

**Strategic Plan Document for 2014-19**  
**County Durham & Darlington NHS Foundation Trust**

**SUMMARY**

# **1. Right First Time 24/7 – our clinical and quality strategy**

## **1.1 Our ambition for our services**

County Durham & Darlington NHS Foundation Trust (CDDFT) is one of the largest providers of community, hospital and health and wellbeing services in the NHS.

We have a track record of success in delivering quality services and managing change and a growing reputation in innovation, research and development.

We have discussed with staff and stakeholders our shared aspirations and ambitions for the future of the health services we provide.

In all of these discussions it has been clear that we share an ambition for excellent, high quality and sustainable services that deliver the right care, in the right place, at the right time, 24/7.

We want to provide:

- Services that are evidenced based, accessible, safe, sustainable and effective
- Care that delivers improvements in health outcomes and reduces inequalities
- Patient pathways that are integrated across providers

We want to continue to maintain our reputation for financial prudence so that we can continue to invest in the services and facilities that our communities deserve, as part of a sustainable local health economy.

Our five year plan is about how we achieve these ambitions.

## **1.2 Our vision and goals**

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.

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

- 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

## **1.3 Our evolving clinical and quality strategy**

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.

These themes are therefore at the centre of “Right First Time 24/7 - our evolving clinical and quality strategy”. 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.

Our approach to financial and business management has enabled us to invest in our facilities and services, putting us in a strong position for the future.

In developing our clinical and quality strategy, the Board has worked closely with the Council of Governors, in particular the membership of the Governors’ Strategy Committee.

We have also worked with our staff, in particular through a series of workshops early in 2014.

#### 1.4 Key elements of the clinical and quality strategy

The elements of the Clinical & Quality Strategy are as follows:

Programme	Project	Project Workstreams	Outcomes
Centres of Excellence	Theatre Transformation/ Enhanced Mortuary	<ul style="list-style-type: none"> <li>• Theatre Transformation</li> <li>• Enhanced Mortuary</li> </ul>	<ul style="list-style-type: none"> <li>• Enable higher throughput of surgical procedures and improve patient outcomes &amp; experience</li> </ul>
	Centres of Excellence	<ul style="list-style-type: none"> <li>• Orthopaedics</li> <li>• Gynaecology</li> <li>• General Surgery</li> <li>• Cardiology</li> <li>• Endoscopy</li> <li>• Colorectal Breast</li> </ul>	<ul style="list-style-type: none"> <li>• CDDFT recognised as Centre of Excellence in the relevant specialties</li> </ul>
Transforming Unscheduled Care	Admissions, Discharges & Transfers	<ul style="list-style-type: none"> <li>• Review and reconfiguration of assessment areas – medicine</li> <li>• Discharge Management, incl. ADT, EDD &amp; EDL</li> </ul>	<ul style="list-style-type: none"> <li>• Reduce cancellations of surgery due to lack of available beds, Improved site management,</li> <li>• Improved safety of care</li> <li>• Integrated/Stepped model of Unscheduled Care</li> <li>• Minimum % cancellation of surgery due to lack of available beds</li> </ul>

			<ul style="list-style-type: none"> <li>Improved site management</li> <li>Reduce short stay admissions</li> </ul>
	Front of House	<ul style="list-style-type: none"> <li>Ph.1 – ED improvement – senior decision makers at front door</li> <li>Ph. II – Integrated Paediatrics model and co-location with ED</li> <li>Ph. III – Co-location of A&amp;E &amp; Urgent Care</li> <li>Ph. IV - Major Emergency Care Centre</li> </ul>	<ul style="list-style-type: none"> <li>7-day clinical decision makers</li> <li>Meet national A&amp;E &amp; RCPCH standards</li> <li>New Emergency Department information system</li> <li>Clinical Decision Unit at UHND</li> <li>New Paediatric FoH model implemented / APNP supporting UC &amp; new HV service implemented</li> <li>Meet standards set out by RCPCH for emergency care of children</li> <li>Improve patient outcomes &amp; experience,</li> <li>Major Emergency Care Centre open and operating</li> </ul>
	Extended Access to services 7-days	<ul style="list-style-type: none"> <li>Clinical Support Services, e.g. Diagnostics / Radiology / AHPs</li> <li>Back of House – Internal Medicine Services, e.g. ologies / Pregnancy Assessment</li> </ul>	<ul style="list-style-type: none"> <li>Improved access through 7 days to all adult community services</li> <li>Minimise unnecessary waits in ED, Implement Acute Care Toolkit standards</li> <li>7-day clinical decision makers</li> <li>Improve patient outcomes &amp; experience,</li> <li>Improved access through 7 days to all adult community services</li> </ul>
Integration & Care Closer to Homes	Integrated Short-term Intervention Service	<ul style="list-style-type: none"> <li>ISIS Single Point of Access</li> <li>Multidisciplinary ISIS team &amp; frail elderly</li> <li>Commissioning via Durham County Council</li> <li>Telehealth</li> <li>Outpatient Antibiotic Therapy</li> </ul>	<ul style="list-style-type: none"> <li>Enable shorter stays/earlier discharge/prevent readmissions</li> <li>Service successfully commissioned in partnership with Durham County Council</li> <li>Expansion to enable proactive management of patients and reduce unplanned outcomes/admissions - income generation via JV</li> </ul>
	Mobile working	<ul style="list-style-type: none"> <li>Mobile working</li> </ul>	<ul style="list-style-type: none"> <li>Improved access to all adult community services</li> <li>Reduce admission/ readmissions due to difficulty accessing community services</li> <li>Expansion to enable proactive management of patients and reduce unplanned outcomes/admissions</li> </ul>
	Locality-based working	<ul style="list-style-type: none"> <li>Locality Working, incl. frail elderly</li> </ul>	<ul style="list-style-type: none"> <li>Improved access to all adult community services,</li> <li>Reduce admission/ readmissions due to difficulty accessing community services</li> </ul>

			<ul style="list-style-type: none"> <li>Expansion to enable proactive management of patients and reduce unplanned outcomes/admissions</li> </ul>
	Bed Usage	<ul style="list-style-type: none"> <li>Acute Bed Utilisation</li> <li>Community Bed Provision</li> </ul>	<ul style="list-style-type: none"> <li>Enable shorter stays/earlier discharge/prevent readmissions</li> </ul>
	Outpatients	<ul style="list-style-type: none"> <li>Outpatients</li> </ul>	<ul style="list-style-type: none"> <li>Appropriate demand &amp; capacity management implemented across all specialties</li> </ul>

## 2. Supporting the change

Whilst our senior clinicians have been working and continue to work closely with clinical teams on developing the Clinical & Quality Strategy, implementation is being underpinned and supported by enabling programmes as follows:

### 2.1 The Productivity & Efficiency Programme

This programme is closely linked to the Clinical & Quality Strategy and will ensure that all possible efficiencies are realised as a result of its implementation. The programme therefore demonstrates a high degree of crossover with the Clinical & Quality Strategy, as well as the OD Programme.

Key elements include:

- Bed Utilisation
- Outpatient Utilisation
- Theatre Utilisation
- Mobile Working
- Procurement
- Estate Rationalisation
- Agency / Salary Cost Reduction
- Consultant Job Planning
- E-Expenses
- Salary Sacrifice schemes
- Pharmacy Drugs
- ECDM / Back Office Functions / Admin Review

### 2.2 Organisational Development (OD) Programme

The Trust's OD Programme has been updated in 2014 to take account of the Clinical Services and Quality Strategy for the Trust. The next phase of CDDFT's OD Programme will build on the above to create confident contributors at every level as an integral part of delivering our top priorities. The elements of the programme are as follows:

- 24/7 Working
- Job Planning
- T&Cs
- Leadership / Skills development

- Workforce Planning

## **2.3 The Health Informatics Programme**

The Health Informatics team manages the delivery of the Health Informatics programme across the organisation, supporting the services to understand the technologies available to them and enabling them to own and realise the benefits that are possible from these. The Board has agreed a prioritised series of clinical informatics developments that build on previous investments, to support better decision making and deliver safer care for patients, delivering the Trust's Clinical & Quality Strategy.

### **The Capital Estates programme**

For the transformation entailed by the Clinical & Quality Strategy to be realised, together with the required efficiencies, fundamental rationalisation of our estate is key. Significant change has already taken place. Further work is expected to include the following:

- ED reconfiguration at University Hospital of North Durham
- UCC/ED integration at Darlington
- Paediatric FoH at Darlington Memorial Hospital
- Endoscopy at Bishop Auckland Hospital
- Theatre Transformation at Darlington Memorial

## **3. Healthcare needs**

The Trust's extensive analysis of the demographic projections and the health profiles shows significant growth in the high use health resource groups of the elderly and the young. This will clearly present increased demand, which is not clearly offset by existing commissioner clear and credible plans.

The Trust's main catchment area is coterminous with the geographical areas of the Durham County Council and Darlington Borough Council local authorities.

### **3.1 County Durham – health trends**

- The health of people in County Durham is varied compared with the England average. Deprivation is higher than average and about 20,400 children live in poverty. Life expectancy for both men and women is lower than the England average.
- Life expectancy is 8.2 years lower for men and 6.7 years lower for women in the most deprived areas of County Durham than in the least deprived areas.
- Over the last 10 years, all-cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen but remain worse than the England average.
- In Year 6, 22.7% of children are classified as obese, worse than the average for England. Levels of teenage pregnancy, breast feeding and smoking in pregnancy and alcohol-specific hospital stays are worse than the England average. GCSE attainment is better than the England average.
- Estimated levels of adult 'healthy eating' and obesity are worse than the England average.
- Rates of smoking-related deaths and hospital stays for alcohol related harm are worse than the England average. Rates of sexually transmitted infections and road injuries and deaths are better than

the England average. The rates of statutory homelessness, violent crime and drug misuse are better than average.

- While the health of the population has improved significantly in recent years, it still remains worse than the England average. Health inequalities remain persistent and pervasive, and are clearly linked to other issues such as higher levels of deprivation and premature mortality, as well as lower life expectancy.
- Lifestyle choices create specific issues in the creation of avoidable ill-health, health inequalities and premature death although it is clear that social, economic and environmental factors have a direct impact on health status and exacerbate existing poor health conditions.
- Other factors which contribute to health inequalities in County Durham are –
  - Lower household income levels in some areas
  - Lower educational attainment levels in some areas
  - Higher levels of unemployment
  - Higher rates of benefit claimants (at increased risk of mental health or behavioural disorders)

### **3.2 Darlington – health trends**

- Darlington has some of the most deprived areas in England and this situation is worsening. Darlington Borough Council's area is ranked as the 75<sup>th</sup> most deprived local authority out of 326 in England (compared to 87<sup>th</sup> in 2007). The figure below shows those areas of Darlington which were in the most deprived 30% of Lower Super Output Areas in 2010.
- Life expectancy is 14.6 years lower for men and 11.6 years lower for women in the most deprived areas of Darlington than in the least deprived areas.
- Over the last 10 years, all-cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen but is worse than the England average.
- Overall, life expectancy for men living in Darlington is 77 years, 1.6 years less than the England average; for women living in Darlington, the figure is 1.5 years less than the England average.
- Significant inequalities in life expectancy exist within Darlington, with a man in the most deprived area being 14.6 years lower than for men living in the least deprived areas; women have 11.6 years less of life expectancy in the same circumstances.
- Mortality rates from Cancer and Cardio Vascular Disease (CVD) continue to fall in line with England, but remain higher in Darlington and account for around 65% of early or premature deaths in Darlington. Cancer incidences remain higher for men than women with 25% of all cancer deaths from lung cancer.
- Premature mortality rates (under 75 years) for the 'biggest killers' (heart disease, cancer, stroke) in Darlington are higher than England. Smoking remains the biggest single contributor to the shorter life expectancy in Darlington; prevalence of smoking is 29% among manual workers.
- The prevalence of Chronic Obstructive Pulmonary Disease (COPD) and Coronary Heart Disease (CHD) in Darlington is worse than England. 4,350 (c. 4.4%) are registered with CHD and 2,541 (c. 2.5%) with COPD; it is thought 302 people are 'missing' from their GP register and not receiving treatment.

- In Year 6, 18.0% of children are classified as obese. Levels of teenage pregnancy, alcohol-specific hospital stays among those under 18, breast feeding and smoking in pregnancy are worse than the England average. The level of GCSE attainment is better than the England average.
- Estimated levels of adult 'healthy eating', smoking and obesity are worse than the England average. Rates of smoking related deaths and hospital stays for alcohol related harm are worse than the England average. The rate of sexually transmitted infections is better than the England average. The rate of statutory homelessness is better than average.

### 3.3 County Durham and Darlington demographic shift

Population				
Age Range	2014/15		Change	2018/19
0 - 4	37,382		2.0%	38,125
5 - 9	34,712		7.7%	37,334
10 - 14	31,718		9.0%	34,594
15 - 19	37,620		-8.7%	34,314
20 - 24	42,689		-3.4%	41,240
25 - 29	38,189		5.2%	40,137
30 - 34	37,795		4.2%	39,360
35 - 39	34,271		12.8%	38,606
40 - 44	41,071		-15.0%	34,646
45 - 49	46,615		-7.9%	42,882
50 - 54	45,823		3.1%	47,222
55 - 59	41,303		8.3%	44,653
60 - 64	38,347		2.6%	39,381
65 - 69	39,337		-5.7%	37,127
70 - 74	28,568		25.8%	35,688
75 - 79	23,439		2.9%	24,102
80 - 84	16,209		12.6%	18,220
85 - 89	9,629		12.0%	10,754
90+	5,180		21.0%	6,220
<b>Total</b>	<b>629,896</b>		<b>2.3%</b>	<b>644,603</b>

## 4. Commissioning Intentions

Our clinical and quality strategy has been developed based on our understanding of our community, its changing demographics and healthcare needs, working closely with our commissioners, and in line with their commissioning intentions.

### 4.1 A summary of the key LHE Commissioning intentions is as follows

- Acute to Community Shift:
  - Reduce Outpatients (GP Variation Project)
  - Consultant-led to nurse-led
  - Community pathways developed
  - Long term conditions support in Community setting
  - Multi-Disciplinary Teams
- Greater efficiency in Unscheduled Care – shift care into Primary Care:



- Discharge support/Multi-Disciplinary Teams
- Delivering the action plan from the Emergency Care Intensive Support Service
- Integration:
  - Mental Health/Dementia/H&WB/Encouraging Healthy Lifestyles
  - Intermediate Care:
  - Intensive Short term Intervention Service Beds/Home Equipment Loans Service/Step-up beds/Telehealth/Digital Health/Care Home support services
- National tariff requirements
- Standard NHS contract
- Planned care:
  - Outpatient reviews and referral guidelines
- Urgent care
- Long term conditions
  - COPD
  - Diabetes
- Community
  - Short term interventions
  - Home Equipment Loan Service
  - Community Matrons Community hospitals
- Stroke services
- Children's' services
  - Front of house
  - Children's' community nursing
  - Paediatric pathway
  - SEN reforms
- Trajectories covering
  - NHS Outcomes and NHS constitution requirement
  - Activity
- Reorientation around Primary Care:
  - Care shared with Primary Care clinicians
  - GPs opening at weekends
  - Up skill GPs/Practice Staff
  - Federated practices
  - Strategic workforce development

#### **4.2 Securing Quality in Health Services (SEQIHS)**

Securing Quality in Health Care Services (SeQIHS) project brings together commissioners, providers and local authorities with the aim of developing and evaluating options during 2014/15 to secure high quality health care for the populations of County Durham, Darlington and Tees.

The focus of this work is on acute medicine and surgery, urgent and emergency care, maternity, acute paediatrics and neonatal services, intensive care and end of life care.

Transformational work to date has largely been based around "units of planning " which are specific to CCG/local authority boundaries.. There is agreement between the FTs that in addition to existing workstreams there is a need to build provider to provider relationships and capability to allow for testing of models of provision which will meet commissioners' service needs, make best use of available resources across the Local Health Economy and support organisational sustainability.

#### **4.3 Better Care Fund**

We are partners in the work to deliver the Integrated Short-term Intervention Service (ISIS), designed as the main local vehicle for shifting the emphasis from acute to community services in Durham. Slightly different services and approaches are being developed in Darlington. The outcome of these projects will play a significant role in informing Better Care Fund investments.

## 5. Changes in demand

### 5.1 Trajectories

We work with local CCG, Area Team and Specialist commissioners in a range of fora to understand trends in demand and to re-shape the local health economy. In the meantime, although we consider a range of scenarios, the core capacity projections for our main services are based on local CCG commissioning intentions. In summary, these are:

<b>Net Growth Trajectories</b>	<b>2014/15</b>	<b>2015/16</b>	<b>2016/17</b>	<b>2017/18</b>	<b>2018/19</b>
Non Electives	0%	0%	0%	0%	0%
Electives (Day Case and Ordinary)	0%	0%	0%	0%	0%
First Outpatients	-1%	-1%	-1%	-1%	-1%
Outpatient Follow ups	-0.5%	-1.5%	-1.5%	-1.5%	-1.5%
Referrals	-1%	-1%	-1%	-1%	-1%
A&E	-3%	-3%	-3%	-3%	-3%

Commissioners are clearer about the level of their ambition for de-commissioning acute services as the emphasis shifts onto community-based provision. Our core planning assumption is that they will achieve their targets. We are planning to maintain a level of flexibility to meet this challenge.

In financial terms, commissioning intentions indicate an £8.8 million reduction of expenditure on acute services, and a £38 million increase in investment in community based services, which offers the Trust an incentive and an opportunity to transform.

### 5.2 Community Services

County Durham and Darlington FT has been an integrated acute and community provider since 2011, and currently provides around £100 million of community services.

We are committed to working with our local health economy partners to shift from acute into community based settings, and successfully implementing strategies as part of the Better Care Fund.

Although local commissioners have not quantified their intentions for the future of community services in detail, we anticipate that, in line with national guidance, these services will expand to provide care closer to home.

### 5.3 Better Care Fund

The financial impact, focus areas and performance outcomes for the Better Care Fund are as follows:

BCF location	Scale	Focus areas	Performance outcomes
County Durham	£39m total contribution, of which £21m is supporting existing health services to be transferred in 2015-16	<ul style="list-style-type: none"> <li>• Short term intervention services</li> <li>• Equipment and adaptations for independence</li> <li>• Supporting independent living</li> <li>• Supporting carers</li> <li>• Social isolation</li> <li>• Care home support</li> <li>• Transforming care</li> </ul>	<ul style="list-style-type: none"> <li>• Delayed Discharges: reduce the number of delays by 6.7%</li> <li>• Avoidable Emergency Admissions: reduce the rate of avoidable admissions by 1.0%.</li> </ul>
Darlington	£7m total contribution, of which £4m is supporting existing health services to be transferred in 2015-16	<ul style="list-style-type: none"> <li>• Frail elderly / LTC MDT</li> <li>• Care home support and development</li> <li>• Improved access to care (7 day services)</li> <li>• Enhanced self-management</li> </ul>	<ul style="list-style-type: none"> <li>• Delayed Discharges: reduce the number of delays by 6.7%</li> <li>• Avoidable Emergency Admissions: reduce the rate of avoidable admissions by 1.0%.</li> <li>• Reduce hospital and long term care admissions</li> </ul>

## 6. Funding analysis

The Trust has undertaken a full analysis of:

- Monitor's planning assumptions regarding inflation, expected efficiency and resultant tariff deflator.
- Commissioning intentions and investment plans, including their review of services against their desired quality standards
- Better care fund impact
- Demographic analysis by age
- Cost efficiency opportunities
- National policy

The overall impact of that analysis is that income will fall over the period and shift from acute to community services, as follows:

Planned Income	2014/15	2015/16	2016/17	2017/18	2018/19
	£m	£m	£m	£m	£m
Acute Services Income	330	323	320	317	313
Community Services Income	112	112	113	115	117

Other Income	27	25	25	25	25
Total Income	469	460	458	457	455

This will provide a significant challenge to the trust to drive out significant cash releasing efficiency savings and drive up productivity. There are opportunities to do this, as demonstrated by the NHS Better Care, Better Value Indicators data:

Indicator	Financial Opportunity £m p.a.
Reducing Length of Stay	£8.4m
Emergency Readmission (14 day)	£6m
Managing First Follow Up	£4.8m
Outpatient DNA	£2m
Pre-Procedure Bed Days	£2.3m
Day Surgery Rates	£0.5m

Achievement of savings and productivity increases on this scale will only be achieved through transformation of service delivery.

The Trust's capital programme will remain under periodic review by the executive team and trust board as the trust's clinical and quality strategy evolves, to ensure that capital investment enables the delivery of the strategy. The board is already aware that investment will be required to enable the unscheduled care service transformation required at both acute sites. At the time of writing this plan, the options are being developed, and consequently it is too early to reflect them formally in this plan submission.

## 7. Market analysis

### 7.1 Strengths, Weaknesses, Opportunities and Threats

The Trust carried out a SWOT analysis as part of work on its clinical and quality strategy, and this has been used to inform our two year operational plan.

Strengths	Weaknesses
<ul style="list-style-type: none"> <li>• Development of centres of excellence</li> <li>• Established relationships with CCGs</li> <li>• Friends in high places in NHS/DH</li> <li>• Good 'captive' local market</li> <li>• Good estate footprint</li> <li>• Not on regulator's radar</li> <li>• Good and balanced Board and Exec team</li> <li>• Skilled flexible and innovative workforce – who work hard</li> <li>• Strength of community service delivery to develop BCF</li> <li>• Comparatively strong financial position – ability to invest</li> <li>• Strength and market share of community services</li> <li>• Good geographical position to be 3<sup>rd</sup> specialist centre</li> <li>• Increasingly good knowledge of clinical position</li> <li>• Some outstanding services</li> </ul>	<ul style="list-style-type: none"> <li>• Perceived as slow and unresponsive by some commissioners - seen as too protective of activity and performance data</li> <li>• Gaps in clinical leadership, devt processes and succession planning</li> <li>• Still not one organisation – need increased unity of purpose across 2 sites, community and acute</li> <li>• Accountability &amp; CRT delivery not consistent or effective</li> <li>• Slow implementation mgt approaches both in service improvement and in speed to market</li> <li>• Inadequate workforce planning and recruitment process</li> <li>• Tendering and service expansion see as a distraction from day to day working &amp; seen as too risk averse</li> <li>• Some legacy estates issues, e.g. ED infrastructure</li> </ul>
Opportunities	Threats
<ul style="list-style-type: none"> <li>• Growing demand for FE, LTC and children's services with BCF to be delivered closer to home</li> <li>• Breaking historic referral patterns in East Durham due to NT&amp;H moving clinics from Hartlepool to North Tees</li> <li>• Response to changes in areas adjacent to CD&amp;D – Friarage, South Tees and Gateshead districts</li> <li>• Integration of internal pathways to drive efficiency</li> <li>• Telehealth and e-enabled health care services, i.e. development of partnerships to bring new technology to the market place</li> <li>• development of monitoring systems moving from activity based to outcome based</li> </ul>	<ul style="list-style-type: none"> <li>• Entry of primary care providers, especially in historic community service areas</li> <li>• Failure to identify what we do well &amp; what we need to stop</li> <li>• Emergence of new private and 3<sup>rd</sup> sector providers</li> <li>• 'Cherry picking' of low cost/high profit services by new private and NHS providers</li> <li>• Historic high cost base threatens competitive expansion into new service areas</li> <li>• Failure to develop essential internal program change mgt skills</li> <li>• We don't focus on a small critical set of objectives and don't deliver key changes</li> <li>• Recruit of suitable workforce to deliver the vision</li> </ul>

The key issues to be drawn from the above SWOT analysis are as follows:

- CDDFT is a strong and broadly-based NHS provider that has enjoys a robust financial position at the current time.
- However, with transformational change due to take place within the local health economy shortly, there are question marks over the ability of CDDFT to embrace these changes.
- CDDFT does still have some way to go to fully integrate following Transforming Community Services and may struggle to react quickly enough to combat the entry of new providers into the market.

## 7.2 Competitor analysis

The main competitors to CDDFT are covered below, with assessed outcomes based on our SWOT analysis.

### 7.2.1 South Tees NHS Foundation Trust

South Tees Hospitals NHS Foundation Trust is the largest hospital trust in the Tees Valley serving the people of Middlesbrough, Redcar and Cleveland, Hambleton and Richmondshire and beyond. It provides a range of specialist regional services to 1.5 million people in the Tees Valley and parts of Durham, North

Yorkshire and Cumbria, with a particular expertise in heart disease, trauma, neurosciences, renal services, cancer services and spinal injuries.

### **7.2.2 North Tees & Hartlepool NHS Foundation Trust**

North Tees & Hartlepool NHS Foundation Trust provides acute and community based health care to around 365,000 people living in East Durham, Hartlepool, Stockton on Tees and surrounding areas and part of Sedgefield. Breast and bowel screening service extend further than this taking the total population we serve for screening services to around 400,000. The trust has two main sites, The University Hospital of North Tees and The University Hospital of Hartlepool.

North Tees and Hartlepool has planned for a long time to build a new single site hospital, and, as a consequence has withdrawn acute services from Hartlepool General Hospital. With the future of the new hospital still unclear, people living in Hartlepool have a considerable distance to travel to North Tees Hospital, a journey which is not well supported by public transport links. Should the new hospital be approved it may represent competition for Trust services, and also present an opportunity for commissioners to better align services across the local health economy in line with the SeQIHS (Securing Quality in Health Services) agenda.

### **7.2.3 City Hospitals Sunderland NHS Foundation Trust**

City Hospitals serves a local community of around 350,000 residents along with an increasing range of more specialised services provided to patients outside this area, in some cases to a population as great as 860,000. It also provides a substantial range of community based services, particularly within Family Care and Therapy Services. Significant numbers of patients residing in County Durham are referred to CHS for treatment.

### **7.2.4 Newcastle-upon-Tyne Hospitals NHS Foundation Trust**

Newcastle Hospitals is of the largest NHS trusts in the UK, offering a wider range of specialist services than any other. The trust enjoys an international reputation for medical training and in 2006, received the Teaching Hospital of the Year award from Dr Foster. Practitioners come to Newcastle from all over the UK, and from as far afield as Egypt and China. Resulting from this commitment, the trust has a good record in retaining the services of many of the staff who they train.

### **7.2.5 Gateshead Healthcare NHS Foundation Trust**

Gateshead Healthcare delivers acute services at the Queen Elizabeth Hospital in Gateshead, with other services delivered at QE Metro Riverside and Bensham Hospital, all within Gateshead, as well as Blaydon Primary Care and Washington Primary Care Centres.

Gateshead provides breast screening services for Gateshead, South Tyneside, Sunderland and parts of Durham, some from mobile units. Also, the trust is the North Eastern hub for the National Bowel Cancer Screening Programme. The Trust has a joint vascular rota with Gateshead Healthcare and provides vascular services to the Gateshead population.

Local independent sector providers include:

#### **4.8.7 Nuffield Health**

Nuffield Health constitutes the re-branding of Nuffield Hospitals, Proactive Health and Cannons to become Nuffield Health, integrating fitness, prevention and cure across its different services and facilities under a single brand. Two hospitals are operated in this region, one in Newcastle-upon-Tyne and the other in Stockton-on-Tees.

#### **4.8.8 BMI Woodlands Hospital**

BMI Woodlands Hospital is a purpose built independent private hospital set within a 5.25 acre site at Morton Park, Darlington. The Hospital is recently-constructed and well equipped, allowing the organisation to offer a range of medical services and treatments. BMI is a not-for-profit organisation.

#### **4.8.9 Spire Healthcare**

Spire is a purely private provider delivering a wide range of clinical services from the former BUPA hospital near Washington. A clinic in Newcastle is also operated. Services are offered on the basis of 'self-pay'.

#### **4.8.10 Virgin Care**

Virgin Care currently offer direct services in the north-east region at NHS Treatment Centres in Stockton and Langbaugh, together with Sexual Health services across Teesside and MSK Physiotherapy services at Hundens Lane in Darlington. Services are free and available to anyone who needs them.

## **5. Risk to sustainability and strategic options**

### **5.1 Review of sustainability**

As part of the planning process for the Annual Planning Review 2014/15, all of CDDFT's services were analysed under a framework that was developed to determine current sustainability, and sustainability in up to 2 and up to 5 years.

Sustainability has been considered in the context of the Trust's clinical and quality strategy.

The framework uses a '4 pillars' approach in order to understand different aspects of any given services sustainability, with the pillars being:

- Demand & Capacity:
  - Is the service serving a catchment population that is in line with national guidelines for such a service?
  - Are the people, processes and systems in place to correctly deliver the service in accordance with the contract?
  - Are the people, processes and systems in place to correctly deliver the service in accordance with KPIs & statutory requirements?
  - Are we able to manage any future changes to the operating model of the service (e.g. as a result of the CDDFT Clinical & Quality Strategy & Better Care Fund, etc.) with minimal impact/risk to clinical and financial performance?
  
- Workforce:

- Does the service have sufficient consultant, other clinical and non-clinical staffing levels across to maintain either an acceptable service or a 24/7 service based on national requirements or guidance?
- Is the service able to recruit and retain appropriate clinical staffing levels?
- **Quality & Governance:**
  - Is the current clinical performance of the service at an acceptable standard when compared with standard performance metrics?
  - Is the service's governance and operations aligned with its strategy?
  - Is the service progressing to meet the aims of the Trust's quality account and clinical and quality strategy?
  - Do any recent changes to the operating model of the service impact on clinical performance?
  - Will the service achieve the standards set out under the commissioners' SEQIHS programme (Securing Quality in Health Services)?
  - Do services meet, and will they continue to meet, national and royal college guidance?
- **Finance:**
  - Is the service forecast to deliver a surplus for the current financial year and for each of the following five years?
  - Is the service able to generate cash?
  - Is the service able to pay its debts as they fall due without financial support?

## 5.2 Services where there are sustainability issues

Our sustainability review has identified the following services where we believe that action needs to be taken so that services are sustainable during the timescale of this plan and beyond

### 5.2.1 Acute & Long Term Conditions

#### **Unscheduled Care – sustainable within 2 years**

The Trust has identified improving unscheduled care as one of its breakthrough projects outlined in our 2 year operational plan.

The Trust has invested heavily in ED, in particular at UHND, including increasing medical and nursing staffing, extending senior medical cover and increasing assessment capacity. However, at UHND there are over 60,000 attendances a year at a department designed for 30,000.

Commissioners indicate that activity levels will fall, although the Trust sees significant risk that they will continue to rise.

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, covering three key areas: attendance avoidance, admission avoidance and discharge management.

A new informatics system to support this is planned.



There is an urgent need to recruit staff to ED to reduce financial impact of agency spend and improve clinical quality. The ED project which is part of the clinical and quality strategy is seen as the right way forward to put the care group on a better financial footing.

We have recently agreed a plan to extend the footprint of the A&E estate into facilities used by neighbouring departments and agreeing alternative accommodation for displaced services.

There are also plans to integrate ED and urgent care 24/7 at DMH.

### **Acute Medicine – sustainable within 2 years**

Acute medicine is under pressure on both acute sites, but is particularly high at UHND where last year's winter beds remained open throughout the year.

We have recently appointed a Chief Of Service for acute medicine, and are agreeing a programme to improve flow through acute medicine at UHND, by increasing the assessment capacity at the front of house, and making changes to the bed model.

Improvements to acute medicine are also part of the unscheduled care project.

Transformation in acute medicine will involve greater integration with community services and more focus on assessment to reduce admissions.

Improving quality and reducing costs will require a reduction in agency and locum usage, and extending nursing roles.

Our unscheduled care project has identified infrastructure and bed reconfiguration solutions that will enable us to improve medical capacity at UHND.

A peer review is planned of ED and Acute Medicine.

### **Cardiology – sustainable within 3-5 years**

Clinicians are developing a cardiology strategy that will see the two cardiology departments at DMH and UHND come together as one team, although working across two sites.

Although a high quality clinical service is delivered, there remains concerns about sustainability based on the activity vs. capacity.

An expansion of consultant workforce is required to increase capacity and quality of service, and an expansion of cardiac physiologists. There also needs to be better utilisation and integration of the community CHD teams.

Discussions have begun around how to achieve a cardiology on call rota.

We also need to ensure appropriate and realistic apportionment of cardiac and respiratory diagnostics across all clinical services.

The Trust has been operating two cath labs. These do generate substantial revenues but with substantial overheads, and there is opportunity for greater efficiency. Bringing this service together at Darlington would create additional medical space at UHND and is being explored as part of plans for acute medicine.

### **Gastroenterology – sustainable within 3-5 years**

Clinical teams are working on a strategy for gastroenterology Trustwide, looking at one site and two site options and increasing and supporting access to weekend endoscopy as a key diagnostic test.

The team supports the development of a one site model strategy within the context of whole service development, and maintaining a NICE compliant GI bleed rota. The plan is to reduce reliance on locum cover to increase consistency and quality of care, and reduce costs.

### **Elderly Care – collaborate with local health economy partners**

Our average age for patients admitted to hospital is 84 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.

Elderly care is a key area for transformation as part of our clinical strategy, with an emphasis on reducing admissions and care closer to home.

The Better Care Fund will create opportunities and incentives for the service to move closer to home, while reducing income through the acute work streams.

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 working with primary care and commissioners over the period of this plan.

Our goal is to be the identified county wide care of the elderly service within 5 years' time. Collaboration with primary care and intermediate care will be key to the future of elderly care.

### **Clinical Haematology & Clinical Oncology – collaborate**

A small stand-alone service that has faced recruitment difficulties over several years, and has previously been subject to review that has remained unresolved.

Recruitment shortages are likely to impact on long term quality and governance of the service, especially if more temporary staff are brought in to post to deliver on the service. Furthermore the ability to deliver on audits and CQUINs may be further diminished without adequate resource to staff the service.

Strategic options include buying in Consultant Haematology time or moving to being a host service via a hub and spoke model of operation. Loss of activity through non-delivery of clinics could be an issue for the service.

## **5.2.2 Care Closer to Home**

### **Intermediate Care – collaborate with local health economy partners**

The Trust has been working closely with NHS and local authority commissioners on models for intermediate care, and a pilot model called ISIS – integrated short term intervention service – is currently operating, and is a key part of plans for Better Care Fund investment.

There is risk around the service, particularly as the model of care may be subject to change, or the contract subject to tender following the pilot.

### **Gynaecology & Obstetrics – sustainable within 3-5 years**

The Trust provides a high quality Obstetric service to mothers, which was in the top 10 nationally in the CQC survey published at the end of 2013.

Together with Paediatrics and Gynaecology, Obstetrics is responsible for the majority of cost pressures in the care group. The financial pressures in this service are the same as those facing other providers.

Models for delivery of gynaecology have moved towards day case and outpatient settings, and the Trust has opened a new day case unit at one of its community hospitals. We need to look at how we provide gynaecology as a one site service as there are questions around the sustainability of a two site service model, especially for major emergency.

As part of the commissioner led SeQIHS review (Securing Quality in Health Services) 168 hour consultant labour ward cover has been identified as a key standard, and this may drive consolidation of high risk maternity onto fewer sites.

The clinical team has made progress towards SeQIHS standards through extended working, and funding has been gained for improving pregnancy assessment at DMH. The Trust is also planning to make permanent co-located MLU facilities on its acute sites, following the closure for safety reasons of a stand alone MLU at Bishop Auckland.

### **Paediatrics – sustainable within 3-5 years**

The Trust has been working with commissioners on the “poorly child pathway” to develop a new model of service for children.

As part of this work, clinicians have developed and piloted a new front of house assessment model for paediatrics, co-located with A&E.

There is a need for a review of staffing to reorientate staff delivering care in an acute setting to delivery in a community setting, and development of the Advanced Paediatric Nurse Practitioner.

Income needs to be better aligned to the cost of providing the service, and a front of house tariff is being worked on. Together with Obs & Gynae is responsible for 80% of the care group overspend. As with obstetrics and gynaecology, the financial problems in this service are the same as those facing other providers.

## **5.2.3 Surgery & Diagnostics**

### **Breast – sustainable within 3-5 years**

Demand for 2 week appointments is increasing year-on-year by 12.6% in line with recent cancer awareness campaigns.

Senior staffing shortages have also put pressure on this service, and as an emergency measure, clinics have been consolidated from 4 to 2 sites. Inpatient breast surgery continues from both acute sites.

A full review of breast services will begin in July to achieve a sustainable model that best balances local access with timely diagnosis required, and to improve clinical quality via a single MDT and networking.

### **Trauma & Orthopaedics – sustainable within 3-5 years**

Clinicians are working on a plan which will create a single Trustwide orthopaedic department.

Clinicians plan to deliver resourced trauma, revision arthroplasty and patients requiring HDU/ITU on the base sites, with centres of excellence in sub specialties on each site, expanding the amount of arthroplasty work at the planned care centre at Bishop Auckland.

Changes to orthopaedics are seen as part of a wider plan to create more acute capacity at UHND.

**Oral Surgery – exit**

This is a small service, particularly vulnerable to external changes with limited potential to manage workforce, performance and risk.

The Trust depends on the neighbouring South Tees Trust for consultant cover. Should ability to recruit deteriorate this could prove challenging.

**Ophthalmology – collaborate or exit**

issues with staffing make it difficult to sustain the desired quality of service. Patients who require NICE treatments are already referred to other trusts and cover for ROP is being provided by Newcastle.

**Radiology – collaborate**

A quality radiology service is essential to our services. The Trust faces challenges in both imaging and reporting capacity. Recruitment and retention of radiologist staff remains challenging nationally.

The Trust invited the Royal College of Radiology to review the service and their recommendations formed a nineteen point plan covering leadership, workforce, process and governance.

The Trust is investing in the development of advanced practice roles for radiographers and ultrasonographers.

Although this service has issues, there is a clear need to maintain the service to help delivery of quality standards in other services. There is a need for cross working with other CGs to ensure that the service remains sustainable.

The Trust's five year strategic plan was submitted to Monitor on 30 June 2014.