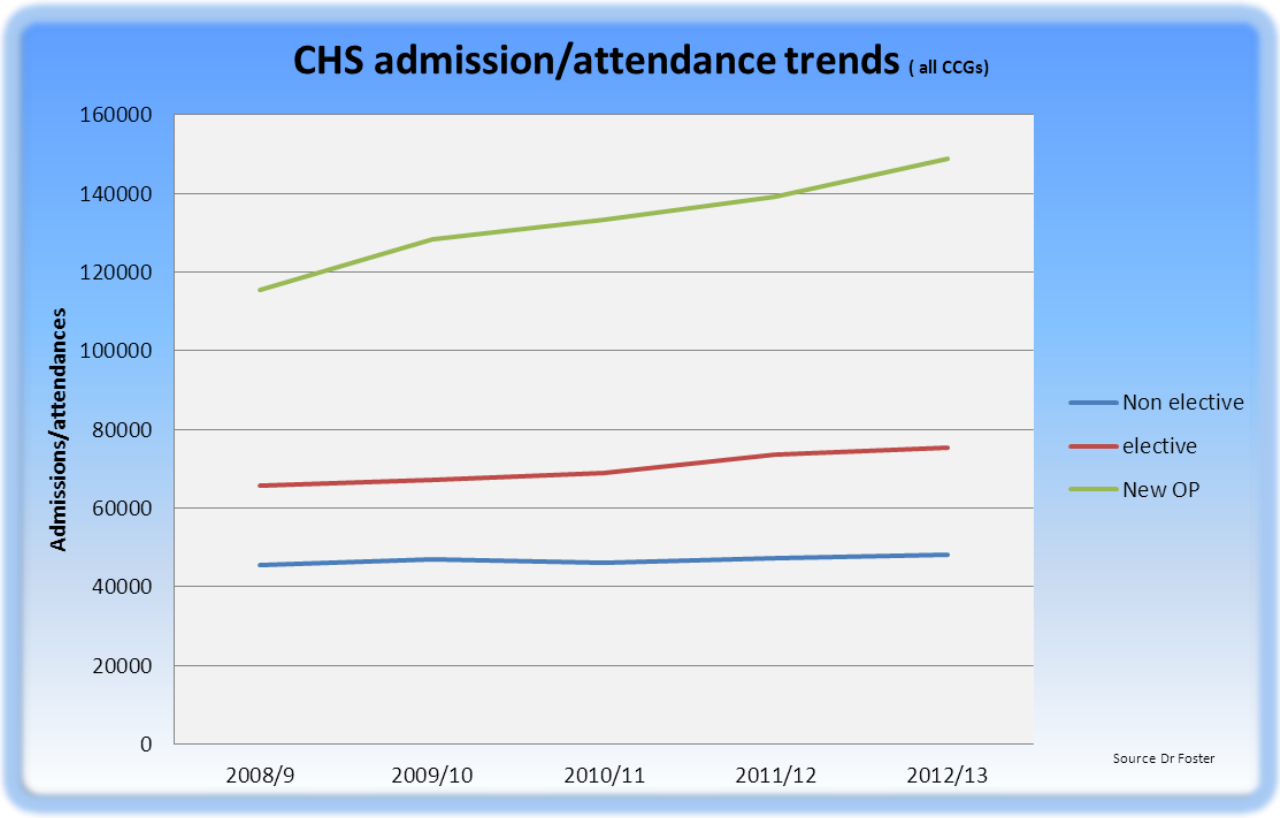

Chart 1 shows the increasing demand for services that City Hospitals Sunderland has faced over the last 5 years split into categories of non-elective admissions, elective admissions and new outpatient attendances. It can be seen that new outpatient attendances have been subject to sustained growth amounting to approximately 29% over the period whereas elective admissions have grown by only 15% and non-elective admissions by only 6%.

The increasing demand for A&E services over the same period amounts to 24% and the lower level of growth in non-elective admissions can be attributed to the increased use of ambulatory care pathways plus the development of readmission avoidance and community support schemes. The increase in new outpatient appointments further demonstrates the shift to treating many A&E patients within ambulatory pathways thus converting potential admissions into new outpatient appointments/outpatient procedures.

The redevelopment of pathways to avoid admissions provides a number of benefits for the Trust and this includes a reduction in the number of bed days required, although the Trust's length of stay for admitted patients may well appear to increase as these patients would typically have been very short stay patients had they been admitted.

IMPACT ON FINANCIAL ASSUMPTIONS

Commissioners have generally accepted the planning assumptions put forward by the Trust and have commissioned in line with the Trust's expected volume changes. However, the Trust and its main commissioner, Sunderland CCG have discussed the anticipated impact of the 'Safe & Sustainable Emergency Care' programme on activity volumes and points of delivery. In order to enable the Trust to work through the activity implications of the expected changed way of working, which could include activity capture being switched from 'emergency' to 'Ambulatory Care Pathways', the Trust and commissioner have agreed a financial risk share which should minimise risk for both parties whilst the detail is being worked through.

The national deadline for the agreement of clinical contracts was the 28th February 2014 though none of the contracts were in place at that point. Nationally there were a number of issues that remained unclear until after that date including the e-contract and impact of pay negotiations. Local negotiations with Sunderland CCG generally progressed well although went beyond the deadline, but those commissioners supported by NECs have struggled to engage in the process due to local capacity issues. In addition, confirmation of CCG and NHS England budget transfers, particularly relating to drugs and specialist services has impacted on the ability to agree contracts with individual commissioners. At the point of submission, the majority of contracts were at least at the stage of being 'agreed in principle', with financial envelopes being confirmed.

QUALITY PLANS

NATIONAL AND LOCAL COMMISSIONING PRIORITIES

Appendix 1 outlines the combined national and local planning priorities for the CCG, and Appendix 2, shows the strategic plan on a page for the local CCG.

The CCG's key planning priorities identified in Appendix 1 are:

- Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care
- Wider primary care, provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective care
- Specialised services concentrated in centres of excellence (as relevant to the locality)

Appendix 2 demonstrates that CCGs will invest in pathways linked to Long Term conditions such as COPD, cardiovascular disease and diabetes as well as substance misuse all of which the Trust is well placed to provide as a partner organisation. Care will also be brought closer to home since the Trust is part of the Prevention and Planned Care Board so any anticipated impact on the hospital can be planned for allowing capacity and cost to be either be removed or redeployed.

The Sunderland Better Care Fund is anticipated to be valued at approximately £169 million in 2015/16 and will reduce the number of non-elective admissions by 15% (estimated). There already exists a constructive dialogue centered on avoiding emergency admissions and readmissions via projects such as geriatrician led services, care home pilots, medicines review and it is therefore anticipated that the Trust will be fully engaged in dialogue with commissioners so that opportunities to reduce costs relating to fewer attendances can be taken in a timely and controlled manner.

The CCG's general direction of travel is to encourage the Trust to move towards more outpatient procedures and this links with the Trust's strategy to improve efficiency by moving procedures from a theatre setting to an outpatient setting. Additionally the CCGs have developed a policy to reduce the number of procedures carried out that have limited clinical value, although this is likely to have little impact on the Trust's activity and income as the Trust already conforms with the majority of these guidelines.

NHS England is concentrating on moving to centres of excellence to provide specialised services. The number of centres required to support the demand in England has not yet been finalised and is likely to vary from specialised service to specialised service.

NHS England has grown their investment in the Trust principally in bariatric surgery in which the Trust excels.

Further growth in bariatric surgery and expansion of vascular surgery, neonatal intensive care and cardiology is likely to be subject to national commissioning strategies and affordability.

Alignment with the key commissioners, excepting specialised, planning priorities can be demonstrated as follows:

Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care

The Trust has a wide range of patient support groups which enable patients to get advice and support from Trust staff and patients or carers with the same condition. The Trust also has a planned programme of Rapid Process Improvement Workshops (RPIW) and Kaizen events (frequently including patient representatives) to improve services and pathways. For example, patient representatives were included on the event that was held to design the new endoscopy unit.

Wider primary care, provided at scale

The Trust has embarked on a number of pilot projects to deliver care in the community which include a collaborative readmissions avoidance bid, diabetes care pilots and community geriatricians all of which are designed to provide more care in the community. The Trust is in discussion with the local GP Federation to explore the potential to offer urgent GP appointments at Urgent Care Centres should the Trust's bid be successful. This has the potential to provide additional GP slots through an extended day, 7 days a week across 3 different locations in the city. This is in addition to the Trust supporting the Federation's drive to offer more appointments from existing GP practices.

A modern model of integrated care

The Trust is actively engaged in the wider health economy strategies in relation to integrated care, the use of the Better Care Fund and the requirement for appropriate patients to be managed outside of hospital. The Trust is also a member of the Sunderland Health and Wellbeing Board and supports the local health economy plans to move to locality working across the city, aimed at reducing admissions. The Trust will contribute to the work being led by Sunderland CCG through the 'Person Centred Coordinated Care Partnership. This is focussed on developing multi agency teams, which are based around GP localities and the Trust will offer appropriate clinical and nursing input into these local teams to help manage patients, where appropriate, in their local area.

Co-operation within the local health economy is further evidenced by our joint bid for the Urgent Care Centre tender in Sunderland which is supported by South Tyneside NHS foundation Trust, Primecare (out of hours GP providers) and the local GP Federation. This project provides the opportunity to deliver truly integrated emergency and urgent care services across the community and demonstrates alignment between our plans and those of our commissioners.

If successful, this will provide the highest quality integrated urgent and emergency care facilities as it will integrate with the Trust's 24-hour urgent care hub and its redesigned/rebuilt Emergency Department. The collaboration between the Trust, a GP provider and the former primary care provider arm will not only provide improved integration of services but also bring better integration of staffing. In the medium term, the GP Federation may be involved in this process and as already mentioned may choose to offer out of hours GP appointments from these locations. At this point the service will be truly integrated and the information sharing that this will allow should facilitate seamless care for patients.

The Trust has worked in collaboration with South Tyneside NHS Foundation Trust in a number of areas, such as cardiology, to develop an integrated service that provides 24/7 cardiology cover and an equitable revascularisation service for all patients across Sunderland and South Tyneside.

The Trust is working with Community nursing, Social services, 3rd sector and voluntary agencies as part of a collaborative readmission avoidance project. The aim of the project is to provide a multidisciplinary approach to support discharge and avoid unnecessary readmission across a wide range of patients. The integration of these different service providers should provide seamless care for many elderly and vulnerable patients.

Access to the highest quality urgent and emergency care

The Phase 1 report from Sir Bruce Keogh - 'Transforming Urgent and Emergency Care Services' highlights the need for significant change across all sectors, primary, community and secondary care. Within secondary care, the report describes the requirement for two types of A&E departments, Emergency Centres and Major Emergency Centres. The latter are not Trauma Centres, of which there are 25 across England and 2 in the North East, but centres that can assess and initiate treatment for all patients and provide a range of specialist services. There would be 40-70 of these centres across England which would offer a range of services for heart attacks, stroke, vascular, critically ill children, etc. This national description is exactly aligned to the Trust's strategy of the '3rd centre' which has full support from local commissioners. For a number of years, through the 'Accelerating Bigger Picture' programme, the Trust has worked closely with other local providers and commissioners and has started service transformation in a number of areas. A key example is that the Trust is now the only the acute inpatient unit for children in the South of Tyne and Wear (SOTW) and the Trust also provides a 7 day TIA service for patients, which covers all of SOTW at a weekend. The Trust has support for this direction of travel from neighbouring FTs - South Tyneside and Gateshead, as they recognise the need for wider service changes.

Step change in the productivity of elective care

The Trust has commenced a Surgery & Theatres Efficiency's Programme (STEP) which aims to deliver a step change in the productivity of elective care. The programme will concentrate on efficient and effective scheduling and reduce waste at all stages of the patient pathway. This should maximise and make most effective use of the existing capacity and should reduce patient waits for surgery. The use of standardised procedures and processes plus the elimination of bottlenecks and consecutive processes will improve utilisation of theatres and improve the outputs and outcomes for patients.

In addition to this the Trust is planning to spend circa £7m to design and build a new state-of-the-art endoscopy unit which will be the first of its type in the UK and will be built on the concepts employed by the Virginia Mason Production System to provide high quality efficient and effective care with an outstanding patient experience. The unique unit is expected to open in summer 2015.

The building of the new endoscopy unit will enable the Trust to have a centralised decontamination facility as well as providing the physical capacity to deal with the increasing demand for endoscopies which are currently growing at around 15% per annum in the north-east region.

In 2014 the Trust will complete a dedicated Day of Surgical Admissions (DOSA) area for Urology as part of its drive to provide day case surgery wherever clinically appropriate. In addition to this the Trust is working with the local CCGs to move many day cases into outpatient settings especially for services such as ENT, Ophthalmology and Gynaecology. These two initiatives will provide significant patient benefits as well as improving the efficiency of elective surgery.

The Trust has also embarked on a Scheduling Corporate Programme which will incorporate the ambition to move to real time capacity and demand planning to ensure the best service for patients by maximising the use of available resources. The scheduling project will cover the patient pathway from outpatients to treatment and final discharge.

Specialised services concentrated in centres of excellence (as relevant to the locality)

The Trust's drive to be the 3rd centre and its investments in areas such as a state of the art endovascular theatre, an additional new catheter lab and the new Emergency Department rebuild demonstrate its commitment to develop as a local centre of excellence. The Trust already operates services on a sub-regional basis in a number of areas such as Bariatric surgery, Urology, ENT, OMFS, Nephrology, Neonatology and Ophthalmology and is looking to develop this further by becoming an endovascular centre.

The Trust is confident it has the ability to further develop services in areas such as Interventional Radiology, Cardiology (PPCI) and Vascular Surgery over the next two years and there are robust plans in place for each area covering workforce, population, infrastructure requirements, critical mass for procedure numbers and each development has local commissioner support.

This strategy is closely aligned to the national review of urgent and emergency care and the Trust plans to be a 'Major Emergency Centre' offering a range of services to patients across Sunderland, South Tyneside and County Durham.

THE TRUST'S QUALITY GOALS

The Trust's Quality Priorities for 2014/15 have been drawn from consideration of national priorities and initiatives and review of its own performance across a range of quality areas. This has enabled the Trust to focus on areas where further work is still required to improve quality whilst also reflecting national priorities. The quality priorities identified in 2013/14 were:

- Enhancing the quality of life of patients with long term conditions: Improve the in-hospital management of patients with Dementia
- Ensuring that we give compassionate care and people have a positive hospital experience
- Treating and caring for patients in a safe environment and promote 'harm free' care

These will continue to remain priorities for the Trust in 2014/15 and in addition the Trust has carefully considered its response to the Francis, Berwick and Keogh reports and add new priorities as a consequence (see later in the document).

Our Clinical and Quality Strategy is founded on our commitment to the delivery of high quality services for patients (patient safety, patient experience and clinical effectiveness), and demonstrated in our values of 'Best Quality, Highest Safety, Shortest Lead Time, Highest Morale, Cost Leadership'.

Our quality strategy will be delivered through:

- Effective clinical leadership to drive clinical input into the organisational strategy and managerial decision making processes
- Patient, partner and stakeholder engagement and responding to feedback in order to improve services and our workforce being engaged in our clinical and quality strategy
- Building on our achievements in quality and being the preferred provider based on the quality of our services
- As a minimum, ensuring compliance with all statutory requirements and the national quality indicators, including CQC
- Explicit service specific quality outcome measures aligned to local business plans and the Trust annual plan with robust mechanisms for monitoring performance
- Maintaining and improving our risk and safety culture, sharing and learning when things go wrong to reduce or eliminate incidents that result in harm to our patients (developing a risk aware and harm free culture)
- Using the evidence base to develop and improve pathways of care and change practice to deliver clinically and cost - effective patient care
- Ensuring the proactive use of national, local and Trust benchmark data to drive clinical practice and quality improvements
- Developing and promoting a culture of Research and Development, innovation and technology
- Implementation of Excellence in Health/Energising for Excellence Ward Quality accreditation programme
- Clinical Audit Strategy
- Implementation of a new advanced Electronic Medical Record (EMR) with integral decision support for electronic prescribing, evidence based nursing care plans and best practice order set for disease management. This will allow us to both monitor and demonstrate that we are consistently providing optimal and safest care for all of our patients

The key changes required to progress the Trust from its present position are:

- To further develop and embed a culture of risk management and patient safety
- Embed service improvement methodology which puts patients and quality improvement at the centre
- Visibility and monitoring of performance on quality at ward/department level
- Implementation of First Data Bank decision support (within Meditech V6) for prescribing and Zynx Care and Zynx Orders for evidence based care.
- Implementation of the new Compassionate Care Strategy for 2014/15.
- Nurse/Midwife revalidation

The sub strategies that have been put in place to support achievement are:

- Maintaining the delivery of the Quality Assurance Programme to all wards and departments. Contributors to the programme include Non-Executive Director, Matrons, Estates and Facilities staff as well as a CCG Non-Executive Director in 2013/14
- Staff from a range of disciplines being engaged in leadership development opportunities through the North East Leadership Academy (NELA); the Nye Bevan, Elizabeth Garret Anderson and Mary Seacole programmes
- Cohort 2 of the Trust Ward Sister/Charge Nurse Programme, commencing in 2014/15
- The Ward Sister/Charge Nurse Forum being in place to support senior nurses in their role
- Improvements developed from a Rapid Process Improvement Workshop for the PALS/Complaints Service to address issues and feedback from patients and carers
- Ensuring compliance with the Duty of Candour requirements from April 2013, and implementation of the 2014 requirements and ensuing legislative framework
- Continuing to monitor and develop our C.difficile action plan
- Application of the NHS Safety Thermometer and the Tissue Viability Team making steady progress in assisting staff across the Trust to reduce hospital acquired pressure ulcers
- Retaining a focus on improving incident reporting levels particularly in relation to "near misses/no harm" and ensuring that lessons are learned quickly from rapid root cause analysis and fed back to staff and patients
- The assurance programme will be further developed in 2014/15 to improve the "independent" scrutiny of compliance with risk management standards and CQC outcomes, as well as to provide assurance of lessons learned from incidents, Ombudsman cases, Coroner's inquest (Rule 28) etc.
- The process of mid-year reviews of nurse staffing and skill mix has been established and will be maintained

Plans as identified for 2013/14 and being further developed for 2014/15

The Trust aims are to enhance the quality of life of patients with long term conditions especially by:

Improving the in-hospital management of patients with dementia through:

- Patients assessed as 'at-risk' having diagnostic assessments, investigations and appropriate follow-up
- Reducing the number of falls and serious injury
  Patients being assessed on their risk of developing malnutrition and dehydration within 24 hours of admission (MUST score)
- Reducing the length of stay of patients
- Appropriate training of staff who care for patients
- Ensuring that carers feel supported

Ensuring that we give compassionate care and people have a positive hospital experience through:

- Improving the likelihood that patients would recommend our services to their friends and family
- Increasing the proportion of patients who feel listened to and involved in their care
- Enhancing the patients perception of pain management, i.e. reduce number of delayed / omitted analgesics
- Continuing to offer all patients a choice of food
- Ensuring real time feedback is acted on and improvements are made to practice
- Improving end of life care through implementation of the 'Deciding Right' programme
- Training of staff in compassionate care

Treating and caring for patients in a safe environment and promoting 'harm free' care by:

- Reducing the number and severity of hospital acquired pressure sores
- Reducing the number of medication errors, with a particular focus on insulin related errors
- Increasing the number of 'No Harm' incidents reported by staff
- Improving staff recording, recognition and response to deteriorating National Early Warning Scores (NEWS)
- Reducing the number of patient slips, trip and falls and associated injury
- Reviewing and taking action to maintain the Trust's low mortality figures
- Ensuring continued focus on prevention of hospital acquired infection.

EXISTING QUALITY CONCERNS AND PLANS TO ADDRESS THEM

During 2013/14 the Trust has explored the issue of the sustainability of the Breast Service with local commissioners given that the organisation is dependent upon one consultant operating as a single practitioner. Following a serious patient safety incident involving the consultant the Trust commissioned the Royal College of Surgeons (RCS) to review the individual's clinical practice and local service provision. Discussions are being held with the commissioners to agree the way forward for the service and the Trust are awaiting publication of the service review by the RCS.

BOARD ASSURANCE PROCESSES

The Trust's overall vision, strategy and philosophy reflect the pivotal dimensions of quality; patient safety, clinical effectiveness and patient experience.

The strategic business planning process provides a framework for delivering against key national, local and internal quality and performance objectives. Overall performance is aligned and tracked against these Trust-wide priorities for quality improvement. This ensures that quality underpins any major service change.

Our quality priorities reflect local and national priorities, as well as discussions with key stakeholders. We also consider key 'hard' and 'soft' intelligence and outcomes from a broad range of internal monitoring and assurance mechanisms. There are clear lines of responsibility in relation to the quality targets within our Performance Report presented by the monthly corporate dashboard.

The Clinical Governance Steering Group on behalf of the Board of Directors, reviews progress against clinical quality benchmarks. The Corporate Governance Steering Group oversees corporate and strategic risk on behalf of the Board. Both groups escalate any strategic clinical and non-clinical risks to the Governance Committee, which is a sub-committee of the Board of Directors, to give assurance to the Board of Directors.

The Trust routinely analyses organisational performance on key quality indicators, benchmarked against national comparisons, leading to the identification of priorities for quality improvement.

The Board of Directors and the Executive Committee review the Performance Report and Dashboards monthly. There is a monthly Quality Risk and Assurance Report to the Board of Directors from the Governance Committee to provide further assurance from external sources such as the Care Quality Commission's Quality and Risk Profile, nationally reported mortality and outcome data, information from our quality provider (CHKS), the results of national audits and external inspections and the Trust Assurance Programme. The Governance Committee provides assurance upon the adequacy and effectiveness of risk management and integrated governance within the organisation but ultimately the Board of Directors confirm assurance on receipt of the reports/information.

The Board of Directors receives quarterly self-assessment of the Trust's performance against Monitor's Quality Governance Framework in addition to an improvement action plan. An independent assessment of the Monitor Quality Governance Framework was carried out by Price Waterhouse Cooper in 2012/13 and has been repeated by internal audit in 2013/14. The report is expected after submission of this plan.

WHAT THE QUALITY PLANS MEAN FOR THE FOUNDATION TRUST'S WORKFORCE

A key recommendation of the Francis Inquiry is that Trusts review their workforce establishment to ensure that appropriate levels of staff are in place to support the delivery of safe and effective care. The Trust has carried out a review of staffing and skill mix levels and has made the necessary adjustments. This process will take place every 6 months or whenever there is a service development to ensure that staffing levels are monitored and appropriate. NICE has been commissioned to develop an evidence based tool for staffing and there may be a requirement to implement this in the future. Following the publication of the second Government response "Hard Truths" there will be a requirement to publish ward level data on actual-versus-planned nursing and midwifery staffing levels from April 2014.

In the following section (Francis, Berwick and Keogh) the impact of the quality plans on the Trusts workforce can be seen in terms of improved communication, transparency and development linked to increased accountability.

THE TRUST'S RESPONSE TO FRANCIS, BERWICK AND KEOGH

Following an initial review of the recommendations of the Francis Inquiry, the Board of Directors recognises that a number of recommendations in the second Inquiry are new and should be taken forward by the Trust. Actions have been mapped against the headings provided as part of the Government response to 'Patients first and foremost' and the subsequent "Hard Truths" document.

Transparency, Communication and Complaints

The Trust has a number of methods of ensuring transparency with the public, engaging the public and for using feedback from patients and the public to improve services. These include:

- Board of Directors meetings, Council of Governors Meetings, and an Annual General Meeting all of which are held in public
- Community Panel (currently being further developed)
- Real time feedback from patients, collected by volunteers and governors
- Carers Reference Group
- Specialist patient support groups
- Scores and themes from the Friends and Family Test
- National patient surveys

The Trust is committed to working openly with commissioners of the service, through the provision of appropriate information, data etc. to provide assurance on the quality of services to patients. The Quality Review Group is the mechanism by which information on quality and safety is shared with commissioners.

The Trust is engaging with the second phase of the national Transparency Pilot. This involves developing methods for publishing information about quality and safety at ward level which can be shared with the patients and the public through Trust websites and NHS Choices. This is likely to be a contractual requirement for 2014/15.
In relation to 'transparency', the Trust is developing a Communications Strategy, which will address communication with the public and internal communication with Trust staff. This will also consider the range of media available to engage and communicate with the public e.g. social media, use of the internet, digital recordings etc.

The Trust has a number of mechanisms by which staff can raise concerns. The Trust has a whistle blowing policy and also a number of independent Dignity at Work advisors who are able to advise and signpost staff who have concerns about how they are being treated. The Chief Executive has a number of engagement forums for senior managers, senior nurses, and consultants. The Executive Director of Nursing and Quality has a regular Nursing and Midwifery Reference Group which enables all staff to attend to discuss issues about care, professional issues etc. The Medical Director attends the Chief Executive's Clinical Directors Forum which meets regularly and provides a forum for Clinical Directors to take forward clinical issues. There is an AHP Forum with a similar remit.

The Trust has implemented the Duty of Candour requirements which require healthcare professionals to inform patients and their relatives when there has been a patient safety incident and to immediately apologise for that incident. Staff are aware that there is a need to complete investigations rapidly so that the Trust can learn lessons and patients can be assured necessary actions have been taken. The recommendation that the NHSLA may not cover compensation costs for Trusts which do not follow a duty of candour process is a clear signal that an open, honest culture is the expectation. The Trust will continue to improve the processes for the management of complaints, and has recently relocated the Complaints service to the main hospital building from the Trust HQ building and co-located with the PALS service with a view to developing a 'Customer Services' centre, to deal with issues/concerns by patients and relatives in a more timely and accessible way.

The Trust had a Complaints RPIW in March 2013 to improve the processes for responding promptly to complaints and ensuring there is learning and improvement from complaints. The new approach of telephoning the complainant immediately on receipt of the complaint to resolve the issue through discussion is being rolled out in a phased way and is proving to be positive with early resolution of complaints. The more complex complaints often take longer to investigate and are sometimes concluded outside of specified timescales. Lessons learned from complaints are cascaded to directorates and included as part of Lessons Learned lunchtime sessions for staff.

The Trust has carried out a gap analysis against the recommendations of the national complaints review (Clwyd and Hart) in order to identify issues and implement solutions.

The Trust is building relationships with the local Health Watch to ensure any concerns flagged through this route are picked up quickly and dealt with openly.

Culture

The Trust is currently involved in a regional initiative to develop a 'safety culture' in the NHS. As part of this initiative called 'Investing in Behaviours' the Trust has undertaken a validated safety culture survey with a random sample of staff. This provides a baseline assessment for the staff perception of safety awareness and will help us to understand if our approach is working. 'Open' Lessons Learned seminars are held to which all staff are invited to hear about and discuss serious issues which have required the Trust to reflect on and learn from. These seminars are very well attended by diverse staff groups, both clinical and non-clinical.

The prevention of problems is about 'culture', which is a cross cutting theme in the Inquiry and all subsequent reviews and responses. The Trust is currently working with stakeholders (members of staff groups, community panel, lay reps and governors) to develop its Compassionate Care Strategy. This will build on the Trust vision and values (Excellence in Health: Putting People First) and use the principles of the DH national care strategy '6Cs' – (care, compassion, competence, commitment, courage, communication). Early work has included engagement of patients and staff in conversations about what compassion means for them in practice. The strategy will also encompass a 'customer care' approach and the development of a Care Academy, placing value on the skills of 'care' in the broadest sense of the word from clinical care to customer care. Progress on this strategy will be overseen by the Patient Carer and Public Experience Committee which has Governor and Community Panel membership as well as representation from Sunderland Carers Centre.

The rapid detection of problems is not only about having processes in place and the culture of an organisation but also about the transparency of an organisation. The Trust has a number of ways in which we review and share data and information on mortality, infections, serious incidents, complaints, litigation, clinical audit, etc. with staff, the Board and external parties e.g. commissioners, CQC, Monitor, etc. Performance on clinical quality is also monitored by the Trust through the review of information provided by CHKS and quarterly performance reviews with directorates. The Board receives monthly reports on quality and safety. The announcement of a new criminal offence applicable to providers who supply false or misleading data, demonstrating the Government's commitment to openness, honesty and transparency.

Monitoring and Assurance

The Trust already has an internal unannounced inspection and assurance process managed through the Executive Director of Nursing plus the Quality team and the Matrons. A Non-Executive Director takes an active role in the inspections which are also used as an opportunity to speak to patients and staff about any issues they want to discuss. The inspections are currently based on the previous CQC essential standards. A lay representative from Sunderland CCG also attends the inspections. The Board of Directors receives reports which enable triangulation of information to provide assurance that the Trust is compliant with regulatory standards and performs effectively with regard to quality, safety and risk.

The Medical Director is leading work around mortality with other Medical Directors in the region and reviewing the Trust's process for triggering a review if any directorates appear, from our data, to be an outlier. The Board of Directors has had a workshop on mortality to enhance Directors' understanding thereby strengthening their ability to challenge the information presented.

Future reports for Board of Directors will include assurance on the quality of care demonstrated from the ward inspections. The model for the ward assurance visits is still developing and in future may include a junior doctor representative and a student nurse representative in line with recommendations from the Keogh reviews. Students are seen to be able to provide an 'objective' view as they have no specific alignment to a ward or department and move around organisations as part of their training and therefore can be a useful source of intelligence about safety and quality of care.

Ward level quality metrics are currently being developed. The Trust currently reports performance at directorate level but acknowledges that this could be strengthened and that an 'organisation/directorate level' assurance process could potentially mask pockets of poor care. It is anticipated that information will be displayed at ward level as part of the drive for transparency. The Trust is part of an NHS England and regional pilot for the Open and Honest Programme formerly known as transparency. The Trust will review the use of the format of the Keogh Mortality reviews as a baseline for the performance/quality/risk and assurance reports for the Board of Directors.

The Trust triangulates data and information from a number of sources to ensure that appropriate and timely responses are made and actions taken. The Rapid Review Group reviews all serious incidents and complex complaints and initiates a 'deep dive', which is an in depth investigation of a particular ward or department, if there are a number of triggers. The triggers may include any of the following mortality, infection rate, poor performance in Safety Thermometer or Friends and Family Test, high rate of complaints related to care, serious incidents, complex inquest cases etc. An improvement process is also then put in place lead by the Head of Nursing and Patient Safety or the Head of Nursing and Patient Experience depending on the elements which require improvement.

The Trust will continue to explore options for ensuring staff are able to engage appropriately in discussions about care standards and raise concerns if they wish to, so that problems are detected early. The Trust has an action plan based on the results of the NHS Staff Survey. The Trust is currently developing the implementation plan for the national "Friends and Family Test" for staff which can demonstrate staff morale and engagement which is an indicator of the quality of patient care provided.

The Trust's Rapid Review Group also reviews all moderate and serious incidents which are reported online through the Trust incident reporting system. Any immediate 'safety messages' arising from the review are posted on the Trust intranet and cascaded to local teams. There is a review underway of the process for the root cause analysis investigation of serious incidents, to ensure a more timely process. All serious incidents as defined by NHS England and "Never Events" are reported externally as required contractually.

The process for action on safety alerts has recently been reviewed to ensure the Trust takes rapid action in relation to safety alerts. The Trust welcomes the recommendation in the Government response which will ensure a clearer framework with regard to patient safety alerts.

The current Assurance Programme has provided an independent checking function including the application of the internal audit processes. The programme is currently being reviewed and will be based on the new CQC approach and standards, the programme for 2014/15 will be approved by the Governance Committee early in 2014.

There is a new programme of development in place for Senior Nurses (i.e. Ward Sisters and Charge Nurses) and Directorate Managers in recognition of the importance of these roles in determining the culture at operational level. A key theme will be accountability at frontline. Further developments are also underway e.g. Quality dashboard at ward level which will be monitored by Matrons as part of the assurance process, and further strengthening of the role of the Matron in assurance.

Leadership, Accountability and Development

A cross cutting theme from the Inquiry and the subsequent reviews is the theme of accountability at all levels from frontline staff to the Board. Robert Francis is clear that engagement of frontline staff is important in keeping patients safe and providing high quality care. Staff are in the unique position of being able to directly influence the quality of care at the point of care. One of the recommendations from the Francis Inquiry is the implementation of the 'named nurse' and 'named doctor' role i.e. that each patient (in particular the older patient, would have a named professional to take responsibility for the care of each patient) with the name at the head of the bed of each patient. On the older people's wards in the Trust we are implementing this good practice with the responsible clinician already displayed.

Trusts and Boards in particular have responsibility for ensuring the systems and processes for the delivery of high quality care are in place as enablers and drivers. The Trust's Board of Directors is focused on the strategic leadership of the organisation and the delivery of Excellence in Health: Putting People First. The Board meets in public 5 times a year and the Council of Governors holds all meetings in public and is expected to have regular contact with the public they represent.

There is a programme of training for non-executive directors and governors to ensure that they are able to fulfil their duties with respect to ensuring the Trust delivers high quality, safe and effective care.

The Trust is currently seeking a non-executive director with a clinical background to provide effective challenge to the Medical Director and Executive Director of Nursing and Quality on clinical and care issues and this will further strengthen the assurance processes of the Board.

The revalidation process for medical staff is in place in line with national requirements. This strengthens the arrangements for appraisal and performance review and ensures that only doctors who perform within expected criteria are able to re-register. In October 2013, the Nursing and Midwifery Council announced that revalidation processes for registered nurses and midwives needs to be in place by September 2015. The Trust has already worked with the current provider of software for medical revalidation on a pilot to help develop a system for revalidation for nurses and midwives, in anticipation of this announcement.

The NMC has announced that revalidation for nurses will be introduced in 2015. The Trust is currently piloting an e-portfolio system for nurses similar to that for doctors.

A key theme running through the Francis Inquiry recommendations is leadership and engagement at every level and the need to have staff (especially nurses and healthcare assistants) who demonstrate the right values to work in a personal care role in the NHS. The Trust currently uses evidence based questions on compassion to test the values of potential recruits to new Registered Nurse positions and Health Care Assistant positions. We have also included lay representation on interview panels (representatives from the Sunderland Carers Centre) which has proved to be very helpful. Both newly qualified nurses and HCAs undergo a Trust development programme which will be reviewed again if further recommendations emerge following the Inquiry. A day conference for HCAs was held in November 2013 to focus on the findings of the Francis Inquiry, Compassionate Care and the role of Health Care Assistants in delivering high quality care. The Trust is the largest pilot site for the national pre-nursing experience in the north east.

The role of the Ward Manager (Ward Sister/Charge Nurse) is also seen as a key role in ensuring the quality of care and safety of patients. The Trust has developed a Senior Nurse Development Programme which will be accredited through Sunderland University. The programme is to support ward leaders in developing their teams to deliver high quality care.

The Trust has ensured the participation of a large number of staff in the North East Leadership Academy Programme (NELA) provided through Health Education North East (HENE). This high quality programme has ensured that individuals with key leadership roles in the organisation have personal development opportunities to strengthen their leadership skills.

The assessment process for Consultant recruitment in the Trust is based on a ten point competency framework that was developed via a number of focus groups involving over 60 staff across the various staff groups including admin, nursing, AHPs and doctors. The assessment process involves psychometric testing, 'meet and greet' sessions are with staff at all levels across the particular service, a simulated exercise e.g. dealing with a patient complaint, mock ward round, mock MDT and then finally an interview and presentation. The entire process is scored against the various competencies and addresses the values and behaviours of the candidate.

A further issue which the Trust is currently considering is the recommendation on the 'supervisory' status of ward sisters and charge nurses. Currently these nurses are part of the required staffing to deliver hands on care for patients but they also have a role in managing the ward, dealing with complaints, discharge processes etc. In recognition of their role in influencing care at the frontline all Trusts have been asked to consider how to provide them with the time to supervise clinical care as well as manage their wards.

The engagement of staff in the development of the Trust Compassionate Care Strategy is an important element of making improvements to the culture of the Trust and the quality of care for patients. A stakeholder group has been set up to work on the strategy which will provide a meaningful and pragmatic approach to engaging staff in compassionate care. The Trust compassionate care strategy involves the development of a Care Academy for Sunderland in partnership with academic, health and social care providers and commissioners.

The Trust has engaged with the national 'Year of Care' pilot which is the programme for potential nurse recruits who will work for a year in a caring role as a health care assistant prior to nurse training. The Trust is one of 4 sites in the north east and will be part of the national evaluation.

Summary

The overarching finding of the Francis inquiry, Keogh and Berwick Reports and subsequent reviews is that there needs to be a radical change in culture within the NHS. The actions outlined above are either already in place, or are planned, and will develop as further information about how the recommendations are to be taken forward arise. Due to the agreement by Directors that a further Francis Action Plan was not required, it is proposed that the required actions are built into the Trust Annual Plan and there will be monitoring processes through this mechanism at directorate level. A series of road shows will be held with staff to outline the actions, roles and responsibilities and progress with recommendations from the Francis Inquiry. In addition, a summary report of progress aligned to the themes of the 'Patients First and Foremost' document, will be provided to Directors monthly as part of the Quality Risk and Assurance Report, and as part of the Trust Annual Quality Report. The response has been made available on the Trust website.

OPERATIONAL REQUIREMENTS AND CAPACITY

For the next 2 years the Trust is confident that it has the physical capacity, workforce and beds to manage the anticipated activity and demand. The CCGs priorities are to reduce emergency admissions and readmissions by approximately 15% and the Trust's own developments such as the move towards ambulatory care pathways and the Emergency Department rebuild should provide the Trust with the headroom necessary to manage over this period.

In addition the potential that the Trust will be successful with the Urgent Care Centre bid will enable the Trust to exert greater control on its levels of non-elective activity.

Although the Trust is confident that it has the overall capacity and capability to deliver anticipated demand there are number of smaller areas which the Trust will concentrate on to improve delivery and sustainability and these are discussed below.

Urgent Care Pressures

The Trust faces a continual increase in demand for its services with A&E being a prime example and this brings with it the problem of delivering a quality patient experience with excellent outcomes from a department of finite size. Delivering all the A&E targets in a robust and sustainable manner is a key priority for the Trust and so delivery of projects such as the Emergency Department rebuild, Safe and Sustainable Emergency Care and 7 Day Services are key elements in terms of delivering sustainable performance.

When linked to the opportunity that the Urgent Care Unit tender provides (see Appendix 2) to deliver seamless joined up urgent and emergency care, the Trust will be in a better position to manage its demand from start to finish within the whole system. The changes will also enable the Trust to more robustly respond to changes in demand and flex its capacity accordingly.

At periods of peak demand bed pressures can cause problems with the flow of patients through the hospital and the Trust has chosen to invest in projects such as the Emergency Department rebuild, Safe and Sustainable Emergency Care and 7 Day Services rather than building extra wards or increasing the number of beds. These projects will reduce admissions by moving to ambulatory care pathways and reduce length of stay/number of beds required in order for the Trust to be able to more easily flex its capacity to meet demand.

In terms of dealing with the operational pressures that the Trust faces there are 5 elements that will enable the Trust to cope:

- Demand management programs, such as improved GP access, provided by the local CCGs.
- Infrastructure and capacity investments by the Trust
- A culture and practice of continuous improvement to deliver improved efficiency, productivity and outcomes.
- A set of corporate programmes to deliver transformational change.
- Working with the CCG on collaborative projects such as the Urgent Care Centres and the urgent care hub.

Endoscopy Pressures

Our Endoscopy Department is facing increasing demand and the current endoscopy facilities will not be able to deliver the anticipated future demand. The Trust is therefore investing in a new endoscopy unit which should future proof capacity for between 7 to 10 years.

Theatre Pressures

With the ever-increasing demand for elective procedures, the Trusts theatre capacity is coming under increasing pressure and this is compounded by the development of more complex procedures which, whilst giving better outcomes, require more theatre time. The Trust has chosen to invest its resources in corporate projects such as Scheduling and the Surgical and Theatre Efficiency Programme to improve efficiency and quality of existing assets rather than building additional physical capacity in the first instance.

Urology Pressures

There is current pressure on the Urology service which is impacting on the Trust's cancer performance for Quarter 4. This has been as a result of demand for certain procedures and there are plans in place which include additional theatre sessions, to ensure these targets are met going forwards and therefore this should not be a risk by the end of Q1 2014/15.

Breast

Although there are quality concerns regarding the breast service, the capacity issues in the service have improved and performance is improving in relation to breast symptomatic patients seen within 2 weeks from GP referral.

PRODUCTIVITY, EFFICIENCY AND CIPs

Improvement interventions

The Trust has developed a Lean Continuous Improvement Strategy for 2014-2017 which outlines our approach to the implementation of a lean continuous improvement philosophy. The goals and objectives of the strategy are:

- To do things right, first time every time
- To ensure continuous improvement programmes and projects are clearly linked and aligned to the Trust's vision and priorities identified within our annual planning cycle ensuring quality and performance measures are met
- To utilise a programme management approach to ensure that new organisational capacity is delivered and benefits realised
- To continue to build organisational capacity and capability in lean and programme management methodology across corporate and clinical services
- To support a culture where sharing of best practice and learning from each other is the norm

During 2013 there have been many improvement events (RPIWs) including; complaints handling, ambulance handovers, trust wide escalation, TSSU, theatre recovery and diagnostic test results and communication. These have improved efficiency, safety, lead time and patient experience. Improvement activities are planned throughout 2014/15 as well as increasing organisational capability through training 'lean leaders' to lead improvement projects within the Trust.

As a response to the ever-increasing demands on the Trust it has embarked on an infrastructure development programme which includes projects such as the Emergency Department rebuild, the Multi-Storey Car Park, the Endovascular Theatre, the new Endoscopy unit and the Diagnostic Outpatient Imaging Centre. In addition to these capital developments The Trust is devoting resources to a number of corporate programmes which include:

- 7 Day Services programme
- Safe and Sustainable Emergency Care
- Scheduling programme
- Surgical and Theatre Efficiency Programme
- Diagnostics programme
- Medicines programme
- Procurement programme

All of these projects and related investments are designed to improve the quality of the service provided and deliver a more effective and efficient service. In addition many of these projects will rely on benefits realisation through the use of the recently implemented Meditech V6 system to deliver their objectives/outcomes. These projects, when taken together, will improve the quality of care, improve the flow of patients through the hospital and eliminate waste by reducing non-value adding steps and non-essential waits. The programmes are described as follows:

Seven Day Services

The Trust has commenced a 7 day services programme in order to meet the ambitions set out in the Francis, Berwick and Keogh reports.

The Trust is in complete agreement with the Academy of Medical Royal Colleges in stating that it “is ethically unjustifiable to provide a lower standard of care to patients at weekends than on weekdays”. The NHSE paper “NHS services, seven days a week paper” provides a set of standards which will be delivered by the Trust; however we feel that these standards need to be met with greater immediacy than the proposed timeline of 16/17 and the Trust has a specific programme of work to implement these and other standards during 14/15 and 15/16.

Safe and Sustainable Emergency Care

It can be seen that the Trust’s major investments have shifted from the building of new ward blocks to a major redevelopment of the flow of patients through the hospital. This is encompassed within Safe and Sustainable Emergency Care (SSEC) corporate programme which is linked to the current rebuild of the Trust’s Emergency Department requiring an investment of circa £5.2 million during 2014/15 and a further £9.6 million in 2015/16. In essence, SSEC is an internal reconfiguration to radically improve the flow of patients through the hospital from admission to discharge. This will help to avoid inappropriate admissions, eliminate waiting, improve pathways and hence reduce the length of stay whilst improving the patient experience

Scheduling

The scheduling programme covers the whole pathway from GP referral to discharge and will ensure that unnecessary delays are removed from the patient pathway in order to improve patient experience and maximise capacity utilisation. The aim is to improve the use of resources and eliminate waste/unnecessary waits wherever possible. The programme has just completed a Rapid Process Improvement Workshop aimed at improving and smoothing the flow of patients from the start of their outpatient journey to the completion of their treatment.

The Scheduling programme also includes the development of robust capacity and demand planning tools. The Trust already has a non-elective activity planning tool which proved invaluable over this winter by informing the Trust’s decision making. The Trust is also looking to further develop the model in order to plan more robustly elective demand from outpatient attendance through diagnostic and pre-assessment requirements ending with final theatre and bed requirements. It is hoped to develop this as a near real-time model which will inform detailed proactive decision-making up to 6 weeks in advance. Part of the model will also be able to predict long-term capacity and demand requirements using a set of assumptions more appropriate and more useful to consider for scenario planning rather than for detailed individual day-to-day activity planning.

Surgery & Theatres Efficiency Programme

With the ever-increasing demand for elective procedures, the Trust's theatre capacity is coming under increasing pressure and this is compounded by the development of more complex procedures which whilst giving better outcomes require more theatre time. The Trust has chosen to invest its resources in corporate projects such as Scheduling, Surgical and the Theatre Efficiency Programme to improve the efficiency and quality of existing assets rather than building additional theatres in the 1st instance.

Surgery &Theatres Efficiency's Programme (STEP) aims to deliver a step change in the productivity of elective care. The programme will concentrate on efficient and effective scheduling with waste elimination at all stages. This should maximise and make most effective use of the existing capacity and should reduce patient waits for surgery. The use of standardised procedures and processes along with elimination of bottlenecks and consecutive processes will improve utilisation of theatres and improve the outputs and outcomes for surgeons.

Diagnostics Programme

As part of the drive to be an emergency centre the Trust still plans to develop a Diagnostic Outpatient Imaging Centre to further separate the flow of elective and emergency patients. In addition to this the Trust continues to improve its on-site Imaging assets and processes using lean process improvement tools.

Medicines Programme

The Medicines programme aims to improve the medicines reconciliation process so that this is achieved within 24 hours of admission for all patients. When coupled with improving the use of Trust protocols and fewer delayed/missed doses for patients this should reduce patients' length of stay. The programme should also deliver savings on nutritional feeds, home oxygen and IV fluid sets.

Procurement programme

The Trust has historically delivered significant savings on procurement, with a key focus on cost effectiveness and best value. Further procurement work plans are in place to ensure we maximise purchasing efficiency in the upcoming years. In addition to delivering internal efficiencies from standardisation, the Trust continues to work with other organisations to take maximum advantage from volume discounts achieved through aggregated purchasing.

CIP Delivery

Historically CIP design has been a mixture of broad themes matching the overall Trust direction plus smaller individual Directorate plans. For example a number of schemes have been based on national best practice projects and designed to deliver quality improvements.

These themes combined with key corporate projects such as Safe and Sustainable Emergency Care will be the foundation of cost saving plans in the upcoming two years. The main drivers for cost improvements are improved efficiencies; hence STEP overlapping the Surgical and Theatres areas recognising a holistic drive towards improved working practices and efficiency.

The underlying aim of these projects is the improvement of patient care and the delivery of world class services. The organisation set a CIP target of £12.2m for the 2013/14, actual delivery against this is expected to be £11.6m resulting in an under delivery of £0.6m. Historically the organisation has delivered the CIP programme despite a challenging environment; this slippage in 2013/14 is a reflection of the one off pressures faced by the Trust in embedding a new patient information system, Meditech version 6.0.

The current and future focus has been a move away from just specialty specific CIP plans and more towards cross cutting Divisional, Trust or organisational CIPs to identify opportunities to change the way that services are delivered. Much of the work around these transformational corporate programmes has been led by the Kaizen Promotion Office (KPO) ensuring consistency of approach coupled to strong managerial and clinical leadership. Linked with the workforce strategy, leadership and project management skills have been provided to those leading these projects to maximise the likelihood of success.

CIP Governance and clinical involvement

The overall governance of the CIP programme is provided by the Finance Committee, a sub-committee of the Board of Directors, attended by Non-Executive Directors, Executive Directors plus Clinical Directors from individual services.

All CIP programmes have been signed off by Clinical Directors and Matrons for those areas affected. Programmes have been developed bottom up, reflecting opportunities as identified by clinical and managerial leads.

Clinical Directors attend an Away Session on an annual basis to develop and validate improvement plans aligned to the Trust's priorities. These are then interrogated and assessed by key Executive Directors, i.e. Finance Director, Medical Director and Nursing Director, for their ambition, robustness, impact, affordability and deliverability. All CIPS have been risk rated according to deliverability and impact on quality and signed off by the Clinical director, Nursing Director and Matron as well as being scrutinised by managerial leads. The signed off plans have been reviewed by the Finance Committee and the process and outcomes have been shared with the lead CCG who has confirmed that they are assured that the Trusts processes are robust.

The Director of Nursing and Quality has carried out nurse staffing reviews of all Directorates, to confirm baselines prior to CIP discussions and sign off. The process has involved triangulation of staffing numbers against professional bodies' guidelines (where these are available), incidents, complaints, mandatory training uptake, staff sickness and use of bank staff. This review is being used to inform the sign off of CIPs.

The Trust uses existing quality and performance mechanisms to monitor progress with cost improvement plans and has escalation measures in place for plans that are appearing to drift from their targets. The Governance Committee assesses indicators that may show a detrimental impact on the quality of services such as an increase in incidents or complaints. The Medical, Nursing and Finance Directors as members of the Governance Committee and the expanded Finance Committee can assess any associations with CIP plans as part of an on-going review process. Monitoring of quality will be through the Trust Clinical Governance Steering Group and the Quality Review Meeting which is chaired by commissioners. In addition, the Director of Nursing and Quality and Medical Director will attend the Finance Committee to provide challenge to the discussion on CIPs from a quality and safety perspective. There will be a mid-year review of the nurse staffing reviews to monitor any proposed changes and potential impact on quality and safety.

Key CIP schemes for the next two years include:

- Surgical and Theatres Efficiency Programme (STEP)
- Safe and Sustainable Emergency Care
- Scheduling
- Procurement

Details of these schemes can be found on pages 21 and 22.

These corporate programmes align closely with the vision of the Foundation Trust and its direction to become the 3rd centre and as such are mainly transformational. As these corporate programmes cover significant programmes of work to improve quality, efficiency and productivity it is no surprise that they appear as major elements within our CIP schemes. Many of these corporate programmes have been initiated on the basis of national or local benchmarking data and whilst the themes are transformational many will be achieved in an incremental manner using Lean tools and techniques

All CIP schemes have been risk rated for both likelihood of success and impact on quality and safety. There are no schemes that have a high risk in relation to safety whilst approximately 25% are expected to have a positive impact on patient safety, effectiveness and overall experience. Some schemes are expected to be challenging to deliver and will be closely monitored in year by the Finance Committee. In addition, the Finance Committee membership has widened to include the Medical and Nursing Directors at key points in the year.

Financial plan

Income

The Trust has made the following income assumptions:

- The Trust has assumed a net tariff deflator of 1.2% against PbR agreements and 1.5% against non PbR agreements for 2014/15. For 2015/16 there is an assumed net tariff reduction of 0.5% across all clinical income agreements.
- The net tariff reduction in 2015/16 reflects 1.2% tariff reduction plus 0.7% inflation for changes to employer pension contributions as noted in annual guidance. This approach aligns with the approach taken by Sunderland CCG in their calculations.
- The above assumptions have been aligned with our main commissioner Sunderland CCG, however delays in contract proposals from other local commissioners have made complete alignment difficult.
- No impact of Better Care Fund has been included
- CQUIN – assumed at the current rate of 2.5%
- Readmission and reablement schemes – assumed investment in line with current arrangements, including continuation of those schemes deemed to be effective to date
- No changes to the national PbR rules, e.g. the maintenance of the marginal rate principles
- During 2013/14 clinical income was greater than plan. This was predominantly due to one-off funding streams such as the national 'winter' funds which have not been assumed again. However the plan also assumes that the level of unanticipated costs associated with this level of activity will not reoccur.
- Activity assumptions reflect the known commissioning intentions of lead commissioners. Horizon scanning around demographic changes and anticipated market share have been factored into the Strategic Plan. The aim of expanding services as part of the ambition for '3rd Centre' will include opportunities to increase market share, particularly around specialised services. Many of these opportunities are being explored, but the impacts of these changes have not as yet been factored into the plans. Activity plans have therefore been relatively prudent at this stage with minimal growth assumptions.
- Every year the Board of Directors considers whether additional activity should be assumed reflecting the continuing growth experienced year on year. This year, the Board of Directors have also considered the potential impacts. However, given the level of growth already factored into the plan and the heightened risks associated with the changes in commissioners, and particularly the risk around affordability for smaller commissioners, the Board of Directors has confirmed the 2014/15 and 2015/16 income assumptions are as per the contract planning agreements to date, with a small growth assumption for future years.

Expenditure

- Assumed pay and inflation assumptions at a level of 1.3% for pay in 2014/15 (covering a pay award of 1% for staff on the top of agenda for change pay scales per annum plus increments), and 0.8% on non-pay costs.
- Assumed pay and inflation assumptions at a level of 2.0% for pay in 2015/16 (covering a pay award of 1% for staff on the top of agenda for change pay scales per annum, plus increments, plus 0.7% impact for increased employer pension contributions), and 0.8% on non-pay costs.
- Costs associated with increased activity growth have been assumed to be in line with income received as the Trust is at capacity in many areas and therefore step costs would be incurred to expand capacity. For instance the change in facility provision will result in increased depreciation, leases/lease costs, PDC and/or interest payments and therefore whilst direct staff and non-pay costs will not increase in line with growth funding, other generally non-operating costs are expected to rise.
- An increase in nursing staff costs has been included in line with Trust nursing workforce review and the subsequent recruitment of staff.
- Additional pressure funding has been made available for energy costs and increasing costs associated with NHS Litigation Authority.
- In addition provision has been made for the costs associated with the draw-down of the FTFF loans for both the A&E rebuild and the multi-storey car park and the related depreciation costs.
- CIP assumptions have been made of a 5.0% and 4.3% for 2014/15 and 2015/16 respectively, equating to £15.9m in 2014/15 and £13.9m in 2015/16.
- The Trust has planned for a £0.5m surplus per year, equating to approximately 0.2% of total income.

Developments

- Accelerated Bigger Picture service changes:
    - **Pathology** - staff transferred to Gateshead FT during 2013/14. In addition, a combined IT system has been procured to support the integration of pathology services across the three Trusts. The system is planned to be in place by July 2014 from which time the new centralised service will commence, operated from a purpose built lab at Gateshead FT. At this point commissioner contracts with City Hospitals Sunderland will move to Gateshead, this contract variation has been included in our plans as has the subsequent change in cost base.
    - **Medical Physics** – transferred from Gateshead and South Tyneside FTs to Sunderland FT in 2013/14. The values included represent City Hospitals Sunderland now being the central purchasing point and cross charges made to the other two Foundation Trusts.
    - **Paediatrics** – this service is now embedded within the Trust and the financial agreements associated with this service transfer conclude in 2014/15 and have been factored into the plan
    - **Breast service** – discussions have been on-going with Gateshead Foundation Trust around the transfer of the management of this service to Gateshead. At this time, this is being finalised and is not yet included in the plan

- **Pallion** – for the next two years, the CCGs have supported the opening of a walk in centre facility in Pallion Health Centre which is located on the City Hospitals Sunderland site and managed by the Trust. This will enable the Trust's activity to be appropriately managed in the appropriate location, with more complex activity being managed through the main A&E service. This will then enable Grindon walk in centre to close over the summer of 2014/15 and some of that activity is expected to be transferred to either the Pallion centre or the new Houghton centre. The financial and activity assumptions have been factored into the plan supported by funding streams to support this.

- **Safe and Sustainable Emergency Care** – As part of the Trust's long term plans on redeveloping the delivery of emergency care and patient flows additional step up costs such as extended senior medical cover, have been funded by the CCG to support the new ways of working. These have been factored into the plans.

- **Sunderland CCG has put the management of three local Walk-in Centres out to tender (Urgent Care Centres)**. The Trust has applied to run these services as there are significant benefits from a patient flow perspective, for these services to be run as a combined service with A&E. However, at the time of the Annual Plan submission, the CCG has not made a decision around the outcome of the tender and therefore the impacts of this have not been factored into the financial or activity plans. Should the Trust be successful, this will be a variation in 2014/15.

Workforce

The workforce assumptions include:

- Pay awards of 1% per annum for staff on the top of agenda for change pay scales plus the anticipated impact of Agenda for Change increments
- A step up in recruitment associated with the national guidance on nurse staffing which is an outcome of the Francis Inquiry. Whilst national guidance is still being finalised and NICE guidelines are being produced, a ratio of 1 Registered Nurse to 8 Patients (1:8) is being proposed, and this has been reflected in our plan.
- In addition to the above for 2015/16 an additional 0.7% increase has been included for the changes to employer pension contributions as per national guidance.
- During 2013/14 there was a significant increase in the use of medical agency staff as part of delivering winter plans, Pallion and the Safe & Sustainable Emergency Care programme. For the period of the plan, it is expected that these posts will be substantially recruited to and therefore consultant numbers will increase and agency costs reduce
- Many services are working through the implications of expected junior doctor reductions and planning to increase the reliance on specialist nurses to mitigate this risk. This has been factored into the plan
- During 2013/14 there was an increase in Admin & Clerical workforce through temporary recruitment and agency staff to support the implementation of Meditech V6. It is expected that these numbers will reduce now that Meditech is in place. In addition a number of the corporate workstreams are targeting the more effective use of the system to drive efficiencies, and therefore there is an expectation of further non-clinical staff reductions during the period of the plan

Risks

Due to the changing commissioning environment and earlier deadline for contract agreements there was a substantial delay in agreeing the final contracts with commissioners. Known agreements, and offers have been included within the plans. In addition, where areas of dispute are subject to on-going discussion, prudent assumptions have been made around the likely outcomes of these discussions recognising CCG affordability and stance. Therefore, there are risks that these 'likely' outcomes do not translate into final contracts, and these risks have been factored into the downside planning assumptions.

Our CIP targets for both 2014/15 and 2015/16 are challenging and at this stage full plans to deliver these volumes are to be identified. The Trust generally has a good track record around delivery of CIPs, however it is becoming more difficult to identify and deliver at the scale identified as well as local CIP 'burn-out' with individual services struggling to go further. These risks have been factored into the downside planning assumptions.

Given the risks identified, the Trust is assuming a lower level of surplus in comparison with previous years, at a net £500k. The implications as detailed in the main financial submission are summarised in the table below:

	Forecast		Plan	
	2013/14 £000s		2014/15 £000s	2015/16 £000s
Income				
Clinical Income	296,987		296,988	299,704
Other Income	24,874		25,903	26,491
Total Income	321,861		322,891	326,195
			0.3%	1.0%
Expenditure				
Pay	196,460		198,416	201,878
Non Pay Costs	111,176		107,970	107,277
Total Expenditure	307,636		306,386	309,155
			-0.4%	0.9%
EBITDA	**14,225**		**16,505**	**17,040**
Non Trading				
Depreciation and PDC	13,825		14,543	14,793
Interest	1,274		1,462	1,747
Total Non Trading	15,098		16,005	16,540
NET (DEFICIT)/SURPLUS	**-874**		**500**	**500**

Capital Plans

The key capital schemes are detailed in the main submission but include:

- A&E new build and associated enablers to support the 'Safe and Sustainable Emergency Care' work programme. The impacts will be reflected in relevant years of the programme (£5.2m in 14/15 and £9.6m in 15/16) plus additional lease costs for equipment
- Multi-storey car park (MSCP) new build scheme which commenced in 2013/14 and is scheduled for completion in October 2014/15 (balance of £4.6m)
- Endovascular theatre to progress the Trust ambition to be the 3rd vascular centre in the region
- Radiology equipment including a wide bore MRI scanner, and a gamma camera for the medical physics service.
- Endoscopy service – relocation and expansion of the service to the highest national standards and to ensure business continuity
- Backlog maintenance programme based on a rolling risk assessment

The A&E build and MSCP will be funded from approved FTFF loans; all other capital schemes will be funded from depreciation funding.

Liquidity

The Trust is undertaking a substantial capital programme over the next 2 years to support the move towards Safe and Sustainable Emergency Care. These commitments require significant investment over this timeframe and the scale of investment will have an impact on the Trust's cash flow. In light of this, discussions are on-going with external companies to access sustainable funding streams to support these programmes, at this stage future loans the Trust may take out have not been included in the plan.

Risk Ratings

It is expected that the risk ratings over the period of the plan will be no lower than a 3.

Downside Planning

As identified within the risks section, CIP shortfalls and contractual risks have been factored into the downside planning assumptions, equating to approximately £5m in 2014/15. Counter to this the Trust never factors into the plan any assumed level of over-performance, and at this stage there are a number of elements within the contract proposals that indicate a level of under-commissioning. This has not as yet been included in the plans. Therefore, it is expected that any shortfall on contract assumptions will be matched by some degree of over-performance at least level with, if not higher than, the current assumptions.

CIP shortfalls however are a concern in that any issues of financial balance must be addressed by going further elsewhere. At this stage financial plans associated with the corporate programmes are prudent and further opportunities are being worked through to close the CIP gap in year. In addition, standardised processes relating to consultant job planning and nurse rota management are being worked through for part delivery in 2014/15. This includes the outsourcing of the flexibank system which has been put out to tender and is expected to improve processes and deliver financial benefits. The impacts of these are yet to be factored into the plan but could be significant