

Sheffield Teaching Hospitals

NHS Foundation Trust



Chief Executive: Sir Andrew Cash OBE Chairman: Tony Pedder

Strategic Plan for 2013-14

Sheffield Teaching Hospitals NHS Foundation Trust

Strategic Plan for year ending 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)	Tony Pedder
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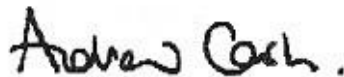
Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Sir Andrew Cash
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Signature



Approved on behalf of the Board of Directors by:

Name (Finance Director)	Neil Priestley
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Signature



FOR PUBLICATION:

Executive Summary

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- Commissioning intentions
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- Outline of existing quality concerns (CQC or other parties) and plans to address them
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NOT FOR PUBLICATION

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Executive Summary

The Strategic Plan 2013/14 sets out how the Trust Board will deliver high quality, cost effective and sustainable services to our patients. It analyses the internal and external challenges we face and our plans to address and manage those challenges over the next three years.

Strategic Context and Direction:

The Trust's vision and key objectives that were set out in our Corporate Strategy **Making a Difference** are outlined.

Since publishing our strategy, there have been a number of developments across the NHS and our strategy will provide the basis of how we respond to those. Principal among them is the publication of The Mid-Staffordshire NHS Foundation Trust Public Inquiry (the Francis Report) with its emphasis on a fundamental requirement to put patients at the centre of the NHS.

We will need to deliver this requirement in a healthcare system that continues to face the challenge of significant and enduring financial pressures and is made up of a range of new commissioners with whom we need to establish effective relationships. How commissioners will respond to these challenges is set out in an analysis of commissioning intentions.

Future demographic changes are also outlined together with recent activity changes, notably the significant rise in non elective admissions since October 2012.

Approach taken to Quality

This section details the Trust's formal approach to quality through its five year Quality Strategy. It covers how the Board derives assurance on the quality of its services and safeguards patient safety. Existing quality concerns and plans to address them are explained. These include:

- Accident and Emergency Waiting Times Improvement Work 2012/13
- Never Event Improvement Work 2012/13
- CQC Compliance
- Quality Surveillance Groups

- Mental Health Act (MHA) Improvement Work 2012/13
- Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital Mortality Indicator (SHMI)

Clinical Strategy

Existing clinical plans have been incorporated alongside the Trust's Quality Report Objectives and are set out in a table that shows recent performance and targets for the next

three years for 16 quality measures ranging from promoting a good experience for those with dementia to reviewing mortality and morbidity of patients at weekends.

Plans for our Service Line Management strategy, which links cost and income at individual patient level, are included in this section together with the future challenges for our clinical workforce.

Productivity and Efficiency

The Trust has run a formal Efficiency Programme for several years and it is estimated that almost £200m of savings have been achieved over the seven years to 2012/13. In this section, we explain that our aim is to drive efficiency savings in such a way that they deliver improvement, or at least no deterioration, to quality. Details around our specific Productivity and Efficiency workstreams and CIP programme are included together with an assessment of historic performance and governance of the programme, including the quality impact of CIPs.

Developing capability and capacity has always been a crucial element of the Trust's Efficiency Programme. The various ways we do this are set out including our use of the Clinical Microsystems Coaching Academy. Implementing the major IT Plan which will also have many positive impacts on efficiency.

Financial and Investment Strategy

The Trust achieved a £2.42m surplus from continuing operations in 2012/13 which was 0.27% of turnover. If technical non-cash items were to be excluded the surplus would have been marginally better than the £6.7m planned position. The Trust has now achieved a surplus in every one of the 12 years since it was created and the 9 years since it became a Foundation Trust.

This section includes an assessment of the Trust's current financial position; key financial priorities and a risk assessment to achieving the financial strategy.

Key priorities and investments for 2013/14 and beyond include achievement of activity, CQUIN and performance targets to ensure delivery of planned income within the context of major commissioner changes; delivery of efficiency savings requirements; facilitating workforce change; working with challenged Directorates; control and prioritisation of potential cost pressures with limited investment to support quality, governance and efficiency objectives; a Capital Programme which enables on-going improvement to the property, plant and equipment infrastructure whilst enabling service development where appropriate, particularly the IT Plan and to continue to improve the Trust's working capital position.

Research, education and innovation

We are committed to innovation in the delivery of care, demonstrated both in our support for research and in the rapid adoption and diffusion of the best, most transformative ideas, services and clinical practice. Our approach to innovations in care delivery, our research strategy, our role within the Academic Science Health Network and our education and training strategy plans are outlined in this section.

Sheffield Teaching Hospitals NHS Foundation Trust Strategic Plan for 2013-14

Strategic Context and Direction

Sheffield Teaching Hospitals' Board of Directors approved its five year strategy in March 2012.

Our vision is to be recognised as the best provider of health, clinical research and education in the UK and a strong contributor to the aspiration of Sheffield to be a vibrant and healthy city region.

Our mission is based on the NHS Constitution and is:

"We are here to improve health and well-being, to support people to keep mentally and physically well, to get better when they are ill and when they cannot fully recover, to stay as well as they can to the end of their lives. We aim to work at the limits of science - bringing the highest levels of human knowledge and skill to save lives and improve health. We touch lives at times of basic human need, when our care and compassion are what matter most."

The key aims for the organisation to deliver in the next five years are to:

- Deliver the best clinical outcomes
- Provide patient centred services
- Employ caring and cared for staff
- Spend public money wisely
- Deliver excellent research, education and innovation

Since publishing our strategy, there have been a number of developments across the NHS and our strategy will provide the basis of how we respond to these. Principal among them is the publication of The Mid-Staffordshire NHS Foundation Trust Public Inquiry (the Francis Report) with its emphasis on a fundamental requirement to put patients at the centre of the NHS. We will need to deliver this requirement in a healthcare system that continues to face the challenge of significant and enduring financial pressures and is made up of a range of new commissioners with whom we need to establish effective relationships.

Forecast health and demographic changes

The population of Sheffield has been steadily rising since 2003. Within the overall rise, there has been a decrease both in the number of children under 10 years old and in the 50 to 74 age group. There has been a 33% increase in the 20 to 29 age group, a large increase in the number of over 75 year olds and people with a disability or long term condition. Around 19.2% of the population is from black or minority ethnic groups. Sheffield's Joint Strategic Needs Assessment (JSNA) noted that substantial inequalities persist within Sheffield with large numbers of people still experiencing much lower levels of health and wellbeing than the city or national average. The JSNA also noted that the number of people who will need health care to maximise their health and independence will increase over the next decade

and beyond. It is recognised that people have increasing expectations of services, wanting greater quality, choice and control, whilst public sector funding growth will be much lower.

Commissioner intentions

Since 1 April 2013, the Trust has contracts with two major commissioners (NHS England and NHS Sheffield CCG); a consortium of CCGs in Yorkshire, Humberside and the East Midlands; and, for a range of public health services, Local Authorities principally Sheffield City Council.

- **NHS England**

NHS England (NHSE) published its commissioning intentions for prescribed specialised services in December 2012. Key themes are:

- An emphasis on improving quality and clinical outcomes
- A consistent, national approach – with a single national operating model and a national set of contract products
- Clinically-developed service specifications with a national time-limited derogation process
- National commissioning policies

A detailed impact assessment for all specialised services will be carried out in the first quarter of 2013/14 and derogation applied for, if necessary, to become the provider of choice for specialised services. An analysis is also being carried out of service developments within the commissioning policies to enable the Trust to continue to be at the forefront of new technologies.

For all services commissioned by NHSE, the emphasis in 2012/13 has been on a safe transfer of services into the new commissioning system. NHSE has published its planning process for 2013/14 and it is expected that their future commissioning intentions will become clearer in the autumn. The Trust's business planning round in the autumn of 2013/14 will focus on the implications of NHSE plans and will include the opportunities from the focus on specialised providers serving larger populations.

- **NHS Sheffield CCG**

NHS Sheffield Clinical Commissioning Group (CCG) is a clinically-led membership organisation that gives frontline professionals a strong leadership role in commissioning. It is the coordinating commissioner for a consortium of other CCGs in Yorkshire, Humberside and the East Midlands.

It published its five year Integrated Commissioning Plan in 2012. The plan has four priority aims:

- To improve patient experience and access to care
- To improve the quality and equality of healthcare in Sheffield
- To work with the City Council to continue to reduce health inequalities in Sheffield
- To ensure there is a sustainable, affordable healthcare system in Sheffield

The plan outlines the key changes in services to patients including providing care closer to their home in a primary/community care setting; greater self-care, including clinical and

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patient led remote monitoring; reducing outpatient follow ups through developing alternative models and developing clinical pathways with no hospital-based service provision; establishing Integrated Care Teams for patients with long term conditions to deliver supported self- management and community based care; streamlining the Urgent Care assessment process and reducing delayed transfers from hospital; and improving care for people with dementia in hospital with acute medical needs.

The QIPP schemes for 2013/14 focus on reducing referrals through referral management and reducing follow ups for elective care. For non-elective care, the Trust is an active partner in the community-wide Right First Time initiative and is keen to focus on improving the flow of emergency admissions to ensure that the peaks of activity that have caused such difficulty in the winter of 2012 are avoided in future. The Trust is also an active partner in the new Urgent Care Board, which will oversee health community wide efforts to improve A&E performance and the development of a robust Winter Plan for 2013/14.

The CCG is keen to consider transformational changes in the way that systems of healthcare are commissioned. This will mean moving away from the traditional primary care/secondary care split, to focus more on outcome measures and using new ways of contracting to deliver the change. The CCG is working with Sir Muir Gray and his team at Better Value Healthcare and has selected Musculo Skeletal Services, including Orthopaedics as an area for focus. We are keen to design and deliver integrated pathways that focus on improving clinical outcomes and will work with the CCG to develop outcome-based contracts within a Payment-by-Results system.

In line with our strategy, each Clinical Directorate has begun to identify potential business opportunities for expanding, developing and entering new markets. The Trust was successful in 2012/13 in securing a number of Any Qualified Provider contracts such as Direct Access Cardiology and Direct Access Flexible Sigmoidoscopy. During 2013/14 and 2014/15, a number of services currently provided by the Primary and Community Care Group are due to be tendered (MSK service, Weigh Ahead service, Primary Care Addiction Service Sheffield (PCASS) and the Community Intermediate Care Service (CICS)).

The Trust will appoint to a senior post within its Commercial Team in the summer of 2013, which will enable it to develop its commercial strategy including the detailed analysis of market share trends. This will include developing a plan to pursue the strategic aim of exploring the potential for the development of fee - paying services to private patients in some elective specialties. This income would then be reinvested in providing NHS services.

- **Sheffield City Council**

Sheffield City Council has not published commissioning intentions for the public health services it commissions from STHFT but has made clear its intentions for 2013/14 to reduce funding for these services by approximately 11%, including Dental Public Health, PCASS and GUM/Sexual Health. Negotiations are ongoing with the City Council.

Activity Analysis

Referrals were at or above target levels in 2012/13 and were at a similar level or higher than the previous year.

The major change in 2012/13 has been the growth in non elective activity which has been higher every month compared to 2011/12. In quarter 4, activity was 8.4% higher than the same quarter in the previous year. The increase in activity in the period October 12 – March

13 is the major factor to have impacted upon A&E performance. As a result, a detailed analysis of the change in emergency admissions since 2010 has been carried out to examine trends and variation. This showed a relatively stable picture until October 2012 when the numbers show a marked increase.

Approach taken to Quality

The heart of our strategy, Making a Difference, was the need for every member of staff to treat patients, the public and our colleagues with care and compassion.

The Trust has formalised its approach to quality through the production of a five year Quality Strategy which commenced in 2013. The strategy sets out high-level, strategic quality goals and outlined development activity for quality improvement and quality governance.

During this first year of the Strategy, we have established a Quality Board to oversee the implementation of the Quality Strategy that reports to the Healthcare Governance Committee of the Board of Directors. To align with the definition of quality adopted within the Trust's Quality Strategy, the agenda for the Healthcare Governance Committee has been restructured to the key areas of patient safety, patient experience and clinical effectiveness (outcomes). This approach ensures the Committee gives equal focus to each area of quality.

There is a wide range of quality improvement work underway at organisational, departmental and team levels. A consistent improvement methodology called the 'Clinical Microsystems' team coaching approach has recently been introduced. Building and sustaining capability and capacity for improvement is a key priority within the Trust's Quality Strategy.

A detailed 'true for us' analysis has been undertaken comparing the principles set out in the National Quality Board's report, ***Quality in the new Health System – Maintaining and Improving Quality from April 2013***. The initial review concentrated on those issues that related specifically to the Trust. Several limited areas for improvement were identified and these are currently being addressed. A second 'true for us' review will be undertaken now that the Francis Report has been published during the first half of 2013/14.

A short term Working Group has been established to look at the most effective way of engaging individuals, services and external partners in the development work required as a result of the Francis Report. Other partners will need to be involved in the development plans, such as, Healthwatch, Overview and Scrutiny Committee, etc, and this issue will be considered by the Working Group.

Our collective approach to quality improvement and governance, supported by a robust performance management framework, ensures that quality matters are monitored and, where deficits occur, timely and proportionate action is taken to address these. Under the direct lead of an Executive Director, a thorough root cause analysis and risk assessment is undertaken and a mitigating action plan developed and implemented. The Trust Executive Group and the Board of Directors monitor the implementation of the action plan (and any responsive changes to the plan) via regular progress reports by the nominated leads.

Outline of existing quality concerns (CQC or other parties) and plans to address them

- **Accident and Emergency Waiting Times Improvement Work 2012/13**

During 2012/13, the Trust faced significant challenges from September to March in ensuring that patients were seen, treated, admitted or discharged from the Accident and Emergency department within 4 hours. This was related to a number of factors including the pressures that have faced emergency care and unscheduled care nationally; an increase in attendances, acuity and admissions, particularly in people over 85; increases in delayed transfers of care; and the adverse weather and virus patterns which affected the local community for a protracted period of time. Whilst there have clearly been a number of organisations across the country experiencing these pressures, early analysis in conjunction with the University of Sheffield, indicates that the increased activity was even greater in Sheffield than that experienced elsewhere.

In addition to implementing the major transformation programme *Right First Time*, the Trust has focused on taking actions to mitigate the pressures and to ensure that the patients' experience of services was as positive as possible. Moving forward, we have developed a comprehensive action plan to address the flow of patients through the emergency and unscheduled care and admissions pathways with partners in the wider health and social care community. Action plans have been developed in five main areas:

- Maintaining flow and length of stay through existing pathways where performance is in the upper quartile
- Trust wide actions to improve, flow and length of stay through key pathways where performance can be improved
- Improving flow and length of stay in community services
- Improving flow and length of stay with Healthcare partners
- Organisational Structures and processes to optimise efficiency

Within each programme of work a number of specific actions will be taken to ensure that the Trust is able to deal with the projected demand for emergency and unscheduled care in 2013/ 14 and also to respond to the challenges which will result from the roll out of the Major Trauma Centre. From the 1 April 2013, STHFT became one of three designated Major Trauma Centres for adults in Yorkshire and the Humber. A major improvement scheme is underway within the A&E department to improve facilities and also to provide improved facilities in the trolley bay areas and the Clinical Decisions Unit. Once completed, the Department's capacity will be significantly improved which will also enable us to better manage peaks in activity.

- **Never Event Improvement Work 2012/13**

The Trust unfortunately experienced seven 'Never Events' during the year 2012/13. These included three retained objects, three medication incidents following the incorrect prescribing and administration of Methotrexate and a misplaced nasogastric tube. A full review of never events has taken place and we have been in close liaison with commissioners, Sheffield Clinical Commissioning Group. A comprehensive robust action plan has been agreed by the Trust Executive Group, and progress against this plan is monitored by the Healthcare Governance Committee on a monthly basis. Improvement work continues to ensure that the Trust has in place a robust framework to prevent a Never Event occurring.

- **CQC Compliance**

Over the past year the Trust has received two general CQC unannounced inspections, to the Royal Hallamshire Hospital and the Northern General Hospital. The wards and departments visited received positive feedback and no compliance concerns or action points were raised. By law, the Care Quality Commission (CQC) is required to monitor compliance with the requirements of the Mental Health Act 1983 (MHA) to provide a safeguard for individual

patients whose rights are restricted under the Act. Mental Health Act Commissioners do this on behalf of CQC, by talking to relatives, carers, staff, advocates and managers, and by reviewing records and documents. During March the Trust received a Mental Health Act Commission visit on behalf of CQC, to review our compliance with the MHA. We have some improvement work to undertake to ensure full compliance with the Code of Conduct; this includes finalising the MHA Policy, formalising arrangements with Sheffield Health and Social Care NHS Foundation Trust in relation to support for detained patients and ensuring all relevant staff are appropriately trained. A comprehensive action plan was approved by the Healthcare Governance Committee in March.

- **Quality Surveillance Groups**

Our local Quality Surveillance Group has to date held two meetings at which no concerns around care at the Trust have been raised. Though we are not currently invited to the meetings, we are keen to be as involved as possible, in the meantime we are confident that our lines of communication with the Group are robust and if any concerns are raised we are in a position to take action at the earliest possible time.

- **Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital Mortality Indicator (SHMI)**

Mortality rates in a hospital can be seen as a high level indicator of quality and are used in the Trust alongside other indicators of quality, such as, patient experiences, readmission rates, length of stay, adverse events and compliance with known good practice. The two main ways of measuring and understanding mortality ratios in the Trust are Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital Mortality Indicator (SHMI). A combination of internal and external reporting and monitoring systems enables appropriate oversight and scrutiny of the Trust's mortality information.

As part of its mortality management programme, the Trust incorporates data on crude hospital mortality into its local reporting and monitoring systems alongside HSMR and SHMI values in a quarterly Trust Mortality Report to the Healthcare Governance Committee. Along with the most current HSMR and SHMI values, this report provides: trend analyses; values for elective vs non-elective admissions; and, relative values for comparator trusts set against the "background" values for all acute trusts.

Diagnosis breakdown of both summary measures provides the detail to appropriately target any further analysis which leads to a better understanding of the data, our coding and ultimately the quality of care. This is further facilitated by access to a suite of Dr Foster tools that enables further scrutiny of the data.

The mortality management programme also includes a robust process for the formal monitoring and reporting of "mortality alerts" from Dr Foster tools via the bimonthly meetings of the Trust Clinical Effectiveness Committee. This has provided a mechanism whereby directorates can scrutinise mortality outcomes that differ significantly from the national norm and then report findings to a central committee.

Key quality risks inherent in the plan and how these will be managed

The future risks included in the Annual Governance Statement are:

- Failure to maintain financial balance in future years from 2013/14 onwards
- Failure to meet the A&E 4-hour Waiting Time target
- Care of patients in an inappropriate setting

- Infection Prevention and Control
- Managing the implementation of the Health and Social Care Act 2012 as it affects the Foundation Trust and the wider health economy.

How the Board derives assurance on the quality of its services and safeguards patient safety.

The Board of Directors gains an understanding of the key risks to quality and patient safety and receives assurance from a wide range of internal and external sources, notably the Performance Management Framework report; the Assurance Framework and Top Risk Report; Internal and External Audit reports, delivered against a risk-based annual plan; standard and ad hoc reports from Trust committees; national survey results; inspection reports from CQC and other regulators; and, external agency visits, inspections and accreditations.

The Board of Directors is supported by a number of formal committees including the Audit Committee, the Healthcare Governance Committee and the Finance and Performance Committee. The committees of the Board are each chaired by a non-executive director.

The Healthcare Governance Committee has the lead responsibility for quality and patient safety. It works to a Board-approved annual plan to ensure the systematic monitoring and review of complaints, patient and staff incidents, inquests, mortality and infection control statistics, local and national clinical audits, patient experience feedback and ongoing compliance with CQC essential standards. Quality and patient safety priorities are reviewed and agreed via the Trust's Quality Report process which ensures input from clinical staff and key partner stakeholders including patient representatives. These priorities are approved by the Board of Directors.

As part of the Quality Strategy implementation, the way in which quality matters are reported to the board has been reviewed. The Healthcare Governance Committee work plan has been refined to ensure appropriate time for debate and discussions regarding improvement plans. The draft local Quality Healthcheck is currently under review by the Trust Executive Group. The Healthcheck aligns to the NHS Outcomes Framework and also provides the Trust with a locally contextualised approach to the national indicators.

Serious Untoward Incidents (SUI) are reported to, and investigations and action plans overseen by, the SUI Group which meets weekly. Membership includes the Medical Director, the Chief Nurse / Chief Operating Officer and the Trust Secretary. All SUIs are reported to the Healthcare Governance Committee and the Board of Directors, and during 2013/14 this reporting mechanism will be reviewed to ensure better contextual detail is provided.

In order to provide assurance in relation to patient experience a number of methods of collecting feedback from patients and families are used. These include comments cards, real-time patient surveys, website feedback, complaints and the new Friends and Family Test. Patient feedback is regularly reported through monthly complaints reports, quarterly Trust, Group, Directorate and Ward-level Patient Experience Reports and detailed ad hoc reports - for example, a review of feedback in relation to staff attitudes and communications. Actions to improve services as a result of feedback are also reported and a new, comprehensive patient experience action planning process was introduced 12 months ago to ensure service improvements following patient feedback.

Clinical Strategy

The Trust's overall clinical strategy over the next three years

Existing clinical plans have been incorporated alongside the Trust's Quality Report Objectives, agreed in collaboration with the Trust key partners.

Quality issues and measures	Contribution to the strategy	Key actions and delivery risk	Performance in 2012/13	3 year targets / measures for 2014/15 and 2015/16
1 To keep our patients safe from infections such as C.difficile, MRSA, MSSA & E.Coli Bacteraemia.	Deliver the best clinical outcomes	C difficile action plan implementation monitored by Healthcare Governance Committee. Infection Control Programme. <u>Risk</u> – non-compliance with Infection Control Programme	104 Trust attributable cases of C.difficile.	C.Difficile <ul style="list-style-type: none"> 2013/14- as per DH trajectory (77 Trust attributable cases or less) 2014/15, 2015/16 - as per DH trajectory
			3 Trust attributable case of MRSA Bacteraemia	MRSA <ul style="list-style-type: none"> 2013/14, 14/15, 15/16 - Zero Trust attributable cases
			74 MSSA Bacteraemia 202 E.Coli Bacteraemia	MSSA & E. Coli-continue to monitor incidence during 2013/14
2 To keep patients informed about how long they will wait in outpatient departments.	Provide patient centred services Quality Goal: Improve patient experience	Develop a local outpatient frequent feedback survey to provide better and more targeted patient experience data. <u>Risk</u> – failure to act on tangible survey outcomes that require review	Data from local outpatient frequent feedback survey will be available towards the end of 2013. To reduce or eliminate waiting, this work is now being supplemented with Service Improvement work.	2013/14 – Ensure the issues highlighted from the surveys in 2012/13 are addressed through tangible actions.
3 Safety – Achieve NHSLA Level 3.	Deliver the best clinical outcomes	Implementation of project plan and monitoring of policy compliance organisation wide. Evidence quality assurance and validation exercise. <u>Risk</u> – non compliance with standards	Maintained Level 1 compliance and continued to develop systems and processes across the organisation to enable monitoring of compliance with the 50 criteria.	2013/14 Retain Level 1 and audit for L2 compliance.
	Provide patient centred services Employ caring and cared for staff		Due to strategic changes within NHSLA all future assessments are on hold, therefore the Trust remained at Level 1	2014/15, 2015/16 Continue to audit compliance for L2 assessment and assess potential for achievement of level 3. Situation and objective will be reassessed following any national changes

				to the NHSLA risk management scheme.
4	Safety - Safer Surgery – reduce avoidable incidents in the perioperative pathway.	Deliver the best clinical outcomes. Quality Goal: Improve patient experience and reduce harm events.	Continue to Audit and test the 'culture' of the check. <u>Risk</u> of non-delivery – failure to effectively implement WHO safer surgery checklist and maintain improvements	2013/14 - Continue to ensure checklist is fully adopted in all theatres and review the potential for peer benchmarking with NHS Quest members.
				2014/15 – 2015/16 Incorporate compliance monitoring into Quality Improvement reporting and maintain compliance.
5	Safety - Reduction in Inpatient Falls.	Deliver the best clinical outcomes. Quality Goal: Improve patient experience and reduce harm events.	Introduce measures and roll out interventions. Link work to national service improvement initiative (FallSafe) <u>Risk</u> of non-delivery – failure to effectively implement care bundles and limited impact of interventions.	2013/14 Roll out new Falls Risk Assessment and Falls Prevention Care Record documentation in line with new NICE guidance (June 2013). Secure funding and implement FallSafe care bundle on GSM wards
				2014/15 Achieve over 90% compliance with FallSafe care bundle on GSM wards. Implement FallSafe care bundle across STH and incorporate compliance monitoring into Quality Improvement reporting.
6	Safety - Reduction in Ventilator Acquired Pneumonia (VAP) rates.	Deliver the best clinical outcomes. Quality Goal: Improve patient experience and reduce harm events.	Introduce measures and roll out interventions. <u>Risk</u> of non-delivery – failure to effectively implement care bundles and limited impact of interventions.	2013/14 Extend interventions to include increased numbers of patients ventilated in theatre. Reduce VAP rates in long term ventilated patients (>7 days). Improve the quality of sputum sampling in ventilated patients. Continue to monitor and maintain low VAP rates.

				<p>2014/15, 2015/16</p> <p>Continue to monitor and maintain low VAP rates.</p> <p>Assess potential for further reductions in VAP rates.</p>
<p>7 Safety - Improved care for deteriorating patients.</p>	<p>Deliver the best clinical outcomes.</p> <p>Quality Goal: Improve patient experience and reduce harm events.</p>	<p>Introduce measures and roll out interventions.</p> <p>Develop actions plans to resolve newly identified barriers.</p> <p>Risk of non-delivery – failure to effectively implement care bundles.</p>	<p>Work stream and interventions established.</p> <p>Developed and implemented care pathways.</p> <p>Measures show improvements in the Early warning score process on wards implementing the care pathways</p> <p>25 wards involved in the Deteriorating Patient programme.</p> <p>Hospital @ Night (H@N) introduced throughout STH</p>	<p>2013/14 Introduce measures and roll out interventions. Achieve 90% compliance with pathway on work stream wards and/or develop actions plans to resolve newly identified barriers.</p> <p>Roll out interventions across the organisation and highlight further developments for improvement.</p> <p>Establish routine compliance monitoring processes</p> <p>Establish a process for the ongoing education and promotion of the deteriorating patient pathway to junior medical staff. Promote the documentation of 2222 call response.</p>
				<p>2014/15 Reduce Cardiac arrest calls by 20%</p> <p>Link in with electronic systems H@N type system for the weekend</p>
				<p>2015/16 Assess potential for further reduction in cardiac arrest calls.</p>
<p>8 Venous Thrombo-Embolism</p>	<p>Deliver the best clinical outcomes.</p> <p>Achieving excellence in all clinical services through implementation & measurement of evidence based practice.</p>	<p>Completion of VTE risk assessment form for every patient admitted to STH.</p>	<p>At least 90% of all inpatients have been risk assessed for VTE since February 2011</p>	<p>Improve completion of risk assessment, to at least 95% for all inpatients</p>
		<p>Surveillance of returns and feedback to Directorates on performance.</p>	<p>To achieve the local CQUIN target on VTE prevention, 90% of patients in four high risk specialties had to be risk assessed and receive appropriate preventative treatment</p> <p>This was achieved in</p>	<p>In four high risk specialties, to achieve at least 90% of patients who have been identified as requiring treatment to prevent thromboembolism and receive preventative</p>

	Supports Trust objectives to audit NICE guidance throughout STHFT and to 'be patient focused'.		Q4 at 91.74%	treatment during 2013/14
		Root cause analysis of cases of VTE which are thought to be hospital associated. <u>Risk to initiative - failure to complete risk assessment by admitting clinician.</u>		
9 Optimising length of stay	Provide patient-centred services. Quality Goal: Reducing length of stay	Provide service level data to directorates.	Work continued to achieve a clinically appropriate length of stay when compared to national and local benchmarks.	2013/14 to implement the key actions and aim to reduce average spell length of stay.
		Identify areas for improvement	The main focus was on non-elective activity, and particularly the medical specialties of Geriatric & Stroke Medicine and Respiratory Medicine. It included improvements to patient discharge into community and social care services as agreed and supported through the Right First Time Programme.	During 2013/14 there will be an organisation-wide programme on Patient Flow. The project has been scoped and the governance arrangements will be finalised by mid April.
		Review lessons learnt from Geriatric & Stroke Medicine improvement work.	Opportunities in elective services are less pronounced, but work continues to increase day case rates, improve processes and build on the enhanced recovery programme. The Surgical Pathways work stream is focusing on Foot & Ankle; Gynaecology; Colorectal; Arthroplasty; Ophthalmology; Renal; Neurosurgery & Cardiology Catheter Labs	2014/15 – 2015/16 Ensure the lessons learnt in 2012/13 are addressed through tangible actions & continue with improvement workstreams.
		Implement speciality specific projects such as enhanced recovery in surgery. Align work to 'Right First Time' improvement initiatives.	Planning is currently underway to identify the priority activities for 2013/14 to support improved patient flow, including a Trust-wide review of emergency flow.	

10 Improving immediate discharge notes for GPs	<p>Provide patient-centred services.</p> <p>Quality Goal: Improves patient experience and reduces harm events.</p>	<p>Formally audit the proportion of discharge notes sent to GPs.</p> <p>Where necessary, draw up improvement plans.</p> <p><u>Risk</u>: Poor compliance at local level</p>	<p>Process undertaken as per requirements: Baseline audit – Q1; Action planning - Q2; Re-audit – Q3; Re-audit – Q4 A final Q4 audit was undertaken of 495 (35%) immediate discharge letters. There was improvement in one area of concern but the improvement found in Q3 on the other three areas of concern was not sustained.</p>	<p>The Trust is currently rolling out e-discharge summaries which will allow clinicians to fill in an electronic discharge template, helping to speed up the delivery and improve the discharge information sent to GPs.</p> <p>It is expected that all inpatient areas will be live by the end of summer 2013. This improvement objective will be progressed through the e-discharge project in order to address the areas for improvement.</p>
11 Making it easier to communicate with the organisation	<p>Provide patient-centred services.</p> <p>Deliver excellent research, education and innovation.</p> <p>Quality Goal: Improves patient experience</p>	<p>Provide a variety of methods to capture patient feedback. Provide directorates with local experience data. Identify trends and themes.</p> <p>Implement service improvements based on outcomes.</p>	<p>All targets achieved: <u>Frequent Feedback Surveys</u> Target: 2976 Achieved: 4824 Increase of: 94%</p>	<p>2013/14: Ensure the issues highlighted from the feedback received in 2012/13 are addressed through tangible actions.</p>
			<p><u>Comments Cards</u> Target: 863 Achieved: 2857 Increase of: 397%</p>	<p>All comments and feedback received are reported to directorates in the quarterly Patient Experience Reports, these comments are considered alongside all other patient feedback in agreeing local action plans.</p>
12 Review Mortality and morbidity for weekend patients	<p>Deliver the best clinical outcomes.</p> <p>Quality Goal: Harm free care, improves patient experience</p>	<p>Implement linked projects:</p> <ul style="list-style-type: none"> • 24/7/365 services • Review systems for measuring harm linked to the safety Thermometer work. • Reducing harm including improved management of the deteriorating patient • Promoting excellence in End of Life Care <p><u>Risk</u>: Improvement work may not impact on mortality ratios.</p>	<p>Overall the Mortality ratio for the Trust remains low. HSMR – 98 (2012/13) 'Significantly lower than the national benchmark'</p> <p>SHMI – 0.92 (July 2011 to June 2012) 'Lower than expected' (Dr Foster) and 'As expected' (Information Centre).</p> <p>Within weekend mortality, there is variation depending on day of admission. This variation is</p>	<p>2013/14 – Continue to Implement individual projects aligned to NHS Quest network and Dr Foster Global Comparators approach.</p> <p>This will include a standardised framework for the management of Mortality and Morbidity meetings.</p>

			<p>anticipated and does not result in a mortality rate which is rated as 'higher than expected'. Dr Foster analysis identified that the Trust was not rated as an outlier when looking for significant variation between week-day and weekend admissions.</p> <p>The Trust is working with the Global Comparators Stroke group of the Dr Foster GOAL project with one of the work streams looking at weekend mortality.</p>	
13 Promoting a good experience for those with dementia	<p>Provide patient-centred services.</p> <p>Quality Goal: Harm free care, improves patient experience</p>	<p>Align work carried out by estates with good practice identified in the Kings Fund Dementia environmental audit.</p> <p>Develop model ward (B7)</p> <p>Promote attendance on the Dementia Care training course.</p> <p>Continue roll out of dementia care pathway.</p>	<p>In 2012, the Trust has created a ward environment to meet the needs of our specialist Dementia Ward.</p> <p>Following an environmental audit and talking to patients, visitors and staff, changes were planned to the ward in line with best practice guidance from both the Kings Fund and Stirling University. A significant refurbishment was then undertaken.</p>	<p>Having successfully completed this work, the Trust is currently in the planning stage for two further refurbishments involving the Assessment Units at the Northern General Campus.</p> <p>This workstream will continue to be progressed through the Trust's internal processes. This work will be led by the Dementia Care Steering Group and align to the national Dementia Care initiatives.</p>
14 Understand why operations are cancelled.	<p>Provide patient-centred services.</p> <p>Improve Patient Experience</p>	<p>To put in place a process to systematically review a representative sample of cancelled operations to ensure the Trust fully understands the reasons for cancellations.</p> <p>To use a root cause analysis methodology to review the sample cases and provide a rich data source for analysis.</p> <p>To undertake a trend analysis on the data obtained in order to</p>	<p>Operations cancelled on the day of surgery for non-clinical reasons</p> <p>2010/11 – 768</p> <p>2011/12 – 1106</p> <p>2012/13 - 1161</p>	<p>2013/14: Undertake review of representative sample of cancelled operations to inform improvement activity.</p> <p>2014/15: Ensure the issues highlighted from the analysis undertaken are addressed through tangible actions</p>

		<p>inform further improvement work in this area.</p> <p><u>Risk:</u> Limited analysis of cancellations resulting in variable outcome data. Multifactorial causation, leading to difficulty in implementing remedial actions quickly.</p>		
<p>15 To reduce the prevalence of all (*) Grade 2, 3 & 4 pressure ulcers city wide.</p> <p>*All pressure ulcers include those patients who have pressure ulcers when they first receive care from STH and those who acquire pressure ulcers under the care of STH.</p>	<p>Deliver the best clinical outcomes.</p> <p>Patient Safety</p>	<p>The aim is to reduce the 'all' Pressure Ulcer Rate from 5.95% to 5%</p> <p>The target has been calculated on the basis of achieving the equivalent of a 50% reduction in the proportion of patients with ulcers acquired whilst receiving STHFT care, but expressed as a reduction in the overall proportion (that is, both those acquired in STHFT services and those acquired in the community). On this basis, the target proportion for quarter 4 2013/14 is 5.0%.</p>	<p>Monthly survey data for the period from October 2012 to March 2013</p> <ul style="list-style-type: none"> • Proportion with pressure sores acquired whilst in STHFT beds - 1.77% • Proportion with community-acquired pressure sores - 4.18% • Overall proportion - 5.95% 	<p>2013/14: Reduction in the prevalence of Grade 2, 3 and 4 pressure ulcers reported within STHFT acute and community based services, including both ulcers acquired whilst receiving STHFT care and community-acquired pressure ulcers</p>
<p>16 Discharge information for patients</p>	<p>Provide patient-centred services.</p> <p>Clinical Effectiveness (Outcomes)</p>	<p>To improve the provision of discharge information for patients by auditing the information provided and available for patients against Trust wide standards.</p> <p>Deficiencies identified during this process will be addressed by improvement activities at Directorate and Trust level.</p>	<p>The quality of discharge information available for patients is variable, and has been a cause for complaint. Whilst local improvement work has taken place this audit work aims to ensure a Trust wide consistent standard for discharge information.</p>	<p>2013/14: Ensure the issues highlighted from the audit undertaken are addressed through tangible actions at Directorate and Trust level.</p>

Service Line Management Strategy:

The Trust has been applying the initiative of Service Line Reporting (SLR) since 2007/08. We have invested in the Synergy Costing System which produces cost and income at the individual patient level for each unit of activity. This means we can report a comparison of income and expenditure for each prescribed “service line”. The Trust strategy target remains for all specialties move towards SLR balance or better.

In future years, as NHS resources become even more constrained, the key to SLR balance will be achieving cost base savings. A critical building block for this is instilling ‘cost consciousness’ across the organisation and encouraging all staff to fully appreciate the cost of the resources they use.

Over the next three years, there is an emphasis to consolidate work undertaken in the last two years and build upon areas not fully completed including:

- Incorporate Community Services into SLR.
- Mapping of admitted activity to sub-specialties.
- Cost Per Case/Block Income/Other Income
- General Critical Care & Cardiac Critical Care
- High Cost Consumables (Drugs)
- Pathology and Radiology

Clinical Workforce Strategy

Although challenged by intermittent recruitment difficulties, the Trust has not historically been exposed to significant medical staffing problems other than in Emergency Medicine which is facing a national shortage of medical staff. This stability has enabled us to conclude our reconfiguration programme, integrate our community service, deliver an out of hours (Hospital at Night) service and develop a Major Trauma Centre.

This now allows us to look forward to where the future challenges lie. These include:

- Ongoing financial challenges which create uncertainty for staff, particularly about pension planning and expected age of retirement.
- Continued reconfiguring and reduction of training numbers in medical staffing as a result of the publication of ‘specialty recruitment planning guidance’. The Deanery is looking to reconfigure and reduce training numbers, particularly in surgical specialties, anaesthesia and initially a small number in medical specialties. The funding associated with these posts will be withdrawn accordingly.
- NHS reform including Foundation Trusts becoming integrated providers of healthcare; the move to seven day working signalled in NHS England’s Everyone Counts: Planning for Patients 2013/14; increased patient choice and competition between providers as result of the “Any Qualified Provider” initiative; and commissioning decisions leading to significant change in service delivery.

The Trust clearly understands that it must respond to a varying demand; it is a mature organisation that largely recruits and retains well but we must consider making changes to our workforce profile with increased specialty doctor, nurse specialists and/or allied health professionals.

The reduction in training grade numbers will need to be closely managed. The challenges will be the delivery of a 24/7 service across all specialties whilst maintaining the delivery of junior doctor training programmes. Alternative ways of working to deliver clinically safe services by

non-medical professionals are already being explored together with the development of a Trust Doctor surgical rotation. These reductions have the potential to impact on most directorates although initially it will have the biggest impact on surgical and anaesthetic services; there will be reductions from August 2013 and further reductions for August 2014. As a result, we have set up a project group led by the Medical Director to review the impact of the changes across all directorates; to develop innovative solutions to maintain clinically safe services and to ensure educationally-sound training programmes for junior doctors.

Productivity and Efficiency

The Trust has run a formal Efficiency Programme for several years and it is estimated that almost £200m of savings have been achieved over the seven years to 2012/13. The Trust, therefore, has demonstrated very effective processes for delivering efficiency savings. The explicit aim has always been to drive efficiency savings in such a way that they deliver improvement, or at least no deterioration, to quality. There is a clear ethos that quality, finance and performance targets all have to be achieved, is everyone's business and are generally complementary objectives.

However, it is clear that the position is becoming ever more challenging from the cumulative requirement and given the pressures from quality requirements; national pay terms and conditions; and commissioner financial constraints. It is, therefore, necessary to be realistic in financial planning about the extent of sustainable efficiency savings that are deliverable each year.

CIP Governance

Arrangements for planning for 2013/14 have built on previous arrangements. The Trust drives the efficiency planning in a matrix with:

- A Corporate Efficiency Programme which identifies opportunities and drives specific workstreams under the four headings of: Clinical; Workforce; Corporate; and, Commercial & IT. Each area is led by an Executive Director and is supported by and reports to a Chief Executive led PMO function. The Trust has a Service Improvement Director who leads the PMO and Service Improvement functions. External consultants, project management and other resources are provided as necessary.
- Directorate Efficiency Plans are a key element of Directorate Financial Plans. Efficiency Targets are set each year and the relevant budget is withdrawn to drive delivery. Directorates are required to start planning several months before the start of the financial year and provide draft plans for central scrutiny. Directorates draw on and are driven by the relevant central Efficiency Programme workstreams. Directorates are supported with external consultants and other resources where necessary to help drive the identification of opportunities and their delivery.

Governance arrangements can be summarised as follows:

- The Chief Executive is accountable to the Board for overall delivery and achievement of financial and efficiency targets.
- The four Sub-Programmes of the Efficiency Programme are each led by an Executive Director.

- An Executive Director leads the Trust's Performance Management Framework (PMF) process which drives Clinical Directorate operational and financial performance.
- The Efficiency Programme PMO is responsible for supporting workstreams, by ensuring that they are set up to succeed, and then monitors progress against plans, KPIs and financial targets. The function is led by the Service Improvement Director but is personally overseen by the Chief Executive.
- Directorates are accountable for developing and delivering their efficiency plans to meet the targets set and to ensure budget balance.
- Directorate Plans are developed in conjunction with key managers and clinicians and approved by the Directorate Management Team which for Clinical Directorates will include the Clinical Director, Nurse Director, General Manager and Group Finance Manager.

The Trust-wide 2013/14 Efficiency Plan was approved by the Board of Directors at its April 2013 meeting and Directorate Plans are approved as part of the PMF.

Monthly reports are produced on Directorate performance against plans and by the PMO on the Trust-wide Programme workstreams. This information is considered monthly by the Trust Executive Group and the Finance and Performance Committee. Quarterly Reports are considered by the full Board of Directors.

Monitoring information at Directorate level is largely financial and evidenced by Directorate budget positions. PMO reports will also reflect KPIs and progress against project plans.

The Director of Finance has the role of ensuring that Efficiency Plan workstreams and Directorate plans are adequate and consistent, and that interfaces are effective.

The Medical Director and Chief Nurse/Chief Operating Officer provide a central quality oversight function and the Clinical Director/Nurse Director provide a similar function at Clinical Directorate level. The clear and stated aim of the Efficiency Programme remains to drive efficiency savings in the right way with quality of services maintained or improved.

CIP Profile

The Trust has 4 elements to its Efficiency Programme as shown, with the key workstreams, below:

- Clinical – Length of stay reductions, improvement to surgical pathways/theatre efficiency, improved outpatient department efficiency, medical manpower utilisation, medicines management savings, improved usage of medical and surgical consumables and improvements to clinical support services and functions.
- Workforce – Workforce cost reductions and initiatives, improved staff management/HR processes, reduced sickness absence, E Rostering and various cross cutting schemes to facilitate improved administrative processes, e.g. contact centre technology.
- Corporate – Procurement savings, estate rationalisation, energy usage, CNST premiums, “back office function” efficiencies and VAT savings.
- Commercial & IT – IT enabling schemes, clinical service expansions, commercial income opportunities, coding improvements, exploiting opportunities around hospital and community service pathways and improved efficiency of MDTs.

The major programmes remain the Clinical and Workforce areas given the nature of the organisation and the high proportion of staff costs. Length of stay reductions and enhancing patient flow through the hospitals is crucial to most aspects of Trust performance including efficiency. The IT enabling projects are also vital. The length of stay/patient flow project also interfaces with the health and social care community's Right First Time Programme, which aims to improve Sheffield's urgent care system

CIP Enablers

Developing capability and capacity has always been a critical element of the Trust's Efficiency Programme. There are a number of aspects to this as follows:

- Corporate leadership, prioritisation and governance around the Efficiency Programme.
- Clinical engagement corporately within the Board/Executive Group, within the Clinical Programme (led by the Medical Director) and within the Service Improvement Team (including a 5 PA clinical lead).
- Clinical engagement within Directorates through the Clinical Director, Nurse Director and Clinical Leads for key services.
- Significant investment in the Service Improvement Team (incorporating the PMO), project management, external consultancy, additional management capacity and investments to facilitate change.
- A Microsystems Coaching Academy which is developing the principles of Microsystems and a cadre of coaches to help drive "bottom-up" continuous improvement.
- On-going communication with staff of all disciplines to ensure that they understand the need for efficiency savings, the principle opportunities and their ability to contribute.
- Working with the Sheffield health and social care system on the Right First Time Programme to improve patient flow through the hospitals.
- Implementing a major IT Plan which will have many positive aspects for efficiency.

Quality Impact of Productivity and Efficiency Plans

It is important that the issues relating to the requirement to deliver efficiency savings are not seen in isolation from the rest of the Trust's business. We have a major and on-going focus on the quality of services supported by a considerable infrastructure and robust governance arrangements. NHS Sheffield CCG is aware of the structures in place and is involved in a number of areas.

The Trust explicitly assesses the quality impact of its Productivity and Efficiency Plans through its governance arrangements. In particular, it ensures that clinical staff are involved with the Efficiency Programme throughout the Trust and there is a clear ethos that quality, finance and performance targets all have to be achieved, are everyone's business and are generally complementary objectives.

This is underpinned by a clear and unambiguous statement from the Chief Executive that the views of the Medical Director and Chief Nurse have primacy such that any concerns over quality implications have to be addressed before an efficiency scheme progresses.

In addition, this year we shared with our commissioners the details of our approach and the key schemes being pursued. They were assured by the process and the safeguards in place to ensure quality for patients is maintained.

Financial and Investment Strategy

Current Financial Position

The Trust achieved a £2.42m surplus from continuing operations in 2012/13 which was 0.27% of turnover. If technical non-cash items were to be excluded the surplus would have been marginally better than the £6.7m planned position. The Trust has now achieved a surplus in every one of the 12 years since it was created and the 9 years since it became a Foundation Trust.

The Trust had net current assets of £14.2m at 31st March 2013, although a sum broadly equivalent to this has been committed to the 2013/14 Capital Programme. Cash balances were £71.1m. The working capital position has been gradually improved since the Trust became a Foundation Trust. The Trust has outstanding borrowings of £54.0m at 31st March 2013 which are significant, but eminently manageable, for such a large organisation.

The Trust's 2013/14 Financial Plan again assumes a £6.7m surplus, although it is recognised that this will be a challenge to achieve given the risks below. The Trust's 2013/14 capital expenditure plans are affordable from internally generated resources without reliance on the 2013/14 planned surplus which, if achieved, will be applied to the capital programmes in subsequent years.

Financial Priorities and Investments

The Trust's financial strategy can be summarised as follows:-

- To plan to achieve a surplus each year and in doing so generate resources equivalent to around 1% of turnover to enhance capital investment and to gradually improve the Trust's working capital position.
- To drive and invest in the Trust's Efficiency Programme in order to deliver sufficient efficiency savings each year to meet the national efficiency target and cover education and training income losses; to maintain a planned surplus; and to enable investment to improve services, whilst delivering savings in the right way to maintain and improve the quality of services.
- To continue to refine Service Line Reporting and Patient Level Costing and to use the information to drive improved financial and operational performance at specialty level.
- To not rely on significant growth in patient service income in the current financial climate but to work hard to maintain overall income levels, including maximising CQUIN funding, whilst managing the consequences of changes to some income lines.
- To maintain and develop high standards of financial governance, financial/business planning and decision making.
- To ensure adequate levels of capital investment each year from internally generated resources in order to maintain the asset base and provide some level of development, with use of loans and other external finance only for key strategic developments with a strong business case.
- To continue to develop the financial management skills of clinicians and managers to ensure full engagement in the management of the financial challenges ahead.

- To consider all financial risks, both short-term and more long-term, and ensure that they are carefully monitored and managed.
- To seek new income streams where they will deliver a significant margin and are complimentary to the Trust's strategy, services and ethos.
- To continue to press, with other similar organisations, for improvements to NHS tariffs to properly reflect the complex work undertaken at Teaching/Tertiary Centres and for NHS business rules/contract terms to be fair to providers.

Key priorities and investments for 2013/14 and beyond are:-

- Achievement of activity, CQUIN and performance targets to ensure delivery of planned income within the context of major commissioner changes.
- Delivery of efficiency savings requirements.
- Facilitating workforce change.
- Working with challenged Directorates through the Performance Management Framework to ensure improved financial performance.
- Control and prioritisation of potential cost pressures with limited investment to support quality, governance and efficiency objectives.
- A Capital Programme which enables on-going improvement to the property, plant and equipment infrastructure whilst enabling service development where appropriate, particularly with regard to a major IT Plan over the next 5 years.
- To continue to improve the Trust's working capital position by reducing stock levels, recovering debts quicker and by identifying other financing opportunities to create working capital flexibility.

Financial Risks

The principal financial risks which the Trust faces in 2013/14 and beyond are as follows:-

- Delivering the necessary efficiency savings each year. The mitigation of this risk comes via the Efficiency Programme arrangements which are described above and from good operational management.
- National contract terms, commissioning policies and PbR Business Rules which result in further lost income which can not be offset by further efficiency savings. Mitigation of this risk comes from strong contract management and from being part of strong national frameworks which it is hoped can influence national policy.
- Additional service, quality and regulatory requirements which create additional costs for which there is no funding. Mitigation of this risk is through strong business planning and good operational management.
- Inability to deliver CQUIN targets such that baseline income is lost. This risk is mitigated by strong leadership, engagement of clinicians and managers, identification of additional resource requirements, careful agreement of targets and close performance management.
- Inability to generate affordable capital and revenue funding to facilitate the necessary capital investment. This risk is mitigated by good planning and prioritisation, good management of capital schemes and generation of surpluses each year.

Research, education and innovation

Innovations in care delivery

We are committed to innovation in the delivery of care, demonstrated both in our support for research and in the rapid adoption and diffusion of the best, most transformative ideas, services and clinical practice. Our strategy set out our intention to conduct a detailed analysis of the potential for additional clinical research and innovation activity and selecting those areas where the Trust has or could develop a comparative advantage.

Recent examples include:

1. Approval of STHFT as a Major Trauma Centre from April 2013
2. Integrating acute and community services – for example, the integration of Sexual Health services, bringing together Genito-Urinary Medicine and community-based contraception services and sexual health promotion, now commissioned by Local Authorities
3. The development of a business case for the acquisition of a surgical robot for minimally invasive surgery. The most advanced robotic technology available today enables surgeons to perform delicate and complex operations through small incisions with increased vision, precision, dexterity and control.
4. Using technology to reduce the number of outpatient follow up appointments– for example, the piloting of a Chronic Kidney Disease remote management programme and increasing the number of non face to face outpatient consultations
5. Facilitating the increased participation of patients in their own care, for example in the development of ‘shared-care’ in haemodialysis which enables patients to carry out the full range of tasks in the haemodialysis process.

Research Strategy

With annual research income of over £15m, the Trust is one of the largest healthcare research institutions in the UK. Together with the University of Sheffield and Sheffield Hallam University, we have formed a partnership to promote, host, facilitate and implement the findings of clinical and healthcare research in Sheffield. The research focus ranges from basic science through to clinical research and clinical application. Research is carried out in a modern, purpose built research environment.

Although we perform well against national targets, there is room for improvement particularly in the type and number of studies and the breadth of research portfolio. A more coordinated approach to deliver integrated innovation, research, adoption and spread will be developed.

Notable recent achievements include the launch of the Insigneo Institute, which is a collaboration with the University of Sheffield and is a multi-disciplinary institute involving over 80 academics and clinicians who collaborate to develop computer simulations of the human body and its disease processes that can be used directly in clinical practice to improve diagnosis and treatment.

Academic Science Health Networks (ASHN's)

The Yorkshire and Humber Academic Health Science Network (AHSN) brings the NHS, Higher Education, Industry and Third Sector partners together to improve the quality and cost effectiveness of health services and establish a wealth creation system with a particular focus on medical technology that will contribute to national economic growth.

To achieve this radical change in culture, it will establish a Transformation Academy. The Academy will harness the enthusiasm of staff and the rigour of a high quality innovation practice programme to develop them into entrepreneurial leaders. A new Improvement and Innovation Observatory will help the AHSN deliver its objectives by seeking out evidence and leading edge thinkers and applying that thinking to our own local challenges.

Education and training

High quality patient care and a positive patient experience are synonymous with investment in the education and training of all our staff to ensure they have the knowledge and skills to undertake their roles effectively. It also depends on high quality practice placements for all our students and good relationships with our education partners.

Nationally the model for commissioning education is changing, making Trusts more accountable for the education and training of their workforce. As a major Trust in Yorkshire and the Humber, it is important that we are at the forefront of these reforms and in turn review how we govern education and training internally as well.