University Hospitals of North Midlands
NHS Trust

Summary of Final Annual Plan
2015/16

29 May 2015
1. Strategic Context and Direction

The Trust is working towards becoming an FT within the next 3-4 years in the context of a challenged local health economy. In order to achieve this it needs to address the following key strategic issues:

- Achieve faster flow through the RSUH site in order to not only hit A&E targets but also to protect elective capacity which generates positive financial contribution. It is actively working with local commissioners to achieve this and has been asked to assume responsibility for the step down pathway from acute care in order to reduce the number of medically fit for discharge patients.
- To successfully integrate the County Hospital into its operations through accelerating the implementation of the TSA model by mid-2015. The County Hospital also offers the opportunity to offer protected capacity for day cases and short stay planned work along with specialist rehabilitation services.
- In addition to these two challenges the Trust needs to continue to expand its tertiary capabilities and capacity to service the population of the North West Midlands, North Wales, South Manchester and the northern suburbs of Birmingham.

As part of the TSA settlement the Trust is investing in a lot of new infrastructure. The big challenge is to attract and retain sufficient staff to utilise this capacity to its full extent. Whilst RSUH runs at an agency rate of approximately 5% of staff we inherited a position at County of 20%. Plans have been put in place to reduce this to the RSUH level or below.

Over the past 12 months the Trust has developed a stable and experienced board which is well placed to play a leading role in developing health services across the local health economy (LHE) and meeting these challenges. Alongside this the Trust has moved towards its belief in a clinically led organisation with the creation of four clinical divisions led by experienced clinicians supported by appropriate infrastructure to ensure the divisions succeed.

With the completion of the integration of County Hospital with RSUH and the demise of the Local Transition Board which has overseen the implementation of the TSA proposals, it is essential that a new pan Staffordshire structure is established to agree a clinically and financially sustainable model for the county. The TSA model for County Hospital was not sustainable and the financial challenges facing Staffordshire will continue to grow beyond those detailed in the recent KPMG report unless a timely solution is found, not only for County Hospital but for the wider Staffordshire health economy. The Trust will work with the CCGs, NHS England and NTDA to develop a clinically and financially sustainable model, but cannot do this by itself.

The Trust has consulted on a longer-term vision for the development of our services and the “2025 Vision” was agreed by the Trust Board in October 2014.
The Trust ensures that the vision is taken forward by ensuring a clear thread from the overall vision to the strategic objectives derived from that vision, and through to the shorter-term critical success factors towards the longer-term vision which in turn are translated into specific and measurable actions in our plans (see diagram).

The Trust Board has reviewed and refreshed the Strategic Objectives and Critical Success Factors at the 2015 March Board meeting.

The 5 strategic objectives are:
1. Delivering quality excellence for our patients
2. Delivering our obligations to the taxpayer
3. To achieve excellence in education, training and research
4. Create an integrated, vibrant Trust and develop strategic alliances with neighbouring Trusts and partners
5. Create a resilient Urgent and Emergency Care System and increase Integrated Healthcare Provision

Table 2 shows the objectives the critical success factors, and the key delivery mechanisms for each one.

<table>
<thead>
<tr>
<th>Strategic Objectives</th>
<th>Critical Success Factors</th>
<th>Key Delivery Mechanisms</th>
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</table>
| SO1 Delivering quality excellence for our patients | 1.1 Patient experience will be in the top 20% of all NHS hospitals by 2016/17  
1.2 Reduce avoidable harm by a further 20% by 2018  
1.3 HSMR and SHMI to be 80 by 2017/18 | Patient Care Improvement Plan (PCIP)  
Proud to Care Programme  
Sign up to Safety Programme |
<table>
<thead>
<tr>
<th>Strategic Objectives</th>
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<tr>
<td>SO2</td>
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| Delivering our obligations to the taxpayer | 2.1 Achievement of I&E plans set over 3 years to secure breakeven – income and expenditure  
2.2 Delivering the CIP Programme of £85m by 17/18  
2.3 Achieve continuity of service Liquidity risk rating of 3  
2.4 Delivery of the £100m capital programme to time and cost over 3 years | Integrated Business Plan  
Annual Plan  
Marketing Strategy  
Capacity Plan  
Commissioning intentions  
Provider relationships  
CIP Programme  
Service transformation plan  
Commercial Strategy  
Procurement Strategy  
People Strategy  
Liquidity Strategy  
Capital Strategy |
| SO3                  |                          |                         |
| To achieve excellence in education, training and research | 3.1 To deliver £5 million grant income by 2018/2019  
3.2 To deliver £5m commercial trial income by 2018/19  
3.3 To be rated in The Guardian Undergraduate Training Survey in the top 5 for 2014/15 to 2018/19.  
3.4 To be seen by Health Education England, Keele University as the top performing postgraduate medical teaching and undergraduate teaching organisation by 2017/18.  
3.5 80% of staff rate their teaching and education as excellent by 2016/17. | Research Strategy  
Learning and Education Strategy |
| SO4                  |                          |                         |
| Create an integrated, vibrant Trust and develop strategic alliances with neighbouring Trusts and partners | 4.1 Full delivery of TSA model by 2017/18  
4.2 Increase number of staff recommending the Trust as a place to work  
4.3 Sustainable vision for a thriving County Hospital  
4.5 Marketing strategy to grow local elective share by 2% and overall market share in our specialised catchment area by 2% per annum. | Service Transition Plan  
People Strategy  
Annual HR Plan  
Local Health Economy Planning Group  
Integrated Business Plan  
Marketing Strategy  
Annual Plan |
<table>
<thead>
<tr>
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<th>Critical Success Factors</th>
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<tr>
<td>SOS5</td>
<td>5.1 Deliver 92% bed occupancy or less</td>
<td>Ambulatory Care Strategy</td>
</tr>
<tr>
<td>Create a resilient Urgent and Emergency Care System and increase Integrated Healthcare Provision</td>
<td>5.2 System wide demand and capacity plan</td>
<td>OD Strategy</td>
</tr>
<tr>
<td></td>
<td>5.3 High quality Major Trauma Centre</td>
<td>Clinical Leadership Strategy</td>
</tr>
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<td></td>
<td>5.4 Deliver the 95% 4 hour standard sustainably</td>
<td>Length of stay reduction plan</td>
</tr>
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<td></td>
<td>5.5 An integrated ‘home first’ culture</td>
<td>Admissions reduction plan</td>
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<td></td>
<td></td>
<td>System-wide demand and capacity plan by 2015/16 - 2017/18</td>
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<tr>
<td></td>
<td></td>
<td>Sturgess Report 6 measures (in hospital)</td>
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<td></td>
<td></td>
<td>Deliver 6 OOH Sturgess recommendations</td>
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Both the overall Trust Plan and the Divisional Plans have therefore been agreed to:

- Demonstrate explicit links to the Strategic Objectives and Critical Success Factors of the organisation.
- Demonstrate key performance indicators and SMART plans for track delivery.
2. Quality and Safety

2.1 Our Approach

This is now our third year of intense focus on quality improvement with our Patient Care Improvement Programme setting out clearly our priorities, namely:

- Patient experience will be in the top 20% of all NHS hospitals by 2016/17
- Reduce avoidable patient harm by a further 20% by 2018
- HSMR and SHMI is 80 by 2017/18.

Our core vision continues to be a leading centre in health care, driven by excellence in patient experience, research, teaching and education, our overall ambition is to equal or exceed the best performing Trusts in England. We will achieve our vision by setting challenging standards and placing quality at the heart of everything we do, ensuring we place the interests of patients ahead of individual or organisational ambition.

Our aim is to provide safe, clean and effective person centred care to every patient, every time. To achieve this we recognise that we must:

- Build stronger clinical leadership
- Provide valid, reliable and meaningful information as a basis for measurement
- Build greater capacity and capability of our staff to interpret the information and implement sustainable change
- Embed our Clinical Assurance Framework.

In 2015/16 we have set and will focus on, five core patient safety, outcome and experience priorities to drive our improvement goals set above.

2.2 Improve Patient Experience, ensuring we are in the top 20% of all NHS hospitals by 2016/17

Our ambition is that our patients experience is the best it can possibly be. Our priorities have been identified through feedback from our patients though complaints, focus groups, clinical audit, national and local patient and public surveys. Our focus is to ensure:

- care is delivered with privacy and dignity, in a clean, safe and comfortable environment
- care is delivered in a timely way that manages our patients condition or supports a dignified death according to their individual needs
- staff listen to patients and their relatives/carers and provide emotional support
- patients are given appropriate and timely written and verbal information on which they can make informed decisions.
Improvements to address these areas are detailed in the Divisional Patient Experience Improvement Plans. The key themes include:

- To manage patients pain effectively
- To ensure patients are given a choice in relation to nutrition
- To provide clear written information to patients about their medication and side effects
- To ensure patients are informed about what they could expect after their operation or procedure and what they should or should not do after leaving hospital.

In addition to this the Trust is reviewing all patient information with the intention that all diagnostic and procedural information is harmonised as far as possible across the Royal and County Sites.

On-going measurement of these themes will be achieved through the in year in patient survey and improved use of the Friends and Family Test.

2.3 Reducing avoidable harm

Our ambition is to continually reduce errors of all kinds and promote reliability and sustainability. We will abandon blame as a tool and we will actively listen to our staff and encourage them to speak openly about their concerns or when things go wrong and therefore learn from mistakes. Our focus will be on:

- Eliminating avoidable hospital acquired pressure ulcers
- Reducing falls by a further 5 % from 2014/15 levels
- Eliminating avoidable hospital acquired infections
- Eliminating hospital acquired VTE
- Reducing medication errors and omission of medication.

Reliability will be achieved through the extensive use and audit of packages of care including:

- Sepsis Care Bundle
- Falls Bundle
- Skin Bundle
- Ventilator Acquired Pneumonia Care Bundle
- Amber Care Bundle
- Acute Kidney Injury Bundle.
The wards have specific improvement plans to reduce harm which are measured through the ward indicators and overseen by our trust-wide and divisional quality and safety forums. In addition, the Trust is currently investing heavily in information technology to support this agenda with a new electronic prescribing system and a clinical handover system.

2.4 Reducing our HSMR and SHMI to 80 by 17/18

Achieving best outcomes for our patients requires us to provide care which is safe and based on recognised best practice and evidence. We will achieve this by:

- Using the clinical audit programme to inform improvement and management of clinical risk
- Using national outcome measures to inform ourselves, our commissioners and the community we serve about our performance
- Investing in or changing clinical services, processes and systems where these directly or indirectly improve clinical services
- Ensuring the timely availability of specialist skilled staff working as a team to improve outcomes
- Building further on a research culture and encouraging involvement in and leading research on clinical outcomes
- Developing excellent clinical teams which work together to improve outcomes.
3. Delivery of Operational Performance Standards

3.1 Overview 2014/15

The overwhelming theme across the Royal Stoke in 2014/15 was that the demand for services increased. The number of patients choosing the Trust for their treatment and care increased, and the Trust in turn expanded services where possible to meet this demand. A clear indicator of this was the 46,000 increase in outpatient appointments and an additional 3,500 day case procedures performed.

The Trust has failed to deliver on a number of operational targets from January to March 2015, and this has continued into April 2015. The following targets were delivered:

- Access standards – continued achievement of the 18 weeks non-admitted standard and no patients waiting over 52 weeks
- The national cancelled operations standard ensuring no urgent operations are cancelled for a second time and cancelled operations rebooked >28 days
- Four out of eight national cancer standards.

However, the standards not achieved were:

- 18 weeks admitted and incomplete pathway standards
- A&E 4 hour wait standard
- 12 hour trolley waits in A&E
- Diagnostic tests >6 weeks
- Four out of eight cancer standards for:
  - 31 day - First treatment and subsequent surgery
  - 62 day GP referral, 62 day screening.

There are a number of root causes around this, they are:

- There remains too many acute admissions to the acute sector and we must address better admission reductions into the hospital, particularly Royal Stoke
- There is a paternalistic attitude that patients need to stay in hospital rather than go to their place of residence. This causes harm to frail, elderly patients who stay in too long because we refer on to community beds, nursing and residential homes, which mean they lose their physical and cognitive functions
- There are significant shortfalls around the number of GPs and community staff available to provide out-of-hospital care at the scale needed
- The Trust has reviewed and is addressing wasted time for patients in beds each day where nothing happens, key areas of focus include; slow speciality opinions, discharge planning, internal referrals within the multi-disciplinary team which increases lengths of stay on our wards.
Outside our admission portals in A&E/FEAU/SAU there is a culture of waiting for patients to be pushed to specialty wards rather than these speciality teams taking ownership of patients and actively pulling their patients out of these areas. This is being addressed.

### 3.2 2015/16 Overview

The Trust has plans to increase the size and scale of its services further and these figures will continue to grow in 2015/16. The activity in the 2015/16 plan (see table below) is set at a level to address the outstanding waiting list and backlog issues.

<table>
<thead>
<tr>
<th></th>
<th>14/15 Forecast Outturn</th>
<th>Growth</th>
<th>Waiting List / Backlog</th>
<th>Other</th>
<th>TSA Activity</th>
<th>15/16 Demand</th>
</tr>
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<tbody>
<tr>
<td><strong>A&amp;E</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>A &amp; E</td>
<td>129,488</td>
<td>0</td>
<td>0</td>
<td>-5,363</td>
<td>33,933</td>
<td>158,059</td>
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<tr>
<td><strong>Elective</strong></td>
<td></td>
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<td></td>
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<tr>
<td>1 Day Case</td>
<td>60,926</td>
<td>1,913</td>
<td>2,759</td>
<td>-289</td>
<td>12,447</td>
<td>77,756</td>
</tr>
<tr>
<td>2 Elective</td>
<td>14,289</td>
<td>317</td>
<td>745</td>
<td>272</td>
<td>1,973</td>
<td>17,597</td>
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<tr>
<td>3 Regular Day Case</td>
<td>403</td>
<td>11</td>
<td>0</td>
<td>2,898</td>
<td>1,937</td>
<td>5,249</td>
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<tr>
<td></td>
<td>75,618</td>
<td>2,242</td>
<td>3,504</td>
<td>2,880</td>
<td>16,357</td>
<td>100,601</td>
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<tr>
<td><strong>Non Elective</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Non Elective</td>
<td>89,316</td>
<td>2,215</td>
<td>0</td>
<td>-1,451</td>
<td>14,178</td>
<td>104,258</td>
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<tr>
<td><strong>Outpatients</strong></td>
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<td>7 New</td>
<td>172,392</td>
<td>4,660</td>
<td>7,382</td>
<td>6,122</td>
<td>32,888</td>
<td>223,444</td>
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<tr>
<td>8 Follow Up</td>
<td>329,260</td>
<td>7,488</td>
<td>29,715</td>
<td>29,431</td>
<td>81,069</td>
<td>476,962</td>
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<tr>
<td>9 OP Procedure</td>
<td>69,156</td>
<td>722</td>
<td>116</td>
<td>10,394</td>
<td>18,249</td>
<td>98,637</td>
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<tr>
<td></td>
<td>570,808</td>
<td>12,870</td>
<td>37,213</td>
<td>45,947</td>
<td>132,206</td>
<td>799,044</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>865,230</td>
<td>17,327</td>
<td>40,718</td>
<td>42,013</td>
<td>196,674</td>
<td>1,161,962</td>
</tr>
</tbody>
</table>

The figures above include:

- Growth assumptions and service developments in 2015/16
- Additional capacity available for 15/16
- Delivery of all operational waiting time targets and reduction of waiting list backlogs
- Impact of implementation of the “Physician of The Week” model that was introduced into medicine in order to speed up discharges during 2014/15. This has resulted in a loss of physician capacity for planned work. The impact of this has been separately identified in the ‘other’ column.
3.3 2015/16 Improvements

The annual plan envisages that we will deliver diagnostic tests and 31 & 62 day cancer targets by June 2015, the 18 week admitted performance target by early Autumn 2015. The delivery of the A&E 4 hour target remains a challenge, however positive steps are being taken within the Local Health Economy (LHE) and the Trust:

- A decrease in the average length of stay from 5.1 days in December 2014 to around 4.3 days in March 2015
- An increase in the number of community beds from February 2015 to restore these to October 2014 levels. The commissioner step down and step up initiatives should reduce the number of community beds from the winter peak based on improving patient flow through the whole system
- A significant reduction in under 75s length of stay
- A rise in simple and timely discharges by more than 20% from the same period last year
- An expansion of domiciliary care capacity with AMG, a private sector domiciliary care provider. This capacity needs to be incorporated as part of the step down model described in more detail below
- The creation of discharge to assess pathways as part of the process adopted to improve long term care planning across the system.

The Trust has worked with clinical teams to develop clear admission reduction plans and length of stay reduction plans to secure and build on the gains above.

Taken together these plans should allow significant improvement to secure delivery of the 95% standard.

The Trust is committed to achieving all operational standards in 2015/16 and progress against delivery will be monitored through the Trusts Performance framework. The key challenges for 2015/16 are:

3.4 A&E /Emergency Flow

The solutions to the A&E performance include:

- Seeking to support all clinical specialties to reduce admissions by investing in out of hospital and community services. For example, we admit 1,374 patients with COPD
per annum but could reduce these by more than 800 if we invested more in community respiratory nurses – we are doing so. If we reduce admissions by 25 per day – less than 10% of total emergency, admissions per day - we would release 100 beds per day. We have secured commissioner support to bring together under UHNM leadership three high admission pathways across acute and community resources in respiratory, heart failure and diabetes. This will give the Trust greater responsibility and risk in managing these admission areas down over 2 – 3 years.

- Continue to improve internal ward processes eg. test and imaging turnaround times, early discharge planning, pharmacy in order to shift forward the daily discharge profile to earlier in the day.

- Despite good length of stay overall, we have specialties who could and must do better. This is about clinical leadership, well organised multi-disciplinary teams and a focus on the consultant as lead for discharge. If we reduce our average length of stay by just one day across the Trust, we would release 70-80 beds per day.

The evidence base tells us we could achieve these, but it requires a change in culture. We should no longer admit to decide but admit to treat and intervene – seeing each patient as almost a day case patient. We are working with all specialties on their length of stay reduction plans and admission reduction plans to secure change.

The Trust has put in place an Emergency and Urgent Care Improvement Board to oversee the implementation of the Trust’s “home first” policy. This includes membership from across the Division of Medicine including all senior clinical leaders and is chaired by the CEO/Chief Operating Officer (COO).

At the Trust’s request, Dr Ian Sturgess undertook a rapid review of the LHE processes to support the quality improvement programme in urgent care. The outcome of which recommended 12 high impact actions and six ‘set up’ systems that need to be put in place now and managed to ensure delivery of impact. An event was held in February 2015 with clinical and executive leaders from across the system to feedback the review findings and gain sign up to take the recommendations forward.

- Our ratio of admission per 1,000 patients is amongst of the highest in England but we have areas with similar deprivation admitting much less.
- Historically when we increase the number of beds our length of stay goes up.
- A recent survey of the small number of wards using the red/green day tool showed that circa 50% of patients stay were red rather than green days. It is intended to roll out this tool to raise awareness across wards and encourage managers to tackle the delays.
- The discharge processes are too risk adverse, complicated and consultants are not consistently responsible for delivery of it on medical wards.
There are some excellent wards in the Trust who discharge high levels per week but even in the same speciality others who do not. This suggests a culture which is not standardised around delivery quality excellence for patients. In cardiology, the service is seeing 100 more patients per month in the last three months – its length of stay has reduced and it has fewer beds than three months ago. Consultants work with many other staff but take responsibility for their admitted patients until discharge. This contrasts with certain medical specialities where patients may, in a 4-5 day, period be looked after by 2-4 consultants in a single stay. It is intended to replicate the clear lines of responsibility evidenced in cardiology across other specialties.

Discharge to Assess (D2A) is being rolled out at pace with the implementation of three pathways, resulting in over 25% now discharged through the process, an average of 50 patients per week. In addition, the Trust continues to implement its plans for Ambulatory Emergency Care, which is due to commence as a service in September 2015. This will become the default service for medical patients, with a shift away from the acute emergency service, where clinically appropriate.

In order to achieve sustained improvement of the emergency pathway and target delivery, the LHE have implemented a programme management approach to ensure consistency and alignment of plans, robust project management and implementation and monitoring of delivery. A programme brief was presented and approved by the SRG in March along with a draft programme plan.

3.5 18 Weeks

Since 2013/14 the Trust has had a strong reputation and track record for delivering the 18 week standards however, since December 2014, emergency demand and the consequent reduction in the Trust’s elective programme resulted in the number of patients waiting over 18 weeks rising to over 2,500 at the end of Q4.

The plan will achieve sustainable 18 week pathways in the majority of specialities going forwards, with the exception of General Surgery, T&O and Gynae, who will still have a significant volume of over 18 weeks. These services will continue to implement longer term plans to reduce their waiting times. The impact of the Cannock workload from July 2015 as per TSA model is currently being assessed.

Surgery, T&O and gynaecology will increase the use of County Hospital for day case patients where we have capacity unused. This will increase day case volumes in the Trust by 100 per week. We are also outsourcing over 400 patients in these services to Rowley Hall to provide a more responsive service to our patients. We will be investing in additional physical estate and day case and theatre capacity linked to our recruitment to open four more theatres in 2015/16 to ensure service sustainability.

The activity in the 2015/16 submission is set at a level to address the outstanding waiting list and backlog issues and to achieve the overall 18 week RTT by early Autumn 2015.
3.6 Cancer

The Trust needs to improve on cancer 31/62 day targets. The Trust is focused on delivery of a number of internal standards within the cancer diagnostic phase of the pathway, and ensuring services have sufficient capacity in place across the whole pathway to meet growing demand levels. The Trust should deliver the standard from 31st May 2015. The remedial action plans that are in place are:

- A demand and capacity tool for two week wait referrals, in line with IMAS best practice principles, and used on a routine basis to highlight and respond to shifts in demand patterns.
- Demand and capacity planning in response to national and annual cancer campaigns.
- Escalated performance management arrangements to ensure patients progress through the pathway in a timely manner.
- Robust performance information to support operational delivery of the cancer pathway and to ensure visibility and oversight of performance by the Executive Team.
- Oversight of cancer performance and of delivery of actions through the weekly governance structure for access within divisions, in addition weekly oversight by the COO and Divisional Associate Directors (ADs).

To support sustainable achievement of the target from May 2015 onwards the Trust is taking further action, including:

- The Surgical Divisional Team and the Cancer Services Team have met with all cancer clinical leads during March/April 2015 to ensure full clinical ownership of cancer performance and to change systems to ensure that improvement against the standards continue are embedded in the MDT process.
- A Cancer Clinical Lead Forum has been established and will take place on a monthly basis from May 2015 onwards. This is chaired by the Clinical Director for Cancer Services and the Chief Operating Officer to ensure that agreed improvements are driven forward.
- An overview performance report has been developed for each cancer site, with the expectation that this is presented and discussed at weekly MDTs.
- Weekly meetings between directorate team, clinical lead, CNS and cancer co-ordinator to review the forecast position and identify pathway delays.
- Capacity constraints remain a challenge however, in two key pathways – lung and urology. Specific actions plans have been developed for these.
- The Cancer team is relocating to sit within the Surgical Division to improve communication and allow further embedding within Clinical forums.
3.7 Diagnostics 6 weeks

The Trust under achieved the maximum six week wait diagnostic standard in three out of four quarters in 2014/15. Demand and capacity pressures within MRI, paediatric sleep and gastro, have affected delivery of the target. The Trust has implemented robust remedial action plans within these areas, such as increasing MRI capacity and expanding paediatric sleep services, to increase capacity and improve trajectories, which have been agreed with the NTDA. The Trust should deliver the standard from 31 May 2015.

There will be significant investment in MRI with new scanners commissioned at County and Royal Stoke in 2015/16 along with extended opening hours. Alongside this there is service investment in key bottlenecks funded in the plan to address diagnostic waits.
4. Workforce Plans

4.1 Introduction

The Trust is developing as a clinically led organisation and has communicated its clear vision to be a world-class centre of clinical and academic achievement, where staff work together to ensure patients receive the highest standards of care and the best people want to come to learn, work and research.

The workforce underpins achievement of all the strategic objectives set out in section one with some key critical success factors identified:

3.3 To be rated in The Guardian Undergraduate Training Survey in the top 5 for 2014/15 to 2018/19.

3.4 To be seen by Health Education England, Keele University as the top performing postgraduate medical teaching and undergraduate teaching organisation by 2017/18.

3.5 80% of staff rate their teaching and education as excellent by 2016/17.

4.2 Increase number of staff recommending the Trust as a place to work.

4.3 Sustainable vision for a thriving County Hospital.

The Trust’s People Strategy outlines how the Trust will lead and support its staff to achieve this vision based around six overarching objectives:

1. Implementing effective Organisational Development to deliver the Trust’s vision.

2. Enabling the delivery of effective workforce plans to support the recruitment of the right people, in the right numbers at the right time to deliver safe, high quality patient care.

3. Enabling Change through innovation, transformation and productivity improvement to secure a stable future.

4. Improving Workforce Information and HR Governance to ensure that we have the tools and technology to understand the nature of our workforce and support our decision making.

5. Improving and maintaining learning, leadership and development to continually enhance opportunities for staff to progress their careers and further develop their skills to be at the leading edge of healthcare provision.

6. Supporting improvements in Staff Wellbeing, Reward and Recognition to offer excellent staff experience at work and become an employer of choice.
In working towards this vision, the key changes to the workforce will arise from:

- Full integration and reconfiguration of County Hospital and Royal Stoke Hospital services
- Marketing/growth opportunities to ensure business expansion across majority of clinical areas.
- Development of strategic alliances and partnerships.
- Increases in activity and demand for services.

A key element of this will be reviewing skill mix and job plans to lead to:

- A consultant delivered, seven-day service.
- Greater integration of health and social care services.

4.2 Quality Impact

The Trust’s Divisions produce operational workforce plans based on their activity and capacity projections, service developments, CIP plans and other plans, such as the transfer of services to community providers. These operational workforce plans form part of the annual business planning cycle and are subject to confirm and challenge sessions, as are other facets of business planning, to ensure all plans are aligned.

The operational workforce plans, which set out the staffing levels needed to deliver safe services, are triangulated against the Trust’s high level Workforce Plan, which is a financial model and sets out the workforce that can be afforded, thus ensuring as far as possible that our workforce is one which can enhance efficiency and productivity, build on business opportunities, and continue to deliver safe, quality services.

The difference in approaches between the way the Trust builds up its staffing requirements from the operational base and the financially driven model provided by the NTDA comprise the following reconciling factors:

1. As a matter of course the level of funded establishment is provided through the bank and agency staff due to staff shortages across differing areas.

2. The NTDA workforce model drives a large part of the CIP through savings in establishment costs. In the case of an extended Trust such as UHNM much of the CIP comes from greater productivity through providing additional service at marginal costs which require an increase in workforce.

3. The Trust is also striving to convert bank and agency and other premium costs into substantive posts which obviously represent better value for money.
4.3 Recruitment

The growth in activity required in 2015/16 poses major recruitment challenges for the Trust. Vacancies and growth between them would ideally require the recruitment of another 1,761 FTEs as set out in the table below:

<table>
<thead>
<tr>
<th>Recruitment Gap</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Establishment 31st March 2016</td>
<td>10621</td>
</tr>
<tr>
<td>Staff in Post 31st March 2015</td>
<td>8860</td>
</tr>
<tr>
<td>Vacancy / Growth</td>
<td>1761</td>
</tr>
<tr>
<td>Less unapproved growth</td>
<td>241</td>
</tr>
<tr>
<td>Expected vacancy level based on turnover plus adj for County (business as usual recruitment)</td>
<td>1520</td>
</tr>
<tr>
<td>Additional Recruitment Need (approved growth above normal recruitment levels)</td>
<td>399</td>
</tr>
</tbody>
</table>

This shows recruitment plans in place for between 50 – 70% of total recruitment needs overall. However, this will vary by staff group and specialty. The size of the challenge means that the use of agency and premium payments will continue in the medium term. Work is still continuing to establish the precise phasing of the divisional recruitment plan requirements. However, there are acute skill shortages in key areas such as theatres and critical care where alternative roles/role re-design will be necessary.

The Trust mitigating actions include:

- Rolling recruitment campaigns
- International recruitment for nursing and medical staff
- Building relationships with the military
- Use of apprentices
- Introduction of golden hellos/recruitment and retention premiums
- Theatres/critical care task force established
- Enhanced use of social media/marketing
- Review current staff in post versus establishment against productivity and need
4.4 Staff Engagement

Workforce capacity to deliver the pace of change – The 2014 NHS Annual Staff Survey shows the percentage of Trust staff saying they are able to contribute to improvements at work has improved to better than average (compared to other acute trusts nationally), although staff engagement scores remain average, staff motivation at work has remained below average and sickness rates have seen an increase.

To mitigate this risk, the Trust is reviewing its staff engagement activities, updating its Staff Health and Wellbeing Plan and providing further resilience training.

The Trust has a five point staff engagement plan structured around:

1. Values, culture and strategic alignment
2. Leadership, support and development
3. Reward, recognition and staff wellbeing
4. Clarity of roles, responsibilities, accountability and empowerment
5. Effective communication.

Key activities identified in the plan have been communicated out to all managers. Managers are expected to demonstrate leadership commitment to engaging staff in service delivery and service development.

4.5 Developing the Organisation

The Organisational Development Strategy is designed to ensure that the organisation has in place the capabilities in terms of systems, processes and skills and knowledge to support the delivery of the Trust’s vision and strategic objectives. It includes our mission:

“We will be a leading centre in healthcare driven by excellence in patient experience, research, teaching and education”

Our Organisational Development Strategy will enable UHN to achieve the following:

- Improvements in patient and staff experience and well-being
- Tangible improvements in patient outcomes aligned to Trust performance measures and NHS Outcomes Framework
- Development of the required capacity and capability across the Trust
- The continuous development of staff to improve productivity, support quality and financial management, innovation and transformation
- Improved leadership and a greater focus on flexibility to adapt quickly to new ways of working and new models of care.

The Organisational Development Strategy’s criteria for success are:

- Reduced sickness levels
- Improved Quality of appraisals
University Hospitals of North Midlands NHS Trust

- Post evaluation of programmes to ensure transference of learning into the workplace is having impact
- Improved Staff retention rates
- Improved organisational KPIs
- Improved staff survey results
- Ensure 95% of staff participate in a meaningful Trust and departmental induction by 2015
- Increased staff engagement.
5. Financial and Investment Strategy

The Trust has a plan with a deficit of £16.8m and a cash requirement of £55m (£42m PDC Capital and £12m PDC Revenue). The deficit figure takes into account the fully delivery requirement of £36m CIP in 15/16.

The plan does not reflect any commissioning changes that may occur as recommended by the Challenged Health Economy Review. The Trust is currently working with the North Staffordshire and Stoke-on-Trent CCG’s on Step up and Step Down provision however these schemes are not sufficiently developed to reflect within the financial position. Commissioners have accepted that these proposals will not be included in commissioned activity contracts until business cases, which will inform CVOs in year, are fully worked up and jointly approved.

2014/15 Outturn

For 2014/15 the Trust has delivered a surplus of £3.7m following the receipt of £17m non-recurrent deficit support. The Trust has been under significant operational pressure and has been on Major Incident status due to the unprecedented levels of demand on the ED and non-elective admissions. This pressure is expected to continue into the first quarter of the 15/16 financial year.

The Trust’s efficiency programme is a significant part of the Trust’s plans to return to a break-even position. The £30m CIP programme for 2014/15 has been delivered however £7m of this has been achieved non-recurrently.

2015/16 Plan

The delivery of the Stafford integration introduced considerable additional complexity to the annual planning process, both internally and externally.

Contracts for both the CCGs and NHS England have been finalised and signed off. Overall the UHNM plan is in line with the contracted activity and also reflects planned income CIPs and expected performance fines.

Risks

The main risks to the achievement of the £16.8m planned deficit in 2015/16 are:

- The extent of improvement in the health system unscheduled care transformation proposals required to support the LHE system plans, UHNM annual plan and the
basis of the contract with the commissioners. Achievement of these improvements is critical to delivery of 15/16 and 16/17 financial plans.

- A continuing increase in the underlying deficit from 2014/15 as a result of the increase in the non-elective demand for acute beds in the Trust.
- Any unforeseen issues arising as a result from the continuing County integration into the Trust.
- The impact of the Challenged Health Economy review on the Trust, which is not known at present as currently the final report has not been formally published and therefore no timetable for agreement and implementation is available.
- Delivery of the CIP target, currently £23.9m of the £36m planned saving has been fully identified.
- The Trust has opted for the Default Rollover Tariff and has assumed that this will be in use for the whole year. Any new tariff that may be agreed during the financial year could change the planned deficit. It is estimated that the risk is £2.5m loss of income for each quarter that a new tariff is imposed.

Capital

The Trust’s £207m capital programme over five years (from 2015/16) is based on the assumption that it will be funded by:

- £121m - depreciation on Trust funded assets
- £60m - new Public Dividend Capital (Agreed in the Acquisition and the Contingency Business Cases)
- £23m - PFI additions
- £3m - donated assets.

It is normal to re-prioritise capital plan in year and this will be done using the Trusts existing mechanisms i.e. Capital Investment Group, Trust Executive Committee and Finance and Efficiency Committee to obtain authorisation.

Cash implications

The forecasts are consistent with a requirement for additional cash, assumed to be funded through PDC Dividend Capital:

- £43m PDC Capital and £12m PDC Revenue in 2015/16.