Agenda Item:

Board of Directors Report

Subject:	**Service Improvement Strategy/ Transformation Agenda**
Date:	**27th February 2014**
Authors:	**Head of Service Improvement and Executive Medical Director**
Lead Director:	**Executive Medical Director**

Executive Summary

A new Service Improvement Strategy is presented for consideration and approval. The content has been informed by conversations held with executive and senior management colleagues and discussions held at Executive Team on 27.01.14 and 03.02.14.

The strategy has been structured using the NHS Change Model, and the content has been designed to be consistent with the new Organisational Development Strategy, our Patient Engagement and Involvement Strategy and the soon to be refreshed Quality Strategy.

The strategy incorporates proposals for a new service improvement capability framework, along with suggestions for identifying and addressing capability gaps within the management and the frontline workforce. It also incorporates proposals for how the Trust can better facilitate the development of a culture of innovation, in line with the ambitions outlined in the OD strategy.

A related paper is to be considered by Trust Management Board on 24.02.14 which includes a business case for increasing programme management and service improvement resources to support delivery of the strategy and the Trust's Integrated Improvement Programme.

Recommendation

The Board of Directors is asked to consider and approve the Service Improvement Strategy.

Relevant Strategic Objectives (please mark in bold)	
Achieve the best patient experience	**Achieve financial sustainability**
Improve patient safety and provide high quality care	**Build successful relationships with external organisations and regulators**
Attract, develop and motivate effective teams	

Links to the BAF and Corporate Risk Register	
Details of additional risks associated with this paper *(may include CQC Essential Standards, NHSLA, NHS Constitution)*	Failure to deliver 2014/15 CIP Failure to build sustainable improvement capability in the workforce (as envisaged in OD

	Strategy)
Links to NHS Constitution	Principles 3, 4, 5, 6
Financial Implications/Impact	Previously considered by Trust Management Board
Legal Implications/Impact	
Partnership working & Public Engagement Implications/Impact	Our integrated improvement programme has close links to “Better Together” delivery plans
Committees/groups where this item has been presented before	Trust Management Board and Executive Team have considered previous iterations of the Service Improvement Strategy.
Monitoring and Review	If the strategy is approved progress will be monitored via the newly established Transformation Board.
Is a QIA required/been completed? If yes provide brief details	No

Service Improvement Strategy

Board of Directors
27 February 2014

Dr Andrew Haynes
Executive Medical Director

Contents

1. Introduction and Context

At the heart of everything we do is our dedication to giving the best possible care for our patients, safely, respectfully and efficiently.

This strategy sets out how we will organise and develop our service improvement and programme management capability, in the context of delivering our Integrated Improvement Programme.

The strategy has been structured using the NHS Change Model, and the content has been designed to be consistent with the new Organisational Development Strategy, our Patient Engagement and Involvement Strategy, and the soon to be refreshed Quality Strategy – please see Figure 1.

The strategy incorporates proposals for a new service improvement capability framework, along with suggestions for identifying and addressing capability gaps within the management and the frontline workforce. It also incorporates proposals for how the Trust can better facilitate the development of a culture of innovation, in line with the ambitions outlined in the OD strategy.

The reason for developing a new Service Improvement Strategy now is the recognition that whilst we have developed many innovative service improvement initiatives during recent years we have struggled to deliver truly transformational benefits. The assertion is that we need to fundamentally review our capability and capacity for improvement and the behaviours that can underpin sustainable business change, in conjunction with the work to deliver the changes included within the OD and quality strategies.

This strategy includes suggestions that have emanated from conversations and discussions held to date and also includes proposals to undertake further engagement and consultation on our improvement framework and implementation approach.

A related paper is to be considered by Trust Management Board on 24.02.14 which includes a business case for increasing programme management and service improvement resources to support delivery of the strategy and the Trust's Integrated Improvement Programme.

Figure 1 – Alignment of service improvement, OD and quality strategies

2. Service Improvement Strategy

2.1 Structuring our Strategy

The NHS Change Model (please see Figure 2) has been used to structure the Service Improvement Strategy. The following extract from the NHS Change Model website helps to articulate the reasons why it has been used for this purpose:

> *"The NHS Change Model has been created to support the NHS to adopt a shared approach to leading change and transformation.*
>
> *We need to understand **what** needs to change and **why** to make the NHS the best quality service for the best value, sustainable over time. The NHS Change Model is not rocket science – it brings together what we know helps make change happen. It informs **how** we make change happen and **who** needs to be involved.*
>
> *The NHS Change Model brings together collective improvement knowledge and experience from across the NHS. It has been developed with hundreds of our senior leaders, clinicians, commissioners, providers and improvement activists who want to get involved in building the energy for change across the NHS by adopting a systematic and sustainable approach to improving quality of care. Through applying all eight components change can happen"*

Figure 2: NHS Change Model

A number of the NHS Change Model domains align with key themes in our OD strategy; the narrative included in the following sections of this paper seeks to flag these connections in the context of ensuring we have consistent approaches to both organisational and service improvement.

2.2 Our Shared Purpose for Service Improvement

Our OD strategy identifies 'Our enduring purpose' as being:

To champion and deliver the best care, service and wellbeing outcomes possible for each individual in the communities we serve

It also states our "Quality for All" values:

- Communicating and working together
- Aspiring and improving
- Respectful and caring
- Efficient and safe

The 'Strategic Bridge' included within the OD strategy provides "a high level summary of the ambition and activities that will guide our work to improve patient and staff engagement over the next three years".

In the language of the NHS Change Model therefore we have already our **organisational 'shared purpose'**, wrapped up in the content referred to above.

We have also collectively identified our **service improvement 'shared purpose'** in the form of the ambitions for 'Reflective practice and continuous improvement' included in Section 4.7 of the OD Strategy. Some of the key statements include:

> *"We want to apply the best improvement techniques, expertise and experience from around the world to enable our staff to deliver the highest quality, most cost-effective treatment ad care to each and every patient we serve"*
>
> *"Our ambition is to create a culture across our organisation where we take every opportunity to involve patients and carers in improvement and innovation and for our teams to be driving daily improvements in quality and productivity"*

Year 1 and year 2 activities to deliver these priorities are included in the OD strategy and these activities are referenced in Section 2.3 to 2.9 below

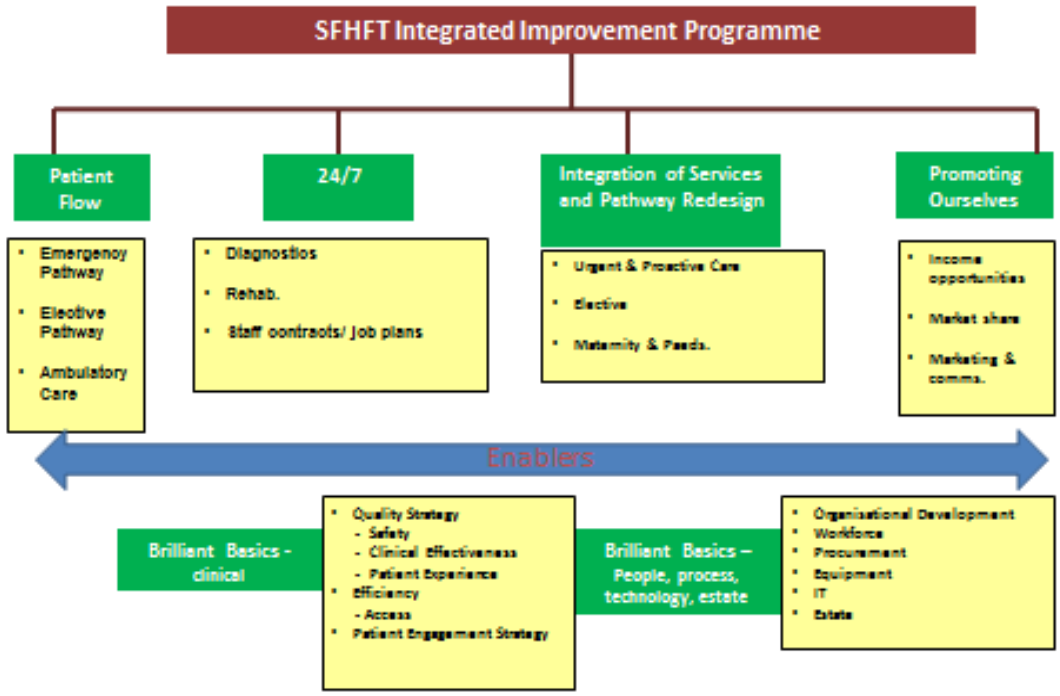
2.3 Leadership for Change

<u>Transformation Board</u>
A Transformation Board, chaired by the Chief Executive will drive our service improvement strategy, the delivery of our Integrated Improvement Programme (IIP) and the development of our culture for continuous improvement. The proposed terms of reference for the Transformation Board are currently being drawn up.

Structure for Leading Delivery of our Integrated Improvement Programme

The Executive Team agreed the IIP as our 2014/15 framework for transformation in December 2013, following service improvement consultation events, held in September and October 2013. The IIP is summarised in Figure 3 below:

Figure 3: SFHFT Integrated Improvement Programme



A proposed structure for leading the delivery the IIP was agreed in principle by the Executive Team during meetings held on 27.01.14 and 03.02.14. The structure is based upon the principle that we will organise transformation resources under three portfolios, each with its own programme board:

- **Elective Care**
- **Emergency Care**
- **Clinical Support and 24/7 working**

The portfolios will support delivery of IIP priority projects, including the three highest priorities identified at the Executive annual planning session held on 13.12.13:

- 24/7 working
- PAS
- Delivering “Better Together”

Executive Leadership and Sponsorship

The Executive Medical Director will be the executive lead for the service improvement strategy and the IIP.

The three transformation portfolios will have an executive sponsor, agreed as follows:

- Elective = Executive Medical Director
- Emergency = Director of Operations
- 24/7 & clinical support = Executive Director of Human Resources

The proposals included within the paper and business case being considered by the Trust Management Board will allow for the Head of Service Improvement to take a more strategic change management role, focusing on continuous improvement of the transformation approach and ensuring effective alignment of our service improvement strategy and the IIP with other strategic planning activities.

2.4 Rigorous Delivery

This section includes a summary of the suggested work streams and projects that will fall under the three transformation portfolios (Figure 4) and the proposed leadership and management capacity to run and support these portfolios.

Structuring the Delivery Programme

Figure 4 cross-matches the IIP headings with the three transformation portfolios. The reason why transformation resources are not being organised under the IIP headings is because this would not allow us to fully connect and align our change management resources; for example we would be undertaking improvement work on elective orthopaedics under multiple programmes including 'Elective Flow', 'Better Together', 'Brilliant Basics', and 'Promoting Ourselves', running the risk of dislocating our improvement efforts.

The rationale for this structure therefore is to connect our improvement activities in a way which addresses the following challenges:

- The changes we are seeking to deliver are invariably complex in nature
- It is helpful to link people, process and technology when designing and delivering improvement programmes
- Transformation resources need to focus on bridging organisational silos - transformational change is unlikely to happen just within departments or even divisions, patients generally follow pathways that cross our organisational structures and the IIP headings.

Quality Strategy and Associated Priorities

Service improvement resources are currently used to support some of our clinical quality improvement priorities. However further discussions are to take place with the Executive Director of Nursing and Quality and the Executive Medical Director on the project content included in Figure 4 and on the best way to connect the delivery of priorities included within the Quality Strategy, and the Patient Experience and Involvement Strategy to the IIP the and transformation portfolios.

*Figure 4: Transformation Portfolios (top three priorities highlighted in **red**)*

IIP work streams & projects	Elective portfolio	Emergency portfolio	Clinical Support & 24/7 portfolio
Elective Flow			
OP scheduling	✓ - sustain and improve		
OP efficiency	✓ - sustain and extend		
Pre-op	✓ - ongoing		
Theatre scheduling	✓ - sustain and improve		
Theatre efficiency	✓ - sustain and improve		
Enhanced recovery	✓ - sustain and extend		
Emergency Flow			
Admission avoidance		✓- sustain and improve	
Frail elderly		✓ - sustain and extend	
Internal waits			✓ - significant project
Flow & capacity mgmt.		✓ - sustain and improve	
Discharge		✓ - major project, complex	
24/7			
Diagnostics			✓ - major project, complex
Rehab			✓ - major project, complex
Clinical support			✓ - major project, complex
External agencies			✓ - major project, complex
HR			✓ - major project, complex
Better Together			
Urgent & proactive care		✓ - major programme, complex	
Elective care	✓ - major programme, complex		
Women and children	✓ - query complexity?		
Brilliant Basics – Clinical			
Safety		✓ - #NOF pathway, handover	✓ - E-prescribing
Patient experience	✓	✓	✓
Clinical effectiveness		✓ - CGA, frailty, dementia	
Service line reviews	✓ - health planners to support	✓ - health planners to support	✓ - health planners to support
Managed equipment serv.			✓ - significant project
NH surgery	✓ - significant project		
Brilliant Basics – Other			
Service improvement & project mgmt. capability		✓ - major programme (see section 2.5)	
Finance Transformation			✓
Patient admin			✓ - centralised reception ✓ - PPC; sustain and improve
PAS	✓ - OPD, RTT, wait. List	✓ - bed mgmt., ED, EAU	✓ - case notes, coding
ICRS	✓ - theatres, Winscribe	✓ - Jonah replacement	✓ - ICE
Procurement	✓	✓	✓
Promoting Ourselves			
Income opportunities	✓	✓	✓
Market share	✓		✓

Management Capacity to support Service Improvement Strategy and IIP delivery

A business case is being considered by TMB for additional programme management and service improvement resources that will allow for the following roles / functions to be set in place to drive transformational change and deliver expected benefits under the three transformation portfolios:

- Executive sponsorship (see Section 2.3)
- Programme lead – senior manager post to drive change across the IIP headings
- Clinical lead – senior clinician with dedicated time to support change
- Service improvement leads and facilitators
- Project management support
- Business intelligence leads
- Business analysis support

It is critical that we co-design service improvements with local CCGs and other provider organisations, aligning fully with 'Better Together' – the Mid-Nottinghamshire Integrated Care Transformation Programme.

Consideration needs to be given therefore as to how our transformation approach best integrates with the 'Better Together' delivery infrastructure. This will include how the three SFHFT programme leads can best match up with the Better Together programme leads. It is for this reason that the roles referred to above do not include a CCG/ GP lead, it is important that we do not set up an unconnected parallel system.

As well as driving their own transformation portfolios the Programme Leads will each be given at least one cross cutting service improvement strategic priority to drive e.g. facilitating service innovation, developing our improvement capability framework and the associated TED plan, and the further development of business intelligence capability for service improvement.

Succession planning

As well as providing the capacity required to deliver the Trust's change agenda, the proposals included above will also provide excellent opportunities for developing talent within the Trust and will help with the development of future divisional general managers and clinical directors.

Learning from others and benchmarking our resourcing levels

Some work has been undertaken to understand the approach to transformation and the resources deployed by other acute trusts, to inform the aforementioned business case. It is not a straightforward task to benchmark SFHFT proposals with capacity elsewhere, due to the number of factors that need to be considered in order to make an accurate comparison, for example:

- Whether PAS/ IT business change is organised and funded separately
- The levels of change management support available within divisional management teams
- The levels of support provided by external companies/ management consultants
- The levels of clinician input that may not be included in costs attained from elsewhere

Whilst it is helpful to understand how our proposals compare to other trusts, our decisions need to be made based upon our particular circumstances, recognising the scale of our ambitions to deliver a challenging agenda in a relatively short space of time including a new PAS and integrated care record system, 7 day working, care quality that allow us to come

out of special measures, delivery support to “Better Together”, a continually challenging CIP, and a number of new organisational strategic delivery plans including OD, quality and patient engagement and involvement.

2.5 Transparent Measurement

Return on investment

The proposed additional investment included in the business case (£700k per annum) must achieve a significant return on investment. There needs to be a clear line drawn between the additional input and the achievement/ over-achievement against CIP targets in 2014/15 and other potential financial benefits.

Whilst the current high-level benefits plan articulates known and potential financial benefits, the portfolio leads and the PMO need to establish challenging RoI targets, based upon the delivery of IIP work stream programmes and projects.

Benefits plan

High-level benefits plans are included below incorporating change management/ service improvement elements from the current draft of the divisional proposed CIP schemes for 2014/15. With significant additional investment being proposed it is imperative that benefits become more granular and definitive as soon as possible:

Figure 5 - Potential Crosscutting Benefits

Benefit Description	Benefit Category	Impact
Improved patient experience, care safety and effectiveness of care	Quality	Implementation of IIP priorities and our quality strategies
Development of health economy integrated care pathways, co-created with primary, community, and social care	Access, patient experience and productivity	Better Together blueprint delivery
Large scale increase in the improvement capability of the SFHFT workforce, to support continuous improvement	OD	Increased numbers of staff capable of delivering improvements in the workplace
Support succession planning for DGMs and Clinical Directors	OD	Leaders developed in situ, who will be ideally placed to take on DGM and CD roles in the future
Achievement of PAS/ ICRS project benefits strategy	Enabling cost reduction & OD	Being collated for Board in Feb.
CQUIN achievement	Income	TBC
Increased market share for targeted specialties	Income	TBC
Reduction in non-pay expenditure	Cost reduction	£400k Corporate (current PMO estimate)
Reduction in infections, errors and incidents	Quality Cost reduction Productivity	Reduce LoS and associated wasted costs of not getting things right first time

Figure 6 - Potential Elective Care Benefits

Benefit Description	Benefit Category	Impact
Re-designed elective pathways	Cost, productivity and quality	Support LOS reduction, removal of waste and improved quality outcomes

Benefit Description	Benefit Category	Impact
Sustained benefits achievement following Newton Europe deployment	Cost reduction	£665k theatres FYE £773k outpatients FYE
Further productivity improvement based on NE stretch targets	Cost reduction	c.£200k theatres FYE c.£330k outpatient FYE
Reduce follow up appointments by increasing telephone contacts and letters (for negative results)	Productivity Target compliance	Reduce follow ups and replace with new appts to reduce risk of contract fines for new:FU ratios and 1st appt waiting times
Improved RTT performance, relating to improved pre-operative assessment, OPD & theatre productivity and better pathway management	Target compliance	RTT target achievement
Maximise achievement of best practice tariffs	Income	BPT gap to be calculated
Generate additional income from allowing use of clinics and theatres at weekends by private providers	Income	TBC
Improved efficiency within key PC&S specialties – joint work with health planners	Cost/ productivity	TBC

Figure 7 - Potential Emergency Care Benefits

Benefit Description	Benefit Category	Impact
Re-designed emergency pathways	Cost, productivity and quality	Support LOS reduction, removal of waste and improved quality outcomes
Reduced variation in ED 4 hour wait performance	Target compliance	4 hour wait and other ECC target achievement
Admission reduction coupled with increase in ambulatory care	Income (BPT) Cost reduction (capacity)	Income - TBC Reduction in (EAU) capacity in line with recommendations
Reduction in LOS to facilitate bed number reduction	Cost reduction	Current estimate = £1.5m FYE
Improved efficiency within key EC&M specialties – joint work with health planners	Cost/ productivity	TBC
Maximise achievement of best practice tariffs	Income	BPT gap to be calculated
Further expansion of endoscopy service	Income/ productivity	£300k
In depth review of non-pay and pharmaceuticals	Cost reduction	£500k

Figure 8 - Potential Clinical Support & 24/7 Benefits

Benefit Description	Benefit Category	Impact
Range of benefits from 24/7 working	Quality Efficiency/ Flow	TBC but including Patient experience, time to first review and assessment, handover, diagnostics, timely interventions,
Address key internal waits, that cause unnecessary delay to the patient pathway	Quality Efficiency/ Flow	LOS and capacity requirements
Cost savings and flow benefits relating to equipment (via MES)	Cost/ flow	MES for Pathology (£217k) MES for POCT (£46k)

Benefit Description	Benefit Category	Impact
Improved efficiency of the out of hours radiology service	Cost	TBC
Review benefits of pharmacy subsidiary proposal	Income	TBC
Improved productivity & performance and staff satisfaction in patient admin services	Cost reduction Staff satisfaction	£330k
Reduced patient admin costs	Cost	Centralised reception (£129k)

2.6 Improvement Methodology

Consistency with Organisational Development Strategy

This strategy needs to respond to and support delivery of Year 1 OD Strategy activities including:

(From Section 4.7 – Reflective Practice and Continuous Improvement)

- Agreeing a Trust improvement capability framework that connects our teams with the patients and communities they care for, and with the fellow health professionals who share that care.
- Further developing and embedding team based Service Improvement skills within our clinical teams, through training programmes and work-based support and secondments.
- Establishing team based KPIs, and feeding performance against these into regular continuous improvement forums that teams run and own
- Embedding the practice of using measurement for improvement rather than measure for judgement
- Exploring how we can bring quality assurance and quality improvement closer together

(From other sections in the OD Strategy)

- Further spreading of our "Communication Cell" tool across our organisation (*Section 4.5 Two-way communication and engagement*)
- Increasing patient engagement (*4.6 Robust governance, measurement and performance management*)

This section and those that follow include proposals for supporting these Year 1 activities.

Agreeing a Trust improvement capability framework

The current SFHFT improvement framework is used to support service improvement activities and to design and deliver training, education, and development on the following programmes:

- Senior Clinician Quality Improvement Development Programme
- Leadership and Management Development Programme
- Clinical Leadership Programme (nursing Band 6)
- Supervisors Development Programme

Over 650 staff have been trained in our improvement methodology since 2009, (please note the number of trained staff in post will be lower as this figure does not account for staff who have subsequently left the organisation).

The content of the training has evolved from being predominantly lean based to now incorporating a mix of lean, IHI model for improvement and other relevant topics, including staff engagement, visual management, change management, measurement for improvement, systems thinking, human factors and project management.

Historically we have not codified training and competencies into categories of capability, due to the variety of training taking place. The proposal moving forward however is that we do codify service improvement competence into the following levels, to create clearer expectations and tracking of improvement capability:

- **Expert –** "I train others and develop our improvement practice"
- **Senior practitioner –** "I can lead and train others"
- **Practitioner –** "I can lead improvement with support"
- **All staff –** "I am aware and get involved"

A draft SFHFT framework has been developed that describes the competencies under each level and is included in **Figure 9**. This framework has been developed using a range of sources from the improvement literature, including the following documents:

- "Building innovation and improvement capability". NHS Institute development framework for cost and quality" (Maddocks-Brown, Penny, Price-Dowd 2012)
- "Quality improvement curriculum framework". NHS Scotland

The framework is a draft for discussion at this stage and requires further consultation before it can be tested. The training and development material that the ABC Team currently use to train staff can be translated into these four levels with some refinement work.

Figure 9: Draft Capability Framework for Service Improvement (Note: Stages are drawn from the current ABC improvement toolkit)

Levels	Requirement	Example Roles	Platform knowledge	Stage 1 Motivate	Stage 2 Map & Measure	Stage 3 Move & Maintain	Stage 4 Manage
All staff (Foundation) "I am aware and get involved"	Understand the basics and the personal responsibilities for continuous improvement	All staff	• Trust values & behaviours • Understands our culture for improvement • User experience training	• Looks at their practice to identify problems and opportunities for improvement • Plays active role in daily comm cell and understands the need for effective team working	• Collect, display & explain data • Can contribute to team-based process mapping & identification of changes • Participates in activity follows, 5S waste walks, Ohno circles	• Can contribute to team-based PDSA • Follow SOPs and offer opportunities to improve them	• Can talk to colleagues about the importance of continual improvement and sustaining changes
Practitioner "I can lead improvement with support"	Equipped to innovate and improve local services	Supervisors, consultants, dept . leaders, service managers, service improvement facilitators	• Engage colleagues with improvement and innovation initiatives – lead local projects • Facilitate dialogue within teams • Basic project management skills • Deming • IHI model for improvement • 5 lean steps • Basics of change management	• Lead a team to identify areas for improvement • Drive a comm cell • Stakeholder mapping • Can use the IHI model to drive improvement • Understand key system/ pathway features • Human factors basics	• Design and run range of observational exercises • Collate data, understand run & SPC charts, pareto, demand & capacity data • Conduct patient engagement • Conduct staff engagement • Lead 5S • Run mapping sessions, capture and codify waste (understanding of VSM) • Use resource calculators	• Lead PDSA cycles • Run problem solving sessions • Produce SOPs • Produce skills and competency matrix • Design and run visual mgmt. • Produce RACI	• Address key factors for sustainability • Respond to variation on run charts • Maintain benefit reporting templates • Participate in improvement networks & trust QI faculty
Advanced Practitioner "I can lead and train others"	Equipped to lead, coach and support others in service improvement initiatives	Heads of Service & Nursing, Service Directors, DGMs, senior business unit managers,	• Actively promotes service improvement & innovation • Lead cross-dept. & cross-org. pathway projects • Understands basics of ToC and 6sigma • Social movement theory • Large-scale change management skills • Skilled presenter • Trains colleagues in QI • Describe how systems and complexity theories can be applied	• Uses "Thinking Differently" techniques to facilitate and promote innovation • Advanced knowledge of resilience, conflict and other human factors • Review, improve comm cell	• Interpret run charts/ SPC • Calculate takt and cycle times, yamazumis and resource calculator • Run patient /staff engagement & design sessions • Run VSM sessions • Produce demand and capacity data	• Link PDSAs with other depts to produce system improvements • Optimise visual management • Quality indicator boards • Use ToC principles to address constraints	• Produce sustainability plan • Embed use of run charts in daily activity • Produce and improve benefits reporting • Present to improvement networks outside of Trust and SFH faculty • Can produce return on investment data
Expert "I can train others and develop our improvement practice"	Provide expert support to practitioners, the wider organisation and contribute to the development of improvement practice and this framework	ABC Service Improvement Managers and c.50 senior staff across the trust	• Trust Champion for improvement • Advises policy and strategy for improvement • Design training progs • Large group facilitation skills • Lead complex & system wide programmes	• Runs training on innovation , human factors and reliable design skills • Systems re-design expertise • Employs social movement thinking	• Designs run charts and SPC • Expert knowledge of lean workflow calculations and can train others • Supports others to produce VSMs and calculate benefits • Advises on demand and capacity tools and problem solving	• Link local PDSAs with meso and macro levels • Advise on types of visual management • Combine ToC approach as integral part of IHI/ Lean projects • Produce business cases	• Advise and train others on sustainability plans • Sustainability plans for system level progs • Support development of SFH faculty for QI and improvement network • Present nationally on SFH and local community improvement work

2.7 Engagement to Mobilise

Board-led engagement
We have a board-led narrative in the form of the OD strategy, and engagement in the form of the Transformation Board, and executive leadership and sponsorship for this strategy.

Further work is required however to frame this strategy within trust communications on 'Quality for All', to ensure service improvement is seen as an integral, and not an additional, component of the 'Quality for All' implementation approach.

We also need to describe how the organisation will be different as a result of implementing this strategy to capture people's imaginations; we need to describe how problems that exist today will be minimised in the future, using real-life examples to illustrate the benefits that can ensue. It is proposed that this description is aligned with the further development and communication of the Strategic Bridge included in the OD Strategy.

A communications plan regarding these proposals and the content of this paper will be developed, subject to feedback on and approval of this strategy.

Patient engagement
The active involvement of patients and carers in changing how we deliver our services is a fundamental requirement for the success of this strategy. Working with colleagues leading on the Patient Experience and Involvement Strategy, sponsors and leads for the transformation portfolios will ensure that patients and their carers are wherever possible seen to be driving change from the front.

Further developing and embedding team based service improvement skills within our clinical teams
There is a high level of ambition included within this strategy. The aim is to transform the capability of the SFHFT workforce, so that clinical staff, operational leads, and their teams drive sustainable improvements within their departments and across local systems. We need to create a sustainable cadre of staff that are skilled in and can lead improvement.

We also need to ensure:

a) we create the conditions so that when staff have been trained in improvement methodologies they have the time and space to reflect on individual and team practice and performance in their workplace and apply continuous improvement principles.
b) our leaders support the application of continuous improvement practices in the workplace, placing high value on these activities.

It is recommended that these requirements form critical aims for the implementation of our OD strategy.

Gap Analysis:
Whilst a formal organisational gap analysis has not yet taken place (comparing current capabilities with that described within the framework – Section 2.6), it is possible to predict the following requirements:

- Significant training resources will be required
- Significant need for staff release for training

- Time for staff to practice and apply their learning and focus on improvements

Work needs to be undertaken to collate the levels of capability that exist across the workforce to inform the gap analysis. It is proposed that this exercise is undertaken in parallel with the aforementioned consultation on the capability framework.

Closing the Gap:
The pace at which we proceed will determine how much additional resource will be required to train staff, and to support them whilst they learn in the workplace. The new roles included within Section 2.4 will allow for training to continue at the current pace, with some acceleration, but the time it will take to achieve the skills level coverage outlined in the capability framework with these resources is estimated at 2+ years.

There is the option to buy in additional training and development capacity, to allow us to accelerate the pace at which we close the skills and knowledge gap. This option has not been costed at this stage, as we first need to undertake the gap analysis and reach agreement on the content of the capability framework, as well as the scope for a train the trainer approach and the implications this would have on staff time. The use of additional external training and development providers would therefore require a further business case to be developed for consideration by TMB.

In the meantime it is recommended that the ABC Team continue to refine existing training and development material based upon participant feedback and themes included within this paper, ahead of a comprehensive review linked to the consultation on the capability framework. Joint work will also be undertaken with the TED Department and this work will help inform relevant sections of the updated TED strategy.

The business case submitted to TMB also recommended that the external training support provided to the Senior Clinician Quality Improvement Development Programme is budgeted for on the basis of running four further cohorts (20 staff per cohort) in 2014/15. Agreement on the use of this budget will however be subject to consistency with our agreed capability framework, the forthcoming evaluation of the first cohort (the training days element of which was completed on 14.02.14), and agreement on the speed at which the ABC/ TED teams have the capability and capacity to run the programme with reduced external support. These issues will be the subject of a paper to the Executive Team in March 2014.

Instigating a more structured approach to secondees rotating into service improvement focused roles is another approach to increasing organisational capability. It is recommended that secondments be used to fill at least some of the new posts listed in Section 2.4 and that a range of flexible short term secondments into the ABC Team are explored.

Exploring how we can bring quality assurance and quality improvement closer together:
Within our management workforce we have a number of staff that have been trained in patient safety improvement methodologies and others who are skilled in undertaking service quality assurance visits and measurements.

This paper argues the case for identifying how the skills of these managers can be extended to incorporate broader quality improvement skills and knowledge and for trying to introduce more of a quality improvement focus to our current quality

assurance systems and processes (as discussed at a recent time out to discuss the future development of QA activities).

2.8 Spread of Innovation

Discussions have been held with the Executive Team and at the Healthcare Science Innovation Forum to identify practical steps that can be taken, to help facilitate and support innovation throughout the organisation. The following list of proposals is the outcome of discussions to date and is included for comment and consideration. An initial paper was produced in late 2013 to help facilitate discussion on innovation and which influenced the suggestions below. This initial paper was based upon the NHS Institute for Innovation and Improvement published work on developing a "Culture for Innovation":

1. Finalise our research and innovation strategy
2. Increase our levels of collaboration with the local Academic Health and Science Network, CLARHC, Leadership Academy and LETB
3. Establish an innovation fund that staff/ teams can apply to for innovative ideas and improvements
4. Produce a SFHFT innovation report to showcase our innovative practices and convey a positive message to the rest of the organisation about our 'culture for innovation'
5. SFHFT library to create a local innovation portal
6. Set up training sessions for staff and teams on innovation using the NHS Institute for Innovation and Improvement's "Thinking Differently" material
7. Produce an options paper for testing the concept of innovation scouts, who have set time to scan the external environment and the literature, for innovation funding sources and for innovations that could be adopted or adapted by SFHFT teams
8. Continue to bid for known innovation funds

It is proposed that these suggestions will support delivery of the OD Strategy objectives relating to innovation and innovative practice amongst our workforce and therefore it is recommended that the IIP programme leads work alongside organisational development strategy implementation leads to ensure there is a combined and consistent approach to promoting and supporting innovation across the Trust.

2.9 System Drivers

The intention throughout this paper has been to align the proposals presented with key system drivers including:

Internal drivers

- OD strategy
- Quality strategy and patient experience and involvement strategy
- Training, education and development strategy
- 2014/15 CIP

External drivers

- Next stage of the “Better Together” programme
- CCG Contract – the benefits tables included in Section 2.5 includes reference to improving contract performance as a result of implementing the IIP
- Partnership opportunities - Section 2.8 includes the recommendation that we improve the way in which we collaborate with organisations such as the Academic Health and Science Network, CLARHC, Leadership Academy and the LETB

The proposals included within this strategy are heavily influenced by systems thinking and theories, to reflect the cross departmental and organisational dimensions associated with transformational change in our context.

3. Conclusion

Our Trust has developed many innovative service improvement initiatives during recent years. Some of these initiatives have been successful and have been recognised nationally as examples of good practice.

It is recognised however that truly transformational benefits have not been realised and that we need to fundamentally review our capability and capacity for improvement and the behaviours that can underpin sustainable business change.

This strategy includes suggestions that have emanated from conversations and discussions held to date and proposals to undertake further engagement and consultation on our service improvement framework and implementation approach.

These proposals need to be fully aligned and combined with the implementation of our OD and quality strategies, given our knowledge of how staff, leadership and management behaviours can impact on the acceptance and implementation of innovative, improvement initiatives.

The Board of Directors is invited to consider this strategy.

Dr Andrew Haynes
Executive Medical Director
20.02.14