SOUTH TEES HOSPITALS NHS FOUNDATION TRUST

5 Year Strategic Plan Summary

Introduction and Outline of Recovery Programme

This plan sets out South Tees Hospitals NHS Foundation Trust's five year strategic plan which has been prepared in line with the Guidance for the Annual Planning Review 2014/15 issued by Monitor who regulate NHS Foundation Trusts and which provides:

- an assessment of the future challenges facing the local health and social care system and the foundation trust,
- the options available to address the identified challenges,
- key service line strategic plans.

The Guidance asked for a demonstration of the extent of each foundation trust's ambition for patients and to outline the practical ways in which key services will be transformed.

Our ambition for patients has always been and remains to deliver exceptional services and our vision continues to be to set the national standard for excellence in patient safety, quality and continuous improvement.

In preparing this plan we have:

- Carried out a assessment of national and local factors influencing health care and developed our assumptions in conjunction with clinical commissioning groups (CCGs);
- Reviewed commissioning strategies and assessed their implications;
- Carried out a workforce assessment which has involved all of our clinical teams;
- Worked with all of our clinical teams to carry out a service line assessment which required them in a structured way to assess the challenges and opportunities they face and the possible strategic responses. These responses were reviewed by the senior clinical and managerial staff for the services for which they are responsible and then by their peers;
- Shared our assessment and our strategic direction with CCGs to check alignment of ambition.

One of the constraints we recognise in preparing this plan is that outlined by Simon Stevens (NHS England Chief Executive) at the NHS Confederation Annual Conference 2014 – that planning at a national level cannot be done without knowing what NHS funding will be over the next parliament. He signalled the intention to provide a five year forward review in the autumn, taking into account the forward views of CCGs and providers. This is our forward view, identifying pressure points and constraints that need to be overcome to produce locally sustainable solutions and our summary of the current thinking developed with local partners as to how this could be achieved.

This plan is presented in the context of a Trust facing very significant financial challenge and committed to returning to financial sustainability.

The Annual Plan 2014/15 - 2015/16 submitted in April 2014, forecast a worsening of the then forecast £5.2 million deficit at year end 2013/14, to a projected £29.8 million in 2014/15. The

Plan set out that, after closely scrutinising the financial plan, the Board's belief was that £29.8 million was a worst case figure and that action was being taken to reduce the deficit through recovery plans. In the absence of a recovery mechanism then being in place, the financial forecasts in our plan were based on evidenced cost improvement programmes (CIPs) schemes for 2014/15 of £11.8 million (2.2%) and 2.1% for 2015/16.

During May and June, the Trust has completed a first, intensive phase of a financial recovery programme, under the banner of "Continuing the Journey". Six work streams were selected by the executive team on the basis that they were areas of high potential, including based on external benchmarking data. The areas chosen were; Corporate Services; Procurement; Non-ward Nursing; Outpatients; Surgery; Theatres.

Over 60 clinical and non-clinical staff have been involved in one or more workstreams. Each workstream was also overseen by an Executive Director who was responsible for guiding the teams and challenging them to be ambitious, while delivering realistic, safe plans to make recurrent cost savings.

Further work to explore new opportunities will be undertaken every quarter until all elements of the cost base have been addressed. The first wave has leant heavily on McKinsey (management consultants) for process, challenge, data analysis and governance around implementation while the skills and approach have been learnt by Trust staff. McKinsey's role will lessen through the second wave and be complete by November 2014.

On the basis of this process, the minimum CIP assumptions within the 5 year financial plan we have submitted to Monitor have been set at 4% for 2014/15, 4.5% for 2015/16 and 4% for subsequent years.

In summary, the elements of the framework for sustainability are:

- A rolling programme of workstreams to address the entire Trust cost base and deliver radical cost improvement.
- Co-ordination with Monitor to provide Public Dividend Capital (PDC) to bridge the period during which the financial gap is closed, supporting the costs of making change, and ensuring the funding of the capital expenditure programme.
- Engaging with all levels in the local health economy to bring about transformational change.

1. MARKET ANALYSIS & CONTEXT

1.1 Context

South Tees Hospitals NHS Foundation Trust operates from two hospital sites, James Cook University Hospital in Middlesbrough and the Friarage Hospital Northallerton, seven community hospitals and twenty two health centres and GP practices. The Trust provides secondary and community services to a population of 470,000 principally in the local authority areas of Middlesbrough, Redcar and Cleveland, Hambleton and Richmondshire and extending into adjoining areas and tertiary services for a population of up to 1.1 million across Teesside, Darlington, County Durham and North Yorkshire. We operate two primary care practices and we host a Ministry of Defence Hospital Unit.

The Trust has built links with the Universities of Teesside, Durham and Newcastle and is a lead centre for clinical teaching for students from Teesside, Newcastle and Durham and supports high quality research for all diseases and areas of patient need. We are also the

host site for a new network of Research Design Services, set up by the National Institute for Health Research, which supports investigators in the North East in preparing proposals for research to improve patients' health and care.

Our principal Commissioners are South Tees CCG, Hambleton and Richmondshire and Whitby (HRW) CCG and Cumbria, Northumberland Tyne and Wear Area Team for specialised commissioning.

Our Mission is
To provide high quality, safe and integrated specialist, secondary and community healthcare services for patients, their families and carers

Our Vision is
To set the national standard for excellence in patient safety, quality and continuous improvement

Our Values are:
Delivering continuous quality improvement
Putting our patients at the centre of everything we do
Supporting, respecting and valuing each other

We set measurable objectives to track our performance against our strategic objectives which we describe as:

Quality of Care, Outcomes, Patient Safety and Patient Experience
We will deliver high quality, safe and continuously improving services

Operational Excellence
We will deliver care and services free from errors.

Organisational Capability
We will achieve high quality care because we will be a dynamic and capable organisation and we will realise significant quality and efficiency improvements through major service innovation and research every year.

Business Sustainability
We will be financially secure and efficient investing in service and environmental improvements to increase quality of care

Our strategy for our service lines is:

Specialist Centre
To be the major provider of specialist services in the south of the North East and northern North Yorkshire.

Secondary & Community Care
To be the predominant provider of secondary and community services in Middlesbrough, Redcar, Cleveland, Hambleton and Richmondshire.

Integrated Care
To realise significant quality and efficiency improvements through the integration and transformation of community services.

1.2 Analysis of the Local Health Economy

Healthcare Needs Assessment (demographic and healthcare trends)
There is considerable variation in the health of the populations served, with Middlesbrough suffering some of the highest levels of deprivation and lowest life expectancies in England. In contrast Hambleton and Richmondshire districts are relatively affluent with above average life expectancies. Redcar and Cleveland (part of South Tees CCG) is worse than the national average on most measures but not to the same extent as Middlesbrough. The table below provides some summary measures.

Local authority	Deprivation score	% children in poverty	Life expectancy - Male	Life expectancy - Female
Middlesbrough	56.3	56.3	75.7	79.7
Redcar and Cleveland	33.7	25.1	77.7	81.7
Hambleton	3.8	8.5	80.3	83.5
Richmondshire	3.8	9.4	79.1	82.7
England average	19.9	19.9	78.3	82.3
England worst	59.2	59.2	73.7	79.1

South of Tees population are high users of hospital care with emergency admission rates that are amongst the highest in the country. Within our catchment South of Tees emergency admission rates are 38% higher than HRW. This heavy use of secondary care does not appear to be a result of under-provision of primary care, with South Tees having 1,337 people per GP, slightly higher than the 1,302 per GP of HRW and lower than the 1,482 national average. The table below shows the annual admission rate for local and neighbouring CCGs.

	Rates (1,000 pop)		
	Emergency	Elective	Total
South Tees	138.5	165.6	304.2
HRW	101.1	164.5	265.6
Hartlepool & Stockton	108.6	176.5	285.2
Darlington	128.3	159.4	287.7
Durham Dales, Easington & Sedgefield	120.1	184.5	304.6

For HRW, apart from a few areas of deprivation, the main issue is an elderly and dispersed rural population, often with poor access to transport. There is a high Ministry of Defence (MOD) population that creates some specific issues within children's community and maternity services.

For the future, projections suggest that the local population is hardly increasing in size, it will only have increased by 1.3% by 2018 and by 1.9% by 2020. This compares to England projections of 3.2% and 4.8% respectively. These differences hold true for children and women aged 20 – 34. But while these sub-groups are expected to grow at only half the national average, they are expected to increase, meaning demand for children's and pregnancy related services can be expected to be maintained or increase slightly.

For the elderly, growth in the local population is expected to match the national average, with the number of people over 65 increasing by 7.3% by 2018 and by 11.1% by 2020 compared to national growth of 7.2% and 10.8% respectively.

Applying age weighted population projections to specific services suggests the following changes in activity by 2018 driven by demographic changes alone.

	Change by 2018	
	Spells	%
A&E	1,255	1.0%
Outpatient new attendances	3,808	1.7%
Outpatient review attendances	13,997	2.7%
Inpatient Spells	4,641	3.1%
Average occupied beds	74	6.8%
Annual theatre hours	1,129	2.2%

The most significant pressure is expected to be on inpatient beds with more than two extra hospital wards required by 2018 if practice continues as now.

Locally, some providers have seen significant increases in activity while we have remained fairly static. It should be noted that these changes mask a range of activity variations but as a headline figure this means that our income from general services inpatient activity will have grown less than that of our competitors.

The largest growth has been in the Independent Sector which has become a significant player in the region, particularly in orthopaedics, GI endoscopy and minor surgery. This Independent Sector provision is a conversion from private patient services to NHS rather than new build. It was initially employed for the choice at 6 months project and has since been encouraged by commissioners faced with waiting time challenges. The development has been further bolstered by NHS providers using the Independent sector for waiting list initiatives. As at quarter 4 of calendar year 2013 Independent Sector market share was still rising, though at a slower rate than previously.

There is an opportunity to recapture this work if our waiting times are sufficiently attractive and this will form part of the growth strategies we are developing with individual service lines and then our capacity plans.

Specialised Services

Funding Analysis: historic trends and likely commissioning intentions

CCG funding analysis

A new CCG funding formula has been implemented by the Department of Health and is reflected in published allocations for 2014-2016. Local CCGs in both patches are over target (South Tees 2.92% and HRW 6.81%) and will receive only minimal uplift in the planning period. There is no clear indication yet as to how further pace of change beyond 2015/16 will be implemented, but CCG planning guidance suggests commissioners should plan for growth in allocation as follows:

	2016/17	2017/18	2018/19
CCG indicative growth	1.8%	1.7%	1.7%

Both HRW and South Tees CCGs have reflected these assumptions in their own planning submissions. Whilst this growth is greater than the Trust view of demographic growth (0.94% per annum), It should be noted that the above is before any reduction in respect of Better Care Fund (BCF) contributions. These will be implemented in 2015/16 and equate to 3.6% of allocation. The CCGs intention is to use BCF and other means to reduce emergency

admissions to hospital and between the two main commissioners they anticipate reducing spend with the Trust by around £10.4 million.

Specialised funding
Specialised commissioned activity has traditionally grown at 6% year on year (largely as a result of demography and technology). Cumbria, Northumberland, Tyne & Wear (CNTW) Area Team have indicated that they have growth of 4.4% in 2014/15 and 5.9% in 2015/16. With tariff deflators this gives 'real' growth in allocations of 5.9% and 7.6% respectively, which compares favourably with the growth for CCGs but CNTW still anticipate affordability pressures going into 2014/15 and limited scope for development.

Nationally, specialised commissioning is under financial pressure with an estimated funding gap of around £700 million. All area teams are required to work with providers on schemes aimed at reducing activity in order to bridge the funding gap.

Tariff structure
The plan takes into account key messages from the current consultation on the tariff setting process for 2015/16 and future years, which include:

- Commissioners will have less money for hospital-based acute services, and will want to invest more in preventative, community-based interventions, including mental health services.
- Developing proposals for sharing risk differently both between providers and commissioners and among providers:
    - Considering changes to the currency and price-setting method for planned care, in particular outpatient attendances, to inspire efficiency and innovation.
    - A more sophisticated method for estimating providers' potential to improve their efficiency.
    - Reflecting costs more accurately in national prices by updating our cost base.
- Price-setting principles:
    - Prices should reflect efficient costs.
    - Prices should provide appropriate signals.
- Potentially setting several efficiency factors, which could be:
    - A specific factor for each provider.
    - Different factors for different service types or
    - Different factors for groups of providers that meet certain criteria.

The underlying tariff structure itself does not reflect the Trust's funding structure with its reliance on Private Finance Initiative (PFI) funding or, arguably, the Trust's portfolio of services which includes a high proportion of expensive specialised work. When compared to a traditionally funded schemes we estimate that the excess cost of PFI equates to an additional efficiency requirement of around 1.9% of operating expenditure and around 1.6% in cash terms (see below). Also in recent years the adjustments to tariff seem to have advantaged more traditional DGH type hospitals and we know, anecdotally, that neighbouring Trust have seen more growth in tariff income arising from changes to tariff than we ourselves have experienced.

Finally current tariff design is geared toward steady state and does not support significant capital investment or service redesign. In particular the initial outlay on new build is not fully reimbursed through the tariff mechanism eg impairment costs are excluded from the reference cost return and hence national tariff.

2. CHALLENGES AND OPPORTUNITIES

In preparing our plans we have considered the challenges and opportunities we are currently facing and how these may change over the next five years.

CHALLENGES

Funding:
Monitor recently announced their assessment that there will be a gap of just over £5 billion in the funds available nationally for commissioning secondary care in 2015/16.

- Our principal non specialised commissioners will receive less growth than most others in the planning period.
- Over the planning period commissioners will have less money for hospital-based acute services, and will want to invest more in preventative, community-based interventions, including mental health services.
- All CCGs are having to plan for the implications of the Better Care Fund which aims to bring together health and social care which has traditionally been funded by local authorities, with a transfer nationally of £1.9 million from CCG funds;
- We have no long term indication of specialised commissioning funding. In the short to medium term specialist commissioners are indicating that they will bridge the gap in funding by seeking provider efficiencies.
- The underlying tariff structure itself does not reflect the Trust's funding structure.
- There is a highly uncertain economic outlook for specialist services with the immediate pressure being for efficiency savings.
- Gold plated specifications for specialist services will add to our costs if we are to comply, as there is no external funding to support this and there is a limited likelihood of investment to keep up with pace of clinical developments.
- The future of the tariff is uncertain but unlikely to change significantly until towards the end of the planning period.
- The changing procurement environment will see a greater use of tenders, short term contracts, possibly Any Qualified Provider and competition from other providers for the provision of primary, community and tier 2 type services. This will introduce greater uncertainty to the funding base than previous contracting arrangements.

Trust Organisational Capacity
Financial

- The structure of our services which includes specialised services with expensive infrastructure and which spreads our operations over a large site and requires us to operate a smaller acute site poses particular challenges.
- The excess cost of PFI equates to an additional efficiency requirement of around 1.9% of operating expenditure and around 1.6% in cash terms.
- We will incur high infrastructure costs just to maintain existing services at their existing levels.
- There is a national and local expectation that reductions in emergency admissions will be achieved which will reduce our income from emergency admissions but this will release income for expansion in community services in both localities. Some funding will be needed to support local social care budgets
- In recent years NHS patients have chosen to be treated in Independent sector hospitals. These hospitals can treat less complex patients which is likely to be the more profitable, easier to schedule work;
- When we project our likely costs going forward using the assumptions given by Monitor, assuming growth in income in line with commissioners' intentions and

allowing for efficiency savings at 4% it is apparent that if we continue to operate in the way that we do now there will be a gap between what we need to spend and what we are likely to receive at the end of the five years – which is in line with what Monitor are projecting for the secondary care sector generally.

Workforce

- National shortages have been identified in key staff groups such as adult nursing if recommendations of staffing levels post-Francis are not met.
- Changes in medical training have created a problem in supply of junior doctors, difficulty maintaining rotas and cover, which will require more Nurse Practitioner roles developing to meet the resultant gaps and service pressures.
- The national direction is for more community/home-based delivery of care and less reliance on acute beds. We will require a flexible workforce equipped with the skills and competencies to respond confidently to the shift to working in community and domiciliary services.
- There is growing national evidence of the difficulty of meeting national standards in smaller hospital settings and this has led to change in the delivery of our paediatric and obstetric services.

Estate

- Our estate is generally in good condition, functionally suitable and well maintained but our biggest priority is upgrading of ward areas which need investment to meet current and future patient needs.
- IT infrastructure and clinical applications both need investment to support our ambitions for patients.
- There are challenges with the quality of some of the community estate, but the South Tees CCG consultation currently underway proposes that services are consolidated in the best quality estate.

Health Care Needs/and health care trends)

- The South Tees population are high users of hospital care with emergency admission rates which are amongst the highest in the country. Within our locality there is a difference between urban and rural communities in terms of demographics and healthcare seeking behaviours. As a result the pace of change and approach by the two main CCG commissioners will be different.
- There is a traditional high dependency culture in the local population, which places heavy demand on primary as well as secondary care. This has been further driven by recent political initiatives to promote patient choice and expectation.
- Demographic growth will drive an increased need for an additional two hospital wards by the end of the period unless there is change in practice across all sectors.
- We are a relatively small specialist centre which means that our specialist services could be adversely affected by specifications for service which set minimum volumes, or if consultants is surrounding hospitals choose to send their patients elsewhere.
- Our specialist activity is static whilst Newcastle Hospitals FT's is increasing, although what is driving this growth is unclear.
- Our specialist activity is predominantly from the immediate catchment area.
- Waiting times appear to be the biggest determinant of choice of provider. When we can provide a service with reasonable waiting times then capacity can be filled, when services are disrupted (eg staff sickness, vacancies, winter pressure cancellations) then patients choose to go elsewhere.

OPPORTUNITIES
The opportunities arising from the analysis above are:

Health Care Needs/Demographic Trends

- We do not have the fragmentation/proliferation of specialist provision apparent in other areas eg the North West.
- The geography of North East supports north/south specialist hubs (ourselves and Newcastle Hospitals) which is the current pattern of delivery.
- We have all the relevant interdependencies to support specialist status – ie we have all the services needed to support a Major Trauma Centre on one site, all the services which support specialist work for cancer and the required diagnostic and critical care infrastructure.
- We have stable patient flows which means that the proximity of other secondary care providers is not a threat but does present opportunities for greater collaboration and more formal joint working in future.
- The ageing population demographic will drive the need for investment in domiciliary and community services to support the frail elderly, as part of the Trust's integrated care delivery.

Organisational Capacity

- We have a strong local reputation for clinical services.
- Our clinical sustainability is enhanced because of the recruitment and retention benefit that being a specialist provider has brought.
- We have built organisational capability in managing integrated community and secondary services in the three years since we took on management of community services and have an opportunity now to realise the benefits of this by moving to more extensive integration across pathways and services.
- Overall our workforce position is positive, with nursing establishments in line with need, good workforce profiles on pay-bandings and age-profiles and some examples of proactive recruitment approaches and in-hour development of enhanced practitioners and supporting roles to address areas of recruitment difficulty.
- Use of volunteers, therapeutic assistants and apprenticeships have been well-received by Clinical Centres and have enhanced the patient experience.
- Our estate is generally good and generally suitable to meet future need.
- The Trust can grow further if we can reduce waiting times.
- Some services now classified as specialist provided in surrounding hospitals may in future be required by commissioners to be provided by or in partnership with a specialist hospital.
- There are high barriers to wholesale movement of specialist services into very big centres.
- Our knowledge of the local area, population needs and our established multi-agency partnerships, puts us in a strong position for expanding our role in community services.
- There have been pilots in recent years of new models of care in community settings and investment, both CCGs have ambitions for more integrated services delivering fast responses and home based care.

External Processes

- There are strong relationships with local CCGs and their commissioning intentions support continuation of our current range of services and mirror our demographic projections.
- There are good working relationships with local authorities.

- There is established commitment across the area to cross organisational working.
- The Trust has strong clinical engagement in the Clinical Reference Groups which influence specialist commissioning.
- There are strong relationships with the local specialised commissioning team.
- Commissioners are looking nationally and regionally at limiting 'new entrants' to specialist services.
- Our interpretation of the national debate about centralisation of specialised services into fewer sites is that it is likely to consolidate the role of Trusts like ours with significant specialist volumes rather than shift current volumes of activity to other centres.
- We are an active partner on the CCG transformation boards and workstreams for community service development

3. RISK TO SUSTAINABILITY & STRATEGIC OPTIONS

This section considers the likely impact of the challenges we have identified on our services.

We describe our key services as being Specialist Services and Integrated Care (encompassing secondary care services, community and primary care services).

We group our specialist services into the following areas:

- Trauma
- Hearts
- Neurosciences
- Cancer
- Specialist children's services

SPECIALIST SERVICES

The sustainability risk across key specialist service lines are:-

Trauma – The Major Trauma Centre (MTC) which serves the southern part of the North East and parts of North Yorkshire is now well established. Two MTCs for the North East is sensible geographically and sustainable in population terms. The principal risk to sustainability arises from the service specification which will require some investment (ie to provide 24 hour, 7 day a week consultant cover). As yet there are no national requirements for paediatric MTCs so it is not possible to assess the challenges we may face to continue to meet the needs of children locally.

Hearts – These are strong services with an excellent reputation. There is a risk that commissioner intentions for more specialist services in DGHs could impact on our volume but this is contrary to the national drive for centralisation and is assessed as of low likelihood. Anaesthetic recruitment is problematic but the Trust has a strategic approach to resolve this. Nationally there is a high level of growth projected in cardiac imaging – the Trust is investing in MRI (with some charitable support) to provide general capacity and to keep pace with cardiac demand.

Neurosciences – These are generally stable services although there have been specific issues with medical staffing. There is a potential loss of low volume activity as a result of changes in commissioning. The impact of this on volume and income is small but there is a need to ensure that we back fill these activities with other work to ensure that neurosciences posts remain attractive so that we retain staff and recruit in future. Retaining key skills will

also be dependent on our ability to make investments in order to offer the same range of services as other Specialised Service Centres.

Cancer – There is uncertainty about the impact of specialist services reviews, but our cancer services are sustainable. As highlighted for neurosciences there is a potential loss of low volume work and we need effective provider to provider discussions about the unintended consequence of changes in flow. There are specific workforce risks which are being taken into account in our plans, specifically in Gastroenterology; Radiology (for MRI) and Histopathology. NICE guidance on robotic surgery is risk to designation as a centre for urology but impact of any loss of capability in this specialty has consequences for specialist services as a whole and we are in discussion with commissioners about commissioning of a robotic service.

Children – Commissioners have confirmed their intentions to continue to commission paediatric and high dependency services which are essential for our children's surgical more complex children's services. Medical staffing and cover for paediatric rotas is a difficult issue nationally. The changes taking place in inpatient services at Friarage Hospital, Northallerton (FHN) will helps alleviate this for the Trust in the medium term.

Our overall assessment for specialist services is that the Trust has the right interdependencies between services to continue to be a strong provider and that this is in line with commissioning intentions (although with some reservations as outlined about uncertainty regarding the overall direction of travel for specialist commissioning nationally). Some change in low volume areas is inevitable so we need strategies to ensure that we can retain skills in services affected by this change to sustain the remainder of the service portfolio after changes occur. There are national system issues about how we can generate the required level of investment to support these high cost services and high costs will act as a constraint to our future growth in these services.

INTEGRATED SERVICES (SECONDARY AND COMMUNITY SERVICES)

The key risks to our integrated care service lines resulting from these challenges are:

- The health needs of our population for our integrated care services generate a high level of demand for secondary care and a key challenge facing these services is to balance the requirement to meet surges in demand for urgent care, whilst delivering the levels of planned care commissioners project they will require over the period of the plan. The transformation plan set out in section 5 describes the programmes of work the Trust will take forward over the next five years to underpin quality of services and patient experience.

- One in four of all patients admitted to the Trust are over 75 years of age. There are programmes of work aimed at ensuring services better meet their needs including centre specific programmes, a dementia programme, work on the role of the care of the elderly team but a more coherent strategy is needed which ensures that there is a consistent focus on ensuring the frail elderly receive the most appropriate care in the most appropriate place.

- Our Front of House services face very high levels of demand and acuity. The Trust is working with local partners in development of the urgent care strategies and actively engaged with CCGs in implementing measures for admissions avoidance. Front of House services in South Tees have been nationally recognised for good

practice but clinical teams have recognised the need for systematic review across the whole system, which is being undertaken. A and E has faced sustained growth in demand. The Trust is working with the CCG on new approaches to Minor Injuries Units.

- Our Annual Plan 2014-2016 sets out in detail the immediate capacity constraints the Trust has identified in its ability to meet performance requirements. The risks to sustainable, long term delivery of the 18 week target have been worked through by the relevant clinical teams with external support and detailed plans are in place to support delivery addressing identified workforce, bed and theatre constraints and this will be kept under continuous review.

- There are risks in some areas because of the national difficulties of supply and rising demand of workforce – for particularly acute physicians, gastroenterologist and spinal surgeons. Radiology services are also under pressure here and in surrounding Trusts. This is a key sustainability issues for both integrated and specialist services. There are specific strategies to address this in each service area which will be underpinned by our workforce strategy and plans. Pathology services have identified issues of sustainability because of rising demand and supply of skills in core areas and as a result are working with North Tees and Hartlepool NHS FT which will help both organisations overcome these constraints.

- The South Tees CCG is leading a formal public consultation over summer 2014 leading to planned system wide changes in the delivery of community services in Middlesbrough, Redcar and Cleveland and HRW are undertaking engagement work on their own programme. The Trust has been actively involved in developing and designing the proposed solution and will continue to work in close partnership with the CCGs and local authorities on this agenda and will face a rapid pace of change in the scale and required skill mix of the workforce. Our new Integrated Medical Care Centre is well-placed to work on this change agenda with our workforce, as their services span this integrated pathway. Workforce plans will be developed to create a flexible workforce by building in staff-rotation between the sectors.

- Our busiest secondary care wards are in our worst accommodation and gaining access to wards to carry out the major refurbishment work which is required is difficult given the high levels of occupancy. Our forward plans include a continuing programme of investment and our immediate priority is to develop a decanting strategy which will allow us to carry out work quickly and without adverse impact on our bed capacity.

- The challenges set out in section 1 and 2 pose particular challenges for smaller sites. We have just successfully concluded a public consultation with Hambleton, Richmondshire and Whitby CCG which recognised the sustainability problems of paediatric and maternity services at FHN and are in the process of implementing changes but we and the CCG recognise the need for a broader review of how best to meet the health care needs of a rural population and to achieve a clinically and economically viable role for the Friarage hospital at the heart of this.

- Seven day working expectations for emergency and urgent care will place considerable pressures on all services and hospital sites where patients are admitted acutely. The combination of reduced emergency activity if the BCF is successful, coupled with the requirement to still maintain senior medical presence to meet the Seven Day Working standards, will raise particular problems for FHN sustainability.

The overall assessment for our integrated secondary and community services is that the Trust has generally very good clinical capability and is clinically sustainable but is facing a very complex agenda. The biggest issues affecting the clinical sustainability of integrated care is the level of demand generated by our local population and the local reliance on secondary care which means that the scale and pace required to deliver CCGs ambitions for the future and our aligned ambition for quality and patient experience is very challenging. Our "Transforming Care" programme and our continuing programmes for quality, outcomes, patient safety and patient experience which are our current strategies to drive change and improvement, together with the local framework for partnership and collaboration are set out in section 4.

4. STRATEGIC PLANS

From the analysis of challenges and opportunities we have set priorities for the next five years to support our vision of setting the standard for excellence in patient safety, quality and continuous improvement and our mission to provide high quality safe an integrated specialist secondary and community health care for patients, their families and carers

4.1 Overriding Priorities

To return to financial stability

The introduction set out our plans for recovery based on a rolling programme of work to address the entire Trust cost base and deliver radical cost improvement This will be underpinned by improved skills, data analysis, stronger governance around implementation and a cultural shift within the organisation. We will increase the pace of adoption of change and promote greater standardisation, matched with clearer lines of accountability as envisaged by the structural re-organisation completed in 2013/14 under the banner of 'Continuing the Journey'

To continue to drive our programmes for

Quality – built on four themes of world class outcomes: to continuously reduce mortality rates; delivering care free from avoidable harm; delivering outstanding patient experience; and delivering care free from process errors. Our specific progammes are:

- Further driving down healthcare associated infections through a focus on cleaning and the implementation of antibiotic awareness campaigns for prescribers and nurses,
- Establishing a multi-agency, multi-professional pressure ulcer collaborative with a focus on education, resource, prevention, partnership and culture.
- Implementing an award quality accreditation system to provide assurance on the maintenance of clinical standards and provide evidence to support the new CQC assessment process
- Further improve the patient safety culture through assessment of the safety climate and promotion of the human factors approach to identify critical behaviours that underpin a safety culture
- Reducing clinical process errors through the use of Rapid Process Improvement methodology to standardise eight pre-determined clinical processes.
- Undertaking quarterly nurse staffing and patient acuity reviews and make information on staffing levels readily available to the public both on the wards and through the Trust website.

- Roll out of the friends and family test to community services, out patients, day cases and staff.
- Continue to embed the use of patient stories, specifically utilise innovative ways of engaging staff through patient experience in the pressure ulcer collaborative, dementia strategy and health care associated infections (HCAI) improvement work.
- Development of a Clinical Strategy incorporating detailed plans to further drive high quality care.

Organisational capability – through giving teams the capability to continuously improve their services through improvements to information available to them; through developing service improvement capacity and capability and leadership development;

The programmes are:

- Provide quality information to support effective decision making, supporting users ate every level to use quality information to drive excellence in all aspects of our business.
- Develop a more robust information analysis function that supports users in using and interpreting information. Provide training in how to access, use and interpret information.
- Develop the Trust strategy for healthcare records**.**
- Have effective and engaging leaders at all levels. The Trust has an established structure of internal leadership development programmes for senior and frontline clinical and managerial leaders, plus extensive coaching and mentoring resources to support leaders in their development. We work in close partnership with the NHS Leadership Academy and the North East Leadership Academy and secure a significant number of places on their full range of leadership programmes and events.
- Build capacity and capability in the organisation for service improvement. Our aim is that all staff are trained, as a minimum, in basic service improvement techniques. In partnership with the School of Health at Teesside University, the Improvement Alliance runs a number of service improvement training packages at different levels, from basic to Masters degree level. We have established the Faculty of Service Improvement and Transformation which provides a renewed focus on workforce capability for service improvement and leads the development of service improvement capability. We have adopted Rapid Process Improvement Workshops (RPIW) which have been successfully used elsewhere. RPIW is an event focused on a particular process in which people who do the work are empowered to eliminate waste and reduce the burden of work'. We have a structured approach to introducing RPIW starting with Board of Directors and other senior leaders as champions.

4.2 Strategic Programmes

Our ability to sustain and improve our clinical quality and patient experience and achieve improvements in market share will be driven by our five programmes, in addition to the overarching financial programme:

- **Transforming Care** is a programme which aims to ensure that services, tailored to the individual needs of patients, are delivered; in the place that is right for the patient, through integration across clinical and organisational boundaries. More effective and efficient service models will improve the quality of care provided, the patient's experience of care and ensure best use of health and social care resources. The programme dovetails with CCG initiatives (IMPROVE and Fit for the Future and the Better Care Fund) and incorporates work on service improvement, discharge, care of the elderly and dementia.

- **The Trust's vision for Information Technology** is to: provide the best and safest health care experience through the use of technology and information that is fast, accurate, dependable, secure and easy to use; ensure information is available every time and everywhere it is needed and informs and supports better, safer, faster care; offer accessible technologies which are intuitive and user-friendly; deliver a responsive, helpful and customer focused service. The strategy is therefore an enabler to support the patient and clinician benefits sought through the Transforming Care Programme.

- **A workforce strategy** based on development of our own staff to overcome recruitment challenges and to develop new, more demanding and more flexible roles.

- **Friarage Hospital** the Trust is working with Hambleton, Richmondshire and Whitby CCG on an important area of joint innovation and service development in relation to the future of the Friarage Hospital to ensure its clinical and financial viability at the centre of a new model for rural healthcare.

- **Partnership and Collaboration** the Trust is fully engaged in partnerships with CCGs and local authorities to drive transformation and working with other providers will take the lead in driving the transformation agenda across the Local Health Economy (LHE) in which we operate to ensure that there is sufficient strategic capability and capacity to evaluate and implement the large scale changes which are needed for future sustainability.

4.3 Clinical Service Strategy

Beyond this, based on our assessment of the external challenges we face and the opportunities derived from our strong clinical capability and the structure of our service portfolio we have developed and quantified a growth scenario. Given the uncertainty recognised in our introduction about the overall direction of travel for the NHS we have not modelled this into our financial plan but it illustrates that there is potential for improvement on our base case during the next five years. The elements of this are:

- Transform community services.
- Improve our waiting times so that patients will choose our services
- Some growth in our specialised services because of changes commissioners will implement
- Make best use of our capacity.
- Work collaboratively with other providers.

4.3.1 Transform community services to better meet the needs of local people, reduce the dependency on secondary care we described in section 1 and meet local commissioners' aspirations for care closer to home and increased integration.

We have described in section 1 the improvements made in community services through close working with local CCGs and primary care and the development of our capability as an integrated care provider. CCGs have plans in place for investment and change in 2014/15 and 2015/16. Beyond this their general aspiration is clear but there is as yet less detail.

The Trust will be affected by Better Care implementation plans involving two CCGs and three local authorities. The assumption in commissioner plans is that the Trust will lose £10.4 million of income through the successful impact on reduced emergency admission

activity (with £8m of this coming from the Tees locality) but that there will be substantial investment in community services of around £12 million.

For the HRW CCG area of North Yorkshire BCF additional investment of circa £2m in a portfolio of services has been agreed with the Trust over a two year period. The implications of the reductions in emergency admission activity and increase in community service delivery for the HRW CCG population upon the future role of FNH will form part of the dedicated joint transformation programme between the CCG and the Trust. There are good relationships with the CCG and the local GPs who are proactive and supportive of the change agenda and the part that primary care needs to play to make this a success.

On Tees, the pooled resource has been committed for the Middlesbrough BCF and Redcar & Cleveland BCF for 2014-15, but there is still uncommitted resource for 2015/16, totalling circa £10m. The indication from the South Tees CCG is that they would wish to see the a significant proportion of this resource invested locally with this Trust, as their major supplier of community services. The Trust has worked closely with the CCG and other agencies for the past three years and there is common agreement about the direction of travel – greater integration of services, breaking down boundaries between health and social care, improved information sharing and ensuring patients receive the care they need in the most appropriate environment which will often be the domiciliary setting. The 'Continuing the Journey' approach adopted in the Trust has seen the creation of a new Clinical Centre for Integrated Care, specifically aimed at building on this agenda.

Investment has been made in 2014/15 through the CCG and the BCF to allow piloted services such as the Rapid Response Team and Integrated Community Care Team, to continue and their full potential to be realised and impact evaluated. The expectation is that the uncommitted resource for 2015/16, for both local authority areas, will be targeted at delivery of the CCG's community transformation project 'IMPROVE' (Integrated Management and Proactive Care for the Vulnerable Elderly). This is currently out to public consultation and firm reconfiguration proposals will be confirmed after this is concluded, but the expectation is to see investment in areas such as: improved stroke services (consolidated stroke rehabilitation unit and community stroke service for supported discharge), reconfiguration of community hospital provision including minor injury units, development of a single point of access for health and social care needs, expansion of the RRT and reablement teams, improving discharge from JCUH hospital, improved outpatient and diagnostic services closer to the patient and increased community rehabilitation services delivering care in patients' homes. The Trust will need to ensure that full cost of delivery is recovered when developing provision in response the CCG requirements.

4.3.2 Improve our waiting times

We know that the local population and GPs want to use our services and the drift of work to alternatives was driven by the deterioration of our waiting times. They have now reduced and will be reduced further as a result of improvements in efficiency in our pathways through the Transforming Care programme.

With competitive waiting times and excellent outcomes we expect to gain additional activity through:

- Reducing the amount of work requirements being subcontracted to the Independent sector by the Trust to meet waiting time targets;
- Regaining South Tees and HRW patients who are choosing to use directly
- commissioned NHS provision in the private sector;

- Regaining the South Tees and HRW patients who are choosing other NHS providers;

4.3.3 Grow our specialist services

On top of this there will be net growth in our specialist services as a result of changes in commissioning and service reviews. It is difficult to quantify the impact of these and we cannot at this stage be certain of the final configuration of revised services but we can make reasonable estimates.

Growth in these specialist services (unlike the opportunity of regaining CCG activity lost to the Independent Sector) is dependent on commissioning decisions and we have insufficient basis on which to assess what the scale of future changes driven by greater centralisation might be. We do know however that specialist work generates, has longer lengths of stay and that the strategic benefits of a consolidated position as a specialist provider resulting from future shifts of work needs to be assessed against the economic impact on the Trust.

4.3.4 Release capacity to accommodate this growth

Section 1 sets out the challenges we face of because of the dependency of our local population on secondary care and the resulting pressures on acute sector capacity. Over the period of the plan, demographic change will continue to fuel this pressure but our plans and those of our commissioners will create opportunities to release capacity and so allow the activity growth detailed above:

- We will create additional theatre capacity through a new theatre recently commissioned at JCUH; through a programme of theatre efficiency and additional staffing built into our 2014/15 plan to support 18 week delivery.
- Through our Transforming Care programme we will drive improvements for patients and release beds. The Trust has a range of planned improvement and transformation programmes (including Improving the patient pathway, Early Supported Discharge and RRT/ ICCT) in collaboration with the CCGs, which in combination are expected to reduce the need for beds over the next 2-3 years. This benefit will absorb the demographic pressure for additional beds that the Trust anticipates over this period. Further investment and initiatives through the Better Care Fund programmes in both Tees and HRW localities are expected to generate a further bed saving over the subsequent 2 years. In total therefore, the beds we have available over the lifetime of this plan will keep track with the anticipated pressure generated by demographic growth and generate a small surplus.

The impact of these changes will be to help offset the projected loss of income to the Trust resulting from the reduction in emergency admissions resulting from the Better Care Fund initiatives and to help enhance the overall sustainability of services – it will not in itself however be enough to offset the probable loss of income that will result from projected changes to our income through tariff efficiency. As well as making its own efficiency savings the Trust will need to work with commissioners, local authorities and other providers to find ways to find sustainable ways of meeting local health needs over the next five years.

4.3.5 Impact on Service Lines

From our analysis of challenges and opportunities some of the strategic issues at service level which will be addressed in our plans over the five years will be:

Specialist Services

Specialist Children's Services

We will achieve: PICU/HDU designation from commissioners to support delivery of children's work

Robotic Surgery
We will seek to be commissioned as a robotic surgery centre to offer a local service and support our urology, colorectal and gynaecology services.

Major Trauma Centre – we will grow in strength as a Major Trauma centre. This will need some investment to comply with commissioners' specifications.

Spinal Surgery
There are national shortages in this specialty and we have had difficulty in keeping pace with demand. We are developing options to address workforce/capacity issues.

Cardiothoracic:
We will look at ways to deal with difficulties in recruitment of anaesthetists through separation of ICU anaesthetic cover from more general cardiac anaesthesia and development of a team of ICU specialists.to ensure the sustainability of the service.

Renal
We will pursue growth in capacity and modernisation of delivery to keep pace with rising demand funded through income from increased activity.

Integrated Services:

Gastroenterology
We are funding phased expansion. in response to increasing demand for lower GI endoscopy and further 10% year on year growth expected until 2016/17.through income generated from the increased work. Gastroenterology is a core service with significant interdependencies, especially with cancer services.

A and E
We will need to increase the department's resilience to cope with rising demand, meet targets and protect patient flow.

Acute Medicine
We are in the process of increasing our consultant workforce to provide senior decision makers at front of house and support appropriate admission (both JCUH and FHN)

Community
Transformation to greater delivery of care in the community. We will collaborate to secure the necessary resource to recruit / develop a new community-focused workforce and integrated teams (including pump-priming and recurrent investment by CCGs for new models of care), and produce a comprehensive workforce programme to ensure a flexible workforce is developed, which can respond to the shift from acute to community care delivery (including proactive rotation of staff across settings, open day recruitment drives and skills development).

4.4 Key Infrastructure Schemes:

FHN relocation of paediatric and maternity services – in 2014 we will implement a change programme now formally agreed through public consultation which puts children and maternity services at the Friarage Hospital on to a clinically sustainable basis by moving to a paediatric short stay assessment model and midwifery led unit in line with national good

practice. This has implications for staffing as staff will need to work more between sites or to be redeployed and for physical accommodation as we create additional capacity at JCUH to deal with additional births and relocated SCBU cots (these changes are included in our capital plans). We will work closely with the ambulance services on the changes needed to support the revised flows and with County Durham and Darlington FT may be a flow of patients to Darlington Memorial as a result of the change. The transfer of services is planned to take place in October 2014.

Wards 1 to 12 refurbishment – over the period of the plan we will reconfigure and upgrade our oldest wards at JCUH to meet changing clinical needs and offer a high standard of patient experience. Our programme is innovative and involves the addition of external structures providing additional bathrooms which free space within the ward footprint to increase space between beds improving clinical functionality, reducing the infection control risks and generally offering a better patient experience. We have piloted this approach highly successfully on one ward and from 2015/16 will be extending this to other areas.

IT transformation – we have a programme of modernisation for which £9.6 million is built into our capital programme to be supplement by national funding.

MRI expansion – to support our diagnostic capacity which is core to all services and in particular to support our cancer service lines and cardiac imaging we have an agreed expansion plan for our MRI capability. This will include an additional machine to be located at FHN offering both increased capacity and enhanced access for a population which currently relies on JCUH for its service and which increases our functionality through the procurement of a 3T MRI in general radiology. This is a phased programme which will complete in 2016 and which is in part dependent on fundraising – with two very well supported schemes in place.

PET/CT – we will secure a fixed PET-CT facility through the revised national contacting arrangements at no cost to the Trust in conjunction with a private provider within the next two years. PET/CT has a pivotal role in the management of patients with cancer. . Currently patients with cancer requiring PET-CT are scanned on a mobile scanner, scan volumes have grown rapidly since the service commenced. A fixed machine will allow streamlining of the patient pathway, improved patient care and a better patient experience. This would also simplify the scan requesting and booking pathway and fulfil the care delivery model of patients undergoing specialist diagnostic imaging, radiotherapy planning and delivery of state of the art radiotherapy at the one site.

JCUH site access – patient experience data and public and staff comment illustrates the difficulty of access and parking at the JCUH site. This is a strategically important issue as it clouds the perception of patients about the hospital – despite rating the clinical care very highly. By early 2015 we will have completed plans for in excess of 500 additional car parking spaces and a new access road which will transform patient and staff experience of the site

A and E – we will find a way of improving our facilities for children at JCUH. This will be a financial and logistical challenge and we will need to explore non mainstream sources of funding.

5. Conclusions

We are an organisation with high ambitions for patients, meeting the health care needs of the populations we serve very effectively and fully engaged with the strategies of our

commissioners and committed to returning to financial sustainability within the next three years.

Our specific local challenges are:

- The nature of the Teesside population we serve and its traditional reliance on secondary care.
- The funding position of our CCGs.
- The structure of our services with high cost specialist services infrastructure and dual site running costs and PFI infrastructure.

Our strategy for the next five years for our key service lines is that we will continue to be a strong provider of specialist services offering exceptional outcomes and experience. Our service lines are developing in detail the strategies required to ensure that we can retain skills and grow services in target areas. We have the appetite and the capability for change over the next five years in our own processes and in the way we work with others. Over the last three years we have laid the foundations for a successful integrated care organisation and in the next five will be working in partnership with others locally to drive efficient pathways based on much greater integration across all sectors and will benefit from sustainable investment in community services. With other providers we will develop approaches to service delivery which are clinically and economically sustainable. We will transform our pathways across all our service lines to ensure that we deliver the best patient experience. We can only do this by further developing our highly skilled workforce - creating new roles to deal with changes in the availability of junior and middle grade doctors and to meet the requirements for more health care delivered in community locations - harnessing their creativity and enthusiasm as we strive to improve our efficiency in all aspects of our services to respond to the funding challenges the NHS faces over the next five years.