Tameside Hospital NHS

NHS Foundation Trust

Strategic Plan Document for 2013-14

Final Version

30th April 2013

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

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

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Date	**31 May 2013**

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:

Paul Connellan *(Chair)*	

Signature

Approved on behalf of the Board of Directors by:

Christine Green *(Chief Executive)*	

Signature

Approved on behalf of the Board of Directors by:

Barbara Herring *(Finance Director)*	

Signature

Executive Summary

Tameside Hospital NHS Foundation Trust (THFT)'s 3 year strategic direction is informed by national drivers (major cost efficiency requirements, 7 day consultant presence care, regulatory requirements), the Greater Manchester clinical service reconfiguration programme "Healthier Together", local commissioning intentions and demographic changes and the Trust's own financial challenges, quality drivers and internal Service Line Reporting (SLR) data.

This Strategic Plan details THFT's vision and plans for a radically different service delivery model in order to ensure that the organisation remains clinically sustainable and financially robust within the increasingly challenging environment.

THFT recognises that it is not possible to continue to operate as a stand-alone organisation in isolation of other providers across the conurbation and needs to focus on collaboration and partnership models in order to maintain clinical and financial sustainability. The Trust's strategy details the critical importance of developing two strong local partnerships. The first is a horizontal partnership (with Stockport Foundation Trust [SFT] and University Hospitals of South Manchester Foundation Trust [UHSM]) to address the challenges the Trust is facing regarding safe and sustainable consultant led services (specifically for general surgery) and to respond to the Greater Manchester "Healthier Together" progamme. UHSM and SFT have signed a Memorandum of Understanding (MoU) with East Cheshire NHS Trust for collaboration on clinical service models. Therefore the 3 way partnership detailed with this Strategic Plan Document could be expanded to a 4 way partnership. The second is a vertical integration service model (with Tameside Metropolitan Borough Council [TMBC] and local community and primary care services) to address the need for a more sustainable, affordable and integrated model of health and social care going forward. The integrated model of care should help to reduce the continued upward pressure on the Trust's non elective medical service and reduce the length of stay for patients admitted to hospital.

The Trust's Quality Strategy centres on continuing to meet all quality standards, fully implementing the Dignity in Care programme, continuing to improve patient safety and experience and improving outcomes with a particular focus on reducing mortality and health care acquired infections.

The Trust's other strategic priority is to implement transformational change programmes to deliver large scale changes to productivity, efficiency and effectiveness, by maximising capacity and use of existing assets. These change programmes, together with the two partnership models, form the majority of the recurrent CIPs for the next 3 years.

This plan demonstrates that the Trust will meet Monitor's requirement to deliver a Financial Risk Rating (FRR) of 3 in the final quarter of 2013/14 and in the 2 years hereafter. The key risk to achieving this level of financial sustainability is the efficiency savings (Cost Improvement Programme [CIP]) requirement of £27.4m over the 3 years. Whilst an independent review of 2013/14 CIP processes raised concerns about CIP delivery, the Board id clear that by working in partnership with other organisations, greater efficiencies, transformational service changes and potentially new income streams will all contribute to driving the delivery of the financial plan.

It is noteworthy that the Trust Executive Team and Board of Directors have a history of strong delivery against a wide range of standards and targets. The combination of experience and organisational memory of longer serving Board members, combined with the innovation and challenge brought by newer Directors provides the strong leadership required to continue to drive delivery of the Trust's agenda.

Strategic Context and Direction

The Trust's Strategic Position within the Local Health Economy

Overview of the Trust's competitors and key areas of strength and weakness

Tameside Hospital NHS Foundation Trust (THFT) serves a population of just over 250,000. The main commissioner is Tameside and Glossop Clinical Commissioning Group (T&G CCG) which provides approximately 82% of the Trust's annual income. The other key commissioners are Oldham and Stockport Clinical Commissioning Groups.

The Trust has developed excellent working relationships with local GP commissioners and has, during 2012/13, increased the elective activity referred to the Trust. The number of referrals for outpatient appointments increased by 4.1% in 2012/13 (from 41,005 in 2011/12 to 42,688 in 2012/13).

The Trust has a good understanding of the market within which it is operating. The main competitors for elective services are Stockport NHS Foundation Trust (SFT) and Pennine Acute Hospitals NHS Trust (PAHT). SFT attracts 7.3% of referrals from Tameside and Glossop GPs – particularly from the GPs in Glossop. PAHT attracts 4.7% of referrals from Tameside and Glossop GPs – particularly from GPs in the north Tameside area. The other competitors are Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospitals of South Manchester NHS Foundation Trust (UHSM). CMFT attracts 10.6% of the GP referrals and UHSM 1.1%, predominantly due to the specialist services which they provide.

The Trust does attract referrals from GPs outside the Tameside and Glossop area. 6,186 referrals (14.5% of the total volume of referrals) were received from GPs outside the area in 2012/13 (8.1% from Oldham, 2.9% from Manchester, 1.5% from Heywood, Middleton and Rochdale, 1.2% from Stockport and 0.1% from other areas). The Trust has a clinical partnership arrangement with NHS Oldham CCG for the provision of Orthopaedic consultant input to their local Musculoskeletal service, which saw 329 Orthopaedic elective inpatient and daycase procedures undertaken at THFT in 2012/13. The Trust also provides a full Dermatology service to Oldham and Heywood, Middleton and Rochdale CCGs, with activity of 4,755 outpatient attendances and income of £575k in 2012/13.
The other main area of competition comes from private providers of NHS healthcare, namely the neighbouring BMI hospitals and Care UK, the latter provides the Greater Manchester Clinical Assessment and Treatment Services (GMCATS). The Trust saw a decreased number of referrals into the 5 specialties (ENT, MSK, Urology, Gynaecology and General Surgery) covered by the GM CATS in 2011/12 of 8.8% compared to 2010/11 rates. However, referrals for these specialties increased in 2012/13 by 3.4%, meaning that there was a net decrease of 5.7% in 2012/13 from 2010/11 referral rates. The levels of referrals to the Care UK delivered service are therefore assumed to have abated and no further decreases to activity at THFT are expected moving forward into 2013/14. The levels of referrals to other private hospitals have not increased in 2012/13 and there is no indication that these will increase in 2013/14 and beyond.

Forecast Health, Demographic and Demand Changes

The Index of Multiple Deprivation (IMD) shows that 13 of Tameside's 141 lower super output areas (LSOAs) are in the top 5% most deprived areas nationally. Tameside is now ranked as the 42nd most deprived area in England (out of 326 areas). The population of Tameside and Glossop has continued to grow. Based on the 2011 Census, the resident population was just under 253,000. However, on current projections, this will expand by 10% by 2033, and particular growth is expected in the number of older people. This means that across the Tameside and Glossop area there will be a growing number of patients living with multiple long term conditions and an increasing number of frail elderly. The impact on the Trust will be significant in terms of non elective admissions if service models commissioned across health and social care are not radically changed. The key strategic model of vertical integration between THFT, TMBC and primary and community health care services is therefore critical for the local health and social care economy. This is detailed in the section below.

Strategic Partnership Development

The Trust has a vision for a radically different service delivery model over the next 3 years in order to ensure that the organisation remains clinically and financially robust within the increasingly challenging environment. It reflects the need to significantly improve productivity and efficiency to reduce expenditure, whilst ensuring the continuation of high quality care and excellent patient experience. This is in the context of an ageing population with the need to ensure that high quality alternatives are available to ensure that people who do not require acute care are not admitted to hospital.

The Trust's strategic direction recognises the critical importance of developing two strong local partnerships. A horizontal partnership is essential to address the challenges the Trust is facing regarding safe and sustainable clinical services. Increasing specialisation combined with the goal of 24/7 consultant care has led the Trust to seek to work in partnership with larger organisations for the delivery of emergency and complex elective general surgery and other clinical services.

Similarly the continued upward pressure on the Trust's non elective medical service and the increasing challenge of the number of medically fit people in the hospital has been a key contributor to the development of a vertical integration model with the local authority (TMBC) and the local clinical commissioning group (T&G CCG). All three organisations have signed up to a joint strategy to drive a radically different pattern of service over the next two years. This will see a significant reduction in the reliance on acute hospital care, with much greater community based support.

THFT has entered into a strategic partnership with two local Greater Manchester NHS organisations, UHSM and SFT. The Foundation Trusts are working together to provide a clinical service model whereby complex elective and emergency general surgical work takes place at the larger specialist centres, leaving daycase and other non complex elective general surgical work at THFT. The collaboration facilitates transformational changes to non clinical services across the 3 Trusts to deliver efficiencies and also to ensure clinical services are provided in a safe and sustainable way.

This fits very well with the Greater Manchester "Healthier Together" programme, which is looking to collaboration between NHS providers to ensure clinically sustainable services are delivered across populations to drive efficiency savings across whole health economies.

THFT is working with T&G CCG and TMBC on the design and implementation of a Vertical Integration model. This will integrate services across the hospital, social care and the community. T&G CCG have served notice to Stockport FT (who currently provide the Tameside and Glossop Community Services). The services will be tendered in the early part of 2013/14 and working with TMBC, the Trust expects to be in a strong position to win the procurement. This will further enhance the Vertical Integration model with THFT providing the full healthcare pathway, working in collaboration with primary care clinicians.
The outcomes of this partnership model are to reduce the need for patients (particularly the frail elderly and those with Long Term Conditions) to be admitted to hospital or long term residential care by providing a comprehensive range of health and social care packages to the population to enable them to live independently and also to ensure that, when patients do require a hospital stay, this is as short as possible, with patients being discharged home with a comprehensive support package to prevent readmission to hospital. This work is being jointly driven by all three organisations and is supported by Ernst Young and will enable the Trust to reduce its bed base by reducing emergency admissions and length of stay.

Threats and opportunities from changes in local commissioning intentions

The Tameside and Glossop Joint Strategic Needs Assessment (JSNA) highlights that the major health challenges facing the local population are circulatory diseases, cancer and respiratory disease. The JSNA underlines the need to ensure that people are cared for at home as far as possible and stresses that the number of elderly people being placed in care and residential homes

needs to be reduced, along with the number of emergency admissions to hospital.

The local health economy has a heavy reliance on acute hospital services. Non-elective admissions (primarily medical) account for 54% of the hospital's activity - against a national average of 36%. The National Audit Office publication "Management of NHS Hospital Productivity" recognises that a higher non elective admission to elective admission ratio results in higher running costs.

Tameside and Glossop Clinical Commissioning Group (T&G CCG) has published its 5 year strategy. The main aims of the CCG are:

- To design and implement integrated health and social care pathways during 2013/14 – working in collaboration with Tameside Metropolitan Borough Council and Derbyshire County Council – there is an explicit statement that T&G CCG's local hospital will deliver care as part of these integrated services. This works links to the national Community Budgets programme
- A shift of health care into the community (care closer to home) with GPs seeing patients who would previously have been referred to hospital (especially patients with long term conditions)
- Earlier interventions for patients to prevent deterioration in condition
- Focus on integrated care across primary, community and secondary health care and social services
- Working with THFT on service reconfiguration including:
    - Focus on reducing A&E attendances for minor illness/injury
    - Development of same day emergency clinics at the hospital to avoid non-elective admissions
    - Delivery of medical care in patients homes to avoid hospital admission or reduce length of stay
    - Deliver outpatient appointments outside core working times
    - Delivery of most diagnostics in primary or community care
    - A shift of "routine" hospital care into community clinics including specialist clinics and some day case surgical treatment
    - Centralisation of specialist services across Greater Manchester (in line with "Healthier Together") – which will mean a change in services provided at THFT (with some patients having to travel further for treatment) and also a shift in care at THFT with patients being treated for more specialist medical conditions during the acute phase in specialist centres and transferred back to their local area for their ongoing medical care and rehabilitation
- An increased focus on patient experience and specifically on improved health outcomes
- Ensure that patients on End of Life pathways are not brought into hospital to die

The impact in THFT would be a reduction in acute beds if emergency admissions and readmissions are reduced as a result of integrated pathways with community services and social care services. There is also a strong potential for THFT to win the tender for the community services and provide these from April 2014 – which would help the Trust to reduce length of stay through fully integrated services and also to increase its income base.

The CCG's Quality, Innovation, Productivity and Prevention (QIPP) plans for 2013/14 have a £1m recurrent impact to THFT (£867k in 2013/14). The schemes are predominantly aimed at reducing follow up outpatient appointments, emergency admissions and length of stay. The Trust has worked in collaboration with the CCG on the development of these QIPP plans and is reducing expenditure in these areas through redesign of internal pathways and reduction of pay and non pay costs associated with the activity (much of which had been additional activity to the Trust outside of core contracted activity).

The CCG has served notice to all current providers for the provision of Diabetes services. The CCG

is retendering the entire diabetes service across secondary and community care, which forms the majority of the commissioner's QIPP programme for 2013/14. This gives the Trust the opportunity to bid for the whole service, working in partnership to deliver fully integrated services. Should the Trust be unsuccessful in providing the service from October 2013, plans are in place to reduce the expenditure to match the reduced level of income.

T&G CCG tendered Audiology and GP Direct Access Diagnostics under Any Qualified Provider (AQP) in 2012/13 along with all other Greater Manchester commissioning groups. THFT was successfully qualified under the AQP contract and the Trust has not seen any reduction in activity as a result of this. In fact, GP referrals for Diagnostics increased by 9% in 2012/13 compared to 2011/12 outturn. The only other specialty which the CCG have indicated that they may look to tender under AQP is musculoskeletal services. The Trust would be in a good position to tender for this, having a strong physiotherapy service and collaborative working across Orthopaedics, Rheumatology and Pain Management.

The Trust's demand for outpatients has remained fairly consistent overall, although there have been larger increases in referrals to medical specialties over the past 2 years. The 2013/14 contract reflects this growth in activity. Demand for elective services has also remained fairly consistent, with the additional growth seen in endoscopies in 2012/13 reflected in the 2013/14 contracted activity levels (an increase of 15% above 2012/13 outturn). The Trust has increased the percentage of patients treated as daycases to 84.2% in 2012/13 (from 82.8% 2011/12) which has brought efficiency savings to the organisation.

The demand for non elective services and A&E has increased in 2012/13 by 3.1% and 3.2% respectively above 2011/12 outturn levels. The CCG has acknowledged that demand has not been stemmed through their commissioned services and has increased the contract activity plan by 2.5% in 2013/14 accordingly. This means that the Trust has been able to recruit permanent staff to fund the appropriate bed base for this activity, thereby reducing costs and increasing quality.

The Trust is ensuring that savings are delivered through the partnership work with UHSM and Stockport FTs. The collaboration on clinical, clinical support and non-clinical services will bring efficiency savings of £469k to THFT in 2013/14, which increases to £1.56m recurrently from 2014/15. The scope for further savings will develop further as the partnership becomes established.

The Trust has identified that further opportunities exist for diversification of its income streams through research and development. THFT recognises that research is vital to improve the knowledge needed to develop the current and future quality of care for patients. Carrying out high quality research gives the Trust the opportunity to minimise inequalities in healthcare and improve the treatments patients receive.

The Trust currently supports 71 active research studies, which have received a favourable opinion from the National Research Ethics Service. It has 58 studies which are adopted on to the National Institute for Health Research (NIHR) Clinical Research Network portfolio. These studies are high quality trials that benefit from the infrastructure and support of the Clinical Research Network (CRN) in England. The Trust is currently involved with 16 actively recruiting clinical trials involving medicinal products, which demonstrate the hospital's enthusiasm to improve and offer the latest medical treatments.

The Trust has 6 dedicated research nurses working on a variety of research studies. There are currently 37 clinical staff acting as the Trust lead investigator on approved research studies. The number of patients who choose to participate in a clinical trial has increased by 87% over the past year.

The Trust is working on the further development of Research and Development, working in collaboration with a key strategic partner organisation, UHSM, with a specific focus on oncology,

orthodontics, diabetes and paediatrics, further strengthening the partnership established for the horizontal integration model.

The Trust already has strong departments for research for diabetes (Tameside hospital has been identified as the Top recruiter in the North Sea Cluster for one Clinical Research Network adopted study, which covers the UK, Belgium and the Netherlands. The study is investigating a medicinal product and its effectiveness of preventing heart attacks in diabetic patients) and orthodontics (the Trust's research active consultant in Orthodontics has received the Journal of Orthodontics' Manay Publishing prize, for best orthodontic scientific paper in the UK in 2012 for the second consecutive year. This is in addition to the three national awards the department has won in the 10 years since it started running clinical trials).

The implications of the "Healthier Together" strategy (including the need for rationalisation of services, 24/7 consultant care and improvement in clinical outcomes) taken together with the local Tameside health economy challenges described above, indicate that the Trust's partnership strategies, both vertical and horizontal (which are described in detail in the next section) are key to the long term success of all parties.

Collaboration, Integration and Patient Choice

Strategic Partnership – Horizontal Integration

The proposed collaborative alliance with UHSM and Stockport FT will enhance both efficiency and clinical care through clinical and back office service rationalisation.

An integral feature of the proposed strategic collaboration would be the eventual transfer of emergency general surgery and complex elective general surgery to the partner organisations, leaving THFT to focus on daycase and non complex general surgery inpatient activity. This would be subject to Public Consultation and agreement with commissioners. The strategic plans also recognise the scope for a state of the art new operating theatre to be developed to undertake much more elective Orthopaedic work, potentially providing strong competition to the Trafford Surgical Centre. This change to general surgery reflects the recommendations of the Royal College of Surgeons, together with the initial strategic direction advised by the Greater Manchester acute reconfiguration under the 'Healthier Together' Programme. The Trust has sought early guidance from the Co-operation and Competition Panel to ensure that choice and competition issues are appropriately addressed.

The horizontal strategic collaboration has identified the areas to be developed under 4 categories:

- Clinical Services – Productivity
- Clinical Services – Service Delivery Models
- Clinical Support Services
- Back Office and Non Clinical Services

<u>Clinical Services</u>

Partnership working to deliver sustainable clinical services across the 3 organisations is the most complex part of the strategic collaboration. There are issues of consultation and patient choice which need to be considered for many clinical service changes. Therefore this element of the partnership has been divided into two distinct elements.

1. Productivity through Best Practice

The first element is being implemented. This involves sharing of clinical service models and benchmarking data on productivity across the organisations for the main specialties. The Trusts are sharing outpatient and daycase/inpatient activity, clinic and theatre list templates and other productivity and efficiency metrics (including theatre utilisation, points per list and daycase rates by procedure). This programme of work has identified recurrent annual productivity savings (2014/15) of £920k per annum at THFT.

2. Service Delivery Models

The second element of this workstream is the development of shared clinical models across a number of specialties, with a focus initially on General Surgery and Orthopaedics. This is in the planning phase which includes determining the degree of consultation required as well as the impact on patient choice.

The Trust has sought guidance from the Co-operation and Competition Panel (CCP) with regards to the transfer in and out of General Surgery and Orthopaedic activity (elective and non elective) across the partnership. A response is expected imminently. THFT has worked up an activity and financial impact plan for this activity shift. Maximising theatre and length of stay productivity is critical to ensuring that the activity which remains and any new activity to THFT are as profitable as possible. The theatre and bed modelling work is being undertaken. It is recognised that any change would be subject to Public Consultation, which would be led by commissioners, whose outline support for the proposed changes is being discussed. Activity and capacity modelling will also need to be undertaken in partner trusts. The financial modelling highlights that this element of the collaboration would mitigate the income loss (of £3.5m) to THFT recurrently by £1.69m (commencing in October 2014).

The proposed Partnership Board will also oversee collaborative service delivery models for other specialties including Urology, ENT, Paediatrics, Cardiology, Oral Surgery and Orthodontics. The financial modelling has identified savings of £1.99m recurrently, commencing in 2014/15. Some of the clinical service changes proposed would not require public consultation and would not be subject to CCP approval (shared on call rotas, for example).

It is also important to note that the three Foundation Trusts would also work together going forward to respond to any clinical service changes specified by commissioners as part of the “Healthier Together” work programme.

<u>Clinical Support Services</u>

The 3 Trusts have worked together to determine the most appropriate potential for joint working across the following clinical support services

- Radiology
- Pathology
- Pharmacy

For each of these a project team has been established with key clinical support service representatives from the 3 Trusts. The projects would deliver £752k recurrent savings for THFT.

Non Clinical Services

The 3 Trusts have worked together to determine the most appropriate potential for joint working across the following non clinical services

- Human Resources
- Information Technology
- Finance
- Estates and Facilities
- Procurement
- Corporate/Nursing

For each of these a project team has been established with key representatives from the 3 Trusts. The projects would deliver recurrent savings of £810k to THFT.

Governance and Due Diligence

In order to formally progress with the strategic alliance, the Board of the 3 Trusts have agreed to use a Memorandum of Understanding (MOU) to govern the initial work in respect of how the organisations will work together in the period running up to service transfer/completion. The 3 Foundation Trusts intend to establish a legal collaboration agreement to underpin the partnership going forward.

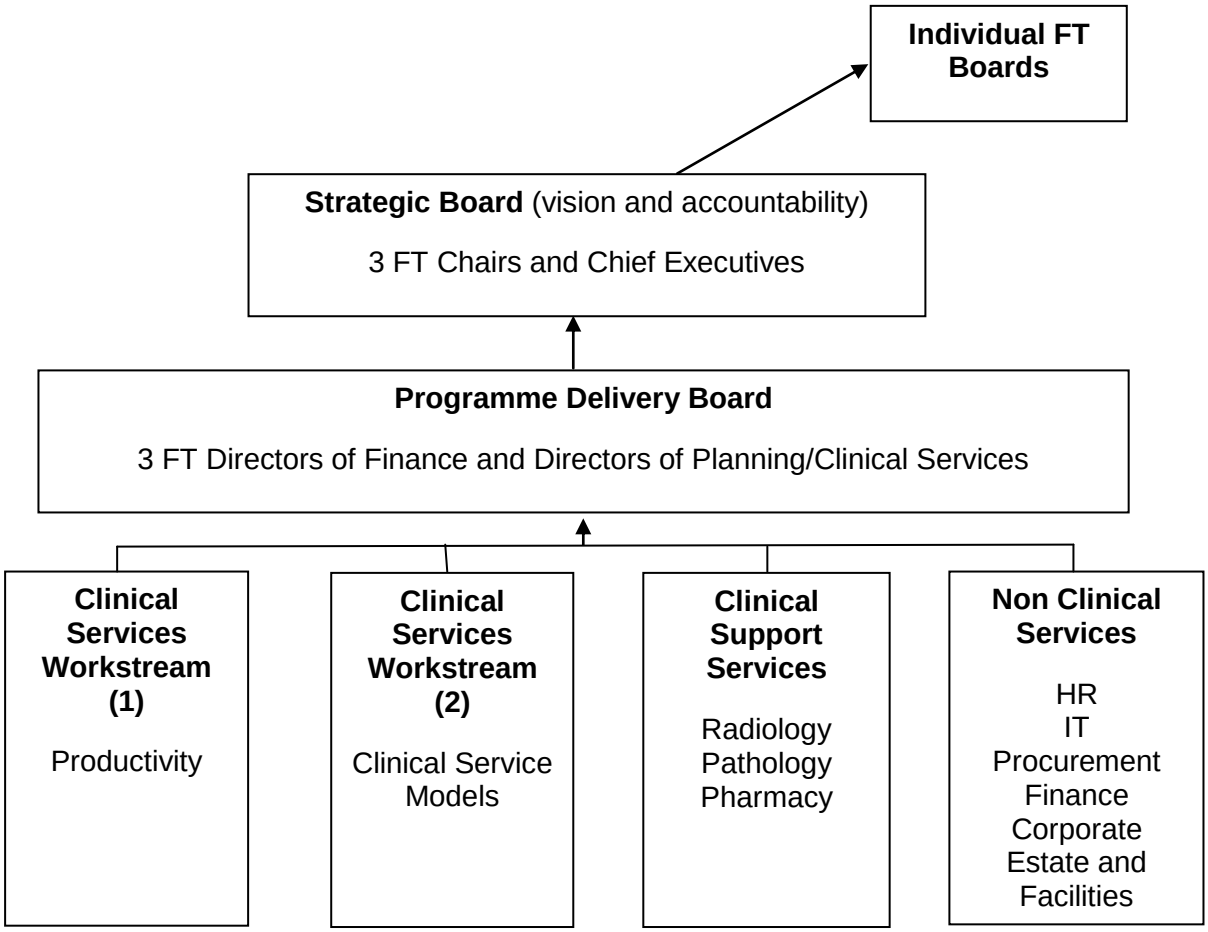
A Strategic Board is being formally established of which all three Foundation Trusts Chief Executives and Chairs are members. This Board will provide the vision for the partnership and the Chairs and Chief Executives ensure accountability back to each statutory Board.

A Programme Delivery Board is being established with membership from the three Foundation Trusts of the 3 Directors of Finance and the Director of Strategy at SFT, the Director of Planning at UHSM and the Director of Clinical Services at THFT.

The Programme Delivery Board will meet monthly and has responsibility for driving progress in respect of each of the workstreams.

There are 3 key workstream areas which have responsibility for working up the clinical and non clinical service models for each area.

The governance structure for the partnership is detailed below.



Phasing

Phase 1- the first phase focuses on Due Diligence and other regulatory requirements, along with the preparation of legal documents. The 3 Trusts will agree a Memorandum of Understanding (MoU) in respect of how the organisations will work together in the period running up to potential service transfer/completion. This will cover issues such as the provision of information to support a Due Diligence process. This stage will commence in June and last for three months - detailing the clinical and non clinical support services joint models. Additional time may be required following Due Diligence to support the clarification of any contractual issues arising.

Phase 2 - the second phase focuses on managing the transition and the run up to formal service commencement (Completion). This stage runs from signature of the Collaborative Alliance to the formal commencement of the Partnership Board. This stage focuses on the associated transition arrangements including any staffing implications and the effective deployment of the agreed transitional management arrangements, together with an assessment of the need for Public Consultation for stage 4. It is clear that any significant service change will require public consultation and so service change in this phase will concentrate on clinical support and corporate support functions. This stage is scheduled to commence from September and conclude at the end of December 2013.

Phase 3 - the third phase is the deployment of the stage 1 clinical services plan (Productivity through Best Practice) and the clinical support and non clinical service models across the 3 organisations.

The planning phase for the productivity workstream is being progressed. The second stage will be the implementation of the changes to outpatient clinics, led by the Clinical Directors. This work will be

undertaken in conjunction with revised pathways across specialties in line with best practice and the project to improve theatre productivity. The latter 2 projects are more complex and require changes in clinical working practices. The scoping work is being progressed and the redesign work will commence in summer 2013, led by the relevant Clinical Director. The revised pathways for outpatients and new theatre models will be fully implemented by end March 2014.

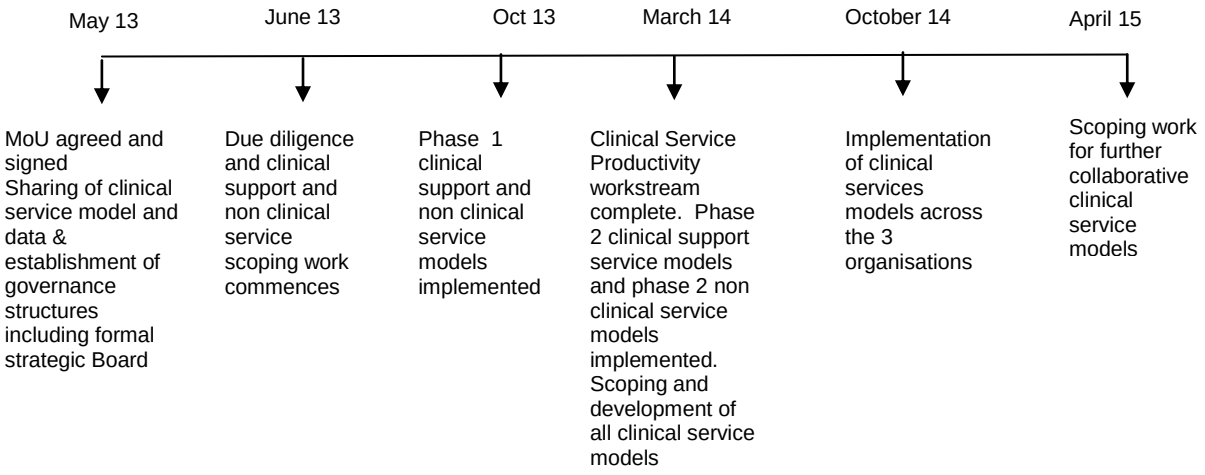
The clinical support service models are being scoped. Many of the projects have 2 distinct stages, with implementation planned for the first by the end of October 2013 and the second by the end of March 2014.

The non clinical support service models are also being scoped and are split into 2 phases, based on ease of implementation and delivery. All new non clinical service models (phase 1) are planned to be implemented by the end of October 2013 and the second phase by the end of March 2014.

Phase 4 - the fourth phase is the potential transfer of clinical activity to/from Tameside FT for General Surgery and Orthopaedics. The modelling work for this for THFT is underway and once the advice from the CCP is received, the 3 organisations will undertake due diligence on costs and income. This will include plans for the reconfiguration of bed complements at all 3 trusts as well as workforce implications. The case will then be presented to commissioners who would take the lead on public consultation. The activity transfer would take place in October 2014 subject to formal agreement by the commissioners/partners.

Phase 5 - the fifth phase is the design, development and implementation of further clinical collaboration models across the organisations within the planned partnership. This will also involve responding to the changes proposed through the Greater Manchester "Healthier Together" programme. The work will commence as more becomes known about the "Healthier Together" changes but initial work is already underway to consider the implications of the likely direction of travel. The planned changes to service provision will be developed from April 2014, followed by consultation and implementation from October 2014, subject to the "Healthier Together" timescales.

The timeline for the horizontal integration model is set out below.



Strategic Partnership - Vertical Integration

The demographic, financial and operational challenges facing the Tameside Health & Social Care economy are such that the current, conventional approach to providing services is unsustainable in the short to medium term, with a projected £140 million funding shortfall forecast by 2018/19.

The Trust has been actively engaged with the main commissioners of health and social care within

the borough (Tameside Metropolitan Borough Council and Tameside Clinical Commissioning Group) in the development of alternative models of care delivery which integrate community, acute and social care with the objective of providing more integrated care in community settings. By radically changing the nature of the response to health and social care needs and the subsequent design and configuration of services, it is anticipated that the demand for acute services will reduce, along with the average length of stay in hospital where admission is appropriate, thus improving the overall efficiency of care delivery. The proposed service models aim to reduce demand for access to the Emergency Department, offer alternative, clinically appropriate alternatives to an acute admission and provide early supported discharge for patients that are admitted.

The Business Case is planned to progress through the Commissioners governance processes by July 2013, with the commissioning process commencing at this juncture. The commissioners intend to have the full service implemented by August 2014.

Approach taken to Quality

The Trust is committed to achieving the highest possible standards of quality, safety and dignity in care, the principles of which drives its relationship with patients and staff along with partner organisations and community services, aiming to be the hospital of choice for the population of Tameside and Glossop.

The Trust's Clinical Strategy aspires to ensure that a comprehensive range of high quality services continue to be delivered at the Hospital, being underpinned by a collaborative partnership with University Hospital South Manchester (UHSM) and Stockport Foundation Trust (SFT). As the Greater Manchester "Healthier Together" programme further develops it is envisaged that this will strengthen collaborative working across the conurbation, ensuring sustainability of local secondary care healthcare services at Tameside General Hospital.

Following on from a Governance Review that was undertaken in 2011/2012 by Price Waterhouse Cooper (PWC), the Trust's Medical and Nursing Directors have fully implemented all of the actions identified to strengthen governance across the Trust ensuring that the Trust has early warning systems in place to identify the risks faced, clear lines of accountability and well defined ward to Board and Board to ward structures. A further assessment by PWC in 2012 clearly identified significant improvement with regards to the Trust's governance systems.

The assurance provided by PWC has been further strengthened by other external inspections, by the Clinical Commissioning Group (CCG), the Care Quality Commission (CQC) and the Local Involvement Network (LiNK).

An unannounced visit by the Clinical Commissioning Group in 2012/13 identified significant progress with regard to the quality, safety and dignity of patients at Tameside Hospital compared to previous visits.

The Care Quality Commission undertook unannounced inspections over the course of the year which initially identified 3 minor and one moderate impacts. The implementation of identified actions ensured a focus and drive on the specific CQC outcomes and resulted in the Trust achieving full compliance against the Essential Standards of Quality and Safety following the February 2013 unannounced inspection which focussed on Outcome 4 – Care and Welfare of People who Use our Services and Outcome 13 – Staffing.

The final round of LiNK (Local Involvement Network) unannounced visits in March 2013, across several wards at the Trust has further supplemented the findings of the CCG and the CQC acknowledging the progress made to date in terms of patient experience, quality and safety of care. The Trust however recognises that there is still more to do at the Hospital going forward, to ensure

exemplary patient experience first time, every time.

The Trust continues to systematically monitor improvements in clinical quality through existing robust reporting arrangements and strong governance structures. The Trust Board's Assurance Framework is underpinned by a review of the impact on quality, patient safety and experience. Detailed action plans are agreed and monitored for all areas of identified risks, with a primary focus on quality.

The Quality and Clinical Governance Committee as a Committee of the Trust Board is tasked with ensuring the systematic monitoring of robust processes and systems across the Trust are undertaken; reporting back to the Trust Board on a monthly basis, along with the Risk Management and Corporate Governance Committee.

The Trust ensures it participates in and reviews and acts on the findings of national audits (including CEPOD). In addition, the Trust adopts best practice guidance, including NICE and speciality guidance.

Bespoke quality dashboards have been developed (and further enhanced) for each clinical division and are reported to the monthly Clinical Audit Patient Safety and Effectiveness Committee (CAPSEC) where deviation from agreed quality and performance indicators is discussed in detail and remedial actions identified where necessary, escalating areas of concern to the Quality and Clinical Governance Committee.

Ward and Divisional Governance meetings ensure the flow of information and quality metrics from Ward to Board and Board to Ward via the Trust robust Governance Framework.

Patient Safety Strategy

The Patient Safety Strategy has been updated. This centres on the reduction of SHMI and the further reduction of harm to patients. A suite of new metrics has been developed to monitor the progress of actions against the strategic aims. These include: HSMR, Global trigger tool, patient safety walkrounds, MRSA, C Difficile, safety in theatres (using the WHO surgical checklist), never events and reportable SUIs, frequency of "red" clinical incidents, resuscitation calls, VTE prophylaxis, falls, nightime discharges from Critical Care Unit, fractured neck of femur surgery and the use of care bundles.

The Trust will continue to focus on key quality issues over the course of this planning period, those being mortality, infection prevention and control, CQC compliance and improving the patient experience.

The Trusts Hospital Standardised Mortality Ratio (HSMR) to January 2013 is 91. This has increased by the rebasing to 96. The Trust is statistically below national average for HSMR. The Summary Hospital Mortality Indicator (SHMI) from October 2011 to September 2012 is 118. The Trust will continue to investigate the reasons why the SHMI is elevated and implement health economy wide actions to reduce this mortality indicator through the joint strategy with the local CCG. This will be further informed by the Keogh review.

The Health Economy wide Mortality Group continues to focus and drive actions to improve mortality across the Health and Social Care economy, reporting to CAPSEC and the Quality Committee of the Clinical Commission Group (CCG).

The Trust has made significant inroads with regard to the risks to patients from Clostridium Difficile, with a 58% reduction on lasts year's outturn, ending this year with 35 cases against a target of 60. Working collaboratively across the health economy with General Practitioners has undoubtedly

helped to safeguard patients. This drive will continue.

The trajectory for MRSA was unfortunately missed but the Trust has continue to take the opportunity to learn from the detailed root cause analyses undertaken in respect of the six cases of MRSA and remains committed to achieving a reduction in the number of avoidable cases.

Improving patient experience continues to be central to the Trusts approach to improving Quality at the Hospital. Over the course of 2012/13 the Trust has developed a “Patient At The Heart” (PATHWAY) Intentional Rounding Programme, utilising knowledge and experience gained as part of the National Care Quality Forum, buddied with Salford Royal NHS Foundation Trust, which is being rolled out across the Hospital. The hourly focussed interventions of nursing staff ensure quality, safety and dignity are core to driving up patient experience. The comprehensive roll out of this programme is scheduled for the first half of 2013/14.

The Trust’s inpatient survey results are better than last year, with a number of questions showing an improvement and a statistically significant improvement in respect of 12 questions. In questions showing a worse result than last year, the deterioration was not significant. The national benchmarking undertaken by the CQC groups all responses into 10 areas. For 8 of the 10 areas the Trust is rated the same as other hospitals, but disappointingly for two areas, “waiting for a bed on a ward” and “doctors”, the Trust’s position is worse than other hospitals. The capacity issues relating to beds are already the subject of intense scrutiny and actions, and remedial actions are being identified to address other key areas highlighted by the survey findings.

The Trust recognised the requirement to further supplement the national patient surveys, and local pulse patient experience surveys by investing in a state of the art real time patient experience monitoring system, building a programme whereby real-time action and intervention in relation to real time feedback from patients experience for patients at the Hospital.

The Trust’s quality strategy – including real time information - is supported by the 5 year information technology (IT) programme - 'Digital by Design'. The Trust will be the first to adopt CSC's Lorenzo Electronic Patient Record (EPR) in October 2013. This provides the centrepiece of the IT strategy which seeks to progressively reduce reliance on the paper record. In realising this aim, Lorenzo is a critical success factor in enhancing patient safety and improving clinical care delivery. The EPR is being designed to enable fast communication with and between staff, patients and GPs. EPR adoption will enable information to be collected once at the point of care and shared effectively across healthcare providers. To this end, clinical workflow is being automated wherever possible, and visual management systems are being deployed to facilitate improved patient flow. Significant investment has been made in change management to develop Standard Operating Procedures designed to streamline existing processes to enable reductions in re-work and free up clinical time to care. The system will allow clinical and managerial staff to see what is happening across the organisation in real time which will allow for accurate analysis and robust decisions to be made.

Inpatient bed capacity is significantly impacted by the processes enacted across the health economy. The local health economy has a multi-agency forum in the form of an Emergency Care Network which is tasked with enhancing the urgent care agenda by ensuring that patients are treated in the most clinically appropriate environment. A key action going forward is the reduction in demand for inpatient bed capacity. The Trust is actively developing several additional ambulatory care pathways which will reduce demand at the front door and is also implementing pathway changes for patients who require an endoscopy with the objective of reducing the time from admission to a management plan being enacted. The integration agenda is key to ensuring that, once admitted, a patient’s stay within the acute setting is minimised. Although the longer term commissioning objective is the implementation of an integrated model of care, there are also areas which can be enacted in the short term (e.g. early supported discharge for patients requiring home IV therapy). The Emergency Care Network Board (ENNB) will be pursuing these issues in the intervening period.

Medical Education

Over the course of many years, the Trust has built a productive relationship with the Northwest Postgraduate Medical Education Deanery to continuously improve the quality of medical education at Tameside Hospital and address any concerns or issues raised.

A triggered visit of surgical trainees undertaken in February 2013 has lead to a number of key changes being made that will embed sustained improvement. These are as follows:

Clinical & Educational Governance

- Embedding medical education within the clinical governance framework to ensure that robust action plans are developed through Divisional structures and are reported to, and monitored by, the Clinical Governance Accountability Committee.
- The Clinical Governance Accountability Committee will oversee delivery of an immediate response to concerns about the care pathways in A&E/MAU and ensure that the clinical protocols are improved.

Educational Supervision

- Further bespoke training on the fundamentals of educational supervision delivered to all Consultants.
- Promotion of formal qualifications in medical education (Modules 2 & 3 at Edge Hill University) to Educational Supervisors and aspirant College Tutors.
- Ensuring that all Educational Supervisors are fully trained and have an enhanced educational appraisal that feeds into their revalidation.

Strengthening Leadership

- Considering the creation of a Clinical Director for Medicine - job plan to incorporate medical education responsibilities, care pathways and protocols between A&E / MAU and will also have clinical sessions on the shop floor.
- Identification of A&E Consultant to look specifically at the quality of patient care and treatment as they move from A&E to MAU, reporting directly into the Clinical Governance Accountability Committee.
- Leadership development for Lead Consultants in May and June focusing on the changing leadership needs of Lead Consultants in the evolving clinical, political and healthcare landscape.

Developing 24/7 Consultant Care

- Ongoing development of 24/7 Consultant Care as a key element within our corporate objectives for 2013/14, underpinning the delivery of safe, high quality care and as part of our Clinical Services Strategy.

The Medical Director is reviewing the medical staff related issues with the Director of Medical Education and Lead Consultants to identify improvement actions by speciality. Further pulse surveys will then be undertaken later in the year.

Senior Nursing Review

A Senior Nursing review has taken place to ensure the Senior Nurses identified, going forward have a refocused job description and role definition primarily focussing on Safety, quality of care and patient experience. Their roles have been underpinned by an extensive development programme to support them to deliver the best possible care for patients at the hospital in the future. Further detailed work has been undertaken with regard to ward staffing levels, as set out in the section below, triangulating and validating both quality data from various systems alongside ward based budgets and current establishment to ensure all wards have sufficient staff and skill mix to deliver the care that is required.

Nursing Acuity and Dependency Modelling

Prior to the 2013/14 contract, last November, significant investment was agreed by the Trust Board in relation to the funding of permanent staff in respect of escalation ward areas to ensure quality and safety standards.

Staffing levels have always been an issue across the whole of the NHS, with the perennial question being what is the optimum level and skill-mix of nurses required to deliver quality care as cost-effectively as possible.

The Trust Board has a duty to ensure staffing levels are adequate and at a level to maintain quality and safety in the delivery of nursing care. Demonstrating sufficient staffing is also one of the standards that all health care providers must meet to comply with Care Quality Commission (CQC) - Essential Standards of Quality & Safety.

The nursing acuity and dependency modelling project took data from a number of Trust wide quality projects and triangulated these with a range of other metrics (such as the North West Clinical Indicators) in order to understand the current baseline staffing position and to outline any actions that need to take place across the Trust as to ensure that all wards and departments are adequately and safely staffed.

This triangulation has developed into a Hospital Staffing Assurance Heat Map. The Director of Nursing is overseeing the implementation of plans at ward level to recruit to the required staffing establishment for every ward, including the Medical Assessment Unit and the A&E Department.

Quality Impact of CIPs

There are a set of quality metrics which are reported to Trust Board every month. The 5 key metrics which are monitored by the Trust Board to provide assurance that the cost improvement schemes are not adversely impacting on quality and staffing are: staff sickness absence rates, mandatory training compliance, PDR compliance, nursing moves, nursing shift with less staff than planned.

Clinical Strategy

Taking into account the current economic climate, the continued drive for consultant-led care 24/7 and the centralisation of complex surgery, THFT recognises the need for further clinical service collaboration, at both horizontal and vertical level.

Future demand for primary care is already driving the national workforce agenda, with the shift towards training a higher proportion of GPs and fewer numbers of hospital consultants. The reducing number of hospital-based trainees in specialty training programmes requires a significant workforce

transformation, as acute hospitals have traditionally been reliant upon specialty trainees for service delivery alongside their medical education. Such changes can only be accommodated in the future through collapsing/amalgamating medical rotas at all levels, with greater emphasis on network arrangements. Smaller District General Hospitals (DGHs) do not have the economies of scale and will therefore feel the impact of this sooner than the teaching hospitals, tertiary units and larger DGHs.

Tameside has traditionally had lower levels of specialty trainees than other Acute Hospitals in Greater Manchester as it has not been able to provide the higher specialty trainees with the highly specialised skills required in certain specialties. With the reduction in hospital-based specialty-trainees across the Northwestern Deanery, the impact of the loss of training posts in areas such as Orthopaedics and General Surgery has a disproportionate impact which, if it continues, will destabilise continuation of these services.

At the same time there is also a general shift towards greater sub-specialism in training programmes at earlier points to reflect the reduced training pathway.

As a district general hospital with an annual turnover of £155m, the Trust is impacted upon by many diseconomies of scale, meaning that support services are relatively small in size and a number of clinical services are made up of a small number of consultants – making contingency cover and consultant on call arrangements expensive and less able to cope with fluxes in capacity.

In addition, the Greater Manchester Local Area Team (GM LAT) healthcare reconfiguration programme “Healthier Together” is changing the way that many services are delivered across the Greater Manchester footprint, with a focus on centralisation of services. To date, the impact of commissioning changes on THFT amount to £13m over 4 years – with disinvestment of specialist general surgery work (Upper GI, emergency vascular) and further changes planned to acute stroke services.

The Trust has used the national and local direction of travel, combined with local commissioning intentions and internal Service Line Reporting (SLR) data and Trust-wide and speciality specific SWOT analysis to inform the organisation’s clinical strategy.

One key health direction of travel for the local health economy is the need to redress the balance between non elective and elective services at the Tameside General Hospital (TGH) site. This will, in part, be addressed by the transfer of emergency general surgery and trauma work to tertiary centres – but this only makes up 8.9% of total non elective activity at THFT. Therefore the focus for T&G CCG, TMBC and THFT is a Vertical Integration model for secondary, community and social care services in order to significantly reduce emergency admissions and readmissions. This integration would encompass the complete pathways, from both an elective and non-elective perspective, encompassing pre-hospital activity through to reablement or rehabilitation. This approach would provide a significantly enhanced service to the residents of Tameside & Glossop at a reduced cost to the Health and Social Care economy. There would be a specific focus on urgent care, with a co-located walk-in centre and A&E Department to fully integrate non elective primary and secondary care. The model would also see acute Trust consultants (specifically Care of the Elderly Consultants) providing an outreach service to nursing and care homes on a sectorised basis to enable the pro-active management of patients to prevent hospital admissions.

The rationalisation of complex surgery into fewer hospitals and the need to collaborate with other hospital providers to ensure clinical sustainability of services, efficiencies and critical mass has shaped the clinical model of a Horizontal partnership which is being taken forward with THFT and UHSM and SFT.

This would see the shift of complex elective and all emergency general surgery work from THFT. The released bed and theatre capacity would permit the expansion of increased levels of ambulatory and short stay surgical activity, maximising the utilisation of ambulatory, day case and enhanced recovery

surgical pathways. In addition, the partnership would provide rationalisation and sharing of clinical support and non clinical services to provide efficiency savings and deliver greater resilience of clinical services.

In terms of service line strategy, THFT is developing patient level costing (PLICs) from its new costing system which goes live in 2013/14. This development will be undertaken with the input of clinicians to ensure that outputs are robust and able to be used to understand cost drivers and to identify potential areas for improvements in patient care and cost efficiencies. A training programme will be introduced in 2013/14 for all consultants to ensure that they understand the benefits of PLICs which enables them to identify procedures and part of pathways which cost more to provide than they gain in income and any practices which are outside the norm. This means that consultants and managers will work together to redesign those services where a loss is being made or those where there is the potential to make a greater new financial gain as well as areas where quality of patient care may be improved.

Clinical Workforce Strategy

The Clinical Workforce Strategy is clearly influenced by the strategic direction of the Trust and the strategic plans for CIPs. The Trust plans to decrease length of stay and maximise productivity will have an impact on the workforce strategy and the form this will take.

The Trust is mindful of specific workforce risks associated with elements of the service, especially within difficult to recruit to areas such as A&E and Radiology. The proposed Strategic Partnership will look at the configuration of a number of services across organisations including Orthopaedics, General Surgery, Pathology and Radiology, as well as a number of back office functions.

The longer-term Strategic Partnership would look to exploit opportunities presented by vertical integration of community services, allowing for transformational change along clinical pathways in order to improve patient experience and quality, reduce costs and reduce long-standing issues associated with patient flow within the wider health economy.

The overall clinical workforce strategy will be based around transformation of services to improve quality and reduce costs allied to a robust performance management and review process. It will also be about maximising quality, and ensuring that the workforce is flexible and robust enough to withstand the demand of the service.

The transformational work will be guided by nationally benchmarked productivity analysis against:

- All Acute Trusts
- All Foundation Trusts
- Peer Group Providers (based on turnover, speciality mix, etc)

Key workforce priorities will be to address long-standing critical medical and nursing vacancies, and in ongoing skill-mix reviews to ensure that the supply of doctors and nurses is appropriate for the acuity and dependency of the patient cohort.

This work will be linked with the reduction of locum, bank & agency usage across the Trust in order to reduce reliance on contingent staff to support capacity, minimise costs and maximise quality. Our focus (in both medical and nursing workforce) will be to recruit to substantive posts (as appropriate), effective rostering, movement to productivity-based job planning and robust performance management.

The focus on the reduction in length of stay and the corresponding reduction in beds will have an impact on the nursing workforce, with a potential headcount reduction of approximately 5% within the Emergency Services & Critical Care Division. However, it is not envisaged at this time that this will attract short-term redundancy costs, as the Trust is intending to use the agreed framework for

managing workforce reductions which will use turnover forecasting, vacancy management, redeployment processes, development of an internal nursing cover pool and MARS Schemes to minimise the need for any compulsory redundancies. The head count reduction resulting from the CIPs is detailed within the financial appendix.

The focus on medical productivity will look at applying a robust model of capacity and demand analysis for job planning, based on benchmark analysis, in order to maximise throughput within DCC sessions. The Trust is also exploring the option of extending the e-rostering system to maximise efficiencies within medical rosters, which would lead to a reduction in Programmed Activities across Consultant and SAS Doctors.

However, it is important to note that all potential workforce reductions can only take place once the required transformation process has been implemented and after the change has been fully impact assessed to ensure that the reduced staffing levels still meet the service requirements and are not at a detriment to service quality.

In line with the Academy of Medical Royal Colleges "Seven Day Consultant Present Care" report (December 2012), the Trust is working on the delivery of consultant care for emergency patients for 7 days per week. The current consultant rotas ensure 12 hour consultant presence for MAU and A&E Monday to Friday and for 9 hours on Saturdays and Sundays. The Trust is working to increase the amount of senior cover throughout the week (to a minimum of 12 hours per day for 7 days per week).

Clinical Sustainability

The Trust has assessed its clinical services against the critical mass required to ensure clinically safe service provision across all specialties.

Sustaining high quality 24/7 emergency surgical care was considered a future risk. This included the management of emergency surgical admissions 24/7 and undertaking complex elective surgery that might require 24/7 consultant support. This assessment has driven the strategic partnership model where the activity would transfer to a specialist centre.

The Trust Clinical Strategy addresses the issues of longer term sustainability of medical rotas through innovative pooled rota models. The concept of shared appointments with the 2 larger centres, particularly UHSM (as a teaching hospital) would be actively developed within the partnership to enhance recruitment.

Productivity & Efficiency

The Trust's strategic plans for CIPs centre around the delivery of transformational schemes which are focussed on improved productivity and efficiency – working in collaboration with key partners across the health economy.

The Trust has used benchmarking information from peer organisations using Dr Foster data and Better Care Better Value Indicators to identify specific areas and specialties where THFT is an outlier and could make efficiency improvements.

The Trust has 5 key transformational schemes:

Reducing Length of Stay – this programme of work is focused predominantly around non elective acute medicine. The Trust is driving a clinician-led pathway redesign programme which has used Dr Foster data to identify the specific conditions for which THFT is an outlier, compared to the performance of national peer organisations. The project team has reviewed the current length of stay for specific conditions (predominantly within respiratory and cardiology) and is redesigning the patient pathways to reduce overall length of stay for patients. The potential productivity gain has been calculated as a recurrent CIP of £1.8m in 2013/14 and further opportunities for savings in years 2014/15 and 2015/16.

Theatre Productivity – this programme of work focuses on improving the productivity of theatre

sessions and increasing the throughput of cases by ensuring that lists start on time and finish on time, are effectively planned and maximise throughput.

Outpatient Productivity – this programme of work focuses on improving the productivity of outpatient clinics and increasing the throughput of patients by ensuring that clinics start on time and finish on time and that DNAs are reduced from the 7% seen in 2012/13 to a target of 5% for 2013/14.

Appropriate Use of Diagnostics – this programme is multi-facteted. It includes reducing pre-operative bed days through ensuring timely access to the right diagnostics so that patients are not admitted to an acute bed if they are fit to go home or those who require an intervention receive this more quickly. The other elements include reducing internal demand for inpatient-related endoscopy, MR and CT and introducing point of care testing in A&E.

Reducing Locum and Agency Spend – this programme centres on the use of E-rostering for all nurses and doctors across the organisation, underpinned by establishment, patient acuity and rota reviews.

CIP Governance

In 2012/13 the Trust delivered an in year CIP of £9.4m and a recurrent CIP of £9.3m, this followed on from the 2011/12 CIP performance which delivered a £10.65m recurrent CIP.

The requirements for CIP delivery over the next three years are: 2013/14 - £9.7m, for 2014/15 - £9.3m and for 2015/16 - £8.4m

The approach to the CIP plans for 2013/14 has been to group saving projects around the opportunities identified through the transformational programmes of work. These savings span all areas of the Trust business (from workforce, medicines management to procurement). The focus of these transformational programmes is to develop workstreams that are aligned with the Trust's strategic priorities of improving quality whilst driving efficiency, change and transformation in order to reduce costs. Each programme is led by a workstream lead who works in partnership with the clinical and financial leads and reports to an Executive Director. The programmes are then broken down into individual projects, each having a dedicated project manager, lead clinician and finance manager. Target savings (derived from benchmarking work) were originally set in November 2012 for each programme area. The projects have subsequently been worked up in detail and have accurate savings agreed which have been profiled across 2013/14.

The Trust has embedded a Programme Management approach for the management and delivery of the programmes, learning from the experience of working with an experienced Turnaround Director in 2011/12. Each project has clinical leadership and a fundamental step in the planning process is the risk and quality assessment which is completed at planning stage. Any projects which could have a detrimental impact on quality (which cannot be mitigated) do not proceed to implementation.

The Cost Improvement Plans (CIPs) are developed by a multi-disciplinary team which includes an Executive Director Sponsor, Workstream lead, Clinical Lead, project manager/service lead and financial lead. For the key transformational projects formal project structures have been set up. The project plans are designed and owned by the project teams and are signed off by all leads before the projects are approved by the Programme Management Office (PMO).

THFT has a dedicated and resourced PMO in place – which has been operationally functioning since March 2011. Up until the end of 2012/13 this has been led by the Director of Planning and Performance and has dedicated PMO managerial and financial support – provided by senior managers.

The Trust commissioned a review of the 2013/14 CIP plans by PwC in March 2013. This review was twofold: a detailed review of the delivery plans with an emphasis on operational, clinical and financial deliverability and a benchmarked evaluation of areas for further opportunity for savings to be made. The report following the review identified a list of six next steps which are included in the table below

together with an update on the actions that the Trust has taken since the report was received on 22nd April.

Agreed Next Steps	Actions Taken and Planned
1. Urgent focus on development of robust, granular and challenging CIP plans to the full value of in-year target accounting for the cost of delivery	• 1st "Dragon's Den" between Executive Team and Workstream leads completed to challenge existing plans and identify potential further opportunities. • Financial profiling of all existing CIP schemes was submitted 19/04/13. • Terms of Reference and Project team structures in place for all key transformational schemes. • Detailed PID audit scheduled for 30/04/13 to provide assurance of the financial value and quality governance of the schemes. • Additional A&C scheme being developed • Workforce plan being developed to detail 7% WTE (and 7% pay cost reduction) reduction across divisions/staff groups to identify opportunities and focus to existing schemes. • Staff Consultation strategies being discussed by executive team 25/04/13
2. PMO to provide further hands-on dedicated support for Trust staff to support PID completion and track/report progress	• Funding in place for additional dedicated PMO resource, focusing specifically on transformational change management and workforce change management. • Revised project structure in place with new Executive lead, and additional admin support. • Releasing existing PMO staff from other non PMO duties to focus attention on monitoring.
3. Further identification and procurement of additional project management support to key projects in order to bolster the PMO function	• Dedicated Project Manager for the Theatre Productivity workstream appointed and due to commence on 1st May. • Dedicated nursing project team in place (e-rostering) • Further additional support to be identified and procured
4. Development of the PMO's reporting tools to provide additional insight of development and delivery of the CIP programme	• Development of a single Finance and PMO spreadsheet to track financial progress against the CIP plans. • Project teams established for all key projects and Terms of Reference/ Membership confirmed. • Revised meeting structure facilitates the embedding of support functions into the CIP project teams. • Monthly key milestone tracker in place to challenge workstream and executive leads and ensure proactive management of potential delays. • PMO risk register being complied to monitor and actively manage risks which may affect delivery. • Revised PMO meeting structure in place.
5. Ensuring that project teams and their activities are fully inclusive of all enabling and support functions	• New meeting structure will support clinical engagement as they will be involved in project team meetings and 'Dragon's Den' meetings. • Terms of Reference for project meetings include all relevant enabling and support functions (ie finance, HR,

	business intelligence etc) • Staff and Clinical engagement underway through presentations at 'open house forum' and monthly communication in staff magazine.
6. Detailed review of the additional opportunities presented in the report, in particular:-	
i. Staff/corporate opportunities	• Workforce plan will identify staffing opportunities at divisional level and map across to existing vacancies to expedite delivery of workforce savings and minimise costs. • These reviews are underway and opportunities for savings in 2013/14 will be extended
ii. Mapping vacancies to efficiency opportunities	• Rigorous and enhanced vacancy review in place
iii. Clinical engagement sessions to take clinicians through the opportunities	• CIPs are a standing agenda item within the Divisional Management meetings. • Clinical leads, where appropriate, to attend bi-monthly dragon den reviews
iv. Staff engagement planned through project lead discussions with staff side representatives to ensure full staff support	• Plans are in place for project leads to meet with Staff side representative and overarching consultation strategies to be discussed and progressed 25/4/13. • CIP's are a standing agenda item at meetings with staff side representatives

A refresh of the PMO has been actioned. The Director of Estate and Facilities (an experienced Project Director with a track record of delivering large scale projects) took over as Programme Director in March 2013. This, together with additional PMO support is intended to strengthen the PMO function for this challenging third year of the CIP delivery.

The PMO uses standard project documentation for CIPs. This includes a high level summary, detailed action plan, phased savings plan, workforce plan, Quality Impact Assessments (QIAs), detailed risk analysis (and mitigation plans) and Analysis of Effects assessment for each project.

The PMO manages all CIPs: from overseeing the development of the plans through to monitoring the delivery of the planned savings and final evaluation of the projects.

A formal project management structure has been adopted by the Trust, led by the PMO, which includes daily PMO internal meetings to review specific risks and required actions, weekly work stream leads meeting to review current scheme progress and explore opportunities to design and implement new schemes and a weekly Executive Delivery Group performance review meeting in which executive leads are required to highlight scheme progress, risks and mitigating actions. The PMO also ensures a bi weekly update submission of each individual project action plan. Prior to the detailed formal CIP monthly reporting to the Board of Directors, a monthly performance review of quality KPIs and financial performance takes place with an agreed "stock take" of actions required. The five transformational projects will present their progress to the Trust Board at regular intervals throughout the year.

This PMO process has been running well since it was established and has overseen the successful delivery of the £19.98m of recurrent CIPs over the years 2011/12 and 2012/13. Key to this is having robust action plans in place and a range of metrics by which the success of the projects are

measured. The Key Performance Indicators (KPIs) are set at the project development stage and reviewed prior to project sign off. The KPIs include qualitative and quantitative metrics as appropriate to the specific workstream. These KPIs are monitored on a bi-weekly or monthly basis (dependent upon the frequency of required metric reporting) by the PMO, with action required being fed back to the project team.

External assurance is provided through ongoing scrutiny by the Tameside Metropolitan Borough Council (TMBC) Overview and Scrutiny Committee (OSC) and the External Stakeholder Reference Group, which is chaired by a Trust Non Executive Director. Further internal assurance is provided by the Internal Stakeholder Reference Group, which is also chaired by a Trust Non Executive Director.

CIP Profile

The key CIP schemes are predominantly transformational schemes.

The top five schemes, in terms of financial delivery together with their current risk ratings are included in the table below

Scheme	Description	Risk Rating (April 2013)
Reducing Length of Stay	Reducing length of stay across the organisation to 75th centile through realignment of specialty bed base, introduction of ambulatory care pathways and increased use of enhanced recovery principles in order to improve efficiency and reduce the Trust bed base.	AMBER
Collaborative Partnership	Horizontal collaboration with 2 acute trusts to achieve critical mass of activity to deliver efficient services at each site.	AMBER
Theatre Productivity	Improved theatre productivity, focusing on rigorously managing start and finish times and increasing 'in-theatre' time to 92%.	AMBER
Effective Medical Job planning and Rostering	Robust job planning in line with activity and capacity planning tools and the introduction of an e-rostering tool to manage Medical workforce rostering and reduce locum usage.	RED
Estates and Facilities	Delivery of non-clinical efficiencies across estate and facility functions including closure and sale of underutilised estate stock.	GREEN

The Programme Management Office process for risk rating 2013/14 schemes is based on the complexity of the scheme, quality impact assessment of the scheme, clinical engagement in the process, requirement for third party input to deliver the savings and completeness of the project documentation and inclusion of key project milestones.

There are a number of transformational CIP schemes within the 2013/14 programme which relate to changing the way in which services are delivered and the multi-disciplinary working across all specialties at THFT. It has been recognised that these transformational schemes will require a change in the culture across the organisation and therefore a Transformational Project Board has been established to facilitate and oversee the delivery of the changes, these projects will also be subject to increased Trust Board scrutiny. Clinicians are fully engaged in driving delivery of the transformational CIP schemes, through redesign of pathways to reduce waste and ensure maximum productivity. The transformational schemes which are subject to project board review are as follows:

1. Reducing Length of Stay
   - 1.1 Reduce LoS for all areas, with initial focus on non-elective Adult Medicine
   - 1.2 Develop and implement ambulatory care pathways to reduce diagnostic bed days.
   - 1.3 Reduce non elective pre-operative bed days for adult medicine
   - 1.4 Demand management for inpatient endoscopy diagnostics
   - 1.5 Reduce delayed discharges

2. Theatres: Improved Productivity
   - 2.1 Theatre Start Times (within 15 minutes of scheduled start time)
   - 2.2 Improved flow, reduced delays between cases to increase knife to skin time and overall theatre utilisation to 92%.
   - 2.3 Increase number of cases on lists (use of point system for transparency), use of "floating" Anaesthetist to increase number of joints undertaken on Orthopaedic lists

3. Outpatients
   - 3.1 Clinic Templates – uplift to peer groups for specific specialties (including Gastro, Cardiology, Rheumatology and Plastic Surgery)
   - 3.2 DNAs – longer term work to reduce DNAs to 5%. Interim work – increase clinic templates as appropriate for specific new and follow up DNA%
   - 3.3 Ensure clinics start and finish on time
   - 3.4 Map out and streamline patient pathways to improve clinic flow – specifically for pathways where diagnostics are required, including Cardiology
   - 3.5 Ensure capacity and demand are in balance recurrently and are linked to job planning at speciality level

4. Managing Diagnostic Demand
   - 4.1 Demand management for inpatient related diagnostics.
   - 4.2 Supporting ambulatory care pathways to manage inpatient bed days.
   - 4.3 Improve productivity in diagnostics and reporting

5. Workforce: Reducing Locum and Agency Spend
   - 5.1 Locum / Bank and agency usage across Nursing and Medical workforce, including introduction of E-rostering tools
   - 5.2 Reduced Waiting list initiative clinics including job planning through planned efficiency increases.
   - 5.3 Benchmarking clinic templates to drive clinical productivity.

The Trust has recognised that these schemes are challenging to deliver and has therefore brought in external expertise for the key transformational projects (as set out in the CIP Enablers section below).

Processes are in place through the PMO to manage CIP delivery; this includes closely monitoring the

strategies to meet the 'unidentified' CIP gap. This gap is to be filled by a combination of identifying new projects or stretch to existing and the identification and delivery of non-recurrent month by month savings to off-set planned shortfalls in meeting the required in-year recurrent delivery.

CIP Enablers

The CIP programme for the Trust remains an absolute priority for the organisation therefore CIP development and performance is a standing agenda item at the monthly Joint Liaison and Negotiation Committee (JLNC) and Corporate, Clinical, Management Group (CCMG) meetings with the Medical workforce.

All CIP projects have a Clinical Lead (nominated by the JLNC) who has been instrumental in developing the project. The Clinical Leads are an integral member of the project team (along with the project lead, HR lead and finance lead) and clinical sign off of CIP schemes, including the quality impact assessment is a requirement of the PMO governance arrangements

Progress against CIP delivery is discussed at the monthly and bi-annual performance meeting with senior clinical leaders.

External support has been sourced for the major transformational projects. The Trust is in the process of deploying a new Electronic Patient Record (EPR) system (Lorenzo), which will be fully implemented in October 2013 which is a key enabler for the reducing length of stay project and future IT-driven efficiencies as it allows real time patient tracking, this has been supported with a full externally resourced project team. The benefits realisation process of this new system dovetails into the PMO processes to identify additional CIP opportunities and to challenge existing schemes to deliver stretch targets.

The theatre productivity scheme requires a high level of time commitment and expertise to deliver the transformational changes and savings and the Trust has commissioned external support in which commences on 1st May.

The Trust had recruited a full project team to roll out and embed the nursing e-rostering tool in 2012/13, this will be further developed during 2013/14 as part of the CIP scheme to reduce the locum, bank and agency spend.

All significant capital investment proposals explore the potential efficiencies that can be derived. There are a number of capital investment programmes underway in 2013/14 which enable CIP saving schemes:

1. The sale of under used land and buildings from the THFT estate enables the rationalisation of the Trust site and delivers recurrent savings and non recurrent sale receipts.
2. Point of Care testing facilities in the Emergency Department will support improved performance against the A&E timeliness indicators, reduce unnecessary admissions and support the reducing Length of Stay CIP scheme.
3. Reconfiguration of wards to place the right patients in the right beds will further support the reducing length of stay scheme.

Bringing the new CT scanner purchased from capital expenditure in 2012/13 into operational use in May 2013 and the procurement and installation of replacement MR scanner during 2013/14 will help enable the Appropriate Use of Diagnostics transformational project.

Quality Impact of CIPs

The Cost Improvement Plans (CIPs) are developed by a multi-disciplinary team which includes an Executive Director Sponsor, Clinical Lead and project manager/ service lead.

As part of the CIP programme the Trust recognises the need to have assurance processes in place to ensure that clinical services and quality are not negatively affected by the cost reductions. Therefore the Trust has established a robust Quality Impact Assurance process as part of the overall Financial Recovery CIP programme.

Quality Impact Assurance Sign Off Process

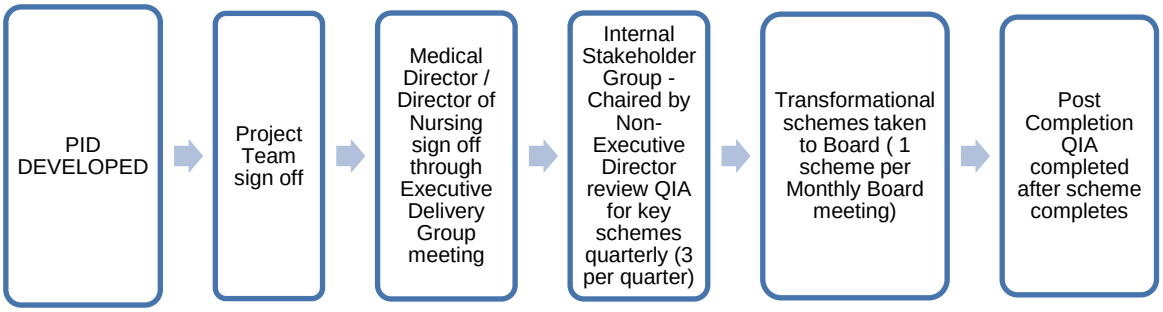
1. All projects should have appropriate support including a Clinical, Finance and HR lead who are involved in the development of the projects (except for a small number of non-clinical schemes which have no direct or indirect impact on clinical services or workforce).
2. Once the scheme is fully developed and agreed as a viable cost improvement scheme all project documentation is completed in detail including the inclusion of key performance indicators and financial profiles which allow the projects to be monitored on an ongoing basis. (PID documentation).
3. Documentation includes a Quality Impact Assessment (QIA) to identify and manage any potential impacts on the clinical quality being provided as a result of the scheme.
4. Once documentation is fully completed and the Project Team is satisfied, the PID is progressed to sign off by clinical leads, project leads, finance and project executive director/ sponsor.
5. Following sign off QIAs are passed to Medical Director and Director of Nursing for sign off in order to provide Trust Board assurance that the CIP schemes do not negatively impact on the quality of services provided across the organisation and also to highlight quality benefits resulting from the cost improvement schemes.
6. An internal stakeholder group is established and meets on a quarterly basis to provide further internal quality assurance on the CIP programme

Post Project Completion Assurance

Projects are monitored against the financial profiles and key performance indicators on a weekly/monthly basis through the meeting structure of the PMO.

3 months following final completion of each cost improvement project a post completion QIA is conducted, this is to review the impact of the project against the potential quality impacts identified on the original QIA and aims to identify any further impacts that may not have been anticipated but have resulted from the implementation of the scheme.

Where any negative impacts are identified these are reviewed by the Executive Sponsor, Director of Nursing and Medical Director and any changes required implemented to provide assurance to the Trust Board. External assurance is also required by the Trust's commissioners that the CIP schemes will not negatively impact the services commissioned from THFT for the residents of the local commissioning organisation therefore an external stakeholder group is established and reviews the QIAs of the key CIP schemes. The CIP Quality Assurance Process is detailed below



The QIAs have been built upon those designed and implemented since 2011/12, reflecting learning points during the course of 2011/12.and 2012/13.

Financial & Investment Strategy

The Trust's current financial position

The Trust has achieved its financial plans for 2012/13 with a normalised surplus of £1.5m against a target of £200,000 and a Financial Risk Rating (FRR) of 2. Within the overall FRR calculation the Trust recognises that its liquidity is weak and understands the historical reasons for this performance. In setting its financial plans for 2012/13 the Trust recognised that liquidity would not increase from 1 to 2 until 2013/14.

In response to an external audit recommendation in 2011/12 the Trust has reassessed the liabilities in relation to the PFI contract which has increased the long term liability by £2.3m in 2012/13; this change, affecting the Trusts Prudential Borrowing Requirement was notified to Monitor during 2012/13.

Key financial priorities and investments and linkages to the Trust's overall strategy

The Trust's three year financial plan supports the Trust's objectives to remain clinically sustainable by working in a collaborative alliance with other providers and stakeholders and to remain financially sustainable by achieving modest surpluses and a strengthening liquidity position. The Trust's financial priorities are to achieve financial sustainability whilst maintaining adequate investment in capital infrastructure, developing a modern IT platform and continuing to employ the right level of well trained staff. The financial impact of the proposed collaborative alliance with Stockport FT and UHSM is included in the 3 year financial plans and the longer term implications of the Integrated Care model will be incorporated into plans as they emerge from the joint working underway with Tameside MBC and T&G CCG. The Trust sees these changes as opportunities to further secure the financial viability of its services.

Key risks to achieving the financial strategy and mitigation

The Trust recognises that the CIP requirement identified in its three year plans to 2015/16 is a significant risk.

The recent review by PWC concludes that the current CIP plan may deliver no more than £3.8m savings in year against a target of £9.7m, a shortfall of £5.9m. The impact of this shortfall would be mitigated by a reduction in the planned surplus of £1.7m to break even, use of the contingency reserve of £1.5m and use of non recurrent reserves of £1.5m, leaving a deficit in year of £1.2m.

However, the Trust is confident that the strengthened processes around CIP delivery will increase the likelihood of delivery of CIP (from £3.8m) to at least £5m. The underperformance on CIP at this level would reduce cash balances to £8.1m at the year end and the liquid metric to 1.

In response to the CIP challenge the Trust also expects that its collaborative alliances with other providers and within the wider local health economy will offer opportunities for further efficiencies in the range and delivery of care.

The Trust is committed to minimising its estate footprint to maximise the utilisation of its most modern facilities and release fixed costs wherever possible without any adverse impact on patient facing services.

The Trust takes every opportunity to benchmark its costs against other organisations to target CIP projects to areas where benefits can be realised and to compare its plans with other organisations to ensure a comprehensive and contemporary approach to identification of CIP opportunities.

At this stage the Greater Manchester 'Healthier Together' initiative may result in a future change in the nature and value of services delivered from the hospital site; however the Trust has already recognised some of these potential changes in its plans with collaborative partners and believes it is well placed to respond.