Operational Plan Document for 2014-16

County Durham and Darlington NHS Foundation Trust

1.1 Operational Plan for Years 1 April 2014 to 31 March 2016

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

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Date	**4 April 2014**

The attached Operational Plan is intended to reflect the Trust's business plan over the next two 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 Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;**
- **The Operational 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 Operational 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; and**
- **All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directors by:

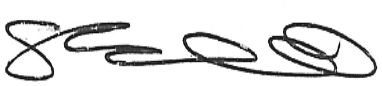
Name *(Chair)*	Dr Tony Waites

Signature

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Mrs Sue Jacques

Signature



Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Mr Peter Dawson

Signature

1.2 Executive Summary

Our vision, 'With you, all the way', represents our commitment to patient centred care - putting patients at the centre of everything we do, working with staff and stakeholders to provide the best experience and outcome for the people we serve.

All the way – means:

- Across the care pathway for prevention, treatment and rehabilitation
- And in different care settings – in the home, in community facilities, in local hospitals
- Working with our partners – our patients, our staff, our stakeholders

In order to deliver:

- The best health outcomes for patients – we need to achieve the highest possible standards of care and improved results for patients
- The best patient experience – because evidence shows that better outcomes are linked to a better experience.
- The best efficiency – reducing our costs so we can continue to invest for the future
- Being a best employer – because high levels of staff motivation and satisfaction are related to better patient care

Our four "best" touchstones are at the heart of a quality service for our patients.

Our strategic direction 2012- 2015 identified four key areas where we need to change the way we provide services, driven by national policy, best practice guidance on quality and safety, the requirements of commissioners and our aspirations to provide the best services to local people:

- Unscheduled care
- Integration and care closer to home
- Women's and children's services
- Centres of excellence.

The Trust and our commissioners recognise that the current pressure on our services means that getting care right for the emergency patient must be our first priority. In particular, we need to focus on the needs of our frail elderly patient population.

These themes are therefore at the centre of "Right First Time 24/7 - our evolving clinical and quality strategy" They are also our key areas of short term challenge for 2014/15 and 2015/16.

As part of our clinical strategy and integrated business plan development, we have identified a series of "strategic breakthroughs" and workstreams in three areas:

- Transforming unscheduled care – including avoiding unnecessary attendances, avoiding admission, and improving discharge
- Integration and care closer to home – making care as seamless as possible between the Trust's hospital and community services, primary care and local authority provision
- Centres of excellence – providing the best quality of specialist services for our population

We are also progressing our development of women and children's services within our plans, and expect, during 2014/15 to increase our care to families in North Yorkshire in the light of changes at the Friarage Hospital in Northallerton.

From 2014/15, Directors have committed to working more closely with clinical services as part of a new framework to strengthen accountability ensure alignment between care group and leadership business needs and priorities, and that these reflect the organisation's strategic breakthroughs and operational plan.

Our quality plans for 2014/15 and 2015/16 are outlined in our Quality Strategy, agreed by the Board following consultation during 2013/14, and our quality account, which is also being finalised following consultation with stakeholders.

Our Quality Strategy 2013/18 has been triangulated with the findings of the Francis report, Professor Sir Bruce Keogh's review into the quality of care and treatment provided by 14 hospital trusts in England, and Don Berwick's report A Promise to Learn, a Commitment to Act. The Quality Strategy has a strong focus on improvements in frontline care, in line with the "six Cs" national strategy.

Our quality priorities, which are outlined in the Trust's Quality Strategy are described under the following headings, reflecting the nationally recognised domains:

- Patient Safety - reducing mortality and harm
- Service Effectiveness - improving care outcomes and the use of best practice and evidence based care
- Patient and Staff Experience – improving the experiences of patient, service users and our staff.

Our workforce and organisation development plans focus on 4 key areas:

- Ensuring that we have the right establishment, particularly in nursing, so that we can reduce our dependency on bank and agency, and on locums

- Developing new roles for staff that will support changed ways of working reflecting the shift of care to outside acute settings and the development of our community services

- Recruiting and retaining a high calibre workforce, with an emphasis on our research and academic offering through the clinical research and innovation unit, recently opened at Darlington Memorial, the new Learning Centre at University Hospital of North Durham, and plans for a simulation centre

- Strengthening clinical engagement and developing our clinical leadership.

Commissioner's high level intentions for 2014-15 include a reduction of 3% in A&E activity and savings in non-elective activity and costs arising from the multi-agency Intermediate Care Strategy (ISIS). Work is also planned to review out-patient pathways to reduce elective demand on Secondary Care services and move more patient care closer to home. The detail behind these intentions aspirations is still being developed; so detail is currently unavailable about commissioning intentions beyond the next financial year.

However, although non-elective activity in 2013-14 has shown some signs of stabilising in A&E and Medicine, rises have been experienced. 2013-14 has also seen a 6.2% growth in referrals, including a 7.9% growth in GP referrals. As a result, both the out-patient and in-patient waiting list sizes have grown.

The Trust is therefore planning on the basis of a range of scenarios, which include contingencies if the economy does not achieve commissioners' high level intentions.

The Trust recognises that the Better Care Fund offers both challenges and opportunities for the future delivery of service. We are working with commissioners and local authorities to ensure that plans for the implementation of the fund are robust and deliver the intended improvements in care closer to home and

reduce reliance on care in acute settings. Our Plan for 2015/16 recognises the commissioners' ambition in terms of proposed shift of activity away from acute hospital settings, but further collaborative work is required to work up and implement transformational service models to achieve this ambition.

The Trust has delivered a strong financial performance during 2013/14, and is forecast to exceed its financial plan for that year. This has enabled the Trust to agree a forward capital programme to invest c£70m in capital schemes from 2014 to 2018 from resources generated from its historic and planned revenue position. This will ensure that the Trust's capital assets support the strategic development of its services as well as enable improvements in productivity, patient experience and outcomes.

The Trust has a strong track record of delivering its overall financial plan each year since it was authorised in 2007. Whilst the cost improvement target has not always been delivered in accordance with the original plan each and every year, the trust has demonstrated the strength of its financial risk assessment and mitigation planning, and its financial flexibility in dealing with in year deviation from plan, whilst being able to deliver overall financial results.

Experience of 2013/14 delivery of Care Group identified CIPs indicates that this current model of detection and subsequent delivery is not having the long term sustainable effects that the Trust deems essential for delivering quality services in forthcoming years.

The Trust has acknowledged the need to access the more challenging areas of cost reduction predominantly around changes in current clinical practice and subsequent impact on bed, outpatient and theatre utilisation.

The Trust is therefore moving towards a formalised director and associate director-led programme management approach in order to deliver the CIP plan for the next 2 years.

The IT and estates capital programme is a key enabler for improvements in efficiency alongside the trusts other guiding touchstones of improved patient outcome and experience and workforce. The Board will be reviewing the Trust's IT strategy during 2014/15.

Key elements of the capital plan include:

- Redevelopment of theatres at DMH
- More efficient deployment of staff via nurse and medical rostering systems.
- Embedding our electronic clinical document management system introduced in 2012/13 and beginning to achieve clinical and efficiency benefits

The quality impact assessment process requires all CIPs to be clinically-owned and clinically led and validated by Executive Medical and Nursing Directors, with the overall process being owned by the Trust Board. A programme board will control the programme and ensure assurance on delivery across clinical strategy, estates, workforce and CIPs to ensure a coherent and balanced approach which achieves the Trust's goals.

The Trust has involved its staff and stakeholders in developing this plan, through a series of engagement events in February and March 2014. We will be continuing to engage our staff as we continue our strategic development and plan implementation during 2014/15-15/16. We are establishing a clinical reference, chaired by one of our Governors to improve the engagement of clinical professions. Its terms of reference include:

- providing innovative ideas and solutions to existing and future challenges within the organisation and regional health economy
- developing ideas for models of care in line with the strategic breakthrough areas identified above
- review feasibility of proposals emerging as part of clinical strategy development.

We have also involved our Council of Governors by working with their Strategy Committee,

representatives of which join a group, the Foundation Trust Planning Group, chaired by the Executive Director of Commercial Services, which leads the development of the plan.

The Trust has engaged KPMG as a critical friend to offer advice and commentary on our two year plan. They have supported the Trust in a review of our self-assessment against Monitor's 12 Board assurance standards involving our stakeholders and commissioners.

1.3 Operational Plan

A.THE SHORT TERM CHALLENGE

County Durham and Darlington NHS Foundation Trust has been an integrated provider of health and wellbeing services since 2011.

Our mission “with you all the way” reflects our commitment to caring for our patients throughout their lives, improving health and wellbeing, providing treatment and supporting rehabilitation, across the whole of the care pathway and in different environments – hospital, community and home.

Our strategic direction 2012- 2015 identified four key areas where we need to change the way we provide services, driven by national policy, best practice guidance on quality and safety, the requirements of commissioners and our aspirations to provide the best services to local people:

- Unscheduled care
- Integration and care closer to home
- Women’s and children’s services
- Centres of excellence.

The Trust works closely with its commissioners through our two local Health and Wellbeing Boards, a Clinical Programme Board which brings together the Trust and three local CCGs – North Durham, Durham Dales, Easington and Sedgefield and Darlington – and a joint commissioner/provider urgent care board.

The Trust and our commissioners recognise that the current pressure on our services means that getting care right for the emergency patient must be our first priority. In particular, we need to focus on the needs of our frail elderly patient population. This is our core business.

- We know our performance in A&E is inconsistent. This pressure is experienced on both acute sites, but is particularly high at UHND where last year’s winter beds have remained open throughout the year.

- We know that there are patients, usually frail elderly, who are admitted to hospital unnecessarily because services are not organised to respond appropriately to their needs at an early stage.

- We also know that work needs to be done to strengthen some of our key services in centres of excellence, to ensure they are sustainable at a time of increased specialisation. We have seen the benefits of this in stroke, and in vascular surgery. This is key to emergency acute care being sustainable within County Durham and Darlington. This reflects our commissioners’ ambition to ensure that local services meet recognised quality standards as part of the Securing Quality in Health Services (SeQuiHS) programme.

These themes are therefore at the centre of “Right First Time 24/7 - our evolving clinical and quality strategy” a discussion document that has been shared with internal and external stakeholders, and has been the subject of stakeholder and staff events in early 2014.

They are also our key areas of short term challenge for 2014/15 and 2015/16.

Accident and Emergency performance

The Trust has already taken a series of steps to improve performance in ED, including increasing medical and nursing staffing, extending senior medical cover and increasing assessment capacity.

We have been working with our internal Service Transformation Team, and have involved the national Emergency Care Intensive Support Team (ECIST). We have an action plan which we are committed to delivering and which covers three main areas:

Attendance avoidance

- Actions within the Trust include ED/UCC integration at Darlington Memorial Hospital
- Action with North East Ambulance Service/111 includes the development of a directory of services & alternate dispositions, and new ways of working including development of advanced care paramedics and paramedic callback
- Action with Primary Care / Local Authorities includes the agreement of the Integrated Short Term Intervention Service (ISIS) business case, including a single point of access; an increase in GP appointments and increase support to nursing homes

Admissions avoidance

- **Actions include:**
- Increasing the assessment & ambulatory care footprint, including extended opening times & 7 day services, co-locating short stay beds, assessment & ambulatory care
- Developing a front of house model for adults and paediatrics
- Developing 7 day working strategies (whole system)
- Reviewing GP referrals to identify alternative dispositions such as telephone advice / GP to consultant conversations; rapid access clinics and outreach services

Discharge Management

- Actions include reviewing all aspects of the discharge process including Expected Date of Discharge, early supported discharge, prior day discharge planning, daily consultant review; criteria led discharging and smoothing discharges over 7 days
- Weekly MDT review of delayed transfers of care
- Improving pharmacy support through an electronic prescribing IT solution
- (disproportionate discharge numbers on Monday & Tuesday
- Enhanced Case Management

Meeting the needs of frail elderly patients

Our average age for patients admitted to hospital is over 80 years old. We know that there are patients who are admitted to hospital because alternative services are not available, or are not well understood, and that there are patients who could be discharged earlier with the right support in place.

This is a particular issue in terms of reducing pressure on acute services, improving care quality, and the development of services in line with the requirements of the Better Care Fund.

We have appointed a senior clinician as Chief of Service for elderly medicine to lead the development of our elderly care strategy working across hospital and community services over the period of this plan and beyond.

Our community services are realigning their provision along locality lines, and we are planning to introduce community based elderly care teams including consultant geriatrician support.

The health and social care economy in County Durham has worked together to develop ISIS – Integrated Short term Intervention Service. The model is being evaluated over an 18 month period to inform future commissioning of the service and build a robust 'invest to save' business case moving forward

Its primary objectives are:

- Admission avoidance to acute or permanent residential care
- Re-admission avoidance
- Timely hospital discharge

ISIS includes:

- Development of a 24/7 Single Point of Access through a phased approach in keeping with plans for a contact centre managing wider community service referrals. The single point of access has now been rolled out to all acute and community hospital wards.
- An expansion of the current 4 multidisciplinary assessment teams to enable each locality to operate 8-8, 7 days a week as well as manage the additional demand placed on the service.
- A number of supporting services are commissioned as part of this model to ensure a holistic approach to delivering care, improved outcomes and enable sustainable recovery and independence to be achieved.
- Robust discharge planning with a much more joined up approach across the organisations reducing length of stay in an acute or intermediate care bed.

The model encompasses all pilots and smaller services which have a short term intervention focus.

Centres of excellence

Since being established as a County Durham and Darlington wide acute trust in 2002, the Trust has shown its willingness to address challenges in services where expertise has been spread thinly across several sites, to bring these together to improve outcomes and experience for patients.

The Trust continues to operate acute services across two sites, and remains committed to that model as the best way to meet the needs of its populations. We must design our future configuration to make sure that we make the best use of our hospital sites and that each site has a strong portfolio of services.

However, we want to offer services that are evidence based, accessible, safe and effective. Where this will deliver an improved service, specialist services should be delivered from a lead site within the Trust. Some of the most specialist services and interventions will need to be centralised on one site, in order to ensure we have the critical mass of specialist staff and patients to ensure we meet nationally recognised quality standards.

A principal enabler for this is a new suite of theatres at Darlington Memorial Hospital, a business case for which is in preparation, and will be presented to the Board in 2014/15.

Strategic breakthroughs

As part of our clinical strategy and integrated business plan development, we have identified a series of "strategic breakthroughs" and workstreams in three areas:

Transforming unscheduled care:

- Improving discharge management, including reconfiguration of our assessment areas, and improving our performance on issuing discharge summaries and meeting Expected Date of Discharge
- Integrated Front of house activity for adults & children, including greater access to senior decision makers at front door; embedding our integrated paediatrics model, following a trail in 2013/14; co-location of ED and Urgent Care at DMH, and, as appropriate at UHND

- Exploring the opportunities for the Trust under the Keogh model of emergency care centres and major emergency care centres
- Extending access to services across 7 days, particularly in support services including diagnostics and access to AHPs

Integration and care closer to home:

- Implementation of the Integrated Short-term Intervention Service (ISIS) across the County Durham health economy which includes: a single telephone point of access to improve care co-ordination, including for the frail elderly; multi-disciplinary teams supporting short term interventions; increased use and development of telehealth; and providing outpatients antibiotic treatment in the community
- Further development of care co-ordination and case management
- Optimising use of acute and community beds
- Strengthening locality based working to support better integration of services across health and social care
- Reconfiguring outpatients where demand is putting pressure in Trust performance for 18 weeks and breast cancer 2 week waits.

Centres of excellence

- Bringing services together to improve clinical outcomes for patients across our services including:
- Surgery & Diagnostics
    - Increased use of the orthopaedic facilities at Bishop Auckland
    - Expansion of Endoscopy as a leading screening centre
    - Consolidation of breast services to optimise clinical outcomes
    - Reshaping our colorectal and general surgery service to provide the best clinical outcomes
- Care Closer to Home
    - Increasing outpatient based gynaecology, while consolidating complex work
- Acute & Long Term Conditions
    - Drawing together medical and surgical outcomes in gastroenterology
    - Developing cardiology as a single service across two sites to provide more consistent 7 day provision

Each breakthrough has an executive and clinical sponsor and a series of outcome measures.

Workforce and OD

Delivery of our breakthroughs will require the right staff with the right skills. Our workforce and organisation development plans focus on 4 key areas

- Ensuring that we have the right establishment, particularly in nursing, so that we can reduce our dependency on bank and agency, and on locums

- Developing new roles for staff that will support changed ways of working reflecting the shift of care to outside acute settings and the development of our community services

- Recruiting and retaining a high calibre workforce, with an emphasis on our research and academic offering through the clinical research and innovation unit, recently opened at Darlington Memorial, the new Learning Centre at University Hospital of North Durham, and plans for a simulation centre

- Strengthening clinical engagement and developing our clinical leadership.

B. QUALITY PLANS

Our quality plans for 2014/15 and 2015/16 are outlined in our Quality Strategy, agreed by the Board following consultation during 2013/14, and our quality account, which is also being finalised following consultation with stakeholders.

Our Quality Strategy 2013/18 has been triangulated with the findings of Professor Sir Bruce Keogh's review into the quality of care and treatment provided by 14 hospital trusts in England, and Don Berwick's report A Promise to Learn, a Commitment to Act. The Quality Strategy has a strong focus on improvements in frontline care, in line with the "six Cs" national strategy.

Our Quality Strategy and Clinical Strategy both reflect our short term challenges in particular around improvement of care for the emergency patient, particularly the frail elderly, which is recognised as a health economy wide priority, and reflected in our Strategic Breakthroughs.

This encompasses

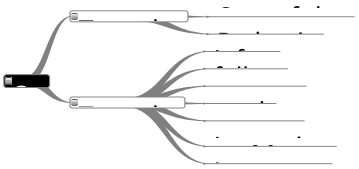
- NHS Safety Thermometer including specific falls indicator
- Dementia and delirium
- End of Life Care
- Friends and Family Test
- Seven day working
- Privacy and dignity for patients

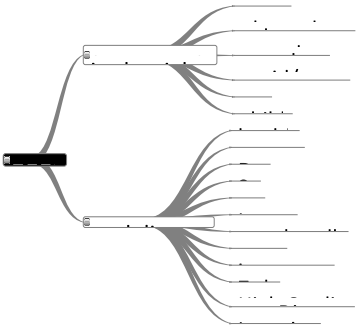
Our quality priorities, which are outlined in the Trust's Quality Strategy are described under the following headings, reflecting the nationally recognised domains:

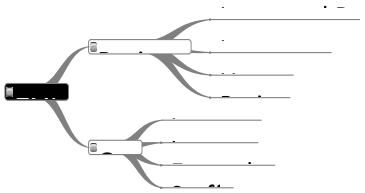
- Patient Safety - reducing mortality and harm
- Service Effectiveness - improving care outcomes and the use of best practice and evidence based care
- Patient and Staff Experience – improving the experiences of patient, service users and our staff.

The three domains and their themes have been chosen as these represent the key quality areas for improvement for the Trust. In addition, some are more of a priority than others, e.g. unscheduled care. Nonetheless, all of the areas described are areas that require further focus, improvement and attention in order to improve care for patients.

The specific aims and objectives under each of these three quality domains are:







The most recent unannounced visits by the Care Quality Commission to Darlington Memorial and Bishop Auckland Hospitals showed that services were meeting all CQC national standards.

An unannounced visit by Care Quality Commission to University Hospital of North Durham on 21 November 2013 resulted in a compliance action. This was in relation to Outcome 21: Records and was assessed as having minor impact. Actions to address this have been agreed with the CQC and progress is being monitored through Senior Nurse/ Leadership Group, chaired by Executive Director of Nursing. The CQC will revisit the hospital to reassess this outcome in the near future.

Key risks to quality

Principal and key risks relating to clinical and quality matters, which are also recorded in the Board Assurance Framework, are summarised in the table below:

Objective	Principal inherent risks	Specific risks in risk registers	Key actions
No avoidable deaths	Mortality exceeds acceptable thresholds Deaths from avoidable infections Deaths from failures in clinical practice	Mortality hotspots in some areas are not yet fully understood.	Each Care Group has implemented a programme of audits, to move towards auditing each death in real-time, with results being reviewed and actions agreed through the Mortality Reduction Committee The Healthcare Acquired Infections Reduction Group continues to monitor the effectiveness of a range of

			actions on a quarterly basis.
Reduce avoidable harm	Poor clinical and nursing policies increasing the risk of harm Poor clinical practice / compliance increasing the risk of harm Failure to secure clinical engagement and leadership Failure to prevent avoidable healthcare infections	Avoidable patient falls Gaps in clinical record-keeping and inconsistent compliance with policies on record-keeping and patient observations. Gaps / weaknesses in management of the deteriorating patient C-difficile trends	Roll out of a 'falls care bundle' and active monitoring of trends, including providing additional training in hotspot areas, through the Safety Committee. Record-keeping compliance monitored daily and weekly by senior nurses. Documentation being streamlined and improved for ease of use. On-going audits of compliance with policies on observations, fluid balance and DNAR with rapid follow up with individual consultants and nursing staff and at specialty / care group level. HCAI Reduction Group and Plan (see above)..
Right place and time	Insufficient bed capacity / poor bed configuration Poorly designed pathways Weaknesses in patient flow leading to blockages Lack of staffing capacity in the right places at the right time	The risk register includes a number of risks around demand pressures on A&E, ambulance handovers, patient flow / bed pressures and A&E staffing.	Mitigations are summarised in Section C.
Best outcomes	Poorly designed and / or under-performing services (specific current risk re radiology) Failure to develop sustainable service development plans in particular for centres of excellence.	Risk registers highlight some service pressures, in relation to Cardiology, Rheumatology, Retinal Screening, Ophthalmology and, most notably, Radiology. Risks concern gaps in capacity and, in some cases, gaps in clinical governance putting patient safety and	All services have been assessed with respect to quality, demand and capacity and workforce as part of the planning process and a range of specific actions agreed for risks arising. The Trust is actively working with commissioners and third parties (including, in the case

		outcomes at risk.	of Radiology, the Royal College and other providers in the region, to fund / improve service capacity and (where necessary) governance.
Patient experience	Failure to obtain and understand patient views on service developments and performance Failure to act on patient views Lack of / unrepresentative patient and public engagement.	The Trust has lower than average results for the Friends and Family Test, particularly for its A&E departments	Friends and Family Test performance is being reviewed and action plans required on a ward by ward basis. Pressures on our A&E departments (see section C below) are having some influence. Mitigations are noted in Section C below. Responses are being triangulated with other patient feedback leading to development of ward / area specific action plans.

Risk registers also include quality risks relating to workforce shortages in some areas. Workforce issues related to quality are considered below.

How the Board derives assurance on quality

Board members recognise their collective responsibility for quality of care. The Director of Nursing and Medical Director have joint lead responsibility for quality, and there is non- executive director engagement on quality governance at Board and sub- committee level.

Progress against quality priorities is measured by specific key performance indicators. The Board reviews monthly reports which include key quality metrics which are reviewed to ensure they reflect the Trust's core purpose and priorities.. The monthly Patient Safety, Medical Director's and Operational Performance reports escalates issues for the attention of the Board, and action plans are put in place to address quality performance issues:

- Patient safety report covers key quality issues including safety, infection control, serious incidents, complaints and PALs (quarterly), and strategic clinical quality. An example of a significant issue would be the review around the safety of the midwife-led unit at Bishop Auckland Hospital
- The Medical Director reports on matters specific to doctors and medically led services and research and development
- The Operations report covers National targets and standards priority indicators, CQUIN and contractual issues
- The Estates and Facilities Director's report covers issues relating to the care environment, catering and other services.

The Quality & Healthcare Governance Committee is a Board sub-committee and provides assurance to the Board around all aspects of quality. Membership of the Committee includes non- executive and executive directors. Each Care Group also has a quality group/ committee which meets regularly to support delivery of the quality agenda.

All cost improvement programme (CIP) schemes including major productivity and efficiency schemes around bed utilisation, outpatient utilisation and theatre utilisation are quality impact assessed to ensure savings are not be at the expense of the quality agenda.

The Trust shares intelligence and learns from other trusts through, for example, its membership of NHS QUEST.

During 2013/14 The Trust has appointed a senior associate director for assurance and compliance, working across clinical and non-clinical areas. He has taken a lead role in the development of the risk management committee and risk register, linking with board assurance framework. There is also greater clinical involvement in these processes, with risk management committee now including strong care group representation, including group clinical directors.

The risk management and performance management systems provide the Board with assurance about how the organisation is able to identify, monitor, escalate and manage concerns around quality.

There is an annual clinical audit programme in place and reports are received and reviewed by the Clinical Audit Committee which reports to Quality & Healthcare Governance Committee. Internal audits are undertaken following a risk based approach.

During the year the Trust commissioned KPMG to review the above arrangements against Monitor's Quality Governance Framework. The significant majority of the 20 recommendations made by KPMG have been implemented.

The above arrangements were also reviewed on the recent CQC inspection at UHND, which included an in-depth assessment of arrangements to monitor the quality of service provision and were found to be compliant and as part of a successful assessment against Level 2 of the NHS Litigation Authority's Risk Management Standards in January 2014.

From 2014/15, directors have committed to working more closely with clinical services as part of a new framework to strengthen accountability ensure alignment between care group and leadership business needs and priorities, and that these reflect the organisation's strategic breakthroughs and operational plan.

Francis, Berwick and Keogh

The findings and recommendations included in Robert Francis' report, and the implications of the Berwick and Keogh reports have been considered at all levels within the Trust.

- Subcommittee chairs used meetings between March and May to consider the issues formally, reporting minuted/noted discussions through to Board committees.

- Executive Directors attended team meetings across the organisation

- A series of Trust wide "by invitation" staff listening events took place between 3 and 30. 1,000 staff were personally invited to 36 sessions. 532 attended.

- In September, at two larger scale events "Great All Round" Executive Directors discussed organisational priorities with staff. This was repeated on 4 November.

- The Trust Board met on 13 February 2013 for a preliminary discussion, and subsequently discussed the report at its meetings on:

    - 23 February 2013

- 24 April 2013
- 22 May 2013
- 19 July 2013 (also discussed by the Audit Committee)
- 23 October 2013

- The Francis Report, Berwick and Keogh reports were the subject of a Board seminar on 27 November 2013

At each Board meeting, directors have been updated on work that has been under taken within the Trust.

Key actions are as follows:

- The Trust has strengthened its senior clinical management following the appointment of executive medical and nursing directors, with the appointment of a deputy medical director and clinical director of service transformation.
- The Mortality Committee has been established, chaired by the Executive Medical Director. A standardised process for auditing case notes has been agreed, and each care group has carried out an audit of deaths. A dashboard of mortality indicators has also been agreed.
- A review of the discharge and handover policies, to streamline paperwork and improve transfer and handover procedures. This has been discussed and approved by the Quality and Healthcare Governance Committee
- The Clinical Strategy Steering Group (SSG) has been established and is meeting weekly, reporting into Executive and Clinical Leaders. Chaired by the Medical Director its membership includes Care Group Clinical Directors and Associate Chief Operating Officers, the CEO and Executive Directors. The SSG is developing a programme of work to support delivery of the strategy including immediate priorities for action to address serious current pressures and ensure safe services.
- The Trust and our commissioners have been approved as an “early adopter” in moving the NHS towards seven day working as part of our Strategic Breakthroughs, following the Chief Executive’s involvement in the national working group led by Sir Bruce Keogh.

Quality plans and workforce

We are reviewing our workforce in line with National Quality Board’s guidance.

We have identified key areas where we need to improve our workforce capacity and capability, particularly around medical and nursing workforce, where our strategy is to increase access to senior decision makers including consultant delivered care.

This will require recruitment of senior and experienced clinicians. We are currently looking to recruit physicians in renal medicine and care of the elderly, having recently appointed a senior consultant as Chief of Service for elderly care. We face particular challenges in strengthening our radiology service.

Our Director of Nursing is in the process of reviewing our nursing and midwifery establishment across the organisation in line with requirements of the 10 expectations of the National Quality Board. Preliminary work on this has been presented to the Trust Board in March 2014, with further work ongoing to ensure a stable nursing and midwifery workforce.

Our clinical strategy Strategic Breakthroughs will impact on staff where services move towards seven

days, or need to move between hospital sites, or move from hospital to community, and these issues were discussed at a major staff clinical strategy event on 14 February 2014, and are being taken forward as part of the programme.

As part of the development of the evolving clinical strategy and integrated business planning process (IBP) for 2014/15, we have defined demand and capacity requirements for each service, mapped the workforce against them and identified any shortfalls, together with priorities for investment and options to address them.

A key issue for our care groups is a reduction in use of bank and agency staff in favour of substantive appointments, which is a key part of the quality agenda, and which will reduce costs associated with bank and agency workers.

Risks to the delivery of quality plans

The main risks around delivery of the quality plans are:

- Workforce issues – including the ability to recruit nursing and medical staff in the current climate to pressurised services, clinical leadership and accountability to drive forward change.
- Health economy wide action – and whether this will have the required impact to reduce unscheduled care pressures in hospital.

c. OPERATIONAL REQUIREMENTS and CAPACITY

2013-14 BASELINE

Elective demand

2013-14 has seen a 6.2% growth in referrals, including a 7.9% growth in GP referrals. One key driver is the recent Cancer campaigns, which have helped increase cancer-related out-patient referrals by 10.9% although the numbers being diagnosed with cancer has fallen by 15.2%.

As a result, both the out-patient and in-patient waiting list sizes have grown. We continue to achieve the 18 week RTT standard but pressures are evident in Orthopaedics, Colorectal and breast surgery, Ophthalmology and Dermatology. Re-admissions following an elective spell have fallen slightly (2.1%), probably largely as a result of successful telephone follow-up services in Surgery. The Trust achieved the 18 weeks targets despite pressures created by the significant growth in referrals, but with only a small margin for admitted patients in the third quarter.

Accident and Emergency/Urgent Care

Non-elective activity in 2013-14 has shown some signs of stabilising but in the crucial areas of A&E and Medicine, rises have been experienced. The actions taken by Primary Care may have contributed to a fall in activity at the CDDFT Urgent Care Centres, but Emergency Department activity has continued to grow modestly. Ambulance arrivals at hospital also continue to increase. Over 45% of patients arriving at our Durham A&E Dept and over 35% of arrivals at Darlington do so by NEAS ambulance.

	Apr - Jan 2012-13	Apr - Jan 2013-14	% Variance
Urgent Care activity (all types)	204,191	199,007	-2.5%
A&E Type 1 attendances (total)	102,222	102,665	0.4%
A&E Ambulance attendances (total)	40,639	42,044	3.5%

(NEAS ambulances only – excluding YAS ambulances)

As a result, our performance against the 4-hour and ambulance handover standards continues to be under pressure, and this area has been identified as a key issue under "the short term challenge" section above.

All Specialties non-elective activity has fallen this year, largely as a result of falls in births and paediatrics activity; the latter as a result of successful pilots involving Consultant paediatricians see, treat and discharging patients at the front-door. However, although in line with our clinical strategy activity in Ambulatory Care and short stay units rose by 23.8%, the acuity of patients is such that demand for in-patient medical beds rose by approximately 1.5%; and medical bed occupancy regularly continues to be exceed 100% at both Acute sites. We estimate the average age of admitted patients to be 84 years. Re-admissions following a non-elective spell also rose by 8.5%.

OPERATIONAL REQUIREMENTS and CAPACITY 2014-16

Commissioning Intentions

Commissioners have provided us with their high level intentions for 2014-16 (see Table below). As work continues on developing these, we are using them as the basis for our core assumptions about future demand, whilst planning for a range of scenarios.

Activity type	2014-15	2015-16
Non-electives	0%	0%
Electives	0%	0%
1st Out-patients	-1%	-1%
Follow-up out--patients	-0.5%	-1.5%
Referrals	-1%	-1%
A&E	-3%	-3%

Elective requirements

Risks

- Ability of the wider health economy to arrest growth in demand.
- Capacity and growth pressures will come from:
- demographic change
- recent and proposed cancer campaigns. We expect this will result in additional out-patient and diagnostic demand but will not necessarily translate into additional surgical procedures. This growth is unlikely to be on a larger scale than this year.
- workforce constraints in some Specialties
- the need to shift work from acute to community settings and reduce the overall acute footprint

CDDFT Response

Our response is based on:

- well established processes to identify referral trends in a timely manner, backed up by escalation processes which provide assurance that sufficient capacity is in place to meet emerging demand:
- a weekly 18 week capacity planning meeting, chaired by the Associate Director of Operations and Performance, and involving all Heads of Service, agrees capacity plans for the coming months.
- This meeting is informed by a comprehensive suite of patient-level waiting time data
- An 18-week Task Group, also chaired by the Associate Director of Operations and Performance, considers and agrees medium and longer-term capacity plans.
- Executives hold monthly meetings with Care Groups to review their performance across the range of quality, operational, financial and other standards/targets. When necessary, there is an escalation procedure in which a Care /Group's performance and action plans are scrutinised monthly by the Planning and Workforce sub-committee of the Board.
    - These mechanisms ensure that we consistently meet the 18 week and diagnostic waits standards at Trust level and in most Specialties, and that we can flex capacity to meet emerging demand by prudent use of additional ad hoc sessions or over-booking, when needed.
- Our emerging Clinical Strategy, which is currently the subject of consultation and which involves the creation of Centres of Excellence to maintain sufficient critical mass in all services in spite of increased financial stringency.
- In some Specialties we expect to continue to experience 18 week pressures: particularly Orthopaedics, General Surgery, Ophthalmology and Dermatology. Each of these Specialties has an Action Plan which is overseen by the 18 week Task Group led by the Associate Director of Operations and Performance. The scope of this Task Group will be widened in 2014-15 to include improvements to our Choose and Book offering.
- Where there are persistent demand pressures we have agreed with commissioners the following approach:
- Out-patient pathways. There will be a rolling programme of Specialty and sub-specialty pathway reviews, undertaken in partnership with commissioners to move care closer to home and reduce the need for Secondary Care follow-up. The Specialties to be the first subjects of this process will be chosen by agreement with commissioners, based on a joint evaluation of service pressures and opportunities for change.
- Service reviews in Specialties facing particular capacity challenges, whether due to workforce constraints (such as dermatology, breast surgery; or demand pressures, such as colorectal surgery, ophthalmology and radiology).
- There are some areas where additional investment and service change may be needed to achieve full NICE compliance. We have agreed a programme of work with commissioners to explore solutions in these areas. The initial Specialties to benefit from this work will be cardiology and ophthalmology.
- Where rising demand affects CDDFT community services, we will ensure that commissioners have a robust Service Specification in place and that we work closely with them through Contract discussions to ensure services have sufficient resources to support the care closer to home agenda.
- In addition, within the Specialty-level Plans for 2014-16 we aim to:
- provide more 7/7 and direct access diagnostics
- introduce and extend telephone advice lines and follow up services in several specialties
- expand community-based clinics for long-term conditions such as diabetes and rheumatology
- develop nurse-led follow-up services

Despite the mitigations noted above, there are residual risks, arising from growth in referrals and current lack of clarity from commissioners as to how they intend to arrest this growth. Given some of the pressures experienced in 2013/14, the Trust has taken a prudent view and flagged risk to Monitor in

respect of the target for 18 weeks (admitted).

Non-elective requirements

Risks

Growth pressures and risks will come mainly from:

- demographic change, including more elderly patients with complex health needs.
- Experience so far with the development of community-based services as an alternative to Acute care is mixed in that:
- On the one hand:
- there is some indication that GP Practice opening at week-ends may be having a dampening effect on the growth in work for the Urgent Care Centres.
- The pilot paramedic call-back scheme appears to be successfully diverting patients from A&E.
- The community-based admission avoidance schemes are popular with patients and, according to some metrics, seem to have a dampening effect on re-admissions.
- On the other hand:
- Provision of GP care at week-ends has not so far completely halted the growth in A&E (Type 1) activity.
- Investments in community-based admission avoidance schemes have not so far arrested the rise in non-elective medical admissions or re-admissions.
- Whilst commissioners in Darlington have decided on their preferred model of Urgent Care, involving full integration with A&E at DMH, and plans are moving ahead, commissioners in Durham have indicated they wish eventually to shift more urgent care work into Practices but are yet to decide how and over what time-scale this can be achieved.

CDDFT Response

Actions on unscheduled care are part of the Trust's programme of Strategic Breakthroughs identified as part of the clinical strategy and integrated business planning process. The local Urgent Care Board, on which CDDFT has clinical and managerial representation, is responsible for ensuring the delivery of efficient and safe whole-system non-elective care. Our performance on the 4-hour standard and ambulance handovers has been a cause of concern, particularly in Q3 and Q4 of the current year.

Local commissioning intentions include a reduction in A&E activity of 3% per year. However, commissioners and other external partners have recognised that the solutions lie in whole system actions and change, in that pressures in A&E are caused by the numbers of patients requiring in-patient admission and the difficulties of maintaining good patient flow through the Acute beds. To this end, the Urgent Care Board has asked NHS Improving Quality to facilitate the development of its vision and strategy by June 2014.

In the meantime, CDDFT has taken a number of key actions to mitigate the risks posed by rising demand for A&E and non-elective medical care. These include investments in:

- keeping open throughout 2013-14 the Winter 2012-13 escalation beds at our Durham site.
- additional A&E staffing
- the Ambulatory Care Units at both Acute sites to enable them to open until 10pm and at week-ends. The Unit at DMH is now open during these extended hours and we hope to have recruited sufficient staff for our Durham site to open extended hours in April 2014.

- Additional medical assessment capacity at our Durham site.
- Paediatric front-of-house pilots at our two Acute sites have reduced our paediatric admissions dramatically this year, as well as reducing paediatric demands on A&E.
- Spot purchase step-up and step-down beds in nursing homes.
- Additional acute beds at DMH over Winter 2013-14.
- Extended hours diagnostics.

Some of these are initially funded through Winter pressures monies but those services which can demonstrate a contribution to improved 7/7 opening and patient flow will be considered for potential substantive funding.

CDDFT also commissioned ECIST to undertake an audit of the whole-system non-elective pathway. ECIST propose action to improve patient flow and reduce demand across the whole non-elective care pathway. An Action Plan is being developed with a number of short and long term actions for all partners. ECIST will provide continuing support to implement its recommendations. Key short term actions for CDDFT include:

- CDDFT are working with CCGs and local authority partners to implement the recently agreed Intermediate Care Strategy
- A Rapid Assessment and Treatment model will be introduced into the two A&E Depts in April to ensure early senior review of all appropriate patients.
- Work to embed more effectively processes such as Estimated Date of Discharge and to make better use of the discharge lounge earlier in the day.
- Indications that the paramedic call-back scheme has been very successful in diverting patients from hospital mean that commissioners are likely to commission this service on a long-term basis.
- Follow-up on an audit showing that 20-30% of 111 referrals to A&E are not appropriate. We will work with local GPs and 111 to revise protocols.

Further CDDFT actions:

- CDDFT Executives have recently approved the re-configuration of front-of-house medical services at our Durham site. Our proposals will involve the co-location of medical ambulatory and short stay assessment facilities alongside A&E and the local Urgent Care Centre. Although this will require some estates work it is hoped to have the re-configured facility in place in time for next winter.
- Discussion is continuing about the re-modelling of our bed stock to increase the number of medical beds and reduce medical boarding into surgical beds. This will improve patient flow and care.
- We are working with commissioners to agree 2014-15 CQUIN schemes with a strong focus on non-elective care, including specifically, schemes to improve ambulance handovers, access to timely Consultant assessments and empower Community Hospitals and others to provide improved care for end of life patients.
- These changes are underpinned by a workforce strategy in each Care Group Operational Plan, which includes opportunities for nurses and other non-medics to extend their skills.

There are clearly residual risks pending implementation and realisation of benefits from the above actions which have been declared to Monitor.

Cancer

Cancer referrals continue to grow without necessarily generating additional cancer diagnoses.

	Apr 12-Jan 13	Apr 13-Jan 14	Variance
All Cancer Referrals	15,388	17,309	12.5%
All Cancer Referrals Diagnosed	2,212	2,013	-9.0%

All Cancer Referrals No Cancer Diagnosed	13,176	15,296	16.1%
2-Week-Wait Referrals	11,090	12,896	16.3%
2-Week-Wait Referrals Diagnosed	1,054	1,150	9.1%
2-Week-Wait Referrals No Cancer Diagnosed	10,036	11,746	17.0%

Risks

It is worth noting that cancer pressures continue to rise across the Cancer Network, largely due to the ageing population and the impact of the various public awareness campaigns. The Network as a whole failed to fully achieve 62 cancer wait standards in November 2013 and again in January 2014. CDDFT had one 62-day screening breach in January. The patient was not fit for surgery until day 64.

In addition to the national Oesophago-Gastric Awareness campaign and the Breast Cancer awareness campaign for women over 70, a local campaign to raise awareness of ovarian cancer and a national campaign to raise awareness of lung cancer are planned. These are all expected to increase referrals.

In this context, small numbers of breaches can put the 62 day wait standard at risk, even when the reasons are outside of our control. We are continuing to review the configuration of our breast cancer services and have therefore taken a prudent view and flagged risk to Monitor in respect of both of these indicators.

CDDFT Response

Key Actions/mitigation include:

- Proactive management of the cancer 2ww patients who choose an appointment outside of the 2 week window will continue including:
    - Daily communication between Cancer managers and heads of Service to highlight emerging pressure areas
    - Senior cancer services team member now overseeing all screening tracking
    - Meetings planned in key service areas to raise awareness of targets and the need to document allowable adjustments
- Review of the number of sites at which we offer breast surgery out-patient clinics to manage the impact of Consultant workforce changes.
- Capacity planning continues to be managed through the 18-week Task Group.
- A commissioner-CDDFT working group to improve colorectal pathways is about to be established.

A key project going forward will be the development of the Cancer Information Management System (CMIS) to reduce administration and the risk of tracking errors.

D. PRODUCTIVITY, EFFICIENCY & CIP'S

The Trust has drawn on available benchmarking data from a number of sources in order to source opportunities for productivity and efficiency gain. These include:

- NHS Better Health, Better Value indicators
- Audit Commission PbR Benchmarking Tool
- Reference Cost data
- CHKS
- Dr Foster
- NHS Comparators

Internal cost and data sources provides information on a further group of efficiency opportunity, and so provides overall assurance that the requisite level of productivity and efficiency gain can be made over the 2 year time horizon of the operational plan. Measures incorporated into year 2 of the plan are indicative at this stage, based on the overall opportunity available, and reflect the requirement to further develop and quality impact assess the programme.

CIP governance

The Trust has a strong track record of delivering its overall financial plan each year since it was authorised in 2007. Whilst the cost improvement target has not always been delivered in accordance with the original plan each and every year, the trust has demonstrated the strength of its financial risk assessment and mitigation planning, and its financial flexibility in dealing with in year deviation from plan, whilst being able to deliver overall financial results.

CIP planning is an integral part of the trust's operational planning process. Care Groups and Corporate Departments are required to produce operational plans each year demonstrating how they will deliver services which meet contractual, regulator and other targets within available resources (net of CIP targets) and improve patient outcomes and experience.

Experience of 2013/14 delivery of Care Group identified CIPs indicates that this current model of detection and subsequent delivery is not having the long term sustainable effects that the Trust deems essential for delivering quality services in forthcoming years.

The Trust has acknowledged the need to access the more challenging areas of cost reduction predominantly around changes in current clinical practice and subsequent impact on bed, outpatient and theatre utilisation.

The Trust is therefore moving towards a formalised programme management approach in order to deliver the CIP plan for the next 2 years.

We have identified a series of transformational Strategic Breakthroughs as part of our clinical strategy and integrated business planning processes. The identification of these breakthroughs has been based on evidence that exists in respect of cost reduction coupled with productivity improvement,

The overall governance framework in respect of CIPs will include:

- Each scheme being sponsored by a Director or Senior Associate Director.
- A systematic approach being imposed, which will ensure the development and implementation of plans and to quickly detect and correct any variation from plan.
- Individual schemes aggregated by theme, in order to make the programme manageable.
- The finance report to the Trust Board contains (each month) information on delivery against CIPs and forecast positions, both in year and on a recurrent basis.
- Monthly performance management reviews with Care Groups explores progress, risk and mitigation.
- CIPs are assessed for their impact on quality (see later section)
- A programme board will control the programme and ensure assurance on delivery.

CIP enablers

Care Group specific CIPs are identified within care group operational plans, which are signed off by group clinical directors – each of whom are practising clinicians.

CIP plans from each of our clinical care groups have been reviewed by the Trust's Executive and Clinical Leadership Committee (ECL), which includes 15 of the senior clinical leaders within the Trust.

The Trust has a senior nurse as Clinical Director of Service Transformation, reporting to the Executive Medical Director. She manages a service transformation team, with service improvement and project management skills, and experience in other areas of change management.

Quality Impact Assessment of CIP plans is led by the Director of Nursing (see below).

The IT and estates capital programme is a key enabler for improvements in efficiency alongside the trusts other guiding touchstones of improved patient outcome and experience and workforce.

The capital programme will support:

- The equipping of a new learning centre at the University Hospital of North Durham, acquired to support our workforce and organisation development and which will allow the demolition of poor quality estate

- Redevelopment of theatres at DMH, following completion of a detailed business case that will demonstrate improved efficiency and new ways of working whilst simultaneously improving patient experience, reducing waiting times and improving patient care quality.

- More efficient deployment of staff, and use of bank, to reduce agency and other premium costs via nurse and medical rostering systems.

- The on-going digitisation of clinical documentation to improve the efficiency, and reduce the clinical risk, associated with the patient/clinician interface and record keeping using funding awarded from the Safer Hospitals, Safer Wards Technology Fund

Quality Impact of CIPs

The quality impact assessment process has been developed taking into account the high profile failings in the health and social care system (esp. Mid Staffs) which have highlighted the need for greater clarity about who is responsible for identifying and responding to failures in quality.

The process requires all CIPs to be clinically-owned and clinically led (including formal clinical sign-off), and validated by Executive Medical and Nursing Directors, with the overall process being owned by the Trust Board.

This includes testing for impact against the Trust's four touchstones: best outcomes, best experience, best efficiency and best employer.

Schemes have been RAG rated, and amber and red schemes returned to care groups for further consideration or work. No amber or red schemes have been approved.

Better Care Fund

The Trust has engaged with CCGs in relation to commissioning intentions and the refresh of the Joint Health and Wellbeing Strategy. The trust has also been involved in events designed to shape future services and the transformation agenda. The trust recognises that the BCF offers both challenges and opportunities for the future delivery of service and is currently working with CCGs to ensure that key issues such as workforce and the timing and implementation of the programme are addressed through regular communication and engagement as the BCF plan develops. Detailed information is still awaited from the CCG's which will enable the proposed pathway changes to be understood and demonstrate how funds removed from secondary care will be reinvested to facilitate the changes required.

E. FINANCIAL PLAN

Financial Plan 2014-16 Summary

The Trust is aiming to deliver surpluses of £2m per annum over the operational plan period, on the basis that this is the minimum required to support its capital programme ambition.

At the time of submission, acute and community contract values have not been agreed with local Clinical Commissioning Groups, and so a prudent assessment of the likely income levels under the national payment rules has been made as the basis for 2014/15 plan. The headlines of the current operational plan are therefore:

- Delivers surpluses of £2m in 2014/15 and 2015/16
- Requires cost reduction scheme delivery of £22.5m in 2014/15 and £20.3m in 2015/16
- A continuity of service risk rating of 3 is achieved each year
- The efficiency impact reflected through tariff/non-tariff prices is 4% for 2014/15 and 4.5% for 2015/16
- A shift of resource of £4.6m is assumed in 2015/16 from acute services to community services in response to commissioners' stated ambition for the Better Care Fund

The prime risks to the financial plan are:

- Contract values with local commissioners are not yet agreed
- Delivery of the cost improvement programme
- Achievement of operational budgets, given the ongoing and increasing pressure in unscheduled care
- Recognition of the need for significant service transformation, including the impact of the better care fund, and the current lack of detailed implementation plans to achieve this, including the impact on manpower.

An assessment of the Trust's current financial position.

The Trust has delivered a strong financial performance during 2013/14, and is forecast to exceed its financial plan for that year. This has enabled the trust to agree a forward capital programme to invest c£70m in capital schemes from 2014 to 2018 from resources generated from its historic and planned revenue position. This will ensure that the trust's capital assets support the strategic development of its services as well as enable improvements in productivity, patient experience and outcomes.

Key financial priorities and investments and how these link to the Trust's overall strategy.

The key financial priorities remain the delivery of the agreed financial plan and the inherent CIPs. Specific developments and investments include:

Intermediate Care Strategy (ISIS)

Following the development of a detailed business case for a short term intervention service, an investment of £4.2m has been agreed which has the following key objectives for the local health economy:

- Avoid admission to an acute bed
- Avoid Re-admission to an acute bed (NHS National Standard 30 days)
- Avoid admission to 24 hour care
- Timely Hospital Discharge

The key targets are:

- reduction in admissions for those aged 65+ with a length of stay of 0-1 days
- Reducing delayed discharge 'awaiting a CHC assessment' from 10 to 2 days
- Delaying admission straight to residential care by 3 – 7 months
- Reducing the numbers going straight to long term packages of care by 35%
-

As a minimum, it is envisaged that the model will stem future demand and the need for surge beds

Keogh Investment

Pending the finalisation of the Nursing Directors staffing review, it is envisaged that the funding inherent within the national uplift will be utilised to increase nursing WTE's and support the Trusts quality agenda.

Friends and Family

In line with the NHS mandate the Trust will be expanding the Friends and Family test to community services and other acute services.

Electronic Clinical Document Management (ECDM)

The trust continues to invest in the digitisation of it records, this will allow the contents of current paper clinical notes to be scanned and presented electronically in any location across the Trust, reducing paper storage requirements, provide operational efficiencies and ensure our patients have access to information, which will support the quality of care provided.

Ophthalmology Vitreoretinal (VR) Service Development

Development of a specialist Ophthalmology services, which can provide enhanced emergency care provision and enhance the existing service provision

Capital Investments:

2014/15 sees the continuation of the two major estates projects which address backlog maintenance issues whilst contributing to the trusts strategic and clinical strategy.

The Surgical Theatre and Enhanced Mortuary Project.

The business case is currently being progressed by the Trust from outline to full business case position. The trust has approved the adoption of the NHS Procure 21+ (P21+) Framework for the design and construction of the capital works for this project. Subsequently, the Trust has appointed a third party as its Principle Supply Chain Partner up to agreement of the Guaranteed Maximum Price (GMP).

The Learning Centre at UHND

This £2m development will support the trusts objectives to be the best employer by providing modern state of the art learning facilities for its staff. It will also remove some of the trusts poorest accommodation. The trust is currently performing option analysis to determine the most cost effective method of delivering this development.

The following schemes are also key to the delivery of the next two years capital programme:

- Safer Hospitals Safer Wards – Patient Flow digitised system implementation.
- Safer Hospitals Safer Wards – Electronic Prescribing System implementation.