North Cumbria University Hospitals

Medical Workforce Strategy
2014-19
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1 Executive Summary
Executive Summary

North Cumbria University Hospitals (NCUH) is a medium sized acute non-foundation Trust with University status that serves a resident population of approximately 327,500 across four North Cumbria districts (Carlisle, Eden, Allerdale and Copeland). The Trust provides a comprehensive range of secondary (District General Hospital) and some tertiary hospital services for elective and emergency patients, largely from its two main hospital sites, Cumberland Infirmary in Carlisle (CIC) and West Cumberland Hospital in Whitehaven (WCH), has 714 inpatient beds and employs approximately 4,272 people totaling around 3,214 full time equivalents (FTE) staff. Each year the Trust has approximately 400,000 patient contacts.

NCUH has a turnover of £230m, fixed assets of £175m and has historically struggled to achieve financial balance with a year on year reliance on external support to balance its books. Whilst the financial situation provided the stimulus for NCUH to seek acquisition the recent difficulties experienced by the Trust have not been purely financial and despite sustained efforts services in a number of areas have become increasingly fragile, with limited capacity including the permanent clinical workforce necessary to address the challenges faced. Sir Bruce Keogh’s findings, published in July 2013 resulted in NCUH being one of eleven Trusts placed into ‘Special Measures’, and in the Trust Development Authority (TDA) highest level of escalation, with progression of the anticipated acquisition halted until such time as sufficient improvement can be demonstrated.

Key concerns highlighted related to inadequate governance pace and focus of change to improve overall safety and experience of patients; slow and inadequate responses to serious incidents and a culture which does not support openness, transparency and learning; staffing shortfalls and workforce issues across both nursing and medicine which may be compromising patient safety; lack of support for staff and effective, honest communications from the middle and senior management level; failure in governance to ensure adequate maintenance of the estate and equipment and significant weaknesses in infection control practices.

In addition to these NCUH challenges, there are also numerous national and local drivers influencing the shape of the North Cumbrian landscape over the medium term, including ongoing significant national financial constraints; an ageing population and changing demographics; a need to address health inequalities within North Cumbria; the need to shift from secondary care to primary, community and social care investment; reduced reliance on trainee doctors for service delivery requiring an increased focus by Deaneries and GMC on training experience; changes to medical training with an increasing focus on subspeciality training led by the medical colleges; the requirement to meet 10 new clinical standards for 7 day working; technological advances, new drugs and an enhanced evidence base and implementation of NICE and other national standards; a changing regulatory landscape and an increasingly well-informed and engaged public which rightly
places escalating expectations on health and social care providers and the recently published **FIVE YEAR FORWARD VIEW** which outlines a Vision for the NHS over the next 5 years and emphasises the need to remain focused around the ‘triple challenge’ of Financial Stability, Quality and Patient Access that the NHS now faces and on the need to take decisive steps to break down the barriers on how care is provided between family doctors and hospitals, between physical and mental health and between health and social care.

In order to meet the challenges and pressure we face the Trust has embarked on a programme of transformational change which has included a strengthening of the Trust Leadership Team and the redevelopment of the Trust Integrated Business Plan. As part of this work we developed our Trust vision in partnership with our staff in early 2013 and are committed to the following:

**‘To provide person centred, world-class quality healthcare services’**

in order to deliver this vision the Trust is focusing on five key strategic objectives:

- Building the platform necessary for long term sustainable delivery
- Continuous quality and safety improvement
- Consistent achievement of all NHS constitutional standards, national and local performance targets
- Ensuring workforce capability and capacity
- Delivering long term financial stability

Fundamental to the achievement of the strategic objectives, constitutional standards and other national and local targets set out in the Trust Integrated Business Plan is a fit for purpose, full establishment, permanent medical workforce which has the clinical, managerial and leadership capability to transform the care delivered to our patients.

In delivering this transformation we face the following specific medical workforce key challenges, which must be addressed in and overcome through implementation of the medical workforce strategy:

**Current Establishment Medical Workforce Profile:** We need to address the difficulties in relation to the levels of temporary workforce within our establishment figures as not only is this a huge drain on the Trust financially, but there are significant quality implications relating to the current workforce profile.

**Employment Costs:** We need to focus on reducing the inflated employment costs of locum medical staff by 20% in 2014 in order to deliver a savings of £1.3M and move to more Trust-wide on call arrangements create a more sustainable and stable permanent workforce.
Medical Staff Age Profile as at 31st March 2014: Our Retirement Profile also shows major issues to be managed over the next five years in relation to some key clinical post holders, with an increased spike in individuals eligible to take retirement compounded by changes to pension rules.

Current service configuration and models of care: What is abundantly clear is that our current service configuration and models of care delivery cannot be sustained. It is critical that Care Closer to Home’ is now fully implemented with a service delivery and staffing model created that can be sustained in the longer term.

Unsustainable medical staffing rotas and clinically unstable working practices: Running two full DGH facilities geographically distant from each other and from tertiary/specialist support, as well as being expensive, has resulted in clinically unsustainable working practices and major difficulties in sustaining medical staffing rotas which we need to address.

Recruitment and retention of permanent medical staff: Of major concern is the difficulty in recruiting and retaining high calibre medical staff. A combination of Trust geography, structural configuration of services and past reputational issues both as an employer and a place for care has impacted our ability to recruit and retain the best team.

Improvement in productivity, costs and patient outcomes: Benchmarking by McKinsey has highlighted low consultant productivity and so in tandem with creating a stable and permanent workforce, productivity improvement and the implementation of cost controls must become a key area of focus for our clinical leaders.

Clinical skills development and maintenance: Maintaining multiple sites with low levels of activity and small teams on each site not only restricts both skills development and maintenance for experienced staff and training experience for junior staff but also increases professional isolation. As a result some services are operationally extremely fragile and so we need to build staffing models that ensure clinicians can work in a networked way across multiple sites to maintain clinical contact and expertise.

Medical staff health and wellbeing: Whilst we have improved in all aspects of the Staff Survey in the past year, we remain in the bottom 20% of trusts, and will need to ensure our medical staff benefit from greater health & wellbeing support to not only meet the recommendations of the Boorman report but also improve their health and wellbeing and attendance at work.

Medical staff engagement and culture: We currently have low levels of engagement with our medical workforce and the findings of Medical Engagement Survey and follow up focus groups must be addressed by re-engaging the medical workforce to work together on the solutions required.

All of which must be addressed as part of the implementation of this medical workforce strategy.
During the course of 2014 we have developed our medical workforce vision and we are committed to:

‘Working together to deliver the best in patient care’

and this vision which is underpinned by our organisation wide values:

- Put patients first
- Quality and safety is at the heart of everything we do
- Take personal responsibility and accountability
- Everyone’s contribution counts
- Respect each other

To deliver our vision we have set out three key workforce strategic goals:

**Develop Workforce Capacity**

**Develop Workforce Capabilities**

**Deliver Cultural Improvement**

And we will achieve our workforce goals by implementing three key strategies:

‘Improving the working lives of our people’

‘Improving effectiveness, efficiency and patient outcome’

‘Improving medical leadership and engagement’

In order to deliver the following key strategic outcomes:

**Improving the working lives of our people:** We build an engaged and motivated workforce that is aspirational in terms of its own development and work life balance and which always puts the patient first.

**Improve effectiveness, efficiency and patient outcome:** We will build a work environment where clinicians feel challenged professionally and in which they are given the freedom but also the accountability to deliver the best in patient outcome in the most effective and efficient manner possible.

**Improve medical leadership, accountability and engagement:** We will develop a model of clinical leadership where all clinicians are engaged in resolving the organisational challenges we face and who feel accountable and therefore responsible for driving the improvements in our service forward.
We are currently developing a comprehensive implementation plan to ensure delivery of this three year medical workforce strategy and the key actions, timelines, milestones and deliverables will be reflected in the Master Change Plan. In 2014 / 15 we have a number of priority actions identified and these are detailed below:

- Develop senior medical leaders (M2.15.3)  
  July 2014
- Develop Medical Workforce Strategy and sign off at CPG and Board (M4.2.1)  
  Nov 2014
- Medical Engagement of the strategy rolled out (M4.2.2)  
  Mar 2014
- Strategy roll out across the Trust (M4.3.1)  
  April 2014
- Medical Workforce Strategy fully rolled out (M4.3.1)  
  Sept 2014

Over the next three months we will develop a fully resourced implementation plan for the planning period 2015/16. This plan will identify interdependencies with other key Trust strategies, in particular the Clinical Strategy, Nursing Strategy, OD Strategy and Quality Strategy and will outline priority tasks, key milestones and deliverables and the resource requirements for successful implementation.

Ultimately the purpose of this medical workforce strategy is to develop a fit for purpose, full establishment, permanent medical workforce which has the clinical, managerial and leadership capability to transform the care delivered to our patients. In order to do that we must succeed in implementation and deliver on our promises. During the lifetime of this strategy we will have deliver following strategic outcomes:

**‘Improving the working lives of our people’**

- We will have a medical workforce model that provides the right mix of work in the right volume for our team.
- We will be an employer of choice enabling us to attract, develop and retain the best team.
- We will have reduced our lead time to recruit, our number of medical vacancies and the number of locum staff within the workforce.
- We will have created a training workforce and have deployed a number of innovative flexible resourcing models.
- We will be known for providing challenging professional and personal development opportunities for our people.
- We will be performance managing those teams that don’t deliver and rewarding those that do.
- We will have just in time culture with regard to incidents and will listen and act on the views, concerns and ideas of our people.
• We will have a culture of transparency, fairness and engagement at all levels within our Organisation.
• We will have improved the recording of sickness absence within the medical workforce and improved it through implementation of the staff health and wellbeing strategy.
• We will have robust services which ensure safe service provision at WCH in: acute medicine; obstetrics and gynaecology; paediatrics and surgery.

‘Improving effectiveness, efficiency and patient outcome’
• We will have appointed and developed Clinical Directors and fully implemented the triumvirate management team structure and improved patient outcome.
• We will have built a clinician led culture of innovation and improvement driven by information from patients, carers and clinical outcome.
• We will be working at a specialty level in co-operation rather than competition across the system to deliver patient pathways of care and improved outcome.
• We will have a flexible resourcing model and will have maximized our resource utilisation across professions so making better use of our clinicians, managers and nurses. (Cumbrian Production System)
• We will have implemented improved patient focused, integrated community care models.
• We will be delivering outcome focused patient care based to National standards of care (NICE).
• We will have a culture of accountability and delegating responsibility and the requisite levels of authority within our teams.
• We will have replaced locums with substantive recruitment in order to reduce staff turnover, reduce costs and improve ownership and accountability for service improvement and patient outcome.
• We will have service level agreements in place where required
• We will have improved medical productivity levels by reducing waste
• We will have delivered 18 week, diagnostics and cancelled operations targets.
• We will have improved access to quality individual information for all the medical workforce
• We will have implemented values based performance management and moved all medical staff onto the online ‘Clarity’ appraisal system.
• We will have a flexible, skilled and innovative workforce, with a focus on learning together to improve together.
‘Improving medical leadership and engagement’

- We will have implemented a medical staff leadership behavioural competency framework.
- We will have implemented a clinical managerial leadership model which will allow for greater clinical input into decision making and the co-leadership of services.
- We will have a fully effective Clinical Policy Group (CPG) who advise the Trust on key strategic issues.
- We will have High Performing Clinical Leaders.
- We will have delivered a new Consultant Program with a clear focus on leadership and management development.
- We will have reformed our medical staff committees to represent the collective views and opinions of all consultants SAS doctors and trainees in the Trust.

We will have improved medical engagement and so be delivering clinically service improvement and speciality led innovation.

There are of course a number of implementation risks:

- Failure to agree clinical strategy due to politics (gap between public and clinical expectation) – working closely with CCG. Public forums with Healthwatch, meet MPs, attendance at Scrutiny, open and honest dialogue about problems
- Failure to get out of special measures This will lead to administration
- Failure to be acquired: look for alternative partners, voluntary administration
- Failure to identify sufficient capacity and capability to make improvements: recruitment, locums etc
- Failure to recruit (change model of care)

But these risks will be managed through the development of mitigation plans and implemented as part of the wider NCUH transformational change programme.
2 Purpose and Scope of this strategy

The purpose of this strategy document is to outline the vision North Cumbria University Hospital (NCUH) has for its medical workforce, the strategic goals, key strategies, objectives and priority actions we have set ourselves and the strategic outcomes we will deliver.

The scope of this strategy relates to the medical workforce employed by NCUH. There is a separate workforce strategy contained within the nursing strategy which covers the nursing staff.
3
Organisation Context
3.1 Trust Profile

North Cumbria University Hospitals (NCUH) is a medium sized acute non-foundation Trust with University status that serves a resident population of approximately 327,500 across four North Cumbria districts (Carlisle, Eden, Allerdale and Copeland) in one of the largest geographically dispersed areas in England.

The Trust operates from two District General Hospitals, Cumberland Infirmary in Carlisle (CIC) and West Cumberland Hospital in Whitehaven (WCH), as well as from a midwifery led Birthing Unit at Penrith Hospital. The Trust provides a comprehensive range of secondary (District General Hospital) and some tertiary hospital services for elective and emergency patients, largely from its two main hospital sites and has 714 inpatient beds and employs approximately 4,272 people totaling around 3,214 full time equivalents (FTE) staff. Each year the Trust has approximately 400,000 patient contacts.

* Post-acquisition the combined Trust plans to provide a wider range of services as detailed in the Trust Integrated Business Plan.

The geographical and social characteristics of the county are very different from other rural and semi-rural areas in England and this has an important bearing on the health care economy. The population as a whole is isolated from the North East and North West conurbations where more specialised or tertiary services are provided: the travel distance and time from WCH to the nearest tertiary centre is one of the greatest in England (nearly 100 miles and 2.5 hours). This has implications for both patients and also staff.

NCUH has a turnover of £230m, fixed assets of £175m and has historically struggled to achieve financial balance with a year on year reliance on external support to balance its books. Given its financial position the Trust was unable to achieve foundation trust status as a stand-alone organisation and so sought an acquisition partner. Northumbria Healthcare Foundation Trust (NHFT) was selected as preferred bidder in January 2012 and acquisition remains a key priority in order to deliver organisational sustainability.
3.2 Key Challenges

Whilst the financial situation provided the stimulus for NCUH to seek acquisition the recent difficulties experienced by the Trust have not been purely financial and despite sustained efforts services in a number of areas have become increasingly fragile, with limited capacity including the permanent clinical workforce necessary to address the challenges faced.

Sir Bruce Keogh’s findings, published in July 2013 resulted in NCUH being one of eleven Trusts placed into ‘Special Measures’, and in the Trust Development Authority (TDA) highest level of escalation, with progression of the anticipated acquisition halted until such time as sufficient improvement can be demonstrated.

The key concerns highlighted were:

- Inadequate governance pace and focus of change to improve overall safety and experience of patients;
- Slow and inadequate responses to serious incidents and a culture which does not support openness, transparency and learning;
- Staffing shortfalls and workforce issues across both nursing and medicine which may be compromising patient safety;
- Lack of support for staff and effective, honest communications from the middle and senior management level;
- Failure in governance to ensure adequate maintenance of the estate and equipment;
- Significant weaknesses in infection control practices.
3.3 National and Local Drivers

In addition to these NCUH challenges, there are also numerous national and local drivers influencing the shape of the North Cumbrian landscape over the medium term, including:

- Ongoing significant national financial constraints
- Ageing population and changing demographics
- A need to address health inequalities within North Cumbria
- The shift from secondary care to primary, community and social care investment.
- Reduced reliance on trainee doctors for service delivery: recognising the changes to medical training with a reduction in trainee numbers and an increased focus by Deaneries and GMC on training experience.
- Changes to medical training with an increasing focus on subspeciality training led by the medical colleges.
- The requirement to meet 10 new clinical standards for 7 day working
- Technological advances, new drugs and an enhanced evidence base and implementation of NICE and other national standards
- A changing regulatory landscape and an increasingly well-informed and engaged public which rightly places escalating expectations on health and social care providers.

**FIVE YEAR FORWARD VIEW**: On October 24th 2014 the respective CEOs of NHS England, the TDA and Monitor published a joint Vision for the NHS over the next 5 years. The emphasis of this Vision was focused around the ‘triple challenge’ that the NHS now faces around Financial Stability, Quality and Patient Access and it is encouraging that many of the proposed strategies recommended to meet these challenges are already in the line of sight of NCUH and are reflected in the strategic objectives set in our Integrated Business Plan. Areas of attention in relation to the development of this Medical Workforce Strategy that have been highlighted are:

- The need to take decisive steps to break down the barriers on how care is provided between family doctors and hospitals, between physical and mental health and between health and social care. The vision set out sees a future with far more care delivered locally but with some services still remaining in specialist centres, organised to support people with multiple health conditions, not just single diseases.
The three potential new models of care underpinned by integrated organisation structures outlined:

- **Multidisciplinary Community Providers** which will permit groups of GPs to combine with nurses, other community health services, hospital specialists and potentially health and social care to create integrated out of hospital care.
- **Primary Acute Care Systems**: which will combine for the first time General Practice and Hospital Services.
- **Integration of Urgent and Emergency Care** involving a re-design of services to integrate A&E Departments with GP out of hours services, Urgent Care Centres, NHS 111 and ambulance services. In addition smaller hospitals will have new options to help them remain viable, including forming partnerships with other smaller hospitals further afield and partnering with specialist hospitals further afield.

In order to deliver these new models of care we must create a workforce that also extends to the workforces of our partner organisations and which has the capacity and capability to deliver this Vision, whilst at the same time retaining a clear focus on affordability and financial stability, the reduction of waste and the delivery of improved patient experience and outcome.

The Trust has recently re-developed its 5 year Integrated Business Plan which details its response to the short and medium term challenges it faces and the service improvement programmes that will be put in place in order to deliver performance improvements in not only quality, productivity and patient experience and outcome but also strengthen its financial position and stability.
3.4 Our Improvement Plan for the future

Given the challenges it faces, the Trust has implemented a short term improvement plan in order to ensure that the organisation remains stable and where improvements can be made prior to the acquisition that these are delivered swiftly.

Our key areas of focus have been:

1. Strengthening the management & leadership team
   - Appointment of a new Chair, Chief Executive and Executive Team and a number of Non-Executive changes.
   - Introduction of Clinically-led ‘business units’
     In addition to the Trust’s committee structure the Trust also has effective systems and structures within the Clinical Business Units to support the delivery of robust clinical governance. This is based on a ‘triumvirate’ model of the Clinical Business Unit Director (senior Clinician), Chief Matron (Senior Nurse) and Deputy Business Unit Director (Senior Manager) being in charge of clinical services. This is replicated at Board Level with the Executive Medical Director, Executive Director of Nursing and Director of Governance.

   - Establishment of a Trust Clinical Policy Group (CPG)
   - Delivery of a ‘High Performing Clinical Leaders’ programme
2. Improving Governance

- Introduction of a number of key policies supported with comprehensive staff training including:
  - Revised approaches to risk, incident and complaints management
  - A robust Mortality Framework
  - Weekly Safety Panels and a fully consolidated corporate risk register and Business Assurance Framework
  - An estates & equipment assurance programme

3. Tackling Clinical Performance

- Introduction of a new nursing structure and supporting acuity tool
- Improvements in standardised care with the introduction of ‘care bundles’ and decision making aids
- Improved consistent application of the National Early Warning Score (NEWS)
- Strengthened leadership, processes and tools for infection control
- Introduction of a new acute care physician (ACP) model with 7 day consultant cover 8am -10pm to manage acute admissions at CIC, and partial implementation at WCH; other 7 day working models introduced include physiotherapy, pharmacy and ambulatory care and occupational therapy.
- Key service changes to improve clinical outcomes including:
  - Centralisation of complex vascular, trauma and emergency orthopaedic surgery
  - Centralisation of all high-risk surgical procedures with dedicated and permanent surgical teams on one site available 24/7 ensures earlier clinical review and access to theatre.
  - Introduction of Northumbria’s award-winning patient experience programme
  - Implementation of a Board to ward – our “measuring to improve” project
  - Alignment of statutory and mandatory training to that of NHFT
4. Continuous Quality and Safety Improvement

Over the last 6 months the Trust has developed with staff a new Quality Improvement Strategy - Every Improvement Counts – with the aim of ensuring that all who work in our hospitals strive for excellence in all that they do and believe that the focus of the organisation is on providing safe care, which is responsive, caring and effective in terms of good outcomes for our patients.

Our Quality Strategy sets out six aims:

Our Quality Aims:

- To ensure that Quality underpins every decision
- To provide the safest health and care services to patients and service users
- To be recognised as a caring organisation locally, regionally and nationally
- To ensure Quality and best use of resources are not considered in isolation, but together through the concept of value.
- Attract, retain, support and train the best staff
- Develop an internationally recognised brand and build strong local and national relationship

Underpinned by four key strategic objectives:

Our key objectives for 2014-2019:

- Deliver a year on year reduction in mortality metrics across all our hospital sites.
- Ensure that level of preventable harm (Hogan methodology) remains below the 5% national average as per the Prism studies.
- Achieve and sustain the mandatory NHS Constitutional Standards, including Care Quality Commission Regulations.
- Improve how we ensure we evidence delivery of care in accordance with best practice and nationally recognised outcomes across our services. Achieve and maintain and where possible exceed our top decile position for patient and staff experience.
A Governance Framework that focuses on values and behaviours that need to be in place to enable the Board and Chief Executive to discharge their responsibilities for quality. The Trust Board’s responsibilities for quality are defined as threefold:

- To ensure that the essential standards of quality and safety are at a minimum being met by every service that the organisation delivers
- To ensure that the organisation is striving for continuous quality improvement and excellence in every service; and
- To ensure that every member of staff is motivated and enabled to deliver our quality aims.

Underpinning this are the enabling structures and processes required at and below board level which will lead to a Trust wide focus on and implementation of continuous Quality improvement. Those key processes and areas of focus within the strategy are set out as follows:

- Ensuring required standards are achieved
- Investigating and taking action on sub-standard performance
- Identifying and managing risks to quality of care
- Planning and driving continuous improvement
- Identifying, sharing and ensuring delivery of best-practice
The implementation of the key processes and supporting requisite values and behaviours will clearly have implications for the way in which we lead, manage and hold accountable our medical workforce. The key changes or improvements to our approach are identified under 5 key headings as outlined below:

**Our People**
- All staff will be asked to incorporate the organisational values that drive the quality strategy within their annual performance review and learning plans.
- All staff will be asked to evidence their participation in improvement activities, big or small, at a team or organisational level.
- All staff will be asked to feedback on the opportunities for improvement they see and our progress as an organisation in addressing them through our ‘We’re listening’ platform.

**Our Leaders**
- We will build leadership at all levels and at scale, with attitudes, purpose and resilience consistent with the strategy & vision.
- Clinical and management team leaders will see rigorous performance management linked to real consequences and staff rewards.
- Our Quality panels will oversee a sophisticated scheme of ward / team accreditation to create big incentives for front line teams to improve, with the aim of linking accountability to professional purpose and pride.
- Results will be displayed at the entrances to wards. Our Annual staff awards will celebrate our high performing individuals and teams.

**Our Care Teams**
- Our Care and Support Teams will be supported through a Team Based Improvement Plan to understand and measure current and future state, identify and prioritise opportunities for improvement, and then implement change.
- These plans may be significant stand-alone projects in their own right or quick small test cycles of change to test a great idea. Our intention is to develop leaders of change at all levels to support sustainability and spread.
Our Clinical pathways and Supporting Processes

- Each year we will focus on the redesign and improvement of Clinical Pathways or Supporting Processes to represent large cross system based work addressing our most important clinical priorities. These will be linked to the implementation of our clinical strategy.

- Our executive management team will agree these focused breakthrough pathways / quality programmes in line with our annual plan. This will allow for a “rational portfolio of projects” - with the scale and pace needed to achieve their aims.
Our organisational readiness to identify, share and ensure delivery of best-practice

- We must build a system of leaders capable of rapidly recognising, translating, and locally implementing change concepts and improved designs
- We will develop a Quality Improvement Council to help embed improvements and learning across NCUH
- We intend to strengthen our governance structure for quality improvement through the development of a QI (Quality Improvement) faculty formed by representatives of both Business Unit and Corporate function teams
- Our Executive management team will lead the way by themselves becoming coaches and sponsors to the necessary service improvement projects planned each year
- We will need to develop a faculty of 100 improvement coaches over the next three years all of whom can deliver and support implementation of the CLIC improvement methodology.

All of which will ensure we deliver our Quality Aims, Key Objectives and the following strategic outcomes:
- Improved mortality rate
- Improved patient experience
- Improved CQC inspection findings
- Improvements across all indicators of patient and staff survey.
3.5 Our Trust Vision and Values

Our vision, developed with our staff in early 2013 is:

‘To provide person centred, world-class quality healthcare services’

This means achieving provision of:
- Outstanding healthcare to improve the health and wellbeing of our local communities through consistent delivery of excellent clinical outcomes along closely integrated pathways
- First rate patient centred care
- Distinction in safety, quality and regulatory compliance and highly efficient care which is provided within our financial means.

In securing this we will:
- Build relationships and work in partnership with others, creating integrated care pathways which span the hospital sites, the community and homes
- Ensure we understand the distinctive and changing needs of our communities and continuously look for better ways of doing things, making use of health informatics to create integrated health information, and engaging with and listening to our stakeholders
- Modernise and optimise our estate, infrastructure and equipment, and align a capital plan to our strategic objectives
- Secure our long-term financial strength, deliver efficiency savings through well-tried approaches, and grow our income by ensuring competitiveness of our services.

Core to the delivery of this vision are our staff who we will support to ensure excellent staff experience, ensuring they are fully developed in order to build clinical business units which have the right capabilities and leadership. We will create trust and confidence in the senior leadership throughout the Trust so that we can attract, recruit and retain talent, and create the best education and training environment.
3.6 Our Trust Strategic Objectives & Key Priorities

The Trust is focusing on five key strategic objectives:

1) Building the platform necessary for long term sustainable delivery
2) Continuous quality and safety improvement
3) Consistent achievement of all NHS constitutional standards, national and local performance targets
4) Ensuring workforce capability and capacity
5) Delivering long term financial stability

*However, in the medium to long term, clinical financial and operational sustainability can only be achieved through the anticipated NHFT acquisition.*

3.7 Key Strategic Outcomes – What will it look like in 2019

- There will have been a reduction in reliance on in-patient care: more patients will be treated in community or ambulatory care settings involving NCUH staff directly supporting patients in their own homes, through support of primary and community teams, through high quality outpatient and ambulatory care services, and through integrated approaches to admission avoidance and early discharge. Our focus will be on supporting patients and their families with the “right care, at the right time, and in the right place”.

- For those patients who do require hospital inpatient care, high quality, safe and effective care with early senior assessment and rapid access to specialists and diagnostic tests will be provided, with timely onward referral for tertiary support where indicated.

- Delivery will be through ‘integrated’ teams, both multi-disciplinary and inter-provider/agency, which work to minimise duplication and maximise continuity and efficiency of care: our focus will increasingly be on prevention (both primary and secondary), and included within this as core practice will be patient involvement in proactive care planning and an emphasis on enabling self-management.

- Delivery of care will not just be technically excellent, but will be caring responsive and compassionate, tailored to individual needs and wishes at all times. This will enhance both patient and staff satisfaction: patients and families will meet staff who are proud of their work, and who have time to continually improve their services.

- The nature of the teams that our consultants work in will have changed: they will be larger and have partners in the community, they will work in different locations in the community and they will have a focus on prevention of hospital admission and public health.
Through our partnership in ‘Together for a Healthier Future’ will have discussed and implemented several new models of care:

- Primary Care Communities/Multidisciplinary Community Provider teams which will see GPs combine with nurses and other community health services and hospital, mental health and social care specialists to provide integrated out of hospital care
- Primary and Acute Care Systems which will combine general practice and hospital services.
- Integrated urgent and emergency care services integrating A&E, GP out of hours, urgent care centres, NHS 111 and ambulance services.
4

Our Medical Workforce Strategy

Fundamental to the achievement of the strategic objectives, constitutional standards and other national and local targets set out in the Trust Integrated Business Plan is a fit for purpose, full establishment, permanent medical workforce which has the clinical, managerial and leadership capability to transform the care delivered to our patients.

In delivering this transformation we face a number of specific medical workforce key challenges, which must be addressed in and overcome through implementation of this strategy.
4.1 Key Challenges

4.1.1 Medical Workforce Profile

The Trust and consequently its staffing is organised into four clinical Business Units, with clinical and non-clinical staff working in partnership to provide management leadership across each area:

- Emergency Care and Medicine
- Emergency Surgery and Elective Care
- Child Health
- Clinical Support

Current Establishment

Consultant Medical Staff Analysis: August 14

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As evidenced in the table above the need to address the difficulties in relation to the levels of temporary workforce within our establishment figures is crucial – not only is this a huge drain on the Trust financially, but there are significant quality implications relating to the current workforce profile. Locum performance can be variable, and whilst use of a Master Vendor contract should ensure minimum competency requirements are met, inevitably staff skills are not being developed to align with the specific requirements of the Trust and clinical team. In addition, over-reliance on locums has negative implications for continuity of care, supervision, support and training of juniors, and on provision of leadership for service improvement. The development of a strong, positive multidisciplinary team based culture is obviously challenged by a continual churn of temporary senior staff, which must be addressed.
4.1.2 Employment Costs

Consultant medical staff are all substantively appointed on 2004 Consultant Contract. The majority of substantively appointed Trust Doctors are on the Speciality Doctor Contract. Our current agency costs per month are £1.2m against a budget of £3.2m, with locums currently representing 14% of our consultant medical workforce. Our challenge and therefore our focus is to reduce the inflated employment costs of locum medical staff by 20% in 2014 in order to deliver a saving of £1.3M. Recruiting to all consultant posts currently filled with agency staff would save the Trust £6.24m, to then recruit up to establishment would cost £2.85m and so recruiting and retaining a permanent workforce not only offers organisational stability and ensures workforce capacity and capability but would also deliver an overall cost saving of £3.39m.

Negotiations to move to more Trust-wide on call arrangements have concluded successfully although the Trust has yet to open discussions in relation to implementation of all aspects of the national pay progression model. Discussions with staff side will commence shortly to strengthen NCUH appraisal and performance management mechanisms.

European Working Time Directive - Substantive Agenda for Change staff have a contractual requirement to advise of secondary employment. Whilst previous monitoring of junior doctors compliance has been patchy, most recent monitoring will be shortly reported to Workforce Committee, with any resultant actions being agreed and reviewed.

4.1.3 Medical Staff Sickness

The NHS Operating Framework requires sickness absence not to exceed a threshold of 3.5 % for the rolling year. The current recorded medical staff sickness rate of 1.79% certainly represents an under-recording. The full year effect financial impact 1.79% consultant sickness is significant: it would be up to £1.23m in wasted salary and require and estimated £1.57m to cover at agency rate card averages. Importantly sickness is a significant disruption to service provision. The Board is aware that each annual percent of absence across the Trust carries a 'sick pay cost' of about £1m and this is therefore an area for focus.

A range of measures are required to bring this indicator to an acceptable standard including a review of the absence management policy with staff side. Absence triggers for raising concerns with a staff member are not currently appropriate, and core HR processes such as return to work interviews, sickness reviews and looking flexibly at health capability to enable early return to the workplace require further attention. Investment in psychological support within Occupational Health is needed given the proportion of sickness absence due to mental health issues and spend on external support, and other approaches including fast track of physiotherapy will assist; EMT has recently approved an integrated Occupational Health service incorporating these
elements. The required cultural shift to a more supportive employment style will significantly contribute as will a focus on the health and well-being of staff.
4.1.4 Medical Staff Age Profile as at 31st March 2014

The age profile of the Trust poses some significant challenges over the next 5 years. Emphasis on growing the 16–35 years cohort will be essential, ensuring that individuals have generic skills to work across a number of settings, along with the right culture and behaviours conducive to delivery of our Trust objectives and the particular needs of our client groups.

Our Retirement Profile also shows major issues to be managed over the next five years in relation to some key clinical post holders, although they may potentially be retained post retirement in some capacity in line with flexible retirement options. The retirement profile is likely to look slightly different beyond 5 years with an increased spike in individuals eligible to take retirement:

![Age Profile Chart]

Changes to the rules on pensions has affected the age at which NHS professionals retire. In 2013 45% of NCUH resignations were due to retiral, so far in 2014 the equivalent figure is 64%.
4.1.5 Current service configuration and models of care

What is abundantly clear is that our current service configuration and models of care delivery cannot be sustained. It is critical that Care Closer to Home is now fully implemented with a service delivery and staffing model created that can be sustained in the longer term. A Draft Clinical Strategy to resolve these issues has been developed with options to transfer of high risk medical and surgical pathways from WCH to CIC, further development of WCH as a low risk elective centre, and the building of a flexible and modern staffing model using multi-disciplinary medical teams which see an increase in the role played by nurse practitioners nurse and a move towards shared roles within primary care was published in October 2014.

We will continue to work closely with partners in developing whole-system reconfiguration plans for sustainability in North Cumbria including options for hospital consolidation; acute reconfiguration and/or pricing modifications and the next phase of our joint work requires comprehensive modeling supported by a sense of urgency for change which is shared by all partners.
4.1.6 Unsustainable medical staffing rotas and clinically unstable working practices

Running two full DGH facilities geographically distant from each other and from tertiary/specialist support, as well as being expensive, has resulted in clinically unsustainable working practices and major difficulties in sustaining medical staffing rotas.

Current consultant contract on-call requirements mean that it is financially highly inefficient to run with a rota of less than 5 consultants. However, in practical terms recruitment is, and will become increasingly difficult. 7 day working requirements and other specific College requirements (for example, dedicated intensivists, 24/7 A&E ATLS trained consultant/middle grade presence) will add significantly to this challenge, although it is noted that proposed but postponed national contract changes may in part alleviate some of this pressure.

Frailty of WCH Medical Rota: as noted above the over-reliance on locums in Medicine at WCH is impacting on the Trust’s ability to provide an appropriately supervised high quality educational experience at WCH; the unfilled trainee posts (who provide a significant proportion of resident medical cover) from August 2014 now put in jeopardy the Trusts ability to maintain emergency medicine in its current form and the Trust is urgently pursuing operational risk mitigation plans to resolve this. These plans include strenuous efforts to appoint to the 9 gaps in training posts including locum recruitment, seeking support from the Deanery for provision of higher trainees pre consultant placement, and requests for assistance from neighbouring Trusts. This is in addition to rota and surgical support changes, the planned use of nurse practitioners and development of shared posts for GPs. The Trust is also ensuring robust contingency plans are developed for managing a ‘worst case scenario’ requiring changes to emergency flows in West Cumbria, and use of CIC overnight if unable to adequately close the gaps in rota. This risk is flagged as the highest risk for the Trust within our Board Assurance Framework.
4.1.7 Recruitment and retention of permanent medical staff

Overview of Consultant Establishment

Detailed accurate establishments for medical staff, with common coding and regular, accurate tracking against ‘master establishment’ is now allowing better management of the locum workforce and recruitment requirements. Use of a Master Vendor Contract (since February 2014) is expected to allow us tighter financial controls as well as ensuring basic competencies and other NHS recruitment requirements are consistently met.

Of major concern is the difficulty in recruiting and retaining high calibre medical staff. A combination of Trust geography, structural configuration of services and past reputational issues both as an employer and a place for care has limited trust ability to reduce the current reliance on locum medical staff, who currently represent 14% of the overall consultant workforce (please note that the agency locums are not evenly spread with a preponderance at consultant and resident level in specialties covering general medical on call, with more at WCH than CIC). One solution has been to recruit staff into NHFT with formal secondment (or honorary status) into NCUH within either single or joint organisation job plans and this has had a degree of success within some service areas. Use of newly trained nurse practitioners to replace some junior doctor presence will commence from August 2014.

The issues of onerous medical rotas and potential lack of clinical skills development in addition to having an impact on quality, productivity and patient outcome also has a significant impact on the attractiveness of posts and ability to recruit and retain consultants, particularly in consultant specialties where there are national shortages. This also means that whilst safety of services has been currently maintained these services are not necessarily resilient, with over-reliance on a few individuals, an ageing workforce, and with the potential that a single resignation may de-stabilise an already fragile service.

There is broad agreement that significant use of locums is not an acceptable long-term solution either financially or more importantly in terms of service quality and continuity. Middle grade recruitment is also challenged by similar issues, with onerous on-call requirements, inability to develop speciality skills and professional isolation. The inability to provide substantive consultant and middle grade support then threatens the provision of junior doctors.

Whilst a clinically sustainable model may be agreed in theory, where recruitment proves impossible and all avenues to address this have been exhausted, this in itself may make the model unsustainable in practice: it is therefore crucial to develop service models that are sufficiently attractive to potential staff to be deliverable.

Work is currently underway to attract and retain substantive post holders across medicine, nursing and allied health professionals (see Strategic Theme 4 and Section 8 in IBP). This
includes active work with the Deanery to ensure our junior doctors are well supported during their placements with North Cumbria. The recruitment and development of specialist nurses and allied health professionals is also a core strand of the sustainable workforce strategy (Section 8.3).

**Other Recruitment Strategies**

Strategies have included horizon scanning with on-going adaptation of approaches to support business outcomes. A major recruitment campaign was launched in April with significant media coverage and proactive communications. Recruitment activities have included participation in Recruitment Fairs (Glasgow, Manchester), new approach to individual post profiling and advertisement, and use of social networking and media promotions.

The Trust seeks to introduce more competency based recruitment methods which enable both individuals to make the right long term career choices, as well as the Trust to recruit individuals with the right skills, and behaviours to succeed in post. As part of this and in line with approaches being used throughout the NHS, NCUH is also implementing a system of Values Based Recruitment (VBR) whereby it seeks to attract and select students, trainees and employees whose personal values and attitudes align with those of the Trust and wider NHS. These values will also be an intrinsic part of the new appraisal scheme to help drive a positive change in the culture of the organisation, and will shape our future workforce.
4.1.8 Improvement in productivity, costs and patient outcomes

Service reconfiguration fully implementing Care Closer to Home (C2H) and beyond will be necessary to address staff recruitment, retention and agency issues, and reduce overall workforce numbers as the drivers for our pay costs are directly linked to the necessary stabilisation of our medical staff rotas and enhancement of our nursing workforce in line with Keogh recommendations.

Benchmarking by McKinsey has highlighted low consultant productivity and so in tandem with creating a stable and permanent workforce, productivity improvement and the implementation of cost controls will become a key area of focus for our clinical leaders supported by skills development in and implementation of the CLIC methodology / Waste Wheel.
4.1.9 Clinical skills development and maintenance

Maintaining multiple sites with low levels of activity and small teams on each site not only restricts both skills development and maintenance for experienced staff and training experience for junior staff but also increases professional isolation. In addition, increasingly consultants wish, and should be encouraged, to sub-specialise to enable improved outcomes for patients, with a range of skills provided across a team (note in this instance services such as general surgery, gynaecology, orthopaedics).

In turn the restricted skills development opportunity impacts the Trust’s quality governance arrangements and achievement of regulatory and emerging college standards. Although ‘buddying’ arrangements may address this issue in part, they are not cost effective in the long term and will not fully address the continuous professional development or consequent recruitment issues this situation creates. These problems have had a direct impact on recruitment and have led to major difficulties in retaining and recruiting staff with a subsequent over reliance on locums. As a result some services are operationally extremely fragile; this is particularly true of emergency medicine at WCH. The solution to this is for all clinicians to work in a networked way across multiple sites to maintain clinical contact and expertise.

4.1.10 Medical staff health and wellbeing

Whilst we have improved in all aspects of the Staff Survey in the past year, we remain in the bottom 20% of trusts, and will be focusing in on specific areas that we know (from Prof Michael West’s research) link directly to patient experience. Work must be completed to introduce learning from the Boorman Review and Dame Carol Black’s findings to support staff to improve their health and well-being, and improve attendance at work.

We need to work closely with staff side, the medical local negotiating committee (LNC), and staff focus groups to ensure our medical staff benefit from greater health & wellbeing support to not only meet the recommendations of the Boorman report but also improve their health and wellbeing and attendance at work.

The Trust will use a ‘back to basics’ approach to ensure individual objective setting is fully aligned to Trust and team objectives, with appropriate levels of both support and ‘holding to account’ by line managers becoming second nature within the organisation. Appraisal and job planning are key but need to part of an on-going process, not simply an annual event. The appraisal will be strengthened for all medical staff with the use of the “Clarity System” and a revised appraisal based on Trust values and objectives for all other agenda for change staff. Job planning and Leave planning will be improved by implementation of ‘Allocate’ e-job planning and leave requesting.
4.1.11 Medical staff engagement and culture

Following the publication and findings of the Medical Engagement Survey for NCUH the Trust commissioned some focus groups work during the period from July through to August 2014 to further explore the findings with a representative group of Doctors around the reasons for the current low engagement and their suggestions around the action required to create an improved culture of medical engagement. This work has highlighted a number of areas of concern and opportunities for improvement and these can be grouped under the following headings:

- Improvement in Leadership and Management style
- Improvement in Medical Leadership
- Improvement in communication styles and processes
- Clarity and engagement in the strategic direction of the Trust
- Medical staffing and improvement in Recruitment and Retention and Training and Development
- Improvement in Job Planning
- Creation of a supportive culture around patient safety
- Creation of time to engage

All of which must be addressed as part of the implementation of this medical workforce strategy.

4.2 Our Workforce Vision and Values

Our medical workforce vision, developed with our medical staff over the last few months is:

‘Working together to deliver the best in patient care’

a vision which is underpinned by our organisation wide values:

- Put patients first
- Quality and safety is at the heart of everything we do
- Take personal responsibility and accountability
- Everyone’s contribution counts
- Respect each other
4.3 Workforce Strategic Goals

To deliver our vision we have set out three key workforce strategic goals:

**Develop Workforce Capacity**

Detailed work is being undertaken to understand the exact medical staffing establishments and future (including 24/7 and rota) requirements; medical workforce issues at WCH (see 3.6.3) are an urgent priority. Detailed review plus necessary short to medium term medical workforce proposals and mitigation plans in advance of system-wide service changes being agreed through (North Cumbria Programme Board) NCPB (see 3.6.1) are currently being developed with support from the TDA. This includes use of other roles/ professions such as Nurse Practitioners and GPs.

**Develop Workforce Capabilities**

The Trust is committed to ensuring that staff can access appropriate training and development opportunities: whilst enormous strides have been made in relation to statutory and mandatory training, we now need to focus on developing skills specific to team requirements to enable service improvement. These need to focus on creating flexibility within teams and individuals to be able to adapt to changing requirements, developing individuals into new and innovative roles and ensuring staff are equipped for change through use of improvement methodologies. Key to this is work with partners, particularly through Cumbria Learning and Improvement Collaborative (CLIC). We will adopt an approach within the Trust for achieving change through use of the NHFT Quality Improvement Way and through use of improvement methodologies to support our teams on a journey of continuous improvement.

**Deliver Cultural Improvement**

Following work in 2013 to develop our shared values, cultural improvement has been a priority for the Trust and will continue to be, in acknowledgement of the time it takes to build confidence and disseminate new ways of working. This is not a task for our HR & OD colleagues alone – it is an intrinsic part of good leadership and emphasising our values and expectations must be part of leadership throughout the trust. We will take this forward through multiple mechanisms including our OD programme, medical and nursing engagement plans, new Nursing Strategy, our work with staff-side, appraisals and line management arrangements, senior team walk-rounds, team brief, Chief Executive Bulletins and other communication mechanisms.
4.4 Workforce Key Strategies and Objectives

We will achieve our workforce goals by implementing three key strategies:

‘Improving the working lives of our people’

‘Improving effectiveness, efficiency and patient outcome’

‘Improving medical leadership and engagement’

In order to deliver the following key strategic outcomes:

4.5 Key Strategic Outcomes

Improving the working lives of our people

It is right to ‘put patients first’, but organisations that treat patients with happy, engaged motivated staff perform much better in all aspects than those that don’t and so we build an engaged and motivated workforce that is aspirational in terms of its own development and work life balance and which always puts the patient first.

Improve effectiveness, efficiency and patient outcome

Clinicians are trained lifelong to care about the outcomes they deliver, the standards they set and the improvements they make. Recruitment of great clinicians is about creating an environment to work in that is attractive and can meet their aspirations. Effectiveness, efficiency and great patient outcomes are where the aspirations of patients, clinicians and Trusts meet and so we will build a work environment where clinicians feel challenged professionally and in which they are given the freedom but also the accountability to deliver the best in patient outcome in the most effective and efficient manner possible.

Improve medical leadership, accountability and engagement

Leaders create the will to change and foster an environment rich in ideas for improvement. The evidence of the effect of medical leaders on creating the right environment to improve outcomes, recruit effective clinicians and meet targets has been shown in studies of high performing hospitals and so we will develop a model of clinical leadership where all clinicians are engaged in resolving the organizational challenges we face and who feel accountable and therefore responsible for driving the improvements in our service forward.
5 Implementation
5.1 Our Implementation Planning Assumptions

- The Together for a Healthier Future (via the North Cumbria Programme Board) is responsible for the development, project planning and consultation of the CCG 5 year strategy. It is the responsibility of the CEO, Medical Director (MD) and Director of Strategy to ensure that the NCUH 5 year plan and each years business plan reflect the changes required to implement the health economy project plan (on a year by year basis). Each phase of hospital consolidation and the out of hospital strategy will require workforce models, including new roles to be consulted upon locally. The workforce models will underpin the financial and clinical strategies.

- The MDs in NCUH, CPFT (Community Partnership Trust) and CCG are responsible for agreeing the job descriptions (JD) of new roles required of the medical staff to either enhance recruitment opportunity or implement the plan. Where new roles are not training roles the Director of Medical Education will coordinate with Deanery as how to ensure there is a learning plan for the incumbents.

- The NCUH MD, Director of Nursing and HR director will coordinate the production of JDs, training and recruitment to new non-medical roles.

- The Directors of Finance and Strategy for the partners are responsible for ensuring the modelling of the workforce capacity aligns with the finance.

- The Director of Strategy and the Chief Operating Officers will work to ensure each annual plan is fit for purpose.

- The demands put upon Organisational Development on a year-by-year basis will be determined by the requirements of the various annual strategies (eg. Quality, Nursing and Medical workforce), the annual plan and the requirements for the development of the strategic plan. The Directors will be jointly responsible for ensuring that, by colocation of training (the principle is to train in teams) that the best use of OD is made on a year-by-year basis. The HR Director is responsible for advising items that are best delivered via mandatory training and those delivered via OD.
5.2 Our Implementation Plan

We will improve the working lives of our people by:

Developing a medical workforce model that provides the right mix of work in the right volume for our team whilst meeting service need and which is supported with an appropriate funding model.

Implementation Actions:
- Agree Clinical model
- Commence formal engagement plan with Clinical body
- Review Job Plans of substantive staff
- Ensure Funding Model in place

Reviewing job roles, including job plans for all substantive staff, and improving job planning to ensure we provide balanced and fulfilling job roles which enable us to attract, develop and retain the best team and so become an employer of choice.

Implementation Actions:
- Review Job Descriptions
- Completing a rigorous second round of Job Planning in 2015/16

Delivering innovative but targeted values based recruitment campaigns to attract the right candidates whilst at the same time reducing lead time to recruit, the number of medical vacancies and the number of locum staff within the workforce.

Implementation Actions:
- Re-engage on framework used for consultant selection process
- Recruit priority posts (Consultants & Specialty Doctors)
- Acute Care Physicians
- Respiratory
- Care of the Elderly
- Gastroenterology
- Emergency Medicine
- Radiology
- Histopathology
- Anaesthetics
- Implement Recruitment Premia for agreed posts if required
Developing innovative, flexible staff resourcing and development models, including non-medical alternatives, to ensure staffing levels match service needs and cross-site medical rotas are fair, balanced and sustainable. This will include the much needed creation of a training workforce who can supervise clinical skills development programmes and a real intent to introduce alternative resourcing models ranging from developing the role of the nurse practitioners and the introduction of specialty grades to ease transition, hospital doctor specialty accreditation schemes, consultants in the community, associate specialist roles and ultimately portfolio style careers for hospital doctors and GPs allowing them to move along the integrated care pathway as part of a deliberate career choice.

Implementation Actions:

- Design and implement a training workforce structure
- Define and implement alternative resourcing models to include:
  - Nurse practitioners & specialty grades
  - Hospital doctor specialty accreditation schemes
  - Consultants in the community
  - Associate specialist roles
  - Portfolio style career paths

Providing innovative professional and personal development opportunities for our people through the implementation of innovative ‘portfolio’ career paths and ‘collaborative learning models’ and so deliver wider opportunities for job enrichment and progression within our organisation.

Implementation Actions:

- Attend the Cumbria wide ‘Workforce’ implementation group at Executive level
- Director of Medical Education to develop alternative Job Descriptions to West GP VTS posts in association with lead GP trainer
- At Cumbria Alliance CEOs and MDs will discuss implementation of the vertical integration and innovative workforce models articulated in NHS Five Year Forward Plan particularly in relation to viable smaller hospitals

Putting the Trust values at the heart of what we do and how we work and recognise, value and reward the contribution made by both our teams and individuals in delivering our vision. In addition we will role model our values with penalties in place for those teams that don’t deliver.

Implementation Actions:

- Implement new appraisal system for A4C staff
- Include values in staff award scheme, Disciplinary policy and OD Program
Review Clarity system for inclusion of Trust values

Implementing a just in time culture with regard to incidents and listen and act on the views, concerns and ideas of our people in order to drive innovation and improvement throughout our organisation.

Implementation Actions:

- Implement and engage on ‘Stop The Line’ program to empower frontline staff to be quality champions
- Implement anonymous incident reporting.
- Develop ‘Learning’ website with CCG for all clinical staff

Developing a culture of transparency, fairness and engagement at all levels within our Organisation and so reduce the need for staff to rely on formal grievance processes.

Implementation Actions:

- Launch an open and independent helpline for staff and address their concerns by form a response.

Improving sickness absence within the medical workforce through implementation of the staff health and wellbeing strategy.

Implementation Actions:

- Implement and apply Trust sickness policy to medical staff by training CDs and managers.
- All Business Unit Boards to monitor and report sickness rates in medical staff.

Address the immediate frailty in acute medicine to ensure safe service provision at WCH from August 2014 in: acute medicine; obstetrics and gynaecology; paediatrics and surgery.

Implementation Actions:

- Publication of Draft Clinical Strategy October 2014
- Implement four project management groups, supported by executive direction, management and information resource to report to North Cumbria programme Board.
We will improve effectiveness, efficiency and patient outcome by:

Appointing and developing Clinical Directors supported by a Buddy Trust to lead implementation of our service development programme supported by the enabling triumvirate management team structure of Clinician, Business Manager and Matron critical to successful implementation and improved patient outcome.

- Implementation Actions:
  - Develop group of Senior Medical Leaders
  - Establishment of a ‘Change Team’ including Service Improvement Managers to support implementation of improvement initiatives in conjunction with CLIC in 4 key clinical areas.
  - Implementation of improved elective efficiency through ‘PERFORM’ process in surgery.

Building a culture of innovation and improvement which is led by clinicians and driven by information from patients, carers and clinical outcome.

- Implementation Actions:
  - Roll out High Performing Leaders Programme
  - Develop skills in and implement the ‘Cumbrian Production System’ and focus on waste reduction and service improvement
  - To appoint a Clinical Director for Improvement to engage medical staff in CLIC and improvement initiatives
  - To appoint a band 8 manager attached to MDs Office to support the CD for Improvement and the Service Improvement Managers in the ‘Change team’.

Implementing a clinical care model which re-configures the current service model and ensures allocation of the appropriate case mix and resources to better balance of high risk working between the sites and develop elective expertise on the other and so reduce the number of rotas required.

- Implementation Actions:
  - Establish staffing baseline for each service to match service needs
  - Commence formal engagement plan with Clinical body
  - Review Job Plans of substantive staff
Aligning the vision and values of specialities and building a commitment to work in co-operation rather than competition across the system and so optimise resourcing and cooperation to deliver patient pathways of care and improved outcome.

- Implementation Actions:
  - All clinical leaders to undergo leadership development and have senior mentor
  - All significant service change to be discussed by all specialty representatives at CPG
  - Cumbrian production system methodology supports process mapping that identifies co-dependencies underpinning successful improvement. Celebrate success and learn at patient safety events.

Developing a flexible resourcing model which can be proactively managed and so optimise resource utilisation across professions and so make better use of our clinicians, managers and nurses. (Cumbrian Production System)

- Implementation Actions:
  - Aim for 80% of all staff to have been trained or involved in implementation of CLIC methodology by 2019

Reviewing and implementing improved patient focused, integrated community care models that enable, team, profession and speciality working across organisational boundaries reducing the need for duplication and re-work.

- Implementation Actions:
  - North Cumbria programme Board to implement actions identified by 2014 Gateway review
  - Cumbria Care Alliance to add to list of initiatives that implement NHS ‘Five Year Forward Strategy’ and implement those agreed via North Cumbria programme Board.

Clearly committing to delivering outcome focused patient care based to National standards of care (NICE), with the status quo no longer acceptable but a clinically led drive to improving patient care and outcome the norm.

- Implementation Actions:
  - Appoint a Clinical Director for Audit supported by band 8 manager attached to MDs Office
  - Work with Northumbria to implement a plan to complete NICE and National Enquiry (eg NCEPOD, NPSA) audit by April 2015
  - Implement revised department audit processes via CLIC methodology to better support clinicians
Developing a culture of accountability and delegating responsibility and the requisite levels of authority to our teams so that they have increased autonomy in decision making and a real ability to influence and improve the delivery of patient care.

- Implementation Actions:
  - Role review, appraisal against clear objectives for all triumvirate members
  - Programme for all staff to engage and understand their responsibility to identify and contribute to improvement via OD programme and CLIC.

Rigorously replacing locums with substantive recruitment in order to reduce staff turnover, reduce costs and improve ownership and accountability for service improvement and patient outcome.

- Implementation Actions:
  - Reduce number of medical vacancies
  - Reduce expenditure on Locums
  - Performance Management of recruitment process to eliminate delays
  - Pursue overseas recruitment alternatives
  - Consider R&R fees for specific specialties
  - Complete process for gastroenterology, COTE, anaesthetics & respiratory consultants
  - Appoint to bridging posts for GP trainees (WCH)
  - Recruit to agreed funded establishment with rota to cover cross site
  - Use of NHFT brand and secondment
  - Appointment & development of Clinical Directors supported by Buddy Trust
  - Ensure appropriate response to deanery trainee issues

Negotiating service level agreements where required

- Implementation Actions:
  - provision for service level agreement in revised job planning agreement negotiated with LNC by 2015
  - Implementation of such agreements via Allocate e-job planning process via objective setting.
Improving medical productivity levels by reducing waste

- Implementation Actions:
  - Use of PERFORM piloted in process in Surgery Business Unit
  - The ‘Change Team’ Service Improvement Managers will support clinicians in efficiency improvement using the Cumbria Production System; work will be aligned to PERFORM. Include improved clinical administration system by implementing a booking centre and centralised medical records
  - Improved clinical information by Cumbria wide use of linked IT systems

Deliver 18 week, diagnostics and cancelled operations targets – as per improvement plans and trajectories

- Implementation Actions:
  - Enable medical staff to undertake properly remunerated additional work by agreement regarding payment for additional work (November 2014)
  - Implementation of TDA supported RTT and Cancer plan by capacity plan implemented by job planning and coordination of additional work, sourced both internally and externally
  - Implement improved clinical administration system by implementing a booking centre and centralised medical records
  - Improved monitoring by coordination of efforts of trackers in booking centre

Notify clinicians and managers and embed the business conduct rule that Outpatient clinics not to be cancelled within 6 weeks Improve medical productivity levels and reduce medical workforce costs

- Implementation Actions:
  - Electronic leave application and job planning via Allocate piloted
  - Transfer or terminate agency staff not on master vendor/NHS locum rates
  - Implement costed establishment control for filling all vacancies
  - Reduction to normalised peer for sickness & immediate vacancy cover
  - Take out WCH locums from Aug covering F1; replace with NPs
  - Rigorously replace locums with substantive recruitment
  - Explore alternative temporary cover
  - Complete rigorous second round job planning
  - Negotiate service level agreements with surgical specialties
  - Reduce locums by 20% @ cost reduction of £1.3M
  - Peer Benchmark Medical productivity levels
Improving access to quality individual information for all the medical workforce

- Implementation Actions:
  - Appointment of Head of Information tasked to improve use of consultant performance reporting via Service Line Tool.
  - Improved linkage of consultant HQIP information to appraisal
  - Improved Business unit and Trust level information.

Implementing values based performance management within the clinical teams by linking values to job performance and moving all medical staff onto the online ‘Clarity’ appraisal system.

- Implementation Actions:
  - Implementation of October 2014 Medical Appraisal Policy
  - Appraisal completed within clinical teams
  - Appraisal training (OD strategy) to cover North Cumbria values
  - PDPs to be available at job planning

Supporting the development of a flexible, skilled and innovative workforce, with a focus on learning together to improve together, supported by the implementation of the Trust Organisation Development Strategy, CLIC led Cumbrian Production System and the development of problem solving and continuous improvement tools and techniques which link to improved patient experience and outcome.

- Implementation Actions:
  - Improvement methodology agreed by EMT
  - Develop OSMs, Matrons and ward managers to use improvement tools – supported by Service Improvement Managers
  - Develop tools and techniques of continuous improvement with a link to patient experience, support small scale improvement initiatives
  - Implement Active transformation programme
We will improve medical leadership, accountability and engagement by:

Introducing a medical staff leadership behavioural competency framework by job level and will specify the values, competencies, behaviours and decision making accountabilities required for success. This framework will also provide a focus for and underpin our Values Based Recruitment, Induction, Performance Management, Learning and Development and Career Development strategies.

- Implementation Actions:
  - Follow up Medical Engagement Survey work with further organisation wide consultation on desirable behaviours of medical staff that would implement the Cumbria values. Including engagement on a non-technical skills framework applied to medical staff based on existing framework of Northumbria consultant recruitment competencies (which identifies 10 key non-technical skill areas and is currently used in consultant recruitment)
  - Agree implementation via recruitment process and further communication and discussion at reconstituted MSC.

Introducing a clinical managerial leadership model, which will allow for greater clinical input into decision making and the co-leadership of services.

- Implementation Actions:
  - Implementation of NHS Medical Leadership framework via the OD program

The establishment of a Clinical Policy Group (CPG) which aims to engage senior clinicians in advising the Trust on key strategic issues

- Implementation Actions:
  - Ensure attendance possible via job planning and better notification
  - Creation of networked CPG with attendance of community clinicians and ‘Group’ CPG with Northumbria.

Nurturing the development of our medical staff leadership skills through the continuing roll out of the ‘High Performing Clinical Leaders Programme’.

- Implementation Actions:
  - Please see OD Implementation Plan
Developing a new Consultant Program with a clear focus on leadership and management development.

- Implementation Actions:
  - Please see OD Implementation Plan

Reforming our medical staff committees to represent the collective views and opinions of all consultants SAS doctors and trainees in the Trust.

- Implementation Actions:
  - Implement recommendations of independent Lead clinicians Dr U Prabhu and Prof I Singh (engagement session with medical staff 27/11/2014)

Developing a formal medical staff engagement plan to improve medical engagement and so deliver clinically service improvement and speciality led innovation.

- Implementation Actions:
  - Hold focus Groups to develop a common view
  - Develop a medical engagement strategy that references and links to staff values and encourages medical specialty innovation and improvement.

5.3 2014/5 MCP Priority Actions

- Develop senior medical leaders (M2.15.3) July 2014
- Develop Medical Workforce Strategy and sign off at CPG and Board (M4.2.1) Nov 2014
- Medical Engagement of the strategy rolled out (M4.2.2) Mar 2014
- Strategy roll out across the Trust (M4.3.1) April 2014
- Medical Workforce Strategy fully rolled out (M4.3.1) Sept 2014

5.4 2015/16 Priority Tasks

Over the next three months we will develop a fully resourced implementation plan for the planning period 2015/16. This plan will identify interdependencies with other key Trust strategies, in particular the Clinical Strategy, Nursing Strategy, OD Strategy and Quality Strategy and will outline priority tasks, key milestones and deliverables and the resource requirements for successful implementation.
5.5 Workforce Strategic Outcomes – What will be different in 2019

‘Improving the working lives of our people’

- We will have a medical workforce model that provides the right mix of work in the right volume for our team.
- We will be an employer of choice enabling us to attract, develop and retain the best team.
- We will have reduced our lead time to recruit, our number of medical vacancies and the number of locum staff within the workforce.
- We will have created a training workforce and have deployed a number of innovative flexible resourcing models.
- We will be known for providing challenging professional and personal development opportunities for our people.
- We will be performance managing those teams that don’t deliver and rewarding those that do.
- We will have just in time culture with regard to incidents and will listen and act on the views, concerns and ideas of our people.
- We will have a culture of transparency, fairness and engagement at all levels within our Organisation.
- We will have improved the recording of sickness absence within the medical workforce and improved it through implementation of the staff health and wellbeing strategy.
- We will have robust services which ensure safe service provision at WCH in: acute medicine; obstetrics and gynaecology; paediatrics and surgery.

‘Improving effectiveness, efficiency and patient outcome’

- We will have appointed and developed Clinical Directors and fully implemented the triumvirate management team structure and improved patient outcome.
- We will have built a clinician led culture of innovation and improvement driven by information from patients, carers and clinical outcome.
- We will be working at a specialty level in co-operation rather than competition across the system to deliver patient pathways of care and improved outcome.
- We will have a flexible resourcing model and will have maximized our resource utilisation across professions so making better use of our clinicians, managers and nurses. (Cumbrian Production System)
We will have implemented improved patient focused, integrated community care models.

We will be delivering outcome focused patient care based to National standards of care (NICE).

We will have a culture of accountability and delegating responsibility and the requisite levels of authority within our teams.

We will have replaced locums with substantive recruitment in order to reduce staff turnover, reduce costs and improve ownership and accountability for service improvement and patient outcome.

We will have service level agreements in place where required.

We will have improved medical productivity levels by reducing waste.

We will have delivered 18 week, diagnostics and cancelled operations targets.

We will have improved access to quality individual information for all the medical workforce.

We will have implemented values based performance management and moved all medical staff onto the online ‘Clarity’ appraisal system.

We will have a flexible, skilled and innovative workforce, with a focus on learning together to improve together.

‘Improving medical leadership and engagement’

We will have implemented a medical staff leadership behavioural competency framework.

We will have implemented a clinical managerial leadership model which will allow for greater clinical input into decision making and the co-leadership of services.

We will have a fully effective Clinical Policy Group (CPG) who advise the Trust on key strategic issues.

We will have High Performing Clinical Leaders.

We will have delivered a new Consultant Program with a clear focus on leadership and management development.

We will have reformed our medical staff committees to represent the collective views and opinions of all consultants SAS doctors and trainees in the Trust.

We will have improved medical engagement and so be delivering clinically service improvement and speciality led innovation.
5.6 Implementation Risks and Mitigation Plans

- Failure to agree clinical strategy due to politics (gap between public and clinical expectation) – working closely with CCG. Public forums with Healthwatch, meet MPs, attendance at Scrutiny, open and honest dialogue about problems
- Failure to engage staff or public in the strategy
- Failure to get out of special measures, this will lead to administration
- Failure to be acquired: look for alternative partners, voluntary administration
- Failure to identify sufficient capacity and capability to make improvements: recruitment, locums etc
- Failure to recruit to the planned or existing model of care (consider change model of care)