South Tyneside NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

South Tyneside NHS Foundation Trust

Operational Plan for y/e 31 March 2015 and 2016

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

Name	**Helen Patterson**
Job Title	**Deputy Director of Finance**
e-mail address	**Helen.Patterson@stft.nhs.uk**
Tel. no. for contact	**0191 2032975**
Date	**4 April 2014**

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

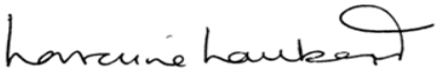
In signing below, the Trust is confirming that:

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

Approved on behalf of the Board of Directors by:

Name *(Chair)*	Peter Davidson
Signature	

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Lorraine Lambert
Signature	

Approved on behalf of the Board of Directors by: Name *(Finance Director)*	Mike Robson
Signature	

1 EXECUTIVE SUMMARY

This plan covers the period 2014-15 and 2015-16 and builds on the integration of services following the transfer of community services to South Tyneside NHS Foundation Trust in 2011 and the implementation of a revised portfolio of clinical pathways as part of our work with partners to ensure safe, sustainable and high quality services out into the future.

The external environment in which we work is increasingly complicated and more challenging; demand for urgent care continues to escalate and new patterns of commissioning are resulting in changes to the levels of planned care. The volatility of new commissioning arrangements presents us with a greater degree of challenge and organisational uncertainty. From working closely with essentially a single commissioner we will now be providing services to seven or more main commissioners; some with conflicting priorities. These organisations are at an early stage in the development of their own strategies and must respond to mandatory requirements in some cases to review service specifications. Engagement in these discussions will be key to ensure that our levels of business are maintained over the course of this plan.

The plan reiterates our commitment to collaborative and partnership working whilst supporting patient choice. Major strategic reshaping and transformation of services is embedded in our work with Foundation Trust partners to deliver the Bigger Picture agenda with the aim of developing clinical networks that provide safe, sustainable, cost effective services across South of Tyne & Wear. We work particularly closely with our Local Authority and Clinical Commissioning Group partners in South Tyneside in the development of integrated self care in our role within the national Pioneer bid and in developing the Better Care Fund submissions across Gateshead, South Tyneside and Sunderland. We recognise the areas in which we can be market leader and are actively working with health and Local Authority partners to accelerate commissioning of those areas to consolidate and develop our market presence.

We will continue to ensure that patient safety and quality of care is at the forefront of our work, building on our achievements in 2013-14 which saw successful CQC inspections and multiple accreditations of achievements at service and organisational level. We will continue to implement our Patient Safety Assurance Framework, Safety Thermometer and Choose Safer Care work in increasing harm free care. The framework will be used to underpin the results of our internal review of the Francis Report, and to be a guide when considering the impact on quality of any cost improvement projects. This plan details the significant work the Trust has carried out and continues to deliver to ensure the highest quality of local services.

This plan provides the detail behind our major cost improvement initiatives, with our Programme Management Office (PMO) overseeing the development of a pipeline of projects throughout the review period and beyond. The PMO ensures all projects in the pipeline demonstrate clarity on the size, source and allocation of any potential savings. The PERFORM methodology developed jointly with PricewaterhouseCoopers will continue to be implemented as a major element of our transformation programme. Our Transformation Board reviews progress on the

programme and provides Board Members with assurance that our savings plan is on target and an early view of any areas of concern. To ensure that our Cost Improvement Programme does not have an adverse impact on quality of care, we have ensured extensive clinical involvement in schemes throughout their development and implementation.

Summary of Key Financial Data

The following table summarises the key financial data included within the Annual Plan.

	2014/15 £m	2015/16 £m
Operating Income	212.43	193.73
Operating Expenses	195.76	190.14
Surplus from Operations	16.66	3.59
EBITDA	8.75	9.47
Surplus for the Year	13.80	0.50
Cash Balance at 31 March	15.87	12.56
Taxpayer's equity as at 31 March	113.73	114.23
Continuity of Services Risk Rating	4	4

Note: Operating Income, Surplus from Operations and Surplus for the Year for 2014/15 include £13.3m for the transfer of St. Benedict's Hospice

The financial plans are presented against a period of unprecedented commissioning uncertainty. In 2012/13 the Trust worked with a single cluster based management team covering three Primary Care Trusts for the vast majority of its activity. The introduction of three separate Clinical Commissioning Groups (CCG) and the splitting of a number of services to the equivalent three local authorities, Public Health England, two NHS England Local Area Teams and NHS England Specialist Services commissioning along with the uncertainties introduced by the Better Care Fund and the need to plan over two years, has introduced a degree of uncertainty not present in previous planning rounds. The Board of Directors will, therefore, keep the delivery of this plan under constant scrutiny and anticipates the need to re-set objectives and targets throughout the period as these uncertainties are addressed.

2 THE SHORT TERM CHALLENGE

This Operational Plan is drawn up in what are undoubtedly the toughest economic conditions that the Trust has faced since becoming a Foundation Trust. After a period of continuous cost reduction requirements the presumption in the Plan is of a 4% reduction in income due to tariff price reductions plus reductions in contract income as a result of procurement activity as Clinical Commissioning Groups look to reduce their spend as they face increased pressures and the prospect in the future of reduced allocations due to changes in national allocations. In addition a number of services have been transferred to Local Authority commissioning responsibilities and the economic outlook for Local Authorities inevitably means re-procurement of many of these services. The establishment of the Better Care Fund creates both opportunities for increased joint planning and joint working but also represents a financial risk. Whilst plans for development of the Better Care Fund are well advanced in terms of identification of shared services 2014/15 will see refinement of the programme and the changes that Commissioners will wish to see introduced. The Trust is an equal partner in the Better Care Fund development in all three localities and expects that the impact of the changes envisaged within each Fund will be better understood during 2014/15.

These changes are being introduced against a background of increasing complexity in the commissioning authorities as the allocation of responsibilities is still to be finalised and the tendency to review services which leads to whole procurement exercises increases. At this stage contracts for 2014/15 remain to be finalised.

From a service perspective the increasing complexity of patients, in particular the frail, elderly, advances in medical technology and the desire to move care out of hospital, the need to deliver high quality care seven days a week and the increased focus on patient safety and patient and carer experience continues to put pressure on all parts of the Trust's business.

Despite many initiatives to manage the demand for emergency care we have seen a year on year increase in pressure across our services and it is notable that in the area in which we live and work there are very many health problems that have a higher incidence than elsewhere in the country and indeed than elsewhere locally. This poor health profile often means that when people do come to us for care they have more than one problem affecting their overall health and their treatment and recovery is therefore more complex and their outcomes can be poorer as a result of these factors. We also know that many people do not access treatment as early as they should to get the best outcome and that they often come to us with advanced disease with the added complications that brings. What this means is that we must work in partnership across agencies to tackle this issue, to work intensively on health improvement initiatives and to tackle some of the basic causes of ill health.

For these reasons we are fully committed to the Health and Wellbeing Boards in the key Local Authority areas we serve in Sunderland, South Tyneside and Gateshead. We are a full member of the Health and Wellbeing Board in South Tyneside and expect this to be the case in Gateshead at the start of 2014/15. In Sunderland we are members of a support group to the Health And Wellbeing Board, the 'provider

forum' and we give maximum commitment to these important interagency discussions and contribute fully to plans to deliver health improvement across health, social care and other sectors. We understand that health is not simply about treating disease, it is affected by the whole infrastructure of how society works and factors such as joblessness, diet, lifestyle and poverty are major issues that we must tackle if we are to successfully make long term changes.

As a provider of both hospital and community services we are uniquely placed to make a really meaningful contribution in this area. We see the integration of services across health and social care as a major opportunity to improve care for our population and to put in place the foundations of long term and sustainable change. There is no doubt that the current economic climate combined with increased pressure across public services means that integrated working and achieving the best we can using our collective power and responsibility will be an essential factor for the continued delivery of high quality services. We understand this and will continue to play our full part and indeed lead some of these initiatives. Particularly important will be our continued work with our partners as a national pioneer in integrating health and social care and developing models of self care.

Of course we have other extremely important areas of partnership working. One of these is with our colleagues who commission our services both in terms of our formal contractual relationships and in terms of service development. We have spent a great deal of time in the past year building on these foundations and ensuring that we approach service improvement and quality with a common agenda and based on an open culture and sharing of information for the benefit of the patients we serve. In this way we have seen several service developments and changes to the way services are provided based on the first-hand experience of staff delivering services and of the users who receive them.

We also have long standing and well established partnership working arrangements in a number of clinical networks with other local provide Foundation Trusts. The majority of our services are now closely linked with other providers to ensure that we each meet high standards of care, that services are safe and sustainable and that we work collaboratively to design care pathways for the future that are fit for purpose and provide our patients with equity of access to services provided in the best place to meet their needs by the right expert staff to achieve the best outcome for them. Whilst these partnerships are with a wide range of Trusts our principle collaboration has been with the two provider foundation Trusts South of Tyne in Gateshead and Sunderland. This work programme known locally as the Bigger Picture has seen a number of very important initiatives to secure local services of the right quality that are sustainable and affordable out into the future. Notably in 2013/14 we consolidated an innovative partnership model of stroke services built on a telemedicine model allowing patients to be diagnosed and treated locally without having to travel out of their area. This was enhanced by the provision of services across the work for Transient Ischaemic Attacks which had previously not been available to that extent. This is a good example of how by working in partnership we have been able to secure and extend local provision which otherwise would not have been possible.

Also during 2013/14 we implemented planned changes to pathology services as part of this programme with services in Sunderland transferring to a centralised model

with a state of the art facility in Gateshead. Whilst locally each site will retain hot lab facilities for emergency and urgent tests this move will enable the joint development of pathology services that are second to none – another outstanding example of collaboration and mature partnership working. We have a number of ongoing partnership discussions of a similar nature which we expect to bear dividend in the coming year and increasingly see this networked approach as a fundamental aspect of the way we work to ensure high quality local service provision with appropriate access to specialist care.

During 2013/14 we also extended our work with the local voluntary sector and introduced in partnership with South Tyneside CVS a local volunteer programme initially targeted on our elderly care wards. This has been an excellent development and is highly valued by staff and patients alike and we are grateful to all involved for their efforts. Looking ahead we would like to see a major effort on developing a widespread approach to coordinated volunteering in the health and social care sector looking at this as a key strand of ending social isolation and providing real added value across care services releasing care staff to focus more on their specialist skills. This will be an important partnership development in the coming year involving close working initially with the Local Authority in South Tyneside.

We have refined and further developed our formal links during the year. Not only have we played a full role in the Health and Wellbeing Board we have established a local leadership group aimed at making sure that we have a common understanding of and focus on the key priorities facing the Borough. Similar groups are emerging in Sunderland and Gateshead involving our partners in the Local Authority, Clinical Commissioning Groups and other provider organisations and again given the complex agenda we are facing with the financial challenges ahead we see this common approach as the appropriate way to get the best for the people we serve

Locally we have been faced with a very significant financial target to achieve a recurrent cost improvement plan exceeding £12m in 2013/14 and this will rise to approaching £15m in 2014/15 and 2015/16. Cost reductions of this scale cannot be achieved by simply doing more of the same. We must either do more for less or attract new sources of income. With limited resource available for investment, most of our commissioners are also looking to make savings and to reduce the cost of the care they buy for their local populations. It is likely that commissioners will have to make some critical decisions about the type and scale of local services they wish to purchase and there are some risks in that process for all providers of healthcare.

We have worked hard therefore to build effective partnerships with our key commissioners understanding that in this climate a healthy and mutual business relationship is essential to get the best result for our patients. In addition to regular Board to Board meetings we also meet jointly at Executive level and have regular Board to Board meetings to understand each-others plans, priorities and pressures.

2.1 National and local commissioning priorities

The Trust is an active partner in many forums with both local and regional commissioners, and has developed its approach under the umbrella of the strategic objective of *Deliver excellent partnerships for the benefit of patients.*

Discussions regarding contracts for 2014-15 continue to highlight the complex relationships now in place in the commissioning landscape. As a provider across three localities, the number of contracts we have has multiplied. Clinical Commissioning Groups (CCGs) in Sunderland and Gateshead have agreed to again be co-signatories of the contract with South Tyneside CCG, however NHS England will move to a separate contract covering both specialised commissioning and local area team managed services. Separate contracts will each cover the three local authorities of Gateshead, Sunderland and South Tyneside. Each of those will differ slightly from the others, however a key theme is the much reduced notice period for service terminations that increases the risk of redundancy costs being unavoidable for the Trust.

The commissioning intentions of the CCGs and local authorities with whom we work are continuing to develop. Integration in various forms runs through each of them, with the key priority within this plans timescale is the preparation and implementation of the Better Care Fund (BCF). This fund will see the combination of health and social care funding, with the anticipated effect on the LHE being a reduction in acute care and an increases in community services. It is evident that each of the three local authority and clinical commissioning group combinations has a different approach to the BCF, and that they have to accelerate their planning considerably to meet their deadline for submission. The Trust has been represented in those planning sessions, but the net impact remains unclear, and the translation into specific contract changes looks likely to be some way in the future presenting significant planning difficulties for the Trust. While there are different approaches being taken in each case, the risks associated with any transfer of funding away from acute based services is mitigated by the Trust's position as the provider of community services.

The three local authorities became responsible for public health funding in 2013-14 and began a process of review that will be actioned through 2014 to 2016. While the transferred funding was protected, all of the authorities are anticipating significant funding reductions at the end of this planning period. They have each developed separate initiatives that aim to produce "integrated wellness plans" in their areas; the impact on the Trust has been significant with several smaller service teams being decommissioned. This has focused the Trust thinking on its service portfolio and the need to identify those services it sees as core to its future. The local authority rules regarding contract duration and market testing are also driving a constant stream of procurements for services the Trust currently holds across sexual health and substance misuse services.

It is also evident that commissioners inherently favour tenders from consortia bidders. Particularly in public health, it appears that they believe a health based organisation needs to partner with other specialist organisations to give the diversity of competency that they are looking for. The Trust has partnered with Age UK on the Integrated Care Hub tender, and is identifying suitable partners for other upcoming tenders. The Trust will be proactive in creating strategic partnerships in these areas, which may result in the other parties assuming the role of lead provider for a service if it will increase the likelihood of success.

The three clinical commissioning groups again have some variation in priorities, against a backdrop of the continued national deflation of funding both through

payment by results and block contracts. However, in all cases they have a strong focus on reviewing the community nursing teams that the Trust provides; albeit with different solutions in mind. The Trust is committed to working in partnership on the new models that will see district nursing, intermediate care and urgent care teams integrated into single teams that have a strong locality basis. As the current demand for those services continues to cause pressure on staffing, it is anticipated that the reform will not see a reduction in levels of funding.

Over the next two years several of our major existing community services will be tendered or are already in the process of being competitively tendered by commissioners:

- Sunderland Urgent Care Centres (to replace the Trust Minor Injury Units in Sunderland)
- Gateshead Substance Misuse service
- Gateshead Sexual Health services (an integration of existing GUM and Contraceptive and Sexual Health services)

In addition there are significant new opportunities already in process – the South Tyneside Integrated Care Hub for example. This is now typical of the number of active tenders at any given time, and the Trust has developed a virtual multi-disciplinary team approach to identifying which tenders to compete for, and to develop a winning submission.

The impact of increasing acuity amongst our patient population presents many challenges - A&E attendances, emergency admissions, longer length of stays and difficult discharges. However, we believe that we have a strategic strength in this area and are developing services that will be increasing sought after by commissioners, with innovative solutions such as the Care Home Nursing Team and the Premier Pathway Patients particular examples.

Our plan reflects changes being introduced in Gateshead to Minor Injury/Walk in Centre provision as the Commissioning Group elected to allow the Trust's existing contracts to lapse and be replaced by a single tender action with Gateshead NHS Foundation Trust. The plan, therefore, reflects the loss of the Gateshead Walk in Centre contract from 1 April 2014 and the Blaydon Minor Injury Unit/Walk in Centre from 1 June 2014.

Throughout 2013/14 the Trust has been reviewing its provision of Primary Care GP services and will work with NHS England as Commissioners to manage a smooth transition of the 4 GP practices, which the Trust took over as part of Transforming Community Services, to alternative providers.

3 QUALITY PLANS

3.1 Quality goals

The Trust quality strategy underpins its strategic objective of *Deliver high quality and safe services to patients.* The aims developed by the Trust to underpin this strategy and ensure the long term delivery of safe high quality services are:-

- Safe Care
    - A patient safety culture which is integral to our service delivery.
    - Demonstrable leadership for patient safety.
    - Systems and processes are in place to deliver safe care.

- Effective Treatment
    - Care and treatment will be based upon the best up to date evidence available.
    - A range of measures to monitor the safety and effectiveness of care and treatment.
    - Care and treatment that focuses on outcomes for patients.

- Quality Services
    - A workforce who are developed and have the relevant skills and knowledge to deliver safe, high quality care.
    - A workforce with compassion and caring skills and the right attitude and behaviour.
    - Transformation and modernisation of services to improve safety and quality.
    - Excellent patient care and experience
    - Continuous monitoring of safety and service improvement.

3.2 Leadership

The culture of an organisation, often described as 'the way things are done around here', can both explain the way people behave, and be the vehicle for improving patient safety and outcomes. *Choose to Lead* sets out South Tyneside NHS Foundation Trust's (STFT) leadership development strategy for 2014 to 2016 and incorporates the clinical leadership framework. The strategy is value led and as far as possible aims to develop our staff to become the leaders of the future at every level, some of whom will be able to take on more complex and demanding leadership roles. The success of the strategy will be measured in a range of ways from hard data related to increased productivity to the softer, but vitally important measures, of staff morale and motivation, innovation, cultural climate and leadership behaviours. The link between high staff morale and excellent patient care is clear as is the converse where low levels of staff motivation lead to unhappy patients.

Leadership and culture have a symbiotic relationship; the purpose of excellent leadership in the NHS is to create a positive patient safety culture. In 2013 in STFT we undertook a benchmark measure of our patient safety culture and had positive results; 59% of staff respondents expressed the belief that we are either

proactive or generative in our approach to patient safety. In 2015 the patient safety team will re measure the organisations cultural assessment in order to ensure that initiatives we are undertaking both with patients and staff are building on this solid foundation.

A ward /team /service level cultural assessments, currently in the pilot stage, will be rolled out across the Trust. This level of assessment will allow the patient safety team to examine the variation in culture between teams and target those in need of intensive support and coaching to improve team motivation and therefore patient care. This improvement initiative is aligned to the 'Investing in Behaviours' programme funded by the Health Foundation North East and is being taken forward nationally as an element of the Compassion in Practice Programme nationally. The Investing in Behaviours programme has two elements ; firstly it is underpinned by the Kirkpatrick evaluation model which ensures that any action, intervention or training actually delivers behaviour change rather than the simple acquisition of a new technical or theoretical skill .Secondly staff will be supported by the further roll out of Insights Discovery, led by the Continuous Quality Improvement Team, across all teams and services. The aim of Insights Discovery is to increase self-awareness and facilitate change in individual's teams and organisations, focusing on engaging "hearts and minds". The Trust will be a pilot site for the further development of Insights Discovery methodology as a tool to support staff to better engage with patients. The Trust is one of ten selected nationally to be involved in Insights Training for patients which will be embedded in the Trust over the period of the strategy.

3.3 Staff Engagement

A measure of success for the organisation will be when *everyone* in the Trust sees delivery of the best possible patient experience as their business and can quantify their contribution to our success and be proud to be part of it. Staff engagement is the key tenet to both delivering safe and effective patient care and excellent patient experience.

In line with the Patient Experience Strategy 2013 to 2016 the patient safety team will use Barbara's story, a series of powerful short films about a woman with dementia and her experiences with health care services, to engage staff to really focus on patient centred care. All staff are expected to have a good understanding of the issues faced by dementia patients so that they can all provide exceptional care. It doesn't matter whether or not staff work with patients directly; the reality is that they will come across a patient with dementia just by walking down the corridor, into clinics or patients' homes every day. Barbara's Story is a powerful reminder of just how important everyone's contribution is when it comes to creating a safe and positive environment and is profound and a stark reminder of the importance of understanding things from the patient's point of view. Barbara's story will be shared as widely as possible across all staff groups supported by a dementia training programmes suitable for all levels of staff. The programme focuses on staff behaviour and attitude change to care delivery and produces culture change.

The Carer and Patient Involvement team will compliment this work by carrying out an annual rolling programme of capturing patient stories, using semi structured

interviews, which will take place in patients' homes or in Trust premises. The information will be shared with each ward/team and service will drive improvement and understanding of patient experience in their areas.

From April 2014 a 'Friends and Family' test for staff will be introduced as a national requirement. Research has shown a relationship between staff engagement and individual and organisational outcome measures, such as staff absenteeism and turnover, patient satisfaction and mortality; and safety measures, including infection rates. The more engaged staff members are, the better the outcomes for patients and the organisation generally It is recommended that the results of the staff Friends and Family test should be used by providers and commissioners to celebrate success or make improvements where services do not live up to expectations. The staff Friends and Family results should be used alongside the patient Friends and Family test results, and other local intelligence, to drive improvement.

The Trust has recently published the "Being Open Policy" which sets out the organisations approach to the Duty of Candour ,a contractual requirement under the NHS Standard Contract to ensure that patients/their families are;

- told about patient safety incidents that are rated as moderate harm or above
- receive a sincere apology and informed of action taken
- are kept informed of investigations
- are supported to deal with the consequences of the harm

This policy also supports staff to meet their professional and organisational obligations with regard to being open with patients and families about clinical incidents and any resulting harm. The risk and compliance team have ensured that the systems and processes put in place ensure that the new requirements, with regard to writing letters to patients, do not add an extra burden to clinical staff, while at the same time making sure patients and families are treat with compassion and competence in this matter.

The Trust has an ambition to become a magnet organisation, increasing our ability to attract and retain the best staff to work with us in the face of intense competition from neighbouring trusts and actual/ predicted national shortages in some key professional groups. The patient safety team is supporting this work by ensuring that the organisation is perceived as attractive to both experienced and newly qualified staff by highlighting the diversity of what we offer the leadership and patient focus. New initiatives in this area include working in partnership with the University of Northumbria, to promote the Trust during the third year of the nursing degree course, highlighting leadership and the opportunities we can offer working as part of an integrated health care organisation. The Trust has expressed interest in being a pilot site for the widening access programme for nurses, participating in the apprenticeship scheme when finalised; building on our experience of running a successful, award winning cadet programme. The patient safety team will continue to offer engagement events to meet with potential recruits over 2014- 2017 and will support the development of the Trust "recruiting for values, behaviours and culture" to ensure we attract people with values congruent with our own to work as part of our teams.

3.4 Safety Metrics

STFT is one of the leading organisations nationally with regard to open and honest care; one of only 16 trusts in the country who were in a position to publish data in November 2013. The classic safety thermometer was implemented nationally in August 2012 and the Trust initiative "Choose Safer Care" was launched in October 2012. These tools have been expanded with other data and developed by the patient safety team to the current position in which patient safety dashboards are available by ward and team. These dashboards underpin the continuous dialogue between the patient safety and operational teams which ensure that teams needing support to deliver excellent care are identified at an early stage, and the appropriate improvement arrangements are put in place. This work will continue to develop with the expansion of the open and honest care into community services in March 2014.

Medicines safety is a high priority in STFT. In October 2013 the Trust became a pilot site for the medication safety thermometer, a national tool under development by a national steering group including senior nurses, medical directors, pharmacists, safety policy leads, and improvement and measurement specialists. The medication safety thermometer is designed to provide a snapshot on one day each month to understand medication error and associated harm to patients. This has provided the Trust with an opportunity to influence the development of the national tool, engaging with frontline teams in improving medication errors and reducing harm, collecting data and establishing a baseline from which to measure improvement. It is expected that this new tool will be rolled out nationally in 2014 and the patient safety team lead this process supporting operational teams. The Trust has been identified in the pilot as a national exemplar for the work to date. A maternity safety thermometer is also in development and is expected to be in place later in 2014.

In 2014/2015 the Infection Prevention and Control Team will broaden its work in relation to zero tolerance to avoidable infections. In 2013 - 2014 work commenced in the surveillance of hospital acquired pneumonia, including a retrospective audit for any case of hospital acquired pneumonia to determine avoidability. Further work will be undertaken in 2014 -2015 to develop a pathway for the prevention of hospital acquired pneumonia with the introduction of a visual tool designed to prompt staff to tilt patient's bed head by 30 degrees, a standard case definition and standardise reporting. It is expected that this initiative will effect a significant reduction in hospital acquired pneumonia which will significantly improve patient safety and experience and could potentially save up to £400,000 annually. A continuous improvement event will be held to ensure this work is embedded, developing standard work and ensuring staff are engaged with the initiative and understand the process required. This will be monitored through the Infection Prevention Control Team audit process and ward based champions. Prevalence data of hospital acquired pneumonia will be presented at the Infection Prevention Control Committee and shared with clinical teams.

The patient safety team will also launch initiatives designed to reduce falls and urinary tract infections; supporting operational staff to develop and change practice and monitoring and reporting progress at a ward/team level. In the

next year there will be a major focus on reducing unavoidable falls across the Trust and managing the increasing number of patients using our services with dementia safely.

3.5 Existing Quality Concerns

The Trust has had a number of inspections in line with National requirements. This has included visits from the Care Quality Commission, peer reviews and National Litigation Authority assessments. There are no restrictions on Trust activity, and any resulting action plans are in progress under the scrutiny of the Board.

3.6 Key Quality Risks

The organisation has carried out a robust review following the outcome of Francis 2. A task and finish group has been put in place and the Trust has developed an action plan to address any gaps or new developments.

The Trust is challenged by the range of patients who access our services who have very complex care and increasing frailty. The dependency of these patients is continuing to increase and many patients in this group are requiring one to one supervision and care delivery.

The increase in demand on the services, the dependency and complexity has led to developing systems to closely monitor and manage the demand.

The risks to the quality are impacted in addition by the challenges of change in social care and the parity and standards of the range of providers in social care that can impact on health care delivery. The growth in this market often leads health to meet the gaps in the market and with block contracts in health the demand is having to be constantly managed with the resources available. The challenges from commissioning and embryonic understanding of services could further impact on services stretched due to the current financial challenges facing the NHS.

3.7 Board Quality Assurance

Our approach to quality is encompassed within some key patient safety and quality strategies and sets out the trust vision and aspiration for quality, patient experience and patient safety.

Those strategies include:

- Patient Safety Strategy 2014 – 2017
- Choose to Care – Our Patient Experience Strategy 2013 – 2016
- Clinical Audit Strategy 2012 – 2014
- Francis 2 outcomes – Action Plan

The Trust has reviewed the Board Quality Assurance systems and process and a Patient Safety Assurance Group has been set up as a sub-committee to the Board of Directors to strengthen governance in relation to quality and patient safety. The Patient Safety Assurance Group has the autonomy to ensure appropriate measures

are taken to address any deficiencies or gaps in patient safety systems or processes. The group assess the annual programme of patient safety activity and monitors key patient safety performance indicators. A Patient Safety Panel has been developed in the Trust to analyse and triangulate information around patient safety indicators to identify trends of good practice and focus on areas not achieving optimum patient safety care standards.

Visible leadership is a key element of our strategy as a Board and we place great emphasis on leading by example, being accessible and encouraging feedback at all levels. Our Patient Safety Strategy and monitoring plan demonstrates high levels of assurance that key policy, systems and procedures are well established; audit and improvement plans in place with clear evidence of implementation and effectiveness throughout the organisation.

The development of the Patient Safety Division has enabled a step change in patient safety, patient experience, clinical staff development and improving staff experience. The focus of the Division is to drive the cultural change in the Trust to achieve a culture of improvement and delivering care to the highest standard to improve patient outcomes. The patient safety team work aligned to operational staff to achieve the highest level of clinical practice and professional standards competency and behaviours, ensuring that patient safety is at the core of everything we do.

3.8 Impact of Quality Plans on Workforce

Well developed, skilled and knowledgeable staff are the most valuable resource in any organisation. South Tyneside NHS Foundation Trust is very good at recruiting staff with the skills and experience needed for their role and also in developing newly qualified staff through a period of preceptorship. Ensuring staff remain fit for purpose is challenging to any Trust due to the fast pace of change within the NHS as technologies develop and new ways of working emerge. Following the Francis 2 and the Cavendish review of health care assistants a number of recommendations emerged which will directly affect our staff. Recent changes in professional regulation have highlighted the requirement for staff to have evidence of their fitness for practice to support their continued registration and leading to revalidation. Revalidation for Medical staff has been implemented in the Trust.

Revalidation for nurses will become an NMC requirement by 2015 and there will be a similar revalidation requirement for allied health professionals. Revalidation will require all nurses who wish to remain on the register confirming that they;

- Continue to remain fit for practice by meeting the principles of the revised code.
- Have completed the required hours of practice and learning activity through continuous professional development(CPD)
- Have used feedback from patients and colleagues to review and improve the way they work.
- Have received confirmation from someone well placed to comment on their continuing fitness to practise.

This process is a different approach to medical revalidation and has a resource impact on the Trust.

To support nurses and allied health professionals meet these requirements the patient safety team have developed core, specialist and advanced competency frameworks which will be rolled out to all staff in 2014.These frameworks will guide the development of practitioners as leaders, managers and clinical decision makers and will be supplemented by clinical competency frameworks appropriate to the area of clinical practice. These frameworks will form the basis of the personal portfolio of evidence that clinical staff will require to renew their registration and will become embedded in the appraisal process. The patient safety team will update the accompanying guidance to ensure that new developments and changes in practice are reflected in a timely manner, and will register a clinical audit to ensure that the standard of evidence collected by staff and how the staff are signed off as competent are standard and robust.

The Fundamentals of Care Certificate for health care assistants is a recommendation of the Cavendish review and the development of which will be developed by Health Education England (HEE). This recommendation is in recognition that 1.3 million frontline staff who are not registered nurses now deliver the bulk of hands on care in hospitals, care homes and peoples own homes. In the fullness of time it is expected that the CQC will require all health care assistants in health and social care to have completed the Certificate of Fundamental Care before they can work unsupervised. STFT has expressed an interest in being one of six pilot sites in the North of England to work in partnership with HEE to develop this process; reflecting the commitment of the organisation to ensure all levels of staff receive the training and support they need to do their job.

The Fundamentals of Care Certificate is part of the Talent for Care Strategy led by HEE for all band 1 to band 4 staff, engaging with staff through consultation to develop the support and training appropriate for these key staff groups. In STFT the patient safety team is leading on the clinical element of this initiative, working with the learning and development department who are leading with non-clinical staff.

3.9 The Learning Cycle

Continuous Quality Improvement (CQI) is already a key strength of our organisation, supporting the transformation programme and ensuring that patients are central to service improvements and best practice is embedded. The Continuous Quality Improvement Team support the development, monitoring and maintenance of patient safety initiatives by spending time observing patient and staff processes, collecting data and information; engaging staff in change projects and re measurement. Continuous Quality Improvement events focussed on reducing patient harm will take place in 2014 focussed on reducing falls, pressure damage, venous thromboembolisms and urinary tract infections in patients with indwelling catheters. In addition, the Continuous Quality Improvement will focus on the long term plan of the Trust and the Continuous Quality Improvement requirements to deliver safe care pathway changes and staff changes needed. The Trust has committed to implementing ‘Perform’ in

partnership with Price Waterhouse Cooper(PWC) to embed new ways of working in clinical teams to increase productivity and effectiveness. The Continuous Quality Improvement team will support this process in key areas across the organisation during 2014 - 2017.

The priorities for Quality Clinical Audit 2014/15 underpins the continuing development of the Trust as a learning organisation; providing the assurance that the clinical audit activities will be implemented to take changes into practice and improve patient outcomes. The integrated audit programme will continue, measuring compliance against fundamental standards of care and sharing results with wards and teams to support ownership of care delivery. Open and honest care and the safety thermometers require collection of data both for publication but also, and more importantly, to drive improvements for patients. This activity is undertaken by the clinical audit team to support front line teams and ensure results are received and reported in a timely manner. The demand from this work stream will increase during 2014 and 2017 as the national drive for open and honest care is expanded to all areas.

National audits, an example of which is Trauma Audit Research Network (TARN), continue year on year and provide assurance both internally and to external partners around the quality of care delivered by our clinical services.

Research and Development is vital to the development of new, more effective treatments for NHS patients. Being research active demonstrates a commitment to provide high quality patient care and embeds a culture of quality and innovation across the organisation. The Trust has a well-established clinical research team with academic support from Durham University and is actively developing its research capabilities. In 2013 -2014 there were a number of important developments within R&D and encouragingly there has been an increase in the number of studies submitted and in the range of specialities participating in research. Moving forward there is a need to increase the commercial studies and be involved in a range of national development.

3.10 Resourcing

There is a nationally accepted and growing body of evidence that patient outcomes are linked to whether or not organisations have the right people , with the right skills, in the right place at the right time. Following the publication of the of the report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry and the Keogh Reviews into 14 trusts with higher than expected mortality levels, the importance of NHS Trusts making the right decisions with regard to safe staffing levels is coming under increasing scrutiny.

In 2013 a staffing review of the acute bed based area in the Trust was conducted by the Executive Director of Nursing and Patient Safety. This review used the current evidence base, professional judgement and benchmarking with other local Trusts, to establish recommended staffing levels and identify areas of variation. The Board approved an investment of £1.8 million to address the gap identified in the acute areas.

During 2014 – 2017 the challenges to recruit into these posts will be high but the Trust must attract staff into the Trust using a range of innovation in how posts can be attractive. It will be vital to continue recruiting to meet the recommendations for both staffing and skill mix to ensure the Trust has the capacity and capability necessary to provide safe care for our patients; it will also be important to continue with the establishment review process for other areas across the Trust in 2014 - 2017.

New guidance from NHS England and the National Quality Board expect that staffing reviews across the whole Trust, led by the Executive Director of Nursing, will be undertaken twice per year and reported to the public at board meeting. The Board is expected to receive staffing reports every month detailing variance from recommended staffing levels. The Board will receive a new type of report in this way from March 2014.

New and innovative technologies are also continuing to be developed and rolled out to ensure that we as a Trust are getting the efficiencies and effectiveness from the staff resource. “eRostering” is a Transformation project which has the potential to improve patient safety and experience by ensuring visibility of safe, consistent staffing levels. The eRostering software automatically generates rotas aligned to a prepopulated template which defines agreed safe staffing levels and skill mix by shift. eRostering has already been rolled out across the acute bed base and the programme will be rolled out across community services in 2015. Linked to this initiative is the use of the nurse bank and the development of a new type of workforce in annualised hours posts. The Nurse banks used by the Trust have been centralised in 2013 and eBank will go live in 2014.eBank will become the only access point for bank staff moving forward, ensuring transparency with regard to bank usage and also providing assurance that we have robust standardised systems in place. The centralised bank will guarantee staff working for us on the nurse bank are up to date, fit for purpose and compliant with training requirements and with working time directives to ensure they are delivering the best care to patients.

South Tyneside NHS Foundation Trust is an award winning organisation, leading technical innovations which streamline processes freeing up time to care for front line staff, providing easy access to visibility of patient information systems and therefore reducing errors of omission. The recognition nationally has been in the patient safety business change team who lead the safe transformation of professional practice, ensuring innovative technology is safely procured, implemented and utilised within the Trust to support delivery of high quality, efficient, effective, safe patient care. This work will continue in 2014 – 2017 with priority areas being the development of new models of care supported by innovative technology an example of which is the integrated care hub. The development and spread of assisted technology, built from the bottom up from with clinicians and patients, will continue to be a priority in order to improve and streamline patient pathways.

3.11 Delivering Quality in line with National Policy Changes

In 2013/14 the Trust has reviewed the national requirements following the publication of Francis 2 in February 2013. The 290 recommendations were

reviewed and the Trust considered the base line position, new requirements and changes needed. The Board of Directors agreed a focus for the implementation of the main changes in the Francis " Report and the Berwick Report and a task and finish group, led by the Executive Director of Nursing and Patient Safety was instrumental in providing the framework for the Trust's Francis Action Plan. The outcome of the changes included the delivery of:

- Implementation of transparent care nationally and locally
- Being open about harms to patients
- Monitoring patient experience in "real time"
- Reviewing how we listen to patients and staff
- Strengthening triangulation of patient safety with the development of a Patient Safety Division and Patient Safety Panel

The Trust has achieved all actions set out in the national policies and practice. The Trust is part of a local Quality Surveillance Group reviewing the information available across the service providers and local population to understand areas of risk or concern and working together to share intelligence, delivery of actionable changes to improve patient safety at a range of levels.

4 OPERATIONAL REQUIREMENTS AND CAPACITY

Whilst the Commissioning Intentions of our three main Commissioners demonstrate little real growth through the Operational Plan period and there is a clear expectation of reducing resources as a new allocation formula is applied we cannot stand still as an organisation. Whilst ensuring we meet current demands and expectations we are of course always looking towards new developments and areas where we can grow our service portfolio. One area in which we see ourselves developing as a major provider is the provision of integrated health and social care services and we are in active discussion with local authority and commissioning colleagues in respect of this. As Local Authorities increasingly move away from direct provision into commissioning services from other providers we believe we are well placed to offer high quality care across the spectrum of health and social care services and have major ambitions in this respect.

Looking ahead we are developing our future clinical strategy based on our own service transformation programme combined with the ongoing Bigger Picture programme and our work with Health and Wellbeing Boards and key commissioners. Within our hospital services we see a number of potential areas for change in the years to come and in particular will focus on ensuring that we provide locally what we can do safely and sustainably whilst looking to partners to support our patients with specialist input where required. Broadly however we see there being a requirement for an ongoing provision of a full range of emergency medical services locally with appropriate support facilities and enhanced by world standard diagnostic services provision. We aspire to be a leading provider of diagnostic and rehabilitation services to support this ambition. Within our surgical specialties we envisage the continuation of high quality planned surgery locally in partnership with other providers, primarily our colleagues in Sunderland, whilst recognising that given the very small numbers involved it is likely that emergency surgery will need to be provided in a centralised model for the acute phase of care with local services for diagnostic and rehabilitation aspects of care. This will be essential to maintain quality standards and expertise going forwards and our clinicians are working hard with colleagues elsewhere to develop models that give our patients and our expert staff the very best opportunity to ensure the right quality and range of services.

Within community services we are working with commissioners to agree the scope and pattern of care to be provided moving primarily to a model based on GP and Local Authority localities. We share the aim of having comprehensive and coterminous local teams as far as possible to smooth the patient pathway and ensure the very best continuity of care. Some of this work has been completed in the last year or so and will be helpful on shaping how we go forward in these essential elements of our service portfolio.

4.1 Business Development

Developments under choice and competition will present both opportunities and potential threats for us and we will continue to assess these on a case by case basis to determine their viability for us both financially and clinically.

All new opportunities are assessed by our business development, clinical operational and finance teams and a recommendation made on whether to

progress with a bid or not is made to the Financial Risk Management Group.

During the early stages of this Plan we will assess the whole of our service portfolio to establish future sustainability and determine likely responses to tendering opportunities. Criteria to support this decision are:

- Fit with clinical strategy and annual plan
- Financial assessment
- Competition and likelihood of success

The Trust strategic objective of *Continuously improve our services* defines our operational and clinical strategy and early priorities include:

- Implement cardiology pathway in partnership with City Hospitals Sunderland – The two consultant cardiology teams recognise the benefit of closer working. The Trust is also the provider of community cardiac and cardiac rehabilitation services in both Sunderland and South Tyneside, and this partnership will enable fully integrated pathways across both localities.

- Implement out of hours rota in General Surgery with City Hospitals Sunderland – The two trusts have established that there will be mutual benefits in developing a joint rota for out of hours emergency surgery.

- Review obstetric service provision – The current maternity model provides high quality care for mothers and babies, but the number of births each year results in relatively high costs. The service intends to proactively review options to ensure that there is a long-term, sustainable service locally for the residents of South Tyneside.

- Review radiology service provision and be part of the Perform process – The Trust will review the use of diagnostic resources to support 7 day working. Hospital inpatients will have scheduled seven-day access to diagnostic services including x-ray, ultrasound, computerised tomography (CT), and magnetic resonance imaging (MRI). Consultant-directed diagnostic tests and their reporting will be available seven days a week:

    - within 1 hour for critical patients;
    - within 12 hours for urgent patients; and
    - within 24 hours for non-urgent patients

    The organisational benefits to moving toward provision of 7 day services include:

    - avoidance of waste and repetition;
    - fewer complications;
    - admission to the right place, first time;
    - better supervision of the work of doctors in training;
    - more efficient use of expensive plant and equipment;
    - shorter length of stay; and
    - reduced bed pressure Monday to Friday.

- Align clinical and estates strategies – The changes in services, both acute and community, will generate challenges and opportunities to align those developments with the ongoing refreshing of the Trust estate. The work on the Integrated Care Hub has demonstrated how the Trusts excellent position on its land stock can be used as a significant competitive advantage.

- Implementation of eRostering – The Trust has invested in and implemented an eRostering system that is starting to generate high quality data. In the next year, this data will be used to dynamically manage the staffing establishment in selected areas, to maximise the efficiency of core and bank staff by aligning staffing levels with demand on a real time basis and provide the basis for public reporting of staffing levels.

- Implement Elderly Care strategy – The Trust will move to centralise inpatient elderly care services on the district hospital site whilst we design and complete a full business case to support the development of a new care of the elderly centre. This will co-locate the three elderly care wards in a purpose built unit, dementia friendly environment boasting an enhanced environment and single sex en suite rooms to promote independence and privacy/dignity. This may include investing in additional nursing and medical staff for the unit.

Other sources of service developments agreed with Commissioners are the Commissioning for Quality & Innovation (CQUIN), the Service Development and Improvement Plan (SDIP) and the Better Care Fund (BCF). These schemes are yet to be finalised and, indeed, a number would require significant additional resources to deliver and as a result would be very challenging. Current proposals include:

<u>Commissioning for Quality and Innovation (CQUIN)</u>

- Building on the existing programme of improving the experience of patients utilising the Friends & Families Test, the Trust will roll out the Test to all staff members.

- Reduction of harm using the NHS Safety Thermometer. In addition to the nationally mandated elements, the Trust will include its work as one of the pilot sites for Medication Errors Safety Thermometer.

- Continuing the nationally mandated improved identification of patients with dementia, and building on the work within District Nursing.

- Reductions in planned and unplanned care for priority long term conditions. These two schemes are weighted heavily by commissioners; however there remains some work to do to clarify what would be possible, and what the incentive to the Trust would be.

- Implementation of the six Cs Compassion in Practice, focusing on a reduction in complaints based on staff attitude.

- Improvements in end of life care by ensuring the End of Life Care plan is

agreed and used by all agencies

- Ensuring retinopathy screening in premature babies is completed within the prescribed timescale

- Improve the levels of breast feeding of pre-term babies in Special Care Baby Unit

- Integrated shared assessment framework between maternity and health visiting services

Service Development and Improvement Plan (SDIP)

The contractual discussions with commissioners have resulted in a number of significant pieces of work to be completed in-year during 2014-15. The priority areas are:

- Agree implementation of clinical standards within NHS Services, Seven Days a Week Forum review.

- Review the implementation of the 6 high impact innovation areas in the Innovation, Health and Wellbeing report.

- Agree the implementation of the AQP Podiatry contract and its impact on the complex podiatry block contract.

- Service specific improvements in diabetes, cardiology, CAMHS, paediatrics, dermatology, chemotherapy

- Review the provision of Continuing Healthcare assessments across the three localities

- Review the provision of specialist palliative care in South Tyneside

- Demonstrate compliance with post discharge tariffs

The Trust has worked hard during the contract negotiations to ensure that the SDIP is a fair reflection of the issues that both parties want to push forward on during the year, rather than being purely a commissioner wish list.

Better Care Fund (BCF)

The Trust is an active partner in the development of the Better Care Fund within the three main localities that we serve. Whilst the plans are still in development the key themes which are likely to emerge include:

Gateshead

- Single Point of Access. This will be a single contact point for the public and professionals who need intermediate health or social care services. Trust

teams will support the local authority as the lead provider.

- Alignment of Community Nursing teams and establishment of a GP 'frailty register'. The Trust will work with the CCG to develop locality based nursing teams with a range of skilled nurses wrapped around a group of GP practices.

- Alignment of hospital based frailty team with community nursing teams. The Trust nursing teams will share continuous assessment using standard tools and principles across a flexible system, alongside the QEH frailty team.

- Establish a dementia pathway across Gateshead. Trust nursing teams will continue to assess and refer patients for dementia services

- Expansion of ambulatory care conditions. The Trust intermediate care team currently successfully deliver the IV antibiotic service, which will be expanded to cover other conditions

- Establish a 24/7 seamless palliative care service. As the provider of specialist palliative care nursing services, we will contribute to the development of a single care plan that is accessible and used by all agencies.

- Establish an urgent domiciliary care service. Trust therapy and nursing teams will contribute to a robust pathway that responds rapidly to a health or social care crisis.

- Alignment of discharge support teams and coordination officers. Agreed pathways of care will be developed that ensure a clear interface between hospital discharge, social work teams and community health and social care services.

- Introduce 'roving GP'. The Trust Urgent Care Team will be supported by the new post with clinical decision making, and prescriptions of medications outside of existing Patient Group Directives

- Expansion of Care Homes initiative. This award winning service was developed by the Trust, and will be expanded to include residential homes

- Enhance a seamless falls service. The Trust will work with the appointed Falls Coordinator to develop a common pathway.

South Tyneside

- Self Care Integration Pioneer Work. The development of a standardised self care offer which will be offered at a scale by health and social care professionals, as well as by non traditional professional groups.

- Planned Care. Review of all community teams contributing to planned care to achieve maximum integration.

- The implementation of an Integrated Care Hub which includes a new model of care for people with dementia from early diagnosis to end of life, reablement services and day care

- Change4Life integrated wellbeing programme. Developing an integrated approach to prevention and early intervention across the life course, providing a Standardised Point of Access to a holistic wellbeing service addressing multiple behaviours across the life course

Sunderland

The Sunderland local health economy is proposing to introduce a Better Care Fund to address the total health and Local Authority spend on out of hospital care services which will be significantly in access of the required scale of a Better Care Fund. The following broad initiatives are proposed:

- Integrated community teams. Review of all community teams within locality areas to ensure maximum integration.

- Seven day access. Review of access to services in line with the NHS Services 7 days a week forum review.

- Expansion of intermediate care reablement services.

- Review of packages of care including continuing health care and care home provision.

- Establish a dementia friendly communities programme.

- Establish a single pool arrangement for learning disability services.

- Support and respite breaks for carers initiative.

4.2 Workforce

The most critical resource to ensure delivery of the ambitions set out in our Plan is the Trust workforce and the Board recognises having the right staff with the right skills, available at the right time, is essential to delivery.

<u>Medical Staffing</u>

We have an excellent track record of investment in medical staffing to ensure our ambition to be provider and employer of choice is achieved. We will continue to invest in a number of services in response to the needs of the population we serve and based on historical and predicted demand. Priorities within the Plan period include:-

- An additional Consultant General Surgeon
- An additional Consultant in Trauma and Orthopaedics
- Investment in elderly care through Consultants and junior medical staff to

enable a full review of our bed profile recognising the changes in the age profile and the complex needs of our elderly frail patients and ensure sustainable services going forward.

We also anticipate ongoing pressures in respect of trainee placements and have made contingency plans to manage these through internal bank staff recruitment which reduces the risk of rota gaps.

Nursing & Other Clinical Staff

We recognise that well educated, skilled and knowledgeable staff are our most valuable resource in achieving safe standards of patient care, improved patient outcomes and excellent patient experience.

An assessment of ward based nurse staffing levels concluded in 2013/14 that significant additional investment was required in some key areas. This Plan includes a phased recruitment plan in recognition of the difficulties of achieving significant recruitment in a short period. As detailed elsewhere in the Plan the recruitment programme and the need for further investment will be monitored by the Board.

Non Clinical Staff

With regard to the non-direct clinical workforce, our aim is to ensure that we provide the right support to enable direct patient care staff in the delivery of high quality safe services. In doing so, we must ensure that these services are provided efficiently and are comparable in terms of cost with other similar Trusts.

The Board of Directors have reviewed the Human Resources Strategy to underpin the Operational Plan of the Trust and ensure the availability of the correct staffing resources to underpin the Plan. The following objectives, are the high priority objectives which will be implemented by a series of HR Matrix Groups

Workforce Planning

We will produce and agree a multi-disciplinary “Trust force Plan – 2014 – 2017”, incorporating knowledge of all staff groups, and regional and national workforce trends, including the identification of new job roles.

Recruitment and Retention

We are developing a range of selection tools which are designed to measure whether applicants will fit with our values. Over the period of the strategy these will be in widespread use. We will also produce alternative terms and conditions that can be adopted through a subsidiary company, to tender competitively for integrated health/social care service contracts.

Health, Safety and Welfare

We will fully implement a programme of activities and initiatives designed to prevent staff being stressed at work which will be based on a Stress Prevention survey. We will seek to reduce the average sickness absence rate to no more than 4.6% by the

end of the Strategy period.

Fairness at Work

We will fully implement the actions required to comply with the NHS Equality Delivery System. We still have a number of outstanding equal pay claims as most north east Trusts have and we will clear all of these during the next three years.

Communications

We will fully implement a revised digital and non-digital version of our Communication Zones in 12 locations across the Trust. One of our 5 People Management Standards is to ensure effective communications and we will evaluate how success we have been to date.

Reward & Recognition

Our new Staff Appreciation Strategy 2013, aimed at recognising staff's loyalty, innovation and willingness to go the extra mile will be fully implemented.

Lifelong Learning

We will introduce new and innovative ways to ensure that we have 95% compliance with all statutory and mandatory training requirements. We will also aim to employ 50% of all apprentices and nurse cadets within the Trust on completion of their programmes.

Organisational Development

Our newly agreed CHOOSE to LEAD, Leadership Development programme will be rolled out across the full Trust, establishing a consistent style of leadership. Every ward and department will have identified their own value related behaviours and these will be published and displayed.

Investors in People

For many years now the Trust has held the prestigious IIP accreditation and we will seek re-accreditation in 2014.

Evaluation

We want to be sure that our HR Strategy is achieving its aims so we will produce an HR evaluation tool kit, including the first 4 tools/methods to measure HR success.

4.3 Activity

The Trust Contracting Team uses a "service life cycle" approach to manage its portfolio of services, which recognises that:

- Non acute contracts are for fixed terms; services need to quickly achieve profitability following start-up, improve that position through the consolidation

phase and ensure cost exposure is limited during any termination phase.

- Commissioners are becoming more successful in identifying options for moving acute activity into primary and community care.

The CCGs are actively committed to managing and reducing both planned and unplanned activity levels. Attendances to A&E and the minor injury units continued to increase in 2013/14 and saw uncharacteristically high levels with associated high emergency admission levels. Commissioners have contracted at the 2013/14 outturn levels but the activity changes further into the plan period are more uncertain particularly as the Better Care Fund is introduced in 2015/16. As the initiatives to be introduced under the Better Care Fund are not in sufficient detail yet, it is impossible to estimate their impact on activity levels.

In planned care, the activity assumptions are based on a continued focus on retaining patients within primary care, balanced by an increase in acuity of patients. There is likely to be a further pressure on new to review ratios and the consultant to consultant referral policy, with some new areas moved from inpatient to outpatient (or community activity).

The opportunity for new income is limited in the general economic environment; however the Trust is at an advantage to benefit from the readmission reduction initiatives pursued by commissioners and schemes introduced within the Better Care Fund to enhance integrated working within community and social care in order to reduce emergency admissions to hospital.

The activity assumptions within the plan do not create a significant pressure on the estate resources although we will rationalise care of the elderly provision and centralise 24/7 in patient services on the South Tyneside District Hospital site. Across community services, the Trust continues to take advantage of its purchase of Clarendon House and other opportunities as they arise in other locations to develop “community hubs” that will consolidate teams into a smaller number of sites, significantly reducing lease and other accommodation costs. Community rationalisation will, however, take account of our desire to work with Clinical Commissioning Groups and Local Authorities to create community locality teams as part of the shared integration agenda. In addition we will take formal ownership of our flagship St Benedict’s Hospice in 2014.

The early stages of the elderly care strategy which will see the centralisation of services on the elderly care site is expected to allow a reduction of 18 beds and is reflected in the forecast bed capacity in the plan. Key activity measures included within the plan which reflect the likely contract agreements include:

	2014/15	2015/16
Community Contracts	£1,454,000	£1,419,000
Elective & Day Case Patients	£13,548	£13,748
Non Elective Patients	£16,144	£16,144
Outpatients	£86,000	£86,000
A & E attendances	£61,000	£61,000
Beds	443	438

5 FINANCIAL STRATEGY

The Trust has a consistent history of delivering financial targets having delivered underlying surpluses for every year since authorisation, excluding exceptional costs for transformational schemes and the impact of revaluations.

The financial plans are presented against a period of unprecedented commissioning uncertainty. From working closely with essentially a single commissioner the Trust is now providing services to seven or more main commissioners; some with conflicting priorities. These organisations are at an early stage in the development of their own strategies and must respond to mandatory requirements in some cases to review service specifications.

The earlier submission of the annual plan for 2014/15 has also brought a number of challenges for the Trust. Initial contract offers from the various commissioners were not received until late in February and, therefore, the plan was developed based upon the Trust's best estimate of what those offers might be. There was also uncertainty surrounding the impact of the Better Care Fund from 2015/16. Whilst the Trust expects that income for Community Services will grow in 2015/16, the extent of this and the impact on Acute Services is still unknown and, therefore, not reflected in this plan.

The implementation of the Risk Assessment Framework in October 2013 resulted in a change to the calculation of a Foundation Trust's risk rating. The Continuity of Services Risk Rating (COSRR) replaced the Financial Risk Rating (FRR) and changed the focus to the Trust's ability to continue to provide its services by ensuring that it could pay its staff and suppliers and service its debt. The COSRR is based upon 2 metrics; liquidity and capital service cover, both of which are equally weighted.

The change in the calculation has been of benefit to the Trust, which historically was disadvantaged by risk ratings based around EBITDA measures, however, the large cash balances generated by the Trust are now reflected in a planned COSRR of 4 throughout 2014/15 and 2015/16 which is the highest rating and indicates no emerging concerns.

Our financial plans reflect national policy, including the requirement for 4% efficiency and further reductions in income as a result of local commissioning decisions. Over the next two years several of the Trust's existing community services will be tendered or are already in the process of being competitively tendered by commissioners. Where the outcome of the tender is known this has been reflected in the operational plan and has resulted in a reduction in income. Direct costs of the services have also been removed and the Trust will continue to work on reducing indirect costs associated with the services.

During 2014/15 the ownership of the new purpose built hospice in Ryhope, Sunderland (St Benedict's Hospice) will transfer to the Trust following completion of the defects liability period. The transaction will be a Statutory Transfer at nil consideration, however, for accounting purposes it is shown in the plan as capital expenditure of £13.3m funded from a flow of donated/granted income. The £13.3m

income is outside of the scope of the COSRR although it does impact on the surplus in 2014/15. It does not impact on cash balances.

Income generation schemes arising from work carried out on continuous improvement projects are included within the plan. The Trust is working in partnership with Age UK on an Integrated Care Hub tender for South Tyneside. However, as the outcome of this is currently uncertain it has not been included within the financial plans. The Trust will continue to respond positively to opportunities for business development within its core services, in line with our developing strategy of integrating health and social care, which emerge during the lifetime of the plan.

Whilst the Board has agreed a strategy of expanding the scope and range of services offered, particularly in the field of integrated health and social care, no estimates of the benefit of this are included in the plan at this stage. The plan, therefore, assumes delivery of savings to close the gap between planned income and expenditure. Whilst any growth of business will reduce this gap the current delivery of savings required to achieve the Trust's plans will remain a significant challenge, with targets of 7.1% and 7.2% required over the two years of the plan. Achieving these savings, whilst controlling emerging costs pressures as the Trust continues to main the highest quality of services, will undoubtedly represent a constant focus for the Board. The main strategy in addressing this gap will be the deployment of PERFORM throughout the Trust. PERFORM is the Trust's proven approach to continuous improvement and embedding operational excellence, providing managers with the tools/techniques to improve performance and is discussed later.

Throughout the lifetime of the plan the Trust will continue with its internal investment in estate and equipment (medical and IT) in support of its operations and will look to rationalise its use of accommodation not owned by the Trust. This strategy of rationalisation is expected to generate operational savings. This internal investment exceeds internally generated funds in the financial plan for 2014/15 and 2015/16 and as a result of this cash balances are expected to fall. However, the fall in cash balances will be managed to ensure no impact on the liquidity rating in the COSRR.

5.1 Productivity, efficiency and CIPs

Continued delivery of more and more challenging cost improvement programme (CIP) targets will be difficult, however, we can build upon successful delivery over recent years utilising not just traditional CIP measures but also service transformation and redesign.

Within our organisation we have also seen a major programme of change and modernisation in recent years. Our 'Choose Change -Driving Transformation Forward' programme has led to some very important strategic reshaping of services. Over the past two years we have looked at all aspects of how we deliver care, at how we organise our resources to support that care delivery and at the business systems and processes that underpin this important work. This has led to a new way of organising our staff teams into pathways of care supported by new working arrangements. This has been a difficult period of change and we intend to build on these foundations in the coming year with a greater degree of devolved authority from the Board of Directors to the operational service areas to allow them to move

swiftly to identify and find solutions to key challenges and to act on them with responsibility and accountability. This is part of our 'Choose to Lead' programme and forms an essential part of transformational change in all that we do. The Board has undertaken some development work to identify how it can best lead the organisation through this challenging time and to identify the tools and systems it needs to do this effectively. In the last two years we have had a number of changes to the membership of the Board of Directors which has brought some new skills and expertise and this fresh perspective has provided an ideal opportunity for us to reflect on how we wish to work to give the right leadership to our operational services whilst maintaining a strong focus on our strategy, thinking ahead to where we want our organisation to be in three to five years time. This has led us to think critically about the governance structure that supports the Board and resulted in a new formal Sub Committee structure to enable us to balance the work of the board at a strategic level with the more detailed and rigorous scrutiny required of operational service delivery.

To ensure that we can make the best of this way of working the Board has undertaken a programme of development aimed at challenging ourselves openly about how effective we are, what we can do to improve and to ensure that we act on any changes required. A good example of this is our decision to review our scheme of delegation to ensure that matters that come to the Board for approval are of a significant scale and that we do not lose sight of the important issues by being faced with a large amount of routine and detailed operational scrutiny, more suited to the work programme of sub committees and the Executive Board.

A significant programme of work during 2013/14 was the development of a strategic partnership with PricewaterhouseCoopers (PWC) to further develop our approach to efficiency. Having undertaken some very good work with PWC the previous year as part of our transformation programme, we saw an opportunity to extend this and to adopt a methodology developed by PWC called 'PERFORM' as a fundamental strand of our approach to service transformation and efficiency on a much wider scale. Having not had the opportunity to test this in the health arena before, this also provided PWC with an opportunity to refine the methodology with us as we tested its implementation over a number of areas. The early results from this work have led us to extend the programme into a pipeline of schemes over the life of our Annual Strategic Plan and in the coming year we will be putting a dedicated team in place to support this important initiative so as not to lose the momentum,

We have used this methodology to rethink how we manage the systems and processes that support the delivery of care. For example in our theatres we have made significant changes to the way we plan, organise and manage our work to reduce waste, improve throughput and make the best use of the operating time available. Our staff have been truly remarkable in the way they have embraced this way of working showing real leadership and supporting the team from PWC in developing and refining the approach. We are extending the work across most of our key service areas and anticipate this becoming a fundamental part if the way we deliver services in the future to ensure all of our teams operate to the same principles of ensuring that all of our efforts are designed to achieve maximum efficiency and effectiveness in the provision of our services to patients.

Whilst we have used the PERFORM programme as a fundamental part of our

approach to efficiency we have also used it to improve quality and effectiveness and recognise that there will be areas of our work where financial gain may not be possible but where there are major opportunities for patient safety and quality by using the same approach to the way we manage and deliver services. It is important that we do not lose sight of this. There can be a tendency to focus solely on cost reduction but for us service quality and continuous improvement is a fundamental part of our belief system about the service we provide and our responsibilities to our patients.

We have a very strong track record in service improvement and evidence of this can be seen in many of our front line services and indeed in our support services. We have a highly trained service improvement team that supports field staff in thinking about what they do and objectively challenging themselves as to how they could do things better and in making plans to do so. We use a number of well tried and tested service improvement methodologies to support this work and are extremely proud of the many awards which we have achieved across our services at local, regional and national level. Further detail is available about these throughout our annual report and it is without doubt a real pleasure to work with enthusiastic people who are driving forward for improved quality at all times.

Key to success in our programme of transformation has been the team who support our Programme Management Office. Whilst few in number these key individuals have brought a rigour to the process which has enabled the Board to have a high degree of confidence in the delivery of change and the rewards this has yielded.

The PMO team regularly reviews progress of projects with delivery teams at “checkpoint” meetings, where there is a focus on delivery against agreed milestones. They then consolidate this information and present a performance dashboard to Transformation Board that highlights exceptions, such that Transformation Board can gain a level of assurance that the programme remains on target overall.

This approach was developed during 2013/14, accelerating and performance against milestones has been good overall, with the key learning points now being included in future iterations of the project portfolio. These include:-

- Identification of opportunities using a top down approach based on available performance data benchmarked to other organisations is more likely to generate “big ticket” schemes than a bottom up assessment of existing spending areas
- A multi-disciplinary approach to developing a Project Initiation Document (PID) will lead to a more robust project; one where the benefits can be identified and tracked out at the end of the work

The Board now meets as a whole quarterly as a Transformation Board to review progress on the programme and has overseen some really fundamental changes to the way we do things which have bed identified by field staff delivering services and supported by the programme management office and Transformation Board in their delivery. Examples include the extensive use of new technology to support community nurses in scheduling their workload and maintaining effective records. This award winning scheme has been further supplemented by the development of an 'app' to further enhance the ability of the community teams to work whilst in the

move without the need to keep returning to base to input data about each visit. Again these developments are at the leading edge of work in this field and are already being emulated by others following our lead.

5.2 CIP Profile

Cost Improvements amounting to £11.2m are expected to be delivered against a target of £12.5m in 2013/14. In the year a number of major projects were brought to fruition under the Driving Transformation Forward Programme including:-

- a major review of administrative and clerical staffing systems and structures
- a major review of clinical and nursing management structures
- rationalisation of IT services
- new more efficient arrangements for lease cars
- an extensive realignment and rationalisation of our estate
- centralisation of community bases

The cost improvement target for 2014/15 amounts to £13.8m which is approximately 7% of estimated turnover and is recognised by the Board as challenging. However a number of the schemes commenced in 2013/14 are on going and will deliver benefits in 2014/15, these together with the work carried out on the Perform project and other additional schemes as part of the 2014/15 programme have been presented to and approved by the Board.

Cost improvement schemes have been grouped within the Plan across the following themes:

- Perform Project
- Departmental efficiency
- Estates Rationalisation
- Other

Appendix 2 contains broad details of the key CIP schemes. Of those schemes, those that represent step changes in processes include:

Perform Project – As noted above the Trust continued engaging services from PricewaterhouseCoopers LLP in the year. One of the schemes implemented in 2013/14 relates to efficient utilisation of theatres for Orthopaedic elective inpatients and day cases. This has been included as a revenue generation scheme in 2014/15 and 2015/16 and is therefore accounted for outside of the CIP plan. However, other cost saving schemes have been identified.

Departmental Efficiency – a number of schemes, other than the Perform project, have been identified for development in the year. These include a review of services retracted in the year to identify further indirect costs and overheads that can be removed and a review of areas where service reform has been implemented to ensure services are cost effective.

Estates Rationalisation - Office Accommodation – The further development of locality hubs for community clinical staff will significantly reduce estates costs. In addition to

this the Estates Strategy and capital plans will review options for utilising properties vacated in the year. To ensure that this is not offset by increased travel costs and reduced efficiency, the Trust has introduced mobile working solutions that minimise the need for return to base trips. The method for the valuation of the estate will also be reviewed.

The Trust has taken a step forward in being able to provide patient level costing for community services as well as acute services. This will be further developed during the period of the plan. Improvements in data quality through continuous review of the allocation of costs and income to key service lines will enable accurate targeting of improvement initiatives. Engagement with clinicians and service managers will identify the key drivers of costs and income and the actions required to deliver those initiatives.

5.3 CIP Enablers

Clinicians are fully involved in the process of transformation; this is particularly evident in the development of schemes under the Accelerating Bigger Picture banner, where the initiatives often come from the clinical teams, and rely on their ability to work effectively with colleagues in the other Foundation Trusts.

The Medical Director and Executive Director of Nursing and Patient Safety are full members of the Transformation Board, and therefore have oversight of new schemes as they are being developed and approved. The Trust Chief Operating Officer, as well as the operational managers, all have clinical backgrounds and are key leaders of the transformation projects.

The need for enabling investment is a key part of the PID development, and the Trust takes a balanced view on “invest to save” proposals. The IT team is often called on to support major change, as new hardware or software is often seen as the solution. The IT service is concluding a period of expansion, which includes strengthening its project management resource; however it is also taking a more proactive role in supporting transformation project development enabling delivery by operational teams to increase ownership of implementation.

In addition to additional resource we continue to look to develop the competency of existing staff. We are committed to a programme of continuous improvement, listening and encouraging staff to use their ideas and influence to improve services, and the Kaizen Promotion Office both trains staff in lean methodology, and supports the application in operational areas. We have a refreshed programme of continuous improvement events for the next 2 years where front line staff work together intensively to address specific service issues that have been identified. The continuous improvement programme focuses on service improvements developed at the event which are then implemented immediately, making this way of working very effective. The learning that emerges from this improvement work is shared across the organisation through the Management Forum, where managers hear from colleagues about service changes. This structured approach of sharing has proved very powerful in promoting new ideas as a result of success in other areas, and increasing improvements in patient outcomes across the organisation.

5.4 Quality Impact of CIPs

We firmly believe it is possible to deliver increased quality of care for patients at a lower overall cost. A number of the areas covered in the initial phase of the Transformation Programme focus on back-office and administration costs, and we will continue to drive up efficiency in those areas. Those schemes with elements of clinical efficiency improvement often have a direct benefit to quality; this indeed is a key element of the PERFORM programme. PERFORM is carried out by clinical teams in their workplace where they set their own standards of performance and daily assess their impact and agree improvements for immediate implementation.

Assessing the impact on quality of any initiative requires the baseline position to be known. To support this we have developed an extensive Patient Safety Dashboard that directly measures a range of indicators and correlates the effects of such issues as absence rates and turnover. We have very stable baseline positions in respect of mortality rates, hospital acquired infection rates, mixed sex accommodation breaches, waiting times, both elective and non-elective and cancelled operations. Our extensive patient experience survey programme also provides an existing reference point against which to assess the impact on quality of any changes.

We believe the PID development approach contributes significantly to the mitigation of any risk to quality of care. It encourages a robust debate regarding a potential scheme through a number of iterations before finally being put forward to Transformation Board for approval

A development of the PMO process is to discuss a new PID with the Nursing and Patient Safety team, identifying the direct and indirect impact of the initiative on the measures included within the Patient Safety Dashboard. This step represents a formal “Quality Impact Assessment” and is used to inform the Transformation Board approval decision. The Medical Director and Director of Nursing & Patient Safety are required to give their opinion on the impact of CIPs at each Transformation Board as a standing item on the agenda. This approach has been endorsed by the Trust’s main Commissioner.

Key to ensuring that the quality of care is not reduced we remain committed to recruiting, developing and maintaining a competent workforce. Throughout the cost reduction process, there remains a commitment to resourcing our training programme for all staff and ensuring staff have been appraised and have a personal development plan in place.

5.5 PERFORM Supporting the Delivery of the Trusts 2014/15 Annual Plan

Essentially, Perform optimises what managers in the Trust do, how they do it and provides them with the tools / techniques to improve performance. It provides managers and their teams a framework that helps them and their teams act and behave differently and become equipped with capabilities and support needed to channel resources effectively and efficiently towards securing the Trusts vision and strategic objectives. Work carried out during 2013/14 has demonstrated that Perform works and provided some confidence that it can help the Trust release between 15 – 20% of its capacity to be used to either generate additional income or

reduce operating costs.

However, it is not just about reducing cost or increasing revenue; it is also about improving productivity, operational control, quality of service provided and importantly, employee engagement. Employees in the areas where Perform has been deployed as a way of working have embraced it and find it easier to do their jobs effectively. The Trust's experience of Perform so far has shown that it engages people, makes improvements quickly with no IT, acts as enabler to change and delivers organisation outcomes for the Trust such as reduced cost or increased income. For these reasons, Perform will be at the heart of our approach to driving up performance and quality of our services during 2014/15 and beyond.

Rolling Out Perform Across the Trust

Set out below is a summary of the 3 main ways Perform will be embedded into the 2 year planning process:

- How Perform will link to and enable the delivery of the Trust's six strategic objectives;
- How to address the financial sustainability challenge levied on the Trust by Monitor; and
- How the expected benefits from the next phases of Perform might flow through based on the agreed deployment schedule

Delivering the 6 strategic objectives

- Each of the planned Perform projects over the next 3 months are linked to one or more of the 6 strategic objectives
- At the start of each Perform project targets will be set to demonstrated movement on the relative objectives, the progress of which will be tracked at the Trust's Transformation Board

Sustainability points, based on experience (including the STNHSFT pilot)

- Perform focuses on people and the way they work rather than 'event driven' interventions such as Kaizen
- The approach embeds a suite of sensible ways of working into business as usual.
- Progress and sustainability will be driven by the number of people within the Trust working in a Perform way (this is expected to be close to 1,300 within the Trust by the end of 14/15)
- Leadership level Perform audits will be in place to ensure the ways of working are sustained and improved upon
- External visits are also being arranged to help with sustainability and also to show case Perform to the NHS when requested
- Lagging and leading measures are being tracked at management level (e.g for Theatres, lagging is revenue, leading is available theatre sessions and no of planned procedures in each list and for Wards, leading will be the estimated date of discharge (EDD) and lagging will be the Average length of stay (AvLoS)

- In addition to releasing capacity which can be used to reduce costs or increase revenue, Perform drives a different way of working, which means it is important to keep cost reduction and behavioural change separate. This means having a plan at the outset for how capacity will be used e.g. Perform one area, create capacity, divert work / activity from a second area which is not performed and release the cost from there.

Expected Benefits

The following outlines how the expected benefits might flow through based on the PERFORM deployment plan.

- Beyond the pilot and Phase 1, the Perform rollout essentially has 3 further phases over the next 18 – 24 months, each predicated on the previous phase being successful and demonstrating the benefits of a different way of working.
    - Phase 2 - First 3 months – In the next 3 months there will be 6 PERFORM interventions covering approximately 720 people expected to deliver between £3 – 6m worth of benefits in either cost out or revenue. This phase will build on the success of the pilot and focus on the delivery of either cashable savings i.e. money out or the provision of additional income and is expected to start at the end of April 2014.
    - Phase 3 - The next 6 months – Will see PERFORM extending beyond current areas as a way of working into areas such as Community Nursing services. The plan in terms of expected benefits is less defined at present and will evolve in parallel to the delivery of the areas included in the first 6 months
    - Phase 4 - Extending Perform into Care Pathways and how the Trust works in Partnership with its customers including the Clinical Commissioning Groups / Primary Care / Social Care - The benefits here are more difficult to quantify at present, however as Perform grows as a demonstrable improved way of working within the Trust and business benefits continue to be delivered, the more difficult challenges such as this are expected to become more achievable. Early discussions have already been held with South Tyneside CCG as to how the methodology might be applied within the broader Local Health Community.