Tameside Hospital NHS

NHS Foundation Trust

Operational Plan Document for 2014-16

Operational Plan Guidance – Annual Plan Review 2014-15

The cover sheet and following pages constitute operational plan submission which forms part of Monitor's 2014/15 Annual Plan Review

The operational plan commentary must cover the two year period for 2014/15 and 2015/16. Guidance and detailed requirements on the completion of this section of the template are outlined in section 4 of the APR guidance.

Annual plan review 2014/15 guidance is available here.

Timescales for the two-stage APR process are set out below. These timescales are aligned to those of NHS England and the NHS Trust Development Authority which will enable strategic and operational plans to be aligned within each unit of planning before they are submitted.

Monitor expects that a good two year operational plan commentary should cover (but not necessarily be limited to) the following areas, in separate sections:

1. Executive summary
2. Operational plan
    a. The short term challenge
    b. Quality plans
    c. Operational requirements and capacity
    d. Productivity, efficiency and CIPs
    e. Financial plan
3. Appendices (including commercial or other confidential matters)

As a guide, we expect plans to be a maximum of thirty pages in length. Please note that this guidance is not prescriptive and foundation trusts should make their own judgement about the content of each section.

The expected delivery timetable is as follows:

Expected that contracts signed by this date	28 February 2014
Submission of operational plans to Monitor	4 April 2014
Monitor review of operational plans	April- May 2014
Operational plan feedback date	May 2014
Submission of strategic plans to Monitor (Years one and two of the five year financial plan will be fixed per the final plan submitted on 4 April 2014)	30 June 2014
Monitor review of strategic plans	July-September 2014
Strategic plan feedback date	October 2014

Operational Plan for y/e 31 March 2015 and 2016

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

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Date	

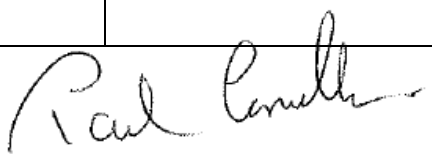
The attached Operational Plan is intended to reflect the Trust's business plan over the next two years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

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

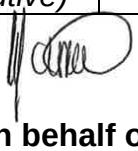
Approved on behalf of the Board of Directors by:

Name *(Chair)*	Paul Connellan

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Karen James

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Barbara Herring

Signature 

Executive Summary

1. Tameside Hospital NHS Foundation Trust's (THFT) 2 year Operational Plan (2014/2016) is informed primarily by its response to its safety and quality challenges, and its current financial position. The plans to address these challenges are framed by national requirements and drivers for change;
   - The Greater Manchester clinical service reconfiguration programme "Healthier Together";
   - The collaboration and partnership agreement with University Hospitals of South Manchester NHS Foundation Trust (UHSM), Stockport NHS Foundation Trust (SFT) and East Cheshire NHS Trust (ECT);
   - Local commissioning intentions and demographic changes.
   - Other collaborations

2. The plan details increased focus on collaboration and partnership models of service delivery both vertically (acute, community and primary care services) and horizontally (secondary and tertiary services). The aims of these integrated models of care are to ensure affordable, sustainable, clinically safe and high quality consultant led services; and to develop pathways of care which support patients within the community. This approach reduces the burden and pressure on the acute Trust through admission avoidance and reductions in length of stay for those that are admitted.

3. The Trust's goal is to become an organisation in which every member of staff understands their role and responsibility in delivering high standard safe quality care and works to that goal every day. The plan emphasises a commitment to improving patient safety, patient experience and patient outcomes through setting challenging targets that will show patients that we provide safe, personalised, effective care, first time, every time. This goal is reflected in the Trust's mission statement and corporate objectives; and incorporates themes which have been identified in the work that has been undertaken with staff in respect of values and behaviours, all of which have been supported by the Trust Board.

4. Further, the plan details issues affecting the Trust's financial position and acknowledges that the Trust anticipates a deficit of £17.5m in 2014/15 and will have a CoSRR of 1, and will require cash support from the Department of Health in the form of Public Dividend Capital (PDC) funding.

5. The Trust's indicative contract income levels over the 2 year period have been agreed with the main Commissioner and reflect changes for demographic growth and changes in services such as diabetes the main provision for which has transferred to a Community setting.

6. The Trust has identified and developed a Cost Improvement Programme (CIP) to deliver efficiency savings of £6.1m which equates to 4% of operating income. The CIP centres around a set of established efficiency schemes and newly identified opportunities to deliver the Trust's improvement agenda in conjunction with efficiency savings. The Trust has used recognised benchmarking and productivity tools to analyse and identify opportunities for improvements in areas of performance where it is an outlier against peer organisations. Alongside the traditional CIP schemes are transformational schemes, which are focussed on working internally across clinical specialities to drive clinical pathways which deliver effective and efficient patient care and in collaboration with Southern Sector partners to deliver sustainable services for patients across the partnership footprint.

Operational Plan

1. The Short Term Challenge

1.1. The challenge faced by THFT and the local health economy is to develop and deliver a health care solution that meets the diverse needs of the local population, ensuring clinical safety and quality, while delivering financial sustainability.

1.2. The health care solution needs to be in line with and driven by the developments and intentions being discussed in relation to:

- The Southern Sector Partnership
- Healthier Together
- Keogh Review findings
- Commissioning Intentions

1.3. THFT serves a population of just over 250,000; this is expected to increase by 10% by 2033, with particular growth in the number of older people. Thirteen of Tameside's 142 lower super output areas are in the top 5% most deprived areas nationally and Tameside is ranked as the 42nd (out of 326 areas) most deprived in England.

1.4. The extent of the challenge for the Trust is informed by its financial position and its response to its safety and quality challenges, highlighted by external reviews (Keogh, Care Quality Commission (CQC) and Health Education England) into its services. The Keogh Review in July 2013 highlighted concerns around quality and called for additional investment in staffing. Staffing issues particularly supervision and training for Junior Doctors were also highlighted by Health Education England, whilst the CQC in October 2013 rated the Trust at the highest level of risk.

1.5. The Tameside and Glossop Joint Strategic Needs Assessment highlights that the major health challenges facing the local population are Cardio-vascular disease (heart disease and stroke); respiratory disease (Chronic Obstructive Airways Disease); Cancer and Diabetes. It also highlights the main causes of these diseases as being alcohol; obesity; smoking and age related issues such as frailty and dementia. Life expectancy is lower than the England average and whilst there has been an improvement, the rate of improvement is slower in the more deprived areas; in the period 2008-10 the difference in life expectancy between the most deprived and least deprived areas was over 13 years.

1.6. Financially the Trust reported a normalised surplus of £1.5m in 2012/13 and a normalised deficit of £3.5M to £3.9M in 2013/14. In 2014/15, the Trust therefore intends to make the necessary changes to address the impact of tariff changes, redesign of health and social care services and the need to meet national standards for service delivery and consultant staffing levels, which will require PDC funding support in the first quarter of the financial year.

1.7. As highlighted above, the Keogh review raised concerns around quality and staffing, and the Trust responded by reviewing and increasing establishment for certain clinical groups. This specifically related to an increase of the registered and unregistered nursing establishment across the Trust, and increases in middle and senior level medical cover. This has brought further challenges, as many of the roles seen as 'critical' by the Trust are within shortage occupations, and as such, the Trust is in competition with larger and more specialist Trusts, and is experiencing difficulties in recruiting. This applies in particular to qualified nurse roles, and middle/senior medical roles in Emergency/Adult Medicine.

1.8. The Trust has run a number of recruitment campaigns for these posts, with varied success and is currently focussing on international recruitment campaigns, in an attempt to fill key roles. While this is proving partially successful, international recruitment campaigns attract additional costs. This also brings further challenges in terms of induction, training and integration for cohorts of

international clinical staff – although it should be noted that this challenge is not unique to Tameside.

1.9. The difficulty in recruiting to various middle grade and senior medical roles has compounded some of the other issues the Trust faces, such as the issues raised as part of the Deanery Action plan regarding junior doctor supervision, and issues relating to quality of care on the wards.

1.10. The Trust continues to provide safe levels of staffing, by utilising bank, agency and locum cover, at premium costs**.** The Trust has developed a recruitment strategy to focus on permanent staff to deliver 24/7 care and seven day working.

1.11. The Keogh report also raised concerns regarding quality of care, which echoed concerns raised through the Francis Report regarding the general behaviours & values of staff in acute settings. The Trust, like all Trusts, has the challenge of understanding what the current 'state of play' is in terms of overall staff attitude and competence. Added to this, the Trust also has the challenge of how best to recruit those with the values & behaviours inherent to care for vulnerable patients, and how best to develop basic care skills and values within its current staff base.

1.12. Through work commissioned by THFT from McKinsey, to develop an initial set of future service reconfigurations, the following 6 key areas to maintain and sustain clinical and financial viability were identified:

a) Work to develop horizontal integration through partnership and collaboration with South Sector colleagues to redesign services to ensure the delivery of high quality clinical care.
b) As part of the collaboration and supported by T&G CCG, focus on local service delivery for general medicine and cease provision of non-elective and complex general surgery.
c) Work with Tameside & Glossop Clinical Commissioning Group (T&G CCG), SFT, Pennine Care NHS Foundation Trust (PCFT) and Tameside Metropolitan Borough Council (TMBC) to develop, implement and deliver a radically different model of service delivery, one that supports integrated patient pathways and reduces reliance on hospital based services.
d) Work with local NHS providers to improve efficiency and deliver greater resilience to clinical services through the federation of management of selected clinical and clinical support services and rationalisation of the provision of back office functions.
e) Implement transformational schemes and maximise capacity and use of assets to deliver and increase productivity, efficiency and effectiveness.
f) Collaborate with the Greater Manchester "Healthier Together" programme.

1.13. Further work around developing reconfiguration models was undertaken and six options were generated of which an option of developing an Integrated Care Model was declared to be the preferred option. This option sets out the following changes necessary for the Trust to ensure financial sustainability whilst meeting clinical safety and quality requirements. The Trust would need to transform and reconfigure services to an extent that the portfolio of services remaining on site under the preferred option could be:

- 24x7 urgent care with an A&E consultant present for 10 hours a day, 7 days a week,
- Short stay medical unit,
- Day cases (including additional day case activity from neighbouring Trusts, specifically Pennine Acute Hospitals Trust (PAHT)),
- Short stay and less complex elective inpatients
- Outpatients,
- Diagnostics
- Midwife led unit

1.14. Strong support from the local health economy to further develop this option was articulated and supported by the CCG to the extent that the consultants were reappointed to develop this option further. This is currently being explored by the CCG, who are due to report at the beginning of May 2014.

1.15. Maintaining the 6 key areas identified above in 1.13 as the basis for any future strategy, the Trust

has continued to develop the key themes which will be detailed in the strategic plan submission due in June 2014.

1.16. Therefore an alternative or, in addition to the preferred option should the submission in May 2014 by the CCG prove to be not viable, is for the Trust to develop strategic alliances, formal agreements with other institutions, based along clinical, financial and commercial considerations to strengthen the Trust.

1.17. It is vital that we are able to demonstrate that we will ensure the clinical viability of future services – and also demonstrate how the current and future management team will ensure a safe and smooth transition to a future model of care. We will describe how collaboration with other organisations will enable the Trust to draw on clinical and managerial resources and expertise to help us move forward.

1.18. The strategic alliances discussed above is a response to the challenge by Monitor around Plan B, we agree that there needs to be a solution other than just the ICO future provision The strategic alliances or partnering will form the bedrock for the Trust to develop both clinically and managerially and establish, in line with wider health economy strategies, an organisation that is and remains a FT, affording the health economy a flexible, adaptive and agile solution for future provision.

1.19. In addition to the ICO concept, the Trust would develop a series of models which would be fit for purpose, and the Trust would transform to an outcome based organisation. Further detail around this concept will be developed in the Strategic Plan.

2. Quality Plans

2.1. THFT's goal is to become an organisation in which every member of staff understands their role and responsibility in delivering high standard safe quality care and works to that goal every day. The Trust is committed to improving patient safety, patient experience and patient outcomes through setting challenging targets that will show patients that we provide safe, personalised, effective care, first time, every time.

2.2. This goal is reflected in the Trust's mission statement and corporate objectives which have been agreed by the Trust Board. The mission statement has been developed to ensure it is future proof with regards to the Trust's strategic direction and also incorporates the themes which have been identified in the work that has been undertaken with staff in respect of values and behaviours. The mission statement is:

At Tameside Hospital 'everyone matters'

Our aim is to deliver, with our partners, safe, effective and personal care, which you can trust

2.3. The corporate objectives, each with a number of key outcomes, aligned to the Trust's Patient Safety Programme and Quality Improvement Strategy, are as follows:

- All patients receive harm free care through the delivery of the Trust's Patient Safety Programme.
- To improve the quality of patient care through the implementation of the Trust's agreed Quality Strategy.
- To improve the patient experience through a personalised, responsive, compassionate and caring approach to the delivery of patient care.
- To develop a continuous quality improvement culture which promotes patient quality, safety, personalised and effective care.
- To develop a Strategic Service Plan which will secure clinical and financial sustainability for the Trust in conjunction with the Trust's strategic partners and key stakeholders.
- To work with our partners, stakeholders and the community to develop the reputation of Tameside Hospital as a provider of safe, high quality, effective care.
- To deliver against the required local and national frameworks in order to meet all the requirements of the Trust's operating licence and the commissioners' requirements.

2.4. The Trust has recently agreed a new Organisational Development (OD) strategy. The OD Strategy has been developed to support and complement other key organisational strategies such as the Quality Improvement Strategy, Patient Experience and Carers Strategy, Nursing & Midwifery Strategy, Patient Safety Programme and the Communications & Engagement Strategy

2.5 The OD Strategy and accompanying plan sets out an enabling framework for achieving the Trust's Mission, of *'delivering, with our partners, safe, effective and personal care, which you can trust.'*

2.6. It provides a clear view of a culture of openness and candour and a mechanism for engaging and developing staff and leaders within the organisation to enable the cultural changes necessary to deliver safe, effective patient care, which is at the heart of everything we do.

2.7.The key themes of the OD strategy are as follows:

- Leadership – Creating a leadership and management team which enables the Trust to thrive, and to meet the challenges it faces. This includes a Board Development programme, an accredited Ward Manager development programme, equipping managers with skills to hold difficult conversations, and a training needs analysis for middle management.
- Culture – Creating a culture of openness and continuous learning. This includes a re-brand

and a re-launch of the Trust's values & behaviours, and ensures that these values underpin all our processes and procedures

- Continuous improvement – Ensuring that we continuously learn from mistakes, and best practice, through the strengthening of our information gathering processes and governance frameworks.
- Engagement - Embedding our 'Everyone Matters' theme, via a revised Communication Strategy for both staff and patients.

2.8. The OD strategy also focuses on medical development and engagement, which is fundamental to ensuring that the Trust can meet the challenges it faces. The Trust has always previously had a structure of 'Lead Consultants' for each specialty, who would report professionally through to the Medical Director. The Trust has recently implemented a structure which includes 'Clinical Directors' for each Division, who are supported by Lead Consultants/Specialty Leads. These Clinical Directors are managerially accountable to the Chief Operating Officer. This structure gives significantly more visibility and accountability for the Senior medical team, as well as giving them an active role in governance, quality, and finance and KPI performance within the Division. This also recognises that there are key challenges for the Trust where the management and solution will need to sit with the senior medical team.

2.9. As highlighted within section 1, during 2013 the Trust was subject to a number of reviews and inspections, these identified a number of concerns related to the quality of care and also training for junior Doctors. A summary of the concerns raised, actions taken and progress to date are detailed below:

Summary of Concerns	**Summary of Urgent Actions Required**	**Progress**
Quality of emergency care, patient monitoring and pathways	Conduct review of nurse staffing levels against patient acuity and dependency	Complete and on-going with reviews 6 monthly
	Implementation of the Urgent Care recovery plan	Recovery plan is on track
	Further develop ambulatory care pathways	Revised process for ambulatory Care activity is being put in place
	Manage the deteriorating patient	Workstream within Patients Safety Programme – assessment in April 14
	Weekly safety thermometer audits	Complete – in place since September 2013
	Reinforce the critical care outreach policy to clinical staff	Complete Assurance assessment due in April 14
	Appoint Head of Patient Flow	Complete
	Improve ward-based pharmacy interventions & reconciliation	Complete – Assurance assessment due in April 14

Summary of Concerns	Summary of Urgent Actions Required	Progress
Supervision and support of junior doctors overnight and at weekends	Enhance out-of-hours resident on-call cover	Interims in place. Consultation to allow changes to substantive terms and conditions to complete in March 2014
	Provide additional middle-grade doctor cover	Substantive recruitment complete
	Establish weekly safety barometer with junior doctors	Assessment due in April 14
Clinical leadership and engagement	Review out-of-hours clinical leadership	Assessment due April 2014
	Appoint clinical governance leads for all divisions	Recruitment complete
	Accelerate ward leadership programme	Commissioned and commenced in November 2013
	Develop clinical links with Southern Sector	Ongoing communication and planning
Organisational culture	Develop an Integrated Quality Board Report	Currently being audited
	Improve safety reporting in the electronic rostering system	Assessment due in May 2014
	Review Trust behaviours to encourage transparency & develop an OD strategy to support this change	Staff engaged in development process
	Development of over-arching quality strategy	Assessment due in May 2014
	Development of values-based recruitment process	Assessment due in May 2014
Board reporting of quality and safety of services	Develop an Integrated Quality Board Report	Complete – reported to Board monthly
	External governance review to include focus on Board capacity, capability and effectiveness.	Complete – November 2013
	Development of over-arching quality strategy	Complete – Assurance assessment in May 2014
	Invest in quality reporting capacity	Complete – Assurance assessment in May 2014
	Develop patient safety ambassadors through the Advancing Quality Alliance Academy	Complete – 2 safety ambassadors appointed September 2013

Summary of Concerns	Summary of Urgent Actions Required	Progress
Transparency and engagement with stakeholders	Review structure and frequency of Council of Governor meetings	Complete – Assurance assessment in May 2014
	Develop Governor development programme	Complete – Assurance assessment in May 2014
	Introduce a listening exercise, "Tameside Listens" for patients, staff and the public	Complete – Assurance assessment in May 2014
	Widen involvement of stakeholders in quality strategy	Complete – engagement on-going

2.10. To support achievement of the Trust's goals and its response to recent reviews and inspections the Trust has developed an Improvement Central Action Plan (ICAP) which allows the Trust to articulate its Improvement Strategy and align its business to that strategy.

2.11. The ICAP is delivered and monitored through the Improvement Board. The ICAP associated key performance indicators (KPIs) and milestones track progress, ensure sustainability and enable rapid escalation where necessary. The Trust will provide assurance on delivery to its stakeholders through the gathering of evidence to demonstrate the delivery of milestones, unannounced visits, audits and the formal presentation of hard and soft data to Commissioners at Star Chambers.

2.12. The full ICAP has been reviewed to identify KPIs which could be used to demonstrate continued improvement against delivered milestones. Defining KPIs for each ICAP area ensures that a comprehensive picture of the organisation's progress towards achieving its performance targets / goals is provided for stakeholders and commissioners. The monitoring of KPIs will enable the Trust to be a learning organisation by reporting on achievement and taking action where there are outcomes which differ from the expected impact.

2.13. The CQC revisited the Trust in January 2014; the findings published in March 2014, found that improvements to patient services had been made. The report also highlighted the continued need to improve against national standards, these are included within the ICAP and actions are being taken to address them, with improvements to care implemented for the benefit of patients. A full Chief Inspector of Hospitals visit is scheduled for May 2014.

2.14. The Trust is committed to an integrated governance approach to quality which is achieved by a structure that supports a coordinated approach to governance and risk management. This revised governance structure and patient safety programme with clinical and managerial leadership will manage the process for improving areas highlighted by the CQC review in January 2014, including DNAR, Safeguarding, Mental Health Act, Record Keeping, Nutritional Support, Communication and Staff Attitude. The key committees with responsibility for receiving assurances on patient safety and quality including the delivery of this quality strategy are the Trust Board and its identified Committees and Sub-Committees.

2.15. The Quality & Governance Unit will monitor the quality agenda, supported by information and performance management, business planning and reporting processes. Quality will be assured through scrutiny by the Quality and Governance Committee of the Board and the assessment of performance against the Care Quality Commission's standards and requirements. The responsibility for delivering patient safety and quality rests with clinical teams and operational management, led by the Chief Operating Officer. The Quality & Governance Department is accountable for quality support, enablement and assurance, led by the Director of Nursing and

Medical Director.

2.16. To deliver the organisational aim to improve patient safety, patient experience and patient outcomes, the Trust has developed a Quality Improvement Strategy, which details its ambitions for these key aims, the areas the organisation will focus on, what will be measured to provide assurance of improvement and what outcomes are expected by March 2015. The 3 key ambitions, their priority areas and outcomes for delivery are detailed below:

Safety Ambitions: All Patients will receive Safe Care	
Priority Areas	**Delivery Outcome**
1. Pressure Ulcer prevention and improved Tissue Viability and Continence. 2. Earlier recognition of the deteriorating patient and management of the acutely unwell. 3. Reducing the number of falls and falls with injury. 4. Improved nutritional care and hydration. 5. Reducing harm from Venous Thrombosis. 6. Reducing harm from high risk medicines and providing safe and effective medicines management. 7. Improving peri-operative outcomes through safer surgery. 8. Better Infection prevention.	• We will have a clinically led patient's safety programme • Each priority area within the safety programme will have a designated Board level Clinical lead and Senior Professional lead • Each workstream will have clear reporting lines to the Board and key quality and safety metrics • The patient safety programme will be communicated to and understood by all staff. • Patient safety metrics will be displayed in each clinical area. • We will improve our culture of incident reporting, being open, with fair blame and learning approach. • Patient safety at Tameside will encompass safeguarding for both Adults, Children and unborn. • We will establish baselines for all our safety metrics from which to measure improvement and establish meaningful targets. **The percentage of harm free care will increase from the current baseline of 95% with the aim of harm free care for every patient.**
Patient Experience Ambitions: All patients will receive high quality care that is tailored to their personal needs.	
Priority Areas	**Delivery Outcome**
1. Patients will experience compassionate, caring and communicative staff who work in partnership with patients, relatives and their carers to achieve the best possible health outcomes. 2. All patients will: – Be treated as individuals, with their individual needs taken into account – Be treated with dignity, respect	• Demonstrate increased engagement between patients, carers and healthcare professionals • Receive positive comments and plaudits which confirm that the standard of care patients receive is good. • Routinely share patient experience stories with the Trust Board and make these available to wider staff groups. • Regularly undertake patient experience surveys, benchmarked against other acute providers. • Publish Net Promoter 'family and friends' scores from the survey results in each service, with year on year improvements. That is, "How likely is it that you would recommend this service to friends and family?"

and compassion – Be treated/cared for taking into account best practice – Be involved in their own care and kept fully informed – Have any concerns addressed 3. We will ensure continuity and communication between the hospital and the GP	• Show how the involvement of patient, carers and public groups supports service delivery in the areas of information, support and advocacy
Clinical Effectiveness Ambitions and Effective Care: All patients will receive the most appropriate care which is evidence based.	
Priority Areas	**Delivery Outcome**
Aim of this strategy is to promote a clinical environment where patient care is based upon the best available evidence and clinical audit demonstrates effective practice with improved outcomes delivered in a consistent manner.	• Ensure services are based on reliable evidence and continue to implement the National Institute of Clinical Excellence (NICE) guidance and monitor compliance with these standards, in line with contracts and service specifications. • Increase the use of evidence based care bundles and shared decision making. • Demonstrate findings and report on progress made as part of Tameside Hospital's participation in National Clinical Audit and National Confidential Enquiries programmes. Review the implications of National Clinical Audit and National Confidential Enquiries reports for Tameside Hospital and make recommendations and implement actions required as a result. • Undertake self-assessment for compliance against all National Quality Standards applicable to services in Tameside General Hospital and make recommendations and implement actions required as a result. • Undertake a defined Clinical Audit programme each year and report the outcomes and improvements to quality in an Annual Report to the Board. • Ensure Lead Clinicians play an active role in Clinical Audit. • Strengthen arrangements for the participation in Research and Development demonstrating an increased number of staff pursuing research and development. • Engage with specialities to further develop speciality specific patient outcome metrics • Establish baselines for all our safety metrics from which to measure improvement and establish meaningful targets.

2.17. Delivery of the strategy is supported by the Patient Safety Programme, the Nursing & Midwifery Strategy, Organisational Development Strategy, Values and Behaviours Strategy and Patient, Family & Carer Experience Strategy. These additional supporting strategies and work programmes ensure connectivity to assist the achievement of our aims and goals as an organisation and deliver cultural change.

2.18. The Trust acknowledges that progress needs to be made on the collection and use of data.

Work will initially focus on establishing robust baselines for our Quality metrics ensuring that we measure improvement from the correct starting position. We will then monitor the trend and work with clinical leaders to establish challenging targets for each metric. These metric targets will be detailed in a refresh of the Quality Improvement Strategy in September 2014.

2.19. The Board receives a Quality dashboard which allows the Board to identify at a glance its strengths and weaknesses, to raise staff awareness of the current service performance and to raise concern when there are issues relating to poor performance. To enhance this throughout 2014 a Quality Dashboard for each service will be developed to enable internal benchmarking and drive continuous improvement.

2.20. The national agenda for nursing has changed over the last few years following the publication of the Francis Report, Berwick Report and the Chief Nursing Officer for England's work around the 6 C's – Care, Compassion, Competence, Communication, Courage and Commitment. This together with the more recent reports from Keogh and the CQC in relation to nursing at Tameside was the driver to the work undertaken over the past year to review and update the nursing strategy with nursing and midwifery colleagues to ensure that it remains reflective of current and modern nursing and midwifery practices, and has clear, measurable outcomes.

2.21. The Nursing Strategy is based upon the vision of Tameside Hospital with the aim to embrace the values and behaviours of the organisation, combine these with the key drivers from the Quality Improvement Strategy and together with the 6C's for nursing and midwifery enable us to deliver a culture of compassion, care and candour where the patient is at the heart of everything we do.

2.22. The Nursing Strategy clearly outlines what will be done during the period 2014 – 2016 and describes the activities processes, learning and development opportunities, patient safety and quality assessments and methods of communication which will deliver a high standard of quality care, safely and effectively for all our patients, their families and carers.

3. Operational requirements and capacity

3.1. The Trust recognises that in order to meet future challenges, the Trust must work in collaboration and partnership with other providers. The Trust is currently working to develop its 5 year strategy in line with the plans being developed by T&G CCG, TMBC and across the wider GM footprint. The current fluidity of the plans for delivery of health care both locally and across GM requires the Trust to initially plan to continue to provide its full range of services for the next 12 to 18 months, whilst plans for vertical integration of health and social care across the locality and alternative service models for acute care across the South Sector Partnership and the wider GM footprint (Healthier Together) are clarified and confirmed. It is anticipated that the last 6 – 9 months of this 2 year operational plan will be one of transition as the Trust implements and embeds new models of care and service delivery. Therefore within the last 6 months assumptions will be based on the completion of the strategic plan due for end of June 14.

3.2. One of the main areas of activity will be to develop a transitional plan that will detail the possible double running of services while the transition takes place to a new service model, the decommissioning of services, the re-commissioning of services outside of the Trust and the necessary 'safety net' to ensure that patients continue to receive safe care during this period.

3.3. T&G CCG and TMBC will continue to develop a programme of integration with their partners (THFT, SFT & PCFT) to deliver service change across the locality, in line with and supported by principles of the Better Care Fund. The aim of the integration "Care Together Programme" is to transform the way care is delivered to improve the quality and outcomes of care for patients. The integration model will be based on four levels of care:

Level 1 Building up the strength of individuals and communities

Level 2 Integrated teams based in localities

Level 3 Specialist pathways

Level 4 Hospital based care

3.4. Whilst the exact timescales are still being worked through, the ambition is that integrated care pathways will be "live" and a new model of delivery in place from April 2016. Whilst continuing to provide its full range of services, over the next 12 – 18 months the Trust will work with partners to develop, implement and embed services and integrated pathways to enable transition to an Integrated Model of Care by 2016.

3.5. Therefore in addition to, or as part of the integration programme the Trust will work with the CCG on specific developments detailed within their commissioning intentions and plans. These developments include:

- Relocation of Ophthalmology Services to a Tameside and Glossop site
- Increased use of straight to test diagnostics in Endoscopy
- Increased number of cancer pathways where primary investigation reports are available at first outpatient appointment
- Redesign of symptomatic Breast Cancer Services
- Redesign of Pain Management Services
- Increased access to MSK conservative management out of hospital
- Use of specialist Physiotherapy as alternatives to surgery or to improve recovery
- Reduced DNA rates to maximise productivity of outpatient sessions
- Maximising opportunities for outpatient procedures and day cases to avoid overnight stays
- Reduced use of A&E for non-emergency patients
- Improvements in the dementia care pathway.
- Reducing variation in the cut-off point between children's and adult services

3.6. During 2013 the CCG retendered the way diabetes services would be commissioned across secondary and community care, The Trust working in partnership with SFT made a joint bid to develop and implement community based outpatient diabetes services with Consultants outreaching to provide specialist expertise in clinics held across the locality. This joint venture was successful with the revised service model implemented with effect from February 2014. The learning from the development and implementation of this service will be used to support the development of further community based services.

3.7. It is recognised that a higher non-elective admission to elective admission ratio results in higher running costs and this has a direct impact on the Trust's financial position. However there is some evidence that the admission avoidance schemes commissioned by T&G CCG, such as the outreach service by Care of the Elderly Consultants into Nursing and Care Homes to enable proactive management of patients and prevent admission and the implementation of Ambulatory Care Pathways are beginning to deliver; with demand for A&E decreasing by 1.2% and non-elective admissions by 0.7% in 2013/14 compared to the previous year. The Trust will therefore continue to develop and implement Ambulatory Care pathways and work with commissioners to radically change service models across health and social care to reduce the number of non-elective admissions and reliance on hospital care.

3.8. During 2013 the Trust has worked with GPs to review and understand the reasons for the Trust being an outlier against some indicators when compared to peers, e.g. Consultant to Consultant referrals and readmissions within 30 days. The aim of the joint work being to identify and develop joint policies and strategies to drive improvement in contributing care pathways both within the Trust and across the health economy. The Trust will continue to strengthen relationships with GPs through working collaboratively to identify care pathways that develop and implement improvement strategies.

3.9. For the Trust, delivery of the option detailed in section 1.14, will require a reduction in beds to enable the estate to contract and the disinvestment in Charlesworth and Ladysmith buildings**.** This will have a specific impact on the workforce, in terms of reduction in headcount and WTE. It will also have an impact in terms of the types of roles which the Trust retains, as these may have a different reporting structure (e.g. across the Southern Sector) or focus than is currently in place. Dependant on the details of the service/bed reduction and the reconfiguration of services across the region, there may be TUPE implications for specific employee/s and significant retraining/reskilling as we move to a more community based service in the future.

3.10. This transformation and reconfiguration of services provided by the Trust fits with work being developed by the Southern Sector Partnership and Healthier Together, to link/pair specialist and local hospitals to better meet minimum standards of safe service provision and produce better outcomes for patients.

3.11. The South Sector Partnership was established in 2013 with the signing of a 4 way memorandum of understanding across 4 Trusts (UHSM, SFT, ECT & THFT) who volunteered to collaborate where practical and feasible to benefit the patient and improve quality and effective use of resource.

3.11.1 The Partnership is designed to provide an alternative to formal integration and acquisition, and to establish a strong and formal network of collaboration across multiple partners and sites, whilst allowing the retention of the values and principles of the partners. Each partner/site will develop its own purpose and strategic direction under the umbrella framework/strategy of the sector. Therefore enabling true collaboration and co-operation for patient and customer benefit whilst ensuring economic value for money and improved outcomes. It allows in the future for greater concentration of centres of excellence for both patient and research benefit.

3.11.2 The Partnership enables us to respond to the needs of Healthier Together and other

external developments and changes utilising the best elements of the partnership and sourcing partners as required to meet gaps or provide further opportunities.

3.11.3 The partnership is still in its early development stages but there is very strong support across the clinical and non-clinical community to progress the model and its wider deployment.

3.12. The Trust is working with the southern sector on back office, surgical and tertiary services. However the Trust will continually be seeking other partners within the system who are able to better align and develop services as the Trusts strategy evolves. There is no exclusivity within the southern sector from the Trusts point of view. Where collaboration is necessary we will work within the sector, without prejudice to outcomes of discussions with industry and other sectors, where we believe new or other models will emerge and shape our commercial strategy.

3.13 Healthier Together is a review of health and social care and is part of a wider public service reform, seeking to improve outcomes for all Greater Manchester residents. Healthier Together wants to improve the quality of treatment in and out of hospital under integrated care, primary care and hospital care. The programme is clinically led, and is managed by the Service Transformation team which is accountable to Greater Manchester's twelve Clinical Commissioning Groups.

3.13.1 The Healthier Together programme aims to develop a model of care that will help the NHS and other care providers in Greater Manchester provide quality services that are safe, accessible and sustainable for future generations. It will consider how best to provide the right service, at the right time, in the right place to achieve the best outcomes within the resources available.

3.14. The reconfiguration/transformation of healthcare within the Southern Sector Partnership and across the wider GM footprint would see a shift of complex elective and all emergency general surgery work from THFT. The released bed and theatre capacity would support an expansion of ambulatory pathways, short stay and day case surgery at the Trust.

3.15. The Trust has undertaken a gap analysis to identify what needs to be done to deliver seven day working and the 10 standards of care, outlined by the National Medical Director, Sir Bruce Keogh, by end of the 2016/17 financial year.

3.16. The timeframe for rollout of seven day services is ambitious and will be a challenge for the Trust, both in terms of recruiting and retaining appropriately skilled staff and financially. The Trust will work with its Southern Sector partners to identify solutions and cross organisational working to support delivery of the standards of care and the associated improvements in patient care and outcomes.

3.17. There are however, inherent risks and constraints within the plans being developed across the Southern Sector, in terms of patient flow and patient choice, ambulance flows and timeliness, and bed, critical care, theatre and outpatient capacity and infrastructure within the Trust, the Southern Sector Partnership, and across the GM footprint. Whilst the Trust is working in partnership with T&G CCG and TMBC to develop the integration agenda and programme within the locality, there is also the risk that the Trust will not win any tender process to be the prime provider of services.

3.18. Further work is being undertaken to understand risks and ramifications of delivery of the changes proposed to the delivery of care models and any alternatives for the Trusts long term future as part of developing the 5 year Strategic Plan.

4. Productivity, efficiency and CIPs

4.1. The Trust's 2014/15 CIP programme essentially continues to deliver against the aims of the 2013/14 programme which centre around a set of established efficiency schemes and newly identified opportunities to deliver the Trusts improvement agenda in conjunction with efficiency savings. The Trust has used recognised benchmarking and productivity tools to analyse and identify opportunities for improvements and areas of performance where it is an outlier against Peer organisations and has commissioned external review of the programme to assess and assure the robustness of the programme.

4.2. Alongside the traditional CIP schemes are key transformational schemes which are focussed on working internally across clinical specialities to drive clinical pathways which deliver effective and efficient patient care and in collaboration with key partners across the health economy to deliver sustainable services for patients across the Southern Sector collaboration. The Trust has identified efficiency savings of £6.1m which equates to 4% of operating income and has grouped the savings schemes into 4 broad categories:

- Income schemes – schemes which rely on additional income either through additional activity, from delivery of activity currently undertaken by a 3rd party, enhanced payment for current activity or improved contractual arrangements within existing Service Level agreements.
- Productivity Schemes – traditional schemes to deliver increased productivity or efficiency across services to deliver quality and financial benefits.
- Collaboration Schemes – schemes which focus on collaborative working across health organisations to deliver high quality, sustainable services and financial efficiencies.
- Tactical Schemes – largely transactional schemes focused on amending or changing service providers or procurement methods to achieve financial benefit.

4.3. The Trust has the following transformational schemes:

4.3.1 Reducing Length of Stay – This programme of work is focused predominantly around non elective acute medicine. The Trust is driving a clinician-led pathway redesign programme which has used benchmarking information from peer organisations using Dr Foster data and Better Care Better Value Indicators to identify specific areas and specialties where THFT is an outlier against Northwest and National Peer organisations and could make efficiency improvements and deliver the sustainable reduction in beds required as part of the Trusts strategic plan to rationalise the Trust estate. This scheme is a 3 year project which commenced in 2013/14 (and has delivered £440k in 13/14). The 2014/15 scheme is reviewing the current length of stay for specific conditions and redesigning the patient pathways and where appropriate co-location of specialties to reduce overall length of stay for patients. The potential productivity gain has been calculated as a reduction in 16 seasonal and 7 core beds, with a recurrent CIP of £600k.

4.3.2 Outsourcing Beds – This scheme works in collaboration with healthcare providers within the community to deliver safe quality care for the specific patient group who are 'heading for home' in a more residential setting than an acute hospital under the clinical management of the Trust's medical teams. The scheme will provide 20 medical beds within the community setting for patients preparing for discharge from the Acute wards and awaiting input or assessment from health partners, delivering quality care and enhanced patient experience for those patients as their clinical management needs are reduced. This scheme will embody the development of transformational collaboration across the healthcare economy to deliver high quality patient care in the most appropriate and cost effective environment. The scheme will be a long term efficiency programme in support of the delivery of the Trust's strategic plan and will achieve cost improvement savings of £400k in 2014/15.

4.3.3 Collaboration – This scheme commenced development in 2013/14 with the establishment of the Southern Sector collaboration across 4 Trusts, Tameside Hospital FT, Stockport FT, East Cheshire FT and University Hospital of South Manchester. A programme Board has been established to run the scheme across the 4 Trusts with a remit of reviewing clinical, clinical support and back office corporate functions to look at opportunities to redesign services and

functions in a safe, sustainable and more cost effective way across 4 trusts in Southern Sector and other local trusts where clinical synergies align.

4.3.4 Integrated Care Model – This is a transformation scheme which is not planned to be delivered within the 2014/15 CIP programme but is in development in conjunction with the Clinical Commissioning Group and the Local Authority to redesign and reconfigure community health services from 2015 onwards through the establishment of an Integrated Care Organisation.

4.3.5 Ambulatory Care Pathways - redesigning emergency pathways in line with national guidance and best practice to avoid unnecessary admissions and significantly impact on length of stay.

4.4. The remainder of the 2014/15 CIP programme is made up of traditional efficiency CIP saving projects;

4.4.1 Income – collection of income opportunities around coding improvements and contractual, Best Practice Tariff and 3rd party efficiencies.

4.4.2 Divisional Support Functions – review of structure of operational divisional support functions.

4.4.3 Outpatient Productivity – this programme of work focuses on 8 workstreams including improving the productivity of outpatient clinics and increasing the throughput of patients by ensuring that clinics start on time and finish on time and a reduction in DNAs.

4.4.4 Theatre Productivity – focusing on improving the productivity of theatre sessions and increasing the throughput of cases by ensuring that lists start on time and finish on time, are effectively planned and throughput maximised

4.4.5 Reduction in Premium Pay Costs – Reducing the Trust's reliance on overtime, bank, agency, locum Medical and Nursing staff which attract premium costs, in line with the Trusts quality and safety strategy through matching of substantive posts to anticipated demand and a robust recruitment programme.

4.4.6 Review of organisational structural arrangements within divisional management teams and Specialist Nursing teams to identify opportunities for efficiencies whilst providing consistent effective management support.

4.4.7 Tactical savings across clinical support and corporate functions of Pharmacy, Radiology, Procurement, Correspondence, Legal costs, Estate and Facilities to maximise efficiency of services and deliver contractual, sourcing and procurement improvements.

4.5. The Trust has embedded a Programme Management approach for the management and delivery of the CIP programme with each project having clinical leadership. A fundamental step in the planning process is the Quality Impact Assessment which is completed prior to any project being approved for implementation. The CIPs are developed by a multi-disciplinary team which includes an executive director sponsor, clinical lead, project manager and financial lead. External assurance for the quality impact of schemes is provided through ongoing scrutiny of CIP schemes by the CCG through the Improvement Board and the Star Chamber process. Internal assurance is provided by the Finance and Performance Committee on financial delivery of the CIP schemes and by the executive led Service Quality and Operational Governance Group on the quality assurance of the programme.

4.6. A Cost Improvement Programme Turnaround Director is in post at the commencement of the 2014/15 programme to maintain focus on the delivery of the Programme from the start of the financial year. External programme and project management support is also in place for Collaboration, Outpatient and Theatre productivity schemes and peer support is in place from Tameside's partner organisation (UHSM) for Radiology and Outpatients.

5. Supporting Financial Commentary

5.1 Forecast Outturn 2013/14

5.1.1 The Trust has experienced a challenging year and is projecting a deficit of circa £3.5m for 2013/14 compared with an original planned surplus for the year of £1.7m. This deterioration is due to increased levels of investment within the Trust to reflect the findings of the Keogh review and a local Health Education England review. As a result the Trust has put considerable investment into nursing and medical staff as well as supplementing staff to ensure that suitable clinical and corporate governance structures are in place. The Trust has had to invest circa £6m, but without any additional funding streams to support this, as a consequence the Trust has moved into a deficit position, with a projected CoSRR of 1.

5.2 Financial Plans

5.2.1 The Trust has set income budgets of £150.9m for 2014/15. Within this income £140m relates to NHS Clinical Income and is supported by contracts with Commissioners, and as such there is no risk relating to differing assumptions.

5.2.2 The income plan for 2014/15 has been based on projected outturn activity levels for 2013/14 at month 6, adjusted for full year effect of CIP and QIPP schemes. The contracted NHS Clinical Income reflects tariff deflation of 1.29% across all contracts, but also incorporates agreed changes with the Trust's main CCG – Tameside and Glossop for demographic growth (£2.7m) in line with assumptions being made within the GM Healthier Together programme. The contract also reflects changes for services which have been transferred to a community setting – the main service transfer being Diabetes, for which the Trust will now have an in-reach service for inpatients from the new provider. The other key contract change relates to QIPP schemes which will reduce the contract value by £2.1m to reflect admission avoidance schemes being implemented by the CCG to reduce the number of emergency admissions into the Trust. The potential risk is that the QIPP schemes do not work or slip in year resulting in the Trust having removed contract capacity and then over-performing against its contract, but at premium costs. There is sufficient headroom within the contract settlement for the Trust to receive full tariff payment if the QIPP schemes were to fail, but the cost to the Trust will be at premium rates. T&G CCG have also acknowledged that the Trust will be unable to withdraw costs to the full value of the QIPP plans in year and have agreed an element of transitional support within the contract baseline.

5.2.3 The 2015/16 financial plan is currently reflecting agreed QIPP plans of £5.1m as discussed with the CCG. On-going discussions have indicated that this figure is likely to change once schemes have been validated. As such discussions around 2015/16 remain on-going with the CCG, and therefore the 2015/16 financial plan is likely to change. The current 2015/16 financial plan does not reflect the impact of integrated care proposals, as this is not possible until a detailed proposal and timeframe for change is available in May 2014.

5.2.4 The Trust has carried out its normal budget setting process including application of inflation assumptions to pay and non-pay budgets and contrasting actual spend in 2013/14 against the planned budgets and activity levels for 2014/15, funding any consequential pressures arising from the activity changes, and any known changes in the year such as NICE related drug costs, CNST changes etc. The Trust has also recurrently funded the pressures resulting from the various external reviews of the Trust which will secure an improvement in the quality of services provided and ensure that the action plans agreed with Monitor are met.

5.2.5 The Trust has set CIP targets for the coming two financial years of £6.1m each year within its planning assumptions. The CIP plans aim to achieve the savings by targeting areas where benchmarking indicates that further efficiencies can be achieved. The Trust is also actively working with its partners in the Southern Sector Collaborative partnership to look to identify

further savings by the four organisations working together to achieve further CIPs. These CIPs are aimed at back office functions as well as clinical functions.

5.2.6 The Trust is planning a deficit of £17.5m in 2014/15, and will have a CoSRR of 1, and acknowledges that it will face running out cash within quarter 1 of 2014/15, and as such is in the process of seeking cash support from the Department of Health through Monitor. Over the coming years the Trust plans to minimize its capital expenditure to a level below its level of internally generated resources in order to improve its liquidity as much as possible, whilst maintaining a safe estate. The Trust is also seeking to rationalize its estate as much as possible thereby allowing it the benefit of any sale proceeds to improve its liquidity and ensuring the maximum utilisation of its most modern facilities. During 2013/14 the Trust completed the relocation of part of the site to allow the sale of over an acre of land and associated buildings and to reduce overheads. The level of estate rationalisation will be dependent on the future structure and services offered by the Trust.

5.2.7 The capital plan for 2014/15 includes the replacement of the existing MRI Scanner which is due to come to the end of its useful life and will no longer be supported by its manufacturer. This re-provision accounts for 50% of the capital allocation and will ensure the provision of diagnostic equipment going forward to support patient safety and improve access.

5.2.8 The remaining 50% of the budget has been allocated across four categories:

- Estate Schemes
  Integration of medical HDU beds into the critical care unit and alteration in the Pathology department as an enabler for the South Sector Collaboration Pathology Scheme**.**

- Condition and Statutory Estate Schemes
  These schemes involve life cycle investment in the retained (non PFI) estate in order to maintain the standards of accommodation and to carry out energy improvement and fire safety work.

- IM&T Schemes
  The planned expenditure for 2014/15 is for investment in systems that support the recent EPR system that was installed in Q3 of 2013/14.

- Medical Equipment
  Replacement of medical equipment which has come to the end of its useful life.

5.2.9 The provision for 2015/16 capital works has been allocated across the same four categories but, with an increased resource for all categories as there are no major diagnostic equipment requirements in year, the following schemes are planned for 2015/16.

Estate Schemes:-

The final phase of replacement food trolleys, provision of a chemotherapy / haematology unit, ante natal unit upgrade and phase 1 of the provision of bedside information systems to the retained estate.

Condition and statutory schemes will continue to invest in the life cycle of the retained estate.

IM&T and medical equipment investment will focus on replacement of existing equipment to ensure patient safety is maintained and support the Digital by Design Strategy.

5.2.10 The Trust is currently facing unforeseen financial challenges as a consequence of the findings of external reviews which have resulted in additional investment in service costs thereby resulting in the 2014/15 forecast deficit. The Trust is currently working with the local health economy (T&G CCG and TMBC) to look at the future provision of health and social services within the area, in

order to meet the known financial challenges facing the economy in the coming years. The CCG has employed external advisors to support them in this process to look at the development and implementation of the integrated care services and the “Care Together Programme”. The report however will not be available until May 2014 and will form part of the Trust’s longer term plans and financial strategy.