South Tyneside NHS
NHS Foundation Trust

Strategic Plan Document for 2013-14

South Tyneside NHS Foundation Trust Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

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

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Date	**31 May 2013**

In signing below, the Trust is confirming that:

- **The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;**
- **The Strategic 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 Strategic 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;**
- **All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission.**

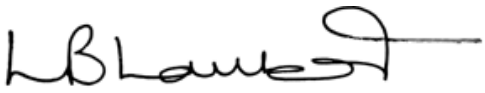
Approved on behalf of the Board of Directors by:

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 

SOUTH TYNESIDE NHS FOUNDATION TRUST

STRATEGIC PLAN 2013-14

EXECUTIVE SUMMARY

Key Elements of Plan

This plan covers the period 2013-14 through to 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 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 2012-13 which saw successful CQC inspections and multiple accreditations of achievements at service and organisational level. We will continue the development of 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 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. 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.

	2012/13	2013/14	2014/15	2015/16
	£m	£m	£m	£m
Operating Income	216.88	209.40	206.65	204.54
Operating Expenses	216.73	206.09	203.50	201.39
Surplus from Operations	**0.15**	**3.30**	**3.15**	**3.14**
EBITDA	**8.17**	**8.10**	**8.10**	**8.10**
Surplus for the year	**(2.64)**	**0.66**	**0.50**	**0.50**
Cash balance as at 31st March	**20.27**	**16.76**	**17.71**	**18.40**
Taxpayer's equity as at 31st March	**99.59**	**100.25**	**112.75**	**113.25**
Financial risk rating for the year	**3.00**	**3.00**	**3.00**	**3.00**

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 has introduced difficulties in agreeing contracts for 2013/14.

Particular uncertainty has arisen around funding for control of infection which was defunded from former Primary Care Trust allocations and contracts and has been passed to Local Authorities. The full details of this transfer (approximate value £800k) were only established in late May 2013 and the lack of certainty has been one of the barriers to the agreement of contracts.

An additional uncertainty exists around the funding of the District Nursing Services to all three CCGs. A District Nursing review has been underway for a number of years (pre-dating the transfer of services to the Trust) and pressure has been building within the Trust with direct budgetary overspends in 2012/13 for over £700k. The full value of the shortfall based on fully absorbed costs is closer to £2m. The CCGs have given positive indications that additional funding will be forthcoming in 2013/14.

Against this background the Trust have maintained service levels and therefore financial pressure at 2012/13 levels, assuming that funding will be forthcoming. However, it is assumed that final decisions will not be made within Quarter 1 of 2013/14.

During 2012/13 the Trust reported an Financial Risk Rating (FRR) of 2 at Quarter 3 which resulted in regulatory action by Monitor. Whilst the Trust returned to an FFR of 3 in Quarter 4 of 2012/13, the outcome of the Monitor review is a requirement for the Trust to commission an external review of its financial governance arrangements and to present its strategic planning assumptions to demonstrate clinical sustainability during Quarter 1 of 2013/14. Aligned to this work the Board intends to commission an external baseline financial review and development programme.

Given this uncertain background the Board considers that the prudent approach would be to assume within the plan delivery of an FRR of 2 in quarter 1 whilst striving and putting action plans in place to deliver an FRR of 3.

1 STRATEGIC CONTEXT & DIRECTION

1.1 Trust Strategic Position Within the Local Health Economy

Since 2005 South Tyneside NHS Foundation Trust (STFT) has been a highly successful provider of acute services, predominately to the people of South Tyneside. In July 2011, we successfully integrated community services across Sunderland, Gateshead and South Tyneside into our Foundation Trust effectively doubling our turnover and number of staff. This change in our scale of operation has been significant and together with our breadth of services and range of staff, places us in a different and stronger market position than previously.

At the heart of our service provision is the philosophy that we "Choose" to go further to exceed our customers' expectations. We achieve this with a focus on patient safety, valuing our staff and by a focus on patient experience and patient outcomes. Our aims and objectives identify our priorities and are clear about our delivery plans with this overriding philosophy in mind. We believe that this theme and our future plans are consistent with our values and right for our organisation, our staff and our communities. They also are right for the current climate, where there is significant uncertainty within the NHS system resulting from not only structural reform but also the national financial outlook. We believe this will create the right culture to enable us to deliver our shared purpose: to provide the best care for our patients, in the best place, at the right time.

The breadth of services we now deliver, particularly in the community, means that we are affected by a consistent focus on procurement activity by commissioners. Whilst competition for acute services is relatively limited and, indeed there has been little evidence to date of private sector organisations looking to move into the area of mainstream core community services, there are areas where third sector organisations perform well in tendering opportunities, particularly in specific targeted areas such as substance misuse. This strategic plan is based on the assumption that this position will not change significantly in the period, however, we will increase our focus on business development and the identification of growth opportunities together with the avoidance of loss of core business.

We reviewed trends in market share in 2012-13 and identified some reduction in referrals to specific services. Working with CHKS to identify the underlying causes showed that there was a small shift in market share in orthopaedics to the Tyneside Surgical centre based at Gateshead NHS Foundation Trust, particularly coming from one or two GP practices. In the case of geriatric referrals, the data suggests that GPs are looking to manage patients as far as possible within primary care. The activity assumptions that underpin this plan are based on a levelling off in those trends. For orthopaedics the rationale is that we have strengthened our consultant team, recruiting to posts in 2012-13 and are now actively promoting the team to those practices which have referred elsewhere. For geriatrics, we believe that the GP efforts will at best ensure a standstill position, as the increasing frailty of elderly patients will challenge their ability to be safely cared for in primary care.

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.

1.2 Impact of Changes in Local Commissioning Intentions

Discussions regarding contracts for 2013-14 highlight the many changes that have taken place in the commissioning landscape. As a provider across three localities, the number of contracts we have has multiplied. Clinical Commissioning Groups (CCG) in Sunderland and Gateshead have agreed to be co-signatories of the contract with South Tyneside CCG, as have the NHS England Local Area Team and South Tyneside Local Authority. Separate contracts cover Gateshead Local Authority, Sunderland Local Authority and NHS England Specialist Commissioning. We have looked to negotiate terms and conditions comparable to those within the NHS Standard Contract, to mitigate risk associated with moving to local authority contracting.

The commissioning intentions of the CCGs with whom we work are consistent with those which they developed in 2012-13 as shadow organisations. As the majority provider of community services in South Tyneside, Gateshead and Sunderland, we are actively involved in securing new business as a result of commissioning work to deflect patients from acute hospital care in these localities. Several projects initiated in 2012-13 using "readmission monies" have been extended into 2013-14, and additional bids will be made in all three areas. Our expertise in providing a model for a nursing care home support teams fits directly with CCG and local authority priorities aimed at addressing quality standards. It is hoped that will be an area of development throughout the period of this Plan, including the potential to extend beyond our traditional boundaries. However, no specific impact is yet assumed within the financial forecasts.

Our urgent and intermediate care nursing teams were praised in an Emergency Care Intensive Support (ECIST) report into emergency pressures in Sunderland. We will look to promote the work of those teams during the intended reviews of urgent care services in all three localities.

At this stage we are not aware of any further intentions to develop "Any Qualified Provider" (AQP) services within our core geographical area, and those initiated to date have shown little or no impact on core business. We remain the single AQP provider for podiatry in both South Tyneside and Gateshead, and for INR, a measure of anti-coagulant activity monitoring within South Tyneside. We did not enter into the procurement process for Adult Hearing Aids and Community Carpal Tunnel surgery based on our assessment of strategic fit in the former and financial viability in the latter. However, we will review every AQP opportunity to ensure that where appropriate we look to maximise any development opportunities.

Local Authority commissioners are developing their health strategies, particularly in respect of public health commissioning. We anticipate that several services will be reviewed by Local Authority commissioners under notice in 2013-14. We expect to work in partnership with our Local Authorities to refine current models of service delivery and secure on-going contracts wherever possible.

As part of the development work for contract negotiations with commissioners, all service managers took part in an analysis of activity trends over the past three years. Combining statistical modelling with their frontline experience and intelligence, we developed an activity plan that commissioners commented on positively in respect of its depth and ease of use. The contracts agreed for 2013-14 have been based almost entirely on our analysis and forecasting of activity.

1.3 Collaboration, Integration & Patient Choice

Choosing Change

For several years now we have been working with colleagues in the Foundation Trusts in Sunderland and Gateshead and with the previous Primary Care Trust in South of Tyne and Wear to develop a plan for the delivery of safe, sustainable and affordable services for our patients out into the future. There are a number of reasons why these changes are necessary:-

i) Local Sustainability

Across the three main hospitals in each of the localities there are a number of clinical specialties where each organisation may have only one or two consultants or other specialists providing certain services. This poses obvious problems in relation to sustainability, for example covering the service as soon as the consultants take annual leave, go on essential training courses or if they need to be absent for any other reason. Small departments are sometimes not attractive when we are looking to recruit new consultants and sometimes we are all three running services which are stretched in terms of these issues and can be difficult to sustain.

ii) Critical Mass

As clinical medicine has developed it is clear from national advice from Royal Colleges, the Department of Health and expert groups that a certain critical mass of population is needed to maintain the best quality services in some specialties. This guidance supports patient safety, to ensure that when a doctor is treating a patient they have enough experience to treat complex conditions which in a smaller population they may only see from time to time. Research shows that something is more likely to go wrong when a patient is treated in a unit where the doctors are not seeing sufficient volumes of certain types of conditions.

The critical mass of population required differs between specialties but across the three hospitals there are some specialties, and clinical teams who only get

the opportunity to treat certain conditions infrequently. This makes it more difficult to maintain their skills. A good example of this is Vascular Surgery, where guidance Suggests further centralisation based on population figures and minimum numbers of certain operations.

iii) Quality Standards

Over the coming years the NHS will be expected to achieve ever demanding quality standards and to do so will need, in some cases, to make significant investments, whether that is new technology, new ways of working or more doctors and nurses. For example, it is expected that hospitals will have to increase the number of senior doctors present at weekends in hospitals given evidence that people admitted on a weekend on average have a poorer outcome than those admitted during the week.

For some specialties there are simply not enough senior doctors available for every hospital to implement these standards. Getting this balance of the right skilled staff in the right place to maintain and develop their expertise based on the right critical mass of patients is a key challenge for us.

iv) Workforce

In addition to some of the difficulties highlighted in recruiting new Consultants to comparatively small teams, other factors such as onerous on-call rotas can be unattractive. Larger teams working collaboratively together can reduce this burden and this is a factor we have been able to influence by our partnership working to date. Other changes to workforce rules and regulations are also putting pressure onto the local system. The introduction of the European Working Time Directive (EWTD) meant additional costs and cover arrangements were required to support reduced working hours for junior doctors. Restrictions on overseas recruitment create even further pressures. Taken together with the predicted reduction in the overall number of doctors in training it can be seen that the present pattern of service delivery and organisation of our specialist workforce needs to change to ensure that high quality services can be sustained and can be staffed by teams with appropriate expertise.

v) Care Closer To Home

With the national strategy of wherever possible trying to provide care closer to the patients home and avoiding hospital admission, we must assess the likely impact on hospitals and ensure that our partnership work between agencies provides an integrated network of hospital, community, primary and social care services that effectively underpins this agenda.

vi) Financial

The NHS as a whole is facing a significant financial challenge and locally we are no different . Simple year-on-year cost cutting will not achieve the required savings and all of the partners working together are clear that we need to

work differently to deliver the required levels of care and provide sustainable services out into the future.

The Bigger Picture

To address these problems we established a major and intensive work programme called the “Bigger Picture”, a collaboration designed to look at what the future pattern of service delivery should be and to map a path for us to work toward that outcome. All three Foundation Trusts have played an equal role in this process together with the South of Tyne and wear Primary Care Trust.

This work is designed to strengthen and improve the services we offer to our patients by building on the different strengths of each partner creating a system where residents across South of Tyne and Wear and beyond will have access to the best healthcare available.

By utilising the strengths of each organisation we aim to work together to use our resources most effectively to create sustainable quality services for the future. This will mean that one organisation may stop providing some services but may begin to provide others. We call this the “give the get using this approach to ensure that hospital and community services continue successfully in each of the three localities out into the future. At the centre of our debate is the likely final shape of services and whilst this discussion is on going the developing picture which is being worked on jointly by our clinical teams is based on the concept that Having three hospitals in close proximity each doing identical things is no longer viable going forward . All of us will need to change in some way and to do so cooperatively to get the best outcome for our patients and staff. Broadly the Chief executives have described what the long term shape of services might be as follows:-

For South Tyneside Foundation Trust it is likely that the future focus will be on delivering world class diagnostic, screening, rehabilitation and out of hospital services for the whole of South of Tyne & Wear and possibly beyond working together with other Foundation Trusts, Local Authorities and Primary Care. Within South Tyneside itself local hospital services will move away from complex unplanned surgical care which will be provided as part of wider clinical networks together with other complex care pathways. The population will continue to have local access to emergency medical services including elderly and end of life care supported by the new emergency and assessment centre facilities for adults and children which were opened in 2011.

For Gateshead, the main surgical focus will be on providing capacity for non-specialist elective activity across the South of Tyne, using the Treatment Centre as a commercial hub to handle high volume contracts for low complexity surgery. It will retain its status as a Cancer Centre for Gynaecology Oncology and will increasingly develop a Breast Cancer Service, and continue to provide and develop a range of national screening services. Gateshead residents will have local access to a range of emergency medical services, including Elderly Care and Old Age Psychiatry, and A&E Services, enhanced

by a brand new development locally and supplemented by more same day assessment facilities.

For City Hospitals, the focus will be on becoming the third specialist centre (or main hub) across the North East and it will increasingly specialise in the more complex/specialised services, both elective and non elective. More complex Colorectal, Vascular and Stroke services will start the beginning of a Cardiovascular, Renal and Metabolic Service being developed to work alongside Primary Care. Its focus as a Trauma Unit will be supplemented by a world class Critical Care unit and it will offer complex diagnostics such a full interventional radiology service. Local access to emergency medical services will also be available complemented by a brand new A&E department and admission pathways. The Trust will continue to enhance and expand its Medical Education role through its responsibility as the hub for the Wear based educational unit.

To date the Bigger Picture programme has delivered some real change to frontline services as can be seen below:-

- As part of this reshaping of care we have established a collaborative system for the delivery of hyper acute stroke services supported by a telemedicine model where our combined Consultant teams jointly deliver the service across all three localities.
- We jointly developed, consulted upon and implemented a new model of child health services which has reshaped care both in hospital and in the community. In particular we have combined our inpatient resources into a centre at Sunderland supported by a new model of 24/7 assessment and emergency treatment in each locality.
- Despite the delays in developing a solution to the reshaping of pathology services nationally we, through our collaborative working have completed a full review of options, agreed a combined service model and have been successful at developing a proposal for a new centre of excellence based in Gateshead with hot lab facilities in Sunderland and South Tyneside. National capital funding has now been secured to support this collaborative development.
- We successfully bid jointly to be one of the first bowel cancer screening centres in the country, a service administered from Gateshead with a clinical lead from Sunderland and expert Consultant and other staff input from all three localities. Building on this South Tyneside became the first hospital in the country to begin the new bowelscope screening project early in 2013.
- Recognising the likely longer term shape of services the partner organisations agreed that the lead Trust for taking forward the transformation of community services should be South Tyneside and all of the community services across South of Tyne and wear were transferred to South Tyneside in 2011. Extensive work is now on going in developing integrated pathways of care across all three localities.
- Vascular services were initially combined between South Tyneside and Sunderland and discussions are actively on going about the expansion of this collaboration to Gateshead and potentially beyond.

- We have agreed to combine our resources in Medical Physics creating a hub in Sunderland delivering a single managed service across all three sites.
- Breast cancer services and breast surgery have been successfully combined between Gateshead and South Tyneside and it is expected that this will shortly extend to Sunderland with Gateshead continuing to lead this important area.

These are only some of the examples of the changes already delivered and there is an extensive work programme on going with a major commitment from each of the partners both in terms of time and the commitment of each senior and clinical team. Projects currently on going include a review of out of hours surgery with a view to creating a single hub to support all three sites; a review of trauma again with a view to developing a single hub approach; work has begun to look at what could be achieved by combining our resources in some or all of the specialist radiological services and a workstream has been commissioned to look at Maternity services. This is not an exhaustive list but gives a flavour of the scale and commitment to the exercise.

In terms of governance the Accelerating the Bigger Picture programme is overseen by a Programme Board comprising the Chief Executives of each partner agency together with their lead Operational Directors, Medical and Finance Directors. This core group meets fortnightly and accounts periodically to our combined Chairmen on progress made as well as individually to our own Boards. Discussions are currently on going as to whether it is now an opportune time to formalise an overarching partnership working arrangement with a clearly defined Terms of reference and delegated responsibilities in order that continued delivery can be maintained at pace as we go forward.

2 OUR APPROACH TO QUALITY

Our approach to quality is encompassed within our Strategy "Choose Safer Care – Patient Safety at the Centre of our Work".

We aim to provide a comprehensive range of high quality health care services in our hospital, patients own home or care homes to meet the needs of the local population and others who wish to make use of our services.

To support this we aim to ensure the long term delivery of safe, high quality services through:

Safe Care

- A patient safety culture which is at the heart of our service delivery.
- Demonstrating clear leadership for patient safety.
- Having systems and processes in place to deliver safe care.

Effective Treatment

- Care and treatment based upon the best up to date evidence available
- A range of measures in place to monitor the safety and effectiveness of care and treatments.
- Care and treatment focussed on outcomes for patients

Quality Services

- A workforce with relevant skills and knowledge to deliver safe, high quality care
- Transformation and modernisation of services to improve safety and quality
- Excellent patient care and experience
- Continuous monitoring of safety and service improvement

2.1 Board Quality Assurance

When we joined with community services across Gateshead, South Tyneside and Sunderland in 2011 this gave us an opportunity to review how we could further develop patient safety assurance systems going forward. We used our existing Patient Safety Committee to lead this work and develop proposals for consideration by the Board as a whole. The Patient safety Committee used the Assurance Framework and Patient Safety Committee action plan to provide high level assurance on all clinical services using a red, amber or green rating against key criteria. These criteria are aligned to those in the Monitor report 'The Board Role in Patient Safety'; identifying six elements which are crucial to the delivery of safe patient care. These are:

- Leadership
- Staff engagement
- Guidelines and training

- Safety metrics
- The Learning Cycle
- Resourcing

The Patient Safety Assurance Framework Assessment and Patient Safety Committee Action Plan were received and approved by the Risk Management Executive Committee, and act as a benchmark from which we can track progress.

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 Assurance Framework demonstrated high levels of assurance that key policy, systems and procedures were established; audit and feedback mechanisms and improvement plans were in place with clear evidence of implementation and effectiveness throughout the organisation.

In September 2012, the Nursing, Allied Health Professional and Patient Safety Directorate was fully established. The focus of the Directorate is to achieve and maintain the highest standards of care for our patients, working to continually improve outcomes and patient experience. The patient safety team support operational staff to achieve and maintain the highest levels of professional standards and competence; ensuring that patient safety is at the core of everything we do.

Visibility walls are used across the organisation to report and track progress. These sessions provide a unique opportunity for clinical and management staff to share with executive leadership exactly what is happening on the ground; what the opportunities for and barriers to progress are. These sessions help to create a culture of openness and transparency with the opportunity for very honest conversations about areas that need further work.

In 2012/13 listening and learning from our patients experiences has been a very important area of development which has been delivered in a range of ways;

- A&E national survey
- Outpatient department patient experiences
- Inpatient annual survey
- Cancer peer review
- Oncology review
- Safeguarding peer review

The combined impact of this work by the patient experience team has delivered 906 qualitative stories from patients and additionally surveyed 3738 patients.

There have been two main initiatives implemented to underpin the patient safety programme. In August 2012, the “Safety Thermometer” was introduced in all adult wards and in district nursing services. The national tool measures

four high volume patient safety areas as a snapshot once per month capturing information on patients within our services who on that day have a:

- Pressure ulcer
- Fall occurring while in care
- Urinary infection while requiring a urinary catheter
- Treatment for venous thromboembolism (VTE)

Since beginning to collect this information the Trust has improved from 85% harm free care to 91% by February 2013.

The point prevalence information provided by the Safety Thermometer is valuable but in itself will not provide the more detailed ward/team based intelligence we need to drive out avoidable harms. In order to provide this rigour we joined the national initiative "Choose Safer Care" in October 2012. When a patient falls or develops a pressure ulcer in our care, it immediately triggers a root cause analysis in real time. Part of the process will involve asking patients and staff how they feel about their care or the way care is delivered. Since October 2012, the clinical audit team have surveyed around 100 patients and staff every month. Patients have reported a good experience during their care in 90% of questions asked.

Using the principles of Choose Safer Care we are now using data and information from multiple sources to develop a comprehensive picture of each ward and team; highlighting their strengths and areas of improvement needed. Using this information, the patient safety team can empower and support staff to develop more tangible ownership of the care they deliver and drive improvement where this is shown to be necessary. This intelligence is beginning to provide us with a robust early warning system to trigger rapid intervention where this is needed to support both patients and staff. Areas of good practice and excellent care are also highlighted providing the opportunity for sharing and learning. Clinical forum and audit meetings for both medical and nursing staff are well established opportunities for sharing of experiences, developments and practice. These meetings have been reviewed and their focus strengthened during 2012/13 to ensure that they remain fit for purpose to support the patient safety agenda. For example the review of mortality and morbidity management and scrutiny remains a priority and the group leading this has been further strengthened. Clinical audits have been registered for all directorates to carry out peer review in relation to morbidity.

<u>Safety Metrics</u>

In terms of assurance about safety metrics, our Patient Safety Assurance Framework rated our progress at a mixture of Amber and Green, which indicated that at that time that although we were providing high levels of assurance against some criteria, in other areas there was room to improve the clarity of the evidence. The development of Trust-wide safety metrics was key tenet of the Patient Safety Action Plan for 2012/13 and has now been successfully achieved. Further work over the coming months will refine the metrics to appropriately tailor them for different levels of governance.

Two leading patient safety initiatives implemented in 2012 are the NHS Safety Thermometer and Choose Safer Care both of which are underpinned by the collection of metrics from a wide range of sources.

a) Agreeing a prioritised list of key metrics for the Board to monitor

Choose Safer Care has led to the development of a patient safety dashboard which is reported monthly to the Safer Care Panel and regularly to the Board of Directors. The metrics consist of 52 measures recording progress and achievement across the following themes;

- Priority patient Safety Areas
- Quality of Clinical Care
- Patient Experience
- Staff Experience and Development
- Serious incident/events

The extensive list of measures is under constant development and is evolving over time to a key list of metrics tailored to different levels of governance which includes the Board of Directors.

b) Ensuring that the metrics are tailored to different levels of governance

Work is underway to develop ward/team level dashboards which can be used to drive improvements in patient care at individual team level. A pilot ward dashboard is being currently used on a care of the elderly ward; the intention is to roll out this approach to all wards and teams.

c) Checking that the metrics are delivered in conjunction with the staff

In terms of the newly developed patient safety metrics, in the pilot area the ward metrics are owned by the staff as a narrative describing care in their ward area .Evolution of these metrics is used to truly understand the environment of the care area and the quality and safety of the care delivered. All ward and teams will have access to this level of tailored intelligence in 2013.

d) Publishing the metrics widely and transparently across the organisation

The new safety metrics have been widely reported to staff across the organisation during 2012/13 at visibility walls and in professional and clinical forums. A measured approach has been taken to developing greater transparency in sharing of information between services and will be an area of development throughout 2013. This “slow track” approach to transparency has been deliberate while data streams were new and untested, and to provide time to allow staff to gain confidence

in the systems and data which will in turn support the development of a culture of trust and continuous improvement.

Use of the Global Trigger Tool was discontinued in 2012 as it was overtaken by a range of other systems, which prospectively and retrospectively review the same level of information.

Compliance with National Standards

During 2012/13 the Trust was subject to a number of inspections in line with national requirements. The Care Quality Commission (CQC) has inspected and noted compliance in all standards reviewed in the following services. There are no outstanding CQC concerns:

- St Benedict's Hospice, Sunderland
- Primrose Hill Hospital, Jarrow
- Hospital adult wards
- Safeguarding of children in Gateshead, Sunderland and South Tyneside
- Learning Disability Service, Woodside Close, Jarrow
- The NHS Diabetic Eye Screening Service Programme was reviewed as part of the national accreditation programme and declared compliant.
- Human Tissue Authority inspected the Mortuary in September 2012 and achieved compliance.

In February 2013 the Trust achieved NHS Litigation Authority (NHSLA) level 2 accreditation in recognition of standards in place to manage risk. In March 2013 Trust maternity services achieved Level 1 compliance with the Clinical Negligence Scheme for Trusts (CNST).

2.2 Key Quality Risks

We will be intensively reviewing the recommendations of the Francis Report and the Board has established a Task to Finish Group to do this and account to the Risk Management Assurance Group, a formal Board Sub Committee. The Task to Finish Group will be expect to identify any lessons to be learned locally together with any gaps which need to be resourced for consideration by the Board.

The continued increase in emergency activity puts increasing pressure into the whole system. This is not just an A&E problem with the 4-hour target. The impact is seen throughout patient pathways and can affect patient experience both directly e.g. with cancelled operations and indirectly. We continue to work with commissioners in all areas to manage demand through urgent care networks.

Similarly, there has been activity growth in community services, particularly district nursing, over several years. We have been negotiating with commissioners for increased funding for the service for some time, with a

decision expected early in 2013/14. In the absence of agreed funding increases we will need to negotiate with Commissioners the element of service which can no longer be delivered.

3.0 CLINICAL STRATEGY

3.1 Clinical Strategy

Patient Choice is a key component of our strategic aim to deliver high quality and safe services to our patients, continuously improving the delivery of services and providing integrated, seamless pathways of care. We recognise that the key to successful delivery of this aim is to ensure that our collaborative approach to service delivery secures local services within South Tyneside.

To deliver this we are working with the Health and Wellbeing Boards across South Tyneside, Gateshead and Sunderland to ensure there is a joined up approach to the clinical and quality strategy across the health and social care interface.

Collaboration will ensure that patient choice is supported to ensure the services accessed by our patients are of the highest quality. This work links to Accelerating the Bigger Picture and there are a number of strands of work which support these strategic aims:-

- Management of acute hospital admissions and readmissions through a shared approach to both the public health agenda making every contact count and the management of patients with complex conditions through the Premier Patient Pathway.
- Management of acute and emergency pathways through single point of contact ensuring primary, community and social care teams are engaged in case management that facilitates patient care in the home wherever practical.
- Sharing of good practice across the three local Foundation Trusts to ensure emergency care pathways link to ambulatory care services and that there is an embedding of Emergency Care Intensive Support Team recommendations.
- Embedding of integrated services for children that ensure district and specialist services are seamless for children and their families.
- Management of clinical pathways with opportunities for partnership in surgery, maternity, trauma and orthopaedics, radiology and cardiology all in discussion.

Working with the newly formed Clinical Commissioning Groups and Local Authority commissioners during the coming year will provide a platform for exploring in detail a number of service specifications to enhance our commitment to being the provider of choice for all services we provide.

<u>Business Development</u>

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.

Criteria to support this decision are:

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

3.2 Clinical Workforce Strategy

Staff Engagement

With regard to staff engagement our Patient Safety Assurance Framework rated our progress as Green, providing high levels of assurance that key policies, systems and procedures were in place to support staff engagement and that audit and feedback mechanisms to staff were effective and that improvement plans were in place throughout the organisation.

Further progress has been made to strengthen staff engagement in respect of the patient safety agenda which is a key tenet to delivering safe and effective patient care.

a) Measures to increase front line staff engagement

There have been a number of measures established in 2012/13 to increase the engagement of frontline staff with the patient safety agenda. The following are a few examples of the progress that has been made.

Visible senior clinical leadership has been strengthened in 2012/13 with wards, teams and department staff having regular opportunities to meet senior clinical nursing staff and share any concerns, areas of challenge or ideas for improvement of services to patients. Safer Care Leads have been identified in each community team to provide focussed leadership for patient safety and professional issues. Modern Matrons provide this function in our inpatient areas.

Intentional-rounding was introduced to ward areas in November 2012. This is a structured process where nurses on wards in acute and community hospitals carry out regular checks with individual patients at set intervals, typically hourly. The idea is that “rounding” helps frontline teams to organise ward workload to ensure all patients receive attention on a regular basis. The critical element to this approach is reliability and a consistency of care which brings with it the confidence of staff and patients alike. The development of a care round checklist by front line staff to support intentional-rounding has been a key mechanism for engaging them in this important initiative. The visual tool is designed to support nursing staff in delivering the highest standards of care to patients every day. The tool focuses on meeting all aspects of patients’

needs including comfort, privacy, dignity, nutrition and hydration. The outcome of the tool is to reduce patients relying on summoning nursing help to receiving regular care delivery and attention.

The safeguarding team are involved in Care Quality Commission, Ofsted inspections and peer reviews with the three local authorities. The team also have an important role in both serious case reviews and case reviews for adults and children in 2012/13. It has been recognised that frontline staff need to also be closely involved and engaged with the safeguarding agenda. With this in mind in 2012/13 eighty two safeguarding champions were put in place across the organisation supported by an on-going development programme. To underpin this work a new policy for Criminal Records Bureau (CRB) checks to include the disclosure and barring service was implemented in this period with Board level agreement to review staff checks in all high risk areas.

We actively support clinical research as a key method of engaging frontline staff in improving patient outcomes. We have a multidisciplinary research team with an organisational focus and includes nurses, allied health professionals, doctors and pharmacists.

In 2012/13 there were 57 portfolio research studies across the organisation covering a wide range of specialist clinical areas. The Trust hosts three Clinical Research Fellows and a Clinical Research Associate; one of our consultants, Dr Colin Rees, was appointed as a Professor at Durham University.

b) Engaging junior doctors in the patient safety agenda

The Choose Safer Care initiative has been further developed to include a medications safety review; intelligence from the National Patient Safety Authority (NPSA) has highlighted medication errors as being a cause for concern nationally. All missed doses of medication, wrong dose medications and delayed medications have been reviewed and these results have been fed back to staff at all clinical nursing forums and at speciality specific team meetings and at Medical Director led learning events known in the Trust as “Uncle Ed’s” meetings, these are multi professional open learning forums where staff present cases where lessons for wider learning have been identified. A medication safety briefing has been developed and issued to all staff including an agreed list of critical medicines.

c) Maximising opportunities for team work to improve staff allegiance

One area of progress which has empowered clinical staff to deliver more joined up care is the initiative focusing on *premier patients*. The purpose of this initiative was to identify the highest users of services across the hospital and the community; these patients are typically very complex and require the input of a wide range of clinical and social care teams to meet their needs. An integrated care record was developed for this group of patients to guide more effective communication. This record

has enabled staff to have an overview of the total care package accessed by these patients, including equipment and the range of services involved. Each patient has now been assigned a key worker in the hospital and community and “visual flags” are used to highlight patients to staff when they access their services so that they are aware of their individual needs and care at the time of delivery. These patients have reduced their Accident and Emergency attendance by 24% and in-patients stay by 21%.

Early patient discharge has been progressed by supporting ward managers to lead patient decision making through daily “cluster” multi-disciplinary team (MDT) meetings on the ward. These meetings ensure that a timely review of patient care and facilitate decisions happen daily.

The Learning Cycle

The Trust Patient Safety Assurance Framework rated our progress at Green in matters regarding the Learning Cycle, providing high levels of assurance that key systems and procedures were established, audit and feedback mechanisms and improvement plans were in place with clear evidence of implementation and effectiveness throughout the organisation. From this strong position, further headway has been made.

Continuous development as a learning organisation is a key objective and is underpinned by the Quality, Research & Audit and Continuous Quality Improvement Programmes. In 2012 the Trust developed the “Strategy for Clinical Audit 2012/14” the aim of which is to use clinical audit as a process to embed clinical quality over two years at all levels in the organisation, and to ensure it is effectively carried out by clinicians in order to improve the quality of patient care. In the past year the Quality, Research and Clinical Audit Team have been involved in 51 national audits and 350 local audits. The major audit in the Trust is based on the Essence of Care/Integrated Audit which measures basic standards of fundamental patient care.. In 2012/13 all 132 teams have delivered integrated audit which provides a benchmark for each service around the twelve standards of fundamental care.

The Continuous Quality Improvement (CQI) team support the delivery of an annual CQI plan. The CQI team undertake the pre work for improvement events including establishing the baseline measures of pathways and processes as well as the analysis of data using a range of productivity tools and methods to support mapping of the current state. The data and information is then used to support front line staff in generating ideas for improvement through continuous quality improvement events (Kaizens). The team has developed these improvement ideas, implemented the outcomes locally and undertaken re measures to enable the reporting of improvement gains. To strengthen this approach a data base has been established in 2012/13 to allow continued recording of baselines, re measures and therefore greater understanding and reporting of improvement gains. In 2012 the CQI team supported staff to identify 511 quality defects in patient care systems and processes, 515 ideas for improving patient pathways and enabled the

training of 315 staff in productivity measures and tools to improve patient safety.

The following is one example, in the case from the Infection Prevention and Control Team (IPC), detailing how the learning cycle has been strengthened in 2012.

a) Proactively managing risk on the basis of robust interrogation of the data.

The IPC team have developed a standardised audit which has been implemented across the whole organisation in 2012/13 providing monthly assurance.

b) Giving direction for rigorous root cause analysis of patient safety incidents.

A standardised approach has been introduced to the investigation and reporting of all incidents and follow up systems

c) Seeking assurance that incidents are appropriately followed up

A trigger tool has been developed and implemented to trigger monthly follow up of the IPC audit results. This tool prompts action by the IPC team to support an identified ward/team as appropriate, carry out validation audits and if necessary place a member of the IPC team to work in the ward or team to support actions and improvement.

d) Resourcing and implementing a structured team based debrief programme following patient safety incidents.

The IPC team work closely with speciality teams where specific trends in IPC have been identified. The multi-disciplinary clinical teams are debriefed by the IPC team; sharing the data and the action plan which increases staff engagement and ownership of the issues and the actions moving forward.

Medical Staffing

Ensuring that we have a medical workforce with the right skills for our services and retaining those staff as part of our core team is a vital part of our workforce strategy.

We have an excellent track record of investment in medical staffing to ensure our ambition to be provider and employer of choice is achieved.

During 2013/14 we will be investing significantly in a number of services in response to the needs of the population we serve and based on historical and predicted demand:-

- An additional Consultant Respiratory Physician in recognition of the growth in the prevalence of respiratory disease which reflects the historical heavy industry of this area.
- An additional two Consultants in Emergency Medicine to facilitate extended working to manage the significant growth in emergency care attendance over the last 3 years and new emergency care pathways.
- 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
- Completion of investment in anaesthetic staffing started in 2012/13 to enable enhanced service delivery across this complex specialty and to facilitate growth in surgical contracts over time.

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. This is evidenced in 2012/13 by members of the Patient Safety Team being involved in the strategic development of the "tomorrow's workforce" curriculum for nurses, midwives, physiotherapists and operating department practitioners.

As part of a comprehensive and inclusive approach to nurse training the education assurance team has also successfully designed and implemented a new programme for cadet nurses in response to changes in adult nurse training moving to degree level. A pilot programme was agreed by the previous Strategic Health Authority (SHA) and Northumbria University. Study is at level 3 for a BTEC Diploma in Clinical Health Care Support and a BTEC National Diploma in Health Studies. Six Cadets were recruited and commenced training in April 2012. All cadets in the Trust have been successful in gaining a place on the Student Nurse Degree Programme.

In 2012/13 the education assurance team have developed an accredited preceptorship programme for newly qualified nurses, physiotherapists, occupational therapists and operating department practitioners. All of those newly qualified practitioners who have commenced this accredited work based learning (AWBL) programme have completed the academic assignments and successfully completed the course.

At a national level, our health visiting services have been part of the Early Implementer National Programme for service change. This initiative has led to the introduction of NICE guidance for health visitors a year earlier than national roll out plans and enabled Health Visiting Services balance the preventative work and the vulnerability caseloads.

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. In 2013/14 the priority will be to complete the transformation of administrative and clerical support provided to clinical services and ensure that the agreed revised structures, systems and modernised ways of working are implemented smoothly and quality is monitored. The review of the organisation and delivery of administrative and clerical staff in corporate services will be undertaken in 2013/14. These reviews, together with further management restructuring below Clinical Business Manager level will result in a leaner, more streamlined service. Cost savings in these areas will contribute significantly to our overall Cost Improvement Plan and we envisage between 100 to 150 staff leaving the organisation as part of these changes.

4 PRODUCTIVITY & EFFICIENCY

4.1 CIP Governance

Driving transformation forward

Internally within South Tyneside a very major programme of service transformation has been on going since 2011 in our "Choose Change – Driving Transformation Forward" programme. We engaged the services of PricewaterhouseCoopers to assist us in developing a rigorous Programme Management Office designed to underpin and support the delivery of real shifts in thinking about the way we do things and how we can re shape services going forward to ensure they are safe , sustainable, high quality and cost effective.

The programme is designed to challenge all that we do and focus our attention on working smarter and more cost effectively whilst improving quality and modernising services. We have on going programmes looking at transforming a wide range of clinical pathways, business systems and the way we use our resources. The programme is overseen by the Programme Management Office and accounts to the Transformation Board comprising the full membership of the Board of Directors meeting specifically for that purpose.

Our Project Management Office has experience in programme management, financial management and service improvement and is responsible for ensuring there is a continuous development of projects in the "project pipeline" that covers a horizon of not less than two years. We have worked hard to ensure that the Project Management Office acts as a driver of transformational development and applies rigour and governance to the process. It does not, however, take the responsibility for continuous transformation away from service providers while operational delivery experience rests. Our Transformation Board governance structure ensures accountability for delivery remains with Executive Directors in each of their respective areas.

The Transformation Board is a sub-committee of the Board of Directors, chaired by the Trust Chairman and comprising all members of the Board itself. It reviews the progress of the programme and scrutinises regular reports as part of an agreed performance management structure that provides assurance that:-

- There is a process for developing and approving the implementation of projects
- The programme is sufficient to meet the financial needs of the organisation
- That progress against the plan is maintained, risks are mitigated and support is provided where necessary
- Success is embedded, sustained and shared across the organisation

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 2012/13, 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

Further assurance was gained from an Internal Audit report into the governance of the CIP programme management.

4.2 CIP Profile

Cost Improvements amounting to £10.2m were delivered against a target of £10.6m in 2012/13. In the year a number of major projects were brought to fruition under the Driving Transformation Forward Programme including:-

- efficiency and productivity in theatres
- a major review of administrative and clerical staffing systems and structures
- a major review of IT support structures
- new more efficient arrangements for lease cars
- e expenses
- e Rostering
- a major review of our bed base
- an intensive review of our high volume attenders
- changes to our urgent care stream
- an extensive realignment and rationalisation of our estate
- centralisation of community bases
- electronic system support for community nursing staff activity planning
- introduction of electronic white boards to support patient flow in hospital
- a scheme to develop a new energy centre

The cost improvement target for 2013/14 amounts to £12.5m which is approximately 5.9% of estimated turnover and is recognised by the Board as challenging. However a number of the schemes commenced in 2012/13 are on going and will deliver significant benefits in 2013/14, these together with additional schemes as part of the 2013 /14 programme have been presented to and approved by the Board. Given the challenging commissioning

environment the Trust does not believe it is prudent to rely upon any element of income generation or new growth to contribute to the cost improvement target.

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

- Streamlining clinical pathways
- Productive People
- Strategic IT
- Departmental efficiency
- Estates Rationalisation
- Other including procurement

Appendix 2 contains broad details of the top 5 CIP schemes. Of those schemes, those that represent step changes in processes include:

Productive People - Review of Non Clinical Admin & Clerical Staff – The significant reduction in staffing numbers will be based upon the full use of available technology to increase efficiency.

Estates Rationalisation - Office Accommodation – The development of locality hubs for community clinical staff will significantly reduce estates costs. To ensure that this is not offset by increased travel costs and reduced efficiency, the Trust will deploy mobile working solutions that minimise the need for return to base trips.

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.

4.3 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 her 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 3 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 in the form of Visibility Walls, where staff attend and 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.

4.4 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; for instance Theatre Productivity includes areas such as improving knife to skin time – which ultimately will lead to fewer over runs and cancellations. Other schemes combine the two approaches; Recruitment Efficiency looks to reduce the time taken to fill posts thereby reducing the need for the use of locums that are both expensive and inherently more risky due to their unfamiliarity with our clinical pathways.

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.

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.

5.0 FINANCIAL & INVESTMENT STRATEGY

The Trust has a consistent history of delivering financial targets having delivered underlying surpluses for every year since authorisation. In 2012/13 a number of transformational schemes were commenced which incurred exceptional costs in that year but for which the benefits will only be realised in 2013/14. Taking account of exceptional costs the Trust reported a deficit of £2.6m, excluding exceptional costs the Trust would have reported a surplus of £534k.

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 has introduced difficulties in agreeing contracts for 2013/14.

Particular uncertainty has arisen around funding for control of infection which was defunded from former Primary Care Trust allocations and contracts and has been passed to Local Authorities. The full details of this transfer (approximate value £800k) were only established in late May 2013 and the lack of certainty has been one of the barriers to the agreement of contracts.

An additional uncertainty exists around the funding of the District Nursing Services to all three CCGs. A District Nursing review has been underway for a number of years (pre-dating the transfer of services to the Trust) and pressure has been building within the Trust with direct budgetary overspends in 2012/13 for over £700k. The full value of the shortfall based on fully absorbed costs is closer to £2m. The CCGs have given positive indications that additional funding will be forthcoming in 2013/14. Against this background the Trust have maintained service levels and therefore financial pressure at 2012/13 levels, assuming that funding will be forthcoming. However, it is assumed that final decisions will not be made within Quarter 1 of 2013/14.

During 2012/13 the Trust reported a Financial Risk Rating (FRR) of 2 at Quarter 3 which resulted in regulatory action by Monitor. Whilst the Trust returned to an FFR of 3 in Quarter 4 of 2012/13, the outcome of the Monitor review is a requirement for the Trust to commission an external review of its financial governance arrangements and to present its strategic planning assumptions to demonstrate clinical sustainability during Quarter 1 of 2013/14. Aligned to this work the Board intends to commission an external baseline financial review and development programme.

Given this uncertain background the Board considers that the prudent approach would be to assume within the plan delivery of an FRR of 2 in quarter 1 whilst striving and putting action plans in place to deliver an FRR of 3.

Our financial plans reflect national policy including the requirement for 4% efficiency and further reductions in income as a result of local commissioning decisions. No income generation schemes are included within the plan however,

the Trust will continue to respond positively to opportunities for business development and within its core services which emerge during the lifetime of the plan.

In keeping with the current economic climate and reflecting commissioners plans little is included within our plans for external investment in new services other than expansion in health visiting and continuing health care assessments. During 2013/14 St Benedict's Hospice will move from its current location to a new purpose built hospice in Ryhope, Sunderland. Commissioners have provided an additional £1m in 2013/14 to cover increased running costs and expansion of service. The ownership of the Hospice will transfer to the Trust in 2014/15 following completion of the defects liability period.

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 significant operational savings.

Delivery of savings required to achieve the Trust's plans will remain a significant challenge with targets of 6.1%, 5.6% and 5.3% required over the three years of the plan. Achieving these savings whilst controlling emerging cost pressures as the Trust continues to maintain the highest quality of services will undoubtedly represent a constant focus for the Board.

6.0 MEMBERSHIP COMMENTARY

In 2012/13 we grew the public constituency by 1.5% and are aiming for a similar increase in 2013/14. Similarly for the staff constituency we grew by 1.3% during the past year, with an intention to maintain that level this year. Details of the membership size and movement by constituency type, and analysis of current membership are provided in within the accompanying financial template. Election details for 2012/13 are also provided within that template. All elections to the council of governors are held in accordance with the election rules.

Implementation of our membership strategy

Our strategy aims to ensure that our membership reflects the local community and the local geography, socio-economic, racial and cultural diversity. In addition, it aims to continue to grow the membership and to see a year on year increase in membership.

Staff recruitment

Staff members are recruited automatically when joining the Trust on a substantive contract or after 12 months employment on a temporary contract. Information on membership is included within the staff handbook, given to new starters, and includes information on the option to opt out of membership, if desired. To date very few staff have opted out of membership.

Public recruitment

Our strategy for achieving our annual target has initially focused on those methods which have proved successful in the past. Although we are always keen to explore new ways in which we could increase our membership base. Members of the Council of Governors assist in membership recruitment by attending outpatient clinics, explaining the benefits of Foundation Trust membership and encouraging patients to complete membership application forms as well as raising awareness of membership in their communities. Benefits of membership have also been advertised in public areas of the Trust as well as on the website.

We aim to ensure all patients and public involvement activity is of a high quality, consistent and co-ordinated. We do this by working closely with our governors and our membership.

Recruitment initiatives to date have included:

- Offering special ‘Members Only” events and visits, including Medicine for Members presentations.
- Ongoing recruitment by Governors
- Offering tangible benefits to encourage residents to become members of the Foundation Trust, e.g. offering to members the same discount as staff in the Staff Restaurant and in local shops and premises
- Discounts for public members with a company called Health Service Discounts (www.nhsdiscounts.com.) You can register with them and receive

regular updates on the latest discounts on things such as holidays, electrical goods, entertainment, insurance, etc.

- 'Join Us' link added to landing page of website.
- Letters sent to former patients within Sunderland and Gateshead.
- Attendance at Older Peoples Festival, South Shields
- Attendance at Local Democracy Event, Jarrow
- Attendance at World COPD Day, Sunderland
- Attendance at Blaydon event organised by Gateshead LINk
- Targeted press coverage in all local newspapers promoting membership.

The gradual increase in our public membership base and the development of the role of the Governors has provided additional opportunities for more engagement with the people of Gateshead, South Tyneside and Sunderland. The Governors play a key role in the forward planning process and commented on our performance in relation to the Care Quality Commission standards against which we are measured.

Communication with Members

All new members receive a Membership pack and Membership card, which provides information on membership and governance arrangements. They will then receive regular Membership Newsletters throughout the year.

Membership recruitment remains a high priority for us and we are delighted at the enthusiasm and willingness of staff and members of the Council of Governors and Board of Directors to become actively involved in this important work.

We aim to continue to strive not only to increase our membership numbers but to make membership an interesting and worthwhile process for all concerned.

7.0 VIEWS OF GOVERNORS

The views of the Council of Governors on this strategic plan have been gained via a presentation and discussion session.