

# building a caring future

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NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST  
OPERATIONAL PLAN 2018/19

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# 1. Planning approach / overview

The Trust is now in the third year of operating the specialist emergency care hospital in Cramlington (NSECH). The model of service provision and changes to patient flows between NSECH and the reconfigured general hospital sites and community sites has greatly improved operational effectiveness, through the separation of emergency flows and the way in which elective and community services are planned and managed. More recently, our ability to create a more effective and efficient alignment between demand and capacity, including surge capacity, has improved as a result.

High sustained growth in emergency activity, coupled with seasonal outbreaks of flu and norovirus, has placed significant pressure on the NSECH model, which the Trust is actively managing through increasing and reconfiguring capacity, in part by repatriating appropriate activity back to its base sites. Whilst this is providing some relief, the Trust is in the process of developing a more sustainable solution which focuses on the establishment of primary care hubs, protecting ambulatory care capacity, separation of emergency and urgent activity at NSECH and the introduction of hot clinics to reduce pressure on A&E and unscheduled care, with the eventual aim of further moving care into alternative settings to hospital.

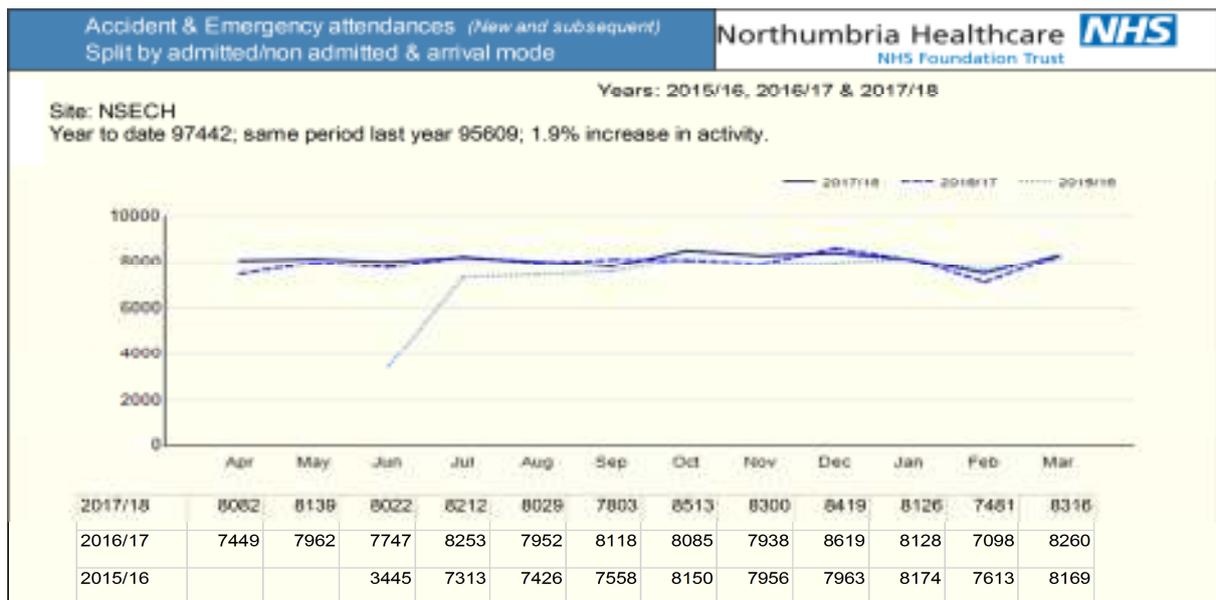
We are continuing to work closely with health and care system partners to think and act beyond traditional organisational boundaries in order to provide seamless care to individuals within a system-wide financial framework. Our plan includes the steps we are taking with partners to establish an outstanding integrated care system – a system which better predicts, plans and delivers care to individuals in a way which ensures the future sustainability of services. We want to shift incentives and behaviours to focus on population health and in doing so, rebalance capacity in the health and care system from acute to non-acute settings.

## 2. Approach to activity planning

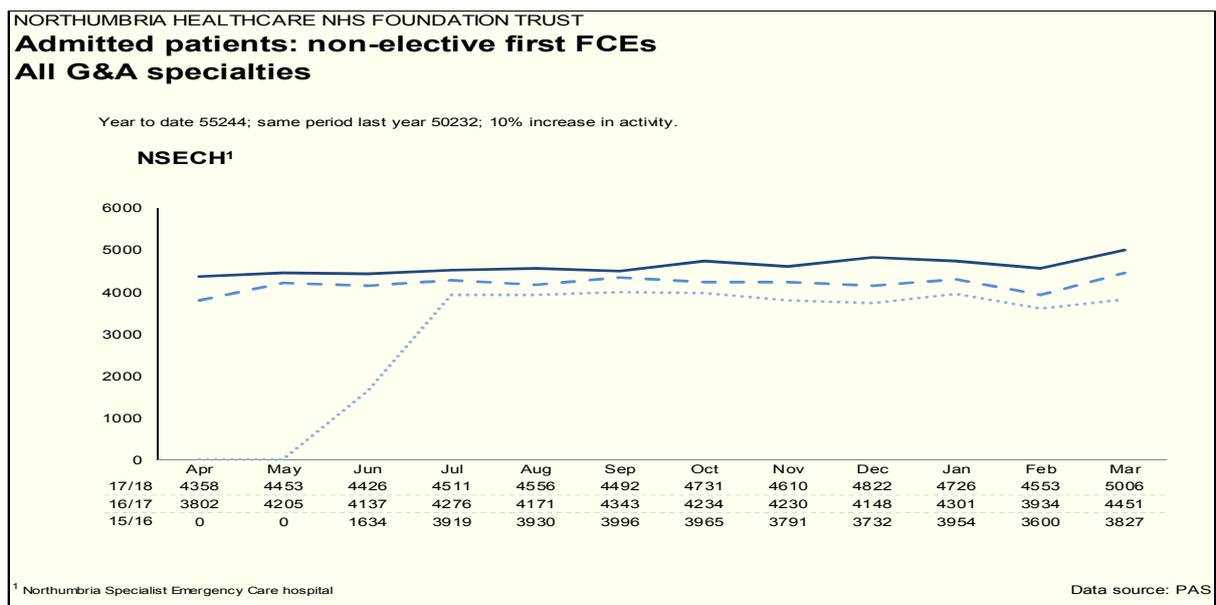
The Trust continues to adopt an evidence-based approach to forecasting demand and understanding its capacity needs over the next 12 months. It builds on and updates the plan submitted in April 2018 which covered both 2017/18 and 2018/19.

The model at NSECH is experiencing a significant and sustained increase in attendances and admissions.

### A&E attendances at NSECH



### Admissions at NSECH (including ambulatory care)



Our plan for the next year take these effects into account alongside our expectations of further improvements as we continue to adapt the NSECH model with consideration of the wider implications to the configuration of services across the Trust.

## 2.1 Demand and capacity approach for 2018/19

Much of our demand and capacity work has been associated with the modelling of NSECH and the change in function of the associated 'base' hospital sites in Hexham, Wansbeck and North Tyneside. Our on-going focus on recalibrating the NSECH model following 2 and a half years in operation incorporates learning from winter 2017/18.

Lessons learned from the winter of 2015/16 have meant that in recent years, we have analysed three years of data and developed proactive plans to flex staff capacity and avoid performance issues. This has been part of an effort across the health economy to create a robust system wide approach to changes in demand and case mix over winter and other time of high demand. We have shared and stress tested our approach with local health economy partners through the A&E Planning Board, which has cross system representation and are clear on the requirements for winter 18/19.

## 2.2 Demand and capacity modelling tools

Through NSECH, detailed data is collected on volume and acuity and shared with commissioners. The Medicine and Emergency Care Business Unit regularly uses modelling data to determine peaks in demand in order to identify demand and required capacity. This includes an analysis of patterns of attendances (volume, complexity and time/day/month). Each business unit has documented its escalation protocols for increases in demand or a reduction in capacity. These plans have been used to support the Trust-wide Operational and Resilience Plan.

## 2.3 Agreed planning assumptions

The CCGs and Trust are currently in the process of agreeing growth assumptions for the contract. At this stage the STP wide assumption of 1.8% is being modelled to take account of increased demographic demand. The Trust composite growth assumption is equivalent to 1.3% across the combined contractual forecast outturn for 2017-18. Underpinning this growth assumption there are a range of growth rates applied dependent upon the type of activity. The maximum growth factor applied is 2.5%.

Additionally there is a further 0.7% applied in respect of reducing the level of elective waiting which has increased by over 20% in 2017-18.

## 2.4 Capacity planning

Our capacity planning is based on the outputs of the demand and capacity models we jointly agree with commissioners. The key areas of capacity planned for are: staff, beds, theatre sessions, diagnostics and key equipment. Capacity is deemed sufficient in order to:

### Meet key national and commissioning quality standards:

- At a service line level, we explored minimum required staffing levels:
  - I. Using standard nurse to bed acuity tools alongside the opinions of senior nursing staff and the input of other staff groups into the ward
  - II. Reviewing medical and nursing requirements from key guidance.
- Our medical and nursing director reviewed the outputs of the modelling on a ward-by-ward basis to reflect local pressures and acuity.
- We will be making the best use of junior doctor roles to deliver care

### Meet key operational targets:

- We have triangulated the capacity outputs against actual delivery of operational performance in the prior year to flex where required;
- Linked in system wide plans for operational resilience to allow for flexing demand levels.

## 2.5 Plans to achieve national targets

The Trust has submitted a plan which will deliver all relevant targets as identified in the Single Oversight Framework (SOF). Appendix 3 outlines the Trust's current year performance.

Whilst the Trust has a demonstrable track record of delivering all standards, the unprecedented level of demand and pressure in the systems has resulted in underperformance against the four-hour A&E target, and the 62 day cancer waiting times GP referral to treatment target. The Trust has been prudent in the quarterly submission of its improvement trajectories for A&E aligned with submissions required by NHSI. Detail on our actions against these risks are provided in Appendix 3.

## 2.6 Managing unplanned surges in demand, including winter

The Trust plays a lead role within the local Northumberland & North Tyneside A&E Delivery Board (LADB) which is chaired by the Trust's Chief Executive Officer. This forum is developing well to enable a co-ordinated system approach to flow management and improvement.

Following the mass casualty Exercise Pelican (scheduled for March 2018), the Trust will work with system partners to address both internal and wider system recommendations and actions as identified by the NHSE Emergency Preparedness Team.

The recently refreshed Trust Operational Resilience & Capacity Plan sets out the Trust's approach to managing the challenges of increased demand and/or reduced capacity at any time of the year, with individual service escalation plans detailing actions in anticipation and response to times of pressure. The Trust is undertaking a significant review of internal flow arrangements, reviewing and 'recalibrating' NSECH and Base Site working arrangements as part of its clinical strategy. This includes use of a QI approach to focus in on demand and capacity pressures and bottlenecks at times of increased activity including surge; specific projects are aimed at internal ED flow, 'frailty ED', ambulatory care and NSECH ward/base

site working. Work will continue to make further use of Nerve Centre and information to support front-line teams, allowing real-time cross-site information and communications. Further work is on-going to identify and refine activity 'triggers' which can provide early warning of flow challenges, as well as a further refresh of escalation response at all levels within the organization. Use of Nerve Centre will be fully established for flow management including within the ED by October 2018.

As in 2017/18, the LADB will produce a single system-wide Winter Plan, which will include system learning from the 2017/18 winter period. Pressure built early within the system in winter 2017/18 due to complex case mixes, norovirus and influenza challenges which resulted in significant strain on colleagues in ED and wards to maintain flow for both admitted and non-admitted patients. The Trust instituted internal 'Winter Response' arrangements, with the establishment of a 'Winter Room' at NSECH, and rotas providing senior clinical and managerial leadership to co-ordinate escalation responses across the Trust alongside close liaison with commissioning, primary care, ambulance and local authority colleagues to facilitate safe but speedy discharge. The Trust will start work in summer 2018 to develop a specific task-orientated Internal Winter Action Plan, building on learning from Winter 2017/18 and designed to create the additional capacity required to meet predicted peak demand in line with scenario planning and detailed modelling.

## 2.8 Key areas of focus for 2018/19

The Trust is currently undertaking a detailed recalibration exercise following 36 months of operating the NSECH model. This is a top priority for the Executive Management Team and also the Board. Following this exercise, there is a need to assess the implications and revise plans accordingly for:

- The services and configuration of the base site hospitals.
- Work with care homes to support them to access the right care for their residents.
- Development of multi-disciplinary hubs across the catchment area of the Trust to support health and wellbeing
- Expansion of the hospital@home model across wider specialities to help patients receive treatment in their own homes
- Safe and robust streaming of patients to ambulatory care and primary care practitioners where appropriate.
- A review of the traditional outpatients service to provide more effective, efficient and safe access to specialist opinion
- Use the benchmarking data and principles of "Right Care" to ensure safe, effective and efficient practice in elective care.

Overall, the NSECH model is a success, with metrics around mortality and readmission rates showing improvement. Our approach to continuous quality monitoring and improvement highlights areas to better streamline to optimise capacity. There is also recognition that the

physical capacity at the NSECH site needs to be increased and plans to identify how this is to be achieved will be finalised during 2018/19.

In line with the planning guidance for 2018/19, our plan has been developed on the basis that our referral time to treatment 52 weeks (incomplete pathway) waiting list will be no higher in March 2019 than March 2018 – the Trust is aiming for no patients to be waiting more than 52 weeks.

Further information on this and how growth in demand will be managed is provided in Appendix 4.

## 2.9 Operational risks

The Trust's top operational risks for 2018/19 are identified as:

- Managing demand (non-elective) and the impact of this on performance;
- Strengthening information technology, including the implementation of new systems to achieve a step change in care;
- Maintaining financial resilience at the Trust and working with partners to strengthen the financial stability of the local health and care economy.

Each risk is matched with actions which are regularly reviewed and refined, alongside ongoing work to ensure the potential impact is fully understood and mitigated accordingly. External modelling on potential activity movements has been completed and financial plans adjusted accordingly. Similarly, the data flows have been mapped in a similar manner to when the Trust successfully implemented its new PAS.

# 3. Approach to quality planning

## 3.1 Approach to quality improvement

The Trust has a comprehensive quality strategy, which reflects our vision to “Be the leader in providing high quality, safe and caring, health and care services.” The strategy outlines our approach to ensuring compliance with national guidelines and regulations whilst prioritising local areas of quality which are important to patients, staff and the Trust. Our approach is to ensure that any plans align directly with our strategic vision, lead to measurable quality improvements and encourage continuous improvement.

### 3.1.1 Named executive lead for quality improvement

The named Director for Quality is Dr Birju Bartoli who is supported by the Clinical lead for Quality, Dr Richard Curless – Consultant Physician. In addition, she is supported by a number of clinicians who are Q fellows and clinicians and managers who are recognised flow coaches and/or have had formal Quality Improvement training.

### 3.1.2 Organisation-wide improvement methodology

The Trust’s Quality Improvement programme is monitored via the Quality Lab, a forum attended by a wide range of executive representatives, senior clinicians, transformation managers and service leads who not only have an interest in quality improvement but who have opportunities to influence and break down barriers within the organisation. They have developed our formula for improvement and supported the use of the Sheffield roadmap within our quality priorities.

### 3.1.3 Details of the provider’s quality improvement governance systems

The Board regularly undertakes a self-assessment against NHS Improvement’s Well Led Framework. This was most recently undertaken in 2016 as part of our independently commissioned well led review (provided by Deloitte). Whilst a number of areas of improvement were highlighted, no material concerns arose. The Trust is in the process of undertaking a renewed self-assessment in line with its board development plan – commenced April 2018.

### 3.1.4 How quality improvement capacity and capability will be built in the organisation to implement and sustain change

The Trust is in the process of establishing a faculty for staff trained in quality improvement, working alongside the Sheffield Coaching Academy. Over the next year, the Trust will be developing three clinical pathways with respect to flow. By Jan 2018, following training by Sheffield and their franchise model, the Trust will be a designated as a ‘flow centre’ and able to support other organisations.

In addition, the Trust has developed a QI training programme that is run over three days and incorporates the Trusts ‘formula for improvement’. This is currently being rolled out across the organisation for all levels of staff – clinical and non-clinical.

## 3.2 Summary of the quality improvement plan, including alignment with national and local priorities

### 3.2.1 National and local commissioning priorities

The NSECH operating model has ensured adherence to the Royal College staffing guidelines across key medical and surgical specialities. We have also long been compliant with the Association of Medical Royal Colleges' guidance on the responsible consultant. The new hospital system supports junior doctor training and has ensured continued development of our general workforce into alternative clinical roles where appropriate. The development of new clinical roles is a key strand of our revised five-year strategy. The Trust continues to receive regular feedback from trainees with regards to their training and has been further modifying how this is delivered as a consequence of increasing consultant presence on the emergency hospital site.

The new model also ensures that nursing guidelines of staff to patient ratios are met. Assessment of these ratios is undertaken using accredited nursing acuity and the expertise and assessment of senior nursing staff on the ward. It is envisaged that any changes will be managed within existing resources.

### 3.2.2 Quality priorities

The Trust has refreshed its quality priorities following year one of the plan and these are outlined below:

- 1) Sepsis
- 2) Frailty
- 3) Patient flow
- 4) Falls
- 5) Patient and staff experience

Breathlessness and abdominal pain were priorities for year one and remain key areas of focus from an improvement perspective for the Trust.

Risks to delivery of the sepsis management, frailty and falls priorities are low, both using the implementation of care bundles as per the established evidence base. The risk to delivery of improvement to flow of the emergency patient is complex and further work is required to assess the scope of the staff experience improvement project. Delivery of these projects will continue to rely on the aforementioned faculty for quality improvement.

### 3.2.3 Seven Day Hospital Services

NSECH delivers consultant led specialist care 7 days a week and also provides Emergency department consultants working 24/7. This senior clinical presence at speciality level, alongside dedicated 7-Day access to diagnostics, has significantly altered the patient pathway through the department. In addition, due to separation of serious injuries/illness from those patients requiring minor injury/illness treatment, the Trust has been able to establish three

urgent care centres to support the overall clinical model and to ensure local provision is available 7 days a week.

### 3.2.4 Care Hours per Patient Day and Safe Staffing

The Care Hours per Patient Day (CHPPD) metric is recorded and reported monthly in the Trust's Ward and Community Nursing report along with Hard Truths fill rates for all in patient wards. The reporting of CHPPD from May 2016 is now a mandatory requirement along with Hard Truths safe staffing submission to NHS Digital. This monthly data is also published on the Trust's website and also available for the public through NHS Choices.

The National Quality Board (NQB) published in July 2016 its revised safe staffing guidance for NHS Provider Boards. The revised guidance has three expectations; Right Staff, Right Skills, Right Place and Time. With the exception of section 1.3, Expectation 1 (compare staffing with Peers) all NQB Expectations have been covered in the Trust's safe nurse staffing reviews in 2017 and will continue in 2018/2019 reviews. For section 1.3, Expectation 1, work nationally is underway to support Trusts to compare nursing and midwifery staffing with peers through the model hospital dashboard.

### 3.2.5 Mortality review

The Trust has a Learning From Deaths Policy that is delivering significant areas of work related to learning from deaths, understanding our mortality data and provides a quarterly dashboard to public meetings of the Board of Directors that provide assurance that we identify and act upon preventable factors in deaths. The trust continues to lead the regional mortality meeting where the eight regional acute trusts meet regularly to discuss and share learning with regards to mortality.

### 3.2.6 Issues and concerns with quality, together with mitigation plans

Given the current environment of national instability in the NHS, there remain some inherent risks within the plan. These are notably linked to:

1. The financial position of the NHS; and
2. Continued tensions that exists between balancing quality and financial requirements against a backdrop of increasing demand, driven by an ageing population.

The Trust has a robust process in place to manage all efficiencies within Business Units and ensures a quality impact assessment (QIA) is undertaken with full clinical challenge (across Business Units and at Board level) in advance of the scheme being undertaken, during implementation and six months post-delivery of the scheme (for significant value schemes).

There are also threats to quality relating to A&E/ambulance handover (although due to recent changes in the ED Model, significant improvement has already been observed) and staff vacancies. A number of actions are being taken to manage these risks which can be found in Appendix 5.

### 3.2.7 Quality goals and related key milestones and performance indicators

The Trust has defined quality goals and associated milestones/KPIs to ensure it remains: safe, caring and targeting specific quality improvements.

Delivery of the key quality goals is managed through the Safety and Quality Committee (S&Q), and Finance, Investment and Performance Committee (FIP) via monthly reporting, both of which are formal subcommittees of the Board. Any consistent deviation from the set trajectories results in clinical leads identifying relevant actions and the sub committees ensuring delivery of these plans. The FIP, S&Q and the Clinical Policy Group (CPG) have oversight of improvement plans and ensure cross Trust challenge, including from NEDs. These forums ensure that where changes are necessary, these lead to improvement rather than deterioration, and that changes are appropriately evaluated for effectiveness and efficiency.

### 3.2.8 Existing quality concerns (from CQC or other parties) and plans to address

Notwithstanding the threats to quality highlighted in section 3.2.5, the Trust does not have any material quality concerns that have been identified by the Trust itself, CQC or other third parties. The Trust had its formal CQC ratings inspection in November 2015. This review rated the Trust as 'Outstanding'.

A formal letter was sent to NHS Improvement in June 2015 highlighting the potential impact on the Trust's SHMI post implementation of the NSECH. The Trust's SHMI released in September 2016 showed that it remains within expected range. Following further analysis the Trust has confirmed that there are no material concerns in this regard and in fact the predicted increase was not actually observed. The latest release of the Trust's SHMI continues to be 'within expected range'.

## 3.3 Summary of the quality impact process

### 3.3.1 Description of how CIPs and improvement programmes are identified and assessed for their impact on patient safety, clinical outcomes, patient experience and staff experience at sub board level, taking account of clinical engagement

The cost improvement programme is driven by significant clinical involvement, with ownership taken at the individual Business Units where Clinicians and Managers jointly agree the forward programme.

The Executive Management Team acts as the group which ensures consistency across the Trust and reviews the overall programme prior to sign-off by FIP, and ultimately the Trust Board. The Trust in pulling together the programme has taken steps to ensure agreed quality standards are maintained and, it is clear throughout, that patient safety and quality must not be compromised.

Each Business Unit engages in a robust process, involving key clinical leaders, to ensure each cost reduction plan is sustainable and does not adversely impact on safety or quality. All potential schemes are measured for impact against the three domains of patient safety; clinical effectiveness and patient experience

### 3.3.2 Board QIA process, including sign-off by the medical and nursing directors

Each scheme is quality impact assessed and “signed-off” by the relevant clinical lead. Where there are significant schemes (financial or potential service impact), these are formally reviewed and assessed six months’ post implementation.

In order to ensure external clinical scrutiny each Business Unit is required to present to CPG their plans for the year ahead. The CPG comprises key clinicians and managers, together with GP representatives from the community.

Each Business Unit programme must be “signed-off” by the CPG and thereafter quarterly presentations on the Business Unit performance in terms of delivery and impact on safety and quality are relied on to inform the Quality Declaration to NHS Improvement.

### 3.3.3 The provider’s plan for its in-year monitoring of QIA.

Monthly reports go to FIP and Board detailing the safety, quality, service standards and finance performance across the Trust. Underpinning this process each Business Unit reviews on a weekly/monthly basis the overall progress in order to manage delivery and also pick up any risk of or actual quality impact.

## 3.4 Summary of triangulation with finance and workforce planning

### 3.4.1 Approach to triangulation

As described earlier, the Trust has achieved a very effective method of triangulation through the operation of a number of committees and through the membership of those committees providing an effective level of cross-fertilisation. It remains the ambition of the Trust in future to supplement and complement this with the development of an Integrated Dashboard to ensure workforce, activity and finance indicators are brought together and formally triangulated into a single report.

There are a number of forums where workforce, finance and activity indicators and data are discussed and triangulated, including weekly Executive Management Team, Monthly FIP and CPG, as well as weekly meetings of the Delivery Management Team. Business Unit leads present to CPG quarterly to describe proposed efficiency schemes and provide written assurance (via a signed statement) regarding their impact on quality.

### 3.4.2 Key indicators used in this process

The Trust has fully embedded the use of indicators within its risk monitoring processes. The key indicators used are turnover, sickness, vacancies, headcount/WTEs and standard professional groups.

In the past 12 months no material issues have been identified through the use of these indicators. The Trust does also rely on excellent communication channels from wards upwards and invests a significant amount of time into ward and site visits to ensure it can triangulate indicators with feedback and local intelligence.

# 4. Approach to workforce planning

## 4.1 Workforce planning methodology linked to our strategic aims

The Trust use the 6 steps methodology developed by Skills for Health. Our strategic goals are:

- Reshape the settings in which people receive healthcare to provide a safe, seamless and sustainable service
- Be the best place to work and to train, where innovative roles and ways of working are embraced and encouraged
- Become the flagship health and social care organisation for quality of care and quality improvement
- Embrace the principles of Realistic Medicine to provide truly patient centred care
- Secure the financial success and sustainability of the local health care economy
- Work collaboratively on the public health agenda to reduce the burden of ill-health for future generations
- Develop an internationally recognised brand and build strong local and national relationships

## 4.2 An underpinning workforce strategy developed with staff involvement, linked to clinical and wider STP strategies

The workforce plan is linked directly to the strategic vision and priorities of the Trust, which, in turn, have been aligned with local and national commissioning intentions. The workforce plan is currently under review in order to reflect the growing need for consideration of alternative roles to meet workforce supply challenges particularly in the medical and nursing professions. The aim of the new workforce plan is to capture the short, medium and long term needs for the Trust and will be designed to enable the delivery of sustainable, high quality, safe and compassionate care for patients in an evolving healthcare system.

To develop the new workforce plan, Business Unit representatives and key stakeholders both internally and externally are being consulted to ensure that the plan captures the most significant workforce risks to the organisation in the coming years and that appropriate strategies for mitigation are identified. Information has been drawn from local regional and national sources, also primary and secondary data has informed our plan.

## 4.3 Robust governance process including alignment with financial and activity plans, affordability and quality of care

The Trust has an established Workforce Committee, which reviews workforce issues on a monthly basis. Patient safety initiatives have been integrated into key workforce events for example, human factors training, Trust induction and also patient experience educational sessions. Budgetary service and quality objectives are reviewed on a regular basis, at various

forums such as CPG, the Executive Management Team and Trust Board committees including FIP and Workforce Committee.

The workforce implications of efficiency targets including QIPP are discussed at different levels and forums within the Trust. Our QIA process has been very effective in ensuring safety and quality are not adversely affected through the development of efficiencies.

The Board is made aware of workforce plans and risk after these issues are discussed at Executive management meetings, FIP and workforce committee – the latter two being formal board sub committees. For example, prior to the opening of NSECH, the Executive Team was made aware of the need to invest in the nurse practitioner workforce to ensure that there was sufficient junior doctor provision at the new hospital and base sites. Similarly, the level of gaps in junior doctor rotas due to reductions in recruitment to training posts in the region is a current challenge for the organisation therefore investment in some new roles such as Physicians Associates has recently been agreed by the Executive Team. Failure to develop this new workforce in a timely manner would potentially risk the implementation of the new clinical model. The budget planning process and CIP targets take account of major workforce pressures and developments and are signed off by budget holders and in formal committees such as FIP.

## 4.4 Workforce transformation

During the next year, we will focus on:

- Developing the capabilities and skills required for greater integration across health and social care, importantly, the delivery of care closer to home. This will include a gap analysis of any outstanding capabilities and skills, and whether they can be met by training existing staff, or recruitment, or the development of/investment in new roles.
- Meeting the current challenge of the shortage of GPs and other medical specialities, with the development of alternative models such as the use of clinical pharmacists, physicians associates and nurse practitioners, along with system changes such as the development of doctor first models
- Continuing to develop our in house nursing degree programme/nurse associate pilot /model ward pilot and exploration of alternative roles to support challenges in supply of the nursing workforce such as Ward Medicine Assistants.
- Working closely with clinical teams as they re-model pathways based on the STP

Continue to maximise opportunities to invest the apprenticeship levy back into workforce, specifically expanding the apprenticeship Leadership Development programme which commenced in 2017, maximising the utilisation of apprenticeships for band 1 – 4 roles, nursing training and considering appropriate substantive posts to develop apprentices and then place into permanent positions.

## 4.5 Balancing workforce supply and demand, and skill mix

We have recently undertaken a number of nursing reviews. These highlighted discrepancies between staffing across different sites, with community hospitals having fewer nurses, and the need to address skill mix at certain times of day, leading to changes across the Trust.

Our in-house nursing degree (“Growing Our Own Nurses”) successfully launched in 2016, and will enhance our ability to recruit excellent nurses. There has also been success in integrating the AHP workforce and offering pre-nursing education for Band 1-4 staff. The investment/changes we have made in these areas has resulted in a significant reduction in nursing vacancies across the Trust by the end of 2017.

In the future, we will also look at our options for recruiting nursing staff from Europe taking into account the impact of Brexit when this is known. Where there are national shortages, such as in radiology, we will investigate the possibility for a recruitment and retention premium, and assess the need to recruit from overseas.

In the future, we will also look at our options for recruiting nursing staff from Europe. Where there are national shortages, such as in radiology, we will investigate the possibility for a recruitment and retention premium, and assess the need to recruit from overseas.

New roles will be developed, including increasing the scope of clinical pharmacy, nurse practitioner, physiotherapy, nurse associate and physician assistant roles. An innovative approach to skill mix will address bottlenecks in patient flow, improve care, and make roles more attractive to high quality applicants. A model ward pilot is due to commence early in 2018 to assess the ideal skill mix on a ward and evaluate the impact of such new roles.

These new roles will also respond to shortages in other professions, for example the reduction in medical training numbers. We will work with local education providers to continue to meet skills needs in our workforce.

We have had success in using e-rostering to reduce bank usage and deploy registered and unregistered staff more efficiently across the Trust. This will be expanded to include e-rostering modules for consultant job planning and rostering.

A collaborative staff bank will have been developed for the STP footprint, reducing duplication and maximising the potential number of bank staff available to all sites. This will reduce reliance on agency staff. Bank post holders will be offered a minimum number of shifts a month, and assistance with professional development, to make the roles more attractive.

### 4.5.1 Balancing of agency rules with the achievement of appropriate staffing levels

Following NHSI’s additional guidance and rules on agency spend released in September 2016, the Trust has implemented a number of information collection and reporting requirements and as such remains at risk of breaching the ceiling for the year. The main driver of this risk remains medical staffing costs.

A number of actions were recently discussed at the November Board to mitigate this risk. These actions are targeted at increasing accountability, strategies to improve the

attractiveness of nurse bank roles and developing a medical bank which could, in time, be expanded regionally. Other actions include further negotiation with agencies to obtain a reduction in rates towards capped levels.

#### 4.5.2 Supporting national programmes

The Trust is involved presently in supporting two national pilots which are being run over two years, where the Trust is approaching the end of year one. Firstly 'Workforce Culture' linked to the recently published 'Developing People – Improving Care' strategy. The second pilot is run by NHS England, focusing on developing a healthy workforce.

# 5. Approach to financial planning

## 5.1 Overall narrative

The Trust recognises that in line with the NHS as a whole, it faces significant challenges, including rising costs and increasing activity within a limited financial envelope. Nevertheless, the Trust is confident that it has a robust strategy to ensure that it remains financially and operationally resilient throughout. The draft operational plan for 2018 to 2019 forms the platform for the Trust's longer term strategy which forecasts the Trust:

- Maintaining at a least a Use of Resources rating of 2.
- Delivering the proposed control total for 2018-19 (based upon the assumption that contracts reflect a realistic assessment of potential volumes and has a balanced and acceptable approach to risk management)
- As a foundation trust we have used our freedom to target a control total for 2018/19 which is in line with 2017/18.

The 2018-19 projection is shown below alongside the 2017-18 forecast outturn:

Figures in £000's	2017/18	2018/19
Income	541,429	561,908
Expenditure	504,862	521,685
EBITDA	36,567	40,223
Other net costs	10,071	11,072
Surplus	25,496	29,151
Exceptional items	3,500	
Surplus / STP Control Total	21,996	29,151
Sustainability and Transformation Funding	8,580	12,066

The forecast 2017-18 outturn position is based upon the reported performance in line with the quarter 3 monitoring return.

## 5.2 Efficiency savings for the next two years

The vast majority of cost reduction development and design is undertaken at Business Unit level which results in greater clinical engagement and ownership. Approximately 80% of the programme is developed by the Business Units within the Trust, with the balance reflecting corporate themes or Group-wide commercial activities.

Each Business Unit has its own operational plan which is consistent with the Trust plan and overall consistency is ensured via the embedded gateways within the process in order to sign-off the programme. In arriving at the content, each Business Unit will review specific internal and external benchmarking. The programme is built around key themes.

### 5.2.1 Accountability and monitoring of efficiencies

Key accountability resides with each business unit as they represent the key drivers of change and accountability, including where risks are identified and addressed. Within each Business unit there are identified individual project managers who are responsible for managing delivery and provide a report/monitoring which assesses delivery on a rolling fortnightly basis. At corporate level, performance is reported to the Finance, Investment and Performance (FIP) Sub-Committee of the Board. Contingency is held at corporate level.

The core programme plan for this year totals a recurring value of £30.3m (including £ 6m of non-NHS income generation schemes) and a £5m non-recurrent target. The income schemes relate primarily to expected growth in commercial and associated income.

In deciding on the level of cost reduction, the Trust Board has taken into account a range of different factors, including the current and future economic outlook, NHSI guidance and the on-going trading position of the Trust, both historic and projected.

## 5.3 Lord Carter's provider productivity work programme

The NHS is expected to deliver efficiencies of 2-3% per year, effectively setting a 10-15% real terms cost reduction target for achievement by April 2021. Whilst the NHS ranks as the best value healthcare system in the world, we know more could be done to improve quality and efficiency in our hospitals so they can meet this expectation. The review found that there is significant unwarranted variation across all of the main resource areas, and that this amounts to £5bn of efficiency opportunity, or 9% of the acute hospital budget in England.

The productivity opportunities by speciality identified within the model hospital were identified as:

Specialty	Productivity Opportunity £'000	%
Pathology	2,500	33.8
O&G	1,700	7.8
Paediatrics	1,500	16.2
Orthopaedics	1,300	2.4
Respiratory	689	3.9
General Surgery	568	1.8
Urology	443	11.7
Diabetes	267	3.6
Breast Surgery	231	4.2
General Medicine	217	1.5
Geriatric Medicine	150	0.5
Plastic surgery	142	3.2
Cancer Services	129	4.7
Cardiology	112	0.9
Gastroenterology	108	0.8
Rheumatology	56	1.6
<b>Total</b>	<b>10,112</b>	

A number of service changes are planned to be undertaken to deliver the productivity opportunity highlighted.

### 5.3.1 Procurement

The Trust is part of a procurement shared service with Northumberland County Council. There is executive level oversight of the shared service, which is governed by a quarterly board, and we are identifying a non-executive director to provide challenge and scrutiny.

Procurement Transformation Plans are in place to deliver against the procurement aspects of the Lord Carter report, and support the delivery of the STP. We will meet level one of the NHS Standards of Procurement in October 2017.

## 5.4 Agency rules

As evidenced from Lord Carter data and other national comparators, the Trust has consistently been a low user of agency staff. An action plan remains in place to, where possible, transfer agency staff to substantive or bank contracts. There is weekly reporting of performance to the Executive Management Team and monthly reporting to the FIP and Board. Further reporting changes have been made to align with NHSI October 2016 guidance.

Should an agency worker risk breaching the NHS Improvement cap, the agency must then seek approval from the Trust Director of Operations (those which are over £120 per hour

require CEO sign off in line with NHSI guidance), who is in a position to balance the financial implications with the risk to patient safety.

## 5.5 Capital planning

The Trust has in place a wholly owned subsidiary company (NHFML) with responsibility for the design, procurement and development of capital developments. Where appropriate, the company will take on responsibility for the on-going maintenance and facilities management of its portfolio of premises and assets. To date, the company has taken on responsibility for assets such as Hexham General and NSECH. It is also currently responsible for the design and development of the Berwick hospital site. Wherever possible, where redevelopment is proposed, the opportunity is taken to bring together secondary and primary care services enabling improved service and estate rationalisation.

# 6. Emerging ‘Sustainability and Transformation Plan’ (STP)

## 6.1 Summary of the STP

Northumberland and North Tyneside (NNT) form one of the three local health economies which constitute the Northumberland Tyne and Wear STP (NTW). In many ways NNT is a unique and advanced local health economy (LHE), driven by a number of factors including the level of challenging service transformation already delivered in respect of emergency care, and meaningful inroads towards integration of services and social care. The Trust is also in a relatively healthy financially state, with evidence from Lord Carter / Model Hospital data linking this in part to its low cost base.

The Trust submitted an application (April 17) to develop an Accountable Care Organisation during 2017/18 and awaits a response. The planning guidance for 2018/19 refers to an ‘integrated care system’ which is in keeping with the key principles underpinning the Accountable Care Organisation business case. The Trust, along with its system partners, has also submitted an expression of interest (wave 2) application (Jan 2018) to become an ACS. Given that this was prior to the release of the planning guidance and the development of Integrated care systems (ICS), the Trust continues with its partners to develop local mechanisms of system leadership and the development of integrated care.

## 6.2 Understanding the gaps

A detailed assessment of gaps has been conducted as part of an exercise across our sub-footprint in 2016/17. The full summary of the evidence can be found in Appendix 1.

NNT’s phased journey towards an ACO is well supported by all stakeholders, although there is a need for more urgent work across NNT and NTW, in advance of an ACO or integrated care system, to drive and enable some of the changes required to address gaps in Health and Well Being and Finances. Emerging conclusions from the STP are:

- The need for a radical upgrade in prevention, requiring a larger and more sustainable program of investment across NNT and NTW. This should ideally consider how upcoming ‘shadow’ ACO arrangements from 2017/18 can create wider ownership in the planning, investment and delivery of the prevention and wellbeing agenda.
- Consider a medium term ambition to establish a single integrated care system for NNT to achieve value for money and provide more streamlined and effective governance to ensure standardisation across the LHE.

- Defining the optimal operational and strategic relationship between providers within NNT and NTW to initially address clinical sustainability risks and leverage system wide efficiencies.

### 6.3 Developing innovative models of care

The Northumberland and North Tyneside Health and Care system is characterised by a number of high performing organisations who have worked together in collaboration for a number of years. Much has been achieved clinically over this time, with integration of clinical pathways and joint working demonstrating real patient benefits. Furthermore, longstanding partnership arrangements between the Northumberland County Council (NCC) and NHS bodies are nationally recognised as a model of effective health and social care integration.

The foundations of the proposed place-based integrated care system are based on solid relationships between local health and care providers and a clear recognition of the need for a system leadership approach to delivering health and care services, something which has been impeded by more traditional silo models of care delivery.

The acute providers, together with NEAS, the local authority, the GP federation and Northumberland CCG have created a transformation board to collectively address these issues at a system level rather than separately at an individual organisational level. The transformation board is independently chaired and currently supported administratively by the CCG, with provider CEO and Exec director membership.

Whilst the board has not yet formally / legally been constructed, members have made a commitment to work together in the best interests of the system, whilst at the same time being mindful of the individual organisational constraints and requirements – for example organisational control totals vs system control totals. There is a willingness to openly share and understand contributions to the system control total, but with a provision to understand / develop a retraction model to allow for actual release of funds and ensure system and control totals can be delivered.

There is significant work to do over the coming year to understand the fine details of what such an agreement should look like and the considerations and potential governance arrangements that would need to be in place to support such a model.

The transformation board has commenced a process to identify system wide efficiency opportunities, potentially available to individual organisations as well as across the system. Some of the options that are being discussed are potentially controversial politically and therefore system ownership and joint engagement of these will be essential – especially when navigating the public engagement and consultation requirements. Full alignment and support from NHSE / I will be required in this process if the system is to meet its system wide financial and operational plan. Success of this process will be key in determining the future shape of both the patch based integrated care organisation and a regional integrated care system.

The partners in the currently defined integrated care system have delivered historically on core constitutional standards and members of the place based integrated care system have also met this requirement. This year there has been a challenge in ensuring consistent delivery of the national ED target, however both acute provider trusts remain in the top 20 position nationally. Working as a wider integrated system will further support delivery of this and other constitutional standards, with sharing of best practice and mitigation at times of pressure.

The Northumberland system has a developing clinical strategy that supports the work of the transformation board. A clinical strategy forum meets quarterly to inform and develop the strategy, with approximately 70 clinicians from across the system meeting to develop work streams and build relationships to support an out of hospital model of care - the redesigning of care around people at risk of becoming acutely unwell. The clinical strategy also has a focus on long term population health with a number of the work streams identifying patient empowerment and shared decision making as well as an opportunity in the longer term to develop our capability in population analytics.

Currently the transformation board in Northumberland functions via a common desire and recognition of partners for a need to work differently as a system rather than in pre-existing organisational silos.

At the present time there is no formal memorandum of understanding or collaboration agreement binding members of the transformation board together (although a number of these exist as a consequence of previous ACO work). However, formalising this arrangement would be part of the next step in the process to move Northumberland towards a fully functioning place based integrated care system.

The integrated care work is most progressed in Northumberland due to previous collaborative work undertaken as part of the ACO development. It is envisaged that through 18/19 further work will be undertaken with North Tyneside partners so that similar progress can be made. Collectively there will be the development of system wide objectives (including financial and service reconfiguration / development plans) across Northumberland and North Tyneside as well as more specific place based objectives.

The next steps that will need to be taken will be:

- Identification and agreement of a shared system control total which has been allocated to relevant parties by an agreed methodology via the transformation board
- Development of the transformation board such that they are collectively responsible for delivery of the contractual standards (including financial, quality and safety measures) thereby reducing the hours spent over contractual meetings and corresponding CCG costs
- Collective decision making and accountability

- Development and agreement of a retraction model by the transformation board to ensure the agreed system control total is met – incl provider trust requirement for delivery of a control total (where appropriate)
- Confirmed system objectives with joint delivery plan and where relevant a joint engagement and consultation plan
- Signed collaboration and integration agreements that provide a more formal commitment to how partners will work across the system.
- Ensuring that the transformation board and any further development of governance arrangements will remain responsive to the local population
- The transformation board and therefore place based integrated care system will oversee the development of service redesign proposals and associated funding arrangements

The Next Steps on the NHS Five Year Forward View and the 18/19 planning guidance reaffirmed a commitment to NHS organisations who would like to move to an integrated, system-focused way of operating so as to ensure the future sustainability of services. Northumberland was specifically named in this document as a system that was ready for this change and it is envisaged that this and local, wider integrated systems will be realised in the year ahead.

# 7. Membership and elections

As the largest geographical trust in England, we also have one of the largest memberships with over 52,000 patient and public members and almost 10,000 staff members. We regularly review our membership strategy to ensure that it is fit for purpose and delivers a highly effective membership across the area we serve. We are committed to high quality community engagement and a key element of this engagement is the continuing development of a large and representative membership, where members are informed and can choose to become involved and influential in the development of the trust.

To accurately represent the membership, we have a large council of governors with 72 public, staff, co-opted, and patient governor positions – 50 per cent of the council are public governors elected by our public members. Each year, we hold elections for those positions where governors have come to the end of their three year term and for any vacancies we may have in constituencies.

# Appendix 1:

## Evidence on gaps for Health and Wellbeing, Care and Quality and Finance and Productivity from the STP

### Health and Wellbeing

The NNT footprint is doing a better job of treating ill health than it is addressing the underlying causes and behaviours;

Successfully delivering the 0-19 Agenda, especially for children 0-2, is essential for future success

- Indicators relating to healthcare provision (e.g. diabetes packages offered, antimicrobial resistance, percentage with personal health budgets) all perform well nationally
- Percentage of people with LTCs who feel supported is in the best quartile nationally – but the quality of life for carers, as measured on the EQ5D, is in the worst quartile nationally, as are the rates of injury from falls per hundred thousand (2709 N Tyne, 2111 Northumberland).
- The difference between healthy life expectancy and life expectancy is especially severe in the most deprived areas of the footprint, with smoking, diet, lack of exercise and the wider determinants of health all contributing to inequalities.
- Indicators relating to identification of poor health are high; this may be a positive (identification) or a negative (prevalence) – hypertension QOF prevalence is 15.3 for North Tyneside and 17.2 in Northumberland vs. 13.8 nationally
- Mortality from suicide is above average, with Northumberland in the worst quartile nationally
- Indicators relating to lifestyle perform badly against England averages (except overall adult smoking rates)
- Adult obesity in worst quartile nationally, coupled with high rates of physically inactive adults, with Northumberland in the worst quartile. This will lead to severe problems in the future, especially with reference to diabetes.
- Childhood obesity (reception & year 6) both above average with year 6 rates in the worst quartile nationally for Northumberland.
- Alcohol specific hospital admissions are 519 (per hundred thousand) in North Tyneside and 378 in Northumberland, compared to 374 nationally
- Smoking at time of delivering a baby 12.1% in North Tyneside and 14.6% in Northumberland – worst quartile nationally
- Public health teams across the footprint are working on an asset based, community approach where communities identify their needs and solutions. This includes physical activity, maximising the use of green space and existing resources.

- The 0-19 and in particular the 0-2 agenda is critical in the long term. This will include measures to address domestic violence, poor mental health and drug and alcohol misuse. Across the NNT area, children's services are being re-rendered on a more integrated basis, learning from the successes in older adults.
- Vaccination rates are high
- Children in parts of the NNT footprint are more likely to be in care or subject to safeguarding procedures than the national average, and less likely to go on to higher education if they are from North Tyneside

## Care and Quality

The Trust has recently been rated as Outstanding by the CQC. There are still too many people being admitted for avoidable causes. There needs to be a greater focus on urgent and ambulatory care admission and attendance avoidance.

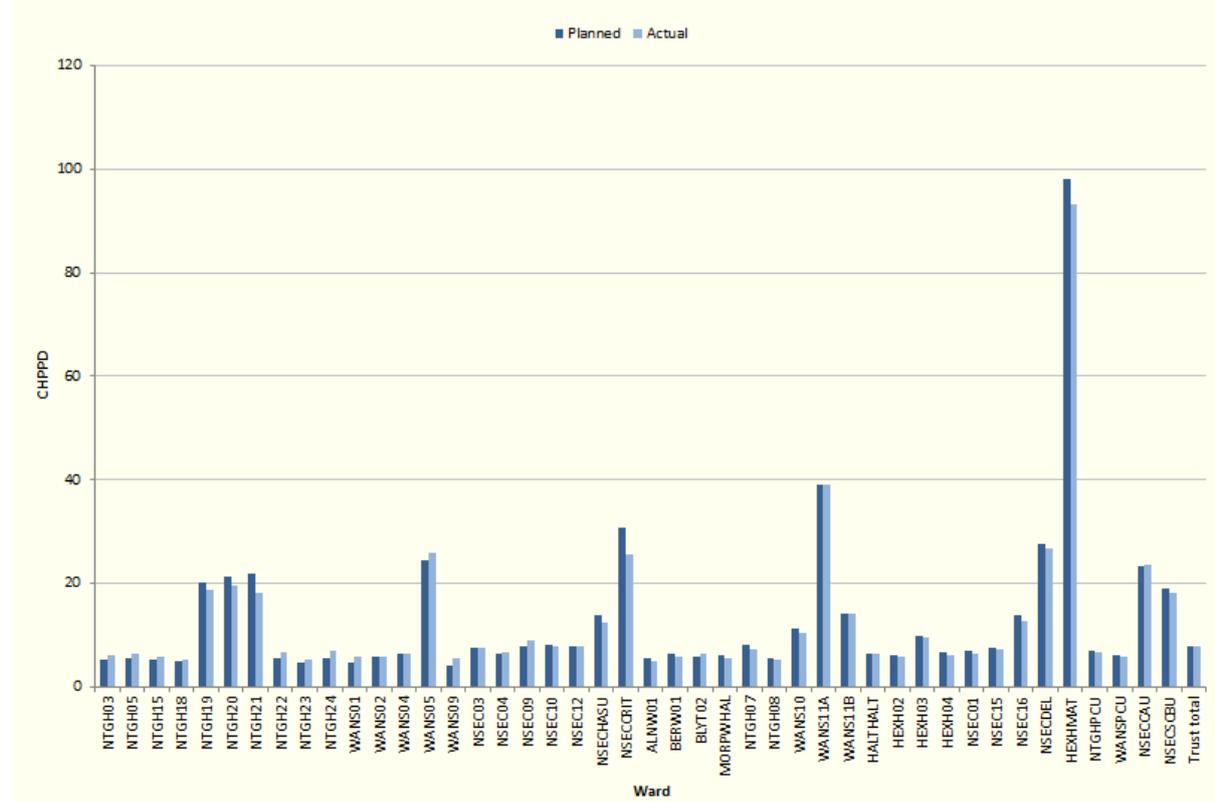
- Indicators relating to waiting times for cancer, 18 week waits, health checks for people with learning disabilities and dementia diagnosis are all in the best quartile nationally. Patient experience with GPs is also in the best quartile nationally and providers generally good or excellent. Access to IAPT could be improved, but is not in the worst quartile.
- Prevalence of dementia, depression and psychosis are above national means.
- Emergency admissions for conditions sensitive to urgent care 799 per hundred thousand for Northumberland and 845 for North Tyne – worst quartile nationally
- Emergency bed days overall – Northumberland (0.97 per 1000 population) is the best in the region but still worse than national mean and North Tyneside (1.12) is in the worst quartile nationally
- Ambulatory care sensitive conditions are in the worst quartile – 1266 (North Tyneside) and 1122 (Northumberland) per hundred thousand.
- Neonatal mortality and stillbirth for North Tyneside is 8.3 per 1000 – worst quartile nationally (Northumberland is 5.7, in the top quartile). Breastfeeding rates also need to improve.
- 16.5% of GPs and nurses in Northumberland and 19.1% of GPs and nurses in North Tyneside are over the age of 55 which compares well against other areas within NTW apart from South Tyneside at 16.2%.
- North Tyneside Local Authority estimate that 7900 children in the borough have a long standing physical illness or disability and 3000 have mental health or behavioural disorders. These children will require long term support
- Hospital admissions for under 18s are significantly higher in North Tyneside compared with the England average – the Local Authority highlights admissions due to injury, substance misuse and as a result of self-harm

- North East of England councils are facing cuts of around 70% during life of STP – severe impact on ability for social care to support discharge and admission avoidance.
- Highlights need to take prevention seriously, including need to address self-care; shared decision making, home health monitoring and CAMHS services.

# Appendix 2:

## Care Hours Per Patient Day

**NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST**  
**Care Hours Per Patient Day (CHPPD) - Planned plotted against actual**  
**January 2018**



# Appendix 3:

## Trust performance under the Single Oversight Framework

### Northumbria Healthcare NHS Foundation Trust

NHS Improvement - Single Oversight Framework 2017/2018: Operational Performance Metrics

Targets	Standard Threshold	Monitoring period	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
<b>SCF - OPERATIONAL PERFORMANCE METRICS</b>														
Accident & Emergency: Total time in A&E: percentage 4 hrs or under rounded down Sustainability and transformation improvement fund Targeted Total time in A&E: percentage 4 hrs or under	95%	Monthly	80%	90%	95%	95%	95%	95%	94%	94%	91%	91%	89%	92%
		Quarter	92.00%			96.00%			97.00%			92.30%		
		Quarter	91.40%			95.10%			93.90%			93.2%		
All cancers: 62 day wait for 1st treatment: from urgent GP referral to treatment	85%	Monthly	80%	81%	81%	90%	80%	75%	80%	85%	85%	84%	85%	83%
All cancers: 62 day wait for 1st treatment: from national screening service referral	90%	Monthly	100%	75%	100%	100%	80%	80%	85%	100%	91%	100%	100%	8%
<b>NUMBERS - do minimum 5 per quarter; each shared pt counts as 0.5</b>			3.0	4.8	5.5	2.5	5.0	2.0	7.0	1.5	6.0	3.0	1.5	8.5
<b>18 weeks referral to the breast**</b>														
- admitted patients	90%	Quarter	81%	83%	81%	82%	83%	83%	82%	82%	87%	82%	80%	78%
- non-admitted patients	90%	Quarter	84%	94%	84%	92%	92%	92%	94%	92%	97%	91%	91%	91%
- incomplete pathways	90%	Monthly	80%	90%	90%	92%	92%	92%	93%	93%	92%	92%	94%	92%
Maximum 8 weeks wait for diagnostic procedures	90%	Monthly	88.8%	89.7%	88.0%	89.7%	88.9%	88.8%	89.5%	89.9%	89.9%	88.9%	88.0%	89.9%
Dementia assessment and referral: proportion of pts aged 75+ admitted as an emergency for more than 72 hours	90%	Quarter	92.3%	91.9%	92.7%	94.4%	94.9%	91.8%	91.8%	94.2%	91.4%	91.4%	91.1%	
<b>WARREARS</b> Most recent data provisional	90%	Quarter	100%	100%	100%	99%	100%	100%	100%	100%	99%	99%	100%	
Improving access to psychological therapies (IAPT)	70%	Quarter	82.3%	82.5%	88.7%	91.0%	85.9%	91.7%	84.6%	84.8%	88.0%	86.9%	83.9%	83.9%
	50%	Quarter	91.9%			98.0%			85.0%					88.8%
Data Quality Maturity Index	50%	Quarter	100%	100%	100%	98.5%	100%	100%	100%	100%	100%	100%	100%	99.5%
	50%	Quarter	100.0%			98.8%			100.0%					98.8%
Mental Health Services data DOM score	95%	Quarter	43.2%	45.6%	60.0%	50.7%	59.4%	56.5%	58.4%	44.4%	57.2%	51.0%	51.3%	49.8%
	95%	Quarter	50.8%			58.8%			58.8%					50.8%
2m WARREARS	95%	Quarter	86.7%	97.7%	99.7%	98.8%	98.8%	88.0%	98.7%	98.8%	98.1%	98.0%	98.8%	
	95%	Quarter	87.0%			98.7%			98.9%					

### 4 Hour A&E target:

The Trust continues to experience significantly higher than expected attendances at NSECH since its opening in June 2015. A range of actions remain in place and additional actions. The Trust achieved the target in Q2 and anticipates an improvement through the remainder of 2017/18, however our performance in Q1 and Q3 means it is unlikely that we will meet this target for the full year.

The Trust is taking key steps to improve its performance against the target for 2018/19. This includes enhanced partnership working with the ambulance service to avoid batching and delays in handovers, as well as steps to strengthen capacity in A&E, such as a dedicated frailty A&E pathway, the separation of emergency work from urgent work at NSECH, and using QI methodology to match capacity and demand.

### 62 Day screening to treatment target:

The Trust has previously outlined to NHS Improvement the difficulty with delivery of the 62 Day cancer waiting time – GP referral to treatment target. Summary level performance is adversely affected by performance at cancer-site level where there is a combination of low percentage achievement and relatively high volume. A key area of focus for the Trust over the next 12 months will be the urology pathway, process mapping associated capacity and demand.



# Appendix 4:

## NSECH post implementation review and plans to manage growth in demand

### Significant growth in attendances

Attendances have consistently grown since the opening of the NSECH, with attendance at NSECH and the urgent care centres up 10.6% April to September. The growth rate is less marked in North Tyneside than in Northumberland, although the acuity is the same. There is also a marked increase in attendances after 5pm.

The reasons for this increase are under continuous review to ensure an integrated response with Primary and Community Care, and our Commissioners. The acuity mix is broadly stable, and there is likely to be an effect of ease of access, reflecting patient need alongside evidence of a contraction in primary care capacity.

We have managed this increase in attendances successfully through our new model and efficient use of ambulatory care. However, the do-nothing scenario would see a continued increase in attendances which could cause pressures on A&E targets and staffing levels.

The NSECH model was built on the basis of an average of 200 attendances per day. Excluding Winter, daily attendances for 17/18 are c.250. This is reducing as appropriate activity is shifting to the base sites. Staffing to meet a potential 20% increase is not possible or sustainable. However, the model of care is new, and streamlining, in conjunction with primary care hubs, may ease the pressures. In addition, new measures to separate emergency from urgent work at NSECH is supporting delivery of performance against an overall increase in ED attends.

### Admissions

Whilst admissions remain below pre NSECH levels, levels of emergency activity during 2016 have seen admissions significantly increase. The efficiency and resilience of the NSECH model has and continues to make a positive impact, reflected through a significant reduction in conversion rates from 3:1 to 4:1, despite reductions in primary care provision and supported by a shift of activity back to Hexham.

With more unnecessary admissions being avoided, there are now new challenges in managing bed capacity. In particular, the percentage of people who stay in hospital for more than 3 days is at 30%. Whilst this performance is better than the old pre NSECH model and reflects appropriate admissions, the Trust is developing actions to further reduce this statistic.

### Managing capacity and demand in 2018/19

The plan going forwards is to manage demand at current levels and not materially increase capacity levels. This will be achieved through

- Fully utilising the medical care model
- Improvements to the use of ambulatory care

- A frailty assessment service
- Addressing staffing issues (see section 4 on workforce)
- Greater flexibility in the use of beds

# Appendix 5:

## Actions being taken to manage quality risks

- A&E target and ambulance handovers
  - I. Winter 2017/18 has been extremely challenging due to complex case mix, influenza and norovirus. As such the Q3 target was not achieved which is a key quality risk for the Trust. The Trust is focusing on increasing capacity wherever possible which includes protecting ambulatory care, strengthening GP streaming and the separation of emergency and urgent work at NSECH.
  - II. A plan is in place to ensure that there is no delay in handover for anyone requiring resuscitation. The queues are then managed accordingly. Eight purpose built ambulance hand over bays have been created to support a reduction of delays whilst maintaining both safety and patient dignity.
  - III. Root cause analyses are undertaken for all one hour breaches. There have been no systematic issues identified. The new model of separation of emergency and urgent work at NSECH is supporting a reduction in ambulance handover delays.
  - IV. The Trust is planning to purchase its own transport to bring in GP referrals earlier in the day when most of the workforce is operating. The Trust will test the impact of this on activity and the sustainability of such actions.
- The number of staff vacancies, especially qualified nurses, has grown since last year. This has been managed through flex agency use, but we are aware that agency costs must be reduced.
  - I. No morale issue has been identified using staff surveys or patient surveys.
  - II. The issue is across the board, not related to specific wards or specialitiesWe will mitigate this through our workforce plan (see section 4)

# Appendix 6:

## Top 10 opportunity areas for the Trust as identified in Lord Carter review

Area	Actual Cost	Potential saving opportunity (PSO)	As % of actual cost
Obstetrics and Gynaecology	£26m	£7.6m	29.1%
Cancer Services	£12.5m	£3.5m	28.2%
Psychiatry and Mental Health Services	£12.4m	£3.5m	28.3%
Trauma and Orthopaedics	£50.9m	£3.9m	6.1%
Paediatrics	£7.1m	£1.3m	17.8%
Intensive and Critical Care	£10.4m	£0.8m	7.5%
Urology	£4.2m	£0.8m	18.2%
General Surgery	£15m	£0.4m	3.0%
Respiratory Medicine	£11.9m	£0.4m	3.3%
Diabetic Medicine	£4.0m	£0.4m	8.9%
<b>Top 10 areas total</b>	<b>£154m</b>	<b>£21.7m</b>	

# Appendix 7:

## Cross cutting themes for efficiency schemes:

Theme	Focus
Procurement	Obtaining best value and reducing transaction costs.
Premises	Review estate utilisation, letting to Commercial and NHS Partners. Disposal and re-configuration of under-utilised or inefficient estate.
Paybill	Terms and conditions, premium payments, agency usage, skill-mix, rostering, duplication
Back-Office	Duplication, value added, local vs central, processes and systems
Commercial	Developing new commercial income streams e.g. services to external bodies (e.g. NHS Fleet Solutions), extended employee benefits (e.g. salary sacrifice schemes, home computing).
Capital Investment	Sharpen and prioritise investment linked to future payback (lower costs, income stream)
Service Integration	The synergies resulting from the integration of Acute and Community services
Clinical Efficiency	Length of stay, cancellations, theatre utilisation, service line reporting metrics, reducing DNAs, minimising marginal costs of additional activity