South Tees Hospitals NHS
NHS Foundation Trust

Strategic Plan Document for 2013-14

South Tees Hospitals NHS Foundation Trust

Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

This document completed by (and Monitor queries to be directed to):

Name	Iain Fuller
Job Title	Head of Corporate Finance
e-mail address	Iain.fuller@stees.nhs.uk
Tel. no. for contact	01642 854265
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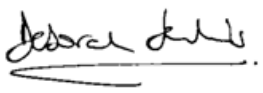
The attached Strategic Plan is intended to reflect the Trust's business plan over the next three years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- **The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;**
- **The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;**
- **All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	Deborah Jenkins

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Tricia Hart

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Chris Newton

Signature 

EXEC SUMMARY

As always, South Tees Hospitals NHS Foundation Trust continues to focus on continuing to enhance our strong tradition and culture of clinically led continuous improvement in quality and safety, focussing on the specialised services we provide and ensuring greater integration in our acute and community services. Our strategic plan sets out the key issues we face, our long-term strategy and the actions we plan to take over the next 3 years.

Our strategic plan is developed through an annual integrated planning cycle – a comprehensive analysis of our current situation looking at both external factors and internal issues, a review of our strategy and the updating and development of the organisation's three-year rolling plan.

Situation Assessment

For 2013/14, the most important issue facing the Trust is a significant mismatch of capacity and demand. Across the North East, and at times nationally, winter 2012/13 saw a surge in emergency demand well above the general trend which led to huge pressure on our emergency capacity and elective programme. In response, we know we must invest in additional capacity in the forthcoming year – this is critical to maintaining the quality of our services and achieving national targets, particularly around 18-weeks and accident and emergency.

On quality and safety, maintaining our outstanding performance on healthcare associated infections from 2012/13 (no MRSA infections and only 49 cases of C Difficile) into 2013/14 will be a key challenge, as will ensuring that the Francis recommendations are implemented.

The wide-ranging reforms under The Health and Social Care Act which came into force from 1 April 2013 also pose challenges, particularly due to the changes in commissioning organisations, especially specialised commissioning. In general, the development of GP led clinical commissioning groups has been positive and has improved clinical engagement between commissioners and providers. We are working in partnership with them on their key intentions including moving care closer to home, improving urgent and emergency care, and reducing demand for acute elective care.

Across the North East, Tees Valley and North Yorkshire there are a number of potential service reconfiguration proposals at various stages of development, such as paediatric neurosurgery, vascular services, the Tees Valley acute services quality legacy project and the NYY Strategic Review. We are maintaining close involvement in this work to influence it and respond to its outcomes. Internally, we continue to manage issues around paediatric and maternity services at the Friarage Hospital, gastroenterology capacity, rehabilitation service development, imaging capacity and medical workforce risks in clinical specialties.

Strategy

Although the situation assessment identified some serious risks and issues for the Trust to address, we are very confident that none undermine the essential elements of our strategy. As set out in our 2012/13 Strategic Plan, our strategy is based on a longstanding tradition and culture of clinically led continuous improvement in quality and safety, ongoing development and growth of specialised heart, cancer, children's, trauma and neurosciences services, and increasing integration of our local acute and community services.

3 Year Plan

Given the key issue of capacity described above, the Trust's top priority for 2013/14 is to increase capacity through additional staff at front of house and by opening an additional 50 beds to ensure we can meet winter demand.

In addition to increasing capacity, we continue to focus on our six strategic programmes:

- Quality and patient safety - implementing critical care outreach, improving and standardising surgical pre-assessment services, progress on our key patient safety themes and redeveloping and refurbishing a number of ward areas to improve patient experience

- Specialised services growth - increasing capacity in cancer services, cardiothoracic services, gastroenterology and MRI scanning; enhancing the range and resilience of trauma services and developing a specialised neuro-rehabilitation service

- Improving the patient pathway – continuing to work to improve the internal, acute patient pathway especially front of house and discharge processes, working with clinical commissioning groups to develop their strategies to enhance services in the community

- Transforming the care we deliver – taking forward this key programme to transform how we care for patients through a revolution in our use of information technology by completing the competitive dialogue process and developing a business case for an affordable, achievable programme

- Innovation, research and development – taking a leading role in developing the North East and Cumbria academic health sciences network and rolling out the Trust's new research and development strategy to increase the volume and profile of the Trust's research

Delivering the first five of our strategic programmes above is underpinned by our sixth strategic programme – financial stability – which enables us to generate the financial resources for investment in them. For 2013/2014, our cost improvement target is £22million which will be achieved through a combination of corporate and divisional programmes. Our corporate schemes are focussing on medical productivity, nursing productivity, procurement, medicines management and outpatient efficiency and while we continue to work in a challenging financial environment, we believe there are still areas of opportunity to develop new services, generating additional income, through repatriating NHS activity from our local area back to the trust and through non-NHS sources of income such as private patients.

Governance

Delivery of the trust's strategy and plan is monitored by the board through the monthly board assurance framework and corporate risk register, plus a quarterly report is produced on progress against milestones for each programme. For 2013/14, we are considering enhancing this using a balanced scorecard and strategy map approach.

Quality, safety and service performance are extensively monitored – from board to ward. Monthly divisional patient safety and quality dashboards are produced and reviewed in detail at the quarterly performance reviews and through the quarterly governance report, mortality report, infection prevention and control report.

Assurance on delivery of the cost improvement programme is provided by the programme assurance office, which reports to the director of finance, and progress reports are included in the monthly finance reports to the board. The programme assurance office is also responsible for ensuring that every cost improvement programme has a quality impact assessment and that their impact on quality is monitored. For 2013/2014 we are investing in a programme management software package which will enhance our ability to track delivery and monitor quality impact.

INTRODUCTION

The South Tees Hospitals NHS Foundation Trust (STHFT) Strategic Plan is structured into the following sections:

Current Situation – setting out: the external and internal factors which affect the Trust's strategy and plans. External factors are considered at national, regional and local level, including policy, regulation, demographics, competition and collaboration etc. Internal factors include issues and risks relating to specific services, workforce issues, financial issues and cost improvement requirements.

Strategy – setting out the Trust's strategy including our mission, vision and strategic objectives. The strategy is expected to provide an enduring, long term direction of travel for the organisation, but is reviewed annually in response to our analysis of the current situation to ensure it remains appropriate.

3 Year Plan – setting out our plans over the next 3 years to enable us to make progress towards our objectives and strategic vision. The Trust has structured the plan into 6 strategic programmes which each contribute towards achieving our strategic objectives and vision. Underpinning the strategic programmes are our workforce and financial plans. For 2013/14 there is an additional programme to increase capacity in response to the surge in demand and activity seen in 2012/13.

Governance – setting out the systems and processes by which the Board receives assurance on quality (including patient safety), performance, financial control and CIP delivery (including quality impact assessment). The Trust's internal and external audit plans are also included.

These four sections address the areas set out in the table of guidance provided by Monitor on production of the 2013/14 – 2015/16 Strategic Plan.

CURRENT SITUATION

As part of our annual planning cycle, the Trust completed a thorough analysis of its current situation using a modified PESTLE[1] analysis of national, regional and local issues by corporate teams and Porter's "Five Forces"[2] model to analyse issues at service level. The key issues which were identified are presented below.

Quality & Patient Safety

- **Mortality & HCAIs.** The Trust has continued to deliver high standards of quality and patient safety in 2012/13. Our mortality rate, measured by the Standardised Hospital Mortality Index, is in the top 30% of hospitals in the North of England. Our performance on healthcare associated infections was exceptional with no cases of MRSA and only 49 cases of C Difficile (against a threshold of 80). For 2013/14, this performance has led to a reduced, and very demanding, C Difficile target of only 37 cases and we have declared compliance with this target as a performance risk.

- **Waiting Times.** Despite significant pressure on our services over winter 2012/13 we maintained a good level of performance on the 18 weeks referral to treatment standard at Trust level up to Q3 2012/13 and significantly reduced waiting lists for elective patients waiting more than 36 weeks. But as a result of the continuing increased activity described below, several specialties failed the 18 week target in Q4 of 2012/13 and are likely to fail it in Q1 of 2013/14 due to a growing backlog of patients waiting over 18 weeks. Reducing the backlog to acceptable levels and such that the Trust has a sustainable 18 week Referral to Treatment position will put us at risk of also failing Q2 2013/14, a third consecutive quarter. From Q3, however, we expect to be compliant with the 18 week target and our plans to increase capacity (described in the 3 Year Plan below), including sourcing additional capacity with alternative providers, will ensure that we can maintain elective activity levels through the winter and achieve the targets sustainably. Performance on the cancer access standards has been good but we are continuing to work to improve the timeliness of referrals from other providers.

- **A&E Performance.** With the surge in emergency demand described below, it is no surprise that waiting times in A&E and for ambulance handovers are the main areas of concern. However, we have continued to meet the 4 hour A&E waiting time target and we are confident that we can maintain compliance at Trust level in 2013/14. Ambulance arrivals at A&E have risen to unprecedented levels which has led to handover delays. This is a particular concern to us and we are working internally and across the health and social care system to understand and address the issues.

- **Francis Report.** Following publication of the Francis Report, the trust has commenced implementation of the recommendations led at Board level by the Directors of Nursing and Operational Services. 13 work streams, categorised in 5 themes, have been developed to implement the recommendations:

    - Responsibility for, and effectiveness of, healthcare standards
    - Commissioning for standards
    - Performance management and strategic oversight
    - Caring for the elderly
    - Information

[1] Political, Economic, Social, Technological, Legal, Environmental

[2] Purchaser power, Existing Competitors, Substitute Products or Services (Future Clinical Developments), Supplier power, Market Entry/Exit

National/Regional External issues

- **Health & Social Care Act 2012**. As the transition to the new structures and organisations established by the H&SCA has progressed during 2012/13 the Trust has been establishing new relationships with clinical commissioning groups, various NHS England area teams, and local authority public health functions and Health and Wellbeing Boards. It will be important that we continue to develop these relationships in 2013/14 and beyond.

- **Specialised Services Commissioning.** From April 2013, specialised services will be nationally commissioned to a single service model by NHS England. National service specifications and policies are being produced and the Trust's services will be expected to meet the specifications, or agree time limited derogations and action plans for full compliance by the 31 March 2014. Although initial review of the draft specifications does not indicate significant non-compliance, completion of the reviews and investment to address any gaps will be required to ensure that the Trust maintains its position as the specialised service provider for the south of the North East and the north of North Yorkshire. There may also be opportunities for the Trust to be commissioned to provide additional services where we can meet the national specifications. A particular opportunity is in neuro-rehabilitation where the Trust already provides specialised care but now expects to be formally commissioned during 2013/14 as a specialised neuro-rehabilitation centre.

- **Regional reconfigurations and reviews.** A number of regional service reviews have been completed or are underway, which could have implications for the Trust:

    - **"Safe & Sustainable" Paediatric Neurosurgery Review.** The review team published a framework for Children's Neurosciences Networks (CNN) in February 2012 which states that services should migrate into a number of networks across England with each network based around at least 2 Children's Neurosurgical Centres (Newcastle and Leeds in the North East). The networks also have roles for children's neurological centres, major trauma centres, specialised neuro-rehabilitation centres and designated local DGHs in providing care, including some neurosurgery. The documents state that the implementation of the recommendations will be taken forward by NHS England over a number of years. Ensuring that the James Cook University Hospital (JCUH) plays an appropriate part in any northern CNN will be important for the Trust's specialised trauma, children's and neurosciences clinical services strategy.

    - **North of England Vascular Services.** The North of England Cardiovascular Network, Vascular Advisory Group, has recommended that vascular services in the North East are rationalised from 5 to 3 units, with JCUH as one of the units. This would result in a significant increase in the vascular activity at JCUH but at present it is not clear whether commissioners have agreed to the reconfiguration or its timescale.

    - **Northern Neonatal Intensive Care Services.** In October 2012, the Northern Neonatal Network Board approved an outline strategy for Neonatal Intensive Care Units in the region. Recognising financial and workforce constraints, the strategy states that the status quo of 4 units is not sustainable and that the service should consolidate into 2 larger units. Further work is ongoing on how this could be achieved to enable CEO and commissioner approval to be sought. Retaining a NICU service at JCUH is critical to the Trust's clinical services strategy objective to be a specialised children's services provider so the Trust will remain closely engaged with this process.

    - **North of England Cancer Network Radiotherapy Satellite Unit.** Due to a lack of radiotherapy capacity and long transport time to access radiotherapy services for patients between Newcastle and Middlesbrough, the North of England Cancer Network (NECN) proposed that an additional radiotherapy satellite unit should be established in the Durham / Sunderland area through a competitive tender process. The case for the satellite unit is

based on improved access to radiotherapy leading to an increased volume of activity which offers an opportunity to grow the Trust's radiotherapy service. But there is also a risk to the Trust's JCUH service if another organisation provides the satellite unit and activity volumes do not increase since patients from the northern end of our catchment are likely to choose the satellite unit instead of JCUH. Recognising both the risk and opportunities of this development, the Trust has already established a working group and done a significant amount of development of the potential clinical service model, financial model, location, facilities and equipment. We have also set up a partnership arrangement with HTI to work with us to provide the satellite unit. Issue of the tender documentation is expected later in 2013.

- **Tees Valley Acute Services Quality Legacy Programme.** The outgoing Tees PCTs commissioned work on standards for acute care, the 'Acute Services Quality Legacy Project ', designed to inform the developing commissioning strategy for the incoming Tees CCGs. The scope and impact of this project will be an influence upon the future planning for the Trust in the years beyond 2013-14.

- **North Yorkshire & York Strategic Review**. The NYY Strategic review in 2011 recommended a significant reduction in acute beds and more care in the community. Subsequently NHS NYY commissioned KPMG to review the configuration of acute services. For Hambleton, Richmondshire and Whitby, it has been recognised that activity flows and clinical networks look northwards towards the Tees Valley rather than southwards to the rest of North Yorkshire. As a result implementation of the review recommendations is focussing on York, Harrogate and Scarborough.

Local CCG Commissioning Intentions

- **Care closer to home.** The Trust works predominantly with South Tees and Hambleton, Richmondshire and Whitby (HRW) CCGs, but also provides services on behalf of a number of other surrounding CCGs. For South Tees and HRW the Trust provides both acute and community services and the main theme remains the drive to reduce secondary care activity by moving care into the community and closer to home. This is reflected in both CCGs' Clear and Credible Plans and the commissioning intentions agreed with them for implementation in 2013/14. The Trust has agreed to work with both CCGs on their strategies to enhance and reconfigure community services to improve the management of patients with long term conditions, improve access to primary and community care and avoid admissions.

- **QIPP unplanned care – improving care in the community to avoid acute admission** The demand management plans of local CCGs have the potential to impact upon Trust income. But the very high levels of non-elective activity seen in 2012/13, particularly over the winter, disrupted the Trust's elective programme and the emergency activity threshold meant that the Trust is only paid a marginal (30%) tariff for that activity. Reducing non-elective activity is good for patient care and should make the Trust more cost effective so there is very close working between the Trust and the CCGs on the shared agenda to reduce non-elective admissions. During 2013/14, however, our commissioners have recognised that the Trust will need to invest in additional acute beds to ensure we have sufficient capacity to manage the expected level of non-elective demand and maintain our elective programme.

- **QIPP planned care – reducing referrals, attendances, admissions.** CCG QIPP plans and elective pathways have been factored into the demand plans underpinning the 2013/14 contracts. The threats to the Trust from decommissioning are assessed as marginal over the three years of this plan, as no significant changes have been signalled by Commissioners.

- **Retendering.** As with decommissioning, the threat to the Trust's services from commissioners seeking to market test services through competitive procurement is assessed as marginal. Only our Local Authority Public Health commissioners and NHS England as commissioner of our two primary care practices have indicated that they want to review their services over the next year with a view to identifying ones they need to re-procure. We were given notice on our community stop smoking service in 2012/13 and are expecting public health to commence a tender process soon. No other commissioners have indicated any intention to re-procure any of our services through AQP or any other process. Opportunities to provide additional services through AQP or other competitive procurements continue to be closely monitored

Demand and Demographic Impact

- **Demand Trend.** With the exception of outpatient activity, the Trust is expecting steady growth in acute activity across the broad range of trust services. Growth is driven by general demographic growth (particularly for over 75 year olds where activity growth is 3 times the rate of population growth) plus growth in specific services, such as radiotherapy, interventional cardiology, lower GI endoscopy, cancer awareness campaigns etc, driven by commissioning intentions to meet national guidance on expected levels of demand for our population. Activity changes due to demographic growth have been calculated by analysis of ONS prevalence rates for 5 year age bands for each specialty, point of delivery and geographic area. Overall this generates around 1% growth in activity per year. In addition service developments to ensure that the Trust is offering our patients the best treatment options contribute to the general increase in acute activity. Activity growth is offset by commissioners' QIPP demand management plans and plans to enhance community services and move acute activity closer to home.

- **Winter 2012/13 Surge.** In addition to the general trend in activity growth, 2012/13 has seen an additional surge in emergency demand well above the trend. The winter period has been particularly severe and started earlier and ended later than is normal. This phenomenon has been acknowledged across the whole of the North East and at times nationally. The Trust's designation as a major trauma centre at the start of 2012/13, the increasing centralisation of specialised services and the resulting reputation of JCUH all seem to have contributed to increased activity coming to the Trust. A&E attendances by ambulance have seen a particularly high rate of increase.

  This surge in activity has led to significant numbers of outlying patients[3], predominantly from acute medicine but also from surgery and occasionally from specialty medicine, peaking with 118 outlying patients on one day during the winter. This pressure has had a significant impact on the Trust's elective programme with widespread cancellations caused by the unavailability of beds. It has become increasingly apparent that the number and allocation of beds at JCUH is no longer correct. The scale of the mismatch between capacity and demand means that the normal responses of process efficiency improvements to reduce length of stay will not address the issue and the Trust has concluded that we need to invest in additional capacity to ensure this winter is not repeated in 2013/14. The current Payment By Results rules on only a 30% marginal payment for emergency activity above the level seen in 2008/9 mean that this investment will increase the financial pressure on the Trust.

  As a result of the increased activity and mismatch of capacity and demand, several specialties failed the 18 week target in Q4 of 2012/13 and are likely to fail it in Q1 of 2013/14 due to a growing backlog of patients waiting over 18 weeks. Reducing the backlog to acceptable levels and such that the Trust has a sustainable 18 week Referral to Treatment position will put us at risk of also failing Q2 2013/14, a third consecutive quarter. From Q3, however, we expect to be compliant with the 18 week target and our plans to increase capacity (described in the 3 Year Plan below), including

[3] An outlying patient is one who is on a ward run by a different specialty to the one they are admitted under.

sourcing additional capacity with alternative providers, will ensure that we can maintain elective activity levels through the winter and achieve the targets sustainably.

Market Share, Choice & Competition

The Trust's local market share (ie for South Tees and Hambleton, Richmondshire and Whitby areas) has remained fairly static over the last 18 month period (where Independent Sector provider data submission has been comprehensive) at around 87-88%. There is little service competition in our core areas of patient population from Middlesbrough, Redcar & Cleveland and Hambleton, Richmondshire and Whitby. The Trust has a strong position within the local health economy, based on a strong local geographic preference through patient choice and service delivery. There is however both competition and opportunity in the boundary areas of Stockton-on-Tees, Hartlepool, Darlington and South Durham. The table below shows the Trust's main competitors and market share for our main catchment areas and services:

Area	Services	STHFT Market Share	Competitors
South Tees	Community Services	Vast majority[4]	North East Community Health Network Independent sector (eg AQP Audiology) 3rd sector
	General secondary care	90.6%	Independent Sector (5.3%) North Tees & Hartlepool FT (1.7%) Newcastle Upon Tyne Hospitals FT (1.6%)
	Specialised (tertiary) care		
Stockton	General secondary care	22.4%	North Tees & Hartlepool FT (68.6%) Independent Sector (5.2%) Newcastle Upon Tyne Hospitals FT (2.4%)
	Specialised (tertiary) care		
Hartlepool	General secondary care	12.2%	North Tees & Hartlepool FT (68.6%) City Hospitals Sunderland FT (6.1%) Independent Sector (1.6%) Newcastle Upon Tyne Hospitals FT (3.0%)
	Specialised (tertiary) care		
Darlington	General secondary care	8.5%	County Durham & Darlington FT (81.8%) Independent Sector (3.9%) Newcastle Upon Tyne Hospitals FT (3.6%) North Tees & Hartlepool FT (1.3%)
	Specialised (tertiary) care		
Durham Dales, Easington, Sedgefield	General secondary care	5.7%	County Durham & Darlington FT (53.6%) City Hospitals Sunderland FT (17.8%) North Tees & Hartlepool FT (17.3%) Newcastle Upon Tyne Hospitals FT (4.6%)
	Specialised (tertiary) care		
Cumbria	General secondary care	4.0%	City Hospitals Sunderland FT (1.7%) Northumbria Healthcare FT (12.4%) Newcastle Upon Tyne Hospitals FT (77.7%)
	Specialised (tertiary) care		
Hambleton, Richmondshire, Whitby	Community Services	Vast majority[5]	Independent sector 3rd sector
	General secondary care	80.5%	York & Scarborough FT (7.9%) County Durham & Darlington FT (5.1%) Independent Sector (1.9%)
	Specialised (tertiary) care		

[4] Patient choice has not yet been extended to most community services and STHFT provides the majority of the community services in South Tees. Activity is not reported in the same way as for acute services yet so it is not possible to provide a percentage market share for community services.

[5] Patient choice has not yet been extended to most community services and STHFT provides the majority of the community services in Hambleton, Richmondshire & Whitby. Activity is not reported in the same way as for acute services yet so it is not possible to provide a percentage market share for community services.

Looking forward, the main competition issues which could affect our market share are assessed as:

- **Impact of increasing waiting times and cancellations on market share.** The main weakness identified for the Trust in maintaining our local market position has been the impact of emergency admissions pressures in 2012-13, particularly during the winter months, on the elective programme and on patient experience of cancelled operations, compared to Independent Sector providers. This exposes the Trust to risk that patients may choose alternative providers for their planned care needs in future, based on lower waiting times and less risk of having their operation cancelled. Cancellation of planned surgery has resulted in lost income to the Trust during 2012/13, due to pressures on bed and theatre capacity. As mentioned above, the Trust plans to invest in increased capacity for 2013/14 to mitigate this risk and more details on our plans are provided in the 3 Year Plan section below.

- **Competition for Specialised Service Provision.** For our specialised services there is always a risk that patient flows will change as other providers develop services. In particular there is a risk that patients from South Durham could increasingly head to Newcastle for treatment. This risks current flows of activity into the Trust with implications for cancer, heart and neurosciences services. With a specialised services catchment population near the minimum required to sustain the services, retention of these services in the long term is dependent on maintaining our market share in our catchment area by matching or exceeding developments in other providers to maintain the reputation of our services. The key competition in terms of specialised tertiary services comes from NUTH. The Trust's plans to mitigate these risks through ongoing service developments and process improvement are described in the plan section below.

- **Community services competition & tendering.** Since there is no entitlement to choice of community services outside of AQP services there is minimal competition currently for the delivery of community services to the local populations covered by South Tees CCG and Hambleton, Richmond & Whitby CCG. Commissioners are, however, increasingly considering the use of tenders to introduce new providers and make savings as barriers to entry in community services are usually much lower than in acute, consultant led services. Although competitive procurement activity is currently low, some small elements of Local Authority Public Health contracts are currently undergoing procurement processes and others are expected to follow over the next three years. No new AQP tenders have been currently indicated by the local commissioners covering services provided under contracts with the Trust. To mitigate this risk and seize any new opportunities the Trust has a robust monitoring process to ensure tenders are identified, shared with relevant services and reviewed for their strategic fit so that a decision to bid or not can be taken.

Key Service Issues

- **Friarage Hospital Northallerton Paediatric and Maternity Services**. During 2012/13 Hambleton, Richmondshire and Whitby CCG and the Trust undertook an engagement process about a planned service reconfiguration for paediatric and maternity services. In December 2012, the North Yorkshire County Council Overview and Scrutiny Committee referred the proposals for consultation to the Secretary of State as they were unhappy about the options to be consulted on. The Secretary of State responded on 23rd May confirming that consultation should proceed on the two options previously proposed by the CCG and Trust. The timing of consultation is being linked by HRW CCG to a wider strategic planning exercise being proposed by Tees Valley CCGs which has implications for the HRW population.

- **Gastroenterology Demand & Capacity.** The national bowel cancer awareness campaign has led to significant increases in demand for lower gastro-intestinal endoscopy and national guidance is for Trusts to plan for annual 10% increases in lower GI endoscopy each year until 2016/17.

Existing increases in demand have put the service under pressure already and the Trust has recognised that a significant investment in additional capacity is required. As most gastroenterology services are facing similar issues, demand for staff is high so we expect that recruiting additional consultant staff may be difficult.

- **Rehabilitation Services.** As a specialised neurosciences, spinal injuries and major trauma centre rehabilitation services play an important part in delivering high quality care. In addition rehabilitation and re-ablement are key to maintaining quality of life and avoiding further admissions for the increasingly elderly population that we care for in our secondary care and community services. The Trust has recognised that more strategic attention to these services is required.

- **Primary care practices.** Our current contracts for Resolution Health Centre and Marske Health Centre end on 31 December 2013 and 31 March 2014 respectively. The new commissioners for primary care services are the Area Teams for core GP services and the CCG for unregistered patient activity. They will be reviewing services to inform decisions on whether to offer a contract extension or to re-tender the services.

- **Imaging (particularly MRI) Capacity.** Demand for diagnostic imaging continues to increase year on year, particularly in MRI which has seen more than 10% annual growth in activity for the past few years with no sign of this trend abating. Access to MRI is particularly important for many cancer services, cardiology (where cardiac MRI is becoming a standard tool) and in musculoskeletal services. MRI technology is also advancing rapidly and 3 Tesla machines, which can provide higher quality or more rapid scans, are becoming more commonplace. The Trust needs to increase MRI capacity now and has an opportunity to both increase capacity and keep abreast of new technology by using the planned replacement of one of our existing scanners to install a 3T scanner.

- **James Cook University Hospital Obstetric Capacity.** A rising birth rate means that the obstetric unit at JCUH is at capacity. The draft business case supporting planned changes to paediatric and obstetric services at Friarage includes proposals for increased capacity both to accommodate the increase in births from this catchment but also to ensure that there was headroom to accommodate future increases in the number of deliveries.

- **Maintaining market and clinical leadership.** While the current situation section of our Strategic Plan has identified many major issues which the Trust must address, we must also ensure that our services continue to implement new techniques, procedures and technology. Neglecting investment in these areas risks our services falling behind those in other trusts and so puts our reputation as a leading healthcare organisation at risk. Despite the financial climate and the pressure of other issues, particularly the current mismatch of capacity and demand, we are continuing to seek ways to develop our services in specific areas by developing business cases that generate income to offset the additional costs.

Workforce

The demand for the Trust's services continues to grow as it deals with the health related consequences of high levels of socio-economic deprivation and an ageing population. To address this there will be an on-going need to restructure, re-profile and change the skill mix of the workforce to ensure services are affordable and provide the highest level of care. The workforce needs to be highly flexible in response to changes in demand for healthcare and the move of more treatment from hospital to community based services and the increased use of tele-health technology.

Key workforce risks and issues identified are:

- Reduction in specialty training numbers. National plans to reduce the number of medical trainees, primarily in general surgery, trauma and orthopaedic surgery, obstetrics and gynaecology and anaesthetics, will potentially impact on the sustainability of out of hours cover, on call rotas etc which currently rely on medical trainees. More use of nurse practitioners will be required.

- Specific senior medical staffing. Specific senior medical workforce risks include:

    - Replacement consultant neonatologists

    - Consultant neuroradiology capacity

    - Haematology, oncology and dermatology medical staffing (potentially at risk as specialty training is diverted to cover acute medicine)

    - Cardiac physiologists

    - Cardiothoracic anaesthetics (regular use of locums as a national shortage in this specialism)

    - Erosion of critical care skills of cardiothoracic surgical registrars

- Modernising Scientific Careers and impact on practitioner training

- Nursing workforce staffing levels and skill mix, recruitment for attitude and the change to degree entry;

- The impact of voluntary registration of healthcare assistants

Finance

- **NHS Income.** Income in 2012/13 was £15.1m above plan due in the main to receipt of non-recurrent monies from PCT's linked to specific projects and a small overtrade against PCT contracts. For 2013/14, with the exception of Hambleton, Richmondshire and Whitby CCG, the Trust has signed contracts with all our main commissioners. Although the contract negotiation process began late due to the transition to the new commissioning organisations and was complicated by the changes in responsibility for specialised commissioning and some significant tariff changes, the outcome has been generally positive. After two years of risk share contracts with NHS Tees, both the Trust and all our commissioners were keen to return to full PbR based contracts for 2013/14. In contrast to the expected 1.8% reduction in tariff which we predicted in the 2012/13 Monitor Plan, we have seen an actual tariff reduction (on a broadly like for like basis) of around 1%. Adding in income for increased demand, fully funding a number of previously underfunded services and some important new developments, the Trust has secured an increase in contracted income compared to 2012/13 of £16.3m (£531m compared to £514m). After a number of years of discussion, we have finally gained agreement from commissioners to fund critical care outreach which we believe is a significant step forward for patient care in the Trust.

- **Income Diversification**. The Trust is exploring opportunities to diversify our income streams, but the potential in local health economy is limited. The two key areas are private patient income and research and development income.

    - **Private Patient Income.** Currently the Trust earns around £1.5m from private patient activity but we are aiming to significantly increase this over the next few years. In 2012/13 we completed a detailed market assessment which indicated that we only capture a small proportion of the local private market, based on the number of private providers in the vicinity of the Trust and their capacity. Our research also indicated that margins of 20% or more are achievable. Based on our research we established a pilot programme to set up a number of

new private services and to redesign and improve our private patient processes. This project was completed in March 2013 with the first patients being treated in the new services in February. Although the financial returns to date have only been small, the pilot project has given us a firm basis for further growth and a key outcome has been a huge improvement in consultant engagement leading to increasing numbers of consultants approaching us wanting to develop their private practice with the Trust. However, while this is a positive development, it is important to note that the private patient market in our region is small and so even with a significant increase, private patient income will only ever be a very small proportion of the Trust's income.

- **Research & Development Income.** In late 2012/13 the Trust launched a new Research & Development Strategy which aims to expand the Trust's R&D programme. While we intend that this will attract additional research funding to the Trust, the nature of research funding is that it is ring-fenced for research and so contributes very little direct financial benefit. As with private patients, research funding is likely to remain small in comparison to the Trust's total income. The primary benefits of enhancing our R&D programme are not financial, but in quality and reputation. There is good evidence that organisations with a strong research programme deliver better care and are able to attract and retain high quality staff.

- **Expenditure.** Operating expenditure in 2012/13 was £17.5m above plan due to the additional income described above and costs associated with delivery of additional activity, not all of which was recoverable. For 2013/14 our expenditure forecast is £14.1m ahead of the previous plan due to: additional running costs associated with increased activity assumptions; CCG service development investments; and general cost pressures greater than previously anticipated.

- **Cash.** Cash in 2012/13 was £11.9m above plan, due to a combination of slippage on capital schemes, a significant reduction in NHS debt, and additional non-recurrent funding received from PCTs in year. Cash carried over from 2012/13 will be deployed during 2013/14 to ensure that planned investments can be delivered.

- **Cost Improvement.** P&E delivery in 2012/13 was in line with plan, although the % split between recurrent and non-recurrent savings was less favourable, 90:10 plan vs 63:37 actual. The shortfall in recurrent delivery (£2.1m) has been reflected as a cost pressure in the 2013/14 plan. For 2013/14, P&E planning requires divisions to identify 75% of savings as recurrent. The remaining 25% can be delivered non-recurrently and allows some flexibility to meet unexpected circumstances e.g. income generation opportunities. Based on our assumptions in 2012/13, the expected cost improvement target for 2013/14 was £24.7m. Based on the actual contracted income agreed with commissioners and updated estimates of costs, this has been revised slightly now to £22.0m

STRATEGY

The Trust Board was presented with a summary of the analysis above, outlining the Trust's current situation, in October 2012. Based on the analysis the Board confirmed that the Trust's strategy, as set out in our Strategic Plan for 2012/13, remained valid.

At this point the extreme pressure from increased non-elective activity over winter 2012/13 was not apparent. But, while that issue changed the priority and focus of our plans for 2013/14 from bed reductions achieved through increased efficiency to increased bed capacity to match demand, we are still confident that our long-term strategy focussed on specialised services, integrated acute and community services and a culture of clinically led continuous improvement in quality and safety is correct.

For completeness, the Trust's strategy is restated below:

MISSION

The Trust's purpose is to deliver the best clinical outcomes for patients, without causing them harm while offering them, their families and carers the best experience possible. There is significant evidence that integration is critical to delivering high quality, efficient services and, as a provider of acute and community healthcare, the Trust must be at the forefront of delivering integrated services. To reflect the importance of focussing on quality and particularly safety, even in difficult financial times, and the opportunities of integration, we have defined the Trust's mission as:

> **To provide high quality, safe and integrated specialised, secondary and community healthcare services for patients, their families and carers**

VISION

While our mission simply states what the Trust exists to do, our vision states our ambition for how well we will do it. The Trust is already nationally recognised as one of the leading healthcare providers in England for the quality of our services, as reflected by our 12 years running in the CHKS "Top 40 Hospitals", our membership of NHS QUEST and our recent performance on pushing forward patient safety. We have always placed the highest priority on patient safety and we recognise the importance of continuous service improvement and development if we are to maintain and improve our status and reputation amongst the other leading providers in the country. Our vision, therefore, is for our standards of patient safety, quality and continuous improvement to be recognised as those which others aspire to:

> **To set the national standard for excellence in patient safety, quality and continuous improvement**

VALUES

Our values, below, express our ethos as an organisation, setting out the fundamental standards and expectations we all have of each other. Our first and most important value is that we focus on our patients and on delivering the best that we possibly can for them. The second focuses on how we work together, recognising that everyone employed by or involved with the Trust contributes to our success. Our third and final value reminds us all that we cannot stand still but must always be looking for ways to improve what we do and how we do it.

> **Putting our patients at the centre of everything we do**
>
> **Supporting, respecting and valuing each other**
>
> **Delivering continuous quality improvement**

STRATEGY

To deliver on our mission and achieve our vision, in a manner consistent with our values, the Trust's strategy is in two parts: our Clinical Services Strategy for what services we provide; and the Transformational Themes which describe how we deliver them.

The basis of the Clinical Services Strategy is for the Trust to be the specialised services provider for the North of North Yorkshire and the South of the North East, and to provide integrated healthcare for our local communities of Hambleton, Richmondshire and Whitby, and Middlesbrough, Redcar and Cleveland. Our specialised services provide a strong identity for the Trust as having expertise in complex, tertiary care and attract patients from a much wider area than could be achieved with only our secondary services. They have helped establish our reputation as an outstanding provider and attract highly skilled staff to the Trust. Our secondary and community services provide a high volume of activity which enables us to achieve the critical mass in our clinical teams, essential to support the specialised services.

The Transformational Themes describe the way in which we work as an organisation to deliver, develop and improve our services. With our unrelenting focus on quality and patient safety, this is the first transformational theme which covers mortality, patient safety, patient experience and operational excellence. Achieving our goals for quality is supported by the other three themes:

- Organisational Capability which focuses on the leadership, engagement, teamwork and capability, particularly for service improvement, of our workforce
- Business Sustainability which focuses on our ability to generate and use financial and information resources
- Partnerships and Engagement which focuses on developing and maintaining the external relationships which are critical to our success.

To define what we need to do in order to deliver on our mission and achieve our vision, we have set 18 strategic objectives across the four transformational themes and the clinical services strategy. Measurement of our progress against the objectives provides a balanced scorecard for the Trust's development and improvement, ensuring that we are balancing delivery today vs development for tomorrow, internal and external issues, quality and finance. For each objective we have identified a measure or measures and set a long-term improvement target and a short-term target for the next year. In addition to more regular reports on specific areas such as finance, performance and quality, a single report on all the objectives and our performance against the targets is reported to the Board quarterly in the Strategy Balanced Scorecard.

3 YEAR PLAN 2013/14-2015/16

To deliver the strategy set out above, the Trust's annual plan is structured into six strategic programmes:

- Quality & Patient Safety
- Specialised services development and growth
- Improving the patient pathway
- Transforming the Care we Deliver
- Innovation, Research & Development
- Financial sustainability

For 2013/14, however, our top priority is to increase our operational capacity to ensure that the situation we experienced in 2012/13 does not recur. These programmes are underpinned by workforce development and financial plans. Brief descriptions of the key projects and workstreams in each programme are set out below, with the operational capacity plan first as our top priority.

Operational Capacity Plan

As described in the current situation section, winter 2012/13 has highlighted a serious mismatch between demand, particularly for emergency care, and the Trust's capacity. A repeat of winter 2012/13 in 2013/14 could put the Trust's reputation with the public, patients and commissioners at risk and would severely affect the morale, engagement, confidence and trust of our staff. Most importantly it would present unacceptable quality and patient safety risks. Together these issues could pose a serious strategic risk to the organisation. Increasing capacity to match demand has therefore been agreed by Management Group and the Board as the Trust's highest priority for 2013/14. In outline, the Trust's plan consists of the following:

- Increase bed capacity at JCUH by 50 beds, retain the temporary additional 10 SAU beds and re-allocate 15 beds from current cardiology bed complement to acute medicine.
- Increase consultant presence at front of house (AAU, short stay unit, A&E) including increased geriatrician presence in AAU.
- Increase front line infrastructure (junior doctors supporting acute physicians, hospital @ night capacity, emergency nurse practitioners)
- Continue existing pilot schemes for A&E therapists, alcohol follow up clinic, acute respiratory assessment service.
- Support the routine elective programme by planning additional weekend operating lists in January – March 2014 and ring fencing elective capacity for 6 months in 2013/14 (June – December) and 9 months in future years (April – December)
- Develop 7 day working in support services to match the non-elective programme
- Investigate the potential to make greater use of the Friarage and Community hospitals to create capacity at JCUH, and to purchase capacity in the independent sector or other organisations to relocate elective work.

In total this represents a recurring investment of in excess of £6m. The part year effect in 2013/14 is planned to be £5m although there may be some limited non-recurrent financial support in 2013/14 via the A&E Recovery Plan announced by NHS England in mid May.

Quality & Patient Safety

- Improved prevention, identification and management of the acutely ill patient
    - Embed the use of the early warning score and SBAR tool (CQUIN)
    - Establish a critical care outreach service. Commissioners have funded this service to start in October 2013 with an annual cost of £900k.
- Improve and standardise surgical pre-assessment services, particularly for high risk surgical patients
- Prevention of HCAIs
    - Improve the prevention and management of infection related to surgical sites and urinary catheters
- Improved prevention and management of pressure ulcers (CQUIN)
- Improved prevention and management of venous thrombo-embolism (CQUIN)
- Improved care of patients with dementia and support to their carers (CQUIN)
- Implement the NHS Friends & Family Test (CQUIN)
- Sterile Services decontamination improvements.
- Improvements to ward 3 to provide a fit for purpose infectious diseases ward. This work will also establish the template for modernisation of the remaining eleven wards requiring upgrading.
- Relocation of Haematology into appropriate accommodation on ward 33 to address long standing concerns about the environment provided for this service.

Specialised Services Development & Growth

- **Cancer Services**
    - Endeavour Unit (Radiotherapy & Oncology Development).
        - Final completion of the capital programme: upgrade of linear accelerator 5
        - Increase radiotherapy activity to: 48K fractions in 2013/14, 50K in 2014/15, 51K in 2015/16
    - Radiotherapy Satellite Unit. Develop a bid to provide a satellite unit in response to North of England Cancer Network / Specialised Commissioners competitive procurement process.
    - Gastroenterology (lower GI endoscopy) Capacity. In response to increasing demand for lower GI endoscopy and further 10% year on year growth expected until 2016/17, the Trust is planning to invest around £2m in a phased programme to increase endoscopy capacity. A business case has been developed which identifies a requirement to move the service to

3 session working and recruit 4 wte consultants or nurse consultants plus supporting staff. This would provide the capacity required up to 2015 to meet demand and train additional nurse endoscopists for future capacity increases.

- Haematology Day Unit and Ward redevelopment. The current haematology day unit accommodation is the worst in the Trust and is not up to the standards we aspire to. There is also insufficient capacity to meet rising demand for haematology. Work will start in 2013/14 on a £0.8m programme (£500k charitably funded) to develop a new day unit and ward, including dedicated accommodation for the teenagers and young adults cancer service, for occupation in 2014/15.

- Increase involvement in cancer trials and research (linked to R&D strategy)

- Ovarian cancer screening. A national study is expected to be published in 2013 with recommendations on a national screening programme. Subject to the conclusions of the study, the trust intends to prepare and position itself during 2013/14 to be designated as a screening centre, probably during 2014/15.

- Increase cancer diagnostic capacity. Demands on diagnostic services for cancer are continuously increasing and the Trust expects that additional investment in diagnostic capacity will be required in the next few years.

    - MRI Capacity. We are developing proposals to use the planned replacement of one of our existing MRI scanners in 2013/14 to upgrade to a 3 Tesla MRI scanner. This will provide increased MRI capacity as well as access to higher quality imaging. As well as cancer services, this will support a wide range of services including cardiothoracic, musculoskeletal services. During 2013/14 we will also continue to develop plans and seek to approve a business case for an additional MRI scanner at the Friarage Hospital to be implemented probably in late 2014/15.

    - Beyond MRI, current diagnostic capacity and expected demand will be reviewed in 2013/14-2014/15 to identify options for further development.

- **Heart Services**

    - Cardiac Catheter Lab Refurbishment and Expansion. Complete the refurbishment of Labs 1 & 2 which by the end of 2013/14 will result in the Trust having four catheter laboratories to support service expansion for the unmet demand for interventional cardiology.

    - Service developments. Implement or expand services for:

        - Renal denervation

        - Left Atrial Appendage Occlusion

        - Minimally Invasive Repair of Pectus Excavatum

        - Transient Loss of Consciousness Service expansion

    - Advanced Critical Care Practitioners. Expand the ACCP training programme to train 3 further practitioners to reduce reliance on cardiac anaesthetist consultants and medical trainees.

- **Trauma Services**

    - Vascular interventional radiology. Implement a 24/7 vascular interventional radiology on call service to support the Major Trauma Centre

- Vascular Services Reconfiguration. As identified above, the North of England Cardiovascular Network is developing proposals to reduce the number of vascular centres in the north east. Our vascular team is closely engaged with this work and the Division of Surgery is developing plans to increase capacity in the vascular service in readiness for the changes.

- A&E Capacity and Resilience. The Operational Capacity Plan (above) includes an expansion of A&E staffing to increase the service's capacity and resilience. In addition, options to increase resuscitation capacity are being developed.

- Trauma rehabilitation. Review and improve post trauma rehabilitation services and pathways

- **Children's Services**

  - Friarage Hospital Paediatric & Maternity Services. Complete the formal consultation on the service reconfiguration, develop and gain approval for the final business case and begin implementation of the new service model.

  - Maternity IT. Implement an improved, single system on both sites which supports the maternity pathway tariffs.

  - Paediatric Plastic Surgery. Establish a dedicated paediatric plastic surgery clinic within the children's ward area (currently the clinic is run within an adult clinic which does not provide the best patient experience or the most appropriate environment for children).

  - Elective Caesarean Section Lists. Currently there are no dedicated elective caesarean section theatre lists so elective caesareans can be cancelled to accommodate emergency procedures. A business case to address this risk is being developed for Board consideration during 2013/14.

  - Additional Obstetric Theatre. To accommodate the increasing demand for births at JCUH, the Trust intends to begin a programme to create an additional obstetric operating theatre during 2013/14.

- **Neurosciences**

  - Neuro-rehabilitation. A needs assessment produced on behalf of specialised commissioners has established the requirement for two specialised neuro-rehabilitation centres in the North East. Commissioners have indicated that they would commission JCUH as one of the centres subject to it meeting the requirements for a specialised centre. The Trust has approved investment in the additional medical and therapy staff to meet the requirements in order to be commissioned as a specialised centre in 2014/15.

  - Paediatric Neurosurgery Reconfiguration. As described above, the Safe & Sustainable review has proposed a new, network based model of care for children's neurosurgery. It is not yet clear exactly how services will be reconfigured into this model, but we will continue to monitor developments to ensure we can respond as necessary.

Improving the Patient Pathway

- Front of House. Winter 2012/13 and a visit by the Emergency Care Intensive Support Team (ECIST) have highlighted a number of aspects of the Trust's front of house processes which could be improved. One of South Tees CCG's top priorities in its commissioning intentions for 2013/14 is to work with the Trust to review front of house processes within the Trust and their interface to the rest of the system. The CCG has agreed to support the Trust to run a number of RPIWs to look in detail at the issues and make improvements in time for winter 2013/14.

- Discharge. Winter 2012/13 also demonstrated that discharge processes within the Trust, but also across the whole health and social care system, are not working well. To address the issues the Trust has invested in dedicated case managers whose role is to facilitate the discharge of the more complex patients. The impact of these staff will be reviewed in 2013/14. In addition the Trust, supported by South Tees CCG, and working in partnership with the local authorities, will run a number of RPIWs to look at discharge across the local health and social care system

- Reducing Non-Elective Re-admissions. During 2012/13 the Trust reduced non-elective re-admissions by 10%. Improved patient pathways, discharge processes and more care options for patients in the community setting are required to further reduce re-admissions. During 2013/14 the Trust will continue to work with the CCGs and Social Services to continue this improvement work.

- South Tees Enhanced Community Services. During 2012/13, the Trust established a rapid response community nursing service, an integrated therapy service and an integrated community care team (or virtual ward) to enhance services in the community and avoid acute admissions. During 2013/14 the Trust will continue to work to embed these services and ensure that they are fully utilised, particularly by GPs.

- South Tees Future of Primary Care. Currently the Trust provides two primary care practices, including a walk in centre, in South Tees. Both contracts expire in 2013/14 and the Trust has already begun to review the strategic case for providing these services. Their future is also being reviewed by commissioners.

- South Tees Integrated Frail Elderly Care Pathway. Towards the end of 2012/13, the Trust began a major piece of service improvement work to redesign the acute and community frail elderly care pathway. This work will continue during 2013/14 and probably into 2014/15.

- South Tees CCG "IMPROVE". South Tees CCG is developing a strategic outline case for the future of community services, particularly for the vulnerable elderly, and intends to run a public engagement and consultation process during 2013/14. The Trust is closely engaged through the Chief Executive and Director of Operational Services with the development of the strategy. The strategy is likely to have a significant impact on the Trust's community services in South Tees, including the workstreams above.

- HRW enhanced community nursing. HRW CCG has secured some local authority controlled health and social care funding to increase community nursing capacity in 2013/14. The Trust has begun the recruitment process with a view to increasing capacity as early as possible in 2013/14.

- HRW frail elderly services strategy. Similarly to South Tees CCG, HRW CCG is developing an engagement and consultation plan on the future of the area's services for the frail elderly. The initial engagement stage is currently underway.

- Divisional Transformation Plans. As well as the corporately led workstreams, each division has developed its own transformation plan to improve areas such as increasing day of surgery (or procedure) admission, use of daycases and outpatient procedures as standard processes and

standardising pathways of care all aimed at reducing length of stay. Reviews of the transformation plans are currently underway to assess divisional progress and agree new targets for improvement

Transforming the Care we Deliver

- Transforming the Care we Deliver is the Trust's programme to use the opportunities presented by modern communications and information technology to radically redesign how we provide care to our patients. Our aim is to increase quality and safety significantly, while also achieving substantial cost reductions. The programme will include a new patient administration system, electronic patient record, electronic document management and other systems such as e-prescribing.

- During 2012/13 the Trust has been running a competitive dialogue process and by December 2012 had narrowed the bidders down to two, Capita and CSC. In March 2013, however, CSC decided to withdraw from the process since the Trust could not commit to the interim agreement reached between CSC and the Department of Health for use of its Lorenzo patient administration system. As a result the process is left with only one bidder, Capita.

- In 2013/14 the Trust aims to complete the competitive dialogue process with a best and final offer from the remaining bidder. Based on this offer the Trust will develop the business case for the programme to demonstrate its quality and financial benefits, but also its affordability. At present no costs or savings have been built into our financial plan. It is likely that expenditure will be required before benefits and savings can be realised which will increase costs and reduce our financial risk rating in the early part of the implementation programme. The Trust will continue to keep Monitor fully informed of the progress of the programme and will present a full analysis of the costs and benefits once the implementation programme and business case have been confirmed.

Innovation, Research & Development

- Academic Health Science Networks. The North East and Cumbria submitted a bid to be designated as an AHSN in October 2012. We want to be at the heart of the AHSN and our Chief Executive and Medical Director were involved in developing the proposal. Following evaluation by a panel convened by NHS England, it was planned to interview AHSN teams in January / February 2013, following which an announcement would be made. NHS England has recently announced that 15 AHSN's will be established, including the North East and Cumbria, and work is now progressing to appoint a chairman.

- Research & Development Strategy. The Trust's new R&D strategy was launched in April 2013 and aims to increase the profile and volume of research in the Trust. Actions in 2013/14 will focus on improving governance and communications, increasing the resources available to support applications for research funding and developing divisional research strategies. Beyond 2013/14, the strategy will focus on increasing recruitment to portfolio studies, increasing grant income and increasing academic appointments.

Financial Sustainability

- As outlined above, the Trust's cost improvement target for 2013/14 is £22.0m. This will be delivered through a combination of trust wide corporate programmes and individual division and directorate plans. A key lesson we have learnt over the last year is that that, while the corporate programmes may be designed and managed centrally, the savings can only be made in the divisions and directorates where the budgets are held and are spent. So this year, the overall savings from the corporate programmes will be distributed to divisions and directorates.

- The programmes are:

Programme	Description	£m
Workforce pay and productivity	Medical workforce productivity including: minimising locum use, standardisation of additional pay. Nursing workforce productivity including: Minimising bank, agency staffing, cost effective rostering, skill-mix. Agenda for Changes sick pay changes	11.3
Business Improvement	Income generation, division and directorate schemes which are not workforce or procurement related, patient flow improvements	8.5
Procurement	Centrally coordinated supplies savings for both clinical and non-clinical supplies	2.3
Medicines Management	A range of projects to reduce medicine costs and waste, including gainshare on pass through drug costs, coordinated by clinical support division	1.4
TOTAL		**22.0**

- To support robust delivery of the CIP the Trust established a Programme Assurance Office in 2012/13. To enhance the PAO's ability to support the CIP and provide timely and accurate reporting and escalation of issues the Trust is investing in a programme management software tool for 2013/14.

Workforce

- Many of the project and workstreams set out in the strategic programmes above have significant workforce implications. With the Trust's devolved management structure and culture of strong clinical leadership, responsibility for managing workforce issues and developing our staff sits with the divisions and directorates, supported by the HR directorate. As a result we do not have a single, corporately managed, workforce plan; instead the HR directorate ensures that the workforce issues and development plans in each division and strategic programme are coordinated and managed in a coherent and consistent way, with the links and interdependencies between them recognised. The sections below outline the general themes and areas of work being undertaken across the Trust through the strategic programmes and divisional plans.

- **Medical Staffing.** The recruitment and retention of medical staff in some specialities will be increasingly challenging in the light of national proposals to reduce the number of medical training posts. The implications of the national plan will be worked through in association with Health Education North East (HENE), to ensure the appropriate numbers of trainees are available to cover retirements and other vacancies for consultants and other career grade medical staff plus respond to service configuration changes. A different workforce will be developed to support reconfigured and amalgamated rotas. The feasibility of nurse practitioners replacing medical staff, non-career grade consultants and consultant expansion to increase cover both at the 'front of

house' and in the evenings and weekends will be explored. Specific issues that we are addressing include:

- Recruitment of additional specialty doctors in teams such as haematology, oncology and dermatology where medical staffing is potentially at risk as specialty training is diverted to cover acute medicine
- Introduction of assistant practitioner roles in the electrophysiology lab to support the physiologists plus structured teaching programmes are being adopted to stimulate in house specialisation of physiologists;
- Further development of the advanced critical care practitioner role to address the erosion of critical care skills of the cardiothoracic surgical registrars and provide a 24/7 rota
- Work with the HENE to develop a local solution to the future supply of neurophysiology practitioners (affected by the introduction of Modernising Scientific Careers).

- **Nurse Staffing.**
  - A review of nurse staffing levels on all inpatient wards excluding maternity, neonates and paediatrics was completed in late 2012, reporting in early 2013 to determine if current staffing levels and skill mix across the Trust are appropriate for the provision of safe and effective care in the light of patient acuity and throughput. Further work is to be undertaken on the ratios of nurses to beds and patients, specifically at night. Analysis of nurse staffing levels against patient acuity levels has also been included and where staffing levels are low given patient acuity work is being taken forward to address this.
  - The move to a degree only entry route for nursing risks the loss of applicants who will not meet the educational criteria to study at degree level. Work with local education providers is underway to identify potential opportunities to enable these applicants to access training following a period of employment as an HCA.
  - As highlighted at national level and in the Francis Report, ensuring that clinical staff have a caring, compassionate attitude is a high priority within the Trust. By enhancing recruitment processes we aim to ensure that future healthcare staff have the right values, behaviours and a caring and compassionate attitude to deliver excellent patient care, aligned to the NHS Constitution. We plan to work with education and service providers to develop and implement effective mechanisms to recruit students who possess the values and demonstrate the behaviours that we need.

- **Transformation.** Delivering many of the strategic programmes will require significant changes to the working patterns and roles of many staff. For instance: addressing the capacity issues we face will require more 7-day working and more staff presence outside normal working hours; nationally there is a clear intention to move towards more 7-day working to improve quality and safety; integrating acute and community services means staff will have to work in different ways and in different settings. Good staff engagement, including the involvement of trade unions and staff representatives, is critical to success. Dedicated HR resources have been allocated to supporting this scale of organisational change and specific guidance has been developed to guide managers through the processes associated with organisational change.

- **Training & Development.** The Trust provides apprenticeships, access to a wide range of academic and vocational training to support the development of staff. In line with the Francis Report recommendations, we will investigate the feasibility of a vocational trainee / apprenticeship health care support worker 'pool' to ensure that all Healthcare Assistants are appropriately trained to perform their duties and to assist in managing the availability of staff in this role.

- **Cost Improvement.** As with all healthcare organisations, a large proportion of the Trust's cost base is in its staff so it is inevitable that the Trust's cost improvement plans rely heavily on reducing workforce costs. In general this has not been achieved through reductions in staff numbers but by focussing on the cost effectiveness of our staffing through skill mix changes, reducing sickness absence and reducing the use of expensive temporary staff, premium and additional payments. Where staff numbers are being reduced, the Trust has an effective voluntary severance scheme which can be used during organisational change or transformation programmes. The medical productivity cost improvement programme is working on minimising the use of medical locums and standardising systems and processes for the management, sourcing and authorisation of medical locum staff to reduce cost. Work to reduce sickness absence is also continuing with a revised Management of Attendance at Work Policy implemented since the end of 2012, with associated training for managers and staff representatives. Targets at both an organisational and divisional level have been identified with progress being monitored through regular performance meetings and the organisational performance report. A working group has also been established to provide a focus for this activity, focusing on staff health and wellbeing. Involvement in a national DH project lead by NHS Employers on sickness absence has not only reviewed the Trust's existing practices in the management of absence but also provided access to best practice elsewhere. Opportunities through changes in terms and conditions are being explored along with the introduction of harmonised on-call arrangements, mileage allowances, and redundancy entitlements in an attempt to reduce workforce costs. An impact assessment will be undertaken on the implications of the DH pay body review – both financial, operational and management process

Financial Plan

- **Income.** Following successful negotiations with commissioners for 2013/14, the Trust has secured an overall increase in contracted income of £16.3m compared to 2012/13.

Commissioner / Contract	Value £m	Comments
South Tees CCG – Acute	222.6	PbR contract, signed. Includes associate CCGs
South Tees CCG – Community	29.1	Mainly block contract, signed
HRW CCG – Acute	70.2	PbR contract, not signed. Includes associate CCGs
HRW CCG – Community	8.8	Block contract, not signed
NHS England (Specialised)	129.8	PbR contract, signed
NHS England (DDT AT)	10.9	PbR contract, signed
NHS England (Y&H AT)	4.9	PbR contract, not signed Includes MOD related activity
Tees Valley Public Health	4.1	Local authority public health block contract Includes Middlesbrough, Redcar & Cleveland, Stockton and Hartlepool local authorities
Other Commissioners	8.5	Non-contracted activity
Health Education England	14.8	
Other Income	27.7	Includes R&D, private patient and other divisional income
Total	**531.4**	

- **Expenditure.** Expenditure estimates have been completed based on 2012/13 out-turn adjusted for non-recurrent items, full year effect of investments and growth and CIP assumptions.

Expense head	Value £m	Comments
Pay	317.3	Includes pay inflation and workforce changes
Drugs	38.9	Includes inflation and activity growth
PFI	25.6	Revenue element of unitary charge
Other costs	118.6	All other operating costs including inflation
Total	**500.4**	

- **Key Financial Priorities and Investments**. The Trust's overall financial priorities for the next three years are to maintain financial sustainability and create headroom for investment in service and environmental improvements to enhance the quality of care for patients. Specifically, delivery of the cost improvement programme (described above under the Financial Sustainability strategic programme) is the top financial priority as this underpins our ability to deliver our strategic programmes and investments. The key investments are included within the strategic programmes above, but from a financial perspective they are listed below:

Title	2013/14 Investment (£m)		Comments
	Cap	Rev	
Operational Capacity Plan	---	5.1	Includes additional bed capacity and winter pressures
Cardiac Catheter Lab Refurbishment and Expansion	---	0.3	4th Cath. Lab expected to be operational in Q4
Additional Theatre JCUH	1.0	---	Supports obstetric expansion
Refurbishment of Ward 3	1.5	---	
MRI Capacity	1.5	---	
Haematology Day Unit and Inpatient Ward	0.8	---	
Sterile Services decontamination improvements	1.1	0.3	
Critical Care Outreach	---	0.4	
Gastroenterology (lower GI endoscopy) Capacity	---	0.8	
Specialised Neuro-rehabilitation	---	0.2	
Total	**6.9**	**7.1**	

(Note: The Trust's capital programme also includes PFI lifecycle, estate maintenance and planned equipment replacement costs)

- **Key risks and mitigations.** The main risks to our financial investment plans are:
    - Failure to achieve targeted income growth without commensurate reductions in costs;
    - Cost pressures exceeding anticipated levels driven by inflation or other pressures;

- Failure to deliver our cost improvement plans.

These risks will be managed through the Trust's operational delivery processes and will be mitigated by:

- Identification of additional cost improvement opportunities and acceleration of future schemes where feasible;
- Review and revision to income generation schemes where anticipated activity is not meeting anticipated levels. All of the significant developments have phased implementation plans which can be adjusted should there be a risk of over commitment of resources;

GOVERNANCE

Strategy Delivery Governance

Risks to the delivery of the Trust's strategic objectives and programmes (including quality and safety risks) are included in the Board Assurance Framework and the corporate risk register. The corporate risk register is reviewed every month at the Board and on a quarterly basis the Board Assurance Framework, together with a report describing progress against the key milestones for each strategic programme and the position in relation to the target for each strategic objective (the Strategy Balance Scorecard) is presented to Formal Management Group and the Board. For 2013/14 the Trust is revising its approach to the Balanced Scorecard and considering implementing an approach based on the Strategy Map concept (Kaplan and Norton, 1992).

Service Quality, Safety & Performance Governance

The indicators and measures used to track the Trust's quality and safety objectives are reported through the patient safety and quality dashboards, these are produced each month and comprise a range of measures across the domains of quality. The measures include national priority indicators and regulatory requirements, incidents, complaints and clinical effectiveness measures. These dashboards are monitored at quarterly performance reviews with the divisional teams and are reported to the Board through the quarterly governance report, the monthly performance reports and the mortality monitoring report, plus other reports by exception. SUIs are considered in detail at the Risk and Assurance Sub group each month together with complaints and incidents to ensure that lessons learnt are disseminated across the Trust and any trends identified. Healthcare associated infections are reported to Board members weekly and SUIs are reported to the Board monthly. In addition further analysis of trends in types and numbers of SUIs and infection prevention and control are reported to the Board via the Integrated Governance Committee through the quarterly governance report. The reports contain qualitative descriptions and commentary to back up quantitative information.

A number of Trust strategies support continuous quality improvement including the Patient Safety and Risk Management Strategies, the Infection Prevention and Control Strategy, and the Nursing and Midwifery Strategy. Improvement targets are set through the strategies and the divisional patient safety and quality action plans. Improvement targets are RAG rated and focus on outcomes rather than processes, performance is monitored at Trust, divisional and directorate level.

Service performance against the national (eg 18 weeks referral to treatment, A&E waits, cancer waiting times) and locally agreed performance measures is monitored monthly through the Performance Report which is presented to Formal Management Group and Board. Detailed review of divisional and directorate performance is done at quarterly performance reviews. Specific issues will be addressed as they arise by the Performance team in the Operational Services Directorate who monitor performance against the measures, waiting lists and referrals on an ongoing basis. Progress with delivery of the CQUIN targets is also reviewed regularly by the Board through the Performance Report. The Trust reviews and declares compliance with Monitor's Quality Governance Framework on a quarterly basis.

Workforce Governance.

Since quality and patient safety is of paramount importance to us, it is essential to have robust arrangements in place to identify and manage any risk associated with the workforce. Regular reports are presented to the Organisational Capability Sub Group which is the workforce assurance group that reports

to the Integrated Governance Committee. Where necessary workforce risks and the actions to mitigate the risks are monitored in the corporate risk register.

Cost Improvement Programme Governance

Overall accountability for the delivery of CIPs is with the Board of Directors, with the Director of Finance as the lead Director. Reports on developing and delivering CIPs, in particular critical and at risk projects, are received by the Board, as part of the Director of Finance reports. Divisional managers and corporate directors are signed up to their budgets. This sign up includes agreement to CIP delivery. Progress is discussed at quarterly performance reviews.

Day to day assurance of the delivery of the CIP is the responsibility of the Trust's Programme Assurance Office (PAO). The PAO lead reports directly to the Director of Finance and is responsible for ensuring consistent validation and reporting of all CIPs and for intervening where schemes are not delivering to support the re-planning of projects. The PAO is also responsible for ensuring that quality impact assessments for all CIPs are completed and their impact monitored. As described in the plan section above, for 2013/14, we are investing in a programme management software system to enhance the PAO's ability to track and report progress on CIPs, record and monitor quality impact assessments and to identify and react to delivery risks.

The overall risk of non-delivery of CIP is included in the Trust's risk register as a strategic risk. The register is regularly reviewed and updated and reported to the Trust's Integrated Governance Committee and Board of Directors. At a more detailed level the reporting and monitoring system overseen by the PAO records specific risks to delivery along with mitigation. Managers and the PAO monitor delivery on a monthly basis before it is reported to the Board of Directors.

Historic delivery of CIPs.

CIP	2009/10	2010/11	2011/12	2012/13
Plan	17.24	15.00	19.8	20.7
Delivery	13.48	11.94	18.0	20.7
%	78.2	79.6	91.0	100

The rate of delivery has improved year on year and in 2012/13 the CIP was fully delivered although not all savings were recurring. Maintaining our robust processes for monitoring CIP delivery, realistic and early planning and the other measures outlined above will ensure the Trust continues this level of achievement in future.

CIP Quality impact Assessment. To satisfy the National Quality Board requirements to demonstrate that potential quality impacts have been considered before a CIP is implemented, the Trust is procuring a programme management system which will include a Quality Impact Assessment tool. Once in place, this system will be used to project manage all divisional and corporate projects and to record and report QIAs. In the interim, an in-house QIA tool is being used to assess the divisional and corporate CIPs identified for 2013/14 which have a direct impact on patient care:

- Each division / directorate identifies which CIP schemes link directly to delivery of care to patients and complete a QIA and risk rating.
- Risk rating assesses both the likelihood of occurrence and consequences for safety, quality, human resources and adverse publicity/reputation.

- The key factors assessed for impact are: patient safety, clinical outcomes, patient experience and other quality measures.
- The templates will be incorporated into the QIA on the PAO software once this is available.
- This QIAs and risk ratings are signed off by the Divisional Manager and Chief of Service at Divisional level and by the Medical and Nursing Directors at Trust level..
- Schemes which have an overall risk rating of 'green' are reviewed mid-year. Schemes with an amber risk rating form part of the divisional / directorate risk register and the risk rating and mitigating actions are monitored in accordance with the divisional risk management plan. Divisional risk registers are reviewed formally at the quarterly performance review meetings. Schemes with a red risk rating are not progressed without the approval of the medical director and director of nursing.

In addition to the quality impact assessment and assurance process described here, further ongoing assurance of the impact of CIPs on quality and safety is provided through the routine processes described under service quality, safety and performance governance above.

Internal & External Audit

In addition to our internal assurance and governance processes, the following external assurance and audit was provided in 2012/13:

- **Regulatory / Mandatory Inspections or Assurance**
    - CQC Inspections. Both the Trusts acute hospitals and two of our primary care (community) hospitals were inspected in 2012/13 and all were found to be fully compliant with the assessed standards for quality and safety:
        - Guisborough PCH, 12 June 2012
        - Carter Bequest PCH, 13 August 2012
        - Friarage Hospital, 27 February 2013
        - James Cook University Hospital, 5 March 2013
    - CQC Inspection of Termination of Pregnancy Services. Both the James Cook University Hospital and Friarage Hospital termination of pregnancy services were inspected by the CQQ on 22 March 2012, but the final reports were only received by the Trust in June 2012. Both services were found to be meeting essential standard 21 relating to accuracy and confidentiality of people's personal records, which was the specific focus of this inspection.
- **Trust Commissioned Assurance**
    - Emergency Care Intensive Support Team Visit. The ECIST team visited the Trust in June 2012 to investigate the emergency care pathway, including A&E, elderly care, bed management and discharge. The team identified a number of areas in which the Trust could improve which have been incorporated into the Improving the Patient Pathway programme.
    - James Cook University Hospital NHSLA Level 1 Inspection. The NHSLA inspected JCUH for compliance with its risk management criteria in August 2012. The hospital was found to be compliant with all 50 criteria at level 1.

- Maternity CNST Visit. The NHSLA visited the Trust's maternity services in March 2013 to advise on preparations to achieve the level 3 risk management criteria. The full inspection is planned for September 2013.

- KPMG Transforming the Care we Deliver**.** KPMG were engaged in 2012/13 to support the Trust in the procurement process surrounding the Transforming the Care We Deliver project. Their work to date has focussed on the financial elements of the project (costs and benefits) with a view to ensuring that the Trust achieves value for money from the procurement. The Trust has agreed a final work package which will follow the project through to contract signature and will include development of the final business case, supporting the contract negotiation and shaping the financial deal.

- **Internal Audit work** Internal Audit provide assurance to the Trust on key systems of internal control on an annual basis. In addition the internal audit plan has provision for 'client directed' work e.g. specific ad-hoc work that the audit committee can request is undertaken. In 2012/13 client directed work included reviews of the Trusts scheme of delegation and spinal injuries information system controls. These reviews resulted in recommendations to further improve systems of control.

- **External Audit work** The Trust engaged PWC as external auditors with effect from 1 April 2011. PWC's remit is to provide an opinion on the Trusts annual report and accounts and is based upon reviews of key systems of internal control, review of internal audit findings, detailed testing of transactions and a review of the Trust as a going concern. In 2012/13 and 2013/14 PWC issued an unqualified opinion upon the Trusts 2011/12 and 2012/13 annual report and accounts respectively.