



Strategic Plan Document for 2013-14

County Durham and Darlington NHS Foundation Trust

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

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

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Date	31 May 2013

The attached Strategic Plan is intended to reflect the Trust's business plan over the next three years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

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

Approved on behalf of the Board of Directors by:

Name (Chair)	Tony Waites
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Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Sue Jacques
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Signature



Approved on behalf of the Board of Directors by:

Name (Finance Director)	Peter Dawson
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Signature



1.0 Strategic Context and Direction – Trust’s Strategic Position in the local health economy

1.1 Overview of the Trust

County Durham and Darlington NHS Foundation Trust is one of the largest organisations in the NHS with a track record of success.

Our 8,000 staff serve a population of around 600,000 people across County Durham and Darlington, into North Yorkshire and the Tees Valley, and the South of Tyne.

Since 2011, we have been an integrated healthcare provider – bringing hospital, community services and health and wellbeing services together in one organisation.

We provide acute hospital services from:

- Darlington Memorial Hospital
- and University Hospital of North Durham

And a range of planned hospital care at Bishop Auckland Hospital

We provide services including inpatient beds, outpatients and diagnostic services in the local network of community hospitals:

- Shotley Bridge
- Chester-le-Street
- Weardale in Stanhope
- Peterlee
- Stanley Health Centre
- Sedgfield
- The Richardson in Barnard Castle

We provide community services in patients’ homes, and in around 80 premises including health centres, clinics and GP practices, enabling close links with primary care, and shared accommodation with local authority teams.

As part of our integrated service portfolio CDDFT also provides integrated health and social care in connection with the two local authorities, Durham County Council and Darlington Borough Council.

Operationally the trust is divided into three care groups, Care Closer to Home, offering mainly community services, Acute and Long Term Conditions and Surgery & Diagnostics, which also includes the Health and Well-being Team.

1.2 Key competitors

Our geography means that many patients have to travel some distance off patch to use alternative hospital providers, and the Trust historically has been the “monopoly” provider of community based services. This position continues to be challenged by any qualified provider, tendering of services (particularly community services), and an increased willingness of patients to travel for elective care.

- In Easington, on the East coast, most of the 90-100 thousand population either travel North to City Hospitals Sunderland FT, or South to North Tees and Hartlepool FT for secondary care services
- Part of the population of Sedgfield Borough, to the South East of County Durham also use the

“off patch” but geographically accessible North Tees and Hartlepool FT

- Newcastle Upon Tyne Hospitals FT and South Tees FT are the main tertiary providers, and their reputation for specialist services attracts patients for secondary care
- Also to the North, Gateshead FT and Northumbria FT offer competition
- Private sector hospital provision exists in Washington, County Durham, and in Darlington and Newcastle, with a focus on elective surgery and diagnostics
- Primary care offers competition in community and some urgent care and day surgery, and some therapies
- Any qualified provider has resulted in high street competition in audiology and some diagnostics (warfarin testing)

In response to our competitors, the Trust’s strengths are its abilities to provide an integrated hospital and community service to patients in its catchment area, and to link effectively with partners in local authorities and primary care by developing single documentation and joint pathways of care.

Relationships with commissioners are being strengthened for 2013/14 by commissioning agreements, which are underpinned by a shared desire to transform services, particularly around unscheduled care.

The Trust is also seeking to emphasise its own portfolio of specialist services and its role in research and development to strengthen its credentials as a provider of choice.

The Trust has worked hard to develop strong links with GPs and developing CCGs. The CCGs began 2013/14 as well established and robust organisations with focused clear and credible plans. It is the Trust’s intention to continue to build on these relationships.

1.3 Forecast health, demographic, and demand changes

County Durham and Darlington have been left with a legacy of poor health and inequalities as a result of heavy industry and subsequent unemployment following its decline. Many wards have amongst the poorest health in the country.

In recent decades, County Durham and Darlington, along with the rest of the north-east, has seen a decline in population. The ONS now forecasts a reversal of this trend over the next 25 years, where the effects will mainly be felt in those people aged 65 years and over.

Key forecast demographic changes include

- Between 2011 and 2016 there will be a 2% rise in over 65’s
- Dependency ratio expected to increase between 2011- 2016 by 5%, which is higher than both North East and National ratios.
- Numbers of people with more than one long term condition will increase
- Numbers of those at retirement age will peak in 2037
- 85+ age group will peak in 2056
- An increased birth rate

We are already seeing an increase in frail elderly patients with multiple health conditions, including dementia.

The impact is increased demands on both health and social care, and the need for more local services and care closer to home. The Trust is working with CCGs to address these demands through integration and exploring opportunities for greater use of technology.

The Ministry of Defence recently announced plans to move a further 7500 troops to their training facility at Catterick Garrison (North Yorkshire). As 70% of these will have families, there is likely to be an increase in demand as Darlington Memorial Hospital is the nearest acute care hospital.

We expect that changes at the Friarage Hospital in Northallerton, in North Yorkshire, will also increase patient flows to Darlington Memorial.

We are also developing our service portfolio to reflect changes in healthcare requirements as a result of lifestyle. We now have a strong bariatric service, based at Darlington Memorial, and are developing a joint approach to diabetes management with primary care.

2.0 Threats and opportunities from changes in local commissioning intentions

The Trust sees the introduction of CCGs as an opportunity to create dynamic relationships between primary care and Trust clinicians, to transform services and deliver more care outside hospital.

The shared will to do this has been reflected in the approach to contracting discussions for 2013/14, and the shared priorities as outlined in clear and credible plans and in the Trust's strategic direction.

2.1 QIPP & demand management

A clinical summit was held with primary care in order to identify health economy priorities and ways to improve local innovation activities in terms of impact and speed of implementation.

CCGs are continuing to look for QIPP initiatives and innovation funding is currently being identified to support this work. CDDFT are working closely with local CCGs and primary care providers to improve clinical engagement and alignment around the QIPP process.

The priority area identified for 2013/14 is unscheduled care, including the future model for urgent care. The Trust is working with the CCGs on the business cases, and has been developing capital plans ready for implementation following agreement of the model.

2.2 Decommissioning

The Trust recognises the need to review services, in order to deliver more effective patient centred services, and to release efficiencies for reinvestment.

We believe that it is important to engage effectively in these processes, working closely with commissioners, in order to manage relationships effectively, and to minimise the impact on patients.

During 2013/14, we seek to improve processes to prepare for and risk manage any decommissioning that might occur.

In 2012/13, the Trust worked with commissioners on the decommissioning of the Darzi centre in Darlington.

Commissioners have announced plans to decommission the existing children's speech and language and occupational therapy service, provided by the Trust, and tender based on a new specification.

The Trust plans to tender for the revised service, and has begun discussions with staff about the way forward, in line with good HR practice.

During 2013/14, we will be working with CCGs on a new community services contract, as the existing contract comes to an end in March 2014.

2.3 Potential “Any Qualified Provider” Tenders;

There are 6 planned AQP proposals to be launched in County Durham and Darlington as follows:

- Musculoskeletal services for back and neck pain
- Adult’s and children’s continence services
- Diagnostic testing closer to home
- Wheelchair services
- Venous leg ulcer and wound healing
- Primary care psychological therapies (adults)

Again, our intention is to continue providing these services to maximise our market share, working with our commissioners.

2.4 Analysis of how the Trust’s demand profile and activity mix has evolved over recent years and what changes are forecast

Following integration with community services in 2011, the Trust has over 90% of the local community services market.

Retaining market share in community services is a key strategic goal for the Trust which sees its future as an integrated care provider.

We expect to see growth in health visiting services as the national program is rolled out.

We expect further growth in unscheduled care, emergency admissions and A&E, reflecting demographic changes, and continuing the trends we have seen in recent years – and, as mentioned above, this is a key area of work with commissioners.

Cancer screening is also an area of growth, and subsequent increase in demand.

We are developing our endoscopy services at the Trust as demand for tests increases, with a particular focus at Bishop Auckland Hospital, where our bowel screening service is provided.

2.5 Shifting care delivery outside of hospitals; and reconfiguration plans

The Trust has recently opened a new chemotherapy unit in Shotley Bridge Community Hospital, and an outpatient gynaecology service at Chester-le-Street Community Hospital.

The Trust is engaged in a series of pathfinder developments in key market areas to test a range of care closer to home delivery approaches, these pathfinders include – nurse led diabetes care, COPD in local settings, virtual ward and a range of telehealth applications.

The new model for urgent care being developed by CCGs is likely to result in the move of urgent care from community based facilities at Dr Piper House in Darlington into an integrated unscheduled care front of house at Darlington Memorial. This possible change has the support of the local OSC.

This will facilitate the move of an appropriate service from Darlington Memorial into Dr Piper House.

The Trust has played an active role in the recent legacy project led by the outgoing PCT

commissioners, to inform the future commissioning intentions of CCGs and Area Teams. More details are included under clinical sustainability.

2.6 Details of how the Trust is diversifying its income streams (e.g. research, private patients, exploiting intellectual property)

The Trust has been looking to diversify its income stream in the following ways:

- Building on its developing reputation for research by developing a bespoke R&D facility at Darlington Memorial Hospital, which will strengthen our ability to attract research and trial funding
- Working with private sector organisations to explore and develop new income streams based around innovations in Telehealth

2.7 Collaboration, Integration and Patient Choice

The Trust has a strong track record in collaboration and partnership working. To sustain the advantages of being an integrated provider, this record needs to be sustained.

Examples include:

- Integrated Intermediate care services with our two local authorities
- The integrated children's services with local authorities
- Collaborations on adult LTC with social care and the Trust's community nursing teams
- Health and wellbeing delivery carried out with local authorities
- The IAPT partnership with the local mental health trust, the Trust and a third sector provider
- Joint urology pathways with South Tees and City Hospitals Sunderland FTs
- Joint vascular services with Gateshead FT
- Joint bariatric service with North Tees and Hartlepool and South Tees FTs
- Readmission avoidance work with care homes in the Durham Dales, Easington and Sedgefield CCG

A key part of patient choice is also to ensure that both patient and primary care are aware of our services, and that they are actively marketed and communicated.

Work is underway to further develop the Trust website, choose and book and patient management systems to ensure all patients have knowledge of and feedback from other patients about our services.

3.0 Approach taken to quality

The Board has overseen the development of a five year Quality Strategy from 2013 which provides the over-arching framework that encompasses the Trust's Quality aims, and the performance and governance arrangements linked to these to support:

- Monitor's Quality Governance Framework and compliance statements
- The Trust's Integrated Business Plan and its Annual Plan
- The Trust's Annual Quality Accounts
- The Trust's contract with commissioners, including all nationally and locally-agreed quality requirements, including NHS Outcomes
- Best practice and national guidance

The Quality Strategy includes an accountability framework to give assurance to the Trust Board that the strategy is being implemented and that the responsibilities of individual staff are being discharged.

3.1 Quality priorities

The Trust will work to deliver sustainable and reliable improvements in the quality of care and service provided in the following key subject areas:

- **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 patients, service users and our staff.

These have been taken forward as part of our quality account and consulted on with all our stakeholders , as follows:

Patient Safety

- Falls
- Dementia
- HCAI
- VTE
- Pressure Ulcers
- Discharge summaries
- Severe and above safety patient incidents

Effectiveness

- Mortality
- Stroke pathways
- Avoidable re-admissions
- Clinical quality (ED)
- PROMS

Patient and staff experience

- Nutrition and hydration
- End of life care
- Learning disabilities
- Responsiveness to patient's personal needs

- % staff who would recommend the Trust

We will focus our attention on a number of priority areas to deliver year-on-year improvements in the quality of patient care and safety.

We are developing key performance improvement objectives for all priorities in the quality strategy, supported by clear indicators to enable their effectiveness to be measured and reported on.

Risks in the delivery of this strategy will be captured in the Board Assurance Framework.

Sources of assurance will continue to be enhanced, to enable the Quality and Healthcare Governance Committee and the Board to be assured of both the reliability of the processes and systems and, more importantly, their effectiveness in realising outcomes targeted within the Quality Strategy. These sources of assurance will be combined to ensure that assurance is timely and, at the same time, sufficiently robust and evidence-based.

3.2 Principal risks to quality

The Trust's principal risk to quality is in achieving our thresholds for healthcare acquired infection. During 2012/13, we achieved our threshold for MRSA cases, but did not meet our C diff threshold. Both thresholds are even more challenging in 2013/14, and the Board is determined to pursue all possible measures to meet its requirements.

Whilst achieving nationally prescribed A&E performance in each quarter during 2012/13, unprecedented increases in activity, compounded by structural and organisational changes in the local health economy, will culminate in significant risk in 2013/14.

A number of clinical services are currently reliant on agency medical staff or equivalent. While plans are being developed to remedy this there is clearly potential risk to the quality of these services which are being kept under close scrutiny by the medical director.

3.3 Use of external assurance (including internal audit)

Data Assurance- In order to ensure the data being used to support performance monitoring and decision support is of the highest quality alongside the PBR clinical coding audit and Deloitte data testing programmes a rolling programme of independent internal audit is undertaken every year. Results are reported into the Information Quality Assurance group (which acts on behalf of the Board with delegated authority from the P&W Committee) and the Audit Committee. During 2012/13 this programme included Quality Account Nutrition, Bed Boarders, Falls, MRSA screening (re-audit), Community Information dataset and spot checking cycles for previous audit areas. A similar programme, focussed on quality measures and the inclusion of a data quality kite marking system to support reporting to the Board is to be implemented during 2013/14 and a data quality strategy is to be developed to support the quality strategy.

Quality Assurance – the Trust has maintained NHSLA level one for both General and Maternity services during 2012/13 and is working towards level 2 during 2013/14

Audits carried out by the Commissioning body - during 2012/13 these have included a review of patient satisfaction in ED departments, specific value based commissioning audits, an audit supporting quality in relation to discharge letters and readmissions. Programmes of work as required to support delivery of commissioning for quality and innovation goals have also been undertaken as joint audits. The results and completed remedial actions are all fed back to the joint Quality Review Group or

supporting sub groups.

Audits to review quality – An active clinical audit programme has been undertaken in relation to national audits, confidential enquires, national clinical audits and local clinical audits and are embedded into our quality account. Nice guidance and standards and well as areas of local clinical interest. A similar programme will be undertaken throughout 2013/14.

Benchmarking – as well as supporting the national audit programmes we have participated in a benchmarking programme relating to Radiology services and we are a member of the NHS benchmarking network. The Trust is an active member of NHS Quest and is supported by North East quality observatory service (NEQOS), particularly in reference to benchmarking for mortality and this will continue into 2013/14.

Care quality commission – site visits and reviews - During 2012/13 there have been four unannounced site visits (July 2012 Weardale hospital, October 2012 University hospital of North Durham (UHND) and Bishop Auckland Hospital and November 2012 Darlington Memorial Hospital). All results have been favourable, with only one minor compliance issue raised for UHND, which has now been revisited resulting in full compliance against the relevant standard being awarded.

In addition there has been an announced visit in relation to mental health act during March 2013 which has given us positive results overall, with an agreed action plan being taken forward during 2013/14.

4.0 Clinical Strategy

The Trust's clinical strategy has been developed with the engagement of internal and external stakeholders, and further engagement events will take place in 2013/14 as we develop detailed actions, working with our commissioners.

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

All the way – means:

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

In order to deliver:

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

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

The Board has overseen the development of an overarching five year quality strategy, which includes priorities for improvement, as outlined above.

The Trust's annual quality account is already formatted under these key headings and the standards within have been consulted on widely with patients public and other key stakeholders including OSCs, LINKs and local authorities.

Three core areas of our business underpin our vision of patient centred care:-

- Health and wellbeing - Making every patient contact count as an opportunity to improve their health
- Care closer to home - Streamlining services to provide effective and timely pathways of care by integrating hospital and community services
- Quality hospital care – with Darlington Memorial and the University Hospital of North Durham as major providers of acute and emergency care, and Bishop Auckland as a centre for planned care.

We are developing new and innovative ways of providing services, in particular focusing on:

- Unscheduled care - becoming a truly 24 hour, seven day service in hospital and community, with senior decision makers on the frontline around the clock, supported by excellent diagnostics
- Integration and care closer to home - supporting people with long term conditions to manage their own conditions, better support at home for frail elderly and vulnerable people and people with dementia to reduce avoidable admission
- Sustaining and developing women and children's services on two sites – meeting the needs and desires of our local communities to have locally based consultant and midwife led care, and emergency children's care
- Developing specialist services/centres of excellence - to provide the best care to the highest required standards, and keep services within County Durham and Darlington
- Health and wellbeing - An increased focus on prevention as well as treatment to encourage lifestyle choices which are not detrimental to good health.

During 2013/14, we expect to focus particularly on unscheduled care, building on work in 2012/13. We are seeing an increase in frail elderly patients with multiple co-morbidities and including dementia. This will involve transformational change of services within hospital, and also further development of alternatives to hospital admission, streamlining the services that have been developed since integration of hospital and community services in 2011.

4.1 Clinical Workforce Strategy

One of the Trusts 4 strategic touchstones is our ambition to be the "best employer".

During 2012/13 we have been fine tuning our approach to workforce monitoring via triangulation of quality, workforce reductions and/or developments and financial planning.

2013/14 Care Group and Corporate business plans and Corporate plans have integral workforce plans, all of which have been developed in response to their identified key service requirements in line with the clinical strategy objectives.

2013 will see the development and implementation of a Quality Strategy with workforce at its heart as we aim to deliver high quality, safe and reliable services.

In 2013/14 our strategy is centred on:

- Appointing into existing Nursing Vacancies and other mission critical roles, in particular so that ward sisters and managers take on a more supervisory role
- Reducing usage and reliance on Agency Medical and Nursing staff
- Increasing the focus on Health and Wellbeing of the Workforce
- Delivering reductions in workforce, in line with business plans
- Responding to the reduction in junior doctor numbers particularly in Medical Specialties
- Improving staff engagement and delivering other actions to deliver our “best employer” ambitions
- Delivering our wider HR and OD plan, focused around improved clinical engagement and great line management

We will also take account of our approach to leadership and talent management, specifically the development of succession plans for critical leadership roles.

Clinical workforce challenges and pressures include:

- Shortages in medical & nursing workforce, both current vacancies and anticipated changes. Pressures include recruitment of Health Visitors, Consultant Medical staff in areas such as Palliative Care and Radiology and nursing staff generally
- The impact of the anticipated reduction in junior medical staff on the nursing workforce as experienced nurses develop extended skills to meet the service gap
- Recruiting and retaining high quality staff in an ever increasing competitive environment
- Improving the recruitment process including marketing, turnaround times and a new approach to recruiting senior medical staff
- The cultural shift required to move some services to 7 day working (areas such as inpatient services, Pharmacy, Cardio and Diabetes in 2013/14). This will necessitate changes in staffing numbers, working practices and transformation of the way in which services are delivered across the extended working week.
- Changes in the pattern of service delivery, including more consultant delivered care in unscheduled care
- Building on our improved staff engagement scores in the 2012 Staff Survey, which showed a positive improvement in how our staff feel and whether they would recommend us as a place to work and or receive care.
- Reward and Recognition – our approach, will build on current good practice (salary sacrifice and staff benefits portfolio, Annual Awards Ceremony, staff development, leadership and management development) as evidence tells us this is a major factor in recruiting, retaining and motivating staff.
- Implications of a large scale, complex service transformation/change programme which will lead to workforce efficiencies.
- Retaining staff during significant periods of uncertainty to maintain systems whilst new systems are implemented – as a result of service change and transformation, and driven by other issues such as services subject to potential contract renegotiation.
- Delivering the requirements of the Francis, in particular as they effect clinical workforce

The Trust undertakes workforce benchmarking frequently throughout the year as a matter of routine, and benchmarks and audits workforce metrics to ensure efficiencies are realised and quality maintained.

Three recent examples (all of which are/will be reflected in Care Group Plans) are:

- External benchmarking to support delivery of cost improvement in 2013/14
- An internal Nurse Staffing Review led by the Executive Director of Nursing (in anticipation of the Francis Report recommendations) which will lead to a planned recruitment campaign during the next 12 months
- Use of the Workforce Assurance Tool in response to Mid Staffs and the Francis Report, with a report being considered by the Executive Team in July 2013.

4.2 Clinical Sustainability

The Trust has a history of addressing difficult challenges around the clinical sustainability of services.

In 2009 we consolidated acute admissions and accident and emergency on two sites, and in 2011 centralised acute stroke admissions on one site to meet national best practice guidance. We now have the second best door to needle performance nationally.

The Trust has committed in its clinical strategy to maintaining acute services on two sites.

The outgoing PCT commissioner led the acute legacy project to identify where services may not meet Royal College or other guidance going forward. This work is now being taken forward by CCGs.

This work highlighted pressures particularly in women's and children's services. The Trust has developed its own plans to address these pressures, and we believe we can meet the women's and children's care emerging over the next few years.

We are also working with the CCG in North Yorkshire on plans for more women and children to be cared for at Darlington Memorial Hospital, following consultation on the future of services currently provided at the Friarage Hospital, Northallerton, and with the trust which manages the service, South Tees FT, believe are unsustainable.

There are areas of service where the Trust is working hard to recruit further consultant staff. This includes palliative care - a key part of our plans for improving end of life care, and where the Trust has recently successfully appointed a further consultant.

The Trust also needs to strengthen its diagnostic services to support 24 hour 7 day care. This is a priority area for 2013/14.

There is also pressure with middle grade rotas across a number of medical specialities. Speciality Trainee numbers in general medicine particularly are reducing and there are likely to be vacancies for the August 2013 intake. Alternative solutions to the challenges this brings are being sought and the Trust is on a transitional path to a more consultant led workforce.

5.0 Productivity & Efficiency

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

- NHS Better Health, Better Value indicators
- Audit Commission PbR Benchmarking Tool

- Reference Cost data
- CHKS
- Dr Foster
- NHS Comparators

In addition, the trust engaged an external company to undertake a significant diagnostic review of its operations to further explore potential opportunities compared to a comparable peer group of trusts.

Internal cost and data sources provides information on a further group of efficiency opportunity, and so provides overall assurance that the requisite level of productivity and efficiency gain can be made over the 3 year time horizon of the plan. Measures incorporated into years 2 and 3 of the plan are indicative at this stage, based on the overall opportunity available, and reflect the requirement to further develop and quality impact assess the programme.

The overall potential, over and above existing plans, is seen as:

Opportunity	Potential Productivity Gain expressed in £m
Reducing length of stay	£8.1m
Managing First to Follow Outpatient attendances	£6.9m
Emergency Readmissions	£5.4m
Outpatient DNA	£1.9m
Pre-Procedure Bed Days	£1.8m
Increasing Day Case rates	£0.5m
Integrating care pathways	£10m
Procurement	£3m
Estates rationalisation	£2m
CNST – level 3	£2m
Theatre Utilisation	£2m
Outpatient Utilisation	£2m
Agency – Premium costs	£5m
Improved scheduling of elective cases	£0.5m
Travel costs	£0.5m
Administration review	£1m
Staff Benefit schemes	£0.2m
Total	£52.8

6.0 CIP governance

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

plan, whilst being able to deliver overall financial results.

Historically, the prime cause of deviation from original CIP plans has been overperformance on acute activity compared to activity and income plans. This has thwarted those cost improvement plans which were based on reducing capacity and cost, as the capacity has had to remain in situ to deal with the overperformance. However, the trust has generally been able to recover the lost CIP by replacement with undertaking additional activity at marginal rates.

In recognition of the tough agenda with regards to CIP delivery going forward, the trust is engaging external support to help identify opportunities for further CIPs whilst also looking to improve the quality of services. The diagnostic work is also aiming to identify transformational schemes which aim to improve patient experience and outcomes as well as being more efficient.

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

- Care Group presentation to board periodically to review plans and gain assurance on delivery
- Executive and Clinical Leadership Committee (ECL), chaired by the Chief Executive, reviews progress on CIP planning and delivery each month on behalf of the Trust Board. This ensures that clinical leaders are actively engaged in CIP planning and delivery.
- The finance report to the Trust Board contains (each month) information on delivery against CIPs and forecast positions, both in year and on a recurrent basis.
- Monthly performance management reviews with Care Groups explores progress, risk and mitigation.
- Escalation processes exist where risk is not being mitigated.
- CIPs are assessed for their impact on quality (see later section)
- ACOOs and Corporate Directors are directly accountable to the Chief Executive for CIP delivery.

6.1 CIP Profile

The Trust's top 5 CIP schemes are summarised in appendix 2, and together with other plans are expected to deliver £15.8m in 2013/14, with a full year effect of £17.2m. Delivery against £3.5m of these schemes is currently rated high risk.

Care Group and Corporate Departments have other plans for cost control and mitigation, which they believe limits the overall level of risk of failing to deliver balanced budgets to £7.4m. The trust board has agreed budgets for 2013/14 which includes sufficient uncommitted reserves to cover this risk, and give it assurance that the overall financial plan will be achieved.

In terms of transformational schemes, the Trust will be working with its local commissioners to:

- Integrate Urgent Care and Emergency Department services
- Redesign front of house adult and paediatric unscheduled care services to increase the level of ambulatory care provided
- Review its readmission and other admission prevention schemes, with a view to integrating those which have the greatest impact.
- Review long term condition pathways to provide increased support for independent living to

reduce the need for acute interventions.

6.2 CIP enablers

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

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

ECL is also playing a key role in the identification and appointment of external support to help the Trust deliver its cost reductions over the next three years.

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

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

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

The capital programme will support:

- The integration of urgent care and the emergency department
- Redevelopment of theatres at DMH to facilitate improved productivity and the move to 24/7 working
- More efficient deployment of staff, and use of bank, to reduce agency and other premium costs via nurse and medical rostering systems.
- The aim to secure vascular specialist status through the development of a specialist vascular theatre.
- The digitisation of clinical documentation to improve the efficiency, and reduce the clinical risk, associated with the patient/clinician interface and record keeping
- Improved access to patient systems and information through a single clinical ITportal

6.3 Quality Impact of CIPs

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

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

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

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

The Trust will be going through the QIA process with our CCG commissioners in a "star chamber" – providing them with assurance of the process we have deployed.

Director of Nursing is developing a Quality Strategy under the headings of Safety, Effectiveness and Experience and supported by an Integrated Governance reporting and accountability process which will pick up post CIP implementation issues.

7.0 An assessment of the Trust's current financial position.

The Trust has delivered a strong financial performance in 2012/13, and has significantly exceeded its financial plan for that year. This has enabled the trust to agree a forward capital programme to invest c£76m in capital schemes from 2013 to 2017 from resources generated from its historic and planned revenue position. This will ensure that the trust's capital assets support the strategic development of its services as well as enable improvements in productivity, patient experience and outcomes.

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

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

7.2 Capital Investments:

2013/14 sees the development of two major estates projects which both address the backlog maintenance issue and contributes to the Trust's strategic plan.

The Surgical Theatre and Enhanced Mortuary Project, for which the Business Case is currently in production, will deliver additional theatre capacity necessary to meet the growing demand on the service. It will also address some of the greatest estates risks around the replacement of the major engineering plant for the operating theatres

The Learning Centre at UHND, a £2m development which will support the Trust's objective to be the best employer by providing modern state of the art learning facilities for its staff. It will also replace some of the poorest Trust accommodation. The project will also facilitate the provision of an additional 75 car

parking spaces on the UHND site.

The following schemes also form part of this year's capital programme:-

- Clinical Research Unit – a £285k investment at DMH which will co-locate a clinical trial outpatient facility with research nurses, research fellows and the R&D office to provide a dedicated environment for commercial and non-commercial clinical trials. This will provide the only dedicated clinical trials unit in the North East outside of Newcastle
- Decant Ward at DMH – £219k is being spent to upgrade an existing and currently empty ward (Ward 51) to provide spare capacity for winter pressures but also a much needed decant facility which will allow the estates department to undertake major upgrades of other wards.
- A £260k installation of additional washbasins in support of the HCAI action plan and to allow better access to handwash facilities for staff and visitors. A further £180k has been allocated to provide doors to existing open bay areas at UHND to improve HCAI resilience

7.3 Service Developments:

The Trust has identified a transformation programme for 2013/14 based around its clinical strategy objectives.

UNSCHEDULED CARE

Front of House

Back of House / Diagnostics

Discharge Process

Matching capacity with demand 24/7

Bed Bureau / Real Time Bed Management

WOMEN'S & CHILDREN'S

Obstetrics & Gynaecology 7 Pledges programme

Paediatrics Programme

INTEGRATION

Care Planning for the Frail Elderly

Contact / Co-ordination Centre

Long Term Conditions Collaborative

CENTRES OF EXCELLENCE

Theatre Expansion & Service Redesign

7.4 Key risks to achieving the financial strategy and mitigations.

The key financial risks facing the trust are:

- Increasingly disparate nature of commissioning organisations, and the lack of a coherent commissioning strategy
- Ongoing efficiency requirement running at 4.6% to 4.8% per annum without adversely

affecting the quality of services is becoming increasingly challenging.

- Readmissions business rule, and lack of schemes which have a real impact on reducing readmission numbers, and also lead to reducing capacity and cost.
- Increasing levels of unscheduled care demand putting pressure on resources working constantly at or near capacity.

The main mitigations include:

- Provision of contingency reserves and risk reserves to withstand financial pressure.
- Relentless focus on efficiency, alongside improvements in quality, to drive out waste and cost and increase productivity.
- Focus on quality of services to increase market share and demand and attract new income sources
- Fundamental reviews of service provision to generate transformational schemes.
- Lever efficiency improvement through capital investment.
- Improved service line reporting, allowing the Trust to clearly demonstrate where it is unable to deliver services economically, and thereby take action as appropriate.

8.0 Involving the Governors

The Governors have been represented at the meetings of the Trust's Strategic Planning Group, where the Annual Plan has been developed.

Governors have also been amongst the stakeholders invited to and involved in a series of clinical strategy events held throughout 2012/13.

The Annual Plan, in draft, has also been reviewed by the Governors' Strategy Committee on 15 April and 21 May 2012, where it received the Committee's support.

The Annual Plan was then approved by the full Council of Governors on 22 May 2013.